



GUIDE TO SETTING UP THE INTEGRATED COMMUNITY CARE PROVIDER (ICCP)

DEVELOPED BY AIC AND MOH, IN COLLABORATION WITH
COMMUNITY CARE PARTNERS

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CHAPTER 1: INTRODUCTION

RIISING NEEDS OF A RAPIDLY AGEING POPULATION

Singapore's population is ageing rapidly, with many seniors enjoying longer lives. **By 2030, 1 in 4 citizens will be aged 65 and above**, with life expectancy projected to increase to 84.9 years by 2030. This means that many of us can look forward to more time with our families, friends, and communities.

While we celebrate this increased longevity, it also brings new challenges. We want to stay as healthy and active as possible, even as we age. We may need more assistance, especially in our later years. The number of seniors who require assistance in one or more Activities of Daily Living (ADLs) is estimated to double in just one decade, increasing to 105, 000 seniors by 2030. To support Seniors to age with dignity, we must prepare our care systems to meet the needs of all Seniors.

WE NEED TO ACT NOW

Our community care sector has made great progress in the past decade.

We have worked hard to increase care options, develop new skills, and create person-centred programmes. The wide range of Providers, programmes and resources is a strength that we can build on.

We must do more on preventive care, helping Seniors stay as healthy and active as possible. For Seniors needing care, we must rethink how we plan and organise care.

Our vision is a system that prioritises health; for Seniors with care needs, we must simplify the care seeking journey for them and their Caregivers so that Seniors can stay connected, supported, and well cared for within their communities.

IN THINKING ABOUT THE FUTURE DESIGN OF THE CARE SYSTEM, WE ADOPTED THE FOLLOWING PRINCIPLES:

- (1) **Senior-Centeredness.** Improve Seniors' experience of care, ensuring that services are more accessible and delivered in a seamless, coordinated, and timely manner. Seniors' preferences and choices are respected.
- (2) **Provider Centricity.** Recognise, preserve, and build on relationships with Seniors established by our Community Care Providers, valuing their strengths and expertise to support Seniors.
- (3) **Continuity of Care.** Promote deep links between Providers and Seniors – i.e., the same provider(s) to serve the same group of Seniors across care needs and across time.
- (4) **Place-based.** Community Care is organised geographically to promote collaboration among Providers so that Seniors can experience wrap around care. Instead of the Senior having to search elsewhere for services, the Provider that conducts care planning pulls in services needed by the Senior.
- (5) **Partnership.** Provider(s) function not only as an individual service provider, but key partners working with MOH, AIC and one another to improve Seniors' well-being and manage overall costs.

WHAT ARE THE KEY SHIFTS?

(1) Strengthening Care In Local Communities

We have expanded the support and services available for seniors. Across Singapore, we have more than doubled the number of eldercare services such as Active Ageing Centres (AACs), Senior Care Centres (SCCs), and Home Care, over the past decade.

To make care more accessible and personalised, we will bring services closer to where seniors live, shifting from nation-based planning to a more local, neighbourhood-based approach. **At the local level, we will organise care and services within sub-regions**, each serving about 8,000 to 16,000 seniors, aligned with URA planning area.

(2) Integrated Community Care Provider (ICCP) to Support and Coordinate Seniors' Care Needs in The Sub-Region

Our Service Providers have worked hard to better support Seniors, and many Seniors are pleased with the care they receive. However, we are organised by service types today, thus services are delivered to Seniors separately.

The Integrated Community Care Provider (ICCP) will serve as a key partner to the Seniors and their Caregivers.

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For Seniors who are well, the ICCP Partners will work together to keep them well and socially engaged in the community. Seniors-at-risk will be identified earlier and linked to preventive interventions to improve their health or delay frailty.

When Seniors need long term care services, the ICCP will assist the Seniors with a **Care Assessment**, work with them on a **Long-Term Care (LTC) Plan**, assist them to **Effect the LTC Plan**, and review the LTC plan when needs change. To do this, the ICCP works with Providers in the sub-region, and pulls in services outside the sub-region where needed.

IF WE DO THIS WELL...

Seniors will:

- (1) Know where to seek help;
- (2) Understand what services they may be eligible for;
- (3) Be involved as a partner in their care plan;
- (4) Receive required service(s) and support promptly;
- (5) Have a care partner to support longitudinally with them as their conditions change; and



Providers are able to journey with Seniors longitudinally. The journey begins with helping them to stay healthy and active as long as possible. When Seniors develop care needs, Providers pull in services to support them and their Caregivers, while optimising resources to care for the larger group of Seniors.

At the Sub-regional Level, with MOH and AIC, we are able to improve health outcomes for Seniors. Hospitals, Primary Care doctors and Social Service Agencies are able to partner with the ICCP to coordinate our support for Seniors.

