STANDARD OPERATING PROCEDURE

Careteam Use for the Integrated Palliative Care Program (IPCP)

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Approved By: Operations Leadership Team
Review Cycle: Yearly, or as changes required

Quick Access

Use the links below to jump to the section you need:

1. Background

The Integrated Palliative Care Program, serving Mississauga and South Etobicoke, brings together health care providers from multiple palliative care teams under one program to provide integrated team-based care to those needing palliative care. The One-Team approach means there is one patient story and providers participate in a shared care plan and communicate to collaborate in the best care experience for that patient and their family/care provider. The Careteam platform is a digital location to share that story and communicate with one another.

Careteam is a secure, person-centered collaboration platform designed to support integrated care across organizations.

For the Integrated Palliative Care Program (IPCP), Careteam enables:

- Integrated, person-centred care
- Reduced back-and-forth communication
- One shared care story
- Clear visibility of roles, updates, and next steps
- Improved patient and caregiver experience

In Careteam a shared care plan is called an Action Plan. This plan is accessible to authorized care team members across:

- Dorothy Ley Hospice
- Hospice Mississauga
- MOHT Integrated Palliative Care Team
- Palliative Care Specialists at Trillium Health Partners and Dorothy Ley Hospice
- Spectrum Health Care Palliative Team
- Ontario Health at Home (OHaH) Palliative Nurse Practitioners

Important: Careteam is not an Electronic Health Record (EHR/EMR) and does not replace legal documentation within your organization's charting system.

2. Purpose

This SOP is for the IPCP to enable collaboration, communication and shared care planning amongst the integrated care team, patients, families and care partners.

- Who is responsible for what in Careteam
- Documentation and communication expectations
- When to use Careteam vs phone vs fax
- How IPCP partners collaborate within the platform

The goal is to promote consistency, accountability, and clarity across all participating organizations. For patients, families and their care partners this tool allows them to be more informed of their care team, the care plan and how to access resources.

3. Careteam Roles, Permissions & Organizational Accountability

This section outlines system roles, permission levels, and each organization's responsibility for user access management.

Each participating organization is responsible for appropriate role assignment, onboarding, and ongoing access governance.

A. Careteam System Roles

Provider

Health care providers who are actively involved in patient care.

Permissions:

- View the patient list
- Create and contribute to Action Plans (Status Updates, General Information, PPS, ESAS, Things to do, Checklist etc.)
- Communicate with team members using Action Plan messaging

Manager

Users who require administrative oversight without access to patient-level information.

Permissions:

- Access administrative functions
- No access to Action Plans or personal health information

B. Additional Permissions

Administrator Access

Administrators:

- Add and remove users
- Manage organization libraries (resources, documents, videos, tasks, etc)
- Support onboarding and account maintenance
- Have access to Audit log viewer

Each organization must designate at least one Administrator responsible for maintaining accurate user access.

Intake Receiver

Users with this permission can:

- Review incoming Action Plan invitations
- Approve or decline invitations from other organizations
- Ensure appropriate internal team members are added

C. Organizational Accountability

Each organization is responsible for:

- Adding new staff to Careteam

- Ensuring onboarding and training are completed prior to use (Training resources provided)
- Assigning appropriate roles and permissions
- Auditing activity as per organizational practices
- Reviewing active users regularly
- Disabling access immediately when staff leave or change roles

Maintaining accurate user access is required to support privacy, security, and compliance standards.

D. Privacy and Confidentiality

Use of the platform must comply with Ontario's *Personal Health Information Protection Act* (PHIPA). Careteam is built to meet PHIPA requirements, with safeguards in place to protect the security, confidentiality, and integrity of patient information. Users may only access patient information where they have a legitimate, ongoing care relationship with that patient. Access outside of an active care relationship is not permitted. Each organization remains responsible for ensuring its staff understand these obligations before using the platform.

4. Program Workflow & Responsibilities

A. Integrated Palliative Team Assistants (MOHT)

Primary Accountability: Action Plan Creation and Team Set-Up

Responsible for:

- Starting all IPCP Action Plans (opening patient file in Careteam)
- Adding the appropriate MOHT Integrated Care Coordinator
- Inviting appropriate partner organizations:
    - Dorothy Ley Hospice
    - Hospice Mississauga
    - Spectrum Health Care
    - Trillium Health Partners
    - Dorothy Ley Hospice Palliative Physicians
    - Ontario Health atHome Palliative Nurse Practitioners

- Ensuring accurate patient demographics are entered
- Archiving the Action Plan upon program discharge

Expectation:
The Action Plan must be created and appropriate partner organizations invited within **1 business day** of IPCP enrollment.

