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

*Follow-up to IDM Use and Impacts*

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## Notes

- “IDM” is an acronym for the Interactive Domain Model. “MDI” is an acronym for the Modèle des domaines interactifs, the French language IDM.
- Quotes identified with initials are from Follow-up interviews or survey responses; to preserve confidentiality, initials are not the person’s real initials.
- Research in this report includes evaluation and general information gathering.
- Profiles, reflections or jottings mentioned in the text refer to monthly features posted on the IDM Best Practices website.
- For more information about the IDM, to download IDM resources, or to view current or archived profiles, reflections or jottings, visit the IDM Best Practices website [www.idmbestpractices.ca](http://www.idmbestpractices.ca).
- For French language resources visit [www.opc.on.ca/francais//projets/pratiques.htm](http://www.opc.on.ca/francais//projets/pratiques.htm).
INTRODUCTION
This section introduces the Interactive Domain Model (IDM) and this Follow-up.

IDM Approach to best practices for better health
Practitioners at a 1996 health promotion effectiveness symposium called for tools to guide their work, instigating development of the Interactive Domain Model (IDM) under the auspices of the Centre for Health Promotion, University of Toronto and later as part of the Best Practices Partnership, composed of the Centre for Health Promotion and several other partners.

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

The Model
The IDM has evolved over time to its current state, shown on the following page. The IDM, based on its definition, contains several domains and subdomains which interact in the context of the socio-political, economic, psychological and physical environments:

- underpinnings (values, goals and ethics; theories and beliefs; evidence)
- understanding of the environment (vision and analysis of organizational and health-related issues)
- practice (processes and activities for research, policy, program implementation and addressing organizational issues)

The essence of the IDM is that consistency among all the domains will result in best practices. Embedded in the IDM definition is the view that the best practices for one place and time depend on a number of factors, ranging from available resources to culture, and are not necessarily the best practices in other contexts. The IDM is a critically reflective approach which stresses the need for awareness of issues, dialogue, clarity, and reflection in order to ensure that practice and its impacts improve on an ongoing basis. An underlying belief is that best practices are achieved only if all key players participate in identifying and defining subdomain contents and, where appropriate, applying the results of the IDM process.
The General IDM Framework

The Model as described above contains a set of key concepts. The IDM Framework, shown on the next page, is a tool designed to translate the Model’s concepts into practice. The IDM Framework asks the following questions of each of the Model’s subdomains related to underpinnings, understanding of the environment and practice:

- What guides us?
- Where are we now?
- Where do we want to go?
- How do we get there?
- What did we do?
- How did we do it?
- What were the results?
- What do we need to change?

These questions compose the four essential steps of the IDM Framework: prepare a strong foundation for action; develop an action and evaluation plan; implement, reflect and document; and revise. Each step is applied to each IDM subdomain. The steps are best used organically rather than linearly, so that, for example, several steps are sometimes
worked on simultaneously, the order of the questions changes depending on the situation, and the IDM Framework process is ongoing with no beginning or end.

The Interactive Domain Model Framework for Best Practices in Health Promotion & Public Health

### The IDM Evidence Framework

The IDM Evidence Framework, based on the same key IDM concepts as the general IDM Framework, assists people whose primary interest in using the IDM is to identify and use high quality evidence. The IDM Evidence Framework relates evidence to underpinnings, the environment, and practice. The Evidence Framework steps, meant to be applied in a continuous loop, are:

- identify the health promotion/public health question (based on health promotion/public health underpinnings, understanding of the environment, and practice)
- conduct research to answer the question, resulting in evidence which merges information from the local situation with information from other situations
- apply the resulting evidence, along with other IDM elements (underpinnings and understanding of the environment), to decisions
- implement the decisions in practice
- evaluate
- based on evaluation results, revise where necessary

### Timeline

The following timeline provides a history of the IDM. (This timeline is summarized from the timeline contained in the Reports section of the *IDM Manual*.)

- **1996-1997.** Participants at the International Symposium on the Effectiveness of Health Promotion call for tools to assist them in resolving issues related to health promotion...
evaluation and effectiveness. The Centre for Health Promotion, University of Toronto, creates the Continuous Quality Improvement (CQI) Work Group which evolves into the Best Practices Work Group. Members represent a variety of sectors. Health Canada, Population and Public Health Branch funds the next five years of what becomes known as the Best Practices Project.

- **1997-1998.** A literature review and synthesis by a Work Group member results in two background papers, on CQI and best practices. The best practices background paper includes the first version of the Model. The review draws on literature from the quality movement, evidence of effectiveness, and health promotion. Members explore best practices through a series of workshops and develop their own set of best practices principles.


- **1999-2000.** The Best Practices Partnership pilots the IDM approach with three Ontario sites: Durham Region Health Department; East End Community Health Centre (Toronto); The Willett Hospital (Paris site; part of the Brant Community HealthCare System). Negative results or lack of impact at one or more sites include: volunteer disaffection, resistance, no change in planning process.

  On the positive side, pilot test results confirm that the Model and Framework are flexible enough for use in different situations. One or more sites report increases in knowledge, skills, understanding, group cohesion, enthusiasm, systematic planning, credibility, and ability to identify and address work-related issues. Based on pilot site results, ways to improve IDM processes and materials are identified and implemented.

  The Francophone sub-committee is formed, funded by what is currently the Public Health Agency of Canada, Ontario and Nunavut Region, with a mandate to adapt the IDM to the Franco-Ontarian context.

- **2000-2001.** The Francophone sub-committee conducts an assessment of Francophone practitioners’ needs and capacities regarding best practices in health promotion. The Ontario Hospital Health Promotion Network joins the Best Practices Partnership. The first version of the *IDM Manual* (a guide to the IDM approach to best practices for health promotion) is produced, the peer-reviewed journal *Health Promotion Practice* publishes an article explaining IDM Best Practices key concepts, and the IDM Computer Program is developed.

- **2001-2002.** The Ontario Ministry of Health and Long Term Care funds the development of a learning module based on the newly developed IDM Evidence Framework. Six sites participate in testing this learning module and the Evidence Framework: Access Alliance Multicultural Community Health Centre (Toronto); Brant Community HealthCare System (Brantford site); Peterborough County-City Health Unit; Sudbury & District Health Unit; St. Joseph’s Healthcare, Women’s Detox and Mary Ellis House Treatment Program (Hamilton), which later evolves into Womankind Addiction Service; West Hill Community Health Centre (Toronto). Results from participation in
the learning module and application of the Framework include increases in:
knowledge of health promotion, research, and sites’ selected issues; team and
organizational cohesion; the value and degree of enthusiasm associated with research
and evidence. Materials and processes are revised based on feedback.

- **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; to make resources available develops a website at
  [www.opc.on.ca/francais//projets/pratiques.htm](http://www.opc.on.ca/francais//projets/pratiques.htm).

- **2004 to present.** Individuals continue to volunteer their support to enhance the ease of
  use of the IDM, 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 at [www.idmbestpractices.ca](http://www.idmbestpractices.ca) and the Best Practices in Health
  Promotion website at [http://www.bestpractices-healthpromotion.com](http://www.bestpractices-healthpromotion.com), and conducting
  this *Follow-up* of the IDM.

  Organizations also 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 2004 session Best Practices at Home and Abroad; the
  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.

  A growing number of individuals and groups around the world show interest in
  and begin to use the IDM in areas such as planning, evaluation and values
  clarification.

  Because the IDM has been used with public health units, hospitals, and other
  health-related organizations, and because of the overlap between health promotion,
  public health and population health, some people now refer to the IDM as a best
  practices approach for better health rather than as a best practices approach for health
  promotion.

**IDM Resources**

English-language IDM resources were developed based on adult education principles and
on pilot testing and workshopping experiences. They have been revised on an ongoing
basis as the result of feedback from pilot site participants, workshop participants, Best
Practices Partnership members, and other individuals with relevant expertise. English
language resources include:

- IDM Model and Framework
- *IDM Manual: a guide to the IDM Best Practices Approach to Better Health* (sections:
  Basics, Guidelines, Evidence, Research/Evaluation, Using the IDM, Reports on Using
  the IDM)
- *IDM Best Practices Road Map for Coaches*
- *Best Practices Check-In forms*
- *IDM Best Practices Computer Program*
- *The Interactive Domain Model of Best Practices in Health Promotion: Developing and
  Implementing a Best Practices Approach to Health Promotion* (published in the peer
  reviewed journal Health Promotion Practice)
- IDM Best Practices website ([www.idmbestpractices.ca](http://www.idmbestpractices.ca)): reflections, profiles, jottings, resources
French language MDI (Modèle des domaines interactifs) resources have also been developed. These include:

- Cadre d’utilisation du MDI
- Terminologie des Meilleures pratiques en promotion de la santé
- Guide d’utilisation du MDI pur établire les meilleures pratiques en promotion de la santé
- Modules de formation sur le MDI
- Critères et principes directeurs de Meilleurs pratiques suggérées en promotion de la santé
- website page on OPC website

A key resource for both English and French language speakers is assistance from individuals familiar with the IDM/MDI.

**Follow-up to IDM Use and Impacts**

The purpose of this *Follow-up* was to assess the ease and effectiveness of the IDM’s application – and ultimately to improve the IDM’s processes and resources – and to gather information for a chapter in an upcoming book. Planning for this *Follow-up* began in January 2007. In mid-January the first requests for participation were sent or posted and the collection of documents for review was underway.

This *Follow-up* is based on information from survey responses and interviews, a group discussion, six case studies based on a variety of sources, author observations, IDM Best Practices website profiles and reflections and relevant documents. In total this *Follow-up* is based on information from 26 individuals and relates to 23 projects or organizations. (See Appendix I for the case studies, Appendix II for other examples of IDM use, and Appendix IV for more details about the methods used for this *Follow-up*.)

The time period for this *Follow-up* is from 2001, a year after the end of the first formal pilot-testing period, to June 2007. Information from the two pilot testing periods was not included in this *Follow-up*. (Details of processes and impacts at the time of the pilot testing are contained in the two pilot testing reports *Pilot Testing the Best Practices in Health Promotion Framework* and *Pilot Testing the IDM Evidence Framework Learning Module*, contained on the IDM Best Practices website at [www.idmbestpractices.ca](http://www.idmbestpractices.ca).)
RESULTS

An overview of Follow-up results follows.

Discovering the IDM

The individuals and organizations included in this Follow-up discovered the IDM through one of four methods:

- They were part of the original Best Practices Work Group and so played an active role in the development of the IDM.
- They participated in one of the two pilot testing phases of the IDM.
- They had personal contact with someone familiar with the IDM in situations other than the two described above, either through informal discussions or attending a presentation or workshop.
- They conducted a search for a health promotion tool, for example searching the literature and the internet.

Who Has Used the IDM

During the Follow-up time period, the IDM was used in a number of different ways, from planning to teaching, by people speaking English, French, Polish and Portuguese. It was used by, or influenced, individuals and groups based in North America, Europe, Australia and South Pacific islands. It is possible that it has been used in other places as well: the IDM and its resources are in the public domain and many individuals or groups may be using the IDM without the knowledge of the authors. The known individuals or organizations who have actively used the IDM fall into the following categories:

- hospitals
- public health departments
- community health centres
- grassroots community groups
- consultants developing plans or conducting evaluations, for example with multi-stakeholder partnerships or community health centres
- academic institutions
- privately owned business

IDM Uses and Benefits

The IDM was most commonly used for planning and/or research (including evaluation and general information gathering). Other uses included building team or organizational capacity and cohesion, increasing individual capacity, and contributing to the conceptual foundations of other approaches or frameworks. In almost all cases the purpose for using the IDM was achieved. No negative impacts were identified during the Follow-up period.

Examples of reported benefits of using the IDM included development of a successful program from its conception stage on, resurrection of an organization that was failing,
increased awareness of the connections between practice and underpinning pieces such as values, and stronger relationships among an organization’s staff and other stakeholders.

A year after the end of the pilot testing of the general IDM Framework all three sites were still reporting benefits. At the time of this Follow-up, seven years later, no response was received from one site. Two people who had participated in the second site differed in their responses to the Follow-up request: one reported that knowledge of the IDM had made no difference to the quality or outcomes of that participant’s work; the other reported a continued positive difference in personal understanding and approach. At the third site, positive benefits deriving from IDM use were reported as late as 2004.

Two years after the end of the pilot testing of the IDM Evidence Framework learning module two out of six sites responded to a call for presentations on best practices use and reported continued positive impacts. Participants from these two sites and another participant from a third site responded to the current Follow-up request. At one of these three sites two participants reported lasting personal benefits though the organization was not formally using it and two participants had no memory of having used the IDM. At the second of the three sites the IDM was still in active use and achieving positive results. At the third site use of the IDM had been discontinued after a year and a half but the participant responding reported that benefits had resulted from its use.

In the sites for which information is available, discontinuation of formal IDM use appears to have been due to: lack of support, lack of appropriate tools at that time (a number have since been developed), and/or organizational issues.

The various ways the IDM has been applied and the benefits that have resulted are discussed below.

**Planning and Research**

Many people identified the IDM as a useful guide, structure, blueprint or road map for program planning or research. Examples follow.

- Using the IDM for planning helped develop health promotion-based Womankind Addiction Service from its inception on.
- The IDM helped L’Association des communautés francophone de l’Ontario – Toronto (L’ACFO-TO) revive the organization and its programming by supporting the development of objectives and resources, providing concrete direction, and strengthening its vision.
- Use of the IDM at East End Community Health Centre, one of the original pilot sites, resulted in an action plan for one of its programs which, a year after the end of the pilot testing, was being implemented with positive results.
- The IDM was used to review effective primary prevention interventions for Type 2 diabetes. This Health Canada research project analyzed studies and developed a set of guidelines and recommendations for prevention strategies based on selected IDM domains.
- One Follow-up participant used the IDM as a checklist to ensure no key elements were omitted from an initiative.
• One evaluator reported using the IDM to provide a structure for questions, methods and analysis. Similarly, another evaluator analyzed data using the IDM domains.
• The IDM Evidence Framework helped one Follow-up participant define search parameters and conduct a literature review that identified and selected information reflecting health promotion values.
• One public health department reported two years after the end of the second pilot testing that the use of the IDM Evidence Framework had increased the use of evidence based research and the number of community consultations.

Other comments related to the use of the IDM for planning or research are that it fits with other planning models, forces integration of planning and evaluation, and ensures no important pieces are omitted. In addition, its questions help identify practice choices that move a program forward and are appropriate to the particular population and context. A general statement by one person was that using a best practices model supports continuous quality improvement, professional reflexivity, and criteria to measure effectiveness. Observations specific to the IDM Evidence Framework were that it increased awareness of the effectiveness literature, and supports addressing an issue’s challenges, use of qualitative research, and a systematic approach to applying research results to everyday practice.

Selected quotes about the IDM and planning and research

— [The IDM was used] to frame how we went about planning and incorporating best practices into our work – we used the IDM and its Framework to develop an end product, a new addiction program and service for women based on current best practices…[Using the IDM Framework] provided direction and a set of clear steps, provided reminders, and made sense. [Deb Bang, Womankind Addiction Service case study]

— 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. [East End Community Health Centre report 2001]

— Because of the MDI we were able to take an organization that was on an artificial breathing system – it was about to die – and three years later have a complete “building community” concept as a result of working on the foundations etc. The MDI has helped tremendously… It forced us to develop not just a program but organizational objectives as well. We didn’t have the things we needed at an organizational level, we needed to acquire resources – we have used the MDI a lot to assist us in getting those resources…

   We’re really using the Model as a way to structure everything we do… The end result [of using the MDI] is a concept that is really solidly focused – our community development focus… It gave us a sense of where we want the organization to move to… The Model will continue to remain the blueprint of where we are going. [Hélène Roussel, L’ACFO-TO case study]

— I analyzed some studies using the whole IDM, all the domains, to see if we could decide if something was good or not. I looked at primary prevention using all the underpinnings – values, goals, evidence. I looked at guiding principles, the current situation…

   What’s really neat is looking at the ideal situation, where we want to go – when planning something [it is important to] ask the question “what do you have to do to change that?” A lot of people forget that question and can’t break that down. The IDM questions get you really thinking through each stage. They give you a map to think through the stages – how do you get from point A to point B to point C?… The Model is a good tool to operationalize something. If you pick a topic, you have to ask why is that important, what are you going to do, who is the target group – it’s all in the Model. It helps you to be more precise and fine tune things… [Jackie Kierulf, interview]
Using [the IDM] elements of values, beliefs and the rest as a checklist [for conducting evaluations] guarantees nothing important is overlooked, and helps organize the information that is gathered in a way that is meaningful. [Barbara Kahan, jottings]

The definition I know best is the IDM’s, where we pay attention to revisiting and aligning our approach, strategies and activities with health promotion values. The core vision and values don’t really change over time; the IDM framework provides an anchor to keep us on our path AND to help us see when and where to try new or different paths. [Peggy Schultz, profile]

...the utilization of this [evidence] framework allows for a systematic approach to incorporating research into practice as well facilitates justification and validation of the value for utilization of qualitative research as this type of research may be more reflective of the values held within health promotion. In addition the utilization of the evidence framework assists with “making the case” to middle and senior management regarding need for focus on or resources allocated to a particular public health problem. [David Groulx, reflection]

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. [Ghislaine Goudreau, Sudbury & District Health Unit report 2004]

Conceptual Foundation

The IDM’s basic concepts contributed to the development or content of other models, tools, and individual understanding, for example:

- It was adopted to formulate the foundational underpinning of the Toronto Public Health Practice Framework (TPHFP). The IDM domains complement two other TPHFP core components: diversity of Toronto’s population and Health Canada’s Population Health Promotion Template, which guides the practice cycle.
- It influenced the Nova Scotia Best Practices Framework.
- It contributed to the Association of Ontario Health Centres best practices approach, in particular with respect to the role of principles and values.
- The IDM was one of 17 tools included in a synthesis and Delphi rounds process which resulted in the European Quality Instrument for Health Promotion (EQUIHP).
- It influenced the research framework constructed by one PhD level student.
- A number of people noted that becoming familiar with the IDM led them to a broader understanding of health promotion and best practices, recognizing the importance of a number of factors such as values, not just evidence. It also led them to recognize the interconnectedness of the factors, for example how values affect the choice of goals and the methods used to achieve goals. In addition, several people commented that this new understanding was applicable to personal life as well as work.
Selected quotes about the IDM’s contribution to conceptual foundations

— Actually I ended up deciding that no available model did fit exactly my aims/perspective [for PhD level research], so I opted to try and develop my own framework. In this IDM was very inspirational and though it is difficult for me to say exactly how, I know it definitely influenced (and helped) my thinking in this matter:
  – maybe in its very ample/comprehensive scope;
  – probably in its logic/approach – namely in valuing a systematic process of reflection and making explicit, instead of an established set of contents; in highlighting the importance of values; etc.
  – definitely in some of the specifics as well (like some of your underlying beliefs and assumptions, concepts, and so on) [DJ, email]

— The work [related to the IDM] has been an insightful resource in developing this Nova Scotia Best Practices Framework…[The IDM’s] idea of a health promotion framework that utilizes a process of critical reflection is an important feature of our Framework…[Joyce Emmanuel, Overview and A Framework for a Best Practices Approach to Health Promotion]

— The IDM informed the best practices work we did at the AOHC (Association of Ontario Health Centres), particularly the principles piece. [Rishia Burke, profile]

— The IDM gives you a broader scope for what you’re doing at work but it also translates personally – in my life I can think “these are my values and my passions.” [Catherine MacPherson, Ceridian-Leade Health case study]

— My current understanding is much more broad and inclusive. It does not only focus on the best evidence but how this information interacts with all the other domains. My involvement in the pilot phases has strengthened my belief in the importance of reflection on my practice in public health. [David Groulx, reflection]

— Some connections I was familiar with [before in-depth acquaintance with the IDM] – for example, looking at evidence – but particularly the values connections I hadn’t thought about. Now even in other areas I think about that more, how do underlying values affect what methods people use to achieve their goals, even what goals they choose. [Evan Morris, profile]

Building Organizational Capacity and/or Cohesion

At team, program or organizational levels the IDM was used to:

• clarify values and increase consistency between underpinnings and practice
• develop a common language, understanding and/or goals
• increase understanding of organizational and health-related issues
• focus discussions and increase dialogue between groups with different perspectives
• support positive organizational change
• support best practices and quality improvement

Even when the primary reason for adopting the IDM did not fall into one or more of the above categories, similar benefits resulted. A frequent benefit, regardless of intent, was an increase in cohesion resulting from:

• the development of a shared language, purpose and conceptual understanding
• inclusion in processes and activities of key players who previously had little or no involvement in some areas. For example, at Leade Health (now Ceridian), as the result of using the IDM, health coaches were invited to join work teams for the first time. At another organization, the IDM was used as an advocacy tool; staff have used it to back
up requests to increase the number of community forums for knowledge-sharing among stakeholders and to provide more opportunities for youth input into projects.
- viewing the team’s work in relation to the work of the organization over all
- relationship building as players, some of whom may have had little to do with each other in the past, come together to discuss aspects of work that are meaningful to all of them

Other benefits, intended or unintended, included an increase in reflectiveness and insights into organizational and health/social issues, identification of ways to address organizational and selected health or social issues, improved communication, and development of guidelines for decision making and to assess consistency among the domains. For example, as a result of using the IDM, L’ACFO-TO experienced increased consistency and rigour in its work and developed a set of ethical principles.

A major impact resulting from the Brant Community HealthCare System (BCHS) process of using the IDM Framework to identify underpinnings such as health promotion values was the integration of health promotion into the hospital's work. The IDM process also assisted a BCHS-community partnership.

Selected quotes about the IDM and organizational capacity/cohesion

- Through the [IDM] Framework process, both teams came together…Our Mission and Values Statements emerged out of our work with the IDM Framework…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. [Deb Bang, Womankind Addiction Service case study]

- The [IDM] 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. [Durham Region Health Department report 2001]

- Our IDM work kickstarted this new portfolio of Primary Healthcare Development. The Willett’s work in health promotion was part of the reason this portfolio was created. What the portfolio would look like was completely open, so our work on the IDM Framework shaped it. The new portfolio was based on the Framework’s underpinnings that we developed and resulted in business being done in a new way in a hospital setting. It helped us identify how the hospital could work with the community as a partner and how we could work as a system to address health issues. Health promotion became a part of the hospital’s core business – that was a big deal for a hospital, hospital are into surgery and managing waiting lists. [Dilys Haughton, Willett Hospital/BCHS case study]

- Using the IDM helped us fine tune our designs, enhanced our coach training through developing competencies, brought us together. I feel like we were doing a lot of things before but we didn’t understand these were part of a best practices approach, the IDM helped us put it together and have a cohesive approach, it helped us add more good and best practices to what we were already doing…[Catherine MacPherson, Ceridian-Leade Health case study]

- Drawing from the IDM domains TPHPF made explicit that the health of the public and practices in public health do not exist independent of the physical, social, economic and political environments. These underpinnings constitute a common ground of practice for all TPH members and staff across all programs and services…TPHPF enabled the staff to reflect on their work and identify the missing components that could make the campaign more effective and inclusive…As a result, TPH staff working on a health promotion campaign had put ‘community involvement’ as one of the key priorities in the subsequent phases of the campaign. [TPHPF case study]
I used the IDM to guide me in identifying key elements that would lead to organizational understanding of best practices and also change in practices. [VV, email]

...Groups have been able to tie their team level work to the organization’s strategic planning work so that they can see how their team’s work related to others and to the organization as a whole. [Rishia Burke, Langs Farm example]

The [IDM] process brought the entire company together through a common purpose... Maybe they were working in finance or IT [information technology] and instead of their task being only about numbers it all came alive for them, they knew what services our company delivered and why...

Before we had staff members in the work groups but we never had a [health] coach. Because they were all busy in the field we didn’t think they’d be interested. Then [with the introduction of the IDM] we decided that’s not a best practices approach, we need the perspective of every stakeholder. Including them really enhanced what we accomplished in our work groups, the variety of perspectives was helpful. And coaches appreciated having input, they got excited about developing services...

It makes everything come together, at least it did for us. We had a number of pieces we were working on and the IDM was the web that connected everything for us. When we talked about developing a practice we would look for our evidence, our experience, what else do we need. We were able to use what we learned from the IDM in decision making. The IDM gave us a framework to say “is this part of our best practices, does it fit our focus” or “that’s not working, that doesn’t fit”. [Catherine MacPherson, Ceridian-Leade Health case study]

...I also use the IDM as a way to have a dialogue with colleagues from various disciplines and frame questions/issues. Although our work is based on the same action plan with the same targets and goals our interpretation is sometimes different because of the different perspectives. [Hélène Gagne, reflection]

The whole IDM process helped bring everyone involved into play. Often in an organization the environmental overview is done by high level managers and the board; it is very positive that the Model allowed everyone to be part of strategic thinking...

It’s been to me a very good way of creating synergy within a group – it brings people onto the same wave length and so creates a basis that supports the decisions we’re making. [Hélène Roussel, L’ACFO-TO case study]

Thanks to my exposure to the IDM, my Pacific colleagues and I are further along the way towards best practice in health promotion in their island countries. [Jan Ritchie reflection]

Individual Learning and Approach

The IDM was introduced in several universities: University of Toronto’s health promotion program in Canada; Medical University of Warsaw’s Department of Public Health in Poland; and School of Public Health and Community Medicine, University of New South Wales, in Sydney, Australia. It was also used to teach strategic thinking to volunteers, mostly immigrants, in L’ACFO-TO, a grassroots Francophone organization. In addition, it increased understanding of health promotion for at least one person and assisted another person to transition from the area of acute care into community based programming.

For many people learning about the IDM provided a foundation for how to approach their work, for example to look for links, critically examine underpinnings and the environment, go beyond journal articles to other sources in order to understand an issue, and to be systematic and reflective.

