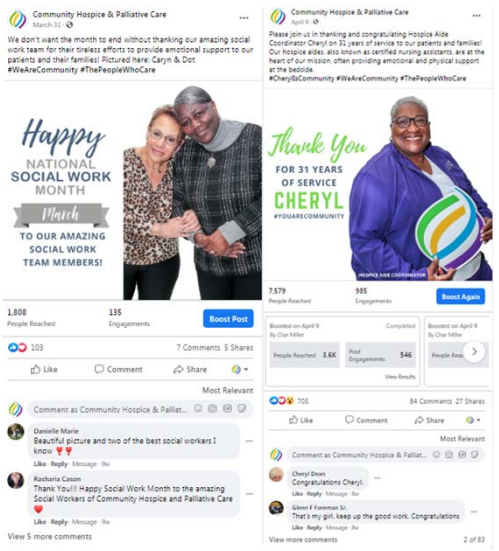
Hospice Overview

We Are Community. The People Who Care.

- In 2019, we identified **27 individuals from across all disciplines within our organization who are our tenured brand ambassadors**. We coordinated interviews, photo shoots, etc. to put together a new 2020 advertising, marketing and communications campaign.
- **We launched the "We Are Community. The People Who Care."** external and internal campaign in February **focusing on our people**, the ones who provide the care.
- Then **COVID-19** impacted our world.

We Are Community. The People Who Care.

- In early March, we started **communicating by email and text daily** with our staff, and in some instances multiple times a day for a total of 25 communications through multiple channels just in the month of March.
- At the same time, we launched the "We Are Community" campaign on our social media channels, and we noticed something. **People wanted to openly express their thanks to our staff for being on the front lines!** Some of those people were our **own staff, and it gave them the opportunity to give a "shout out" to their colleagues near and far.**

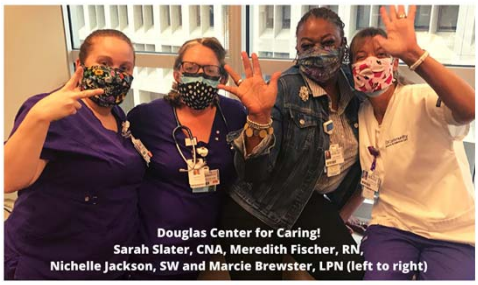


Hospice Overview

What Are You Doing?

- **In mid-April, we launched the "What Are You doing?"** internal campaign as a way to **thank and stay connected to our staff across 16 different counties**, and break the monotony of constant operational email and text communications. **We simply asked staff to send in photos** of what they were doing, and they did!

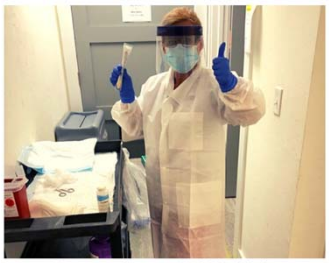
WHAT ARE YOU DOING?



Douglas Center for Caring!
Sarah Slater, CNA, Meredith Fischer, RN,
Nichelle Jackson, SW and Marcie Brewster, LPN (left to right)

SEND IT TO: Communications@communityhospice.com

WHAT ARE YOU DOING?

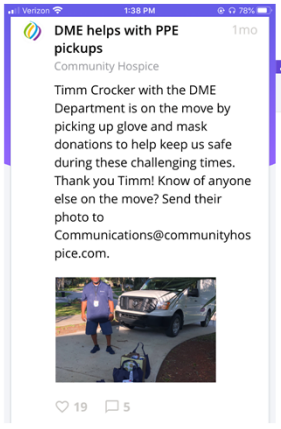


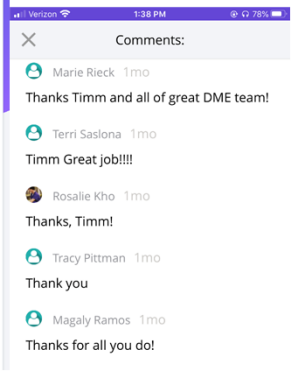
Not sure, but we THINK this is
NC Regional Director Billie Adkins under there?!

