Big Sistah

User Manual

Updated 3/08

Big Sistah is a secure, web-based records management system designed specifically for CSCT clients. All users must have a user name and password to gain access to a user site. Passwords should be changed regularly and not shared with others.

GENERAL INFORMATION

Users will be timed out after 45 minutes of use and all information typed in during this period will be lost if it has not been saved. If users are working for periods longer than 45 minutes, they must click on the "save and continue" button at the top of the page prior to reaching the time limit. A warning will appear when a user is close to reaching the 45 minute time limit. When the user has completed entering information into the system, he/she must press the save and close button at the bottom of the page.

If two users are in the same file at the same time they must be sure to both hit the save and close button or information will be lost.

CLIENT FILE DATA ENTRY

Assessment

To enter a new client:

- Click on “add a client.”
- Enter all fields in assessment
- Click on “save and finish”

Assessments must be entered into system prior to writing progress notes for billing. Assessments must be printed out, signed by the therapist and placed in the client’s file. Assessment fields will be locked **30** days after initial date of entry. Users must contact program administrator to make assessment changes after 30 days.

- ***Functional Behavior Assessment***

To create an initial behavior assessment and enter initial baseline data:

- Click on “Baseline Behavior Update”
- Enter all fields in behavior assessment
- Enter baseline data
- Click “save and finish”

The client’s baseline data for attendance, discipline referrals, referrals to a higher level of care, encounters with law enforcement and target behavior must also be entered in order to generate 90 day data graphs and indicate baseline on monthly progress reports. Baseline data from the initial functional assessment will show up in parenthesis for the respective fields on the monthly progress report.

- ***Data Definitions***

Absences: Absences are recorded by day or fraction of a day. If a client is gone the whole day it would be recorded as “1”. If a client missed 2 periods from an 8 period day it would be recorded as “.4.”

Law Enforcement: An incident is counted for any known face to face meeting with law enforcement and client due to client behavior.

Discipline Referral: An incident is counted for client referral to principal, responsibility room attendant or other personnel in charge of handling client discipline. Discipline must be counted as a “Major” on SWIS or result in a documented office referral.

Higher Level of Care: Incident counted when client is moved to an attention home, group home, residential treatment facility, hospitalized or out-of-home placement due to client behavior.

- ***Target Behaviors***

The following behaviors may be used for target behavior. Therapists will choose target behavior that provides best indicator for client progress. *Target behaviors must remain the same for the entire school year.*

Suicide:	Reports of thoughts of death, suicide ideation and/or suicide attempts.
Hygiene:	Incidents of client attending school not showered, teeth and/or hair not brushed, clothes unclean or smelling of body odors.
Defiance/ Disrespect	Refusal to follow adult directions, talking back or socially rude interactions with adults.
Disruption	Behavior causing an interruption in a class or activity. Disruption includes sustained loud talk, yelling or screaming; noise with materials, horseplay or roughhousing; and or sustained out-of seat behavior.
Physical Aggression	Actions involving serious physical contact where injury may occur (e.g. hitting, punching, hitting with an object, kicking, hair pulling, scratching, etc)
Harassment/ Bullying	Student delivers disrespectful messages to another person that includes threats and intimidation, obscene gestures, pictures, written notes. Disrespectful messages include negative comments based on race, religion, gender, age and or national origin, disabilities or other personal matters.
Lying/Cheating	Client delivers message that is untrue and/or deliberately violates rules.
Skip/Truancy	Client leaves class/school without permission or stays out of class/school without permission.
Running/Hiding	Student leaves class or activity and runs or hides to avoid consequences, and/or activity
Substance Use	Client reports use or is found in possession of alcohol or drugs (does not include tobacco)
Sleep Problems	Self or other report of incidents of inadequate or excessive sleep that severely impair client ability to function in everyday life.
Outburst Tantrum	Sustained and intense incident typically involving behaviors such as yelling, flailing, crying, throwing self on ground, etc.
Stealing	Client is found with others' possessions without their permission.

