Summa Health System is an Integrated Healthcare Delivery System that provides coordinated, value-based care across the continuum for the people and populations we serve. We hold ourselves clinically and financially accountable for health outcomes in our communities.

We integrate the resources of seven owned, affiliated and joint venture hospitals; a regional network of ambulatory centers, a network of more than 1,000 physicians that includes a 250+ employed multi-specialty group, a 150,000+ member health plan, a System-level foundation and 10,000 employees, nurses and healthcare professionals to provide the right care at the right time in the right place for our patients.

As an Integrated Healthcare Delivery System, we are positioned to utilize the strengths of the organization to become a national model of excellence for other organizations to follow.

At Summa Health System today, you see the healthcare system of tomorrow.
**Summa Health System’s Institute for Senior and Post Acute Care: A Comprehensive Approach**

**Goal:** To improve the health, quality of care and functional status of older adults through research, education of healthcare professionals, patients and caregivers and provision of consultative, clinical and supportive services and programs for older adults, their caregivers and healthcare providers.

**Education**
- Geriatric Medical Education
- Geriatric and palliative medicine fellowships
- Geriatric education for nursing and other disciplines
- Provide interdisciplinary team training and support
- Geriatric Concepts Nursing Orientation Program
- ACE and Institute Site Visits and Consultation

**Research**
- Health Services Research and Education Institute (HSREI)
- Acute Care for Elders (ACE) Project
- Strategies to Enhance Post-Stroke Care and Recovery (STEPS) Trial
- After Discharge Care Management of Low Income Frail Elderly (AD LIFE) Trial*
- Elder Abuse
- Promoting Effective Advance Care for Elders (PEACE) Trial (NPCR Center)**

**Community Collaborations**
- Care Coordination Network - 36 Skilled Nursing Facilities (SNF) preferred provided network
- SAGE Project: Area Agency on Aging Partnership
- Alzheimer’s Association
- Akron Regional Hospital Association
- Interdisciplinary Consortium for Aging Research and Education (ICARE)
- Geriatric Mental Health Coalition
- Caregiver Institute

**Clinical Care**
- **Inpatient**
  - ACE Unit
  - Stroke Unit
  - ACE of Hearts

- **Post Acute**
  - Summa HomeCare
  - Summa Home Infusion
  - Palliative Care and Hospice Services
  - SNF-Geriatric Rehabilitation Units
  - Physician House Call Program
  - Transitional Care - “Bridge to Home” Program

- **Palliative Care Unit and Consults**
  - Geriatric Consult Service
  - Geropsychiatry Unit

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*Funded by grant # R01 HS0 14537
**Funded by the National Palliative Care Research Center Grants
Dear Colleague:

It’s been an exciting year – one filled with innovation, achievements and recognition – but also with a great deal of uncertainty and change. With healthcare reform, payment for services will be increasingly tied to achieving quality outcomes.

As an integrated healthcare delivery system, Summa Health System is well positioned to provide added value to patients, payers and the communities we serve – and to thrive, not just survive, in the post-healthcare reform era. We are pleased to share some of the highlights of the past year in this issue of Summa Geriatrics.

Inside this edition, you will learn how:

• Two hospitals reduced the substantial morbidity and mortality associated with delirium in acutely ill, hospitalized older adults.

• A medical school helps ease the critical shortage of physicians with geriatric training by partnering with Summa to implement the CRIT program.

• A new program called It’s My Health eases patients’ transition from hospital to home after discharge.

• Members of the Care Coordination Network (CCN) improve patient outcomes through effective care coordination across a range of healthcare settings.

• A unique partnership between Summa and the local Area Agency on Aging mends gaps in care for dual-eligible patients.

The valuable work of the Institute for Senior and Post Acute Care team continues, albeit without Dr. Kyle Allen at its helm. Dr. Allen leaves behind a lasting legacy at Summa – a collaborative, creative atmosphere where healthcare professionals, community resources, medical researchers and others share innovative ideas and work together to improve the quality of life for older adults in the greater Akron region. Summa Health System’s Institute for Senior and Post Acute Care continues to maintain its place of leadership in the field of geriatric medicine, with ongoing research programs and community outreach activities designed to improve care for older adults.

We look forward to sharing our ongoing journey with you. We invite you to visit our website at summahs.org/seniors or contact us directly with any questions or comments via e-mail or by calling (330) 375-3747.

Sincerely,

Maryjo L. Cleveland, M.D.
Interim, Chief, Division of Geriatrics
Interim, Co-Medical Director, Institute for Senior and Post Acute Care
Medical Director, Center for Senior Health
clevelam@summahealth.org

Steven Radwany, M.D., FACP, FAAHPM
Interim, Co-Medical Director, Institute for Senior and Post Acute Care
Medical Director, Summa Palliative Care and Hospice Services
Program Director, Palliative Medicine and Hospice Fellowship
Chair, Ethics Committee
radwany@summahealth.org
Delirium is defined as an acute fluctuating disturbance of consciousness, attention, cognition and perception that affects sleep, emotion and psychomotor activity.

It is the most common complication of hospitalization and affects up to 20% of elderly patients – with even higher rates of occurrence found in oncology, intensive care and surgical units.
Patients who develop delirium:
- Have higher rates of morbidity and mortality which are comparable to that of sepsis and myocardial infarction
- Have significantly longer length of hospital stay
- Require significantly higher rates of post-hospital institutionalization

Prevention of delirium in high risk groups is by far the most effective strategy.

Studies have shown that by using non-pharmacologic interventions, there is more than a 33% decrease in incidence of delirium. The tactics used to achieve this reduction include:
- Avoiding sleep deprivation
- Enhancing mobility
- Addressing visual and hearing impairments
- Avoiding dehydration
- Cognitive-stimulating at-risk elderly patients

Established in 2007, the members of the Delirium Prevention and Treatment Quality Improvement...
The electronic Delirium Order Set aids physicians in conducting a prompt work-up on the patient to discover the underlying causes of delirium. It includes relevant lab tests, a medication review by a pharmacist and the appropriate nursing orders.

If a patient identified with delirium becomes severely agitated (at risk to harm themselves or others) or exhibits behavior which interferes with their care, the delirium order set also includes appropriate pharmacologic management strategies.

