Physician Experience:

Provincial Tuberculosis Services at the BC Centre for Disease Control

FACILITY ENGAGEMENT
An SSC Initiative

BC CENTRE FOR DISEASE CONTROL

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November 2023

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Executive Summary

Introduction

Provincial Tuberculosis (TB) Services at the BC Centre for Disease Control aims to reduce the impact of TB in the province through health promotion and education, program evaluation and research, disease prevention, treatment and follow-up support. The program offers testing, diagnosis and treatment services to the majority of active TB cases in BC, including case management of drug-resistant TB and complex pediatric cases. The program also supports screening and treatment of TB infection.

In June 2023, physician leadership at TB Services commissioned a process evaluation of the program to examine the physician experience working within the program. The main drivers behind this work include anecdotal reports of sub-optimal physician experience at TB services, escalating physician turnover, and concerns regarding the long-term retention of physician colleagues, as well as succession planning. The following summary report presents an overview of key evaluation findings.

Evaluation Methods

The evaluation collected and analyzed data from physicians who currently and previously worked at TB Services. The following data collection methods were employed:

- 16 semi-structured interviews
  (10 current physicians; 6 past physicians)
- An online survey with 19 physicians
  (14 current physicians; 5 past physicians)

Key Findings

Satisfaction with TB Services

The majority of physicians are satisfied working at TB Services overall, where highest satisfaction ratings were provided for the collegial workplace environment and their co-workers. Nearly 80% reported dissatisfaction with the clinic's electronic medical records system (Panorama), in addition to lower levels of satisfaction with remuneration and scheduling for clinics/patients.

Pain Points

There are several 'pain points' for physicians working at TB Services that negatively impact their experience, most frequently being: Panorama; use of physician time; clinic flow and processes; remuneration; and patient scheduling. At a high level, most physicians explained that the inefficient and dysfunctional nature of the clinic compromises the physician experience and quality of patient care provided.

Physician Engagement

Physician engagement in non-clinical program activities is primarily limited by the sessional compensation model employed, in addition to the low sense of belonging and connection for physicians at TB Services.

Learning from Physicians Who Left TB Services

The primary reason physicians no longer working at TB Services left was to pursue work in their specialty areas; a factor beyond the control of the program. However, other program-related issues were reported to be contributing factors in their decision-making process, such as frustrations with administrative processes and/or policies within TB Services; concerns with administration; and too little money for work.

Recruitment & Retention

Half of the physicians surveyed said that they are considering leaving TB Services in the next 3 years, primarily due to retirement. Several strategies were proposed to improve recruitment and retention of physicians to the program in the future, such as increased remuneration and implementation of solutions to address pain points comprising the physician and patient experience.

> **"Findings from this evaluation show that while the majority of TB Services physicians are satisfied working within the program overall, several clinic flow, efficiency and structural issues were identified that compromise the patient and provider experience."**

Conclusion & Recommendations

Findings from this evaluation show that while the majority of TB Services physicians are satisfied working within the program overall, several clinic flow, efficiency and structural issues were identified that compromise the patient and provider experience. Solutions to such issues should be identified in the near future to make the work more attractive for new recruits and to reduce the departure of physicians from the program.

Based on findings from this evaluation, the following recommendations have been put forward for consideration by the physician leadership at TB Services.

Disseminate findings

Consider circulating this report to key internal stakeholder groups (e.g. TB Clinical Leadership, CPS Leadership) to enhance their understanding of the physician experience at TB Services and to inform decision-making related to areas for program improvement. Among other groups, findings should be shared with: physicians consulted in this evaluation (e.g. MD/NP Monthly meeting or focused retreat); all other staff and healthcare providers currently working at TB services (e.g. TB Clinical Operations, TB All-Staff); SSC Facility Engagement; PHSA Physician Compensation and BCCDC operational staff/leadership (e.g. BCCDC Leadership, SLT).

Determine & prioritize solutions

This report identified various ways in which the patient and provider experience at TB Services can be improved. The following are suggested to determine and prioritize solutions for implementation:

- TB Services physician leadership should aim to address tangible issues that are within the program's control (e.g., timing of payments; physician confusion regarding whether they can be compensated for clinic overtime and meeting attendance; share TB Ward rounds weekly Zoom invite; prescription direct entry by pharmacy; developing a triage tool; review benchmarks with metrics work).
- Organize a 'retreat' to review the evaluation findings, identify solutions, and prioritize actionable next steps for the program. Given the various stakeholder groups involved in clinical care and operations at TB Services, it is recommended that the retreat should be multidisciplinary in nature, including staff, allied health, nurses and physicians currently working at TB Services, as well as BCCDC operational staff/leadership.
- Based on findings from this work, look at relevant program metrics to monitor (e.g. patient volumes, time to appointments, unfilled schedules)

Introduction

Provincial Tuberculosis (TB) Services at the BC Centre for Disease Control aims to reduce the impact of TB in the province through health promotion and education, program evaluation and research, disease prevention, treatment and follow-up support. The program offers testing, diagnosis and treatment services to the majority of active TB cases in BC, including case management of drug-resistant TB and complex pediatric cases. The program also supports screening and treatment of TB infection. TB Services was tasked with leading the implementation of the BC TB Strategic Plan and is now working to develop a TB Quality Care and Elimination Plan. The program operates out of two physical clinics in the lower mainland, which are located in New Westminster and Vancouver, as well as a virtual/consultative service for the rest of the province (Island exclusive) on-site at the BCCDC. The majority of physicians are compensated on a sessional basis, while the minority are on a service contract or are salaried.

