Paramedic Chiefs of Canada

Chefs Paramédics du Canada

Building Community Paramedicine into the Canadian Healthcare Landscape: An Economic Analysis of 'Community Paramedicine at Clinic' (CP@clinic) from the Paramedic Service Perspective

We're taking a virtual role call today for those on the WebEx.
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This session will be recorded, and a link sent out to attendees.

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Paramedic Chiefs of Canada

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Guest Speaker:

Dr. Gina Agarwal

Associate Professor,
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David Braley Health Sciences Centre

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Save the Date for Upcoming Webinars

Thursday, December 3 – 10:30am PT (1:30pm ET)

"Developing a National Paramedic Workplace Violence Prevention Framework"

Speaker: Steve Sutton

Thursday, January 21 – 10:30am PT (1:30pm ET)

"Mobile Integrated Health"

Speaker: Matthew Crossman

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Please mute your phone

- All attendees are automatically muted by WebEx, but **we recommend muting your phone on your end**, as sometimes we unmute everyone on the WebEx side to anyone who wants to speak, and if you have background noise it will limit everyone's ability to share.

Thank You!

Asking Questions

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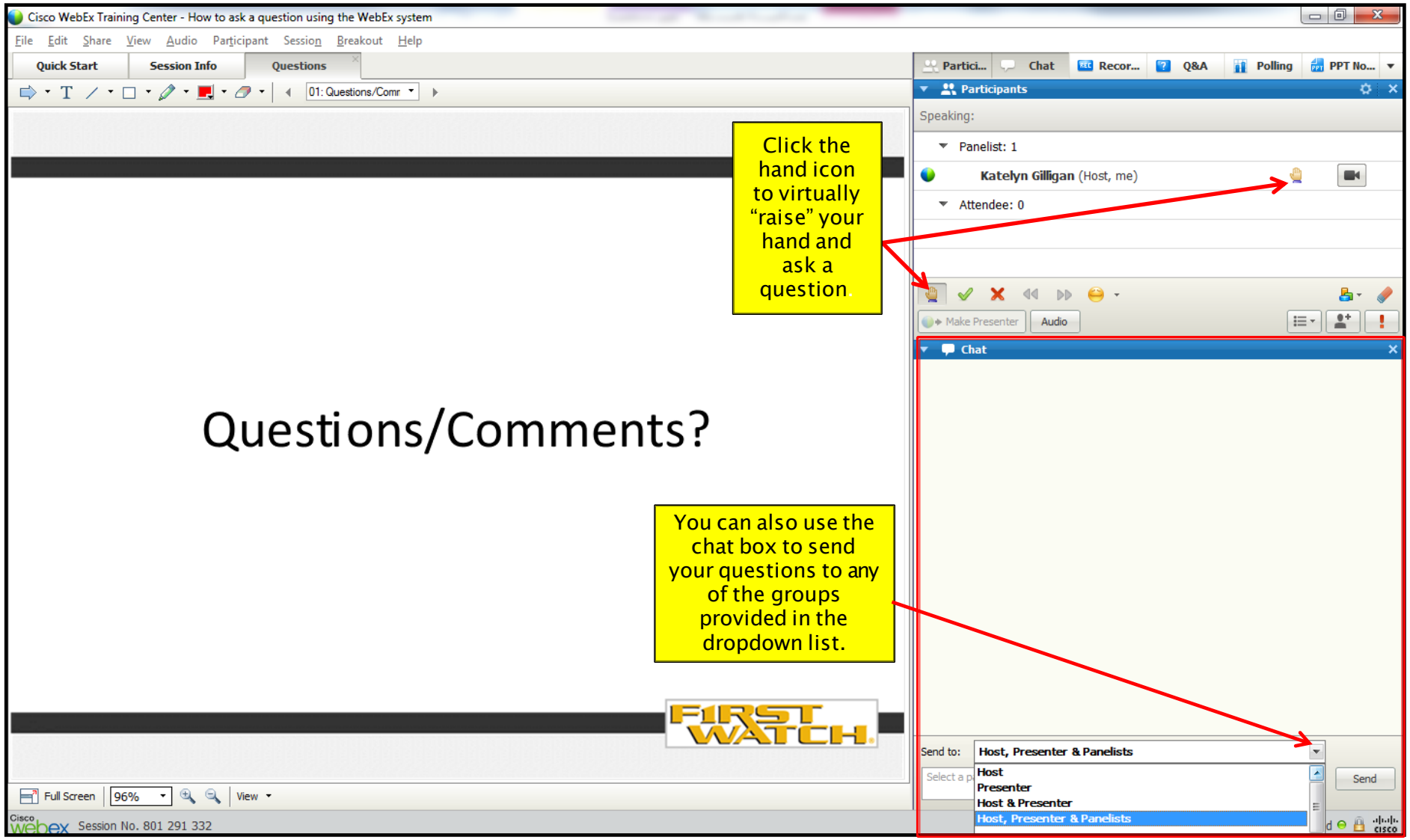

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McMaster Community Paramedicine Research

Building Community Paramedicine into the Canadian healthcare landscape:

An economic analysis of 'Community Paramedicine at Clinic' (CP@clinic) from the paramedic service perspective

Presented by:

Dr. Gina Agarwal

Director of CP@clinic, Professor

Dr. Gina Agarwal

Director of CP@clinic, Professor

Gina Agarwal is a practicing family physician (MBBS MRCGP CCFP FCFP). She is one of a few family physicians with a PHD in Epidemiology (2011). Dr. Gina Agarwal has facilitated, led and supervised the development of community paramedicine research at McMaster University. She established the CP@clinic Program in Ontario, including all of its program components and scientific evaluation plan (CIHR-funded multi-site randomised controlled trial; 2014 - 2017).

