



CANS

NEWSLETTER

California Association of Neurological Surgeons

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President's Message

To my fellow Neurosurgeons in the State of California

Marc Vanefsky, M.D.

We wade ever deeper into uncertain times. As of January 6, 2011 John Boehner has been sworn in as Speaker of the House. One of the first things he has pledged to do is repeal the *Affordable Health Care Act* enacted by the 110th Congress. He has also pledged to be more fiscally responsible while exempting the repeal from being offset by additional cuts elsewhere. He has also chosen to ignore the Congressional Budget Office estimates that a repeal of the Affordable Healthcare Law would result in an additional deficit of \$136-230 Billion over ten years. I think we're talking some real dollars here.

Where do we go from here? Well it seems unlikely that repeal by the house would be able to get past either the Senate, or President Obama's Veto. But it also seems likely that Healthcare reform 2010 is not the finished product. I am a firm believer that Healthcare reform is absolutely necessary to be able to continue to provide high quality care to all Americans. I also believe that we as an organization need to make sure that any changes made to the Healthcare act work for our patients, as well as our providers. Organized Neurosurgery has a responsibility to continue to influence healthcare legislation to make sure that we can continue to provide the highest quality care to our patients. Dragging our heels and demanding to go back to 1975 is not an option.

Okay, so we have talked about things not to do. How can we help fix this? I could start by talking about direct to consumer advertising done by big Pharma, but that would be too easy. So let's consider medical records. Follow me on this. I do my banking with a local California bank. I've noticed that I can leave my house in the morning and get on a plane and go to another state, or even another country. I can take my ATM card out of my wallet and put it in an automated teller machine of another bank and withdraw funds. My bank immediately knows this transaction has taken place and my account reflects the withdrawal. Now this transaction occurs in complete privacy.

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***"It is no longer  
enough to say I  
am just the  
neurosurgeon."***  
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Nobody else has access to my information except for my bank and me, even if I chose to look up my balance online. It doesn't matter what bank or ATM machine I use. It doesn't matter what time of day. It doesn't matter what state or even what country I'm in. So

I ask why is the banking industry so much ahead of us when it comes to sharing and containing vital information about our financial health as compared to our actual health? Why doesn't your primary care doctor know that when you went to visit your kids at college back in Ithaca and you slipped on the ice and landed in the local ER to stitch up your chin that your blood pressure was 170/108? Or that when they checked your hemoglobin A1c it showed your diabetes was well controlled.

Okay, so now you're asking why as a neurosurgeon am I worrying about this? Simply because we need to make sure our patients are getting the best healthcare the world has to offer. Period. It is no longer enough to say I am just the neurosurgeon. We need to look at the whole healthcare delivery system and make sure it works for our patients and our providers. Historic change is upon us. It is up to us to make sure it is change that works. ❖

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Definition for the month

Compromise: The art of dividing a cake in such a way that everybody believes he got the biggest piece.

CANS Annual Meeting a Keeper

Randall W. Smith, M.D., Editor

The recently concluded annual meeting of CANS held in San Francisco was worth attending and 72 docs took the opportunity. Sixteen of the attendees were residents, reflecting the push by President Ken Ott to include residents in the annual meeting. The residents (all of whom were offered a complimentary banquet dinner) came from all the California training programs except UCLA and Cedars-Sinai with the most from UCSF as might be expected. Seven of the residents were provided a complimentary hotel stay and **NeuroCare Electrodiagnostics, Zimmer** and **Weatherby** (a locum tenens company) were kind enough to cover the banquet and hotel costs for 4 of the overnights. CANS covered the other three. A total of 27 exhibitors added interest and contributed to the fiscal success of the meeting.

The rollicking excitement of the annual business meeting was marked by the induction of three new members (**Kurtis Auguste** and **Edward Chang** from San Francisco and **Joseph Chen** from South Pasadena) bringing the total new members for 2010 to ten and the election of the Nominating Committee's slate of officers and Board members for 2011. Noteworthy were three new Board members (**Patrick Rhoten, Langston Holly** and **Ken Blumenfeld**), a new President (**Marc Vanefsky**) and President-Elect (**Austin R.T. Colohan**), new Vice-Presidents (**Ted Kaczmar** and **Michael Robbins**) and a new Treasurer (**Phillip Kissel**).