Disengage/ Avoidance	Incidents of client refusal to participate in classroom or school activity can include withdrawn behavior such as "shutting down" and sleeping in class. This behavior does not typically include overt defiance or disruption.
Isolation	Incidents of client avoiding interactions with peers and/or adults or reports of having no friends or engagement in social activities.
Enuresis	Incidents of voiding urine during the day or night into bed or clothes**.**
Encopresis	Incidents of passage of feces into inappropriate places (clothing or floor).
Expressions of Worthlessness	Reports of unrealistic negative evaluations of one's worth or guilty preoccupations over minor past failings.
Self Harm	Incidents of self harm or self injurious behavior (e.g. cutting or burning parts of body, hitting or biting self, etc.).
Anxiety	Incidents or reports of extreme worry may include restlessness, difficulty concentrating, irritability, muscle tension, disturbed sleep or panic attack.
Somatic Complaints	Incidents when client complains of medical illness, physical pain, stomach upset with no medical basis.

Client, parent, guardian and teacher names, target behavior, and diagnosis from assessment will automatically fill fields in therapist treatment plan. Client name from assessment will automatically fill behavior assessment, behavior plan, and all progress note fields. The definition, frequency/rate, duration and severity of the problem behavior will transfer to the behavior plan.

Client payment source for caseload reports is also generated from the assessment.

- ***Updating or adding a new Functional Behavior Assessment -***

To complete a new behavior assessment when changing an existing behavior plan:

- Click on "add a behavior assessment"
- Complete all fields
- Press "save and finish."

Assessments are saved by date of first entry. The definition, frequency/rate, duration and severity of the problem behavior will transfer to the behavior plan.

TREATMENT PLAN

Initial treatment plans must be entered within 5 contacts or 21 days from the first contact, whichever is later. Treatment plans must be reviewed at least every 90 days and whenever there is a significant change in client's condition, change in level of care, or referrals for additional mental health services. The review is comprehensive and should result in an amended treatment plan or a statement of the continued appropriateness of existing plan.

- ***Initial Treatment Plans***

To develop a new treatment plan:

- Click on "add a treatment plan."
- User must enter date of treatment plan and date of 90 day review along with concerns, treatment goals, objectives and interventions.
- Users must also enter a short description for each goal. These short descriptions will be generated in both the daily and monthly progress note fields.

- ***90 Day Treatment Plans***

To develop a 90 day treatment plan or amend the existing treatment plan:

- Click on "add a treatment plan"
- Click on "copy latest treatment plan."
- The user may then edit and change the existing plan according to the needs of the client
- Press "save and finish."

All plans must be printed out, signed by treatment team members and placed in client's file. Plans will be saved in the system by date of initial entry.

BEHAVIOR PLAN

To develop a behavior plan:

- Click on "add a behavior plan."
- Enter all fields
- Click on "save and finish."

MONTHLY PROGRESS NOTES

Monthly progress notes must be entered into the system by the 10th of each month.

To enter a monthly progress note:

- Click on add a monthly progress notes
- Enter information in all existing fields
- Users must also enter data in monthly progress reports that indicate the last 30 days of attendance, encounters with law enforcement, incidents of target behavior and referrals to the principal's office or higher level of care. (see Data Definitions in Assessment section.)
- Click on "Save and Finish."

Baseline data are indicated in parenthesis next to the monthly data boxes.

PROGRESS NOTES

All progress notes must be completed by midnight Sunday following the week the service was provided. To enter a client progress note:

- Click on "add a daily progress note."
- Enter date, time and make sure billing code is correct. See billing table below to select correct code. If service is not billable (not face to face or indirect) choose "Indirect."

CSCT per 15 minute unit	H0036
Community Psychiatric Support per 15 minute unit	H2019
Psychiatric Diagnostic Interview per visit = 1 unit	90801
20-30 Min per visit = 1 unit	90804
45-50 Min per visit = 1 unit	90806
75-80 Min per visit = 1 unit	90808
Fam W/O Pat per visit = 1 unit	90846
Fam W/Pat per visit = 1 unit	90847
Group per visit = 1 unit	90853

- Select place where client was served
- Select primary goal from the mental health treatment plan relating to the service from the drop down menus.
- Enter narrative describing intervention provided
- Enter narrative describing client response and client progress.
- Click on "save and finish."

Users will not be allowed to enter progress notes if the treatment plan is older than 90 days. *User may edit or complete note no later than midnight on the first Sunday following the date the note was entered.*

Progress note reports must be printed and placed in client files weekly. To print a progress note report, enter dates of service, print out, write client name at top of page if necessary. All notes must be initialed or signed by the provider of the service. Providers must sign first progress note and initial all other progress notes on each page.