WHAT IS THE INTEGRATED COMMUNITY CARE PROVIDER (ICCP)?

Today, services are organised according to Seniors' health archetypes – AACs generally serve seniors who are well, SCCs and Home Therapy (HT) serve seniors who are frail and need rehabilitation, while Home Personal Care (HPC) assists home-bound seniors. Seniors have to navigate the care system to find out the services they are eligible for and which service providers to approach. As Seniors age or recover from their conditions, they have to transit between services and Service Providers.

We envisage a different Senior experience in each sub-region. Each sub-region will have an appointed ICCP that offers a suite of baseline services for **all Seniors** who require them, and coordinate care for Seniors who require multiple services. This model is **designed to make these transitions smoother, ensuring Seniors receive continuous, coordinated support.**

The **Integrated Community Care Provider (ICCP)** comprises:

(1) Baseline Services: The Provider(s) come together and deliver the following baseline services for all seniors:

- (a) Active Ageing, Befriending (*typically delivered by an AAC or AAC(Care)*);
- (b) Day Care (*typically delivered by a SCC or AAC(Care)*);
- (c) Rehabilitation (*typically delivered by Day Rehab Centres, AAC(Care) or HT*);
- (d) Personal Care and Support for ADLs and instrumental ADLs (*iADLs; typically delivered by Home Personal Care*).

(2) Assessment, Care Planning: The Provider(s):

- (a) Receives referrals and conducts Care Assessment;
- (b) Develops and reviews a LTC Plan;
- (c) Effects and Monitors the LTC Plan by delivering services or pulling in Services for the Senior.

EXAMPLE OF HOW COMPONENTS OF THE ICCP COME TOGETHER FOR ALL SENIOR ARCHETYPES:

Senior Archetypes	Clinical Frailty Score	Senior Experience
Well, robust, active Seniors (approx. 80% to 90% of Seniors in the sub-region)	~1-3	The ICCP creates opportunities for Active Ageing (AA). AACs, SCCs are tapped on as community nodes for AA, and Seniors are able contribute to their community.
Seniors at risk of frailty		The ICCP encourages Seniors to take part in strength-based activities at AACs and/or SCCs to maintain and/or help delay frailty. Maintenance exercise is available at the AACs to increase access. Seniors worried about falling are strengthened, so that they become more community ambulant. Seniors at higher risk receive a care assessment proactively, and the ICCP works with the Senior on their care goals and plan. The ICCP effects the LTC plan.
Frail Seniors (approx. 8% of Seniors in the sub-region)	~4-6	Seniors receive a care assessment from the ICCP and the ICCP works with the Senior on their care goals and plan. The ICCP effects the LTC plan. The ICCP provide services such as day care and rehabilitation. Where appropriate, Seniors can continue to take part in AA and social

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		activities with the AAC. The ICCP pulls in other services as needed, which could include mental health, home care, etc.
Very frail Seniors (approx. 10% of Seniors in the sub-region)	~7-9	Seniors receive a care assessment from the ICCP and the ICCP works with the Senior on their care goals and plan. The ICCP supplies Home Personal Care, Home Therapy, and befriending; and pulls in Services from its partners, e.g. Home Medical and Nursing. Where appropriate, Seniors could be assisted to take part in AA and social activities or be connected digitally. The ICCP coordinates with primary care and hospitals.
End-of-Life Seniors		The ICCP supports the goals of the Seniors. The ICCP supplies Home Personal Care and pulls in Services like Home Care and Home Palliative Care. The ICCP coordinates with primary care and hospitals where appropriate.

CHAPTER 2: OPERATIONALISING THE ICCP

GOAL: SENIORS ENJOY IMPROVED HEALTH, SOCIAL AND CARE SERVICES AT SUB-REGIONAL LEVEL



(1) Stay healthy and active for as long as possible

Seniors stay socially connected and active through the AACs.



(2) Earlier, more proactive, and preventive care

Seniors-at-risk will be identified earlier and linked to preventive interventions to improve health or delay frailty.



(3) Seniors with care needs are supported in the community

As seniors' condition changes, they can receive care service(s) in a timely and coordinated manner, and have a main point of contact to assist them.

TO ACHIEVE THIS, PARTNERS IN THE SUB-REGION MUST FIRST WORK COLLECTIVELY TO ESTABLISH:

- (1) **Common Senior Experience:** Seniors receive proactive and comprehensive information across different community care touchpoints;
- (2) **Standardised Care Assessment:** Seniors are assessed using a common care assessment tool;
- (3) **Shared LTC Plan:** Seniors have a care plan accessible amongst Providers supporting the Senior;
- (4) **Timely Services:** Seniors receive LTC services based on their care needs in a timely manner. Partners should agree on the turnaround time across the Senior's care journey;
- (5) **Continuity of Care:** Seniors remain supported in the community, and as their care needs changes, the appropriate support services will be pulled in.

