30/03/2026

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The University of Queensland
Via email acdarr.project@uq.edu.au

Dear Prof Comans,

Aged Care Data and Reporting Review: Clinical, Care Needs, Quality and Service Delivery Data

Thank you for the opportunity to provide feedback on the *Aged Care Data and Reporting Review: Phase 2 Consultation Paper*.

Ageing Australia is the national peak body representing providers across the aged care sector, including retirement living, seniors housing, residential care, home care, community care and related services.

This submission reflects feedback from Ageing Australia members and outlines practical challenges providers face in meeting current data and reporting requirements, including system capability, workforce capacity, interoperability limitations and duplication in reporting. It also identifies opportunities to improve the efficiency, consistency and usefulness of the aged care data ecosystem while supporting the sector's ongoing digital transformation.

Ageing Australia has been supportive of the Aged Care Data and Reporting Review (ACDaRR) and the findings align with the experiences of providers. The administrative and reporting requirements for providers continue to increase, often with little clear value to participants, providers or governments. In addition to the responses to the questions in the consultation paper, we would like it noted that phase one of the review was conducted prior to the commencement of the new *Aged Care Act 2024* on 1 November 2025. The reporting requirements for providers, particularly Support at Home providers, have increased well beyond what was expected. As such, the report is already partly out of date.

We strongly believe there should be a pause in the introduction of any new reporting requirements for the aged care sector while the review is finalised and the recommendations considered.

Summary of recommendations

R1: Prioritise foundational reform by reducing duplication, retiring low-value collections, establishing governance structures, and implementing national data standards before introducing additional reporting requirements.

R2: Ensure a move to person-level clinical data reporting is supported by automated extraction from provider systems using nationally standardised definitions.

R3: Provide clear implementation timelines for including home care providers in the QI Program and adopt a staged approach that initially focuses on non-clinical indicators.

R4: Adopt a staged implementation over 2–3 years to allow time for standards development, system upgrades, sector testing and workforce preparation.

R5: Develop a consistent national framework for clinical and care data in home care, recognising differences in service models and providing sufficient time and support for providers to update systems and data practices.

R6: Progress the national data standardisation in aged care through a coordinated digital strategy that establishes agreed definitions, ensures vendor system readiness, enables API-based reporting, and provides transition funding and implementation support.

R7: Align reporting cycles with existing clinical workflows, such as routine care plan reviews, and progressively move toward automated or near real-time reporting via system integration.

R8: Ensure IAT data is used as a supplementary information source rather than a substitute for provider clinical assessments, and implement mechanisms to improve the timeliness and updating of assessment data before service commencement.

R9: Align aged care clinical and care needs data with national coding systems and interoperability standards, including SNOMED CT-AU for terminology and HL7 FHIR for data exchange.

R10: Adopt staged implementation and invest in national data infrastructure, guidance and provider support to ensure successful implementation.

R11: Establish a national aged care data dictionary that includes authoritative data definitions, mapping to national coding systems, data lineage and transformation rules and version control and change management.

R12: Ensure the data dictionary is centrally governed, publicly accessible and aligned with national digital health frameworks.

R13: Prioritise datasets that directly support care quality and system oversight, including core clinical and functional status data, Quality Indicator measures, care delivery events, medication and polypharmacy data, serious incident reporting, and key AN-ACC funding elements.

R14: Establish a National Aged Care Data Governance Council responsible for oversight of reporting requirements, data standards and sector consultation.

R15: Introduce governance mechanisms including impact assessments before new reporting requirements, sunset reviews to retire low-value data collections, and mandatory sector consultation for data definition changes.

R16: Develop a National Core Aged Care Dataset applicable across residential care and Support at Home that is minimal but comprehensive, standards-aligned, and designed around a "collect once, use many times" principle.

R17: Ensure the core dataset replaces existing reporting requirements rather than adding to them, is stable and version-controlled, and evolves through sector-government agreement.

