Primary Care Nurse Practitioner Model

Victorian Nurse Practitioner Project Phase 4, Open Round 4.13- 2014
AUTHORS

Simon Powell- Manager, VAC Clinical Services

Anthony Snow- Nurse Practitioner (Sexual Health), Melbourne Sexual Health Centre

Danielle Collins- Practice Nurse/ Nurse Practitioner Candidate, VAC

ACKNOWLEDGMENTS

Melbourne Sexual Health Centre

Chris Helms- Nurse Practitioner, West Belconnen Health Cooperative, ACT

A/Prof Jane Tomnay- Director CERSH at University of Melbourne
## Contents

AUTHORS ........................................................................................................................................... 2  
ACKNOWLEDGMENTS ......................................................................................................................... 2  
ENVIRONMENTAL SCAN ....................................................................................................................... 4  
SERVICE MODEL AND SCOPE OF PRACTICE ....................................................................................... 8  
VAC NURSE PRACTITIONER BUSINESS MODEL ............................................................................... 10  
APPENDICES ...................................................................................................................................... 17
ENVIRONMENTAL SCAN

The Service
The Victorian AIDS Council (VAC) was formed in 1983 as a central part of the Victorian community response to the HIV/AIDS epidemic. VAC is state funded community organisation which continues to lead the response by providing health promotion, prevention and support to people living with HIV (PLHIV) and those at risk of acquiring HIV and other sexually transmitted infections. VAC’s clinical services include the Centre Clinic and PRONTO!

The Centre Clinic is a bulk billing community general practice which focuses on gay, lesbian, bisexual, transgender and intersex (GLBTI) communities. The Centre Clinic provides HIV treatment and management, sexual health and general practice services to approximately 2,000 gay and other men who have sex with men (GMSM) within a primary care framework. Approximately 500 PLHIV utilise the clinic either under a share care model with alternate services such as a tertiary facility, or as a sole health care provider. The clinic is also a provider of emergency HIV Non-occupational Post Exposure Prophylaxis (NPEP), in partnership with the NPEP service at Alfred Health. The clinic also has a strong commitment to furthering HIV, GLBTI and sexual health research and is involved in numerous clinical trials in collaboration with Alfred Health, the Kirby Institute, the Burnet Institute and with private pharmaceutical companies. The Centre Clinic participates in the Victorian Pre-Exposure Prophylaxis (PrEP) Demonstration Project; an innovative strategy developed to address increasing HIV incidence by providing antiretroviral medication prior to potential HIV exposure. The clinic employs seven part time general practitioners (GPs), one practice nurse (PN) and a practice manager. A clinical trials nurse, clinical psychologist, acupuncturist and a dietician are also located within the service.

PRONTO! was developed in response to the increasing HIV incidence amongst GMSM in Victoria. It is a Department of Health funded joint initiative between the Burnet Institute and VAC. PRONTO! is Victoria’s first peer-led shopfront HIV rapid testing service. It opened in August 2013 and provides HIV and syphilis rapid testing to the GMSM community. Data from an initial six month evaluation report indicated that 66% of clients were considered ‘high risk’ according to the Sexually Transmissible Infections in Gay Men Action Group (STIGMA) guidelines, with nearly two thirds of PRONTO! clients reporting unprotected anal intercourse and approximately one in seven clients reporting drug use during sex in the past six months respectively. 15% of clients attending PRONTO! have never tested for HIV or other sexually transmissible infections (STI).

---


This suggests PRONTO! is effective in reaching GMSM at significant risk of acquiring HIV and other STI's.

Furthermore, these data, along with the high burden of HIV transmission amongst people who are unaware of their HIV status, supports the need for increased access to testing, treatment and clinical support⁴. The Centre Clinic and PRONTO! are able to cross-refer clients. PRONTO! clients newly diagnosed with HIV are encouraged to engage with a specialist general practice service such as the Centre Clinic, and HIV negative GMSM attending the Centre Clinic for sexual health screening are advised of PRONTO! as an alternative to traditional lab-based HIV & syphilis screening, ensuring they are still appropriately screened for other blood borne viruses (BBVs) and STI through the Centre Clinic. PRONTO! is currently exploring novel ways to increase the uptake of testing by undertaking outreach testing services at sex on premises venues, the Centre Clinic and in more remote Victorian locations.

**The Population**

GMSM are disproportionately affected by HIV and STIs within the Australian population with at least 75% of incident HIV infections occurring within this population⁵. The Centre Clinic has a high caseload of GMSM, as well as a small cohort of women living with HIV, lesbians and transgender people.

