

**Applying the IDM Interactive Domain
Model (IDM) Best Practices Approach to
Better Health:
*IDM Case Studies***

**Appendix I of *Follow-up to IDM Use and
Impacts*, prepared for the Centre for Health
Promotion, University of Toronto by Barbara Kahan,
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2007**

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Notes

- “IDM” is an acronym for the Interactive Domain Model. “MDI” is an acronym for the Modèle des domaines interactifs, the French language IDM.
- The following case studies illustrate the application of the IDM in various practice settings, from community grass roots groups to large health care institutions. Information about the content of the IDM domains, which varies from organization to organization, is presented. The case studies examine the purpose, process of introduction, and results of using the IDM.
- Profiles, reflections or jottings mentioned in the text refer to monthly features posted on the IDM Best Practices website.
- For more information about the IDM, to download IDM resources, or to view current or archived profiles, reflections or jottings, visit the IDM Best Practices website www.idmbestpractices.ca.
- For French language resources visit www.opc.on.ca/francais/projets/pratiques.htm.

L'ASSOCIATION DES COMMUNAUTÉS FRANCOPHONE DE L'ONTARIO - TORONTO (L'ACFO – TORONTO)

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

- *Using the IDM Model: experience of Association des communautés francophone de l'Ontario – Toronto* (Hélène Roussel, report presented at Best Practices at Home and Abroad, September 2004; included in the *IDM Manual* section Reports on Using the IDM)
- *IDM Experiences of L'ACFO-TO, a Volunteer-Based Organization* (Hélène Roussel, reflection archives, IDM Best Practices website, November 2004)
- *Using the IDM/MDI* (Hélène Roussel, IDM Best Practices website reflection archives, April 2007)
- *Profile of Hélène Roussel* (IDM Best Practices website profile archives, March 2007)
- *Planification Stratégique de l'ACFO-Toronto 2004-2005* (ACFO-TO, 2005)
- *Cadre d'utilisation du MDI – Programme des bâtisseurs de la francophonie torontoise 2006-2007* (ACFO-TO, 2007)
- a series of conversations with Hélène Roussel in January, April and August 2007
- additional written comments by Hélène Roussel in June, July and August 2007

Notes

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

Description

The Issue and its Environment

The degree of power and degree of social inclusion experienced by individuals are strong determinants of health. Although there has been a Francophone presence in Toronto for

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

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

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

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

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

Organizational Environment and Practice

L'ACFO-TO is a regional chapter of a provincial Franco-Ontarian grassroots volunteer-based organization which began in 1922.

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

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

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

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

- **Toronto Francophone Community Builders.** Volunteers will identify and create a database of people who speak French to keep people informed of what is happening in the community. A relationship-building approach will be used, for example with personal invitations to events rather than an ad in the newspaper. This program is close to implementation, with plans to recruit the first 50 builders in fall 2007. Objectives to reduce the gap between the ideal and actual situation will be reviewed and possibly revised.
- **French Bistro.** "This social economy initiative, in addition to raising money to allow L'ACFO-TO to be as independent from funders as possible, will be a visible spot in this city where French speaking people can come to socialise and/or practise their French" with events such as French literature evenings. This project is in the planning phase.
- **Francophone Village.** L'ACFO-TO is lobbying for recognition of the once thriving Francophone village that existed in Toronto: "history has been erased." In addition, work is ongoing to build the current Francophone community where the village was located, for example by encouraging businesses to serve people in French.
- **Community Leadership and Capacity Development.** This program assists volunteers, primarily recent immigrants to Canada, to develop strategic thinking and other leadership skills.
- **Website.** A website, to be launched in fall 2007, "will bring to the forefront Toronto's historical Francophone village and demonstrate virtually many elements that still form today a Francophone village."

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

Values

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

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

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

- **Respect.** "Are we at all times working in a respectful manner?"
- **Employability.** "What we're doing is building the economic capacity of the excluded members of the community, but also becoming an economic value-added for the City."

- **Comprehension.** Comprehension is about understanding issues. “When entering into a program or intervention, is this done with a full understanding of the issue? Is it evidence based? It is also about how open we are at a personal and social level to understand each other’s point of view.”
- **Transformation.** “Is what we’re doing going to offer personal transformation and also community transformation?”
- **Engagement.** “Is the creation of community engagement processes making people happy to be together? Is it creating a true sense of belonging? It is also an acknowledgment that without the community engagement of our valuable volunteers nothing would be possible.”

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

Theories/Beliefs

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

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

Beliefs as of 2004-2005 follow:

- There is no Francophone community in Toronto.
- There are no mistakes, only lessons learned.
- Everyone has something to contribute.
- Being French is value added.
- One-on-one personal contact is important.
- There is a lack of French services.
- It is important to stand up as Francophones.
- It costs dearly to be a Francophone group.

