Community Paramedicine Needs Assessment Tool

A system planning tool for those developing community paramedicine programs.

Healthcare Excellence Canada
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Front matter

Community Paramedicine Needs Assessment Tool

Version 1, October 2024

Funding

This project was funded by Healthcare Excellence Canada, who advised on the design of the study.

Conflicts of interest

Tyne Lunn, Brendan Shannon, Aman Hussain, Elizabeth Caperon, and Alan Batt have no previous or existing relationship with HEC to declare. Cheryl Cameron was previously faculty with HEC on the *Paramedics and Palliative Care: Bringing Vital Services to Canadians* initiative.

Ethical Considerations

Ethics approval for the convening at the International Roundtable on Community Paramedicine in Quebec City was provided by the Human Research Ethics Committee at Monash University in May 2024 (approval #42775).

Land Acknowledgment

This collaborative project was conducted on colonised Indigenous lands now referred to as Canada. These lands are home to the many diverse First Nations, Inuit, and Métis Peoples whose ancestors have stewarded this land since time immemorial.

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Suggested Citation

Lunn TM, Shannon B, Cameron C, Hussain A, Caperon L, Batt AM. Community Paramedicine Needs Assessment Tool. 2024. Ottawa: Healthcare Excellence Canada.

Published by Healthcare Excellence Canada, 150 Kent Street, Suite 200, Ottawa, Ontario, K1P0E4, Canada.

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Acknowledgments

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International Roundtable on Community Paramedicine

Paramedic Chiefs of Canada

Paramedic Association of Canada

Ontario Association of Paramedic Chiefs

McNally Project for Paramedicine Research

Foreword

Community paramedicine programs may think of a community as the people served in their specific location. We use the term community in this tool to refer to any group of people who have something in common - this could be a group of people who share location, culture, experience, characteristics, or interest - and often have intersecting commonalities.

Those developing community paramedicine programs can use this tool to assess the needs of people experiencing homelessness in a city or town. They can use it to assess the needs of Black Canadians living in a neighbourhood or suburb. Or use it to explore the needs of Indigenous community members living within or outside of their community. Program designers can also use the tool more broadly to assess the needs of a designated location, such as a city or region, exploring the needs of a community's diverse populations.

The needs of these illustrative communities will differ - thus highlighting the importance of a detailed community assessment to ensure programs are designed to meet community health and social needs. Undertaking a community needs assessment involves exploring both quantitative and qualitative data and can be broad (examining a city or suburb) or focused (on a specific issue or population - small area analysis). It is important to remember that health and social needs exist on a continuum and meeting needs is limited by resource and workforce capacity. Therefore, this tool guides the assessment of community health and social needs, as well as resource and workforce capacity.

Community paramedicine leaders should approach conducting needs assessments with humility and a strengths-based approach. Here, health and social care professionals aren't the experts, rather, community paramedicine is a resource to community members. This approach recognizes that communities are the experts in their health and social needs and supports communities in self-determination and agency in co-designing community paramedicine programs to best meet community needs.

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Glossary and abbreviations

Care partner — person or persons chosen to participate in ongoing care for a family member, friend, or significant person who because of a lifelong condition, illness, disability, serious injury, mental health condition, or addiction requires their support.

Competency framework — an outline of the skills, judgment, knowledge, and attributes required to perform a role effectively.

Equity — the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.

Intersectionality — interconnected nature of social categorizations such as race, class, disability, sexual orientation, sex, and gender identity as they apply to a given individual or group.

Person receiving care — a person who, because of their physical or mental condition, requires a level of care and services suitable to their needs to contribute to their health, comfort, and welfare.

Social prescribing – a mechanism for linking patients with non-medical sources of support within the community

Structurally marginalized populations — groups and communities that experience discrimination and exclusion (social, political, cultural, and economic) because of structures of unequal power relationships across economic, political, social, and cultural dimensions.

2SLGBTQ+	Two-spirited, lesbian, gay, bisexual, transgender, queer +
ALS	Advanced Life Support
BLS	Basic Life Support
CSA Group	Canadian Standards Association Group
ESL	English as a second language
HIV	Human Immunodeficiency Virus
ICU	Intensive Care Unit
IRCP	International Roundtable on Community Paramedicine
MAiD	Medical Assistance in Dying
NCFP	National Competency Framework for Paramedics
NICU	Neonatal Intensive Care Unit
PAC	Paramedic Association of Canada
PCC	Paramedic Chiefs of Canada
SDH	Social determinants of health

Background

Human health and social needs exist along a dynamic continuum. This continuum (see Figure 1)[1] illustrates that increases in health incidences may be related to unmet social needs, while those with social privileges and adequate support may experience less frequent or severe health incidences.[2,3] Recognizing that health status is inextricably impacted by social determinants of health (SDH), community paramedicine has both an opportunity and a responsibility to address social needs to reduce healthcare inequities.[4,5]

