Agenda Spine Section Executive Committee Meeting
September 17, 2007
Washington DC

Members Present:

Guests:

1. Secretary's report D. Resnick
    a) Minutes review and approval
    b) Updated Executive Grid and welcome new members
    c) Updated email addresses
    d) Informational items
        Letterhead
        Report to Parent Organizations
        Washington Committee activities

2. Treasurer's Report C. Wolfla

    a) Review and Approve Budget
    b) The section reimbursement form is included.

3. Committee Reports (see reports in agenda book)

a) Annual Meeting	J. Hurlbert/C. Kuntz/D. Resnick
b) CPT	J. Cheng
c) Exhibits	J. Knightly/P. Mumanneni
d) Future sites	I. Kalfas
e) World Spine	E. Benzel
f) Research and Awards	P. Gerszten
g) Education	M. Groff
h) Guidelines	P. Matz/M. Kaiser
i) Outcomes	M. Kaiser/Z. Ghogawala
j) Peripheral nerve TF	A. Moniker
k) Publications	M. Wang

l) Public Relations	M. Steinmetz
m) Membership	Z. Gokaslan/M. Wang
n) Washington Committee	T. Tippett
o) Fellowships	P. Mummaneni
p) PAC	S. Ondra
q) Web Site	J. Cheng
r) CME	E. Mendel
s) Nominating Committee	C. Branch
t) Rules and Regs	T. Choudhri
u) Newsletter	M. Groff
v) ASTIM	G. Trost
w) NREF	J. Guest
x) AANS PDP	M. Groff
y) Young neurosurgeons committee	H. Aryan

4. Old Business

<u>Updates Only</u>:

CME Issues	D. Resnick
Industry Relationships	C. Branch
Past President's Council	J. Alexander

<u>Issues to Discuss</u>

Liaisons	M. Rosner
Lumbar Fusion Task Force	D. Resnick
Orthopedic membership	G. Trost

New Business:

Bone and Joint Representative	M. Wang
ABNS Request for Comment	J. Alexander

AANS/CNS SECTION ON DISORDERS OF THE SPINE AND PERIPHERAL NERVES

A Section of the
American Association of Neurological Surgeons
and
Congress of Neurological Surgeons

Education and Innovation

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MEMBERS-AT-LARGE

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Gregory R. Trost, MD
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Minutes Spine section Executive Committee Meeting
April 16, 2007
Washington DC

Members Present:
Zo Ghogowala, Peter Gerszten, Ziya Gokoslan, Eric Woodard, Greg Trost, Mike Wang, Charles Branch, Praveen Mumanneni, Joseph Alexander, Jack Knightly, Chris Wolfla, Charles Kuntz, Dan Resnick, Steve Ondra, Mike Rosner, Ehud Mendel, Ian Kalfas, Robert Heary, Marjorie Wang, Kevin Foley, Eric Zager, Mike Steinmetz

Guests: Laurie Behnke, Paul McCormick

1. Secretary's report D. Resnick

a) Minutes reviewed and approved

c) Updated Executive Grid and welcome new members *Alexander and Heary on FDA- update CPT with Joe Cheng*

d) Updated email addresses

2. Treasurer's Report C. Wolfla

In agenda book, the section had a successful meeting and is financially sound. Annual meeting revenue largely offset the NREF contribution last year. The annual meeting was much more profitable due to increased registration and better management. The plan will be to transfer funds back into long term investments once the final numbers are in from the meeting.

The reimbursement form was presented.

3. Committee Reports

a) Annual Meeting J. Hurlbert/C. Kuntz

Dr. Kuntz presented the report. The meeting was a huge success with record medical attendance and a positive financial outlook.

Dr. McLaughlin's suggestion for an honorarium policy was discussed and voted upon. Reconciliation with the current reimbursement policy was discussed. The policy reflects the committee's wish that KEYNOTE and MERITORIOUS AWARD winners be given honorariums, other invited speakers would not. Other issues will be left to the discretion of the AMC/SPC. The revised policy was voted upon, passed, and will be included in the next agenda book.

John Hurlbert and Mark McLaughlin were officially recognized for their work as were Laurie Behnke and Regina Shupak were thanked for their hard work in making the meeting a success.

b) CPT R. Johnson

The re-formation of a CPT committee was discussed with Joe Cheng as chair. A motion was made, seconded, and passed to appoint Joe to take over immediately. An ad hoc committee will be formed under Joe's guidance.

c) Exhibits J. Knightly/P. Mumanneni

Dr. Knightly reported progress on developing a floor plan that would allow us to reach our exhibit revenue goals and have adequate space for display, posters, and special exhibits. Several options were proposed and Drs. Kightky and Mumanenni were tasked to move forward with plans to allow a satellite exhibit hall for ancillary and complementary exhibitors and slightly smaller tables.

d) Future sites I. Kalfas

Dr. Kalfas and Ms. Behnke will be visiting Orlando in May to explore sites with regards to feasibility of hosting our somewhat larger meeting.

e) World Spine E. Benzel

We are not part of the sponsorship of world spine. Apparently at one point the EC voted not to be part of this process. Dr. Resnick will look through minutes and find out if this is true. Dr. Trost will speak with Dr. Benzel about exploring section involvement in the organization- do they want us and what will be required.

f) Research and Awards P. Gerszten

Dr. Gerszten reported on the awards that were given. A request was made that the rules for the fellowships and awards include a proviso that awardees must attend the meeting in order to receive the award.

g) Education M. Groff

No report given.

h) Guidelines P. Matz/M. Kaiser

Report in agenda book.

i) Outcomes Z. Ghogawala

Report in agenda book. Dr. Ghogawala presented his proposal for a clinical trials fellowship in addition to the award previously approved. Suggestions were made to make sure that the wording reflects that only the lead author would receive an honorarium for attending the meeting. It was also suggested that 0-1 award per year be given. If several outstanding proposals come up, a consideration would be considered on

a case by case basis. Dr. Ondra suggested a close tie in with the CMS. Dr. Resnick asked Dr. Ghogawala to meet with Drs. Resnick, McCormick, and Ondra to coordinate with the NASS Lumbar fusion task force.

The award was seconded and passed.

A second motion was made to provide matching funds from the section up to 50 000 if the project was of sufficient magnitude to warrant extra funds. This passed as well.

j) Peripheral nerve TF — E. Zager

No new business.

k) Publications — M. Wang

Twenty three authors have agreed to provide manuscripts. We are awaiting submission to JNS Spine.

l) Public Relations — M. Steinmetz

Dr. Steinmetz suggested mechanisms for enhancing our public relations efforts. A formal report will be submitted. Dr. Steinmetz will interact with the PR committee of the AANS and try and dovetail our efforts with other PR efforts within neurosurgery and NASS.

m) Membership — Z. Gokaslan/M. Wang

No change since March meeting. Eblasts to residents were an effective recruiting tool.

n) Washington Committee — T. Tippett

Katie Orrico gave the report. Dr. Trost volunteered to serve as the disability reviewer for the AMA. Joe Cheng will help staff the coding and reimbursement committee. The MCAC effort was discussed. PR efforts related to SPORT were discussed. A conflict with NASS regarding the AMA CPT authorship committee. A desire for a “summit” meeting with NASS to avoid further miscommunications was expressed. The section expressed enthusiasm for establishing a formal mechanism for communication with NASS leadership. The continued work of section members on the PCPI and NQF was recognized.

o) Fellowships — P. Mummaneni

No report given.

p) PAC — S. Ondra

No new activity.

q) Web Site J. Cheng

The Friday session was put out as a podcast as were digital posters- all are password protected. Members were encouraged to view the sessions and provide feedback as to how the content can be used. The Spine Logo project will be moving forward. Mike Wang will be pursuing an online journal club.

r) CME E. Mendel

s) Nominating Committee C. Branch

No report.

t) Rules and Regs T. Choudhri

The document was approved with the proviso that the size of committees be determined by the committee chairs.

u) Newsletter M. Groff

v) ASTIM G. Trost

Ongoing reviews are occurring. Payment for travel will be covered.

w) NREF J. Guest

x) AANS PDP M. Groff

y) Young neurosurgeons committee H. Aryan

4. Old Business

New CME requirements D. Resnick

Dr. Resnick explained the new CME requirements and how the CNS is interpreting them. The spine section SPC was charged with using an eblast to poll the membership regarding potential issues for exploration at the meeting dealing with educational and clinical gaps.

Industry Relationships C. Branch

Dr. Branch presented a plan to allow for a more democratic process for platinum sponsorship that would not impact upon overall sponsorship revenue but would make the process more transparent. Packages would be offered with potential “seats” at prime

events as part of the package. The executive dinner would no longer be open to sponsorship.

Past President's Council J. Alexander

A senior advisory council was proposed to include past officers and contributors to the section to help with policy and public relations issues. The group would convene at the annual meeting and would have a dinner meeting as well. A meeting at the CNS would also be concerned. This will be an ad hoc committee for the present time.

New Business:

Liasions S. Ondra

Dr. Ondra suggested a series of liasons between the section and other spine societies to help with facilitating communication at the section level. (NASS, SRS, CSRS). Dr. Rosner will come back with a proposal for the fall meeting.

Orthopedic Membership in Section: G. Trost

In order to facilitate cross talk with our orthopedic colleagues the concept of allowing orthopedic surgeons to be members. Issues related to the need for permission from our parent organizations, bylaws changes, as well as issues related to governance were discussed. G. Trost was charged to work with Vince Traynelis to create a formal proposal.

Report for AANS Board of Directors and CNS Executive Committee
Joint Section on Disorders of the Spine and Peripheral Nerves
Fall, 2007
Joe Alexander
Daniel Resnick
Chris Wolfla

Minutes of the last Spine Section executive committee meeting are attached and reflect some of the new initiatives being considered by the spine section. Highlights include the development of a clinical outcomes research award and committee to administer that award, supported by a $50,000 grant from the Wallace foundation and matching funds (if necessary) from the section. A description of "The Lumbar Fusion Task Force" is also enclosed. The section has been working with NASS, AAOS, SRS, and the Washington Committee to respond to the charge brought by the CMS at the November 2006 MCAC meeting regarding the lack of outcomes data supporting lumbar fusion. The Lumbar Fusion task Force will serve as an advisory committee and as a clearinghouse for coordinating and publicizing outcomes research dealing with lumbar fusion performed by organized societies or other entities. A small financial contribution is sought from the section, as well as the parent organizations to help support administrative and epidemiological expertise in order to better advise constituent organizations and the CMS. The formation of a "Senior Advisory Council," comprised of ex-officers and other prominent spine surgeons who are no longer active in the day to day administration of the section was approved and this body will meet for the first time this year. The purpose of the council will be to provide advice and council to current officers and executans regarding the history, political background, and wisdom of proposed programs now and in the future. The section continues to contribute substantially to the Washington Committee in terms of work. A list of current section members who are actively involved in the Washington Committee is attached.

Spine Section and the Washington Committee:

NQF Episodes of Care Project and Back Pain Technical Advisory Panel: Joe Alexander
PCPI General Liaisons: Dan Resnick and Mike Kaiser
PCPI Spinal Stenosis Workgroup: Dan Resnick and Mike Kaiser
NCQA Back Pain Recognition Program: Charlie Branch, Dan Resnick and Chris Shaffrey
FDA Orthopaedic Device Panel: Paul McCormick
CMS Spine Fusion Group: Charlie Branch and Dan Resnick
Washington Committee: Steve Ondra
Coding and Reimbursement Committee: Greg Przybylski, Joe Cheng
Quality Improvement Workgroup: Dan Resnick, Vice Chair, Mike Kaiser, Bob Heary, Mark McLaughlin
Guidelines Committee: Dan Resnick, Tim Ryken
Drugs and Devices Committee: Rick Fessler chair
AMA Disability: Greg Trost

Executive Committee

Officers and Committee Chairs

JOINT SECTION ON DISORDERS OF THE SPINE & PERIPHERAL NERVES

September, 2007

Position	2004-05	2005-06	2006-07	2007-2008
Chair	G. Rodts	R. Heary	C. Branch	J. Alexander
Chair Elect	R. Heary	C. Branch	J. Alexander	D. Resnick
Immediate Past Chair	R. Haid	G. Rodts	R. Heary	C. Branch
Secretary	C. Branch	D.Resnick	D. Resnick	D. Resnick
Treasurer	T. Ryken	T. Ryken	C. Wolfla	C. Wolfla
Members at Large	D. Kim R. Apfelbaum J. Alexander	J. Alexander D. Kim K. Foley	D. Kim K. Foley G. Trost	K. Foley G. Trost C. Shaffrey
Ex-Officio Members	Z. Gokaslan	Z. Gokaslan	C. Shaffrey G. Rodts	Regis Haid Eric Woodard Pat Johnson
Annual Meeting Chair	C. Shaffrey	M. Groff	M. McLaughlin	J. Hurlbert
Scientific Program Chair	M. Groff	M. McLaughlin	J. Hurlbert	C. Kuntz
Exhibit Chair	M.McLaughlin	J. Knightley	J. Knightly	J. Knightly/P. Mumanneni
Future Sites	J. Alexander	J. Alexander	I. Kalfas	I. Kalfas
Education Committee Chair	J. Hurlbert	J. Hurlbert	C. Kuntz	M. Groff/P. Matz
CME Representative	T. Ryken	T. Ryken	E. Mendal	E. Mendel
Newsletter	L. Khoo	J. York	M. Groff	M. Groff
Rules and Regulations Chair	D. DiRisio	D. DiRisio	T. Choudhri	T. Choudhri
Nominating Committee Chair	R. Haid	R. Rodts	R. Heary	C. Branch
Research and Awards Committee Chair	J.Guest	C. Wolfla	P. Gerszten	P. Gerszten
Publications Committee Chair	C. Dickman	C. Dickman	M. Wang	Mike Wang
Web Site Committee Chair	C. Wolfla	C. Wolfla	C. Wolfla	Joe Cheng
Guidelines Committee Chair	D. Resnick	P. Matz	P. Matz	P. Matz M. Kaiser
Membership Committee	G. Trost	G. Trost	Z. Gokoslan	Z. Gokoslan, Marg. Wang
Outcomes Committee Chair	P. Gerszten	M. Kaiser T. Choudhri	M. Kaiser	M. Kaiser Z. Ghogawala
CPT Committee	W. Mitchell	W. Mitchell R. Johnson	R. Johnson	J. Cheng
Peripheral Nerve Task Force Chair	R. Midha	E. Zager	E. Zager	E. Zager
Washington/FDA	P. McCormick	R. Rodts	R. Heary	J. Alexander/R. Heary
Section Rep.,P.A.C.	S. Ondra	S. Ondra	S. Ondra	Z. Gokoslan

Public Relations	C. Kuntz T.Choudhri	C. Kuntz T. Choudhri	T. Choudhri	M. Steinmetz
Fellowships		J. Alexander	P. Mummaneni	P. Mummaneni
NREF Advisory Board			J. Guest	J. Guest
AANS PDP Representative			M. Groff	M. Groff
Young Neurosurgeons Representative				H. Aryan
FDA Disability				G. Trost
ASTIM				G. Trost
Inter- Society Liaison				S. Ondra/M. Rosner

JOINT SECTION ON DISORDERS OF THE SPINE & PERIPHERAL NERVES

Committee Membership
September, 2007

	2003-04	2004-05	2005-06	2006-07	2007-08
Nominating Committee Mem	R.Fessler	J. Campbell	V. Traynelis	R. Apfelbaum	R. Midha
	J.Campbell	V. Traynelis	R. Apfelbaum	R. Midha	G. Trost
	V.Traynelis	R. Apfelbaum	R. Midha	G. Trost	G. Rodts
Strategic Planning Committe	R.Haid	R. Rodts	R. Heary	C. Branch	J. Alexander
	C.Branch	R. Heary	C. Branch	J. Alexander	D. Resnick
	R.Rodts	C. Branch	T. Ryken	D. Resnick	C. Wolfla
	T.Ryken	T. Ryken	G. Rodts	C. Wolfla	C. Branch
	N. Baldwin	R. Haid		R. Heary	
Research and Awards Comm	C.Wolfla	J. Guest	C. Wolfla		
	P.Sawin	C. Wolfla	J. Guest		
	G.Trost	G. Trost	G. Trost		
		C. Shaffrey	C. Shaffrey		
Fellowships			J. Alexander S. Ondra C. Shaffrey Z. Gokaslan C. Kuntz		

American Association of Neurological Surgeons

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web: www.AANS.org

August 24, 2007

Christopher Wolfla, MD
Department of Neurosurgery
9200 W. Wisconsin Ave.
Milwaukee, WI 53226

Dear Doctor Wolfla:

The enclosed financial statements for the AANS/CNS Section on Disorder of the Spine & Peripheral Nerves are for the Year Ended June 30, 2007, and comparative information for the Year Ended June 30, 2006.

The financials statements have been audited by the auditing firm of RSM McGladrey. Until their final report and opinion are presented, changes to Fiscal Year 2007 are a small possibility. After your review of the financial statements and commentary, if you have any questions, please do not hesitate to contact me at 847-378-0509 or rwe@aans.org.

Sincerely,

Ronald W. Engelbreit, CPA
Deputy Executive Director

Enclosures

Cc: Joseph T. Alexander, MD
Jon H. Robertson, MD
Douglas S. Kondziolka, MD
Paul C. McCormick, MD
Joel D. MacDonald, MD
Laurie Behncke

AANS/CNS Section on Disorders of the Spine
Statement of Financial Position
As of June 30, 2007

	Current Year 06/30/07	Prior Year 06/30/06
ASSETS		
Checking & Short Term Investments	$616,883	$854,910
Accounts Receivable, net of Allowance for Uncollectible Accounts	25,940	32,800
Prepaid Expenses	12,398	12,548
Long-Term Investment Pool, at Market	1,342,952	1,211,422
TOTAL ASSETS	***$1,998,173***	***$2,111,680***
LIABILITIES AND NET ASSETS		
Liabilities		
Accounts Payable and Current Liabilities	$12,592	$46,250
Deferred Contribution Revenue	35,000	41,000
Deferred Dues	28,175	32,450
Total Liabilities	*$75,767*	*$119,700*
Net Assets		
Unrestricted	$1,991,980	$1,618,077
Net Revenue (Expense)	(69,574)	373,903
Total Net Assets	*$1,922,406*	*$1,991,980*
TOTAL LIABILITIES AND NET ASSETS	***$1,998,173***	***$2,111,680***

AANS/CNS Section on Disorders of the Spine
Statement of Activities
For the Twelve Months Ending June 30, 2007

	FY '05 Final	FY '06 Final		YTD FY '06	YTD FY '07		FY '07 Budget	FY '08 Budget
REVENUES								
Membership Dues	55,650	49,488		49,488	55,975		50,750	49,750
Mailing List Sales	1,100	1,500		1,500	1,475			
Publications Sales Revenue								
Fellowship/Award Sponsorship	50,000	203,000		203,000	129,390		136,000	133,000
Miscellaneous Revenue					108			
Contributions for Operating Expenses	8,363	8,672		8,672	9,368		9,368	10,864
Annual Meeting Revenue	714,810	730,042		730,042	915,425		792,376	
TOTAL REVENUES & SUPPORT	***829,923***	***992,702***		***992,702***	***1,111,741***		***988,494***	***193,614***
EXPENSES								
Audio Visual	906	2,979		2,979	1,011		1,000	1,000
Bank Fee	426	297		297	484		460	508
Contributions & Affiliations	25,000	25,000		25,000	75,000		75,000	75,000
Decorating	271	504		504	594		250	250
Depreciation								
Dues & Subscriptions								
Facility								
Food & Beverage	2,769	1,936		1,936	3,636		3,500	5,000
Fellowships	131,156	89,491		89,491	140,092		140,800	139,500
Grants					500,000		500,000	
Gifts & Gratuities								
Honoraria & Awards					300			
Marketing & Advertising							6,000	
Legal Services								
Office & other Supplies	950	521		521	229		600	600
Photocopy	8	90		90	0		200	200
Postage & Distribution	1,745	1,182		1,182	1,214		2,000	2,000
Printing/Typesetting	324	36		36				
Professional Services	1,576	538		538	3,192		1,000	7,500
Signs								
Speaker Expenses		5,134		5,134				
Telephone	632	27		27	2		800	250
Temporary Personnel								
Volunteer Travel					1,462			1,500
Uncollectible Accounts								
Staff Coordination	8,421	8,781		8,781	9,461		9,618	10,864
Miscellaneous	(100,000)							
Cervical Degenerative Spine Guidelines Projec					15,948		40,000	33,600
Lumbar Fusion Guidelines Project								
Annual Meeting Expense	452,030	568,396		568,396	583,402		623,053	
TOTAL EXPENSES	***526,214***	***704,911***		***704,911***	***1,336,028***		***1,404,281***	***277,772***
Investment Earnings	64,169	86,112		86,112	154,713		65,000	53,000
NET REVENUE	***367,878***	***373,903***		***373,903***	***(69,574)***		***(350,787)***	***(31,158)***

