SGFP
GENERAL & FAMILY PRACTICE

# A Foundational Reset:

# An Actionable Roadmap for Ontario's Digital Health

**Discussion Paper**

## January 2026

The Section on General & Family Practice is a section of the Ontario Medical Association representing over 15,000 family physicians.

# About the Authors

The OMA Section on General & Family Practice (SGFP) represents the 15,000+ general and family practice physicians of Ontario in negotiations and advocacy. SGFP also works collaboratively with our primary care partners, patient advocates and all system partners. We believe that we can achieve the goal of a high-performing integrated health system by working together. As mentioned in Ontario's Primary Care Action Plan, health systems with robust primary care systems have better health outcomes, lower health care costs, and more equity.

This paper was developed by the SGFP Digital Health Team, composed of five physicians from across the province and a non-clinician co-lead. Its members represent a diversity of practice settings, career stages, and levels of technological savvy, ensuring a comprehensive view of all family physicians in Ontario is brought to this work.

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This important work is only possible through the contributions of our members, and dedicated colleagues. This advocacy effort has not been funded by the OMA.

***The SGFP acknowledges Indigenous health must remain in Indigenous hands. The strategies outlined in this paper are not intended to prescribe solutions for Indigenous populations, but rather focus on primary care transformation within the non-Indigenous healthcare system.***

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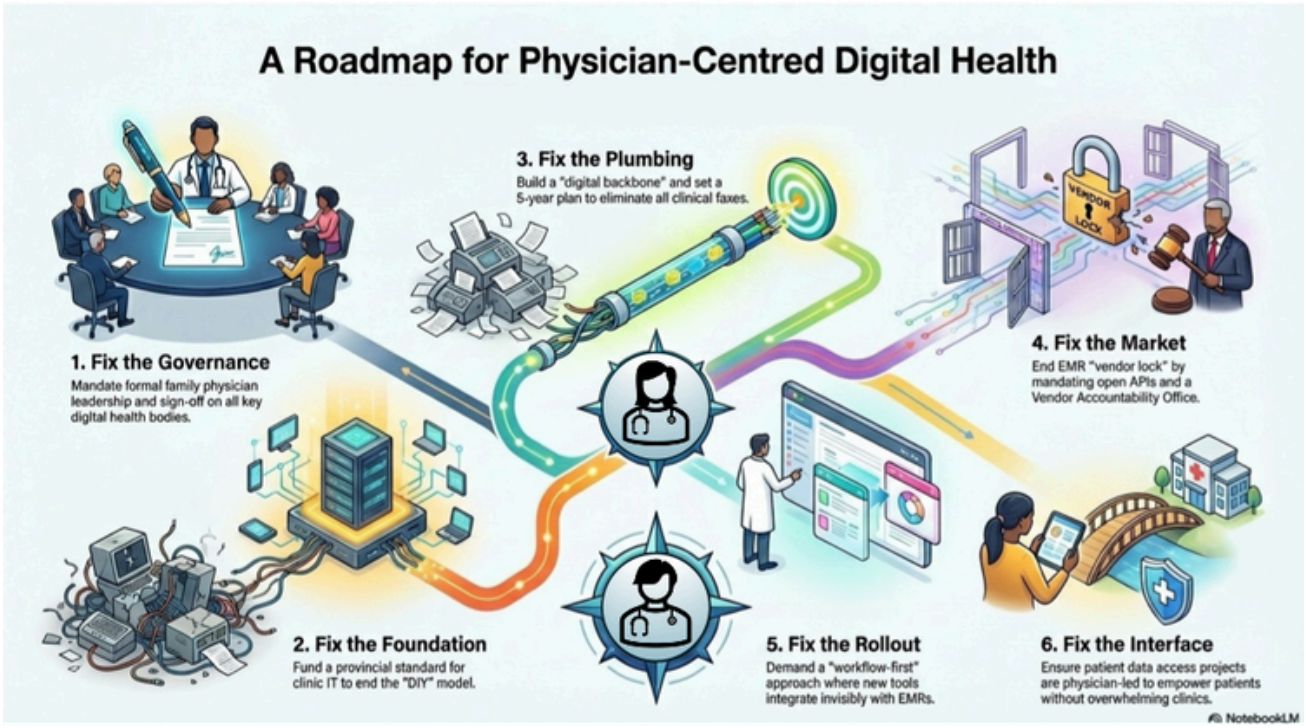
# EXECUTIVE SUMMARY

