HEALTHCARE PASSPORT

A PERSON CENTERED APPROACH TO PREPARING FOR TIMES OF CRISIS

AD ASTRA PER ASPERA
Kansas
Department of Administration
Office of the State Long-Term Care Ombudsman

Creating Your Person-Centered Description and Healthcare Passport for Times of Crisis

Sometimes people must make an unplanned trip to the hospital or other healthcare facility due to illness or injury. When this happens, people may need to go alone and the workers may not know you.

Because crisis events like this can affect anyone, at any time, we want to help you plan ahead.

Our goal is to help you work on a two-page form to tell healthcare workers about you in case you have to go alone to a hospital or other healthcare facility.

The completed form has two parts – a front and a back:

1. **Person-Centered Description:** tells what is important to you while getting care in a hospital or healthcare location.
2. **Healthcare Passport**: tells brief information about your health.

This booklet has directions, examples to help you, and blank forms so you can make your own forms.

If you need help or cannot complete your own Person-Centered Description or Healthcare Passport, you can ask a trusted person who knows you well to help.

Let's get started on your plan!

Directions for Developing Your Person-Centered Description

If you need help or cannot complete your own Person-Centered Description, ask a trusted person who knows you well to help.

Tips

- Think about who will read your Description. It may be your doctor, nurse, or other healthcare worker.
- What are the most important things you want healthcare workers to know about you?
- Remember the information should be easy to understand.
- The Description should be short and take no longer than one minute to read.

How to Make a Person-Centered Description

- Look at the example Descriptions provided on **pages 5 and 7** for ideas.
- Complete the enclosed form on **page 9** for your Person-Centered Description.
- Write short thoughts and focus on what is most important to you.

The Person-Centered Description has three parts, which we will discuss in detail in the next few pages. Some ideas about what you might want to include are provided below**.** You can add your picture if you would like to.

1. **Consider what people like, admire, and appreciate about you.**
    a. Describe what you are good at or what you are most proud of.
    b. Include what people who know you well would say they like or admire about you.
2. **Think about who and what is important to you – things healthcare workers need to know**
    a. List people who are important to you and their phone numbers.
    b. List ways you can be a part of your health care team.
    c. List what helps you relax or sleep.

3. **How to best support me** - ways healthcare workers can help you feel comfortable
    a. What makes you comfortable?
    b. How do you want to take medication?
    c. How can healthcare workers help you feel calm and safe?
    d. How do you let people know you are in pain?
    e. What is the best way for people to communicate with you?

Directions for Developing Your Healthcare Passport

The Healthcare Passport can help healthcare workers provide you with good care and help them follow your wishes. Examples are provided on **pages 6 and 8.** If you need help or cannot complete your own Healthcare Passport, you can ask a trusted person who knows you well for help.

Read through each part carefully and add your own information. The blank form for you to use is provides on **page 10.** Your Healthcare Passport should be short and take no longer than one minute to read.

Your Healthcare Passport includes:

1. Personal Information
2. Current Medication List
3. Current Risk Factors
4. Assistive Devices (Hearing aid, walker, wheelchair, etc.) and Health Conditions and may include a service animal
5. Allergies and Dietary Restrictions
6. Current Symptoms - to be completed if needed
7. Advanced Care Planning—Other planning documents you have completed and where they may be found.

The information on the Healthcare Passport may not be complete byitself. A full list of current medications, treatments, and/or current symptoms also may be included on separate, additional form(s).

MY PERSON-CENTERED DESCRIPTION

Please call me by this name

MaryAnne Bailey

1. What people like, admire, and appreciate about

Kind, caring, good listener, patient with people, never gives up, no nonsense

2. What is important to me

- My sister Gwendolyn and my friend, Ester. Please keep them up to date about me, and keep me up to date about them.
- My faith.
- My violet plant collection.
- To know what is happening with me; don't tell others without telling me.

