Research and Practice Notes/Notes sur la recherche et les méthodes

Challenges in Evaluating a Prototype Project in a Large Health Authority: Lessons Learned

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Abstract: A developmental evaluation was undertaken to evaluate a prototype test of a new model of perinatal healthcare across acute maternity, public health, and primary care in two hospitals in a large health authority. The project was initiated to bridge gaps in care across the acute and community settings to ensure a seamless perinatal healthcare journey for women. The objective of the evaluation was to support the prototyping process by providing data to inform decisions as the prototype was developed and by documenting decisions as they were made. This article explores challenges faced during the evaluation, including unfamiliarity of the health sector with prototype projects and their inherent uncertainty, a disconnect between the rapid pace of a prototype project and bureaucratic hurdles of working within a large organization, and high leadership turnover throughout the project. How these challenges were addressed, and the lessons learned for future evaluations, are discussed.

Keywords: developmental evaluation, healthcare, interdisciplinarity, prototyping

Résumé : Une évaluation évolutive a été entreprise pour évaluer un essai de prototype d’un nouveau modèle de prestation de soins de santé périnataux déployé dans les unités de soins de maternité de courte durée, de soins de santé publique et de soins de santé primaires de deux hôpitaux d’une grande région de la santé. Le projet a été lancé pour combler les lacunes dans les soins à travers les contextes aigus et communautaires pour s’assurer que les expériences des femmes dans les soins de santé périnatale sont homogènes. L’objectif de l’évaluation était de soutenir le processus de prototypage en fournissant des données pour aider à éclairer les décisions tout au long du développement du prototype et documenter les décisions prises. Cet article
explore les défis rencontrés durant l'évaluation, notamment le manque de familiarité du secteur de la santé avec les projets de mise à l'essai de prototypes et leur incertitude inhérente, le fossé entre le rythme rapide de tels projets et les obstacles bureaucratiques liés au travail au sein d'une grande organisation ainsi qu'un haut taux de roulement des personnes responsables de la direction du projet. La manière dont ces défis ont été gérés ainsi que les leçons apprises, lesquelles éclairent les futures évaluations, sont aussi abordées.

*Mots clés*: évaluation évolutive, soins de santé, interdisciplinarité, prototypage

**DESCRIPTION OF CASE AND EVALUATION CONTEXT**

**Why Was the Evaluation Conducted? What Did the Client Want to Learn?**

Gaps in care at transition points between public health, primary healthcare, acute maternity, and neonatal intensive care units (NICUs) in a large, regional health authority created duplication, inefficiencies, and reduced quality of care. A need to address specific care gaps (e.g., inadequate information sharing among healthcare providers as clients move between hospital and community settings) was recognized based on findings from a literature review, gap analysis, and healthcare provider and client surveys (Chopova, 2011; Fraser Health, 2011). A cross-disciplinary steering committee (SC) and planning team were created to develop a new collaborative model for providing perinatal care to bridge the gaps. The model focused on coordinating care for high-risk and vulnerable clients across transitions between hospital and community settings by promoting seamless communication, coordination, and collaboration (the “3 Cs”) between all involved healthcare providers for the best care of women, babies, and families. This compelling vision resonated with care providers from all disciplines and served as a touchstone for all involved in the project to help guide decision-making during the prototyping process.

The initial conceptual model, called the Seamless Perinatal Transition Team (Figure 1), listed the roles included on the team, and indicated that a referral form is used to refer clients to the team and that feedback should be provided to the referring party; however, the model does not detail the ways in which team members interact with one another or with clients. To support the transition team’s work, a referral form was created and distributed to potential referral sources (e.g., public health unit, primary maternity care providers), and a feedback form was created for the transition teams to close the communications loop by informing the referring party of their referral’s outcome. The model was prototyped from November 2012 to December 2013 (Figure 2). As it was intended to use the findings from the prototyping to inform the roll-out of the model at all maternity hospitals in the health authority, the prototype was tested in one large tertiary hospital and one smaller community hospital, to determine which elements would work in these different contexts.
The process of prototyping, which is common in computer sciences and engineering, is gaining traction in healthcare (Ferguson, n.d.). As opposed to a pilot project, in which a model is fully designed and then launched at a test site, a prototype project involves part of the design work being conducted on the ground by the end users—in this case, front-line healthcare staff—where ideas can be tested in an iterative fashion in a real-world setting. In a pilot project, a model including all the details of the protocols and procedures would be created; the evaluation would typically involve assessing if the pilot was implemented as designed and, if so, whether or not the intended outcomes were achieved. Prototyping also differs from continuous quality improvement, a methodology used in healthcare that focuses on improving existing processes through incremental improvements (American Society for Quality, n.d.), while prototyping is used to design entirely new processes.

