The IDM Manual

a guide to the IDM (Interactive Domain Model) Best Practices Approach to Better Health

♦ Basics ♦

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Centre for Health Promotion, University of Toronto
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Foreword by Irv Rootman

IDM Manual sections:

♦ **Basics**
♦ **Suggested Guidelines**
♦ **Evidence Framework**
♦ **Research & Evaluation**
♦ **Using the IDM Framework**
♦ **Reports on Using the IDM**

Other IDM resources of interest:

♦ **IDM Best Practices Road Map for Coaches**
♦ **Best Practices Check-In Forms**
♦ **IDM Computer Program**
♦ **IDM Best Practices peer-reviewed journal article**

♦ **The *IDM Manual*, other IDM resources and links to general health-related resources are available from <www.idmbestpractices.ca>.**
♦ **The *IDM Manual* is also available from <www.utoronto.ca/chp/bestp.html>.**
♦ **Egalement disponible en français de <www.opc.on.ca/francais/nosprogrammes/centre/projets/ meilleurespratiques.htm>.**
♦ **See also <www.bestpractices-healthpromotion.com>.**

The IDM Manual

The IDM (Interactive Domain Model) Best Practices Approach to Better Health

- The contribution of Health Canada, Population and Public Health Branch, Ontario and Region (now the Public Health Agency of Canada, Ontario and Nunavut Region) in funding the original IDM Manual is gratefully acknowledged.
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- The *IDM Manual* is written from the perspective of health promotion and public health practitioners of all types and at all levels. That is, "we" refers to program implementers (front-line staff and managers), policy and decision makers, and researchers.
- **IDM** refers to Interactive Domain Model.

TABLE OF CONTENTS

FOREWORD

This Manual represents a "labour of love" for many people. Chief among them are Barbara Kahan and Michael Goodstadt who have spent more hours than they can count articulating the ideas that are so ably captured in the Manual. However, the members of the Centre for Health Promotion's Best Practices Working Group also committed many hours of their time to develop and formulate the thoughts about "best practices" that were the basis for the Manual. Similarly, the participants in the pilot sites devoted energy "beyond the call of duty" testing the ideas developed by the Working Group in real work situations thus giving them the practical content that they needed.

One of the net results of this work is this Manual which outlines for the user what is meant by "best practices" in the context of health promotion and how to go about identifying such practices in the context of their everyday work situations. In my view, this will contribute significantly to the improvement of the quality of practice in health promotion in Canada and internationally. I therefore enthusiastically recommend that you use it to guide your efforts in improving your own practice and the practices of the organizations that you work for.

One of the interesting features of the project on "best practices" in health promotion is the fact that it developed out of a felt need of practitioners in the field for tools that would help them in their work. This need was expressed at the First International Symposium on the Effectiveness of Health Promotion which took place in 1996 at the University of Toronto. As a result of the honest effort to meet this need in partnership with practitioners, I believe we now have an approach and tools that does respond to the needs expressed at the Symposium and that we can be proud of.

At the same time, there is room for further development. This will only come about if people like yourself use the Manual and provide feedback to the authors regarding your experiences in doing so and your suggestions for making it more useful to others. Thus, I hope that you too will make the refinement of this Manual and associated tools a "labour of love" and thereby contribute to the improvement of practices in health promotion throughout the world. In the

meantime, I hope that you find the current Manual to be intellectually challenging and helpful in your work.

Finally, I would like to express the gratitude of all of us in the field of health promotion to the people "whose labour of love" has led to this excellent Manual as well as to the many organizations, especially Health Canada (Population and Public Health Branch, Ontario Region), that have supported this endeavour from its inception.

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INTRODUCTION

It has been a few years since the last version of the *IDM Manual*. In that time the IDM (Interactive Domain Model) approach has developed considerably. More groups are using it (or modified versions of it), the number of its supporting resources has grown, and it has provoked international activity and interest. In the spirit of ongoing reflection and continuous improvement, I have revised and re-organized the *IDM Manual* in an attempt to make it more helpful to people wanting to understand the IDM and/or use the IDM Framework.

Before I introduce the *IDM Manual*, let me mention a few points about the IDM best practices approach to better health. IDM best practices is a comprehensive guidelines approach which emphasizes the importance of consistency between practice and a number of decision-making factors ranging from values and goals to theories, evidence and understanding of the environment. A number of years after the initial pilot testing of the Framework we know that the IDM is not only doable but results in a wide range of benefits. A number of people and groups successfully use the IDM or approaches similar to the IDM in their work.

If the IDM initially appears complex, this is partly because it accurately reflects the complexity of life, and partly because it is a different way of approaching work than most of us are used to. Many people using the IDM find that it soon begins to make sense and becomes second nature. A compelling argument for the usefulness of a comprehensive approach such as the IDM is the number of organizations using this kind of approach — without ever having heard of the IDM — because it achieves good results.

And that is the reason for the *IDM Manual* — to help other groups achieve good results as well. The *IDM Manual* is designed to assist busy health promotion and public health practitioners (including all levels of program implementers, decision makers, policy makers, and researchers/evaluators) to do the best we can given our particular circumstances. It provides a Model and Framework to guide us in a systematic, comprehensive and critically reflective approach to practice.

