SHP HIS V3.02 to HOPE V1.01 Crosswalk Guide

STRATEGIC HEALTHCARE PROGRAMS

Developed by **Strategic Healthcare Programs** • www.SHPdata.com

v1.2

SHP is pleased to provide a complete side-by-side comparison of the HIS V3.02 and HOPE V1.01 assessment forms. Items that have been **added**, **removed**, or that have **changed** between the two versions are indicated with color coding.
This document includes all items recorded at Admission (Admit), HOPE Update Visit (HUV), and Discharge (DC). Next to each item is a box listing the assessment reasons at which each item is recorded.

This guide is an excellent reference for anyone who works with the HIS and HOPE Assessments and will improve accuracy, help reduce errors, and potentially reduce the number of returned claims.
We recommend printing copies for your staff to aid in the transition to HOPE and beyond. **Note: When printing from browser, set the scale to "Fit to paper" in the print dialog box for best results.**

Item Summary

Item #	Sec.	Description	HIS 3.00 Time Points		Hope 1.00 Time Points			Notes
			Admit	DC	Admit	HUV	DC	
A0050	A	Type of Record	✓	✓	✓	✓	✓	
A0100	A	Facility Provider Numbers	✓	✓	✓	✓	✓	
A0205	A	Site of Service at Admission	✓					Item Removed
A0215	A	Site of Service at Admission			✓			Item Added
A0220	A	Admission Date	✓	✓	✓	✓	✓	
A0245	A	Date Initial Nursing Asmt Initiated	✓					Item Removed
A0250	A	Reason for Record	✓	✓	✓	✓	✓	Options Updated
A0270	A	Discharge Date		✓			✓	
A0500	A	Legal Name of Patient	✓	✓	✓	✓	✓	
A0550	A	Patient ZIP Code	✓	✓	✓			
A0600	A	SSN and Medicare Number	✓	✓	✓	✓	✓	Wording Update
A0700	A	Medicaid Number	✓	✓	✓	✓	✓	
A0800	A	Gender	✓	✓				Item Removed
A0810	A	Sex			✓	✓	✓	Item Added
A0900	A	Birth Date	✓	✓	✓	✓	✓	
A1000	A	Race/Ethnicity	✓					Item Removed
A1005	A	Ethnicity			✓			Item Added
A1010	A	Race			✓			Item Added
A1110	A	Language			✓			Item Added
A1400	A	Payer Information	✓		✓	✓		
A1802	A	Admitted From	✓					Item Removed
A1805	A	Admitted From			✓			Item Added
A1905	A	Living Arrangements			✓			Item Added
A1910	A	Availability of Assistance			✓			Item Added
A2115	A	Reason for Discharge		✓			✓	Options Updated
F2000	F	CPR Preference	✓		✓			
F2100	F	Other Life-Sustaining Trt Pref	✓		✓			
F2200	F	Hospitalization Preference	✓		✓			
F3000	F	Spiritual/Existential Concerns	✓		✓			
I0010	I	Principal Diagnosis	✓		✓			Options Added and Updated
I0100	I	Comorbidities: Cancer			✓			Item Added
I0600	I	Comorbidities: Heart CHF			✓			Item Added
I0900	I	Comorbidities: Heart: PVD/PAD			✓			Item Added
I0950	I	Comorbidities: Heart: Cardiovasc			✓			Item Added
I1101	I	Comorbidities: Gastro: Liver			✓			Item Added
I1510	I	Comorbidities: Genitour: Renal			✓			Item Added
I2102	I	Comorbidities: Infections: Sepsis			✓			Item Added
I2900	I	Comorbidities: Metabolic: DM			✓			Item Added
I2910	I	Comorbidities: Metabolic: Neurop			✓			Item Added
I4501	I	Comorbidities: Neuro: Stroke			✓			Item Added
I4801	I	Comorbidities: Neuro: Dementia			✓			Item Added
I5150	I	Comorbidities: Neuro: Neuro Cond			✓			Item Added
I5401	I	Comorbidities: Neuro: Seizure			✓			Item Added
I6202	I	Comorbidities: Pulmonary: COPD			✓			Item Added
I8005	I	Comorbidities: Other			✓			Item Added