For some people learning about the IDM did not change their basic approach, but did affirm or reinforce the already-existing IDM-like aspects of their practice.
Selected quotes about the IDM and individual learning and approach

— [IDM knowledge] has made me think about my values and beliefs when addressing issues and has lead me to more critically examine the environment when addressing an issue. [David Groulx, reflection]

— The IDM offered a different way of looking at things. It gave me a usable framework...I liked the health promotion bit when I was looking at understanding the environment. I didn’t understand health promotion before – the IDM gave me a better perspective to understand my work. I was coming from a statistical and research background, I didn’t have a lot of experience in health promotion. It gave me that learning about the topic, the field – how things worked…[Jackie Kierulf, interview]

— Sometimes I wonder, do I use the IDM? Then I realize that I do, in the way I look at issues. Having worked to support the IDM and its Framework I now have a tendency in my work to look for what’s behind things, what are the underlying assumptions, are we talking about the same things, do we have the same values…The IDM pushes me to ask different questions of my colleagues – to know if we are using a common language, are we defining the research questions or issue statements the same way. It has forced me to have a systemic approach – having the IDM in mind helps me make the links. [Hélène Gagne, profile and reflection]

— I think the IDM has influenced me in the kind of process that I take with the groups that I am working with. I work hard to get them to think about all the pieces that that need to come together to make a best practice. I ask them to think about the values that they bring to their work and how that effects what outcomes they expect. I ask them to consider the theory and the evidence in literature when they are developing a practice.

    I think my involvement has been a factor in increasing my reflectiveness. I like to make sure that at some point in a project I take time to sit back and make sure that we haven’t missed ay steps, that everyone who needs to be involved has been and that where we are going is grounded in evidence. [LS, email]

Outcomes

Ultimately it is important to know whether the IDM, in addition to improving processes, capacities, consistency among the domains, and other areas related to health promotion and public health, contributes to improved program outcomes for the selected priority population. Unfortunately at this point in time it is not possible to answer this question with any certainty. This Follow-up does not have the resources to rigorously examine the specifics of a number of program outcomes and whether they would have been achieved without the IDM. In addition, a longer timeframe is likely required in order to fairly judge the IDM’s impact on program outcomes.

The information collected to date, however, is promising. People have made general comments reporting improved outcomes. As well, the Regina Early Learning Centre which for nearly 30 years has been using an IDM-like approach – that is, an approach which contains all the key elements of an IDM approach but was developed without knowledge of the IDM – has had extremely positive outcomes according to an outcome evaluation. It is hoped that in a few years resources will be found to study more thoroughly the impact the IDM has had on program outcomes.
Selected quotes about the IDM and outcomes

— Since the IDM model was introduced in 2001 to the SDHU, several elements of the model have helped us achieve several Best Practices outcomes. [Ghislaine Goudreau, Sudbury & District Health Unit report 2004, revised 2007]

— The IDM project appeared to be very useful for health promotion community programs. [HG, email]

— I believe that the steps [related to the IDM] have had a positive impact on the outcomes associated with my work. [LS, email]

— Practices, changes, directions that are most successful come from premises pervasive in the IDM – values, theories, understanding our environments such as the corporate culture, what are people’s practices, what works, what doesn’t. Our best outcomes emerge when we use the IDM at least as the backbone of what it is we’re doing – the IDM is a way of being, of thinking, of starting things. [Deb Bang, Womankind Addiction Service case study]

IDM Content

The content of the subdomains, that is, the actual values, theories, beliefs, environmental vision and analysis, and practices identified by using the IDM approach varied from organization to organization and project to project. (See, for example, Appendix I for case studies and Appendix II for other IDM examples.) To illustrate, the table below provides a set of values, beliefs and/or principles from two different organizations. Note that both organizations share two values: inclusion and respect. Other values differ, but do not conflict.

<table>
<thead>
<tr>
<th>L’Association des communautés francophone de l’Ontario – Toronto (L’ACFO-TO)</th>
<th>KidsFirst Regina (KFR)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>project description</strong></td>
<td>A grassroots volunteer-based group for Francophones living in Toronto (Canada).</td>
</tr>
<tr>
<td></td>
<td>A multi-agency program for families with young children living in challenging circumstances in Regina (Canada).</td>
</tr>
<tr>
<td><strong>priority issue</strong></td>
<td>The degree of power and degree of social inclusion experienced by individuals are strong determinants of health. Francophones do not have much power or visibility in Toronto.</td>
</tr>
<tr>
<td></td>
<td>To assist families living in challenging circumstances in their efforts to provide nurturing and stimulating environments supportive of their young children’s healthy development, because:</td>
</tr>
<tr>
<td></td>
<td>• families in challenging circumstances require more support</td>
</tr>
<tr>
<td></td>
<td>• nurturing and stimulating environments give children a better start in life and prevent difficulties later in life</td>
</tr>
<tr>
<td></td>
<td>• the first three years of life are critical in terms of learning and development</td>
</tr>
<tr>
<td><strong>general goal or purpose</strong></td>
<td>The purpose of L’ACFO-TO is to build the feeling of belonging, and the visibility, of Francophones and Francophiles in their community and in the community at large.</td>
</tr>
<tr>
<td></td>
<td>KFR works collaboratively with families and organizations to maximize opportunities for KFR parents and children to achieve optimal physical, emotional, cognitive, social, and spiritual health.</td>
</tr>
<tr>
<td><strong>activities</strong></td>
<td>L’ACFO-TO’s Community Leadership and Capacity Development assists its volunteers to develop leadership skills. The Toronto Francophone Community Builders program is close to implementation, the French Bistro is in</td>
</tr>
<tr>
<td></td>
<td>The key program component centres around peer home visitors who work with parents to identify and reach their goals, develop their strengths, increase their parenting skills, and address challenges such as housing and food</td>
</tr>
</tbody>
</table>
L’Association des communautés francophone de l’Ontario – Toronto (L’ACFO-TO)  

the planning phase, and the French Language School is in the preliminary phase of discussing values and identifying theory and evidence-based research.

KidsFirst Regina (KFR)  
insecurity. Other program components include support from a mental health and addictions team and early learning and child care.

**IDM use**  
The IDM has been used intensively since 2004 for planning and evaluation.

The IDM has been used for a series of evaluations, beginning with a process evaluation of the set up and start of implementation period 2002-2003 and most recently a 2006 outcome evaluation. All evaluations included some planning aspects.

**process for developing the set of values, beliefs listed below**  
L’ACFO-TO volunteers developed a set of seven defined values linked to practice which are integral to the organisational motto “building a community one person at a time” through “D.I.R.E.C.T.E.”

The KFR evaluation committee drafted a set of principles, along with the content of other IDM elements, which were then reviewed by personnel of all KFR program components and KFR’s Management Committee. The principles and other IDM elements were revised accordingly.

**values, beliefs and/or principles**  
The values of D.I.R.E.C.T.E. are:
- **Diversity.** “Is what we’re doing in the image of the diversity of our community?”
- **Inclusion.** “Are we inclusive or are we working in silos within that diversity?” L’ACFO-TO’s “inclusion indicator” is having a feeling of belonging.
- **Respect.** “Are we at all times working in a respectful manner?”
- **Employability.** “What we’re doing is building the economic capacity of the excluded members of the community, but also becoming an economic value-added for the City.”
- **Comprehension.** Comprehension is about understanding issues and other points of view.
- **Transformation.** “Is what we’re doing going to offer personal transformation and also community transformation?”
- **Engagement.** “Is the creation of community engagement processes making people happy to be together? Is it creating a true sense of belonging?”

KFR processes and activities should be:
- **beneficial to families:** the priority of KFR is to benefit families through enhancement of healthy child development and prevention of health and social issues
- **strengths based:** strengths are used to develop capacities and address challenges
- **inclusive:** no individual or group stakeholder is excluded from KFR processes and activities, all major stakeholders participate in decision making, and resources are shared equitably on the basis of need
- **collaborative:** KFR actively cooperates and coordinates with, and enhances, existing networks/services
- **respectful:** all stakeholders are treated with dignity; processes and activities are sensitive to differences in culture, income, gender, age, health status, or other
- **accountable:** processes and activities are transparent, efficient, based on evidence, continuously improved on the basis of ongoing reflection and evaluation, and consistent with KFR values, theories and underlying beliefs, and understanding of the environment

**information source for this table**  
The L’ACFO-TO case study (see Appendix I). Comments in quotation marks are from Hélène Roussel as included in the case study.

The KFR logic model (see Appendix II).

**Application Methods**
An overview of how people went about learning and applying the IDM follows.

**Learning about the IDM**
People learned about the IDM in a variety of ways: participating in workshops, reading IDM materials, and talking to people familiar with the IDM. According to at least one
person, using the IDM with their work made the Model easier to understand over time. Others identified that the ease of use of the IDM is related to readiness to use the Model, familiarity with the Model’s concepts based on previous experiences, and/or an understanding of health promotion.

Follow-up results show that the IDM was introduced in different ways, some of them very creative. In one organization, for example, the IDM lead introduced the IDM to colleagues using a “stepping stones” analogy in a PowerPoint presentation. At another organization the IDM lead facilitated an exercise where the organization’s volunteer members used the IDM to plan a wedding, thereby learning about the IDM in a hands-on fashion and increasing their strategic planning skills at the same time.

**Process of Applying It**

The process of applying the IDM varied from situation to situation in order to make it relevant and usable in the particular context. For example, when working in the South Pacific islands, one person gathered IDM information through the use of story, an approach which fits the oral tradition of the community, and then translated the narrative into the IDM components. This method contrasted with places which used a table format with rows and columns to guide discussions centred on the IDM domains. Some places attempted to use the whole IDM while others focused on only a few parts. In some cases the IDM was named as the best practices approach that was being used, while in other cases the approach was used but not named. At L’ACFO-TO the IDM domains were revised every year and new people oriented to it. In most situations the IDM was explored as a group process. (See Appendix III: *Case Example of Applying the IDM for a composite picture illustrating the application of the IDM.*

The IDM Framework’s process of painting a picture of the ideal situation does not specify a time frame; L’ACFO-TO limited the time to within the next three years. A major modification instituted by L’ACFO-TO was to analyze the organizational and issue-related environments together rather than separately. In the case of the Toronto Public Health, the IDM is integrated with the Population Health Promotion Template and the organization’s access and equity policies and materials as a framework to guide its practice at all levels.

In all cases it appears that the Model supplied the content and the Framework supplied the questions; the process of working through the IDM involved answering the questions explicit or implicit in the Framework about the domains and subdomains included in the Model. In some if not all cases using the IDM is an iterative process; details are identified over time and revised on an ongoing basis rather than at once.

**Selected quotes about applying the IDM**

— A colleague and I worked closely with the reference group (through many reflections and debates) to identify and to extract relevant elements from these two models [the Population Health Promotion template and the IDM to formulate our own practice framework that is relevant to Toronto’s diverse populations]. [Josephine Wong, profile part II]

— ...the framework has slowly been rolled out to managers, but not the frontline staff yet, but managers who support best practices already send the information to their staff. Through word of mouth among peers, some staff have taken the initiative to learn more about the framework.
About two months ago, [some staff invited me] to present to them what the framework is all about... They have since used the framework to advocate for more community forums to share knowledge with other stakeholders and to ensure that there are opportunities for youth to provide input into the projects. [VV, email]

Our Mission and Values Statements emerged out of our work with the IDM Framework... As part of the Framework process we checked out the environment; we conducted site visits, garnered support, looked for partnerships, etc. ... We also explored what kind of evidence meant something to us and what didn’t... [The IDM continues to be used for values clarification and] as a filter to make sure organizational practices are meeting its values and mission...

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. [Deb Bang, Womankind Addiction Service case study]

Before I start the logic model process I work with staff to identify underpinnings. Then relate principles to strategic plan; think about outcomes, indicators, evidence to substantiate the outcome, look at literature. [Rishia Burke, Langs Farm example]

When working on strategies or undertaking certain programs I have used the IDM to ground the discussion. It’s been very useful — often when I’m talking to people they ask an initial question such as, “Can I get an example of a program on diabetes prevention?” I ask them, “How did you get to this point, who else is involved, what kind of perspective are you bringing to it?” They start thinking about that, they realize what else they need to know besides who else has done it before, they think about their own beliefs and values that they bring to their program. You can put it in a strategic plan format but that leaves out what I think is very important in terms of a values base. It’s not just “here’s the objectives and plan” but what’s underneath that’s driving it...

[In my work] I have emphasized the foundations of best practice — values and principles, goals, theories, evidence or data or knowledge that is available, understanding the context and environment — all come as part of practice. When someone asks for an example of an effective program so that they can apply it in their organization, I always discuss their interests, needs, goals and situation, and encourage them to put “evidence” of a previous practice or program into a mix of their own “best practice.” [Alison Stirling, profile]

The reason we have been so successful in using it at the grassroots is that we don’t let it bog us down, we use what we can in our own way. For example in the case of a project on partnership building we concentrated on three or four squares and that’s fine, it’s enough to give us a good basis to create a common language... [Sometimes we] round the corners, we don’t have time to fine tune things... We work in the spirit of it, then we need to go back to it, here’s what we’ve learned... [Hélène Roussel, L'ACFO-TO case study]

I worked with the quality assurance person, she was a good partner... the two of us did the background work, filled in the boxes. We went to different committees, took different pieces of information from different individuals in the company. A lot of information already existed, for example the company values and mission. We went back to the CEO to show him what we were doing, asked him questions for pieces we were unsure about. We didn’t fill in every box, it wasn’t an exercise in perfection... The next step was to open it up to the larger company. We had a company-wide brown bag session. We had a projector with the tool up on the screen. I had prepared a PowerPoint presentation, introduced them to the model and introduced them to health coaching... After working with the whole company [including nine work groups who analysed the organization’s values, culture, and environment] we published a white paper on best practices, had some public speaking opportunities, incorporated the best practices schema we had developed with the IDM into the overall plan for the long term. We will continue to incorporate it into the over all plan for quality assurance. [Catherine MacPherson, Ceridian-Leade Health case study]

Having been convinced of the worth of the Model, I added it to my resources and took it to the Pacific islands. I had been working with Pacific peoples in upgrading their health promotion skills for the past decade and had workedshoped different aspects of these skills innumerable times over this period. Immediately that I started discussing the Model with these Pacific peoples, I realised that if I were going to convince them of its merit, I had to take into account their traditional ways of teaching and learning, while being actively aware of their lower level of educational qualifications and their limited access to appropriate resources... Thus the IDM has...
infiltrated our Pacific work, but it is not used as set out for Canadian or other resource-rich countries. Instead of a series of boxes and checks, we use story or narrative to draw attention to those issues we want covered. We make certain we include understanding of the environment; we always consider values and meanings in the underpinnings… I will use a bit of story when I introduce different concepts, for example I will tell a story about a sea voyage before talking about the Ottawa Charter [for Health Promotion]. If I am wanting to learn about something I ask them to tell me their version, I phrase my question in such a way to allow them to give me their answer in a story format. They then might tell me, for example, about their uncle – the story is concrete, about a real body… Talking about things like “creating supportive environments” is so up in the air. Rather, I might talk about getting the village on-side, and choosing a night to meet when there’s a full moon. The full moon is the spiritual piece, getting the village on-side is the social piece, the meeting place is the physical. [Jan Ritchie, profile]

Resources

In general the particular resource used most or found most helpful varied from person to person. Follow-up results however indicate that the most useful resource to understand and apply the IDM was talking to someone knowledgeable about the IDM. People also commented on using and finding helpful the following: the Framework template and Model themselves; written materials such as the IDM Manual, Road Map for Coaches, peer-reviewed Health Promotion Practice article, and IDM Framework examples; the IDM Computer Program; the PowerPoint presentation; and the IDM Best Practices website. Two Follow-up participants had used and spoke highly of French language resources. Some people who were extremely familiar with the IDM no longer used the resources, relying instead on their own knowledge of the IDM, which had become internalized. (For Follow-up participants’ suggestions for improving the resources see section on Challenges and Suggestions for Addressing Suggestions).

Resources not specific to the IDM also played a role in applying the IDM. One person noted reviewing general health promotion materials such as the Ottawa Charter, for example to identify health promotion principles. Support from upper level management was helpful, and people drew on organizational materials.

Selected quotes about IDM resources

— One of the challenges I experienced in using the hard copy version of the Framework was retaining a mental image of the linkages across the various columns, or dimensions. The use of the [IDM computer program] software made this easier. For example, my seniors’ health framework was now broken down into more manageable pieces. At any point I could return to the whole to assess the coherence of the points input into the program. [Erica MacIntyre, reflection]

— Talking to [one person familiar with the IDM and a colleague] helped. I needed to talk about it, have a conversation and verbalize things, especially for this model – the dialogue is important, a good resource… I read the Manual from cover to cover and when needed referred to each section e.g. underpinnings. I looked at the breast cancer example and definitions of concepts. The examples and definitions were most helpful… To really understand health promotion I had to go back to the Ottawa Charter and other core health promotion resources – for principles and things like that. [Jackie Kierulf, interview]

— I probably relied more on the Manual itself (first the 2002 edition, later the 3rd one/2005), though I also found other materials useful – like the “Road Map for Coaches” and the 2001 [Health Promotion Practice] article… The model and other materials found on your websites were also very very important. [DJ, email]
Follow-up to IDM Use and Impacts (October 2007)

I read the IDM Manual, I took slides from the PowerPoint presentation, I contacted the individuals listed – that live support helped me most. I love the resources on the website, I read everything on it. Reading the website profiles of people was helpful – seeing how people interpreted it differently, the different ways people use the IDM. I used the tool, cited the IDM research papers. Definitely the published papers were wonderful – I wanted something peer reviewed, it really helped. I used the IDM computer program – I had it installed on our computers, that’s what showed up on the screen for the company-wide session. The examples such as the filled in framework for ABC [Against Breast Cancer] also helped. [Catherine MacPherson, Ceridian-Leade Health case study]

Strengths

People identified many strengths of the IDM: comprehensive, systematic, and coherent; reflective; adaptable; credible; and dynamic. In addition, and for many people the key strength, it incorporates values and other underpinnings in its process, which most other approaches do not. People also commented on specific IDM strengths relevant to understanding the environment, planning and evaluation, and increasing inclusion and cohesion. More detail and selected comments for each strength follow.

- **values and other underpinnings.** For many people the underpinnings piece, missing in other models or tools, was the “value added” component of the IDM: it provides a health promotion filter and increases integrity of practice as it promotes the evaluation of alignment between values and practice. It also ensures that values and other underpinning elements are made explicit, discussed, and clarified for their meaning in relation to practice, for example so that issues related to inequities can be brought into the open for transformation and change, rather than implied or ignored for fear of the conflict that might arise if differences are exposed.

- **understanding of the environment.** Some people also identified the understanding of the environment domain as a strength because it helps to contextualize practice in relation to the environments that are internal and external to any organization or project. This domain assists in navigating through and addressing environmental issues.

- **reflective.** As reflection is built into the Model and Framework through its implicit and explicit questions, it facilitates individual and organizational reflexivity.

- **comprehensive, systematic and coherent.** A number of people commented on the IDM’s holistic, organized and “big picture” nature. People appreciated that the IDM’s domains contained the complete range of factors necessary to the practice of health promotion, that it organized these factors in a systematic way, and that the end result was a coherent or integrated picture.

- **adaptable.** Many people highlighted the adaptability of the IDM to different circumstances and to different methods of use. Regarding its adaptable use, Follow-up participants reported that it can be used as a whole or in part and there is no set order to working with its elements. Regarding its adaptability to different circumstances, it is flexible enough to accommodate a variety of values, organizations, cultures, and local interests or needs. Although no Follow-up participant specifically mentioned the IDM’s adaptability to a number of different purposes, this was evident in the range of uses it was put to. In addition to uses such as planning, evaluation, values clarification, and cohesion building, participants also mentioned its possibilities as an advocacy tool and framework for health promotion competencies based on IDM domains and subdomains.
credible. The IDM, according to Follow-up results, is credible because it is based on common sense, theory, and peer review. Its credibility also derives from an evidence base of a thorough literature review and pilot testing in a range of settings. In addition it is well thought out, includes key health promotion elements, and integrates the best of many models. This credibility promotes its uptake and the application of its key messages.

dynamic. People talked about the IDM being alive, fluid, dynamic, interactive not static, and not step by step. They talked about how its dynamic or interactive nature supported stronger relationships between the domains, promoted positive change, fits with the organic nature of health promotion, and brings programs alive.

promotes inclusion and cohesion. The IDM encourages the inclusion of all players in processes and activities including group discussions about what the different underpinning and other IDM elements mean on individual and group levels.

other. One person mentioned as a strength the IDM’s focus on assets. Another person mentioned that unlike other models the IDM has a place to put mistakes.

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**Selected quotes about IDM strengths**

— I like the [IDM] model – it’s not step by step, it’s more like a web. [Catherine MacPherson, Ceridian-Leade Health case study]

— I think that probably the thing I valued the most about [the IDM] was its comprehensiveness, how it takes into account all those different things (values, beliefs, theories, evidence, environment, practice, steps in the planning process, etc.), trying to link it all up into something coherent. What I understood as the most important messages of the IDM were the importance of considering all those things, (more or less) systematically, and to do it in a way that suits you and your context. To convey such a message will always be complex business – and probably the end result will almost inevitably be something different from the IDM!... as everyone will feel the need to simplify and adapt, prioritizing some of the “ingredients”, and rearranging and processing them their own way. [DJ, email]

— The IDM was the best HP [health promotion] model I found, and seemed to me to be highly suited to my purpose… The key here was that, uniquely in my view, the IDM was a tried-and-tested, all-in-one, integrated, comprehensive, holistic and best-practice-oriented model of HP. It seemed to me to be a HP one-stop-shop with no key bits missing, and I saw no need to look elsewhere for essential HP ingredients… I was very sorry that I didn’t encounter the IDM earlier in my literature search. It would have made my lit review and my workplan a lot clearer and more systematic. [NR, email]

— [The IDM Framework] helps you move fluidly [so you] don’t get stuck in a box – which is important for health promotion, which is fluid and organic and doesn’t fit a linear model. [WB, interview]

— 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. [East End Community Health Centre report 2001]

— 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. [Ghislaine Goudreau, Sudbury & District Health Unit report 2004]

— I really like the way the boxes encourage the model user to start with the ideal, then consider the current situation and develop the practice as a way of moving forward to attain the ideal. This focus on the positives rather than the usual epidemiologically-based plan of starting with negative problems is again most progressive. [Jan Ritchie, reflection]
I usually refer to the IDM definition if I’m asked to define best practices – I think that’s a well thought out definition, it captures what we have to be looking at regarding best practices, especially for health promotion. [Irv Rootman, profile]

I found there are so many things you need to consider [in the IDM] – you need to scan the whole environment, not just journal articles. You need to look at all the pieces – in best practices you don’t just look at what works, you have to look at what doesn’t work so you don’t make same mistakes again and so you can learn from the mistakes. In other models there is no place to put the mistakes… [The IDM] makes you understand that there’s a policy maker and you and an environment – can I connect or am I a person alone who thinks this is a bad thing? It gives you a picture of the players… Some pieces were more relevant for me than for other people. Other people only used this part or another part. It’s helpful that you can just use one part… [The IDM helps people] organize their world and their concepts and puts it together in a visual picture for themselves. [Jackie Kierulf, interview]

[The IDM is a] good framework to allow for crucial examination of mission, values and goals to see if the services you are providing are meeting these… [It] is based on theory and best practice, has been peer reviewed, written about in the literature, presented at conferences nationally and internationally, used and appreciated in a number of settings for a variety of reasons… [Deb Bang, Womankind Addiction Service case study]

In my literature search on ‘best practice model’, I came across materials and models that were not satisfactory… For example, some models only focus on decontextualized ‘individual behaviours’, ignoring the environmental, social and political influences…

I was totally impressed by the comprehensiveness of the IDM and more importantly, it emphasizes the ‘interactive’ nature of the three key domains…

I was extremely impressed by the amount of work that has been put into the development of the IDM, the supporting literature, the comprehensiveness to address health promotion or other health issues from a range of angles. And I was MOST happy with how the model leads the users to become explicit about the underpinnings of their organizations and their own practices…

In addition the context domain: ‘understanding the environment’ was also a critical domain because…the organization’s] members (different program staff, managers, directors, board members) all perceive the internal and external environment differently; their perspectives were limited to their positions and experiences both within and outside the organization…

The strengths of the IDM include its ‘flexibility and adoptability’, its comprehensiveness – bringing in the critical dimensions (contexts, underpinnings) that most HP or public health practitioners tend to forget or avoid…I would say that the IDM model is a model that promotes ‘integrity’ and ‘honesty’; it is also a model that can be used to advocate for ‘transparency’ and in doing so, it facilitates ‘empowerment’ and promotion of equity…I see the IDM as a tool for me to advocate for a framework that addresses equity, power relations and transparency [VV, email]

The MDI is a breathing model, not static… [It] is unbelievably powerful. It forces us to integrate planning and evaluation. It brings us to that place where every time we create an objective we ask ourselves how will we demonstrate that we have achieved this. We are forced to think about evaluation from the beginning. It also helps us evaluate things like values and beliefs – to see whether what we do is based on values, the values are not just on paper… It reduces the gap between the talk and the walk – it provides integrity…

The MDI allows people to come to a common reality. For example, if we want to be inclusive – what does it mean to be inclusive, where are we at right now, where do we want to be. It’s okay not to be perfect – but is it okay to not be inclusive for the next two years because we need to develop the expertise, and then in the third year when we have the capacity we can be more inclusive? We need to discuss all of this…

The MDI integrates the best of many models – that’s why I think it’s a true best practice – it’s a holistic model…One of the key points is to demystify the idea that it’s complicated, if our group has been using it as a grass roots group, any group would be able to use it… Although at first the Model seems complicated, we have found it to be based on common sense. [Hélène Roussel, L’ACFO-TO case study]

This model guides individuals to navigate through this inherent complexity and multi-dimentionality [of health-related issues]. It allows for the identification of all the information necessary to guide health promotion practice for a given field that is best suited for a given population… [The IDM
facilitates] self reflection and examination of one’s own personal beliefs, values, and ethics and the environmental context in which these interact. Furthermore it allows and facilitates discussion…amongst organizational members on the varying viewpoints on their individual, team and organizational values, goals and ethics. In addition there may be variances in how one interprets the environment and the IDM model allows for identification and examination of these differences. These discussions are often absent in the examination of an issue yet inherently impact on the decisions practitioners make relating to addressing public health issues…

The utilization of the evidence framework assists with and gives insight into how to break down barriers that may be affecting an issue. For example in understanding the social and economic structures that exist one can begin to identify how to break down barriers such as financial constraints…

One of the most important strengths of this model is its portability. The IDM framework allows for the variations in values, ethics, goals, and environments that can be seen across cultures, organizations, and individuals, locally, nationally and internationally. [David Groulx, reflection]

Challenges and Suggestions to Address Challenges

Follow-up results indicate two main categories of challenges for individuals and groups who want to use the IDM: challenges in the organizational environment and challenges specific to the IDM and its processes or materials.

