What Do Patient Satisfaction Scores Really Mean?
Welcome to a new year full of unknowns. We have a pivotal year ahead of us, with a new President that will likely have dramatic implications for the healthcare landscape. Over the last 8 years the medical community has navigated the ever changing landscape of the Affordable Care Act. We accommodated and adjusted to the new requirements, learned new terminology of Bundled Care, Clinically Integrated Networks and Accountable Care Organizations. We tried to make sense of the goals and expected outcomes while keeping the patient at the center of it all.

Now we find ourselves in a land of uncertainty all over again. What does Repeal and Replace mean? How much do we continue to invest in the current path of implementing software and care redesign to satisfy the ACA goals? Will the programs that were established to fund the mandated changes remain in place? How long do we play “wait and see”? One thing is certain — there will be change; but just how far reaching a change and how fast will it come?

Proliance Surgeons have chosen to take this time and reflect internally on our organization to make sure we are meeting our patients’ needs. We want to ensure we provide value at every patient visit with our care centers and their surgeons. We are revisiting our processes and workflow to make sure there is a clear purpose and value added to the patient experience. Can we take out extra steps or eliminate redundant forms? If a step is added, where can we take two out? Can we remove non-value added tasks to be as efficient as possible? Ultimately, our goal is to be as streamlined as possible and provide cost effective care that is adaptable to the coming changes, whatever they may be. We are focused on the things in our control, the things that affect our everyday life and the things that we feel make a difference to our patients.

We look forward to working with our partners across the Puget Sound area to accomplish these goals as we evolve as an organization to retain our values, maintain our mission, and realize our vision for the patients we serve.

Sincerely,

David G. Fitzgerald
CEO, Proliance Surgeons
OPA Welcomes Neurosurgeon Kyle Kim on Board!

Dr. Kim is a board certified neurosurgeon who specializes in the treatment of a variety of conditions affecting the brain and spine. He attended University of Chicago’s Pritzker School of Medicine and has extensive experience in the minimally invasive approach to treatment of tumors, vascular lesions, and degenerative conditions.

Although, this isn’t Dr. Kim’s first time treating patients in Washington. Dr. Kim underwent a general surgery internship, neurological surgery training and a cerebrovascular surgery fellowship at the University of Washington here in Seattle. His neurological surgery training also included a year at Atkinson Morley Hospital in Wimbledon, United Kingdom.

After completing his training, Dr. Kim spent eight years at Allegheny General Hospital/Hahmemann Medical College in Pittsburgh, Pennsylvania. He then moved his practice back to Seattle at Group Health Permanante where he spent the last ten years before joining our practice here at OPA. Most importantly out of all of his years training, what Dr. Kim has found is that he likes to apply an individualized approach to achieve the best outcome for every patient.

His professional memberships include the American Association of Neurological Surgeons, the Congress of Neurological Surgeons, and Joint AANS/CNS Section of Cerebrovascular Surgery. He also is a recognized “Top Doctor” by both Seattle Magazine and Seattle Metropolitan Magazine.

Dr. Kim primary activities outside of work revolve around his wife Mia and their three children. Brains run in the family, as his two older children are physicians as well. He also enjoys reading, following sports, and bicycling in his spare time.

Dr. Kim at a glance:

- **Education**
  - BA, University of Chicago
  - MD/PhD, Pritzker School of Medicine at the University of Chicago

- **Residency**
  - Neurological surgery, University of Washington, Seattle, WA

- **Fellowship**
  - Cerebrovascular surgery, University of Washington, Seattle, WA

- **Board certification**
  - American Board of Neurological Surgery
Patient Satisfaction vs. Quality Scores: What They Really Mean

Hospitals are in constant pursuit of both quality and patient satisfaction, and it is easy to assume that good marks in one will mean good marks in the other. That often is not the case, however, and hospital quality leaders must be careful not to assume correlation.

The importance of patient satisfaction has increased in recent years, particularly with the implementation of Hospital Value-Based Purchasing (HVBP), part of CMS’ effort to link Medicare payment to a value-based system. Under the HVBP, hospitals are paid for inpatient acute care services based on the quality of care rather than just quantity of the services, with poorly performing hospitals receiving less reimbursement. Patient satisfaction is one of the metrics used to determine quality, via the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey, the first national, standardized, and publicly reported survey of patients’ perspectives of hospital care.