Continued…

Item #	Sec.	Description	HIS 3.00 Time Points		Hope 1.00 Time Points			Notes
			Admit	DC	Admit	HUV	DC	
J0050	J	Death is Imminent			✓	✓		Item Added
J0900	J	Pain Screening	✓		✓			
J0905	J	Pain Active Problem	✓		✓			
J0910	J	Comprehensive Pain Assessment	✓		✓			
J0915	J	Neuropathic Pain			✓			Item Added
J2030	J	Screening for Shortness of Breath	✓		✓			Skip Instruction Update
J2040	J	Treatment for Shortness of Breath	✓		✓			Portion Removed
J2050	J	Symptom Impact Screening			✓	✓		Item Added
J2051	J	Symptom Impact			✓	✓		Item Added
J2052	J	Symptom Follow-up Visit (SFV)			✓	✓		Item Added
J2053	J	SFV Symptom Impact			✓	✓		Item Added
M1190	M	Skin Conditions			✓	✓		Item Added
M1195	M	Types of Skin Conditions			✓	✓		Item Added
M1200	M	Skin and Ulcer/Injury Treatments			✓	✓		Item Added
N0500	N	Scheduled Opioid	✓		✓	✓		
N0510	N	PRN Opioid	✓		✓	✓		
N0520	N	Bowel Regimen	✓		✓	✓		Skip Instruction Update
Z0350	Z	Date Assessment was Completed				✓		Item Added
Z0400	Z	Signatures of Persons Comp Record	✓	✓	✓	✓	✓	Wording Update
Z0500	Z	Signature of Person Verifying Record	✓	✓	✓	✓	✓	

This version of HOPE is based on the **HOPE-v1.01_All-Item_508c (PDF)** and the corresponding technical data spec identified as v1.00.1, available at CMS.gov
HOPE is scheduled for implementation on October 1, 2025.

This guide is provided by SHP as a service and is for informational use only. Always consult CMS.gov for the most up-to-date information including future changes.

HIS | Section A | Administrative Information

A0050. Type of Record — Admit DC

Enter Code ☐

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

A0100. Facility Provider Numbers. Enter code in boxes provided. — Admit DC

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

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

A0205. Site of Service at Admission — Admit

Enter Code ☐☐

01. **Hospice in patient'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 a 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**

A0220. Admission Date — Admit DC

☐☐ Month ☐☐ Day ☐☐☐☐ Year

A0245. Date Initial Nursing Assessment Initiated — Admit

☐☐ Month ☐☐ Day ☐☐☐☐ Year

A0250. Reason for Record — Admit DC

Enter Code ☐☐

01. **Admission**
09. **Discharge**

A0270. Discharge Date — DC

☐☐ Month ☐☐ Day ☐☐☐☐ Year

A0500. Legal Name of Patient — Admit DC

A. **First name:** ☐☐☐☐☐☐☐☐☐☐☐☐

B. **Middle initial:** ☐

C. **Last name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. **Suffix:** ☐☐☐

A0550. Patient ZIP Code. Enter code in boxes provided. — Admit

Patient ZIP Code: ☐☐☐☐☐ - ☐☐☐☐

A0600. Social Security and Medicare Numbers — Admit DC

A. **Social Security Number:** ☐☐☐ - ☐☐ - ☐☐☐☐

B. **Medicare number** (or comparable railroad insurance number)**:** ☐☐☐☐☐☐☐☐☐☐☐☐

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid Recipient — Admit DC

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0800. Gender — Admit DC

Enter Code ☐

1. **Male**
2. **Female**

A0900. Birth Date — Admit DC

☐☐ Month ☐☐ Day ☐☐☐☐ Year

HOPE | Section A | Administrative Information

A

A0050. Type of Record — Admit HUV DC

Enter Code ☐

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

A0100. Facility Provider Numbers — Admit HUV DC

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

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

A0215. Site of Service at Admission — Admit

Enter Code ☐☐

01. **Patient's Home/Residence**
02. **Assisted Living Facility**
03. **Nursing Long Term Care (LTC) or Non-Skilled Nursing Facility (NF)**
04. **Skilled Nursing Facility (SNF)**
05. **Inpatient Hospital**
06. **Inpatient Hospice Facility (General Inpatient (GIP))**
07. **Long Term Care Hospital (LTCH)**
08. **Inpatient Psychiatric Facility**
09. **Hospice Home Care (Routine Home Care (RHC)) Provided in a Hospice Facility**
99. **Not listed**

