The IDM Manual

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

♦ Reports on Using the IDM ♦

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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.

- The views expressed herein are solely those of the authors and do not necessarily represent the official policy of the Department of Health (nor the Public Health Agency of Canada). Les vues exprimées ici sont uniquement celles des auteurs et ne représentent pas nécessairement la politique officielle ni du Ministère de la Santé, ni de l'Agence de santé publique du Canada.
- 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.

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ABOUT THIS SECTION

This section of *The IDM Manual* contains on the IDM in action. Note that formatting in reports is as close to the original formatting provided by presenters as possible. A list of reports included in this section follows:

- Report on the English- and French-language activity timeline related to the IDM/MDI, presented as part of a poster display at the Workshop on the Canadian Best Practices System for Chronic Disease Prevention in March 2005.
- Reports at the Best Practices Project Annual Stakeholder Meetings from sites who participated in the original pilot testing of the IDM Framework (reporting March 2000 and 2001) and/or in the "Bridging the Gap Between Research and Practice" project, (reporting March 2002). Some of these sites also reported in September 2004 at the session on Best Practices at Home and Abroad. These sites included:
  - East End Community Health Centre
  - Brant Community Health Care System/The Willett Hospital
  - Durham Region Health Department
  - Peterborough County-City Health Unit
  - Sudbury and District Health Unit
  - West Hill Community Services
  - Womankind Addiction Services
  - Access Alliance Multicultural Community Health Centre
- Report at the 2002 Annual Stakeholder Meeting from a project which used the IDM Framework independently of the Best Practices Project to review primary prevention interventions for type 2 diabetes.
- Report on the use of the IDM by the Association des communautés francophone de l'Ontario – Toronto at the 2004 session.

See also the brief case study in:

- *The Interactive Domain Model of Best Practices in Health Promotion: Developing and Implementing a Best Practices Approach to Health Promotion*. Kahan, B., & Goodstadt, M. (2001). Health Promotion Practice, 2(1), 43-67.

BEST PRACTICES PROJECT

Best Practices Project Timeline 1996-2004

This timeline for activities related to the Interactive Domain Model (IDM)/Modèle des domaines interactifs (MDI) — the focus of the Best Practices Project — was compiled by Barbara Kahan (Member, Centre for Health Promotion, University of Toronto) and Christiane Fontaine (Consultant, Ontario Prevention Clearinghouse). It was presented as part of a poster display at the *Workshop on the Canadian Best Practices System for Chronic Disease Prevention* (Toronto Canada, March 10-11, 2005).

1996-1997

- Practitioners at the International Symposium on the Effectiveness of Health Promotion express a desire to actively participate in resolving issues related to evaluation and effectiveness of health promotion.
- The Centre for Health Promotion, University of Toronto, creates the Continuous Quality Improvement (CQI) Work Group; members represent a variety of sectors:
  - public health units
  - community health centres
  - hospitals
  - community groups
  - provincial government
  - federal government
  - academic institutions
  - private sector
- Health Canada, Population and Public Health Branch (now Public Health Agency of Canada, Ontario and Nunavut Region), funder of the Symposium, also funds the next five years of what becomes the Best Practices Project.

- CQI Work Group Members clarify their understanding of concepts and practices related to CQI and how CQI might contribute to health promotion practice.

1997-1998

- A literature review and synthesis by one of the members results in two background papers (on CQI and best practices) for reference use by the CQI Work Group.
- Members decide to become the Best Practices Work Group.
- Members participate in a series of hands-on workshops. Through these workshops they explore best practices, in the process identifying potential benefits and risks and developing their own set of best practices principles.

1998-1999

- The original best practices Model evolves. It is now based on three interactive components or "domains" which exist in the context of social, political, psychological, and physical environments: underpinnings (values, theories, evidence), understanding of the environment, and practice (addressing organizational and health-related issues, and research and evaluation).
- A Framework, designed to implement the Model in practice, is developed. It contains a cycle of steps which are applied to the Model's domains. The Framework's questions are:
  — Where are we now?
  — Where do we want to go?
  — How do we get there?
  — What guides us?
  — What did we do?
  — How did we do it?
  — What were the results?
  — What do we need to change?
- A set of suggested guiding principles and criteria or guidelines is drafted.

- The Work Group conducts an Ontario scan of practitioners' needs and capacities regarding best practices, using interviews and a survey.
- A years-long series of national and international workshops, presentations and consultations begins with groups ranging from the Ontario Public Health Association to the International Union of Health Promotion and Education.
- The Centre for Health Promotion's Best Practices Work Group joins with the Association of Ontario Health Centres and the Ontario Public Health Benchmarking Partnership to form the Best Practices Partnership.

1999-2000

- The Best Practices Partnership pilots the draft IDM approach (based on the Model and its operational Framework) with three Ontario sites:
  — Durham Region Health Department
  — East End Community Health Centre (Toronto)
  — The Willett Hospital (Paris)
- Facilitators consult extensively with each site to take into account local internal and external conditions. As a result, focus issues and processes for working through the Framework vary from site to site.
- Facilitators conduct workshops and provide supporting materials to introduce basic concepts. In between workshops site participants work to develop their own frameworks, contacting the facilitators as required when questions arise.
- Positive pilot test results include:
  — for the approach: confirmation that the Model and Framework are flexible enough to be used in different situations, in different ways, and for different purposes; and, identification of ways to improve IDM processes and materials (e.g. gaps to fill, concepts to clarify, explanations to reword, exercises to reorganize, essential supports to put in place)
  — for one or more sites: increases in knowledge, skills, understanding, group cohesion, consensus, enthusiasm, systematic planning, credibility, and ability to

identify and address work-related issues (e.g. clinical vs. non-clinical perspectives, restructuring, funding)

- Possible negative/lack of impact on individual pilot sites include: volunteer disaffection, resistance, no change in planning process.
- Based on facilitator and participant observations and evaluation results (group discussions and written feedback) the Framework and materials are modified.
- The Francophone sub-committee is formed, with a mandate to adapt the Interactive Domain Model (IDM) to the Franco-Ontarian context. Members include representatives from academic, government and community sectors. What is currently the Public Health Agency of Canada, Ontario and Nunavut Region, provides funding.

2000-2001

- The Francophone sub-committee conducts a needs assessment to document the needs of Francophone practitioners and their capacities and interest regarding best practices in health promotion.
- The Ontario Hospital Health Promotion Network joins the Best Practices Partnership.
- The first version of the IDM Manual for Best Practices in Health Promotion is produced.
- The peer-reviewed journal Health Promotion Practice publishes an article explaining IDM Best Practices key concepts.
- Following a suggestion from one of the original pilot sites, the IDM Computer Program is developed.
- The Ontario Ministry of Health and Long Term Care funds the development of an IDM "bridging the gap between research and practice" learning module. Six sites participate:
  — Access Alliance Multicultural CHC (Toronto)
  — Brant Community HealthCare System (Paris and Brantford)
  — Peterborough County-City Health Unit

— Sudbury and District Health Unit
— St. Joseph's Healthcare, Women's Detox and Mary Ellis House Treatment Program (Hamilton)
— West Hill Community Health Centre (Toronto)
Results are positive.

2002-2004

- The Francophone sub-committee:
  — adapts and translates into French the IDM Manual and article
  — develops French-language IDM training modules
  — conducts three workshops with 30 participants from health and education sectors and community-based groups in Sudbury, Ottawa and Toronto
  — develops a website which makes resources available: <www.opc.on.ca/francais/nosprogrammes/centre/projets/meilleurespratiques.htm>
- Individuals continue to support the IDM on a volunteer basis, for example by:
  — producing the IDM Best Practices Road Map for Coaches and Best Practices Check-In Forms
  — developing and maintaining the IDM Best Practices website: <www.idmbestpractices.ca>
  — developing and maintaining the Best Practices in Health Promotion website: <www.bestpractices-healthpromotion.com>
- Organizations continue to support the IDM, for example:
  — the Centre for Health Promotion, University of Toronto maintains a Best Practices section on its website and sponsors the session Best Practices at Home and Abroad
  — Ontario Prevention Clearinghouse/Centre Ontarien d'information en prevention (OPC/COIP) English- and French-speaking consultants network with and provide consultation to others regarding IDM/Best Practices work, and the OPC/COIP Health Promotion Resource Centre hosts the francophone IDM website.

- Groups continue to use the IDM, for example:
  — The Association des communautés francophone de l'Ontario - Toronto, which has a multi-cultural membership and is volunteer based
  — Womankind Addiction Service, a new approach to women's addictions which provides a complete range of services in one place
- The IDM continues to influence models and frameworks being developed by other groups, for example:
  — The IDM was "an insightful resource in developing this Nova Scotia Best Practices Framework."
  — "The IDM informed the best practices work we did at the AOHC [Association of Ontario Health Centres], particularly the principles piece."
  — "The development of 'Core Domain #2 - The Underpinnings of Best Practices' [in a not yet released practice framework] was inspired and influenced significantly by the [IDM]."
- The international community shows interest in the IDM.

