HOPE is on the way!

What it means for your agency and how to prepare.

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Purpose of the Session

Objectives

1. Gain a clear understanding of the HOPE assessment and its significance in hospice care.
2. Explore the key changes from HIS to HOPE.
3. Understand the implementation process of the HOPE assessment.
4. Discuss the impact of the HOPE assessment on hospice care and how to prepare now.

What is the HOPE Assessment?

1

Definition and Overview

The HOPE (Hospice Outcomes & Patient Evaluation) Assessment is a comprehensive tool used to evaluate and document patient needs and outcomes in hospice care.

It is designed to ensure a holistic approach to patient care, addressing physical, emotional, spiritual, and social needs.

2

History and Development

The HOPE Assessment was developed in response to the need for standardized patient care assessments in hospice settings. It was collaboratively created by healthcare professionals, including doctors, nurses, social workers, and other caregivers.

Medicare saw a need for updating their processes for ensuring proper care.

Importance of HOPE in Hospice Care

Patient-Centered Care

This change ensures that care plans are tailored to the unique needs of each patient.

This personalized approach helps to improve the quality of life for patients and their families.

Improved Care Coordination

The assessment aims to facilitate better communication among interdisciplinary (IDG) team members, patients, and families.

This open and honest communication helps to build trust and support.

Quality Improvement

The HOPE Assessment provides data for evaluating and improving the quality of care provided.

This data helps to identify areas for improvement and ensure that patients receive the best possible care.

Regulatory Compliance

The HOPE Assessment helps meet regulatory requirements and standards for hospice care.

This ensures that patients receive the appropriate level of care and that hospice programs are operating within legal guidelines.

HOPE beyond the assessment.

Caring for the entire patient.

Components of the HOPE Assessment

1

Physical Needs

Includes an assessment of pain levels, symptoms, and physical discomfort. It also involves monitoring and management of medication and treatments.

2

Emotional Needs

Evaluates the patient's emotional well-being, including anxiety, depression, and coping mechanisms. It also means providing psychological support and counseling as needed.

3

Spiritual Needs

The HOPE assessment understands and respects the patient's spiritual beliefs and practices. It also offers spiritual care resources and chaplaincy services.

4

Social Needs

The HOPE assessment assesses social support systems, including family and community connections. It also addresses practical needs such as legal and financial concerns.

HOPE is on the Way!

Quality Measures:

- Two new process measures will be implemented using HOPE data:
    a. Timely Reassessment of Pain Impact
    b. Timely Reassessment of Non-Pain Symptom Impact

These measures will assess whether patients with moderate or severe symptoms are reassessed within two calendar days from the initial visit.

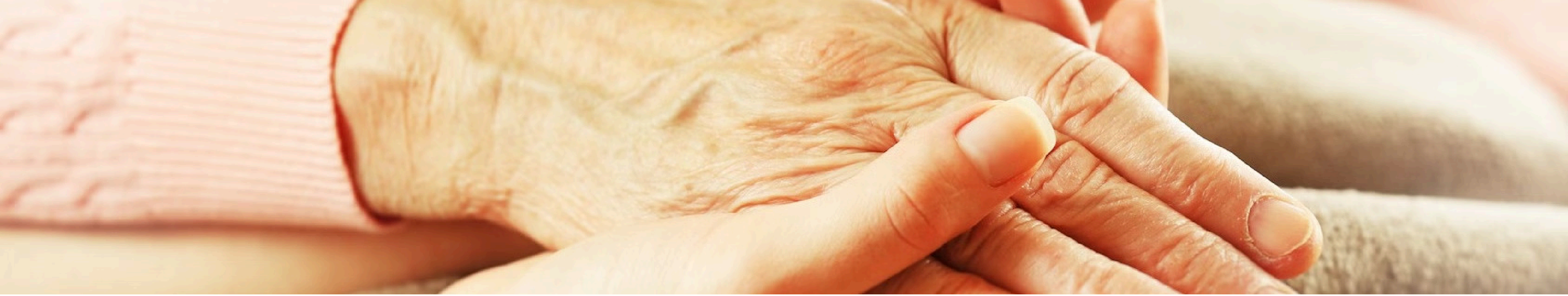
HOPE data will not affect star ratings right away.

