

Initiatives Report

Name	Public Description	Section/Column	Priority 1-10
Prevent service edit when staff association does not exist to program	Currently, if a user can see a service via the Service Detail screen, and they are able to edit the Service Detail screen, they are able to make edits to it regardless of whether this service is associated to one of their programs or not. We are requesting that if the service being created/edited is associated with a program that the user is not associated with, the user should not be able to save any changes. This would mean that Sys Admin and County-Level Billers would need to have ALL program associated with their accounts.	Billing / Compliance	1
CARE Act Reporting - Item 3.11.5 missing on report spreadsheet	A data point is missing in the CARE Act report (item 3.11.5). This item is present on multiple tabs. For current reporting, which requires a copy/paste into the DHCS document, we recommend that this column be entered manually.	Fixed Issued Pending Deployment to Prod	1
Initializations for Active CARE Act Documents are Clearing out on Save	This is related to selecting the CARE Episode. Before the Fix: Users experienced a delay between selecting 'OK' in the pop-up and the completion of the initialization process. Unaware of the background activity, they often clicked the save button prematurely, resulting in blank data being saved. After the Fix:	Fixed Issued Pending Deployment to Prod	1
BUG - Date format design for CARE Ep	Known Issue: The dates in the CARE Act documents use format MM/DD/YYYY. However, when selecting the CARE Episode within the CARE Act Reporting Document, the format is DD/MM/YYYY. We are requesting that Streamline fix this ASAP to avoid confusion.	Urgent Issues	1
Need CARE Act Narrative Note	This was reported as a bug by a county. The current CARE Act procedure codes use the Narrative Note, which is used in other non-CARE Act procedure codes and is therefore permissioned to all user roles. CalMHSA will create a new CARE Act Narrative note in order to limit permissions to only the CARE Act Add On user role. UPDATE: scheduled to be deployed to QA on 12/2. CalMHSA will test and then plan to deploy to Prod on 12/8. Should be available in Prods on 12/9.	Urgent Issues	1
Prevent service edit when staff association does not exist to program	Currently, if a user can see a service via the Service Detail screen, and they are able to edit the Service Detail screen, they are able to make edits to it regardless of whether this service is associated to one of their programs or not. We are requesting that if the service being created/edited is associated with a program that the user is not associated with, the user should not be able to save any changes. This would mean that Sys Admin and County-Level Billers would need to have ALL program associated with their accounts.	Other	1
Service Notes - Should be associated with a ClientProgramId as well as the ProgramId	Service Notes were not included in the original deployment when we requested CDAG be tied to program enrollment rather than just program (ClientProgramId v. ProgramId). This was in the original request, as we assumed "documents" included service notes. We are asking that the client program enrollment be associated with the Service Note so that when filtering in list pages such as "Documents (Client)" or in the Disclosures Add Documents popup ("Attach Documents"), service notes are filtered in the same way as other documents. Right now, service notes are only being associated with ProgramId, so when a person uses a filter on one of these pages, which filters based on ClientProgramId, documents (service notes) that are not associated with that ClientProgramId are showing. The user also has to filter by date range in order to properly limit the service notes showing.	Clinical Documentation /Compliance	1
Program drop-down to associate to a calendar entry for when adding to the staff calendar	Every service appointment in SmartCare requires a client, program, and provider. However, every calendar entry only requires a provider. This type of event is often used for tracking the administrative tasks done. Sometimes this may need to be tracked to a specific program, however. Counties therefore requested that a Program field be added to the calendar entry for tracking purposes. Estimated to be deployed to QA on 9/26/24	Patient Admin	2
Update Productivity Reports with CARE ACT codes		Design Changes	2
BUG - CARE Act Reporting Document - Other Reporting> Substance Use> Secondary Substance Use Validation Error	Known Issue: When a user is completing an Active CARE Act Reporting Document, in the Substance Use section, if they select "None" as the Secondary Substance of Choice, the frequency for this goes away, per design. However, the validation remains that this field is required.	Fixed Issued Pending Deployment to Prod	2
