Components and Quality Measures of DIME (Devitalized Tissue, Infection/Inflammation, Moisture Balance, and Edge Preparation) in Wound Care

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ABSTRACT

OBJECTIVES: To discuss how patient considerations and the initial wound environment can affect wound treatment and summarize the way in which the initial US Wound Registry measures capture aspects of the DIME (Debridement/devitalized tissue, Infection or inflammation, Moisture balance, and wound Edge preparation/wound depth) principles.

DISCUSSION: The treatment of chronic wounds often involves extended hospital stays and long-term outpatient follow-up visits with costly advanced therapeutic interventions. As complex care is required for chronic wounds, treatment guidelines such as DIME have evolved to include consideration of patient-centered concerns and etiology, as well as features of wound bed preparation. The US healthcare system is in the midst of transitioning to a quality-based system. However, as wound care is not yet a recognized specialty, it is poorly represented in the current approved quality-based measures.

CONCLUSION: This article helps to identify the practice guidelines that are not currently represented by quality metrics.

KEYWORDS: wound care, chronic wounds, comorbidities, quality measures, DIME

INTRODUCTION

Patients with chronic wounds often bear significant financial burdens associated with their treatment, in addition to loss of productivity, anxiety, and decreased quality of life.1-3 The treatment of chronic wounds often involves extended hospital stays and long-term outpatient follow-up visits with costly advanced therapeutic interventions.3,4 The current US payment system rewards healthcare providers according to the number of interventions performed without a feedback mechanism for quality of care, outcome, or patient-centered concerns.5 In the hope of controlling costs while improving the quality of care, efforts are underway to transition the US healthcare payment system from the current “volume-driven” model to one that is determined by value and that links cost to improved patient outcomes and satisfaction. This is being accomplished by linking reimbursement to the reporting of “quality measures,” usually designed to assess the clinician’s adherence to specialty-specific clinical practice guidelines.

Wound care guidelines have taken on new importance now that they serve as the principal ingredients for quality measures and, through quality measures, clinician reimbursement. Many types of guidelines exist, particularly in wound care where technological advances have allowed a variety of wound care strategies to be developed. Although many different types of guidelines exist, the elements of wound bed preparation, controlling infection/inflammation, and maintaining moisture balance are common to all guidelines.1,6-8 Unfortunately, few clinical practice guidelines address patient-centered concerns, despite the fact that outcomes are improved when patient-centered issues are addressed prior to initiating wound care treatments.9 One wound care guideline, DIME (Debridement/devitalized tissue, Infection or inflammation, Moisture balance, wound Edge preparation and wound depth), has evolved to include a holistic patient-centered approach to wound care. The DIME approach first assesses and addresses patient concerns and the underlying comorbidities before treatment of the wound begins (Figure 1, Table 1).9-11

In 2006, the US Centers for Medicare & Medicaid Services (CMS) established the Physician Quality Reporting Initiative, now called the Physician Quality Reporting System (PQRS), which initially provided incentive payments to qualified healthcare professionals reporting quality measure data on Medicare patients. Now moving into the penalty phase, US healthcare providers who fail to successfully report PQRS measures in 2016 will lose 4% of their Medicare revenue in 2018. The CMS also has many quality programs targeting hospitals.12 The Affordable Care Act includes a new value-based payment modifier that will be used to provide...
differential payments to healthcare providers, inpatient facilities, outpatient departments, and accountable care organizations based on quality and cost of care.\textsuperscript{13} When these changes are combined, substantial reductions in reimbursement are on the horizon for both wound care clinicians and hospital-based outpatient wound centers unless a suite of quality measures is developed that can convey the evidence-based practice of wound care.

Most quality measures were created by specialty societies; however, because wound care is not yet a specialty recognized by the American Board of Medical Specialties, wound care quality measure development has been poorly focused. In 2007, the American Medical Association convened a Physician Consortium for Performance Improvement initiative in collaboration with the American Society of Plastic Surgeons to develop wound care quality measures,\textsuperscript{14} 2 of which were incorporated into PQRS by CMS. These 2 “overuse” measures were (1) performing a swab culture of any wound and (2) not using a saline wet-to-dry dressing.\textsuperscript{15} Despite being the only 2 wound care measures in PQRS, these measures were limited in their ability to reflect wound care principles like DIME and have since been retired from PQRS. For example, the swab culture measure was intended to encourage better methods of wound culture (such as biopsy for quantitative culture), thereby limiting the overuse of antibiotics in chronic wounds; however, as written, practitioners