AANS/CNS Section on Disorders of the Spine
Statement of Activities
Annual Meeting
For the Twelve Months Ending June 30, 2007

	FY '05 Final	FY '06 Final		YTD FY '06	YTD FY '07		FY '07 Budget
REVENUES							
Registration Fees	195,820	149,680	II	149,680	228,175	II	214,075
Exhibitor Fees	269,725	261,900	II	261,900	407,800	II	275,000
Contributions/Sponsorships	229,500	282,000	II	282,000	274,500	II	285,000
Banquet Revenue	8,565	24,284	II	24,284	4,950	II	8,301
Miscellaneous Revenue	11,200	12,178	II	12,178		II	10,000
TOTAL REVENUES & SUPPORT	***714,810***	***730,042***	***I***	***730,042***	***915,425***	***I***	***792,376***
EXPENSES							
Scientific Program	143,943	193,476	II	193,476	199,851	II	216,188
Poster Session	6,595		II			II	
Abstract Management	742	897	II	897		II	
Program Book	21,791	24,285	II	24,285		II	
Special Courses	16,671	18,678	II	18,678		II	
Opening Reception	63,200	55,993	II	55,993		II	
Social Events	32,110	30,282	II	30,282	138,139	II	163,735
Committee Dinner/Events	21,190	34,538	II	34,538		II	
Exhibit Program	11,908	17,292	II	17,292	49,121	II	34,510
Exhibit Marketing	5,850	4,965	II	4,965		II	
Registration	19,873	19,108	II	19,108	33,882	II	34,350
Onsite Registration	8,555	4,486	II	4,486		II	
Preliminary Program	12,981	11,931	II	11,931		II	
Marketing	6,453	8,684	II	8,684	65,360	II	65,670
Onsite Coordination	12,938	2,644	II	2,644	12,757	II	15,950
Planning Committee	10,822	6,819	II	6,819		II	
Miscellaneous	263	66,069	II	66,069	0	II	
Future Meetings		0	II	0		II	
Staff Coordination	56,144	68,250	II	68,250	84,291	II	92,650
TOTAL EXPENSES	***452,030***	***568,396***	***I***	***568,396***	***583,402***	***I***	***623,053***
NET REVENUE	***262,780***	***161,646***	***I***	***161,646***	***332,023***	***I***	***169,323***

AANS/CNS SECTION ON DISORDERS OF THE SPINE

NOTES TO FINANCIAL STATEMENTS

June 30, 2007

General & Administrative

Fellowships/Award Sponsorships – Budget 136,000, Actual $129,390

The section was to receive $30,000 from DePuy for the Sanford Larson Award but actually received $26,890 due to budget restrictions. Additionally, the section received $1,500 from Integra for the Kline Lectureship that was not included in the budget.

Decorating – Budget $250, Actual $594

The cost of the joint section booth at the AANS Annual Meeting was higher than anticipated.

Marketing & Advertising – Budget $6,000, Actual $0

This variance occurred because the section did not place ads in the *JNS* or *Neurosurgery* publications. During the FY08 budgeting process, the section determined this budget item was no longer necessary because there are other free media's available they could utilize.

Professional Services – Budget $1,000, Actual $3,192

The section spent additional monies updating the website than originally anticipated. All expenses over the budgeted amount were approved by the section treasurer.

Volunteer Travel – Budget $0, Actual $1,462

This represents the expenses that were reimbursed to Dr. Branch and Dr. Resnick for attending the Medicare Coverage Advisory Committee meeting. These expenses were not included in the budget.

2008 Section on the Disorders of Spine and Peripheral Nerves
Annual Meeting Budget

DRAFT

Section on the Disorders of Spine and Peripheral Nerves Annual Meeting Revenue		2008 Orlando Preliminary Budget			2007 Phoenix Actual		
		Qty	Fee	Amount	Qty	Fee	Amount
Registration 75-00-000-000-44025							
	Spine Section Member	180	$450/$550	82,500	176	$450/$550	80,200
	NASS Member	45	$450/$550	20,750	45	$450/$550	21,150
	Non-Member	95	$500/$600	47,500	95	$500/$600	49,300
	Resident	47	$300/$400	14,300	46	$300/$400	14,800
	Nurse	15	$300/$400	4,500	16	$300/$400	5,100
	Physician Assistant	15	$300/$400	4,500	14	$300/$400	4,500
Subtotal Medical		**397**		**$ 174,050**	**392**		**$ 175,050**
	Exhibitors (Advance)	235	$0		234	$0	-
	Exhibitors (Additional Advanced)	130	$75	$9,750	133	$75	7,875
	Exhibitors (Additional Onsite)	75	$100	$7,500	82	$100	9,900
	Spouse/Guest	70	$100/$130	$7,000	93	$100/$130	6,990
	Child	25			25	$ -	-
	Staff (CNS Staff/Laser Staff/Vendors)	41			17	$ -	-
	Guests (Complimentary)	25			24	$ -	-
	Non Registrants (guests not attending)	5			4	$ -	-
	Total Attendance	**1,003**		**$ 198,300**	**1,004**		**$ 199,815**
	Registration Rebates						(8,210)
	Late Cancellations			3,500			3,810
	Total Registration	**1,003**	-	**$ 201,800**	**1,004**		**$ 195,415**
Exhibits 75-00-000-000-							
44010	Booth Sales	107		415800	122		407,800
46500	Data Sales Lead Revenue						
	Total Exhibits	**107**		**$ 415,800**	**122**		**$ 407,800**
Contributions/Sponsorships							
41550	Exhibit Corporate Funding			285,000			274,500
	4% increase						

6/20/2007

2008 Section on the Disorders of Spine and Peripheral Nerves
Annual Meeting Budget

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Section on the Disorders of Spine and Peripheral Nerves Annual Meeting Revenue		2008 Orlando Preliminary Budget			2007 Phoenix Actual		
		Qty	Fee	Amount	Qty	Fee	Amount
	Total Sponsorships	-		**$ 285,000**	-		**$ 274,500**
Auxiliary and Social Event Ticket Sales							
44100	Golf Outing	35	200	7000	-	$197	-
44200	Tennis Round-Robin						
44000	Opening Reception	30	$100	$3,000	44	$100	4,400
44300	Reception with Exhibitors	5	$75/$100	$375	6	$75/$100	550
	Reception with Exhibitors (Included)					$0	
	Total Social Events	**70**		**$ 10,375**	**50**		**$ 4,950**
Special Courses/Symposium							
45000	Special Courses - Medical	150	$200	$30,000	144	$200	28,800
	Special Courses - Resident & Faculty		$0		69	$0	-
45010	Symposium for nurses	30	$110	$3,300	36	$110	3,960
	Symposium for nurses		0		11	0	-
	Total Special Courses	**180**		**$ 33,300**	**260**		**$ 32,760**
Miscellaneous							
46000	Room Rebates (offsets online reg fees)						
	Total Miscellaneous	-		**$ -**	-		**$ -**
Total Gross Revenue				**$ 946,275**			**$ 915,425**
Total Expenses				**$ 693,995**			**$ 495,835**
				$ 252,280			**$ 419,590**

2008 Section on the Disorders of Spine and Peripheral Nerves
Annual Meeting Budget

Account Number	Description	2008 Orlando Budget	2007 Phoenix Actual
Scientific Program/Special Courses (75-00-083-000-)			
71510	Audio/Visual	52,000	39,739
71530	AV Labor	24,800	17,579
71600	Awards	900	400
73005	Decorating	3,800	3,507
76500	Food & Beverage	89,000	86,635
77500	Gifts & Gratuities	750	576
78000	Insurance	3,500	2,628
80500	Postage	50	42
	Printing	2,500	
81050	Signs	3,800	3,384
81500	Accreditation Fee	-	
83010	Facility	3,900	216
83500	Security	1,700	1,235
84010	Honoraria	8,000	4,500
84020	Speaker Expenses.	12,000	11,239
85530	Telephone/Internet	4,000	230
	Subtotal	**$ 210,700**	**$ 171,910**

2008 Section on the Disorders of Spine and Peripheral Nerves
Annual Meeting Budget

Account Number	Description	2008 Orlando Budget	2007 Phoenix Actual
Abstract Management & Selection (75-00-090-101)			
73005	AV/Electric/Décor/Carpet	20,000	17,674
75510	IT Services	1,800	1,265
80520	Overnight Shipping	1,500	691
85500	Telecommunication - Vlans	690	811
	Total Abstract Management	**$ 23,990**	**$ 20,441**
Total		**$ 234,690**	**$ 192,351**

2008 Section on the Disorders of Spine and Peripheral Nerves

Annual Meeting Budget

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Account Number	Description	2008 Orlando Budget	2007 Phoenix Actual
OFFICIAL SOCIAL EVENTS (75-00-)			
Golf Outing (082-000)			
76500	Food & Beverage	6,920	
84010	Honoraria & Awards		
86500	Transportation	1,000	
	Total Golf Outing	**$ 7,920**	**$ -**
Opening Reception (082-001)			
71510	Audio/Visual	1,200	336
73005	Decorating	3,500	
75000	Entertainment	6,200	
76500	Food & Beverage	75,000	69,590
	Total Opening Reception	**$ 85,900**	**$ 69,926**
Reception with Exhibitors (082-002)			
75000	Entertainment		
76500	Food & Beverage	29,000	25,824
	Total Reception with Exhibitors	**$ 29,000**	**$ 25,824**
Committee Dinners and Events (082-003)			
76500	EC Dinner	8,550	5,204

2008 Section on the Disorders of Spine and Peripheral Nerves
Annual Meeting Budget

Account Number	Description	2008 Orlando Budget	2007 Phoenix Actual
76510	Chairmen's Dinner	25,000	24,028
76520	YNS Dinner	8,300	9,070
76530	EC Meeting	4,865	3,291
76540	Planning Committee Meeting		
	Senior Advisory Reception and Dinner	12,860	
71510	AV		796
86500	Transportation	4,000	
	Total Committee Dinners and Events	**$ 63,575**	**$ 42,389**
	TOTAL OFFICIAL SOCIAL EVENTS	**$ 186,395**	**$ 138,139**

2008 Section on the Disorders of Spine and Peripheral Nerves
Annual Meeting Budget

Account Number	Description	2008 Orlando Budget	2007 Phoenix Actual
Print and Production (75-00-)			
Exhibitor Prospectus & Inserts (084-002)			
80500	Postage	1,000	909
80520	Overnight Shipping	100	35
81000	Printing	2,650	2,560
81070	Typesetting	3,550	5,528
	Total Exhibitor Prospectus	**$ 7,300**	**$ 9,032**
Preliminary Program Booklet (084-004)			
80500	Postage/Admin	8,500	7,585
80520	Overnight Shipping	300	278
81000	Printing	6,500	6,097
81070	Typesetting	5,000	3,438
84510	Mailing Label Supplies	1,200	1,075
	Total Preliminary Program	**$ 21,500**	**$ 18,473**
Poster Program CD (084-005)			
80520	Overnight Shipping		
80540	Other Delivery		
81000	Printing		
81070	Typesetting		
	Total Poster Program Book	**$ -**	**$ -**
Scientific Program Book (084-006)			
80520	Overnight Shipping	700	549
81000	Printing	13,200	11,753
81070	Typesetting	8,500	8,157
	Total Scientific Program Book	**$ 22,400**	**$ 20,459**
Annual Meeting Marketing (095-000)			

2008 Section on the Disorders of Spine and Peripheral Nerves
Annual Meeting Budget

Account Number	Description	2008 Orlando Budget	2007 Phoenix Actual
70500	Eblast Service	650	630
80500	Postage/Shipping	4,000	1,807
81000	Printing	6,600	7,406
81050	Mail Services	1,400	440
81070	Typesetting	5,300	3,605
84050	Letterhead	3,900	3,508
84510	Mailing Label Supplies		
	Total Annual Meeting Marketing	**$ 21,850**	**$ 17,396**
TOTAL PRINT AND PRODUCTION		**$ 73,050**	**$ 65,360**

2008 Section on the Disorders of Spine and Peripheral Nerves
Annual Meeting Budget

Account Number	Description	2008 Orlando Budget	2007 Phoenix Actual
Exhibit Hall Program (75-00-085-000)			
71510	Audio/Visual/Internet	20,500	15,567
73005	Decorating Labor	1,000	900
73080	Decorating	6,800	5,329
76020	Credit Card fees	14,000	13,500
76500	Food & Beverage		
80530	Freight & Shipping	250	
81050	Signage	6,460	6,162
83010	Facility	2,400	1,000
83500	Security	6,500	6,663
85530	Telephone	250	
	Total Exhibit Program	**$ 58,160**	**$ 49,121**
	TOTAL EXHIBIT HALL PROGRAM	**$ 58,160**	**$ 49,121**

2008 Section on the Disorders of Spine and Peripheral Nerves
Annual Meeting Budget

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Account Number	Description	2008 Orlando Budget	2007 Phoenix Actual
Annual Meeting Registration (75-00-)			
Registration-Advanced (086-000)			
75500	Equipment		
76020	Credit Card Fees	7,000	6,000
75510	Computer Technology		
81000	Postage	200	190
82000	Printing		
84500	Professional Services	22,500	21,990
85500	Supplies		
86000	Telephone	200	113
	Temporary Help		
	Total Registration-Advanced	**$ 29,900**	**$ 28,293**
Registration-Onsite (086-001)			
71530	Audio/Visual Equipment	200	
73005	Audio/Visual Labor		
73040	Decorating	500	410
81000	Overnight Shipping/Freight	200	111
82000	Printing	-	
83500	Professional Services		
	Security		
84500	Supplies	775	654
86000	Telephone	1,200	926
87010	Temporary Help	3,500	3,488
	Total Registration-Onsite	**$ 6,375**	**$ 5,589**
	TOTAL ANNUAL MEETING REGISTR	**$ 36,275**	**$ 33,882**

2008 Section on the Disorders of Spine and Peripheral Nerves
Annual Meeting Budget

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Account Number	Description	2008 Orlando Budget	2007 Phoenix Actual
Onsite Staff Coordination & Offices (75-00-087-000)			
71500	Audio/Visual	275	
73010	Decorating	2,400	2,367
75500	Equipment		
75530	Computer Labor/Hardware		
76500	Food & Beverage	2,000	2,027
77500	Gratuities		
80520	Shipping	150	135
81040	Photocopy		
83010	Facility Rental		
84500	Supplies	100	
85500	Telephone	1,200	1,015
86000	Temporary Help		
87020	Staff Travel	8,500	7,213
	Total Onsite Coordination	**$ 14,625**	**$ 12,757**

2008 Section on the Disorders of Spine and Peripheral Nerves
Annual Meeting Budget

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Account Number	Description	2008 Orlando Budget	2007 Phoenix Actual
Annual Meeting Planning General (75-00-090-000)			
79500	Miscellaneous	200	146
86000	Meeting Management **	80,000	
80520	Shipping	100	
	Total Annual Meeting Planning General	**$ 80,300**	**$ 146**
Pre-Meeting Site Visits (75-00-090-102)			
76500	Food & Beverage	6,000	1,704
80520	shipping		
85500	Telephone		
87020	Staff Travel	2,200	1,223
87070	Guest Travel	2,300	1,152
	Total Pre-Meeting Site Visits	**$ 10,500**	**$ 4,079**
Hotel Attrition (75-00-090-103)			
85540	Attrition		
	Total Hotel Attrition	**$ -**	**$ -**
Annual Meeting Stationery (75-00-090-105)			
81000	Printing	-	
81070	Typesetting	-	
	Total Annual Meeting Stationery	**$ -**	**$ -**
	TOTAL PLANNING GENERAL	**$ 90,800**	**$ 4,225**
	** NOTE:		
	2007 Actuals do not include the $80,000 management fee.		
	2008 Budget includes $80,000 management fee.		

2008 Section on the Disorders of Spine and Peripheral Nerves

Annual Meeting Budget

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NET REVENUE & EXPENSES SUMMARY			2008 Orlando Budget	2007 Phoenix Actual
Revenue				
	Registration		201,800	195,415
	Exhibits		415,800	407,800
	Contributions/Sponsorships		285,000	274,500
	Social Events		10,375	4,950
	Special Courses		33,300	32,760
	Miscellaneous		-	-
Total Gross Revenue			**$ 946,275**	**$ 915,425**
Expenses				
	Scientific Program/Special Courses		234,690	192,351
	Social Events		186,395	138,139
	Marketing		73,050	65,360
	Exhibit Hall Program		58,160	49,121
	AM Registration		36,275	33,882
	Onsite Coordination & Offices		14,625	12,757
	AM Planning General **		90,800	4,225
Total Expenses			**$ 693,995**	**$ 495,835**
Net Revenue			**$ 252,280**	**$ 419,590**
** NOTE:				
2007 Actuals do not include the $80,000 management fee.				
2008 Budget includes $80,000 management fee.				

EXPENSE VOUCHER

AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves

For Non-Annual Meeting expenses send to:

AANS
5550 Meadowbrook Drive
Rolling Meadows, IL 60008

For Annual Meeting expenses send to:

Congress of Neurological Surgeons
10 N. Martingale Rd., Suite 190
Schaumburg, IL 60173

Date						
Name				S.S. or Tax ID #:		
Address						
City			State		Zip	
Telephone			Fax			
Email						
Meeting/Function Attended:						
Date:						**Total**
Air Fare						
Taxi-Limo						
Auto (Parking, Tolls, Mileage)						
Breakfast						
Lunch						
Dinner						
Housing						
Telephone						
Gratuities						
Other (attach itemized list by date)						
Total by Day						
						Grand Total

- *Vouchers should be submitted within 30 days following a reimbursable expenditure*
- *Please refer to the AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves "Reimbursement Policy" for an explanation of reimbursable expenses*

I hereby attest that the above expenses are valid and in accordance with Section Policy_____

Signature

AANS/CNS JOINT SECTION ON DISORDERS OF THE SPINE AND PERIPHERAL NERVES

Reimbursement Policy (2007.04.16)

A. Chair

Registration	Fee waived. Spouse and Children fee waived
Travel	Complimentary. Includes: ▪ Advance purchase (within 30 days of departure) economy airfare for President only. ▪ Ground transportation to and from airport (limousine).
Hotel	Complimentary Includes: ▪ Presidential suite at VIP hotel ▪ Incidentals placed on master bill for official meetings and entertainment purposes.
Meals	As related to travel.
Misc.	Items necessary for completion of Section business may be reimbursed.

B. Executive Officers, Annual Meeting Chairman, Scientific Program Chairman, Past President

Registration	Fee waived.
Travel	No reimbursement.
Hotel	Complimentary for Past Chair, Chair-Elect, Secretary, Treasurer
Meals	No reimbursement.
Misc.	Items necessary for completion of Section business may be reimbursed.

C. Executive Committee

Registration	No reimbursement.
Travel	No reimbursement.
Hotel	No reimbursement
Meals	No reimbursement.
Misc.	Items necessary for completion of Section business may be reimbursed.