Ontario's digital health strategy for primary care is failing at its foundation — the over 161,000 daily visits handled by family physicians in Ontario, more than any other healthcare professional. Built without meaningful family physician input, the resulting digital disarray has created a staggering administrative burden that drives burnout and erodes patient care. We are guaranteeing a poor return on investment, creating critical security risks, and failing to deliver a modern, connected system.

The Ontario's Digital Health strategy can only succeed if it becomes a **Physician-Centred digital strategy** that delivers person-centred care. We cannot build a modern system on a broken foundation of digital duct tape and chaotic plumbing. This work is the prerequisite for achieving a high-performing, integrated health system aligned with the SGFP's vision of implementing the Patient's Medical Home (PMH).

This document presents an actionable roadmap built on six interconnected pillars with recommendations to fix this foundation. It provides a pragmatic plan to:

1. **Fix the Governance** by mandating the clinical **leadership and expertise** of family physicians who are accountable and formally representative of Ontario family physicians on leadership and data councils.
2. **Fix the Foundation** by funding a centralized, minimum standard for **Digital Readiness.**
3. **Fix the Plumbing** by building an EMR-fed digital backbone for **Data Flow & Digital Attachment**, led by **Primary Care Networks (PCNs)**.
4. **Fix the Market** by mandating open Application Programming Interfaces (APIs) by 2027 to end vendor lock-in and achieve true **Interoperability**.
5. **Fix the Rollout** with a workflow-first approach to **Innovation and Change Management** that respects physicians' zero capacity for disruption and is community led.
6. **Fix the Interface** by delivering **Patient Access** to their health information through a safe, physician-led, staged rollout that protects **Continuity of Care**.



We call on the government to partner on this physician-led vision and take immediate, decisive action on these foundational prerequisites. This is the only path to de-risk our digital investments and build the secure, efficient, and fiscally responsible healthcare system Ontarians deserve.

Fixing this foundation is the only way to achieve our shared goal: a high-performing, integrated health system aligned with the SGFP vision of **Patient's Medical Home (PMH) implementation**. This is the unified digital front door Ontario needs, one that is not just a piece of technology, but a new way of delivering care.

This new front door will be:

- **POWERED TO support** the Patient's Medical Home vision.
- **GOVERNED WITH family physicians**.
- **CONNECTED VIA** mandated **Interoperability** standards.
- **SECURED THROUGH** universal **Digital Readiness**.
- **ACCESSED BY** a single, safe, staged **Patient Portal**.

# INTRODUCTION: ONTARIO'S DIGITAL STRATEGY IS FAILING AT ITS FOUNDATION - PRIMARY CARE

Every 24 hours in Ontario, the vast majority of all patient care, over 161,000 patient visits, is delivered by family physicians, more than any other healthcare professional. Family physicians, the foundation of our health system, handle more than double the volume of all specialist visits and over ten times the volume of our emergency departments combined.

Yet, Ontario's digital strategy is being built *in spite* of this reality, not *in support* of it. This digital disarray has placed a staggering and unsustainable workload on family physicians—the very foundation of our health system. Our most valuable clinical assets are being forced to act as manual data clerks and unpaid default interpreters for a system that was built without meaningful family physician input.

Digital transformation is immensely complex, and no jurisdiction has a perfect system. However, Ontario's lack of a cohesive digital vision places us significantly behind our Canadian peers. For example, while other provinces have successfully consolidated their systems, Ontario is still struggling to merge its three clinical viewers into one for clinicians and patients still have no access.

## The Canadian Overview: Availability of A Single, Comprehensive Patient Viewer


**Figure 1: Example of digital health progress:**
As the graphic demonstrates, provinces including Alberta, Saskatchewan and Manitoba have "complete" systems for a single provincial EHR viewer, dispensed prescriptions, and lab results. Ontario is marked as "In Progress" for its viewer and the repository still lacks a complete view of all dispensed medications, showing only publicly funded ones. In summary, Ontario's EHR is still under construction while residents and their clinicians of other provinces have had long-standing, comprehensive access. See Appendix 1 for a detailed comparison.