- **organizational environment.** One major organizational challenge to using the IDM was limited time and other resources. Another major organizational challenge was that the IDM approach and traditional approaches to practice do not mesh. Although the intent of both IDM and traditional approaches are to achieve positive outcomes, the IDM approach is holistic, reflective and process oriented while more traditional approaches consider a more limited range of factors and are oriented to immediate action and quick and easy solutions.

  Traditional approaches also tend to avoid identifying or addressing issues related to topics such as power and resource distribution, whereas the intent of the IDM is to make explicit the values, assumptions and current situation associated with these and other issues. Additionally, traditional approaches generally do not include a mechanism for checking consistency between actions and words, another point of difference from the IDM which requires action that matches what is said.

  Other organizational challenges included lack of familiarity with planning and frameworks, lack of a health promotion orientation, and existing or potential differences regarding understandings of underpinnings pieces. One Follow-up participant identified the need to develop IDM champions and an IDM-supportive infrastructure within organizations in order to address organizational challenges. Similarly another suggestion was to have one person initially dedicated to supporting the use of the IDM and collecting IDM-relevant information.

- **individual orientation.** Regardless of the organizational environment, sometimes individuals associated with the organization are action focused and resistant to reflection. A suggestion was to allow people disinterested in the strategic thinking process to join in once objectives are developed and the implementation process begins.

- **specific to the IDM.** According to Follow-up results one key challenge specific to the IDM was its complexity which made it difficult to learn, appear overwhelming, and difficult to keep in mind all IDM elements and their relationships. The second key challenge was that it is time consuming to work through. Related to the first challenge were comments about the need to simplify the appearance of some of the IDM resources and
to present the increasing number of resources in a less daunting way.

One Follow-up participant mentioned getting confused about what belongs to which domain and an occasional feeling of repetitiousness, but concluded that interactivity among the domains will inevitably result in overlap and that there is no right or wrong way to organize the information.

Not surprisingly, a common suggestion was to simplify the IDM and its resources. Another suggestion was to provide more examples to make it easier to grasp. As a result of this feedback the 1-2-3 IDM Quick Start has been developed. Other suggestions were: develop an abridged version of the IDM; develop a user-friendly guide to help people quickly identify which parts of the IDM and which IDM resources are most relevant to their immediate purpose; change the linear look of the Framework; and develop more tools to assist with evaluation. Other challenges mentioned by Follow-up participants were that the IDM's concern with effectiveness blocked creativity and that because of the open-ended nature of the IDM it could be misused.

One Follow-up participant who had listed a number of strengths and positive benefits of the IDM commented that the solution to the apparent overwhelmingness of the IDM was for people to work harder at it.

- Other challenges. Examples of other challenges to using the IDM included the difficulties of achieving consistency and maintaining focus, that the health promotion field is not valued, and that the IDM is not well known. Regarding this last point, Follow-up participants suggested a number of dissemination possibilities.

Many of the challenges listed above provide some explanation of why more places are not using the IDM: they are pressed for time, have a practice approach incompatible with the IDM’s, don’t know about it, or are daunted by it. In addition, one Follow-up participant who had intended to use the IDM for research ended up not doing the research because of illness. One pilot site stopped using the IDM after a year and a half because of the lack of time and personnel to collect and synthesize information and meet for evaluation purposes. This site however is considering using it again because of an increase in organizational resources. According to one person who participated at two different pilot sites in the two pilot testing phases, IDM use at an organizational level was discontinued at each site because of reduced contact with the pilot-test researchers and absence at that time of IDM-supportive tools.

While acknowledging the challenges to using the IDM, some people noted that the IDM was worth the effort.

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Selected quotes about challenges to using the IDM

— …I was also disturbed to find how much erosion of HP ideals was occurring, especially in the context of the (literally) competing approaches of Public Health and Population Health…I was very disappointed to discover that HP was still very much the poor relation of Public Health and was a bit of a lost soul really, at least in our neck of the woods…

My impression was that the IDM was relatively unknown in Europe, which surprised me because of its obvious utility. [NR, email]

— We struggled to use it for 1½ yrs however did not continue to use the tool in the program primarily due to time required to synthesise information and to meet on a regular basis for program evaluation… We looked at the IDM very enthusiastically however our challenges were
solely based on resources in order to ensure we were “doing it right” and the man power to assist with questions etc. I thought the Framework could have been incorporated more throughout the agency— a dedicated person to assist with information collection and interpretation using the IDM would have been beneficial at the time of introduction. We printed and discussed the framework at 1 of our meetings. My perception is that staff felt overwhelmed re: the amount of information to be collected and the process of evaluation seemed to be very time consuming. With our expansion of programs and services I thought it would have been prudent to continue & explore the framework as we expanded programs. Timing & introduction of the framework at that time was the issue.

[To increase use of the IDM:] Change the format and simplify the processes… Make it less daunting and overwhelming… I am not familiar with the new IDM material(s) and once they are reviewed by the Health promotion team [they] could assist our organizational capacity to resurrect implementation. Likewise connecting us with individuals/groups who have utilized the tool would be helpful. A core group of “users” to connect [with] on a regular basis would be great! With our recent growth, technology is now being incorporated within the agency. That will make it easier to use the Framework. [TP, interview and email]

— …Use of whole model may be difficult…One does not always have time to meet and think of issues in a comprehensive fashion. Steps get skipped due to resource purposes… Makes you realize what you need but you do not always have what you need. This can be frustrating. [JN, interview]

— Most Health Promoters juggle many projects and couldn’t possibly use this complex tool with all their projects… In general, the tool sort of pulls me in two directions. One I feel that it is too concerned with effectiveness (scientific) literature to the point where you lose your ability to be creative (that is my right brain speaking)… [OL, email]

— At first I was somewhat overwhelmed at the idea of applying the entire model to the process evaluation. [Evan Morris, reflection]

— People often find frameworks too theoretical and difficult to understand. We have found that managers are asking for a simpler version of the framework, or have consultants do the actual work of knowledge transfer. We had hoped to have a train-the-trainer version of implementing the framework but this has so far been proving difficult… [To address this,] provide articles on what a framework is, how it is used. [RF, email]

— …the IDM was excellent in identifying the critical domains and sub-domains that we need to consider in practice…But in reality when we try to bring these domains and sub-domains out on the table, they are sometimes met with opposition, not so much in the domains themselves but in coming to agreement of what our domains and sub-domains look like. This is where struggles of power and dominance come in. As these domains and sub-domains are contextualized, we had to put in a lot of energy and effort to define the sub-domains; for example, public health ethics and the law; what counts as evidence, etc. At the end, some of us fought to ensure that one of the sub-domains is not just called evidence, but ‘inclusive’ evidence. [VV, email]

— [Action oriented people] are usually motivated by tangible results and bringing them to a reflective process can be an extremely difficult task…[However] the model allows those who are more reflective to start the process up to the development of the objectives, and from there the action oriented people can finalise the process by creating the action plan which is basically the second and third parts of the model…

Our problems are way too complex now for a linear way of thinking – thinking in an integrated health promotion upstream way demands that we take the time, breathe that whole thing, create a whole culture, and that we’re good to each other in the process – this requires using a reflective process. But when you say that to people they say, ‘Yes, we want that. The problem is that conditions out there are not conducive to that.’ …For so many organizations the values and what they do are disconnected. There’s a gap, and often they let the gap go because they don’t have that reflective practice… [Hélène Roussel, L’ACFO-TO case study]

— Unfortunately practitioners themselves may be unable or unwilling to work through such complex models [as the IDM] in favour of more simplistic linear approaches, focussing in on, or addressing one aspect of the solution to a particular health promotion issue. I would speculate that this occurs as this approach would require less time on introspective, retrospective and prospective thought and analysis and would focus more on action toward program development
and implementation.

...as humans have varying values, goals and ethics, as well as understanding of theories, evidence, and their environment, there exists the potential for conflicting ideas on what would constitute “best practices” between individuals, teams or even between organizations within a community. This conflict has the potential to delay implementation of health promotion practices until such conflict is resolved.

...after the pilot phases of the project, access to expert support in model interpretation was diminished lending to the discontinued use of the model. At the time of the pilot testing there were no supplemental tools developed as there is today, nor were there identification of expertise to facilitate model utilization as there currently exists. [David Groulx, reflection]

—— I think the biggest challenge is still trying to get clients to consider the whole process and not just rush to the goal of a report for a funder. Reflecting on evaluation evidence and improving programs/services is the critical and yet logical step that we seem to busy to do...Can we develop an abridged, quality product that keeps the essence of the IDM to ensure that it has a larger impact? [LS, email]

—— At first I didn’t totally understand the IDM, it took a while – it’s not something that I could read and totally understand what it was about right away, it took me some time with the model, and to work with it. [Catherine MacPherson, Ceridian-Leade Health case study]

—— If your reference point is a framework of health promotion and the components of the domains you can pick up [the IDM] easily – [otherwise] it is difficult to pick up. [NE, interview]

—— It is not an easy model to learn – I found a learning curve to this model. You do have to be patient, to be able to really absorb it. It doesn’t happen over night. It is not a quick fix, it is a process...In the end you need to consider other things besides what works – that’s a hard lesson to learn. People want quick answers and this is a process based model. If you’re not a process oriented person, if that’s not your style, if a person is more focused on the product and the end point they wouldn’t get a lot out of it. The challenge is to convert people if they’re more product focused, get them to think in another dimension...

Because there’s a learning curve to the IDM and it takes a while to really get it you would have to break it down to a lot of pieces to get it to work with other people. Take an everyday example from the newspaper related to the health field and use that to illustrate a thought for the day or week. Eventually if you discuss a different component each time they will find they’re using the model without even thinking about it – by using everyday connections they will have internalized...For example substance use is so timely. Breaking things down into pieces helps – when you use an everyday example someone could see in that very small slice how it worked. [Jackie Kierulf, interview]

—— Although the IDM has been challenging to use, it is like climbing a mountain, and it has been worthwhile to get to the top. [Ghislaine Goudreau, Sudbury & District Health Unit report 2004]

—— I have no concern about [the IDM] being overwhelming – if people don’t get it they need to work harder at it... People can pick up IDM and do whatever they want, it could be misused...It is only as perfect as those people using it ... [group comments]

—— I sometimes get confused when I am applying the IDM, particularly between what is theory and what is analysis of the environment, and between what belongs to the evidence subdomain and what belongs to the environmental analysis subdomain. And sometimes when I am writing up results based on the domains I start to think “this is awfully repetitious, isn’t this covered already?” But in all these cases I always come to the same conclusion, that it is not surprising if there is overlap and no clear demarcations among the domains – interactivity among the domains is one of the key thoughts behind the IDM, which means it isn’t always easy to separate them out. I find this momentary confusion even between values and practice – if a value is being applied in practice, does that mean it belongs to the values subdomain or to the practice domain? Well, both! And then I also realize that the point is not getting the information into the right “box” but making sure that the information is identified and organized in a way that makes sense to me and whoever else will be using the information – there is no right or wrong box. [Barbara Kahan, jottings]
SUMMARY AND CONCLUSION

The IDM is a comprehensive model designed to achieve best practices in health promotion. This report has reviewed the characteristics of the IDM’s conceptual model and operational framework, use of the IDM to date, and the impact its use has had on programs, organizations and individuals. Strengths and challenges associated with implementing the IDM were also presented.

Many people have noted that the examination of underpinnings distinguishes the IDM from other models in the field. The IDM has demonstrated a critically reflective approach which can be applied to a number of various situations, populations and settings. Framework implementation has been to date an organic process demonstrating the flexibility of the IDM. The Framework’s comprehensive nature, flexibility and adaptability reflect the inclusive process that supported the evolution of the Model and Framework.

A number of initiatives have successfully used the IDM with very positive results. Although initially developed for planning purposes, the Model and Framework have provided much more than a planning structure. The IDM has guided evaluation and other research activities, helped build individual and organizational capacity, and provided conceptual foundations for other best practice approaches and tools.

Feedback from those who have utilized the IDM has provided encouragement and optimism regarding the sustainability and future use of the IDM in the health promotion field. Based on this feedback, in an effort to increase the use and effectiveness of this innovative best practices approach, work will continue to disseminate the Model, identify and provide appropriate supports for its use, and develop and improve IDM resources.
APPENDIX I: CASE STUDIES

The following case studies illustrate the application of the IDM in various practice settings, from community grass roots groups to large health care institutions. Information about the content of the IDM domains, which varies from organization to organization, is presented. The case studies examine the purpose, process of introduction, and results of using the IDM.
L’Association des communautés francophone de l’Ontario - Toronto (L’ACFO – Toronto)

This case study is based on information from the following sources:

- *Using the IDM Model: experience of Association des communautés francophone de l’Ontario – Toronto* (Hélène Roussel, report presented at Best Practices at Home and Abroad, September 2004; included in the IDM Manual section Reports on Using the IDM)
- *IDM Experiences of L’ACFO-TO, a Volunteer-Based Organization* (Hélène Roussel, reflection archives, IDM Best Practices website, November 2004)
- *Using the IDM/MDI* (Hélène Roussel, IDM Best Practices website reflection archives, April 2007)
- *Profile of Hélène Roussel* (IDM Best Practices website profile archives, March 2007)
- a series of conversations with Hélène Roussel in January, April and August 2007
- additional written comments by Hélène Roussel in June, July and August 2007

Notes

- All quotes are from Hélène Roussel.
- Hélène Roussel is a health promotion consultant with Centre ontarien d’information en prévention/Ontario Prevention Clearinghouse (OPC). She is also a volunteer board member with L’Association des communautés francophone de l’Ontario - Toronto, Canada.
- *IDM* stands for Interactive Domain Model and *MDI* stands for Modèle des Domaines Interactifs, the French-language version of the IDM.
- In Canada a Francophone is defined as someone whose first language was French and who still understands the language, or someone whose first language was not French but was educated in a French-language school system. A Francophile is someone who speaks French but whose first language was not French.
- The L’ACFO-TO MDI Framework working document was translated by a Public Health Nurse at one of the pilot sites. Her assistance is gratefully acknowledged. An excerpt from this Framework, provided at the end of this case study, was edited by Hélène Roussel.
- The program Ambassadeurs de la Francophonie was recently renamed as Toronto Francophone Community Builders program.
- This case study was prepared by Barbara Kahan and reviewed for accuracy by Hélène Roussel.

Description

The Issue and its Environment

The degree of power and degree of social inclusion experienced by individuals are strong determinants of health. Although there has been a Francophone presence in Toronto for
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four centuries, Francophones do not have much power or visibility in Toronto. Historically
this minority group has been discriminated against and is still perceived negatively by
some. L'Association des Communautés Francophone de l'Ontario – Toronto (L'ACFO-TO)
aims to assist the approximately 300,000 Francophones and Francophiles of Toronto to
value the French language in order to avoid assimilation. “L'ACFO-TO is doing this by
creating community engagement initiatives and an awareness of the continuum of various
services in French.” The intent of L'ACFO-TO is to make it possible for people to speak
French on a daily basis in a city of about four million (in the Greater Toronto area) where
English is the language spoken by the majority. Other objectives are to increase
Francophone visibility in a positive way, to increase participation of Francophones in all
aspects of city life including economic aspects, and to increase the feeling of belonging.

At the beginning of the century, French-speaking Canadians had a stronger presence in
Toronto, concentrated in two areas close to each other in the centre of Toronto. However,
they were displaced when their housing was lost because of public health issues, “creating
the loss of a vibrant and visible Francophone community in Toronto.” Currently
Francophones are dispersed throughout Toronto.

Although traditionally Toronto’s Francophone community was mostly composed of
Canadian-born French speakers, today’s Francophone community includes a large
number of immigrants from various African, European, Caribbean and other locations
around the world. “Close to 40 French-speaking nations are represented in the Toronto
Francophone community.” Although they share a common language, cultural backgrounds
vary widely.

Many people in Toronto whose first language is French are unaware of French-language
activities. Assimilation is a clear danger; the level of assimilation of a Francophone
immigrant family whose children do not attend a French language school can rise to 85%
after elementary school. “Because of the invisibility of the community many French-
speaking people are not always aware how to socialize in French whether it is in a family
environment or other social setting.”

A key strength is that “the Francophone community can qualify as a best kept secret”
which has “the potential of becoming an emerging valuable cultural and economical asset
for an international city like Toronto.” A key challenge is to increase inclusion within the
diverse Francophone community and in the larger community as well. Although most
Toronto Francophone community agencies offer front line services, with the exception of
L'ACFO-TO “very few agencies focus their work on building community capacity at other
levels. Unfortunately, working in this niche in the Francophone community is not very
viable financially. However at L'ACFO-TO we have developed a strong volunteer-based
grassroots community building model that makes it possible to increase citizen
engagement at a very low cost, and therefore to be more sustainable in our initiatives.”

organizational environment and practice
L'ACFO-TO is a regional chapter of a provincial Franco-Ontarian grassroots volunteer-
based organization which began in 1922.
It mobilised around the desire of creating a Francophone school system in order to avoid assimilation. Up until recently the organisation focused mostly on Francophone-rights advocacy work until funders of all the ACFOs in Ontario reduced their financial support. Many of the regional ACFOs then were facing major financial crisis, including L’ACFO-TO. It was in the process of closing its door when a group of visionary Francophones took over the organisation in 2003 and created a new direction for the organisation. Four years later L’ACFO-TO has become a renewed organisation that is valuable and meaningful for many in the community. It remains a very small grassroots organisation with a yearly budget that varies between $15,000 to $50,000 a year. L’ACFO-TO, like many grassroots organisations, functions on a project funding basis and has no full-time employees. All initiatives are driven by volunteer efforts. Whatever the volunteers can offer is welcome, from financial support, to talents and competencies, to a living room for our meetings, etc. The volunteer workforce also mirrors diversity of the community. L’ACFO-TO’s current key objectives are:

- Developing the leadership and capacity of the community
- Promotion of the Francophone cultures, language and services
- Developing the Francophone social economy
- Raising the profile of the Francophone community to the larger community

L’ACFO-TO’s membership is composed of three groups: Francophones from Ontario; Francophones who have moved to Toronto from other parts of Canada such as Quebec; and immigrants from French speaking countries in Africa, Europe and the Caribbean. Members represent a variety of cultures and religions, from Catholic to Muslim.

L’ACFO-TO’s activities, either in the planning or implementation stage, include:

- **Toronto Francophone Community Builders.** Volunteers will identify and create a database of people who speak French to keep people informed of what is happening in the community. A relationship-building approach will be used, for example with personal invitations to events rather than an ad in the newspaper. This program is close to implementation, with plans to recruit the first 50 builders in fall 2007. Objectives to reduce the gap between the ideal and actual situation will be reviewed and possibly revised.

- **French Bistro.** “This social economy initiative, in addition to raising money to allow L’ACFO-TO to be as independent from funders as possible, will be a visible spot in this city where French speaking people can come to socialise and/or practise their French” with events such as French literature evenings. This project is in the planning phase.

- **Francophone Village.** L’ACFO-TO is lobbying for recognition of the once thriving Francophone village that existed in Toronto: “history has been erased.” In addition, work is ongoing to build the current Francophone community where the village was located, for example by encouraging businesses to serve people in French.

- **Community Leadership and Capacity Development.** This program assists volunteers, primarily recent immigrants to Canada, to develop strategic thinking and other leadership skills.

- **Website.** A website, to be launched in fall 2007, “will bring to the forefront Toronto’s historical Francophone village and demonstrate virtually many elements that still form today a Francophone village.”
### Working with Other Francophone Organizations

L’ACFO-TO has supported FrancoQueer in its growth. It works with other groups as well, such as a women’s immigrant employment organization. Graduates of L’ACFO-TO’s leadership program join other groups or initiatives. L’ACFO-TO supports community initiatives in various ways: financially; by offering the skills of its volunteers; and by sitting on various boards of directors. “At present the volunteer leaders who have emerged from the leadership program of L’ACFO-TO in the last four years have been involved in over 30 projects of all kinds. In the theoretical framework of L’ACFO-TO we call them ‘activation agents.’ They bring the vision and values of L’ACFO-TO and infiltrate them in various other organisations, which creates after a while a momentum around values. The early influence of L’ACFO-TO in the Ontario Francophone community around the importance of inclusion is one impact of the approach.”

### Values

“Values at L’ACFO-TO provide the foundation of all its work and initiatives. The value lens at L’ACFO-TO is quite different than most other organisations. In the desire to create an inclusive community, members realised that although the French language was bringing them together it wasn’t what was keeping them together.” Their insight was “that only the adoption of humanistic and democratic values was really creating cohesion amongst each other. Using a model such as the MDI has been fundamental to come to this realisation. The model allowed for a dialogue to occur around values which now is constantly reinforced.” L’ACFO-TO volunteers developed a set of seven defined values linked to practice which are integral to the organisational motto “building a community one person at a time” through “D.I.R.E.C.T.E.” The values included in this D.I.R.E.C.T.E approach follow.

- **Diversity.** “Is what we’re doing in the image of the diversity of our community?”
- **Inclusion.** “Our approach to inclusion is mixing people who would not normally be together... Are we inclusive or are we working in silos within that diversity?” L’ACFO-TO’s “inclusion indicator” is having a feeling of belonging. “We started to ask ourselves at a community level, how do we create that? It became clear that it’s not at an organizational level, it’s when each individual is important.” An example of how ACFO-TO translates this value into practice follows:

  In the leadership program we mixed volunteers who were mostly newcomers from Africa with a group of mostly gay males and said, “You have to organize a fundraising activity for the community.” It was magical. For instance, the African women in the group wanted to be in the kitchen but the kitchen had to be shared with the transgendered group. The people from Africa had never had the opportunity to be in that kind of queer culture. We did some debriefing at the end, and although the discussion around queer issues (which included bisexuality, transgendered issues, homophobia, etc.) was filled with a lot of myths, it was not prejudice, in a way it was for the purpose of learning more, not for judging or condemning. The experience of being together brought them to a place of being open rather than a place of judgement.

- **Respect.** “Are we at all times working in a respectful manner?”
- **Employability.** “What we’re doing is building the economic capacity of the excluded members of the community, but also becoming an economic value-added for the City.”
Comprehension. Comprehension is about understanding issues. “When entering into a program or intervention, is this done with a full understanding of the issue? Is it evidence based? It is also about how open we are at a personal and social level to understand each other’s point of view.”

Transformation. “Is what we’re doing going to offer personal transformation and also community transformation?”

Engagement. “Is the creation of community engagement processes making people happy to be together? Is it creating a true sense of belonging? It is also an acknowledgment that without the community engagement of our valuable volunteers nothing would be possible.”

Ethics are strongly related to values. L’ACFO-TO’s ethical principles include: respect, inclusion, integrity, solidarity, social justice, building on strengths, working by consensus, transparency, accountability, supportive environment, and collaboration.

Theories/Beliefs

Theories shaping ACFO-TO’s activities include those related to social marketing, linguistics, social psychology, community development, adult education, vocational, post-modernism, and health promotion. The following is a list of the various theories and models used at L’ACFO-TO.

- Definition of Inclusion from the Count Me In project (2005)
- L’analyse du discours dans la communauté franco-ontarienne
- les modèles le discours de la communauté (Heller et Labrie)
- Intéractionniste (Limoges)
- L’étude de vitalité des communautés Francophones en situation minoritaire (Anne Gilbert 2006)
- La sociologie des groupes opprimés en particulier les études gaies et lesbiennes (Foucault, Sedgwick and Rubin)
- L’historiographie de longue durée (Fernand Braudel) sur les droits civiques, linguistiques et politiques au Canada depuis 1755
- Healthy Communities model - Hancock and Duhl (1986)
- Ottawa charter in Health Promotion (1986)
- Health Promotion Framework (Hershfield 2003)
- Psychology of human development (Loevinger, Piaget, etc.)
- L’Orientation professionnel (modèle intér-actioniste)
- Various adult education principles (Multiple intelligences, 4 mat system, etc.)
- Popular education model (Friere)

Beliefs as of 2004-2005 follow:

- There is no Francophone community in Toronto.
- There are no mistakes, only lessons learned.
- Everyone has something to contribute.
- Being French is value added.
- One-on-one personal contact is important.
- There is a lack of French services.
- It is important to stand up as Francophones.
- It costs dearly to be a Francophone group.
• Francophones are a closed group which is difficult to join.
• It isn’t always necessary to have money to implement projects

In addition, a strong belief is the importance of building community one person at a time. This belief links to the concept of inclusion and belonging. Another guiding belief is the importance, given the diverse nature of L’ACFO-TO’s membership, of building on commonalities “rather than looking at what’s wrong with you.”

An example of how beliefs have changed over time as a result of reflection follows.

