

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Program Protocol
DOCUMENTATION

Initial Date: July 23, 2020

Revised Date:

Section 11-05

Purpose: To provide guidance for documentation of CIP services

- I. Patient contacts will be documented in an EPCR system including:
 - a. Face to face contact with or without treatments rendered
 - b. Telephone/telehealth contact
- II. Communications with all persons regarding a patient will be documented in an EPCR system. Examples include but are not limited to:
 - a. Licensed health care providers
 - i. Communications with licensed health care providers that influence the route of care (receiving an order from or reporting an issue to) should include name, agency, date, time and issue relayed to provider.
 - b. Family members
 - c. Social service organizations
 - d. Meals on wheels
 - e. Volunteer organizations
 - f. Community organizations
- III. EPCRs will be available to the referring physician within 24 hours of the completion of the visit. Transmission of electronic records will be determined by MCA.
- IV. Things that cannot be documented directly into the EPCR will be attached to the EPCR. This includes but is not limited to forms and checklist that are not housed within the EPCR such as:
 - a. Consent forms
 - b. Physician created care plans
 - c. Checklists
 - d. Medication lists
 - e. Physician's orders
- V. Procedure protocol documentation will include:
 - a. Evaluation findings
 - b. Interventions
 - c. Response to interventions (Results may be improved, unchanged, or worsened)