ADMINISTRATIVE SITE

Add a Site

Adding, deleting or rendering sites inactive may be done through the administrative site only. To add a site

- Click on “Add a Site”
- Enter site name and choose “active.”

To inactivate a site:

- Select the “Edit” button next to the site name
- Choose “Inactive.” From the drop down menu
- Click on “save.”

Adding or Editing User Information

Adding, deleting or rendering a user inactive must be done through the administrative site only. To add a user click “add a user” and enter all necessary information. Choose active from the drop down menu and press save. To delete a user press the delete button next to the user’s name. To change user information, press the edit button next to the user name, make changes and press save.

Editing Client Assessments

Editing or changing client assessments can only be done through the administrative site after 30 days of initial entry. To edit assessments Go to the client’s site, click on edit next to client name and add or change information. After changing assessment information email therapist at the client’s site and direct them to print new assessment for client file.

Progress Note Restriction

When box is checked in “System Settings” on home page, users can only enter progress notes for the week they are in. Users have until Sunday at midnight to enter all notes for the week. To unlock this setting, click box to remove check and choose “Save Setting.”

Changing Client Progress Notes

Progress notes should only be changed or edited if user or billing clerk notices an error in times entered or notices an error or typographical error in the note. Users will not be able to change progress notes after the first Sunday following the date the note was written. Editing or changing client progress notes must be done through the administrative site.

To edit a progress note, go to the client's site and go to client site:

- Under "add a daily progress note" enter dates in start and end boxes that correspond to the note requiring change.
- Click on "edit" next to the date of the progress note and make necessary changes.
- Save changes
- Notify the user at the site to print out a new copy of progress notes for client files.

Note: A log of these changes is in a red folder in the rack on Kathy's lateral file cabinet. These changes should be logged and email documentation requesting the change should be placed in red folder.

Caseload Reports

Caseload reports are generated from the home page. Caseload reports include client name, social security number and payment source. Select the site from the drop down menu for caseload report.

To deactivate a client:

- Click on site
- Find client's name, choose "edit" to right of client's name. This brings up the clinical assessment. In the box in the upper right of the assessment, change "active' to 'inactive." Then scroll down to bottom of page and choose "save and close." This will take the client's name off the caseload list but not the billing report. This will put the client's name in an inactive box below the names of the active patients.

To activate an inactive client to a different site:

- Click on the site the client was last active in
- Find client's name and choose "activate"
- Choose appropriate site from list that pops up and click "activate."

To change the payer of a client:

- Choose site from drop down menu on caseload report
- Find client's name, choose edit, choose proper payment source, and unclick the box to the left of the payer which no longer applies.
- Choose "save and close."
- Must be done monthly in order for the teams at each site to see how many Medicaid units they accumulated in the month.
- Must be done monthly so billing reports are accurate.

System Settings:

Progress note Date of service restriction – when this box is checked users will not be able to enter progress notes for the week after Sunday at 12:00am. Users will need to contact an administrator to request restrictions be lifted. All requests to enter progress notes late will be logged and monitored by BVEC administration.

Allow baseline behavior update – when this box is checked users will be able to enter and or change baseline data for clients. When this box is unchecked, users will not be able to enter or change baseline data for clients unless they contact and administrator.

Allow Initial Assessment edit – when this box is checked users will be able to edit initial assessments after 30 days from initiation of the assessment. Users will need to contact administration to request restrictions be lifted.

RUNNING REPORTS

Weekly Billing Reports

- Once a week billing reports are run using the date of service option.
- Run two reports for each site, one for CSCT, payment source Medicaid and one for Outpatient with payment sources Medicaid, CHIP and Private Insurance.
- Only billable services will show on the billing reports. CSCT or outpatient services for clients with no eligibility are not entered into Softaid.
- Enter all billable services into Softaid. Sometimes the services for clients who have temporarily lost eligibility are entered into Softaid, if it can be determined that the client has a very good chance of getting eligibility for the current month back.

Running Monthly Caseload Reports

- Once a month, caseload reports are run.
- The names on these reports are checked on the Medicaid website for current eligibility for Medicaid or CHIP.

- If a client loses eligibility, the therapist should be notified and asked to check with the family. The therapist should report any information he/she receives to Kathy.
- Kathy edits the payment source section of the clinical assessment in Big Sistah according to the latest eligibility information.