PILOT SITE REPORTS 2000-2004

Access Alliance Multicultural Community Health Centre 2002

Best Practices in Health Promotion Project
5th Annual Stakeholders' Meeting – March 26, 2002

Sonja Nerad, Community Health Programs Manager
Access Alliance Multicultural Community Health Centre
Toronto, Ontario

Participants and Issues

- Health promotion staff – food security
- Project staff – best practices research in homelessness and diabetes prevention
- Volunteer/Communications Coordinator – developing a volunteer program

Learnings

- The volunteer program means different things to different staff within the organization (ie: charitable model vs community development model) and decision making re: the direction of the program needs to take into account organizational values and mission
- Have just engaged in a process for other issues – no learnings yet

Project Impact

- Being exposed to the model validated that which we do intuitively as a part of the planning process and helped us be more systematic
- Helped us create an organizational culture that recognizes the importance of research and actively creating space and time to do research

- Supported us in moving towards organizational goal of becoming a learning organization and use best practices and evidence to provide leadership as an immigrant services organization
- Provided us with a logic model (Interactive Domain Model) and tools (worksheets) to help us link research to our practice by linking our values and mission to the research process as well as empirical and community evidence
- helped the organization develop its capacity and knowledge regarding research and "good" models for research – better positioned to contract with consultants

Challenges

- Most of our work is done in networks/coalitions, is responsive mainly to funding pressures (ie: Early Years) and it is not viable to implement a formal planning model
- Planning model contravenes funder criteria (ie: funding for early years programs was followed by funding for a comprehensive community needs assessment that needed to be completed in 2 months)

Brant Community Health Care System/The Willett Hospital

2000

The Willett Hospital

Best Practices Project Report

Description of the Local Context

Located in Paris, The Willett Hospital is a small rural hospital that serves, for certain services, the "Natural Community" surrounding it. The area includes all of Brant County, and some of the surrounding townships in Oxford County and the Regional municipality of Waterloo. The catchment area population served is approximately 115,000.

The Willett provides chronic, short term acute and palliative care services, ambulatory services including urgent care, laboratory and diagnostic imaging services, as well as in and outpatient therapy services, and outpatient counseling. Over the years, a hallmark of the Willett has been its creativity in meeting the needs of its community, and providing outreach services in conjunction with the Community Well Being Team (CWBT). The CWBT is a committed group of volunteers who help to identify community needs, develop and deliver programmes based on those needs.

Over the last 18 months, The Willett Hospital and Brantford General Hospital have come together as the Brant Community HealthCare System. Many of

existing programmes and services are being integrated. In the new system, The Willett has a newly appointed Vice President of Community Integration with responsibility for developing Primary Health Care Services.

Our working team for this project included interested staff and managers, and members of the Community Well Being Team. We chose Teen Health as our topic for this project.

RESULTS

There has been a significant impact within the organization as a result of this project. Health promotion thinking now has a higher profile in the organization. The project allowed the team to step back, and develop a team vision, values, principles and goals. There was considerable skill enhancement for staff and volunteers.

We developed two goals, specifically with regards to teen health and determining the needs and capacities of The Willett in relation to teen health (team development, development of a budget, recognition of the need for staff resources etc). Partnerships were developed with McMaster University second year nursing students, the local high school staff and parent council. A teen volunteer group is working on a needs assessment.

The Community Well Being team (CWBT) began to see itself in a newer role, with a change in focus and approach. The CWBT is planning a retreat, expanding its membership and revising its terms of reference. Despite the complexity of the project, the staff and volunteers have a greater appreciation for what is required in programme development.

It became obvious during our work on this project that considerable work needed to be done at the organizational level to lay a strong foundation of health promotion principles. Timing is opportune as we develop the Primary

Health Care portfolio. A framework is now being developed that has health promotion at its heart. Planning will be carried out at the board level, and our goal is to give leadership in the Brant Community Healthcare System as a health promoting hospital.

Factors that Facilitated and/or hindered

We found Barbara and Michael's guidance, teaching and support over the course of the project invaluable. Our broader understanding of health promotion helped us think about all the work that we do, and we have systematic approach to doing a gap analyses. We have health promotion resource binder that we continue to use as a resource. Several of the worksheets and templates helped us to fill out the framework. Working on an evidence based model gives our work needed credibility in the hospital system.

Meeting with the other site leaders gave us support, encouragement and ideas!

Internal environmental factors gave us most of our challenges. Over the last six months, restructuring and system integration had a significant impact on staffing resources. There were many pulls on staff time, and we had difficulty finding time to work on the framework between Barbara and Michael's visits. For some of our staff, the demands of clinical work drew from their ability to work on the project. As well, the CWBT staff/liaison left our organization, as did some of our volunteers. Implementation of our Teen Health project programme will be delayed due to staffing issues.

We learned from our volunteers that we needed to provide much greater support for them to participate. Our expectations of the volunteers probably exceeded their capacities. The amount and level of information given as well as the time commitment needed overwhelmed them. Staff had insufficient time or full recognition of the amount of support needed.

There was a broad range of understanding of health promotion among our group members, and competing paradigms within the group. A benefit of the project was to enhance skills of the group, and to come to some common agreement around values, goals etc. as a group.

With regards to the framework itself, we had some difficulty understanding the categories and what fit where. A working example helped us to fill in the model. Fitting this all on paper using our computer programmes was time consuming.

Plans for the Future

We drafted a workplan for the project needs assessment. One staff member continues to work with university students and teen volunteers to work on community needs assessment, including key informant interviews. We developed several templates to help complete the project. Lisa Connelly is working with the local high school principal, and Parent Council.

The Willett is recruiting new staff to provide community programming, and will provide additional support for this project.

In the Primary Health Care Portfolio, we are incorporating health promotion values in its developing framework, and will continue to give leadership in this area.

2001

Brant Community Health Care System

Best Practices Project Report

2000-2001

Setting the Context

The Willett Hospital participated as a pilot site from September 1999 to March 2000. We selected Teen Health as the topic to work through using the IDM model, and developed two goals:

- To determine the capacities, resources and attitudes of the BCHS with respect to teen health and related issues.
- To determined and nature and priorities of teen related issues.

During the pilot testing, we worked with our Community Well-Being Team to record our health promotion values and beliefs, which was an invaluable exercise. Many of these have been incorporated in our Primary Health Care Team statement of beliefs and values. As a result, the members of our team function in the three domains of

- Clinical practice (incorporating health promotion philosophy)
- Health promotion activities, and
- Participating in and/or leading community initiatives.

The teen project has focused primarily on assessing the needs of teens using a teen led process and partners including McMaster University, Grand River District Health Council, Paris District High School, Brant County Public Health Unit, with the ongoing support of the Centre for Health Promotion.

We are in the early stages of developing a project to address mental health needs of rural youth.

The IDM Framework

The Board of Governors from the two facilities, Brantford General Hospital and The Willett Hospital, along with staff and senior management participated in a strategic planning day, and agreed to the principles of and to work towards becoming a Health Promoting Hospital. The IDM Framework was presented to the group during the planning day. Strategic planning related to this is ongoing.

We are familiar with the computer version of the IDM, and find it more user friendly than the paper version. We will use this version of the IDM in the further development of our teen health project.

As a result of the visioning we did during the IDM pilot-testing project, health promotion practices form the foundation of our Department of Primary Health Care Development. The portfolio continues to expand to include a variety of disciplines and departments. The focus of much of our activity this last year has been integration between the two hospitals, and building our team. While this has prevented us from proceeding further with the IDM, we have succeeded in laying excellent groundwork through team consolidation and collaboration with many departments in the larger hospital system. We are therefore much better positioned to give leadership in the area of best practices in health promotion.

The Centre for Health Promotion continues to provide outstanding telephone advice and mentoring, and Michael and Barbara provided an IDM workshop for BCHS staff and community partners.

Our work in Best Practices is highlighted in the BCHS in last years' as well in the upcoming Operating Plans to the Ministry of Health, two project funding proposals, and at an Insight Conference on Primary Health Care.

We are working with Paris Primary Care Reform Project by helping to develop their health promotion goals, and hiring staff with health promotion interests and abilities. We also conduct health promotion activities and provide support to their staff. We recently held a joint training session on the IDM framework with the PrimaCare Nurse Practitioner and our own experienced and new Primary Health Care team members.

Plans for the Coming Year

Our team is continuing to work on the area of teen health, and is in the beginning stages of a concrete project plan. The IDM will help guide us through the project.