Since 323 CANS members chose not to attend, what follows is this writer's précis of what transpired.

Anne McLeod from the California Hospital Association presented the anticipated impact from ObamaCare which will be that by 2014, one in three Californians will be on Medi-Cal with the Feds picking up the tab for the millions of expected new additions, at least until 2017. She noted that many neurosurgeons do not accept Medi-Cal patients but upon joining an Accountable Care Organization (ACO), caring for the Medi-Cal patient will be mandatory. California hospitals provided \$12 billion in uncompensated care in 2009.

John Jenrette, M.D., CEO of Sharp Community Medical Group, a 750 member IPA in San Diego, noted that IPAs like his and others in California who already have risk based contracts with insurance companies, are very well positioned to meet the qualifications for an ACO and if partnering with a hospital, be in a good position to negotiate on behalf of their members so they get a fair share in any resulting savings. He also documented the requirements (not yet totally finalized by the Feds) of an ACO, a mind-numbing array beyond the comprehension of this writer or the space available in this newsletter.

Gary Spradling, Esq., one of the principal attorneys at Duckor Spradling Metzger & Wynne, went through the litany of legal hurdles that ACOs and physician/hospital arrangements including foundation models need to navigate. He was clear that when docs in whatever kind of a small group arrangement embark on joining an ACO or other physician/hospital arrangements, they better have their own legal representation from attorneys well versed in healthcare industry business and regulatory matters. His best advice when choosing such representation is to take the recommendation of your own personal or corporate/practice attorney as to who in your locale is well known for providing this special kind of legal help.

On the locum tenens front, **Weatherby Locums** made a three-man presentation on how to get into this arena and how rewarding it can be. This company has more than 100 neurosurgeons in their stable, most of whom end up covering trauma centers and EDs. Their advice was to enter this field when you are still in practice of some sort and not to expect to be a desirable commodity if you are some years after retirement, particularly if a septuagenarian.

Angela Carlson of Alliance Surgical gave an informative down and dirty talk on how to form a true and legal distributorship for surgical implants. She was clear to point out the danger of having a phantom distributorship with one company who pretends to supply you with stuff but really just delivers it to the OR as usual and lets you bill for it, then when you get paid accept less than that for the equipment. Her company helps a group of surgeons establish a true LLC that has a Board of Directors, appropriate corporate insurance, real paid-for-in-advance inventory and a profit structure where the doc doesn't get any more or less corporate profit if he uses the implants the corporation carries or not. She noted an example of a group of 3 busy spine surgeons and a joint replacement orthoped who coughed up 100K apiece to form such a corporation who in their first year ended up saving the hospitals who chose to use their distributorship \$1 million and each doc pocketed 200K of corporate profit.

Matthew Cutler of Select Healthcare Solutions described how his company helps docs set up predominantly outpatient radiotherapy and diagnostic centers and manages them, the profits from which are shared between their company, who provides most of the financing, and the investor docs. They would appear to do a rather comprehensive

community needs evaluation and investor docs will have to be the right number and specialty to make this fly. He didn't have much to say about gain sharing with hospitals and he noted that building a special care hospital starting now is a dead issue because of Federal law.

Rosalie Hamilton of Expert Communications (expertcommunications.com) spoke to establishing and marketing yourself as an expert witness regarding which she arranges for the training you need to be a good witness and the advertising necessary to get used. She noted that if you are not in active practice, you can forget about pursuing this form of realizing additional income.

Bob Carter, M.D., Professor and Chairman of Neurosurgery at UCSD, delivered his take on how ObamaCare will affect academic neurosurgery. He feels it will likely result in less basic research and a lot more clinical/best practices studies and that Federal funding for residents will be limited to something like 5 years and 7 year programs will have to pay for a couple of years of training from other sources, no small task for the programs.

