



Summary of findings from the first year of aged care data improvement activities

What have we learnt so far?

This paper provides an overview of the consultation and background research activities we have undertaken in 2021-22, and summarises the key findings from these.

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Activities to date

Following the conclusion of the Royal Commission into Aged Care Quality and Safety, and the Government’s response to the final recommendations, the AIHW has been tasked with a broad body of work on aged care data improvements.

Key elements of AIHW’s work are to:

- Understand the context of aged care data – which will in turn determine the scope of the National Aged Care Data Strategy. We call this the Aged Care Data System (data system) and it covers both data related to aged care in Australia, and the arrangements that support how these data are captured, used and shared.
- Establish a standard set of core items that are required – as a minimum – to meet the needs of the data system users. This is the Aged Care National Minimum Data Set (NMDS) and it will be implemented progressively from 2023.
- Create an ongoing connection between aged care and other data sources to complete the picture beyond what can be collected within aged care data alone. The working title for this is the Aged Care Data Asset (data asset), and it will include not only data from

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the NMDS but also other aged care data, as well as data relating to other areas of life for aged care services users (such as their health service use).

Each of these elements comes with a need for consultation and engagement with different stakeholders, although many stakeholders have an interest in all aspects of our work. For example, to understand the data system – how system users supply, use and access data, and what data currently exist in the system – the AIHW have consulted with a range of stakeholders during 2021-22. Consultation and engagement on how to develop the NMDS (and what should be included in it as a priority), and which information needs may be better served through data integration and the data asset, understandably overlap with any conversations about the broader data system. These also overlap with other activities currently underway in the aged care sector, as a consequence of the Royal Commission and otherwise.

Background investigations

Department of Health and Aged Care-led reform activities

Our process began with a desktop review. The aims of this work was to understand the data-related implications arising from the Royal Commission's final recommendations, the Government's response and planned activities at the Department of Health and Aged Care.

We have identified focal areas and summarised these for a simple overview, but note that there are interactions and overlap between them (Table 1).

Table 1: Aged care reform activities overseen by the Department of Health and Aged Care

Focal area	Activities	Data implications
New legislation	Aged Care Act re-development Potential changes to other legislation (e.g. the AIHW Act)	Collection and management of system data must be considered (including data flows and platforms) Regular supply of identified unit record data must be able to be provided to the AIHW Novel data sharing, data linkage and data improvement opportunities Opportunity for more data and information about outcomes within aged care
Changes to programs and reporting requirements	Integrated long-term support and care for older people Other changes to programs, policy settings and processes Pilot expansion of the National Aged Care Mandatory Quality Indicator Program New casemix and funding allocation tool (Australian National Aged Care Classification; AN-ACC) Expansion of quarterly financial reporting for providers/services Update to the workforce census [and survey]	Capacity to capture appropriate data must be built into new processes and incorporated in the National Minimum Data Set
Expanded access to services	Designing for diversity, difference, complexity and individuality Primary, allied and health care (including mental health, dental and hospital care)	Process and mechanism for capturing these data must be established Development of the National Aged Care Data System and interaction with My Health Record must be taken into account
Quality and safety	Requirements relating to staffing Complaints management and serious incident reporting Food and nutrition reporting Monthly care statements to aged care users Consumer experience, quality of life and quality indicator development (inc. Star Ratings) COVID-19 vaccination reporting	Data requirements (and collection mechanisms) for ongoing monitoring, reporting and modelling must be determined Capacity to capture appropriate data must be built into new processes and incorporated in the National Minimum Data Set Appropriate public reporting must be established
ICT architecture and data governance	Business-to-Government, Government-to-Business and Government-to-Government capability to allow seamless exchange of data and interoperability Aged care ICT strategy Governance for data supply and access (e.g. Aged Care Data Asset) Aged care data strategy	Data system users must be considered (taking into account the National Aged Care Data System as a whole) The appropriate mechanism/s for data capture must be identified Improvement must come through understanding current needs/gaps and establishing a process to guide future change and implementation

Other activity within government and across the sector

In addition to the reforms led by the Department of Health and Aged Care, related activities are underway at other government agencies, within the research sector and across aged care providers. We noted that these may take place in parallel to AIHW aims, activities and

responsibilities, and AIHW sometimes have limited visibility. The COVID-19 pandemic also continued to have a impact throughout 2021-22 on the aged care sector.

Many of the activities underway in the sector share similar aims to our work in aged care data improvement. These include work undertaken by the Aged Care Quality and Safety Commission, Australian Digital Health Agency, CSIRO, other areas at the AIHW and research organisations and consortiums.

