



Ngununggula

Walking and Working Together

A MANUAL FOR HEALTH PROFESSIONALS SUPPORTING ABORIGINAL PEOPLE WITH CANCER

online appendices



ONLINE APPENDIX 1 CONTINUOUS QUALITY IMPROVEMENT (CQI) IN CANCER CARE

WHAT IS CONTINUOUS QUALITY IMPROVEMENT?

Continuous Quality Improvement (CQI) is part of a range of activities that support and improve quality in health care, including in cancer care, in our communities.

- CQI drives service improvements through continuous and repeated cycles of changes;
- CQI is for teams to use data to identify areas for action, develop and test strategies, and make changes in service delivery; and
- CQI is part of the core business of providing health care.

While there is always scope for improvement in CQI in ACCHOs, there has already been wide take-up and use of CQI.¹ Aboriginal and Torres Strait Islander Health services use CQI at a higher level than mainstream providers.²

The National Community Controlled Aboriginal Health Organisation (NACCHO) documented the four domains to consider in CQI for ACCHOs:⁵

EFFECTIVE CQI REQUIRES:

- Ongoing commitment to improvement from our CEOs, Board and staff of our health care services
- Community driven priorities
- CQIs to be embedded in the local historical and cultural context
- Two-way learning about CQI
- Teamwork and collaboration
- Ongoing support from government agencies, Primary Health Networks and mainstream services
- A coordinated approach
- A stable, trained and supported workforce with CQI leaders and teams
- Ability to collect and analyse data, for example from electronic medical records
- Access to the evidence, tools and resources that inform and support change.³

There is scope for further research and development in QI in Aboriginal communities.⁴

DOMAIN 1: BEING CULTURALLY RESPECTFUL IN CQI

Culturally respectful CQI ensures that Aboriginal and Torres Strait Islander people, communities and health care services are actively engaged in identifying priorities and developing policies and programs that lead to improved access, high-quality care, positive experiences and better health outcomes.

DOMAIN 2: DOING CQI

CQI to improve health care services for Aboriginal and Torres Strait Islander people is embedded as part of organisational and clinical governance, in the roles and responsibilities of staff and teams, and in the use of indicators, data and patient information management systems.

DOMAIN 3: SUPPORTING CQI

Partnerships between government, the ACCHO sector and PHNs provide leadership, resources and a collaborative environment for CQI. CQI capability is supported through investment in data analysis and interpretation, CQI tools and resources, and workforce.

DOMAIN 4: INFORMING CQI

Quality indicators and benchmarks that align with evidence for good practice in primary health care are used to inform CQI planning, implementation and reporting. CQI research and knowledge translation must support improved primary health care services and health outcomes.

ONLINE APPENDIX 1 CQI IN CANCER CARE CONT'D

PLAN, DO, STUDY, ACT

Support CQI by planning new activities using 'Plan Do Study Act' (the PDSA framework).

Other frameworks can also be used in, including the ABCD/ABCDE and One21seventy CQI cycle.⁶



PDSA in cancer care for Aboriginal Community Controlled Health Services

Each ACCHO needs to decide priorities for their Community. Plan, Do, Study, Act cycles can be used to:

1. support our Community to prevent cancer by taking part in breast cancer, bowel cancer, cervical cancer screening and smoking cessation programs
2. improve uptake of more general prevention programs such as delivering health checks and promoting healthy lifestyle
3. support people during investigation or at first diagnosis of cancer
4. support people with existing cancer, for example, support at follow-up investigations and specialist appointments, or by running yarning groups
5. support people at the end of life—for example providing home visiting programs.

CQI using Communicare

Communicare is a health software supporting Aboriginal and Torres Strait Islander organisations who deal with complex and chronic care needs in Indigenous and remote communities.

The software assists healthcare providers in their implementation of preventative healthcare measures, as well as supporting clients with chronic diseases such as cancer.

Many ACCHOs use Communicare for reporting and for quality improvement by extracting data, by implementing programs and by reviewing data to look for improvements.

