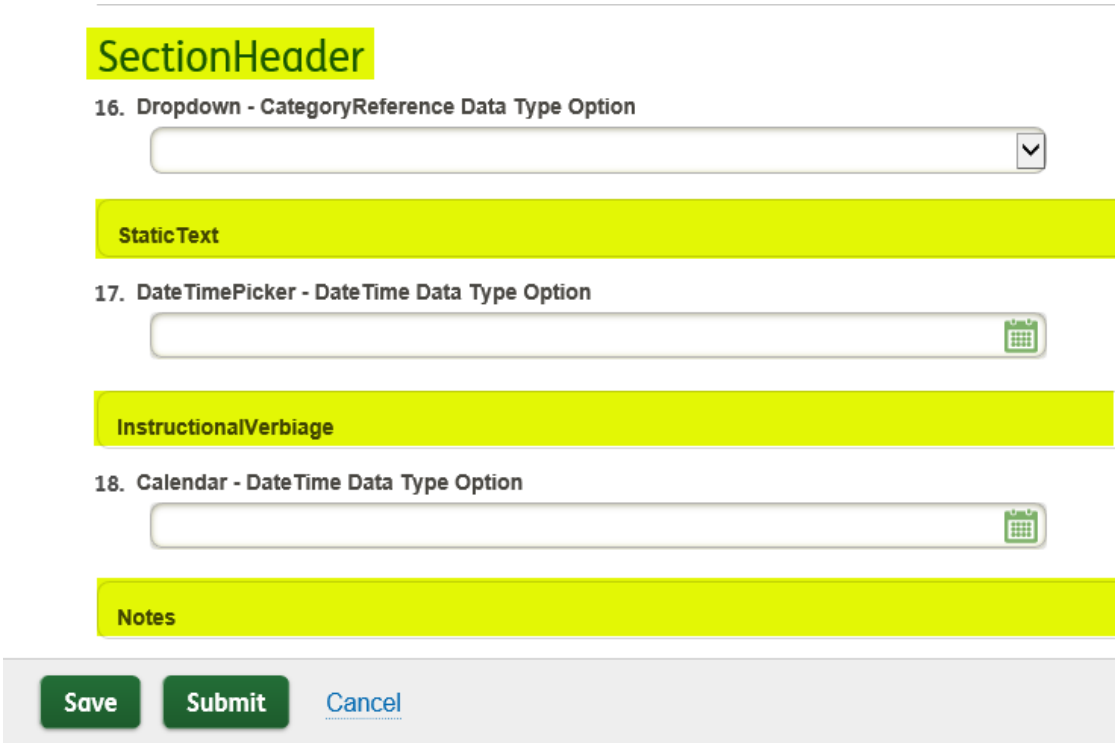
Instruction Guide for Completing the CGX Assessment Template
If you are adding a new care plan, please see the Assessment Template tab
The instruction tab has some definitions that may be helpful in your Assessment request
If you are making updates to a current assessment, please attach the prior assessment along with all changes highlighted.
Any additional information that you need to explain, please add to this worksheet, or to the assessment template. Thank you.
Acuity Scoring applicable? - please indicate if you want scoring to apply to this assessment
Carry Over - allows for responses from a previously taken assessment to to carry over to the new one
Allow Referral - screens if member is eligble or ineligible for another program
Date to be effective - Target date that you would like to see the assessment in the Production environment of CGX 2.0
Name of Assessment - Title of Assessment
if Header Image is required, please attach - if you want an image for the header of the assessment, please include with the Assessment request
Department Owner - Department that owns the 'assessment' (See lines 69-71 below for a complete list of available departments)
Other departments: Other departments utilizing this Assessment/Survey: (See lines 69-71 below for a complete list of available departments)
Question/Text - document the question/text you want the user to see or answer If you want a different font or color, or bold/underlined, etc, please document the question in that format you want
Question Type - identify the type of 'question/text' you are asking for
Answer Options - document ALL the possible answers you want to have for the question. Define also is any response will require a TextBox option and define what title you want for the TextBox (Example; an "Other" response would yeild a TextBox that might be titled, "Explain:", "Comments:", etc.
Branching Condition - document if ANY branching is required. If a certain response will lead to conditional questions, please define which respons(es) will lead to conditional questions. Keep in mind; for example, a "Yes" response may lead to one line of conditional quesitons, and a "No" response may lead to an entirely different line of conditional questions. Also, document any question and response that will link out to other assessments.
Mandatory - indicate if the question is to be marked as mandatory
Element - indicate type of element you are requesting
Recommendations for Care Plan - based on specific question and answers, will recommend care plans
Associated Keywords (for ICS use only) - do not put anything in this box
Element Id # (for ICS use only) - do not put anything in this box
Exhaust To (Inbound/Outbound): HIT, ATLAS, Rosalind, etc.

Generic Control Type:
Section Header - Appears in bigger font to help distinguish one section from another. Future Quick Jump enhancement will key on this.

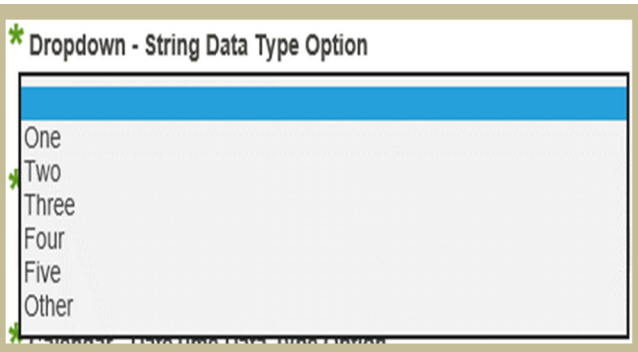
Static Text, Instructional Verbiage, and Notes - all three behave the same in CGX 2.0 (see

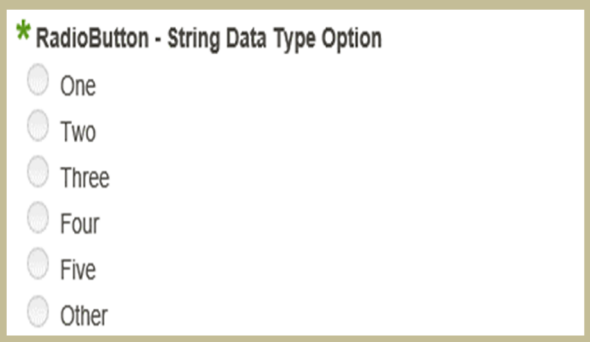


Question Type: Checkbox, Textbox, Multi Select Dropdown, Radio Button, Dropdown, Date Time Picker, or Calendar