R18: Implement a national aged care data literacy program to support the transition to structured data, improved reporting and evidence-based care improvement.

R19: Adopt a tiered training framework by leveraging on existing programs (e.g., Sparked) and develop aged-care-specific modules.

R20: Target training to senior leadership, clinical staff, administrative staff, and digital and IT teams.

R21: Fund capability development through government workforce programs, sector partnerships and education provider collaboration.

R22: Strengthen inter-departmental data sharing capability to support integrated care, reduce duplication and enable a holistic view of older people's health and care needs.

R23: Ensure essential datasets include consistent capture of clinical health status, care needs and functional assessments, service delivery events, and quality and safety outcomes.

R24: Develop a national aged care data model that uses standardised data definitions, links clinical, care, service and quality data, supports interoperability across systems, protects privacy and security, and remains adaptable to future policy and clinical changes.

General comments

Ageing Australia supports the Review's objective of improving data quality, consistency and reuse while reducing administrative burden. Strengthening the aged care data system presents an opportunity to improve care outcomes, inform policy and enhance transparency and oversight.

However, future data and reporting arrangements must be purposeful, proportionate and designed to minimise administrative burden while maximising the value of collected data. Importantly, clinical and care data should primarily support care delivery rather than government reporting. Data collection frameworks should therefore prioritise information that improves care planning, risk management and quality improvement, while ensuring reporting requirements strike an appropriate balance that avoids duplicative data entry and additional unfunded administrative burden for providers.

Aged care should also not be treated as a standalone sector. The growing complexity of people's health needs means clinical and care data must align across health data systems to support integrated care for an ageing population with increasing multimorbidity. Alignment across the broader care economy will be essential to support coordinated care pathways and to ensure aged care reforms remain consistent with wider health system reforms.

This alignment is particularly important given many providers operate across aged care, health and disability sectors. New aged care data requirements must therefore align with existing regulatory and reporting frameworks to avoid creating conflicting or duplicative reporting obligations for organisations delivering services across multiple systems.

Key concerns raised by providers include:

- **Extensive duplication in reporting**. Providers report overlapping clinical, care needs, quality and service delivery data across multiple programs and agencies.
- **Collection of low value data**. Data that is not meaningful for providers, residents or government diverts clinical and managerial time away from care delivery and quality improvement.
- **Growing reporting burden**. Reporting requirements have expanded further since 1 November 2025, often without retiring existing requirements or aligning definitions. This creates significant operational pressure, particularly for small, regional and rural providers.
- **Risk of further fragmentation**. Introducing new reporting requirements before this Review is completed risks embedding duplication and low-value data collection.

- **Underutilised automation opportunities**. Automation and data reuse cannot deliver burden reduction while duplication and inconsistent standards persist.

Any reforms to the aged care data system must also align with existing national digital health infrastructure and standards. This includes alignment with national minimum data sets maintained by the Australian Institute of Health and Welfare and interoperability standards such as HL7 FHIR. Ensuring consistency with these national frameworks will protect existing investments in interoperable electronic care records and support more efficient data exchange across the health and care system.

Without addressing these issues first, further reporting changes risk increasing burden and undermining rather than improving system performance.

R1: Prioritise foundational reform by reducing duplication, retiring low-value collections, establishing governance structures, and implementing national data standards before introducing additional reporting requirements.

Ageing Australia's responses to the consultation questions

Person-level clinical data and QI Program alignment

1. *Should QI Program reporting be adjusted to person-level data? Would this increase or decrease the administrative burden on your organisation?*

We believe transitioning the Quality Indicator (QI) Program to person-level data could improve the accuracy, clinical relevance and usefulness of quality reporting. Person-level data would support better risk adjustment, identification of trends in care outcomes and stronger alignment with modern digital health and interoperability standards.

However, the impact on administrative load will depend on implementation. If data can be automatically extracted from provider clinical systems using standardised definitions and interoperable formats, reporting burden could decrease by removing manual aggregation and quarterly reporting processes.

