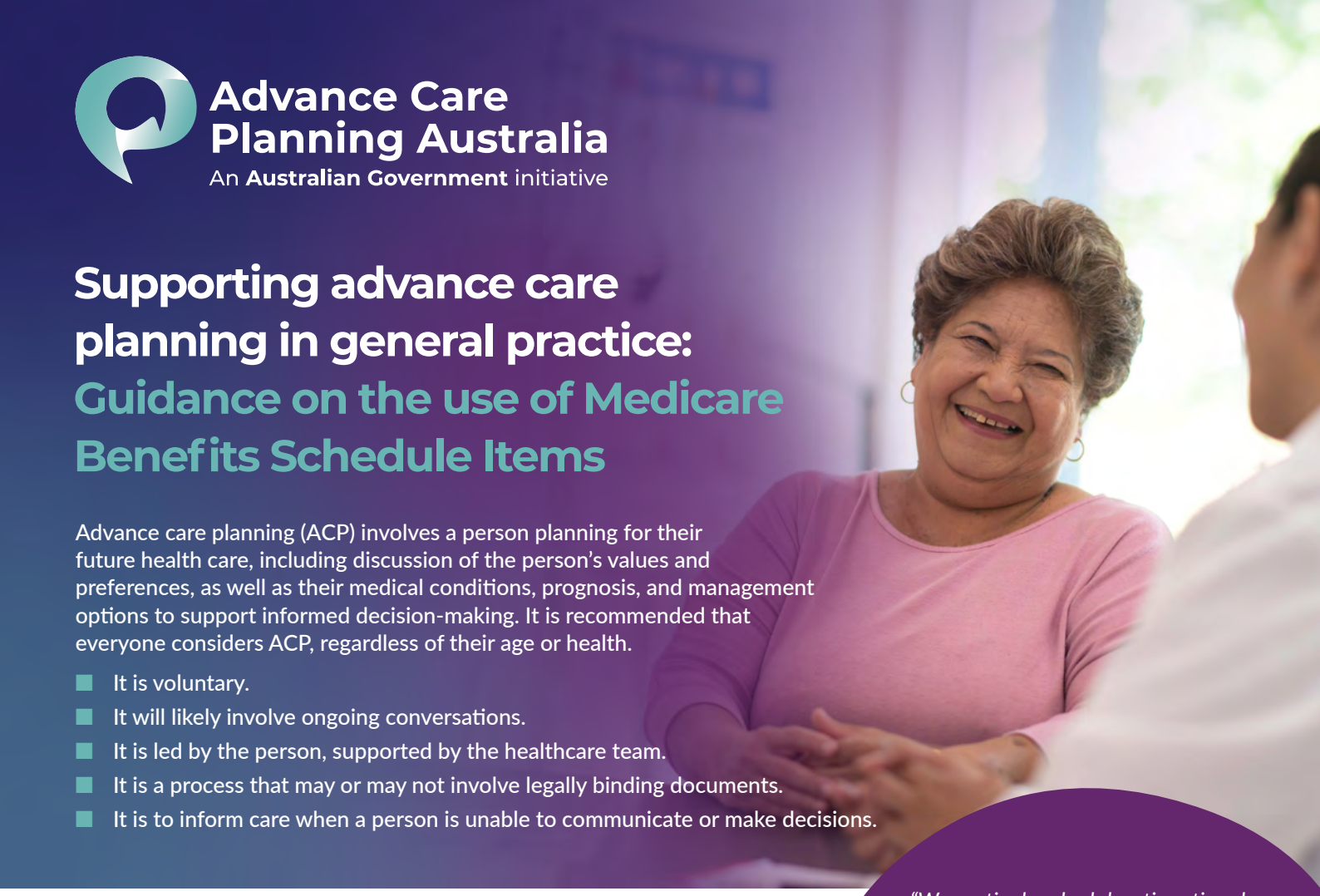
Advance Care Planning Australia
An **Australian Government** initiative

Supporting advance care planning in general practice: Guidance on the use of Medicare Benefits Schedule Items



Advance care planning (ACP) involves a person planning for their future health care, including discussion of the person's values and preferences, as well as their medical conditions, prognosis, and management options to support informed decision-making. It is recommended that everyone considers ACP, regardless of their age or health.

- It is voluntary.
- It will likely involve ongoing conversations.
- It is led by the person, supported by the healthcare team.
- It is a process that may or may not involve legally binding documents.
- It is to inform care when a person is unable to communicate or make decisions.

Conversation starters

Here are some ways to begin sharing what's most important to you.