SEND IT TO: Communications@communityhospice.com

What Are You Doing?

- **Photos and stories flooded in, so we shared them with our 6,549 followers on Facebook, and with our employees** on our newly launched internal mobile app!





What Are You Doing?

- **Our staff still sends in photos daily,** but this one might be our favorite. Amidst the crisis, our staff found a way to be resilient by infusing humor into their "What Are You Doing" submittal in the form of a **unique "tip jar!"**

Business Continuity: COVID-19

Action Plan Snap Shot

Date	April 30, 2020

BCP Team

- **Core Team:** Michele Edenfield, Char Miller, Eric Brown, Christina McCurdy, Brandon Culp, Sherrie Bennett, Bobbie Hoover, Dr. Ana Sanchez, Jennifer Nicks, Patrice Austin, Faith Moorhouse, Stephen Choate, Cheryl Dean
- **Stakeholders:** Phil Ward, Mary McElroy, Kenny Stevenson

Action Items	Owner	Due Date	%	RAG
HCR PPE Solicitation Letter	Missy/Charlene	03/24/20	100%	Complete
PPE Vendor Solicitation List	Brandon/Charlene	FLUID	-	*FLUID*
Volunteer Quilt Solicitation	Eric/Dan	03/24/20	100%	Complete
iPads for LTCs	Bobbie/Brandon	04/24/20	100%	Complete
Letter of Refusal	Kenny	03/25/20	100%	Complete
Circle of Exposure Chart	Eric/Jennifer	03/26/20	-	Removed
EE FAQ	Eric/Jennifer	03/26/20	100%	Complete
Curfew Waiver	Kenny/Char	03/26/20	100%	Complete
Communication Plan	Char	FLUID	-	*FLUID*
# of LTC to GIP Xfers	Bobbie	03/25/20	100%	Complete
WFH P&P	Eric	03/25/20	95%	Complete
Hotline Clarification Verbiage	Sam/Brandon	03/26/20	100%	Complete
Update Allscripts Label	Sam	03/25/20	100%	Complete
P&P – Alternate PPE	Mary/Craig	04/01/20	100%	Complete
PPE Burn System	Craig	04/03/20	95%	In Progress
Staff Clothes P&P	Mary	04/01/20	100%	Complete
Additional Resources for Jennifer Nicks	Mary	03/25/20	100%	Complete
PPE Supplier Analysis	Jim G.	03/25/20	100%	Complete
Telehealth for Clinical	Kenny/Michele	FLUID	-	*FLUID*
PPE Afterhours P&P	Mary/Craig	04/08/20	100%	Complete
HR Pool	Eric	04/10/20	75%	Complete
New Call Out Process	Eric	04/17/20	75%	Complete
Operational Plan	Phil	05/01/20		In Progress

Current Overall Status	In Progress

Previous Overall Status	In Progress

Key Decisions

N/A

Call Outs

- COVID Specific Call Outs:
- Isolation/Quarantine = 3
- Work Related = 0
- Non-Work Related = 3
- Returned to Work = 1

GIP/Office Screening (*daily data for prior day*)