There are three distinct sub-groups within the PLWHIV general population; those who are well and not on treatment who require monitoring; those who are stable on treatment who require ongoing monitoring and treatment; and those who are on complex treatment regimes and/or are living with other multiple co-morbidities⁶. Clients living with HIV who attend the Centre Clinic utilise 60% of available GP appointments and a significant proportion of these clients are on complex treatment regimes and/or are living with multiple co-morbidities. In addition to using the service as a general practice, HIV negative GMSM and other members of the GLBTI community attend for HIV and sexual health screening, testing, diagnosis and treatment.

Evidence suggests that members of the GLBTI community experience higher rates of mental and physical illness and morbidity than the general population, and may experience significant barriers to accessing appropriate primary health care due to their sexual or gender identity⁷.

---


Koh et al emphasise that General Practitioners and other primary health care providers play an important role in ensuring members of the GLBTI community have equitable access to health care. VAC’s Strategic Plan 2012-2017 articulates a set of organisational principles that are consistent with these research findings. They include the meaningful participation of our communities, social justice, honesty and fairness, working to the highest standards and working collaboratively.

Service Demand

In 2012 there was a sharp increase in HIV incident cases with the highest rate of new diagnosis recorded in twenty years. The Centre Clinic currently experiences an approximate 15% increase in registered clients per annum. Within 12 months of opening, PRONTO! saw 30% of clients more than once, indicating that these clients are utilising the service on a regular basis. If recent trends in epidemiological data continue, then increasing service demand is likely to follow.

As novel responses to HIV prevention and PrEP become widely acceptable and demand increases, so too will the demand placed on specialist services to provide monitoring, treatment and education. This anticipated increase in demand for specialist services has not currently been matched by a proportionate increase in the number of GP’s taking up HIV s100 prescriber training.

With a population wide increase in chronic disease incidence throughout Australia such as type 2 diabetes mellitus and cardiovascular disease, it seems fitting that expanding the nursing services within VAC under a primary care context will further encompass chronic disease management.

The increased demand on existing services supports the implementation of novel models of service delivery. Within VACs clinical services the advanced practice role of a nurse practitioner (NP) to both support the GPs in the management of PLHIV, provide a wider repertoire of nursing services and to ensure timely and equitable access to health care for all members of the GLBTI community is apposite.

---


GAP ANALYSIS

Existing service gaps that employing an NP will address:

- Increasing service demands:
  
  o Due to the success of combined anti-retroviral therapy (cART), PLHIV experience a decrease in mortality and an increased life expectancy, leading to an aging population of PLHIV.
  
  o Due to sustained increases in new HIV diagnoses more people require HIV treatment and care.
  
  o Prompt access to HIV and STI screening, diagnosis and treatment are considered to be necessary for the management of STIs within high risk populations. Current guidelines recommend regular screening for HIV and other STIs among GMSM (up to four times per year)\(^{13}\).
  
  o Proposed expansion of the PRONTO! service to include screening for gonorrhoea and chlamydia will necessitate a practitioner onsite to enable the ordering of pathology, prescribing and administering of treatment.
  
  o HIV negative GMSM require prompt provision of NPEP (within 72 hours of potential exposure); the potential for an expansion of PrEP prescribing and monitoring (pending outcome of the current demonstration project) also exists through both services.
  
  o Preventative health strategies amongst wider GLBTI population such as smoking cessation and drug and alcohol initiatives are imperative to improving health outcomes in this population.

- Access and clinic flow
  
  o Demand for GP appointments at the Centre Clinic often exceeds capacity. This can result in fragmented health care through clients deferring visits or needing to be referred to other non-specialist GP practices or locum services.
  
  o Currently the PN either has to interrupt or refer a client to a GP to acquire pathology requests or prescriptions (e.g. for treatment of STIs) or for further clinical assessment

---

SERVICE MODEL AND SCOPE OF PRACTICE

The successful integration, viability and sustainability of the NP role within the VACs clinical services is reliant on a number of key factors. For successful integration of the role it must be acceptable and of benefit to clients, GPs, the organisation and, arguably, the sector in general. The role must also be economically viable and sustainable within the environment of a wholly bulk billing practice (See below 'VAC Nurse Practitioner Business Model'). When these key factors are considered together the NP service model of best fit is one based on the role of the current PN, but with an expanded and advanced scope of practice to encompass the existing service gaps across VACs clinical services, the Centre Clinic and PRONTO!

Consistent with contemporary Australian definitions of NPs\(^{14}\), the VAC NP will have both an autonomous and collaborative role within a defined scope of practice. In this way, access to healthcare will be enhanced - clients will have direct access to the NP for a broad range of services, clinic flow will be also more seamless and capacity more able to meet demand.

