March 2026

MQIC

Michigan Quality Improvement Consortium Guideline

Advance Care Planning

This guideline assists practitioners in engaging adults in a discussion of goals, preferences, and priorities regarding patient care at different stages of life. The guideline recommends tools and interventions to address Advance Care Planning across the patient population. Individual patient considerations and advances in medical science may supersede or modify these guidelines.

For this Population:	Recommendation
Patients aged 18 and over, in any stage of health	**Relevant topics include:** ◆ Encourage the patient to make his/her goals, preferences and choices for care and treatment known both verbally and in writing and to revisit these conversations periodically as their health status or personal circumstances change. ◆ Promote early conversations with family in a non-crisis situation, including cultural sensitivity, awareness of health literacy levels, and the use of qualified medical interpreters. Ensure that ACP materials are provided in the patient's preferred language and at an appropriate reading level. ◆ Discussion should include family members, the patient advocate, and others who are close to the patient. ◆ Any individual can start the conversation (patient, family, physicians, nurses, behavioral health providers, social workers, clergy, trained facilitator, etc.). ◆ Evidence-based training in advance care planning is recommended for any person facilitating advance care planning conversations with a specific focus on navigating difficult prognostic conversations and identifying surrogate decision-makers in non-traditional family structures (e.g., Respecting Choices, ACP Decisions, or equivalent). ◆ Review the patient's goals and preferences for end-of-life care and advance directives at least annually, or sooner if there is a significant change in health status, a new serious diagnosis, or following any acute hospitalization or transition in care settings. ◆ Help the patient identify a patient advocate (also known as a healthcare agent or surrogate decision-maker), with consent, and ensure this individual understands their role and responsibilities.
	Key elements of Advance Care Planning: Encourage the patient to discuss their preferences and care plan with the patient advocate, family member, spiritual counselor and others. Use digital health tools and videos to supplement in-person or telehealth advance care planning conversations. These resources should be used to enhance, not replace, direct communication between patients, families, and clinicians[1]. Incorporate the patient's goals preferences and choices into the Treatment Preferences portion of the Advance Directive[2]. Help the patient identify a patient advocate who would make decisions on their behalf if they did not have decision-making capacity. Encourage the patient to complete an Advance Directive (including Healthcare Power of Attorney and Patient Advocate Role Acceptance).
Patient with New or Established Diagnosis of a Serious Illness	With a significant change in prognosis, work with the patient through shared decision making to update his/her advance directives, giving consideration to specific potential scenarios. Plan can include information such as starting or stopping treatment, symptom control with palliative sedation. The facilitator should have experience with/knowledge of the patient's specific condition (e.g. CHF, cancer).
Patients whose death in the next twelve months would not be surprising	A Physician's Orders for Life-Sustaining Treatment (POLST[3]; Michigan Physician Order for Scope of Treatment [MI-POST[4]]) form in those for whom death within 12 months would not be surprising. Consider using the POLST tool to address the patient's specific requests for end-of-life care, ensuring that the form is reviewed and updated as the patient's condition or preferences change. Guidelines can address: artificial nutrition and hydration, CPR, Do Not Resuscitate, Do Not Intubate and other issues. Make the Advance Directive and POLST accessible throughout the health system, including the Emergency Department, EMS, nursing homes, home health, hospice, and any other settings where the patient may receive care. Given current limitations in EHR interoperability, clinicians should prioritize providing the patient and advocate with a high-quality physical copy (or a patient-accessible digital PDF) and instruct them to present it at every point of care, especially during emergency department visits or hospital admissions. Place a copy of the Advance Directive documenting the designation of a patient advocate, patient's values and beliefs, and goals for end-of-life care, and POLST, in the health record and in retrievable electronic format when available (follow the laws in your state). If patient has limited life expectancy, consider using the POLST tool to address the patient's specific requests for end-of-life care.

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[1] Up to Date: Advance Care Planning and Advance Directives

[2] 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 in Michigan.

[3] Physician's Orders for Life-Sustaining Treatment

[4] Michigan Department of Health and Human Services Michigan Physician Order for Scope of Treatment MI-POST (Use of this form is voluntary)

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 2014; NCCN Clinical Practice Guidelines in Oncology: Palliative Care, Version 2.2011; Physician Orders for Life-Sustaining Treatment Paradigm; Advance Care Planning Decisions (www.acpdecisions.org); Annals of Oncology Clinical Practice Guidelines; MI-POST Executive Summary; Advance Care Planning: Ensuring Your Wishes Are Known; Dying in America Institute of Medicine; Five Wishes (www.fivewishes.org)**;** and *Being Mortal,* by Atul Gawande (www.atulgawande.com/book/being-mortal/)

Approved by MQIC Medical Directors January 2012, 2014, 2016, 2018, 2020, 2022; February 2024: March 2026 **MAHP.ORG**