Advance care planning

Recent changes to the Health Care (Consent) and Care Facility (Admission) Act and other acts, which include the new legal status of advance directives in BC, are a reminder to both patients and physicians of the benefit of planning for future health care wants and needs.

Advance care planning is the ongoing, iterative process whereby a capable adult discusses his or her beliefs, values, wishes, or instructions for future health care with trusted family and health care providers.

Until recently, advance care planning was often limited to a discussion of a patient's feelings about "code status." And often this discussion followed a significant medical episode that had resulted in a patient's trip to the emergency department or hospitalization.

Recognizing this, the General Practice Services Committee (GPSC) has developed a number of tools, resources, and fees to enable family physicians (FPs) to more effectively incorporate advance care planning into their care of patients with multiple comorbidities and end-stage medical conditions, as well as those requiring palliative care.

Billing incentives

The Complex Care Planning fee (14033) compensates FPs for working with patients with multiple medical conditions to develop a written advance care plan. The physician and patient discuss the patient's wishes for future care, including end-of-life care and which life-prolonging medical interventions the patient may wish to have or refuse if he or she becomes incapable of deciding later. The advance care plan can be reviewed on a regular basis and when a patient's medical status changes. (Note: An advance directive cannot be witnessed by a physician, but may be included in a patient's advance care plan. If it is, the health care provider is legally bound by consent refusals in the advance directive.)

The Palliative Planning fee (14063) compensates FPs for developing a palliative care plan that more specifically addresses the needs and wishes of a patient with an end-stage medical condition who is felt to be in the last 6 months of life.

Once either the Complex Care Planning or Palliative Planning fee has been billed, FPs can bill for follow-up two-way communication (by telephone or e-mail) with the patient, or the patient's medical representative (14079).

Additionally, there are a number of conferencing fees (face-to-face and telephone) that compensate FPs for collaboration with other health care professionals (including home and community care and palliative care providers) in the care of these patients, both facility based (14015, 14017) or community based (14016).

Specialists (10001, 10002) and GPs with specialty training (14021, 14022) are also compensated for providing urgent and non-urgent telephone advice to other physicians, as are FPs who initiate this two-way communication (14018). These fees are not restricted to treatment of patients with specific conditions and can be billed for treatment of patients who are facility- or community based.

There are also fees to compensate specialists (10003) and GPs with specialty training (14023) for providing telephone advice to patients. (Note: Specialist physicians will soon be compensated for undertaking advance care planning through a new incentive being developed by the Specialist Services Committee.)

Visit www.gpscbc.ca/billing-guide-fees for more information, including video tutorials on when and how to bill these fees.

Tools and resources

The GPSC's Practice Support Program (PSP) provides training and support for physicians and their MOAs to improve clinical and practice management. The program recently completed a new end-of-life learning module that provides training for FPs to improve care of patients and families living with, suffering, and dying from life-limiting and chronic illnesses. The module helps physicians learn how to identify patients who could benefit from a palliative approach to care, to increase confidence and communication skills to enable advance-care planning conversations, and to improve collaboration with palliative care and non-palliative specialist services, patients, families, and caregivers.

The module includes numerous tools and resources to help FPs increase their confidence and level of comfort discussing advance care planning with their patients, all of which are available on the PSP website at www.pspbc.ca.

There is also a provincial advance care planning tool (My Voice: Expressing my Wishes for Future Health Care Treatment) available to the public at www.health.gov.bc.ca/hcc/advance-care-planning.html to assist patients and their families with the planning process.

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This article is the opinion of the GPSC and has not been peer reviewed by the BCMJ *Editorial Board.*