As a point of difference from the role of the PN, the foundations of the extended scope of practice for the NP broadly relate to:

- Advanced health assessment
- Ordering, interpretation and follow-up of pathology and diagnostic investigations
- Diagnosis
- Prescribing of medications
- Referral to other health professionals
- Care coordination around hospital admission or discharge.

In clinical practice these extensions to practice will underpin both independent and collaborative role functions. For example, in terms of independent practice, it is envisaged clients it will be able to directly access the NP for:

- Asymptomatic HIV, STI and BBV testing, including treatment and follow-up management for positive STI results and vaccination. (NB: Treatment and management of HIV, Hepatitis B or Hepatitis C infection requires at least collaborative practice with a GP and in some instances referral to a medical specialist such as a hepatologist).
- Assessment, diagnosis, treatment and follow-up management of clients who present with symptomatic STI.

• Assessment, treatment and follow-up management of clients who present for HIV NPEP (and potentially HIV PrEP in the future).
• Provision of services including primary and secondary consultation to clients across other VAC program including Alcohol & other Drugs Services.

There are a number of identifiable instances where the NP will engage in collaborative practice with GPs and/or refer to GPs;

• The NP will engage in collaborative practice when they are faced with a clinical scenario that is outside their scope of practice or when significant diagnostic uncertainty exists.
• Collaborative practice will also occur with respect to management and monitoring of chronic disease, as detailed in GP chronic disease management plans.

In the case of HIV it was initially envisaged that the NP would be able to provide cART prescriptions under a continuing therapy only or shared care model\textsuperscript{15}. However NPs are not authorised to prescribe cART for the treatment of HIV infection under the PBS s100 HSD scheme\textsuperscript{16}, even under a continuing therapy/shared care model\textsuperscript{*}. To change this impediment to the NPs scope of practice will likely take a significant investment of time and a coordinated effort from key stake holders across the sector. Therefore, at this point, prescribing of cART, under the PBS, for the treatment of HIV infection is considered a longer term goal for the NPs scope of practice. However, prescription for medications for other chronic conditions (e.g. hypertension, hyperlipidaemia, depression) will fall within the NPs scope of practice under a continuing therapy model\textsuperscript{17}. Under this model access to service for clients would be enhanced.

*NB: It should be noted that prescribing for the treatment of HIV infection (PBS funded) is different to that of an NP prescribing NPEP (also antiretroviral medication). Medication for NPEP is not PBS funded, rather it is funded by the state and supplied through the state-wide Victorian NPEP Service based at the Alfred Hospital. Furthermore antiretrovirals are listed as class on the medication formulary for NPs endorsed under the Primary Care category notation in Victoria\textsuperscript{18, 19, 20}.


\textsuperscript{17} Refer to footnote 15.


VAC Victorian Nurse Practitioner Project Phase 4, Open Round 4.13- 2014
VAC Nurse Practitioner Business Model

VAC Clinical Services

Centre Clinic

VAC operates a fully bulk billing specialist general practice (The Centre Clinic) within which patients assign their entire Medicare Benefit Schedule (MBS) rebate for services provided to the practice. No gap fee is charged for any consultation. The practice is entirely self funding and receives no financial support from VAC or from any other source than the MBS, clinical trials, and Medicare Programs such as Practice Incentive Program (PIP) and Practice Nurse Incentive Program (PNIP).

The Practice employs 7 part time General Practitioners (GPs), each of whom has received accredited training to prescribe HIV antiretroviral agents listed on the Pharmaceutical Benefit Scheme (PBS) to treat or prevent Human Immunodeficiency Virus (HIV) infection.

Each GP is employed by VAC and each is salaried. The practice also employs a full-time Practice Nurse (PN) who is also salaried and who works at an advanced and relatively autonomous level within the collaborative framework in operation at Centre Clinic.

Recent financial modelling for the Centre Clinic in the Centre Clinic Renewal Project made recommendations for achieving a break-even annual financial position. These recommendations have been fully implemented and include clearly articulated levels of Practice Nurse activity that would support the financial sustainability of the practice generally. The modelling also indicated levels of GP activity that are necessary to ensure financial viability and sustainability. Pathways to a variety of MBS item numbers that are able to be accessed through a collaboration between the GPs and the Practice Nurse were defined within the model.

The pathways articulated involve the Practice Nurse at particular stages of various health initiatives and recognise the Practice Nurse is able to contribute significantly to these initiatives. Whilst the Practice Nurse is currently unable to use the MBS for her time directly (apart from the item number 10997 for a service provided to a person with a chronic disease) the model now in place at The Centre Clinic maximises access to preventative and chronic disease care initiatives, maximises MBS income and utilises both GP and Practice Nurse time in the most efficient manner.