The day ended with a pleasant evening cocktail hour and a nice banquet (hosted bar; good food and wine) at which **Gerald Silverberg, M.D.** received the 2011 Byron Cone Pevehouse Award for his many years of research and service to California and specifically to his long tenure on the faculty of Stanford where he was a good supporter of CANS. He lamented the loss to all neurosurgery when Cone died in 2010. After dessert, an unguarded live mike was commandeered by a few attendees who lightly roasted Jerry and Ken Ott, outgoing CANS President. All in all, a very good day. ❖

Sobering Statistics

Deborah Henry, M.D., Associate Editor

The January *Archives of Surgery* (vol. 146, No. 1, January 2011) reports startling statistics on the prevalence of suicidal ideation among surgeons. In 2008, an anonymous questionnaire was sent to members of the American College of Surgeons. Of the 32% responding, 6.3% reported having thoughts of suicide in the previous 12 months (501 /7905). Suicidal ideation was significantly associated with the phases of burnout, including emotional exhaustion, depersonalization and low personal accomplishment, and with depression. Surgeons over age 45 were 1 1/2 to 3 times more likely to experience suicidal ideation than their cohorts in the general population. Approximately 1/4 sought psychiatric or psychological help. Nearly two-thirds did not seek professional help because of concerns over medical licensure.

In the general population, the Center for Disease Control (CDC), states that men make up almost 80% of completed suicides. Suicide is the second leading cause of death in 25-34 year olds. It is the first cause of death in those 15-24, accounting for 12.2% of deaths. Also in this young age group, there are 100-200 attempts for every completed suicide. In those over 65, there are four suicide attempts for each successful one.

A meta-analysis in *The American Journal of Psychiatry* (Am J Psychiatry 161:2295-2302, December 2004) looked at the suicide rate of doctors versus the general population. The study concluded that male doctors had an aggregate suicide rate ratio of 1.47 compared to the general population while in female doctors, the rate escalates to 2.27.

The Medical Board of California web site states that between 13-16% of practicing physicians from 2007-2010 underwent some type of disciplinary procedure each year due to chemical dependency or mental illness. The rate of suicide in physicians in California alone is not clear.

Help is available. The Physician and Dentist Confidential Line is in their 30th year of providing help to California physicians and their families and more recently dentists as well. According to the Chairman of the committee Dr. Leland Whitson of Redondo Beach, the confidential line receives around a 100 calls a year requesting help usually for chemical dependency, but also burnout depression and anger management. One simply needs to call the confidential line and an answering service will take the individual's name and refer them to the doctor on call. The on-call doctor may be a psychiatrist and/or a recovered physician. The goal of the committee is to help impaired physicians and dentists before it becomes a medical board issue. The service is completely free and confidential. In Northern California, call 650-756-7787 and in Southern California the number is 213-383-2691. ❖

Tidbits from the Editors

Update on EMTALA from the AMA

The CMS is again tackling the *Emergency Medical Treatment and Labor Act (EMTALA)*. The CMS announced an *Advance Notice of Proposed Rulemaking* to address whether EMTALA obligations should end when the patient is stabilized rather than ending at the time of admission as it does presently. Specifically, the CMS is requesting commentary on whether EMTALA should cover inpatients who require specialized care at a higher-level facility, but were admitted to the first hospital prior to becoming unstable. Comments can be directed to the CMS before 5pm on February 22 at <http://edocket.access.gpo.gov/2010pdf/2010-32267.pdf>. ❖

EHR Program intense and informative

For those who chose to stay until Sunday at the annual meeting, and 40 registered docs and their office personnel did, CANS presented a complimentary session on electronic health records (EHR). After a delightful buffet breakfast, an advertised 3-hour program was presented in an intense one hour by **Peter Longo**, the western region VP of **Allscripts**, and **Lorraine Ewing** of **Prime Clinical Systems**, both nationwide EHR companies. The goal was to educate the audience on how to get into and meet the requirements of the Federal meaningful use of electronic records program which can provide at least \$44,000 over 5 years to each doc that plays ball. The take-home messages:

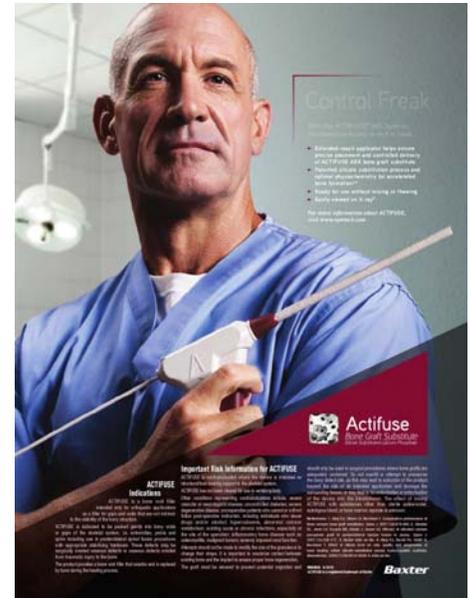
1. You start out by registering at a Federal online site that won't be created until around April 1st. If you are to get your system up and running in 2011, you have to register this year although you can begin your sojourn in 2012 and not register until then and still qualify for the full 44K. If you don't start until 2013, you lose 5K and if not until 2014 you lose 20K. Registration has to be completed before you do your initial 3 month official use period.
2. In the first two years, you only have to use the EHR system for three months with most docs choosing the October through December epoch. Your system should be up and running by at least July so problems and bugs can be ironed out prior to the October-December now-it-really-counts timeframe.
3. You need to choose an EHR vendor from amongst the dozens that have been blessed by the Feds. Points to consider: Company with at least a 10 year history of operation; use a CA company or a national one with a fairly local office; be alert to what ongoing support will cost not just the start-up and maintenance costs; compatibility issues with your local labs/ pharmacies/hospitals; company willing, within limits, to make their system fit your practice rather than vice versa; and a guarantee. The system will need to be able to document that you have followed 15 measures of EHR use (10 mandatory, 5 chosen by you from a list of 10 others).
4. You can get \$63,000 in support if 30% of all your patient encounters in the 3 month reporting period are MediCal (only 20% if a pediatric only neurosurgeon) whereas for the 44K there is no minimum patient volume required but you would have to bill Medicare at least 24K the first year to get the full first year incentive payment of 18K.
5. You can't get incentive money for the current stand alone Medicare bonus for eprescribing and the meaningful use of EHR at the same time as eprescribing is considered part of any EHR. If you are doing the MediCal approach, you can get both.
6. If you are also being helped in getting an EHR by a hospital or large practice group, you can accept up to 29K from another source in your first year and still qualify for the full first year Federal incentive of 18K. In the following 4 years of receiving Federal incentive payments, you can only get \$ 10,610/year from other sources.
7. In the first two years of using your system for a minimum of three months, establishing that you have actually done so will be by simple attestation that during the three months you are using the system for 50% or more of your patient encounters as well as identifying your vendor. After that, you will need to generate significant annual reports that can only be generated if you have a really up and running system.
8. If you already have an up and running system, so long as it is with one of the blessed companies and meets the meaningful use criteria, you still get the incentive money.
9. Not having a qualified EHR program in place by 2015 will cost you 1% of your Medicare billings with an additional 1% added for 2016 and 2017. After then, it will probably get increasingly nasty. ❖

Brain Waves

Deborah Henry, M.D., Associate Editor

This month's tragedy in Arizona brings up two well heated discussions - that of mental illness treatment and secondly, gun or at least, semiautomatic weapon control. Mental illness in our country remains poorly studied, poorly controlled, and poorly tolerated. Unless you are a celebrity with mental illness- a la Lindsay Lohan, it is difficult to obtain the treatment you need. I found this out early in my career while taking psychiatry emergency room call at Ben Taub Hospital. On Friday nights, the bus from Austin's state mental institution would allegedly drop off at the Houston bus station the mentally ill whose time (read "money") had run out. The scouting police scooped up those lingering on the street corners and towed them into the Psych emergency room only to start the cycle again. I was amazed and almost enamored with how crazy you could be. And these people were flipping my hamburgers at the local burger joint! But on medication, they could function fairly normally.