- Francophones are a closed group which is difficult to join.
- It isn't always necessary to have money to implement projects

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

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

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

Evidence

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

Using the IDM/MDI

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

Process

L'ACFO-TO uses the questions inherent in the IDM/MDI as a guide and "reference tool at each committee meeting. It is a work in progress and a very organic working tool as far as we are concerned." For example, "With the MDI we're always asking ourselves what's

going on with the internal and external environments.” Other IDM/MDI questions are, “Where are we at, where do we want to go ideally. This is really fun when you start asking these questions.”

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

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

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

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

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

An example of how the IDM/MDI was used to teach strategic thinking to leadership program participants by choosing a project with immediate relevance to people’s lives follows.

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

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

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

Strengths and Challenges

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

strengths

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

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

The MDI allows people to come to a common reality. For example, if we want to be inclusive - what does it mean to be inclusive, where are we at right now, where do we want to be. It’s okay not to be perfect - but is it okay to not be inclusive for the next two years because we need to develop the expertise, and then in the third year

when we have the capacity we can be more inclusive? We need to discuss all of this...

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

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

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

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

challenges

Challenges of using the IDM/MDI follow.

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

The challenge described in the last point can be addressed through the IDM’s flexibility: “The model allows those who are more reflective to start the process up to the development of the objectives, and from there the action oriented people can finalise the process by creating the action plan which is basically the second and third parts of the

model. This way the action oriented people can participate fully in the planning process and integrate their action with the foundation of part 1.”

Results

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

- **Improve communication.** “The definition work we did with the IDM has provided the base to present our work in the community.” In addition, “We used it to successfully disseminate information within the organization, give us an overall visual glance, and develop a common language.”
- **Increase planning skills.** After using the IDM/MDI to plan a wedding, most volunteers in the leadership program “said ‘this is like learning how to plan your life – you can use this for anything in life.’ ... It was wonderful making them aware. It’s a tool of teaching.”
- **Increase reflectiveness.** “It has helped us to be strategic, in the sense of being reflective. This reflective process is really part of the model.”
- **Increase group consensus and synergy.** “The whole IDM process helped bring everyone involved into play. Often in an organization the environmental overview is done by high level managers and the board; it is very positive that the Model allowed everyone to be part of strategic thinking.” In addition, “It’s been to me a very good way of creating synergy within a group – it brings people onto the same wave length and so creates a basis that supports the decisions we’re making.” Using the IDM/MDI also assisted the development of a common understanding of various concepts. For example, regarding inclusion, “We realized that the value means something completely different to different participants. This created very exciting discussions that served the purpose of letting go of our personal agendas around the value and helped us shape organizational values in a consensus manner.”
- **Increase consistency.** “The IDM definitely kept us on track with consistent thinking.” For example, “The IDM made it easier to be consistent when developing overall objectives for each committee.” As a result of using the IDM/MDI, “We have developed questions to use as a checklist, to keep in mind for decisions, things like C for comprehension or understanding – do we understand all the facets for the issues we want to address... Eventually we may develop that a bit more to make it a values policy piece. It gives us a guideline, at any time people can look at this and say. ‘Okay, if all of this on the checklist is not integrated into our ideas, then our ideas will not move forward.’”
- **Develop ethical principles.** “We also spent a lot of time on ethics, which some participants had never thought of. The discussion helped us create awareness around the issue of building a solid organization, with transparency, accountability, etc. as part of its foundation.”
- **Increase rigour.** “Using the MDI to plan our activities has forced us to be a lot more solid in how we approach things, more rigorous.”
- **organizational development.** “Because of the MDI we were able to take an organization that was on an artificial breathing system - it was about to die - and three years later have a complete ‘building community’ concept as a result of working on the foundations etc. The MDI has helped tremendously... It forced us to develop not just a program but organizational objectives as well. We didn’t have the things we needed at

an organizational level, we needed to acquire resources – we have used the MDI a lot to assist us in getting those resources.”

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

IDM/MDI Framework for L'ACFO-TO's "Les Bâisseurs de la Francophonie Torontoise"

