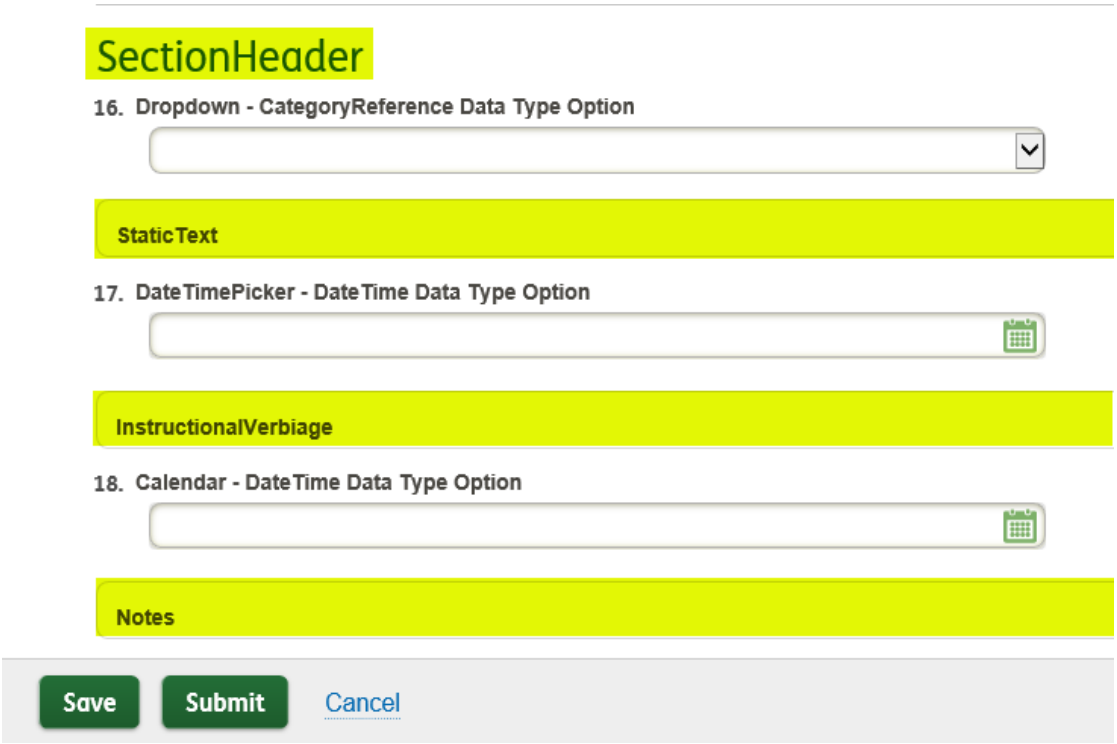
Instruction Guide for Completing the CGX Assessment Template
If you are adding a new care plan, please see the Assessment Template tab
The instruction tab has some definitions that may be helpful in your Assessment request
If you are making updates to a current assessment, please attach the prior assessment 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.

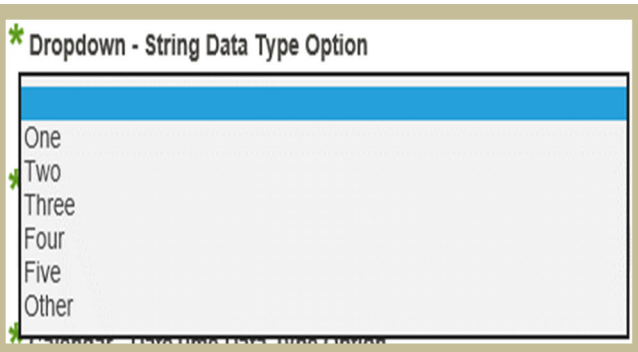
Static Text, Instructional Verbiage, and Notes - all three behave the same in CGX 2.0 (see

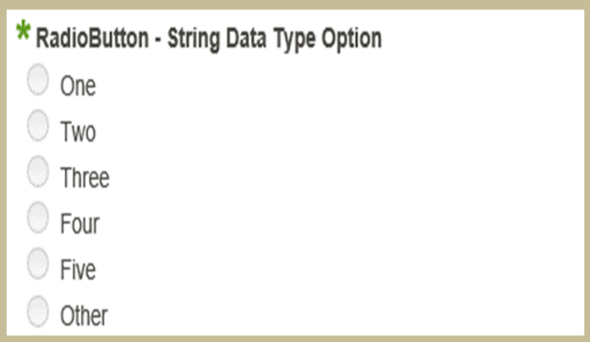


Question Type: Checkbox, Textbox, Multi Select Dropdown, Radio Button, Dropdown, Date Time Picker, or Calendar

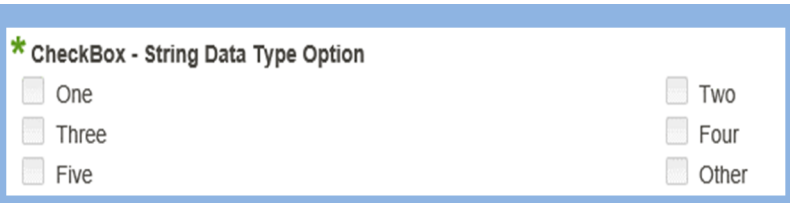
4 Question Types	
1. Single Select Question Types	Allows for only one response to be selected from the available list of options.
Dropdown	Best for > 3 responses
RadioButton	Best use for 2-3 responses; good for mandatory type questions that you want your users to answer
2. Multiple Select Questions Types	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	

