



The Wound Care Center Healing Rate Controversy

Many wound centers report healing rates of between 90 – 94% and healing times from 21-46 days. Almost exclusively, these centers are operated by for-profit management companies who use these ‘outcomes’ measures principally as a primary and self-promoting marketing strategy to win and keep hospital contracts

Healing rates are a very subjective measure. They are generally based upon the assumption that all patients and their respective wounds are equal and that the first day in the wound center is the point at which their outcomes calculations begin. Likewise, patients are invariably considered ‘healed’ on the day they are discharged from the center. This practice is more representative of a length of stay or duration of treatment calculation, than it is a ‘healing rate’. It is also customary to ‘throw out’ (eliminate from data reporting) any patients who don’t fall within a given center’s anticipated (previously planned?) outcomes success rate. As a consequence of this selection bias much more impressive outcomes are reported than otherwise would be achieved if all patients had been included and reported. This highly selective data collection (in some cases representing an actual minority of patients) process also allows many variables to come into play, from person to person and day-to-day perspectives. Wound center staff members are encouraged to make assumptions (guesses) as to how such patient variations should be accounted for and reported, which further skews the ability to achieve true healing rates. Because of a failure to appropriately stratify patients, healing rates and/or days to heal are very easily manipulated and hold little, if any, objective scientific validity.

In order for healing rates and/or days to heal to be statistically significant, information would need to be obtained objectively, rather than subjectively. This means that data collection and reporting would be performed in a manner which stratified patients according to their diagnosis, any secondary and co-morbid conditions, respective treatment protocols, and their compliance with these protocols. In the absence of these factors, too many variables exist to produce, and certainly reproduce, meaningful data to generate reliable and statistically significant outcomes results.

One has to ask the question, therefore, if you choose to collect healing rate data without appropriate protocols to capture information as close to the true state of each discharged patient as one can get, what will you do with the patients, or physicians who are treating these patients, who fall outside of the desired or expected healing rate? Will you discipline, or otherwise ‘call out’, the physician and direct how they should be performing better patient care? Will you simply discharge and discount a patient if they don’t respond as quickly as other patients have? And who would be telling the physician and

surgeon exactly how they should be to practicing wound care in order to manipulate these healing rate expectations? Data collection with no purpose in mind will often lead to unintended consequences. If we, as a specialty, choose to use days treated or length of stay to represent 'healing rates', are we setting ourselves up for this to become a compliance standard which payors then expect us to adhere to from a reimbursement standpoint? This may then serve to deprive patients with more complex problems access to necessary care. Additionally, if providers become consumed with worry over healing rates, are they subsequently going to be hesitant to provide care to the more complex cases and/or less compliant patients, patients who are likely to lower overall success rates? Patients with chronic wounds are frequently non-compliant in nature, whether it is related to their prescribed wound care, management of their diabetes, or other complicating medical conditions. This contributes to the "chronic" nature of a great deal of their wounds from the very beginning.

Before making the determination to collect 'healing rate' statistics, one should ask how would the following situations be accounted for.

- A patient still has an open wound, but just stops coming to the wound center. (You wouldn't know if, or when, their wound ever closed.)
- A patient has an amputation, the wound is excised, but the stump doesn't heal. (Do you start counting their days over as a new wound after the dehiscence occurs? It isn't the same wound, but you didn't heal the first one either.)
- A patient has a wound that you are unable to close it by conventional means. They go on to have an amputation, which heals without complications. (Did you close the wound? If so, at what point would it be considered closed? For instance, would it be as soon as they leave the operating room with a surgically closed amputation site?)
- A patient has a skin graft and heals initially, but it breaks down a few days or weeks later. (Did you 'heal' the wound that was subsequently grafted? It would most likely have already been entered as healed in the database. Would the breakdown be considered a new wound, at which point you start calculating a healing rate all over again?)
- A patient has a venous stasis ulcer, which closes and then reopens within a short time frame. (How would you calculate their days to healing, or 'healing rate'?)
- A patient dies, but the wound is still open at the time that they passed away. (Did you fail to heal the wound?)
- A patient being treated in the wound center is admitted as an inpatient, where another provider assumes their wound care. (If they don't come back to the wound center, did you fail to heal the wound? If they do come back to the wound center, but the wound had worsened or stalled while in the other provider's care, does your 'healing rate' calculation reflect the care provided by the other provider, or do you start and stop your 'days to heal' rate with each admission?).
- A patient is non-compliant with their prescribed treatment. (Are providers going to have extended 'days to healing' or 'healing rates' attached to the care they provided because the patient was non-compliant?)

- A patient develops a new medical condition which impacts their ability to heal. (How is this factored into your 'healing rate' calculation?)
- When is a wound considered to be 'healed'? Is it as soon as the very thin layer of epithelial tissue appears to cover the wound bed, or is it after it has been a wound center patient for a predetermined number of days or weeks?
- A patient has a wound, which has a bridge of epithelialization over part of the wound, so there are now two remaining areas on each side of the bridge which remain open. (Many providers are inclined to close out the original wound as 'healed' and rename the remaining areas which are open as two new wounds. The clock is restarted to calculate new healing rates. Did you really ever close the original wound if there are areas which are clearly not yet healed? What percentage of the wound, if any, needs to be closed before you can count a wound as healed?)
- A patient presents from a nursing home with a Stage IV pressure ulcer. The patient is so debilitated that from your first assessment that you sense that you will never be able to get the wound to close. (Do you discharge the patient following the consultation because you know you won't be able to 'heal' them? Do you refuse patients the option of palliative care because they are at the end of their life and you know you will not be able to heal them?)

As clearly evidenced above, there are many factors which can have an adverse impact on a healing rate, or provide an incorrectly reported high rate of successful healing. Before making a determination to move forward with a 'healing rate' calculation, providers should determine the intent of the data collection. If improving patient care, rather than simply touting a number for marketing purposes, is the true intent, then providers should appropriately stratify, collect and report data. To do anything else is inaccurate and irresponsible.