Community Partner Mobilization Strategies and Practices Employed by Public Health Professionals in Ontario's Public Health Units to Prevent Falls among Community-dwelling Older Adults

by

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AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

The prevention of falls among older adults remains a significant and complex problem that cannot be solved without community collaboration, partnership, support, and expertise. Ontario's Public Health Units (PHU) have a key responsibility in preventing falls by mobilizing with the community. While PHU's do already work with community partners, little is known about what community partner mobilization strategies and practices are being employed by PHU professionals to prevent falls among community-dwelling older adults, whether these efforts are productive, which community partners they are working with, who best to work with, and what might be done to strengthen future practices.

This qualitative study explored and described the mobilization strategies and practices employed by public health professionals in Ontario's PHUs in working with their community partners to prevent falls among community-dwelling older adults (65 years of age and older). Although fall prevention among community-dwelling older adults is an important public health issue and is part of a broader range of interventions by PHUs and partners pertaining to injury prevention, the primary focus of this research is on community mobilization.

A purposeful sample of five PHU professionals tasked with preventing falls among community-dwelling older adults, six community partners, and two future potential partners provided rich data through in-depth, semi-structured interviews. Interview questions explored the individuals' knowledge, engagement processes, performance, benefits and challenges of community partner mobilization, and public health professionals' views on capacity building and policy development. Analysis of the data, guided by grounded theory methods, generated multiple themes related to each topic.

Regardless of geographic location, population served, organizational and funding structure, all interviewed PHU professionals reported mobilizing with community partners.

Community partners and future potential partners primarily represented not-for profit organizations, offering a range of services to older adults, although none were falls specific. The majority of participants had heard of the term community mobilization and defined it in terms of several major themes including engaging in action, gathering community support and involvement, establishing community togetherness and partnership, and change. Reducing and preventing falls and having seniors' age in a much healthier way was described as a frequently shared mobilization goal or value among PHU professionals and their partners. However, descriptions of the purposes, community partner mobilization processes, and activities engaged in and the order in which these occurred varied among participants and research sites. Common themes describing activities engaged in included initiation, research and data collection, bringing people together, partnership organization, planning, implementation, and evaluating and reviewing work. Other themes related to roles, strategy performance, benefits, challenges, and views about capacity building were also found.

The findings of this study are discussed considering existing models of community mobilization used in public health practice in other jurisdictions and presents a practical community partner mobilization framework for future application. It advances knowledge by providing evidence of current mobilization practices to prevent falls and a conceptual approach to engage community partners for falls prevention among community-dwelling older adults.

Keywords: community-dwelling older adults; community mobilization; community partner mobilization; community partnership; community engagement; fall prevention; frameworks; practices; public health; strategies

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Chapter 1: Introduction and Overview

The purpose of this dissertation was to describe and identify the mobilization strategies and practices employed by public health professionals in Ontario's Public Health Units (PHUs)[1] working with community partners to prevent falls among community-dwelling older adults. This chapter provides a statement of the problem, describes the project background, and briefly describes the conceptual framework used to inform the research. The chapter concludes with a summary of the introduction and overview of the paper.

1.1 Introduction

The need to prevent falls is a significant public health issue in Canada (Accreditation Canada, Canadian Institute for Health Information [CIHI], & Canadian Patient Safety Institute, 2014; Ministry of Health and Long-Term Care [MOHLTC], 2018; Public Health Agency of Canada [PHAC], 2014). More than half (51%) of injury-related hospitalizations in Canada concerned older adults, with the majority (81%) due to falls (CIHI, 2019). In Ontario, falls are the leading cause of emergency room visits, hospitalization, and death in older adults (Parachute, 2018). Half (50%) of all fall-related hospitalizations in Canadian older adults were the result of a fall that occurred in the home compared to 17% in residential institutions (i.e., long-term, and complex care settings) (PHAC, 2014). One third (35%) of older adults hospitalized for a fall were discharged to continuing care settings in 2008/2009

[1] A list of acronyms used throughout the paper is presented in **Appendix A**.

(Scott, Wagar, & Elliott, 2011). Additionally, experiencing a fall can result in fear of falling, loss of confidence, physical activity, independence, and social engagement (Yardley & Smith, 2002).

With the population aging (Ontario Ministry of Finance, 2018), increasing numbers of older adults are becoming at risk for falls at home and in the community. Consequently, strategies to "Age in Place" or "Age at Home" are being readily implemented across the province to help older adults live independently in their homes and communities for as long as possible (Government of Ontario, 2013). Therefore, preventing falls among community-dwelling older adults is critical for population and community health, as well as individual health, quality of life, and the ability to remain independent. For these reasons, falls in the older adult population has been identified as a key injury prevention topic by the Ministry of Health and Long Term Care (MOHLTC, 2018a). However, because falls in older adults are the result of complex interactions between the social, environmental, and behavioural determinants (World Health Organization [WHO], 2007), prevention at the population level requires the coordinated efforts of multiple agencies, organizations, and stakeholders (Crizzle et al., 2019; Hyndman, 2018; PHAC, 2014).

Public health programs and services involve widespread partnerships with community partners[2] including government, non-governmental, and private organizations (e.g., PHAC, MOHLTC, health teams, local city halls and service divisions, Ontario Public Health Association, teaching institutions, recreation service groups and clubs [e.g., YMCA,

[2] **Appendix B** contains definitions of community partners, public health professionals, and other key terms used throughout the paper.

Kiwanis], community support groups, retailers, workplaces, informal caregivers, etc.). Partnership and collaboration is a foundational principle of the Ontario Public Health Standards [OPHS] (MOHLTC, 2018b). Partnership and collaboration is seen as necessary for optimally achieving overall health goals and societal outcomes through collective contributions in knowledge, resources, delivery of programs and services, and action to address the broad determinants of health (MOHLTC, 2018b, pp. 6-7). According to the OPHS, public health professionals working in Ontario's (PHUs) are expected to take the lead in creating a supportive environment that fosters and meaningfully engages community partners to work together with Public Health to solve and address the public health needs of the community through effective partnership, consultation, collaboration, knowledge exchange, and increased capacity (MOHLTC, 2018b, p. 55-57). Despite this responsibility, PHU professionals working to prevent falls among community-dwelling older adults have received little guidance how to best mobilize with community partners. Better knowledge of mobilizing with community partners has the potential to not only reduce falls among community-dwelling older adults, but the entire population.

1.2 Statement of the Problem

Fall prevention is a complex problem that cannot be solved without community collaboration and partnership. Public health professionals in Ontario's PHUs are responsible for collaborating and partnering with community members to prevent falls among community-dwelling older adults. In order to prevent falls, PHU professionals need strategies and practices that mobilize a range of community partners. Public health

professionals in Ontario's PHUs are already actively employing various strategies and have received some guidance regarding the prevention of falls from the Ontario Ministry of Health and Long-term Care's Injury Prevention Guideline (MOHLTC, 2018a). However, there are significant gaps in knowledge about what PHU professionals are currently doing and how they can best mobilize with community partners. To date, there has been no formal study to document and evaluate current mobilization strategies and practices of partners employed by PHU professionals in Ontario. Consequently, PHU professionals have received no feedback about their own practices or approaches being used by public health professionals working in other PHUs in Ontario, including what strategies are being used, which partners are these strategies reaching, and whether these strategies are working.

1.3 Project Background

This study is part of a larger program of research examining specific collaboration practices used by public health professionals in Ontario's PHUs to engage community partners in the prevention of falls among community-dwelling older adults and to address gaps in knowledge and practice. Previous studies in this program of research (described in **Chapter 2**) have examined the perceived potential and readiness of partners to engage in fall prevention among older adults (Markle-Reid, Dykeman, Reimer, et al., 2015), the collaborative leadership practices of PHU professionals (Markle-Reid, Dykeman, Ploeg, et al., 2017), and the perceived barriers and strategies to implementing falls prevention practices by community service providers (Dykeman, Markle-Reid, Boratto, et al., 2018). Specifically, this study emerges from work completed as a research assistant contributing to

the development of a Locally Driven Collaborative Project [LDCP] research proposal between August and December 2015 and continued involvement in bi-weekly teleconferences with PHU professionals across Ontario and academics at the University of Saskatchewan, Trent University, and University of Waterloo. During the research proposal drafting phase, the Falls Prevention Project Team decided to focus on community partner mobilization as a collaborative community engagement strategy and identified two research priorities.

The first priority was a need to examine the literature to identify evidence-informed community mobilization frameworks which could be used to inform and guide existing practices. With funding and support from Public Health Ontario (PHO) through the LDCP program (Ontario Agency for Health Protection and Promotion/Public Health Ontario [PHO], 2016), the Falls Prevention Project Team initiated a scoping review of the grey and academic literature to identify different evidence-based approaches to community mobilization and assess which of these approaches would be applicable and transferable to the work PHU professionals do with community partners to prevent falls among community-dwelling older adults. With Ontario's health care and public health systems undergoing re-organization (i.e., to create an integrated, patient-centered, community-based health care delivery model; ending hallway medicine) (Bill 74, 2019), the knowledge gained from this review is an important contribution to addressing injury prevention. The review identified several mobilization theories, frameworks, and models; however, found that many lacked sufficient detail and evidence in order to support and guide public health

professionals in their work with community partners on community-based adult injury prevention (Crizzle et al., 2019). Despite the lack of detail and evidence, the Falls LDCP team developed a Logic Model for Mobilizing Partners in Injury Prevention to guide future efforts based on the identification and synthesis of common mobilization approaches. The Logic Model for Mobilizing Partners in Injury Prevention is described in greater detail in **Sections 1.4** and **2.5**.

The second priority was to examine existing mobilization strategies and practices being employed by PHU professionals with community partners to prevent falls in community-dwelling older adults to understand who is mobilizing, what are they currently doing, with whom, what impact these practices are having on partners and the community, and what can be done to strengthen practices. This is the focus of the current research which concentrates on community-dwelling older adults given that the prevention of falls among this group is a Public Health mandate, it was of considerable interest and priority in Ontario's public health units at the time this research was undertaken, and because more hospitalizations are a result of a fall leading to long-term care (PHAC, 2014, Scott et al., 2011). And while fall prevention among community-dwelling older adults is an important public health issue and is part of a broader range of interventions prioritized by PHUs and partners pertaining to injury prevention, the primary focus of this research is on community partner mobilization given its potential widespread applicability to the prevention of falls, injury, and other public health issues.

This research contributes to and overlaps with the larger program of research by exploring and expanding upon knowledge of partnership and collaboration to implement older adult fall prevention strategies between PHU professionals and community service providers and identifying the processes of community partner mobilization. It differs from previous studies in that this research is expected to provide an understanding of and baseline evidence of current PHU professional practices in a particular area. Further, this study is distinct from the larger program of the research as it is the first study to document current PHU professional practices and strategies to collaborate with community partners and to describe these practices and strategies as a macro level process. The findings from this study will be used to inform future research testing community partner mobilization models to strengthen PHU professional practices and prevent falls among community-dwelling older adults. The public health model for community-based falls prevention is complex, comprehensive, multi-faceted and integrated in nature (i.e. consistent with the general guidelines set out in the Ontario Public Health Standards (MOHLTC, 2018b). It is realized that specific interventions may have particular partnership arrangements, these are important foci for future falls prevention intervention research and development, and not addressed in this study.

1.4 Conceptual Framework

To guide the research, a conceptual framework based on community mobilization frameworks and theories applied to public health and the prevention of community-based adult injury was used. A conceptual framework is an illustration of the relationship between

key factors, constructs or study variables (Miles & Huberman, 1994, p.434). The conceptual framework for this study was based on the Logic Model for Mobilizing Community Partners in Injury Prevention developed by the Falls LDCP identifying common approaches to community mobilization from theories, frameworks, and models relevant to injury prevention (Crizzle et al., 2019, p. 15).

The theoretical lens for this study was drawn from the Falls LDCP logic model for several reasons. First, at the time of this study, no published examples of mobilization theories, frameworks, and models applied to communities in Ontario or Canada and/or the prevention of falls were found. Second, the model was developed by summarizing and identifying the key elements of mobilization from several community mobilization theories, models, and frameworks relevant to community-based injury prevention initiatives. Third, the model presents a clear and comprehensive description of the processes necessary to mobilize partners jointly to prevent injuries based on the review and synthesis. Fourth, the Falls LDCP logic model was led and developed in collaboration with PHU professionals tasked with the prevention of falls among community-dwelling older adults in Ontario. As such, the Falls LDCP logic model provides a more theoretically developed and relevant framework for understanding the mobilization strategies and practices PHU professionals use in their work with community partners to prevent falls among community-dwelling older adults in Ontario.

Briefly, the Falls LDCP logic model is a theoretical model of change outlining the assumptions, conditions, resources, and activities required for jointly mobilizing with

community partners to achieve desired outcomes related to community-based injury prevention (**Figure 1**, Crizzle et al., 2019). The model describes the inputs, outputs, outcomes, assumptions, and external factors necessary for mobilizing community partners in injury prevention. The model involves three main phases: *pre-mobilization*, *mobilization*, and *post-mobilization*. *Pre-mobilization* includes partnership start-up (i.e., partnership recruitment, structure, development/skill building, and a united commitment), community assessment (i.e., understanding issue, needs, and assets), and evidence-based strategic planning (i.e., formulating logic models, planning and adaptation). The *mobilization* phase involves establishing ongoing involvement (i.e., continued participation, commitment, leadership, and a collective aim), instrumental supports (i.e., collective resources, public accountability), and a detailed course of action (i.e., planned action, and implementation). *Post-mobilization* consists of evaluation (i.e., planning for and implementing evaluation, and celebrating/improving/sustaining partnership and efforts). A more detailed description of the Falls LDCP logic model is described in **Chapter 2**.

Components of the Falls LDCP logic model were used to formulate the research tools and to detect, explore, and understand PHU professionals' practices for mobilizing community partners into action to prevent falls among community-dwelling older adults in Ontario.

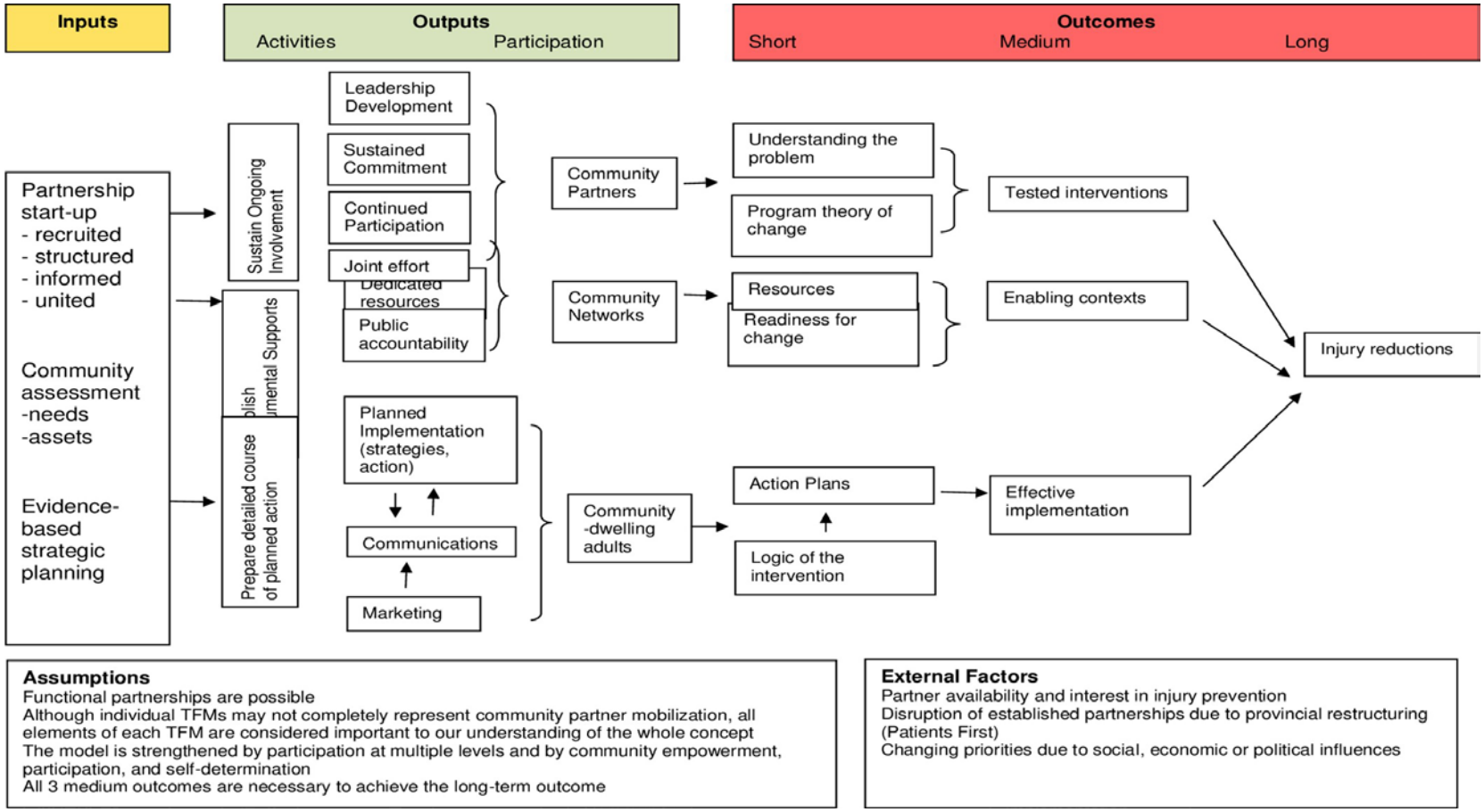

Figure 1.Logic Model: Mobilizing community partners in injury prevention

From "A public health approach to mobilizing community partners for injury prevention: a scoping review," by A. Crizzle et al., 2019, *PLoS ONE, 14(*1), p. 15. Copyright 2019 by Crizzle et al. Reprinted with permission.

1.5 Summary and Overview

This chapter has provided background information on the need to prevent falls among community-dwelling older adults, the importance of PHU professionals to effectively partner and collaborate with the community to prevent falls among community-dwelling older adults, described existing PHU research to understand partnership and collaboration, identified the need for knowledge about mobilization approaches employed by public health professionals working in Ontario's PHUs with community partners, and identified the conceptual framework used to guide the study.

The remainder of this paper is divided into a series of chapters and is organized as follows: **Chapter 2** reviews the literature, providing definitions of the role of Ontario's PHUs in preventing falls among community-dwelling older adult, and effective interventions to prevent falls. This chapter also describes community mobilization, factors that influence community mobilization, and how community mobilization of partners may work to prevent falls among community-dwelling older adults. **Chapter 3** defines the study purpose and significance. **Chapter 4** provides a detailed explanation of the study perspective, qualitative method, design, sampling and recruitment, data collection, and analysis. **Chapter 5** describes the research findings. **Chapter 6** presents the study conclusions, limitations, and recommendations.

Chapter 2: Literature Review

The purpose of this chapter is to situate the current study within the literature on falls among community-dwelling older adults, fall prevention, and community partner mobilization relevant to the context in Ontario. The content is designed to provide an understanding of the background, context, theory and concepts informing the proposed study. The chapter is divided into six main sections. The first two sections describe the significance of falls among community-dwelling older adults, fall risk factors, effective interventions for preventing falls among community-dwelling older adults, and why the community is viewed as an ideal setting for falls prevention efforts. The third section outlines the mandated responsibility of PHU professionals to prevent falls through partnership and collaboration. The fourth and fifth sections describe community mobilization and the Falls LDCP logic model as a community mobilization guide for public health professionals working with community partners. The sixth section describes the core concepts from the literature that will be used to inform and guide the study toward a description of how community partner mobilization is practiced by PHU professionals in order to prevent falls among community-dwelling older adults.

2.1 Falls and Falls among Community-dwelling Older Adults

Falls are a significant public health issue given the impact on the health system and individuals (Accreditation Canada, Canadian Institute for Health Information [CIHI], & Canadian Patient Safety Institute, 2014; MOHLTC, 2018a; PHAC, 2014). In Ontario, falls are

the leading cause of injury-related emergency room visits, hospitalizations, and deaths (Parachute, 2018; Parachute, 2015). Between 2014 and 2016, more than 850,000 emergency room visits to hospitals in Ontario were due to falls, with 85,873 requiring hospitalization (Parachute, 2018). More than 10,000 Ontarian's died as a result of a fall between 2008 and 2012 (Parachute, 2018). In 2010, $2.8 billion was spent treating fall-related injuries in Ontario (Parachute, 2015).

While a fall can occur at any age, adults aged 65 years and older experience a disproportionate number of fall-related injuries and deaths. Each year, approximately 20-30% of adults aged 65 years and older fall at least once (Pearson, St. Arnaud, & Geran, 2014; PHAC, 2014). Half of all falls among older adults in Canada reportedly occur in or near the home and result in more hospitalizations than in residential care homes (PHAC, 2014; Scott et al., 2011). In Ontario, between 2014 and 2016 there were 257,738 fall-related emergency room visits and 61,665 hospitalizations by adults aged 65 years and older, representing more than 30 per cent of fall-related emergency room visits and 70 per cent of hospitalizations for all ages (Parachute, 2018). More than 90 per cent (91.1%, *n* = 9,197) of all fall-related deaths in Ontario between 2008 and 2012 were experienced by adults 65 years of age and older (Parachute, 2018). Beyond 65 years of age, fall-related injury numbers and rates steadily increase with age (Do, Chang, Kuran, & Thompson, 2015; Parachute, 2018; Pearson et al., 2014; PHAC, 2014), with adults aged 80 years of age and older contributing to more than half (51.6%) of fall-related emergency room visits and 64.5 per cent hospitalizations among older adults in Ontario between 2014 and 2016 (Parachute,

2018). The number and rates of fall-related death also increase with advancing age, with adults aged 80 years of age and older contributing to 80.4 per cent of fall-related deaths among older adults in Ontario between 2008 and 2012 (Parachute, 2018).

Gender differences also exist in fall-related injuries and death. Several studies have reported that compared to men aged 65 years and older, women are significantly more likely to report falling in the past year, experience higher rates of fall-related injuries, and hospitalization due to a fall-related injury (Do et al., 2015; Parachute, 2015; Pearson et al., 2014; PHAC, 2014). Among those aged 85 years and older, men are more likely to die whereas women are more likely to be hospitalized as a result of a fall (Parachute, 2015). Women aged 65 years and older have also been found to have a greater perceived risk of falling compared to men (Pearson et al., 2014).

The consequences of falls among older adults can be life changing. Physical injuries may vary in severity and include injuries ranging from scrapes and bruises, sprains or strains, broken and fractured bones, to death (Do et al., 2015; Parachute, 2018; PHAC, 2014). According to the 2018 Ontario Injury Data Report common locations of injuries to the body include the head, hip and thigh, knee and lower leg, and shoulder and upper arm (Parachute, 2018). As a result of physical injury, older adults may require prolonged hospital stays or transitions to a long-term care home which can lead to poor mental health including delirium, fear of falling, loss of autonomy, depression, and social isolation (PHAC, 2014; Yardley & Smith, 2002). In 2008/2009, one third of older adults hospitalized for a fall were discharged to continuing care settings (Scott et al., 2011).

2.1.1 Risk factors for falls

Falls among older adults occur as a result of the complex interplay of multiple risk factors (PHAC, 2014; Speechely, 2011). The World Health Organization (WHO) has developed a risk factor model for falls in older adults which describes the four key risk dimensions of falls and their interactions (**Figure 2**) (WHO, 2007). The four key risk dimensions are biological (e.g., age, gender, race, chronic illness, and declining physical, cognitive, and affective capacities due to ageing), behavioural (e.g., multiple medication use, alcohol consumption, sedentary behaviours, choice of footwear), environmental (e.g., narrow or uneven steps, loose rugs, insufficient lighting, poor building design, poorly maintained sidewalks), and socioeconomic factors (e.g., income, education) (WHO, 2007). Each of these factors is connected to one another and influences the risk for falling. Considerable research has demonstrated that falls among older adults follow predictable risk patterns that are largely preventable (Gillespie et al., 2012) although there are many individual risk factors that contribute to falls (e.g. muscular degeneration, motor control loss, neurological or cognitive impairment, changes in bone health, changes in balance, etc.) that may not be preventable with population level intervention approaches.

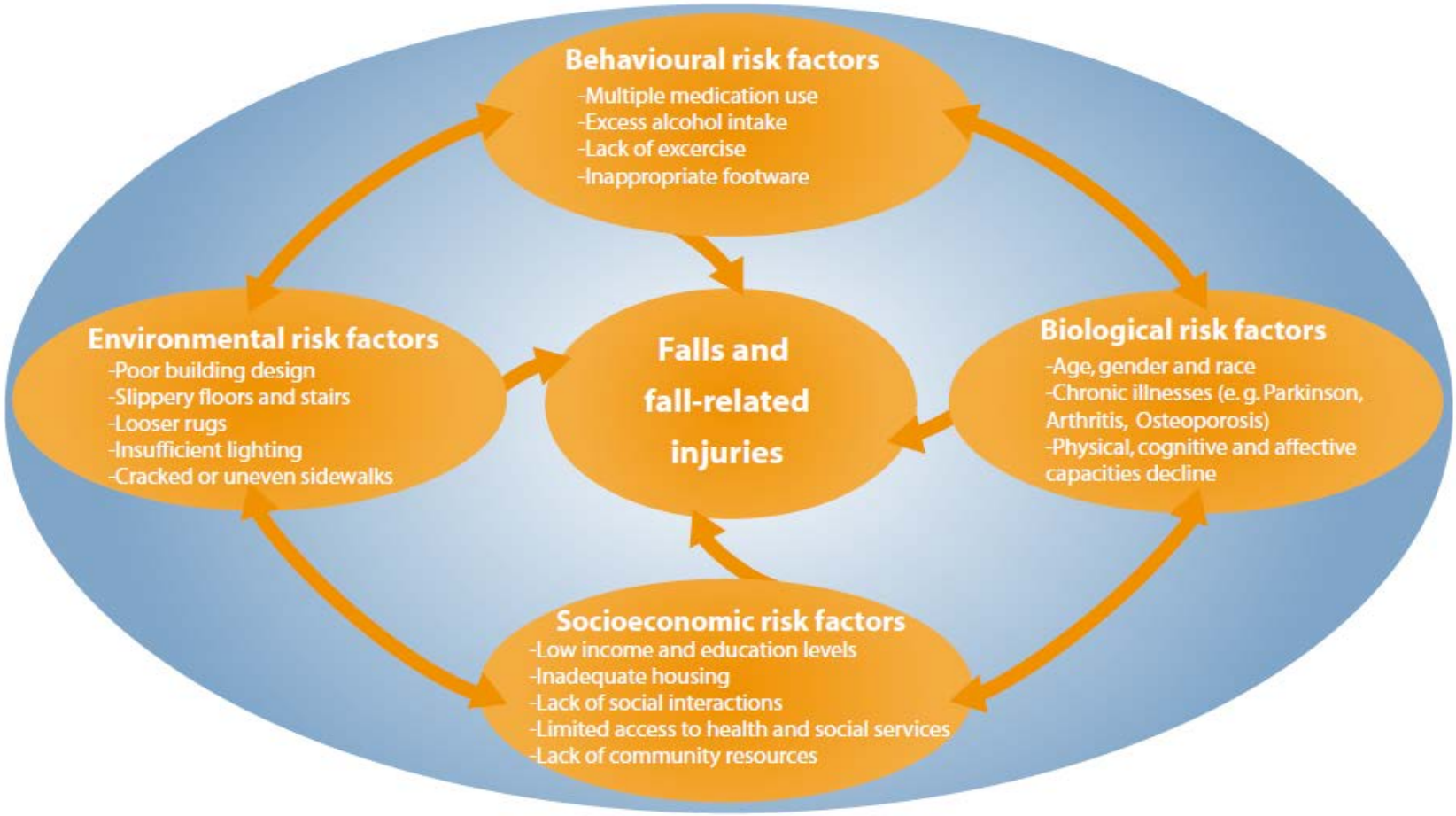

Figure 2. Risk factor model for falls in older age.

Reprinted with permission from *WHO Global Report on Falls Prevention in Older Age, World Health Organization, Magnitude of falls – a worldwide overview*, Figure 3, Page No. 5. Copyright World Health Organization (2007).

2.1.2 Interventions for effectively preventing falls

The prevention of falls requires not only identifying who is at risk, knowledge of the risk factors, but also effective and appropriate interventions targeting these risks. An extensive literature can be found describing and testing interventions that address risk factors contributing to a community-dwelling older adult's likelihood of falling. Several reviews and meta-analyses of these interventions have been conducted (e.g., Chang et al., 2004; Clemson, Mackenzie, Ballinger, Close, & Cumming, 2008; Gillespie et al., 2012; Guo et al., 2014; Stubbs, Brefka, & Denkinger, 2015). **Table 1** provides a synthesized summary of the effectiveness of components of interventions for preventing falls among community-dwelling older adults identified by these reviews by fall risk dimension.

According to these reviews, interventions that have been consistently identified as effectively contributing to both reduction in fall risk and rate among community-dwelling seniors include multifactorial fall risk assessment and management programs delivered in health care settings (e.g., physician's office, hospital, clinic, Specialized Geriatric Service) which provide systematic risk factor screening and individually tailored treatment or referral recommendations (Chang et al., 2004; Gillespie et al., 2012; Stubbs et al., 2015) and group or individual at-home exercise interventions that improve or sustain gait, balance, function, strength, spatial awareness, and general physical fitness (e.g., walking, cycling, aerobic exercises, Tai Chi) (Change et al., 2004; Gillespie et al., 2012; Stubbs et al., 2015).

Table 1 *Summary of the effectiveness of interventions for preventing falls among community-dwelling older adults by fall risk dimension*

Intervention	Description	Notes on effectiveness
Behavioural, Biological, Environmental, Socioeconomic		
Multifactorial fall risk assessment and management programs	Systematic risk factor screening and individually tailored treatment or referral recommendations delivered in a health care setting (e.g., physician's office, hospital, Specialized Geriatric Service).	Reduces fall risk and rate (Chang et al., 2004; Gillespie et al., 2012; Stubbs et al., 2015).
Behavioural		
Education	Targeted provision of educational information about fall risk factors to individuals, groups or communities (e.g., pamphlets, posters, counselling).	Inconclusive evidence for the provision of educational materials alone (Gillespie et al., 2012). Education does not reduce falls (Chang et al., 2004; Stubbs et al., 2015).
Group or at-home exercise interventions	Tailored exercises that address gait, balance, function, strength, and general physical fitness (e.g., walking, cycling, aerobic exercises, Tai Chi).	Certain types of exercise reduce falls risk and rate (Chang et al., 2004; Gillespie et al., 2012; Guo et al., 2014; Stubbs et al., 2015).

Table 1 Continued

Intervention	Description	Notes on effectiveness
Behavioural		
Pharmacotherapy review and modification	A medication review that may lead to the adjustment of medication to reduce total number, dose, replacement, or removal medications that may increase the risk of falls.	Conflicting evidence (Gillespie et al., 2012). Interventions that include gradual withdrawal of medications that increase fall risk effectively reduces fall rate (Gillespie et al., 2012). Similar interventions with physicians may significantly reduce fall risk (Gillespie et al., 2012).
Podiatric treatment	Podiatric assessment with the provision of insoles and tailored foot and ankle exercise. Use of anti-slip footwear for icy conditions.	Multifaceted treatment reduced fall rate (Gillespie et al., 2012). Anti-slip shoe devices for icy conditions reduce fall rate (Gillespie et al., 2012).
Biological		
Surgical treatment	Procedures to address medical conditions that increase the risk of falls (e.g., cataract surgery, cardiac pacemaker implantation).	Interventions effectively reduce the fall rate for certain individuals and conditions. For individuals with carotid sinus hypersensitivity who have received pacemakers, the fall rate but not the risk is effectively reduced (Gillespie et al., 2012). The fall rate for women who receive expedited cataract surgery on the first affected eye is effectively reduced. The second surgery does not reduce fall rate (Gillespie et al., 2012).

Table 1 Continued

Intervention	Description	Notes on effectiveness
Biological		
Vitamin D supplementation	Provision of vitamin supplements with or without calcium supplements or increased consumption of calcium rich foods or reduction of foods inhibiting calcium absorption.	Conflicting evidence (Stubbs et al., 2015). Vitamin D supplementation has been found to reduce the rate of falling when combined with calcium (Gillespie et al., 2012; Guo et al., 2014), and with people who have lower vitamin D blood levels before treatment (Gillespie et al., 2012).
Environmental		
Environmental/home safety assessment and modification	Home or community safety reviews using validated tools followed by modifications that may include the installation or provision of assistive technology and mobility devices.	Conflicting evidence (Stubbs et al., 2015). Intervention has been shown to be effective in reducing the rates of falls and risk of falls, particularly with older adults at higher risk of falling (Clemson et al., 2008; Gillespie et al., 2015) and when delivered by occupational therapists (Gillespie et al., 2012).

In 2017, the Registered Nurses' Association of Ontario [RNAO] (2017) published the fourth edition of the "Clinical Best Practice Guideline Preventing Falls and Reducing Injury from Falls" based on their own review of effective fall prevention interventions. The guideline was designed to be an evidence-based resource for nurses and health-care providers working with adults at-risk of falls and fall-related injuries. Previous versions of the guideline have been used by a variety of other organizations and individuals including Ontario's Public Health Units (RNAO, 2015). Recognizing the need of various stakeholders, the fourth edition, expanded its review to included evidence from studies conducted and applicable to the community (RNAO, 2017, pp. 6-7). The evidence considered in determining the recommendations included meta-analyses, systematic reviews, randomized control trials, quasi-experimental studies, qualitative research, analytic and descriptive studies, and expert opinion. The level and strength of recommendations was determined using the AMSTAR and AGREE II tools. Based on the review, several best practice guidelines were recommended for use in the community including:

- screening individuals for fall risk;
- multifactorial risk assessment when appropriate;
- educating those at-risk and their families in conjunction with other falls prevention interventions;
- implementing a combination of interventions tailored to the individuals and context (e.g., exercise, vitamin D supplementation, hip protectors);
- recommending exercise and physical training interventions to improve strength and balance based on individual abilities and functioning;

- gradual reduction of medications associated with increased risk of falls in collaboration with prescribers;
- referring at-risk individuals for advice on vitamin D supplementation; consider the use of hip protectors to reduce risk of hip fracture among those at risk (e.g., those with osteoporosis, engaging in higher-risk activities);
- ongoing, site-wide organizational training of staff in conjunction with other activities; and
- apply implementation science strategies to promote the adoption of best practices, recognizing barriers and providing supports.

Figure 3 presents a summary of the full list of recommendations and the process to prevent falls and reduce injury.

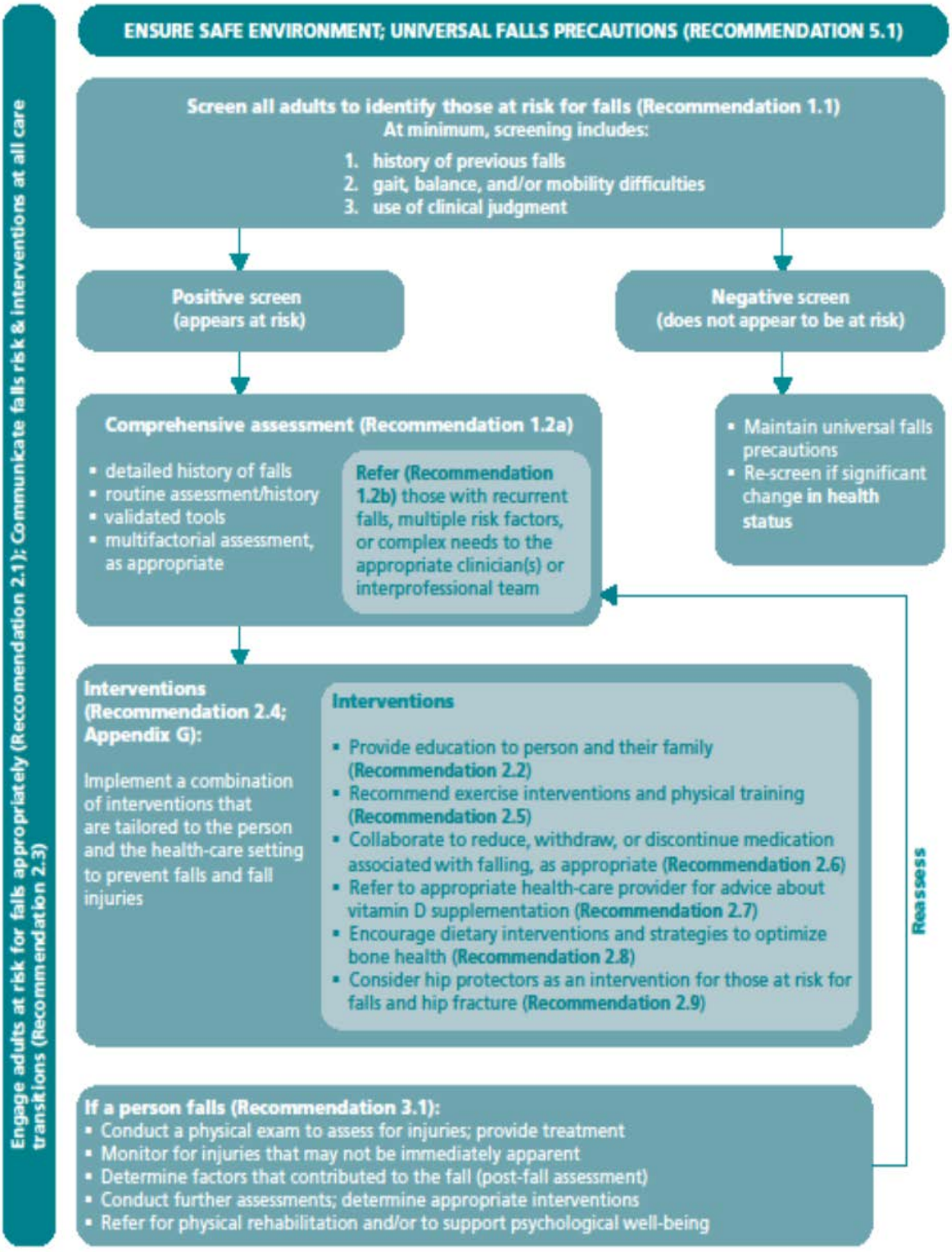

Figure 3. Flow Chart for Falls Prevention and Injury Reduction.

From Registered Nurses' Association of Ontario, *Preventing Falls and Reducing Injury from Falls (4th Ed.)*, Figure 1, p. 24. Copyright 2017 by the Registered Nurses' Association of Ontario. Reprinted with permission.

2.2 The Ontario Public Health Standards and Fall Prevention

The prevention of injuries in Ontario, including falls, is a fundamental public health program requirement for Boards of Health mandated by the OPHS. The OPHS is a guiding document, identifying the core population-based programs and minimum requirements that boards of health are expected to implement in order to achieve both societal and board identified health goals (MOHLTC, 2018b). The OPHS outlines four principles and foundational standards that serve as the backbone for all Program Standards. The four principles are need, impact, capacity, and partnership and collaboration. The foundational standards are – population health assessment, health equity, effective public health practice, and emergency management. The foundational standard of Effective public health practice includes three sections which are: 1) Program Planning, Evaluation, and Evidence Informed Decision-Making; 2) Research, Knowledge Exchange, and Communication; and 3) Quality and Transparency.

In Ontario, Boards of Health govern and appoint medical officers of health to direct the delivery of public health programs and services in communities by official government health agencies known as Public Health Units (PHUs) (see **Appendices C** and **D** for a map and profiles of each PHUs by peer group, Board of Health governance model, size of region, population served, and number of municipalities within each PHU). Each PHU is responsible for following the OPHS Principles, Foundational Standards, and implementing nine Program Standards, covering different public health areas. The prevention of falls is one of several topics covered by the Program Standard for Substance Use and Injury Prevention. Under Substance Use and Injury Prevention Standard, PHUs are directed to reduce the burden of preventable Injuries and substance misuse by fulfilling several requirements (MOHLTC, 2018b, pp. 56-57). Within the

requirements, PHUs are expected to adopt a comprehensive health approach that includes consultation and collaboration with community partners in order to reduce the burden of preventable injuries.

2.3 Partnership, Collaboration and Engagement

Partnership, collaboration, and engagement are viewed by the OPHS as essential for creating the conditions for health change, meeting the public health needs of the community, and working towards shared outcomes (MOHLTC, 2018b, p. 6). Partnership, collaboration, and engagement are considered necessary for improving the health of the public because no organization or individual acting alone provides the necessary skills, resources, or programs. Expertise and contributions to public health are made by those who live and work in the community (CDC, 2008). According to the OPHS community partners include governmental, non-governmental, educational, and private sector individuals and organizations, as well as other stakeholders but may vary by jurisdiction and program (MOHLTC, 2018b). Some examples of community partners include Local Health Integration Networks (recently dissolved and replaced by Ontario Health Teams), municipalities, fall prevention experts, family physicians and allied health practitioners (e.g., physiotherapists), home health care equipment suppliers, seniors' recreational sports clubs, seniors, and caregivers.

Despite the fact that the OPHS specifies the need for partnering, collaborating, and engaging with community partners as part of the Foundational Standards; less clear is how or to what extent PHUs and the professionals working within the PHUs are expected to partner and mobilize with community partners in order to achieve the goals for preventing injuries such as falls. In the prevention of falls among community-dwelling older adults, Ontario's PHU

professionals are already working with community partners to prevent falls among-community dwelling older adults by partnering with various groups and individuals (e.g., Ontario Health Teams, emergency medical services, health care providers, college training programs), raising community awareness of the issue through media advocacy, providing falls prevention education, programs, and resources, conducting health assessment and surveillance of falls, and developing community policies. However, operational definitions and further guidance describing the processes involved in partnerships, collaboration, and mobilization would be particularly beneficial to professionals working in Ontario's PHUs and their community partners.

Three previous research studies have examined partnership and collaboration between public health professionals in Ontario's PHUs and their community partners. These studies were conducted by PHU professionals working with academic partners at McMaster University as part of a previous LDCP. The first study explored the potential of community service providers to engage in population-based fall prevention strategies for community-dwelling older adults throughout communities (Markle-Reid, Dykeman, Reimer, et al., 2015). The study consisted of a survey examining service provider knowledge, attitudes, use, capacity, collaborative practices, and organizational readiness to implement evidence-based fall-prevention activities. The surveys were sent to 84 purposely selected front-line senior-serving community providers representing different health and non-health organizations from within the North Bay Parry Sound District Health Unit, Simcoe Muskoka District Health Unit, and York Region Community Health Services catchment areas.

The survey results revealed several important findings such as the shared perceptions among all service providers that falls are preventable (82%), the risk of falling is a top concern

for older adults (75%), and prevention would be beneficial for their clients (75%) (Markle-Reid, Dykeman, Reimer, et al., 2015). The survey also identified several gaps in perceived confidence, knowledge, skills, and resources to provide and support the implementation of fall prevention activities among community service providers. For example, 86% of health sector providers agreed or strongly agreed that they were confident in providing fall prevention activities versus 47% of non-health sectors providers. Less than half of health sector and non-health sector providers (49% vs 35%) agreed or strongly agreed that they had knowledge about how to best provide fall prevention activities for older adults, although no examples of how participants could provide these activities was reported. Few service providers (21%) reported that staff in their organization had the necessary knowledge and skills to implement fall prevention activities. Even fewer participants (10%) reported to a great extent that their organization had the necessary human, physical, and financial resources to support the implementation of fall prevention activities. Regarding collaboration, the research showed that nearly three quarters (75%) of providers were already collaborating and would like to work with other service providers in fall prevention activities in the future. However, the study did not specify who participants were collaborating with. Further, half of providers in the non-health sector (50%) and 64% of providers in the health sector indicated they could help other organizations provide fall prevention activities for older adults. Although the findings are limited in terms of the geographic areas represented in Ontario, the findings highlight the interest and potential of community partners to engage in effective falls prevention at the community level as well as opportunities for PHU professionals to foster community service provider potential by addressing knowledge and resource gaps.

Building on the findings of the first study, the second study examined the collaborative leadership practices PHU professionals have used to engage community partners in fall prevention initiatives for community-dwelling older adults (Markle-Reid, Dykeman, Ploeg, et al., 2017). Using a multiple case study design, the study consisted of a review of background documents (i.e., meeting minutes, terms of reference, plans, reports, newspaper clippings, and web postings) and interviews (n=26 individual interviews, n=4 focus groups) with key stakeholders participating in one of four multi-stakeholder groups from different communities in Ontario that have worked with Public Health to collaboratively implement a falls prevention initiative. Through inductive qualitative analysis, the research team identified seven practice themes for working collaboratively. These themes were: 1) tailoring approaches to local contexts; 2) making connections; 3) enabling communication; 4) forming the vision; 5) building community partner skill sets to mobilize and take action; 6) organizing people and projects; and 7) contributing knowledge through information and experience to support community action. Although no details were provided, the research identified variability in community partnerships attributable to memberships, PHU professional role, and type of implemented initiative and concluded with the need for further research to evaluate the specific practices of collaboration engaged in by PHUs in working with their community partners (Markle-Reid, et al., 2017).

The third study examined the perceived barriers and strategies to implementing older adult fall prevention practices by diverse community service providers (Dykeman, Markle-Reid, Boratto, et al., 2018). Interviews and focus groups were used to gather information-rich data from a purposive sample of 84 community service providers (e.g., health care professionals,

emergency service providers, recreation/fitness leaders, direct service providers, retailer, social services workers) serving three different PHU catchment areas. Participants were asked questions about current and additional fall prevention services offered by their organizations and the factors (i.e., barriers and facilitators) involved in implementing and deciding to offer new activities. Community service providers reported high usage of evidence-based fall prevention practices with recognition more could be done. Multiple barriers related to their organizations and the community service system, were revealed including weather and geographic challenges; limited coordination of communication; restrictive organizational mandates and policies; insufficient resources; and misbeliefs about aging and falls. The implications of these barriers prevented some organizations from working together, duplicating services, integrating falls prevention into their regular work, and ability to serve older adults and their caregivers. Strategies to promote implementation of fall prevention activities that emerged included: educating providers on effective fall prevention strategies and resources; working together; and changing policies and legislation. The findings highlight how evidence-based falls prevention is being adopted by community service providers and that community service providers have a desire to work together, that there are valued benefits to working together, and perceive that working together will effectively address falls. Still, issues related to partnership may be hindering progress toward desired outcomes.

The results of these studies provide further insight into partnership, collaboration, and engagement in order to prevent falls among community-dwelling older adults. However, the studies point out that there are gaps in current practices and a need for a greater understanding of the nature and processes involved in partnership and collaboration between

PHU professionals and community partners. The studies also emphasize the need for public health professionals working in PHUs to mobilize with community partners. Yet, none of these studies addressed what processes community partner mobilization entails and how Ontario's PHU professionals are engaging community partners in the mobilization of falls prevention among community-dwelling older adults.

2.4 Community Mobilization of Partners

The WHO (2006) identifies community mobilization as a vital public health strategy that can link health institutions and community members to build sustainable solutions to improve health. Community mobilization focuses on the community as the setting, target, and agent capable of change (Cheadle et al., 1998). Widespread interest and use across disciplines (e.g., health promotion, sociology, education, and politics) has resulted in numerous definitions, theories, and examples of community mobilization approaches and components exist (Cheadle et al., 2001; Cheadle et al., 1998; Galavotti et al., 2012; Kim-Ju, Mark, Cohen, Garcia-Santiago, & Nguyen, 2008; Lippman et al., 2013; Lippman et al., 2016; Tedrow et al., 2012). Some examples of these models include the *Coalition Development Model* (Downey, Ireson, Slavova, & McGee, 2008), *Intervention Mapping* (Donaldson, Lloyed, Gabbe, Cook, & Finch, 2016), *Mobilizing for Action through Planning and Partnership (*Corso, Wiesner, & Lenihan, 2005; Hershey, 2011; NACCHO, 2004), and the *Sustainability Planning Guide for Health Communities* (Batan, Butterfoss, Jaffe, & LaPier, 2011). Further, other terms such as community activation, community collaboration, community development, community empowerment, community engagement, community partnership, and community organization have also been used synonymously to describe community mobilization (Cheadle et al., 1998; Lippman et al., 2016).

As a result, there is no standard definition or strategy for engaging in community mobilization (Cheadle et al., 1998; Tedrow et al., 2012).

Broadly, community mobilization is a capacity building process that empowers communities, organizations, and individuals to organize and work collectively to develop, implement, and maintain solutions to community goals or needs (Cheadle et al., 1998; Howard-Grabman & Snetro, 2003; Lippman et al., 2013; Lippman et al., 2016). For the purposes of studying the application of community mobilization to the prevention of falls among community-dwelling older adults, the Falls Prevention Project Team has defined community mobilization as:

> "the use of capacity to bring about change by joining together the strengths of the community into an action plan. 'Community mobilization is based on the belief that when a community is mobilized to address and solve its own problems, more efficient and effective results will materialize than could be achieved by any other means' (Hastings, 2001). The anticipated goal is for a safe and healthy community with 'buy in' from all community members" (Falls Prevention Project Team, 2016).[3]

Community mobilization focuses on changing social interactions, norms, behaviours, conditions, and institutions to address community needs and challenges. Community mobilization processes can be expert- or community-driven (Kim-Ju et al., 2008; Treno & Holder, 1997). The processes can include activities that increase community awareness of an issue, gather support and commitment, strengthen community capacity and relationships, prepare communities to receive or actively address the issue, and evaluate progress toward

[3] The definition for community mobilization was separated from community partners in the LDCP publication although the focus of the publication was on community partner mobilization.

addressing an identified issue (Abramsky et al., 2012; Corso et al., 2005; Howard-Grabman, 2007; Tedrow et al., 2012). Some of the potential benefits of community mobilization include:

- increased community engagement (support, awareness, involvement, investment) and ownership;
- increased access and inclusion of diverse perspectives and voices;
- sharing and leveraging of resources;
- community empowerment through participatory decision-making and involvement;
- more relevant community interventions (i.e., addresses community needs and concerns);
- more comprehensive (i.e., tackles a range of the determinants of health);
- more innovative, effective, appropriate interventions;
- more sustainable interventions;
- improved social capital;
- increased community capacity;
- new and stronger community partnerships; and
- greater long-term impact (Batan et al., 2011; Boyd & Peters, 2009; CDC, 2008; Donaldson et al., 2016; Hershey, 2011; Mercy Corps, 2009; NACCHO, 2004; Salem, Hooberman, & Ramirez, 2005; Surman, 2006).

Community mobilization has been used in health promotion to improve sexual and reproductive health (Babalola et al., 2006; Galavotti et al., 2012; Moore et al., 2014), prevent violence (Abramsky et al., 2012; Francisco et al., 2013; Griffith et al., 2008), reduce alcohol and

drug use (Harachi, Ayers, Hawkins, Catalano, & Cushing, 1996; Ogilvie et al., 2011), reduce diabetes (Damond et al., 2003), reduce obesity (Frerichs et al., 2015), and diminish social and health inequities (Llovett, Denardi, & De Maio, 2011).

However, despite widespread interest and application of community mobilization approaches, many models are poorly defined, atheoretical, fail to describe or note contextual factors, and have not been evaluated (Kuhlmann, Galavotti, Hastings, Narayanan, & Saggurti, 2014; Lippman et al., 2016; Pettifor et al., 2015). This presents a challenge for public health professionals who are seeking to identify and apply theoretically grounded and evidence-based community mobilization approaches that are applicable to their own practices and communities and mobilize community partners into action for fall prevention.

2.5 Falls LDCP Logic Model for Mobilizing Partners in Injury Prevention

The Falls LDCP Logic Model for Mobilizing Partners in Injury Prevention (Crizzle et al., 2019) arose out of a call by PHU professionals for guidance on how to best mobilize with community partners to address injury in adults. The development of the Falls LDCP Logic Model for Injury Prevention was led by a project team consisting of PHU professionals tasked with working with community partners to prevent injury in adults, academics, a graduate student, and a researcher consultant. The project team's efforts focused on a scoping review of theories, models, frameworks that were relevant to community-based injury prevention and could be used to successfully explain how to mobilize community partners. Using a methodological framework to guide the scoping review process and The Meta-QAT or the Public Health Ontario Meta-tool for Quality Appraisal of Public Health Evidence (Rosella, Pach, Morgan, & Bowman, 2017) to assess the quality of articles retrieved, the team found ten sources of relevant

information. The ten sources were reviewed for descriptions of theories, frameworks, and models for mobilizing partners and broken down into components describing key constructs, steps, components, phases and tasks. This allowed the project team to identify common elements and timing of steps (i.e., pre-requisites, transitional elements, and results of community partner activity) related to mobilizing partners. However, the project team found none of the theories, frameworks, or models provided a full description or enough evidence about how to successfully mobilize with community partners.

Synthesizing the theories, models, and frameworks reviewed, the project team developed the Falls LDCP Logic Model for Mobilizing Partners in Injury Prevention depicted in **Figure 1** (p. 9). The Falls LDCP Logic Model focuses on the factors to successfully partner in order to achieve desired injury prevention outcomes in the community. The Falls LDCP Logic Model incorporates the prerequisite conditions for community partner activity, partner mobilization, and mobilization results of community partner activity. Prerequisite conditions for community partner activity are noted in the logic model inputs (i.e., partnership set-up, community assessment of needs and assets, and evidence based strategic planning). Partner mobilization activities (e.g., ongoing involvement) and participation (e.g., community partners, community-dwelling adults) are outlined under the logic model outputs. Mobilization results are outlined under the outcomes and broken into short-, medium-, and long-term (e.g., understanding of the problem, tested interventions, and injury reductions). Crizzle et al. (2019) also note underlying assumptions and external factors (e.g., partner interest, availability, changing priorities that may affect the mobilization process and achievement of outcomes.

To date, the Falls LDCP Logic Model for Mobilizing Partners in Injury Prevention has not yet been applied or evaluated; however, it reflects key components of community mobilization theories, frameworks, and models, is consistent with existing literature on developing and supporting partnerships, outlines the partnership process and activities required to achieve specific community-based injury prevention outcomes, and allows for future evaluation to judge and improve mobilization efforts.

2.6 Towards a Description of How Community Partner Mobilization is practiced by PHU Professionals

While the literature on community mobilizations models, theories, and frameworks is growing, little is known about how community partner mobilization is currently being practiced by Ontario's PHU professionals to prevent falls among community-dwelling older adults. Asking PHU professionals and their partners about their practices, experiences, and perspectives on community partner mobilization may help identify not only what is being done, but what is working well, what isn't working, and what gaps might exist in current practices. Understanding what is currently being practiced by describing key actions and the relationship between these actions would help researchers, public health professionals, their community partners, and communities shape future practices. In order to describe how community partner mobilization is practiced by PHU professionals to prevent falls among community-dwelling older adults this study will draw upon sensitizing concepts and a conceptual framework from the literature.

Sensitizing concepts are a general set of ideas or categories that a researcher uses as informative instruments to interpret data (Bowen, 2006; Blumer, 1954; Charmaz, 1990; Patton, 2015). Sensitizing concepts are a general set of ideas or categories that a researcher uses as

informative instruments to interpret data (Bowen, 2006; Blumer, 1954; Charmaz, 1990; Patton, 2015). Sensitizing concepts are exploratory tools that can be used to initiate inquiry, providing researchers with a general sense of direction to ensure data collection and analysis is not simply random and inconsequential to the research topic (Charmaz, 2014). As Dey argued, "there is a difference between an open mind and an empty head" (Dey, 1999, p. 251). Sensitizing concepts are not to be used to reproduce the original concepts, systematically force the data inquiry process, or force the data into pre-conceived ideas (Charmaz, 2014). The sensitizing concepts used in this study were used to initially 'loosely' guide data collection and analysis; however, the data collected ultimately determined the content of the findings. **Table 2** contains a list of the sensitizing concepts that will be used to aid in the detection of the community partner mobilization strategies and practices. The list is based on core concepts from the literature describing how to make community mobilization happen. A list defining other terms used throughout this paper is presented in **Appendix B**.

Table 2 *Sensitizing concepts to be used to identify community partner mobilization strategies and practices*

Sensitizing concept	Description
Preparing	Organizing for the mobilization process. It includes gathering information about the health issue and community and the internal resources needed to begin the mobilization process.
Partnering	Establishing a collaborative relationship between groups and individuals.
Problem recognition and definition	Scoping of problem. Identification, articulation, and assessment of the problem and its significance Understanding what the problem is and who it affects.
Shared vision	Establishing a joint idea of the future based on values and goals for the community.
Organizational structure	The creation/presence of authority, communication, roles, rights, and responsibilities.
Collaboration	"a recognized relationship among different sectors or groups, which have been formed to take action on an issue in a way that is more effective or sustainable than might be achieved by the public health sector acting alone" (Public Health Agency of Canada [PHAC], 2008, p. 9).
Empowerment	"A process through which people gain greater control over decisions and actions affecting their health. Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs" (PHAC, 2008, p. 10).