When we started we had a belief that there was no such thing as a mistake, it’s not a word that we’re using in our organization – there was only learning. But over the years people have made major mistakes… but because we wanted to be strong on values we said that there is no mistake only learning so we have to behave like that – so we have put a lot of energy into coaching, but the end result is not what we were hoping for. That has created a little crisis around that belief – we discussed it this year quite heavily, that it’s good to say there’s no such thing as a mistake but somehow better to say a mistake has learning consequences. We realized when we started to apply it, as much as it was lovely and sweet and capacity building, we realized that it was a belief that was not supporting what we want to do. We brought it back to the group – what are we doing with this? It is one thing to put something in a square in a model, another to walk the talk. How do you re-evaluate this, create a reflective practice? We will revise this belief this year, it will probably be something in the area of “all mistakes equal learning.”

Evidence
L’ACFO-TO’s evidence gathering activities are an integral part of its practice. They include research, for example identifying relevant Statistics Canada data, and ongoing program evaluation. “If we want to be consistent with our D.I.R.E.C.T.E. values, the ‘C’ for comprehension and understanding demands that we support some research that is part of our community. We like to try to do at least one research project a year so we can contribute to the evidence base. We also make sure we are aware of the various research results that may help us build our understanding of our issues as a community.” L’ACFO-TO integrates the evidence it gathers into its practice.

Using the IDM/MDI
Since 2004 L’ACFO-TO has used the IDM/MDI to plan and implement the activities previously outlined. L’ACFO-TO has also used the IDM/MDI as a learning tool, “as a way to teach strategic thinking” in the leadership program, and as a way to increase credibility with funders. “To me the whole thing is the spirit of the MDI, we’re together in a team, we’ve created a vision of capacity building – revised it every year – every new person is oriented in it...The MDI is a breathing model, not static.”

Process
L’ACFO-TO uses the questions inherent in the IDM/MDI as a guide and “reference tool at each committee meeting. It is a work in progress and a very organic working tool as far as we are concerned.” For example, “With the MDI we’re always asking ourselves what’s
going on with the internal and external environments.” Other IDM/MDI questions are, “Where are we at, where do we want to go ideally. This is really fun when you start asking these questions.”

Exploring IDM/MDI foundation pieces such as values is conducted as a group process. The IDM/MDI is approached a bit at a time. “With the IDM, we usually use the section that is the most appropriate for our projects. Sometimes we don’t need all the sections, we plan up to where we can and then revise our IDM as we move on in the project.” As a result, each project is at a different stage of the Framework, with some projects having used more of the Framework than others. “The reason we have been so successful in using it at the grassroots is that we don’t let it bog us down, we use what we can in our own way. For example in the case of a project on partnership building we concentrated on three or four squares and that’s fine, it’s enough to give us a good basis to create a common language.” Although the IDM/MDI can be used in chunks rather than whole, “the big rule is consistent thinking.”

The IDM/MDI process has been led by one of the volunteer board members who is extremely familiar with the IDM/MDI, having participated in the adaptation of the English language IDM materials to the Francophone context, and facilitated a number of French-language workshops to test the model and materials.

L’ACFO-TO has slightly modified the IDM/MDI in a couple of ways. The picture of the ideal is viewed as “the ideal situation in the next year or the next three years. When working with volunteers, some topics like ideals mean nothing to anyone, people like a more concrete vision, it’s easier to operationalize the foundation if we have a more modular approach: this year it’s this, next year build on that” rather than developing a more long-term view. Another modification is to apply a SWOT analysis (strengths, weaknesses, opportunities, threats) to the environment as a whole rather than separating out the organizational and issue-related environments.

The IDM/MDI provides a structure rather than a rigid step-by-step method. “For instance at our strategic planning day we didn’t have the IDM/MDI there and follow all the squares but we organized the day with that in mind, with that process in mind; that brought us to a certain place. We got a mandate from the community, here’s the kind of thing we think you guys should do. We’ll take this and shape it into a three-year IDM/MDI type focus.” Ongoing reflection and revision is part of the process. Sometimes with the IDM/MDI we “round the corners, we don’t have time to fine tune things... We work in the spirit of it, then we need to go back to it, here’s what we’ve learned…”

In general, “The thread of evolution in the last four years is around values and theories and models and beliefs – this has been moving forward... The rest was normal operational planning kind of stuff – forcing us to be strategic and take the pulse of what’s happening in the community.”

An example of how the IDM/MDI was used to teach strategic thinking to leadership program participants by choosing a project with immediate relevance to people’s lives follows.
One year we wanted to get into “how do we plan a project.” We’re talking about new immigrants, they’re not concerned about planning, they’re concerned about getting a job. The project was to plan the Francophone Community Builders program, but they skipped strategic thinking to go directly to concrete action without a sense of how the program would look at the end. After trying to do it for two or three Saturdays we were stuck, they didn’t get the thinking process. So I said, “Let’s choose a different example.” I said to one participant, a traditional Algerian woman who wears a hijab, “We could plan your wedding – we’ll use the MDI to do it.” The need for strategic thinking became clearer because it was in their reality. Everyone knows someone who’s gotten married.

Planning her wedding was wonderful, a beautiful example of inclusion and respect for culture. We had a Russian Francophile and people from France and Congolese – 10 nations in all – focusing on this one wedding. Talk about inclusion, I had tears in my eyes every Saturday. It was a lot of fun. We looked at values: “What kind of values do you want in your wedding? Is there something that needs to be done in a specific way at the mosque?” We went into the evidence base, the theory part of the Muslim religion – what’s the philosophy behind the rituals for the wedding. They learned that life is strategic. They were able with that easy example to put themselves into the process. It took a while – something like five or six Saturdays – at the end when we did the debriefing they said, “Wow this is really amazing.” They said, “This has taught me that I need to think about things in life. I can apply this in all areas.”

Note: The Framework example at the end of this case study illustrates the application of the IDM to the Toronto Francophone Community Builders program.

Strengths and Challenges
A discussion follows of the strengths and challenges of the IDM/MDI, based on L’AFCO-TO’s experience.

strengths
L’AFCO-TO’s use of the IDM/MDI revealed many strengths.

The MDI is unbelievably powerful. It forces us to integrate planning and evaluation. It brings us to that place where every time we create an objective we ask ourselves how will we demonstrate that we have achieved this. We are forced to think about evaluation from the beginning. It also helps us evaluate things like values and beliefs – to see whether what we do is based on values, that the values are not just on paper. For so many organizations the values and what they do are disconnected. There’s a gap, and often they let the gap go because they don’t have that reflective practice. The MDI is powerful because it allows people to grow within the organization. It reduces the gap between the talk and the walk – it provides integrity...

The MDI allows people to come to a common reality. For example, if we want to be inclusive - what does it mean to be inclusive, where are we at right now, where do we want to be. It’s okay not to be perfect - but is it okay to not be inclusive for the next two years because we need to develop the expertise, and then in the third year
when we have the capacity we can be more inclusive? We need to discuss all of
this…
The MDI integrates the best of many models – that’s why I think it’s a true best
practice – it’s a holistic model…One of the key points is to demystify the idea that
it’s complicated, if our group has been using it as a grass roots group, any group
would be able to use it… Although at first the Model seems complicated, we have
found it to be based on common sense.

Our experience using the model showed that not only can it be applied successfully
to a small grassroots organization, but can also become a very effective tool to help
with organizational development and even partnership development.

In summary, in addition to being a usable multi-purpose tool, the strength of the
IDM/MDI is its emphasis on the following:

- consistency between practice and foundation pieces such as values, vision and
  environmental scan
- comprehensiveness
- ongoing reflection
- clarity
- inclusion of all members regardless of organizational role and consensus building
- integration of planning and evaluation

challenges

Challenges of using the IDM/MDI follow.

- While consistency is a strength of the IDM/MDI, consistency is difficult to achieve.
- The IDM/MDI appears overwhelming.
- It takes some time and a knowledgeable facilitator to understand it.
- The application is time consuming.
- Maintaining focus is not always easy, for example because of people’s passion around
  their values.
- Conditions are not conducive to being reflective: “Our problems are way too complex
  now for a linear way of thinking – thinking in an integrated health promotion
  upstream way demands that we take the time, breathe that whole thing, create a
  whole culture, and that we’re good to each other in the process – this requires using a
  reflective process. But when you say that to people they say, ‘Yes, we want that. The
  problem is that conditions out there are not conducive to that.’”
- Some people are action oriented rather than reflective. “The action oriented people
  don’t value processes and reflection as much and may not be very comfortable in
  participating in part 1 of the IDM [Foundations]. They are usually motivated by
  tangible results and bringing them to a reflective process can be an extremely difficult
  task.”

The challenge described in the last point can be addressed through the IDM’s flexibility:
“The model allows those who are more reflective to start the process up to the
development of the objectives, and from there the action oriented people can finalise the
process by creating the action plan which is basically the second and third parts of the
model. This way the action oriented people can participate fully in the planning process and integrate their action with the foundation of part 1.”

**Results**

Using the IDM/MDI resulted in a number of benefits for L’AFCO-TO. It helped to:

- **Improve communication.** “The definition work we did with the IDM has provided the base to present our work in the community.” In addition, “We used it to successfully disseminate information within the organization, give us an overall visual glance, and develop a common language.”

- **Increase planning skills.** After using the IDM/MDI to plan a wedding, most volunteers in the leadership program “said ‘this is like learning how to plan your life – you can use this for anything in life.’ … It was wonderful making them aware. It’s a tool of teaching.”

- **Increase reflectiveness.** “It has helped us to be strategic, in the sense of being reflective. This reflective process is really part of the model.”

- **Increase group consensus and synergy.** “The whole IDM process helped bring everyone involved into play. Often in an organization the environmental overview is done by high level managers and the board; it is very positive that the Model allowed everyone to be part of strategic thinking.” In addition, “It’s been to me a very good way of creating synergy within a group – it brings people onto the same wavelength and so creates a basis that supports the decisions we’re making.” Using the IDM/MDI also assisted the development of a common understanding of various concepts. For example, regarding inclusion, “We realized that the value means something completely different to different participants. This created very exciting discussions that served the purpose of letting go of our personal agendas around the value and helped us shape organizational values in a consensus manner.”

- **Increase consistency.** “The IDM definitely kept us on track with consistent thinking.” For example, “The IDM made it easier to be consistent when developing overall objectives for each committee.” As a result of using the IDM/MDI, “We have developed questions to use as a checklist, to keep in mind for decisions, things like C for comprehension or understanding – do we understand all the facets for the issues we want to address... Eventually we may develop that a bit more to make it a values policy piece. It gives us a guideline, at any time people can look at this and say. ‘Okay, if all of this on the checklist is not integrated into our ideas, then our ideas will not move forward.’”

- **Develop ethical principles.** “We also spent a lot of time on ethics, which some participants had never thought of. The discussion helped us create awareness around the issue of building a solid organization, with transparency, accountability, etc. as part of its foundation.”

- **Increase rigour.** “Using the MDI to plan our activities has forced us to be a lot more solid in how we approach things, more rigorous.”

- **organizational development.** “Because of the MDI we were able to take an organization that was on an artificial breathing system - it was about to die - and three years later have a complete ‘building community’ concept as a result of working on the foundations etc. The MDI has helped tremendously... It forced us to develop not just a program but organizational objectives as well. We didn’t have the things we needed at
an organizational level, we needed to acquire resources – we have used the MDI a lot to assist us in getting those resources.”

- **Provide concrete direction.** The IDM/MDI helped strengthen L’ACFO-TO’s vision and clearly define its objectives. “We’re really using the Model as a way to structure everything we do...The end result [of using the MDI] is a concept that is really solidly focused – our community development focus...It gave us a sense of where we want the organization to move to. We’ve focused on our organizational motto ‘building community one person at a time.’ Our work with the MDI has helped shape it.” For the future, “The Model will continue to remain the blueprint of where we are going.”
## IDM/MDI Framework for L’ACFO-TO’s “Les Bâtisseurs de la Francophonie Torontoise”

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<th>Underpinnings</th>
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<th>Evaluation</th>
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<tr>
<td><strong>Values</strong></td>
<td>Brotherhood, respect for others, mutual support, valuing various francophone cultures, solidarity, collaboration</td>
<td>Excellent</td>
<td>Improve collaboration and independent team work</td>
<td>Create a working group reporting to the ACFO administrative council by way of an activity report. Monthly meetings. Name a person responsible for follow-up and program evaluation. Assign program tasks.</td>
<td>Involvement agreement. Volunteer.</td>
<td>Creation of a feeling of membership and long term commitment to volunteering.</td>
<td>Evaluation of the volunteers’ behaviours.</td>
<td>Values are discussed and reinforced regularly.</td>
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<tr>
<td><strong>Goals</strong></td>
<td>Promote visibility, use of French services</td>
<td>Nothing done. Starting point.</td>
<td>The first team of volunteers will be formed and will be ready to address the goals.</td>
<td>Development and adoption of policies for the management of volunteers. Application of policies in the management of the volunteers / recruitment, selection, motivation, training, supervision, evaluation.</td>
<td>Translators for the policy. Discussion about the policy. Compiling existing volunteer management tools and discuss their pertinence.</td>
<td>Having a team of volunteers set up a volunteer management operational structure for the program</td>
<td>Evaluate the increase in French language services visibility among francophones recruited by our ambassadors</td>
<td>3 specific volunteer teams will be created, volunteer management committee and electronic newsletter, database committee, promotion and advertising sales committee</td>
<td></td>
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<tr>
<td><strong>Ethical Principles</strong></td>
<td>Information sharing, zero tolerance for harassment, open to culturally diverse behaviours as long as they do not infringe the law</td>
<td>Excellent situation in the group.</td>
<td>Apply these principles to the implementation of the program</td>
<td>Provide training to the volunteers about the zero tolerance for discrimination policy</td>
<td>Research = Identification Harassment situation Identify a trainer who adopts these ethical principles Consistency in the application of principles Install an evaluation system that verifies the application of principles</td>
<td>Evaluation of the ethical behaviour of the program volunteers who have been recruited by our ambassadors</td>
<td>Evaluation of the ethical behaviour of the program volunteers who have been recruited by our ambassadors</td>
<td>Insertion of ethical principles in the management and orientation of the volunteers</td>
<td></td>
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<tr>
<td><strong>Theories</strong></td>
<td>Principles of adult learning. Community development (grassroot)</td>
<td>No adult education. Yes, we apply (grassroot).</td>
<td>Adult learning principles applied in the orientation and training of volunteers.</td>
<td>Development of a volunteer orientation and training manual.</td>
<td>Information networks about what is happening in French in Toronto. Dissemination of information to various volunteers.</td>
<td>Our volunteers evaluate their orientation in terms of satisfaction, of knowledge gained and teaching approach.</td>
<td>Our volunteers evaluate their orientation in terms of satisfaction, of knowledge gained and teaching approach.</td>
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<tr>
<td><strong>Beliefs</strong></td>
<td>Information = Power = Mobilization &quot;United we stand&quot;.</td>
<td>Beliefs adopted by the actual group.</td>
<td>Making sure that the beliefs transfer is done to other participants to the programme</td>
<td>Define the programs essential and optional criteria vs. beliefs. Educate volunteers about the franco-minority problem vs.</td>
<td>Transfer Marcel’s knowledge to a group of</td>
<td>Create knowledge transfer modalities.</td>
<td>Assess the impact of the program on the changes</td>
<td>Reinforce beliefs within the management of</td>
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<table>
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<tr>
<th>general guidelines</th>
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<th>evaluation</th>
<th>implement, reflect, document</th>
<th>revis e</th>
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<tr>
<td>“He who seeks finds”. French is a value added in Toronto. French speaking population at risk of assimilation. Difficult to create financial partnerships with organizations.</td>
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<td>beliefs.</td>
<td>trainers.</td>
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<td>volunteers.</td>
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<tr>
<td>Probing issues?</td>
<td>Invisible French-speaking world. Ratio of French-speaking readers/listeners of mass media in comparison with the actual population rate. Limited resources to unite the community.</td>
<td>Mostly personal observations.</td>
<td>Perform a small feasibility study about the consumer behaviours of our French speakers. (?)</td>
<td>Analyze the needs, the interests and the expectations; better understanding of the behaviours of the francophone community. (?)</td>
<td>Feasibility study, expertise.</td>
<td></td>
<td>Find financial resources to fund study.</td>
<td>A study was performed on the inclusion of franco-phones in Toronto. The data will be used to develop our communication strategies.</td>
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<tr>
<td>understanding of the environment</td>
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<tr>
<td>Organizational</td>
<td>Working group, interdependent team work. Decisions made by consensus. Power of decision linked to responsibility.</td>
<td>There is a working group in place but not firmly engaged.</td>
<td>Set up a working group. Look at recruitment, motivation and competences</td>
<td>To identify a human resources available after April 1st, to identify required competences. Recruit people with competences.</td>
<td>Everyone’s job resume; discuss interests &amp; competencies, description of the committee’s tasks.</td>
<td>Have volunteers coordinate volunteer work groups.</td>
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<tr>
<td>Vision</td>
<td>Full time program coordinator. Work group to support coordinators.</td>
<td>No financing to access a full time coordinator.</td>
<td>Work to obtain the necessary financing for a program coordinator.</td>
<td>Identify method of financing. Write a request for financing. Establish a relationship with the financial backers.</td>
<td>Resource person to assist with funding application. Internet research, Find partners, Membership to Philanthropy association</td>
<td>Find sources of financing. Creates programme self financing possibilities through advertising</td>
<td>A coordinator is in the process of being hired.</td>
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<tr>
<td>Analysis of the environment</td>
<td>Conduct an analysis of the environment identifying Strengths, Weaknesses, Opportunities, Threats (SWOT analysis).</td>
<td>Strengths: unique idea, responds to the potential need to mobilize French speaking population. Planning of our program... ACFO’s commitment to the program. Danger: lack of long-term investment. Difficult to create financial</td>
<td>Discuss the possibility of transferring knowledge about our idea (« train the trainer »). - Reinforce financial commitment for the projects. Efficient volunteer selection strategy. Efficient strategy for</td>
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<tr>
<td>Opportunities: take the pulse of the invisible French-speaking world. Create links and numerous partner-ships. Promote the French-speaking world. Reach those who do not about the existence of the community.</td>
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<td>Weakness: lack of expertise in management of volunteers, fundraising, database. Limited actual capacity for program management.</td>
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<td>Knowledge transfer. Follow-up with ACFO program alumni to find out why they are no longer there. Regularly assess motivation. Identify what stimulates us.</td>
<td>Ensure that we communicate effectively.</td>
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<td>processes and activities</td>
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<tr>
<td>address organization issues</td>
<td></td>
<td></td>
<td>Creation of partnerships vs. recruitment of volunteers and finding francophones</td>
<td>Identify who does what Use volunteers</td>
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<tr>
<td>address health issues</td>
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<td></td>
<td>Reinforce knowledge gained in management of volunteers. Identify expertise in database. Set up data. Maintain the database. Train volunteers on how to use database. Financing Consultant and Equipment.</td>
<td>Marcel is the resource person</td>
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Ceridian-Leade Health

This case study is based on information from the following sources:

- interview with Catherine Macpherson April 2007
- *Profile of Catherine Macpherson* (profile archives, IDM Best Practices website, May 2007)
- *Using the IDM for Health Coaching* (Catherine Macpherson, reflection archives, IDM Best Practices website, May 2007)
- comments during the revision process August 2007

Notes:

- Leade Health, where the work with the IDM as described in this case study was initiated, was recently acquired by Ceridian Corporation of Minneapolis, Minnesota.
- Catherine Macpherson is a Senior Product Manager for the LifeWorks Division of Ceridian. She lives in Ann Arbor, Michigan. Catherine Macpherson took the lead for introducing the IDM to Leade Health.
- Unless otherwise noted, quotes are from Catherine Macpherson’s profile, reflection or interview.
- This case study was prepared by Barbara Kahan and reviewed for accuracy by Catherine Macpherson.

Background

Brief descriptions of the IDM domains as they relate to Leade Health (now part of Ceridian Corporation) and health coaching follow.

Health Coaching

Health Coaching is a collaborative partnership between Coach and Client that facilitates lifestyle change through initiating self-discovery and utilizing behavioral evidence-based methods. These methods include motivational interviewing, reflective listening, transtheoretical model, decisional balance, values exploration, self-efficacy, solution-oriented therapy, reality therapy, and positive psychology. (*Defining Best Practices in Health Coaching*)

Health coaching focuses on areas such as nutrition, physical activity, tobacco cessation and stress management in order to facilitate overall health and well being and prevent health issues such as cardiovascular disease and diabetes. Whereas in the medical model “health care experts deliver advice and patients are asked to comply” in health coaching coach and clients are partners, with clients identifying “which behaviors to address” and “encouraged to think about and express their reasons for and against change.” In addition, “Rather than focusing on selective aspects of an individual’s mental or physical health, health coaching addresses the whole person” and “spotlights an individual’s assets, rather than focusing on his or her deficiencies.” Leade Health was one of the first organizations to focus on health coaching. It has been involved in developing and delivering health
coaching since 1997. (The information and quotes in this paragraph are from the white paper *Defining Best Practices in Health Coaching.*)

Leade Health is now integrated into Ceridian’s LifeWorks business unit, which helps companies maximize the value of their people by helping their employees lead healthier and more productive lives. It includes: EAP (Employee Assistance Programs) for emotional health, financial and legal assistance, and other issues; WorkLife Program such as elder care and child care locaters; and Leave Administration Programs. Ceridian LifeWorks also delivers health and wellness programs, including “coaching to individuals enrolled in worksite and health plan programs for weight management, smoking cessation, and stress reduction.”

The health coaching occurs primarily on the telephone, although there is also online coaching. “Most programs last for a year and the coach works with the same person throughout that time. The individual owns the process, while the coach’s role is to ask questions to guide self-discovery ranging from ‘why do you want to quit smoking’ to ‘what are your values related to smoking.’ Asking the right questions helps the individual to do some thinking. Coaches use appreciative inquiry, stage of change theory, and motivational interviewing techniques. It’s very non-judgemental since coaches meet people where they’re at.”

**Understanding of the Environment**

The popularity of coaching for self improvement has increased significantly since the 1990s. The growth in health coaching has resulted from a number of factors including “the desire to stem spiraling medical costs, halt rising obesity rates, prevent disease, meet the needs of an aging population, and provide a ‘higher touch’ interaction with health care.” Despite the increased interest in health coaching, in 2006, “No defined health coaching best practices currently exist.” (*Defining Best Practices in Health Coaching*)

When examining the environment, Ceridian-Leade Health takes into account “the phone and electronic environments that envelop our coaching, and even the physical, psychological, and medical history that makes up the environment in which our clients live.” (*Defining Best Practices in Health Coaching*)

**Values/goals/ethics**

A list of Ceridian-Leade Health values follows, taken directly from *Defining Best Practices in Health Coaching*:

- **Service:** Best practices organization serving internal and external individuals and teams.
- **Individual:** Individuals are supported toward achieving goals and personal successes.
- **Teams:** Teams are empowered to be highly functioning and interdependent.
- **Environment:** We interact in an inviting, relaxing, and warm atmosphere. We recycle, provide healthy snacks, and enjoy natural light in every workstation. Our office is compliant with the Americans with Disabilities Act (ADA). Our coaches work flexibly from home in a designated area that is compliant with the Health Insurance Portability and Accountability Act (HIPAA).
Culture: We facilitate an optimistic and encouraging environment. We seek to bring congruence between our philosophies and our operations.

Wellness: We encourage a balanced healthy lifestyle.

Philanthropy: We support local health-related charities and encourage volunteer service.

Theories
The organization's key theories follow:
- Transtheoretical model
- Carl Rogers' client-centered approach to behaviour change
- Motivational interviewing
- Appreciative inquiry
- Reflective listening
- Decisional balance
- Values exploration
- Self-efficacy
- Positive psychology
- Solution-oriented therapy
- Reality therapy

“The health coach training and communication materials are continually updated to reflect novel theories, concepts, and models. This includes integration of collaborative and self care models into the approach.”

Evidence
Evidence for the health coaching program was gathered through several methods. In addition, a commitment to ongoing review and integration of new knowledge into practice was articulated.

We conducted an extensive literature review of research in fields related to health coaching. These included coaching, counseling, behavior change, psychology, psychotherapy, disease management, and best practices...

To ensure that we are offering the best and most effective training and ongoing support for our coaches, we have performed an international search for coach training programs and methods...

[As well, survey results from Leade Health coaches and staff were analysed] to add to our understanding of what makes health coaches fully competent and successful in their roles...

Our practices must evolve to reflect ongoing evaluation of our programs, continuous feedback from our stakeholders, new knowledge gained from research, and environmental changes. We tie in to other best practice models, including the Health Enhancement Research Organization (HERO) best practices scorecard and best practices that emerge from the Centers for Disease Control and Prevention (CDC), to ensure that the model we have chosen, the IDM, continues to be the best model for our company. (Defining Best Practices in Health Coaching)
**Using the IDM**

Leade Health adopted the IDM in 2006 in order to “achieve and maintain the highest quality in our coaching services, as well as establish best practices that can serve as a model for the industry.” *(Defining Best Practices in Health Coaching)* Leade Health has used the IDM for program planning and evaluation, organizational change, evidence gathering, team building, values clarification and as an everyday approach to work. It is still being used since the takeover by Ceridian to ensure consistency between all domains. “I’m still using the IDM in product management. When I develop a product I’m looking at evidence, underpinnings, if it fits our company’s values.”

**Process**

The IDM was introduced to Leade Health in the following way:

I found the IDM through web research. We started using it maybe a year and a half ago...First I showed the published papers to our CEO, I called a meeting with him and talked him through the model, walked him through the papers, he read them. He got excited; once he was on board I was able to go forward with it. Because I got the CEO on board right away the project was made a priority.

