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White Point, Nova Scotia

CONSULTATION  
REPORT

# A Best Practices Approach to Health Promotion



Sponsored by:  
Unit for Population Health and  
Chronic Disease Prevention  
Sharing Strengths  
Nova Scotia Sport and Recreation  
Commission

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- Barbara Kahan, Member of the Best Practices Working Group, Centre for Health Promotion, University of Toronto

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# Project Background

Throughout the past decade, many organizations in the Western Region of Nova Scotia have been actively promoting community-based approaches to the prevention of cardiovascular disease using a health promotion approach. During this time, various partnerships and networks were developed that brought together representatives from many organizations and government departments to further develop strategies for health promotion work in the region. Some of these intersectoral partnerships in turn engaged in further community activation and were instrumental in creating a number of local coalitions such as Heart Health Action Teams and Physically Active Children and Youth projects. As this infrastructure has evolved, those community groups and organizations have continued to broaden their understanding and gain extensive experience in this health promotion work.

In the winter of 2001, funding was received through the Canadian Diabetes Strategy to initiate work on a Best Practices approach to chronic disease prevention as a way to further strengthen community capacity for health promotion work. Two outcomes from that project were *A Framework for a Best Practices Approach to Health Promotion* and a symposium on adopting a best practices approach. Both the Framework and the symposium met with enthusiastic support and laid the groundwork for further development of a Best Practices approach to chronic disease prevention.

In November of 2001, funding through the Canadian Diabetes Strategy was again approved for a second phase of the project. With the intent of building on the earlier work, the current phase of the project has two primary objectives. First, hosting a consultation with representatives of the University of Toronto Best Practices Collaborative so that we may learn from their years of practical and academic experience in developing tools for a best practice approach. Second, to revise the existing Nova Scotia Best Practice Framework and develop complementary tools to further increase the capacity for effective delivery of health promotion initiatives.

## Purpose of the Consultation:

To increase our capacity for adopting a Best Practices approach to health promotion and chronic disease prevention in the Western Region of Nova Scotia through learning from the years of practical and academic experiences of the University of Toronto's Best Practices team.

### Objectives

- 1) To learn about the benefits and challenges of using a Best Practices tool such as the Interactive Domain Model, developed by the Centre for Health Promotion, University of Toronto, and apply these insights to further development of the Nova Scotia *Framework for Best Practices*.
- 2) To learn how health practitioners have been trained to use the Interactive Domain Model and relate this to training models for using our *Framework for Best Practices*.
- 3) To gain new ideas for health promotion work at the community level.
- 4) To develop a vision and strategy for a Best Practices approach for health promotion work in the Western Region of Nova Scotia.

# AGENDA

## Thursday, January 24, 2002

- 10:00 - **Welcome, Opening, Introductions, Review of Agenda**
- 10:15 - **The Nova Scotia Climate for Health Promotion** - What is the “state of health promotion” in the Western Region of Nova Scotia? An opportunity to summarize, reflect, and share how we feel about health promotion developments in Nova Scotia.
- 1:00 - **The Ontario Story – Best Practices & Introduction to the Interactive Domain Model (IDM)** (Barbara Kahan and Debbie Bang)
- Description of the context from which the model emerged
  - A diversity of approach to Best Practices
  - Working definitions
  - Introduction of the IDM - decision-making exercise for group
  - Benefits of using the model
- 3:20 - **Stories and Training from Pilot Testing the Framework** (Kahan and Bang)
- Introduction to the IDM Framework
  - How to use the IDM Framework
  - Description of pilots
  - Training used in Pilot Testing (how Framework was introduced, activities, results) Sample Exercises
  - Critique of the training approach
- 4:30 - **Reflection and Discussion:**
- How is Best Practices relevant to our work? What is our vision of a best practices approach?
  - In our view, how is the Ontario experience relevant to the Nova Scotia situation?
  - What are our hopes and fears around best practices?
- 7:00 - **A Walking Tour of the Nova Scotia Best Practices Framework:**
- How are people using the framework? In what ways do you see using it in the future?
  - Do we think differently about the NS Framework after hearing about the IDM Framework and the broader picture of best practices? Similarities and differences between the two frameworks.
  - Reflections on the day

## Friday, January 25, 2002

- 9:15 - **Long Term Application:** (Kahan and Bang)
- What was learned from pilot testing the IDM Framework
  - Vision – Long Term Plans
  - Complementary Tools and ongoing work
- 11:00 - **Discussion and Reflection:** What can we learn from the Ontario experience to support training and use of our Framework?
- 1:05 - **Application of the Nova Scotia Framework: Challenges, Solutions and Insights**
- How are we currently working with specific components of the Nova Scotia framework?
  - What are the challenges we face to incorporating various aspects of the Framework into our practice?
  - What solutions have we found helpful in addressing these difficulty?
  - What resources already exist in the health promotion community to assist with support in these areas?
  - What additional supports would be helpful to further our work in this area?
- 2:45 - **Wrap Up: What is the Forecast for Best Practices in Health Promotion in Nova Scotia?**
- What is going to sustain us in adopting a Best Practices approach in our work and using our Best Practices tool?
  - Closing comments from Barbara and Debbie
  - Summary of what insights we have come to. What is the vision? Next steps.
  - Evaluation of Consultation
- 3:15 - **Good-byes**

# Reflections on Best Practices

**I**N THE OPENING session of the Consultation, participants were asked for a short reflection on what best practice means to them. Following are some of the comments.

**QUESTION: *What does best practice mean to you?***

- Not reinventing the wheel
- Getting practical about what is going to work on the ground
- Having evidence and passion that builds momentum as we move forward to increase funding and give more attention to health promotion.
- What's exciting. Incorporating research and evaluation into our work.
- Best practices make sense. They are tried and true.
- Best practice is two simple words. Let's keep it simple!
- Opportunity to marry what we know in our heads and hearts, with research.

Midway through the first day, after participants were more immersed in thinking about best practice, there was a second opportunity for reflection.

**QUESTION: *How is Best Practices relevant to your work?***

- Helping communities to use research information in their planning processes and to document our own work.
- To ensure we're putting resources to best use.
- Will contribute to getting positive results.
- Helpful to the development of new programs.
- A way to respond to pressure for evidence based approach.
- To make best use of resources.
- Most of us are doing most of the pieces of the model in our work already.

**QUESTION: *What are your fears about Best Practices?***

- Best practice phobia – fear that people at community level will feel this is all just too much.
- Lack of clear understanding at the different levels of community boards, community groups.
- Might be perceived as being too complex, even though they may inherently understand it and not realize this.
- Over-analyzing. Getting mired in analysis is not a good thing to do at the community level. It can stop action.

**QUESTION: *What are your hopes for Best Practices?***

- Hope that people catch this! That people get the bug.
- By using Best Practices, we would have more proof and a greater ability to make the case for health promotion.
- Broader shared understanding.
- Hope this is a catalyst for more health promotion.
- Create a movement around health promotion.

# The Ontario Experience

- Introduction to Best Practices and Development of the Interactive Domain Model
- The IDM Best Practices Framework
- Learnings and Long Term Plans

## Guest Presenters

### **BARBARA KAHAN**

Member of Best Practices Working Group  
Centre for Health Promotion, University of Toronto,  
Principal of Kael Consulting

*And*

### **Debbie Bang**

Member of Best Practices Working Group  
St. Joseph's Healthcare, Hamilton, Ontario

**BARBARA KAHAN** is the principal of Kael Consulting and a Member of the Centre for Health Promotion, University of Toronto. She received a degree in health promotion from the University of Toronto (MHSc, 1998). She has extensive experience working for both government and non-profit groups in a variety of roles concerned with a variety of health, social and cultural issues in Montreal, Toronto, London (England), and Regina (Canada). She has a number of publications to her credit, including the book *Healthier Children*. For the last five years Barbara has been extremely active, along with Michael Goodstadt and the University of Toronto's Centre for Health Promotion's Best Practices Work Group, in the conceptualization and development of the Interactive Domain Model's best practices approach to health promotion. Together with Michael, Barbara has facilitated workshops on best practices in health promotion locally, nationally, and internationally.

**DEBBIE BANG** is a graduate of McMaster University's Nursing program, has a Master's degree in Health Promotion from the University of Toronto and has an Assistant Clinical Professor faculty appointment at McMaster University School of Nursing. She is actively involved in the consumer health information field, in the implementation of the regional plan for Addiction Services in Hamilton and is project managing the amalgamation of the Women's Detox Service with Mary Ellis House, a women's treatment service. Ms. Bang has presented research, evaluation and quality study findings at a number of conferences and meetings throughout North America and recently won an award with her co-authors for a paper on Consumer Health Information Services in Canada.

# Introduction to Best Practices and Development of the Interactive Domain Model

## Context from which the IDM model emerged

The initial push for the Best Practices project came from practitioners at the World Health Organization symposium on Effectiveness on Health Promotion (June 1996). Practitioners voiced the need for an approach or tool to give increased credibility to their work. This resulted in the formation of the Continuous Quality Improvement /Best Practices Work Group (1997). Eventually this working group merged with two others, one on evaluation and the second on consolidating evidence. Two motivating factors were 1) to avoid having a best practices approach imposed; 2) the desire to develop something that would help improve practice.

Within many fields, including industry, education, and social work, there has been a growing interest in the “quality” movement (CQI, TQM, quality assurance). There has been growing acceptance and emphasis on the importance of basing practice on “evidence.” Clinical best practices guidelines are proliferating in all areas (e.g. diabetes, blood pressure). In addition, there is increased pressure for accountability to various stakeholders. Funders want documented outcomes and consumers want to know what is going on and how this is affecting the population.

Adopting a Best Practice approach has presented both potential for benefits and risks. The benefits relate to increased possibility of achieving health promotion goals. However, many felt the risk in using a Best Practices approach might be an emphasis on a narrow application (cookie cutter approach), which could dampen creativity, ignore situational difference, and address only easily quantifiable issues. The challenge was to find an approach that minimized the risks and maximized the benefits.

## A Diversity of Approaches to Best Practices

In examining the best practice literature, one finds a diversity of meanings, perspectives, and anticipated risks and benefits. Front line health promotion practitioners, government representatives, NGO funders, the general public, evaluators and researchers may all have different perspectives on what is important and how to achieve it. In developing the IDM a diversity of interpretations of best practices were identified:

- **PRINCIPLES APPROACH:** initiatives are assessed according to their consistency with a set of values and principles thought to be integral to the essence of health promotion.
- **GUIDELINES APPROACH:** a voluntary set of guidelines identify general conditions (including types of activities and attitudes) required for best practices to occur.
- **SERVICE STANDARDS APPROACH:** either voluntary or mandatory standards are set (internally by the organization or externally by an outside body such as an accreditation agency) outlining expected provision of services. For example, “x% of the community being served must have received x number of services (such as screening) within x amount of time.”

- **OUTCOMES APPROACH:** either voluntary or mandatory standards are set (internally or externally) based on expected outcomes arising out of an organization's actions. For example, "within x amount of time, x% of the community being served will have achieved x level of health as measured by indicators x, y and z."
- **"WHAT WORKS" OR EVIDENCE-BASED APPROACH:** actions and strategies are chosen based on indications of effectiveness from the scientific literature or modelled after the actions of other organizations who have achieved the desired results.
- **"TELL ME WHAT TO DO" APPROACH:** a recipe or formula lists specific steps to follow to achieve desired results. For example, "do a, b, and c, and you will achieved."
- **A COMBINATION APPROACH:** two or more of the above approaches are combined in order to achieve best practices in health promotion

The approach adopted in the Interactive Domain Model falls into the "combination" category. The IDM combines a "principles approach," a "guidelines approach" and the "evidence based approach."

## Working Definitions

The Best Practices Work Group had to find definitions they could all agree on in order to communicate effectively. This meant that they could all speak the same language, or at least understand what each other was talking about. The following working definitions are used for the terms health, health promotion, practice, evidence and best practices.

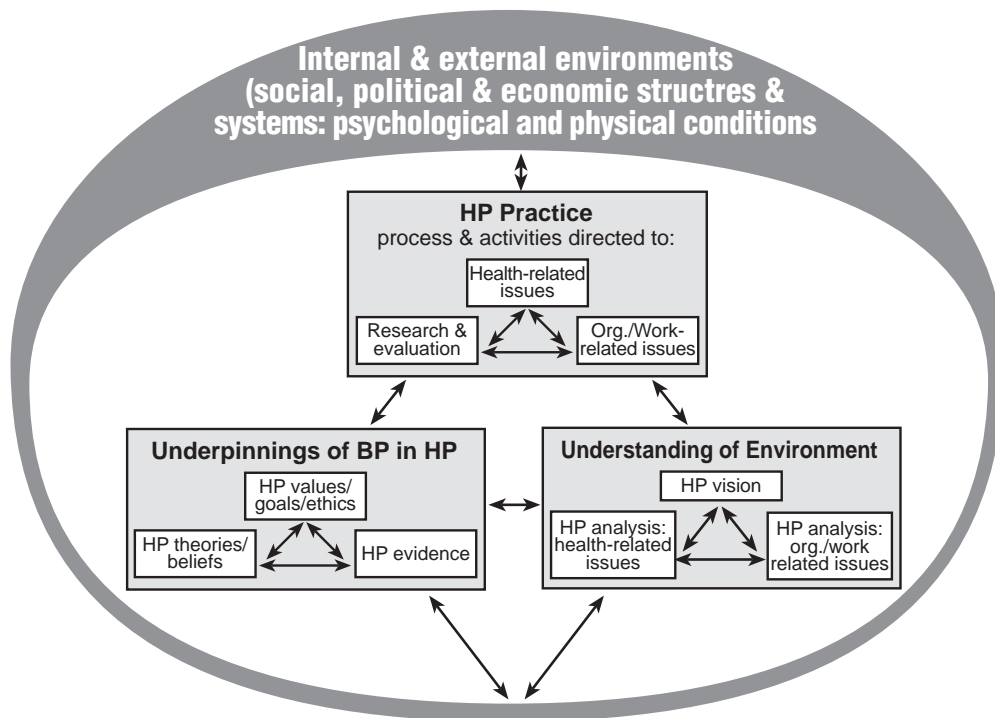
*"Health is the extent to which an individual or group is able, on the one hand to realize aspirations and to satisfy needs and, on the other hand, to change or cope with the environment." (WHO European Region, 1984)*

*"Health promotion is the process of enabling people and communities to increase control over factors that influence their health, and thereby to improve their health." (adapted from the Ottawa Charter for Health promotion, 1986)*

*"Practice refers to processes and activities involved in conducting our work. This includes our response to health-related issues, organization/work-related issues, and research/evaluation."*

*"Evidence is information that is used in making decisions." (From Butcher, 1999)*

*"Best Practices in Health Promotion are those sets of processes and activities that are consistent with health promotion values, theories, evidence, and understanding of the environment, and that are most likely to achieve health promotion goals in any given situation." (Kahan and Goodstadt 2001)*



Interactive Domain Model (Kahan & Goodstadt 2001)

## (BP: Best Practices (HP: Health Promotion

The IDM works with three main domains, each with sub-domains which all interact with each other. If they are consistent with each other and with health promotion principles, then best practices will be achieved.

