Managing HOPE Records

Hospice Outcomes and Patient Evaluation (HOPE) Overview

Effective October 1, 2025, hospice providers are required to meet a mandate to collect and submit patient data to replace the previous effort to capture Hospice Items Set (HIS) data. The Hospice Outcomes and Patient Evaluation is commonly referred to as HOPE. Unlike HIS, HOPE is an assessment tool and not simply a method to abstract patient data. For specific CMS guidance, users should refer to the CMS Resources. The following links may prove useful, but agencies are encouraged to review compliance resources as necessary:

HOPE Main Page:	https://www.cms.gov/medicare/quality/hospice/hope
HOPE Technical Specifications:	https://www.cms.gov/medicare/quality/hospice-quality-reporting-program/hospice-outcomes-and-patient-evaluation-hope-technical-information
HOPE Training Resources:	https://www.cms.gov/medicare/quality/hospice/hqrp-training-and-education-library

HOPE Administrative Configuration Settings

HOPE Records (Administration>System>Settings)

This settings page for HOPE Records controls the export process for the HOPE Records.

Please note the comments below for additional clarification of the screen options:

- **Export Start Date:** The Export Start Date will be set to 10/1/25 based on effective date of the CMS HOPE mandate (or later for new implementations after 10/1/25). Agencies are able to create HOPE records prior to the date, but if the patient's admin date is prior to the Export Start Date then the records will not export. Additionally, missing/incomplete HOPE Records will not appear on employee dashboards if the patient's admit date is prior to the Export Start Date.
- **Export Queue:** The Export Queue Settings give agencies a method to determine the timing of HOPE records to be queued for export. For HOPE, the settings are based on the verification date as captured in Z0500. The default setting is configured for Verified + 5 days before the record is queued for validation and export. This date can be changed at the discretion of the agency. <u>NOTE</u>: This will control the automated exports. Agencies can use the Export Now option if an earlier export is needed.
- **ID Numbers:** Agency Assigned Provider Submission ID, Facility National Provider Identifier Number (NPI), and Facility CMS Certification Number (aka Medicare Provider Number): These fields need to coincide with the related CMS issued identification numbers.
- **User Type Hold Permissions:** Option enables agencies to control the user types allowed to place a record on Hold after export.
- **Hold Reason Logic:** Gives the agency the ability to set defaults for hold reasons.

Company Table (Administration>System>Tables)

The Company Table includes unique hospice related configuration settings that previously applied to HIS Records, but now apply to HOPE. These fields determine the values that flow to the HOPE Record XML for submission to iQIES per the logic described below.

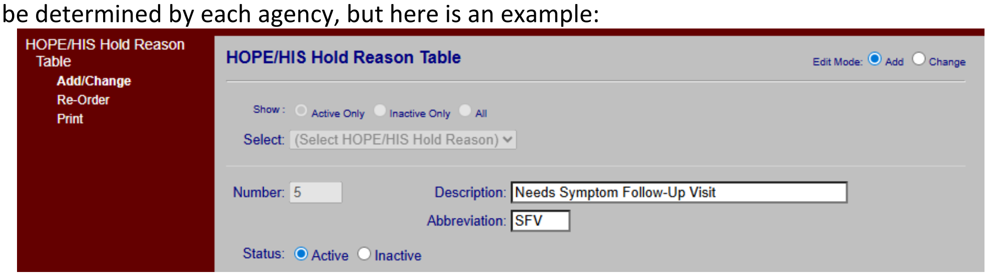
SPECIAL NOTE REGARDING HOPE SUBMISSION CONFIGURATION

NDoc is designed to work for agencies with one or multiple facilities. When auto populating the HOPE Records with the administrative details, the system defaults to first look at the table entry for the patient's assigned Company. If the Company Table (Administration>System>Tables) entry has values within the HOPE Record Information section, it will use those to complete the HOPE Record. If those fields are blank, the system will then go to the HOPE Record settings page under Administration>System>Settings. The fields there will then be used in the absence of Company Table information. Here are the HOPE items and the related NDoc fields:

HOPE Field	NDoc Field (under HOPE Settings and Company Table)
Facility ID (FAC_ID)	Assigned Provider Submission ID
Facility Provider Numbers>A0100 (A): NPI	Facility National Provider Identifier/NPI
Facility Provider Numbers> A0100(B): CMS Certification Number (CCN)	Facility CMS Certification Number

HOPE/HIS Hold Reason Table (Administration>System>Tables)

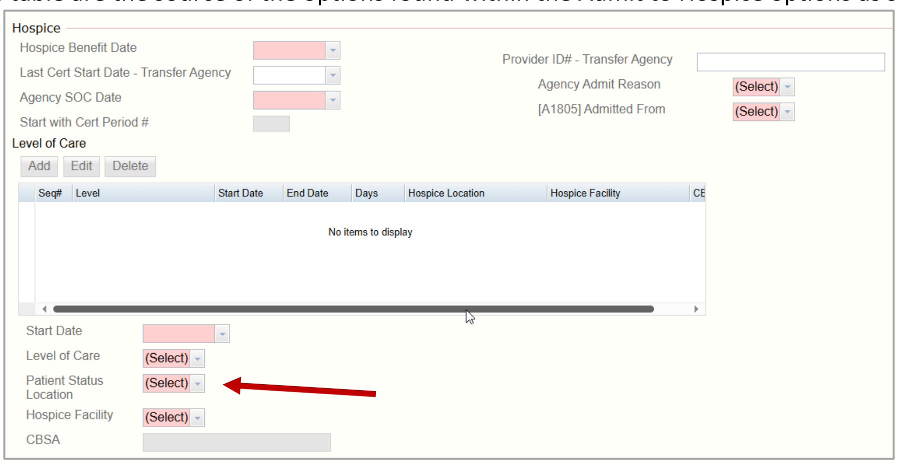
The HOPE/HIS Hold Reason Table allows users to configure HOPE assessment hold reasons in order to communicate the status of a HOPE Record. These entries generally reflect the reason why a HOPE Record is not ready for export. The reasons are especially helpful in alerting supervisors or quality assurance teams to the record's readiness for review, as well as alerting the clinician of needed changes post review. Beyond displaying in the drop-down list when signing out of the HOPE (either via Visit Charting or Back-Office), the contents of this table appear in HOPE Records Maintenance (Administration>Patient) and various patient and document tracking reports. Any HIS Hold Reasons previously configured apply to HOPE. Agencies can edit the description accordingly. NOTE: To aid in managing internal workflows, agencies should consider adding a Hold Reason to apply to assessments that need to be placed on hold awaiting the Symptom Follow-Up Visit as called for in J2052 - Symptom Follow-up Visit (SFV). The description can be determined by each agency, but here is an example:



Patient Status Location Table (Administration>System>Tables)

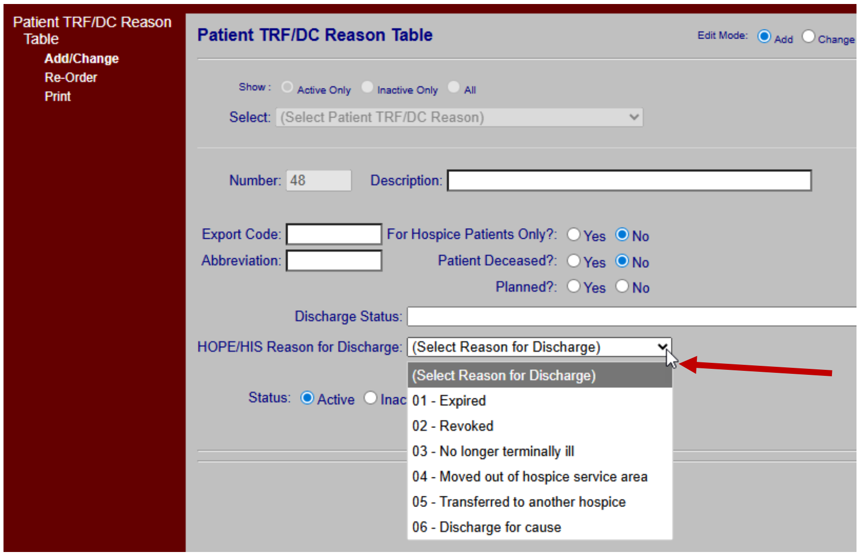
This table populates the Location drop down within Patient Status to document the site of service or "Patient Status Location" field where services are provided. Agencies can customize the Patient Status Locations selections and descriptions at their discretion, but the entry must be linked to the applicable Site of Service option to correspond with the values in the HOPE A0215-Site of Service at Admission question. The Site of Service value will flow to the HOPE Record based on this mapping.