In June 2023, physician leadership at TB Services commissioned a process evaluation of the program to examine the physician experience working within the program. The following summary report presents an overview of key evaluation findings.

Evaluation Methods

The evaluation collected and analyzed data from physicians who currently and previously worked at TB Services. The following data collection methods were employed:[1]

- 16 semi-structured interviews
  (10 current physicians; 6 past physicians)
- An online survey with 19 physicians
  (14 current physicians; 5 past physicians)

1 Note that while some physicians completed both the evaluation interviews and online survey, others only participated in one of the data collection methods.

Findings

Physician Profile

Table 1 outlines a series of variables describing the nature of survey respondents' work at TB Services. Roughly two-thirds were trained as respirologists (68%), while the remainder were infectious disease specialists (32%). Their median initial year of work at TB Services was 2010, with start years ranging from 1980 to 2022.

Among the physicians currently working at TB Services, 64% work at the Vancouver clinic and 57% work in New Westminster, while 43% work virtually and 7% in the 'travel clinic'. In the past 12-months, most worked within the TB clinics more than once a week (57%) or once a week (29%), followed by those who are scheduled once a month or less (14%). The majority worked both morning and afternoons but not necessarily on the same day (71%), while others were only scheduled for clinics in the afternoons (21%) or mornings (7%).

Table 1. Background & nature of work at TB Services for physician survey respondents (N=19)

Variable	Responses
Specialist type	• Respirologist (68%) • Infectious disease specialist (32%)
Initial year of work at TB Services (median; range)	• 2010 (range: 1980 - 2022)
Place of work[2]	• New Westminster (57%) • Vancouver (64%) • Virtual (43%) • Travel (7%)
Frequency of work at TB Services in the past 12-months	• More than once a week (57%) • Once a week (29%) • Once a month (14%) • A few times (0%) • Did not work (0%)
Typical shift time in the past 12-months	• Both morning and afternoon (72%) • Morning (7%) • Afternoon (21%)

2 Respondents could select more than one location for their TB work with BCCDC Physician Services.

Work Satisfaction

KEY MESSAGE: The majority of physicians are satisfied working at TB Services overall, where highest satisfaction ratings were provided for the collegial workplace environment and their co-workers. Nearly 80% reported dissatisfaction with the clinic's electronic medical records system, in addition to lower levels of satisfaction with remuneration and scheduling for clinics/patients.

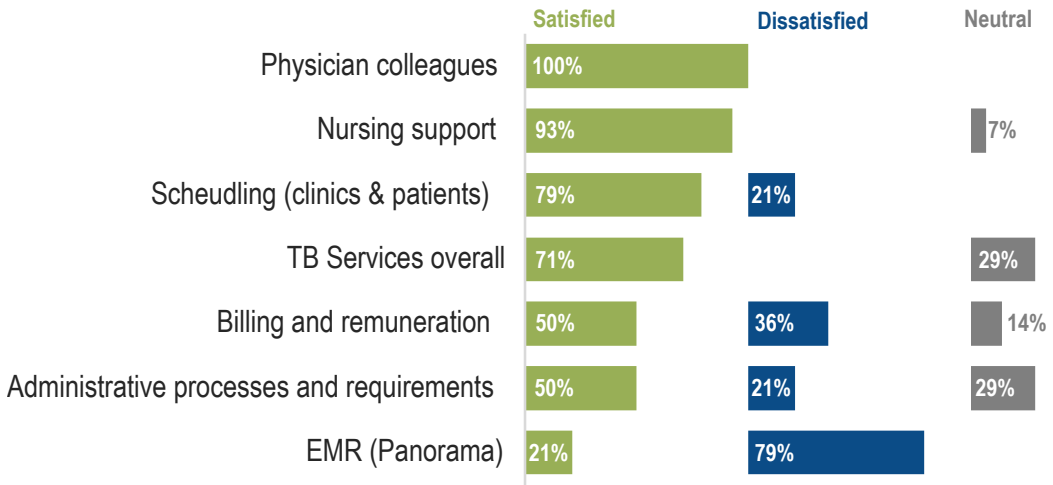
Physicians currently working at TB Services were asked to rate their satisfaction with different aspects of the program (Figure 1). The majority reported being satisfied with TB Services overall (71%), while the remainder provided neutral responses (29%). Over 90% said that they are somewhat satisfied or very satisfied with their physician colleagues (100%) and nursing support (93%) in the program (Figure 1). This survey finding was corroborated by physician interviewees frequently mentioning the collegial workplace environment and the positive work relationships they have with their physician leaders and colleagues, nurse practitioners (NP), nurses and administrative staff.

