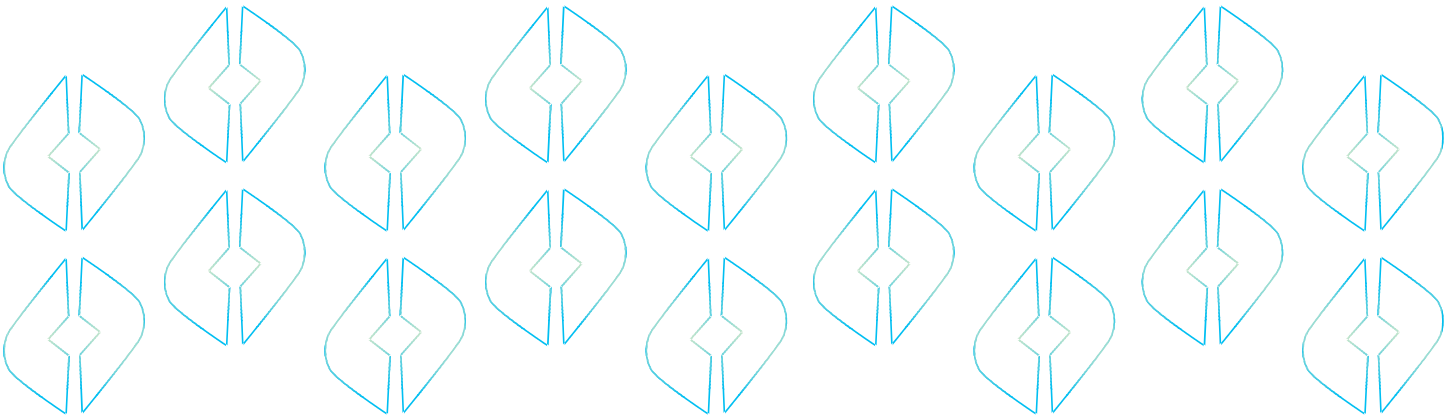
UBC-Sauder Physician Leadership Program (PLP)

IMPACT EVALUATION REPORT

May 25, 2019



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Executive Summary

BACKGROUND

In Fall 2018, the University of British Columbia (UBC)-Sauder Physician Leadership Program (PLP) Joint Advisory Board commissioned a formal evaluation of the program to assess the impact of the PLP in developing the capacity of physicians to be leaders of change in the health system. Penny Cooper & Associates was selected as an external consultant to conduct the evaluation.

APPROACH

A sequential, mixed methods approach was used to complete the evaluation. Key informant interviews (n=35) were conducted with a wide range of stakeholders, including program funders, health authority vice presidents responsible for physician leadership development, other health authority stakeholders whose roles intersect with the PLP, former program participants and PLP coaches. A review of key internal documents was also conducted. The document review and interview findings formed the foundation for two surveys: one for former program participants (N=362), and one for participants' health authority sponsors (N=137). The survey response rates were 41% for the participant survey (n=150), and 43% for the sponsor survey (n=59). Response rates are within normal parameters for surveys involving BC physicians.

FINDINGS

The evaluation results were overwhelmingly positive. The evaluation confirmed that the PLP is meeting its mission and objectives. PLP participants are being retained in leadership roles in the health system and the program is perceived to have had a significant impact on participants' interest in leadership. The program also appears to have had a significant impact on participants' effectiveness as leaders across a range of dimensions. There are opportunities to increase the system-level impact of the program by improving the connections between the program and the organizations that sponsor participation.

PLP participant profile & target market

The evaluation confirmed anecdotal evidence that the market for the program has changed over time. Newer PLP cohorts are less experienced leaders than earlier cohorts. They are more likely to have less than five years of leadership experience, less likely to have a formal leadership role, and less likely to have prior leadership training than earlier cohorts. This trend is reflected in some disagreement among key stakeholders as to the target market for the program. It also raises questions about whether the program can be stretched to accommodate the wide range of leadership experience that participants bring and that stakeholders want to send on the course.

Impact of the PLP on engagement in physician leadership

PLP graduates are being retained in leadership roles in the health system. Over 90% are currently in leadership roles, and over two thirds have more responsibility compared to prior to the PLP. A large majority of PLP graduates (over 80%) indicated that the PLP had a significant

impact on their interest in formal leadership roles. Qualitative data suggests the PLP plays an important role in triggering or re-energizing engagement in leadership.

Impact of the program on physician leader effectiveness

Over 90% of PLP participants and 77% of PLP sponsors indicated that the PLP had a significant impact on the participant's effectiveness as a physician leader. The key areas of individual impact were related to effectiveness in communication and relationship-building (e.g. behaving as a confident leader; building relationships to influence change; presenting a persuasive case for change; adopting more collaborative approaches to problem-solving; inspiring others to action). There was also evidence of impacts around the application of systems-thinking and evidence-use, although these impacts appeared to be less strong. Organizational impacts were challenging for stakeholders to identify; this may be due in part to the absence of clearly articulated system-level program objectives (i.e. objectives that relate to how the program contributes to more effective or engaged leadership at the organizational or health system level) and embedded mechanisms for assessing organizational impacts.

Organizational support to increase the impact of the PLP

The PLP is starting to be anchored within broader leadership development programs or pathways in some health authorities, which supports the program's impact. Overall, however, there appear to be many opportunities to strengthen the connection between the PLP and health authorities to increase the program's impact.

No unintended consequences of the PLP, either positive or negative, were identified by the evaluation.

RECOMMENDATIONS

Formal recommendations from the evaluation will be developed by the Joint Advisory Board. Recommendation "territory" for consideration include the following:

1. Consider whether there is a need / opportunity for two separate streams of physician leadership training. In addition to the existing PLP, a separate stream could include team-based leadership training, and / or leadership training for potential physician leaders.
2. Articulate more concrete, measurable program outcomes for the PLP (individual & organizational)
3. Embed systems to monitor PLP performance against outcomes (individual & organizational)
4. Define an increased role and set of expectations of sponsor and operational counterparts in the PLP
5. Consider mechanisms to better integrate Action Learning Projects with organizational structures and / or priorities
6. Consider developing content and delivery mechanisms for PLP "refreshers"
7. Support / continue to advocate for health authorities to:
    a. Adopt systematic, pro-active approaches to PLP participant selection (e.g. Interior Health, Fraser Health)

b. Systematize internal reporting after PLP participation
c. Design opportunities for ongoing coaching / mentoring for PLP graduates
d. Create opportunities for PLP peer networking and shared learning
e. Improve support for effective data access and data use by PLP participants and graduates

1. Project Background

The University of British Columbia (UBC)-Sauder Physician Leadership Program (PLP) was created in 2013 to build capacity for leading change in health care in BC. The program targets physicians who are taking on leadership roles in their health authority, and aims to help develop the leadership knowledge, behaviours and skills they need to effectively engage in the planning, delivery and transformation of BC's health care system. The program is supported primarily through funding from the Specialist Services Committee (SSC) and Shared Care Committee (SCC). It is overseen by a Physician Leadership Program Joint Advisory Board which consists of various representatives from Vancouver Coastal Health Board, Health Authority Vice Presidents of Medicine (VPs), SSC, UBC-Sauder, and the BC Patient Safety and Quality Council. As of Fall 2018, ten cohorts of physicians (approximately 350 individuals) had completed the program.

