



Australian Government
Department of Health



An Australian Government Initiative

Updated Activity Work Plan 2016-2018: Integrated Team Care Funding

The Activity Work Plan template has the following parts:

1. The updated Integrated Team Care Annual Plan 2016-2018 which will provide:
 - a) The strategic vision of your PHN for achieving the ITC objectives.
 - b) A description of planned activities funded by Integrated Team Care funding under the Indigenous Australians' Health Programme (IAHP) Schedule.
2. The updated Budget for Integrated Team Care funding for 2016-2018 (attach an excel spreadsheet using template provided).

Hunter New England Central Coast

When submitting this Activity Work Plan 2017-2018 to the Department of Health, the PHN must ensure that all internal clearances have been obtained and has been endorsed by the CEO.

The Activity Work Plan must be lodged to [Kate McGregor](mailto:Kate.McGregor@health.gov.au) via email Kate.McGregor@health.gov.au on or before 17 February 2017

Updated July, 2017

Overview

This updated Activity Work Plan covers the period from 1 July 2016 to 30 June 2018. To assist with PHN planning, each new activity nominated in this work plan should be proposed for a period of 12 months. The Department of Health will require the submission of a new or updated Activity Work Plan for 2018-19 at a later date.

1. (a) Strategic Vision for Integrated Team Care Funding

Hunter New England Central Coast PHN's (HNECC) purpose is to deliver innovative, locally relevant solutions that measurably improve the health outcomes of our communities.

A primary aim is to improve care in the whole of the health system producing measurable outcomes in Aboriginal health. As part of this commitment, HNECC aims to contribute to improving health outcomes for Aboriginal and Torres Strait Islander people and contribute to closing the gap in life expectancy.

ITC activities will achieve this vision through the delivery of high quality and culturally appropriate services across a very large geographical footprint that includes the Hunter, New England and Central Coast regions. There are over 60,800 people in the HNECC who identify as being of Aboriginal and/or Torres Strait Islander descent, equivalent to 5% of the resident population which is greater than the national average of 3%.

Key elements of this strategic vision are:

- Visibility – services are known to other health professionals
- Accessibility – services are easily accessible to those who need them and are provided in regions where individuals require treatment. Waiting times for access to services do not negatively impact patient outcomes nor deter individuals from seeking treatment.
- Integration – different providers understand and work closely with each other to ensure collaborative relationships are developed and nurtured. Region wide planning occurs at an appropriate level, utilising a patient centred approach to ensure:
 - o Decisions that may impact parts of the system are fully understood by all stakeholders
 - o Evidence based, efficient and effective treatment services are supported
 - o Referral pathways and service integration occurs seamlessly between providers.
- Resourcing – services that provide treatment are appropriately supported

Our strategic approach and activities to meet the needs of Aboriginal communities within the HNECC footprint include:

1. Care Coordination activities that focus on developing and measuring improvements in individuals in health system/service navigation, skill and technique acquisition, self-monitoring and health insight, social integration and support.
2. Our standard program of care coordination lasts 12 weeks, however patients may stay on longer if required. This includes face to face assessment and stratification, the development of GP MP and/or Shared Care plan, the implementation of action plans and associated education. Once stable, a follow up assessment is completed and patients will usually

transition to Supplementary Services only. If they require further Care Coordination at a later date, they will return to the 12 week program through a GP referral.

3. That we will make progress towards 'closing the gap' through improved collaboration and working relationships between mainstream General Practice, Aboriginal Health Service providers, Local Health Districts and other key stakeholders to assist with a uninterrupted patient journey and inform needs and assessment planning and the development of multi programme approaches and cross sectoral linkages. 3. Focusing on mainstream health services that exist in proximity to Aboriginal communities throughout the region.
4. Providing comprehensive and culturally appropriate access to clinical support and chronic disease management for Aboriginal people.
5. Increasing the uptake of Aboriginal and Torres Strait Islander specific Medicare Benefits Schedule items
6. 6. Overseeing the ITC workforce including ensuring Indigenous Health Project Officers, Care Coordinators and Outreach Workers receive appropriate ongoing peer support, professional guidance and mentoring.

1. (b) Planned activities funded by the IAHP Schedule for Integrated Team Care Funding

PHNs must use the table below to outline the activities proposed to be undertaken within the period 2016-18. These activities will be funded under the IAHP Schedule for Integrated Team Care.