In April of 2019, Dr. Agarwal was awarded Health Care Policy Contribution Program (HCPCP) funding by Health Canada to expand the innovative CP@clinic program with paramedic services across Canada. CP@clinic is the leading evidence-based community paramedicine wellness clinic model and has the potential to benefit communities across Canada.

Objectives of the Webinar

- To learn about evidence from the CP@clinic Randomized Controlled Trial
- To understand how the economic analysis was conducted for CP@clinic

About the CP@clinic© Program

CREDIBLE

CP@clinic is a product of McMaster University's innovative research and endorsed by **Health Canada.**

EVIDENCE-BASED

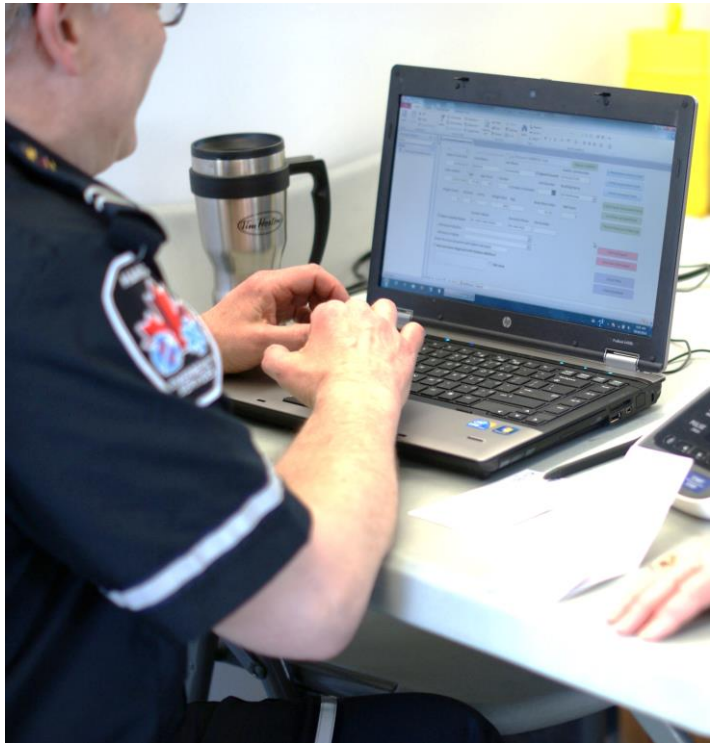
CP@clinic has been implemented & evaluated for 10 years. It is supported by two robust randomized control trials and other scientific evaluations.

RECOGNIZED

CP@clinic is recognized by funders. Automated reports can be generated for quality improvement and to help access funding through the LHINs and other funders.

ADAPTABLE

CP@clinic has received Health Care Policy Contribution Program funding from Health Canada to facilitate program expansion & adaptations.




PARAMEDIC


CP@clinic
PARAMEDIC


AUTOMATIC
CAUTION
DOOR
ACTIVATE SWITCH
TO OPERATE

An Evidence-Based Program

19-25% reduction in EMS calls

Decreased blood pressure

Reduced diabetes risk

Improved QALYs & quality of life

Social relationships facilitated between older adults

- Focuses on vulnerable low-income older adults who are socially isolated, residing in social housing and with multi-morbidity
- Empowers participants and improves health literacy
- Encourages primary care visits and appropriate healthcare use
- Expands the reach of community paramedicine into primary care