Table 2 Continued

Sensitizing concept	Description
Engagement	*"*the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices" (Centers for Disease Control and Prevention [CDC], 1997, p. 9).
Capacity building	"the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organizations, and; the development of cohesiveness and partnerships for health in communities" (Smith, Tang, & Nutbeam, 2006, p. 2).
Resource sharing	Gathering and sharing of assets (i.e., human, non-human –> financial, technical).
Community assessment	Assessment of community resources and conditions (i.e., strengths, weaknesses, assets, needs) to establish a contextual understanding of the problem and conditions in which solutions may be derived and executed.
Strategic planning	Defining and determining priorities, roles, responsibilities, priorities, and actions.
Collective action	Group action toward a common goal(s).
Evaluation	Analysis of the entire mobilization process and activities.

A conceptual framework is an illustration of the relationship between key factors, constructs or study variables (Miles & Huberman, 1994, p. 434). The conceptual framework for this study is the Falls LDCP Logic Model for Mobilizing Partners in Injury Prevention (Crizzle et al., 2019) depicted in **Chapter One** (**Figure 1**, p. 10) and described in detail earlier in this chapter.

2.7 Chapter summary

This chapter has described the costs and impact of falls on community-dwelling older adults, their risk factors, and identified aspects of interventions effective for preventing falls among community-dwelling older adults based on the literature. The chapter has outlined the OPHS for the prevention of falls and related expectations for PHU professionals to prevent falls among community-dwelling older adults using partnership and collaboration and limited amount of guidance for using partnership and collaboration to achieve fall prevention goals. The chapter has provided a description of the importance of community partner mobilization as a strategy to improve health, and introduced the Falls LDCP logic model for mobilizing community partners in injury prevention and central ideas that will be used as sensitizing concepts which will be used as a framework for this research. The next chapter identifies the study purpose and significance.

Chapter 3: Study Rationale

3.1 Rationale for the Study

As noted in **Chapters 1 and 2**, falls in the community and particularly among community-dwelling older adults is an important public health issue. Ontario's PHU professionals want and have a responsibility to engage with community partners to effectively prevent falls among community-dwelling older adults. Ontario's PHU professionals are already mobilizing with community partners. However; little is known about what mobilization strategies and practices are being employed by PHU professionals to prevent falls among community-dwelling older adults, whether these efforts are any good, which community partners they are working with, who best to work with, and what can be done to strengthen practices.

3.2 Study Purpose

The purpose of this qualitative study is to document mobilization strategies and practices employed by public health professionals in Ontario's PHUs in working with their community partners to prevent falls among community-dwelling older adults (65 years of age and older). The study objectives are to:

1) identify and describe the Ontario PHU professionals engaging in community partner mobilization;
2) identify and describe the context within which the PHU professional(s) are working and the populations they serve;

3) identify and describe the community partners that Ontario's PHU professionals are mobilizing;
4) identify and describe community partners that are not currently collaborating with PHUs but would add value;
5) identify and describe the mobilization strategies and practices employed by public health professionals in Ontario's PHUs in working with their community partners to prevent falls among community-dwelling older adults;
6) examine strategies employed by public health professionals in Ontario PHUs, the benefits and challenges of community partner mobilization; and to
7) identify public health professionals' views about capacity building activity and policy by provincial and federal public health ministries and agencies to support implementation of comprehensive falls prevention programs by Ontario PHU's.

3.3 Significance of the Study

This study will be the first to describe the mobilization strategies and practices employed by, and factors influencing the ability of Ontario's PHU professionals to engage community partners in fall prevention among community-dwelling older adults. The results of the research are expected to allow public health professionals in Ontario's PHUs and abroad to exchange knowledge and experiences, document the current state of community partner mobilization practices involving PHU professionals, provide data to help strengthen the capabilities of Ontario's PHU professionals to mobilize community partners, and to facilitate the identification or development of an appropriate community partner mobilization framework to guide PHU professionals in how to best engage community partners in the prevention of falls

among community-dwelling older adults, other groups at-risk of falls, and other public health issues, as deemed appropriate.

Chapter 4: Research Method and Design

The present study emerges out of collaborative research being conducted by and in consultation with Ontario's PHU professionals and academic partners at the University of Saskatchewan, Trent University, and University of Waterloo examining community partner mobilization as a strategy to prevent falls among community-dwelling older adults. The primary purpose of this study is to explore how public health professionals working in Ontario's PHU's are engaging in community partner mobilization to prevent falls among community dwelling older adults. The previous chapters have described the study topic, background, context, problem, relevant literature on theories of behaviour change and community partner mobilization, purpose, and rationale. This chapter provides a detailed description of the research method and procedures used in conducting this qualitative grounded theory study. The chapter begins with a description of the study perspective, method, design, role of the researcher, reflexive statement, sampling and recruitment, data collection, analysis, and ethics approval. The chapter concludes with a description of study rigour.

4.1 Perspective

The study is based on the ontological and epistemological perspectives of critical realism (Bhaskar, 1998; Danermark, Ekstrom, Jakobsen, & Karlsson, 2002). Ontologically, critical realism asserts that the real world exists independent of human knowledge; is an open system that is beyond human ability to control directly; stratified into three nested ontological domains (the real, actual, and empirical) comprised of structures, generative mechanisms, and experiences; and emergent (Bhaskar, 1998; Danermark et al., 2002; Easton, 2010; Wynn & Williams, 2012).

Epistemologically, critical realism asserts that our understanding of the real world is fallible but can be understand through the application of multiple theoretical and methodological tools to descriptions of observed experiences and other data (Danermark et al., 2002, p. 10; Easton, 2010; Wynn & Williams, 2012). The epistemological approach adopted to understanding community partner mobilization strategies within the given context, is based on inductive emergence of structures and mechanisms from data of observed experiences corroborated through other data, theoretical perspectives (e.g., Falls LDCP logic model), data and analysis process, and member checks (Wynn & Williams, 2012).

4.2 Method

To answer the question, "how are public health professionals in Ontario's PHUs mobilizing their community partners to prevent falls among community-dwelling older adults (65 years of age and older)?" a qualitative method was adopted. The decision to use a qualitative method was based on the nature of the research question and limited knowledge about the topic. Qualitative research is characterized by the collection and analysis of descriptive data such as words or text (Patton, 2015, p. 14). Qualitative research methods allow for in-depth and detailed descriptions that can be used to contribute to the generation, testing, and modification of theory and knowledge about how the world works, why, and the implications on people's lives (Patton, 2015, pp. 14-18; Sofaer, 1999). Qualitative approaches are often recommended for research seeking to describe, explore, and explain experiences, relationships, events, and processes (Sofaer, 1999). Some examples of qualitative methods include in-depth, open-ended interviews; field observations; written communication; and documents (Janesick, 1994, p. 211; Patton, 2015, pp. 14-36). This study used in-depth, semi-

structured telephone interviews to collect data to describe the process, strategies, and practices used by Ontario's PHU professionals to mobilize with their community partners.

4.3 Design

A grounded theory design was used to guide the collection and analysis of data, and develop an understanding about how community mobilization of partners to prevent falls is practiced (Bowen, 2006; Corbin & Strauss, 2015, pp. 6-7; Creswell, Hanson, Plano Clark, & Morales, 2007; Patton, 2002, p. 109). Grounded theory is a design strategy for systematically collecting and analyzing participant-based data (e.g., interviews, observations) in order to develop a theory or address theoretical inadequacies (Corbin & Strauss, 2015, pp. 6-11; Creswell et al., 2007; Janesick, 1994, p. 218-219). Although several qualitative designs exist (e.g., narrative, case study, phenomenology, participatory action research), grounded theory was chosen because it is well suited for exploratory investigations with the goal of understanding the actions and processes of a phenomenon over time (Corbin & Strauss, 2015, p. 11; Creswell et al., 2007; Morse, 1994, p. 224; Patton, 2002, p. 111).

Grounded theory was originally developed by Glaser and Strauss in the 1960s (Corbin & Strauss, 2015, pp. 3-7). Since its inception, multiple approaches have emerged based on epistemological and methodological differences (Rupsiene & Pranskuniene, 2010; Chun Tie, Birks, & Francis, 2019). Some of the most notable approaches include Glaserian Classic/Traditional Grounded Theory, Straussian Grounded Theory, and Charmaz's Constructivist Grounded Theory (Glaser & Strauss, 2017, Kenny & Fourie, 2015; Rupsiene & Pranskuniene, 2010; Chun Tie et al., 2019). This qualitative study used a Straussian Grounded Theory design (Corbin & Strauss, 2015, pp. 1-2).

Straussian Grounded theory involves deciding on a general research topic, framing the research question, theoretical sampling, collecting data, systematically analyzing the data, memo writing, and constructing a theory or framework derived from the data (Corbin & Strauss, 1990; Corbin & Strauss, 2015, pp. 57-202; Kenny & Fourie, 2015). Theoretical sampling refers to the sampling of concepts not people (Corbin & Strauss, 2015, p. 156). Theoretical sampling involves identifying, collecting, and analyzing data from a small group of individuals, places, or events based in order to find, define, and relate the concepts underlying emerging theory (Corbin & Strauss, 2015, pp. 155-156). Theories about the research topic emerge from the data by applying a constant comparative method in three coding stages. The practice of constant comparison is critical to the emergence of theory from the data. Constant comparison refers to noting events or ideas and comparing this with other events and ideas in the data in order to discover patterns, relationships, and propositions concerning the research topic (Bitsch, 2005; Corbin & Strauss, 1990). The three coding stages are:

- open coding which involves identifying significant concepts and the properties and dimensions of these concepts;
- axial coding which involves establishing the relationships between concepts; and
- selective coding which involves refining and integrating concepts based on their dimensions, properties, and relationships in order to develop the core categories that will serve as the basis of the emerging explanatory theory (Bitsch, 2005; Corbin & Strauss, 1990).

A Straussian Grounded Theory design was chosen over Glaserian/Traditional/Classic and Constructivist Grounded Theory designs for several reasons. First, the techniques may be used

for purposes other than developing theory, including description which aligns with the objectives of this study (Rupsiene & Pranskuniene, 2010). Second, Straussian Grounded Theory provides a more structured set of procedures for novice researchers to follow during analysis. Third, because the design allows for the inclusion of a literature review throughout the research process in order to enhance the research (Corbin & Strauss, 2015, pp. 49-52; Kenny & Fourie, 2015). This was an important consideration because a literature review on community mobilization had been completed as part of the research assistantship with the Falls LDCP team and requirement for the PhD dissertation proposal prior to initiating this study. The literature review was used to guide the development of study materials, study proposal, and sensitize the researcher to existing theories and concepts. Recognizing that literature reviews and personal experiences have the potential to also bias results through the forcing of pre-conceived ideas on the data (Corbin & Strauss, 2015Giles, King, & de Lacey, 2013), a reflexive journal and memos were kept. The reflexive journal served to identify and maintain awareness of existing theory, personal opinions, feelings, and experiences. Memos were used to track and document the analysis process. The reflexive journal and memos were reviewed frequently throughout the research process to ensure pre-conceived ideas were not imposed on the data and that the emerging findings were data driven.

4.3.1 Use of the Falls LDCP logic model within Straussian Grounded Theory

This research utilized a theoretical framework developed from the literature – the Falls LDCP logic model (described in **Chapters 1 and 2**). The use of theoretical frameworks are not typically recommended for use with Straussian grounded-theory design; however, there are some exceptions to this when the theoretical framework is used for justifying a research

methodology, used as a starting point to extend and develop theory, or develop alternate theories and theoretical explanations (Corbin & Strauss, 2015, pp. 72-75). In the current study, the Falls LDCP logic model was used as a starting point to develop an understanding of the processes of how PHU professionals were practicing community partner mobilization to prevent falls among community-dwelling older adults. Specifically, the Falls LDCP logic model was used to: 1) enhance theoretical sensitivity to specific concepts and their relationships; 2) develop research questions about the process of community partner mobilization given the limited relevant literature on the topic; and 3) confirm aspects of the findings in terms of similarities and differences between theory and practice (Corbin & Strauss, 2015; pp. 70-72).

Because the Falls LDCP logic model was still in development at the time this study was designed and conducted, only aspects of the model and its underlying assumptions and worldview were used to inform the current research. For example, the concept of partnership start-up (i.e., recruited, structured, informed, and united) was used to develop the questions "How did you/your PHU engage the different organizations and individuals to participate? What information was provided? Was there commonality in the partners' goals and values around this issue in order to work together? How did you and your partners organize themselves for community mobilization?"

The strengths of the Falls LDCP logic model with respect to answering the main research question include the following:

- represents an up-to-date summary of the mobilization literature relevant to PHU professional practices to prevent injury including a widely recognized model

developed by the U.S. CDC and the National Association of County & City Health Officials (i.e., the MAPP);

- the provision of a clearly detailed community process illustrating the relationship between various elements;
- the provision of concepts describing specific inputs, actions and activities, outputs, and outcomes; and
- general enough to apply to a variety of circumstances.

Limitations of the model include that it is untested, not based on specific practices that communities may engage in (e.g., program development, advocacy for policy, common data gathering), and was still in development at the time this study was developed and conducted. This influenced which concepts were used to develop the study, sensitize the research, and compared at the end of the analysis phase.

4.4 Role of the Researcher

For this qualitative grounded research study, I served as the primary instrument for collecting, analyzing, and summarizing the findings from the data (Patton, 2015, p. 700). My role included: developing the research questions, study, research materials (i.e., recruitment materials, and interview guides), recruiting participants, conducting and analyzing the interviews, and writing the findings.

As a graduate student I have received training in qualitative research methods and techniques. This training has exposed me to a variety of perspectives (i.e., epistemology and ontology), approaches, techniques, and opportunities to apply the knowledge learned. These opportunities included practice designing qualitative research studies, developing study

materials, conducting interviews, transcribing and analyzing qualitative data, and presenting findings. While it may take years of experience to become an expert, this training has helped to sensitive me to the opportunities afforded by and challenges that may be experienced conducting qualitative research. This training also led to employment opportunities and the topic for the current research study.

Prior to beginning this research, between August 2015 and December 2015, I worked as a research assistant in the School of Public Health and Health Systems at the University of Waterloo aiding in the preparation of a funding proposal for a LDCP and preliminary design of a scoping review examining community mobilization models, frameworks, and theories to prevent falls among community-dwelling older adults. As a result of this work, I developed an understanding of some of the individuals, and context within which PHU professionals were working to prevent falls. This helped enhance my perception and sensitivity of the challenges encountered by PHU professionals as well as the passion they have for their work. The development of sensitivity regarding the subject matter and PHU professionals helped in designing the study, research materials, and building rapport with participants in order to increase the probability of obtaining meaningful information from participants. I did not have any personal or professional leverage over participants at any time before or during the study which might influence their participation or responses. Further, my role as a research assistant ended prior to conducting this study, providing some distance between myself and the PHU professionals with whom I developed a professional relationship.

4.5 Reflexive Statement

In qualitative research, the researcher plays an important role as the instrument in the construction of research and findings (Corbin & Strauss, 2015, p. 75; Finlay, 2002; Patton, 2015, pp. 70-73). The researcher's own position, perspectives, and experiences can influence and shape all aspects of the research inquiry process including the motivation for studying a specific topic, methods chosen, data collection, analysis, and reported findings (Corbin & Strauss, 2015, p. 75). The research process itself can also have an influence on the researcher (Corbin & Strauss, 2015, p. 48). Reflexivity is a process of critical self-introspection, discovery, and disclosure which helps to identify, minimize, and make transparent the influence of these perspectives and experiences on the research and findings (Patton, 2015, p. 70).

I am a PhD candidate in the School of Public Health and Health Systems at the University of Waterloo. I self-identify as a novice researcher with a strong interest in public health, health systems, population approaches to health, and evidenced based policy. My interests have developed out years of studying, participating, and contributing to research on global tobacco control policies. I acknowledge that my research beliefs and values contribute to interest in improving the health and well-being of others and systems for delivering improvements and serve as part of the motivation for conducting the current research.

During my graduate studies I received training in the foundations of the Canadian and Ontario public health systems, qualitative and evaluative research, and had opportunities to train and work with public health professionals. One of these opportunities included working as a research assistant helping to secure funding to conduct research intended to support PHU professionals in their work with community partners to prevent falls among community-

dwelling older adults. The welcoming and passionate nature of the public health professionals working on this project motivated me to learn more about falls among older adults and support their need to develop knowledge, tools, and evidence to help them and their partners work better together to prevent falls among community-dwelling older adults.

While these opportunities have helped to sensitize me to the individuals, work, and context within which public health professionals' practice, have contributed to my skills as a researcher, and provide the motivation for this research, admittedly I am an outsider (Gentles et al., 2014). I am not a trained nurse, nurse practitioner, nurse trainee, medical doctor, or another specially trained professional working within Ontario's Public Health Units. I am also not an older adult, a caregiver to older adults, or someone who works with older adults. This can be both a benefit and detriment in conducting the current research. As an outsider, I can approach aspects of the research from a fresh prospective wonderingly deeply what it must be like to be immersed in Ontario's public health units and community organizations actively trying to prevent falls among community-dwelling older adults. I am free of any commitments to specific organizations and any historical "baggage" between organizations or individuals that could influence my perceptions of the research or reporting of the findings. However, as an outsider I may be missing certain facts, relationships, and contextual connections to the research. I acknowledge that this requires me to be patient with participants, build their trust, establish a relationship, be mindful of my own shortcomings in knowledge, and be inquisitive in order to more fully understand how community mobilization is being practiced. Further as a novice researcher I acknowledge there is always room to improve upon my understanding and ability to apply various research methods and analytic techniques.

The possibility of developing a model of community mobilization that works for PHU professionals, their community partners, communities, and older adults at risk for falls is exciting. There are many people who would benefit from a working model; however, my training reminds me that there is value in understanding what is currently being practiced and collecting evidence to support decision-making processes. Therefore, it is my hope that this research can provide those currently mobilizing and those that plan to mobilize in the future a rich information base from which to draw upon to strengthen practices and develop a working model. Through reflexive practices (self-disclosure, identification of personal perspective, research role, keeping a reflexive journal), adherence to the chosen methods of grounded theory, and attempts to be transparent, I hope to be able to identify and minimize the intrusion of any biases throughout the research process (Lincoln and Guba,1985, p. 327).

4.6 Sampling

Purposive sampling was used to identify and recruit participants for the study. Purposive sampling is a technique which involves the researcher selecting participants based on specific criteria relevant to the purpose of the study (Daniel, 2012, pp. 109-110). In the early stages of grounded theory research, purposive sampling is often used to collect data from the individuals believed to maximize and identify future sources of rich data for theory development and subsequent theoretical sampling (Coyne, 1997; Moser & Korjstens, 2018).

PHU professionals tasked with preventing falls among community-dwelling older adults were considered a key source of knowledge about their strategies for mobilizing with community partners. A PHU professional is defined as a designated PHU employee(s) (e.g., physician, nurse, gerontologist, public health practitioner, public health worker, public health

promoter) who is responsible for working with community partners to prevent falls among community-dwelling older adults. At the time this study was initiated there were 36 PHUs in Ontario. Each PHU was expected to employ at least one PHU professional tasked with preventing falls among community-dwelling older adults, but may employ more depending upon the municipality type, size, and funding structure of the PHU. Therefore, the number of PHU professionals responsible for preventing falls among community-dwelling older adults was estimated to be between 36 and 72. The selection criteria for the sample of PHU professionals in this study were based on whether participants:

- were a PHU employee tasked with preventing falls among community-dwelling older adults at the time of the study;
- worked at a PHU representing one of the PHU municipality types across Ontario (e.g., urban/metro, urban/rural mix, rural). In Ontario there are seven municipality types (**Appendix D**) which will be collapsed into three groups: 1) rural northern regions, mainly rural, sparsely populated urban/rural mix; 2) urban/rural mix; and 3) urban centres, mainly urban, and metro centre. Attempts were made to recruit at least one PHU professional from each municipality type; and
- represented a PHU that had or had not participated in Falls LDCP scoping review on community mobilization. Attempts were made to recruit at least two PHU professionals from PHUs that had not and three PHU professionals from PHUs that had participated in the Falls LDCP scoping review.

These criteria were selected with the intention of providing a richer understanding of how community partner mobilization is practiced throughout Ontario (e.g., an understanding of the range and commonality of mobilization strategies across different contexts), and knowledge that may be transferable to a broad range of PHU professionals and their community partners working to prevent falls.

Community partners and future potential partners were also considered as valuable sources of knowledge for understanding PHU professionals' strategies for mobilizing with community partners. A community partner is defined as anyone who has a vested interest in health promotion and injury prevention or who may have a vested interest in the well-being of community-dwelling older adults. Community partners include "governmental agencies, non-governmental agencies, coalitions, networks, industry employers, community-based organizations, health authorities, etc." (Falls Prevention Project Team, 2016). A future potential partner is defined as anyone in the community who the PHU professional would like to mobilize with in the near future to prevent falls among community-dwelling older adults. Because it was not known in advance who would provide the best data the sample was selected using a respondent-assisted referral strategy. A respondent-assisted referral strategy is a sampling technique in which study participants aid in the identification and recruitment of other study participants because the population may be hard-to-reach, and/or there is no or insufficient information to construct a sampling frame, but members of the population are known to one another (Daniel, 2012, pp. 130-139). This recruitment procedure is also described as 'referral' or 'snowball sampling' (Daniel, 2012, pp. 130-139). In the current study, participating PHU professionals were asked to identify community partners they were mobilizing with who might

be most knowledgeable about their community partner mobilization practices, and future potential partners they were interested in mobilizing with in the near future to prevent falls among community-dwelling older adults. These individuals were then contacted until a target sample size or saturation was reached.

The sample size for qualitative research is typically small (Creswell, 2014, p. 189). For grounded theory research, the size of the final sample is determined by theoretical saturation. Theoretical saturation refers to when no new concepts emerge from collected data and the concepts are well-developed in terms of properties, dimensions, and variation (Corbin & Strauss, 2015, pp. 160-162). Creswell (2013, p. 157) recommends conducting 20-30 interviews and no more than four or five cases for theory research. Based on these recommendations and in consultation with the dissertation committee, the initial sampling goal was to interview:

- five PHU professionals at different PHUs;
- 15 community partners (three from each PHU site); and
- 10 future potential partners (two from each PHU site).

The final study sample consisted of data from 13 individuals (five PHU professionals, six community partners, and two future potential partners). Details about the characteristics of the sample are provided in **Chapter 5: Findings**.

4.7 Recruitment

Multiple procedures were used to recruit PHU professionals, community partners, and future potential partners between December 2017 and September 2018. The process of recruiting began following ethics approval with the purposeful selection of PHUs to represent diversity of PHU peer group types (rural, urban/metro, urban/rural mix), regions across Ontario

(Central East, Central West, Eastern, North East, North West, South West), and involvement with the falls LDCP scoping review on community mobilization (CM) of partners. Purposeful selection was made by constructing a list of all PHUs in Ontario and then dividing the list by PHU representation on the falls LDCP (yes versus no). Each list was then further divided by geographical area and peer group. The five PHUs to be contacted were selected randomly from these lists using Microsoft® Excel 2010 ensuring each of the study sample criteria was represented. The list of potential participants was then reviewed in consultation with the dissertation committee. Some changes were made to the list based on knowledge of changes going on in the Public Health Unit system (e.g., changes in leadership and staffing, amalgamation of PHUs, etc.) at the time of the study.

Once the list was finalized, the researcher and A. Crizzle sent e-mails to the Medical Officer of Health and PHU professional tasked with preventing falls from the first PHU randomly selected from the falls LDCP list. The researcher sent all subsequent e-mails to Medical Officers of Health or designated Public Health Official. Each Medical Officer of Health or designated Public Health Official was contacted by e-mail for permission to conduct the study within their PHU and referral to the appropriate PHU professional(s). The e-mail contained a summary of the request and study, detailed information letter, and request to respond to the e-mail if permission was granted (**Appendices E and F**). If permission was granted, the researcher proceeded to contact the appropriate PHU professionals at each PHU by e-mail. E-mails to the PHU professionals included a brief description of the researcher, the nature and scope of the study, detailed information letter, and request to respond to e-mail with suggested interview dates and times if interested (**Appendices E and F**). Interested individuals were then sent an e-

mail containing a copy of interview script including procedure for providing oral consent and confirming interview dates and times (**Appendices E and F**). If, e-mails were not replied to, the researcher followed-up with a telephone call. If after three e-mails and three telephone messages the PHU was not reached, another PHU was sampled.

Community partners and future potential partners were initially recruited by a mix of telephone and e-mail messages, depending on what contact information was provided by PHU professionals. If no contact information was provided, the researcher conducted a search for the individual on Google to locate either a telephone number or e-mail address. If a telephone number was provided, the researcher called and asked to speak with the referred individual, briefly described the study, and asked to provide more information about the study by e-mail (**Appendix E and F**). All recruitment e-mails contained a brief description of the researcher, the nature and scope of the study, detailed information letter, and request to respond to e-mail with suggested interview dates and times if interested (**Appendices E and F**). Interested individuals were sent an e-mail containing a copy of the interview script including procedure for providing oral consent and confirming interview dates and times (**Appendices E and F**). If e-mails were not replied to, the researcher followed-up with a telephone call. If after three e-mails and/or three telephone messages the referred individual was not reached, the researcher contacted the PHU professional to ask for additional recommendations.

4.8 Data Collection

Interviews with study participants served as the primary source of data. Memos, a reflexive journal, and member checks were used to supplement the interviews and increase the richness of the data collected as well as the quality of the research. Participants also provided

recommendations for other data sources (i.e., websites, videos, and reports) which were reviewed as part of background data. The content of most of these recommendations concerned specific falls and injury prevention projects and campaigns and were less focused on the processes involved in community mobilization of partners, as such the recommended materials were not included in the analysis.

4.8.1 Interviews

In-depth, semi-structured interviews were conducted with PHU professionals, their community partners, and future potential partners to develop an understanding of how community mobilization of partners to prevent falls among community-dwelling older adults was being practiced. In-depth semi-structured interviews are a type of data collection tool that is guided by a thematic framework of questions which can be flexibly tailored by the researcher in order to gain a deeper understanding of a topic (Corbin & Strauss, 2015, pp. 59-60). In-depth, semi-structured interviews were chosen for this research to ensure each of the research objectives would be addressed.

Separate interview guides were developed for each target sample group (i.e., PHU professionals, Community partners, Future potential partners). The guides were designed to be conducted by the researcher via telephone, one-on-one. The guides were developed using the Falls LDCP framework and sensitizing concepts from the literature described in Chapter 2. Probes were included in each guide to allow the researcher opportunities to ensure certain topics were discussed and could be explored in detail.

Contents of the interview guide for PHU professionals included questions about what and how strategies and practices are being/were used, whether the strategies are

working/worked as expected, what factors (internal or external) facilitated or impeded efforts, and additional comments about community partner mobilization to prevent falls among community-dwelling older adults (**Appendices E.4 and F.4**). Community partners received a guide asking a few brief demographic questions, and about their knowledge and experiences of community partner mobilization strategies and practices employed by the PHU partners (i.e., job title, type of organization worked for, awareness of what/experience with practices and strategies were being employed), knowledge of the performance and factors facilitating or impeding of strategies and practices, and additional comments about community partner mobilization related to the prevention of falls among community-dwelling older adults (**Appendices E.9 and F.9**). The interview guide for future potential partners contained questions about their organizations, interest in preventing falls, awareness of PHU professionals' efforts to mobilize with community partners to prevent falls and partnering to prevent falls (**Appendices E.13 and F.13**).

A pilot study of the research protocol and interview guides was conducted to determine the acceptability of research questions, whether questions provided the information needed to address the researcher objectives or needed to be changed, and time to complete. The pilot study sample consisted of one PHU professional who had been involved in the Falls LDCP scoping review chosen in consultation with the dissertation supervisors, one community partner, and one future potential partner. Two community partners expressed interest in the study but were unable to participate by the proposed pilot end date. No one declined participation. All three interviewed participants were enthusiastic about the study subject and provided full cooperation in completing the study. At the end of each interview participants

were asked to provide feedback about the study, questions, and review their transcripts for accuracy. A full account of the modifications made to the interview guides is highlighted in **Appendix F**.

All interviews, including the pilot study, were conducted between January and September 2018. Interviews were scheduled at a mutually convenient time. Each interview began with brief remarks about the study purpose, procedure, participant rights, opportunity to ask questions, and their consent for participating in the study. Participants were also asked for their permission to audio-record the interview for the purposes of accuracy and data analysis. Interviews were recorded on a cell phone using the app Automatic Call Recorder for Android (https://play.google.com/store/apps/details?id=com.appstar.callrecorder&hl=en_CA). Once permissions were provided, participants were asked questions covering the topics outlined in their respective interview guide. Each interview concluded by asking participants whether they had any comments to add about the study topic or study in general. Following the interview, participants were sent an e-mail and feedback letter thanking them for their assistance (**Appendices E and F**).

4.8.2 Memos

During data collection, analysis, and writing, memos were written about the data, analysis, and emerging theory (e.g., categories, relationships between categories). Memos are written notes that are considered an essential component of the grounded theory process aiding in the systematic tracking of analysis and development of theory (Corbin & Strauss, 2015, p. 142; 1990). The memos generated during this study documented exploration of the data, identification of nodes, coding, development of core concepts, and relationship between

concepts. The content and length of the memos varied depending on when each memo was written during the research process. The memos were used to track and historically document the analysis process, review the development of categories, and assist with writing of the preliminary summary of findings and dissertation. NVivo 12 for Windows (QSR International, https://www.qsrinternational.com/nvivo/nvivo-products/nvivo-12-windows) was used to create and store the memos.

4.8.3 Reflexive journal

Throughout this study a journal was kept for tracking research activities (e.g., daily schedule, appointments, initiation of different study phases, problems encountered, writing), decisions (e.g., changes in method and design, sampling, instruments, when to stop sampling and analysis), rationale for decisions, and personal thoughts (e.g., progress, response to interview events or reading). Reflexive or research journals have been identified as a means of increasing researcher awareness of bias, critical reflection, and self-growth (Corbin & Strauss, 2015, pp. 57-58; Ortlipp, 2008). Journal notes were made primarily on paper and in NVivo 12 and reviewed regularly and used to provide status updates to dissertation supervisors.

4.8.4 Member checks

Member checking was conducted in October 2019. The member check involved providing participants with a preliminary summary of the research findings for their review and comment. Member checking was done to ensure that the research findings accurately presented and described participants' experiences and responses (Birt, Scott, Cavers, Campbell, & Walter, 2016). The member check was conducted by preparing a summary of the research

and preliminary findings and e-mailing all participants with a request for review and feedback. Feedback questions were provided at the end of the preliminary findings to help guide the feedback process and reduce participant response burden (Carlson, 2010). The specific feedback questions included were:

- Do these findings reflect you and your experience(s) mobilizing to prevent falls among community-dwelling adults? If no, please describe. In your description please identify the objective or main research question which is different.
- Do you want to change anything? If yes, please describe. In your description please identify the objective or main research question which you would like to make changes to.
- Do you want to add anything? If yes, please describe. In your description please identify the objective or main research question you would like to add to.
- Do you have any other comments about the research? (e.g., is there anything you've learned? Is there anything you would like to see/result from the research in general or from any reports?). If yes, please describe.
- Do you have any other comments about your interview? If yes, please describe.
- Do you have any other comments about the study? If yes, please describe.

A copy of the e-mail message, summary of preliminary findings, and feedback form are presented in **Appendix G**. Participants were asked to respond to the member check two weeks after the initial e-mail request was sent. If no reply was received after the requested response date, the researcher sent participants a follow-up e-mail asking if they had any questions or needed more time.

4.9 Analysis

All transcription, data preparation, and analysis of the data were conducted by the researcher. Interviews from audio recordings were transcribed using Nuance® Dragon® Professional Individual version 15 (Nuance Communications Inc.). Digital audio recordings made with Automatic Call Recorder for Android were downloaded from the cell phone to a computer in .amr format. Each .amr formatted file was then imported into Audacity® version 2.2.1 for Windows using the FFmpeg Import/Export Library and then converted to a WAV (Microsoft) signed 16-bit PCM file with a sampling rate of 11.025 kHZ. Audio files were then converted to a supported audio file format that conformed with Dragon® Professional Individual's Transcribe Recording tool. Dragon® Professional Individual was then opened and the Transcribe Recording tool was run using the WAV file, "someone else", and "Open the file in MICROSOFT Word" selected. Once the tool had completed the first round of transcription in Microsoft Word, the transcript was checked for accuracy by listening to the original audio file for errors or omissions. Errors and omissions were corrected by dictating or "parroting" the words in the interview verbatim. Transcripts were formatted by speaker, section, and research question before being imported into NVivo 12 Pro for data storage and analysis.

Data were analyzed and coded following Straussian Grounded Theory procedures and strategies (Corbin & Strauss, 2015, pp. 105-121; 1990). The process involved open, axial, and selective coding using constant comparison. The process began with three interviews (one PHU professional, one community partner, and one future potential partner) and included additional interviews once the interview had been transcribed. Interviews, notes, and memos were read twice to familiarize the researcher with the data. To manage the coding process and ensure the

research objectives were met, section headings from the interview guides were initially used as cut off points for coding the data and later reviewed for coding relevant to other objectives. Each section was reviewed line-by-line with the researcher looking for the main idea or concept being expressed (e.g., what is the event, activity, or interaction going on?). In some cases, it was necessary for the researcher to review several sentences or a paragraph to identify the main idea or concept. Main ideas and concepts were initially coded using the terms provided by participants, where possible, and refined as more data was coded. Open coding included identifying quotes exemplifying each concept and providing a description of the code along with any properties.

Codes and transcripts were then reviewed to identify relationships between the open codes and form categories. Questions about the phenomenon, causal conditions, context, actions, and consequences described in the data were used to establish and verify the relationships between codes and group open codes into core categories. Discrepant data and codes were used to bound and refine core categories.

Core categories were then reviewed to identify the major explanatory themes which explained the research objectives. This was done by asking questions about how the categories are related, what are the main ideas conveyed by categories, how do the categories explain each research question, and do the data support the decisions made. In addition to asking these questions, the researcher constructed concept maps to help illustrate and visualize the relationships between core categories and main themes, and reviewed feedback from the member checks to determine if changes needed to be made to the findings.

4.10 Ethical Approval, Consent, and other Considerations

4.10.1 Approval

Approval from the University of Waterloo, Office of Research Ethics [ORE] was sought prior to contacting prospective sample sites and participants. The pilot study was reviewed by and received ethics clearance in December 2017. The modifications to the pilot for the conduct of the full study were reviewed by and received ethics clearance in May 2018. As a requirement of conducting research at the University of Waterloo, the student researcher and supervisors completed the Tri Council Policy Statement: Ethical Conduct for Research Involving Humans online Course on Research Ethics (TCPS 2: CORE) (see **Appendix H**).

4.10.2 Consent

As part of the process for obtaining informed consent, all prospective participants were sent a recruitment e-mail or telephone call to assess potential interest in participating in the study along with an information letter describing the study purpose, nature of participation (i.e., format, time commitment, participant eligibility criteria), participant rights (i.e., voluntary participation, withdrawal, benefits, risks, anonymity, confidentiality), and information about who to contact should they have any questions (**Appendices E - F**). Potential participants who replied expressing interest were then sent a follow-up e-mail containing the verbal consent procedures and research questions to review prior to their scheduled interview (**Appendices E - F**). At the beginning of each scheduled interview, the verbal consent procedures were read and reviewed prior to obtaining verbal consent for study participation and recording the interviews. Verbal consent was provided for: participation in the interview, audio recording of the

interview, and permission to contact the individual at a later point for the purposes of clarification, triangulation, or further recruitment (**Appendices E - F**). Throughout the consent process participants were informed that the choice to participate was voluntary and that they could withdraw from the study by informing the researcher.

4.10.3 Other ethical considerations

Participant anonymity, confidentiality, privacy protection, and study benefits and risks

To protect the identity of participants, all participants were assigned a unique study number at the outset of the study and personal names were removed from the audio recordings, transcripts, and electronic data. Other steps taken to protect the identity, confidentiality, and privacy of participants included reporting findings in aggregate, modification of descriptive characteristics (e.g., altering job titles to make more general), using pseudonyms (e.g., for participants related to role and PHU sample site) and omitting immaterial identifying details (e.g., names of co-workers, community partners, communities) (Kaiser, 2009). Because referrals were used to identify potential study participants, those agreeing to participate were asked not to discuss the study with others. Future efforts to protect participants will include the application of these same strategies in presentations or publications based on this research (e.g., reports, conference posters, on-line abstracts, or descriptions of the study).

Participants did not receive any incentives or compensation for completing the study. However, participants were offered a copy of the final study report when complete. There are no known risks to participating and participants were given the opportunity to not answer or skip to another question for any reason throughout the interview.

Data storage and protection

This study involves both written and electronic records. Written records will be retained for up to seven years or at the end of the research, whichever occurs first, and then destroyed. Written records will be stored in a locked filing cabinet at the student researcher's home residence (in London, Ontario). Electronic data (i.e., digital audio recordings, transcripts, journals, and memos) will be stored on a password protected computer and will be stripped of any personal identifiers. Only the student researcher and thesis supervisors will have access to the electronic files. Electronic records will be retained for up to seven years or at the end of the research, whichever occurs first, and then destroyed. Access to written and electronic records will be limited to the student researcher and thesis supervisors. There are no conditions under which anonymity or participants confidentiality of data cannot be guaranteed.

4.11 Strategies to ensure the quality of the research

Qualitative researchers have developed a broad range of standards for judging the quality of their research depending on their ontological, epistemological, and methodological perspectives (Elliott & Lazenbatt, 2015). In consideration of the perspectives chosen for this research, multiple strategies for ensuring the quality of the research and grounded theory design were employed. The following paragraphs describe relevant standards for evaluating qualitative grounded theory research and the corresponding strategies that were used.

According to Lincoln & Guba (1985) there are five criteria for evaluating the *trustworthiness* (i.e., truth value, applicability, consistency, and neutrality) of qualitative research, which include *credibility*, *transferability*, *dependability*, *confirmability*, and *reflexivity* (pp. 290-327). *Credibility* can be described as the confidence that can be placed in the truth or

trustworthiness of the research findings (pp. 301-316). *Transferability* refers to the degree to which findings can be applied to other settings and contexts (p. 316). *Dependability* signifies the consistency and repeatability of the research (pp. 316-318). *Confirmability* describes whether other researchers can verify or corroborate the data and findings (pp. 318-327). *Reflexivity* refers to the degree to which researcher bias has influence over the findings (p. 327). The strategies recommended by Lincoln and Guba (1985, pp. 290-327) and used throughout this research to address questions about the *Trustworthiness* of this qualitative research are described in **Table 3**.

Table 3 *Strategies used for addressing the criteria of Trustworthiness based on Lincoln and Guba (1985)*

Criterion	Suggested strategy	Decision	Comments/Notes
Credibility	• Prolonged engagement with participants • Persistent observation • Triangulation • Peer debriefing • Negative case analysis • Referential adequacy • Member checks	• Prolonged engagement and persistent observation not feasible • Researcher to triangulate different sources by purposefully recruiting different personnel at each PHU site (i.e., PHU professionals, community partners, future potential partners) • Researcher to note negative cases in analysis • Researcher to conduct a member check using a summary of the research instead of transcripts	• Limited engagement with participants has occurred: Researcher completed a brief research assistantship with PHU professionals tasked with preventing falls • Researcher collected data from multiple sources (i.e., purposive sample of PHU professionals, community partners, future potential partners) to provide a more detailed understanding of community partner mobilization (i.e., converging or discrepant themes). • Researcher noted when there was a discrepant participant view and adjusted analysis accordingly as well as documenting differences in the findings • A summary of the research (Appendix X) was sent to all participants to ask for their opinions on the accuracy of the findings (do the findings reflect your experiences?) (Oct 2019)

Table 3 Continued

Criterion	Suggested strategy	Decision	Comments/Notes
Transferability	• Rich, thick description • Purposeful sampling	• Researcher to provide detailed descriptions of setting, participants while protecting anonymity • Researcher to recruit individuals representing different locations, peoples, and members involved in community partner mobilization	• Detailed descriptions of settings and individuals are presented • A purposeful sample of individuals representing different jurisdictions and positions was recruited to provide a wide range of experiences in analysis
Dependability	• Inquiry audit	• Researcher will maintain detailed notes and logs to allow for inquiry audit	• An electronic log of methodological process and decision-making (e.g., codes, categories, key questions, rationale, descriptions) was created and maintained in NVivo
Confirmability	• Confirmability audit • Audit trail • Triangulation • Reflexivity (see notes below)	• Researcher to maintain an audit trail of decisions made and processes followed • Researcher will use a purposeful sample of participants representing a range of experiences which can be compared with one another • Researcher will include copies of research materials, quotes, and tables to allow readers to externally audit study	• Notes about study decisions and processes followed made on paper and in NVivo • See notes on Triangulation under Credibility • Copies of study materials have been appended • Tables illustrating various codes and categories as well as quotes have been presented in chapter on findings

Table 3 Continued

Criterion	Suggested strategy	Decision	Comments/Notes
Reflexivity	• Reflective journal of daily schedule and logistics, personal reflections, and log of methodological decision-making (p.327)	• Researcher to maintain a reflective journal and notes • Researcher to declare ontological and epistemological perspectives	• Daily schedule and logistics recorded on paper • Personal reflections were made on paper and NVivo throughout study process • A log of methodological decision-making (e.g., codes, categories, key questions, rationale, descriptions) was maintained in NVivo • Declaration of researcher's ontological and epistemological perspectives and background made

For grounded theory, Corbin and Strauss (1990; 2015) emphasized the quality, credibility, and applicability of research depends on demonstrating/meeting certain methodological and theoretical components. They group these components into two categories or sets of "checkpoints": a) the *Research Process* which deals with questions about the consistency with which the research method was conducted; and b) the *Empirical Grounding of Findings* which deals with questions about how useful, significant, and well the findings fit the phenomena and data being studied. In their more recent work, Corbin and Strauss (2015) provided 16 checkpoints for evaluating the *Research Process* (pp. 435-436) and 17 checkpoints for the *Empirical Grounding of Findings* (pp. 436-438). **Table 4** lists each of the checkpoints and how they were applied to this research.

Table 4 *Checkpoints for establishing quality research according to Corbin and Strauss (2015)*

Checkpoint	Comments
The Research Process	
1. What was the target sample population? How was the original sample selected?	Described in sections 4.6 Sampling.
2. How did sampling proceed? What kinds of data were collected? Were there multiple sources of data and multiple comparative groups?	Described in sections 4.6-4.8.
3. Did data collection alternate with analysis?	Described in section 4.9 Analysis
4. Were ethical considerations taken into account in both data collection and analysis?	Described in section 4.10 Ethical approval, consent, and other considerations
5. Were the concepts driving the data collection arrived at through analysis or were the concepts derived from the literature and established before the data were collected?	Described in sections 4.8 Data collection and 4.9 Analysis.
6. Was theoretical sampling used, and was there a description of how it proceeded?	Described in sections 4.8 Data collection and 4.9 Analysis.
7. Did the researcher demonstrate sensitivity to the participants and to the data?	Yes. Researcher carefully listened to participants' experiences, views, questions, and comments. Researcher respected participants' requests to not answer or skip questions.
8. Is there evidence or examples of memos?	Described in section 4.8 Data collection
9. At what point did data collection end or a discussion of saturation end?	Data collection ended following the return of participant feedback on the study findings and the need to adhere to dissertation timelines. Saturation was not achieved fully for all categories. Please refer to the discussion for a note on the appropriateness of saturation upon which to judge the current research.

Table 4 Continued

Checkpoint	Comments
The Research Process	
10. Is there a description of how coding proceeded along with examples of theoretical sampling, concepts, categories, and statements of relationship? What were some of the events, incidents, or actions that pointed to some of these major categories?	Described in section 4.9 and in Chapter 5: Findings.
11. Is there a core category, and is there a description of how that core category was arrived at?	Described in Chapter 5: Findings.
12. Were there changes in design as the research went along based on findings?	Minor changes were made to the interview guides following completion of the pilot study. This is described in section 4.8 Data collection.
13. Did the researcher encounter any problems while doing the research? Is there any mention of a negative case, and how was that data handled?	Challenges were encountered with recruiting participants (i.e., community partners, future potential partners). This may have been due to the time of year the study was conducted (i.e., summer vacation). No negative case was encountered; however, disconfirming perspectives are noted in the findings section.
14. Are methodological decisions made clear so that the readers can judge their appropriateness for gather data and doing analysis?	The methodological process has been explained in detail in Chapter 4: Research method and design.
15. Was there feedback on the findings from other professionals and from participants? And were changes made in theory based on this feedback?	A summary of preliminary research findings was sent to all study participants for feedback. There were no suggested changes.
16. Did the researcher keep a research journal or notebook?	Yes, a research journal was kept. Described in section 4.8 Data collection.
Empirical grounding of findings	
1. What is the core category, and how do the major categories relate to it? Is there a diagram depicting these relationships?	Described in Chapter 5: Findings.

Table 4 Continued

Checkpoint	Comments
Empirical grounding of findings	
2. Is the core category sufficiently broad so that it can be used to study other populations and similar situations beyond this setting?	Yes, I believe so. Community partner mobilization is not a process or experience unique to falls prevention. In order to engage in community partner mobilization, multiple strategies such as those identified may arise or be engaged in other situations and setting in order to achieve specific outcomes.
3. Are each of the categories developed in terms of their properties and dimensions so that they show depth, breadth, and variation?	Described in Chapter 5: Findings. Some of the categories are well developed. Others less so. More interviews may have helped in providing sufficient data to illustrate these properties.
4. Is there descriptive data given under each category that brings the theory to life so that it provides understanding and can be used in a variety of situations?	Descriptive data including thick, rich descriptions and use of quotes have been provided in Chapter 5: Findings.
5. Has context been identified and integrated in the theory?	Aspects of context have been identified (e.g., study setting, PHU sites); however, more interviews and data may have helped in developing a more nuanced understanding of context in relation to the theory (e.g., differences related to regions, PHU structure, partnership structures, etc.).
6. Has process been incorporated into the theory in the form of changes in action – interaction in relationship to changes in conditions? Is action-interaction matched to different situations, demonstrating how the theory might vary under different conditions and therefore be applied to different situations?	Process has been incorporated in the theory. This is particularly visible in the findings and figures illustrating community partner mobilization definitions and practices. See Chapter 5: Findings.

Table 4 Continued

Checkpoint	Comments
Empirical grounding of findings	
7. How is saturation explained, and when and how was it determined that categories were saturated?	Saturation was not fully achieved in the study. The development of categories ended following data collection and analysis and the need to adhere to dissertation completion timelines. I have presented several tables illustrating the logic behind the thematic structure contributing to the development of the main themes based on the data and provided quotes to illustrate these themes. Please refer to the discussion for a note on the appropriateness of saturation upon which to judge the current research.
8. Do the findings resonate or fit with the experience of both the professionals for whom the research ended and the participants who took part in the study? Can participants see themselves in the story even if not every detail applies to them? Does it ring true to them? Do professionals and participants react emotionally as well as professionally to the findings?	A member check was sent to participants and asked to comment on a summary of preliminary findings in terms of its accuracy. Participants responded that the summary looked good.
9. Are there gaps, or missing links, in the theory, leaving the reader confused and with a sense that something is missing?	Comments from study participants indicate the theory described in the findings seem logical, although, additional data could have strengthened the theory.
10. Is there an account of extremes or negative cases?	No negative cases were encountered. Deviations or contradictory data were noted throughout Chapter 5: Findings.
11. Is variation built into the theory?	Yes. For example, not all community partner mobilization efforts were initiated by the same individual or group of individuals. As such the concept map identifies that both PHU professionals and Community partners may initiate the community partner mobilization efforts.

Table 4 Continued

Checkpoint	Comments
Empirical grounding of findings	
12. Are the findings presented in a creative and innovative manner? Does the research say something new or put old ideas together in new ways?	Findings are among the first to explore community partner mobilization practices to prevent falls and answer a call for evidence made by PHU professionals themselves.
13. Do findings give insight into situations and provide knowledge that can be applied to develop policy, change practice, and add to the knowledge base of a profession?	The findings provide insight and knowledge that can be applied to develop future research and practices.
14. Do the theoretical findings seem significant, and to what extent?	These findings are expected to allow PHU professionals to develop future research, standards, and enable them to strengthen practices with community partners to prevent falls.
15. Do the findings have the potential to become part of the discussions and ideas exchanged among relevant social and professional groups?	Yes.
16. Are the limitations of the study clearly spelled out?	See discussion of the limitations in Chapter 6: Discussion.
17. Are there suggestions for practice, policy, teaching, and application of the research?	Yes. Described in Chapter 6: Discussion.

4.12 Chapter summary

This chapter has focused on the research design and methods. It has described the study perspective, method, design, sampling and recruitment, data collection, analysis plan, ethics considerations, and strategies to ensure rigour. The following chapter describes the research findings.

Chapter 5: Findings

The purpose of this study is to document the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls among community-dwelling adults. This chapter presents the findings from semi-structured interviews with public health professionals in Ontario's Public Health Units (PHUs), their community partners, and future potential partners engaging in community mobilization to prevent falls. The first part of this chapter describes the recruitment process, study sample, and interviews. The second section provides a detailed description of the characteristics of PHU professionals and community partners taking part in community mobilization to prevent falls, the context and communities in which community partner mobilization is being practiced, the processes engaged by PHU professionals, the benefits and challenges to community partner mobilization, and PHU professional's views about capacity building and policy development by those supporting implementation of comprehensive falls prevention by Ontario's PHUs. The final section presents a conclusion to the chapter.

5.1 Recruitment and Sample

As illustrated in **Table 5** the final study sample consisted of thirteen participants – five PHU professionals, six community partners, and two future potential partners. All sampled PHUs were represented by a PHU professional designated to fall prevention among community-dwelling adults. Four PHUs were represented by interviews with at least one of their community partners. Two PHUs were represented by interviews with one future potential

partner. One PHU was not represented by interviews with community partners and future potential partners.

Multiple procedures were used to recruit the sample for this study which included PHU professionals, community partners, and future potential partners from five different PHUs across Ontario. As described in the **methods** section (pp. 53-58), PHU professionals were recruited via purposeful sampling while community partners and future potential partners were recruited via chain-referral sampling. The initial plan was to first recruit and interview PHU professionals to pilot test the interview guide. Subsequently, an additional five PHU professionals were to be recruited to take part in the study representing different geographic regions, population types, and participation in the Falls LDCP. However, a decision was made to include the pilot data in the full study in order to increase the number of participants and richness of the qualitative analysis. This decision was due to challenges associated with recruiting participants and scheduling interviews over the summer months, limited referrals of community and future potential partners to be interviewed, degree completion timelines, and the fact that pilot testing did not result in significant changes to sampling procedure, materials or interview guide (see **Appendix E** for copies of the pilot study materials and **Appendix F** for copies of the main dissertation study materials which include changes highlighted in grey).

Theoretical sampling was also used as part of the recruitment decision-making process as interviewing and data analysis progressed. Theoretical sampling began with the selection of key sensitizing concepts that were identified in the literature review. In particular, the Falls LDCP Logic Model for Mobilizing Partners in Injury Prevention provided a basis for gathering data by defining key things to probe during the interviews. Also, the research used inductive

and confirmatory deductive approaches. Constant comparison of data to categories emerging from the data and against sensitizing concepts was needed to help address research questions relevant to understanding how PHU professionals were engaging in community partner mobilization to prevent falls among community-dwelling older adults. Theoretical sampling was used to inform the choice of questions and affiliated probes. Categories started to emerge from the data following the coding of the seventh interview (N.B. as previously noted, the first three interviews were used in the pilot and included in the final sample near the end of the study when it was determined that more data was needed to enhance the richness of qualitative analysis). It was decided that the study needed to collect data from specific participants to populate and increase the density of concepts, categories and key themes as much as possible. Waiting until the seventh interview allowed for an initial set of codes and categories that emerged from the data to be elaborated and described vis-à-vis gaps in the data. This information lead to a decision to continue sampling in order to discover whether different PHUs, partners, and future potential partners report the same or different community partner mobilization processes. Subsequent sampling, adjustment of the research questions, coding and analysis was used to confirm/disconfirm some of the main ideas, fill in gaps and identify new areas to direct the research, determine whether data from more interviews were needed, and who might be most knowledgeable to speak to next.

For example, when asked about how PHU professionals and partners organized themselves for community mobilization, the first PHU described using "*Terms of Reference*". This formal document was also described by the next PHU professional interviewed. Thus, an expectation was formed that formal documents like Terms of Reference would be an important

concept in organizing community partner mobilization. Accordingly, an attempt was made to remain sensitive to discussions about using Terms of Reference and inquiries were made as to whether other formal documents were used while simultaneously exploring whether Terms of Reference and other formal documentation were standard tools used in organization.

The constant comparative method started after the first two interviews had been transcribed (i.e., at the initial coding stage). Each interview was read for familiarity and then the data was coded for significant ideas or concepts, relationships between concepts, and properties. Following this initial coding, data from each interview was compared for similarities, differences, and consistencies in the coding. This procedure helped to identify key concepts and relationships, as well as gaps in the data to explore further in subsequent interviews. As each interview was completed, the process of constant comparison was completed to determine if the emerging codes, categories, themes were dense, detailed and well-integrated into a theoretical framework supported by rigorous systematic examination of the data. This process also identified some gaps in the data and the need for further data collection which were not filled within the dissertation timelines. Some of these remaining gaps are evidenced by sparsely populated columns in the tables presenting the thematic structure of different research questions. Theoretical saturation was not possible for all categories identified in the data and complete theoretical saturation for all aspects is not claimed. Frank disclosure of theoretical sufficiency (Dey, 1999) and strengths and limits of qualitative research is encouraged in qualitative research reporting (Thorne, 2020). The sections which follow present recruitment and sample details from the combined studies.

Table 5 *Participant Representation by Participating Public Health Unit (PHU)*

	# PHU professionals interviewed	# Community partners interviewed	# Future potential partners interviewed	PHU Site Total
PHU				
Central West #1	1	1	1	**3**
Central West #2	1	1	0	**2**
South West	1	3	0	**4**
North West	1	1	1	**3**
Eastern	1	0	0	**1**
Total	**5**	**6**	**2**	**13**

5.1.1 PHUs and PHU professionals

Out of the 35 eligible PHUs (one PHU was amalgamated during the study period), eight Medical Officers of Health or authorizing Public Health officials were sent emails requesting their permission and allowance of time to speak with the designated fall prevention professional at their respective PHU (**Appendices E and F**). These emails consisted of a letter outlining the study purpose, what participation would entail (i.e., a telephone interview, answering questions on specific topics, amount of time needed), methods for contacting the study investigator and University of Waterloo's ORE, and the interview questions (**Appendices E and F**). Seven Medical Officers of Health or authorizing Public Health officials responded by e-mail with permission to contact their staff and conduct the study. One PHU declined due to changes in staffing.

Once permission had been granted by the Medical Officer of Health or authorizing Public Health official, an e-mail invitation was sent by the researcher[4] to the PHU professional designated to fall prevention among community-dwelling adults (**Appendices E and F**). This e-mail contained information about the study purpose and procedures, methods for contacting the investigators and University of Waterloo's ORE, and the interview questions (**Appendices E and F**). Six PHU professionals replied; five of whom provided verbal consent and scheduled an interview. One PHU professional who initially expressed interest declined participation after it was discovered they had received the wrong interview questions in error, and due to

[4] Initial e-mail contact to the PHU professional about the pilot was made by the dissertation co-supervisor AC with follow-up regarding the details of the study by the researcher. Initial contact with all other PHU professionals was made by the researcher.

restrictions on their time. One PHU did not respond to the invitation to participate after two e-mail attempts and three phone calls.

As shown in **Table 6**, the final interview sample consisted of five PHU professionals representing a combination of different geographic areas (Central West, Eastern, North West, and South West), populations (urban/metro, urban/rural mix, and rural), and prior participation in the LDCP falls project. All geographic areas except for the North East and Central East were represented. The populations served were Urban/Rural mix (*n=3*, 60.0%), followed by Rural (*n=1*, 20.0%) and Urban/metro (*n=1*, 20.0%). Three of the five PHU professionals (*n=3*, 60.0%) represented PHUs that had taken part in the falls LDCP. Additional descriptive information about the PHU professionals is presented in the Analysis section for objectives one and two.

Table 6 *Geographic, Peer Group, and Falls Locally Driven Collaborative Projects Classification of Participating Public Health Units (PHUs) and Public Health Unit Professionals (n=5)*

Classification	Number (%)
Geographic area	
Central East	0 (0.0%)
Central West	2 (40.0%)
Eastern	1 (20.0%)
North East	0 (0.0%)
North West	1 (20.0%)
South West	1 (20.0%)
Peer group	
Rural (Rural northern regions, Mainly rural)	1 (20.0%)
Urban/metro (Urban centres, Mainly urban, Metro centre)	1 (20.0%)
Urban/rural mix (Sparsely populated urban/rural mix, Urban/rural mix)	3 (60.0%)
Falls LDCP participation	
No	2 (40.0%)
Yes	3 (60.0%)

Notes. Geographic area classifications from Association of Local Public Health Agencies (alPHa), n.d. Information used for PHU peer group classifications is from Ontario Ministry of Health and Long Term Care, 2016. Peer groups have been combined in order to protect the anonymity of participants.