There can be some overlap in the measures used to compute scores, such as Medicare’s star ratings and HCAHPS, but the scores must be interpreted correctly, says Emma Mandell Gray, a senior manager at ECG Management Consultants, who specializes in care model transformation and performance improvement.

Research has shown that there often is no correlation between patient satisfaction and hospital quality scores, but Mandell says that may be changing. (See the story in this issue for more on the research.) As the healthcare environment continues to transition toward value and patient satisfaction, and experience measures are being integrated into overall quality scores, additional emphasis is being placed on these areas, Mandell says. That will help to ensure a positive correlation between patient satisfaction and hospital quality scores, she says.

There are good reasons a hospital may have good quality scores and poor patient satisfaction scores, or vice versa, Mandell says. “Hospitals are, oftentimes, a place where patients go as a last resort, admitted to the ED appropriately or not appropriately, and are a place where providers have to deliver difficult news to patients,” she says. “Those participating in patient satisfaction surveys often only remember the outcomes of the situation, such as a death or a diagnosis of cancer, so the scores become skewed.” (See the story in this issue for more on the accuracy of patient satisfaction scores.)

Resource Use Can Affect Scores

Hospital quality scores, however, are often focused on improvements in health outcomes, re-admissions, mortality, safety, and resource use. With regard to resource use, this may mean that providers are more mindful of prescribing unnecessary medications or conducting unnecessary testing, regardless of the patient’s request demand to receive more medications or tests. “If the provider does not comply because she or he may feel it is not necessary or quality care, then the patients may feel they are not being treated...
well and will report as such on their patient satisfaction survey,” Mandell says. “Some providers, who may be doing well with patient satisfaction scores, may end up over-prescribing or over-treating, which then could result in negative quality scores.”

In addition, hospitals are a fast-paced environment with staffing models that could be fairly lean, she says. The shift toward value-based care delivery is still fairly new and hospitals are now investing in the additional resources to ensure patients have the best experience while staying in the hospital. Mandell offers the examples of hospitals using care managers to help further explain treatment plans and get patients connected to resources once they are discharged, patient navigators to help patients through the system while in the hospital, and social workers or life coaches to assist with various community resources or social needs while in the hospital.

“The patient does not want to feel a rushed experience; rather, that they were attended to and their needs were met,” Mandell says. “This is difficult in the historical, volume-based environment we have been part of for many years.”

Mandell notes that hospital quality measures and patient satisfaction measures continue to be reassessed and evolve year after year, with the goal of identifying and prioritizing those measures that are most applicable and achievable. That analysis must take into consideration the value-based environment and patient population, she says.

“This conundrum of a negative correlation between the two should hopefully dissolve over the coming years as the healthcare environment continues to transform,” Mandell says.

**Subjective vs. Objective**

For the time being, though, the two measures should be seen as completely separate tools, each useful in its own way but having no relation to each other, says Shakil Haroon, CEO of MPIRICA Health Analytics in Bellevue, WA. The company analyzes hospital quality by focusing only on outcomes.

Patient reviews on public forums are particularly unreliable, he notes.

“We find absolutely no correlation between actual outcomes and patient satisfaction reviews, or other subjective reviews,” Haroon says. “Using those subjective reviews to assess a hospital or surgeon’s perfor-

Sometimes patient satisfaction scores are not even an accurate measure of how patients perceive the hospital, says William Fletcher, clinical outcomes analyst with Proliance Surgeons, a system of surgical practices based in Seattle. Unlike objective measures, a patient satisfaction score can be influenced easily, and usually in a negative way.

“We have found over and over again that the entire list of 25 questions on a patient satisfaction survey can be ruined if a patient has to wait 45 minutes in the waiting room,” Fletcher says. “To that patient, everything was miserable. The doctor was awful, the front office was awful, the back office was awful. Everything was awful because they had to wait 45 minutes.”

A long wait time is a valid complaint and has a place in measuring satisfaction, Fletcher says, but a problem like that can unreasonably affect the rest of the survey. The hospital needs to know that the patient was unhappy with the wait time, but it will be misled if the patient answered the other questions in a negative way out of anger.

