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Hospice HOPE Tool in Practice: Common Outliers, Coding Pitfalls, and Next Steps

Moving Beyond Compliance to Documentation Excellence

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Audience Poll

Which HOPE area has been the most challenging for your organization?

1. Pain Assessment
2. Symptom Impact
3. HOPE Update Visits/Symptom Follow-up Visits
4. Documentation consistency
5. Quality Auditing

One Year Later: Where Are We Now?

The conversation has shifted from implementation to reliability.

THEN		NOW
Learning the HOPE Tool	→	**Improving documentation consistency**
Completing the assessment	→	**Improving data quality**
Educating clinicians	→	**Coaching clinical reasoning**
EMR implementation	→	**Quality monitoring and auditing**
Compliance	→	**Performance improvement**

PRACTICE PEARL **Completing the assessment correctly is the starting point. Consistently telling the patient's clinical story is the goal.**

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Understanding HOPE Outliers

An outlier is a signal to investigate—not proof of poor care.

Clinical assessment

Two clinicians may interpret the same patient differently.

Documentation

The assessment may be accurate, but the record may not support it.

HOPE interpretation

The patient is understood, but the coding guidance is applied differently.

Why it matters

- Quality measures
- Public reporting
- Agency benchmarking
- Performance improvement
- Survey readiness

LEADERSHIP TAKEAWAY **Outliers should start conversations—not assign blame.**

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Five Patterns We See Repeatedly

These are the patterns worth targeting in education and audit.

1. **Symptom presence ≠ symptom impact**
2. **0 vs. 9 is misunderstood**
3. **Moderate/severe impact triggers workflow**
4. **HUV timing is treated as optional**
5. **Documentation does not explain the code**

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SECTION 1

Common Outliers

What are clinicians misunderstanding most often?

Outlier #1: Symptom Impact

J2051 asks how the symptom affected the patient—not whether the symptom exists.

Over the past 2 days, how has the patient been affected?

0	1	2	3	9
Not at all	**Slight**	**Moderate**	**Severe**	**Not applicable**
Symptom may be present but well-controlled	Minimal impact	Meaningful impact; triggers SFV	Major impact; triggers SFV	Patient is not experiencing the symptom

COMMON PITFALL **Coding 9 because the symptom is controlled. CMS defines 0 as “not at all,” including symptoms well-controlled with current treatment.**

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Documentation Challenge #1

Pain is present—but is the impact 0 or 9?

“Patient reports chronic low-back pain. Scheduled morphine is effective. Patient slept through the night, visited with family, and denies pain limiting activity today.”

What would you code for pain impact?

0 — NOT AT ALL | **9 — N/A** | **NEED MORE INFO**

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Outlier #2: The Symptom Follow-up Visit

Moderate or severe symptom impact creates a time-sensitive workflow.

J2051
Impact = 2 or 3

→

Trigger
SFV required

→

Timing
Within 2 calendar days

→

Visit
In person

If the visit is not completed, document the CMS-coded reason accurately.

PRACTICE PEARL **A moderate or severe symptom score is not just a data point—it creates an operational obligation.**

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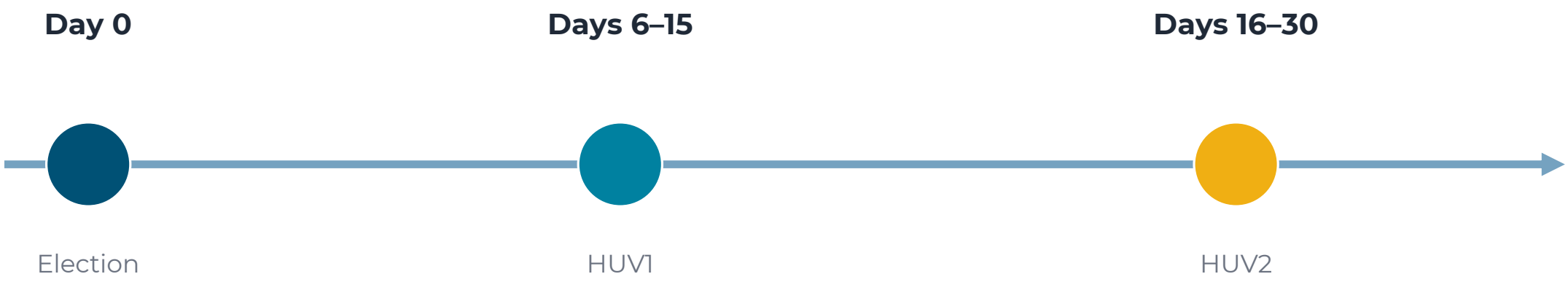
Outlier #3: HOPE Update Visit Timing