Public Accountability	
<p>What are the sensitive components of the PHN's Annual Plan? Please list</p>	<p>The commissioning process and procurement of services to provide the ITC program has been a difficult space. It has strained relationships between the PHN and some of the AMSs and others have embraced the process and been successful in the tendering process securing contracts with HNECC PHN. There is currently a strategy to mend these relationships with good initial feedback from the AMS CEO Group. There was some attempt by the AMS CEOs to form a consortium and boycott the tender process, however this fell down with some AMS ECOs pulling away from this consortium and placing a tender with the ITC Program as well as Indigenous Mental Health and Drug & alcohol Services.</p> <p>The difference between how individual PHNs have chosen to fund the ITC Program has also impacted on our local relationships with the 10 AMSs in our PHN region, with some PHNs choosing to directly fund AMSs. This has led to the HNECC PHN Region AMSs questioning the entire approach to commissioning process.</p> <p><i>PLEASE NOTE: It is the preference of HNECC PHN not to include this table in the version of this AWP on the website when approved by the Department</i></p>

Proposed Activities	
<p>ITC transition phase</p>	<p>The first six months of the HNECC PHN transition to ITC process involved the extension of pre-existing service provider contracts for CCSS/IIAMPS to ensure service continuity across the HNECC PHN region. Those contracts were extended to December 31, 2016 and the extension was necessary to ensure a culturally appropriate, smooth transition from one provider to another. It also meant HNECC PHN was able to minimise disruption in terms of access for patients continuing to access the program.</p> <p>The only issue experienced during the transition phase was experienced when contracts were moved from former CCSS/IIAMPC providers to the new ITC providers. The PHN supported with the transition by providing staff to support the transition planning process and the supply of a template to assist in planning and in some instances funding to assist with transition of patients to maintain continuum of care. These were predominantly administrative processes which resulted in some delays in the transfer of information because staff employed at the previously funded organisations were no longer employed (their employment contracts had expired and there weren't fund to renew) and as a result there were not adequate staff in those organisations to effect a proper clinical hand over. The only other barrier experienced has been a delay in the employment of staff to newly funded contracts. This delay was the result of wanting to ensure the most appropriate and qualified applicants were</p>

	<p>appointed to ensure the successful and culturally appropriate trajectory of the program.</p>												
<p>Start date of ITC activity as fully commissioned</p>	<p>Following the six month transition phase, newly commissioned services commenced delivery on January 16, 2017.</p> <p>Successful contractors for ITC in the HNECC PHN region were:</p> <table border="1" data-bbox="448 461 1417 824"> <tr> <td data-bbox="448 461 772 607">HealthWISE New England North West</td> <td data-bbox="772 461 1096 607">New England North West region</td> <td data-bbox="1096 461 1417 607">Mainstream Primary Care Provider previous provider of CCSS / IIAMPC program</td> </tr> <tr> <td data-bbox="448 607 772 645">Biripi AMS</td> <td data-bbox="772 607 1096 645">Greater Taree region</td> <td data-bbox="1096 607 1417 645">AMS</td> </tr> <tr> <td data-bbox="448 645 772 683">Yerrin AMS</td> <td data-bbox="772 645 1096 683">Central Coast</td> <td data-bbox="1096 645 1417 683">AMS</td> </tr> <tr> <td data-bbox="448 683 772 824">Hunter Primary Care</td> <td data-bbox="772 683 1096 824">Newcastle and Hunter region</td> <td data-bbox="1096 683 1417 824">Mainstream Primary Care Provider previous provider of CCSS / IIAMPC program</td> </tr> </table>	HealthWISE New England North West	New England North West region	Mainstream Primary Care Provider previous provider of CCSS / IIAMPC program	Biripi AMS	Greater Taree region	AMS	Yerrin AMS	Central Coast	AMS	Hunter Primary Care	Newcastle and Hunter region	Mainstream Primary Care Provider previous provider of CCSS / IIAMPC program
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Yerrin AMS	Central Coast	AMS											
Hunter Primary Care	Newcastle and Hunter region	Mainstream Primary Care Provider previous provider of CCSS / IIAMPC program											
<p>Is the PHN working with other organisations and/or pooling resources for ITC? If so, how has this been managed?</p>	<p>HNECC PHN will not be pooling resources for this program but will collaborate with relevant local stakeholders as required to meet outcomes.</p>												
<p>Service delivery and commissioning arrangements</p>	<p>HNECC PHN utilised the first 6 months to transition from CCSS / IIAMPC to implement a commissioning process and extend existing contracts. As detailed above, to enable commissioning to begin 2015/2016 provider contracts were extended to December 31, 2016.</p> <p>Ahead of commencing the commissioning process for ITC, HNECC PHN undertook a review of all aspects of its functionality in order to ensure the services commissioned were informed by need, were culturally relevant, appropriate and respectful.</p> <p>This process included partnering with the University of Sydney in the roll out of a comprehensive Aboriginal Needs Analysis and consulting with existing 2015/2016 Aboriginal Health Service providers and the AMS / ACCHO sector to develop a set Principles for the Commissioning of Indigenous Health Services. This process further informed the development of HNECC PHN's commissioning assessment criteria which was established to ensure services, when commissioned were able to achieve the ITC objectives.</p> <p>HNECC PHN's commissioning process for all programs is underpinned by a Commissioning Framework and supporting policies. This framework and subsequent tools have been developed and tested in previous rounds of commissioning for healthcare services, and rigorous reflection has been undertaken to consider area for generalised improvement,</p>												