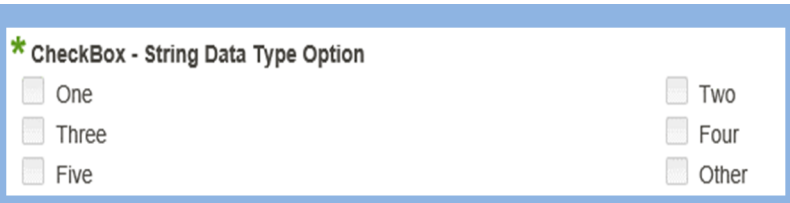
4 Question Types	
1. Single Select Question Types	Allows for only one response to be selected from the available list of options.
Dropdown	Best for > 3 responses
RadioButton	Best use for 2-3 responses; good for mandatory type questions that you want your users to answer
2. Multiple Select Questions Types	Allows for a user to select multiple options from the available list of options.
CheckBox	Best for seeing all responses at one time, but utilizes a lot of white space. Can mean more scrolling.
MultiSelectDropdown	Best for conserving white space, but only first 3 options viewable without scrolling.
3. TextBox	Can be set up to have alpha only, numeric only, or alpha numeric characters. Character limitations can be set for TextBox options.
4. Date Entry	Can allow past dates only, future dates only, or both past and future dates
DateTimePicker Calendar	

Examples of Single Select Question Types (Drop down and Radio Button)

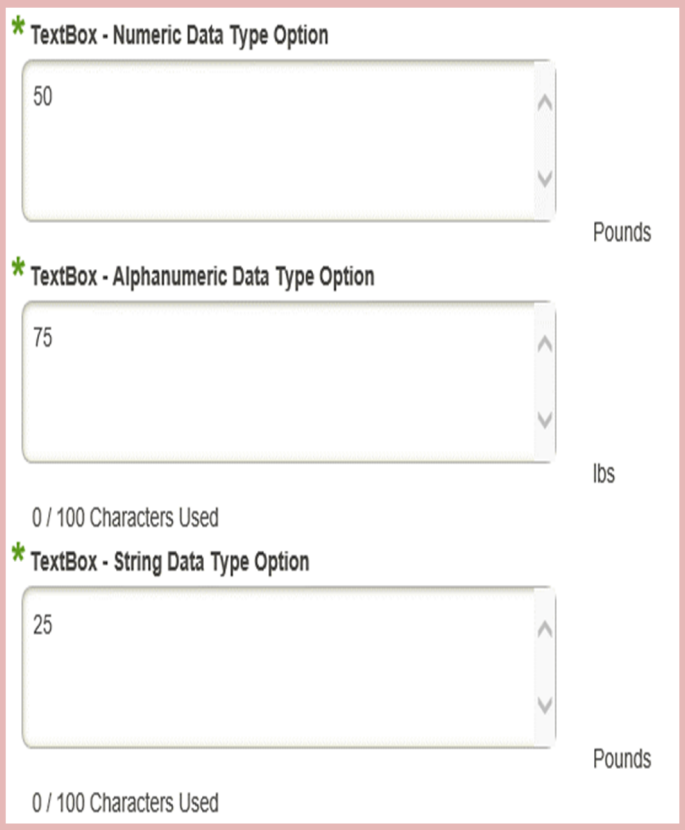




Examples of Multi-Select Question Types (Check Box and Multi-Select Drop down)

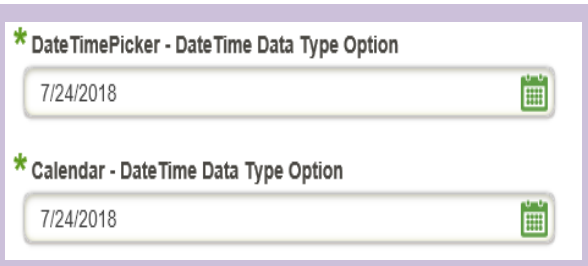


Examples of Text Box Question Types



Examples of Calendar Entry Question Types (Date Time Picker and Calendar).

Note: at the time there is no real discernable difference



List of CGX 2.0 Departments: **Use this list as a guide for the Owning department and Other department fields**:
Bariatric
Cancer Program
Care Delivery
Careplus
CCR Sourced Vendor
CDM Model of Care Frequency – Past Due
CDM Referral Specialist Activity
CDM Referral Specialist Frontline
CDM Referral Specialist Queue Activity Summary
CDM Referral Specialist Queue Assignment
CDM Unmanaged Population Counts
CGX CAC User
CGX Genetic Counselor
CGX Humana Behavioral Health CM
CGX Humana Behavioral Health Um/CM
CGX Medicaid Outreach
CGX MSO
CGX POD
CGX PODS Bariatric
CGX PODS CLD
CGX PODS HPS
CGX PODS Humana Beginnings
CGX PODS HumanaCares
CGX PODS ICS
CGX PODS Internal Asthma
CGX PODS Internal Cancer
CGX PODS Internal Diabetes
CGX PODS MHSO
CGX PODS MIT
CGX PODS Moms First
CGX PODS NICUCM
CGX PODS NICUGRAD
CGX PODSNICUHB
CGX PODS Pediatric Care Management
CGX PODS Personal Nurse
CGX PODS RMD
CGX PODS Transplant
CGX PODS Commercial Case Management
CGX PODS Intake
CLD
Clinical Metrics
Clinical Programs
Commercial Case Management
Disease Management
Florida Only Medicare/Medicaid
GENERAL
Health Choice Florida
Health Help
HealthChoice
HPS
Humana Beginnings
Humana Behavioral Health
Humana Cares
ICGS
Intake
Internal Asthma
Internal Diabetes
IT
LTSS
Metabolic Syndrome
Moms First
NA
NaviHealth
NICU Case Management
NICU Graduate
NICU Humana Beginnings
Pediatric Care Management
Personal Nurse
Read Only
Resolution Team
RMD
Senior Products
STARS Outreach
Transplant

Note: See Instructions tab for details regarding category and option descriptions. Instructions Tab also provides guidance to help you choose the best option for each element on the excel.