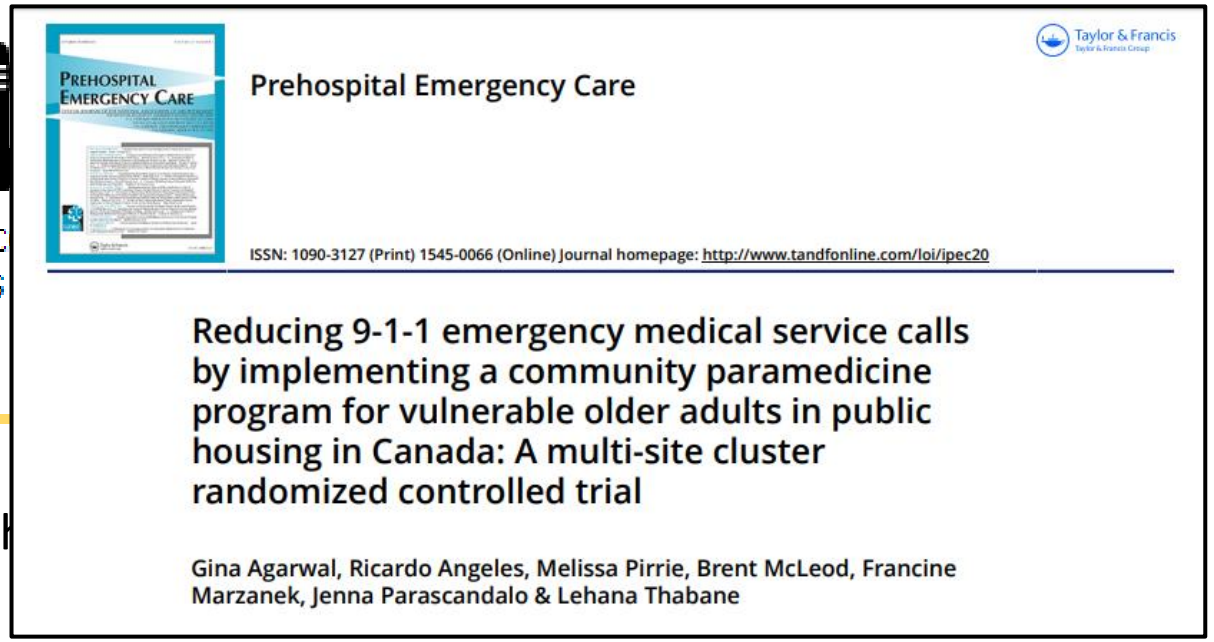
An Evidence-Based Program


RESEARCH VULNERABLE POPULATIONS

Evaluation of a community paramedicine health promotion and lifestyle risk assessment program for older adults who live in social housing: a cluster randomized trial

Gina Agarwal MBBS PhD, Ricardo Angeles PhD, Melissa Pirrie MA, Brent McLeod MPH, Francine Marzanek BSc, Jenna Parascandalo BA, Lehana Thabane MSc PhD

Cite as: *CMAJ* 2018 May 28;190:E638-47. doi: 10.1503/cmaj.170740



with multi-morbidity

- Empowers participants and improves health literacy
- Encourages primary care visits and appropriate healthcare use
- Expands the reach of community paramedicine into primary care

McMaster
Community
Paramedicine
Research Team

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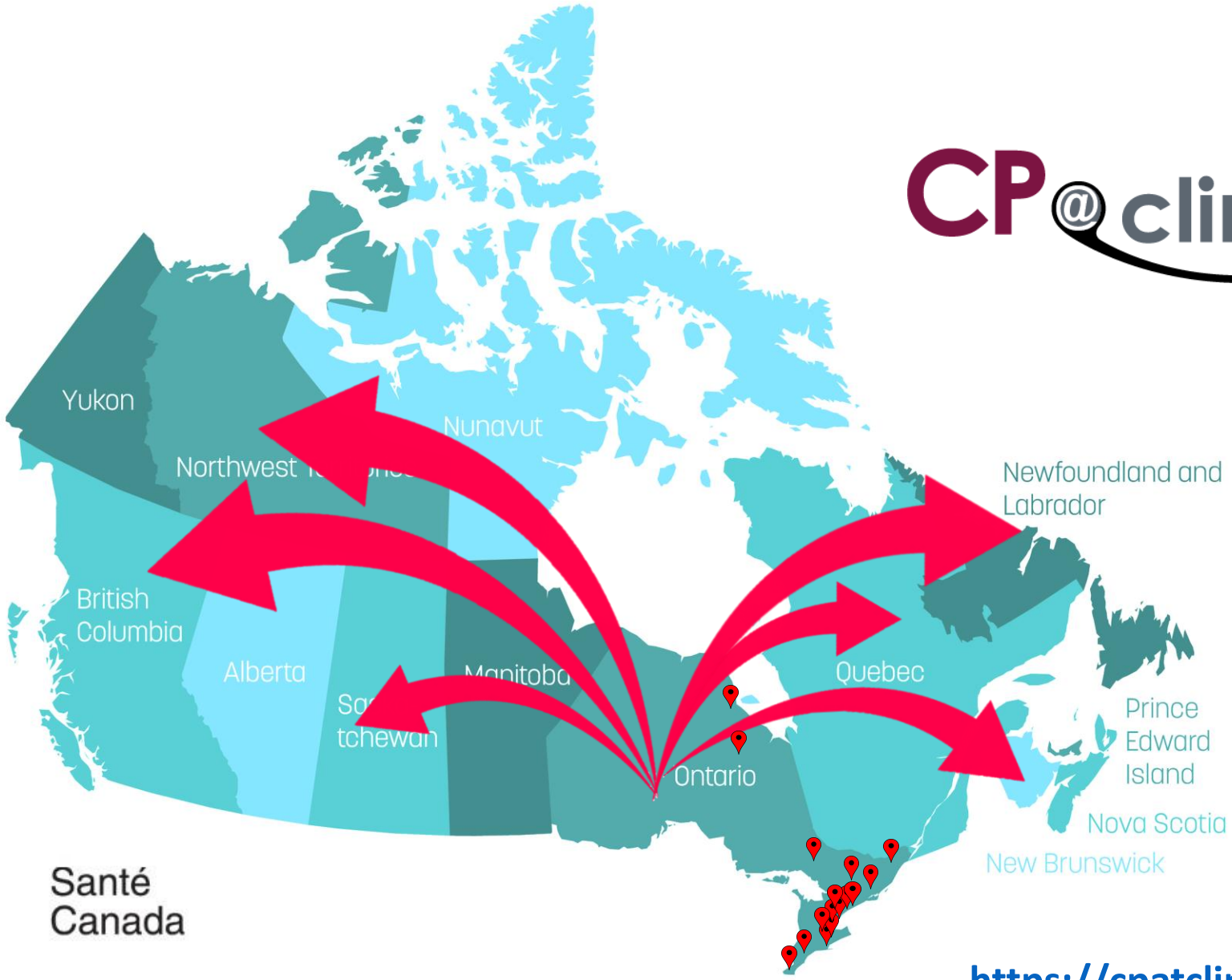


CP@clinic©

Health Canada Santé Canada

Health Care Policy Contribution Program Funding

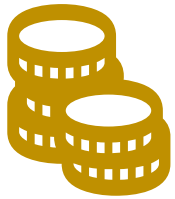
https://cpatclinic.ca/who-we-are/

Why Do an Economic Analysis?