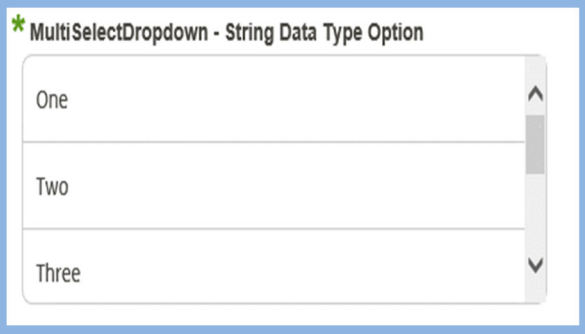
Examples of Single Select Question Types (Drop down and Radio Button)



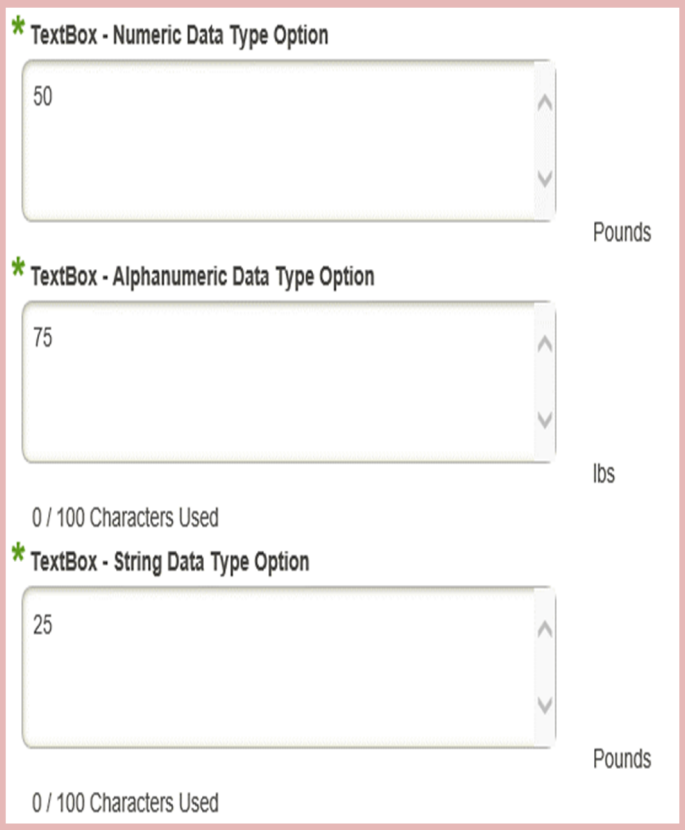


Examples of Multi-Select Question Types (Check Box and Multi-Select Drop down)



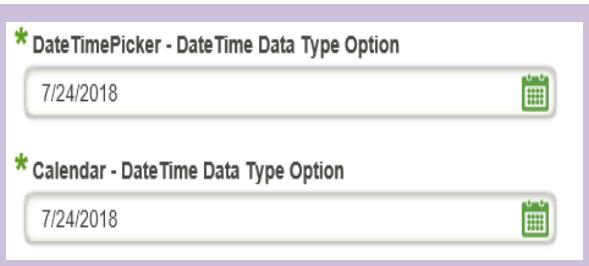


Examples of Text Box Question Types



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 Pediatric				**Department Owner:** Florida Only Medicare/ Medicaid			**Date to be Effective:** 01/01/2020		**Acuity Scoring Applicable:** No		**Exhaust To:** CDM						
Assessment ID: MEDTBD				**List any other departments utilizing this Assessment/Survey:** KY Medicaid			**Allow Referral:** No		**Carry Over:** Yes		**Is a Header Image required:** No						
Notes	**Question #**	**Element Type:**	**Element Id # (for ICS use**	**Associated Keywords**	**Question/Text (Text within the cell will be copied directly into the template. Please**	**Question Type:**	**Answer Options (List all answer options pertaining to question in one**	**Mandatory Yes/No**	**Branching Condition (for ICS use only)**	**Branching Location**	**Recommendations for Care Plan**	**Response that Prompts Care**	**Area of Focus**	**Problem**	**Goal**	**Potential Interventio**	
		Question			What do you think is the most important health concern at this time for the member?	TextBox		Yes									
		Generic Control			Authentication	SectionHeader											
		Generic Control			Care Manager Prompt: Are you a SCM? Complete authentication in Communication Record and then proceed to Comprehensive Survey	StaticText											
		Generic Control			Demographics	SectionHeader											
		Question			Do you have any religious and/or cultural beliefs that may influence your healthcare decisions for member? For example, are there any foods or medications that would be avoided? (If preferences identified, describe in comments)	CheckBox	Member/Caregiver/Parent reports no religious or cultural beliefs that may influence healthcare decisions Diet Medication Religious/cultural Blood products Other (Textbox -> on all items except "no")	Yes									
		Question			Care Manager prompt. Member Preferences and/or Alternate information created or updated?	RadioButton	Yes No	Yes									
		Question			What is Member/Parent/Caregiver preferred language for verbal communication?	CheckBox	English Spanish American Sign Language Arabic Armenian Chinese French French Creole German Greek Gujarati Hebrew Hindi Hmong Italian Japanese Korean Persian Polish Portuguese Russian Tagalog Urdu Vietnamese Yiddish Member Declined to State Other (TextBox -> "Specify other	Yes									
		Question			What is Member/Parent/Caregiver preferred language for written communication?	CheckBox	English Spanish American Sign Language Arabic Armenian Chinese French French Creole German Greek Gujarati Hebrew Hindi Hmong Italian Japanese Korean Persian Polish Portuguese Russian Tagalog Urdu Vietnamese Yiddish Member Declined to State Other (TextBox -> "Specify other	Yes									