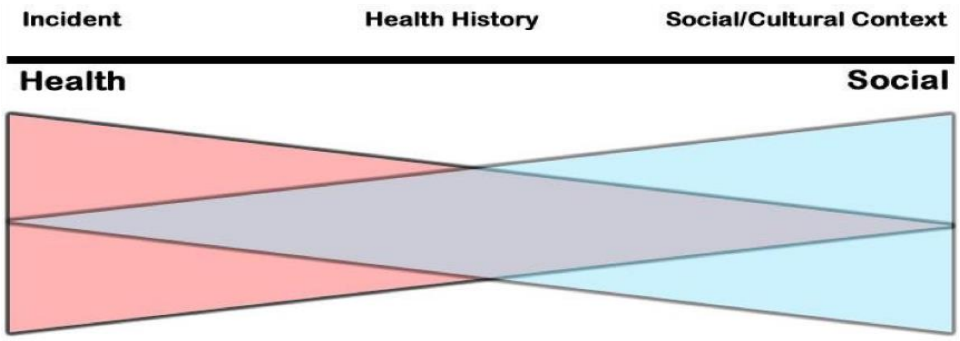

Figure 1. Health and social continuum[1]

Community paramedicine programs have existed since the early 2000s and are largely focused on resource optimization.[6,7] While this remains a predominant driver, innovation in recent years demonstrates that when community paramedicine is integrated into healthcare, it is well-positioned to meet the needs of structurally marginalized communities by focusing services for those facing barriers accessing equitable care.[6,8–11] In early 2023, Lunn et al. explored how community paramedicine supports social needs along a health and social continuum.[12] The review described the evolving ways community paramedicine models are addressing health and social needs within communities around the world. A key recommendation from the review was the need to meaningfully engage communities when developing programs to understand, co-design and implement a model that addresses the specific needs of each community; however, there was a lack of evidence to guide this approach. The results highlighted the opportunity to determine best practices for conducting community needs assessments that include equitable engagement.

Communities are experts in their health and social experiences and are therefore key partners in co-designing service delivery. Where community paramedicine programs continue to develop programming without meaningful community engagement, they risk exacerbating health services inequities. Where health systems remain the sole architects and without understanding and addressing the needs of communities, there will be gaps in delivery and challenges in conducting meaningful evaluation. Conversely, co-designing community-led and integrated healthcare programming will enhance efficacy, feasibility, sustainability, and ideally, promote equitable experiences and meaningful outcomes, guided by communities. Paramedicine has a social responsibility to meaningfully engage in community needs assessments to co-design service delivery and generate upstream health and social solutions for individuals and communities.[5,8,13] There is a lack of a standard to guide needs assessments in community paramedicine, leading to inconsistencies in design, development, implementation, and evaluation of outcomes.[12]

This project identified and synthesized community health and social needs assessment tools and frameworks. These synthesized findings informed the *Community Paramedicine Needs Assessment Tool* (CPNAT). The CPNAT will enhance health equity by guiding community paramedicine programs to better align their services with the health and social care needs of communities.

Aims

1. Identify and explore existing community needs assessment tools informing community paramedicine and health-social services program development.
2. Identify gaps in community needs assessment strategies to enhance community-led and co-designed service delivery for community paramedicine programs.
3. Produce foundational materials to present at a future convening of community paramedicine system partners to solicit feedback.
4. Incorporate feedback from the convening to inform a final version of the CPNAT.

Methods

- ✓ Completed a document analysis of existing community needs assessments as well as a review of literature, reports, and best practice tools across multiple disciplines and jurisdictions.
- ✓ Contacted community paramedicine programs across Canada to identify current tools or processes used to identify community needs, as well as determine gaps to address and support.
- ✓ Synthesized findings into a comprehensive draft version of the CPNAT.
- ✓ Presented to community paramedicine experts at a national convening meeting in June 2024 for review, discussion, and feedback.
- ✓ The Paramedic Association of Canada (PAC), International Roundtable on Community Paramedicine (IRCP), the Paramedic Chiefs of Canada (PCC) and others have endorsed the tool in principle pending review of this final version.

Document Analysis

This project involved a document analysis of existing community needs assessment tools. Due to the lack of standard needs assessment in paramedicine and the potential to learn from strategies implemented in other professions, we conducted a focused literature review to identify community needs assessments tools in other health and social care professions in both published and grey literature. Document analysis is a qualitative research approach where texts are systematically explored and interpreted by the researcher to evoke meaning, understanding and generate knowledge relative to specific research question(s).[14–16] While document analysis is often used to complement other methodologies, it can be used as a stand-alone method.[15] Document analysis is an effective approach for completing the necessary foundational work of identifying best practices to inform resource development. We registered the project on the Open Science Framework (OSF) to enhance transparency and trustworthiness [https://osf.io/2d9j6/].

Search strategy

The search strategy involved searches using combinations of phrases and keywords informed by the following terms:

- Needs assessment
- Community needs assessment
- Health needs assessment
- Social needs assessment
- Conducting needs assessment
- Community-level needs assessment

The review by Lunn et al.[12] demonstrated a lack of peer-reviewed studies which aligns with Shannon et al.'s review of community paramedicine programs internationally.[6]

Planning

We used O'Leary's eight-step approach for document analysis to plan and process this study.[17] We identified and collected the following documents:

- Community needs assessment published and grey literature in community paramedicine and other health and social care professions in Canada with a targeted literature review.
- Community needs assessment tools used to guide program design and development by community paramedicine service providers in Canada. These were requested through AB's membership of the *CSA Group Technical Committee on Community Paramedicine*.