D. Non-Neurosurgeon, Non-Member, Invited Keynote Speakers at Annual Meeting

Registration	Fee waived
Travel	Complimentary Includes: ▪ Advance purchase (within 30 days of departure) economy airfare (domestic travel) or business class airfare (international travel) or mileage @ .485/mile. ▪ Ground transportation to and from airport
Hotel	Housing at meeting hotel complimentary ▪ Does not include incidentals
Meals	As related to travel
Honorarium	North American physician **keynote** speaker - $1,000.00 Non North American physician **keynote** speaker- $2,000.00

	Special nonmember non-physician **keynote** speaker - Chair/ SPC discretion
Misc.	Items necessary for completion of Section business may be reimbursed

*AMC/SPC is responsible for making sure sponsorship has been obtained prior to invitation

E. Meritorious Service Award Winner

Registration	Fee waived
Travel	Complimentary Includes: ▪ Advance purchase (within 30 days of departure) economy airfare (domestic travel) or business class airfare (international travel) or mileage @ .485/mile. ▪ Ground transportation to and from airport
Hotel	Housing at meeting hotel complimentary ▪ Does not include incidentals
Meals	As related to travel
Honorarium	Guidelines left to discretion of AMC, SPC.
Misc.	Items necessary for completion of Section business may be reimbursed

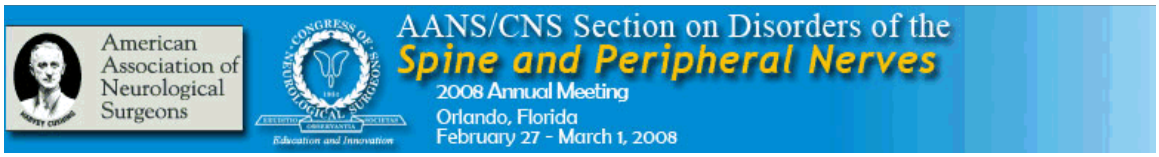
*AMC/SPC is responsible for making sure sponsorship for these speakers has been obtained prior to invitation

F. Neurosurgeon Invited Speakers at Annual Meeting (Excludes Honored Guest, Keynote Speakers Identified by the Scientific program Committee)

Registration	No reimbursement Non-Section Members charged at Member rate
Travel	No reimbursement.
Hotel	No reimbursement
Meals	No reimbursement.
Misc.	Items necessary for completion of Section business may be reimbursed

G. Invitees to Sanctioned Section Committee Meetings Separate From Annual Meeting

Travel	Complimentary Includes: ▪ Advance purchase (within 30 days of departure) economy airfare or mileage @ .485/mile. ▪ Ground transportation to and from airport
Hotel	Housing at meeting hotel, for meeting duration • Incidentals at the discretion of the Committee Chair and/or Treasurer
Meals	As related to travel
Misc.	Items necessary for completion of Section business may be reimbursed



CPT Ad Hoc Committee Report (August 28, 2007)

Chair: Joseph Cheng, MD, MS

Members: Robert Johnson, MD, Jack Knightly, MD, Michael Rosner, MD, FACS, Karin Swartz, MD, David Hart, MD, Kurt Eichholz, MD

CPT Course (Annual Meeting)

1. J. Cheng and R. Johnson, Co-Chairs
    a. Wednesday: February 27, 2008 (4 Hours)
    b. Faculty selection
    c. Topic selection

Recent Coding Updates

1. Phase V MUE Edits
    a. Evaluation of these Edits in conjunction with NASS.
2. CMS Restructures DRGs
    a. Take effect October 1, 2007.
    b. Replace current 538 DRGs with 745 Medicare Severity DRGs (MS-DRGs).
        i. Current DRGs would be consolidated to 335 base MS-DRGs.
            1. 106 would be split into two subgroups
            2. 152 would be split into three subgroups,
            3. Creating 745 total MS-DRGs.
        ii. Expanded Complications and Comorbidities (CCs) to include Major CC
        iii. Major CCs significantly increase the expected resource consumption.
    c. Payment increases for spine surgeries noted.
3. Implants
    a. CMS decides against covering Synthes Pro-Disc (8/16/2007).
    b. Cervical disc launches as class III device with tracking code 0090T.
    c. X-Stop remains class III device with tracking code 0171T.
4. Washington
    a. House passes Children's Health Access and Medicare Protection (CHAMP) Act of 2007.
        i. AANS and CNS supported this legislation.
        ii. Prevent scheduled Medicare physician payment cuts in 2008 and 2009, providing instead, .5% increases.
        iii. Total net increase of 16%.

As always, comments or suggestion are always welcome. Please feel free to contact me at: joseph.cheng@vanderbilt.edu.

Respectfully Submitted,

Joe Cheng, M.D.
Vanderbilt University

Education Chair report.
We were very active in planning the spine IML session for this CNS meeting.
We are currently putting togther the AANS program.
We are working on a new course for the AANS professional development committee. Topics being considered are MIS or arthroplasty.
We are in discussion with Roland Torres and Odette Harris from Neurotrauma and Critical Care section regarding a joint spine trauma session at the AANS. They are taking the lead on this and we are helping out.
The Pain Section approached us regarding a joint day long course on the state of the art back pain info. They wanted to cover arthroplasty, fusion, analysis of SPORT data. This would be a course in their annual meeting and we are coordinating with Josh Rosenow.

Newsletter chair report.
The CNS quarterly has been publishing our newsletter. A newsletter is currently pending.
AANS will only publish as a "point of view" which I do not think is what we want.
Should we be pursuing an electronic, email mailing

CNS GUIDELINES FOR INTERACTION WITH COMMERCIAL ENTERPRISES AND MEDICAL INDUSTRY

2005

PREAMBLE

The Congress of Neurological Surgeons (CNS) exists to promote neurosurgical education for its members and for the community. The purpose of continuing medical education ("CME") is to enhance the physician's ability to care for patients. CNS-sponsored educational programs should be designed primarily for that purpose. Support from commercial interests can contribute significantly to the quality of CME activities, and to the overall mission of the CNS. The purpose of these Guidelines is to describe appropriate behavior in planning, designing, implementing, and evaluating CNS activities for which commercial support is received.

SCOPE OF GUIDELINES

It is acknowledged that the CNS and Commercial Interests may interact on many levels. These include programs for the advancement of medical technology, instruction on the safe and effective use of technology, research and education projects, consultation, and conference support. The activities of the Joint Sections of the AANS/CNS are considered under the umbrella of the CNS parent, and in this document will be considered under the CNS moniker.

These Guidelines apply to all CNS CME activities.

Commercial Support is defined as financial, or in-kind, contributions given by a commercial interest, which is used to pay all or part of the costs of a CME activity.

"Commercial interest" includes any proprietary entity producing health care goods or services, with the exemption of non-profit or government organizations and non-health care related companies.

Commercial exhibits and advertisements are promotional activities and not continuing medical education. Therefore, monies paid by commercial interests to providers for these promotional activities are not considered to be 'commercial support'. However, accredited providers are expected to use sound fiscal and business practices with respect to promotional activities.

GUIDELINES

GUIDELINE I: Independence

A. The following CME activities must be made free of the control of a commercial interest:
    1. Identification of CME needs;

2. Determination of educational objectives;
3. Selection and presentation of content;
4. Selection of all persons and organizations that will be in a position to control the content of the CME;
5. Selection of educational methods;
6. Evaluation of the activity.

B. A commercial interest cannot take the role of non-accredited partner in a joint sponsorship relationship.

GUIDELINE 2: Resolution of Personal Conflicts of Interest

A. The CNS must be able to show that everyone who is in a position to control the content of an education activity has disclosed all relevant financial relationships with any commercial interest to the provider. *The ACCME defines "'relevant' financial relationships" as financial relationships in any amount occurring within the past 12 months that create a conflict of interest*.
B. An individual who refuses to disclose relevant financial relationships will be disqualified from being a planning committee member, a teacher, or an author of CME, and cannot have control of, or responsibility for, the development, management, presentation or evaluation of the CME activity.
C. The provider must have implemented a mechanism to identify and resolve all conflicts of interest prior to the education activity being delivered to learners. Paper and/or electronic disclosures will be collected for each individual potentially in a position to control the content of an educational activity, prior to the educational activity. Resolution of conflicts will be performed by the Chair of the CNS Education Committee and/or President of the Congress of Neurological Surgeons. After review of all relevant information, one or both of these individuals will make a determination regarding the participation of an individual with a potential conflict of interest.

GUIDELINE 3: Appropriate Use of Commercial Support

A. The CNS must make all decisions regarding the disposition and disbursement of commercial support.
B. The CNS cannot be required by a commercial interest to accept advice or services concerning teachers, authors, or participants or other education matters, including content, from a commercial interest, as conditions of contributing funds or services.
C. All commercial support associated with a CME activity must be given with the full knowledge and approval of the CNS.
    1. Written agreement documenting terms of support
        a. The terms, conditions, and purposes of the commercial support must be documented in a written agreement between the commercial supporter that includes the CNS and its educational partner(s) (i.e. AANS/CNS Joint Sections). The agreement must include the CNS, even if the support is given directly to the provider's educational partner or a joint sponsor.
        b. The written agreement must specify the commercial interest that is the source of commercial support.

c. Both the commercial supporter and the CNS must sign the written agreement between the commercial supporter and the CNS.

2. Expenditures for an individual providing CME
    a. The CNS must have written policies and procedures governing honoraria and reimbursement of out-of-pocket expenses for planners, teachers and authors.
    b. The CNS, the joint sponsor, or designated educational partner must pay directly any teacher or author honoraria or reimbursement of out-of–pocket expenses in compliance with the CNS's written policies and procedures.
    c. No other payment shall be given to the director of the activity, planning committee members, teachers or authors, joint sponsor, or any others involved with the supported activity.
    d. If teachers or authors are listed on the agenda as facilitating or conducting a presentation or session, but participate in the remainder of an educational event as a learner, their expenses can be reimbursed and honoraria can be paid for their teacher or author role only.
3. Expenditures for learners
    a. Social events or meals at CME activities cannot compete with or take precedence over the educational events.
    b. The CNS may not use commercial support to pay for travel, lodging, honoraria, or personal expenses for non-teacher or nonauthor participants of a CME activity. The CNS may use commercial support to pay for travel, lodging, honoraria, or personal expenses for bona fide employees and volunteers of the provider, joint sponsor or educational partner.
4. Accountability
    a. The CNS must be able to produce accurate documentation detailing the receipt and expenditure of the commercial support.

GUIDELINE 4. Appropriate Management of Associated Commercial Promotion

A. Arrangements for commercial exhibits or advertisements cannot influence planning or interfere with the presentation, nor can they be a condition of the provision of commercial support for CME activities.
B. Product-promotion material or product-specific advertisement of any type is prohibited in or during CME activities. The juxtaposition of editorial and advertising material on the same products or subjects must be avoided. Live (staffed exhibits, presentations) or enduring (printed or electronic advertisements) promotional activities must be kept separate from CME.

    • For print, advertisements and promotional materials will not be interleafed within the pages of the CME content. Advertisements and promotional materials may face the first or last pages of printed CME content as long as these materials are not related to the CME content they

face and are not paid for by the commercial supporters of the CME activity.

• For computer based, advertisements and promotional materials will not be visible on the screen at the same time as the CME content and not interleafed between computer 'windows' or screens of the CME content

• For audio and video recording, advertisements and promotional materials will not be included within the CME. There will be no 'commercial breaks.'

• For live, face-to-face CME, advertisements and promotional materials cannot be displayed or distributed in the educational space immediately before, during, or after a CME activity. Providers cannot allow representatives of Commercial Interests to engage in sales or promotional activities while in the space or place of the CME activity.

C. Educational materials that are part of a CME activity, such as slides, abstracts and handouts, cannot contain any advertising, trade name or a product-group message.

D. Print or electronic information distributed about the non-CME elements of a CME activity that are not directly related to the transfer of education to the learner, such as schedules and content descriptions, may include product promotion material or product-specific advertisement.

E. The CNS cannot use a commercial interest as the agent providing a CME activity to learners, e.g., distribution of self-study CME activities or arranging for electronic access to CME activities.

GUIDELINE 5. Content and Format without Commercial Bias

A. The content or format of a CME activity or its related materials must promote improvements or quality in healthcare and not a specific proprietary business interest of a commercial interest.

B. Presentations must give a balanced view of therapeutic options. Use of generic names will contribute to this impartiality. If the CME educational material or content includes trade names, where available trade names from several companies should be used, not just trade names from a single company.

GUIDELINE 6: Disclosures Relevant to Potential Commercial Bias

A. Relevant financial relationships of those with control over CME content

1. An individual must disclose to learners any relevant financial relationship(s), to include the following information:
   • The name of the individual;
   • The name of the commercial interest(s);
   • The nature of the relationship the person has with each commercial interest.
2. For an individual with no relevant financial relationship(s) the learners must be informed that no relevant financial relationship(s) exist.

B. Commercial support for the CME activity.

1. The source of all support from commercial interests must be disclosed to learners. When commercial support is 'in-kind' the nature of the support must be disclosed to learners.

2. ‘Disclosure’ must never include the use of a trade name or a product-group message.

C. Timing of disclosure
    1. The CNS must disclose the above information to learners prior to the beginning of the educational activity.

CNS POLICIES FOR COMMERCIAL SUPPORT OF CME ACTIVITIES: LUNCHEON SEMINARS AND PRACTICAL COURSES

Information for Course Directors

The purpose of continuing medical education (CME) activities sponsored by the Congress of Neurological Surgeons (CNS) is to enhance the neurosurgeon's ability to care for patients. It is our responsibility to assure that the activity is designed primarily for that purpose.

In the planning and implementation of practical courses and luncheon seminars at the CNS Annual Meeting, we may receive "Commercial Support", which is defined as financial, or in-kind, contributions given by a commercial interest, which is used to pay all or part of the costs of a CME activity. "Commercial interest" includes any proprietary entity producing health care goods or services, with the exemption of non-profit or government organizations and non-health care related companies. While such support can contribute significantly to the quality of the CME program, we must work to ensure that the CME activity is designed primarily to enhance the neurosurgeon's ability to care for patients, and to ensure that the CME activity meets the standards of the ACCME.

As a guide for Course Director, the following policies have been adopted:

GUIDELINE I: Independence

When designing your course, the following choices must be made free of the control of a commercial interest:

- Determination of educational objectives;
- Selection and presentation of content;
- Selection of all faculty
- Selection of educational methods

GUIDELINE 2: Resolution of Personal Conflicts of Interest

A. You and all of the faculty members must disclose all relevant financial relationships with any commercial interest to the provider. The ACCME defines "'relevant' financial relationships" as financial relationships in any amount occurring within the past 12 months that create a conflict of interest.
B. Anyone who refuses to disclose relevant financial relationships will be disqualified from being a course director or faculty member
C. Your disclosure must be made prior to the CNS Annual Meeting
D. Faculty disclosures must be made prior to their presentation, preferably prior to the CNS Annual Meeting.
E. In the case of a potential conflict of interest, the Chair of the CNS Education Committee and/or CNS President, after reviewing all relevant information, will make the final determination as to whether an individual may participate.

GUIDELINE 3: Appropriate Use of Commercial Support

A. *Please check with the CNS office before accepting any type of commercial support.* The CNS must ultimately make and approve all decisions regarding the disposition and disbursement of commercial support.

B. *You cannot accept any commercial support if there are "strings attached"*. The CNS cannot be required by a commercial interest to accept advice or services concerning teachers, authors, or participants or other education matters, including content, from a commercial interest, as conditions of contributing funds or services.

C. *A commercial entity cannot give any type of support without your permission, and the permission of the CNS.* All commercial support must be given with the full knowledge and approval of the CNS.

D. *If your course includes any type of commercial support, make sure that the CNS office has a written agreement with the commercial entity*. The terms, conditions, and purposes of the commercial support must be documented in a written agreement between the commercial supporter that includes the CNS and its educational partner(s) (i.e. AANS/CNS Joint Sections). The agreement must include the CNS, even if the support is given directly to the provider's educational partner or a joint sponsor.

E. *Neither you nor your faculty may be paid for their participation, except as allowed by CNS policy*.

F. *No commercial entity may pay you or your faculty member directly*.

G. *Please communicate with CNS office, especially if there are any questions regarding commercial support.* The CNS must be able to produce accurate documentation detailing the receipt and expenditure of the commercial support.

GUIDELINE 4. Appropriate Management of Associated Commercial Promotion

Advertisements of any kind are prohibited during your course. This includes the time during lectures and "hands-on" demonstrations, as well as in any associated handouts. Product-promotion material or product-specific advertisement of any type is prohibited in or during CME activities. The juxtaposition of editorial and advertising material on the same products or subjects must be avoided. Promotional activities must be kept separate from CME.

GUIDELINE 5. Content and Format without Commercial Bias

Courses must be unbiased. The content or format of a CME activity or its related materials must promote improvements or quality in healthcare and not a specific proprietary business interest of a commercial interest. Presentations must give a balanced view of therapeutic options. Use generic names as much as possible. If your course includes trade names, where available trade names from several companies should be used, not just trade names from a single company.

May 17, 2007

To: Joseph T. Alexander, MD
R. John Hurlbert, MD
John J. Knightly, MD
Charles Kuntz, IV, MD
Daniel K. Resnick, MD
Charles Branch, Jr., MD
Mark McLaughlin, MD
Ian H. Kalfas, MD

From: Michele Lengerman

Subject: Section on DSPN Sponsorship Campaign Project

Background:

The leadership of the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves charged its meeting management team with researching and developing a new sponsorship campaign.

Recommendation:

Our research on corporate sponsorship shows organizations are beginning to move away from traditional Gold, Silver and Bronze Level labels as well as a trend toward increased customization of sponsorship packages.

Because of this research, we recommend a complete revision of the section's sponsorship program to include four new levels of sponsorship:

- Supporter (up to $24,000)
- Benefactor ($25,000-$49,000)
- Partner ($50,000-$64,000)
- Ambassador ($65,000 +)

The Ambassador and Partner Level benefits include access to the meeting's top social events – Chairman's Dinner, Young Neurosurgeons' Dinner and new Senior Advisory Reception and Dinner (not yet approved; still under consideration by the EC).

Please note that inside the Ambassador and Partner Levels, we have bundled opportunities together, each of which is tailored to a specific theme of sponsorship and includes a corresponding benefits package.

We recommend rolling the program out as a completely redefined sponsorship program and opening all opportunities to all sponsors, on a first-come, first-served basis. In subsequent years we can extend the right of first refusal.

We would like the opportunity to walk through the key elements and benefits of this campaign via a conference call once you have had an opportunity to review.

Thank you.

cc: Laurie L. Behncke
Regina Shupak
Christopher J. Carlson

Annual Meeting Sponsorship Proposal for the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves

Sponsorship Levels:

- Supporter - $2,500-$24,000
- Benefactor - $25,000-$49,000
- Partner - $50,000 - $64,000
- Ambassador - $65,000 +

Sponsorship Opportunity	Amount
Special Courses (Nurse/PA)	$2,500.00
Special Courses (Neurosurgeon)	$5,000.00
Demonstration Theater in the Exhibit Hall (two 10-minute time slots)	$5,000.00
Speaker Grants	$5,000.00
Pens and Note Pads	$7,500.00
Key Cards	$7,500.00
Meeting Bags	$7,500.00
Badge Lanyards	$10,000.00
Cyber Café	$15,000.00
Beverage Breaks	$15,000.00
Continental Breakfast *(Co-Sponsorship with AANS/CNS DSPN)*	$20,000.00
Lunch in the Exhibit Hall (Thursday)	$35,000.00

Sponsorship Benefits:

Supporter Benefits Include:

- Acknowledgement in Scientific Program Book general sponsor ad.
- Recognition on Section web site.
- Recognition on general sponsor signage at resort.
- Inclusion in general sponsor slide during Scientific Session slideshow.
- Acknowledgment in registration packet general sponsor insert.
- Logo inclusion on sponsored item (registration bags, pens & notepads, etc.)
- Acknowledgement placard at sponsored event/service, if applicable (special course, lunch, etc.).

Benefactor Benefits Include:

- All Supporter Benefits.
- Complimentary pre- and post-meeting mailing list (mailer content approval required).
- Ability to distribute company literature at sponsored event (if applicable).
- Additional tickets/invites to sponsored event (if applicable).

Partner Benefits Include***:***

- All Supporter and Benefactor Benefits.
- Acknowledgement banner at resort, as space permits.
- Acknowledgment in Scientific Program Book (half-page).
- Two complimentary invites to the Chairman's Dinner, Young Neurosurgeons' Dinner, Senior Advisory Reception and Dinner.