In Fall 2018, the PLP Joint Advisory Board commissioned a formal evaluation to assess the impact of the PLP in developing the capacity of physicians to be leaders of change in the health system. Penny Cooper & Associates was selected as an external consultant to conduct the evaluation. The primary purpose of this evaluation was to assess the effectiveness of the PLP in meeting its key goal of building capacity of physicians to be leaders of change in the health system.

The evaluation was guided by six high-level questions:

1. What is the PLP ***participant profile*** and how has this changed over time?
2. How are PLP participants ***engaged*** in physician leadership, and what is the ***role of the PLP in their leadership journey***?
3. How has the PLP affected participants' ***effectiveness*** as physician leaders?
4. How have PLP participants been ***supported in their leadership journeys*** during and since the PLP?
5. Have there been any ***unintended consequences*** from the PLP?
6. How could the program be modified to increase its impact?

The PLP objectives were used as the framework against which to measure impact.

A sequential, mixed methods approach was used to complete the evaluation. Key informant interviews (n=35) were conducted with a wide range of stakeholders, including program funders, health authority VPs responsible for physician leadership development, other health authority stakeholders whose roles intersect with the PLP, former program participants and PLP coaches. A review of key program documents was also conducted. The document review and interview findings formed the foundation for two surveys: one for former program participants (N=362), and one for participants' health authority sponsors (N=137[1]). The survey response rates were 41% for the participant survey (n=150), and 43% for the sponsor survey (n=59). Response rates

[1] Many sponsors had sponsored more than one PLP participant.

are within normal parameters for surveys involving BC physicians. Response distribution for the participant and sponsor surveys was reflective of cohort numbers and distribution of cohort seats across health authorities.

2. Limitations

A key limitation of this evaluation was the absence of clearly articulated, measurable program objectives against which to measure the impact of the program. Related to this, the absence of baseline or monitoring data meant that the evaluation design was reliant on participant and sponsor recall, self-report data and organizational stakeholders' perceptions of impact. The engagement of a wide range of program stakeholders as well as the mixed methods design aimed to mitigate these limitations as far as possible, and the consistency of findings across data sources does provide a level of confidence in the evaluative conclusions.

3. Findings

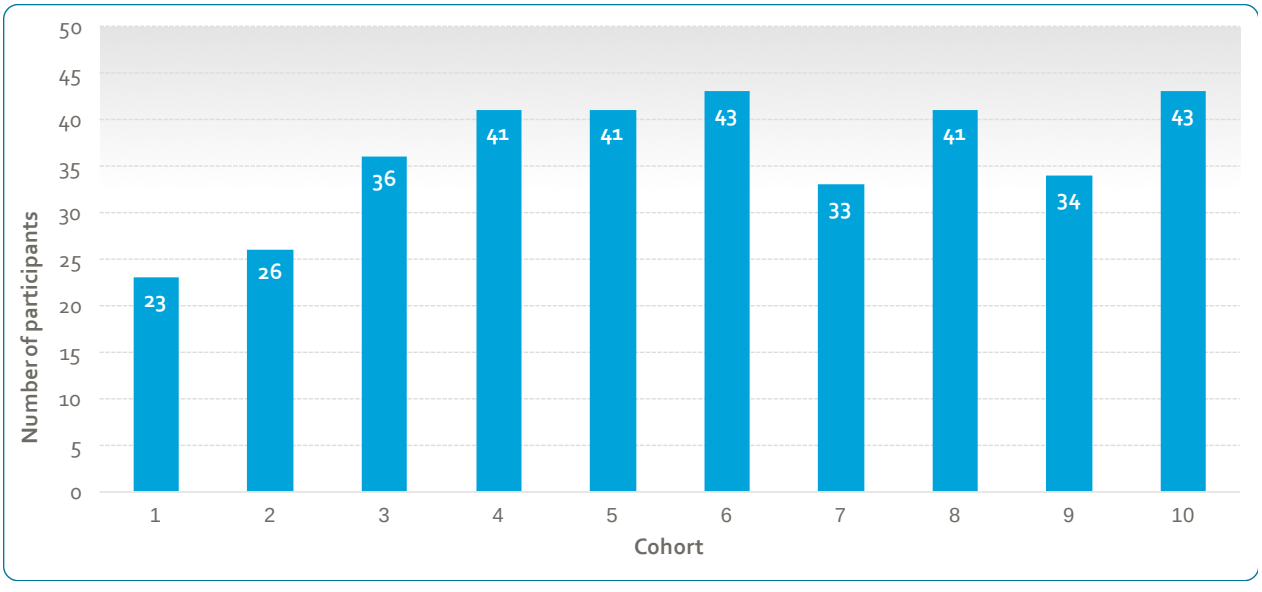
3.1 PARTICIPANT PROFILE & MOTIVATIONS

3.1.1 Participant profile

The PLP is reaching its intended target market (i.e. senior physicians taking on leadership roles in health authorities). However, the participant profile has changed over time. Overall, later cohorts[2] are less experienced physician leaders than earlier cohorts.

The earliest cohorts (2013-2014) had around 25 participants. Cohorts since then have had between 33-43 participants, with variability particularly over the past four cohorts.