This guide is designed to support ACCHOs do CQI in cancer care using Communicare (Version 21.1 and onwards), although some services use other health software. Communicare is also able to develop a Cancer Screening Plan for clients.

ONLINE APPENDIX 1 CQI IN CANCER CARE CONT'D

Cancer screening and primary care: A quality improvement toolkit

This is a guide, developed by the Cancer Institute NSW, designed for general practice and Aboriginal Medical Services and allows services to clean, extract and analyse data on cancer from a range of software including:

- Best Practice
- Medical Director
- Zedmed
- Genie

It contains a guide to calculating number of cancer clients, and 'recipes' for clients up to date with cervical cancer, breast cancer and bowel cancer screening and to record family history for use in screening programs, as well as guides to using recall and reminders systems.

<https://www.cancer.nsw.gov.au/what-we-do/working-with-primary-care/cancer-screening-and-primary-care-quality-improvement>

PenCs Stand up to Cancer

This is a guide, designed for general practice and Aboriginal Medical Services and allows services to extract data on cancer from a range of software including:

- Best Practice
- Medical Director
- Zedmed

It contains a guide to calculating number of cancer clients, and 'recipes' for clients up to date with cervical cancer, breast cancer and bowel cancer screening.

https://www.pencs.com.au/wp-content/uploads/2020/03/20200303_Cancer-Toolkit-CatPlus-and-Cancer.pdf



REFERENCES

1. Centre for Research Excellence in Integrated Quality Improvement. Improving the quality of primary health care for Aboriginal and Torres Strait Islander Australians. CRE-IQI 2019. Lismore.
2. Panaretto KS, Gardner KL, Button S, et al. Prevention and management of chronic disease in Aboriginal and Islander Community Controlled Health Services in Queensland: a quality improvement study assessing change in selected clinical performance indicators over time in a cohort of services. *BMJ Open* 2013;3:e002759.
3. Larkins S, Carlisle K, Turner N, et al. 'At the grass roots level it's about sitting down and talking': exploring quality improvement through case studies with high improving Aboriginal and Torres Strait Islander primary healthcare services *BMJ Open* 2019;9:e027568.
4. Sibthorpe B, Gardner K, Chan M, Dowden M, Sargent G, McAullay D. Impacts of continuous quality improvement in Aboriginal and Torres Strait Islander primary health care in Australia: A scoping systematic review", *JHOM* 2018; 32(4): 545-571.
5. National Aboriginal Community Controlled Health Organisation (NACCHO). National Framework Continuous Quality Improvement in Primary Health Care for Aboriginal and Torres Strait Islander People 2018-2023', NACCHO; 2018 [Accessed at <https://www.naccho.org.au/wp-content/uploads/NACCHO-CQI-Framework-2019.pdf> 9 November 2020]
6. Menzies SHR, Improving the quality of primary health care (V4). Menzies SHR, Darwin; 2014. [Accessed https://www.menzies.edu.au/icms_docs/253978_Improving_the_quality_of_primary_health_care.pdf]

ONLINE APPENDIX 2 QUALITY IMPROVEMENT (QI) IN CANCER PROGRAMS

Aboriginal Community Controlled Organisations (ACCHOs) wishing to improve their cancer programs are able to seek information in a range of ways:

Yarning

Sometimes services need to gather information about cancer program delivery in other ways involving listening to client perspectives. Lin, Green and Bessarab⁷ discussed the role of 'clinical yarning' including 'research yarning'.

Research yarning might be helpful when evaluating cancer programs in your health service as part of QI.

Research yarning for QI might involve talking to clients individually or in groups and asking what they liked about the program and how they think the program could be improved. It could involve audio recording clients' views or taking notes regarding their suggestions, or 'co-design' where clients can have input as to how the program could be improved.

Surveys

Many services also use surveys to allow clients to give feedback on programs. This could be in the form of a paper survey, or an online form. This feedback can be used to use client feedback to improve programs.

