Pilot Testing the Best Practices in Health Promotion Framework

Prepared by Barbara Kahan and Michael Goodstadt for the Centre for Health Promotion, University of Toronto

October, 2000

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BACKGROUND TO THE PILOT TESTING

The pilot testing of the Best Practices in Health Promotion Framework was conceived in the context of the University of Toronto's Centre for Health Promotion's Best Practices Work Group and its ongoing exploration of best practices in health promotion. This Work Group, whose members come from public health units, community health centres, hospitals, community groups, provincial and federal government, academic institutions, and the private sector, was created as the result of an International Symposium on the Effectiveness of Health Promotion organized by the Centre for Health Promotion in June, 1996.

Initially, the Best Practices Work Group focused on understanding the meaning of best practices and identifying the potential benefits and risks of taking a best practices approach to health promotion. Its next step was to undertake a scan of Ontario practitioners' needs and capacities concerning best practices in health promotion. With the development of a conceptual model of best practices in health promotion (the *Interactive Domain Model*), and its related criteria and Operational Framework, the Work Group turned its attention to the operationalization of a best practices approach to health promotion, and the pilot testing of the *IDM* Operational Framework.

Two other organizations, which shared the strong interest in best practices in health promotion, joined with the Work Group as partners in pilot testing the *IDM* Framework. The resulting "best practices partnership" consisted of: the Association of Ontario Health Centres (AOHC), the Ontario Public Health Benchmarking Partnership (OPHB) as represented by the Association of Local Public Health Agencies (alPHa), and the Centre for Health Promotion, University of Toronto (CHP). The AOHC's Best Practices Steering Committee had previously conducted a clinical practice guidelines survey, focus groups on health promotion practices, principles, and indicators, and produced a discussion paper on the relationship between best practices indicators and guidelines. Likewise, the OPHB had produced *The Benchmarking Tool Kit: A blueprint for public health practice.*

The AOHC and OPHB partners played a major role by recruiting two sites for the pilot-testing: Durham Region Health Department, and East End Community Health Centre. A third site, The Willett Hospital (Paris, Ontario) was recruited independently. All three sites generously volunteered their time and energy to actively participate in the pilot testing.

Funding for the pilot testing was provided to the Centre for Health Promotion by Health Canada, Ontario Region.

OVERVIEW OF THE PILOT TESTING

Time frame

The pilot testing described in this report, including preparation time, took place from September 1999 to beginning of March 2000.

Objectives

The pilot testing was designed to answer the following questions:

1. How does the Interactive Domain Model's Operational Framework work in a real life situation:
   a. in what ways does it work well?
   b. in what ways does it not work well?
   c. in what ways is it helpful?
   d. in what ways is it not helpful?
2. How should the Operational Framework be modified in order to:
   a. make it easier to use?
   b. make it more effective?
3. What is the best way to introduce the Operational Framework to practitioners and facilitate their understanding of it?

These questions were explored by working closely with the three pilot test sites in the application of the Interactive Domain Model Operational Framework: a community health centre, a community hospital, and a public health department. Through a series of workshops, participants at each of the three pilot sites reviewed fundamental health promotion concepts, and were introduced to the Interactive Domain Model and its Operational Framework. Following these hands-on workshops, the pilot test sites applied the Framework to their own or selected projects.

The expectation was that, by following the steps of the Best Practices Framework, each pilot site would have an opportunity to develop, implement and evaluate a Best Practices action plan specific to their group and health-related issues. Specifically, it was hoped each site would:

1. define its own view of health promotion; this included defining health promotion goals and values, theories and beliefs, evidence, and understanding of the environment practitioners work in and health-related issues exist in
2. translate this view of health promotion into concrete terms that would be relevant and appropriate to their own specific group and its selected health-related issues; this would include developing their own set of criteria for Best Practices in health promotion
3. practise health promotion in such a way that the processes and actions relating to the group, its selected health-related issues, the creation of supportive environments, and research and evaluation would be consistent with the group's own (health promotion-defined) goals and values, theories and beliefs, evidence, and understanding of the environment.

Selection of sites

Criteria for selection and involvement of the pilot sites were:

1. that there was at least one team in the organisation/institution that (1) was addressing a health promotion issue, and (2) was interested in pursuing a best practices approach to their work
2. that members of this team were willing to spend time in applying and evaluating the Operational Framework to their work
3. that the organizations/institutions be in different geographic locations
4. no prior or minimum knowledge was required concerning health promotion or best practices.

Selection of the pilot sites occurred in the following way:

- *Selection of the community health centre:* AOHC invited all CHCs to submit an application if they were interested in becoming a pilot site — only one application was received.
- *Selection of the public health department:* alPHa invited all public health departments to submit an application if they were interested in becoming a pilot site — again, only one application was received.
- *Selection of the community hospital:* this occurred by word of mouth — someone knew a senior staff person at a hospital who was very interested in participating in the project.

