OLD MISSION
WOUND CARE

THE WOUND CARE MARGIN TRAP

Why “Handling It In-House” ***Will Cost*** Home Health Agencies in 2026

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The Problem:
The Wound Care Margin Trap

On Jan. 1, 2026, the economics of mobile wound care quietly collapsed.

An inefficient fee-for-service model that was acceptable for years became mathematically insolvent as reimbursement compressed based on the 2026 Physician Fee Schedule — and **wound care risk will now shift downstream to home health agencies.**

Under current PDGM economics, a standard wound patient generates a loss in the first 30 days and those losses linger in subsequent periods, regardless of clinical competence.

At the same time, mobile wound care providers that took advantage of high-reimbursements, mainly from the use of skin substitutes, are exiting the market, leaving agencies to ultimately absorb a growing population of complex wound patients.

With the exit of high-margin mobile providers, the 'safety valve' for complex wounds is gone. You are now the provider of last resort for the most expensive patients in the system.

If agencies don't plan now, wound care becomes your main margin killer. Not because outcomes got worse, but because the math flipped. What used to be a tolerable loss leader now compounds into a multi-month bleed, one patient at a time.

The wound care margin trap isn't coming. It's already here, and most agencies won't realize they're in it until they can't get out.

In the next 6–12 months, home health agencies that keep treating wound care as "business as usual" will watch margins erode as more acute referrals increase and risk concentrate at the branch level until it shows up in clinical outcomes impacting HHVBP (home health value-based purchasing).

The Clinical Reality:
Chronic Wounds Are Different

Chronic wounds are not just another diagnosis layered into a home health caseload. They are time-sensitive biological problems that behave differently than almost everything else agencies manage.

While most conditions improve gradually with compliance and time, chronic wounds often do the opposite. When early progress stalls, biology turns hostile. Tissue degrades, bacterial burden increases, and risk compounds quietly while visits, documentation, and utilization climb.

What matters clinically is not how often a dressing is changed. It is whether the wound is showing clear, meaningful improvement on a predictable timeline. The first several weeks determine that trajectory.

When improvement happens early, the episode compresses. When it does not, escalation comes late, infection risk rises, and the wound begins to drive downstream cost and readmission exposure long before it shows up in performance reports.

Chronic wounds also rarely exist in isolation. They are often the sentinel of advancing cardio-renal-metabolic disease. The patients who develop chronic wounds are typically the same patients carrying diabetes, vascular disease, renal impairment, immobility, and impaired tissue perfusion. This population represents the highest utilization and highest downstream risk in home health, with disproportionate exposure to infection, hospitalization, and cascading complications.

This is Where Specialist-led Care Changes The Curve.

The wound is not just a local failure. It is a visible signal of systemic fragility.

This is where specialist-led care changes the curve. Specialists recognize early signals that generalist protocols often miss, particularly in deeper or mixed-etiology wounds. They take ownership of escalation decisions sooner, apply the right intensity of care at the right time, and shorten the window where biology is allowed to work against the patient. The result is not just better healing, but fewer stalled weeks where cost and risk quietly accumulate.

Internally, we plan against an 8 to 12 week improvement and closure trajectory. That is not a promise, and it is not appropriate for every patient. But it is a benchmark grounded in experience. We have seen, repeatedly, that when wounds are addressed early, intensity is matched to depth, and escalation is owned from the start, meaningful improvement within that window is achievable.

When wounds drift beyond it, the problem is rarely effort. It is timing.

The longer a wound remains open, the less forgiving the biology becomes. One wound rarely stays one wound. Moisture, pressure, immobility, and poor circulation turn isolated issues into cascading failures, especially in patients without caregiver support. By the time a wound has lingered for months, the clinical outcome and the margin outcome are already tied together.

This is the core clinical reality behind the wound care margin trap.

Chronic wounds do not fail loudly at first. They fail slowly, then all at *once*. Agencies that understand this early still have room to act. Agencies that treat wounds as business as usual will not realize the damage until the math has already turned against them.

The **‘We Can Manage This Internally’** Assumption

“We can handle our wound patients in-house.”

This is the most common and most understandable response we hear from home health leaders. On the surface, it makes sense. You already have nurses in the field. Dressing changes are familiar. Supplies are predictable. Early wounds often look manageable, and for a short period of time, they can be.

It feels reasonable at first because dressing changes are a known expense, but the model collapses when improvement stalls and the visit count keeps climbing. Without early escalation and specialist ownership, the episode stretches, costs compound, and the margin evaporates.

This approach works for some wounds, some of the time.

