Michigan Quality Improvement Consortium
Clinical Practice Guideline Update Alert

Guideline: Advance Care Planning

Released: January 2016

Updated recommendations include:

Eligible Population

- Patients whose death in the next twelve months would not be surprising
- Patient with New or Established Diagnosis of a Serious Illness
- Consider patients aged 18 and over, in any stage of health

Advance Care Planning Process

- Evidence-based training in advance care planning is recommended for any person facilitating ACP conversations*

Assist patient in Advance Care Planning

- Encourage the patient to complete an Advance Directive (including Healthcare Power of Attorney and Patient Advocate Role Acceptance)
- Incorporate the patient's goals preferences and choices into the Treatment Preferences portion of the Advance Directive

Documentation and Implementation

- 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, in the health record and in retrievable electronic format when available
- Incorporate the Advance Directive into the person's plan of care
- Make the Advance Directive and POLST accessible throughout the health system, to emergency departments, EMS companies, nursing homes, and share with family

*Respecting Choices
Making Choices Michigan
Five Wishes

This alert provides a brief summary of updated recommendations. Refer to the complete guideline for all recommendations and level of evidence.