Aged Care Data and Reporting Review Project: Phase 2 Consultation Paper

The Department of Health, Disability and Ageing (the Department) initiated a comprehensive review of data that aged care providers report to the Australian Government in early 2025. The Department engaged The University of Queensland (UQ), in partnership with the National Ageing Research Institute (NARI), to conduct this review. This project aims to guide improvements in the scope, quality, consistency and utility of aged care data – to enable improved care outcomes, timely monitoring of care quality, systems interoperability to support continuity of care, and streamline reporting to reduce administrative burden.

The Royal Commission into Aged Care Quality and Safety noted the importance of data quality and the need for comprehensive data to assess the performance and impact of services provided to older people. This Review contributes to the Department's response.

Phase 1 of this project (April to November 2025) reviewed both the financial and workforce data aged care providers report to the Australian Government. Phase 2 (July 2025 to May 2026) is reviewing clinical, care needs, quality, and service delivery information.

Purpose of consultation

The review team has conducted an environmental scan of the policy, strategic, regulatory and operational imperatives that drive the collection of data in scope for Phase 2. The scan includes a review of international approaches to collection, reporting to government and system-wide use of clinical, care needs, quality and service delivery information in aged care. Insights from the environmental scan have been summarised in this paper and have guided the concepts and questions that will support consultation with providers, vendors and aged care workers through online forums, meetings and written submissions.

The purpose of the current consultation process is to develop a deeper understanding and to test solutions with key stakeholders about ways to improve the collection and reporting of aged care clinical, care needs, quality and service delivery information.

Through extensive consultation, we aim to:

- gain additional insights on the aged care data ecosystem (including governance mechanisms) and validate findings from the environmental scan.
- consolidate current and emerging information needs across stakeholders, aligned to system builds and reforms.
- identify and validate opportunities to streamline and standardise data collection, provision and reporting based on the principle of "collect once, use many times."

How to have your say

Online forums – open registration

We are hosting consultation forums tailored to different stakeholder groups in March 2026, including aged care service providers, software vendors, and health professionals working in aged care. All forums will be 90 minutes in duration and the concepts discussed will be consistent throughout the consultation process. More detailed or targeted questions may also be explored with specific audiences. Forums will be particularly relevant for clinicians, clinical managers, quality managers and business analysts.

11 Mar 2026 11.30 am AEDT	Residential aged care provider forum REGISTER HERE	24 Mar 2026 1 pm AEDT	Residential aged care provider forum REGISTER HERE
12 Mar 2026 2 pm AEDT	In-home care provider forum REGISTER HERE	18 Mar 2026 11.30 am AEDT	In-home care provider forum REGISTER HERE
17 Mar 2026 11.30 am AEDT	Software vendors forum REGISTER HERE	25 Mar 2026 12.30 pm AEDT	Software vendors forum REGISTER HERE

Targeted meetings

We will also run targeted forums with key sector organisations. If your peak or advocacy organisation would like to request a targeted meeting, please contact acdarr.project@uq.edu.au

Written submissions

Written submissions are welcome and can be submitted via an online survey accessed through the portal **here.** Alternatively, please directly email your submission to: acdarr.project@uq.edu.au.

You may wish to reflect on data usage, reporting challenges, opportunities for improvement, or broader system-level considerations. Submissions will be treated as confidential and suitably deidentified prior to being incorporated into project materials.

Written submissions will be accepted from **25 February to 30 March 2026**.

About the Environmental Scan

An environmental scan was conducted of the Australian policy, strategic and regulatory imperatives that drive clinical, care needs, quality and service delivery data collection – **see Appendix 1** for a list of the data items in scope for Phase 2. The scan included a review of international approaches, as well as the mechanisms used to capture and transfer data between providers and government, and within government (see **Appendices 2 and 3**).

Policy context

A range of legislation, contractual obligations, regulatory requirements, policies and strategic plans determine the clinical, care needs, quality, and care delivery data the aged care sector is required to report to government.