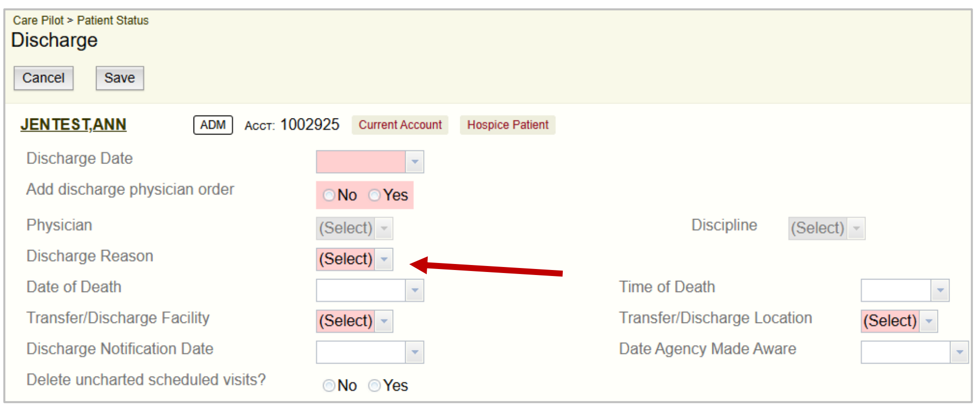
The entries from this table are the source of the options found within the Admit to Hospice options as shown below:



Patient TRF/DC Reason (Administration>System>Tables)

This table populates the drop down for the Discharge reason within Patient Status. The Reasons can be customized by the agency, but for the purposes of handling the response to the HOPE (previously the HIS) A2115-Reason for Discharge item the table must be linked to the appropriate mapping for the HOPE/HIS Reason for Discharge. For clarity agencies may wish to have the "Description" field reflect what is included in the HOPE record. However, edits are not necessary. The HOPE record automatically populates with the Reason for Discharge response linked accordingly from this table.



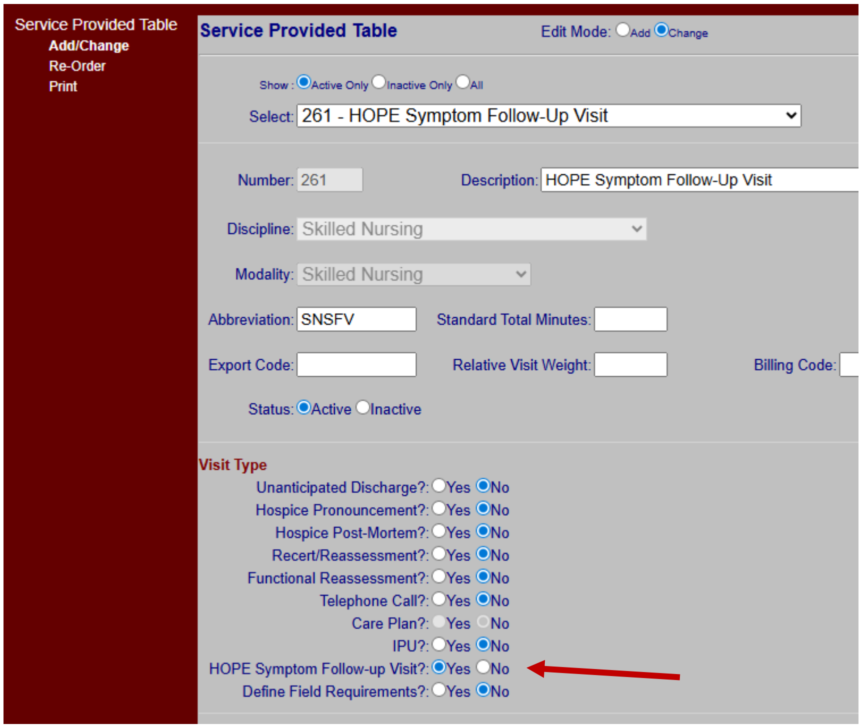


Service Provided Code Table (Administration>System>Tables)

The Service Provided Code Table under Administration>System>Tables has an option to designate a visit as a Symptom Follow-Up Visit (SFV) as referenced in the Symptom Impact Screening section of the HOPE assessment. Specifically, if J2051 includes a response of 2-Moderate or 3-Severe within an Admission or HUV Assessment, then charting of J2052-Symptom Follow-up Visit (SFV) is set as required. As noted in the HOPE Guidance manual, the following conditions would apply:

- *The in-person SFV should occur within two calendar days as a follow-up for any moderate or severe pain or non-pain symptom impact identified during an Admission or HUV.*
- *Since the clinician has two days to conduct the SFV, completion of this visit could stretch beyond the specified Admission or HUV assessment timeframes.*
- *An SFV cannot be conducted during the same visit as the initial assessment to conduct a HOPE Admission or HUV, but it can occur later in the same day, as a separate visit.*

The option of "HOPE Symptom Follow-Up Visit?" is available under the Visit Type settings. Setting this to Yes, triggers the visibility and requirement of J2052 and applicable J2053 questions accordingly within Today's Care charting screens for this particular Service Provided Code. These fields will be found under the Hospicecare Assessment section and can be used to document the information that needs to be captured back in the corresponding HOPE assessments. **NOTE**: Due to imbedded charting logic, SFV Visits cannot be set with IPU charting logic.

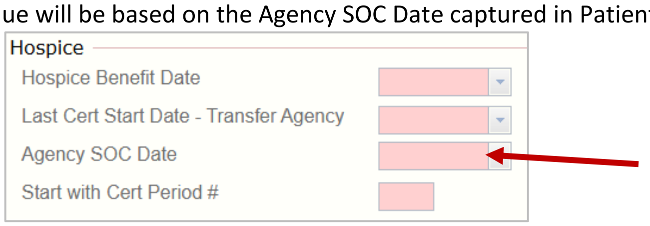


HOPE Navigation Considerations

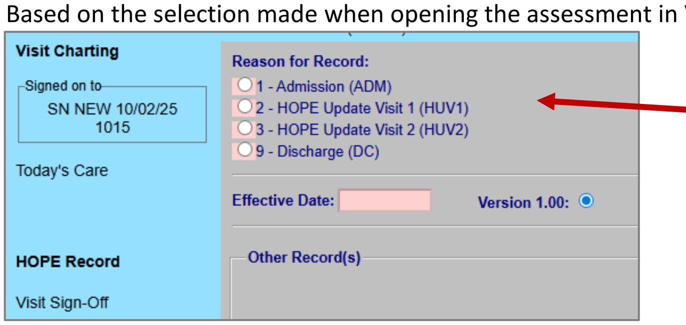
As users complete HOPE records, there is guidance that may be useful to consider and remember going forward.

