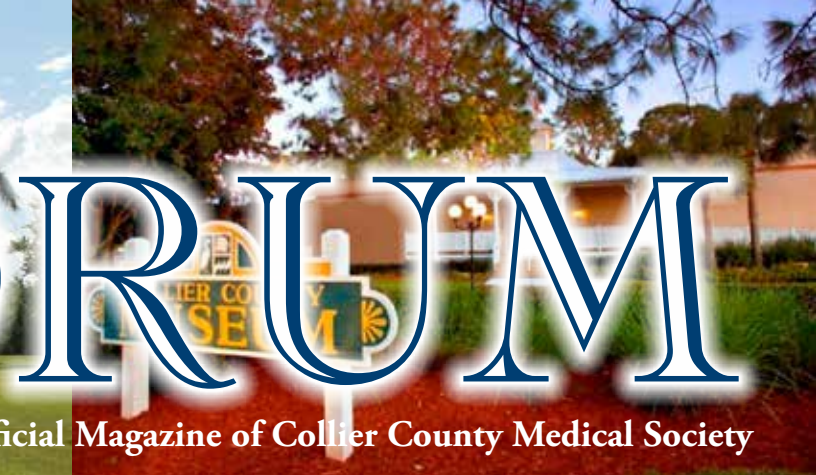




# THE FORUM

January/February 2017 • Volume 16, No. 1 • The Official Magazine of Collier County Medical Society

## Community Health Assessment for Collier County



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## CALENDAR OF EVENTS

Register at [www.ccmsonline.org](http://www.ccmsonline.org)  
or call (239) 435-7727

Thursday, January 12, 6:00pm  
**CCMS Webinar: MACRA and the Evolving Health  
Care Reimbursement Landscape**  
Online Presentation

Friday, February 10, 6:00pm  
**Foundation of CCMS Social Fundraiser**  
Location TBA

Saturday, March 4, 8:30am  
**9th Annual CCMS Women's Health Forum**  
St. John the Evangelist Catholic Church

Thursday, March 30, 6:00pm  
**CCMS 2017 Spring General Membership Meeting**  
Arthrex

Saturday, May 13, 6:30pm  
**60th Anniversary CCMS Annual Meeting &  
Installation of Officers**  
Quail Creek Country Club

### *Save the Date!*

Saturday, September 23, 8:30am  
**4th Annual Foundation of CCMS "Docs & Duffers"  
Charity Golf Tournament**  
Bonita Bay Club East in Naples

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# MEMBER NEWS

## New Members:


**Sadiq Al-Nakeeb, M.D.**

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Board Certified: Pulmonary Medicine, Critical Care Medicine & Sleep Medicine, Internal Medicine


**Victoria Chang, M.D.**

Bascom Palmer Eye Institute  
3880 Tamiami Trl N  
Naples, FL 34103  
Phone: (239) 659-3945 Fax: (239) 659-3921  
Board Certified: Ophthalmology


**Robert E. Eilers, M.D.**

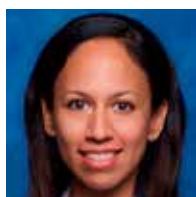
Riverchase Dermatology & Cosmetic Surgery  
1108 Goodlette Rd N  
Naples, FL 34102  
Phone: (239) 434-0303 Fax: (239) 262-8730  
Board Certified: Dermatology


**Carmella Fernandez, M.D.**

Joint Implant Surgeons of Florida  
1020 Crosspointe Dr Ste 110  
Naples, FL 34110  
Phone: (239) 337-2003 Fax: (239) 337-3168  
Specialty: Hand & Upper Extremity Surgery


**Rodolfo Freire, M.D.**

RF Medical Services, Inc.  
12264 Tamiami Trl E Unit 203  
Naples, FL 34113  
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Specialty: Internal Medicine


**Angeline V. Galiano, M.D.**

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**Marie T. Olivero, M.D.**

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**Supriya M. Parowski, D.O.**

NCH Physician Group  
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Naples, FL 34110  
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Board Certified: Physical Medicine and Rehabilitation


**Clinton J. Potter, M.D.**

Advance Medical of Naples  
720 Goodlette Rd N, Ste 500  
Naples, FL 34102  
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## Reinstated:

**Lawrence J. Albert, M.D.**

Naples Pulmonary Concierge Medical Practice  
3021 Airport Rd Ste 103  
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Board Certified: Internal Medicine, Critical Care Medicine

**Kenneth Bookman, M.D.**

Naples Pulmonary Concierge Medical Practice  
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**Christine S. Forszpaniak, M.D.**

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Board Certified: Infectious Diseases, Internal Medicine

**J. Ryan Jackson, M.D.**

The Jackson Center  
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Naples, FL 34109  
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**Anurag S. Kushawaha, M.D.**

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## The 60th Anniversary of Collier County Medical Society

*Throughout this year, issues of The Forum will feature a look back at the 60-year history of Collier County Medical Society and its members in celebration of this milestone anniversary. Also, be sure to continue celebrating with us at the 60th Annual Meeting of CCMS on May 13th at Quail Creek Country Club – stay tuned for more details.*

Once part of a four-county medical society, Collier County Medical Society members received their charter from the Florida Medical Association in January 1957. Many factors contributed to the decision to separate from the four-county format, which included Lee, Charlotte, Collier, and Hendry counties.

As detailed in a letter to Dr. Ralph W. Jack, chairman of council for the Florida Medical Association in April 1956, Dr. Ethel Trygstad gave several reasons why these doctors desired to establish a Collier society. The main reasons were:

- ◇ The rapid growth of the county would encourage more business,
- ◇ This growth would increase activity at the new hospital,
- ◇ Many world-famous specialists in various fields visited the area and already agreed to be guest speakers at membership meetings, and
- ◇ Traveling to Ft. Myers to attend the current society meetings took too much time away from their patients.

The fledgling organization began with 10 physician members:

- ◇ President James A. Craig, M.D.
- ◇ Vice-President Reidar Trygstad, M.D.
- ◇ Treasurer Loral F. Gwaltney, M.D.
- ◇ Secretary Ethel H. Trygstad, M.D.
- ◇ Delegate Daniel B. Langley, M.D.
- ◇ Members John J. Meli, M.D.; William J. Bailey, M.D.; John Garland, M.D.; Kenneth E. Snyder, M.D.; and Forrest Hinton, M.D.

Dr. James A. Craig was the first president of the Collier County Medical Society, a highly-respected surgeon among colleagues, and a close friend of President Eisenhower's personal cardiologist, renowned heart specialist and winter resident Dr. Paul Dudley White.

There were only a handful of doctors in town, so Jim had little time to himself. On the rare occasion he did, he was usually hunting quail. He liked to travel 30 miles outside of town to a sawgrass patch in the Everglades swamp. Jim liked thrills. Legend has it a group of fellow doctors attached 300 pounds of lead to the bottom of his Jaguar to prevent it from flipping over on high-speed trips to Lee Memorial Hospital – which were usually twice a day from 1948 to 1956. He loved everything about South Florida except the red tide, which gave him headaches.

In 1957, the annual dues for the Collier County Medical Society were \$15. A typical office visit in 1957 was \$4. Doctors relocating to the area in 1958 could rent a one-bedroom, fully-furnished house for \$68/month.



*The first CCMS members gather at the Old Cove Inn to receive their charter. Back row (l-r): Dr. Loral Gwaltney, Dr. Reidar Trygstad, Dr. Frances Langley, [president, Florida Medical Association], Dr. James Craig, Dr. Ethel Trygstad. Front row (l-r): Dr. John Meli, Dr. William Bailey, Dr. John Garland, Dr. Forrest Hinton, and Dr. Daniel Langley.*

Naples didn't have a daily newspaper when the Society was created in 1957. Instead, doctors relied on The Miami Herald for news on advancements in medicine. One such article alerted local doctors that a "Modern Gadget" was the newly created tripod cane. Medical Society members met at the Elk's Club in the summer of 1957 to hear guest speaker Dr. Cary Barry talk about common causes of hematuria.

Collier County is one of the fastest growing areas in the country. The physician members of CCMS have upheld a tradition of providing quality healthcare to keep our area one of the best-served medical counties in Florida, educating one another in the rapidly-changing world of medicine, providing professional resources to maintain successful practices, and advocating on behalf of their colleagues and patients on important health issues.