The LA Times (Monday, January 24, 2011-Health Section) published a wonderful series of articles on the difference in rehabilitative care that those with gunshot wounds to the brain and insurance (e.g. Gabrielle Giffords) versus those with Medi-cal or no insurance (e.g. Danny Rodriguez). Nicely, the articles point out that their neurosurgical care remains relatively equal. Danny Rodriguez, shot in the head while in the back seat of a car under attack by a gang, "was whisked to USC where his treatment was largely indistinguishable from that given Rep. Gabrielle Giffords." Both received a hemicraniectomy and ICU care. It is here, states the LA Times, where the care is likely to differ. Rodriguez had five weeks of inpatient care and has limited outpatient services. It is unknown yet the amount of rehabilitative services available to Giffords. As our healthcare economy is busting at the seams like the aged levees of New Orleans, lack of adequate brain injury rehabilitation for all is one more item on the plate. I guess this is a third tragedy. ❖



Perspectives in Neurosurgery: How Shall We Practice? (Part II)

John T. Bonner, M.D., F.A.C.S., Associate Editor

We just completed a very interesting and productive CANS Annual Meeting in San Francisco this January. It was especially interesting as to how we shall practice in the future. We heard and discussed potential practice possibilities: from the concept of we neurosurgeons controlling our practices completely in patient care delivery, to hospital system control. Other potential ways to practice include large groups of organized physicians, or participation in Accountable Care Organizations – either physician controlled, or as appears to be the trend, or hospital administration controlled. Another option is the Foundation Model, or perhaps physician and hospital system administration integration, which would include cooperation and equal participation, a concept that I believe is not very likely.

The practice options also extend to complete physician employment, quite prominent in many states. But if this were to occur in California, it would involve the loss of Business and Professional Code section 2400, the bar to the corporate practice of medicine. This important provision states that only physicians can practice medicine, not hospitals or other such systems. As we learned at our meeting, the California Hospital Association would like to see the corporate bar eliminated, a fact which we were already aware of.

It appears that the time has come for us to decide which master we are to serve. Ideally, in my opinion, we want to have the option, freely, to be able to direct patient care ourselves. The other extreme is for us to become employees of a hospital or another such system. We must remember that he or she who controls the finances of medicine also controls the delivery system and determines how medicine is to be practiced. We physicians have influence, if we desire to use it, in how the medical delivery system will evolve. Hopefully we can organize and use that influence in a manner that serves our patients properly, while also protecting our profession. ❖

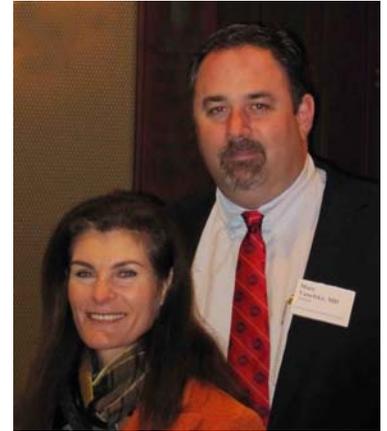
MEET YOUR OFFICERS

President: Marc Adam Vanefsky, M.D.