Description of pilot sites

- ***Durham Region Health Department*** is a public health department serving an area that combines both urban and rural populations in southern Ontario. This site was experiencing major organizational change throughout the time of pilot-testing. This team's concern was to develop and implement a "smoke-free cars" campaign in their community; this was a new topic for them, though it was a natural development from their previous involvement in developing a "smoke-free homes" campaign. The site's pilot-testing team was composed of male and female clinical/community staff (i.e., public health nurses). One of the site's managers participated in some of the pilot testing workshops.
- ***East End Community Health Centre*** is a community health centre located in downtown east Toronto. Two teams from this site participated in the pilot testing, both working on issues that were already in progress, namely, heart health and food security. The team's all female staff represented both clinical and non-clinical disciplines; the team also included a board member. The organization's program coordinator worked with both teams throughout the pilot testing.
- ***The Willett Hospital*** is a small community hospital located in a rural area in southern Ontario — this site experienced major organizational change throughout the pilot-testing period. A single team from this site participated in the pilot testing. This team had recently identified teen health as an important issue for the hospital and surrounding community. The site's all-female pilot-testing team was composed of (1) a

senior manager who was responsible for health promotion at the site, (2) clinical and non-clinical staff, and (3) community-outreach volunteers.

Note: in order to maintain confidentiality as much as possible, in the rest of this report sites will be referred to as Pilot Sites A, B, and C, which may or may not correspond to the order listed above. As much as possible, identifying characteristics have been omitted.

Each site had a "lead" person. All pilot sites experienced heavy demands on their time and a drop in numbers participating in the pilot testing between the time of the first workshop and the final evaluation meeting. All sites also experienced "conflicts" of some sort, including: (1) clinical vs. non-clinical; (2) staff vs. volunteer; and (3) among parts of the organizations with respect to their understanding of and support for health promotion. At one site in particular (and perhaps at others) there was a conflict between "thinkers" and "doers." All sites started with differences among team members in their levels and ways of understanding basic concepts such as health, health promotion, and best practices. All experienced difficulties, in different ways, with their selected topics: (1) at one site there were reservations about their issue which had been imposed as a result of government requirements; (2) for another there was lack of enthusiasm due to their issue's apparent focus on lifestyle; and (3) a third site was unclear concerning how to specifically define their issue.

The pilot testing operated under two constraints, namely:

- ***Its short time frame.*** This resulted in limited amounts of time (a) for the facilitators to prepare for the pilot testing, (b) for the facilitators to spend on site, (c) for the site teams to work through the Operational Framework, and (d) for the teams to apply the Operational Framework.
- ***Communication difficulties.*** This resulted in more time than expected being spent making contact with participants and co-ordinating details rather than (a) consulting/supporting the sites, and (b) working on the pilot testing process itself (e.g., refining the Framework).

The process of pilot testing the Operational Framework was developed and implemented primarily by two individuals, with support from the Centre for Health Promotion's Best Practices Work Group, and the contacts at AOHC and alPHA.

METHODS

This section describes how the pilot testing was conducted, and the limitations of the pilot testing.

Steps

1. Preparation

a. Participants answered a set of questions (related to their understanding and knowledge of health, health promotion, and best practices) before reading material about the Framework and before the first workshop.

b. Introductory material was distributed to the pilot sites, with the request that participants read the material as preparation for the first set of workshops. Some participants reviewed the material and others didn't.

2. Introductory workshop

a. The introductory two-day workshop was conducted at each site.
b. The workshop was highly participatory and included a combination of small and large group work and individual work.
c. Discussion points were noted on flip charts.
d. Facilitators took extensive notes; some participants at all three sites also took notes.
e. The introductory workshop was led primarily by the facilitators (with site contacts playing major roles, and with input from the participants); at Site B a portion of one workshop was actively facilitated by one of the participants.
f. The Framework was introduced in an "organic" rather than "linear" fashion through a series of exercises.
g. A workbook and supplementary material were provided for each participant.
h. This workshop covered, through a series of exercises, the following topics:

- introduction to health promotion (omitted at Pilot Site C at the request of site participants; at Pilot Site A a lecture approach was used for this segment of the workshop; at Pilot Site B a participatory approach was used)
- introduction to a best practices approach to health promotion
- introduction to the IDM Operational Framework
- diagnosis phase of the Framework, involving the application of the first three steps of the Framework:
  i. describe the current situation
  ii. identify the health promotion ideal
  iii. apply the ideal to the current situation

3. Follow-up to Introductory Workshop

a. At the end of the first day at each site, one of the facilitators "transcribed" the outcome of discussions into the Framework itself.
b. After delivering the workshop at each site, extensive revisions were made to the workshop design, exercises, and handouts before delivering the workshop at the next site. These revisions were based on participant feedback and facilitator observation. In other words, each site participated in a slightly different workshop.
c. Site A did some follow up work to the first workshop, developing a summary of some of the changes required to make their current situation consistent with the health promotion ideal.

