Healthcare Excellence Canada

Social Prescribing and Community Paramedicine in Canada

A Guide to Promising Practices

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Contents

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About this guide

The Social Prescribing and Community Paramedicine in Canada: A Guide to Promising Practices ("guide") is designed to help paramedics across Canada systematically use social prescribing within their paramedicine programs. The goal is to help address a wide range of health and social needs of the participants.

This guide defines key concepts like community paramedicine and social prescribing. It highlights the three basic steps of social prescribing and their supporting components. For each step, it shares real-world examples and practical strategies (called promising practices) from across Canada to help paramedics use these approaches in their own communities.

Note

Throughout this guide, we use 'participants', 'people' or 'clients' rather than 'patients', 'person receiving care' or other commonly used terms. We do this to show that people have choice and control over their care and how they participate in the healthcare system.

Community paramedicine and social prescribing

Community paramedicine is an evolving model of care where paramedics primarily deliver community-based, preventive, and primary healthcare, at times alongside their traditional emergency response and transport role.

It involves paramedics collaborating with healthcare professionals and community agencies to provide preventive care, offer support, and help people navigate social services (1). This approach focuses on addressing health and social needs by connecting people with community resources to improve their overall well-being (2).

Evidence shows this approach improves health outcomes for underserved populations while reducing avoidable ambulance calls, emergency department visits, and hospital admissions (3).

Social prescribing is the process of helping to connect people with support and services in their community to address non-medical needs that affect their health and well-being.

It involves healthcare providers and community members working together with the person (patient or client) and others in the care circle (family, friends, caregivers, etc.) to co-create a plan (the 'social prescription') to improve their own health and connect them with others in their community (4).

For example, this could be a connection to a food bank, seniors centre, class, recreational activity, legal support, or grief support group. Ideally, it also includes a way to track and measure the impacts of these social supports on the person's health experiences, health outcomes, and use of healthcare services.

Social prescribing can improve a participant's mental health and well-being, has led to significant reductions in repeat emergency department visits, and can also lead to significant return on investment (5-7).

The role of social prescribing in community paramedicine

Social prescribing complements community paramedicine by bridging between clinical care and social/community services. When used in community paramedicine programs, social prescribing emphasizes self-determination by supporting individuals to actively participate in their own wellness. Self-determination includes four elements: having choice (autonomy), feeling capable (competence), feeling connected to others (belonging), and wanting to help or give back (beneficence) (8).

Community paramedics are uniquely positioned to implement social prescribing because they meet people where they are – in their homes and communities. This also means they are in a strong position to identify social factors affecting their health during home and community visits (9).

While this guide focuses on social prescribing within community paramedicine programs, the practices can be adapted by any paramedic service looking to integrate social prescribing into their care model.

A three-step process for social prescribing

Social prescribing is a structured and collaborative process that connects people to non-medical supports to address their health-related social needs. The most basic model of social prescribing supports community paramedics to do three things when serving people in their community.

Step one: identify

Identify that a person has non-medical, health-related social needs (e.g. issues with housing, food, employment, income, and/or social support) and build trust. Identification can be based on a paramedic's professional judgement and/or the use of structured screening tools.

Step two: collaborate

Collaborate with the person as an equal partner, to make a social prescription based on what is important to them (a process often called co-production). Collaboration can happen through a direct conversation with a community paramedic, or a community health worker called a 'link worker' or 'community connector' that the person has been referred to.

Step three: connect

Connect the person to non-clinical supports and services within the community, document the referral, support participation, and follow up about the results. Successful connection relies on strong partnerships between community paramedics and non-health services and organizations in the community. Ongoing monitoring and documentation are also essential for learning, improving and assessing the effectiveness of social prescribing.

Many community paramedicine services are already using one or more components of this basic model of social prescribing, often referring to it by different names (including system navigation).

Community paramedics excel at identifying non-medical needs (step one) and connecting people to community services (step three). However, community paramedicine services across Canada are not yet consistently engaging people as active partners in developing personalized solutions (step two), and there are opportunities to improve and systematize promising practices in each step.

Applying the three-step process: Promising practices

This section shares promising practices from community paramedicine services across Canada. To support the application of the three-step process, we have overlayed a more detailed model of social prescribing called the Common Understanding of Social Prescribing (CUSP) Framework (Appendix A).

The CUSP Framework expands social prescribing to seven key components which global experts agree are the best way to help people with their social needs. (4).