The first record of the Medical Society's involvement as a voice for the medical community is found in a letter from CCMS secretary Dr. Ethel Trygstad to Florida Congressman Paul Rogers in 1957. In the letter, the Medical Society stated its opposition of the Forand Bill, which intended to provide free hospitalization only to persons covered by Social Security.

CCMS board members believed the bill would wrongly empower those covered under it in such a manner that they might demand hospitalization for conditions that could be treated in a physician's office. The Forand Bill never passed. Over the last 60 years, CCMS has written hundreds of letters to a multitude of government officials to support or oppose legislation that affects a physician's ability to deliver quality medical care.



*The imagery in the first CCMS logo reflected our Southwest Florida community.*

Since 1957, Collier County Medical Society has grown to nearly 600 members, and continues to grow. Exciting new programs have been implemented throughout the last six decades and are being planned for the near future – stay tuned for more on what's to come. In the meantime, we look forward to our 60th year and beyond!





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## Community Health Assessment

Stephanie Vick, MS, BSN, RN – Administrator, Florida Department of Health–Collier



input from individuals throughout the county. An overview of our most recent assessment results follows.

In the past two decades, Collier County has experienced tremendous growth and change in terms of population dynamics and demographics, socioeconomic transitions and in patterns of the health of the community. Various characteristics of the population of Collier County correlate with select health status factors and outcomes which drive the quality of life throughout the county.

Between 1995 and 2015, the resident population of Collier County grew at a swift pace of 2.8 percent per year compared with Florida at 1.6 percent and the United States at 1.0 percent during the same period. Ethnic and socioeconomic transition has created a shift in a number of public health indicators at the county level. The latest census bureau data available indicate that in 2014, 53 percent of Collier County residents spoke a language other than English in the home. This is directly correlated with the growth of the Hispanic population. The number of children living in poverty in Collier County increased by 27.3 percent over the past decade.

The leading cause of death in Collier County is cancer, which accounted for 25.5 percent of all mortality in 2014. Collier County has seen a substantial decline in this mortality rate since 2005. Diabetes is the 7th leading cause of death in Collier County. The most significant risk factor for the development of diabetes is overweight and obesity. Diabetes is also a significant cause of heart disease and stroke and the leading cause of kidney failure. Obesity, as it relates to chronic diseases, has been identified by community health care leaders and the general public as a key focus area for improvement within the county.

Between the years 2005 and 2014, the incidence of all communicable diseases increased by 5.5 percent in the county. Chlamydia is the leading communicable disease in Collier County accounting for 58.1 percent of all reported

infectious diseases in the county in 2014. Tuberculosis, once considered to have been virtually eliminated from the United States, continues to be present in Collier County at a greater than average rate. In Florida and Collier County, medically underserved low income populations tend to have a high rate of tuberculosis exposure and infection. These vulnerable population groups disproportionately represent the majority of tuberculosis cases in the county.

Maternal and infant health is the foundation for a vibrant and prosperous society. The infant mortality rate for Collier County declined to a new low of 4.6 infant deaths per 1,000 live births in 2014. The Hispanic infant mortality rate in the county (4.0 per 1,000 live births) was 20 percent lower than the non-Hispanic rate (5.0 per 1,000 live births). Pregnant women in Collier County continue to improve upon their health behaviors by decreasing their reliance on alcohol and tobacco use. Collier County lags behind the state of Florida for all three indicators related to adequate prenatal care: births with first trimester prenatal care, births with late or no prenatal care, and births with adequate prenatal care. Community focus groups have pointed to the need for a good support system for receiving obstetrical care.

The two most prevalent unhealthy behaviors or lifestyle related habits in Collier County are tobacco use and overweight and obesity. These two behaviors account for approximately 35 percent of all premature and preventable deaths in the county. While Collier County is healthier than the state of Florida regarding overweight and obesity levels, these conditions account for 17 percent of all deaths annually in the county or about 1 out of every 6 deaths.