This gap presents an opportunity to learn from the lessons and challenges of these other jurisdictions, both nationally and internationally, to accelerate Ontario's progress and build a system that is successful for both patients and all physicians.

The current path is untenable. The direct consequences of this failed approach are undermining all of our shared provincial goals.

# The Cost of Inaction: A Crisis of Burnout and Wasted Investment

The costs of a poorly constructed digital health environment are significant.

- **Physician Burnout:** The crushing administrative burden of a poorly designed system is a primary driver of burnout, pushing experienced physicians out of the profession—the very workforce that manages about 90% of patient encounters daily.
- **Fiscal Waste:** We are guaranteeing a poor return on investment as we spend millions on disconnected, inefficient tools that clinicians reject because they increase workload.
- **Systemic Risk:** Our do-it-yourself approach to clinic information technology has created a critical provincial security risk, while a lack of physician representation in data and digital governance creates profound reputational and ethical risks.

# The Solution: A Foundational, Physician-Led Reset

We cannot build a modern system on this broken foundation. A Digital First strategy can only succeed if it is a Physician-Centred strategy, built to support the person-centred, longitudinal care interactions that *are* the health system. This work is the prerequisite for achieving a high-performing, integrated health system built to support the SGFP's vision of implementing the Patient's Medical Home (PMH).

The following six recommendations present the actionable roadmap Ontario has been lacking. They are not six separate problems, but one interconnected, foundational solution. They detail how we must:

1. **Fix the Governance** by mandating the clinical **leadership and expertise** of family physicians who are accountable and formally representative of Ontario family physicians on leadership and data councils.
2. **Fix the Foundation** by funding a centralized, minimum standard for **Digital Readiness.**
3. **Fix the Plumbing** by building an EMR-fed digital backbone for **Data Flow & Digital Attachment**, led by **Primary Care Networks (PCNs)**.
4. **Fix the Market** by mandating open APIs by 2027 to end "vendor lock-in" and achieve true **Interoperability**.
5. **Fix the Rollout** with a workflow-first approach to **Innovation and Change Management** that respects physicians' zero capacity for disruption and is community led.
6. **Fix the Interface** by delivering **Patient Access** to their health information through a safe, physician-led, staged rollout that protects **Continuity of Care**.

# PILLAR 1: FIX DIGITAL HEALTH GOVERNANCE: MANDATING CLINICAL EXPERTISE AT THE TOP

A fundamental flaw in our current approach guarantees our digital investments will fail. The flaw is simple: the rules for our digital ecosystem are designed without the leadership of **family physicians** who use it every day. By excluding family physician representation from digital health, including emerging work on artificial intelligence and data governance, we are building systems blind to clinical and operational reality and devaluing the profession as mere "providers" instead of the clinical keystone of the system. This isn't a theoretical risk; it is actively creating inefficient tools that clinicians won't use, slowing down our progress and frustrating our most critical front-line partners.

## The Cost of the Status Quo: Why This Demands Urgent Action

Continuing on this path creates direct, predictable consequences that undermine key government priorities included in the Your Health: A Plan for Connected and Convenient Care: patient-centred and connected care.

**Fiscal Waste & Failed Projects:** We are building expensive systems that increase administrative burden. As clinicians reject these tools, we are guaranteeing a cycle of failed pilots, abandoned multi-million dollar projects, and a poor return on investment of taxpayer dollars.

**Bureaucratic Drag, Not Digital Speed:** Instead of accelerating care, these flawed systems slow it down. A 30-second referral becomes a three-minute bureaucratic task. This multiplies across the system, burning out clinicians and directly contradicting the goal of a more efficient, modern healthcare system.

**Reputational & Ethical Risk:** A system designed without trusted stewards risks alienating vulnerable populations and failing our commitments to Indigenous Reconciliation. Mishandling data, even with good intent, can shatter public trust and set back health outcomes in Indigenous communities for years.

