A Report on the Proceedings for

Best Practices at Home & Abroad

making health promotion decisions for the best results

Victoria College, Toronto
September 20, 2004

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INTRODUCTION

On September 20, 2004, 66 participants (including organizers and presenters) gathered together in Alumni Hall of Victoria College on the University of Toronto campus to discuss what is happening with best practices in health promotion — in Canada and around the world. This event was sponsored by the Centre for Health Promotion (University of Toronto). Health Canada, Population and Public Health Branch, now the Public Health Agency of Canada, Ontario and Nunavut Region, funded travel for most Canadian out-of-town presenters. Presenters came from Australia, Nova Scotia, Saskatchewan, and different parts of Ontario (Sudbury, Hamilton, Cambridge, Grand River, and Toronto).

The day consisted of four parts, with Michael Goodstadt as Master of Ceremonies. In the first part, presenters gave overviews of the range of best practices activity in Canada and internationally. The second part was a workshop on using best practices with cultural sensitivity, based on the example of working with people in South Pacific Islands. In the third part of the day, a number of people described their experiences using specific best practices approaches. The last part of the day was a combination of small and large group work, identifying and discussing participants' best practices success stories and participants' questions about best practices. Jan Ritchie, the event's international guest of honour from Australia, provided a reflective summary of the day.

The day was very full, providing a broad range of information and ideas to carry away for further thought and action. Some of the key learnings were:

- A number of different kinds of best practices approaches and initiatives exist — in Canada and elsewhere — providing a wide variety of resources. Extensive lists and contact information for many of these were provided by presenters. Balanced against the trend towards equating best practices with evidence based practice is a growing focus on values, the environment and other factors.
- It is possible to work effectively with people from other cultures by: listening to what they say; understanding their values, practices, and context; and fitting in with what works for them rather than imposing external materials and ways of doing things.
- To measure effectiveness we need to look at unexpected as well as expected outcomes. We also need to include in our repertoire untraditional measurement tools such as stories, and to consider as acceptable not just quantitative/experimental evidence but qualitative/non-experimental evidence as well.
- Using the IDM (Interactive Domain Model) approach to best practices in health promotion — a best practices approach which reflects the complexity of life — presents challenges, but has been found to be definitely worth the effort by the sites using it, as it has produced a number of benefits.

One small group provided a written account of their discussion. Their conversation focused on programs for falls prevention, tobacco prevention, and sexual health. The theme they identified is that practice is very dependent on the situation, including the nature of the social environment, priority population, politics, and self identified needs.

Many of the questions from small groups focused on learning more about the IDM approach so participants could use it in their own organizations. Possibilities such as developing a "train the trainer" program and visits with sites using the IDM were

discussed. A topic that energized the large group was best practices terminology, sparked by the following question: "Is the term 'Best Practices' really representative of health promotion values? i.e. Best Practices seems more of a medical model or RCT term than a health promotion term." Other criticisms of the term "best practices" were that it seemed like a competitive term and that it probably had its origins in business. Participants suggested alternatives such as "doing things in a good way."

Jan Ritchie, in her "reflective summary" of the day, made the following points:

- An opportunity like today is more than just more opportunity for reflection – it's an essential part of health personnel capacity building – life long learning needs to be facilitated and bringing an interested group together like this is a wonderful way to do this.
- Facilitating the initial learning is an important part of a best practice approach – discussion today has indicated that starting off can be daunting but with appropriate facilitators it really can be worthwhile.
- The Framework put together by Barbara and Michael gives us a systematic checklist that is always accessible and used by many of us depending on what we need to do.
- The IDM helps us to recognize that health promotion principles are relevant across all of our work but best practice means that the facilitation of these principles is context dependent – taking into account all aspects of the "humanity" of the people whose health we are promoting and all aspects of the environment.
- How do we evaluate a planning/decision-making model? At this stage by case studies – stories!!

Several people commented on how useful the day had been in terms of meeting in person people they had previously only heard of or talked to on the phone. Other comments ranged from how inspiring the day had been with excitement expressed about new ideas to disappointment that the day had not been what they had expected.

Below are written versions of most of the presentations. (Because presentations were delivered orally, reports are worded informally.) Summaries of each presentation are provided in boxes. PowerPoint slides for some of the presentations are available by contacting Nora Sellers at the Centre for Health Promotion (University of Toronto): email <nora.sellers@utoronto.ca> or phone 416-978-2182.

This report was prepared by Barbara Kahan (Kael Consulting and Member of Centre for Health Promotion, University of Toronto), email <bkahan@sasktel.net> or phone 306-569-2094.

PART I: OVERVIEW

The first part of the morning was an overview of health promotion best practices' initiatives worldwide.

Update on the Interactive Domain Model (IDM) Approach to Best Practices in Health Promotion

presented by Barbara Kahan (Kael Consulting, Regina; Member of Centre for Health Promotion University of Toronto; member of former Best Practices Work Group)

Summary

The IDM approach to best practices in health promotion is a holistic guidelines approach where practice is thought to be "best" if it is consistent with a range of decision-making variables, from health promotion values and goals to health promotion theories, evidence and understanding of the environment. The IDM Framework is a tool designed to assist practitioners in this process. While the IDM approach does take time, it is "doable"; a number of organizations in Canada and other countries are using this or similar approaches, and achieving good results.

Current IDM-related best practices resources include a peer-reviewed article on IDM concepts, the *IDM Computer Program*, the *IDM Manual* (containing a variety of sections ranging from the *Evidence Framework* to *Working through the IDM*), the *IDM Best Practices Road Map for Coaches* (containing 11 modules and 34 exercises to lead a group through an IDM process), tools to increase consistency between practice and health promotion decision-making variables (including sets of worksheets and informal check-in forms), and two companion websites which between them contain numerous resources for people working in health promotion, public health and population health — *IDM Best Practices* at <www.idmbestpractices.ca> and *Best Practices in Health Promotion* at <www.bestpractices-healthpromotion.com>. More information about the IDM can be obtained from the websites and from Barbara Kahan (306-569-2094, <bkahan@sasktel.net>) or Michael Goodstadt (416-691-7860, <m.goodstadt@utoronto.ca.

The "people factor" has been extremely important to the development and support of the IDM approach to best practices in terms of the people and representatives of the organizations who contributed time and energy to making the IDM as good as it is, including the Centre for Health Promotion's Best Practices Work Group, the Best Practices Project partners, IDM pilot sites, Health Canada (which funded the project for five or so years), Ontario Ministry of Health, and a number of others who provided information and feedback in different ways.