4. Second Workshop

a. Sites A and B participated in a second two-day workshop which covered the following topics:

- Identification of changes needed to make their current situation consistent with the health promotion ideal
- The planning phase of the Framework, involving identification of the following:
  i. actions needed to make changes

ii. existing and additional resources required to implement actions
iii. steps involved in action plan

b. Site C decided to work on their own rather than participate in the planned second workshop. Instead, the equivalent of this workshop was facilitated in-house by the site contact. In addition, a subcommittee of three people at this site worked through the Framework, including identifying changes required to make their current situation consistent with the health promotion ideal. This was presented to the whole team for further clarification. Regular contact was maintained with this site.

5. Follow-up to Second Workshop: Application of the Framework

a. After the workshops, sites worked on their own to complete the Framework as far as possible and to implement the full or partial action plans they had developed during this process. Each site worked in different ways. For example:
   i) Neither Site A nor Site B made modifications to the Framework.
   ii) Site A didn't fill out every box; they felt that the Framework process provided general direction for their thinking.
   iii) Site C worked across rather than down, and at times found it helpful to move back and forth within the Framework; they also made modifications to the Framework according to what made sense to them (for example, they omitted step 2 [ideal/guidelines/criteria], since they felt they had a consensus on this issue; this was also an attempt to reduce redundancies in the Framework).
   iv) Site C, in effect, completed two cycles of the Framework, one cycle resulting in an action plan to address underpinning and internal environmental issues, and the second to implement an action plan addressing health-related issues.

b. This application phase also included a half-day visit from the facilitators which constituted a mid-point review of the implementation phase. In addition, there was ongoing phone contact with the sites (to varying degrees, depending on the site) for feedback and consultation; there were also two meetings of the facilitators and the three sites' contact people.

6. Evaluation/reflection

a. At the end of the funded project's timeline, an evaluation occurred which involved a site visit by the facilitators and written reports by each of the sites.

7. Continuation

a. At the end of the funded part of the project, all three sites decided to continue working with the Framework process and implementing a best practices approach to their work.

Limitations to the pilot testing

There were several limitations to the pilot testing:

- Because of the short time-frame imposed by the funding cycle, the planning and implementation phases were not far enough along to allow for firm conclusions (i.e., whether the benefits or negatives are long-lasting; whether other benefits or negatives would appear further down the road of the process).
- The lack of continuity of the membership of the sites' teams makes it hard to assess impact.

- It was sometimes difficult to know whether all site team members agreed regarding the Framework and the value of the pilot-testing experience, or whether there were differences they didn't feel like expressing.

RESULTS

Teams at all three sites, in spite of the heavy demands on them with respect to their regular work-related activities, spent a great deal of time and energy on the pilot testing process, both in learning about the Interactive Domain Model and its Operational Framework, and in applying them to their work. All three sites found this challenging to do, but ultimately all sites felt that, knowing what they know now, they would still do it again — they felt the results had been worth the effort, and it was worth their while to continue with the Framework application even after the formal end of the pilot testing. There was agreement that the modified Framework would eliminate some of the confusion they experienced; and, in addition, having gone through it once with one issue, doing it again with another issue would be much easier. As one participant commented, "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." Overall, despite its sometimes difficult and stressful parts, the pilot testing seems to have been a positive experience for all three sites.

The results described below are based on a combination of participant feedback through feedback forms, group discussion and individual conversations, and facilitator observation.

General findings

the Interactive Domain Model and Operational Framework

The pilot testing supported the conceptual validity and integrity of the Interactive Domain Model and its Operational Framework. It also confirmed the utility of the Operational Framework, and its applicability in different organizational contexts and to different health-related issues. However, as expected, the pilot testing experience of introducing the concepts of the Model and Framework to participants, and training participants in their use, resulted in the identification of a number of weaknesses or gaps; by addressing these weaknesses and gaps during the pilot testing period, there were significant improvements in:

1. *understanding* of:
   - the role and contributions of the Model's various domains and sub-domains to best practices in health promotion — especially with respect to the "Understanding of the Environment" domain
   - the different ways in which the Framework can be processed — e.g., linearly, organically, cyclically, with modifications
   - the different purposes for which the Framework can be used — e.g., planning, communication
   - factors that facilitate or hinder the Framework's use
   - the Framework's potential impacts, both positive and negative

2. *clarity* concerning:
   - the portrayal of the Model's sub-domains
   - the organization and wording of the Framework
3. the *methods* by which the Model and Framework are:
   - introduced to practitioners
   - used by practitioners

communicating and training re. the Framework

Pilot testing involved the ongoing development, testing and modification of processes and support materials for (a) introducing the Model and Framework, and (b) training people in their application. These communication and training processes and materials were closely related to the challenge of building capacities among participants with respect to:

- their understanding of the meaning of best practices and the factors that affect best practices in health promotion
- their skills in applying best practices in their own work.