We've organized the promising practices to show how they apply the key components of the CUSP framework, within the basic three-step process for social prescribing.

How we collected the promising practices

We collected these promising practices through a literature review and key informant interviews with 14 community paramedicine programs across Canada (Appendix B), including Nova Scotia, Prince Edward Island, Ontario, Saskatchewan, British Columbia, Manitoba, Alberta, Northwest Territories and Nunavut.

1

Step one: identify

Identify health-related social needs

Identifying participants who have unmet non-medical needs affecting their health (e.g., housing, food insecurity, employment, income, or lack of social support) is a key first step. Community paramedics are using structured assessment tools, remote monitoring, and proactive identification during clinical calls to identify health-related social needs.

Structured assessment tools

To effectively help participants, leading community paramedic programs are using **structured assessment tools** to identify social factors that affect health. These structured assessments ensure that paramedics consistently check for non-medical needs that significantly impact a person's overall health, allowing for more comprehensive care.

Winnipeg Fire Paramedic Service's Community Paramedic Program in Manitoba, paramedics complete a **detailed home assessment** during their first visit. This helps them understand how people see their own health and what they might be missing. They ask specific questions about things like transportation, food, social connections, and support systems. For instance, they might ask how someone gets groceries, if they have reliable transportation, who they can count on for help, and if they feel lonely. This gives a more complete view of the person's situation, so they can be connected with the right resources.

Twenty-seven paramedic services across Canada use a **standardized assessment tool** developed by McMaster University CP@clinic Program (10). This tool examines health history, financial security, and mental health support using validated health risk assessments that look at things like the risk of heart disease, diabetes, falls, as well as quality of life, social isolation, and poverty.

Remote monitoring

Oxford County Paramedic Services (Ontario) uses **remote patient monitoring** for chronic conditions like hypertension, diabetes, congestive heart failure, and chronic obstructive pulmonary disease. This allows paramedics to identify and address health issues early, helping prevent hospital admissions by shifting to a preventative care model.

Proactive identification of social needs

In Alberta's EMS Mobile Integrated Healthcare program, paramedics **proactively identify social needs** during clinical calls. They can either support the person directly or refer them to a patient navigator (who is a staff member within the dispatch centre). The patient navigator will provide preventive service recommendations and contacts. By taking a holistic approach to patient assessment, community paramedics identify not only medical needs but also social determinants that may be contributing to health issues. Additionally, 911 paramedics proactively refer to community paramedic programs, as well as to the patient navigator.

Build trust

Trusted professionals or community members, such as community paramedics or community leaders, identify people who could benefit from social prescribing. These individuals play a key role in initiating the process of social prescribing. By building trust and developing relationships first, community paramedics can more effectively connect people with social services, especially in communities with historical reasons to distrust authority.

Adapting appearance and service delivery

In the Community Paramedicine Program at British Columbia Emergency Health Services, community paramedics are **changing their appearance** to build trust in some communities by removing the red stripe from their vehicles and wearing polo shirts instead of standard uniforms. Services are **adapted to community rhythms** like fishing seasons and religious observances. In rural Mennonite and Hutterite farming communities, paramedics in British Columbia recognize the significance of Sunday church services and help **coordinate transportation** for individuals who may not have family support. Ongoing collaboration with local leaders and organizations, and policy adaptations, ensure sustainable, culturally grounded healthcare solutions. For example, they have previously developed relationships with the broader community to enable community paramedics to be physically embedded within rural and remote communities, rather than deployed from ambulance stations, and they want to build on this approach.

Meaningful engagement with First Nations, Inuit and Métis communities

Medavie Health Services West's Mobile Integrated Health program in Saskatchewan emphasizes genuine collaboration with the Saskatoon Tribal Council. Paramedics receive training from First Nations, Inuit and Métis organizations and are **embedded within the Tribal Council's health bus**. This reciprocal relationship builds deep understanding of community services and aligns care with First Nations, Inuit and Métis needs. Paramedics participate in First Nations, Inuit and Métis-led programming, recognizing their role as part of a broader support network. This collaborative approach fosters trust and ensures culturally responsive care.

In the Community Paramedicine Program at British Columbia Emergency Health Services, trust is built through face-to-face interactions and **partnerships formed through direct community**

requests, like the K'ómoks First Nation initiative where community paramedics were engaged to help support local health literacy efforts and the role of the community paramedic was developed to address community-specific needs rather than provide pre-determined services.