as well as areas that can be modified to ensure cultural sensitivities are also factored into the process.

Following the roll out of the comprehensive Aboriginal Needs Analysis to identify priority areas and engage relevant clinical and community stakeholders, HNECC undertook a two-step tender process as part of commissioning ITC services.

This involved taking an expression of interest (EOI) to the open market, followed by a selective request for tender (RFT). The EOI was widely circulated to providers currently registered with the eTenderbox, those currently included on our client management system (CRM), and advertised in the print media and on social media platforms. Specific publications with an Aboriginal audience (i.e. Koori Mail) were also included in the broader advertisement to ensure a comprehensive market approach was achieved. Direct engagement with the Aboriginal Community Controlled Health Organisations (ACCHOs) also formed part of HNECC PHN's broader communication strategy. HNECC PHN developed Guidelines for Commissioning Indigenous Health Services which informed the entire commissioning process. These guidelines and principles were widely distributed for comment and feedback both externally and internally to the organisation and can be found through the following link:

<http://www.hnecphn.com.au/media/13920/indigenous-commissioning-principles-oct16.pdf>

As part of that process a series of direct communications between HNECC and all ACCHOs in the region were used to inform commissioning arrangements.

Capacity building initiatives were implemented into the commissioning process for all prospective tenderers and a series of Tender Writing Workshops were held across the region throughout July and August 2016 in preparation for the release of the selective RFT.

ACCHOs and 2015/2016 service providers were directly invited to attend the sessions, which were developed and delivered with the dual aim of:

- i) Improving the capacity of ACCHOs to respond to future tenders by providing support to practically assist with the completion and submission of tender documentation
- ii) Provide HNECC an opportunity to further engage with potential ITC providers during these forums in order to continue to gather information and data that would inform the ongoing needs assessment.

Coinciding with this two-stage approach to market, HNECC will also developed and refined, based on clinical and community feedback and the Commonwealth ITC Guidelines, contract specification, service scope, key performance indicators (KPIs) and reporting mechanisms that will form the basis of the ITC Schedule for commencement of services in January 2017.

As part of the RFT process, industry briefing/respondent forums were also held. Again, this engagement opportunity served a dual purpose – assisting to build strong trusting relationships through an open and transparent dialogue while also informing the ongoing Aboriginal Health needs assessment and identifying potential areas of future program development. These forums were held at locations across the region, and were made available as a webinar presentation to ensure respondents in rural and remote locations were not disadvantaged. RFT submissions were rigorously evaluated to ensure that potential service providers were business fit and able to provide services under the ITC contracts, and also comply with the Commonwealth Deed of Funding.

Tenders were evaluated using a four stage approach as outlined below, using weighted criteria.