A strong statistical association exists between alcohol consumption and alcohol impaired driving. Alcohol related motor vehicle collisions and fatalities constitute a significant proportion of alcohol related deaths. On average, in Collier County 54 residents are killed annually in motor vehicle crashes with approximately 25 percent attributed to alcohol use. Overall, Collier County residents are more likely than Florida residents to engage in heavy or binge drinking, 18.1 percent compared with 17.6 percent. Collier County does have a greater proportion of the population 65 years and older engaged in heavy or binge drinking than Florida, 9.8 percent compared to 7.2 percent, respectively. It is important to note that the community recognizes the high percentage of drinking and auto accidents associated with the older population in the county.

Despite the fact that poor mental health days as reported by the public are less than 12.7 percent for Florida in 2013 compared

*continued on page 7*

*continued from page 6*

to 7.3 percent in Collier, the community has been highly verbal about the need for more mental/behavioral health services, as currently a void exists for various levels of mental/behavioral healthcare, particularly around the issues of substance abuse. Public awareness exists on the issue and clearly feels the professional resources are lacking.

During 2015, within Collier County over 12,000 residents 65 years of age and older had Alzheimer's disease; by 2030 using conservative population estimates, over 18,600 residents will be diagnosed with the disease. Not surprisingly, community members identified the need for more nursing home beds within the county and specifically indicated facilities that accept lower income residents were needed. The increased need for expanding memory care facilities was identified as the population 65 years of age and over continues to grow at historically high rates. The community perceived that the current market is catering to higher-end assisted living facilities despite the increasing need for affordable long-term care and skilled nursing facilities.

Almost one half of all deaths in Collier County are potentially preventable, based on the premise that major actual causes of mortality can be modified through education and access to care. Tobacco use is the leading cause of preventable mortality followed by overweight and obesity resulting from physical inactivity and poor dietary habits. Together, these two actual causes were responsible for 72 percent of all preventable causes of death in Collier County in 2014.

Health status analysis combined with the local public health system assessment results and information from community focus groups and community surveys were used to identify the current key strategic focus areas for Collier County. The top ten areas have remained similar to the assessment three years ago, although there has been a shift in the perceived importance of particularly the top five. The top five strategic issues in order of importance ranking that were identified are: Chronic Diseases, Mental Health, Access to Care, Alcohol and Drug Abuse and Obesity. We appreciate your help in addressing the needs of our community and we look forward to working with you in various capacities to address the currently identified issues.

Priority Health Rankings   2012 and 2016 Comparisons											
All Focus Groups (Combined)	September, 2012	Chronic Diseases	Access to Care	Obesity	Alcohol & Drug Abuse	Mental Health	Health of the Elderly	Communicable Diseases	Dental Health	Disabilities	Unintentional Injuries
	April, 2016	Chronic Diseases	Mental Health	Access to Care	Alcohol & Drug Abuse	Obesity	Health of the Elderly	Communicable Diseases	Disabilities	Dental Health	Unintentional Injuries
		1	2	3	4	5	6	7	8	9	10
		1	2	3	4	5	6	7	8	9	10

## MEMBER NEWS *(continued)*

*continued from page 3*

### **Janice N. Young, M.D.**

Woman to Woman GYN of Naples  
3920 Via Del Rey Ste 1  
Bonita Springs, FL 34134  
Phone: (239) 676-9406  
Board Certified: Obstetrics and Gynecology

### ***New Practice:***

#### **Manuel F. Bustamante, M.D.**

Gastroenterology  
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Naples, FL 34109  
Phone: (239) 631-2662

### ***New Location:***

#### **Richard J. de Asla, M.D.**

Orthopaedic Surgery  
NCH Physician Group  
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Naples, FL 34109  
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### **Maria T. Vargas, M.D.**

Endocrinology, Diabetes & Metabolism  
Physicians Regional Medical Group  
8340 Collier Blvd Ste 202  
Naples, FL 34114  
Phone: (239) 348-4221 Fax: (239) 354-4308