Service Request - List pages don't seem to be working accurately (workgroup issue)	Known Issue: List pages don't seem to be showing the correct results. List pages don't match widget. Some of this is related to workgroups, as it doesn't seem to be filtering by assigned staff or workgroup correctly. Streamline is working on a fix.	Compliance	2
"End Consent" and "Revoke Consent" functionality does not carry over to ROI Document's .pdf	A while ago, CalMHSA had Streamline develop a way to easily see on a consent type document that the consent had been revoked. That way, when looking at the consent itself, the user would see that it had been revoked, rather than looking at a separate document or list page to see that information. This was meant to minimize risk. In that requirements document, ROI documents were included. However, we discovered recently that the ROI documents, which are not considered "consent" type documents in SmartCare, were not included in this development. We are requesting that the ROIs receive the same functionality as the Consent documents. This would include: 1. Showing "revoked" on the pdf itself 2. Showing "revoked" next to the document in the Documents (Client) list page	Compliance	2
General - Add ability to track all changes made in the system	We would like to be able to track all changes that occur in the system, including what user made the change and when. Right now, this amount of audit tracking would greatly impact performance. However, we still see this as a need. We are currently in compliance with all tracking regulations regarding client chart access, but feel the ability to track changes is key to quality assurance.	Compliance	3

Initiatives Report

Name	Public Description	Section/Column	Priority 1-10
Service Request List Pages - Need a way to Allow Sys Admins to See Records NOT Created By/Assigned to Themselves	In order to best protect screen records that can't be assigned to a specific program like documents are, we designed the list pages to only show records created by or assigned to the logged in user or their supervisees. However, there is a need for administrative staff to be able to see any and all records that were created. Example: a system administrator needs to be able to view a request that a user put in and is assigned to a billing staff who is on vacation. They need to be able to see this record to troubleshoot it. In the meantime, we recommend that any staff who needs to oversee or troubleshoot these issues be added as a supervisor to the people they're overseeing.	Design Changes	3
(PDev) CARE Act Claiming Report - Update total column to also round to the nearest .25 hour	The CARE Act Claiming Report is used for reimbursement of CARE Act activities. DHCS indicates that time must be rounded to the nearest 0.25 hours. This is already the case on the report, except for the total staff time. This request is to change the column for total staff time to also round to the nearest 0.25 hours.	Non-Urgent Issues	3
Screening Tools - New Override Options (BHIN 25-020)	BHIN 25-020, which supersedes BHIN 22-065, provides updated guidance regarding the Mental Health Medi-Cal Screening Tools and the Transition of Care Tool. One item is that certain SMHS providers may override the Screening Tool score (page 11). We are exploring methods of adding this override capability to the Screening Tools in SmartCare, but must determine how to ensure only these certain providers may override the score.	Clinical Documentation	3
CalMHSA Program Assignments List Page	The Program Assignments list page date ranges relate to when a program assignment was changed (e.g. requested date, enrolled date, discharged date) but doesn't provide a list of clients who were in status "enrolled" on a specific date or within a specific date range. We want a list page that can show this which clients were in X status during Y date range for Z program.	Clinical Documentation /Workflows	3
Add ability to track all changes made in the system	We would like to be able to track all changes that occur in the system, including what user made the change and when. Right now, this amount of audit tracking would greatly impact performance. However, we still see this as a need. We are currently in compliance with all tracking regulations regarding client chart access, but feel the ability to track changes is key to quality assurance.	SysAdmin/ Compliance	3
Add "client present" and "other person present" to Service Note	Some counties seem to want to track whether the client was actually present or not (to be able to track collateral contacts) and to track other people present in the session (e.g. family members). This already exists on the Service Detail screen. CalMHSA is exploring adding these fields to the Service Note screen. Doing so would also impact service uploads and other data-entry methods.	Clinical Documentation /Compliance	3
SmartCare - ability to use non-English characters, including umlaut, tilde, cedilla, etc	We found that accent marks such as é and other special characters, including umlaut (ü), tilde (ñ), cedilla (ç), etc., are not allowed. ¿ and other non-standard characters would be required when creating client-facing documents in other languages. Streamline is addressing this as part of their core enhancement.	System Level	4
