Domestic and Family Violence

Quality Improvement in general practice

For Primary Health Networks

phn
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An Australian Government Initiative

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Disclaimer

Acknowledgements

North Western Melbourne Primary Health Network (NWMPHN) acknowledges the peoples of the Kulin nation as the Traditional Custodians of the land on which our work in the community takes place. We pay our respects to their Elders past and present.

We also recognise, respect and affirm the central role played in our work by people with lived experience, their families and/or carers.

In partnership:

THE UNIVERSITY OF MELBOURNE

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1. About this toolkit

A quality improvement partnership project

North Western Melbourne Primary Health Network (NWMPHN) and the University of Melbourne (UoM) have designed a quality improvement (QI) project enabling primary care practitioners to deliver evidence-based care and support for domestic and family violence (DFV) response. The project builds capability in general practice to recognise, identify and refer people at risk of, or experiencing, DFV. It was funded by the Department of Health.

Called the Primary Care Pathways to Safety, the project was an intensive QI project, piloted by NWMPHN between 2020 and 2022. Read more about it here.

This toolkit was developed by NWMPHN to assist other primary health networks to develop locally relevant versions of the project.

It provides insights and suggestions gleaned from the pilot, along with a step-by-step plan to best support general practice participation and engagement.

2. A national response to domestic and family violence

"Everyone has the right to safety. Addressing all forms of gender-based violence, including domestic, family and sexual violence, must be a priority for all Australians to achieve our shared vision of a community free of violence against women and children."

Delegates' Statement, National Summit on Women's Safety, September 2021 [1]

"Family violence" refers to violence between family members – typically where the perpetrator exercises power and control over another person. The most common and pervasive instances occur in current or former intimate partner relationships, and this is usually referred to as "domestic violence".

Domestic violence occurs across all ages, socioeconomic and demographic groups but predominantly affects women and children. In Australia, on average, one woman is killed by her current or former intimate partner every week, and a child is killed by a parent on average every two weeks[2].

Aboriginal women and children are victim to the highest rates of violence. Women who live with a disability, who live in remote areas, and who are from culturally and linguistically diverse backgrounds are all also likely to experience higher-than-average rates of violence. They are also more likely to have issues accessing support services[3].

DFV often results in long-term social, physical, psychological and economic impacts on victim-survivors. Violence against women and their children costs the Australian economy an estimated $13.6 billion, equivalent to 1.1 per cent of GDP, every year.

At least one in 10 women attending general practice will have experienced family violence. However, not all patients disclose their situation – and not all staff members know how to respond if they do[4].

The World Health Organisation (WHO) and the Australian Government have prioritised preventing and reducing the extensive damage, particularly to children, caused by family violence. Primary care is recognised as a suitable, feasible and acceptable setting for identifying and responding to DFV. Women are twice as likely to disclose DFV if asked by their general practitioner. The majority of female patients attending general practices state they would not object to being asked about abuse, but only a minority are actually asked[5].

GPs have unique opportunities to identify, assess and respond to DFV because of the trusting therapeutic relationships they develop with patients. Managing DFV requires a safe place for patients to disclose, skilled risk assessments, careful documentation and safety planning from GPs, together with ongoing therapeutic processes that validate, empower, and connect patients to wider social supports[6].

1. Statement from Delegates – 2021 National Summit on Women's Safety, 2021, p.1 http://www.womenssafetysummit.com.au/
2. https://www.safesteps.org.au/statistics/
3. https://www.dss.gov.au/our-responsibilities/women/publications-articles/reducing-violence/national-plan-to-reduce-violence-against-women-and-their-children/economic-cost-of-violence-against-women-and-their-children?HTML#overview
4. Hegarty, K., McKibbin, G., Hameed, M., Koziol-McLain, J., Feder, G., Tarzia, L., & Hooker, L. (2020). Health practitioners' readiness to address domestic violence and abuse: a qualitative meta-synthesis. PLoS one, 15(6), e0234067.
5. Hegarty, K., Hindmarsh, E. D., & Gilles, M. T. (2000). Domestic violence in Australia: definition, prevalence and nature of presentation in clinical practice. The Medical Journal of Australia, 173(7), 363-367.
6. Lynch, J., Stone, L., & Victoire, A. (2022). Recognising and responding to domestic and family violence in general practice. Aust J Gen Pract, 51(11), 863-69

3. Building capacity and capabilities of domestic and family violence response in general practice

Quality Improvement projects encourage general practices to find local solutions to achieve their objectives. They are supported to trial ideas, measure outcomes and reflect on what is or isn't working. Sharing these experiences is strongly encouraged.

