

California Care Management Center*
2007 EAP Chart Review Results

Chart Review Item	Score
1. Is the Statement of Understanding (SOU) completed and signed? (If a required company-specific SOU was not used, score "N".)	73%
2. Is there a history, course and duration of the presenting problem?	99%
3. Is demographic information presented, either on face sheet, client intake form or documentation?	100%
4. Is permission to contact and how to contact client clear? (Both are required. See Client Information Form.)	100%
5. Is there documentation of environment or home support?	99%
6. Is the client's relevant medical information documented?	95%
7. Were workplace issues identified where present?	96%
8. Does documentation include descriptions of client's strengths and limitations in achieving goals?	81%
9. Was risk of suicide and threat of harm to others, including access to guns, assessed?	98%
10. Is the DSM IV diagnosis, problem formulation and prognosis complete?	98%
11. Does documentation include a screening for Substance Abuse? If screening indicates potential substance abuse, was complete evaluation that includes detailed current pattern of use and consequences completed if client is age 12 and older?	95%
12. Are the goals and strategies behaviorally specific and measurable?	99%
13. If there were special identified needs (e.g., religion, race, culture, gender, sexual orientation or physical condition) did the therapist appropriately address these issues?	100%
14. If risk/threat of violence (TOV) was identified, was the intervention appropriate and adequate?	100%
15. For treatment involving more than one session, do progress notes document the client's effort to implement interventions or attempts at behavior change (i.e., progress toward goal)?	97%
16. Does the documentation support the clinician's decision to refer or not to refer for specialized treatment?	100%
17. When a post-treatment referral is indicated, were appropriate providers/resources identified and the client given choices (i.e., MD for medication needs, higher level of care and/or community/self help resources)?	100%
18. If the client was referred, is there documentation of link-up and follow-up?	90%
19. Were there follow-up contacts (or attempts) with the client within 4 weeks?	88%
20. Is there documentation of the outcome of the case? (i.e., client chose not to continue, case resolved or case referred)?	87%
21. Results of supplemental assessments are included when appropriate. (i.e., chemical dependency assessment, depression assessment)	77%
22. Documentation of case consultation when needed.	60%
23. Is the Release of Information (ROI) complete, including a) to whom, b) signature, c) witness signature and d) date?	92%
24. Were all entries/documents signed by the clinician with credentials noted?	93%
25. Is the record legible, organized and easy to follow?	96%
26. For treatment involving more than one session a counseling plan is developed and the client agrees to the plan.	100%
Average Score	93%

*Scores reflect services to members of Magellan subsidiaries, Magellan Health Services of California, Inc. – Employer Services and Human Affairs International of California.