	general guidelines	current situation	picture of the ideal	objectives	resources	challenges	evaluation	implement, reflect, document	revis e
<i>underpinnings</i>									
Values	Brotherhood, respect for others, mutual support, valuing various francophone cultures, solidarity, collaboration	Excellent	Improve collaboration and independent team work	Create a working group reporting to the ACFO administrative council by way of an activity report. Monthly meetings. Name a person responsible for follow-up and program evaluation. Assign program tasks.	Involvement agreement. Volunteer.	Creation of a feeling of membership and long term commitment to volunteering.	Evaluation of the volunteers' behaviours.	Values are discussed and reinforced regularly.	
Goals	Promote visibility, use of French services	Nothing done. Starting point.	The first team of volunteers will be formed and will be ready to address the goals.	Development and adoption of policies for the management of volunteers. Application of policies in the management of the volunteers / recruitment, selection, motivation, training, supervision, évaluation.	Translators for the policy. Discussion about the policy. Compiling existing volunteer management tools and discuss their pertinence.	Having a team of volunteers set up a volunteer management operational structure for the program	Evaluate the increase in French language services visibility among francophones recruited by our ambassadors	3 specific volunteer teams will be created, volunteer management committee and electronic newsletter, database committee, promotion and advertising sales committee	
Ethical Principles	Information sharing, zero tolerance for harassment, open to culturally diverse behaviours as long as they do not infringe the law	Excellent situation in the group.	Apply these principles to the implementation of the program	Provide training to the volunteers about the zero tolerance for discrimination policy	Research = Identification Harassment situation Identify a trainer who adopts these ethical principles	Consistency in the application of principles Install an evaluation system that verifies the application of principles	Evaluation of the ethical behaviour of the program volunteers who have been recruited by our ambassadors	Insertion of ethical principles in the management and orientation of the volunteers	
Theories	Principles of adult learning. Community development (grassroot).	No adult education. Yes, we apply (grassroot).	Adult learning principles applied in the orientation and training of volunteers.	Development of a volunteer orientation and training manual.	Information networks about what is happening in French in Toronto.	Dissemination of information to various volunteers.	Our volunteers evaluate their orientation in terms of satisfaction, of knowledge gained and teaching approach.		
Beliefs	Information = Power= Mobilization "United we stand".	Beliefs adopted by the actual group.	Making sure that the beliefs transfer is done to other participants to the programme	Define the programs essential and optional criteria vs. beliefs. Educate volunteers about the franco-minority problem vs.	Transfer Marcel's knowledge to a group of	Create knowledge transfer modalities.	Assess the impact of the program on the changes	Reinforce beliefs within the management of	

	general guidelines	current situation	picture of the ideal	objectives	resources	challenges	evaluation	implement, reflect, document	revis e
	"He who seeks finds". French is a value added in Toronto. French speaking population at risk of assimilation. Difficult to create financial partnerships with organizations			beliefs.	trainers.		of beliefs and / or the strengthening of these beliefs.	volunteers.	
Probing issues?	Invisible French-speaking world. Ratio of French-speaking readers / listeners of mass media in comparison with the actual population rate. Limited resources to unite the community.	Mostly personal observations.	Perform a small feasibility study about the consumer behaviours of our French speakers. (?)	Analyze the needs, the interests and the expectations; better understanding of the behaviours of the francophone community. (?)	Feasibility study, expertise.	Find financial resources to fund study.		A study was performed on the inclusion of franco-phones in Toronto. The data will be used to develop our communication strategies.	
understanding of the environment									
Organizational	Working group, interdependent team work. Decisions made by consensus. Power of decision linked to responsibility.	There is a working group in place but not firmly engaged.	Set up a working group. Look at recruitment, motivation and competences	To identify a human resources available after April 1st, to identify required competences. Recruit people with competences.	Everyone's job resume; discuss interests & competencies, description of the committee's tasks.	Have volunteers coordinate volunteer work groups.			
Vision	Full time program coordinator. Work group to support coordinators.	No financing to access a full time coordinator.	Work to obtain the necessary financing for a program coordinator.	Identify method of financing. Write a request for financing. Establish a relationship with the financial backers.	Resource person to assist with funding application. Internet research, Find partners, Membership to Philanthropy association	Find sources of financing. Creates programme self financing possibilities through advertising		A coordinator is in the process of being hired.	
Analysis of the environment	Conduct an analysis of the environment identifying Strengths, Weaknesses, Opportunities, Threats (SWOT analysis).	Strengths: unique idea, responds to the potential need to mobilize French speaking population. Planning of our program.. ACFO's commitment to the program. Danger: lack of long-term investment. Difficult to create financial	Discuss the possibility of transferring knowledge about our idea (« train the trainer »). - Reinforce financial commitment for the projects. Efficient volunteer selection strategy. Efficient strategy for	Announce the existence of our program to other French-speaking Ontario communities. Identify 4-5 networking opportunities.	Develop pamphlets, develop a check list, Media Information, Press release				

	general guidelines	current situation	picture of the ideal	objectives	resources	challenges	evaluation	implement, reflect, document	revis e
		<p>partnerships with organizations. Volunteers burnout.</p> <p>Opportunities: take the pulse of the invisible French-speaking world. Create links and numerous partner-ships. Promote the French-speaking world. Reach those who do not about the existence of the community.</p> <p>Weakness: lack of expertise in management of volunteers, fundraising, database. Limited actual capacity for program management.</p>	<p>volunteer motivation. Creation of partnerships. Evaluation of interest, problems, needs, feelings of membership to "francophonie".</p> <p>Creation of expertise in management of volunteers. Program management capacity. Database management capacity.</p>						
practice									
processes and activities				<p>Knowledge transfer. Follow-up with ACFO program alumni to find out why they are no longer there. Regularly assess motivation. Identify what stimulates us.</p>	<p>Ensure that we communicate effectively.</p>				
address organizational issues				<p>Creation of partnerships vs. recruitment of volunteers and finding francophones</p>	<p>Identify who does what Use volunteers</p>				
address health issues				<p>Reinforce knowledge gained in management of volunteers. Identify expertise in database. Set up data. Maintain the database. Train volunteers on how to use database. Financing Consultant and Equipment.</p>	<p>Marcel is the resource person</p>				