**Figure 1. Seamless Perinatal Transition Team Model**
Figure 2. Project Timeline

Legend

- Implementation Planning Team meeting
- Steering Committee meeting
- Advisory Committee meeting

*Advisory Committee members also consulted via phone/email on an ad hoc basis
In this project, the prototyping process required front-line teams to operationalize the model, experimenting to determine what worked in each site as different situations arose. For example, the initial model showed that different types of healthcare providers (who previously worked independently of one another in separate settings) were intended to work together to provide client-centred care in the maternity unit, but it did not identify in what ways they would interact with one another and with the client; those details were determined by front-line providers during the prototyping process, with a focus on testing options and learning from those tests. Details worked out during prototyping included whether public health nurses (PHNs), who had not previously been working in the hospital, would interact directly with clients or only work with the other healthcare providers; how often PHNs would attend the maternity unit and for how long; and how acute care nurses would update PHNs on client issues occurring when PHNs were not onsite at the hospital. Also, referral and feedback forms were substantially changed by front-line nurses as they learned what information was required—and what information was not required—to do their work. Management, the front-line staff engaged in the prototyping, and the evaluator met regularly to discuss their experiences as the implementation planning team (IPT); regular IPT meetings allowed staff from both sites to share learnings with one another. For decisions beyond this group’s scope, recommendations were brought to the SC, comprising management with decision-making authority for the project. An advisory committee (AC) provided advice to the SC (Table 1).

A developmental evaluation (DE) approach (Patton, 2011) was chosen to allow the evaluation to be adaptive and responsive to the prototype nature of the project, where final details of the model emerged from the implementation. Table 2 lists the characteristics of a situation that makes it suited to DE as described by Dozois, Langlois, & Blanchet-Cohen (2010).

The objective of the evaluation was to support the Seamless Perinatal project through tracking the model’s development throughout the prototyping process, providing data to inform decisions, and documenting decisions as they were made. Specifically, the evaluation addressed the following questions:

- What have we learned from implementing this prototype?
  - What worked well?
  - What challenges were encountered and how were they dealt with?
  - What could be improved? How could it be improved?
- What has the prototype taught us that can be applied to spreading Seamless Perinatal Transition Teams to other maternity hospitals?

In addition, three “intended contribution statements,” which are measurable progress markers providing stakeholders with goals to orient them in their work, were set for the project (Table 3).
<table>
<thead>
<tr>
<th>Governance committee</th>
<th>Membership</th>
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| Implementation planning team (IPT) | • Antepartum outpatient nurses  
• Public health nurses  
• Maternity unit managers  
• Public health unit supervisors  
• Public health unit managers  
• Physician  
• Social work leads  
• Project manager  
• Evaluation specialist |
| Steering committee (SC) | • Director, public health  
• Director, acute maternity  
• Medical lead  
• Clinical nurse specialist  
• Public health unit managers  
• Maternity managers  
• Antenatal outpatient nurse  
• Physician  
• Project manager  
• Evaluation specialist |
| Advisory committee (AC) | • Director, public health  
• Director, acute maternity  
• Director, maternity/neonatal intensive care  
• Director, maternity/child/youth  
• Clinical nurse specialist  
• Program medical director  
• Medical health officers  
• Decision support services lead  
• Health information management leads  
• Privacy lead  
• Perinatal outpatient clinic lead  
• Quality improvement/patient safety consultants  
• Project manager  
• Evaluation specialist |
Table 2. Elements That Make a Situation Appropriate for Developmental Evaluation