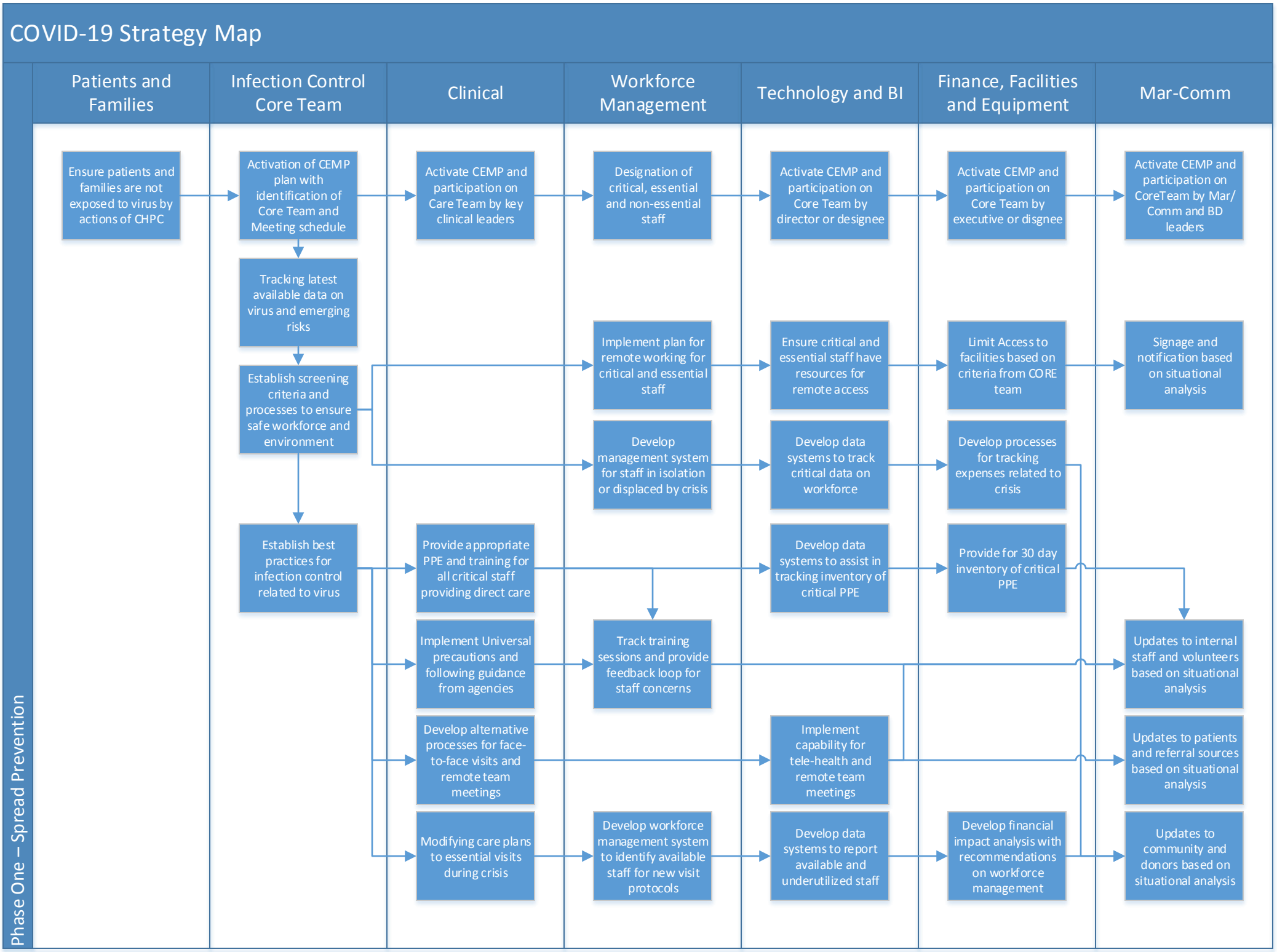
- Screened 04/29/2020 :
- Visitors = 45
- EEs = 140
- Vendors = 24
- Daily Turned Away: 0
- Cumulative Screened: 5,323
- Cumulative Turned Away: 4

