pitals. BMC has also made it clear that it will fight hard for its own economic well-being as the state ponders global budgets and further Medicaid cuts.

Some observers may see the BMC litigation as proof that the Massachusetts reform model has failed. But interpreting it in this way would be a grave mistake. Medicaid litigation occurred before reform and would have continued without it. Indeed, the dispute between BMC and Massachusetts probably stems more from the state's long-running battle to cut Medicaid costs than from any innovation brought about by health care reform. Nevertheless, the case demonstrates that the Massachusetts model cannot solve all the problems faced by our health care system. Nor will it end all litigation. As long as powerful interests clash over limited health care resources, parties will do what they have always done: go to court.

Ms. Parmet reports serving on the boards of directors of Health Care for All and Health Law Advocates. No other potential conflict of interest relevant to this article was reported.

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Payment Reform for Safety-Net Institutions — Improving Quality and Outcomes

C. Jason Wang, M.D., Ph.D., Kathleen N. Conroy, M.D., and Barry Zuckerman, M.D.

In the U.S. health care system today, many hospitals have the market power to raise the prices of their services without showing evidence of improvements in the quality of care.[1] In an effort to realign incentives, health care reformers are now proposing to link provider payments to quality of care and health outcomes. As we move toward such a payment system, however, we must ensure that reimbursement is adjusted for patients' coexisting conditions so that hospitals cannot get high marks for quality by choosing to treat only patients who are considered to be at low risk.

Although risk adjustment has long been an interest of both insurers and providers, health risks have yet to be defined with sufficient granularity for hospitals to bear the full financial risks of caring for high-risk patients in a non–fee-for-service environment. Low-income patients are more likely than high-income patients to have multiple coexisting conditions, and hospitals serving a high proportion of low-income, high-risk patients may therefore have to do more than other hospitals to achieve the same outcomes. We believe that given the same level of quality, safety-net institutions should therefore be reimbursed more per patient under any pay-for-quality scheme that is implemented.

Achieving high-quality health care and positive outcomes in safety-net institutions can be extremely challenging. Social status and health outcomes are linked the world over, and recent research highlights how unfavorable social conditions can directly interact with genetic and biologic processes. As a group, low-income people have a greater predisposition to a range of illnesses than their higher-income counterparts, and they often have more severe forms of illness when they arrive at a health care facility.

Even when they have health insurance, people with low income often have more difficulty gaining access to the care they need. They may be faced with such challenging circumstances as disconnected telephones, transportation difficulties, multiple or inflexible jobs, unaffordable copayments for medication, and often cultural and language barriers as well. For low-income patients who manage to obtain care, adherence to treatment plans may also be complicated by competing priorities. Many low-income families must make tradeoffs between health care and other basic needs, such as housing, food, and heat.[2] In part because of the necessity of such juggling acts, safety-net institutions are more likely than

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other health care institutions to have high no-show rates and high rates of nonadherence to treatment regimens. Delivery systems have thus far dealt with such problems inadequately, some of them adopting punitive approaches (such as putting late patients at the bottom of the waiting list or canceling appointments) that further discourage patients from seeking necessary care.

For these and related reasons, health disparities persist in the United States. For example, the rate of leg amputation, a devastating complication of diabetes and peripheral vascular disease, is four times as high among blacks as among whites.[3] Moreover, the quality of care in institutions that primarily serve patients who are members of minority groups is reported to be worse than the quality in those primarily serving white patients. So far, policymakers have been unable to bridge this gap, and we believe that payment reform for safety-net institutions is part of the solution.

Under existing fee-for-service payment schemes, providers do not get paid more per patient when they serve high-risk populations, in part because there is an assumption that patients at greater risk will end up using more services and that their providers will therefore be able to claim greater reimbursement under the fee-for-service model. However, payment reform involving the "bundling" of payments is under way. With the "alternative quality contracts" now being offered by some payers, providers will be rewarded for high-quality care and positive health outcomes through capitated or bundled payments. Under such a system, safety-net institutions, which care for a disproportionate share of patients who are at risk for complications and poor adherence, are at great financial risk. If quality and outcomes are to be maintained or improved in these institutions, there must be a mechanism that will help level the playing field by augmenting reimbursement to cover expenditures that are necessary for attaining such improvement.