<table>
<thead>
<tr>
<th>Elements that make a situation appropriate for developmental evaluation</th>
<th>How it applied to the project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly emergent and volatile (e.g., the environment is always changing)</td>
<td>• Prototype nature of the project meant the design of the model was emergent from the work on the front-line.</td>
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<td></td>
<td>• Healthcare settings are inherently complex (Begun, Zimmerman, &amp; Dooley, 2003).</td>
</tr>
<tr>
<td>Difficult to plan or predict because variables are interdependent and nonlinear</td>
<td>• The operationalization of the model emerged from interactions between an interdependent group of healthcare practitioners, making results difficult to plan and predict.</td>
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<tr>
<td>Socially complex, requiring collaboration among stakeholders from different organizations, systems, and/or sectors</td>
<td>• Bringing together acute and community healthcare providers—who have different priorities, languages, and cultures—to work in close collaboration was socially complex.</td>
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<tr>
<td></td>
<td>• Multiple levels within the organization (from front lines to senior leadership) were required to work together, adding another layer of complexity.</td>
</tr>
<tr>
<td>Innovative, requiring real-time learning and development</td>
<td>• Prototype nature of the project required real-time learning as the model was developed by front-line staff.</td>
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</table>

What resources (time, money, in-kind, etc.) were available for conducting the evaluation? Were they suitable for answering the evaluation questions?

The internal evaluator from the Population & Public Health program was approached to conduct the evaluation work for the prototype. Given the DE approach taken, the evaluator was embedded at all levels of the project governance structure as a member of the AC, SC, and IPT.

The DE process involved tracking the prototype model implementation at both sites, facilitating transparent decision-making, and generating data to assess the model, thus supporting accountability while allowing the flexibility necessary for an emergent process (Dozois et al., 2010; Rey et al., 2014). Examples of types of data collected and what they were used for is provided in Table 4. Data were brought to meetings of all levels of the governance structure to be collectively interpreted and to determine how to apply learnings from the data to further model testing and development (Rey et al., 2014).
### Table 3. The Evolution of the Intended Contributions for the Project

<table>
<thead>
<tr>
<th>Domain</th>
<th>Original intended contribution statement</th>
<th>What was learned</th>
<th>Action taken as a result of learning</th>
<th>New intended contribution statement</th>
</tr>
</thead>
</table>
| Communication| 100% of referrals will receive a feedback form.                                                           | • Most of the fields on the original feedback form repeated what was on the referral form, resulting in duplication of effort to fill it out only to provide the referring party with information they already knew.  
  • The large tertiary hospital had more clients referred to the Transition Team after they had given birth in the hospital than were referred prenatally, so there was not a community-based referring party to “feedback” information to. Instead, the transition team needed to inform primary care provider (and other relevant providers) about issues related to client. | An interdisciplinary Shared Work Team created a protocol for communication among the disciplines with respect to perinatal clients, rather than requiring that a feedback form be used as the method of communicating from the hospital maternity unit to community-based healthcare providers. | Documented protocol for communication among the disciplines with respect to perinatal clients is created. |
| Collaboration| 100% of women who need complex care from at least 3 of the partners on the Transition Team (i.e., primary care provider, PH, acute maternity, NICU, social work) receive a care plan. | No complex care plans were completed, so group was prompted to re-examine the definition of “complex care plan.” After deciding it did not fit with their work, they instead re-defined it as “collaborative care plan.” | A process was developed to create “collaborative care plans.” | Process is developed for creating collaborative care plans. |
When an attempt was made to measure the extent to which the various types of healthcare providers understood each others’ roles, it was discovered that there was no explicit articulation of what those roles were. Each group was tasked with providing a documented description of their discipline’s role on the Seamless Perinatal Transition Team. This activity helped to eliminate confusion around roles, reduced duplication, highlighted the disciplines’ shared goal of providing the best possible care to the patient, and informed the ways in which the disciplines worked together to support their patients. Documented descriptions of the role of each member of the Seamless Perinatal Transition Team are created.

Coordination

100% of healthcare providers on the Perinatal Transition Teams report understanding of roles of all members of the team.
Table 4. Data Collection

<table>
<thead>
<tr>
<th>Type of data collected</th>
<th>How it was used</th>
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</table>
| Data from referral forms, including numbers of referrals and characterstics of the clients being referred | • Provided a picture of who the clients being served by the Transition Teams were, including their demographic profile and risk factors  
• Provided a picture of the workload                                  |
| Details on feedback being provided to referral party                | • Provided data on how well the communications gap was being bridged            
• Assessed progress toward achieving the intended contribution of “100% of referrals receive a feedback form” |
| Workload data                                                       | • Provided data to inform leaders of decisions regarding staffing requirements for the model 
• Provided a picture of when public health nurses were attending the maternity unit and for how long |
| Document reviews                                                    | • Provided information on how forms were actually being used by staff to inform re-design of the forms to be more useful  
• Assessed progress toward achieving the intended contribution of “100% of women who need complex care from at least 3 of the partners on the Transition Team” |
| Observations at meetings                                            | • Allowed for the documentation of why decisions were made                     |
| Interviews and focus groups with staff and leaders                  | • Provided information about the outcomes experienced by the clients            
• Provided information on what was working and what challenges were being faced by staff to inform decisions about what practices to adopt and when alternative practices should be tested out  
• Assessed progress toward achieving the intended contribution of “100% of healthcare providers on the Perinatal Transition Teams report understanding of roles of all members of the team” |

