METHODS IN HEALTH SURVEY RESEARCH – BRUSSELS, 17th DECEMBER 2010

THE DASHBOARD OF ‘MAISONS MÉDICALES’

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‘MAISON MÉDICALE’: PRIMARY HEALTH CARE CENTER (PHCC)
- First line primary health care
- Multidisciplinary
- Particular goals such as: prevention, health promotion, community health
- Lobbying for equality in health & a strong first line for health care

GOALS

Observatory:
- To improve the knowledge of PHCC’s population
- To get information about the problems that occur in primary health care

Quality assurance:
To create a tool the teams can use to guide their activities in health quality assurance.

DESCRIPTION

Since 2006, the dashboard is built up with the data encoded in each patient’s electronic health file in the PHCC’s. Every year, each team sends its data to the Federation to analyze it.

19 VARIABLES

Population characteristics: number of patients, year of birth, gender, postal code, access to health care, titular codes (code CT12), health insurance status (child, titular,…), education level (after the age of 25).

Health data: flu vaccination (65 years old & above), tetanus vaccine (18 years old & above), mammography (between 50 and 69 years), ‘mumps, measles, rubella’ vaccination (13 years old, only for Brussels), Type 2 diabetes mellitus, BMI, blood pressure (30 years old & above), obesity, high blood pressure (30 years old & above), nicotine addiction (15 years old & above).

USING THE OUTPUT

Each team gets personal feedback on their own data.
All the results are presented annually during a special seminar.
Lobbying for the PHCC model.
Research on population health issues.
Information for politicians.

USEFULNESS INSIDE THE TEAMS

The dashboard encourages the teams to use the electronic health file
Guiding the choice of activities.
Evaluation of activities.

LIMITS

Encoding data is first of all useful for individual follow-ups, it does not always fit for epidemiological studies.
All software are not suitable.
It will take a while to have a good data encoding for all the variables in every team.
The population we take care of is not exactly representative of the general Belgian population.

SPECIFICITIES

First line primary health care.
A lot of teams work with subscription forms, the population is therefore well defined.
Most of the teams use a software which is appropriate to epidemiological research.

SET UP

Normally, accepting to collaborate in the dashboard project should not be linked to overtime hours. But at the beginning of the project, there were only a few teams really working with electronic health files; there was therefore a lot to be done at this level.

Main actions:
- Try to fight against computer resistance factors.
- Convince the teams to use their electronic health files.
- Resolve privacy problems (consent form to be signed by each patient in every center).
- Solve technical problems.
- Create didactic tools for therapists (practical coding guides, specification sheets,…).
- Organize local user groups to exchange knowledge.

2009 PARTICIPATION

We have gathered databases in 43 capitation fee teams. This represents 98 600 patients.
We should be able to double those numbers within a few years.

A FEW RESULTS

Encoding progress [Fig.1]
Example of progression for one variable in 4 years.
Each line represents a team.

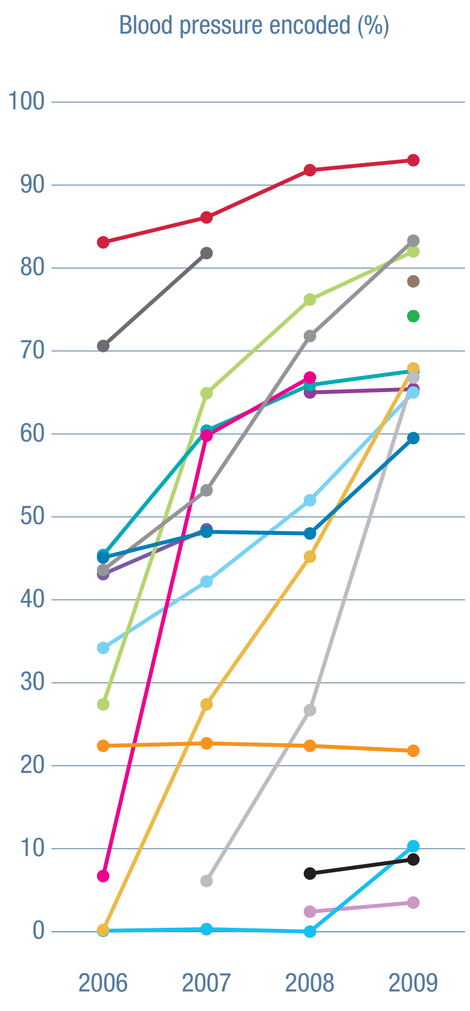
Population Description [Fig.2,3,4]
Younger people, more deprived and more invalid.

Social inequalities in health [Fig.5,6]
A significant number of health issues appear in a more deprived population (BIM[2], better reimbursement of health care). Results illustrating this can be found in international studies for several diseases such as high blood pressure, overweight, nicotine addiction & type 2 diabetes mellitus. The next graphics shows our results for type 2 diabetes mellitus.
The prevalence for the population of our centers is 3,9%, if the population had same age and same gender as Belgian one, we would have a 6,3% prevalence.
[Fig.5] Type 2 diabetes is more frequent in a deprived population, but litterature shows that this people do not always have a diagnosis. We can see here that they are a little bit more detected than not deprived ones.
[Fig.6] An even more pertinent thing to observe is the education level which is relevant to the relationship between the disease & socioeconomic status. It shows an even higher correlation than the deprived/non-deprived ratio. The higher the education level, the lower the prevalence of diabetes. A statistical significance is only reached between the lowest level & the three other ones.