At first I didn’t totally understand the IDM, it took a while – it’s not something that I could read and totally understand what it was about right away, it took me some time with the model, and to work with it – the more I worked with it the more it made sense. [I kept going because of] the CEO’s support, I didn’t have to have a best practices approach in a month, I could be evolutionary, see how others understood it – their understanding helped my understanding. We weren’t just outcomes oriented, didn’t need to have something right away on paper; we could be philosophical and abstract. We could be evolutionary.

I worked with the quality assurance person, she was a good partner...the two of us did the background work, filled in the boxes. We went to different committees, took different pieces of information from different individuals in the company. A lot of information already existed, for example the company values and mission. We went back to the CEO to show him what we were doing, asked him questions for pieces we were unsure about. We didn’t fill in every box; it wasn’t an exercise in perfection. Filling in the schema [the IDM Framework] is only one part, the schema is just a tool – the work is not done when the tool is filled in. The outcome is the change in mindset.

The next step was to open it up to the larger company. We had a company-wide brown bag session. We had a projector with the tool up on the screen. I had prepared a PowerPoint presentation, introduced them to the model, and introduced them to health coaching. Even though they worked for the company some people didn’t know what health coaching was. That’s when it became more cohesive –you never know where you’ll get your best ideas from.

Although the company values and mission were down on paper for the outside world, for the first time in our company-wide session those got explained to some people for the first time. We held a similar session with coaches by phone so they also could understand about the company.

After working with the whole company we published a white paper on best practices, had some public speaking opportunities, incorporated the best practices
schema we had developed with the IDM into the overall plan for the long term. We will continue to incorporate it into the overall plan for quality assurance.

The white paper *Defining Best Practices in Health Coaching* provides additional information on work that occurred at Leade Health: “Our efforts to ensure that our underpinnings and environment support and define our practices have led to several endeavors. Leade Health has organized into nine cross-practice work groups that are made up of individuals with different responsibilities within the company, and therefore offer a variety of perspectives.” The work groups range from budget and culture to operations and best practices. These work groups were used to analyze Leade Health’s values, culture, and environment: “Ensuring that Leade Health’s values, culture, and environment are aligned with those of our goals, and the goals of health promotion was an important step in getting our whole organization focused around our objectives.” (*Defining Best Practices in Health Coaching*)

Each work group met monthly to discuss best practices for their individual work group. “When a question came up about how to do something, the group would talk about the best practices in this case – based on research, past experience, they would get the client’s and coach’s perspectives.”

A key organizational change was for the first time inviting coaches to join the work groups.

Before we had staff members in the work groups but we never had a coach. Because they were all busy in the field we didn’t think they’d be interested. Then [with the introduction of the IDM] we decided that’s not a best practices approach, we need the perspective of every stakeholder. Including them really enhanced what we accomplished in our work groups, the variety of perspectives was helpful. And coaches appreciated having input, they got excited about developing services.

Catherine Macpherson used a number of IDM resources to assist in the application of the IDM:

I read the IDM Manual, I took slides from the PowerPoint presentation, I contacted the individuals listed – that live support helped me most. I love the resources on the website, I read everything on it. Reading the website profiles of people was helpful – seeing how people interpreted it differently, the different ways people use the IDM. I used the tool, cited the IDM research papers. Definitely the published papers were wonderful – I wanted something peer reviewed, it really helped. I used the IDM computer program – I had it installed on our computers, that’s what showed up on the screen for the company-wide session. The examples such as the filled in framework for ABC [Against Breast Cancer] also helped.

**Strengths and Challenges**

Based on Catherine Macpherson’s experience, one of the strengths of the IDM is that it adjusts to the specific circumstances. Another strength is that it transcends the work sphere.
I like the fact that the IDM isn’t a one size fits all approach - you can use it to fit your company, what you’re doing. It takes into account your own experience...

The IDM gives you a broader scope for what you’re doing at work but it also translates personally – in my life I can think “these are my values and my passions.” Health is one of them – a lot of things I do in my life, personal and professional, are related to health, even my leisure activities, the food I cook with my kids, the activities I do with my friends, many are health related. Even further I care about the health of the environment, I drive a hybrid. Do the choices I make, personally and professionally, fit with my beliefs?

A challenge is increasing the take up of the IDM throughout all of Ceridian.

The new company wants to pursue best practices and already is in many areas. Things were fast paced at Leade Health but on a smaller scale. How to translate the best practices to a new, larger company – this will be our challenge – making the jump from the smaller to the larger company and integrating with best practices already in place.

Results

Using the IDM had a number of positive effects for the organization.

Using the IDM helped us fine tune our designs, enhanced our coach training through developing competencies, and brought us together. I feel like we were doing a lot of things before but we didn’t understand these were part of a best practices approach, the IDM helped us put it together and have a cohesive approach, it helped us add more good and best practices to what we were already doing...

I like the [IDM] model - it’s not step by step, it’s more like a web. It makes everything come together, at least it did for us. We had a number of pieces we were working on and the IDM was the web that connected everything for us. When we talked about developing a practice we would look for our evidence, our experience, what else do we need. We were able to use what we learned from the IDM in decision making. The IDM gave us a framework to say “is this part of our best practices, does it fit our focus” or “that’s not working, that doesn’t fit”...

The process brought the entire company together through a common purpose. At meetings on best practices development I saw a lot of people get excited about the work we were doing. Maybe they were working in finance or IT [information technology] and instead of their task being only about numbers it all came alive for them, they understood what services our company delivered and why. The communication about the practice invigorated everyone and brought everyone together...

The IDM was great for our organization.
Regina Early Learning Centre
This case study is based on information from the following sources:


Notes

- Unless otherwise noted all quotes are from Anne Luke, founder of the Regina Early Learning Centre (ELC) and its executive director for nearly 30 years. Anne Luke still works with the ELC.
- A key information piece, extracted from the evaluation report listed above, was results from the IDM’s Best Practices Check-In Forms. In 2002 the ELC’s then executive director and teaching staff used these Check-In Forms to check consistency between the ELC’s practice and other IDM-identified domains. This reflective exercise was part of the evaluation conducted for the years 1999-2002. Some of the details contained in the Check-In Forms may have changed since then.
- Results from the Best Practices Check-In Forms are sometimes referred to in this case study as the 2002 best practices check-in.
- “We” in statements from the Best Practices Check-In Forms refers to ELC teaching staff. Bullet points from the Check-In Forms are verbatim.
- This case study was prepared by Barbara Kahan and reviewed by Anne Luke for accuracy.

Introduction

This case study of the Regina Early Learning Centre (ELC) presents an organization which long before the IDM came into being was using an approach to practice very similar to that recommended by the IDM. Pre-dating the IDM by two decades, the ELC has from its beginning integrated into its practice foundation pieces such as values, evidence and an understanding of the environment. Similar to the IDM, the ELC approach stresses the importance of ongoing reflection and evaluation with the aim of continuous improvement.

The ELC’s experience of applying its home grown approach to practice lends credibility in two different ways to the IDM, which was developed without knowledge of the ELC’s approach. First, an organization with limited resources other than passion and determination developing and using an IDM-like approach for three decades solely because it made sense and achieved positive results speaks to the “groundedness” of the IDM. That is, the IDM is not just another academic exercise that takes time and energy with nothing concrete to show at the end of the day. Second, the positive results themselves speak volumes to the benefits of using an IDM-like approach, whatever name
it goes by, that supports consistency between practice, underpinnings and understanding of the environment.

**Background**

Healthy child development is considered a determinant of health. A child's early years are extremely important; the absence of an environment which supports healthy child development can have lifelong negative consequences. Children in low income families are particularly at risk because they live in extremely challenging circumstances. The ELC has for three decades worked to achieve healthy child development for low income children. The ELC is a community based organization whose Board of Directors is composed mostly of parents.

The Early Learning Centre is a child and family development centre offering a range of programs for children, prenatal to school entry, and their parents. The preschool is the longest running program. It was started in 1977 by a small group of parents and me, a teacher, who were aware that low income families were largely excluded from accessing existing early childhood programs because of financial and transportation barriers. In addition, no culturally relevant programs existed off-reserve for Aboriginal parents and their children. Anthropologist Margaret Mead has said that a small group of people can change the world. In 1977, the small group of mostly Aboriginal parents and me were determined to change the small piece of the world we occupied by establishing a collaborative preschool which would blend parents' hopes and dreams for their children with thoughtful pedagogical practices...

...what I had to offer was my sense of social justice, my professional expertise in early child pedagogy and my desire to learn and work in partnership with the parents. In turn, the parents had the knowledge of their children, enormous personal strength in the face of overwhelming odds such as poverty and racism and their hope that their children would have a better start in life and more success in school than they themselves had had. By putting these together, we built an effective, mutual relationship with the good of the children as the common goal.

The learning philosophy of the ELC, from its inception on, was child-centred:

Building a relationship of trust with the children and helping them build relationships with each other and with the world around them became a key pedagogical approach. The curriculum was built on the children's exploration of the carefully prepared materials in their environment. Children were encouraged to choose what they wanted to play with and the teacher's job was - and still is today - to support and extend the child's explorations, encourage curiosity and a sense of wonder, in a warm supportive environment.

**Description**

A description follows of the ELC's domains and subdomains which the IDM suggests interact with each other.
Underpinnings

goals
The 2002 best practices check-in identified the two following ELC goals:

- To equalize educational opportunities for children.
- To work cooperatively with the parents towards the achievement of this goal.

values
A description of the key principles underlying the ELC’s practice from its inception, and how they evolved from personal to publicly shared, follows.

The underlying principle guiding our thinking and action was one of social justice. This principle was based on observation and experience that society marginalizes some people. In the case of the Early Learning Centre parents, most were marginalized by racism and poverty as a result of culture contact and ongoing colonization... As we planned how and what the preschool would look like, two values were inherent in the process. These were mutuality (understood as the willingness to influence and be influenced), and respect (understood as the willingness to take others seriously)...

These values, although underpinning all activities, were not publicly named until later when the Centre participated in a program assessment and development process conducted by Dr. Mary Cronin in 1995. Prior to this time I was reluctant to talk about the “touchy feely” stuff; it seemed too personal...Looking back, I’m not sure why I was so reluctant to voice these principles...

It was not an easy road - in those early years I felt very alone. But when I named my principles many years later to staff, it was liberating - people said “that fits with our beliefs too, that’s how we want to live our lives.” That was so liberating for me, it was just amazing - it was like I had this secret inside myself that I wanted to work but didn’t want to impose. When it became collectively owned it was “wow!” - together we can relate these principles and values to how we work with children, families, each other, the larger community. Sometimes we have setbacks and then we look at where things broke down, and we have our code to measure it against and we try again a different way. This code has kept me going for nearly 30 years.

During the 2002 best practices check-in, ELC staff identified their values and how these are translated into practice:

- **children**: by honouring their choices, and by building curriculum around their interests
- **families**: by involving them at all levels
- **healthy development**: by recognizing what it is and supporting all aspects
- **relationships that are respectful and mutual**: by being welcoming in the school, being non-judgmental, and listening
- **empowerment**: by giving children and families tools to solve their own problems, ownership of the school, shared power
- **cultural diversity**: by including it in everything we do, and in the classroom acknowledging and affirming it
- **inclusiveness**: everyone is valued (not hierarchical)
- **Life long learning**: through programs for parents, modelling it, setting aside time for teaching staff to learn, bringing others in and sharing

- **Research**: our approach of wanting to find out and trying new things; we're ongoing researchers ourselves

**Ethics**

At the time of the 2002 best practices check-in, there was no identified code of ethics; at the session participants decided to develop one. They developed a list of possible ethical principles to include in a code of ethics:

- treat people, ourselves and the environment respectfully
- do the best we can through ongoing reflection on our actions
- maintain confidentiality
- “professionally human”
- some staff were uncomfortable with the principle “do no harm” being framed as a negative and see themselves as promoting the common good by taking an active role, e.g. creating growth opportunities for children and adults

**Beliefs**

At the 2002 best practices check-in staff discussed how beliefs are translated into practice at the ELC:

- **All children have the right to grow and learn in a supportive environment that is sensitive to their needs.** Teaching staff set objectives that address individual and group rights.
- **Parents are their child’s first teacher.** We engage parents as partners.
- **The community has a responsibility to support the healthy development of children and families.** We advocate.
- **All learning occurs within the context of relationships.** Teaching staff try to develop strong relationships with children.
- **Respect and mutuality characterise the relationships between staff, children and families.** Children learn a lot from each other; we encourage peer-support (children to help each other).
- **Using a strengths-based model empowers all participants.** Planning, careful attention to environment, careful thinking through our curriculum, strong supports towards parents.
- **ELC supports the developmentally appropriate practice of comprehensive assessment of children vs. testing (except in specific circumstances).** Teaching staff, not tests, are seen as most authentic assessors of children’s capacities; they use observations, anecdotes, and children’s products, e.g. as in the portfolios.

**Theories**

ELC teaching staff use a variety of theories/concepts according to the 2002 best practices check-in:

- children’s learning theory from Reggio Emilia: Reggio techniques stress importance of children playing an active role in defining their education goals and teachers becoming facilitators to allow children to explore a subject area and to deepen their understanding
- High Scope theory
adult learning theory: start where people are at, use hands on participatory approach rather than expert approach, etc.

- family literacy theories
- D.A.P. (Developmentally appropriate practices)
- prekindergarten curriculum
- strength-based approach
- constructivist theory: We are just developing an understanding of constructivist theory.

evidence
ELC guidelines for identifying evidence in 2002 included the use of both qualitative and quantitative methods, use of all major stakeholders as evidence sources, and that evidence should be high quality and reviewed/colllected regularly. In addition, both evidence generated by the ELC and by other groups is used: “We acknowledge the research out there and what’s applicable to our situation. We see existing knowledge as useful but we have a hand in creating knowledge too, with what we’ve gathered and reflected.”

Understanding of the Environment
The elements of understanding the environment – vision and analysis of the organization and of healthy child development - are outlined below.

organizational vision
How the organizational vision is translated into practice, as described in the 2002 best practices check-in, follows:

- **A collaborative community building approach is used.** We work together, Board/staff/families/community supporters.
- **Together we build shared values and beliefs.** We talk about these things at Board/community/staff meetings.
- **Everyone has a role and something to offer.** Reinforced at regular meetings, issues are presented as questions not answers.
- **Each person, no matter their position, is recognized as equally important as any other, and as vital to the ELC community.** [same as above]
- **Everyone does their best to fulfil their role.** Regular group reviews and individual job performance reviews.
- **The organization is healthy and exciting.** People volunteer this information; see retiring chair’s speech.
- **Together we construct a community of learners that goes beyond our walls.** People like to visit the centre and learn about how we do things.

vision of healthy child development
How the ELC’s vision of healthy development for children is translated into practice, as outlined in the 2002 best practices check-in, follows:

- **Families are provided with the supports they need to be the best they can for their children.** We work towards this but recognize the limitations of socio-economic policies outside our control.
- **Children are provided with the supports they need by their parents and the community so they can fulfil their learning and development potential.** [see above]
- A collaborative approach is used, which involves a journey of exploring how children learn and adults’ role in promoting that. Ongoing staff development.
- A collaborative approach in the classroom means sharing power with children. Children are seen as powerful, creative and competent; teaching staff construct a climate of shared power; children make decisions about their learning.
- Education is transformational, it’s not just putting in another piece of knowledge.

**analysis of our organizational environment**
The analysis of ELC’s organizational environment, from the 2002 best practices check-in, follows.

- **priority issue:** lack of stable funding
- **factors underlying issue:** funding structure, lack of political prioritization of early learning
- **what will influence issue positively:** continued advocacy
- **decision making structure:** parent controlled Board of Directors responsible for overall operation of ELC, all major decisions subject to Board approval; committees (e.g. Finance Committee, Steering Committee, Evaluation Committee) advisory to Board
- **major players:** parent board, committee members, staff (admin, teachers/associates, PAT/Family Outreach/Family Support, KidsFirst, drivers/cook), parents, children

**analysis of environment for healthy child development**
The ELC analysis of the healthy child development environment, identified by the 2002 best practices check-in, follows:

- **priority issue:** increase healthy development of children (birth to age 5 years) in low income families
- **major stakeholders:** ELC, low income families with young children, government agencies, funders, community organizations
- **factors underlying issue:** re. First Nation/Métis families, a history of economic and cultural oppression which began with colonialism, continued through the residential school system and is still being felt. Aboriginal people in Saskatchewan are over-represented in poverty statistics, in prison populations, in child protection case loads, in drug and alcohol treatment programs etc. At the same time, they are the fastest growing portion of Saskatchewan’s population.
- **strategies which will positively affect issue:**
  — see community as a partner
  — work with families in partnership to increase opportunities for their children rather than try to fix these problems
  — respect and validate traditional values of Aboriginal cultures and provide positive role models (emphasize in preschool curriculum traditional Aboriginal values, introduce children to Cree language, ensure within preschool program at least one member of each team is Aboriginal)
  — respect and incorporate input from families throughout program

In addition to the points made in the analysis above, the ELC exists in a global environment:

One thing I’ve discovered from my reading is about people like Paulo Freire who did all that wonderful work in South America - we're not just a Regina preschool
but part of a larger vision, whether it’s gay rights or food for the hungry or votes for women. We’re part of a movement that seeks justice, a transformation of larger systemic approaches that are not concerned with human development, that are concerned with holding onto power.

Practice
Practice involves both activities and processes. Many practice pieces are mentioned above, in the context of their match to underpinnings and understanding of the environment. Further details regarding practice are found below.

activities
Key ELC program activities include:
- preschool program for children ages three to five
- Parents as Teachers for families with children from birth to age three
- Family Outreach (activities and programs for families participating in either PAT or the preschool program)
- Family Support (in-home support such as life and home management skills for families facing critical issues)
- Kids First (a home visiting program for families with children under a year old when they join)

processes
The ELC incorporates into its work a number of important processes, ranging from capacity building based on professional development and parent skill-building activities to partnering with families and other organizations. This section focuses on the combined processes of ongoing reflection, evaluation and learning which are intrinsic to the work of the ELC.

...A determination to offer only the best possible programmes to the children required a practice of ongoing learning, research, and reflection on how to adapt and implement new learning. Thus began the cycle of assessing and enhancing our approaches and practices, a process of constant renewal and excitement...

Best practices at the Regina Early Learning Centre is essentially a circular process. Matching beliefs, values and principles to practice means constantly reviewing progress in a cycle of plan, do, reflect, re-do and so on...

The ELC regularly reviews goals, values, underlying beliefs, theories/concepts, and new knowledge, with an aim to integrating them into daily practice. “By constantly reflecting on our work, and the beliefs and values that underpin all activities, we deepen our understanding and improve our skills and knowledge.” To assist the process of reflecting and learning, Friday afternoons are reserved for examining the relevant literature and discussion, feedback from parents is collected on an ongoing basis, and regular planning and evaluation sessions are built into the ELC’s schedule. According to the 1999-2002 evaluation report, “key informants provided numerous examples of positive evolution over time due to the ongoing identification, acknowledgement and resolution of issues; key informants indicated this was not always an easy, quick or perfect process, but that the rewards of going through the process made it worthwhile.”
Anne Luke sums up the best practices process this way:

I think best practices are a code to live by. Generally it means looking at the context of the whole and aligning what you do with principles and values. From a social justice foundation it means understanding people’s history, where they’re coming from, what they’re facing, what they have to share and what I have to share too - what we can learn and put into practice and then reflect on. Things don’t stay the same, new people come along, we learn from what we do. You constantly have to revisit what you do in light of what we know now - the knowledge base changes. The knowledge changes but the basic principles - respect, mutuality - stay the same.

Results

With its strong emphasis on ongoing reflection and review and on integrating values, theories, evidence and other foundation pieces into practice, the ELC has had a strong impact on children, parents and the broader community.

The focus on beliefs, values and principles in a cycle of plan, do, reflect, re-do has resulted in a number of excellent outcomes, not just on the children’s development, but on the parents. Studies conducted on the Early Learning Centre show that children consistently improve in all developmental areas as a result of their positive experience. Parents state they learn confidence and competence in supporting their children’s development and learning. As a result of their involvement with the Centre, some parents returned to school to complete their high school and went on to study at university. Some are now teachers. Staff turnover is low because, although wages are unfortunately low, job satisfaction is high. Most of all, children, parents and staff know their ideas are taken seriously and that their input is valued.

Evaluation results showed positive results for children participating in the preschool in the three areas reviewed: cognitive, language, and social emotional development. According to the evaluation, “In all three areas the number of children with delays decreased between the time they started the preschool program and the time they finished. In addition to these children who moved from having either a severe or moderate delay to having no delay at all, a number of children who started with a severe delay improved to a moderate delay.” These positive results were greater than could be explained by maturation alone.

Beyond these more easily quantified results, according to the evaluation report, “The impact on children of using a best practices approach at the Regina Early Learning Centre is that they learn to see themselves as learners...as part of a group, and that they are powerful people with something to contribute.”

The evaluation’s key informant interviews indicated that the ELC’s impacts on the broader community included “dissemination of knowledge and expertise, providing a model for other organizations, coordination with other initiatives, parents with increased skills who go on to participate in other organizations, and an increase in equality between Aboriginal and non-Aboriginal people.”
From the perspective of the ELC’s founder, “The impact of using a best practices approach on myself is that it has provided a code to live by – a way of being in the world that is respectful – resulting in impacts that are not always measurable. It’s an alternate away of being and living and seeing.”
Toronto Public Health Practice Framework

This case study is based on information from the following source:

- An interview with Josephine Pui-Hing Wong, who was the Co-lead Consultant in developing the Toronto Public Health Practice Framework. She was also a health promotion consultant to the sexual health program at Toronto Public Health. Currently, Josephine Pui-Hing Wong is on educational leave from Toronto Public Health; she is a Doctoral Fellow with CIHR-Institute of Gender and Health, University of Toronto – Department of Public Health Sciences.

References

- Toronto Public Health Practice Framework (Toronto Public Health, 2005)
- Access and Equity Policy (Toronto Public Health, Planning and Policy Section, 2001)
- The population health template: key elements and actions that define a population health approach (Population and Public Health Branch, Health Canada, Ottawa, 2001 draft)
- IDM Manual 1st edition (Barbara Kahan and Michael Goodstadt, Centre for Health Promotion, University of Toronto, 2002)

Background

Toronto Public Health (TPH) is one of the largest health units in Canada. In 1997, upon the legislated amalgamation of five municipalities, Toronto became a mega-city with a population of 2.5 million. At the same time, Toronto is one of the key destinations of choice among Canada’s immigrant populations. The increased cultural and linguistic diversity, growing social and economic disparities and the emergence of globalized patterns of infectious diseases (e.g. SARS, West Nile Virus, etc.) all led to increasingly complex demands in public health. To meet the public health needs of its diverse populations, TPH undertook numerous organizational change efforts. The Toronto Public Health Practice Framework (TPHPF) was an outcome of these efforts; its goal was to provide a broad template that guides and supports Toronto Public Health and its members in integrating social justice, access and equity principles into its programs and services (TPH, 2005).

The TPHPF was developed through extensive internal and external consultation. It drew from three key documents: (1) the TPH Access and Equity Policy (TPH, 2001), which emphasizes ‘people-centred’ public health and addresses issues of diversity, access and equity; (2) Health Canada’s Population Health Template (Health Canada, 2001), which focuses on the cycle of practice and related activities; and (3) the IDM (Kahan & Goodstadt, 2002), which provides a comprehensive model of best practices.

A detailed review of the IDM showed that its interactive domains are dynamic and can easily be adopted to meet the needs of different organizations. Drawing from the IDM domains of “underpinnings” and “understanding of the environment”, the TPHPF made explicit that the health of the public and practices in public health do not exist independent of the physical, social, economic and political environments. The TPHPF merges these two IDM domains and establishes nine subdomains as the foundational
underpinnings of practice: goals, vision and values, beliefs and assumptions, ethics and law, determinants of health, theories and concepts, understanding of practice context, inclusive evidence, and core competence and practice standards. These underpinnings constitute a common ground of practice for all TPH members and staff across all programs and services.

Application of the Toronto Public Health Practice Framework: One example – The “Taking Action on Chlamydia Social Marketing Campaign”

In the fall of 2004, the Sexual Health Promotion Program at TPH identified the reduction of chlamydia infection among young women aged 15-24 and young men aged 20-24 as a program priority based on epidemiological data and other evidence. Social marketing, in conjunction with other sexual health programs and services, was identified as an important strategy to reduce chlamydia infection through increased chlamydia testing, treatment and safer sex practices among young people.

In 2005, TPH launched a multi-year social marketing campaign – Taking Action on Chlamydia. The development and implementation of the campaign were guided by the
TPHPF. The campaign illustrated that the core domains were ‘interactive’ and do not exist independent of one another. Rather, they overlap and exert mutual influences on one another.

**Core Domain 1: Diversity Dimensions**

The target population of the social marketing campaign was defined based on current epidemiological data and research evidence.

- **Gender & age:** Chlamydia infections are highest among young women aged 15-24 and young men aged 20-24.

**Core Domain 2: Foundation elements**

- **Social determinants of health:** Geographic mapping of chlamydia infection shows that chlamydia does not affect young people equally across the city of Toronto. Instead, it identifies a number of priority neighbourhoods with disproportionately high rates of chlamydia. These neighbourhoods share some common characteristics such as low income, less than high school education, and fewer available health/social services, etc.

- **Understanding of practice context:** TPH recognized that existing sexual health clinics did not have the capacity to meet increased demands for sexually transmitted infection (STI) testing; there were long waiting periods at these clinics. At the same time, TPH also recognized that the potential capacity for family physicians and physicians at walk-in clinics to provide sexual health care to youth had not been fully utilized. As a result, TPH chose to focus on family physicians and walk-in-clinics as the Phase I target audience for the social marketing campaign. The goal was to influence physician behaviours to increase proactive STI testing and treatment.

- **Theory & concepts:** Drawing from the framework of health promotion, health communication and other health behavioural change theories, the social marketing workgroups established the need to develop a campaign that is relevant to the reality and experiences of the youth in the priority neighbourhoods. This was achieved through research and audience analysis with both physicians and youth.

