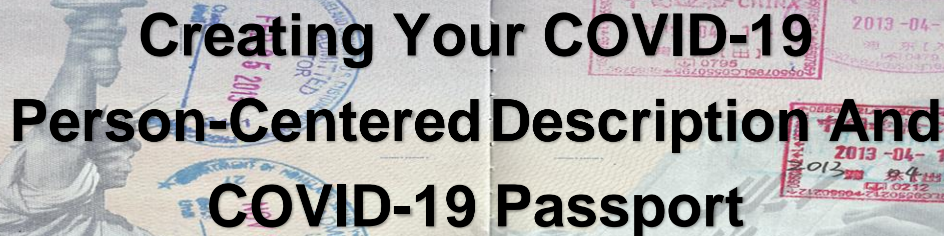
A COVID-19 PERSONAL PLANNING RESOURCE

CREATING YOUR COVID-19 PERSON-CENTERED DESCRIPTION AND COVID-19 PASSPORT

Office of Ombudsman for Long-Term Care

MINNESOTA BOARD ON AGING



Creating Your COVID-19 Person-Centered Description And COVID-19 Passport

COVID-19 has brought a lot of change into our daily lives.

We know that some people may have to go to the hospital or a COVID-19 Unit to get better. Sometimes people have to go alone to places where workers don't know them.

Because COVID-19 can affect anyone at any time, we want to help you plan ahead.

Our goal is to help you work on a 2-page form to tell COVID-19 workers about you if you have to go alone to a hospital or COVID-19 Unit.

The form has two pages – a front and a back:

1. **COVID-19 Person-Centered Description:** tells what is important to you while getting care in a hospital or COVID-19 Unit.
2. **COVID-19 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 COVID-19 Person-Centered Description or COVID-19 Passport, you can ask a trusted person who knows you well to help.

Let's get started on your plan!

Directions for Developing Your COVID-19 Person-Centered Description

If you need help or cannot complete your own 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 COVID-19 worker.
- What are the most important things you want COVID-19 workers to know about you?
- Remember that information should be easy to understand.
- The Description should be short and take no longer than one minute to read.

How To Make A COVID-19 Person-Centered Description

- Look at the example Descriptions provided for ideas.
- Complete the enclosed form for your COVID-19 Person-Centered Description.
- Write short thoughts and focus on what is most important to you.

There Are Three Parts To Fill Out: Here are some ideas of what you might want to include. You can add your picture if you want.

1. **What people like, admire, and appreciate about me**
   a. Describe what you are good at and what you are most proud of.
   b. Include what people close to you say they like or admire about you.
2. **Who and what is important to me –** things COVID-19 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.
   d. List any religious or spiritual practices that help you feel at peace.
   e. List any personal items you like to have with you.

3. **How to best support me** - ways COVID-19 workers can help me feel comfortable
   a. What makes you comfortable?
   b. How do you want to take medication?
   c. How can COVID-19 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?
   f. Explain how people know when you are getting upset, afraid, or stressed - and how they can help.

Directions for Completing Your COVID-19 Passport

The COVID-19 Passport can help COVID-19 workers to provide you with good care and to follow your wishes. If you need help or cannot complete your own COVID-19 Passport, you can ask a trusted person who knows you well to help.

Read through each part carefully and add your own information. Your COVID-19 Passport should be short and take no longer than one minute to read.

Your COVID-19 Passport includes:

1. Personal Information
2. Medication List
3. Current Risk Factors
4. Assistive Devices and Health Conditions - may include service animal
5. Allergies and Dietary Restrictions
6. Current COVID-19 Symptoms - to be completed if needed
7. Other Planning Documents you have completed and location

The information on the COVID-19 Passport may not be complete. Full list of current medications, treatments, and/or current symptoms may be on separate form(s).

MY COVID-19 PERSON-CENTERED DESCRIPTION

Please call me by this name

Maria

1. What people like, admire, and appreciate about me

Kind, caring, friendly, responsible

2. What is important to me

- My family and friends are important to me. I like to be able to talk with or message them daily: husband George @XXX-XXX-XXXX; son Dalton @XXX-XXX-XXXX. I also enjoy viewing Facebook although I rarely post.
- I like to know what is going on at all times. Keep me updated even if it's to let me know there are no changes or updates.
- I like to have a cold Mountain Dew near me at all times. I like to snack and eat several small meals throughout the day. I may continue to eat lunch for several hours. I do not drink milk or eat eggs.
- I like to be comfortable and like warm comfy clothes and lots of pillows and blankets.
- I have a high pain tolerance and do not like to complain.

3. How to best support me

- Insure I have access to my phone and charger so that I can stay connected to family and friends and can view Facebook.
- Allow me to have pop and snacks. Do not rush me to eat.
- Keep me informed of what is going on, any test results, procedures, recommendations, plans. Even if it's just to say that there are no changes.
- I am always cold. Offer me warm blankets, extra pillows, and comfy clothes.
- If I say I'm in pain, believe me. Don't ask me to rate pain on scale of 1-10 as this irritates me. Instead - use "mild, moderate, severe" scale.
- Allow me to play "calm" background noise on my phone.
- I do not tolerate medication well. Do not use meds unless necessary.