“We have surgeons with the highest satisfaction scores I’ve ever seen, but their outcomes are not better than our other surgeons, at least not to any degree that the score would suggest,” Fletcher says. “And we have other surgeons who, for whatever reason, just bottom out on patient satisfaction scores — they get horrible scores — and yet they’re some of the best surgeons in the country.”

Fletcher also notes that patient satisfaction is different from patient-reported outcomes, in which patients are asked how they fared after surgery. That is a valid measure of quality, though it can be influenced by subjective assessments to a lesser degree than satisfaction surveys, Fletcher says. Proliance uses patient-reported outcomes as a key measure of quality.

Proliance also relies on data on quality outcomes from sources such as MPIRICA and ProPublica, a non-profit news organization that publishes information on hospital quality, mostly derived from Medicare data.

“With those sources, we can get a much more accurate understanding of the quality of our physicians than we could ever get by asking patients if they were satisfied with their wait time and if the nurse explained the medication,” Fletcher says.

**SOURCE:**

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mance is extremely unreliable. We’ve seen numerous instances in which we’ve compared our scores to patient satisfaction scores like those on Yelp or HealthGrades, and the reviews have no correlation with reality.”

Subjective reviews are generally easy to acquire and curate, Haroon says, so they have become useful tools for hospital marketing departments. The marketing campaigns often are misleading and intentionally imply a connection between patient satisfaction and quality that does not exist, he says. Haroon recalls one hospital system’s marketing campaign boasting that 100% of its surgeons had at least a four-star rating, of a possible five, on satisfaction surveys.

“These corporations want to give the impression that their staff and facilities are uniformly excellent, but the facts don’t support that assertion,” he says. “Consumers need to know the difference between marketing and actual performance. If that information is kept from them, you create a situation that is extremely dangerous.”

**Quality Overstated by Marketing**

Haroon and his colleagues have studied surgeons’ publicly available qualifications, such as patient reviews and their educational background, alongside those surgeons’ outcomes. The results can be surprising, he says.

“The marketing will talk about how the surgeon went to Harvard, is board certified, and has a 4.5-star rating on HealthGrades. You’re presented with this information as if that’s all you need to know about picking a surgeon,” Haroon says. “When you look at the actual data, the number of procedures performed, and the outcomes, you might find that the Harvard guy has consistently delivered a low level of care over four years, whereas the surgeon with the more pedestrian background and a lower HealthGrades review has consistently delivered excellent outcomes.”

Even when considering only patient satisfaction and not overall quality, patient-derived scores usually represent a small fraction of a physician’s patients, Haroon notes. That can be misleading if the score is based on as few as 10% of a physician’s patient population, he says.

Haroon says hospitals should distance themselves from any metric that significantly underrepresents case volume and has no correlation with outcomes, he says. Many hospital leaders know from outcomes data and other objective measurements that their actual level of quality is not as high as patient reviews in their marketing campaigns suggest.

“I’d say they know exactly what they were doing. The use of patient surveys is self-serving and potentially dangerous,” Haroon says. “There are hospitals that are paying fines and losing reimbursement because Medicare penalizes low quality, but they’re still advertising that they have excellent-quality physicians and facilities across the board.”

**Scores Can Frustrate Clinicians**

Putting too much emphasis on patient satisfaction reviews also can frustrate physicians and staff, says Donald Fry, MD, executive vice president for clinic outcomes management with MPA Healthcare Solutions in Chicago, and adjunct professor of surgery at Northwestern University Feinberg School of Medicine. Patient reviews are influenced by a range of factors, he notes, including many that have nothing to do with the actual medical care.

“Quality metrics actually are examining whether the measures of care and the outcomes of care were appropriate,” Fry says. “Patient satisfaction and quality metrics are two independent variables in the overall scheme of what happens to patients in the hospital.”

Patient satisfaction should not even be the purview of a hospital quality department, Fry says. The scores from patient surveys can be legitimate and useful, he says, but they have little-to-no bearing on the quality of medical care at the facility. They can be helpful in recruiting patients, so satisfaction scores should be the concern of marketing or another business-related department, Fry suggests.

That does not mean patient satisfaction ratings are unimportant, Fry says. Hospitals have a legitimate reason to measure patient satisfaction and act on any problems identified, he says.

“Treating people with respect and kindness, and having the conveniences in the hospital that they expect, will give them a favorable impression that they will pass on to friends and family, and remember when they need care,” Fry says. “If I were a hospital CEO, I would have a great deal of interest in patient satisfaction. But patient satisfaction should not be a metric in measuring the hospital’s quality of care.”