Stage 1 - Organisational Evaluation – that included evidence or responses related to:

- o Public Liability and Professional Indemnity Insurances
- o Workers Compensation / Income Protection Insurance
- o Business Profile addressing business credentials and certificate of registration
- o Clinical Qualifications, Experience and Capacity of providers
- o Risk Management policies/frameworks
- o Quality Assurance/Clinical Governance
- o Evidence of the Quadruple AIM Approach in evaluating service provision
- o Evidence of the use of Health Pathways, with a willingness to contribute content to the HealthPathways portal
- o Measurement and monitoring of patient participation
- o Clinical governance and compliance

Stage 2 - Program Evaluation – outlining a response to the service specifications and including an outline of how services will be accessed and provided

Stage 3 - Price Evaluation

Stage 4 - Combination of Organisational, Program Specific and Tendered Pricing
The tender evaluation panels form an integral part of this process.

HNECC formed three evaluation teams to be convened to consider each sub-region (Central Coast, Hunter and New England) within the HNECC area. This process ensured that local variations in Aboriginal healthcare needs were at the forefront of considerations made throughout the evaluation process, and informed the recommendation submitted to the Executive and Board when considering successful providers.

Each evaluation team will be comprised of a minimum of three panel members, including:

- A HNECC Subject Matter Expert specific to the contract area;
- A Regional Expert specific to the sub-region; and
- An Independent. Participation of others in the evaluation panels will be considered by HNECC as part of the commissioning process to ensure equity and transparency is maintained throughout the process.

A probity auditor was engaged to oversee the process.

Guidance notes and an evaluation panel briefing were prepared and provided to the Evaluation Panel members to assist with the decision making process and to ensure decisions were made based on merit through pre-determined evaluation criteria. All Evaluators were required to sign HNECC's Confidentiality and Conflict of Interest Declarations prior to receiving access to any Tender documents.

HNECC PHN ensured there were supportive processes in place to manage services being transitioned from existing providers to new providers where necessary. As part of this process the Aboriginal Health Access Team, in partnership with other HNECC PHN staff worked together to:

- Review the schedules, KPIs and reporting requirements to clarify expectations;
- Establish/building key relationships with providers to plan and monitor ongoing service provision

	<ul style="list-style-type: none"> • Support consumer/community choice • Contribute to the ongoing development of models of care and co-design opportunities that remain culturally sensitive and in line with the identified healthcare needs and priorities • Collating provider feedback and reporting requires to inform HNECC Annual Activity Work Plan and Strategic Plan
Decommissioning	<p>No decommissioning is likely to take place during 2017/2018 however, the extended contracts for CCSS/ IIAMPC expired on December 31, 2016.</p> <p>As a result of the commissioning process (finalised in January 2017) one CCSS/IIAMPC service provider was decommissioned. The process to transition clients from that service to the new provider was guided by a transition plan which facilitated ongoing engagement between the PHN, former provider and the new provider. Another service was partly de-commissioned from a Primary Care Provider to an AMS in one part of the region. This process happened smoothly and was undertaken in the same way as described above.</p>
Decision framework	<p>An extensive Aboriginal Needs Analysis continues to be under development. Its analysis builds upon and supplements the Baseline Needs Assessment recently carried out by the PHN but the document itself is designed to be a “living document” constantly informed and updated by the HNECC PHN Aboriginal Health Access Team to record and monitor the ever changing and evolving needs of the region’s Aboriginal and Torres Strait Islander population.</p> <p>A multi-faceted approach to research and gather qualitative data to inform the analysis was undertaken through 2016.</p> <p>This process included:</p> <p>Phase 1- Review</p> <ul style="list-style-type: none"> • Review of the published and grey literature regarding the health needs and status of Aboriginal and Torres Strait Islander people living in the HNECC PHN region. • Review of the published and grey literature regarding health service provision and access of Aboriginal and Torres Strait Islander people living in the HNECCPHN. • Identification of health programs for Aboriginal and Torres Strait Islander people within the HNECCPHN that have been demonstrated to be effective or are anecdotally considered to be effective. <p>Phase 2 – Quantitative Analysis</p> <ul style="list-style-type: none"> • Identification of all available data about the health of Aboriginal and Torres Strait Islander people in the HNECCPHN (ABS, Medicare, local data) • Identification of questions that should and can be answered using the available data • Critique of the quality of the data about Aboriginal and Torres Strait Islander people used to facilitate health service planning and delivery <p>Phase 3 – Barriers and enablers to healthy living and service access</p> <ul style="list-style-type: none"> • Using a qualitative approach – interviews with Aboriginal and Torres Strait Islander health consumers and service providers about barriers and enablers to healthy living and accessing health services in the HNECCPHN. <p>Phase 4 – Report and recommendations</p>

- Integration of information gathered in phases 1-3 to report on findings and make recommendations about how to improve the health of Aboriginal and Torres Strait Islander people living in HNECCPHN.