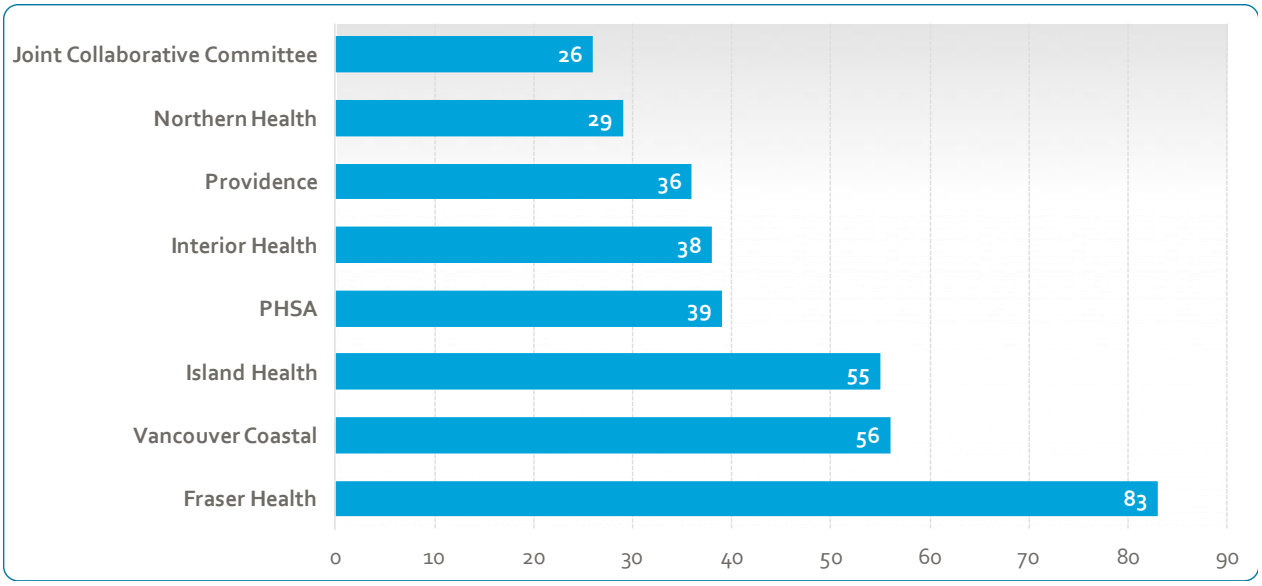
Figure 1. Number of Participants by Cohort



[2] Cohorts 1-5 were grouped as "early cohorts" and compared to cohorts 6-10 "later cohorts".

The distribution of participants reflects the number of seats that have been allocated to each of the health authorities and the Joint Collaborative Committees. At present, there are no seats allocated to physician leaders in the First Nations Health Authority. Stakeholders did not articulate any concerns about the allocation of seats.

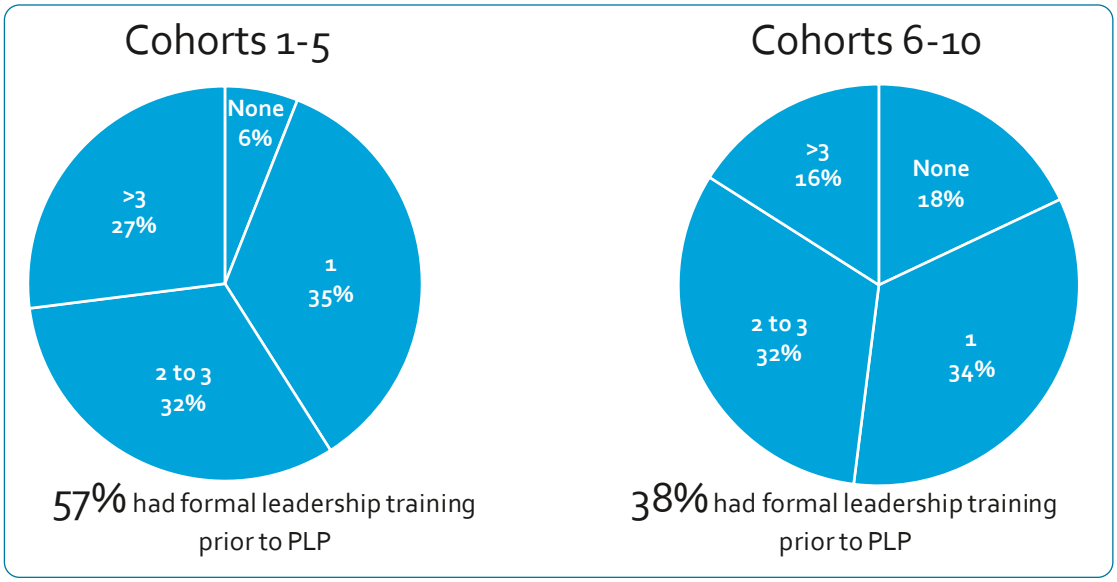
Figure 2. Number of PLP Participants by Organization



As noted earlier, the PLP is designed for senior physicians. The evaluation found that over three quarters (76%) of program participants have been practising for over ten years, and more than one third (34%) have been practising for over 20 years.

However, upon program entry, later cohorts are less experienced physician leaders than earlier cohorts. More among later cohorts did not have a leadership role when they entered the program, and fewer held three or more leadership roles. More among later cohorts had less than five years' leadership experience (66% of later cohorts compared to 52% of earlier cohorts) and fewer had more than ten years' experience (9% of later cohorts compared to 24% of earlier cohorts). Fewer among later cohorts had any prior formal leadership training.

Figure 3. Number of Leadership Roles and Leadership Training Prior to PLP

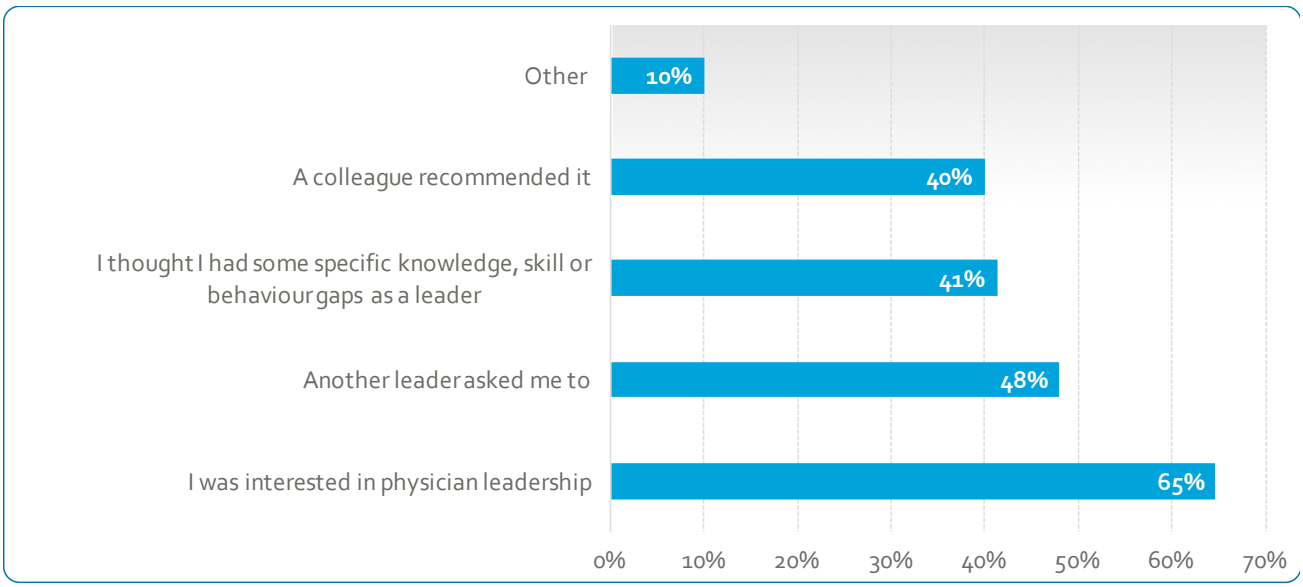


3.1.2 Participant motivations

Interest in leadership is the most common motivation for taking the PLP, in line with one of the PLP's key target market objectives.