Implementation should therefore prioritise automation, integration with clinical workflows and elimination of duplicate reporting.

With regard to QI for home care, however, we seek clarity on the proposed timing for the inclusion of home care providers in the QI Program. While we support extending quality measurement to home care, implementation should initially prioritise non-clinical indicators that are more aligned with current service delivery models.

Before introducing QIs in the home care sector, improvements are needed in the standardisation of data definitions and collection methods. Members highlighted that (based on past experience) some indicators have been introduced with definitions that do not align well with provider practice, creating additional administrative workload and requiring providers to collect data in ways that are not currently part of routine operations

R2: Ensure a move to person-level clinical data reporting is supported by automated extraction from provider systems using nationally standardised definitions.

R3: Provide clear implementation timelines for including home care providers in the QI Program and adopt a staged approach that initially focuses on non-clinical indicators.

2. *What barriers would need to be addressed, and what timeframe would be realistic for your organisation to report person-level data?*

Several barriers must be addressed before providers can reliably report person-level data.

Clinical and care management systems will require updates to capture and export structured data aligned with national standards, and software vendors will require time to develop and test new functionality. Nationally consistent definitions, coding frameworks and metadata standards will also be required.

Clear governance arrangements are needed to address privacy, consent, data security, de-identification and secondary data use. Workforce training will also be required to support structured and consistent data capture.

Given these requirements, a phased implementation over two to three years would be a realistic timeframe, allowing for standards development, vendor updates, pilot testing and staged rollout.

R4: Adopt staged implementation over 2–3 years to allow time for standards development, system upgrades, sector testing and workforce preparation.

3. What clinical information does providers of in-home care currently collect and how is it used?

Providers delivering in-home care already collect a range of clinical and care-related information to support safe, person-centred care. This typically includes client demographics, care plans, health conditions, functional status, clinical risk indicators, incident reporting and service delivery data.

This information is primarily used for care planning, risk management, coordination between health professionals and monitoring changes in health and functional status. However, much of this information is captured in provider-specific systems and is not consistently standardised for external reporting.

Introducing clinical quality indicators in home care will require careful implementation. Existing systems would require significant updates and providers would need to change data collection practices. While greater consistency in clinical data across aged care is desirable, community services will require significant time and support to achieve this.

R5: Develop a consistent national framework for clinical and care data in home care, recognising differences in service models and providing sufficient time and support for providers to update systems and data practices.

There are differences between QI Program data and local provider quality improvement and clinical governance practices

4. If standardising reported clinical data made the reporting process faster, would the benefits be greater than the costs involved

Ageing Australia believes, a nationally coordinated and digitally enabled approach to data standardisation has the potential to deliver long-term benefits that outweigh transition costs.

Standardisation could reduce administrative burden by enabling automated data extraction from provider systems, eliminating duplicate reporting and improving comparability across services. However, these benefits depend on several critical enablers including nationally agreed definitions, vendor readiness, API capability, transition funding and strong governance.

Without coordinated implementation, there is a risk that standardisation could initially increase reporting burden.

R6: Progress the national data standardisation in aged care through a coordinated digital strategy that establishes agreed definitions, ensures vendor system readiness, enables API-based reporting, and provides transition funding and implementation support.

It is important to acknowledge that increasing standardisation and structured data entry can contribute to clinician burnout and reduced job satisfaction by limiting clinical nuance in documentation. Data standards should therefore be co-designed with clinicians to ensure the right balance between structured reporting and professional clinical judgement, particularly if the sector aims to attract and retain clinical staff in aged care.

5. How could data collection and reporting timeframes be better aligned?

Reporting timeframes could be better aligned with existing clinical and operational processes.

For example, QI reporting could align with routine care review cycles such as monthly or six-weekly care plan reviews. Moving towards automated person-level data submission through API integration would also reduce the need for retrospective quarterly aggregation.

Greater alignment could also be achieved by linking funding and quality data triggers, for example where AN-ACC reassessments update relevant quality indicators automatically. Real-time dashboards would further support continuous monitoring rather than retrospective reporting.