Data Analysis

An initial draft of the CPNAT was created using the findings of the review, and then further refined via analysis of extracted data. We identified key elements of community needs assessments via prevalence of terms and used the review findings of Lunn et al.[12] to inform our analysis and identify missing items. Extraction and analysis were performed by TL, with a sample of items then reviewed by AB.

Needs assessment domains

Social needs underpin health needs; therefore, we grouped elements according to the social determinants of health outlined in the scoping review and further refined these categories by grouping and collapsing common items to align with the WHO Social Determinants of Health Equity domains [18] (see Table 1 and Figure 2). The items were organized into their respective key concept areas by TL and reviewed by AB. We identified gaps by considering what was not present in the data (informed by a systems thinking approach used as part of a larger pan-Canadian paramedicine project[19]) and identified elements in the scoping review that did not appear in the data for this study. Interpretation of the data was completed in a summative process, while remaining objective to the content and its relevance to the research question.

Table 1. WHO Operational framework for monitoring social determinants of health equity.[18]

Domain A	Domain B	Domain C	Domain D	Domain E	Domain F
Economic security and equality	Education	Physical environment	Social and community context	Health behaviours	Health care

Figure 2. Community needs domains informed by Lunn et al. 2023.[12]

Limitations

This review was limited to those documents that can be collected. While we aimed to be comprehensive in identification and collection methods, there may be additional documents that exist but aren't available in a public domain. We limited the review to English-language documents, thereby excluding potentially useful information from other jurisdictions.

Convening of system partners

We presented a working draft of the CPNAT to system partners in community paramedicine from across Canada and internationally at the 20th International Roundtable on Community Paramedicine meeting which took place on June 7th and 8th 2024 in Quebec City, Canada.

The draft of the tool was distributed by email to conference attendees a week in advance of the meeting, and they were asked to read it prior to the feedback session. An explanatory statement on the nature of the session along with a copy of the ethics approval letter was also attached to this email. Participants were informed of the voluntary nature of their participation and their right to withdraw or not participate at any stage of the process.

On the day, four members of the project team facilitated a 60-minute feedback session with participants. During this 60-minute period, participants worked in small groups to review and provide feedback on the draft tool using an online Google form. All form data were collated and organised for review by the project team after the event.

Results and Findings – document analysis

We identified a total of 26 full-text articles from database searching. These were combined with seven grey-literature documents and two additional peer-reviewed studies supplied via the *CSA Group Technical Committee on Community Paramedicine*, two additional peer-reviewed studies identified during full-text review, and one additional grey literature source. This resulted in a total of 38 documents that were included for analysis. See Figure 3 for details of the screening process.

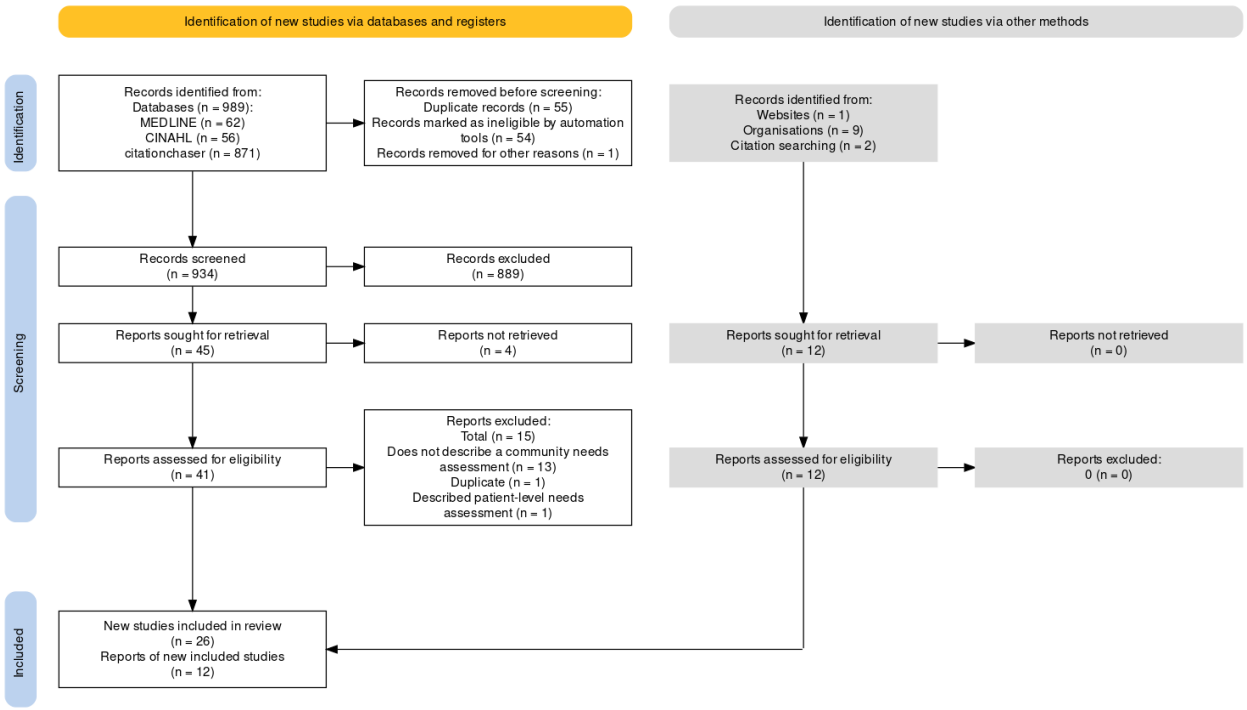

Figure 3. PRISMA flow diagram of included reports.