The protocol was initially piloted on the Acute Care for the Elderly (ACE) unit located at Summa Akron City Hospital in 2009 and was effective as shown by the following results:

- The incident rate of delirium post-protocol implementation improved by 2.3%
- Mean days of delirium decreased
- Average length of stay (LOS) decreased
- Cost per case decreased
- Mortality and transfer to intensive care units (ICU) decreased
- Percentage of patients returning home and to prior level of care increased
- Thirty (30) day hospital and emergency department readmission rates decreased
- High-risk medication use (benzodiazepines) decreased

This protocol has already been implemented at Summa Akron City and St. Thomas Hospitals in three areas: medical surgical, telemetry and rehabilitation units.

Since the expansion of the program to two campuses, the overall metrics utilized are LOS and cost per case.

Since this is a quality improvement initiative, a delirium nursing-specific audit tool was developed to provide protocol compliance feedback to nursing staff.

Physician reeducation sessions and electronic medical record reports showing the use of the computerized order set are also a part of the success measures. It is important to note that these measures have indicated increased acceptance and use by physicians.

The momentum for this initiative continues as Summa’s critical care unit establishes their own program and other system hospitals express an interest in beginning their own initiatives.

To date, the program reflects positive patient outcomes, which are the primary focus of Summa Health System as it is our mission to provide the highest quality, compassionate care to our patients and members and to contribute to a healthier community.

Please contact Lyn Benedict at (330) 375-3716 or geriatrics@summahealth.org to learn more about the delirium protocols implemented at Summa Health System.
Delirium Project 2011 Accomplishments


Benedict L. Outcomes of an Acute Delirium Detection, Prevention and Treatment Intervention Program. Robinson Memorial Hospital, an affiliate of Summa Health System, Nursing Research Day, Ravenna, OH, April 29, 2011.

Deen M. The Effect of Haloperidol Loading Dose on Duration of Delirium. Great Lakes Residency Conference, Purdue University, West Lafayette, IN, April 28, 2011.


**Benedict L.** Outcomes of an Acute Delirium Detection, Prevention and Treatment Intervention Program. Robinson Memorial Hospital, an affiliate of Summa Health System, Nursing Research Day, Ravenna, OH, April 29, 2011.


**Benedict L, MSN, R.N., CNS; Sabo A, BSN, R.N.**

Summa Health System Patient Safety Award

Delirium Initiative: Implementation

In recognition of the outstanding contribution to patient safety. June 18, 2010.

**Benedict L, MSN, R.N., CNS; Sabo A, BSN, R.N.; Allen K, D.O.**

Risk Management Award from American Excess Insurance (AEX)

Dealing with Delirium: An interdisciplinary strategy for addressing the most common psychiatric syndrome in the hospital.

The overall trend in healthcare today is to be more patient-centric – which means motivating patients to take an active, primary role in their own care.

Summa Health System is on the leading edge of this endeavor – thanks to a group of nurses at Summa Akron City and St. Thomas Hospitals.

After examining the literature – especially in the area of transitional coaching models – Carolyn Holder, MSN, R.N., GCNS-BC, Manager, Transitional Care, for Summa Akron City Hospital, and the members of the Transitional Care Task Force, devised a method that would fit into the existing hospital structure where nurses could teach patients to get involved in their own care after they were discharged from the hospital.

The result is It’s My Health, a program developed to support patient-centered care and improve the transition of care between hospital and home.

It’s My Health begins with a folder (given to a patient upon admittance) and a process, which helps patients understand how to take care of themselves, and a system that helps them keep their materials together to share with their healthcare providers.

The folder contains a brief review of discharge instructions, along with a single-page checklist to make sure patients understand and are prepared for discharge. There is also a medication list and reminder, several blank pages to record questions for their doctor and other notes, a medical history section and an area to store healthcare providers’ business cards.

Nurses on every shift talk with the patients regarding key symptoms they should look for post-discharge.
“For example, with patients with heart failure, instead of just telling them what to look for, we ask them, ‘Can you tell me what symptoms you need to watch for when you get home?’” Holder said.

The It’s My Health program also includes a follow-up call made 24 to 48 hours post-discharge, asking patients whether they’ve made their follow-up appointment calls with their physicians.

If the answer to the question is “No,” the caller makes it clear to the patient they really need to make that crucial phone call.

Past studies have shown that more than one-half of patients that are readmitted to the hospital did not follow-up with their doctors post-discharge.

A pilot study of the It’s My Health program was conducted on three nursing units (4 North, 5 North and 7 West) at Summa Akron City Hospital during the third quarter of 2010.

During the pilot, 504 patients were discharged with 62% of follow-up calls made to patients in their homes. Follow-up phone calls revealed that 76% of patients in the program had made follow-up appointments with physicians and 78% had filled their prescriptions.

But compliance wasn’t the only positive impact noted during the pilot study.

Press-Ganey patient satisfaction scores also increased from the 5th to 80th percentile range for some of the discharge measures. For patients who completed both a follow-up call and the satisfaction survey, there was a significant increase in satisfaction with admission, discharge, nursing, personal issues and physician care.

Results from the pilot indicated that the “It’s My Health” care delivery model effectively prepares patients for the transition from hospital to home and can be incorporated into routine care with little difficulty.

More studies are needed to see whether this model impacts readmission rates, according to Holder.

The program also supports Summa Health System’s vision of an Accountable Care Organization (ACO), which is expected to be implemented on a widespread basis in 2011 at Summa Akron City and St. Thomas Hospitals.

Several new staff positions have been created to conduct follow-up calls following patients’ discharge from the hospital.

Full-scale implementation of It’s My Health was completed in August 2011 at Summa Akron City and St. Thomas Hospitals. The program will be rolled out to other Summa hospitals beginning in 2012.

For more information about the It’s My Health program, contact Carolyn Holder at (330) 375-7784 or geriatrics@summahealth.org.
SAGE PARTNERSHIP MENDS CARE GAPS FOR DUAL-ELIGIBLE PATIENTS

Written by: Kyle Allen, D.O. and Sue Hazelett, MS, BSN

As currently structured, the healthcare delivery system in the U.S. is both ineffective and unsustainable, especially regarding chronic illness care. As the population ages, there will be a substantial increase in the number of people with chronic diseases.

Indeed, 75% of people more than 65 years old have at least one chronic condition – and 50% have at least two, according to the Agency for Healthcare Research and Quality.1 Chronic illnesses will place an increased burden on the U.S. healthcare system since people with chronic conditions account for 78% of all healthcare spending and 90% of all hospital costs.2

Patients who rely on Medicare and Medicaid to pay for their healthcare needs (dual-eligibles) present additional challenges to both state and federal policymakers. They account for nearly half of Medicare spending and more than a quarter of Medicaid spending. Because these two funding streams are not integrated, these patients often experience fragmented care. A lack of access to coordinated care can lead to poor quality care, inadequate management of chronic health conditions and potentially avoidable hospitalizations.
Purpose
The purpose is to describe the development of a unique collaboration between a healthcare system and a community-based long-term care provider whose goal was to mend known gaps in care for dual-eligibles by integrating the social and biomedical models of care and coordinating the Medicare and Medicaid funding streams using existing resources.