The IDM best practices approach is a holistic guidelines approach which emphasizes the importance of consistency between practice and a number of decision-making factors ranging from values and goals to theories, evidence and understanding of the environment. It is made up of three domains:

- practice, which includes research and evaluation and addressing organizational and health-related issues
- underpinnings which includes the sub-domains of values, goals and ethics, theories, concepts, and underlying beliefs and assumptions, and evidence

- understanding of the environment, for both the organization and for the health-related issue. The environments considered include not only the physical but the socio-cultural, political, economic, and psychological environments. In the model all domains and sub-domains interact with and influence each other.

In the IDM, practice is thought to be "best" and achieve the best results if it is consistent with all other domains and sub-domains (that is, values, theories, evidence, and understanding of the environment). The IDM Framework, based on the Model, can be used in a number of different ways — ranging from strategic planning and evaluation to "making the case" and team building. Down the side of the Framework are the IDM domains and sub-domains which act as a health promotion filter. Major planning, evaluation and implementation steps are across the top.

A major criticism of the IDM has been that it is too hard, too complicated, and would take too long to do in real life. While the IDM approach is not exactly an easy approach — mainly because it accurately reflects the complexity of life — several years later we know that it is "doable" as well as helpful. We know this because some IDM pilot sites are still using the IDM best practices approach, and because there are other organizations working in a way similar to the IDM approach without ever having heard of the IDM. These organizations are committed to reflecting on their values, theories and beliefs, evidence, and the environments around them, and to integrating them into their practice. They are doing this reasonably successfully and as a result are getting good results with their work.

International IDM activity and interest ranges from Jan Ritchie with her work in Australia and the South Pacific to discussions and correspondence with people in Sweden, Holland, Belgium, Ukraine, Chile, and most recently from a doctor in Poland who wants to translate some of the IDM Manual into Polish for his health promotion work.

In Canada, the Francophone health promotion community has been very active and doing all sorts of wonderful things through the "Meilleures pratiques en promotion de la santé" project.

In Canada on the English-language side, the current status is that there has not been funding for the last two and a half years. Despite this, there is still to some extent ongoing dissemination (responding to requests, presentations, Michael Goodstadt's university class and summer school workshop), application (some pilot-testing sites continue to use the IDM approach, some new sites are doing IDM based evaluations and framework development), collaboration (ongoing discussions, reviewers of materials, website contributors, this event), and resource distribution and development.

The IDM-related resources people are most likely to be familiar with include the peer-reviewed article which appeared in *Health Promotion Practice* in 2001, the *IDM Computer Program* which was suggested by a pilot site and has turned out to be quite a useful tool for some people, and the *IDM Manual* which contains a number of sections related to topics of interest for the IDM approach, such as sections on values, research and evaluation, working through the Framework, and case studies. The most popular section of the *IDM Manual* is the *Evidence Framework*, which continues a series of guiding questions for people interested in using evidence in their practice, lists of things to consider, and quotes from people with extensive experience using evidence in practice.

One of the resources people are less likely to be familiar with because they have been more recently developed is the *IDM Best Practices Road Map for Coaches*, the distillation of over five years of experience working with sites and conducting workshops. The *Road Map* is designed to help coaches lead groups through all or parts of the IDM Framework. It contains 11 modules with a total of 34 exercises.

Other recent resources include tools designed to increase consistency between practice and other domains and sub-domains such as values and evidence. These tools include a set of informal check-in forms, designed to check the current status of consistency and to increase consistency. The second "consistency" tool is a diagram and worksheet to help make strong connections between what we want, know and think in our heads and what we actually do. With this set of tools, concrete links between practice and other domains are made by developing objectives to translate each underpinning or understanding of the environment sub-domain into practice. For example, if a group identifies power sharing as a value, incorporating this value into practice might involve the following objectives:

- to use a consensus approach to decision making
- to involve the population the program is for in key decisions about the program
- to have ongoing activities to increase knowledge and skill sharing

Another set of recent resources are two companion websites. The first — *Best Practices in Health Promotion* — was developed by Michael Goodstadt and includes information about the IDM Model and Framework, and has the IDM Manual available in html format; it links to Michael's teaching website, which contains numerous extremely useful resources for anyone working in a health-related area. The second, *IDM Best Practices*, is co-edited by Barbara Kahan and Michael Goodstadt. In addition to information about the IDM, and a complete set of IDM resources including the Manual, computer program, article, Road Map, and tools for increasing consistency, it contains an annotated set of links to general resources for people working in health promotion, public health and population health. It also includes a set of features which change every month — a profile of a person active in best practices, a best practices reflection piece, jottings by the co-editors, and a resource of the month. Everyone is invited to contribute to these website features in order to increase discussion, information sharing, and collaboration amongst the best practices community. People interested in finding out more about the IDM approach can get more information by going to <www.idmbestpractices.ca> and <www.bestpractices-healthpromotion.com>.

Best Practices in Health Promotion: The Franco-Ontarian Context

presented by Christiane Fontaine (Centre ontarien d'information en prévention/Ontario Prevention Clearinghouse, Toronto)

Summary

The mandate of the Francophone sub-committee, whose members included representatives from academic, governmental and community sectors, was to adapt the Interactive Domain Model (IDM) to the Franco-Ontarian context. Activities to accomplish this ranged from a needs and capacity assessment, translation and adaptation of IDM documents into French, a workshop, development of training modules, and workshops in Sudbury, Ottawa and Toronto to validate the materials. A number of French-language tools — IDM workbook, training modules, case studies, and references — are now available on the web at <http://www.opc.on.ca/francais/nosprogrammes/centre/projets/meilleurespratiques.htm>.

Strengths of the IDM range from the fact that it is grounded in health promotion and can be used as a planning, implementation and evaluation tool to its adaptability to different cultural and linguistic work environments. Drawbacks range from the length of the process to the possible need of support for first time users.

Challenges encountered while adapting the IDM to the Franco-Ontarian context ranged from changing an academic model to a practical format that can easily be understood and used by Francophone practitioners to funding. Examples of success factors included the common vision shared by partners and members of the Francophone sub-committee, flexible partners, and collaboration of practitioners to validate and evaluate the project.

Plans for the future include the further development of case studies and supporting materials, promotion of the use of the IDM, support IDM users, and research for additional funding to support activities. For more information contact Christiane Fontaine, Health Promotion Consultant: phone (416) 408-2249, ext. 229 or 1 800 263-2846; e-mail <christiane@opc.on.ca>.

