Harvard Suspends Funds To Primary Care Division

The division is deemed as largely symbolic; 'there weren't significant resources going to it.'

BY JOYCE FRIEDEN

Harvard Medical School's decision to suspend funding to its primary care division has drawn sharp criticism from many in the health care community.

Based on an ongoing review of Harvard's department of ambulatory care and prevention, "funding for the division of primary care has been suspended until the review is complete, at which point we expect to have a much clearer vision of the most meaningful structure for the programs within the division and how they can be most effectively leveraged for primary care education and clinical training."

David Cameron, spokesman for the medical school, said that the suspended funding—about $200,000—mainly paid for "lectures and symposia." There is no timeline for completion of the review, he added.

Members of the Harvard community protested the suspension via a petition urging the school to support primary care.

"We request that the administration renew its commitment to primary care and present a detailed action plan for expanding institutional support despite this budget cut," the petition reads. "As a leader in medicine, you have an opportunity to help solve [the] crisis in primary care and we look forward to working with you on this important task."

The petition, which had garnered nearly 1,200 signatures at press time, asked Harvard to reaffirm that "leadership in primary care research and education is central to Harvard's mission as the nation's premier academic medical institution," that "Harvard must continue to expand loan forgiveness initiatives that encourage students to pursue primary care specialties," and that "Harvard should support initiatives to train future leaders and innovators in primary care." It also asked the administration to "solicit and implement proposals from the [medical school] community that support the above goals."

Dr. David Himmelstein, an internist and faculty member who signed the petition, said that the primary care division "has been a joke for years," and as a result the suspension of funding "is a largely symbolic act."

When Harvard initially set up the department of ambulatory care and prevention, "primary care was going to be part of that … and they were going to do more preventive and primary care," he said. "But the department changed leadership and there was no money to pursue research and initiatives in primary care, so they followed the money and focused on epidemiologic research … and the primary care division became really a minor afterthought."

The move to de-fund the division raised hackles because it represented the last straw, said Dr. Himmelstein. "There weren't significant resources going to it, but at least there was the symbolism of being part of Harvard Medical School, and they didn't see fit to continue that."

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Dr. Ted Epperly, president of the American Academy of Family Physicians, said he found Harvard's action ironic in light of Massachusetts' recent move to provide health care for all its residents.

"I find it incomprehensible that at a time when [the state needs primary care physicians] that Harvard is turning its back on the people that produce them," he said. "Medical schools are very good at training a workforce good for medical schools and teaching centers, but very bad at producing a workforce good for the community and people in the state."

He noted that Harvard's is one of 10 U.S. medical schools that does not have a family medicine department. "They have never invested the resources in training the doctors to shore up the primary care base," he added.

Mr. Cameron said that the decision to suspend funding "in no way reflects on Harvard Medical School's commitment to primary care training. Rather, it is an administrative matter."

He pointed out that the medical school currently has 31 centers, divisions, and institutes, "and not all receive funding from us."

One program that does receive significant funding from the medical school, Mr. Cameron said, is the primary care clerkship program, in which students are assigned to a general internist, general pediatrician, or family physician with whom they see patients three or four afternoons a month for 8 months beginning in September of their third year. The school's investment in the clerkship is increasing by roughly 20% this year, Mr. Cameron said. ■

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More HIPAA Goes to Rights Office

The Health and Human Services' Office for Civil Rights will now enforce the confidentiality of electronic health information as well as other patient records, HHS Secretary Kathleen Sebelius announced. The office already had responsibility for enforcing the HIPAA's "privacy" rule, which guards nonelectronic personal health information. But enforcement of HIPAA's "security" rule for electronic health information had been delegated to the Centers for Medicare and Medicaid Services. Legislation approved as part of the Recovery Act of 2009 mandated better enforcement of both rules. Ms. Sebelius noted in a statement that electronic and nonelectronic health information increasingly overlaps. "Combining the enforcement authority [for both rules] in one agency within HHS will facilitate improvements by eliminating duplication and increasing efficiency," she said. CMS will continue to have authority for the administration and enforcement of other HIPAA regulations.

HHS Issues Privacy Breach Rules

The federal government is requiring physicians and other HIPAA-covered entities to notify individuals when their protected health information has been breached. The interim final rule, issued in August, goes into effect this month. Under the rule, physicians have up to 60 calendar days from when they detect unauthorized access of protected health information to notify the patient. If the breach involves more than 500 individuals, the HHS secretary and a major media outlet in their area must be notified. "This new federal law ensures that covered entities and business associates are accountable to [HHS] and to individuals for proper safeguarding of the private information entrusted to their care," said Robinsue Frohboese, acting director of the Office of Civil Rights at HHS. There are exceptions: Notifications are not necessary if the information that was disclosed is unlikely to be retained. For example, if a nurse gives a patient the wrong discharge papers but quickly takes them back, it's reasonable to assume that the patient could not have retained that protected information, according to HHS. More information about the regulation is available at www.hhs.gov/ocr/privacy.

Public Is Biggest ED Payer

More than 40% of the 120 million visits that Americans made to hospital emergency departments in 2006 were billed to Medicare and Medicaid, according to the Agency for Healthcare Research and Quality. In all, 34% of visits were billed to private insurance companies, 18% weren't covered at all, and the rest were billed to workers' compensation, Tricare, and other payers. However, uninsured people were 1.2 times as likely to visit the ED than were people with public or private insurance, AHRQ said. The uninsured also were the most likely to be treated and released. About 38% of the 24.2 million visits billed to Medicare ended with the patients being admitted, compared with 11% of the 41.5 million visits billed to private insurers, fewer than 10% of the 26 million visits billed to Medicaid, and 7% of the 21.2 million visits by the uninsured, the report found.

Obesity Medicine Exam to Come

Ten professional societies are jointly developing an Obesity Medicine Physician Certification Examination to credential physicians who care for obese adults and children. Last year, the group began assembling the body of knowledge that physicians need to be experts in obesity. The societies have now begun writing questions for the exam, which is scheduled to be completed by March 2010, according to the Obesity Society. The 10 groups are the Obesity Society, the American Academy of Pediatrics, the American Association of Clinical Endocrinologists, the American Diabetes Association, the American Gastroenterological Association, the American Heart Association, the American Society for Parenteral and Enteral Nutrition, the American Society for Metabolic and Bariatric Surgery, the American Society for Nutrition, and the Endocrine Society.

Bill Seeks Pay for Performance

A small bipartisan group of senators has cosponsored legislation that would pay a physician for work under part of Medicare only if a patient's health status improves. Sen. Ron Wyden (D-Ore.), Sen. John Cornyn (R-Tex.), and Sen. Tom Harkin (D-Iowa) offered the Take Back Your Health Act of 2009 (S. 1640) to create a new Medicare program based on "comprehensive lifestyle programs." Such treatment plans would be designed by physicians specifically for each patient in the program. The plans can include nutritional therapy, exercise, medication management, care coordination, and tobacco-use cessation. Physicians wouldn't be paid if a patient were rehospitalized for a chronic illness accounted for in his or her plan. Sen. Wyden said in a statement that several trials of such a system, including those at Mutual of Omaha Insurance Co. and Highmark Blue Cross Blue Shield, have shown that comprehensive lifestyle programs can result in up to 50% reductions in medical costs.

—Jane Anderson