Ambassador Benefits Include:

- All Supporter, Benefactor and Partner Benefits.
- Special acknowledgement in attendee registration packets.
- Additional signage acknowledgement.
- Special Ambassador ribbon.
- Two additional invites to any one (1) social event (Chairman's Dinner, Young Neurosurgeons' Dinner or Senior Advisory Reception and Dinner).

The Partner and Ambassador sponsorship level bundled opportunities are noted below by specific themes: Education, Resident, Future of Neurosurgery, Leadership and Networking. Each of these five themed opportunities offer distinct benefits. Sponsors may add additional opportunities to these bundles, but bundled opportunities will not be negotiated.

Neurosurgical "*Education*" Ambassador ($70,000) inclusive of the following opportunities:

- Program Book,
- Digital Poster Center, and
- Scientific Sessions Thursday – Saturday.

Benefits:

- *Individual acknowledgement banner at resort, as space permits.*
- *Acknowledgement Placard outside General Scientific Session.*
- *Acknowledgement Banner in Digital Poster Center.*
- *Logo inclusion on Scientific Program Book cover.*
- *Half-page acknowledgement in Scientific Program Book.*
- *Individual acknowledgment slide in Scientific Session Slideshow.*
- *Two complimentary invites to YNS Dinner, Chairman's Dinner and Senior Advisory Reception and Dinner.*
- *One complimentary "What's New" Session timeslot on Friday or Saturday.*
- *Complimentary pre- and post-meeting attendee mailing lists (section approval required).*
- *Acknowledgement on section web site.*
- *Acknowledgement in all general sponsor recognition materials.*

"*Resident*" Education Partner ($50,000) inclusive of the following opportunities:

- Young Neurosurgeons' Dinner,
- First 25 Resident Registrations, and
- Select Special Course – Complimentary to Residents. (Course to be designated by Scientific Program Committee.)

Benefits:

- *Individual acknowledgement banner at resort, as space permits.*
- *Acknowledgement Placard at YNS Dinner and outside Special Course.*
- *Acknowledgement on YNS Dinner Invitation.*
- *Half-page acknowledgement in Scientific Program book.*
- *Individual acknowledgment slide in Scientific Session Slideshow.*
- *Special Insert in Resident registration packets.*
- *Six complimentary invites to YNS Dinner.*
- *Two complimentary invites to Chairman's Dinner and Senior Advisory Reception and Dinner.*
- *One complimentary "What's New" Session timeslot on Friday or Saturday.*
- *Complimentary pre- and post-meeting attendee mailing lists (section approval required.)*
- *Acknowledgement on section web site.*
- *Acknowledgement in all general sponsor recognition materials.*

"*Future of Neurosurgery*" Partner ($50,000) inclusive of the following opportunities:

- Senior Advisory Reception and Dinner and
- Cahill Memorial Controversies Session (Interactive Response System).

Benefits:

- *Individual acknowledgement banner at resort, as space permits.*
- *Acknowledgement Placard at Chairman's Advisory Reception and outside Cahill Session with interactive handheld auto-response.*
- *Logo Inclusion on handheld device opening screen.*
- *Half-page acknowledgement in Scientific Program Book.*
- *Individual acknowledgment slide in Scientific Session Slideshow.*
- *Six complimentary invites to Senior Advisory Reception and Dinner.*
- *Two complimentary invites to YNS Dinner and Chairman's Dinner.*
- *One complimentary "What's New" Session timeslot on Friday or Saturday.*
- *Complimentary pre- and post-meeting attendee mailing lists (section approval required.)*
- *Acknowledgement on section web site.*
- *Acknowledgement in all general sponsor recognition materials.*

Neurosurgical "*Leadership*" Partner ($60,000) inclusive of the following opportunities.

- Chairman's Dinner and
- Speaker Grant in Support of Meritorious Award Recipient.

Benefits:

- *Individual acknowledgement banner at resort, as space permits.*
- *Acknowledgement Placard at Chairman's Dinner and outside session with Meritorious Award Recipient Presentation.*
- *Half-page acknowledgement in Scientific Program Book.*
- *Individual acknowledgment slide in Scientific Session Slideshow.*
- *Six complimentary invites to Chairman's Dinner.*
- *Two complimentary invites to YNS Dinner and Senior Advisory Reception and Dinner.*
- *One complimentary "What's New" Session timeslot on Friday or Saturday.*
- *Complimentary pre- and post-meeting attendee mailing lists (section approval required.)*
- *Acknowledgement on section web site.*
- *Acknowledgement in all general sponsor recognition materials.*

Power of "*Networking*" Ambassador ($65,000) inclusive of the following opportunities.

- Opening Reception – Co-Sponsorship in conjunction with the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves and
- Cocktail Reception in Exhibit Hall.

Benefits:

- *Individual acknowledgement banner at resort, as space permits.*
- *Acknowledgement Placard at Opening Reception.*
- *Acknowledgement Banner in Exhibit Hall during Cocktail Reception.*
- *Logo napkins at Cocktail Reception (provided by sponsor).*
- *Half-page acknowledgement in Scientific Program Book.*
- *Individual acknowledgment slide in Scientific Session Slideshow.*
- *Two complimentary invites to YNS Dinner, Chairman's Dinner and Senior Advisory Reception and Dinner.*
- *One complimentary "What's New" Session timeslot on Friday or Saturday.*
- *Complimentary pre- and post-meeting attendee mailing lists (section approval required.)*
- *Acknowledgement on section web site.*
- *Acknowledgement in all general sponsor recognition materials.*

Joe

As we discussed, I completed the site visit for the 2010 Joint Section meeting in Orlando with Laurie and Regina from CNS. As reported at the last Executive Committee meeting in Washington, we had narrowed the choices to the Contemporary Resort (a Disney property) and the Rosen Shingle Creek Resort. We had looked into the Marriott and the Hyatt Grand Cypress but both were unavailable for our selected dates. The Disney Yacht Club was ruled out because of limited convention floor space.

We all came away from the visit very favorably impressed with the Rosen Shingle Creek Resort. It is comparable to the Marriott Desert Ridge Resort in Scottsdale with regard to quality, convenience and recreational activities. It is rated as a Mobil 4 diamond hotel (scale of 5). Some other facts for the committee to consider:

It is located only 15 minutes from the Orlando Airport

As a frame of reference, it is within a mile of the Orlando Convention Center and the Peabody Hotel.

Rosen is a local Orlando hotel developer. He has two other hotels that flank either end of the Orlando Convention Center. Judging from the way the hotel staff talk about him, he has achieved "cult" status.

The resort is 2-3 miles from Universal Studios Amusement Park and 1 mile from Sea World. There is a free shuttle to these parks from the resort. The Wet n Wild park is 2 miles away.

It is approximately 12 miles from Disney World and Epcot. The drive took us about 20 minutes. There is a shuttle available from Shingle Creek to Disney for a charge of $14 round trip.

The rooms are very nice (as good, if not better than Desert Ridge) with plasmas screens and all of the appropriate tech stuff. There are 1500 rooms. There are plenty of suites. There is a concierge floor.

There are two upscale restaurants on the property with plenty of other dining options at Pointe Orlando, a collection of upscale stores and restaurants 1 mile away (just down the street from the Peabody)

There are several informal dining options available including a 24 hour market and deli.

There are 4 swimming pools, 2 tennis courts, a fully equipped fitness center, a spa and an impressive 18-hole golf course just outside the back door. There is also a "nature walk".

There is a childrens activities center (The Swamp) with arts, crafts movies, treasure hunts, board games computer games etc.

The convention space is massive and closely located to the lobby.

The resort staff that took us around was very thorough and knowledgeable.

In summary, The Rosen Shingle Creek Resort exceeded our expectations. For a closer look at the resort, the website is: http://www.shinglecreekresort.com/default.asp

As much as we were impressed with the Shingle Creek Resort we were disappointed with the Contemporary Resort. Although it has the distinct advantage of monorail proximity to Disney World and Epcot, it was unimpressive from just about every other standpoint. The major

renovations that had been advertised prior to our visit were still ongoing. What had been done did not look all that good. With regard to the renovated hotel rooms, Laurie felt that the hotel needed to “fire their decorator”. I agreed. The California Grill on the top floor did look good. They have a private dining room with roof access for viewing fireworks. This would be a good option for the Chairman’s Dinner. The convention facilities were a step up from the rest of the resort but not on the level of those at Shingle Creek. The hotel employee who took us around was relatively clueless.

In summary, all three of us voted thumbs down on the Contemporary.

Our final visit was to the Buena Vista, next year’s meeting site. We were all impressed with the renovations they have made and are still making. The rooms are significantly improved from the time of our last meeting there. They are comparable to those at Shingle Creek. The lobby was being completely renovated at the time of our visit. As far as the Convention facilities are concerned, we were able to grab some additional breakout rooms but could not find any way to increase our exhibit hall space unless the Cyber Café, Posters and What’s New Session are moved out of the hall.

So, the Buena Vista, while not in the league of Shingle Creek, is definitely improved from our 2006 meeting.

Following this site visit, our recommendation is to proceed with Shingle Creek for 2010 with an option for 2012.

I hope this helps. Feel free to share my comments with the rest of the Executive Committee.

Regards,

Iain

SPINESECTION.ORG

American Association of Neurological Surgeons

CONGRESS OF NEUROLOGICAL SURGEONS

AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves

Monday, May 7, 2007

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Logo Contest

The AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves is holding a contest for a new logo design.

Deadline: **September 7, 2007 @ 12:00 PM CDT**

Finalists will be announced _____

Rules

- All submitted work must be original and not based on any pre-exisiting design.
- If your entry produces trademark problems due to potential similarities to existing trademarks it will not be considered.
- By entering a logo design you agree to transfer the copyright on the design to the AANS/CNS Joint Section on Disorders of the Spine and Peripheral Nerves should your design win first, second, or third place.
- Entries should not contain any text other than the word 'SpineSection' or 'SpineSection.org'
- Only one entry is accepted per person.
- You must be 18 years of age or older to enter.
- To receive a prize, you must be located in either the United States or Canada.
- Your logo must not contain any copyrighted images (e.g. datamined textures, artwork, screenshots, etc).
- Winners will need to send their image project files (i.e. pre-compiled) once they have been chosen.

First Place Apple iPod 80GB with Video

Second Place SmartParts 8.4" Digital Picture Frame

Third Place Apple iPod Shuffle

First Name

Last Name

Email

Your Title (e.g. medical student, resident, attending @ __ University, etc)

Logo Browse...

Submit

Special Announcement from the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves

June 27, 2007

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*

Spine Clinical Trial Proposal - $500
Spine Clinical Fellowship Award - $50,000

The AANS/CNS Section on Disorders of the Spine and Peripheral Nerves is pleased to announce the creation of a clinical trials fellowship award to promote clinical trials in spine. Neurosurgical residents/ fellows/ junior faculty are eligible to submit proposals ($500). Only **junior faculty** are eligible for the Fellowship Award ($ 50,000). The objective of this Fellowship is to foster the spirit of team-building necessary for executing multi-center studies, which are critically needed in neurosurgery in general, and spinal surgery in particular. The procedure for applying for the award is summarized below. Please check the section Web site (http://www.spinesection.org) for updates.

Step 1. - **Clinical Trials Proposal Award - $ 500**
This award will be presented annually by the AANS/CNS Spine Section to three or less neurosurgical residents or BC/BE junior faculty neurosurgeons/ fellows in North America who submit an outstanding clinical trials proposal in spine (five pages maximum) that demonstrates relevance, sound methodological design, and feasibility. Preference will be given to a team that designs a multi-center trial. Awardees (up to three per year) will be given a $500 honorarium plus expenses paid to attend the AANS/CNS Spine Section Annual Meeting (awardee only).

Step 2. - **Clinical Trials Fellowship Award - $ 50,000**
All proposals will be considered for a Fellowship Award. Meritorious proposals will be formally critiqued by the Outcomes Committee. A revised proposal may be submitted for a $50,000 Clinical Trials Fellowship Award (1-year) to carry out a pilot study for the proposed research plan. The Fellowship winner must be junior faculty to accept the award.

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American Association of Neurological Surgeons
5550 Meadowbrook Drive , Rolling Meadows, Illinois 60008-3852
(888) 566-AANS (2267) or (847) 378-0500

Outcomes Committee Report
Spine Section Executive Committee Meeting
Monday, September 17, 2007

Committee Members:

Mike Kaiser mgk7@columbia.edu
Tanvir Choudrhi tanvir.choudhri@mountsinai.org
Zoher Ghogawala zoher.ghogawala@yale.edu
Subu Magge subu.n.magge@lahey.org
Juan Bartolomei bartolomeij@sbcglobal.net
Peter Angevine pda9@columbia.edu

A. Clinical Trials Award – Zoher Ghogawala

1. We have created a Clinical Trials Award to promote more clinical trials in neurosurgery in general and spinal surgery in particular. We have obtained a $52,000 grant from the Mr. and Mrs. David and Jean Wallace (Wallace Foundation) to support this endeavor.

2. In order to publicize the Award, Marjorie Wang E-blasted the following announcement* through the Congress and the AANS. In addition Joe Cheng has posted the Award on the Section Website and also posted a sample proposal using a trial comparing outcomes from decompression alone versus decompression with fusion for spinal stenosis with grade I degenerative spondylolisthesis as an example.

3. We have received several proposals. One has been circulated to all members of the Outcomes Committee. We will work with the Awards/ Fellowships Committee (Chair – Peter Gerszten) to select winners.

4. In addition, we are keeping the section website current with a section on all active clinical trials registered with the NIH site clinicaltrials.gov that relate to spinal diseases.

B. MOC instruments for Evidence of Performance in Practice

a) Updated/reassessed at the request of the ABNS
b) Anticipated online date of fall 2007

C. Joint Section Clinical Outcomes Research award -$2000

a) To be awarded at upcoming Joint Section

TO: Chris Shaffrey, Mike Wang, Christopher Wolfla, Dan Resnick, and Paul McCormick

Gentlemen,

Journal of Neurosurgery: Spine is interested in publishing papers presented at the Joint Section. There are two mechanisms available to accomplish this.

First, all papers could be accepted without peer review and published as a supplement. It would be clearly stated that these papers were not peer reviewed, and the cost of the publication would be borne by the Joint Section.

Second, an expedited review would be done within the Journal of Neurosurgery submission site and follow the usual review protocol. If enough articles were submitted to Journal of Neurosurgery: Spine and reviewed promptly, an attempt would be made to publish them in the same issue. Candidly, an expedited review means a positive attitued on the part of the reviewers, the Chairman of the Journal of Neurosurgery: Spine Editorial Board, and myself.

I favor the second method. In the present state of affairs where for instance evidence-based medicine, randomized clinical trials, and FDA oversight are in the non-peer reviewed publications, they have lost a great deal of credibility.

I would be glad to expand on these points but I wanted to make clear my enthusiasm and interest in the presented papers.

Sincerely yours,

John A. Jane, Sr., M.D., Ph.D.

Editor

Journal of Neurosurgery

RESEARCH AND FELLOWSHIP AWARDS COMMITTEE REPORT

Spine Section Executive Committee Meeting
CNS Meeting San Diego September 17th, 2007

Current Awards:

Award	Vendor Support	Amount
Larson Research Award	Depuy Spine	$30,000
Kline Research Award	Integra	$15,000
Apfelbaum Research Award	Aesculap	$15,000
Cloward Fellowship	Sofamor Danek	$30,000
Cahill Fellowship	Synthes	$30,000
Sonntag International Fellowship	Sofamor Danek	$5,000
Crockard International Fellowship	Depuy Spine	$5,000
Outcomes Committee Award	Wallace Fund	$3,000
Mayfield Award (Basic Science)	Spine Section	$3,000
Mayfield Award (Clinical)	Spine Section	$3,000

Deadline for all submissions will be December 1st, 2007

Theme: Back to the Future: Legends in Spine and Nerve Surgery

Day	Start Time	End Time	Event
Tuesday, February 26	**Tuesday**		
	6:30 PM	8:30 PM	**Executive Committee Dinner**
Wednesday, February 2	**Wednesday**		
	11:00 AM	6:00 PM	Registration / Speaker Ready Room
			Afternoon Sesions
	1:30 PM	5:30 PM	Special Course I
			Special Course II
			Special Course III
			Special Course IV
			Special Course V
			Special Course VI (NP and PA)
			Evening Session
	6:30 PM	8:30 PM	**Opening Reception**
Thursday, February 28	**Thursday**		
	6:00 AM	6:00 PM	Registration / Speaker Ready Room
	9:00 AM	6:00 PM	Exhibit Hall / Poster Viewing
			Morning Sessions
	6:30 AM	6:55 AM	Continental Breakfast / Case Presentations
	6:55 AM	7:00 AM	Introductory Remarks / Meeting Announce
	7:00 AM	**9:00 AM**	**Scientific Session I**
	9:00 AM	9:10 AM	Presidential Address
	9:10 AM	9:30 AM	Meritorious Award Winner
	9:30 AM	10:15 AM	Coffee Break / What's New?
	10:15 AM	12:30 PM	Oral Platform Presentations I
	12:30 PM	1:25 PM	Lunch Break / What's New?
			Afternoon Sessions
	1:25 PM	1:30 PM	Meeting Announcements
	1:30 PM	**3:15 PM**	**Scientific Session II**

	3:15 PM	4:00 PM	Coffee Break / What's New?
	4:00 PM	5:30 PM	Oral Poster Presentations I and II
	5:30 PM		Adjourn
			Evening Session
	6:30 PM	8:30 PM	**Chairman's Dinner**
Friday, February 29	**Friday**		
	6:00 AM	6:00 PM	Registration / Speaker Ready Room
	9:00 AM	12:30 PM	Exhibit Hall / Poster Viewing
			Morning Sessions
	6:30 AM	6:55 AM	Continental Breakfast / Case Presentations
	6:55 AM	7:00 AM	Meeting Announcements
	7:00 AM	9:00 AM	**Scientific Session III**
	9:00 AM	9:30 AM	Fellowship Awards and Updates
	9:30 AM	10:15 AM	Coffee Break / What's New?
	10:15 AM	12:15 PM	Oral Platform Presentations II
	12:15 PM	12:30 PM	Annual Business Meeting
	12:30 PM		Lunch on Your Own
			Afternoon Sessions
	12:30 PM	2:30 PM	Luncheon Symposium I
	12:30 PM	2:30 PM	Luncheon Symposium II
	12:30 PM	2:30 PM	Luncheon Symposium III
	1:30 PM	5:30 PM	Special Course VII
	1:30 PM	5:30 PM	Special Course VIII (NP and PA)
			Social Events

			Evening Sessions
	6:30 PM	8:30 PM	**Young Neurosurgeon's Dinner**
	6:30 PM	7:30 PM	**Senior Advisory Council Reception**
	7:30 PM	9:30 PM	Chairmans Advisory Council Dinner
Saturday, March 1	**Saturday**		
	6:00 AM	6:00 PM	Registration / Speaker Ready Room
	9:00 AM	12:30 PM	Exhibit Hall / Poster Viewing
			Morning Sessions
	6:30 AM	6:55 AM	Continental Breakfast / Case Presentations
	6:55 AM	7:00 AM	Meeting Announcements
	7:00 AM	8:00 AM	**Scientific Session IV**
	8:00 AM	9:30 AM	**David Cahill Mem Controversies**
	9:30 AM	10:15 AM	Coffee Break / What's New?
	10:15 AM	11:00 AM	Mayfield Awards / Presentations
	11:00 AM	12:30 PM	Oral Poster Presentations III
	12:30 PM		Lunch on Your Own / Exhibit - Poster Dism

Description

Coding Update and Review
Spine and Nerve Oral Board and Recertification Review
Learning Adult Spinal Deformity Surgery: Principles and Techniques
Advances in the Treatment of Thoracic and Lumbar Spine Trauma
Advances in Minimally Invasive and Outpatient Spine Surgery
Evaluation and Management of the Spine Trauma Patient

s
ments

Back to the Future
History of Spinal Surgery
Craniovertebral Junction Anomolies: Classification and Treatment
Diagnosis and Treatment of Degenerative Spinal Stenosis
Evolution of Peripheral Nerve Surgery
Management of Pediatric Spinal Trauma
Deformity Surgery over 30 years: Lessons Learned
Panel Discussion

