

COMMENTARY

Who Will Establish a Proper Data Model for Family Medicine and Primary Care?

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The policy brief in this issue¹ used recent data concerning published accounts of primary care workforce innovations to contrast the way questions were formulated and the grants and interventions designed for National Institutes of Health (NIH)-funded studies versus studies based on routine practice. The majority of NIH-funded studies focused on diseases, biomedical data, and adherence to requirements of the research design. In contrast, innovating practices typically focused on plausible solutions to practice problems, given local conditions and constraints. Critical contextual factors in practices were ignored in many NIH-funded studies. The practice-based, contextualized approach tended to yield results that were easier to implement and sustain in practice. To quibble about the precision of the contrasts is to miss the point of this brief, which contemporizes a persistent, stubborn problem for primary care as a function and family medicine as a discipline. Given the importance of expanding usable knowledge to improve practice, these findings matter.

In the policy brief, Etz et al¹ recommend that the NIH alter some of its research policies to place higher value on contextual learning and change the way studies about practice innovation are evaluated, along with the measures they use to do so. This situation, a contest in which advocates “es-

pouse competing understandings of reality and the nature of knowledge and struggle in various realms to achieve validation . . . for their styles of reasoning,”² is not news in general or in family medicine and primary care in particular.³⁻⁶ While research policymakers would do well to act immediately on this brief’s recommendations, perhaps family medicine and primary care should recognize again that instead of external factors, conditions internal to the discipline and primary care may play a dominant role in underachievement.⁷ One serious internal deficiency within family medicine and primary care is the lack of an agreed on, proper data model that helps organize what is studied and how it is studied.

A data model can be thought of as a description of the objects to be represented in a system, their properties and interrelationships, and the subject(s) of interest. Such a model contains a collection of concepts, involves classification, and requires rules be used in dealing with the model. The contrasts declared in this policy brief reflect the use of different underlying data models by the NIH and innovating practices. The NIH model seems to be clearer than family medicine’s.

Innovating practices and family medicine academicians could turn their gaze toward articulating a proper data model fit for their purposes, to good effect. Episodes of care organized around individuals of all ages and families; the quality of therapeutic relationships; team functionalities; linkage of practices with public health; and the integration of primary care practices with mental health, subspecialty medicine, and care at home and in institutions are examples of what could be included in the family medicine and primary care data model. This is not virgin territory, as previous collaborative conferences⁸ and the International Classification of Primary Care⁹ confirm. The timeliness of an aggressive focus on this basic work is suggested by keen national interest in “big data.”¹⁰⁻¹² Its plausi-

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bility is supported by the vision of the Office of the National Coordinator for Health Information Technology and its investment of billions of dollars into data systems.¹³ Its feasibility is supported by widespread, ongoing work to establish data standards (content, architecture, transport, security, vocabularies, stewardship) that permit interoperability and patient protection across care settings and within communities, becoming learning systems for health.¹³⁻¹⁵

This policy brief is important because it uses contemporary data to reconfirm longstanding, serious research problems impeding the discovery and innovation necessary to achieve affordable, better health care that yields better health—the central focus of health policy in the United States today. Policy briefs aim to use contemporary data to stimulate thinking about important issues and thereby generate movement to address them. This one succeeds and challenges research funders and practice-based investigators to collaborate to clarify frameworks and methods and make some changes in research policy to enable rapid improvements of clinical practices serving millions of people each day. How might family medicine and the rest of primary care seize this opportunity and challenge? Who can establish a proper data model to unite and guide the discovery of family medicine and primary care?

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