> **"If I take a step away from the day-to-day challenges, I'm really happy the team is collegial and supportive. There are good people on the team."**

Nearly 80% reported being somewhat or very satisfied with the scheduling of clinics and patients in the program, while 21% were dissatisfied.

The majority of physicians (79%) were dissatisfied with the electronic medical record (EMR) system used in the clinics called Panorama. Lower levels of satisfaction were also reported for physician billing and remuneration and administrative processes/requirements.

Figure 1. Physician satisfaction with different aspects of working at TB Services in the past 12-months (N=14)



Physician interviewees explained that they continue to work at TB Services for the following reasons:

- Strong leadership, dedication and approachability of the program's physician leaders
- Flexibility and sense of support when needing to schedule time away from the clinic
- Shift-based, modular work schedule without responsibilities at the end of the day
- Desire to support the program given concurrent work at the TB hospital ward
- Medical interest in working with TB and passion for working with the patient population

"One of the things I really like about the TB clinic is that it is quite flexible with my schedule. If I have weeks that I am away or have commitments, they are very accommodating if I am not able to work. This makes me feel appreciated and supported."

Pain Points Working at TB Services

KEY MESSAGE: There are several 'pain points' for physicians working at TB Services that negatively impact their experience, most frequently being: Panorama; use of physician time; clinic flow and processes; remuneration; and patient scheduling. At a high level, most physicians explained that the inefficient and dysfunctional nature of the clinic compromise the quality of patient care provided.

In both the survey and interviews, physicians were asked to describe key pain points related to working at TB Services. Key pain points are summarized on the next page along with potential solutions (Table 2). At a high level, physicians often described the clinic as inefficient and dysfunctional given its current structure and processes, which ultimately compromises patient volume and the quality of care provided.

"The clinic is so inefficient and cumbersome. If we can deal with these inefficiencies, we are going to have so many more patients seen, better care and happier physicians."

"I find TB services to be a very frustrating place to work. It is highly inefficient and exists within a very bureaucratic environment that prevents good quality of care and innovation."

Table 2. Key pain points related to working at TB Services and potential solutions

Key pain points	Potential solutions

1. **Panorama**
• Slow, inefficient and cumbersome EMR
• Specific issues include: difficulties in searching for information; lots of repeat, manual entries; several clicks required to complete different tasks; layers of screens, etc.
• Prescriptions
  • Requirement to enter prescriptions into Panorama.
  • Process of modifying prescriptions is particularly time consuming (i.e., 2-minute task takes 15-to 20-minutes).
  • Cannot modify prescriptions, have to discontinue them and then re-enter.
  • Cannot delete all medications at once, have to delete each one individually.
• Platform requires substantial use of physicians' limited time, which comprises clinic flow, patient care and the physician experience.
• Despite ongoing improvements, substantial issues remain and appear to be unresolvable. The process of creating changes in Panorama is slow (i.e., needs to go through committees and layers of approval).
• Physician leadership expressed concerns with the platform when it was initially being suggested, but were not heard. Other clinical programs did not adopt Panorama, such as the STI clinic.
• Vendor never provided training to physicians.
	• Advocate for transition to a new EMR and scheduling system that will allow for digital health solutions (e.g. automated appointment reminders, texting platform).
	• While continuing to work with Panorama:
	  • Advocate for the option to write pen and paper prescriptions.
	  • If prescriptions have to be entered into Panorama, ask the pharmacists, nurses or clerical staff to complete this time-consuming task rather than using physician time.
	  • Continue to make ongoing improvements to the platform given some success with this in the past.
	  • Create more auto-populated fields/ drop-down menus to reduce manual data entry.
	  • Train clerical staff to be well-versed with the platform so they can help troubleshoot issues.
	  • Advocate for process to prioritize patient care, as opposed to spending unnecessary time with the EMR.

Key pain points	Potential solutions

2. **Use of physician time & scope of work**
• Inefficient use of limited physician time within the clinics. A substantial amount of physician time is spent doing activities that others can complete (e.g., immigration assessments, searching for test results, etc.).
• Time taken to complete non-clinical tasks reduces the number of patients physicians can see.
• The current model of care is contingent on physicians making decisions, yet other team members are often capable of being responsible.
• Ongoing cultural issue of nurses bringing complex, difficult cases to physicians without completing basic background steps (e.g., collecting history).
	• Optimize physician time by focusing on their area of expertise (e.g., making medical decisions).
	• Consider shifting towards a team-based care model where healthcare professionals and administrative staff work together to support patients' needs. In such a model, some of the physicians' clinical and administrative tasks would be delegated to team members, so they can see more patients and focus on activities that align with their expertise. Each team members' roles and responsibilities would be clear and compliment each other.
	• Shift team members' scope of work.
	  • Administrative staff/MOAs
	  • Streamline collection of lab test results and other patient paperwork for physician review.
	  • In-clinic, hands-on support (e.g. patient care navigator, physician assistant) for physicians and NPs to organize testing, schedule follow-up appointments, etc.
	  • Nurses
	  • Management of uncomplicated, active TB cases and latent TB follow-up.
	  • Complete all patient background work for physician review and communicate this as a part of the care model.