About me	About life	About health care	About choices
Being able to ___ is the most important thing to me because ___ .	A good day for me is one where I ___ because ___ .	I would prefer to receive my health care at ___ because ___ .	An unacceptable health outcome for me would be ___ because ___ .
I was thinking about what happened to ___ and it made me realise ___ .	What I value and enjoy most in my life is ___ because ___ .	When ___ happens I get worried about my health care because ___ .	I would not want ___ treatments if there was little chance of recovery because ___ .
As part of my culture, values, and beliefs ___ is important to me because ___ .	The most important things on my bucket list are ___ .	I would want these people ___ included in discussions about my health.	If I was choosing between quantity and quality of life, I would choose ___ because ___ .

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"We routinely schedule a time-tiered consultation after an Older Person's Health Assessment to support our patients complete their advance care planning documentation. This gives them time to think and talk about their wishes and preferences with family or friends. They often start the document/s and bring them in for review."

- Practice nurse

Download this conversation starter to help guide conversations between patients, people they trust and their healthcare team.

Key local information (e.g. ACP support services and contacts, key documents):

Metro South Advance Care Planning Service. Ph: 1300 227 674 Email: ACP-MSH@health.qld.gov.a

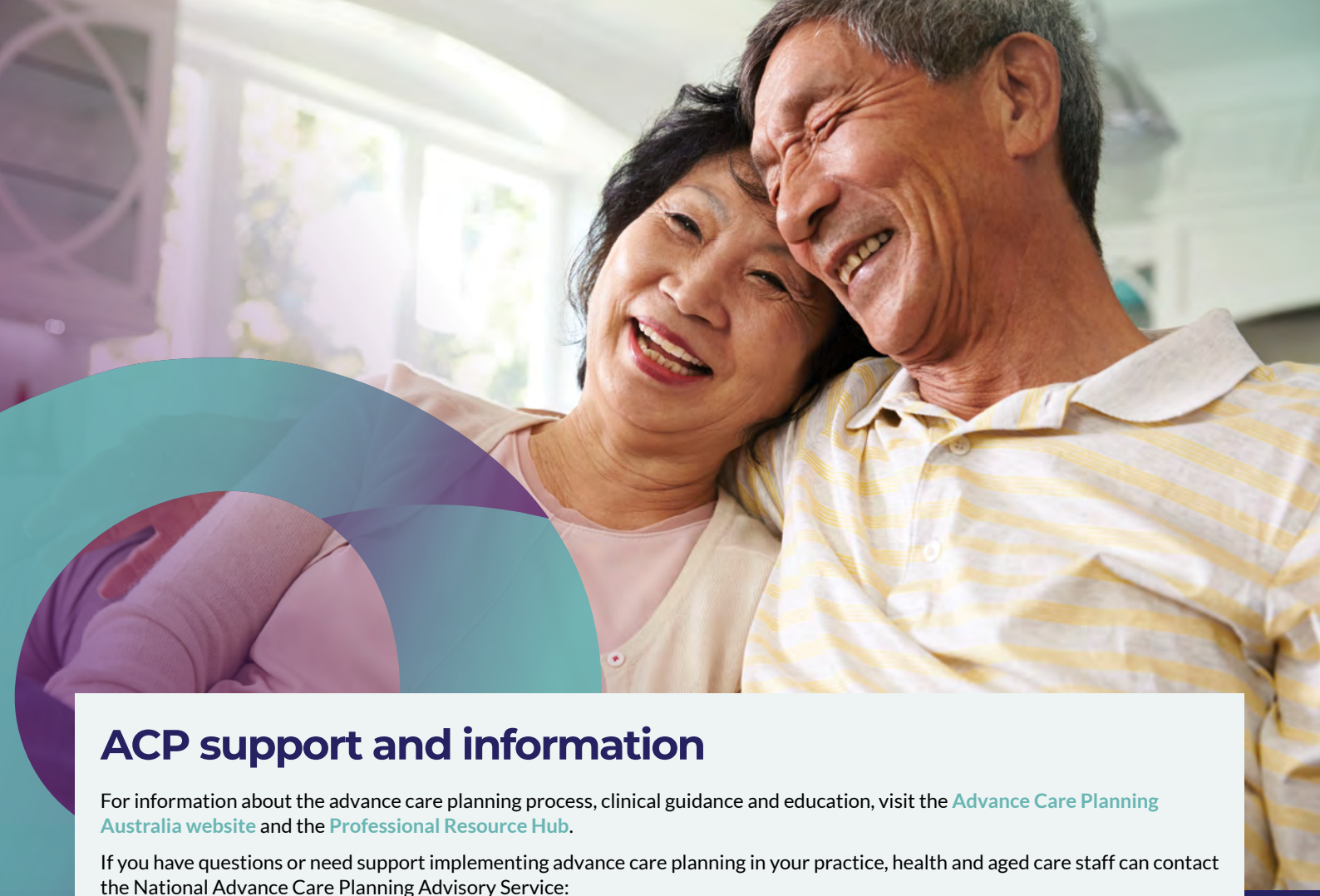
ACPA thanks the following organisations who participated in the review process of this document: Australian Practice Nurses Association, Department of Health Disability and Ageing, Medicare, Primary Health Networks, Royal Australian College of General Practitioners, Queensland Statewide Office of Advance Care Planning