Tracking Documentation and Travel Time	Pre-CalAIM, services were claimed based on the minutes it took to complete the service. This claim included service time, travel time, and documentation time. CalAIM Payment Reform changed this to pay for services based on encounters. The rates for encounters are supposed to include the expected travel and documentation time. The only way to ensure fiscal solvency is to be able to track all time spent on services to ensure a county's rates are accurate. County directors are requesting that the travel and documentation time fields are completed to allow them to track rate accuracy, which would allow them to lobby the state if a rate adjustment is needed. CalMHSA is exploring methods to increase data entry into these fields, including the option of making these fields required, or conditionally required. UPDATE: CalMHSA is planning to make the Documentation Time and Travel Time fields required, but allow 0 (zero) to be entered. We're hoping this can be not-required for non-billable services.	Clinical Documentation /Workflows	5
Add language and interpreter fields to Inquiry Details screen	Add Language and Translator information to Inquiry. Language and translation service tracking is required for the NACT.	State Reporting	5
NOABD Improvements (screen that makes template language un-editable)	Currently, NOABDs exist in SmartCare as letter templates. This is somewhat clunky, as the user has to replace certain sections of the letter template with their own, individualized words. Users also have the option to edit the language of the letter before sending, which can result in them changing the letter template language, which is required by DHCS. CalMHSA is working to create a data-entry screen where a user can instead select what type of NOABD they're sending and then only fill out the sections they need to customize. This would then create the appropriate NOABD document which would include all necessary language. There's also the consideration of automatically including the required attachments in the SmartCare document. Currently, these would simply be added when mailing the letter itself, but counties have requested that these attachments be included in the SmartCare document. CalMHSA is considering this option.	Clinical Documentation /Workflows	5
C-SSRS - Need "Unknown/Didn't Answer" option	We have heard that many counties use the C-SSRS documents but are having an issue when a client refuses to complete the assessment. One county reached out to Columbia to confirm the appropriate practice when a client was unable or unwilling to continue when mid-way through a screening. In response to Columbia's feedback, we are requesting that a checkbox be added on each C-SSRS document that indicates that the client was unable/unwilling to complete the screen and that this checkbox may be selected at any given time during the assessment. Checking this box will remove the validations requiring the rest of the document to be completed and will add a notation on the PDF indicating why some questions are not answered. We are also requesting that when this change is made it be applied to any in-progress C-SSRS documents so that users will not have to delete the in-progress document and start over. While the C-SSRS forms are not required by DHCS, we understand that many of our counties use them, and therefore are taking steps to ensure they can use them fully.	Other	5
Add language and interpreter fields to Inquiry Details screen	Add Language and Translator information to Inquiry. Language and translation service tracking is required for the NACT.	Other	5

Initiatives Report

Name	Public Description	Section/Column	Priority 1-10
Reviewer Process	This is the process in which documents must first be reviewed by a supervisor before being marked complete in the system. This includes the Resident/Attending process. This also includes a service not billing until the Reviewer has signed.	Other	5
Calendar - There's no blocked time for appointments that aren't visible to a CDAG	When someone tries to schedule for a staff member who works in a CDAG outside their own, they may not be able to see all the staff's availability, since some appointments will be hidden from view. We are working with Streamline to figure out a solution for this, such as having a "Service Exists" block to show when a service outside the user's CDAG exists on a staff's calendar.	Other	6
Reviewer Process	This is the process in which documents must first be reviewed by a supervisor before being marked complete in the system. This includes the Resident/Attending process. This also includes a service not billing until the Reviewer has signed.	Other	5
Add WalkMe to Client Information Address field	Request to have a Walk-Me prompt in the Client Information screen regarding addresses. This was requested because prescribers cannot prescribe medications for clients if the client's address is not fully entered into the Client Information screen correctly.	Patient Admin	5