The program may be beneficial to implement in terms of results

Better blood pressure, better quality of life, less EMS calls….

BUT what did it cost for you - the paramedic service *i.e. the payer*



Economic analysis provides evidence for funders

Methods

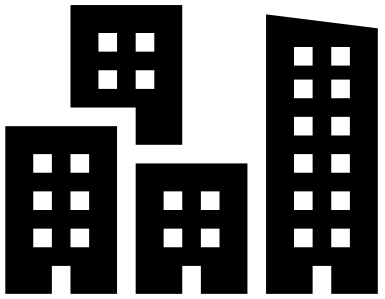
Cost-utility analysis of the 1-year CP@clinic RCT

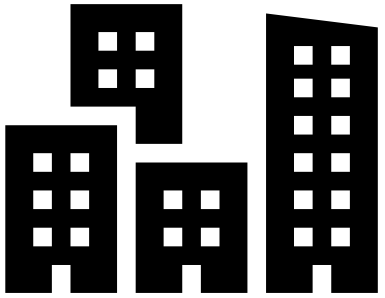
Multiple sensitivity analyses

Paramedic service perspective

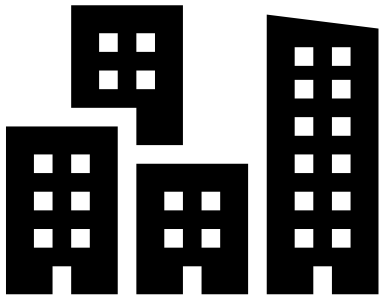
Methods: Design and Setting

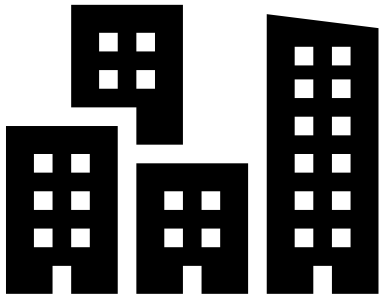
Five Communities, 26 Buildings (13 intervention vs 13 control)

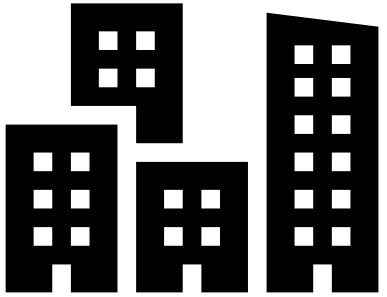




- Inclusion criteria for each building:
  - At least 60% of residents aged 55 years and older
  - More than 50 residential units
  - Unique postal code
  - At least one building of similar size and demographic to form a matched pair
- No exclusion criteria







Key Components of Cost-Utility Analysis

Basic cost-utility analysis:

$$\text{Incremental Cost-Effectiveness Ratio (ICER)} = \frac{\text{Costs}}{\text{QALY}}$$

Costs ← Program and Staffing Costs

QALY ← Quality-adjusted life years gained

"What is the cost for each year of high-quality life gained through the intervention?"

Key Components of Cost-Utility Analysis

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Costs ← Program and Staffing Costs

QALY ← Quality-adjusted life years gained

"What is the cost for each year of high-quality life gained through the intervention?"

Can also consider cost offsets:

$$\text{ICER}_{\text{sensitivity analysis}} = \frac{\text{Costs - Cost offsets}}{\text{QALY}}$$

Costs - Cost offsets ← Program and staffing costs MINUS savings through reduction of EMS calls

*"What is the **net cost** for each year of high-quality life gained through the intervention?"*

Data Collection and Results

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Demographics

Descriptive Variables	Intervention building n=358 n (%)	Control building n=320 n (%)
Age years: mean (SD)	73.90 (9.05)	70.44 (7.94)
Female	286 (79.9)	229 (71.6)
Lives alone	322 (90.7)	287 (90.0)
Education		
Some High School or lower	160 (45.1)	146 (45.8)
High School Diploma	83 (23.4)	75 (23.5)
Some College/University or Higher	56 (15.8)	50 (15.7)
College or University	56 (15.8)	48 (15.0)
Poor Health Literacy[a]	80 (84.2)	84 (81.6)
With Chronic Diseases		
Heart Problems	111 (31.1)	80 (25.0)
Hypertension	192 (53.6)	177 (55.3)
High Cholesterol	135 (37.7)	119 (37.2)
Stroke	43 (12.0)	39 (12.2)
Diabetes	96 (26.8)	90 (28.1)

Descriptive Variables	Intervention building n=358 n (%)	Control building n=320 n (%)
Risk Factors		
Low Physical Activity	148 (41.9)	166 (51.9)
Low Fruits and Vegetable intake	123 (34.6)	106 (33.2)
High Alcohol Intake	5 (1.4)	11 (3.4)
Smoker	87 (24.5)	122 (38.4)
High BMI	247 (69.6)	221 (69.0)
Risk of Diabetes		
Moderate	104 (39.8)	98 (42.6)
High	151 (57.9)	123 (53.5)
Health Status and Quality-of-Life		
Reported Poor to Fair health	135 (38.0)	139 (43.5)
With mobility problems	218 (61.4)	192 (60.0)
With self-care problems	83 (23.4)	59 (18.4)
With problems doing usual activities	166 (46.8)	133 (41.6)
With pain/discomfort	249 (70.1)	239 (74.9)
With anxiety/depression	176 (48.5)	154 (48.1)
Has a Family Doctor	327 (91.3)	298 (93.1)