Completed by: ____________________________________ Date:________________

☒ Me ☐ Someone else (specify name and role): ____________________________

COVID-19 PASSPORT

Personal Information

First Name: Maria	(Nickname):	Last Name: Lopez	DOB: 4/18/1948 Age: 72
Street Address: 111 River Drive		City, State, ZIP: Little Falls MN 56345	
Phone number: XXX-XXX-XXXX	Preferred Language: English	Emergency Contact Name and Phone/Email: George Lopez XXX-XXX-XXXX	
Legal Representative Name and Phone/E-mail: N/A		Communication needs: N/A	
Insurance Information: Health Partners and BCBS **(####-#####) (####-####)**		Pharmacy Information (most commonly used): Walgreens Little Falls	
Primary Care Provider/Contact Information: Dr. Johnson St. Gabriel's Health System Little Falls XXX-XXX-XXXX		Specialty Care Providers/Contact Information: Dr. Smith – Oncology Coborn's Cancer Center-CentraCare	

Medications / Risk Factors

MEDICATIONS:

Tamoxifen 20 mg 1Xper day

Multi vitamin

Calcium Chew

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

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

Note: Information on this form may not be complete

Assistive Devices/ Health Conditions	Allergies and Diet Restrictions	Current Symptoms
Gull bladder removed Tonsils removed	Penicillin Morphine Intolerance to milk and eggs	☐ 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: COVID-19 Person-Centered Description on Reverse Side

MY COVID-19 PERSON-CENTERED DESCRIPTION

Please call me by this name

Theresa

1. What people like, admire, and appreciate about me

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 need 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 that it is never out of power.

Remaining on my whole food plant-based diet is important to me.

3. How to best 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 that will 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 to me. If I become scared or weepy, let me speak to my family. You can also offer that I talk to a Chaplain. Preferably a Catholic Chaplain but if none is available, any caring soul would be appreciated. I am also OK 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.
- I have a lot of medical issues. My primary Doctor, Doctor Olson, knows me the best. If available, I would like you consult with her. I am also well-versed in all of my health care 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):___________________________

COVID-19 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: COVID-19 Person-Centered Description on Reverse Side

MY COVID-19 PERSON-CENTERED DESCRIPTION

Please call me by this name

OPTIONAL PHOTO

1. What people like, admire, and appreciate about me

2. What is important to me

3. How to best support me

Completed by: ____ Date:_________________

☐ Me ☐ Someone else (specify name and role):_______________________________

COVID-19 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	☐ Cancer
	☐ Transplant:	☐ Age 65 or older
	☐ COPD/Emphysema/Asthma	☐ Pregnant
	☐ Current/former smoker	☐ Severe obesity (40+ BMI)
	☐ Liver disease	☐ HIV/AIDS
	☐ Intellectual disability	☐ Kidney disease
	☐ Neurological disorder	☐ Homeless
	☐ Heart disease	☐ Other:
	☐ Corticosteroid use	
	☐ Mental illness/substance use	

Note: Information on this form may not be complete

Assistive Devices/ Health Conditions	Allergies and Diet Restrictions	Current COVID-19 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)

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IMPORTANT: COVID-19 Person-Centered Description on Reverse Side

COVID-19 Person-Centered Description and COVID-19 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 Ombudsman for Long Term Care (OOLTC) staff members; Tiffany Carlson, Self-Advocacy specialist, Ann Holme, RFACE (Resident and Family Council Education Specialist), and Jane Brink Regional Ombudsman.

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 with 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/)

The Office of Ombudsman for Long-Term Care (OOLTC)

OOLTC 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.

OOLTC in partnership with MHM (Moving Home Minnesota) has developed self-advocacy training. The training is available to nursing home residents throughout the state and includes seven different modules that promote self-advocacy, person-centered practices, and empowerment.

Contact Information

If you are in need of advocacy services, please contact: The Office of Ombudsman for Long-Term Care at 651-431-2555, (Toll Free) 1-800-657-3591, or MBA.OOLTC@state.mn.us or visit: www.mnaging.org.

For more information or to request Self-Advocacy training, please contact: Tiffany Carlson, Self-Advocacy Specialist, at (cell) 651-341-3247, (office) 218-855-8717, or tiffany.carlson@state.mn.us.

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Additional Resources

- To learn about COVID, you may go to the CDC website: https://bit.ly/cdc_covid.
- MN COVID-19 SITUATION UPDATES: You can receive Situation Update for COVID-19 on Minnesota Department of Health (MDH) website: https://www.health.state.mn.us/diseases/coronavirus/situation.html
- MINNESOTA HELPLINE: For questions related to the COVID-19 pandemic, call 651-297-1304 or 1-800-657-3504; Mon-Fri: 8 AM-5 PM.
- WARMLINE: If you need someone to talk to, feel isolated, anxious, or depressed, you may call: 1-844-739-6369. Lines are open every night from 5 PM to 9 AM.
- To learn about medical decisions, such as a breathing machine or CPR, visit: https://bit.ly/covid_tools
- To learn more about MN Health Care Directives visit: https://honoringchoices.org/health-care-directives
- MAARC: (Minnesota Adult Abuse Reporting Center): 1-844-880-1574
- Minnesota Department of Health's Office of Health Facility Complaints (OHFC): 651-201-4200; or email at health.ohfc-complaints@state.mn.us.