A0220. Admission Date — Admit HUV DC

☐☐ Month ☐☐ Day ☐☐☐☐ Year

A0250. Reason for Record — Admit HUV DC

Enter Code ☐

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

A0270. Discharge Date — DC

☐☐ Month ☐☐ Day ☐☐☐☐ Year

A0500. Legal Name of Patient — Admit HUV DC

A. **First name:** ☐☐☐☐☐☐☐☐☐☐☐☐

B. **Middle initial:** ☐

C. **Last name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. **Suffix:** ☐☐☐

A0550. Patient ZIP Code — Admit

Patient ZIP Code: ☐☐☐☐☐ - ☐☐☐☐

A0600. Social Security and Medicare Numbers — Admit HUV DC

A. **Social Security Number:** ☐☐☐ - ☐☐ - ☐☐☐☐

B. **Medicare number:** ☐☐☐☐☐☐☐☐☐☐☐☐

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid Recipient — Admit HUV DC

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0810. Sex — Admit HUV DC

Enter Code ☐

1. **Male**
2. **Female**

A0900. Birth Date — Admit HUV DC

☐☐ Month ☐☐ Day ☐☐☐☐ Year

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A1000. Race/Ethnicity — Admit

↓ 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 Pacific Islander
- ☐ F. White

A1400. Payor Information — Admit

↓ 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 payor source**
- ☐ X. **Unknown**
- ☐ Y. **Other**

A1802. Admitted From. Immediately preceding this admission, where was the patient? — Admit

Enter Code ☐☐

- 01. **Community residential setting** (e.g., private home/apt., board/care, assisted living, group home, adult foster care)
- 02. **Long-term care facility**
- 03. **Skilled nursing facility (SNF)**
- 04. **Hospital emergency department**
- 05. **Short-stay acute hospital (IPPS)**
- 06. **Long-term care hospital (LTCH)**
- 07. **Inpatient rehabilitation hospital or unit (IRF)**
- 08. **Psychiatric hospital or unit**
- 09. **ID/DD facility**
- 10. **Hospice**
- 99. **None of the above**

A1005. Ethnicity — Admit

Are you of Hispanic, Latino/a, or Spanish origin?

↓ Check all that apply

- ☐ A. No, not of Hispanic, Latino/a, or Spanish origin
- ☐ B. Yes, Mexican, Mexican American, Chicano/a
- ☐ C. Yes, Puerto Rican
- ☐ D. Yes, Cuban
- ☐ E. Yes, Another Hispanic, Latino, or Spanish origin
- ☐ X. Patient unable to respond
- ☐ Y. Patient declines to respond

A1010. Race — Admit

What is your race?

↓ Check all that apply

- ☐ A. White
- ☐ B. Black or African American
- ☐ C. American Indian or Alaska Native
- ☐ D. Asian Indian
- ☐ E. Chinese
- ☐ F. Filipino
- ☐ G. Japanese
- ☐ H. Korean
- ☐ I. Vietnamese
- ☐ J. Other Asian
- ☐ K. Native Hawaiian
- ☐ L. Guamanian or Chamorro
- ☐ M. Samoan
- ☐ N. Other Pacific Islander
- ☐ X. Patient unable to respond
- ☐ Y. Patient declines to respond
- ☐ Z. None of the above

A1110. Language — Admit

Enter Code ☐

A. **What is your preferred language?** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

B. **Do you need or want an interpreter to communicate with a doctor or health care staff?**

- 0. **No**
- 1. **Yes**
- 9. **Unable to determine**

A1400. Payer Information — Admit HUV

↓ 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 payor source**
- ☐ X. **Unknown**
- ☐ Y. **Other**

A1805. Admitted From — Admit

Enter Code ☐☐

Immediately preceding this admission, where was the patient?

- 01. **Home/Community** (e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care arrangements)
- 02. **Nursing Home (long-term care facility)**
- 03. **Skilled Nursing Facility (SNF, swing beds)**
- 04. **Short-Term General Hospital (acute hospital, IPPS)**
- 05. **Long-Term Care Hospital (LTCH)**
- 06. **Inpatient Rehabilitation Facility (IRF, free standing facility or unit)**
- 07. **Inpatient Psychiatric Facility (psychiatric hospital or unit)**
- 08. **Intermediate Care Facility (ID/DD facility)**
- 10. **Hospice (institutional facility)**
- 11. **Critical Access Hospital (CAH)**
- 99. **Not Listed**

A1905. Living Arrangements — Admit

Enter Code ☐

Identify the patient's living arrangement at the time of this admission.

