

# Case Study



## Provincial Health Contact Centre Improves Chronic Disease Management with Call Center Technology

### At a Glance

#### Organization

Provincial Health Contact Centre  
Manitoba, Canada

- State-of-the-art, 35-seat contact center technologically supporting health and social services delivery
- Operates more than 30 inbound and outbound calling programs in 110 languages, including English and French
- Handles more than 600,000 inbound and outbound calls per year

#### Solution Spotlight

- CareEnhance® Call Center
  - Triage
  - Disease management
  - Survey system

#### Critical Issues

- Management of chronic disease, particularly congestive heart failure (CHF)
- Unnecessary ED utilization
- Unusually high hospital length of stay and readmission rates

#### Results

- Lowered risk stratification for 25% of CHF patients, with 70% losing weight
- Identified individuals in early CHF, facilitating intervention
- Reduced unnecessary visits to the ED and hospital readmissions
- Improved medication compliance and overall health

The Provincial Health Contact Centre (PHCC) provides nurse symptom assessment, triage, health education and referral to a diverse population throughout the Canadian province of Manitoba. In 2005, the Winnipeg Regional Health Authority enlisted the center to launch a program to better manage patients with chronic diseases, specifically congestive heart failure (CHF). To answer the call, PHCC turned to healthcare partner RelayHealth®, McKesson's connectivity business. Using RelayHealth's CareEnhance® Call Center triage and disease management modules and survey solution, PHCC has improved CHF patient health, decreased ED visits, and reduced length of stay and readmissions to hospitals in the province.

#### Challenges

The Winnipeg Regional Health Authority (WRHA), in conjunction with Manitoba Health, provides services to more than 1 million residents of Winnipeg and the province of Manitoba. Many residents in the largely rural area have inadequate access to primary care. Unnecessary hospitalizations were skyrocketing because individuals with congestive heart failure (CHF) were not well managed. In fact, four of WRHA's community hospitals and two tertiary care hospitals had lengths of stay ranging from one and a half to nearly twice the Canadian national average for CHF patients. Readmission rates for CHF cases were also unusually high due to

poor patient self-management skills, inadequate patient education and follow-up, and the demands on primary care physicians to serve the needs of the entire community.

"We needed a pragmatic, low-cost solution to connect more closely with our community's population and better manage CHF," explains Paul Nyhof, chief contact centre officer, Provincial Health Contact Centre.

#### Answers

The contact center launched an innovative care management program designed to integrate with community health providers and improve health for CHF patients through the power of technology. First, center staff recruited primary care physicians – about a third from rural areas – to encourage their patients to enroll and actively participate in the program.

Next, the center expanded its use of the CareEnhance Call Center technology. Already using the triage system to manage inbound calls, the call center added the disease management module with clinical decision support to manage routine outbound calls to patients. The module included CHF protocols modified to Canadian standards.

As the program progressed, the center added a survey system from RelayHealth to monitor and report patient progress and health outcomes. CareEnhance Call Center disease management protocols were integrated with an interactive

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**Paul Nyhof**

*Chief Contact Centre Officer*

*Provincial Health*

*Contact Centre*

voice response system to create an efficient and effective way to collect the patient’s vitals signs and symptoms over the phone and monitor them. The center also provided patients with digital scales and blood pressure cuffs.

The center conducted automated calls three times a week to remind CHF patients to monitor weight, blood pressure, swelling, fatigue, chest pain and discomfort. With a regular monitoring schedule in place, call center staff can readily identify patients who need intervention and quickly provide treatment plans and self-care education.

## Results

Using RelayHealth’s call center technology, the PHCC created an innovative disease management program and enabled WRHA to build a more connected healthcare community and achieve significant improvements for CHF patients.

Through the program, 70% of patients lost weight and 25% lowered their risk stratification. Better medication compliance by patients resulted in better health and a reduction in ED visits. Assessment and monitoring calls also identified individuals in early CHF, facilitating intervention and reducing unnecessary visits to the ED or hospital admissions.

“We also found that patients who followed the recommended low-sodium diet reported decreased swelling, increased their activity tolerance, and felt much better overall,” notes Linda Coote, R.N., clinical manager, PHCC. “Patients with co-morbid conditions demonstrated better diabetes management, blood sugar control and improved cholesterol levels.”

Primary care physicians stretched thin in caring for chronic disease patients also report improvements in patient compliance with self-care as well as fewer clinic and ED visits.

“Healthcare dollars are precious,” says Nyhof. “When we can redirect inappropriate use, healthcare is more readily available to those who really need it.

“With the right call center and the right technology, we’ve been able to improve access to care,” Nyhof adds. “McKesson and RelayHealth are the leaders in disease management. We gain not only from their solutions, but we also benefit from their advice and experience. Together, we’re pointing the way to better disease management for patients across rural Canada.”

**McKesson Provider Technologies**

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