DEL Report
Data Element Assessment Version Report

Note: * indicates an empty value.

Assessment Instrument: HIS

Assessment Version: 3.00.0

Assessment Item ID	Question Text	Response Code - Response Text	Item Use(s)	Changed since Last Assessment
A0050	Type of Record	1-Add new assessment/record 2-Modify existing record 3-Inactivate existing record	*	N
A0100	Facility Provider Numbers	*	*	N
A0100A	National Provider Identifier (NPI)	^-Blank (not available or unknown) Text-National Provider Identifier (NPI)	*	N
A0100B	CMS Certification Number (CCN)	Text-CMS Certification Number (CCN)	*	N
A0205	Site of Service at Admission	01-Hospice in {patient's/resident's} home/residence 02-Hospice in Assisted Living facility 03-Hospice provided in Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF) 04-Hospice provided in Skilled Nursing Facility (SNF) 05-Hospice provided in Inpatient Hospital 06-Hospice provided in Inpatient Hospice Facility 07-Hospice provided in Long Term Care Hospital (LTCH) 08-Hospice in Inpatient Psychiatric Facility 09-Hospice provided in a place not otherwise specified (NOS) 10-Hospice home care provided in a hospice facility	*	N
A0220	Admission Date	MMDDYYYY--Admission date	QM	N
A0245	Date Initial Nursing Assessment Initiated	MMDDYYYY-Date initial nursing assessment initiated --Not assessed/no information	*	N
A0250	Reason for Record	01-Admission 09-Discharge	QM	N
A0270	Discharge Date	^-Blank (skip pattern) MMDDYYYY--Discharge date	QM	N
A0500	Legal Name of Patient	*	*	N
A0500A	First name.	Text-{Patient/Resident/Person} First name	*	N
A0500B	Middle initial	^-Blank (not available or unknown) Text-{Patient/Resident/Person} Middle initial	*	N
A0500C	Last name	Text-{Patient/Resident/Person} Last name	*	N
A0500D	Suffix	^-Blank (not available or unknown) Text-{Patient/Resident/Person} Suffix	*	N

Note: * indicates an empty value.

Assessment Instrument: HIS

Assessment Version: 3.00.0

Assessment Item ID	Question Text	Response Code - Response Text	Item Use(s)	Changed since Last Assessment
A0550	Patient ZIP Code	Text-{Patient/Resident/Person} Zip Code	*	N
A0600	Social Security and Medicare Numbers	*	*	N
A0600A	Social Security Number	^-Blank (not available or unknown) Text-{Patient/Resident/Person} Social security number	*	N
A0600B	Medicare number (or comparable railroad insurance number)	^-Blank (not available or unknown) Text-{Patient/Resident/Person} Medicare number or Medicare Beneficiary Identifier (MBI)	*	N
A0700	Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient	^-Blank (not available or unknown) +-Enter "+" if Medicaid application is pending N-Enter "N" if not a Medicaid Recipient Text-{Patient/Resident/Person} Medicaid number	*	N
A0800	Gender	1-Male 2-Female	*	N
A0900	Birth Date	MMDDYYYY-{Patient/Resident/Person} Birth date MMYYYY-{Patient/Resident/Person} Birth date (if day of month is unknown) YYYY-{Patient/Resident/Person} Birth date (if month and day unknown)	QM	N
A1000	Race/Ethnicity. Check all that apply	A-American Indian or Alaska Native B-Asian C-Black or African American D-Hispanic or Latino E-Native Hawaiian or Other Pacific Islander F-White --Not assessed/no information	*	N
A1400	Payor Information: Check all that apply	A-Medicare (traditional fee-for-service) B-Medicare (managed care/Part C/Medicare Advantage) C-Medicaid (traditional fee-for-service) D-Medicaid (managed care) G-Other government (e.g., TRICARE, VA, etc.) H-Private Insurance/Medigap I-Private managed care J-Self-pay K-No payer source X-Unknown Y-Other	*	N

Note: * indicates an empty value.