### UNDERPINNINGS:

- 573 Values, goals & ethical principles
- 574 Theories, concepts, underlying beliefs & assumptions
- 575 Evidence

### UNDERSTANDING OF THE ENVIRONMENT:

- 576 Vision of desired environments
- 577 Analysis of organization/work issues
- Analysis of health-related issues

### THREE ASPECTS OF PRACTICE:

- 578 Response to organization/work issues
- 579 Response to selected-health related issues
- 580 Research & evaluation

## Introduction to the Interactive Domain Model

The presenters introduced the Interactive Domain Model to the participants at the Nova Scotia Consultation by using a participatory exercise that asked people to “consider all of the factors that influence how you make decisions.” Each of the factors was written on an index card and posted on the wall. The group then clustered the factors according to themes. The presenters then demonstrated how the IDM reflects the processes that health promoters are using all the time in decision-making processes. What the IDM approach has done is to formalize these processes into a diagram, above.

The underlying premise of the IDM is that the quality and value of practice depends on the degree of awareness, articulation, clarity, and reflection associated with every factor related to practice.

The following example, serves to illustrate how the domains interact or influence one another:

If equity is an important value for us, and we discover there are theories that say equity has a major impact on health, and there is a lot of evidence to support this theory, and then we analyse our environment to identify what the situation is concerning equity (how equitable/inequitable, who has more, who has less, why) and which processes, activities and strategies will most effectively increase equity, and which of these it is possible and appropriate for us to do, and then we follow through in our practice with the processes, activities and strategies we have pinpointed as being most effective in increasing equity (that it is feasible for us to do), then we will have best practices. If equity is an important value but we don't follow through then we won't have best practices.

## Benefits of the IDM Approach

The IDM approach attempts to maximize benefits and minimize risks in the following ways:

1. The model takes into consideration the nature and interactivity of all major factors influencing practice. If we only focus on a select few (e.g. evidence) this can result in a shallow understanding of the issue. Considering the full range of factors results in a deeper understanding and a more effective practice.
2. The model considers unique circumstances of each situation. There is recognition that stakeholders in each situation need to define their own guidelines and criteria rather than having them predefined by an external body. The benefits of this approach are that the guidelines and criteria a) can have more relevance (every situation is different), b) have more meaning (we understand things better when we develop them ourselves), and c) can be continuously reviewed and revised as necessary at the level at which they are being used.
3. The model considers the relationship between processes and outcomes. These two areas are integrally linked. High quality processes support high quality activities which lead to high quality outcomes.
4. The model is strengthening by combining the best features of several Best Practice approaches in the areas of principles, guidelines, outcomes, and evidence.

# The Interactive Domain Model Best Practices Framework

## From the Model to the IDM Framework

The Best Practices Framework is based on the Interactive Domain Model. It is a tool that can be used for a variety of purposes. Some of the ways it can be used are: as a decision and policy making filter, for planning/evaluation/strategic direction, for team building, for “making the case,” or for building capacity.

The intent of the Framework is to help practitioners to be holistic, systematic and comprehensive so that important factors are not overlooked and the interconnections between factors are taken into account. After pilot testing, multiple uses have been identified by health promoters. The IDM Framework is not simply a formula to tell people what to do!

## Brief Overview on How to Use the Framework

There are 4 basic steps to follow as one works across the top row of the IDM Framework table.

1. Prepare Groundwork
  - What are our general guidelines and criteria?
  - Where are we now (current situation)?
  - Where do we want to go (picture of ideal)?
2. Developing an action and evaluation plan. How do we get to where we want to go?  
Who does what? When? How?
  - Identify specific objectives
  - Establish the evaluation processes
  - Identify resources needed
  - Anticipate challenges.
3. Document Implementation
  - What did we do? How did we do it?
  - What were the results?
4. Revise
  - What do we need to change?

The steps down the left side of the Framework provide a “health promotion filter,” and are based on the three domains of the Interactive Domain Model:

- Underpinnings (Values, Theories, Evidence)
- Understanding of the Environment
- Health Promotion Practice<sup>1</sup>

# IDM Framework (Kahan and Goodstadt 2001)

**Step 1: Prepare Foundation for Action re. selected issue**

**Step 2: Make Action & Evaluation Plan**

- *how do we get to where we want to go: who does what, when & how?*

**Step 3: Document Implementation of Plan**

**Step 4: Revise**

1a. health promotion criteria & guiding principles

1b. current situation

- *where are we now?*

1c. picture of ideal situation

- *where do we want to go?*

2a. specific objectives to achieve ideal

2b. resources

2c. challenges

2d. evaluation plan

3a. activities & processes

- *what did we do? how did we do it?*

3b. outcomes of activities & processes

- *what were the results?*

4a. revisions

- *what do we need to change?*

## Underpinnings

*values*

*goals*

*ethics*

*theories*

*beliefs*

*evidence*

## Understanding of environment

*vision (org/work)*

*vision (health)*

*analysis (org/work)*

*analysis (health)*

## Practice

*processes/activities*

*org/work response*

*health response*

*research/evaluation*

## Pilot Testing the IDM Framework

The IDM Framework was pilot tested primarily at three sites throughout Ontario: a community health centre in Toronto working with people living on low income, a rural hospital working with their Community Well-Being team and a Public Health Department. The goal of the Framework pilot test was to find out:

1. How does the Best Practices Framework work in a real life situation?
2. How can we modify the Framework?
3. How can we improve the process of introducing the Framework?

Each site used the Framework to develop, implement & evaluate a situation-specific action plan. This involved creating their own definition of health promotion, translating this into concrete terms relevant and appropriate to the specific group and issue; and developing a practice in such a way that processes and actions were consistent with their own definition of health promotion.

## Training to use the IDM Framework

Training was provided at all three sites, using adult education principles which incorporated each site's own issues and experiences into the workshop. Multi-level support was provided through materials, tele-conferences and e-mail. Due to funding timelines, materials had to be developed in only six weeks. The criteria the project used to choose sites was mainly the level of enthusiasm of the site/people involved. Each organization defined the number of participants, and chose the project to be used to test the Framework.

Overall, the facilitated training provided by the project was a positive factor. Some of the challenges encountered in the training included: wording and complexity of the Framework; some process issues; concerns around wording and the amount of supporting material; a lack of concrete examples. After the one day training workshop, participants at one site decided they would prefer to work through the rest of the material on their own.

The training used a participatory model of adult education. The exercises were designed to provide each of the participants at the test site with an opportunity to explore their own views, understand the views of their colleagues and to reflect on views and information from other sources. The synthesis of these ideas then became the content needed to fill in the boxes in the IDM Framework. During the training, worksheets were used extensively to help people capture their ideas. The trainers attempted to address a variety of learning styles and to elicit the experience of participants.

## Sample Exercises used in Training Sessions

The presenters offered a few examples of training exercises:

### **1. Exercise to assist group to develop their own working definition of health:**

Prior to the training workshop, each participant provided their definition of health to the trainers. The list was presented at the training workshop, for participants to discuss similarities and differences. The group then voted with a show of hands to indicate which of the definitions members most strongly agreed with. Participants then discussed the following questions: How does the group define health? Is there a consensus? What are the differences/similarities? The group then made choices from their list. The next step involved adding more formal definitions to the list, such as the WHO and Ottawa Charter's definitions of health. A comparison was then made between the group's definition and the more formal ones, strengths and weaknesses were noted and then a final choice of the definition of health was made and entered into the Framework.

## 2. Exercise to develop an analysis of environment.

In groups, participants were asked to make a list and/or draw a map of their environment, focusing on what relates directly or indirectly to their work concerning the selected issue. They were directed to include such factors as: other people/groups including their positions, roles, responsibilities, skills; structures/systems/policies including such things as decision making, communication; the psychological conditions including values, attitudes, feeling; the physical conditions including space, noise, light air quality, equipment.

Then group members were instructed to individually begin jotting down a few notes concerning how they understood the issue the group was working on and draw a picture of the issue. Some of the ideas might include: Who is primarily affected by the issue? What factors helped produce the issue and keep it in place? How this issue fits with your view of "health." Interrelationships among the factors that affect the issue. Who is affected by the issue?

As this analysis of the environment emerged participants were asked to identify what they knew about how to influence or change the issue their group was concerned with. Which actions or strategies could make a positive difference? What is required to implement these actions/strategies? Who needs to be involved in these actions/strategies?

3. Another technique used was to take the major points of each component and break the topic into questions, and then work in small groups to put together a 5 minute presentations on a topic such as "How do you recognize high quality evidence?"

## What worked and what did not work in the Training?

In critiquing their training, the presenters noted the following problems:

- Lecturing does not work. It is important to use adult principles and approaches.
- Cooperation of a co-facilitator was vital.
- Not having real life examples to give participants was problematic. This was compensated by developing a hypothetical example.
- There were problems with the complexity of concepts. Simplifying language and using exercises worked well.
- Important that once workshop is designed to stick to it.

## What was learned from Pilot Testing the IDM Framework?

The pilot testing revealed a variety of benefits to using the Framework as well as challenges. One participant's comment summed up the learning experience. *"The more you work at it, the more you understand it and become more proficient; and, while doing it you may have difficulty with the flow, but when you go back you can see the pattern."*

The pilot sites also recommended that a computerized format be developed for the IDM Framework, which the project has now developed.

From the pilot testing the following benefits and challenges were identified.

### **BENEFITS** of using the IDM Framework:

1. Individuals and teams found an increase in:
  - awareness, knowledge, understanding, and skills
  - group cohesion and consensus building
2. For programs:
  - there was comprehensive and systematic planning
  - there was greater clarity regarding issue and underpinnings
3. For organizations:
  - there was greater awareness of best practices and health promotion issues
  - there was greater credibility for health promotion

**CHALLENGES** to working through the Framework:

Meeting the learning needs of a diverse group of participants.

- Different levels of understanding of health promotion and in some cases an over confidence of participants.
- The amount of time committed impacts on effectiveness of Framework.
- Challenge to work around time and workload of participants in addition to working through Framework
- Framework-related issues (e.g. complexity, terminology)
- Internal issues such as different priorities and perspectives (For example: a clinical vs. a non-clinical approach, volunteer vs. staff approach)
- Change in participant membership meant a lack of continuity

## Learnings and Long Term Application of IDM

Additional learnings from all of the work with IDM, were noted in the following areas:

### 1. Basic needs that are necessary for the Framework process to work.

- a committed point person, resource person
- a recorder
- supportive management
- committed participants
- awareness of challenges, realistic expectations
- safeguards selected issue

### 2. Importance of stabilizing a common understanding

- to increase understanding where necessary
- to identify similarities and differences re. health, health promotion, empowerment, equity, etc.
- to identify ways to work with differences or build consensus if appropriate

### 3. When introducing the IDM and Framework

- use adult education principles (e.g. everyone has expertise to offer based on their years of experience) and a participatory hands-on approach
- make sure everyone understands the basics before moving on

### 4. In working through the Framework

- find a way that is comfortable and workable for the group (e.g. work linearly through the Framework or moving around)
- start where people are at (i.e. what is the current situation)
- use exercises to draw out information where appropriate (E.g. Ask “what are we currently planning/doing, and why?”)
- initially brainstorm rather than get bogged down in details (forget “right” and “wrong”)
- initially, work in regular concentrated blocks of time, not sporadic short periods
- combine individual, small group and large group work
- choose appropriate medium (paper, flip charts, word processor, computer program, or combination)
- schedule regular reviews once initial Framework process has been completed

**5. Capacity building is very important to health promotion and the IDM has been able to support this in different ways.**

- capacity building has focused on team and organizational levels, with implications for community volunteers and programs at community level
- capacity building in general is supported through workshops, conference presentations, meetings, general outreach

**6. Capacity building has also been supported by providing a tool to facilitate critical thinking that:**

- raises questions
- encourages discussion
- increases understanding
- supports clarification

## Vision – Long Term Plans

The vision for IDM which will increase the sustainability of a best practices approach to health promotion includes the following plans.

To further develop &/or establish

- program to train in-house coaches
- demonstration sites across Canada
- learning modules for each IDM sub-domain (E.g. values) including relevant materials (e.g. case studies)
- revised version of computer program
- best practices network
- national get together for best practices “think tank”

The specific requirements for future sustainability of the Best Practices work include:

- committed individuals and organizations
- best practices network and expertise
- ongoing capacity building including
- broader experience (documented & shared) in using Framework
- in-house “coaches” to assist understanding and use of Framework
- development and dissemination of resources such as information, skills, attitudes time, money

## Complementary Tools and ongoing work

The current projects of the Best practices Working Group are:

- IDM Manual revision
- Evidence Framework Manual (see Appendix)
- Ongoing Identification of Health Promotion Best Practices Resources
- Further development of components of the model (ethics, policy)
- Using research in practice (learning module)
- Other publications

# The Nova Scotia Experience

- The Nova Scotia Climate for Health Promotion
- Review of the Nova Scotia Best Practices Framework
- Application of the Nova Scotia Best Practices Framework
- Challenges and Supports

## The Nova Scotia Climate for Health Promotion – Health Promotion Timeline

**FACILITATOR:** Cari Patterson, Sharing Strengths

**T**HE PURPOSE of this session was to collectively develop a picture of the events, reports and activities that have had an impact on the state of health promotion in Western Nova Scotia. The intent of developing a collective time line was to get a feel for the Nova Scotia climate for health promotion.