Background
This collaborative effort began in the mid-1990s between two entities, Summa Health System and the Area Agency on Aging (AAoA) 10B, Inc., both located in Akron, Ohio. Summa Health System, an integrated healthcare delivery system with its own health insurance plan, had adopted Wagner’s model of chronic illness care (Wagner et al, 1996) on several of its inpatient units. This model emphasizes that effective chronic illness care can only be achieved through redesigning the healthcare delivery system, including the use of interdisciplinary teams.

The Center for Senior Health
As an Integrated Healthcare Delivery System, Summa Health System has a vested interest in keeping its members as healthy as possible. As a result, in the mid-1990s, Summa Health System expanded its use of Wagner’s model and created the Center for Senior Health (CSH). The CSH is an outpatient consultative service that supports the primary care physician (PCP) through interdisciplinary comprehensive geriatric assessment, high risk assessment, a geriatrics resource center, a clinical teaching center and post-inpatient consultation follow-up. The CSH is staffed by geriatricians, nurse practitioners and social workers, which allows the Center to integrate the medical and social models of care so that a more complete picture of the patient’s strengths and needs emerges.

However, a major limitation of the CSH was that it did not have access to patients in their homes – nor could it provide long-term case management services to patients and their families. Instead, the CSH had to rely on self-reporting by patients when devising its interdisciplinary care plans, which is often unreliable. Since the home is the place where the majority of chronic illness care occurs, the CSH began to rely heavily on information obtained during home assessments made by community-based long-term care providers from the local Area Agency on Aging.

The Area Agency on Aging 10B, Inc.
At the same time, the Area Agency on Aging was encountering its own challenges with the dual-eligible population. In addition to its other programs, the AAoA administers a Medicaid waiver program called PASSPORT, which is conceptually a social model of care delivery that addresses the functional, social, and psychological needs of low-income chronically-ill older adults whose functional status qualifies them for nursing home placement. The primary goal of PASSPORT is to delay or prevent nursing home placement for dual-eligibles.

Care managers at the AAoA found themselves managing a growing number of consumers with functional deficits, geriatric syndromes and multiple chronic illnesses.

In fact, as much as 10% of their total consumer population fell into this high-risk category. As a result, they implemented a high-risk case management program that focused on health promotion and illness prevention.

Although this program included health promotion, the AAoA still operated under a social model where care managers had limited interactions with primary care physicians and no access to an interdisciplinary team or to hospital discharge planners. Care managers also did not have extensive knowledge about geriatric syndrome management, medication management or basic medical care. Without input from medical professionals who can manage chronic illnesses within the home care setting, too many consumers were dis-enrolling from PASSPORT and being placed in nursing facilities. Indeed, despite PASSPORT’s explicit goal to keep individuals living independently in their own homes, almost half of PASSPORT consumers were being transferred to nursing facilities each year.

1 Agency for Healthcare Research and Quality, (2002). Chronic disease self-management program can help prevent or delay disability in patients. AHRQ.
The SAGE Partnership
Both Summa Health System and AAoA leaders realized they needed a way to formalize and expand the communication process that had begun when CSH began relying on AAoA care managers to provide information about the patient’s home situation.

Leaders from both entities identified a lack of continuity of care and realized that much of the problem related to communication problems and fragmentation of care according to funding streams (Medicare for medical issues and Medicaid for social issues).

Thus, in 1995, Summa and AAoA embarked upon the SAGE project (Summa Health System/Area Agency on Aging, 10B/Geriatric Evaluation Project). SAGE provided the structure where individuals from both entities could come together to redesign the care processes that were in place to effectively integrate acute medical care services, outpatient medical services and the network of community-based long term care services. Importantly, this project was unlike other programs that seek to integrate Medicare and Medicaid services because there was not an integrated funding mechanism or contractual relationship to work from, just a collaborative effort on behalf of both organizations to meet common goals.

The goal of SAGE was to provide a coordinated healthcare delivery system to improve linkage to community resources and reduce fragmentation of care to improve the health and functional status of older adults, while also preventing institutionalization of those seniors who were at risk for nursing home placement. The SAGE project furthered the goals of all organizations involved by offering a “value-added” method of coordinated comprehensive health and human service delivery.

Operationally, the first step in this process was to form a task force.

The SAGE task force consisted of physicians, nurses, social workers, care managers and administrators from both institutions. The task force met monthly for two years, then changed to quarterly meetings. During those initial two years, the task force successfully:

• Developed screening and referral protocols for all care providers for at-risk older adults who require integrated care management services
• Established mechanisms for sharing information
• Devised follow up protocols
• Identified gaps and potential duplication in service delivery
• Stationed an AAoA case manager at the CSH as part of the interdisciplinary planning process
• Established a contact person at each institution
• Educated staff
• Tracked outcomes and statistical data
• Identified and addressed barriers to implementation of the protocols

The R.N. Assessor Program
In 2000, an in-hospital R.N. assessor program was added to SAGE to address a services lag issue. Patients were discharged from the hospital with skilled home care services and, after 30 to 60 days, were often referred to PASSPORT, which caused a lag in services until Medicaid was approved.

The R.N. assessor program bridges the gap between acute medical care and the community-based aging network to maximize services without duplication. It also helps Summa staff transition older adults to the appropriate care setting.
Outcomes from SAGE

Numerous benefits were realized by all parties as a result of the SAGE collaboration.

Some of the benefits SAGE provided to consumers include:
• Improvement in function
• Reduced hospitalizations
• Increased patient and caregiver satisfaction with care

The benefits SAGE offered to the healthcare delivery system include:
• Improved communication among all parties involved in the patient’s care (PCPs, hospital, AAoA) with the establishment of direct organizational linkages
• Decreased fragmentation of care
• Decreased costs

Both Summa Health System and AAoA staff members offered positive feedback about how SAGE impacted patient care, including:
• Improved communication amongst all participants
• Improved ability to better serve consumers
• A better understanding of each discipline’s internal operations
• A better understanding of the “big picture” of healthcare delivery, funding streams and resources
• Savings in staff time due to streamline communications and tasks

Finally, the community (taxpayers, legislators) saw benefits from SAGE in the form of continuing participation in the PASSPORT program and delaying and/or eliminating costly institutional care for older adults.