Members of the Francophone sub-committee, created in 1999, included representatives from academic, governmental and community sectors. Members were: Manon Lemonde, Denise Hébert, Mary Cerré, Hélène Gagné, Huguette Jacobson, and Christiane Fontaine. Its mandate was to adapt the Interactive Domain Model (IDM) to the Franco-Ontarian context. To accomplish this, in May 2000 a needs assessment was conducted to document the needs of Francophone practitioners and their capacities and interest regarding best practices in health promotion. Subsequent steps included:

- translation and adaptation of English-language documents including the IDM Framework, Manual and article
- a workshop to acquaint Francophone sub-committee members with the IDM
- development of French-language IDM training modules
- validation of materials through three workshops conducted with 30 participants from health and education sectors and community-based groups in Sudbury, Ottawa and Toronto

Various tools, including an IDM workbook, training modules, case studies, and references, are now accessible in French through the Web at <http://www.opc.on.ca/francais/nosprogrammes/centre/projets/meilleurespratiques.htm>.

The benefits to using the IDM include that the Model:

- is grounded in health promotion
- serves as a planning, implementation and evaluation tool for projects, programs and strategic planning exercises
- helps maintain consistency between values and planned activities
- encourages discussion when developing of a common vision and shared values among user groups
- is applicable to health promotion activities and adaptable to different cultural and linguistic work environments

There are also drawbacks, including a lengthy process, the possibility of animated discussions when a group has to agree upon values, and that support may be required for first time users.

A number of challenges existed in adapting the IDM to the Franco-Ontarian context. The first challenge was changing an academic model to a practical format that can easily be understood and used by Francophone practitioners. Second was the development of a common language for health promotion. Third was the difficulty involved in recruiting and retaining members of the Francophone sub-committee given the province's limited French-language resources. The last challenge was funding.

There were also a number of success factors:

- the common vision shared by partners and members of the Francophone sub-committee
- the different levels of support from various government levels, researchers, academic and public health sectors and NGOs
- flexibility of the partners, who were there when their contribution and/or involvement was needed
- the broad sectoral representation within the Francophone sub-committee
- the commitment of organizations to using the IDM for their strategic planning process (e.g. Association des communautés francophones de l'Ontario - Toronto)
- the collaboration of the practitioners during the validation and evaluation phase of the project

Yet to come are the further development of case studies and supporting materials, on-going promotion of the use of the IDM, on-going support to the users of the IDM, and research for additional funding to support activities. To learn more about this project, contact Christiane Fontaine, Health Promotion Consultant: phone (416) 408-2249, ext. 229 or 1 800 263-2846; e-mail <christiane@opc.on.ca>.

Best Practices for Chronic Disease Prevention and Health Promotion: A Canadian Perspective

presented by Marie DesMeules (Chief, Population Health Assessment Section, Centre for Chronic Disease Prevention and Control, Health Canada; National Best Practices Consortium for Chronic Disease Prevention, Ottawa)

Summary

There are no commonly accepted definitions for best practices and no consensus on best practices criteria. However, best practices are needed to produce evidence and increase "knowledge exchange" efforts between research and decision-making.

Best practices activity in Canada ranges from health promotion frameworks and the Heart Health initiative to the Cochrane Collaboration and the Chronic Disease Prevention Alliance of Canada. Health Canada has initiated a National Best Practices Consortium to bring all these groups together.

The first activity of the new Consortium was an environmental scan. Early results of the scan indicate that respondents incorporate the following concepts into best practices: effectiveness, impact, and what works; evidence and research; and context. The scan also identified respondents' priority areas (criteria, research, examples of interventions, and need for a systematic approach) and barriers (funding, and access to information).

The Consortium's second activity was a systematic review of 24 best practices programs and related resources (almost half of them Canadian). Most of the programs and resources reviewed focused on prevention of chronic diseases, were intended for practitioners, and focused on a single domain, such as a risk factor, a setting, a disease, or a population. Initiatives reviewed generally designated as best practices (or equivalent term) only those interventions evaluated using the "gold star" Randomized Control Trial (RCT). A second "level of evidence" is accepted as the "silver medallist" (most commonly for health promotion interventions). Research gaps and opportunities were also identified, ranging from the need for a tool to indicate the suitability of a program for uptake to opportunities for including qualitative and quantitative studies in the research pool.

Results of the review and subsequent analysis indicate overwhelming support for a coordinated and consistent approach to the development, assessment, labelling and dissemination of best practices in Chronic Disease Prevention and Control in Canada. Examples of next steps include further development of a comprehensive action plan, a consensus meeting to discuss methods and definitions, and building membership.

What are Best Practices?

One definition of best practices is: "Initiatives that have been assessed as being effective and worthy of replication." There are, however, no commonly accepted definitions. Terms include: best practice, promising practice, public health observatory, knowledge translation. Included as best practices are: Clinical practice guidelines, National / Provincial / Territorial Strategies, Policy Development, Legislation, and Community Interventions Implementation / Mobilization / Development.

Why are Best Practices needed?

An enormous amount of information is available from research findings worldwide. However, there is insufficient "evidence" information and insufficient "knowledge exchange" efforts between research and decision-making. There are multiple approaches for assessing what actually constitutes a "best practice" including those based on scientific - research evidence and those based on context. There is no consensus on criteria.

Current Environment in Canada

There is lots of great work going on in the country. We can bring it together to make sense through communication mechanisms and developing a common language. In addition to "isolated islands of excellence" and development of Health Promotion Frameworks, best practices work in Canada includes: Tobacco Best Practices Model, Socio-behavioural Cancer Research Network, Heart Health Initiative / Diabetes Strategy / Cancer Strategy, Cochrane Collaboration, Chronic Disease Prevention Alliance of Canada, Task Force on Preventive Care, Enhancing Preventive Practises Coalition, and Health and Society (BSSHHR).

Health Canada Think Tank

Health Canada sponsored a "Think Tank" in Toronto, February 2003, which involved 40 individuals from across Canada to discuss a national Best Practices Consortium. An Interim Steering Committee (ISC) was formed to draft an action plan.

Consortium Environmental Scan

The first activity of the new Consortium was an environmental scan in 2003 to identify: Canadian stakeholders, current national activities related to best practices, priority needs, and groups / organizations to involve in a Consortium. Early results of the scan indicate that respondents incorporate the following concepts into best practices: effectiveness, impact, and what works; evidence and research; and context. Priority areas identified by respondents included: criteria, research, examples of interventions, and need for a systematic approach. Barriers identified by respondents included funding, and access to information. This scan will be released after further analysis and strengthening.