Key pain points	Potential solutions

	• Pharmacists
	  • Play an active role in medication reconciliation with patients.
	  • Can support creation/changes to prescriptions given the time-consuming nature of these activities in Panorama.
	• Increased scope of work will likely require additional training for team members.
	• Build upon successes of involving nurse practitioners and trainees/fellows to reduce physician workload.
	• Explore TB fellowship model.
	• Optimize the nurse practitioner model.

3. **Clinic flow & processes** • Currently, patients first see the nurses for an assessment, followed by a physician assessment. • Physicians often viewed this as a fragmented, inefficient process that negatively impacts the patient experience. • Little to no communication and/or collaboration between nurses and physicians about individual patients. They need to look up the same information, often ask patients the same questions, and patients can spend 1 to 2 hours at the clinic seeing/waiting to see each healthcare provider when visits could be 15-minutes long. Duplication of work and documentation. • Unclear which nurse is linked to which patient and which nurse is available to support.	• Facilitate open conversations between physicians and nurses to identify strategies to reduce duplication of work and improve communication/collaboration (e.g., nurse to complete work and brief physician as needed; outline situations in which physicians do not need to see patients, or nurse includes MD in visit etc.). • Increase clarity on roles and responsibilities of nurses and nurse practitioners/physicians to reduce overlap. • TB Services should continue 'lean' work to improve clinic flow and patient experience.

Key pain points	Potential solutions
4. Remuneration & payment • 71% said the financial remuneration for the clinic is too low, while 29% said it's about right. • Remuneration is insufficient when compared to what others with the same training receive in similar settings. • Physicians are only paid during clinic hours, however many explained that they often need to come in early and/or stay late unpaid. There was confusion about whether physicians can submit overtime hours for compensation, or not. • When asked how much pre-clinic preparation time physicians need to facilitate their work for a ½ day clinic, responses were fairly evenly distributed between: less than 15-minutes (31%); 15- to 30-minutes (39%); and more than 30-minutes (31%). • No financial incentive to work at TB Services. The program will continue to lose physicians unless compensation is addressed. • Often takes 6- to 8-weeks for physicians to be paid.	• Advocate for competitive remuneration (i.e., equivalent to what physicians with the same training make in similar clinical settings). • Clarify policy on physicians billing for overtime hours. • Assuming financial equivalence, most would prefer to continue to be paid on a sessional basis (71%), while others would prefer a salary (14%) or service contract (7%). • Explore opportunities to provide TB physicians with benefits and other related incentives. • Explore strategies to reduce time delays in processing physician payments. • Clarify with Physician Compensation the benefit of service vs. salary.

Key pain points	Potential solutions
5. **Patient scheduling & length of appointments** • Cambian was reported to be a dysfunctional scheduler. • Workflow can be chaotic and unpredictable. Some days you are able to see all patients faster than expected, other days you are running behind. • Patients double-booked at times. The scheduled times are not actually when physicians are to see patients. • Physician bookings to see patients often overlap with when nurses are still seeing them. • Little to no physician control/input into how patients are booked. Physicians can prepare for a clinic and then the schedule changes during the session without any discussion with MD. • On average over the last 12-months, 39% said there are too many patients scheduled for physicians to review per clinic (39%), while 46% reported that patient volume per clinic is too variable/ unpredictable to comment and 15% said the amount of patients is just right. • 31% said the length of patient appointments is too short, 23% said the length is just right, and 46% said that the clinics are too variable/unpredictable to comment. • Appointment lengths are not responsive to complexity or condition of patients (e.g., some patients require 2-minutes but are booked for 15; complex patients require 30-minutes but only have 15).	• Discuss strategies to better triage patients/ determine appropriate appointment lengths, such as providing tools to nurses to more effectively triage and/or offering training to build their capacity to triage. Consideration could also be given to hiring a physician to do patient triaging. • Create different appointment lengths for patients that are responsive to their complexity/conditions. • Create a system when physicians are notified of patients that will likely require more time. • Consider continuing to use fellows to help manage busy clinic days. • Continue to use virtual/phone appointments for straightforward appointments given the efficiency of this approach. Open a “window” for these appointments to allow for flexibility (e.g. not at 1:00pm but between 1:00pm to 2:00pm.). • Continue booking new or complex patients in the mornings/early afternoon to prevent the clinic from running late. • Explore the use of electronic waiting lists for patients. • Prioritize ways to limit the variability/ unpredictable nature of the clinic.