Implementation

The SAGE project required no additional funding or formal contractual agreements between care providers—simply a commitment from staff to collaborate.

The use of existing resources makes the SAGE project relatively easy to replicate and adapt for use in other communities. The main barriers to implementation, besides the technical logistics of information-sharing between agencies, had more to do with the “human” side of managing change than working through technical challenges.

The three critical barriers to implementation are listed in the chart above, along with suggestions on how to mitigate risk and ensure project success.

Conclusion

Today, our healthcare agencies and institutions see that continuing on separate tracks is no longer in the best interest of medicine, managed care or community-based long term care and certainly not in the best interest of the consumers we share. In the years ahead, with the projected significant growth in the older population and the advent of accountable care, the development of new healthcare delivery models designed to respond to the complex needs of this population, such as the SAGE project, will become a necessity.

For more information about the SAGE project, contact Sue Hazelett at (330) 375-3051 or geriatrics@summahealth.org.
The Care Coordination Network (CCN) is a group of skilled nursing facilities who have agreed to work collaboratively with Akron-based Summa Health System in order to:

• Increase communication and coordination of care for patients

• Optimize the combined expertise and knowledge of a multidisciplinary team to achieve desired clinical outcomes for patients

• Leverage combined efforts to effectively manage healthcare resources

Led by medical director Dr. Nancy Istenes, APN Carolyn Holder and Mike Demagall, administrator of Bath Manor, an Akron area long-term care facility, the CCN includes Summa Health System staff members and representatives from each of the CCN nursing facilities.

CCN representatives meet regularly to:

• Address quality measures

• Improve communication between hospitals, acute care providers and skilled nursing facilities

• Provide education about various clinical topics, i.e., new care delivery options, new guidelines, etc.
• Collaborate on developing measures to improve patient care

Meeting participants include representatives from many disciplines, including:
• Advanced practice nurses
• Nursing quality coordinators
• Home care staff
• Hospice nurses
• Social workers
• Physical and occupational therapists
• Geriatricians
• Palliative care physicians

Other meeting participants may include staff from Summa Health System and from the nursing facilities, i.e., nursing directors, Minimum Data Set (MDS) nurses, admissions representatives, therapists and others, as the need arises.

One of the first issues tackled by the CCN team was the lack/quality of information about patients who were being transferred from acute care to a nursing facility.

Pertinent data required for the MDS assessment was often missing, which required follow-up by nursing facility staff. An MDS assessment is required for all patients at any facility receiving reimbursement from Medicare or Medicaid for patient care.

Through the collaborative work of the CCN, several contributing factors were identified as root causes of this problem, including:
• A lack of knowledge about the information required for completing an MDS assessment on the part of the acute care staff
• Nursing facilities were asking for patients’ charts to be copied as a prerequisite for the referral, which was very time-consuming
• The delay in obtaining a referral often resulted in significant lag-time in the identification of post acute bed availability

The CCN committee developed a nursing facility transfer form with input from acute care nurses, social workers and nursing facility members.

The form contained core information needed by the nursing facilities to make a decision about whether they could effectively manage the patient.

This referral form was put into an Internet-based information system, which allowed rapid referrals and expedited feedback from multiple facilities concerning bed availability.

In acute care, patient care coordinators and social workers were trained how to use the system and input information into the referral form.

The benefits of using the improved online referral process included:
• The nursing facilities received the information they needed
• The amount of information faxed to the nursing facilities by the acute care staff was reduced
• The entire process of transfer was streamlined which decreased acute care and extended care facility staff’s transfer processing time

Due to the excellent results, the network has been very well received and participation in the network has grown from 26 member facilities in 2002 to 39 participating facilities in 2011.

The collaborative efforts of the Care Coordination Network haven’t gone unrecognized within the greater Akron community.

In 2004, a continuum of care task force was created by the Akron Regional Hospital Association, with the goal of creating a nursing facility transfer form which could be used by all 16 member hospitals.

Members of the Care Coordination Network participated in this effort to streamline the transfer process, as well as nurse case managers from many competing hospitals and healthcare systems.

Team members from the Care Coordination Network.
The form was finalized and implemented in 2005.

This committee has continued to work on other quality of care initiatives, including some which were initiated by the CCN.

One initiative focused specifically on the information required by emergency departments that must be gathered from the nursing facilities. This resulted in the design and development of the Post Acute Care to ED/Hospital form, which is now in use by all area nursing facilities.

A Care Coordination Skilled Nursing Facility Data Trend report was created by Dr. Kyle Allen and Don Jackovitz, Director of Quality and Resource Management, to provide blinded facility-specific performance data for the network members on a semi-annual basis. Some of the data that is included in the report follows:
- The number of discharges to a nursing facility
- A facility’s 31-day readmit rate
- Mortality rates
- Average lengths of stay
- Case mix indexes

The report allows facilities to track quality improvement over time and also enables comparison to the group for benchmarking purposes.

The Care Coordination Network has continued to work to improve the process for transferring patients between hospital and nursing facilities through regular reviews of cases where patients were readmitted within seven days and/or were deemed poor transfers. Poor transfer cases are forwarded to Quality Improvement for detailed review regarding nursing and medical issues. These cases are then addressed through a peer review process.

One crucial segment in the process of providing a continuum of care for older adult patients is the Geriatric Rehabilitation Program, which eases the transition from hospital to home for patients and their families.

36 Care Coordination Network Locations in 5 Northeast Ohio Counties

[Map showing locations of hospitals and care coordination network sites in Summit, Portage, Medina, Wayne, and Stark counties]
Geriatric Rehabilitation is a program of skilled rehabilitation that incorporates specialized and coordinated interdisciplinary care designed to allow patients to return home sooner and with more independence when compared to a traditional skilled rehabilitation facility.

How does the Geriatric Rehabilitation Program work?

A Summa Health System geriatrician works with a geriatric-trained nurse practitioner to provide the patient’s medical care along with the facility staff who is educated on geriatric syndromes and medical conditions that commonly affect older adults. They work collaboratively with the patient and his/her family to establish discharge goals and a comprehensive discharge plan.

The discharge plan often includes skilled homecare and other services that are appropriate. Patients’ lengths of stay (LOS) at the geriatric rehabilitation facility are often shorter than those at a traditional skilled rehabilitation facility.