Participating in this project provides a way for general practices to be supported in developing protocols for identifying and responding to DFV.

It establishes tailored support to primary care providers, builds internal capacity to respond to DFV by normalising questions about it and making the practice a safe place in which to disclose. It aims to build sustainable practice, increase capability, boost teamwork and embed knowledge.

Model for Improvement

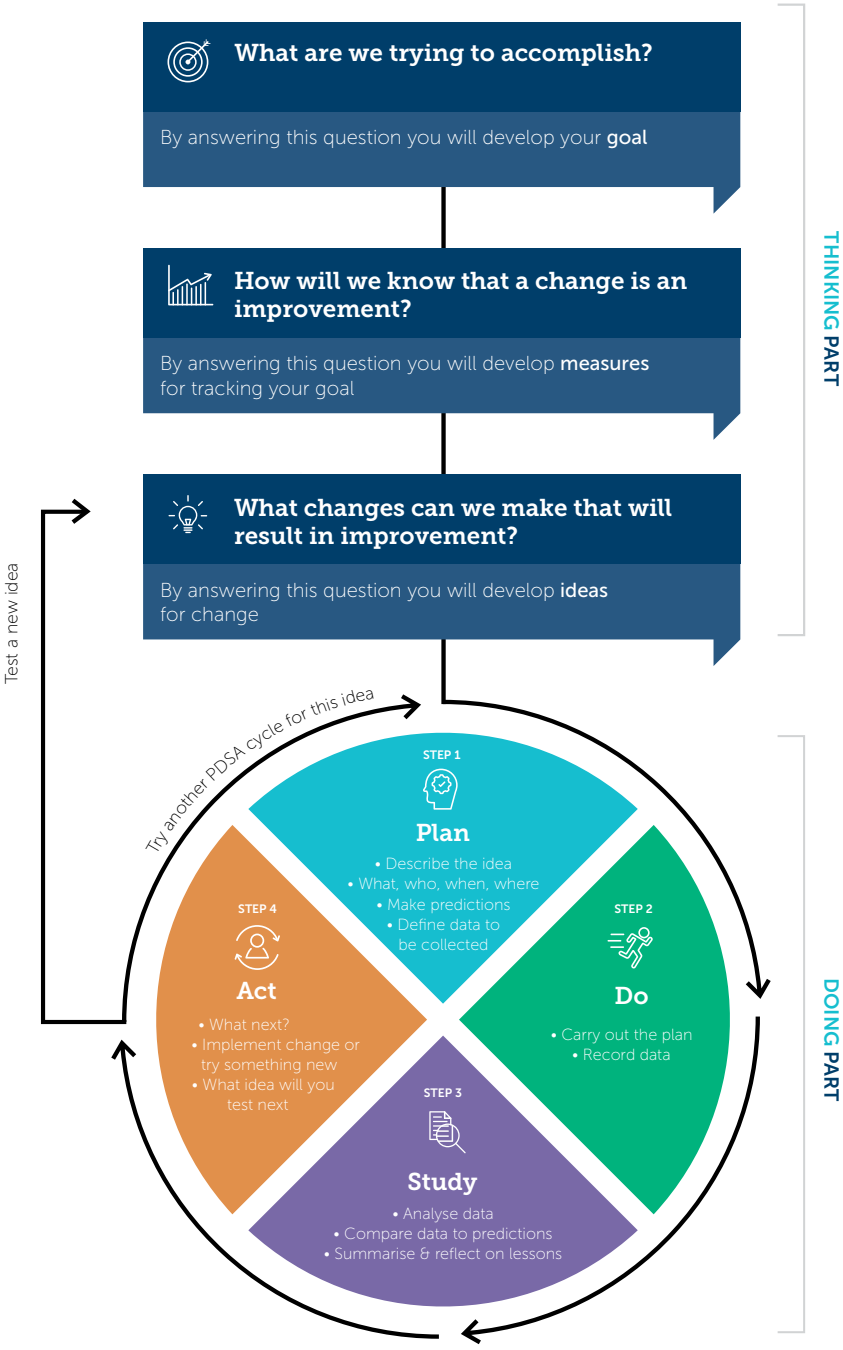
The Model for Improvement (MFI) is an approach for developing, testing, and implementing changes in primary care. It involves choosing specific and measurable goals, selecting objective measures of improvement that can be tracked over time, and identifying key change ideas. The approach is divided into manageable steps, which are tested to determine whether improvement is being achieved. The MFI is a two-part process comprising the 'Thinking Part' and the 'Doing Part'. It works in cycles – styled as Plan, Do, Study, and Act (PDSA).