Assessment Instrument: HIS

Assessment Version: 3.00.0

Assessment Item ID	Question Text	Response Code - Response Text	Item Use(s)	Changed since Last Assessment
A1802	Admitted From. Immediately preceding this admission, where was the patient?	01-Community residential setting (e.g., private home/apt., board/care, assisted living, group home, adult foster care) 02-Long-term care facility (LTC) 03-Skilled Nursing Facility (SNF) 04-Hospital emergency department 05-Short-stay acute hospital (IPPS) 06-Long-term care hospital (LTCH) 07-Inpatient rehabilitation facility or unit (IRF) 08-Psychiatric hospital or unit 09-ID/DD Facility 10-Hospice 99-None of the above	*	N
A2115	Reason for Discharge	01-Expired 02-Revoked 03-No longer terminally ill 04-Moved out of hospice service area 05-Transferred to another hospice 06-Discharged for cause	*	Y
F2000	CPR Preference	*	*	N
F2000A	Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)?	0-No 1-Yes, and discussion occurred 2-Yes, but the {patient/resident/person}/responsible party refused to discuss	QM	N
F2000B	Date the patient/responsible party was first asked about preference regarding the use of CPR	^-Blank (skip pattern) MMDDYYYY-Date the {patient/resident/person}/responsible party was first asked about preference regarding the use of CPR --Not assessed/no information	QM	N
F2100	Other Life-Sustaining Treatment Preferences	*	*	N
F2100A	Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR?	0-No 1-Yes, and discussion occurred 2-Yes, but the {patient/resident/person}/responsible party refused to discuss	QM	N

Note: * indicates an empty value.

Assessment Instrument: HIS

Assessment Version: 3.00.0

Assessment Item ID	Question Text	Response Code - Response Text	Item Use(s)	Changed since Last Assessment
F2100B	Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR	^-Blank (skip pattern) MMDDYYYY-Date the {patient/resident/person}/responsible party was first asked about preferences regarding life-sustaining treatment other than CPR --Not assessed/no information	QM	N
F2200	Hospitalization Preference	*	*	N
F2200A	Was the patient/responsible party asked about preference regarding hospitalization?	0-No 1-Yes, and discussion occurred 2-Yes, but the {patient/resident/person}/responsible party refused to discuss	QM	N
F2200B	Date the patient/responsible party was first asked about preference regarding hospitalization	^-Blank (skip pattern) MMDDYYYY-Date the {patient/resident/person}/responsible party was first asked about preference regarding hospitalization --Not assessed/no information	QM	N
F3000	Spiritual/Existential Concerns	*	*	N
F3000A	Was the patient and/or caregiver asked about spiritual/existential concerns?	0-No 1-Yes, and discussion occurred 2-Yes, but the {patient/resident/person}/responsible party refused to discuss	QM	N
F3000B	Date the patient and/or caregiver was first asked about spiritual/existential concerns	^-Blank (skip pattern) MMDDYYYY-Date the {patient/resident/person} and/or caregiver was first asked about spiritual/existential concerns --Not assessed/no information	QM	N
I0010	Principal Diagnosis	01-Cancer 02-Dementia/Alzheimer's 99-None of the above	*	N
J0900	Pain Screening	*	*	N
J0900A	Was the patient screened for pain?	0-No 1-Yes	*	N
J0900B	Date of first screening for pain	^-Blank (skip pattern) MMDDYYYY-Date of first screening for pain --Not assessed/no information	QM	N

Note: * indicates an empty value.

Assessment Instrument: HIS

Assessment Version: 3.00.0

Assessment Item ID	Question Text	Response Code - Response Text	Item Use(s)	Changed since Last Assessment
J0900C	The patient's pain severity was	0-None 1-Mild 2-Moderate 3-Severe 9-Pain not rated ^-Blank (skip pattern) --Not assessed/no information	QM	N
J0900D	Type of standardized pain tool used	1-Numeric 2-Verbal descriptor 3-{Patient/Resident/Person} visual 4-Staff observation 9-No standardized tool used ^-Blank (skip pattern) --Not assessed/no information	QM	N
J0905	Pain Active Problem. Is pain an active problem for the patient?	0-No 1-Yes	*	N
J0910	Comprehensive Pain Assessment	*	*	N
J0910A	Was a comprehensive pain assessment done?	0-No 1-Yes ^-Blank (skip pattern)	*	N
J0910B	Date of comprehensive pain assessment	^-Blank (skip pattern) MMDDYYYY-Date of comprehensive pain assessment --Not assessed/no information	QM	N
J0910C	Comprehensive pain assessment included: Check all that apply	1-Location 2-Severity 3-Character 4-Duration 5-Frequency 6-What relieves/worsens pain 7-Effect on function or quality of life 9-None of the above ^-Blank (skip pattern) --Not assessed/no information	QM	N
J2030	Screening for Shortness of Breath	*	*	N

Note: * indicates an empty value.

