Make Advance Care Planning part of routine care

phn SOUTH EASTERN 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 MBS items can support ACP as part of other health interventions.

This resource has been adapted with permission from a NWMPHN resource.

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
Follow-up post health assessment: 10987

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 everyday care

Consider a longer appointment to discuss ACP.

GP consultation items

Patients in the community: 23, 36, 44, 123
Patients in a RACF: 90035, 90043, 90051, 90054 (Can be used as a follow up post a health assessment or care plan.)

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.

The Surprise Question: Consider discussing ACP if you would not be surprised if your patient died within the next 12 months.

ACP helps to ensure people receive care that is consistent with their beliefs, values and preferences.

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.

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

For more information on ACP, please refer to semphn.org.au/advance-care-planning

Note: Information in this document is accurate as of March 2023 though may be subject to change.