In this session, participants created a “Timeline” of health promotion events, from the mid 1970’s onward. Participants noted each significant event on an index card, which was placed along the timeline. The discussion about these events provided an opportunity for everyone to consider the significance of each event in terms of challenges and opportunities that had been created. The contents of the timeline, which extends beyond Western Nova Scotia, present an interesting history of the development of health promotion from the perspective of the Consultation participants.

<b>DATE</b>	<b>EVENT</b>
1920’s	N.F.B. film “When All The People Play,” Annapolis Royal, NS. People come together to solve problems.
1976	LaLonde Report.
1976	Provincial and Municipal Support to Communities to “Help Communities Help Themselves”
1978	World Federation Of Public Health Associations (W.F.P.H.A.) Conference in Halifax, NS.
Early 1980’s	Support to Seniors through New Horizons and organization of Seniors Councils & Clubs in counties throughout the province.
1982	Primary Care Showcase, Halifax, NS.
1980’s	Quality Assurance (QA)_Continuous Quality Improvement (CQI)_Continuous Improvement (CI)_Best Practices._ System level of analysis.
1986	PHANS Health Promotion Conference. Epp Health Promotion Framework.
1986	Heart Health Survey. First Rails to Trails in Nova Scotia, Queens County.
Mid 1980’s	Health Action Coalition.
1987	Nova Scotia Select Committee on Health Report.

<b>DATE</b>	<b>EVENT</b>
1987	Shelburne County Senior Games.
1988	"How do the poor afford to eat?" NSNC study.
1988/89	Royal Commission on Health.
1989	Nova Scotia Royal Commission on Health Care
1989	Heart Health Nova Scotia began
1989	"Globalization" (Free Trade).
1989	Healthy Communities comes to Nova Scotia –Dartmouth, Parrsboro, etc. Thinking re: determinants of health. Coordinated Home Care Program began. CHC program rolled out across Nova Scotia with volunteer services identified as core service (with funding available through VIG and VICS). Lunenburg/Queens /Shelburne establish "CHC Program Advisory Committees" – intersectoral collaboration and strategies/ actions to address issues of seniors, people with disabilities.
Early 1990's	Whitehall Study (Black Report, income and health).
Early 1990's	Family Support Centres appear. Client-based HP.
1989/90	Community Health Promotion Fund (CHPF)
1990's	Writings by: Trevor Hancock, Ron Labonte, Dennis Raphael Beginning of Military Family Resource Centres.
1992	Nova Scotia Nutrition Survey
1992	FPT Advisory CTTE Population Health established. Federal government recognized Population Health.
1991	Community Links, CKC
1993	South Shore Community Eating Disorder Resource Group developed.
1990-94	HE & PA
1993	Atlantic Health Promotion Research Centre established. \$10 million research funding.
1994	Working Heart report released. (Good report, hasn't been adopted.)
1994	Blueprint Report. Regionalization.
1994/95	National Forum on Health
1994	Population Health Research Unit established.
1994	CHBs established. Regionalization – communities felt disconnected.
1994/95	Auditor General Report – Accountability, Outcomes.
1994/95	Finance Measures Act. Can't live in debt – fiscal agenda solution.
1995	Identification and discussion re: determinants of health.
1995	Canada Prenatal Nutrition Projects started. (Health Canada).
1995	Nova Scotia Health Survey. Good data with DOH.
1995	Seniors Volunteer Coordinated Program in western Nova Scotia.
1995	Tobacco Control unit created.
1995/96	CAYAC concept developed.
1996	Population Health Promotion Framework. Hamilton and Bhatti.
Mid 1990's	Cutbacks to social programs. Government decision to reorganize governance and management of publicly funded health system. To blueprint_ stressful impact.
1996	Worksite Program in Nova Scotia recognized as International Best practice! Partnership – accepted now, work together.
1996/97	Community Health Boards are first introduced in Nova Scotia and established in Western Region Heart Health Action Team established.
1998	Challenges to Medicare (Universality). Threat of two-tiered system.
1998	Beginnings of partnership with Population Health Research Unit and Public Health.
1998	CAPC Population Health Workshop: Tatamagouche, Halifax.
1998-2002	Health Promotion 101 & Train the Trainer developed and delivered.
1998	Nine Heart Health Action teams established in western Nova Scotia.
1998	Program Evaluation Guide (PEG) - Using Pop. Health, Health Promotion, Community Development guide. - Easy for staff to use. - Guiding program development. Central region PHS.
1998	Our House, Shelburne County Youth Wellness Centre.
1998/99	Focus on importance of early years using Population Health approach.
1998/99	Health Promotion Clearinghouse set up
Jan. 1999	Sharing Strengths founded - Western Region.
1999	PACY born – Provincial PACY Western. Eating Disorder Conference, Bridgewater. Prevention broader

<b>DATE</b>	<b>EVENT</b>
Sept. 1999	Consultation Panel on Child/Youth Health, Cornwallis.
Oct. 1999	Demise of Regional Health Boards. Government decision to, once again, reorganize the governance and management of publicly funded health system.
1999	Canadian Diabetes Association includes prevention of diabetes as part of their mission.
Nov. 1999	Population Health Conference, White Point.
2000	Regions to Districts. Significant expansion of public transportation system in Annapolis Valley.
2000	SCAT (Shelburne County Active Team). Development of The Alliance for Healthy Eating & Physical Activity.
May 2000	Open Space Conference on Health Promotion, Cornwallis.
Aug. 2000	Summer Learning Retreat.
2000	Steel Curves Women's Fitness Centre.
2000	Centennial Trail established, Bridgewater. Government commits to building an integrated, community-based health system.
2001	Smoke-free public spaces by-laws in Kings County. Provincial Tobacco Conference - Tobacco Strategy Announcement.
Aug. 2001	Summer Learning Retreat.
<b>Date</b>	<b>Event</b>
	Canadian Strategy for Cancer Control – recommendation of a National Alliance for Chronic Disease Prevention. Action against Tobacco in Your Community National Diabetes Strategy Funding, Round #1. Nova Scotia Nutrition Council – funding received for Food Security research project.
2001	Heart Health NS becomes Unit for Population Health & Chronic Disease Prevention. I.Y.O.V. Population Health in Action Workshop.
2001	DHAs established
2001	Heart Health Dissemination research outcomes published in: - Journal for Health Promotion & Education; Health Promotion International. Trend in Municipal smoke-free by-laws. Tobacco Conference. \$1 million towards tobacco strategy.
2001	Nova Scotia Tobacco Strategy. DOH adopts Population Health approach.
2001	Symposium on Best Practices in Health Promotion for Physical Activity and Healthy Eating. – Launch of Nova Scotia Best Practices Framework
2001	An inventory of accessibility done for recreation. CHB's legitimized.
2001	Population Health template published by Health Canada. Wellness Fund.
Fall 2001	Nova Scotia Department of Health officially adopts Health Canada's Population Health principles. National Diabetes Strategy Funding, Round #2.
Jan. 24, 2002	Government announces watering down of smoking in public places legislation. PACY strategy for Nova Scotia.
Jan 2002	Consultation on Best Practices For Health Promotion in Diabete Prevention
Feb. 2002	Population Health Conference, Truro.
2002	"High Five" demo sites established in Nova Scotia.

# Review of the Nova Scotia Best Practices Framework

## Developing a Best Practice Approach:

**FACILITATORS:** Kari Barkhouse, Joy Emmanuel - Unit for Population Health and Chronic Disease Prevention

**D**URING THE Dissemination Phase of Heart Health Nova Scotia, resources were put toward building organizational capacity for health promotion in the Western Region of Nova Scotia. Many organizations were involved in discussions about how to collectively do more health promotion work. As part of this Phase, research was undertaken to develop individual organizational profiles on the capacity for health promotion work. For many organizations, receiving a qualitative piece of research on this aspect of their work, was a new thing, which stimulated within the organizations, reflection on their organizational practice. From this, Heart Health started to look at the work on “best practices” happening in other provinces. Could a shared vision of best practices, developed among health promotion organizations, further enhance the health promotion work in the Western Region? This idea continued to develop through a process of collective thinking among representatives of many organizations. In the fall of 2000, the discussion was formalized through an application for funding through the Canadian Diabetes Strategy. A proposal which included the development of a Nova Scotia Best Practices Framework was submitted and approved.

## How the Framework was developed:

In the winter of 2001 the work on a Best Practices Framework for Nova Scotia began. One of the first steps was a review of the literature on Best Practices. This search revealed two main approaches. The first, a “criterion approach” was commonly used to evaluate interventions on the bases of such things as: a project’s research design model, the use of evidence, practicality, and sustainability. A second approach seemed to be more focused on the “process” or looking at how people do their work. Ontario’s IDM best practices work was at the forefront of this stream within work being done in Canada

As the Nova Scotia Framework developed it drew on both of the above approaches. The project Steering Committee and Advisory Group helped shape the Framework into a relevant document for use in Nova Scotia. This meant ensuring that the Framework was user friendly, with content applicable to be used at the community level. The NS Framework was launched in March 2001 at the Doing Our Best! Symposium and also posted on Health Promotion Clearinghouse website. Although there has been extensive on-line interest in the Framework, lack of funding has meant there has been no follow-up, until now, to further develop and disseminate.

The Nova Scotia Framework consists of 12 components which reflect essential aspects of health promotion work and are relevant not only to projects, but potentially also for organizational development, and to the health promotion community as a whole. Key features of the Nova Scotia Framework are:

1. It is primarily a process oriented approach. Within the Nova Scotia framework, “critical reflection” is key to this process approach. This process encourages stepping back to reflect on how we currently do our work. Through sharing and collective reflection many insights can be gained on ways to continuously improve what we do. It involves looking at the totality of our work.
2. This approach also incorporates many aspects of a “criteria approach.” Many of the criteria identified in the literature that are considered important in rating a best practice approach are reflected in the Nova Scotia Framework components.
3. The Framework is adaptable to particular settings. The Nova Scotia Framework is not a recipe or formula, but offers a guide for reviewing one’s work. The critical questions may be expanded and can be seen as a place to start discussion.
4. The Nova Scotia Best Practice Approach supports the use of research-based decision making throughout the various stages of planning and implementing an intervention.
5. Using the Framework does not require that an initiative has to address all the components. It raises the primary question of ‘*how do we continue to improve on our practice?*’ however, it is stated in the Framework that the more you can incorporate the components into your work and go through a process of reflection, the more effective the outcomes will be.

This consultation provides the opportunity to further investigate into how people are using the NS Framework. We are looking for direction on what revisions might need to be made to improve the Framework, what needs to happen to encourage use of the Framework and what additional tools would be useful. In this consultation we have taken the approach of not re-inventing the wheel but learning from others experience. In reviewing and reflecting on what is needed to move us ahead with the Nova Scotia Best Practices Framework, we have invited members of the Best Practices Working Group of Ontario to share with us so that we can learn from their experience and as well as learning from the collective experience of all participants present at this Consultation.

## A Walking Tour of the Nova Scotia Best Practices Framework

This session was an opportunity for participants to reflect on their own experience and understanding of the components of the Nova Scotia Framework. This activity was designed as a “walking tour” of the 12 components. A description and visual image for each component was posted around the room. Participants were invited to visit each component and record their thoughts on the following question:

### **What does this component mean to me, both in my work and my life?**

Following are some of the responses participants provide for each component.

#### **1. Values:**

- Shared values provide a bond for the group
- Personal beliefs that are reflected in behaviour/attitude
- We carry our values with us. They are our very inner self. It is what is fair and good
- The very core and most foundational beliefs about what is “good”
- Essential, but not always articulated
- Helps ensure ideas are implemented to satisfaction of stakeholders and community
- Creates a supportive environment for doing challenging work
- Shape decision making all along program planning, implementation and evaluation
- The reason for action, beliefs and causes each person chooses to be involved in.

## **2. Principles and Assumptions:**

- Common threads across sectors
- Principles allow people to avoid getting buried in detail and possible conflict. When this happens the group can go back to the principles for clarification and a “regrouping”
- Groups need to validate with each other principles and assumptions, better to do earlier than later.
- Principles are our building blocks
- Help guide decisions/work
- Assumptions are the things we believe but don’t know we believe until uncovered = surprises
- Assumptions are dangerous

## **3. Determinants of Health:**

- Look at all factors that affect a person’s health
- Many things affect the health of individuals and their families. At any one time one or more of those things may make us unwell
- Comprehensiveness
- Common framework for collective action
- Getting to the root of the problem rather than focusing on symptoms
- Upstream approach
- The foundation for actions/planning
- Emphasizes the need for collaborative work with many partners

## **4. Theories**

- Helps in understanding and explaining way things are as they are
- Can provide ground breaking ideas for unique health promotion initiatives
- Helps understand behaviours = predictability
- Provide a place to start

## **5. Evidence:**

- Proof that it works. It has been tried previously
- Identifying what you will be able to collect that links your project to outcomes = proof
- Objective info that lends credibility
- Finding out what works and what doesn’t
- The qualitative data is often very valuable but may be harder to get
- The program works and the result was...
- Evidence guides your planning

## **6. Planning Tools:**

- Ensures you don’t miss any steps
- Guidelines – general guidance to follow to expedite process
- Helps organize
- Can be used in a variety of contexts – transferable
- Good teaching/learning tool to build capacity
- Creates focus and keeps projects on track
- Need to ensure “research” is incorporated at appropriate components

## **7. Strategies for Action:**

- Multiple action approach, multiple “targets”/audiences
- Gives you ideas on how to make your program effective
- Thinking broadly for maximum impact
- Comprehensiveness
- Good for several groups to be working on the same issue in different ways

## **8. Partnerships and Intersectoral Approaches:**

- Allows sharing of responsibilities and workload
- Many hands and minds make the task easier when all share equally
- Can’t imagine working without partners
- Better resulting outcomes/plans
- Takes time to build trust, identify common goals, but absolutely essential
- Breaking down the old “silo” mentality
- Variety of views/all working on different issues – it’s a benefit

## 9. Process and Implementation:

- Process – how you get from point A to B, steps
- Implementation – doing – carrying out the steps/process
- Teamwork
- The “process of your work can make or break the activity/project
- Finding an effective way to leverage the wisdom and abilities of partners
- The process has to be fun

## 10. Social and Physical Context:

- Understanding how things get done within the context of various groups and communities
- Using social/physical/community resources to address health promotion concerns
- It’s challenging to work across cultures
- It’s like a “where we are” and how can you make it work “there”

## 11. Evaluation:

- Allows continual improvement
- Checking our work to be sure it is working, and committing to change when necessary
- Challenge of measuring long term effects
- Need to deconstruct/demystify evaluation with community groups so they can do it when they’re ready

## 12. Sustainability:

- Generating lasting commitment
- People continue to feel the issue is important enough to continue on after the money is gone and they struggle to find a way to go on to make a difference
- Building commitment
- The snowball effect of action – it continues to grow and roll without extra/new infusion of energy and money.
- Building capacity

# Application of the Nova Scotia Framework

**PRESENTER:** Judy Purcell - Canadian Cancer Society, NS Division  
**FACILITATOR:** Joy Emmanuel –  
Unit for Population Health and Chronic Disease Prevention.

