In the volume, or fee for service reimbursement model, the patient is billed for individual services or procedures. For example, Jim's CT with contrast requires an IV, the actual contrast, and the radiology read. There is also the ED physician assessment/exam, the lab studies, and ultras sound (U.S.) that each incur charges. Finally, the surgical procedure is going to have the costs of anesthesia and the surgical procedure itself. Two CTs and an U.S. seem to be overkill. Had it been a pregnant female or child I could see the U.S. and perhaps an MRI to avoid the radiation of the CT.

In the alternative, had this been a value-based system, one which provides value through improved quality outcomes with incentives that reduce costs (Eriksson et al. 2023), Jim likely would have had a CT with and labs and been done as far as diagnostics are concerned and then on to surgery.

Based on the date we are given, a reasonable conclusion that could be drawn was Jim was seen by a volume-based system, and he was rushed through his procedure, received poor post op education, and sent on his way, which led to his post operative infection. Perhaps, during the patient education they did not consider his diabetes and potential complications to the incision healing. This resulted in a poor patient outcome, readmission to treat the infection, and of course, poor patient satisfaction. The extra revenue collected on the front end was lost due to the readmission.

Had Jim been in a value-based reimbursement system, he likely would have reduced diagnostic tests to those necessary and required rather than others that are optional. In value reimbursement systems emphasis is placed on patient engagement and care coordination (McAlearney et al. 2018.) Perhaps the nursing staff would emphasize the potential for healing issues due to his diabetes. One could conclude a patient centered focus would lead to a more aware patient who noticed post op issues sooner and when they might have been treated via outpatient options and avoiding a readmission.

One factor we did not have is Jim's socio-economic status. He was likely a Medicare patient (age 69) so one thing to consider is the penalties from CMS that the facility likely felt due to the readmission. That alone should be incentive for a facility to think about the need to only provide the necessary care and to focus on quality vs quantity in care for patients.

References

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