Participants identified a number of motivations for taking the PLP, including interest in physician leadership, a request from another leader, awareness of specific knowledge, skill or behaviour gaps and colleagues' recommendations.

Figure 4. Participants' Motivations for Taking the PLP (% of Survey Respondents)



Qualitative data suggest that many of the 35% who did not indicate interest in physician leadership as a motivation simply had more immediate or top-of-mind needs (e.g. specific gaps) rather than a lack of interest in physician leadership. However, interviews with non-participant stakeholders suggested that some physician leaders who participate do not have a high level of inherent interest in physician leadership (i.e. may be in leadership roles by default or were told they needed to take the course) and that these individuals often benefit less from participation.

3.2 PROGRAM IMPACTS

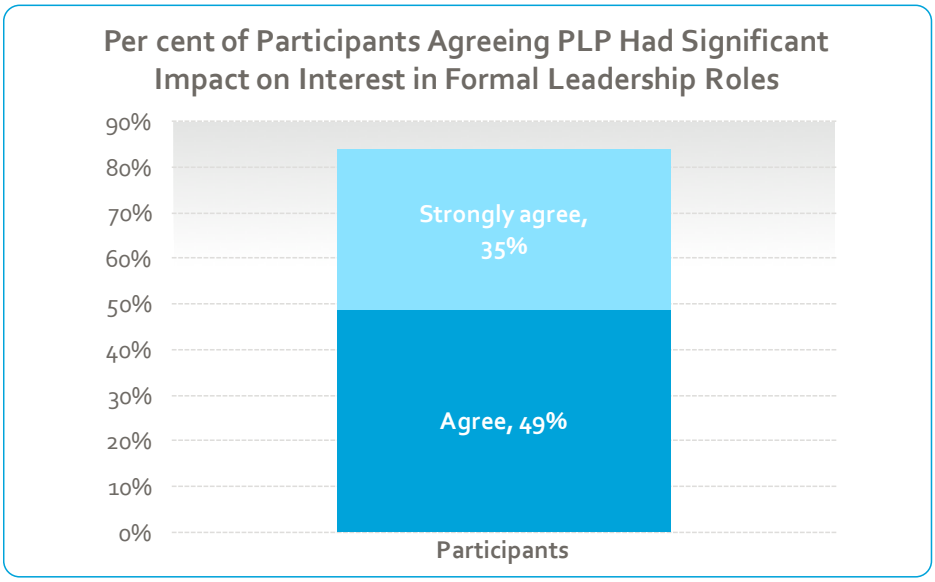
3.2.1 Impact of the PLP on participants' leadership journey

PLP participants are being retained in leadership roles in the health system and the program is perceived to have had a significant impact on participants' interest in leadership.

The evaluation found that over 90% of PLP graduates are currently in leadership roles[3]. Qualitative data suggests that many of those who are not currently in leadership roles have retired or are semi-retired.

Furthermore, over two thirds of participants have more responsibility now than they did prior to the PLP.

Figure 5. Retention and Responsibility in Leadership Roles



52% have taken **further formal leadership training** since the PLP to enhance their leadership abilities

A strong majority (over 80%) of participants agreed that the PLP had a significant impact on their interest in formal leadership roles; over one third (35%) strongly agreed. As a further sign

[3] The participant survey asked respondents to identify the type of leadership position they held; however, data were insufficient for reporting.

of sustained interest in leadership development, over half (52%) of respondents indicated that they had taken further formal leadership training since the PLP to enhance their leadership abilities.

At a system level, stakeholders were not able to make a clear link between physician participation in the PLP, interest in leadership, and retention in leadership roles. This did not appear to be problematic, as stakeholders indicated that the program was not necessarily set up to increase retention and recognized that there are many other factors that influence a physician leader's ongoing interest in leadership after taking the PLP.

Qualitative data supports the hypothesis that the PLP's role in fostering leadership interest is about triggering or re-energizing engagement. Participants spoke enthusiastically about this impact:

> *"It let the genie out of the bottle in terms of finding out how interesting leadership is."*
>
> *"I initially went in to improve my skills. But it really sparked my interest in leadership. I realized I really like this."*
>
> *"I think this opportunity opened many doors for me and started me on a journey that I had not expected but find challenging and rewarding."*
>
> *"Participating in the PLP actually kept me in my role. I was frustrated with myself as a leader, the organization, the barriers to change. This course helped me take a very different view."*

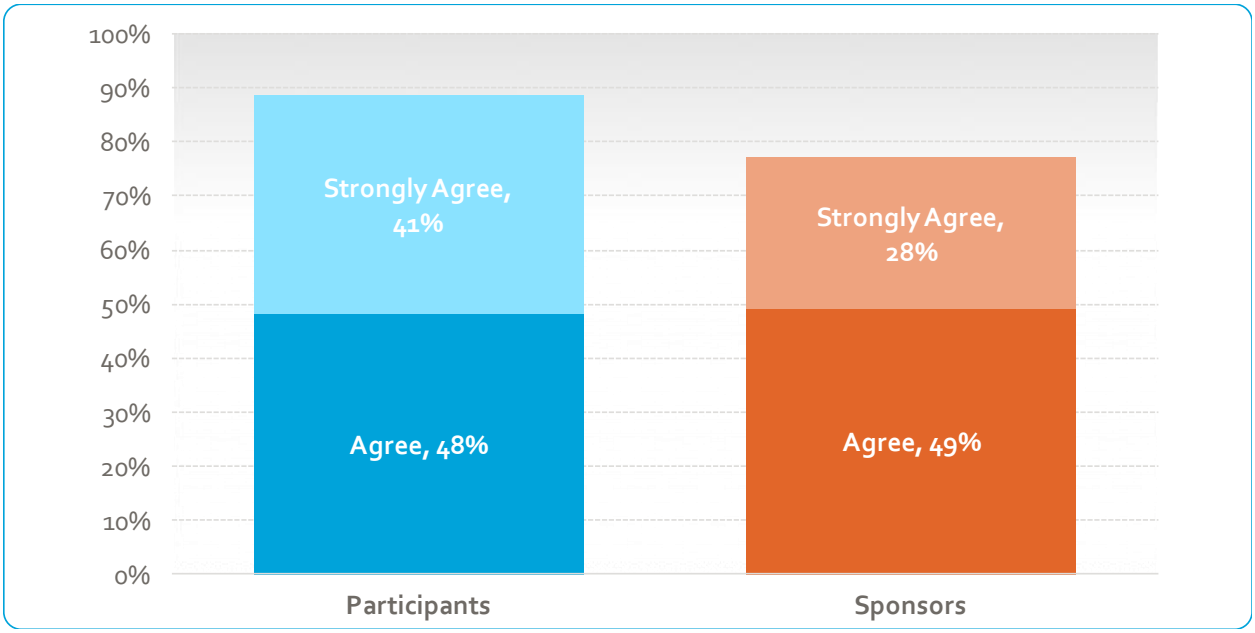
No positive or negative unintended consequences with respect to the PLP's impact on physician leadership engagement or the leadership journey were identified.

