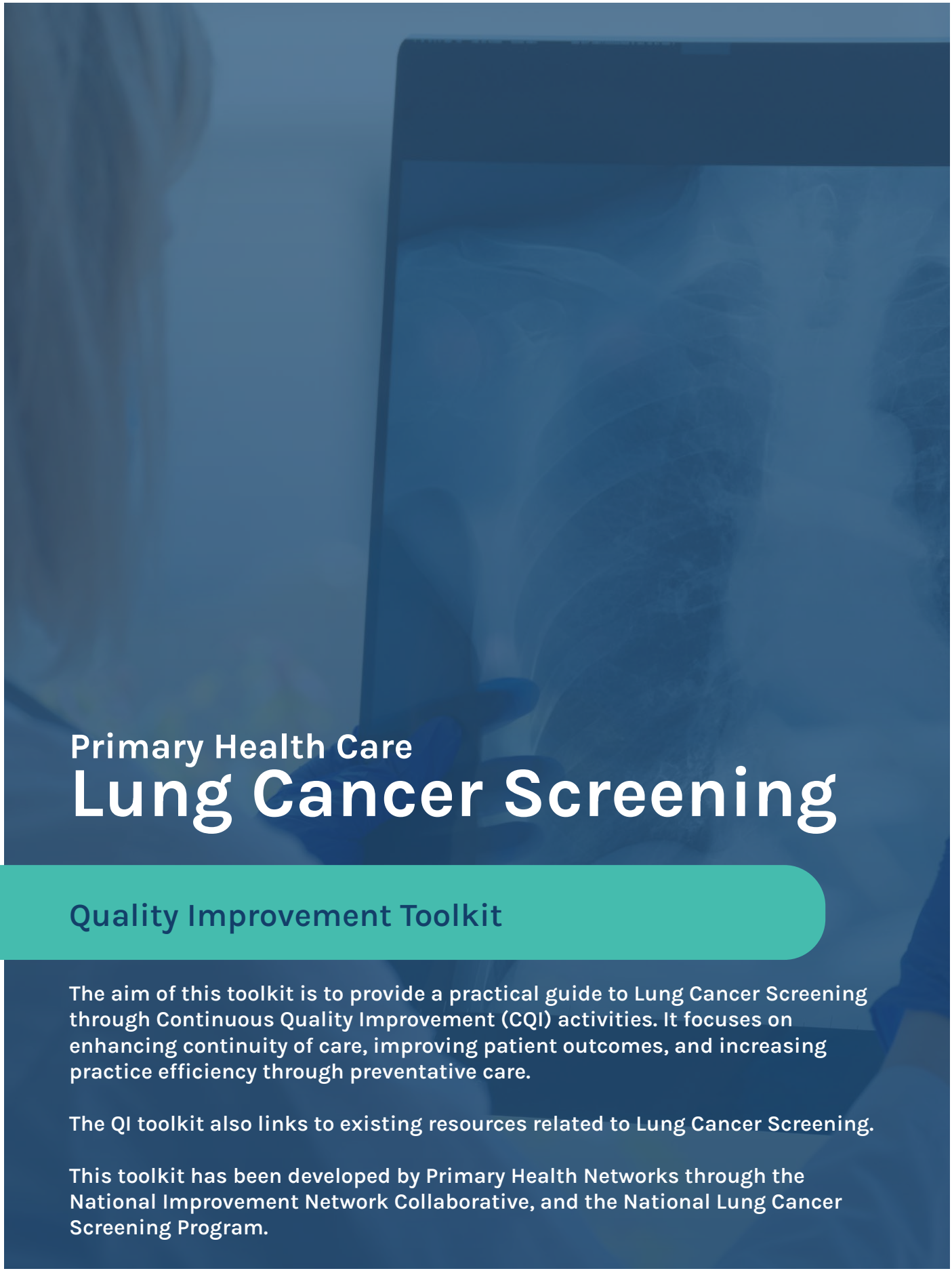


Primary Health Care
Lung Cancer Screening

Quality Improvement Toolkit

The aim of this toolkit is to provide a practical guide to Lung Cancer Screening through Continuous Quality Improvement (CQI) activities. It focuses on enhancing continuity of care, improving patient outcomes, and increasing practice efficiency through preventative care.

The QI toolkit also links to existing resources related to Lung Cancer Screening.

This toolkit has been developed by Primary Health Networks through the National Improvement Network Collaborative, and the National Lung Cancer Screening Program.

phn NATIONAL IMPROVEMENT NETWORK COLLABORATIVE
An Australian Government Initiative

National MyMedicare PHN Implementation Program

phn COOPERATIVE
An Australian Government Initiative

phn GOLD COAST
An Australian Government Initiative



Gold Coast Primary Health Network would like to acknowledge and pay respect to the land and traditional practices of the families of the Yugambeh Language region of South East Queensland and their Elders, past, present and emerging.

Artwork: Narelle Urquhart. Wiradjuri woman.
Artwork depicts a strong community, with good support for each other, day or night. One mob.

Acknowledgements
This QI toolkit has been developed by PHNs nationally through the PHN Cooperative, the National Improvement Network Collaborative (NINCo), and the National Lung Cancer Screening Program. We acknowledge that some resources used or referenced within this toolkit are from organisations including the Department of Health, Disability and Ageing, NACCHO, Lung Foundation Australia Services Australia, Royal Australian College of General Practitioners (RACGP); National Cancer Screening Register, Best Practice; and Medical Director. These organisations retain copyright over their original work. Referencing of material is provided throughout.

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Where to get help?

Gold Coast Primary Health Network
07 5635 2455
practicesupport@gcphn.com.au

Navigating this toolkit



Click on the section of interest or scroll through.

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Navigation suggestions

This toolkit is designed to be applied practically. Navigate straight to the section that is most relevant to your practice.

- Start in Section 1 and Section 2 to assess your practice's knowledge and readiness to effectively deliver the NLCSP, these sections cover: Practice integration with the National Cancer Screening Register (NCSR), practice awareness of how many eligible patients there are within the practice.
- Section 3 covers the details for preparation for the National Lung Cancer Screening Program (NLCSP).
- Section 4 covers steps for commencing delivery of the NLCSP to eligible patients.
- Section 5 includes QI resources and activities to assist your team build on work you have already undertaken. Use the checklist in this section as a tool to ensure you have not missed any important steps in your NLCSP journey!