B. Integrated Palliative Care Coordinators (MOHT)

Primary Accountability: Patient and Family Engagement

Responsible for:

- Introducing Careteam to the patient and/or family
- Sending the Careteam email invitation
- Reinforcing Careteam as the primary shared care coordination tool
- Encouraging ongoing patient and caregiver engagement

Standard Script:

> *It helps to know what comes next in your care. We use a secure digital platform called **Careteam**. It keeps your care plan in one place. Today, we will send you an email. Please open the email and accept the invite. Your **Action Plan** will show you the next steps for **Mississauga Health Integrated Palliative Care Program**. We will update it when things change. You may get a message when there is an update. Please check Careteam often. It is the best place to see your care plan. You can also invite people who help you, like family or care providers. Do you have any questions you would like to ask about using Careteam?*

Expectation:
The Care Coordinator invites the patient and/or care partner within 1 business day of the initial visit. Patients and/or family have a choice whether they wish to use the tool or not.

C. Dorothy Ley Hospice, Hospice Mississauga, Spectrum Health Care, Trillium Health Partners & Ontario Health atHome

Primary Accountability: Organizational Intake and Team Engagement

Intake Receiver Responsibilities:

- Monitor for Action Plan invitation emails
- Accept invitations within **1 business day**
- Add appropriate team members from their organization
- Ensure internal staff understand use and documentation expectations

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5. Health Care Providers Contribution to the Shared Action Plan

All health care providers are expected to actively contribute to the shared Action Plan to support coordinated, person-centred care across organizations.

The Integrated Palliative Team Assistant is accountable for creating the Action Plan and inviting appropriate partner organizations at program start. Both the Team Assistant and the Integrated Palliative Care Coordinator have authority to archive (close) the Action Plan at client discharge from the program. Beyond that, keeping the Action Plan current, complete, and coordinated is a shared team responsibility — every organization and health care provider on the Action Plan is expected to contribute updates relevant to their involvement in the patient's care.

Careteam captures the **shared care story — not the full clinical note.**
It does not replace your organization's EMR and is not intended for detailed charting.

When involved in a patient interaction, providers must use Careteam to:

- Share clinically relevant updates that impact the plan of care
- Reflect changes in functional status (e.g. PPS)
- Update symptom scores (ESAS) when completed or supported
- Adjust care goals or interventions as needed

- Identify and assign next steps to the appropriate team member
- Share information that is important for both the health care team and the patient/family

Entries in Careteam should:

- Reflect high-level, care-planning information
- Be timely (Posting updates same day whenever possible; Responding to direct communications on next working shift)
- Be meaningful and action-oriented (signal, not noise)
- Be clear for cross-organizational understanding (include only approved abbreviations)

Careteam serves as the shared coordination tool across IPCP partners.
Updates should support continuity, reduce duplication, and improve team alignment.

Expectation:

Health care team members will **login to Careteam each shift** to view updates (Notification centre or Action Plans) to support the goals of integrated palliative care program.

Team members are not expected to login or use the tool outside of regular work hours.

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6. Careteam Updates & Communication Standards

Careteam supports coordinated care through timely, high-level updates. Team members are not expected to log in or use Careteam outside of regular work hours. Careteam is not intended for urgent communication — use phone for time-sensitive or emergency matters.

Careteam is:

- Live dynamic shared care plan
- High-level
- Action-oriented
- Collaborative

Careteam is not:

- A replacement for your organization's EMR
- A place to duplicate full clinical notes
- A tool for urgent communication
- A tool for medical orders

Careteam reflects the shared care story across IPCP partners.

A. Provider-to-Provider Communication (HCP View Only)		
Block (Location in the tool)	Purpose	Who uses it
Status Update	Non-urgent, clinically relevant updates for the health care team. Used to communicate meaningful changes, assessments, and care decisions. Avoid duplication and minor details.	All teams
Secure Messaging	Direct or group communication between specified providers. Used for clarifications, follow-up questions, or time-sensitive but non-emergent coordination.	All teams

B. Shared Clinical Tracking		
Block	Purpose	Who uses it
PPS Check-in (HCP viewable only)	Updates the patient's Palliative Performance Scale (PPS) score to support shared understanding of functional status .	All teams
ESAS Check-in (Visible to patient/family)	Records ESAS symptom scores to track trends over time and support symptom management decisions.	All teams Patient/Family

C. Shared Care Plan Updates (Visible to Patient/Family)

Block	Purpose	Who uses it
General Information	Non-urgent updates intended for the patient and family. Supports understanding of the care plan. Not used for internal clinical discussions.	All teams
Things to do	Coordinates next best actions (Tasks, Appointments) across organizations and for the patient/family. Ensures clear ownership and accountability of tasks.	All teams Patient/Family