3.2.2 Impact of the PLP on participants' effectiveness as physician leaders

The program appears to have had a significant impact on participants' effectiveness as leaders across a range of dimensions. The strongest impacts were related to effectiveness in communication and relationship-building. There was also evidence of impact around application of systems thinking and evidence-use.

Nearly 90% of participants, and more than three quarters (77%) of sponsors agreed that the PLP significantly increased the participant's effectiveness as a physician leader. More than three quarters (77%) of sponsors also agreed that the PLP contributed to building the physician's capacity to lead change in BC's health care system.

Figure 6. Participants and Sponsors Agreeing PLP Had a Significant Impact on Participant's Effectiveness as a Physician Leader (% of Survey Respondents)



Overall, the qualitative data supports the survey data about the overall impact of the program on participants' effectiveness as physician leaders. Many program participants used strong language to describe the positive impacts:

> *"Excellent program that changed my thinking and likely the course of my career."*
>
> *"PLP actually has the capability of influencing how you view the world and interact with others. It can change what you do on a day-to-day basis, even outside medical leadership. Powerful."*
>
> *"The experience was transformative."*
>
> *"It was an amazing program and I learned so much about human behavior, communication, and personal ownership that I use every day."*

Sponsors and other stakeholders were more measured in their observations about the program's impact on physician leadership effectiveness, but still broadly supportive of the program's capacity for positive impact on participants going in with sufficient self-awareness and interest in leadership.

A key theme among program stakeholders is that the personal qualities a participant brings into the program affects the likelihood of the program having an impact on their effectiveness. The most frequently mentioned qualities were self-awareness and interest in leadership.

> *"The physician I sponsored was already very engaged, skilled and a strong leader. The responses I provided [in the sponsor survey] are reflective on her already having strong leadership skills rather than on the program necessarily."*
>
> *"The sponsored physician turns out to have little insight into their personal behaviours. [They were] not "mature" enough in a leadership capacity to benefit from the course. Organizationally I believe the program has been a great success, but for this individual there has been no measurable impact."*

Among health authority VPs, there were a range of opinions about the program's impact on the effectiveness of individual leaders. The most enthusiastic VPs were able to identify specific behaviour changes.

> *"I can see behaviour change. They are more energized, more empowered, and more "can do". They become better at working with other physicians. They learn how to leverage people to get what they want. They recognize that you have to work with the Ministry and administration to get stuff done. And they realize it's not always about asking for more money."*

Other VPs were more qualified in their response, observing that it is difficult to isolate the effects of the PLP from other influences:

> *"It's hard to say, measurably, because there's such a spectrum of starting points for leaders. It gives people a lot of background and seeds ideas … and it has made people better in their roles."*

The least enthusiastic VPs were still very supportive of the program, even if they were not convinced about its impact on participants' effectiveness as leaders.

> *"Before and after, I can't see much of a difference in the participants. But it does provide perspective and helps them understand there's another way to do things. It maybe broadens their horizons and they become more effective in their experiential learning. I still support it because there is a demand, and it is a nice reward for people who are taking on the roles. From that perspective alone, it has value."*

The key impacts were related to participants' effectiveness in communication and relationship-building[4]. There was also evidence of impacts around the application of systems thinking and evidence-use, although these impacts appeared to be less strong.

[4] The key informant interviews were used to identify the types of impacts that the program was perceived to have had. These formed the basis for survey questions, which aimed to quantify the extent to which the impacts applied to the wider participant base. The impact types generated from the interviews were compared against the PLP's stated objectives. Impact areas that were in the program objectives but which did not emerge from the interviews, were added to the list of survey items.

Figure 7. Top 6 Effectiveness Impacts: Communication & Relationship-Building (% of Survey Respondents)

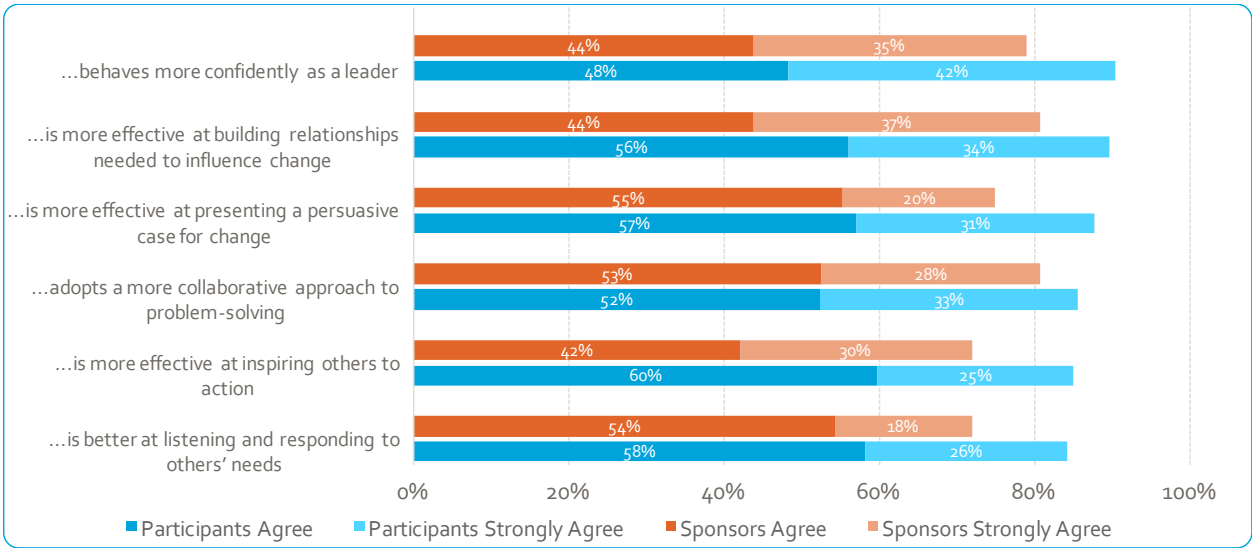
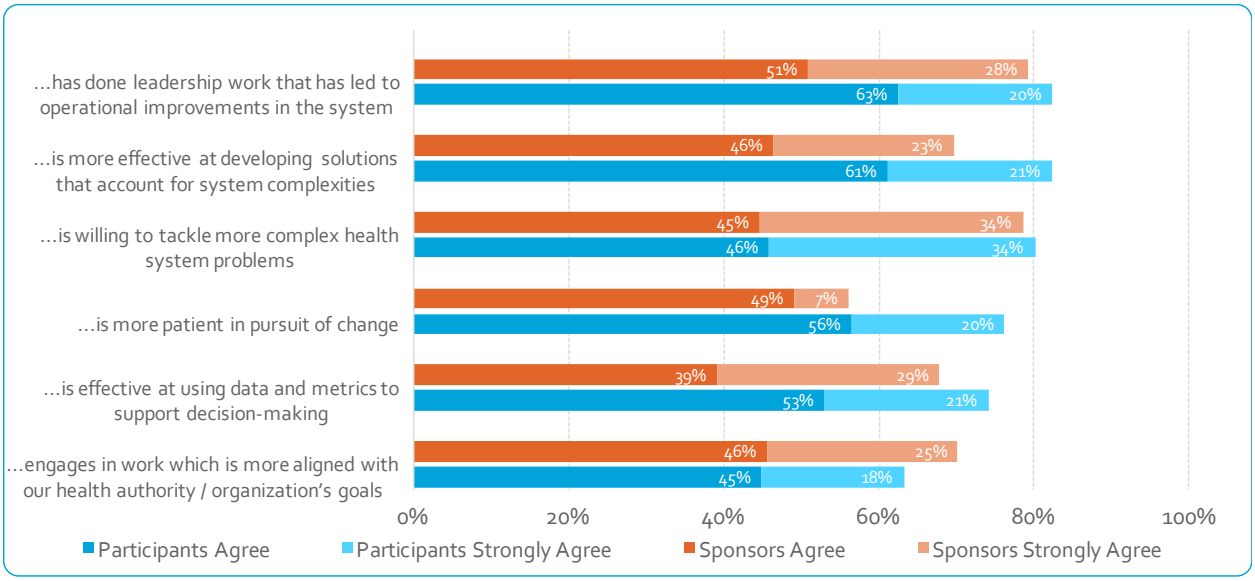