While data collection begins October 1, 2025, it will not impact outcome scoring and public reporting until fiscal year 2028 (starting October 1, 2027).

Currently, **star ratings rely heavily on CAHPS survey results**. The introduction of HOPE will provide additional quality data to potentially inform future star ratings.

The HOPE tool will replace the current Hospice Item Set (HIS), providing more comprehensive patient-level data throughout a hospice stay, rather than just at admission and discharge.

HOPE data will be collected at multiple points: **admission, update visits, and discharge**. This more frequent data collection could provide a more nuanced view of hospice quality for future star ratings.



HOPE is on the Way!

1 **Implementation and Compliance**:

The tool will officially take effect on October 1, 2025. It will be part of the Hospice Quality Reporting Program (HQRP) and will require hospices to submit data within 30 days of specific events, such as admission and discharge.

90% of HOPE data must be transmitted and accepted into the CMS database within 30 days of the event or completion date.

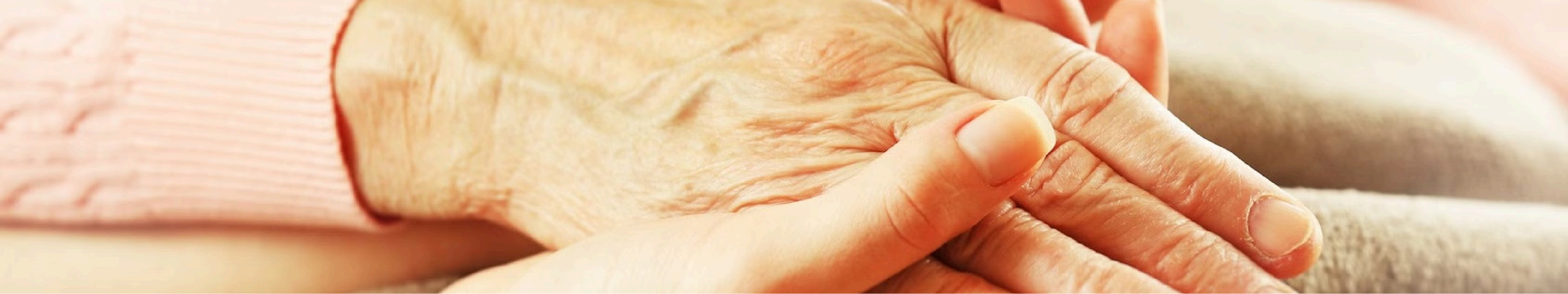
Compliance with timely data submission is crucial, as failure to meet the 90% threshold could result in a 4% payment reduction in subsequent years.

Applicable Patients Completion of HOPE records (formerly HIS) applies to all patient admissions to a Medicare-certified hospice program regardless of the following:

- Payer source (Medicare, Medicaid, or private payer)
- Patient age
- Where the patient receives hospice services, such as a private home, nursing home, assisted living, or hospice inpatient facility.
- Hospice LOS

2 **Assessment Schedule:**

- An admission assessment by nurse is due day of admission.
- Upon admission, your agency has 5 days to have your Chaplin, Social Worker, Bereavement Coordinator in to see the patient.
- Two case manager or nursing visits update visits (Hospice Update Visit): one between days 6 and 15, and another between days 16 and 30, if the patient remains in hospice care for at least 17 days.
- A nurse or LPN would need to see a patient two days after an HUV, for a "symptom follow up visit", if a patient shows moderate or severe pain or uncontrolled symptoms.
- A discharge assessment.



Continued

1

Data Collection and Reporting:

The tool will collect demographic, screening, and clinical data elements to provide a comprehensive assessment of hospice patients.