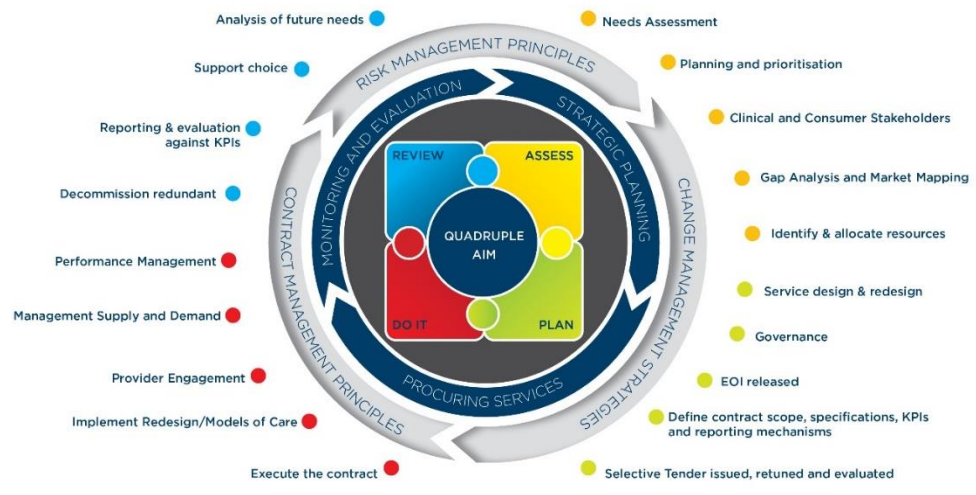
Originally the Needs Analysis was intended to be an internal document however, considerable interest from the Local Health Districts and AMS / ACCHO sector in the document and its contents have resulted in the decision to make the document available publicly when it has been finalised and is in a position to be considered for endorsement by HNECC PHN service providers and the wider community.

Indigenous sector engagement

HNECC PHN meets regularly on a formal and informal basis to engage, seek and provide feedback to Aboriginal Community Controlled Health Organisations and Aboriginal Medical Services sector across the HNECC PHN region. A formalised Engagement strategy is currently under development.

Decision framework documentation

The Commissioning Framework as outlined below is underpinned by a commitment to continuous improvement incorporating ongoing needs and market analysis and incorporation of stakeholder feedback on how ensure the decision making process matches market need with cost effective and quality focussed supply.



The Decision Making Framework incorporates the following critical elements:

- Assessment of EOI applications against specified criteria followed by targeted request for tenders (RFTs)
- Evaluation of RFTs against weighted criteria incorporating an organisational evaluation, program evaluation and price evaluation
- Evaluation panels that include a subject matter expert, a regional expert (knowledge of sub-regional needs) and an independent person (ensuring objectivity of decision making)
 - Guidance notes and an evaluation panel briefing to ensure consistency of practice against established decision making guidelines
- Aboriginal Health Access Team involvement in all stages of the commissioning process to ensure cultural appropriateness of critical activities and maximise commissioning outcomes