### ***New Phone and Fax Numbers:***

#### **David J. Lamon, M.D.**

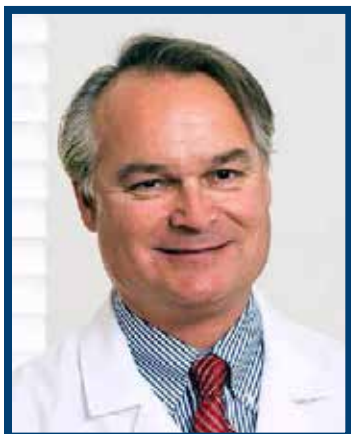
General Surgery  
NCH Physician Group  
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#### **Ketan H. Trivedi, M.D.**

Family Medicine  
Physicians Regional Medical Group  
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# Taking Control of Your Practice: Alternative Payment Models Can Simplify Your Practice and Improve Both Patient and Physician Satisfaction

Michael T. Havig, M.D. – Founder & CEO of HealthMe Technology and CCMS Member



Healthcare is at a crossroads. Our current healthcare model, utilizing third party payment, is simply unaffordable for individuals and their employers. Increased financial burden for the consumer in the form of skyrocketing insurance premiums, coupled with higher deductibles, have prompted the growth of consumer driven healthcare.

At the same time healthcare providers are frustrated with lack of control they have in providing quality healthcare to their patients. We all face an ever-increasing administrative burden in the form of documentation, data collection, and billing regulations such as ICD-10, cumbersome EMRs, and MACRA. These have made healthcare providers much less efficient in the face of declining reimbursement resulting in decreased job satisfaction. The current system is broken for both patients and providers. Can we reverse this trend with alternative payment models?

Consumer driven healthcare (CDHC), defined broadly, refers to the practice of patients managing their own health care dollars, which helps them become more conscientious consumers. CDHC encourages consumer-oriented provision of healthcare involving patients with more decision making and financing of their care. The most common form of CDHC is the high deductible health savings account but concierge, direct care, and direct pay models fall into this category as well. These alternative models allow patients to shop for medical services based on quality, convenience and price. Doctors who participate in these plans repackage their services, competing for patients based on the same quality and pricing metrics.

We are all familiar with the most common payment models. Traditional third party reimbursement has become intolerable due to the inefficiencies described above. Documentation and administrative hurdles have taken precedent over patient interaction and quality care. In response, alternative payment models such as concierge, direct care and direct pay practices have gained popularity.

Concierge medicine may be the ideal model for physicians but it is unaffordable to the majority of patients. Direct care models, in which the physician or medical group charges a monthly fee for healthcare services, are also gaining in popularity. Both of these models have been well received by patients and physicians but require major changes to your practice. Concierge and direct care providers usually opt out of Medicare and this is a

big step many physicians are uncomfortable taking.

Perhaps the simplest model - direct pay fee for service - has been forgotten by the majority of healthcare providers. Why have we not embraced this model? Unlike concierge and direct care models, there are little to no costs or major changes to your practice to participate. However, traditionally physicians and their practice managers have equated “cash pay” with “no pay.” What if we could offer reasonable upfront pricing for our services and get paid our price without excessive documentation, ICD-10 codes and other headaches? In addition, what if we could attract high deductible, HSA, or uninsured patients willing to pay reasonable transparent prices via an online, mobile medical marketplace?

Fortunately, technology has made this possible with software platforms that allow this type of payment for service. HealthMe is one such platform created by local doctors that brings a familiar shopping experience to patients and their employers. Specifically, HealthMe brings pricing transparency to healthcare via consumer centric care plans. These plans address the most common reasons patients see the doctor.

For example, a knee pain care package includes a visit with the doctor, an x-ray of the knee, and a treatment plan for a reasonable upfront fee. To participate in the marketplace, physicians simply create an online practice profile, choose the care packages they wish to offer and name their own price. Listing your services on HealthMe comes at no cost to doctors or their practices. Healthcare providers (doctors, therapists, clinics, hospitals, and outpatient centers) use the platform to bring reasonable up front pricing to this group of patients, which creates a free market that has previously not existed in healthcare.

To control costs, both patients and their employers are seeking consumer driven solutions that allow them to shop for their healthcare like they shop for other products – using quality, convenience, and price. Doctors want to become more efficient by offering care plans with simple pricing of their services. In other words, physicians want to spend their time caring for their patients and not spend countless hours of the day providing extensive documentation and staff resources dedicated to the billing process.