Reviewing current state

A brief literature review was also undertaken – this was to understand current gaps, limitations and opportunities as the Australian aged care research community reported them. Key themes relate to consistency of collection and useability of data (Table 2). Similar points were also raised in the National Ageing Research Institute’s round table and outlined in the published [aged care research priorities](#).

Table 2: Overview of findings from recent literature

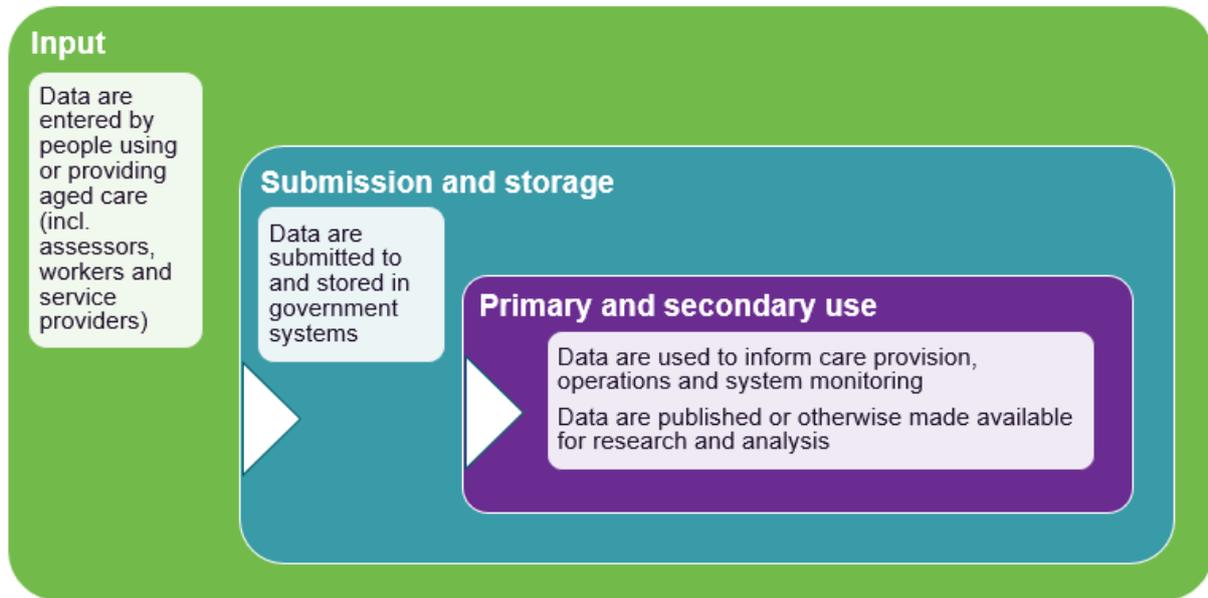
Theme	Sub-theme	Data improvement needed
Apply consistent standards to collect comprehensive data	Collect information relevant to people	Collect person-centred data Make data collection, care planning and care provision seamless Consumer experience and care provision Quality of life and quality of care Wellbeing, choice and safety Cost of care Access to care (including waiting time) Health/functional status Care needs and outcomes Diversity (population groups of interest) Integrate data to maximise usefulness
	Make data and information available to the public, researchers and other users	Allow comparisons between organisations and over time
Reduce burden of data collection		Measure sector/service performance Outcomes on health, safety and quality Complaints and serious incidents Collect person-centred data (aggregate as required) Remove duplication and remove redundancies
	Understand workforce	Scope and coverage, including: <ul style="list-style-type: none"> ● Staff characteristics ● Staff skills and qualifications ● Staff retention ● Work across sectors or work across services/facilities

As part of our background investigations into the aged care data system, we also established an understanding of the current administrative flows of data as they relate to aged care. At the point of data collection – whether within a residential aged care facility or in a person’s home as they receive aged care services – multiple systems can be used, and the data collected may be broader or structured differently to the requirements set out by the government for submission.

This means that sometimes more data are collected than are needed for submission to government, and aged care services may use some of these data to inform their activities.

The breadth and scale of the data are further transformed as they are processed within government systems and ultimately made available for use (Figure 1).

Figure 1: Aged care administrative data flow



During this initial phase of review, we identified our likely future areas of focus – the data strategy is seeking to influence all aspects of the data system from input through to secondary use, while the NMDS and data asset are focused on the inner (purple) core of administrative data.

Consultation and communication

Looking beyond data within the administrative aged care system, we reached out to a range of stakeholders to understand current holdings, gaps and activities as they relate to improving aged care. These began as fact-finding conversations with stakeholders on what people need from the system in the future and what related activities they are undertaking, before we moved into more targeted actions.