5.1.2 Community partners

The second sample consisting of community partners was gathered from referrals made by the interviewed PHU professional. PHU professionals were asked to provide references for community partners who were most knowledgeable about the work they've been doing together to prevent falls among community dwelling adults. Each PHU provided references for three community partners, except for one PHU which provided four references. In total, PHU professionals identified 16 community partners who they felt would be most knowledgeable about the work they had been doing to prevent falls.

The 16 community partners were contacted by phone or e-mail, depending on the recommended contact method provided by the referring PHU professional. All phone calls identified the researcher, discussed the reason the individual was being contacted, the purpose of the research and interest in receiving an e-mail invitation providing further details about the study (**Appendices E and F**). The e-mailed invitations included the study purpose and procedures, contact information for the investigators and University of Waterloo's ORE, and a copy of the interview questions (**Appendices E and F**). Verbal consent to participate in the study was provided at the beginning of the interview.

Out of the 16 referrals, nine community partners agreed to participate in the study; however, three could not participate within the data collection timeframe. Five of the referred community partners declined; three from to lack of organizational capacity (i.e., time and/or staff), one due to an unspecified change in organizational focus, and one for personal reasons. Two referred community partners did not respond to the invitation. A total of six community partners were interviewed. **Table 7** summarizes the number of community partners referred by

each participating PHU. Other descriptive information about interviewed community partners is presented in **Description of Findings by Research Objective** under objective three (p. 104).

Table 7 *Number of Community Partners Referred and Participating by Public Health Unit (PHU)*

		Number of partners referred and contacted	Number of partners interviewed
PHU			
	Central West #1	3	1
	Central West #2	4	1
	Eastern	3	0
	North West	3	1
	South West	3	3
Total		**16**	**6**

5.1.3 Future potential partners

The third sample consisted of future potential partners, also identified by PHU professional referrals. Each PHU professional was asked to provide references for at least[5] "two of the top individuals/organizations they were most interested in partnering with to prevent falls in the community." During the telephone interviews, all PHU professionals identified one or more future potential partners although not all were able to identify specific individuals or organizations. Some of the reasons given for challenges identifying future potential partners were related to already being well represented, waiting for the results of a partnership review, not having "any connection within the organization," not knowing the key players, and "currently working on operational plans" with the intention to identify and reach out to community organizations in 2019. Further correspondence with PHU professionals resulted in the identification of an additional 19 future potential partners, with 18 of these referrals having been provided by a single PHU professional. In total, 29 future potential partners were identified for referral; however, only three of these referrals were for specific individuals with contact information.

Invitations to participate in the study were sent to the three future potential partners by phone or e-mail, depending on the recommended contact method provided by the referring PHU professional. The phone calls identified the researcher, discussed the reasons for being contacted, the purpose of the research and interest in receiving an e-mail invitation providing further details about the study (**Appendices E and F**). The e-mailed invitations included the

[5] The PHU professional participating in the pilot study was asked to identify up to five future potential partners while all other PHU professionals were asked to identify two. The precise wording of the PHU questions for the pilot can be found in **Appendix E** and for the full study in **Appendix F**.

study purpose and procedures, contact information for the investigators and University of Waterloo's ORE, and a copy of the interview questions (**Appendices E and F**). Verbal consent was provided at the beginning of each interview.

Two of the three future potential partners agreed to participate and were interviewed. The third future potential partner did not respond to telephone or e-mail invitations and reminders. **Table 8** outlines the number of future potential partners referred by each participating PHU. Other descriptive information about the future potential partners including future potential partners identified without specific contacts is presented in the Analysis section for objective four.

Table 8 *Number of Future Potential Partners Referred and Participating by Public Health Unit (PHU)*

		Number of future potential partners referred and contacted	Number of future potential partners interviewed
PHU			
	Central West #1	2	1
	Central West #2	2	0
	South West	2	0
	North West	4	1
	Eastern	19[a]	0
Total		**29**	**2**

Note. [a]18 references provided post interview.

One-on-one telephone interviews with participants occurred between January and September 2018. On average, interviews with PHU professionals took 106 minutes; range 75 minutes and 152 minutes. Interviews with community partners averaged 94 minutes and ranged between 44 minutes and 109 minutes. The average length of interview for future potential partners was 16 minutes and ranged between 13 minutes and 20 minutes. Average page lengths of transcribed interviews were 59.4 pages for PHU professionals (range: 44 – 77 pages), 50.8 pages for community partners (range: 28 – 75 pages), and 11.5 pages for future potential partners (range: 10 – 13 pages). All interviews were transcribed by the researcher. **Table 9** lists the interview dates, length of time to complete, transcript page length, and transcript word length according to participant.

Table 9 *Description of Interviews and Transcripts by Participant*

Participant	Interview date	Interview length (h:mm:ss)	Transcript (pages)	Word count (words)
PHUprof1	January 22nd, 2018	2:32:00	73	24,169
PHUprof2	June 7th, 2018	2:03:10	70	13,729
PHUprof3	June 18th, 2018	1:37:10	55	13,748
PHUprof4	July 6th, 2018	1:24:35	55	10,012
PHUprof5	July 10th, 2018	1:15:00	44	9,482
Partner1	March 1st, 2018	0:56:45	47	7,914
Partner2	July 6th, 2018	0:58:50	42	9,046
Partner3	July 23rd, 2018	0:44:25	28	6,894
Partner4	July 30th, 2018	1:34:45	75	14,208
Partner5	July 31st, 2018	1:49:25	63	12,897
Partner6	July 19th, 2018	1:16:00	50	11,521
FuturePartner1	March 6th, 2018	0:13:20	10	1,317
FuturePartner2	September 18th, 2018	0:19:35	13	3,027
Total		16:45:00	625	137,964
Average		1:17:18	48	10,613

5.2 Description of Findings by Research Objectives

To answer the question of how Ontario's PHU professionals are mobilizing with community partners to prevent falls among community-dwelling adults, a mix of descriptive and emergent findings are presented. The findings are organized into sub-sections according to the research objectives as follows:

- Section 5.2.1, characterizes participating PHU professionals engaging in community partner mobilization. The findings describe PHU professionals engaging in community mobilization, their Public Health and falls prevention experience, as well as community mobilization training to understand who is mobilizing and the experience/skills/knowledge influencing how community partner mobilization is being practiced (study objective 1);
- Section 5.2.2, describes the context within which the PHU professionals are working and populations they serve, providing insight into the conditions, resources, and opportunities influencing practices (study objective 2);
- Section 5.2.3, identifies the community partners that Ontario's PHU professionals are mobilizing and describes the community partners interviewed, further revealing who is mobilizing, their experience/skills/knowledge/resources, and influence on current practices (study objective 3);
- Section 5.2.4, describes the community partners that are not currently collaborating with PHUs but are viewed as adding value according to participants, providing insight into who is not currently mobilizing and who has been identified as needed (study objective 4);

- Section 5.2.5, provides emerging themes from participants' descriptions of their knowledge of community partner mobilization, purposes for mobilizing, roles, and strategies and practices being employed by PHU professionals in working with their partners to prevent falls. The themes directly address issues about the community partner mobilization process, roles of individuals, and activities (study objective 5);
- Section 5.2.6, examines the participants views about the strategies employed by PHU professionals, the benefits and challenges of community partner mobilization, and under what contexts successes and challenges have occurred These findings provide details about community partner mobilization outputs and outcomes, and how practices are working or could be changed (study objective 6); and
- Section 5.2.7, explores how public health professionals view capacity building and policy development by provincial and federal public health ministries and agencies to support implementation of comprehensive falls prevention programs by Ontario PHUs. These findings describe external contextual factors related to the impact of provincial and federal agencies on the current and future community partner mobilization practices employed by Ontario's PHU professionals (study objective 7).

To protect the anonymity of participants throughout this study, personally identifiable information has been removed and only partial and generalized descriptions of the individuals and their work contexts are provided in the sections that follow.

5.2.1 Objective 1: Characteristics of participating PHU professionals

As noted earlier, five PHU professionals tasked with fall prevention among community-dwelling adults were interviewed. The majority (*n = 3*, 60%) of PHU professionals interviewed represented PHUs that had participated in the LDCP identifying ways to mobilize community partners by looking at models and frameworks related to health promotion and injury prevention. The remaining public health professionals (*n = 2*, 40%) represented PHUs that had not been involved with LDCP. All five PHU professionals stated that they were mobilizing with community partners.

All the participants were female. Participants' job titles included one health planner, one health promoter, one program manager, and two public health nurses. The number of years of public health experience totaled 60 years for the five participants with a range of three to 25 years (M = 12, SD = 8.5). The total number of years of fall prevention experience was 28.5 years with a range of 2 to 15 years (M = 6; SD = 5.3). A demographic summary of selected characteristics of the interviewed PHU professionals is presented in **Table 10**.

Table 10 *Summary Characteristics of Public Health Unit (PHU) Professionals Interviewed (n = 5)*

PHU professional characteristics	Number (%)
Gender	
Female	5 (100.0%)
Male	0 (0.0%)
Job Title	
Health planner	1 (20.0%)
Health promoter	1 (20.0%)
Program manager	1 (20.0%)
Public health nurse	2 (40.0%)
Years of public health experience	
0-4	1 (20.0%)
5-9	1 (20.0%)
10-14	1 (20.0%)
15-20	1 (20.0%)
25+	1 (20.0%)
Years of experience in fall prevention	
0-4	3 (60.0%)
5-9	1 (20.0%)
10-14	0 (0.0%)
15+	1 (20.0%)

5.2.2 Objective 2: Characteristics of the PHUs and population served

The PHU professionals who partook in this study worked under a variety of contexts. Participating PHU professionals represented a range of geographic and population groups as described in **section 5.1.1** (pp. 85-87). The total number of PHU staff working in each unit varied from more than 100 to more than 250 personnel working in a variety of positions including janitors, administrators, public health nurses, etc. All PHU professionals identified differing organizational structures, program areas or divisions, and departments or teams responsible for the prevention of falls. Work to prevent falls fell predominantly under chronic disease and injury prevention, healthy families, and health promotion and programming. Within some PHUs this was further divided into different age, stage, or target populations (e.g., 0-6 year olds, school age children, older adults). The number of PHU professionals tasked with the prevention of falls at each PHU ranged from one to three.

Due to organizational differences, it was challenging for some of the participants to provide an estimate of the operating budget devoted to falls and injury prevention and the number of PHU staff hours allocated to fall prevention. Three participants could not provide estimates of the budget for falls and injury prevention for their PHUs. One PHU professional provided an estimated annual budget of $10,000 for injury prevention with $3,500 allocated for fall prevention. The other PHU professional estimated that $55,000 was allocated to their department with $10,000 assigned to falls prevention. More than half (n = 3) of the PHU professionals noted that the budget allocated to falls and injury prevention fluctuated depending on other responsibilities, public health priorities, or community needs.

The total number of PHU staff hours allocated to fall prevention was estimated to be between 25.5 and 42.5 hours per week. When asked how the time assigned for fall prevention compared to other injury sectors, two participants felt it was smaller, one participant felt it was about the same, one participant said "*it really just sort of depends on what's happening at the moment," [PHU professional 3]*, and one participant did not provide an estimate.

Most (*n = 4*) of the PHU professionals interviewed served communities with populations of less than 250,000 people except for one where the population exceeded 350,000. In speaking about their communities, participants commented on several population characteristics, including the presence of older adults and growth. More than half (*n = 4*) of the participants noted their PHU served a significant number of adults aged 65 years or older. One participant did not mention the number of older adults served. All participants commented that the number of older adults in their population was increasing or expected to increase over the next few years. Aboriginal populations were also included in community descriptions by three participants (e.g., presence of people, presence of reserves, or percentage of population).

The need to prevent falls in their community was identified by all participants (*n = 5*). Four participants agreed that there was a need to prevent falls among community-dwelling older adults and stated that their PHUs had conducted assessments of the need to prevent falls among community-dwelling adults. The remaining participant felt that there was a need to focus on fall prevention in their community but the PHU needed *"to do some research first to figure out which populations need our help the most"* and determine the role that the PHU could play in serving the community. The participant also noted, *"We haven't done that kind of analysis before and it's because …. no one has asked for it" [PHU professional 1]*.

When asked, whether their PHU has different materials or strategies for preventing falls among community-dwelling older adults versus the general population, all five PHU professionals said they had different materials or strategies targeting community-dwelling older adults. However, two participants indicated that they did not do specific interventions or strategies targeting the general population. One participant stated although they target older adults with different materials and strategies, they were cautious about using and applying the term *"older adult"* to their work because they found older adults did not *"identify with the term older adults very well" [PHU professional 3]*. Some of the different materials or strategies for preventing a fall among community-dwelling older adults described by participants included: education (*n = 3*) (e.g., awareness of fall hazards, strategies to prevent falls), support and promotion of community programming (*n = 2*), developing and implementing age-friendly communities (*n = 2*), and community partnerships (*n = 1*). A summary of selected characteristics of the PHUs and populations served is presented in **Table 11**. Characteristics are broadly categorized and not provided by PHU to protect the anonymity of participants.

Table 11 *Summary of Public Health Unit (PHU) and Community Characteristics (n = 5)*

Public Health Unit characteristics	Number (Percent)
Number of public health staff	
0-49	0 (0.0%)
50-99	0 (0.0%)
100-149	2 (40.0%)
150-199	1 (20.0%)
200+	2 (40.0%)
Number of public health staff dedicated to falls	
1	1 (20.0%)
2	1 (20.0%)
3	3 (60.0%)
Size of population served	
0-149,999	2 (40.0%)
150,000-249,999	2 (40.0%)
250,000-349,999	0 (0.0%)
350,000+	1 (20.0%)
Need to prevent falls in community?	
No	0 (0.0%)
Yes	5 (100.0%)
Assessment of need to prevent falls conducted?	
No	1 (20.0%)
Yes	4 (80.0%)
Different materials/strategies for preventing falls?	
No	0 (0.0%)
Yes	5 (100.0%)

5.2.3 Objective 3: Description of community partners mobilizing.

This section is divided into two sub-sections that describe the community partners mobilizing with Ontario's PHU professionals to prevent falls. The first sub-section presents the community partners identified and depicted by the PHU professionals. The second sub-section describes the six community partners who participated in the study.

5.2.3.1 PHU professionals' description of mobilizing community partners.

PHU professionals stated that they were mobilizing with between 10 and 35 community partners to prevent falls among community-dwelling adults. Three PHU professionals reported that their mobilization work involved approximately 10 community partners, one PHU professional reported mobilizing with 20 community partners, and one PHU professional stated they were mobilizing with 35 community partners. **Figure 4** illustrates the number of community partners being mobilized according to represented PHU.

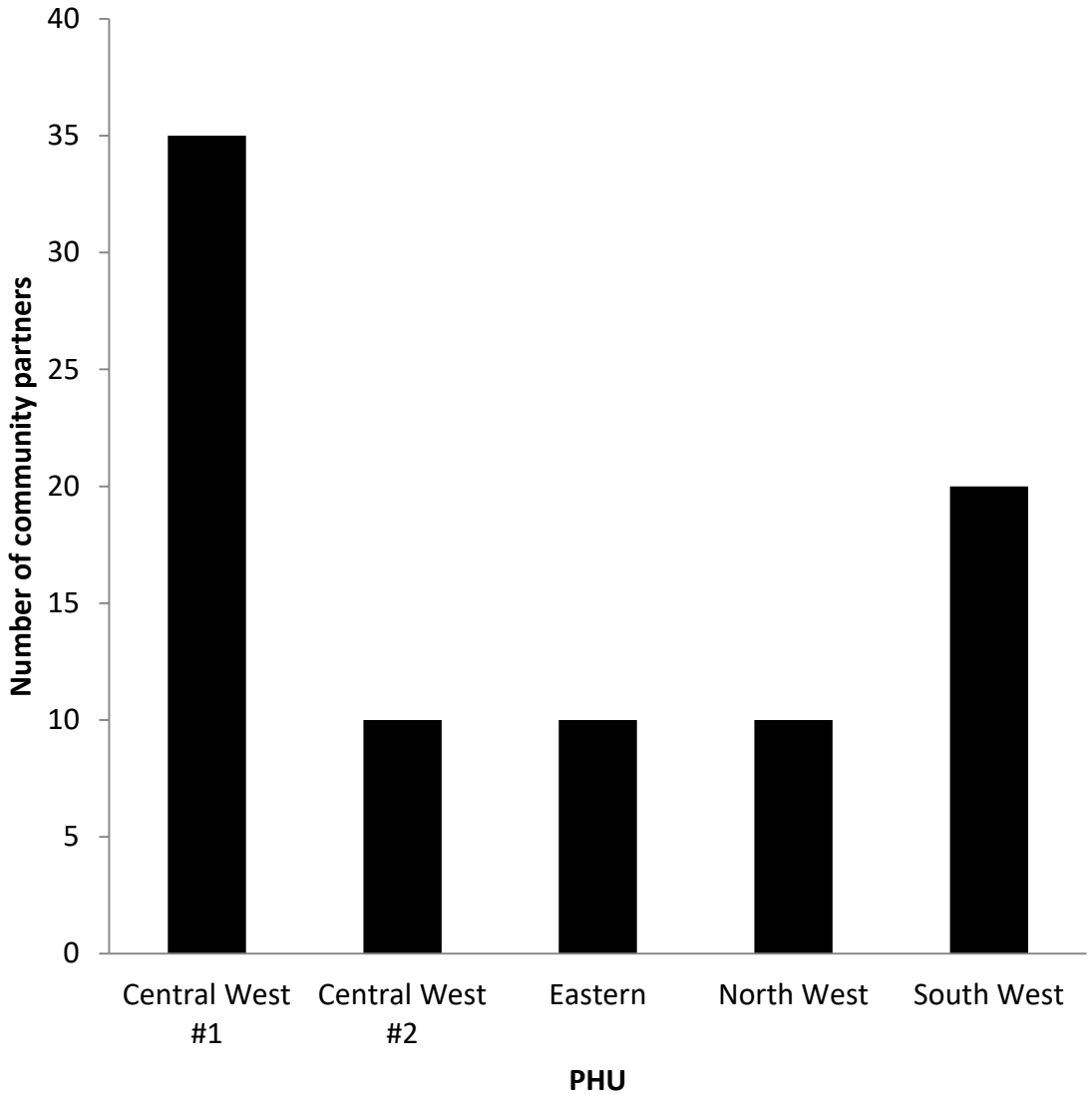

Figure 4. Number of reported community partners mobilizing with each Public Health Unit (PHU)

Sixteen of these community partners were identified by PHU professionals as organizations or individuals who they felt would be most knowledgeable about the work being done to prevent falls. Fifteen of the recommended partners were from organizations and one was an individual who had done work previously as part of a municipal government but was currently working independently. The 15 organizations were described by PHU professionals as representing a range of not-for-profit (*n = 9*), government (*n = 7*), charitable (*n = 3*), community (*n = 1*), and academic groups (*n = 1*).[6] Ten organizations were health related. Partnerships with the referred community organizations or individuals were estimated to be between 2 months and 15 years in length. As shown in **Figure 5**, the majority of referred community partnerships (*n = 11*) were reported to be less than five years in length.

[6] Some PHU professionals described their community partners using more than one organization category and so the total number of groups according to type exceeds the number of referred partners.

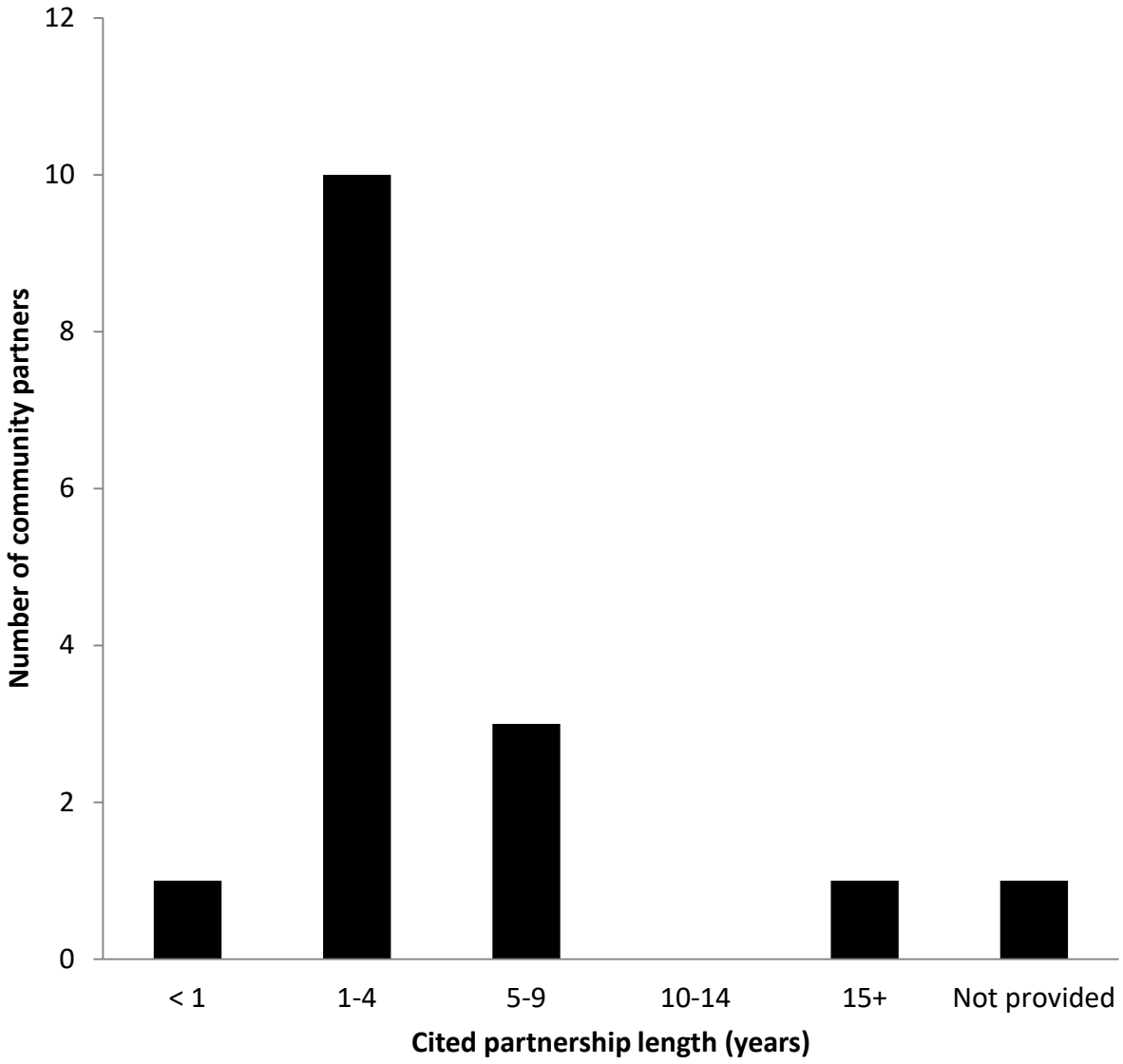

Figure 5. Partnership length in years for referred community partners and Public Health Unit (PHU) professionals according to interviewed PHU professionals.

PHU professionals described these community partners as fulfilling a variety of roles related to their joint work to prevent falls among community-dwelling adults. Two major themes emerged describing community partners' roles: (1) building networks, coalitions, and strategic plans; and (2) delivering and supporting health promotion, education, and programming. Roles related to building networks, coalitions, and strategic plans focused on roles contributing to coalitions, committees, and task groups (e.g., leadership, decision making, intellectual engagement, networking, establishing and sitting on coalitions and task groups) and the developing strategic and community-wide plans. Roles related to delivering and supporting health promotion, education and programming involved providing fall-related prevention programs and education, delivering health promotion activities (e.g., exercise classes to older adults, information fairs), providing resources (e.g., space, time, personnel), and attracting and reaching target populations (e.g., increasing awareness of programs, providing PHUs and target population with access, serving as a conduit). **Table 12** illustrates the thematic structure describing the roles of referred community partners according to interviewed PHU professionals.

Table 12 *Thematic Structure Describing Roles of Referred Partners According to Public Health Unit (PHU) Professionals*

Main theme	Sub-themes	Dimensions
Building networks, coalitions, and strategic plans	Contributing to coalitions, committees, and task groups	Decision making Intellectual engagement Networking Partnership opportunities Providing and exchanging knowledge Providing leadership Sitting on coalitions, committees and task groups
	Developing strategic and community wide action plans	Conducting strategic work Preparing and introducing community-wide action plans
Delivering and supporting health promotion, education, and programming	Attracting and reaching intended target audience	Increasing awareness of programming Providing access to target audience Providing and/or increasing reach Serving as a conduit
	Providing health promotion, education, and programming	Offering programs and activities Offering education Providing presentations Supporting messaging
	Providing resources for health promotion, education, and programming	Providing participants Providing personnel Providing space Providing time

5.2.3.2 Description of interviewed community partners.

Table 13 provides a summary of selected characteristics of interviewed community partners engaging in community mobilization with Ontario's PHU professionals. Of the six community partners interviewed, five were female and one was male. Three of the community partners were organizational or program directors, two were coordinators, and one was a lead. The total number of years of experience in these positions ranged from three to 15 years (M = 9.7, SD = 4.6). Five of the community partners represented non-profit organizations and one represented a municipal government although was currently working independently.

The primary services offered by community partners covered a range of areas including:

- two partners who provided community health care;
- one partner who served as an older adult day center;
- one partner who provided recreation programming for older adults;
- one partner that primarily supported research; and
- one partner that provided research, advocacy, education, and health management.

Most of the community partners (*n = 5*) reported providing services targeting older adults (i.e., seniors, and adults aged 55+ years), with four partners focusing exclusively on older adults. The remaining two partners focused on a mix of older adults, caregivers, health care practitioners, policymakers, and researchers.

Table 13 *Summary of Interviewed Community Partner Characteristics (n = 6)*

Community partner characteristics	Number (Percent)
Gender	
Female	5 (83.3%)
Male	1 (16.7%)
Job Title	
Coordinator	2 (16.7%)
Director (includes organizational and program)	3 (16.7%)
Lead	1 (16.7%)
Years of Experience	
0-4	1 (16.7%)
5-9	1 (16.7%)
10-14	3 (50.0%)
15-19	1 (16.7%)
Organization Type	
Municipality	1 (16.7%)
Non-profit	5 (83.3%)
Primary Service	
Community health care	2 (33.3%)
Older adult day care centre	1 (16.7%)
Recreation programming for older adults	1 (16.7%)
Research	1 (16.7%)
Research, advocacy, education, and health management	1 (16.7%)
Key Service Demographic	
Adults aged 55+	2 (33.3%)
At risk individuals, patients, and health care providers	1 (16.7%)
Health care practitioners, researchers, policymakers	1 (16.7%)
Seniors, frail seniors, caregivers	1 (16.7%)
Seniors with chronic issues and caregivers	1 (16.7%)
Amount of focus on adults 55+ years	
All	4 (66.7%)
Mixed (Some but not all)	2 (33.3%)

Note: Values may add to more than 100% due to rounding

Regarding their work to prevent falls among community-dwelling older adults, participating community partners described engaging in a variety of activities. The majority of community partners (*n = 4*) expressed engaging in fall prevention education and exercise programming in various locations including the community (*n = 3*), centres (*n = 1*), clients' homes, and retirement homes (*n = 1*). Other fall prevention programming specifically described by community partners included client support (*n = 1*); fall event tracking (*n = 1*); fall hazards identification (*n = 1*); health professional training about fall risks and prevention (*n = 2*); research funding, capacity building, and implementation practices (*n = 1*). All community partners offered separate fall prevention programs for different groups of people with some programs separated by target group and others by ability or medical condition.

The average numbers of years that community partners had been working on fall prevention ranged from three years to 15 years. Most partners indicated that their organization had been working on the prevention of falls for more than five years. All community partners reported that at least one staff member was dedicated to falls. At two organizations, more than 10 staff members were dedicated to fall prevention. In addition to the dedicated staff, two community partners noted that other individuals (e.g., staff and volunteers) also received training to recognize hazards for and prevent falls. Estimates of the number of hours per week that staff were given to focus on fall prevention included two hours, 19 hours, 50 hours, 95 hours, and 108 hours. One participant did not provide a value.

Partnerships with the referred PHU were estimated to be between zero months and 15+ years in length. All community partners, with one exception, reportedly had partnered with other organizations as part of the work with PHUs to prevent falls. The number of organizations

or individuals that had been partnered with ranged between five and 18 partners. One community partner noted that they were working with 41 other organizations or individuals to prevent falls; however, this estimate was not specific to work with one PHU. A summary of selected characteristics of interviewed community partners' fall-related programming is presented in **Table 14**.

Table 14 *Summary of Selective Characteristics of Interviewed Community Partners' Fall-related Programming (n = 6)*

Community partners' fall-related program characteristics	Number (Percent)
Single or separate falls programs serving population [a]	
Single	0 (0.0%)
Separate	6 (100.0%)
Number of staff dedicated to falls	
0-9	4 (66.7%)
10-19	1 (16.7%)
20+	1 (16.7%)
Amount of time allocated to fall prevention (hours per week)	
0-9	1 (16.7%)
10-19	1 (16.7%)
20-49	0 (0.0%)
50-74	1 (16.7%)
75-99	1 (16.7%)
100+	1 (16.7%)
No response	1 (16.7%)
Number of years working with PHU to prevent falls	
0-4	2 (33.3%)
5-9	1 (16.7%)
10-14	2 (33.3%)
15+	1 (16.7%)
Number of organizations partnered with to prevent falls[b]	
0-4	0 (0.0%)
5-9	2 (33.3%)
10-14	1 (16.7%)
15-19	1 (16.7%)
20+	1 (16.7%)

Note: Values may add to more than 100% due to rounding. [a] Single refers to the organization offering one common program to all individuals. Separate refers to the organization offering multiple programs to individuals based on need or target population. [b] One community partner indicated that they were not aware of any partnerships and could not provide a value.

5.2.4 Objective 4: Description of future potential partners.

This section is into broken into three sub-sections. The first sub-section describes the future potential partners identified by the PHU professionals as being most interested in partnering with. The second sub-section presents a description of future potential partners identified by community partners and their reasons for collaboration. The third sub-section describes the two interviewed future potential partners.

5.2.4.1 PHU professionals' descriptions of future potential partners.

The 29 future potential partners identified by participating PHU professionals represented several different community organizations and individuals. Future potential partners included: Aboriginal organizations; community groups (e.g., centers, churches, housing centers, Legions, seniors' groups, volunteer management and placement organizations, YMCAs); government health organizations (i.e., Ontario Health Teams or LHINs); health care centers (i.e., community, hospitals); health care providers (i.e., nursing services, pharmacists, physicians); municipalities and municipal departments and services (i.e., community services, maintenance, parks and recreation, planning and development, transportation); post-secondary programs at local institutions (i.e., nursing, rehabilitation, physiotherapy, occupational therapy); and seniors care and support centers (i.e., long term care homes, retirement homes).

While discussing future potential partnerships, four PHU participants described multiple reasons for their interest in working with other individuals and organizations. Reasons for future potential partnerships could be categorized into the following themes (see **Table 15** for thematic structure):

- **Addressing the needs of individuals and communities**. This was the most prominent theme, with PHU professionals identifying older adults' boredom, isolation, mental health, and guidance through processes, the high proportion of older adults within communities, and community volunteer service gaps as motivating factors for future partnerships. As an example, one PHU professional stated:

  > *"The reason why is because we are going to try and start up a volunteer initiative here. To get seniors who were isolated out more to serve in their community and also to make sure that they're not bored anymore. Because a lot of them are reporting that they're bored. They don't know what to do. There's nothing to do in [area]. So, and there's a lot of gaps for example in volunteers for school. Parents don't have the time. And they might have three kids. They can't… necessarily commit the time to that plus working and stuff. So if we can fill that gap with seniors. And if...We want to fill their time with things that are of interest to them. If they used to be a teacher, right. And they've retired… Maybe they can still, but they still want to work with kids, they can volunteer in a school. If they used to coordinate something maybe they could be in charge of running a community garden, for example - so to give them something to do. And also it will help fill lots of gaps in terms of just service. So we definitely want to do that and push that kind of initiative forward. It will help with social isolation, which is definitely a big thing here." [PHU professional 1*]

- **Enhance capability and capacity**. This was the next most prominent theme, with PHU professionals commenting that future potential partners had connections, experience, knowledge, and skills that would benefit or address existing gaps and limitations in current capacity and capability to prevent falls. One example of this was:

  > *"Essentially try and negotiate to see if they are able and willing to help us in this initiative because they have the skills already and for us to take the time to learn is inefficient. So we can bridge that gap." [PHU professional 1]*

Some of the remaining responses referred to fall prevention efforts more broadly:

- **To provide more comprehensive fall and injury prevention**. One PHU professional discussed that future potential partnerships would allow them to address other identified causes of falls and focus more on fall and injury prevention. For example:

> *"Well we've long thought about working with the local municipalities…would be beneficial – just the whole environmental piece. The WHO talks about, there is a level of disability, we can work to decrease that threshold of disability by making our, our, to more accessible environments." [PHU professional 2]*

Table 15 *Thematic Structure Describing Reasons for Partnering with Referred Future Potential Partners According to Public Health Unit (PHU) Professionals*

Main theme	Sub-themes	Dimensions
Address the needs of individuals and communities	Community needs	High proportion of older adults Volunteer service gaps
	Seniors needs	Guidance through processes Mental health Reduce boredom Reduce isolation
Enhance capability and capacity	Capability	Bridge gaps Increase community engagement Starting an initiative
	Capacity	Connect with others (i.e., volunteers, seniors) PHU capacity Shared pool of knowledge (i.e., learning, practices, expertise, skills)
Provide more comprehensive fall and injury prevention	Address built environment	Making more accessible environments Prevent environmental causes
	Support preventative approach	Prevent problem in the first place

5.2.4.2 Community partners' descriptions of future potential partners.

Participating community partners were asked to identify up to five organizations or individuals that they would like partner with in the future as part of their work with the PHU. All but one community partner identified at least one organization or individual. In total, more than 20 future potential partners were identified by community partners and included:

- Aboriginal groups;
- government health organizations (i.e., Health Shared Services Ontario, all 14 LHINs, Ontario Ministry of Health and Long-Term Care);
- health clinics and teams (e.g., emergency medical clinics, publicly funded physiotherapy clinics, walk-in clinics);
- health professionals (i.e., physicians, pharmacists);
- non-profit health organizations such as CNIB foundation, Heart and Stroke Canada, Multiple Sclerosis, Osteoporosis Canada, Parkinson Society and the Victorian Order of Nurses;
- retailers such as McDonalds and Tim Hortons; and
- other places where older adults congregate (i.e., malls, casinos, where lottery tickets are sold, and recreation centres).

All the suggested future potential partners were identified once except for physicians who were mentioned twice. One community partner also suggested the need to partner with a senior who could serve as an agent of change (i.e., community educator, champion, or spokesperson).

Reasons community partners provided for future potential partnerships with the suggested organizations and individuals varied. A total of 10 reasons were found for future partnerships. The most common theme was to provide more comprehensive health promotion, education, and programming related to fall prevention such as offering different programming or offering programming to different groups of individuals. An illustrative example is:

> *"So, I have reasons for those. I have a lot of connections with the community right now. We're providing general falls prevention exercises. Seeing the people that are being referred to my program, I feel that the next step for my company would be to provide specific groups for individuals like with Parkinson's that need certain exercises to help them, same thing with MS. Not that I don't want this to come across like I don't think they're capable of doing the programs I provide in the community, I just want to be able to give them more." [Community partner 1]*

The next most common theme was community partners' desire to gain a greater perspective on fall prevention priorities. As one community partner commented, "*Just to have a better perspective on what is being done and what should be done." [Community partner 4]*. Some of the remaining community partners' responses referred to gaining access to knowledge or people, and community support and involvement. One partner did not provide any referrals and as such did not provide any reasons for future partnerships. **Table 16** illustrates the thematic structure that emerged from community partners' descriptions of the reasons for partnering with other organizations and individuals in the future.

Table 16 *Thematic Structure Describing Reasons for Partnering with Referred Future Potential Partners According to Interviewed Community Partners*

Main theme	Sub-themes	Dimensions
Greater perspective of fall prevention priorities	Gain a provincial understanding of priorities	Have better perspective
	Gain an organization understanding of priorities	Clarify priority on falls prevention
Gain access to knowledge and people	Gain access to people	Get in front of physicians
	Gain access to information	Share information
Gain community support and involvement		Community buy-in
Provide more comprehensive health promotion, education, and programs	Extend programming	Extend client care
	Provide programming that is different or meets different client needs	People need different programming Provide slightly different programming Provide more programming

5.2.4.3 Description of interviewed future potential partners.

The two future potential partners were female. One future potential partner worked as an organization's president while the other was a program coordinator. The future potential partners described their organizations as a volunteer, informal organization, and a non-profit organization receiving government funding. The total number of years worked in these organizations ranged from less than one year to 17 years. Future potential partners' primary services included supporting and promoting community volunteerism through networking, education, recognition, and opportunity, and providing community care services including exercise and fall prevention.

At the time of the interview, only one organization provided services to prevent falls among community-dwelling older adults. Specifically, this organization offered community exercise programs to adults aged 55+ years, falls assessments, and education about falls and fall prevention. The future potential partner reported that their organization had been working on fall prevention for 3 years, had allocated 13 dedicated staff, and approximately 166.5 hours per week to fall prevention.

Both future potential partners stated they were interested in preventing falls and partnering with other organizations to prevent falls. Specifically, the future potential partners were interested in partnering with organizations that support individuals with exercise programs (e.g., other non-profits, local day centre for seniors, health teams, seniors housing, city and county recreational programming); and seniors' groups. They were also interested in partnering with the PHUs to prevent falls, although one admitted they had not thought about partnering with the PHU until receiving information about this study. One future partner

described interest in partnering with the PHU to prevent falls because the PHU had a large scope and knowledge about the community; and capabilities in research, data, evaluation which can be used to support exercise programs and assist with finding funding and funders. Neither future potential partner had been in contact with the PHUs to discuss partnering to prevent falls. Selected characteristics of future potential partners' fall-related programming are summarized in **Table 17**.

Table 17 *Summary of Selected Characteristics of Interviewed Future Potential Community Partners' Fall-related Programming (n = 2)*

Characteristics	
Services provided to prevent falls	
Community exercise programs to adults aged 55+ years, falls assessments, and falls education	1 (50.0%)
None	1 (50.0%)
Amount of focus on adults 55+ years	
All (program)	1 (50.0%)
N/A	1 (50.0%)
Number of years organization has been working on falls	
0	1 (50.0%)
1-4	1 (50.0%)
Number of staff dedicated to falls	
0-9	1 (50.0%)
10-19	1 (50.0%)
Amount of time allocated to fall prevention (hours per week)	
0-9	1 (50.0%)
10-19	0 (0.0%)
20-49	0 (0.0%)
50-74	0 (0.0%)
75-99	0 (0.0%)
100+	1 (50.0%)
Organization interested in preventing falls	
Yes	2 (100.0%)
No	0 (0.0%)
Interest in partnering with others to prevent falls	
Yes	2 (100.0%)
No	0 (0.0%)
Interest in partnering with PHU to prevent falls	
Yes	2 (100.0%)
No	0 (0.0%)
Contact with PHU about partnering to prevent falls	
Yes	0 (0.0%)
No	2 (100.0%)

5.2.5 Objective 5: Community partner mobilization, strategies, and practices.

The research findings related to knowledge of (i.e., awareness, definitions, PHU professional training, future potential partners' awareness of community partner mobilization activity), reasons for engaging in community partner mobilization, community partner mobilization activities to prevent falls among community-dwelling adults, and response to Falls LDCP community partner mobilization scoping review are described successively in this section.

5.2.5.1 *Knowledge of community partner mobilization.*

5.2.5.1.1 *Awareness.*

Table 18 contains a summary of the number of participants aware of the term community mobilization. Overall, 10 of the 13 individuals interviewed (76.9%) reported that they had heard of the term. This included all five of the interviewed PHU professionals, four out of six community partners, and one out of two future potential partners.

Table 18 *Number of Participants Aware of the Term Community Mobilization*

Participant group	No	Yes	Don't know/Not sure	Total
PHU professionals	0	5	0	5
Community partners	0	4	2	6
Future potential partners	1	1	0	2
Total	1	10	2	**13**

5.2.5.1.2 *Definitions of community mobilization.*

Participants' definitions of community mobilization. All participants were asked to define community mobilization, regardless of whether they were aware of the term. Their responses yielded the emergence of seven main themes: action, change, community capacity, community support and involvement, community togetherness and partnership, planning, and roles (**Tables 19 and 20**). Notably, more than half of participants (*n = 8*, 61.5%) described community mobilization as engaging in action, gathering community support and involvement, and establishing community togetherness and partnership.

In the Action theme, participants described community mobilization as doing "*something.*" While not all the participants in this theme described specific actions, some participants spoke about doing "*events*," "*activities*," and "*interventions*." One participant defined community mobilization as involving the promotion of "*a specific cause or joint cause*."

Within the Community Support and Involvement theme, participants defined community mobilization as backing, assisting, and getting partners and the community to participate. Participants used terms like raising *"awareness,"* "*rallying*" and *"motivating people,"* "*finding community buy-in,*" *"engaging members within the community,"* "*showcasing*" the abilities of the community, providing *"support"* to one another, volunteering, and having the community take *"ownership,"* in order to bring people together or make change.

In the Community Togetherness and Partnership theme, eight participants emphasized that community mobilization is gathering and joining the community together. Two of these participants defined community mobilization as gathering partners, while one participant described going out and forming partnerships.

Table 19 *Emerging Themes for Participant Definitions of the Term Community Mobilization*

Theme	Description	Number of participants with theme (*n* = 13)	Example quote
Action	Participants' description of the term community partner mobilization as doing something or an act	8 (61.5%)	Community partner #1: "*My thought was getting together with other community organizations to promote a specific cause or joint cause."*
Change	Participants' description of the term community partner mobilization as altering something	7 (53.8%)	PHU professional #2: "*And in public health, it would be to do something together to improve health of the community, of people living in the community."*
Community capacity	Participants' description of the term community partner mobilization as using or building community strengths, knowledge, and other resources	3 (23.1%)	PHU professional #1: *"It's like the capacity to bring about change but by using the strengths of the community and joining community together. So it's strength in numbers essentially."* Future potential partner #2: *"I'm going to guess that it's the community working together to move forward and preventing falls and getting the practices out there. So being able to use all the resources that we have in order to prevent falls."*

Table 19 Continued

Theme	Description	Number of participants with theme (*n* = 13)	Example quote
Community support and involvement	Participants' described the term community partner mobilization as gathering interest, getting engagement, and have others take part	8 (61.5%)	PHU professional #3: *"I would say that my role on that would be that I would provide a like lot of the support. So when you look at it through like, we often look at it through like the collective impact kind of model. And I would say for that, we would often be like that backbone. So you need someone to like chair your meetings, provide a space, do your evaluation reports, like I'm gonna, I'll do whatever parts of those you need. And hoping that the community itself is able to do a lot of the other pieces."*
Community togetherness and partnership	Participants' described the term community partner mobilization as bringing the community together and partnering	8 (61.5%)	Community partner #5: *"And it's all about bringing in the different community partners to work together. And, and raise the awareness and figure out the best ways to work with individuals."*
Planning	Participants' described the term community partner mobilization as organizing, developing strategies, identifying issues, and recognizing community needs	5 (38.5%)	PHU profession #5: *"I would define it as… Maybe a process by which stakeholders come together, identifying an issue and work to develop strategies that, identify an issue in their community and were to identify strategies that address the issue and where it's reflective of the actual need in the community."*

Table 19 Continued

Theme	Description	Number of participants with theme (*n* = 13)	Example quote
Roles	Participants' described the term community partner mobilization as involving different roles	4 (30.8%)	PHU professional #4: *"So when the community takes on the role of getting together with other community partners and organizing a concept or an idea or a policy and supporting that through whatever the initiatives are that the community deems to this."*

Table 20 *Thematic Structure Describing Participants' Definitions of Community Mobilization*

Main theme	Sub-themes	Dimensions
Acting	Action	
	Activities	
	Events	
	Interventions	
	Promote a cause	
Changes	Specific changes	Accessibility
		Active (Physically)
		Improve health
		Mobility (Physical)
		Prevent falls
	Properties	Impact
		Keep happening
Community capacity	Knowledge	
	Resources	
	Strength	
Community support and involvement	Awareness	
	Community buy-in	
	Engaging community members	
	Ownership	
	Rallying	
	Showcase the community	
	Support	
	Volunteerism	
Community togetherness and partnership	Together	
	Partnership	
Planning	Identify issues	
	Identify needs	
	Organizing	
	Strategies	
Roles	Backbone support	
	Experts	
	Leadership	

The next most frequently occurring theme was Change. In the Change theme, community mobilization was defined in terms of altering or changing something. Seven participants noted community mobilization was a way about bringing or creating change. Four participants described specific changes including *"making the community more accessible to seniors,"* continued and easier *"mobility," "keeping people active," "improve [the] health of the community,"* and *"preventing falls."* One participant also described community mobilization as a change that would result in *"impact,"* and would continue to *"happen."*

The definitions from five participants suggested community mobilization involved planning. In the Planning theme, three participants identified *"finding," "figuring out," "identifying," "developing"* and *"using" "strategies"* as way of achieving an outcome such as a bringing the community together, specific actions, or change in the community. One participant described community mobilization as process in which partners needed to "*organize*" themselves for action. Another participant suggested community mobilization involved *"identifying issues"* and community *"needs"* before working on strategies to ensure community issues and needs are met.

Within the Roles theme, four participants suggested community mobilization involved individuals taking or serving in specific roles in order to bring people together or take action. Some talked about their own roles while other talked about the roles of others. One participant described the role of "*backbone support*," which included chairing meetings, providing space, and doing evaluation reports as part of their definition of community mobilization. Another participant described the role of *"experts"* and enabling the community to view themselves as

"experts" capable of making change. Two participants spoke about the role of *"leaders"* with leaders being seen as part of taking action.

Only three participants discussed capacity as part of their definitions of community mobilization. Capacity was viewed by one participant as entailing "*resources*" that would allow for the formation of partnerships. Another viewed capacity as the *"strength"* in numbers, *"knowledge,"* and *"resources"* to make change occur.

The participants' definitions revealed the term community mobilization was composed of many connected concepts, with certain concepts being linked and occurring before others. For example, many participants defined community mobilization as beginning with the theme "community togetherness and partnership" in order to *"do something"* or "make "change." A concept map representing the relationship between selective codes emerging from participants' definitions of the term community mobilization is presented in **Figure 6.**

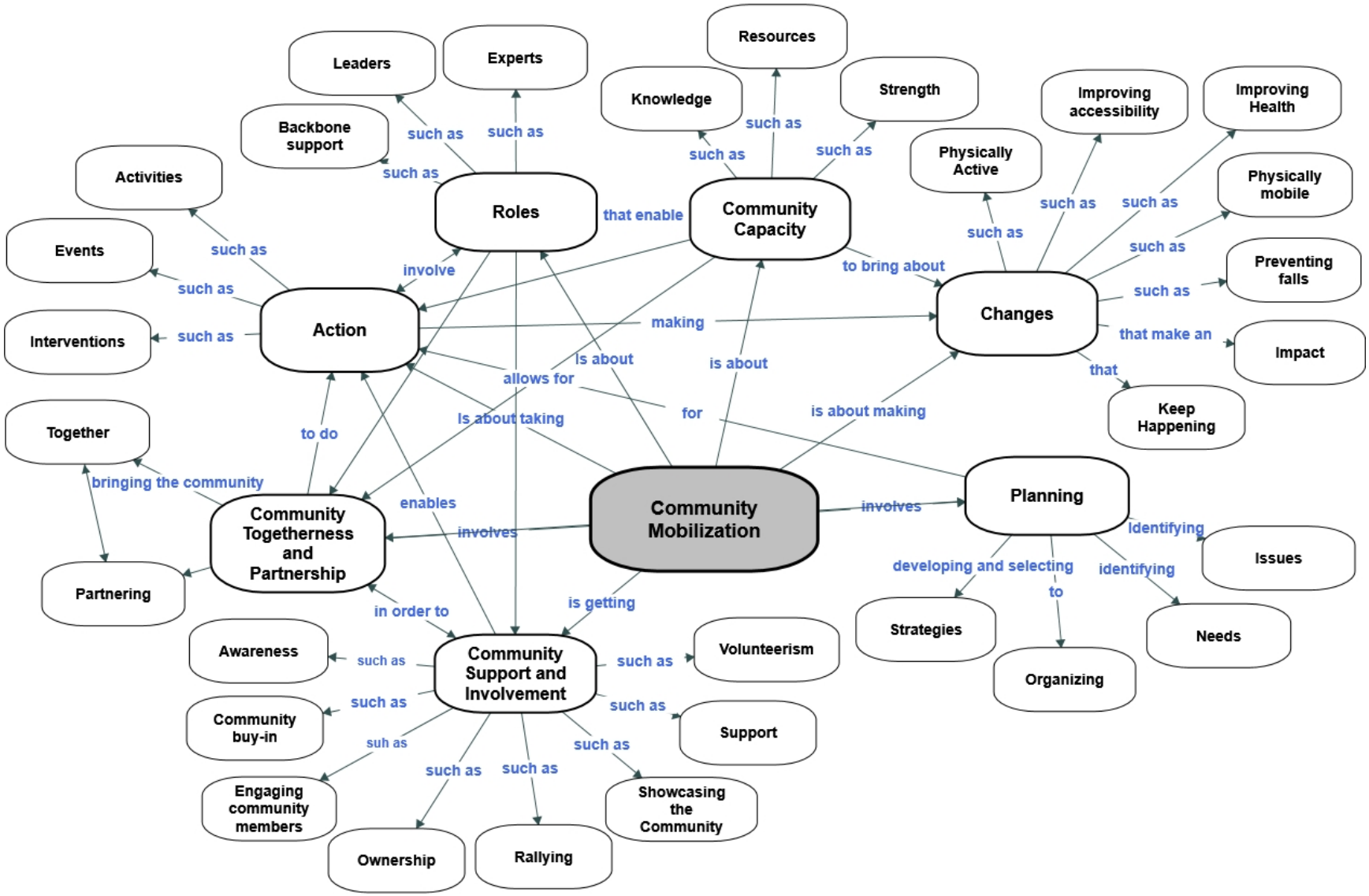

Figure 6. Concept map of the terms used by participants to define the term community mobilization

Response to Falls LDCP definition of community mobilization.

Following responses about how they would define community mobilization, participants were provided with a definition of community mobilization used by the Falls LDCP and asked what they thought about that definition. Participants spoke about their general impressions of the definition, specific elements, and how the definition related to their own experiences.

Of the 12 participants who were questioned,[7] nine participants (four PHU professionals, four community partners, and one future partner) endorsed or supported the definition to varying degrees, describing the definition as "*fantastic*," "*the vision*," "*what we want CM to be,*" and "*fits the way I think of the way that we do work*." Specific elements of the definition participants referred to positively included action, bringing people together, community, leadership, and working together. Some participants also related the definition positively to the function and goals of "*Asset Based Community Development*," "*Grass roots community development*" and "*Self-management*." Two participants who were generally supportive expressed some concerns about the definition. One participant felt the definition was "*wordy*" and "*lofty,*" while another participant raised some concern about whether the definition was realistic.

Three participants (one PHU professional and two community partners) did not endorse the definition, raising a variety of concerns. These concerns included the definition being "*very broad*," "*overarching*," and "*it doesn't really talk about implementation of anything*," use of the terms community and capacity, sustainable capacity, whether collaboration is effective, there is evidence to support the impact of collaboration, and resource allocation and management.

[7] The Falls LDCP definition of community mobilization was not discussed with one future potential partner.

Congruency between CM definition and working experience with local PHUs to prevent falls.

Participants were asked to relate the LDCP's definition of CM with their own experiences working with their local PHUs. Three participants (27.3%, two PHU professionals and one community partner) agreed that the definition did describe their experiences. The remaining participants (*n* = 8; three PHU professionals and five community partners) felt their experiences differed from the definition. Analysis of their explanations for why their experiences differed revealed multiple reasons (**Table 21** contains a summary of the thematic analysis):

- ***Activities*.** This was the most recurring theme with two participants (one PHU professional and one community partner) discussing that unlike the definition, their current efforts focused more on their community partners. One community partner stated that they had only done activities related to increasing awareness because they were in the beginning stages of community partner mobilization, and one community partner described that they and the PHU needed to *"get that word out about you can start preventing falls"* to the community;
- ***Challenges* had been encountered.** One PHU professional and one community partner described that their experiences differed due to some challenges which included *"difficulty getting buy-in"* from the community, *"building trust"* with the community, *"follow-through"* from committee members;

- **"*The definition as a goal.*"** Two participants (one PHU participant and one community partner) felt that the definition reflected a desirable goal. With one of the participants indicating it wasn't how *"we get there;"*
- ***"Approach."*** How community partner mobilization was being approached was described by one of the PHU professionals as a difference between the definition and their experience. The participant indicated that they thought, *"community mobilization speaks more grass roots. I think that typically our approach has been more kind of top-down. Where we work with the agencies who are working with the seniors;"*
- ***"Not everybody understands community mobilization."*** A community partner discussed that *"having a fall coalition"* is not community partner mobilization, yet some PHUs *"are just happy having a committee"* while other PHUs go beyond, actively rounding up and engaging with the community and ensuring partners are *"very much into the community mobilization strategies;"* and
- **Unable to say.** One community partner said that they could not *"corroborate that that is in fact the case or that is happening"* because they hadn't seen or been exposed to it yet.

Table 21 *Thematic Structure Describing Participants' Views on Differences between the Falls Locally-Driven Collaborative Project definition of Community Mobilization and their own Experiences*

Main theme	Sub-themes	Dimensions
Activities	In the beginning stages Not involving older adults PHUs need to get the word out	
Approach		
Challenges	Difficulty getting buy-in Building trust Follow through	
Definition is a goal		
Not understanding community mobilization	PHUs that think a fall coalition is enough	

5.2.5.1.3 *PHU professional training.*

PHU professionals were asked if they had received any training in community partner mobilization. Two PHU professionals answered "*no*" and three professionals answered "*yes*". Of those responding "*yes*", two were involved in the Falls LDCP. Examples of the community partner mobilization training that had been received included:

- "*Tamarack collective impact*";
- "*evaluating community impact*";
- "*National Collaborating Centre on methods and tools and knowledge transfer*";
- "*Canadian Falls Prevention Curriculum E-Learning Course online*"; and
- "*Locally Driven Collaborative Project on theories and frameworks*".

5.2.5.1.4 Future potential partners' awareness of community partner mobilization activity.

After discussing the term community mobilization, the two Future Potential Partners were asked if they were aware of any of the fall prevention work being done by their local PHU with other partners in their community. Neither partner was aware of the work being done.

5.2.5.2 Purpose for mobilizing.

Public health purpose for mobilizing.

PHU professionals were asked to identify the public health purpose(s) for mobilizing community partners into action for fall prevention (i.e., programming, policy, media, implementation and evaluation, or something else). In total, PHU professionals raised nine main public health purposes. The main purposes discussed were:

- ***Evaluation*.** This public health reason was discussed by all PHU professionals, however, three PHU professionals acknowledged, while evaluation was important it was something either the community wasn't skilled at yet, or they "*haven't done too much on that end.*" Two PHU professionals acknowledged that evaluation was part of their mobilization work with one participant describing the use of evaluation in their activities and partnerships.
- ***Programming*.** This was the second most commonly discussed reason by PHU professionals, with four out of five PHU professionals noting how programming was part of their efforts. The fifth PHU professional did not discuss programming. PHU professionals who identified programming as a reason for their current mobilization efforts also referred to awareness, education, implementation and evaluation, and planning as part of their programming. An illustrative example is:

> *"But in terms of programming, we do, we do the sort of awareness raising that kind of thing. There has been I'm just going to go back to the, the falls prevention strategy because there's been a fair amount of work and sort of there's been – 1, 2, 3, 4, 5. Five pillars. That, of where kind of the work needs to happen. One is around public awareness and education. And that's really where public health has its role. Another pillar is providers' skill development and education. So that's really at the health care level. Whether it's, tools and things like that need developed - common tools or something like that. And in service navigation and integration is one of the other pillars. And then followed by assessment and management and engagement and advocacy is the final one. So really where public health, kind of, does our thing is in the public awareness and education piece of things. So whether for example, there was a joint effort in falls prevention month in November for, for the last two years, actually. For people who sit on this committee to have a joint communication strategy for the month of November. And then engagement and advocacy. I think this is where the work of trying to*

figure out who needs to be at the table to, to be able to move the strategy forward." [PHU Professional 5]

- ***Policy*.** Four out of five PHU professionals also discussed policy as a public health purpose for mobilizing partners into action for fall prevention. Two PHU professionals indicated policy was among the public health reasons for their efforts. One PHU professional stated in terms of policy they *"were not doing all that much."* One PHU professional also added:

  "In terms of, we would love if policy was on the list, but they still need a lot of work on that. So and a lot of people are not ready for policy. It's…I don't know, a…word that scares people." [PHU Professional 1]

- ***Media*.** Three PHU professionals described media, social media in particular, as a reason for their community partner mobilization efforts.