**T**HIS SESSION provided an opportunity for participants to deepen their understanding of the Nova Scotia Framework through applying it to an actual project. The initiative that was chosen was Action in Your Community against Tobacco (ACT). Judy Purcell provided an overview of the ACT project. Participants were then invited to use critical reflection to first, identify how the components of the Framework were illustrated in the project and second, to reflect and share on their own insights and challenges working with this component. In addition the guest speakers were requested to provide feedback on the Nova Scotia Framework drawing on their experience of developing and using the IDM approach.

The session engaged participants in thinking about each component of the NS Framework, illustrating the use of questions for critical reflection, which is a key aspect of Nova Scotia Framework. *“Critical reflection allows the opportunity for asking questions that relate to how we can continually improve on our work.”*

A short summary of the ACT project follows:

## **ACT – Action in Your Community against Tobacco – The Tobacco Toolkit**

The purpose of this collaborative initiative is to increase community capacity to take action against tobacco. The initiative is co-led by Cancer Care Nova Scotia (CCNS) and the Canadian Cancer Society, Nova Scotia Division (CCS). A provincial Tobacco strategy developed over the summer of 2000 with the input of many partners, including CCS and CCNS, created renewed momentum. The strategy is based on CDC Comprehensive tobacco control model, so it encompasses all aspects of tobacco control, including community-based activity. An important contextual piece is the commitment of the two organizations to collaboration, both with each other and with other partners in chronic disease prevention, as well as commitment to supporting communities to take action against tobacco.

The ACT Steering Committee has representatives from both government departments and the health sector. The Steering Committee Members have province-wide networks that will ensure that Community Volunteers are well supported in their efforts. Partners include Heart and Stroke Foundation of N.S, Heart Health N.S. Addiction Services, Public Health Services, Capital District Health Authority and Tobacco Control Unit, Dept. of Health.

The Principles of the ACT project:

- Based on evidence
- Based on principles of adult education and take literacy issues into account
- Include practical low cost activities that are feasible for volunteer implementation
- Evaluated
- Emphasize building capacity in communities
- Avoid duplication of effort by building on what already exists in coordination with the provincial strategy

ACT will provide a solid program around which to recruit volunteers and the practical skills and tools to help them put their energy into action. The structure – the train the trainer model will also provide support for local volunteers and encourage networking among community volunteers working to address tobacco control. The goal is to recruit 10 Coaches from all regions of Nova Scotia and to have within one year a total of 100 Action Team Members recruited and trained to implement the activities of the Tool Kit in communities throughout the province. Ongoing support of Community Coaches and Action Team Members is being built into the Tool Kit implementation plan. Thirteen coaches were recruited from across the province who were oriented to the tool kit. Their role is to provide encouragement, support, and networking opportunities. Action Team Members implement activities from the Tool Kit in their community.

The resource, which is called a Tool Kit includes evidence-based activity ideas - activities that have been shown to be effective elsewhere. By using activities shown to work elsewhere – we are not re-creating the wheel. A framework was developed to enable the Steering Committee to identify effective activities – “tried and true” activities that communities could implement with confidence and that were practical for communities to do – that did not cost money or require extensive resources to do.

Historic evidence shows that significant change in a community only takes place when local community people are committed to investing themselves in the effort. While assistance can be provided from outside communities to help increase their capacity to change, the actual change is brought about from within the community. Diffusion of Innovation theory – is concerned with how a new idea, resource

or technique migrates from creation to widespread use. These innovations pass through several stages through time. (knowledge, persuasion, decision, implementation, confirmation.) The Tobacco Tool Kit has been structured to reflect this progression of an innovation. The other part of the diffusion theory relates to roles in the innovation process. Two key roles are identified – the change agents – who positively influence innovation decision and change aides – who have more intensive contact with the clients. Both theories have informed the development of the Tobacco Tool Kit initiative.

Communications plan takes advantage of existing communications vehicles to promote the kit and recruit (newsletters etc.). CCNS also launched radio campaign designed to get people thinking about what they can do to take action against tobacco. Brochures and displays were prepared. All ACT Coaches were supported in attending the Provincial Tobacco Control Conference held in October at which the ACT initiative was launched.

Sustainability is guaranteed by multi-partner steering committee that has taken ownership (e.g. finding dollars to sustain from within organizations). Evaluation is designed to look at design and delivery, impact and application of theory.

## Application of the Nova Scotia Framework:

Following the above presentation, the facilitator asked participants to identify how the components of the Nova Scotia Framework were illustrated through the ACT initiative. Several questions for critical reflection were then posed to participants to help draw out their insights and collective knowledge about working with each component.

### Questions for Critical Reflection:

- *How are you currently working with this component?*
- *Why is this component important to your work?*
- *What are the challenges you have encountered in trying to work with this component?*
- *What solutions and insights have we identified to enhance how we can work with this component?*

The discussion is summarized below.

## VALUES

### In response to the ACT presentation some values participants noted were:

- Equity
- Being open
- Involving people in the community
- Respecting diversity of communities

### How are you currently working with this component?

- Heart and Stroke includes values in Strategic Planning – This is one place where organizational values are flushed out.
- NS Sport and Recreation – Brainstormed a list of values and then went through and asked what does this mean to each one of us. Through dialogue, got to clarity of what each value meant. In Fair Play initiative, a values clarification process was used, asking people to make choices between values. Then people were asked what this would mean in terms of their actions.
- In meetings with partners organizations, Heart Health – Brainstormed, with other partners, a list values and then dialogued about their meaning. In future meetings these values were posted around the room and referred to on an ongoing basis. For example, referring to them as decisions were made by asking – how does this decision reflect our values?

Other comments and questions:

- At times, there can be conflicting values within and between organizations, individuals, or cultures. We need to be aware of the value sets and where people are coming from and how to respect the various sets.
- How do we keep coming back to our values to ensure that they are a part of our work?
- How important are values to health promotion work?

Feedback from Debbie Bang and Barbara Kahan based on their experience with the IDM model:

Both of the models contain a Values component.

## Principles

The facilitator noted that principles are core statements that form the foundation of our practice. Principles reflect our values. Assumptions are our underlying beliefs about the social world. We make assumptions all the time throughout the day. The value of critical reflection is that it helps us to become more aware of how we are thinking based on assumptions, and how they are at play.

In response to the ACT presentation, participants noted the following principles and assumptions:

### **PRINCIPLES:**

- That people need to understand material
- Partnerships
- Capacity building emphasized
- Building on what exists to avoid duplication
- Communication about their product was important, and they built capacity for doing this – conscious communication

### **ASSUMPTIONS:**

- that readability of printed material was important

## Other comments and questions about Principles

- What's the difference between values and principles? If you take one of those values and it is core to what you are doing, it will be raised to the level of a principle. The two get mixed up
- In last night's session, the way people identified assumption, principles and values is all quite similar. This could indicate that the Nova Scotia Framework needs more work in this area. How are we going to further define these items? This will also be a task that individual groups will want to go through, this sorting out.
- A tool is needed to give examples of processes that can be used to make meaning of these components.

Feedback from Debbie Bang and Barbara Kahan based on their experience with the IDM model:

There is a difference in the use of words in both Frameworks. However, discussions regarding the difference between values and principles can bog people down. In our work in Ontario, we decided to define them up front for participants. We recommend not spending too much time on labelling whether something is a value or a principle. Instead, let whoever is speaking say what they think it is, and let it be reorganized later. What each person means by a particular value is the critical point. Values are the basis for all further work.

## Determinants of Health

In response to the ACT presentation, participants noted the following Determinants of Health were addressed in some way through the project:

- Income – addressed barriers around volunteers being able to implement activities by seeking additional funding, also low cost activities in toolbox
- Income - One group is linking ACT initiative with building youth employment skills
- Personal health practices and coping skills
- Education – literacy level in kits focused on inclusion
- Social Support Networks – Teen Centre included as sites to do activities
- Culture – Communities were encouraged to adapt materials.
- Gender – Gender specific activities included in kit.
- Employment and Working Conditions: Workplace activities are provided
- Activities for other various settings also included

Other comments about Determinants of Health

- People tend to have trouble understanding the meaning of “social environments.” How is this different than peer support?
- Perhaps the Determinants of Health and Partnerships, since they open up how to address the Determinants of Health, belong under Theory component.

Feedback from Debbie Bang and Barbara Kahan based on their experience with the IDM model:

In the IDM Framework the Determinants of Health is approached through theory. We have used exercises where people define their own Determinants of Health and then relate it to practice and how they would chose to address a wider range of determinants in their work. We have found that people often prioritized only a few determinants. We follow up with a group discussion about why these choices were made. We have also found “Jason’s Story” (developed by Health Canada) to be useful, in terms of helping people to broaden their views on the Determinants of Health. In addition, we make use of prompting questions in our Theory section and through the analysis of the political environment to encourage people to take a step back and reflect on wider issues. We have found some of the Determinants are easier to operationalize than others. E.g. social support is easy, income level is hard. This also influences people choices of which one’s to address.

## Theories

In response to the ACT presentation, participants noted that the following theories were used to develop the intervention:

- Diffusion of Innovation Theory
- Community Development: Communities can identify and take action on their issues.

Other comments about Theories:

- From last night’s session it was noted that participants had lots of questions about theories. People struggle with where to find the information and how to integrate theory into their work.
- Recommended resources: *Theory in a Nutshell*. Also Joan Feather’s Manual (Prairie Health Promotion Centre) both present the major theories in an accessible format.

Feedback from Debbie Bang and Barbara Kahan based on their experience with the IDM model:

Theory can dictate action and planning. We recommend the following exercise for deepening people’s understanding of theory. Have participants identify and define their ideas and feelings about what theory is. Also ask people to decide how theory is relevant to their situation.

In the Ontario group we have keeners that like to do literature searches to see if there are any theories that support the groups thinking.

The Nova Scotia model may want to consider moving the Determinants of Health into Theory component.

## Evidence

In response to the ACT presentation, participants noted the following uses of evidence:

- They defined evidence.
- They performed a literature search that looked at models that were shown to be effective and then adapted some of these models.
- They looked at Nova Scotia data on smoking patterns.
- The ACT developers used qualitative and subjective community input to review the project outline and see if it would meet the need at the community level.
- They also identified gaps within the provincial strategy by doing a scan of what other related projects were taking place.

### **If we were to improve on this, what other evidence might be taken into account?**

Community stories that focused on the experiences of community initiatives involved with smoking cessation could have been included as evidence.

Other comments about Evidence:

- It takes resources and skills to work with both theory and evidence at the community level. It is a gap in terms of the support we can offer to communities.
- The key is what question do you want to answer. Start from there.
- Various workshops and programs, like last years 2001 Summer Learning Retreat, are offered from time to time to help us better understand how to work with research.

Feedback from Debbie Bang and Barbara Kahan based on their experience with the IDM model:

It is important to have a broad definition of what Evidence means. For example, evidence could include information about projects which didn't work, and other information from "grey literature." In our working groups Ontario participants generated a whole list of potential sources of evidence. At the top of their list was to talk to others who had developed similar projects so they developed their own questionnaire to talk to these people about their projects.

Is there less focus on theory than evidence in the IDM? The Evidence definition Ontario developed was a big factor in helping us move forward. The definition was very broad. We are trying to demystify theory. We also noted that we all operate on informal theories which we don't identify. But when we do identify the theories then we can see how we are collectively thinking. Also, it is valuable to try to demystify what research is. What is valid and what can be done at the community level.

## Planning tools

In response to the ACT presentation, participants noted the following use of planning tools:

- They did a scan on strategies, picked a niche that was not being filled and developed project strategy around this.
- They developed an action plan to envision goals, objectives and ensure commitment of two organizations as starting point.
- They did not use a specific tool.

Other comments regarding planning tools:

- Often planning processes are in our heads, part of our experience. Tools aren't necessary, but good to look at as refresher.
- The importance of objectives is that they link not only to actions, but also to values and principles.
- People have inherent understanding of steps necessary in order to implement an action. Sharing Strengths draws on this experience by helping people name these steps as steps in the "planning cycle".
- Results based planning is also coming into use by Nova Scotia Department of Sport and Recreation. We need to look at the use of planning tools as an additional tool to enhance current tools.
- Recommended planning tool: Strategic Planning resource (on the Health Promotion Clearinghouse web site)

Feedback from Debbie Bang and Barbara Kahan based on their experience with the IDM model:

In the IDM Framework, the Action Plan is given more attention than in the Nova Scotia Framework. It may be helpful to look at several planning tools.