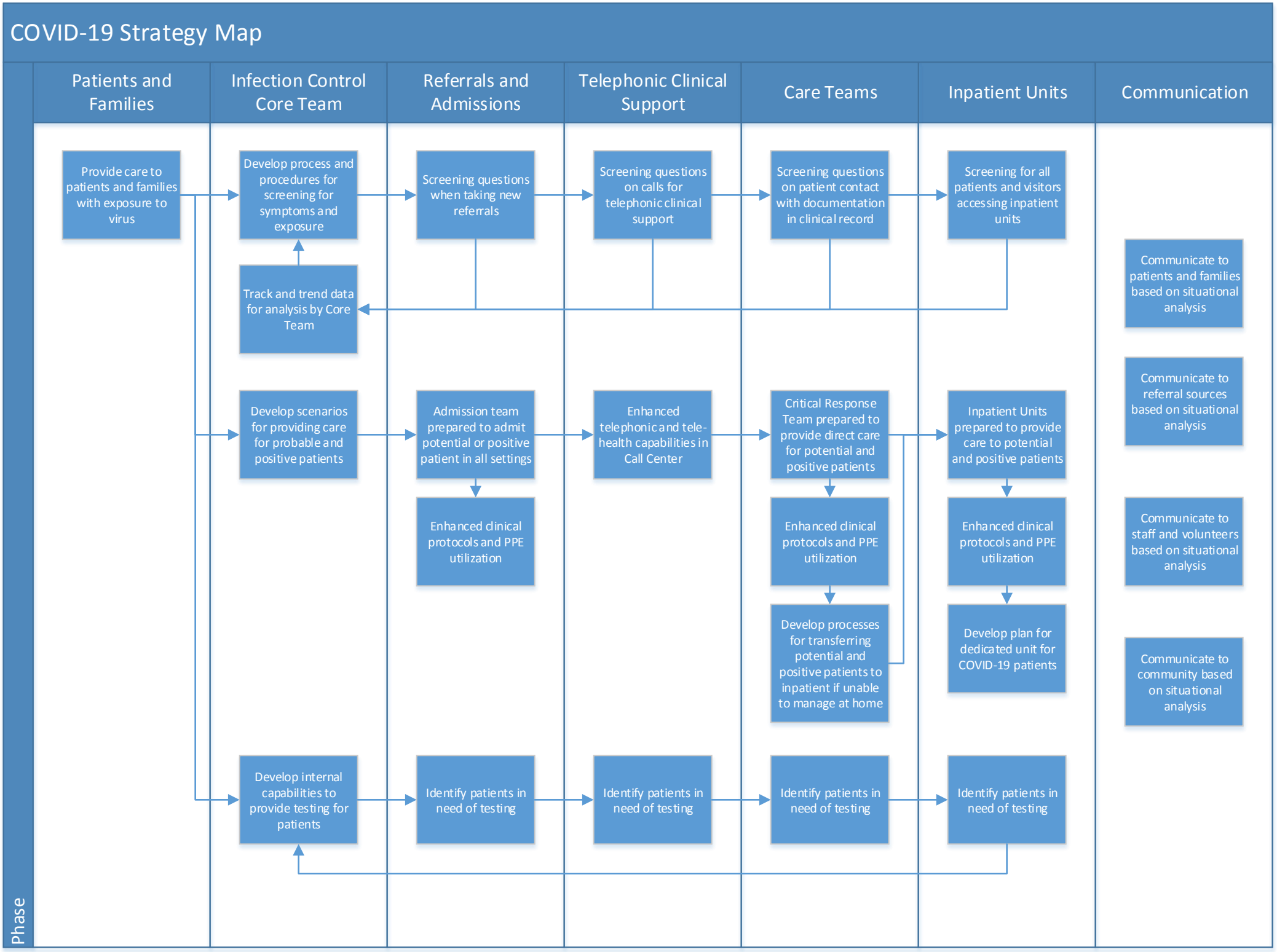
PPE Inventory

- Surgical Masks = 117,073
- Surgical Masks w/Shields = 3,145
- Isolation Gowns = 4,207
- Cloth Gowns = 988
- N95 = 4,586
- Goggles = 171
- Hand Sanitizer = 744 4oz bottles, 16 1oz bottles
- Gloves = 88,362 (xs-xl)