Some of the remaining public health purposes raised by PHU professionals included: awareness and education of the health professionals and the public; implementation of planned promotion, programs, and policies; planning; promotion; and achieving the best possible health for all. **Table 22** illustrates the distribution of identified emerging themes describing public health purposes for mobilizing by PHU site.

Table 22 *Distribution of Emerging Themes Describing the Public Health Purposes for Mobilizing by Public Health Unit (PHU) Site*

PHU Site	Emerging Themes Identified								
	Achieve best possible health for all	**Awareness and education**	**Evaluation**	**Implementation**	**Media**	**Planning**	**Policy**	**Programming**	**Promotion**
Central West #1			X	X		X	X	X	X
Central West #2	X	X	X				X	X	
Eastern		X	X		X		X	X	
North West			X		X				
South West			X	X	X	X	X	X	

5.2.5.3 Community Partner Mobilization Activities.

This section serves to provide a snapshot of how community partner mobilization was being practiced at the five PHU's at the time of the interview. All PHU professionals and community partners (*n = 11*) were asked to describe the steps and activities they had been involved in and prompted for additional details where appropriate (time permitting). To provide a more complete picture, participants' responses were also taken from other points in the interview.

5.2.5.3.1 *Initiation.*

Six participants identified themselves as the initiator of their community partner mobilization work (four PHU professionals and two community partners). Two of these PHU professionals indicated that while at times they initiated the work they were doing with their community partners this wasn't always the case. Two participants (community partners) indicated the work had been initiated by their local PHUs. Another two participants (one PHU professional and one community partner) identified committees as initiators. One community partner was unsure of who initiated the community partner mobilization work. In the case of two PHU's, a community partner and the PHU professional both described themselves as the initiator.

5.2.5.3.2 Identifying the problem.

Identifying the problem is an essential component of community partner mobilization. Ten participants (five PHU professionals and five community partners) described who and how the problems motivating their community partner mobilization work was identified. Of these

participants, one community partner couldn't *"remember the exact reason and how that was (determined)."* Regarding who identified the problem, nine participants (five PHU professionals and four community partners) said the problem was identified by the PHU. Four participants (three PHU professionals and one community partner) said that the problem was identified by the community, referring to committees in particular. Three of the PHU professionals indicated that the problem was sometimes identified by the PHU at other times the problem was identified by the community. As one PHU professional stated:

> *"So traditionally we identify the problem. Not often is it that the community will identify a problem and then come to us. If the community identifies the problem, they tend to deal with it themselves. They don't traditionally come to us. Sometimes the community will identify a problem and they'll write a report. And then we take that into consideration. Because, for us, that's them asking. That's them identifying a need." [PHU professional 1]*

Eight of the participants (five PHU professionals and three community partners) described how problems were identified. All participants indicated that the problems were identified through research. Examples of the types of research used included: *"community consultations,"* talking to people in the community, the collection of *"injury stats"* by PHU epidemiologists, PHU *"injury"* and *"burden of reports,"* and reviews *"of the Status of Falls*."

5.2.5.3.3 Determining the need for Community Partner Mobilization.

Not all problems or solutions require community mobilization of partners and so participants were asked to describe how the need for a community partner mobilization strategy was determined. Six participants (one PHU professional and five community partners) were unable to identify how the need was determined. The remaining five participants (four PHU professionals and one community partner) each provided reasons. The responses varied from community partner mobilization being an approach that is valued and engrained in public

health to one that address specific community needs. Examples of these responses are provided below:

> *"So that community engagement and participation is a strong public health value. So, the desire was there to approach falls in that way." [PHU professional 2];* and

> *"So, we had to, we really felt strongly that we needed to have, okay, we're not really all communicating very well, and we need to better serve our community. We needed to have some kind of integrated approach to delivering falls prevention programming." [PHU professional 5]*

5.2.5.3.4 *Determining how to mobilize partners.*

Seven participants (four PHU professionals and three community partners) described their knowledge of how the steps needed to mobilize were determined. Two of these participants (community partners) were unsure how the steps were determined. The remaining five participants (four PHU professionals and one community partner) described that the steps needed to mobilize partners were determined through discussions with others at meetings or round tables. Three PHU professionals described that their meetings involved group discussion around a problem. For example, one stated:

> *"Usually in a meeting, in terms of what steps that we take or resources or tools...Yeah. Usually it's when we are in meetings we do all of that. So, it's usually a discussion that we have and then everybody pitches their ideas on what they think is necessary to be able to get this to work, or who is necessary, or how do we get them on board kind of thing." [PHU professional 1]*

Another participant described the decision as emerging from a proposal in which all the members could *"add," "refine,"* and *"sign off"* on it before *"it went in."*

Six participants (four PHU participant and two community partners) described the use of frameworks, theories, or guidelines in determining the steps for partner mobilization. Two of

the PHU professionals said that no framework, theories or guidelines were used. The other four participants made reference to using a framework, theory, and guideline for mobilization or for falls prevention. Specifically, they identified:

- the Collective Impact Approach [PHU professional 5];
- the Falls LDCP scoping review logic model [PHU professional 2];
- the Integrated Falls Prevention Framework and Tool Kit, their own paper on Falls Across the Lifespan, the Ecological Model of Change, and the Lifespan Approach [Community partner 4]; and
- a social network mapping tool and a literature review they conducted on best practices for falls prevention [Community partner 5].

5.2.5.3.5 Steps taken to mobilize community partners.

All PHU professionals and community partners were asked to describe the steps and activities they had employed as part of their community partner mobilization efforts. One community partner, who had only recently begun mobilizing with their local PHU, said they did not know what steps and activities had been employed. The remaining ten participants (five PHU professionals and six community partners), who had been partners much longer or initiated the mobilization work, described engaging in multiple steps and activities to varying degrees.

Analysis of these responses yielded eight main themes describing community partner mobilization practices. As can be seen in **Table 23,** the main themes describing the steps engaged in included: bringing people together, evaluating and reviewing work, identifying a problem, implementation, initiation, partnership organization, planning, and research and data

collection. It should be noted that not all themes were observed across the interviews. Further there were some differences in the descriptions of the order with which certain themes occurred. This is described in greater detail in the text below and **Figure 7** which presents an aggregated model of the sequence and connections between emerging themes describing the steps and activities used to engage in community partner mobilization.

Table 23 *Distribution of Emerging Themes Describing the Community Partner Mobilization Steps and Activities Public Health Unit (PHU) Professionals and their Partners Described Engaging in*

Theme	Description	Number of participants with theme (*n* = 10)[a]	Example quote
Bring people together	Participants described bringing members of the community together as one of the community partner mobilization steps they employed	10 (100.0%)	*PHU professional 1: "We are always trying to bring other people into solve it together because many, many hands make work light is kind of the motto. So we usually identify the problem. Based on that identification, then we go and seek out if we need help. And then we'll go talk to people and call people, and connect with them and say look we, for example with the food skills building for healthy eating – because that, eating well contributes, and good nutrition contributes to falls prevention."*
Evaluate and review work	Participants described evaluating and reviewing their work as one of the community partner mobilization steps they employed	7 (70.0%)	*Community partner 4: "We have official formal evaluations. In the case of <name of initiative>, well we assess the impact of the work. We don't assess the partnership or say other than on an ongoing basis like with the team we do check ins at least on an annual basis to see if the way we are working is working. And we check our Terms of Reference annually to make sure we're on track. We modify them accordingly if things are resolved. But for the performance of the initiatives we have, we have formal evaluations in both cases with external evaluators."*

Table 23 Continued

Theme	Description	Number of participants with theme (*n* = 10)[a]	Example quote
Identify a problem	Participants described identifying a problem or need as one of the community partner mobilization steps they employed	8 (80.0%)	*PHU professional 3: "Problems would probably be identified by compiling the data that we have. On, what are the problems in our area and putting those things together to see who, where are the places that are at most risk, and that there's the most opportunity for a group to get together for action."*
Implementation	Participants described implementing their plan or specific activities as one of the community partner mobilization steps they employed	8 (80.0%)	*PHU professional 2: "So we, that's where we started. And we were...We started out with a number of coordinating activities. But as people changed over time they kind of got disconnected from the, the passion that brought people together in the first place. And so things have changed over. So I think, once… The first thing that the group wanted to do, I think was make some educational materials. Again, that seems to be the go to for everybody, "well if people are falling it's because they don't know how not to fall." And so… That was where we worked with the older adults' organization for the companion booklets."*
Initiation	Participants described the individual who was responsible for starting the community partner mobilization work	4 (40.0%)	*PHU professional 3: "So I would say that what... We would often be an initiator I would say. But not always. Sometimes we would be hopping on with them something that was happening, if there was sort of an opportunity."*

Table 23 Continued

Theme	Description	Number of participants with theme (*n* = 10)[a]	Example quote
Partnership organization	Participants described organizing their partnership as one of the community partner mobilization steps they employed	9 (90.0%)	*Community partner 4: "I always bring partners together. And from various areas of <name of location>. And <name of local PHU> is often a partner on this. But we know that to have engagement of the partners it has to be through discussions, and formal vision statements, in terms of reference, and discussions about mandate, and what the actions will be together. So we shape this together."*
Planning	Participants described planning out how they were going to work together to address a problem or need as one of the community partner mobilization steps they employed	10 (100.0%)	*PHU professional 5: "Yes. And then we also started having conversations about implementation science. And it was an interesting conversation and we did have someone come in and do a little bit of training about that. And, and, I'm not sure that was all that helpful at the time because we were still, we were trying to struggle at that time to sort of get what are we trying to achieve for this group and things like that? What we ended up doing was certainly looking at let's develop logic models, let's develop, make sure we have clear goals, clear objectives for each pillar. So we use a very, what in public health we call them program planning cycles. To inform the development of the strategy."*

Table 23 Continued

Theme	Description	Number of participants with theme (*n* = 10)[a]	Example quote
Research and data collection	Participants described doing research and/or data collection as one of the community partner mobilization steps they employed	8 (80.0%)	*PHU professional 2: "it came through our, our person before, who I replaced, had started and had done a community consultation. But I'm sure it must have been based on, on injury stats. And she had done a big community consultation. That's why our fall prevention information was framed positively based on the info, the feedback that she got in the community consultation."*

[a] Only 10 out of 11 participants responded to the question and were included in the thematic analysis.

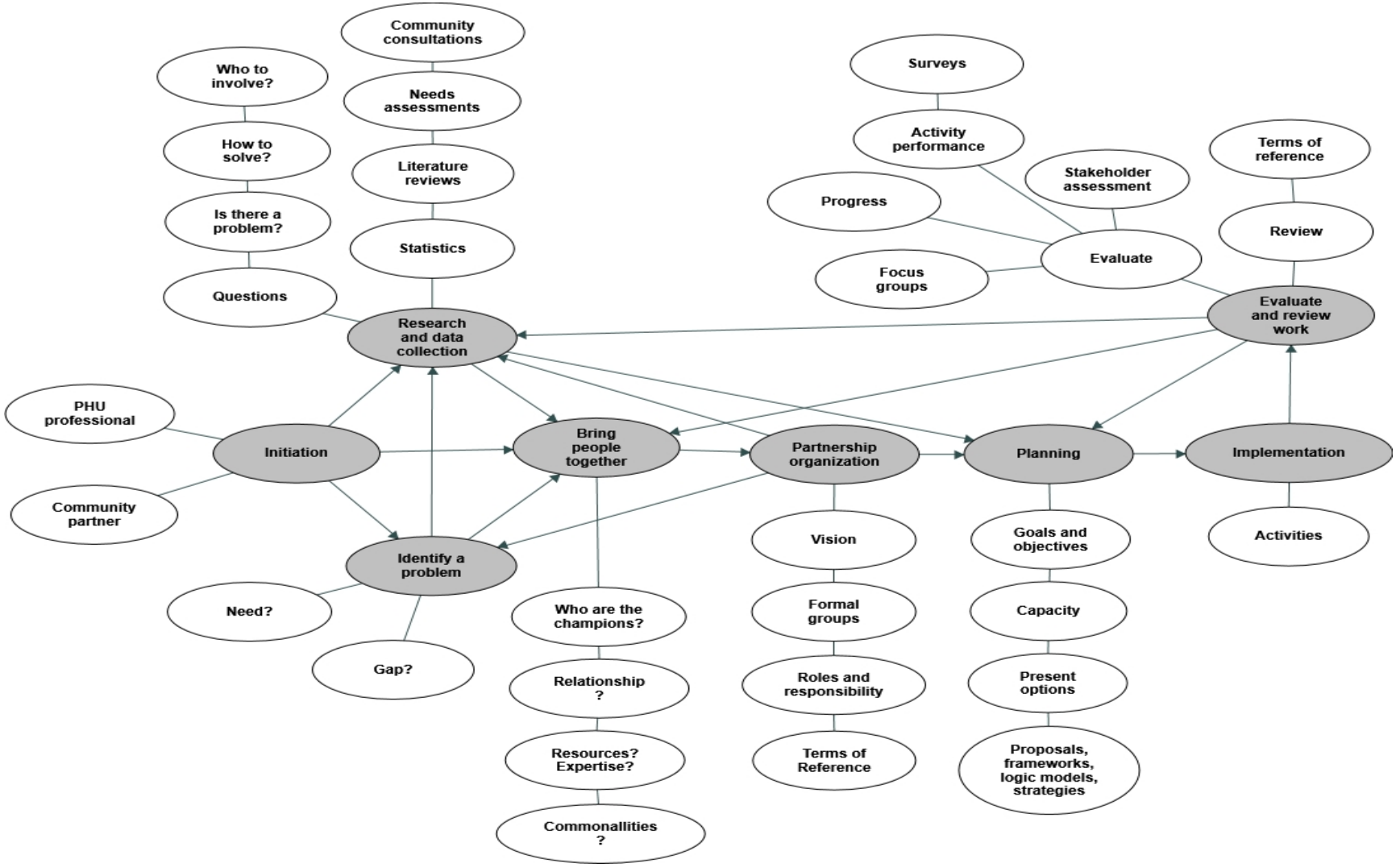

Figure 7. Concept map illustrating the community partner mobilization steps and activities Public Health Unit professionals and their partners described engaging in.

Note. Items highlighted in grey represent main themes or sub-themes emerging from analysis of descriptions.

- ***Initiation*.** Four participants (three PHU professionals and one community partner) described their community partner mobilization efforts as beginning with someone who acted as the initiator. The initiator was identified as either a local PHU professional or a community partner who would bring everyone together because of an opportunity, pre-identified need or problem, or standards requiring individuals to work with the community.
- ***Bring people together*.** This was one of the most frequently discussed themes. Ten participants (five PHU professionals and five community partners) said that their community partner mobilization activities included bringing people together. In some cases, the initiator identified potential partners by themselves. In other cases, a group of individuals identified who needed to be brought together. Potential partners were reportedly brought together by using different techniques such as a *"partnership audit," "brainstorming who needed to be involved," "existing relationships,"* and knowledge of organizational *"commonalities"* (e.g., *"same goal,"* services, *"interest"*). Most participants (*n = 5*) described people being brought together at meetings which were then used to identify a problem, establish and organize partnerships, and plan.
- ***Identify a problem*.** Eight participants (five PHU professionals and three community partners) described identifying a problem or need as one of the steps involved in their community partner mobilization efforts. Five of these participants described identifying the problem prior to bringing people together, while three discussed and identified the problem once people were brought

together. Problems were identified though opportunities (e.g., *"funding announcement,"* OPHS, physiotherapy reform, lack of connection between programs or services), or research.

- ***Research and data collection*.** Eight participants (five PHU professionals and three community partners) described engaging in research and data collection as part of their mobilization of community partner efforts. Specifically, participants described engaging in research and data collection to identify things like: the problem; *"who will be good at the table to solve this problem;"* figuring out *"how can we solve this problem?"* Some of these questions were answered through the collection of "statistics" (e.g., emergency room statistics, injury statistics), *"needs assessment," "community consultation,"* an audit of community services, and a *"literature review on what was best practice."* Participants described research and data collection occurring both before and after bringing people together.
- ***Partnership organization*.** Many participants (five PHU professionals and four community partners) spoke about how their ability to take charge together *"evolved"* out of individuals and groups coming together and connecting to one another. Participants' descriptions included the establishment of formal partnership groups (groups, teams, committees, etc.), *"Terms of Reference and discussion about mandate," "establishing that vision and that mission to get every, to have something that everybody can identify with,"* and taking *"on*

different roles and responsibilities" in order to plan and support the work that will be done together.

- ***Planning*.** This was another commonly discussed theme. All five PHU professionals and five community partners who described the steps involved in their community partner mobilization efforts spoke about planning. Some of the topics related to planning that were discussed included *"planning sessions"* or meetings where partners discussed *"ideas," "goals," "objectives,"* looked at their *"capacity"* (e.g., resources, time), made *"decisions,"* determined *"what activities would happen,"* and developed logic models, proposals, frameworks, or strategies.
- ***Implementation*.** Eight participants (five PHU professionals and three community partners) spoke about the specific activities and programs that had implemented in their communities to prevent falls among community-dwelling older adults (e.g., Stay on Your Feet, home exercise programs, Personal Support Worker training, etc.).
- ***Evaluate and review work*.** Conducting evaluation or assessment and reviewing work was an emerging theme described by eight participants (five PHU professionals and three community partners) as one of the steps taken in their community partner mobilization efforts. Examples of some of the evaluation topics participants touched upon included *"focus groups," "progress evaluations," "stakeholder assessments,"* and evaluations of activities. Some of the participants noted reviews of their Terms of Reference. Evaluating and

reviewing work came after most participants described implementing their work and was discussed as being used to inform repetition of early steps (e.g., bringing new people together, organizing the partnership, planning, and implementation).

A summary of the thematic structure describing how partners engaged in community mobilization is presented in **Table 24**.

Table 24 *Thematic Structure Describing How Participants Engaged in Community Partner Mobilization*

Main theme	Sub-themes	Dimensions
Bring people together	Partnership audit	
	Brainstorming who needed to be involved	
	Existing relationships	
	Knowledge of organizational "commonalities"	Goals Services Interest
	Meetings	
Evaluate and review work	Evaluate	Activity Focus groups Progress Stakeholder assessments
	Review	Terms of reference
Identify a problem		
Implementation	Activities	
Initiation	Individual	PHU Community partner
	Opportunity	
Partnership organization	Establish vision and mission	
	Formal groups	
	Share resources	
	Take on different roles and responsibilities	
	Terms of reference	
Planning		

Table 24 Continued

Main theme	Sub-themes	Dimensions
Research and data collection	Questions	How can we solve this problem? Who will be good to solve this problem?
	Types	Community consultations Literature review Needs assessments Statistics

5.2.5.3.6 Identifying partners.

Partnerships are a critical component of many community mobilization theories, influencing what work is done and whether the desired results are achieved. Out of the 11 participants, seven (four PHU professionals and three partners) discussed how they determined which partners needed to be involved. Five participants (three PHU professionals and two community partners) described that their decision was based on knowledge of organizations offering similar programming or serving a similar demographic (e.g., falls prevention, older adults) and shared vision. As one community partner stated:

> *"Falls prevention has become such a huge thing and there (are) different organizations, or different government-funded programs that are offering falls prevention so why don't connect and try and work towards the same goal." [Community partner 1]*

In addition, one PHU professional also said they identified partners based on whether *"they were people too we had existing relationships with."* Two participants (one PHU professional and one community partner) described that the decision was made by their group *"brainstorming who needed to be involved"* according to certain criteria (e.g., who was missing from the group, expertise in different pillars of health).

5.2.5.3.7 Engaging partners.

A variety of approaches were reported to have been used to engage different organizations or individuals to participate in community partner mobilization. A total of eight participants provided descriptions. These descriptions were condensed into three themes (**Tables 25 and 26**). *Relationship* was the most common main theme, with five participants (three PHU professionals and two community partners) describing partners are/were engaged

through the *"building"* of relationships, leveraging of "*existing relationships*" and *"recommendations"* made through relationships. Two community partners described common *"interest"* as a method used for engaging partners. One of these community partners described *"interest"* and *"relationship"* as ways partners were engaged. Finally, one community partner felt because *"that varies from one public health unit to another,"* they couldn't *"pinpoint one specific way."*

Table 25 *Distribution of Identified Emerging Themes Describing How Partners are Engaged*

Theme	Description	Number of participants with theme (*n* = 8)[a]	Example quote
Can't say	Participant was unable to describe how partners were engaged because approaches varied	1 (12.5%)	Community partner 4: *"Again, I think that varies from one Public Health Unit to the other. Again, I think it's on the basis of capacity. I think that some people are very systematic in doing community mobilization. Through all the steps of the community mobilization like determining its strength, the need, the champions. What needs to happen, I think that some (of) them are very aware. And on the other hand, others go through the same old, same old. Approaches with coalitions and representation on committees. And, I'm not judging. I'm just saying they may not have the capacity or the knowledge or the know-how. So, so I can't quite pinpoint one specific way per se."*
Interest	Participants' described how common interest was used to engage organizations or individuals in community partner mobilization	3 (37.5%)[b]	Community partner 2: *"I think definitely just identifying, approaching somebody and identifying [that] we're very interested in falls prevention as an issue and a concern and sort of seeing the similar interest and then asking them to join."*

Table 25 Continued

Theme	Description	Number of participants with theme (*n* = 8)[a]	Example quote
Relationship	Participants' described how relationships were used to engage organizations or individuals in community partner mobilization	5 (62.5%)	Community partner 1: *"They will make a recommendation as to where we can go next. A lot of times it is, we sit on a committee for something and we meet people that way. And a lot of times, like I was part of an LDCP because I took over a role for somebody. So I met people, because it was my job to be sitting on this committee or this organization, right. And then through meetings with those people I am able to leverage those relationships – learn about people, learn about what they do, what they offer, who they are in the community, kind of thing. And making sure that you nurture those relationships. Asking them if they need anything? What is it that they, what is it they are focusing on for next year?"*

[a] Only eight out of the 11 participants described how partners were engaged.
[b] One participant described both the interest and relationship theme.

Table 26 *Thematic Structure Describing Participants' Responses about How Partners are Engaged*

Main theme	Sub-themes	Dimensions
Can't say		
Interest	Falls prevention	
	Older adults	
	Opportunity	Learning To work together to address a problem
Relationship	Building	
	Existing	

5.2.5.3.8 Establishing goals and values

All five PHU professionals and six community partners indicated that there was commonality in the partners, goals and values around the prevention of falls among community dwelling adults. In giving their explanations, eight participants (three PHU professionals and five community partners) identified the theme of *"reducing, preventing falls and having seniors' age in a much healthier way"* as their common goal or value. Two of these community partners also included the need to get people *"physically active." "Valuing that there are older adults in the community"* was identified by two PHU professionals as a theme – one of which also identified *"reducing, preventing falls and having seniors' age in a much healthier way"* as a common goal or value. *"Trying to be better for the community"* was identified by one community partner as the common partnership goals or values. One participant did not provide a description. **Table 27** summarizes the emerging themes from descriptions of mobilizing partners' common goals and values.

Table 27 *Distribution of Identified Emerging Themes Describing Mobilizing Partners' Common Goals and Values*

Theme	Description	Number of participants with theme (*n* = 10)[a]	Example quote
Reducing, preventing falls and having seniors' age in a much healthier way	Participants' described preventing or reducing falls and improving health as their common goal or value	8 (72.7%)	*PHU professional 1: "So when the groups and committees were forming, [name of groups], the whole premise was to make sure that we all were there for the sole purpose of either reducing, preventing falls and having seniors age in a much healthier way. So when it was starting everybody did a pitch where we told them what our goals were. And then those that came to the table agreed and had the same kind of goals."*
Trying to be better for the community	Participants' described trying to be better for the community as their common goal or value	1 (9.1%)	*Community partner 1: "How do we get everybody onboard knowing that we are all trying to promote the same thing. No one's trying to steal clients, nobody's, we're just trying to be better for community."*
Valuing that there are older adults in the community	Participants' described valuing older adults as their common goal or value	2 (18.2%)	*PHU professional 3: "Sure that the, that we value that there are older adults in our community that we have rising numbers of older adults and that they are. That we all see that as a, from like a strength of base perspective, not as a problem. And that people have the, the right to access what they need to choose what they, what they want to be healthy and deserve from a fall."*

[a] Only 10 out of the 11 participants described partners goals and values.

Despite most participants indicating that there was commonality in their own partners' goals and values, five participants (two PHU professionals and three community partners) described how differences in organizational goals and values around falls prevention in community-dwelling older adults were resolved if any differences emerged. All these participants spoke about resolving differences through discussion and talking with one another. Some of the topics participants described as being helpful in aligning differences included talking about: *"the overall goal,"* being accountable and thinking about the needs of "*seniors as well and our community*," and relating *"everything back to that life span approach."* In addition to discussing differences, one of the PHU professionals spoke about taking a break:

> *"If we can't, literally, the group just says all right, we're going to take a break. We're going to take a break because sometimes you need space and clarity. And a lot of the times, the thing is people need to go and get information from a higher, who makes more money than them, who has more authority to say yes or no because not everybody at the table is a decision-maker. Most of the people at the table are not decision-makers. So a lot of times it's, "listen, I don't know if my organization would be okay with that, or if we did that. I need to go back." Otherwise it's like a lot of discussion and trying to potentially sell the idea to those not in favour. But if there's like a stalemate, we just take a break." [PHU professional 1]*

Another participant also spoke about having conflict resolution teams and voting to resolve differences:

> *"There's different things happening like that and we just, we just work around them. Some of my teams have conflict, conflict resolution subgroups, or I don't even know what you call them. A group of people who agree to be on the conflict resolution team. If there is some issue, that you can bring it to that team to, to come to a decision. So we've had things like where we've had votes where people wanted something different and then we could vote and then the vote is tied, it would have to go to the conflict resolution subgroup." [PHU professional 3]*

5.2.5.3.9 How partners organized for community mobilization

Ten participants (five PHU professionals and five community partners) described how they and their partners organized themselves for community mobilization. All described organizing themselves into formal groups such as *"committees" (e.g., executive, lead, steering, sub-committees), "teams," "Communities of Practice,"* and *"round tables."* One of the community partners also described working in a free-form manner focused on programming with no specific *"break-down of those different roles."* As part of their descriptions, several participants described ways in which the organization was supported. These responses generated the emergence of five sub-themes: adopting roles, formal documentation, communication, a review process, and evaluation. These sub-themes are described below:

- ***Adopting roles*.** Identifying and taking on different roles such as being an *"advocate," "leader," "chair," "co-chair," "decision-maker," "knowledge user,"* etc., was the most frequently occurring sub-theme. Nine participants (four PHU professionals and five community partners) described adoption and outlining of different roles as part of how they organized themselves for mobilization. For example, one participant stated roles were useful for decision making:

  > *"And then sometimes we have people who take on roles. So, we'll have...Like some of the groups will have a Sec (Secretary). They do all the communications kind of thing. Decision-making. How's it going to be done? Is it going to be a voting system? Is it going to be a dictatorship?" [PHU professional 1]*

- ***Formal documentation*.** The use of various forms of formal documentation to organize the partnerships for mobilization was described by eight participants (five PHU professionals and three community partners). All these participants

described using a *"Terms of reference"* document to organize aspects of their partnership. As one participant described:

> *"So first of all there's the Terms of Reference. And the Terms of Reference is reviewed regularly, once a year. When I first started they were sort of going through a bit of a, not necessarily a redefining exercise, I can't say redefining because it wasn't involved before, but going through it - what is our vision? What our goals? That sort of thing. And so revising the Terms of Reference from that point." [Community partner 2]*

Other formal documents that were described included *"agendas," "attendance"* at meetings, *"logic models,"* meeting *"minutes," "Memorandums of Understanding"* or *"MOUs," "mandates," "reports,"* and *"work plans."*

- ***Communication*.** Different methods and forms of communication were described by five participants (two PHU professionals and three community partners). Some of the different forms of communication that were used to organize the partnerships included *"e-mails," "discussions," "meetings,"* and *"newsletters."* One participant described how a form of communication was used to keep partners informed of activities:

  > *"There, one of the key pieces was sending out to community members that couldn't attend regularly not only minutes but a newsletter with the highlights of activities etc. went out, was developed, because not everybody reads minutes and sometimes minutes are hard to filter through. The newsletter was a synopsis of it so it gives an easy read. And for busy health professionals it works much nicer as a tool to inform and keep people up-to-date." [Community partner 5]*

- ***Review process*.** Three participants (two PHU professionals and one community partner) described engaging in a review process with their partners to help them organize for the year ahead. In particular, one PHU professional stated:

> *"So, of late, I'd say we're, we're, we've developed a process where we will every year kind of revisit our terms of reference where we talk about what we're trying to do and what we hope to achieve. So establishing that vision and that mission. To get every, to have something that everybody can identify with. Then to also look back at the previous year say, and say, "is this what we did?" And I think probably over the years, it's become a little more concrete."*

- ***Evaluation*.** One community partner commented on using evaluation to organize their partnership. Specifically, they described:

> *"And then we also, I think on a yearly basis, do an evaluation as well. Of the collaborative what's working and what's not working. There's a strong effort I think - those I think are two activities that refocus, err not refocus, but emphasize what are we here for, how (are) we doing? And I think that's an important part so you don't get side tracked."*

A summary of the thematic structure emerging from the participants' description of how they and their partners organized themselves for community partner mobilization is presented in **Table 28**. **Table 29** shows the distribution of identified sub-themes describing how partners organized themselves for mobilization by PHU site. As shown adopting roles, and using formal documentation, were identified as being used at all PHU sample sites to organize partnerships. Communication, a review process, and evaluation were identified less across the PHU sample sites.

Table 28 *Thematic Structure Describing Participants' Responses about How They Organized for Community Partner Mobilization*

Main theme	Sub-themes	Dimensions
Structure	Formal group	Committees Collaboratives Communities of Practice Teams Executive committees Lead committees Round tables Steering committees Sub-committees
	Free form	
Support	Communication	Discussions Emails Meetings Newsletters
	Evaluation	
	Formal documentation	Agendas Attendance Logic model Mandate Memorandum of understanding (MOUs) Minutes Report Terms of reference Work plan
	Review process	
	Roles	Advocates Chairs Co-chairs Core members Decision-makers Educators Leaders Members Knowledge users Minute takers Stakeholders

Table 29 *Distribution of Identified Sub-themes Describing How Partners Organized Themselves for Community Partner Mobilization by Public Health Unit (PHU) Site*

PHU Site	Identified Sub-themes				
	Adopting roles	Communication	Evaluation	Formal documentation	Review process
Central West #1	X	X		X	X
Central West #2	X		X	X	X
Eastern	X	X		X	
North West	X			X	
South West	X	X		X	

5.2.5.3.10 Level of partnership.

The reported level of partnership integration or nature of teamwork varied. As shown in **Figure 8**, most participants felt their partnerships were collaborative in nature, followed by communicative, cooperative, and coordinated. Five participants described the level of partnership integration using more than one category. These participants described the nature of their partnerships as follows:

- **communicative and collaborative** (one PHU professional and one community partner);
- **communicative, cooperative, and collaborative** (one PHU professional);
- **communicative, coordinated, and collaborative** (one community partner); and
- **all four terms** (one PHU professional).

Almost all participants (*n = 10*, 90.9%, five PHU professionals and five community partners) noted that the level of partnership integration changed or depended on the partners in the partnership (number, *"personality," "level of interest"*), *"events"* (number and size), organizational priorities and *"capacity"* (e.g., *"resources," "funding,"* time and staffing), the work being done, staff *"turn-over,"* and time. One community partner felt that the level of partnership did not change because the organization they represented needed to be accountable to the people they served, were knowledgeable about *"what works and that's what keeps people feeling engaged,"* as well as having a PHU professional who was "very engaged" and valued the work being done. The terms used to describe the nature of partnerships were not identified for participants in advance and no one asked for a definition of each term.

During the interviews one participant described having *"limited participation"* with their local PHU regarding fall prevention initiatives. Another community partner also expressed that their partnership seemed to have gone by the *"wayside"* because partners did not have the time and seemed to be "*doing their own thing right now.*"

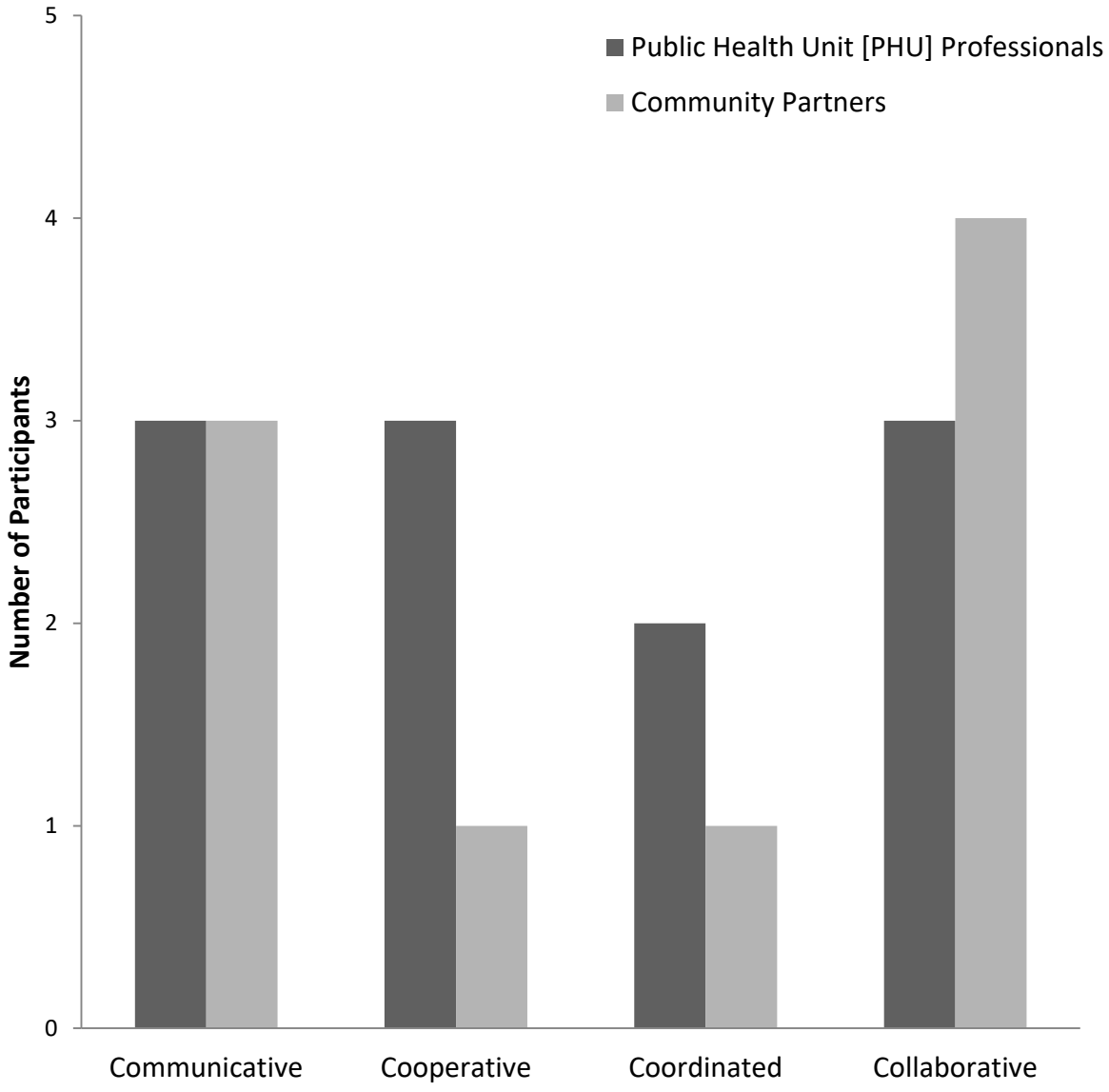

Figure 8 . Frequency of endorsed level of partnership integration identified by participants.

Note. Five participants described the nature of their partnership using more than one term. One PHU professional and one community partner identified their partnership as communicative and collaborative. One PHU professional identified their partnership as communicative, cooperative, and coordinated. One community partner described their partnership as communicative, coordinated, and collaborative. One PHU professional endorsed all four levels. Definitions for each of the terms were not provided.

5.2.5.3.11 Communication with partners.

Communicating with partners is vital for keeping partners engaged and informed. Participants described communicating with their partners through multiple modes and formats. Ten participants (five PHU professionals and five community partners) said communication with partners was made through e-mails. Meetings either face-to-face, teleconference, or videoconference formats were identified by seven participants (five PHU professionals and two community partners). Agendas were identified by a PHU professional as a communication method that was useful to *"keep everything structured and organized"* and *"to keep people accountable."* Other ways of communicating with partners included: telephone (one PHU professional) and conversations (one community partner).

Figure 9 illustrates the frequency of reported communication between partners. As shown, the most commonly identified frequency was bimonthly. PHU professionals identified communicating with partners more frequently than community partners. Some participants identified multiple communication frequencies due to communication occurring more or less frequently for different formats (e.g., e-mail versus in-person meetings), activities, and stage of community partner mobilization. For example, as one PHU professionals stated:

> *"the frequency of meetings has decreased over time. During the development stages of the strategy it was very frequent. Monthly. Sometimes, I think the steering committee would meet almost weekly. I would say every couple of months now. It depends on what initiatives are coming up. For example, so under the public awareness and education pillar of the strategy, falls prevention month in November is kind of a rallying point. And so there's some preparatory things that happen before then. And so the frequency of those meetings might increase a little bit." [PHU professional 5]*

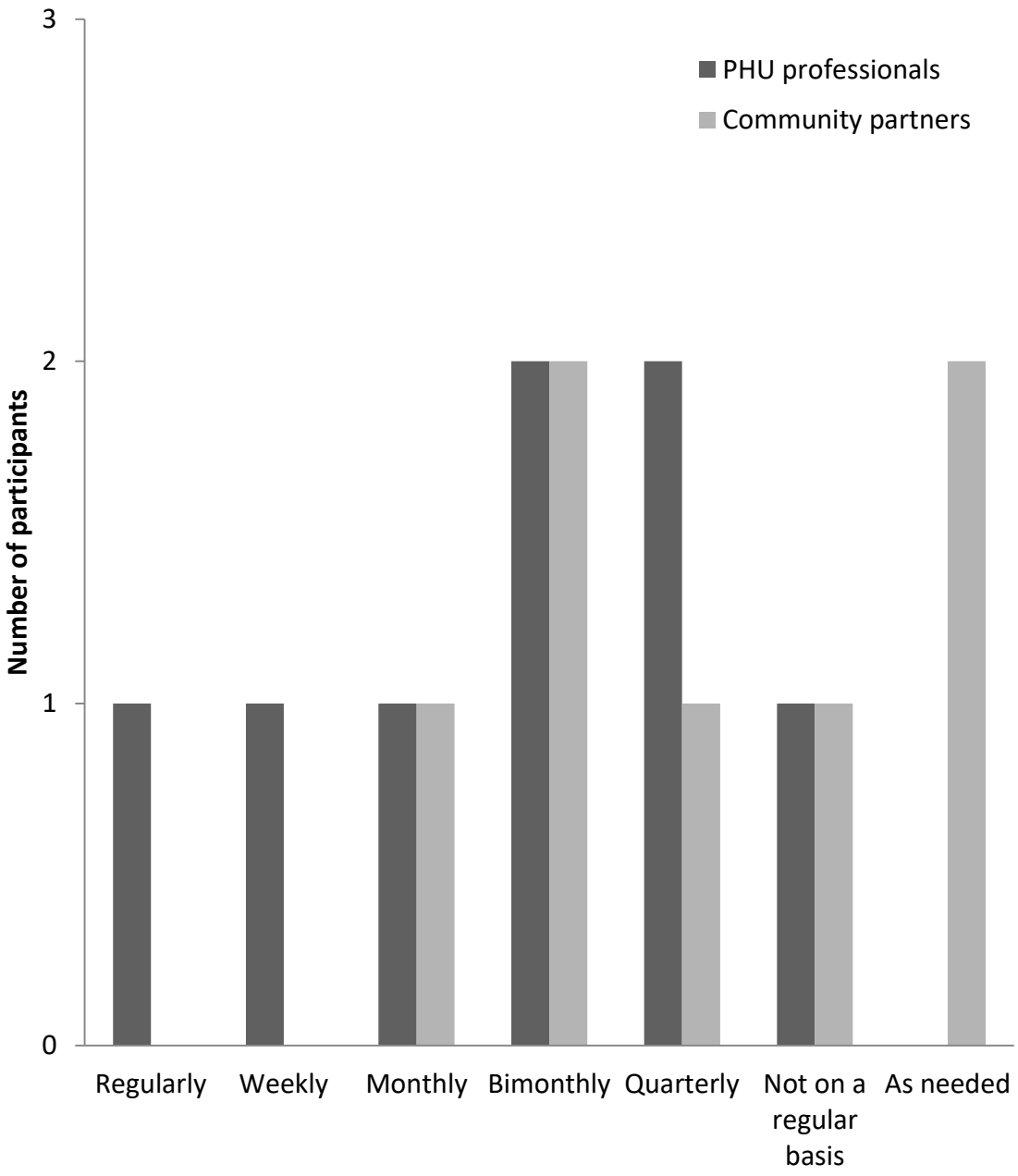

Figure 9. Distribution of reported frequency of communication between partners.

Note. Some participants described multiple communication frequencies for different communication formats, activities, and stage of community partner mobilization.

5.2.5.3.12 Partnership activities.

Participants (five PHU professionals and six community partners) described engaging in a few different activities together. Analysis of their responses yielded four main themes: program development, implementation, and promotion; systems approaches and integration; research; and training, awareness, and education (**Tables 30 and 31**).

All participants (*n = 11*, 100%) described engaging in activities related to training education, and awareness with the focus on health care providers and/or older adults. Nine participants (five PHU professionals and four community partners) described employing activities specific to older adults such as *"Falls prevention month,"* falls prevention *"handbooks"* and *"brochures," "health fairs," "media campaigns,"* and *"presentations"* about community resources, health and nutrition, and falls prevention. Activities targeting providers were described by eight participants (four PHU professionals and four community partners). Some of the activities that were identified included *"presentations"* on *"getting individuals more active,"* providing *"training in falls prevention and in-home exercise,"* fall-risk assessment tools and *"toolkits"* (e.g., multifactorial checklists that include cognitive and vision screening, Fall Prevention Month toolkit, Greater Los Angeles VA Geriatric Research Education Clinical Centre falls risk self-assessment tool) and *"LOOP"* (an online portal for networking, training and information).

The next most common theme which emerged from the descriptions given by eight participants (four PHU professionals and four community partners) was program development, implementation, and promotion. Within this theme, participants spoke about *"exercise programs"* for older adults and those with existing health conditions that would promote

balance, strength, and mobility. Other examples of activities described by these participants included the *"Stay on your Feet"* program and *"referral cards"* to connect older adults with fall prevention agencies, programs, and individuals.

Table 30 *Emerging Themes from Participants' Descriptions of Partnership Activities*

Main theme	Description	Number of participants with theme (*n = 11*)	Example quote
System approaches and integration	Participants' description of partnership activities related to systems approaches and integration (e.g., strategies and frameworks)	4 (36.4%)	*Community partner 4: "So the Integrated Fall Prevention Framework was meant to have a different approach, which was, you have a provincial oversight. So with a group that would look at the key functions that could be centralized. What could be those functions? Data and surveillance would be one. Performance management would be another. Communications."*
Program development, implementation, and promotion	Participants' description of partnership activities related to programming (e.g., exercise classes)	8 (72.3%)	*PHU professional 1: "And then for another time we were doing, umm, exercise resources. So we had bought videos that others could take out to clients. We had home support exercise training. We did, we produced Exercises by the Kitchen Sink that another group, another area had done."*
Research	Participants' description of partnership activities related to research (e.g., evaluation, focus groups)	5 (45.5%)	*Community partner 5: "Again there was a literature review done and looking at best practices then all that area adopted the same home safety checklist. So there's consistency at least in some areas."*

Table 30 Continued

Main theme	Description	Number of participants with theme (*n = 11*)	Example quote
Training, awareness, and education	Participants' description of partnership activities related to training (e.g., health fairs for older adults, education workshops and sessions for health providers)	11 (100.0%)	*Community partner 5: "so the other thing we've done in my time, we've organized forums for health professionals. And forums for public as well. And brought in speakers. And presented on various aspects of fall prevention."* *Community partner 6:"They've done the, they've done the falls prevention pop up kind of display unit. Where they've moved it around to different activities. They've had it in their, in the Health Unit, in the clinic screening, kind of life-size blow-up pictures. They've done, they've been involved with different community events. For example, health affairs talking to people directly."*

Table 31 *Thematic Structure Describing the Activities Partners Engaged in as Part of Community Partner Mobilization*

Main theme	Sub-themes	Dimensions
Program development, implementation, and promotion	Assessments	General Home
	Exercise programs	
	Falls related activity promotion	
	Peer-to-peer education	
	Referral cards	
	Stay on your Feet	
Research	Evaluations	
	Focus groups	
	Literature reviews	
Systems approaches and integration	Falls Prevention Framework	
	Falls Prevention Strategy	

Table 31 Continued

Main theme	Sub-themes	Dimensions
Training, awareness, and education	Provider skill development and education	Conferences Forums Health provider education sessions Knowledge translation LOOP Newsletter Tools and toolkits Workshops
	Public awareness and education	Booths Contests Displays Events (e.g., health fairs, workshops) Fall prevention month Healthy eating and nutrition classes Information sessions Media campaigns Presentations Print materials (e.g., booklets brochures) Websites Workshops

Four participants (two PHU professionals and two community partners) described engaging in activities related to systems approaches and integration. Specifically, these participants spoke about falls prevention *"strategies"* and *"frameworks"* that were developed, being promoted, and implemented within their communities and elsewhere and focused on integrated approaches across multiple organizations, sectors, and systems.

Research was a theme emerging from descriptions of activities made by five participants (two PHU professionals and three community partner). Examples of research activities included *"community consultations," "evaluations"* of community needs, *"focus groups,"* "formal evaluations" for "the performance of the initiatives", and *"literature reviews"* of best practices for falls prevention.

5.2.5.3.13 Expected outcomes.

All but one participant described the expected outcomes of the activities the partnership had decided to do in the community. Analysis of the responses of the remaining participants generated 30 nodes. A summary of the thematic structure for expected outcomes of activities based on the analysis is presented in **Table 32**.

Table 32 *Thematic Structure Describing the Expected Outcomes of Community Partner Mobilization Activities*

Main theme	Sub-themes	Dimensions
Ability to satisfy requirements of grant		
Event and program performance	Metrics	Number attending events and programs Number of calls for referrals Number of events held Number of pamphlets/brochures distributed Satisfaction with events
Falls (General)	Metrics	Number and severity Number of falls related admissions Reduced risk
	Awareness around prevention Hazards and how to be safe Risks	
Falls (Population specific)	General population	Concussions
	Kids	
	Older adults	Physical aspects: balance, strength, etc. Prevention: not falling in first place Prevention: build environment
Health	Improved health and well-being Improved health management People will be safer	

Table 32 Continued

Main theme	Sub-themes	Dimensions
Improved system navigation and integration		
Increased capacity		
Increased knowledge about programs and resources that can be accessed		

As can be seen in **Table 33,** the main themes that emerged were outcomes related to:

- *Falls* (generally). This was the most commonly emerging theme, identified by eight of the ten participants (five PHU professionals and three community partners). Expected outcomes of community partner mobilization for falls spoken about in a general sense included *"increased awareness around fall prevention,"* fall hazards, fall risks, and metrics (e.g., number and severity of falls, number of falls related admissions, reductions in risk);
- *Event and program performance.* Four of the ten participants described expected outcomes specifically related performance measures for events and programs such as *"number of"* events, talks, or workshops held, *"numbers"* of people attending," *"number of brochures distributed,"* and *"satisfaction"* with events; and
- *Falls (population specific).* Three participants (one PHU professionals and two community partners) spoke about outcomes related to falls for specific population groups (i.e., outcomes for the general population, children and youth, and older adults). Some of the effects discussed were falls-related "*outcomes"* like *"concussions"* in the general population, preventing fall outcomes among children and youth by increasing safety, and *"prevention"* of falls among older adults.

Other expected outcomes described by participants included: the *ability to satisfy requirements of the grant, improved health, improved system navigation and integration,*

increased capacity, partner engagement and advocacy, and *increased knowledge about programs and resources that can be accessed*.

Table 33 *Emerging Themes for Participants' Expected Outcomes from Community Partner Mobilization Activities*

Theme	Description	Number of participants with theme (*n = 10*)[a]	Example quote
Ability to satisfy requirements of grant	Participants' description of their community partner mobilization efforts resulting in their ability to meeting grant requirements	1 (10.0%)	*Community partner 6: "Well, if it's a grant, it's satisfying the requirements of the grant."*
Event and program performance	Participants' description of their community partner mobilization efforts resulting in event and program performance outcomes	4 (40.0%)	*PHU professional 2: "I mean, in the early years we were going to reduce falls. But knowing how complex and they are, that's not going to be likely. And so, we've, so things have been scaled back more to performance type measures. So we monitor how many events we've held and how many people attended and their satisfaction with the, with the event."*
Falls (Generally)	Participants' description of their community partner mobilization efforts resulting in general falls-related outcomes (e.g., awareness of hazards and how to be safe, metrics like reduction in number and severity of falls)	8 (80.0%)	*Community partner 5: "Well when you talk about outcomes from say. Well reducing falls it's obviously the overall goal. But that's very hard to track because, we always laugh at this, because we can track the number of falls and injuries, at least number of injuries. And do you ever really get a true picture of how many falls happen? Or how many falls are prevented? How do you count the number of falls prevented?"*

Table 33 Continued

Theme	Description	Number of participants with theme (*n = 10*)[a]	Example quote
Falls (Population specific)	Participants' description of their community partner mobilization efforts resulting in falls-related outcomes for specific populations	3 (30.0%)	*PHU professional 1: "We also do falls prevention education and we bring individuals in to help seniors realize what the tripping hazards that exist are and how to safely go up and down stairs if you still live in a place that has them. What can you do to ...what changes can you make to your bathroom to make sure that you, if you slip, you have the handle bar to grab on to? Stuff like that. So we bring those supports to them in the various programming that we have... Where seniors are target audience office. But it's definitely, definitely I would say for the general population it's we focus on the outcomes, but for seniors we definitely focus on the strategies for preventing a fall."*
Health	Participants' description of their community partner mobilization efforts resulting in improved health	2 (20.0%)	*PHU professional 5: "Like things like improved health and well-being, improved health management, reduced risk, number, and severity of falls, improved system navigation and integration, and improved collective capacity."*

Table 33 Continued

Theme	Description	Number of participants with theme (*n = 10*)[a]	Example quote
Improved system navigation and integration	Participants' description of their community partner mobilization efforts resulting in the ability to better movement through the system	1 (10.0%)	*PHU professional 5: "Like things like improved health and well-being, improved health management, reduced risk, number, and severity of falls, improved system navigation and integration, and improved collective capacity."*
Increased capacity	Participants' description of their community partner mobilization efforts resulting in increased capacity	2 (20.0%)	*Community partner 4: "It's to build the capacity. It's to build the capacity for people to be able to implement best practice interventions. So it's not just knowing which interventions there are but it's how to do it. And to have the knowledge, the skills, the resources. At times we bring those resources forward knowing that Public Health Units have limited resources. And they can't access everything individually. So we tried to support their capacity to be able to implement best practice interventions."*

Table 33 Continued

Theme	Description	Number of participants with theme (*n = 10*)[a]	Example quote
Increased knowledge about programs and resources that can be accessed	Participants' description of their community partner mobilization efforts resulting in increased knowledge of how to access programs and resources	2 (20.0%)	*Community partner 2: "I think part, so the two parts really, the first part hopefully was in communities. And then the audience we targeted to provide some increased awareness around falls prevention and not just the importance of it, but the importance of knowing what's out there to help you. Right? So it's one thing to know that it's a risk, but it's much more effective and important to know if I'm concerned, what can I access. Definitely that would be the main goal."*

[a] Only ten out of the 11 participants described the expected outcomes.

5.2.5.4 Response to Falls LDCP community mobilization scoping review.

Four out of the five PHU professionals were asked whether their community partner mobilization practices had changed as a result of the community mobilization scoping review (Crizzle et al., 2019).[8] Three PHU professionals said that the Falls LDCP scoping review had not changed their practices. Although not all PHU professionals gave reasons why the review had not changed their practices; one PHU professional had not changed their practices because the work they had done was prior to the report's internal release to the PHUs and another PHU professional felt:

> *"The models and theories that were there and frameworks…(they) didn't really meet the needs of my community."*

One PHU professional stated that the review had not yet changed their community partner mobilization practices but was using it "*for planning*" to "*make sure that I've got my bases covered.*" This PHU professional also expressed how they wanted to see the review published, others to be aware of the review, and had hoped that the book, Ignite: Getting your community coalition fired up for change (Butterfoss, 2013), which had been distributed to participating PHUs as part of the Falls LDCP work was being read.

5.2.6 Objective 6: Performance, benefits, and challenges of community partner mobilization and practices

This section presents the findings from PHU professionals' and community partners' responses about the performance of their community partner mobilization efforts (i.e.,

[8] The Falls LDCP scoping review question was added after completing the pilot study. As a result, the pilot study participant was not asked about the impact of the report on their community partner mobilization practices.

perceived impact, what's working, what's not working), evaluation, benefits, and challenges of community partner mobilization. Each topic is presented in succession.

5.2.6.1 Performance.

Two themes emerged from PHU professionals' and community partners' responses about the performance of their community partner mobilization efforts in terms of the impact on the community, partners, and themselves were:

- **Capacity.** Two PHU professionals and three community partners noted that their efforts were helping to develop, support, and change the community or their partnerships in a variety of ways. In relation to capacity, these participants spoke about people, communication, knowledge, resources, and training. For example, one participant described how community partner mobilization now provided them with access to people who could provide that *"perspective of what the reality is locally and regionally and also to have various perspectives."* Another participant spoke about how they were receiving knowledge that led to an opportunity for themselves and others to attend the Canadian Fall Prevention Curriculum, a two-day training program on developing fall prevention programming, which improved their fall prevention strategy.
- **Reach.** Another common theme was the ability to connect to others through increased awareness of community programs and offerings as well as community referrals to programs. As one community partner stated:

> *"I think people are more aware. Especially kind of, again, I know that <name of PHU professional>'s promoting the fact that there are physio and programs in the community centres. And the Health Unit had put*

together a list of community walking programs so that seniors can find walking programs to do year-round." [Community Partner 6]

Other topics discussed by participants in relation to performance of their mobilization efforts included better integrated programs and services, and not having data or information on the impact of efforts. One community partner did not feel they could assess the *"success or the progress of a program"* given that they had not yet done any work with their local PHU. **Table 34** illustrates the thematic structure emerging from PHU professionals' and community partners' views on the performance of their community mobilization efforts.

Table 34 *Thematic Structure Describing Participants' Views on the Performance of their Community Partner Mobilization Efforts*

Main theme	Sub-themes	Dimensions
Better integrated programs and services		
Capacity	People Forum for communication Knowledge Resources Training	
Reach	Awareness Community referrals to program	

Three PHU professionals and five community partners discussed what they were doing that was working well and what was not working. From these discussions, two main themes emerged describing what was working well: activities and programs, and strategies and approaches (see **Table 35** for the thematic structure).

Activities and programs. Six participants (three PHU professionals and three community partners) described a variety of specific activities and programs that they and their partners were working on (or had completed) that they felt performed well. The most commonly cited activity was health fairs, road shows, and education sessions which were seen as successful in a variety of ways such as bringing the community together (e.g., partners, seniors), *"addressing a number of risk factors,"* increasing awareness of what partners are able to offer, and making *"a difference in people's knowledge."* Programs noted by participants were performing well were a peer-to-peer education program run by trained volunteers that was seen as filling gaps in community needs and reducing program duplication, and a falls prevention exercise program and healthy eating and nutrition sessions based on popularity and attendance. Promotion of physiotherapy, community centre where programs were available, and walking programs were activities believed to be performing well by one PHU professional. Print materials (e.g., brochures, flyers, newspaper advertisements, and posters), radio, and T.V. advertising about programs were identified by one PHU professional as successful activities for reaching reach seniors. The Fall Prevention Month website was identified by a community partner as a way of having resources reach people and organizations as evidenced by the number of downloads and new materials being created by organizations (i.e., articles, and newsletters). Reaching target partners and audience were

described by three participants (one PHU professional and two community partners), as efforts that were performing well.