Under a bundled payment system, safety-net institutions, which care for a disproportionate share of patients who are at risk for complications and poor adherence, are at great financial risk.

Beyond the enhancement of basic but costly offerings, such as interpreter services, some safety-net institutions have implemented innovative programs to promote better outcomes among low-income patients. For example, medical–legal partnerships,[4] which were started at our institution and now exist at more than 180 clinical sites around the country, use attorneys to help eligible families break down access barriers to existing health-promotion programs, permitting them to obtain such assistance as food stamps and housing vouchers — both of which have been shown to improve health outcomes — as well as Supplemental Security Income and fuel assistance. These partnerships can also work to ensure that homes are free of asthma triggers and lead contamination. Other programs have used monetary incentives to improve adherence among particularly high-risk patients — for example, for tuberculosis treatment in low-income populations.[5] Project Health, a nonprofit organization that is active in six cities, asks physicians to "prescribe" food or housing for patients and their families; volunteers then connect those families to local resources, enabling them to achieve stability and better health for their children. We believe that such interventions should be viewed as similar to drug regimens, and providers should receive appropriate reimbursement for these services if they improve outcomes. Comparative-effectiveness research that includes the study of health care delivery systems will help to provide an empirical basis for such enhancements.

Improving the quality of care requires a systems approach. As we learn more about the interaction between social factors and genetic determinants of health, we will need to expand care delivery beyond the boundary of the hospital walls into surrounding neighborhoods, and safety-net institutions serving poor neighborhoods will need to be paid fairly for such efforts. A novel approach to payment reform would be to reimburse institutions for innovative programs that address patients' unmet basic needs related to overall health (e.g., food, housing, and fuel), as well as needs that create barriers to care (e.g.,

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transportation and child care). These incentives could be formalized as part of a payment bundle for safety-net institutions in order to facilitate care coordination. As the largest health care payer in the marketplace, government is in a position to make such changes as it sets and oversees policies regarding health insurance and payment.

Despite the fact that their jobs are tougher than many others in health care, providers in safety-net hospitals have often received the short end of the stick, in the form of discounted payments from Medicaid. Adjustments in payments to safety-net hospitals would attract more physicians to institutions serving poor neighborhoods and allow those institutions to set up systems to facilitate the tracking of patients and their adherence to treatment regimens. Thus, it is important that payment for safety-net institutions be part of the current wave of health care reform discussions, which have largely focused on increasing access to care. Only when access and payment reform are discussed jointly can incentives be aligned properly to improve the quality of care and health outcomes. The proposed efforts to bridge the quality gap can also help to reduce health disparities. Without adjustments for coexisting medical and social conditions to level the playing field, health care reform may actually widen, rather than narrow, disparities.

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Novel H1N1 Influenza and Respiratory Protection for Health Care Workers

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Your hospital has been seeing a large number of patients with influenza-like symptoms, many of whom turn out to be infected with the novel H1N1 influenza A virus. You have been asked to consult on the case of a 28-year-old woman who is in an isolation room because of an influenza-like presentation and shortness of breath. You put on a gown, carefully clean your hands with hand soap or an alcoholic gel, pull on gloves, and reach for a mask. Guidelines from the Centers for Disease Control and Prevention (CDC) recommend the use of an N95 filtering facepiece respirator. Some states and many professional groups have suggested that a standard surgical mask is satisfactory in this situation, except when a clinician is performing high-risk procedures, such as airway suctioning, in which case the N95 is still recommended. What should the hospital and its infection-control officer provide when you reach into the box for a respiratory protective device? What should be available to others who will enter this room, including nurses, respiratory technicians, cleaners, and food servers?

On September 3, 2009, the Institute of Medicine (IOM), which has conducted studies on personal protective equipment for health care workers,[1] released a report entitled *Respiratory Protection for Healthcare Workers in the Workplace against Novel H1N1 Influenza A.*[2] The report was based on our IOM committee's review of the scientific evidence about the efficacy of personal respiratory protection measures, medical masks, and respirators.

Seasonal influenza usually peaks in the winter months, and each year in the United States

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