**SOURCES:**

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According to the Arthritis Foundation, over 50 million Americans live with arthritis or chronic joint symptoms. Arthritis symptoms limit everyday activities such as dressing, bathing, and cooking. Many Americans living with arthritis are unaware of options that are available to help alleviate their symptoms and improve their quality of life.

The most common forms of arthritis are osteoarthritis and rheumatoid arthritis. Osteoarthritis is a degenerative joint condition, in which the joint cartilage deteriorates resulting in pain and loss of movement when bone begins rubbing against bone. Rheumatoid arthritis, on the other hand, is an autoimmune disease in which the joint lining becomes inflamed as part of the body’s immune system response. Rheumatoid arthritis is one of the most serious and disabling types of arthritis and affects mostly women. Arthritis can affect all joints, including the small joints of the hand.

Your hands are constantly on the go. Everyday activities, such as preparing a meal, woodworking, carrying grocery bags or using your computer, can damage your joints over time. Joint protection techniques can help reduce pain, stress, and inflammation of your joints. These techniques can also help prevent further deformities and increase your independence in daily activities. There are many easy and inexpensive ways to protect your hands. Here are a few tips to keep your hands healthy:

**Give your Hands a Break**

- If you have pain during an activity, stop the activity. Pain is one of the best ways your body has of letting you know that you are causing tissue damage, so listen to and respect your pain.
- Whenever possible, use a stand to support your portable electronic device, instead of holding it with your hand(s).
Protect the small joints of your hands and avoid carrying several plastic grocery bags at once to save time. Use recyclable or paper bags, carry them one at a time and hold them at the bottom instead of using the handles.

If writing is painful, try using a thick, rubber grip pen with a gel tip or roller ball to decrease the amount of pressure used.

Remember to stretch and take breaks every 15 minutes during repetitive or prolonged activities such as needlework, painting, sewing, knitting and crocheting, hammering and filing.

Figure out which activities aggravate your symptoms and avoid or modify them. Don’t be afraid to ask others for help.

Use pump shampoos, conditioners, and soaps. Use the palm of your hand to pump instead of squeezing the container.

Use enlarged grips on every day equipment or tools to reduce strain on your joints, e.g. potato peelers, gardening tools, tooth brushes, and hair brushes.

Keep scissors and knives sharp to minimize your own effort.

Always use two hands when lifting heavy objects. A gallon of milk weighs about 8 pounds, and lifting it with only your fingers places excessive stress on your joints.

Don’t Use your Hand as a Tool

Don’t tear open your mail - use a letter opener to open mail.

Use utility scissors in the kitchen - do not rip open bags.

Always use the right tool for the job - use pliers for tight pinch and a small hammer for pounding.

Use a staple remover instead of your fingers and thumb.

Get rid of your manual can opener - go electric! Manual can openers place excessive strain on your fingers and thumb.

Instead of holding open books or magazines with one hand, use a book stand or holder to bring the book to eye level, and a book clip or “chip” clip to avoid prolonged gripping.

Use adaptive equipment to decrease stress on your joints.

Use devices to hold objects so that you don’t have to, e.g. a vice, cutting board with picks to hold food, etc.

Use foam to enlarge small diameter objects such as paring knives, cutlery, toothbrushes, paint brushes, pens, and pencils.

Purchase lightweight kitchen, gardening, and workshop tools with built-up handles.

Opening jars places undue stress on your joints - use a non-slip jar opener.

If you have pain when using keys to open doors, consider adding a key extender to your keys.

If you have difficulty opening door knobs or faucets, purchase door knob or water faucet handle extenders.

Consider a card holder if you play cards for extended periods of time.

Perform a search on the Internet for “adaptive equipment” to see what products are available.

When Symptoms Become Severe

If you have already tried these techniques but are still experiencing symptoms, it might be time to consider other treatment options, such as hand therapy. Certified Hand Therapists are either occupational or physical therapists with specialized training in the treatment of hand and upper extremity conditions. Hand therapy can play an important role in the management of arthritis; long term benefits include reducing pain, increasing motion and strength, and improving overall function. If your condition is more serious and you would benefit from hand therapy, request a referral from your physician. If you have any questions, please contact our Certified Hand Therapists Sheila Yakobina or Stephanie Yakobina at 425-313-3055.