About this toolkit

This QI toolkit has been developed to help general practices implement lung cancer screening as a systematic, sustainable component of preventive care. Aligned with current evidence-based guidelines and the NLCSP, it provides practical strategies, workflows, and ready-to-use tools to enhance patient identification, shared decision-making, and referral and follow-up processes.

The toolkit empowers practice teams to undertake targeted improvement using data and iterative testing. By embedding screening into routine care, the goal is to increase early detection, reduce mortality, and promote equitable access and outcomes.

The toolkit uses the **Model for Improvement** to guide structured testing and adaptation of workflows via **Plan-Do-Study-Act (PDSA)** cycles. It aligns with evidence-based best practices, supporting teams to develop approaches that suit their local context and patient population. Through collaborative effort and continuous improvement, general practices can significantly increase the number of eligible patients screened and reduce delays in diagnosis.

Learn more: Model for Improvement – Institute for Healthcare Improvement (ihi.org)

Section 1

Lung Cancer Screening in Primary Care

Section Navigation

Introduction
1.1 Lung Cancer and Screening
1.2 Person Centred Care in Lung Cancer Screening
1.3 National Lung Cancer Screening Program
1.4 Program eligibility
1.5 Practice Readiness and planning checklist

Introduction

This section introduces the lung cancer and screening initiative, overview of the NLCSP, which aims to detect cancer early in high-risk individuals. The section highlights the importance of integrating screening into primary care, and presents practical strategies for identifying eligible patients, embedding screening into clinical workflows, and driving continuous improvement through data-informed QI processes. The goal is to support timely, proactive, and high- quality care that improves early detection and outcomes.

1.1 Lung cancer and screening

Timely clinical investigation is advised for screening in cases of persistent cough, coughing up blood, unexplained shortness of breath, exhaustion, shoulder or chest pain, and weight loss.

Evidence from large international trials shows that low-dose CT scans can detect up to **70% of lung cancers at an early stage,** when treatment is most effective, with **over 65% of cases successfully treated** if found early.

Why is it important?

Prevalence: Fifth most commonly diagnosed cancer in Australia (approximately 15,108 new cases in 2025)
Mortality: Leading cause of cancer death (approximately 8,994 deaths in 2025)
Survival Rates: 5-year survival: 18% > increases to 56% at early stages.

Cancer Australia, 2025

1.2 Person-centred care in lung cancer screening

Person-centred care is essential to the successful delivery of the NLCSP. It means placing the individual's values, preferences, and experiences at the heart of care. Healthcare providers are encouraged to approach conversations about lung cancer screening with sensitivity, ensuring patients feel respected, informed, and supported in making decisions that are right for them. This includes acknowledging and addressing potential stigma around smoking, understanding cultural needs especially for Aboriginal and Torres Strait Islander peoples and tailoring communication to each person's background, language, and health literacy.

Refer to 2.2 Health Workforce Education and Training for cultural safety and awareness training and other training options to enhance your knowledge in providing person centred care.

Lung cancer in Australia is a disease of health inequity. Lung cancer disproportionately affects:

- Aboriginal and Torres Strait Islander people
- people living in rural and remote areas
- people with disability
- people from culturally and linguistically diverse communities
- people in the LGBTIQA+ community
- people with mental illness

1.2.1 Lung cancer screening for First Nations patients

Lung cancer is a significant issue for Aboriginal and Torres Strait Islander people and communities. NACCHO lead the co-design of the NLCSP and is partnering with the Aboriginal Community Controlled Health Organisation (ACCHO) sector to make sure that the program is equitable, accessible, and culturally safe for Aboriginal and Torres Strait Islander people.

1.3 National Lung Cancer Screening Program

The National Lung Cancer Screening Program is designed to improve early detection of lung cancer among Australians, with the goal of reducing mortality and enhancing health outcomes.

Using low-dose computed tomography (low-dose CT), the program targets individuals aged 50-70 who are asymptomatic and have a history of tobacco smoking, including those who have quit within the past 10 years. Early detection significantly improves treatment options, survival rates, and quality of life by identifying lung cancer at early stages, when it is more treatable.

1.4 Program eligibility

Eligibility assessments must be completed by a healthcare provider, even for those who self-refer into the program. Clinical judgement is essential when estimating smoking history, and all referrals require informed consent and a program-specific low-dose CT scan request. Healthcare providers play a crucial role in assessing eligibility, guiding informed decision-making, enrolling participants with the National Cancer Screening Register (NCSR), and supporting ongoing care.

Participants may self-refer into the program or be identified via the health setting as potentially eligible. Those who self-refer will need an eligibility assessment by a healthcare provider and be provided with a request for a low-dose CT scan.

For more information about patient eligibility, see *Section 3 – Identifying your Eligible Patients.*

1.5 Practice Readiness and planning checklist

PLANNING AREA	TASKS TO DO
Step 1 Plan the transition	☐ Designate a lung cancer screening change lead and form a change team
	☐ Document the screening implementation plan – *Contact the Gold Coast PHN*
	☐ Plan team roles in the transition according to staff skills, interest, and position – Refer to *Health workforce roles and responsibilities*
	☐ Register practice with the *National Cancer Screening Register*
	☐ Have an implementation team meeting
	☐ As a team, plan key activities and timelines
	☐ Set up a shared file/folder to share documents, etc

PLANNING AREA	TASKS TO DO
Step 2 Prepare your team	☐ Discuss the delivery of the NLCSP with your wider team
	☐ Get staff ideas and feedback on proposed plans
	☐ Ensure team members have dedicated time to do their required tasks
	☐ Test *pack year calculation tools* and decision aids
	☐ Ensure integration with the NCSR is functioning properly
	☐ Plan regular meetings of the change team to track progress
	☐ Communicate progress regularly with whole of practice via noticeboard, email, group chat, staff meetings
	☐ Discuss the upcoming changes with your allied health providers, etc