The *IDM Manual* originally focused on health promotion. This version focuses on health promotion and public health, reflecting the overlap between the two fields. The *IDM Manual* is divided into a number of sections for easy reference:

- ♦ *Basics:* an overview of the Model and Framework, with explanations of basic IDM ideas and answers to frequently asked questions
- ♦ *Suggested Guidelines:* the set of guidelines upon which the IDM approach is based, useful in helping practitioners identify their own practice guidelines
- ♦ *Using the IDM Framework:* tips, challenges to prepare for, different ways to use the Framework, terminology, examples
- ♦ *Evidence Framework:* guiding questions and worksheets for people interested in using evidence in practice, lists of things to consider, and quotes from people with extensive experience with evidence
- ♦ *Research & Evaluation:* a comparison of approaches, designs, and methods to help practitioners choose the best way to conduct their research and evaluation
- ♦ *Reports on Using the IDM:* reports from IDM pilot test sites and other groups who have used the IDM; includes a timeline of the Best Practices Project

The *IDM Manual* is best used with a number of complementary tools such as: the *IDM Best Practices Road Map for Coaches*, the *IDM Computer Program*, the *Best Practices Check-In Forms*, the *IDM Logic Model*, and a wide variety of general health-related resources. These resources and more are available from the IDM Best Practices website at <www.idmbestpractices.ca>.

The wonderful people who contributed to the Best Practices Project (1997-2002) are mentioned on the next page. To the many people who have contributed to IDM ideas, materials and dissemination since 2002 my very special thanks. In particular, for ongoing support in a variety of ways, I give heartfelt thanks to: Evan Morris, EcoTech Research Ltd; Peggy Schultz, Ontario Prevention Clearing House; Mary Cerré, Public Health Agency of Canada, Ontario and Nunavut Region; Nora Sellers, Centre for Health Promotion, University of Toronto; and Irv Rootman, University of Victoria. Please also note the continuing work of: the Francophone IDM Best Practices Steering Committee, led first by Hélène Gagné (now with Cancer Care Ontario) and

currently by Christiane Fontaine (Ontario Prevention Clearinghouse); and of Michael Goodstadt, Centre for Health Promotion, University of Toronto.

I hope that those of you reading this Introduction find the *IDM Manual* and other IDM resources of use in your efforts to improve the health of the populations with which you are working. Please feel free to contact me with feedback or questions about the IDM and IDM materials.

with best wishes to all of you,
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♦ **IDM Evidence Framework reviewers:** David Rosenbluth, Evan Morris, Lisa Brownstone, Mary McNutt

♦ **Resources which stimulated ideas and insights:** numerous resources were reviewed and undoubtedly have influenced the contents of this Manual (most are included in the resources sections of the IDM Best Practices website at <www.idmbestpractices.ca>)

OVERVIEW OF THE IDM & FRAMEWORK

This overview summarizes the IDM approach to best practices.

IDM definition of best practices

Many different definitions of best practices exist, depending on who is doing the defining. The *IDM* definition of best practices in health promotion or public health follows.

> Best practices in health promotion/public health are those sets of processes and activities that are consistent with health promotion/public health values, goals and ethics, theories and beliefs, evidence, and understanding of the environment, and that are most likely to achieve health promotion/public health goals in a given situation.

Underlying premise of the IDM

> The underlying premise of the Model is that the quality and value of practice depend on the degrees of awareness, discussion, clarity, and reflection associated with each of its domains and sub-domains (values, goals, ethics; theories, beliefs; evidence; understanding of the environment; and practice).

The IDM's underlying premise is explained below using violence against women as an example:

♦ *importance of awareness*: If we're not aware that violence against women is an issue we won't do anything about it.

♦ *importance of discussion*: If we don't talk openly about violence against women with others we are restricted in what we can do about it.

♦ *importance of clarity*: If we are unclear about who violence against women affects, which factors influence it, and possibilities for dealing with it, we won't address it effectively.

♦ *importance of reflection*: If we don't reflect on our thoughts, knowledge and activities related to violence against women, we won't improve in our efforts to address it.

IDM in brief

At its heart the IDM is very simple. When asked in workshops what influences decision making, people identify a wide sweep of factors which inevitably fall into the broad categories of values, theories, evidence, and the environment (ranging from the physical to the political). These categories, including practice itself, correspond to the IDM domains and sub-domains:

- ◆ **Underpinnings** includes the sub-domains of *values/goals/ethics*, *theories/beliefs*, and *evidence*. Our underpinnings are our "foundations," which influence us even when we are not consciously aware of how we define or prioritize them.
- ◆ **Understanding of the environment** includes sub-domains of *vision* and *analysis* of organizational and health-related issues. Our environments include social, political and economic structures and systems, and physical and psychological conditions, at group, organizational, community, regional, national, and international levels.
- ◆ **Practice** includes the sub-domains of *addressing issues* — related to the organization and to health — and *research* (including evaluation). Practice is composed of processes, activities and strategies.

The diagram on the next page shows the domains and sub-domains existing in the context of the broader environment. Domains and sub-domains are interactive; each influences and is influenced by the others.