Auto-filled/Carried Forward fields

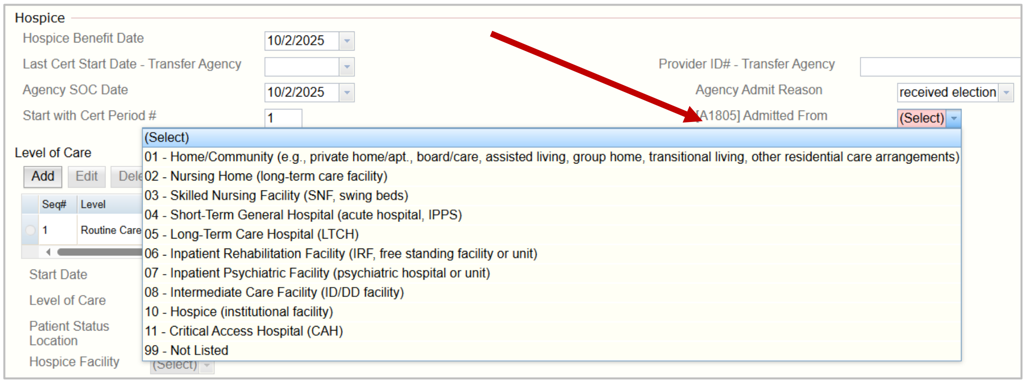
- **Site of Service at Admission [A0215]** – As described above and as with the HIS Record, the HOPE question for Site of Service at Admission (now A0215) is pulled from the Patient Status Location response captured within the Level of Care fields when charting the Admit to Hospice event within the Patient Status function. The drop-down entries for this field are sourced from the Patient Status Location Table under Administration>System>Tables. Refer to the table to confirm the entries are linked correctly to the Site of Service mapping option and review the guidance previously detailed in this document
- **Admission Date [A0220] -** This value will be based on the Agency SOC Date captured in Patient Status>Admit to Hospice charting.



- **Reason for Record [A0250] -** Based on the selection made when opening the assessment in Visit Charting or Back-Office.



- **Discharge Date [A0270] -** Based on discharge date captured in Patient Status.
- **Patient Zip Code [A0550] -** Based on the value of the zip code entered on the address flagged as the Visit Address (set with the Visit Address Radio Button) at the time of the HOPE Admission Record. **NOTE:** This may not be the same as the zip code entered for the Permanent Address.
- **Ethnicity [A1005] and Race [A1010]** - Fields that replace the old HIS - A1000 Race/Ethnicity field.
- **Admitted From [A1805]** - This question replaces the HIS A1802 field. The value is pulled from Admit to Hospice option and will switch to A1805 based on an Agency SOC Date captured with a value of October 1, 2025, or later.



Diagnoses Section I – Active Diagnoses

I0010-Principal Diagnosis and Comorbidities and Co-existing Conditions – This field will only be set as required for the first portion of the question related to Principal Diagnosis. **NOTE**: The second portion related to Comorbidities and Co-existing Conditions should be reviewed by users, but the fields will not have required logic applied to them because there is no option to capture a response when there is no applicable response. Agencies are encouraged to educate users to review the list carefully and chart accordingly without relying solely on required field prompting.

Symptom Impact and Symptom Follow-Up Visit Management and Use of Appropriate Hold Reason

Agencies should review the CMS Guidance on the J2051/J2052 - Symptom Impact and Symptom Follow-Up Visit (SFV) Management when guiding staff on how to manage these questions. As noted in the CMS Guidance, if J2051 - Symptom Impact is charted as 2-Moderate, 3-Severe on either the Admission or an HUV assessment, then charting of J2052 will need to be completed with an SFV. This field is set as required based on the applicable response in J2051 and clinicians will need to manage these fields manually. Per the HOPE Manual, *"the in-person SFV should occur within two calendar days as a follow-up for any moderate or severe pain or non-pain symptom impact identified during an Admission or HUV."*

As previously mentioned, agencies should consider adding a hold reason to the HIS/HOPE Hold Reason Table for the purposes of managing visits that require an SFV. Clinicians should place the assessment on HOLD and complete the SFV, ensuring that all relevant answers are then entered in the HOPE record as appropriate.

To manage the SFV, agencies should consider the following:

- Creating a Service Provided Code (Administration>System>Tables>Service Provided Code) for these visits. As described previously, the table setting can control access and required charting of J2052 and J2053 within Today's Care charting outside of a HOPE assessment.
- Create a new SFV Visit Reason (Administration>System>Tables>Visit Reason) for scheduling these visits and link the applicable Service Provided Code.

IMPORTANT CONSIDERATIONS:

- The values captured for J2052 and J2053 in the SFV will NOT flow back into the HOPE record.
- Answers from the SFV visit can be added into the applicable HOPE Record by:
  - reopening the respective visit in Visit Charting; or
  - opening the record in HOPE Back-Office
- In cases where the SFV Visit details are captured by a clinician other than the one that charted the applicable ADM, HUV1, or HUV2, then adding the SFV Visit information into the record may be best handled by going into the assessment via HOPE Back-Office. In this case, the only way that another clinician could add information to the Visit Charting screens would be to ensure the clinician has Clinical Oversight. Instead, to avoid accessing the visit in Care Pilot>Visit Charting, using Back-Office may be a more prudent approach.

Possible Scenarios:

- **SCENARIO #1**: Nurse Jane starts a HOPE ADM on 10/2/2025 for Patient Doe. The response to J2051-Symptom Impact triggers the need to complete a Symptom Follow-Up Visit and answer J2052- Symptom Follow-up Visit (SFV). Nurse Jane performs the SFV visit in Visit Charting>Todays Care on 10/4/2025 with responses to J2052 and J2053 documented. On 10/5/2025, Nurse Jane reopens her 10/2/2025 visit in Visit Charting and documents the appropriate responses for J2052 and J2053 and then files the visit and HOPE Record as complete. Adds notes to the Z0400 Response for sections completed with dates.
- **SCENARIO #2**: Nurse Jane starts a HOPE ADM on 10/3/2025 for Patient Doe. The response to J2051-Symptom Impact triggers the need to complete a Symptom Follow-Up Visit and answer J2052- Symptom Follow-up Visit (SFV). Nurse Mary performs the SFV visit in Visit Charting>Todays Care on 10/4/2025 with responses to J2052 and J2053 documented. On 10/5/2025, Nurse Mary opens HOPE Back-Office, selects the appropriate visit date/time/assessment to access the HOPE ADM charted by Nurse Jane. Nurse Mary documents the appropriate responses for J2052 and J2053 and adds notes to Z0400 Response for sections completed with dates. Places the HOPE on Hold awaiting Nurse Jane setting the HOPE to complete.
- **SCENARIO #3**: Nurse Jane starts a HOPE ADM on 10/3/2025 for Patient Doe. The response to J2051-Symptom Impact triggers the need to complete a Symptom Follow-Up Visit and answer J2052- Symptom Follow-up Visit (SFV). Nurse Mary performs the SFV visit in Visit Charting>Todays Care on 10/4/2025 with responses to J2052 and J2053 documented. Nurse Mary alerts Nurse Jane the SFV was done with notes available in Visit Summary screens. On 10/5/2025, Nurse Jane opens the HOPE Record either via Visit Charting or HOPE Back-Office charts the J2052 and J2053 fields using notes from the 10/4/2025 visit. Nurse Jane sets the HOPE Record as Complete.