R7: Align reporting cycles with existing clinical workflows, such as routine care plan reviews, and progressively move toward automated or near real-time reporting via system integration.

The IAT and AN-ACC are bespoke assessment tools and are not intended as substitutes for clinical assessments undertaken by the provider for the purposes of care planning

6. Do you see any opportunities for the Department to reuse any of the clinical data collected through IAT or AN-ACC?

While there is potential to reuse data from the Integrated Assessment Tool (IAT), the time lag between assessment and funding allocation often means the information is outdated by the time providers commence services. Given the rapid changes that can occur in an older person’s condition, providers cannot rely on IAT data as a substitute for their own clinical assessments for care planning and risk management. This limitation is further heightened under a multi-provider Support at Home model, where clinical risk and accountability are shared across multiple organisations

R8: Ensure IAT data is used as a supplementary information source rather than a substitute for provider clinical assessments and implement mechanisms to improve the timeliness and updating of assessment data before service commencement.

There are opportunities to standardise aged care clinical, care needs, quality and care delivery data for greater alignment with other care settings

7. Should clinical assessment and care needs data collected in aged care be aligned to clinical code systems and data transfer standards?

Aligning aged care clinical and care needs data with recognised coding systems and interoperability standards would significantly improve the consistency and usability of aged care data.

Standard terminologies such as SNOMED CT-AU and data exchange standards such as HL7 FHIR would enable structured, comparable and machine-readable data across providers, government systems and the broader health system.

This would support better integration between aged care, primary care and hospitals, reduce duplication of assessments and strengthen the analytical value of aged care data for care planning, policy development and system oversight.

Implementation should be staged and supported by appropriate sector capability building.

R9: Align aged care clinical and care needs data with national coding systems and interoperability standards, including SNOMED CT-AU for terminology and HL7 FHIR for data exchange.

However and where possible, aged care should build on existing healthcare clinical terminology standards, using established resources such as the National Clinical Terminology Service, as the starting point.

8. If yes, what impact might this have on reporting clinical data, e.g. quality indicators, to Government?

Aligning clinical data with recognised coding systems and interoperability standards would substantially improve the efficiency and accuracy of reporting to government. Standardised data structures would enable more automated extraction and submission of data from provider clinical systems, reducing the need for manual aggregation, interpretation or reformatting of information for reporting purposes.

Over time, this could enable a shift from periodic, retrospective reporting toward more automated and near real-time reporting of quality indicators and other regulatory datasets. Quality indicators could be derived directly from structured clinical data already captured during routine care and assessments, improving both timeliness and reliability.

For government, this would support more robust system monitoring, improved benchmarking across providers and the ability to undertake more sophisticated analytics to inform policy, funding and quality improvement initiatives.

However, the transition would also require careful implementation to avoid increasing reporting burden during the early stages. System upgrades, mapping of existing data fields to standard terminologies, and clear national data definitions would be required. Government investment in national data infrastructure, guidance and provider support would be essential to ensure successful implementation.

R10: Adopt staged implementation and invest in national data infrastructure, guidance and provider support to ensure successful implementation.

9. To what extent could your organisation align its internally collected and externally reported clinical data with data standards? What barriers would need to be addressed, and what timeframe would be realistic?

Many providers already collect clinical information electronically, but the ability to align with national standards will depend on system capability, vendor readiness and sector support.

Key barriers include limitations in existing care management systems, the cost of system upgrades, and workforce capability to move from narrative documentation to structured data capture. Clear national definitions and strong governance will also be required to ensure consistency.

A phased implementation over three to five years would be a realistic timeframe, beginning with priority datasets such as assessments, care plans and quality indicators.

10. What should an aged care data dictionary consider when including clinical, care needs or quality indicator data items?

We believe an aged care data dictionary should establish authoritative definitions for data elements to ensure consistency across the sector. It should document data lineage, transformation rules and include robust version control and change management processes.