The intention was to have the evaluator spend 0.4 full-time-equivalent days (15 hours/week) on the project. In reality there were times where the workload on her other projects had to be shifted to accommodate the work required for this evaluation. There were no additional resources provided for the prototype project, meaning all planning and evaluation work was conducted by reallocating existing staff. Some data collection and analysis was conducted by nursing staff working on the project (e.g., nurses recorded their time in a spreadsheet, a nurse analyzed some client data extracted from referral forms), but otherwise the evaluation work was conducted by the evaluator. Thus, there was not sufficient evaluation capacity...
available to conduct some elements that would have enhanced the evaluation, such as interviewing individuals who did not work for the health authority (i.e., primary care providers and clients) about their experiences.

**DESCRIPTION OF CHALLENGES, HOW THEY IMPEDED THE EVALUATION PROCESS, AND HOW THE CHALLENGES WERE ADDRESSED**

*What challenges did you face in conducting this evaluation? To what extent did you anticipate or could you have anticipated these challenges?*

As with any project occurring in a complex environment, numerous challenges were faced in this project. These can be broken down into two types: challenges associated with the prototype project implementation and challenges associated with the DE approach. The challenges included (a) unfamiliarity and uncertainty associated with a prototype project, (b) bureaucratic hurdles in a large organization not aligning with the rapid pace of a prototype project, and (c) high turnover in leadership throughout the project. The nature of most of these challenges, with the exception of the high turnover in leadership, was anticipated; however, the extent to which they affected the work was underestimated.

*How did these challenges affect the implementation of the evaluation? How did you address each of these challenges?*

**Unfamiliarity and uncertainty associated with a prototype project**

Most of those involved in this project had never been involved in a prototype project, and features of a prototype were not always clearly understood by the participants. Prototyping is a very different way of working than most people in healthcare are used to. New healthcare programs are often introduced as pilot projects, where a fully formed protocol or procedure is tested in a setting, with little to no opportunity to focus on and capture learnings or to change or adapt the procedure. By contrast, it was difficult, especially in the beginning, for stakeholders to understand exactly what the Seamless Perinatal Healthcare Initiative was, as the model presented to staff at the start of prototype implementation was high-level, without specific details for procedures to be followed. In addition, staff were not provided with specific “rules” around what to do to operationalize the model, which made it difficult for the staff involved to understand if they were doing what they were “supposed” to be doing. In addition, concerns were raised about what, exactly, was being evaluated. Unfamiliarity with this way of working led to some distrust of the evaluator, who was viewed by some stakeholders as collecting information to report back to leadership for punitive reasons, instead of for the purpose of learning to improve the model being prototyped.

To address these challenges, the evaluator was embedded in all levels of the governance structure including the IPT, where front-line staff and managers
discussed their progress with the prototype (see Figure 2 for meeting frequency). These meetings provided regular opportunities to use data from the prototype to inform decisions. In addition, she attended the two hospital sites to talk to staff, reiterate the prototyping purpose and process, listen to concerns, and answer questions. This allowed her to employ a variety of DE practices such as orienting staff to the prototyping process’s emergent nature and intervening through moderating discussions around their assumptions (Table 5).