		Question			Does member or Parent/Caregiver have any barriers or challenges to vision or hearing? Select appropriate dropdown and describe in comments.	MultiSelectDrop down	No vision or hearing deficits reported Vision Hearing Vision Screening completed (date picker and comment box on results) Hearing Screening completed (date picker and comment box on results) Comments (TextBox for all except "no" -> "Specify barriers or challenges:")	Yes								
		Generic Control		header	Caregiver & ADLs/IADLs	SectionHeader										
		Question			Does the member require any assistance with activities of daily living and who is providing care?	CheckBox	Self Parent/Guardian Family Member PDN services with HH PPEC (medical day care) Other (Textbox -> "Specify Other:"	Yes								
		Question			Identify ADLs member requires assistance with.	MultiSelectDrop down	Mobility Transfers (chair, bed) Eating Medication Administration Walking Dressing Grooming Bathing Toileting Managing Incontinence Shopping Cooking Stooping/Crouching/Kneeling Carrying Heavy objects (like a sack of potatoes) Other (Textbox -> "Specify Other:") Branch all selections (independent,	Yes	Independent Dependent (comment box)							
		Question			Care Manager prompt: If any of the 6 ADLs are identified as a need, describe status and plan in detail for each. (Bathing, dressing, toileting, transferring, feeding, and continence)	TextBox										
		Question			Care Manager Summary: Document current caregiver status and assistance provided. If caregiver assistance is not adequate, provide additional details.	TextBox										
		Generic Control		Advanced Directives	Advanced Directives	SectionHeader										
		Question			What legal documents do you have in place to capture member's health care wishes, like healthcare power of attorney? In comments box, elaborate on status of legal documents.	CheckBox	None PHI on File Guardianship Living Will Healthcare POA Financial POA Do Not Resuscitate (DNR) Organ/Tissue Donation Comments (Textbox -> "Specify Comments")	Yes								
		Question			Care Manager prompt: Describe the appropriate education offered to the member/caregiver.	CheckBox	State Approved Advanced Directives Provided Humana.com for Life Planning Forms Medical Foster Care limited with life planning decisions Member/Caregiver Refused Other (Textbox -> "Specify Other:"	Yes								
		Generic Control		header	Child's Social History	SectionHeader										
		Question			Current School/Work history	MultiSelectDrop down	Age appropriate grade Below age appropriate grade Above age appropriate grade Dropped out of school Home schooled Hospital Home Bound Medical Day Care (PPEC) Public school Private school College/Technical/University Daycare/Preschool Employed Unemployed Vocational Rehab Disabled None Individualized Education Plan (IEP) Other (TextBox -> "Other:")	Yes									

		Question			Does the parent/guardian have any concerns about member's development such as:	CheckBox	Activity Bed Wetting Behavior Patterns Discipline Picky Eating Change in Appetite Toileting Friends School Bullying Sexuality Sleep Use of Social Media Video Gaming Use of Caffeine/Energy Drinks Overuse of Electronics Other All responses text box to "Specify	Yes								
		Question			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 and Contact Information.	MultiSelectDrop down	Agency for Persons with Disabilities (APD) Autism Waiver Child Care Assistance Program Early Intervention Head Start Individualized Education Program (IEP) Intellectual and Developmental Disabilities Waiver (ICD/IDD) Medical Day Care (PPEC) Medical Foster Care Traumatic Brain Injury Waiver Other	Yes	all **selecions** should have comment box to provide contact information/case manager name, except "not involved or enrolled"								
		Question			Describe the Enrollee's family structure and living situation:	Checkbox	Lives at home with parents Multiple generation household Foster care Medical Foster Care Adopted Lives with guardian Lack of supervision Runaway Homeless	Yes	Comment box for all selections								
		Generic Control		header	Member Perception of Health	SectionHeader											
		Generic Control		header	Healthy Days	SectionHeader											
		Question			Now thinking about member's physical health, which includes physical illness and injury, for how many days during the past 30 days was member's physical health not good?	Dropdown	Don't know/Not sure Member/Parent/Guardian refused 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 26	Yes								

		Question			Now thinking about member's mental health, which includes stress, depression, and problems with emotions (bullying, self mutilating, sleep issues, bedwetting, destructive behavior, suicidal ideations), for how many days during the past 30 days was member's mental health not good?	Dropdown	Don't know/Not sure Member/Parent/Guardian refused Member under 2 years of age, unable to assess 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	Yes								
		Generic Control		header	Social Determinants of Health	SectionHeader												
		Generic Control		static text	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.	StaticText												
		Question			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: Within the past 12 months, we worried whether our food would run out before we got money to buy more. Was that Often true, Sometimes true, or Never true for you?	RadioButton	Often true Sometimes true Never true	Yes										
		Question			Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Was that Often true, Sometimes true, or Never true for you?	RadioButton	Often true Sometimes true Never true	Yes										
		Question			What transportation help does member/parent/guardian need with getting places, for example, to get to member's doctor appointments or pharmacy?	CheckBox	None Doctor appointments Pharmacy General needs (errands, groceries, etc.) Resides in Skilled Nursing Facility, transportation provided Other (Textbox -> "Specify other:")	Yes										
		Question			What is keeping member from getting places they need to go?	CheckBox	Caregiver unavailability Unable to use transportation due to constraints of childcare for other children No access to Car Seat/Booster No available public transportation Financial issues No access to handicap transportation Other (Textbox -> "Specify other:")	Yes										
		Question			What trouble do you as the Member or Parent/Caregiver have paying for your monthly expenses such as rent, heating, or electric bills?	CheckBox	None Trouble paying rent/mortgage Does not have housing, living with friends/family/hotel Does not have housing, living in car/shelter Heat/Electric Water Resides in Skilled Nursing Facility, services covered Other (Textbox -> "Specify other:")	Yes										
		Question			What kinds of care do you as the Member or Parent/Caregiver have problems accessing? For example, getting an appointment to see member's PCP.	CheckBox	None PCP appointments Specialty appointments Access to a vision provider HHC access Dental care Behavioral Health care Therapies (PT, OT, ST) Access to a Pharmacy Access to PPEC (Medical Day Care) Other (TextBox -> "Specify Other:")	Yes										