	<ul style="list-style-type: none"> • The engagement of a Probity Auditor to oversee the process HNECC has established Clinical Councils and Community Advisory Committees with related Terms of Reference that add to other feedback and engagement mechanisms in place to harvest continuous feedback for the purpose of monitoring effectiveness and efficiency of service delivery and inform future improvements. HNECC’s core business involves the provision of services to and with the Aboriginal community through the commissioning of culturally appropriate quality services. It is therefore critical that HNECC effectively engages the Aboriginal community in order to achieve its vision and purpose. <p>A cost effective Community Engagement and Advisory Model is an important tool to facilitate this process. Furthermore, in addition to capturing input from Clinical Councils and Community Advisory Committees, the HNECC is in the process of strengthening the Aboriginal member numbers within these groups to then form a HNECC Aboriginal Advisory Committee (AAC). The purpose of this group is to provide advice that will inform a coordinated, whole of organisation, whole of HNECC approach to the effective, efficient and culturally safe development and delivery of HNECC services and related systems and policies to Aboriginal people in accordance with the HNECC vision and purpose.</p> <p>The AAC will achieve its purpose by:</p> <ul style="list-style-type: none"> • Providing cultural advice to HNECC in terms of relevant policies and practice • Supporting the development and implementation of a HNECC Reconciliation Action Plan that ensures cultural competence and integrity is embedded in HNECC systems and practices • Monitoring and supporting activities aimed at promoting and communicating HNECC services and reinforcing the HNECC brand • Providing advice on the HNECC Strategic Plan to ensure it meets the needs of Aboriginal people • Representing Aboriginal people and communities and advocating needs on their behalf • Identifying issues and solutions relating to the commissioning and delivery of services • Providing communication and engagement mechanisms for Aboriginal people and communities across the HNECC footprint • Providing a two-way channel of communication with HNECC Community Advisory Committees.
Description of ITC Activity	<p>The HNECC PHN Integrated Team Care program will be delivered in the same way the Care Coordination and Supplementary Service Program has run historically across the region.</p> <p>The main difference between ITC and CCSS is that HNECC PHN has made the decision to return IHPO roles to the PHN (now called Aboriginal Health Access Officers). This decision was made to ensure that Service Providers contracted to deliver the programs across the region and Practitioners Working in mainstream Primary Health were able to access and be supported to ensure they were delivering culturally relevant and appropriate care and access for Aboriginal and Torres Strait Islander patients.</p> <p>The role of the AHAOs is to work strategically with mainstream general practice, service providers and community to ensure the needs of Aboriginal and Torres Strait Islander people are being met and</p>

understood by health care providers and when a need arises or is identified it can be understood and responded to.

In a general sense HNECC PHN's ITC Program is based on four desirable outcomes/ deliverables:

1. Care Coordination activities that focus on developing and measuring improvements in individuals in health system/service navigation, skill and technique acquisition, self-monitoring and health insight, social integration and support. Our standard program of care coordination lasts 12 weeks, however patients may stay on longer if required. This includes face to face assessment and stratification, the development of GP MP and/or Shared Care plan, the implementation of action plans and associated education. Once stable, a follow up assessment is completed and patients will usually transition to Supplementary Services only. If they require further Care Coordination at a later date, they will return to the 12 week program through a GP referral.
2. That we will make progress towards 'closing the gap' through improved collaboration and working relationships between mainstream General Practice, Aboriginal Health Service providers, Local Health Districts and other key stakeholders to assist with an uninterrupted patient journey and inform needs and assessment planning and the development of multi programme approaches and cross sectoral linkages.
3. Focussing on mainstream health services that exist in proximity to Aboriginal communities throughout the region.
4. Providing comprehensive and culturally appropriate access to clinical support and chronic disease management for Aboriginal people.
5. Increasing the uptake of Aboriginal and Torres Strait Islander specific Medicare Benefits Schedule items.
6. Overseeing the ITC workforce including ensuring Indigenous Health Project Officers, Care Coordinators and Outreach Workers receive appropriate ongoing peer support, professional guidance and mentoring.
7. Work with the AMS/ ACCHO sector, Service Providers and General Practices to undertake cultural competency assessments build understanding of the importance of culturally friendly and appropriate care and its importance.
8. Work with general practice to develop culturally appropriate education and referral pathways that are response to the needs of Aboriginal and Torres Strait Islander people.

Cultural Competency

HNECCPHN has a clear intent and responsibility to have strong Aboriginal Cultural standards throughout the organisation, in particular when commissioning of Aboriginal Health services and delivering community

engagement. HNECC PHN Executive and the Aboriginal Health Access team have identified that an organisational cultural competencies audit would provide a solid base line, a future plan and evaluation to ensure the HNECC PHN meets quality cultural competency standards across it's contracted service providers and to inform interactions at an appropriate level with other organisations, services and providers, as well as community.