## The Solution: A Pro-Practice Approach to Building Better, Faster

The fastest way to accelerate our digital agenda and ensure its success is to stop designing in a vacuum. Involving family physicians in governance is not about adding red tape; it is a **bureaucracy-buster**. They are our in-house experts who can stress-test ideas, prevent costly design flaws, and ensure the systems we build are practical, efficient, and immediately adoptable.

A single conversation with a physician during the design phase can save months of a failed pilot project and millions in wasted spending. Family physicians are the key to unlocking our digital potential and becoming a leader in Canada, rather than falling behind digitally connected jurisdictions like Alberta and British Columbia.

# Our Recommendation: Three High-Impact Actions

To correct our course, de-risk our investments, and accelerate our digital agenda, we urge the government to take the following common-sense steps:

1. **Mandate Clinical Expertise at the Top**: Involve family physician representatives, **accountable to their profession**, in the provincial strategy and appoint at least two SGFP-nominated family physicians to the Ontario Health Data Council, the organization that provides advice to the Minister of Health on the strategic management of Ontario's health data to foster a person-centred learning health system. This embeds real-world expertise at the source, ensuring our provincial strategy is grounded in reality.

2. **Implement a Clinical Workflow Quality Check**: Require a mandatory sign-off from a clinical expert panel, including family physicians, for any new data initiative. This simple quality gate will prevent the rollout of flawed, inefficient tools and save millions in rework.

3. **Build a Partnership Based on Transparency**: Grant physicians clear insight into how their contributed data is being used. This no-cost action builds the trust necessary to turn physicians from passive users into active champions of our digital transformation.

Clinical data governance should also involve representation from patients, other clinicians, administrative clinic leaders and team members that interface with digital platforms. Co-designing with patients strengthens trust and aligns with the Patient's Medical Home principle of shared responsibility.

AI governance is also key. A patient-centred, physician guided framework would help ensure transparency, accountability and equitable outcomes when integrating digital tools in primary care.

# PILLAR 2: FIX THE FOUNDATION: MOVING FROM DIGITAL DUCT TAPE TO A PROVINCIAL STANDARD

**A Rural Clinic's Cyber Nightmare**

Dr. Trent Lockout manages a small clinic in rural Ontario. Because reliable high-speed internet is non-existent in their area, the clinic operates entirely on a local, server-based system.

Officially, Dr. Trent Lockout is the "IT administrator" for the clinic. In reality, he's a physician with zero technical training, juggling patient care and the overwhelming task of trying to maintain an aging, complex IT infrastructure. There is no budget for dedicated IT support, and none of his administrative staff have ever received formal training on digital privacy or cybersecurity best practices.

One busy Tuesday morning, the clinic administrator opens an email from his personal account that looks like an urgent message from a medical supplier. He clicks on the link to view an "invoice." Instantly, the malware is deployed across his computer and rapidly spreads to the central server that holds all patient records.

The clinic is immediately paralyzed. Patient data is encrypted and locked down by a ransomware attack. The incident shuts down the clinic, compromises patient privacy and leaves Dr. Lockout facing an impossible choice: pay the hackers a ransom or risk permanent data loss and regulatory fines.

Ontario is investing in an advanced, interconnected digital health system. But this vision is being built on a crumbling and dangerously insecure foundation. The province's digital health planning assumes a baseline of digital readiness that simply does not exist in most community clinics.

This has created a two-tier system: well-resourced urban practices leap ahead, while rural, remote, and solo practices are left running on digital duct tape. For these clinics, mandated cloud-based EMRs are often unusable—with unreliable internet, physicians watch a circle on the screen for 10 seconds just to open a chart. When the internet fails, they are non-operational. We are building a system that is widening the digital divide and setting up our frontline for failure.

## The Cost of the Status Quo: A System-Wide Security Catastrophe

As recent ransomware attacks have shown, a more connected system means more points of entry for cyberattacks. As Ontario builds its provincial digital infrastructure, this is not a local clinical problem –it is a critical provincial security risk. A single under-resourced clinic with an 8-year-old computer and no staff phishing training becomes a backdoor to our entire provincial health information infrastructure.

The current do-it-yourself approach to security and information technology is fiscally irresponsible and operationally dangerous. We are forcing physicians—who are Health Information Custodians—to manage complex IT they are not trained for, or to hire ad-hoc consultants, which creates fragmented, inconsistent privacy and security.

