Ontario
Palliative Care
Network

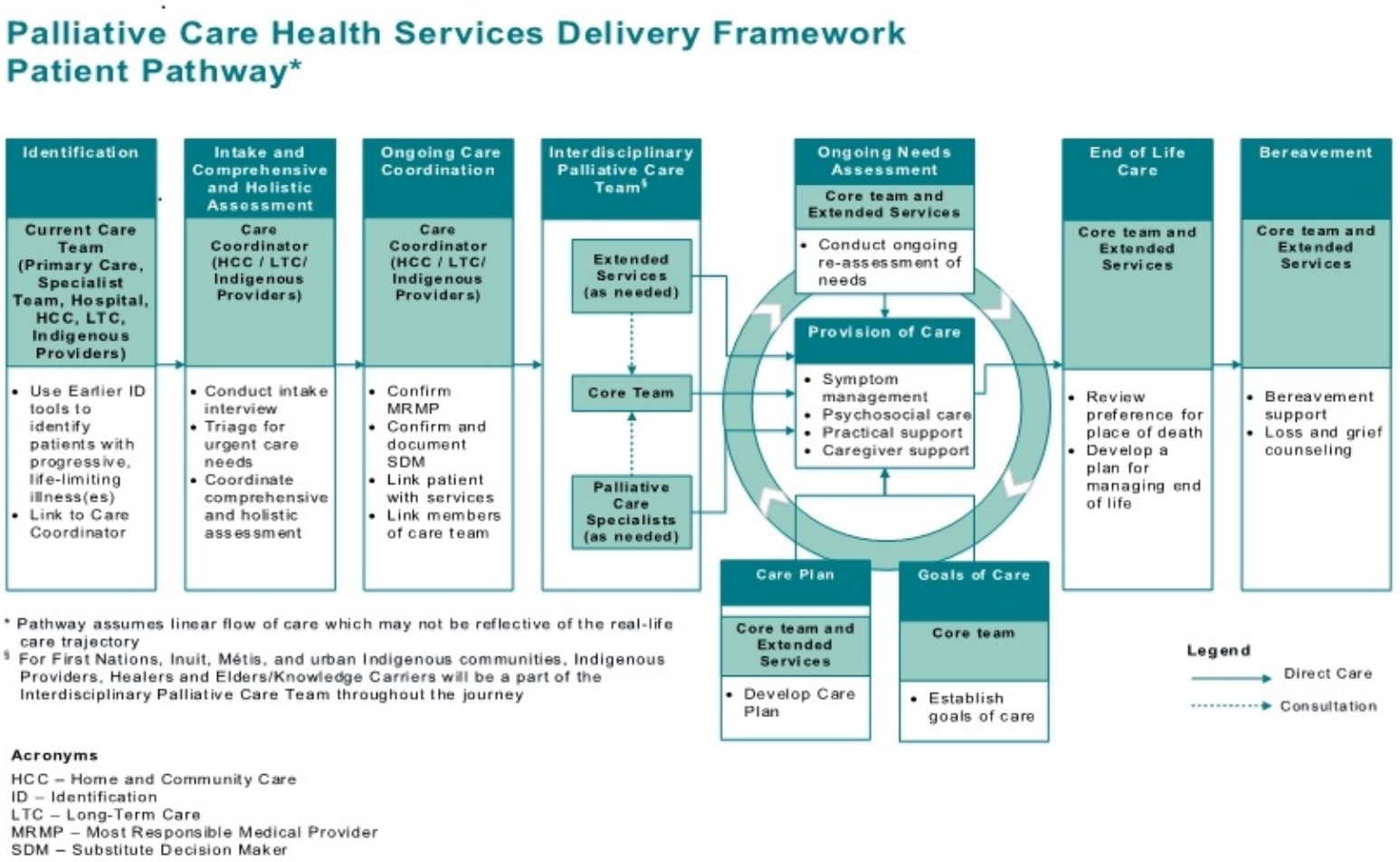

Figure 1. Palliative Care Health Services Delivery Framework: Patient Pathway

This diagram provides a high-level summary of the Health Services Delivery Framework that depicts the key interactions between the patient and their family/caregiver, the responsible provider/team member, and key decision points or responsibilities. The patient's journey starts with early identification, followed by intake, assessment and referral to a Care Coordinator who connects the patient and their family/caregiver with palliative care services. The inter-disciplinary palliative care team is described as a collaborative model of three layers of providers (Core Team, Extended Services, and Palliative Care Specialists). The Pathway also features ongoing assessment of needs, conversations about goals of care, regular updates to the palliative care plan, care at the end of life, and supports for the family/caregiver after patient's death. The pathway includes care throughout the person's illness trajectory, at the end of life, and through death and bereavement, including supports for the family/caregiver.

This diagram is an excerpt from the Palliative Care Health Service Delivery Framework, April 2019. For a detailed description, download the full document. Available at https://www.ontariopalliativecarenetwork.ca/en/resources/palliative-care-health-services-delivery-framework.