Make Advance Care Planning part of routine care

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**
Practice nurse incentive program (PNIP)
Nurses and Aboriginal health practitioners can provide ACP support, follow-up and interventions under PNIP 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: 35, 43, 51
- Can be used as a follow up post a health assessment or care plan.

**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