The Secretary of the Department of Health, Disability and Ageing is the System Governor of the aged care sector, but other government departments and agencies also play a key role in administering, funding and regulating aged care, including the Department of Social Services, Services Australia, the Department of Veterans' Affairs, the National Disability Insurance Agency and the Australian Taxation Office.

The Aged Care Data and Digital Strategy 2024-2029[1] sets the national direction for how aged care information will be structured, governed and shared across the sector, with a clear shift away from fragmented program-by program reporting toward a coherent national data architecture. Priorities under the strategy are directly linked to this review, including strengthening care connections, improving security and access control, optimising data collection and utilisation, and building and embedding data and digital maturity.

The extensive program of reforms following the Royal Commission into Aged Care Quality and Safety has improved the amount of clinical, care needs, quality and care delivery information reported to government by the aged care sector. Phase 2 of this review considered relevant data elements from:

- the Serious Incident Response Scheme.
- the Integrated Assessment Tool.
- Residential aged care funding assessments.
- Star Ratings for residential aged care.
- the National Aged Care Quality Indicator (QI) Program.

The review also considered the drivers for collection of data items in the above programs and tools, as well as the planned inclusion of clinical and care needs data items in future versions of the Aged Care National Minimum Data Set.

The *Aged Care Act 2024* impacted the type and amount of data available to government about the Australian aged care sector. Changes to reporting arising from the Act were considered in Phase 2, including those related to Support at Home, the strengthened Aged Care Quality Standards, changes to provider registration and accountabilities, and amendments to the Healthcare Identifiers Act that expand the scope health professionals eligible for a Healthcare Provider Identifier and create Health Administration Entities to support the delivery and monitoring of health services.

Recent reviews

It is important to acknowledge that clinical, care needs, quality and care delivery data in aged care has been the focus of several recent reviews and reports in Australia. The Australian aged care data landscape report[2], released by CSIRO and the Digital Health Cooperative Research Centre in March 2025, included desktop research and interviews with key stakeholders. The report provided

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[1] Aged Care Data and Digital Strategy 2024-2029

[2] The Australian aged care data landscape report: Gaps, opportunities and future directions

a comprehensive summary of data flows in aged care, from point of collection through to submission to government, including data collected outside of aged care settings (e.g. hospitals, primary health care). Key recommendations included promoting common data languages with adequate support for adopting standards, leveraging existing programs, and focusing on interoperability between the aged care and healthcare systems. The key challenges and opportunities identified regarding data standards and systems interoperability in the aged care sector informed this review.

A feasibility assessment for implementing a standardised clinical assessment system in Australia[3] was completed in March 2025. The assessment identified a number of core factors required for establishing successful data interoperability in aged care in Australia, including integration with existing systems, centralised data storage, training and workforce development, government leadership and stakeholder engagement, emphasis on data reuse, and consumer access and transparency.

CSIRO's Australian eHealth Research Centre (AEHRC), as part of the Sparked partnership of the Department of Health, Disability and Ageing, the Australian Digital Health Agency (ADHA), and HL7 Australia (HL7 AU) promotes the development, management and ongoing support of the Fast Healthcare Interoperability Resources (FHIR) standards for healthcare data exchange. The Sparked program brings together stakeholders across the healthcare ecosystem to drive the development and adoption of nationally prioritised FHIR standards. Over a three-year period, the initiative aims to deliver a core set of FHIR standards for use in Australian healthcare settings.

The Aged Care Data and Reporting Review Project team is working in close collaboration with the Department, ADHA, AIHW, CSIRO and the Digital Health CRC to draw upon and integrate these programs of work into the findings and recommendations of the project.