## The Solution: A Smarter, Centralized Approach

Other jurisdictions in Canada are not making this mistake. Other provinces have recognized that digital readiness is a shared responsibility. They provide centralized support, including readiness assessment tools, security funding, free privacy training for staff, and professional technology support. The UK's NHS goes even further, with centralized procurement of cyber tools.

This approach is smarter, safer, and **dramatically more cost-effective**. Instead of forcing thousands of clinics to individually purchase expensive cyber insurance policies, a centralized security standard—paid for once at the provincial level—provides a higher level of protection for the entire system at a fraction of the cost.

## Our Recommendation: Mandate and Fund a Provincial Minimum Standard

Ontario cannot transform digitally until we support every clinic to meet a mandatory provincial standard. We call on the government to:

1. **Fund the Foundation**: Establish a Digital Infrastructure Stabilization Fund to ensure all clinics, especially small, rural and remote, have the resources to meet these standards without out-of-pocket costs.

2. **Mandate Specific Minimum Digital Standards** for all clinics, including:

- **Infrastructure:** All EMRs must be hosted on provincially approved, SOC2/ISO-compliant cloud servers by 2027. All clinic hardware (e.g., computers, routers) must be refreshed in keeping with Information and Privacy Commissioner recommendations and industry standards, be within vendor support lifecycle (e.g. 5-7 years) and run supported and up-to-date operating systems with appropriate anti-virus and encryption software.
- **Connectivity:** Define and fund minimum reliable upload/download speeds for clinical operations, especially for non-urban areas.
- **Cybersecurity**: Implement a provincially-funded and centrally procured, centralized security suite (e.g., advanced firewalls, threat detection) for all clinics, modeled on the successful UK approach.
- **People & Privacy (The Human Firewall)**: Mandate and fund standardized annual training for all clinic staff on cybersecurity, phishing, and PHIPA compliance, recognizing that human error is the leading cause of breaches. Establish a provincial **Privacy Officer Support Program** that provides a formal community of practice, training, a centralized library of policy templates, and a dedicated resource handbook. This work must be supported by the **provincial transformation workforce of practice facilitators** outlined in Pillar 5.

# PILLAR 3: FIX THE PLUMBING: BUILDING THE DIGITAL BACKBONE FOR DATA FLOW

**Bridging the gaps: The dangers of fragmented patient records**

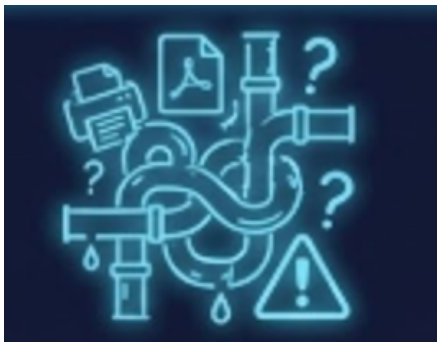
A 48-year-old male is in the family doctor's office for an ADHD assessment. While reviewing his medical history and current medications, the patient fortuitously mentions he is taking apixaban (a blood thinner). The family doctor is both surprised and concerned. Further inquiry reveals the patient had recently been seen in the emergency room for chest pain, referred to cardiology, and subsequently diagnosed with atrial fibrillation—information that was never relayed back to the family physician. This missing diagnosis is critical, as the doctor must now carefully weigh the cardiovascular risks associated with prescribing stimulant medication for ADHD.

Ontario is investing billions in a modern, connected health system, but these investments are being built on a broken foundation. The fundamental "plumbing" of our system—how patient data moves—is chaotic, archaic, and dangerously inefficient.

Every family practice is drowning in a complex array of faxes, unsearchable PDFs, and duplicate reports; even batch faxing is still permitted. This isn't just an inconvenience; it is a critical system failure. We are forcing our most valuable clinical assets to spend their time managing data chaos instead of focusing on what matters most – patient care.