- **Inclusive evidence:** To develop a relevant campaign, the workgroup undertook 2 small scale studies – one with 115 Toronto family physicians and one with 49 young women aged 16-24 from the neighbourhoods that had the highest rates of chlamydia. Findings from these two studies were used to guide the development of the campaigns targeting physicians and subsequently targeting youth.

**Application of Domain 3: The practice cycle**

- **Assessment:** During Sexual Health Redesign, an environmental scan supported by research evidence, current literature, epidemiological data and staff reports were used to assess the sexual health needs of Toronto’s diverse populations.

- **Priority setting:** Based on findings in the assessment stage, chlamydia reduction among youth was identified as one of the program priorities and social marketing was adopted as one of the key strategies.

- **Taking actions:** The sexual health staff undertook 2 studies to generate local knowledge to guide the development and implementation of an inclusive and effective social marketing campaign.
- **Generate local and inclusive knowledge** (Phase 1): 49 young women were recruited from the clusters of 20 priority neighbourhoods to identify their current knowledge about STIs and chlamydia, influencers of their sexual health, elements of social marketing that appeal to them, etc. Recruiting young women from the priority neighbourhoods generated ‘inclusive’ knowledge that is critical to the development of programs specific to this population. At the same time, a study with 115 physicians had also provided the campaign with critical information on the physicians’ current STI testing practices, constraints and facilitators of testing, and their preferred social marketing vehicles, etc.

- **Community consultation**: during the development of the social marketing messages and products, sexual health staff engaged physicians and youth in focus-testing the materials to ensure that these materials would be most effective in reaching the target audiences.

- **External partnership**: community physicians and staff from community organizations serving youth were recruited to participate in sub-committees to provide consultation and feedback. In addition, connections were established with other health units that were undertaking similar campaigns to explore potential collaboration.

- **Internal partnerships**: a collaborative approach was reflected in workgroup memberships made up of family health PHNs, sexual health clinic PHNs, sexually transmitted infection case managers, sexual health educators, health promotion consultants, program evaluator, epidemiologist together to achieve the desire.

- **Mentorship**: staff of diverse skill sets worked together to facilitate mutual learning through mentorship and shared leadership in different sub-committees.

- **Evaluation & Research**: An evaluation sub-committee was established to integrate an evaluation plan into the action plan.
  - Pre-campaign surveys were sent to family physicians to establish a baseline on their current chlamydia testing practices in order to measure the effectiveness of the campaign. Post-campaign surveys were also sent out to physicians at specific time intervals after the campaigns. Other points of data collection for evaluation included the AIDS-Sexual Health InfoLine, and the Health Connection intake phone line that kept track of requests and reactions resulting from the media campaign.
  - Knowledge transfer: Findings from the 2 studies in Phase 1 were presented at a community forum attended by 80 service providers from different agencies serving youth in Toronto.
  - A second community forum for service providers working with youth was organized to provide updates on the progress of the campaign.
Reflexivity and Continuous Quality Improvement

The use of a practice framework or best practice model is critical in achieving organizational continuous quality improvement and professional reflexivity. A practice framework provides a template and a set of criteria for us to measure our effectiveness, areas of strengths and areas requiring improvement. In the case of the Taking Action on Chlamydia campaign, process evaluation of Phase I showed that while the campaign was exemplary in integrating numerous elements (as identified above) from the three core domains into practice, it required improvement in other areas. For example, within the practice domain, “involving the public and community” is a critical component. However, during Phase I of the campaign, involvement of community stakeholders was minimal and uneven across the different stakeholder groups. While a number of service providers working with youth in the community took part in different sub-committees of the campaign and youth had taken part in the local research and in the focus-tests of draft campaign materials, active participation of youth in the practice cycle was absent. The TPHPF enabled the staff to reflect on their work and identify the missing components that could make the campaign more effective and inclusive of the affected community, groups and individuals. As a result, TPH staff working on the campaign had put ‘community involvement’ as one of the key priorities in the subsequent phases of the campaign.
The Willet Hospital/Brant Community HealthCare System

This case study is based on information from the following sources:

- *The Willet Hospital: Best Practices Project Report* (Dilys Haughton, report presented March, 2000; included in the *IDM Manual* section Reports on Using the IDM)
- *Pilot Testing the Best Practices in Health Promotion Framework* (Barbara Kahan and Michael Goodstadt, Centre for Health Promotion, University of Toronto, October 2000)
- *Brant Community Health Care System: Best Practices Project Report* (Dilys Haughton, report presented March, 2001; included in the *IDM Manual* section Reports on Using the IDM)
- *Quality of Work Life (QWL) Project: Brant Community HealthCare System* (Dilys Haughton, report presented March, 2002; included in the *IDM Manual* section Reports on Using the IDM)
- *IDM Framework: The Brant County Experience* (Dilys Haughton, report presented at Best Practices at Home and Abroad, September 2004; included in the *IDM Manual* section Reports on Using the IDM)
- *Profile of Dilys Haughton* (profile archives, IDM Best Practices website, January 2005)

Notes

- All quotes are from Dilys Haughton unless otherwise stated.
- Dilys Haughton was Director, Primary Health Care Development, for the Brant Community Health Care System in Ontario, Canada when the IDM was introduced and after. She is currently Senior Director of Client Services, Central West Community Care Access Centre.
- This case study was prepared by Barbara Kahan and reviewed for accuracy by Dilys Haughton.

Background

In fall 1999, when the IDM was introduced to The Willett Hospital in Paris Ontario, The Willett Hospital and Brantford General Hospital were being integrated into the Brant Community HealthCare System (BCHS) as part of Ontario’s hospital restructuring initiative.

At this time The Willett Hospital was a small rural hospital in southern Ontario serving a population of about 10,000 people from the surrounding area. In addition to providing traditional hospital services ranging from in-patient (chronic and acute care) to out-patient clinics and urgent care, the Willett also provided outreach community services in association with its Community Well Being Team (CWBT), “a committed group of volunteers who help to identify community needs, develop and deliver programmes based on those needs.”

The first IDM project with BCHS was a pilot testing of the IDM and its operational framework from September 1999 to March 2000. The Willet Hospital site in Paris applied the IDM Framework to the topic of teen health, recently noted by the CWBT “as an important issue for the hospital and surrounding community.” The need to address the
issue had been identified in a County Health Status report (Brant County District Health Council), by the Brant County Health Unit, and anecdotally through the Community Well Being Team.

The group participating in the pilot-testing project included the hospital manager responsible for health promotion, clinical and non-clinical staff, and community-outreach volunteers from the CWBT. “We developed two goals, one specifically with regards to teen health and the other 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.).”

The second IDM project took place at the Brantford site over a period of about four months from late fall 2001 to early spring 2002. It was carried out by the Quality of Work Life (QWL) working group, a sub-committee of “Patient Satisfaction.” Team members were BCHS physicians, nurses, managers, directors, and staff from departments such as Community Relations and Marketing, Volunteer Services, and Human Resources.

The team identified as assets for their work the new health resource centre, the new librarian, desktop access to the internet for most staff, and the movement of the organization “towards a ‘best practices’ approach.” However, “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 also noted.”

The QWL team’s research question was: “How do you foster a culture that facilitates a healthy balance between work and home?” The question arose out of the recognition of the importance of positive work and home environments. However, “Healthcare workers are among the most likely employees to feel overworked...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.”

**Project Domains**

By March 2000, the pilot testing group had filled in a large portion of the IDM Framework. A brief overview of the content follows. The content is based on the IDM’s domains: underpinnings (goals/values, theories/beliefs, evidence), understanding of the organizational and health/social environments, and practice (research, addressing organizational and health/social issues).

**Goals**

The Framework listed the following two goals:

- Determine the capacities, resources and attitudes of The Willett Hospital (BCHS) with respect to Teen Health related issues.
- Determine the nature and priorities of Teen Health related issues.
Values
Examples of values included:
- Community & individual needs
- Community participation - important to get people to participate and feel comfortable participating, give their ideas freely, say how they are feeling
- Tolerance
- Emotional health
- Betterment of community
- Respect
- Trust

Beliefs
Some of the key beliefs listed in the Framework included:
- Power/control have a major impact on health.
- Assumption \( \Rightarrow \) most people are like us.
- Programs should be grass roots driven not top down.
- Teens feel invalidated.
- Teens are in a box.
- Male/female roles affect individuals.
- People can change.
- Role models are important.

Theories
Examples listed in the Framework of theories to draw on included:
- Organizational theory.
- Change theory.
- Health promotion theory.
- Developmental theory (Piaget).
- Transtheoretical model – stages of change.

Elements of the team’s theory of teen health as outlined in the Framework follow.
- 3 levels: individual; family/social; organization
- Determinants of health include: genetics, family supports, economy, etc.
- Influences on teen health: Public policy; Legal system; Economy; Formative years; Religion
- Casual factors of teen health: Self-esteem; Motivation; Peer pressure; Responsibility; Choice
- Complex relationship among casual factors, e.g. teens are judged on: who their friends are; socioeconomic background. This may determine how they are treated in school and how employable they are.
- What is a healthy teen? Eats well; Sexually responsible; Place/role in society; Good self-esteem; Encourage to look towards future, not just present; Feel valued by society; Feel they are contributing; Environment \( \Rightarrow \) access to resources they need; Adequate resources, e.g. love/support, non-violence; Family/parents supported in their role
- What makes a difference to teens? Show them we value what they do. Listen. Trust they can make decisions. Facilitate teens in making decisions. Allow them to make
mistakes. Develop inner capacities, skills and talents. Resources in community. Appropriate power distribution. Larger issues → inequity (media, food, government policy).

Evidence
Evidence requirements as listed by group members in the Framework follow.

- Need a good database for:
  - health promotion in general
  - teen health.
- Resource centre.
- Epidemiology evidence.
- Demographic information.
- Qualitative and quantitative research data.
- County list of resources.
- Key informant interviews.
- Ongoing needs assessments.
- Variety of sources, e.g. internet.
- Evaluate reliability/validity of evidence.

Understanding of the Environment
Examples from the group’s analysis of the environment as listed in the Framework follow.

- **key players:** the CWBT, other people associated with the hospital ranging from housekeeping staff to physicians, and the community in general including schools, churches, businesses, media
- **resources:** available resources in areas such as counselling unknown
- **challenges:** hierarchical hospital structure; no mechanisms for networking; lack of teen connection with service clubs; weak on finding research; “don’t get enough feedback from community to tell us if what we’re doing is right – need more direction”; and “Sometimes tradition gets in the way – need to let go of it.”
- **priorities:** “Decide whether to follow a wellness or illness model”; “Changing hierarchical structure to a shared decision making model”; and “Identify pathways for change.”
- **opportunity:** “Hospital in a state of change, which means the changes we want to make may be more possible.”

Practice
Some of the practice pieces listed in the Framework were:

- Literature search regarding health promotion and rural health underway.
- Key informant interview (high school principal) completed.
- McMaster Year 2 students working with teens at Paris District High School to conduct needs assessments also doing some key informant interviews.
- Incorporate health promotion principles in planning in BCHS system.
- Senior team (vice president, director, planner) working on health promoting hospital development.
- Board retreat planned in April to look at “health promoting hospital”.
- Staff to attend CWBT meetings on rotational basis as part of their jobs.
• Job posted for community program development position.

**Using the IDM**

A description of the process, strengths and challenges, and results related to BCHS’s use of the IDM follow.

**Process**

The key pieces of the pilot testing project at the Willett Hospital site follow.

- The preparation step included collecting background information from participants related to their understanding of health promotion of best practices and provision of introductory material.
- A two-day workshop provided introductions to health promotion, a best practices approach to health promotion, and the IDM Operational Framework. The adult education design was followed for most parts of the workshop except the introduction to health promotion, which ended up as a lecture format. The workshop also included exercises to apply the first three steps of the Framework: describe the current situation, develop health promotion guidelines, and apply the guidelines to the current situation.
- A second two-day workshop focused on identifying changes to increase consistency between the current situation and guidelines, and development of an action plan to achieve the changes. This planning phase involved identifying specific activities and resources required to make the changes.
- After the second workshop the group continued its work of completing the Framework. During this time period there was ongoing contact with the facilitators, including phone conversations, a half-day site visit, and two meetings with the facilitators and the contact people from the other two pilot sites. “Meeting with the other site leaders gave us support, encouragement and ideas!” The group used some of the IDM materials as resources in the ongoing work of completing the Framework. “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.”
- At the end of the funded project, the group decided to continue to use the IDM. Contact was maintained with the facilitators through phone and email, and the IDM computer program, newly developed as the result of a suggestion from another of the pilot sites, was adopted to assist with the IDM process to support teen health.

A year after the end of the pilot testing period, having “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,” the group was “in the early stages of developing a project to address health needs of rural youth.”

During this period awareness and application of the IDM had extended beyond the original team and the topic of teen health to the BCHS strategic planning process. “The IDM Framework was presented to [the Board of Governors, staff and senior management] during the planning day. Strategic planning related to this is ongoing.” In addition to “incorporating the IDM in our current project planning initiatives” in 2001 the IDM
approach was being incorporated into “quality improvement, and accreditation preparation.” As well, education about the IDM continued. For example, in 2001, “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.”

In fall 2001 the QOL team began its participation in the “bridging the gap between research and practice” project to test the IDM evidence framework learning module. This project, less intensive than the pilot testing, involved an initial focus group to identify research assets and needs. This focus group was followed by a one-day workshop which introduced topics such as the relationship of research to everyday practice, the IDM, and the IDM Evidence Framework. In the last half of the workshop participants applied the IDM Framework to the quality of life issue and organizational challenges related to finding and using research. After this workshop, the team spent its time “identifying the current situation in the hospital, investigating initiatives already under way and reviewing literature and internal surveys.”

At the end of the funded project the group was “very comfortable finding evidence and developing a Best Practice Model. We will continue to develop expertise in evaluating the quality to health promotion evidence.”

Strengths and Challenges
Observations about strengths and challenges of the IDM are described below.

strengths
Based on BCHS’s experience with the IDM, “We believe that the IDM is a values based planning tool and is unique, innovative, and invaluable.” The IDM has potential “in the development of community wide activities…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 [to reduce the incidence of falls for seniors], 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.”

challenges
In 1999-2000, during the first IDM project, “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 [the facilitators’] 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.”

A key challenge related to participation by volunteers. “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.”
Other challenges included: “a broad range of understanding of health promotion among our group members, and competing paradigms within the group”; the amount of time required to complete the Framework; and “getting understanding and buy-in from management and staff, a scarcity of resources, and financial constraints.”

**Results**

At the end of the funded pilot testing project in 2000 the site contact listed a number of benefits that resulted from using the IDM. “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.” In addition, “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.” Other benefits identified in 2000 included a “broader understanding of health promotion,” a “systematic approach to doing a gap analyses,” increased credibility from “working on an evidence based model,” and recognition of the “considerable work needed to be done at the organizational level to lay a strong foundation of health promotion principles.”

A year later, in 2001, “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 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.”

Our IDM work kickstarted this new portfolio of Primary Health Care Development, The Willett’s work in health promotion was part of the reason this portfolio was created. Our work on the IDM Framework shaped it. The new portfolio was based on the Framework’s underpinnings that we developed and resulted in business being done in a new way in a hospital setting. It helped us identify how the hospital could work with the community as a partner and how we could work as a system to address health issues. Health promotion became a part of the hospital’s core business - that was a big deal for a hospital, hospitals are into surgery and managing waiting lists.

In 2004 the site contact noted that, “In the ‘understanding of the environment’ domain the IDM Framework helped us understand and manage the internal and external enabling and obstructing factors.” Also in 2004 the site contact stated that “the concrete results [of the IDM process] were a rural health initiative with Health Canada funding, to expand CWBT’s to four other rural communities and incorporated evaluation of the strategy. In addition, new funding for diabetes care was used to deliver services in rural communities rather than ‘add-on’ services at the hospital. This initiative was planned jointly by the Department of Ambulatory Care, Primary Healthcare and the CWBT’s.” In addition:
Four years after the beginning of the IDM project, the website —<www.bchsys.org> — has a new look, which incorporated some of the principles we articulated through our use of 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.”

On a personal level, “When working at the Willett Hospital [in Paris, Ontario] as part of the IDM best practices pilot testing project I realized how important values-based practice was, it is a part of best practices. During the pilot project that was almost the most important piece of our work – it was the foundation for all the work that we did after that.”
Womankind Addiction Service

This case study is based on information from the following sources:

- *Best Practices in Health Promotion: Meeting the Needs of Women with Addictions* (Deb Bang, report presented March 2002; included in the IDM Manual section Reports on Using the IDM)
- *Planning Womankind Addiction Services using Best Practices* (Deb Bang, report presented at Best Practices at Home and Abroad, September 2004; included in the IDM Manual section Reports on Using the IDM)
- *Profile of Deb Bang* (profile archives, IDM Best Practices website, February 2005)
- Taking off with “Taking Steps” – a pre-treatment program for women (Bang, Debbie & Green, Cassandra, presented to Addiction Ontario Conference, June 2007, Mississauga, Ontario)
- Womankind Addiction Service data
- conversations with Deb Bang in February and April 2007
- email correspondence with Deb Bang August 2007

Notes

- All quotes are from Deb Bang.
- Deb Bang is Manager of the Consumer Health Information Service, of Womankind Addiction Service, St. Joseph’s Healthcare and Men’s Withdrawal Management Centre, Hamilton Health Sciences, Hamilton, Canada. She is also a founding member of the former Best Practices Work Group.
- This case study was prepared by Barbara Kahan and Deb Bang.

Description

The Issue and its Environment

By 2000/2001, funding of the Ontario addiction sector had not kept pace with the changing face and needs of clients. Client use of the existing programming varied across the province with over use in some areas of the province and under use in other areas. The Ministry of Health and Long Term Care (MOHLTC) directed all addiction services in Ontario to participate in a regionalization and rationalization process to look at how addiction services were delivered and opportunities for improvement. Hamilton completed its plan and one of its recommendations was to amalgamate Women’s Detox and Mary Ellis House (MEH) treatment service. This recommendation was identified as the top priority in Hamilton and unanimously endorsed. The MOHLTC’s approval of the amalgamation, a new operating budget and eventually capital funding to relocate the services stimulated the planning cycle.

Amalgamation of a withdrawal management and treatment service was a rarity in the province and thus there were few models, limited evidence and little experience in bringing the two services together. One of the services provided treatment programming
for women and was governed by a voluntary community board with an inadequate operating budget. The other service provided withdrawal management programming for women, was governed by a hospital and had a limited but adequate budget.

**Organizational Environment and Activities**

Womankind Addiction Service resulted from the November 22, 2004 merger of the Women’s Detox Centre (seven withdrawal management beds) and Mary Ellis House (eight treatment beds and six emergency shelter beds). The Women’s Detox and Mary Ellis teams had different cultures but worked with similar women. Womankind was developed “to support women with addictions along the road to recovery. They enter into our service as part of their journey to recovery from any point in their journey: initial engagement through to active treatment, aftercare and/or back as a volunteer.” Womankind is part of St. Joseph’s Healthcare in Hamilton, Canada. Womankind’s program components include the following:

- 24 hour Telephone Support – support line for women and their families
- Withdrawal Management – 10 beds for women withdrawing from substance use
- Emergency Shelter – 6 beds for women who need a short term shelter bed
- Pre-treatment – weekly groups to assist women to get ready to attend treatment programming
- Treatment – 8 beds for women in treatment for their substance use and 4 day treatment places for women in the community
- Aftercare – weekly groups to assist and support women using DBT approaches to continue in their recovery
- Support and Recreational Groups – groups for women to assist them to learn new skills and meet other women (for example, a creative writing group)

A day program for women using substances and their children under the age of six is also on site.

Womankind’s mission is to provide “effective and compassionate withdrawal management and substance abuse treatment to all women.” It envisions a centre for all women, which supports holistic healing and works from an empowerment model towards the restoration of dignity, self-esteem and women regaining control of their lives. Womankind’s Planning Framework includes elements such as clarifying, participation from the front line team and board, inviting innovation, and trying new approaches and evaluation. Best practices are intrinsic to planning at Womankind: “I would never think of beginning a process of planning anything without first rooting myself and others in current reality and the values base from which we’re developing it.”

Currently, Womankind is conducting a process evaluation and making revisions based on results. Womankind’s “Taking Steps” pre-treatment program has had “over 2,500 participants in two years; initially we didn’t know if we’d created the right program, it’s been an amazing response.” The pre-treatment program was developed based on evidence and the goals for the program were filtered through the Womankind mission, vision and values. “We are doing an in-depth evaluation now to understand our success.”
Womankind’s Clients
A brief profile of Womankind’s clients, based on information for the period November 2004 to March 2007, follows. During this time period Womankind had over 3,000 residential admissions.

- Clients ranged in age from 16 to 54 years old.
- The largest proportion of clients (64%) used crack or cocaine, followed by alcohol (53%). Clients also used cannabis (21% of clients), opioids (15%) and ecstasy (4%).
- Just over a fifth of clients (21%) were in a relationship (married or common law). The rest were single (either never married, separated or divorced).
- A third of clients were unemployed (35%) and 20% were employed full time or part time. An additional 20% received disability allowances, 19% were not in the workforce, and the status of the remainder was unknown.
- Over half of clients (55%) had completed all or some of high school and 35% had completed all or some of university or college.

Values/Goals/Ethics
Womankind is part of St. Joseph’s Healthcare, Hamilton (SJHH) and as such embraces the values and ethical parameters of SJHH. Some of the key values/goals/ethics underlying Womankind’s approach follow:

- We are a faith-based organization dedicated to providing compassionate, sensitive care to our clients and their families and to achieving excellence in health care through our on-going commitment to education and research.
- We have a special obligation to the poor and unwanted.
- As a premier academic and research health care organization, St. Joseph’s Healthcare commits to making a difference in people’s lives and the future of our community, through integrated health services and internationally recognized programs.
- Womankind’s specific goals are to provide programming based on evidence and best practices, to adapt programming to emerging evidence and ongoing evaluation and to share our learning with others.
- Safety for the women and the team is a primary concern of Womankind.

Theories/Beliefs
Some of the key beliefs underlying Womankind’s approach follow:

- Providing a complete range of services to women in one place and seeing them over a long period of time will make a difference to women in their journey to recovery.
- Knowledge is multi-layered. For example, intrinsic or internal knowledge includes people’s experiences while external knowledge includes evaluation, evidence and best practices. Being open to all kinds of knowledge is essential to achieving a quality approach.
- Programming is based on key theoretical approaches including stages of change, relational theory, trauma-informed and solution focussed approaches, cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT) and emerging evidence and best practices for working with clients with concurrent disorders – i.e. having a mental health diagnosis and an addiction.
Evidence
evidence-gathering activities include:

- evaluation based on goals and objectives
- a “grounding” process based on literature reviews, client input, and staff knowledge and experience (“our own and others”)
- information from a database designed to track women’s progress throughout their involvement in any of the services.

Using the IDM

Womankind uses the IDM for a number of purposes. “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.” Initially the IDM was used “to frame how we went about planning and incorporating best practices into new programming. Once the amalgamation was approved, the IDM was used to develop a new addiction program and service for women based on current best practices.” The IDM continues to be used for values clarification and “as a filter to make sure organizational practices are meeting its values and mission.” In addition, the IDM is being used to build the organization’s strategic direction.

Process

The IDM was introduced to Women’s Detox and Mary Ellis House staff in 2001 in the preliminary stages of their merger, which would result in Womankind Addiction Service. Staff participated in a workshop, which introduced the IDM and its evidence framework. Staff then worked through the IDM process. The process continued after the project ended under the guidance of Womankind’s manager. “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.”

The first step in using the Framework was to define Womankind’s clients, values and mission statement. Next, “as part of the Framework process we checked out the environment, gaining an understanding of the political climate related to addictions. We conducted site visits, garnered support, looked for partnerships, etc....We also explored what kind of evidence meant something to us and what didn’t...This work finished and then the pending 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.” The manager developed a PowerPoint presentation for staff, which adapts the IDM to “stepping stones.” Currently the IDM is not used formally at every stage and not all pieces are applied, but IDM concepts continue to guide the program.

The program manager was extremely familiar with the IDM, having been part of the original Best Practices Work Group, which helped develop the model. “I have played with it, I have practised it.” The program manager was also a key reviewer of the IDM materials. “I have used all of them.” Because of the in-depth working knowledge of the
content of the materials, it is no longer necessary to refer to them. Currently it is the IDM Framework itself that is used, with its categories and descriptions. The IDM can be used “throughout Womankind’s career. We are still toddlers at Womankind, still having to make all kinds of changes…”

For example, clients presenting with a concurrent disorder pose unique challenges within the current programming. To address this issue Womankind is building a 28-person team across the Mental Health and Addiction service composed of physicians, nurses, social workers, managers, psychologists and occupational therapists. This team is being developed using an IDM-type framework.

Strengths and Challenges
Strengths and challenges of the IDM that were observed through Womankind’s experience with the IDM are described below.

strengths
“The strengths of using the IDM Framework were that it provided direction and a set of clear steps, provided reminders, and made sense.” Its key strength is its relevance to health promotion planning. It provides a structure for health promotion planning, fits well with other planning models, and, uniquely, has a health promotion “filter”: it is a “good framework to allow for crucial examination of mission, values and goals to see if the services you are providing are meeting these.” It is easiest to pick up if the person using it has a good understanding of health promotion philosophy and theory and becomes easier over time. “I can do it in my head as well as on paper now.” In addition, the IDM has credibility; it “is based on theory and best practice, has been peer reviewed, written about in the literature, presented at conferences nationally and internationally used and appreciated in a number of settings for a variety of reasons…”

challenges
Challenges of using the IDM follow.
- “Limitations were that there is a lot to learn and at the time it was important for us to develop a new program for the amalgamated service within a defined timeframe.” Because of time constraints, instead of all staff learning the IDM, “my knowledge of the Framework became one of my contributions to the process.”
- It is not always feasible to do the formal process.
- “In the beginning people were not used to a planning process, therefore the utilization of this framework was a harder to sell.”
- Not everyone understands health promotion well. It is harder to pick up without a health promotion grounding.
- The environment is medically focused. Health promotion is still not a focus in the hospital. But this is changing.