Consortium Systematic Review Results

The second activity was a systematic review of best practices programs and related resources, undertaken in February 2004. This review analysed 24 existing collections of relevant best practices published since 1998, of which 46% were from Canadian sources. Most focused on prevention of chronic diseases as opposed to the control aspect, the most frequent intended audience for the documents reviewed was practitioners (21 reviews, 87%), and most focused on a single domain, such as a risk factor, a setting, a disease, or a population. More results from this review follow.

Specific Canadian initiatives which have focused on best practices include:

- Alberta Consortium for Health Promotion Research and Education – "Health Promotion Effectiveness in Alberta: Providing the Tools for Healthy Albertans"
- Canadian Task Force on Preventive Health Care - Canadian Task Force Methodology
- Cancer Care Ontario - Nutrition Interventions for Cancer Prevention

- Canadian Cancer Society – Skin Cancer Report, and BP in Group Based Smoking Cessation
- Canadian Tobacco Control Research Initiative – "Better Solutions for Complex Problems: Description of a Model to Support Better Practices for Health." This Model is useful to a range of stakeholders, and is most likely to be employed by decision-makers to review knowledge. It is also applicable to variety of health problems not limited to tobacco.
- Cochrane Collaboration – "Cochrane Systematic Reviews"
- Health Canada – "Preventing Substance Use Problems Among Young People A Compendium of Best Practices; FAS/FA effects and effects of other substance use during pregnancy and Examining Youth Tobacco Prevention"
- Heart Health Resource Centre (Ontario) - International Scan in Best Practices, International Best Practices in Diabetes Prevention
- Heart Health Nova Scotia – "Best Practices Approach to Health Promotion
- Nutrition Resource Centre (Ontario) – "What Works in Nutrition Promotion"
- Program Training & Consultation Centre (PTCC) (Ontario) - Toolkit of Better Practices in Tobacco Control
- Public Health Research, Education and Development (PHRED)- Effective Public Health Practice Project

Canadian initiatives which have produced Best Practices Methodological Resources include:

- Nova Scotia Heart Health - Nova Scotia Best Practices in HP Framework
- Jackson, S., et. al. (Centre for Health Promotion, U of T) – "An Assessment of the Methods and Concepts Used to Synthesize the Evidence of Effectiveness in Health Promotion: A Review of 17 Initiatives"
- Kahan, B. & Goodstadt, M. – "Interactive Domain Model of Best Practices in Health Promotion"

There were some common elements across reviews. Initiatives generally require that an intervention needs to have been evaluated using the "gold standard" of a Randomized Control Trial (RCT) design to qualify as "best practices" (or the equivalent term used by the author). The second "level of evidence" is accepted as the "silver medallist" (most commonly health promotion interventions). A common process for reviews of interventions is required to identify best practices.

Gaps in research include:

- missing element in summaries: knowledge exchange, transfer and utilization related to the identified "best practices"
- follow-up needs to be included to harvest learnings (e.g. identification of further research opportunities)
- amount and type of detail provided about "best practice" interventions varies greatly

In addition:

- Assessment of whether a program is well-suited for uptake would be facilitated by the availability of a tool highlighting the practical considerations to be made
- Expand research into sectors such as recreation, education, justice, urban planning, transportation and agriculture to lead to a richer harvesting of potential programs

- Include in a "best practices" model an element addressing the fidelity of the program when transferred to a new context other than that within which it was developed.

Opportunities identified in research include:
- Broaden inclusion criteria.
- Hierarchy of evidence needs to include more criteria than quality of study design.
- Comprehensive inclusion criteria create requirements for a complex analysis whereby an integration of a range of research designs is required.
- Include qualitative and quantitative studies.

Results of the review and subsequent analysis indicate overwhelming support for a coordinated and consistent approach to the development, assessment, labelling and dissemination of best practices in CDP&C (Chronic Disease Prevention and Control) in Canada.

Gap Analysis Phase

We are now in the gap analysis phase:
- To identify what domains do not currently have relevant best practices summaries available.
- Describe any limitations or opportunities for evolution in the summaries available.
- Assist the Public Health Agency of Canada BP Interim Steering Committee to decide what actions to take towards a more coordinated approach to best practices in chronic disease prevention and health promotion in Canada.

The Consortium Approach

The Consortium approach involves face to face and virtual interactions. Value added for the Consortium involves:
- Consensus surrounding definitions / scope
- Forum to Develop Recommendations
- Support the synthesis of best practice evidence
- Focal point for communication and networking

Next Steps

Next steps include:
- Further develop comprehensive action plan
- Consensus meeting on methods and definitions
- Demonstration projects
- Further develop a Consortium model
- Scope
- Membership
- Mechanism

Best practices in health promotion: International initiatives

presented by Michael Goodstadt Ph.D., C.Psych. (Professor, University of Toronto, Member, Centre for Health Promotion, member of former Best Practices Work Group)

Summary

The four major thrusts in best practices initiatives internationally include: assessing, synthesizing and disseminating evidence; bridging the gap between research and practice; developing decision-making models; and conducting international conferences.

A number of specific examples for each of these areas was provided such as: the Health Development Agency in the United Kingdom (synthesizing and disseminating); the Cochrane Collaboration (assessing quality of experimental research); Australian National Public Health Partnership (assessing quality of non-experimental/qualitative research); CDC Guide to Community Preventive Services in the United States (bridging the gap between research and practice); The PREFFI Project (Health Promoting Effectiveness Fostering Instrument) in Holland (decision making model); IUHPE Conference on Effectiveness and Quality of Health Promotion (international conferences).

In addition to initiatives outside of Canada, several Canadian initiatives were also identified, such as: Ontario Public Health Research, Education and Development (PHRED) Program (synthesizing and disseminating); Health Canada's National Best Practices Consortium for Integrated Chronic Disease Prevention and Health (bridging the gap between research and practice); IDM (Interactive Domain Model) of Best Practices in Health Promotion (decision making).

Results from an analysis of phrases contained in 2,134 conference abstracts for the 18th World Conference on Health Promotion and Health Education (Melbourne, 2004) were presented. Of the five key phrases searched — best practices, values, evidence/evidence-based, effectiveness, environment — "best practices" was found in the least number of abstracts (68) and "effectiveness" and "environment" were found most frequently (100 abstracts each). Of the 68 abstracts containing the phrase "best practices," the word "values" was found in only 3 and "evidence" was found in 21; "effectiveness" and "environment" were in between these two end points (10 and 12 abstracts respectively).