Key pain points	Potential solutions

6. **Continuity of care & complex patient cases**
• Given shift-based work and physicians working periodically, little continuity of care for patients.
  • Particular concern for complex cases.
  • Inefficient for physicians given the need to repeat patient reviews and search for clinical information from past visits.
• Different physicians explain things differently to patients, leading to confusion.
• Physicians often defer complex issues/ cases to future visits, likely with a different physician.
  • Insufficient time to deal with complex cases. Little ownership of them.
  • Care is suboptimal as a result, as it prolongs issues and can further complicate patient issues.
  • Missed opportunities to make improvements for patients earlier on in their course of care.
	• Explore strategies to incorporate longitudinal clinical care for complex cases (e.g., nurse practitioners offer continuity or a small group of physicians to manage such cases).
	• Create clearer pathways for TB Services physicians to access consult help as soon as cases become complicated/complex (i.e., deviate from standard care). Consider partnership with BC Childrens to better support complex pediatric cases.
	• Ensure ongoing, continuing professional development for physicians to strengthen management of complex cases and increase engagement/accountability. This includes appropriate documentation of pertinent issues for cases. Explore standardized templates for care.
	• Expand upon the initial success of nurse practitioners in providing more continuity of care for patients.

7. **Quality of nursing staff**
• Most nursing staff working in the clinics are relatively new to TB and have little work experience. Too much emphasis on Public Health experience and not enough on clinical care.
• Quality of nursing staff is variable depending on the nurse placed in the clinics by the union.
• Common reliance on only physicians to make decisions (i.e., asking questions rather than taking initiative).
• Lack of strong clinical nurse leadership in both clinics.
	• Explore strategies to:
	  • Cultivate nurse engagement at TB Services.
	  • Build the confidence of nurses to take more initiative with patients.
	  • Foster relationships where nurses view physicians as their colleagues, as opposed to their resource.
	• Require nurses to batch their questions and set aside a 1-hour time slot for them to ask them during the clinics.
	• Modify nurses' clinical work experience requirements to work at the clinic (more clinical experience required).

Key pain points	Potential solutions
• Low level of engagement in work at TB Services (i.e., seeing work as a pay cheque) and the clients we serve. • Physicians explained that nurses often pop into patient appointments to ask questions they perceive as urgent. There is currently an open door policy. This can cause interruptions for physicians and reduce their efficiency.	
8. **Turnover in staff** • High turnover in nursing and administrative staff given decisions to exit into other roles. This results in the need to constantly train new hires. • Some physicians were unclear about the factors contributing to this turnover, while others speculated that it has largely been related to insufficient compensation.	• Determine factors contributing to turnover among nurses and administrative staff. • Advocate for competitive pay for nurses and administrative staff.

9. **Quality improvement**
• Insufficient metrics/key performance indicators to assess clinic performance, patient experience, and provider experience.
• Protocols and physician recommendations for baseline screening/surveillance labs often do not appear to be followed on the prescribed time course.
	• Physicians suggested that the following clinically relevant benchmarks/metrics should be followed by TB Services:
	  • 2-week IGRA reports back to ordering physician.
	  • New active cases start on drug therapy within 24-hours of decisions to start treatment.
	  • LTBI cases start on drug therapy within 7-days of decisions to start treatment.
	  • LTBI completions vs. non-completions.
	  • Readmissions of active cases.
	  • Relapse rate.
	  • Mortality of active cases.
	  • Patient and provider satisfaction ratings.

Key pain points	Potential solutions

	• On average, physicians suggested that the following should be considered acceptable turnaround times for patients to be seen in the following scenarios:
	  • New active cases: 2 days.
	  • Contact under 5 for primary. prevention: 7 days.
	  • Other contact for latent TB treatment start: 31 days.

10. **Bureaucracy & operations at the BCCDC** • Physicians explained that TB Services exists within a highly bureaucratic environment at the BCCDC. Decision-making power rests with operational staff/leadership who have limited understanding of TB or clinical care. • Physician leadership feels disempowered and has limited ability to innovate/make clinical improvements to enhance patient care. • Past attempts to consult with TB physicians on different matters were felt to be tokenistic (e.g., not listening to TB physicians, making decisions before consulting with physicians, etc.).	• Provide TB physicians with more decision-making power to support enhanced clinical care for patients (e.g., access to surveillance data, control of budgets, etc.).
11. **Physician leadership** • Substantial administrative duties under physician leaders' contracts consume the majority of their time, as opposed to clinic-specific issues. • Some sessional physicians do not feel there is adequate space to discuss clinic-related issues. Others explained they have raised concerns, but have not been heard by physician leadership (e.g., sent emails but no action).	• Consider reviewing the roles of the physician leaders to see which administrative duties can be removed to optimize their time on resolving clinic-related issues. • Create opportunities for sessional physicians to discuss and troubleshoot issues. • Explore the idea of a new salaried physician hire that could focus on optimizing clinical operations.

"Panorama is this beast of an old EMR, very inefficient. You can lose 15 to 20 minutes just doing a prescription. We've only got three and a half hours to try to turn through as many files as possible... If there's one thing in this clinic that will drive physicians mad and force them to quit, it's the prescriptions and panorama."