Developing cultural competency

At Advanced Medical Solutions in Nunavut and Northwest Territories, paramedics serving First Nations, Inuit and Métis communities receive specialized cultural sensitivity training. This training includes modules on cultural traditions, communication styles, and community needs, with a focus on Inuit-specific communication like non-verbal cues. Paramedics also learn trauma-informed care principles to understand how historical trauma impacts health behaviours. This training ensures paramedics engage respectfully and responsively with the communities.

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Step two: collaborate

Referral to connector

Once identified, participants are referred to a 'connector' (sometimes called a 'link worker' or 'navigator') who specializes in providing personalized support and helping the person make their own decisions. The referral ensures that individuals are guided toward relevant resources and services. In many cases across the country, the community paramedic service is playing the role of the 'connector' or 'link worker'.

Community paramedic programs create opportunities for self-referral, utilizing electronic systems, and convening situation tables between organizations and agencies to connect the dots.

Self-referral models

Innovative programs have evolved to allow individuals to **self-refer.** Medavie Health Services West's Mobile Integrated Health program in Saskatchewan initially only accepted referrals from other healthcare providers. Now anyone can self-refer directly to community paramedics through phone or text, removing gatekeeping barriers and broadening access to community paramedic services and their associated supports.

Electronic referrals

Many services use **electronic referral** systems to streamline real-time coordination. Paramedics in Alberta's EMS Mobile Integrated Healthcare program submit referrals directly to Alberta Health Services community partner services (like palliative or home care supports) through the Connect Care platform. Manitoba's program integrates with Winnipeg's medical charting system, allowing paramedics to access and contribute to patient records.

Situation tables for complex cases

Situation tables are collaborative forums where multiple agencies address complex community cases. These forums enable rapid, coordinated responses to high-risk situations by bringing together organizations like mental health associations, child services, and police together with the community paramedic service. At Oxford County Paramedic Services, weekly meetings involve 18 agencies using risk-tracking databases to identify and mitigate risks. These tables facilitate quick access to services and strengthen connections to social determinants of health, ensuring holistic care. By integrating with community paramedicine and partnerships, these initiatives deliver timely and comprehensive supports.

Connector role and co-production

The connector is vital to social prescribing. They provide personalized support by building trust, collaboratively creating action plans, removing barriers to community resources, supporting self-management, ensuring ongoing support, and maintaining accountability through documentation and follow-up.

Social prescriptions should be co-produced with the participant, identifier, and connector. This ensures the intervention is tailored to the person's unique circumstances, goals, needs, and strengths.

Successful programs from across the country prioritize building relationships before connecting people to services, shifting away from 'patients' language, and focusing on holistic assessments and person-directed goal setting. This involves person-centered listening and long-term engagement, recognizing that meaningful connections take time.

Shifting terminology

Some programs, like the Community Paramedicine Program at British Columbia Emergency Health Services, use the term **'clients' instead of 'patients'** to emphasize a supportive, needs-based approach that focuses on individual needs, preferences and autonomy rather than traditional clinical care.

Holistic assessment and client empowerment

The Ottawa Paramedic Service community paramedics emphasize **holistic assessments and client empowerment**, focusing on personal dignity and self-determination to improve well-being.

> "I just sat down with [a client] and talked to him about what he wants out of the future. And a lot of it was just around pride. He wanted some pride back... In less than four weeks the apartment was spotless. The next time I came to see him, he was brushing his hair, doing up a button-up shirt and he was quite happy."

This case illustrates how addressing what matters to the client—in this case, personal pride—can lead to significant improvements in wellbeing. This person-centred approach not only enhances satisfaction of the person receiving care but also promotes sustainable health outcomes by aligning interventions with what truly matters to individuals.

Client-directed goal setting

> "We're trying to build a goal of care that they are responsible for. So, when we meet with them it's like, 'Why were we here? How can we help you? What's your goal of us communicating with you and spending time with you?'"

Leading programs emphasize **client-directed goal setting** rather than provider-determined interventions. County of Renfrew Paramedic Service community paramedics program focuses on collaborative goal development.

Niagara Emergency Medical Services' community paramedics program implements a similar approach with monthly wellness visits to track progress on personalized goals.

> "When [we] revisit at the next monthly wellness meeting, [we say] 'here are the goals we set together last month, how are we doing [now]?'"

Relationship-first approach

While concrete examples of both the connector role and co-production are still emerging, most community paramedics note that successful programs prioritize relationship **building before making connections to services**, recognizing that these connections may take "six, seven, eight visits" and that "everyone has a story [...] it's really up to us to be able to just sit down and listen to that story."