With respect to the challenges associated with disseminating the Framework, the pilot testing process resulted in:

- a more usable and effective Framework
- a more effective process for introducing the Framework
- relevant support materials
- a groundwork for further application, and broader testing, of the Framework

Impacts

Pilot testing resulted in a number of significant impacts at each of the three sites. Below is a summary of positive impacts (i.e., how pilot testing the Model and Framework helped) that occurred at **one or more** of the sites.

At the level of participating ***individuals and teams***, there was an increase in:

- awareness, discussion, knowledge, understanding, and skills related to health, health promotion, and best practices in health promotion
- group cohesion, enthusiasm, energy, and common understanding of concepts and terminology
- identification of, and ability to address, work-related issues within the team (e.g., clinical vs. non-clinical perspectives), within their organization (e.g. restructuring), and in their external environment (e.g., lack of funding)
- time spent reflecting on their practices
- positive attitude to research
- creativity (rather than, as one participant stated, "staying stuck in the box")

With respect to the team's ***programs and activities***, pilot-testing resulted in:

- more comprehensive and systematic planning
- greater clarity regarding issues and the underpinnings of practice
- identification of actions and strategies to address issues
- stronger rationales for addressing health-related issues
- increased rigour
- affirmation of quality of current work
- insight into amount of work being done
- stronger programming
- increased networking with other groups/organizations

At the ***organizational*** level, experience with the pilot-testing led to:

- greater awareness of best practices and health promotion issues within the organization
- greater credibility for health promotion within the organization
- adoption of a best practices approach beyond the pilot site team

There were a few instances of ***no*** or ***negative impact***:

- the pilot testing may have been one factor, though not necessarily the most important one, in volunteer disaffection at one site (this situation has since resolved itself positively)
- Site B was unsure about the added value of the Framework regarding their planning, that is, it may not have made a difference (although they felt there were compensating benefits)

Participants also identified potential negative impacts:

- people may use the Framework on only a limited number of occasions (e.g., once a year) rather than continuously
- a health promoter may be designated to implement the Framework alone rather than this being a group process
- an organization could take over and distort the best practices approach
- the lengthy time requirement to work through the Framework may turn people off a reflective planning process

Processes

As indicated earlier, the processes involved in the pilot testing can be divided into four main phases:

1. ***preparation*** (for the workshop and application phases)
2. ***workshops***
3. ***follow up/application*** (to the workshops/of the Framework)
4. ***reflection/evaluation***.

These phases did not necessarily follow each other consecutively, there being considerable overlap among the latter three phases.

preparation

There were many reasons for the preparation phase:

- to increase *familiarity* with health promotion and best practices concepts, and to *reduce variability* among participants regarding concepts, understanding, etc.
- to ensure *realistic expectations* regarding the workshops and Framework application
- to establish *safeguards* against potential pitfalls (e.g., to make sure volunteers didn't feel uncomfortable or unvalued; to make sure appropriate materials were available for guidance)

For a variety of reasons (e.g., short time frame; newness of the Model/Framework and its processes and materials), the preparation phase was not as thorough as might have been desirable.

familiarity. There were variations among site participants in their familiarity with health promotion and best practices concepts. During the preparation phase, participants were asked to review (provided) background material on best practices in health promotion; the workshop experience was easier for those who reviewed the material in advance. Addressing differences in participants' understanding of health promotion resulted in reactions among participants that ranged from boredom ("not learning anything new") to feeling overwhelmed ("too much").

> ***next time:***
> what is the best way to address variations in levels of knowledge and understanding?

expectations. While an attempt was made to clarify what participants should not expect from the workshops, this did not prevent unrealistic expectations.

> ***next time:***
> based on the pilot testing experience, which expectations are realistic and what is the best way to communicate this?

safeguards. While some safeguards were in place to avoid pitfalls during the workshops, less thought was given to safeguards against out-of-workshop events and dynamics. These latter pitfalls included:

- volunteer discomfort at one site
- long lapses of time before working on the Framework application at Site B

In addition, more or different safeguards were required for Site C — participants felt very dissatisfied after their workshop.