Title of Assessment: Medicaid BH Comprehensive Survey (This will display in CGX when selecting Assessment)					**Department Owner:** (i.e. Senior Products, Humana Beginnings, etc.) Senior Products		**Date to be Effective:** 12/8/19 (MM/DD/YYYY format)		**Acuity Scoring Applicable:** (Yes/No)			**Exhaust To:** (Inbound/Outbound to ATLAS, HIT, etc.)						
Assessment ID: SCM050 (for ICS use only)					**List any other departments utilizing this Assessment/Survey:** Florida Only Medicare / Medicaid		**Allow Referral:** (Yes/No)		**Carry Over:** (Yes/No)			**Is a Header Image required:** (Yes or No; If Yes, please attach)						
Notes	**Element Type:** (i.e. Question	**PH comp element ID's - if present**	**Element Id #** (for ICS use only)	**Section (hide)**	**Question/Text** (Text within the cell will be copied directly into the	**Question Type:**	**Answer Options** (List all answer options pertaining to question in one cell)	**Mandatory Yes/No**	**Associate free text**	**Branching Condition**	**Branching Location**	**Recommendations for Care Plan**	**Response that Prompts Care**	**Area of Focus** (i.e. Health,	**Problem**	**Goal**	**Potential Interventio**
			GEN_07150	AUTH AND CONSENT													
	Question		Que_071504		What is the reason for this assessment?	Dropdown	Initial Monthly Update Quarterly Update Annual Significant Change in Condition										
	Question		Que_072457		Care Manager provided name role and responsibility	Radio Button	Yes No										
	Question		Que_072458		Did Enrollee answer correctly to the following: Enrollee Full Name; Today's Date; Enrollee's DOB; Day of the Week?	Dropdown	Enrollee answered all correctly Enrollee not oriented to one or more areas(Text Box -> "Provide details:")										
	Question		Que_072459		Is Enrollee oriented x 4?	Dropdown	Oriented to Place, Time, Person, and Situation Enrollee not oriented to one or more areas(Text Box -> "Describe status of any area Enrollee NOT oriented to:")										
	Question		Que_071501		Verbal consent to participate in care management services was given by:	Single Select Dropdown	Enrollee Legal Guardian POA Enrollee Representative Other Enrollee/Representative declined consent to participate in care management services		If Other or Enrollee/Representative declined consent is selected, Associate Free text box Label: Specify Details:	for answer option Enrollee / Representative declined consent to participate in case management services - branch to Que_072461 - Are you sure you want to discontinue case management. For any other answer option selected branch to Que_071502 -	Que_071502 - calendar picker or Que_072461 based on branching condition stated in column P						
	Question		Que_071502		Select the date consent was given:	DateTimePicker	Calendar Picker										
	Question		Que_072461	Add Question mark	Are you sure you want to discontinue case management?	Dropdown	Yes No										
	Question		Que_071503	Edit answer option "of"	Assessment completed with:	Dropdown	Enrollee Parent Legally Appointed Guardian Caregiver Family of Enrollee Other (Text Box -> "Specify other:")										
	Question		Que_072462	Edit 2 answers	Referral reason (check all that apply):	Checkbox	Provider Referral Self Referral BH Post Discharge Medical Post Discharge Incarceration Child Protective servicesFoster Child Human Trafficking Other Humana CM										
	Enrollee Preferences		GEN_07185	Enrollee Preferences													
	Question		Que_071511		What is your preferred language for verbal communication?	Checkbox	English American Sign Language Arabic Armenian Chinese French French Creole German Greek Gujarati Hebrew Hindi Hmong Italian Japanese Korean Persian Polish Portuguese Russian Spanish Tagalog Urdu Vietnamese Yiddish Enrollee Declined to State Other (Text Box -> "Specify other language:")										

	Question		Que_071512		What is your preferred language for written communication?	Checkbox	English American Sign Language Arabic Armenian Chinese French French Creole German Greek Gujarati Hebrew Hindi Hmong Italian Japanese Korean Persian Polish Portuguese Russian Spanish Tagalog Urdu Vietnamese Yiddish Enrollee Declined to State										
	Question		Que_072463		Do you have any need for support in reading written materials sent to you by Humana?	Dropdown	Need Help Reading (Text Box -> "Describe support given:") No Help Reading Needed										
	Question		Que_072464		Do problems with vision or hearing ever interfere with you receiving the care you need?	Dropdown	Vision Problems (Text Box -> "Describe support given:") Hearing Problems (Text Box -> "Describe support given:") Vision and Hearing Problems (Text Box -> "Describe support given:") No Problems Noted										
	Question		Que_071505		Do you have any religious and/or cultural beliefs that may influence your healthcare decisions? For example, are there any foods or medications you avoid?	Checkbox	None Diet Medication Blood products Other (All responses -> "Specify details:")	Yes									
			Gen_07184	Caregiver													
	Question		Que_072465		Document current caregiver status and assistance provided. If caregiver assistance is not adequate, provide additional details.	Dropdown	Caregiver Not Needed and Enrollee meets needs independently Caregiver in Place but not Adequate (Text Box -> ""Describe intervention taken to assist.") Caregiver in Place and Adequate										
	Question		Que_072466		If Caregiver is in place, who is your caregiver? Provide Name of Caregiver and Relationship to the Enrollee	Text Box		Yes									
	Question		Que_072467		Would you like your Care Manager to have contact with this person?	Radio Button	Yes No										
	Question		Que_072468	Edit question	Is there an ROI / PHI release, POA, or other legal document on file?	Radio Button	Yes No										
	Question		Que_072469		CM educated the Enrollee on options to complete an ROI and offered assistance	Radio Button	Yes No										
	Question		Que_072470		Is the Enrollee under age 18?	Radio Button	Yes No			Equals Yes	Does the parent/guardian have any concerns about the Enrollee's development such as:						
			Gen_07153	Pediatric													
	Question		Que_071533	Alphabetize list as shown	Does the parent/guardian have any concerns about the Enrollee's development such as:	Checkbox	Activity Bed Wetting Behavior Patterns Bullying Change in Appetite Discipline Friends Overuse of Electronics Picky Eating School Sexuality Sleep Toileting Use of Caffeine/Energy Drinks Use of Social Media Video Gaming Other None										
	Question		Que_072456		Is Enrollee involved or enrolled in one of the following programs: Case Manager Prompt: If Enrollee is involved or engaged in programs, please capture the Case Manager or Key Contact for that program in the Providers & Natural/Community Support Contact Information.	Multiselect Dropdown	Autism Waiver Child Care Assistance Program Early Intervention Head Start Individualized Education Program (IEP) Intellectual and Developmental Disabilities Waiver (ICD/IDD) Traumatic Brain Injury Waiver Other Not involved or enrolled in a program		If Other answered, associate free textbox for "Specify Program/Waiver:"						