The service has a relatively large cohort of patients living with HIV – about 500 patients in number. Revenue from General Practitioner Management Plans (GPMPs), Team Care Arrangements and the

reviews of these, together with Health Assessments and GPMPs for a range of other chronic diseases comprise a significant proportion of Centre Clinic MBS income (about 60%).

Currently The Centre Clinic Practice Nurse is available to patients for 8 sessions a week (a session being a morning or afternoon).

**PRONTO!**

**PRONTO!** is a rapid HIV testing service which is fully funded by the Victorian Department of Health until July 31st 2015 and derives no funding from the MBS having no eligible provider of services on site. **PRONTO!** is open for five 4 hour sessions per week. Two ‘non health-professional’ peer testers conduct a maximum of 14 rapid tests per session. The Centre Clinic Practice Nurse is currently available to patients of **PRONTO!** for one session per fortnight on site at **PRONTO!** and the PN usually see’s 7 clients per session.

Whilst this activity does not generate income for VAC, it affords cross-organisational clinical cover and oversight.

**Nurse Practitioner Financial Modelling - considerations**

There are no freely available financial models for Nurse Practitioners (NP) operating in the specialist Primary Care environment in Australia.

Financial modelling that has been conducted for NP’s operating in other environments, however, has proposed that high activity levels (i.e 20-24 patient consultations/day) are essential to the financial viability of the role in those environments if the NP is operating in a private or part private/part public capacity (where NP income is derived in part or wholly from NP MBS item numbers). These high levels of activity would not be achievable or sustainable with current Centre Clinic population levels nor culturally appropriate in the collaborative framework in place at The Centre Clinic.

**Risk**

The acceptability of a NP model to the organisation and to the individual Nurse Practitioner depends upon the relative burden of financial and clinical risk to both parties and also the financial viability and sustainability of the model through candidacy and post endorsement periods.

This risk per se, however, also needs to consider the broader context in which the Nurse Practitioner is operating – both organisational and sector specific - and should acknowledge the non-financial benefits of the model such as improvements to patient access, patient health outcomes and patient experience within the service.

It is important to note that The Centre Clinic is different to the HIV specialist private primary care services in metro Melbourne. The Centre Clinic population is smaller (about 2000 patients) and confined primarily to the gay and men who have sex with men (G/MSM) population, 500 or so of whom are living with HIV infection.
If the financial risk to the VAC Nurse Practitioner operating in a private capacity is related to activity levels, then the Centre Clinic is immediately at a disadvantage to these other private clinics which have higher GP equivalent full time (EFT), larger and broader clinic populations, higher throughput levels and higher visibility.

Given that the GPs at The Centre Clinic are currently all salaried, it is unreasonable to expect a NP to accept a private arrangement when access to MBS item numbers are currently so restricted for NP’s (and approximately half of what a GP can expect for a similar time-related attendance).

An explicit acknowledgement needs to be made regarding the current limitations of the Nurse Practitioner MBS item numbers which are generalist in nature and which do not reflect the specialist Nurse Practitioner’s scope of practice. General Practitioners have access to a much wider range of MBS item numbers than the Nurse Practitioner item numbers, are limited to four generalist and time related activities (see Table 1).

It has been acknowledged that the design of the Nurse Practitioner MBS item numbers may not adequately reflect the nursing model of care.

Patient pathways

Under the model we propose patient pathways to the Nurse Practitioner at Centre Clinic are unlikely to be significantly different to those for access to the current Practice Nurse (Indeed, NP models proposed in other settings might involve a period of cultural acceptance and integration by staff and patients within those services). Predictions of Nurse Practitioner activity at The Centre Clinic, therefore, can reliably be made on the basis of current Practice Nurse pathways (and activity).

The model within which the NP will operate at VAC has been clearly defined in this document. The financial modelling proposed here relies heavily upon the collaborative framework articulated in the Service Model and Framework chapter in which the NP is anticipated to be operating across the medical program of VAC. The NP role is envisioned as one that broadens the range of access options to patients across VAC clinical services and which relies upon a defined and evolving scope of practice together with the explicit collaboration of GPs.

Whilst VAC may consider supporting the role financially (given the extended engagement with VAC’s target population that is anticipated through the creation of the role), we propose a model that predicts a break even model for the Nurse Practitioner during Candidacy and post Endorsement without VAC support.

---

**Timeframes**

Business modelling for the NP role is split into two timeframes – NP Candidacy (2015/16 and 2016/17) and Post Endorsement (2017 onwards).

**NP Candidacy business model**

This Nurse Practitioner financial modelling proposes that current Practice Nurse work arrangements remain in place during the period of Candidacy at The Centre Clinic and at PRONTO!, that is, 16 sessions/fortnight at The Centre Clinic, 1 session a fortnight at PRONTO!