- 1. **Alone** (no other residents in the home)
- 2. **With others in the home** (e.g., family, friends, or paid caregiver)
- 3. **Congregate home** (e.g., assisted living or residential care home)
- 4. **Inpatient facility** (e.g., skilled nursing facility, nursing home, inpatient hospice, hospital)
- 5. **Does not have a permanent home** (e.g., has unstable housing or is experiencing homelessness)

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A2115. Reason for Discharge		DC
Enter Code ☐☐	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**	

A1910. Availability of Assistance		Admit
Enter Code ☐	**Code the level of in-person assistance from available and willing caregiver(s), excluding hospice staff, at the time of this admission.** 1. **Around-the-clock** (24 hours a day with few exceptions) 2. **Regular daytime** (all day every day with few exceptions) 3. **Regular nighttime** (all night every night with few exceptions) 4. **Occasional** (intermittent) 5. **No assistance available**	
A2115. Reason for Discharge		DC
Enter Code ☐	1. **Expired** 2. **Revoked** 3. **No longer terminally ill** 4. **Moved out of hospice service area** 5. **Transferred to another hospice** 6. **Discharged for cause**	

HIS	Section F	Preferences

F2000. CPR Preference — Admit

Enter Code ☐

A. **Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)?** - Select the most accurate response

0. **No** → Skip to F2100, Other Life-Sustaining Treatment Preferences
1. **Yes, and discussion occurred**
2. **Yes, but the patient/responsible party refused to discuss**

B. **Date the patient/responsible party was first asked about preference regarding the use of CPR:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

F2100. Other Life-Sustaining Treatment Preferences — Admit

Enter Code ☐

A. **Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR?** - Select the most accurate response

0. **No** → Skip to F2200, Hospitalization Preference
1. **Yes, and discussion occurred**
2. **Yes, but the patient/responsible party refused to discuss**

B. **Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

F2200. Hospitalization Preference — Admit

Enter Code ☐

A. **Was the patient/responsible party asked about preference regarding hospitalization?** - Select the most accurate response

0. **No** → Skip to F3000, Spiritual/Existential Concerns
1. **Yes, and discussion occurred**
2. **Yes, but the patient/responsible party refused to discuss**

B. **Date the patient/responsible party was first asked about preference regarding hospitalization:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

F3000. Spiritual/Existential Concerns — Admit

Enter Code ☐

A. **Was the patient and/or caregiver asked about spiritual/existential concerns?** - Select the most accurate response.

0. **No** → Skip to I0100, Principal Diagnosis
1. **Yes, and discussion occurred**
2. **Yes, but the patient/caregiver refused to discuss**

B. **Date the patient and/or caregiver was first asked about spiritual/existential concerns:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

HOPE	Section F	Preferences for Customary Routine and Activities	F

F2000. CPR Preference — Admit

Enter Code ☐

A. **Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation (CPR)?** - Select the most accurate response

0. **No** → Skip to F2100, Other Life-Sustaining Treatment Preferences
1. **Yes, and discussion occurred**
2. **Yes, but the patient/responsible party refused to discuss**

B. **Date the patient/responsible party was first asked about preference regarding the use of CPR:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

F2100. Other Life-Sustaining Treatment Preferences — Admit

Enter Code ☐

A. **Was the patient/responsible party asked about preferences regarding life-sustaining treatments other than CPR?** - Select the most accurate response

0. **No** → Skip to F2200, Hospitalization Preference
1. **Yes, and discussion occurred**
2. **Yes, but the patient/responsible party refused to discuss**

B. **Date the patient/responsible party was first asked about preferences regarding life-sustaining treatments other than CPR:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

F2200. Hospitalization Preference — Admit

Enter Code ☐

A. **Was the patient/responsible party asked about preference regarding hospitalization?** - Select the most accurate response

0. **No** → Skip to F3000, Spiritual/Existential Concerns
1. **Yes, and discussion occurred**
2. **Yes, but the patient/responsible party refused to discuss**

B. **Date the patient/responsible party was first asked about preference regarding hospitalization:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

F3000. Spiritual/Existential Concerns — Admit

Enter Code ☐

A. **Was the patient and/or caregiver asked about spiritual/existential concerns?** - Select the most accurate response.

0. **No** → Skip to I0100, Principal Diagnosis
1. **Yes, and discussion occurred**
2. **Yes, but the patient/caregiver refused to discuss**