> ***next time:***
> which pitfalls are most likely to occur, which safeguards will best avoid which pitfalls, and who should develop them?

workshopping

- Site C participated only in the introductory workshop conducted by the facilitators, preferring, after this, to conduct their own workshops. They felt the introductory

workshop had been repetitious and slow; they expressed feelings of fatigue, being overwhelmed, and confused. Despite its shortcomings, this workshop did provide enough grounding in the Interactive Domain Model and its Operational Framework that Site C participants were able to work on their own after (with regular contact from the facilitators). Site C participants felt positive and upbeat about the subsequent workshops.

- Participants at Sites A and B generally found the workshops with the facilitators helpful and enjoyable and felt that over time things became clearer.
- It is not clear what accounted for the different responses between the sites; possibilities include: (1) differences in levels of preparation, style preferences for facilitation and learning, dynamics between facilitators and participants, team and organizational contexts, and (2) the influence of physical environments (e.g., room size, space, temperature, ambience, and seating).

Workshops can be characterized in terms of four features: *content*, *design*, *facilitation*, and *participation*.

Content

1. Workshop content was fairly consistent at Sites A and B, in that all major aspects of the Model and Framework were covered, as well as health promotion basics.
2. Site C did not participate in the second workshop, and did not cover health promotion concepts in the introductory workshop.
3. Reaction to content varied considerably between and within sites:
   a. Site C felt there was too much theory/philosophy and not enough emphasis on the practical/relevant.
   b. While a few participants at the other two sites indicated similar sentiments, a number enjoyed and valued the more abstract discussion (e.g., regarding ideals and values).
   c. Many participants at Sites A and B felt that re-examining definitions (e.g., of health, etc.) brought them closer to a common understanding and to speaking a common language.

next time:
what is the best way to maintain/encourage participants' interest/energy in the less tangible foundational and abstract pieces, and to increase their understanding of the relevance/importance of these to practice?

Design

1. Workshops were designed with adult learning principles and the adult learning cycle in mind. An attempt was made to start from participants' own experiences and to build on this. A combination of individual, small and large group work was used. Flipcharts were used extensively. Workshop delivery was primarily through participatory exercises.
2. The design changed from site to site, as facilitators used participants' feedback and their own observations to make improvements before conducting the next workshop (and in the case of Site C, after Day 1 and before Day 2 of the same workshop).
3. Design changes were primarily with respect to the exercises, which kept getting simpler and simpler (and some eliminated totally).
4. There were a number of design challenges, particularly with respect to time; the workshops attempted to cover a relatively large amount of material in a relatively short period of time:

a. Site B participants in particular mentioned wishing they'd had more time for activities, analysis, and reflection.
b. Site A would have liked shorter hours/more breaks.

5. Introducing and "unpacking" the nature of the Framework requires a certain amount of repetition, covering the same topics from slightly different perspectives — this resulted in some participants feeling the process was repetitious and slow.
6. Another challenge, not surprisingly, is that what some people like others don't — for example regarding the round-robin approach used in discussions

> ***next time:***
> how much time is required to adequately cover what content? how can the somewhat iterative nature of the Framework be made to seem less repetitious in a workshop context? what is the best way to address differences in personal preferences?

Facilitation

1. The facilitators' philosophy was that participants, whether staff or volunteers, had a wealth of wisdom, knowledge and expertise to contribute to the workshop. Given the newness of the field of best practices, with so much of it still undefined and many questions still unanswered, the facilitators did not feel particularly more "expert" than the participants (all of whom had varied and extensive experience in one or more areas of life in general and work in particular). In a sense, the facilitators were there to learn from the participants, as well as to facilitate the learning of participants.
2. A major handicap to facilitation was the newness of the best practices approach, resulting in few real life experiences to draw on for examples or the knowledge to say definitively rather than speculatively "in this case, it's like this" and "in that case, it's like that."
3. The challenge of co-facilitating (e.g., differing styles and opinions) was either a positive or negative force — negative, especially, when exacerbated by stressful circumstances (i.e., a heavy schedule with short turn-around time for developing/revising workshop exercises and materials).
4. Sites varied in their responses to the facilitation. Sites A and B generally commented very favourably on the facilitation. Site C participants were extremely critical of the facilitation (e.g., they felt the facilitators didn't respond appropriately to questions and didn't give enough guidance). At one site, volunteers felt the presentation level was too high.

> ***next time:***
> at which points, if any, are lectures appropriate? what new ways that have not been tried are there to use participatory exercises? what ways are there to determine in advance which particular facilitating styles will work in a specific situation? how is it possible to encourage participants who want definite "answers" to recognize that they are in a much better position to provide these answers than an outside facilitator who does not know their particular situation very well — that the only appropriate response to a question sometimes is "it depends"?