Over the last six months, the BCHS has further developed its organization quality improvement processes based on it corporate goals. Our Primary Health Care Team has developed community indicators for regular reporting to the board. At the next meeting of the Board Quality Improvement Committee on March 28, we are presenting the IDM, and our plan for further using the IDM during 2001/2002. We see using this tool as an integral part of quality assurance.

The BCHS is preparing for accreditation in 2002. With the incorporation of community indicators in hospital accreditation, our continued work with the IDM will be provide good documentation of an evidence based health promotion approach. A focus over the next few months will be to apply the IDM to current and future projects.

We see a potential for IDM application is in the development of community wide activities. Key partners in Brant County are developing county-wide health goals based on the County Health Status Report. For example, we know Brant County has a high incidence of falls in seniors. The hospital and PrimaCare, along with the Health Unit are currently working on a social marketing campaign. We could use the tool to identify our values and beliefs, evaluate evidence, and develop a coordinated approach in the county. A community wide initiative such as this, including many partners and strategies could use the tool at a broader project planning level, as well as individual partners using it to develop their particular strategies.

Summary

The work we did during the initial phase of the IDM project gave an excellent kick-start to the development of a health promoting Primary Health Care Portfolio in an otherwise traditional hospital system. Our team uses the health promotion values and beliefs we developed last year as our underlying principles. We believe that the IDM is a values based planning tool and is unique, innovative, and invaluable.

While we have not actively used the tool in the last few months, our focus has been on education about the IDM, and

the development of our team and partnerships as a strong foundation for its future implementation.

We are incorporating the IDM in our current project planning initiatives, quality improvement, and accreditation preparation.

We look forward to continued involvement in its broader applications.

Respectfully submitted

Dilys Haughton
Director
Primary Health Care Development

2002

Quality of Work Life (QWL) Project

Brant Community HealthCare System

Project Background

In Fall 2001, the "Quality of Work Life" working group was formed as a sub-committee of Patient Satisfaction Team for the newly integrated Brantford General and Willett Hospitals (Brant Community HealthCare System). The mandate for this team is to address areas for improvement as noted in the

Standardized Hospitals of Ontario Patient Satisfaction Survey (SHOPSs). Patient satisfaction, as measured through the SHOPSs survey, involves a survey of individuals who were inpatients and outpatients in Ontario hospitals in recent months.

The Quality of Work Life working group was initiated as a Quality Improvement Initiative to:

- Improve understanding of the relationship between quality of work life and patient satisfaction
- Evaluate and make recommendations to the Senior Leadership Team to improve the quality of work life for all Brant Community Healthcare System staff, physicians and volunteers.

Team membership comes from Community Relations and Marketing, Physicians, Nurses, Managers, Directors, Organizational Development and Project Management staff, Volunteer Services, and Human Resources.

The Quality of Work Life Project is seen as an important link with patient satisfaction as well as an important issue for recruitment and retention of staff.

The goals of the group include:

- Researching & developing a rationale that QWL directly impacts productivity, effectiveness and patient satisfaction.
- Ensuring that initiatives to improve QWL are implemented and assessed.
- Creating ways by which all staff can provide input into QWL committee.

Much of our time to date has been spent identifying the current situation in the hospital, investigating initiatives already under way and reviewing literature and internal surveys. The team has hosted two staff appreciation breakfasts and is currently organizing a “Parents Night Out.”

Knowledge and Insights Gained

The focus group provided an opportunity to discuss the organizational and resource capacities, and barriers and challenges. We began to complete a work sheet that identified health promotion criteria, the current situation and began to identify the health promotion ideal.

We discussed how individual group members used research and evaluation in their own practice. A new health resource centre and librarian are seen as a tremendous asset. Many staff has desktop access to the Internet. The culture of our organization is moving towards a "best practices" approach. With the integration of three distinct cultures due to amalgamation of three hospitals, it was agreed that it would take time to establish a culture of shared values and beliefs. Barriers and challenges included the fact that not everyone placed the same value on research; "lack of time", "attitude to research", and "access to research materials" were noted.

During the education day, the group learned more about health promotion beliefs and values, and the IDM model. A web search in the afternoon provided some immediate resources. The resource manual is now located at both hospital sites, including the health resource centre. The group is very comfortable finding evidence and developing a Best Practice Model. We will continue to develop expertise in evaluating the quality to health promotion evidence.

What we learned about the chosen issue, and challenges encountered.

The question our team has chosen to address is: "How do you foster a culture that facilitates a healthy balance between work and home?

Healthcare workers are among the most likely employees to feel overworked. The Quality of Work life committee understands the importance of a supportive work/life culture and is committed to initiatives that foster a balanced work/life environment. The Brant Community Healthcare System's own work/life initiatives, and the experience of other public and private

employers, demonstrate that positive human and business outcomes can be derived from a supportive work/life culture. Scholarly research, and research findings at other institutions, confirms the measurable benefits that result from a positive work/life environment.

Considerable evidence supports the benefits of promoting healthy work practices and encouraging employees to adopt healthy lifestyle choices. In a hospital setting, QWL is a complex issue consisting of many variables in the work environment. The scope, complexity and unpredictability of the roles and responsibilities of healthcare providers present unique challenges for the implementation of QWL initiatives. Additional research will be conducted to determine the feasibility of incorporating a "quality of work life" statement into employee service descriptions.

Helpful resources

Several sources of primary and secondary research were employed:

- Literature reviews
- Websites (National Quality Institute (www.nqi.ca); JobQuality.ca (www.jobquality.ca)
- Internal surveys (Change and Transition Workshops; I Care Program; Nursing Practice Council Practice Setting Consultation)
- Networking and contacts who provided additional resources (Wellness Works; e-network (www.cprn.org); Ontario Health Promotions Bulletin (www.ohpe.ca)
- Benchmarking / Site Visits

2004

IDM *Framework*: The Brant County Experience

Dilys Haughton (Brant Community HealthCare System; now with Shalom Village Nursing Home, Hamilton)

Report presented at the session Best Practices at Home and Abroad, September 20, 2004, Toronto Canada.

Context

The use of the Interactive Domain Model (IDM) took place in the context of two hospitals integrating and a third hospital closing, and the initiation of a new portfolio Community Integration which was to provide health promotion and ambulatory clinical services across three sites. Our task was to figure out what this new "creature" would look like.

The project

The group which worked with the IDM was the Paris Community Well Being Team, composed of health promotion and interdisciplinary clinical staff and community members. To conduct a community needs assessment regarding Teen Health in a rural context, this Team joined in a partnership with the local municipality, McMaster University School of Nursing, Brant County Public Health, the school board, and the newly created Brant Community Healthcare System.

Challenges

Challenges in piloting the IDM were that it was a big commitment and taxing for the volunteers involved, and that completing the Framework is time consuming. Environmental challenges identified were getting understanding and buy-in from management and staff, a scarcity of resources, and financial constraints.

What worked well

What worked well in the "underpinnings" domain of the IDM Framework was that the pilot project group exercise formed the foundation for the new portfolio — a very important and enduring accomplishment. Doing the underpinnings started the ball rolling. The IDM process allowed us to work with different people. In the "understanding of the environment" domain the IDM Framework helped us understand and manage the internal and external enabling and

obstructing factors. In the "practice" domain, the concrete results were a rural health initiative with Health Canada funding, an impact on inner-city population health, and diabetes services being delivered in a new way.

Outcomes

Outcomes for the organization were that the IDM process helped our vision of the new portfolio became a reality. We were able to demonstrate a new way of doing business — the hospital working with community. In addition, an integrated/systems approach to rural health care was developed with health promotion as a core business. And, with Health Canada funding, the Community Well Being Team was expanded. An evaluation was conducted, and there are now sustainable rural well being teams.

Two years later, the website — <www.bchsys.org> — has a new look, which incorporates some of the work we did with the IDM. In particular, the Mission Statement states explicitly that *"We will focus on health promotion."* Another part of the Mission is *"working in partnership"* and the Vision is *"A healthier community is at the centre of everything we do."* Values, something else we worked on with the IDM, are *"Trust, Respect, Integrity."*

Personal impact

Working with the IDM was a turning point for me, with values based practice becoming very important. When I changed jobs, I looked for an organization that had a strong values base and found it in the A.T. H.O.M.E program at Shalom Village Nursing Home, which provides a change to traditional long term care. It provides a setting with values and beliefs clearly identified and practised:

- Acknowledge
- Together
- Home
- Organization
- Memories
- Enablement

Durham Region Health Department

2000

DURHAM REGION HEALTH DEPARTMENT BEST PRACTICES REPORT

Description of Local Context

Durham Region Health Department serves an area of 1,600 sq. km. to the east of Toronto, encompassing 8 municipalities. Durham Region's population is approximately 480,000. The area is characterized by a variety of communities. A series of major lakeshore urban communities contrasts with a variety of small towns, villages, hamlets and farms in the north.