The IDM is being used internationally in such diverse places as Australia and the Ukraine. IDM materials have been or will be translated into Spanish and Polish. In addition, the IDM has been cited by others, for example by the World Health Organization's Making Pregnancy Safer Initiative.

One major challenge for best practices in health promotion/public health is how to integrate growing interest in "environment", "evidence", "effectiveness," and "values" into a coherent approach to best practices in health promotion. Another is how to resist the trends towards equating best practices with evidence based practice and equating acceptable evidence with quantitative/experimental evidence.

The two major best practices approaches focus on principles underlying practice (practice guidelines and standards of practice) and evidence of effectiveness (what

works, "tell me what to do"). The IDM is a comprehensive approach to best practices which combines elements of both.

Internationally, there are four major thrusts in best practices initiatives:

- Assessing, synthesizing and disseminating evidence
- Bridging gap between research and practice
- Decision-making models
- International conferences

Assessing and synthesizing evidence

Synthesizing and dissemination initiatives around the world include those in Canada, the United Kingdom, and elsewhere:

- Ontario Public Health Research, Education and Development (PHRED) Program: The Effective Public Health Practice Project (EPHPP) (www.city.hamilton.on.ca/phcs/EPHPP)
- the Canadian Cochrane Network & Centre (www.cochrane.org; www.cochrane.mcmaster.ca/annualreports.asp)
- Cochrane Health Promotion & Public Health Field (www.vichealth.vic.gov.au/cochrane/)
- The Campbell Collaboration (www.campbellcollaboration.org/)
- Health Development Agency (HDA) (www.hda-online.org.uk/evidence/)
- NHS Centre for Reviews and Dissemination (CRD) (www.york.ac.uk/inst/crd)
- Evidence for Policy and Practice Information and Co-ordinating (EPPI) Centre (http://eppi.ioe.ac.uk)
- Centre for Evidence Based Public Health Policy (www.msoc-mrc.gla.ac.uk/evidence/evidence.html)

Initiatives to establish criteria for assessing quality of *experimental* research evidence include:

- *The Cochrane Collaboration* criteria (RCTs) (www.cochrane.dk/cochrane/handbook/; www.cochrane.mcmaster.ca/annualreports.asp)
- *Australian National Public Health Partnership*: A schema for evaluating evidence on public health interventions (2002) (www.nphp.gov.au/publications/phpractice/schemaV4.pdf)
- Criteria for assessing quality of *experimental* research (RCTs) [Gray, J. A. M. (2001). Evidence-based healthcare: How to make health policy and management decisions (2nd ed.). New York: Churchill Livingstone.]

An example of an initiative to establish criteria for assessing quality of *non-experimental (qualitative)* research evidence is:

- *Australian National Public Health Partnership*: A schema for evaluating evidence on public health interventions (2002) (www.nphp.gov.au/publications/phpractice/schemaV4.pdf)

A sample of articles regarding assessment and use of *qualitative* evidence include:

- Centre for Health Evidence: A user's guide to qualitative research in health care (www.cche.net/usersguides/qualitative.asp) (based on Giacomini, M. K., & Cook, D. J. (2000). Users' Guides to the Medical Literature: XXIII. Qualitative Research in

Health Care B. What Are the Results and How Do They Help Me Care for My Patients? JAMA, 284(4), 478-482.)

- Greenhalgh, T., & Taylor, R. (1997). How to read a paper: Papers that go beyond numbers (qualitative research). *BMJ*, 315(7110), 740-743.
- Des Jarlais, D. C., Lyles, C., Crepaz, N., & The TREND Group. (2004). Improving the Reporting Quality of Nonrandomized Evaluations of Behavioral and Public Health Interventions: The TREND Statement. *American Journal of Public Health, 94*(3), 361-366.
- Victora, C. G., Habicht, J.-P., & Bryce, J. (2004). Evidence-Based Public Health: Moving Beyond Randomized Trials. *American Journal of Public Health, 94*(3), 404.

Bridging gap between research & practice

There are a number of initiatives worldwide to bridge the gap between research and practice:

- International Union of Health Promotion & Education (IUHPE) (www.iuhpe.nyu.edu/) is sponsor for two projects: *"The Evidence of health promotion Effectiveness: Shaping Public Health in a New Europe" (1999 & 2000)* and *Global Programme in Health Promotion Effectiveness (GPHPE) Project*
- USA: *CDC Guide to Community Preventive Services* (http://www.thecommunityguide.org/)
- European Commission*: Getting evidence into practice project*
- Health Canada initiatives:
  — *An Assessment of the Methods and Concepts Used to Synthesize the Evidence of Effectiveness in Health Promotion: A Review of 17 Initiatives* (2002: Jackson, S. F., Edwards, R. K., Kahan, B., & Goodstadt, M.)
  — *National Best Practices Consortium for Integrated Chronic Disease Prevention and Health* Promotion, which has sponsored two reports:
    - *Results of Environmental Scan of Best Practices in Chronic Disease Prevention and Health Promotion in Canada* (Report prepared by Ann Lessio for Evidence and Information Chronic Disease Policy Division, Centre for Chronic Disease Prevention and Control, Health Canada, January 2004)
    - *Systematic Review: Best Practice Programs & Related Resources/Contacts* (Report prepared by Nancy Dubois, Cindy Andrew, & Tricia Wilkerson for the National Best Practices Consortium, Centre for Chronic Disease Prevention & Control, Health Canada, May 2004).

Decision-making models

Two examples of best practices decision-making models around the world include:

- Canada: IDM (Interactive Domain Model of Best Practices in Health Promotion) (www.idmbestpractices.ca; www.bestpractices-healthpromtion.com)
- Holland: The PREFFI Project (Health Promoting Effectiveness Fostering Instrument) (see supplementary slides)
  (www.nigz.nl/dossiers/index.cfm?action=dossier&vardossier=27)
  (www.cfes.sante.fr/30000/pdf/colloque_031204/Molleman.pdf)

International best practices conferences

Examples of international best practices conferences include:

- *4th European IUHPE Conference on Effectiveness and Quality of Health Promotion* (Helsinki (Finland) and Tallinn (Estonia))

- *17th & 18th World Conferences on Health Promotion and Health Education* (2001, 2004)
- *6th IUHPE European IUHPE Conference on Effectiveness and Quality of Health Promotion: Evidence for Practice* (Stockholm, June 1-4, 2004) (www.bestpractice2005.se)

An analysis of phrases contained in 2,134 conference abstracts for the 18th World Conference on Health Promotion and Health Education (Melbourne, 2004) was conducted. The following results identify the number of abstracts containing the listed key phrases:

- "Best practices" 68
- "Values" 79
- "Evidence" & "evidence-based" 96
- "Effectiveness" 100
- "Environment" 100

In a further analysis, of the 68 abstracts containing the phrase "best practices," 21 contained the word "evidence," 12 contained the word "environment," 10 contained the word "effectiveness," and 3 contained the word "values."