Back to the Future: Legends in Spine and Peripheral Nerve Surgery
Evolution of Cervical Spinal Instrumentation

(8 min papers in blocks of 3, 10 minutes questions) 12 abstracts

Spinal Alignment and Treatment Implications

Cervical Spinal Alignment in Asymptomatic Adults
Treatment of Cervical Myelopathy
Thoracic-Lumbar-Pelvic Alignment In Asymptomatic Adults
Classification of Adult / Geriatric Spinal Deformity
Importance of Spinal Alignment in Patient Outcomes
Restroing Spinal Alignment
Panel Discussion / Case Presentation

(3 min papers in blocks of 3, 6 minutes questions, 2 concurrent sessions) 36 abstra

s

Critical Review of New Randomized Contolled Trials for Lumbar Degenerative Dise
Synopsis of Results
Critical Evaluation of Results
Implications for Clinical Practice
Panel Discussion

Clinical and Socioeconomic Implications of Spinal Surgery
Socioeconomic Impact of Spinal Surgery
Influence of Industrial Sponsorship
Clinical Impact of Spinal Surgery
Panel Discussion / Case Presentation

(8 min papers in blocks of 3, 10 minutes questions) 10 abstracts

Revision Spine Surgery and Complication Avoidance
Evolution of Minimally Invasive Spine Surgery Techniques
Treatment of Primary and Metastatic Spine Tumors

Peripheral Nerve Exposures and Nerve Repair Techniques
Evaluation and Management of the Post-Operative Spine Patient

Organized golf tournament - Tennis on your own

Approxiamte 50 people - Guest Speaker: Ronald I. Apfelbaum
Approximate 75 people
Approximate 50 people

s

Evolution of Motion Preservation
Cervical Arthroplasty: From Trial to Practice - What is Reality?
Lumbar Arthroplasty: New Disks Arriving
Posterior Dynamic Stabilization: 1 to 2 year Followup Results
Facet Joint Replacement: Early Results
Panel Discussion / Case Presentation

Spine andl Nerve
Spinal Balance: Important or Not
Spinal Cord Injury: Emergent or Urgent Surgery
Piriformis Syndrome: Real or Not
Low Back Pain from DDD: Normal Aging or Pathological Condition

(3 min papers in blocks of 3, 6 minutes questions) 18 abstracts
nantling

Responsible Person	Speaker Time	Notes
R John Hurlbert	2 hours	Business casual
Robert R Johnson / Joseph S Cheng	4 hours	
Michael G Kaiser / Charles L Branch	4 hours	
Stehen L Ondra / Michael Y Wang	4 hours	
Robert F Heary / Gregory R Trost	4 hours	
Kevin T Foley / Mark R McLaughlin	4 hours	
Peter C Gerszten / Andrea Strayer / Erin Vill	4 hours	
R John Hurlbert		Business casual
Edward C Benzel / Frank LaMarca	25 min	
Joseph T Alexander	5 min	
R John Hurlbert / Charles Kuntz, IV	**Moderators**	
Volker K H Sonntag	18 min	
Arnold H Menezes	18 min	
Philip R Weinstein	18 min	
David G Kline	18 min	
Dachling Pang	18 min	
David S Bradford	18 min	
Panel	12 min	
Joseph T Alexander	12 min	
Ronald I Apfelbaum, MD	18 min	
Mark R McLaughlin / Chad J Morgan	**Moderators**	
	5 min	
Robert E Isaacs / Julie E York	**Moderators**	

Michael W Groff	15 min	
Junichi Mizuno	15 min	
Stephen L Ondra	15 min	
Christopher I Shaffrey	15 min	
Tyler R Koski	15 min	
Praveen V Mummaneni	15 min	
Panel	15 min	
John J Knightly / Daniel H Kim	**Moderators**	
R John Hurlbert	2 hours	Formal

Arnold H Menezes / Paul G Matz	25 min	
	5 min	
Christopher E Wolfla / Michael G Fehlings	**Moderators**	
Robert E Isaacs	15 min	
Richard G Fessler	15 min	
Daniel K Resnick	15 min	
Panel	15 min	
Charles I Branch / P. Colby Maher	**Moderators**	
Sohail K Mirza	15 min	
Paul C McCormick	15 min	
Christopher I Shaffrey	15 min	
Panel	15 min	
Praveen V Mummaneni	30 min	
Rajiv Midha / Joseph S Cheng	**Moderators**	
Daniel K Resnick		

Christopher I Shaffrey / Timothy C Ryken	2 hours
Richard G Fessler / John C Liu	2 hours
Ehud Mendel / Ziya L Gokaslan	2 hours
Allen H Maniker / Robert J Spinner	4 hours
Gregory R Trost / Andrea Strayer / Erin Villa	4 hours

		Business casual
R John Hurlbert	2 hours	Business casual
R John Hurlbert	1 hours	Business casual
R John Hurlbert	2 hours	

Ziya L Gokaslan / Tanvir F Choudhri	25 min
	5 min
Michael P Steinmetz / Brian R Subach	**Moderators**
Regis W Haid	12 min
Iain H Kalfas	12 min
William C Welch	12 min
Larry T Khoo	12 min
Panel	12 min
Eric L Zager / Regis W Haid	**Moderators**
Stephen L Ondra / Peter D Angevine	22 min
Michael G Fehlings / Edwaed C Benzel	22 min
Robert L Tiel / Aaron G Filler	22 min
Sohail K Mirza / Daniel K Resnick	22 min
Tyler R Koski / Michael W Groff	**Moderators**

Special Announcement from the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves

June 28, 2007

****

Spine Clinical Trial Proposal – $ 500
Spine Clinical Fellowship Award – $ 50,000

The AANS/CNS Section on Disorders of the Spine and Peripheral Nerves is pleased to announce the creation of a clinical trials fellowship award to promote clinical trials in spine. Neurosurgical residents/ fellows/ junior faculty are eligible to submit proposals ($500). Only **junior faculty** are eligible for the Fellowship Award ($ 50,000). The objective of this Fellowship is to foster the spirit of team-building necessary for executing multi-center studies, which are critically needed in neurosurgery in general, and spinal surgery in particular. The procedure for applying for the award can be found on the section Web site (http://www.spinesection.org) and is also summarized below:

Step 1. – Clinical Trials Proposal Award - $ 500
This award will be presented annually by the AANS/CNS Spine Section to three or less neurosurgical residents or BC/BE junior faculty neurosurgeons/ fellows in North America who submit an outstanding clinical trials proposal in spine (five pages maximum) that demonstrates relevance, sound methodological design, and feasibility. Preference will be given to a team that designs a multi-center trial. Awardees (up to three per year) will be given a $500 honorarium plus expenses paid to attend the AANS/CNS Spine Section Annual Meeting (awardee only).

Step 2. – Clinical Trials Fellowship Award - $ 50,000
All proposals will be considered for a Fellowship Award. Meritorious proposals will be formally critiqued by the Outcomes Committee. A revised proposal may be submitted for a $50,000 Clinical Trials Fellowship Award (1-year) to carry out a pilot study for the proposed research plan. The Fellowship winner must be junior faculty to accept the award.

****

American Association of Neurological Surgeons
5550 Meadowbrook Drive, Rolling Meadows, Illinois 60008-3852
(888) 566-AANS (2267) or (847) 378-0500

OUTCOMES COMMITTEE SUMMARY

Ghogawala-Kaiser
Spine Executive Committee Meeting
September 17, 2007

1. We have created a Clinical Trials Award to promote more clinical trials in neurosurgery in general and spinal surgery in particular. We have obtained a $52,000 grant from the Mr. and Mrs. David and Jean Wallace (Wallace Foundation) to support this endeavor.

2. In order to publicize the Award, Marjorie Wang E-blasted the following announcement* through the Congress and the AANS. In addition Joe Cheng has posted the Award on the Section Website and also posted a sample proposal using a trial comparing outcomes from decompression alone versus decompression with fusion for spinal stenosis with grade I degenerative spondylolisthesis as an example.

3. We have received several proposals. One has been circulated to all members of the Outcomes Committee. We will work with the Awards/ Fellowships Committee (Chair – Peter Gerszten) to select winners.

4. In addition, we are keeping the section website current with a section on all active clinical trials registered with the NIH site clinicaltrials.gov that relate to spinal diseases.

E-BLAST
Spine Clinical Trial Proposal - $ 500
Spine Clinical Fellowship Award - $ 50,000

Application Deadline – December 1, 2007

The Spine Section is pleased to announce the creation of a clinical trials fellowship award to promote more clinical trials in neurosurgery. Neurosurgical residents/ fellows/ and junior faculty are eligible to submit proposals. Only Junior faculty are eligible for the Fellowship Award ($ 50,000). The objective of this fellowship would be to create the spirit of team-building, necessary for executing multi-center studies, which are badly needed in neurosurgery in general, and spinal surgery in particular. The procedure for applying for the award can be found on the section website and is also summarized below:

Step 1. Clinical Trials Proposal Award - $ 500

This award would be presented annually by the AANS/CNS Section on Disorders of the Spine and Peripheral Nerves to three or fewer neurosurgical residents or BC/BE neurosurgeons/ fellows in North America who submit an outstanding clinical trials proposal (5 pages maximum) that demonstrates relevance, sound methodological design, and feasibility. Preference would be given to a team that designs a multi-center trial. Winners (up to 3/ year) would be given an honorarium of $ 500 dollars each plus expenses paid to attend the annual AANS/CNS Spine Section Meeting (presenter only).

Step 2. Clinical Trials Fellowship Award - $ 50,000

All proposals will be considered for a Fellowship Award. Those individuals whose proposals are meritorious would be formally critiqued by the Outcomes Committee and would be invited to submit a revised proposal to apply for a $ 50,000 dollar Clinical Trials Fellowship Award (1-year) to carry out a pilot study for their proposed research plan. The Fellowship Winner must be Junior Faculty to accept the Award.

SPINESECTION .ORG

Committee Report (April 16, 2007)
Chair: Joseph Cheng, M.D.
Members: Tom Yao, M.D. (Resident), Ben Rosenbaum (Medical Student)

Recent Updates

1. General/Home Web Page Updates
    a. Divided Meetings and Education into separate pages to provide more content.
    b. (Question)Should we post audio/video podcast of Annual Business Meeting on public home page?
2. Newsletters Page (Dr. Mike Groff)
    a. Post Newsletters Quarterly Updates.
    b. Get database of membership e-mails.
    c. Software for mass e-mails of content through AANS or CNS office.
3. Meetings Page Updates
    a. Annual Meeting Content (Podcast) Project
        i. Audio and video Podcast of lectures and presentations now available.
        ii. Database created to track which media files are downloaded to determine user preferences.
        iii. This will also track which podcasts (audio or video) are requested to determine which format or topics are more popular.
            1. May help future scientific program development to determine popular areas.
        iv. Secure login requirement to protect the media files.
            1. Mid-level protection: Files are on the server similar to the current level of protection afforded to the password-protected member's page.
            2. If security is a concern, we can protect within the database.
            3. **Username: spine Password: podcast**
            4. Can develop database for users to register onto the sight for their own user name and password.
                a. Will add need to verify registration before assigning temporary password.
        v. A robots.txt file was added to the top-level of the site to disallow robots/spiders from crawling the files directory, except for the pdfs to keep them out of the media content.
            1. The protocol is purely advisory and relies on the cooperation of the web robot (does not guarantee privacy).

2. Can eventually add more protection to the files directory such as locking folders via Apache (**will take a lot of time to set up**).

vi. Audio ripped from video at 64kbps into mp3 format to condense file for Web Page but can provide 192kbps mp3's if desired (much larger file).

vii. **Podcast by dragging the icon/link into their iTunes**.

b. Annual meeting abstracts and digital posters are now on Web page.

4. Education Page
   a. Spine Journal Club Audio Podcast Project (Drs. Joe Cheng/Mike Wang)
   b. Article Reviews
      i. Summaries of 5-10 articles from spine journals each month.
      ii. Monthly Team of 1 Moderator and 4 reviewers.
         1. Moderator will choose articles and assign to reviewers.
      iii. Goal: Roll out date of October 1, 2007 and e-blast of this to members.
   c. Roundtable Reviews
      i. Discussion of 1-2 "high profile" articles from spine journals each month.
      ii. Monthly Team of 1 Moderator and 2 reviewers.
         1. Conference call recorded of Moderator giving quick review of article and 5-10 minutes of discussion between the moderator and 2 reviewers.
         2. Goal: Roll out date of October 1, 2007 and e-blast of this to members.
5. Web Committee Budget: $10,000
   a. ($1,750) AV charge to capture meeting in raw video format of Friday morning session.
      i. Declined charge of $2,900 to edit video into individual talks.
      ii. Declined additional charge to convert video to Podcast/streaming video formats.
   b. ($1,900) Purchases of multimedia software and equipment to edit and convert audio and video files and development items.
   c. Discussion
      i. Approval for gift-in-kind and consultant stipends to have undergraduate students help with time consuming portions of project.
      ii. Approval for resident/student meeting grants (travel/housing) participating in Web page work.
         1. Future project of providing live updates of web page during meeting.
      iii. Consider asking for specific corporate sponsorship of this project (Web advertising space).
      iv. Approval to upgrade account for increased bandwidth or set up separate server for media files as time goes on.

v. Approval for time and effort for web development of databases and secure areas.

Future Proposals

Goals

1. Provide more value added content to entice membership.
2. Provide a central location for members to get news, updates, and communications quickly.

Plans

1. Create a Meeting News area on homepage during meeting to provide news, reports, and announcements "live" during meeting.

Archive Page

- Accessed by link "For Members Only" at the bottom of the entry page
- The archive page is protected using a common username/password.
- The password is: Dandy
- The download page has zipped individual files that require a password.
- This password is: Cushing

As always, new content is always welcome and any suggestions for the website are appreciated. Please feel free to contact me at, or send website materials to: joseph.cheng@vanderbilt.edu.

Respectfully Submitted,

Joe Cheng, M.D.
Vanderbilt University

SPINESECTION .ORG

Web Committee Report (August 28, 2007)
Chair: Joseph Cheng, MD, MS
Members: Tom Yao, MD (Resident), Ben Rosenbaum (Medical Student)

Web Site Projects

1. Spine Journal Club Audio Podcast Project
    a. Editors/Speakers: Drs. J. Cheng, M. Wang, M. Schmidt, M. Steinmetz
    b. Article Reviews
        i. Summaries of 5-10 articles from spine journals each month.
        ii. Expected roll out date of October 1, 2007.
2. SpineSection Logo Contest
    a. Contest ends on September 7, 2007.
    b. Only a handful of entries received, and voting survey to be sent to all EC members to vote.
3. Annual Meeting Content (Podcast) Project
    a. Audio and video files of annual meeting lectures and presentations.
    b. ?? Consider making a single video file available each month on the Education Page for a "Lecture of the Month" series.
    c. Login required for access to media files.
        i. Username: **spine** Password: **podcast**
4. Meeting News Area Project
    a. Early plans for a web page that is "live" during the meetings to provide current news, notices, reports, and announcements.
    b. Tied into an informational board (large plasma TV monitor) that will cycle through the same information that the web page is linked to.
    c. Early development phase, not expected until 2009 Annual Meeting if launched.

Recent Web Page Updates

1. Home Web Page Updates
    a. Added ***AANS Online Case Studies*** link.
    b. Updated 2008 Annual Meeting Information links.
2. Newsletters Page
    a. **Need new Newsletters Quarterly Updates (Last one was Fall 2006).
3. Meetings Page Updates
    a. New 2008 Annual Meeting Information now available.
    b. Abstract submission link and Exhibitor prospectus on-line.
    c. Prior Annual Meeting abstracts, digital posters, and audio/video media are on-line.
4. Education Page
    a. AANS Online Case Studies link on-line.

b. Spine Journal Club Audio Podcast Project pending.

5. Fellowships and Awards Page
    a. Clinical Trials Fellowship information now on-line.

Web Page Spending

1. Web Budget: $10,000 requested annually
    a. Computer Software updates for Web publishing and maintenance, audio and video manipulation and conversion programs will be the bulk of the software purchases in the coming year.
    b. Computer Supplies will need to be included as well such as DVD-R's, labels, memory, hard drives, video players, and other computer items related to the development of Web content.
    c. Logo Contest Prizes will still need to be purchased for the contestants.
    d. AV costs of recording the upcoming annual meeting will be from the Web budget at this time, but expected to go into the meeting budget if continued.
    e. Plan to upgrade account for increased bandwidth and allow streaming video and audio.
    f. Approval for time and effort for web development of databases and secure areas.
2. Web Site Personnel
    a. Summer Stipend awarded to Ben Rosenbaum, a medical student at Vanderbilt to help with development and maintenance of the web page.
3. Consider asking for specific corporate sponsorship of this project (Web advertising space).

Archive Page

- Accessed by link "For Members Only" at the bottom of the entry page
- The archive page is protected using a common username/password.
- The password is: Dandy
- The download page has zipped individual files that require a password.
- This password is: Cushing

As always, new content is always welcome and any suggestions for the website are appreciated. Please feel free to contact me at, or send website materials to: joseph.cheng@vanderbilt.edu.

Respectfully Submitted,

Joe Cheng, M.D.
Vanderbilt University

My 2 cents. NASS is functioning as the meeting planner/coordinator for the World Spine Society meeting. It appears that the meeting will make a few dollars for NASS, but not anything overwhelming, barely worth the effort.
Frankly, this is not a must do project for the Spine Section. We have many other potential projects with much better return for our effort.
If we can be a sponsoring organization of the WSS meeting to get our name on the program, without any financial risk etc., then fine. We don't need to take the lead on this project..in particular we don't need to take on sponsorship or ownership of the World Spine Society.
CB

-----Original Message-----
From: Gerald Rodts [mailto:Gerald.Rodts@emoryhealthcare.org]
Sent: Tuesday, July 10, 2007 1:22 PM
To: p. mummaneni; r. haid; m. groff; e. woodard; m. steinmetz; m. Kaiser; j. pat johnson; h. aryan; Chris I *HS Shaffrey; z. gokaslan; marjorie wang; t. choudhri; michael.rosner@na.amedd.army.mil; j.buisse; Resnick (Daniel); g. trost; r. johnson; i. kalfas; s. ondra; e. mendal; m.mclaughlin@princetonbrainandspine.com; k. foley; j. hurlber; Robert Heary; e. zager; p. gerszten; m. wang; kfoley@usit.net; j. cheng; Charles Branch; c. kuntz; j. alexander; p. Matz; z. ghogawala
Subject: World Spine: feedback

Chris and Bob's recollection and sentiment are right on the money. I would be opposed to any further involvement in World Spine. It was of little additional value to our Section, put us at financial and legal risk (more accurately, our parent organizations), and detracts from our mission to provide outstanding education at our own annual meeting. I vote no.
Rusty

Gerald E. Rodts, Jr., M.D.
Professor of Neurosurgery and Orthopaedic Surgery; Chairman, CNS Scientific Program Committee
59 Executive Park South
Suite 3000
Atlanta, GA 30329
Tel. 404-778-6303
Fax 404-778-6310

>>> "Robert Heary" <heary@umdnj.edu> 07/09/07 3:06 PM >>>
guys:
chris is 100% correct in his recollection of our previous involvement.

we gave back our "profit" to be used toward the future success of the next world spine meeting. when the next world spine meeting came around, it was run and organized without input from the spine section.

i also agree that we received virtually no credit for world spine 1. furthermore, it sounds like NASS may want to bail on the project if world spine 4 is not financially solvent. since world spine has chosen NASS, rather than the spine section, years ago, to be its partner, why would the section now want to re-visit this group? understanding, of course, that if world spine 4 is a winner, they won't need our involvement. i agree with chris in that each individual proposal should

be carefully reviewed on its own merit and the section should make informed decisions. certainly, prior track record of performance enters into the informed decision process. in this case, the world spine group turned its back on the section when the section's involvement did not appear necessary.
bob heary

>>> "Shaffrey, Chris I *HS" <CIS8Z@hscmail.mcc.virginia.edu> 7/9/2007 2:48 PM >>>

I have enough gray hair (the few that are left) to remember that we partnered with NASS for the first World Spine meeting (in Chicago). The
executive committee of the Joint Section generously gave the "profit" for the meeting back to the world spine organizing committee for seed money for preparation for the next World Spine Meeting. Despite our "equal" partnership with NASS we got very little visibility for our support and were somehow disengaged from the subsequent meeting. I really think we should think carefully before we engage in the monetary sink holes of international meetings. I am also leery because of the shortcomings with our previous involvement in this meeting.