Electronic medical records (EMR)

Many services use electronic medical records (EMR) such as Communicare as part of QI activities. This can be useful for documenting number of clients who attend programs or activities, for example yarning groups, or healing days as well as to record improvements in preventive care.

For example, many health services use their EMR to do QI activities to improve the number of Aboriginal Health Checks delivered.

REFERENCE

7. Lin I, Green C, Bessarab D, 'Yarn with me': applying clinical yarning to improve clinician-patient communication in Aboriginal health care. 2016. Australian Journal of Primary Health 22(5) 377-382.

CLIENTS WITH CANCER AT YOUR SERVICE - 'QI 'RECIPE'

Knowing how many people have been diagnosed with cancer in a service can be useful in planning services.

PLAN

- Run reports in Communicare to find out how many regular clients have or have had cancer.
- Run a report for different types of cancer. Don't forget to include men and women of all ages.
- For example, for breast cancer use: Toolbar/Report/Conditions/Conditions report/Carcinoma: breast:F.
- Add the term Carcinoma breast/M to include men with cancer. Other terms to search on might include Breast cancer, Breast carcinoma, Carcinoma in situ; breast/F, Carcinoma in situ; breast/M
- Search on other cancers.
- For example, to record all people with carcinoma of the lung, include: Carcinoma:respiratory and Neoplasm:respiratory
- Ask staff if they can recall any other clients with cancer in case staff have not correctly coded their condition.

DO

- Form a Cancer Group to list all clients with cancer. To create a report on all clients with cancer, run a report: Toolbar/Report/Patients/Group members/ Cancer.
- Train all staff to correctly code cancer diagnosis in the electronic medical record (EMR) and to add clients to the Cancer Group.
- Use the Cancer Group to invite clients to Yarning Circle, or other events.
- Review the files of clients with cancer to ensure they are receiving regular care such as follow-up for their cancer, Health Checks and Chronic Disease Care Plans.

STUDY

Knowing the different types of cancer in your services may help you plan programs, for example, if many clients have lung cancer, your service may prioritise smoking cessation programs.

ACT

- Review your findings and consider what other changes could be made.
- Some services or community boards will be interested in knowing how many people die of cancer in their community.
- Search Toolbar/Report/Patients/Deaths to provide a list of deaths and cause of death for a period of time.

ONLINE APPENDIX 3 FAMILY HISTORY – QUALITY IMPROVEMENT

Family history can be important when planning how often clients should be screened for cancer. People with a strong family history of breast cancer, bowel cancer, melanoma, or other cancers may need more regular screening. Primary care services are required to record family history in the electronic medical record (EMR), as part of RACGP accreditation.

PLAN

- How many regular clients have their family history entered?
Go to Report on toolbar.
- Search: Toolbar/Report/Clinical record/Social and Family History Analysis.
- This will allow you to calculate the number, and proportion of regular clients with family history recorded.

DO

- Training all staff in how to enter family history.
- For all clients: Toolbar/Clinical Record/ Social and Family History.
- Health workers/ GPs will need to consider adding reminders according to national guidelines for those clients at higher risk of some conditions (for example, breast cancer, bowel cancer and melanoma).

STUDY

Review data after 6-12 months and feed back to staff.

ACT

- Think of ways to increase how often staff record family history:
- Ensure your programs are culturally safe and that staff can discuss this sensitively;
 - Record or update family history at Aboriginal Health Checks.

ONLINE APPENDIX 4 BREAST CANCER SCREENING – QUALITY IMPROVEMENT

Breast cancer screening can detect breast cancer early, when it is easier to treat.

Who can be screened?

Breast cancer mammography screening is recommended for all women 50 to 74 years of age. Women 40-49 can be screened through Breastscreen. Some women at higher risk (eg with a family history of breast cancer or other cancers) may be eligible for earlier testing or other testing such as MRI. They may need a clinical breast exam or genetic testing.

Mammography results are sent to BreastScreen. Health professionals or clients can call Breastscreen to see if a woman is due for a mammogram: ph 132050.