Key findings

The Environmental Scan includes 5 key findings about the clinical, care needs, quality and care delivery information reported to the Australian Government. Each of these findings led to the identification of opportunities to improve the quality, consistency and interoperability of the aged care data ecosystem. Findings include:

- There are differences between aggregate Quality Indicator data reported to the Department and person-level clinical data collected and held by residential aged care providers.
- Local quality improvement and clinical governance practices conducted by residential aged care providers may require different and/or additional data than that required by the Quality Indicator program.
- The IAT and AN-ACC are bespoke assessments not intended as a substitute for clinical assessments undertaken by the provider for the purposes of care planning.
- The format of clinical, care needs, quality and care delivery data for aged care is generally not aligned to other care settings or international approaches.
- Data governance and data and digital literacy are key enablers of a transition to better use and reuse of data.

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[3] Digital Health CRC: interRAI Implementation Feasibility Analysis

Person-level clinical data in residential aged care is not aligned to data reported to the QI Program

Information on the quality of care (e.g. QI Program measures) is reported to the Department by residential aged care services each quarter. Providers review local records and conduct specific assessments to collect the information required for QI Program reporting, with aggregate service-level information reported, i.e. as a percentage of all residents.

The Environmental Scan identified differences in the data items reported for the QI Program and those collected and used by residential aged care homes to identify the current and changing clinical and functional status of individuals, inform care planning, document the care delivered and to monitor the quality of care delivered to older people. Differences include those relating to:

- the way some items are defined and/or classified (e.g. activities of daily living).
- the timing of routine assessments and the measurement periods specified by the QI Program.
- the granularity of data collected and reported (e.g. individual-level data is used for daily care and to calculate QI data, but QI data is reported at the service level).

These differences also arise between providers and between care settings (i.e. quality measures are not currently reported to the Department by providers of in-home care). This lack of consistency limits the utility of this data for quality improvement initiatives, continuity of care as older people move between care settings, and analysis and planning by government.

The Environmental Scan identified two opportunities to improve clinical data reporting:

1. Adopt the reporting of **person-level data to the QI Program** to enable reuse for other purposes such as system planning, needs assessment, calculation of additional QIs, tracking progress over time, and data sharing - without contributing to data burden.
2. Explore options to reach agreement on a **set of clinical data items** that should be collected by providers of **in-home care**. The Support at Home Program (and the future transition of CHSP) are likely to increase the importance of care-quality visibility for in-home care for consumers and government.

Consultation questions

- Should QI Program reporting be adjusted to person-level data? Would this increase or decrease the administrative burden on your organisation?
- What barriers would need to be addressed, and what timeframe would be realistic for your organisation to report person-level data?
- What clinical information do providers of in-home care currently collect and how is it used?

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

The QI program data differs from the information residential aged care services may use to monitor the quality of the care they deliver. Providers use information from the assessments they conduct to monitor the indicators of interest or that are of particular concern – some of which differ to those included in the QI Program. QI data is compiled by the Department and published for providers to compare their performance against the rest of the sector, but local **clinical data reporting cycles**

may differ from QI Program reporting timeframes, reducing the utility of the QI data for continuous improvement efforts.

It was also noted during the Environmental Scan that QIs are reported by residential aged care services each quarter, but similar information is not reported by providers of in-home services. The introduction of the Support at Home Program in November 2025, and the future transition of CHSP, are likely to increase the importance of care-quality visibility in home care for consumers and government.

Consultation questions

- If standardising reported clinical data made the reporting process faster, would the benefits be greater than the costs involved?
- Can you share any thoughts about how the data collection and reporting timeframes could be better aligned?

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

The majority of information available to the Australian Government about the clinical and care needs of older people is collected by independent assessors at the time of eligibility and funding assessments through the Single Assessment System. The assessment instruments (e.g. Integrated Assessment Tool (IAT) and Australian National Aged Care Classification (AN-ACC)) incorporate clinical tools, some of which are already standardised in digital health systems. This includes the GP-COG in the IAT and the Braden Scale for Predicting Pressure Sore Risk in the AN-ACC.