Developing our understanding of the activity underway in the sector also led to identifying new stakeholders. We commonly used this form of ‘snowball sampling’ to broaden our reach.

Preliminary conversations

A number of initial conversations were held with internal and external stakeholders. At this stage, we focused on broad questions, such as:

- How do you see the AIHW’s aged care data improvement activities interacting with the work you are undertaking?
- What is the most important aged care data improvement that the system needs?
- Consider what your input will be as we progress this work and how we should consult and communicate with you.

These stakeholders included different areas within the AIHW, at the Department of Health and Aged Care and other parties within the aged care sector, such as advocacy groups, peak bodies and research organisations.

Advisory, decision-making and governance arrangements

To support the data improvement activities, we recommended that the Department of Health and Aged Care establish a new Aged Care Data Strategy Advisory Committee. This committee will provide consolidated advice from their respective organisations, with membership drawn from the Department of Health and Aged Care, Aged Care Quality and Safety Commission, Australian Bureau of Statistics, Australian Digital Health Agency, Department of Social Services, Services Australia, Department of Veterans' Affairs and other government entities. The AIHW will provide secretariat functions while the Department of Health and Aged Care chairs the committee.

In addition, the AIHW has an existing Aged Care Data Advisory Group, with membership drawn from Government, the aged care sector and the research community. We have updated the Terms of Reference for this group to ensure members' input can be sought to inform the aged care data improvement work program as applicable.

The establishment of new processes are also expected to shape future governance arrangements regarding aged care data. These include:

- Legislative change for aged care – the new Aged Care Act will alter the framework under which aged care services are delivered, and changes to the framework will have an impact on data collection, supply and access arrangements. These must be considered as part of the process and the AIHW have approached the relevant stakeholders to begin these conversations.
- Data flows and data infrastructure – developing data linkage infrastructure and improving the timeliness of data are considerations that extend far beyond the aged care work. Broader developments can be expected to feed into aged care data improvement work.

As work progresses, we will also have increasingly more detailed conversations and consultation to establish the necessary governance arrangements for the NMDS and the data asset, in particular.

Targeted actions

In February 2022, we released an issues paper on *Exploring future data and information needs for aged care*. This invited written submissions on the matters raised within the paper, and was accompanied by a brief survey to capture similar input. Participants could choose to use either mechanism to provide their feedback, or contact us for other options. Feedback was encouraged by 11 March, but we received a number of approaches for late submissions and further conversations, which we accommodated.

The issues paper outlined our activities and our understanding of the current aged care data landscape and future information needs. We posed some questions to further generate conversation on these topics, such as to what extent current data meets people's needs, where improvements are needed most and what opportunities or challenges people anticipate. Similar questions were used in the survey.

We received 42 responses to our issues paper and survey. We also met with 35 stakeholder groups to initiate engagement and seek their input this way.

Outcomes of our activities

What do we currently know about aged care data?

Data landscape

Using the person-centred model as the basis for assessing current aged care data, the information collected on aged care services and providers is relatively comprehensive (for example, capturing information about who is funded to provide services, where they are located, and the interactions between services and providers but little information about the workforce delivering care). As a by-product of the administration of the system, some information is also captured on the people using aged care, particularly the types and dates of care.

Thematically, the largest gaps in the current data relate to information that goes to the experience of aged care – such as updated information on what care people need (beyond initial assessment), what care they receive (beyond broad program descriptor), from whom (workforce), how this care relates to their assessed needs, how people experience aged care and the outcomes and quality of their care. There are also gaps information about the context in which aged care is delivered – such as the support people receive from others in their lives or how they are able to participate in activities, what makes it difficult for them to access aged care and how they use other services outside of aged care such as general practitioners (Table 3).

Table 3: Domains covered by administrative aged care data

Object of data collection	Domain – Subgroup	Coverage
Person using aged care (person-level attributes and activities)	Demographic information – Identifying details	Available
	Demographic information – Cultural and linguistic background	Partial
	Demographic information – Location	Partial
	Demographic information – Other characteristics	Partial
	Demographic information – Housing, living and support arrangements	Partial
	Health information – Physical and mental health conditions	Partial
	Health information – Functional status	Partial
	Health information – Death	Partial
	Socioeconomic information – Financial characteristics	Partial
	Socioeconomic information – Educational background	Lacking
	Socioeconomic information – Work	Lacking
	Psychosocial information – Wellbeing	Lacking
	Psychosocial information – Justice and safety	Lacking
	Assessments – Identifying details	Partial
	Assessments – Dates	Partial
	Assessments – Assessment details	Partial
	Assessments – Support needs, health conditions and functional status	Partial
	Assessments – Assessment outcomes	Partial
	Aged care service use – Identifying details	Available
	Aged care service use – Dates	Available