Average Length of Stay in Community Hospitals 1989 – 2009

The elderly account for a disproportionate share of hospitalizations. For example, while individuals age 65 and older comprise about 12% of the U.S. population, they account for approximately 35% of all hospital stays. Although advances in medical technology have allowed the average hospital length of stay (LOS) to decrease from 7.2 days in 1989 to 5.4 days in 2009, often patients are not fully recovered at the time of their hospital discharge.¹

As a result, many patients still need close management of their medical condition(s), along with frequent medication adjustments and increased assistance with Activities of Daily Living (ADL), such as bathing, dressing and toileting.
skilled nursing facility due to the high level of coordinated care that patients receive at a geriatric rehabilitation facility. As a result, a higher percentage of patients are able to return to community living.

One key component of the geriatric rehabilitation unit is the weekly interdisciplinary team meeting.

During the meeting, team members offer their perspectives on each patient’s needs according to insights garnered from their respective disciplines. Out of this collaborative discussion, an effective discharge plan is crafted that meets each patient’s specific needs. The end result is a better outcome for patients and their families.

Members of an interdisciplinary team typically include a/an:
- Physician (geriatrician)
- Nurse practitioner
- Dietitian
- Activities director
- Therapy director
- Insurance company representative
- Patient case manager at the facility

Decisions regarding date of discharge and the services that need to be coordinated are implemented at these meetings.

Weekly team meetings allow ample opportunity for staff to discuss each patient’s care requirements soon after their admission to the facility. Early discussion of patients’ needs leads to improved discharge planning for each patient.

Another advantage of interdisciplinary cooperation and communication is improved coordination of care and the
receipt of valued input from all team members from the perspective of their area of expertise. This keeps the team focused on common goals and how each discipline supports these goals.

The inclusion of an insurance representative on the team improves communication and encourages shared decision-making regarding the patient’s discharge date.

Meetings are facilitated by the nurse practitioner, who plays a lead role in the discharge process. Nurse practitioners coordinate all services and help maintain the correct balance of the medical, social and community resources required to best meet patients’ needs.

By using the interdisciplinary team approach, the team can develop a comprehensive plan of care for patients. This translates to obvious benefits for patients, families and healthcare insurance providers, including:
- Decreased lengths of stay
- Better outcomes
- Prevention of disabilities
- Recovery of function during the rehabilitation stay
- Cost savings

In 2005, SummaCare, the Akron, Ohio-based health insurance provider which is part of Summa Health Network, adopted the Geriatric Rehabilitation Program as their preferred care model for the delivery of Skilled Nursing Services. SummaCare worked closely with Summa Health System’s geriatric services department to implement this specialized model of care in three contracted skilled nursing facilities.

As the collaborative effort grew, so did the partnerships that were added to the interdisciplinary team.

The interdisciplinary team in 2005 included not only medical providers and facility staff, but also added representatives from:
- SummaCare’s case management program
- Summa Health System’s HomeCare program
- Summa’s Palliative Care and Hospice Services program
- Akron’s Area Agency on Aging

By 2007, the program was expanded to include transitional care and a patient home visit performed by a geriatric-trained nurse practitioner provided within 72 hours of a patient’s discharge from a skilled nursing facility.

For more information about the Care Coordination Network or Summa’s Geriatric Rehabilitation Program, e-mail geriatrics@summahealth.org.

By 2010, SummaCare membership had grown – with an increased patient population who reside in the four counties contiguous to Summit County, Ohio (Medina, Portage, Stark and Wayne counties). A modified geriatric rehabilitation program was developed to provide increased access to geriatric rehabilitation for patients living in these outlying counties.

SummaCare contracted with regional Skilled Nursing Facilities and physicians who worked with Summa geriatric nurse practitioners and SummaCare case managers to increase the efficiency of care delivery and discharge planning. These patients also receive a post-discharge transitional care visit.

The combined geriatric rehabilitation programs include care which is delivered in seven nursing facilities across five counties with interdisciplinary and interagency collaboration for the effective medical and social management of patients’ care and discharge needs.
Hospice and Palliative Medicine: The Road to Recognition

Written by: Steven Radwany, M.D., FACP, FAAHPM

The Aging of America and the Rising Need for Palliative and End of Life Care

Current estimates suggest the demand for certified palliative medicine and hospice physicians will exceed supply by over 6,000 physicians within 10 years. While over 2,000 hospital-based palliative care programs exist across the U.S., few hospitals have the depth or breadth of Summa’s Palliative Care and Hospice Services.

Summa offers a full range of palliative care services to our community including:
• palliative care consult service at five system hospitals, five nursing homes and an outpatient cancer center,
• a palliative care clinic,
• an inpatient palliative care unit and
• a large hospice program

Summa’s palliative medicine fellowship and research arm aim to develop and train future professionals in this important and growing field. By December 2011, Summa’s Palliative Care and Hospice Services will have nine certified physicians, which positions our program to meet the growing demands throughout Northeast Ohio.
For most of human history, life has been short. Life expectancy in the U.S. in 1900 was just 50 years of age— in 1995, a woman could expect to reach age 79, while her husband might live to age 73.

As a result of these changes in mortality rates, people aged 65 and above are now a much larger proportion of the American population. In 1994, this age group accounted for about one in eight persons (13%) of the population; in 2030, when the majority of baby boomers have entered old age, one in five people (20% of Americans) will be in this group.

Americans are living longer, but with more chronic illnesses that require management by skilled physicians. Demographic changes and the rise of the hospice movement across the U.S. have created an awareness of the increased need for both specialist and generalist physicians who can provide effective palliative and end of life care.

**The Road to Recognition**

The American Board of Hospice and Palliative Medicine (ABHPM) was formed in 1995 by the American Academy of Hospice and Palliative Medicine (AAHPM) as an independent certifying body for those seeking to have high-level competency in hospice and palliative medicine recognized as a medical specialty.

To obtain formal recognition as a specialty by the American Board of Medical Specialties (ABMS) and the Accreditation Council for Graduate Medical Education (ACGME), certain criteria must be met, including:

- A distinct body of medical knowledge exists in the field
- There is a body of practicing physicians with defined professional roles in patient care
- Formal training is available in the specialty
- The field has a thriving professional society

**Why Seek Recognition?**

Formal recognition as a specialty by the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education helps define and sustain a medical discipline by creating practice standards and defined competencies within a specific domain of knowledge and practice.

It encourages professionalism and is recognized by governmental bodies and the public as an area of medical practice.