Key Issues and Risks

1. Acquiring/Procuring PPE
2. EE Anxiety and Fatigue


COVID-19 Strategy Map
Phase One – Spread Prevention
Patients and Families
Infection Control Core Team
Clinical
Workforce Management
Technology and BI
Finance, Facilities and Equipment
Mar-Comm
Ensure patients and families are not exposed to virus by actions of CHPC
Activation of CEMP plan with identification of Core Team and Meeting schedule
Activate CEMP and participation on Care Team by key clinical leaders
Designation of critical, essential and non-essential staff
Activate CEMP and participation on Core Team by director or designee
Activate CEMP and participation on Core Team by executive or disgnee
Activate CEMP and participation on CoreTeam by Mar/ Comm and BD leaders
Tracking latest available data on virus and emerging risks
Establish screening criteria and processes to ensure safe workforce and environment
Implement plan for remote working for critical and essential staff
Ensure critical and essential staff have resources for remote access
Limit Access to facilities based on criteria from CORE team
Signage and notification based on situational analysis
Develop management system for staff in isolation or displaced by crisis
Develop data systems to track critical data on workforce
Develop processes for tracking expenses related to crisis
Establish best practices for infection control related to virus
Provide appropriate PPE and training for all critical staff providing direct care
Develop data systems to assist in tracking inventory of critical PPE
Provide for 30 day inventory of critical PPE
Implement Universal precautions and following guidance from agencies
Track training sessions and provide feedback loop for staff concerns
Updates to internal staff and volunteers based on situational analysis
Develop alternative processes for face-to-face visits and remote team meetings
Implement capability for tele-health and remote team meetings
Updates to patients and referral sources based on situational analysis
Modifying care plans to essential visits during crisis
Develop workforce management system to identify available staff for new visit protocols
Develop data systems to report available and underutilized staff
Develop financial impact analysis with recommendations on workforce management
Updates to community and donors based on situational analysis


COVID-19 Strategy Map
Phase
Patients and Families
Infection Control Core Team
Referrals and Admissions
Telephonic Clinical Support
Care Teams
Inpatient Units
Communication
Provide care to patients and families with exposure to virus
Develop process and procedures for screening for symptoms and exposure
Track and trend data for analysis by Core Team
Screening questions when taking new referrals
Screening questions on calls for telephonic clinical support
Screening questions on patient contact with documentation in clinical record
Screening for all patients and visitors accessing inpatient units
Communicate to patients and families based on situational analysis
Develop scenarios for providing care for probable and positive patients
Admission team prepared to admit potential or positive patient in all settings
Enhanced clinical protocols and PPE utilization
Enhanced telephonic and tele-health capabilities in Call Center
Critical Response Team prepared to provide direct care for potential and positive patients
Enhanced clinical protocols and PPE utilization
Develop processes for transferring potential and positive patients to inpatient if unable to manage at home
Inpatient Units prepared to provide care to potential and positive patients
Enhanced clinical protocols and PPE utilization
Develop plan for dedicated unit for COVID-19 patients
Communicate to referral sources based on situational analysis
Communicate to staff and volunteers based on situational analysis
Communicate to community based on situational analysis
Develop internal capabilities to provide testing for patients
Identify patients in need of testing
Identify patients in need of testing
Identify patients in need of testing
Identify patients in need of testing

Community
Hospice & Palliative Care®

Patient Visit Guidelines

(Pertains to Home, LTC, ALF and Admissions)

As we continue to evaluate the needs of our patients, families and our staff we are implementing the following measures to triage visits to patients in the Hospital, LTC, ALF and Home settings. Many of the facilities and some families are also asking that visits by our staff be for essential care only, thereby limiting not only the number of visits to your patients but also limit the number of clinicians that you are sending to your patients.

All of us are familiar with the triaging that we do for our patients and the list that we create in the event of a disaster. We suggest you start with that process and with those patients who could/would be stable enough to go without a visit or have a low risk of complications for period of time.