HUV timing is a clinical and data-quality requirement.



If an HUV is missed or late: conduct the visit as appropriate and submit the record once completed.

COMMON PITFALL	**Treating the window as a documentation date instead of the timepoint for the actual HUV assessment.**

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Coding Pitfall: 0 vs. 9

The difference is symptom impact versus symptom absence.

0 — Not at all

Use when the symptom does not affect the patient. This includes a symptom that is present but well controlled with current treatment.

9 — Not applicable

Use when the patient is not experiencing the symptom.

MANAGER COACHING TIP

Ask: “Is the symptom absent—or is it present and not affecting the patient?”

Coding Pitfall: Turning a Scale Into the Answer

J2051 is based on clinical assessment—including patient and caregiver input.

PRACTICE PEARL **A numeric pain or dyspnea scale can inform the assessment—but it does not replace the impact question.**

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Coding Pitfall: What If Symptoms Are Still Moderate or Severe?

A repeat HOPE SFV is not automatically required after the SFV.

Initial ADM/HUV → **Impact = 2 or 3** → **SFV within 2 days** → **Still moderate/severe?**

Continue clinically appropriate follow-up. No additional HOPE SFV is required solely because the SFV still shows moderate/severe impact.

COMMON PITFALL	**Confusing the HOPE reporting requirement with the hospice's ongoing clinical responsibility to manage symptoms.**

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Outlier #4: Skin Conditions

Small documentation differences can create big coding differences.

Identify

What skin condition is present? Use consistent terminology and location.

Differentiate

Pressure injury, other skin issue, or no skin condition? Avoid vague terms.

Trend

If the condition changes, make the change visible in the clinical record.

QA question: Could two clinicians read the same wound note and choose the same HOPE response?

PRACTICE PEARL **Consistency in wound terminology is a data-quality strategy, not just a documentation preference.**

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SECTION 2

Documentation Challenges

Would your documentation lead another clinician to the same HOPE response?

Documentation Challenge #2

Would this support your pain-impact response?

“Patient reports pain is controlled. Taking morphine every four hours. Resting comfortably. Grimaces with repositioning. Daughter reports patient cries during bathing.”

What is missing before you code symptom impact?

- IMPACT
- FREQUENCY
- RESPONSE
- CONTEXT

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Documentation Challenge #2 — Discussion

Better documentation makes the impact visible.

Stronger example

"Patient reports pain 3/10 at rest and increasing with repositioning and bathing. Grimacing and guarding observed with movement. After scheduled morphine, patient is able to rest and participate in conversation; movement-related pain continues to limit bathing and repositioning."

- ✓ **Symptom is present**
- ✓ **Impact is described**
- ✓ **Treatment response is documented**
- ✓ **Residual impact is clear**

PRACTICE PEARL **The goal is not "more words." The goal is documentation that makes the selected impact code understandable.**

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Documentation Challenge #3

"Short of breath. Oxygen in use."

Would you feel confident coding symptom impact from this note?

SHORT OF BREATH. OXYGEN IN USE.

What else do you need?

- When?
- What triggers it?
- What does it prevent?
- Does treatment help?

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Documentation Challenge #3 — Discussion

Describe the patient's experience, not just the symptom.

