Practice Assist
Strengthening general practice in WA

Fact Sheet
V1 / May 2021

Advance Care Planning (ACP) and supporting MBS items

General practices are uniquely placed to support patients with Advance Care Planning (ACP) because of the enduring and trusted relationships that exist between general practitioners and their patients. ACP is a key part of patient-centred health care and should be a part of routine general practice care.

What is Advance Care Planning (ACP)?

The Royal Australian College of General Practitioners (RACGP) describes ACP as a process of reflection, discussion and communication that enables a person to plan for their future medical treatment and other care, for a time when they are not competent to make, or communicate, decisions for themselves.

ACP is a discussion between the patient, their carers and/or family and their general practitioner about the patient's future treatment and care preferences. It is particularly valuable to have a record of a patient's wishes for future care should they be unable to communicate their decisions towards the end of life.

Advance care planning may include topics such as the kind of treatments they agree or don't agree to, where they would like to be cared for when they die, who they would like to be there with them and the type of funeral they would prefer.

Although often about end-of-life care (the last 12 months) or terminal care (the last days to weeks of life), ACP is a process that all patients can benefit from, especially those at risk of deterioration in health.

What is an Advance Health Directive (AHD)?

ACP will often lead to the completion of an Advance Health Directive (AHD), which is a legally binding document specifying the type of care a patient would like in the future, including resuscitation, mechanically assisted ventilation, assisted nutrition and hydration, antibiotics, etc. WA Health is currently undertaking consultation on a standardised AHD format.

The RACGP describes an AHD as a written document, intended to apply to future periods of impaired decision-making capacity, which 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.

AHDs are not clinical care or treatment plans, but clinical care or treatment plans can and should be informed by AHDs. Although a completed AHD is desirable for the purposes of ACP, the discussions that are central to ACP are valuable in their own right. It is important to note that verbally communicated instructions and values also hold weight.

The Advance Project

The Advance Project is a practical, evidence-based toolkit and training package, specifically designed to support Australian general practices to implement a team-based approach to initiating ACP and palliative care into everyday clinical practice.

The toolkit and training program were informed by literature reviews as well as extensive input and feedback from an expert advisory group, general practitioners, general practice nurses, practice managers and consumer representatives.

The training program is available for free for nurses, general practitioners and practice managers working in Australian general practices. The Advance Project is funded by the Australian Government Department of Health and delivered by a national consortium.

HealthPathways WA

HealthPathways WA is an online tool that offers clinicians locally agreed information to make the right decisions, together with patients, at the point of care. HealthPathways WA includes a pathway to support GPs with Advance Care Planning (ACP).

MBS items for Advance Care Planning (ACP)

There are no MBS items specifically for ACP, however there are MBS items that may support ACP in general practice, which are outlined on the following pages.

Further information

If you would like further information about Advance Care Planning (ACP), visit the links below:

- RACGP Advance Care Planning
- MBS Online
- The Advance Project
- HealthPathways WA

WA Primary Health Alliance is supported by funding from the Australian Government under the PHN Program.
Rural Health West is funded by the Australian Government and WA Country Health Service.

Practice Assist
Strengthening general practice in WA

Fact Sheet
V1 / May 2021

MBS items to support Advance Care Planning

GP Management Plans and Team Care Arrangements

- There are three MBS items available for the preparation, coordination or review of a GP Management Plan or Team Care Arrangement.
- These item numbers provide funding for GPs to develop and review a chronic disease management plan for patients with one or more chronic diseases. The initiation of ACP and/or palliative and supportive care needs assessment, if indicated for the patient, could be incorporated into the planning and review processes.
- These items are available to patients in the community and private in-patients of a hospital being discharged from hospital.
- For more information about GP Management Plans and Team Care Arrangements, visit MBS Online.

Item number	Fee*	Description and recommended frequency
721	$148.75	Preparation of a GP Management Plan, once every 12 months
723	$117.90	Coordination of Team Care Arrangements, once every 12 months
732	$74.30	Review of a GP Management Plan or coordination of a review of a Team Care Arrangement, once every 3 months

GP consultation items

- There are four time-based health assessment items available for standard consultations.
- Level B-D GP consultation item numbers may be used to fund consultations involving the initiation of ACP and/or palliative and supportive care assessments. The number and length of consultations required will depend on the complexity of the patient's needs.
- For more information about standard GP consultation items, visit MBS Online.

Item number	Fee*	Description and recommended frequency
23	$38.75	Professional attendance by a GP, less than 20 minutes
36	$75.05	Professional attendance by a GP, at least 20 minutes
44	$110.50	Professional attendance by a GP, at least 40 minutes

Health assessment for people aged 75 years and over

- There are four time-based health assessment items available.
- These items can be used for people aged 75 years and older and permanent residents of residential aged care facilities, as well as people in specific target groups.
- The initiation of ACP and/or palliative and supportive care needs assessment could be incorporated into the health assessment process. Patients may also need further follow up GP consultations (see below) on a different day after the health assessment if they have complex palliative care needs or require additional time to discuss ACP.
- For more information about the health assessment items, visit MBS Online.

Item number	Fee*	Description and recommended frequency
701	$61.20	A brief health assessment, lasting not more than 30 minutes and including: a) collection of relevant information, including taking a patient history; and b) a basic physical examination; and c) initiating interventions and referrals as indicated; and d) providing the patient with preventive health care advice and information
703	$142.20	A standard health assessment, lasting more than 30 minutes but

WA Primary Health Alliance is supported by funding from the Australian Government under the PHN Program.
Rural Health West is funded by the Australian Government and WA Country Health Service.

		less than 45 minutes, including: a) detailed information collection, including taking a patient history; and b) an extensive physical examination; and c) initiating interventions and referrals as indicated; and d) providing a preventive health care strategy for the patient
705	$196.25	A long health assessment, lasting at least 45 minutes but less than 60 minutes, including: a) comprehensive information collection, including taking a patient history; and b) an extensive examination of the patient's medical condition and physical function; and c) initiating interventions and referrals as indicated; and d) providing a basic preventive health care management plan for the patient
707	$277.20	A prolonged health assessment (lasting at least 60 minutes) including: a) comprehensive information collection, including taking a patient history; and b) an extensive examination of the patient's medical condition, and physical, psychological and social function; and c) initiating interventions or referrals as indicated; and d) providing a comprehensive preventive health care management plan for the patient

Nurse chronic disease management consultation items

- Patients with GP management plan +/- team care arrangements are eligible to receive rebates for 5 visits each year to the general practice nurse for chronic disease management.
- These visits could be used by general practice nurses or Aboriginal and Torres Strait Islander health practitioners to provide self-management advice, monitoring medication compliance or checking clinical progress.
- This item may be used to assist the patient with completing the Advance Project assessment booklets (where the patient requires assistance).
- For more information on this item, visit MBS Online.

Item number	Fee*	Description and recommended frequency
10997	$12.40	Service provided to a person with a chronic disease by a practice nurse or an Aboriginal and Torres Strait Islander health practitioner, maximum of 5 times per calendar year.

*Medicare rebates are paid as a percentage of the Medicare Schedule Fee. Please use the MBS Online search to confirm the available rebate.

WA Primary Health Alliance is supported by funding from the Australian Government under the PHN Program.
Rural Health West is funded by the Australian Government and WA Country Health Service.