Superficial Stage 1 to early Stage 2 wounds, especially when a caregiver is present and engaged, can often be managed internally for a limited window. Weekly visits, caregiver education, and basic protocols may be enough to keep the wound moving in the right direction.

The problem is not that this never works. **The problem is that leaders assume it will keep working as complexity increases.**

Where the model breaks is not subtle. Visit frequency rises as wounds deepen or stall, turning a controlled case into a utilization problem. Staff mix becomes misaligned, with generalist nurses managing complex wound biology that demands specialist judgment. Documentation requirements expand as complications and exceptions grow. Escalation happens late, after weeks or months of slow progress, when infection risk is higher and options are fewer.

By the time a wound is clearly failing, the agency is already absorbing the cost. Visits have multiplied. Supplies are being consumed at a higher rate. Clinical staff are spending disproportionate time on a single patient. The wound is no longer a manageable case, it is a margin liability that continues until closure or discharge.

There is also a hidden strategic risk in simply saying no. Turning away wound referrals does not just reduce workload. It affects hospital relationships, discharge flow, and referral trust. Hospitals are under pressure to move patients out quickly and safely. Agencies that cannot reliably accept and manage wound cases become less attractive partners, even for non-wound referrals.

It isn't just about the P&L. It's about your people. Forcing generalist nurses to manage complex, non-healing Stage 3/4 wounds drives burnout. They feel unsupported, overwhelmed, and fearful of liability.

The Result: Higher turnover.

The Fix: Offloading these complex cases to a specialist team protects your core staff, allowing them to focus on what they do best.

This is not a question of competence or effort. Home health clinicians are skilled professionals. The issue is specialization. Generalists are designed to manage breadth. Wound specialists are built to manage depth, escalation, and biology under time pressure. When wounds behave, internal management can hold. When they do not, the math and the medicine both turn against the agency.

The wound care margin trap does not come from trying to do the right thing. It comes from waiting too long to recognize when "handling it internally" is no longer neutral, and has already started to cost more than it saves.

The Math HHAs Are Not Seeing

This is not about total labor cost or fully loaded agency economics. CFOs do not manage to that number. They manage direct, controllable cost as utilization rises. That is where wound care quietly breaks the model.

Below is the comparison most agencies ***never run.***

COST UNIT	IN-HOUSE WOUND MANAGEMENT	CAPITATED WOUND SPECIALIST MODEL
Cost Unit That Matters	Cost Per Visit	Fixed PMPM
Nurse Visit Cost	~$85 Fully Loaded	$0 Variable
Visit Frequency	Rises as Wounds Stall	Controlled and Planned
Episode Length	4-6 Months if Delayed	Compressed by Design
Cost Behavior	Linear Turning Exponential	Flat and Predictable
Readmission Exposure	Increases Over Time	Actively Reduced
HHVBP Risk	Lags But Compounds	Mitigated Early

"This is the Comparison ***Most Agencies Never Run***"

What the Math Looks Like in Practice

A home health nurse visit costs roughly $85 once mileage and supplies are included. That number feels manageable until utilization spikes.

A wound that starts as one visit per week looks harmless.

- **1 visit per week = ~$340 per month**
- **Manageable, predictable, familiar**

Now add stalled improvement.

- **Stage 3–4 wounds often require 3 visits per week minimum**
- **12 visits per month = ~$1,020 in direct cost**
- **Daily care pushes this higher, fast**

Stretch that over time..

- **4 months stalled = ~$4,000+ in direct cost**
- **6 months stalled = ~$6,000+**
- **All *before* factoring documentation burden, staff strain, or readmission fallout**

This is why wound cases stop behaving like neutral volume and start acting like margin leaks. The cost does not explode on day one. It creeps, then compounds.

Why Specialist Economics Are *Different*

Specialists are not cheaper per visit under fee-for-service. That comparison *misses* the point. What matters is utilization control and episode compression.

