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Advance care planning and My Health Record

Information for GPs

What is advance care planning?

Advance care planning enables patients with decision-making capacity to plan for their future medical treatment and care for a time when they're not able to make or communicate their wishes and decisions. It provides an opportunity for patients to plan for their possible future medical needs and discuss their personal values and healthcare preferences with their family, friends and GP, as well as their wider healthcare team.

For GPs, the process helps you to understand your patient's values and treatment preferences, and to provide person-centred care across their illness trajectory.

An advance care directive is considered a legal document and must be implemented as part of the clinical decision-making process for a patient who lacks the capacity to make decisions for themselves.

For advance care plans to be effective, family members and treating clinicians need to know they exist and be able to access them.

Why is it important?

Advance care planning can improve your patient's certainty and reduce their anxiety about the care they receive and can reduce their family members' anxiety and stress during illness and at end of life.

It can also improve adherence to your patient's preferences for ongoing and end-of-life care and reduce unwanted interventions and non-beneficial transfers to acute care facilities.

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What is the GP's role?

As a GP, you have ongoing and trusting relationships with your patients. You're well positioned to discuss future care when patients have decision-making capabilities. An advance care planning conversation can fit in well as part of ongoing health assessments and when giving advice on healthcare options for any current diagnosis. The *RACGP aged care clinical guide (Silver Book)* provides further information on advance care planning in general practice.

The RACGP's *Standards for general practices* (5th edition) recognises advance care planning is part of providing continuous and comprehensive care (Criterion GP2.1). You could develop systems within your practice to support advance care planning as part of routine care. This could include:

- creating a practice-team approach to support patients
- identifying priority patient groups
- providing education for practice staff on discussing advance care planning
- establishing systems to store and share patients' advance care planning documents.

What can be included in advance care planning?

Advance care planning may result in your patient appointing a substitute medical decision-maker, creating a written values statement regarding their goals of care or developing a specific and instructional advance care directive.

The rules regarding advance care directives and appointing substitute medical decision-makers differ between states and territories, and specific information is available on the Advance Care Planning Australia website.

1. Appointment of a substitute medical decision-maker

Your patient can document the details of the person they appoint to make healthcare and treatment decisions on their behalf when they're unable to make these decisions for themselves. The substitute medical decision-maker also needs to document their agreement to undertaking this role.

2. Advance care directive

Creating an advance care directive is the best way for your patients to make their preferences known regarding the type of treatment they'd want if they were no longer able to make their own decisions. For example, accepting life-prolonging treatments such as CPR, the use of artificial ventilation and tube feeding. A directive also helps to ensure family members and healthcare providers are aware of these decisions.

While it's preferable patients complete the specific documents required by their state or territory, advance care directives do not need to be in a particular format or follow any formal requirements.

3. Goals-of-care document

These documents provide information about medical and non-medical goals of care in relation to a specific episode of care.

Goals of care would normally be determined during an admission to hospital or at the beginning of a new treatment program. They are agreed upon by the patient, their family and carers, and their healthcare providers.

A trial is currently being conducted by WA Health and various healthcare services to create goals-of-care documents to plan medical treatment in the event of clinical deterioration. The trial is designed to ensure care is delivered in line with patient preferences and improve the uptake of advance care planning. A key component is the uploading of goals-of-care plans, developed in the context of end-of-life care, to the My Health Record.

How can advance care documents be managed and shared?

Once an advance care directive is created, copies of these documents should be shared and stored so they're accessible when needed.

A copy should be stored as part of your patient's local medical record. Your patient should provide copies to any other healthcare providers involved in their care, family and friends, and their substitute medical decision-maker if they have one.

Patients can also upload a copy of their advance care directive to their My Health Record to make it available to all healthcare providers involved in their care. They can also add information about an advance care document custodian, a person or organisation chosen by the patient to hold copies of any advance care planning documents. Including these details enables other healthcare providers to contact your patient's custodian to discuss their preferences for care.

There are currently no general practice clinical information systems (CISs) that have the functionality to upload a patient's advance care planning documents to their My Health Record. When this functionality is available, GPs will be able to upload these documents on behalf of the patient with their consent.

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How can I view my patient's documents in My Health Record?

If your patient has uploaded advance care planning documents to their My Health Record, you can view these via your CIS if you're registered to use the My Health Record. In most CISs, advance care planning documents can be found in the documents list. Depending on which CIS you use, you may need to adjust the document filters to ensure the documents are showing. Some CISs will feature a flag indicating your patient's My Health Record includes advance care planning information.

If your CIS does not provide access to the My Health Record, you can use the National Provider Portal to access your patient's Health Record Overview. This will indicate if advance care planning information has been added.

Where can I get more information?

RACGP

- *RACGP aged care clinical guide (Silver Book) – Part B Advance care planning*

Australian Digital Health Agency

- Advance Care Planning National Guidelines
- My Health Record: Advance care planning and goals of care

Advance Care Planning Australia

- Advance care planning in general practice

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