**Leave**

NP Candidacy period is expected to last from March 2015 to September 2016.

It is expected that a total of 208 hours over 26 weeks are required for the NPC to be on Campus (out of Centre Clinic) over the 4 Semesters (see Table 2). 104 of these hours will be supported by VAC (study leave) together with up to 4 days examination leave per annum. The entire 240 hours per annum will need to be accommodated for in the financial modelling for the Candidacy period.

In total up to 240 hours (equivalent to 30 days) of employment costs and lost income generating potential are required to be costed for each year of the Candidacy.

**Impact**

**Centre Clinic**

Calculations of lost income that will be incurred through the NPC absence from the The Centre Clinic whilst on study leave involves the application of financial modelling conducted for The Centre Clinic Renewal Project and the projected level of Practice Nurse activity (on a session-by-session basis) required for a break even model.

Our financial modelling indicates that the contracting of a Practice Nurse for two days a week on a profit share basis servicing specific MBS initiatives identified in this financial modelling for the full period of NPC will result in a net gain to The Centre Clinic of approximately $13k p.a. over the NPC period.

Threats to the viability of this modelling include:

a) An unsuccessful recruitment campaign (unlikely given remuneration predicted)
b) Underperformance of the PN recruited (minimised by profit share arrangement)
c) Changes to the MBS which affect billing opportunities upon which the modelling relies (possible)
d) A cure for HIV (unlikely)
e) A fall in GP EFT at the Clinic (possible)
f) An exodus of clients to other services (unlikely)
g) paucity of patients eligible for chronic disease prevention and/or care initiatives for PN and NPC activity (unlikely given current clinic population, a media campaign to attract new patients and the potential for contractor PN to focus on underserviced client population e.g. asthma (279 patients)/smokers(700 patients)/hypertension (297 patients)/ Osteoarthritis (101 patients)/ hyperlipidemia (339 patients)).

**PRONTO!**

No MBS income generation from PRONTO! is able to be accessed by the service to support the Nurse Practitioner Candidacy period. There is the potential for modest MBS income through the expected employment of a GP Registrar for up to two sessions/week at PRONTO!, however.

**Post NP Endorsement business model**

Our Nurse Practitioner financial modelling proposes that current Practice Nurse work arrangements also remain in place after NP endorsement at The Centre Clinic and at PRONTO!.

Post Nurse Practitioner endorsement financial modelling is based upon an activity level of 100% with the NP daily appointment schedule at The Centre Clinic constructed to encompass specific MBS Item Number activities that are based on those determined for The Centre Clinic Renewal Project.

Excluding any access to NP MBS item numbers through the PRONTO! service, we project a modest loss outcome of $15k for a salaried, endorsed NP operating within The Centre Clinic each year. However, with the inclusion of endorsed NP access to NP MBS item numbers through consultations at PRONTO! one session per week we project an annual loss of about $8k. Whilst funding arrangements for PRONTO! may change, it is likely that rapid testing will, at some point, attract an MBS rebate, that it will commence at The Centre Clinic at least for one session/week during NPC and that after endorsement the NP will be able to access the MBS for rapid testing, either at PRONTO! or via the Centre Clinic.

If Practice Nurse contractor arrangement is retained on the same basis, we project an ongoing annual gain of about $43k.

**TABLE 1**

**Nurse Practitioner MBS Item Numbers (as at 09/10/2014).**

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Description</th>
<th>Schedule fee (100%)</th>
<th>Benefit paid (85%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>82200</td>
<td>Professional attendance by a participating nurse practitioner for an obvious problem characterised by the straightforward nature of the task that requires a short patient history and, if required, limited examination and management.</td>
<td>$9.60</td>
<td>$8.20</td>
</tr>
<tr>
<td>82205</td>
<td>Professional attendance by a participating nurse</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
practitioner lasting less than 20 minutes and including any of the following:

a) taking a history;  
b) undertaking clinical examination;  
c) arranging any necessary investigation;  
d) implementing a management plan;  
e) providing appropriate preventive health care,

for 1 or more health related issues, with appropriate documentation.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$20.95</td>
<td>$17.85</td>
<td></td>
</tr>
</tbody>
</table>

Professional attendance by a participating nurse practitioner lasting at least 20 minutes and including any of the following:

a) taking a detailed history;  
b) undertaking clinical examination;  
c) arranging any necessary investigation;  
d) implementing a management plan;  
e) providing appropriate preventive health care,

for 1 or more health related issues, with appropriate documentation.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$39.75</td>
<td>$33.80</td>
<td></td>
</tr>
</tbody>
</table>