Concierge, direct care, and direct pay models allow us to do this while improving patient satisfaction and quality of care. Direct pay models can be implemented without major changes to your practice. Fortunately, software platforms like HealthMe make it simple to grow this segment of your practice. These technologies will transform the way healthcare is bought and sold, benefitting both doctors and patients. Think Uber for healthcare!





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## Three Ways Medical Practices Can Budget Smart

Nick Hernandez, MBA, FACHE - CEO, ABISA, LLC



At the end of each year, medical practices should be working to finalize their operating budget for the next calendar year. Unfortunately, too few practices actually take the time to create a meaningful budget, instead seeing the endeavor as a complex, time-consuming process that likely will not be used. Creating and following a budget involves self-discipline and sacrifice, but will help you develop wise spending habits to better manage your practice's finances now and into the future.

If you're continually seeing failure at budgeting, the best place to look is usually at the fundamentals. It only takes a fundamental misstep or two to transform a well-planned and well-formed budget into a complete disaster. Budgets should be realistic, flexible, and consistent with practice goals and objectives.

It's not too late to implement a budget for 2017. Here are three keys to consider that will point you on the right track toward success as you build your budget:

1. **Know why you are budgeting.** If you're developing a budget just because someone says it's a good idea, it probably won't help very much. Similarly, if you're just following the steps in a practice finance workbook because it suggests this is a great way to move towards financial success, budgeting won't help much at all. The reason for budgeting is to help you spend less than you earn. It shows you where your spending weaknesses are and provides the structure for you to get stronger in those areas. If you're in the dark about how much your practice spends and where you spend it, changing habits will be difficult. And even if you're financially comfortable, a budget can help you identify unnecessary expenditures and deduce ways to redirect funds towards your priorities.

2. **Be realistic.** It's not going to work if you make huge, unrealistic assumptions right off the bat. Small steps work; big steps result in failure. Operating a medical practice can be unpredictable at times, and things happen that are out of your control. Consequently, look at where money can be moved around within a budget. For example, practices often use budgets to plan for future business growth and expansion. Capital saved on regular business expenditures may be placed into a special reserve account designated for selecting new business opportunities. Budgeting for future growth opportunities ensures that practices have capital on hand when needing to make quick decisions for expanding business operations. This capital may also be used during slow economic times as a safety net for paying regular business expenses.

3. **Be flexible.** There will usually be moments when you're learning to budget when you discover that some element of your budget is just not right. Take time to readjust figures. It's not realistic because you forgot about some key piece of information while making your plans, and that means the budget you developed doesn't really work. Don't panic. Don't abandon your plans. Just go back to your plans, make the needed adjustments, and start over again. This is normal, it happens to everyone. It does not mean your budget was a failure at all, it just means it needed to evolve a little bit. Regularly revisiting your practice's budget will help you better control financial decisions because you will know exactly what you can afford to spend versus how much the practice is projecting to make.

An accurate, useful budget can be a valuable decision-making tool to analyze potential business threats and opportunities and help physician owners and practice administrators make sound, strategic, and disciplined choices. Having a business budget in place enables you to plan ahead, prioritize your allocation of funds and gauge whether your financial predictions are being met. It will also enable you to make educated decisions to enhance your business operations with added clarity and efficiency.

When properly executed, a practice budget will quickly become one of the most valuable resources in a practice's decision-making toolbox. A proactive, comprehensive budget gives a practice the ability to properly track results, identify areas of concern, and quickly intervene when issues arise. And don't be afraid to seek out the professional advice of a healthcare consultant or CPA. They have worked with many practices and can help identify budgetary items which you may be inclined to overlook.





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## Watch for the Signs: Screen All Patients for Suicidal Thoughts

Robin Diamond, MSN, JD, RN – Senior Vice President of Patient Safety and Risk Management, The Doctors Company



The suicide of a patient is a tragedy for any physician. Patients with suicidal thoughts or ideation appear occasionally in physician encounters. The Joint Commission recently noted that the rate of suicide is increasing, and suicide is now the 10th leading cause of death in the United States.<sup>1</sup> Most people who commit suicide received healthcare services in the year prior to death, usually for reasons other than mental health issues or suicidal

thoughts. It's a strong reminder that any patient—no matter what issue is being treated and in any setting—could be at risk for suicide.