## Strategies for action

In response to the ACT presentation, participants noted the following strategies for action:

- Train-the-trainer: Developed personal skills among coaches, strengthened community action
- Workplace environments
- Attempting a comprehensive approach over time

**If we were to improve on this, what other strategies might be taken into account:**

- Re-orienting Health System – E.g. Do training-the-trainer with hospital staff, get coaches into these established institutions to encourage them to provide support

Feedback from Debbie Bang and Barbara Kahan based on their experience with the IDM model:

In the IDM Framework, Strategies fit under Practice. IDM's list of strategies is different from the Nova Scotia Framework. We use more than the strategies from the Ottawa Charter. Partnerships are covered under strategies in the IDM.

## Partnerships and intersectoral approaches

In response to the ACT presentation, participants noted the following use of partnerships and intersectoral approaches:

- ACT encourages on-going joining into the partnership

**If we were to improve on this, what other approaches might be taken into account?**

- All partners are within the same sector. Could be expanded to include other sectors.

Other comments:

- In general, we need to build our skills in this area.
- At the community level partnerships are more likely to happen. But what is encountered commonly is the lack of intersectoral co-operation at other levels. What is missing is the commitment from the province.
- It takes a lot of time, committed people and resources.
- It can be a struggle to convince businesses that it is to their benefit for them to work with our project.
- In St. John New Brunswick, they got the business community behind poverty reduction. We might learn from their experience.
- When we do community development, the relationships that are already there are a major asset. We need to develop these relationships at the policy level as well in order to see change. If you have the relationships it is easier to begin to think outside of the box and to be courageous and creative in finding new solutions. Developing new intersectoral partners, with no previous relationships, is difficult.
- Intersectoral partnerships bring forward language differences, which again benefits from discussion about what we mean by these words.
- Heart Health has used analogies to develop common understanding by using a garden metaphor.

Feedback from Debbie Bang and Barbara Kahan based on their experience with the IDM model:

Language and definitions become very important with intersectoral partnerships so that it is clear what we are talking about. This component is contained within the Practice domain of the IDM Framework.

## Process and implementation

In response to the ACT presentation, participants noted the following about Process and Implementation:

- Built on a lot of history between organizations, so they were able to move into the work quickly.
- It was an “active” steering committee, not just advisory group.
- Committee assessed its role after initial phase to ask where are we now and what do we need to be doing. Useful check-in.

Other comments regarding Process and Implementation:

- Listening to the group you are working with is the best way to see what will work in a particular community. What works for them is what is important. Take direction from them. Be prepared to toss your own ideas out the window.
- People often want to ignore the investment in process up front because they want to move to action ASAP. But the investment pays off.
- Having fun in the process is essential.
- Getting commitment from other partners is part of the “process.” Also recognizing that while committed, there are various amounts of time available from each organization. Bringing this up at the group table is very important to create realistic expectations. This is another area of assumptions that can benefit from being discussed.
- It is helpful to discuss how we want to work together, group “norms,” how will decisions be made? etc.
- Big challenge with working with CHBs is turnover. A process is developed and then newcomers come in and aren’t aware of agreements, common values etc. This is true for any group that has turnover. Requires some supports such as facilitator to assist with process review on a regular basis. Be pro-active. Ask what can we be doing differently? Why are we losing membership?

Feedback from Debbie Bang and Barbara Kahan based on their experience with the IDM model:

Process and Implementation is under “Understanding of the Environment” in IDM Framework. Suggest that Nova Scotia go further in this area.

## Physical and social context:

In response to the ACT presentation, participants noted the following about Physical and Social Context:

- Saw opportunity to address community action part of provincial strategy and wanted to ensure that community priorities could be addressed through the strategy.
- Wanted to ensure that supports were out there in communities, so that people didn’t have to call Halifax. So took geography into account.
- Took advantage of human-made environment through creative use of technology. Coaches wanted opportunities for networking, but physical distances a problem. Health Promotion Clearinghouse offered page on web site for coaches to share experiences. Helped to address this need for communication.

Other comments regarding Physical and Social Context:

- Overload within organizations. Lack of resources, lack of provincial infrastructure etc. creates major barrier within cultural context of organizations

Feedback from Debbie Bang and Barbara Kahan based on their experience with the IDM model:

Physical and Social Context is under “Understanding of the Environment” in IDM Framework. Suggestion that Nova Scotia go further in this area, especially on workplace environment. For example, you want to know if health promotion is big on the organizational agenda or small. It is vital to look at how supportive your work environment is for doing health promotion.

## Evaluation

In response to the ACT presentation, participants noted the following Evaluation practices:

- Evaluation was a key piece. They wanted to prove that this works so that funding will continue.
- Looked at assessing community capacity to address tobacco control. Will test to see if ACT interventions make a difference in this.
- Did literature search on indicators regarding community capacity.
- Involved Centre for Behavioural Research in the project.

Other comments regarding Evaluation:

- The challenge is to plan for evaluation from the beginning rather than later. Tools help us do this. Evaluation needs to be demystified if it is to be successful from the beginning.
- Expectations of partners can be different depending on who the various funders of the partners are. Therefore it is important to clarify in the beginning what the expectations are around evaluation. Need to clarify who owns evaluation. Who can distribute this information? And what money resources are needed.

## Sustainability

As the session was running overtime, the comments below reflect a final few comments made by participants on Sustainability and do not reflect how this component was addressed in the Act project.

Comments regarding Sustainability:

- Evaluation can influence sustainability and be used as a marketing tool. People don't realize this. This approach can be a way to get groups to buy in to doing evaluation.
- Initial groundwork with partners is necessary so that there is the potential for them to take more of a major role, so the project doesn't just collapse at end of the funding.
- If our project is successful, we will work ourselves out of a job because capacity will have been built in the communities. This is an important way to view sustainability.
- The transfer of knowledge past the life of a project is another way to look at sustainability. E.g. In the Nova Scotia Tobacco strategy, knowledge was developed, but doesn't seem to have been sustained.

Feedback from Debbie Bang and Barbara Kahan based on their experience with the IDM model:

It is important to have groups identify their resources and to identify gaps in resources within the group/partnership. Take a constructive approach to challenges. Place the emphasis on the way that strategies are developed so that they work towards strengthening the partnership all the way along by promoting participation, respecting differences etc. Come back to core values, if its worth writing the proposal in the first place, it is worth sustaining. Does the data also support the need for the project to continue?

In the IDM Framework, sustainability could fit under values or it could be a goal. It also fits under Environment.

### **Additional Comments about the Nova Scotia Framework from Debbie Bang and Barbara Kahan:**

- It is impressive what Nova Scotia has accomplished. The important pieces are all there.
- Does the Nova Scotia Framework have a section for goals or ethic statements? This may be important to consider.
- Be sure to document as Evidence, what you are learning. The documenting of processes, activities and outcomes is critical if we are to share and review our findings. So much great work is being done and is lost because of a lack of documentation. This emphasis could be added to the Nova Scotia Framework. You can generate your own evidence as you are doing it, if it doesn't yet exist.
- A picture of the ideal situation as well as where we are now, needs to be included at the groundwork stage, and into the specific planning and evaluation. This pushes you forward, past the critical reflecting and into action planning.

- A strong emphasis on specific processes for deepening the understanding of each component is needed. Clarify meaning and language within each component and on various levels such as the individual and organizational. There also needs to be a process for dealing with differences as well as a system for on-going review and revision.
- At the end of the Nova Scotia Framework it says “take what you need, don’t do it all.” This doesn’t give a sense of what should not be omitted, what the priorities are, such as values.
- A graphic model would enhance the understanding of how the components interact and how the components relate to each other. For example, evaluation should be noted as something that happens in planning phase so people don’t see it as an add on.
- How does innovation fit with this model? We have had the concern that imposed frameworks would crush innovation, but now feel that the model is flexible so that you can use parts of it for different reasons. Innovation therefore is part of it. Some people feel a Framework helps them examine things in new ways, to think outside the box. This is innovation. If one of our values is defined as creativity or innovation, this strengthens this possibility for new ways of thinking.
- The questions used today are different than the ones in the Nova Scotia Framework. The questions today were very useful for critical reflection.
- In presenting the IDM Framework to people, you don’t necessarily have to show them the whole thing, with all the boxes etc. Our role has been to be the scribe, then show them the final results all plugged into appropriate categories. It becomes less intimidating and doesn’t have to be this way, or hinder the process. It doesn’t have to be used as boxes. Michael Goodstadt has used it with student projects – none of them use boxes.

## Supports Needed to Further our Best Practices work?

In the closing session, participants were asked to consider what additional supports they felt would be helpful to assist them in using the Nova Scotia Best Practices Framework. Responses to this final question are presented below:

### **FRAMEWORK:**

- “Don’t miss good while looking for perfect.” Get this Framework out soon to communities.
- Revise Framework – identify supports available (mentors, coaches, written materials)
- Pilot test – real situations/projects need time to pilot test Nova Scotia Framework
- Evaluate the Framework – how is it being used? who is using it? is it working?
- Coordinator for the Framework

### **HUMAN RESOURCES**

- Commitment from those involved
- Mentors/Coaches who can offer help on the ground, and who can connect users of framework to each other and to resources
- Provide support staff to coordinate the use/revision/evaluation of the Framework, who could also provide resources

**MODEL/GRAPHICS:**

- Visual representation of process of using Framework
- Diagrams and graphics that illustrate interaction between components

**SUPPORT TOOLS:**

- Toolkits that cover the 12 components, exercises, background reading
- Use of the guide – need a 1 pager on how to use the guide, handbook of activities, worksheets, tools and resources for process of using Framework
- Provide case studies/examples – practical hands on information that illustrate each component
- Create access to published/unpublished tools/data etc in one location (CD Rom/Clearinghouse website, etc.)

**WORKSHOPS/TRAIN-THE-TRAINER/GATHERINGS:**

- Process to deepen understanding of Framework e.g. mechanism/opportunities for ongoing sharing of experiences with others who are using the Framework
- Training on how to use the Framework
- Coaches/mentors (see above)
- Leadership – promote the Framework at various venues including upcoming Population Health conference

**HEALTH PROMOTION CLEARINGHOUSE:**

- Use Best Practices criteria to identify Best Practices resources to put on clearinghouse
- Provide web support
- Create access to support tools (see above)

**COMPUTER PROGRAM:**

- Put NS Framework on computer based program

**VIDEO:**

- Create a video that helps increase understanding of Health Promotion, Population Health and Best Practices (not always RCT's)

**GOVERNMENT'S ROLE:**

- Support and commitment to Best Practices
- Define other aspects of provincial government role – for example, sharing quality work in Western NS could be one of their roles

**LONG TERM:**

- Network
- Sustaining movement for Best Practices
- Broaden network across regions, bringing in more organizations from across NS – results will be new ideas, new energy

**OTHER COMMENTS:**

- We need to articulate why using the Framework is important, to stimulate buy-in
- Supports are needed to use the Framework
- Each organization needs to identify their own readiness in own their own situation
- We need to create opportunities to move climate ahead to use Best Practices.

# Summary of Consultation Evaluation

Thirty one people attended the Best Practices Consultation. The group represented a cross section of health practitioners and administrators from across the Western Region of Nova Scotia. At the close of the two day event, participants were asked to fill out a short questionnaire intended to capture both quantitative and qualitative measures of their impressions on various aspects of the Consultation. For this summary, qualitative comments have been categorized into thematic groupings with direct quotes provided to illustrate participant’s views. Of those present, twenty-five people passed in the evaluation forms.

In question one, participants were asked to provide a few words to describe the Consultation from their point of view. Over two-thirds of the responses reflected a positive view of the event. “Informative.” “Very worthwhile.” “Thought provoking.” “Helped clarify the whole concept of best practices.” “Great location, great people. Incredible information sharing.” Three people expressed some dissatisfaction with the program. “First day too much lecture.” “Very lengthy on the front half - second day.” The final cluster of comments reflected descriptions of the general content of the Consultation. “Sharing of information.” “Discussed what ‘best practices’ means.”

Next participants were asked if their understanding of a best practice approach to health promotion had changed. Nineteen people indicated they felt an increased understanding of best practices as a result of the Consultation. Some comments were short, “broader understanding,” while others went into greater detail.

- Better understanding of BP application in a variety of settings; applicability in other parts of NS, Atlantic Canada.
- I was not aware of the in-depth process; now understand the process.
  - Much better understanding of how one could use BP to both plan initiatives and also to reflect on existing initiatives and improve them; [have] more commitment to use BP framework
  - Better idea of what it means, how I use it & how I can use it better
- More than one way to approach it. Still much to learn, but huge organizational benefits associated with following the NS model

Three suggestions were made regarding 1) the need to keep things simple, 2) the importance of practical tools to help groups use the best practice approach, and 3) the need for small working groups to help formalize the work.

Participants were then asked to rate their level of satisfaction with their understanding of best practices and its perceived usefulness in several ways. The table below shows the results.

**TABLE ONE: LEVEL OF UNDERSTANDING OF BEST PRACTICES**

	Very Satisfied	Satisfied	Somewhat Satisfied	Not Satisfied	% Total	
<i>Increased understanding of best practices in general</i>	30%	48%	22%		100%	<b>n = 23</b>
<i>Increased understanding of best practices in terms of how it relates to your work</i>	35%	39%	22%	4%	100%	<b>n = 23</b>
<i>New ideas that may benefit your organization as to the usefulness of best practices</i>	41%	41%	14%	4%	100%	<b>n = 22</b>

One participant who did not answer the above questions commented: “Nothing has changed regarding this, my understanding is the same.”

In question three, participants were asked: What information or discussion did you find most helpful in the Consultation? For this question, some people had more than one response. The session that people found most helpful was the application of the Nova Scotia Framework to a local health promotion initiative.

- Reviewing the NS Framework item by item; comparing and contrasting our model with the Ontario model was helpful.
- Friday morning; a concrete example and using the expertise of those in the room
- Discussion about the components and what they mean; what activities occur with each component.
- Day 2, but we needed Day 1 too; using the BP Framework [was] helpful.