Professional attendance by a participating nurse practitioner lasting at least 40 minutes and including any of the following:

a) taking an extensive history;  
b) undertaking clinical examination;  
c) arranging any necessary investigation;  
d) implementing a management plan;  
e) providing appropriate preventive health care,

for 1 or more health related issues, with appropriate documentation.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$58.55</td>
<td>$49.80</td>
<td></td>
</tr>
</tbody>
</table>


TABLE 2

Master of Nursing Practice – University of Melbourne, Carlton Campus

YEAR 1 (2015)

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Semester 1</td>
<td>Clinical Leadership in context (12.5)/ Health assessments for advanced practice (12.5)</td>
<td>March 2 – May 31</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Semester 2</td>
<td>Implementing evidence for practice (25)</td>
<td>July 27 – October 25</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13</td>
</tr>
</tbody>
</table>
### YEAR 2 (2016)

<table>
<thead>
<tr>
<th>Semester</th>
<th>Subject (points)</th>
<th>Dates</th>
<th>No. days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Semester 1</strong></td>
<td>Health assessments for advanced practice (12.5)/Pharmacology for health professionals (1) (12.5)</td>
<td>TBC</td>
<td>13</td>
</tr>
<tr>
<td><strong>Semester 2</strong></td>
<td>Advanced nursing practice in context (12.5)/Applications of clinical pharmacology (12.5)</td>
<td>TBC</td>
<td>13</td>
</tr>
</tbody>
</table>

APPENDICES

Terms of reference for VAC NP Model Development steering committee

Role

To oversee the development and implementation of the VAC NP model within VAC’s Clinical Services

To ensure the DH VNPP Key Deliverables are developed in accordance with set the requirements

To provide governance framework for the expansion of nursing services within VAC

Objectives

To ensure the VAC NP role is an acceptable and feasible model

To support the NPC to expand the existing nursing services within the Centre Clinic by integrating the VAC NP model into the clinic setting

To support the NPC throughout the candidacy and endorsement process

To support the VAC NP post endorsement

Develop KPIs, policies and protocols relevant to the VAC NP role

Review the VAC NP in accordance to the KPIs

Membership

Project Officers: Anthony Snow & Simon Powell

NPC Clinical Mentor: Dr Stephen Rowles

NPC: Danielle Collins

Alfred Health Melbourne Sexual Health Pharmacist: Kate Mackie/ Ivette Aguire/ Alison Duncan

VAC Director of Clinical Services: Kent Burgess

Service user: TBA

Frequency of Meetings: Monthly

Quorum: Half membership plus one

Term: Twelve month term commencing July 2014, to be reviewed after that period.
Centre Clinic GP

Nurse Practitioner
- Advanced health assessment
- Ordering, interpretation and follow-up of pathology and diagnostic investigations
  - Diagnosis
- Prescribing of medications
- Referral to other health professionals
- Care coordination around hospital admission or discharge

PRONTO! PeerTest Facilitator

VAC Victorian Nurse Practitioner Project Phase 4, Open Round 4.13- 2014
We have a proud history of direct action. The many services and programs we offer today grew from unique partnerships between community activists, clinicians and political leaders.

Established in 1983 after a public meeting called to express concern at government inaction over an emerging health issue (then known as Gay Related Immune Deficiency, or GRID), the direction of a community and clinical response was driven by those infected and affected by HIV.

Led essentially by the gay community and its supporters, people were mobilised and engaged directly with governments, hospital administrators and health services to create a world first model of care. We began as a genuinely community driven and vocal organisation where most tasks were done by people volunteering their time.

Our structure and issues have changed over time, but our volunteers remain fundamental in the delivery of services. We remain committed to leading the fight against HIV and related social justice issues, so our history is a work in progress.

OUR MISSION

VAC/GMHC leads the fight against HIV/AIDS in Victoria by providing care and support for people living with HIV, health promotion, and advocacy. We advocate, with partner organisations, to improve health outcomes for sexually and gender diverse communities.

OUR PURPOSE

- To reduce HIV transmissions in Victoria by promoting the health of gay men and of people living with HIV.
- To work in partnership to improve health outcomes for the sexually and gender diverse community.

OUR HISTORY

PRINCIPLES

Meaningful Participation of Our Communities

We want all people who are a part of the communities we work in to feel that they are a part of what we do. We encourage and cultivate the meaningful participation of these communities.

Social Justice

We are an organisation founded in the communities we work for, on the principles of social justice. We support people to thrive, express themselves, and to develop skills and capacity.

Honesty & Fairness

We treat our clients, members, volunteers, staff and the organisations with whom we work with honesty, fairness and respect.