The MFI seeks to achieve the outcomes outlined in the Quadruple Aim for quality improvement:

- improved patient experience
- improved provider experience
- population health improvements
- sustainable cost

Visit NWMPHN Quality Improvement projects for more examples.

Model for Improvement diagram



THE THINKING PART

This consists of three questions that are critical for guiding improvement work:

- Identifying the goal. What are we trying to accomplish?
- Identifying measures. How will we know that a change in an improvement?
- Identifying a change idea. What changes can we make that will result in improvement?

THE DOING PART

This part is made up of Plan, Do, Study, Act cycles that will help to trial and implement change.

Not every change will lead to an improvement. Making small incremental changes, allows for the opportunity to test the change on a small scale and learn about the risks and benefits before implementing the change more widely. A number of PDSA cycles may be required to achieve an improvement goal.

4. Planning your quality improvement project

Set up your team

Establish a core project team, including:

- a clinical subject matter expert (SME) to advise on project development, implementation and evaluation
- a project lead to coordinate and manage, including coaching general practices through QI project delivery
- a DFV education and training provider to provide up to date and best practice education and training
- representatives from the local and state-based family violence sectors, such as family violence support workers or specialist services
- the PHN HealthPathways team, to ensure that assessment, management and referral pathways are up-to-date and embedded in project delivery.

If it is available, consider offering grant funding for general practices to participate. You should also consider working with your PHN communications and procurement team to support development.

Determine clinical partners for practice training and education

Consider engaging with partner organisations to support education and training. This should involve local and industry SMEs, including people with lived experiences and clinicians to provide health practitioners with the knowledge and skills to identify and respond to patients experiencing DFV.

Consider training sessions that embrace the varied roles of the whole practice, including GPs, nurses, practice mangers, receptionists, on-site allied health and administrative personnel. These focus on helping all staff to recognise DFV, respond and provide access to practical, local resources to enable patients to feel supported and safe.

Training programs can provide the opportunity to discuss

- issues around strengthening the response to DFV in an individualised way
- the role of the practice in responding to patients experiencing family violence
- how the practice might facilitate an effective response
- practical aspects and opportunities to practice different ways of providing care and experimenting with different communication styles and techniques
- changes to the clinical protocols and procedures
- listening to people with lived experience to better understand the impact of DFV.

Family violence support workers

A key element of the NWMPHN Primary Care Pathways to Safety QI project, on which this program is based, was engaging family violence support workers to assist building capability of the general practices involved.

Family violence support workers understand the dynamic and escalating levels of family violence risk and have expertise in planning for safety. They can be service navigators for victims, including crisis responses and case management, and can provide professional support for healthcare professionals.

They can be sourced from a range of services which hold expertise in the field, including some operating within specific communities.

NWMPHN experience indicates that one support worker per participating practice is optimal, allowing a working relationship to develop.