Data Collection: Program Costs

- Detailed records were kept of all materials required for program implementation and validated with the community paramedicine (CP) supervisors
- Costs collected from the source from which the service, object or goods were obtained
- Fixed costs - number of buildings has minimal impact (e.g. laptop)

Results: CP@clinic Program Costs

Table 3 Direct programme costs in Canadian dollars (excluding staffing)

Item	Source	Cost per site ($C in 2016)
Space	Housing authority of each community	In-kind
Vehicle incl. fuel and maintenance	Paramedic service of each community	10 000
Information technology supports and overheads	McMaster University, DFM IT	500
Database software	McMaster University, DFM IT	235
YubiKey	McMaster University, DFM IT	53
Printing and materials (eg, posters, flyers, BP record card)	McMaster University Media Services	253
Session equipment		
Laptop	McMaster University, DFM IT	726
Weighing scale	Medical supply vendor	240
Tape measure	Medical supply vendor	5
BP machine (WatchBP Office)	Medical supply vendor	750
Glucometer, lancets, swabs, bandages	Paramedic service of each community	150
Carry bag	Office supply vendor	50
Direct programme costs per community		12 962
Total direct programme costs for all five RCT study sites		64 810

BP, blood pressure; DFM IT, Department of Family Medicine - Information Technology team; RCT, randomised controlled trial.

Data Collection: Staffing Costs

- Hours and salary levels verified with paramedic services
- Costs of paramedic hourly salary with benefits obtained from paramedic services implementing CP@clinic
- Combined hourly cost of supervision + administration within paramedic service to oversee the CPs → est. 200% of paramedic hourly salary with benefits

Results: Actual Staffing Costs

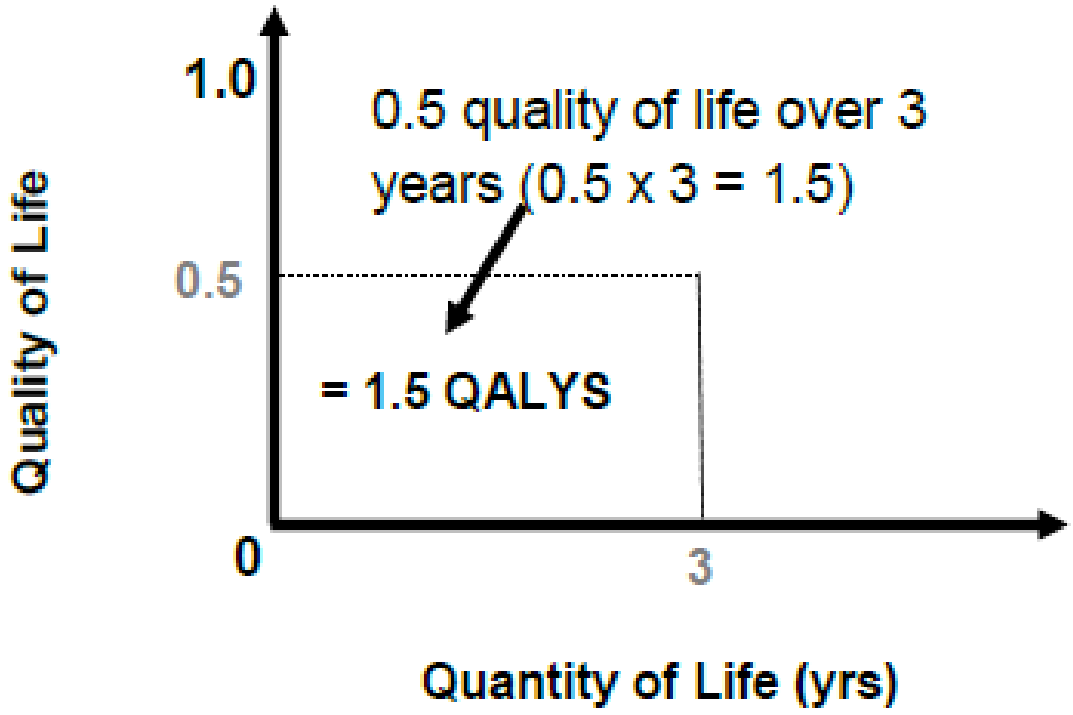
	Total staffing costs as implemented during RCT (5 sites)
Additional paramedic staff*	
Number of buildings implementing CP@clinic	13
Cost of additional paramedic staff per year (50 weeks, hourly salary including benefits ranged from $50.33 to $54.99 per hour)	
▶ Actual: as implemented during the trial	$31 130
▶ Minimum: two paramedics on modified duties	–
▶ Moderate: one funded CP, one paramedic on modified duties	–
▶ Maximum: two funded CPs	–
Additional supervision and administration	
Cost of additional supervisory and administrative staff hours per year (50 weeks)	
▶ Actual: as implemented during the trial	$32 522
▶ Minimum: 1 hour per week	–
▶ Moderate: 1.5 hours per week	–
▶ Maximum: 2 hours per week	–
Other staffing (programme evaluation, data repository, training development)	
Cost of other staffing ($3000/year base cost)	
▶ Actual: as implemented during the trial	$0
▶ Minimum: funded entirely from external source or in-kind	–
▶ Moderate: 50/50 mixed funding model	–
▶ Maximum: funded entirely by the paramedic service	–
Totals	
▶ Actual costs during RCT (five sites)	$63 652
▶ Minimum assumption scenarios (one site)	–
▶ Moderate assumption scenarios (one site)	–
▶ Maximum assumption scenarios (one site)	–