PLANNING AREA	TASKS TO DO
Step 3 Review your resources and clinical data	☐ Do a stocktake of existing *Lung Cancer screening resources*
	☐ Locate resources in central location for ease of access
	☐ Allocate staff members and timelines for updating resources and trainings
	☐ Provide regular updates to the team via internal communication
	☐ Coordinate a *smoking history audit and update patient records*
	☐ Conduct *data cleansing* and archive inactive records
	☐ Ensure that clinical software templates e.g., health assessments are up to date to capture smoking frequency and volume and flag eligible patients

PLANNING AREA	TASKS TO DO
Step 4 Raise patient awareness	☐ Consider *patient messaging* (What is in it for them?)
	☐ *Poster, information sheets and brochures* for patients
	☐ Ensure culturally safe, appropriate, and diverse resources are available for patient information
	☐ Calls *to action/communications to patients* (email, SMS, direct communication)
	☐ Train reception staff in generating *Lung Cancer Screening Reports*

PLANNING AREA	TASKS TO DO
Step 5 Recall existing patients	☐ Communicate ***changes about Lung Cancer Screening*** to existing patients
	☐ Flag eligible patients in the system and set up recall/reminder protocols
	☐ Develop protocol for non-responders
	☐ Determine/review the process for booking review appointments

PLANNING AREA	TASKS TO DO
Step 6 Identify lung cancer screening patients	☐ Use clinical software to ***identify patients aged 50–70 with a significant smoking history***
	☐ Identify patients who have been previously identified for lung cancer but have not taken up the offer and follow up with them (e.g. Primary Sense Lung Cancer Screening reports)
	☐ Implement systematic screening prompts in clinical workflows
	☐ Develop protocol for managing self-referred patients
	☐ Opportunistically ***identify new lung cancer screening patients*** during consultations, HA's, immunisations, etc.

PLANNING AREA	TASKS TO DO
Step 7 Check in, review and celebrate	☐ Offer support for referrals, follow-up appointments, and communication of results
	☐ Establish a system for managing missed appointments or patient concerns
	☐ Document and track QI activities (e.g., PDSA cycles on screening conversations or follow-up rates)
	☐ Monitor participation rates and track patients' screening status via the NCSR
	☐ What is needed to embed the current changes?
	☐ Update workflow documents, position descriptions, policy, and procedures manuals
	☐ Plan your next steps
	☐ How will you celebrate your successes?

Section 2

Preparing your practice for the National Lung Cancer Screening Program

Section Navigation

Introduction
2.1 Health Workforce Roles and Responsibilities
2.2 Health Workforce Education and Training Checklist
2.3 NCSR Integration
2.4 Data Cleansing
2.5 Lung Cancer Screening MBS Items

Introduction

To effectively deliver the NLCSP, general practices need to be well-prepared across several key operational areas. This includes integrating with the NCSR, ensuring health workforce education and training is up to date, and reviewing patient data to accurately record smoking status and pack-year history. Proactive data cleansing and embedding screening prompts into clinical workflows will support the identification and enrolment of eligible patients. This section outlines practical steps to help your practice get ready to implement the program with confidence.

2.1 Health workforce roles and responsibilities

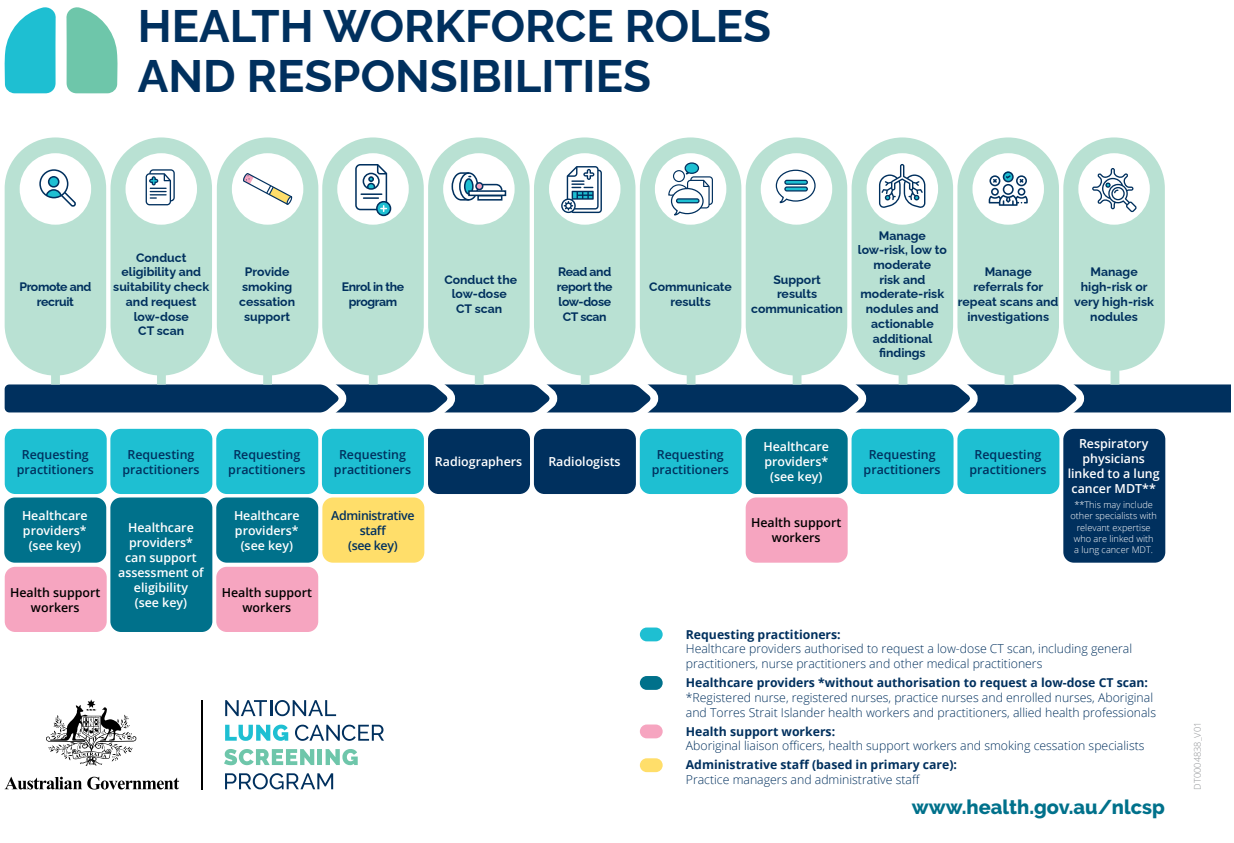
The health workforce plays a critical role in promoting and supporting patients through the NLCSP. General practice roles and responsibilities include:

Requesting Practitioner (GP)

- Promotion and recruitment
- Conducting eligibility and suitability check
- Request low-dose CT scan
- Enrol participant with the NCSR
- Providing smoking cessation support
- Communicating low-dose CT scan results
- Manage low-risk, low to moderate risk and moderate-risk nodules and actionable additional findings
- Manage referrals for repeat scans and investigations

Practice staff

- Promotion and recruitment
- Providing smoking cessation support (nurse)
- Assist patient in making low-dose CT scan appointment
- Ensure NCSR is integrated with practice software



Click on the image to view the flowchart of all health workforce roles and responsibilities.

2.2 Health workforce education and training

Equipping the health workforce with appropriate training is essential to the effective and equitable delivery of the NLCSP. A range of education and training opportunities are available to support general practitioners, practice nurses, Aboriginal health workers, and other primary care staff to confidently deliver the program. These include clinical and culturally safety training, smoking cessation support, and practical tools for navigating program processes. Additional role-specific training will help ensure all healthcare providers are prepared to deliver person-centred care across diverse populations.

Resources:

- National Lung Cancer Screening Program
- Health Workforce Education - Lung Foundation Australia
- Nurse Training - Lung Foundation Australia
- Training for Aboriginal and Torres Strait Islander Health Workers and Practitioners - Lung Foundation Australia
- Training - Lung Foundation Australia
- Cultural Safety Training - Gold Coast Primary Health Network

2.3 NCSR Integration

To ensure practice capability to enrol and monitor patients, integrating your clinical software with the National Cancer Screening Register (NCSR) helps streamline access to patient screening histories and journeys, including those who may have been screened elsewhere. Before discussing lung cancer screening with patients identified as potentially eligible, connect to the NCSR and collaborate with your GPs to review and update patient files, particularly smoking history and pack-year calculations, to support appropriate enrolment and follow-up.

Before integrating your clinical software with the NCSR (compatible with Best Practice, Medical Director and Communicare), your organisation must first be registered in PRODA.

Watch this video to guide you through the information and requirements you'll need to have ready before you begin, navigating PRODA to link the NCSR service to your organisation, manage members and set delegations, and registering your organisation in the NCSR Healthcare Provider Portal.

NCSR Software Registration – Information and requirements to have ready

For other NCSR resources, *see Section 5.*



Access the NCSR via Clinical Software Integration:

- Primary Care Onboarding Kit
- Clinical Software Integration | National Cancer Screening Register

2.4 Data Cleansing

Regularly review and update your policy and procedure for deactivating past patients (non-attending or deceased) to ensure they remain appropriate, up to date, and applied consistently across the practice.

Establish a routine

for deactivating patients, commonly every 3-6 months, based on a clinically determined timeframe (e.g., 2-3 years without attendance).

Assign responsibility

to the Practice Manager or Practice Nurse, include it in their job descriptions, and schedule it in their calendar to maintain continuity during staff transitions.

Train reception staff

to always search "all patients" when looking up records.

Consider archiving or inactivating patients

individually if they no longer meet the practice's active patient criteria, such as; Deceased patients, duplicate records, patients with irrelevant postcodes or out-of-state addresses, patients who registered but never attended (e.g., from online bookings), patients who have moved away or no longer attend the clinic.

Resources:
Data Cleansing Toolkit | Data Cleaning in Medical Director | Data Cleaning in Best Practice

2.4.1 Accurate Recording of smoking status and number of cigarettes

Accurate recording of a patient's smoking history:
- including the number of cigarettes smoked per day
- the number of years smoked is critical for determining eligibility for the NLCSP

Eligibility is based in part on a 30 pack-year smoking history and imprecise or incomplete data can result in missed opportunities to identify at-risk individuals who may benefit from early detection.

Key considerations:
- Clinical judgement may be required to estimate smoking history, especially when records are unclear or self-reported information varies.
- Ensuring this information is consistently and correctly documented in your clinical information system not only supports timely access to
- Accurate data enables effective use of decision support tools and integration with the National Cancer Screening Register,
- Regular audits of smoking history data quality should be conducted.

Resources:
- Improving the smoking status recording of your patients | Brisbane South PHN
- Health Record Data Quality | RACGP
- QIM 2 – Smoking Status - CAT Recipes - PenCS Help
- Accurately Recording CVD Factors| Best Practice

For more information about pack years, see *Section 3.1.1. – Pack-Years.*

2.5 Lung cancer screening MBS Items

To make it possible to provide asymptomatic, eligible patients with access to screening, low-dose CT scans are paid to the radiologist and are not billable by general practitioners under the NLCSP. Two new MBS items will support these scans. Practices may wish to link lung cancer screening activities with Health Assessments (HA), Chronic Condition Management (CCM), and PIPQI measures such as COPD, influenza vaccination, or cervical screening, to embed screening within broader preventive care.

Service	Item Number	Fee
Screening low-dose CT	57410	$338.75
Interval low-dose CT scan	57413	$338.75

Important notes:

- Item numbers will be mandatory bulk-billing items and will have mandatory reporting requirements.
- Individuals can choose to opt-out of the NCSR and still have a free low-dose CT scan. However, they will not be considered a participant of the program or receive any communication from the NCSR.