Participation

1. Almost all participants at Sites A and B participated actively and enthusiastically in the workshops. Participants at Site C also participated actively, but some less enthusiastically than others in the initial introductory workshop; however, enthusiasm levels were high in the subsequent sessions held without the facilitators.
2. There was a decrease in the number of volunteers participating at one site from the first workshop to the second — this was a consequence of complex factors related to their expectations/interests and institutional restructuring.

> ***next time:***
> what is the best way to increase participant initiative/leadership and engagement? in what ways can facilitation by participants be increased?

following up/applying

1. The third phase involved follow up to the workshops and application of the Framework. The aim of the workshops had been to familiarize participants with Model/Framework concepts to the point where they could independently continue a more in depth Framework process after the workshops. This meant that, as far as possible, sites would complete the steps of the Framework, and carry out the action plans they designed as part of the Framework process. In the case of Site C, "follow up and applying" also included revising the Framework to meet their own needs.
2. At Sites A and C, work between and after the workshops was undertaken by individuals or sub-groups of two or three, who then reported on their work back to the whole team. At Site B, work was mostly done by the whole team.
3. At all three sites, there was strong support from senior management for the pilot testing; this, in turn, provided strong support for the follow up and application phase.
4. Working together with other team members was mentioned by all three sites as making the task of follow up and application easier; it also had the benefit of team members getting to know each other better (some of whom otherwise had little contact with each other).
5. The main challenge facing all sites was finding time to work on the Framework, which was more time-consuming than expected. Site B found that not doing its follow up immediately after workshops made it difficult to maintain continuity of focus, understanding and effort.
6. Team-related challenges experienced at all sites included: conflicting schedules, different priorities/perspectives among team members, and changes in team membership resulting in loss of group memory and understanding.
7. At Sites A and B, most of their work specific to the Framework was completed in the workshops, although some organizing of the material was done outside of the workshops. These two sites indicated that the ongoing support from the facilitators was helpful to them.
8. Site B would have preferred more guidance than they received, especially in the form of on-site visits. Site A's contact person particularly noted the importance of the support received from attending meetings with other site contacts and with the Best Practices Work Group. At Site C, participants appreciated the positive role played by their site contact person in pushing the project forward. According to this site's contact, participants generally felt good as they went through the process of follow up/application.

9. At one site, the organization's restructuring process presented both challenges and opportunities for change needed in order to adopt a best practices approach.
10. An important insight emerging from the follow/up application experience is that developing an action plan may involve a two-step process:
    a. first, developing an action plan for the preparatory phase — that is, defining exactly what the issue is, understanding it, and justifying why it is a priority to work on
    b. second, developing an action plan to directly address the selected health-related issue
11. Success in meeting the pilot test's expectations were mixed:
    a. All sites developed a "blueprint" (in varying degrees of detail) that attempted to translate their view of health promotion into concrete terms.
    b. It is unclear (and too soon to determine) whether the sites are now able to practise health promotion in such a way that the processes and actions relating to the sites' selected health-related issues, work/organizational-related issues, and research/evaluation are consistent with their health promotion defined goals and values, theories and beliefs, evidence, and environmental understanding — that is, it is not clear that the sites adequately (i.e., coherently and consistently) related all components of the Framework to each other.
    c. Although it had been hoped that the Framework would have been more fully completed and implemented at all three sites, in retrospect (given the short time frame and the heavy pressures faced by all sites' team members) this was an unrealistic expectation. In addition, as pilot testing progressed, it became clear that working through the Framework is an ongoing iterative process that will never be fully "finished" — as circumstances change, awareness grows, and new issues arise, the content and thinking that goes into the Framework will continually need to be re-examined and modified.

next time:
how is it possible to juggle competing demands and carve out the time required to work on the Framework (sooner as opposed to later)? how can internal team issues be minimized? what is the best/quickest way to check that the Framework is used in the way it is intended, i.e., resulting in all components of the Model/Framework being consistent with each other and in practice reflecting health promotion values, theories, evidence, and understanding of the environment? how can the Framework application be built into busy schedules so that it is an ongoing process?