Data Collection: Outcome - QALY

QALY: Quality-Adjusted Life Year
Gold Standard in Health Economics

- Examines quantity of life lived
  - years, months
- against health-related quality of life
  - where 1.0 represents **perfect health** and 0 represents **death**

EXAMPLE:



Data Collection: Quality of Life Measurement

- Quality of Life Measurement Tool
- Immediately before and after RCT
- All building residents could complete the survey (not just attendees)
  - 55 years and older
  - Invitation posters displayed throughout the building
  - Flyers handed out to residents
- Consecutive sampling method (difficulty surveying vulnerable population)
- On completion, the participants were provided with $10 local grocery store gift card

Results: QALY

Table 2 Difference in QALY for intervention and control buildings

	Intervention building residents vs control building residents		
	Intervention mean (SD)	**Control mean (SD)**	**Mean difference (95% CI)**
Main trial results with multiple imputation (intention-to-treat)	n=358	n=320	
Adjusted* QALY: QALY, regression adjusted for baseline utility score and building pairing	0.72 (0.11)	0.69 (0.20)	0.03† (0.01 to 0.05)

*Intervention and control QoL index scores were found to be significantly different at baseline, despite randomisation, therefore baseline differences were accounted for by adjustment using regression.
†p<0.05.
QALY, quality-adjusted life year.

Result: Incremental Cost Effectiveness Ratio (ICER)

QALY gain:
0.03 per resident

Costs:
Program: $64,810
Staffing: $65,632
Total: $128,462 *or $88/resident*

$$\text{ICER} = \frac{\text{COST}}{\text{QALY}} = \frac{\$2933}{\text{QALY}}$$

Common threshold is $50,000/QALY

Can also consider Cost Offset

$$ICER_{\text{sensitivity analysis}} = \frac{\text{Cost - cost offset}}{\text{QALY}}$$

- Estimated cost of an EMS call:
  - Minimum: $499/call
  - Moderate: $1626/call
  - Maximum: $2254/call

- Since the paramedic service perspective has been taken, the healthcare costs examined in this paper **do not go beyond the EMS call** (e.g. hospital admissions, duration of stay, specialist visits)

Results: EMS calls

- **Reduction** in EMS calls
  - From RCT results published in *Pre-Hospital Emergency Care*
    - 0.9 calls/100 units/month
  - Since the intervention buildings had 1461 units, it can be estimated that **157.8 EMS calls** were avoided during the intervention period

1. Agarwal G, Angeles R, Pirrie M, McLeod B, Marzanek F, Parascandalo J, et al. Reducing 9-1-1 Emergency Medical Service Calls By Implementing A Community Paramedicine Program For Vulnerable Older Adults In Public Housing In Canada: A Multi-Site Cluster Randomized Controlled Trial. Prehosp Emerg Care. 2019 Jan 9;1–12.

ICER Sensitivity Analysis:
EMS Call Offset

Bringing it all together:

- Reduction of **157.8 calls**

Negative ICER

- Saves more $ than the program costs
- **"Intervention Dominant"**

Table 5 Cost–utility analysis of community paramedicine at clinic programme. Intervention in 2016 Canadian dollars

QALY change per resident	0.03
Programme cost per resident for full RCT (direct costs and staffing of $128 462 for 1461 units)	$88
Base case ICER (programme cost per QALY)	$2933
Analysis including potential cost offset due to EMS call reduction*	
Minimum assumption: $499/EMS call	
Cost offset per resident	(–$54)
ICER (cost per QALY)	$1133 ← Minimum
Moderate assumption: $1626/EMS call	
Cost offset per resident	(–$176)
ICER (cost per QALY)	(–$2933) (intervention dominant) ← Moderate
Maximum assumption: $2254/EMS call	
Cost offset per resident	(–$243)
ICER (cost per QALY)	(–$5167) (intervention dominant) ← Maximum

*Reduction of 10.8 EMS calls per 100 residents.
EMS, emergency medical service; ICER, incremental cost-effectiveness ratio; QALY, quality-adjusted life year; RCT, randomised controlled trial.

Hypothetical Sites

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Different Staffing Models

Hypothetical analyses based on **actual costs** in 3 different paramedic resource scenarios in different numbers of buildings:

	Model 1 (minimum)	Model 2 (moderate)	Model 3 (maximum)
Paramedic Staff	2 modified	1 modified/ 1 dedicated	2 dedicated
Supervision/Administration	1 hour	1.5 hours	2 hours
Other Staffing (Evaluation, Data Repository, Training, etc.)	In-Kind	50%	100%

CP@clinic©

	Total staffing costs as implemented during RCT (5 sites)	Potential staffing costs for a future site with 2 buildings	Potential staffing costs for a future site with 4 buildings
Additional paramedic staff*			
Number of buildings implementing CP@clinic	13		
Cost of additional paramedic staff per year (50 weeks, hourly salary including benefits ranged from $50.33 to $54.99 per hour)			
► Actual: as implemented during the trial	$31 130		
► Minimum: two paramedics on modified duties	–		
► Moderate: one funded CP, one paramedic on modified duties	–		
► Maximum: two funded CPs	–		
Additional supervision and administration			
Cost of additional supervisory and administrative staff hours per year (50 weeks)			
► Actual: as implemented during the trial	$32 522		
► Minimum: 1 hour per week	–		
► Moderate: 1.5 hours per week	–		
► Maximum: 2 hours per week	–		
Other staffing (programme evaluation, data repository, training development)			
Cost of other staffing ($3000/year base cost)			
► Actual: as implemented during the trial	$0		
► Minimum: funded entirely from external source or in-kind	–		
► Moderate: 50/50 mixed funding model	–		
► Maximum: funded entirely by the paramedic service	–		
Totals			
► Actual costs during RCT (five sites)	$63 652		
► Minimum assumption scenarios (one site)	–		
► Moderate assumption scenarios (one site)	–		
► Maximum assumption scenarios (one site)	–		