Health services should take special care of clients who have symptoms or signs of breast cancer, or have had breast cancer - through the recall system (rather than the reminder system).

What should we aim for?

Of all Australian women, 54% participate in breast cancer screening. In 2015-6, only 39% of Aboriginal or Torres Strait Islander women aged 50-74 years took part in breast cancer screening.⁸

Aboriginal Community Controlled Health Services can remind and support women to have a mammogram, because they are culturally appropriate and safe.

PLAN

- Run a Communicare report of regular female patients in the eligible age group (50 – 74 years of age).
Search: Toolbar/Report/Procedure/Mammogram
- How many have had mammography recorded in the last two years (or ever)? And how many have had mammography recorded in your service's electronic medical record (EMR) in the last two years (or ever)?
- Check if clients are due for breast cancer screening by calling BreastScreen 132050. BreastScreen is able to provide a report on clients who have had a mammogram in the required period.

DO

- Make sure women who are eligible for breast cancer screening have a reminder entered into the EMR.
- Check who is due for reminders for screening. Search: Toolbar/Report/Recalls/Recalls due/Screening:breast cancer
- Services can also review clients due for mammography (including those who have symptoms or have had cancer) as part of their recall system. Make a report of women who are due for recalls for mammography. Search: Toolbar/Report/Recalls/Recalls due/Mammography: F
- In addition to the national program, services can send reminders for breast cancer screening. Format a word processor merge file to make letters to send to people. Phone or SMS clients to remind them to book for a mammogram, or assist them to book and organise transport.
- Organise a community Breastscreen day, or organise the Breastscreen outreach bus to visit your service. Modify the recall/ reminder to show the recall/reminder has been sent.
- When clients come to the clinic, check for recalls and reminders. In Communicare recalls and reminders are in the bottom right-hand corner of the patient screen.

STUDY

6 or 12 months later, check how many and the proportion of women who are due for breast screening.

ACT

Think of ways to increase participation:

- Ensure your programs are culturally safe;
- Provide easy-to-read plain English information about breast cancer screening, including culturally specific posters and promotional material;
- Remind women about breast cancer screening at Aboriginal Health Checks;
- Ensure services are accessible, e.g. assist to make an appointments, transport available, hold a breast screening day with incentives such as giveaways or raffles;
- Consider how to improve access to surgical and other oncology services;
- Talk to hard-to-reach groups, for example LGBTQIA women, women living with a disability, and homeless women to ask them what would assist to improve screening participation;
- Nominate cancer screening champions, like Community members and AHWs. Include Cancer survivors who have had a positive experience with screening;
- Engage with non-clinical and community groups to promote screening. Set up a stall at community events.

8. BreastscreenAustralia monitoring report. 2018. [Accessed at: <https://screeningresources.cancervic.org.au/communities/aboriginal-or-torres-strait-islander-communities/profile-statistics-aboriginal>]

ONLINE APPENDIX 5 CERVICAL SCREENING - QUALITY IMPROVEMENT

Cervical screening is one of the improvement measures that form part of the Practice Incentives Program (PIP) Eligible Data Set, which means that they form part of the data that practices can submit to their local Primary Health Network (PHN) to be eligible for the PIP incentive payment for Quality Improvement.

Who can be screened?

The Cervical Screening Test (CST) is for all women aged 25 to 74 years of age who have ever been sexually active. Some women who decline screening can self-collect a sample, if they are over 30 years of age and be at least two years overdue for their screening test or have never had a screening test.

Cervical screening results are sent to the National Cancer Screening Register (www.ncsr.gov.au). Health professionals can call or look up the Register to see if a woman is due for her CST. Electronic medical records such as Communicare are now able

to link with the NCSR to check cervical screening status. Health services should take special care of clients who have symptoms or signs of cervical cancer, or those who have had cervical cancer or cervical screening abnormalities in the past, through the recall system (rather than the reminder system).

What should we aim for?