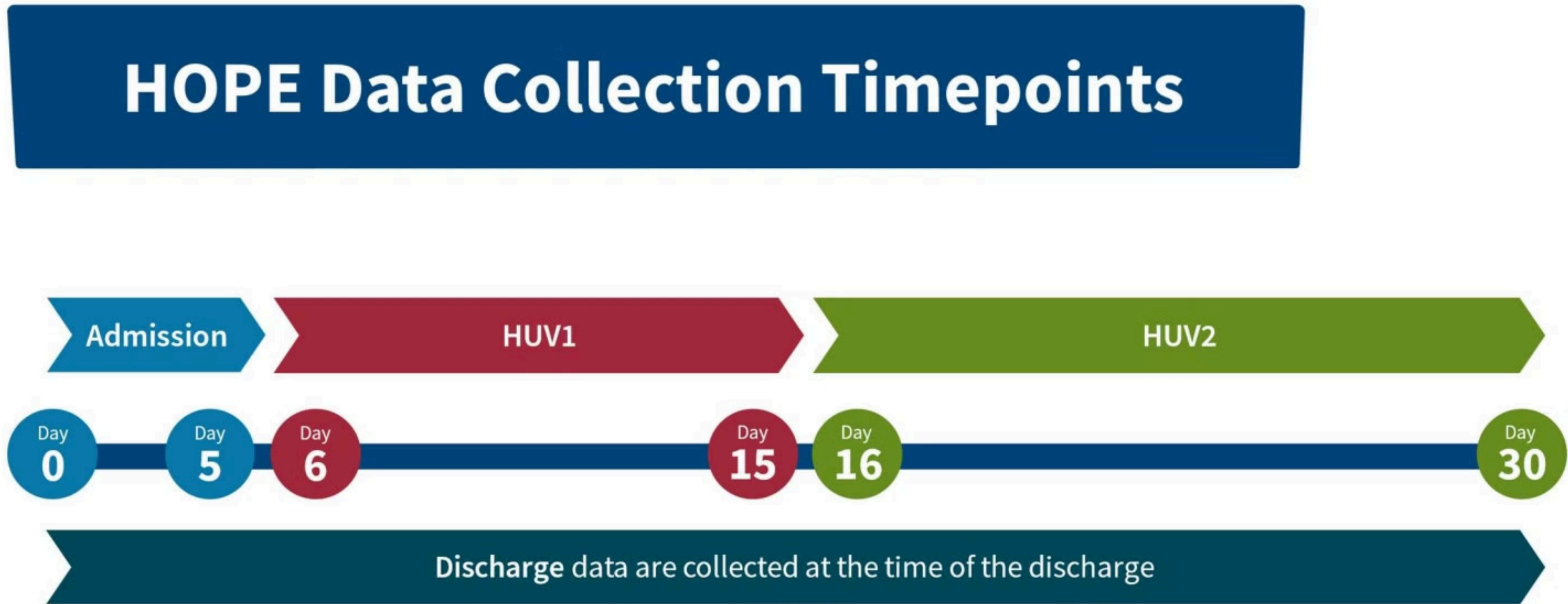
The data collected will contribute to quality measures and public reporting, although outcome scoring and public reporting will not begin until the fiscal year 2028.

2

Transition:

- For all patient admissions on or after July 1, 2014, and prior to October 1, 2025, completion of a HIS Admission and Discharge record is required.
- For all patient admissions on or after October 1, 2025, the HOPE-Admission, HOPE Update Visit (HUV, if applicable), and Discharge records should be fully and accurately completed.

Figure 1: HOPE Data Collection Timepoints



By structuring these timepoints (HUV1 and HUV2) within the first month, hospice care teams can create timely and responsive care plans for the patient, ensuring their comfort and well-being are consistently addressed.

