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.
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!

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!”

Music Therapists Lift Spirits at our McGraw Center for Caring!

SEND IT TO: Communications@communityhospice.com
## 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

<table>
<thead>
<tr>
<th>Action Items</th>
<th>Owner</th>
<th>Due Date</th>
<th>%</th>
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<tr>
<td>HCR PPE Solicitation Letter</td>
<td>Missy/Charlene</td>
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<td>Letter of Refusal</td>
<td>Kenny</td>
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<td>Circle of Exposure Chart</td>
<td>Eric/Jennifer</td>
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<td>EE FAQ</td>
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<td>Curfew Waiver</td>
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<td>Char</td>
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<td>Phil</td>
<td>05/01/20</td>
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</table>

### 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

**Patients and Families**
- Ensure patients and families are not exposed to virus by actions of CHPC

**Infection Control Core Team**
- Activation of CEMP plan with identification of Core Team and Meeting schedule
- Tracking latest available data on virus and emerging risks
- Establish screening criteria and processes to ensure safe workforce and environment

**Clinical**
- Activate CEMP and participation on Care Team by key clinical leaders
- Implement plan for remote working for critical and essential staff
- Develop management system for staff in isolation or displaced by crisis
- Develop alternative processes for face-to-face visits and remote team meetings
- Modifying care plans to essential visits during crisis
- Establish best practices for infection control related to virus
- Provide appropriate PPE and training for all critical staff providing direct care
- Implement Universal precautions and following guidance from agencies

**Workforce Management**
- Designation of critical, essential and non-essential staff
- Track training sessions and provide feedback loop for staff concerns
- Develop workforce management system to identify available staff for new visit protocols

**Technology and BI**
- Activate CEMP and participation on Core Team by director or designee
- Implement capability for tele-health and remote team meetings
- Develop data systems to track critical data on workforce
- Develop data systems to assist in tracking inventory of critical PPE
- Develop data systems to report available and underutilized staff
- Implement plan for remote working for critical and essential staff

**Finance, Facilities and Equipment**
- Activate CEMP and participation on Core Team by executive or designee
- Develop financial impact analysis with recommendations on workforce management
- Develop data systems to report available and underutilized staff
- Develop processes for tracking expenses related to crisis
- Limit Access to facilities based on criteria from CORE team
- Provide for 30 day inventory of critical PPE

**Mar-Comm**
- Activate CEMP and participation on Core Team by Mar/Comm and BD leaders
- Signage and notification based on situational analysis
- Updates to internal staff and volunteers based on situational analysis
- Updates to patients and referral sources based on situational analysis
- Updates to community and donors based on situational analysis
<table>
<thead>
<tr>
<th>Patients and Families</th>
<th>Infection Control Core Team</th>
<th>Referrals and Admissions</th>
<th>Telephonic Clinical Support</th>
<th>Care Teams</th>
<th>Inpatient Units</th>
<th>Communication</th>
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<tbody>
<tr>
<td>Provide care to patients and families with exposure to virus</td>
<td>Develop process and procedures for screening for symptoms and exposure</td>
<td>Screening questions when taking new referrals</td>
<td>Screening questions on calls for telephonic clinical support</td>
<td>Screening questions on patient contact with documentation in clinical record</td>
<td>Screening for all patients and visitors accessing inpatient units</td>
<td>Communicate to patients and families based on situational analysis</td>
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<tr>
<td></td>
<td>Track and trend data for analysis by Core Team</td>
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<td>Communicate to referral sources based on situational analysis</td>
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<tr>
<td></td>
<td>Develop scenarios for providing care for probable and positive patients</td>
<td>Admission team prepared to admit potential or positive patient in all settings</td>
<td>Enhanced clinical and telehealth capabilities in Call Center</td>
<td>Critical Response Team prepared to provide direct care for potential and positive patients</td>
<td>Inpatient Units prepared to provide care to potential and positive patients</td>
<td>Communicate to staff and volunteers based on situational analysis</td>
</tr>
<tr>
<td></td>
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<td>Enhanced clinical protocols and PPE utilization</td>
<td>Enhanced clinical protocols and PPE utilization</td>
<td>Enhanced clinical protocols and PPE utilization</td>
<td>Communicate to community based on situational analysis</td>
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<tr>
<td></td>
<td>Develop internal capabilities to provide testing for patients</td>
<td>Identify patients in need of testing</td>
<td>Identify patients in need of testing</td>
<td>Identify patients in need of testing</td>
<td>Identify patients in need of testing</td>
<td>Communicate to patients and families based on situational analysis</td>
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</table>
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: 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.*