Object of data collection	Domain – Subgroup	Coverage
	Aged care service use – Program type	Available
	Aged care service use – Service use details	Partial
	Aged care service use – Payment for care and services	Partial
	Aged care service use – Experience of aged care	Partial
	Aged care service use – Quality of life in aged care	Lacking
	Aged care service use – Safety in aged care	Lacking
	Aged care service use – Quality in aged care	Lacking
	Other service use – Related non-aged care services	Partial
Services providing aged care (service-level attributes and activities)	Service information – Identifying details	Available
	Service information – Service characteristics	Available
	Service information – Relationship to other services/providers	Available
	Service information – Location	Available
	Service information – Financial characteristics	Available
	Service information – Staffing	Partial
	Service information – Care provision	Partial
	Service information – Referrals	Available
	Service accreditation and monitoring – Accreditation, regulation and compliance	Available
Service accreditation and monitoring – Reporting requirements	Available	
Providers operating aged care services (provider-level attributes and activities)	Provider information – Identifying details	Available
	Provider information – Provider characteristics	Available
	Provider information – Relationship to other services/providers	Available
	Provider information – Location	Available
	Provider information – Financial characteristics	Available
	Provider accreditation and monitoring – Accreditation, regulation and compliance	Available
	Provider accreditation and monitoring – Reporting requirements	Available
Workers in aged care (worker-level attributes and activities)	Demographic information – Identifying details	Lacking
	Demographic information – Cultural and linguistic background	Lacking
	Demographic information – Location	Lacking
	Worker information – Skills, qualifications and eligibility to work	Lacking
	Worker information – Employment situation	Lacking

Aged care data collection in other countries

Many jurisdictions use indicators and other similar, consistent aggregate information to provide an overall picture of their aged care system. The underlying data are collected using different tools and rely on minimum data set specifications (InterRAI is used in New Zealand, Canada, parts of the US and many European countries). In this model, the practice of data collection is embedded into daily care practices, meaning that workers, services and providers collect data about aged care as care is provided. This also means that digital systems must be embedded into care practices.

The system itself is different across jurisdictions and data may not always be directly comparable – but some examples of common indicators include:

- people using aged care by age and sex (e.g. number and proportion of population)
- people in residential aged care who have dementia
- people in residential aged care who receive antipsychotic drugs without a diagnosis of psychosis
- people in residential aged care who experience falls.

Similar elements have gone into informing aged care reporting in Australia, as well as the National Aged Care Mandatory Quality Indicator Program.

Data gaps

Putting together the data that are currently collected within the aged care system, and what could or should be collected, gaps emerge. Detailed and comprehensive information is not available on:

- access to aged care – how do barriers to, and availability, cost, timeliness and suitability of care influence take-up and outcomes?
- workforce – what are the workers' demographics, skills and qualifications, how much staff time do people receive and how we can better understand risk and experience in aged care by also considering the aged care workforce?
- diversity – whether people need different things from aged care depending on their personal background, and how does this affect their experiences of care?
- experiences and outcomes – what do we need to know about people's quality of care and quality of life in aged care, and can we ensure that care and data are both improved simultaneously (where data flows from daily care practices rather than being seen as a separate activity)?
- other service use – how do people interact with health services, and whether people are able to access allied health and dental care throughout their time in aged care, as well as palliative care for appropriate support towards the end of life?

There is considerable overlap between the activities already underway in the aged care sector and the known data gaps. The activities summarised in this document each have implications for aged care data improvement, and in their own way, each represent current data gaps.

What did respondents tell us?

The issues paper and survey were sent to a variety of stakeholders, including government entities, peak bodies, researchers and advocacy groups. The responses were collated, reviewed and grouped by theme to identify key information (see Appendix A).