Several people found the wrap up on Friday afternoon to be the most helpful. “Session after lunch the second day put all into perspective.” “Feedback from Barbara and Debbie, their concrete suggestions for us to apply.” Other activities people found helpful were: time line, discussion around what best practices is, the walking tour of the BP Framework, and three people indicated the sessions on the IDM were most helpful. One person added that the “fact the agenda was flexible” was very helpful.

Participants were then asked what could have been done to make this consultation more effective? Again, some people indicated more than one activity. Six comments were offered on the process of the consultation. These included a call for more interaction among participants, more small group work, and a more practical orientation. “More applied, too vague, did not seem to help refine the NS one; I was very unclear what sessions were trying to achieve.” Another person echoed this view regarding the purpose of the event, “I did not have clarity around the 2 day consultation.” One person stated that s/he “would have liked to actually experience the IDM.” Another indicated a preference to “actually work with the IDM model using small groups and different scenarios. Hands on changes abstract to concrete.” A similar comment was made regarding the session on the Nova Scotia Framework. “I would have found it more valuable to reflect on the ACT example in small groups with a sum up in the whole group and then reflections by Debbie and Barbara on the congruencies/differences in the two approaches. One person requested a “better review on Thursday a.m. regarding tool [Nova Scotia Framework], how developed. Why those components included?” While some wanted more on the IDM approach, others would have preferred more on the Nova Scotia model. One participant suggested that Thursday evening session could have been omitted. There was one comment on the problems with technology. “Be absolutely sure technology works. Double, triple, quadruple check, and then have back up.” The last area identified within this question response was a request for “more availability of resources to take away, even specific resource lists.” Ten people had no comments in this section as to what could have been done to make the consultation more effective.

Question five dealt with the objectives of the consultation. The table below presents the summarized responses of participants. Here, participants were asked to help us determine how well the Consultation objectives were met. Please indicate how satisfied you felt about the following:

<b>TABLE 2: CONSULTATION OBJECTIVES</b>						
	<b>Very Satisfied</b>	<b>Satisfied</b>	<b>Somewhat Satisfied</b>	<b>Not Satisfied</b>	<b>% Total</b>	<b>n</b>
1) what you learned about the benefits and challenges of a Best Practice tool like the IDM Framework?						
	<b>27%</b>	<b>50%</b>	<b>18%</b>	<b>5%</b>	<b>100%</b>	<b>22</b>
2) identification of insights from the IDM work which can be useful for developing our Framework?						
	<b>24%</b>	<b>43%</b>	<b>29%</b>	<b>4%</b>	<b>100%</b>	<b>21</b>
3) identifying ways to increase the use of the Nova Scotia Best Practices Framework?						
	<b>29%</b>	<b>24%</b>	<b>43%</b>	<b>4%</b>	<b>100%</b>	<b>21</b>
4) identifying insights for further training and support for use of the Nova Scotia Framework?						
	<b>21%</b>	<b>58%</b>	<b>16%</b>	<b>5%</b>	<b>100%</b>	<b>19</b>
5) gaining new ideas for health promotion at the community level						
	<b>5%</b>	<b>43%</b>	<b>43%</b>	<b>9%</b>	<b>100%</b>	<b>21</b>
6) development of a vision and strategy for a Best Practices approach to health promotion in the Western Region of Nova Scotia						
	<b>5%</b>	<b>47%</b>	<b>37%</b>	<b>11%</b>	<b>100%</b>	<b>19</b>

Below the table, respondents were asked for any additional comments. One person rephrased the category responses to read objective “met” or “not met” and indicated that only items 1 and 2 were “met.” This person also commented that coverage of objective 4 was “too fast, not critiqued, no consensus – risks!” Regarding items 3 and 4, a participant who checked “somewhat satisfied” added “the last exercise [Friday afternoon wrap up] helped” Another comment referring to item 3 suggested “ I think that time and commitment will be a challenge.” For item 6, one participant added “Not sure we did this” Two comments reflected dissatisfaction. One person wrote: “expected a strategy related to healthy eating/physical activity to be worked on.” Another simply stated, “it was not applied enough.” One person found that through the Consultation “I realized more how appropriate our framework is for us.” Another person wrote “additional opportunities for training and learning would be helpful.”

Question six pertained to the goal of the Consultation. The goal of the Consultation was: To increase our capacity for adopting a Best Practices approach to health promotion for chronic disease prevention in the Western Region of Nova Scotia through learning from the years of practical and academic experiences of the University of Toronto’s Best Practices team. Participants were asked if they felt this goal was met?

Eight people felt that “yes” the goal was met, six people indicated the goal was either not met or only “somewhat met,” there were three comments of a general nature and five people did not answer this question. Some comments follow:

- Yes, we have moved forward.
- Yes. We’ve explored challenges and what needs to be in place to support the adoption of this approach
- Yes. I feel I could try to use this on my own, and [feel] comfortable knowing there will be further support as tools are developed.
- Somewhat. I can appreciate what they have done but I think ours is just as good/comprehensive. They learned from us as well
- Maybe on a very superficial level, but capacity building does not equal information provision solely
- To some extent. I now know about the NS and IDM framework. Not sure I am fully equipped to totally adopt either into practice
- In some ways. We need decision makers and policy makers here

In question seven, participants were asked to rate the organizational and structural quality of the Consultation. Table 3 below, summarizes the responses. A few additional comments were offered. One person checked “good” for item one on “flow of content,” and added “flexible format. Hard to do but thank you for all those last minute changes.” Regarding item two “information presented”

<b>TABLE 3. ORGANIZATIONAL AND STRUCTURAL QUALITY</b>						
	<b>Very Good</b>	<b>Good</b>	<b>Poor</b>	<b>Very Poor</b>	<b>% Total</b>	<b>n</b>
Flow of content and material from session to session						
	<b>38%</b>	<b>54%</b>	<b>8%</b>		<b>100%</b>	<b>24</b>
Information presented by guests speakers						
	<b>42%</b>	<b>46%</b>	<b>8%</b>	<b>4%</b>	<b>100%</b>	<b>24</b>
Quality of discussions						
	<b>52%</b>	<b>48%</b>			<b>100%</b>	<b>23</b>
Accommodations						
	<b>83%</b>	<b>17%</b>			<b>100%</b>	<b>24</b>
Meals						
	<b>78%</b>	<b>22%</b>			<b>100%</b>	<b>23</b>
Overall impression of the Consultation						
	<b>67%</b>	<b>22%</b>	<b>11%</b>		<b>100%</b>	<b>18</b>

there were two comments: “good info poor delivery;” “too didactic.” A couple of comments were made about the facilities: “water quality not [good]; meals “too good,” as well as feedback on improving the vegetarian options. (These comments have been passed on to White Point.)

In the last question, participants were asked if they had any additional comments? Four people expressed some concerns. These comments addressed issues of “timing,” audio/visual equipment “hard to hear speakers at times,” “lack of organization on Thursday evening,” presentation of material felt like a “lecture on IDM,” and a need for more group work. Many people expressed thanks and once again made note of the things they appreciated about the Consultation.

- Guest speakers added value, were approachable, knowledgeable and nice to chat with.
- Very full 2 days. Great discussion, thoughtful facilitation. Really worked to pull out the ‘gems’ to move us forward
- Well organized. Great meeting place. Flexible organizing committee.... Opportunities for networking at coffee breaks – it was a good time to stretch our legs.
- Thanks. Well organized; flexible conference; NS Framework great piece of work.
- This was fabulous! Thank you for inviting me.

In addition, two requests were made that could assist with continued learning.

- Would be helpful to have direct access to all of the papers/tools/ etc. that everyone uses/ has used/ or feels is helpful.
- Need tools to carry out processes for each step.

# Appendices

- **Appendix I - An Introduction to Best Practices Approaches**
- **Appendix II – Resources for Best Practices**
- **Appendix III – Best Practices in Health Promotion:  
A Manual for Using the IDM Approach**
- **Appendix IV – References for IDM Approach**
- **Appendix V – Hypothetical Example for Using IDM  
Framework**
- **Appendix VI – IDM Evidence Manual**
- **Appendix VII– Consultation Participant List**

# Appendix I

## An Introduction to Best Practices Approaches

In reviewing the literature on “best practice” one finds that there is no established consensus among health promotion practitioners on how to define this concept. Indeed there is considerable debate. Examples of two different yet prominent perspectives are presented below.

One approach locates the concept of “best practices” within a scientific, evidence-based model where considerable weight is given to the design of the intervention and its’ ability to measure standardized outcomes as evidence of effectiveness. Two well recognized examples of this approach are the report from the Ontario Health Resource Centre, *International Best Practices in Heart Health* and the study by Cancer Care Ontario titled *Review of Nutrition Interventions for Cancer Prevention*. Both reports offer examples of interventions which have been screened through a set of health promotion criteria and identified as a model of a “best practice” (scores high on all the criteria) or a “promising practice” (a quality intervention however the design model does not provide sufficient information to evaluate the effectiveness of the initiative). A definition for best practices from this approach is:

*“Best practices for heart health intervention are those which have been evaluated under controlled conditions and found to be effective.”* (International Best Practices in Heart Health, 1998, 4)

A second perspective incorporates evidence based planning within a broad health promotion framework to assist practitioners in developing and critiquing their own work. Using a process of “critical reflection,” this model encourages community level reflection at all stages to develop a “best practice stance” in the work they are doing. An example of this approach is demonstrated by Kahan and Goodstadt working out of the Centre for Health Promotion at the University of Toronto.

*“Best practices in health promotion are those sets of processes and actions that are consistent with health promotion values, theories, evidence, and understanding of the environment, and that are most likely to achieve health promotion goals in a given situation.”* (Kahan & Goodstadt, 2000)

The approach adopted in the Nova Scotia framework draws on both of the perspectives discussed above. We examined some of the established models of “best practices” and adopted standards from this work. However, in an effort to develop a tool for guiding health promotion practitioners and volunteers to take a “best practice” approach at the community level we have also drawn on the work of Kahan and Goodstadt.

The purpose of the Nova Scotia framework is to offer a tool for adopting a best practices approach in health promotion for those working at the community level. **For this framework the definition of best practice is that it is a continual process of reflecting on how to improve and enhance our practice within a comprehensive health promotion framework.** The importance of an evidence based approach as the foundation to build our practice on is acknowledged and incorporated into this framework. As well there is recognition that every intervention must be adapted to the unique circumstances of the setting, the intended population, the resources, and the local players. **In adopting a “process approach” to best practice the critical questions is: How do we continue to improve on and enhance our practice so that we can do our best?**

# Appendix II

## Resources on Best Practices

**ARAI, SUSAN.** (2000) *Best Practices: A New Name for an Old Idea?* – Best Practices Discussion Paper 1. Available on the website of Association of Ontario Health Centres <<http://www.aohc.org>>

**BURKE, RISHIA, SUZANNE JOHNSON, AND SUSAN ARAI.** (2000) *Unpacking Evidence in Health Promotion, Best practices Discussion Paper 2.* Available on the website of Association of Ontario Health Centres. <<http://www.aohc.org>>

**KAHAN, BARBARA. AND GOODSTADT, MICHAEL.** (1998) *An Exploration of Best Practices in Health Promotion.* Health Promotion in Canada, 34(4), 9-11.

**KAHAN, BARBARA. AND GOODSTADT, MICHAEL.** (2001) *The Interactive Domain Model of Best Practices in Health Promotion: Developing and Implementing a Best Practices Approach to Health Promotion.* Health Promotion Practices, 2(1), 43-67.

**KAHAN, BARBARA. AND GOODSTADT, MICHAEL.** (2001) *Best Practices in health promotion: A Manual for Using the Interactive Domain Model (IDM) Approach.* Toronto: Centre for Health Promotion, University of Toronto. Available from the Health Promotion Clearinghouse website: <[www.heart-health.ns.ca/hpc](http://www.heart-health.ns.ca/hpc)>

**KAHAN, BARBARA. AND GOODSTADT, MICHAEL.** (2001) *The Interactive Domain Model Computer Program for Best practices in Health Promotion 2.12.* Centre for Health promotion, University of Toronto. Available on the website of the Health promotion Clearinghouse. <[www.heart-health.ns.ca/hpc](http://www.heart-health.ns.ca/hpc)>

**KAHAN, BARBARA. AND GOODSTADT, MICHAEL.** (2002) *IDM Best Practices in Health Promotion Evidence Manual: Bridging the Gap between Research and Practice.* Centre for Health Promotion, University of Toronto. Available on the website for the Health Promotion Clearinghouse <[www.heart-health.ns.ca/hpc](http://www.heart-health.ns.ca/hpc)>

### Internet Resources:

Best Practices Database <http://www.bestpractices.org/> From the site: “This searchable database contains over 650 proven solutions to the common social, economic and environmental problems of an urbanizing world. It demonstrates the practical ways in which communities, governments and the private sector are working together to eradicate poverty, provide shelter, protect the environment and support economic development... The Best Practices database is produced by UNCHS (Habitat) and The Together Foundation with support of Dubai Municipality, the Best Practices Partners, the Governments of Spain, Switzerland and the UK and the Avina Foundation”.