Figure 2: HOPE-Admission Record Flow Chart

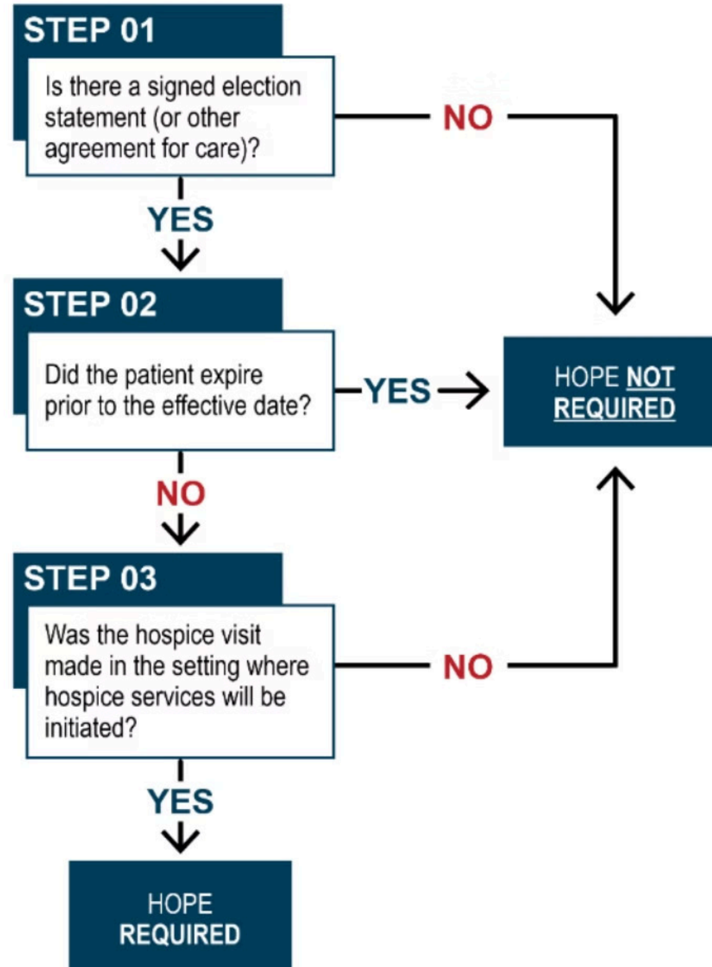


Table 1: Determining the Need to Complete the HUV Timepoints

Scenario	If	Then	Rationale
Death/discharge day 0 to 5	The patient dies or is discharged within five days after the effective date of the hospice election (A0220 + 5).	HUV1 is not required.	No HUV is expected due to the short LOS.
Day 5 of hospice stay	It has been five days since the effective date of the hospice election (A0220 + 5).	The HUV is not required. It is too early to complete HUV1.	HUV1 should not be completed within the first five days after the effective date of the hospice election.
Day 15 of the hospice stay	The patient is still on service on day 15 (A0220 + 15) and beyond.	HUV1 is required and accepted.	Updates to the plan of care via completion of HUV1 is required on or between days six and 15.
Day 30 of the hospice stay	The patient is still on service on day 30 (A0220 + 30) and beyond.	HUV2 is required and accepted.	Updates to the plan of care via completion of both HUVs are required. (on or between days six and 15 for HUV1 and on or between days 16 and 30 for HUV2).
Death/discharge day 10	The patient dies or is discharged on day 10 (A0220 + 10).	HUV1 is not required. The HUV1 record would be accepted if submitted.	The hospice may not have had an opportunity to complete HUV1 due to the death or discharge of the patient.

What sticks out to you and your team?

The new process measures for timely reassessment of pain and non-pain symptoms will encourage hospices to more closely monitor and address patient symptoms.

Symptom Impact (J2051): Collected during an Admission or Hospice Update Visit (HUV). If a patient rates their pain or non-pain symptoms as **moderate** or **severe**, it triggers the need for a follow-up visit.

- **Symptom Follow-up Visit (SFV)**:
- Expected within **two calendar days** after the Admission or HUV, in response to symptom severity.
- Must be **in-person** and **separate** from the Admission or HUV visit.
- Can occur **later the same day** as the original assessment or within the following two days.
- Up to **three SFVs** may be required over the course of a hospice stay, based on ongoing assessments during Admission and HUV.

Pain Management

The way you gauge your patients should be ESAS or something that will measure the pain scale?

J2051. Symptom Impact

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)

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

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 identified during Symptom Impact assessment at Admission or HOPE Update Visit (HUV).