Figure 8. Other Effectiveness Impacts: Systems Thinking & Evidence Use (% of Survey Respondents)



Of note, the impact related to use of data and metrics to inform decision-making did not emerge from the key informant interviews, and the survey confirmed that this impact was not as strong as expected, given the emphasis on this in the course content. The impact related to alignment between the physician leader's work and organizational priorities was also not as strong as expected. Possible contributing factors are explored in **Section 3.3**.

No positive or negative unintended consequences around physician leader effectiveness were identified.

3.2.3 PLP peer network impacts

Ongoing PLP peer network impacts were not as strong as expected. The evaluation found limited evidence of systematic efforts to harness the capacity of PLP peer networks.

The evaluation found that although participants value the peer networking and learning during the course, the relationships are often not sustained. Just over half (51%) of participant survey respondents indicated that they draw support from the peers they met in the PLP. Slightly more (57%) indicated that they draw support from others in their organization who completed the PLP.

Qualitative data confirmed that the peer networks or relationships that do form are typically ad hoc, rather than systematically supported or encouraged:

> *"I didn't keep in touch with my cohort. But I have worked with another graduate from the PLP and I see a group of four or five who keep popping up at similar events and in similar roles. In the agency [where I work] I don't know who has taken it."*

3.2.4 Organizational and system-level impacts

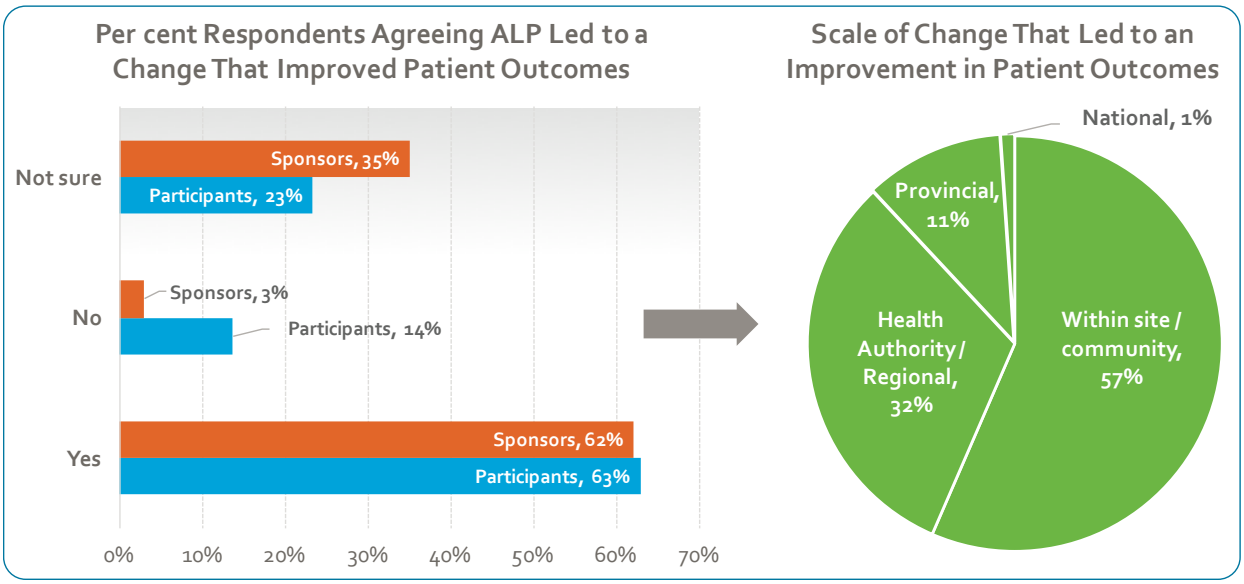
Organizational and system-level impacts were challenging to identify. Although not primarily designed to deliver organizational and system-level impacts, the completion rate and level of change achieved through participants' Action Learning Projects is an early marker of the PLP's organizational or system-level impact.

Organizational and system-level impacts proved very challenging to identify. This is related in part to the limitations mentioned at the outset of this report: specifically, the lack of clearly articulated organizational or system-level objectives, baseline data and an embedded system for measurement.

The Action Learning Projects (ALPs) participants are required to undertake show a "slice" of organizational impact, as well as further signals about the impact of the PLP on individual physician leaders' effectiveness. The primary purpose of the ALPs is to provide a mechanism for participants to apply their learning, by collaborating directly with a team of operational or administrative counterparts from their organization (usually the health authority) to influence real change in their department.

Just over half (54%) of participants were able to fully complete their ALP as planned; a further quarter (25%) were able to partially complete it and 11% are still in progress. A majority of participants and sponsors (60% and 62% respectively) indicated that their ALP led to a change that improved patient outcomes. Of those, well over one third (40%) led to changes that were at the health authority or regional level, or higher.