Strategies and approaches. Four participants (two PHU professionals and two community partners) discussed general strategies and approaches or advice that they felt were important in making community partner mobilization work. These approaches included:

- a sense of being humble - going *"in as if I need them more than anything else, than they need me*" and not *"being like I know everything and that this is what I want anyway" [PHU professional 1];*
- *"answering"* and *"listening to their (target audience) needs" [Community partner 4];*
- bringing *"programming or information to them (older adults) that works"* given challenges some older adults face with income and transportation *[PHU professionals 1 and 2];*
- figuring out *"what's important to them (community partners)" [PHU professional 1, Community partner 4];*
- including a strategy *"around staff competencies"* that offers *"training and coaching" [Community partner 4];*
- *"sharing knowledge" [Community partner 2];*
- *strategies that are "informed by the target audience" [Community partner 4];*
- strategies that are *"a mix of top-down and bottom-up"* and includes *"the leadership" [Community partner 4];* and
- *"working to build relationships" [PHU professional 1].*

Other advice included leveraging interest in order to benefit falls. As the participant stated:

> *"Our work kind of changes as new things develop. So in the past few years, the, the increase in, interest in age friendliness has meant that we, we've been intentional about ways in finding where we can leverage that interest to also benefit falls. So I think it's a lot about looking at finding the opportunities to work, work at, chip away at falls from a different, in a different way. Hoping at some point we are going to find a key." [PHU professional 2]*

As an example of what efforts were working and performing well, one community partner spoke about having community resources to refer people to for fall prevention that weren't available years ago and how this has filled gaps in care and in the community.

Table 35 *Thematic Structure Describing Public Health Unit (PHU) Professionals' and Community Partners' Views on what Efforts are Performing Well*

Main theme	Sub-themes	Dimensions
Activities and programs	Education sessions	
	Falls prevention exercise program	Attendance
	Health fairs	Awareness of activities Awareness of organizations Brings community together Networking Satisfaction
	Nutrition and healthy eating programs	Attendance
	Print advertising (e.g., brochures, flyers, newspaper articles)	
	Radio and T.V. advertising	
	Volunteer peer-to-peer falls education program	
	Website	Data on membership and downloaded content
Community resources		

Table 35 Continued

Main theme	Sub-themes	Dimensions
Strategies and approaches	Be humble	
	Bring programming to seniors	
	Build relationships with partners	
	Build staff competencies	
	Identify what's important to partners	
	Leverage interest in age friendliness to promote falls prevention	
	Sharing knowledge	
	Strategies informed by the target audience	
	Strategies that are a mix of top-down and bottom-up	

All the comments about what is not working were specific to the activities that the PHU and community partners were working together on. Activities that were described as not working by some of the participants were:

- a communications campaign where there were questions about the evidence-base and messaging to older adults *[PHU professional 2];*
- a referral program for seniors to call local experts and find out about community programs *[Community partner 2];*
- e-newsletters which could no longer be sent to people because of spam legislation; *[PHU professional 2];*
- getting health professionals to complete an evaluation and provide feedback on a program *[Community partner 4]*;
- getting seniors to do programs online *[PHU professional 1]*; and
- home assessment programs *[PHU professional 1]*.

5.2.6.2 Evaluation.

The topic of evaluation was discussed openly throughout some interviews, and in relation to community partner mobilization activities, performance, and impact of mobilization activities and partnerships. Out of the 11 participants (five PHU professionals and six community partners) who discussed the evaluation of their community partner mobilization efforts: three community partners did not know if evaluation had been completed or planned; two PHU professionals said that evaluation had not been completed or planned; one PHU professional stated that evaluation was planned; and two PHU professionals and three

community partners said that evaluations for some of the work had been completed. At the time of the interview, not all interviewed participants at each PHU site were in agreement of whether evaluation had occurred, was planned, or not being done. The reasons for any disagreements were not explored; however, are noted in the descriptions that follow.

Several participants who indicated that they were evaluating described the specific evaluation activities they were or had engaged in. At one of the sites, the PHU professional stated that they had done: evaluation surveys with their community partners to figure out which activities to do; focus groups with stakeholders; stakeholder assessment surveys every two to three years looking at partner needs, whether goals and outcomes were achieved, and satisfaction; assessments of activities with *"evaluation is weaved in from the beginning"* for anything being planned; partner assessment surveys looking at whether partnership is:

> *"working? Is it effective? Do they feel they've gained the new skills and knowledge? What skills and knowledge did they gain? How have they taken the skills and knowledge they've used in this partnership to use elsewhere? Have they created new partnerships to work on the problem somewhere else where Public Health is not involved?"*

At another PHU site, the community partner described engaging in yearly evaluations of their collaborative *"to emphasize what are we here for, how we doing?"* and *"evaluations after each event."* The PHU professional, however, indicated that they were not collecting performance or evaluation data although spoke earlier in the interview about past attempts to evaluate the partnership and the desire to do evaluation. At a third PHU site, all but one of the interviewed participants said that were evaluating. Specific evaluation activities included: media evaluation, evaluation of activities, annual evaluation of the collaboration, and formal evaluation of program performance annually. The remaining member was unaware of

evaluation plans or activities in relation to community partner mobilization efforts and performance.

According to one PHU Professional, future plans for evaluation included evaluating an upcoming media campaign. Evaluation activities included tracking and reporting the number of people in different age groups accessing their website and the number of people participating in contests. However, evaluation had not yet been conducted because they were still in the early phases of planning and organizing for community mobilization. The community partner at this site was not aware of any current or planned evaluation activities.

Notably one of the participants who said that they had not conducted an evaluation stated:

> *"I mean I think there are three outcome measures that are easily reviewed at any time. So both the number of falls related admissions, the number of falls related ED [Emergency Department] visits, and repeat ED visits for falls. That's data we have access to, and can easily pull a report together. We haven't. I'll say that. But that that's not a difficult task to do. So if we're looking at those as the outcome measures for the strategy, we probably should be doing periodic coding of the data and reporting back to the group in the community about that. But we haven't yet." [PHU Professional 3]*

5.2.6.3 *Benefits.*

The themes which emerged from the PHU professionals' and community partners' descriptions of the benefits of community partner mobilization are presented in **Figure 10** and summarized in **Table 36**. Most PHU professionals and community partners (*n = 7*, 63.6% - three PHU professionals, four community partners) discussed capacity as a benefit of their community partner mobilization efforts. Descriptions of capacity by some of the participants included, comments about increased abilities (e.g., address several risk factors, conduct

evaluations), knowledge, leadership, and people (e.g., PHU staff, students). Working together was discussed as a benefit of community mobilization by many participants (*n* = 5, 45.5% - one PHU professional, four community partners). Participants describing working together highlighted the value of bringing the community together to do something. Another frequently discussed theme by participants (*n* = 4, 36.4% - three PHU professionals, one community partner) was networking and relationships within which participants described creating networks, relationships, and improving communication. Reach was also a frequently discussed theme.

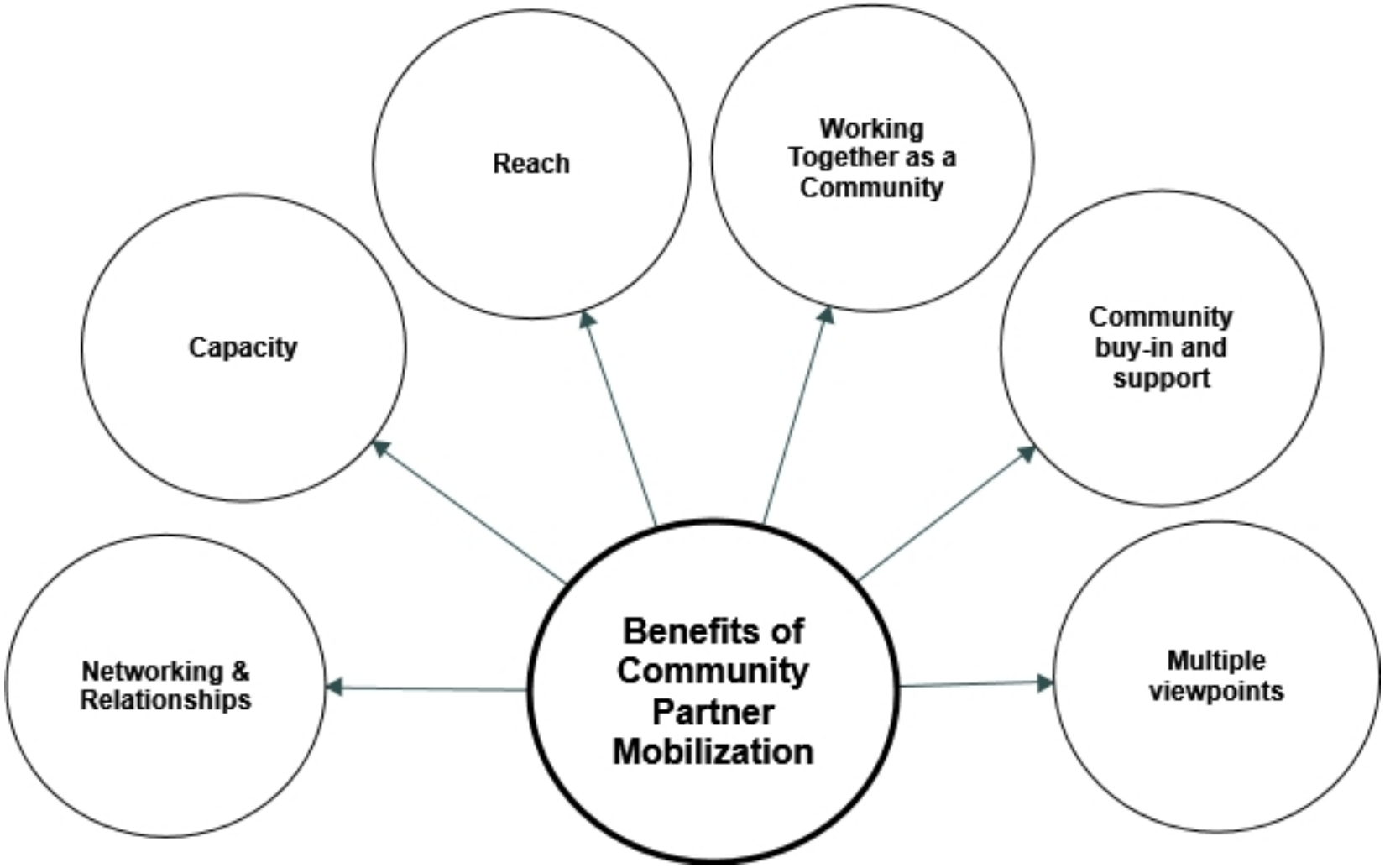

Figure 10. Main themes emerging from descriptions of the benefits of community partner mobilization.

Table 36 *Summary of Emerging Themes for the Perceived Benefits of Community Partner Mobilization*

Theme	Description	Number of participants with theme (*n* = 11)	Example quote
Capacity	Participants described the benefits of community partner mobilization as providing or increasing community capacity in various ways (e.g., abilities, shared knowledge, leadership, people)	7 (63.6%)	*PHU professional 1: "I think it's created a larger network of capacity. A lot of times, especially locally, in the past, a lot of people have been working on the same issue but siloed, which has been the main issue. Everyone is trying to fix the same problem and not working together. So it's definitely opened up larger networks. It's not, it's not one organization trying to fix falls, its seven organizations or eight organizations trying to address falls prevention now. So all of a sudden the capacity's increased tenfold."*
Community buy-in and participation	Participants described the benefits of community partner mobilization as involving gathering community support and involvement	2 (18.2%)	*Community partner 4: "I don't know, I guess a better chance of getting a buy-in if it's coming from multiple sources. If the [local organization and PHU] are both promoting something - more opportunity for participation. And I guess compliance might be the word."*

Table 36 Continued

Theme	Description	Number of participants with theme (*n* = 11)	Example quote
Multiple viewpoints	Participants described the benefits of community partner mobilization as having more than one perspective	4 (36.4%)	*Community partner 6: "By sometimes, working in a collaborative team, you get an idea of something that worked at another project and you can incorporate into what you're doing. So, I always think it's really good. And I think so often, if you just stay in your own silo, you don't get a chance to, to really learn from what you can do in the community, from what other people can offer, what they can share, how they can take over a part of the project to make it work."*
Networking and relationships	Participants described the benefits of community partner mobilization as creating networks, relationships, and improving communication between organizations, individuals, and the community	4 (36.4%)	*PHU professional 2: "The networking is a benefit because it helps create, those, either create some relationships that people can outside of the group feel more comfortable contacting somebody or within the group to jointly problem solve. Or to see duplications or to see gaps. And like I say, to foster coordination rather than to get rid of some of the competition can only be a good thing. The information sharing, so that everybody knows what's happening because people always feel like they don't know what's happening in the community. When the interest in social isolation came out, there were people to draw from because we already knew people who were interested in seniors work. So we had a starting point."*

Table 36 Continued

Theme	Description	Number of participants with theme (*n* = 11)	Example quote
Reach	Participants described the benefits of community partner mobilization as extending ways to connect with people	4 (36.4%)	*PHU professional 3: I would say that one of the best things that's happened with our strategy is that everyone brings different strengths. So we're finding ways to reach different groups that we might not reach if we weren't working together the way that we are."*
Working together as a community	Participants described the benefits of community partner mobilization as working together as a community	5 (45.5%)	*Community partner 2: "I think the biggest benefit, and it's often the benefit when you're on lots of different tables, is just that opportunity to really get to know people from other organizations. And understand better what it is they do and what they offer. Because everybody gets busy and it's really easy just to become siloed. Which we know is a huge healthcare, a huge issue in healthcare. So I think that opportunity to meet with other organizations and to actually work together towards a common goal is always really helpful."*

The four participants (36.4%, three PHU professionals, one community partner) who described reach as a community partner mobilization benefit, talked about how community mobilization aided in getting the word out about their programs and increased their reach to different target audiences (e.g., Indigenous populations, seniors). Other benefits described by participants included having multiple viewpoints that provide input and develop solutions (*n* = 3, 27.3%, three community partners), and community buy-in and support such as increased attendance and program compliance (*n* = 2, 18.2%, one PHU professional, one community partner). **Table 37** contains a summary of the thematic structure emerging from analysis of the perceived benefits of community partner mobilization identified by participants.

Table 37 *Thematic Structure Describing the Benefits of Community Mobilization*

Main theme	Sub-themes	Dimensions
Capacity	Abilities	Address more risk factors Conduct evaluations
	Shared resources	
	People	Students Staff
	Shared knowledge	Research Information/Data
	Leadership	
Community buy-in and participation	Attendance	
	Compliance	
Multiple viewpoints	Ideas Expertise Solutions	
Networking and relationships	Networking Relationships Communication	
Reach	Getting word out	
	Specific populations	Indigenous population Seniors
Working together as a community		

5.2.6.4 Challenges.

Participants identified many different community partner mobilization challenges. **Table 38** shows the themes which came out of the responses describing challenges to community partner mobilization. As shown in **Figure 11**, the six main themes that emerged were challenges related to:

- capacity;
- time;
- priorities, mandates, and standards;
- community buy-in and participation;
- guidance and training; and
- turnover.

Table 38 *Summary of Emerging Themes for the Perceived Challenges to Community Partner Mobilization*

Theme	Description	Number of participants with theme (*n* = 11)	Example quote
Capacity	Participants described the challenges to community partner mobilization as limited community capacity in various ways (e.g., funding, skills, leadership)	10 (90.9%)	*Community partner 4: "They have all, as I said earlier, some smaller Pubic Health Units have greater barriers. In capacity I would say. … Some have issues in terms of understanding of what needs to be done in fall prevention. As I said earlier, the understanding of community mobilization across Public Health Units is not equal. So then it's a little bit difficult to work with some of them that may not see that. It might be based on skill set of the staff. It might be based on resources. It might be based on the fear of not wanting to change."*
Community buy-in and participation	Participants described challenges associated with gathering community support and involvement (e.g., attendance, awareness of need for falls prevention, commitment)	5 (45.5%)	*Community partner 3: "Based on what the program may or may not be, what, whatever the program may be, I think community buy-in or participation by the intended target audience may be an issue - especially when you're dealing with seniors. It can be a challenge to get them to do certain things or implement certain things that are new or foreign to them. Just basically, I don't know, kind of stubbornness of the populace might be a factor."*

Table 38 Continued

Theme	Description	Number of participants with theme (*n* = 11)	Example quote
Forming partnerships	Participant described challenges that included forming partnerships (i.e., identifying partners, convincing others of value of partnership)	1 (9.1%)	*PHU professional 2: "Although the, sometimes the challenge is determining who your, who your community partners should be?"*
Guidance and training	Participants described a lack of guidance and training as a challenge (e.g., training on community mobilization frameworks, guidance on working with partners, and provincial oversight)	4 (36.4%)	*PHU professional 2: "They want to work together because, especially in Public Health, you are mandated to work with partners. So us being involved is necessary. We're told you need to do it. Right. We're not told how but we're told you need to do it."* *Community partner 4: "And those Public Health Standards are very fuzzy wuzzy. They're not clear in what kind of course of action you should take. Particularly around fall prevention. They talk about the evidence, they talk about some of the strategies, but it never says how to do it which is the implementation science piece that is missing. And that's sort of, that's something that the Public Health Units, some more so than others would need support in. How do you implement best practices? It's not just finding out which ones and the practice component or the intervention component, you have to know how to do it."*

Table 38 Continued

Theme	Description	Number of participants with theme (*n* = 11)	Example quote
Implementation	Participants described implementation issues as a challenge (i.e., delivery consistency, technology, uniqueness of municipalities)	3 (27.3%)	*Community partner 5: "However I must say, so say our, <name of program> they do a Workshop, it's a one-off, three hour program. They will go out to different communities to do it. But that's not consistent again. So consistency (in a large geographic area) I guess would be one of the things I see is a challenge."*
Not thinking population level	Participant described getting the community to think about population level as a challenge	1 (9.1%)	*PHU professional 1: "They're not thinking population level yet. In trying to… They want to reduce falls and keep everybody safe, but it's very individual still. They're not thinking, say, how can we reduce falls at the population level, where all 15% of seniors will be impacted. They're more like, okay, we have a group of, an access to 20 individual people right now, how can we get those 20 people to reduce falls? So that's kind of where they are."*
Outcomes	Participant described issues related to outcomes as a challenge	1 (9.1%)	*Community partner 2: "I think in terms of the higher risk folks... I think they are being reached. I don't know. Because we don't see the shifts in or at the population level."*

Table 38 Continued

Theme	Description	Number of participants with theme (*n* = 11)	Example quote
Priorities and Mandates	Participants described changing, competing, or differences in organizational priorities, focus, mandates as a community partner mobilization challenge	7 (63.6 %)	*PHU professional 1: "We are primary prevention, like that is our mandate. And sometimes people want things from you that your mandate prevents you from giving or it's not, or that's not what Public Health does. But their idea's that well, they're coming from a different perspective. That may not be what you do, but you have staff or skills with the capacity to do that. So it's balancing out those priorities and trying to make sure that everybody, still at the end of the day when they go back to their organizations and who they have to answer to, they're still happy. They get what they need out of it, what they need to be able to do to fulfill their mandate and reach whatever their goals, their mandate needs to do. So I think that is the biggest thing because when priorities change, that's difficult right?"*
Time	Participants described having a lack of time to engage in and contribute to community partner mobilization	8 (72.7%)	*PHU professional 2: "Challenges I would say, is time. Time to develop more, more than just keeping a seat at the table. So contributing to the table as well as the… Whatever project, they're going to do."* *Community partner 6: "That people do feel stretched and sometimes it's difficult to commit to doing different things."*

Table 38 Continued

Theme	Description	Number of participants with theme (*n* = 11)	Example quote
Turnover	Participants described changes in personnel and staffing departures as a challenge	4 (36.4%)	*PHU professional 3: "So people getting moved around to different, different work assignments or different work places, has been a huge challenge for us. So just when you start to get some real oomph behind something then you have somebody who switches to a different work assignment is really challenging."*

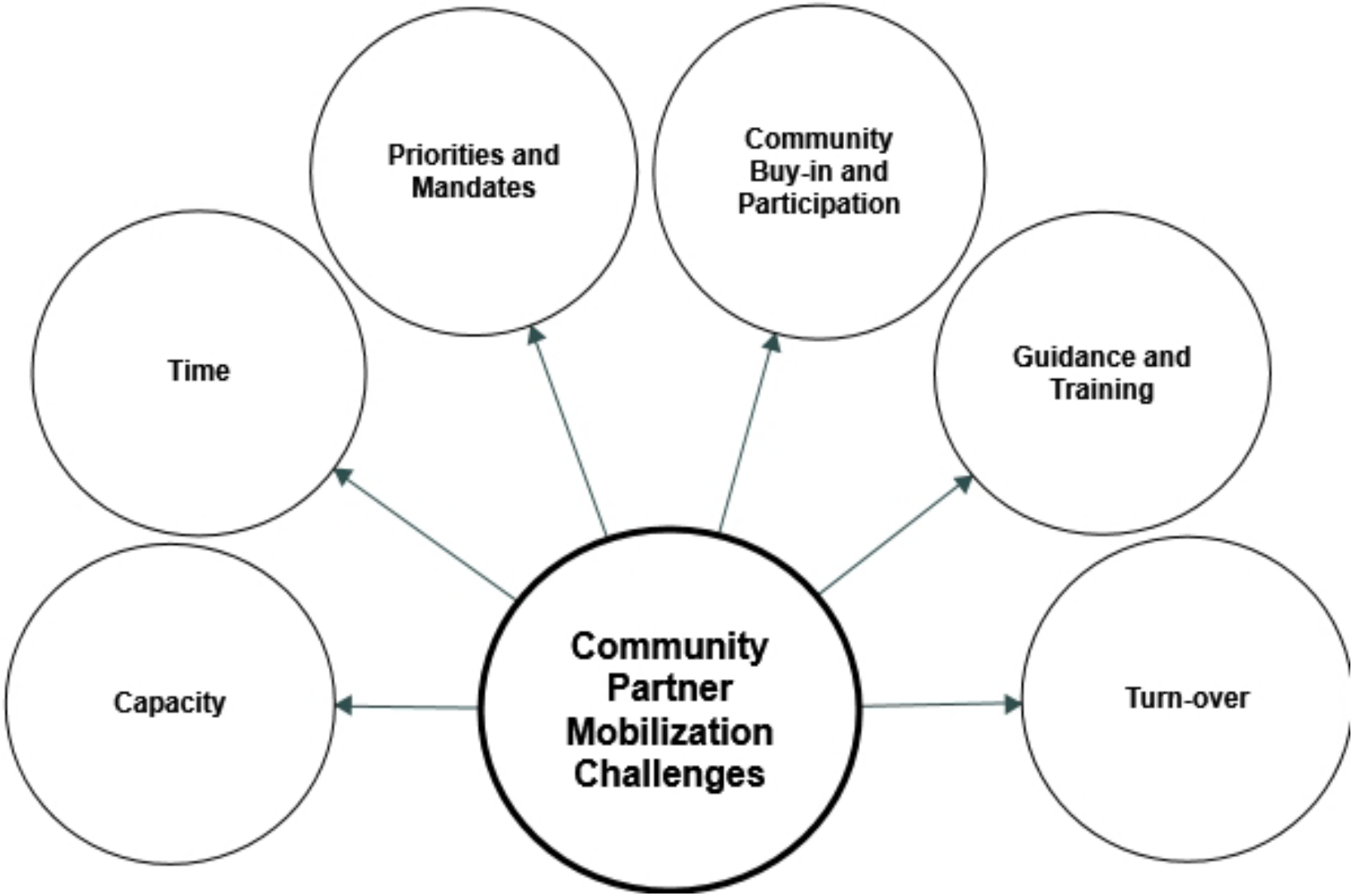

Figure 11. Main themes emerging from descriptions of the challenges to community partner mobilization.

The majority of participants (90.9%, four PHU professionals and six community partners) expressed that limits to *capacity* such as *"staffing," "skills,"* limited *"resources,"* and *"funding"* were hampering community partner mobilization efforts.

Time was described by nearly three quarters of PHU professionals and community partners (72.7%, four PHU professionals and four community partners) as a factor limiting their abilities to focus and "to do the work we need to do" on falls prevention, to attend *"meetings,"* contribute to "*project"* development and implementation, and the abilities of their target audience to take part in programs and training.

Nearly three quarters of participants (72.7%, five PHU professionals and three community partners) described that organizational *priorities and mandates* limits *"the capacity of some of the practitioners to go beyond that mandate,"* and *"pulled"* partners away to other tasks. Some participants spoke specifically about Public Health mandates being *"massive,"* and *"too tight."* Two participants also discussed how priorities and mandates can sometimes overlap between organizations resulting in *"competition."*

Approximately half of participants (45.5%, one PHU professional and three community partners), spoke about challenges related to securing community buy-in and participation, describing concerns with getting seniors to do things that were *"new or foreign to them," "consistency of attendance"* among partners, and how partners sometimes come but *"they don't participate."*

Guidance and training was a theme arising from comments by approximately one third of participants (36.4%, three PHU professionals and one community partner) about

how current guidance and training was lacking. Participants described how there was a need for *"provincial oversight," "a solid provincial strategy,"* and *"public health guidance"* on what needs to be changed, how changes can be made in order to meet standards, and *"so that we could all be doing the same things;" "how"* to work with partners , and providing community partners with training on the use and *"need for different theories, frameworks, and models for doing things"* so that partners understand why PHU professionals are doing things like "*taking minutes"* and *"evaluating collaboratives."*

Turn-over in staff, particularly PHU staff, was seen by several participants (36.4%, three PHU professionals and one community partner) as challenges to continuing to mobilize because *"replacements may not be allowed to come back to the team,"* replacements *"may not be interested in that," "connections"* are lost, and replacements *"have to catch up"* which requires time and slows the mobilization work down.

Other challenges to community partner mobilization that participants spoke about included:

- *Forming partnerships* with respect to identifying partners and how to go about forming partnerships;
- *Implementation* of programs and ensuring consistency, overcoming problems with using technology for delivery, and recognizing the unique characteristics of municipalities when doing work;

- getting the community to think beyond client structures and individual impact and *"thinking at the population level"* in order to significantly reduce falls; and
- *Outcomes* in terms of seeing *"shifts in the population level"* and getting to the point of *"achieving something that will make a difference."*

Table 39 illustrates the thematic structure emerging from PHU professionals' and community partners' perceived challenges to community partner mobilization.

Table 39 *Thematic Structure Describing Community Partner Mobilization Challenges*

Main theme	Sub-themes	Dimensions
Capacity	Communication Funding Leadership Staff with skills	
Change		
Community buy-in and participation	Attendance Awareness of need for falls prevention Commitment	
Forming partnerships	Identifying partners Value in partnerships	
Guidance and training	Theories, frameworks and models How to work with partners Provincial oversight	
Implementation	Consistency Technology Uniqueness of municipalities	
Outcomes	Making a difference Not seeing shifts in population level	
Priorities, mandates, and standards	Competition Mandates Perceived roles in fall prevention Public Health Standards	
Time		
Turn over		
Visioning: Thinking population level		

5.2.7 Objective 7: Capacity building and policy development to support implementation of comprehensive fall and injury prevention by Ontario PHUs

Only the five PHU professionals were asked about capacity building, policy development by the provincial and federal public health ministries and agencies with respect to a potential proposed merger between the LHINs and PHUs in Ontario. Specific topics that were asked about included whether PHU professionals had received information about the merger, their role in the merger, and how the work they do will integrate into such a merger.

One out of the five PHU professionals said that they had received information. The information they had received was, "*they've changed. So we're not merging anymore. The language is now more about us having stronger partnerships.*" The other four PHU participants stated they had not received any information. Despite not hearing anything, three of the four PHU participants also indicated that were not sure that the merger was still happening.

However, if there was a merger, of the four PHU professionals who discussed the theme of changing roles, two PHU professionals expected their roles to change. One of these two PHU professionals described the LHIN's role as providing funding, coming "*up with a work plan*," *"facilitate partnership building and community mobilization,"* and sitting at the partnership table while the PHUs role might entail providing staff and staff time to *"handle,"* and *"to deliver the programming."* A third PHU professional did not expect the PHU and LHIN roles to change. A fourth PHU professional did not speak about changes in

roles, but rather the importance of having the LHIN involved and value of different areas of expertise. As they stated:

> *"So I think that there is a role for the LHIN in this work and helping to move it forward. And kind of recognizing where there is expertise in certain areas. I mean the LHIN is focusing on acute-care. And you know we are doing primary prevention. And that's what our job is."*

In terms of how the work that PHU professionals do to prevent falls would integrate into the merger, the PHU professionals described access and changes to partners, practices, time, resources, capacity, and the effect on the community. **Table 40** illustrates the themes discussed by PHU participants. Three PHU professionals felt the merger would not result in increased access to partners while one PHU professional thought *"it was possible,"* and another PHU professional was hopeful. Some of the reasons given for why the merger would not result in increased access to partners was, *"the LHIN was involved early on…they brought forward those partners,"* and *"I find that the LHINs tend to bring together the public health units, not necessarily the community to work on falls prevention."* No reasons were given for why the merger would result in increased access to partners.

Table 40 *Themes Discussed by Public Health Unit (PHU) Professionals Regarding Integration of Work into Merger*

PHU Professional	Themes					
	Change in capacity	**Change in partners**	**Change in practices**	**Change in resources**	**Change in time**	**Effect on community**
1		X	X		X	X
2		X	X		X	
3		X	X		X	
4		X			X	
5	X	X	X	X	X	

Three PHU professionals expected their practices to change as a result of a merger with the LHIN. Specifically, individuals mentioned concern that there would be a shift *"to focus on maybe secondary and tertiary prevention activities*" versus standard work "*around primary prevention*," and *"taking emphasis off fall prevention."* Two of the three PHU professionals also spoke of positive changes as a result of the merger. Specifically, one PHU professional noted a shift in practices in relation to health services reviewing and implementation of *"the new Registered Nurses' Association of Ontario (RNAO) guidelines*," while the other PHU professional spoke about the possibility of pushing, *"shared measurement forward"* through more data collection and sharing. One participant did not expect any change in practices because:

> *"So the research will trump anything in terms of falls prevention practices. Maybe the organization and facilitation of how those are implemented I think the same practices will be there."*

All PHU professionals discussed changes in time; however, their responses differed. Two PHU professionals didn't know whether their time would change because they were unsure of what the merger *"would look like"* or *"bring."* Two PHU professionals felt that there might be less time because *"there would be a lot of time spent on change,"* and potential shift in practices. One PHU professional suggesting there may be more time because:

> *"ideally, with the LHIN being more in the forefront of fall prevention because they're sharing our mandate, then we shouldn't have to worry about health services really…That should free us up to do more environmental work rather than looking at individual risk factors.*

Only one PHU professional discussed the theme of resources and capacity, suggesting that if there were a shift in the focus of activities as a result of the merger, they would have *"reduced time, reduced resources, reduced capacity."*

One PHU professional discussed that they expected the merger would affect Public Health with respect to the *"groups we sit on and stuff like that, potentially,"* but they weren't sure how it would affect the community whom they described as *"working great in terms of addressing falls prevention on their own, with very little input in terms of us…"*

5.3 Participant Reflections on Community Partner Mobilization and Study

In parting, participants were given the option to provide comments related to community partner mobilization and this study. Ten participants made comments that reflected key study topics. While most comments were incorporated into the findings described already in this chapter, a few comments were worth noting.

Regarding community partner mobilization:

> *"I guess the only thing that I would say is that community mobilization happens. And but I think it happens in a very unstructured way. At least here. But it's not as structured as figuring out a framework that we can implement to try and get the community to get involved with this specific program...Or issue. I haven't found a formula where you implement it and it works for every single issue. So it's not a one-size-fits-all model is what I'm saying. It definitely happens on a regular basis. And it happens every day." [PHU professional 1]*

Specific to the study, a few participants spoke about the importance of and need to prevent falls, and of addressing falls as a community. For example:

> *"I think it's not until you actually see what and how quickly a fall can change someone's life, where something that can just happen in a fraction of a second can change the complete direction of a person's life. And I think it's not until you*

kind of recognize that that does change your life. I think people won't take it as seriously." [Community partner 6]

"I think that it's very important to prevent falls, especially among those that are vulnerable to falling. And I think that it's important that we do those preventative things in getting everybody involved around our community and making everybody work together in order to come to that common goal." [Future potential partner 2]

5.4 Member Checks

Eleven of the 13 participants (84.6%, – five PHU professionals, six community partners, zero future potential partners) replied to the request to review the preliminary summary of study findings (**Appendix G**). Seven participants (four PHU professionals, three community partners) agreed with or had no comments, questions, or concerns about the findings or concept maps. Four participants (one PHU professional, three community partners) suggested changes or added comments. Three of these participants requested changes to some of the wording of the report or specific quotes that they had provided (e.g., change the phrase *"nursing homes"* to *"Long-Term Care homes"*, remove repetitions of words and sentences, and add the term *"partner"* to community mobilization to more accurately reflect the study subject). These requests for changes have been considered and integrated throughout the paper.

Comments made by the four participants touched upon a variety of topics including budgets, partnership, discussion of the findings, comprehensiveness and accuracy of findings, and changes in Ontario's Public Health setting. Specific comments included:

Budgets

"It's interesting how oblivious we are to the infrastructure (e.g., budgets) that shape our work. (e.g., $3500/yr. for fall prevention for a minimum 25.5 hrs./week would be paying staff under $3/hr.)."

Partnership

"PHU professionals' reasons for partnering: a requirement under Ontario public health injury prevention standard; also, a commonly held belief that more can be done together than apart (is that a boomer mentality?)"

"The one comment I would add is that within the PHU's the staffer responsible for falls prevention needs to be working with other staffers within a PHU (i.e., Health Promotion Planner) to address falls prevention." The participant then provided an example of how a PHU professional tasked with falls prevention should be partnering with a PHU professional who might be leading a Walkability committee with various community partners (e.g., city engineers, snow removal services, etc.) given the fit between initiatives.

Discussion of findings

"I'm looking forward to your discussion of the findings! Do we mobilize partners across sectors? Is our model of multisectoral partnerships (i.e., extend reach and capacity for us to do our work or co-deliverers of public health services) optimal? Is community our venue for health behaviour and lifestyle programmes or a place for organizing and mobilizing people to address the challenges that affect their health? (Sorry – your work is just so energizing!"

"Is there an intent to provide potential recommendations moving forward for doing community mobilization around fall prevention in older adults?"

Comprehensiveness and accuracy of the findings

"I did manage to read the summary findings. I skimmed it (as it was well written and very in depth) and didn't really have anything jump to the forefront of my mind regarding additions. It covers all the topics/challenges I can think of (and then some)"

"I am surprised that everyone provides such glowing reports of their work: how then do we justify no impact over the decades. Where is honest critical thinking for quality improvement? If we're mobilizing, are we mobilizing the right people? If we're evaluating, are we asking the right questions? Rigorously? Do the community

mobilization trainings identified actually claim to provide community mobilization training? E.g., LDCProject provided no training as such. Is there any way to objectively corroborate people's perceptions?"

Changes in the Ontario's Public Health System

One participant asked that the researcher include notes about the changes that have been happening to Public Health System at the same time this study was being conducted. A note about this has been added to the **Discussion** under **section 6.1.6** (p. 247).

5.5 Conclusion

This chapter presented the findings from semi-structured interviews with five PHU professionals, six community partners, and two future potential partners to gain an understanding of the mobilization strategies and practices employed by PHU professionals in Ontario's PHUs who are working their community partner to prevent falls. The individuals interviewed were from areas served by five different PHUs representing a range of PHU municipality and population sizes, private and public sector organizations, and areas and individuals of focus with regards to the prevention of falls. Community partner mobilization was generally viewed as a valuable approach to address the prevention of falls; however, experiences with community partner mobilization and activities were varied among participants across the five PHUs. Chapter 6 discusses these findings related to the main research question and relevant research literature, strengths and weaknesses of the study, trustworthiness and limitations of the findings, and implications for future research.

Chapter 6: Discussion

The purpose of this dissertation was to identify and describe the mobilization strategies and practices employed by public health professionals in Ontario's PHUs in working with community partners to prevent falls among community-dwelling older adults. The previous chapters have introduced the study topic (**Chapter 1**), relevant literature on falls, fall prevention, and community partner mobilization (**Chapter 2**), purpose, rationale, and objectives (**Chapter 3**), research methods and design (**Chapter 4**), and findings (**Chapter 5**). This chapter summarizes and discusses the significant findings regarding relevant literature, methodological strengths and limitations of the study, and implications. The final section will provide a brief conclusion of the overall research.

6.1 Addressing the research objectives

This study sought to understand how Ontario's PHU professionals are engaging in community partner mobilization to prevent falls among community-dwelling older adults. This has been done by interviewing PHU professionals, community partners, and future potential partners and conducting a qualitative analysis of their responses. The study is significant given that very little is known about how community partner mobilization is practiced by Ontario's PHU professionals in order to prevent falls among community-dwelling older adults and PHU professionals have identified a need to develop guidance and support. To provide a more in-depth understanding, the research was divided into seven objectives.

- The purpose of the first objective was to identify and describe the Ontario PHU professionals engaging in community partner mobilization which helps to confirm whether Ontario's PHU professionals are engaging in community partner mobilization and provide an understanding of who is mobilizing, the experience/skills/knowledge influencing how community partner mobilization is being practiced, and gaps in their skills set.
- The second objective was to find out about the PHUs and communities in which PHU professionals are practicing in order to understand the conditions, resources, and opportunities influencing practices. Among some of the conditions and resources explored were PHU size, staffing, budget, and community size.
- The third objective sought to identify which community partners had been reached and were involved in current mobilization efforts, their roles, and contributing resources.
- The fourth objective explored the identities of community organizations and individuals currently not mobilizing with the PHUs but perceived as adding value, indicating who is missing from current and future efforts.
- The fifth objective directly addressed the community partner mobilization process, roles of individuals, and activities through participants self-reports of the purposes of community partner mobilization and strategies used across different PHUs.

- The sixth objective sought out information about performance of community partner mobilization practices including the benefits and challenges, providing PHU and their partners with feedback about whether their practices are working as expected.
- The seventh objective explored how PHU professionals perceive capacity building and policy development by provincial and federal governments and agencies. This important information helps to shed light on the political context effecting practice choices and has important implications about how PHU professionals' perceptions of how external support will impact future community partner mobilization practices.

The following sections provide an interpretation of the significant findings beginning with the main purpose followed by each of the research objectives.

6.1.1 Main purpose

The primary purpose of this research was to answer the question, "*how are public health professionals working in Ontario's PHU's are engaging in community partner mobilization to prevent falls among community dwelling older adults*?" This question was used to guide the research and supported by each of the research objectives which follow.

Participants provided a variety of different responses regarding how community mobilization of partners was being engaged in order to prevent falls. There was no clear consensus from the descriptions on the steps and procedures. Further, not all the steps were being practiced or in the same manner across PHUs interviewed. There may be a few

reasons for this. It is possible that differences observed in this study are reflective of the partnerships that exist and roles that PHU professionals play in these partnerships (e.g., ability to lead and drive agenda with partners). This claim is supported by PHU professionals and their partners' statements about who initiated the work and the roles each has adopted in leading, coordinating, and implementing efforts. Alternatively, this could be because models, theories, and frameworks are not widely used or deemed appropriate to apply to work being done in specific communities as noted by one PHU professional (p. 182). In this study, two PHU professionals and two community partners reported the use of a theory, framework, or guideline for their community partner mobilization efforts to prevent falls. A one-size-fits-all approach to community partner mobilization may not exist or if it does, existing models may not be sufficiently flexible for practical application.

Another possibility is that differences exist in how PHU professionals, community partners, and future potential partners define what community mobilization is, what it entails, and achieves. In terms of defining community mobilization knowledge, half of PHU professionals and community partners had heard of the term community mobilization and provided a variety of definitions. These differences are noted in participants own definitions of community mobilization and illustrated in **Figure 6** (p. 134). Regarding training, three out of five interviewed PHU professionals reported receiving some training. However, exactly the content and quality of that training was not explored in this study. Differences in understanding what community mobilization is and is not may hinder efforts by failing to

ensure necessary elements of community partner mobilization and effective partnerships are in place and linked to one another in order to achieve falls reductions.

Despite different approaches to mobilizing community partners, eight key themes emerged from participants descriptions of steps and activities. These themes were: (a) initiation; (b) problem identification; (c) research and data collection; (d) bringing people together; (e) partnership organization; (f) planning; (g) implementation (of activities); and (h) evaluation and review of work. The themes are reflective of some of the main components of other community mobilization theories, frameworks, and models (e.g., Sustainability Planning guide for Health Communities (Batan et al., 2011); Mobilization for Action through Planning and Partnerships (NACCHO, 2004)). This includes the Falls LDCP Logic Model (Crizzle et al., 2019), which served as the theoretical framework used to inform the design of the study materials, data collection, and analysis. Specifically, the Concept map illustrating the community partner mobilization steps and activities (**Figure 7**) (p. 152) aligns with the pre-conditional stages and some of the transitional elements identified in the Falls LDCP Logic Model (Crizzle et al., 2019). The Concept map of community partner mobilization processes aligns less with the outcomes or results depicted in the Falls LDCP Logic Model. It is not clear if the reason for this is due to the design and collection of data in the current study, or if it is because PHU professionals and partners have not yet full reached/realized the results of their efforts.

Although this study did not seek to test the Falls LDCP Logic Model, some of the approaches which could be integrated or made explicit based on the evidence from current practices include activities related to:

- ongoing data collection, analysis, dissemination/exchange;
- ongoing evaluation and review of work;
- training, awareness, and education;

outcomes such as:

- system capacity, integration, and delivery;
- community networking, partnership, and involvement;

The assumption that community mobilization works in light of the absence of evidence (discussed in section 6.3); and the inclusion of context to test and account for the influence of contextual factors on all aspects of the model (e.g., geography, population size, etc.).

In the Concept map of community mobilization processes, evaluation emerges as a prominent well described theme despite lack of consensus about whether it was being done or planned. The prominence of this theme runs contrary to the literature reviewed by Crizzle et al. (2019) who found less attention was dedicated to the topic in the theories, frameworks, and models reviewed. However, the findings about the use of evaluation also support the notion that less attention may be dedicated to evaluation efforts throughout the community mobilization processes although some participants noted they were evaluating, and that evaluation was woven throughout their efforts. Related to the topic of

evaluation is an important question about whether PHUs professionals should be engaging in community mobilization of partners considering insufficient evidence about whether it works to achieve falls reductions. Evaluation throughout the process would provide important information about what efforts are working and how these efforts are working, as well as, what is not working. Another key issue related to conducting evaluation is whether PHU professionals and their partners have the training, skills, resources, and time. One participant noted that evaluation was important to their community partner mobilization efforts, but it was something either the community wasn't skilled at yet (p. 140).

6.1.2 Research objectives 1, 3, and 4: Identify and describe key stakeholders

Research objectives 1, 3, and 4 sought to identify and describe the PHU professionals and community partners engaged in the community mobilization, as well as the future potential partners that currently are not currently collaborating with PHUs but would add value. Underlying these three objectives is an important question about, *"who is engaging in community partner mobilization?"*

The PHU professionals interviewed were all female, held different positions within their PHUs, and represented a range of years of public health (M = 12, SD = 8.5) and fall prevention experience (M = 6, SD = 5.3). Not surprisingly, the findings indicate that all the PHU professionals interviewed, representing different geographic regions and populations were engaging in community partner mobilization. As noted previously, PHU professionals are required by past and present OPHS (MOHLTC, 2018b) and Injury Prevention Guidelines

(MOHLTC, 2018a) to effectively work with community partners to achieve health outcomes including preventing falls and fall-related injuries.

The community partners interviewed indicated that they had formed partnerships with PHU professionals. Interviewed community partners were primarily female (*n* = 5) and held various organizational positions (e.g., program director, coordinator). All had worked for the organizations for more than 3 years (M = 9.7; SD = 4.6). Most community partners provided programs and services for older adults (*n* = 5).

Future potential partners interviewed were female, worked as an organization's president and coordinator. Their experiences working for their respective organizations ranged from one to 17 years. One of the organizations was actively engaging in fall prevention for more than 3 years, while the other organization was not actively engaging in falls prevention. Interviewed future potential partners indicated that they were not working with PHU professionals but perceived potential benefits and opportunities partner with their local PHUs to prevent falls.

The community partners and future potential partners identified by PHU professionals and interviewed for this study represented a variety of service sectors in the community. Although many of the participants interviewed represented traditional partners in the health sector as has been observed in other research on partnerships with Ontario's PHU to prevent falls (Dykeman et al., 2018; Markle-Reid, Dykeman, Reimer, et al., 2015; Markle-Reid et al., 2017), there were others who represented sectors outside of health that were already working with PHU professionals or were identified as valuable future potential

partners (e.g., community support, recreation services, volunteer services, retail businesses, and research). It is hard to say whether or not these partnerships are optimal as this was not studied in the present research; however, it does illustrate how efforts are being made to follow Public Health's emphasis on a community approach to achieving the OPHS and addressing the determinants of falls (Dykeman et al., 2018; MOHLTC, 2018b). It may also reflect discussed community need and perceived opportunities for more comprehensive fall prevention services and a desire for a more integrated system (*Bill 74*, 2019; Hyndman, 2018; Markle-Reid, Dykeman, Reimer, et al., 2015).

6.1.3 Research objective 2: Identify and describe PHU context and population served

The second research objective was to "*identify and describe the context within which the PHU professional(s) are working and the populations they serve*." Interviewed PHU professionals indicated that they worked in a variety of contexts in addition to geographical and population differences used to purposively select study participants. All PHU professionals worked in PHU with more than 100 staff, between 1 and 3 staff dedicated to falls prevention – although not all were assigned to community-dwelling older adults and the responsibility for preventing falls feel under various departments (e.g., chronic disease and injury, healthy families). Two PHU professionals provided estimates of the budgets allocated to fall prevention which ranged between $3,500 and $10,000. The total number of PHU staff hours allocated to fall prevention ranged from 25.5 hours to 42.5 hours per week.

Geography, population size and type, budgeting, staffing, and organizational structure may facilitate or present barriers to engaging in community partner mobilization in order to prevent falls and sharing their experiences with one another. Some of these issues were described by both PHU professionals and community partners when discussing challenges to community mobilization and during the member check. In particular, participants in this study discussed capacity (e.g., funding, leadership, and skills), time, staffing turnover, and organizational priorities, mandates, and standard as prominent challenges to their efforts. When the size and density of populations, size of geographic service areas, community need for fall prevention, and number of partners PHUs are trying to engage are considered with respect to existing infrastructure (e.g., budget, hours), such factors may help to explain the differences in approach and delivery of falls prevention noted here and in other reports (Hyndman, 2018).

6.1.4 Research objective 5: Community mobilization strategies and practices

The fifth research objective sought to "*identify and describe the mobilization strategies and practices employed by public health professionals in Ontario's PHUs in working with their community partners to prevent falls among community-dwelling older adults*." The answer to this objective has been primarily described under the main research objective in **Section 6.1.1** (pp. 232-236); however, other important findings worth discussing emerged from the analysis of data associated with this objective including the purposes for engaging in community mobilization, levels and nature of partnership,

community mobilization activities, and expected outcomes of community mobilization efforts.

PHU professionals discussed a variety of different public health purposes for engaging in community mobilization. The most prominent themes that were described as guiding and included in current efforts were programming and media. Evaluation and policy were also prominently discussed themes; however, were not being used to guide current efforts in two or more instances. Some of the reasons given for why evaluation and policy were not included in the purposes for mobilizing included partners not being skilled enough at evaluation and not being ready to incorporate policy despite the perceived importance of both issues. Including both evaluation and policy has the potential to increase the effectiveness and create supportive conditions for fall prevention (Scott, Wagar, Sum, Metcalfe, & Wagar, 2010).

The levels and nature of the partnerships reported in this study varied with five participants identifying their partnership according to more than one level. Although the terms collaborative, cooperative, coordinated, and communicative were not defined for participants, most participants described the nature of their partnerships as collaborative but changed over time. Partnership is a key component of many aspects of the community mobilization process (Crizzle et al., 2019). In particular, maintaining and building collaborative relationships between PHU professionals and partners may be highly desirable in community mobilization based on the association between collaboration and high levels of both integration and joint activity resulting in partners sharing goals, responsibilities, and

creating together (Camarihna-Matos & Afsarmanesh, 2008, pp. 311-312). Cooperation, coordination, and communication represent the next levels of integration and joint activity (Camarihna-Matos & Afsarmanesh, 2008, pp. 311-312).

Being able to form partnerships, keep partners engaged, and active and involved on an ongoing basis is recognized to establish, facilitate, and achieve community mobilization outcomes (Crizzle et al., 2019). While this study didn't specifically examine what makes partnership work or evaluate best practices regarding partnering, participants in this study discussed a number of elements regarding their experiences forming partnerships, keeping partners involved and engaged, and that contributed to changes in the nature of partnerships. Regarding forming partnerships, **addressing the needs of individuals and communities**, **enhancing capability and capacity**, and **providing more comprehensive fall prevention and injury** were the three main themes emerging from participating PHU professionals' reasons for their interest in working with other individuals and organizations (pp. 115-118). These points were reaffirmed by the main themes describing the roles partners fulfilled related to their joint work to prevent falls among community-dwelling adults which were **building networks, coalitions, and strategic plans;** and **delivering and supporting health promotion, education, and programming** (pp. 108-109). According to seven participants, decisions regarding which individuals and organizations needed to be involved as partners were based on factors related to **knowledge of organizations offering similar programming or serving a similar demographic**, **shared vision,** and **committee or**

coalition brainstorming (e.g., who was missing from the group, expertise in different pillars of health) (pp. 159-160).

Regarding engaging and maintaining partnership engagement, several participants spoke about activities or processes they felt successfully contributed to partner engagement. These activities or processes were organized into themes related to **relationships** (i.e., recommendations identifying partners, building relationships, and leveraging existing relationships) and **interests** (i.e., common concerns, opportunities to learn and work together). One participant also spoke about specific joint involvement and activities as being necessary for partner engagement. Specifically, they stated, "*but we know that to have engagement of the partners it has to be through discussions, and formal vision statements, in terms of reference, and discussions about mandate, and what the actions will be together"* (p. 150). Although this study did not ask specifically about how to keep partners active and involved, there are several comments that reappear throughout discussion of the study that describe communication, organization of the partnership group (e.g., roles, decision-making), discussing goals and values, keeping goals in mind, reviewing progress toward goals, and accountability as important practices. Participants also made comments about factors that influence the nature and level of partnership including: the number of partners in a partnership; personalities; level of interest; events (number and size); organizational priorities and capacity (resources, funding, time and staffing); work being done; staff turnover; and time.

The partnership practices described reflect some of the principles and advice found in prominent guidelines for community engagement by the U.S. National Institutes of Health [NIH], *Principles of Community Engagement (2nd edition)* (Clinical and Translational Science Awards Consortium, 2011) and the United Kingdom's National Institute for Health and Care Excellence [NICE], *Community engagement: improving health and well-being and reducing health inequalities* (NICE, 2016). These detailed guidelines are based upon systematic reviews of the literature and best practices for community engagement and offer practical advice for health care practitioners on how to engage with organizations and individuals in the community in order to work together (Clinical and Translational Science Awards Consortium, 2011, pp. xv-xvii; NICE, 2016). For example, the practice of building relationships as noted by participants in this study reflects principle 3 of the NIH guideline which states:

> *"For engagement to occur, it is necessary to go to the community, establish relationships, build trust, work with the formal and informal leadership, and seek commitment from community organizations and leaders to create processes for mobilizing the community" (Clinical and Translational Science Awards Consortium, 2011, pp. 48-49).*

And principle 1.1.2 from the NICE guidelines which discusses relationships, leadership, capacity, and organization:

> *"Recognise that building relationships, trust, commitment, leadership and capacity across local communities and statutory organisations needs time: plan to provide sufficient resources; start community engagement early enough to shape the proposed initiative; establish clear ways of working for all those involved; and start evaluating community engagement activities early enough to capture all relevant outcomes.*" (NICE, 2016, pp. 6-7).

The activities or processes identified in this study may only represent a subset of the full range of approaches available and being used by PHU professionals and their community partners to best work together. Further research on partnership would add value about understanding what is being practiced and what practices are most effective.

PHU professionals and community partners described engaging in a variety of activities together as part of their community mobilization efforts. These activities were organized into four themes. **Training, awareness, and education** was the most prominently described activity theme followed by **program development, implementation, and promotion**; **research**; and **systems approaches and integration**. Within these themes, participants reported engaging in different activities. For example, within the Training theme participants reported engaging in health fairs, media campaigns, and health care provider training. While all these activities are important and can have an impact of preventing falls to varying degrees, no one described engaging in the same activities across PHU sites. Variations in activities or program delivery have been noted elsewhere (Hyndman, 2018) and present a challenge to understanding what works and why, what to change, outcome measurement, as well as ensuring equitable delivery of health services to prevent falls.

Participants spoke about many different expected outcomes from their community mobilization partnership efforts. These were categorized according to nine themes with **falls (general)**; **event and program performance**; and **falls (population specific)** being the most commonly described themes. These themes may be expected; however, identification

of these themes illustrates the importance of fall prevention and the success of fall prevention program performance to each of the partnerships, helping to ensure common goals among partners.

6.1.5 Research objective 6: Examining strategies

The sixth objective of this study was to "*examine strategies employed by public health professionals in Ontario PHUs, the benefits and challenges of community partner mobilization.*" Participants spoke about many aspects of the performance of their community partner mobilization efforts which were organized into four main themes: **capacity** (i.e., developing, supporting, and changing the community or their partnership in terms of people, communication, knowledge, resources, and training); **reach** between organizations, programs, and individuals; and **better integrated programs and services**, even though there were some acknowledgements about **not having data or information on the impact of efforts**.

When asked about specific activities that were performing well and what was not working, most participants described community-related activities and programs that partners had worked together on with much of the evidence being anecdotal given that very few evaluations for some of the work had been completed. Several strategies and approaches were identified as performing well some of which included suggestions to address barriers participants encountered. These included recognizing the need for partners; answering and listening to the needs of the target audience; figuring out what's important to community partners; a strategy around staff competencies that offers training

and coaching; leveraging interest in order to benefit falls; sharing knowledge; strategies that were informed by the target audience; strategies that were a mix of top-down and bottom-up and included leadership; and working to build relationships. Regarding the benefits, six main themes emerged from participants' responses: **increased capacity**, **working together as a community**; **networks and relationships**; **reach**; **multiple viewpoints**; and **community buy-in and participation**. Challenges or barriers participants described experiencing were categorized into six main themes: limited **capacity**; **time**; **priorities**, **mandates, and standards**; **community buy-in and participation**; **guidance and training**; and **turn over**.

Based on responses, there is a sense that those interviewed valued their partnerships and felt there were several performance benefits. While experiencing some success on certain mobilization aspects and activities, partnerships were also experiencing less success on other aspects and activities. This may be due to some of the challenges faced which have been identified in other fall prevention research (Dykeman et al., 2018; Markle-Reid, Dykeman, Reimer, et al., 2015) and the Falls LDCP Logic Model (Crizzle et al., 2019). That said, some of the strategies and approaches participants discussed as performing well and aiding in mobilization closely reflect the seven practice themes identified for working collaboratively to engage community partners in fall prevention initiatives for community-dwelling older adults (Markle-Reid et al., 2017). However, without regular, ongoing evaluation involving all partners, it is hard to tell why some strategies, activities, and approaches are working and others are not.

It should also be noted that none of the participants spoke about activities, strategies, or approaches reducing the number and severity falls. This point was also observed when participants spoke about the benefits of community mobilization. It is possible that participants did not speak about this point as it may have seemed self-evident from the research questions and study topic. Another possibility is that for some participants, community mobilization is being practiced for non-falls related initiatives (e.g., Active Aging; or other community or partnership issues determined to be important by partners). As such, changes in the number and severity of falls may not be the primary mobilization purpose or outcome. Alternatively, participants might not have spoken about reducing the number and severity because there was a lack of data or that changes in falls have yet to be realized through current efforts despite the fact that changes in falls were previously identified as an expected outcome of community partner mobilization efforts. Several participants had noted they were in the early stages of community partner mobilization efforts, or that they needed to conduct or had future plans for evaluation which might provide much needed feedback on whether their partnership efforts are working to address falls. Another explanation offered by one of the participants is that PHUs and their partners may be examining "*more performance type measures*" instead of reductions in falls because falls are so complex. This point was echoed by another participant who discussed the ability to count the number of falls resulting in injuries but questioned how to truly count the number of falls prevented (p. 188).