	Question		Que_071583	Alphabetize list	Describe the Enrollee's family structure and living situation:	Checkbox	Adopted Foster care Frequent moves/Unstable housing Homeless Lack of supervision Lives at home with parents Lives with guardian Multiple generation household Runaway (All responses -> Text Box -> "Describe impact of living situation and family structure on Enrollee's needs. Impact can be positive or an area of opportunity.")		For all responses associate free text box with Label "Describe impact of living situation and family structure on Enrollee's needs. Impact can be positive or an area of opportunity"								
	Question		Que_071584		Text box with Label "Describe impact of living situation and family structure on Enrollee's needs. Impact can be positive or an area of opportunity"	Textbox											
	Question		Que_072471	Alphabetize list as shown	What barriers specific to achieving the child/adolescent's health goals exist?	Multiselect Dropdown	None Childcare/ Afterschool Care Lack of Family Support Lack of Parental Knowledge No Pediatrician Parenting Skills Other (Text Box -> "Specify other:")										
	Question	Que_012794			Was most recent well baby/child exams completed?	Dropdown	Yes No Unsure (Text Box -> "If unsure, explain")	Yes									
	Question	Que_012795			Date of last well baby/child exam, month (if unsure of exact date, document as first day of month)	DateTimePicker											
	Generic Control	Gen_01300			Static Text: Periodicity schedule: Infancy- 3-5 days by 1 mo 2 mo 4 mo 6 mo 9 mo Early Childhood- 12 mo 15 mo 18 mo 24 mo 30 mo	Static Text											
	Question	Que_012799			Is child up to date on immunizations?	Dropdown	Yes No Unsure	Yes	Que_012799 NotEquals Yes	Que_012800							
	Question	Que_012800			List reasons/barriers to Immunizations, Periodicity Schedule, Screenings	Multi-Select Dropdown	Cultural barriers Finance Lack of community resources Lack of parental knowledge Lack of support system Language barriers Transportation Other										
			Gen_07186	Physical and Behavioral health Overview													
	Question		Que_072472		What are the Enrollee's self reported needs? Describe Enrollee's response:	Text Box		Yes									
	Question		Que_071711		Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?	Dropdown	Don't know/Not sure Enrollee/Parent/Guardian refused 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25	Yes									

	Question		Que_071712		Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?	Dropdown	Don't know/Not sure Enrollee/Parent/Guardian refused 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25	Yes									
	Question		Que_999087		Health systems review	Checkbox	Cardiovascular Respiratory Endocrine Musculoskeletal Gastrointestinal Neurological Renal Blood/Hematological Infectious Disease Skin/Integumentary Reproductive Eyes, Ears, Nose, Throat Cancer Rare Diseases Behavioral Health **Denies any conditions**	Yes		Positive response to any category opens up to further questions for each category.	See "Design (CTX Only) tab for conditional branching for Health System Review	Copy question from current Comprehensive Survey Redesign noting each condition and whether "current" or "past"					
	Question		Que_999088		Cardiovascular condition details	Checkbox	Hypertension High cholesterol Congestive Heart Failure Coronary Artery Disease Myocardial Infarction (MI) A-Fib Stroke Other (Text Box -> "Specify Other:")	Yes		Que_999087 Contains Cardiovascular	Que_999088 Que_999089						
	Question		Que_999089		Cardiac condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									
	Question		Que_999093		Respiratory condition details	Checkbox	COPD Asthma Chronic Bronchitis Emphysema Sleep Apnea Respiratory Failure Pneumonia Other (Text Box -> "Specify other") None	Yes		Que_999087 Contains Respiratory	Que_999093 Que_999094						
	Question		Que_999094		Respiratory condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									
	Question		Que_999098		Endocrine condition details	Checkbox	Thyroid Diabetes Member Unsure Other (Text Box -> "Specify other:")	Yes		Que_999087 Contains Endocrine	Que_999098 Que_999099						
	Question		Que_999099		Endocrine condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									
	Question		Que_999103		Musculoskeletal condition details	Checkbox	Osteoarthritis (Degenerative Joint Disease) Rheumatoid arthritis Cervical stenosis Osteoporosis Fibromyalgia Back problems Joint Replacement Gout Other (Text Box -> "Specify other"	Yes		Que_999087 Equals Musculoskeletal	Que_999103 Que_999104						
	Question		Que_999104		Musculoskeletal condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									
	Question		Que_999109		Gastrointestinal condition details	Checkbox	Appendicitis Ulcerative Colitis Crohn's Diverticulitis Gastritis GERD GI bleed Hiatal hernia Irritable Bowel Syndrome Chronic constipation/diarrhea Ulcers Other (Text Box -> "Specify Other:")	Yes		Que_999087 Equals Gastrointestinal	Que_999109 Que_999110						
	Question		Que_999110		Gastrointestinal condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									

	Question		Que_999113		Neurological condition details	Checkbox	Alzheimer's disease Stroke Neuropathy Seizures Transient Ischemic Attack (TIA) Brain Injury Autism Paralysis Parkinson's Shingles Other (Text Box -> "Specify other:")	Yes		Que_999087 Contains Neurological	Que_999113 Que_999114						
	Question		Que_999114		Neurological condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									
	Question		Que_999117		Renal condition details	Checkbox	Dialysis End Stage Renal Disease Chronic Kidney Disease Urinary Tract Infection (UTI) Incontinence Kidney stones Other (Text Box -> "Specify other:")	Yes		Que_999087 Contains Renal	Que_999117 Que_999118						
	Question		Que_999118		Renal condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									
	Question		Que_999121		Hematological condition details	Checkbox	Anemia Thrombocytopenia Clotting disorder Sickle Cell Anemia Other (Text Box -> "Specify other:")	Yes		Que_999087 Contains Blood/Hematological	Que_999121 Que_999122						
	Question		Que_999122		Hematological condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									
	Question		Que_999125	Update answer options	Infectious Disease condition details	Checkbox	C Diff Hepatitis HIV/AIDS Meningitis MRSA Septicemia Tuberculosis **Other** (Text Box -> "Specify other:"	Yes		Que_999087 Contains Infectious Disease	Que_999125 Que_999126						
	Question		Que_999126		Infectious Disease condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									
	Question		Que_999129	Update answer options	Skin condition details	Checkbox	Eczema Psoriasis Burns Cellulitis Decubiti Non-surgical wound **Other** (Text Box -> "Specify other:")	Yes		Que_999087 Contains Skin/Integumentary	Que_999129 Que_999130						
	Question		Que_999130		Skin condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									
	Question		Que_999133		Reproductive condition details	Checkbox	Erectile dysfunction Inguinal hernia Enlarged prostate STDs Pregnancy Uterine bleeding Polycystic ovaries Other (Text Box -> "Specify other:")	Yes		Que_999087 Contains Reproductive	Que_999133 Que_999134						
	Question		Que_999134		Reproductive condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									
	Question		Que_999140		EENT condition details	Checkbox	Vision impairment Cataracts Glaucoma Glasses/Contacts Diabetic retinopathy Macular degeneration Blindness Hearing disorder Hearing aids Dysphasia Vocal hoarseness Chronic sinusitis Nasal congestion Other (Text Box -> "Specify other:")	Yes		Que_999087 Contains Eyes, Ears, Nose, Throat	Que_999140 Que_999141						
	Question		Que_999141		EENT condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									
	Question		Que_999144		Cancer condition details	Checkbox	Breast Lung Prostate Colon Non-Hodgkin's Lymphoma Multiple Myeloma Ovarian Brain Bone Liver Pancreas Skin Oral Other (Text Box -> "Specify other:")	Yes		Que_999087 Contains Cancer	Que_999144 Que_999145						
	Question		Que_999145		Cancer condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									