The advance care planning process

For patients	For general practice
 **Think** Reflect on what's important to you and who you would want to speak for you if you couldn't make decisions for yourself	Provide inclusive information and resources to all patients in your clinic. Invite all patients to reflect on what's important to them and who they want to appoint as their substitute decision-maker/s. Inform patients about the local ACP service and/or the **Advance Care Planning Australia website and advisory service** if they would like more information. Consider screening patients using common triggers and cues (see **Talk**) or other tools (see **Recommended resources**) to identify opportunities to introduce ACP. This may be supported through use of a clinical decision support tool, for example, **Primary Sense**.
 **Talk** Discuss your choices with the important people in your life. This might include family, friends, carers and your healthcare team	Be open and prepared to have conversations with patients about ACP. Even a short conversation can be meaningful. Not everything needs to be covered in one visit. Common triggers and cues to start a conversation about ACP include: - Routine health checks and activities (for example, part of a 75+ years health assessment, GP chronic condition management plan attendances) - When an older person receives their annual flu vaccination - On admission to residential or community aged care services - When a person experiences a significant health event and / or hospitalisation - Diagnosis of a life-limiting illness or a chronic condition - Beginning palliative or end-of-life care Listen to patients talking about their values and preferences and what quality of life means to them. Talk to patients about their illness/condition to support them understand what types of decisions they might need to make in the future. Discuss treatment options and outcomes associated with specific treatment decisions. Consider using the **ACPA Conversation starter** to support these conversations.
 **Record** Record your choices	Support patients find the words to document their wishes, especially if they want to make specific instructions. Encourage patients to use the formal documents in your state or territory. Review the person's documents and advocate for clear and specific instructions that are clinically appropriate, considering risks and benefits. Participate in witnessing and / or signing documents to support their validity. Become familiar with your **state and territory** advance care planning documents and the legal requirements for signing and witnessing.
 **Share** Share written documents with important people	Provide advice to store original documents safely and share copies with the substitute decision-maker and any other health service providers. Advise the patient of **options to share** their documents in online systems, health department programs or registers in your state or territory. Seek consent from patients to share scanned advance care planning documents: - Upload to MyHealth Record, either through the clinical software or My Health Record portal - Add to patient records
 **Review** Check whether you want to update or change anything	Support patients to review, update or make new documents, depending on the requirements in your state or territory. This is especially important when there are changes to their: - Preferences or goals - Personal, health or living situation - Substitute decision-maker Set up a recall for review based on a needs assessment. Revisit advance care planning at any of the times identified as common triggers and cues to start a conversation about ACP (see **Talk**).

