Data to Monitor Your Progress and Improve the Initiative

Based on feedback collected in the field, the following list of data to capture in the EHR is recommended as useful to monitor and improve your initiative; it is not required for Medi-Cal.

	Data description	**Recommendations for how to document in the EHR**
✓	Referral/services type & name	• Select services/referral type from predetermined list (e.g., Community health worker, social worker behavioral health integration program, therapy, medical specialist, community-based organization resource) to document referral pathways for screened patients • Free-text for notes re: who patient was referred to, e.g., name of doctor, social worker, community-based organization
✓	Strengths/protective factors	• Free-text for notes about what was discussed with the patient re: protective factors, the importance of relationships, community connections, etc. to document response to screened patients
✓	Patient utilization of services	• Select from predefined list (e.g., patient went to appointment, patient received planned referral/services, patient missed appointment (patient no-show)) to document if referral received