According to the IDM, our practices will be "best" if they are consistent with and reflect health promotion or public health underpinnings and understanding of the environment.

what the Model looks like

The Interactive Domain Model Best Practices Approach to Better Health
Kahan & Goodstadt 2005 (revised from 2001 version)
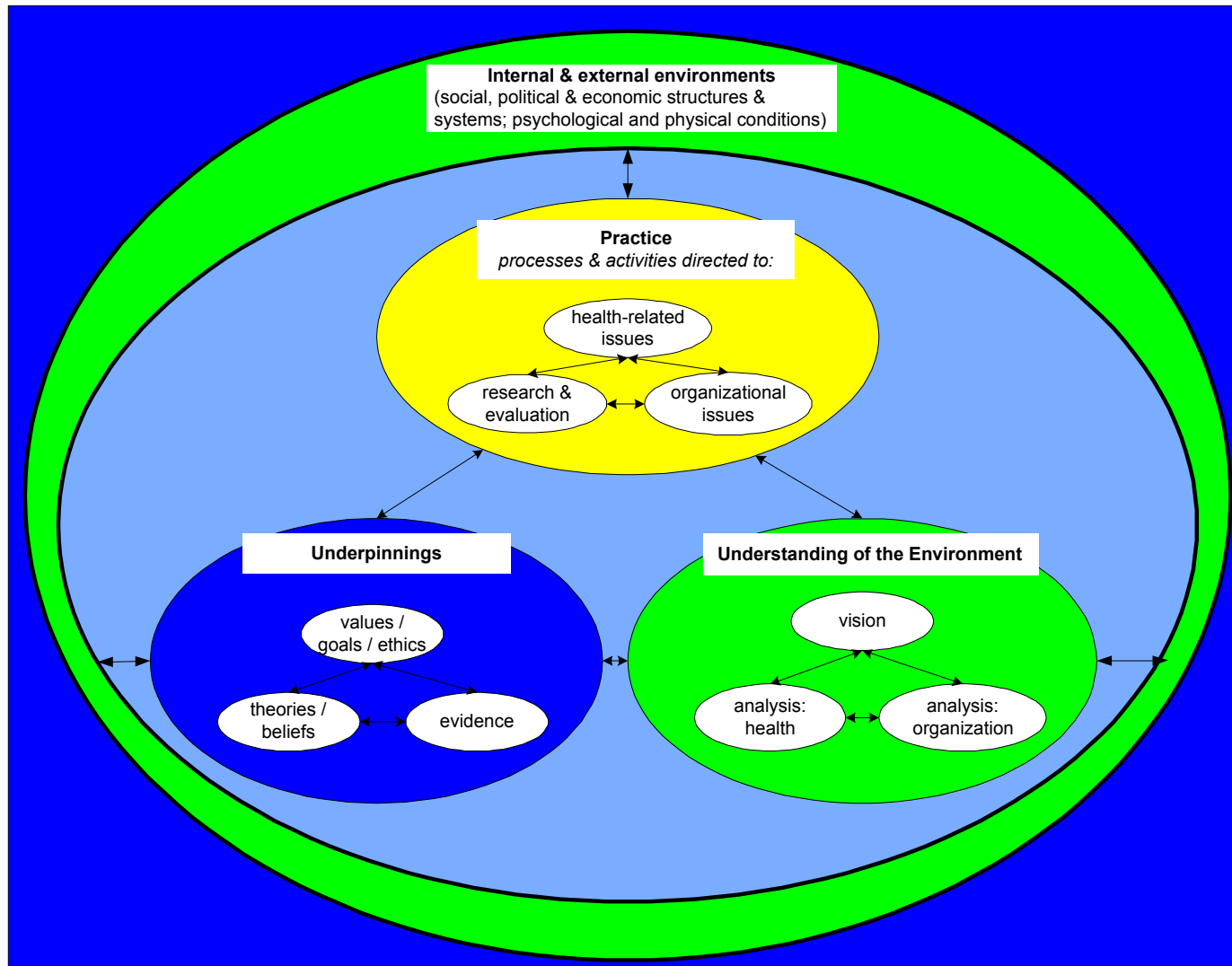
IDM Framework in brief

The challenge facing practitioners is, first, to identify and define our health promotion/public health underpinnings and understanding of the environment, and, second, to apply these to our practice. This is where the IDM Framework comes in.

The IDM Framework, the practical application of the IDM, is a multi-purpose change and decision-making tool for practitioners and organizations in any situation who want to pursue a best practices approach to health promotion or public health. Using a health promotion/public health filter to ensure that practice is consistent with health promotion/public health underpinnings and understanding of the environment, the IDM Framework can help to:

- increase understanding of health promotion/public health
- increase communication and "team build"
- build capacities and supports
- increase sensitivity to local conditions
- make sound decisions and policies
- plan, implement, evaluate, and revise activities and programs
- achieve health promotion/public health goals

The Framework leads us through a process where, from the perspective of health promotion/public health values, goals, ethics, theories, beliefs, evidence, and understanding of the environment, we answer the following questions about our activities and programs:
- Where are we now, where do we want to go, and what guides us?
- How do we get to where we want to go: Who does what, when and how?
- What did we do, how did we do it, and what were the results?
- What do we need to change in order to move forward?