"There is no interaction between the nurses and physicians. The patient comes in, sees the nurse, asks all the same questions as me. Then they look me in the face, don't say anything, give me the chart, and say now it's your turn. It would be so much more worthwhile if we could do it together,"

"There could be more of a horizontal or team-based care model. Right now it is vertical where the physician must do all of these things and each subsequent step is directed by the physician. Whereas it would be much more efficient and rewarding for everyone involved if we had a team mode l where each member compliments each other rather than taking orders from another. Right now, there is so much duplication in work being done."

"The clinic is quite dysfunctional from an efficiency perspective. I went into medicine because I enjoy looking after people, but I spend most of my time either unoccupied because I am waiting for things, fighting the computer, or doing things a clerk could take care of. Many people are leaving the clinic because of these issues."

Physician Engagement

KEY MESSAGE: Physician engagement in non-clinical program activities is primarily limited by the sessional compensation model employed, in addition to the low sense of belonging and connection for physicians at TB Services.

What contributes to lower engagement?

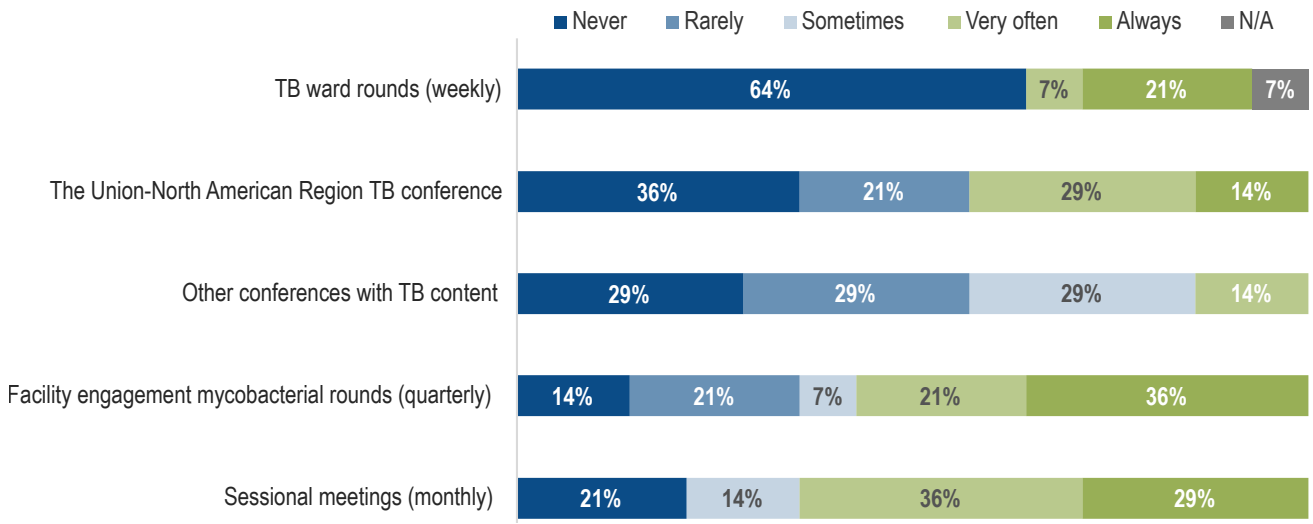
A series of the survey and interview questions explored physician engagement and ownership of their work at TB Services. Generally speaking, physicians explained that the following factors likely contributed to lower levels of engagement among TB sessional physicians: (i) lack of remuneration to participate in other activities outside clinic time; (ii) low sense of belonging within the program given the periodic frequency of work; and (iii) minimal communication and collaboration between TB sessional physicians.

> **"There is a direct link between the compensation model and physician engagement with other clinic activities, like participating in meetings. There's no compensation available outside of scheduled hours and therefore physicians don't want to engage."**

Meeting Attendance

As shown in Figure 2, the self-reported frequency at which physicians attend TB-related meetings was assessed. Interestingly, over half said they rarely or never attend: TB ward rounds; the Union-North American Region TB conference; or other

Figure 2. Frequency at which physicians attend internal and external meetings related to providing TB care (N=14)



conferences with TB-related content. Just over half reported that they very often or always attend the facility engagement mycobacterial rounds meetings and the monthly sessional meetings. Physicians that do not typically attend internal TB-related meetings explained that they are not motivated to do so since they do not believe they are remunerated. Interestingly, those that have attended the ward rounds indicated that such meetings have been helpful in determining next steps for complex patient cases.

Other feedback related to internal meetings was that there is often insufficient time to address all agenda items and discuss clinical cases. The suggestion was made to host a retreat for physicians to build collegial ties and reserve dedicated time to discuss pertinent issues.

Involvement with Research & Quality Improvement

The majority of physicians explained that they are happy to continue supporting research participant recruitment for studies taking place. Most also said that they do not have the time to further support such research efforts. However, some physicians suggested that they would feel more engaged in current investigations if they were provided with brief progress updates (e.g., feedback on recruitment) and if research findings were shared back with them, potentially through a bi-annual 'research day'.