This person-centred approach focuses on helping people tell their own stories and shape their healthcare journey, with an emphasis on long-term relationship building over quick interventions: "As long as we put the client and relative in the centre, we can find a solution."

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Step three: connect

Connection to non-clinical supports and services

Both identifiers and connectors facilitate access to community-based, non-clinical services tailored to the participant's needs (e.g., support groups, educational programs, arts activities). Community paramedic services are focusing on connecting people to supports that aim to improve health equity and address health-related social needs by leveraging co-located services, information sharing, and specifically focusing on supporting underserved communities.

Comprehensive housing continuum

The County of Renfrew Paramedic Service community paramedics program provides a **housing continuum** to support underserved populations. The program established 24/7 warming centers that serve as critical entry points for individuals experiencing homelessness, creating stable locations where community paramedics can consistently locate clients, conduct follow-up assessments, and provide wraparound care services. The program has documented success stories of transitioning individuals out of homelessness through a 9-month process that addresses both medical and housing needs in a coordinated fashion. By creating this housing continuum with multiple intervention points, the program enables community paramedics to maintain consistent relationships with underserved clients while systematically addressing their interconnected health and social needs.

Co-locating Services

At Hamilton Paramedic Service, community paramedics use a co-location model that brings **multiple service providers together in one location**. This includes paramedics alongside eight community partners, such as addiction, social work, and youth navigators. Daily rounds ensure seamless coordination and communication, creating a community hub that simplifies access. Dynamic client management allows for collaborative assessment and immediate support, including addressing medical, legal, and social needs. This holistic approach enhances social prescribing by providing well-rounded client care.

Comprehensive resource sharing

Alberta Health Services Emergency Medical Services' Mobile Integrated Health program facilitates timely referrals before health issues escalate by providing participants with **comprehensive summaries and printed information packages** about available community resources. Printed information packages are given to people with knowledge about available community resources,

enabling proactive engagement with services such as addiction and mental health support. This proactive navigation ensures that people receive the right interventions at the right time, preventing avoidable hospitalizations and promoting sustainable health outcomes.

Bridging gaps in underserved communities

The Community Paramedicine Program at British Columbia Emergency Health Services specifically focuses on **underserved rural and remote areas**, where healthcare services are limited, and access is more challenging. Using technology like Wi-Fi-equipped vehicles to connect people with social services and bridge service gaps, paramedics coordinate with social service providers and community organizations, ensuring individuals can access the broader network of support they need.

Monitoring and evaluation

Ongoing monitoring and documentation are critical for learning, improving and assessing the effectiveness of social prescribing interventions. They help make social prescribing a regular part of systems rather than a one-off occurrence and provide clear structures for accountability and improvement. Successful programs are using structured documentation and collaborating with universities to support their monitoring and evaluation activities.

Structured documentation and tracking systems

Several community paramedicine programs use **structured documentation and tracking systems** for social prescribing-related activities. Hamilton Paramedic Service's program uses a sophisticated Electronic Medical Record (EMR) system through the Future Health Services - Community Paramedicine Report Patient Monitoring Community Partner Relationship Management (CPRPM) App to track incoming referrals, outgoing referrals, client interactions, and service provision. Saskatchewan's program is transitioning from free text to structured documentation with specific social prescribing categories to be able to better track social prescribing activities.

Collaboration with academic institutions

Partnerships with academic institutions strengthen program credibility and sustainability. Hamilton Paramedic Service's program has research partnerships with McMaster University, which was described as a significant enabler of program success. Twenty-seven paramedic services across Canada utilize McMaster University's CP@Clinic micro-credential certificate for standardized assessment, providing evidence-based tools and training (10), and all services that implement the CP@clinic program have research ties to McMaster University. These **academic connections** facilitate evaluation, quality improvement, and professional development.

Conclusion

This guide underscores a transformative approach to healthcare.

Community paramedics across Canada have made impressive strides in using components of social prescribing, demonstrating a strong commitment to holistic and person-centred care. They've pioneered innovative programs and forged valuable community partnerships.

Promising practices have emerged despite a challenging context for practice change:

- Documentation systems can be fragmented, hindering seamless care and outcome tracking.
- Funding models can lack stability, impacting long-term service delivery.
- Lack of standardized tools and pathways can lead to inconsistent implementation.
- Capacity limitations inhibit community paramedics and partners' abilities to meet the core needs of the people they serve.