Results
Benefits identified by participants of the 2001 project, which introduced the IDM and its evidence framework, included increased skills, confidence and understanding related to
applying best practices. In addition, a “clear process emerged … which we could use again in the future.” Examples of the insights gained by participants follow.

- Staff members have different agendas. In addition, language can be a barrier within the group.
- Previously decisions were made “on a whim.”
- It is not difficult to use a best practices approach.
- “We have ‘hidden’ skills.” Confidence in accessing evidence grew.
- Initially the definition of evidence was limited.
- Although participants “struggled with what our question was,” ultimately they came to the conclusion that “defining the question is the most important step.” Their first attempt at their research question assumed part of the solution: “What programming could be offered to women in treatment to help with relapse prevention, on the weekends?” This question evolved to this wording: “Based on the identified needs what programming can we offer women anticipating relapse that will meet their needs and reflect best practices?”

One concrete result that emerged from the on-going IDM planning process was Womankind’s Taking Steps pre-treatment program which to date has been very successful. The number of participants has been “well above our expectations” in its first two years of existence. “This program has also contributed to our reduction in ‘No Beds’ – or the incidences that a woman calls and we do not have a bed available for her to use, even though she meets criteria to be admitted to our program. We have also done an early study to look at clients enrolled in Taking Steps that go onto treatment – meaning Taking Steps facilitates the continuation of their journey towards recovery. Still early in the program to have solid data yet…In my plans to do so in the future as we now have a database that will allow us to track these clients. The program is only 2.75 years old at this point (3 years on November 26, 2007).”

Other benefits resulting from using the IDM process, from 2001 to the present, follow.

- “Through the Framework process, both teams came together.”
- “Our Mission and Values Statements emerged out of our work with the IDM Framework…and continue to be the guiding principles for the program including changing the way we provide programming and developing new programming. All changes and additions are ‘filtered’ through the mission and values we developed together with the IDM.”
- “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.”
- “Practices, changes, directions that are most successful come from the premises pervasive in the IDM – values, theories, understanding our environments such as the corporate culture, what are people’s practices, what works, what doesn’t. Our best outcomes emerge when we use the IDM at least as the backbone of what it is we’re doing - the IDM is a way of being, of thinking, of starting things.”
- “Womankind programming is based on current best practices, is flexible and poised to make changes based on emerging evidence and knowledge, and, most importantly, is achieving its mission and vision: helping women with addiction successfully journey towards recovery.”
APPENDIX II: OTHER EXAMPLES OF USING THE IDM

Notes on the examples included in this section follow:

- *Regina Community Plan 2007: A Home for All*, was prepared for the Regina Homelessness Committee by Barbara Kahan (in press). In addition to the IDM elements shown on the diagram, an explanation or “theory” of housing and homelessness issues was included in the report, covering impacts of housing, influences on homelessness, and solutions.

- *Evaluation 2006 Appendix I: Diagrams, a KidsFirst Regina internal working document*, was prepared by Barbara Kahan, for KidsFirst Regina March 2006.

- *RICCP Evaluation Report Appendix II: Details of Survey Results* was prepared for Regina Inner City Community Partnership and Action for Neighbourhood Change by Barbara Kahan, January, 2006. In addition to the diagram of survey participants’ view of change, which contains elements of theory and an analysis of the environment, the evaluation also covered the remaining IDM subdomains, including values.

- *Evaluating a government partnership using the IDM* by Evan Morris was posted as a reflection on the IDM best practices website in October 2007.

- *Using the IDM with Langs Farm Village Association (LFVA)* by Rishia Burke was posted as an IDM Best Practices website reflection in July/August 2007.

- *Using the IDM - An Individual Perspective* by David Groulx was posted as a reflection in September 2007 on the IDM Best Practices website.
Using the IDM with Langs Farm Village Association (LFVA)

Rishia Burke, May 2007

The organization that I have used IDM pieces with is a community health centre in the City of Cambridge (Langs Farm Village Association). The organization operates within a neighbourhood setting serving and working with families and individuals within those boundaries. The work focuses on health care, health promotion and prevention with services areas that include a clinical practice, a youth and teen service area, an early years team, a resource centre (providing employment supports), adult services programming (focus here includes seniors programming, multicultural programs, and women), and volunteer services.

I have used the IDM model in part, through the logic model and evaluation work that I have been doing with the organization.

Before I start the logic model process I work with staff to identify underpinnings – we talk about the assumptions behind their work, why they do their work and what they hope their work is accomplishing. I ask the team to identify the principles that are critical to them as they do their work.

We then relate those principles to the organizational strategic plan and its underlying principles (e.g. providing opportunity for individuals to grow in their strengths is important in the way that we do our work and/or we want to look for and foster community leadership in the process of doing our work – Strategic Plan direction of capacity building.)

I ask staff to think about what outcomes a program might have and why those outcomes might be achieved. We talk about what indicators they believe they have of those outcomes. In doing this we are able to look at the value of anecdotal story. I find when working with a variety of organizations staff often validate their work through stories that are related to them by participants. There is value in those stories however, I also find that when you have a conversation about this we often challenge the story if it is weak and/or identify additional sources of separate evidence to substantiate the outcome.

We will also look at the literature to
see how well assumptions about outcomes are supported; that literature is then used for the development of outcomes in the logic model and then and indicators in the evaluation framework.

I believe that an underlying approach in the IDM model is the on-going nature of developing best practices. A large part of the message to staff and work to integrate into their practice is that

- Evaluation is part of your front line practice – it is not this separate thing that we do at the end of something; the benefits of embracing that is the associated motivation for needed changes to process, a source of pride and satisfaction for a job well done when outcomes are revealed.
- The planning, implementation and evaluation cycle never ends! One stage feeds the next! (see figure on previous page, with addition of “values, principles, assumptions” to “Consideration of community trends and research”.)

The strength of using these elements of the IDM approach is that we are able to develop a solid foundation of understanding as a team before we move ahead to a logic model and all the other subsequent steps. The conversation in itself is a bit of a team building exercise.

Each team at LFVA will identify some slightly different underpinnings because of the nature of each teams work. However, all of the teams to date have identified the importance of capacity building, leadership development and community engagement in their discussions.

As mentioned earlier the groups have been able to tie their team level work to the organizations strategic planning work so that they can see how their teams work related to others and to the organization as a whole.

We will continue with this process until the entire organizations service area logic models have been completed. We will also use discussion about principles and values when conducting other work - most recently when working through a re-design of the organizations leadership development model.
Using the IDM - An Individual Perspective
David Groulx, June 2007

Type of Organization, Location, Main Focus (Issue and Population)
I am a registered nurse who has worked in different public health departments and was fortunate to be involved in two pilot phases of the IDM model. Public Health in Ontario Canada is delivered by 36 separate/ independent Health Units/departments. These health units deliver programming addressing the population health needs of the various districts. To guide the work that public health practitioners engage in, the Ministry of Health for the province has set prescriptive programming requirements that must be met by all health units within the province. The topics that are addressed within this mandated include chronic disease and injuries, family health and infectious diseases. It is this document that focuses much of the work done in Public Health across the province. As I am a health practitioner practicing in health promotion my involvement and focus of initiatives focussed on chronic disease prevention. I will describe my involvement in utilization of the tool not in as much to address a particular health promotion initiative but more in terms of the actual experience of utilization of the tool and various components within itself. My involvement began with the initial pilot testing phase. This initial pilot phase involved the testing of the IDM model theoretical constructs and framework and how these would be interpreted and understood by practitioners. I was also involved in the pilot testing of the evidence framework (translating research to practice). The questions that were identified by staff in the pilot testing phase of the evidence framework included:

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

The health promotion values that were identified to correlate with the questions posed included optimal health for all, social justice, community empowerment, ecological respect and sensitivity and joy. Support for involvement in both pilot testing phases were supported at senior administrative level as well as middle management and staff. The IDM model was introduced in both pilot testing phases by both Barbara Kahan and Michael Goodstadt, both authors of this contemporary approach to best practices in health promotion.

Strengths/Challenges of Using IDM
The factors or correlates relating to our health are not linear and are extremely complex and multi-dimensional. It is therefore necessary when addressing a particular issue that one understands the different contextual spheres that exist relating to a particular issue.
This model guides individuals to navigate through this inherent complexity and multidimensionality. It allows for the identification of all the information necessary to guide health promotion practice for a given field that is best suited for a given population.

A second strength that can be noted includes the ability of the model to facilitate self reflection and examination of one’s own personal beliefs, values, and ethics and the environmental context in which these interact. Furthermore it allows and facilitates discussion within and amongst organizational members on the varying viewpoints on their individual, team and organizational values, goals and ethics. In addition there may be variances in how one interprets the environment and the IDM model allows for identification and examination of these differences. These discussions are often absent in the examination of an issue yet inherently impact on the decisions practitioners make relating to addressing public health issues.

The utilization of the evidence framework assists with and gives insight into how to break down barriers that may be affecting an issue. For example in understanding the social and economic structures that exist one can begin to identify how to break down barriers such as financial constraints. Furthermore the utilization of this framework allows for a systematic approach to incorporating research into practice as well facilitates justification and validation of the value for utilization of qualitative research as this type of research may be more reflective of the values held within health promotion. In addition the utilization of the evidence framework assist with “making the case” to middle and senior management regarding need for focus on or resources allocated to a particular public health problem.

One of the most important strengths of this model is its portability. The IDM framework allows for the variations in values, ethics, goals, and environments that can be seen across cultures, organizations, and individuals, locally, nationally and internationally.

Interestingly enough the characteristic intrinsic to the innate strength of the model was also the largest challenge with utilizing this tool at the time of pilot testing. This model, like many other models, is complex reflecting the realities in which we as human beings live work, interact and function within our societies. Unfortunately practitioners themselves may be unable or unwilling to work through such complex models in favour of more simplistic linear approaches, focussing in on, or addressing one aspect of the solution to a particular health promotion issue. I would speculate that this occurs as this approach would require less time on introspective, retrospective and prospective thought and analysis and would focus more on action toward program development and implementation. The IDM model in my opinion does not facilitate that immediate need for “action” and this may be difficult for some practitioners.

Furthermore, as humans have varying values, goals and ethics, as well as understanding of theories, evidence, and their environment, there exists the potential for conflicting ideas on what would constitute “best practices” between individuals, teams or even between organizations within a community. This conflict has the potential to delay implementation of health promotion practices until such conflict is resolved.
Finally, after the pilot phases of the project, access to expert support in model interpretation was diminished lending to the discontinued use of the model. At the time of the pilot testing there were no supplemental tools developed as there is today, nor were there identification of expertise to facilitate model utilization as there currently exists.

**Results of Using IDM (Re. Organization and/or Health/Social Issue)**

My participation in the IDM best practices model occurred early in my career in public health. In this infancy stage of my career I had a different view of what “best practices” are. I can truly say that my involvement with the project has had an impact in the way in which I look at the conceptual notion of best practices. There is significant variance in my initial understanding and definition to best practices compared to my current understanding and definition. My current understanding is much more broad and inclusive. It does not only focus on the best evidence but how this information interacts with all the other domains. My involvement in the pilot phases has strengthened my belief in the importance of reflection on my practice in public health. It has made me think about my values and beliefs when addressing issues and has lead me to more critically examine the environment when addressing an issue.

Furthermore, the utilization of the Evidence Framework assisted in defining search parameters and conducting a literature review such that only the literature that reflected the health promotion values was identified and reviewed.

Moreover, reflection on the theoretical constructs that the practice of health promotion and public health are based upon had proven to be quite invigorating, reengaging and reenergizing as a participant in the pilot phases.

**Note:** The experiences and opinions expressed are those of the author and do not necessarily reflect those of other participants in the pilot phases or the organizations where this author was/is employed.
Evaluating a Government Partnership Using the IDM

Evan Morris, April 2007

I recently carried out a process evaluation of a collaboration consisting of several provincial, territorial and federal health departments. During the first month I spent a considerable amount of time reading project documents and interviewing participants. I also spent a lot of time thinking about how to pull all the information together. It finally dawned on me that the IDM Framework could be applied to evaluating projects as well as for planning. Once I determined to use the IDM Framework for the evaluation, the remainder of my evaluation work was straightforward; the IDM provided a road map for my analysis of the processes involved in this project.

The IDM is a useful tool for carrying out both outcome and process evaluations. An outcome evaluation tries to determine if the project activities led to the desired project outcomes, while a process evaluation determines if the processes supported the outcome activities. The diagram below shows how I used the IDM in my process evaluation.

I determined what the activity objectives were, what the process objectives were, and whether or not the process objectives supported these activities. A measure of the success of the processes was whether or not the planned activities took place, and how well they were carried out.

At first I was tempted to limit my evaluation to how well processes supported activities, and this is a common practice in process evaluation. However process and activity objectives aren’t selected in a vacuum. They are the result of a number of factors, including power relationships between collaborators, resources, theories of social change, values, etc. An understanding of these factors makes it possible to determine what project goals were chosen, and what processes were applied. If we can determine how these factors affect our goals, activities and processes, we can provide extremely useful information for other groups or collaborations that are planning projects.

The IDM is a complete logic model, and contains many domains and interactions. At first I was somewhat overwhelmed at the idea of applying the entire model to the process evaluation. However, several extremely useful discussions with Barbara Kahan convinced me that I did not have to apply the entire framework to the evaluation process. The IDM practitioner can select to use portions of the framework depending on the situation. Some of the IDM domains are categories such as values/principles/beliefs, theories, evidence, resources, structures, etc.

I analyzed my data based on the domains shown in the diagram below. One of the main strengths of the IDM is that it includes values and principles as major determinants of both processes and goals. It was clear for this collaboration that the values and principles of the participants had a great influence on the processes and successful activity outcomes of the group. In fact values and structures were the most important determinants of group processes.
Before I began my evaluation I read a number of publicly available evaluation of other collaborations and partnerships. Most collaborative health-related projects involved partnerships involving different types of groups, such as health agencies, community groups, government agencies and academics. In many cases there are unequal power relations between the partners. Typically one partner has greater control over resources, such as funds, facilities, personnel and level of expertise. When such collaborations fail, it is often because these power differences result in partnership processes that become competitive, turf protecting, and antagonistic.

The collaboration I was evaluating was fairly unique in that the partners consisted of representatives from several government jurisdictions. Power relations were fairly (but not completely) equal. If a partner felt that their views were not being heard, or that they were not benefiting form the partnership, they could easily have dropped out of the collaboration.

Based on their values, the partners decided early on to create process and outcome objectives that included the following:
- All partners benefit from the collaboration
- Decision making is by consensus
- All jurisdictions, regardless of how small, are included in decision making and project activities
- There is a sharing of resources
- There is mutual accountability
Overview of Regina Community Plan 2007: A Home for All

Key Service Providers
- government
- charitable foundations
- private sector

Housing Providers
- government
- private sector

People Who Are Homeless/at Risk of Homelessness
- people with low income
- Plan 2007 priority population: Aboriginal peoples; youth; people with severe challenges e.g. mental illness, substance use issues, FASD, legal system involvement

Other Citizens
- family members
- friends & neighbours
- volunteers

Key Stakeholders
- Funders
- Key Service Providers
- Other Citizens
- People Who Are Homeless/at Risk of Homelessness
- Regina Homelessness Committee

Overall Goal
- leadership & partnerships
- integration of housing & services
- programs to facilitate renting & owning high quality housing
- support programs

Key Challenges to Address
- low income & insufficient quality subsidized/affordable housing
- growing depth & complexity of challenges
- system barriers
- rising costs of utilities & materials

Key Values & Beliefs
- equity
- positive relationships
- social inclusion
- working together
- prevention
- holistic approach
- need for choice & flexibility
- resources exist to achieve vision
- a home is more than a physical structure

Effective Strategies
- combine housing & supports
- provide housing subsidies
- use a “housing first” approach
- collaborate & partner
- include people currently or formerly homeless in decisions & activities

Current Assets to Build On & Enhance
- incorporate financial & physical infrastructure
- develop knowledge & capacity
- increase public awareness
- foster partnerships
- enhance local capacity

Key Objectives to Achieve Vision
- Decrease number of people homeless/at risk
- Decrease gap between housing costs & income
- Reduce number of dwellings requiring major repairs
- Improve quality of physical & social environments
- Increase rate of housing satisfaction

Activity Objectives
- Develop an information clearinghouse with housing registry and other components.
- Develop a system of supported/supportive housing.
- Initiate a program of neighbourhood facilitators to work with neighbourhood residents.
- Implement outreach housing/services program with education, mediation & advocacy for priority population.
- Implement a training & awareness program for agency staff and other service providers.
- Implement activities to decrease the income-housing gap.
- Support strategies to improve housing quality.
- Implement a system of one-stop drop-in & service centres.
- Increase life coaching opportunities.
- Improve transportation for the priority population.
- Strengthen crisis services.
- Develop a youth housing strategy.

Process Objectives
- Provide adequate long-term funding for services & programs.
- Prioritize for funding projects that meet a set of criteria based on values, theory & evidence.
- Institute a service broker approach which is person centred and supported by a multi-sectoral team.
- Conduct a series of foundation-building workshops with all key sectors & stakeholders to facilitate collaborative action.
- Establish a coordinated & multi-sectoral approach to policy & program development and review.
- Develop an active housing & service provider network with multi-sectoral membership.
- Support the Plan 2007 through ongoing information gathering, regular review & continuous development of Regina Homelessness Committee.

Vision
not just shelter but A Home for Everyone promoting dignity, health, security, independence, positive social interactions
Each individual community
Communities are healthy
general community goals
- Communities are healthy (equitable, socially cohesive, positive relationships, family-friendly, environmentally supportive).
- Each individual community member is physically, emotionally, cognitively, socially, and spiritually healthy.

general community process objectives re.
- systems/structures external to KFR (e.g., municipal, provincial and federal governments; other programs)

general community activity objectives
- develop health-supporting policies and services
- provide resources for program-related activities

short-term outcome objectives
Complete policy drafts and plans for services designed to increase:
- resources for healthy child development
- equity (re. food, income, services, education, jobs, housing, transportation)
- social cohesion and supports
- positive relationships
- quality of physical environment

long-term outcome objectives
Implement, evaluate and continuously improve policies and services designed to increase:
- resources for healthy child and family development
- equity
- social cohesion and supports
- positive relationships
- quality of physical environment

KFR process objectives re.
- governance/administration/collaboration
- program components

KFR program resources
- money, time, people (expertise, enthusiasm), materials, equipment, space
KFR program challenges:
- complexity of the issues

KFR activity objectives re.
- governance/administration/service delivery/collaboration
- enrolling and retaining families
- home visiting
- mental health/addictions
- early learning/child care centres

short-term outcome objectives
There will be an increase in:
- families' attainment of short-term goals
- supports to families

long-term outcome objectives
There will be an increase in/maintenance of:
- families' attainment of long-term goals
- children's attainment of their age- and capacity-appropriate development

To support healthy child development, the quality of children's learning/nurturing environments will be enhanced with increases in the quality of:
- families' health-promoting behaviours
- parent-child relationships
- families' social engagement
- the physical environment

KFR priority issue
To assist families living in challenging circumstances in their efforts to provide nurturing and stimulating environments supportive of their young children's healthy development, because:
- families in challenging circumstances require more support
- nurturing and stimulating environments give children a better start in life and prevent difficulties later in life
- the first three years of life are critical in terms of learning and development

KFR families
- live in Regina (Al Ritchie, Core, North Central, and North East in particular)
- experience extremely challenging circumstances
- have children newborn to a year or are expecting a child
- willingly agree to participate in KFR with full understanding of KFR

KFR general program goal
- KFR works collaboratively with families and organizations to maximize opportunities for KFR parents and children to achieve optimal physical, emotional, cognitive, social, and spiritual health.

KFR principles
KFR processes and activities should be:
- beneficial to families: the priority of KFR is to benefit families through enhancement of healthy child development and prevention of health and social issues
- strengths based: strengths are used to develop capacities and address challenges
- inclusive: no individual or group stakeholder is excluded from KFR processes and activities, all major stakeholders participate in decision making, and resources are shared equitably on the basis of need
- collaborative: KFR actively cooperates and coordinates with, and enhances, existing networks/services
- respectful: all stakeholders are treated with dignity; processes and activities are sensitive to differences in culture, income, gender, age, health status, or other
- accountable: processes and activities are transparent, efficient, based on evidence, continuously improved on the basis of ongoing reflection and evaluation, and consistent with KFR values, theories and underlying beliefs, and understanding of the environment

Follow-up to IDM Use and Impacts (October 2007)
Regina Inner City Community Partnership

Survey Participants' View of Change

Who is part of making changes?
- community in general
- individuals (residents, youth, elders, landlords, tenants, people in positions of influence, mentors, professionals...)
- government (3 levels)
- organizations (including little ones)
- business
- rest of city
- others...

Why make changes?
- to achieve:
  - positive physical conditions
  - positive social conditions
  - economic well being
  - genuine partnerships
- so that North Central is a healthy community where each resident lives a high-quality life

What gets in the way of change?
- negative conditions ranging from low income and unemployment to lack of caring and slum housing
- ignoring community input

How does successful change work?
- by addressing a number of things that interact with each other at once or by focusing on the most important factor (housing, youth, family, safety/crime, addictions, employment/business, education, gangs, low income, community participation)
- precipitated by different things (choice or force of circumstance, fear or anticipation, concrete action to rally around, people/organizations inside or outside community)
- builds through domino effect, momentum, or accumulation of one bite at a time
- by using key process of active partnerships among community residents and organizations, and between community members and people/groups outside of community, with community involved in planning, policy making, decision making, implementing, lobbying, identifying issues
- key process includes aspects of empowerment, capacity building, good communication, planning, working coherently, working gradually

Which activities will achieve changes?
- use policy, regulations, enforcement to improve housing quality
- institute programs to support affordable home ownership (government assistance for low income, rent to own, more Centenary Homes, housing co-ops, infill housing for variety of incomes)
- use financial strategies (tax incentives for housing purchase & business development, community bank)
- increase & improve services (neighbourhood grocery store, one on one service providers/outreach workers, more Aboriginal service providers, addictions prevention & treatment, better transportation, simplify access/one door, provide supports to people in need e.g. supply proper clothing & food, to increase school attendance...)
- support educational activities (life skills, skill development, how to build houses, letting people know what's available for them, educating tenants & landlords) and making education for youth more relevant (about real life, North Central, their heritage)
- have community events & projects (clean up, composting, recycling, COP, CPTED, improvement projects, use low-cost strategies, restrict traffic flows to decrease access for Johns, improvement projects, use low-cost strategies, restrict traffic flows to decrease access for Johns, etc.)
- increase & improve services (neighbourhood grocery store, one on one service providers/outreach workers, more Aboriginal service providers/outreach workers, more Aboriginal businesses, community bank)
- focusing on the most important factor (housing, youth, family, safety/crime, addictions, employment/business, education, gangs, low income, community participation)
- institute programs to support affordable home ownership (government assistance for low income, rent to own, more Centenary Homes, housing co-ops, infill housing for variety of incomes)
- use financial strategies (tax incentives for housing purchase & business development, community bank)
- increase & improve services (neighbourhood grocery store, one on one service providers/outreach workers, more Aboriginal service providers, addictions prevention & treatment, better transportation, simplify access/one door, provide supports to people in need e.g. supply proper clothing & food, to increase school attendance...)
- others (positive media messages, youth involved with their traditions, restrict traffic flows to decrease access for Johns, looking at social & economic return on investment not just financial return on investment...)

What supports change?
- leadership
- resources (money, investments)
- positive conditions (physical, social, economic)
- positive attitudes (caring, confidence)
- common goal/vision
- will to change
- individual responsibility
- organizational responsiveness
APPENDIX III: CASE EXAMPLE OF APPLYING THE IDM

The following example is a composite of real life experiences illustrating the application of the IDM in practice. All names and identifying characteristics are fictitious. As mentioned previously, the process of applying the IDM varies considerably from situation to situation.
Karen P. is the manager of a “heart health” health promotion program in a medium sized public health department in a city where there is a high degree of poverty. She heard about the IDM from a colleague at another public health department and checked it out on the IDM Best Practices website at http://www.idmbestpractices.ca/. She was immediately enthusiastic about the idea of linking values to practice in addition to looking at evidence, since she herself has always tried to conduct her life and work according to her values. She first read the Basics section of the IDM Manual which gave her a quick overview of the IDM. She then read the article on the IDM in the journal Health Promotion Practice; this article provided more of the theoretical background and roots of the Model. Although still enthusiastic about the IDM’s comprehensive approach, she started to feel overwhelmed at the thought of trying to integrate into practice not just values and evidence but also theories and beliefs, and vision and analyses of the various environments.

She phoned one of the people familiar with the IDM listed on the IDM website to sort out some of her confusion about where to start. The advice she received was to start small, with only one piece of the IDM Framework. Feeling reassured, she contacted a couple of people on her team to ask if they would work with her to introduce a best practices approach to the team and perhaps to the organization as a whole. After browsing the IDM website, Beckie and Al expressed interest and when the three met they decided to start with a values clarification process. But first, they agreed, it was important to check if the team wanted to participate in an IDM best practices process.

To this end, the three organized a half day workshop where team members first talked about their experience with and understanding of best practices. They then participated in an exercise Karen found in the IDM Road Map for Coaches where workshop participants themselves construct the IDM. They also participated in another exercise, designed to illustrate the implications to practice of underpinnings and understanding of the environment choices. The last half hour of the morning was spent discussing whether they wanted to try the IDM approach to best practices; the decision was “yes” and a time was set for a values clarification session two weeks later. Before leaving the room, each team member spent five minutes writing down their list of priority values, which Karen collected.