2) BIM=Bénéficiaire de l’Intervention Majorée = Better reimbursement

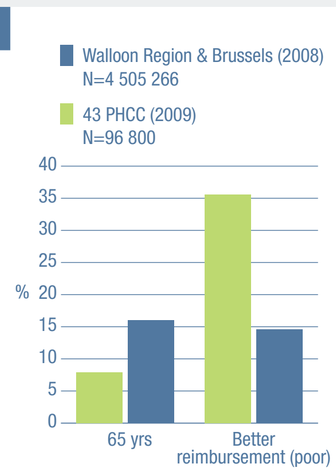
Encoding progress

1



Population Description

2

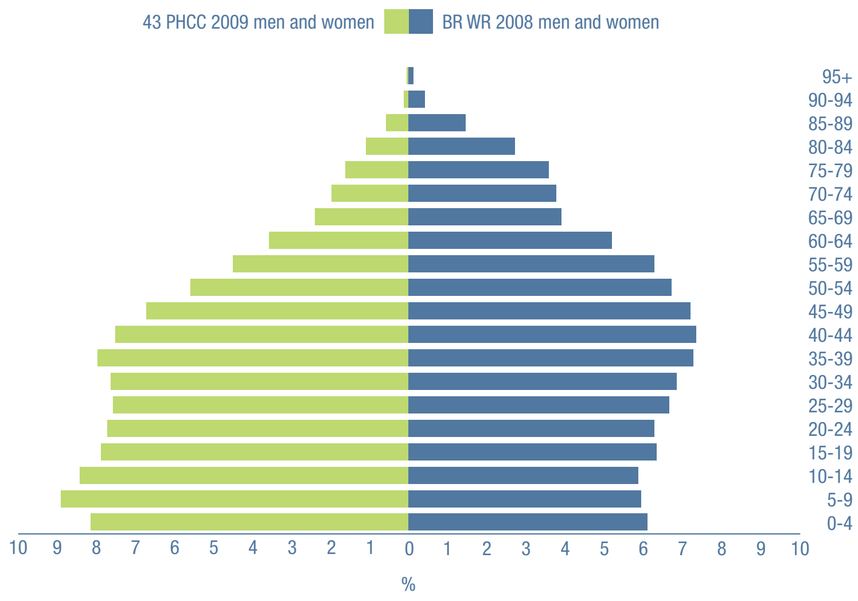


3

	43 PHCC (2009) N=96 800	Belgium (2009) N=10 543 864
Mean Age	32.1 yrs	39.7 yrs
Ratio WDRO[1] better reimbursement (poor)/ WDRO common reimbursement (non-poor)	1.19	0.49

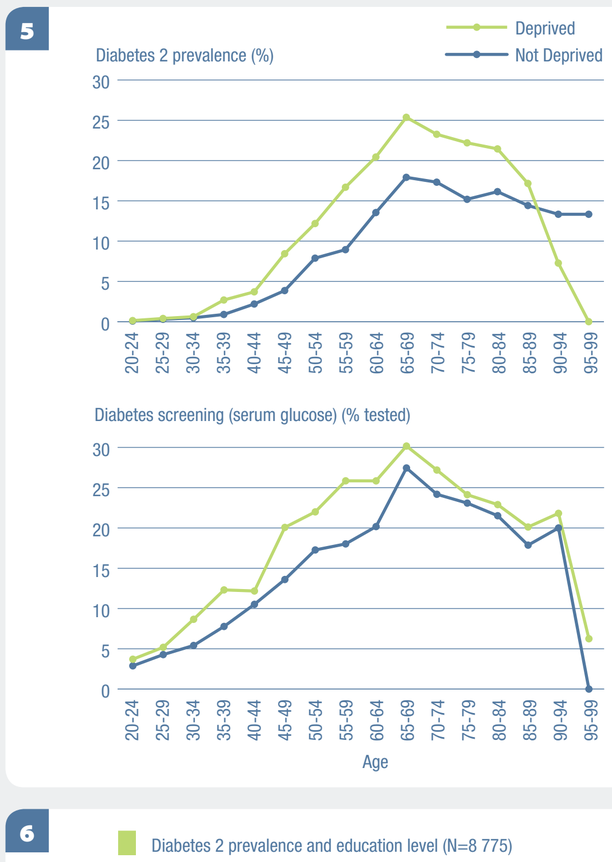
1) WDRO = Widow, disabled, retired & orphan

4



Social inequalities in health

5



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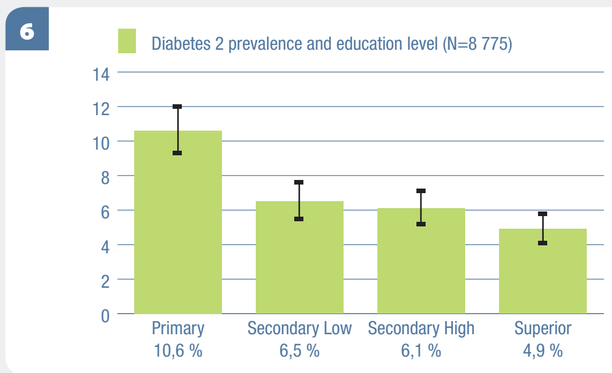

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RÉGION WALLONNE

Poster: Nathalie da Costa Maya, CDCS ngo, Brussels, December 2010