Love Your Hands

No matter what you’re doing, take a moment to think about your hands; you’ll be rewarded with happier and healthier hands. Your hands work hard for you, so treat them with love.

About Sheila and Stephanie Yakobina...

Sheila and Stephanie Yakobina are Certified Hand Therapists and sisters who joined Proliance Sports Therapy & Rehabilitation in February 2012. The Yakobina sisters graduated from McGill University in Montreal, Canada with their Bachelor of Science degrees in Occupational Therapy in 1994. In 1998, they completed a hand therapy fellowship at Texas Woman’s University in Houston, Texas. They have been working as hand therapists since 1998 and became Certified Hand Therapists in 2001. They moved to Washington in 2006. In 2010, they received their Master’s degrees in Advanced Hand Therapy at Texas Woman’s University. Sheila and Stephanie are nationally recognized; they are past recipients of the American Society of Hand Therapists’ Presidential Award and the President’s Gold Award. They have lectured both locally and nationally and are published authors.
Seattle Pediatric Sports Medicine: Collaborating to better meet the needs of young athletes

Steven J. Anderson, MD
Orthopedic Physician Associates

Pediatric sports medicine is a relative newcomer to the field of orthopedics and sports medicine. The specialty has developed and evolved in response to the growing number of injuries in young athletes as well as other young people who are physically active or need to be more active. There are an estimated 46.5 million children involved with team sports each year. Among children in secondary school, 72% play a sport and 29% play a sport year-round. According to the CDC, there are 2.5 million emergency room visits per year for sports-related injuries in the 0-19 age group and an estimated annual cost of treating their injuries of $69 billion. Injuries that don't warrant an ER visit, don't generate an insurance claim, or don't invoke a piece of sports equipment are generally not accounted for in these statistics. The US Consumer Product Safety Commission designates a percentage of these injuries as “addressable”—meaning that there is an obvious way the injury could be prevented. What is not addressed is who is charged with addressing these risks.

There are approximately 200 Board Certified specialists in pediatric sports medicine in the US—obviously not enough to care for even a fraction of these injuries. Unlike a college or professional athlete who may have a full team of specialists to attend to their medical needs, young athletes get their care from a collection of providers whose training and practices are focused more on fields such as general pediatrics, orthopedics, or emergency medicine rather than pediatric sports. The Seattle Seahawks have 50+ players on their roster and, when you count the specialists in orthopedics, physical medicine and rehabilitation, internal medicine, cardiology, family medicine, neurology, neurosurgery, psychology, nutrition, exercise physiology,
neuropsychology, physical therapy, athletic training, massage therapy, and certified strength and conditioning, there is almost a one-to-one ratio of providers to athletes. By contrast, Little League baseball has 2.6 million participants but not a single medical specialist who Little Leaguers can claim as their doctor.

When injured young athletes are seen by non-specialized providers, there is a distinct chance that the treatment recommendation will be “rest,” “you’ll outgrow it,” or “stop playing the sport.” If an injured young athlete is lucky enough to be referred to physical therapy, the therapist, like many of the treating physicans, are likely to have backgrounds and practices that are focused on areas other than pediatric sports medicine.

Existing medical organizations (AAP, ACSM, AMSSM, AAOS, AOSSM, APTA, and NATA) all have sections or subcommittees that address pediatric sports issues. However, none of these organizations have the young athlete as their primary focus. The membership of most of these organizations is comprised of practitioners from a single specialty. Collaboration with specialists from other disciplines is generally not built into the composition or activities of these organizations.

Seattle Pediatric Sports Medicine (SPSM) was organized in 2012 in response to a number of recognized conditions:

1. The greatest number of participants in organized sports are in the pediatric age group.
2. Millions of injuries occur and billions of dollars are spent each year caring for these injuries.
3. The vast majority of care for these injuries comes from an assortment of practitioners whose primary training and practices focus on something other than the pediatric athlete.
4. The medical practitioners who do have specialty training in sports medicine are disproportionately allocated to a much smaller number of collegiate or professional athletes.
5. Medical organizations and training programs recognize epidemic levels of youth sports injuries but the attention devoted to these problems is disproportionate to the magnitude.
6. While many youth sports injuries are considered to be “addressable” or preventable, there is no single organization or funding source solely dedicated to this mission.
7. A functioning “sports medicine” team, and the model exemplified by collegiate and professional teams, involves physicians, physical therapists, certified athletic trainers, and other specialists working in a collaborative and coordinated manner. The medical organizations these providers rely on to improve their knowledge and skills usually involve just members from their own specialties and do not necessarily parallel the make-up of the team they work with on a day-to-day basis.
8. It is impractical to think that young athletes will have the same complement of sports medicine providers available to collegiate or professional athletes. Even elite pediatric athletes are unlikely to have access to a “medical team.” However, there is no obvious reason, other than logistics, to prevent transmission and sharing of existing expertise to the masses of young athletes who could so greatly benefit.

SPSM has been organized in response to these formidable informational and service “gaps.” SPSM also recognizes that no single medical specialty; no single organization; and no single institution is in a position to address these issues alone. The make-up of SPSM includes physicians, physical therapists, and certified athletic trainers. Physician representation includes pediatrics, family medicine, orthopedic surgery, physiatry, as well as surgical and non-surgical sports medicine specialists. The physical therapy and athletic training members represent a variety of interests, backgrounds, subspecialties and practice settings. Membership to SPSM is open to any interested practitioners from these disciplines who seek to improve care for young athletes and other active individuals.

SPSM holds quarterly meetings at Swedish Medical Center, First Hill, and has task forces that meet separately to work on specific projects. Some of the topics that have been discussed in the quarterly meetings include ACL injuries in skeletally immature athletes; elbow and shoulder injuries in young throwing athletes; spondylolysis; hip problems in adolescents; orthotic prescription; prophylactic bracing; osteochondritis dissecans; effective physical therapy prescriptions; evidence based practices; common sports problems seen by general pediatricians; and communicating with adolescent patients. Upcoming topics include stress fractures, regenerative medicine, and a survey on common practice patterns.

An unexpected spin-off from this collaboration has been the formation of 3 task forces. The task forces formed, to date, include: 1. Prevention of throwing injuries, 2. Prevention of ACL injuries, and 3. Evaluation and treatment of hip problems. The task forces have ranged in size from 10-30 participants and meet at a frequency from every few weeks to every few months.

The throwing injury task force is targeting throwing mechanics, training regimens, physical preparation, and coaching/training tips. Our consultants include highly experienced youth coaches and youth coaches who have experience as players at the professional level. Our goal is to create a resource that is clear, readily available, relevant, and free of charge to the users. The resource will target young baseball players, their parents, as well as administrators and medical providers who are not sports medicine specialists.

The ACL injury prevention program is essentially an exercise and warm-up regimen that combines elements of existing ACL prevention programs and exercises that have been shown to enhance neuromuscular control and reduce injuries. The components of the program include dynamic mobility, strength, motion control, and agility. The program has been structured to target the adolescent age group as well as younger athletes in grade school or middle school. The ACL task force, like other
task forces, has been a community wide, collaborative effort and its work has already garnered endorsement from the Seattle Sounders and Seattle Reign professional soccer teams. Our hope is to get further endorsements from any medical group and/or institution that support efforts to make sports participation safer for kids.

The hip task force has been more of a study group and journal club. It is examining “best practice” patterns as they pertain to diagnosis and treatment of hip-related problems. The group meets 4-6 times per year and has been taking a critical look at the reliability and validity of the assessment tools used to evaluate hips and the language we use to communicate our findings. Once again, having surgeons, physiatrists, general physicians, and physical therapists all in the same room together generates discussion and fosters understanding that doesn’t typically emanate from closed circles of specialists. SPSM plans to host a seminar to summarize and share the 3 year proceedings of this task force to all interested physicians and physical therapists.

Support for SPSM quarterly meetings and related activities has generously been provided by physical therapy groups, medical groups, and medical suppliers. Special thanks go to past sponsors including ATI Physical Therapy, OPA Ortho, DJO Global, and Top Shelf Orthopedics. To support future meetings, website development, and on-going community educational and injury prevention programs, further sponsorship opportunities are available.

In summary, over the last 3 years of SPSM activity, we have learned that:

1. There is a tremendous wealth of sports medicine experience and untapped expertise in the Puget Sound area.

2. An opportunity to network with other providers and become more aware of local expertise is a tremendous asset for practitioners and patients when it comes to arranging consults or making referrals within the community.