Figure 9. Action Learning Project Impacts



Although the evaluation showed evidence of organizational impact through the ALPs, it is notable that nearly a quarter of participants and over one third of sponsors could not say whether their ALP led to a change that improved patient outcomes. When directly prompted, organizational leaders (i.e. health authority VPs) were not able to comment on the ALPs' impact, either overall or with respect to individual projects. Possible contributing factors are discussed in **Section 3.3**.

No positive or negative unintended consequences around organizational or system-level impacts were identified.

3.3 ORGANIZATIONAL REQUIREMENTS, PROCESSES AND SUPPORTS FOR THE PLP AND PARTICIPANTS

3.3.1 PLP target market

There was some disagreement between health authority stakeholders about the target market for the PLP. Senior stakeholders expressed a desire to be able to access this type and quality of training for a wide range of leaders, including physicians with leadership potential who are not yet in formal leadership roles.

Stakeholders agreed that the PLP target market includes senior physician leaders. In at least one health authority, the program is considered "finishing school" for senior physicians. This label does not appear to be used as a disparagement or as a negative comment on the program's value:

> *"For us, Sauder is "finishing school". It's for the physician leader who has already been a Department Head that we want to promote to Chief of Staff, or Chiefs of Staff that we want to move to EMD. The PLP is to give them polish, to be able to interact with senior leaders."*

Given that many health authorities' senior leaders have already completed the PLP, the trend towards engagement of less experienced leaders as well as senior leaders represents a natural evolution in the target market. As indicated by the preceding sections, the PLP seems to have been able to accommodate more junior leaders without losing its impact.

However, there was disagreement across health authorities as to how far down the leadership experience chain the PLP effectively reaches. For example, some felt that the program is not for those initial leadership roles, and that participants need to have some "war wounds" to get the most out of it. In other health authorities, there are no parameters around the level of seniority potential participants need to have. At least one funder indicated that health authorities have been encouraged to think about up-and-coming physicians:

> *"There's an urgency to raise up a younger set of leaders. We need to find the "diamonds in the rough" and bring them up. There's really nothing for this group."*

Stakeholder interviews suggested some uncertainty about whether the PLP's target market can be stretched to include these emerging leaders (i.e. those with identified leadership potential but no formal role), or whether a different program would be required. A question on the sponsor survey specifically asked respondents whether they felt there was a need for a separate program that targets emerging leaders. The response was mixed. Those in favour of a separate program (n=25) felt that the learning needs of emerging leaders are substantially different from more established leaders, and that a separate program would enable the PLP to provide more sophisticated material for established leaders. Those against a separate program (n=16) indicated that having a wide range of experience in the cohort is beneficial to the learning of both established and emerging leaders.

3.3.2 Participant selection

Selection processes vary substantially across health authorities. In some health authorities, participant selection appears to be driven almost exclusively by word of mouth and self-nomination. In other health authorities, selection processes are starting to be anchored within broader leadership development programs or pathways.

The PLP's visibility in most health authorities is heavily influenced by word-of-mouth; specifically, promotion of the program by former participants. This is reflected in the program data about sponsorship: over one third (37%) of sponsors completed the program themselves, and just under a third (32%) of participants were sponsored by a former participant.

Formal promotion of the program promotion is generally fairly contained, with the designated leader responsible for physician leadership and / or engagement maintaining a list of senior medical leaders who receive notification about the program whenever a new intake is announced.

Self-nomination to the program is common across all health authorities. This is generally perceived as positive, as it reflects interest in leadership and in developing skills to become a better leader.

However, the extent of active targeting and vetting of suitable candidates varies across health authorities. In some health authorities, the process is entirely driven by self-nomination, with a senior leader or sponsor simply assessing whether the candidate is minimally eligible and signing off. Self-sponsorship is allowed.

In other health authorities, PLP selection is starting to be anchored within a broader leadership program or pathway. Interior Health, for example, has developed a leadership pathway model which defines the leadership knowledge, skills and behaviours required at every level of leadership in the organization. This health authority recently surveyed medical and administrative leaders to identify emerging leaders who will be targeted for leadership and management training, including (but not limited to) the PLP. The PLP application process has recently been revised. An application form, which includes questions about the applicant's leadership aspirations, leadership experience, involvement in change initiatives and understanding of key issues facing the health authority and the provincial system, is required. Applicants are then interviewed by a trio of Executive Medical Directors to determine their candidacy.

Fraser Health has also developed a pathway model for physician leadership development. In this, the PLP is positioned as a program for senior physician leaders. Fraser Health actively targets senior leaders who have not yet completed the PLP, as well as leaders they want to groom. The application process has been recently revised to include expectation of a written statement by the applicant that includes why they want to do the program, what training they have done before, and where they want their career to go with physician leadership.

3.3.3 Organizational supports during the PLP

There are opportunities to strengthen the connection between the health authorities and the PLP structure to improve the program's impact. The key area for improvement is more active involvement and support of health authorities in the Action Learning Projects.

Although the Action Learning Project (ALP) is designed first and foremost as a learning mechanism, the evaluation suggested there may be opportunities to use the ALPs more effectively to improve the organizational impact of the PLP.

For example, at present, ALPs are not necessarily aligned with organizational priorities or capabilities. Less than half of participants sought guidance as to what ALP would best align with

organizational priorities, and qualitative data from both participants and stakeholders suggests that the decision about an appropriate project is mostly left to the discretion of the participant. While recognizing that having a passion for the project is important, there did appear to be some interest in better linking ALPs with organizational priorities.

> *"A more formal linkage between the projects and how they are approved through the organization and aligned with the organizations vision / values [would help to increase the program's impact]".*
>
> *"Could we maybe have a "job jar" of sticky points in the system? ALP participants could choose their ALP from the job jar."*

Furthermore, sponsors are often not involved in the participant's ALP. Nearly one third (32%) of sponsors indicated they were not at all involved in the participant's ALP[5]. The opportunity to strengthen this connection appeared as a theme in the qualitative data.

> *"It would be great if a more intentional connect between the learner and sponsor was incorporated into the program-- it would support system thinking."*

