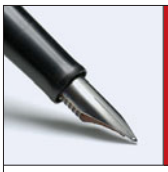


LETTER FROM THE EDITOR-IN-CHIEF

"Why Are You Calling Me?"

How to Fix Relationships with Emergency Departments

In my last column I covered the 3 main causes of poor communication in transferring patients from urgent care centers to emergency departments (EDs). I discussed how poor communication creates risk, disrupts work flow, and erodes professional satisfaction. Poor interprofessional relationships and inadequate planning and structure are creating an environment ripe for these breakdowns. Reversing the trend requires a focus on rehabilitating relationships, initiating outreach, and developing coordinated policies and procedures for transfers and communication.

Step 1: Breaking the Ice

As with all functional relationships, getting to know the people and faces in area emergency departments is a critical first step. In the heat of a busy and frustrating shift, it is easy to demonize faceless names on the other end of the phone line. They are easy targets. Likewise, getting to know your colleagues offers a degree of protection against confrontation. That is just human nature. Scheduling a meeting with the ED medical director is an important first step, one that will almost always bear fruit.

Step 2: Mutual Goal-Setting and Prioritization

During this meeting, you and your counterpart have an opportunity to share your own unique situational challenges. Mutual understanding around limitations and needs is crucial. We make assumptions that our colleagues appreciate our circumstances and that they are simply just being insulting or obstructionist when they give us a hard time about transfers. This is a false assumption. In my experience, most ED physicians do not fully understand the urgent care model, its limitations, or its purpose within health care. Once they do, most are far more collegial. The ED itself has no shortage of challenges, and this meeting can help the urgent care physician better appreciate how those might be affecting the efficiency of transfers. Risk and liability issues should be a high priority for both parties. Nothing is more dangerous than discrediting your peers in front of patients regarding anything that can be interpreted as poor performance or poor decision-making. This is behavior that must be eliminated. Once each party's challenges are more clearly understood, mutual goal-setting and prioritization can commence, and it is invariably productive and helpful.

Step 3: Policy and Procedure Development

Once the two parties are aligned, policy and procedure can be developed to help guide the clinical teams in both settings. The goals of this exercise should be to facilitate transfers, keep communication focused and relevant, reduce interruptions, and eradicate judgmental or insulting commentary. Each medical director should commit to clearly communicating the new policies and procedures to all of their physicians and, importantly, to all members of the nursing staff. A culture of mutual understanding and respect should be expected and clearly communicated to everyone involved.

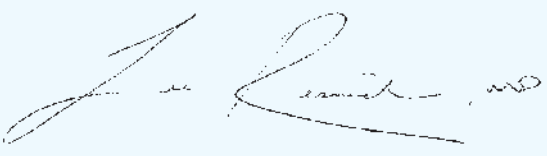
Use of hospital transfer centers, where available, can dramatically facilitate this process. These serve as air traffic control for transfers to and from the hospital and can even assist with urgent referrals to specialists. In this case, all policies and procedures should be coordinated with the transfer center, and urgent care leaders should educate and communicate accordingly.

Step 4: Follow-Up and Reassessment

Once an action plan and policies and procedures are in place, both parties should commit to a scheduled follow-up when feedback from both sides should be reviewed. Incidents should be examined and collaborative performance-improvement plans can be initiated.

Conclusion

With a collegial and organized approach, urgent care leaders can eliminate confrontation with their ED colleagues. The effort is sure to improve the mood and productivity of staff members while reducing the risk of liability and bad outcomes. ■



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