The following pages illustrate the ways that Partners can operationalise the five aspects above.

(1) Common Senior Care Experience

When Seniors or Caregivers need help and approach a Provider, Providers are typically familiar only with the services they provide.

MOH and AIC envisage that the ICCP will be able to offer a common experience across all touchpoints, as part of a **network of services, and guide Seniors to navigate care options that best meet their needs**. Seniors and Caregivers will feel assured that they can approach any provider they are comfortable with, knowing that they will be given comprehensive information on resources available and guided to the right support.

To achieve this, Providers will share information on their services with one another to better serve Seniors. Frontline staff of the ICCP network of Partners shall be trained to understand the services offered by each Partner. This way, they can **proactively connect seniors to the resources that could benefit them**.

Providers should agree on the mode of contact and referral process amongst the network of Providers. This should also be shared with other community agencies such as Grassroots Organisations, Social Service Offices, and Social Service Agencies, as they are also serving Seniors in the sub-region. This will ensure that Seniors have a consistent experience beyond the ICCP network of Partners.

(2) Senior Receives Care Assessment

Seniors who require LTC care services will need to have a care assessment done. **InterRAI is the national care assessment tool** for LTC services. This tool will be progressively rolled out, and will ensure that all long-term care assessments are:

- ✓ **Comprehensive**, based on Senior's care needs;
- ✓ **Consistent** between Providers from organisation to organisation;
- ✓ **Accurate** in giving a picture of a Senior's current vs. changing situation/needs;
- ✓ **Reliable** in capturing data for review and reporting.

With a common care assessment for all LTC services, Seniors will only need to have one care assessment done.

The ICCP will need to **build up capabilities** to conduct InterRAI and identify which Provider(s) will conduct the Care Assessment for Seniors in the sub-region. MOH and AIC will provide training for the staff identified as **Care Assessor(s)**.

Please refer to Annex A for the capabilities and/or skillsets required to conduct InterRAI care assessments.

As the Care Assessment helps Senior access LTC care services, the ICCP should complete assessment(s) and refer senior for the first service **within 5 working days**.

(3) Senior has an LTC Plan

With the Care Assessment, the ICCP **Care Planner** will partner the Senior and their Caregiver(s) to develop the LTC Plan. The **Care Planner** guides the Senior on what services and subsidies he/she is eligible for, the pros and cons of various services and Providers, the frequency of service, service start date and expected costs. It is recommended as good practice that the initial LTC Plan be finalised and signed off with the client **within 30 days** after receiving the case. Should Senior's needs or preferences changes, the LTC Plan can be subsequently updated.

(4) Senior Receives Timely Services

Once the LTC Plan has been agreed on, the ICCP **Care Planner and/or Coordinator** works with its partners to effect the LTC Plan (i.e., providers agree to deliver the service¹). This could include services that the ICCP directly provides and services that the ICCP pulls in from outside the sub-region, such as through referrals to these services. The Care Coordinator should check-in with Senior/Caregiver on the progress of the effected service(s) effected every 90 days as a good practice.

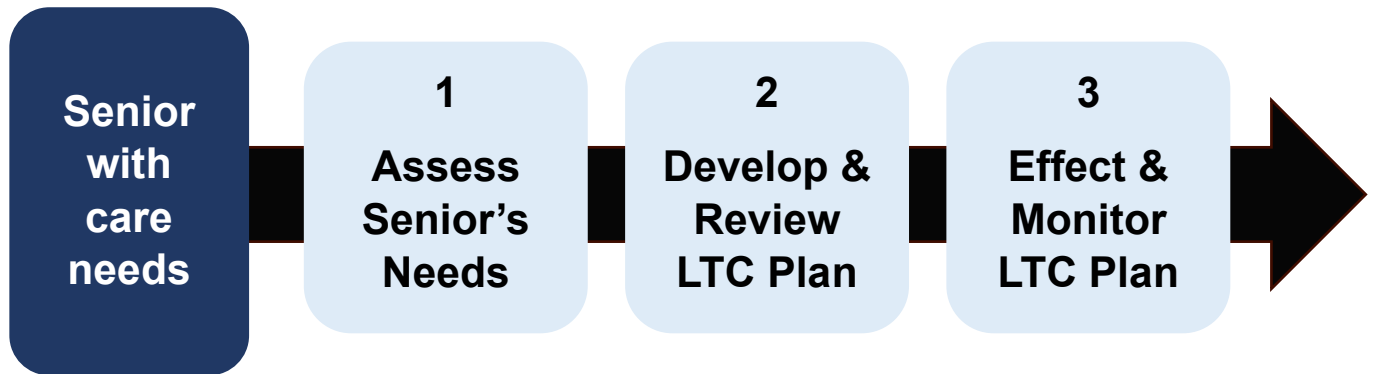
¹ In some cases, the Senior may choose to start the service at a later stage. An LTC Plan is considered to have been effected once the Provider accepts the case and agrees to deliver the Service on the preferred start date.

