Building Better Palliative Care

Remote Care Monitoring (RCM) – Alliance Conference 2026

HPA-OHT

Grand Bend Area Community Health Centre

HURON PERTH & AREA

ONTARIO HEALTH TEAM

The Challenge in Huron Perth & Area

- Palliative patients often have complex and rapidly changing care needs
- Family physicians remain central to coordination of care, but access and capacity challenges can make ongoing support difficult
- Patients and caregivers frequently experience fragmented communication across services
- Many patients are not yet eligible for specialist palliative supports despite their needs
- There was a clear need for:
  - Improved coordination
  - Earlier symptom identification
  - Stronger communication pathways
  - Additional support wrapped around primary care

The Primary Palliative Care Navigation Model

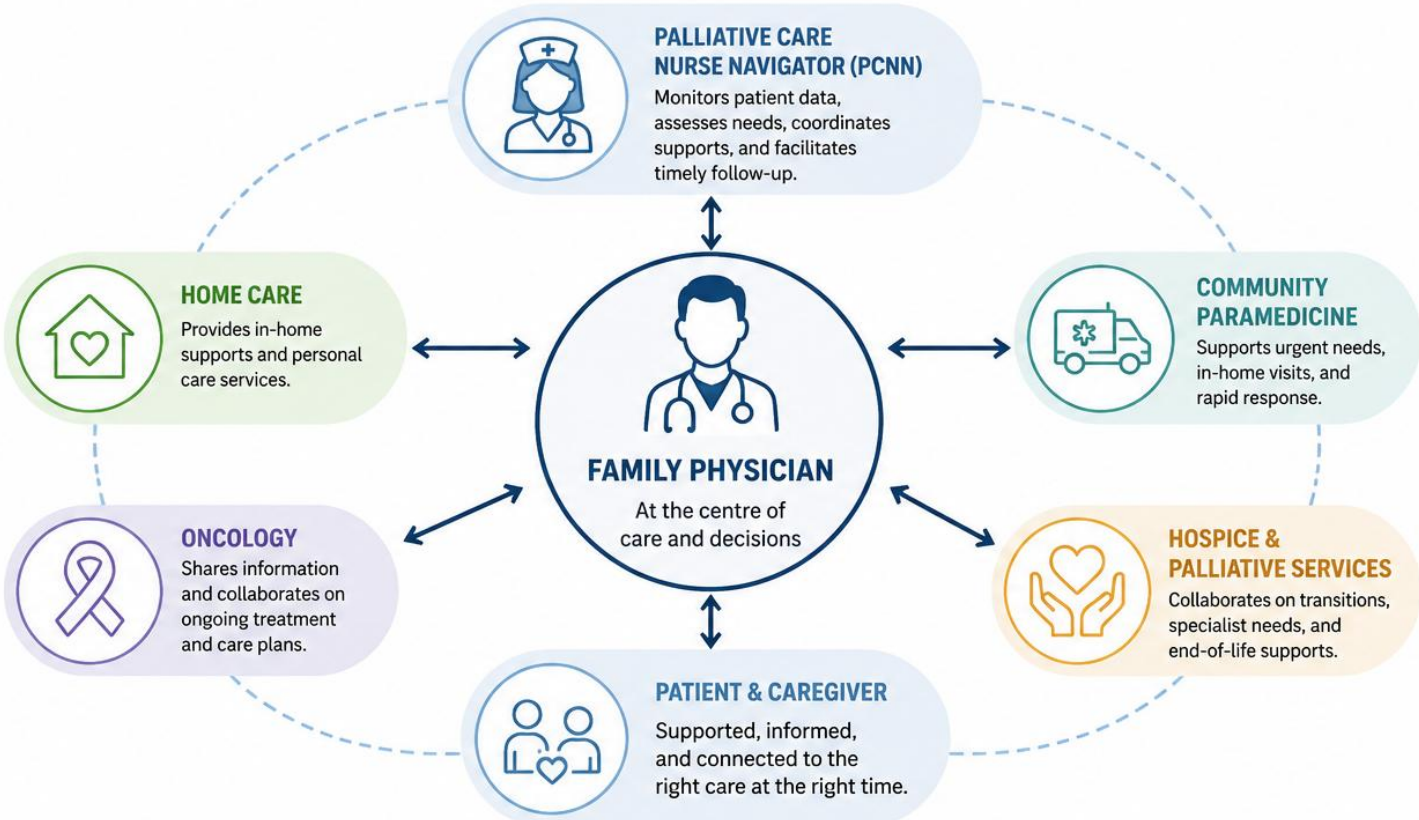
- A Primary Care–embedded model designed to build primary care capacity and improve coordination for patients with serious and life-limiting illness in Huron Perth & Area.