One common idea that appeared repeatedly throughout discussions about the strategy performance was a call for provincial guidance or a provincial strategy. Specifically, participants spoke about the need for an integrated, systems-based approach to fall prevention that would provide guidance and training on what needs to be changed, how to meet OPHS, how to work with partners, train partners on the use and importance of different theories, frameworks, and models used in public health, and offer central key functions such as data measurement and collection. This call has been echoed in a report by the Ontario Fall Prevention Collaborative Working Group (Hyndman, 2018). The Ontario Fall Prevention Collaborative Working Groups is composed of a number of different key stakeholders involved in fall prevention across the province with the goal of developing a system-based approach to and a common agenda across the continuum of care for preventing falls in older adults (Hyndman, 2018; p. 3). Such an approach has the potential to standardize practices across the province, address barriers, provide support in meeting current OPHS and injury prevention guidelines (MOHLTC, 2018a; 2018b) in line with provincial restructuring outlined in *Bill 74 the People's Health Care Act, 2019* (*Bill 74*, 2019) which calls for better integrated health service and delivery.

6.1.6 Research objective 7: PHU professionals' views about capacity building activity and policy by provincial and federal public health ministries

The purpose of the seventh objective was to "*identify public health professionals' views about capacity building activity and policy by provincial and federal public health ministries and agencies to support implementation of comprehensive falls prevention*

programs by Ontario PHU's." As noted previously, at the time this study was being developed and data collected, there was some speculation within the public health system that PHUs and LHINs might merge. PHU professionals were therefore asked about what knowledge they might have about a merger, what they perceived their role to be in the merger, and how the work they currently did would integrate into such a merger.

The findings here suggest that most interviewed PHU professionals had not received any information about a merger or that it was no longer occurring. As a result, PHU professionals gave differing responses about whether it would change their roles and affect their work in terms of partners, practices, time, resources, capacity, and the effect on the community. If, however, there was a merger, two PHU professionals expected their roles to change and were hopeful that a merger would provide increased capacity or resources (e.g., *funding, work plan, facilitate partnership building and community mobilization, time to handle and deliver programming*). Most PHU professionals (*n* = 3) did not feel that a merger would result in increased access to partners but may result in a variety of changes to their practices including a greater focus on secondary and tertiary prevention, new guidelines, and a push toward shared measurement and data collection.

Although a speculated merger between the LHINs and PHUs never occurred, the researcher would like to acknowledge that over the course of this study, Ontario's Public Health System has begun to change. Practices are changing with the release of the new OPHS and Injury Prevention Guidelines in 2018 (MOHLTC, 2018a; 2018b). Most notably, the organizational structure has begun to rapidly change as a result of *Bill 74* (Bill 74, 2019).

Under *Bill 74*, efforts are being made to provide the people of Ontario with more integrated care through a central agency called Ontario Health (MOHLTC, 2019). Several existing health organizations and programs have been merged, the LHINs have been dismantled, and the province is in the process of assembling Ontario Health Care Teams to meet the local health needs of various geographic populations and deliver coordinated health care services (MOHLTC, 2019). Changes to Ontario's PHUs are anticipated; however, the specifics are unclear at this time.

6.2 Strengths and Limitations

Great attention was given to the study design, collection of data, and analysis to develop credible, in-depth, and detailed descriptions that answered the research questions. These decisions have been discussed in detail in **Chapter 4** with respect to the choice of the **Method** (pp. 44-45), **Design** (pp. 45-47), and **Strategies to ensure the quality of research** (pp. 68-78). Some of the strengths include:

- In terms of the method, a qualitative approach allowed for detailed description of the research topic (Patton, 2015, pp. 14-18; Sofaer, 1999). Semi-structured interviews using a mix of open- and closed-ended questions with key stakeholders possessing in-depth knowledge and experience of engaging or being engaged in community mobilization of partners offered rich, thick descriptions that provided a level of breadth and depth on the research topic that would not have been easily captured using a quantitative approach. In-depth, semi-structured interviews also allowed for the

exploration of topics as the emerged, participants to lead aspects of the discussion, maintain focus on the research topic, ensure that a variety of topics were covered, and standardization of certain questions (Patton, 2015, pp. 432-442).

- The Grounded Theory design reduced researcher bias and ensured the findings were data-driven (Bitsch, 2005; Corbin & Strauss, 1990). Specifically, Grounded Theory provided a systematic framework for data collection and analysis including clearly documented processes and decisions, use of the constant comparative approach, and multiple forms of inference (i.e., induction, abduction, deduction, and retroduction) (Bitsch, 2005; Corbin & Strauss, 1990).
- Employing purposive sampling was used to select individuals believed to maximize and identify future sources of rich data, as well as capture a range of perspectives and experiences representing different geographic areas and population types in Ontario. Further interviews with multiple stakeholders at the same sites were used to corroborate responses.
- Member checks with participants served as a form of verification of the accuracy of the data and findings.

While much care was given to the planning and execution of the research, there are several limitations which should be acknowledged. These limitations include:

- Generalizability and transferability. Because this was a qualitative study involving a small sample of participants at a specific point in time, the results are limited to the individuals and contexts included in the study. In order to enhance the transferability of findings to a broad range of PHU professionals and their community partners working to prevent falls, participants were selected according to specific criteria related to geographic region and types of populations served. Expansion of the number of people interviewed and across settings may extend and refine the findings presented.
- Timing of interviews and data collection. Data was collected primarily during the summer when many participants were away attending conferences or on vacation and covering other portfolios. The study timing may have impacted participation rates, and the quantity and quality of data collected. The researcher attempted to mitigate this by sending multiple invitations to participate in the study (up to a maximum of three attempts), offering to talk at a mutually convenient time, and providing participants with research commitment and questions in advance.
- Low recruitment. Although the initial sampling goal included recruiting and interviewing five PHU professionals, 15 community partners, and five future potential partners, the final sample consisted of fewer participants (i.e., five PHU professionals, six community partners, and two future potential partners). This may have impacted the quantity and quality of data collected

in terms of capturing the full range of perspectives and experiences related to community partner mobilization and reported findings. Planned comparisons of group differences (e.g., by PHU, key stakeholder groups) were not possible in some cases. Triangulation of perspectives was also limited. Several attempts were made to mitigate this issue by sending participants more than one invitation to participate by email or phone (up to a maximum of three attempts); sending participants a detailed letter outlining importance of project, content of research, what participation would entail, and ability to conduct interview at a mutually convenient time; and asking PHU professionals for additional referrals.

- Self-report and participant recall bias. This study relied on self-reports about community partner mobilization perspectives and experiences at a specific point and time. There is a concern that what people say may be different than what they do. To mitigate these issues the interviewer reminded participants there were no right or wrong answers, that their identities would be protected, attempted to recruit multiple participants at the same PHU catchment area to corroborate and contrast responses, included several probes about time, encouraged participants to contact the researcher if they had anything else to add to the study, and sent a preliminary summary of findings as part of the member check to solicit additional feedback about experiences.

- Experience. Participants in this study were asked to answer questions about community partner mobilization based on their experiences. Although most were able to provide answers to the research questions, those who were new to their roles or the partnership may not have been able to provide full accounts of their organization's efforts to engage in community partner mobilization. As such the model describing community partner mobilization may not provide a full or accurate account of activities over time. To help address this issue, the researcher sent the interview questions in advance, allowing for some participants to speak with the previous person(s) or draw responses from organizational records of activities. Further review of organizational records or interviews with past staff may be useful for verifying the accuracy of the findings.
- Theoretical saturation. As noted previously, saturation was not achieved for all categories and themes. Therefore, the presented themes and concept maps may be incomplete and could benefit from further research and elaboration. During the interview process, the researcher tried to allow for the full elaboration of topics and provided probes for more in-depth exploration of ideas. However, constraints on time related to the conduct and extensive content covered in the interviews may have limited aspects of the conversation related to specific categories and themes. That said, saturation may not be a reasonable expectation to apply to the current

research topic given that community partner mobilization is an evolving process for which there may be no end point (Thorne, 2020). Theory describing the process of community mobilization may be subject to change depending on several dimensions (e.g., individuals, contexts, problem to be addressed, time, questions asked) and continue to develop with additional inquiry. The findings presented in this study represent a starting point for understanding the process and key concepts underlying community partner mobilization to prevent falls among community-dwelling older adults as practiced by Ontario's PHU professionals based upon the questions asked, individuals involved, data collected, and methods followed.

In addition to these strengths and limitations, the researcher's own experience as part of the Falls LDCP team and conducting a literature review enhanced the methodological approach and sensitivity to understanding community partner mobilization processes aimed at preventing falls among community-dwelling older adults. These experiences also may have introduced unknown or undiscovered researcher bias and perspective on the study and findings. Bias and varying degrees of precision exist in all research. Steps were taken throughout the research to be sensitive to and minimize the impact of bias. This includes being as transparent as possible, providing a declaration of perspective, researcher role, reflexive statement, adhering to research methods, memoing, reflexive journal, reviewing memos and notes, etc. These practices help to assure the quality of the research and confidence that other researchers would find similar results,

albeit with minor differences. Arguably, the most important test of this research is the utility of the work to those engaging in community partner mobilization to prevent falls among community-dwelling older adults and for further research/evaluation. To which, study participants have already expressed interest in the research and look forward to the final report.

6.3 Implications

Community partner mobilization for the purposes of injury and fall prevention is a new and under-researched area. The current study advances knowledge around and provides evidence of current mobilization strategies and practices employed by public health professionals in Ontario's PHUs in working with community partners to prevent falls among community-dwelling older adults. Overall, the findings from the current study indicate that PHU professionals and community partners are engaging in and working to prevent falls among community-dwelling older adults. However, there is considerable variability in how this is being accomplished. The following recommendations are intended to address the needs of PHU professionals and community partners as they work together to reduce falls and fall-related injuries.

Research whether community partner mobilization works

Underpinning the findings of this research is the question of whether community partner mobilization works. Efforts to strengthen existing partnerships, practices, build capacity, and address barriers to community partner mobilization are important. However, if theories, models, and frameworks to mobilize community partners are flawed and do not

deliver the expected outcomes or results of its effectiveness in the absence of evidence, then resources may be better expended on practices known to reduce falls (e.g., multifactorial interventions) or alternate models of community impact. While there is a strong sense that more can be done together through community mobilization, the evidence is lacking (Crizzle et al., 2019; Kuhlmann, Galavotti, Hastings, Narayanan, & Saggurti, 2014; Lippman et al., 2016; Pettifor et al., 2015), case studies and evaluations of existing efforts may help to answer this critical question. Specific future studies include:

Option 1: Prospective comparative case study using the Falls LDCP logic model and evaluating the relationships between activities, outputs, and outcomes throughout the process implied by the model.

Option 2: Retrospective/historical comparative case study of existing efforts comparing PHUs with similar characteristics and documenting and evaluating activities and outcomes in context. This could take a mixed-method approach including surveys, interviews, and administrative documentation, and compare those applying a community mobilization strategy with those who intervene alone. It could also be inspired by realistic evaluation thinking and explore context, mechanism, outcome configuration (per Pawson and others – e.g. Pawson & Tilley, 1997).

Option 3: A secondary analysis of existing efforts based on pre-existing documentation and evaluation of activities and outcomes in relation to hospital catchment area data on falls and fall-related outcomes for community-dwelling

older adults before, during, and after efforts could be performed. This would be dependent on such data existing within PHUs.

Research the implementation and impact of expanding community partners to include older adults as partners

One of the recommendations received was to expand community partnerships to include older adults as partners. While the motivation underlying the recommendation was not explored (e.g., no older adults serving as partners in current partnership, trouble retaining older adults as partners, older adults working well as partners, etc.), older adults should be considered and included in partnerships and not treated just as the target for interventions. Older adults have an important role to play as decision makers and knowledge users with researchers in integrated knowledge translation and ensuring that fall prevention services reflect the characteristics and expectations of older adults – which was identified as a barrier to engagement in an earlier Falls LDCP study (Dykeman et al., 2018). This is in keeping with the movement toward "patient-centered" and "patient-oriented" research that includes the target population as decision-makers and knowledge users with power to influence the design, development, execution, and evaluation of interventions. Some examples of the roles that older adult research partners could play and may already be doing include identifying what problems and solutions are relevant to them, informing and contributing to the development and execution of planned activities, and being champions or advocates. Related to the themes from this research older adults could fulfill roles related but not limited to (1) building networks, coalitions, and strategic plans; and (2)

delivering and supporting health promotion, education, and programming. Older adults bring knowledge, experience, and may gather to contribute to issues that are of "personal interest" or for which they feel a "sense of civic responsibility" (Markle-Reid et al., 2017). However, there may be questions about how to best attract, use and retain older adults as partners.

In order to understand the implementation and impact of this suggestion, there is a need to conduct a mixed-method study with PHUs examining how to include community-dwelling older adults as partners in partnerships to ensure fall prevention strategies and outcomes are informed by the target audience. A quantitative survey could be used to identify and characterize PHUs that are currently partnered with community-dwelling older adults and those that are looking to recruit older adults as partners. This information could be used to construct case studies for retrospectively or prospectively examining recruitment, engagement, retention, experience, impact, barriers, and facilitators of partnering with community-dwelling older adults on fall prevention strategies. A mix of surveys, key informant interviews, focus groups, document analysis, and observation of partnership meetings and activities could be conducted. Study participants should include PHU professionals tasked with preventing falls among community-dwelling older adults, their community partners, community-dwelling older adults that are partners, and those that are not to capture a fuller understanding of expanding partnerships to include older adults.

Research implementation of a general model of community partner mobilization

Contextual factors such as geography, population size and type, budgeting and staffing have been identified as possible reasons for the lack of consistent community partner mobilization processes and practices in the delivery of falls prevention in this study. Indeed, at least one community partner spoke about smaller PHUs facing greater community partner mobilization barriers and one PHU professional indicated that existing models of community mobilization reviewed as part of the Falls LDCP did not meet the needs of their community. One of the goals of this program of research is to consider a general model of community partner problem solving and mobilization for injury prevention that is informative, clear, comprehensive and works in a variety of contexts. Accordingly, there is a need for further real-world accounts and testing of the Falls LDCP logic model with respect to its effects and contextual factors (i.e., geography, population size and type, budgeting and staffing, etc.) under which PHU professionals and their community partners operate. By testing for these factors, it is possible to assess the applicability, generalizability, adaptability, scalability, and robustness of the model to different circumstances. This knowledge can also be used to determine whether modifications need to be made to the Falls LDCP logic model for specific applications or contexts, to assess whether it meets the needs of PHU professionals and works as intended. Although the Falls LDCP logic model was still in development at the time this study was conducted, feedback from study participants indicates that there is interest in using the Falls LDCP logic model, with one PHU professional stating that they were already using the model "*for planning*" purposes.

Existing theoretical models such as PRECEDE/PROCEED (Green & Kreuter, 2005), the Intervention Mapping approach (Bartholomew, Parcel, Kok, Gottlieb, & Fernandez, 2011), Theoretical Domains Framework (Michie et al., 2005; Atkins et al., 2017) may be useful for testing and evaluating the impact of the Falls LDCP logic model on implementation and outcomes. Evaluating the Falls LDCP logic model in this way would provide a deeper understanding of various contexts and mechanisms impact the processes and outcomes in practice, as well as provide direction about how the current theory should be refined for successful implementation more broadly.

Provide a provincial strategic plan or governing body

Throughout this research several requests were made for a strategic plan or a central governing body to provide oversight, guidance, training, and support for community mobilization of partners in order to prevent falls among community-dwelling older adults. A Provincial Strategy or central governing body such as the Ontario Fall Prevention Collaborative (Hyndman, 2018) may help clarify processes, educate, and create a context enabling community partner mobilization toward action, and provide PHUs and their partners with a core program that can be evaluated with clear measures to determine what is working and what is not. It may also help address some of the other challenges experienced by participants in this study such as the need for leadership, skills, community buy-in and participation, as well as the ability to adapt to changes in staff and the public health system. From a policy perspective, development and implementation of a Provincial Strategy or central governing body for falls prevention needs to be supported with

resources (e.g., time, funding, etc.) to help ensure communities have what they need in order to succeed.

Develop a strategic partnership plan

Difficulty recruiting potential future partners in this study could be related to the narrower range of motivations future potential partners have in comparison to community partners already working with PHUs. Because of narrower ranges of motivations, future potential partners may not have been sure the current research was relevant to them or worth investing potentially limited resources (e.g., time, staff, etc.). This speaks to the issue of recognizing the interests and needs of future potential partners, relevance and potential contribution to efforts preventing falls among community-dwelling older adults, communicating the benefits of partnership and involvement to groups with different motivations, and how future potential partners contribute. Some of these steps and activities were described by PHU professionals and community partners in forming existing partnerships.

The implications of this with respect to the community mobilization steps and activities that need to be undertaken to engage community partners include developing a strategic plan for partnership that recognizes the diverse range and motivations of different partners that need to be included in efforts to prevent falls among community-dwelling older adults. Part of this strategic plan should include community assessments of partners to determine who is out there in the community that could serve as potential partners and mapping of this information to the determinants and desired outcomes for falls prevention,

and activities to promote the needs and benefits of partnership within communities to future potential partners with narrow/differing motivations. Comprehensive, integrated, multi-level intense public health strategies require a larger and more diverse set of partners than specific activities in certain areas of importance. Community-wide falls prevention efforts can include a range of partners with different motivations including nurse practitioners who can provide multi-factorial risk assessments; pharmacists who can conduct pharmacotherapy reviews; bath fitting companies who can refit and optimize a bathroom for fall prevention through the installation of grab bars, anti-slip flooring, and improved lighting; policy makers who can set standards and funding for snow and ice removal or investments in local parks and recreation programs; community centres that provide tailored exercise programs to community-dwelling older adults proven to address gait, balance, strength, etc. Further the steps and activities to engage community partners may need to be revisited depending on specific prevention goals, outcomes, changes in partners and the community, etc.

Improve PHU professional training and guidance

This study supports the need and desire for further training and education regarding community mobilization of partners in order to achieve OPHS and reductions in falls. Training and guidance in community mobilization theories, models, and frameworks may increase PHU professional knowledge and skill with regards to planning, developing, implementing and evaluating community partner mobilization, as well as creating and sustaining active and engaged partnerships. Training should include key stakeholders to

help facilitate knowledge translation, development of a common understanding of what community mobilization entails and what it intends to accomplish. Training and guidance materials need to indicate what community mobilization is, who to involve, how to execute it, core activities, expected outcomes, and potential challenges and ways to overcome them. Guidance materials need to be provided with enough detail that PHU professionals and partners understand what is expected of them and how they are expected to achieve desired outcomes.

While the generalizability of the findings of this study are limited to the PHUs and professionals sharing similar experience, training, and characteristics; one might infer the findings are representative of typical and experienced public health professionals and are indicative of the need for widespread training, guidance, and support to strengthen community partner mobilization knowledge and practices to prevent falls among community-dwelling older adults. Given that the practice environment is characterized by limited resources and funding for fall prevention, new public health professionals in PHUs need to be supported by:

- college and university public health professional trainee programs incorporating community mobilization knowledge and practices (e.g., for public health nursing, community social work, community psychology, and community physician trainees);

- partnerships between training programs and PHUs to provide opportunities for public health professional trainees to become involved in and apply their community partner mobilization knowledge;
- guidance strategies and documents to support efforts of new public health professionals once practicing in the field;
- commitments by PHUs, existing community partnerships, and federal and provincial governments and agencies to support documentation and evaluation of existing efforts;
- professional networking opportunities that connect public health professionals across the province to increase knowledge exchange and the negative impact of working in "silos" and with limited resources; and
- further research to determine the needs to new public health professionals and effects of these supports on public health professionals and community partner mobilization practices (e.g., does a specific support strengthen practices? Result in better outcomes? Introduce new barriers and challenges?).

6.4 Conclusion

In summary, falls, particularly among older adults, are a significant public health issue, requiring a considerable coordinated community effort to address. This qualitative study explored how public health professionals working in Ontario's PHU's are engaging in community partner mobilization to prevent falls among community dwelling older adults.

This study contributes to the existing literature and adds important insight into existing community partner mobilization efforts by Ontario's PHU professionals. It is evident from the findings that PHU professionals and community partners from various sectors in the community are already working together and believe there are benefits to working together. The findings suggest that there are eight main themes describing the community partner mobilization steps and activities PHU professionals and their partners engage in: (a) initiation; (b) problem identification; (c) research and data collection; (d) bringing people together; (e) partnership organization; (f) planning; (g) implementation (of activities); and (h) evaluation and review of work. However, less clear is whether these practices work to actively engage partners in fall prevention and result in falls reductions. Future research evaluating practices and models of community partner mobilization will help to clarify whether community partner mobilization works and what practices are needed to ensure reductions in falls and fall-related injuries. Evaluation, guidance in the form of a Provincial Strategy, and further research may help clarify processes, educate, and create a context enabling community partner mobilization toward action.

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Table of Appendices

Appendix A: List of Acronyms

alPHa	-	Association of Local Public Health Agencies
CDC	-	Centers for Disease Control and Prevention (USA)
CIHI	-	Canadian Institute for Health Information
LDCP	-	Locally Driven Collaborative Project
MOHLTC	-	Ontario Ministry of Health and Long Term Care
NICE	-	National Institute for Health and Care Excellence
NIH	-	National Institutes of Health
OPHS	-	Ontario Public Health Standards
ORE	-	Office of Research Ethics
PHAC	-	Public Health Agency of Canada
PHO	-	Public Health Ontario
PHU(s)	-	Public Health Unit(s)
RNAO	-	Registered Nurses' Association of Ontario
WHO	-	World Health Organization

Appendix B: Glossary of Terms

Capacity building: "the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organizations, and; the development of cohesiveness and partnerships for health in communities" (Smith, Tang, & Nutbeam, 2006, p.2).

Coalition: "A community coalition is a group that involves multiple sectors of the community, and comes together to address community needs and solve community problems. The criteria for a community coalition include the following: the coalition is composed of community members; it focuses mainly on local issues rather than national issues; it addresses community needs, building on community assets; it is community-wide and has representatives from multiple sectors; it works on multiple issues; it is citizen influenced if not necessarily citizen driven; and it is a long term, not ad hoc, coalition" (Wolff, 2001, p. 166).

Collaboration: "a recognized relationship among different sectors or groups, which have been formed to take action on an issue in a way that is more effective or sustainable than might be achieved by the public health sector acting alone" (Public Health Agency of Canada [PHAC], 2008, p. 9).

Community: "A specific group of people, often living in a defined geographical area, who share a common culture, values and norms, are arranged in a social structure according to

relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them" (WHO, 1998, p. 5).

Community-dwelling older adult: "The term 'community-dwelling older adults' refers to seniors living in the community who are 65 and older. Older adults living in retirement homes, group homes and those who are homeless are all included in this definition. Those who are not included in the definition are those in hospital, treatment facilities, long term care home, jail or similar institutions" (Falls Prevention Project Team, 2016).

Community mobilization: "the use of capacity to bring about change by joining together the strengths of the community into an action plan. 'Community mobilization is based on the belief that when a community is mobilized to address and solve its own problems, more efficient and effective results will materialize than could be achieved by any other means' (Hastings, 2001). The anticipated goal is for a safe and healthy community with 'buy in' from all community members" (Falls Prevention Project Team, 2016).

Community participation: "Actions that involve members of a community in direct decision-making about issues that affect the community. It covers a spectrum of activities ranging from passive involvement in community life to intense action and participation in community development (including political campaigns and planning)" (Canadian Public Health Association, 2010).

Community partner: "anyone who has a vested interest in health promotion and injury prevention or who may have a vested interest in the well-being of community-dwelling older adults. Community partners may include governmental agencies, non-governmental agencies, coalitions, networks, industry employers, community based organizations, health authorities, etc." (Falls Prevention Project Team, 2016).

Empowerment: "A process through which people gain greater control over decisions and actions affecting their health. Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs" (PHAC, 2008, p. 10).

Engagement*: "*the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices" (Centers for Disease Control and Prevention [CDC], 1997, p. 9).

Fall: an unintended event resulting in a descent to the floor, ground or a lower level and can occur with or without injury (Currie, 2008; WHO, 2018).

Health promotion: "The process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being. Health promotion actions involve building public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services" (Falls Prevention Project Team, 2016).

Injury prevention: Efforts to prevent, eliminate, or reduce the occurrence and severity of injuries (MOHLTC, 2018a, p. 4).

Partnership: "Collaboration between individuals, groups, organizations, governments or sectors for the purpose of joint action to achieve a common goal. The concept of partnership implies that there is an informal understanding or a more formal agreement (possibly legally binding) among the parties regarding roles and responsibilities, as well as the nature of the goal and how it will be pursued" (PHAC, 2008, p. 12).

Public health: Public health is the protection, promotion, improvement, and restoration of health and well-being, as well as the prevention of disease and injury, of the entire population, specific groups, and individuals through shared societal action, programs, policies, services, research, and education (Association of Local Public Health Agencies [alPHa], 2010, p.

4; PHAC, 2008, p. 13). The term can refer to a method of practice, scientific and professional disciplines, and institutions that engage the larger cross-sectoral civil society network (PHAC, 2008, p.13). In Ontario, public health programs and services are primarily provided to communities by PHUs supervised by Medical Officers of Health and governed by local health boards (alPHa, 2010, p.4).

Public health professional: Synonyms: public health practitioner, public health worker. An individual, who protects, promotes, improves, and restores health and well-being, or prevents disease and injury among the entire population, specific groups, and individuals. These individuals typically have specialized qualifications and/or training. "They may be classified according to profession (nurse, physician, dietitian, etc.); according to role and function (direct contact with members of the public or not); whether their role is hands-on active interventions or administrative; or in various other ways" (PHAC, 2008, p. 13).

Values: "The beliefs, traditions and social customs held dear and honoured by individuals and collective society. Moral values are deeply believed, change little over time and are often grounded in religious faith. They include beliefs about the sanctity of life, the role of families in society, and protection from harm of infants, children and other vulnerable people. Social values are more flexible and may change as individuals undergo experience. These may include beliefs about the status and roles of women in society, attitudes towards use of alcohol, tobacco and other substances. Values can affect behaviour and health either beneficially or harmfully" (PHAC, 2008, p. 13).

Vision: “If a strategic plan is the ‘blueprint’ for an organization’s work, then the vision is the “artist’s rendering” of the achievement of that plan. It is a description in words that conjures up the ideal destination of the group’s work together” (PHAC, 2008, p. 14).

Appendix C: Map of Ontario's Public Health Units

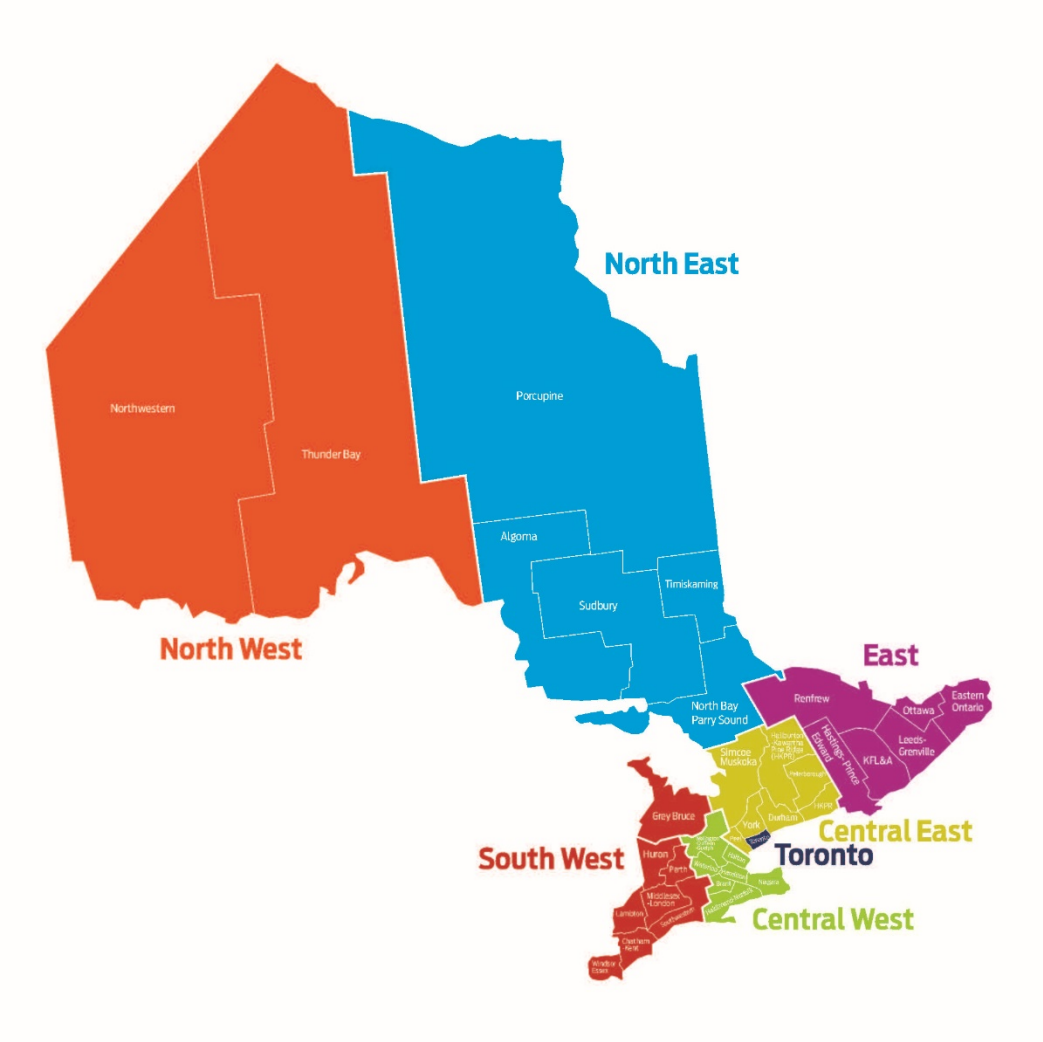

Figure A. Map of Ontario's 35 Public Health Units[9]. Reprinted from "Public Health Units" by the Association of Local Public Health Agencies (alPHa). (n.d.) Retrieved from http://www.alphaweb.org/page/PHU

[9] In 2018, two public health units – Elgin-St. Thomas and Oxford County were merged, forming the Oxford Elgin St. Thomas Health Unit. This merger reduced the number of public health units from 36 to 35.

Appendix D: Public Health Unit Profiles

Peer group (2011)	Public Health Unit	Board of Health Governance Model	Size of region (km^2)	Population estimates (2013)	Population density (km^2) (2013)	# of municipalities within health unit
Rural northern regions	Northwestern	Autonomous	171,288	86,175	0.5	19
Mainly rural	Grey Bruce	Autonomous	8,586	162,822	19.0	17
Mainly rural	Huron County	Autonomous/ integrated	3,397	58,477	17.2	9
Mainly rural	Perth District	Autonomous	2,218	77,919	35.1	6
Mainly rural	Renfrew County and District	Autonomous	14,980	105,344	7.0	19
Sparsely populated urban/rural mix	District of Algoma	Autonomous	44,308	116,498	2.6	22
Sparsely populated urban/rural mix	Chatham-Kent	Autonomous/ integrated	2,471	105,722	42.8	1
Sparsely populated urban/rural mix	North Bay Parry Sound	Autonomous	16,802	128,263	7.6	31

Peer group (2011)	Public Health Unit	Board of Health Governance Model	Size of region (km^2)	Population estimates (2013)	Population density (km^2) (2013)	# of municipalities within health unit
Sparsely populated urban/rural mix	Porcupine	Autonomous	266,291	85,848	0.3	14
Sparsely populated urban/rural mix	Sudbury	Autonomous	46,475	199.711	4.3	19
Sparsely populated urban/rural mix	Thunder Bay	Autonomous	235,531	151,230	0.6	15
Sparsely populated urban/rural mix	Timiskaming	Autonomous	14,125	34,263	2.4	24
Urban/rural mix	Brant County	Autonomous	1,129	142,771	126.5	2
Urban/rural mix	Eastern Ontario	Autonomous	5,308	204,742	38.6	15
Urban/rural mix	Elgin St. Thomas[a]	Autonomous	1,881	90,392	48.1	
Urban/rural mix	Haldimand-Norfolk	Single-tier	2,858	109,855	38.4	8
Urban/rural mix	Haliburton, Kawartha, Pine Ridge	Autonomous	8,988	179,073	19.9	2

Peer group (2011)	Public Health Unit	Board of Health Governance Model	Size of region (km^2)	Population estimates (2013)	Population density (km^2) (2013)	# of municipalities within health unit
Urban/rural mix	Hamilton	Single-tier	1,117	545,585	488.4	12
Urban/rural mix	Hastings & Prince Edward	Autonomous	7,028	163,402	23.3	1
Urban/rural mix	Kingston, Frontenac and Lennox, and Addington	Autonomous	6,449	199,669	31.0	17
Urban/rural mix	Lambton	Autonomous/ integrated	3,002	130,297	43.4	9
Urban/rural mix	Leeds, Grenville and Lanark	Autonomous	6,329	169,229	26.7	11
Urban/rural mix	Middlesex-London	Autonomous	3,317	461,737	139.2	22
Urban/rural mix	Niagara	Regional	1,854	445,351	240.2	9
Urban/rural mix	Oxford[a]	Regional	2,039	110,725	54.3	12
Urban/rural mix	Peterborough	Autonomous	3,806	138,992	36.5	8
Urban/rural mix	Windsor-Essex	Autonomous	1,851	402,060	217.2	9
Urban centres	Durham	Regional	2,523	645,043	255.7	9
Urban centres	Halton	Regional	967	539,423	557.8	8
Urban centres	Ottawa	Semi-autonomous	2,778	943,300	336.3	4

Peer group (2011)	Public Health Unit	Board of Health Governance Model	Size of region (km^2)	Population estimates (2013)	Population density (km^2) (2013)	# of municipalities within health unit
Urban centres	Simcoe Muskoka	Autonomous	8,371	534,067	61.2	1
Urban centres	Waterloo	Regional	1,369	534,762	390.6	24
Urban centres	Wellington-Dufferin-Guelph	Autonomous	4,142	278,511	67.2	7
Mainly urban	Peel	Regional	1,242	1,387,870	1,117.4	16
Mainly urban	York	Regional	1,762	1,106,096	627.8	3
Metro centre	Toronto	Semi-autonomous	630	2,771,770	4,399.6	9
	Ontario Total		907,574	13,537,994		415

Note. [a] In 2018, two public health units – Elgin-St. Thomas and Oxford County were merged, forming the Oxford Elgin St. Thomas Health Unit. This merger reduced the number of public health units from 36 to 35.

Adapted from "Initial report on public health, 2014 update (revised February 2015). Table 1" by the Ontario Ministry of Health and Long Term Care. Toronto, ON, Canada: Queen's Printer for Ontario, 2008. Retrieved from http://www.health.gov.on.ca/en/public/publications/pubhealth/init_report/pdfs/health_unit_profiles_short_version_2014.pdf

Appendix E: Pilot Study Materials

Appendix E.1

Pilot: Email Request for Assistance to Medical Officer of Health

Dear [Insert Medical Officer of Health's name],

This is a request for your assistance with a pilot study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario, under the supervision of Drs. Alexander Crizzle and John Garcia. The title of the research project is "Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls: A Pilot Study".

The purpose of this pilot study is to test the methods and procedures that will be used in a larger scale study to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. The knowledge and information from this pilot project is expected to identify modifications that will need to be made prior to conducting the larger scale study, which is expected to advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to your public health unit.

This pilot project requires at least one participant from your public health unit who is currently working on and knowledgeable about your public health unit's efforts to prevent falls. I am requesting your permission and allowance of time to speak with [insert name of Fall prevention Team member], a staff member in your public health unit who is currently working to prevent falls with community partners. Participation is voluntary and involves a 60-90 minute audio-recorded, telephone interview. Further details about the study purpose, participant eligibility criteria, time commitment, and other information about the study are outlined in the information letter attached. This study has been reviewed and received ethics clearance through a University of Waterloo Ethics Research Committee.

If you are interested and able to assist, could you please respond to this email by <insert date>?

Should you have any questions about the study, I can be reached by responding to this e-mail message <address>. You may also contact my supervisors, Dr. Alexander Crizzle at XXX-XXX-XXXX or by email <address> and Dr. John Garcia at XXX-XXX-XXXX ext. XXXXX or by email <address>. If you have questions for the Ethics Committee contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>. I look forward to speaking with you and thank you in advance for your time and consideration.

Yours sincerely,

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School of Public Health and Health Systems
University of Waterloo

Appendix E.2

Pilot: Recruitment Email for PHU Professionals

Dear [Insert PHU professional's name],

This is an invitation to participate in a pilot study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario, under the supervision of Drs. Alexander Crizzle and John Garcia. The title of the research project is "Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls: A Pilot Study".

The purpose of this pilot study is to test the methods and procedures that will be used in a larger scale study to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. The knowledge and information from this pilot project is expected to identify modifications that will need to be made prior to conducting the larger scale study, which is expected to advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to your public health unit.

As a staff member in your public health unit who is currently working to working with community partners to prevent falls, your expert knowledge around fall prevention and work with community partners would make an invaluable contribution to this research and help to shape future research. Participation is voluntary and involves a 60-90 minute audio-recorded, telephone interview. Further details about the study purpose, participant eligibility criteria, time commitment, and other information about the study are outlined in the information letter attached. This study has been reviewed and received ethics clearance through a University of Waterloo Ethics Research Committee.

If you are interested and able to assist, could you please respond to this email by <insert date>?

Should you have any questions about the study, I can be reached by responding to this e-mail message <address>. You may also contact my supervisors, Dr. Alexander Crizzle at XXX-XXX-XXXX or by email <address> and Dr. John Garcia at XXX-XXX-XXXX ext. XXXXX or by email <address>. If you have questions for the Ethics Committee contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>.

I look forward to speaking with you and thank you in advance for your time and consideration.

Yours sincerely,

Taryn Sendzik, MSc
PhD Candidate
School of Public Health and Health Systems
University of Waterloo

Alexander Crizzle, PhD
Assistant Professor
School of Public Health

University of Saskatchewan

John Garcia, PhD
Professor of Practice/Associate Director, Graduate Professional Programs
School of Public Health and Health Systems
University of Waterloo

Appendix E.3

Pilot: Information-Consent Letter – Public Health Unit Professionals

Title of the study: Mobilization Strategies and Practices Employed by Public Health Professionals in Ontario's Public Health Units to Prevent Falls: A Pilot Study

Faculty Supervisors:

Alexander Crizzle, PhD, School of Public Health and Health Systems, University of Waterloo, and School of Public Health, University of Saskatchewan. Phone: X-XXX-XXX-XXXX, Email: <address>

John Garcia, PhD, School of Public Health and Health Systems, University of Waterloo. Phone: X-XXX-XXX-XXXX ext. XXXXX, Email: <address>

Student Investigator:

Taryn Sendzik, MSc, School of Public Health and Health Systems, University of Waterloo. Email: <address>

To help you make an informed decision regarding your participation, this letter will explain what the study is about, the possible risks and benefits, and your rights as a research participant. If you do not understand something in the letter, please ask one of the investigators prior to consenting to the study. You will be provided with a copy of the information and consent form if you choose to participate in the study.

What is the study about?

You are invited to participate in a pilot study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario about the mobilization strategies and practices employed by public health professional in Ontario's Public Health Units to prevent falls.

Over the past decade there has been increasing emphasis for Ontario's Public Health Units to work with community partners to address public health issues such as fall prevention. Many PHU professionals are already working with community partners. However, not much is known about what is currently being done, how well efforts are performing, and what guidance is needed or could be provided to public health professionals working in Ontario's PHUs to better mobilize with community partners to prevent falls. Research is needed to address these knowledge gaps.

The purpose of this pilot study is to test the methods and procedures that will be used in a larger scale study to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. Your perspectives and knowledge would be valuable in informing how the larger scale study will be conducted and what questions will be asked. The knowledge and information gained from this research is expected to advance knowledge around, provide evidence of, and enable community mobilization

practices and future research, which may be of benefit to Ontario's Public Health Units, community partners, communities, and those at risk for falls.

I. Your responsibilities as a participant

What does participation involve?

Participation in the study involves the completion of a telephone interview of approximately 60-90 minutes in length at a mutually agreed upon time. During the telephone interview you will be asked to describe your Public Health Unit (e.g., name, number of staff, injury prevention staff, budget, time), community (e.g., size, need to prevent falls, availability of materials to prevent falls), knowledge of community mobilization (e.g., what is it?), community partners (e.g., are you mobilizing with community partners to prevent falls, number, type, roles and responsibilities), community non-partners (e.g., are there partners you would like to work with in the future to prevent falls), community mobilization practices (e.g., what is being done, for what reasons, how has the process unfolded over time, how and when are partners involved), performance, benefits, and challenges of community mobilization, and your thoughts on capacity building and policy development by provincial and federal public health agencies.

In addition, you will be asked to assist with identifying three key community partners with knowledge of your work together to prevent falls, and two organizations/individuals with whom would like to work with in the future as part of your collaborative work to prevent falls in your community.

Who may participate in the study?

This study will involve one public health professional working in an Ontario public health unit who is tasked with working with community partners to prevent falls among community-dwelling older adults; three of their community partners; and two organizations/individuals who are not currently working with the public health unit staff but are viewed as valuable future partners that would add value to fall prevention efforts.

II. Your rights as a participant

Is participation in the study voluntary?

Your participation in this study is voluntary. You may decide to leave the study at any time by communicating this to the researchers. Any information you provided up to that point will not be used. You may decline to answer any question(s) you prefer not to answer by requesting to skip the question. You can request your data be removed from the study up until February 2018 as it is not possible to withdraw decisions related to your data once the larger scale study is launched.

Will I receive anything for participating in the study?

You will not receive payment for your participation in this study.

What are the possible benefits of the study?

Participation in this study may not provide any personal benefit to you. The study will, however, aid in shaping how my future research examining the community mobilization strategies and practices of Ontario's public health unit professionals working to prevent falls which is expected to advance knowledge and contribute to discussion surrounding theories, models, and guidelines for use by Ontario's public health unit professionals.

What are the risks associated with the study?

There are minimal risks associated with participation in this study. If a question or the discussion makes you uncomfortable, you can choose not to answer and may ask to skip or move on to the next question. Further, because referrals will be used to identify potential study participants, it may not be possible to guarantee anonymity. To help protect your identity, we would ask that you do not discuss the study with others.

Will my identity be known?

The research team will know what you said. You will be assigned a unique study number. The research team will not publish or discuss your name. Your decision to participate will not be disclosed to other participants in the study.

Will my information be kept confidential?

The information you share will be kept confidential. Identifying information will be removed from the transcripts, the audio recording, and electronic data. All transcripts, audio recordings, and electronic data will be kept for a period of 7 years following publication of the findings from the larger scale study, after which they will be destroyed. Data will be stored in an encrypted folder on my password protected laptop and stored in a locked location. Only the research team will have access to the data. No identifying information will be used in my thesis or any presentations or publications based on this research.

III. Questions, comments, or concerns

Has the study received ethics clearance?

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE# XXXXX). If you have questions for the Committee, contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>.

Who should I contact if I have questions regarding my participation in the study?

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact Taryn Sendzik by email at <address>.

Taryn Sendzik, MSc
School of Public Health and Health Systems
University of Waterloo
<address>

Appendix E.4

Pilot: Verbal Consent and Interview Guide Public Health Unit (PHU) Professional

Introduction:

Hello. This is Taryn Sendzik, from the University of Waterloo' School of Public Health and Health Systems. As you know, I am a Doctoral candidate conducting a pilot study to inform my research examining the community mobilization strategies and practices employed by public health professionals in Ontario's public health units to prevent falls.

Thank you for expressing interest in this study. Just to review, today you will be participating in an individual phone interview, which should take approximately 60-90 minutes to complete. Your participation is voluntary. As a reminder, to help ensure your anonymity and confidentiality, I would ask that you do not discuss this study with anyone else. By taking part in this interview, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

Before proceeding further I would like you to answer the following questions related to your participation:

Have you read the information presented in the information letter? (Yes/No)

Do you have any questions related to the study? (Yes/No)

Have these questions been answered to your satisfaction? (Yes/No)

Do you agree to participate in this study knowing that your participation is voluntary and that you can withdraw your consent by informing the researcher? (Yes/No)

Do you give your permission to have this conversation recorded for the purposes of accuracy and data analysis? (Yes/No)

Would you like a summary of the final study report following the defense of my dissertation? (Yes/No)

Do you have any other concerns?

Thank you for your responses. Let's proceed with the study questions.

<u>Section 1</u>: **General information**.

1. Could you introduce yourself?
   a. What is your name?
   b. What PHU do you work for?
   c. What is your job title/role at the PHU?

d. How long have you work in PH?
e. How long have you been doing work to prevent falls?

<u>Section 2</u>: General PHU and community information.

2. Can you tell me a little bit about the PHU you work for?
    a. What is the official name of your PHU?
    b. How many staff work in your PHU?
    c. How many staff are tasked with preventing falls?
    d. What is the budget for injury prevention?
        i. Is there a specific budget allocated for the prevention of falls?
    e. How much time (% person time, #hours per week) is devoted to fall prevention? (clarify if this is per person or for multiple people and whether it is for full or part-time staff).
        i. How does this compare to other injury prevention sectors?

3. Please tell me a little about the community whom you and your PHU serve?
    a. What are the geographic boundaries of your PHU?
    b. How large is the population you serve?
    c. Is there a need to prevent falls in your community? Is there a need to prevent falls among community-dwelling older adults? Does this need differ from the general population? Has your PHU assessed these needs?
    d. Does your PHU have different materials/strategies for preventing falls among community-dwelling older adults versus the general population?

<u>Section 3</u>: Community partners.

4. Part of what I am interested in is learning about the ways in which PHUs practice community mobilization to prevent falls and how this practice develops and unfolds over time.
    a. Have you ever heard of the term community mobilization? (Yes/No)
    b. How would you define community mobilization?

5. One of the definitions used by Ontario's Public Health Unit professionals to describe community mobilization is "*the use of capacity to bring about change by joining together the strengths of the community into an action plan. 'Community mobilization is based on the belief that when a community is mobilized to address and solve its own problems, more efficient and effective results will materialize than could be achieved by other means' (Hastings, 2001). The anticipated goal is for a safe and healthy community with 'buy in' from all community members*."
    a. What do you think of this definition?
    b. Does this definition describe your experiences working with your local PHU to prevent falls among community-dwelling adults? If no, how is it different?

6. Have you or are you currently mobilizing with community partners?

a. Approximately how many partners does your community mobilization work involve?
b. Could you identify and describe who you have partnered with so far?
    i. Official name
    ii. Organization type – Government, non-profit, volunteer/informal, charitable, private (for profit) organization, academic/research, advocacy, community, educational, consulting group, media, other?
    iii. Name of key contact
    iv. How long have you been partners?
    v. What is their role as part of the partnership?

Section 4: **Community non-partners.**

7. Are there any organizations/individuals you would like to collaborate with as part of your community mobilization efforts to prevent falls among community-dwelling adults in the near future?
    a. If yes, who are the top five organizations/individuals you would like to partner with and why would you like to collaborate with them?
    b. Is there anything stopping you from working with these organizations/individuals that are currently not partners in your mobilization efforts? [Prompt for details]

Section 5: **Community mobilization practices.**

8. Mobilization can be used for various public health purposes such as programming, policy or media communications strategy development, and implementation and evaluation. Could you tell me about the purpose of your current mobilization efforts?

9. What mobilization efforts are you using? [Prompt: Programming, policy, media, implementation and evaluation]

10. Part of what I am interested in is learning about the ways in which PHUs practice community mobilization to prevent falls among community-dwelling adults and how this practice develops and unfolds over time. Thinking about your own community mobilization efforts, please describe the steps and activities you have employed and how this has progressed over time?
    a. Were you the one who initiated the mobilization of community partners?
    b. How did you identify the problem?
    c. How did you determine the need for a community mobilization strategy?
    d. How did you determine what steps you needed to take? Did you use any tools or resources to help you get started? [e.g., use of existing community mobilization theory, framework, or guides?]
    e. How did you determine who needed to be involved?

f. How did you/your PHU engage the different organizations and individuals to participate? What information was provided? [Prompt: Define problem, need, severity, potential for change]
g. Was there commonality in the partners' goals and values around the prevention of falls among community-dwelling adults?
h. How were you and your partners able to align differences in organizational goals and values around this issue in order to work together?
i. How did you and your partners organize themselves for community mobilization? Was anything put in place to manage the partnership, mobilization process and activities? Please describe with examples. [Prompt: Leadership; communication; roles, rights and responsibilities; decision making; resources; level of engagement – inform/share, consult, deliberate, collaborate, empower]
j. How would you describe the level of integration/nature of teamwork between the PHU and your partners? Communicative, Cooperative, coordinated, collaborative? Has this level of integration changed throughout the process?
k. Could you tell me about how and what activities the partnership decided to do? Which activities were carried out by/involved yourself or the PHU? [Probe: Conduct assessments of community needs? resources? capacity? opportunities? Partnership goals, strengths, and resources?]
l. How often do you/PHU professionals and community members talk as part of the partnership? Do you meet regularly? How is contact maintained?
m. How will the performance and impact of the various mobilization activities and partnership be assessed? Please describe with examples.

Section 6: **Performance, benefits, and challenges of community mobilization strategies.**

11. Please tell me how your community mobilization strategies and practices impact fall prevention goals for your community partners? And target population?), and whether performance/evaluation data has been collected or is planned? [Probe: Can you describe specific strategies that are performing well? Are other strategies performing less well and why? Is performance related to specific target groups? Have you had to change any strategies? Are you reaching your desired community partners? Community? Community-dwelling adults as expected? What data has been collected or is planned for collection? When was this data collected/ will data be collected? Has this data been analyzed or is there a plan for future analysis?]

12. What are some of the benefits and challenges to collaborating you have experienced mobilizing with community partners to prevent falls? [Prompts: leadership; trust; organization; communication; commitment/involvement; engagement; power; decision making; membership size or diversity; time and resources – e.g., funding, skills; framing of problem and objectives by partners; conflict between partners; differences in partners organizational goals, vision, strategy; social support; political support]

a. Regarding the challenges you described, do you think there were any actions or steps that were missed or that you would do differently? Could you describe with an example?

<u>Section 7</u>: Capacity building policy development by provincial and federal public health ministries and agencies.

13. How do you see your role with the merger of the PHUs with the LHINs? Have you received any information on what the LHINs are doing? Have you received any information on how the work you do integrate into the LHIN network (related to fall prevention)? [Probe: Will there be a shift in fall prevention practices? Will you get access to different partners? Will you have reduced time with the merger to focus on fall prevention?]

<u>CLOSING QUESTIONS</u>: **Additional feedback.**

14. Do you have any additional thoughts or experiences about community mobilization to prevent falls among community-dwelling adults you would like to add?

15. Are there any additional comments about what you've said or about this study that you would like to add?

Appendix E.5

Pilot: Feedback Letter

Dear [participant name],

I would like to thank you for your participation in this study entitled “Mobilization Strategies and Practices Employed by Public Health Professional in Ontario’s Public Health Units to Prevent Falls: A Pilot Study”.

As a reminder, the purpose of this study is to test the methods and procedures that will be used in a larger scale study to describe the mobilization strategies and practices employed by public health professional in Ontario’s public health units who are working with their community partners to prevent falls. The knowledge and information from this pilot project is expected to identify modifications that will need to be made prior to conducting the larger scale study, which is expected to advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to you and your public health unit.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#XXXXX). Please remember that any data pertaining to you as an individual participant will be kept confidential. If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>. For all other questions contact Taryn Sendzik by email <address>. You may also contact my supervisors, Dr. Alexander Crizzle at XXX-XXX-XXXX or by email <address> and Dr. John Garcia at XXX-XXX-XXXX ext. XXXXX or by email <address>.

If you are interested in receiving more information regarding the results of this study, or would like a summary of the results of the larger scale study, please provide your email address, and when the study is completed, anticipated by September 2018, I will send you the information. In the meantime, if you have any questions about the study, please do not hesitate to contact me by email or telephone as noted below.

Taryn Sendzik

University of Waterloo

School of Public Health and Health Systems

<address>

Appendix E.6

Pilot: Phone Recruitment Script – Community Partners

Hello [potential participant's name], my name is Taryn Sendzik and I am a PhD student at the University of Waterloo' School of Public Health and Health Systems working under the supervision of John Garcia and Alexander Crizzle.

The reason I am calling is that we are currently seeking volunteers for a pilot study to examining the community mobilization strategies and practices employed by public health professionals in Ontario's public health units to prevent falls. I am contacting you because of you have been identified as a key person whose work is contributing to the prevention falls in your community and as someone who is working to prevent falls with the local Public Health Unit. I am wondering if you would be interested in hearing more about the study?

[IF NO] Thank you for your time. Good-bye.

[IF YES] Continue.

Participation in this pilot study involves completing a one-on-one telephone interview about your work preventing falls and knowledge you have about the local Public Health Units work to prevent falls. Participation would take approximately 60 minutes at a mutually agreed upon time. In appreciation for your time, you will receive a feedback letter thanking you for your help. You will not receive any form of payment. The study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee.

However, the final decision about participation is yours.

May I send you an e-mail containing more detailed information about the study?

[IF NO] Thank you for your time. Good-bye.

[IF YES] Thank you. We appreciate your interest in this research. (Ask for e-mail address). I will send the email shortly and will call again in a couple of days to ensure you received the information. If you have any questions, you can contact me by phone at X-XXX-XXX-XXXX or by e-mail <address> Thank you very much for helping us with our research. I look forward to hearing with from you.

Follow-up phone script:

Hi [potential participant]. This is Taryn Sendzik from the University of Waterloo. I am calling to confirm that you received the study information I sent you [insert date].

[IF NO] May I confirm your e-mail address again so that you have the information in your files and have an opportunity to consider any questions you have and your participation? (Confirm e-mail address)

[IF YES] Great. Have you had an opportunity to review the information? Or do you have any questions for me that you'd like to ask before responding to my email? (answer any questions)

Thank you again for your time. I look forward to hearing from you shortly. Good-bye.

Appendix E.7

Pilot: Recruitment Email for Community Partners

Dear [Insert Community Partner's name],

This is an invitation to participate in a pilot study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario, under the supervision of Drs. Alexander Crizzle and John Garcia. The title of the research project is "Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls: A Pilot Study".

The purpose of this pilot study is to test the methods and procedures that will be used in a larger scale study to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. The knowledge and information from this pilot project is expected to identify modifications that will need to be made prior to conducting the larger scale study, which is expected to advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to you and your public health unit.

As someone who is currently working to prevent falls in your community, your expert knowledge around fall prevention and work with the public health unit would make an invaluable contribution to this research and help to shape future research. Participation is voluntary and involves a 60 minute audio-recorded, telephone interview. Further details about the study purpose, participant eligibility criteria, time commitment, and other information about the study are outlined in the information letter attached. This study has been reviewed and received ethics clearance through a University of Waterloo Ethics Research Committee.

If you are interested and able to assist, could you please respond to this email by <insert date>?

Should you have any questions about the study, I can be reached by responding to this e-mail message <address>. You may also contact my supervisors, Dr. Alexander Crizzle at XXX-XXX-XXXX or by email <address> and Dr. John Garcia at XXX-XXX-XXXX ext. XXXXX or by email <address>. If you have questions for the Ethics Committee contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>.

I look forward to speaking with you and thank you in advance for your time and consideration.

Yours sincerely,

Taryn Sendzik, MSc
PhD Candidate
School of Public Health and Health Systems

University of Waterloo

Alexander Crizzle, PhD
Assistant Professor
School of Public Health
University of Saskatchewan

John Garcia, PhD
Professor of Practice/Associate Director, Graduate Professional Programs
School of Public Health and Health Systems
University of Waterloo

Appendix E.8

Pilot: Information-Consent Letter – Community Partners

Title of the study: Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls: A Pilot Study

Faculty Supervisors:

Alexander Crizzle, PhD, School of Public Health and Health Systems, University of Waterloo, and School of Public Health, University of Saskatchewan. Phone: X-XXX-XXX-XXXX, Email: <address>

John Garcia, PhD, School of Public Health and Health Systems, University of Waterloo. Phone: X-XXX-XXX-XXXX ext. XXXXX, Email: <address>

Student Investigator:

Taryn Sendzik, MSc, School of Public Health and Health Systems, University of Waterloo. Email: <address>

To help you make an informed decision regarding your participation, this letter will explain what the study is about, the possible risks and benefits, and your rights as a research participant. If you do not understand something in the letter, please ask one of the investigators prior to consenting to the study. You will be provided with a copy of the information and consent form if you choose to participate in the study.

What is the study about?

You are invited to participate in a pilot study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario about the mobilization strategies and practices employed by public health professional in Ontario's Public Health Units to prevent falls.

Over the past decade there has been increasing emphasis for Ontario's Public Health Units to work with community partners to address public health issues such as fall prevention. Many PHU professionals are already working with community partners. However, not much is known about what is currently being done, how well efforts are performing, and what guidance is needed or could be provided to public health professionals working in Ontario's PHUs to better mobilize with community partners to prevent falls. Research is needed to address these knowledge gaps.

The purpose of this pilot study is to test the methods and procedures that will be used in a larger scale study to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. Your perspectives and knowledge would be valuable in informing how the larger scale study will be conducted and what questions will be asked. The knowledge and information gained from this research is expected to advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to Ontario's Public Health Units, community partners, communities, and those at risk for falls.

I. Your responsibilities as a participant

What does participation involve?