In preparation for the values clarification session, Beckie reviewed the organization’s mission statement, the most recent annual report, and the report of an evaluation conducted the year before, to identify values explicit or implicit in them. Al phoned a health promotion instructor at the local university for her thoughts on the most commonly identified health promotion values. Omitting duplications, Karen printed on a flipchart sheet the values from the team members’ lists, Beckie’s and Al’s results, and the IDM Manual’s section Suggested Guidelines.

Wanting to start with something the team was familiar with, Karen began the values clarification session with a few questions from the exercise “tell story of current situation”:

- Why is our team’s issue, “heart health,” a priority?
- What are our goals regarding heart health?
- What activities, processes and strategies are we using to reach these goals?
- Why are we using these particular activities, processes, strategies?
Al recorded key points from the discussion. During the break after this half hour exercise, Karen and Beckie identified the values implicit or explicit in the responses to the questions. For example, “equity” was identified as a value based on team members’ comments that the new van and outreach activities were important in order to give everyone a chance to participate in the programs. Meanwhile, Al highlighted information relevant to domains such as theories and evidence for use later on in the Framework experience.

Karen added to the flipchart the couple of values not already identified from other sources. After the break, each participant placed a blue star next to their top three priority values. Team members were surprised that some of their values were not shared by other team members. The discussion was lively, but the only major disagreement occurred around the values of “individual autonomy” and “collective good.” Were they compatible or contradictory, and which was the closest to a health promotion value? A decision was made to discuss these values later to avoid getting bogged down. There was also a lack of consensus on the meaning of income equity. Some team members defined it as income based only on need, not on other variables such as educational level. Other members interpreted it to mean that income is adequate to meet everyone’s minimum basic needs; beyond that income differentials may exist. This difference in interpretation was also noted, and left for the time being.

After another break, Karen introduced the one page values check-in from the IDM Best Practices Check-In Forms, shown in abbreviated form below.

<table>
<thead>
<tr>
<th>IDM Best Practices Check-In Forms: values and practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>criteria for values</td>
</tr>
<tr>
<td>[our group/organization]:</td>
</tr>
<tr>
<td>• has an explicitly defined set of values: yes/no [if yes specify]</td>
</tr>
<tr>
<td>• reviews values regularly: yes/no [if yes specify]</td>
</tr>
<tr>
<td>• involves major stakeholders in defining values: yes/no [if yes specify]</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>• Which of the values listed in the previous column are reflected in practice? [give brief explanation or example]:</td>
</tr>
<tr>
<td>• Which of the values listed are not reflected in practice or could be better reflected in practice? [give brief explanation]</td>
</tr>
<tr>
<td>• What do we need to do to increase the reflection of values in practice? [give brief description]</td>
</tr>
</tbody>
</table>

The answers to the Check-In questions provided the start of defining the team’s values more specifically in relation to practice, and direction for future action to increase the reflection of values in practice. One member, Dana, offered to work with one or two others to develop a draft values action plan, including who will do what, when and how, based on the current session’s responses. A couple of team members, impatient with the discussion of what they viewed as abstracts not directly related to their immediate work, breathed a sigh of relief that not everyone would have to be involved. Karen made a silent decision to investigate ways to illustrate more strongly the link between underpinnings and practice. Team members agreed that the involvement of program participants in the values identification and definition process was critical and to make this a priority in the values action plan.

Karen entered the session’s results into the IDM Computer Program, a computerized version of the Framework. As time went on she found it a helpful tool in learning about
and applying the IDM, and often found herself right-clicking on a cell or heading for definitions, explanations, guiding questions and checklists. Every so often she also phoned the IDM person she had originally contacted to bounce around ideas. In addition, she received ideas from reading the IDM Best Practices website’s reflections and profiles.

<table>
<thead>
<tr>
<th>Resources used to support IDM process (available from IDM Best Practices website)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• IDM Best Practices Road Map for Coaches 2nd edition, 2005</td>
</tr>
<tr>
<td>• Best Practices Check-In Forms, 2004</td>
</tr>
<tr>
<td>• IDM Best Practices Computer Program 2.12, 2001</td>
</tr>
<tr>
<td>• The Interactive Domain Model of Best Practices in Health Promotion: Developing and Implementing a Best Practices Approach to Health Promotion, 2001 (in the journal Health Promotion Practice)</td>
</tr>
<tr>
<td>• IDM Best Practices website at <a href="http://www.idmbestpractices.ca/">http://www.idmbestpractices.ca/</a>: reflections, profiles, jottings, and IDM-related and other resources</td>
</tr>
</tbody>
</table>

After two months, Karen and Al introduced the IDM to the community coalition of which the department was a member by conducting the exercise developed by L'ACFO-TO – using the IDM to plan a wedding. A few coalition members – community residents from the lower end of the income scale – responded to Karen’s request for volunteers to join the “best practices” committees the heart health program was forming to ensure participation by all stakeholders.

A bump in the road emerged at the four-month point. When Karen checked in with the non-staff volunteer members of the IDM committees (program participants and community residents) they indicated that they were thinking of quitting. They did not always understand the language that was used by staff members, and thought that their opinions were often ignored.

Karen followed up at the next team meeting, using the statement “the perspective of lay people who are key stakeholders is as important in decision making as the perspective of professionals” to initiate the discussion. Although a few team members agreed, many did not, arguing that professionals had a broader perspective which was relevant to people in general as opposed to lay people whose perspective was limited to themselves and their immediate social group, and that professionals had more knowledge. The counter argument was that different kinds of knowledge exist, none of them superior to the other, with all of them required for good decisions, and that equity as a value meant everyone’s opinions had to be taken seriously when it came to making decisions.

A few staff members also expressed discomfort with the volunteers, for example that some of them rarely said more than the occasional word or two, and that attendance was erratic. At the end of the discussion, there was general agreement that staff would approach committee meetings with a mutual capacity building attitude in mind – learning from each other – and use a “round robin” approach in discussions to ensure everyone a chance
to speak if they wanted. In addition, Beckie suggested starting with a brief check-in where everyone could say a word or two about what was going on in their lives. She also suggesting holding an occasional social event for all committee members in order to build relationships and increase everyone's comfort levels with each other.

When Karen went back to the volunteer committee members to ask what could be done to encourage them to continue with the committees, they mentioned that sometimes they were unable to attend because of transportation or child care issues and that sometimes they felt their contributions were unappreciated – some of them were living very challenging lives and it was not easy to take the time to go to meetings that did not have immediate relevance to their lives. They liked Karen's suggestion that the program's van could transport them to and from meetings and the offer of a child care worker at meetings. Karen made a note to herself to arrange for occasional gift certificates to show the department’s appreciation of the volunteers' efforts, and to review the situation in a month.

At a committee meeting, volunteers approved Al's idea of a short health promotion workshop for committee members, using adult education principles, to help with language issues. Two new staff members, who until joining the team had worked solely on the clinical side of the organization, also liked the idea, as they were still unsure of what health promotion was about.

By six months, after continuing to draw on IDM resources and people familiar with the IDM, IDM committees were still active. Karen was pleased that some volunteers had continued with the committees and thought they were in a good position to attract, and retain, more non-staff members if they built on what they had learned so far.

Karen and the rest at this point in time had completed an outline of the Framework and knew the areas in which they wanted to delve in more detail. They had a set of health promotion guidelines for underpinnings, understanding of the environment, and practice. For each of the domains they had brief notes, not always complete but enough to move forward with, on their current situation and their picture of the ideal.

Team members Dana and Beckie, program participant Roger and community resident Estelle were working to refine the results into a usable action and evaluation plan, with concrete measurable objectives and indicators, and assigned responsibilities for implementing the tasks to achieve the objectives. Defining measurable objectives and indicators was harder than they had thought it would be but they commented that they were learning a great deal. At the same time, Karen and Al and a few others were identifying research questions for future research initiatives. In general, documentation processes were in place and times scheduled to review what they had done so far and decide how to change things for the future. Despite the frustrations they sometimes encountered, all IDM participants, staff and non-staff, agreed that using the IDM was becoming easier over time and that they could see benefits already.

An example of the Framework, still in the process of being filled in at the three month point, follows.
### Hypothetical example of Framework experience, in progress at the three month point

<table>
<thead>
<tr>
<th>Underpinnings</th>
<th>guidelines</th>
<th>current situation</th>
<th>picture of ideal</th>
<th>objectives</th>
<th>resources</th>
<th>challenges</th>
<th>evaluation plan</th>
<th>implement/reflect/document/revise activities/processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>processes: Program participants are not fully integrated into discussions on underpinnings.</td>
<td>draft until discussed by all key players:</td>
<td>underpinnings</td>
<td>processes: All key players work together to identify, define &amp; regularly review underpinnings to ensure they are reflected in practice.</td>
<td>value: Equity goal: Increase the degree of equity related to income and power.</td>
<td>ethical principle: Be conscious of inequities and reduce them where possible.</td>
<td>processes: Program</td>
<td>processes: to initiate an inclusive process for identifying, defining and matching underpinnings to practice – the underpinnings committee will consult with key players and report results to all stakeholders in three months.</td>
<td>available resources: Organization has meeting space &amp; a small budget to contact key players not part of the organization; A has some evaluation experience; K is very interested in the idea of consistency between underpinnings and practice to identify other resources required: D &amp; K will meet next week to develop a plan to find these resources.</td>
</tr>
<tr>
<td>processes: All underpinnings are identified, defined, and translated to concrete terms for practice by all key stakeholders. Key players annually review underpinnings and their match to practice.</td>
<td></td>
<td>underpinnings</td>
<td>values: to complete discussions – K will arrange two facilitated meetings over the next month; to identify whether values are reflected in practice – the underpinnings committee will work with the values logic model</td>
<td>evidence: The link between program outcomes and income level is clarified. Information sources include all key players and journals.</td>
<td></td>
<td>to increase understanding of the link between underpinnings and best practices: K will find examples illustrating the link within the next two weeks to reduce the resentment about time taken to discuss values: B and A will work with the underpinnings committee to identify indicators, timelines, who will do what.</td>
<td></td>
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<tr>
<td>processes: to make sure everyone understands the crucial relationship of underpinnings to best practices and the need to take time to explore them. Discussions on values continue, with all key players involved, until there is agreement about how to define income equity and a description of how equity translates in concrete terms to practice.</td>
<td></td>
<td></td>
<td>evidence: The link between program outcomes and income level is clarified. Information sources include all key players and journals.</td>
<td>evidence: The last evaluation included information from the data system and interviews from managers. Program evaluation Information about the link between income level and program outcomes is unclear. Information on this question from other programs has not been collected. Current evidence supports the major influence of the determinants of health on health status.</td>
<td></td>
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<td>evidenced: The last evaluation included information from the data system and interviews from managers. Program evaluation Information about the link between income level and program outcomes is unclear. Information on this question from other programs has not been collected. Current evidence supports the major influence of the determinants of health on health status.</td>
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<td></td>
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<tr>
<td>vision: Equity and positive determinants of health exist in the workplace and the community. analysis: Identify the organizational &amp; health-related environments: – priority issues – relation to health – contributing factors – ways to positively influence issues – environment in which issues exist (social, economic)</td>
<td></td>
<td></td>
<td>priority health issue: reduce cardiovascular disease contributing factors: combination of the increasing gap between rich and poor, increasing marginalization of people with low income, lifestyle factors, restricted access to programs ways to positively influence it: increase income &amp; power equity.</td>
<td>Continue to review and revise vision and analysis as new information and insights arise. Environmental capacities and challenges are identified. suggestion from one member: There is a more complete understanding of what power equity means and how to achieve it between staff and priority population.</td>
<td>to regularly review understanding of environment – the environmental understanding committee will arrange annual all-stakeholder sessions. to identify capacities and challenges – the committee will prepare a draft list and send it out to people for feedback by the beginning of the next month.</td>
<td>similar to above to minimize potential conflict around power issues – the committee will consult with an experienced facilitator regarding the best process to use when discussing</td>
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<table>
<thead>
<tr>
<th>guidelines</th>
<th>current situation</th>
<th>picture of ideal</th>
<th>objectives</th>
<th>resources</th>
<th>challenges</th>
<th>evaluation plan</th>
<th>implement/reflect/document/revise</th>
</tr>
</thead>
<tbody>
<tr>
<td>political, economic, psychological, physical) – capacities to draw on/enhance – challenges to address</td>
<td>priority organizational issue: staff at low end of pay scale have difficulty making ends meet. capacities/challenges: not yet identified</td>
<td>To better understand power equity: the committee will hold a series of brainstorming sessions over the next three months, following a constructive process (see “challenges”).</td>
<td>to ensure programs are effective – within the next two months form an all stakeholders research &amp; evaluation committee to oversee a 5 year evaluation plan (processes &amp; outcomes), conduct a lit review, develop ongoing feedback process for all staff &amp; priority population members, develop system to measure consistency of programs to underpinnings &amp; understanding of the environment</td>
<td>budget is strained; K will spend 2 hours next week reviewing options and will request a meeting with upper management as to discuss the situation</td>
<td>the health department has certain mandated activities and certain restrictions; discussions will be held with other health departments by the beginning of the new year to identify potential ways to circumvent the restrictions</td>
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Practice

All processes and activities related to addressing health-related and organizational issues and to conducting research will reflect underpinnings and understanding of the environment. They will also:

- enhance health
- be as effective as possible
- encourage equity
- build capacity
- strengthen relationships
- promote participation by all key stakeholders
- respect differences
- be revised on an ongoing basis according to reflection/evaluation results

The organization transports people with low income to its programs with the van it just bought. Nutrition, physical activity and smoking cessation programs are offered. Program participants provide feedback through satisfaction surveys. The organization has recently started participating in a community coalition to increase quality of life, including improved health status, for residents. A formal planning process occurs once a year. A list of possible equity-related topics to research has been developed with one item already underway (scan of community residents’ income levels re. service access, participation in recreational activities, and health status). A review of the staff pay scale is underway.

To translate underpinnings & understanding of the environment into practice, action is taken so that eventually:

- no staff have to struggle to make ends meet
- priority population members live above the poverty line
- members of the priority population are involved in program decision making (not yet clear what this would look like)
- service equity is attained through efforts such as maintaining transportation efforts with the new van
- programs are as effective as possible, taking into account evaluation results, lit review results, feedback and ideas from all stakeholders
- current positive actions continue, e.g. scan of community income levels & review of staff pay scale
- the annual planning process incorporates principles from the IDM approach

To increase staff equity – upper management in consultation with other staff develop a policy based on results of pay scale review

To increase income for priority population – staff work with neighbourhood coalition, which includes priority population members, to explore & implement possibilities (advocating for higher welfare rates and higher minimum wage? start a community economic development initiative?)
APPENDIX IV: FOLLOW-UP METHODS
The purpose of the *Follow-up to IDM Use and Impacts* was to gather information to improve the ease and effectiveness of applying the IDM to practice, and to collect material on the IDM’s use for a book chapter. The time period for the *Follow-up* is from 2001, a year after the end of the first formal pilot-testing period, to June 2007. Information from the pilot testing periods was not included. In total this *Follow-up* is based on information from 26 individuals and relates to 23 projects or organizations. The *Follow-up* was conducted by Barbara Kahan, David Groulx and Josephine Wong.

**Request for participation**

Group notices inviting participation in the IDM *Follow-Up* were posted or emailed to the following list in mid-January 2007. In most cases reminder notices were also sent. Some people were contacted personally through phone or email.

**First Email Notice**

Hello Everyone,

We are conducting a follow-up of the Interactive Domain Model (IDM) best practices approach for better health to understand how to assess the ease and effectiveness of its application, and to gather information for a chapter in an upcoming book. We would be delighted to hear from you:

- if you have considered using the IDM but decided not to
- if you have used - or been influenced by - the IDM, as an individual or part of a group

The follow-up involves a written survey (about 10-15 minutes to fill out) and/or an interview (30-45 minutes). Names and identifying characteristics of individuals and organizations will be excluded unless permission to include them has been granted. For more information about participating, please visit the home page of the IDM Best Practices website at [www.idmbestpractices.ca](http://www.idmbestpractices.ca). The deadline for responses is January 31, 2007.

Please feel free to forward this request to any individuals or post it on any listservs or websites that you think might be interested.

with best wishes and many thanks in advance for your help

**Second Email Notice**

Hello Everyone,

Thank you to all of you who have responded to the IDM best practices follow-up request.

There is still time for others to respond - the deadline is January 31. For more details, visit the IDM Best Practices website at [www.idmbestpractices.ca](http://www.idmbestpractices.ca). We are looking forward to hearing from people who:

- know about the IDM but are not using it for whatever reasons
- are not formally applying the IDM but have been influenced by the IDM one way or another in how they approach their work
- are actively using the IDM, either part of it or as a whole

Your comments and insights - whether you have or haven’t used the IDM - will help increase the ease and effectiveness of the IDM. From feedback received so far we already have some ideas to follow up on. We truly want to know the challenges to its use as well as the positives. Please feel free to contact David Groulx [groulxd@sdhu.com](mailto:groulxd@sdhu.com), Josephine Wong [jph.wong@sympatico.ca](mailto:jph.wong@sympatico.ca), or me [bkahan@sasktel.net](mailto:bkahan@sasktel.net) if you have any questions that the website details don’t answer.

with best wishes
**Website Notice**

IDM follow-up: We want to hear from you: Even if you only thought about using the IDM and didn’t! Or if you didn’t use it formally, but it gave you some insights. And, of course, if you did use it, whatever the results!

Are you working in health promotion, public health or population health?

We are conducting a follow-up of the Interactive Domain Model (IDM) best practices approach for better health to understand how to assess the ease and effectiveness of its application, and to gather information for a chapter in an upcoming book. We would be delighted to hear from you

- if you have considered using the IDM but decided not to
- if you have not used the IDM formally but it has given you insights or influenced you in some way
- if you have used the IDM, as an individual or part of a group

The follow-up involves a written survey (about 10 minutes to fill out) and/or an interview (30-45 minutes). Names and identifying characteristics of individuals and organizations will be excluded unless permission to include them has been granted. **The deadline for responses has been extended to February 28, 2007.** For more information about participating, please read on.

The IDM follow-up involves a written survey and interviews. It is being conducted by three health promotion/public health practitioners: Barbara Kahan, David Groulx and Josephine Pui-Hing Wong.

The information gathered will be analyzed and synthesized for use to improve the ease and effectiveness of applying the IDM to practice. Results will be made available on the IDM Best Practices website. Names and identifying characteristics of individuals and organizations will be excluded unless permission to include them has been granted.

Insights and learning derived from the IDM follow-up will also be included in a chapter on best practices in the second edition of the textbook *Emerging Theories in Health Promotion Practice and Research: Strategies for Improving Public Health* edited by Ralph J. DiClemente, Michelle C. Kegler and Richard A. Crosby (first edition published by Jossey-Bass, 2002). Again, names and identifying characteristics of individuals and organizations will be excluded unless permission to include them has been granted.

**Who the Notices Were Sent to/Where They Were Posted**

- **listservs, bulletins and websites:** Click4HP, OPHE Bulletin, E-Watch, IDM Best Practices website, Centre for Health Promotion (University of Toronto) website.
- **academic:** 9 individual students or professors with IDM link (teaching or learning about it) and a group email notice to recently graduated students from the University of Toronto’s health promotion program, many of whom would have been introduced to the IDM in the master’s level Health Promotion Strategies course.
- **Best Practices work group members:** 8 (excluding those included under other categories)
- **Best Practices Project members:** 4 (excluding those included under other categories)
- **pilot sites:** 14
- **Francophone:** 6
- **Toronto Public Health:** 5
Survey and Interview Questions

If you have considered using the IDM but decided not to:
How did you find out about the IDM?
In what context did you consider using the IDM? (e.g. for what kind of organization, in what location, for what purpose)
What were the reasons for your decision not to use the IDM?
What would have increased the likelihood of you using the IDM?
If you are willing to discuss in more detail your decision not to use the IDM, what is your contact information? (name, position, organization, phone, email)

If you have used the IDM:
How did you find out about the IDM?
With what kind of organization have you used the IDM?
In what kind of location have you used the IDM? (e.g. rural or urban; which country)
Have you used the IDM as an individual or as part of a group?
How long have you used it?
In what ways have you used the IDM? (e.g. program planning/evaluation for specific health-related programs or projects; organizational change; team building; values clarification; evidence gathering; everyday approach to work)
What have been the results? (benefits, negatives, no difference)
What did you like best about the process of using the IDM?
What are the challenges to its use:
- specific to the IDM?
- related to the context people work in?
What suggestions do you have for improving the usability and effectiveness of the IDM:
- specific to the IDM?
- related to the context people work in?
Which materials/resources did you use to help in the application of the IDM? (please see resources list at end of these questions)
Which materials/resources have you found most helpful in using the IDM?
What suggestions do you have for improving any of the resources you have used?

If the IDM has influenced how you approach your work (but you have not formally applied it):
How did you find out about the IDM?
When did the IDM begin to influence your work?
In what context do you do your work? (e.g. in what kind of organization, in what location, with what focus)
In what ways has the IDM influenced how you approach your work? e.g. has it:
- increased your awareness of the role in practice of: values? theories? evidence? the organizational or health-related environments?
- increased your reflectiveness?
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- increased how systematic you are?
How has the IDM’s influence on how you approach your work affected the quality and outcomes of your work? (benefits, negatives, no difference)
Which materials/resources assisted you to learn about the IDM? (please see resources list at end of these questions)
Which resources were most helpful in assisting you to learn about the IDM?
What suggestions do you have for improving any of the IDM resources?
What are the reasons for not formally applying the IDM to your work?
What would increase the likelihood of you formally applying the IDM to your work?

Follow-up Information Sources

Information sources for this Follow-up included interviews, email survey responses, a group session, case studies, author observations, and other sources such as documents and IDM Best Practices profiles and reflections. More details are provided below.

Interviews and Email Responses

Of the 160 individuals contacted by email, 34 emails were returned as undeliverable. As a result of the notices, seven email responses to the survey were received and six interviews conducted representing the following countries: Canada, Ireland, Poland, Portugal, United States. Questions for the survey and interviews are found in the preceding section. In addition, one group session was held in April 2007 with six Canadians with different organizational affiliations, all actively using the IDM; four were present in person and two participated by phone.

Case Studies

Six case studies were developed based on a variety of sources: interviews/conversations; organizations’ internal documents; pilot sites’ public reports contained in the Reports section of the IDM Manual; Pilot Testing the Best Practices in Health Promotion Framework; Pilot Testing the IDM Evidence Framework Learning Module; and profiles and reflections posted on the IDM Best Practices website. Each case study was reviewed for accuracy by the IDM lead for each organization.

The case studies present the following organizations or projects (IDM key contact in parentheses): Brant Community HealthCare System (Dilys Haughton); Womankind Addiction Service, St. Joseph’s Health Care (Deb Bang); L’Association des communautés francophone de l’Ontario – Toronto (Hélène Roussel); Toronto Public Health Practice Framework (Josephine Wong); Ceridian-Leade Health (Catherine MacPherson); Regina Early Learning Centre (Anne Luke). (See Appendix I for full case study descriptions.)

Author Observations

In addition to interview and survey responses and the six case studies, each of the authors also provided written personal observations on using the IDM. One author’s observations are included in Appendix I: Case Studies and Other Examples. Another author’s observations were posted on the IDM website and are listed below in “other sources of information.” The third author’s observations are not publicly identified to preserve the confidentiality of one of the organizations this author has worked with in the past.
Other Sources of Information

The following sources also provided information for this Follow-up. Note that any IDM Best Practices website profiles and reflections or other materials used to develop a case study are not included in the list below: see the individual case studies for a complete list of information sources for that case study. The IDM Best Practices website, found at www.idmbestpractices.ca, is shortened below to “the IDM website.”

- Burke, Rishia (IDM website profile, May 2004)
- Burke, Rishia: Using the IDM with a Community Health Centre (IDM website reflection July/August 2007)
- East End Community Health Centre: Report on Using the IDM Framework at East End Community Health Centre March 2001 (Reports, IDM Manual)
- Gagné, Hélène (IDM website profile, April 2005)
- Gagné, Hélène: Using the IDM in Practice Without Naming It (IDM website reflection, April 2005)
- Goudreau, Ghislaine: Best Practices: The Sudbury & District Health Unit’s Experience September 2004 (Reports, IDM Manual)
- Groulx, David (IDM website profile September 2006)
- Groulx, David: Using a best practices approach (IDM website reflection, September 2006)
- Groulx, David: Using the IDM - An Individual Perspective (IDM website reflection, October 2007)
- Kahan, Barbara: Evaluation 2006 Appendix I: Diagrams, a KidsFirst Regina internal working document (March 2006)
- Kahan, Barbara: Using the IDM for Evaluation (IDM website jottings, June 2007)
- Kahan, Barbara: Momentary Confusion when Applying the IDM (IDM website jottings, September 2007)
- Kahan, Barbara: RICCP Evaluation Report Appendix II: Details of Survey Results (prepared for Regina Inner City Community Partnership and Action for Neighbourhood Change, January 2006)
- Kahan, Barbara (IDM website profile, April 2007)
Limitations

One limitation of this Follow-up is that relying on volunteer time and no other resources restricted the scope of the Follow-up, in particular the ability to track down individuals who did not respond to the request for participation. That the Follow-up was conducted by three people who have been closely associated with the development, testing and use of the IDM and its materials is a possible limitation. A third limitation is that with one exception only individuals who had used the IDM, either formally or informally, responded to the call for Follow-up participation. It had been hoped that individuals who knew about the IDM but had not used it in any way would also have responded. A fourth limitation is that it is unknown if the information gathered for this Follow-up reflects the experiences of a small or large proportion of the individuals or organizations using the IDM.