3. Collaboration between primary care providers and specialists, as well as collaboration between MDs and PT/ATCs, allows for synergistic relationships that enhance knowledge and patient care.

4. Growing community involvement with SPSM and strategic use of technology, including the internet, can bridge the knowledge gap between medical professionals and an underserved group of young athletes, their families, their coaches, and their primary care medical providers.

The tasks that lie ahead are daunting but the future of SPSM is bright. The burgeoning numbers of young people involved in sports; the astounding number of injuries and high cost of injuries; the number of injuries that could be better treated or prevented; the gap (chasm) in medical knowledge and resources between needy athletes and the medical community; and the lack of organizations dedicated to the mission of youth sports safety creates a niche where SPSM can hopefully initiate meaningful action and be a catalyst to needed solutions.

Primary care physicians, specialists, physical therapists, and certified athletic trainers who are interested in this mission are welcome to contact SPSM via e-mail: seattlepediatricsportsmedicine@gmail.com. Opportunities for involvement range from simply being included on the mailing list for meetings, to joining or creating a task force, or getting involved in an educational or community service project. Sponsorship opportunities are also available for the SPSM organization as well as specific events or projects. For more information, feel free to consult http://seattlepediatricsportsmedicine.com/ or contact Seattle Pediatric Sports Medicine via e-mail.

references:


About Dr. Steven Anderson:

Dr. Anderson specializes in non-operative sports medicine. Dr. Anderson sees all age groups of active and athletic individuals but has a special interest in problems unique to the pediatric and adolescent age athlete. He practices at Orthopedic Physician Associates at 3216 NE 45th Pl, Suite 304, Seattle.
Robotically Assisted Knee Surgery

Over the years, our bones see the worst of our everyday life activities. Whether your hobby is gardening in your backyard or cross country skiing, our knees see more wear and tear than almost any other bone. With the production of the MAKO Robot, doctors can now assess and complete the necessary surgery for any partial knee repair with ease and accuracy.

Dr. Jim Crutcher describes it as a sort of virtual reality game; using a robot to determine the most precise measurements of your knee, all while using a 3D digital model.

The MAKO ensures precision by measuring your leg to make sure that the placement of the implant will be in the most appropriate location in order to give you the best range of motion. To do this, Dr. Crutcher places multiple tracker pins in your fibula, tibia and femur to sync with the computer system and teach the robot where your leg is at all points in time during the surgery. So no matter how it is placed, the measurements will remain accurate during the procedure so you get the most precise results.

While doing this, Crutcher likes to take his time and go through extensive "leg balancing", where he moves the leg in order to show how loose or tight the MCL will be in all stages of flexion. While double checking measurements he says, "this is a critical part of the surgery because you need to know that your patient will be comfortable in all positions, just like a normal knee would be".

Once the knee and leg are measured to the exact specifications, Dr. Crutcher begins the resection stage. This is where the virtual reality part of the surgery comes in, as the computer only allows him to resect the bone that’s within the confines of what was considered to be the damaged part of your knee in your surgical "pre-plan", based off your CT scan.

This highlighted area of damaged bone tells Dr. Crutcher where to resect, within .02 millimeters of accuracy. If for some reason a surgeon were to go outside of these limitations, the robot would power down completely. This ensures that all healthy bone and tissue is spared during the surgery, so that the patient has the quickest recovery time possible.

Once the bone is resected, Crutcher uses a tool to fit each patient for the most natural feeling implant for their anatomy. Once the implant is in place, he extends the leg in a number of positions to make sure it’s getting full flexion and moving naturally.

Throughout this surgery, there is a clinical and field trained MAKO Robot representative there at all times operating the computer system to make sure that everything is running smoothly. With this, OPA surgeons are some of the first physicians in Seattle to use the MAKO and have performed over 3,000 surgeries, so their background in these procedures is extensive.

Come December 2017, the Swedish Orthopedic Institute will be the first hospital in Western Washington that will have access to the MAKO robot for total knee replacements, opening up the door to quick and less painful recovery to more deserving patients.
Shoulder Arthritis

I want to discuss a condition that I frequently diagnose and treat in my clinic and for which I have a particular fondness and focus within my orthopaedic surgery practice: shoulder arthritis. I have many patients who come to see me with shoulder pain who are a.) very surprised to find out that they have shoulder arthritis and b.) are even more surprised to find out that there are excellent treatment options available to treat shoulder arthritis.