The patient's well-being should be the primary concern, but physicians also must consider the potential legal liability that can come from failing to adequately screen patients for suicide risk and taking the proper steps when needed. The remorse a physician may face over missing signs can be compounded by legal action claiming the physician is accountable for the patient's demise. A consistent and formal screening process, plus a response plan, will protect both the patient and the physician.

### Case Study: Reviewing Patient's Full History Is Key

A recent case illustrates how even if the patient denies suicidal ideation when asked, the physician could be held liable for the suicide if there were other risk factors to consider. The case involved a 60-year-old woman with chronic back pain from an auto accident 10 years earlier, treated by her family practitioner over several years for pain, depression, and hypertension. Prior to her death, the woman had three appointments with the doctor over nine months for insomnia, pain medication adjustment, antidepressant medication monitoring, and blood pressure checks.

The notes from the last encounter state: "No energy; insomnia; denied suicidal thoughts and denied feeling depressed." Six days later, the patient overdosed on a combination of sleeping medication and anti-anxiolytics. Notes in the medical record from the next-to-last appointment said the patient "complained of insomnia; increased depression and increased anxiety; referral to psychologist." However, she did not see the psychologist and the family practitioner's office did not follow up. The defense experts said that the doctor should have considered the entire history instead of just the last visit and concluded the patient was at risk of suicide.

### How to Help Prevent Tragedies

These are some key strategies for ensuring that a physician practice or hospital is sufficiently addressing suicide risk in patients:

**Establish a formal policy on screening and responding to suicide risk.** Establish a policy that stipulates what screening will be done and how to respond to suspected risk. All employees should be trained. The policy should include front desk staff and

other non-clinicians, who may pick up on signs that the patient could be suicidal.

**Implement an effective screening process.** The questions typically asked on intake can be more of a formality than a true screening. Ask specific questions that can reveal situations that might put the patient at risk for depression and suicide. Examples include asking whether the patient has recently experienced the loss of a family member, a change in marital status, a change in jobs, sleeping difficulty, or loss of appetite.

**Connect with the patient.** If in the screening process, the patient demonstrates suicidal tendencies or it's suspected that the patient may be suicidal, refer the patient immediately to a mental health professional or ask the patient's permission to contact family members or outpatient treatment providers.

**Do not be deterred by HIPAA.** The patient privacy law can leave clinicians thinking that they may not discuss their concerns about suicide with the patient's family. The patient can give permission for the physician to talk to others about his or her healthcare, and refusal to grant that permission might be considered another sign of suicidal risk.

**Establish a relationship with mental health professionals for referral.** In a hospital setting, the physician should always know who is on call for patients with psychiatric risks. In other settings, the physician should establish a referral relationship with at least one or two professionals who can be called as needed. Be sure to document when and how the contact was made and any follow-up. Remember that simply advising the patient to seek help is insufficient. Contact the mental health professional directly and arrange for the patient to be seen quickly. Be sure to follow up to confirm that the patient has seen the mental health professional.

**Establish safety procedures for the patient who may be suicidal.** Once this risk is established, the clinician is responsible for protecting the patient from self-harm. That means keeping the patient away from sharp objects, medications, and bed sheets. Having the patient wait in a typical exam room may not be safe because the patient would have access to scissors, scalpels, needles, and other such items. When appropriate, ask the patient to put on a hospital gown and remove from the room the patient's shoelaces, belt, and any other items that could be used for harm.

**Monitor the patient closely.** If feasible, have staff or the patient's family monitor the patient continuously, in person or on video, until the next step of care. If continuous monitoring is not possible, check on the patient frequently. Carefully document the monitoring procedure, including frequency and type as well as observed patient behaviors.

**Call for help if needed.** Call for additional help if the facility has no ability to isolate the patient from dangerous items or provide adequate monitoring, and if the patient has already left against medical advice. State laws vary regarding how and when a patient may be held against their will.

<sup>1</sup>Detecting and treating suicide ideation in all settings. The Joint Commission. [https://www.jointcommission.org/assets/1/18/SEA\\_56\\_Suicide.pdf](https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf). Accessed November 14, 2016.





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