Ontario Health Promotion E-Bulletin: <<http://www.ophe.ca/ebulletin/>>

- #55.1 Centre for Health Promotion's Best Practices Working Group.
- # 100.1 - Best Practices In Health Promotion
- # 235.1 - An Interdisciplinary Team approach to Best Practices
- #235.2 – An Interdisciplinary Team Approach to Best Practices Development

# Appendix III

## Excerpts from:

**Best Practices in Health Promotion:  
A Manual for Using the Interactive Domain Model (IDM) Approach**

**Barbara Kahan & Michael Goodstadt  
Centre for Health Promotion, University of Toronto  
September, 2001**

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## Included are:

- Interactive Domain Model
- IDM Framework
- IDM suggested best practices guiding principles and criteria
- References for IDM best practices approach

## Interactive Domain Mode

(Kahan & Goodstadt 2001)  
( BP: Best Practices ( HP: Health Promotion

## IDM Framework (Kahan & Goodstadt 2001)

**Step 1: Prepare Foundation for Action re. selected issue**

**Step 2: Make Action & Evaluation Plan**

- *how do we get to where we want to go: who does what, when & how?*

**Step 3: Document Implementation of Plan**

**Step 4: Revise**

1a. health promotion criteria & guiding principles

1b. current situation

- *where are we now?*

1c. picture of ideal situation

- *where do we want to go?*

2a. specific objectives to achieve ideal

2b. resources

2c. challenges

2d. evaluation plan

3a. activities & processes

- *what did we do? how did we do it?*

3b. outcomes of activities & processes

- *what were the results?*

4a. revisions

- *what do we need to change?*

## UNDERPINNINGS

*values*  
*goals*  
*ethics*  
*theories*  
*beliefs*  
*evidence*

## UNDERSTANDING OF ENVIRONMENT

*vision (org/work)*  
*vision (health)*  
*analysis (org/work)*  
*analysis (health)*

## PRACTICE

*processes/activities*  
*org/work response*  
*health response*  
*research/evaluation*

# Interactive Domain Model suggested best practices guiding principles and criteria

(Kahan & Goodstadt 2001)

“Best practices in health promotion” occur when the processes and activities associated with health-related issues, organization/work-related issues, and research and evaluation reflect criteria representing each of the following domains:

- (1) health promotion values/goals/ethics
- (2) health promotion theories & concepts/underlying beliefs & assumptions
- (3) health promotion relevant evidence
- (4) a health promotion understanding of the environment
- (5) health promotion processes and activities.

## UNDERPINNINGS

### values: guiding principles

#### VALUES SHOULD:

- be consistent with and reflect health promotion goals and ethics, theories and beliefs, evidence, understanding of the environment, and practice
- be identified and defined at individual, team, and organizational levels
- identify and constructively address areas of agreement/disagreement
- be reviewed and updated regularly to ensure that they are still appropriate and relevant, and that they are integrated into all aspects of the initiative

### values: concrete criteria

#### OUR HEALTH PROMOTION VALUES INCLUDE:

- **health:** optimal health for all
- **social justice:** equity re: the fair distribution of resources; respect for diversity
- **power sharing:** reduction of power differentials; individual and community empowerment; participation by relevant stakeholders in decision making, partnerships, etc.; individual and community capacity development
- **the environment:** ecological respect & sensitivity
- **enrichment of individual and community life:** authenticity; creativity; critical reflection; joy; meaningfulness; social connectedness

### goals: guiding principles

#### GOALS SHOULD:

- be consistent with and reflect health promotion values and ethics, theories and beliefs, evidence, understanding of the environment, and practice
- be identified in a way that constructively addresses areas of agreement/disagreement
- be identified in a way that constructively addresses areas of agreement/disagreement
- be reviewed and updated regularly to ensure that they are still appropriate and relevant, and that they are integrated into all aspects of the initiative

### goals: concrete criteria

#### OUR HEALTH PROMOTION GOAL IS TO INCREASE OVERALL LEVELS OF:

- health and well-being of communities and individuals
- social justice
- power sharing
- ecological respect & sensitivity
- enriched individual and community life

## ethical principles: guiding principles

### ETHICAL PRINCIPLES SHOULD:

- be consistent with and reflect health promotion values and goals, theories and beliefs, evidence, understanding of the environment, and practice
- be identified and defined on individual, team, and organizational levels
- be identified in a way that constructively addresses areas of agreement/disagreement
- be reviewed and updated regularly to ensure that they are still appropriate and relevant, and that they are integrated into all aspects of the initiative

## ethical principles: concrete criteria

### OUR HEALTH PROMOTION ETHICAL PRINCIPLES INCLUDE THAT WE WILL:

- aim to benefit rather than harm
- think of the consequences of any action re: whom/what might be harmed or benefited
- have an explicit decision-making rationale that is consistent with identified values in cases of conflict (i.e., if what would benefit one might harm another)
- recognize competing ethical considerations and to try to judge these openly, critically and fairly
- always consider whether any action is the best one (i.e. be constantly reflective and critical)
- put principles above self-interest

## theories/concepts: guiding principles

### THEORIES AND CONCEPTS SHOULD:

- be consistent with and reflect health promotion values and ethics, theories and beliefs, evidence, understanding of the environment, and practice
- be identified and defined at individual, team, and organizational levels
- be identified in a way that constructively addresses areas of agreement/disagreement
- be drawn from a wide variety of disciplines
- be appropriate to the level of analysis and intervention—i.e., individual, immediate environments, & social structures
- be used in an integrated way
- be used at each stage of the practice—i.e., in planning, implementation & evaluation
- contribute to understanding the nature and origins of issues/problems
- contribute to an understanding of how to respond to issues/problems by bringing about positive change
- evolve according to new insights and/or new evidence
- be reviewed and updated regularly to ensure that they are still appropriate and relevant, and that they are integrated into all aspects of the initiative

## theories/concepts: concrete criteria

### SOME OF THE MAJOR THEORIES/CONCEPTS USED IN HEALTH PROMOTION FOR US TO

### DRAW ON INCLUDE: (EXTRACTED FROM THEORY IN A NUTSHELL, NUTBEAM & HARRIS)

- **INDIVIDUAL:** health belief model; theory of reasoned action (Ajzen & Fishbein); trans-theoretical stages of change model (Prochaska & DiClamente); social learning theory (Bandura)
- **COMMUNITY:** community mobilisation (a combination of “locality development”, “social planning”, and “social action”); diffusion of innovation theory (Rogers)
- **COMMUNICATION:** communication-behaviour change (McGuire); social marketing; intersectoral action model
- **ORGANIZATION:** organizational change (Goodman et al.)
- **PUBLIC POLICY:** ecological framework (Milio); determinants of policy making model (De Leeuw); indicators of policy-making process (Ziglio)

## Our descriptions of key health promotion concepts include:

- **health promotion:** a set of activities designed to achieve optimal health for all by maintaining and enhancing the health of everyone and facilitating individual & collective control over the determinants of health. Its processes are empowering/capacity-building on both individual and group levels and context-sensitive (that is, taking into consideration culture, specific conditions, etc.). Its main objective is to create supportive environments by making multi-level changes (personal, family, organizational, community, physical environment, society-wide systems). It works with other sectors to achieve its goals and objectives. Its concept of health is holistic (i.e., health includes several interdependent domains, and is determined by a number of socio-political and other factors), positive (it is not only the absence of disease, it is a resource for everyday living), and multi-level (the health of individuals, organizations, communities, and society needs to be considered as the levels interact with each other). Its basic values are health, social justice (equity, respect for diversity), power sharing, the environment, individual/community enrichment; no health promotion strategy works in isolation—each has strengths and weaknesses, and works most effectively in conjunction with other strategies either as an active component or as a support
- **HEALTH:** a major determinant of quality of life which exists on a continuum ranging from poor to optimal; it can be measured in objective terms (e.g., muscle tone, mental alertness, presence or absence of infection) or in subjective terms (e.g., feeling of being “well” or “healthy”); it extends beyond the physical to include mental, emotional, social, spiritual and other aspects, which are connected; it is affected by a complex interrelationship of many factors including biological, environmental, social, cultural, political, and economic influences, and applies to individuals, communities and populations
- **DETERMINANTS OF HEALTH:** factors that influence health; they work synergistically on individual, community and societal levels; they include income (i.e., individual income, and the degree of income equity in a society), social status, education, power/control, social cohesion/support, nature of social, political and economic environments, and individual health-related behaviour and resilience; it is important not to ignore the “pre-determinants” (i.e., those factors that determine the nature of the determinants in any society—for example, *why* a small or large gap exists between the richest and the poorest sectors of a society)
- **ACHIEVEMENT OF OPTIMAL HEALTH FOR ALL:** it is necessary that: all determinants of health be addressed; all aspects of health (i.e., physical, social, emotional, etc.) be taken into account; individuals have as much control over their own lives as possible within a social/community context (requiring an equitable distribution of wealth & resources), have a holistic and open-minded approach to life; the power structure is consistent with health promotion values; those most directly affected by any issue fully participate in relevant decision-making process; relationships are mutually supportive, beneficial, sensitive, and respectful to the greatest extent possible; change that is consistent with health promotion values occur on individual, group and society-wide levels, through both individual & collective action; the means used are consistent with the desired ends

## underlying beliefs/assumptions: guiding principles

### UNDERLYING BELIEFS/ASSUMPTIONS SHOULD:

- be consistent with and reflect health promotion values, goals and ethics, theories, evidence, understanding of the environment, and practice
- be identified and defined on individual, team, and organizational levels
- be identified in a way that constructively addresses areas of agreement/disagreement
- be reviewed and updated regularly to ensure that they are still appropriate and relevant, and that they are integrated into all aspects of the initiative
- at a minimum, be identified with respect to: health, how society works, how to achieve change (at the individual, organizational, community, societal, etc. levels), how we learn & know, human nature, role of self-interest

## underlying beliefs/assumptions: concrete criteria

### OUR HEALTH PROMOTION UNDERLYING BELIEFS AND ASSUMPTIONS INCLUDE:

- **HEALTH:** is positive, holistic, multi-level, and strongly influenced by the “determinants” of health
- **HOW SOCIETY WORKS:** there is a strong interplay between social/system structures and the individual, and it is not possible to say that one is more formative than the other; while structures have a tremendous impact on individuals, individuals contribute to maintaining and changing structures
- **HOW TO ACHIEVE SOCIAL CHANGE:** the prerequisites for lasting substantial change are: a critical mass of people who share a common vision/goal; belief that fundamental change can occur; belief that collectively people have the innate wisdom and capacity to identify and resolve their own issues; recognition that change will occur only through an intersectoral effort; effective appropriate leadership; ability to analyze a situation honestly, critically, creatively and open-mindedly; ability to think strategically; ability to work in good ways with each other; ability to act in ways that are consistent with one’s beliefs in all aspects of one’s life
- **HOW WE LEARN & KNOW:** there is an external reality which everyone experiences, interprets differently, but can (within limits) agree upon; people come to learn, know, understand and integrate their worlds into their lives as a result of: their own experiences, explorations and struggles; through interactions with other people—in this way, everyone has expertise and everyone can learn from others
- **HUMAN NATURE:** given the right circumstances, the majority of people are basically good; collectively, people have the innate capacity to identify and resolve the issues facing them
- **ROLE OF SELF-INTEREST:** ultimately, our true self-interest lies: in working co-operatively, sharing with each other, and supporting each other; emphasizing the intangibles such as friendship, rather than material goods (beyond meeting one’s basic needs for food and shelter)

## evidence: guiding principles

### RE: THE FOUNDATIONS OF EVIDENCE, EVIDENCE SHOULD BE:

- consistent with and reflect health promotion values, goals, ethics, theories, underlying beliefs, understanding of the environment, and practice
- identified and defined on individual, team, and organizational levels
- be identified in a way that constructively addresses areas of agreement/disagreement

### RE: THE SOURCES OF EVIDENCE, EVIDENCE SHOULD:

- be derived from sources that include all key stakeholders and relevant key informants
- be drawn from sources internal and external to the particular initiative
- include results/outcomes related to past and current practice
- collect data using a combination of quantitative and qualitative methods

### RE: THE NATURE OF EVIDENCE, EVIDENCE SHOULD:

- transcend information supporting conventional wisdom (i.e., include information supporting new or non-mainstream ideas as well as information contradicting generally accepted ideas)
- be high quality (i.e., based on accurate data, produced by methods appropriate to the question, includes processes to outcomes, uses both quantitative and qualitative perspectives)
- be qualitative and quantitative, subjective and objective—used in a complementary fashion
- be appropriate to the specific issue, setting, etc.
- include the relationship between results/outcomes and processes

### RE: THE USE OF EVIDENCE, EVIDENCE SHOULD:

- be used at each stage of practice (i.e., planning, implementation, evaluation, redesigning)
- contribute to continuous learning and knowledge development—that is lead to (a) a broad and complete picture of what is happening, (b) insights into why things happen, and (c) how we might make things happen differently
- be reviewed and updated regularly to ensure that it is still appropriate and relevant, and that it is integrated into all aspects of the initiative
- be used with awareness, clarity, and reflection regarding all factors relevant to decision-making about health promotion practice
- be used to evaluate the processes and outcomes of our initiative on a regular basis
- be used to follow up on the evaluation results and recommendations

**evidence: concrete criteria**

**NOT APPLICABLE (VARIES WITH THE SPECIFIC ISSUE/SITUATION)**

## **UNDERSTANDING OF THE ENVIRONMENT**

**vision: guiding principles**

**VISION OF THE ORGANIZATION/WORK- AND HEALTH-RELATED ENVIRONMENTS SHOULD:**

- be consistent with and reflect health promotion values, goals and ethics, theories and beliefs, evidence, analysis of the environment, and practice
- be identified and defined on individual, team, and organizational levels
- be identified in a way that constructively addresses areas of agreement/disagreement
- be reviewed and updated regularly to ensure that it is still appropriate & relevant, and that it is integrated into all aspects of the initiative

**vision: concrete criteria**

**OUR HEALTH PROMOTION VISION OF OUR ENVIRONMENT INCLUDES:**

- emphasis on a team approach\_life/work tasks are done cooperatively in an atmosphere of trust
- clearly defined roles and responsibilities, policies, processes, procedures
- effective leadership and management along with appropriate and effective accountability
- reasonable expectations
- respect for individuals and groups
- power acknowledged and shared as much as possible in order to reduce power-differentials (e.g. through knowledge/skill sharing and a decision making structure that promotes power-sharing in an appropriate way)
- recognition, appreciation and use of individual and collective capacities, with recognition given to “natural” sources of capacities (such as innate gifts, experience, skills, knowledge)
- adequate resources (including time), and appropriate, effective, and efficient use of available resources
- resources shared on the basis of need
- respect for ecosystem
- motivation for the common good rather than for individual/corporate profit
- critical/constructive thinking, with openness to new ideas and ways of doing things, constructive problem solving, and ongoing evaluation & reflection & learning
- fulfilling and satisfying work
- good physical & psychological working & living conditions including social support, manageable stress levels and pleasure and joy
- recognition that processes and outcomes are integrally related and both are important