These themes reinforced the gaps already outlined above, as well as uncovering additional detail on:

- Useability of data – our stakeholders told us that they want detailed data to be available easily and efficiently, and summary data to be regularly updated and fit-for-purpose
- Data quality – our stakeholders told us that this can be an issue within all aged care data and that this could be improved with agreed standards and better systems

- Care provision – our stakeholders told us that data must cover needs for care, care provided and the outcomes of care, and that these must reflect the type of care provided (and to include all types of care, from ‘standard’ aged care to any allied health, dental care and palliative care services people in aged care receive)
- Workforce – our stakeholders told us that all aspects of workforce require careful consideration and considerable improvement
- Diversity – our stakeholders told us that information on people and workers from culturally and linguistically diverse (CALD) backgrounds (and other diverse or marginalised populations) must be consistent and meaningful
- Veterans – our stakeholders told us that this population has many crossovers with aged care and, as with many other issues discussed here, how we define that population is an important starting point
- Carers – our stakeholders told us that carers are an important component of aged care (as informal carers support aged care users) and more must be known about this population and their interaction with the aged care system
- Health characteristics – our stakeholders told us that information must be collected on people’s functional needs, health conditions (such as dementia, chronic conditions and any health conditions that require treatment) and health-related vulnerabilities, and that collecting this information regularly is important (or when there is a clear change in needs, conditions or functioning)
- Expenditure – our stakeholders told us that it is important to consider both people’s out-of-pocket spending on aged care, as well as costs of services and costs to providers.

How will we use this information?

Put together, our background investigations and our outreach to consult and communicate with the sector have helped us to finetune what we know about the current state of aged care data, and develop a shared understanding of the key improvements needed. The conclusions are summarised in Appendix B.

The current priorities, other stakeholders’ activities and general information needs we have learnt about so far will feed into coming next steps. These include:

1. Further development of the NMDS, data asset and data strategy

For each identified gap and need, we are considering the most suitable and appropriate ways for improving aged care data. Much of this will be on a case-by-case basis, where the NMDS, data asset and the data strategy each represent different tools for data improvement. The NMDS will be a suitable tool where data collections and standards already exist, or where it is feasible to develop and implement them. The data asset will integrate existing data (including the NMDS) across aged care and other sectors and can thus fill some gaps that exist within the NMDS. The data strategy sits above this, providing a long-term view for guiding the development of the aged care data system. It is anticipated some core principles are already known: aged care data must be person-centred and the duplication and burden within data collection must be reduced.

To support these bodies of work, we may develop use cases or case studies as appropriate, drawing on the stakeholders we have met and the information we have learnt from them.

2. Expanding and enhancing AIHW reporting on aged care

These findings will inform our work in improving how we report on aged care data. This begins with aged care data collections – to ensure the data needed for reporting are

collected and that data are timely, relevant and supported by appropriate metadata – but also looks at how we then use that data, to identify how to best report on the aged care system (for example at the service- and facility-level). To do this well, we must understand what our stakeholders require, both in terms of content and access to the content. In particular, issues around accessibility, governance and the mechanisms we use to share aged care data with our users must be considered.

3. Communicating about the process (and progress)

We intend to communicate our findings back to our stakeholders as we develop our work program. We will use a number of mechanisms, such as GEN, the AIHW's dedicated aged care data website, and the relationships we have developed in this first year of activity to carry out both general and specific communications.

We will also be seeking to engage our stakeholders on targeted issues, such as workforce. Targeted consultations with individual stakeholders will acknowledge and build on the conversations and feedback we have already heard.

Appendix A: Stakeholder feedback

Theme	Key points
Useability of data	<p>Ease of access and clarity of processes are necessary (ethics, governance and access arrangements present roadblocks)</p> <p>Interoperability and flow of data are poor; these must be considered system-wide (incl. in legislation)</p> <p>Support users with clean, easy-to-interpret, frequently-reported data</p> <p>Data must be collected efficiently, be meaningful to users and get updated regularly (mechanisms to support these must be implemented)</p> <p>Comprehensive, person-level data are required to report against standardised measures and assess sector performance</p> <p>Single collections must support multiple uses (consider need and avoid duplication)</p> <p>Maximise use and re-use of existing collections (do not re-collect data that are already collected)</p> <p>Real-time or near-real-time flows of key data</p>
Data quality	<p>Aged care data are not reliable or accurate</p> <p>Valuable time is wasted in cleaning, linking and verifying data</p> <p>Data collection must rest on agreement on quality and uniformed systems</p> <p>Data must be of sufficient quality and detail to support analysis and further derivations/aggregations</p> <p>Ensure data are comparable across people, programs and time (incl. historical timeseries)</p> <p>Improve data literacy and ICT capability of the workforce/providers/sector (data quality reflects issues at the coalface in collecting the data)</p> <p>Navigate lag between reform and system development (current capabilities range from paper to advanced digital systems) and consider impact of transition on data quality</p>
Care provision	<p>Data are required to assess the level of need/unmet need in aged care services (need for care, care provided and outcomes of care must be measured)</p> <p>Understand the individual needs of people (such as their clinical, physical, social, financial and functional status, as well as their demographic, socioeconomic and healthcare characteristics) to provide support and solutions that meet these</p> <p>Information on e.g. quality measures must disaggregate appropriately to allow informed choices that are relevant for the individual</p> <p>Multidisciplinary care is best practice; data must be collected to capture all aspects of care people receive (including allied health)</p> <p>Data on palliative care delivered within home/flexible care settings are absent; poor in residential aged care</p> <p>Align definitions such as palliative care with best practice (e.g. with the WHO approach)</p> <p>Consider existing/developing clinical care standards and assessment tools</p> <p>Quality of care must also be understood from consumer perspective (current models focus on deficits of quality, not e.g. quality of life and positive experiences)</p>
Workforce	<p>Data must disaggregate appropriately (e.g. by worker qualification, skill level, discipline or industry)</p> <p>Definitions are important (limitations exist with the current Australian Bureau of Statistics frameworks and certain occupation classifications cannot be relied on to suit aged care)</p> <p>Regular, reliable data on the key sociodemographic and employment characteristics of the aged care workforce are needed</p> <p>Ensure that sector workforce is not under-reported or misunderstood (capture self-regulated or independent health professions, platform workers, work across aged care settings or across disability and veteran support)</p> <p>Poor data on workforce impact planning and lead to misidentified gaps</p> <p>Data on migrant workers in aged care are needed (including diversity and visa information)</p>
Diversity	<p>Data for people and workers from culturally and linguistically diverse (CALD) backgrounds must be improved across administrative aged care data sets as well as survey and health and medical research data</p> <p>Understanding data capture issues and barriers to access for people from CALD backgrounds, people who identify as LGBTIQ+, care leavers and others</p>