These workers can support practice staff to develop strong links with local services, and to navigate the broader DFV ecosystem. Their skills and expertise can also be utilised by GPs or nurses during activities such as secondary consultations, and developing referral pathways that accommodate individual patient culture, language and diversity.

To facilitate connections between general practices and family violence support services, consider enabling in practice education sessions delivered by clinical partners in your region.

Set the project goals

NWMPHN's QI project goal was to build and sustain greater internal capability within general practice to respond, identify and refer people at risk of, or experiencing, DFV.

The objectives were to:

- implement structured, whole-of-practice QI activities to improve workforce ability to recognise, identify and refer patients at risk or, or experiencing DFV
- ensure the workforce has the skills, knowledge and attitudes needed to build internal capability within the practice to respond to DFV by making it a safe place in which to disclose normalise questions about DFV
- encourage networking and connections between general practice and family violence support workers and specialists' services to foster long-term professional relationships

PHNs need to decide on objectives and outcomes relevant for their region.

Determine measures of success

It's important to have clear measures that track progress towards achieving the project objectives. Determine the measures early in your planning phase. Measures that include quantitative and qualitative data will also support the evaluation of the project, and impact, at the PHN level.

Quantitative measures

Establish a baseline:

Establishing baseline measures supports practices to track their improvement activities.

Data regarding patients experiencing DFV is hard to identify using a third-party data extraction tool such as Pen CAT or POLAR. However, these may be used to identify patient cohorts which may be at higher risk of DFV, or which show factors impacting on the likelihood or severity of family violence.

However, it is important to acknowledge that there is no definitive risk assessment formula for DFV. A key resource for implementing broad family violence response measures is the Victorian Government's Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM)[7].

PHNs can support practices to establish baseline measures. These might include calculating how many times in any given period patients disclose DFV, how many patients are proactively asked about DFV, and how often practitioners use family violence HealthPathways.

Qualitative measures

Consider developing pre- and post-project surveys to measure the impact of the clinical educational components of the project and the quality improvement activities undertaken by the practice team. See appendix A and appendix B for examples.

7. DHHS - https://providers.dffh.vic.gov.au/family-violence-risk-assessment-and-risk-management-framework)

4. Planning your quality improvement project continued

Determine the structure of the project

NWMPHN's QI project ran for 6 months in each participating general practice. It comprised:

- an orientation meeting
- initial facilitated workshop
- training and education, delivered by an external provider
- activity periods
- and a final workshop.

More details here:

1. Orientation meeting

Host an orientation meeting with general practice teams. This can be done individually, or with all participants. It provides an overview of the project, and outlines the requirements, expectations, and benefits.

2. Facilitated quality improvement workshops

Host two facilitated workshops – one at the start and one at the end of the project. These encourage participants to formulate plans, gain up-to-date information, network with local family violence support services, hear from people with lived experiences and discuss change ideas.

They allow general practices to:

- cultivate a self-sustaining network that leverages experience and skills
- develop communities of practice
- showcase innovation to motivate and promote sustainable improvement ideas
- benchmark data and progress
- share successes and lessons to adopt innovative improvements from their peers
- participate in continuing professional development.

Checklist for planning facilitated learning workshops:

- ☑ Set dates for QI workshops to connect practices with training and education provider
- ☑ Select QI speakers and subject matter experts
- ☑ Determine workshop content, learning objectives, with subject matter expert speaker and clinical advisor and speakers with lived experience (if applicable)
- ☑ Consider submitting learning workshops for RACGP CPD accreditation
- ☑ Develop learning outcomes details, and agenda
- ☑ Develop an evaluation form to measure against your learning outcomes
- ☑ Ensure future engagements and PHN QI coaching is informed by workshop evaluation

3. Training and Education

Support practices to complete education and training provided by partner organisations.