It is noted that the IAT and AN-ACC tools use different data items to characterise similar concepts, and assessments are conducted at the point of entry into aged care or when care needs change triggering a reassessment for services and/or funding. The data collected in these assessments are not currently reused for any other purpose. They may also be out of date, unless the provider has requested a re-assessment.

Consultation question

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

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

Data standards are foundational for seamless data exchange between systems, improving data quality, reducing administrative burden (“collect once, use many times” principle) and supporting better decision-making across clinical settings. Data standards development and implementation is less advanced in aged care than in other care settings (e.g. hospitals). Descriptions and examples of data standards are provided **in Appendix 4**.

The Royal Commission into Aged Care Quality and Safety highlighted the role quality data can play in understanding and monitoring the sector, and this is reflected in the Aged Care Data and Digital Strategy. The anticipated benefits of implementing aged care data standards include:

- An increase in **data quality**, through agreement of components such as definitions.
- Agreement to collect and provide **standardised data** across the sector.
- Reduced administrative burden on data suppliers.
- Enabling **comparability** between datasets within aged care.
- Enabling **automation** of information flows across the sector, resulting in faster information flows.
- Enabling **search** and electronic information templates within systems to order and highlight the most salient information for a given user.

In other parts of the Australian health system, providers are required to use specified clinical assessments or systems to support care planning and delivery. This includes electronic health records in acute and primary care. Integrated aged care reporting systems are operating in some comparable international jurisdictions.

Some clinical assessment systems use standardised data items to build scales and screening tools that interpret data to support clinical or administrative decisions, though these are not widely implemented in Australia. These data items can be mapped to content standards, code systems, and data exchange standards. Internationally, a range of data standards and assessment systems are used to support interoperable reporting and sharing of care data. These include MDS 3.0, LOINC, HL7 FHIR, and interRAI Assessment Systems (see Appendix 2). These standards primarily enable the exchange of clinical, functional, cognitive, and psychosocial data.

The Environmental Scan identified the possibility of **harmonising clinical and care needs assessments and QIs with agreed data standards:** clinical standards (e.g. SNOMED-CT, ICF), and interoperability (data exchange) standards (e.g. FHIR).

Consultation questions

- Should clinical assessment and care needs data collected in aged care be aligned to clinical code systems and data transfer standards?
- If yes, what impact might this have on reporting clinical data, e.g. quality indicators, to Government?
- 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?

Implementation of data standards (in particular, content standards) requires definitions to be consistently applied across care settings. Definitions for aged care data items reported to the Australian Government are currently found in program manuals, instrument-specific data definitions documents, user guides, templates and websites. The disparate locations in which data definitions are published and maintained can lead to misaligned definitions for similar data items among reports. This creates confusion for providers, who may need to re-process data extraction systems to align with the varying definitions.

Further, information provided in definitions is often limited and does not always include sufficient detail for reuse. To remedy the risk of poor data quality through disparate supporting information, an end-to-end data process of collection, processing, edits and outputs is required.

Phase 1 of this Review recommended **establishing an aged care data dictionary** that includes a single definition for all data items reported to the Department. Definitions should include supporting information that aids interpretation by providers during data collection, collation and reporting.

Consultation questions

- What should an aged care data dictionary consider when including clinical, care needs or quality indicator data items?
- What data sets would you want prioritised for the data dictionary?

Enablers for data improvement

Data governance

The data in scope for Phase 2 is submitted to several government departments through a range of systems and portals. In many cases, data is submitted to support a specific function, such as eligibility for care, monitoring of quality of care, and reimbursement for services delivered.

Governance and decision-making processes about the data items to be included in aged care reporting instruments are federated, with no single process or body accountable for evaluating the suitability and necessity of data items to be reported. The Department has established data custodianship and governance structures related to the data security. This level of rigour should also be applied to data-collection decisions.

Phase 1 of the Aged Care Data and Reporting Review Project recommended strengthening a **formal governance process for aged care reporting requirements** that supports the long-term vision of data collection and reporting that is standards-based, streamlined, consistent, responsive and reliable.