**Table 1.**

**INTRODUCTION TO DIME**

| Components of DIME                              | Definition                                                                 | Key References and Levels of Evidence |
|------------------------------------------------|---------------------------------------------------------------------------|---------------------------------------|
| Devitalized tissue                             | Tissue that has reduced oxygen and blood supply and is no longer viable   | Kirshen et al,\textsuperscript{16} 2006 (level 5) |
| Infection/inflammation                         | Bacterial, viral, or fungal colonization of the wound/immune response against injury and/or foreign objects | Robson,\textsuperscript{28} 1997 (level 5) |
| Moisture balance                               | Maintaining sufficient moisture to promote healing and avoid tissue maceration | Sibbald et al,\textsuperscript{32} 2003 (level 5) |
| Wound edge preparation and wound depth         | Altering the wound edge and wound depth to promote healing or to accept a skin graft or biological skin substitute | Winter,\textsuperscript{40} 1962 (level 5) |

Abbreviations: NPWT, negative-pressure wound therapy; ORC, oxidized regenerated cellulose.
passed the measure by never performing a swab culture on any wound. Although the wound dressing quality measure was intended to promote the selection of dressings that improve wound moisture balance, the measure was not specifically written to accomplish moisture balance and thus did a poor job of measuring what it is designed to assess. Both of these PQRS measures were retired after the 2014 reporting period, leaving no wound care–specific quality measures within the PQRS system.

In 2009 and 2011, the US Wound Registry (USWR) submitted several evidence-based wound-care quality measures to CMS during annual open “calls for measures.” None were accepted, presumably because the suggested measures had not been endorsed by the National Quality Forum, a lengthy and expensive process to which the American Medical Association Physician Consortium for Performance Improvement measures had also not been subjected. The USWR is a nonprofit organization that has been a CMS-approved quality registry since 2008 when PQRS was initiated. In 2014, the USWR was accepted by CMS as a Qualified Clinical Data Registry under a new program that allows experienced registries to develop their own quality measures. The CMS has accepted 21 new quality measures specific to wound care developed by the USWR in conjunction with the member organizations of the Alliance of Wound Care Stakeholders, which healthcare providers can report to satisfy their PQRS requirements.16 With the retirement of the only wound care–specific quality measures from traditional PQRS, the qualified clinical data registry process is currently the only mechanism by which wound care clinicians can report relevant quality measures as part of PQRS participation.

In this article, the authors discuss how patient considerations and the initial wound environment can affect wound treatment and summarize the way in which the initial USWR measures capture aspects of the DIME principles. The authors also highlight those practice guidelines that are not currently represented by any quality metrics, in order to provide suggested areas for future measure development.

SEARCH STRATEGY AND SELECTION CRITERIA
Data for this review were identified by search of MEDLINE and PubMed. References were chosen from relevant articles using the search terms “DIME,” “wound care,” “chronic wounds,” “wound healing,” and “quality measures.” Only articles published in English between 1990 and 2014 were included.

PATIENT HEALTH HISTORY AND CONDITION OF THE WOUND CAN AFFECT IMPLEMENTATION AND SUCCESS OF TREATMENT
Patient considerations and etiology are major factors in wound treatment and wound healing. Patient demographics, comorbidities, psychosocial stress and anxiety, and medication use often alter...
the wound healing process. Comorbidities, such as patient age, diabetes, arterial disease, obesity, smoking, and malnutrition, can alter the progression of wound healing and the treatment tolerated by the patient. In addition, medication use (such as steroids) can affect and/or alter healing processes in patients. Studies have indicated that patients with chronic nonhealing wounds additionally suffer from stress and anxiety related to the wound and wound treatment. Little emphasis has been placed on the importance of evaluating wound-related quality of life or the way in which various treatments may affect wound quality of life with or without associated healing. Stalled, complex, or chronic wounds are long-lasting wounds that are unable to complete the healing process because of a number of underlying comorbidities or impairments, including the presence of dead tissue, ongoing inflammation, infection, and deficiencies in epithelialization.