- A Palliative Care Nurse Navigator is embedded within participating primary care practices to support clinicians, patients, and caregivers across the full palliative care continuum. The model aligns with the Ontario Palliative Care Network Health Services Delivery Framework.

- Key elements include:
  - Early identification, symptom assessment and monitoring, and proactive care planning
  - Clear escalation pathways to specialist or community services when needed
  - Digital tools including remote monitoring and secure communication to enhance information sharing and reduce fragmentation – particularly important in rural settings
  - Developed collaboratively with primary care physicians and community partners to ensure feasibility, role clarity, and strong clinician buy-in from the outset

How the Model Supports Primary Care

The pilot creates a coordinated support layer around the family physician and patient.



RCM strengthens primary care by improving coordination, visibility, and timely support.
This helps family physicians deliver proactive, connected, and sustainable palliative care.

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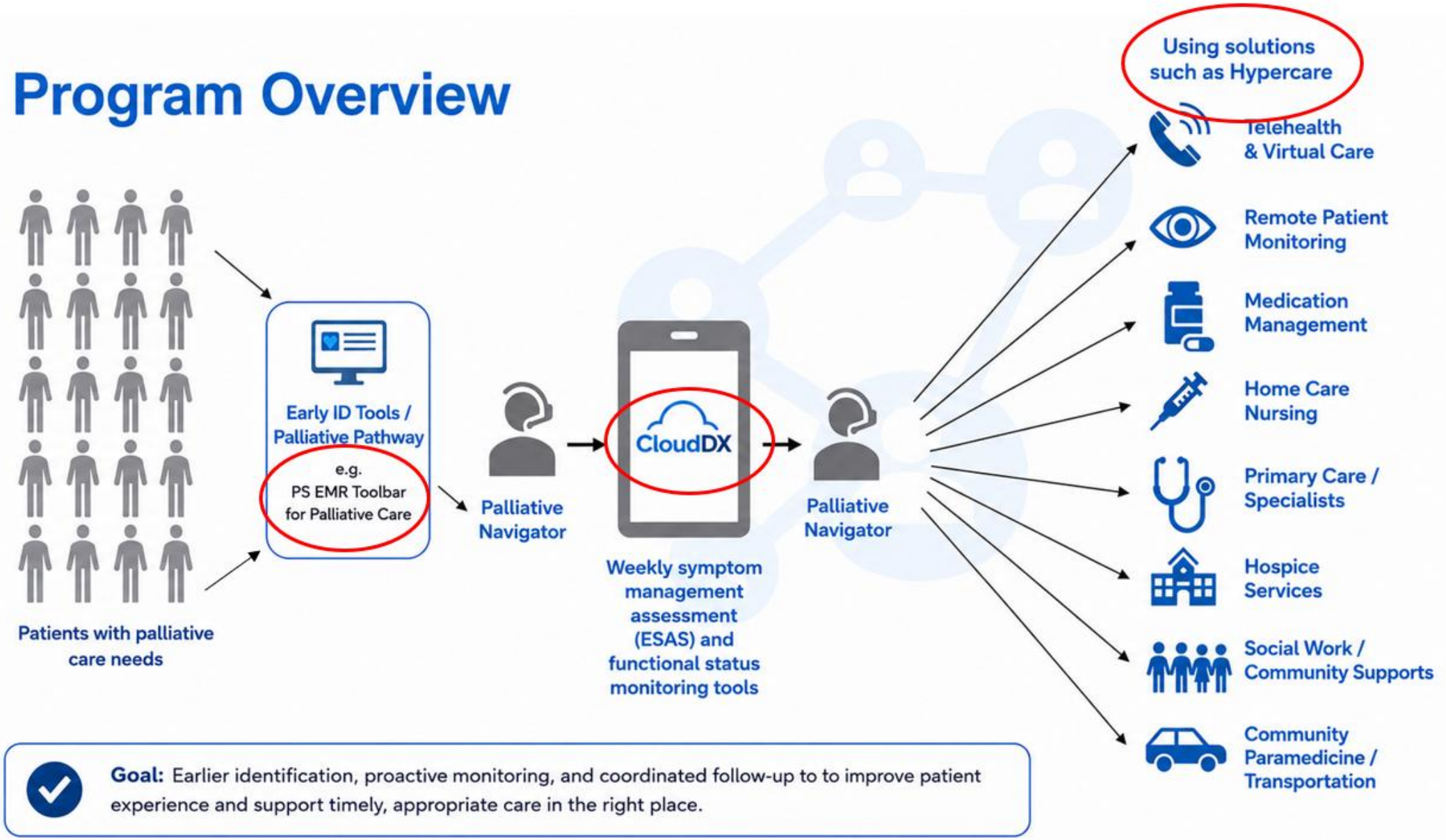
Program Overview