Of the included documents, 25 were published in the United State of America, nine in Canada, and one each in Italy, Israel, Jamaica, and South Korea (based on a project in Vietnam). Documents were published from 2001 to 2023. They comprised a mix of reports, guidelines, reviews, and tools. See *Appendix 1* for the full characteristics of included reports.

Results and Findings – convening

A total of 33 group responses were received from 112 participants at the feedback session. Detailed feedback was received on the structure and content of the tool; the perceived challenges with implementing the tool; the need for additional guidance and resources to use the tool; and finally, several suggestions to develop a branching logic software-based version of the tool (e.g., webpage, app) to encourage uptake in the future. All feedback was reviewed by TL and AB, and edits were made to the draft tool to reflect the feedback. This revised version of the tool was distributed to all team members to provide feedback prior to a final version being drafted.

Community Paramedicine Needs Assessment Tool (CPNAT)

Objectives of performing a community needs assessment

a) Definition of health status
b) Specification of conceptual framework for community health assessment
c) Specification of available resources (feasibility - time, human workforce)
d) Selection and collection of existing data on community health indicators
e) Primary data collection (e.g., household surveys, focus group interviews)
f) Specification of standards for comparison
g) Inventory and analysis of community health resources
h) Identification of community health and social needs
i) Identification of potential role(s) of community paramedicine in meeting these needs

Planning - questions to ask prior to using the tool

Developing a plan for assessing community needs will support community paramedicine developers in understanding how to best serve their communities in logical, efficient, and prioritised ways. It is imperative to ensure communities are lead partners in the co-design of needs-based services from the outset of community paramedicine program development. Planning allows for involvement of key partners from the beginning of the process.

- Identify purpose – why assess community needs?
- Is the CPNAT being used where no community paramedicine program exists to inform the design of a new program?
- Is the CPNAT being used where a community paramedicine program already exists, to inform quality improvement and enhance current design?
- Do community paramedicine services currently exist in the community?
    - If yes, what is the referral/intake process?
    - If yes, what is the community's awareness, understanding, and comfort with community paramedicine services?
- Who will conduct the needs assessment?
    - Consider capacity and competency of assessors
    - Timelines and contingency – allow for flexibility to support community agendas
    - Gather necessary equipment and software
- Identify sources of information (data collection)
    - How will data and records be stored?
- Create and maintain a shared and up to date partner list with contact information
- Communications
    - How will information be shared?
    - How will community members be engaged and informed?
    - Consider a pathway for questions and inquires

Planning - identify the community and partners

1. Describe the community(ies) served. Provide a detailed description of the community served by the program. Consider:
    1.1. Geographical
    1.2. Physical aspects (e.g., terrain)
    1.3. Infrastructure
    1.4. Demographics
    1.5. History
    1.6. Community leaders
    1.7. Culture
    1.8. Institutions
    1.9. Economics
    1.10. Governing structure
    1.11. Social structure
    1.12. Values
2. Are there specific racial or identity considerations for the community?
    2.1. Indigenous Peoples
    2.2. Black Canadians
    2.3. Asian Canadians
    2.4. Immigrants
    2.5. Sexual orientation
    2.6. Gender identity
    2.7. Veterans
3. Outline the partners who should be involved with and/or consulted when conducting the community needs assessment (remember also that this is a continuous process)
    3.1. People with needs that should be addressed
    3.2. Their family and caregivers
    3.3. Members of the community
    3.4. Community paramedics
    3.5. Paramedicine service leadership
    3.6. Health and social care professionals
    3.7. Health and social care volunteers
    3.8. Civic officials
    3.9. Regional officials (includes counties)
    3.10. Provincial officials
    3.11. Funding agencies
    3.12. Indigenous governance (e.g., Chief and Band Council)
    3.13. Economic services officials
    3.14. Corrections officials
    3.15. Public health personnel
    3.16. Public education administrators

3.17. Students, youth
3.18. Representatives of community organisations (e.g., community centres, Friendship centres, shelters)
3.19. Faith and religious organisations
3.20. Respected members of the community (e.g., Elders, teachers)
3.21. Local businesses who can help with the needs (e.g., utility companies, grocery stores, transport operators)

