CME

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A Feedback Tool to Improve Physician–Medical Assistant Communication

Using an evaluation form and face-to-face meetings can help get both sides of the team talking and solving problems.

Medical assistants (MAs) have always been vital to the effective operation of our primary care clinic. Each physician in our university-based, hospital-run clinic has an assigned MA, and a good MA can make a clinic day run smoothly. One who is not efficient or does not understand the physician's work process, however, can slow down the whole clinic and make a workday very frustrating.

Surprisingly, given the importance of the physician-MA dyad, we had no structured process for individuals in these roles to provide feedback to one another. This was due, in part, to unaligned reporting structures. Physicians are employed by the school of medicine while MAs are employed by the hospital that owns the clinic. The clinic supervisor, who manages the MAs and reports to the hospital, would request feedback regarding the MAs' job performance annually, but rarely would there be face-to-face feedback between the MAs and the physicians. ➤

About the Authors

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An MA who is not efficient or does not understand the physician's work process can slow down the whole clinic and make a workday very frustrating.

Poor coordination between physicians and their medical assistants (MAs) can dramatically affect clinic operations.

The "shareport" process started as a way to collect information on how the physician-MA dyad performed.

To help show that the evaluation process would be open and fair, MAs were asked to provide input on creating the evaluation form.

The MAs felt they had to anticipate the physicians' needs without guidance. The physicians felt that they had no control over patient flow because the MAs did not report to them. There was no consistent process for "huddling" before a patient visit. Efficient teams sometimes developed over time, but efficiencies were lost when the regular MA was absent.

The new process evolves

The medical director and the clinic supervisor worked together to find a way to improve physician-MA communication. The process they devised involved five steps.

Step 1: Creating a tool. We wanted a form that would allow us to collect data on how the physician-MA dyad was functioning. Rather than calling this a report card, we called it a "shareport" card to convey that this form was designed as a feedback sharing and communication tool. All the physicians and MAs in the clinic were asked to brainstorm a list of tasks that the MAs perform during a clinic workday that could be included on the form and measured. See "Medical assistant shareport card."

We developed this tool collaboratively to reassure the MAs that gathering the feedback from physicians would be an open and fair process and there would be no surprises on what was evaluated. Some MAs said they were used to the old system and did not like the idea that physicians would be reporting on their performance. "I work hard to do everything the clinic supervisor asks of me. Now, you are going to make the doctors my boss too?" one MA said. "Dr. X is so demanding. What if I cannot do everything she wants me to do?"

Other MAs were less reluctant but still wondered how this process would affect their employment evaluations. We had to work to help all participants understand that the intent was to foster communication, help them grow as employees, and improve teamwork. Finding disciplinary issues was not our primary goal; however, we did forewarn the MAs that the discovery of truly egregious problems – such as repeatedly breaching patient confidentiality or not telling the truth – could result in adverse action.

Step 2: Filling out the form. We gave the form to physicians to complete. Although we have used an electronic health record in our clinic for several years, we opted for a simple, paper form for the evaluations. Some physicians were very willing to complete the evaluations as they saw this as an opportunity to help the MA and, in some cases, perform some self-reflection.

"I had never taken the time to think about how my MA and I work together," one physician said. "This form forced me to realize all that she did and think about how we, as a team, could improve."

Other physicians were more reluctant. Some were worried about the time and effort involved. Others did not want to "upset" the MA they worked with by providing negative feedback. Others felt that this was a useless exercise because they had "no control over hiring and firing." In one-on-one meetings, we were able to convince reluctant physicians that their opinions were valued, their ideas mattered, honest feedback could be framed in a way to promote growth, and the time spent on this activity would pay off in a better, more efficient team.

When we got the feedback forms back, we were surprised. Many physicians had experience giving feedback to medical students and did an excellent job of identifying strengths and weaknesses. But others struggled with it, and some feedback seemed to be too harsh or lenient. At this point, it was clear we needed face-to-face meetings. ➤

MEDICAL ASSISTANT SHAREPORT CARD

Medical assistant _____

_____

Activity	All of the time	Most of the time	50% of the time	Some of the time	Never	NA/Don't know	Comments
PROFESSIONALISM							
Arrives at or before appointed time							
Consults with coworkers and gets oriented							
Is courteous with patients							
Huddles with physician							
Communicates with physician and coworkers about breaks, lunch, and leaving for the day							
Has legible handwriting							
Rooms patients effectively							
Triages patients efficiently							
Completes appropriate tests (UAs, peak flow)							
Ensures appropriate supplies and equipment are in the room when needed (eye tray, suture removal kit)							
Keeps exam rooms clean and well-stocked							
Accurately records vital signs							
Repeats high BPs							
Ensures the patient's medical record is ready to be accessed on the EHR							
Enters patient's preferred pharmacy into the record							
Correctly identifies and notes immunization status							
Gives medication list to patient to review							
COMMUNICATION							
Notifies physician in a timely manner that patient is ready							
Alerts physician to abnormal vitals urgently							
Alerts physician to incomplete charts before the chart is broken down							
PATIENT CARE							
Is available when assistance is needed during visits (chaperoning, etc.)							
Makes study/referral appointments and informs patient							
Correctly processes specimens collected in clinic and sends them to lab							
Is able to perform MA-level procedures (shots, peak flows, splint application)							
Other							

Physician signature _____

Physician name (print) _____ Date completed _____

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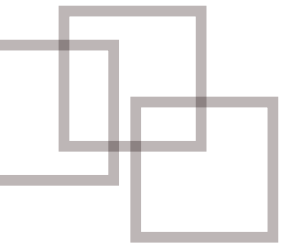

We had to work to make all participants understand that the intent was to foster communication, help them grow as employees, and improve teamwork.

