



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	Education Topics	<ul style="list-style-type: none"> ◆ The Advance Care Planning process ◆ The value of making one's wishes known both verbally and in writing ◆ The importance of early conversations with family in a non-crisis situation ◆ The value of identification of a surrogate decision-maker, with consent ◆ The value of cultural sensitivity ◆ For appropriate patients, the value of having a Physician's Orders for Life-Sustaining Treatment (POLST) ◆ Education should include family members, the surrogate decision-maker, and others who are close to the patient ◆ Any individual can start the conversation (including physicians, nurses, social workers, clergy, trained facilitator, etc.) ◆ These individuals are encouraged to seek training to improve their ability to handle the issues ◆ At the later stages, the facilitator should have experience with/knowledge of the patient's specific condition (e.g. CHF, ESRD, cancer, etc.)
Patients with a chronic, life-limiting illness who are experiencing more symptoms, hospitalizations, etc. (see table page 13 http://www.icsi.org/palliative_care/palliative_care_11918.html)	Completion of Advance Care Plan	<p>Use an Advance Care Planning tool¹ to:</p> <ul style="list-style-type: none"> ◆ Complete an Advance Directive² ◆ Help the patient identify a surrogate who would make decisions on their behalf if they did not have decision-making capacity ◆ Identify the patient's values and perspectives on end-of-life care and their general wishes for end-of-life care ◆ Encourage the patient to discuss their wishes with the surrogate, family member, spiritual counselor and others
Patients aged 55 and over, in any stage of health	Revision of Advance Care Plan	<ul style="list-style-type: none"> ◆ Review the patient's goals and preferences for end-of-life care and Advance Directives at least annually ◆ Work with the patient to update his/her Advance Directives, giving consideration to specific potential scenarios ◆ Discussions should occur with a significant change in prognosis (metastatic cancer, oxygen-dependent COPD, progressive heart failure) ◆ If patient has limited life expectancy, consider using the POLST tool to address the patient's specific requests for end-of-life care
	Documentation	<ul style="list-style-type: none"> ◆ Place a copy of the Advance Directive and other documentation of the patient's goals and preferences for end-of-life care in the patient's record ◆ Share the POLST throughout the health system as appropriate, including nursing homes, EMS companies, etc.

¹Respecting Choices Program (<http://respectingchoices.org/>); Five Wishes (<http://fivewishes.org/>)

²In 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 Joint Commission: JCAHO Requirements for Advance Directives (http://www.ehow.com/list_6312086_jcaho-requirements-advance-directives.html); The American Medical Association: E-2.225 Optimal Use of Orders - Not - To - Intervene and Advance Directives (<https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/E-2.225.HTM>); NCCN Clinical Practice Guidelines in Oncology: Palliative Care, Version 2.2011 (<http://www.nccn.org/index.asp>); Physician Orders for Life-Sustaining Treatment Paradigm (<http://www.ohsu.edu/polst/>); and The National Committee for Quality Assurance: 2010 Special Needs Plan (<http://ncqa.org/tabid/1138/default.aspx>); Palliative Care Guideline, Institute for Clinical Systems Improvement, 2011 (http://www.icsi.org/palliative_care/palliative_care_11918.html); Advance Care Planning Decisions (<http://www.acpdecisions.org/home.html>). Individual patient considerations and advances in medical science may supersede or modify these recommendations.