Just over half (54-56%) of Australian women participate in cervical cancer screening. At a recent review from the national Register, only 27% of regular female Aboriginal and Torres Strait Islander clients had a cervical screening test in the past two years. Aboriginal women have lower participation rates, probably because of barriers to screening. Aboriginal Community Controlled Health Organisations (ACCHOs) are well-placed to carry out cervical screening tests because they are culturally appropriate and safe.

PLAN

- Run a report of regular female patients in the eligible age group (25 – 74 years of age). How many have cervical screening tests recorded?
- Search: Toolbar/Report/National KPI/P122 Cervical screening. This will produce a report for women with a

CST recorded in the last 5 years, more than 5 years ago and women who do not have CST recorded.

- Your service may also be able to ask for this data from your local PHN. Alternatively search: Toolbar/Report/Procedure/Cervical screening analysis.

DO

- Make sure that women eligible for a CST have a reminder entered into the electronic medical record (EMR).
- Check clients who are due for recalls. Search: Toolbar/Report/Recalls/Recalls due/Screening;cervical cancer. This will create a report of women due for CST.
- Services can send clients reminders about cervical screening (in addition to the reminders sent by the

national program). Format a word processor merge file to make letters to send to people. Or phone or SMS clients to remind them to book for a CST. Modify the recall to show that the recall has been sent.

- When clients come to the clinic, check for recalls and reminders. In Communicare recalls and reminders are in the bottom right-hand corner of the patient screen.

STUDY

6 or 12 months later, check how many women are due for CST. Consider groups to focus on:

- Women who are more than 4 years overdue for cervical screening (Toolbar/Report/Recalls/Test; Cervical screening test/enter dates);
- Women who have a history of abnormal CST or Pap

smears are overdue for cervical screening (search Toolbar/Report/Condition/Cervical smear:dysplasia);

- Women who have had HPV 16/18 (search Toolbar/Report/Condition/HPV;type 16/18; detected);
- Women who are overdue for colposcopy (Toolbar/Report/Recalls/Colposcopy).

ACT

Think of ways to increase participation;

- Ensure your programs are culturally safe;
- Provide easy-to-read, plain English, culturally specific information about cervical screening (eg posters & fliers);
- Integrate cervical screening into Aboriginal Health Checks;
- Ensure services are accessible - appointments & transport;
- Female practitioners are needed. Train more staff in cervical screening so CSTs can be offered opportunistically;
- Consider how to improve access to colposcopy services;

- Talk to hard-to-reach groups (eg LGBTQIA women, those with a disability or homeless). Ask what would improve screening participation;
- Hold promotional events with incentives (giveaways/raffles);
- Nominate cancer screening champions, like Community members and AHWs. Include Cancer survivors who have had a positive experience with screening;
- Engage with non-clinical and community groups to promote screening, eg a stall at the Survival Day concert.

9. Australian Institute of Health & Welfare (AIHW). Cervical screening in Australia. AIHW 2019.

10. Whop LJ et al. The first comprehensive report on Indigenous Australian women's inequalities in cervical screening: A retrospective registry cohort study in Queensland, Australia (2000-2011). *Cancer*, 2016.122(10): 1560-9.

ONLINE APPENDIX 6 LUNG CANCER PREVENTION – QUALITY IMPROVEMENT

Smoking cessation programs are an important way to prevent lung cancer. Many services already have existing smoking cessation programs.

Primary care services are required to record smoking status, if they wish to attain RACGP accreditation. Practices are now also required to record smoking status if they wish to get Practice Incentive Payments (PIP). Information regarding smoking status is extracted from the medical records and sent to your local Primary Health Network (PHN).

What should we aim for?

In 2018, 43% of Aboriginal and Torres Strait Islander people over the age of 15 smoked, compared to 15% of other Australians.¹¹

Aboriginal Community Controlled Health Organisations (ACCHOs) are well-placed to give advice on smoking cessation because they are culturally appropriate and safe.