NWMPHN's QI project partnered with The University of Melbourne Safer Families Centre to provide a whole of practice intensive education and training program. It covered these key themes:

- The nature, prevalence and impact of DFV
- Assessing patient risk and safety
- Enabling general practices to reflect on attitudes to DFV
- Improving communication skills, such as active listening and responding
- Providing a first-line response to address patients' needs including safety planning, support and referral options
- Understanding ways to create a safe environment in which patients can disclose

Activity periods

Activity periods occur after general practice completes training and education. They enable teams to test improvement ideas through PDSA cycles (and measure progress through ongoing monthly data collection, reflection, and feedback. For examples see appendix E and appendix F.

A vital component is the proactive practice coaching provided by the PHN project lead – who should schedule regular support and coaching meetings, starting early in the orientation phase. The lead can also share PDSA ideas between practices and support them to implement changes.

PDSA cycles underpin activities at the practice level to change systems and workflows to better recognise, respond and refer patients who disclose experience of DFV. Working through each cycle allows the practice to trial ideas and to target activities to drive improvements. A series of short PDSAs is best. The NMWPHN project used 3.

Secondary consults and connecting practices with local specialist services

Your project may include professional support or service navigation with local partners, including at least one family violence support worker. These can assist general practices by boosting skills, knowledge and confidence, as well as representing options for referral pathways. PHNs should encourage and foster these relationships.

Recruiting general practices

To recruit practices, develop an information sheet to promote an expression of interest (EOI). See appendix C for an EOI template.

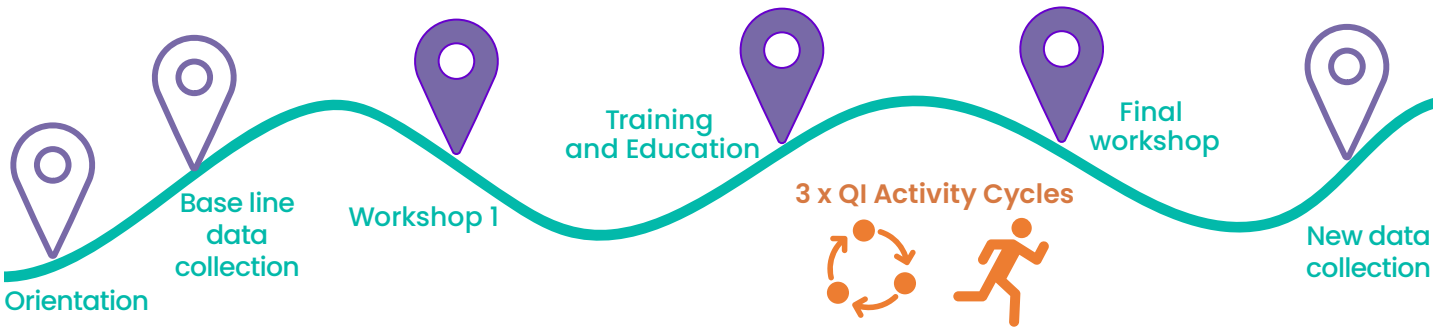
The project structure

A family violence support worker consults and follows-up with family violence specialist services, referral pathways, clinical and non-clinical staff.

Workshop 1
- Project overview
- Introduction to training and eduction
- MFI (QI activity)

Training and Education
- Recognise and respond
- GP facilitator and FV worker
- Role play on communication
- Clinical protocols and procedures

Final workshop
- Practices share achievements/changes
- Embedding sustainable improvements
- Share lessons learnt and reflections



Flowchart: planning the QI project

1.

Pre-project period

2.

Set up your PHN project team and develop a plan.

3.

Insights

- Understand data and population health need to target the activity
- Determine clinical partners
- Consults with subject matter experts and training partners
- Determine project aims and measures
- Determine industry partnerships including education and training providers, local specialsist services and partnerships with people with lived experience.

4.

Develop project resources

This includes:

- EOI and promotional flyer for circulating to general practices
- Project materals, pre and post project surveys ect.

5.

Workshop development

- Work with SMEs to develop workshop content
- invite key presenters such as people lived experiences
- Consider face-to-face or online/ virtual delivery options.
- Engage PHN education/training teams
- Apply for CPD points

6.

Expression of Interest (EOI)

- Promote your EOI to general practices. If your are offering funding for genereal practices involve relevant PHN procurement teams.
- Review EOI applications process
- Review panel/EOI members to evaluate applications.