3. How best to support me

- Please don't raise your voice or repeat yourself it makes me nervous
- Give me time to answer, I know what I want to say, but it can take time for it to come out.
- If I am worn out, I may not answer; if I look to the side and back at you, I have heard you.
- I don't like to ask for help and prefer to do things myself. If I do ask, it is very important.
- Please keep me dressed or covered; make sure everything is in place, no gaps, or openings
- Sit where I can see you

Completed by: _____ Date:_____

☑Me ☐ Someone else (specify name and role): _____

My Health Care Passport

Personal Information			
First Name: MaryAnne	(Nickname): None	Last Name: Bailey	DOB: 8/12/1953 Age: 67
Street Address: 100 Main		City, State, Zip: Her Town, KS 66720	
Phone number: XXX-XXX-XXXX	Preferred Language: English	Emergency Contact Name and Phone/Email Karen Green, 111-222-3333/greenk@email.com	
Parent/Legal Representative Name and Phone/email: N/A		Communication needs: N/A	
Insurance Information: Medicaid		Pharmacy Information (Most Commonly Used): Kindcare, Her Town, KS 66720	
Primary Care Provider/Contact Information: Dr. NotMcdreamy 111-222-3333		Opthamologist Dr Eeyore/ 111-222-4444	

Medications/Risk Factors

Medications:	**Risk Factors (check all that apply):**	
Citalopram (Celexa) Diazepam (Valium) Gabapentin (Neurontin) Preservative-free eye drops	☑ Long-term care resident ☐ Transplant ☐ COPD/Emphysema/Asthma ☐ Current/Former Smoker ☐ Intellectual disability ☑ Neurological disorder/Cerebral Palsy ☐ Heart disease ☐ Corticosteroid use ☐ Mental Illness/substance use	☐ Cancer ☑ Age 65 or over ☐ Pregnant ☐ Severe obesity ☐ HIV/AIDS ☐ Kidney disease ☐ Homeless ☐ Chronic bronchitis ☐ Other

Note: Information on this form may not be complete

Assistive Devices/Health Conditions	Allergies and Diet Restrictions	Current Symptoms
Depression Cerebral palsy muscle relaxant Cerebral palsy anticonvulsant Dry eye (right)	No known	☑ Temp. over **100.4 ° F** ☑ Dry Cough ☑ Malaise/Fatigue ☑ Shortness of breath ☐ Nasal congestion ☐ Diarrhea ☑ Loss of smell/taste ☐ Sore throat ☑ Low blood oxygen ☑ Headache

Advanced Care Planning (check all that apply and location of document if known):

- ☑ HEALTH CARE DIRECTIVE OR LIVING WILL—on file at ABC Nursing Home
- ☑ DO NOT RESUSCITATE ORDER/DO NOT INTUBATE— on file at ABC Nursing Home
- ☐ POWER OF ATTORNEY FOR FINANCES
- ☐ PHYSICIAN ORDER FOR LIFE-SUSTAINING TREATMENT (POLST, MOSLT, OR POST
- ☐ PSYCHIATRIC ADVANCE DIRECTIVE

IMPORTANT: Person-Centered Description on Reverse Side

MY PERSON-CENTERED DESCRIPTION

Please call me by this name

Teresa

1. What people like, admire, and appreciate

Great Sense of Humor, Kind, Friendly, Caring

2. What is important to me

My Family and Friends: I like to talk to them every day and spend time with them. I need my cellphone near me so I can call them when I want to talk.

My God: I am Catholic. When I am sick, I want to receive Communion and Sacraments. I want visits by the Priest or Lay Ministers. I also like my Rosary to be near in case I want to hold it and pray. It gives me comfort.

My Cellphone: I need it plugged in for me so the battery doesn't run out. Remaining on my whole food, plant-based diet is important to me.

3. How best to support me

- I have Rheumatoid Arthritis (RA) and have a lot of pain. I have a very high pain tolerance. So if I ask for help for pain, I am in a lot of pain. Please trust me and give me medication to help relieve the pain. If you cannot give me medication, please use things like hot and cold packs, aromatherapy, music, and prayer.
- I do get fearful when I am in the hospital. If I am scared and anxious, I will ask a lot of questions. Please be truthful when you answer. If I become scared or weepy, let me speak to my family. You can also provide access to a Chaplain, preferably a Catholic Chaplain, but if none is available, any caring soul would be appreciated. I am also okay with taking an anti-anxiety medication.
- When I sleep, I need my CPAP machine and some type of blanket even when it is warm in the room. It can be a sheet. I like the room dark when I sleep.
- I have a lot of medical issues. My primary Doctor, Doctor Olson, knows me the best. If available, I would like you to consult with her. I am also well-versed in all of my healthcare, so please ask me anything you want. My husband Harry (phone XXX-XXX-XXXX), daughter Rose (XXX-XXX-XXXX), and son Jeff (XXX-XXX-XXXX) are also great historians of my health care. If they are not available, my sister Julie (XXX-XXX-XXXX) may be called.