Consultation questions

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

Data and digital literacy are key enablers of a transition to better use and reuse of data

The Environmental Scan identified varying degrees of data literacy across the sector and that a number of organisations, such as CSIRO's Sparked Initiative, are providing training to support increased literacy in the health and aged care sectors. Lower levels of data literacy may limit the ability of some providers to leverage technology effectively.

Consultation questions

- Do you think there is a need to improve data literacy in the aged care sector?
- If yes, what form of training should this take? Initially and ongoing? Leverage existing training available or consider developing new targeted training?
- What groups would benefit most from training? What options may exist for funding ongoing training?

Data sharing between Australian Government departments

Some clinical data is reported to other programs and government departments outside the aged care program, such as the NDIA. The scan identified alignment with the principles in the Aged Care Data and Digital Strategy, specifically to "collect once, use many times" and an opportunity to harmonise data reported to aged care programs with NDIA and the DVA data.

Consultation questions

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

A data model for aged care

Phase 1 of the Aged Care Data and Reporting Review Project identified that multiple government platforms are used by aged care providers to report financial and workforce information to government. This is also true for clinical, care-needs, care-quality and care-delivery data. Each system has its own data model, with data objects, entities and items mapped in ways that support system operation. To date, systems' data models have largely driven the way data items are defined, related and collected. There are significant costs involved in managing these complexities in the current data ecosystem. The absence of an overarching framework to guide aged care data collection may limit the Australian Government's ability to identify and act on opportunities for automation and data reuse over time, consistent with the Aged Care Data and Digital Strategy 2024-29.

A key recommendation from Phase 1 was to **develop a data model for aged care data** that is systems-agnostic, business-focused, standardises vocabulary, clarifies entity relationships and is governance-ready. Just as the GPMS2.0 Conceptual Data Model provides a shared, high-level understanding of care data, requirements and supports governance for a specific system, a data model for aged care would support consistent data definitions and underpin interoperability across systems. It would also enable streamlined reporting to government by aligning data capture with required metrics (e.g. B2G APIs) while remaining flexible enough to accommodate both residential and home care settings.

Consultation question

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

Appendix 1: Scope of Phase 2 data

Phase 2 of the Aged Care Data and Reporting Review Project focuses on clinical, care needs, quality and care delivery information about the aged care sector.

Clinical information includes information related to a resident's and client's medical history, diagnoses, treatments, medications, and clinical observations on functional and psychosocial status.

Care needs information includes functional needs (e.g. activities of daily living, cognition), social support and psychosocial needs, including the information self-reported by older people through My Aged Care or collected by independent assessors using the Integrated Assessment Tool or Australian National Aged Care Classification assessment.

Quality information includes quality indicators reported to government (including the National Aged Care Quality Indicator Program measures). The Environmental Scan did not review information collected as part of routine care, even if it is used to support QI reporting. Note, the data cannot always be derived from local systems, requires manual collection, collation and reporting, and is only available for residential aged care settings.

Care delivery data includes information reported to government about the services delivered to older people, including claims information submitted to Services Australia.

Appendix 2: International use of data standards

Table 1. Summary of data standards, by type, used to support Phase 2 data reporting in selected jurisdictions in home or residential aged care

Type	Australia	New Zealand	Canada	Singapore	USA	United Kingdom	France
Content and terminology standards							
Clinical assessment	interRAI assessments in limited use in Australia but not mandated	interRAI Assessment Systems (HC, LTCF, QoL)	interRAI Assessment Systems (HC, LTCF, MH, QoL)	interRAI assessment systems being introduced	MDS 3.0 (incl interRAI items)	interRAI assessment systems being introduced in Ireland	Not found
MDS	Aged Care NMDS	Not found	RAI-MDS 2.0	Not found	MDS 3.0	Not found	Not found
Clinical terminology	Not found	Not found	ICD-10-CA	Not found	ICD-10	Not found	Not found
Clinical terminology	Not found	Not found	SNOMED-CT	Not found	SNOMED-CT	Not found	Not found
Clinical terminology	Not found	Not found	LOINC and UCUM	Not found	Not found	Not found	Not found
Structure standards							
Metadata standards	METEOR (based on ISO/IEC 11179)	Not found	Not found	METEOR (based on ISO/IEC 11179)	Not found	Not found	Not found
Exchange and technology standards							
FHIR	HL7 FHIR	Not found	HL7 FHIR	Not found	Not found	Not found	Not found
API	B2G APIs	Not found	REST APIs	Not found	Not found	Not found	Not found
Other	Aged Care Clinical Information Standards	Not found	Not found	Not found	PDPM Grouper JAR Packages	Not found	Not found