Enter Code ☐

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

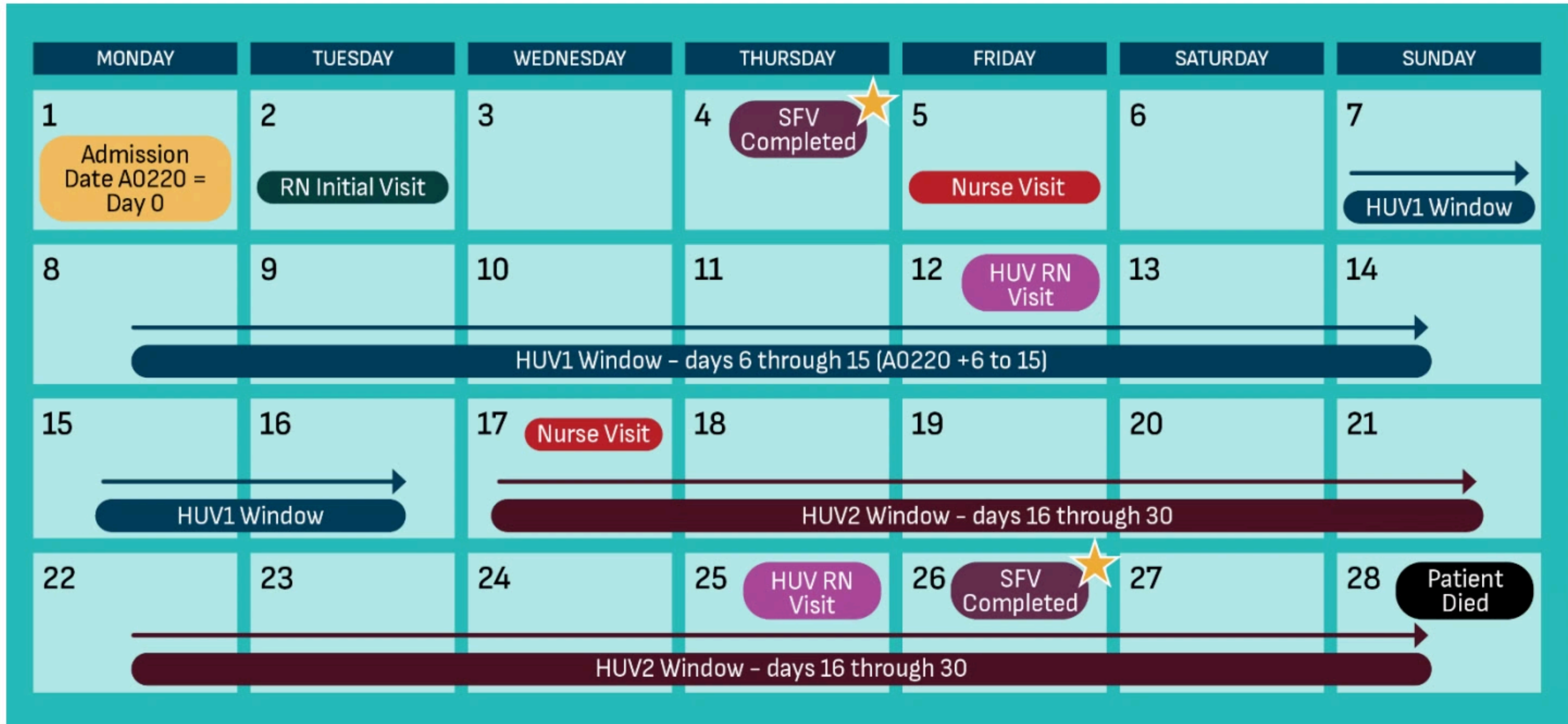
B. **Date of in-person SFV** — Complete and skip to J2053, SFV Symptom Impact.

☐☐ ☐☐ ☐☐☐☐
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

Calendar Depicting Completed HOPE-Admission, both HUV1 and HUV2, and SFVs when Triggered.



What is your agency doing to prepare for HOPE?

How will you manage your patients?

Implementation of the HOPE Assessment

Steps and Process

The HOPE assessment is implemented through a structured process. It begins with a comprehensive nursing assessment conducted at the time of hospice admission.