	Question		Que_999148		I am going to go through a list with you now. Has the doctor ever told you that you have any of these uncommon conditions? (Note to associate: these are the rare diseases.)	Checkbox	ALS Chronic inflammatory demyelinating polyneuropathy (CIDP) Cystic Fibrosis Dermatomyocitis Hemophilia - except Von Willebrand's Multiple Sclerosis Myasthenia Gravis Parkinson's Disease Polymyositis Scleroderma Sickle Cell Disease Systemic Lupus	Yes		Que_999087 Contains Rare Diseases	Que_999148 Que_999054						
	Question		Que_999054		Rare Disease condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									
	Question		Que_999151		Behavioral Health condition details	Checkbox	Major Depression Anxiety Bipolar Disorder Schizophrenia/Schizoaffective disorder Substance Use Disorder (SUD) Eating Disorder (binging, anorexia, bulimia) Suicide Attempt Other (Text Box -> "Specify other:")	Yes		Que_999087 Contains Behavioral Health	Que_999151 Que_999152						
	Question		Que_999152		Behavioral Health condition status	Radio Button	Current (Text Box -> "Describe treatment for current conditions:") Past	Yes									
			Gen_07158	Providers, Appointments, and Support													
	Question	Que_999060			Have you been to the dentist in the last 6 months?	Radio Button	Yes No Did not respond	No									
	Question	Que_999061			What problems or concerns with your mouth, teeth or ability to swallow do you have or have had?	Text Box		No									
	Question		Que_072473		How is your relationship with your current providers?	Dropdown	Good Poor (Text Box -> "Describe plan to assist in identifying provider(s).") No Provider (Text Box -> "Describe plan to assist in identifying provider(s).")										
	Question		Que_071595	Add answer N/A	Attestation that freedom of choice of providers and services has been offered to the Enrollee and/or their caregiver.	Radio Button	Yes No Not applicable (Text Box -> "Reason not applicable")	Yes									
	Question		Que_072474		Do you need help locating a medical or behavioral health doctor or other health service that is right for you?	Radio Button	Yes No Not applicable			Equals Yes	Describe CM action to assist:						
	Question		Que_072475		Describe CM action to assist:	Text Box		Yes									
	Question				Please share a list of all of your providers, both Behavioral Health and Physical Health	Text Box											
			GEN_07163	Medications													
	Question		Que_072479		Medication list reviewed in the CGX with the Enrollee? (Review OML Screen and update. Include samples and pertinent OTC meds)	Dropdown	Yes, Reviewed Enrollee medication list in CGX, no changes needed Yes, Reviewed Enrollee medication list in CGX, updates made Medication list not reviewed (Text Box -> "Describe clinical reason medication list not reviewed.")										
	Question		Que_072480		Do you always fill your medications on time?	Radio Button	Yes No (Text Box -> "Describe member barrier to filling medications:")					If "No," populate free text box labelled "Describe member barrier to filling medications:" and map to summary						
	Question		Que_072481		Do you always take your medication as prescribed?	Radio Button	Yes No (Text Box -> "Describe member barrier to taking medications as prescribed:")					If "No," populate free text box labelled "Describe member barrier to taking medications as prescribed:" and map to summary						
			Gen_07187	Behavioral Health Risk													
	Question		Que_072482		Do you smoke or use other tobacco products (Chewing Tobacco/Vape)?	Dropdown	Yes No Quit within the last 6 months			Equals Yes OR Equals Quit within the last 6 months	Would you like help quitting smoking or do you need more assistance staying						
	Question		Que_072483		Would you like help quitting smoking or do you need more assistance staying tobacco free?	Dropdown	Yes No Not Sure			Equals Yes OR Equals Not Sure	Care Manager Prompt: Select resources provided to enrollee.						
	Question		Que_072484	Update answer options alphabetize as shown and capitalize Support Group	Care Manager Prompt: Select resources provided to enrollee.	Mulitiselect Dropdown	Enrollee declines referrals at this time Referral to Humana Wellness/Healthy Behaviors Referral to Other Provider Referral to Support Group Referral to Tobacco Quitline (All responses -> Text Box -> "Specify details:")										
	Question		Que_071617		In relation to gambling, have you ever felt criticized, had to borrow money, or hid your gambling from friends and loved ones? (Includes lottery, casino, online gambling/gaming, racing)	Radio Button	Yes No Not Sure			Equals Yes OR Equals Not Sure	Would you like assistance learning about how gambling can negatively impact your life or help to stop						
	Question		Que_071618		Would you like assistance learning about how gambling can negatively impact your life or help to stop gambling?	Checkbox	Yes - referral to Gambling Helpline Yes - Referral to Support Group Yes - Referral to Other Provider/Resource (Text Box -> "Specify other:") No	Yes		Equals Yes	Care Manager Prompt: Select resources provided to enrollee						
	Question		Que_072486		Do you ever drink or use recreational drugs?	Radio Button	Yes No			Equals Yes	Is this a child/adolescent or adult?						