Resource:
Lung Cancer Screening | Medicare Benefits Schedule

For more information - *see Section 4.2. NCSR enrolment.*

Section 3

Identify your Eligible Patients

Section Navigation

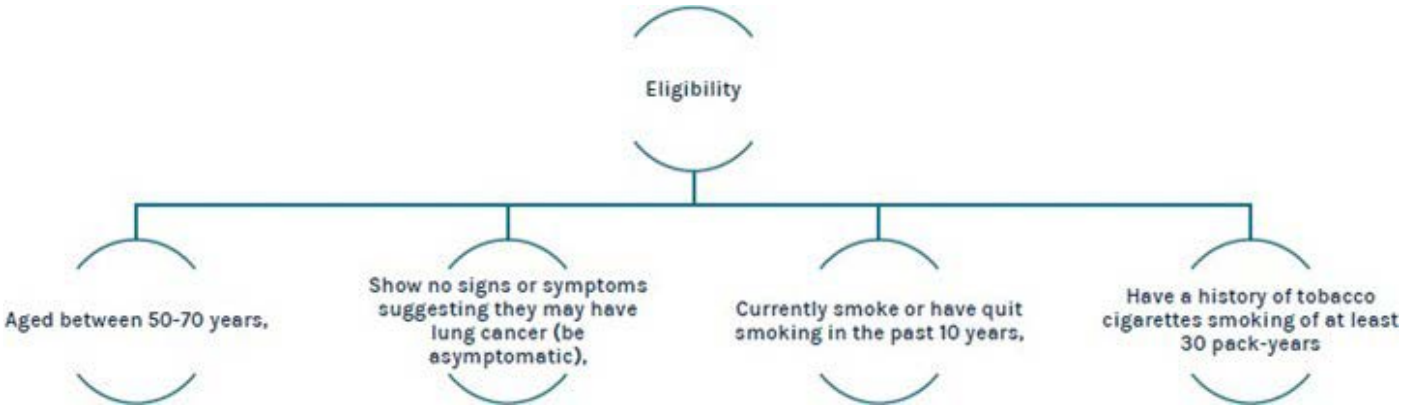
Introduction
3.1 Eligibility
3.2 Identifying Patients through Data Extraction and Population Health Management Tools

Introduction

This section introduces the Lung cancer and screening initiative, overview of the National Lung Cancer Screening Program (NLCSP), which aims to detect cancer early in high-risk individuals. The section highlights the importance of integrating screening into primary care, and presents practical strategies for identifying eligible patients, embedding screening into clinical workflows, and driving continuous improvement through data-informed QI processes. The goal is to support timely, proactive, and high-quality care that improves early detection and outcomes.

3.1 Eligibility

Patients who are **eligible for the program** must:



3.1.1 Pack-years

Calculating the pack-years is an imperfect science. Clinical judgement is required which may err on the side of inclusion.

When calculating a patient's smoking history, clinical staff will need to work with the patient to determine an estimate of the average number of cigarettes smoked per day and over how many years. In some cases, particularly with **Aboriginal and Torres Strait Islander patients,** calculating an exact pack-year history can be challenging. A **proxy approach** may be used, estimating smoking exposure from average frequency and duration.

Formula: Pack years = (cigarettes per day /20) x (number of years smoked).

Examples:

- 1 pack per day (20 cigarettes) for 30 years = 30 pack-years
- 2 packs per day (40 cigarettes) for 15 years = 30 pack-years

Pack-year calculator

3.1.2 Low dose CT scan suitability

Screening may not be suitable for all patients. Examples of a participant not being suitable include:

They have had a full chest CT scan within the last 12 months or have one planned for clinical reasons in the next 3 months.

They have had a symptomatic lung infection (for example, COVID-19, pneumonia, acute bronchitis) within the previous 12 weeks.

They are unable to lie flat for a minimum of 5 minutes and hold their hands above their head for a low-dose CT scan.

Their weight exceeds the restrictions of the scanner (greater than 200kg).

Discuss with your patient when their eligibility can be rechecked and encourage future participation.

3.2 Identifying Patients through Data Extraction and Population Health Management Tools

Unlike other national cancer screening programs, participation in the NLCSP is **not automatic.** Eligibility is based on **age and smoking history** and must be assessed by a healthcare professional

Systematic Identification Strategies

Use clinical software reports to identify patients aged 50–70 with a documented smoking history:

Primary Sense

1. Open Primary Sense Widget
2. Select Lung Cancer Screening Report
3. Export report to Excel for sorting and filtering

PenCS CAT – 4

1. Open Daily CAT
2. General tab: Filter by all genders, ages 50–70, active (3× visit in 2 years)
3. Risk factors tab: Smoking
4. Export patient list to Excel to check patient files for pack-years

POLAR GP

1. Open POLAR reports – Clinic Summary Report
2. Select RACGP & practice active patients
3. Select patients aged 50–70
4. Select Smoker and Ex-Smoker
5. Exclude diagnosis of Lung Cancer
6. Export patient list to Excel

Cubiko

1. Open Clinic Insights
2. Patient cohort analysis
3. Patient list tab
4. Filter by: Age 50–70, active patients, current smoking status recorded
5. Export patient list to Excel to check patient files for smokes per day history

Implement screening prompts in clinical workflows and templates.

Conduct targeted recalls for patients who may be eligible.

Opportunistically identify eligibility during routine consultations and health assessments. For more information, refer to **section 4.3 Optimising Screening Opportunities.**

Conduct database searches through your clinical information system using smoking status and age criteria.

Use your clinical information system to identify potentially eligible patients
Best Practice - Database Search | **Medical Director - Database Search**

Section 4

Deliver the National Lung Cancer Screening Program

Section Navigation

Introduction
4.1 Shared Decision Making
4.2 National Lung Cancer Screening Register (NCSR) enrolment
4.3 Patient Assessment
4.4 Results
4.5 Optimising Screening Opportunities
4.6 Practice Communication Strategies
4.7 RACGP Red Book
4.8 Health Pathways

Introduction

Engaging patients in the NLCSP involves empathetic, culturally sensitive, and informed conversations. Healthcare providers play a vital role by preparing to address stigma, misconceptions, and emotional concerns around lung cancer and smoking. Clear, respectful discussions help patients understand their eligibility (age, smoking history), benefits and risks of screening, and empower them to make informed decisions, using patient-centered communication, including motivational interviewing, culturally safe practices, and appropriate resources (like interpreters or Quitline referrals).

4.1. Shared Decision Making

Shared decision making is a collaborative process where patients and healthcare professionals work together to make healthcare decisions.