ACP process	Activities and suggested relevant MBS items	MBS Benefit 100%
Time-tiered general attendances ACP discussions, documentation in notes and/or reviewing ACP documents, and uploading documents to My Health Record may be completed over a number of short consults or may require long consult/s. Longer consults may involve patients with complex health conditions, those needing additional time for supported communications e.g., patients with dementia, disabilities, or where an interpreter is required.		
Think Review	23 **Level B consultation (6-20 mins)** Video: 91800 Residential Aged Care Facility: 90035 **Introduce ACP and review documentation*	$43.90
Talk Record Share Review	36 **Level C consultation (20+ mins)** Video: 91801 Phone: 91900 Residential Aged Care Facility: 90043 **Follow-up conversations and one or more ACP activities*	$84.90
Talk Record Share Review	44 **Level D Consultation (40+ mins)** Video: 91802 Phone: 91910 Residential Aged Care Facility: 90051 **Useful for patients with complex conditions requiring additional support / time*	$125.10
Talk Record Share Review	123 **Level E Consultation (60+ mins)** Video: 91920 Residential Aged Care Facility: 90054 **Useful for patients with complex conditions requiring additional support / time*	$202.65
Management plans and health assessments Consider including one or more elements of the ACP process. This may include raising the topic and inviting the person to talk about their goals and care needs. It may be beneficial to provide resources for the person to consider and schedule a follow-up appointment using a time-tiered consultation to go through ACP in more detail.		
GP Chronic Condition Management Plan preparation or review		
Think Talk	965 **Prepare a GP chronic condition management plan – face to face**	$156.55
	92029 **Prepare a GP chronic condition management plan - video**	
	967 **Review a GP chronic condition management plan – face to face**	
	92030 **Review a GP chronic condition management plan – video**	
Older Person's Health Assessment provided for people aged 75 years and older		
Think Talk	701 **Brief health assessment lasting no more than 30 minutes** **Ask the question – 'Have you thought about ACP?'*	$69.20
	703 **Standard health assessment lasting at least 30 minutes and less than 45 minutes** **Ask the question – 'Have you thought about ACP?'*	$160.80
	705 **Long health assessment lasting at least 45 minutes and less than 60 minutes** **Ask the question – 'Have you thought about ACP?' Offer ACP information and education.*	$222.00
	707 **Prolonged health assessment lasting more than 60 minutes** **Ask the question – 'Have you thought about ACP?' Offer ACP information and education.*	$313.60
Aboriginal and Torres Strait Islander Peoples Health Assessment		
Think Talk	715 **Professional attendance by a general practitioner at consulting rooms or in another place other than a hospital or residential aged care facility, for a health assessment of a patient who is of Aboriginal or Torres Strait Islander descent (not time-based) Video:** 92004 **Ask the question – 'Have you thought about ACP?' Offer ACP information and education.*	$247.65
Services provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner on behalf of a medical practitioner		
Think Talk	10987 **Follow up service provided by a practice nurse or Aboriginal and Torres Strait Islander health practitioner, on behalf of a medical practitioner, for an Indigenous person who has received a health assessment to provide:** ■ **Education, monitoring and counselling activities and lifestyle advice:** *Consider provision of culturally appropriate ACP information and resources and supporting patients identify values and preferences about future health care.*	$27.95
Think Talk	10997 **Service provided by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner to a person with a chronic condition** Video: 93201 Phone: 93203 ■ **Self-management advice** **Consider provision of ACP information and resources and supporting patients identify values and preferences about future health care.* ■ **Collection of information to support GP/medical practitioner reviews of GP management plans** **Explore and document patient values, preferences and goals around future health care*	$14.00

* Asterisks indicate examples or considerations only. Eligibility, time requirements and clinical appropriateness must meet MBS descriptors.



ACP support and information

For information about the advance care planning process, clinical guidance and education, visit the Advance Care Planning Australia website and the Professional Resource Hub.

If you have questions or need support implementing advance care planning in your practice, health and aged care staff can contact the National Advance Care Planning Advisory Service:

- 1300 208 582
- acpa@advancecareplanning.org.au
- 8 am to 4 pm (AEST), Monday to Friday

Support materials

Visit Support materials to

- Download free starter pack documents
- Access recognised advance care planning forms for your state or territory
- Buy printed resources for local distribution

Recommended resources:

- RACGP aged care clinical guide (Silver Book) - Advance care planning
- Advance Care Planning Australia Microlearning Campaigns – free, short online modules
- **HealthPathways portal** (via your PHN): search *advance care planning*
- Prompts for End-of-Life Planning (PELP) Framework — guidance on ACP activities that support quality end-of-life care
- SPICT tool - identify patients with deteriorating health who may benefit from ACP

Disclaimer

- The GP must ensure that the requirements for the services, as set out in the MBS, are met.
- Items listed are not exhaustive and information provided is a general guide only. Other practitioner and practice level incentives could be considered. It is ultimately the responsibility of treating practitioners to use their professional judgment to determine the most clinically appropriate services to provide, and then to ensure that any services billed to Medicare fully meet the eligibility requirements outlined in the legislation. This factsheet is current as of the last updated date below and does not account for MBS changes since that date.
- The time required to undertake a general attendance in consulting rooms or a residential aged care service or a Health Assessment service may only include the activities described in the Health Insurance (General Medical Services Table) Regulations 2021 (the Regulations). Any aspects of the advance care planning process that are not covered by the requirements of the Regulations may not be included in the time taken to provide the service.
- Telehealth (video and phone) items are subject to eligibility criteria (see AN.1.1) and activities are described in the Health Insurance (Section 3C General Medical Services – Telehealth Attendances) Determination 2021.