		Question			Care Manager prompt: Community resources discussed with member/parent/caregiver relevant to member needs. If community resource need is identified, elaborate on status and plan for each need. (Eligibility and availability of resources).	CheckBox	Community resources reviewed, member reports no needs identified Life Planning and Decision Making for the Future Nutrition/Food Support Palliative Care Local Transportation Resources Community Mental Health Resources Community Resources Wellness Organizations Social Worker Comments (TextBox -> "for all selections")	Yes								
		Generic Control		header	DME/HHC	SectionHeader										
		Question			What kinds of medical equipment does member require to have in the home?	CheckBox	None Wheelchair Oxygen Pulse Oximeter/Apnea Monitor Ventilator Tracheostomy Supplies Nebulizer BiPAP/CPAP Walker Bedside Commode Shower Chair Glucometer Feeding Tube Supplies Cane/Crutches Grab Bars Hospital Bed Blood Pressure Monitor Hoyer Lift Chair Lift Emergency Response Device	Yes	Branches to next questions for all selections except "none"							
		Question			What challenges does member/parent/caregiver have with equipment?	RadioButton	None Knowledge deficit Unable to obtain Delivery issues Not using - not working Not using - issues with space or renter rules Not using - prefers not to use No longer needs Other (TextBox -> "for all selections")	Yes								
		Question			Has member's doctor ordered any home health services?	RadioButton	Yes No Unsure	Yes	Branches to next question for "yes"							
		Question			Has member/parent/caregiver had any difficulty scheduling home health services?	RadioButton	Yes (comment box) No	Yes								
		Question			Care Manager Prompt: Were any issues with current services identified and addressed?	RadioButton	No - Current services and DME are adequate. No further action required No - Gaps identified but member declines assistance Yes - Gaps closed Yes - Gaps not closed or ongoing follow up to close gaps (Comment Box for "yes" selections)	Yes								
		Generic Control		header	Health & Well-being/Healthy Behaviors	SectionHeader										
		Generic Control		medication	Medications	SectionHeader										
		Generic Control			I am going to review member's list of medications we have in our system, and we will make updates as needed.	StaticText										
		Generic Control			Care Manager prompt: Update the Medication List in the proper system for your team, if member/caregiver/parent responses are different than what is on the list. Document dosage, route of administration and frequency in the directions field as well as prescriber, and indication. Make sure to include over-the-counter (OTCs) and meds taken only on an as-needed basis.	StaticText										

		Question			Do you have any worries about or problems with member's medicines?	CheckBox	None Coverage issues with Prior Authorization Financial concerns Transportation issues Forgot to refill Lack of perceived need Problems/issues with medication side effects Other (TextBox -> "all selections, except none")	Yes									
		Generic Control		header	Providers and Appointments	SectionHeader												
		Question			Was the most recent well baby/child exams completed?	Dropdown	Yes No Unsure (comment box to explain)	Yes									
		Question			Date of last well baby/child exam, month (if unsure of exact date, document as first day of the month)	DateTimePicker		Yes									
		Generic Control		static text	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 Yearly for children >30 months												
		Question			Is child up to date on immunizations?	Dropdown	Yes No Unsure (comment box to explain)	Yes									
		Question			List reasons/barriers to Immunizations, Periodicity Schedule, Screenings	MultiSelectDropdown	Cultural Barriers Finance Lack of community resources Lack of parental knowledge Lack of support system Language barriers Transportation Other (comment box to explain)	Yes									
		Question			Does member see any specialist doctors (other than member's primary provider)?	RadioButton	Yes No	Yes	Branches to next question for "yes"								
		Question			What are their names, and what are they treating member for?	TextBox		Yes									
		Generic Control			Care Manager prompt: Advise member/parent/caregiver to contact customer service to update provider information if appropriate or provide guidance on finding a physician	InstructionalVeriage											
		Generic Control		nutrition	Nutrition	SectionHeader											
		Question			Child's current diet:	MultiSelectDropdown	Breast feeding Bottle feeding G-tube feeding Finger Foods Pureed Diet Regular Diet Other (comment box to explain)	Yes									
		Question			Has doctor advised member to be on a special diet?	CheckBox	Regular diet/none Breastfeeding with supplementation of formula Formula (special needs) Allergy/Sensitivity Diet Tube Feeding Cardiac diet Low sodium diet Fluid restricted diet Low fat diet Diabetic diet High calorie/high protein diet Renal without potassium Renal with potassium Sleeve gastrectomy diet Roux-en-y gastric bypass diet	Yes									
		Question			What difficulties does member have following recommended diet?	CheckBox	None Financial/fixed income Lack of knowledge/understanding Cultural Emotional/psychological/eating disorder Inability to read Lack of time Multiple chronic conditions Inability to follow recommendations Other (TextBox -> "Specify Other")	Yes									
		Generic Control		dental	Dental	SectionHeader											
		Question			Has member been to the dentist in the last 6 months?	RadioButton	Yes No	Yes	Branches to next question for "yes"								