"Patient becomes dyspneic with transfers from bed to chair and requires several minutes of rest before speaking comfortably. Oxygen at 2 L/min and pursed-lip breathing reduce distress. Patient now avoids walking to the bathroom because of breathlessness."

Trigger

Transfers / activity

Impact

Avoids walking

Intervention

Oxygen + breathing

Response

Distress improves

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SECTION 3

Next Steps

How do we turn HOPE data into a reliable quality-improvement system?

The HOPE Dashboard Every Leader Should Review Monthly

Move beyond “Did we submit it?”

Timeliness

- Admission completion
- HUV1 window
- HUV2 window
- SFV within 2 calendar days
- Late/missed records

Coding consistency

- 0 vs. 9 usage
- Moderate/severe symptom rates
- Variation by clinician
- Skin-condition agreement
- Correction patterns

Quality follow-through

- Triggered SFVs completed
- Exceptions coded appropriately
- Reassessment documented
- Coaching completed
- Re-audit results

LEADERSHIP QUESTION **Can we defend the pattern behind our HOPE data—not just the individual record?**

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Five Questions for Every HOPE Audit

Audit the clinical story—not just the field.

1. **Does the documentation support the selected response?**
2. **Would another clinician reach the same conclusion?**
3. **Is the timing correct for this HOPE timepoint?**
4. **If J2051 = 2 or 3, was the SFV workflow completed?**
5. **Would the record make sense to a reviewer who never spoke to the clinician?**

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Build Inter-Rater Reliability

One case. Three clinicians. Independent answers.

Same case

Independent coding

Compare answers

Explain reasoning

Reach consensus

GOAL **Not identical personalities or documentation styles—consistent application of the HOPE guidance.**

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EMR Optimization: Make the Right Thing the Easy Thing

Use workflow design to reinforce accurate HOPE practice.

Prompt

Remind clinicians that J2051 is about impact

Trigger

Flag J2051 = 2 or 3 for SFV workflow

Timer

Surface HUV1/HUV2 windows

Trend

Show prior symptom impact for comparison

Audit

Capture corrections and late records

LEADERSHIP TAKEAWAY

A well-designed EMR cannot replace clinical judgment—but it can reduce preventable workflow variation.

Your 90-Day HOPE Improvement Plan

Small, focused changes beat another all-staff manual review.

Days 1–30

Diagnose

Review 20–30 records. Identify the top 2–3 patterns causing variation.

Days 31–60

Coach

Use documentation challenges and inter-rater exercises. Update EMR prompts if needed.

Days 61–90

Re-audit

Measure whether the targeted variation improved. Share results and repeat.

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What’s Next for HOPE?

Data quality matters now because CMS has already finalized HOPE-based measures.

Two HOPE-based measures

Timely Follow-up for Pain Impact and Timely Follow-up for Non-Pain Symptom Impact.

Public reporting pipeline

CMS states HOPE-based assessment measures will support public reporting and consumer information.

Correction discipline

HOPE records have a 4.5-month data correction deadline for public reporting.

LEADERSHIP QUESTION

If CMS froze your HOPE data today, what story would it tell about your hospice?

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Monday Morning Checklist

Three actions you can take next week.

Clinical Leaders

Review five records where J2051 was coded 0, 2, 3, or 9. Ask whether the documentation makes the distinction clear.

QA / Compliance

Audit HUV timing and triggered SFVs. Look for patterns by clinician—not just isolated errors.

Educators

Use one documentation challenge in your next staff meeting and compare independent responses.

ONE QUESTION TO KEEP

“Would another clinician arrive at the same answer from this documentation?”

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Key Takeaways

1. **Symptom impact is not the same as symptom presence.**
2. **0 and 9 are not interchangeable.**
3. **Moderate/severe impact creates a follow-up workflow.**
4. **HUV timing belongs in the operational workflow—not someone's memory.**
5. **Reliable HOPE data starts with reliable clinical reasoning and documentation.**

Let’s solve some real-world HOPE challenges.

- Coding gray areas
- SFV workflow
- HUV timing
- Documentation consistency
- Quality auditing

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Thank You

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