(5) Senior Receives Continuous Care

The ICCP **Care Planner** will conduct a reassessment every 6 months, or earlier if the Senior's condition changes, and adjust the LTC plan with the Senior and the Caregiver(s). If a new/additional LTC service is needed, the ICCP will either directly provide the service or pull in the required service by putting up a referral to other partners. The ICCP **Care Planner** will conduct the final assessment and discharge the Senior if he/she no longer requires any LTC service or monitoring.

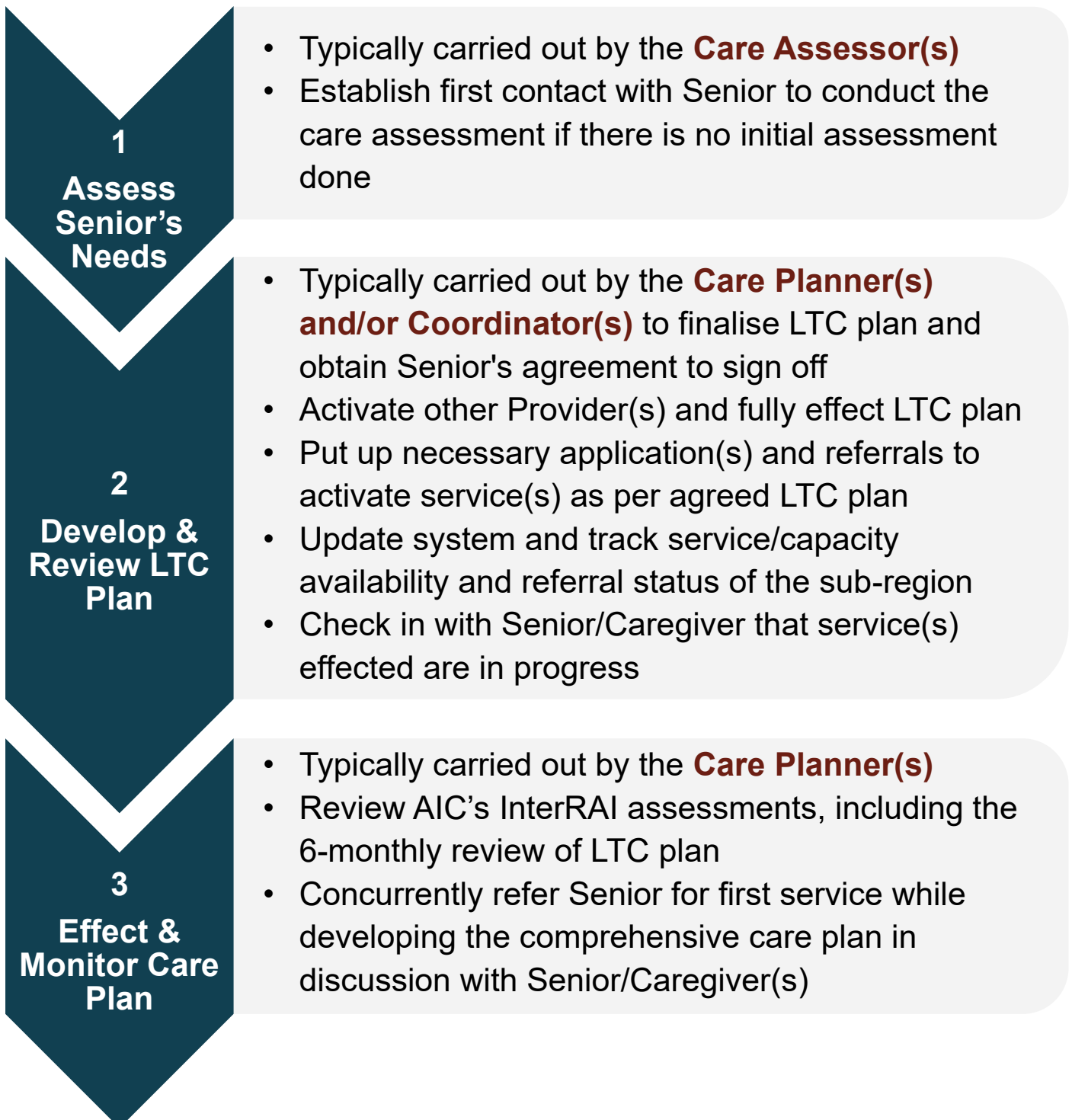
SENIOR CARE JOURNEY UNDER THE ICCP

The figure below provides an illustration of how the ICCP will support the seniors:



Roles of the ICCP

Note: **ICCP will handle new referrals**, while existing clients may continue to receive care from their current Providers to maintain comfort and continuity.