		Question			Were there problems or concerns with member's mouth, teeth or ability to swallow?	Dropdown	Yes (comment box) No	Yes									
		Generic Control		header	Pain/Opioids	SectionHeader											
		Question			Does member experience/complain of any pain?	RadioButton	Yes No Uncertain	Yes	Branches to next questions for "yes"								
		Question			Where is the member's pain located?	TextBox		Yes									
		Question			Is member able to describe the pain?	CheckBox	Dull Sharp Stabbing Tingling Throbbing Burning Unable to describe Other (TextBox -> "Specify Other:")	Yes									
		Question			How often is member experiencing pain?	Dropdown	Daily but not constantly Less often than daily All the time With activity or movement Uncertain	Yes									
		Question			Is this new or worsening pain?	Dropdown	New Worsening Not new, no worsening Uncertain	Yes									
		Question			Is member able to describe pain level on scale of 1 (no pain) to 10 (severe pain)	Dropdown	1 2 3 4 5 6 7 8 9 10 Unable to rate on numeric scale	Yes									
		Question			Does member's pain effect ability to do the things they normally would do?	Dropdown	Yes (comment box) No	Yes									
		Question			Does member have a treatment plan?	CheckBox	Yes (branch to right for selections) No	multiselect	Non-narcotic pain medication Narcotic pain medication Transcutaneous electrical nerve stimulation (TENS) Nerve block/trigger point injection Implantable device Rehabilitation Cognitive therapy (relaxation training, biofeedback, etc.) Physical Therapy Working with Pain Management Provider Medication Assisted Therapy (MAT) Yoga Other (TextBox ->									
		Question			What is the treatment plan?	MultiSelectDropdown	Non-narcotic pain medication Narcotic pain medication Transcutaneous electrical nerve stimulation (TENS) Nerve block/trigger point injection Implantable device Rehabilitation Cognitive therapy (relaxation training, biofeedback, etc.) Physical Therapy Working with Pain Management Provider Medication Assisted Therapy (MAT) Yoga									
		Question			Care Manager prompt: What follow-up actions do you need to take based on the pain assessment?	CheckBox	Member denies pain Contact physician Use medication as prescribed Other medical treatment as prescribed For chest pain, keep member on line and consider 911 Consultation Member chooses not to address pain Pain severity doesn't warrant intervention at this time Other (TextBox -> "Specify Other:")	Yes									
		Generic Control		header	Health History/ Utilization	SectionHeader											
		Generic Control		Senior Products	Birth History	StaticText											

		Question			Gestational age at delivery in weeks (answer for members up to age 1 yo)	Dropdown	22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 N/A-does not apply to member age	Yes								
		Question			Birth weight grams (answer for members up to age 1 yrs)	Dropdown	N/A does not apply to member age group <1500-2498g <2499g(5 lb 7 oz) >2500g(5 lb 8 oz)	Yes								
		Question			If NICU admit occurred, length of stay (answer for members up to age 1 yo)	Dropdown	No admission to NICU Less than or equal to 7 days 8-10 days 11-14 days 15-30 days 31-59 days 60-89 days Over 90 days N/A-does not apply to member age	Yes	all responses branch to next question, except "No admissions to NICU and N/A)							
		Question			NICU admission reason if applicable (answer for members up to age 1 yo)	MultiSelectDropdown	Anemia Apneic and/or Bradycardia spells Bronchopulmonary Dysplasia/Chronic Lung Disease Cardiac Defects Congenital Abnormalities GERD Hyperbilirubinemia Intraventricular Hemorrhage Neonatal Abstinence Syndrome (NAS) Necrotizing Enterocolitis Respiratory Distress Syndrome Retinopathy of Prematurity Septicemia Other (TextBox -> "Comment:") N/A-does not apply to member age	Yes								
		Question			ECMO/Vent/CPAP (answer for members up to age 1 yo)	Dropdown	Yes No N/A-does not apply to member age	Yes								
		Generic Control		header	Child's Current Health Status	SectionHeader										
		URL			https://brightfutures.aap.org/Pages/default.aspx for Pediatric Guidelines.com	Url										
		Question			Height, feet	TextBox		Yes								
		Question			Height, inches	TextBox		Yes								
		Question			Current weight (pounds)	TextBox		Yes								
		URL			https://nccd.cdc.gov/dnpabmi/calculator.aspx	Url										
		Question			BMI Results for members <19 years of age:	Dropdown	Underweight- Less than 5th percentile Healthy Weight- 5th percentile to <85th percentile Overweight-85th to less than the 95th percentile Obese-Equal or >95th percentile N/A member is greater than 19 years of age	Yes								
		Question			BMI Results for member >19 years of age:	Dropdown	Underweight - BMI < 18.5 Healthy Weight - BMI is 18.5 to 24.9 Overweight - BMI is 25.0 to 29.9 Obese - BMI is 30.0 or higher N/A member is less than 19 years of age	Yes								
		Generic Control		header	Health Systems Review	SectionHeader										