Managing HUV1, HUV2, and SFV Visits

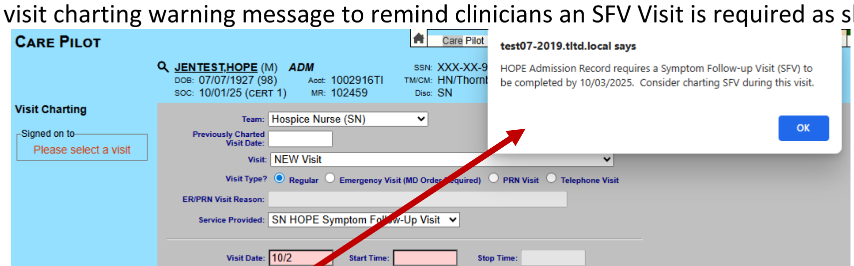
For ease in tracking HOPE Update Visits (HUV) and Symptom Follow-up Visits (SFV), agencies should consider setting up unique Visit Reasons for HUV1, HUV2, and SFV Visits. The reasons are used in scheduling and are configured under Administration>System>Tables>Visit Reason. The Visit Reasons will then be visible on the calendar and the Scheduled Visit Reports and can be sorted accordingly indicating the visit is for an HUV1, HUV2, or an SFV. The Visit Reason Table will then allow agencies to link an applicable Service Provided Code for each corresponding Visit Reason.

As previously described, creating a unique Service Provided Code for SFVs using the special settings for the HOPE Symptom Follow-Up Visit option will enable specific charting logic. These Service Provided Codes should be linked to the SFV Visit Reasons. Similarly, agencies should consider setting up a Service Provided Code for the HUVs either as one code for both HUV 1 and 2 or two separate codes for HUV1 and HUV2 respectively.

Visit Charting Reminders

In an effort to aid users in managing HOPE charting, visit charting warning reminders will be triggered based on follow-up requirements and meeting certain timepoints. The warnings are as follows:

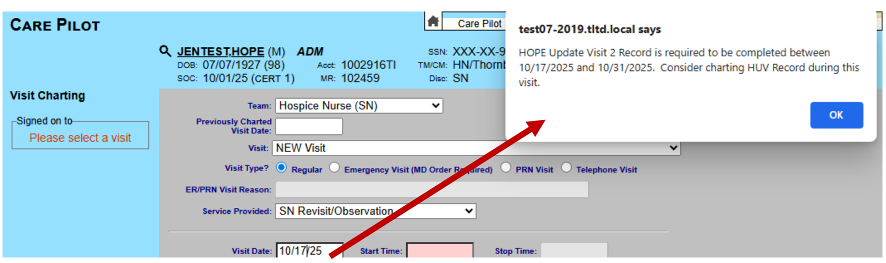
- **SFV Visit Required** – When a Symptom Follow-Up Visit is required as the result of a 2-Moderate or 3-Severe response in J2051, NDoc will trigger a visit charting warning message to remind clinicians an SFV Visit is required as shown below:



  These warnings will persist for two calendar days after the SFV requirement is triggered or until the SFV responses are documented in the corresponding HOPE assessment, whichever comes first. Users linked to a Nursing Team (e.g., SN, HN, LPN) will see the warnings.

- **HUV 1 and HUV 2 Required –** Based on HOPE rules, a HOPE Update Visit (HUV) is required within two timepoints as follows:
  - HUV1 is required on or between days 6 and 15 of the hospice stay.
  - HUV2 is required on or between days 16 and 30 of the hospice stay.

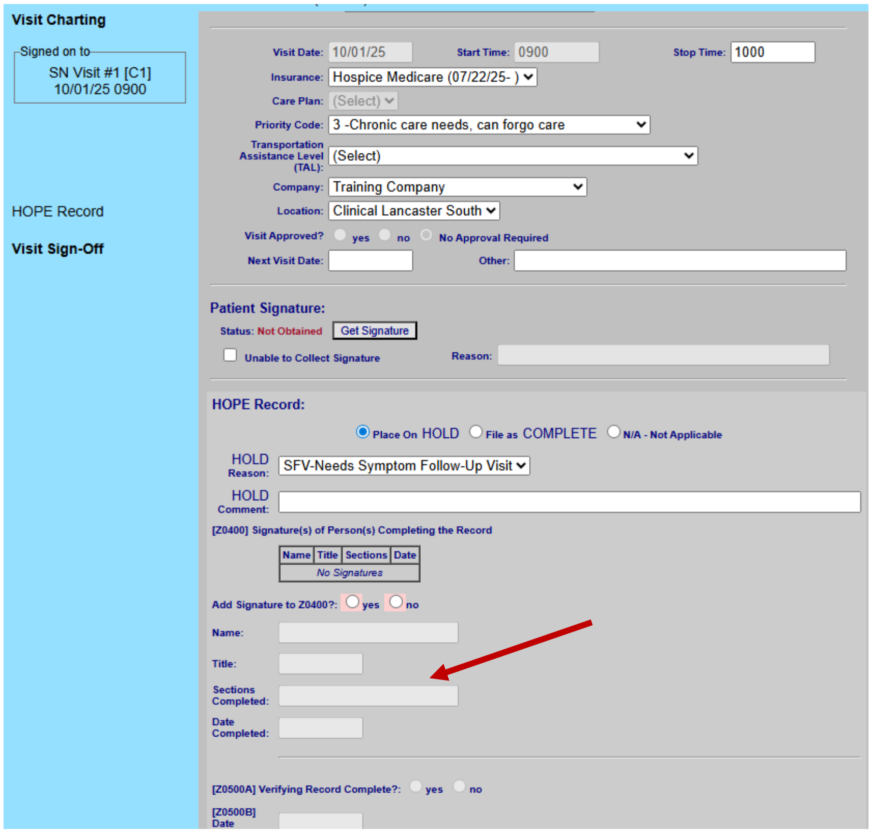
  To assist in the management of these visits, the system will trigger warning reminders based on the applicable time period as follows:



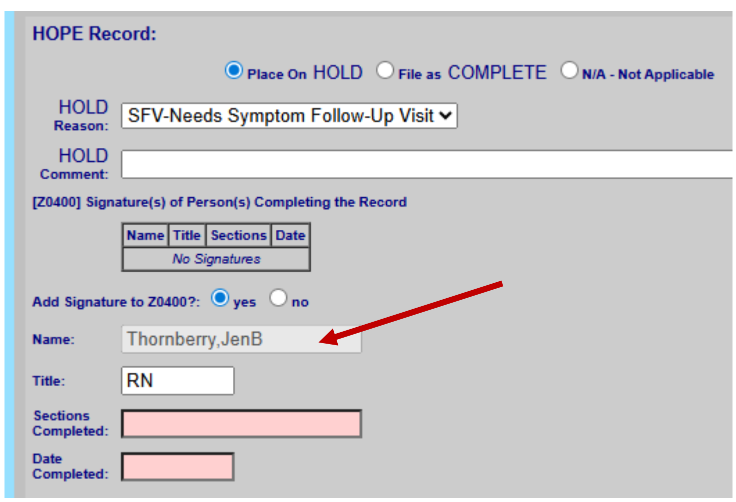
Z0400 Record Administration Information

Z0400 - Signature(s) of Person(s) Completing the Record Z0400 is now a field that can be completed within the charting screens and Back-Office.