Stalled/chronic wounds have unbalanced wound biochemistries, including increased proteases and inflammatory mediators, decreased protease inhibitors, high bacterial loads, and hyperproliferative wound edges. This imbalance favors the stalling of wound healing in the inflammatory stage. Devitalized tissue also impedes the wound healing process and should be assessed (Figure 2). This tissue, with extremely reduced blood and oxygen flow, needs to be removed from the wound in order to “jumpstart” the wound healing process. For effective wound healing to take place, infection and inflammation need to be mitigated (Figure 3). To that end, Robson et al discussed different factors involved in altered wound healing following infection. Here, they reported that the presence of chronic granulation tissue severely decreased the amount of antibiotics that reached the wound infection, thus prolonging the healing process. In addition, Gardner et al evaluated the reliability of clinical tools to assess the signs and symptoms of localized infections in chronic wounds. They found the “Clinical Signs and Symptoms Checklist,” which focuses on primary and secondary signs of infection, to be reliable and complemented clinician wound infection assessments.

**DIME AND WOUND CARE QUALITY MEASURES**

The DIME strategy provides overarching principles for the assessment and treatment of a wound. For instance, wound etiology and biochemistry affect the ability of a wound to heal; as such, the DIME strategy calls for extensive wound bed preparation to accelerate endogenous healing and remove factors that prevent wound repair. Active treatments utilize external mechanisms of action to remove necrotic tissue and/or exudate from the wound, including sharp/surgical, enzymatic, or mechanical

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Figure 3. **WOUND INFECTION AND INFLAMMATION TREATMENT PATHWAYS**

| CBC | ESR | VDRL, HIV, FPD |
|-----|-----|----------------|
| C-reactive protein | Gram stain | Special stains for AFC, fungus |
| Routine culture | AFB, anaerobic, fungal culture | X-rays, nuclear med studies |
| CT, MRI (osteomyelitis, deep abscess, infected prosthesis) | |

**Infection**

Primary signs and symptoms (Heat, Pain, Redness, Swelling)

- **Inflammation**

Secondary signs and symptoms (ie, Wound Deterioration, Pain)

- **Consider Inflammatory Causes or Critical Colonization**
  - Malignancy
  - Vasculitis
  - Vasculopathy
  - Pyoderma Gangrenosum

- **Evaluate Cause**
  - Yes: Positive Biopsy
  - No: Diagnosis of Exclusion

- **Further Evaluation**

- **Antimicrobial or Antiseptic Dressings**
- Collagen Matrix Dressings
- Systemic Antibiotics
- NPWT with Instillation and Dwell Time

- **Other**
- Collagen Matrix Dressings
- NPWT with Instillation and Dwell Time

- **Positive Pathergy**

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Debridement; negative-pressure wound therapy (NPWT); and NPWT with instillation and a dwell time (Table 2). Passive treatments allow the patient’s endogenous healing mechanisms to remove barriers to healing and include autolytic debridement, hydrogels (hydropolymer dressings), hydrocolloid dressings, antimicrobial or antiseptic dressings, collagen-oxidized regenerated cellulose dressings, collagen-alginate dressings, cellulose-alginate dressings, and nonadherent silicone dressings (Table 2). An additional wound care treatment includes cellular- and tissue-based products (allografts, xenographs, dermal matrices, and composite skin) that aid in wound closure and can function as replacement skin (Table 2).^{35}