From: Resnick (Daniel) [mailto:resnick@neurosurg.wisc.edu]
Sent: Mon 7/9/2007 2:32 PM
To: michael.rosner@na.amedd.army.mil; C. Branch; c. kuntz; Shaffrey, Chris I *HS; c. wolfla; d. resnick; e. mendal; e. woodard; e. zager; g. rodts; g. trost; h. aryan; i. kalfas; j. alexander; j. cheng; j. hurlber; j. pat johnson; j.buisse; k. foley; kfoley@usit.net; m. groff;
m. Kaiser; m. steinmetz; m. wang;
m.mclaughlin@princetonbrainandspine.com; marjorie wang; p. gerszten; p. Matz; p. mummaneni; r. haid; r. heary; r. johnson; s. ondra; t. choudhri; z. ghogawala; z. gokaslan
Subject: FW:

Dear Executans:
Please have a look at the correspondence from Ed Benzel regarding the World Spine Society. I have asked Ed to put together some facts for
us
to discuss at the upcoming spine exec meeting in September.
Thanks!
Dan

Daniel K. Resnick, MD MS
Associate Professor
Department of Neurological Surgery
University of Wisconsin Medical School
K4/834 Clinical Science Center
600 Highland Ave
Madison, WI 53792

-----Original Message-----
From: Trost (Gregory)
Sent: Monday, July 09, 2007 8:07 AM
To: Benzel, M.D., Edward
Cc: Resnick (Daniel)
Subject: RE:

Ed,
We can talk in Cleveland. I had wanted to see what you would like the role of the Joint Section to be. It may be useful for you to come to the Exec. Committee meeting in San Diego at CNS. Since Dan is the Chair-Elect we should talk together during the course-he has a better understanding of the Section's desires/wishes.

Gregory R. Trost, MD
Professor and Vice Chair of Neurological Surgery
Director of Spinal Surgery
University of Wisconsin-Madison
600 Highland Ave K3/805
Madison, WI 53792
608-263-1411 Fax 608-263-1728

-----Original Message-----
From: Benzel, M.D., Edward [mailto:BENZELE@ccf.org]
Sent: Sat 7/7/2007 9:34 AM
To: Trost (Gregory)
Subject:

Greg

You had previously wanted to talk about the Spine Section and WSS. Depending on the fiscal success of the WSIV meeting in Istanbul, NASS may think about backing down from its committement to WSS. This is so because of the significant investment they have made re their new main office and skills lab in Chicago area - which has diverted funds from endeavors such as WSS.

Nevertheless, I would love to have the program overseen (or 'parented')
if you will, by a progressive organization that would be interested (with the appropriate infrastructure) to establish paid membership rosters, work on philanthropic endowments, and ultimately work towards fiscal independence of the organization. Is the Spine Section potentially interested in this type of endeavor - either as a stand-alone supporter, or in collaboration wtih NASS?

We can talk at the Course or sooner if you like.

See you soon.

ECB

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We can talk in Cleveland. I had wanted to see what you would like the role of the Joint Section to be. It may be useful for you to come to the Exec. Committee meeting in San Diego at CNS. Since Dan is the Chair-Elect we should talk together during the course-he has a better understanding of the Section's desires/wishes.

Gregory R. Trost, MD
Professor and Vice Chair of Neurological Surgery Director of Spinal Surgery University of Wisconsin-Madison 600 Highland Ave K3/805
Madison, WI 53792
608-263-1411 Fax 608-263-1728

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Sent: Sat 7/7/2007 9:34 AM
To: Trost (Gregory)
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We can talk at the Course or sooner if you like.

See you soon.

ECB

COMBINED PROFESSIONAL SOCIETY TASK FORCE ON
LUMBAR FUSION OUTCOMES

TO: Executive Committee

FROM: Steven D. Glassman, M.D./ Dan Resnick, M.D.

TOPIC: Draft outline of Task Force Goals

Attached is a draft outline of proposed task force activities. Our suggestion is to begin with three primary charges.

1. Review existing literature with emphasis on clinical relevance, and specific reference to the discrepancies between the CMS Tech Report and the October 2006 MCAC discussions..

2. Catalogue and advocate for present and future efforts to generate level I and level II evidence assessing lumbar spine fusion outcomes.

3. Establish a mechanism for communication and collaboration with CMS staff.

Pending the approval of the Executive Committee, the next step would be to contact the proposed panel members regarding their participation. (Please note that most of the proposed participants are not yet aware of this effort) Once the panel structure is established, we would arrange a meeting with CMS staff to review our proposal and obtain CMS agreement regarding process/structure.

A second issue is the level and mechanism of funding. We believe that this effort can be carried out with limited financial support, but that the panel structure will require some assistance with coordination and statistical support. Our proposal is to contract for an epidemiologist (50% FTE) to be split between the two panels. We estimate this cost at approximately $50,000 for year one. We believe that the cost should be divided among the organizations ($5,000 per society) and that this investment would be matched by AdvaMed. If the committee feels that AdvaMed involvement is unacceptable, the cost for each organization would be increased accordingly.

Your comments and criticisms would be welcome. Please also include any suggestions regarding additional panel members.

First Name: Steven
Last Name: Glassman, M.D.
Email: SDG12345@AOL.COM
Comment: June 21,2007
Steve Phurrough, M.D.
CMS
7500 Security Blvd.
S11318
Baltimore, MD 2 1244
Dear Dr. Phurrough,
This letter is written of behalf of the Professional Society Coalition on Lumbar Fusion, representing the North American Spine Society (NASS), the American Association of Neurological Surgeons (AANS), the American Academy of Orthopaedic Surgeons (AAOS), the Congress of Neurological Surgeons (CNS) and the Scoliosis Research Society (SRS). We wish to express our concern with regard to the proposed Coverage Decision Memorandum for lumbar artificial disc replacement issued May 25,2007. This document contains a number of references to the November 2006 Medicare Coverage Advisory Committee (MCAC) meeting which we believe inaccurately represent the data that was presented as well as the discussion that occurred at that meeting. In particular, we are concerned about the use of the draft Technology Assessment, generated prior to the MCAC meeting, and made available for public comment earlier this year.
In a previous communication (Attachment A), we expressed our concern that the executive summary and conclusions of the draft Technology Assessment did not accurately reflect the evidence presented within the document. Further, the conclusions are not consistent with the presentation given by the Technology Assessment authors at the MCAC meeting. We are concerned that propagation of this draft document, as a reference in the lumbar artificial disc NCD,would be contrary to the development of an improved evidence-based approach for evaluating lumbar fusion procedures.
In addition, we believe that consideration of the Technology Assessment or MCAC panel vote outside of the specific MCAC context could lead to significant misinterpretation. A primary reason that the MCAC committee felt that the evidence for fusion for low back pain in the Medicare population was weak was because fusion is generally not performed for low back pain in the elderly population (it is performed as an adjunct to decompression in patients with stenosis or to correct deformity). Since the procedure in question is rarely if ever performed, studies are lacking and the panel was

forced to conclude that there was little evidence to support the practice of fusion for low back pain in the Medicare population. While true, this statement is irrelevant and potentially misleading for the non-Medicare population of patients who do undergo fusion for low back pain. It is also potentially misleading for the relevant Medicare population, who are generally treated with fusion as an adjunct to their primary procedure as opposed to fusion perfirned as the primary procedure.

Beyond the criticisms and concerns outlined in our prior response to the draft Technology Assessment, several interim publications have further bolstered the arguments presented on behalf of the Professional Society Coalition at the MCCAC meeting. In our prior communications, we raised the issue that several European RCTs appeared to be overvalued in the Technology Assessment given their significant design flaws. In an article published since the MCAC meeting, Mirza et a1 reviewed these studies in detail and concluded that "surgery may be more efficacious than unstructured nonsurgical care for chronic back pain but may not be more efficacious than structured cognitive-behavior therapy. Methodological limitations of the randomized trials prevent firm conclusions". (Mirza, SPINE, Volume 32(7), 1 April 2007, pp 816-823) Additionally, more recent data from several arms of the SPORT study demonstrate a benefit for surgical treatments including fusion over medical management. With regard to lumbar fusion for treatment of spondylolisthesis, the authors conclude; "In nonrandomized as-treated comparisons with careful control for potentially confounding baseline factors, patients with degenerative spondylolistesis and spinal stenosis treated surgically showed substantially greater improvement in pain and function during a period of 2 years than patients treated nonsurgically. (Weinstein,N Engl J Med. 2007 May 31: 356(22);2257-70,) We believe this represents further evidence that the draft Technology Assessment needs to be modified before being issued in a final form or utilized in the context of other CMS decisions.

The Professional Society Coalition on Lumbar Fusion has been organized with the primary goal of improving the quality of evidence regarding lumbar fusion surgery. We look forward to continued partnership with CMS, so that we can develop the best evidence and provide the best care to patients. Thank you for your consideration in this matter.

Sincerely,

Steven D. Glassman, M. D.

Co-Chair
Daniel Resnick, M.D.
Co-Chair
Professional Society Coalition Task Force on
Lumbar Fusion Outcomes
North American Spine Society
American Academy of Orthopaedic Surgeons
American Association of Neurological Surgeons
Congress of Neurological Surgeons
AANS-CNS Joint Section
Scoliosis Research Society

Attachment A
Chuck Shih, MHS
Center for Outcomes and Evidence
Agency for Healthcare Research and Qual~ty
540 Gaither Road
Rockville, MD 20850

Re: Society Comments on AHRQ Spinal Fusion Report
On behalf of the medical societies listed below and our approximately 28,OOO members, we would like to thank the AHRQ for the opportunity to comment on the Technology Assessment prepared for the November 30 MCAC meeting on fusions. We appreciate the effort put forth on the tech assessment and the guiding principle of providing the best care. We feel that we all have the same goals.

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that information now.
Diagnosis: Perhaps the most important issue is the imprecision of the diagnosis as currently applied in ICD-9-CM codtng. Rarely is this condition, lumbar degenerative &c disease (755.221, seen in isolation in this patient population. Consequently, there is great heterogeneity in the patient population, treatment regimens and outcomes. When this much heterogeneity is present, the generalizability of narrowly defined RCI's is limited. In the diagnosis where there is the hlghest concordance, which is acquired spondylolisthesis (738.4 (ie., degenerative spondylolisthesis)), the outcomes are quite good with surgical treatment. In addition, it appears that the effect size of surgical treatment is as good as or perhaps better in the over-65 patient population than the under-65 population.
Nonsurgical Treatment and Surgical Treatment Equality: There is an inherent weakness of the tech assessment because of the limitations of the existing literature. The tech assessment a priori presumes the value of nonsurgical treatment without reviewing the nonsurgical literature, yet surgery seems to be held to an asymmetrically higher level of evidence scrutiny compared to nonsurgical treatment. There are few if any nonsurgical versus placebo trials for this diagnosis and none of them have two- year follow up data. Therefore, all would be excluded from the tech assessment indicating no evidence or support for this form of treatment. The concept of minimum clinically important difference was inappropriately applied in the review. Specifically, comparison of group means and loolung for an MCID level of change is not a recognized or validated use of this concept.
Points made about applicability of evidence selected in the tech assessment and the generalizability to the heterogeneous population being treated are valid and perhaps could be enhanced further in additional submissions.
RCTs: The European RCTs were disproportionately weighted in the tech assessment simply because they were RCTs. However, we feel that the entry criteria of these studies were not the typical surgical criteria used in the United States. We understand more weight was attributed to the RCTs, however the RCT's in the review were far from ideal and were all conducted outside of North America As such, the generalizability of these studies is not known. In terms of conclusions from the RCTs, in spite of the differences in entry criteria, the primary outcome variables in the RCTs showed surgeryto be beneficial, even when an "intent to

treat" analysis was used instead of an "as mated" analysis. Further, the nonsurgical regimen of the Fairbanks study, a prolonged inpatient stay, is not avdable in a US setting. At best, RCT's demonstrate efficacy but practice studies are required to demonstrate treatment effectiveness. These studies are completely lacking to date. Such studies are challenging to accomplish and may require future dedicated funding if they are to be correctly done and used for health care policy decision-making.

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In summary, we stand ready to assist HHS in identlfylng and discussing issues in the spine field We seek the best care for our patients and we believe a partnership with HHS can only benefit our mutual understanding about what is best for the patients we serve. We appreciate the chance to participate in this continuing dialogue.

Respectfully submitted,

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Dan Resnick, MD Congress of Neurological Surgeons
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of the AANS/CNS and Association of Neurological Surgeons
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City: Louisville
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Organization: Professional Society Coalition Task Force on Lumbar Fusion
Outcomes

First Name: Steven
Last Name: Glassman, M.D.
Email: SDG12345@AOL.COM
Comment: June 21,2007
Steve Phurrough, M.D.
CMS
7500 Security Blvd.
S11318
Baltimore, MD 2 1244
Dear Dr. Phurrough,
This letter is written of behalf of the Professional Society Coalition on Lumbar Fusion, representing the North American Spine Society (NASS), the American Association of Neurological Surgeons (AANS), the American Academy of Orthopaedic Surgeons (AAOS), the Congress of Neurological Surgeons (CNS) and the Scoliosis Research Society (SRS). We wish to express our concern with regard to the proposed Coverage Decision Memorandum for lumbar artificial disc replacement issued May 25,2007. This document contains a number of references to the November 2006 Medicare Coverage Advisory Committee (MCAC) meeting which we believe inaccurately represent the data that was presented as well as the discussion that occurred at that meeting. In particular, we are concerned about the use of the draft Technology Assessment, generated prior to the MCAC meeting, and made available for public comment earlier this year.
In a previous communication (Attachment A), we expressed our concern that the executive summary and conclusions of the draft Technology Assessment did not accurately reflect the evidence presented within the document. Further, the conclusions are not consistent with the presentation given by the Technology Assessment authors at the MCAC meeting. We are concerned that propagation of this draft document, as a reference in the lumbar artificial disc NCD,would be contrary to the development of an improved evidence-based approach for evaluating lumbar fusion procedures.
In addition, we believe that consideration of the Technology Assessment or MCAC panel vote outside of the specific MCAC context could lead to significant misinterpretation. A primary reason that the MCAC committee felt that the evidence for fusion for low back pain in the Medicare population was weak was because fusion is generally not performed for low back pain in the elderly population (it is performed as an adjunct to decompression in patients with stenosis or to correct deformity). Since the procedure in question is rarely if ever performed, studies are lacking and the panel was

forced to conclude that there was little evidence to support the practice of fusion for low back pain in the Medicare population. While true, this statement is irrelevant and potentially misleading for the non-Medicare population of patients who do undergo fusion for low back pain. It is also potentially misleading for the relevant Medicare population, who are generally treated with fusion as an adjunct to their primary procedure as opposed to fusion perfirned as the primary procedure.

Beyond the criticisms and concerns outlined in our prior response to the draft Technology Assessment, several interim publications have further bolstered the arguments presented on behalf of the Professional Society Coalition at the MCCAC meeting. In our prior communications, we raised the issue that several European RCTs appeared to be overvalued in the Technology Assessment given their significant design flaws. In an article published since the MCAC meeting, Mirza et a1 reviewed these studies in detail and concluded that "surgery may be more efficacious than unstructured nonsurgical care for chronic back pain but may not be more efficacious than structured cognitive-behavior therapy. Methodological limitations of the randomized trials prevent firm conclusions". (Mirza, SPINE, Volume 32(7), 1 April 2007, pp 816-823) Additionally, more recent data from several arms of the SPORT study demonstrate a benefit for surgical treatments including fusion over medical management. With regard to lumbar fusion for treatment of spondylolisthesis, the authors conclude; "In nonrandomized as-treated comparisons with careful control for potentially confounding baseline factors, patients with degenerative spondylolistesis and spinal stenosis treated surgically showed substantially greater improvement in pain and function during a period of 2 years than patients treated nonsurgically. (Weinstein,N Engl J Med. 2007 May 31: 356(22);2257-70,) We believe this represents further evidence that the draft Technology Assessment needs to be modified before being issued in a final form or utilized in the context of other CMS decisions.

The Professional Society Coalition on Lumbar Fusion has been organized with the primary goal of improving the quality of evidence regarding lumbar fusion surgery. We look forward to continued partnership with CMS, so that we can develop the best evidence and provide the best care to patients. Thank you for your consideration in this matter.

Sincerely,

Steven D. Glassman, M. D.

Co-Chair
Daniel Resnick, M.D.
Co-Chair
Professional Society Coalition Task Force on
Lumbar Fusion Outcomes
North American Spine Society
American Academy of Orthopaedic Surgeons
American Association of Neurological Surgeons
Congress of Neurological Surgeons
AANS-CNS Joint Section
Scoliosis Research Society

Attachment A
Chuck Shih, MHS
Center for Outcomes and Evidence
Agency for Healthcare Research and Qual~ty
540 Gaither Road
Rockville, MD 20850

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Fax: 502-584-6851
Organization: Professional Society Coalition Task Force on Lumbar Fusion
Outcomes

August 13, 2007

Joseph T. Alexander, M.D.
Chairman, AANS/CNS
Section on Spine Surgery

Dear Dr. Alexander:

On behalf of the Directors of the American Board of Neurological Surgery, I would like to solicit your input as well as that of your Section's leadership on a matter of high importance to our specialty. The Board views certain subspecialization within the field of Neurological Surgery as fundamental to our history, training, research initiatives, and our future. The question at hand however is whether we as a specialty should recognize those who do subspecialize within Neurosurgery with an additional certificate or in some other way. The Strategic Planning Process of the Board with input from our partner organizations including the AANS, CNS, Society of Neurological Surgeons, RRC, and Subspecialty Sections have been considering this issue for the past couple of years. Recent surveys have demonstrated that close to two-thirds of neurosurgical residents are pursuing advanced training through fellowships and at the time of primary certification, general neurosurgery as a practice pattern has declined from 61% to 39% over the past three years.

To be concise, I will distill a good deal of discussion and thought into the bullet points to help make a few points. The argument in support of subspecialty certification or recognition could be considered as follows:

- To prevent defections of various subspecialty groups
- To acknowledge additional/special expertise
- To strengthen fellowship programs by better oversight and accreditation
- To empower subspecialists regarding the pursuit of hospital credentials
- To assist the public in identifying individuals with special expertise
- To provide an opportunity for a more robust outcomes reporting

Argument against subspecialty certification recognition would include the following major points:

- The primary certificate could be devalued
- Diplomates practicing both within and without certain subspecialties might be disenfranchised
- This process might be used against Diplomates who are in general practice
- This process could potentially be used against those with multiple subspecialty expertise
- If the certification/recognition process is made too easy, this would potentially devalue the concept of true subspecialization
- If certification or recognition required ACGME accreditation of fellowship programs, additional costs would be accrued by our training programs, and trainees would be subjected to work-hour limitations as well as billing restrictions

Our options should we elect to pursue subspecialty certification/recognition are basically three-fold:

1. The ABNS could issue additional general certificates. This would require ACGME accreditation of those fellowship training programs and possibly expansion of our existing RRC or the addition of other neurosurgical RRCs.
2. Subspecialty certificates issued by the ABNS. This process would also require ACGME accreditation of fellowship training but could be administered under our existing RRC.
3. Recognition of Focused Practice. This process would be administered by the Board under the Maintenance of Certification process and would not require ACGME accreditation of fellowships. The Board has considered these issues in depth over the past couple of years and has concluded that for a variety of reasons the MOC pathway of recognition of focused practice might be the best option for Neurosurgery. The concept that subspecialization requires much more than simply a fellowship is widely recognized. Subspecialization requires core training in neurosurgery, advanced subspecialty training, is defined by special expertise and proficiency, requires mentorship, requires years of focus practice, and requires years of continuing education and research. As such, recognition of subspecialization does seem to follow naturally our concepts of maintenance and certification and could logically be housed in this vehicle.