The health department has implemented an annual smoke-free home campaign for the last 3 years. The Ministry of Health's Mandatory Health Programs and Services Guidelines require that we expand our program to include smoke-free cars.

Results

As far as the planning of our initiative is concerned, it is difficult to assess what kind of impact the best practices framework has had. The working group feels that the plans to date are probably similar to what we would have developed using our own program planning methods. It may have made the planning of our focus groups more rigorous in comparison with our previous work in smoke-free homes. We felt that participation in this project gave us permission to be more rigorous. We were also influenced by the paucity of information regarding smoke-free cars, whereas there was useful information available about smoke-free homes.

Our current program planning process does not incorporate an analysis of the internal environment nor recognize its impact on our work with the exception of financial and human resources. Best practices lends credence to the importance of the internal environment and the need to strategize for this. It also highlighted the differences across the department with respect to health promotion and the conflict within the department that can arise as a result.

Within the working group there is a difference in people's experience and background in health promotion. The focus on the health promotion ideal i.e. criteria, guidelines etc. was beneficial in that it gave all staff in the working group a common understanding of health promotion. This process

was very energizing for the group and reaffirming of the work that we do. As a result, the working group has suggested that our program annually review health promotion best practices criteria and guiding principles. As well, we have suggested that the orientation program include information about health promotion principles.

The best practices project has had the support of the senior administration of the health department from the beginning. There is a willingness within the division to consider incorporating the framework into the program planning process currently being used by our program. We hope to share this experience, though it remains to be seen how it will impact on program planning across the department. The working group feels that with the best practices framework there is a greater likelihood of consistency with health promotion ideals in program planning. It is also possible that it may open dialogue around a common understanding of health promotion theory and may assist the department in reaching consensus in our definition of what is meant by best practices.

Factors That Facilitated and/or Hindered

Time was a factor that hindered our ability to use the framework. We felt there was a lack of time to reflect and to discuss it among the group between meetings. We did not have a block of time to work on it on a continuous basis, and

felt that being more immersed in the framework would have facilitated our progress.

We realized that we should have filled in the framework as we went along. It was difficult later to relate the steps to each other and to remember what we had discussed.

It was time-consuming and frustrating to put all of the information down on paper in so many columns. It is our belief that a computer program would be very helpful in this process.

It was difficult for us to know what information was being sought in some of the columns because the probes were unclear. We realize that the researchers have taken steps to improve the clarity of the framework and we recommend that they continue to make it more user-friendly.

Due to staff changes, both of our recorders have not continued with the group, resulting in gaps in our notes. It also may have been more difficult for staff who missed sessions with the researchers to use the framework.

The researchers' facilitation was helpful and we would have benefited from more time with them.

Written materials were helpful. The updated version that we received on March 2 was the most helpful.

Plans For The Future

We will continue to use the framework to complete the smoke-free car project. We hope to incorporate the best practices framework into the present method of program planning used by the Heart Disease and Cancer Prevention, Teen Pregnancy and STD Prevention program. We discussed with the researchers the possibility of their continued involvement with us as we incorporate the best practices framework into our annual program planning.

2001

Durham Region Health Department
Best Practices Report
March 26, 2001

Description of Local Context

Durham Region Health Department serves an area of 1,600 sq. km to the east of Toronto, encompassing 8 municipalities. Durham Region's population is approximately 480,000. The area is characterized by a variety of communities. A series of major lakeshore urban communities contrasts with a variety of small towns, villages, hamlets and farms in the north.

The Health Department has implemented an annual smoke-free home campaign for the last 4 years. The Ministry of Health's Mandatory Health Programs and Services Guidelines required us to expand our program to include smoke-free cars. As a pilot site, we decided to use the Best Practices Framework to plan our smoke-free cars initiative.

Lasting Impacts of the Best Practices process

As a result of working through the framework, the team members enjoyed a shared understanding of the underpinnings of health promotion. This shared understanding positively guided us in our work and continues to influence us in our ongoing planning.

The internal environment has always impacted on the work that we do and we have accepted it as the context in which we do our daily work. The framework encouraged us to do an analysis of the internal environment and to identify the areas that we could and could not change. As a result of working with the framework we have become more pro-active with planning strategies designed to help us manage our internal environment.

There has been an increase in team cohesiveness through the shared experience of working through the challenges and celebrating successes that arose from the Best Practices Framework. Individual group members had high levels of energy at different times which allowed them to take the lead in carrying the group through the process.

As practitioners of health promotion we are appreciative of being involved as a pilot site in this process which will ultimately lead to shaping the future of health promotion. Our working group's involvement has resulted in dissemination of new information to our colleagues.

In December 2000, Barbara and Michael conducted a workshop for our program to introduce the underpinnings domain of the Best Practices framework. The Health Promotion and Disease Prevention program consists of 12 working groups staffed by public health nurses and public health nutritionists working under three managers. We have received positive feedback indicating that other colleagues within our program respect the work that we have done on best practices and consider it to be of value.

Some members of our program have expressed interest in learning the best practices approach in order to determine how it might guide their initiatives. In addition, our operational plan includes the development of a process to disseminate information about the Best Practices framework to other divisions within the Health Department.

Insights and Observations

Utilizing the best practices framework fully is a complex process which has proved to be very time intensive.

Navigating the planning process using the Best Practices Framework can be individualized to best suit the needs of the group. The process is not rigid – more than once we developed sub-steps and worked backwards so as to make everything flow.

The framework will be very helpful to the field of health promotion to establish a foundation and a common language and ideology. At this point in the framework's evolution it is too complex to be easily managed. At times we found it was not clear what was required in each box as the concepts are abstract and difficult to understand. A high level of support from the researchers was required on an ongoing basis and with this support we were able to successfully work through the framework. As a pilot site, we are confident that our input will contribute to making the framework more accessible and user-friendly to anyone working in the field of health promotion.

Recommendations

It is important to realize that there is no set direction in working through the framework. It may seem difficult at times to work without specific direction but eventually the ability to move freely within the framework enables the planners the find the most effective means of working through it.

Working on the framework is a group process as it would be difficult for one individual to work through the framework alone. However, we also recognize that it lends itself to small committed groups (ie. 3-5 people).

We recommend that as the framework evolves the abstract nature of some of the explanations around using the framework be clarified. The background information sheets need to be more user-friendly and provide concrete examples written in plain language.

We found that we made the most progress within the framework when we dedicated a block of time to work through the process. It takes time to "gear up" and get into the process of working on the framework and if blocks of time pass, momentum is lost. We recommend that any group working on the process take time to examine their group dynamics in order to plan the most optimum use of their time. Once a group begins work on the process, we recommend dedicating a set block of time in order to complete the framework.

East End Community Health Centre

2000

East End Community Health Centre
Best Practices Pilot Project

F I N A L R E P O R T

March, 2000

THE CONTEXT

East End Community Health Centre (EECHC) is located in a mixed income, culturally diverse neighbourhood in the eastern most part of the old city of Toronto. Like other CHC's, we offer a range of primary care services and are also involved in community development initiatives that address the broad social determinants of health.

Our hope in participating in the pilot project, was that Best Practices (BP) framework would help us to clarify some very fundamental issues that we grapple with daily such as:

- how it is that we understand and use evidence in our practice
- how we document and share our learnings and not re-invent the wheel
- how we can apply rigour in our analysis and determination of what strategies we should be pursuing with limited resources
- how we can remain true to our core values

The framework was applied to two of the Centre's strategic priority areas: heart health and food security.
Both of these areas were ones that we were having difficulty with and it was felt that the framework could facilitate a rethinking of the issues related to them and help us move forward.

A multidisciplinary team of staff was involved in the best practices pilot project including: the Executive Director (part of the time)., a Nurse Practitioner, a family doctor, a dietician, chiropodist, health promoter, community health worker, Program Co-ordinator, and a board member.

RESULTS TO DATE

There have been a number of concrete results that have been achieved to date. We have:

- developed new partnerships and made important contacts
- developed a clearer understanding of, and terms of reference for multi-disciplinary program teams
- explored and applied for funding
- significantly refocused our direction in the area of food security to include a stronger emphasis on advocacy and income security.
- Because of the discussions, analysis and research that we have engaged in, we are well on our way to developing sound and coherent heart health and food security programs that have a strong results-based orientation.

What is difficult to determine, at this point, is how much of this progress was due to the framework itself and how much owed to simply working as

a multidisciplinary team in a systematic way. Perhaps a broader piloting of the framework and the benefit of hindsight will enable us to be clearer about this.

HOW THE FRAMEWORK HAS BEEN HELPFUL

A) *The framework has been useful for us by offering a systematic & comprehensive way of addressing critical elements related to health promotion practice.* It has enabled us to reflect on these factors in combination. In doing this, the complex and occasional contradictions between different elements have emerged. (e.g. A key value for us is our commitment to working with the most marginalized in our community. This is labour intensive and takes time. Because of this, it is in many ways at odds with our external environment where there is very real pressure to see more and more people and where success and indeed legitimacy are often measured in terms of number of people served).