The indications regarding international trends are that there is less direct mention of "best practice(s)" than of "environment," "effectiveness," "evidence," or "values." Where there is a focus on best practices, most attention is given to "evidence", "environment", and "effectiveness"; little attention is given to "values."

Use of the IDM internationally

The IDM is being used internationally, for example:

- in Australia and Vanuatu by Jan Ritchie
- with the Ukraine-Canada Youth Health Project
- in translation into Spanish (Chile), and possibly in the future into Polish (Poland)
- in citations such as : WHO: Making Pregnancy Safer Initiative: "Working with individuals families and communities to improve maternal and newborn health"
- Evaluation of HIV/AIDS Prevention Programs (Vinh-Thomas, Bunch, & Card, 2003)

Implications

Major challenges for best practices in health promotion/public health include:

- Integrating growing interest in "environment", "evidence", "effectiveness" and "values" into a coherent approach to best practices in health promotion
- Resisting trend towards viewing best practices as ***equivalent to "evidence-based" practice***
- Resisting trend towards defining ***acceptable*** "evidence" as ***quantitative*** (especially experimentally derived) evidence

There are two major streams for approaching best practices. One is an approach which focuses on principles underlying practice, including practice guidelines and standards of practice. The second is an approach which focuses on evidence of effectiveness, that is, "what works" or "tell me what to do." The IDM is a comprehensive approach to best practices which combines elements of both.

PART II: THE CASE OF THE LAWNMOWER FOR PROMOTING HEALTH IN VANUATU: HEALTH PROMOTION PRINCIPLES AND CULTURAL SENSITIVITY

Jan Ritchie (Associate Professor, School of Public Health and Community Medicine, University of New South Wales, Australia)

Summary

The case of the lawnmower took place in the context of the South West Pacific, a large area which is sparsely populated with diverse cultural groups. The overall goal of the Pacific Action for Health Project was to prevent non-communicable disease in the countries of Vanuatu, Kiribati and Tonga. The project took into account values, context, participants' vision rather than problems, and ways of working that were most comfortable for participants.

The evaluation used two different approaches. One was a Logical Framework of inputs, activities, outputs, and indicators. The second was based on participants' stories about the changes they perceived as having occurred. The second approach allowed the capture of unexpected outcomes, one of which was the case of the lawnmower which illustrated an unexpected outcome of economic development.

This project was a cross-cultural effort making cultural competence important. Culture is a collective activity and the degree of cultural competence of systems, agencies or professionals determines the degree of effectiveness in working with different cultures. Examples of essential elements to use in educational materials include starting where the learner is at, leading from the concrete to the abstract, and checking regularly for cultural acceptability. To ensure cultural competence, a number of elements are necessary, such as being conscious of the dynamics of interacting cultures and appropriate adaptation of service delivery. A continuum of cultural competence moves from cultural destructiveness at one end to cultural proficiency at the other end.

Context

The South West Pacific covers an area of 30 million square kilometres of ocean with over 20,000 islands. It has a small population of just over 8.5 million people but is diverse, including 22 Pacific Island countries and territories. The three cultural groups are Melanesian (84%), Micronesian (9%), and Polynesian (7%). The population is isolated, with three quarters inhabiting remote areas or outer islands. Communication is challenging with one third of the world's languages represented. While there are high rates of emigration to Pacific rim countries, the area is politically important and considered valuable to World powers.

Pacific Action for Health Project

The Pacific Action for Health Project was an AusAID-funded project 2001-2004 whose overall goal was the prevention of non-communicable disease in three countries: Vanuatu, Kiribati and Tonga. The entry point was the prevention of alcohol and tobacco use/abuse in youth 10-19 years.

The project looked at both values and context and focused on what participants wanted to be rather than problems. The project worked in ways that were most comfortable for participants. For example, in the middle of a typical western style meeting, participants asked "Can we do it our way?" at which point they put out fruit and flowers and played guitar and sang; in the process a lot of good work was accomplished.

The two evaluation components of this project were:

- Accountability – Logical Framework of inputs, activities, outputs, indicators as a condition of AusAID funding
- Identification of perceived short term impacts through Most Significant Change (MSC) approach

The MSC approach invited stories of perceptions of change as seen by participants including community members, project workers, and other stakeholders. A systematic approach to capturing the unexpected was used which involved inviting, analysing, synthesising, and documenting participants' stories. More information about this can be found at <http://www.healthcomms.org/comms/eval/le02.html>.

The importance of unexpected outcomes was illustrated by the case of the lawnmower. Two young men bought a lawnmower with a small grant they received. People admired the results of their efforts to cut one patch of overgrown grass; soon their services were in great demand. This economic development was an unexpected outcome demonstrating useful results.

Small groups discussed the role story played in their work.

Working cross culturally

This project was a cross-cultural effort, making cultural competence important.

- ***Culture*** refers to the meanings which people create and which create people as members of societies. Culture is in some way collective…(Hannerz 1992)
- ***Cultural competence*** is defined as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals [which enable] that system, agency, or those professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis, Isaacs, 1989).

The elements that are essential to use in educational materials such as handbooks are:

- Use meaningful narrative to engage the learner.
- Start where the learner is 'at.'
- Lead from the concrete to the abstract.
- Keep it simple and relevant.
- Where possible, work towards achieving a vision rather than overcoming a problem.
- Check for cultural acceptability regularly throughout the whole process – respect the 'Pacific way.'

A list of elements which are essential to ensure cultural competence was identified by King, Sims, and Osher (2000):

- Valuing diversity
- Having the capacity for cultural self-assessment
- Being conscious of the dynamics of interacting cultures

- Being able to institutionalise cultural knowledge
- Developing appropriate adaptations in service delivery

A continuum of cultural competence, identified by Cross et al (1989), moves from cultural destructiveness at one point through cultural incapacity, blindness, pre-competence, and competency, ending with cultural proficiency at the other point.