PLAN

- What proportion of regular clients have their smoking status recorded? Search: Toolbar/Report/National KPI/PI 09 Smoking status
- Your service may also be able to get this data from your local PHN.
- How many smokers do we have at our service? Search: Toolbar/Report/National KPI/PI 09 Smoking status patients. This report shows proportion of clients according to status (Smoker, Ex-smoker, Never smoked).

DO

- Train all staff to record smoking status on all clients.
- Run training for staff to learn how to deliver brief interventions on tobacco.
- Support staff to provide/prescribe nicotine replacement therapy/ pharmacotherapy.

STUDY

- 6 or 12 months later, check how many clients have their smoking status recorded and the proportion of clients who are current smokers.
- Consider collecting data on any other smoking cessation activities undertaken.
- How many of the smokers at our service have been prescribed pharmacotherapy for smoking in the last year? (Report/ Medications/Patients on selected generic/ varenicline, bupropion or nicotine replacement therapy)
- How many smokers have been referred to Quitline?
- How many workers have been referred to the Tobacco Worker (if your service has one)?

ACT

Think of ways to increase participation:

- Ensure your programs are culturally safe;
- Provide easy-to-read, plain English, culturally specific information about smoking cessation (eg posters & fliers);
- Asking about tobacco use is part of the Aboriginal Health Check – offer brief intervention during the health check;
- Talk about how to help high risk groups, for example, pregnant women, teenagers, clients with asthma or chronic airways disease and those with mental illness;
- Hold promotional events, with incentives such as giveaways or raffles;
- Engage with non-clinical and community groups to promote smoking cessation, for example on World No Tobacco Day. Set up a stall at the Survival Day concert or a NAIDOC Carnival.

11. AIHW, Alcohol, tobacco and other drugs in Australia, AIHW 2109 [Accessed at: <https://www.aihw.gov.au/reports/phe/221/alcohol-tobacco-other-drugs-australia/contents/population-groups-of-interest/aboriginal-and-torres-strait-islander-people>]

ONLINE APPENDIX 7 BOWEL CANCER SCREENING – QUALITY IMPROVEMENT

Bowel cancer screening, using a home testing kit, can detect bowel cancer early, when it is easier to treat.

Who can be screened?

Bowel cancer screening is recommended for all clients aged 50 to 74 years of age. The government sends a bowel cancer home testing kit to all Australians every two years. Some clients at higher risk, for example due to a strong family history of bowel cancer, may be eligible for earlier testing, more frequent testing or for other testing, such as by colonoscopy.

Bowel cancer screening results are sent to the National Cancer Screening Register (<https://www.ncsr.gov.au>). Health professionals can call or look up the Register to see if a client is due for bowel cancer screening. Electronic medical records such as Communicare are now able to link with the NCSR to check bowel screening status.

What should we aim for?

Many eligible non-Indigenous Australians (43%) take part in bowel cancer screening. In 2015-6, only 21% of eligible Indigenous people aged 50-74 years took part in bowel cancer screening.¹²

Aboriginal Community Controlled Health Organisations (ACCHOs) can support clients to have bowel cancer screening and given them reminders to complete the test, because they are culturally appropriate and safe.

ACCHOs may also stock test kits at their service and support clients to complete these, for example, explaining how to use the kit and completing paperwork before sending the kit away.

PLAN

- How many people in the eligible age group have had bowel screening? Run a report in Communicare of regular clients in the eligible age group (50 – 74 years).
- Search: Toolbar/Report/Procedures/Performed/Screening;bowel cancer. This will produce a list of clients who have had bowel cancer screening performed.

DO

- Make sure that clients who are eligible for bowel cancer screening have a reminder entered into the electronic medical record (EMR).
- Check clients who are due for recalls. Search: Toolbar/Report/Recalls/Recalls due/Screening;bowel cancer.
- Some services might choose to send clients reminders about their bowel cancer screening (in addition to the reminders sent by the national program).
- Many services might choose to remind clients about their test opportunistically. When clients come to the clinic, check for recalls and reminders. In Communicare, recalls and reminders are in the bottom right-hand corner of the patient screen.
- When the service receives the bowel cancer screening results, record that the patient has completed this (Toolbar/Clinical Record/Clinical Item/Screening;bowel cancer).