Aligning promising practices to the CUSP Framework highlights how community paramedics are integrating social prescribing's key steps which aim to holistically improve health outcomes through non-clinical supports.

The promising practices emphasize community partnerships, structured assessments, person-directed goals, and building trust as we shift from reactive to preventative care that addresses the root causes of health issues.

Looking ahead, services have the opportunity to strengthen and systematize their social prescribing practices (deepening their engagement with each step of the CUSP Framework) and enhance their collaboration with community organizations for greater support.

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Appendix A: The Common Understanding of Social Prescribing Framework (in plain language)

The CUSP approach expands social prescribing to seven key components. In this model, trusted individuals such as community paramedics identify people with health-related social needs and refer them to a community connector. The connector works equitably alongside the person to co-produce a social prescription: a connection to non-clinical supports and services and ensures ongoing monitoring and evaluation (4).

1. **Identification of health-related social needs:** The process begins with identifying individuals who have unmet non-medical needs affecting their health (e.g., housing, food insecurity, employment, income, or lack of social support). This identification can occur in clinical or community settings.
2. **Trusted identifiers:** Trusted professionals or community members, such as community paramedics or community leaders, take note of people who could benefit from social prescribing. These individuals play a key role in initiating the process of social prescribing.
3. **Referral to connector:** Once identified, individuals are referred to a "connector" (sometimes called a link worker or navigator) who specializes in providing personalized support and helping the person make their own decisions. The referral ensures that individuals are guided toward relevant resources and services.
4. **Connector role:** The connector is vital to social prescribing. They provide personalized support by building trust, collaboratively creating action plans, removing barriers to community resources, empowering self-management, ensuring ongoing support and maintaining accountability through documentation and follow-up.
5. **Connection to non-clinical supports and services:** Both identifiers and connectors facilitate access to community-based, non-clinical services tailored to the individual's needs (e.g., support groups, educational programs, arts activities).
6. **Co-production:** Social prescriptions are co-produced collaboratively by the individual, identifier, and connector. This ensures that the intervention is tailored to the person's unique circumstances, goals, needs, and strengths.
7. **Monitoring and evaluation:** Ongoing monitoring and documentation is critical for learning, improving, and assessing the effectiveness of social prescribing interventions. It helps make social prescribing a regular part of systems rather than a one-off occurrence and provides clear structures for accountability and improvement.

Appendix B: Intervention specialist interviewed

It is with thanks that we list below those who were interviewed for this guide:

- Alan Batt, Paramedicine Program Lead and an Assistant Professor (adjunct) at Queen's University
- Amy Poll, Director, Community Paramedicine Program: BC Emergency Health Services, Provincial Health Services Authority (British Columbia)
- Angela Sereda, Senior Operations Manager, Mobile Integrated Health Program, Medavie Health Services West (Saskatchewan)
- Brent McLeod, Manager/Commander - Hamilton Paramedic Service (Hamilton, Ontario)
- Donald MacLellan, Director, Mobile Integrated Healthcare, Medavie Health Services (Chatham-Kent, Ontario)
- Husein Lockhart, Leader of Community & Industrial Services, AMS Inc. (Northwest Territories and Nunavut)
- Ian Naugler, Advance Care & Community Paramedic (Ottawa, Ontario)
- Jamie Walter, Superintendent of Community Paramedicine, Oxford County (Oxford County, Ontario)
- JD Heffern, Chief Paramedic for Indigenous Services Canada with the Government of Canada
- Jodi Possia, Training Officer Paramedic Education, Community Paramedicine, Winnipeg Fire Paramedic Service, City of Winnipeg (Manitoba)
- Marty Mako, Commander, Mobile Integrated Health, Niagara Emergency Medical Services (Niagara, Ontario)
- Mathieu Grenier, Deputy Chief - Clinical Programs, County of Renfrew Paramedic Service (Renfrew, Ontario)
- Ryan Kozicky, Director – EMS Mobile Integrated Healthcare, Alberta Health Services – EMS (Alberta)

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Juwairiya Ahmad, MPH, is committed to advancing health equity by addressing social determinants of health and strengthening community health systems. She strives to erase health disparities and ensure equitable access to care by bridging gaps between policy and practice through research, advocacy, and community-driven solutions.

Cheryl Cameron, MEd, is an Advanced Care Paramedic and the Director of Operations with Canadian Virtual Hospice. She is a PhD candidate with Monash University studying engagement practices in the development of integrated care programs and a senior fellow with the McNally Project for Paramedicine Research.