Participate in a shared decision-making discussion with your patient to decide together if screening is right for them. Shared decision making enables people to make an informed choice about lung cancer screening and is a key component of the National Lung Cancer Screening Program. It is important to create a trusting environment to ensure people feel safe to ask questions about lung cancer screening and openly discuss lived experiences and diverse needs.

A shared decision-making discussion follows three steps.

Choice talk	Help people understand that a choice to screen for lung cancer exists.
Options talk	Inform people about their options, including where they can access a low-dose CT.
Decisions talk	Support people to decide if lung cancer screening is right for them.

Resources:

- NLCSP Shared Decision Making
- Provide your patient with the NLCSP privacy information notice

4.2 National Lung Cancer Screening Register (NCSR) enrolment

To ensure you are ready to implement the NLCSP, integrate your clinical software with the NCSR. You will be responsible for enrolling the participant in the NCSR; this section needs to be completed even if the participant is enrolled for bowel and cervical screening.

Healthcare providers need to enrol a participant in the National Lung Cancer Screening Register either through the NCSR integration hub with clinical software or through the NCSR healthcare provider portal and complete and submit the NLCSP low-dose CT scan request form.

All participants need a request for screening. Complete a low-dose CT scan request form including information that the scan is for the program and if the participant has a first-degree family history of lung cancer.

Individuals can choose to opt-out of the NCSR and still have a free low-dose CT scan; however, they will not be considered a participant in the program or receive communication from the NCSR. These individuals will continue to be followed up by the requesting practitioner.

Resources:

- NLCSP low-dose CT scan request form
- NCSR Healthcare Provider Portal

4.3 Patient Assessment

The patient will be required to book an appointment at a radiology provider and advise them they are a NLCSP participant.

QI TIP
Use the NLCSP discussing participation guide to prepare to discuss participation with your patients.

Step 1: Confirm your patient's eligibility by asking them about:

- **Smoking history** – Currently smoking or quit within the past 10 years.
- **And**
- **Pack-year calculation** – 30+ pack years (e.g., 20 cigarettes a day for 30 years).
- **And**
- **Symptom check** – Exclude symptomatic patients (e.g., persistent cough, coughing blood, unexplained shortness of breath) who require immediate investigation.

If your patient is symptomatic, refer to section 4.3.1. Managing patients with signs and/or symptoms of lung cancer.

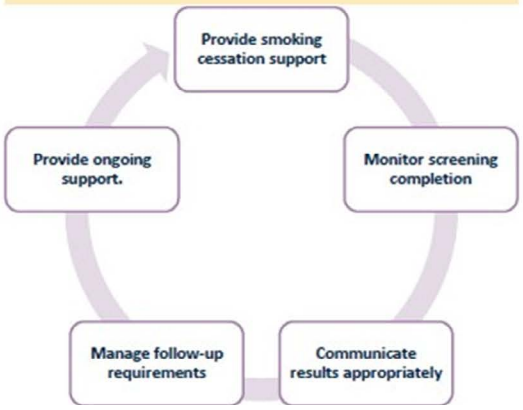
Step 2: Work with your patient to understand whether the NLCSP is the right choice for them.

- The potential harms and benefits of lung cancer screening.
- Program logistics and what to expect.
- Motivational interviewing and provide smoking cessation support.
- Address concerns or misconceptions.
- Review talking scripts to support patient conversations.

Step 3: Enrol and refer your patient if they decide to participate

Complete NCSR enrolment → Provide low-dose CT scan request → Support patient to arrange a radiology appointment → Provide patient education materials.

Step 4: Follow up and provide support.



Videos:

- Best Practice - Enrolling a Patient in the NLCSP | NCSR
- Medical Director - Enrolling a Patient in the NLCSP | NCSR

See the flowchart for next steps on LDCT, refer or recall for investigation and requesting practitioner follow-up and rescreening.

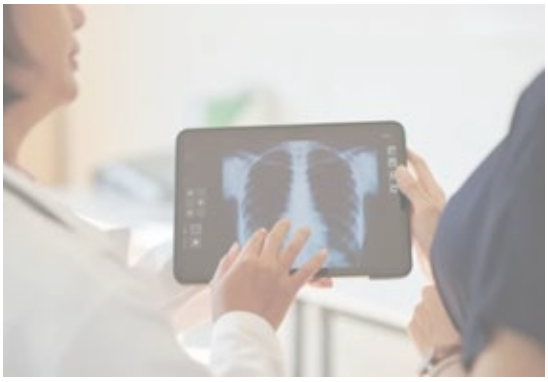
4.3.1 Patients with Signs and Symptoms of Lung Cancer

If an individual is found to have signs and symptoms suggestive of lung cancer at any point of the screening and assessment pathway, the requesting practitioner should investigate these according to Cancer Australia's guide for **Investigating Symptoms of Lung Cancer: a guide for all health professionals** and manage the patient according to the **Optimal Care Pathway for people with lung cancer** or the **Optimal Care Pathway for Aboriginal and Torres Strait Islander People with Cancer.** It is vital that this happens in a timely manner to ensure the prompt investigation of any possible indications of lung cancer.

Signs and symptoms of lung cancer include:

- New or changed cough
- Chest and/or shoulder pain
- Shortness of breath
- Fatigue
- Loss of appetite / weight loss

Investigating Symptoms of Lung Cancer



4.4 Results

4.4.1 Discussing Results

Before sharing screening results, clarify how the participant would like to receive their results, by phone, in person, or via video. Ideally, this preference should be recorded at the time of referral, with participants encouraged to update their communication settings in the NCSR. If a nodule is detected, a face-to-face conversation is generally recommended for clarity and emotional support, though virtual options may suit remote patients.

Ask whether the participant would like a support person to be present during the discussion. Be mindful that preferences may vary, even from previous consultations.

Plan your conversation carefully. The detection of a lung nodule can trigger anxiety and uncertainty. Be prepared to explain the findings clearly and compassionately, using the Nodule Management Protocol to guide clinical next steps and follow-up.



QI TIP

Use the NLCSP discussing results guide to support conversations.