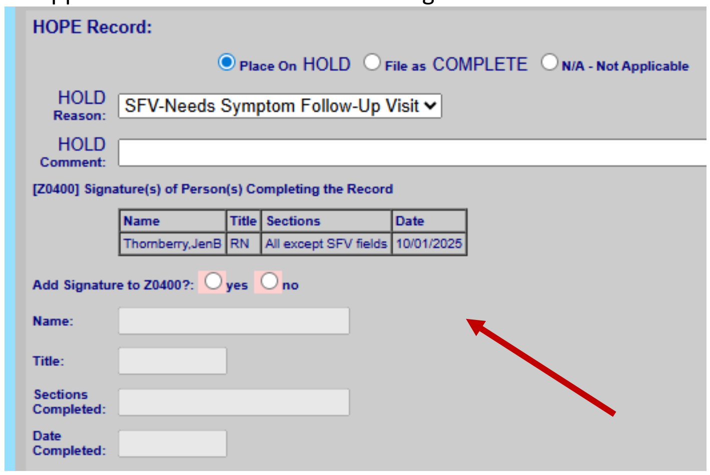
In **Visit Charting**, when signing off the visit, users will see a prompt related to Z0400



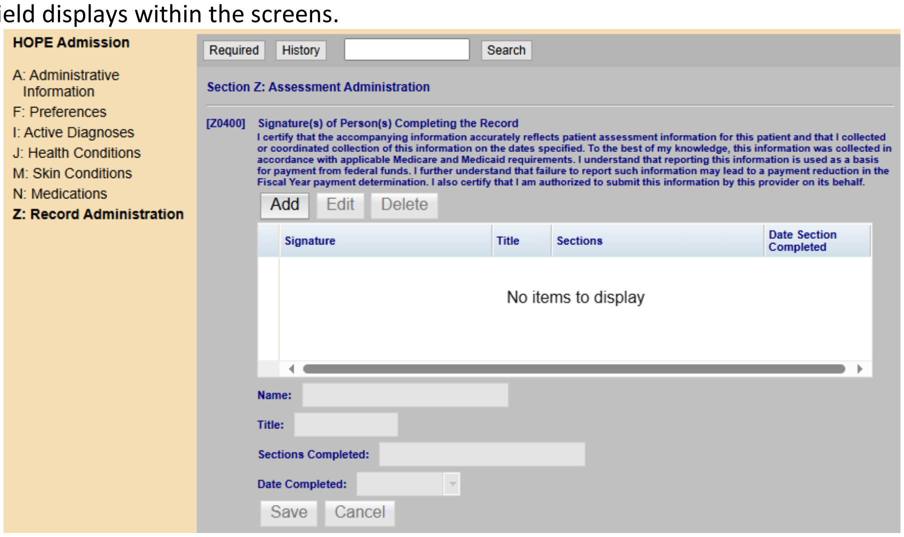
Clicking **Yes** to *Add Signature to Z0400?* will autofill the user's name and the Title based on the Signature User Type Abbreviation as set in the Employee Table but can be edited as needed. The Section Completed (free text) and Date fields can then be edited accordingly.



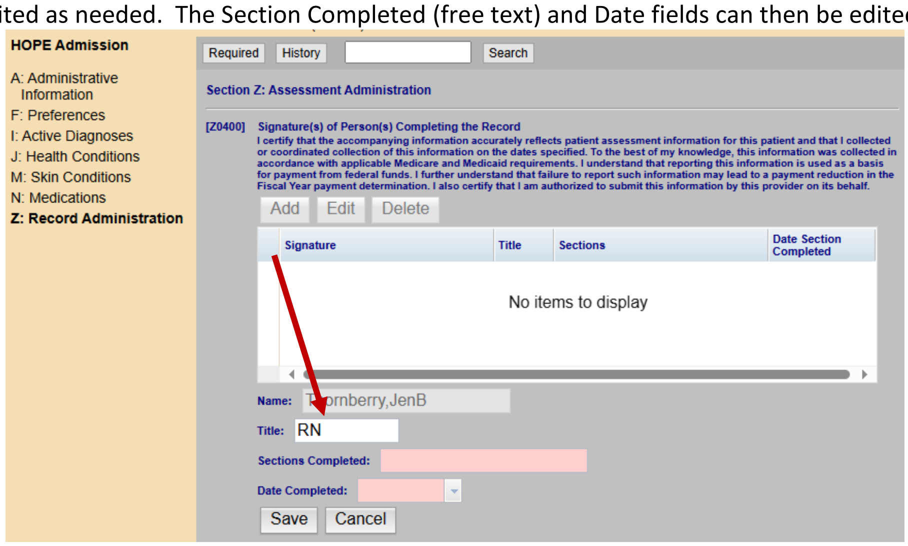
Completing this information will appear as follows in the next visit sign-off.



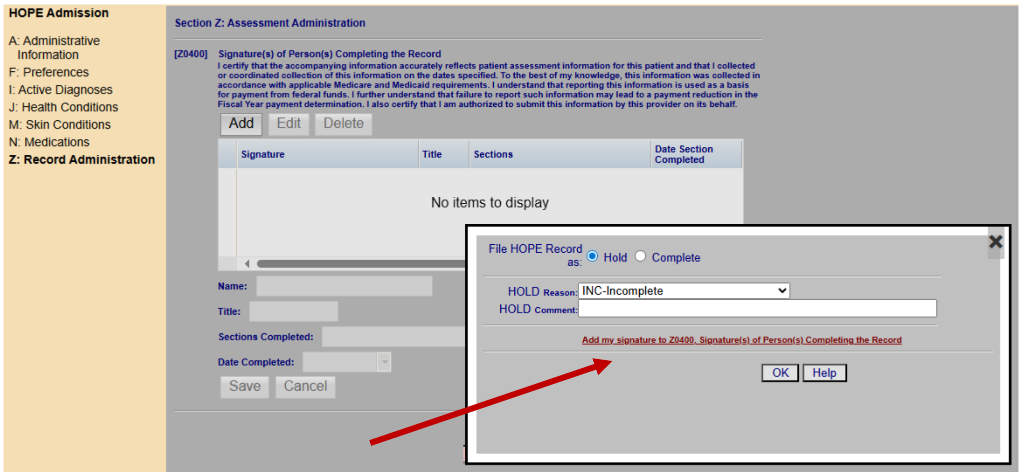
In **Back-Office**, the field displays within the screens.



Clicking the **Add** button autofills the user's name and the Title based on the Signature User Type Abbreviation as set in the Employee Table but can be edited as needed. The Section Completed (free text) and Date fields can then be edited accordingly.