reflecting/evaluating

1. Reflection/evaluation concerning the Model/Framework, workshops, follow/up application activities, supporting materials, impacts on sites, and working relationships was ongoing from beginning to end of the pilot testing.
2. Reflection/evaluation occurred in a number of different ways, formally and informally, on a regular basis, including:
    a. co-facilitators' discussions with each other
    b. one co-facilitator's journal keeping
    c. one co-facilitator's debriefing with a peer (a member of the Best Practices Work Group)
    d. feedback from participants to co-facilitators through written feedback forms and verbally through workshop "check ins"

e. conversations between site contacts and co-facilitators for mutual reflection/evaluation between and after the workshops
f. discussions among site's team members
g. two meetings with site contacts, where they shared with each other what had been happening at their individual sites
h. a half day set aside for a mid-point review part way through the pilot testing
i. a half day for an end-point evaluation for co-facilitators to obtain input from participants on what had and hadn't worked concerning the pilot testing, and what results participants had observed
j. regular reporting to and feedback from the Best Practices Partners and the Best Practices Work Group

3. The ongoing nature of the reflection/evaluation process meant that many issues that arose through the pilot testing were dealt with immediately (e.g., changes to: Model/Framework, workshop design, workshop materials).
4. Although participants were initially asked to keep a journal of their pilot testing experience (e.g., to record thoughts, impressions, questions), none did so.
5. The reflection/evaluation process resulted in a better understanding of the "developmental stages" that participants experience in learning about and becoming familiar with the Model and Framework.

Tools

The major tools used during the pilot testing were the Interactive Domain Model, its Operational Framework, and supporting materials. All of these were revised on an ongoing basis during the pilot testing on the basis of participant feedback and facilitator observation.

Model/Framework

1. Participants appeared to understand the Model itself fairly readily.
2. One factor that made it easier for participants to grasp and use the Framework was that, in some respects, the Framework is not radically different from other planning tools they employ (e.g., regarding strategic/annual planning).
3. The application of the Model, through its Operational Framework, was challenging in a number of different ways:
   a. It was hard for some participants to see the relevance of the Framework to their specific situation.
   b. Participants reservations of the Framework included: its terminology was unclear, it was too complex/detailed/difficult/redundant/static/formulaic, and it lacked "flow."
   c. In terms of the Framework's usability, some felt that it was cumbersome, and hard to follow and fill in.
   d. Some participants noted, however, that the revised version of the Model and Framework were easier to use; some noted that it became clearer the more it was used.
4. It was suggested that a computer program be developed to assist participants in working with and completing the Framework.

next time:
how can the Framework be simplified without losing essential content? what kind of computer program would be best?

materials

1. Material that was presented to participants included:
   a. a brief introduction to the pilot testing
   b. a detailed background paper explaining the Interactive Domain approach, its Model and Framework
   c. a Best Practices Resource Book containing extensive bibliographies and other relevant information
   d. a facilitator's workbook; and a set of materials for participants containing:
      i. definitions
      ii. the Model and its Operational Framework
      iii. suggested criteria and guidelines, workshop exercises and corresponding worksheets
      iv. background information on health promotion
2. In the middle of the pilot testing an example of a hypothetical organization's application of the Framework (with respect to the sub-domains of "values" and "evidence") was developed and provided to participants.
3. At the suggestion of Site C's contact person, poster size versions of the Model and Framework were printed and posted at subsequent workshop sessions.
4. Sites A and B indicated that they found the provided material helpful, especially the revised versions of Framework and criteria. The major challenge, and most frequent criticism, was the lack of illustrative examples drawn from real life experience.

> ***next time:***
> how can the current material be made more clear? what new material in addition to examples, should be developed? what is the right quantity of material (i.e., which will not make participants feel overwhelmed, but will be comprehensive enough to provide participants with what they need)?

DISCUSSION

We now have a better sense of the answers to the original pilot study questions. Although three sites is a small number to base firm conclusions on, we are safe in concluding that:

1. The Framework's utility varies according to the situation — however, despite pilot sites finding the Framework somewhat cumbersome to use, its application resulted in a number of very positive impacts at all sites.
2. There are a number of ways in which the Framework can be improved (in addition to the modifications that occurred during the pilot testing) to make it easier to use and more effective (e.g., by simplifying it, changing the presentation, and developing new materials).
3. The best way to introduce the Framework to practitioners and facilitate their understanding also varies according to the situation. However, in general, the most effective approach is likely to be one that employs adult learning principles, and that includes participatory hands-on experiences, while taking account of a number of variables that include dynamics among participants and facilitators, timing, and level of support from upper management.