> **"We are accessories in the research process, such as our role with recruiting research participants, but not involved otherwise. It would be helpful to receive feedback about how the research is going that we have supported, like if there are useful findings that could support our work."**

Some physicians explained that their engagement with TB Services could be increased by offering them opportunities to participate in quality and systems improvement work, such as quality assurance and improvement projects.

Involvement with Physician Scheduling

Physicians explained that they do not want to be involved in physician scheduling and that they are satisfied with the office manager's current management of this task.

Willingness to be contacted outside scheduled time

While some physicians said they are willing to be contacted by nursing outside scheduled times to address patient issues, most were not supportive of this given the sessional compensation model used.

"I think, I think the mindset for most of us is, when we're not in the clinic, issues should go to somebody else who is now being paid for the three and a half hours. And they'll be there to answer and address that question."

Learning from Physicians Who Left TB Services

KEY MESSAGE: The primary reason physicians left TB Services was to pursue work in their specialty areas; a factor beyond the control of the program. However, other program-related issues were reported to be contributing factors in their decision-making process.

Why did physicians leave TB Services?

The top 5 reasons physicians made the decision to leave TB services were:3

1. Focusing on pursuing work in their specialty areas (80%)
2. Found job or work elsewhere (60%)
3. Administrative processes and/or policies within TB Services (40%)
4. Concerns with administration (20%)
5. Too little money for work (20%)

> **"I loved working at TB Services, we just decided to move for other work opportunities more aligned with our interests."**

Physicians no longer working within the program qualitatively reported that the following also influenced their decision to leave TB Services.

- Minimal sense of belonging given transactional, infrequent nature of work
- Allied health professionals and administrative staff not working to their full scope of practice
- Challenging workplace dynamics/environment created by previous staff and BCCDC leadership
- Need to see patients outside of clinical specialization area
- Requirement to work unpaid overtime when clinics ran late
- Clinical scope too narrow given work with one disease

Could anything have prevented physicians from leaving?

While 60% said nothing could have been done to prevent them from leaving TB Services, 40% reported that the following improvements could have retained them:

- Opportunities to couple global health work alongside work at TB Services
- Resolution of administrative issues and inefficient clinical processes
- Administration fostering a positive and respectful work environment

Could anything bring physicians back to TB Services?

Interestingly, 60% of the physicians no longer working within the program said that they would consider returning to TB services under certain circumstances. They explained that the following would need to be in place in order for them to consider returning:

3 Survey respondents could select up to 3 reasons describing why they left TB Services.

- More competitive remuneration on par with compensation received by physicians working in comparable settings .
- Additional shift types to accommodate physicians living outside the lower mainland, such as on-call shifts to consult on complex cases.
- Ability to exclusively see patients in physicians' areas of specialization (e.g., paediatric TB)
- Opportunity to be involved with provincial programming and strategy for TB (e.g., identifying/executing strategies to optimize patient care in BC, improving pathways for treatment, etc.).

Recruitment & Retention

KEY MESSAGE: Half of the physicians surveyed said that they are considering leaving TB Services in the next 3 years, primarily due to retirement. Several strategies were proposed to improve recruitment and retention of physicians to the program in the future, such as increased remuneration and solutions to address pain points comprising the physician experience.

What initially motivated physicians to work at TB Services?

The majority of physicians were initially motivated to work at TB Services because of their medical interest in the disease, as well as their passion for working with the vulnerable patient population involved. In contrast to being involved with a private practice, the shift work and sessional remuneration structure at TB Services offers flexibility, minimal administrative commitments, and the ability to not bring work home. The program also offers new-to-practice physicians a straightforward way to earn income while they determine where they would like to work in the future.

Are physicians considering leaving?

Fifty-percent of the physicians surveyed indicated that they are considering leaving TB Services in the next 3 years, while the other half did not have plans to leave. Retirement was the most common reason cited for planning to leave the program. Interviewees similarly expressed concern about the future stability of the clinic given that there are quite a few older physicians who heavily support the program and will retire in the near future. Other reasons physicians are contemplating leaving the program were program-related concerns with: remuneration; Panorama; and administrative processes and/or policies.

What strategies should the program use to recruit and/or retain physicians?