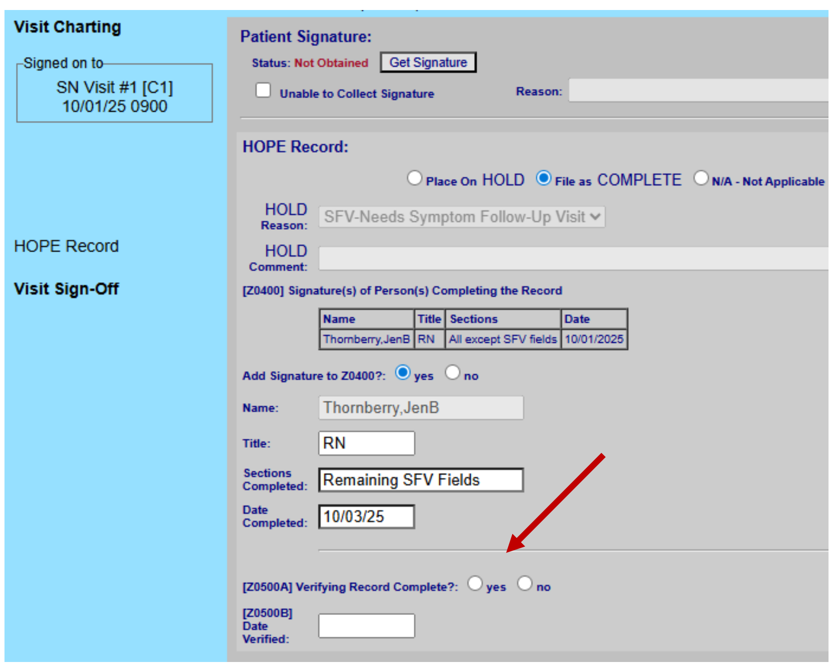


Alternatively, when quitting out of the Back-Office records, users will also see a prompt to redirect to this screen as shown here, which will autofill the details as shown above.



Z0500 - Signature of Person Verifying Record Completion

The Z0500 – Verification Record Complete? – Yes/No question is present in Visit Charting. When all of the required fields are documented and the HOPE Record can be filed as complete, users have the option to complete the Z0500 verification below the Z0400 recording.



As with HIS Records, HOPE functionality in Back-Office does not provide the option to capture the Z0500 verification user or date. The verification, in these cases, can be managed within HOPE Records Maintenance similar to the existing HIS Records logic.

Managing HOPE Files

Identification

A HOPE Record is created within NDoc either in Visit Charting or in Operations>Data Entry>HOPE Back-Office. Each document created will have a document ID number assigned based on the RFA number. These values are then used as prefixes to the related records. For example, a patient's SOC HOPE will be set as 2111 (the first RFR 1 for the record). The corresponding HUV entries will be set as 2121, 2131 accordingly, with the Discharge set as 2191.

RFR Number Description	Document ID Number
HOPE Hospice Admission Record	211
HOPE Update Visit 1 Record	212
HOPE Update Visit 2 Record	213
HOPE Discharge Record	219

Status

HOPE records can be filed with a status of either HOLD or COMPLETE. HOLD status allows the clinician to access the document at any time from a client/field device or via live charting on the server. COMPLETE status is only possible once ALL the HOPE questions and any other required charting fields have been answered. The date displaying as COMPLETE is the date the document was FIRST filed as COMPLETE. Unlike OASIS documents, HOPE Records also have the extra step of having a “verification” date charted. This can be charted at sign-off in Visit Charting or in HOPE Records Maintenance (Administration>Patient).

Managing HOPE with HOPE Records Maintenance (Administration>Patient)

The central location to view details about an individual patient’s HOPE Records is the HOPE Records Maintenance function under Administration>Patient. This tool provides key information about the listed HOPE records including important dates and history of charting. Users can also use this function to perform certain actions, including placing the assessment on hold, deleting the document, verifying a record, or managing inactivations or corrections.

Viewing the Record history

Detail(s) of HOPE Record actions can be viewed within the HOPE Records Maintenance function by clicking the **History [HX]** button after identifying the document by clicking on the bullet in first column. From here you can see who created the document, the visit date and time associated with the document, when it was filed as COMPLETE, who may have placed it on HOLD, Inactivated, Re-Exported and all with the date of this action. You can also view a history of any notes or comments added when placing the record back on HOLD. The notes will appear within the Comments field at the bottom of the screen.

Viewing the Record detail

Detail of a charted HOPE Record can be viewed in both the Patient Summary or within the HOPE Records Maintenance. Within Patient Summary, the Visit tab will provide access to the visit details associated with a HOPE Record if it is linked to a visit. Additionally, the Docs tab provides a hyperlink to a chronological list of the HOPE Item values charted for each HOPE visit. The HOPE Records Maintenance option under Administration>Patient provides access to more specific data related to the record, including a preview of the charted values. Users can click the **Preview [PV]** button, once you identify the record you would like to preview. Since only the HOPE Records are listed within the HOPE Records Maintenance function, this is usually the most efficient way to find a particular record. The Item field #s will display beside each entry.

Editing the Record

When a document is in HOLD status, the clinician originating the HOPE Record may make changes or corrections as needed. Your agency can control a table of HOPE HOLD Reasons under Administration>System>Tables that also promote communications regarding why this document remains in HOLD status. After making corrections/additions, the patient file is updated during the daily Client Synchronization procedure.

Once filed as COMPLETE, the clinician no longer has access to the HOPE Record. If additional editing is necessary by the originating clinician, you must first start in Administration>Patient>HOPE Records Maintenance to return the document to HOLD status. This function is normally assigned to persons managing the HOPE record process in your agency and is NOT available on a client device.

Once you have selected the patient and the RFR record, you can place it on HOLD and SAVE. In the course of placing the assessment on HOLD, you may select a HOLD Reason to assign for greater communication/ direction. The clinician receives an updated copy of the patient file during their next daily client synchronization. After a successful sync, the assessment will be in HOLD status on the client device, and any changes/corrections can be made. Should the corrections be needed immediately, once the document is in HOLD status, the clinician may use the RECEIVE option via Operations>Client Sync to pull this patient record. Once received, any needed revisions can be achieved and the assessment can again be filed as complete. When completed, the file can be sent back to the server using the SEND option via Operations>Client Sync. Once the SEND is successful, you have a corrected and complete patient file on the server that will export as soon as the export parameters set up by your agency are met. If the corrections are made after the document has reached the agency defined export parameters, the completed, corrected document is queued immediately for export during nightly processing, which then does not add unnecessary delay in submission. Please note that with HOPE Records agencies must also complete the final step of completing Item Z0500A and B to verify the responses are complete.

Consequently, when placed on hold after this response has been entered, the verification response and date are cleared requiring it to be charted again after the assessment has been set to complete. Users may complete the verification within the visit sign-off screens or within HOPE Records Maintenance.

HOPE Record Export Process

Export Process in General

Based on both regulatory definitions and your agency-specific date parameters, every night NDoc creates a file for each completed HOPE Record that is then ready for transmission to CMS. The HOPE Settings screen (Administration>System>Settings>HOPE Record) enables agencies to determine the path for these files. The individual files will be set up within the directory accordingly. For details on the process for accessing and downloading these files, please see the NDoc File Downloads Function FASTForm. The files can be identified using this file naming convention:

HOPE_accountNumber_targetDate_recordType_correctionNumber.XML

For example, users should see the files within the directory as shown below:

HOPE_1002916_20251001_Admission_0.XML
HOPE_1002916_20251007_Update1_0.XML
HOPE_1002916_20251019_Update2_0.XML
HOPE_1002916_20251101_Discharge_0.XML

Please note that per CMS specifications, the file layout results in each file being set up as an XML file. NDoc generates an individual XML file containing the data for a single assessment record. When submitted to the iQIES system, agencies must submit the files in zipped form. ZIP files may contain one or more XML files that will be submitted to iQIES. Additional details are provided below and in the FASTForm related to File Downloads.

Export File Logic

To minimize HOPE submission warnings/errors, NDoc takes many factors into consideration prior to exporting HOPE records. The first of these is the record status -- only records with an active (not deleted) status of COMPLETE (including the Verification check and date as required in Z0500) will be considered for export. The HOPE Record Settings page will determine the time of the export trigger.