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Theme	Key points
	<p>Data must support ability to identify cohorts and questions of interest (e.g. vulnerable populations, younger people or particular geographies)</p> <p>Some population groups may require additional consideration (e.g. regarding historical or current sensitivities)</p> <p>Improved data are needed to build capacity for culturally appropriate care</p> <p>Appropriate measures of diversity are essential for palliative care and across all types of aged care service provision</p> <p>Indigenous Elders must be considered a priority across all types of aged care (key information e.g. on age, location and carers would improve services for older Aboriginal people)</p>
Veterans	<p>Expand aged care data to include data from Department of Veterans Affairs (specialist services relating to aged care as well as transport and allied health data)</p> <p>Define veterans and their families in aged care appropriately (distinguish between people who have access to a DVA card and who are veterans)</p> <p>Ensure health, support needs and outcomes are captured</p> <p>Consider interactions between disability, aged care and veterans support (workforce is shared)</p>
Carers	<p>Detailed data on carers are needed to understand the characteristics of carers and how they support people using aged care (including interactions with emergency and planned respite care)</p> <p>Diversity data should consider carers of aged care service users (e.g. carer information about Aboriginal Elders is important to improving services for older Aboriginal people)</p>
Health characteristics	<p>Data must capture health conditions and identify vulnerabilities</p> <p>Clinical data standards and shared information metrics are important</p> <p>Consider clinical information standards being developed for aged care</p> <p>Use of health services (e.g. hospital, primary care and allied health), particularly relative to need</p> <p>Flow of information at trigger points between health and aged care</p>
Expenditure	<p>People's out-of-pocket spending on aged care</p> <p>Financial information about services and providers</p> <p>Interaction between cost of services and care offered/taken up</p>

Appendix B: Opportunities for data improvement

Object class/ Category	Domain – Subgroup	Current coverage	Improvement needed
People (person-level)			
Attribute	Demographic information – Identifying details	Name and date of birth are generally collected; mix of sex and gender is collected; no specific and comprehensive data on other special populations.	Separate collection of sex, gender and sexual orientation Apply existing standards and definitions consistently Identify special population groups of interest
	Demographic information – Cultural and linguistic background	Data on country of birth and Indigenous status are generally collected. Mix of data on main language and preferred language are collected; no data on English language proficiency or migratory background.	Apply existing standards and definitions consistently Include further key markers of cultural and linguistic diversity
	Demographic information – Location	Specific and comprehensive data are collected or can be derived.	Address information can be used to derive or auto-populate higher-level geographies
	Demographic information – Housing, living and support arrangements	Mix of data on living arrangements, accommodation setting and marital status are collected. Existence of carer is generally captured at point of initial assessment; no further detail.	Separate collection of registered and social marital status Apply existing standards and definitions consistently Expand capture of core information (carer availability and relationship; consistency of information on carers; support provided by carers)
	Demographic information – Other characteristics	Range of other data are collected, particularly through the National Screening and Assessment Form.	Expand capture of core information (veterans and other key information) Apply existing standards and definitions consistently
	Health information – Physical and mental health conditions	In some instances, data on physical/mental health conditions are collected (generally as per ICD-10).	Align methods and standards used across different settings and assessment tools Consider not only what health conditions are collected (and how) but also when; adaptability to cater to changing circumstances such as emergence of COVID-19 pandemic Consider staff skill/training/qualifications to assess people for conditions, or code data appropriately
	Health information – Functional status	Some data on functional status through assessments (particularly support needs prior to aged care use). Mix of data on disability, functional status and funding-related needs assessments are collected; the Australian National Aged Care Classification (AN-ACC) will be implemented in residential aged care, replacing the Aged Care Funding Instrument, and the Modified Barthel Index (MBI) is used in transition care, but similar information is not currently collected in any	Align methods and standards used across different settings and assessment tools Document interaction between function, frailty and health