## The Cost of the Status Quo: Why This Demands Urgent Action

The government's core objectives are being directly undermined by our failure to fix this foundational data flow:



- **Fiscal Waste & Project Failure**: We are paying for a system that is running on duplication. We are paying for insecure, unreliable faxes. Most importantly, we are forcing family practices—the most cost-effective part of our system—to bear the administrative and financial costs of managing this chaos.
- **Direct Patient Safety & Privacy Risk**: The daily inbox overload and inbox fatigue caused by this duplicative data directly leads to **errors and missed critical reports**. Furthermore, physicians routinely receive data for patients not in their practice, creating **constant privacy breaches** and an added administrative burden to report the error. Digital attachment ensures patient data flow to the correct family physician.
- **System-Wide Blindness**: We cannot build a connected system if we do not know who is connected to whom. The current provincial rostering system is flawed and limited, misclassifying unattached patients who actually have a family doctor. This means hospital discharge summaries are lost, care is fragmented, and Ontario is unable to accurately measure the unattached population.

# The Solution: A Single Source of Truth to Unlock Efficiency

We do not need to invent a new, complex system. We need to install the right plumbing. The solution is to establish a **digital backbone** for the entire system based on a single source of truth: the clinic's EMR that contains the attachment information between the patient and family physician.


Instead of relying on a flawed provincial registry, a new **Provincial Digital Attachment System** must be fed directly by the practice EMRs. This single, high-impact move:

1. **Instantly** provides an accurate, real-time map of patient attachment in Ontario. This information would be a significant asset to the Primary Care Action Plan.
2. **Automatically** routes all hospital reports, labs, and notifications to the correct physician, every time.
3. **Eliminates** the data chaos, administrative burden, and safety risks that are currently plaguing primary care.

This digital backbone is the non-negotiable plumbing required to achieve the **Connected Care foundation of the Patient's Medical Home, Fix the Market (Pillar 4)**, and **Fix the Interface (Pillar 6)**.

# Our Recommendation: Three High-Impact Actions

To de-risk our digital investments, accelerate our agenda, and restore time to patient care, we urge the government to take the following common-sense steps:

1. **Establish the Digital Backbone by 2027**: Mandate and fund a provincial digital attachment system that is **fed directly by clinic EMRs** as the single source of truth.
2. **Mandate Data Standardization**: Enforce common naming conventions for all digital reports and **immediately ban batch faxing**. Implement a 5-year plan to **sunset all clinical faxing**.
3. **Build the Unified Front Door through** Family Physician-Led PCNs: Develop a singular provincial patient portal that integrates with this new digital backbone. This work must be led by **Primary Care Networks (PCNs)**, positioning them as the primary vehicle for system transformation and resource distribution.

**Digital Attachment and Artificial Intelligence:**

A provincial digital attachment backbone could also enable responsible AI use. Once data flows securely and consistently, AI models can support population-level insights, early detection, and proactive management of chronic conditions.

# PILLAR 4: FIX THE MARKET: ENDING VENDOR LOCK-IN AND MANDATING INTEROPERABILITY

**Locked Out of Modern Care: The Consequences of EMR Vendor Lock-In**

In 2013, a primary care group transitioned to an EMR (Electronic Medical Record) system, seeking to modernize their practice. They adopted the system with the explicit understanding that its data-sharing feature—a prerequisite for certification by OntarioMD at the time—would ensure seamless continuity of care as they operated across different physical clinic locations. This shared record allowed them to focus on what matters most - their patients.

But somewhere along the way, without notice, support for this essential data-sharing feature was phased out. The function within the system became a phantom, non-functional for both new and existing physicians within the group. The clinics were forced backward in time. To communicate vital patient information between their own locations, they had to rely on outdated technology: faxing.

After protracted discussions regarding their options, the only solution presented to regain functionality was an expensive data merge—a cost prohibitive for physicians already struggling with the rising expenses of running a practice. And switching to a new EMR? It's also a massive, disruptive and time-consuming undertaking that the group was wary to undertake. They were stuck, trapped by ongoing subscription fees in a system that felt increasingly monopolistic.

Ontario's digital health innovation will never take off the ground as long as we are trapped in a market dominated by EMR vendors who lock in physicians, and hold their data hostage. This lack of data portability means lack of free market choice for physicians to switch to better products and hefty fees to even access their own data for quality improvement.