Export NOW

There are times when users may need to force a submission to the export queue (e.g., a key field error is found or the staff determines a response needs to be corrected and the agency wishes to avoid submission errors). This is accomplished within the HOPE Records Maintenance function. In that case, the users can select the record within HOPE Records Maintenance and use the Export NOW option to force the generation of a file to the export queue.

Corrections After File has been Exported

If an error has been identified after the document has been exported from NDoc, you are still able to correct the document within NDoc and re-export as needed. Agencies determine the user type(s) authorized to place an already exported document back on HOLD status using the drop-down selection within the agency settings under Administration>Systems>Settings>HOPE Settings. Since HOPE submissions are of great importance, this is a tool within NDoc that allows for enhanced management and coordination.

If the error found is a non-key HOPE field, follow this procedure:

- Select the appropriate document from the **HOPE Records Maintenance** table display
- Place the document on **HOLD** to begin the correction process
- Select Resubmit Assessment = YES
- NDoc will auto-calculate the next “Correction Number.” Please be sure to reference the current CMS rules regarding correction number changes. If needed, it can be overwritten/changed to original numbering.
- **SAVE** the action you have just initiated
- Advise the clinician of the necessary correction.

Once the document is corrected and filed as COMPLETE by the clinician and Verified, NDoc will place it into the export queue to appear in the next day’s export files. You can export the document immediately by utilizing the Export NOW action. This is important to consider should the assessment involved be associated with other assessments currently being withheld from the export files due to sequencing rules.

If the error found is a key OASIS field as defined by CMS on an **ACCEPTED** record, follow this procedure:

- Select the appropriate document from the **HOPE Records Maintenance** table display.
- Select **Inactivate Assessment**. The correction number for the inactivation record is to be one higher than the last exported correction number. If the file has never been corrected, then first inactivation record must have a correction number of 1. Enter the required correction number as needed based on the timing of the correction and determination of whether incremented numbers are necessary (refer to CMS guidance).
- Determine if a replacement record is necessary.

If no replacement record is needed,

- No further action is necessary.

If a replacement is required to be sent,

- Indicate that you want a new assessment created from the inactivated assessment.
- NDoc will inactivate the original assessment, indicating this with the appropriate date in the **Inactivate Date** column in **HOPE Records Maintenance** table display.
- NDoc will create a second duplicate assessment that will be on hold. Please note that the newly created assessment is no longer linked to the originating visit. The user executing the inactivation process and associated with the assessment being placed on hold is now the responsible clinician.
- Go to **Operations>Data Entry>HOPE(Back-Office)** to access the assessment by selecting the clinician, the appropriate RFR selection, and other relevant options.
- Make the necessary corrections to the assessment and file it as complete.

PLEASE NOTE: Users should ensure that the Inactivation Record has been **ACCEPTED** in iQIES BEFORE sending the replacement. This will prevent problems with rejections of the replacement when the inactivation is not in place.

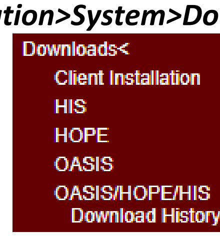
HOPE Record Download and Submission Process

Accessing HOPE Exports

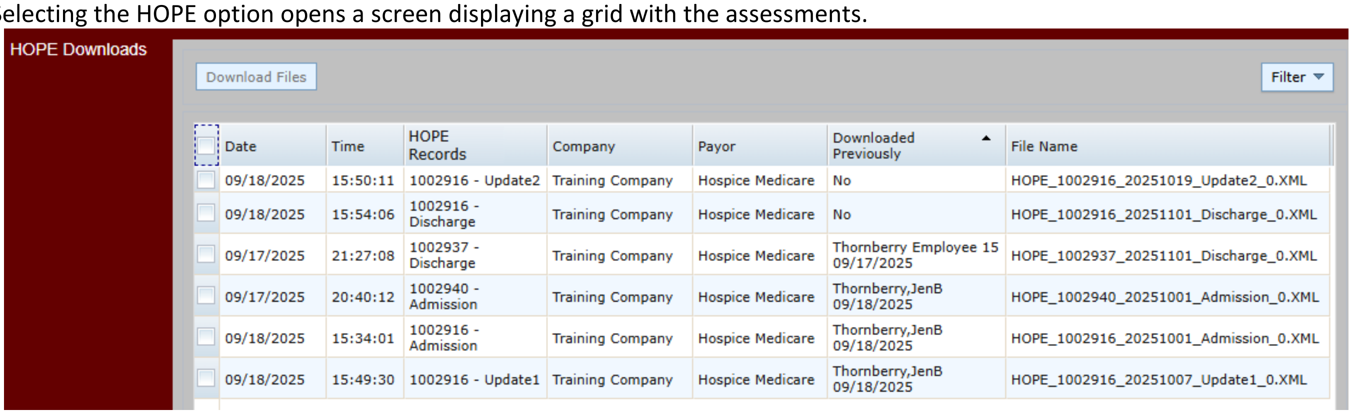
As explained previously, NDoc generates the HOPE files formatted with the proper XML standards and can be accessed within this directory for manual submission to CMS if preferred rather than the download process explained below.

Downloading HOPE Exports using the Downloads Function (Administration>System>Downloads)

To manage the file creation process for submitting HOPE files to CMS, agencies should utilize the download option within the Administration Module (Administration>System>Downloads>HOPE). This feature gives agencies easier access to files and aids in managing download files, including HOPE files.



Selecting the HOPE option opens a screen displaying a grid with the assessments.



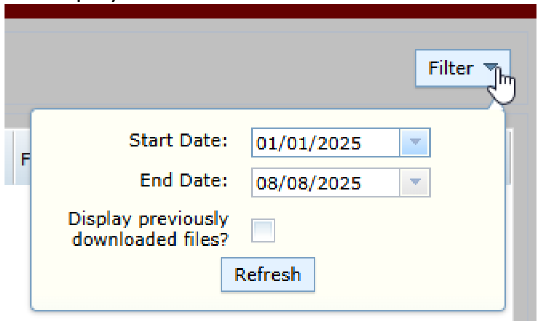
	Date	Time	HOPE Records	Company	Payor	Downloaded Previously	File Name
	09/18/2025	15:50:11	1002916 - Update2	Training Company	Hospice Medicare	No	HOPE_1002916_20251019_Update2_0.XML
	09/18/2025	15:54:06	1002916 - Discharge	Training Company	Hospice Medicare	No	HOPE_1002916_20251101_Discharge_0.XML
	09/17/2025	21:27:08	1002937 - Discharge	Training Company	Hospice Medicare	Thornberry Employee 15 09/17/2025	HOPE_1002937_20251101_Discharge_0.XML
	09/17/2025	20:40:12	1002940 - Admission	Training Company	Hospice Medicare	Thornberry,JenB 09/18/2025	HOPE_1002940_20251001_Admission_0.XML
	09/18/2025	15:34:01	1002916 - Admission	Training Company	Hospice Medicare	Thornberry,JenB 09/18/2025	HOPE_1002916_20251001_Admission_0.XML
	09/18/2025	15:49:30	1002916 - Update1	Training Company	Hospice Medicare	Thornberry,JenB 09/18/2025	HOPE_1002916_20251007_Update1_0.XML

The Downloads page includes columns with a variety of details. The grid within the HOPE Downloads function provides agencies a variety of options:

- Each column is sortable by double clicking the column header.
- Users can select files individually with each checkbox, multi-select using the shift key and highlighting multiple rows or select all files using the checkbox in the top row above the checkboxes.

- Use the Filter button on the top right of the screen to determine the results on the screen.