We are actively soliciting your input at this time because the Board will be finalizing our plans at the ABNS Winter Meeting in January of 2008,

which would be geared to operationalizing our MOC program along these lines. Hopefully the timing of this letter will give you and your Section time to consider the issue and discuss it in detail at your September CNS venue. If you would like, either I or one of the officers of the ABNS would be happy to attend your Executive Council meeting to make a brief presentation and answer any questions.

Thank you in advance for your consideration and support ad we very much look forward to your input on this matter.

Sincerely,

H. Hunt Batjer, M.D., F.A.C.S.
Chairman, American Board of Neurological Surgery

HHB:cj

cc: Sean Grady, M.D.
Paul McCormick, M.D.
Kim Burchiel, M.D.
Doug Kondziolka, M.D.
Jon Robertson, M.D.
Mary Louise Sanderson

2007 NEUROSURGICAL EDUCATION SUMMIT MEETING Minutes -- DRAFT

Ritz-Carlton Hotel, Washington DC

Saturday, July 14, 2007 - 10:00 am to 5:00 pm.

ATTENDEES:

Participants: P. David Adelson, MD, FACS, CNS; H. Hunt Batjer, MD, FACS, ABNS; James Bean, MD, AANS; Deborah Benzil, MD, CSNS; Gary Bloomgarden, MD, CSNS; William Couldwell, MD, PhD, ABNS & SNS; Steven Giannotta, MD, FACS, RRC; M. Sean Grady, MD, ABNS; Robert Harbaugh, MD, FACS, AANS; Charles Hodge, Jr., MD, SNS; Catherine Mazzola, MD, CSNS; Paul McCormick, MD, AANS; Edward Oldfield, MD, SNS; Tae Sung Park, MD, ABNS; A. John Popp, MD, SNS; Donald Quest, MD, AANS; Jon Robertson, MD, AANS; James Rutka, MD, PhD, AANS; Nathan Selden, MD, PhD, SNS; Robert Solomon, MD, ABNS; Dennis Spencer, MD, SNS; Troy Tippett, MD, Washington Committee; Christopher Wolfla, MD, CNS

Staff: Thomas A. Marshall, AANS Executive Director; Mary Louise Sanderson, ABNS Administrator; Katie Orrico, JD, AANS/CNS Director, Washington Office; Susan E. Funk, AANS Governance Administrator

Invited but unable to attend: Kim Burchiel, MD, FACS, SNS; Ralph Dacey, Jr., MD, RRC; Arthur Day, MD, FACS, RRC; and Laurie Behncke, CNS Executive Director

	Agenda Item	Action Items
I.	**Introduction -** Redesign of Neurosurgical Residency Training: The Impossible Dream or the Perfect Storm. For additional information and detail, see Dr. Popp's slides in the attached PDF. There may be some opposition to suggestions coming out of the Summit. There has been previous discussion regarding the need to change the residency training cycle and create a new training paradigm. There is some common ground and also some areas that are less easy to agree upon. Strategic Principles factoring into the redesign discussion: ▪ Disease burden – the number of operations performed by subspecialty. ▪ The spectrum of the neurosurgical field – diverse subspecialties. ▪ Evolution of the field – changes over time and the need for flexibility to those changes. ▪ Generalist and specialist practitioners – many practitioners subspecialize. ▪ Academic and private venues – differences between practice environments. Tactical Issues regarding changes to the residency training: ▪ Completely recover PGY1 – neurosurgery should completely control the PGY1 curriculum. ▪ A strategy for research – one size does not fit all. ▪ Varying size and depth of individual training programs – not all programs can train in all subspecialties. ▪ Generalists vs. Specialists training – core curriculum and curriculum specific to each subspecialty. ▪ The match process and specialist match. ▪ Length of training – shorten or restructure training.	
II.	**Background**	
	For reference, Dr. Quest's presentation can be found in the attached PDF file. ▪ Neurosurgery can attract more women and minorities by addressing lifestyle changes within the new training paradigm. ▪ Access to medical students can be improved through increased involvement with curriculum committees controlling the medical school curriculum. Currently this is controlled by deans of students and usually not physicians. ▪ Resident positions must be maintained; thirty percent more neurosurgeons will be necessary in the coming years but there is a cap on the number of residents allowed.	

Some potential factors to consider when considering shortening the training include: eliminating the irrelevant material and tasks from the training, moving PGY1 into neurosurgery, enfolding fellowship experience, redesigning the core experience and maintaining a meaningful research experience.

The current requirements for PGY1 were shared (detail available within the slides).

A newly proposed Neurosurgery PGY1 could entail: three months of neurology including neuro ICU, consult service, and outpatient experience; three months of surgery including surgical critical care and emergency/multi-system trauma care; and six months neurosurgery.

The training could potentially be shortened to five years rather than the current six or seven years.

The barriers to achieving change in the training paradigm include:

- The philosophy of "a few good men"; that neurosurgery does not need those that do not want to invest the time in training.
- Curriculum committee resistance by primary care specialists
- Perceived inadequate credentials if the requirements are less rigorous
- Obstruction by general surgery – manpower
- ACGME and American Board of Medical Specialties (ABMS) approval
- Increasing scrutiny by CMS regarding Medicare and Medicaid funding of graduate medical education (GME)
- Difficulty by weak programs to provide a robust core experience
- The need to avoid "Neurosurgery Lite" or the perception that it is a scaled back version of the training.
- Difficulty for some programs to provide a meaningful research experience
- Tradition: "If it ain't broke, don't fix it."

Perspectives of the Organizations: AANS, ABNS, CNS, CSNS, RRC, SNS

AANS Resident Education July 2007 - Copies of Dr. Robertson's slides are available in the attached PDF file.
Three areas were addressed in the presentation: What AANS does as far as resident education, why AANS is interested in resident education and what are the perceived obstacles for neurosurgery?

In the past five years interest has grown in resident education. In 2003, the AANS residents started to receive benefits including: complimentary *Journal of Neurosurgery* and *AANS Bulletin* subscriptions, access to *Neurosurgical Focus*, discounts on publications, DVDs and meeting registrations, AANS/SNS Neurosurgical Online Sessions (modules), and core competency courses. North American residents also receive complimentary registration to the AANS Annual Meeting, complimentary breakfast seminars and practical clinics through participation in the Marshals Program, and complimentary resident-specific practical clinics.

The AANS Development Program provides essential financial backing to support resident education.

Neurosurgery Research and Education Foundation (NREF) - In 2007, the NREF awarded 12 grants: five young clinician investigator awards; one research fellowship; five two-year research fellowships; and one two-year ACS/AANS-NREF Career Development fellowship representing a total of $390,000 for resident-level research.

The AANS Pinnacle Partners Program - This program directs corporate financial support to educational activities. There were 11 Pinnacle Partners in 2007 totaling $250,000.

Resident Education Courses - AANS offers resident education courses, with content directed by AANS faculty, which are entirely funded by unrestricted educational grants from corporate interests. There are five courses in 2007 including Pediatric Neurosurgery Review, Introduction to Endovascular Technique, Minimally Invasive Spine, Fundamentals in Spine, and a Socioeconomic course. Seven courses are planned for 2008. An estimated total cost for these programs in 2007 is $650,000.

AANS-SNS online training modules - Five modules are now online; 25 additional modules are planned within the year.

Resident mentoring program - Currently 180 residents participate in a program linking residents at all stages in training to neurosurgeon volunteer mentors.

- Neurosurgery needs to investigate increased use of simulators in training.
- Coordination amongst organized neurosurgery will be critical so efforts complement one another rather than compete or overlap.

The ABNS Perspective – Dr. Batjer's slides are attached for reference.
ABNS' key priorities for 2007 include: 1) Clinical Data Management - MOC, P4P; 2) Recognition of Focused Practice – MOC; 3) Training Program Re-design.

Dr. Batjer provided an example of a chief neurosurgical resident in his seventh year that evidenced a lack of responsibility and lack of commitment to a patient (additional details available within slides). Using the example, he contemplated whether the example shows a failure of the neurosurgical training within his program or the result of a broader issue in transition of care and the "shift-based" mentality. Work hours restrictions have changed the education process. The importance of a training program that instills responsibility as opposed to the "shift-mentality", ownership, commitment and follow-through was noted.

Details about the primary/oral exams and Maintenance of Certification were shared (for additional details see slides).

Program redesign:
- ABNS engages in discussions with organized neurosurgery - AANS, AANS/CNS Sections, CNS, RRC, Washington Committee, and SNS - as well as educational entities involved in resident education - ABMS, and ACGME.
- Other educational models are being considered, including competency-based trainging.
- ABNS is committed to public responsibility and trust.
- ABNS is committed to the integrity of the Certification Process and certification must be meaningful.
- Neurosurgery should be made attractive to women and minorities
- Historical training strategies were exhausting. ABNS is supportive of any measures that prevent fatigue-related errors and enhance patient safety. Creative efforts will be required to address patient safety concerns engendered by work hour restrictions.
- Neurosurgery is not for everyone. Some fine physicians are not neurosurgeons.
- Residents are physicians - not students.
- The stakes are high - inadequately trained neurosurgeons in practice are a liability.
- Requirements for neurosurgeons are a higher standard than expectations in almost any other field.
- The Fast-Track Generalist Module is not supported.
- Regardless of modifications that might be forthcoming from the collective efforts of the group, certification from ABNS will always require breadth and depth of knowledge and experience.
- Subspecialization and research are fundamental to neurosurgery and residents should have access to those opportunities.

CNS Perspective - Dr. Adelson's slides are attached for reference and additional detail.

Challenges to neurosurgical practice include: practice related issues such as medical liability, declining reimbursement, and increased regulation; explosive growth in technology and information; work hours restrictions; unanticipated behavioral changes of educators and residents and changes in expectation.

Medical liability presents challenges to education; educators are reluctant to give residents autonomy and they focus on subspecialties that are less risk-prone. Trainees acquire decreased operative experience and breadth of clinical experience as a result.

Declining reimbursement pressures educators to focus on clinical activities (they are rewarded less for teaching and research). There is also pressure to increase patient volume and reduce time in the OR. This forces educators to transition to a "business" model of practice rather than educational model. Declining reimbursement also affects residents; they receive less consistent exposure to the educator, have fewer opportunities to undertake scholarly research and it can change attitude regarding lifestyle and financial remuneration.

Regulation puts pressure on the training model. Educators find it difficult to teach the changing requirements and have difficulties staying in compliance while time and resources are expended to comply with mandates. Residents have limited understanding of the regulatory environment and the regulations emphasize "process" rather than "product" or "outcome".

Work hours restrictions result in increased overhead to cover the extra hours that residents are not permitted to work and affect the neurosurgical work force. Residents need to balance "educational" and "service" activities and acquire adequate skills in less time. Residents need to deal with continuity of care and sometimes personal responsibility for the patient is forgotten.

The key question in revising the resident training experience is: "What are the skills necessary for the neurosurgeon of tomorrow?" Core skills differ by subspecialty.

Initiatives that would be of benefit include:
- Standardization of the core curriculum
- Standardization of non-clinical core competency education
- Streamlining the resident record-keeping requirements
- Standardization of the resident evaluation and promotion process
- Clinical core curriculum should provide adequate training for neurosurgical emergencies
- "Subspecialization" can enable residents to further develop advanced skills

CNS Perspective
- Scholarly research and thoughtful analysis should be untaken before any change in the current system.
- CNS is prepared to conduct research designed to answer critical questions regarding resident education.

CSNS Perspective - Dr. Bloomgarden's presentation is available within the attached PDF.

Detailed statistics were provided on United States population, number of Board certified neurosurgeons, residency programs, graduating residents, and candidates for the oral board. These statistics can be referenced within Dr. Bloomgarden's presentation slides.

Future needs were presented:

- Procedural growth rates are estimated at 14 percent in five years; 27 percent in 10 years.
- Need to examine how fulltime neurosurgeons' work hours are effected by workforce diversity (women, increased use of PA/NP and potential work hour restrictions).
- Continued variation is expected in regional distribution especially as it relates to subspecialists.

Workforce trends were discussed including starting salaries, types of incentives offered, and recruiting issues (additional detail in the slides). The goal is to find equilibrium in the supply and demand of the neurosurgical workforce.

CSNS contributions include: medical ethics, economic and professional questions supplied to SANS, AANS/CSNS Resident Socio-economic course; and development of a Socioeconomic Fellowship (additional details about the fellowships are available within the slides).

Improved educational efficiencies should be addressed when redesigning training:

- Clinical competency should be based on learning for life, increased use of simulators, and demonstrated skill for advancement.
- A research period should be required and focused on clinical research, critical analysis of medical literature, and statistical methodologies.
- Professionalism, socioeconomic, and ethical issues should be included in the training; some coursework should be available remotely (web courses and modules).
- The faculty should be educated and evaluated on new teaching methodologies and formats.

RRC Perspective - Dr. Giannotta's slides are available within the PDF file for reference.

The ABNS tells neurosurgery *what* to teach and the RRC tells neurosurgery *how* to teach through program requirements and data monitoring (data related to both institution and resident). Almost everyone on the RRC has previously served on the ABNS Board (for roster of the RRC, see slides).

ACGME sets policy; institutional requirements, common requirements; and delegates authority to the RRC to accredit programs (though a Monitoring Committee).

The RRC feels strongly about protecting and enhancing the resident experience. Introduction of formalized subdisciplines into residency training is being discussed. The RRC monitors the learning environment through surveys and resident data.

Details were provided on the institutional requirements of Graduate Medical Education (details available in the slides).

Definitions of both the discipline and neurosurgery were presented. The current design of the PGY-1 residency training was discussed. (Additional details are available within the slides).

There are strategic and operational pitfalls to avoid in redesigning the training:

- Standardized (time-based) training vs. competency-based.
- Core requirements vs. subspecialty requirements.
- Diminishing the role of research.
- Expanding the specialty.
- Getting acceptance for changes.
- Industry driving the changes vs. evidence driving the changes.

	▪ Impact on common requirements - need to be circumspect on changes we make to the neurosurgical residency program as it may affect other programs and specialties. **SNS Perspective** - Dr. Spencer's slides – AWAITING Dr. Spencer's SLIDES. **Resident Education and Training** **What SNS currently does:** ▪ Provides information to program directors regarding the rules and regulations in training. ▪ Provides a forum for communication between programs and now organized neurosurgery (Summit Meetings). **What SNS should be doing:** ▪ Provide direction regarding the educational component of academic programs. **Some suggested changes to resident training:** ▪ Advancement through the training should be by competency, not time. ▪ Establish a tiered training program with core requirements plus subspecialty requirements. - Define the core requirements. - Define competency. ▪ A strategic plan is needed that is practical and reduced to parts that can be addressed. ▪ SNS should continue to bring the leaders of organized neurosurgery together to achieve this. ▪ ACGME has a committee, the Committee on Innovation in the Learning Environment (CLIE) that brought about the changes in work hours and they deemphasize work hours as the major box within which education must be fit. CLIE is launching a pilot program that will enhance issues important to training. An RFP will be sent. If communicating and educating about patient responsibility is important, and work hour regulations are impeding that, then can neurosurgery should propose an alternative approach. ▪ If changes are made to training, measuring the success of the changes will be important and should be addressed before instituting any change.	
	C. Models and Overview **ABNS** - Dr. Grady's sides are available within the PDF file for reference. ▪ The ABNS Mission Statement and statistics about United States neurosurgeons, diplomates, residents, and the neurosurgical match were shared. ▪ The ACGME requirements as they relate to neurosurgery and other specialties were shared. (additional details are available within the slides.) **Several proposed training models were presented.** **Possible Program Format I:** PGY 1 - Fundamental Clinical Skills with or without neurology PGY 2-4 - Core Clinical requirements PGY 5 - Elective PGY 6 – Focused clinical experience **Possible Program Format II:** PGY 1 - Fundamental Clinical Skills with or without neurology	

	PGY 2 – Neurology, neuropathology, neuroradiology, basic neuroscience PGY 3-5 - Core clinical neurosurgery PGY 6 - Elective PGY 7 - Focused clinical experience **Possible Program Format III:** PGY 1-3 - Core clinical neurosurgery and neurology PGY 4 - Elective PGY 5 - Chief Resident Some considerations to take into account when redesigning the curriculum were noted: ▪ Encourage the study – change the climate in the field for women to encourage them into neurosurgery. ▪ Improve the practice – duty hours; time for faculty/chief residents to teach; medico-legal/CMS concerns. ▪ Elevate the standards – expectations of trainees; demands of career. ▪ Advance the science – encourage a culture of study and investigation.	
	D. Discussion ▪ The Chief Residency program description/experience was shared from ACGME; anecdotal examples from the monograph were discussed. ▪ When discussing changes to the core curriculum, neurosurgery should be careful that it does not become "Neurosurgery Lite". The respect and value of the current training must be maintained. ▪ Simulators are needed but are still in development; Simulators will work better within certain subspecialties and procedures than others. ▪ As residents progress through the years of training, changes in autonomy and exposure are important. ▪ Web-based online resident portfolios were discussed.	
	E. Curriculum - Dr. Popp's slides are available within the attached PDF for reference. Attributes of the neurosurgical core curriculum were shared: A. Defines a comprehensive body of knowledge but not a method of obtaining knowledge. Defines evidence for clinical applications of knowledge (performance). B. Organizes knowledge into definable units. C. Constructed hierarchically guiding the resident throughout training and establishes milestones to be attained before progressing. D. Interfaces with six core competencies (medical knowledge, patient care, interpersonal and communication skills, professionalism, practice-based learning/improvement, systems based practice) and four measures (assessments) of competency (professional standing, life long learning, practice performance, cognitive expertise). E. Evolves The Functions of Core Curriculum were discussed: A. To guide residents and Diplomates in the core knowledge & skills necessary to attain and maintain certification and to meet competency objectives of the RRC (ACGME) and ABNS (ABMS). B To guide development of education programs and objective resident evaluation. C. To define for ABNS a body of knowledge, skills and attributes necessary and aid in the development of assessment tools to meet the ABNS standards. D. To clarify the body of knowledge, skills and other attributes of an individual for maintenance of certification.	

Cognitive Core and On-Line Modules - Dr. Hodge's slides are available within the attached PDF file for further reference.

- Sources of information for the modules – SNS, SANS CNS, Programs, ABNS written exam.
- Modules arose due to a need to synch curriculum, RRC requirements, and ABNS testing; shorten the work week due to work hours restrictions; increase the input from a broader spectrum of neurosurgical educators, and cater to the preferred learning techniques of today's residents that are increasingly technology-savvy and prefer online learning.

Online learning successes from the Thoracic Surgeons were shared (examples available within the slides).

Mastery of the basics allows residents to focus on more sophisticated issues, appreciate and understand better what is being presented, and have a better opportunity to contribute. It does not mean that the cognitive core curriculum is the end of their education or that "Neurosurgery Lite" is acceptable.

- The modules combine content provided by SNS, and technical and financial support from AANS.
- They can be seen as an online text and topics coincide with resident training progression.
- Each module is 20-25 minutes long. There is a statement of goals, a PowerPoint presentation, a follow-up test, references, and an evaluation of the module itself. Some modules have integrated video clips and voice-overs.
- The data collected from the modules is password protected; the individual can see their own results and the program director can see all of their residents' results. Other users able to view the data include SNS Council, AANS Board of Directors, ABNS/RRC (to determine if there is a correlation between written exam scores and resident performance on the modules).
- Five modules are already online (How to talk to patients, Ventriculostomy, Assessing spinal stability, Spinal cord anatomy/syndromes, and Evaluation of comatose patient).
- They cost approximately $3,500-4,000 per module – plus AANS staff time. Industry support may be investigated to off-set costs.
- Potential uses of the data include: training programs to determine who completed the modules, how they performed, and assess further needs; SNS, RRC, and ABNS to define curriculum; neurosurgery to document what is being taught (defend position to other specialties or CMS); and potentially MOC.
- The list of topics is currently under development (additional detail on potential courses is available within the slides).
- Defining the core curriculum in procedures "every neurosurgeon should be able to do" is difficult. There are some obvious procedures including: trauma, basic spine, basic oncology, and basic vascular procedures. There is a lack of agreement when it comes to a comprehensive list; however a conclusion can be drawn that every neurosurgeon should be able to manage essentially all patients but not every neurosurgeon should be able to do all operations.