		Generic Control		health history	Would you mind sharing with me medical conditions that member has been treated for in the past as well as those conditions that member is currently being treated for?	StaticText										
		Generic Control		health history	Care Manager Prompt: CheckBox any systems for which member has a history of conditions and complete branching related question below	StaticText										
		Question			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	Yes	Positive response to any category opens up to further questions for each category. Except "denies any conditions"	See "Design (CTX Only) tab for conditional branching for Health System Review						
		Question			Cardiovascular condition details	CheckBox	A-Fib Aortic aneurysm and dissection Aortic stenosis Arrhythmias Atrioventricular canal Atrial septal defect Bacterial endocarditis Berlin Heart Cardiomyopathy Chest pain Chest wall deformities Cholesterol Coarctation of the aorta Congenital heart disease Congestive heart failure Coronary Artery Disease Heart murmurs High blood pressure High cholesterol Hypertension Hypoplastic left heart syndrome Kawasaki disease Marfan syndrome Myocardial Infarction (MI) Pacemaker Patent ductus arteriosus Pericarditis Pulmonary atresia	Yes	Each selection has branching to choose "current or past" multi select--see next row							
		Question			Cardiac condition status	MultiSelectDropdown	Current Past	Yes								
		Question			Respiratory condition details	CheckBox	Apnea Asthma Bronchopulmonary Dysplasia Chronic Bronchitis Congenital abnormalities of airway and lung development (comment box) COPD Cystic Fibrosis Emphysema Pneumonia Sleep Apnea Reactive airway disease Respiratory Syncytial Virus (RSV) infection Respiratory Failure Tracheostomy Dependent Ventilator Dependent Rare lung diseases (comment box) Other (TextBox -> "Specify other")	Yes	Each selection has branching to choose "current or past" multi select--see next row							
		Question			Respiratory condition status	MultiSelectDropdown	Current Past	Yes								

		Question			Endocrine condition details	CheckBox	Adrenal glands disorders Adrenoleukodystrophy Bone and mineral disorders Childhood obesity Diabetes Type 1 Diabetes Type 2 Electrolyte Imbalances (comment box to explain) Growth disorders Lipid disorders Multiple endocrine neoplasia, type 1 (MEN 1) Multiple endocrine neoplasia type2 (MEN 2) Pituitary disorders Puberty disorders Rare Endocrine Disorders Turner Syndrome	Yes	Each selection has branching to choose "current or past" multi select--see next row							
		Question			Endocrine condition status	MultiSelectDropdown	Current Past	Yes									
		Question			Musculoskeletal condition details	CheckBox	Back problems Cervical stenosis Craniosynostosis Hip Dysplasia Joint Replacement Juvenile Rheumatoid Arthritis Muscular Dystrophy Osteoarthritis (Degenerative Joint Disease) Osteogenesis Imperfecta Osteoporosis Rare Musculoskeletal disorders Scoliosis Torticollis	Yes	Each selection has branching to choose "current or past" multi select--see next row							
		Question			Musculoskeletal condition status	MultiSelectDropdown	Current Past	Yes									
		Question			Gastrointestinal condition details	CheckBox	Appendicitis Celiac Disease Chronic constipation/diarrhea Crohn's Gastritis GERD GI bleed Hepatitis Hernia (comment box to provide type) Inflammatory Bowel Disease Irritable Bowel Syndrome Lactose Intolerance Pancreatitis Pyloric Stenosis Short Bowel Syndrome Ulcerative Colitis Ulcers Rare Gastrointestinal Diseases Other (TextBox -> "Specify Other:")	Yes	Each selection has branching to choose "current or past" multi select--see next row							
		Question			Gastrointestinal condition status	RadioButton	Current Past	Yes									

		Question			Neurological condition details	CheckBox	Acute Disseminated Encephalomyelitis Aneurysms Arterial Dissection Autism Spectrum Disorders Brain Injury Brain Tumors Cavernous Malformations Cerebral Palsy and Spasticity Charcot-Marie-Tooth Disease Congenital Brain Malformations Craniofacial abnormalities Devic's Disease Epilepsy Guillain Barre Syndrome Hydrocephalus Moyamoya Multiple Sclerosis Muscular Dystrophy Neonatal Hypoxic Ischemic Encephalopathy Optic Neuritis Paralysis Post Concussive Syndrome Seizures Spinal Muscular Atrophy Spina Bifida Stroke	Yes	Each selection has branching to choose "current or past" multi select--see next row								
		Question			Neurological condition status	RadioButton	Current Past	Yes								
		Question			Renal condition details	CheckBox	Chronic Kidney Disease Congenital Kidney condition (comment box) End Stage Renal Disease Incontinence Kidney stones Nephrotic Syndrome Nephritic Syndrome Polycystic Kidney Disease Urinary Tract Infection (UTI) Vesicoureteral reflux Rare Renal Conditions	Yes	Each selection has branching to choose "current or past" multi select--see next row	**Nephritic is correct**							
		Question			Renal condition status	MultiSelectDropdown	Current Past	Yes								
		Question			Hematological condition details	CheckBox	Anemia Clotting disorder Hemophilia Iron Deficiency Rare Hematological Condition Sickle Cell Anemia Thrombocytopenia	Yes	Each selection has branching to choose "current or past" multi select--see next row								
		Question			Hematological condition status	MultiSelectDropdown	Current Past	Yes								
		Question			Infectious Disease condition details	CheckBox	Clostridium Difficile (C Diff) Hepatitis HIV/AIDS Lyme disease Lymphadenopathy Meningitis MRSA Osteomyelitis Septicemia Tuberculosis Recurrent infections UTI Rare infectious disease (ext box to explain) Other Infectious Disease(TextBox ->	Yes	Each selection has branching to choose "current or past" multi select--see next row								
		Question			Infectious Disease condition status	RadioButton	Current Past	Yes								