4.4.2 Nodule Management Protocol

Pulmonary nodules detected through screening should be managed according to evidence-based protocols to ensure appropriate follow-up, minimise harm, and support early detection of lung cancer. The NLCSP Nodule Management Protocol provides a structured approach for interpreting and managing lung nodules detected on LDCT screening. It stratifies findings into categories based on risk of malignancy, guiding appropriate follow-up or referral. Management decisions are informed by imaging characteristics, nodule size and volume, growth behaviour, and use of the PanCan risk calculator. This protocol supports early detection of lung cancer while minimising unnecessary investigations.

Nodule Management Protocol

4.5 Optimising Screening Opportunities

Checklist

- ☐ Provide opportunities for eligible individuals to be referred immediately.
- ☐ Collect smoking history including:
  - Smoking status including ex-smoker history
  - Duration of smoking history
  - Cigarettes per day

  on new patient registration forms and set reminders to discuss the NLCSP for eligible patients.
- ☐ Routine appointments or appointments for other reasons should include a review of the patients smoking history and eligibility check for the NLCSP. Consider adding a reminder to the patient file.
- ☐ Monitor participation e.g., using an Excel spreadsheet or through Data Extraction and Population Health Management tools e.g., Primary Sense.

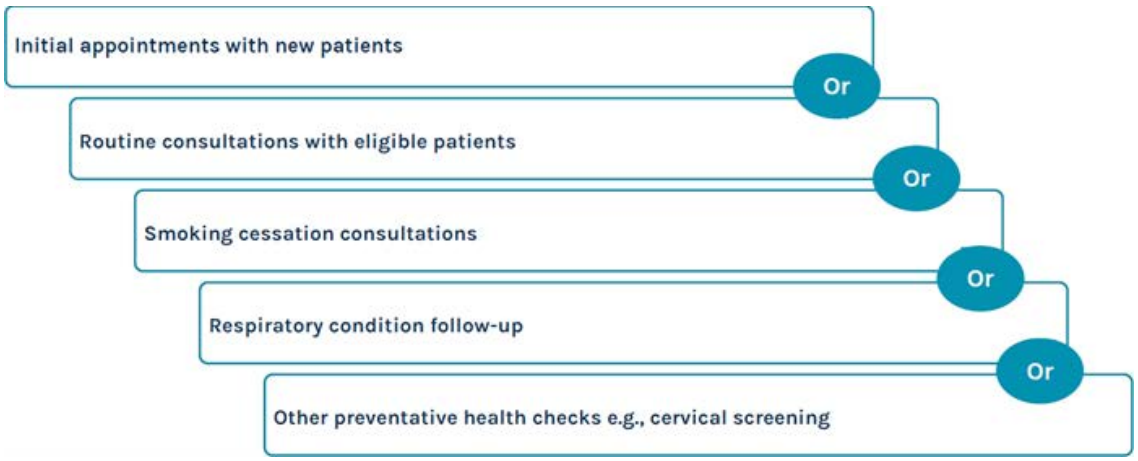
4.5.1 Health Assessments

Incorporate conversations about lung cancer screening as part of **Medicare Benefit Schedule (MBS)** health Assessments and/or GP management plans:

HEALTH ASSESSMENTS (HA)	ELIGIBLE GROUPS		
• Time-based health assessments • Comprehensive Medical Assessment (CMA) for Residents of RACFs (ANNUALLY) • People with an Intellectual Disability (ANNUALLY) • One-off Veterans' Health Check (ONCE ONLY) • Refugees with Medicare access (ONCE ONLY)	• 45 to 49 Years at risk of developing chronic disease (ONCE ONLY) • 40 to 49 Years at High Risk of Diabetes following AUSDRISK Tool (3 YEARLY)	701 ~	< 30 mins
		703 ~	30-45 mins
		705 ~	45 - 60 mins
		707 ~	≥ 60 mins

OTHER HEALTH ASSESSMENTS	Face-to-face	Telehealth*
Aboriginal and Torres Strait Islander Peoples Health Assessment (EVERY 9 MONTHS)	715	92004
Assessment, diagnosis, and plan for patient aged <25 with an eligible disability consult lasting ≥ 45 mins	139	92142

Opportunities for Lung Cancer Screening Discussions:



4.6 Practice Communication Strategies

Engaging patients in the NLCSP involves empathetic, culturally sensitive, and informed conversations. Healthcare providers play a vital role by preparing to address stigma, misconceptions, and emotional concerns around lung cancer and smoking. Clear, respectful discussions help patients understand their eligibility (age, smoking history), benefits and risks of screening, and empower them to make informed decisions, using patient-centered communication, including motivational interviewing, culturally safe practices, and appropriate resources (like interpreters or Quitline referrals).

For more information - *see Section 5 - National Lung Cancer Screening Program – Communications toolkit.*

Communication	Purpose	Practical Example
Waiting Room Displays	Raise awareness of the NLCSP, eligibility and benefits of screening. Use simple, culturally appropriate visuals.	NLCSP posters, QR codes to more information, patient brochures.
Patient Recall and Reminders	Use SMS, phone calls, or letters to invite eligible patients to screen.	Share eligibility tool or use SMS templates: ***You may be eligible for a free lung cancer screening check. Please book an appointment with your GP.***
Team Communication	Ensure all staff share consistent, clear messages about the NLCSP. Keep the whole team updated and confident discussing the program.	Ensure team complete relevant training. Develop a short script for reception, nurses, and GPs to use when explaining eligibility and benefits. Run short team huddles.
Motivational Interviewing and Stigma Reduction	Use open-ended questions and reflective listening to explore patient hesitancy. Frame conversations around health and prevention.	Use NLCSP discussing participation resources to guide conversations. Participate in shared decision- making conversations so the patient understands the choice to screen.
Results Communication and Follow Up	Deliver results according to patient preference, with compassion and clarity.	Develop processes and procedures to deliver results to patients within an appropriate timeframe of receipt. Ask patients their results preference when referring into the NLCSP. Involve support people if required.

4.7 RACGP Red Book

- The RACGP Red BOOK provides a comprehensive guide.
- RACGP – Guidelines for preventive activities in general practice
- RACGP – Lung Cancer

Resources:

- *Gold Coast HealthPathways*
- *Lung Cancer Screening - Gold Coast PHN HealthPathways*
- *National Lung Cancer Screening Program – Screening Providers - Gold Coast PHN HealthPathways*

4.8 HealthPathways

HealthPathways are available to support best practice lung cancer screening care in your local area, including hospital and specialist service referrals. Sign in or register for HealthPathways.