F. Technology Support - Dr. Selden's slides are available in the attached file for reference.

The SNS Web site was redesigned. The design and features of the Web site were shared (see slides for additional details). Within a password-protected area, the following features will be offered: tool kit (portfolio), meeting presentation archives, program director chat room and meeting planning and registration.

There are two challenges perceived: 1) Even without making changes to the training, competency must be tracked and evaluated; and 2) Individual training experiences such as senior electives, practice setting-specific experiences, and experiences over the lifelong learning continuum must also be tracked and evaluated.

Two models were discussed: 1) Low cost and immediately achievable – using the web as digital interactive textbook; and 2) More expensive and requiring additional coordination with other entities (but potentially more valuable) – using the web as an

	interactive educational clearinghouse (both textbook and workbook/portfolio/tool kit). An ACGME portfolio includes 360 degree competency-based evaluations; case data; reflexive written projects/tasks (ethical principles, patient communication/consent, quality improvement work, and clinical and scientific papers). Centralizing and housing the information in an online repository allows: ▪ Workbooks to be reviewed in a centralized format and location (by faculty, program directors, others). ▪ Examples to be shared. ▪ Curricular expectations to be tracked. ▪ ACGME to use it to determine program effectiveness. Examples of the types of items to be included within workbooks were shared (additional detail available within the slides). Implementation was suggested in stages: 1) Launch textbook model; 2) Create curricular modules and evaluations for use within the program of study; 3) Gather input from stakeholders before investing in a national software platform (data from ACGME, outcomes data movement, and lifelong data tracking/MOC should be weighed). ▪ Per the adult learning theory, the most powerful learning involves problem solving in practical setting. ▪ Data used for training and certification can also be used as a tool for learning and discovery. 2. Data Management - Dr. Harbaugh's slides are available within the attached PDF for further reference. Neurosurgical practice data is needed by residents, training programs, fellows, candidates for certification and MOC, specialty organizations, pay-for-performance (P4P), comparative effectiveness, and hospital privileges. A single data entry, storage and feedback system should be developed to meet all the needs of neurosurgeons. **Recommendations:** NeuroKnowledge should include participation from AANS, CNS and ABNS. The database project under NeuroKnowledge could be managed under the Washington Committee. ABNS owns and controls the flow of the data and as the most trusted entity within neurosurgery, is the right entity to do so. The database could be a revenue source in the future.	
III	**Developing an Action Plan**	
	A. The Data - Dr. Popp's slides are available within the attached PDF for reference. A pre-meeting data gathering form was requested from each invitee that pertained to challenges to neurosurgical practice and challenges in changing the resident training paradigm. The "homework" document and the summary of the responses are included as attachments for reference and additional detail. **Question 1 – Biggest challenges facing neurosurgical practice** The responses, in order of prevalence, were: 1) Financial – the responses related to reimbursement, cost of doing business/malpractice insurance and financial rewards as a measure of success in the field. 2) Neurosurgery Specialty General – the responses related to specialization, work force, education (use of new technology, need for CME, and technology overload dealing with practice and guidelines), and professionalism (lack thereof, public perception). 3) Regulatory – the responses related to administrative burden, practice assessment/P4P, outside influences and regulation of	

	practice (by hospital, system, other outside entities), difficulty of practice (fear of going out of network, issues with insurance and government oversight). 4) Practice Issues – the responses related to neurosurgeons taking emergency call and ER coverage, regionalization, encroachment of other specialties, and limitations placed on practice (access to the ICU). **Question 2 – Biggest challenges facing neurosurgical education** 1) Curriculum – responses included length of residency, general neurosurgery/subspecialization, growth of neurosurgery knowledge, clinical experience adequacy and uniformity, need for simulation/procedural training, professionalism, data, research, and socio-economic education. 2) Training programs, Technical/Bureaucratic – responses included work hours restrictions, oversight, institutional educational infrastructure, and declining reimbursement at education centers. 3) Workforce – responses included dedication of workforce and professionalism. 4) Educators – responses included neurosurgery economics over neurosurgery academics and faculty. **Question 3 – Challenges that are the most complicated facing any change to residency training** 1) Training Needs – responses included standardization of training program, subspecialization, work hours restrictions, research training, varied needs of trainees, "adequate" training definition, and procedural care/simulation. 2) Political/Logistical – responses included workforce, political, funding, maintain flexibility, and bureaucracy. **Question 4 – Challenges that are easiest to resolve in changing residency training** 1) Curriculum – responses included cognitive curriculum, modification of PGY1, operative requirements, compliance with work hours restrictions, promotion by competency and digital resource sharing. 2) Bureaucratic/Political/Resources – responses included help with documentation/approval, delivery of education and financing. 3) Workforce – responses related to cultivating applicants/enhancing the quality of the workforce.	
	B. Developing Priorities 1) Technology and Data – standardization, collection, and management of data for education. 2) Procedural Training – specificity vs. general 3) General Training Core Curriculum – research and cognitive components 4) Politics or Strategy – dealing with ACGME and funding of the process ▪ Modification of the PGY1 year: should it be modified and how. ▪ Need to define expectations and some of the issues regarding competency, responsibility, professionalism. ▪ Volume and complexity changes and is a challenge.	
	C. Breakout Sessions The meeting divided into four breakout discussion groups that will become subcommittees and continue to work on issues specific to their group. It was requested that the subcommittees research and discuss the issues, then report back with suggested recommendations at the next meeting. Core Curriculum Subcommittee Dr. Grady presented the information for the Core Curriculum Subcommittee. The group felt that core clinical training for neurosurgery requires about 36 months (three full years). The Senior Society should give a more firm definition of "core clinical training".	

- PGY1 would consist of six months of neurosurgery (part of the core), three months (neurology), and three months of other training/general surgery.
- Throughout the next three-four years of training, 42 months neurosurgical training would be required.
- An Elective Component – 18 months for clinical, elective and/or research (any combination thereof, but must include at least six months research). The research component does not need to be fulfilled within own program; there would be a possibility to travel to another program to do research there.
- More training would be included within the internship period.
- This equals a subtotal of 60 months.
- The concept of an "independent chief residency" which would be focused clinical training was controversial among the subgroup but warrants additional discussion. The last 12 months the individual has their own practice under the quasi-supervision of the more senior faculty. They have their own clinics, OR time, and patients and are demonstrating professionalism, skill and independence. This last 12 months would be required before that individual can take the ABNS exam. Whether the resident would be paid for that work and whether it would fit within ACGME requirements are questions that would need to be investigated further.
- The 60 month training subtotal plus the 12 months independent chief residency training would total 72 months of neurosurgical residency training.

Under this model residents could finish their core training in the first five years.

Consensus was reached on the 36 months of required neurosurgical focused clinical training.

Procedural Subcommittee

Dr. Hodge presented on behalf of the subcommittee.
They approached the exercise trying to account for the patients' best interests. They noted that it is not in best interests to have residents nearing completion of the training that were not trained for certain types of common procedures; but that they do not need to be able to perform each varied kind of case.

- Flexibility in the training is necessary.
- A procedure list is so varied that it would be extremely difficult to develop a complete comprehensive list.
- The group wanted to keep six years: PGY1 – six months neurosurgery plus other rotations (at discretion of program director); PGY2 & 3 – general neurosurgery; PGY4 – an elective year; PGY5 - Chef resident stage (PGY5 & 6 could vary at discretion of the program director); PGY6 – Subspecialty Clinical Training or advantaged research. This model would shorten training by one year but still accomplish everything that the current seven year program does.
- This new model could be brought to CILI (ACGME)to convince them about the changes to years five and six and that this would be adequate training.
- Trying to find a place for the subspecialty training. This model would be six years and one could not finish the program any earlier than six years.

Technology/Data Management

Dr. Harbaugh presented on behalf of the Technology Subcommittee. The group discussed the overall fit of information technology and data management within resident education.

Information technology could help accomplish:
- Development of online standardized tools for Program Directors (a toolkit all program directors can draw from). As better tools become available or the requirements change, everyone can have access to the new materials.
- Making educational materials universally available – digitizing presentations and meeting materials; educational modules

	(make them available to medical students and high school students to market profession). ▪ Linking/Sharing information – some of the data would be shared and then at the end of ACGME section, individuals could link to a neurosurgery data site and enter a few more details concerning outcomes or quality improvement. ▪ Standardization of resident online portfolios to track progress. ▪ Instilling an ethics of self assessment – The profession is becoming de-professionalized due to work hours restrictions adding in a component where individuals track and assess their own abilities and outcomes on a daily basis. **Funding** - Educational grants could be investigated. - A free-standing company handling all the data for neurosurgery (which is being considered by AANS/ABNS/CNS) could contract with outside groups for neurosurgical data collection and analysis. ▪ Would allow for continuous evaluation data for program directors and other groups to assess resident performance. ▪ Program directors look for checklists or some sort of guarantee that "if resident does 'x' then that requirement is met". ▪ If residents complete part of the training in another facility, it would allow the tracking and access to their data from institution to institution – allowing portability for the tool kit or portfolio. ▪ Similar to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) continuous readiness program - data would always be available. ▪ After getting all groups together and achieving consensus on the contents of the profile, the product would have credibility as the best evaluation tools available. ▪ It would also allow for an online exchange program if a student needs exposure to certain kinds of cases that they do not see often within their facility, they can arrange to train some time at a facility that has more volume. Sociopolitical and Financial subcommittee Dr. McCormick presented on behalf of the subcommittee. ▪ The group knew that much of what they were going to work on would be dependent upon the recommendations put forth from the other three groups. ▪ The first step from a socio-political standpoint is to identify the key stakeholders within organized neurosurgery and outside. Some of the key stakeholders include Public, Government, Payors that would need to be accepting of the changes. Sociopolitical Barriers were discussed: ▪ Funding would be an issue. Some potential sources of funding include government, organized neurosurgery, industry ▪ Vetting and approval from all of the relevant stakeholders including the actual training programs. **Action plan:** ▪ The most important first step is to identify/define the "product". What the new resident training will look like. ▪ Get organized neurosurgery to work together and eventually reach consensus. ▪ Analyze all of the strategic initiatives that will be required to achieve the change and communicate about it. ▪ Develop a way to monitor/assess the implementation of the new training regimen.	
IV.	**The Next Steps**	
	Committees/Assignments - The subcommittees should continue to work on their particular focus areas. Much work needs to be undertaken by each subcommittee before another meeting of the entire group. A future meeting will be planned and availability will be sought from invitees.	Subcommittees should research and discuss the issues

		and report back with suggested recommendations at the next meeting/Committee Chairs Work on suggestions to the CILI committee; send them to attendees for comment/Dr. Spencer

Breakout Groups:

Socio-political and Financial Subcommittee - Paul McCormick, John Popp, Mary Louise Sanderson, Gary Bloomgarden, Katie Orrico
Procedural Subcommittee – Charles Hodge, Dennis Spencer, Hunt Batjer, Robert Solomon, Catherine Mazzola, William Couldwell, David Adelson
Technology/Data Management Subcommittee – Robert Harbaugh, James Bean, Nathan Selden, Deborah Benzil
Curriculum Subcommittee: Donald Quest, Tae Sung Park, Steven Giannotta, Christopher Wolfa, James Rutka, Edward Oldfield, Sean Grady

From: Michael Wang [mailto:myw@usc.edu]
Sent: Wednesday, June 27, 2007 12:02 PM
To: donald quest; Charles Branch
Subject: Bone and Joint Decade

Dear Don and Charlie,
I wanted to thank you again for nominating me to be the AANS representative to the Bone & Joint Decade initiative. The first meeting was last week and functioned as a bit of a "Think Tank." The assemblage included roughly 30 individuals representing various organizations of rheumatologists, orthopedists, neurologists, radiologists, educators and the AMA. The apparent charge has been to form a framework for educating medical students about musculoskeletal disease. The exact methodology, goals, support structure, and organizational details have yet to be decided, and much of the time was spent trying to refine the mission and vision statements of the group. The plan is to have a yearly meeting in person and perhaps quarterly "web-based" discussion. It seems like a reasonable group with good intentions, but one of the potential stumbling blocks has been that the "Decade" is 2002-2001. So much for an early start! I will definitely keep you informed on the goings-on, as th e group obviously would ideally accomplish its goals through the modification of medical school curricula.
Cheers,
Mike

Michael Y Wang, MD
Assistant Professor & Spine Director
Department of Neurological Surgery
University of Southern California

A reply to Dr. Mummaneni and the ODG editorial staff working on cervical fusion based on correspondence dated 11/16/06

On this date, Dr. Mummaneni expressed concerns about several points that had been made in the then current ODG summary on cervical fusion. Each will be addressed separately: The most recent on-line entries are highlighted in yellow

I. Performance of an anterior cervical discectomy without fusion:

Fusion, anterior cervical

(1) Anterior cervical discectomy compared to anterior cervical discectomy with interbody fusion with a bone graft or substitute: Three of the six randomized controlled studies discussed in the 2004 Cochrane review found no difference between the two techniques and/or that fusion was not necessary. The Cochrane review felt there was conflicting evidence of the relative effectiveness of either procedure. Overall it was noted that patients with discectomy only had shorter hospital stays, and shorter length of operation. There was moderate evidence that pain relief after five to six weeks was higher for the patients who had discectomy with fusion. Return to work was higher early on (five weeks) in the patients with discectomy with fusion, but there was no significant difference at ten weeks. (Jacobs-Cochrane, 2004) (Abd-Alrahman, 1999) (Dowd, 1999) (Martins, 1976) (van den Bent, 1996) (Savolainen, 1998) ….

This sentence was added as per the suggestion of Dr. Mummaneni (later in the summary): Patient selection: This study concluded that anterior cervical discectomy without fusion is a safe and effective procedure for disc herniation, but they still prefer anterior cervical discectomy with interbody fusion for patients with advanced spondylosis. (Yamamoto, 1991)

Dr. Mummaneni suggested that the point be made that anterior cervical discectomy had been abandoned by spinal surgeons over the past ten years. He stated that this "older" technique "led to collapse of the disc space and kyphotic deformity of the neck with significant neck pain in a significant number of patients." He submitted the following article as support:

Yamamoto I, et al. Clinical long-term results of anterior discectomy without interbody fusion for cervical disc disease. Spine 1991;16:272-9.

I went back and looked through the literature. The last article that actually directly addressed this debate was the following:

Abd-Alrahman N, Dokmak AS, Abou-Madawi A. Anterior cervical discectomy (ACD) versus anterior cervical fusion (ACF), clinical and radiological outcome study. Acta Neurochir (Wien). 1999;141(10):1089-92.

As an outsider looking in it appears that fusion did become the "treatment of choice," as noted by Dr. Mummaneni, but this doesn't appear to be based on any evidence-based research I could find. In fact, when again looking at the Jacobs-*Cochrane* reference, it was noted that there was conflicting evidence to support either of the techniques. I think outside of just saying something like "spine surgeons all just do it this way" the

alternative might be to add this sentence to the end of the original summary and leave out the "tacked on" sentence above:

One disadvantage of fusion appears to be abnormal kinematic strain on adjacent spinal levels. (Eck J, 2002) (Matsunaga,, 1999) (Katsuura A 2001) The advantage of fusion appears to be a decreased rate of kyphosis in the operated segments. (Yamamoto, 1991) (Abd-Alraham, 1999)

II. "Use of anterior cervical plates to supplement anterior cervical fusion has been shown to enhance fusion rates…" There was some concern that this was inadequately supported (the use of plating).

A. Addressing Dr. Mummaneni's concerns in terms of plate fixation and fusion
Before starting, I am not sure that Dr. Mummaneni saw the ODG entry labeled, "Plate fixation, cervical spine surgery." There is a fairly extensive discussion of this topic in this section.

The current entry (listed below) discussed plating with autograft in the 'Fusion, anterior cervical" entry:
(5) Fusion with autograft versus fusion with autograft and additional instrumentation: Plate Fixation: In single-level surgery there is limited evidence that there is any difference between the use of plates and fusion with autograft in terms of union rates. For two-level surgery, there was moderate evidence that there was more improvement in arm pain for patients treated with a plate than for those without a plate.

The following sentence has been currently added to this summary:
Fusion rate is improved with plating in multi-level surgery. (Wright, 2007)

Dr. Mummaneni referred to two articles. The first was the following:
Kaiser MG, Haid RW Jr, Subach BR, Barnes B, Rodts GE Jr. Anterior cervical plating enhances arthrodesis after discectomy and fusion with cortical allograft. Neurosurgery. 2002 Feb;50(2):229-36; discussion 236-8.
This article discussed plating after allograft. This was not included in the Jacobs-*Cochrane* article because it wasn't a randomized controlled trial. I went ahead and added two new sections to cervical fusion based on this reference:

(3) Fusion with autograft with plate fixation versus allograft with plate fixation:
Single level: A recent retrospective review of patients who received allograft with plate fixation versus autograft with plate fixation at a single level found fusion rates in 100% versus 90.3% respectively. This was not statistically significant. Satisfactory outcomes were noted in all non-union patients. (Samatzis D, 2005)

In "Fusion with autograft versus allograft" I added details as outlined in the Deutsch, 2007 articles which compare the two techniques (Dr. Mummaneni is an author of this article).

(*6) Fusion with allograft alone versus with allograft and additional instrumentation: Plate Fixation:* Retrospective studies indicate high levels of pseudoarthrosis rates (as high as 20% for one-level and 50% for two-level procedures) using allograft alone. In a recent comparative retrospective study examining fusion rate with plating, successful fusion was achieved in 96% of single-level cases and 91% of two-level procedures. This could be compared to a previous retrospective study by the same authors of non plated cases that achieved successful fusion in 90% of single-level procedures and 72% of two-level procedures. (Kaiser MG, 2002) (*Martin, 1999*)

B. Addressing Dr. Mummaneni's concerns in terms of maintaining normal cervical lordosis.

The following article was referenced:
Katsuura A, et al. Anterior cervical plate used in degenerative disease can maintain cervical lordosis. J Spinal Disord 1996;9:470-6.

I think the problem here is that there have been several articles that have not found that maintenance of cervical lordosis affects clinical outcome. I added the following to the summary, "Plate fixation, cervical spine surgery."

Collapse of the grafted bone and loss of cervical lordosis: collapse of grafted bone has been found to be less likely in plated groups for patients with multiple-level fusion. Plating has been found to maintain cervical lordosis in both multi-level and one-level procedures. (Troyanovich SJ, 2002) (Hermann AM, 2004) (Katsuura, 1996) The significance on outcome of kyphosis or loss of cervical lordosis in terms of prediction of clinical outcome remains under investigation. (Peolsson A, 2004) (Haden N, 2005) (Poelsson, 2007)

III. *Dr. Mummaneni noted that there was a problem with morbidity at autograft donor sites.* This was just a great point and one that was not previously listed in the ODG. I added this sentence to "Fusion with autograft versus allograft."

A problem with autograft is morbidity as related to the donor site including infection, prolonged drainage, hematomas, persistent pain and sensory loss. (*Younger, 1989*) (*Sawin, 1998*) (*Sasso, 2005*)

IV. *Addressing the issue of pseudoarthrosis*
There are now multiple citations that note that plating decreases the rate of pseudoarthrosis. These have been placed within the body of the text. I did make some slight modifications to the previously added sentence on pseudoarthrosis.

Pseudoarthrosis: This is recognized as an etiology of continued cervical pain and unsatisfactory outcome. Treatment options include a revision anterior approach vs. a posterior approach. Regardless of approach, there is a high rate of continued moderate to severe pain even after solid fusion is achieved. (Kuhns, 2005) (Mummaneni, 2004) (Coric, 1997)

V. and VII. *Costs and cost-effectiveness*
I took these out for now. Just as background, my dissertation is a cost-effectiveness model using Markov modeling. With that said, plating costs about $32K more per case than non-plating. While this falls under the magic number of $50K per QALY, I am not sure the average reader will appreciate this. I will tackle this topic in terms of costs at a later point.

Additional sections added

The following section was added for completion:

Predictors of outcome of ACDF