Some physicians were overly harsh or too lenient in their evaluations.

The process includes face-to-face physician-MA meetings, which provide opportunities to better explore and solve problems.

The MAs don't formally evaluate the physicians, but their meetings often identify problems physicians didn't realize they had.

Step 3: Arranging meetings between MAs and physicians. Time is always a scarce commodity in a busy clinic, so we had to carve out time for meetings between our 25 physicians and 20 MAs, each of which included the clinic supervisor and the medical director. This initially required 30 minutes to an hour, but as the participants became more experienced, the time needed for an effective meeting has shortened to 10 to 15 minutes. Meetings are conducted quarterly, or as needed.

During the meeting, the physician gives reasons and examples for the ratings on the form, and the MA has an opportunity to give feedback to the physician as well. Sometimes the physician changes the rating during the meeting after a short discussion. More important, the MA and physician are able to talk through the issues.

Although we did not develop a formal tool for the MAs to provide feedback to the physicians, we found that the meetings tended to be a "two-way" street. Both physicians and MAs noted that sometimes it is the physician's behavior that is disruptive to the team. In one case, a physician realized that arriving late to clinic meant that the clinic ended late. In another case, a physician discovered that her handwriting was very difficult to read.

We have been so pleasantly surprised by how well our physicians have responded to the feedback they have been given during meetings that we've deferred plans for implementing an evaluation form filled out by the MAs. But as our mix of physicians changes, we may need to revisit the idea.

Step 4: Planning for improvement. As a result of these meetings, physicians, MAs, the medical director, and the clinic supervisor came up with useful plans to address issues with specific teams. Here are a few examples:

- One physician was frustrated that her MA never obtained the patient's height, making it impossible to calculate the patient's body mass index. The MA disclosed that the stadiometer used to measure height was broken, and this had never been reported to the physician or the clinic supervisor. The equipment was replaced.
- One physician started work at 7:30 a.m., but his MA started at 8 a.m. Another MA could cover the 30-minute gap, but sometimes one wasn't available. The clinic supervisor realized that changing the MA's hours would make this dyad more functional.
- One physician did a lot of procedures. The physician and MA developed lists of the necessary equipment and forms for the most commonly performed procedures to avoid having to reschedule patients or force them to endure a long wait if the equipment wasn't immediately available. The MAs also developed caddies for each physician and procedure so that a substitute can assist the clinician even if the regular MA is out.
- Most MAs would not ask their physician to huddle before a patient visit if they believed that the physician was busy. The importance of the pre-clinic huddle was emphasized to both the MAs and physicians during the meetings.
- One physician empowered his MA to manage his schedule more efficiently. Previously, a patient who arrived early for an appointment would have to wait for the scheduled time. Going forward, the MA had permission to process the patient if a room was available. Likewise, the MA would "work in" late patients as time allowed.

Step 5: Disseminating best practices. In order to make the changes last, the whole clinic needed to know what was happening. To this end, all of the MAs met as a group to share best practices. To encourage this type of knowledge sharing, we added mentoring,

as well as participation in safety and quality projects in the clinic, as items that physicians could note on the evaluation form.

Results

Six months after implementing the form and follow-up meetings, we noticed a 10 percent jump in patient satisfaction scores. This increase has been sustained for several months now. Physicians reported increased satisfaction with clinics, and some even noted that they were able to complete clinic work a little earlier than before. Overall staff satisfaction improved, and one additional benefit is that our staff have more time for the preclinic work needed for our eventual transition to the patient-centered medical home model, such as reviewing charts for needed test results, chronic disease management, and calling patients to remind them of their appointments.

We initially had physicians fill out the feedback forms quarterly, but we extended that to every six months as the dyads got to know each other better. New physicians and MAs still go through the process quarterly for the first year.

This initiative took some time and effort but has been very successful. One physician put it this way: "I used to think that the clinic flow was not something that I could impact. I hated the inefficiencies, but I had just given up. This new system has empowered me to make changes. It also caused me to look at my processes. For example, flow goes better when the MA gets my completed charge ticket at the end of the visit."

One MA said, "Dr. X was so quiet that I always thought he was mad at me. I was very nervous about the shareport session, but then I found out I was mostly doing what he wanted. It was easy to talk through the things that needed to be changed once I knew I was on the right track after all. Our communication has really improved, and now I can mentor other MAs."

The clinic supervisor commented, "I still am in charge of the MAs' annual evaluation, and I can track things the physician does not see, like timeliness and working well with others in the clinic. But this format gives me so much more information about the day-to-day process and allows me to intervene when there is an issue."

Although this evaluation process has worked well for our physician-MA teams, very dysfunctional teams or those with major personnel issues might require a more robust and extensive intervention, such as group meetings and a redesign of the entire clinic process. We are aware of clinics where this level of intervention has been necessary.

In this health care environment where many hospitals own clinics, it is not uncommon for physicians and clinic staff to have different employers. To build an optimal operation, the physician-MA dyad needs to function at a high level. In our clinic, the development and use of the MA evaluation form and meetings helped us improve communication and clinic efficiency. This tool could be used in nearly any setting. Even physicians who are employers tend to delegate feedback to middle managers. A more direct approach can lead to advancement of teamwork. FPM

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The MAs share the best practices they develop.

The process led to improvements in patient and staff satisfaction scores.

Seriously dysfunctional clinic teams would need a more extensive intervention.

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