CERIDIAN-LEADE HEALTH

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

- *Defining Best Practices in Health Coaching: From Competencies to Processes* (Catherine Macpherson and Michael Mulvihill, Leade Health, Inc. Ann Arbor, Michigan, June 2006)
- interview with Catherine Macpherson April 2007
- *Profile of Catherine Macpherson* (profile archives, IDM Best Practices website, May 2007)
- *Using the IDM for Health Coaching* (Catherine Macpherson, reflection archives, IDM Best Practices website, May 2007)
- comments during the revision process August 2007

Notes:

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

Background

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

Health Coaching

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

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

coaching since 1997. (The information and quotes in this paragraph are from the white paper *Defining Best Practices in Health Coaching*.)

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

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

Understanding of the Environment

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

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

Values/goals/ethics

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

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

- **Culture:** We facilitate an optimistic and encouraging environment. We seek to bring congruence between our philosophies and our operations.
- **Wellness:** We encourage a balanced healthy lifestyle.
- **Philanthropy:** We support local health-related charities and encourage volunteer service.

Theories

The organization's key theories follow:

- Transtheoretical model
- Carl Rogers' client-centered approach to behaviour change
- Motivational interviewing
- Appreciative inquiry
- Reflective listening
- Decisional balance
- Values exploration
- Self-efficacy
- Positive psychology
- Solution-oriented therapy
- Reality therapy

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

Evidence

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

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

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

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

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

Using the IDM

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

Process

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

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

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

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

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

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

After working with the whole company we published a white paper on best practices, had some public speaking opportunities, incorporated the best practices

schema we had developed with the IDM into the overall plan for the long term. We will continue to incorporate it into the over all plan for quality assurance.

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

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

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

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

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

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

Strengths and Challenges

Based on Catherine Macpherson’s experience, one of the strengths of the IDM is that it adjusts to the specific circumstances. Another strength is that it transcends the work sphere.

I like the fact that the IDM isn't a one size fits all approach - you can use it to fit your company, what you're doing. It takes into account your own experience...

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

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

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

Results

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

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

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

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

The IDM was great for our organization.

REGINA EARLY LEARNING CENTRE

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

- *Profile of Anne Luke* (IDM Best Practices website profile archives, June 2007)
- *Best practices and early learning three decades later* (Anne Luke, IDM Best Practices website reflection archives, June 2007)
- *The Spiral Dance: Aligning Values, Principles and Beliefs in a Regina Preschool* (Anne Luke, IDM Best Practices website reflection archives, July 2005)
- *TLC³ at the Regina Early Learning Centre 1999-2002: an Evaluation Report* (submitted to Hincks-Dellcrest Institute, prepared by Barbara Kahan, December 2002)

Notes

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

Introduction

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

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

Background

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

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

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

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

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

Description

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

Underpinnings

goals

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

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

values

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

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

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

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

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

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

ethics

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

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

beliefs

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

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

theories

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

- children’s learning theory from Reggio Emilia: Reggio techniques stress importance of children playing an active role in defining their education goals and teachers becoming facilitators to allow children to explore a subject area and to deepen their understanding
- High Scope theory
- adult learning theory: start where people are at, use hands on participatory approach rather than expert approach, etc.
- family literacy theories
- D.A.P. (Developmentally appropriate practices)
- prekindergarten curriculum
- strength-based approach

- constructivist theory: We are just developing an understanding of constructivist theory.

evidence

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

Understanding of the Environment

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

organizational vision

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

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

vision of healthy child development

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

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

analysis of our organizational environment

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

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

analysis of environment for healthy child development

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

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

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

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

Practice

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

activities

Key ELC program activities include:

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

processes

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

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

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

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

Anne Luke sums up the best practices process this way:

I think best practices are a code to live by. Generally it means looking at the context of the whole and aligning what you do with principles and values. From a social justice foundation it means understanding people's history, where they're

coming from, what they're facing, what they have to share and what I have to share too - what we can learn and put into practice and then reflect on. Things don't stay the same, new people come along, we learn from what we do. You constantly have to revisit what you do in light of what we know now - the knowledge base changes. The knowledge changes but the basic principles - respect, mutuality - stay the same.

Results

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

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

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

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

The evaluation's key informant interviews indicated that the ELC's impacts on the broader community included "dissemination of knowledge and expertise, providing a model for other organizations, coordination with other initiatives, parents with increased skills who go on to participate in other organizations, and an increase in equality between Aboriginal and non-Aboriginal people."