The shoulder joint (termed the “glenohumeral joint” in medical nomenclature) is the third-most common large joint affected by degenerative joint disease (knee and hip arthritis are more common). There are multiple types of shoulder arthritis and all of these ultimately result in a wearing away of the “cushion” of the joint, the smooth outer covering of the bone known as the articular cartilage. As the cartilage wears away, the protective space within the shoulder joint narrows and the cartilage becomes rough and frayed and eventually wears completely away. This results in the bones of the shoulder joint rubbing against each other, causing pain. Because of the increased pressure on the surfaces of the bone, there can be structural changes that gradually occur within the shoulder including the formation of bone spurs (termed “osteoophytes”) and changes of the shape of bones of the shoulder. Although there is no cure for shoulder arthritis, there are many treatment options available. The goals for treatment are to manage pain and to allow you to remain active.

Pain is the most common symptom of arthritis of the shoulder and it is exacerbated by activity. The natural progression is for the pain to worsen over time, although how rapidly the pain progresses is unique to each patient. With shoulder arthritis, the pain is typically centered deep within the shoulder and may intensify with weather changes. Patients typically describe their pain as a deep ache, which worsens with activity.

Other symptoms include limited range of motion, sensations of clicking, grinding, and or snapping with movement of the shoulder, and, as the disease process progresses, pain at night which causes significant difficulty with sleep.

Initial treatment of shoulder arthritis is nonsurgical and includes options such as:

- Rest or change in activities to avoid exacerbating the pain. This also includes changing how you move your shoulder to accomplish specific tasks to minimize discomfort
- Physical therapy to maximize range of motion
- Nonsteroidal anti-inflammatory medications (NSAIDS) to reduce pain and inflammation. These medications can have significant side effects and should be taken with food. They can irritate the stomach lining and cause internal bleeding. If you have a history of ulcers or other GI problems, are taking blood thinning medication, or have cardiac disease, you should consult your doctor before taking over-the-counter NSAIDS

- Corticosteroid injections performed by me directly into your shoulder joint. Although the results, which can be dramatic in terms of reduction of pain and inflammation, are typically temporary, injections may play an important role in initially managing shoulder arthritis
- Icing your shoulder 20 minutes two to three times a day to reduce pain and inflammation
- Moist heat, particularly in the morning
- Special prescription medications for patients with a specific type of shoulder arthritis called rheumatoid arthritis
- Dietary supplements, such as glucosamine and chondroitin sulfate (with the caveat that the FDA does not test dietary supplements, there is little scientific evidence supporting the use of glucosamine and chondroitin sulfate, and there is the possibility of negative interactions with other medications).

If your pain from your shoulder arthritis is not adequately addressed with the nonoperative treatments above then surgery is the next treatment step and usually consists of shoulder replacement surgery. There are multiple different types of replacements available and I will spend a lot of time talking with you about which option is the most appropriate to address your specific situation.

Briefly, the replacement surgery options include:

- Hemiarthroplasty: Only the head of the humerus (ball of the shoulder) is replaced by an artificial component
- Total shoulder arthroplasty: Both the head of the humerus (the ball) and the glenoid (the cup of the shoulder joint) are replaced with artificial components
- Reverse total shoulder arthroplasty: In this type of replacement, the cup of the shoulder is replaced with a ball and the ball of the shoulder is replaced with a cup. This reversal of positioning allows patients with a particular type of shoulder arthritis called “rotator cuff tear arthropathy” to move the arm well despite not having a functional rotator cuff.

If you are having shoulder pain, consider scheduling an appointment to find out what is causing your pain and the best treatment(s) for you.

About Dr. Sara Jurek:

Dr. Jurek is a board-certified orthopedic surgeon fellowship trained in advanced shoulder surgery, arthroscopy and sports medicine. She served as a team physician for the LA Lakers, LA Galaxy and LA Sparks professional sports teams. With each and every patient interaction, she focuses on providing the highest quality of care while fostering an honest, informed relationship and dialogue. As a physician and orthopedic surgeon Dr. Jurek’s goal is to return her patients to their activities as safely and efficiently as possible.
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