IDM Framework steps are best used organically rather than linearly, that is, according to the demands of our particular situation and how we work best rather than in a set order.

what the IDM Framework looks like

	Step 1: Prepare Foundation for Action re. selected issue			Step 2: Make Action & Evaluation Plan *How do we get to where we want to go: Who does what, when & how?*				Step 3: Implement, Reflect & Document		Step 4: Revise
	general guidelines *What guides us?*	current situation *Where are we now?*	picture of ideal situation *Where do we want to go?*	specific objectives to achieve ideal	resources	challenges	evaluation plan	activities & processes *What did we do? How did we do it?*	outcomes of activities & processes *What were the results?*	revisions *What do we need to change?*
UNDERPINNINGS										
values										
goals										
ethics										
theories										
beliefs										
evidence										
UNDERSTANDING OF ENVIRONMENT										
vision (organizational)										
vision (health)										
analysis (organizational)										
analysis (health)										
PRACTICE processes/activities										
address issues (organizational)										
address issues (health)										
research/evaluation										

The steps along the IDM Framework's top help us to: prepare a foundation for action; develop an action/evaluation plan; implement, reflect and document; and revise. Down the side of the Framework are the IDM's domains and sub-domains, that is, underpinnings (values, goals and ethics, theories and beliefs, evidence), understanding of the environment (vision and analysis), and practice (addressing issues, and conducting research and evaluation). These act as a health promotion/public health filter for the Framework steps.

The application of the IDM to practice involves constant questioning and reflection:

♦ What are our health promotion/public health underpinnings and understanding of the environment?
♦ How well does our practice match our underpinnings and understanding of the environment?
♦ How can we increase the consistency between practice, underpinnings and understanding of the environment?
♦ How do our processes, activities and outcomes relate to each other, and how can we improve them?
♦ What resources do we have to draw on and how can we maintain and enhance them?

> To effectively use the IDM Framework requires:
> ♦ a cooperative effort by everyone involved to determine areas of agreement and difference for each sub-domain
> ♦ a process to address differences so we can: (a) constructively use the creative tension sometimes produced by differences; and (b) minimize possible negative effects
> ♦ an explicit definition for each major term or concept used (for example, for health, health promotion, public health, equity, empowerment) so we speak a common language
> ♦ processes to follow up on the results of ongoing reflection and evaluation to ensure continuous improvement

IDM Domains and Sub-domains

The IDM has three domains which exist in the context of the broader environment. They are interactive, that is, each influences and is influenced by the others.

Underpinnings

Underpinnings are one IDM domain. Underpinnings (or "foundations"), although often not visible, are at the very heart of practice. If we consciously identify, define and prioritize our health promotion/public health underpinnings and make our practice decisions consistent with them, we are more likely to achieve health promotion/public health goals than if our underpinnings remain unexamined. If we do not consciously examine our underpinnings, two things are likely to happen. One is that we will be unaware of what our underpinnings are and how they influence our practice. The second is that practice may be inconsistent with underpinnings; in other words, we may make practice decisions that achieve results incompatible with our underpinnings.

values, goals & ethics

Values, goals and ethical guidelines make up one of the sub-domains of underpinnings. **Values** are those things that are most important to us. Our values, if we are true to them, affect which issues we choose to address and how we choose to address them. For example, valuing social justice over individualism has obvious practice implications, such as a focus on reducing inequities and an inclusive participatory approach.

Goals are a translation of our values into concrete terms. For example, a goal associated with valuing social justice is to increase the extent of social justice in our community.

Our **ethical guidelines** provide direction for appropriate values-based conduct and decision-making. "Evidence-based practice" is a common phrase these days. However, **ethics-based practice** is also important. Values drive ethical practice directly, and also indirectly through

values-based evidence. As a result, to practise health promotion and public health in an ethical fashion requires that we clarify our values by identifying:

- ◆ our values and how we define and prioritize them
- ◆ the influence of context on our values
- ◆ how our values translate into ethics
- ◆ in which ways our values influence our definition, identification, and use of evidence

theories & underlying beliefs

Theories and concepts, and underlying beliefs and assumptions, make up another sub-domain of underpinnings. **Theories and concepts** range from the formal transtheoretical model of change to the informal explanations we give ourselves concerning life and work issues. Theories/concepts explain how and why things happen, and predict how things might happen; they can be simple or complex. The theories/concepts we adopt affect our practice choices. For example, if our "theory" is that health education is more likely to stop people from smoking than public policy, we will take more of a lifestyles than a structural approach to health promotion/public health.

Our **underlying beliefs and assumptions** include what we believe about human nature, how society works and changes, what kind of change is needed, where our self-interest lies, and how we learn and know. The nature of our beliefs and assumptions, like other underpinnings, has strong implications for practice decisions. If we believe that people often do not know what is best for them and need to be assisted by professionals, we will act quite differently than if we believe that people can solve their own problems if adequate supports are available. Underlying beliefs and assumptions do not necessarily refer to external/objective evidence.

evidence

Evidence is information which we deem to be high quality and appropriate enough to use in making our decisions. Questions which guide us in gathering this information may range from "How can we do a better job?" to "What resources exist in our community?" Our informal and

formal research methods to answer our questions may range from a few phone calls, if the question is simple enough, to a full scale study. The nature of evidence is strongly shaped by values, theories and beliefs. These other underpinnings determine the questions we ask, what counts as evidence, and the methods we use to gather, analyze, synthesize, and disseminate evidence. The IDM Manual's *Evidence Framework* and *Research & Evaluation* sections provide more detail on using evidence in practice.

Understanding of the environment

Understanding of the environment is another IDM domain, and includes the sub-domains of vision and analysis, with respect to our health-related and organizational environments. The environment strongly affects what we do, what we think, and how we interpret things. This makes it extremely important to step back and have a very close look at our environment, in terms of how it affects us — and how we in turn affect it. Our environments include social, political and economic structures and systems, and physical and psychological conditions, at group, organizational, community, regional, national, and international levels. To truly understand our environments in all their dimensions we need to have both a vision and an analysis of them.