Specialist-led models reduce:

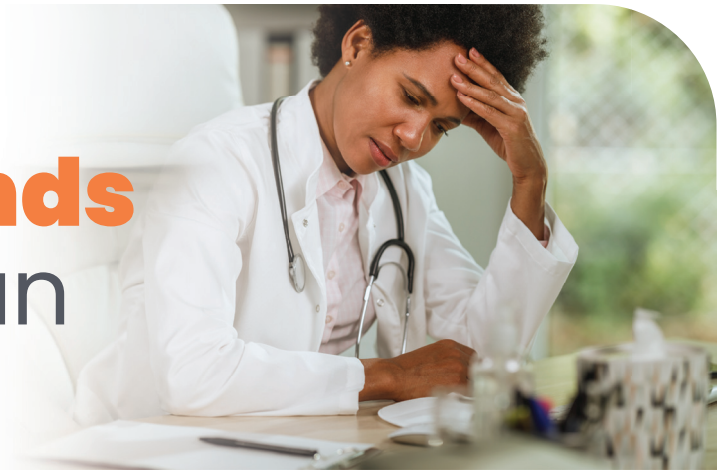
- **The number of weeks a wound stays open**
- **The number of visits required to stabilize biology**
- **The probability that escalation happens late**

When improvement happens earlier, visits do not spike, infections do not stack, and readmissions do not erase branch margin months later when HHVBP settles.

The mistake agencies make is assuming the early math holds. It does not. Once visit frequency rises, the wound is no longer a clinical issue alone. It is a controllable-cost problem that compounds quietly until leadership finally sees it on the wrong report.

This is the math behind the margin trap. It doesn't spike or shock. It compounds quietly, one visit at a time, until the loss is *unavoidable.*

Why This Compounds Faster Than Expected



Wound care rarely fails in isolation. As mobile wound providers exit and hospitals push to discharge faster, volume increases precisely when options narrow. Agencies do not just inherit more wound patients. They inherit more complex ones, with deeper risk and fewer downstream safety valves.

The losses themselves look small at first. An extra visit here. A few more weeks there. But wound care does not compound vertically, it compounds horizontally. The same slow-moving pattern repeats across multiple patients, then across months, quietly eroding branch contribution margin. What feels like a tolerable exception becomes a structural drag.

Quality penalties make this worse, not better. HHVBP and readmission impacts lag behind the operational decisions that create them. Leaders do not see the full damage when choices are made. By the time performance scores finalize, the clinical patterns are already locked in and the financial consequences are no longer reversible.

Decisions *you make today* around wound care do not stay contained to a single episode. They ripple through utilization, referral trust, and HHVBP performance for years.

The math is not dramatic, but it is relentless, and it does not forgive slow improvement.

Wound Care Provider Exits Are Already Happening

Fee-for-service mobile wound care is structurally broken.

The reimbursement model that supported frequent visits and high-cost biologics no longer works under current and upcoming payment rules. As the math tightens, providers are quietly pulling back.

Some have already shut down. Others have stopped accepting complex cases, reduced service areas, or exited home-based care entirely. These moves do not always make headlines, but agencies are feeling the impact in real time through harder discharges, fewer specialist options, and longer delays.

Private equity-backed models are especially exposed. Their economics depended on volume, utilization, and reimbursement assumptions that no longer hold. When margins compress, the fastest lever is exit.

The result is simple and unavoidable.

Home health agencies are becoming the default destination for complex wound patients as specialist capacity disappears. This is not a future risk. It is already happening, and it shifts both clinical responsibility and financial exposure downstream whether agencies are prepared for it or not.

What a Responsible Executive Does Next

The environment around wound care has already changed.

The economics are different, the referral mix is shifting, and specialist capacity is thinning. The question for leadership is no longer whether wound care deserves attention, but whether current assumptions still hold under today's math.

A responsible next step is not to purchase a program or commit to a vendor. It is to understand exposure. That starts by pressure-testing internal assumptions and running the current wound census through updated utilization and duration models. When visit frequency increases and wounds stay open longer, the financial impact does not remain isolated. It spreads across staffing, documentation, readmissions, and performance metrics.

This is why a wound census assessment matters. It provides visibility into where risk is already accumulating, which cases are most likely to stall, and how quickly controllable costs can escalate if escalation happens late. This is due diligence. It is an executive-level view of risk before it quietly hardens into operational reality.

Wound care does not become a problem all at once. It becomes one patient at a time, then one branch at a time, until leadership is forced to respond under pressure. The leaders who stay ahead are not the ones who react fastest. They are the ones who see the pattern early enough to make deliberate decisions while options still exist.

The Solution: Get Your Data

The question is not whether this will impact your organization.
It is how much exposure you already have.

Don't Guess. Know.

We are offering a complimentary **"Margin Risk Scorecard"** for your current wound census. We will run your active wound patients through our utilization model to show you exactly:

- Current monthly cash Burn on wound care.
- Projected Loss over the next 90 days if status quo remains.
- Net savings opportunity by switching to the capitated wound specialist model

Stop The Bleeding Before it Starts.

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Contact

231-333-4388

contact@oldmissionwoundcare.com

oldmissionwoundcare.com