CP@clinic©

	Total staffing costs as implemented during RCT (5 sites)	Potential staffing costs for a future site with 2 buildings	Potential staffing costs for a future site with 4 buildings
Additional paramedic staff*			
Number of buildings implementing CP@clinic	13	2	
Cost of additional paramedic staff per year (50 weeks, hourly salary including benefits ranged from $50.33 to $54.99 per hour)			
► Actual: as implemented during the trial	$31 130	–	
► Minimum: two paramedics on modified duties	–	$0	
► Moderate: one funded CP, one paramedic on modified duties	–	$21 996	
► Maximum: two funded CPs	–	$43 992	
Additional supervision and administration			
Cost of additional supervisory and administrative staff hours per year (50 weeks)			
► Actual: as implemented during the trial	$32 522	–	
► Minimum: 1 hour per week	–	$5499	
► Moderate: 1.5 hours per week	–	$8249	
► Maximum: 2 hours per week	–	$10 998	
Other staffing (programme evaluation, data repository, training development)			
Cost of other staffing ($3000/year base cost)			
► Actual: as implemented during the trial	$0	–	
► Minimum: funded entirely from external source or in-kind	–	$0	
► Moderate: 50/50 mixed funding model	–	$1500	
► Maximum: funded entirely by the paramedic service	–	$3000	
Totals			
► Actual costs during RCT (five sites)	$63 652	–	
► Minimum assumption scenarios (one site)	–	$5499	
► Moderate assumption scenarios (one site)	–	$31 745	
► Maximum assumption scenarios (one site)	–	$57 990	

CP@clinic©

	Total staffing costs as implemented during RCT (5 sites)	Potential staffing costs for a future site with 2 buildings	Potential staffing costs for a future site with 4 buildings
Additional paramedic staff*			
Number of buildings implementing CP@clinic	13	2	4
Cost of additional paramedic staff per year (50 weeks, hourly salary including benefits ranged from $50.33 to $54.99 per hour)			
▶ Actual: as implemented during the trial	$31 130	–	–
▶ Minimum: two paramedics on modified duties	–	$0	$0
▶ Moderate: one funded CP, one paramedic on modified duties	–	$21 996	$43 992
▶ Maximum: two funded CPs	–	$43 992	$87 984
Additional supervision and administration			
Cost of additional supervisory and administrative staff hours per year (50 weeks)			
▶ Actual: as implemented during the trial	$32 522	–	–
▶ Minimum: 1 hour per week	–	$5499	$5499
▶ Moderate: 1.5 hours per week	–	$8249	$8249
▶ Maximum: 2 hours per week	–	$10 998	$10 998
Other staffing (programme evaluation, data repository, training development)			
Cost of other staffing ($3000/year base cost)			
▶ Actual: as implemented during the trial	$0	–	–
▶ Minimum: funded entirely from external source or in-kind	–	$0	$0
▶ Moderate: 50/50 mixed funding model	–	$1500	$1500
▶ Maximum: funded entirely by the paramedic service	–	$3000	$3000
Totals			
▶ Actual costs during RCT (five sites)	$63 652	–	–
▶ Minimum assumption scenarios (one site)	–	$5499	$5499
▶ Moderate assumption scenarios (one site)	–	$31 745	$53 741
▶ Maximum assumption scenarios (one site)	–	$57 990	$101 982

Hypothetical Projections for CP@clinic Only

		Potential programme costs—two intervention buildings (direct costs and staffing)		
		Minimum assumption ($18 461)	Moderate assumption ($44 707)	Maximum assumption ($70 952)
Potential cost offsets*	Minimum assumption ($12 114)	6347	32 593	58 838
	Moderate assumption ($39 474)	(−21 013)	5233	31 478
	Maximum assumption ($54 720)	(−36 259)	(−10 013)	16 232
		Potential programme costs—four intervention buildings (direct costs and staffing)		
		Minimum assumption ($18 461)	**Moderate assumption ($66 703)**	**Maximum assumption ($114 944)**
Potential cost offsets†	Minimum assumption ($24 228)	(−5767)	42 475	90 716
	Moderate assumption ($78 949)	(−60 488)	(−12 246)	35 995
	Maximum assumption ($109 440)	(−90 979)	(−42 737)	5504

*Expected offset for two future buildings, based on the randomised controlled trial results of 157.8 fewer calls in 13 buildings, and a value of $499/call for minimum, $1626/call for moderate and $2254/call for maximum cost offset assumptions.
†Expected offset for four future buildings, based on the randomised controlled trial results of 157.8 fewer calls in 13 buildings, and a value of $499/call for minimum, $1626/call for moderate and $2254/call for maximum cost offset assumptions.
QALY, quality-adjusted life year.

Conclusion

McMaster Community Paramedicine Research Team

Cost-effectiveness of the CP@clinic© Program

Data from the CP@clinic Multi-Site Randomized Controlled Trial

Based on 13 social housing buildings & 1461 residents

For every $1 spent on the CP@clinic Program, the Emergency Care System sees $2 in benefits!