The objective of the ABHPM is to create a specialty whose members can:

- Provide expert consultation and role models for colleagues, students and other healthcare professionals
- Supply educational leadership and resources for evidence-based, useful undergraduate, graduate and continuing medical education
- Organize and conduct biomedical, clinical, behavioral and health services research
- Define the hospice and palliative care model to include prevention and relief of symptoms in order to lessen pain and suffering at the end of life, as well as stressing interdisciplinary, comprehensive and continuing care of patients and those close to them

Supporters felt that formal recognition as a subspecialty would:

- Improve patient care
- Create and distribute new knowledge
- Establish credibility and recognition of the discipline
- Develop an infrastructure to provide support for training and research
- Increase funding for training, research and clinical practice
- Encourage payers (government and private health insurance providers) to reimburse for clinical care related to the specialty

**Defining Primary and Secondary Palliative Care**

It was widely believed that any physician caring for patients with serious or life-threatening illnesses should have some basic training and skill in primary palliative care, such as the ability to:

- Manage pain and other symptoms
- Assess psychosocial distress
- Communicate about what to expect during a chronic or progressive illness

A small number of specialist physicians reach a higher level of competency in secondary palliative care, where, in addition to skill in the basic competencies listed above, they also:

- Practice within interdisciplinary teams
- Manage complex cases with multiple chronic illnesses
- Coordinate care across several treatment settings
- Provide assistance and support to caregivers
- Manage the needs associated with imminent death
- Train other healthcare professionals in hospice and palliative medicine
- Conduct research to add to the body of knowledge about chronic and terminal illness

**Certification and Accreditation**

Both the certification of physicians and the accreditation of training programs are crucial milestones in the creation and development of any new medical specialty.

In 1996, the ABHPM created a certifying exam with eligibility criteria with two tracks to achieve certification: a post-fellowship track and an experiential track. The ABHPM certification process enjoyed wide acceptance by those in the field and there were 2,883 physicians certified during the period 1996 to 2006.

One important part of ABHPM’s strategy was their decision to accept candidates from all primary specialties rather than limiting eligibility to just one or two specialties. This deliberate choice resulted in broad-based support for the new specialty, along with an increased breadth and depth of its knowledge base. It also allowed palliative services to be utilized in a much wider array of treatment settings. Palliative care has grown tremendously as a discipline with over 2,000 hospital-based palliative programs in the U.S.

The ABHPM also implemented a recertification process in 2004. Between 2004 and 2006, more than 300 physicians were recertified in hospice and palliative medicine.

In both the initial and recertification processes, the ABHPM made a conscious decision to mirror the procedures used by ABMS member boards. This choice proved to be an effective strategy that helped pave the way for eventual application to the ABMS.

Applications were prepared and submitted by ABHPM to both ABMS and ACGME stating that the field of hospice and palliative medicine met the criteria established for the recognition of a new medical specialty.

In June 2006, ACGME accepted hospice and palliative medicine and agreed to provide accreditation for its fellowship programs.

In October 2006, ABMS announced its approval of hospice and palliative medicine as a subspecialty.

One key item is the unprecedented level of interest from member specialties in sponsoring the new subspecialty.

As a result, hospice and palliative medicine is now a formal subspecialty of 11 underlying medical specialties, including: anesthesiology, emergency medicine, family medicine, internal medicine, neurology, obstetrics and gynecology, pediatrics, physical medicine and rehabilitation, psychiatry, radiation oncology and surgery.

In 2008, the first ABMS certification exam was held, with 1,200 physicians passing the exam. Also submitted in June 2008 was the first round of program accreditation applications to ACGME.

In January 2009, 48 hospice and palliative medicine training programs achieved ACGME accreditation, including Summa’s Palliative Medicine fellowship.

At Summa Health System, 100% of our palliative medicine physicians have received this certification. And 34% of our nursing staff – inpatient, home setting and extended care facilities have received certification.

For more information about the certification process, contact Steven Radwany, M.D. at (330) 379-5100 or geriatrics@summahealth.org.

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In the picture (l to r) front row: Avon Mehaffey, R.N.; R. Daniel Cerasco, M.D.; Melissa Soltis, M.D.; Cathy Bishop, R.N. have received additional certification in palliative and hospice medicine through their respective certifying agencies.
Educating Future Geriatricians

Geriatric Medicine Fellow Yoleetah Richards-Iodzi M.D.

Written by: Aileen Jencius, MLIS, Geriatric/Palliative Medicine Fellowship Coordinator
For a time, Richards-Ilodi worked both as a waitress and a bartender to help pay expenses. While still a young mother, she decided to pursue what seemed like an unrealistic goal: a career in medicine. She cites strong mentoring during medical school as the reason why she chose internal medicine as her specialty. Richards-Ilodi noticed significant changes in patients as a result of simple treatments for high blood pressure and diabetes.

When it was time to choose a residency, Richards-Ilodi had already settled on a large academic health system in northeastern Ohio. But after a single meeting with Dr. Dave Sweet, program director of the internal medicine residency program at Summa Health System, she realized that Summa was the place she wanted to be. Impressed with Sweet’s genuine concern for his residents, his kindness was the deciding factor in her decision to join the Summa “family.” And Richards-Ilodi has never looked back.

She completed her internal medicine residency at Summa Health System in 2011. Her subsequent decision to pursue a fellowship in geriatric medicine at Summa was simply the next logical career step. Aware of the impact that retiring baby boomers will have on the U.S. healthcare system, Richards-Ilodi wanted to be well-prepared to care for the tidal wave of aging boomers.

Being a busy resident hasn’t stopped Richards-Ilodi from getting involved in the local Akron community. One project that captured her interest is the community garden she implemented to encourage healthy exercise and eating habits in her patients.

Why a Garden?

Obesity exacerbates many chronic conditions in the patients she sees every day at the Internal Medicine Clinic at Summa Akron City Hospital. Knowing that nutrition and exercise are vital to good health, Richards-Ilodi began to encourage her patients to make positive changes in their health by starting with small, easy steps. She began with helping patients learn more about nutrition – and how to shop for healthier foods. Richards-Ilodi scheduled clinic appointments in which she would read labels on cereal boxes with patients to teach them how to be nutrition-savvy consumers. She filled balloons with sand and asked patients to hold them to illustrate the difference losing five pounds could make in their mobility.

When she realized that many of her patients lived in areas not suitable for solo exercise, Richards-Ilodi encouraged them to walk in groups. The end result? Patients were moving again. She celebrates each victory, too, like the walker who lost 20 pounds — and the older adult whose entire family now joins her on her walks. The exercise has reduced her dependence on a wheelchair.

