



# Michigan Quality Improvement Consortium Guideline

## *Advance Care Planning*

**The purpose of this guideline is to assist the practitioner in engaging the patient in a discussion of goals, preferences, and priorities regarding the patient's care at different stages of life. The guideline recommends tools and interventions to address Advance Care Planning across the patient population.**

| Eligible Population   | Key Components                          | Recommendation   |
|---|---|--|
| Patients whose death in the next twelve months would not be surprising<br><br>Patient with New or Established Diagnosis of a Serious <b>Illness</b><br><br>Consider patients aged 18 and over, in any stage of health | Advance Care Planning Process           | <b>Relevant topics include:</b> <ul style="list-style-type: none"> <li>◆ The value of making one's goals preferences and choices for care and treatment known both verbally and in writing</li> <li>◆ The importance of early conversations with family in a non-crisis situation</li> <li>◆ The value of identification of a surrogate decision-maker, with consent</li> <li>◆ The value of cultural sensitivity</li> <li>◆ For appropriate patients, the value of having a Physician's Orders for Life-Sustaining Treatment (POLST)<sup>1</sup></li> <li>◆ Discussion should include family members, the surrogate decision-maker, and others who are close to the patient</li> <li>◆ Any individual can start the conversation (patient, family, physicians, nurses, behavioral health providers, social workers, clergy, trained facilitator, etc.)</li> <li>◆ Evidence-based training in advance care planning is recommended for any person facilitating ACP conversations<sup>2</sup></li> <li>◆ At the later stages, the facilitator should have experience with/knowledge of the patient's specific condition (e.g. CHF, cancer)</li> </ul> |
|   | Assist patient in Advance Care Planning | <b>Use an Advance Care Planning tool<sup>2</sup> to:</b> <ul style="list-style-type: none"> <li>◆ Help the patient identify a surrogate who would make decisions on their behalf if they did not have decision-making capacity</li> <li>◆ Encourage the patient to complete an Advance Directive<sup>3</sup> (including Healthcare Power of Attorney and Patient Advocate Role Acceptance)</li> <li>◆ Incorporate the patient's goals preferences and choices into the Treatment Preferences portion of the Advance Directive</li> <li>◆ Encourage the patient to discuss their preferences and care plan with the surrogate, family member, spiritual counselor and others</li> </ul>   |
|   | Revision of Advance Care Plan           | <ul style="list-style-type: none"> <li>◆ Review the patient's goals and preferences for end-of-life care and advance directives at least annually</li> <li>◆ With a significant change in prognosis, work with the patient to update his/her advance directives, giving consideration to specific potential scenarios</li> <li>◆ If patient has limited life expectancy, consider using the POLST<sup>1</sup> tool to address the patient's specific requests for end-of-life care</li> </ul>  |
|   | Documentation and Implementation        | <ul style="list-style-type: none"> <li>◆ Place a copy of the Advance Directive documenting the designation of a surrogate/decision maker, patient's values and beliefs and goals for end of life care, and POLST<sup>1</sup>, in the health record and in retrievable electronic format when available</li> <li>◆ Incorporate the Advance Directive into the person's plan of care</li> <li>◆ Make the Advance Directive and POLST<sup>1</sup> accessible throughout the health system, to emergency departments, EMS companies, nursing homes, and share with family</li> </ul>   |

<sup>1</sup>[Physician's Orders for Life-Sustaining Treatment \(POLST\)](#)

<sup>2</sup>[Respecting Choices](#)

[Making Choices Michigan](#)

[Five Wishes](#)

<sup>3</sup>In Michigan, the only legally recognized advance directives are Durable Power of Attorney for Health Care (DPOA) and Do Not Resuscitate (DNR). Living wills are not legally recognized by the State of Michigan.

**Levels of evidence for the most significant recommendations:** A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the Institute of Medicine Dying in America, Improving Quality and Honoring Individual Preferences Near the End of Life Key Findings and Recommendations (<http://iom.nationalacademies.org/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx>); The American Medical Association: E-2.225 Optimal Use of Orders Not To Intervene and Advance Directives (<http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/about-ethics-group/ethics-resource-center/end-of-life-care/ama-policy-end-of-life-care.page>); NCCN Clinical Practice Guidelines in Oncology: Palliative Care, Version 2.2011 ([http://www.nccn.org/professionals/physician\\_gls/f\\_guidelines.asp#palliative](http://www.nccn.org/professionals/physician_gls/f_guidelines.asp#palliative)); Physician Orders for Life-Sustaining Treatment Paradigm; and The National Committee for Quality Assurance: 2010 Special Needs Plan (<http://www.ncqa.org/Programs/OtherPrograms/SpecialNeedsPlans.aspx>); Institute for Clinical Systems Improvement, Palliative Care for Adults health care guideline, Updated November 2013 ([https://www.icsi.org/\\_asset/k056ab/PalliativeCare.pdf](https://www.icsi.org/_asset/k056ab/PalliativeCare.pdf)); Advance Care Planning Decisions (<http://www.acpdecisions.org/>). Individual patient considerations and advances in medical science may supersede or modify these recommendations.