7.

Inform and prepare

- Inform sucessful practices
- Practice orientation meetings scheduled and Workshop 1 dates and resources shared
- Finalise project evaluation questions for pre-project surveys.

End of Planning Phase

5. Implementing the quality improvement project

Once you have received EOIs and selected the participating practices, begin project support and engagement by arranging orientation meetings with each team, as outlined in section 4.

Here is a suggested agenda:

Workshop 1

- Facilitated by SME or GP with QI expertise
- Overview of the project
- Topic-specific overview and content, delivered by clinical SME
- Introduction to training and education partner and local support services, including family violence worker (if relevant)
- Shared stories and experiences from people with lived experiences (if relevant)
- QI: defining the practice team and introducing the PDSA concept

Once practices have been oriented, facilitate collaboration and coordination between them and the clinical education and training partner organisation.

PHN support to practices includes:

- assisting them to complete education and training with project partners
- advocating for general practice needs and considerations with training and education partner

Final Workshop

Facilitated by SME or GP with QI expertise

- Provide the practices opportunity to share what they have achieved
- Demonstration and detail on changes made from each practice
- Plans for embedding practice improvements sustainability in practice
- Share lessons learnt and reflections
- Plans for continuous networking and relationship building with local support services, including family violence worker (if relevant)

PHN support

PHN support is fundamental to engaging general practices in between each workshop. The project lead supports them to adopt and implement lessons and improvement ideas. PHN practice support includes:

- discussing data measures
- QI coaching to assist staff to complete PDSAs
- celebrating improvements and achievements
- discussing challenges and barriers
- providing feedback and insights
- guidance regarding embedding successful improvement activities into practice systems and workflows for sustainability and continuous improvement.

Toolkits and resources for project implementation

QI methodology

The NWMPHN Quality Improvement Guide and Tools provides a PDSA project planner and an empty PDSA template that can be adapted and shared with practices.

Self-directed QI

Based on the NWMPHN Primary Care Pathways to Safety QI project, two self-directed QI activities have been developed.

- Identifying people at risk of or experiencing family violence
- Increase the confidence of your practice team to identify and respond to family violence

These make it quick and easy for general practices to drive and record sustainable improvements in practice. To learn more visit the NWMPHN family violence self-directed QI activities or NWMPHN QI activities page.

HealthPathways

HealthPathways provides up-to-date best practice guidelines, advice, and links to help guide clinicians with management and referral support for patients experiencing DFV.

Pathways include information about making referrals to services in the local health system.

When developing QI project PHNs can consider incorporating HealthPathways within projects by:

- reviewing the current pathways
- identifying any improvements, updates or new relevant pathways
- supporting general practices to use access and use relevant pathways
- incorporate relevant pathways in workshops

See vtphna.org.au/care-pathways-and-referral in Victoria and Tasmania

Flowchart: Impliementation activities

6. Evaluating the quality improvement project

Practice data reports and measuring progress

In addition to compiling reports and updates throughout the project to help track improvement activities, practices need to complete a final report which demonstrates the value of the QI activities.

It can also measure the support the practice received from the PHN and contribute to the requirements for Practice Incentives Program Quality Improvement (PIP QI) payment eligibility. Final reports should include a summary of all activities completed, successes and hurdles, and strategies for embedding sustainable changes

Undertake an analysis of the pre-and post-project surveys to measure the impact of the clinical educational components, as well as the quality improvement activities undertaken by the practice team. See appendix D for a final report template.