- An audit will be under taken by an external provider to address:
- The requirement for an initial baseline assessment including all "external" Aboriginal Services
 - A review of current commissioned Aboriginal Health Service Providers
 - Recommendations for inclusion / changes for future commissioning processes

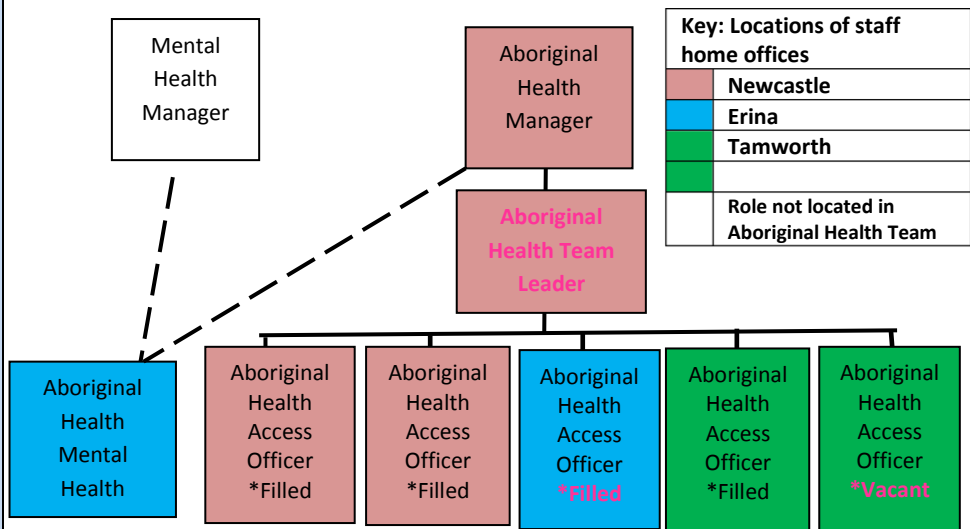
This information will also be utilised to bench mark and identify ways to further increase the cultural competencies of HNECC PHN as a lead agency, general practice and other primary care providers across the HNECC PHN region.

The activity will be procured and executed in the 2017/2018 financial year.

HNECC PHN Health Access Team Staffing Model

The HNECCPHN has previously funded external Indigenous Health Project Officer (IHPO) positions with this ITC funding. After a decision to bring the IHPO funding to the PHN the IHPO positions have been transformed into Aboriginal Health Access Officers who will commence work in line with the new contracts in January 2017. This decision and development of the below staffing structure has been identified to best service the communities needs across the HNECCPHN region.

ITC Workforce



The decision to develop a strong Aboriginal Health Access Team has required a significant commitment from the HNECCPHN from both a human resourcing and financial perspective. This approach highlights the PHN's commitment to Aboriginal Health in the region, and will position the HNECCPHN to deliver positive health outcomes.

The physical office locations of the new Aboriginal Health Access Positions was determined using information collated to inform the Aboriginal Needs Analysis with consideration of existing HNECC Office locations and workforce support for the positions. The HNECC PHN Aboriginal Health Access Officer (AHO) positions are located:

Position Title	HNECC PHN Sub-region	Office Location	FTE	Status
Aboriginal Health Access Manager	All	Newcastle	1 FTE	Commenced December 2016
Aboriginal Health Access Supervisor	TBA	TBA	1 FTE	Recruiting
Aboriginal Mental Health Coordinator	All	Erina	1 FTE	Commenced December 2016
Aboriginal Health Access Officers	Hunter	Newcastle	1 FTE	Commenced January 2017
	Central Coast	Erina	1 FTE	Recruiting
	New England	Tamworth	2 FTE	Commenced January 2017

This significant increase in staffing in the Aboriginal Health Access Team will provide a strong platform to increase engagement with both industry and communities.

The role of HNECC PHN's AHOs will include:

1. Development of new Staffing model to improve industry and community engagement
2. Development of a pilot workforce model project to increase Aboriginal Health Practitioners in communities.

Commissioned Services – Care Coordinators and Outreach Worker Employment.

The roles of the Care Coordinators (CC's) and Outreach Workers (AOW's) will be commissioned to the following external organisations:

	Service Region	Contracted Service Provider	Service Provider Type	Number of Care Coordinators	Number of Outreach Workers
	Central Coast Gosford Wyong	Yerin AMS	Aboriginal Medical Service	3.0FTE Under recruitment	1.0FTE Under recruitment
	Newcastle Port Stephens Upper & Lower Hunter Great Lakes	Hunter Primary Care (HPC)	Mainstream Primary Care organisation	5.9 FTE (7 staff employed)	2.0 FTE (2 staff employed)
	Taree Manning	Biripi AMS	Aboriginal Medical Service	3.0 FTE (4 staff employed)	2.0 FTE (2 staff employed)
	New England & North West	HealthWise	Mainstream Primary Care Organisation	5.3 FTE (7 staff employed)	2.4FTE (5 staff employed)