LEVEL 1 **High: Essential Visits – Needs In-Person Visit**

MD*APRN*RN*CIC*LPN*Triage Runners

- Patients in this priority level need uninterrupted services
- The patient must have care due to:
  - New Admission for any program in Hospice
  - Initial assessments including psychosocial/spiritual assessments collaborating with respective disciplines. RN will collaborate with core team to determine if a visit is needed.
  - Clinical needs: PICC line dressing changes those needing highly skilled wound care, pts with pumps and drains and unstable patients with a caregiver with limited or no support
  - Unmanaged pain
  - Marked decline/ EOL decline symptoms/ actively dying/death visits/10% PPS (visits will move to every other day in person visits with telehealth used to supplement the daily visit requirements).
  - Pt. or family: Inability to cope, suicidal ideation
  - Patient or Caregiver is manifesting emotional distress, lack of information or understanding: preparation and process of impending death circumstance or death
  - The patient's condition is highly unstable and deterioration or hospital admission is highly probable if the patient is not seen
  - Meeting compliance (Initial Comp. Assessments (RN), Daily CIC visits)

Social Worker: Essential Visit

- Social/ Spiritual/ Psychosocial extreme isolation
- Pt. or family: Inability to cope, suicidal ideation, safety issues
- Pt living alone, no support system, needs living situation addressed
- Actively dying pt with high caregiver need for support, maladaptive coping

Chaplain: Essential Visit

- Social/ Spiritual/ Psychosocial extreme isolation
- Pt. or family: Inability to cope, suicidal ideation, safety issue

LEVEL 2 Moderate: Essential Contact / Communication: Telehealth video / phone

MD*APRN*RN*CIC*LPN*Triage Runners

- Services for patients at this priority level may be modified with video or telephone contact.
  - Subsequent Comp visits (approved for every 21 days)
  - Face to Face – required after 3rd benefit period and as it applies for the certification process(APRN)
  - Check-in visits
  - For patient with 20% PPS will receive (1) in person visit and (1) telehealth visit to meet the requirements.
  - Potential GIP inpatient admission can be done via telehealth
  - Continued education following a new admission
  - Education and support with a medication change or physical change
  - Symptom or pain concern
- A caregiver can provide basic care until the emergency situation improves. The patient's condition is somewhat unstable and requires care that should be provided with a visit that day but could be managed with telehealth video or call without harm to the patient.

Social Worker: Moderate Visit

LTC/ALF patients with no support (family not permitted to enter facility), whereby our visit is the only connection pt has to family, via coordinated video chat.

- Social Workers will continue telephonic calls and utilize telehealth when further assessment deemed necessary

Chaplain: Essential Visit

LTC/ALF patients with no support (family not permitted to enter facility), whereby our visit is the only connection pt has to family, via coordinated video chat.

- Chaplains will continue telephonic calls and TeleHealth when further assessment deemed necessary

LEVEL 3 **Low: Essential Connection: Phone/ Telehealth (video)**

MD*APRN*RN * CIC*LPN*Triage

Patients in the Palliative and PIC: TFK level of care: established with a primary care provider

- The patient may be stable and has access to informal resources to help them.
- Extended support and contact to decrease isolation, add to resources if needed, maintain continuity of caring
- Patients who could/would be stable enough to go without a visit or have a low risk of complications for period of time: could be safely cared for by their caregiver or other informal support
- Caregiver support Family/Caregiver education and training

Social Worker: Low Priority Visit

- Patients who could/would be stable enough to go without a visit or have a low risk of complications for period of time: could be safely cared for by their caregiver or other informal support via telehealth or reportable phone call

Chaplain: Low Priority Visit

- Patients who could/would be stable enough to go without a visit or have a low risk of complications for period of time: could be safely cared for by their caregiver or other informal support via telehealth or phone

Telehealth Use in Admissions

- For information visits where telephonic information is not sufficient. (i.e. to a group of people that are interested in gathering together to learn/provide information)
- For contract bed visits, where the patient is in isolation and can still communicate but cannot be assessed in person, Telehealth will be used.
- For those admissions (Hospital, ALF, LTC) where the family cannot be present during our assessment, Telehealth can supplement the assessment to help provide information to the RN as to the decline the patient has had that might not be found in the medical records.

***PLEASE NOTE: All scenarios dependent on home/facility/hospital protocols (i.e if you are unable to provide care in the facility/hospital/home, you MUST document the type of collaboration that did take place and clearly document why.**