From the perspective of the ELC's founder, "The impact of using a best practices approach on myself is that it has provided a code to live by – a way of being in the world that is

respectful – resulting in impacts that are not always measurable. It’s an alternate way of being and living and seeing.”

TORONTO PUBLIC HEALTH PRACTICE FRAMEWORK

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

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

References

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

Background

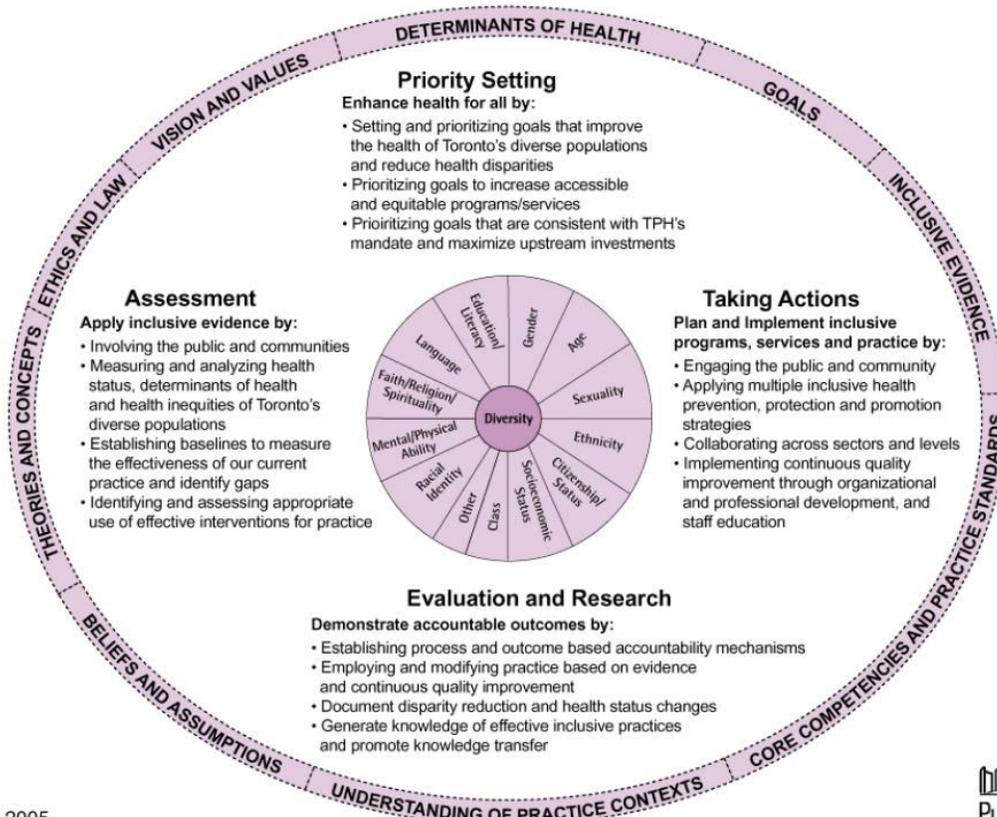
Toronto Public Health (TPH) is one of the largest health units in Canada. In 1997, upon the legislated amalgamation of five municipalities, Toronto became a mega-city with a population of 2.5 million. At the same time, Toronto is one of the key destinations of choice among Canada's immigrant populations.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

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

A detailed review of the IDM showed that its interactive domains are dynamic and can easily be adopted to meet the needs of different organizations. Drawing from the IDM domains of "underpinnings" and "understanding of the environment", the TPHPF made explicit that the health of the public and practices in public health do not exist independent of the physical, social, economic and political environments. The TPHPF merges these two IDM domains and establishes nine subdomains as the foundational underpinnings of practice: goals, vision and values, beliefs and assumptions, ethics and

law, determinants of health, theories and concepts, understanding of practice context, inclusive evidence, and core competence and practice standards. These underpinnings constitute a common ground of practice for all TPH members and staff across all programs and services.

Toronto Public Health Practice Framework (Detailed)



September 2005



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

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

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

Core Domain 1: Diversity Dimensions

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

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

Core Domain 2: Foundation elements

- **Social determinants of health:** Geographic mapping of chlamydia infection shows that chlamydia does not affect young people equally across the city of Toronto. Instead, it identifies a number of priority neighbourhoods with disproportionately high rates of chlamydia. These neighbourhoods share some common characteristics such as low income, less than high school education, and fewer available health/social services, etc.
- **Understanding of practice context:** TPH recognized that existing sexual health clinics did not have the capacity to meet increased demands for sexually transmitted infection (STI) testing; there were long waiting periods at these clinics. At the same time, TPH also recognized that the potential capacity for family physicians and physicians at walk-in clinics to provide sexual health care to youth had not been fully utilized. As a result, TPH chose to focus on family physicians and walk-in-clinics as the Phase I target audience for the social marketing campaign. The goal was to influence physician behaviours to increase proactive STI testing and treatment.
- **Theory & concepts:** Drawing from the framework of health promotion, health communication and other health behavioural change theories, the social marketing workgroups established the need to develop a campaign that is relevant to the reality and experiences of the youth in the priority neighbourhoods. This was achieved through research and audience analysis with both physicians and youth.
- **Inclusive evidence:** To develop a relevant campaign, the workgroup undertook 2 small scale studies – one with 115 Toronto family physicians and one with 49

young women aged 16-24 from the neighbourhoods that had the highest rates of chlamydia. Findings from these two studies were used to guide the development of the campaigns targeting physicians and subsequently targeting youth.