D. Shared Resources

Block	Purpose	Who uses it
Resources	Educational materials and shared documents relevant to the patient, family, and care team (e.g., guides, referrals, forms). Upload only materials that add value.	All teams Patient/family

E. Care Coordination Checklists

Block	Purpose	Who uses it
Key Milestones	Tracks significant milestones in the patient's palliative journey to maintain shared awareness of progression and planning needs.	All teams
Service Plan	Snapshot of current services in place to ensure visibility across organizations and reduce duplication or service gaps.	Spectrum IPCC
Equipment	List of equipment provided to the patient to ensure coordinated management and shared awareness.	Spectrum IPCC

F. Out of Office Communication

Planned Absence

- Status Update: Post a Status Update before going out of office so all health team members can see it.
  Example: "I will be out of office from Feb 12–16. If you need support, please contact [backup person]."
- Secure Messaging: If a 1:1 message is important and involves someone who will be out of office, start a new message with their backup and summarize key points.

Unplanned Absence

- Status Update: A Team Lead or Administrator posts a Status Update on the person's behalf.
  Example: "[Name] is currently unavailable. Please direct urgent matters to [backup person]."
- Secure Messaging: If a message to someone who is out of office isn't answered within a reasonable time, start a new secure message with their backup, referencing the earlier conversation if needed.

7. Practical Examples of Appropriate Use

The examples below illustrate the type of updates that belong in each Careteam block. These are examples only.

A. Status Updates (HCP View Only)

Organization	Example of Appropriate Update
Spectrum	Patient reporting increased dyspnea over the past 48 hours. PPS declined from 60% to 50%. Will reassess next visit.
IPCC	Family expressing caregiver strain. Exploring respite options.
Physician	Medication adjusted: Hydromorphone increased to 1 mg q4h PRN.
Hospice	Hospice staff (or worker) met with patient to review coping supports.

B. General Information (Visible to Patient/Family)

Organization	Example of Appropriate Update
Spectrum	Nurse visit scheduled for Thursday at 10:00 AM.
IPCC	Next care conference planned for March 18.
Physician	Medication adjustment made today to help with pain control.
Hospice	Volunteer support referral submitted.

C. Secure Messaging (Provider-to-Provider)

Scenario	Example messages
Nurse to Physician	Just wanted to let you know this patient had a good response to their enema yesterday.
Nurse to IPCC	I am planning to reassess the wound in 2-3 days, I will let you know if there are further concerns.
Physician to nurse	Can you call me when you get some time in the next couple days to discuss a case
IPCC to hospice	I just left a status update, but can you put this patient on your radar for hospice admission in the next week or two?

D. Things To Do (Task/Appointment Coordination)

You can assign/tag activities in Things to do to team members active on the Action Plan team. If you don't assign/tag anyone - it is assumed for the patient/support team. If you assign/tag a health care provider they will be notified.

Organization	Example of activities

Spectrum	Please complete the ESAS symptom check list before your next home visit. (Assigned to patient/care partner)
IPCC	Arrange family meeting – due March 15. (Assigned to health care provider)
Physician	Talk to your pharmacy about setting up blister packs. (Assigned to patient/care partner)
Hospice	Think about what is important to you about your end-of-life care plan, discuss it with your support team and health care providers. (Assigned to patient/care partner)

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8. Communication Standards

Clear guidance on when to use each communication method:

Situation	Fax	Phone	Careteam Secure Messaging	Careteam Status Update	Careteam General Information
Referrals	✔️				
Orders	✔️	✔️			
Emergency Situations		✔️			
Critical Results		✔️			
Complex issues needing discussion		✔️		✔️ (follow up)	✔️ (follow up for family)
Non-urgent team updates (HCP only)				✔️	
Specific/ direct inquiry (not team-wide)			✔️1:1/group messaging		

Key Principles

- Use Phone for urgent, critical, or emergency matters.
- Use Fax for formal orders or required documentation transmission.
- Use Secure Messaging for direct, non-urgent provider (1:1/group) communication.
- Use Status Updates for team-wide updates and shared clinical summaries.
- Use General Information to update the patient/family.

9. Data and Accountability

Each organization is responsible for:

- Ensuring staff document accurately and consistently.
- Ensuring Action Plans reflect current status.
- Reviewing user access quarterly (if applicable).
- Auditing staff access to Careteam for utilization and responsiveness or other program goals.
- Removing inactive staff in a timely manner.