STUDY

6 or 12 months later, check the number of and proportion of regular clients who are due for bowel cancer screening.

ACT

- Think of ways to increase participation;
- Ensure your programs are culturally safe;
 - Provide easy-to-read, plain English, culturally specific information about bowel cancer screening (posters & fliers);
 - Stock bowel screening kits at your service if available;
 - Remind clients about bowel cancer screening at Aboriginal Health Checks;
 - Hold a bowel cancer screening day with showing how to use the testing kit;
 - Talk about how to help hard-to-reach groups – for example homeless people, those with intellectual disabilities, those who need support to complete the paperwork;
 - Nominate cancer screening champions, like Community members and AHWs. Include Cancer survivors who have had a positive experience with screening;
 - Engage with non-clinical and community groups to promote screening. Set up a stall at community events.

12. AIHW, National Bowel Cancer Screening Program monitoring report, AIHW 2019. [Accessed at; <https://www.aihw.gov.au/reports/cancer-screening/national-bowel-cancer-screening-program-monitoring/contents/table-of-contents>].

ONLINE APPENDIX 8 ADVANCE CARE PLANNING – QUALITY IMPROVEMENT

Who needs an Advance Care Directive?

Preparing an Advance Care Directive (ACD) can be useful for people of all ages, regardless of whether they have a serious illness. Many people with cancer will not have an ACD, but some may be interested in preparing one so as to record how they would prefer to be cared for should they not be able to make their own decisions.

Some people with cancer will not be interested in preparing

an ACD, especially those who are younger or those who have a cancer with better survival rates.

What should we aim for?

Aboriginal Community Controlled Health Organisations (ACCHOs) can support clients with cancer who are interested to complete an ACD.

PLAN

- Run a report in Communicare of regular clients in the Cancer Group. Search: Toolbar/Report/Patients/Group members
- Search files to see if the client has an up to date ACD in their medical record to see how many regular clients with a cancer diagnosis have an ACD on their file.

DO

- Make sure that clients who do not have an ACD have a reminder entered into the electronic medical record (EMR) so that staff can discuss this with them.
- Enter a reminder about discussing ACDs with clients who do not have one recorded.
- Run a report on clients who have a recall or reminder for ACD. Search: Toolbar/Report/Recalls/Recalls due/Admin:advance health directive
- Many services might choose to discuss ACD opportunistically. When clients come to the clinic, check for recalls and reminders. In Communicare recalls and reminders are in the bottom right-hand corner of the patient screen.
- Adapt a standard template for your service; consider using local artwork.
- Run a training day for staff in how to talk to clients about Advance Care Planning
- Upload ACDs to EMRs and the client's MyHealthRecord. Consider completing documentation for state Ambulance Services. Encourage the client to store the ACD with their Chronic Disease Care Plan.

STUDY

6 or 12 months later, check the number of and proportion of regular clients with cancer who have an ACD.

ACT

Think of ways to increase participation:

- Ensure your programs are culturally safe;
- Provide easy-to-read plain English information about Advance Care Planning, including culturally specific posters and promotional material;
- Stock ACD templates at your service for clients to take home and discuss with family;
- Remind clients about ACDs at the Aboriginal Health Checks;
- Hold a community information day to promote Advance Care Planning.

Yarning about Advance Care Directives

Sometimes using EMR or surveys may not be the best way to consider the best ways of improving services as part of Quality Improvement, particularly for sensitive issues like end of life care.

Research yarning might be helpful when evaluating programs to improve uptake of ACDs.

Research yarning for QI might involve talking to clients individually or in groups and asking what they thought about the process of preparing an ACD and how they think the program could be improved. It could involve recording clients' views or taking notes regarding their suggestions as to how the program could be improved.