Table 5. Developmental Evaluation

<table>
<thead>
<tr>
<th>Developmental evaluation practice</th>
<th>Description of the practice</th>
<th>Example of how it was used in this project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orienting</td>
<td>Helping stakeholders frame their work, including defining its elements, testing their models, and understanding their roles within a broader context</td>
<td>Setting “intended contributions,” which were measurable progress markers that provided stakeholders with a goal to orient them in their work and a way to assess progress toward their goals. Moreover, an “intended contribution” was set for each of the “3 Cs” of the vision (improving communication, coordination, and collaboration in the care of vulnerable pregnant women and new mothers) to frame the work around these important goals.</td>
</tr>
<tr>
<td>Watching</td>
<td>Attending to key moments, dynamics, power, and collective learning</td>
<td>The evaluator noted high leadership turnover, which coincided with a breakdown in the normal schedule of steering committee meetings, led to a gap in decision-making, and thus was stalling the project. To mitigate, there was a concerted effort to provide a formal orientation for the incoming project manager, including a transition period of working with the outgoing project manager and a tight collaboration with the evaluator.</td>
</tr>
<tr>
<td>Sense-making</td>
<td>Helping the group to analyze and give meaning to the data being collected</td>
<td>The evaluator collected and analyzed data on the characteristics of the clients being referred to the Transition Teams to gain a better understanding of the patient population being served. These data, which showed, for example, very different referral patterns at the small community hospital compared to the large tertiary hospital, were brought to the implementation planning team and steering committee for discussion, interpretation, and determination of how these data would inform the future roll-out of the model at other hospitals.</td>
</tr>
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### Developmental evaluation practice

<table>
<thead>
<tr>
<th>Description of the practice</th>
<th>Example of how it was used in this project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervening</td>
<td>Taking actions such as asking questions, moderating discussion, reminding, and supporting collaboration to influence the development of the program/intervention</td>
</tr>
<tr>
<td>When a stakeholder expressed concern they would be punished for testing out a way of working that was different from what they believed leadership wanted, the evaluator asked questions to reveal the assumptions being made. In this case, this stakeholder expressed the desire that the evaluator withhold from leadership the information that public health nurses were working directly with patients in the hospital for fear of being reprimanded by leadership. The evaluator led the group through a thought experiment by asking, “What would happen if you continued to work this way but did not tell the steering committee?” The group realized that because they had been seeing positive results, the steering committee would conclude that the positive results were coming from public health nurses not seeing patients in the hospital, and then they would finalize the model that way. The evaluator used this opportunity to remind the group that the purpose of the prototype was to learn, and thus testing out a different way of working was encouraged. This helped the stakeholder to see this work as providing evidence demonstrating this new way of working achieved the intended results and would inform leadership on decisions for the program. Thus, the evaluation supported stakeholders to analyze and synthesize learnings to make sense of them in the context of both the prototype sites and for future roll-out of the initiative to other sites.</td>
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**Bureaucratic hurdles in a large organization not aligning with the rapid pace of a prototype project**

In the prototype project, staff were making quick changes to how they did their work to test which ways of working were most effective. For example, staff tried out a process where the PHN working in the hospital did not see patients directly (working instead with inpatient maternity nurses on care planning) as
opposed to working directly with the patients in the hospital (again, planning care as opposed to providing direct care). Similarly, as staff worked with the initial referral and feedback forms, they continually found ways to improve them, adapting the form by adding new fields to it as they worked. In contrast, systems within the health authority are much slower than a prototype (e.g., the turnaround time for a privacy impact assessment by the organization on changes made to the forms was 6–8 weeks versus staff making changes to the form in an ongoing manner).

With respect to the evaluation process itself, data collection was challenging, as the required data evolved along with other aspects of the prototype. For example, data required at the start (e.g., detailed client information to gain understanding of the patient population being referred to the transition team) was not necessarily required later on, so some data being collected was dropped once it was no longer necessary, and new data to collect (e.g., interviews/focus groups with staff about the ways in which they were working together) was added as needs arose. Moreover, attempting to collect data to assess the three “intended contributions” surfaced issues around the appropriateness of those measures for the prototype; as those issues were discussed with project staff, new “intended contributions” were established (Table 3). Clear communication was necessary to ensure all stakeholders understood why data collection was changing during the evaluation.

To address these challenges, it was necessary to balance the speed of changes inherent in a prototype project with not overwhelming and confusing participants by making too many changes at the same time. Moreover, since different individuals assumed the role of PHN on the transition team on a given day, it was necessary to find ways to clearly communicate changes in a timely manner to everyone involved. Having staff from both sites meet together as the IPT to discuss their process was helpful in this regard. It was important to be clear about what changes were being made and why, and for the evaluator to prioritize what data needed to be collected and in what timeframes, given the limited evaluation resources. In addition, a clinical nurse specialist stepped in to help with data collection and analysis to ease some of the workload for the lone evaluator.