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Object class/ Category	Domain – Subgroup	Current coverage	Improvement needed
		other program type. No specific and comprehensive data on care needs.	
	Health information – Death	In some instances, data on date of death are collected.	Align methods and standards used across different settings Capture timely data on cause of death
	Socioeconomic information – Financial characteristics	In some instances, data on income and asset details are collected.	Capture data on payment for care and services (total cost of aged care) Collect information on income and asset details (develop/apply data standards)
	Socioeconomic information – Educational background	No data are collected on education.	Collect information on educational background (develop/apply data standards)
	Socioeconomic information – Work	No data are collected on current employment or employment history.	Collect information on current or past employment (develop/apply data standards)
	Psychosocial information – Wellbeing	No specific or comprehensive data are collected on psychosocial aspects of life (some summary elements are captured in assessments prior to care).	Collect information on people’s mental health and wellbeing throughout their time in aged care (develop/apply data standards)
	Psychosocial information – Social support and participation	No data are collected on social connections; minimal data are collected on social isolation.	Collect information on social support and participation (develop/apply data standards)
	Psychosocial information – Justice and safety	Minimal data are collected on experiences of abuse, neglect or violence; these relate to aged care service.	Collect information on elder abuse, neglect or violence (develop/apply data standards)
Activity	Assessments – Dates	Data on dates are collected.	
	Assessments – Assessment details	Details vary by type of assessment. Data are primarily collected in residential aged care for funding and casemix purposes; data are collected in home support for care planning and provision.	Capture comprehensive and standard data on assessments across all settings for care planning and to inform care provision (incl. health conditions, functional status and care needs)
	Assessments – Support needs, health conditions and functional status	Data on support needs, health conditions and functional status prior to entry are collected; some data in residential aged care and home support, no data in home care.	Align methods and standards used across different settings and assessment tools
	Assessments – Outcomes	Data on approvals, recommendations and referrals to services are collected.	Collect information on waiting times, reasons for seeking/entering care and barriers to accessing care (develop/apply data standards)

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Object class/ Category	Domain – Subgroup	Current coverage	Improvement needed
	Aged care service use – Dates	Data on episode start and end dates, leave dates and some setting dates are collected.	
	Aged care service use – Program type	Data on program type are collected. Data on level of care and sub-type of care are collected for some programs. No person-level data on most flexible aged care programs are available to the AIHW.	Capture data on service use, care provision and staffing (develop/apply data standards) Align collection of core data across settings and programs
	Aged care service use – Payment for care and services	Data on government expenditure (funding provided to services) are collected; in some instances, data on what person is assessed as paying are collected. No specific and comprehensive data on full cost.	Collect information on full cost of aged care (incl. total cost of care to person) (develop/apply data standards)
	Other service use – Related non-aged care services	No data on health, disability or other aged care-adjacent services used by people in aged care (including allied health care, dental care or palliative care).	Collect information on type and quantity of care received and its outcomes (develop/apply data standards) Collect information on transfers between settings
Outcome	Aged care service use – Experience of aged care	Some information on feedback and complaints are collected.	Collect information on how people experience aged care (incl. those using aged care, seeking access to aged care or supporting those using/seeking aged care) (develop/apply data standards)
	Aged care service use – Quality of life in aged care	Nil.	Collect information on quality of life at person-level (develop/apply data standards)
	Aged care service use – Safety of care in aged care	Data on safety are collected at the service-level and do not relate to individual people using aged care; no data on cause or degree of seriousness of safety issues as experienced by the person.	Collect information on safety of care at person-level (develop/apply data standards)
	Aged care service use – Quality of care in aged care	Data on quality are collected at the service-level and do not relate to individual people using aged care; no data on suitability of care, culturally appropriate care or outcomes of care.	Collect information on quality of care at person-level (develop/apply data standards)
Services (service-level)			
Attribute	Service information – Identifying details	Data on program type are collected. Service sizes are based on number of places offered or number of people using care.	Determine an appropriate basis for identifying services (e.g. home care) Identify services and providers on an enduring basis (as well as reflecting changes to business structure and relationships between services and providers) Consider future changes to program settings, policy and data needs

