CPHCS CIRRHOSIS/ESLD QUALITY OF CARE REVIEW*

Reviewer: _____ **Date of Review:** _____
Patient Name: _____ **CDCR #** _____ **DOB:** _____
PCP: _____ **Date(s) of Visit(s):** _____

1.) Does the clinical history include relevant information? • Are current complaints/symptoms documented? • Does history include risk factors for chronic liver disease, including history of alcohol use, hepatitis, autoimmune diseases, family history of liver disease, etc? • Was information regarding development of complications documented, such as weight gain/loss? Mental status changes? Blood in stool? Hematemesis/Melena? • Reference or listing of current medications? Adherence to medications? • Was history of combination therapy documented, if Hepatitis C history? • Were medication side-effects documented? • Were consultant notes/recommendations reviewed/discussed with patient?	❑ Yes ❑ No
2.) Does the focused clinical exam give relevant details? • Abnormal vital signs noted? Weight change noted? • Cardiac, Respiratory, and Abdominal exam noted? Extremity exam for edema? • Neurologic exam/Mental status assessed, if history of encephalopathy? • Pertinent labs recorded, such as AFP, PT/INR, Hepatitis serologies, HIV, CBC, CMP? • Diagnostic/Surveillance tests recorded, such as U/S, EGD, CT scan, liver biopsy?	❑ Yes ❑ No
3.) Does the assessment/plan address cirrhosis/ESLD & complications? • Was diagnosis of cirrhosis confirmed through biopsy or imaging study? • If blood pressure is elevated, was it addressed? • If indicated, did patient have EGD ordered for varices screening. If varices present, is patient on non-selective beta-blocker? • Is hepatoma screening up to date? • If ascites present, is patient on diuretics? Is weight being monitor? Are electrolytes being monitored? • If history of spontaneous bacterial peritonitis, is patient on prophylaxis with Ciprofloxacin or Bactrim? • If history of hepatic encephalopathy, is patient on lactulose? Is dosing optimized?	❑ Yes ❑ No
4.) Was there documentation of patient education? • Instructions on lifestyle, medication adherence or complication avoidance? Other?	❑ Yes ❑ No
RECOMMENDATIONS/COMMENTS:	

*All elements in the each domain are suggestions for good documentation, not requirements.
Use clinical judgment when reviewing the documentation
Patient disease severity and corresponding management should be clear to the reviewer, in all documentation.
Please consider the elements in this review tool when completing Access Measure Audit Tool.