CHAPTER 3: FORMING PARTNERSHIPS TO OPERATIONALISE THE ICCP

GOAL: PROVIDERS COLLECTIVELY WORK TOWARDS IMPROVING SENIORS' WELLBEING

For Seniors to receive seamless and coordinated care and support through their different life stages, Providers need to work together to combine their resources and capabilities. It necessitates a shift from **operating as individual service provider, to working together as a united “sub-regional” entity.**

Each of the Providers in the sub-region comes with their own social capital with Seniors, their partners, and unique capabilities. Providers in a sub-region need to come together to **establish clear roles, responsibilities, and accountability among partners that will enable them to support the Seniors they serve.**

PARTNERSHIP FOR THE SUB-REGION

With a sub-regional approach to supporting Seniors, partnerships will need to be **more structured, formalised, and sustained.**

Partnership building:

- (1) Needs to be intentional;
- (2) Requires like-minded partners who are willing to work together to achieve common goals;
- (3) Requires time and commitment to build trust; and
- (4) Must be supported by having joint SOPs and clarity of each other's roles.

GUIDING PRINCIPLES FOR PARTNERSHIPS:

- (1) Preserve social capital and valuable relationships built over the years by allowing providers to continue serving their seniors.
- (2) Foster a collaborative partnership where partners align and agree on goals and outcomes that will best support seniors of the sub-region.
- (3) Work collaboratively to define roles, establish decision-making processes, SOPs and protocols, and optimise resources for seamless, efficient, and effective delivery of coordinated care to meet seniors' needs.
- (4) Build trust, openness, and transparency among partners.
- (5) Establish joint accountability to meet KPIs and service level agreements set by funders, ensuring partners win or lose together.

Goals for the Sub-Region

At steady state, Partners in each sub-region would be required to work together to achieve the following KPIs:

- (1) 95% of Clients referred to ICCP have:
 - (a) Received InterRAI assessment; and
 - (b) Been referred to first relevant service;
- (2) 95% of Clients who have had an InterRAI reassessment conducted in the last 6 months;
- (3) Time taken for ICCP to refer Seniors for first relevant service;²
- (4) Client and Caregiver satisfaction on seamlessness of care.³

And as we work towards helping Seniors remain healthier and have better quality of life, MOH/AIC will track and monitor the following longer-term indicators:

- (1) Cost of delivery each “unit” of service;
- (2) Percentage of utilisation of sub-regional SCC services;
- (3) Percentage of Clients with improved or maintained ADL, cognitive function and falls;
- (4) Percentage of ICCP Clients admitted into a Nursing Home;
- (5) Avoidable Emergency Department (ED) attendance rate;
- (6) Rate of adherence by Clients to LTC plan.

² Tentative target in FY27: 90th percentile within ≤5 working days.

³ Tentative target in FY27: 85%.

Partners in the sub-region would have developed a deep understanding of the profile and needs of your Seniors. Using data from AIC combined with Partners' ground understanding, Providers in the sub-region would need to discuss and collectively:

- (1) Set goals on the improving the health and well-being of Seniors in the sub-region;
- (2) Agree on how each Provider would contribute to the goals and KPIs; and
- (3) Agree on how Provider would account to each other for the achievement of the agreed goals and KPIs.

Establishing Role Clarity

Baseline Services

There are four (4) different Provider-types that would need to come together in each sub-region to provide a suite of baseline services ([here](#)) to serve the seniors.

Partners should have clarity on how each Partner and the services they provide contribute towards meeting the goals and KPIs for the sub-region.

ICCP Roles

Refer to the ICCP roles outlined [here](#).

Partners should collectively assess the capabilities and capacity of each partner to determine which Partner is best placed to take on the different roles.

If more than one Partner within the sub-region takes on the same role, it would become critical for Partners to be clear of how the work would be distributed, and develop communication protocols, accountability, and escalation protocols across the different organisations for the shared role.

As part of ICCP Phase 1 implementation, a self-assessment checklist will be provided to facilitate the discussion and allocation of roles amongst Partners in the sub-region.

Leadership Teams

Good partnership requires strong leadership to provide guidance and direction for the sub-region. It is recommended that a Leaders Group for the **sub-region be convened, consisting of representatives from ALL Providers in the sub-region.**

The sub-region Leaders Group should meet regularly to:

- (1) Set strategic directions and align goals;
- (2) Set priorities and oversee the actions for the sub-region;
- (3) Identify areas of duplication, gaps in services and capabilities and direct resources to improve;
- (4) Review performance and provide guidance for improvements such as new initiatives and models of care;
- (5) Review resources and identify win-win collaborations amongst ICCP partners as well as other partners.

Developing Joint SOPs And Protocols

While this document provides a guide on Seniors' care journey, it would be important for Partners to come together to determine how they will work together.