Planning - consider equity and reconciliation

1. Is the community located on Indigenous territory (treaty, ceded, or unceded)?
2. Are health and social care providers required to take comprehensive Indigenous cultural safety training? If so, what program? Is training ongoing?
3. Do established reciprocal relationships exist between health and social care professionals and Indigenous Peoples and their communities?
4. What cultural considerations must be incorporated into health and social care provision?
5. How are health and social care services funded in the community?
6. What bureaucratic processes are involved in the funding and jurisdiction of health and social care provision in the community?
   6.1. Do strategies exist to implement Jordan's Principle?
   6.2. Do strategies exist to implement Joyce's Principle?
7. Are family and kin included in care decisions and caregiving?
   7.1. Is there accommodation for kin lodging?
8. In addition to physical, is mental, spiritual, and emotional well-being included in holistic health assessments?
9. Are traditional ceremonial processes respected and conducted?
10. Are traditional healing practices and traditional medicine included in approaches to care?
11. Are Traditional Knowledge Keepers engaged in the design and provision of health and social care services?
12. Are there Indigenous facilities, centers, lodges?
13. What languages are spoken among the community?
14. Is time allowed in health and social care provision to tell and listen to stories?
15. Is information related to health and social care services provided in a format and manner that is appropriate to the community?
16. What are the impressions of the community related to health and social services?
17. Are childcare services available for those who may need to travel for health or social appointments outside of the community?
18. Does the community have residential school survivors or suffer from intergenerational trauma due to residential school experiences?
19. Do Indigenous Peoples have ownership and autonomy over their data collection, storage, and use?

20. Are strategies in place to support displacement for care and social services? (including repatriation, transport funding, accommodations, food services)
21. Is there an Indigenous-specific resources included in a community health map, identifying health and social care services? (e.g., healing centers)
22. Is culturally relevant health education available (use of storytelling, traditional symbols, languages)?
23. Do Indigenous-specific health and social care services exist?
24. Do Indigenous owned and led health and social care services exist?
25. Are there Indigenous community-specific barriers to healthcare utilization?
26. Are there 2SLGBTQ+ services accessible in the community?
27. Are there Elder care support services?
28. Does the healthcare system view Indigenous culture as a healthcare resource?
29. Any other considerations?

Using the tool

Once you have gathered the foundational information on the community outlined in the previous sections, this will inform and guide decisions related to using the remainder of the CPNAT.

You should seek to establish and cultivate trusting partnerships from the outset of the project – this can be achieved through applying various community organizing and community-based participatory research methods to conduct community needs assessment.[21–24] We strongly suggest that you consider co-designed, community-based and community-led approaches to using the CPNAT and ensure data stewardship as per OCAP. Aim for inclusive engagement - consider and address barriers to participation. Participatory approaches to consider when conducting community needs assessments include:

- Co-design with community members – involve community members at all stages of the project to ensure perspectives of the community are included.
- Community listening events
    - Talking Circles (in-person)
    - Public forums (in-person, virtual)
- Oral histories, storytelling
- Surveys
    - Online
    - Door-door
    - Telephone
    - Photovoice
- Interviews
    - Structured
    - Semi-structured
    - Focus Groups
- Observation
    - Windshield surveys

- Walking surveys

There are many resources available to guide you on using these and other methods of data collection.

Question	Response	Perceived or identified strengths (aka the capacity)	Perceived or identified gaps (aka the needs)	Potential role for community paramedicine program
A. Economic security and equality				
A.1. How is the community organized? A.1.1. Politically A.1.2. Structurally A.1.3. Socially				
A.2. Are there accessible descriptions of public and community health policy in the community?				
A.3. How is the healthcare system organized in the community? (e.g., regional health authority, municipality, county, district)				
A.3.1. What is the governance structure? (including Indigenous governance)				
A.4. Are specific vulnerabilities or characteristics associated with this population that may result in marginalization? (e.g., older adults aged >65, minors, children in care, incarcerated, victims of human trafficking, sex workers, undocumented or illegal immigrants)				

A.5. What is the status of social determinants of health for the community in question?				
A.5.1. Income				
A.5.1.1. What is the mean income for the community?				
A.5.2. Food security				
A.5.2.1. Are grocery stores within an accessible distance by foot or ground transportation?				
A.5.2.2. Is the price of goods within the means of community members?				
A.5.2.3. Is there evidence of food deserts?				
A.5.2.4. What is the utilisation rate of the food bank(s)?				
A.5.2.5. Are there local food producers?				
A.5.3. Disability				
A.5.3.1. Are there housing resources to support those living with disabilities to live independently?				
A.5.3.2. Mobility aid suppliers and services?				
A.5.3.3. Disability Transportation services?				

A.5.3.4.	Financial aid services?				
A.5.3.5.	In-home support services?				
A.5.3.6.	Respite services?				
A.5.3.7.	Accessible infrastructure?				
A.5.4.	Employment				
A.5.4.1.	Are community members in full-time or part-time employment?				
A.5.4.2.	Are community members unemployed or in precarious employment (e.g., seasonal)?				
A.5.4.3.	Are community members retired?				
A.5.5.	Public transport				
A.5.5.1.	Does the community rely on air or water transport connections?				
A.5.5.2.	Are air or water connections scheduled or chartered?				
A.5.5.3.	Does the community rely on a seasonal road connection?				
A.5.5.4.	Does the community rely on a rail connection?				