The dictionary should map data elements to recognised coding systems and align with key national frameworks including AN-ACC, the Integrated Assessment Tool and Quality Indicator measures. It should also include metadata covering collection methods, timing and validation rules.

To be effective, the data dictionary should be centrally governed and publicly accessible.

R11: Establish a national aged care data dictionary that includes authoritative data definitions, mapping to national coding systems, data lineage and transformation rules and version control and change management.

R12: Ensure the data dictionary is centrally governed, publicly accessible and aligned with national digital health frameworks.

10. What data sets would you want prioritised for the data dictionary?

Ageing Australia believes priority datasets should focus on information that supports care quality and system oversight. This includes core clinical and functional status data, QI measures and care delivery events such as service episodes.

Medication and polypharmacy indicators, serious incident data and key AN-ACC funding elements should also be prioritised to ensure alignment between clinical information, care needs and funding arrangements.

R13: Prioritise datasets that directly support care quality and system oversight, including core clinical and functional status data, Quality Indicator measures, care delivery events, medication and polypharmacy data, serious incident reporting, and key AN-ACC funding elements.

Enablers for data improvement

Data Governance

11· How would you expand the recommendation for a formal governance process for aged care reporting in the context of clinical, care needs, quality and service delivery data?

Ageing Australia believes expanding formal governance for aged care reporting should involve establishing a National Aged Care Data Governance Council and clearly defining custodianship for each dataset. Governance processes should include impact assessments prior to introducing new reporting requirements, sunset review mechanisms to retire outdated measures, and mandatory consultation before making changes to data definitions.

Additionally, these structures should be aligned with existing digital health governance frameworks to ensure consistency and interoperability.

R14: Establish a National Aged Care Data Governance Council responsible for oversight of reporting requirements, data standards and sector consultation.

R15: Introduce governance mechanisms including impact assessments before new reporting requirements, sunset reviews to retire low-value data collections, and mandatory sector consultation for data definition changes.

12· Should a common set of clinical, care needs, quality and service delivery data items be agreed across the aged care program?

Ageing Australia believes strongly that a National Core Aged Care Dataset should be established, applying consistently across both residential care and Support at Home services.

It should be minimal yet comprehensive, aligned with recognised data standards, and designed to enable a "collect once, use many times" approach, reducing duplication and improving efficiency in data collection and use.

Providers will benefit if the dataset is stable, version-controlled and replaces existing reporting requirements rather than adding to them.

R16: Develop a National Core Aged Care Dataset applicable across residential care and Support at Home that is minimal but comprehensive, standards-aligned, and designed around a "collect once, use many times" principle.

13· Would you benefit from having a core set of data items that is collected and agreed to by aged care providers? This core set of items may be amended through mutual agreement to meet sector changes. It could be added to or decreased as a need arises.

Providers will benefit from a core agreed dataset if it reduces duplication, is stable and version-controlled, and any changes are negotiated with the sector. Importantly, it should replace existing reporting requirements rather than add to them, streamlining data collection and easing the administrative burden on providers.

R17: Ensure the core dataset replaces existing reporting requirements rather than adding to them, is stable and version-controlled, and evolves through sector-government agreement.

Data and digital literacy

14· Do you think there is a need to improve data literacy in the aged care sector?

Improving data literacy across the aged care sector is critical to enable providers to effectively collect, interpret and use data to improve care quality and operational performance.

While providers already collect significant data electronically, capability gaps remain in areas such as data standards, analytics and translating data into actionable insights.

Strengthening data literacy will also support alignment with national standards and enable providers to participate more effectively in benchmarking and reporting initiatives.

R18: Implement a national aged care data literacy program to support the transition to structured data, improved reporting and evidence-based care improvement.

15· If yes, what form of training should this take? Initially and ongoing? Leverage existing training available or consider developing new targeted training?

Training should include both foundational and advanced components.

Initial training should focus on digital and data literacy, including data standards, structured data capture and interpretation of quality indicators. Ongoing training should build capability in analytics, data visualisation, interoperability and clinical informatics.