Not found = no evidence of widespread use in aged care was identified during the review, ACCIS = Aged Care Clinical Information Standards; CHA = interRAI Community Health Assessment; FHIR = Fast Healthcare Interoperability Resources; HC = interRAI Home Care; LOINC = Logical Observation Identifiers Names and Codes; LTCF = interRAI Long Term Care Facilities; MH = interRAI Mental Health; METEOR = Metadata Online Registry; NMDS = National Minimum Data Set; QoL = interRAI Quality of Life; ROSA = Registry of Senior Australians; SNOMED CT = Systematized Nomenclature of Medicine – Clinical Terms; UCUM = Unified Code for Units of Measure.

Appendix 3: Reporting summary

Table 2 presents a summary of data transfers between DHDA and other government departments. It is intended to offer a broad overview of the reporting landscape and does not capture every possible reporting pathway or variation. An overarching purpose of government reporting requirements is to support transparency and accountability with both the care services delivered to older people and the taxpayer funds used to deliver them. The table highlights the functional alignment between reporting objectives and the platforms used and illustrates the complexity that providers navigate in meeting regulatory and operational requirements.

Table 2. Summary of data transfers between DHDA and other government departments

Data type	Data types	From		To*		Mechanism	Frequency	Purpose
		System	Dept	System	Dept			
Client personal details	Medicare number, demographics.	MAC Online Account MAC Online Account	DHDA Services Australia	ACG ACG	DHDA DHDA	MAC Online Account .NET MAC Contact Centre Portal	At least daily	Generate MAC ID, register for care
Client Identifier (My Aged Care ID)	Name, date of birth, address, MAC client ID	MAC (Client)	DHDA	ACMPS	Services Australia	Client Registration Service	At least daily	To allow Services Australia to link individuals across systems and enable data sharing.
Means test outcome / funding decision	Outcome of income & assets assessment, identifying information.	Centrelink to ACMPS	Services Australia	MAC	DHDA	Interface	At least daily	To confirm individual eligibility for government-subsidised care.
IAT and AN-ACC data items	Responses to assessment items	MAC Aged Care Assessor app	DHDA	ACG	DHDA	Interface	At least daily*	Communicate care needs of older person based on assessment
IAT and AN-ACC outcomes	Approved package level and referral codes	ACG	DHDA	MAC Website ACMPS	DHDA Services Australia	MAC OA and MAC SSP .NET Interface	At least daily	Communicate outcome of assessment to inform provider selection and funding allocation
Provider registration data	Provider name, MAC Provider ID, address, services offered, accreditation status.	MACSSP (ACG)	DHDA	GPMS ACMPS	DHDA Services Australia	Interface	At least daily	Advise Services Australia that a provider is eligible to receive payment for particular services.
Entry to care	Provider ID, Client ID, services registered	MACSSP (ACG)	DHDA	GPMS ACMPS	DHDA Services Australia	Entry/Exit interface	At least daily	To associate a care recipient with a provider