		Question			Skin condition details	CheckBox	Burns Cellulitis Decubiti Dermatitis (text box for details) Eczema Epidermolysis Bullosa Fungal skin infections (text box for details) Non-surgical wound Psoriasis Rare skin condition/disease (text box for details) Stevens Johnson Syndrome Other Skin **conditions** (TextBox ->	Yes	Each selection has branching to choose "current or past" multi select--see next row								
		Question			Skin condition status	RadioButton	Current Past	Yes								
		Question			Reproductive condition details	CheckBox	Congenital Ambiguous Genitalia Congenital Reproductive Track Abnormality (includes: vagina, cloacal, cervix, uterus, ovaries, fallopian tubes, hymen, genital, penis, testicles, vas deferens) (text box to explain) Hormonal Abnormality (text box to explain) Inguinal hernia Polycystic ovaries Pregnancy STDs (text box for details) Uterine bleeding Rare reproductive conditions (text box to explain) Other (TextBox -> "Specify other:")	Yes	Each selection has branching to choose "current or past" multi select--see next row								
		Question			Reproductive condition status	RadioButton	Current Past	Yes								
		Question			EENT condition details	CheckBox	Adenoiditis and Adenoid Hypertrophy Amblyopia Blindness Childhood Glaucoma Cholesteatoma and other Chronic Ear Problems Chronic sinusitis Cleft Lip / Palate Congenital Abnormalities of the Ear Dysphasia Epistaxis (nose bleeds)Cataracts Facial Nerve Injuries/Paralysis Glasses/Contacts Hearing disorder Hearing aids Laryngopharyngeal Reflux Lump or Mass in the Neck Nasal congestion Nasal Deformities Nasal Obstruction Parathyroid Diseases Ptosis Thyroid Diseases Tonsillitis Traumatic Injuries to the Head and Neck Vocal Cord Paralysis Vocal hoarseness	Yes	Each selection has branching to choose "current or past" multi select--see next row								
		Question			EENT condition status	RadioButton	Current Past	Yes								
		Question			Cancer condition details	CheckBox	Brain Breast Bone Colon Liver Lung Multiple Myeloma Non-Hodgkin's Lymphoma Oral Ovarian Pancreas Prostate Skin	Yes	Each selection has branching to choose "current or past" multi select--see next row								
		Question			Cancer condition status	RadioButton	Current Past	Yes								

		Question			I am going to go through a list with you now. Has the doctor ever told you that the member has any of these uncommon conditions? (Note to associate: these are the rare diseases.)	CheckBox	ALS Chronic inflammatory demyelinating polyneuropathy (CIDP) Juvenile Dermatomyocitis Myasthenia Gravis Scleroderma Systemic Lupus	Yes	Each selection has branching to choose "current or past" multi select--see next row								
		Question			Rare Disease condition status	RadioButton	Current Past	Yes									
		Question			Behavioral Health condition details	CheckBox	Anxiety Attention-Deficit/Hyperactivity Disorder (ADHD) Bipolar Disorder Conduct Disorder (CD) Depression Eating Disorder (binging, anorexia, bulimia) Obsessive-Compulsive Disorder (OCD) Oppositional Defiant Disorder (ODD) Post-traumatic Stress Disorder (PTSD) Schizophrenia/Schizoaffective disorder Self Harm/Self Mutilate Substance Use Disorder (SUD) Suicide Attempt Tourette Syndrome	Yes	Each selection has branching to choose "current or past" multi select--see next row								
		Question			Behavioral Health condition status	RadioButton	Current Past	Yes									
		Question			What major surgeries has the member had?	TextBox		Yes									
		Generic Control		Health Risk Assessment	Cognitive for members 14 years of age and older	SectionHeader											
		Question			Prior to asking Cognitive questions, care manager to obtain consent from parent to speak with member (minor child, under 18yo) if applicable.	RadioButton	Consent obtained to speak with member (minor) Parent/Guardian refused/and or member (child) unavailable for member (child) to respond and Parent/Guardian will provide responses for cognitive questions Member >18 years old, consent not applicable											
		Question			What is your date of birth?	RadioButton	Correct response Incorrect response Unable to assess (comment box)	Yes									
		Question			What year is this?	RadioButton	Correct response Incorrect response Unable to assess (comment box)	Yes									
		Question			What is your zip code?	RadioButton	Correct response Incorrect response Unable to assess (comment box)	Yes									
		Question			Who is the President of the United States?	RadioButton	Correct response Incorrect response Unable to assess (comment box)	Yes									
		Question			Care Manager prompt: Are any cognitive deficits noted?	Dropdown	Alert and oriented, able to listen, process information and respond appropriately. Requires prompting (cueing, repetition, reminders) when under stress or in a new situation Requires assistance and direction in specific situations or consistently requires low stimulus environment due to distractibility Requires routine direction. Is not alert and oriented or is unable to maintain attention and recall directions more than half the time Unable to engage due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium	Yes									
		Generic Control		header	Behavioral Health	SectionHeader											
		Generic Control		Sr Dia	Depression Screening	SectionHeader											
		Generic Control		HGB	Over the past 30 days, how often has the member been bothered by any of the following problems?	StaticText											
		Question			How often does member feel left out at school, activities, or social settings?	RadioButton	Member under 5 years of age, unable to assess Not at all Several days More than half the days Nearly everyday	Yes									