**analysis of organization/work and health-related issues:  
guiding principles**

**analysis of organization/work- and health-related issues should identify:**

- priority issues
- which priority issue to address immediately
- relationship of selected issue to health and/or to the organization/work
- the environments within which the selected issue exists with respect to: social, political, and economic systems and structures; psychological and physical conditions
- the etiology of the selected issue
- existing/potential capacities and challenges related to influencing the selected issue
- ways to make use of/enhance current/potential capacities and to address current/potential challenges
- ways to positively influence the selected issue

### **analysis of the organization/work- and health-related environments should:**

- be consistent with and reflect health promotion values, goals and ethics, theories and beliefs, evidence, vision, and practice
- be identified and defined on individual, team, and organizational levels
- be identified in a way that constructively addresses areas of agreement/disagreement
- reviewed and updated regularly to ensure that it is still appropriate & relevant, and that it is integrated into all aspects of the initiative

### **selection of issue should:**

- be based upon appropriate participation by relevant stakeholders
- reflect the influence of the broader determinants of health (including their structural origins)
- give attention to power-related issues and the potential role of empowering strategies

### **the selected issue should:**

- have the potential to be influenced
- be specific
- unite members of the group/organisation/community
- involve partners in a meaningful way in achieving problem solution
- be part of a larger plan or strategy

### **analysis of organization/work and health-related issues: concrete criteria**

**not applicable (varies with the specific issue/situation)**

## **PRACTICE (processes & activities)**

### **practice: guiding principles**

#### **PROCESSES AND ACTIVITIES/STRATEGIES RELATING TO SELECTED ORGANIZATION/WORK-RELATED AND HEALTH-RELATED ISSUES, AND RESEARCH AND EVALUATION, SHOULD:**

- be consistent with and reflect health promotion values, goals and ethics, theories and beliefs, evidence, vision, and analysis
- be identified and defined on individual, team, and organizational levels
- be identified in a way that constructively addresses areas of agreement/disagreement
- be reviewed and updated regularly to ensure that they are still appropriate & relevant, and that they are integrated into all aspects of the initiative
- be ongoing [with respect to evaluation]

#### **PROCESSES AND ACTIVITIES/STRATEGIES SHOULD (AT BOTH INDIVIDUAL AND COLLECTIVE LEVELS):**

- enhance health
- be maximally effective
- be maximally efficient
- support [other] chosen activities and strategies
- empower
- build capacity
- strengthen relationships
- promote participation
- respect differences
- be flexible

**ACTIVITIES SHOULD BE DESIGNED TO RESPOND TO:**

- the selected organization/work-related issues
- the selected health-related issues

**STRATEGIES SHOULD:**

- be used in combination with other strategies rather than individually
- be multi-level (i.e. addressing individuals, immediate environments, and social structures)
- [if a multi-level approach is not possible] be implemented with an awareness of the limitations of a single level approach, and with an appreciation for the importance of the remaining levels
- be revised on an ongoing basis according to changing circumstances and to research and evaluation results

**PROCESSES SHOULD:**

- be clearly identified
- provide appropriate and adequate support for the implementation of activities/strategies

**practice: concrete criteria****OUR HEALTH PROMOTION PROCESSES INCLUDE THOSE DESIGNED TO ASSIST:**

- assessment (of needs and capacities)
- visioning
- planning/revising
- evaluation/reflection
- relationship building
- skill sharing/capacity building
- coordination/cooperation
- decision making
- communication
- documentation
- resource management

**OUR HEALTH PROMOTION ACTIVITIES/STRATEGIES INCLUDE:**

- health education
- health communication
- community change
- organizational change
- policy development
- advocacy
- enabling
- mediation
- intersectoral collaboration
- self-help
- modelling

**OUR HEALTH PROMOTION RESEARCH/EVALUATION ACTIVITIES INCLUDE:**

- identification of issues of concern
- specification of research/evaluation questions
- identification of sources of information
- identification of methods for gathering information
- collection of information/data
- analysis and summary or synthesis of information/data
- identification of recommendations
- dissemination of findings

# Appendix VI

## References for IDM Best Practices Approach

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- **INTERACTIVE DOMAIN MODEL MANUAL:** *Best Practices in Health Promotion: A Manual for Using the Interactive Domain Model (IDM) Approach.* Kahan, B., & Goodstadt, M. (September, 2001). Toronto: Centre for Health Promotion, University of Toronto.
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# Appendix V

## Hypothetical Application of IDM Operational Framework

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### Step 1 (Kahan & Goodstadt 2001)

See the **Suggested IDM best practices criteria and guiding principles** under the section *about the Interactive Domain Model*. This set of criteria is an example that can be used for Step 1a (health promotion criteria and guidelines) of the Framework.

### Steps 1 & 2 (re. values and evidence): Against Breast Cancer

ABC (Against Breast Cancer) was formed a couple of months ago, when over 50 people — women with breast cancer, family members, health professionals, and other concerned citizens — met to address the issue of breast cancer in their community. It was decided the main goals would be prevention of breast cancer and improving quality of life for breast cancer survivors. ABC currently receives no funding from government, corporations, or other organizations; it is dependent on memberships, donations, and volunteer time. There is an elected executive, and no paid staff. At the last meeting of the executive, the executive decided to use the IDM Operational Framework as a planning tool in the identification and implementation of a best practices approach to health promotion in addressing the issue of breast cancer. They set aside one day last month to begin applying the Framework to their initiative. What they accomplished at that time concerning the application of the Framework to “values” and “evidence” is found in the table below.

### Step 1: Foundation

### Step 2: Action & Evaluation Plan

criteria & guiding principles  
current situation  
picture of ideal situation  
achieving the ideal  
resources  
challenges  
evaluation

**VALUES** values agreed upon by the executive group to act as our health promotion criteria:

- health
- social justice
- the individual
- community
- the environment

**our health promotion guiding principles re. values:**

- the whole organization will participate in identifying and defining values
- values are reviewed on a regular basis current values listed by members of the ABC executive:
  - good health
  - quality of life
  - prevention vs. treatment
  - empowerment of women with breast cancer

- self-determination
- respect for different opinions
- accessibility of services for all women
- community participation
- ongoing learning
- being supportive of others
- efficiency
- cost effectiveness
- sustainability

**the only values initially listed by all members were: health, accessibility of services, prevention**

currently there are no processes in place for a regular review of values by the whole membership our values as they ideally apply to the issue of breast cancer (based on health promotion criteria agreed upon by executive group):

- health: increase/enhance health of women with breast cancer; prevent breast cancer in other women; support the health of those who live or work with women with breast cancer (e.g. family members, health professionals)
- the individual: women with breast cancer are treated with respect and dignity; diversity is accepted, appreciated and accommodated for (whether in terms of cultural differences, differences in treatment choices, etc.)
- social justice: ensure that: all women with breast cancer have equitable access to services by addressing barriers that affect some women more than others, gender inequities within the health care system affecting women with breast cancer adversely are redressed, women with breast cancer are full participants in making decisions concerning themselves and have as much control over their lives as possible (as long as others are not negatively affected), all women with breast cancer are able to enjoy the highest possible quality of life
- community: positive interactions and links among women with breast cancer, their friends and families, and others are fostered so that social and practical support is available when necessary
- the environment: ensure that all environments surrounding women with breast cancer will be as supportive as possible, that the environment and its associated resources will be respected as much as possible when addressing breast cancer issues so that resources will not be wasted or damaged

**ideal processes re. values:**

- the whole membership of ABC will have an opportunity to identify and define ABC's values
- these values will be reviewed regularly to make sure we still agree with them and to make sure we are actively integrating them into ABC's work
- we will decide whether to aim for consensus and how to handle disagreements constructively
- there will be a process in place to ensure that the actions we choose reflect our values tasks/activities to meet objective *to have a regular membership review of values:*
- distribute to membership the values drafted by executive
- ask for written or oral feedback
- call a meeting to discuss ABC's values: set a time, book space, send out notices, find someone who is skilled at consensus building and dealing with disagreements constructively to facilitate the meeting
- set up a values committee who will be responsible for organizing processes to ensure ABC's actions reflect values and that values are reviewed regularly
- set a time to further discuss who does what, and timelines
- time (available in small amounts; works best for group if spread out over a longer period)
- meeting space (available: room in local church)
- expertise: one member knows a consultant in organizational development who might be a good facilitator or might be able to recommend one
- volunteers (required): to be on values committee
- desire and commitment to follow through (enthusiastically available): e.g. designing, producing and distributing notice; collecting feedback from members

- set a time to further discuss: available/ additional **resources** required, actions/tasks to attain/use resources, who does what, timelines
- set a time to meet re. identification of challenges likely to present themselves in carrying out actions/ tasks, the actions/tasks to address challenges, who does what, and timelines
  - set a time to meet re. identification of evaluation questions, measurable objectives, sources, methods; actions/tasks for **evaluation**; who does what; timelines

**EVIDENCE evidence should:**

- include results/outcomes of past and current practice (from both the specific project itself and other projects); and the relationship between these results/outcomes and processes
- in content be qualitative and quantitative, and subjective and objective
- derive from ongoing research and evaluation, including individual and group critical reflection
- derive from a variety of methods and sources including key informants and key stakeholders
- contribute to continuous learning and knowledge building
- be reliable, trustworthy, credible
- be appropriate to the issue, setting, etc.
- include information supporting new or non-mainstream ideas as well as evidence that contradicts generally accepted ideas (i.e. not be restricted to that supporting conventional wisdom)
- be reviewed and updated regularly
- experiences of some group members were shared at the initial meeting and recorded; the membership-at-large has been requested to supply written summaries of their experiences and observations (whether in a personal or professional capacity)
- one member has done a literature search on Medline concerning screening issues (e.g. age and frequency for mammograms, breast self exams)
- another member has started collecting material on pros and cons of using tamoxifen as a preventive
- possible sources for demographic information e.g. mortality and morbidity rates were identified
- it was agreed there are many unknowns with respect to breast cancer and in some cases conflicting evidence. The group feels there is a need for more evidence concerning: screening issues; the roles of diet, alcohol, organochlorine compounds, hormone replacement therapy, radiation, lack of exercise, electromagnetic fields in contributing to breast cancer; use of tamoxifen
- we will have a comprehensive set of information including the following:
  - results of activities by groups similar to ABC (locally, nationally, internationally) and what contributed to these results (including processes)
  - basic demographics of people with breast cancer in our area
  - morbidity and mortality statistics according to sub-populations for our area
  - the range of opinion and data concerning breast cancer prevention (including traditional medical approaches and non-traditional complementary or alternative approaches)
  - the feelings, observations, experiences of people directly affected by breast cancer in our area
- the information we gather will be from:
  - women with breast cancer
  - their families and friends
  - professionals involved in breast cancer (e.g. health promotion practitioners, nurses, physicians, radiologists, counselors, etc.)
  - researchers
  - community breast cancer groups
  - others with an interest in breast cancer (e.g. government bureaucrats, politicians, hospital administrators, etc.)
- we will draw on written and oral sources
- before acting on any of the information we collect we will make sure it is appropriate for our area's particular circumstances
- we will also scrutinize it critically to make sure it is reliable (e.g. believable sources, proper methodology, etc.)
- we will make this information readily available to our members and to others who are interested through bi-monthly bulletins

- we will review and update information regularly through an ABC “evidence” committee
- we will evaluate and review our own processes and activities on an ongoing basis, and synthesizing, making available and acting on the results from these evaluations and reviews
- we will conduct comprehensive literature search and review on relevant breast cancer topics
- we will compile required statistics
- we will do a survey key informants and key stakeholders
- we will identify procedures for figuring out which information is appropriate to our area and which information is reliable
- we will produce bi-monthly newsletter which will include column on evidence
- we will design evaluation processes tasks/activities to meet objectives listed in “picture of ideal situation”:
- identify: relevant journals, databases, organizations; key informants, key stakeholders
- identify how to contact them (e.g. phone numbers, web site addresses)
- design collection tools such as interview/survey questions
- review what others have done in terms of criteria for judging which information is appropriate and reliable
- collect, synthesize and analyze data
- organize the newsletter (solicit/write material, input it, lay it out, print it, distribute it, etc.)
- identify and review evaluation options
- set up committees to be responsible for tasks in their areas: e.g. collecting evidence, producing newsletter, evaluating
- set a time to further discuss who does what, and timelines
- volunteers: to be on committees
- skills: library/internet searches, research and evaluation, group, publications
- equipment: computer with internet access, printer, photocopier
- resource centers such as libraries
- people who are willing to take on tasks
- time
- money: for printing newsletter, long distance phone costs, postage, transportation, copying/obtaining material
- cooperation: of key informants, key stakeholders, etc.
- set a time to further discuss which available/ additional supports/ **resources** are required to carry out actions/ tasks, the actions/tasks to attain/use resources, who does what, and timelines
- set a time to meet re. identification of challenges likely to present themselves in carrying out actions/ tasks, the actions/tasks to address challenges, who does what, and timelines
- set a time to meet re. identification of evaluation questions, measurable objectives, sources, methods; actions/tasks for **evaluation**; who does what; timelines

# Appendix VI

## Model for Using Evidence with the IDM Framework

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### What the IDM Evidence Framework looks like

The IDM Evidence Framework in model format is shown on the next page. It has the same pieces as the general IDM shown on the front cover, simply rearranged, illustrating the interactivity of the IDM. The difference between the two is that the more detailed Evidence Framework, which is directed specifically towards the decision making process, highlights evidence and research.

#### **REFERENCE:**

- Goodstadt, Michael and Barbara Kahan (2002) IDM Best practices in Health promotion Evidence manual: Bridging the gap between research and practices. Centre for Health promotion, University of Toronto, pp. 8-9.

# Appendix VII –

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1 Participants of the Consultation were provided with background reading material on the IDM Framework prior to the event. Further information on the components of the IDM Framework can be found in Appendix 3, 4, 5, and 6