Working to the Highest Standards

Our work is evidence-based, drawing on current knowledge, with a thorough understanding of the epidemiological and social context of HIV in Australia, and the needs of our communities.

Working Collaboratively

We deliver accessible and responsive programs in collaboration with others in our communities.
VICTORIAN AIDS COUNCIL / GAY MEN’S HEALTH CENTRE

STRATEGIC PLAN
2012-2017

OBJECTIVE 1:
WORK TO DECREASE RATES & IMPACT OF HIV

OBJECTIVE 2:
PROVIDE TRUSTED LEADERSHIP

OBJECTIVE 3:
LEAD THROUGH EXCELLENT & INNOVATIVE PROGRAMS & SERVICES

OBJECTIVE 4:
BE A UNIFIED & STRENGTHENED ORGANISATION

OBJECTIVE 5:
ENSURE FINANCIAL SUSTAINABILITY

OBJECTIVE 6:
ENSURE PROFESSIONAL EXPERTISE

OUR VISION

A future without HIV.

A world where all sexually and gender diverse people live with dignity and equal rights, and participate fully in our society.

At VAC/GMHC we:
• Deliver HIV prevention, education and health promotion to gay men
• Provide services, support and advocacy for all people living with HIV
• Respond to emerging needs and developments in HIV prevention and care
• Support and promote the health and wellbeing of sexually and gender diverse communities
• Promote access to our services for these communities.

By embracing innovative evidence-based HIV prevention approaches and technologies to respond effectively to changes in the epidemic and;

By strengthening our policy capacity to capitalise on developments in prevention and care.

By working inclusively with sexually and gender diverse communities, particularly on the improvement of health outcomes, providing capacity development, and using our policy capacity to argue for reforms to laws and policies which undermine good health.

By addressing a broad range of health issues that affect wellbeing in sexually and gender diverse communities and making the most of our expertise in services and programs delivered by volunteers and staff.

VAC/GMHC will strive to solve the problems associated with having two separate organisations through a process of consultation over the life of this plan.

By sharing our expertise and resources to support the capacities of other community organisations and;

By keeping abreast of proposed changes in health reform and collaborating with partners to take advantage of new funding opportunities.