The pilot-testing raised a number of further questions that require examination. We need to examine how we can build on what we have learned through the pilot testing to:

- improve our facilitation of practitioners' understanding of the Framework
- increase the Framework's effectiveness, usability, availability, and accessibility to the broader community
- enhance the potential benefits and minimize the potential negative consequences associated with the Framework
- involve various stakeholders, including program/intervention planners, clinical and non-clinical practitioners, and community members

There are a number of implications arising from the pilot-testing, especially related to participants' suggestions for improving practitioners' process of working through the Framework, including:

- develop a computer-based program that will provide assistance as practitioners go through the process of using the Framework
- provide more examples of how the Framework can be used/implemented — that is, examples relevant to each stage/element of the Framework
- address issues related to time required to understand and implement the Framework
- provide better preparation for practitioners with respect to their expectations concerning the Framework, for example regarding time needed throughout the whole process of becoming familiar with the Framework and working through it

Finally, other implications include the need to:

- conduct a more in-depth process of pilot testing with more sites, a wider range of organizational types, and over a longer time period
- continue to work on building more supports/resources at the broader health promotion level for individual practitioners and organizations to access/use

CONCLUSION

The pilot testing of the newly developed Interactive Domain Model of Best Practices in Health Promotion and its Operational Framework clearly demonstrated that, despite the Model/Framework's current imperfections, it was still able to contribute significantly and positively to the practice of the three sites who participated. Through the pilot testing we now have specific directions for improving the Framework and the way it is introduced to practitioners, and the promise of very significant benefits for health promotion practice, if we continue to improve and apply the Framework. It has been very exciting to be part of such a groundbreaking effort and we look forward to the next stage of the Framework's development.

APPENDIX A: REPORTS FROM PILOT SITES

DURHAM REGION HEALTH DEPARTMENT
BEST PRACTICES REPORT

Description of Local Context

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

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

Results

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

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

Within the working group there is a difference in people's experience and background in health promotion. The focus on the health promotion ideal i.e. criteria, guidelines etc. was beneficial in that it gave all staff in the working group a common understanding of health promotion. This process was very energizing for the group and reaffirming of the work that we do. As a result, the working group has suggested that our program annually review health promotion best practices criteria and guiding principles. As well, we have suggested that the orientation program include information about health promotion principles.

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

Factors That Facilitated and/or Hindered

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

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

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

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

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

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

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

Plans For The Future

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

East End Community Health Centre

East End Community Health Centre

Best Practices Pilot Project

F I N A L R E P O R T

March, 2000

THE CONTEXT

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

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

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

The framework was applied to two of the Centre's strategic priority areas: heart health and food security.

Both of these areas were ones that we were having difficulty with and it was felt that the framework could facilitate a rethinking of the issues related to them and help us move forward.

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

RESULTS TO DATE

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

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

What is difficult to determine, at this point, is how much of this progress was due to the framework itself and how much owed to simply working as a multidisciplinary team in a systematic way. Perhaps a broader piloting of the framework and the benefit of hindsight will enable us to be clearer about this.

HOW THE FRAMEWORK HAS BEEN HELPFUL

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

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

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

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

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

- Our lack of knowledge of the literature/coalitions/what's working in the area of heart health
- The need to work more effectively as a multi-disciplinary team Through this process, we have been able to de-construct why, for example, clinical staff feel their 1:1 work is more valued, recognized &

supported than their involvement in community programming. We have also discussed what *is* appropriate involvement of clinical staff in programming and how is it that we can develop an interdisciplinary team and also are efficient and make the best use of people's skill sets.

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

  The framework hasn't made these issues any less difficult or complex, but it certainly has provided us with a way of defining, and articulating these issues and developing short & long-term strategies to address them. In this way, it is an important capacity-building tool.

ISSUES AND CHALLENGES FOR EECHC IN USING THE FRAMEWORK

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

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

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

D) *Time is one of the major barriers that will discourage some agencies from embarking on this process.* It is ironic in that taking time to do careful and thoughtful planning and having clarity about why we're doing what we're doing, can in the long run actually save us time and help us achieve greater efficiency and effectiveness. However, the reality, as we know, is that people working in the "front line" are completely 'maxed' out. And given this reality, it is important that we find different ways of adapting & using the tool so that it can be used by organizations that don't necessarily have big blocks of time to set aside to do this work.

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

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

framework our own, the experience became increasingly energizing and productive.

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

FUTURE DIRECTIONS

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

The Willett Hospital

The Willett Hospital

Best Practices Project Report

Description of the Local Context

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

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

Over the last 18 months, The Willett Hospital and Brantford General Hospital have come together as the Brant Community HealthCare System. Many of existing programmes and services are being integrated. In the new system, The Willett has a newly appointed Vice President of Community Integration with responsibility for developing Primary Health Care Services.

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

RESULTS

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

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

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

It became obvious during our work on this project that considerable work needed to be done at the organizational level to lay a strong foundation of health promotion principles. Timing is opportune as we develop the Primary Health Care portfolio. A framework is now being developed that has health promotion at its heart. Planning will be carried out at the board level, and our goal is to give leadership in the Brant Community Healthcare System as a health promoting hospital.

Factors that Facilitated and/or hindered

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

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

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

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

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

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

Plans for the Future

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

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

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