Partners will need to develop and implement plans that will ensure Seniors are well-supported. Partners should consider developing joint SOPs and protocols for their staff to enable Seniors:

- (1) To be aware of their point of contact of required services;
- (2) To receive proper care assessment and care planning;
- (3) To receive adequate care and services in a timely manner.

The joint SOPs and protocols should also provide clarity to staff on what is/are their role(s) and what they need to do as part of their ICCP role(s) in the sub-region. This may prevent service gaps between the four baseline services and ensure Seniors have a consistent care experience.

FORMALISING THE PARTNERSHIPS

As the partnerships within the sub-region needs to be **structured, formalised, and sustained**, Partners would need to develop a **Collaboration Agreement**.

The Collaboration Agreement serves as a formal document that outlines the roles, responsibilities, commitments, and expectations of each partner. It ensures clarity, promotes accountability, and provides a structured approach for collaboration. A sample template will be provided as part of ICCP Phase 1 implementation. Providers should seek independent legal advice when formalising the agreement with Partners.

OPTIMISING RESOURCES THROUGH STRATEGIC PARTNERSHIPS

Strategic partnerships allow Providers to pool their resources and expertise together, maximising their efficiency and effectiveness. By collaborating, partners can share costs, access specialised skills, and leverage combined assets to reduce duplication and streamline service delivery.

Some examples of strategic partnerships include:

- (1) **Shared programming** i.e., leveraging on existing SCC and AAC activities to cross promote activities and programmes within the sub-region. This would mean that seniors can visit different AACs to keep them healthy, active, and happy.
- (2) **Shared assets** i.e., spaces could have multiple purposes and be a shared resource within the sub-region. For example, HPC+ or HT staff could meet a Senior at one of the Centres / tap on Centres as a resource, such as a therapy node or a resting point between visits.
- (3) **Capacity management** i.e., if SCC A is at full capacity and has a waitlist, Senior can go to SCC B in the sub-region, allowing more timely access to services.

CHAPTER 4: ENABLING DATA SHARING AMONG PROVIDERS

ENABLING DATA SHARING AMONG PROVIDERS

Data sharing is a key component to fulfilling ICCP roles such as care coordination. To enable effective data sharing among Providers within the sub-region, it is crucial to establish clear data sharing mechanisms which meet data protection obligations. These data sharing mechanisms should define how data – ranging from administrative information to health-related data – will be collected, used, and shared among Community Care Providers, Public Healthcare Institutions, other healthcare Providers such as General Practitioners and the Ministry of Health, and other organisations.

Note, however, that these components or mechanisms detailed below are not intended to be exhaustive, and their consideration and use may not necessarily mean that Providers are in complete fulfilment of their data protection obligations when sharing data. Providers should therefore consult their Data Protection Officers (DPOs) and seek professional advice wherever necessary.

(1) Collection, Use and Disclosure of Individual's Personal Data

As an organisation involved in the collection, use and disclosure of personal data, compliance with the Personal Data Protection Act (PDPA) is an existing and mandatory requirement. Organisations will need to understand the compliance requirements for data sharing, such as ensuring adherence to the Consent Obligation when collecting personal data of individuals.

Providers should have consent clause(s) for seeking consent from individuals for the collection, use and disclosure of their personal data. At the stage of collecting client's data and obtaining their consent, Providers shall ensure that their **consent clause(s) / statement(s) / declaration / notification is sufficiently robust for their usage and onward sharing to third parties.** It is also important the Providers communicate the same in a manner and language that is understood by clients.

For example, Providers may consider including the ICCP purposes and necessary onward sharing of data with relevant third parties into their express consent liners, such as:

- (1) The data will be collected, used, and disclosed for the purposes of:
 - (a) Development of care plans to evaluate client's suitability and eligibility for care services;
 - (b) Planning and referring clients towards suitable care services offered by our Partner(s) or other Community Care Provider(s);
 - (c) Administration and provision of service when the need arises.
- (2) In fulfilling the purposes above, data may be shared with relevant third parties including:
 - (a) Other Community Care Provider(s);
 - (b) Other healthcare providers such as General Practitioner(s);
 - (c) Public Healthcare Institutions including but not limited to AIC, NUHS, NHG, and SingHealth;
 - (d) Ministry of Health ("MOH");
 - (e) Other organisations such as Ministry of Social and Family Development ("MSF) and People's Association ("PA").

Ideally, Providers should obtain express consent when collecting Personal Data of their clients. Providers should also inform clients of their data protection policy, or at least afford an opportunity for clients to view it before the collection of personal data where practicable.