B. **Date the patient and/or caregiver was first asked about spiritual/existential concerns:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

HIS	Section I	Active Diagnoses

I0010. Principal Diagnosis		Admit
Enter Code ☐☐	01. **Cancer** 02. **Dementia/Alzheimer's** 99. **None of the above**	

HOPE	Section I	Active Diagnoses	I

I0010. Principal Diagnosis		Admit
Enter Code ☐☐	01. **Cancer** 02. **Dementia** (including Alzheimer's disease) 03. **Neurological Condition (e.g., Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (ALS))** 04. **Stroke** 05. **Chronic Obstructive Pulmonary Disease** (COPD) 06. **Cardiovascular** (excluding heart failure) 07. **Heart Failure** 08. **Liver Disease** 09. **Renal Disease** 99. **None of the above**	

Comorbidities and Co-existing Conditions			Admit
↓ Check all that apply			
		Cancer	
☐	I0100.	Cancer	
		Heart/Circulation	
☐	I0600.	Heart Failure (e.g., congestive heart failure (CHF) and pulmonary edema)	
☐	I0900.	Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)	
☐	I0950.	Cardiovascular (excluding heart failure)	
		Gastrointestinal	
☐	I1101.	Liver disease (e.g., cirrhosis)	
		Genitourinary	
☐	I1510.	Renal disease	
		Infections	
☐	I2102.	Sepsis	
		Metabolic	
☐	I2900.	Diabetes Mellitus (DM)	
☐	I2910.	Neuropathy	
		Neurological	
☐	I4501.	Stroke	
☐	I4801.	Dementia (including Alzheimer's disease)	
☐	I5150.	Neurological Conditions (e.g., Parkinson's disease, multiple sclerosis, ALS)	
☐	I5401.	Seizure Disorder	
		Pulmonary	
☐	I6202.	Chronic Obstructive Pulmonary Disease (COPD)	
		Other	
☐	I8005.	Other Medical Condition	

HIS	Section J	Health Conditions

J0900. Pain Screening — Admit

Enter Code ☐

A. **Was the patient screened for pain?**

0. **No** → Skip to J0905, Pain Active Problem
1. **Yes**

B. **Date of first screening for pain:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

Enter Code ☐

C. **The patient's pain severity was:**

0. **None**
1. **Mild**
2. **Moderate**
3. **Severe**
9. **Pain not rated**

Enter Code ☐

D. **Type of standardized pain tool used:**

1. **Numeric**
2. **Verbal descriptor**
3. **Patient visual**
4. **Staff observation**
9. **No standard tool used**

J0905. Pain Active Problem — Admit

Enter Code ☐

A. **Is pain an active problem for the patient?**

0. **No** → Skip to J2030, Screening for Shortness of Breath
1. **Yes**

J0910. Comprehensive Pain Assessment — Admit

Enter Code ☐

A. **Was a comprehensive pain assessment done?**

0. **No** → Skip to J2030, Screening for Shortness of Breath
1. **Yes**

B. **Date of comprehensive pain assessment:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

C. **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

HOPE	Section J	Health Conditions	J

J0050. Death is Imminent — Admit HUV

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**

J0900. Pain Screening — Admit

Enter Code ☐

A. **Was the patient screened for pain?**

0. **No** → Skip to J0905, Pain Active Problem
1. **Yes**

B. **Date of first screening for pain:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

Enter Code ☐

C. **The patient's pain severity was:**

0. **None**
1. **Mild**
2. **Moderate**
3. **Severe**
9. **Pain not rated**

Enter Code ☐

D. **Type of standardized pain tool used:**

1. **Numeric**
2. **Verbal descriptor**
3. **Patient visual**
4. **Staff observation**
9. **No standard tool used**

J0905. Pain Active Problem — Admit

Enter Code ☐

A. **Is pain an active problem for the patient?**

0. **No** → Skip to J2030, Screening for Shortness of Breath
1. **Yes**

J0910. Comprehensive Pain Assessment — Admit

Enter Code ☐

A. **Was a comprehensive pain assessment done?**

0. **No** → Skip to J2030, Screening for Shortness of Breath
1. **Yes**

B. **Date of comprehensive pain assessment:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

C. **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

J0915. Neuropathic Pain — Admit

Enter Code ☐

Does the patient have neuropathic pain (e.g., pain with burning, tingling, pins and needles, hypersensitivity to touch)?

