



ICANOTES EHR

EXTENDED PROFILE



OVERVIEW

ICANotes is a behavioral health EHR system accessed via a web-based platform. The EHR system was designed for use by mental health practices and offers an efficient note-taking system through the use of pre-formatted buttons.

FEATURE OVERVIEW

- ✓ Patient Demographics
- ✓ Patient Portal
- ✓ Scheduling
- ✓ Appointment Management
- ✓ Billing Management
- ✓ Document Management
- ✓ Clinical Workflow
- ✓ EM Coding
- ✓ Patient History
- ✓ Reporting and Analytics
- ✓ Patient History / EMR
- ✓ e-Prescription
- ✓ E&M Coding

SOFTWARE SPECIFICATION

OVERVIEW	
PRODUCT NAME	ICANotes EHR
COMPLIANCE	
HIPAA	✓
ICD-10	✓
CPT	✓
HL7	✓
SPECIALTY	
ALLERGY AND IMMUNOLOGY	✗
ANESTHESIOLOGY	✗
BARIATRICS	✗
CARDIOLOGY	✗
COMMUNITY HEALTH CENTERS	✗
CORRECTIONAL HEALTH	✗
DENTISTRY	✗
	✗

DERMATOLOGY	
DIALYSIS CLINIC	×
ENDOCRINOLOGY	×
FAMILY MEDICINE	×
GASTROENTEROLOGY	×
GENERAL PRACTITIONER	×
INFECTIOUS DISEASES	×
INTERNAL MEDICINE	×
MENTAL AND BEHAVIORAL HEALTH	✓
NEPHROLOGY	×
NEUROLOGY AND NEUROSURGERY	×
OBSTETRICS AND GYNECOLOGY	×
OCCUPATIONAL MEDICINE	×
ONCOLOGY AND HEMATOLOGY	×
OPHTHALMOLOGY	×
ORTHOPEDICS AND SPORTS MEDICINE	×
OTOLARYNGOLOGY	×
PAIN MANAGEMENT	×
PEDIATRICS	×
PHYSICAL THERAPY AND REHABILITATION	×
	×

PLASTIC SURGERY	
PODIATRY	✗
PROCTOLOGY	✗
PULMONOLOGY	✗
RADIOLOGY	✗
RHEUMATOLOGY	✗
SLEEP MEDICINE AND CENTERS	✗
SPEECH THERAPY	✗
SURGERY	✗
URGENT CARE	✗
UROLOGY	✗
VASCULAR DISEASES AND PHLEBOLOGY	✗
OTHER SPECIALTIES	✗
CHIROPRACTIC	✗
PRACTICE SIZE	
SOLO PRACTICE	✓
1-10 PHYSICIANS	✓
11-50 PHYSICIANS	✓
OVER 50 PHYSICIANS	✓
ADDITIONAL INFORMATION	

IOS APP	✗
ANDROID APP	✗
MULTI-OFFICE	✗
WEB APP	✓
SOFTWARE FEATURES	
APPOINTMENT MANAGEMENT	✓
BILLING MANAGEMENT	✓
CLINICAL WORKFLOW	✓
DOCUMENT MANAGEMENT	✓
EM CODING	✓
INSURANCE AND CLAIMS	✓
LAB INTEGRATION	✓
MEDICAL TEMPLATES	✓
PATIENT DEMOGRAPHICS	✓
PATIENT HISTORY	✓
PATIENT PORTAL	✓
REFERRALS	✓
REPORTING AND ANALYTICS	✓
SCHEDULING	✓
VOICE RECOGNITION	✓

E-PRESCRIPTION	✓
FURTHER INFORMATION	
ONC-ATCB	2014
ONC-ATCB CERTIFYING BODY	Drummond
PRICING	\$155 / provider / month

SOFTWARE SCREENSHOTS

FileMaker Pro - [icn-r (ICANotes 1.01)]

File Edit View Format Go Reports Help

ICANotes Behavioral Health EHR

Chart Room Chart Face

Patient's Name : **Smith, Samantha** Date of Service : **9/13/2011** Site :

Coding Matrix

If you add any elements, push the associated button to recalculate code.

History of Present Illness

Location	
Quality	1
Severity	1
Duration	
Timing	
Context	1
Modifying factors	1
Assoc. Signs & Symptoms	1

History total elements: **5**

(1) **Problem Focused**
= 1 to 3 elements

(2) **Expanded Problem Focused**
= 1 to 3 elements
+ Prob. Pert. ROS

(3) **Detailed**
= 4 elements
+ Extended ROS
+ Pert. PFSH/ROS or rev.

(4) **Comprehensive**
= 4 elements
+ Compl. PFSH or rev
+ Complete ROS

PFSH markers
PPH SH FH

History is: **2**

Exp. Prob. Focused

Examination

Thought Process	
Speech	1
Psychosis	
Associations	
Judgment Insight	
Orientation	
Memory	
Attention Span Conc.	1
Language	1
Fund Of Knowl.	
Mood	1

Exam total elements: **4**

(1) **Problem Focused**
= 1 to 5 elements

(2) **Expanded Problem Focused**
= at least 6 elements

(3) **Detailed**
= at least 9 elements

(4) **Comprehensive**
= 11 elements

Constitutional
Musculoskeletal

Go to MSE

Exam is: **1**

Problem Focused

Medical Decision Making

Low Complexity	<input checked="" type="checkbox"/>
Moderate Complexity	<input type="checkbox"/>
High Complexity	<input type="checkbox"/>

Low Complexity
Low severity. A 30' admission; or interval history in which patient is stable, recovering or improving.

Moderate Complexity
Moderate severity. A 50' admission or interval history characterized by inadequate response or minor complication.