The passion Dr. Yoleetah Richards-Ilodi has for improving the health of at-risk, older adults is almost as infectious as her smile.

Richards-Ilodi is Summa Health System’s current fellow in geriatric medicine. She has a history of working with older adults – and a strong belief in the importance of community involvement. As a teen, she worked in a nursing home because she enjoyed working with geriatric patients. Her path to a career in medicine has had its twists and turns, however.

And it hasn’t always been easy.
But Richards-Ilodi acknowledges that long-term changes in her patients’ lifestyle and nutritional habits will take time and require a broader approach.

Recognizing that sound nutrition and exercise are important components of good health, she began investigating the possibility of creating a community garden. The opportunity to share the work and the harvest would benefit participants in a number of ways.

The Center for Disease Control and Prevention in Atlanta supplied the evidence base for the project. Numerous case studies have documented the benefits that gardening offers both to communities and individuals. Improving access to healthy foods, fostering community involvement, encouraging social relationships and providing the opportunity for regular exercise in a safe, supportive environment are just some of the positive outcomes of community garden projects.

Richards-Ilodi had the idea and the passion for the garden – but she still needed land!

She approached the Summa Foundation in 2010 for assistance in obtaining plots for a pilot gardening project. The Foundation gave its support, and the garden project was a success!

Currently, Richards-Ilodi is scouting for a new larger location for the garden in 2012.

In the meantime, she continues to encourage her patients to make healthy changes in their lives. She hopes the community garden is just the beginning.

For more information about our accredited fellowship programs, contact Aileen Jenicus at (330) 375-7436 or geriatrics@summahealth.org.
CRIT Program Reduces Impact of ‘Silver Tsunami’ on U.S. Healthcare

By 2030, the number of adults age 65 and older will almost double to 70 million. Americans are not only living longer – they’re living longer with multiple chronic illnesses.

In fact, according to the American Geriatrics Society (AGS), about 20% of the Medicare population has at least five chronic conditions, i.e., hypertension, diabetes, arthritis, etc.

An untold number also suffer from geriatric syndromes often associated with the aging process such as incontinence, frequent falls, memory problems and side effects caused by taking multiple medications.

Caring for these patients is often complicated, expensive – and requires special training in geriatric medicine.

Unfortunately, a shortage of geriatricians already exists in the U.S. and is expected to worsen over the next 20 years. Currently, there is one geriatrician for every 5,000 adults age 65 and older. In 2030, it is estimated that this ratio will be only one geriatrician for every 7,665 older adults, representing a 50% decline over the next 25 years.

According to the American Geriatrics Society, fewer than 320 physicians entered geriatric medicine fellowship training from 2004 to 2008.

Happening just as the first wave of the “silver tsunami” of boomers reaches retirement age, the shortage of geriatricians is forcing medical educators to develop new strategies for educating the next generation of physicians to meet the healthcare needs of this growing (and graying) population.

In July 2011, The Association of Directors of Geriatric Academic Programs (ADGAP), in partnership with Boston Medical Center (BMC), was awarded a $600,000 grant from the

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Written by: Natalie Kayani, M.D. and Barb Palmisano, MA
Hearst Foundations to support the Chief Resident Immersion Training in the Care of Older Adults (CRIT) program. This is the first year of a potential four-year $2.2 million project that will be evaluated annually, with the possibility of renewed funding.

Recognizing America’s growing need for physicians who have both the training and clinical experience required to effectively treat older patients, Northeast Ohio Medical University (NEOMED) was one of four U.S. medical schools selected to offer geriatric training to all medical and surgical residency programs within the NEOMED consortium.

The three goals of the CRIT program are:

- Provide geriatrics training to chief residents in a variety of medical and surgical specialties through intensive educational retreats and mentored year-long projects
- Foster institutional collaboration across specialties and healthcare disciplines to improve the coordination and quality of care for hospitalized older adults
- Enhance the teaching and leadership skills of chief residents

Chief residents are the target group for this educational intervention because they play key teaching, patient care and communications roles in their hospitals.

The CRIT program is based on a train-the-trainer model. Senior faculty from medical centers, selected through a peer-reviewed application process, attend an annual chief resident geriatrics training retreat held by BMC to learn how to plan and facilitate CRIT retreats at their own institutions.

Then, with a grant issued to each participating institution, these senior faculty members and their CRIT project teams conduct retreats for incoming chief residents. Following the retreat, participating chief residents, under the guidance of faculty mentors, develop and implement year-long patient care or education projects designed to improve the care of older patients at their hospitals.

Summa Health System physicians have partnered with NEOMED’s Office of Geriatrics to implement the CRIT program.

The NEOMED team includes Anthony Costa, M.D., principal investigator, and team members George Litman, M.D., Barbara Palmisano, MA and Margaret Sanders, MA, LSW.

The Summa Health System team consists of Natalie Kayani, M.D., co-principal investigator, along with team members Elizabeth Baum, M.D., Maryjo Cleveland, M.D., Aileen Jencius, MLIS, John Kasper Jr., M.D., Timothy Lewis, M.D., Steven Radwany, M.D. and Scott Wilber, M.D. Team members serve on the project’s steering committee and as faculty mentors to chief residents.

The first educational retreat is scheduled June 1-3, 2012, at Sawmill Creek Resort in Huron, Ohio. Residents and program directors will attend the event at no cost, thanks to the financial support provided by the Hearst Foundations.

Northeast Ohio Medical University

Northeast Ohio Medical University (NEOMED) formerly known as Northeastern Ohio Universities Colleges of Medicine and Pharmacy is a community-based, public medical university with a mission to improve the quality of healthcare in Northeast Ohio working in collaboration with its educational and clinical partners. With a focus on scientific and medical research, and the interprofessional training of health professionals that is unique to the state of Ohio, NEOMED offers a doctor of medicine (M.D.) and a doctor of pharmacy (Pharm.D.) degree, in addition to graduate-level coursework and research opportunities leading to master’s and doctoral degrees in other medical areas. NEOMED also is a founding member of the Austen BioInnovation Institute in Akron. For more information, visit www.neoucom.edu.

For more information about the CRIT program, contact Natalie Kayani at (330) 375-3800 or geriatrics@summahealth.org.