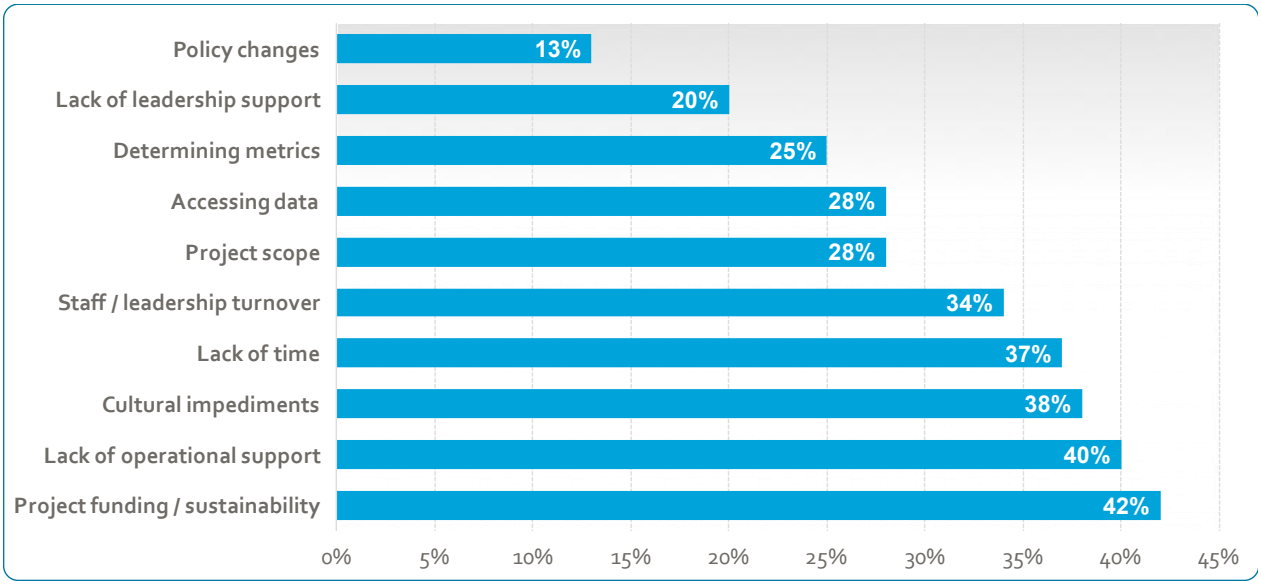
There was also limited evidence of systematic mechanisms for reporting back on the experience and outcomes of the ALP. This is reflected in the finding (reported in **Section 3.2**) that over a third of sponsors were unable to say whether the ALP of the participant they sponsored led to a change that improved patient outcomes.

> *"It would be good if the participants could bring back their projects. There's no process to do this. Is there a way to identify the top two projects by physicians from our health authority in each cohort, to give them the opportunity to get in front of the executive?"*

Finally, a large majority (over 80%) of PLP participants reported experiencing barriers to completing their ALP; 28% reported significant barriers. Only 60% felt they had adequate support from their organization to implement their ALP. A range of barriers to completing the ALP were mentioned by participants.

[5] 47% were indirectly involved, and 17% were directly involved.

Figure 10. Participants Reporting Barrier to Completing ALP (% of Survey Respondents)



Participants recognized that encountering barriers to completing the ALP is part of the learning. However, both participants and other stakeholders recognized that closer collaboration between the participant, sponsor and operational counterpart(s) during the planning and implementation of the ALP would improve the potential for organizational impact.

> *"Before finalizing a decision about the ALP it would be helpful to have a session at which the physicians could meet with site and health authority operational leaders to refine the scope and goal of the project. Sometimes this has been done after the fact and resulted in project modification. This type of session would improve clarity from the outset."*

3.3.4 Ongoing organizational supports for PLP participants

Ongoing organizational support for PLP participants could help to sustain the impacts of PLP participation. Improved institutional support for use of data in decision-making, coaching / mentoring, "refresher" courses for graduates, and organized PLP peer networking events were the key supports identified. Barriers to career progression are being experienced by more participants in later cohorts than in earlier cohorts, but qualitative data did not signal this as a major issue.

A frequent theme in the stakeholder interviews and qualitative survey data was that participants go through the PLP and experience substantial growth, but that when they return to the organization, support for their ongoing development is very limited. Just over half (58%) of PLP participant survey respondents indicated that support for further leadership development had been adequate.

Participants and stakeholders identified a number of ways in which health authorities and other sponsoring organizations could help to sustain the impacts of PLP participation, and thus increase the program's overall impact.

Access to formal coaching or mentoring from within the health authority was identified as one key opportunity. This was thought to be particularly important in the first few months after PLP participation, as a means of support to implement learning and overcome early barriers.

> *"I think graduates need ongoing support in their first few years to develop their skills. We are very vulnerable to early failures when we return to organizations that don't understand the modern leadership approach."*

Access to "refresher courses" to consolidate or extend learning on the course concepts was also thought to be useful.

> *"There should be a PLP course for graduates of the initial course to review and consolidate and further our skills."*
>
> *"I wish there was a next level I could attend."*

A third opportunity for improvement is to provide structured mechanisms for regularly bringing together PLP graduates for networking, mutual support and shared learning.

As noted in the section above, determining metrics and accessing data were key barriers to implementation of ALPs, and the evaluation found that this is an ongoing challenge. A majority of PLP participants (71%) indicated that they had experienced ongoing barriers to using data and metrics to improve decision-making in leadership roles; of these 21% had experienced significant barriers. In the participant survey, there were comments from over 100 respondents (of a total 150 respondents) describing these barriers. Almost all of these related to data access.

> *"Real time data is needed for QI. Retrospective data is not helpful. Real time data is very difficult to retrieve from electronic data systems or from MoH."*
>
> *"Current legislative framework does not support data sharing between and among health authorities and the college and the Ministry of Health."*
>
> *"Difficulty accessing information … due to the fragmented system and different electronic systems."*
>
> *"Difficulty extracting data from health records."*
>
> *"Ease of access to complex metrics on performance."*

Many participants indicated that increasing resources to support leaders to access data would be helpful.

> *"There is limited access to professionals within the health authority who can find the information and make it meaningful."*
>
> *"Lack of decision support resources, each request can be a fairly large thing for them to take on, especially with our very limited IT system."*

Finally, a substantial portion (22%) of PLP graduates reported barriers to career progression, with later cohorts reporting barriers more frequently than earlier cohorts (24% vs. 19% respectively). However, examination of participants' comments about the barriers did not reveal any discernable patterns or obvious opportunities for intervention, and only five specifically mentioned the lack of leadership positions available as a barrier to career progression.

4. Recommendations

Formal recommendations from the evaluation will be developed by the Joint Advisory Board. Recommendation "territory" for consideration include the following:

1. Consider whether there is a need / opportunity for two separate streams of physician leadership training. Separate streams could include team-based leadership training, and / or leadership training for potential physician leaders.
2. Articulate more concrete, measurable program outcomes for the PLP (individual & organizational)
3. Embed systems to monitor PLP performance against outcomes (individual & organizational)
4. Define an increased role and set of expectations of sponsor and operational counterparts in the PLP
5. Consider mechanisms to better integrate Action Learning Projects with organizational structures and / or priorities
6. Consider developing content and delivery mechanisms for PLP "refreshers"
7. Support / continue to advocate for health authorities to:
    a. Adopt systematic, pro-active approaches to PLP participant selection (e.g. Interior Health, Fraser Health)
    b. Systematize internal reporting after PLP participation
    c. Design opportunities for ongoing coaching / mentoring for PLP graduates
    d. Create opportunities for PLP peer networking and shared learning
    e. Improve support for effective data access and data use by PLP participants and graduates