Participation in the study involves the completion of a telephone interview of approximately 60 minutes in length at a mutually agreed upon time. During the telephone interview you will be asked to describe yourself (e.g., name, job title, type of work/service you provide to prevent falls, time allocated to fall prevention), work with the public health unit (e.g., what public health unit, how long you've been working together), organization/individuals in your community that you would like to work with to prevent falls (e.g., names), knowledge of community mobilization (e.g., what is it?), knowledge of community mobilization practices being done by your local public health unit professional (e.g., what is being done, for what reasons, how has the process unfolded over time, how and when are partners involved), and the performance, benefits, and challenges of community mobilization with the public health unit and other community partners to prevent falls.

Who may participate in the study?

This study will involve one public health professional working in an Ontario public health unit who is tasked with working with community partners to prevent falls among community-dwelling older adults; three of their community partners; and two organizations/individuals who are not currently working with the public health unit staff but are viewed as valuable future partners that would add value to fall prevention efforts.

II. Your rights as a participant

Is participation in the study voluntary?

Your participation in this study is voluntary. You may decide to leave the study at any time by communicating this to the researchers. Any information you provided up to that point will not be used. You may decline to answer any question(s) you prefer not to answer by requesting to skip the question. You can request your data be removed from the study up until February 2018 as it is not possible to withdraw decisions related to your data once the larger scale study is launched.

Will I receive anything for participating in the study?

You will not receive payment for your participation in this study.

What are the possible benefits of the study?

Participation in this study may not provide any personal benefit to you. The study will, however, aid in shaping how my future research examining the community mobilization strategies and practices of Ontario's public health unit professionals working to prevent falls which is expected to advance knowledge and contribute to discussion surrounding theories, models, and guidelines for use by Ontario's public health unit professionals.

What are the risks associated with the study?

There are minimal risks associated with participation in this study. If a question or the discussion makes you uncomfortable, you can choose not to answer and may ask to skip or move on to the next question. Further, because referrals will be used to identify potential study participants, it may not be possible to guarantee anonymity. To help protect your identity, we would ask that you do not discuss the study with others.

Will my identity be known?

The research team will know what you said. You will be assigned a unique study number. The research team will not publish or discuss your name. Your decision to participate will not be disclosed to other participants in the study.

Will my information be kept confidential?

The information you share will be kept confidential. Identifying information will be removed from the transcripts, the audio recording, and electronic data. All transcripts, audio recordings, and electronic data will be kept for a period of 7 years following publication of the findings from the larger scale study, after which they will be destroyed. Data will be stored in an encrypted folder on my password protected laptop and stored in a locked location. Only the research team will have access to the data. No identifying information will be used in my thesis or any presentations or publications based on this research.

III. Questions, comments, or concerns

Has the study received ethics clearance?

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE# XXXXX). If you have questions for the Committee, contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>.

Who should I contact if I have questions regarding my participation in the study?

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact Taryn Sendzik by email at <address>.

Taryn Sendzik, MSc
School of Public Health and Health Systems
University of Waterloo
<address>

Appendix E.9

Pilot: Interview Guide Community Partners

Introduction:

Hello. This is Taryn Sendzik, from the University of Waterloo' School of Public Health and Health Systems. As you know, I am a Doctoral candidate conducting a pilot study to inform my research examining the community mobilization strategies and practices employed by public health professionals in Ontario's public health units to prevent falls.

Thank you for expressing interest in this study. Just to review, today you will be participating in an individual phone interview, which should take approximately 60 minutes to complete. Your participation is voluntary. As a reminder, to help ensure your anonymity and confidentiality, I would ask that you do not discuss this study with anyone else. By taking part in this interview, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

Before proceeding further I would like you to answer the following questions related to your participation:

Have you read the information presented in the information letter? (Yes/No)

Do you have any questions related to the study? (Yes/No)

Have these questions been answered to your satisfaction? (Yes/No)

Do you agree to participate in this study knowing that your participation is voluntary and that you can withdraw your consent by informing the researcher? (Yes/No)

Do you give your permission to have this conversation recorded for the purposes of accuracy and data analysis? (Yes/No)

Would you like a summary of the final study report following the defense of my dissertation? (Yes/No)

Are you willing to provide contact information for community partners or other community groups/individuals who are involved in the prevention of falls in your community for the purposes of this study outlined in the study information letter? (Yes/No)

Do you have any other concerns?

Thank you for your responses. Let's proceed with the study questions.

<u>Section 1</u>: Community partners.

1. Could you introduce yourself?
2. What is the official name of the organization you work for?
3. What is your job title/position in the organization?
4. Do you work in a particular department or unit in the organization?
5. How long have you worked for the organization? (years/months)

6. I'd like to know more about you/your organization's work.
    a. How would you classify yourself/your organization? – Government, non-profit, volunteer/informal, charitable, private (for profit) organization, academic/research, advocacy, industry, employer, community, educational, consulting group, media, other?
    b. Could you please briefly describe you/your organization's primary service(s)?
    c. What services do you/your organization provide to prevent falls? [Probe: How much focus do you have on seniors? Do you offer a single program for everyone or are there separate programs for different groups of people (e.g., children, seniors, community-dwelling individuals, institutional)?]
    d. How long have you/your organization been working on preventing falls? How long have you/your organization been working on preventing falls among community-dwelling older adults?
    e. Do you work with others to prevent falls? (Yes or No)
    If yes:
        i. What is the total number of people?
        ii. How many people working on preventing falls among community-dwelling older adults?
    f. How much time (#hours per week, % person time) is devoted to fall prevention? (clarify if this is per person or for multiple people and whether it is for full or part-time staff).
    g. Could you identify and describe specific activities that you (and those you work with) do to prevent falls?

7. Could you tell me a little about your work with the PHU to prevent?
    a. How long have you been working with the PHU to prevent?
    b. Approximately how many other organizations or individuals have you partnered with?

<u>Section 2</u>: **Community non-partners.**

8. In your work with the PHU to prevent falls s, are there any organizations/individuals you would like to collaborate with in the near future?
    a. If yes, who are the top five organizations/individuals you would like to partner with and why would you like to collaborate with them?

<u>Section 3</u>: **Community mobilization practices.**

9. Part of what I am interested in is learning about the ways in which PHUs practice community mobilization to prevent falls and how this practice develops and unfolds over time.
    a. Have you ever heard of the term community mobilization? (Yes/No)
    b. How would you define community mobilization?

10. One of the definitions used by Ontario's Public Health Unit professionals to describe community mobilization is "*the use of capacity to bring about change by joining together the strengths of the community into an action plan. 'Community mobilization is based on the belief that when a community is mobilized to address and solve its own problems, more efficient and effective results will materialize than could be achieved by other means' (Hastings, 2001). The anticipated goal is for a safe and healthy community with 'buy in' from all community members*."
    a. What do you think of this definition?
    b. Does this definition describe your experiences working with your local PHU to prevent falls? If no, how is it different?

11. Thinking about the community mobilization efforts between your local PHU and partners, please describe the steps and activities you have been involved in and how this has progressed over time?

Prompt:

- a. How did you become involved? Who reached out to you? What information were you given? [Prompt: Defined problem, need, severity, potential for change, commitment]
- b. Are you aware of what work the PHU professional had done leading up to your partnership in order to prepare for mobilizing with community partners?
    - i. Can you tell me about how did your local PHU professional identify problem?
    - ii. How did your local PHU professional Determine need for a community mobilization strategy?
    - iii. How did your local PHU professional determine what steps needed to be taken to mobilize? Did they use any tools or resources to help get started? [e.g., use of existing community mobilization theory, framework, or guides?]
    - iv. How did your local PHU professional determine who needed to be involved?

c. Could you tell me about how your local PHU professional engaged different organizations and individuals to participate in mobilization? [Prompt: Define problem, need, severity, potential for change]
d. Was there commonality in the partners' goals and values around the prevention of falls among community-dwelling older adults?
e. How were you and your partners able to align differences in organizational goals and values around this issue in order to work together? What role did the local PHU/PHU professional take during this process?
f. How did you and your partners organize themselves for community mobilization? Was anything put in place to manage the partnership, mobilization process and activities? Please describe with examples. [Prompt: Leadership; communication; roles, rights and responsibilities; decision making; resources; level of engagement – inform/share, consult, deliberate, collaborate, empower] What role did the local PHU/PHU professional take during this process?
g. How would you describe the level of nature of teamwork/integration between the PHU and your organization? With your other partners? Communicative, Cooperative, coordinated, collaborative? Has this level changed throughout the process?
h. Could you tell me about how and what activities the partnership decided to do? Which activities were carried out by/ involved the PHU? [Probe: Conduct assessments of community needs? resources? capacity? opportunities? Partnership goals, strengths, and resources?]
i. How often do you talk as part of the partnership? Do your meet regularly? How is contact maintained?
j. How will the performance and impact of the various mobilization activities and partnership be assessed? Please describe with examples.

<u>Section 4</u>: **Performance, benefits, and challenges of community mobilization strategies.**

17. Please tell me about how the community mobilization strategies and practices impact fall prevention goals for yourself/organization? And target population?, and whether performance/evaluation data has been collected or is planned? [Probe: Can you describe specific strategies that are performing well? Are other strategies performing less well and why? Is performance related to specific target groups? Have you had to change any strategies? Are you reaching your desired community partners? Community? Community-dwelling older adults as expected? What data has been collected or is planned? When was this data collected/ will data be collected? Has this data been analysed or is there a plan for future analysis?]

18. What are some of the benefits and challenges to collaborating you have experienced mobilizing with the PHU and other community partners to prevent falls? [Prompts: leadership; trust; organization; communication; commitment/involvement; engagement; power; decision making; membership

size or diversity; time and resources – e.g., funding, skills; framing of problem and objectives by partners; conflict between partners; differences in partners organizational goals, vision, strategy; social support; political support?]

CLOSING QUESTIONS: **Additional feedback.**

19. Do you have any additional thoughts or experiences about community mobilization to prevent falls you would like to add?

20. Are there any additional comments about what you've said or about this study that you would like to add?

Appendix E.10

Pilot: Phone Recruitment Script – Public Health Unit Non-Partners

Hello [potential participant's name], my name is Taryn Sendzik and I am a PhD student at the University of Waterloo' School of Public Health and Health Systems working under the supervision of John Garcia and Alexander Crizzle.

The reason I am calling is that we are currently seeking volunteers for a pilot study to examining the community mobilization strategies and practices employed by public health professionals in Ontario's public health units to prevent falls. I am contacting you because of you have been identified as a key person whose work is contributing to the prevention falls in your community. I am wondering if you would be interested in hearing more about the study?

> [IF NO] Thank you for your time. Good-bye.
> [IF YES] Continue.

Participation in this pilot study involves completing a one-on-one telephone interview about your work preventing falls and knowledge you have about the local Public Health Units work to prevent falls. Participation would take approximately 20-30 minutes at a mutually agreed upon time. In appreciation for your time, you will receive a feedback letter thanking you for your help. You will not receive any form of payment. The study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee.

However, the final decision about participation is yours.

May I send you an e-mail containing more detailed information about the study?

> [IF NO] Thank you for your time. Good-bye.
> [IF YES] Thank you. We appreciate your interest in this research. (Ask for e-mail address). I will send the email shortly and will call again in a couple of days to ensure you received the information. If you have any questions, you can contact me by e-mail <address>. Thank you very much for helping us with our research. I look forward to hearing with you.

Follow-up phone script:

Hi [potential participant]. This is Taryn Sendzik from the University of Waterloo. I am calling to confirm that you received the study information I sent you [insert date].

[IF NO] May I confirm your e-mail address again so that you have the information in your files and have an opportunity to consider any questions you have and your participation? (Confirm e-mail address)

[IF YES] Great. Have you had an opportunity to review the information? Or do you have any questions for me that you'd like to ask before responding to my email? (answer any questions)

Thank you again for your time. I look forward to hearing from you shortly. Good-bye.

Appendix E.11

Pilot: Recruitment Email for Non-Partners

Dear [Insert Community Partner's name],

This is an invitation to participate in a pilot study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario, under the supervision of Drs. Alexander Crizzle and John Garcia. The title of the research project is "Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls: A Pilot Study".

The purpose of this pilot study is to test the methods and procedures that will be used in a larger scale study to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. The knowledge and information from this pilot project is expected to identify modifications that will need to be made prior to conducting the larger scale study, which is expected to advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to you and your public health unit.

As someone who is currently working to prevent falls in your community, your expert knowledge around fall prevention and working with the community would make an invaluable contribution to this research and help to shape future research. Participation is voluntary and involves a 20-30 minute audio-recorded, telephone interview. Further details about the study purpose, participant eligibility criteria, time commitment, and other information about the study are outlined in the information letter attached. This study has been reviewed and received ethics clearance through a University of Waterloo Ethics Research Committee.

If you are interested and able to assist, could you please respond to this email by <insert date>?

Should you have any questions about the study, I can be reached by responding to this e-mail message <address>. You may also contact my supervisors, Dr. Alexander Crizzle at XXX-XXX-XXXX or by email <address> and Dr. John Garcia at XXX-XXX-XXXX ext. XXXXX or by email <address>. If you have questions for the Ethics Committee contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>.

I look forward to speaking with you and thank you in advance for your time and consideration.

Yours sincerely,

Taryn Sendzik, MSc
PhD Candidate
School of Public Health and Health Systems

University of Waterloo

Alexander Crizzle, PhD
Assistant Professor
School of Public Health
University of Saskatchewan

John Garcia, PhD
Professor of Practice/Associate Director, Graduate Professional Programs
School of Public Health and Health Systems
University of Waterloo

Appendix E.12

Pilot: Information-Consent Letter – Public Health Unit Non-Partners

Title of the study: Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls: A Pilot Study

Faculty Supervisors:
Alexander Crizzle, PhD, School of Public Health and Health Systems, University of Waterloo, and School of Public Health, University of Saskatchewan. Phone: X-XXX-XXX-XXXX, Email: <address>
John Garcia, PhD, School of Public Health and Health Systems, University of Waterloo. Phone: X-XXX-XXX-XXXX ext. XXXXX, Email: <address>
Student Investigator:
Taryn Sendzik, MSc, School of Public Health and Health Systems, University of Waterloo. Email: <address>

To help you make an informed decision regarding your participation, this letter will explain what the study is about, the possible risks and benefits, and your rights as a research participant. If you do not understand something in the letter, please ask one of the investigators prior to consenting to the study. You will be provided with a copy of the information and consent form if you choose to participate in the study.

What is the study about?

You are invited to participate in a pilot study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario about the mobilization strategies and practices employed by public health professional in Ontario's Public Health Units to prevent falls.

Over the past decade there has been increasing emphasis for Ontario's Public Health Units to work with community partners to address public health issues such as fall prevention. Many PHU professionals are already working with community partners. However, not much is known about what is currently being done, how well efforts are performing, and what guidance is needed or could be provided to public health professionals working in Ontario's PHUs to better mobilize with community partners to prevent falls. Research is needed to address these knowledge gaps.

The purpose of this pilot study is to test the methods and procedures that will be used in a larger scale study to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. Your perspectives and knowledge would be valuable in informing how the larger scale study will be conducted and what questions will be asked. The knowledge and

information gained from this research is expected to advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to Ontario's Public Health Units, community partners, communities, and those at risk for falls.

I. Your responsibilities as a participant

What does participation involve?

Participation in the study involves the completion of a telephone interview of approximately 20-30 minutes in length at a mutually agreed upon time. During the telephone interview you will be asked to describe yourself (e.g., name, job title, type of work/service you provide to prevent falls, time allocated to fall prevention), work with other community organizations and your local public health unit (e.g., who are you working with, who would you like to work with, interest in working with public health unit), knowledge of community mobilization (e.g., what is it?), knowledge of fall prevention work being done by your local public health unit professional (e.g., awareness, what is being done, impact).

Who may participate in the study?

This study will involve one public health professional working in an Ontario public health unit who is tasked with working with community partners to prevent falls among community-dwelling older adults; three of their community partners; and two organizations/individuals who are not currently working with the public health unit staff but are viewed as valuable future partners that would add value to fall prevention efforts.

II. Your rights as a participant

Is participation in the study voluntary?

Your participation in this study is voluntary. You may decide to leave the study at any time by communicating this to the researchers. Any information you provided up to that point will not be used. You may decline to answer any question(s) you prefer not to answer by requesting to skip the question. You can request your data be removed from the study up until February 2018 as it is not possible to withdraw decisions related to your data once the larger scale study is launched.

Will I receive anything for participating in the study?

You will not receive payment for your participation in this study.

What are the possible benefits of the study?

Participation in this study may not provide any personal benefit to you. The study will, however, aid in shaping how my future research examining the community mobilization strategies and practices of Ontario's public health unit professionals working to prevent falls which is expected to advance knowledge and contribute to discussion surrounding theories, models, and guidelines for use by Ontario's public health unit professionals.

What are the risks associated with the study?

There are minimal risks associated with participation in this study. If a question or the discussion makes you uncomfortable, you can choose not to answer and may ask to skip or move on to the next question. Further, because referrals will be used to identify potential study participants, it may not be possible to guarantee anonymity. To help protect your identity, we would ask that you do not discuss the study with others.

Will my identity be known?

The research team will know what you said. You will be assigned a unique study number. The research team will not publish or discuss your name. Your decision to participate will not be disclosed to other participants in the study.

Will my information be kept confidential?

The information you share will be kept confidential. Identifying information will be removed from the transcripts, the audio recording, and electronic data. All transcripts, audio recordings, and electronic data will be kept for a period of 7 years following publication of the findings from the larger scale study, after which they will be destroyed. Data will be stored in an encrypted folder on my password protected laptop and stored in a locked location. Only the research team will have access to the data. No identifying information will be used in my thesis or any presentations or publications based on this research.

III. Questions, comments, or concerns

Has the study received ethics clearance?

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE# XXXXX). If you have questions for the Committee, contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>.

Who should I contact if I have questions regarding my participation in the study?

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact Taryn Sendzik by email at <address>.

Taryn Sendzik, MSc
School of Public Health and Health Systems
University of Waterloo
<address>

Appendix E.13

Pilot: Community Non-partner Questions

Introduction:

Hello. This is Taryn Sendzik, from the University of Waterloo' School of Public Health and Health Systems. As you know, I am a Doctoral candidate conducting a pilot study to inform my research examining the community mobilization strategies and practices employed by public health professionals in Ontario's public health units to prevent falls.

Thank you for expressing interest in this study. Just to review, today you will be participating in an individual phone interview, which should take approximately 20-30 minutes to complete. Your participation is voluntary. As a reminder, to help ensure your anonymity and confidentiality, I would ask that you do not discuss this study with anyone else. By taking part in this interview, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

Before proceeding further I would like you to answer the following questions related to your participation:

Have you read the information presented in the information letter? (Yes/No)

Do you have any questions related to the study? (Yes/No)

Have these questions been answered to your satisfaction? (Yes/No)

Do you agree to participate in this study knowing that your participation is voluntary and that you can withdraw your consent by informing the researcher? (Yes/No)

Do you give your permission to have this conversation recorded for the purposes of accuracy and data analysis? (Yes/No)

Would you like a summary of the final study report following the defense of my dissertation? (Yes/No)

Do you have any other concerns?

Thank you for your responses. Let's proceed with the study questions.

<u>Section 1</u>: **Community non-partners.**

1. Could you introduce yourself?

a. What is the official name of the organization you work for?
b. What is your job title/position in the organization?
c. Do you work in a particular department or unit in the organization?
d. How long have you worked for the organization? (years/months)

2. I'd like to know more about you/your organization's work.
    a. How would you classify yourself/your organization? – Government, non-profit, volunteer/informal, charitable, private (for profit) organization, academic/research, advocacy, industry, employer, community, educational, consulting group, media, other?
    b. Could you please briefly describe you/your organization's primary service(s)?
    c. What services do you/your organization provide to prevent falls? [Probe: How much focus do you have on seniors? Do you offer a single program for everyone or are there separate programs for different groups of people (e.g., children, seniors, community-dwelling individuals, institutional)?]
    d. How long have you/your organization been working on preventing falls? How long have you/your organization been working on preventing falls among community-dwelling older adults?
    e. Do you work with others to prevent falls? (Yes or No)?
    If yes:
        i. What is the total number of people?
        ii. How many people working on preventing falls among community-dwelling older adults?
        iii. How much time (#hours per week, % person time) is devoted to fall prevention? (clarify if this is per person or for multiple people and whether it is for full or part-time staff).
3. Could you identify and describe specific activities that you (and those you work with) do to prevent falls?

4. In your work to prevent falls among community-dwelling adults, are there any organizations/individuals you would like to collaborate with in the near future?
    a. If yes, who are the top five organizations/individuals you would like to partner with and why would you like to collaborate with them?

5. Have you ever considered partnering with your local PHU to prevent falls among community-dwelling older adults? (Yes/No)
    If yes:
    a. Could you tell me why you are considering partnering with the PHU?
    If no:
    - Could you tell why you have not considered partnering?
    - Have you been in contact with anyone from a PHU about partnering to prevent falls? (Yes/No)

<u>Section 2</u>: **Community mobilization practices.**

6. Part of what I am interested in is learning about the ways in which PHUs practice community mobilization to prevent falls and how this practice develops and unfolds over time.
   a. Have you ever heard of the term community mobilization? (Yes/No)
   b. If yes, how would you define community mobilization?

7. Are you aware of any of the fall prevention work being done by your local PHU with other partners and individuals in your community?
   a. If yes, could you tell me what you know or are aware of (e.g., what is being done? who is involved? any impact the work is having)?

<u>CLOSING QUESTIONS</u>: **Additional feedback.**

8. Do you have any additional thoughts or experiences about community mobilization work being performed by your local PHU to prevent falls among community-dwelling adults you would like to add?

9. Are there any additional comments about what you've said or about this study that you would like to add?

Appendix F: Full Study Materials

Appendix F.1

Full study: Email Request for Assistance from Public Health Unit[10]

Dear [Insert name and title of Public Health Official permitted to provide permission for PHU participation],

This is a request for your assistance with a study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario, under the supervision of Drs. Alexander Crizzle and John Garcia. The title of the research project is "Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls".

The purpose of this study is to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. The knowledge and information from this study is expected to advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to your public health unit.

This study requires at least one participant from your public health unit who is currently working on and knowledgeable about your public health unit's efforts to prevent falls. I am requesting your permission and allowance of time to speak with [insert name of Fall prevention Team member], a staff member in your public health unit who is currently working to prevent falls with community partners. Participation is voluntary and involves a 60-90 minute audio-recorded, telephone interview. Further details about the study purpose, participant eligibility criteria, time commitment, and other information about the study are outlined in the information letter attached. This study has been reviewed and received ethics clearance through a University of Waterloo Ethics Research Committee (ORE#XXXXX).

If you are interested and able to assist, could you please respond to this email by <insert date>?

Should you have any questions about the study, I can be reached by responding to this e-mail message <address>. You may also contact my supervisors, Dr. Alexander Crizzle at XXX-XXX-XXXX or by email <address> and Dr. John Garcia at XXX-XXX-XXXX ext. XXXXX or by email <address>. If you have questions for the Ethics Committee contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>. I look forward to speaking with you and thank you in advance for your time and consideration.

Yours sincerely,

Taryn Sendzik, MSc
PhD Candidate

[10] Changes made after pilot study are denoted in grey.

School of Public Health and Health Systems
University of Waterloo

Alexander Crizzle, PhD
Assistant Professor
School of Public Health
University of Saskatchewan

John Garcia, PhD
Professor of Practice/Associate Director, Graduate Professional Programs
School of Public Health and Health Systems
University of Waterloo

Appendix F.2

Full study: Recruitment Email for PHU Professionals[11]

Dear [Insert PHU professional's name],

This is an invitation to participate in a study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario, under the supervision of Drs. Alexander Crizzle and John Garcia. The title of the research project is "Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls".

The purpose of this study is to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. The knowledge and information from this project is expected to identify community mobilization practices used by public health unit professionals, advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to your public health unit.

As a staff member in your public health unit who is currently working to working with community partners to prevent falls, your expert knowledge around fall prevention and work with community partners would make an invaluable contribution to this research and help to shape future research. Participation is voluntary and involves a 60-90 minute audio-recorded, telephone interview. Further details about the study purpose, participant eligibility criteria, time commitment, and other information about the study are outlined in the information letter attached. This study has been reviewed and received ethics clearance through a University of Waterloo Ethics Research Committee.

If you are interested and able to assist, could you please respond to this email by <insert date>?

Should you have any questions about the study, I can be reached by responding to this e-mail message <address>. You may also contact my supervisors, Dr. Alexander Crizzle at XXX-XXX-XXXX or by email <address> and Dr. John Garcia at XXX-XXX-XXXX ext. XXXXX or by email <address>. If you have questions for the Ethics Committee contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>.

I look forward to speaking with you and thank you in advance for your time and consideration.

Yours sincerely,

Taryn Sendzik, MSc

[11] Changes made after pilot study are denoted in grey.

PhD Candidate
School of Public Health and Health Systems
University of Waterloo

Alexander Crizzle, PhD
Assistant Professor
School of Public Health
University of Saskatchewan

John Garcia, PhD
Professor of Practice/Associate Director, Graduate Professional Programs
School of Public Health and Health Systems
University of Waterloo

Appendix F.3

Full study: Information-Consent Letter – Public Health Unit Professionals[12]

Title of the study: Mobilization Strategies and Practices Employed by Public Health Professionals in Ontario's Public Health Units to Prevent Falls

Faculty Supervisors:

Alexander Crizzle, PhD, School of Public Health and Health Systems, University of Waterloo, and School of Public Health, University of Saskatchewan. Phone: X-XXX-XXX-XXXX, Email: <address>

John Garcia, PhD, School of Public Health and Health Systems, University of Waterloo. Phone: X-XXX-XXX-XXXX ext. XXXXX, Email: <address>

Student Investigator:

Taryn Sendzik, MSc, School of Public Health and Health Systems, University of Waterloo. Email: <address>

To help you make an informed decision regarding your participation, this letter will explain what the study is about, the possible risks and benefits, and your rights as a research participant. If you do not understand something in the letter, please ask one of the investigators prior to consenting to the study. You will be provided with a copy of the information and consent form if you choose to participate in the study.

What is the study about?

You are invited to participate in a study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario about the mobilization strategies and practices employed by public health professional in Ontario's Public Health Units to prevent falls.

Over the past decade there has been increasing emphasis for Ontario's Public Health Units to work with community partners to address public health issues such as fall prevention. Many PHU professionals are already working with community partners. However, not much is known about what is currently being done, how well efforts are performing, and what guidance is needed or could be provided to public health professionals working in Ontario's PHUs to better

[12] Changes made after pilot study are denoted in grey.

mobilize with community partners to prevent falls. Research is needed to address these knowledge gaps.

The purpose of this study is to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. Your perspectives and knowledge would be valuable in informing how community mobilization is practiced. The knowledge and information gained from this research is expected to advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to Ontario's Public Health Units, community partners, communities, and those at risk for falls.

I. Your responsibilities as a participant

What does participation involve?

Participation in the study involves the completion of a telephone interview of approximately 60-90 minutes in length at a mutually agreed upon time. During the telephone interview you will be asked to describe your Public Health Unit (e.g., name, number of staff, injury prevention staff, budget, time), community (e.g., size, need to prevent falls, availability of materials to prevent falls), knowledge of community mobilization (e.g., what is it?), community partners (e.g., are you mobilizing with community partners to prevent falls, number, type, roles and responsibilities), community non-partners (e.g., are there partners you would like to work with in the future to prevent falls), community mobilization practices (e.g., what is being done, for what reasons, how has the process unfolded over time, how and when are partners involved), performance, benefits, and challenges of community mobilization, and your thoughts on capacity building and policy development by provincial and federal public health agencies.

In addition, you will be asked to assist with identifying three key community partners with knowledge of your work together to prevent falls, and two organizations/individuals with whom would like to work with in the future as part of your collaborative work to prevent falls in your community.

Who may participate in the study?

This study will involve:

- five public health professional working in public health units across Ontario who are tasked with working with community partners to prevent falls among community-dwelling adults (one at each of five different public health units);
- fifteen community partners (three in each public health unit service area);
- and ten organizations/individuals who are not currently working with the public health unit staff but are viewed as valuable future partners that would add value to fall prevention efforts because of the work they do that influences or has the potential to

influence the behavioural, environmental, social, or biological risk factors for falls (two in each public health unit service area).

II. Your rights as a participant

Is participation in the study voluntary?

Your participation in this study is voluntary. You may decide to leave the study at any time by communicating this to the researchers. Any information you provided up to that point will not be used. You may decline to answer any question(s) you prefer not to answer by requesting to skip the question. You can request your data be removed from the study up until August 2018 as it is not possible to withdraw decisions related to your data once the dissertation is presented.

Will I receive anything for participating in the study?

You will not receive payment for your participation in this study.

What are the possible benefits of the study?

Participation in this study may not provide any personal benefit to you. The study will, however, aid in shaping how my future research examining the community mobilization strategies and practices of Ontario's public health unit professionals working to prevent falls which is expected to advance knowledge and contribute to discussion surrounding theories, models, and guidelines for use by Ontario's public health unit professionals.

What are the risks associated with the study?

There are minimal risks associated with participation in this study. If a question or the discussion makes you uncomfortable, you can choose not to answer and may ask to skip or move on to the next question. Further, because referrals will be used to identify potential study participants, it may not be possible to guarantee anonymity. To help protect your identity, we would ask that you do not discuss the study with others.

Will my identity be known?

The research team will know what you said. You will be assigned a unique study number. The research team will not publish or discuss your name. Your decision to participate will not be disclosed to other participants in the study.

Will my information be kept confidential?

The information you share will be kept confidential. Identifying information will be removed from the transcripts, the audio recording, and electronic data. All transcripts, audio recordings,

and electronic data will be kept for a period of 7 years following publication of the findings from the larger scale study, after which they will be destroyed. Data will be stored in an encrypted folder on my password protected laptop and stored in a locked location. Only the research team will have access to the data. No identifying information will be used in my thesis or any presentations or publications based on this research.

III. Questions, comments, or concerns

Has the study received ethics clearance?

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE# XXXXX). If you have questions for the Committee, contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>.

Who should I contact if I have questions regarding my participation in the study?

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact Taryn Sendzik by email at <address>.

Taryn Sendzik, MSc
School of Public Health and Health Systems
University of Waterloo
<address>

Appendix F.4

Full study: Verbal Consent and Interview Guide Public Health Unit (PHU) Professional[13]

Introduction:

Hello. This is Taryn Sendzik, from the University of Waterloo' School of Public Health and Health Systems. As you know, I am a Doctoral candidate conducting a study to inform my research examining the community mobilization strategies and practices employed by public health professionals in Ontario's public health units to prevent falls.

Thank you for expressing interest in this study. Just to review, today you will be participating in an individual phone interview, which should take approximately 60-90 minutes to complete.

Your participation is voluntary. As a reminder, to help ensure your anonymity and confidentiality, I would ask that you do not discuss this study with anyone else. By taking part in this interview, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

Before proceeding further I would like you to answer the following questions related to your participation:

Have you read the information presented in the information letter? (Yes/No)

Do you have any questions related to the study? (Yes/No)

Have these questions been answered to your satisfaction? (Yes/No)

Do you agree to participate in this study knowing that your participation is voluntary and that you can withdraw your consent by informing the researcher? (Yes/No)

Do you give your permission to have this conversation recorded for the purposes of accuracy and data analysis? (Yes/No)

May I recontact you to clarify any of your answers or to ask for additional partners or future potential partners? (Yes/No)

Would you like a summary of the final study report following the defense of my dissertation? (Yes/No)

Do you have any other concerns?

[13] Changes made after pilot study are denoted in grey.

Thank you for your responses. Let's proceed with the study questions.

Section 1: **General information**.

1. Could you introduce yourself?
    a. What is your name?
    b. What PHU do you work for?
    c. What is your job title/role at the PHU?
    d. How long have you work in PH?
    e. How long have you been doing work to prevent falls?
    f. Have you received any formal training in community mobilization? [Probe: If yes, from who? What training was received?]

Section 2: **General PHU and community information.**

2. Can you tell me a little bit about the PHU you work for?
    a. What is the official name of your PHU?
    b. How many staff work in your PHU?
    c. How many staff are tasked with preventing falls?
    d. What is the budget for injury prevention?
        i. Is there a specific budget allocated for the prevention of falls?
    e. How much time (% person time, #hours per week) is devoted to fall prevention? (clarify if this is per person or for multiple people and whether it is for full or part-time staff).
        i. How does this compare to other injury prevention sectors?

3. Please tell me a little about the community whom you and your PHU serve?
    a. What are the geographic boundaries of your PHU?
    b. How large is the population you serve?
    c. Is there a need to prevent falls in your community? Is there a need to prevent falls among community-dwelling older adults? Does this need differ from the general population? Has your PHU assessed these needs?
    d. Does your PHU have different materials/strategies for preventing falls among community-dwelling older adults versus the general population?

Section 3: **Community partners.**

4. Part of what I am interested in is learning about the ways in which PHUs practice community mobilization to prevent falls and how this practice develops and unfolds over time.
    a. Have you ever heard of the term community mobilization? (Yes/No)
    b. How would you define community mobilization?

5. One of the definitions used by Ontario's Public Health Unit professionals to describe community mobilization is "*the use of capacity to bring about change by joining together the strengths of the community into an action plan. 'Community mobilization is based on the belief that when a community is mobilized to address and solve its own problems, more efficient and effective results will materialize than could be achieved by other means' (Hastings, 2001). The anticipated goal is for a safe and healthy community with 'buy in' from all community members*."
    a. What do you think of this definition?
    b. Does this definition describe your experiences working with your local PHU to prevent falls among community-dwelling adults? If no, how is it different?

6. Have you or are you currently mobilizing with community partners?
   Approximately how many partners does your community mobilization work involve?

7. As part of my research, I am interested in speaking with three of your community partners who are most knowledgeable about the work you have been doing together to prevent falls among community dwelling adult.
    a. Could you provide me with some information about the first partner:
        i. Official name
        ii. Organization type – Government, non-profit, volunteer/informal, charitable, private (for profit) organization, academic/research, advocacy, community, educational, consulting group, media, other?
        iii. Name of key contact
        iv. How long have you been partners?
        v. What is their role in the partnership?
    b. Could you provide me with some information about the second partner:
        i. Official name
        ii. Organization type – Government, non-profit, volunteer/informal, charitable, private (for profit) organization, academic/research, advocacy, community, educational, consulting group, media, other?
        iii. Name of key contact
        iv. How long have you been partners?
        v. What is their role in the partnership?
    c. Could you provide me with some information about the third partner:
        i. Official name
        ii. Organization type – Government, non-profit, volunteer/informal, charitable, private (for profit) organization, academic/research, advocacy, community, educational, consulting group, media, other?
        iii. Name of key contact
        iv. How long have you been partners?
        v. What is their role in the partnership?

Section 4: **Community non-partners.**

8. Are there any organizations/individuals you would like to collaborate with as part of your community mobilization efforts to prevent falls among community-dwelling adults in the near future?

   If yes, I am interested in speaking with two of the top individuals/organizations you are most interested in partnering with as part of your community mobilization to prevent falls among community dwelling adult.

   a. Could you provide me with some information about the first individual/organization:
      i. Organization name
      ii. Name of key contact (if known)
      iii. Why would you like to collaborate with this individual/organization
      iv. Is there anything stopping you from working with this organization/individual in your mobilization efforts? [Prompt for details]
   b. Could you provide me with some information about the second individual/organization:
      i. Organization name
      ii. Name of key contact (if known)
      iii. Why would you like to collaborate with this individual/organization
      iv. Is there anything stopping you from working with this organization/individual in your mobilization efforts? [Prompt for details]

Section 5: **Community mobilization practices.**

9. Mobilization can be used for various public health purposes such as programming, policy or media communications strategy development, and implementation and evaluation. Could you tell me about the **public health purpose** of your current mobilization efforts?

10. What mobilization efforts are you using? [Prompt: Programming, policy, media, implementation and evaluation]

11. Part of what I am interested in is learning about the ways in which PHUs practice community mobilization to prevent falls among community-dwelling adults and how this practice develops and unfolds over time. Thinking about your own community mobilization efforts, please describe the steps and activities you have employed and how this has progressed over time?
    a. Were you the one who initiated the mobilization of community partners?
    b. How was the problem identified? [Probe: by whom?]
    c. How was the need for a community mobilization strategy determined? [Probe: by whom?]
    d. How was it determined what steps you needed to take? Were any tools or resources used to help you get started? [e.g., use of existing community mobilization theory, framework, or guides?]

e. How was it determined who needed to be involved?
f. How did you/your PHU engage the different organizations and individuals to participate? What information was provided? [Prompt: Define problem, need, severity, potential for change]
g. Was there commonality in the partners' goals and values around the prevention of falls among community-dwelling adults?
h. How were you and your partners able to align differences in organizational goals and values around this issue in order to work together?
i. How did you and your partners organize themselves for community mobilization? Was anything put in place to manage the partnership, mobilization process and activities? Please describe with examples. [Prompt: Leadership; communication; roles, rights and responsibilities; decision making; resources; level of engagement – inform/share, consult, deliberate, collaborate, empower]
j. How would you describe the level of integration/nature of teamwork between the PHU and your partners? Communicative, Cooperative, coordinated, collaborative? Has this level of integration changed throughout the process?
k. How often do you/PHU professionals and community members talk as part of the partnership? Do you meet regularly? How is contact maintained?
l. Could you tell me about how and what activities the partnership decided to do? Which activities were carried out by/involved yourself or the PHU? [Probe: Conduct assessments of community needs? resources? capacity? opportunities? Partnership goals, strengths, and resources?]
m. What are the expected outcomes of the activities you and your partners have chosen?
n. How will the performance and impact of the various mobilization activities and partnership be assessed? Please describe with examples.
o. Has your community mobilization practices changed as a result of the community mobilization scoping review by the Locally Driven Collaboration Project Fall prevention Team? If yes, could you describe how?

Section 6: **Performance, benefits, and challenges of community mobilization strategies.**

12. Please tell me how your community mobilization strategies and practices have impacted fall prevention goals for your community partners? And target population?), and whether performance/evaluation data has been collected or is planned?
[Probe: Can you describe specific strategies that are performing well? Are other strategies performing less well and why? Is performance related to specific target groups? Have you had to change any strategies? Are you reaching your desired community partners? Community? Community-dwelling adults as expected? What data has been collected or is planned for collection? When was this data collected/ will data be collected? Has this data been analyzed or is there a plan for future analysis?]

13. What are some of the benefits and challenges to collaborating you have experienced mobilizing with community partners to prevent falls? [Prompts: leadership; trust; organization; communication; commitment/involvement; engagement; power; decision making; membership size or diversity; time and resources – e.g., funding, skills; framing of problem and objectives by partners; conflict between partners; differences in partners organizational goals, vision, strategy; social support; political support]
    a. Regarding the challenges you described, do you think there were any actions or steps that were missed or that you would do differently? Could you describe with an example?

<u>Section 7</u>: Capacity building policy development by provincial and federal public health ministries and agencies.

14. How do you see your role with the merger of the PHUs with the LHINs? Have you received any information on what the LHINs are doing? Have you received any information on how the work you do integrate into the LHIN network (related to fall prevention)? [Probe: Will there be a shift in fall prevention practices? Will you get access to different partners? Will you have reduced time with the merger to focus on fall prevention?]

<u>CLOSING QUESTIONS</u>: **Additional feedback.**

15. Do you have any additional thoughts or experiences about community mobilization to prevent falls among community-dwelling adults you would like to add?

16. Are there any additional comments about what you've said or about this study that you would like to add?

Appendix F.5

Full study: Feedback Letter[14]

Dear [participant name],

I would like to thank you for your participation in this study entitled "Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls".

As a reminder, the purpose of this study is to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. The knowledge and information from this pilot project is expected to advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to you and your public health unit.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE#XXXXX). Please remember that any data pertaining to you as an individual participant will be kept confidential. If you have questions for the Committee contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>. For all other questions contact Taryn Sendzik by email <address>. You may also contact my supervisors, Dr. Alexander Crizzle at XXX-XXX-XXXX or by email <address> and Dr. John Garcia at XXX-XXX-XXXX ext. XXXXX or by email <address>.

If you are interested in receiving more information regarding the results of this study, or would like a summary of the results of the larger scale study, please provide your email address, and when the study is completed, anticipated by December 2018, I will send you the information. In the meantime, if you have any questions about the study, please do not hesitate to contact me by email or telephone as noted below.

Taryn Sendzik
University of Waterloo
School of Public Health and Health Systems
<address>

[14] Changes made after pilot study are denoted in grey.

Appendix F.6

Full study: Phone Recruitment Script – Community Partners[15]

Hello [potential participant's name], my name is Taryn Sendzik and I am a PhD student at the University of Waterloo' School of Public Health and Health Systems working under the supervision of John Garcia and Alexander Crizzle.

The reason I am calling is that we are currently seeking volunteers for a study examining the community mobilization strategies and practices employed by public health professionals in Ontario's public health units to prevent falls. I am contacting you because of you have been identified as a key person whose work as part of (insert name of organization) is contributing to the prevention falls in (insert name of community and as someone who is working to prevent falls with the local Public Health Unit. I am wondering if you would be interested in hearing more about the study?

[IF NO] Thank you for your time. Good-bye.
[IF YES] Continue.
Participation in this study involves completing a one-on-one telephone interview about your work preventing falls and knowledge you have about the local Public Health Unit's – (insert name of Public Health Unit), work to prevent falls. Participation would take approximately 60 minutes at a mutually agreed upon time. In appreciation for your time, you will receive a feedback letter thanking you for your help. You will not receive any form of payment. The study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee.

However, the final decision about participation is yours.

May I send you an e-mail containing more detailed information about the study?

> [IF NO] Thank you for your time. Good-bye.
>
> [IF YES] Thank you. We appreciate your interest in this research. (Ask for e-mail address). I will send the email shortly and will call again in a couple of days to ensure you received the information. If you have any questions, you can contact me by e-mail <address> Thank you very much for helping us with our research. I look forward to hearing from you.

Follow-up phone script:

[15] Changes made after pilot study are denoted in grey.

Hi [potential participant]. This is Taryn Sendzik from the University of Waterloo. I am calling to confirm that you received the study information I sent you [insert date].

> [IF NO] May I confirm your e-mail address again so that you have the information in your files and have an opportunity to consider any questions you have and your participation? (Confirm e-mail address)
>
> [IF YES] Great. Have you had an opportunity to review the information? Or do you have any questions for me that you'd like to ask before responding to my email? (answer any questions)

Thank you again for your time. I look forward to hearing from you shortly. Good-bye.

Appendix F.7

Full study: Recruitment Email for Community Partners[16]

Dear [Insert Community Partner's name],

This is an invitation to participate in a study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario, under the supervision of Drs. Alexander Crizzle and John Garcia. The title of the research project is "Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls".

The purpose of this study is to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. The knowledge and information from this project is expected to identify community mobilization practices used by public health unit professionals, advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to you and your public health unit.

As someone who is currently working with (insert name of organization) to prevent falls in your (insert name of community), your expert knowledge around fall prevention and work with (insert name of public health unit) would make an invaluable contribution to this research and help to shape future research. Participation is voluntary and involves a 60 minute audio-recorded, telephone interview. Further details about the study purpose, participant eligibility criteria, time commitment, and other information about the study are outlined in the information letter attached. This study has been reviewed and received ethics clearance through a University of Waterloo Ethics Research Committee.

If you are interested and able to assist, could you please respond to this email by <insert date>?

Should you have any questions about the study, I can be reached by responding to this e-mail message <address>. You may also contact my supervisors, Dr. Alexander Crizzle at XXX-XXX-XXXX or by email <address> and Dr. John Garcia at XXX-XXX-XXXX ext. XXXXX or by email <address>. If you have questions for the Ethics Committee contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>.

I look forward to speaking with you and thank you in advance for your time and consideration.

Yours sincerely,

Taryn Sendzik, MSc
PhD Candidate

[16] Changes made after pilot study are denoted in grey.

School of Public Health and Health Systems
University of Waterloo

Alexander Crizzle, PhD
Assistant Professor
School of Public Health
University of Saskatchewan

John Garcia, PhD
Professor of Practice/Associate Director, Graduate Professional Programs
School of Public Health and Health Systems
University of Waterloo

Appendix F.8

Full study: Information-Consent Letter – Community Partners[17]

Title of the study: Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls

Faculty Supervisors:
Alexander Crizzle, PhD, School of Public Health and Health Systems, University of Waterloo, and School of Public Health, University of Saskatchewan. Phone: X-XXX-XXX-XXXX, Email: <address>
John Garcia, PhD, School of Public Health and Health Systems, University of Waterloo. Phone: 1-XXX-XXX-XXXX ext. XXXXX, Email: <address>
Student Investigator:
Taryn Sendzik, MSc, School of Public Health and Health Systems, University of Waterloo. Email: <address>

To help you make an informed decision regarding your participation, this letter will explain what the study is about, the possible risks and benefits, and your rights as a research participant. If you do not understand something in the letter, please ask one of the investigators prior to consenting to the study. You will be provided with a copy of the information and consent form if you choose to participate in the study.

What is the study about?

You are invited to participate in a study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario about the mobilization strategies and practices employed by public health professional in Ontario's Public Health Units to prevent falls.

Over the past decade there has been increasing emphasis for Ontario's Public Health Units to work with community partners to address public health issues such as fall prevention. Many PHU professionals are already working with community partners. However, not much is known about what is currently being done, how well efforts are performing, and what guidance is needed or could be provided to public health professionals working in Ontario's PHUs to better mobilize with community partners to prevent falls. Research is needed to address these knowledge gaps.

The purpose of this study is to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. Your perspectives and knowledge would be valuable in informing how community mobilization is practiced. The knowledge and information gained

[17] Changes made after pilot study are denoted in grey.

from this research is expected to advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to Ontario's Public Health Units, community partners, communities, and those at risk for falls.

I. Your responsibilities as a participant

What does participation involve?

Participation in the study involves the completion of a telephone interview of approximately 60 minutes in length at a mutually agreed upon time. During the telephone interview you will be asked to describe yourself (e.g., name, job title, type of work/service you provide to prevent falls, time allocated to fall prevention), work with the public health unit (e.g., what public health unit, how long you've been working together), organization/individuals in your community that you would like to work with to prevent falls (e.g., names), knowledge of community mobilization (e.g., what is it?), knowledge of community mobilization practices being done by your local public health unit professional (e.g., what is being done, for what reasons, how has the process unfolded over time, how and when are partners involved), and the performance, benefits, and challenges of community mobilization with the public health unit and other community partners to prevent falls.

Who may participate in the study?

This study will involve:

- five public health professional working in public health units across Ontario who are tasked with working with community partners to prevent falls among community-dwelling adults (one at each of five different public health units);
- fifteen community partners (three in each public health unit service area);
- and ten organizations/individuals who are not currently working with the public health unit staff but are viewed as valuable future partners that would add value to fall prevention efforts because of the work they do that influences or has the potential to influence the behavioural, environmental, social, or biological risk factors for falls (two in each public health unit service area).

II. Your rights as a participant

Is participation in the study voluntary?

Your participation in this study is voluntary. You may decide to leave the study at any time by communicating this to the researchers. Any information you provided up to that point will not be used. You may decline to answer any question(s) you prefer not to answer by requesting to skip the question. You can request your data be removed from the study up until August 2018 as it is not possible to withdraw decisions related to your data once the dissertation is presented.

Will I receive anything for participating in the study?

You will not receive payment for your participation in this study.

What are the possible benefits of the study?

Participation in this study may not provide any personal benefit to you. The study will, however, aid in shaping how my future research examining the community mobilization strategies and practices of Ontario's public health unit professionals working to prevent falls which is expected to advance knowledge and contribute to discussion surrounding theories, models, and guidelines for use by Ontario's public health unit professionals.

What are the risks associated with the study?

There are minimal risks associated with participation in this study. If a question or the discussion makes you uncomfortable, you can choose not to answer and may ask to skip or move on to the next question. Further, because referrals will be used to identify potential study participants, it may not be possible to guarantee anonymity. To help protect your identity, we would ask that you do not discuss the study with others.

Will my identity be known?

The research team will know what you said. You will be assigned a unique study number. The research team will not publish or discuss your name. Your decision to participate will not be disclosed to other participants in the study.

Will my information be kept confidential?

The information you share will be kept confidential. Identifying information will be removed from the transcripts, the audio recording, and electronic data. All transcripts, audio recordings, and electronic data will be kept for a period of 7 years following publication of the findings from the larger scale study, after which they will be destroyed. Data will be stored in an encrypted folder on my password protected laptop and stored in a locked location. Only the research team will have access to the data. No identifying information will be used in my thesis or any presentations or publications based on this research.

III. Questions, comments, or concerns

Has the study received ethics clearance?

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE# XXXXX). If you have questions for the Committee, contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>.

Who should I contact if I have questions regarding my participation in the study?

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact Taryn Sendzik by email at <address>.

Taryn Sendzik, MSc
School of Public Health and Health Systems
University of Waterloo
<address>

Appendix F.9

Full study: Interview Guide Community Partners[18]

Introduction:

Hello. This is Taryn Sendzik, from the University of Waterloo' School of Public Health and Health Systems. As you know, I am a Doctoral candidate conducting a study to inform my research examining the community mobilization strategies and practices employed by public health professionals in Ontario's public health units to prevent falls.

Thank you for expressing interest in this study. Just to review, today you will be participating in an individual phone interview, which should take approximately 60 minutes to complete. Your participation is voluntary. As a reminder, to help ensure your anonymity and confidentiality, I would ask that you do not discuss this study with anyone else. By taking part in this interview, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

Before proceeding further I would like you to answer the following questions related to your participation:

Have you read the information presented in the information letter? (Yes/No)
Do you have any questions related to the study? (Yes/No)
Have these questions been answered to your satisfaction? (Yes/No)
Do you agree to participate in this study knowing that your participation is voluntary and that you can withdraw your consent by informing the researcher? (Yes/No)
Do you give your permission to have this conversation recorded for the purposes of accuracy and data analysis? (Yes/No)
Would you like a summary of the final study report following the defense of my dissertation? (Yes/No)
Do you have any other concerns?

Thank you for your responses. Let's proceed with the study questions.

Section 1: Community partners.

1. Could you introduce yourself?
   a. What is the official name of the organization you work for?
   b. What is your job title/position in the organization?
   c. Do you work in a particular department or unit in the organization?
   d. How long have you worked for the organization? (years/months)

2. I'd like to know more about you/your organization's work.

[18] Changes made after pilot study are denoted in grey.

a. How would you classify yourself/your organization? – Government, non-profit, volunteer/informal, charitable, private (for profit) organization, academic/research, advocacy, industry, employer, community, educational, consulting group, media, other?
b. Could you please briefly describe you/your organization's primary service(s)?
c. What services do you/your organization provide to prevent falls? [Probe: How much focus do you have on seniors? Do you offer a single program for everyone or are there separate programs for different groups of people (e.g., children, seniors, community-dwelling individuals, institutional)?]
d. How long have you/your organization been working on preventing falls? How long have you/your organization been working on preventing falls among community-dwelling older adults?
e. Do you work with others in your organization to prevent falls? (Yes or No)?
   If yes:
   i. What is the total number of people?
   ii. How many people working on preventing falls among community-dwelling older adults?
f. How much time (#hours per week, % person time) do you/your organization devote to fall prevention? (clarify if this is per person or for multiple people and whether it is for full or part-time staff).
g. Could you identify and describe specific activities that you (and those you work with) do to prevent falls?

3. Could you tell me a little about your work with the PHU to prevent falls among community-dwelling adults?
   a. How long have you been working with the PHU to prevent falls?
   b. What activities have you partnered to do?
   c. Approximately how many other organizations or individuals have you partnered with?

Section 2: **Community non-partners.**

4. In your work with the PHU to prevent falls s, are there any organizations/individuals you would like to collaborate with in the near future?
   a. If yes, who are the top five organizations/individuals you would like to partner with and why would you like to collaborate with them?

Section3: **Community mobilization practices.**

5. Part of what I am interested in is learning about the ways in which PHUs practice community mobilization to prevent falls and how this practice develops and unfolds over time.
   a. Have you ever heard of the term community mobilization? (Yes/No)
   b. How would you define community mobilization?

6. One of the definitions used by Ontario's Public Health Unit professionals to describe community mobilization is "*the use of capacity to bring about change by joining together the strengths of the community into an action plan. 'Community mobilization is based on the belief that when a community is mobilized to address and solve its own problems, more efficient and effective results will materialize than could be achieved by other means' (Hastings, 2001). The anticipated goal is for a safe and healthy community with 'buy in' from all community members*."
    a. What do you think of this definition?
    b. Does this definition describe your experiences working with your local PHU to prevent falls? If no, how is it different?

7. Thinking about the community mobilization efforts between your local PHU and partners to prevent falls (such as: insert suggested activities from question 3b and PHU professional), please describe the steps and activities you have been involved in and how this has progressed over time?
   Prompt:
    a. How did you become involved? Who reached out to you? What information were you given? [Prompt: Defined problem, need, severity, potential for change, commitment]
    b. Are you aware of what work the PHU professional had done leading up to your partnership in order to prepare for mobilizing with community partners?
        i. Did your local PHU professional identify problem and if yes, how?
        ii. How did your local PHU professional determine need for a community mobilization strategy?
        iii. How did your local PHU professional determine what steps needed to be taken to mobilize? Did they use any tools or resources to help get started? [e.g., use of existing community mobilization theory, framework, or guides?]
        iv. How did your local PHU professional determine who needed to be involved?
    c. Could you tell me about how your local PHU professional engaged different organizations and individuals to participate in mobilization? [Prompt: Define problem, need, severity, potential for change]
    d. Was there commonality in the partners' goals and values around the prevention of falls among community-dwelling older adults?
    e. How were you and your partners able to align differences in organizational goals and values around this issue in order to work together? What role did the local PHU/PHU professional take during this process?
    f. How did you and your partners organize themselves for community mobilization? Was anything put in place to manage the partnership, mobilization process and activities? Please describe with examples. [Prompt: Leadership; communication; roles, rights and responsibilities; decision making; resources;

level of engagement – inform/share, consult, deliberate, collaborate, empower] What role did the local PHU/PHU professional take during this process?

g. How would you describe the level of nature of teamwork/integration between the PHU and your organization? With your other partners? Communicative, Cooperative, coordinated, collaborative? Has this level changed throughout the process?
h. Could you tell me about how and what activities the partnership including the PHU decided to do? Which activities were carried out by/ involved the PHU? [Probe: Conduct assessments of community needs? resources? capacity? opportunities? Partnership goals, strengths, and resources?]
i. How often do you talk as part of the partnership? Do your meet regularly? How is contact maintained?
j. What are the expected outcomes of the activities you and your partners have chosen?
k. How will the performance and impact of the various mobilization activities and partnership be assessed? Please describe with examples.

Section 4: **Performance, benefits, and challenges of community mobilization strategies.**

8. Please tell me about how the community mobilization strategies and practices impact fall prevention goals for yourself/organization? And target population? And whether performance/evaluation data has been collected or is planned? [Probe: Can you describe specific strategies that are performing well? Are other strategies performing less well and why? Is performance related to specific target groups? Have you had to change any strategies? Are you reaching your desired community partners? Community? Community-dwelling older adults as expected? What data has been collected or is planned? When was this data collected/ will data be collected? Has this data been analysed or is there a plan for future analysis?]

9. What are some of the benefits and challenges to collaborating you have experienced mobilizing with the PHU and other community partners to prevent falls? [Prompts: leadership; trust; organization; communication; commitment/involvement; engagement; power; decision making; membership size or diversity; time and resources – e.g., funding, skills; framing of problem and objectives by partners; conflict between partners; differences in partners organizational goals, vision, strategy; social support; political support?]

CLOSING QUESTIONS: **Additional feedback.**

10. Do you have any additional thoughts or experiences about community mobilization to prevent falls you would like to add?

11. Are there any additional comments about what you've said or about this study that you would like to add?

Appendix F.10

Full study: Phone Recruitment Script – Public Health Unit Future Potential Partners[19]

Hello [potential participant's name], my name is Taryn Sendzik and I am a PhD student at the University of Waterloo' School of Public Health and Health Systems working under the supervision of John Garcia and Alexander Crizzle.

The reason I am calling is that we are currently seeking volunteers for a study examining the community mobilization strategies and practices employed by public health professionals in Ontario's public health units to prevent falls. I am contacting you because of you have been identified as a key person whose work as part of (insert name of organization) may contribute to the prevention falls in (insert name of community. I am wondering if you would be interested in hearing more about the study?

> [IF NO] Thank you for your time. Good-bye.
>
> [IF YES] Continue.

Participation in this study involves completing a one-on-one telephone interview about your work, interest in preventing falls and knowledge you have about the local Public Health Unit's – (insert name of Public Health Unit), work to prevent falls. Participation would take approximately 20-30 minutes at a mutually agreed upon time. In appreciation for your time, you will receive a feedback letter thanking you for your help. You will not receive any form of payment. The study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee.