B) *The framework also requires that participants define and articulate key concepts and theories that underlie our work.* This has included discussions regarding, for example, how we define prevention, how we understand a social justice vs. charity model in doing our work and how we define evidence-based practice.

What has emerged from these discussions, is a strengthened understanding of health promotion principles and how these need to be present in our work.

C) *The process clearly highlighted areas where we tend to be weak – the gaps.* It didn't take long for themes to emerge and these have been used as important starting points for action.

For example, in our heart health program, the following gaps emerged:

- Our lack of knowledge of the literature/coalitions/what's working in the area of heart health
- The need to work more effectively as a multi-disciplinary team Through this process, we have been able to de-construct why, for example, clinical staff feel their 1:1 work is more valued, recognized & supported than their involvement in community programming. We have also discussed what is appropriate involvement of clinical staff in programming and how is it that we can develop an interdisciplinary team and also are efficient and make the best use of people's skill sets.

- A third theme that emerged through the process was our collective discomfort with the fact that many heart health programs appeared to have a strong lifestyle orientation and because of this seemed to "miss the boat" in terms of addressing the more fundamental basic needs of poor people. We identified that this may have been a factor that has contributed to our historical inaction in this area. And, that any programming that we pursue has to recognize and address income disparity and how this influences people's ability and desire to participate in programs.

The framework hasn't made these issues any less difficult or complex, but it certainly has provided us with a way of defining, and articulating

these issues and developing short & long-term strategies to address them. In this way, it is an important capacity-building tool.

ISSUES AND CHALLENGES FOR EECHC IN USING THE FRAMEWORK

A) *The main challenge for EE participants in using the BP framework was that the relevance for action and practice was not evident enough – this was particularly the case during the initial diagnosis phase of the framework.* For example, participants questioned the value of engaging in broad and lengthy discussions regarding health promotion and wanted instead to move quickly to identifying the gaps and changes required

B) *Participants felt that there were some redundancies in the framework and some confusion about how to fit our reality into the boxes.* In general, it was felt that the framework needed to be simplified if the hope is that it is used and usable by community-based organizations.

C) *The framework assumes a fairly high level of literacy – this has implications for community involvement.* Although this wasn't an issue for us during this pilot project, community members *are* often part of our planning processes. Given that one of the core values of East End and CHC's in general is to foster participation, particularly among those who are marginalized, there needs to be more thinking about how the tool can be used inclusively.

D) *Time is one of the major barriers that will discourage some agencies from embarking on this process.* It is ironic in that taking time to do careful and thoughtful planning and having clarity about why we're doing what

we're doing, can in the long run actually save us time and help us achieve greater efficiency and effectiveness. However, the reality, as we know, is that people working in the "front line" are completely 'maxed' out. And given this reality, it is important that we find different ways of adapting & using the tool so that it can be used by organizations that don't necessarily have big blocks of time to set aside to do this work.

Rapid action-oriented tools such as checklists – may better serve front line organizations with limited resources for extensive planning.

E) *A continuing challenge is to find ways of using the framework dynamically.*
Its linear format doesn't always invite the kind of iterative thinking that needs to happen. In our case, we got bogged down in what needed to go in what box. Then we started using the tool in different ways – moving in different directions, skipping some of the boxes if they didn't feel relevant, and even moving off the matrix entirely when we needed to. As we took greater ownership of the process and, in a sense, made the framework our own, the experience became increasingly energizing and productive.

This is partly a statement about any type of theoretical constructs or models– they're not a panacea - they are tools that will be more or less useful at different moments in an organizations history. Mostly, they need to be shaped and adapted differently so that they don't become static, filed blueprints but instead –living and dynamic frameworks that can continually respond to new information and the chaos in our environments.

FUTURE DIRECTIONS

We will continue the process of developing our heart health program plan based on the strategic areas of focus that were identified through the best practices pilot process. For food security, we may try to continue to use the framework in order to clarify programming directions in this area. We would also like to stay abreast of the health promotion best practices debates and literature and seek out and foster various methods of incorporating a best practices culture within our organization.

2001

Report on Using the IDM Framework at East End Community Health Centre

The initial process of pilot testing the IDM Best Practices Framework resulted in an action plan for our Heart Health program. Over the last year we have been implementing this plan and making headway - we collected a great deal of necessary information and have been working on developing partnerships and implementing a variety of initiatives, with positive results so far.

The Heart Health "best practices team" has met only a couple of times as a whole group over the last year. While each meeting was helpful in terms of sharing information and moving on with our action plan, it is clear there are still issues such as: maintaining an integrated clinical/non-clinical heart health team, limited health promotion resources, and the challenge of evaluating our efforts. It is possible that by going through a "mini" Framework process, we might come up with other approaches to address these issues.

Due to time pressures, staff turnover, etc., we have not formally reviewed the Framework in the last year. However, we have found that informally we have integrated much of the Framework thinking into how we approach our work. For example, while we always did pay attention to things such as theory and evidence, we now do it much more systematically, comprehensively and routinely.

Overall, we still feel a year later that the Framework process was helpful to us, would like to continue using it, and would recommend it to others. That we were able to modify the Framework and use it flexibly to suit our needs was an important feature of the IDM model.

Peterborough County-City Health Unit 2002

"BRIDGING THE GAP BETWEEN RESEARCH & PRACTICE"

Centre for Health Promotion
University of Toronto

Stakeholder's Report from: Peterborough County-City Health Unit (PCCHU), Wellness Opportunities in the Workplace (WOW) program.
David Fell, Health Promoter

1)Our research question for the best practices project had been tentatively set as: "When we come to the barrier of income (as a determinant of health), in relation to health (issues, nutrition, tobacco use, etc.), in the workplace (setting), what do we do?"

The phrasing of our question seems awkward. Instead of trying to finalize one specific question to answer, our group tried to incorporate all of the relevant components of the question into a diagram. (See attached)

A subset of related questions, that have influenced the choice of this particular issue, in this program, at this time: Is it sufficient to offer lifestyle health promotion programs (heart health, tobacco, physical activity, etc, awareness, behaviour change, supportive environment) in low income workplaces, in light of local data and research evidence identifying income as a determinant of health? By entering and engaging low income employers/workplaces, are we violating ethical values and principals of health promotion? IE. Should we refuse to offer programs unless certain criteria are met? Does public health have a role in addressing income as a determinant of health in specific workplaces? How should we balance the weight of rights/responsibility between individuals and corporations for poor health outcomes related to income? What works in addressing income as a determinant of health in

specific workplace settings - as opposed to individual intervention strategies and public policy? In light of dwindling program resources (WOW staffing level is down to 2.5 days a week), do we need to prioritize regarding target audiences in workplaces, ie. Should low income workplaces be our first priority? What can we do anyway?

2) What we learned about our issue.

History of issue in health unit - Awareness of income as a determinant of health has existed for some time in the public health field. Individual programs in public health (nutrition, tobacco prevention, substance abuse prevention, heart health, etc.) have grappled with this issue on an ongoing basis. Lots of evidence is available regarding the link between low income and poor health outcomes, as well as some evidence regarding successful intervention strategies.

History of issue in community - Social planning councils (and other groups) have worked on income issues on a variety of levels: education, research, advocacy, policy change, etc. on an ongoing basis. Lots of evidence to support these strategies. Health and social service agencies also deliver programs and services in response to income issues at the individual level: employment training, housing, income supplement, etc. Income as an issue in community is being addressed (adequately or not) at both the individual and community level.

History of issue in workplace health promotion (WHP) - WHP has been around for about 15 years. Local public health initiatives initially focused on: getting access to workplaces; building the business case for employers; putting together an evidence based intervention strategy; building partnerships to generate access to workplaces; learning about the unique aspects of the workplace as a setting (generic MBA issues), and bringing together the diverse internal and external components of a comprehensive, coordinated strategy - family friendly workplaces, lifestyle issue based health promotion, work/life balance, employee assistance programs, organized labour perspective, organizational culture, work related stress, occupational

health and safety, leadership strategies, etc. With increased access and increased amount of local data on the health of employees (health data on approx 2000 local employees), obvious trend emerged which mirrors determinants of health literature - employees in low income workplaces have poor health status compared with employees in higher income workplaces. Local eg's: higher than average # of employees paying more than 30% of income for housing, over 80% smoking rates compared with 23% of Canadians over age 15 who smoke.

We uncovered two important issues in our cursory review of the literature/evidence: 1) A more thorough literature review of the evidence should be conducted by someone with an academic background and a mandate to research this issue; 2)We have probably uncovered a need for more primary research on this particular topic - there is a research/evidence gap. What is missing from the evidence is some form of clear "conceptual control" regarding the links between: income as a determinant of health, workplace health promotion theories, and the fact that specific workplaces are the source of low wages.