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Medical Staff for the Institute for Senior and Post Acute Care

Physicians

Steven Radwany, M.D., FACP, FAAHPM
Interim, Co-Medical Director, Institute for Senior and Post Acute Care
Medical Director, Summa’s Palliative Care and Hospice Services
Program Director, Palliative Medicine and Hospice Fellowship
Chair, Ethics Committee
Board certified in geriatrics, hospice and palliative medicine and internal medicine

Maryjo L. Cleveland, M.D.
Interim, Chief, Division of Geriatrics
Interim, Co-Medical Director, Institute for Senior and Post Acute Care
Medical Director, Center for Senior Health
Board certified in geriatrics medicine

Preeti Betkerur, M.D.
Board certified in geriatrics and internal medicine

Thomas Breen, M.D., Ph.D.
Medical Director
New Horizons Adult Day Services
SummaCare Physician House Calls
Board certified in geriatrics and internal medicine

R. Daniel Cevasco, Jr., M.D.
Associate Medical Director
Summa’s Palliative Care and Hospice Services
Board certified in family medicine and holds Certificate of added qualifications in palliative medicine

Kevin F. Dieter, M.D., FAAHPM
Associate Medical Director
Summa’s Palliative Care and Hospice Services
Board certified in family medicine and holds Certificate of added qualifications in palliative medicine

Charina Gayomali, M.D.
Medical Director, Palliative Care Clinic
Board certified in internal medicine, nephrology and hospice and palliative medicine

Christine D. Hudak, M.D., FAAFP
Associate Medical Director
Summa’s Palliative Care and Hospice Services
Board certified in family medicine and holds Certificate of added qualifications in palliative medicine

Nancy A. Istenes, D.O., CMD
Medical Director, Long-term and Transitional Care Services, Summa’s HomeCare and Geriatric Rehabilitation Units
Board certified in geriatrics and internal medicine

John A. Kasper, M.D.
Board certified in general psychiatry, forensic psychiatry and geriatric psychiatry

Natalie A. Kayani, M.D.
Medical Director
Geriatric Medical Education
Board certified in geriatrics and internal medicine

Timothy Lewis, M.D.
Board certified in geriatrics and internal medicine

Catherine S. Maxwell, M.D., FACP
Medical Director
Geriatric Inpatient Consult Service
Board certified in geriatrics and internal medicine

Shorin Nemeth, D.O.
Medical Director
Palliative Care
Summa Western Reserve Hospital
Board certified in internal medicine
Melissa Soltis, M.D.
Associate Medical Director
Summa’s Palliative Care and Hospice Services
Board certified in hospice and palliative medicine and internal medicine

Kathleen Senger, M.D.
Associate Medical Director
Summa’s Palliative Care and Hospice Services
Board certified in hospice and palliative medicine and internal medicine

Sara Snyder, D.O.
Board certified in family medicine

Simona Suchan, M.D.
Board certified in general psychiatry and geriatric psychiatry

Nurse Practitioners

Laurie Brown-Croyts, MSN, CNP
AANP certified adult nurse practitioner

Beth A. Ezzie, MSN, CNP
ANCC board certified geriatric nurse practitioner

Sarah Gedeon, MSN, CNP
ANCC board certified geriatric nurse practitioner

Patricia Gossett, MSN, CNP
ANCC board certified acute care nurse practitioner

Amanda Harvan, MSN, CNP
ANCC board certified adult nurse practitioner

Erica Lynn Hoiles, MSN, CRNP
AANP certified adult nurse practitioner

Michael Klein, MSN, CRNP
AANP certified adult nurse practitioner

Hallie Mason, MSN, CRNP
ANCC board certified in family practice
NBCHPN board certified advanced practice palliative care management

Kelly McGranahan, MSN, CRNP
AANP certified adult nurse practitioner

Stacie Schreiner, MSN, CNP
AANP certified adult nurse practitioner

Sandy Shaw, MSN, CRNP
AANP certified adult nurse practitioner

Scott Spillan, MSN, CNP
AANP certified adult nurse practitioner
REGIONAL GERIATRIC AND PALLIATIVE MEDICINE PHYSICIANS

TOSADDAQ AHMED, M.D.
Board certified in geriatrics
Summa Akron City and St. Thomas Hospitals

IRENE M. CHENOWITH, M.D.
Board certified in internal medicine and geriatrics
Summa Akron City and St. Thomas Hospitals

STEVEN L. COCHRAN, M.D.
Board certified in family medicine and holds a Certificate of added qualifications in geriatric medicine
Summa Akron City and St. Thomas Hospitals

MATTHEW P. FINNERAN, M.D.
Board certified in geriatrics
Summa Wadsworth-Rittman Hospital

JAMES F. GROW, M.D.
Board certified in family medicine and holds a Certificate of added qualifications in geriatric medicine
Summa Akron City and St. Thomas Hospitals

JYOTHI D. GUDLA, M.D.
Board certified in internal medicine and geriatrics
Summa Akron City and St. Thomas Hospitals

RODERICK ISN, M.D.
Board certified in family medicine and holds a Certificate of added qualifications in geriatric medicine
Summa Barbston Hospital

JEFFREY A. KASE, M.D.
Board certified in family medicine and holds a Certificate of added qualifications in geriatric medicine
Summa Physicians Inc.

BONG S. KAOU, M.D.
Board certified in internal medicine and geriatrics
Summa Akron City and St. Thomas Hospitals

DAVID R. LANCE, D.O.
Board certified in geriatrics, hospice and palliative medicine
Summa Wadsworth-Rittman Hospital

BRADLEY R. MARTIN, M.D.
Board certified in internal medicine, critical care and geriatrics
Summa Akron City and St. Thomas Hospitals
Summa Barbston Hospital

KENELM F. MCCORMICK, M.D.
Board certified in family medicine and holds a Certificate of added qualifications in hospice and palliative medicine
Summa Wadsworth-Rittman Hospital

DANIEL L. STEIDL, M.D.
Board certified in internal medicine and geriatrics
Summa Akron City and St. Thomas Hospitals

J. DAVID STOKES, M.D.
Board certified in family medicine and holds a Certificate of added qualifications in geriatric medicine
Summa Barbston Hospital
Summa Health System serves more than one million patients each year in comprehensive emergency, acute, critical outpatient and long-term home-care settings and represents more than 2,000 licensed, inpatient beds on the campuses of Summa Akron City Hospital, Summa Barberton Hospital, Summa St. Thomas Hospital, Summa Wadsworth-Rittman Hospital, Summa Western Reserve Hospital, Robinson Memorial Hospital, an affiliate of Summa Health System, and Crystal Clinic Orthopaedic Center, a joint partnership with Summa Health System. In addition, outpatient care is extended throughout a five county region in more than 20 community health centers. For more information, visit our website: summahealth.org