PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. HOPE is a patient assessment instrument that intends to collect data during a hospice patient's stay. Data collected using this instrument will be used to measure the quality of care provided by a hospice provider. The valid OMB control number for this information collection is 0938-1153. Submission of this data is required by Section 1814(i)(5) of the Social Security Act. The time required to complete this data collection per item set is estimated to average 41 minutes for the Admission, 22 minutes for the Hope Update Visit, and 9 minutes for the Discharge, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the data collected. Submitted patient-level data will remain confidential and is protected from public dissemination in accordance with the Privacy Act of 1974, as amended. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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HOPE Update Visit

Section A Administrative Information

A0050. Type of Record

Enter Code ☐

1. Add new record
2. Modify existing record
3. Inactivate existing record

A0100. Facility Provider Numbers

A. **National Provider Identifier (NPI):**

☐☐☐☐☐☐☐☐☐☐

B. **CMS Certification Number (CCN):**

☐☐☐☐☐☐■■■■■■

A0220. Admission Date

☐☐ ☐☐ ☐☐☐☐

Month Day Year

A0250. Reason for Record

Enter Code ☐

1. Admission (ADM)
2. HOPE Update Visit 1 (HUV1)
3. HOPE Update Visit 2 (HUV2)
9. Discharge (DC)

A0500. Legal Name of Patient

A. **First name:**

B. **Middle initial:**

C. **Last name:**

D. **Suffix:**

A0600. Social Security and Medicare Numbers

A. **Social Security Number:** ___ – ___ – ____

B. **Medicare Number:**

A0700. Medicaid Number

Enter " +" if pending, "N" if not a Medicaid Recipient

A0810. Sex

Enter Code

1. Male
2. Female

A0900. Birth Date

Month Day Year

A1400. Payer Information

↓ Check all existing payer sources that apply at the time of this assessment
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

Section J | Health Conditions

J0050. Death is Imminent

Enter Code	
☐	**At the time of this assessment and based on your clinical assessment, does the patient appear to have a life expectancy of 3 days or less?** 0. **No** 1. **Yes**

J2050. Symptom Impact Screening

Enter Code ☐

A. **Was a symptom impact screening completed?**

0. **No** — Skip to M1190, Skin Conditions
1. **Yes**

B. **Date of symptom impact screening:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

J2051. Symptom Impact

Over the past 2 days, how has the patient been affected by each of the following symptoms? Base this on your clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others.

Coding:
0. Not at all – symptom does not affect the patient, including symptoms well-controlled with current treatment
1. Slight
2. Moderate
3. Severe
9. Not applicable (the patient is not experiencing the symptom)

	Enter Code ↓
A. **Pain**	☐
B. **Shortness of breath**	☐
C. **Anxiety**	☐
D. **Nausea**	☐
E. **Vomiting**	☐
F. **Diarrhea**	☐
G. **Constipation**	☐
H. **Agitation**	☐

J2052. Symptom Follow-up Visit (SFV) (complete only if any response to J2051 Symptom Impact = 2. Moderate or 3. Severe)

Enter Code

An in-person **Symptom Follow-up Visit (SFV)** should occur within 2 calendar days as a follow-up for any moderate or severe pain or non-pain symptom impact identified during Symptom Impact assessment at Admission or HOPE Update Visit (HUV).

A. **Was an in-person SFV completed?**
   0. **No** — Skip to J2052C, Reason SFV Not Completed.
   1. **Yes**

B. **Date of in-person SFV** — Complete and skip to J2053, SFV Symptom Impact.

Month Day Year

Enter Code

C. **Reason SFV not completed** — Skip to M1190, Skin Conditions.
   1. Patient and/or caregiver declined an in-person visit.
   2. Patient unavailable (e.g., in ED, hospital, travel outside of service area, expired).
   3. Attempts to contact patient and/or caregiver were unsuccessful.
   9. None of the above

J2053. SFV Symptom Impact

Since the last Symptom Impact assessment was completed, how has the patient been affected by each of the following symptoms? Base this on your observations and/or clinical assessment (including input from patient and/or caregiver). Symptoms may impact multiple patient activities including, but not limited to, sleep, concentration, day to day activities, or ability to interact with others.

Coding:
0. Not at all – symptom does not affect the patient, including symptoms well-controlled with current treatment
1. Slight
2. Moderate
3. Severe
9. Not applicable (the patient is not experiencing the symptom)

	Enter Code ↓
A. **Pain**	
B. **Shortness of breath**	
C. **Anxiety**	
D. **Nausea**	
E. **Vomiting**	
F. **Diarrhea**	
G. **Constipation**	
H. **Agitation**	

Section M | Skin Conditions

M1190. Skin Conditions	
Enter Code	**Does the patient have one or more skin conditions?**
☐	0. **No** - Skip to N0500, Scheduled Opioid 1. **Yes**

M1195. Types of Skin Conditions	
Indicate which following skin conditions were identified at the time of this assessment.	
↓ Check all that apply	
☐	A. Diabetic foot ulcer(s)
☐	B. Open lesion(s) other than ulcers, rash, or skin tear (cancer lesions)
☐	C. Pressure Ulcer(s)/Injuries
☐	D. Rash(es)
☐	E. Skin tear(s)
☐	F. Surgical wound(s)
☐	G. Ulcers other than diabetic or pressure ulcers (e.g., venous stasis ulcer, Kennedy ulcer)
☐	H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)
☐	Z. None of the above were present

M1200. Skin and Ulcer/Injury Treatments	
Indicate the interventions or treatments in place at the time of this assessment.	
↓ Check all that apply	
☐	A. Pressure reducing device for chair
☐	B. Pressure reducing device for bed
☐	C. Turning/repositioning program
☐	D. Nutrition or hydration intervention to manage skin problems
☐	E. Pressure ulcer/injury care
☐	F. Surgical wound care
☐	G. Application of nonsurgical dressings (with or without topical medications) other than to feet
☐	H. Application of ointments/medications other than to feet
☐	I. Application of dressings to feet (with or without topical medications)
☐	J. Incontinence Management
☐	Z. None of the above were provided

Section N | Medications

N0500. Scheduled Opioid

Enter Code ☐

A. **Was a scheduled opioid initiated or continued?**

0. **No** — Skip to N0510, PRN Opioid
1. **Yes**

B. **Date scheduled opioid initiated or continued:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

N0510. PRN Opioid

Enter Code ☐

A. **Was PRN opioid initiated or continued?**

0. **No** — Skip to N0520, Bowel Regimen
1. **Yes**

B. **Date PRN opioid initiated or continued:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

N0520. Bowel Regimen (Complete only if N0500A or N0510A=1)

Enter Code ☐

A. **Was a bowel regimen initiated or continued?** - Select the most accurate response

0. **No** — Skip to Z0350. Date Assessment was Completed
1. **No, but there is documentation of why a bowel regimen was not initiated or continued —** Skip to Z0350. Date Assessment was Completed
2. **Yes**

B. **Date bowel regimen initiated or continued:**

☐☐ ☐☐ ☐☐☐☐
Month Day Year

Section Z Record Administration

Z0350. Date Assessment was Completed

Month Day Year

Z0400. Signature(s) of Person(s) Completing the Record

I certify that the accompanying information accurately reflects patient assessment information for this patient and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that reporting this information is used as a basis for payment from federal funds. I further understand that failure to report such information may lead to a payment reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

Signatures	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of Person Verifying Record Completion

A. **Signature**

_____

B. **Date**

Month Day Year