Assessment Instrument: HIS

Assessment Version: 3.00.0

Assessment Item ID	Question Text	Response Code - Response Text	Item Use(s)	Changed since Last Assessment
J2030A	Was the patient screened for shortness of breath?	0-No 1-Yes	*	N
J2030B	Date of first screening for shortness of breath	^-Blank (skip pattern) MMDDYYYY-Date of first screening for shortness of breath --Not assessed/no information	QM	N
J2030C	Did the screening indicate the patient had shortness of breath?	0-No 1-Yes ^-Blank (skip pattern) --Not assessed/no information	QM	N
J2040	Treatment for Shortness of Breath	*	*	N
J2040A	Was treatment for shortness of breath initiated?	0-No 1-No, {patient/resident/person} declined treatment 2-Yes ^-Blank (skip pattern)	QM	N
J2040B	Date treatment for shortness of breath initiated	^-Blank (skip pattern) MMDDYYYY-Date treatment for shortness of breath initiated --Not assessed/no information	QM	N
J2040C	Type(s) of treatment for shortness of breath initiated: Check all that apply	1-Opioids 2-Other medication 3-Oxygen 4-Non-medication ^-Blank (skip pattern) --Not assessed/no information	*	N
N0500	Scheduled Opioid	*	*	N
N0500A	Was a scheduled opioid initiated or continued?	0-No 1-Yes	QM	N
N0500B	Date scheduled opioid initiated or continued	^-Blank (skip pattern) MMDDYYYY-Date scheduled opioid initiated or continued --Not assessed/no information	QM	N
N0510	PRN Opioid	*	*	N
N0510A	Was a PRN opioid initiated or continued?	0-No 1-Yes	*	N

Note: * indicates an empty value.

Assessment Instrument: HIS

Assessment Version: 3.00.0

Assessment Item ID	Question Text	Response Code - Response Text	Item Use(s)	Changed since Last Assessment
N0510B	Date PRN opioid initiated or continued	^-Blank (skip pattern) MMDDYYYY-Date PRN opioid initiated or continued --Not assessed/no information	*	N
N0520	Bowel Regimen	*	*	N
N0520A	Was a bowel regimen initiated or continued?	0-No 1-No, but there is documentation of why a bowel regimen was not initiated or continued 2-Yes ^-Blank (skip pattern)	QM	N
N0520B	Date bowel regimen initiated or continued	^-Blank (skip pattern) MMDDYYYY-Date bowel regimen initiated or continued --Not assessed/no information	QM	N
Z0400	Signature(s) or Person(s) Completing the Record	*	*	N
Z0400A	Signature, Title, Sections, Date Section Completed: A	Text-Signature	*	N
Z0400B	Signature, Title, Sections, Date Section Completed: B	Text-Signature	*	N
Z0400C	Signature, Title, Sections, Date Section Completed: C	Text-Signature	*	N
Z0400D	Signature, Title, Sections, Date Section Completed: D	Text-Signature	*	N
Z0400E	Signature, Title, Sections, Date Section Completed: E	Text-Signature	*	N
Z0400F	Signature, Title, Sections, Date Section Completed: F	Text-Signature	*	N
Z0400G	Signature, Title, Sections, Date Section Completed: G	Text-Signature	*	N
Z0400H	Signature, Title, Sections, Date Section Completed: H	Text-Signature	*	N
Z0400I	Signature, Title, Sections, Date Section Completed: I	Text-Signature	*	N
Z0400J	Signature, Title, Sections, Date Section Completed: J	Text-Signature	*	N

DEL Report
Data Element Assessment Version Report

Note: * indicates an empty value.

Assessment Instrument: HIS

Assessment Version: 3.00.0

Assessment Item ID	Question Text	Response Code - Response Text	Item Use(s)	Changed since Last Assessment
Z0400K	Signature, Title, Sections, Date Section Completed: K	Text-Signature	*	N
Z0400L	Signature, Title, Sections, Date Section Completed: L	Text-Signature	*	N
Z0500	Signature of Person Verifying Record Completion	*	*	N
Z0500A	Signature	Text-Signature	*	N
Z0500B	Date	MMDDYYYY-Signature Date	*	N