Our **health environment** involves the environmental factors that affect individual, group, community and societal health. Our **organizational environment** involves the environmental factors that affect organizations. A major contributing factor to the degree of effectiveness of our daily work is the general supportiveness of the organizations with which we are associated.

What makes this domain difficult is that we may clearly see what needs doing but feel powerless to do it. However, from an IDM perspective, actively identifying the big picture of what needs doing along with the accompanying constraints, strengths and opportunities in our environment — and how our initiative fits with other initiatives — opens the door to creative thinking, to small steps that may lead to large changes, and to mutual support and partnerships.

vision of our environments

Having a vision of our *health environment* answers this question: What would our general environment look like if it were truly health-enhancing for all? Having a vision of our *organizational environment* answers this question: What would our organizational environment look like if it were truly supportive of our health promotion/public health practice initiatives? In both cases, developing a vision involves considering structures/systems and psychological/physical conditions (at group, organizational, community, regional, national, and international levels).

environmental analysis of our issues

Environmental analysis in the Model applies to both health-related and organizational issues. While the need for an *analysis of health-related issues* is immediately obvious, the need for an *analysis of organizational issues* is less obvious — but at second glance it becomes clear how we and the organizations we work with are affected, for better and worse, by a variety of environmental factors such as time, funding, morale, and power relationships. The logical conclusion is that a supportive environment for health promotion and public health practitioners and organizations would go a long way towards increasing practice effectiveness.

To achieve supportive environments requires that we identify and describe a number of things — related to health on the one hand and to the organization on the other:
♦ Which issues are priorities?
♦ What makes them priorities?
♦ Which of these priorities should we address first?
♦ In the environments in which our issues exist, what is the nature of social, political, and economic systems and structures, and psychological and physical conditions?
♦ Which factors contribute to the issues?
♦ How can we positively influence the issues?
♦ How can we enhance and build on the strengths related to our issues?
♦ How can we use our strengths to address the challenges related to our issues?

A complete analysis of our health and organizational environments requires that we look not just at local environments but at regional, national and international environments as well, because structures/systems and conditions at all levels affect the health-related issues in our specific situations; they also affect our organizational environment.

Practice

The IDM domain of practice addresses health-related and organizational issues and conducts research (including evaluation). The practice domain is the application of our vision and analysis of the environment and a reflection of our underpinnings. Practice includes activities, strategies and processes. Strategies are planned sets of activities for achieving specific ends, while processes are the ongoing actions undertaken to support our strategies and activities. In order to be consistent with and to reflect our underpinnings and understanding of the environment it is important to consider not only what we do in our practice, but how we do it (e.g. are our processes and strategies as empowering and capacity building as we would like them to be).

addressing organizational and health-related issues

Addressing organizational issues makes our organizational environment more supportive of us, thereby increasing the effectiveness of how we address health-related issues. Addressing organizational and health-related issues involves implementing selected processes, activities and strategies. To achieve best practices when we address our issues, the IDM requires that our processes, activities and strategies be consistent with and reflect health promotion/public health underpinnings and understanding of the environment. As mentioned before, it is not just what we do, but how we do it.

Examples of strategies for addressing organizational and health-related issues include: education, communication, organizational development and change, community change, advocacy, policy development, modelling, and mediation. The processes required to support the implementation of these strategies include: assessing, visioning, planning/revising, evaluating/reflecting, relationship building, skill sharing/capacity building, coordinating/cooperating, decision making, communicating, documenting, and managing resources.

In this sub-domain, if we use an IDM approach, we constantly check our practice choices against our health promotion/public health values, goals and ethics, theories and beliefs,

evidence, and understanding of the environment to ensure that our activities, strategies and processes are "best."

research

The IDM considers research (including evaluation) as a full and necessary partner to our efforts of addressing organizational and health-related issues. The section on *Research & Evaluation* provides more detail.

IDM FRAMEWORK STEPS

The IDM Framework has four basic steps. These are described in brief in the box below, and in more detail in the following pages.

Many practitioners will find the Framework steps familiar, especially the steps related to planning and evaluation. Each step is applied to the health promotion/public health filter of underpinnings, understanding of the environment and practice.

1. **First set of steps:** lay a *solid foundation* for our practice by:
   (a) identifying our general health promotion/public health guidelines: *What guides us?*
   (b) examining our current situation: *Where are we now?*
   (c) developing a picture of our ideal situation: *Where do we want to go?*

2. **Second set:** develop an *action and evaluation plan* to make our picture of the ideal a reality, defining the *what* and *how* (i.e. relevant activities, tasks and processes), the *who*, and the *when*, all with respect to:
   (a) specific objectives to achieve the ideal
   (b) resources
   (c) challenges
   (d) ongoing evaluation

3. **Third set:** *implement* our action and evaluation plan and *reflect on and document* what happens with respect to activities, processes, and outcomes/impacts. In other words:
   (a) *What did we do?*
   (b) *How did we do it?*
   (c) *What were the results?*

4. **Fourth step**: *revise* our picture of the ideal situation and action/evaluation plan, based on our evaluation and documentation. In other words, *What do we need to change in order to move forward?* In practice this step is ongoing and overlaps with the previous sets of steps.