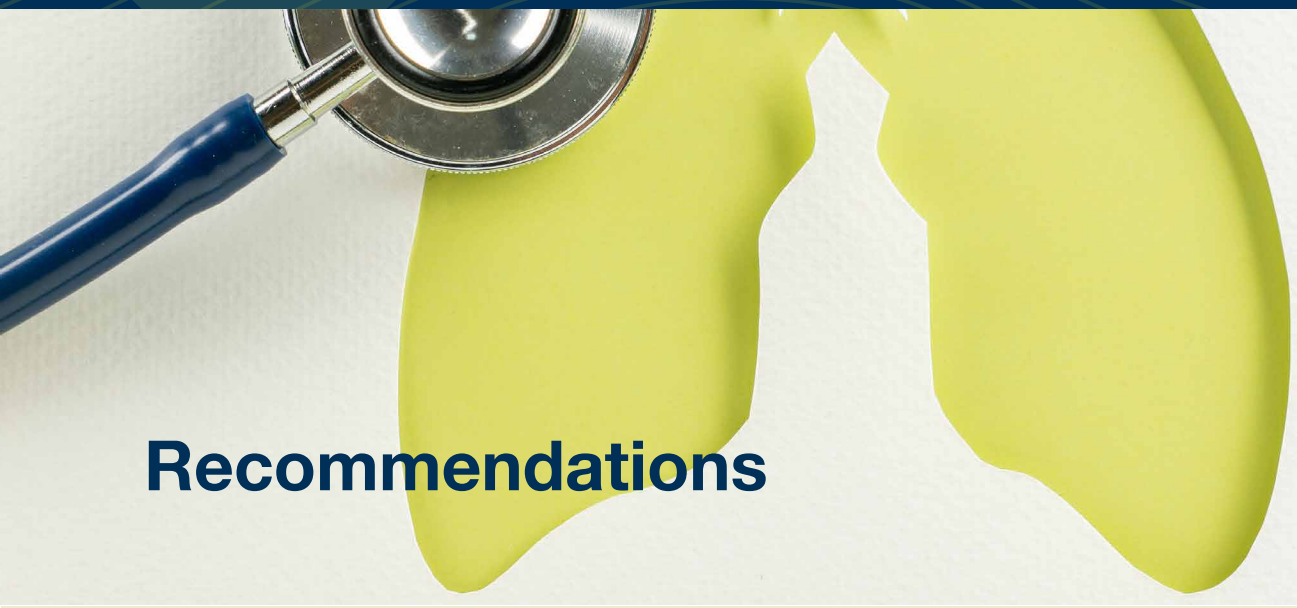
- Physicians suggested that TB Services should consider the following strategies to recruit and retain physicians to the program:
- Advocate for competitive remuneration on-par with compensation for similar work (e.g., respirology clinic).
- Address factors contributing to lower levels of physician satisfaction and experience.
- Proactively recruit physicians through job postings (e.g., in academic journals, through Health Match BC, etc.).
- Explore opportunities to do co-recruitment in collaboration with related hospitals and other divisions (e.g., divisions of respirology at hospitals).
- Continue to open recruitment beyond respirologists (i.e., infectious disease specialists).

- Explore opportunities to work with Associate Physicians who ideally have appropriate backgrounds for working with TB (e.g., respirology, internal medicine). Additional training could be required for such physicians, if necessary.
- If MOCAP was provided, 43% of current TB physicians said they would be willing to be on-call for TB Services (i.e., Life Labs calls through 2 to 3 times per month).
- Create a clinical fellowship program at TB Services given strong medical interest in working with the disease once physicians have been exposed.
- BCCDC to provide TB physicians with more power to make decisions given their desire to improve clinic operations, as well as improve the patient and physician experience.
- Be cautious about the process of moving to a new EMR given 21% of physicians said they would possibly leave the program if it moved to Cerner, while the remainder would not (79%).

> **“If the work isn’t satisfying and there is equal or more money somewhere else, people will leave.”**

Conclusion

Findings from this evaluation show that while the majority of TB Services physicians are satisfied working within the program overall, several clinic flow, efficiency and structural issues were identified that compromise the patient and provider experience. Solutions to such issues should be identified in the near future to make the work more attractive for new recruits and to reduce the departure of physicians from the program.



Recommendations

Based on findings from this evaluation, the following recommendations have been put forward for consideration by the physician leadership at TB Services.

Disseminate findings

Consider circulating this report to key internal stakeholder groups (e.g. TB Clinical Leadership, CPS Leadership) to enhance their understanding of the physician experience at TB Services and to inform decision-making related to areas for program improvement. Among other groups, findings should be shared with: physicians consulted in this evaluation (e.g. MD/NP Monthly meeting or focused retreat); all other staff and healthcare providers currently working at TB services (e.g. TB Clinical Operations, TB All-Staff); SSC Facility Engagement; PHSA Physician Compensation and BCCDC operational staff/leadership (e.g. BCCDC Leadership, SLT).

Determine & prioritize solutions

This report identified various ways in which the patient and provider experience at TB Services can be improved. The following are suggested to determine and prioritize solutions for implementation:

- TB Services physician leadership should aim to address tangible issues that are within the program's control (e.g., timing of payments; physician confusion regarding whether they can be compensated for clinic overtime and meeting attendance; share TB Ward rounds weekly Zoom invite; prescription direct entry by pharmacy; developing a triage tool; review benchmarks with metrics work).
- Organize a 'retreat' to review the evaluation findings, identify solutions, and prioritize actionable next steps for the program. Given the various stakeholder groups involved in clinical care and operations at TB Services, it is recommended that the retreat should be multidisciplinary in nature, including staff, allied health, nurses and physicians currently working at TB Services, as well as BCCDC operational staff/leadership. Consideration should also be given to having the retreat facilitated by an objective party to provide participants with the opportunity to engage with the content and offer the group an external perspective.
- Based on findings from this work, look at relevant program metrics to monitor (e.g. patient volumes, time to appointments, unfilled schedules)