	Question		Que_072487		Is this a child/adolescent or adult?	Radio Button	Child/ Adolescent Adult			Equals Child/ Adolescent Equals Adult	CRAFFT CAGE-AID	If Child/Adolescent, branch to CRAFFT. If Adult, branch to CAGE-AID. Do not share the CRAFFT and CAGE AID question answers to Carebook or Availity due to SUD information and sticking to minimum					
	Generic Control		Gen_1325		CRAFFT Part A	Section Header											
	Question		Que_072489		Drink any alcohol (more than a few sips)? Do not count sips of alcohol taken during family or religious events	Radio Button	Yes No			Equals Yes OR Equals Yes OR Equals Yes	CRAFFT Part B						
	Question		Que_072490		Smoke any marijuana or hashish?	Radio Button	Yes No			Equals Yes OR Equals Yes OR Equals Yes	CRAFFT Part B						
	Question		Que_072491		Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	Radio Button	Yes No			Equals Yes OR Equals Yes OR Equals Yes	CRAFFT Part B						
	Generic Control		Gen_1326		CRAFFT Part B	Section Header											
	Question		Que_072492		Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	Radio Button	Yes No										
	Question		Que_072493		Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	Radio Button	Yes No										
	Question		Que_072494		Do you ever use alcohol or drugs while you are by yourself, or alone?	Radio Button	Yes No										
	Question		Que_072495		Do you ever forget things you did while using alcohol or drugs?	Radio Button	Yes No										
	Question		Que_072496		Do your family or friends ever tell you that you should cut down on your drinking or drug use?	Radio Button	Yes No										
	Question		Que_072497		Have you ever gotten into trouble while you were using alcohol or drugs?	Radio Button	Yes No										
	Question		Que_072498		Care Manager Prompt: Each answer of Yes in Part B of the CRAFFT questions equals 1 point. -If the Enrollee answered Yes to 3 or less questions, this is categorized as Substance Abuse. Describe the CM intervention for supporting the Enrollee. -If the Enrollee scored answered Yes to 4 or more questions, this is categorized as Substance Dependence. Describe the CM intervention for supporting the Enrollee.	Text Box		Yes										
	Generic Control		Gen_07174		CAGE-AID Questions Case Manager Prompt: This section is for adult enrollees only.	Section Header											
	Question		Que_071668		Have you ever felt that you ought to cut down on your drinking or drug use?	Radio Button	Yes No Declines to Answer										
	Question		Que_071669		Have people annoyed you by criticizing your drinking or drug use?	Radio Button	Yes No Declines to Answer										
	Question		Que_071670		Have you ever felt bad or guilty about your drinking or drug use?	Radio Button	Yes No Declines to Answer										
	Question		Que_071671		Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	Radio Button	Yes No Declines to Answer										
	Question		Que_072488		Do you ever take more than what is prescribed of your own medication or other prescription medications that are not your own?	Radio Button	Yes No										
	Question		Que_071672		Care Manager Prompt: If Enrollee answered yes to 1 or more of the CAGE AID questions, describe details of Enrollee's substance use and care manager intervention to support Enrollee.	Radio Button	N/A - Enrollee did not answer Yes to CAGE AID questions Consult with Behavioral Health SME Enrollee already engaged with BH Provider Other (Text Box -> "Specify other:")	Yes									
	Generic Control		Gen_07160		Many things can impact your health beyond medical conditions. I'm going to ask you some question to help determine other ways I may be able to help you overcome obstacles to your health and well-being.	Static Text											
			GEN_07188	Assessment of ADLs													
	Question		Que_072499	Alphabetize answer list as shown	Initial Assessment of Daily Living Activities: In your household, are any of the following activities a concern?	Multiselect Dropdown	None Assistance with bathing, toileting, getting dressed Changes in appetite Continence Issues Eating or meal preparation Enrollee is fully independent with ADL's Have difficulty with walking Heavy housework such as scrubbing floors or washing windows History of falls Hygiene Paying bills on time, writing a check Transferring or Functional Mobility Trouble falling asleep/staying asleep Writing or handling and grasping small objects Other (Text Box -> "Specify other:")			NotEquals None	For any activity marked note the status and plan for addressing unmet needs:					
	Question		Que_072500		For any activity marked note the status and plan for addressing unmet needs:	Text Box		Yes									
			GEN_07159	Social Determinants of Health													

	Question		Que_072501	Alphabetize answer list as shown	Do you have any additional needs or need resources (community or caregiver) to help?	Multiselect Dropdown	None Built Environment Childcare Eldercare Finances Homeless (living on streets or in shelter) Housing instability Housing repairs Inadequate social/emotional support Lack of Community Resources Safety of your home or neighborhood Transportation Victim of violent crime Other (Text Box -> "Specify other:")			NotEquals None	Describe what intervention CM is taking to resolve areas of need and status of need of each area selected: If Homeless note the name of the housing coordinator.						
	Question		Que_072502		Describe what intervention CM is taking to resolve areas of need and status of need of each area selected: If Homeless note the name of the housing coordinator.	Text Box		Yes									
	Question		Que_072503	Placed Foster and Boarding on separate lines --- might already be separated on UI screen and so may not need a screen update Alphabetize	What is the Enrollee's housing situation at the time of the assessment?	Dropdown	Private Home/Apartment/Rented Room Foster Home Boarding Home Assisted Living or Semi-Independent Living Group Home for Intellectual Disability Homeless (Text Box -> "Name and phone number of housing coordinator:") Long-term Care Facility Rehabilitation Unit Hospice/Palliative Care Facility BH Inpatient Medical Inpatient Correctional Facility										
			Que_080238		Homeless	Text Box	Name and phone number of housing coordinator										
	Question		Que_071605	Alphabetize answer list as shown	What trouble do you have paying for your monthly expenses such as rent, heating, or electric bills?	Checkbox	None Does not have housing, living in car/shelter Does not have housing, living with friends/family/hotel Heat/Electric Trouble paying rent/mortgage Water Other (Textbox -> "Specify other:")	Yes									
	Generic Control		Gen_1327		Over the past 12 months, how often have you been bothered by any of the following problems?	Static Text											
	Question		Que_072504		Ask the Enrollee if: We worried whether our food would run out before we got money to buy more.	Dropdown	1 - Never true 2 - Sometimes true 3 - Often true										
	Question		Que_072505		Ask the Enrollee if: The food that we bought just didn't last and we didn't have money to get more.	Dropdown	1 - Never true 2 - Sometimes true 3 - Often true										
	Question		Que_072506		Was the Food Insecurity Score 3 or more?	Dropdown	2 = Low 3 = Medium 4-6 = High		If answer selected is medium or high open Text box - Describe efforts to address enrollee needs through community resources	NotEquals Low						
	Question		Que_072507		How often do you / enrollee lack companionship?	Dropdown	1 - Never true 2 - Sometimes true 3 - Often true	Yes									
	Question		Que_072508		How often do you / enrollee feel left out?	Dropdown	1 - Never true 2 - Sometimes true 3 - Often true	Yes									
	Question		Que_072509		How often do you / enrollee feel isolated from others?	Dropdown	1 - Never true 2 - Sometimes true 3 - Often true	Yes									
	Question		Que_072510		Care Manager Prompt: What is the Enrollee's loneliness score?	Dropdown	3 = Not Lonely 4 - 6 = Lonely 7 - 9 = Severely Lonely	Yes		NotEquals 3 = Not Lonely	Care Manager Prompt: You indicated the Enrollee scored as being lonely. Did you provide education and resources?						
	Question		Que_071600		Care Manager Prompt: You indicated the Enrollee scored as being lonely. Did you provide education and resources?	Radio Button	Yes No	Yes	If either option (Yes or No) is selected, show associated free text Label: Describe education/resources provided or why no education/resources were provided:	Displays if question "Care Manager Prompt: What is the member's loneliness score?" equals "Lonely" or "Severely Lonely"							
	Generic Control				PHQ	Section Header		Yes									
	Generic Control				I am going to read two statements to you, and I am going to ask you to tell me how you would rate each statement. Over the last 2 weeks, how often have you been bothered by any of the following problems:	Static Text											
	Question		Que_071658		Little interest or pleasure in doing things	Checkbox	Not at all = 0 points Several days = 1 point More than half the days = 2 points Nearly everyday = 3 points	Yes									
	Question		Que_071659		Feeling down, depressed or hopeless	Checkbox	Not at all = 0 points Several days = 1 point More than half the days = 2 points Nearly everyday = 3 points	Yes									
	Question		Que_072511		Was PHQ2 score 4 or more?	Dropdown	Yes No	Yes		Equals Yes	7 additional questions						