Step 1: Prepare foundation for action

The IDM Framework's Step 1 includes identifying guidelines, our current situation, and what we would like things to look like in the future.

step 1a: guidelines

In this step we identify general health promotion or public health guidelines with respect to underpinnings, understanding of the environment, and practice, identifying in broad terms what health promotion and/or public health means to us. These guidelines assist us when we are doing other Framework steps: they help us to assess what we are currently doing (what should we keep doing? why are we doing it? what are we missing?). They also help us figure out what a picture of the "ideal" might look like in our specific situation (where do we want to go?).

In general, this step deals with the following topics:
♦ broad-based guidelines relevant to health promotion or public health
♦ definitions/descriptions for each guideline
♦ which guidelines are priorities and therefore override others in cases of conflict
♦ areas of agreement and difference amongst key stakeholders regarding guidelines
♦ processes to address differences and to regularly review/update guidelines

step 1b: current situation

In Step 1b we describe each of the domains (underpinnings, understanding of the environment, practice) and related sub-domains according to their current status, including what we are doing and what we are happy or not happy about. In other words, where are we now?

In general, this step deals with the following topics:
♦ the underpinnings, understanding of the environment and practice currently influencing the project or organization (whether acknowledged or implicit)
♦ current definitions and descriptions relevant to each sub-domain

- current strengths/resources/capacities
- concerns about the current situation
- areas of agreement and difference amongst key stakeholders (about definitions, descriptions, strengths, concerns)
- processes to address differences, and processes to regularly review/update definitions, descriptions, strengths and concerns

Step 1c: picture of ideal situation

In Step 1c we develop a picture of our ideal situation — that is, where do we want to go? — by drawing on our general health promotion/public health guidelines (Step 1a) and our description of our current situation (Step 1b).

In general, this step answers the following questions:
- In our picture of the ideal situation, what would each sub-domain look like if it was consistent with our general health promotion/public health guidelines?
- What do we want to incorporate from our current situation into our picture of the ideal? That is, which positive features do we want to maintain and build upon, and which concerns do we want to address?
- If pieces necessary to completing our picture of the ideal situation are missing, who should do what, and when, to attain the missing pieces?
- What are our areas of agreement and difference?
- What processes will we use to address differences, and regularly review/update our picture of the ideal?

Step 2: Develop action and evaluation plan

Step 2 of the IDM Framework involves consideration of objectives, resources, challenges, and evaluation ion order to develop an action and evaluation plan.

step 2a: specific objectives to achieve ideal

In this step we describe the specific objectives required to move us closer to our ideal picture (developed in Step 1c). In addition, we identify: the activities/tasks/processes needed to achieve these objectives, who will do what, and timeframes/timelines. We also define the indicators which will show us if we have met our objectives.

In general, this step deals with the following topics:
- ♦ specific objectives to achieve our ideal (taking into account consistencies and gaps between current and ideal, and current positive features and concerns)
- ♦ indicators for each objective
- ♦ tasks/activities/processes to achieve objectives
- ♦ who is responsible for each task/activity/process
- ♦ timeframe/timelines: in what order do we do our activities/tasks (which first, which second, which concurrently), when will we start and finish each one, how much time will each take, deadlines

step 2b: resources

In this step we identify the resources required for our activities/tasks/processes. Some resources are already available to us; others we have to develop or acquire. We need resources in order to meet our objectives, address our challenges, and evaluate; we may also need resources in order to attain those resources not currently available to us. This step is not just about the availability of resources, but about our ability to use them as efficiently and effectively as possible. For example, to fully benefit from a computer we need to know how to use all of its different functions.

This step also involves identifying the activities/tasks/processes required to attain and use resources, who will do what, and timeframes/timelines.

step 2c: challenges

In this step we identify challenges that may hinder attempts to meet our objectives for reaching the ideal, challenges related to acquiring and using resources, and challenges related to evaluation. This step also involves identifying the activities/tasks/processes required to address challenges, who will do what, and timeframes/timelines.

step 2d: evaluation

Integrating informal review and reflection and formal evaluation into every aspect of our work on an ongoing basis is necessary to improve our practice as much and as quickly as possible. In this step we identify priority evaluation questions, indicators to help us assess the answers to the questions, information sources, and methods (for gathering and analyzing information, and for reporting on, disseminating and addressing results), in order to:

- ♦ evaluate the validity of our ideal picture and effectiveness of our action/evaluation plan
- ♦ build into our daily work ongoing review of underpinnings, understanding of the environment and practice
- ♦ ensure that our practice, with respect to both activities and processes, is consistent with and reflects our underpinnings and understanding of the environment
- ♦ identify the improvements required to increase our practice effectiveness

This step also involves identifying the activities/tasks/processes required for evaluation, who will do what, and timeframes/timelines. It is critical to develop the evaluation plan at the same time as we develop our plans for meeting our objectives. If not, the quality of our evaluation will be seriously jeopardized.

Step 3: Implement, reflect & document

Step 3 asks us to implement the action/evaluation plan constructed in Step 2, and then reflect on and document what happens when we put the plan into practice. That is, regarding objectives, resources, challenges, and evaluation: what did we do, how did we do it, and what were the results or outcomes?

step 3a: activities and processes

This step looks at what we did and how we did it. Did we follow the tasks/activities/processes as outlined in the action/evaluation plan? What caused us to make changes? Which factors made it easy or hard to carry out each task/activity/process? What could we do differently to make it easier to carry them out?

step 3b: outcomes of activities and processes

This step documents outcomes (both intended and unintended), and links the outcomes to activities, processes and other factors.