PHN project evaluation

PHNs may undertake a high-level project summary that captures the outcomes and project in its entirety. It might include:

- Project overview
- Measures used
- Data collection methods
- Pre and post survey data
- Workshop feedback
- Results for individual practices
- Improvements or changes over time
- Discussions and understanding of outcome differences between practices
- Key lessons
- Case studies - see appendix G for some examples from the NWMPHN DFV QI project
- Recommendations

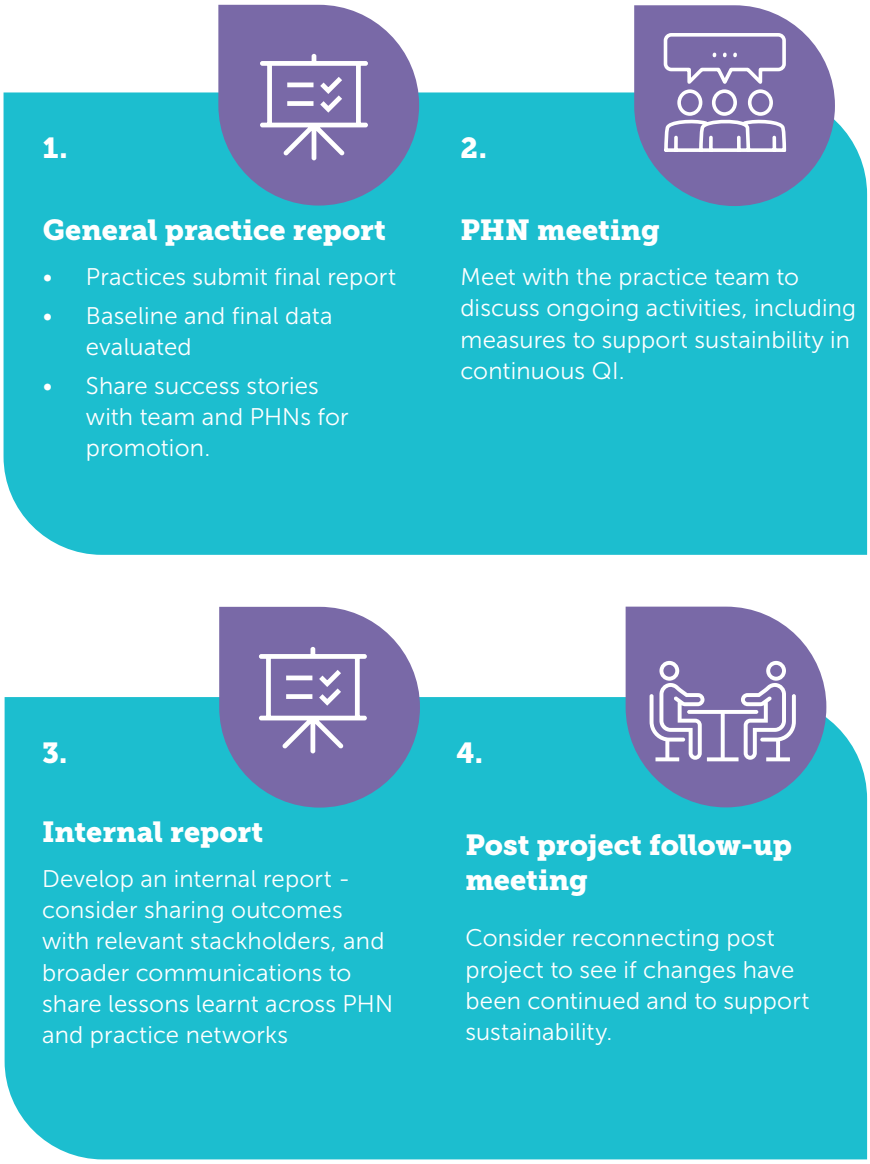
Consider the benefit of sharing lessons and showcasing leadership in your region. PHNs can develop media to capture practice achievements. This can also be used to support ongoing improvement and innovation, and to share outcomes.

Sustainability

Embedding sustainable improvements for screening and responding to DFV is an important component of the project. Activities that can help ensure this include:

- Discussing and sharing improvement ideas and activities that have translated into the routine care and management of patients who have made a disclosure.
- Encouraging all practices in the region to make DFV screening part of routine care.
- Establishing a community of practice in which clinicians and sector professionals can share and support each other to identify, respond and support patients experience DFV.
- Continuous networking and relationship-building with specialist support services and local family violence support workers.

Flowchart: Evaluation post implementation period



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