General - Add Delete Confirmations and Guardrails	There have been numerous instances of county users accidentally deleting something, such as a program, client, or staff member. Recovering this information is difficult, and even if deleted correctly, this will often orphan related records. For example, deleting a program will remove the affiliations of the documents that were associated with that program, thereby making them unable to be CDAG'd. We are requesting more guardrails around deleting items, including a confirmation message and a system review to determine if there are any "child" records (meaning records that rely on the record being deleted in order to function).	Clinical Documentation /Workflows	6
Inquiry - Add ability to lock Inquiry Details screen similar to Flow Sheets	The Inquiry Details screen is just that - a screen. Screens, unlike documents, cannot be "signed" and "completed". The Inquiry Details screen must be a screen rather than a document, since a document must be associated with a client and a program. The inquiry, by definition, does not require either. That being said, the Inquiry is meant to capture data about an event. That information should be able to be locked down so that others cannot edit the information. CalMHSA is looking at the "lock" feature used in the Flow Sheets as a potential option and is working with Streamline to determine if this is possible. This would require someone to "lock" the Inquiry. The ability to "unlock" the record and make changes would be permissioned to only supervisory staff. This functionality was released as part of the March 2025 MSP but has not been turned on for all counties. See https://2023.calmhsa.org/inquiry-overview-sys-admin/ for more details.	Clinical Documentation /Workflows	6
Mobile Crisis Regular DHCS reporting requirements	We have heard that DHCS is working on the final requirements for the Mobile Crisis reporting. This task will track all things related to the DHCS mobile crisis report requirements.	State Reporting	6
Shared Treatment Plan V2 Dev	We plan to create a new shared care plan to replace the static version in SL	Medical	6
Patient Portal: Documents completed through Patient Portal need to be associated with a program	Clients can create documents in SmartCare. However, the CDAG window isn't popping up to allow them to associate that document with a program. This means that the client can't sign or save the document, since a program is required for every document when CDAG is turned on. Streamline is making changes to their patient portal feature so we're waiting for more information.	Clinical Documentation /Workflows	8
Tracking Grievances, Appeals, and other MCPAR items	CalMHSA is exploring methods of tracking grievances, appeals, and other MCPAR items in SmartCare.	Compliance	9
Add a pop-up at login that lets users know that changes have been made - acknowledge and doesn't show up every time they log in	I'm able to see the problem list appropriately and able to select what problems I worked on during this session. But once I sign the document, the problems without a SNOMED don't seem to be showing up on the PDF.	Other	10
Improve group process functionality	We've received a lot of feedback about the group functionality in SmartCare. The current functioning has required a lot of training to avoid errors. We have received many requests to improve this functionality to address these issues.	Clinical Documentation /Workflows	10
Add a School Name field to the Custom Fields tab of Client Information	Received a request to add a school name field in Client Information. This would use a global code category that counties would populate with local schools. This is likely a low-hanging fruit type request.	Patient Admin	10
Add/delete items at scale (example: figure out a way to quickly add more than 1 staff/user to a new program)	Right now when creating a new program, you can't add staff to the program in the program set-up. You have to go to each staff/user profile and add the new program manually. This is very tedious and time consuming. There are numerous other examples of not being able to work at scale. This includes being able to add multiple programs to a user's account at once but having to remove programs one at a time. We're trying to make these types of processes more user-friendly and efficient. This is on Streamline's roadmap for 2026.	Sys Admin / System Level	Parking Lot
ALL COUNTIES - Coordinated Care Consent (and ROI) in Spanish (and other languages)	With all legal forms, we need to provide the document in the client's language. If someone only speaks Spanish, they can't be expected to understand a document in English and agree to something. We've had the form translated and are using a paper version to provide the client with the information in their language. We then scan that in and associate it with the SmartCare version. That is a workaround, and we are hoping to get these forms in multiple languages in SmartCare.		