Step 4: Revise

In Step 4 we revise our picture of the ideal and our action/evaluation plan based on our evaluation results, or on the basis of other information or feedback. We look at what we need to change in order to move forward, for example with respect to our specific objectives, or with respect to our activities and processes.

Interactivity of the Framework steps

While the Framework may look static on the page, in practice it is best used dynamically and interactively, in the same way that the domains it is based on are dynamic and interactive. The steps themselves, though presented in a sequence, in practice overlap, repeat, switch order, or continue parallel to each other rather than progressing linearly.

For example, although identifying health promotion/public health guidelines is placed in the first column of the Framework, people often find it easier to start by describing the current situation (the second column).

In addition, once implementation of developing the picture of the ideal situation begins, much of what was ideal becomes current and the process of working through the steps begins again through ongoing evaluation and revision. Although the steps for evaluation and revision have specific positions in the Framework, in reality they are integral components of each step along the way, informally if not formally.

FREQUENTLY ASKED QUESTIONS

Questions commonly asked about the IDM and the IDM Framework are answered below.

♦ With all those boxes in a table format, isn't the Framework too rigid for health promotion/public health work, which is all about people and not about straight lines?

> The Framework is shown in a table format to provide a clear picture of its component parts, and because tables help organize thoughts and material for many people. An option to a table format is to use the headings and follow a paragraph or point style.

> In addition, because the Framework challenges people to think critically about what they are doing and why, and to explore alternatives, with the right approach the Framework can encourage creativity rather than rigidity. One Framework pilot testing participant stated that one of the things she liked best about the Framework was that it forced her to think outside the box. Other participants stated that discussions outside the norm evolved as a result of using the Framework.

♦ Do we have to use the whole Framework?

> The Framework is just a tool. If we can incorporate the IDM into our work — practise health promotion or public health in a way that is consistent with and reflective of our underpinnings and understanding of the environment — without the Framework, then the Framework is not necessary. The Framework is there to help us *if we need it* and only *in whatever ways we need it*.

> Looked at as a whole the Framework can seem daunting. However, a nice thing about the Framework is that it allows us to break into small chunks the task of reflecting on our underpinnings, understanding of the environment and practice. We can't do it all at once even if we wanted to, there is just too much — the

Framework presents a process for picking a piece at a time, while maintaining a record of all the other pieces for when we are ready to look at them.

♦ How does the IDM fit with an evidence-based approach?

The IDM is an evidence-based approach in that it considers evidence a major factor in decision making. But it is more than an evidence-based approach because it considers a number of other factors to be important as well, including values and theories and understanding of the environment, and emphasizes how all these factors interact with each other. In other words, the IDM is also a values/ethics-based approach, a theory-based approach and an environmental approach. To focus only on evidence would lead to a narrow rather than an in-depth understanding of health promotion/public health issues, environments and practice.

♦ Who can use the Framework?

The Framework is meant for any health promotion or public health practitioner open to taking the time to critically reflect on practice. It is also relevant to those working in other fields if there is an overlap in the areas of concern. The Framework is a generic tool — it gives an outline but allows us to provide the content. It can be used with any range of issues, stages of program development, depth of understanding, type of organization, organizational level, organization role, or professional or practice backgrounds — as long as the commitment to using it exists.

- ♦ Why do we need the IDM Framework – aren't other planning tools out there that we can use?

    Other planning tools have some of the features of the IDM Framework, but none has all of them. The IDM Framework combines features from other health promotion/public health frameworks in a unique way to make it:

    - solidly grounded in health promotion/public health — taking fully into account health promotion/public health values, goals and ethics, theories and beliefs, evidence, understanding of the environment, and practice (including both processes and activities)
    - comprehensive — attending to all the major factors that influence practice
    - systematic — ensuring that nothing gets lost in the shuffle
    - reflective — thoroughly considering the pieces that often are left unexamined (i.e. the underpinnings of practice and understanding of the environment and their fit with practice), as well as ongoing review and revision of practice itself
    - generic — with wide applicability to a variety of circumstances
    - flexible — being wholly sensitive and responsive to the specific conditions of each situation
    - focused on both outcome and process issues — and the relationships between them
    - focused on both building capacities and constructively addressing challenges
    - optimize potential benefits and minimize potential risks

    In addition, it unexpectedly turns out that the IDM is more than a decision-making and planning and evaluation tool. Sites have found it helpful in a number of other ways as well, for example as a communication tool and a team-building tool.

- ♦ How do you know we wouldn't come up with the same results without using the IDM Framework?

    When asked this as part of a panel at the 2001 Best Practices Annual Stakeholders Meeting, one of the original pilot sites responded that as a result of using the Framework they had reached a higher level of analysis than they would

have otherwise, spent more time on planning, and put more stress on the internal environment — which was helpful to them in terms of managing and controlling it. Pilot testing indications are that using the Framework does make a positive difference.

♦ We have too much to do already — why would we want to spend time on the Framework?

> The best reason is that it will help us achieve our health promotion or public health goals. It is a way to make sure we don't overlook important factors, that we continuously reflect and improve, and that we take a holistic rather than a narrow approach to our work — in other words, that we put into practice our values and beliefs, and consider the evidence and our context. In addition, there is a good chance that the time we spend on it now will save us time in the long run. And, believe it or not, some people really enjoy using the Framework and find it energizes them!

♦ Even if we want to use the Framework, where will we find the time in our overwhelmingly busy workdays?