	Generic Control		Gen_1330		I am going to read some additional statements to you, and I am going to ask you to tell me how you would rate each statement: Over the last 2 weeks, how often have you been bothered by any of the following problems:	Static Text											
	Question		Que_072512		Trouble falling/staying asleep, sleeping too much	Dropdown	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	Yes									
	Question		Que_072513		Feeling tired or having little energy	Dropdown	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	Yes									
	Question		Que_072514		Poor appetite or overeating	Dropdown	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	Yes									
	Question		Que_072515		Feeling bad about yourself or that you are a failure or have let yourself or your family down	Dropdown	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	Yes									
	Question		Que_072516		Trouble concentrating on things, such as reading the newspaper or watching television	Dropdown	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	Yes									
	Question		Que_072517		Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual	Dropdown	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	Yes									
	Question		Que_072518		Thoughts that you would be better off dead or of hurting yourself in some way	Dropdown	0 - Not at all 1 - Several days 2 - More than half the days 3 - Nearly every day	Yes									
	Generic Control		Gen_1331		Add all 9 PHQ questions to calculate total score. Score of 5-14 indicates moderate depression and Enrollee should follow up with their physician to discuss treatment options based on the duration of symptoms and functional impairment. If RN CM, consider consultation with Medicaid BH CM if further support is required for the Enrollee. Score of 15-27 indicates severe depression and treatment with a combination of therapy and medication recommended. Ensure treatment options for behavioral health provider are given and include Medicaid BH CM in MDT discussion. If Enrollee is suicidal, follow process for	Static Text		Yes									
	Question		Que_072519		What is the total PHQ9 score and recommended action?	Text Box		Yes									
	Question		Que_072520		Have you had thoughts in the last 30 days of suicide or wanting to harm someone else? (This includes thoughts of wanting to die or not wake up tomorrow).	Radio Button	Yes No			Equals Yes	Describe Enrollee reported symptoms and safety plan. Ensure safety plan is detailed in the plan of care crisis plan						
	Question		Que_072521		Describe Enrollee reported symptoms and safety plan.	Text Box		Yes									
	Generic Control		Gen_1332		Ensure safety plan is detailed in the plan of care crisis plan section	Static Text											
	Question		Que_072522	Update answer option and alphabetize answer list as shown	Have you ever experienced the following? Check any of the following that apply. If speaking with guardian/caregiver ask what they have observed of Enrollee behavior:	Checkbox	None Believed that people were spying on you, or that someone was plotting against you, reading your mind, or trying to hurt you Bothered by thoughts or impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive, or distressing Experienced, witnessed, or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else Felt depressed and hopeless Felt so anxious that you could not perform normal daily activities Have you ever had a period of time when you were feeling up, hyper, so full of energy, or full of yourself that you got into trouble, or that other people thought you are not your usual self (not when using drugs or alcohol) Have you ever heard things other people couldn't hear, such as voices, or seen visions or things when you were awake that other people couldn't see Have any relatives or friends ever considered any of your beliefs strange or unusual			NotEquals None	Describe all symptoms that Enrollee is experiencing in Enrollee's words. Create a plan of care around needs prioritized with the Enrollee.						
	Question		Que_072523		Describe all symptoms that Enrollee is experiencing in Enrollee's words. Create a plan of care around needs prioritized with the Enrollee	Text Box		Yes									
			Que_07175	Behavioral Health Crisis Plan													
	Question	Que_071674	Que_072524	Update question text	Does the Enrollee have or need a Behavioral Health Crisis Plan to prevent ~~unnecessary institutionalization~~ an unnecessary behavioral health admission?	Radio Button	Yes No			Equals Yes	6 questions						
	Question	Que_071675	Que_071675	Delete extra space before (for example)	What are some warning signs/behaviors that you might be in crisis or nearing crisis? (for example, what is different when you are in crisis? What does a bad day look like for your emotional health)	Text Box		Yes									