References

References to the material in this presentation are:

- Cross T, Bazron B, Dennis K, Isaacs M (1989) *Towards a culturally competent system of care.* Volume I. Washington DC: Georgetown University Child Development Center.
- Hannerz Ulf (1992) *Cultural Complexity – Studies in the social organization of meaning.* New York, Columbia University Press (p.3)
- King M, Sims A, Osher D (2000) *How is cultural competence integrated in education?* Available at <http:www.air.org/cecp/cultural/Q_integrated.htm> [accessed 15 Sept 2004].

PART III: REPORTS ON BEST PRACTICES SUCCESSES AND CHALLENGES

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)

Summary

The Interactive Domain Model (IDM) Framework was used to guide the process of identifying programming which would meet the needs of women who relapse, from a woman-centred perspective. Mission and Vision statements were developed, involving a holistic and empowering focus. An environmental scan was conducted and a Womankind Addiction Service Planning Framework developed containing the following elements: normalize, clarify, participation, invite innovation, grounding, defining, seeking, creating, commitment and energy, evaluation.

Using the IDM Framework provided clear direction and made sense, resulting in a better product. A limitation was the amount to learn when it was more important to do the work. This challenge was met because of the Manager's prior knowledge of the Framework; this knowledge helped her work with her team mates to clearly delineate the steps of what needed to be done, allowing them to focus on the work rather than on learning a number of new concepts.

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.

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

Ghislaine Goudreau (Sudbury and District Health Unit)

Summary

Sudbury and district has a large land area with a small population, making distance a barrier. It has a higher unemployment rate than the provincial average. The Health Unit is working towards best practice through the Public Health Research and Education Development program and through its four Health Promoters who work with community, practitioners and researchers. Several projects have drawn on the Interactive Domain Model (IDM) approach ranging from the Working Poor Project to the Tobacco Program.

Successes of using the IDM included increased knowledge of health promotion and best practices, increased use of evidence based research, and an increased number of community consultations. It provided a systematically organized method to approach research on any given topic.

General best practices challenges include lack of a commonly accepted definition, lack of a universal model acceptable to funders as well as others, potential limits to spontaneity and creativity, and difficulties doing research while travelling across large distances. Challenges specific to the IDM are that many practitioners feel that the model is huge and too time consuming, and that it requires training or someone to facilitate the process. The IDM may only realistically be utilized for big projects.

Although the IDM is challenging, it has been a worthwhile process. Recommendations are to train the Health Promoters at the Sudbury and District Health Unit to facilitate the IDM process, and to include Best Practice as part of the program planning process with dedicated time allotted.

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.

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

Hélène Roussel (Association des communautés francophone de l'Ontario – Toronto)

Summary

In recent years Association des communautés francophone de l'Ontario – Toronto, a grassroots volunteer based organization with no staff and a small budget, has undergone some major changes. The IDM is being used to assist with organizational development. It has helped to produce a strategic vision, environmental scan and clearly defined objectives. It also supported a review of values and other foundation pieces, participation from all levels of the organization, and consistency.

Benefits of using the Model ranged from dissemination of information within the organization to enhancing strategic thinking skills. Challenges ranged from the need for a facilitator to difficulties in keeping focus because of members' passion regarding values.

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.

IDM Framework: The Brant County Experience

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

Summary

In the context of two hospitals integrating, a third hospital closing, and the start of a new Community Integration portfolio, the Paris Community Well Being Team piloted the Interactive Domain Model (IDM) Framework. The Team, composed of health promotion and clinical staff and volunteers from the community, focused on Teen Health for the Framework process.

Challenges specific to using the IDM were the large amount of time and commitment required. Environmental challenges included getting buy-in from management and staff, a scarcity of resources, and financial constraints.

A number of things worked well with using the IDM. The pilot project group exercise formed the foundation for a new portfolio, helped us understand and manage environmental enabling and obstructing factors, supported a new rural health initiative, impacted on inner-city population health, and changed the delivery of diabetes services. Other outcomes ranged from the inclusion of health promotion as core business in rural health care and the expansion of the Community Well Being Team.

Working with the IDM had a personal impact as well, particularly in recognizing the personal importance of working in an organization which puts values into practice.

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

Like Parent, Like Child

Ted Mavor (Grand River Hospital, member of the Hospital Health Promotion Network, a partner of the Best Practices Project)

Summary

The project "Like Parent, Like Child" was initiated in the hospital, developed with community partners, then handed off to the community. It is a preventative learning program for prenatal instructors and expectant parents on the prevention of violence. More information can found by referring to the journal *Patient Education & Counseling*, Vol. 45, # 4, December 15 , 2001, pages 261-264.

Identification of Best and Promising Practices in Chronic Disease Prevention

Anne Lessio (Heart Health Resource Centre)

Summary

The Heart Health Resource Centre partnered with the University of Waterloo to identify international best practices in chronic disease prevention. The initiative developed three criteria to assess whether a project demonstrated best practices: strength of evidence, plausibility, and practicality. Best practices and promising practices in Canada, the United States, Finland, and elsewhere were identified for stroke prevention, diabetes prevention, and heart health, as well as for the workplace, schools, and the community-at-large.

The website will contain searchable information that provides for each program an abstract, complete description of implementation methods, and reviewer's comments and ratings. A Best Practices Toolkit will be completed in December 2004. For more information go to <www.hhrc.net>.

The mandate of the Heart Health Resource Centre is *"To enhance the capacity of public health agencies and their community partnerships to provide comprehensive heart health programming"* and for this reason we undertook a project to identify "best practices" as one strategy of enhancing local capacity. In partnership with the University of Waterloo, with Rhona Hanning and Steve Manske as co principal investigators, we identified multi-risk factor, community-based interventions using a population health approach that could be adopted and adapted in the Ontario context. Highlights of the project were the development of criteria, methodology, a website, and dissemination of the results.

The first criterion to assess programs was strength of evidence — was the program shown to be effective? The second was plausibility — was it based on principles of behaviour change and was formative evaluation undertaken? The third was practicality — could it be reproduced?

Results were the identification of best practices for stroke prevention, diabetes prevention, and heart health, as well as for the workplace, schools, and the community-at-large.

An example of a project demonstrating "best practice" was Pathways, a project designed to promote healthy eating and physical activity among students in grade 3, 4 and 5. Resources for this project include activity books, goal-setting materials and teachers' kits.