Application of Domain 3: The practice cycle

- **Assessment:** During Sexual Health Redesign, an environmental scan supported by research evidence, current literature, epidemiological data and staff reports were used to assess the sexual health needs of Toronto's diverse populations.
- **Priority setting:** Based on findings in the assessment stage, chlamydia reduction among youth was identified as one of the program priorities and social marketing was adopted as one of the key strategies.
- **Taking actions:** The sexual health staff undertook 2 studies to generate local knowledge to guide the development and implementation of an inclusive and effective social marketing campaign.
 - Generate local and inclusive knowledge (Phase 1): 49 young women were recruited from the clusters of 20 priority neighbourhoods to identify their current knowledge about STIs and chlamydia, influencers of their sexual health, elements of social marketing that appeal to them, etc. Recruiting young women from the priority neighbourhoods generated 'inclusive' knowledge that is critical to the development of programs specific to this population. At the same time, a study with 115 physicians had also provided the campaign with critical information on the physicians' current STI testing practices, constraints and facilitators of testing, and their preferred social marketing vehicles, etc.
 - Community consultation: during the development of the social marketing messages and products, sexual health staff engaged physicians and youth in focus-testing the materials to ensure that these materials would be most effective in reaching the target audiences.
 - External partnership: community physicians and staff from community organizations serving youth were recruited to participate in sub-committees to provide consultation and feedback. In addition, connections were established with other health units that were undertaking similar campaigns to explore potential collaboration
 - Internal partnerships: a collaborative approach was reflected in workgroup memberships made up of family health PHNs, sexual health clinic PHNs, sexually transmitted infection case managers, sexual health educators, health promotion consultants, program evaluator, epidemiologist together to achieve the desire
 - Mentorship: staff of diverse skill sets worked together to facilitate mutual learning through mentorship and shared leadership in different sub-committees.
- **Evaluation & Research:** An evaluation sub-committee was established to integrate an evaluation plan into the action plan.

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

Reflexivity and Continuous Quality Improvement

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

THE WILLET HOSPITAL/BRANT COMMUNITY HEALTHCARE SYSTEM

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

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

Notes

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

Background

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

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

The first IDM project with BCHS was a pilot testing of the IDM and its operational framework from September 1999 to March 2000. The Willet Hospital site in Paris applied

the IDM Framework to the topic of teen health, recently noted by the CWBT “as an important issue for the hospital and surrounding community.” The need to address the issue had been identified in a County Health Status report (Brant County District Health Council), by the Brant County Health Unit, and anecdotally through the Community Well Being Team.

The group participating in the pilot-testing project included the hospital manager responsible for health promotion, clinical and non-clinical staff, and community-outreach volunteers from the CWBT. “We developed two goals, one specifically with regards to teen health and the other determining the needs and capacities of The Willett in relation to teen health (team development, development of a budget, recognition of the need for staff resources, etc.).”

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

The team identified as assets for their work the new health resource centre, the new librarian, desktop access to the internet for most staff, and the movement of the organization “towards a ‘best practices’ approach.” However, “with the integration of three distinct cultures due to amalgamation of three hospitals, it was agreed that it would take time to establish a culture of shared values and beliefs. Barriers and challenges included the fact that not everyone placed the same value on research; ‘lack of time,’ ‘attitude to research,’ and ‘access to research materials’ were also noted.”

The QWL team’s research question was: “How do you foster a culture that facilitates a healthy balance between work and home?” The question arose out of the recognition of the importance of positive work and home environments. However, “Healthcare workers are among the most likely employees to feel overworked...In a hospital setting, QWL is a complex issue consisting of many variables in the work environment. The scope, complexity and unpredictability of the roles and responsibilities of healthcare providers present unique challenges for the implementation of QWL initiatives.”

Project Domains

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

Goals

The Framework listed the following two goals:

- Determine the capacities, resources and attitudes of The Willett Hospital (BCHS) with respect to Teen Health related issues.

- Determine the nature and priorities of Teen Health related issues.

Values

Examples of values included:

- Community & individual needs
- Community participation - important to get people to participate and feel comfortable participating, give their ideas freely, say how they are feeling
- Tolerance
- Emotional health
- Betterment of community
- Respect
- Trust

Beliefs

Some of the key beliefs listed in the Framework included:

- Power/control have a major impact on health.
- Assumption → most people are like us.
- Programs should be grass roots driven not top down.
- Teens feel invalidated.
- Teens are in a box.
- Male/female roles affect individuals.
- People can change.
- Role models are important.