A.5.5.5.	Does the community have a public transport service such as buses?				
A.5.5.6.	Is public transport accessible to those with mobility issues?				
A.5.5.7.	Does the community have access to taxi and/or crowd-sourced rides?				
A.6.	Are there any other considerations in relation to economic security and equality?				
B.	Education				
B.1.	Does the community have public schools? (list grades)				
B.2.	Does the community have private or charter schools? (list grades)				
B.2.1.	Does the community have outreach schools? (list grades)				
B.2.2.	Does the community have homeschooling?				
B.2.3.	Does the community have adult educational services? (e.g., high school upgrading upgrading)				
B.2.4.	Does the community have literacy classes, English as a second language (ESL)				

classes?				
B.2.5. Does the community have post secondary educational institutions (e.g., community colleges, private colleges, universities)?				
B.2.6. Does the community have technical schools (e.g., vocational, trades)?				
B.3. Do paramedic services have access to electronic medical records?				
B.4. Do community members have access to virtual health and social care services?				
B.5. What platforms or solutions are the community currently using?				
B.5.1. Do these meet their needs?				
B.6. Is there 24/7 access to free public broadband wireless internet?				
B.7. Are any community members disproportionately affected by a lack of access to technology?				
B.8. What barriers does the community face in using digital technology or tools?				
B.9. Does the community have access to computer technology such as desktops, laptops, or tablet devices?				
B.10. Does the community have access to reliable				

	landline phone service?				
B.11.	Does the community have access to reliable cell phone service?				
B.12.	Does the community have access to reliable radio service?				
B.13.	Does the community have access to reliable high-speed internet?				
B.14.	Does the community have access to social media platforms?				
B.15.	Does the internet connection support video calls and/or virtual care technology?				
B.16.	Is access to communication services equitable compared to others across Canada?				
B.17.	Does the community have access to fall and injury prevention telemetry services?				
B.18.	Does the community have access to a source of medical and mobility devices and aids?				
B.19.	Does the community have access to remote patient monitoring facilities?				
B.20.	Does the community have access to voice accessibility services (e.g., text to audio converters)?				
B.21.	What media formats does the community have				

access to?				
B.21.1. news outlets (print)				
B.21.2. news outlets (online)				
B.21.3. radio				
B.21.4. podcasts				
B.21.5. webcasts, live streams				
B.22. Any other considerations in relation to education?				
C. Physical environment				
C.1. Housing				
C.1.1. Is long-term housing supply adequate to meet demand?				
C.1.2. Is short-term, seasonal housing supply adequate to meet demand?				
C.1.2.1. What is the age, architecture, and condition of housing?				
C.1.2.2. Is housing suitable for weather conditions?				
C.1.2.3. Is there evidence of segregation by characteristics (e.g., income, race, ethnicity)?				

C.2. Is the community situated in an urban heat island?				
C.3. Gather existing information on the community (as applicable) related to:				
C.3.1. Community safety				
C.3.1.1. Local police activity reports				
C.3.2. Municipal or local government data - fire incidents, environmental issues				
C.3.3. School board statistics				
C.3.4. Non-profit and population specific organisations (e.g., charities, professional associations)				
C.3.5. Child and family services				
C.3.6. Community proximity to contaminating industry				
C.4. Any other considerations in relation to physical environment?				
D. Social and community context				
D.1. Describe the sense of community - unity, cooperation, belonging, support, transience				
D.2. What are the social norms and attitudes (e.g., discrimination, racism, distrust of government)?				

D.3.Are social activities accessible within the community?				
D.3.1. Are social activities available that are free or low-cost?				
D.3.2. Are social activities accessible by foot or public transport?				
D.3.3. Do programs exist to reduce barriers to accessing social activities (e.g., equipment loans, fee waivers)?				
D.3.4. Are there transportation services available for seniors or people living with mobility disabilities?				
D.4.Are social activities specifically aimed at adults over age 65?				
D.4.1. Do these include outreach services?				
D.5.Do language or communication considerations exist within the community?				
D.5.1. Languages spoken by community members				
D.5.2. Primary language spoken in the home				
D.5.3. Verbal language considerations				
D.5.4. Written language considerations				

D.5.5. Sign language considerations				
D.5.6. Health literacy considerations				
D.5.7. Cognition considerations				
D.5.8. Translation services				
D.5.9. Education levels				
D.6. Are there specific cultural or ethnic considerations for the community?				
D.6.1. Cultural groupings				
D.6.2. International students				
D.6.3. Migrant workers				
D.6.4. Ethnic minorities				
D.6.5. Religious minorities				
D.6.6. Refugees, asylum seekers, and displaced persons				
D.6.7. Citizenship, non-resident status				
D.7. Are supports available to people experiencing the effects of violence or abuse within the community?				
D.7.1. Intimate partner violence				
D.7.2. Child abuse and mistreatment				

D.7.3. Elder abuse and mistreatment				
D.7.4. Sexual abuse or assault				
D.7.5. 2SLGBTQ+ safe spaces				
D.7.6. Female genital mutilation				
D.8. Are health and social care providers required to take specific sexual assault training?				
D.9. Any other considerations in relation to social and community context?				
E. Health behaviours				
E.1. Harm reduction services – are they available after hours; are there wait lists?				
E.1.1. Are alcohol dependency issues present in the community?				
E.1.2. Are tobacco or vaping dependency issues present in the community?				
E.1.3. Are substance use issues present in the community?				
E.1.4. Are there safe consumption sites in the community?				
E.1.5. Does the community have access to safe consumption supplies?				