**High turnover in leadership throughout the project**

An unexpected challenge was high leadership turnover, with six of the nine leaders engaged in the project, and the project manager, retiring or taking new positions during the 13 months of the prototype. Continuity and institutional memory was difficult to maintain with so many players and so much turnover. Some components identified in early planning stages, on which future work was built, did not seem to have been effectively communicated to those who joined in the work later, resulting in some confusion. Moreover, there was no formal transition or orientation for new leaders taking over from previous individuals. In addition to leadership turnover, there was also significant turnover of frontline staff engaged in the prototyping work, as new individuals were brought on
to take part in the Seamless Perinatal Transition Teams as the work took shape. With respect to the evaluation itself, the high turnover in leadership presented a challenge both because it became unclear with whom to share evaluation findings from the IPT and because new leaders needed to be introduced to the concepts of prototyping and DE in the midst of the project.

Through the DE practice of watching, particularly around project structure (Dozois et al., 2010; Langlois, Blanchet-Cohen, & Beer, 2013), the evaluator noted high leadership turnover, coinciding with a breakdown in the SC meeting schedule, leading to a gap in decision-making and stalling the project. To mitigate, there was a concerted effort to provide a formal orientation for the incoming project manager, including a transition period of working with the outgoing project manager and a tight collaboration with the evaluator.

**What should evaluators do to avoid these challenges to start off with? What would you recommend for others faced with similar challenges?**

As noted by Zimmerman et al. (2011), “Evaluating complex interventions requires [...] a willingness to be uncertain at times and to know that being uncertain is crucial to the process” (p. viii). Prototype projects, by definition, involve more uncertainty and ambiguity at the start than traditional pilots. Some people are more comfortable with uncertainty than others, and staff should be supported specifically to work in this new way. Leadership should clearly, consistently, and continually communicate what a prototype is, and they should support staff through the uncertainty (e.g., focus on the concept that learning by doing is a key outcome of this process). An evaluator can assist in this process through facilitating the development of a compelling vision that is motivating to stakeholders and that can help guide those working in situations of uncertainty (Dozois et al., 2010). In addition, an evaluator could help reduce some uncertainty by facilitating the group to explicitly state some rules by which the front-line staff should operate during the prototyping process.

When embarking on a prototype project, particularly with stakeholders unfamiliar with this style of working, it would be wise to provide significant support around change, uncertainty, and complexity. Though some work was done in this regard, it could have been improved by being more thoroughly planned upfront and provided in a timelier, ongoing manner, with particular care taken to orient new staff and leaders who become engaged throughout the project. In addition, more clearly defining the roles of those involved and ensuring there is adequate transition planning and orientation when turnover occurs would be beneficial.

Interestingly, when stakeholders were asked, “If you were to be involved in another such project from the beginning, what would you do differently?” the general consensus was, despite the challenges, prototyping was the appropriate method for the project; there was a sense the group needed to go through the testing and learning process to see how the work would unfold.
was noted that, in the past, projects were often created on paper and expected to be rolled out in a pilot-type fashion; however, once launched, many things were found not to work as planned, yet there was no process to capture learnings and make needed adaptations. It was felt with this initiative, despite it being difficult at times, the group needed to go through the process to arrive at where they needed to be. Many felt the right people were at the table—from the front-line nurse to upper management, and from the different disciplines. Similarly, working together was seen as the most effective way to build trust and relationships.

With a large, multisite prototype, it is impossible for a single evaluator to be present at different sites as learning occurs. If additional evaluation resources are not available, training staff who are conducting the prototype on principles of DE could allow them to take a more active role in monitoring, evaluation, and using real-time findings to inform the prototyping process.

What, if any, are the systemic issues that the evaluation community should address?

Demonstrating (or even defining) “success” is challenging with a prototype project. Decision makers often want to see quantitative outcome data, such as cost savings or improvements in health status, whereas prototyping is a developmental process in which learning is a primary intended outcome; the learnings are used to improve the model during the prototyping process. More research on ways in which DE ultimately contributes to outcomes in the long term could help support evaluators to demonstrate the value of this type of work and in advocating for this approach to evaluation for complex initiatives. Moreover, support in the development of clear and consistent messaging about the ways in which prototyping and DE are different from traditional process or outcome evaluations, as well as mechanisms for building capacity in development evaluation, could be helpful.

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REFERENCES


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