Theories

Examples listed in the Framework of theories to draw on included:

- Organizational theory.
- Change theory.
- Health promotion theory.
- Developmental theory (Piaget).
- Transtheoretical model – stages of change.

Elements of the team's theory of teen health as outlined in the Framework follow.

- 3 levels: individual; family/social; organization
- Determinants of health include: genetics, family supports, economy, etc.
- Influences on teen health: Public policy; Legal system; Economy; Formative years; Religion
- Casual factors of teen health: Self-esteem; Motivation; Peer pressure; Responsibility; Choice
- Complex relationship among casual factors, e.g. teens are judged on: who their friends are; socioeconomic background. This may determine how they are treated in school and how employable they are.
- What is a healthy teen? Eats well; Sexually responsible; Place/role in society; Good self-esteem; Encourage to look towards future, not just present; Feel valued by society; Feel they are contributing; Environment → access to resources they need; Adequate resources, e.g. love/support, non-violence; Family/parents supported in their role

- What makes a difference to teens? Show them we value what they do. Listen. Trust they can make decisions. Facilitate teens in making decisions. Allow them to make mistakes. Develop inner capacities, skills and talents. Resources in community. Appropriate power distribution. Larger issues → inequity (media, food, government policy).

Evidence

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

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

Understanding of the Environment

Examples from the group's analysis of the environment as listed in the Framework follow.

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

Practice

Some of the practice pieces listed in the Framework were:

- Literature search regarding health promotion and rural health underway.
- Key informant interview (high school principal) completed.
- McMaster Year 2 students working with teens at Paris District High School to conduct needs assessments also doing some key informant interviews.
- Incorporate health promotion principles in planning in BCHS system.
- Senior team (vice president, director, planner) working on health promoting hospital development.

- Board retreat planned in April to look at “health promoting hospital”.
- Staff to attend CWBT meetings on rotational basis as part of their jobs.
- Job posted for community program development position.

Using the IDM

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

Process

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

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

A year after the end of the pilot testing period, having “focused primarily on assessing the needs of teens using a teen led process and partners including McMaster University, Grand River District Health Council, Paris District High School, Brant County Public Health Unit, with the ongoing support of the Centre for Health Promotion,” the group was “in the early stages of developing a project to address health needs of rural youth.”

During this period awareness and application of the IDM had extended beyond the original team and the topic of teen health to the BCHS strategic planning process. “The IDM Framework was presented to [the Board of Governors, staff and senior management]

during the planning day. Strategic planning related to this is ongoing.” In addition to “incorporating the IDM in our current project planning initiatives” in 2001 the IDM approach was being incorporated into “quality improvement, and accreditation preparation.” As well, education about the IDM continued. For example, in 2001, “We recently held a joint training session on the IDM framework with the PrimaCare Nurse Practitioner and our own experienced and new Primary Health Care team members.”

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

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

Strengths and Challenges

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

strengths

Based on BCHS’s experience with the IDM, “We believe that the IDM is a values based planning tool and is unique, innovative, and invaluable.” The IDM has potential “in the development of community wide activities...We could use the tool to identify our values and beliefs, evaluate evidence, and develop a coordinated approach in the county. A community wide initiative such as this [to reduce the incidence of falls for seniors], including many partners and strategies could use the tool at a broader project planning level, as well as individual partners using it to develop their particular strategies.”

challenges

In 1999-2000, during the first IDM project, “Internal environmental factors gave us most of our challenges. Over the last six months, restructuring and system integration had a significant impact on staffing resources. There were many pulls on staff time, and we had difficulty finding time to work on the framework between [the facilitators’] visits. For some of our staff, the demands of clinical work drew from their ability to work on the project. As well, the CWBT staff/liaison left our organization, as did some of our volunteers.”

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

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

Results

At the end of the funded pilot testing project in 2000 the site contact listed a number of benefits that resulted from using the IDM. “There has been a significant impact within the organization as a result of this project. Health promotion thinking now has a higher profile in the organization. The project allowed the team to step back, and develop a team vision, values, principles and goals. There was considerable skill enhancement for staff and volunteers.” In addition, “the Community Well Being team (CWBT) began to see itself in a newer role, with a change in focus and approach. The CWBT is planning a retreat, expanding its membership and revising its terms of reference. Despite the complexity of the project, the staff and volunteers have a greater appreciation for what is required in programme development.” Other benefits identified in 2000 included a “broader understanding of health promotion,” a “systematic approach to doing a gap analyses,” increased credibility from “working on an evidence based model,” and recognition of the “considerable work needed to be done at the organizational level to lay a strong foundation of health promotion principles.”