3) Has this project made a difference regarding our knowledge, skills, practice, attitudes, awareness, ways of working together, regarding research/practice?

Yes in all areas. Put this specific issue legitimately on the radar screen. Provided overview of how ideal process might work. Helped us to create a network of like minded practitioners both internally/externally. Helped us to identify many of the organizational barriers that prevent us from successfully translating research into practice. Created an example of how internal teams/groups can overcome institutional barriers. Increased sharing of information/knowledge internally, both with regard to specific issue and research/practice skills in general.

4)Insights/recommendations.

Need to balance thoroughness of process (going through all of the worksheets in sequential order), with practice realities (time, resources, skills,

etc.). ie the process needs to be both comprehensive and easy enough for practitioners to use.

There are not a lot of opportunities for practitioners to inform or participate in the setting the research agenda.

Communities of practice need to be established both within organizations and across the country in order to promote the research/practice process. Share stories, build case studies, strategize about removing organizational barriers, etc.

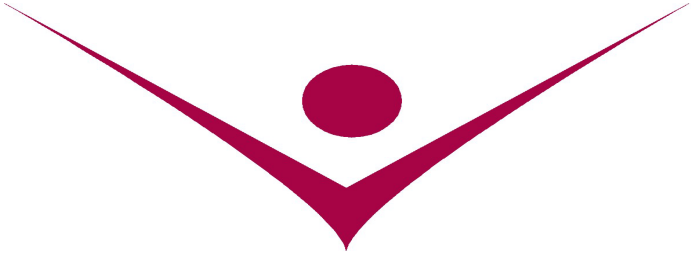
Sudbury & District Health Unit

2002

[this report taken from PowerPoint presentation]

BEST PRACTICES

The Sudbury & District Health Unit Experience!



Sudbury & District Health Unit

Service de santé publique

Sudbury and District

Demographics

Sudbury District	**City of Greater Sudbury**
Population: 22,894	155,219
Land:38,350	3,354
Population Density:	46 per square kilometer
Private Dwellings:	68,690

Sudbury in Comparison To Durham and York

- Durham Regional
- Population 506,901
- Land area 2,523
- Total Private Dwellings 175,738
- Population Density 201 per sq Km.

- York Regional
- Population 729,254
- Land area 1,761
- Total Private Dwellings 229,239
- Population Density 414 per sq Km.

Sudbury

- Average age: 35.9
- Mother tongue: 65% English, 28.7 French
- # Aboriginal 9,190
- # Lone parent families: 14.7%
- Unemployment rates: 12% male, 13% female
- Major industries include retail trade, health and social services, mining.

Sharing Our Experience With Others
The SDHU Experience

The Issues and Questions

- Breastfeeding

  In what ways can we increase the # of public places with supportive breastfeeding policies in order to empower women (increase awareness, increase confidence, take actions) to breastfeed in public places.

- Comprehensive School Health
  - ♦ In what ways can we encourage schools to adopt a comprehensive school health approach in order to improve the health and learning of school aged children.

- Physical Activity
  - ♦ What characteristics do recreational facilities have to have to increase an adults (ages19-55) ability to take control over increasing their physical activity levels

Answering the Questions

- Gaps in the literature/limited research
- Few policies regarding breast feeding in public places.
- Learned about the international experiences in comprehensive school health

The Learning Module and its Impact

- Systematically Organized
- Identification of research that pertains to question and health promotion values can be difficult.
- Expanded knowledge of the information databases.
- Identified who the key players are in our organization with respect to best practices
- Learned about the best practice process identified by Barbara and Michael.
- Health Unit believes it is important and is taking small steps forward.
- Participants are more open to the idea and concept of best practices.
- Reminds us that we need to analyze the internal factors. Once identified we can start to overcome them.

Insights and Recommendations

- Spend the time to develop and define the question.
- Have a question that is focused and have stakeholders involved.
- Get buy in from others.
- help you assess the literature in relation to HP.
- Increases the value and importance of qualitative research.
- Using the research/ BP process helps "make the case" to our managers/funders.
- In order for organizational buy in regarding the BP process involvement of upper management needs to take place.
- When first carrying out this process, take an approach that limits it to one question per organization.
- Process of critically reviewing and incorporating research into practice not intimidating, if follow a systematic approach.
- Clear understanding of the time commitment and dedicate staff to meet the objective.
- The Learning module is not "practical" in our environment (i.e. time consuming).
- Include BP as part of the program planning process with dedicated time allotted

2004

Best Practices: The Sudbury & District Health Unit's Experience

Ghislaine Goudreau (Sudbury and District Health Unit)

Report presented at the session Best Practices at Home and Abroad, September 20, 2004, Toronto Canada.

Context

Sudbury and district has a large land area. Distance can become a barrier for some. Population density for Sudbury and district is 4.1 people per square kilometre compared to 414 and 201 per square kilometres for York Region and Durham Region respectively. According to 2001 Statistics Canada information, the average age of Sudbury and district's population is 35.9 years of age, 65% have English as their mother tongue and 28.7% French, 9,190 members of the population are Aboriginal, 14.7% of families are headed by a lone parent, and unemployment rates are 12% for males and 13% for females, which is higher than the provincial unemployment rates. Major industries include retail trade, health and social services, and mining.

Part of the Sudbury and District Health Unit's underpinnings and understanding of the environment are its Mission Statement and Vision Statement. Its Mission Statement is *"Working with our communities to promote and protect health and to prevent disease."* Its Vision Statement is *"Working with our communities to promote and protect health and to prevent disease."* Accomplishing this vision is based on our ability to build on the following strengths:

- Collaboration
- Innovation
- Confidence
- Passion
- Reflection
- Effective communication
- Caring leadership
- Commitment

Also part of the Vision Statement is that *"We are recognized for our dedication to excellence and for breaking barriers to improve health."*

Sudbury and District Health Unit (SDUH) is working towards best practice. The Unit is a PHRED (Public Health Research and Education Development) site, committed to program evaluations and research, generating and using evidence through systematic reviews and benchmarking. It has four Health Promoters to facilitate the best practice process, who work with community, practitioners and researchers.

Successes and challenges of using the Interactive Domain Model (IDM)

The successes of using the IDM include:

- Increased awareness of Health Promotion Best Practices
- Increased knowledge of the interconnected pieces of health promotion
- Increased usage of evidence based research
- Increased number of community consultations

Since the IDM model was introduced in 2001 to the SDHU, we have achieved several Best Practices outcomes.

There are a number of challenges involved in working with the best practices:

- The first challenge is time constraints and the fact that the Model appears overwhelming; many practitioners feel that the model is huge and too time consuming. Some of our practitioners have difficulty finding time to complete a logic model. The IDM is not practical for the doers. One couldn't just pick up this model and start using it. There needs to be training or someone to facilitate the process. It is not realistic for every HP practitioner to use this model. The ideal person in our health unit to facilitate the process is the Health Promoter. We can work with all the key stakeholders, the community, health promotion practitioners and the researchers.
- At our Health Unit we do not have a standard definition for Best Practice. Many of us have best practice ways of doing things but have never put words to it. In Ojibwe "Best" Practice may seem arrogant and competitive. The closest term for Best Practice is Biimaadiziwin — doing things in a good way. I like the health promotion best practice definition but the term itself is daunting.
- What the field considers to be a best practice may limit spontaneity and creativity. Where do instincts fit in? Where do new and innovative programs fit if there is no supporting literature?

- The Ontario Ministry emphasizes a Logic Model which is different from the IDM Framework. We need a universal Health Promotion Best Practice model.
- We have a large mass of land to cover. Those travelling don't have time to do research or access to research. However, they know their community well. Balance is important.

Best practice examples

These projects have utilized elements of the IDM model:

- Working Poor Project
- Comprehensive School Health Program
- Community Based Physical Activity, Nutrition and Health Weights Program
- FOCUS Community Project
- Tobacco Program

Qualities and impact of the IDM Model

The question is: Has this project made a difference to us — the participants — concerning research/practice? The answer is that it has given us a systematically organized method to approach research on any given topic. It is important to note however that not everyone thinks systematically and that health promotion is holistic.

The IDM is systematically organized, comprehensive and validating. Health promotion encompasses a culmination of intricate processes that must be considered. This model demonstrates the complexity of health promotion which has many aspects to consider. And, although we are not performing a medical procedure, health promotion is complex and as effective at helping people.

The IDM is a credible reference and resource tool as all the key elements of health promotion are included in the Model, and it is accessible right on the internet.

It would be a great exercise for every health promotion practitioner to go through the entire Model and work with all the pieces of the puzzle, like when I was taking statistics and they made me go through the entire equation to understand it in detail.

However, many health promotion practitioners would not have time to go through the entire Model every time. The IDM may only realistically be utilized for big projects.