CONSULT YOUR DATA PROTECTION OFFICER / LEGAL COUNSEL

- (1) The above consent liners are examples that Providers may consider adopting, to obtain express consent from clients for the usage of their data for ICCP roles and responsibilities, while also being able to share this data with other providers for relevant purposes.
- (2) Providers are not limited to only seeking express consent via the consent liners above and should consult their Data Protection Officer (DPO) and seek legal advice if intending to rely on other forms of consent (e.g., deemed consent or exceptions) to meet their business objectives.

(2) Sharing of Data Within Your ICCP

To facilitate sharing among Partners within the same ICCP, it is important to **establish clear data sharing terms that ensure compliance with PDPA and relevant laws and regulations, while also meeting the business goals.** These terms should be outlined in the overall Collaboration Agreement, or specific Data Sharing Agreements⁴ to address business arrangements when it comes to data management practices within the same ICCP.

⁴ Sample Data Sharing Agreement can be found in Annex B under Resources.

KEY CONSIDERATIONS AND GUIDING PRINCIPLES FOR DATA SHARING

Some examples of baseline terms for consideration are:

- (1) Identify the parties forming the partnership within the sub-region and establish the permitted purposes for sharing of data between partners.** Providers shall establish the need-to basis for sharing data with their partners to support ICCP roles and responsibilities such as:
 - (a) Supporting national programmes as authorised by the Government or its agencies, such as Healthier SG and Age Well SG.
 - (b) Provision of care to clients by the Providers.
 - (c) Enabling participation in care programmes, health programmes or outreach engagements.

- (2) Establish baseline expectations in managing data (collection, use, storage, and disclosure) in accordance with PDPA and relevant laws and regulations.** As all Providers are already expected to comply with applicable laws, partners within the same ICCP should balance the need to impose additional measures against business risk exposure and compliance costs.

(3) Establish clear accountability in managing a data breach in accordance with PDPA. Within the agreement, arrangements can be established as to how the partnership would respond to a data breach in line with the PDPA. Partners and Providers should seek professional advice on such obligations and the effectiveness of the arrangements which have been put in place.

(4) Work collaboratively to define mechanism / process for data sharing. If needed, Partners may wish to establish a process for data sharing such that Providers are assured that data is shared in a secure manner.

CONSULT YOUR DATA PROTECTION OFFICER / MANAGEMENT, AND PARTNERS BEFORE FINALISING DATA SHARING TERMS

While the above examples set a baseline for data sharing among partners, parties should collaboratively draft and review such terms, including any other additional data sharing terms deemed necessary to achieve the shared goals and desired outcomes of the ICCP. This process should be conducted in consultation with respective Data Protection Officers and Legal teams based on the partners' risk appetites, before seeking endorsement from the collective leadership team. Parties may reach out to AIC for any queries that require further clarification.

(3) Sharing of Data With Organisations Outside of Your ICCP

If data needs to be shared with another party who is not part of the established ICCP, and more ad-hoc, the Provider should assess if they have obtained relevant and sufficient consent from clients for this data sharing, and if there is a need or valid justification for this data sharing. A Data Request Form⁵ could serve to verify the need for sharing and supplementary administrative information to ensure safe transfer can be considered by the respective parties. Such assessment should be carried out and endorsed by the Provider's Data Protection Officer (DPO).

(4) Sharing of Data Between Public Healthcare Institutions and Providers

Public Healthcare Institutions (PHIs), i.e., AIC, NHG, NUHS, and SingHealth in your locality may share data with your organisation for purposes such as care coordination and programme planning. To facilitate and govern this sharing of data, Providers will be expected **to sign the Community Care – Data Sharing Agreement (CC-DSA).**

⁵ Sample Data Request Form can be found in Annex C.

The CC-DSA **was established as a multi-party agreement to facilitate and govern data sharing between Providers and PHIs. This agreement serves to:**

- (a) Facilitate data sharing between Community Care Providers and PHIs for the agreed purposes.
- (b) Allow for the onward sharing of data received from PHIs with other Community Care Providers for the agreed purposes. This enabler is further explained in the following example of standard terms below.
- (c) Establish baseline data protection standards consistently applied across each Provider, promoting accountability and collaboration.

Examples of standard terms in the CC-DSA that enables Providers to share data sets received from PHIs with other partners:

- (1) The sharing of data should be aligned with CC-DSA permitted purposes.
- (2) Data should only be shared in accordance with PDPA. For example, only data of senior who provided consent to the AAC for onward sharing should be shared.
- (3) Parties have formal written agreements or agreed arrangements with each other relating to the protection of data shared.

