



ND HEALTH INFORMATION NETWORK
ND Healthcare Directive Registry
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ND HEALTHCARE DIRECTIVE REGISTRY

- Registry developed by NDHIN for ND citizens to securely store and share healthcare directives
- Self-service tool allowing a person control over directive



WHAT IS NOT IN THE REGISTRY?

- Wills
- Medical Health Information
- Any information that is not to be viewed by healthcare providers, or individuals with access to this account



WHAT IS IN THE REGISTRY?

- Healthcare Advance Directive
- Physician Order for Life-Sustaining Treatment (POLST)

ND POLST

- Official form for ND
- Gives specific *medical orders* to be followed
- Must be signed by healthcare provider

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
North Dakota POLST: Physician Orders for Life Sustaining Treatment

Physician Orders for Life-Sustaining Treatment (POLST)		
FIRST follow these orders, THEN Call the appropriate medical contact. These medical orders are based on the patient's medical condition and wishes. Any section not completed implies full treatment for that section. Everyone shall be treated with dignity and respect.		Patient's Last Name _____ Patient's First Name/Middle Initial _____ Patient's Date of Birth (mm/dd/yyyy) _____
A Check One	CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing. <input type="checkbox"/> CPR/ATTEMPT RESUSCITATION <input type="checkbox"/> DNR/DO NOT ATTEMPT RESUSCITATION (Allow Natural Death) When not in cardiopulmonary arrest, follow orders in B and C.	
B Check One	MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing. <i>Comfort Measures always provided regardless of level of care chosen.</i> <input type="checkbox"/> COMFORT MEASURES ONLY - Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location. <input type="checkbox"/> Avoid calling 911, call _____ instead (e.g. hospice) <input type="checkbox"/> If possible, do not transport to ER (when patient can be made comfortable at residence) <input type="checkbox"/> If possible, do not admit to the hospital from ER (e.g. when patient can be made comfortable at residence) <input type="checkbox"/> LIMIT INTERVENTIONS AND TREAT REVERSIBLE CONDITIONS - Provide interventions aimed at treatment of new or reversible illness/injury or non-life threatening chronic conditions. In addition to treatment described in Comfort-Measures Only, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Duration of invasive or uncomfortable interventions should be limited. (Generally, avoid intensive care) <input type="checkbox"/> FULL TREATMENT - Use all appropriate medical and surgical interventions as indicated to support life. Transfer to hospital if indicated. Includes intensive care. <i>Additional Orders: (e.g. dialysis, etc.)</i>	
C Check One	Artificially Administered Fluids and Nutrition: Always offer food/fluids by mouth if feasible and desired. <i>Check One</i> <input type="checkbox"/> No artificial nutrition by tube. <input type="checkbox"/> Defined trial period of artificial nutrition by tube. <input type="checkbox"/> Artificial nutrition and hydration unless it provides no benefit. <input type="checkbox"/> Long-term artificial nutrition by tube. <i>Additional Orders:</i>	
D Must fill out	DOCUMENTATION OF DISCUSSION (Required) <input type="checkbox"/> Patient (if patient has capacity) If patient lacks capacity: <input type="checkbox"/> A Health Care Directive <input type="checkbox"/> Health Care Agent <input type="checkbox"/> Person legally authorized to provide informed consent (See reverse)	
Health Care Agent/Legal Representative Name _____		Relationship _____
E	PATIENT or Health Care Agent/Legal Representative (Required)	
Signature _____		(Form Does Not Expire) Date of signature _____
F	ATTESTATION OF MD/DO/APRN/PA (Required) By signing below, I attest that these medical orders are, to the best of my knowledge, consistent with the patient's current medical condition and preferences.	
Print Name of MD/DO/APRN/PA Name _____		Signer Phone Number _____ Signer License Number _____
MD/DO/PRN/PA Signature: required _____		Date: required _____ Time: required _____

ADVANCE DIRECTIVE FORMS

- “legal document”
- Can be written on any paper and notarized

Medical Durable Power of Attorney of MINNIE MOUSE

I, MINNIE MOUSE, the principal, an adult of sound mind, execute this Medical Durable Power of Attorney freely and voluntarily, with an understanding of its purposes and consequences. I intend to create a medical durable power of attorney under the laws of the State of North Dakota. I further intend to demonstrate my wishes concerning medical treatment with clear and convincing evidence. I hereby revoke any Medical Durable Power of Attorney previously granted by me as principal except powers granted by me under any state statutory Medical Durable Power of Attorney.

Article One Recitals

Section 1.01 Designation of Health Care Agent

I designate the individual named below to serve as my Health Care Agent. I give my Health Care Agent the power to make decisions with regard to my health care if I am unable to make my own health care decisions.

Name: MICKEY MOUSE
Address:
Phone:

If MICKEY MOUSE
below as alternate
in this instrument.

Name:
Address:
Phone:

State of _____

LIVING WILL

Advance Directive: Treatment Preferences (“Living Will”) - You have the right to use an advance directive to say what you want about future life-sustaining treatment issues. It lets you decide about life-sustaining procedures in three situations: when death from a terminal condition is imminent despite the application of life-sustaining procedures; a condition of permanent unconsciousness called a persistent vegetative state; and end-stage condition, which is an advanced, progressive, and incurable condition resulting in complete physical dependency. You may complete all or only part of the forms that you use. Different forms may also be used.

A. Preference in Case of Terminal Condition

(If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that my death from a terminal condition is imminent, even if life-sustaining procedures are used:

_____ 1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

OR



HOW IT WORKS

Go to www.nd.gov/hdir/login

- Create an Account

 - Can create your own account

 - Can have someone create it for you (Proxy access)

- Designate access

 - Self

 - Can share access with others if desired

 - PIN numbers are needed for access

 - PIN cards can be generated and printed from the site

PIN CARDS

- Red Card – Emergency
- Emergency staff access if NDHIN not available
- Blue Card – maintenance
- Account owner or proxy uses to manage account




NDHIN ACCESS

Directory can be accessed via NDHIN

The screenshot shows a web browser window with the URL <https://ndistage.orionhealthcloud.com/concerto/Concerto.htm>. The patient information displayed is **TEST, HUGO**, SEX Male, DOB Jan-01-1989 (32y). The user is logged in as Joey HUANG. The navigation menu includes: Patient Summary, Medicines Viewer, Timeline, External Record, Images, Circle of Care, Laboratory Results Flow Sheet, and **Advance Directives** (highlighted with a red box).

Advance Directives

Disclaimer: Accessing this link will launch a web-based application to which an individual has uploaded their own advance directive.

Document Type	Upload Date
 Advance Directive	Dec-28-2020

NDHIN INFORMATION

- NDHIN website <https://www.ndhin.nd.gov/>
- On-demand trainings
<https://www.ndhin.nd.gov/providers/education>

NDHIN CONTACT INFORMATION

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