Completed by: _____ Date:_____

☑Me ☐ Someone else (specify name and role): _____

My Health Care Passport

Personal Information			
First Name: Theresa	(Nickname):	Last Name: Peterson	DOB: 8/12/1953 Age: 67
Street Address: 5275 South Lane		City, State, ZIP: Deerwood, Minnesota 56444	
Phone number: XXX-XXX-XXXX	Preferred Language: English	Emergency Contact Name and Phone/Email: Harry Peterson XXX-XXX-XXXX	
Legal Representative Name and Phone/E-mail: N/A		Communication needs: N/A	
Insurance Information: Health Partners		Pharmacy Information (most commonly used): Guidepoint, Brainerd, MN	
Primary Care Provider/Contact Information: Doctor Olson, Essentia Brainerd		Specialty Care Providers/Contact Information: Doctor Smith, Mayo Rheumatology	

Medications / Risk Factors

MEDICATIONS: Rosuvastatin 20 MG 1 at bedtime
Vitamin D 2000 U 1 tablet evening
Nitroglycerin 0.4 sublingual tablet PRN
Acetaminophen 650 MG tablet 2 tabs daily
Levothyroxine 75 MCG 1 day
Metformin 1/2 500 MG 1 a day
Probiotic 1 cap daily
Aspirin EC 81 MG 1 a day
Cetirizine 10 MG 1 a day
Hydrochlorothiazide 1/2 12.5 tab daily
Bisoprolol 5 MG daily
Prednisone 5 MC daily morning
Hydroxychloroquine 200 MG 2 times daily
Azathioprine 50 MG a.m. and 100 MG p.m.
Abatacept 125 MG/ML solution injection weekly

COVID-19 Severity Risk Factors (check all that apply)

- ☐ Long-term care resident
- ☐ Transplant:
- ☐ COPD/Emphysema/Asthma
- ☐ Current/former smoker
- ☒ Liver disease
- ☐ Intellectual disability
- ☐ Neurological disorder
- ☒ Heart disease
- ☒ Corticosteroid use
- ☐ Mental illness/substance use
- ☐ Cancer
- ☐ Age 65 or older
- ☐ Pregnant
- ☐ Severe obesity (40+ BMI)
- ☐ HIV/AIDS
- ☐ Kidney disease
- ☐ Homeless
- ☐ Other:

Note: Information on this form may not be complete

Assistive Devices/ Health Conditions	Allergies and Diet Restrictions	Current Symptoms
Assistive Devises: CPAP **Other Health:** Rheumatoid Arthritis and Rheumatoid Lung Disease, CAD with CABG 6/10/2019, hypertension, hyperthyroidism, Hyperlipidemia, GERD, Osteopenia, Sleep apnea, Vitamin D deficiency, diabetes, Immunocompromised	**Allergies**: atorvastatin niacin pravastatin propranolol simvastatin tetracycline **Diet:** Whole foods plant-based diet	☐ Temp. over 100.4°F ☐ Dry cough ☐ Malaise/Fatigue ☐ Shortness of Breath ☐ Nasal Congestion ☐ Diarrhea ☐ Loss of Smell/Taste ☐ Sore Throat ☐ Low Blood Oxygen ☐ Headache

Advanced Care Planning (check all that apply and and location of document if known.)