Net Savings Per Resident: $88

Program Cost Per QALY is well below the threshold for program adoption in Canada

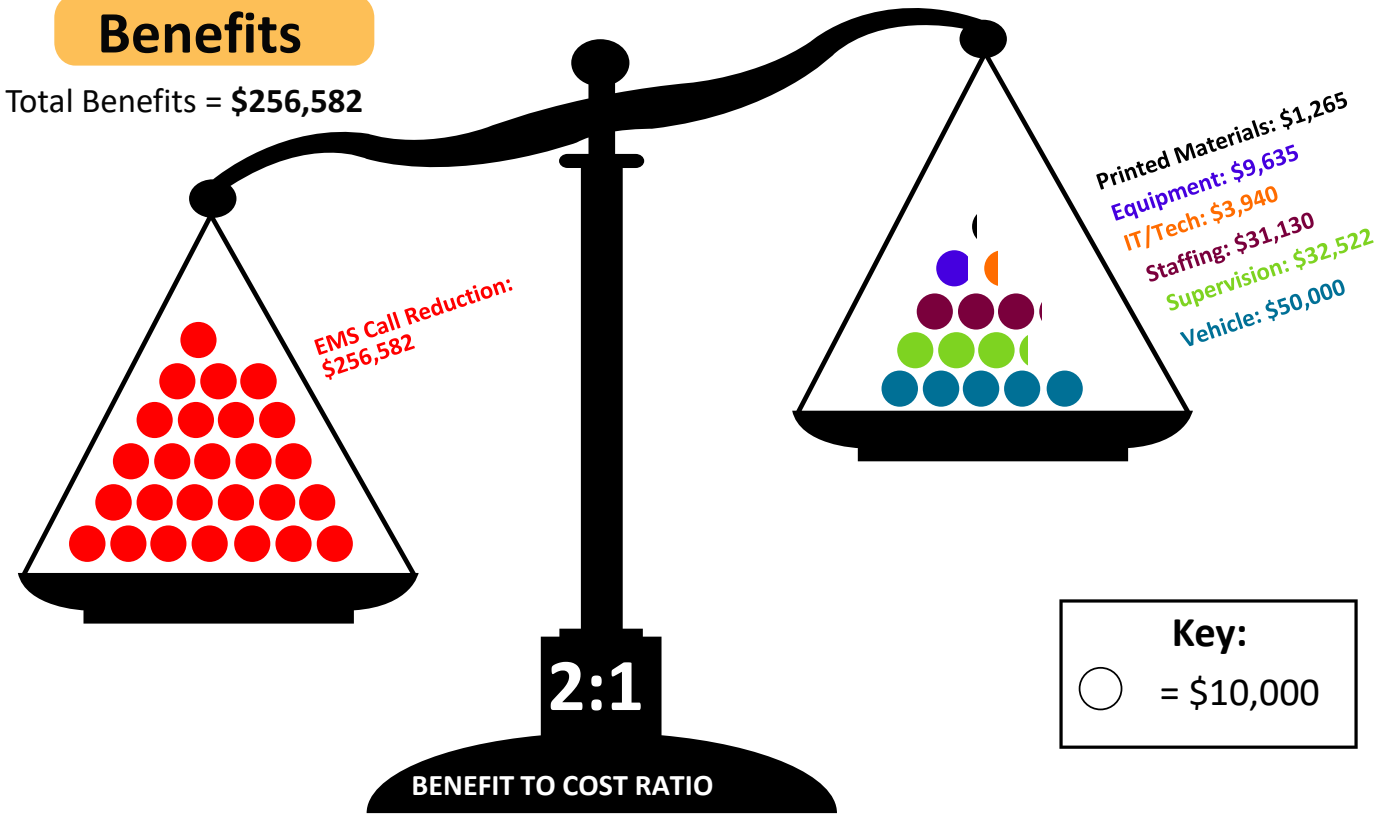
QALY= Quality-Adjusted Life Year

Costs

Total Costs = **$128,462**

Benefits

Total Benefits = **$256,582**



Key: ○ = $10,000

Net Gain = $128,120

Agarwal G, Pirrie M, Angeles R, Marzanek F, Thabane L, O'Reilly D. **Cost-effectiveness analysis of a community paramedicine programme for low-income seniors living in subsidised housing: the community paramedicine at clinic programme (CP@clinic)** BMJ Open 2020;10:e037386. doi: 10.1136/bmjopen-2020-037386

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McMaster **Community Paramedicine** Research

Dr. Gina Agarwal
Director of CP@clinic, Professor
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Building Community Paramedicine into the Canadian healthcare landscape: An economic analysis of 'Community Paramedicine at Clinic' (CP@clinic) from the paramedic service perspective

CP@clinic©

Presented by:
Dr. Gina Agarwal, Director of CP@clinic, Professor

McMaster University | Family Medicine

McMaster Community Paramedicine Research

Paramedic Chiefs of Canada

Chefs Paramédics du Canada

Save the Date for Upcoming Webinars

Thursday, December 3 – 10:30am PT (1:30pm ET)

"Developing a National Paramedic Workplace Violence Prevention Framework"

Speaker: Steve Sutton

Thursday, January 21 – 10:30am PT (1:30pm ET)

"Mobile Integrated Health"

Speaker: Matthew Crossman

Sign up for information and notifications @ www.firstwatch.net/hi

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Q&A and Thank You

Kyle Sereda – ksereda@moosejawems.ca

Todd Stout – tstout@firstwatch.net

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