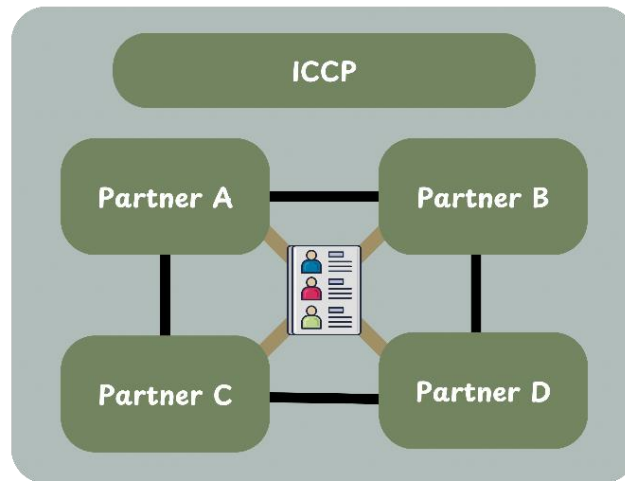
DATA SHARING SCENARIOS AND KEY ENABLERS

With the above mechanisms in place, Providers should be more well-equipped to handle the collection, use and sharing of data with various parties. While there may be a wide variety of data sharing scenarios, Providers may refer to some of the more common scenarios below and how data sharing is enabled via the mechanisms stated in points 1 to 4 above.



(1) Provision of Services to Clients:

- ✓ When collecting data from clients, Providers shall ensure **consent clauses** are sufficiently robust enough to allow sharing with other Providers for care, service delivery and other onward sharing purposes. Refer to point 1 on “COLLECTION, USE AND DISCLOSURE OF INDIVIDUAL’S PERSONAL DATA”.



(2) Sharing of Data with Partners within your ICCP (e.g., management of assigned seniors, service planning, etc.):

- ✓ **Data Sharing Agreement signed, or Data Sharing Terms outlined in Partnership Agreement.** Refer to point 2 on “SHARING OF DATA WITHIN YOUR ICCP.”
- ✓ For care, service delivery and other onward sharing purposes with other Providers within the ICCP, ensure **consent clauses** are sufficiently robust enough to allow sharing. Refer to point 1 on “COLLECTION, USE AND DISCLOSURE OF INDIVIDUAL’S PERSONAL DATA”.



(3) Sharing of Data with organisations outside of your ICCP (e.g. care and service delivery, service planning, programmes/projects, other ad hoc requests, etc.):

- ✓ For operational purposes such as care coordination and service delivery with other organisations, ensure express **consent clauses** are sufficiently robust enough to allow

sharing. Refer to point 1 on “COLLECTION, USE AND DISCLOSURE OF INDIVIDUAL’S PERSONAL DATA”.

- ✓ Beyond operational purposes, such as ad-hoc sharing for outreach, research with Institutes of Higher Learning, etc., Providers **may consider using a Data Request Form** to evaluate the need for data sharing and data transmission safeguards. Refer to point 3 on “SHARING OF DATA WITH ORGANISATIONS OUTSIDE OF YOUR ICCP”.



(4) Sharing of Data between Public Healthcare Institutions and Providers (e.g., care coordination, outreach efforts, etc.):

- ✓ Ensure your organisation has signed the **Community Care – Data Sharing Agreement (CC-DSA)**. Refer to point 4 on “SHARING OF DATA BETWEEN PUBLIC HEALTHCARE INSTITUTIONS AND PROVIDERS”.
- ✓ For care, service delivery and other onward sharing purposes with Public Healthcare Institutions, ensure **consent clauses** are sufficiently robust enough to allow sharing. Refer to point 1 on “COLLECTION, USE AND DISCLOSURE OF INDIVIDUAL’S PERSONAL DATA”.

Case example:

Provider identifies a list of high-risk Seniors, such as those living alone or without any social support. This list is shared with Clusters as data sharing is facilitated via the CC-DSA, enabling Clusters to notify Provider whenever these seniors are admitted to or discharged from the hospital.

For engaged seniors that have provided consent, the Provider will be further enabled to share data and coordinate with other Community Care Providers to closely monitor the seniors and provide necessary follow-up care.

Note: This is merely an illustrative example and not intended to represent the only application of the CC-DSA.

Note: These scenarios are not intended to be exhaustive, and the consideration and use of the suggested data sharing mechanisms may not necessarily mean that partners are in complete fulfilment of their data sharing obligations. Partners should therefore consult their Data Protection Officers (DPOs) and seek professional advice wherever practicable.

RESOURCES

ANNEXES

Chapter 1: Introduction	
NA	
Chapter 2: Operationalising the ICCP	
Annex A: About InterRAI	 Annex A - About InterRAI.docx https://for.sg/iccpguideannexa
Chapter 3: Forming Partnerships to Operationalise the ICCP	
NA	
Chapter 4: Enabling Data Sharing Among Providers	
Annex B: Sample data sharing agreement	 Annex B - Sample CCO Data Sharing Ag https://for.sg/iccpguideannexb
Annex C: Sample data request form	 Annex C - Sample Data Request Form.doc https://for.sg/iccpguideannexc

- End of Document -