Goal: Earlier identification, proactive monitoring, and coordinated follow-up to to improve patient experience and support timely, appropriate care in the right place.

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Role of Primary Care

- Primary care is the foundation of the Huron Perth & Area Primary Palliative Care Navigation Program.

- The model was intentionally designed to wrap additional supports around family physicians caring for patients with complex palliative needs, enhancing continuity and coordination rather than creating a parallel service.

- Key principles:
  - Patients remain connected to their family physician and existing care team
  - The program enhances continuity and coordination rather than creating a parallel service
  - The Palliative Care Nurse Navigator acts as a bridge between patients, caregivers, providers, and community services
  - Escalations and updates are coordinated back to the primary care team
  - The model supports proactive, team-based care and earlier intervention

Who is Eligible for this Program?

The eligibility criteria for this program are broad, encompassing any patient who would benefit from a palliative approach to care.

In Huron Perth & Area, the focus has been on patients newly diagnosed and those not yet eligible for specialist Palliative Services.

Some examples of common patient profiles include:

- Metastatic cancer patients receiving palliative systemic treatment
- Cancer patients who have been discharged from oncology or declined further treatments
- Patients who decline investigation or treatment for serious incurable illness
- Patients who wish to remain at home for end-of-life care
- Patients awaiting hospice care
- Patients with end-stage heart, lung, or kidney disease
- Patients with neurodegenerative diseases like Parkinsons and ALS
- Patients with later-stage dementia
  Complex multimorbid patients with significant clinical frailty and a high risk of death

Impact & Trajectory

- Early outcomes demonstrate positive impact at both the provider and patient levels across Huron Perth & Area.

- Participating family physicians reported increased confidence and comfort in delivering primary-level palliative care, improved knowledge of community resources, reduced administrative burden, and stronger collaboration with partners.

- Patient & caregiver outcomes:
  - More proactive symptom management and clearer care planning
  - High satisfaction with continuity, responsiveness, and support provided through the Nurse Navigator role
  - Expanded participation across additional practices in Huron Perth & Area, informing planning for a broader regional primary palliative care network
  - Model designed for scale and spread – flexible to adapt to workforce pressures and community needs without increasing reliance on specialist resources
  - Key learning: embed support within existing workflows, define navigator roles clearly to complement physician care, and invest in cross-organization relationship building

Thank you.
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