		Question			How often does member feel isolated from others or experiencing bullying?	RadioButton	Member under 5 years of age, unable to assess Not at all Several days More than half the days Nearly everyday	Yes									
		Question			Feeling down, depressed, hopeless, or little interest or pleasure in doing things (such as issues with school, friends, activities, playing, eating, sleeping)	Dropdown	Member under 5 years of age, unable to assess Not at all Several days More than half the days Nearly everyday	Yes									
		Question			Care Manager prompt: The member or parent/guardian has reported several days or more for above questions. What additional actions did you take?	CheckBox	Member/Parent/Guardian refused Behavioral Health Referral Refer to Behavioral Health Provider Refer to Social Worker Member already engaged with BH Provider Other (TextBox -> "Specify other:")	Yes									
		Generic Control		header	Behavioral Health Risk	SectionHeader											
		Generic Control		hedis	Tobacco Use	SectionHeader											
		Question			Is the member exposed to second hand smoke or use tobacco products?	RadioButton	Yes No Did not respond	Yes	Branch to next question when "yes" selected								
		Question			What kind of tobacco is member exposed to or use?	CheckBox	Pipes Cigars Cigarettes Electronic Cigarettes/Vaping Smokeless Tobacco	Yes									
		Question			How often is member exposed to or use tobacco products?	Dropdown	Daily Often Seldom	Yes									
		Question			Care Manager prompt: Has smoking cessation education been given to parent/caregiver/member?	RadioButton	Yes No all responses comment box	Yes									
		Generic Control		Header	CRAFFT Part A (CRAFFT-Car, Relax, Alone, Forget, Friends, Trouble)												
		Question			Prior to asking CRAFFT Parts A and B questions, care manager to obtain consent from parent to speak with member (minor child, under 18yo) if applicable.	RadioButton	Consent obtained to speak with member (minor) Parent/Guardian refused/and or member (child) unavailable for member (child) to respond and Parent/Guardian will provide responses for CRAFFT questions Member >18 years old, consent not applicable											
		Question			Drink any alcohol (more than a few sips)? Do not count sips of alcohol taken during family or religious events.	RadioButton	Yes No Declines to Answer Unable to assess (comment box)	Yes	Yes branches to below questions under Header CRAFFT Part B								
		Question			Smoke any marijuana or hashish?	RadioButton	Yes No Declines to Answer Unable to assess (comment box)	Yes	Yes branches to below questions under Header CRAFFT Part B								
		Question			Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	RadioButton	Yes No Declines to Answer Unable to assess (comment box)	Yes	Yes branches to below questions under Header CRAFFT Part B								
		Generic Control		header	CRAFFT Part B (CRAFFT-Car, Relax, Alone, Forget, Friends, Trouble)												
		Question			Have you ever ridden in a car driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	RadioButton	Yes No Declines to Answer	Yes									
		Question			Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?	RadioButton	Yes No Declines to Answer	Yes									
		Question			Do you ever use alcohol or drugs while you are by yourself, or alone?	RadioButton	Yes No Declines to Answer	Yes									
		Question			Do you ever forget things you did while using alcohol or drugs?	RadioButton	Yes No Declines to Answer	Yes									
		Question			Do your family or friends ever tell you that you should cut down on your drinking or drug use?	RadioButton	Yes No Declines to Answer										
		Question			Have you ever gotten into trouble while you were using alcohol or drugs?	RadioButton	Yes No Declines to Answer	Yes									
		Question			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 Yes to 4 or more questions, this is categorized as Substance Abuse Dependence. Describe the CM intervention for supporting the Enrollee	TextBox--2500 characters		Yes									

		Generic Control		header	ER/IP Utilization	SectionHeader										
		Question			If member has been to the emergency room or urgent care, or Inpatient Admission in the past 3 months, what caused member to go?	MultiSelectDropdown	No visits within past 3 months Emergent or urgent care needed Member doesn't have a physician or PCP/Pediatrician During office hours and physician unable to accommodate member During office hours and didn't call physician office After office hours, non-holiday/weekend Holiday/weekend hours Physician referred 24h Nurse Line provided	Yes								
		Question			Care Manager prompt. If recent within 30 days, ER or Inpatient utilization has been identified, would you like to link out to the Post Discharge ER RT Survey?	Dropdown	Yes No, Survey completed for identified utilization	Yes	Branch to SCM--Post Discharge ER RT Survey	Que_999205							
		Question			Care Manager prompt. Based on assessment of recent admissions and/or ER utilization was member, parent/guardian education needed?	RadioButton	Yes (comment box) No	Yes									
		Generic Control		Header	Summary and Conclusions	SectionHeader											
		Question			Care Manager prompt: What eligible benefits did you discuss with member, parent/guardian relevant to the member needs?	MultiSelectDropdown	24h Nurse Line Behavioral Health Benefit Meal Benefit Expanded Benefits Choice Counseling Humana Pharmacy OTC Benefit Transfer to Customer Service for Claims assist Transfer to Customer Service for Verification Of Benefits Transportation Benefit Benefits not available to meet member needs Benefits/resources are adequate Other - explain (Textbox -> *Specify	Yes								
		Question			Care Manager prompt: Evaluate and describe current status of the member's benefits. If there is a gap in benefits, explain	TextBox		Yes									
		Question			Care Manager prompt: Assess the member's status for social determinants of health that are negatively impacting the member's overall health and describe plan. For example, social isolation, food insecurity, housing, finances, education, transportation, safety	TextBox		Yes									
		Question			Care Manager prompt: After assessing the member , what did you identify as the member's major health concerns, event, and/or diagnoses that qualify the member for complex care management?	TextBox		Yes									

Element ID: (ICS Use Only)	Mandatory	Conditional

Branching Condition	Branching Location	PROD ()	QA2 ()