> There are three ways to look at this:
> 1. Use the Framework to complement or replace rather than as an extra. In this way, it adds value to what we are already doing. For example, most of us already spend time planning. In that sense, using the Framework for planning is time we already have to spend.
> 2. Recognize that to benefit from its full potential, we may need to put a fair amount of time into the Framework in the beginning — but as one site pointed out, it is a case of short term pain for long term gain. Initially, discussing, organizing, refining and documenting our thoughts may take a while — but once completed, future reviewing will go quickly. Also, much of our thinking will be transferable if we want to use the Framework with another program.

And, if by using the Framework we increase the effectiveness of our work, we will save time down the road and have a greater impact on our particular issue.

3. Understand that the Framework can be used superficially or in-depth. In fact, it is probably best to do a quick run-through in the beginning rather than attempt to be comprehensive, possibly bogging ourselves down in details. As time goes on we can refine and add details, especially if we schedule regular times to work on the Framework. Scheduling blocks of time in advance protects that time. There is no reason why the Framework can't be done in planned stages.

♦ The IDM looks really complex and overwhelming — is it possible for most of us to get a grip on it and use the IDM Framework effectively?

While at first sight it may appear daunting, when using an adult education approach in workshops it is clear that people have an intuitive understanding of the IDM as a result of their own practice experiences. The application piece is more challenging. However, it is like any new skill, whether learning to walk, read, use a computer, nurse, teach — at first it is hard because we have to use muscles or parts of our brain we maybe didn't even know we had — but as we practise, the skill becomes more familiar and at a certain point, if we persevere, it becomes second nature. According to some of the original pilot site members, eventually you internalize the process. One of the benefits of working in a group is that we have a combination of strengths to draw on, and through group discussions the Model becomes clearer as group members share their insights.

♦ How can we use the IDM when working with community members — aren't the language and concepts too complicated?

The complexity of the IDM is one of those double edged swords, a strength and a challenge. The strength is that it reflects the complexity of life where numerous

factors and influences interact with each other all the time in all sorts of combinations; the IDM may be many things but it is not a reductionist approach. As one site member stated, the IDM is like an eco-system, and no matter where you start, you end up with all of it, because everything relates to everything else.

The challenge is that the complexity sometimes makes it hard to know where to start, what to do with it all, and how to present it. When working with anyone, community members included, presentation is often the key part. We don't have to start out with models and tables, which many people don't like. And we can make an effort to use plain language. People are social beings and generally like to talk and discuss things.

There are simple "IDM questions" that can get the ball rolling and result in a wealth of information which can help continue the Framework process. Examples of IDM questions include: What are we doing and why are we doing it? What do we value most? If we could have any wish granted, how would we like things to be? What things in our lives — people, organizations, skills — do we find most helpful? What solutions have we discovered to problems we have had that we could share with others?

In addition, as a tool which assists us to identify all the major pieces relating to our health and organizational issues and how they work together, use of the IDM Framework deepens our understanding of the complexity which surrounds us, helping us to grapple more effectively with it — as long as we approach the Framework in bite size pieces rather than attempting to swallow it all at once.

♦ Everyone is at such different levels regarding experience and understanding, how is it possible to work together on the Framework?

Again according to original pilot site members, the Framework helps people work towards a common understanding of terminology, health-related ideas, and health and organizational issues. On the same panel mentioned before, some members stated that the Framework helped people with different backgrounds

and levels to work and learn together as a group, brought cohesiveness and shared understanding to the group, and provided an opportunity for interdisciplinary and community movement towards shared values.

♦ Taking account of diversity is so central to health promotion/public health work; in what ways does the IDM reflect diversity, or is it suitable only for mainstream groups?

The IDM and its Framework, being very flexible, accommodate and reflect diversity extremely well, and are therefore suitable for all groups who want to use them. While the IDM and its Framework outline *categories* of major domains and sub-domains for groups to consider, they do not dictate the *contents*. For example, while the IDM and Framework stress the importance of each group identifying and defining their health promotion values and including them in practice, they do not specify what these particular values are. And rather than insisting everyone should agree with each other on every point, the Framework recommends identifying the range of agreement and differences among key stakeholders and working with that in whatever way stakeholders think best. Particular care was taken in the design of the Framework to make it adaptable to a variety of groups and situations, as practitioners who participated in the initial best practices scan made it very clear they did not want a cookie cutter or "one size fits all" approach.

Even the table format of the Framework is not a necessity, but can be modified to whatever format works best for any particular group; working through the Framework does not have to be done in any set way, but is flexible enough to allow a wide variety of approaches.

While a suggested set of guidelines is provided, this should be viewed as an example, and accepted, rejected or revised depending on the perspective of the particular group. In fact, any group using the IDM Framework is encouraged to develop their own health promotion/public health guidelines; this will result in

guidelines which are more meaningful and applicable to the particular situation, and truly reflective of diversity.

♦ Why do we need to bother with the first column, that is, developing a set of general health promotion or public health guidelines?

Having a set of general health promotion guidelines serves a number of purposes. We can use it as:

- a checklist to identify all important elements in our current situation
- a "measure" to help us assess our current strengths (resources, capacities, what works well) and challenges (concerns, barriers, gaps)
- a selection of options for us to choose from when we start to paint a picture of the ideal appropriate to our specific situation
- our own broad-based definition and understanding of health promotion/public health, usable with any program or initiative we are working on