Where possible, training should leverage existing initiatives such as Sparked while developing aged care-specific modules. A blended approach combining online learning, workshops and practical application would support effective implementation

R19: Adopt a tiered training framework by leveraging on existing programs (e.g., Sparked) and develop aged-care-specific modules.

16· What groups would benefit most from training? What options may exist for funding ongoing training?

Senior leadership, clinical staff, administrative staff and IT teams would all benefit from targeted data literacy training.

Leadership requires skills to use data strategically, clinical staff need training to support accurate documentation and quality improvement, administrative staff support reporting and compliance, and digital teams enable system integration.

Funding could be supported through government workforce development programs, sector-led initiatives and partnerships with universities, training providers and technology vendors.

R20: Target training to senior leadership, clinical staff, administrative staff, and digital and IT teams.

R21: Fund capability development through government workforce programs, sector partnerships and education provider collaboration.

Data sharing

17· Do you consider data sharing capability between different programs and departments to be important in delivering high-quality clinical care?

Data sharing capability is critically important for delivering high-quality clinical care. Seamless exchange of information between programs and departments supports coordinated care, reduces duplication, prevents errors, and ensures that clinicians have timely access to accurate patient information.

Effective data sharing enables a holistic view of each older person’s health and care needs, supporting better decision-making and more personalised, responsive care.

R22: Strengthen inter-departmental data sharing capability to support integrated care, reduce duplication and enable a holistic view of older people’s health and care needs.

18· Which clinical, care needs, service delivery and quality data items would you consider most essential to improving care delivery for older people in residential and Support at Home?

Key clinical and health status data include diagnoses, medications, allergies, vital signs, functional and cognitive assessments, and care plans. Essential care needs data covers activities of daily living (ADL), mobility, nutrition, continence, and social or psychological support requirements. Service delivery information, such as care episodes, interventions, staff assignments, frequency of care, and outcomes, is also critical to ensure coordinated and effective care.

Equally important is the collection of quality and safety data, including adverse events, falls, pressure injuries, hospital transfers, serious incidents, and national quality indicator measures. Consistently capturing and sharing these data items allows providers to monitor care quality, identify risks early, tailor interventions to individual needs, and drive continuous improvement in outcomes for older Australians.

R23: Ensure essential datasets include consistent capture of clinical health status, care needs and functional assessments, service delivery events, and quality and safety outcomes.

A data model for aged care

19· What should such a model consider when including clinical, care needs, service delivery and quality data items?

A model that includes clinical, care needs, service delivery, and quality data items should consider several key factors to ensure it effectively supports high-quality care. It should provide clear, standardised definitions for each data item, enabling consistency across providers and systems.

The model should capture data that is relevant, actionable, and linked to both individual care outcomes and broader quality indicators. It must support interoperability, allowing seamless data sharing between programs, departments, and digital systems, while maintaining privacy and security. Additionally, it should allow for timely and accurate collection, reflect the full spectrum of a person's care needs, and be adaptable to evolving clinical practices, funding frameworks, and regulatory requirements.

R24: Develop a national aged care data model that uses standardised data definitions, links clinical, care, service and quality data, supports interoperability across systems, protects privacy and security, and remains adaptable to future policy and clinical changes.

Conclusion

The Phase 2 Consultation Paper provides an important opportunity to reset the aged care data and reporting system.

However, the key risk to success is not insufficient ambition but insufficient sequencing of reform. Until duplication is reduced, low-value data retired and foundational governance and standards established, introducing further reporting changes risks increasing burden and undermining confidence in reform.

A pause on new reporting requirements while this foundational work is completed would demonstrate a genuine commitment to system-level reform rather than incremental expansion.

It is also important to note that Phase 1 consultation occurred prior to 1 November 2025, and subsequent changes to reporting requirements mean earlier assumptions should be revisited.

Yours sincerely,

Nick Elmitt
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