Although the IDM has been challenging to use, it is like climbing a mountain, and it has been worthwhile to get to the top.

Recommendations

I have two recommendations regarding the IDM:

- Train the Health Promoters at the Sudbury and District Health Unit to facilitate the IDM process.
- Include Best Practice as part of the program planning process with dedicated time allotted.

West Hill Community Services 2002

Health Promotion Best Practice Summarization for West Hill Community Services

Summary Report

West Hill Community Services is a multi-service, Ministry funded, agency in the East End of the City of Toronto. Our agency provides comprehensive community based services within a specific Scarborough encatchment area extending from 401 /Lake Ontario between Markham Rd and the Pickering border.

Our clientele is diverse. We have a high population of seniors, new immigrants & refugees who may use motel rooms for interim housing, youth & children. We service clientele with or without health cards. At the moment our new immigrant and refugee status clientele constitutes approx 70 % of our case load and in most situations are deemed as being high risk, low income, individuals with complex health and/or social issues.

Some of the services provided by our organization are as follows: transportation, congregate dining, health promotion initiatives (both internally/externally), meals on wheels, personal and homemaking services, tax clinics, primary health care, food bank, clothing/furniture bank, social services, finding residency for the homeless, volunteer services, and family resource programming. We strive to establish partnerships with other key stakeholders within the community as well.

West Hill Community Services embarked on this exciting project with the University of Toronto with the objective to explore **how to best implement and utilize** evidence based practice within the organization . The key stakeholders for this specific project included our Executive Director, ECE, Social Worker, Early intervention worker, Nurse Practitioner, Registered Nurse, Integrated Services Co-ordinator for the agency. We were looking for a health promotion framework which could provide us with the tool(s) we

needed for funding proposals, future program planning, program evaluation, and how to enhance our current practice(s)/program initiatives. Participants generally had very little or some experience utilizing and incorporating a health promotion model/framework.

Initially our focus was to **develop and ask the following question**: " What are the positive health outcomes (based on determinants of health) seen **within our existing pre/postnatal program** ". Our intention was to look at this question and cross reference our findings with our family resource centre as many of the participants in the program also attended their programs. Our intention was to gather information and determine how a continuum of multi service care/ programs developed client empowerment, factored + health outcomes, increased sense of well being within the community.
Our first workshop mandate was to familiarize ourselves with the concept of evidence", formally develop "the question", learn how to extract relevant information, and implement/utilize evidence based research within the framework so evaluation would be focussed and purposeful.
We all came away feeling enlightened!

In mid January when we met for our regular 0-6 year program meeting. We discussed the process and each one of us felt the project definitely had merit for us as an agency. Our question however shifted focus for a more generalized question. We began to look at the question **"how integrated, comprehensive service delivery provided better health outcomes for the community"** and not just for the prenatal/postnatal program. Although this was a broader question it was timely for us as an agency to develop our strategic planning in light of funding changes which came about.

One of the things we learned was that the broader question made it somewhat more difficult to extrapolate significant information to support our cause. We recognized the concept of integration was not new for funders or the government (Building a Stronger Foundation: A Framework for Planning and Evaluating Community-Based Health Services in Canada:

(www.hc-sc.gc.ca/hppb/healthcare/pubs/foundation/framework.htr) Our findings illustrated a lack of concrete evidence to support global initiatives; some of which have been in the works for past 3-4 years. Much of the information we were able to obtain was focussed on projects primarily based within the United States. Although the indicators/determinates to support integration for optimal health outcomes were not viewed as being "different" from the States it was still viewed as being "non Canadian" material which we needed. There was however one initiative in Saskatoon; Low- Income Women's Health Working Toward a Healthier Community" (www.pwhce.ca/mothers-hcomm.htm)which illustrated how empowerment of low socioeconomic women prevailed to facilitate change within their community.

One of our team recommendations would be to have a Canadian specific data base; a compendium of US sources and Global sources so we could cross reference. The option to focus on region/area specific info and/or comparative info would have been beneficial.

The manual was informative but thought to be too lengthy and difficult to sort through. Some of the worksheet were also not helpful and they were labour intensive.

We would like to see indexed references specific to the visual diagram for quick use. Some of us liked to using the worksheets while others found the framework more helpful. This supports the need to provide both formats to make the model user friendly for a variety of learning styles.

There is no question that the manual and health promotion framework enlightened us all to realize that health promotion requires dedicated, informed personnel who can consistently utilize a HP promotion model throughout the agency/programs.

As a group we feel the frame must be agency endorsed and mandated at a board level to support program planning so evaluation can be timely and programs adjusted/enhanced accordingly.

Our ED also felt each program co-ordinator/staff should be able to use the framework to develop proposals and submissions as front line workers within the agency.

As a new adventure for many of the key stakeholders we found staff resources were stretched during this project as some key stakeholders were not able to be as dedicated as they would have liked to be. It would have been beneficial to have the project supported by a key person from the University over a project period based on the question and perhaps more supportive site visits to actually work through the model for the first time. Once again a resource issue would be principle determinate for this.

On a positive note we all agreed that although we may still be at various levels with program model we remain enthused about the tool and incorporating it as the foundation for our agency to build on. It is valuable resource for us all having opened the door to research and evidence by reducing the intimidation factor it had a few months ago. Bringing research and evidence to a new level within the agency builds on the professionalism and commitment for quality services within our agency.

Thank you U of T!

Respectfully Yours

The West Hill Community Services Team

Womankind Addiction Services

2002

St. Joseph's Healthcare, Women's Detox and Mary Ellis House Treatment Program (Hamilton)

[this report taken from PowerPoint presentation]

Best Practices in Health Promotion

Meeting the Needs of Women with Addictions

St. Joseph's Healthcare, Hamilton

March, 2002

Womankind Addiction Service

Women's Detox Centre

- **7 withdrawal management beds**
- **entry service**

Mary Ellis House

- **8 treatment beds**
- **6 pre/post treatment / shelter beds**
- **referral**

Best Practices Working Group

- **Detox Attendants (2)**
- **Treatment Attendants (2)**
- **Student**
- **Medical Sociologist / Evaluator**
- **Pastoral Counsellor**
- **Director Women's Detox**

Issues

- **Women's needs as they relate to addictions and relapse prevention**
- **Really understanding what services are available and what needs they meet**
- **Number of audiences … what needs / gaps can we best meet**

Evolving Question

What programming could be offered to women in treatment to help with relapse prevention, on the weekends?

➢ **What is the best practice approach to providing enhancement / relapse prevention programming for women?**

➢ **To better understand the needs of women anticipating relapse and to develop programming to meet their needs (bridge the gap)?**

➢ **Based on the identified needs what programming can we offer women anticipating relapse that will meet their needs and reflect best practices?**

Learnings

- **Local programs exist**
- **Need to speak with the women, currently defining our questions and process of asking**
- **We have an understanding of why women relapse but not an awareness of effective programming / approaches**
- **Differing agendas of members**

What Difference Did Experience Make?

- **Enhanced skills and confidence**
- **Increased understanding**
- **Clear process emerged … which we could use again in the future**

Insights

- **Generally making decisions "on whim"**
- **Not difficult to use a Best Practice approach**
- **We have "hidden" skills**

- **Language can be a barrier within the group**
- **Started with the solution**
- **Hadn't identified the need; narrow view of intended audience(s)**
- **Struggled with what our question was**
- **Initially limited definition of evidence**
- **Confidence with accessing evidence**
- **Common understanding of women's issues and needs**
- **Accessing and analyzing evidence**

Suggestions / Recommendations

- **Defining the question is the most important step**
- **need an opportunity to collectively define values, beliefs in the context of the project**

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2004

Planning Womankind Addiction Services using Best Practices

Debbie Bang (St. Joseph's Healthcare, Women's Detox and Mary Ellis House Treatment Program, member of former Best Practices Work Group, past member of the Hospital Health Promotion Network)
Report presented at the session Best Practices at Home and Abroad, September 20, 2004, Toronto Canada.

We began using the Interactive Domain Model (IDM) with an interest in better understanding the needs of women who relapsed and what programming would help them. We used the IDM Framework as a stepping stone, a framework in which to conduct our work. We are creating something unique and thus the Framework really helped to stabilize our footing. The IDM was a pathway to wander along and gave us a structure. While the IDM Framework clearly delineated the steps we needed to take and what needed to be done, this was invisible to my team mates — but guided my approach to the work we did together.

Using the Framework, we first defined who our clients were and then our values. Our Mission and Values Statements emerged out of our work with the IDM Framework. Our Mission Statement is that *"We are a program dedicated to providing effective and compassionate withdrawal management and substance use treatment to all women."* Our Vision Statement is that *"We strive to create a centre for all women that envisions:*

- *Healing the whole self*
- *Returning women to their home and community with their dignity and self-esteem restored*
- *Empowering women to take control of their lives and their substance use."*

As part of the Framework process we checked out the environment; we conducted site visits, garnered support, looked for partnerships, etc. The situation with the internal environment was

that two teams with different cultures but dealing with similar women were coming together for this project; through the Framework process, both teams came together. We also explored what kind of evidence meant something to us and what didn't.