When Marc Vanefsky took the reins of the CANS Presidency at the annual meeting in San Francisco on January 15th, he was no stranger to administrative duties involving neurosurgeons. As Regional Chief for all Southern California Kaiser neurosurgery for the past 7 years, he was instrumental in establishing local institutional foci of specialty neurosurgical care. Prior to his leadership, each neurosurgical department at the 6 southern California locations were equal with no particular subspecialization talent. Now, Kaiser San Diego has particular talents in skull base surgery and patients from the five other locales come to San Diego for this specialized treatment. Likewise, Kaiser Anaheim, where Dr. Vanefsky works as one of the actively practicing docs there, specializes in cerebrovascular surgery and San Diego patients who need such treatment often journey to Anaheim. In caring for the neurosurgical needs of the more than 4 million Kaiser patients in the Southern region, Dr. Vanefsky says, "We can't be all things to all patients in all locations and our subspecialization talents allow us to be very good and very efficient dealing with certain specific problems in only one or two locations. The patients accept this talent concentration and accept the travel necessary with equanimity."

Dr. Vanefsky is a New Yorker born and bred, getting his B.S. from the University of Rochester, then breaking west to Chicago Medical School for his M.D. and finally out West to Stanford for his neurosurgical training. He seriously considered academics and private practice but chose Kaiser because of the simplicity of a practice without the overhead worries and chose the Anaheim location so he could be near the ocean where he can indulge in surfing, a malady he picked up at Stanford. His wife Helen and 14 year old daughter Angelika keep him company and grounded in a solid family life.

CANS, in which Marc has been active in Board of Directors and officer roles since 2003, isn't his only organized neurosurgery activity. He has been a California delegate to the AANS/CNS Council of State Neurosurgical Societies since 2005 and has served as President of the Society of Neurological Surgeons of Orange County. Dr. Vanefsky has led the increasing involvement of Kaiser neurosurgeons in CANS and is the first Kaiser neurosurgeon to become President. ❖



*CANS President
Marc Vanefsky and wife Helen*

Meetings of Interest for the next 12 months:

Southern Neurosurgical Society: Annual Meeting, February 23-27, 2011, Orlando, FL
 Neurosurgical Society of America: Annual Meeting, March 27-30, 2011, Island of Hawaii, HI
 CSNS Meeting, April 8-9, 2011, Denver, CO
 AANS: Annual Meeting, April 9-13, 2011, Denver, CO
 New England Neurosurgical Society: Annual Meeting, June 11-12, 2011, Chatham, MA
 Rocky Mountain NS Society: Annual Meeting, June 18-22, 2011, Taos, New Mexico
 CSNS Meeting, September 30-October 1, Washington, DC
 Congress of Neurological Surgeons: Annual Meeting, October 2-6, Washington, DC
 Western Neurosurgical Society: Annual Meeting, September 10-13, 2011, Kauai, HI
 North American Spine Society: Annual Meeting, November 1-5, 2011, Chicago, IL
 Cervical Spine Research Society: Annual Meeting, December 7-10, 2011, Scottsdale, AZ
CANS Annual Meeting: January 13-15, 2012, Anaheim, CA

Thank you to the companies that participated in the 2011 Annual Meeting:



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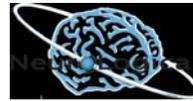
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Neurosurgical Position

✓ Any CANS member who is looking for a new associate/partner/PA/NP or who is looking for a position (all California neurosurgery residents are CANS members and get this newsletter) is free to submit a 150 word summary of a position available or of one's qualifications for a **two-month posting** in this newsletter. Submit your text to me by E-mail (rws-avopro@sbcglobal.net) or fax (858 683-2022). ❖

Comments can be sent to the editor, Randall W. Smith, M.D., at rws-avopro@sbcglobal.net or to the CANS office at janinetash@sbcglobal.net. Past newsletter issues are available on the CANS website at www.cans1.org.

ATTN Vendors: To place a newsletter ad, contact the executive office for complete price list and details.

The newsletter is a mix of fact, rumor and opinion. The facts are hopefully clearly stated. The rest is open to interpretation. The opinion is mine. R.S. The assistance of Janine Tash and Dr. Marc Vanefsky in the preparation of this newsletter is acknowledged and appreciated. If you do not wish to receive this newsletter in the future, please E-mail or fax Janine Tash janinetash@sbcglobal.net, (916-457-8202) with the word "unsubscribe" in the subject line.

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