| Table 2. | ACTIVE, PASSIVE, AND BIOLOGIC SKIN SUBSTITUTE WOUND TREATMENT |
|----------|-------------------------------------------------------------|
| Components of DIME | Wound Characteristics | Active Treatment | Key References and Levels of Evidence |
| Devitalized tissue | Necrotic, hypoxic wound bed | Sharp/surgical debridement, enzymatic debridement, mechanical debridement | Attinger et al,^4^ 2001 (level 5) Ramundo and Gray,^4^ 2008 (level 5) Tan et al,^45^ 2007 (level 4) Stone et al,^46^ 2004 (level 3) Vuerstaek et al,^37^ 2006 (level 1) Kim et al,^48^ 2014 (level 3) Flueraru et al,^49^ 2013 (level 3) Gabriel et al,^50^ 2014 (level 3) Kim et al,^50^ 2014 (level 3) |
| Infection/inflammation | Contaminated/colonized, exudate, malodorous, stalled wound healing, edema | NPWT, NPWTi-d | Stone et al,^46^ 2004 (level 3) Vuerstaek et al,^37^ 2006 (level 1) Kim et al,^48^ 2014 (level 3) Flueraru et al,^49^ 2013 (level 3) Attinger et al,^43^ 2001 (level 5) Ramundo and Gray,^44^ 2008 (level 5) Tan et al,^45^ 2007 (level 4) Kaplan,^51^ 2004 (level 4) Stone et al,^46^ 2004 (level 3) Kim et al,^46^ 2014 (level 3) Flueraru et al,^50^ 2013 (level 3) Gabriel et al,^50^ 2014 (level 3) |
| Moisture balance | Desiccated | NPWTi-d | Flueraru et al,^49^ 2013 (level 3) Attinger et al,^43^ 2001 (level 5) Ramundo and Gray,^44^ 2008 (level 5) Tan et al,^45^ 2007 (level 4) Kaplan,^51^ 2004 (level 4) Stone et al,^46^ 2004 (level 3) Kim et al,^46^ 2014 (level 3) Flueraru et al,^50^ 2013 (level 3) Gabriel et al,^50^ 2014 (level 3) |
| Wound edge preparation and wound depth | Stalled wound healing, tunneling | Sharp/surgical debridement, enzymatic debridement, mechanical debridement, NPWT, NPWTi-d | Attinger et al,^43^ 2001 (level 5) Ramundo and Gray,^44^ 2008 (level 5) Tan et al,^45^ 2007 (level 4) Kaplan,^51^ 2004 (level 4) Stone et al,^46^ 2004 (level 3) Kim et al,^46^ 2014 (level 3) Flueraru et al,^50^ 2013 (level 3) Gabriel et al,^50^ 2014 (level 3) |
| Devitalized tissue | Necrotic tissue, tissue loss, hypoxic wound bed | Passive Treatment | Bradley et al,^52^ 1993 (level 3) Molan,^53^ 2002 (level 5) Hiro et al,^54^ 2012 (level 5) Khan and Naqvi,^55^ 2006 (level 5) Jensen et al,^56^ 1998 (level 2) Thomas et al,^57^ 1998 (level 2) Belmin et al,^58^ 2002 (level 1) |
| Infection/inflammation | Contaminated/colonized, exudate, malodorous stalled wound healing, edema | Silver dressings, dressings with disinfectants | Hydrogels, alginates |
| Moisture balance | Desiccated | Biologic Skin Substitute Treatment |
| Wound edge preparation and wound depth | Stalled wound healing, tunneling | Autolytic debridement, collagen dressings | Bradly et al,^52^ 1993 (level 3) Molan et al,^53^ 2002 (level 5) Ramundo et al,^50^ 2009 (level 5) |
| Devitalized tissue | Necrotic tissue, tissue loss, hypoxic wound bed | Allograft, xenograft, dermal matrix, composite skin substitute | Chiu et al,^60^ 2004 (level 4) Martin et al,^31^ 2005 (level 3) Brigidio,^36^ 2006 (level 4) Falanga et al,^63^ 1998 (level 2) Pham et al,^64^ 2007 (level 5) Snyder,^65^ 2005 (level 5) Chiu et al,^60^ 2004 (level 4) Winters et al,^66^ 2008 (level 3) Pham et al,^64^ 2007 (level 5) |
| Infection/inflammation | Contaminated/colonized, exudate, malodorous stalled wound healing | Allograft, xenograft, dermal matrix, composite skin substitute | Winters et al,^66^ 2008 (level 3) Pham et al,^64^ 2007 (level 5) |
| Moisture balance | Desiccated edema | Dermal matrix, composite skin substitute | Reyzelman et al,^57^ 2009 (level 1) Falanga et al,^63^ 1998 (level 2) Pham et al,^64^ 2007 (level 5) Gibbe et al,^66^ 2006 (level 2) Chiu et al,^60^ 2004 (level 4) Stacey et al,^69^ 2013 (level 4) Falanga et al,^63^ 1998 (level 2) Veves et al,^70^ 2001 (level 2) |

Abbreviations: NPWT, negative-pressure wound therapy; NPWTi-d, negative-pressure wound therapy with instillation and dwell time.