High Complexity
High severity. A 70' admission or interval history; unstable, significant complication; significant new problem.

Decision making complexity is: **1**

L

Re-calculate

Print

What Do I Need?

			History	Exam	MDM
Domicillary	New Patient	99321	1	1	1
	3/3	99322	2	2	2
		99323	3	3	3
Established Patient		99331	1	1	1
		99332	2	2	2
	2/3	99333	3	3	3
ER	Initial Evaluation	99281	1	1	1
	3/3	99282	2	2	1
		99283	2	2	2

From: [Documentation Guidelines for Evaluation and Management Services](#), American Medical Association, HCFA, Nov. 1997; and CPT 1999.

Definitions

Chief Complaint
A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's words.

Counseling
Discussion with patient or family of one or more of the following: *diagnostic results; *recommended diagnostic studies; *prognosis; *risks and benefits of treatment options; *instructions and/or follow-up; *importance of compliance; *risk factor reduction; *patient and family education.

HPI
A chronological description of the development of the patient's present illness ... it includes the following elements: *location, *quality, *severity, *duration, *timing, *context, *modifying factors, and *associated signs and symptoms.

PFSH
A review of Past, Family and/or Social History

CANotes | Chart Room | Patient: Test | Patient's ID: 1000010655796 | DOB: 4-4-1944 | 71 Yrs

Ther. Groups | Telephone Intake Form | Demographics | Documents | Logs | Clinical Order Sheets | Treatment Plan

This is the Chart Face for: Patient, Test

Current Diagnosis (Axis I - V) | Filter Notes >> | Showing 6 of 6 Notes

1) 11/3/15 am | Treatment Plan | Billing Address | Compiled Note | Work Areas

TREATMENT PLAN FOR TEST PATIENT

Treatment Plan
A Treatment Plan was created or reviewed today, 11/3/2015, for Test Patient. Participant(s) developing the Plan were: Brian Test & Nurses

2) 8/4/15 am | Treatment Plan | Billing Address | Compiled Note | Work Areas

TREATMENT PLAN FOR TEST PATIENT

Treatment Plan
A Treatment Plan was created or reviewed today, 8/4/2015, for Test Patient.

Diagnosis: Axis I:

Adverse Drug Reactions/Allergies: Active List

TREATMENT PLAN FOR TEST PATIENT

Treatment Plan
A Treatment Plan was created or reviewed today, 8/4/2015, for Test Patient.

Diagnosis: Axis I:

Patient Notes and Risk Factors: NOTES & RISK FACTORS:

Pre-Admission Assessment	Progress Note	Prescriber	Clinical Msg	Send a Message
Chem Depend Assessment (6 ASAM Dimensions)	Progress Note	Non-Rx	Form Letter	Appt Book
Complete Assessment (of your discipline)	Progress Note	Nursing	Rx Called In	Appt History
	Progress Note	Group Ther.	Med Pickup	Patient Account
	Progress Note	Dietitian	Reminders	
	Progress Note	Play Therapy	Review MAR	
	Progress Note	Case Mgr/SW		
	Custom Forms/Assessments			

● Active
○ Inactive
○ Pending

FileMaker Pro Advanced - [Cn-r (06/4)]

CANotes | Chart Room | Chart Face | 5/16/2012 | Smith, Jill | 1000010644862

Demographics | Hist. Present Illness | Past Psych. Hist. | Medical Hist | Social Hist | Develop. Hist | Family Hist | Mental Status Exam | Finish Initial

HISTORY OF PRESENT ILLNESS

Patient has symptoms of:

- Abuse/Assault
- ADHD
- Anger Problems
- Anxiety
- Chemical Dependency
- Conduct Disorder
- Depression
- Dementia / TBI / Delirium
- Eating Disorder
- Genetic
- Hypoxia
- ICD
- ODD
- Pervasive Dev. Dis.
- Psychosis
- Psych. Testing

Medical Decision Making/Complexity: Low, Mod, High

Problem Pertinent ROS: Pt can't describe...

Denies Anxiety, Denies Depression, Denies Mania, Denies OCD, Denies Psychosis

Other Systems ROS: Constitutional Normal, Musculoskeletal Normal, All other systems normal

Nursing Assessments: De-escalation, Fall Assessment, Mobility, Nutrition, Hygiene/ADLs, Educational Needs

HISTORY: Jill is a married Canadian 45 year old woman. Her chief complaint is, "I am so depressed since my daughter died." Symptoms of a depressive disorder are describe by Jill.

She reports that there is a precipitant for her depression. Problems with her primary support group are described by Jill and her depressive symptoms are attributed to those problems. Her depressive symptoms began insidiously over a period of months. Daily depressive episodes are occurring, she reports. When depressed the mood lasts for hours.

Current Symptoms: Jill reports that her appetite is decreased. Weight loss has occurred. She reports a weight loss of more than five pounds. Weight change has occurred over the following time frame: Three weeks. Jill reports having less energy. She reports that energy and enthusiasm at work has decreased. Previously enjoyed activities are no longer enjoyed, she reports. She describes concentration difficulty associated with her depression. Jill reports that her mind often wanders. Fatigue has been present. She describes feelings of sadness. Jill describes difficulty falling asleep. Feelings of worthlessness are present. Jill does not have a history of manic or hypomanic episodes. Jill describes suicidal ideas but convincingly denies intent. Jill says, "I am Catholic and would never really want to harm myself."

Jill reports that there have been no prior depressive episodes.

Based on the risk of morbidity without treatment and Jill's

create new hpi button

Location	Duration
Severity	Content
Timing	Modifying fact.
Quality	Appeo: 585

Spall Check | History total: 0

Clinicians: Elizabeth Lobao MD | Note Owner: 100081