However, the final decision about participation is yours.

May I send you an e-mail containing more detailed information about the study?

> [IF NO] Thank you for your time. Good-bye.
>
> [IF YES] Thank you. We appreciate your interest in this research. (Ask for e-mail address). I will send the email shortly and will call again in a couple of days to ensure you received the information. If you have any questions, you can contact me by e-mail <address> Thank you very much for helping us with our research. I look forward to hearing with you.

Follow-up phone script:

[19] Changes made after pilot study are denoted in grey.

Hi [potential participant]. This is Taryn Sendzik from the University of Waterloo. I am calling to confirm that you received the study information I sent you [insert date].

> [IF NO] May I confirm your e-mail address again so that you have the information in your files and have an opportunity to consider any questions you have and your participation? (Confirm e-mail address)
>
> [IF YES] Great. Have you had an opportunity to review the information? Or do you have any questions for me that you'd like to ask before responding to my email? (answer any questions)
>
> Thank you again for your time. I look forward to hearing from you shortly. Good-bye.

Appendix F.11

Full study: Recruitment Email for Future Potential Partners[20]

Dear [Insert Community Partner's name],

This is an invitation to participate in a study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario, under the supervision of Drs. Alexander Crizzle and John Garcia. The title of the research project is "Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls: A Study".

The purpose of this study is to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. The knowledge and information from this project is expected to identify community mobilization practices used by public health unit professionals, advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to you and your public health unit.

The causes of falls are complex but research shows that falls can be prevented in many different ways by addressing social, behavioural, environmental, and biological risk factors. As someone whose work with (insert name of organization) is valued as having the potential to prevent falls in your community (insert the name of community), your expert knowledge around the community, your organization's work, and any knowledge you have of fall prevention and the work being done by (insert name of public health unit) would make an invaluable contribution to this research and help to shape future research. Participation is voluntary and involves a 20-30 minute audio-recorded, telephone interview. Further details about the study purpose, participant eligibility criteria, time commitment, and other information about the study are outlined in the information letter attached. This study has been reviewed and received ethics clearance through a University of Waterloo Ethics Research Committee.

If you are interested and able to assist, could you please respond to this email by <insert date>?

Should you have any questions about the study, I can be reached by responding to this e-mail message <address>. You may also contact my supervisors, Dr. Alexander Crizzle at XXX-XXX-XXXX or by email <address> and Dr. John Garcia at XXX-XXX-XXXX ext. XXXXX or by email <address>. If you have questions for the Ethics Committee contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>.

I look forward to speaking with you and thank you in advance for your time and consideration.

[20] Changes made after pilot study are denoted in grey.

Yours sincerely,

Taryn Sendzik, MSc
PhD Candidate
School of Public Health and Health Systems
University of Waterloo

Alexander Crizzle, PhD
Assistant Professor
School of Public Health
University of Saskatchewan

John Garcia, PhD
Professor of Practice/Associate Director, Graduate Professional Programs
School of Public Health and Health Systems
University of Waterloo

Appendix F.12

Full study: Information-Consent Letter – Public Health Unit Future Potential Partners[21]

Title of the study: Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls

Faculty Supervisors:

Alexander Crizzle, PhD, School of Public Health and Health Systems, University of Waterloo, and School of Public Health, University of Saskatchewan. Phone: 1-XXX-XXX-XXXX, Email: <address>

John Garcia, PhD, School of Public Health and Health Systems, University of Waterloo. Phone: 1-XXX-XXX-XXXX ext. XXXXX, Email: <address>

Student Investigator:

Taryn Sendzik, MSc, School of Public Health and Health Systems, University of Waterloo. Email: <address>

To help you make an informed decision regarding your participation, this letter will explain what the study is about, the possible risks and benefits, and your rights as a research participant. If you do not understand something in the letter, please ask one of the investigators prior to consenting to the study. You will be provided with a copy of the information and consent form if you choose to participate in the study.

What is the study about?

You are invited to participate in a study I am conducting as part of my Doctoral degree in the School of Public Health and Health Systems at the University of Waterloo, Ontario about the mobilization strategies and practices employed by public health professional in Ontario's Public Health Units to prevent falls.

Over the past decade there has been increasing emphasis for Ontario's Public Health Units to work with community partners to address public health issues such as fall prevention. Many PHU professionals are already working with community partners. However, not much is known about what is currently being done, how well efforts are performing, and what guidance is needed or could be provided to public health professionals working in Ontario's PHUs to better

[21] Changes made after pilot study are denoted in grey.

mobilize with community partners to prevent falls. Research is needed to address these knowledge gaps.

The purpose of this study is to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls. Your perspectives and knowledge would be valuable in informing how community mobilization is practiced. The knowledge and information gained from this research is expected to advance knowledge around, provide evidence of, and enable community mobilization practices and future research, which may be of benefit to Ontario's Public Health Units, community partners, communities, and those at risk for falls.

I. Your responsibilities as a participant

What does participation involve?

Participation in the study involves the completion of a telephone interview of approximately 20-30 minutes in length at a mutually agreed upon time. During the telephone interview you will be asked to describe yourself (e.g., name, job title, type of work/service you provide to prevent falls, time allocated to fall prevention), work with other community organizations and your local public health unit (e.g., interest in preventing falls, interest in working with public health unit, who are you working with, who would you like to work with, knowledge of community mobilization (e.g., what is it?), knowledge of fall prevention work being done by your local public health unit professional (e.g., awareness, what is being done, impact).

Who may participate in the study?

This study will involve:

- five public health professional working in public health units across Ontario who are tasked with working with community partners to prevent falls among community-dwelling adults (one at each of five different public health units);
- fifteen community partners (three in each public health unit service area);
- and ten organizations/individuals who are not currently working with the public health unit staff but are viewed as valuable future partners that would add value to fall prevention efforts because of the work they do that influences or has the potential to influence the behavioural, environmental, social, or biological risk factors for falls (two in each public health unit service area).

II. Your rights as a participant

Is participation in the study voluntary?

Your participation in this study is voluntary. You may decide to leave the study at any time by communicating this to the researchers. Any information you provided up to that point will not be used. You may decline to answer any question(s) you prefer not to answer by requesting to skip the question. You can request your data be removed from the study up until August 2018 as it is not possible to withdraw decisions related to your data once the dissertation is presented.

Will I receive anything for participating in the study?

You will not receive payment for your participation in this study.

What are the possible benefits of the study?

Participation in this study may not provide any personal benefit to you. The study will, however, aid in shaping how my future research examining the community mobilization strategies and practices of Ontario's public health unit professionals working to prevent falls which is expected to advance knowledge and contribute to discussion surrounding theories, models, and guidelines for use by Ontario's public health unit professionals.

What are the risks associated with the study?

There are minimal risks associated with participation in this study. If a question or the discussion makes you uncomfortable, you can choose not to answer and may ask to skip or move on to the next question. Further, because referrals will be used to identify potential study participants, it may not be possible to guarantee anonymity. To help protect your identity, we would ask that you do not discuss the study with others.

Will my identity be known?

The research team will know what you said. You will be assigned a unique study number. The research team will not publish or discuss your name. Your decision to participate will not be disclosed to other participants in the study.

Will my information be kept confidential?

The information you share will be kept confidential. Identifying information will be removed from the transcripts, the audio recording, and electronic data. All transcripts, audio recordings, and electronic data will be kept for a period of 7 years following publication of the findings from the larger scale study, after which they will be destroyed. Data will be stored in an encrypted folder on my password protected laptop and stored in a locked location. Only the research team will have access to the data. No identifying information will be used in my thesis or any presentations or publications based on this research.

III. Questions, comments, or concerns

Has the study received ethics clearance?

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Committee (ORE# XXXXX). If you have questions for the Committee, contact the Chief Ethics Officer, Office of Research Ethics, at X-XXX-XXX-XXXX ext. XXXXX or <address>.

Who should I contact if I have questions regarding my participation in the study?

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact Taryn Sendzik by email at <address>.

Taryn Sendzik, MSc
School of Public Health and Health Systems
University of Waterloo
<address>

Appendix F.13

Full study: Future Potential Community Partner Questions[22]

Introduction:

Hello. This is Taryn Sendzik, from the University of Waterloo' School of Public Health and Health Systems. As you know, I am a Doctoral candidate conducting a study to inform my research examining the community mobilization strategies and practices employed by public health professionals in Ontario's public health units to prevent falls.

Thank you for expressing interest in this study. Just to review, today you will be participating in an individual phone interview, which should take approximately 20-30 minutes to complete. Your participation is voluntary. As a reminder, to help ensure your anonymity and confidentiality, I would ask that you do not discuss this study with anyone else. By taking part in this interview, you are not waiving your legal rights or releasing the investigator(s) or involved institution(s) from their legal and professional responsibilities.

Before proceeding further I would like you to answer the following questions related to your participation:

Have you read the information presented in the information letter? (Yes/No)

Do you have any questions related to the study? (Yes/No)

Have these questions been answered to your satisfaction? (Yes/No)

Do you agree to participate in this study knowing that your participation is voluntary and that you can withdraw your consent by informing the researcher? (Yes/No)

Do you give your permission to have this conversation recorded for the purposes of accuracy and data analysis? (Yes/No)

Would you like a summary of the final study report following the defense of my dissertation? (Yes/No)

Do you have any other concerns?

Thank you for your responses. Let's proceed with the study questions.

Section 1: **Future potential community partners.**

[22] Changes made after pilot study are denoted in grey.

1. Could you introduce yourself?
    a. What is the official name of the organization you work for?
    b. What is your job title/position in the organization?
    c. Do you work in a particular department or unit in the organization?
    d. How long have you worked for the organization? (years/months)

2. I'd like to know more about you/your organization's work.
    a. How would you classify yourself/your organization? – Government, non-profit, volunteer/informal, charitable, private (for profit) organization, academic/research, advocacy, industry, employer, community, educational, consulting group, media, other?
    b. Could you please briefly describe you/your organization's primary service(s)?

3. These next few questions are about you/your organization's interest and work in fall prevention.
    a. Does your organization currently provide services to prevent falls?
        If yes:
            i. What services do you/your organization provide to prevent falls? [Probe: How much focus do you have on seniors? Do you offer a single program for everyone or are there separate programs for different groups of people (e.g., children, seniors, community-dwelling individuals, institutional)?]
            ii. How long have you/your organization been working on preventing falls? How long have you/your organization been working on preventing falls among community-dwelling older adults?
            iii. How many people in your organization are doing work to prevent falls?
            iv. How much time (#hours per week, % person time) is devoted to fall prevention? (clarify if this is per person or for multiple people and whether it is for full or part-time staff).
            v. Could you identify and describe specific activities that you (and those you work with) do to prevent falls?

        If no:
            i. Does your organization have an interest in working to prevent falls? (Probe: specific goals or activities)

4. To prevent falls among community-dwelling adults, are there any organizations/individuals you would like to collaborate with in the near future?
    a. If yes, who are the top five organizations/individuals you would like to partner with and why would you like to collaborate with them?

5. Have you ever considered partnering with your local PHU to prevent falls among community-dwelling older adults? (Yes/No)

If yes:

a. Could you tell me why you are considering partnering with the PHU?

If no:

b. Could you tell why you have not considered partnering?

c. Have you been in contact with anyone from a PHU about partnering to prevent falls? (Yes/No)

Section 2: **Community mobilization practices.**

6. Part of what I am interested in is learning about the ways in which PHUs practice community mobilization to prevent falls and how this practice develops and unfolds over time.
   a. Have you ever heard of the term community mobilization? (Yes/No)
   b. If yes, how would you define community mobilization?

7. One of the definitions used by Ontario's Public Health Unit professionals to describe community mobilization is "*the use of capacity to bring about change by joining together the strengths of the community into an action plan. 'Community mobilization is based on the belief that when a community is mobilized to address and solve its own problems, more efficient and effective results will materialize than could be achieved by other means' (Hastings, 2001). The anticipated goal is for a safe and healthy community with 'buy in' from all community members*."
   a. What do you think of this definition?

8. Are you aware of any of the fall prevention work being done by your local PHU with other partners and individuals in your community?
   a. If yes, could you tell me what you know or are aware of (e.g., what is being done? who is involved? any impact the work is having)?

CLOSING QUESTIONS: **Additional feedback.**

9. Do you have any additional thoughts or experiences about community mobilization work being performed by your local PHU to prevent falls among community-dwelling adults you would like to add?

10. Are there any additional comments about what you've said or about this study that you would like to add?

Appendix G: Member Check Materials

Appendix G.1

Participant Re-contact Email for Member Check

Title: Reply requested: Follow-up to a doctoral research project on community mobilization practices used to prevent falls

Dear [insert name of participant]:

I hope this message finds you well. Approximately a year ago you took part in a research project entitled "Mobilization Strategies and Practices Employed by Public Health Professional in Ontario's Public Health Units to Prevent Falls." The research was being conducted by Taryn Sendzik at the University of Waterloo's School of Public Health and Health Systems under the supervision of Drs. Alexander Crizzle and John Garcia. The purpose of the study was to describe the mobilization strategies and practices employed by public health professional in Ontario's public health units who are working with their community partners to prevent falls.

Thank you again for your help with my dissertation research. I am writing to let you know we are in the final stages of writing and presenting the findings from the dissertation. To better illustrate and ensure the accuracy of the key ideas and findings about how community mobilization to prevent falls is understood, practiced, and experienced we would like to ask interviewed participants:

- permission to include de-identified quotes in the study findings; and to
- review and provide feedback on a summary of preliminary findings.

Participation in the final stage of this study involves reviewing the list of quotes and summary findings to verify that you approve of the content. The list of quotes contains excerpts from your interview that would be described in a de-identified way (e.g., PHU professional #, Community partner #, Future potential partner #). This review is voluntary and should take approximately 10 to 30 minutes of your time.

As a suggestion, you may wish to skim over the summary of the findings, followed by the summary listing of quotes. This may help place your comments in context of the findings, recall what was discussed, and determine if your responses and experiences are accurately presented. At the end of your review, we would ask that you complete the "Permission for Quotes form" and brief six question feedback form attached and return it by **Wednesday, October 30th**.

If you have any questions, comments, concerns, or would like more detail about how your quotes will be used, please feel free to contact me by email (email address). You may also contact my supervisors, Dr. Alexander Crizzle at (phone number) or by email (email address) and Dr. John Garcia at (phone number) or by email (email address). If you have questions for the Ethics Committee, contact the Chief Ethics Officer at (phone number) or (email address).

As a reminder:

- This study has been reviewed and received ethics clearance through a University of Waterloo Ethics Research Committee (ORE number, formerly ORE number);
- Participation is voluntary. You may decide to leave the study at any time by communicating this to the researchers or not responding to this request. Any information you provided up to that point will not be used. You can request your data be removed from the study up until the end of October 2019 as it is not possible to withdraw decisions related to your data once the dissertation is presented;
- You will not receive payment for this study, however, a copy of the final dissertation will be sent to you once finalized (January 2020);
- There are minimal risks associated with participation in this study. If a question or the discussion makes you uncomfortable, you can choose not to answer and may ask to skip or move on to the next question;
- Your identity will be kept confidential. Identifying information will be removed from the transcripts, the audio recording, and electronic data. All transcripts, audio recordings, and electronic data will be kept for a period of 7 years following publication of the findings from the larger scale study, after which they will be destroyed. Data will be stored in an encrypted folder on my password protected laptop and stored in a locked location. Only the research team will have access to the data. No identifying information will be used in my thesis or any presentations or publications based on this research;
- Please note, when information is transmitted over the internet privacy cannot be guaranteed. There is always a risk your responses may be intercepted by a third party (e.g., government agencies, hackers). University of Waterloo researchers will not collect or use internet protocol (IP) addresses or other information which could link your participation to your computer or electronic device without first informing you.

Thank you again for your time and assistance. Your input is important and valued.

Best regards,

Taryn Sendzik, MSc
PhD Candidate

School of Public Health and Health Systems
University of Waterloo

Alexander Crizzle, PhD
Assistant Professor
School of Public Health
University of Saskatchewan

John Garcia, PhD
Professor of Practice/Associate Director, Graduate Professional Programs
School of Public Health and Health Systems
University of Waterloo

Appendix G.2

Member Check Summary of Preliminary Findings and Feedback Questions

Mobilization Strategies and Practices Employed by Public Health Professionals in Ontario's Public Health Units to Prevent Falls among Community-dwelling Older Adults

Instructions:
This is a preliminary summary of the research findings based on analysis of all the interviews. We would appreciate your careful review of each finding. As you review each of the findings we would like for you to think about whether the results accurately reflect your interview responses and experiences. After reviewing the summary of preliminary study findings, please complete the comment form on page 24 and return to Taryn Sendzik by email **tsendzik@uwaterloo.ca** by Wednesday, October 30th. Thank you again for your time, knowledge, and assistance.

Background

Over the past decade there has been increasing emphasis for Ontario's Public Health Units (PHU) to work with community partners to address public health issues such as falls prevention. Many PHU professionals are already working with community partners. However, not much is known about what is currently being done, how well efforts are performing, and what guidance is needed or could be provided to public health professionals working in Ontario's PHUs to better mobilize with community partners to prevent falls. Research is needed to address these knowledge gaps.

Research Question

This project aimed to answer the question: "How are public health professionals in Ontario's PHUs mobilizing with their community partners to prevent falls among community-dwelling older adults (65 years of age and older)?"

Objectives

1. To identify and describe the Ontario PHU professionals engaging in community partner mobilization;
2. To identify and describe the context in which the PHU professional(s) are working within and the population they serve;
3. To identify and describe the community partners that Ontario's PHU professionals are mobilizing;

4. To identify and describe community partners that are not currently collaborating with PHUs but would add value;
5. To identify and describe the mobilization strategies and practices employed by public health professionals in Ontario's PHUs in working with their community partners to prevent falls among community-dwelling older adults;
6. To examine strategies employed by public health professionals in Ontario PHUs, the benefits and challenges of community mobilization; and to
7. To identify public health professionals' views about capacity building activity and policy by provincial and federal public health ministries and agencies to support implementation of comprehensive falls prevention programs by Ontario PHU's.

Method

A qualitative design was used for this exploratory research involving in-depth, semi-structured, telephone interviews with PHU professionals, community partners, and future potential partners. Interview questions explored topics such as the individuals' knowledge, engagement processes, performance, benefits and challenges of community mobilization, and public health professionals' views on capacity building and policy development. Data was analyzed using a grounded theory approach resulting in the emergence and generation of multiple themes (i.e., major ideas, concepts, or categories) related to each topic.

Recruitment and Sample

PHU professionals were recruited via purposeful sampling (i.e., purposely selected to represent a diverse range of geographic areas, populations, and participation in the LDCP falls project) while community partners and future potential partners were recruited via chain-referral sampling (i.e., referred by PHU professionals).
The individuals interviewed for this study included:

- five PHU professionals:
    - tasked with preventing falls among community-dwelling older adults;
    - representing a combination of different geographic areas;
    - representing different populations; and
    - prior participation in the LDCP falls project (3 – yes, 2 – no).
- six community partners; and
- two future potential partners.

To protect the anonymity of participants throughout this study, personally identifiable information has been removed and only partial and generalized descriptions of the individuals and their work contexts are provided in the sections that follow.

Key Findings

Identification and description of key stakeholder groups

PHU professionals

All of the PHU professionals were female. Participants' job titles included one health planner, one health promoter, one program manager, and two public health nurses. The number of years of public health experience totaled 60 years for the five participants with a range of three to 25 years (M = 12, SD = 8.5). The total number of years of fall prevention experience was 28.5 years with a range of 2 to 15 years (M = 6; SD = 5.3).

Community partners

Description of mobilizing community partners (general)

PHU professionals stated that each PHU was mobilizing with between 10 and 35 community partners to prevent falls among community-dwelling adults. When asked to identify and describe the community partners that were most knowledgeable about the work being done to prevent falls, PHU professionals identified:

- 15 organizations representing a range of not-for-profit, government, charitable, community, and academic groups with 10 organizations being health-related (e.g., Local Health Integration Networks, other PHUs, organizations focused on specific health issues or community care)
- 1 individual who had done work previously as part of a municipal government but was currently working independently.

Partnerships with the referred community organizations or individual were estimated to be between 2 months and 15 years in length. In describing the roles these community partners' fulfilled, two major themes emerged:

- **building networks, coalitions, and strategic plans** which included contributing to coalitions, committees, and task groups (e.g., leadership, decision making, intellectual engagement, networking, establishing and sitting on coalitions and task groups) and the developing strategic and community-wide plans; and
- **delivering and supporting health promotion, education, and programming** by providing fall-related prevention programs and education, delivering health promotion activities (e.g., exercise classes to older adults, information fairs), providing resources (e.g., space, time, personnel), and attracting and reaching target populations (e.g.,

increasing awareness of programs, providing PHUs and target population with access, serving as a conduit).

Description of interviewed community partners

Five community partners were female and one community partner was male. Three of the community partners were organizational or program directors, two were coordinators, and one was a lead. The total number of years of experience in these positions ranged from three to 15 years (M = 9.7, SD = 4.6).

Five of the community partners represented non-profit organizations and one represented a municipal government although was currently working independently. The primary services offered by community partners covered a range of areas including:

- two partners who provided community health care;
- one partner who served as an older adult day center;
- one partner who provided recreation programming for older adults;
- one partner that primarily supported research; and
- one partner that provided research, advocacy, education, and health management.

Most of the community partners (*n* = 5) reported providing services targeting older adults (i.e., seniors, and adults aged 55+ years), with four partners focusing exclusively on older adults. The remaining two partners focused on a mix of older adults, caregivers, health care practitioners, policymakers, and researchers.

Future potential partners

Description of future potential partners (general)

PHU professionals identified 29 organizations or individuals they would be interested partnering with in the future including:

- Aboriginal organizations;
- community groups (centers, churches, housing centers, Legions, seniors' groups, volunteer management and placement organizations, YMCAs);
- government health organizations (i.e., LHINs);
- health care centers (i.e., community, hospitals);
- health care providers (i.e., nursing services, pharmacists, physicians);
- municipalities and municipal departments and services (i.e., community services, maintenance, parks and recreation, planning and development, transportation);
- post-secondary programs at local institutions (i.e., nursing, rehabilitation, physiotherapy, occupational therapy); and

- senior care and support centers (i.e., nursing homes, retirement homes).

The most prominent concepts describing PHU professionals' reasons for partnering were: **addressing the needs of individuals and communities,** to **enhance capability and capacity**, and **to provide more comprehensive fall prevention**.

Community partners identified multiple organizations or individuals they would be interested in partnering with in the future including:

- Aboriginal groups;
- government health organizations (i.e., Health Shared Services Ontario, all 14 LHINs, Ontario Ministry of Health and Long-Term Care);
- health clinics and teams (e.g., emergency medical clinics, publicly funded physiotherapy clinics, walk-in clinics);
- health professionals (i.e., physicians, pharmacists);
- non-profit health organizations such as CNIB foundation, Heart and Stroke Canada, Multiple Sclerosis, Osteoporosis Canada, Parkinson Society and the Victorian Order of Nurses;
- retailers such as McDonalds and Tim Hortons;
- other places where older adults congregate (i.e., malls, casinos, where lottery tickets are sold, and recreation centres); and
- a senior who could serve as an agent of change (i.e., community educator, champion, or spokesperson).

Prominent themes describing community partners' reasons for partnering with these organizations and individuals were: **to provide more comprehensive health promotion, education, and programming related to fall prevention** (e.g., offering different programming or programming to different groups of people); **to gain a greater perspective on fall prevention priorities** (i.e., provincial and organizational priorities); **gain access to knowledge and people** (e.g., physicians); and **gain community support and buy-in**.

Description of interviewed future potential partners

All of the future potential partners were female. One future potential partner worked as an organization's president while the other was a program coordinator. The total number of years worked in these organizations ranged from less than one year to 17 years.

Future potential partners represented a volunteer informal organization and a non-profit organization receiving government funding. Their primary services included:

- supporting and promoting community volunteerism through networking, education, recognition, and opportunity; and
- providing community care services including exercise and fall prevention to prevent falls among community-dwelling older adults (i.e., community exercise programs to adults aged 55+ years, falls assessments, and education about falls and fall prevention).

One future potential partner reported that their organization had been working on fall prevention for 3 years, had allocated 13 dedicated staff, and approximately 166.5 hours per week to fall prevention
Future potential partners were interested in partnering with others (e.g., other non-profits, seniors centres, housing, and groups, health teams, city and county recreational programming) and with PHU to prevent falls. Neither had been in contact with PHU about partnering.

Description of PHU context and population served

PHU professionals were asked to speak a briefly about their PHUs and communities.
PHUs represented a range of geographic areas and population groups:

- 2 - Central West, 1 - Eastern, 1 - North West, and 1 - South West
- 1 - Urban/Metro, 3 - Urban/Rural mix, and 1 – Rural.

Work to prevent falls fell predominantly under the areas of: chronic disease and injury prevention, healthy families, and health promotion and programming. Within some PHUs this was further divided into different age, stage, or target populations (e.g., 0-6 year olds, school age children, older adults).

Table 1 summarizes select characteristics of PHUs and populations served.
Budget:

- Three PHU professionals could not provide estimates of the budget for falls and injury prevention for their PHUs.
- One PHU professional provided an estimated annual budget of $10,000 for injury prevention with $3,500 allocated for fall prevention.
    - One PHU professional estimated that $55,000 was allocated to their department with $10,000 assigned to falls prevention.

Staffing:

- The total number of PHU staff hours allocated to fall prevention was estimated to be between 25.5 and 42.5 hours per week.

All five PHU professionals said they had different materials or strategies targeting community-dwelling older adults. Such as:

- education (*n = 3*) (e.g., awareness of fall hazards, strategies to prevent falls);
- support and promotion of community programming (*n = 2*);
- developing and implementing age-friendly communities (*n = 2*); and
- community partnerships (*n = 1*).

Table 1.

Summary of Public Health Unit (PHU) and Community Characteristics (n = 5)

Public Health Unit characteristics	Number (Percent)
Number of public health staff[a]	
0-49	0 (0.0%)
50-99	0 (0.0%)
100-149	2 (40.0%)
150-199	1 (20.0%)
200+	2 (40.0%)
Number of public health staff dedicated to falls	
1	1 (20.0%)
2	1 (20.0%)
3	3 (60.0%)
Size of population served	
0-149,999	2 (40.0%)
150,000-249,999	2 (40.0%)
250,000-349,999	0 (0.0%)
350,000+	1 (20.0%)
Need to prevent falls in community?	
No	0 (0.0%)
Yes	5 (100.0%)
Assessment of need to prevent falls conducted?	
No	1 (20.0%)
Yes	4 (80.0%)

[a] refers estimates of the number personnel working in a variety of positions including janitors, administrators, public health nurses, etc.

Community mobilization

PHU professionals and community partners were asked a series of questions related to knowledge of, purpose for engaging in community mobilization, community mobilization activities to prevent falls among community-dwelling adults, and response to Falls LDCP community mobilization scoping review. Future potential partners were included but only asked a subset of these questions (i.e., awareness of term and definitions, awareness of community mobilization activity).

Knowledge

Defining Community Mobilization

All PHU professionals and at least half of community partners (4/6) and future potential partners (1/2) had heard of the term community mobilization. Most participants defined community mobilization similarly as engaging in **action**, gathering **community support and involvement**, and establishing **community togetherness and partnership**. Other frequently noted concepts included: **change**, **community capacity**, **planning**, and **roles**. A concept map representing the relationship between concepts emerging from participants' definitions of the term community mobilization is presented in **Figure 1.**

Response to Falls Locally Driven Collaborative Project's definition of community mobilization[23]

The majority of participants (four PHU professionals, four community partners, and one future partner) endorsed or supported the definition to varying degrees.

- Elements of the definition participants referred to positively included:

  action, *bringing people together*, *community*, *leadership*, *working together*, and elements related to *the function and goals of other community action models*.
- Elements of the definition participants raised concerns about included:

  the definition being wordy, *lofty*, *realistic*, *broad*, *overarching*, *not talking about implementation*, *use of the terms community and capacity*, *sustainable capacity*, *whether collaboration is effective*, *there is evidence to support the impact of collaboration*, and r*esource allocation and management*.

[23] The Falls Locally Driven Collaborative Project definition of community mobilization used was "the use of capacity to bring about change by joining together the strengths of the community into an action plan. 'Community mobilization is based on the belief that when a community is mobilized to address and solve its own problems, more efficient and effective results will materialize than could be achieved by other means' (Hastings, 2001). The anticipated goal is for a safe and healthy community with 'buy in' from all community members."

Congruency between CM definition and working experience with local PHUs to prevent falls

Three participants (two PHU professionals and one community partner) agreed that the Falls LDCP definition described their experiences. The remaining participants (three PHU professionals and five community partners) felt their experiences differed from the definition. Reasons offered why experiences differed were categorized under the following:

- **Activities** – the activities done to date did not reflect definition because they were in the beginning stages, focused on community partners and not older adults, or needed to get the word out about preventing falls to the community;
- **Approach** – the approach to community mobilization was more top-down focusing on agencies rather than grass-roots;
- **Challenges had been encountered** – some challenges which included difficulty getting buy-in from the community, building trust with the community, and follow-through from committee members had been experienced;
- **The definition as the goal** – the definition was a goal but did not represent how communities would achieve the goal;
- **Not everyone understands community mobilization** – people characterize the term differently resulting in a focus on different efforts and results (e.g., focus on having coalitions or committees versus getting the whole community engaged in strategies);
- **Unable to say** – limited experience upon which to make a judgement.

PHU professional training

Three of the five PHU professionals reported receiving community mobilization training. Of those saying they had received training, two were involved in the Falls LDCP. Some examples of the training that were identified included:

- Tamarack collective impact;
- evaluating community impact;
- National Collaborating Centre on methods and tools and knowledge transfer;
- Canadian Falls Prevention Curriculum E-Learning Course online; and
- Locally Driven Collaborative Project on theories and frameworks.

Future potential partners' awareness of community mobilization activity

None of the future potential partners were aware of the falls prevention work being done by their local PHU with other partners in their community.

Purpose

PHU professionals discussed many public health purposes for engaging in community mobilization efforts with their community partners. Some of the purposes were those guiding current efforts while others were not. Most PHU professionals discussed: **evaluation**, **programming**, **policy**, and **media**. Some PHU professionals also spoke about **awareness and education of health professionals and the public**; **implementation of planned promotion, programs, and policies**; **planning**; **promotion**; and **achieving the best possible health for all**.

Activities

All PHU professionals and community partners were asked to describe the steps and activities they had been involved in.

Initiation

Four PHU professionals and two community partners identified themselves as the initiator for community mobilization. Two of these PHU professionals indicated that this wasn't always the case and at times community partners were the initiators. Two community partners indicated the work had been initiated by their local PHUs. One PHU professional and one community partner identified committees as initiators. One community partner was unsure of who initiated the community mobilization work. In the case of two PHU's, a community partner and the PHU professional both described themselves as the initiator.

Identifying the problem

Problems were most often identified by the local PHU, followed by the community (referring to committees in particular), and then by a combination of both the PHU and community. One community partner could not remember.

Eight participants (five PHU professionals and three community partners) described that the problem(s) were identified through research including: *community consultations*, *talking to people in the community*, *the collection of injury statistics by PHU epidemiologists*, and *PHU reports*.

Determining the need for community mobilization

One PHU professional and five community partners were unable to identify how the need was determined. The remaining five participants (four PHU professionals and one community partner) each provided reasons varying from community mobilization being an approach that is valued and engrained in public health to addressing specific community needs.

Determining how to mobilize

Four PHU professionals and three community partners described their knowledge of how the steps needed to mobilize were determined.

The four PHU professionals and one community partner described that the steps needed to mobilize were determined through discussions with others at meetings or round tables. One participant described the decision as emerging from a proposal in which all the members could contribute and approve before it was submitted. Two community partners were unsure how the steps were determined.

Two of the PHU professionals said that no framework, theories or guidelines were used. Two PHU professionals and two community partners identified using a framework, theory, and/or guideline for mobilization or for falls prevention such as:

- the Collective Impact Approach;
- the Falls LDCP scoping review logic model;
- the Integrated Falls Prevention Framework and Tool Kit, their own paper on Falls Across the Lifespan, the Ecological Model of Change, and Lifespan Approach; and
- a social network mapping tool and a literature review they conducted on best practices for falls prevention.

Steps taken to mobilize the community

Five PHU professionals and five community partners reported engaging or having been engaged in a multiple steps and activities in order to mobilize as a community[24]. While there were differences in the steps and activities engaged in and the order with which certain steps occurred, the eight most commonly reported ways to mobilize were:

- **Initiation** – beginning efforts as a result of a local PHU professional or a community partner who would bring everyone together because of an opportunity, pre-identified need or problem, or standards requiring individuals to work with the community;
- **Bringing people together** – identifying potential partners either alone or with a group using different techniques such as partnership audits, brainstorming, existing relationships, and knowledge of organizational commonalities. And then often connecting through meetings to identify a problem, establish and organize partnerships, and plan;
- **Identifying a problem** – recognizing an issue or need (e.g., funding announcement opportunities, Ontario Public Health Standards, physiotherapy reform, lack of connection between programs or services, research);

[24] One community partner, who had only recently begun mobilizing with their local PHU, said they did not know what steps and activities had been employed.

- **Research and data collection** – investigating issues (e.g., the problem; who will be good at the table to solve this problem; figuring out how can we solve this problem?), and assembling statistics (e.g., emergency room statistics, injury statistics) and/or conducting of needs assessments, community consultations, audits of community services, and literature reviews on best practices;
- **Implementation** – effecting specific activities and programs to prevent falls among community-dwelling older adults (e.g., Stay on Your Feet, home exercise programs, PSW training, etc.);
- **Partnership organization** – taking charge together through the establishment of formal partnership groups (groups, teams, committees, etc.), Terms of Reference, discussion about mandates, a vision and that mission that everybody can identify with, and taking on different roles and responsibilities in order to plan and support the work that will be done together;
- **Planning** – engaging in sessions or meetings where partners discussed ideas, goals, objectives, looked at their capacity (e.g., resources, time), made decisions, determined what activities would happen, and developed logic models, proposals, frameworks, or strategies,; and
- **Evaluating and reviewing the work** – conducting evaluations, assessments, and reviewing work (e.g., focus groups, progress evaluations, stakeholder assessments, and evaluations of activities).

An aggregated model of the sequence and connections between the main steps and activities used to engage in community mobilization is presented in **Figure 2**.

Identifying partners

Partners involved in community mobilization efforts to prevent falls were identified based on:

- **Knowledge** of organizations offering similar programming or serving a similar demographic (e.g., falls prevention, older adults) and shared vision;
- **Existing relationships** between respondents; and
- **Committee or coalition brainstorming** who needed to be involved according to certain criteria (e.g., who was missing from the group, expertise in different pillars of health).

Engaging partners

Three PHU professionals and five community partners reported a variety of approaches were used to engage partners in community mobilization. The themes discussed were:

- **Relationships** – some participants described partners are/were engaged through the building of relationships, leveraging of existing relationships and recommendations made through relationships;

- **Interest** – other participants described partners are/were engaged through common interest (e.g., falls prevention, older adults, opportunity to learn, opportunity to work together); and
- **Can't say** – approaches varied.

Establishing goals and values

All five PHU professionals and six community partners indicated that there was commonality in the partners, goals and values around the prevention of falls among community dwelling adults. The most commonly reported goal and value was **reducing, preventing falls and having seniors' age in a much healthier way**. The next most commonly reported goals and values were **the need to get people physically active**, and **valuing that there are older adults in the community**. Other common goals and values identified were **reducing, preventing falls and having seniors' age in a much healthier way** and **trying to be better for the community**.

Partnership differences were resolved through **discussion and talking with one another**. Some of the topics participants described as being helpful in aligning differences included talking about the overall goal, being accountable and thinking about the needs of seniors as well and our community, and relating everything back to the life span approach. **Taking a break**, **having conflict resolution teams**, and **voting** were other methods used.

How partners organized for community mobilization

Formal groups such as committees (e.g., executive, lead, steering, sub-committees), teams, Communities of Practice, and round tables were cited as the primary method of organizing partners for community mobilization. One of the community partners also described working in a **free-form** manner focused on programming with no specific break-down of those different roles.

As part of their descriptions, several participants described ways in which the organization was supported such as:

- **Adopting roles** - identifying and taking on different roles (e.g., advocate, leader, chair, co-chair, decision-maker, knowledge user);
- **Formal documentation** - using various forms of formal documentation (e.g., Terms of Reference, agendas, attendance, logic models, meeting minutes, Memorandums of Understanding, mandates, reports, and work plans);
- **Communication** – using different methods and forms of communication (e.g., e-mails, discussions, meetings, and newsletters);
- **A review process** - engaging in a review process with their partners to help organize for the year ahead; and

- **Evaluation** – conducting evaluations of the collaborative and activities.

Level of partnership

The reported level of partnership integration or nature of teamwork varied. Most participants felt their partnerships were collaborative in nature, followed by communicative, cooperative, and coordinated. Five participants described the level of partnership integration using more than one category.

Almost all participants felt that the level of integration change over time due to factors such as partners in the partnership (e.g., number, personality, level of interest), events (e.g., number and size), organizational priorities and capacity (e.g., resources, funding, time and staffing), the work being done, staff turn-over, and time.

One participant felt that the level of partnership did not change because the organization they represented needed to be accountable to the people they served, were knowledgeable about what works and that's what keeps people feeling engaged, as well as having a PHU professional who was very engaged and valued the work being done.

During the course of the interview one participant described having limited participation with their local PHU in regards to fall prevention initiatives. Another participant also expressed that their partnership seemed to have gone by the wayside because partners did not have the time and seemed to be doing their own thing right now.

Communication with partners

Ten participants said communication with partners was made through e-mails. Meetings either face-to-face, teleconference, or videoconference formats were identified by five PHU professionals and two community partners. Agendas were identified by a PHU professional as a communication method that was useful to keep everything structured and organized and to keep people accountable. Other ways of communicating with partners included: telephone (one PHU professional) and conversations (one community partner). The most commonly reported frequency for communication between partners was bimonthly. One community partner did not know.

Partnership activities

Five PHU professionals and six community partners described engaging in a number of different activities together. Analysis of their responses yielded four main themes:

- **Training, awareness, and education** – activities related to training education, and awareness with the focus on health care providers and/or older adults (e.g., Falls prevention month; health fairs; media campaigns; presentations about

community resources, health and nutrition, and falls prevention; health care provider training on falls risks, prevention, and screening tools; LOOP);

- **Program development, implementation, and promotion** – partnership activities related to programming (e.g., exercise classes promoting balance, strength, and mobility; Stay on your Feet; peer-to-peer education, referral cards to connect older adults with fall prevention agencies, programs, and individuals.);
- **Research** – activities related to research (e.g., community consultations, evaluations of community needs, performance of the initiatives, focus groups, and literature reviews of best practices for falls prevention); and
- **Systems approaches and integration** – activities focusing on integrating approaches across multiple organizations, sectors, and systems (e.g., strategies and frameworks).

Expected outcomes

Five PHU professionals and five community partners listed multiple expected outcomes. These outcomes were categorized under the following themes:

- **Falls (generally)** (i.e., efforts resulting in general falls-related outcomes such as awareness of hazards and how to be safe, reduction in number and severity of falls));
- **Falls (population specific)** (i.e., efforts resulting in falls-related outcomes for specific populations);
- **Event and program performance**;
- **The ability to satisfy grant requirements**;
- **Improved health**;
- **Improved system navigation and integration**;
- **Increased capacity**;
- **Partner engagement and advocacy**; and
- **Increased knowledge about programs and resources that can be accessed**.

Response to Falls Locally Driven Collaborative Project's community mobilization scoping review

Three out of four PHU professionals indicated that their practices had not changed as a result of the community mobilization scoping review (Crizzle et al., 2019)[25]. Some the reasons given for why practices had not changed included: completing work prior to the

[25] The Falls LDCP scoping review question was added after completing the pilot study. As a result, the pilot study participant was not asked about the impact of the report on their community mobilization practices.

report's internal release to the PHUs, and feeling the identified models, theories, frameworks did not meet the community's needs. The fourth PHU professional stated they had not yet changed their practices but were using the review for planning purposes to ensure bases were covered.

Examining Strategies

Performance

The most recurring topics emerging from PHU professionals' and community partners' responses about the performance of their community mobilization efforts in terms of the impact on the community, partners, and themselves were:

- **Capacity** – efforts were helping to develop, support, and change the community or their partnerships in terms of *people*, *communication*, *knowledge*, *resources*, and *training*; and
- **Reach** – ability to connect to others through increased awareness of community programs and offerings as well as community referrals to programs.

Other topics discussed by participants in relation to performance of their mobilization efforts included **better integrated programs and services**, and **not having data or information on the impact of efforts**. One community partner did not feel they could assess the work.

What is working?

Comments describing what *is working well* were categorized under the following themes:

- **Activities and programs**:
    - Health fairs, road shows, and education sessions - which were seen as successful in a variety of ways such as bringing the community together (e.g., partners, seniors), addressing a number of risk factors, increasing awareness of what partners are able to offer, and making a difference in people's knowledge*;*
    - a volunteer run peer-to-peer education program - was seen as filling gaps in community needs and reducing program duplication;
    - a falls prevention exercise program;
    - healthy eating and nutrition sessions - based on popularity and attendance;
    - promotion of physiotherapy, community centre where programs were available, and walking programs were activities;

    - print materials (e.g., brochures, flyers, newspaper advertisements, and posters), radio, and T.V. advertising - because of their ability to reach seniors; and
    - the Fall Prevention Month website - as evidenced by the number of downloads and new materials being created by organizations (i.e., articles, and newsletters) and reaching target partners and audience.
- **Strategies and approaches:**
    - a sense of being humble – recognizing you need partners;
    - answering and listening to the needs of the target audience;
    - recognizing the challenges some older adults face with income and transportation and bringing programming or information to them that works;
    - figuring out what's important to community partners;
    - including a strategy around staff competencies that offers training and coaching;
    - leveraging interest in order to benefit falls;
    - sharing knowledge;
    - strategies that are informed by the target audience;
    - strategies that are a mix of top-down and bottom-up and includes the leadership; and
    - working to build relationships.

As an example of how efforts were working and performing well, one community partner spoke about having community resources to refer people to for fall prevention that weren't available years ago and how this has filled gaps in care and in the community.

What is not working?

All of the comments about ***what is not working*** were specific to activities and programs that the PHU and community partners were working together on such as:

- a communications campaign where there was questions about the evidence-base and messaging to older adults;
- a referral program for seniors to call local experts and find out about community programs;
- e-newsletters which could no longer be sent to people because of spam legislation;
- getting health professionals to complete an evaluation and provide feedback on a program;

- getting seniors to do programs online; and
- home assessment programs.

Evaluation

Not all interviewed participants at each PHU site were in agreement about whether evaluation had occurred, was planned, or not being done:

- two PHU professionals and three community partners said that evaluations for some of the work had been completed;
- one PHU professional stated that evaluation was planned;
- two PHU professionals said that evaluation had not been completed or planned; and
- three community partners did not know if evaluation had been completed or planned.

Examples of some of the evaluative work completed or planned included: *surveys to determine what activities to do*; *assessments of activities and programs* (i.e., interwoven throughout process from planning to completion, annual formal evaluation of program performance); *media evaluation*; *partnership assessment surveys* (e.g., annual evaluations of collaboration; stakeholder assessments to determine partner needs, whether goals and outcomes were achieved, and satisfaction).

Benefits

PHU professionals and community partners identified several benefits to community mobilization. The main benefits were reported as:

- Providing or increasing community **capacity** in various ways (e.g., abilities, shared knowledge and resources, leadership, people);
- **Working together as a community**;
- Creating **networks and relationships**, and improving communication between organizations, individuals, and the community;
- Extending ways to connect or **reach** with people (e.g., getting word out, connecting with specific populations);
- Having **multiple viewpoints** to draw upon (e.g., ideas, expertise, solutions);
- Gathering **community buy-in and participation** (e.g., attendance, compliance, support, involvement).

Challenges

Participants identified a number of challenges to community mobilization. The top challenges or barriers to community mobilization were identified as:

- Limited community **capacity** (e.g., funding, skills, leadership);

- Having a lack of **time** to engage in and contribute to community mobilization;
- Changing, competing, or differences in organizational **priorities, mandates, and standards**;
- Gathering **community buy-in and participation** (e.g., attendance, awareness of need for falls prevention, commitment);
- A lack of **guidance and training** as a challenge (e.g., training on community mobilization frameworks, guidance on working with partners, provincial oversight, Ontario Public Health Standards); and
- **Turn over** as a result of changes in personnel and staffing departures.

Other challenges that were described included: **implementation** issues (i.e., delivery consistency, technology, uniqueness of municipalities); **forming partnerships** (i.e., identifying partners, convincing others of value of partnership); **not thinking population level** (i.e., getting the community to think about population level change); and seeing **outcomes** (i.e., seeing change in or at the population level).

Public health professionals' views about capacity building and policy development by provincial and federal ministries of health and agencies

PHU professionals were asked about a potential proposed merger between the LHINs and PHUs in Ontario – whether they had received information, their potential role in the merger, and how the work they do would integrate into such a merger.

Received information about the merger

- Four PHU professionals had not heard anything about the merger.
    - Three of the four were not sure that the merger was still happening.
- One PHU professional had heard that the merger was no longer occurring and that stronger partnerships were now the focus of changes.

Potential role in merger

- Two PHU professionals expected their roles to change
    - One suggested LHIN's role might include providing funding, coming *up with a work plan*, *facilitate partnership building and community mobilization,* and sitting at the partnership table while the PHUs role might entail providing staff and staff time to *handle,* and *to deliver the programming*
- A third PHU professional did not expect the PHU and LHIN roles to change.

- A fourth PHU professional did not speak about changes in roles, but rather the importance of having the LHIN involved and value of different areas of expertise

Work integration

PHU professionals described access and changes to partners, practices, time, resources, capacity, and the effect on the community.

- Three PHU professionals felt the merger would not result in increased access to partners, while one PHU professional thought *it was possible,* and another PHU professional was hopeful. Some of the reasons given for why the merger would not result in increased access to partners was the local LHIN had already brought partners and finding that the local LHINs would bring together PHUs and not the community. No reasons were given for why the merger would result in increased access to partners.
- Three PHU professionals expected their practices to change as a result of a merger with the LHIN. Specifically, individuals mentioned concern that there would be a shift focusing on secondary and tertiary prevention activities versus standard work around primary prevention, and taking emphasis off fall prevention. Two of the three PHU professionals also spoke of positive changes as a result of the merger. Specifically, one PHU professional noted a shift in practices in relation to health services reviewing and implementation of the new Registered Nurses' Association of Ontario (RNAO) guidelines, while the other PHU professional spoke about the possibility of pushing, shared measurement forward through more data collection and sharing. One participant did not expect any change in practices because the research will trump anything in terms of falls prevention practices. Maybe the organization and facilitation of how those are implemented I think the same practices will be there.
- All PHU professionals discussed changes in time; however, their responses differed. Two PHU professionals didn't know whether their time would change because they were unsure of what the merger would look like or bring. Two PHU professionals felt that there might be less time because a lot of time would be spent on change, and the potential shift in practices. One PHU professional suggesting there may be more time because the LHIN would be more at the forefront of fall prevention, sharing the PHU mandate, reducing the need to worry about health services, allowing PHUs to do more environmental work rather than looking at individual risk factors.
- Only one PHU professional discussed the theme of resources and capacity, suggesting that if there were a shift in the focus of activities as a result of the merger, PHUs would have reduced time, reduced resources, reduced capacity.

- One PHU professional discussed that they expected the merger would affect Public Health with respect to the groups they sit on but they weren't sure how it would affect the community whom they described positively.

Reference:

Crizzle, A. M., Dykeman, C., Laberge, S., MacLeod, A., Olsen-Lynch, E., Brunet, F., & Andrews, A. (2019). A public health approach to mobilizing community partners for injury prevention: A scoping review. *PLoS one, 14(*1), e0210734.

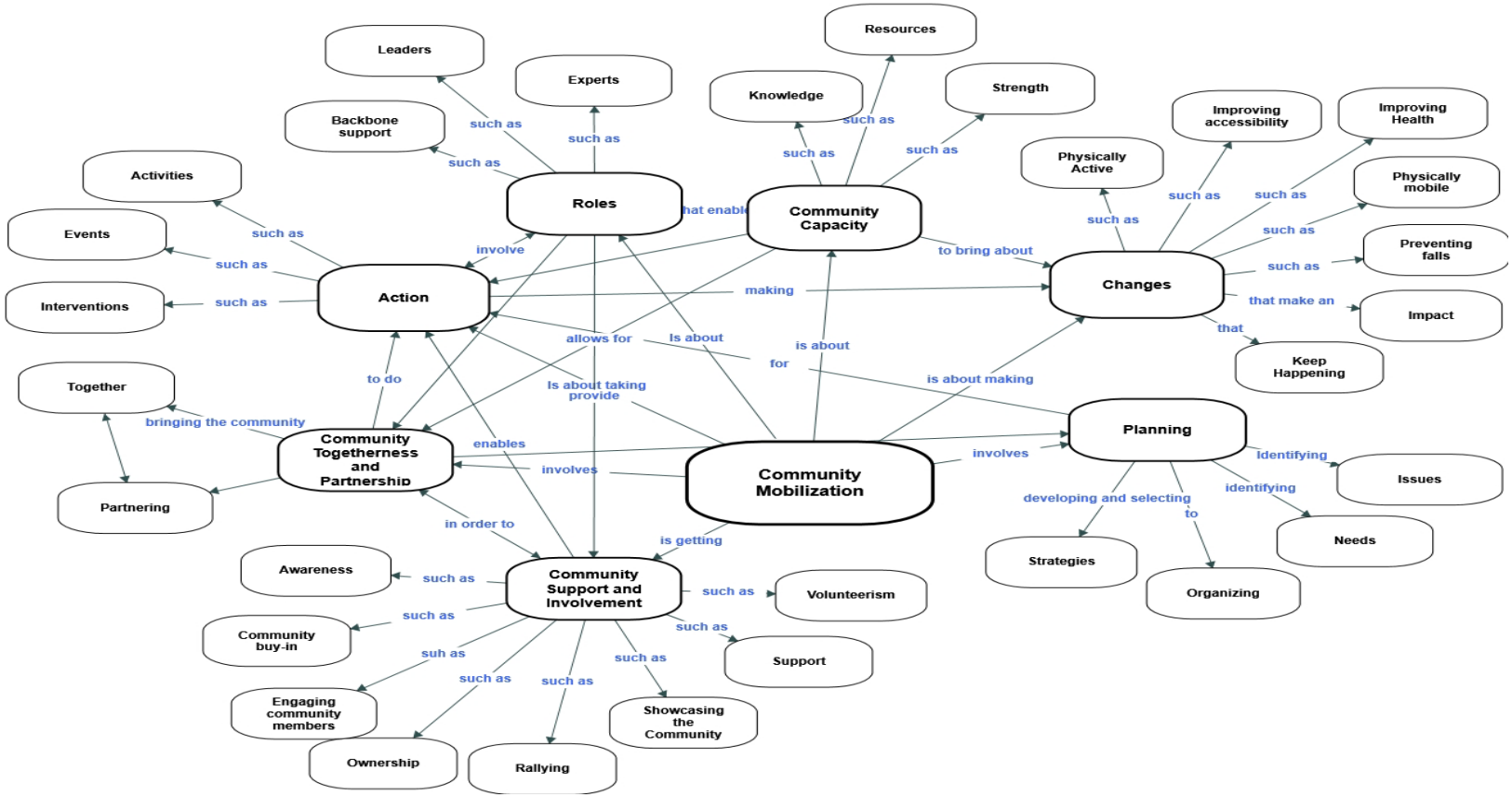

Figure 1 Concept map of the terms used by participants to define the term community mobilization

Note. Common themes used to define community mobilization are noted in bold and appear in the centre of the map. These themes are: Action, Changes, Community Capacity, Community Support and Involvement, Community Togetherness and Partnership, Planning, and Roles.

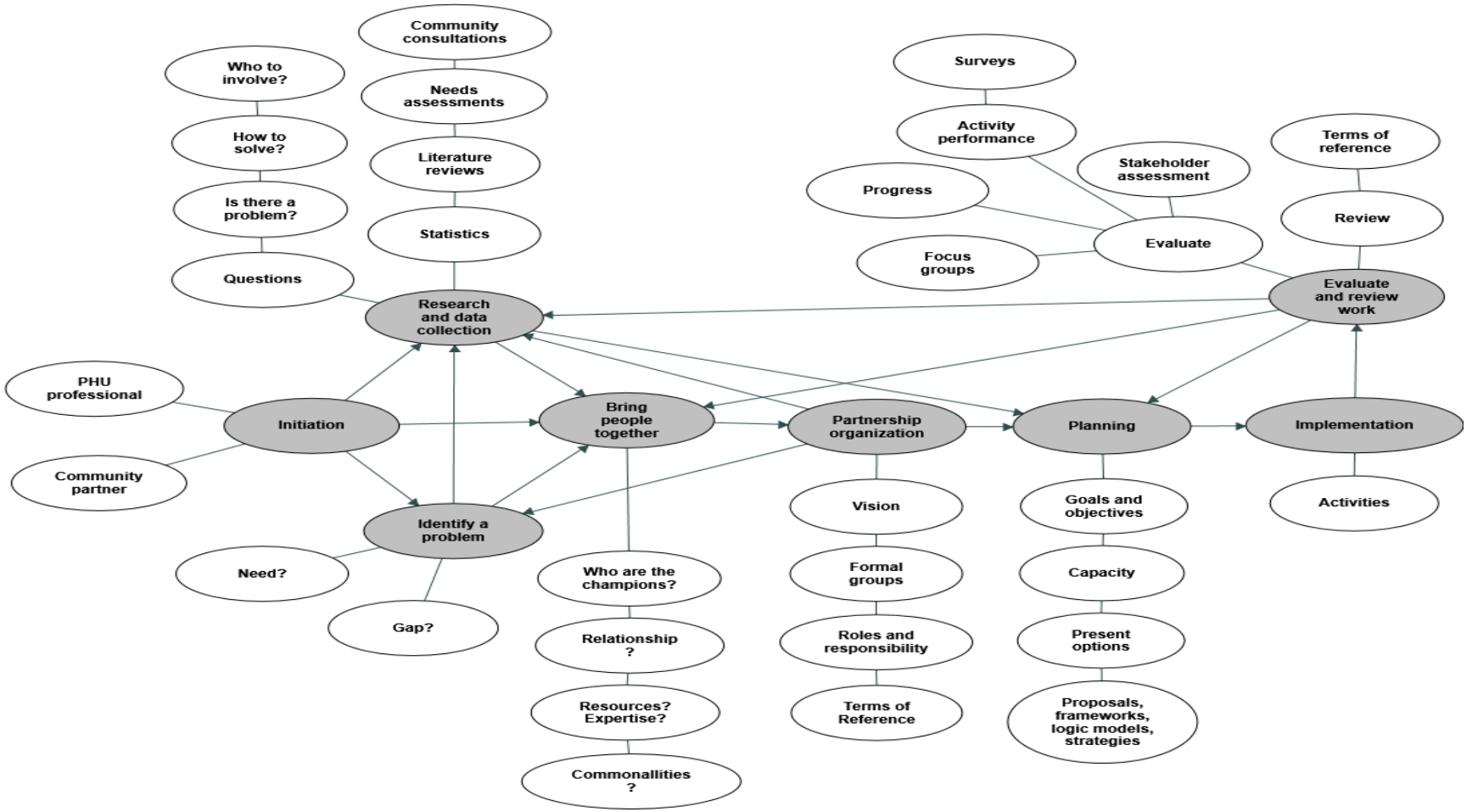

Figure 2 Concept map illustrating the mobilization steps and activities Public Health Unit professionals and their partners described engaging in.

Note. Items highlighted in grey represent main themes or sub-themes emerging from analysis of descriptions.

Comments

Do these findings reflect you and your experience(s) mobilizing to prevent falls among community-dwelling adults? ☐YES ☐NO If no, please describe. In your description please identify the objective or main research question which is different:
Do you want to change anything? ☐YES ☐NO If yes, please describe. In your description please identify the objective or main research question which you would like to make changes to:
Do you want to add anything? ☐YES ☐NO If yes, please describe. In your description please identify the objective or main research question you would like to add to:
Do you have any other comments about the research? (e.g., is there anything you've learned? Is there anything you would like to see/result from the research in general or from any reports?) ☐YES ☐NO If yes, please describe:
Do you have any other comments about your interview? ☐YES ☐NO If yes, please describe:
Do you have any other comments about the study? ☐YES ☐NO If no, please describe:

Thank you for completing this review!

Appendix H: TCPS 2 (CORE) Training Certificate

PANEL ON RESEARCH ETHICS
Navigating the ethics of human research

TCPS 2: CORE

Certificate of Completion

This document certifies that

Taryn Sendzik

has completed the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans Course on Research Ethics (TCPS 2: CORE)

Date of Issue: **30 May, 2012**