This work finished and then the amalgamation of the Women's Detox Centre and Mary Ellis House treatment program became a reality. We were then in a position to create a new service and program using best practices information and the planning took place within the best practices framework.

We developed our own Womankind Addiction Service Planning Framework which included the following elements: normalize, clarify, participation, invite innovation, grounding, defining, seeking, creating, commitment and energy, evaluation:

- In order to ***normalize*** a best practice approach we had a Best Practices working group which looked at the needs of women who relapse (after an extended recovery). To ***clarify*** best practices for women, there was individual supervision with each team regarding best practice for women with addictions (Source: Best Practices – Treatment and Rehabilitation for Women with Substance Use Problems, 2001).
- For ***participation***, we outlined the work of both phases and invited participation from the front line and the board.
- We invited ***innovation*** by giving guidelines for exploring program options. We attempted to think outside the box.
- To ensure a ***grounding*** in what we and others know we reviewed literature, created questions, did a road trip, put into words our own knowledge and experience. We also developed and pilot-tested and completed client program input questionnaire (all client groups) and reviewed results. We wanted to know what was reality.
- Phase One involved ***defining*** the program components and Phase Two involved ***creating*** the service, goals and objectives of each component. We went about ***seeking*** input and fine tuning by presenting the results of both these phases to the front line team, board, addiction colleagues.
- Our ***commitment and energy*** was demonstrated by finalizing the program components.
- Finally, we set up our ***evaluation*** based on goals and objectives. We are not married to the program; we will evaluate it and decide.

The strengths of using the IDM Framework were that it provided direction and a set of clear steps, provided reminders, and made sense. I believe we will have a better product in the end because we used the Framework.

Limitations were that there is a lot to learn and it was more important for us to do the work we needed to. My knowledge of the Framework became one of my contributions to the process.

REPORTS FROM OTHER INITIATIVES

Review of primary prevention interventions for Type 2 diabetes 2002

[this report taken from PowerPoint presentation March 2002]

Using the Interactive Domain Model to review effective primary prevention interventions

Jackie Kierulf (M.Sc.)
Consultant/Health Canada

Issue/Question

- **What are the elements of effective primary prevention interventions for Type 2 diabetes and its related risk factors: physical inactivity, obesity and poor diet?**
  - literature search
  - study review
  - selection of effective interventions

Types of prevention

- **Primary:**
  - attempt to eliminate risk factors associated with disease
  - no symptoms or signs of disease
- **Secondary**
  - intervention to interrupt or slow down disease process in early stages
- **Tertiary**
  - preventing or reducing the impact of disease and complications

our research project focused on primary prevention where intervention occurs to prevent the onset of disease

Question:

- **How can an effective intervention guide research and practice recommendations?**
  - examine study strengths and weaknesses
  - review current reviews, new innovations
  - formulate strategies & recommendations for future research & practice using IDM model

This question focuses on how the IDM model was used in our project.
We looked at issues related to :
1. strengths/weaknesses:

e.g. type of study setting, maintenance of effects, feasibility
2. current reviews, new innovations were also examined
3. the IDM model was used to formulate a set of guidelines and recommendations

Analysis of Issue using IDM

- **Association of research issues to the IDM**
- **Application of the IDM to research issues**
- **Development of strategies & recommendations**

How were we able to use the IDM to understand our research issue?
As we worked through the model there were similarities with the IDM domains and research issues
There were also certain domains that were more applicable to our research question
Finally, the prevention strategy/recommendations were developed using selected domains and subdomains

Research issues and the IDM

- **IDM sub-domains**
  - goals
  - theories
  - evidence
  - research/evaluation
- **Research**
  - goals/study intent
  - supporting evidence
  - study results
  - research methods

This slide illustrates the similarity of research issues to the IDM subdomains

Application of the IDM: Goals

- **current situation: lack of appropriate measurements for subgroups such as children, aged, women, ethnic groups**
- **ideal situation: develop measurements specific to children, aged, women, ethnic groups**

lack of appropriate measurements for specific subgroups e.g. children , aged, etc., for example, measures traditionally used for adults are adapted for use with children, but not devised specifically for them
the results from these tests are inaccurate

developing measurement with children as focus will give us a better understanding of this population..

Application of the IDM: Evidence

- **current situation: short-term maintenance of healthy diet and exercise training**
- **ideal situation: long-term interventions tailored to specific setting, target group, amount of available resources and staff**

current/evidence or study results that documents long-term maintenance of healthy behaviors such as following an appropriate diet and engaging in exercise, but the studies are few; most deal with short term gains
ideal/what we need are more long term interventions & that are designed to target the type of setting (school), age group, available resources and staff

Development of recommendations:

- **use diabetes strategy for criteria/principles**
- **use research results for current situation**
- **use study strengths/limitations for ideal situation**

- **build recommendations (results, strengths and limitations) for achieving ideal**
- **identify challenges from research issues**

How did the IDM fit in with what we wanted to achieve? We used the IDM domains to draft a set of recommendations that may be used for the primary prevention of dm:
1. on slide
2. literature review made up evidence
3. strengths & limitations were from effective interventions
4. specific objectives to achieve ideal were recommended
5. difficult issues needing attention were challenges

Domain groups

- **Research**
  - goals
  - ethics
  - theories
  - beliefs
  - evidence
  - health response
  - research/evaluation
- **Administrative**
  - values
  - beliefs
  - vision (org/work)
  - analysis (org/work)
  - org/work response

By working through the IDM, the distinction between the sub-domains which seem to be more research oriented with ones that have more of an administrative appeal was evident…
The dynamic nature of the model encourages the interrelation of these components

Lessons learned from model

- **reinforced importance of establishing clear foundation for preventive action**
- **formation of research issue into workable components or domains**
- **evaluation of intervention process essential prior to implementation**

- being able to work through the domains and clearly define issues was valuable
- being able to break down the research issue into several components within the domain strengthened the final structure of the project
- working through the various components emphasized the importance of process evaluation which is rarely done or done well

IDM strengths: general

- **informative layout**
- **flexibility of documentation**
- **provides "big" picture**
- **good visual layout /computer program**

layout informative /possible to see how model structure fits together
/flexibility of documenting areas that were familiar first, then filling in other cells as framework became clearer
/liked the way the framework provided a visual picture of the model within and across domains
in particular, computer program layout was visually appealing

IDM strengths: research

- **conceptualize idea/research issue into a workable method**
- **may serve as blueprint for research standards**
- **may serve as effective planning tool for research and evaluation**

being able to conceptualize issue by first building a solid foundation and then adding all the necessary components as the structure evolved was very useful
potential to develop universal research standards by using the model as a decision making tool is appealing
this would allow effective planning research or evaluation with IDM

Conclusions:

- **IDM has the potential to provide effective structure for examining health interventions**

- **IDM has the potential as a reference tool to identify strategies & recommendations**
- **IDM has the potential to build a stronger relationship between research and practice**

Association des communautés francophone de l'Ontario – Toronto 2004

Using the IDM Model: experience of Association des communautés francophone de l'Ontario – Toronto

Hélène Roussel (Association des communautés francophone de l'Ontario – Toronto)
Report presented at the session Best Practices at Home and Abroad, September 20, 2004, Toronto Canada.

What is ACFO-TO

Association des communautés francophone de l'Ontario – Toronto (ACFO-TO) began in 1922 with a mission of advocacy. In 1997 its funding was cut, and in 2003 it developed a new mission. It is a grassroots volunteer based organization of 20 members which has no employees or office and a budget in 2003-2004 of $15,000. Its active board members are involved in strategic vision, program planning, and program implementation. It has a leadership capacity development programme and an urgent need for organizational development regarding policies, committees, volunteer resources, and so on.

Why the IDM at ACFO-TO

Reasons for using the Interactive Domain Model (IDM) included that the Model:

- allowed for strategic vision and environmental scan
- required that we revisit our foundations/values
- required or allowed for participation from all levels of the organization
- helped us to clearly define our objectives
- forced us to remain consistent

Successes from our experience

Using the Model resulted in several benefits. We used it to successfully disseminate information within the organization, give us an overall visual glance, and develop a common language. In addition, it encouraged several skills such as strategic thinking and action oriented thinking.

Challenges

Among the challenges of using the Model we found the following:

- We needed a facilitator.
- It was time consuming (for the first time round).
- Developing a common language required lots of explanation to less experienced volunteers.
- Maintaining consistency was difficult.
- It was hard to keep our focus, because of members' passion regarding values.