Using the Filter button, users can narrow the results by selecting a date range, export type, or determining whether to display previously downloaded files. The screen display defaults to the first of the month forward.



Once you have made your selections, click the Download Files button. Downloading the file(s) varies based on hosted vs. non-hosted agencies:

- **Non-Hosted** - Follow the prompts on the screen to complete the download process.
- **Hosted** – When you click **Save As** next to the file, you are given a Restrictions Error – click **OK**. Choose **Computer** and your local drives should display to which you can download the file. If they do not, go to the Hosted Customers section of the Knowledgebase site to get the latest **Remote Desktop Protocol** icon.

The generated ZIP file can then be accessed and reviewed for content or submitted to CMS. For details on the process for accessing and downloading these files, please see the NDoc File Downloads Function FASTForm.

Submission Process

The process for submitting the XML files should follow the guidance prescribed by CMS. Specifically, the submission files are submitted through an electronic process administered by the Internet Quality Improvement and Evaluation System (iQIES) through the QIES Technical Support Office (QTSO) via the QTSO website. Agencies should refer to this website for specific details regarding system login credentials as described within the site's Hospice Submission User's Guide section. Please refer to the NDoc File Download FASTForm for specific details regarding accessing and downloading the HOPE XML records. This feature is found under Administration> System>Downloads and enables users to select multiple HOPE export files that have been exported on the NDoc server. Those files can then be downloaded into one compressed (zip) file.

Dashboard Reminders

Dashboard Reminders are designed to alert users and Case Managers about needed documentation. The reminders will display on the To Do: Due/Overdue Dashboard with the related logic as shown below:

TIMING:

• HIS ADM - Only for Admissions prior to 10/01/2025	• HIS DC - Only for Discharges prior 10/01/2025
• HOPE ADM/HUV - Only for Admissions on or after 10/01/2025	• HOPE DC - Only for Discharges on or after 10/01/2025

MESSAGING:

Reminder	Messages	Recipient
HOPE Missing	• HOPE Admission Record {RFR 1} – Missing • HOPE Update 1/2 Record {RFR 2/3} – Missing • HOPE Discharge Record {RFR 9} – Missing	Case Manager
HOPE Incomplete	• HOPE Admission Record {RFR 1} – Incomplete [DocID] • HOPE Update 1/2 Record {RFR 2/3} – Incomplete [DocID] • HOPE Discharge Record {RFR 9} – Incomplete [DocID]	Case Manager, Clinician who started the HOPE Record
HOPE SFV Needed	DocID (The DocID of the assessment that triggered the need for an SFV)	Case Manager, Clinician who started the HOPE Record

Reports

Reports in General

Reports are available to aid in the most efficient management of this process. Each report provides a different level of detail designed to manage separate parts of the workflow.

HOPE Status Listing (Reports>Document)

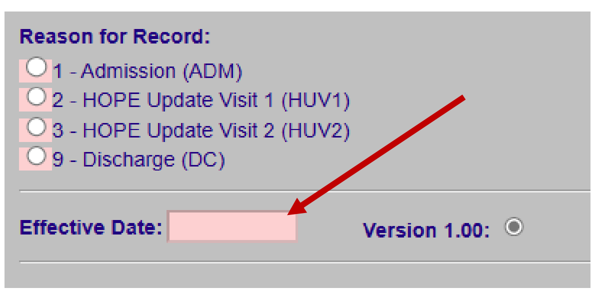
This report provides agencies the tracking functionality of the legacy Report Status Listing and Patient Tracking Reports currently used for OASIS, HIS, and POC tracking. Using this tool, agencies can generate lists of HOPE Records that are missing, incomplete, awaiting completion, or awaiting a verification date. Additionally, the report will provide options to generate lists of HOPE Records that triggered a Symptom Follow-up Visit (SFV). This report can be used to manage HOPE Records before they are in a position to be triggered for internal export in the system and queued for validation. The following are points of clarity related to the report:

- **Due Date Logic:** Due dates are based on the HOPE Manual guidance related to the Timeframe as shown below:

Table 1: HOPE Timepoint Definitions and Timeframes

Timepoint	Definition	Timeframe
Admission	The HOPE-Admission data are collected as part of the comprehensive assessment of the patient.	No later than five calendar days after the effective date of the hospice election.
HOPE Update Visit 1 (HUV1)	The data for HUV1 are collected via an in-person visit to inform updates to the plan of care.[2]	HUV1 is required on or between days six and 15 of the hospice stay and should ***not be conducted*** within the first five days after the hospice election. The date of the hospice election would be considered "Day 0."
HOPE Update Visit 2 (HUV2)	The data for HUV2 are collected via an in-person visit to inform updates to the plan of care.	HUV2 is required on or between days 16 and 30 after the hospice election.
Discharge	The data are collected at Discharge for any reason listed in A2115.	At the time of discharge.[3]

- **Document Date:** This value reflects the "Effective Date" related to the HOPE Record or the date populated or present within the HOPE Record selection page.



Specifically, the Effective Date for a HOPE Admission will be the A0250 Date or the Admission/SOC Date as captured within the Patient Status' Admit to Hospice screen. The HUV Records' Effective Dates will be the Visit Date(s) or the manually entered Effective Date for HOPE Back-Office Records created without a linked visit. Finally, the Discharge HOPE Record's Effective Date will be the A0270 Date or the Discharge Date.

- **SFV Triggered Column:** The YES value in this column indicates a Symptom Follow-Up Visit was triggered within the record. The value will remain present even after the SFV values have been updated within the respective record. This can be used to track HOPE records that are awaiting SFV charting or ever triggered the need for an SFV for future trending if needed.
- **Exported Records:** The status of Exported reflects HOPE records that have been successfully validated. To exclude those records from the report, use the filters to not include the Exported status. For further details related to the exported items, refer to the Interface Activity Report or the OASIS/HIS/HOLD Downloads History report described below.
- **HUVs for Discharged Patients:** If a patient has been discharged within the date range of the HUV Records, the HUV(s) are not tracked as being required. Items on the HOPE Status Listing Report will shift from a status of “Missing” to “Not Required” and will be hidden from the report by default. A checkbox at the bottom of the Filter page is available if agencies wish to see those items listed. Additionally, the HOPE Status Listing report will show “Never Completed” for an HUV that was required, but the patient has been discharged for more than 30 days.

OASIS/HOPE/HIS Download History (Administration>System>Downloads)
This report provides details related to a HOPE Record that has been “downloaded” from the HOPE Downloads page. The columns include details related to the export date and the download date and user that completed the action. Agencies can use this for reference, but the manual upload to iQIES is not tracked internally.

Interface Activity (Reports>Interface)
This report serves as the primary tool to manage exported files, namely OASIS, HIS, and HOPE records. For HOPE tracking, agencies should use the HOPE Export option.

This report details the exported HOPE Records and the success or failure of each. This report is designed to serve as an auditing tool for HOPE files to measure whether the files are successfully validated for export. These files may include assessments that are part of the export actions taken during Nightly Processing, as well as files that are set up for immediate export using the Export NOW function. The report displays the status of the file’s validation and displays an outcome of the validation. Records that are labeled as “Failure” include a fatal error that would constitute a rejection.

Using the View version of the report, users may click the hyperlinked *Activity Detail* text under the Activity Detail column to expand the entry to see the details of the error. Armed with the information, agencies can then go back to the record and make needed corrections. Agencies should review this report frequently as a safeguard to ensure HOPE exports are getting processed correctly and timely.

HOPE/HIS List (Reports>Patient)
This report provides a glimpse of the status of the RFR documents within a particular window of time.