A year later, in 2001, “As a result of the visioning we did during the IDM pilot-testing project, health promotion practices form the foundation of our Department of Primary Health Care Development....The work we did during the initial phase of the IDM project gave an excellent kick-start to the development of a health promoting Primary Health Care Portfolio in an otherwise traditional hospital system. Our team uses the health promotion values and beliefs we developed last year as our underlying principles.”

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

In 2004 the site contact noted that, “In the ‘understanding of the environment’ domain the IDM Framework helped us understand and manage the internal and external enabling and obstructing factors.” Also in 2004 the site contact stated that “the concrete results [of the IDM process] were a rural health initiative with Health Canada funding, to expand CWBT’s to four other rural communities and incorporated evaluation of the strategy. In addition, new funding for diabetes care was used to deliver services in rural communities rather than ‘add-on’ services at the hospital. This initiative was planned jointly by the Department of Ambulatory Care, Primary Healthcare and the CWBT’s.” In addition:

Four years after the beginning of the IDM project, the website — www.bchsys.org — has a new look, which incorporated some of the principles we articulated through our use of the IDM. In particular, the Mission Statement states explicitly that “*We will focus on health promotion.*” Another part of the Mission is “*working in partnership*” and the Vision is “*A healthier community is at the centre of everything we do.*” Values, something else we worked on with the IDM, are “*Trust, Respect, Integrity.*”

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

WOMANKIND ADDICTION SERVICE

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

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

Notes

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

Description

The Issue and its Environment

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

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

operating budget. The other service provided withdrawal management programming for women, was governed by a hospital and had a limited but adequate budget.

Organizational Environment and Activities

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

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

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

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

Currently, Womankind is conducting a process evaluation and making revisions based on results. Womankind's "Taking Steps" pre-treatment program has had "over 2,500 participants in two years; initially we didn't know if we'd created the right program, it's been an amazing response." The pre-treatment program was developed based on evidence and the goals for the program were filtered through the Womankind mission, vision and values. "We are doing an in-depth evaluation now to understand our success."

Womankind's Clients

A brief profile of Womankind's clients, based on information for the period November 2004 to March 2007, follows. During this time period Womankind had over 3,000 residential admissions.

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

Values/Goals/Ethics

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

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

Theories/Beliefs

Some of the key beliefs underlying Womankind's approach follow:

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

Evidence

Evidence-gathering activities include:

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

Using the IDM

Womankind uses the IDM for a number of purposes. “We began using the Interactive Domain Model (IDM) with an interest in better understanding the needs of women who relapsed and what programming would help them. We used the IDM Framework as a stepping stone, a framework in which to conduct our work.” Initially the IDM was used “to frame how we went about planning and incorporating best practices into new programming. Once the amalgamation was approved, the IDM was used to develop a new addiction program and service for women based on current best practices.” The IDM continues to be used for values clarification and “as a filter to make sure organizational practices are meeting its values and mission.” In addition, the IDM is being used to build the organization’s strategic direction.

Process

The IDM was introduced to Women’s Detox and Mary Ellis House staff in 2001 in the preliminary stages of their merger, which would result in Womankind Addiction Service. Staff participated in a workshop, which introduced the IDM and its evidence framework. Staff then worked through the IDM process. The process continued after the project ended under the guidance of Womankind’s manager. “While the IDM Framework clearly delineated the steps we needed to take and what needed to be done, this was invisible to my team mates — but guided my approach to the work we did together.”

The first step in using the Framework was to define Womankind’s clients, values and mission statement. Next, “as part of the Framework process we checked out the environment, gaining an understanding of the political climate related to addictions. We conducted site visits, garnered support, looked for partnerships, etc.... We also explored what kind of evidence meant something to us and what didn’t... This work finished and then the pending amalgamation of the Women’s Detox Centre and Mary Ellis House treatment program became a reality. We were then in a position to create a new service and program using best practices information, and the planning took place within the best practices framework.” The manager developed a PowerPoint presentation for staff, which adapts the IDM to “stepping stones.” Currently the IDM is not used formally at every stage and not all pieces are applied, but IDM concepts continue to guide the program.

The program manager was extremely familiar with the IDM, having been part of the original Best Practices Work Group, which helped develop the model. “I have played with it, I have practised it.” The program manager was also a key reviewer of the IDM

materials. “I have used all of them.” Because of the in-depth working knowledge of the content of the materials, it is no longer necessary to refer to them. Currently it is the IDM Framework itself that is used, with its categories and descriptions. The IDM can be used “throughout Womankind’s career. We are still toddlers at Womankind, still having to make all kinds of changes...”

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

Strengths and Challenges

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

strengths

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

challenges

Challenges of using the IDM follow.

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

Results

Benefits identified by participants of the 2001 project, which introduced the IDM and its evidence framework, included increased skills, confidence and understanding related to

applying best practices. In addition, a “clear process emerged ... which we could use again in the future.” Examples of the insights gained by participants follow.

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

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

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

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