0. **No**
1. **Yes**

J2030. Screening for Shortness of Breath — Admit

Enter Code ☐

A. **Was the patient screened for shortness of breath?**

0. **No** → Skip to N0500, Scheduled Opioid
1. **Yes**

B. **Date of first screening for shortness of breath:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

Enter Code ☐

C. **Did the screening indicate the patient had shortness of breath?**

0. **No** → Skip to N0500, Scheduled Opioid
1. **Yes**

J2040. Treatment for Shortness of Breath — Admit

Enter Code ☐

A. **Was treatment for shortness of breath initiated?**

0. **No** → Skip to N0500, Scheduled Opioid
1. **No, patient declined treatment** → Skip to N0500, Scheduled Opioid
2. **Yes**

B. **Date of comprehensive pain assessment:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

C. **Type(s) of treatment for shortness of breath initiated:**

↓ Check all that apply

☐ 1. Opioids
☐ 2. Other medication
☐ 3. Oxygen
☐ 4. Non-medication

J2030. Screening for Shortness of Breath — Admit

Enter Code ☐

A. **Was the patient screened for shortness of breath?**

0. **No** → Skip to J2050, Symptom Impact Screening
1. **Yes**

B. **Date of first screening for shortness of breath:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

Enter Code ☐

C. **Did the screening indicate the patient had shortness of breath?**

0. **No** → Skip to J2050, Symptom Impact Screening
1. **Yes**

J2040. Treatment for Shortness of Breath — Admit

Enter Code ☐

A. **Was treatment for shortness of breath initiated?**

0. **No** → Skip to J2050, Symptom Impact Screening
1. **No, patient declined treatment** → Skip to J2050, Symptom Impact Screening
2. **Yes**

B. **Date treatment for shortness of breath initiated:**

☐☐ Month ☐☐ Day ☐☐☐☐ Year

J2050. Symptom Impact Screening — Admit HUV

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 — Admit HUV

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)

Admit HUV

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 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

Admit HUV

Since the last Symptom Impact assessment was completed, 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**	☐

HIS	Section -	

HOPE	Section M	Skin Conditions	M

M1190. Skin Conditions — Admit HUV

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 — Admit HUV

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 — Admit HUV

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

HIS	Section N	Medications

N0500. Scheduled Opioid — Admit

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 — Admit

Enter Code ☐

A. **Was a 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) — Admit

Enter Code ☐

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

0. **No** → Skip to Z0400, Signature(s) of Person(s) Completing the Record
1. **No, but there is documentation of why a bowel regimen was not initiated or continued** → Skip to Z0400, Signature(s) of Person(s) Completing the Record
2. **Yes**

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

☐☐ Month ☐☐ Day ☐☐☐☐ Year

HOPE	Section N	Medications	N

N0500. Scheduled Opioid — Admit HUV

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 — Admit HUV

Enter Code ☐

A. **Was a 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) — Admit HUV

Enter Code ☐

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

0. **No** → (Admit) Skip to Z0400. Sig of Person(s) Completing Record; (HUV) Skip to Z0350. Date Asmt Completed
1. **No, but there is documentation of why a bowel regimen was not initiated or continued** → (Admit) Skip to Z0400. Sig of Person(s) Completing Record; (HUV) Skip to Z0350. Date Asmt Completed
2. **Yes**

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

☐☐ Month ☐☐ Day ☐☐☐☐ Year

HIS	Section Z	Record Administration

Z0400. Signature(s) of Person(s) Completing the Record — Admit DC

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 4 percentage point reduction in the Fiscal Year payment determination. I also certify that I am authorized to submit this information by this provider on its behalf.

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

Z0500. Signature of Person Verifying Record Completion — Admit DC

A. **Signature:** _____

B. **Date:** ☐☐ Month ☐☐ Day ☐☐☐☐ Year

HOPE	Section Z	Assessment Administration	Z

Z0350. Date Assessment was Completed — HUV

☐☐ Month ☐☐ Day ☐☐☐☐ Year

Z0400. Signature(s) of Person(s) Completing the Record — Admit HUV DC

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.

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

Z0500. Signature of Person Verifying Record Completion — Admit HUV DC

A. **Signature:** _____

B. **Date:** ☐☐ Month ☐☐ Day ☐☐☐☐ Year