Level 1 = high-quality, multicenter randomized controlled trial; level 2 = randomized controlled trial, or prospective cohort; level 3 = retrospective cohort or meta-analysis; level 4 = case series; level 5 = literature review, expert opinion, or basic science research.
Putting these DIME concepts into clinical practice and then measuring whether care was actually accomplished are the fundamental challenges of the entire quality measure movement. For example, debridement of necrotic or nonviable tissue, a major tenet of the DIME principle, has been captured in “Process Measure: Wound Bed Preparation through Debridement of Necrotic or Nonviable Tissue.” This quality measure assesses the percentage of patients with nonviable tissue who underwent any form of debridement. Although the DIME principle mentions the issue of tissue hypoxia, it does not discuss the framework within which ischemia is assessed prior to debridement or as part of the evaluation for active or passive wound treatments. The “Process Measure: Vascular Assessment of Patients with Chronic Leg Ulcers” accounts for the percentage of patients with lower-extremity leg ulcers undergoing any type of vascular assessment (eg, handheld Doppler, ankle-brachial index, transcutaneous oximetry, skin perfusion pressure, and so on). In addressing the issue of stalled wounds, 2 process measures require the creation of a plan of care for diabetic foot ulcers and venous ulcers that have failed to achieve 30% reduction in surface area within 4 weeks of care. Such a plan of care could include NPWT or the use of cellular and/or tissue-derived products. Another process measure focusing on the appropriate use of cellular and/or tissue-derived products measures the percentage of patients undergoing this treatment who have first undergone vascular assessment and measurement of hemoglobin A1c (Figure 4, Table 3).

Infection can become a significant hurdle in chronic wound healing. Quality measures should include both the resolution of infection through approved treatment methods (eg, topical antimicrobial treatment and systemic antibiotics), as well as process measures for identifying infection through tissue biopsy or validated quantitative swab technique. It is important to identify and properly treat wound infection; however, the use of wound surface culture technique was a PQRS overuse measure that failed when a swab culture was performed. Although this measure was intended to promote the use of better culture techniques (eg, Levine swab or biopsy for quantitative culture), its design likely prevented it from being used as a way to improve quality wound care (Figure 4, Table 3).

Maintaining wound moisture balance allows for progression of wound healing, which can be achieved through various pathways (Figure 5). Quality measures detailing the types of dressings

![Flowchart of Quality Measures Utilized in the DIME Wound Treatment Strategy](http://www.woundcarejournal.com)
that provide continued moisture, manage wound exudate, and protect periwound skin are required. Currently, no quality measures exist that focus on wound moisture. As such, additional measures for wound moisture assessment may be warranted, especially in the case of stalled wound healing following intervention (Figure 4, Table 3).

It is important to note that some aspects of DIME are difficult to encapsulate within the quality measure framework. For

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**Table 3. REPRODUCTION QUALITY MEASURES RELATED TO DIME**

| Components of DIME | Wound Characteristics | Patient-Centered Quality Measure | Wound or Process-Specific Quality Measure |
|--------------------|-----------------------|---------------------------------|------------------------------------------|
| Devitalized tissue | Necrotic, hypoxic wound bed | USWR (GWM001): vascular assessment of patients with chronic leg ulcers | USWR (GWM002): wound bed preparation through debridement of necrotic or nonviable tissue |
| Infection/inflammation | Contaminated/colonized, exudate, malodorous, stalled wound healing, edema | USWR (VLU003): process measure: plan of care for VLU patients not achieving >30% closure at 4 wk | USWR (VLU001): process measure: adequate compression at each visit for patients with VLUs |
| Moisture balance and wound depth | | USWR (DFU003): process measure: plan of care creation for DFU patients not achieving >30% closure at 4 wk | USWR (DFU003): process measure: plan of care creation for DFU patients not achieving >30% closure at 4 wk |
| | | PQRS measure no. 131: pain assessment and follow-up | PQRS measure no. 265: biopsy follow-up |

Abbreviations: CTPs, cellular- or tissue-based products; DFU, diabetic foot ulcer; HBOT, hyperbaric oxygen therapy; VLU, venous leg ulcer.
example, those components that focus on wound tunneling and undermining or rolled wound edges provide awareness of certain aspects of the wound that require intervention; however, this aspect of DIME is difficult to protocolize because several possible actions might be acceptable (Figure 6). An additional challenge is that wound treatment should be sequential as wound environment

![Figure 6. WOUND EDGE AND DEPTH TREATMENT PATHWAYS](image)