10. Unscheduled downtime

A. Scheduled Downtime
Scheduled maintenance takes place overnight. Staff will receive notification in advance of scheduled downtime.

B. Unscheduled Downtime
Careteam is used for team collaboration, coordination, and non-urgent communication — not for urgent or time-sensitive matters. If Careteam is unexpectedly unavailable, continue using phone or fax per Section 8 for anything urgent. Non-urgent updates can wait until access is restored. Staff will receive notification when Careteam is back online.

11. Job aids

The following job aids will support implementation:

For Team Assistants

- Start a New Action Plan - link
- Invite Organizations to Action Plan - link
- Archive Action Plan (Closing a patient file) -link

For Integrated Care Coordinators

- Invite Patient - link
- Adding Support People - link

For All Providers

- Using the Status Updates Block - link
- Using the General Information Block - link
- Using Things To Do - link
- Using Milestone, Service Plan and Equipment Checklist - link
- Uploading the Resources Block - link

For Managers/Superusers

- Managing Users - link
- Record retention principles - link

12. Glossary of Terms

Action Plan

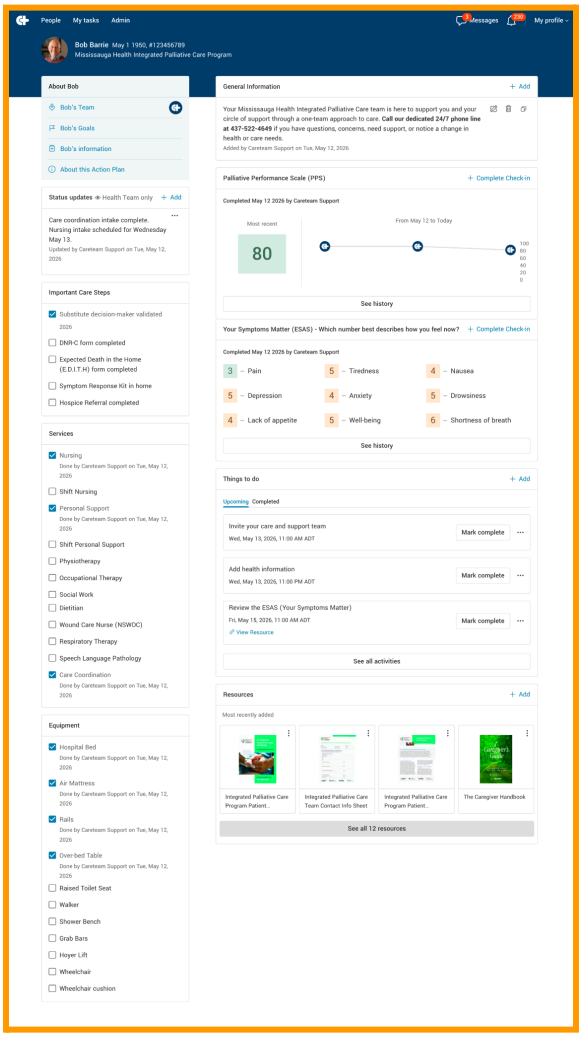
- The cornerstone of the Careteam platform, the Action Plan is an action-oriented, user-friendly care pathway, designed to ensure that everyone involved in the person's care is well informed, and knows their next best step.
- Action Plans can be standardized (Action Plan Template), personalized to the person, or a combination of both.

Action Plan Template

- Action Plan Templates are standardized Action Plans created by you or someone in your organization, that are available to all care provider users, and can be activated for any person at any time. Action Plan Templates are a way to digitize your organization's best practices for delivering care.

Dashboard

- Each Action Plan Template has an associated dashboard — a real-time view of the information being tracked across that Action Plan. For the IPCP, the dashboard is the dynamic shared care plan, giving the health team and support team a consistent, up-to-date picture of the person's care. See below for reference.



Health Team

- Healthcare providers involved in supporting the person. The health team could include people from multiple organizations all collaborating together to support the person.

Intake Receiver

- The person(s) who receive a notification (email and in-platform) when their organization is invited to join an Action Plan. Intake Receivers have permission to review the invitation and accept or decline it on behalf of their organization.

Person

- Careteam's mission is to enable the wellbeing of the whole person, not just one part of them. Careteam views people as, well — people. Their whole selves, not their conditions. That's why you'll see the term "person" to describe the individual whose care is being managed. You and your organization may refer to those you work with as patient, client, participant, member, or anything else — these can be used interchangeably with "person."

Support Team

- A person's caregivers, partner, family, friends, neighbours, and professional caregivers — anyone involved in supporting this person towards optimal wellbeing and invited by the person or their substitute decision maker(s) or with consent by the health team.