E.1.5.1. Are there safe supplies sites? (e.g., clean needles, naloxone kits)				
E.1.6. Does the community have access to opioid agonist therapy?				
E.1.6.1. Can this therapy be initiated in the community or only within a health facility? (i.e., initiated out of hospital by community health nurses or community paramedics)				
E.1.7. Are peer workers available to people who use drugs, alcohol, and/or tobacco?				
E.1.8. Are harm reduction or tobacco/alcohol/drug use cessation strategies in place?				
E.2. Are mental health, substance use and harm reduction services accessible to people experiencing homelessness?				
E.3. Any other considerations in relation to health behaviours?				
F. Health care				
F.1. What methods exist to inform community members of available health and social care services? (e.g., advertising, knowledge translation)				

F.2. Does the community have access to a community health map? (including health and social care resources)				
F.3. Are there healthcare, social care, and community care navigation services/ social prescribing services available in the community?				
F.3.1. Are these available 24/7?				
F.3.2. What is the process to access these services?				
F.4. Are healthcare services public, private, or a combination?				
F.5. Are healthcare services available 24/7?				
F.6. Are healthcare services coordinated and/or integrated?				
F.7. Are timelines and wait times to access health and social care services appropriate?				
F.8. Is there an accessible mechanism for community members to provide service feedback?				
F.9. What healthcare access points exist in the community, what services do they provide, are they accessible and equitable?				
F.10. What is the healthcare funding model for the community?				

F.11. Are specific mental health concerns present within the community?				
F.12. Are there in-patient psychiatric beds available in the community?				
F.13. Is there a mental health facility accessible to the community? (including inpatient services)				
F.13.1. Are services accessible after hours, are there wait lists, is there drop in availability?				
F.14. Gather available information on local determinants of health				
F.15. Identify local health and social indicators as applicable (e.g., trauma deaths, teen pregnancy rate, suicide rate, employment trends)				
F.15.1. Identify rates of chronic conditions				
F.16. Gather local emergency department data (e.g., admissions, wait times, closures)				
F.17. Gather health behaviours data (physical activity, eating habits /nutrition, substance use)				
F.17.1. What is the obesity rate (adult and youth) for the community?				
F.18. Gather census data (e.g., population density, demographic and socio-economic profiles)				

F.19. Gather hospital acute care activity data				
F.20. Gather coroner and medical examiner reports				
F.21. Gather healthcare industry data				
F.21.1. Paramedic services				
F.21.2. Healthcare workforce data				
F.21.2.1. Capacity				
F.21.2.2. Level of training				
F.21.3. Paramedicine service data				
F.21.3.1. Proximity to ambulance station(s) (driving distance)				
F.21.3.2. Level of service, contexts of practice (e.g., BLS, ALS, clinics, in-community)				
F.21.3.3. Staffing Models (e.g., full time, part time, casual, paid on call, volunteer)				
F.21.3.4. Paramedicine workforce data				
F.21.4. Hospitals				
F.21.4.1. Service Level (e.g., tertiary-level, ICU, NICU)				

F.21.4.2. Surgical capacity				
F.21.4.3. Pediatric hospital				
F.21.5. Urgent care center(s)				
F.21.6. Primary care (Family Physician and/or Nurse Practitioner)				
F.21.7. Public Health				
F.21.7.1. Immunization services				
F.21.8. Supportive Living, Long Term Care, Continuing Care				
F.21.9. Specialist physician access				
F.21.10. Blood donation centre				
F.21.11. Clinics (e.g., walk-in clinic, nursing station)				
F.21.12. Chronic care clinics (e.g., diabetic, cardiac, dialysis)				
F.21.13. Cancer care				
F.21.13.1. Clinics				
F.21.13.2. In-patient cancer care				
F.21.13.3. Out-patient cancer care				
F.21.14. Outreach services to support isolated				

seniors access health and social care				
F.21.15. Pharmacies				
F.21.15.1. Prescription delivery available?				
F.21.16. Dental clinics (dental surgery; orthodontics)				
F.21.16.1. Are walk-ins available?				
F.21.17. Dietetics services				
F.21.18. Foot care services				
F.21.19. Traditional Healing				
F.21.20. Occupational Therapy				
F.21.21. Physiotherapy				
F.21.22. Midwifery/Indigenous Midwifery				
F.21.23. Maternal and newborn services				
F.21.24. Hospice care				
F.21.25. Palliative care				
F.21.26. Medical assistance in dying (MAiD)				
F.21.27. Mental health services (including inpatient)				
F.21.27.1. Suicide prevention services				