Examples of projects demonstrating promising practices include:

- Sioux Lookout Diabetes Program in Northern Ontario which since 1990 has provided youth camps, school programs, environmental change programs. Its resources include a Diabetes Jeopardy game and Northern budget-wise food guide.
- Diabetes Challenge in Wolseley Family Place, Manitoba, with a play contest.
- A Health Promotion Project in Finland, for employees of oil refineries.
- NASA Intervention Program in USA, for employees with elevated cholesterol.

- Ottawa Heart Beat – Workplace Health Program in Canada, for adults.

The website will contain searchable information that provides an abstract with an overview of the program, a long implementation description for practitioners interested in reviewing the program for adoption, and a reviewer's comments and ratings. More information can be found at <www.hhrc.net>. A Best Practices Toolkit is scheduled to be completed in December 2004.

Nova Scotia Best Practices

Lisa Pike, Community Health Promotion Network Atlantic (based in Newfoundland), a Steering Committee partner of Nova Scotia Health Promotion Clearinghouse

Summary

Community Health Promotion Network Atlantic is a Steering Committee partner for the Nova Scotia Health Promotion Clearinghouse (HCH). An advisory group of the HCH adopted a best practices framework that offered tools for adopting an approach in health promotion for those working at the community level. They defined Best Practices as a continual process of reflecting on how to improve and enhance our practice within a comprehensive health promotion framework.

A two-day consultation brought together about 30 people from various Nova Scotia organizations to explore best practices through the presentation of case studies, group work, discussion, and evaluation. The vast majority of participants indicated that they had increased their understanding of best practices, gained new ideas for health promotion at the community level, and learned new ideas which would benefit their organization. Capacity was increased for adopting a best practices approach to health promotion in Nova Scotia. The HCH has made the report, analysis and information resulting from the consultation available on its website at <http://www.hpclearinghouse.ca/best_practices.htm>.

For the future, the possibility of forming an Atlantic Best Practices Clearinghouse to highlight Best Practices in all of Atlantic Canada has been discussed. In the meantime, both CHPNA and HCH continue to make tools and information from across Canada available to groups.

Introduction

CHPNA, Community Health Promotion Network Atlantic, is a 300 member strong network of health promoters in Atlantic Canada.

As the Executive Director, I sit on the Steering Committee for the Nova Scotia Health Promotion Clearinghouse (HCH). Kerri Barkhouse, one of the founding members of the Health Clearinghouse, was instrumental in bringing forward the best practices work to the organization.

The purpose of the HCH is to provide health promotion resources in a timely manner and preferred format for communities in Nova Scotia to enhance capacity and build momentum in Nova Scotia. Partners include CHPNA, Heart and Stroke, Active Living, Healthy Eating, Cancer Care, Dietitians, Seniors, Government groups, to name a few.

An advisory group was brought together by the HCH. This group adopted a best practices framework that offered tools for adopting an approach in health promotion for those working at the community level. They defined Best Practices as a continual process of reflecting on how to improve and enhance our practice within a comprehensive health promotion framework. Taking a process approach simply means answering the critical question: How do we continue to improve and enhance our practice so we can do it best?

The advisory committee then gathered together a group of approximately 30 people from various organizations from Nova Scotia for a two-day consultation to explore best practices.

What did the group do?

The two-day session included the presentation of six case studies, group work, good discussion, and a thorough evaluation.

How did it do?

Seventy-eight percent of those who attended had an increased understanding of best practices in general and 81% noted that the new ideas learned would benefit their organization, and 91% gained new ideas for health promotion at the community level.

The big question was — was capacity increased for adopting a best practices approach to health promotion in Nova Scotia? To quote a participant: Yes! One participant noted: "I feel I could try to use this on my own — and feel comfortable knowing there will be further support as tools are developed."

Results

Following the consultation resources were compiled and a final report was written. As a benefit of being web-based, the HCH has made its report, analysis and information available on its website. Through its network of partners and supporters, it has provided what was requested most at the consultations — access to resources and tools on best practices across Nova Scotia and really beyond.

Future

The HCH, and health promotion organizations in general, are going through some changes. We want to keep the spotlight on best practices in Atlantic Canada, when it comes to Health Promotion. There has been some discussion on the possibility of the formation of an Atlantic Best Practices Clearinghouse. Such a Clearinghouse would highlight "Best Practices," not only in Nova Scotia, but all of Atlantic Canada.

Until that time, both CHPNA and the Nova Scotia Health Promotion Clearinghouse, will continue to make tools and information available to groups, along with information on new projects and initiatives all across Canada. As many are aware, it takes funding. We look forward to further working on best practices.

PART IV: QUESTIONS RELATING TO BEST PRACTICES FROM SMALL GROUP SESSION

Note: it is planned to provide answers to as many of these questions as possible over the next few months on the website IDM Best Practices at <www.idmbestpractices.ca>.

1. How do you ensure the flexibility of framework/planning to "think outside the box"? e.g. funding for a lawnmower wouldn't normally be part of a program.
2. Is the term "Best Practices" really representative of health promotion values? i.e. Best Practices seems more of a medical model or RCT term than a health promotion term.
3. What other best practices models exist?
4. What is the consensus (on model to be used) in field to determine best practices?
5. Key differences between logic models and IDM: how do/can they fit?
6. Who is the target group of the IDM (i.e. health promotion professionals, lay people, students)?
7. What setting was the IDM created for: public health, research, community?
8. Can the model be used for communicable disease in the aspect of health prevention and promotion. i.e. latent syphilis, latent TB, HIV, diseases starting as acute then becoming latent or chronic?
9. Can or has this model been used in promoting healthy cultural relations- re racism/discrimination i.e. the workplace?
10. Is there a better time (situation) to use the IDM? e.g. a bigger project with more time/resources?
11. IDM seems like it is structured for larger organizational planning/larger projects: Can it be applied to smaller projects/initiatives?
12. Why would you want to use the model when it sounds so difficult?
13. Apart from today's testimonials, have there been studies evaluating the IDM model? By whom?
14. How do you go about learning about the IDM?
15. IDM resource when using model for the first time: "Network" available?
16. Is there a website/discussion board that has examples of IDM developed?
17. How can organizations be supported to use the IDM (training, funding, facilitation needs)?
18. How can we take back to our work – is there a short cut?
19. How can I sell the IDM to my manager?
20. When the group you are working with is not mandated to discuss the values/vision/underpinnings domain: how can we overcome this?
21. How do you get buy-in to a values-based approach –funders, etc.
22. In the development of IDM, what happens when there are competing/conflicting/shifting values? How would the above be addressed?
23. How can we show that the IDM model is applicable to other sectors beyond health?