TADT - Add general comments field to TADT documents	Request to add a comments text field that is not tied to other logic to the various Timeliness Record documents. The concept is that special circumstances could be described in this comment box to assist with review process when TADT must be compiled.	2025 Updates Needed	
Make CARE Act Reporting Document editable by non-authors	Made the CARE Act Reporting Document editable by non-authors, as this is not a clinical document. This should allow reporting staff to help address errors. These staff currently do not have access to the CARE Act Reporting Document screen, but this will be discussed in this week's CARE Act Reporting training.	Configuration	

Initiatives Report

Name	Public Description	Section/Column	Priority 1-10
Figure out method of tracking Inquiries related to CARE Act	CalMHSA is working on a method to track CARE Act Inquiries. CalMHSA presented this method to counties during the State Reporting Office Hours on 12/19/24. Counties agreed to move forward with this. Global Code: InquiryType - Change "Information about CARE Act" to "CARE Act Inquiry" Referral Type - Add "CARE Act Inquiry Source" with subcodes for all items currently in the draft data dictionary v2.0 section 4.2.2 PresentingProblem - Add all items currently in the draft data dictionary v2.0 section 4.2.3 with "CARE" in the name to help distinguish from other presenting problems InquiryDisposition - Add "CARE Act Inquiry: Action Taken" with subcodes for all items currently in the draft data dictionary v2.0 section 4.2.4	Data Dictionary Version 2	
Short-term method of tracking CARE Act Referrals via Inquiry	CalMHSA is working on a method to track CARE Act Referrals. In the meantime, CalMHSA presented a short-term method to counties during the State Reporting Office Hours on 12/19/24. Counties agreed to move forward with this. Global Code: InquiryType - Already have "CARE Act Referral" ReferralType - Add "CARE Act Referral Source" with subcodes for all items currently in the draft data dictionary v2.0 section 5.5.1 InquiryDisposition - Add "CARE Act Referral Outcome" with subcodes for all items currently in the draft data dictionary v2.0 section 5.5.3	Data Dictionary Version 2	
Overarching ZD ticket for CARE Version 3 (Data Dictionary V2.0)	CalMHSA will work to make adjustments to CARE Act reporting once the DHCS Data Dictionary version 2.0 has been finalized, which is expected to be in Feb 2025.	Data Dictionary Version 2	
Service Request - Sending request back for more information requires multiple fields that shouldn't need to be required	When sending a Service Request back for additional information, the system is requiring the additional information also be entered. The only required information should be "Reason for requesting more information". Basically, the idea behind sending something back to the requester is that the approver cannot move forward with the processing of the authorization until more information is provided.	Design Changes	
CARE Act: Additional development not related to state requirements		Original Design/Request Tickets	
CARE Act: Need ability to map global codes from Client Info to CARE Act multi-to-one		SL Version 2 Rollout	
CARE Plan/Agreement: Add radio button for "CARE Plan" v. "CARE Agreement"		SL Version 2 Rollout	
CARE Act CPT Crosswalk: HK Modifier isn't present in the CARE Act Services to CPT Codes Details screen		SL Version 2 Rollout	
TADT Updates	UPDATE: CalMHSA held a county shared decision-making meeting about this on 9/25/24. The required changes have already been deployed to production systems (any fields that were missing from the current documents). No further changes will be developed until counties provide feedback. Feedback can be given by emailing EHR@calmhsa.org.	Other	
AOT	CalMHSA was hoping that AOT needs would be met via the Care Coordination process. Since the Care Coordination process has been put on hold, we're re-starting this as a separate and distinct project. As we learn more about AOT needs, we may create separate tasks as needed.	Other	
Stanislaus: Diagnosis does not match Problem List	I'm able to see the problem list appropriately and able to select what problems I worked on during this session. But once I sign the document, the problems without a SNOMED don't seem to be showing up on the PDF.	Other	
Client Information: Demographics - Add Disability	Request to add a "Disability" field in the Client Information screen.	Patient Admin	
ASAM / BQUIP	Request is to add the contents of BQUIP screenings into the ASAM state reporting export.	SL Version 2 Rollout	
SysAdmin - User Role Permission Grid Report	This would be a report that would present all permissions and all user roles in a grid format to show which permissions were granted to which user roles in a way that's easy to compare permissions between user roles.	System Level	
ALL COUNTIES - Client Clinical Problems - Need to add field for "person who identified", "date identified", etc for DHCS req's 33058	Streamline is working to add a few fields to the problem list :1. Modified by; 2. Modified date; 3. Identified by; 4. Comments	Compliance	