F.21.28.	Imaging and laboratory services				
F.21.29.	Isolation/quarantine facilities				
F.21.30.	Optician and vision services (e.g. optometrist)				
F.21.31.	Veteran’s services				
F.21.32.	Sexual health services (including screening, gender-affirming care, HIV services, and family planning)				
F.21.33.	Women's health services (including screening; abortion)				
F.21.34.	Men’s health services (including screening)				
F.21.35.	Transgender and gender diverse health services (including screening)				
F.21.36.	Disability support services				
F.21.37.	Land ambulance access				
F.21.38.	Air ambulance access				
F.21.39.	Boat or other ambulance access				
F.21.40.	Respite services				
F.21.41.	Veterinary clinics				
F.22.	What social care access points exist in the				

community, what services do they provide, are they accessible and equitable?				
F.22.1. Housing services				
F.22.2. Social work services				
F.22.3. Food banks				
F.22.4. Meal delivery services				
F.22.5. Home-care services				
F.22.6. Warming centres				
F.22.7. Cooling centres				
F.22.8. Supportive Living				
F.22.8.1. People living with disabilities (under age 65)				
F.22.8.2. Long-term care facilities				
F.22.8.3. Retirement facilities				
F.22.8.4. Daily living assistance				
F.22.8.5. Daily living and medical assisted living				
F.22.9. Mental health services				
F.23. What social services exist in the community, what				

services do they provide, are they accessible and equitable?				
F.23.1. Libraries (including quiet spaces)				
F.23.2. Grocery stores (including delivery services)				
F.23.3. Restaurants (including delivery services)				
F.23.4. Coffee shops				
F.23.5. Community gardens and/or greenhouses				
F.23.6. Collective kitchens				
F.23.7. Bookshops				
F.23.8. Clothing stores				
F.23.9. Used goods/thrift stores				
F.23.10. Hardware stores				
F.23.11. Outfitters				
F.23.12. Indoor recreation facilities				
F.23.13. Outdoor recreation facilities				
F.23.14. Community centres				
F.23.15. Youth centres				
F.23.16. Indigenous centres				

F.23.17.	Cultural centres				
F.23.18.	Veterans' services				
F.23.19.	Religious worship sites				
F.23.20.	Museums				
F.23.21.	Cinemas				
F.23.22.	Theatres				
F.23.23.	Restaurants				
F.23.24.	Childcare facilities (including preschools)				
F.23.25.	After school programs (including summer programs)				
F.23.26.	Petrol/gas stations				
F.23.27.	Electric vehicle charging stations				
F.23.28.	Accessible Public potable water fountains, fill-stations				
F.23.29.	Accessible Public washrooms				
F.23.30.	Accessible Public showers				
F.23.31.	Laundry services				
F.23.32.	Kennel/boarding services				

F.23.33.	Workforce support services (unions, injury control)				
F.23.34.	Composting services				
F.23.35.	Recycling services				
F.24.	Are there public safety services in the community?				
F.24.1.	Police or public safety access points				
F.24.2.	Structural fire and rescue services				
F.24.3.	Wildland fire services				
F.24.4.	Indigenous fire management services				
F.24.5.	Indigenous policing services				
F.24.6.	Serious incident response services				
F.24.7.	Search and rescue services (land, water, remote, arial)				
F.25.	Any other considerations in relation to health care?				
Identify potential integrated care partners					
This section allows for the identification of allied health and social care partners, programs and resources (as identified earlier in the tool) that community paramedicine programs could develop referral and/or integrated care pathways with.					

Identify other community needs				
This section allows for adaptability and reflexivity during conduct of the CPNAT to be populated here. Use this section to collate and organise the 'other' area for items that don't fit into any organized domains above.				
Prioritise needs assessment outcomes				
Consider health equity and capacity of the community and health care workforce when ranking priorities.				
A. Community priorities				
B. Indigenous health priorities				
C. Medical conditions				
D. Health behaviours				
E. Community social/living conditions				
F. Health system priorities				
Follow up				
Examine strengths, gaps, opportunities, barriers, and inequities in follow up to conducting community needs assessment to gain context and causation understanding. Apply an intersectional lens when examining the causes of strengths, gaps, barriers, and inequities. Apply equity-focused implementation strategies to guide solutions.				

Consider how historical and contemporary local, regional, provincial, and federal politics inform healthcare and social care policy.				
a) Current political priorities				
b) Future-thinking priorities				
c) Initiatives				
d) Budget				

Resources

This section will be populated with links to resources based on the questions outlined in the CPNAT and will be kept updated on the OSF project page.

Wildfires - https://cwfis.cfs.nrcan.gc.ca/home

Flooding - https://natural-resources.canada.ca/science-and-data/science-and-research/natural-hazards/data-related-flood-mapping/24250

Climate - https://climate.weather.gc.ca/historical_data/search_historic_data_e.html

Varied topics - Open Government Portal (filters on page) - https://search.open.canada.ca/opendata/?page=1&sort=metadata_modified+desc

Urban heat island - https://www.canada.ca/en/health-canada/services/climate-change-health/urban-heat-islands-tools-resources.html

Food deserts - https://storymaps.arcgis.com/stories/934a49ffcdf347aa8cec1ccde13978c5

Health indicators - https://www.cihi.ca/en/access-data-and-reports

Census data - https://www12.statcan.gc.ca/census-recensement/index-eng.cfm

Hospital acute care activity data - https://www.cihi.ca/en/topics/acute-care/indicators

Coroner and medical examiner reports - https://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=5125

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