Section 5

Resources

Section Navigation

5.1 Health workforce resources
5.2 Health workforce education
5.3 Patient Resources

5.1 Health Workforce Resources

5.1.1 Program and Guidelines Resources

- National Lung Cancer Screening Program Guidelines
- National Lung Cancer Screening Program
- National Lung Cancer Screening Program Eligibility

5.1.2 National Cancer Screening Register Resources

- NCSR Software Registration – Information and requirements to have ready | NCSR
- Primary Care Onboarding Kit | NCSR
- Clinical Software Integration | NCSR
- Video: Best Practice - Enrolling a Patient in the NLCSP | NCSR
- Video: Medical Director - Enrolling a Patient in the NLCSP | NCSR
- Video: Medical Director - Clinical Forms and Participation Management NLCSP | NCSR

5.1.3 Data Cleansing and Maintenance Resources

- Data Cleansing Toolkit
- Data Cleaning in Medical Director
- Data Cleaning in Best Practice
- Improving the Smoking Status Recording of your Patients | Brisbane South PHN
- Health Record data quality | RACGP
- Accurately Recording CVD Factors| Best Practice

5.1.1 Program and Guidelines Resources

- Lung Cancer Screening | Medicare Benefits Schedule
- Pack-year calculator | Should I Screen
- Best Practice | Database Search
- Medical Director | Database Search
- NLCSP Shared Decision Making
- Privacy Information Notice | NLCSP
- NLCSP Low-dose CT Scan Request Form
- NCSR Healthcare Provider Portal
- Discussing Participation Guide | NLCSP
- Discussing Results Guide | NLCSP
- Requesting Practitioner Flow Chart for Eligibility and CT Scan Referral
- Investigating Symptoms of Lung Cancer | Cancer Australia
- Nodule Management Protocol | NLCSP
- Practitioner Guide to Shared Decision Making | NACCHO
- National Lung Cancer Screening Program - Heart of Australia

5.2 Health Workforce Education

- National Lung Cancer Screening Program Health Workforce Education | Lung Foundation Australia
- Nurse Training | Lung Foundation Australia
- Training for Aboriginal and Torres Strait Islander Health Workers and Practitioners | Lung Foundation Australia
- Training | Lung Foundation Australia
- RACGP - Cultural awareness and cultural safety training
- National Lung Cancer Screening Program – Communications toolkit
- Lung Cancer Screening Helpline | Lung Foundation Australia

5.3 Patient Resources

- National Lung Cancer Screening Program – Resources for the public | Australian Government Department of Health, Disability and Ageing

First Nations Resources

- Smoking History Eligibility Assessment | NACCHO
- Should I Screen for Lung Cancer? Shared-Decision Making Booklet | NACCHO
- Participant Postcard to Support Shared Decision Making | NACCHO

Section 6

Appendices

Section Navigation

6.1 MFI Templates, Guidance and PDSA Exemplars
6.2 Check in, review and celebrate
6.3 Finishing point

Appendix 6.1 MFI Templates, Guidance and PDSA Exemplars

PDSA Exemplars

PDSA 1: *Smoking Status and History Recording*
PDSA 2: *NCSR Integration and Enrolment*
PDSA 3: *Smoking Cessation Support*
PDSA Template: *NINCo PDSA-Template*

Appendix 6.2 Check in, review and celebrate

Group reflection after completing activities:

As a team, analysis and review **baseline** data results and discuss change ideas and actions. Use PDSA cycles to test and measure change ideas.	
The degree to which the learning needs were met: ☐ Not met ☐ Partially met ☐ Entirely met	To what degree this activity was relevant to your practice: ☐ Not met ☐ Partially met ☐ Entirely met
What did you learn? What changes would you make to your practise as a result?	
For example, • Has patient awareness and engagement with the NLCSP increased? • Which educational strategies were most effective? • Has the recording of smoking history improved in your CIS? • Did the team successfully use NCSR integration for faster enrolments? • How effective was the team's approach to delivering and discussing screening results with patients?	
RACGP CPD: utilise the self-reporting feature on Quick Log *mycpd.racgp.org.au* to document reflection.	

Appendix 6.3 Finishing point

Sustainability check list – maintaining the change

Cyclical nature of PDSAs- Adopt, adapt, abandon	• Adopt: excellent work, embed that change. • Adapt: determine if a change is needed to the plan and start a new PDSA. • Abandon: Rethink the next PDSA • Lessons can be learned from PDSAs that are abandoned. Keep a record of learnings.
Set a clear review process for QI activities	• Frequency of reviews: Schedule reviews based on activity timeline e.g., every fortnight for a 12-week activity. • Data-driven reviews: Use practice data at each checkpoint to assess progress toward goals. • Identify barriers: During reviews, identify challenges or barriers to progress and plan corrective actions if needed.
Document your improvement activity	• Record your completion. • Documentation must be kept for 6 years for evidence of PIP QI if your practice is audited by the Department of Health, Disability and Ageing.
Sustaining project outcomes	• Updates to Policy and Procedure manual. • Specific task procedures. • Local signs or instructions. • Staff work practices. • Position descriptions. • Staff induction. • Staff skills development or education.
Communication is key to finishing a successful project	• QI project outcome feedback to staff. • Discuss project strengths and challenges. • Feedback to patients, where appropriate. • Consider Incorporating this as part of your practice preventative health care promotion activities.
Celebrate success	• Celebrate your outcomes and achievements by sharing a morning tea with your team. • Consider sharing your practice improvement activity efforts with your patients through practice newsletters, website or waiting room. E.g. displaying ‘run charts’ to demonstrate change over time.
Review and reflect	• Discuss project strengths and challenges. • Annually review the PDSA outcomes to ensure activities are still being adhered to and completed. • Annually review and audit your data related to this activity. Identify gaps, areas for improvement and set new targets if needed. • Where to next on your continuous QI journey? • Consider potential topics for a new CQI activity, and how your experience with this activity can help you to be more efficient and effective

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