- ☒ HEALTH CARE DIRECTIVE OR LIVING WILL – Location: On file at Essentia and Mayo Clinic
- ☐ DO NOT RESUSCITATE ORDER/DO NOT INTUBATE (DNR/DNI) – Location:
- ☐ POWER OF ATTORNEY FOR FINANCES – Location:
- ☐ PHYSICIAN ORDER FOR LIFE-SUSTAINING TREATMENT (POLST, MOLST, or POST) - Location:
- ☐ PSYCHIATRIC ADVANCE DIRECTIVE - Location:

Important Person-Centered Description on Reverse Side

MY PERSON-CENTERED DESCRIPTION

Please call me by this name

Optional Photo

1. What people like, admire, and appreciate

2. What is important to me

3. How best to support me

Completed by: _____ Date:_____

☑ Me ☐ Someone else (specify name and role): _____

My Health Care Passport

Personal Information			
First Name:	(Nickname):	Last Name:	DOB: Age:
Street Address:		City, State, ZIP:	
Phone number:	Preferred Language:	Emergency Contact Name and Phone/Email:	
Legal Representative Name and Phone/E-mail:		Communication Needs:	
Insurance Information:		Pharmacy Information (most commonly used):	
Primary Care Provider/Contact Information:		Specialty Care Providers/Contact Information:	

Medications / Risk Factors

MEDICATIONS:

COVID-19 Severity Risk Factors (check all that apply)

- ☐ Long-term care resident
- ☐ Transplant:
- ☐ COPD/Emphysema/Asthma
- ☐ Current/former smoker
- ☐ Liver disease
- ☐ Intellectual disability
- ☐ Neurological disorder
- ☐ Heart disease
- ☐ Corticosteroid use
- ☐ Mental illness/substance use
- ☐ Cancer
- ☐ Age 65 or older
- ☐ Pregnant
- ☐ Severe obesity (40+ BMI)
- ☐ HIV/AIDS
- ☐ Kidney disease
- ☐ Homeless
- ☐ Other:

Note: Information on this form may not be complete

Assistive Devices/ Health Conditions	Allergies and Diet Restrictions	Current Symptoms
		☐ Temp. over 100.4°F ☐ Dry cough ☐ Malaise/Fatigue ☐ Shortness of Breath ☐ Nasal Congestion ☐ Diarrhea ☐ Loss of Smell/Taste ☐ Sore Throat ☐ Low Blood Oxygen ☐ Headache

Advanced Care Planning (check all that apply and and location of document if known)

- ☐ HEALTH CARE DIRECTIVE OR LIVING WILL – Location:
- ☐ DO NOT RESUSCITATE ORDER/DO NOT INTUBATE (DNR/DNI) – Location:
- ☐ POWER OF ATTORNEY FOR FINANCES - Location:
- ☐ PHYSICIAN ORDER FOR LIFE-SUSTAINING TREATMENT (POLST, MOLST, or POST) - Location:
- ☐ PSYCHIATRIC ADVANCE DIRECTIVE - Location:

Important Person-Centered Description on Reverse Side

Person-Centered Description and Healthcare Passport Acknowledgments

The information in this booklet is adapted with permission from NCAPPS, (National Center on Advancing Person-Centered Practices and Systems)/ACL, (Administration for Community Living) by The Office of the Kansas Long-Term Care Ombudsman staff.

The NCAPPS website (https://ncapps.acl.gov/) has additional resources and a fillable version of their Person-Centered Profile tool and examples used by people from a range of different backgrounds and experiences.

PLEASE NOTE: Some terms are used interchangeably from one resource to another. For example: “Description” and “Profile;” “Directions” and “Instructions;” “Passport” and “Health Care Information.”

Some information in this booklet is developed from concepts, principles, materials, and tools from The Learning Community for Person-Centered Practices (https://tlcpcp.com/); Support Development Associates (https://www.sdaus.com/) and the Office of the Ombudsman for Long-Term Care (OOLTC) Minnesota.

The Office of the Kansas Long-Term Care Ombudsman works to enhance the quality of life and the quality of care and services for consumers of long-term care through advocacy, education, and empowerment. All services are free and confidential.

If you are in need of advocacy services, please contact:

The Office of the Kansas Long-Term Care Ombudsman

785-296-3017, (Toll Free) 1-877-662-8362

Email: LTCO@ks.gov Website: ombudsman.ks.gov.

Additional Resources

- COMPASSIONATE EAR WARMLINE: If you need someone to talk to, feel isolated, anxious, or depressed, you may call: 1-866-927-6327. Lines are open every evening from 4 PM to 6 PM.
- Kansas Adult Protective Services (Kansas Adult Abuse Reporting Center): 1-800-922-5330
- Kansas Department of Aging & Disability Services Long-Term Care Facility Complaints: 1-800-842-0078.