Make Advance Care Planning part of routine care

phn NORTH WESTERN MELBOURNE
An Australian Government Initiative

GPs develop ongoing and trusted relationships with their patients and are well positioned to initiate and promote Advance Care Planning (ACP). ACP is the embodiment of person-centred healthcare and a response to the challenges that an ageing population and modern healthcare present. Several Medicare Benefits Schedule (MBS) items can support ACP as part of other health interventions.

Have the conversation about ACP ...

During a health assessment

Discuss ACP and provide printed information as part of a health assessment.

Health assessment items

Patients in the community & Residential Aged Care Facility (RACF): 701, 703, 705, 707

- Item claimed based on both Practice Nurse (PN) and GP time.

Patients who identify as Aboriginal and/or Torres Strait Islander. It is not a time based item: 715

As part of chronic disease management

Including ACP in chronic disease management discussions promotes collaborative decisions with patients and allows these to be shared with other health care providers.

Chronic disease management items

Patients in the community: 721, 723, 729, 732
Patients in a RACF: 731
Practice nurse or Aboriginal health practitioner monitoring of a care plan: 10997

As part of your practice team care

Workforce Incentive program (WIP)

Nurses and Aboriginal health practitioners can provide ACP support, follow-up and interventions under WIP funding.

As part of everyday care

Consider a longer appointment to discuss ACP.

GP consultation items

Patients in the community: 23, 36, 44
Patients in a RACF: 90035, 90043, 90051

- Can be used as a follow up post a health assessment or care plan.

As part of a case conference

Case conferencing items

Patients in the community and RACF:
GP organises and coordinates: 735, 739, 743
GP participates: 747, 750, 758

- May include pain management and palliative care specialists.

Did you know?

ACP minimises complex grief for family members

Would you be surprised if this patient died in the next 12 months?

If the answer is NO, discuss ACP.

Refer to mbsonline.gov.au for eligibility criteria and service requirements

What is Advance Care Planning?

Advance Care Planning (ACP) involves planning for future health and personal care should a person lose their decision-making capacity. ACP captures peoples' values and wishes, enabling them to continue to influence treatment decisions, even when they can no longer actively participate.

ACP can lead to completing an Advance Care Directive, a written document intended to apply to future periods of impaired decision-making. The directive provides a legal means for a competent adult to instruct a Substitute Decision Maker and/or to record preferences for future health and personal care.

Why do it?

- To ensure people receive care that aligns with their beliefs, values and preferences.
- To ensure the person is at the centre of care.
- To help reduce anxiety, depression and stress of family members.
- To improve the quality of care received at the end of life.
- To reduce unnecessary transfers to acute care and unwanted interventions.

When to have the conversation?

If your patient:

- raises ACP with a member of the general practice team
- has a 45–49 year health assessment (introduce topic and provide information)
- has an advanced chronic illness (e.g. COPD, heart failure)
- has a life limiting illness (e.g. dementia or advanced cancer)
- is 75 years or older, or 55 years or older for Aboriginal and/or Torres Strait Islander people
- is older and receives their annual flu vaccination
- is a resident of, or is about to enter, a RACF
- is at risk of losing competence (e.g. early dementia)
- has a new significant diagnosis (e.g. recent or repeated hospitalisation, commenced on home oxygen)
- may anticipate decision-making conflict about their future healthcare
- does not have anyone who could act as a substitute decision maker.

ACP Resources

Office of the Public Advocate – For information on Advance Care Directives and assessing decision-making capacity
publicadvocate.vic.gov.au/medical-treatment/patient-consent/patient-capacity-to-consent

Medicare Online – MBS item eligibility criteria and service requirements
mbsonline.gov.au

HealthPathways Melbourne
melbourne.communityhealthpathways.org

Advance Care Planning Australia – Extensive information including links to state legislation and forms
advancecareplanning.org.au

RACGP – Overview of ACP and link to Position Statement
racgp.org.au/guidelines/advancecareplans

North Western Melbourne PHN – Program assistance, resources, education and training
nwmphn.org.au/for-primary-care/clinical-support/end-of-life-care

Further information is available in a range of languages to support discussions about Advance Care Planning with your patients.

To download this brochure, search Advance Care Planning at nwmphn.org.au/resources