Data type	Data types	From		To*		Mechanism	Frequency	Purpose
		System	Dept	System	Dept			
Exit from care	Provider ID, Client ID, reason for exit	MACSSP (ACG)	DHDA	GPMS ACMPS	DHDA Services Australia	Entry/Exit interface	At least daily	To disconnect a care recipient and provider.
Detail of services provided – residential and Support at Home	Provider ID, Client ID, service type ID, date.	ACMPS (ACPP)	Services Australia	ACDW	DHDA	Interface	At least daily	To claim subsidy payments from the government.
Details of services provided – CHSP	Provider ID, Client ID, service type ID, date.	GPS (CHSP only)	DSS	ACDW	DHDA	DEX	Daily	To claim subsidy payments from the government.
Details of clients and services provided – MPS	Demographics, dementia status, date of commencement, waitlist, service types, count of clients	Qualtrics survey	DHDA	-	-		Annually	To satisfy reporting requirements and support care planning
Details of services provided – NATSIFAC	Client numbers, cultural events, allied health visits	Grants Management System	DSS	ACDW	DHDA	DEX	Bi-annually	To satisfy reporting requirements and support care planning
Quality indicator data	QI Program indicator data	GPMS	DHDA	RBTIS HDP	ACQSC AIHW	Qlik app Transfer of data	Quarterly	To satisfy reporting requirements and support monitoring of care quality, and for providing data to AIHW for the purposes of public reporting
Serious incidents and responses	Details of priority 1 and priority 2 incidents and the provider's response.	MAC SSP	DHDA	ACRES	ACQSC	SIRS portal	At least daily	To notify ACQSC of reported serious incidents.
Clinical and business practices and processes	Compliance with Aged Care Quality Standards	Digital Audit Tool ACRES	ACQSC	ACDW (compliance data only)	DHDA	Interface	tbc	To inform calculation of the Compliance rating and advise DHDA of non-compliant providers

* While the Department receives some data on a daily basis, it may only become available for reporting or potential reuse at longer intervals, such as on a biweekly basis

Appendix 4: Data standards and examples

Table 3. Data standards, usage and examples

Type	Use	Details	Examples
Content standards	Data creation	Set out an agreed-upon and documented way of defining a health-related concept. They should contain precise information about how to collect data elements such that they are computable, replicable, reusable and interoperable. Content standards are foundational to the health data system. They must be applied to allow for the creation of usable data, or none of the uses and actions below are possible.	Clinical care and administrative data (e.g. admission date, diagnosis, workload). Population data for socio-demographic indicators (e.g. sex, gender). Population health (e.g. self-perceived health status, access to care). Determinants of health (e.g. income, housing). Data quality.
Code systems	Data formatting	Represent related concepts; the code sets and/or formats to which the data must adhere.	Classification systems, clinical reference terminologies and value sets (e.g. ICD-10-CA, CCI, SNOMED CT, Health Utilities Index Mark 3 (HUI3), Low Income Measure (LIM) Thresholds). Clinical documentation standards. International standards (e.g. DSM-5, Dietary Reference Intakes).
Information standards	Data analysis	Turn data into the information that the health system requires (standards for indicators, methodologies for reporting purposes).	Quality, safety and access. Population health and patient experiences. Case-mix grouping methodologies.
Data exchange standards	Data flow	Allow information to be submitted and transmitted, and to move seamlessly between systems and devices.	HL7. FHIR. DDI, SDMX, JSON, xml.
Privacy and security standards	Data protection	Protect the collection, use, disclosure and retention of personal information and de-identified data.	ISO 27001. IPC/ON Manual for the Review and Approval of Prescribed Entities (PHIPA).

ICD-10-CA = International Classification of Diseases – 10th edition – Canadian; CCI = ; SNOMED CT = Systematized Nomenclature of Medicine Clinical Terms; DSM-5 = Diagnostic and Statistical Manual of Mental Disorders, 5th Edition; HL7 = Health Level Seven; FHIR = Fast Health Fast Healthcare Interoperability Resources; DDI = Data Documentation Initiative; SDMX = Statistical Data and Metadata eXchange; JSON = JavaScript Object Notation; xml = extensible markup language; ISO = International Organization for Standardization.