By maximising the skills and abilities of a committed and competent workforce and of our volunteers, to deliver services and programs based on need, research and sound evidence.
<table>
<thead>
<tr>
<th>Year 1 - 2014</th>
<th>Deliverables- NP 5 Year Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Identify service gap within VACs clinical services</td>
</tr>
<tr>
<td></td>
<td>Apply to DH for VNPP funding</td>
</tr>
<tr>
<td></td>
<td>Develop VNPP NP model of care in collaboration with Melbourne Sexual Health Centre (MSHC) sexual health NP, Anthony Snow.</td>
</tr>
<tr>
<td></td>
<td>Develop steering committee</td>
</tr>
<tr>
<td></td>
<td>Appoint NPC</td>
</tr>
<tr>
<td></td>
<td>Appoint clinical mentor</td>
</tr>
<tr>
<td></td>
<td>Partnership with ASHM to develop submission to expand PBS s100 prescribing to NPs under continuing therapy model</td>
</tr>
<tr>
<td></td>
<td>Apply for MANP- NP at Melbourne Uni</td>
</tr>
<tr>
<td></td>
<td>Submit model to DH</td>
</tr>
<tr>
<td></td>
<td>Submit 5 year plan to DH</td>
</tr>
<tr>
<td></td>
<td>Apply for DH MANP scholarship</td>
</tr>
<tr>
<td></td>
<td>Submit budget acquittal to DH</td>
</tr>
<tr>
<td>Timeline</td>
<td>February</td>
</tr>
<tr>
<td></td>
<td>May</td>
</tr>
<tr>
<td></td>
<td>June</td>
</tr>
<tr>
<td></td>
<td>June</td>
</tr>
<tr>
<td></td>
<td>July</td>
</tr>
<tr>
<td></td>
<td>July</td>
</tr>
<tr>
<td></td>
<td>August</td>
</tr>
<tr>
<td></td>
<td>September</td>
</tr>
<tr>
<td></td>
<td>October</td>
</tr>
<tr>
<td></td>
<td>October</td>
</tr>
<tr>
<td></td>
<td>October</td>
</tr>
<tr>
<td></td>
<td>December</td>
</tr>
<tr>
<td>Responsibility</td>
<td>PM</td>
</tr>
<tr>
<td></td>
<td>PM</td>
</tr>
<tr>
<td></td>
<td>PO</td>
</tr>
<tr>
<td></td>
<td>PO</td>
</tr>
<tr>
<td></td>
<td>PO/VAC</td>
</tr>
<tr>
<td></td>
<td>PO/NPC</td>
</tr>
<tr>
<td></td>
<td>NPC</td>
</tr>
<tr>
<td></td>
<td>NPC</td>
</tr>
<tr>
<td></td>
<td>PO/VAC</td>
</tr>
<tr>
<td></td>
<td>PO/NPC</td>
</tr>
<tr>
<td></td>
<td>NPC</td>
</tr>
<tr>
<td>Outcome</td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td>Achieved</td>
</tr>
<tr>
<td></td>
<td>TBA</td>
</tr>
<tr>
<td></td>
<td>TBA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 2 - 2015</th>
<th>Deliverables- NP 5 Year Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NPC attending MANP-NP</td>
</tr>
<tr>
<td></td>
<td>Steering committee meeting</td>
</tr>
<tr>
<td></td>
<td>Clinical mentor supervision</td>
</tr>
<tr>
<td></td>
<td>Submit DH logbook</td>
</tr>
<tr>
<td></td>
<td>Develop clinical practice guidelines</td>
</tr>
<tr>
<td></td>
<td>Partnership with ASHM to develop submission to expand PBS s100 prescribing to NPs under continuing therapy model</td>
</tr>
<tr>
<td>Timeline</td>
<td>February</td>
</tr>
<tr>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Weekly</td>
</tr>
<tr>
<td></td>
<td>Bi-annual</td>
</tr>
<tr>
<td></td>
<td>June</td>
</tr>
<tr>
<td></td>
<td>Ongoing</td>
</tr>
<tr>
<td>Responsibility</td>
<td>NPC</td>
</tr>
<tr>
<td></td>
<td>PO/SC</td>
</tr>
<tr>
<td></td>
<td>NPC</td>
</tr>
<tr>
<td></td>
<td>NPC</td>
</tr>
<tr>
<td></td>
<td>NPC/SC</td>
</tr>
<tr>
<td></td>
<td>NPC</td>
</tr>
<tr>
<td>Outcome</td>
<td>TBA</td>
</tr>
<tr>
<td></td>
<td>TBA</td>
</tr>
<tr>
<td></td>
<td>TBA</td>
</tr>
<tr>
<td></td>
<td>TBA</td>
</tr>
<tr>
<td></td>
<td>TBA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year 3 - 2016</th>
<th>Deliverables- NP 5 Year Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NPC attending MANP-NP</td>
</tr>
<tr>
<td></td>
<td>Steering committee meeting</td>
</tr>
<tr>
<td></td>
<td>Clinical mentor supervision</td>
</tr>
<tr>
<td></td>
<td>Submit DH logbook</td>
</tr>
<tr>
<td>Timeline</td>
<td>February</td>
</tr>
<tr>
<td></td>
<td>Quarterly</td>
</tr>
<tr>
<td></td>
<td>Weekly</td>
</tr>
<tr>
<td></td>
<td>Bi-annual</td>
</tr>
<tr>
<td>Responsibility</td>
<td>NPC</td>
</tr>
<tr>
<td></td>
<td>PO/SC</td>
</tr>
<tr>
<td></td>
<td>NPC</td>
</tr>
<tr>
<td></td>
<td>NPC</td>
</tr>
<tr>
<td>Outcome</td>
<td>TBA</td>
</tr>
<tr>
<td></td>
<td>TBA</td>
</tr>
<tr>
<td></td>
<td>TBA</td>
</tr>
<tr>
<td></td>
<td>TBA</td>
</tr>
</tbody>
</table>
| Year 4-2017 | • Develop drug formulary  
• Finalise portfolio for endorsement  
• Submit portfolio to AHPRA  
• Partnership with ASHM to develop submission to expand PBS s100 prescribing to NPs under continuing therapy model | • June  
• November  
• November  
• Ongoing | • NPC/SC  
• NPC  
• NPC  
• TBA | | • Achieve AHPRA endorsement and apply for PBS & MBS provider numbers  
• Scope of practice: sexual health & HIV  
• Consolidate practice from MANP-NP  
• Steering committee meeting  
• Partnership with ASHM to develop submission to expand PBS s100 prescribing to NPs under continuing therapy model | • January  
• Ongoing  
• Ongoing  
• Quarterlty  
• Quarterly  
• Quarterly | • NPC  
• NP  
• NP  
• PO/SC  
• PO/SC  
• PO/SC | | | • TBA  
• TBA  
• TBA  
• TBA  
• TBA  
• TBA | | | Key:  
NPC: Nurse Practitioner Candidate  
NP: Nurse Practitioner  
PM: Practice Manager  
PO: Project Officer  
SC: Steering Committee  