Does the family know what hospice means?

Opportunity for education to patient and family.

This establishes baseline data for the patient's spiritual, emotional, and practical needs.

Ongoing assessments are then conducted regularly to monitor changes and adjust care plans as needed.

IDG Team Approach

It requires the involvement of a multidisciplinary team. This team includes doctors, nurses, social workers, spiritual care providers, and other specialists.

The team works collaboratively to gather information, assess the patient's needs, and develop personalized care plans.

The transition to HOPE may initially create challenges for hospices, especially smaller ones, as they adapt to new assessment and reporting requirements. This could temporarily affect performance metrics.

Documentation and Care Planning

The findings from the HOPE assessment are carefully documented and integrated into the patient's overall care plan.

This ensures that the patient's spiritual, emotional, and practical needs are addressed holistically.

The care plan is reviewed and updated regularly to reflect the patient's evolving condition and needs.

Manual vs. Tech

Does your EMR have alerts set up to let the back office know about the symptoms to ensure a visit is made?

Example: EMRs already looking at depression, pain, shortness of breath.. etc.

Impact on Service Intensity Add-on (SIA)

The Service Intensity Add-on (SIA) is an additional payment made to hospices for direct patient care provided by a registered nurse (RN) or social worker during the last seven days of a patient's life.

The HOPE Assessment will provide a more comprehensive understanding of patient needs during the end-of-life phase, potentially influencing SIA payments.

By capturing detailed data on patient conditions and care provided, the assessment can help justify the need for SIA payments.

Best Practices for Implementing the HOPE Assessment

Effective communication is crucial for successful implementation of the HOPE Assessment. This includes clear and **compassionate communication with patients and families** about the purpose and process of the assessment. It also involves strategies for interdisciplinary team communication and collaboration.

Patient and family engagement is essential to ensure that their preferences and **needs are fully understood and respected**. This involves providing education and resources to help them understand the role of the assessment in care planning.

Continuous quality improvement is vital for optimizing the implementation and effectiveness of the HOPE Assessment. **This involves utilizing feedback from patients, families, and staff to identify areas for improvement.** It also includes regularly reviewing and updating training materials and protocols based on the latest evidence and best practices.

Timeline and Phases of the HOPE Assessment Rollout

Phased National Implementation

The HOPE Assessment rollout will be implemented in phases, starting with pilot programs and gradually expanding to a nationwide implementation. This phased approach allows for continuous evaluation and adjustments, ensuring a smooth and effective transition for hospice providers.

CMS Communication and Updates

CMS will provide regular updates to hospice providers throughout the rollout process. These updates will include webinars, newsletters, and official communications, keeping providers informed about the latest developments and any changes to timelines or requirements.

Provider Readiness and Preparation for Rollout

The successful implementation of the HOPE Assessment requires thorough preparation by providers.

This includes comprehensive training programs for staff to ensure they are familiar with the assessment tool and its application. Electronic health record (EHR) systems need to accommodate the new assessment data requirements. Additionally, internal policies and procedures should be revised to align with the new assessment standards.

Adequate staffing levels are crucial to manage the increased workload associated with the rollout.

Providers should plan for potential costs associated with training, system updates, and other implementation expenses. Access to CMS-provided resources, including training materials, technical assistance, and support hotlines, is essential.

Opportunities to connect with other providers to share experiences, challenges, and best practices during the rollout phase are also valuable.

Monitoring and Evaluation During Rollout

Continuous data collection and analysis will be conducted from Q1 2024 to Q2 2025 to monitor the effectiveness and impact of the HOPE Assessment. CMS will begin to analyze data from the early phases in Q3 2024 to make necessary adjustments and improvements.

Participating beta providers will be encouraged to provide feedback throughout 2024-2025, which will be critical in refining the tool and the implementation process.

Resources

HOPE | CMS

https://www.cms.gov/files/document/hope-guidance-manualv100.pdf

HospiceQualityQuestions@CMS.hhs.gov

CMS.gov/medicare/quality/hospice