	Question	Que_071676	Que_071676		How will you or others know when you are entering crisis?	Text Box		Yes									
	Question	Que_071677	Que_071677		When you are in crisis, who can help or support you to keep you and others around you safe?	Text Box		Yes									
	Question	Que_071678	Que_071678		When your are in crisis, what can you or others do to help? What has helped in the past?	Text Box		Yes									
	Question	Que_071679	Que_071679		Is there anyone who needs to be taken care of in your household when you are in crisis? (Kids, Pets, others your care for)	Text Box		Yes									
	Question	Que_071680	Que_071680		What do you need to do as a next step? *Consider removal of harmful objects (pills, weapons, etc.) *Who is a safe person for you to contact, spend time with? *Do you need to call your doctor for an urgent appointment? *Have there been changes in	Text Box		Yes									
	Question	Que_071681	Que_071681			Resource(s) and Contact Information	Text Box										
	Question		Que_071682			Behavioral health conclusions	Text Box										
	Generic Control		Gen_07176	ER/IP Utilization and Physical Health Crisis Plan													
	Question	Que_071683	Que_071683	Alphabetize answer list as shown	If you have been to the emergency room or urgent care in the past 3 months, what caused you to go?	Checkbox	No visits within past 3 months After office hours, non-holiday/weekend During office hours and didn't call physician office During office hours and physician unable to accommodate Enrollee Emergent or urgent care needed Enrollee doesn't have a physician or PCP Holiday/weekend hours Nurse/24 hr. Advice Line referred Physician referred Other (Text Box -> "Specify other:")	Yes									
	Question	Que_071685	Que_071685		In the past year, have you been admitted to the hospital?	Radio Button	Yes No Did not respond/ not sure	Yes		Equal Yes	6 Questions						
	Question	Que_071686	Que_071686		Do you have any planned hospital admissions?	Radio Button	Yes **(Text Box -> Specify details:")** No Did not respond/ not sure	Yes									
	Question	Que_071687	Que_071687		Care Manager Prompt. Has the Enrollee had unplanned readmissions?	Radio Button	Yes (Text Box -> "Based on assessment of recent admissions, was Enrollee education needed? Specify details:") No	Yes									
	Question	Que_071688	Que_071688		Does this Enrollee have or need a Physical Health crisis plan to prevent unnecessary hospitalization or institutionalization?	Radio Button	Yes No	Yes									
	Question	Que_071689	Que_071689	Alphabetize answer list as shown	What is the area of need?	Checkbox	Evacuation Falls Fire Frequent ER Isolation Lack of Resources/Support Non-compliance Unplanned Hospitalization Wandering Other (All responses -> Text Box -> "Specify details:"	Yes									
	Question	Que_071690	Que_071690		Physical Health Crisis Plan Details:	Text Box		Yes									
	Question	Que_071691	Que_071691		Resource(s) and Contact Information	Text Box		Yes									
	Question	Que_071692	Que_071692		Is there a need for Transition Planning for this Enrollee?	Radio Button	Yes No	Yes									
	Question	Que_071693	Que_071693		Describe the Transition Plan details:	Text Box											
	Question	Que_071694	Que_071694		Resources/Settings of Care recommended to treating provider:	Text Box		Yes									
	Question	Que_071695	Que_071695		Responsible Party:	Text Box		Yes									
	Question	Que_071696	Que_071696		Target Date for Completion	DateTimePicker											
		Gen_07189		Benefits and Resources													
	Question		Que_071709		What legal documents do you have in place to capture your health care wishes, like healthcare power of attorney?	Checkbox	None Living Will Healthcare POA Financial POA Do Not Resuscitate (DNR) Organ/Tissue Donation Other PHI on File	Yes	If Other is selected, associate free text Label: Specify Other:								
	Question		Que_071710	Update answer	Care Manager prompt: Describe the appropriate education offered to the Enrollee/caregiver.	Checkbox	State Approved Advanced Directives 5 Wishes Website Enrollee/Caregiver Refused Other	Yes	If Other is selected, associate free text Label: Specify Other:								
	Question		Que_071608	Alphabetize answer list as shown	Care Manager prompt: Community resources discussed with Enrollee relevant to Enrollee needs.	Checkbox	Reviewed No resources needed Community Mental Health Resources Community Resources EAP/Wellness Services Financial Planning Life Planning and Decision Making for the Future Local Transportation Resources Nutrition/Food Support Palliative Care Social Worker Wellness Organizations Other	Yes	If Other is selected, associate free text Label: Specify Other:								
	Question		Que_072529		Describe the Enrollee's eligibility and availability for community resources provided or discussed:	Text Box		Yes									

				Alphabetize list remove service type option	What Community Resources where provided?	Check box	~~Service Type options for Non-Plan Payer:~~ 24-hour supports from a Medicaid Waiver Provider Area Agency on Aging (AAA) Behavioral Health Chemotherapy Developmental Therapy Dialysis DME Home Health Agency Services Hospice Medical Care Occupational Therapy Physical Therapy PPEC Private Duty Nursing Prosthetic Fitting Radiation Therapy Rehabilitative Special Education Services Other (textbox -> "Specify Other:")	Yes									
	Question		Que_072532		What eligible benefits did you discuss with the Enrollee relevant to the Enrollee's needs? Provide Detail of Enrollee's current benefits:	Text Box		Yes										
	Question		Que_072533		Are the benefits adequate, explain?:	Dropdown	Enrollee reports benefits are adequate, no needs identified Enrollee reports benefits are inadequate			Equals Enrollee reports benefits are inadequate	What Intervention did the CM use to fill gaps in benefits?						
	Question		Que_072534		What Intervention did the CM use to fill gaps in benefits?	Text Box		Yes										
	Question		Que_071723	23 Add N/A option with associated comments box	Verbal consent to share information with Enrollee's providers obtained, including the sharing of sensitive information for the purposes of care coordination. *Sensitive information includes behavioral health, substance use disorder, HIV, sexual assault/traumatic events.*	Radio Button	Yes No Not Applicable (text box --> "Comments:")	Yes										
	Question		Que_071724	23 Edit question and answer text	Attestation that this assessment and plan of care were reviewed and updated either verbally or in person with the Enrollee, and that copies of the plan of care have been made available to the Enrollee and only with Enrollee's consent above, to their PCP. (For FL MMA select Not applicable as this question is not required)	Radio Button	Yes No Not Applicable	Yes	If No or N/A is selected, associate free text Label "Specify details:"								

Element ID: (ICS Use Only)	Mandatory	Conditional

Branching Condition	Branching Location	PROD ()	QA2 ()
Que_999087 Contains Cardiovascular	Que_999088 Que_999089		
Que_999087 Contains Respiratory	Que_999093 Que_999094		
Que_999087 Contains Endocrine	Que_999098 Que_999099		
Que_999087 Equals Musculoskeletal	Que_999103 Que_999104		
Que_999087 Equals Gastrointestinal	Que_999109 Que_999110		
Que_999087 Contains Neurological	Que_999113 Que_999114		
Que_999087 Contains Renal	Que_999117 Que_999118		
Que_999087 Contains Blood/Hematological	Que_999121 Que_999122		
Que_999087 Contains Infectious Disease	Que_999125 Que_999126		
Que_999087 Contains Skin/Integumentary	Que_999129 Que_999130		
Que_999087 Contains Reproductive	Que_999133 Que_999134		
Que_999087 Contains Eyes, Ears, Nose, Throat	Que_999140 Que_999141		
Que_999087 Contains Cancer	Que_999144 Que_999145		
Que_999087 Contains Rare Diseases	Que_999148 Que_999054		
Que_999087 Contains Behavioral Health	Que_999151 Que_999152		
Que_999088 Equals Congestive Heart Failure	Que_999194		
Que_999088 Equals Coronary Artery Disease	Que_999194		
Que_999093 Contains COPD	Que_999195		
Que_999098 Contains Diabetes	Que_999196		