### Table 4.

| Potential Causes for Impaired Wound Healing | Patient-Centered Quality Measures |
|--------------------------------------------|----------------------------------|
| Comorbidities                               |                                  |
| Obesity                                    | PORS measure no. 128: preventive care and screening: body mass index screening and follow-up |
| Diabetes                                   | PORS measure no. 1: diabetes: hemoglobin A_1c, poor control |
|                                            | PORS measure no. 126: diabetes mellitus: diabetic foot and ankle care, peripheral neuropathy-neurological evaluation |
|                                            | PORS measure no. 127: diabetes mellitus: diabetic foot and ankle care, ulcer prevention—evaluation of footwear |
| Medication use                              |                                  |
| Alcohol use                                | PORS measure no. 130: documentation of current medications in the medical record |
| Smoking                                    | PORS measure no. 173: preventive care and screening: unhealthy alcohol use—screening |
| Malnutrition                               | PORS measure no. 226: preventive care and screening: tobacco use: screening and cessation intervention proposed |
|                                            | NUT 001: is nutritional screening for all patients with wounds and ulcers and nutritional supplementation as appropriate |
| Patient quality of life                     | USWR (GWM003): patient-reported experience of care: wound-related quality of life |

Abbreviations: PORS, Physician Quality Reporting System; QCDR, Qualified Clinical Data Registry; USWR, US Wound Registry.
and healing processes change throughout the treatment plan. As such, identifying wound healing milestones that indicate a need to switch to a different treatment plan is necessary to provide the best quality of care.

The DIME approach to wound healing has a patient-centered component; however, patient-centered quality measures are few and far between. Previous studies have shown that patient comorbidities (eg, obesity, diabetes), medication use, and lifestyle factors (eg, smoking, malnutrition) can alter wound healing.

At point of care, healthcare providers should evaluate patient comorbidities and lifestyle factors and recommend treatment to improve any potential deficiencies (such as high blood glucose, hypertension, or malnutrition) before focusing on wound treatment. Currently, only a handful of quality measures regarding patient-centered components exist (Table 4). More patient-related wound outcomes should be developed. Similarly, patient-reported experience of care can be assessed by measuring the wound-related quality of life at the initial consultation and the final visit, which may provide valuable data to assess the effect of wound treatment on quality of life whether healing is achieved. These quality-of-life measures should be utilized to gauge the effect of wound treatment on the patient. As clinical practice guidelines continue to be refined, the focus should be toward the challenge of putting them into use within patient care.

**DISCUSSION**

Over the years, patient-centered wound treatment has become a prominent portion of wound care. This holistic approach builds a comprehensive treatment plan that takes the patient’s concerns, support system, and environment into consideration during the development and implementation of the treatment plan, which may lead to improved patient compliance and wound healing.

Advances in wound care have created a variety of wound care strategies; even though quality measures have become an important tool in evaluating patient care and treatment outcomes, quality measures for wound care are limited. Currently, “plan of care” quality measures are used in the treatment of stalled, complex, or chronic wounds. However, quality measures are lacking that endorse sequential treatment and continued wound assessment in wounds stalled following intervention. The wound care community needs to collaborate on developing specific quality measures to address this area of need.

Although the CMS prefers to measure outcome of care, it is possible to measure the appropriateness of clinical interventions through “process measures” as long as these processes can be shown to contribute to the desired outcome. Thus, in the field of wound care, improved patient care may need to begin with the reporting of process measures.

Wound care provided through quality improvement programs that offer feedback to clinicians on performance across various quality measures allows practices to compare themselves with others across the country through benchmarking. Maximizing adherence to quality-of-care guidelines should be a high priority for the optimal management of wounds.

**CONCLUSIONS**

The US healthcare system is transitioning to a quality-based system. Wound care, still an emerging specialty, is poorly represented in the current approved quality-based measures. It is clear that the lack of suitable wound care quality measures threatens the survival of wound care provider practitioners and services and therefore, must be urgently addressed. Quality measures are based upon current evidence, validated guidelines, and best practices; however, patient-centered concerns must be considered when advising diagnostic and treatment protocols. In addition, wound healing should be regularly reevaluated to ensure current treatment plans are promoting healing.

**KEY REVIEW POINTS**

- Patient demographics, comorbidities, psychosocial stress and anxiety, and medication use alter the wound healing process.
- Quality measures are based on current evidence, validated guidelines, and “best practices”; however, patient-centered concerns must be considered when advising diagnostic and treatment protocols.
- Quality of life, patient lifestyle, medication use, and comorbidities should be assessed prior to the development of a wound treatment plan.
- Wound assessment and treatment should focus on wound debridement, control of infection/inflammation, providing appropriate moisture balance, and wound edge preparation and wound depth.
- Wound healing should be regularly reevaluated to ensure current treatment plans are promoting healing.
- The US Wound Registry has a number of wound care–related quality measures that are absent in the PQRS measures.

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