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Object class/ Category	Domain – Subgroup	Current coverage	Improvement needed
	Service information – Relationship to other services/providers	Data on provider organisation are collected.	Collect information on service characteristics to identify crossover with other sectors (e.g. disability and retirement living)
	Service information – Location	Specific and comprehensive data are collected or can be derived.	Focus on service delivery location
	Service information – Financial characteristics	Data on funding provided by government are collected; in some instances, data on financial acquittals are collected. No specific and comprehensive data are collected on pricing, investment or competition.	Collect information on funding and spending (such as elements of annual or quarterly financial reporting)
	Service information – Staffing	Some data on staffing minutes are collected for residential aged care; some data are collected via the workforce census. Workforce planning is not part of standard collections; may be collected by individual services. Some data are collected via the workforce census.	Collect information on staff providing care (align definitions and determine key information needs) Identify types of information useful to collect regularly (or link through data asset)
Activity	Service information – Care provision	Some data on care minutes are collected for residential aged care; some data on types of care workforce are collected via the workforce census. Data on program type are collected; in some instances, data on level of care and type of care delivered in a session are collected. No specific and comprehensive data on care received (and whether it meets care needs). Existing data on services, people and the Aged Care Funding Instrument (and in the future, AN-ACC) are used for casemix risk adjustment.	Collect information on care provision Align methods and standards used across different settings Develop data items that are needed for appropriate risk adjustment
	Service information – Referrals	Referral activity is captured within My Aged Care.	Establish data flows and data standards
	Service accreditation and monitoring – Accreditation, regulation and compliance	Data on service monitoring (against standards and for compliance) are collected.	
	Service accreditation and monitoring – Reporting requirements	Various reporting requirements apply to approved services (these generally relate to other domains named here); many different collections and collection mechanisms are used.	Identify core information Align methods and standards used across different settings
Outcome	Service information – Experience of aged care	Consumer experience interviews are conducted on a sample population and aggregated at the service level.	Develop person-level data (aggregated to service- and provider-level)
	Service information – Quality of life	Nil.	

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Object class/ Category	Domain – Subgroup	Current coverage	Improvement needed
	Service information – Safety of care	Data on complaints, compliance actions and serious incidents are collected.	
	Service information – Quality of care	Quality indicators for residential aged care (incoming for home care).	
Provider (provider-level)			
Attribute	Provider information – Identifying details	Data on the organisation name, ABN and other identifying information are collected.	Determine an appropriate basis for identifying provider organisations
	Provider information – Provider characteristics	Data on the provider type	Identify services and providers on an enduring basis (as well as reflecting changes to business structure and relationships between services and providers)
	Provider information – Relationship to other services/providers	Data on the services associated with the provider organisation are collected.	
	Provider information – Location	Specific and comprehensive data are collected or can be derived.	
	Provider information – Financial characteristics	Data on funding provided by government are collected; in some instances, data on financial acquittals are collected. No specific and comprehensive data are collected on pricing, investment or competition.	Incorporate requirements for the Aged Care Financial Report
Activity	Provider accreditation and monitoring – Accreditation, regulation and compliance	Data on provider accreditation and other regulatory functions (some associated with the service) are collected.	
	Provider accreditation and monitoring – Reporting requirements	Various reporting requirements apply to accredited providers (these generally relate to other domains named here, as well as service-level ones); many different collections and collection mechanisms are used.	
Outcome	Provider information – Experience of aged care	Consumer experience interviews are conducted on a sample population and aggregated at the service level (can be further aggregated at the provider level).	Develop person-level data (aggregated to service- and provider-level)
	Provider information – Quality of life	Nil.	
	Provider information – Safety of care	Aggregated from service-level information.	
	Provider information – Quality of care	Aggregated from service-level information.	
Workforce (worker-level)			

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Object class/ Category	Domain – Subgroup	Current coverage	Improvement needed
Attribute	Demographic information – Identifying details	Some data are collected via the workforce census. Data are only collected at the service-level (workforce data are associated with the service providing care).	Develop person-level data (aggregated to service- and provider-level)
	Demographic information – Cultural and linguistic diversity		Identify existing or emerging collections that provide worker-level workforce information (complete information via linkage)
	Demographic information – Location		
	Worker information – Skills, qualifications and eligibility to work		
	Worker information – Employment situation		