The current **monopoly** stifles innovation, keeps prices high, and prevents Ontario from building the modern, integrated system it seeks.

## The Cost of the Status Quo: Why This Demands Urgent Action

This market failure is costing Ontario billions and directly undermining key government priorities:

- **Fiscal Waste**: Canada Health Infoway estimates that basic interoperability would save the Canadian system $2.4 billion annually. With Ontario being the province with the largest population, it would carry the highest costs. We are paying a massive premium for inefficiency, duplication, and inflated prices that result from a distorted market.

- **Clinician Burnout & System Gridlock**: This lock-in is a source of immense stress for physicians, forcing them to act as manual data-entry clerks because systems can't communicate. It is a factor in physicians leaving practice or retiring—a critical loss we cannot afford with the ongoing family physician shortage.
- **Failed Innovation & Patient Harm**: Innovative tools that could improve care—like AI scribes or population health dashboards—are blocked by these closed systems. This fragmentation harms patient care, limits care coordination, and prevents vital health research that would allow the health care system to identify, monitor and address population-level health trends through predictive and preventative measures.

## The Solution: Mandate Open Competition and Fair Market Rules

The solution is to enforce fair market rules and **mandate interoperability**. By requiring all vendors to use modern, open standards (like FHIR and public APIs) by a set date, we break the monopoly. This single move will:

1. **Ignite Innovation**: Allow new, safe and secure, best-in-class tools to plug and play with any EMR, enabling the workflow-first **Innovation (Pillar 5)** the system desperately needs.
2. **Drive Down Costs**: Force vendors to compete on price, quality, and value.
3. **Restore Data Control**: Give physicians the freedom to choose the best tools for their practice and enable access to their practice data.

## Our Recommendation: Five High-Impact, Low-Cost Actions

To de-risk our digital investments and unlock the innovation stalled in primary care, we urge the government to invest the recuperated savings from interoperability to take the following common-sense steps:

1. **Mandate Open Application Programming Interfaces (APIs) by 2027**: Set a hard deadline for all EMR vendors to adopt modern interoperability standards (e.g., FHIR, OAuth2, HALO) as a condition of operating in Ontario.
2. **Establish a Vendor Accountability Office**: Mandate a provincial body to audit vendor compliance, publish transparency reports on data-blocking, and manage a clinician complaints registry.
3. **Launch a Modular Sandbox**: Fund an Ontario Health sandbox to test and certify third-party apps, giving clinics a clear path to adopt new, approved tools.
4. **Fund Modular Innovation**: Create funds at the clinic or OHT level to acquire these new best-in-class tools, driving a market of choice.
5. **Pilot Digital Twinning**: As a parallel strategy, pilot digital twin platforms in primary care to show the immediate value of aggregating data outside the locked EMRs.

# PILLAR 5: FIX THE ROLLOUT: A WORKFLOW-FIRST APPROACH TO INNOVATION & CHANGE MANAGEMENT

Ontario's Digital First for Health strategy is stalling at the most critical point: the clinic workflow. We are pushing top-down solutions that, in practice, increase administrative burden, disrupt care, and are met with massive resistance from burnt-out physicians.


In the current climate, clinicians have **zero capacity for short-term pain for long-term gain.** Any new tool that disrupts their current workflow will be rejected, guaranteeing project failure. Furthermore, our restrictive data rules mean new AI tools are trained on fake data, making them useless in the real world and wasting millions in development.

**Leveraging Lessons Learned**

The timing is prime for a workflow-first approach to innovation and change management, leveraging the recent successes and learnings from the collaborative, clinician-centred approach to AI scribe adoption with OntarioMD. The approach involved engaging directly with key interest-holders, including physicians, as the primary users of AI in clinical practice, who benefit from a significant reduction in paperwork and time-saving on administrative tasks. Other stakeholders involved in the approach included patients, technology vendors, research institutions, policymakers, and innovators. The Ontario AI Scribe Program was a partnership between the Ontario Ministry of Health, Ontario Health, Supply Ontario, and OMD to scale AI scribe use. The program made it easy for clinicians to choose an AI scribe that met their needs and received comprehensive change management support, at no cost to the user, to facilitate the adoption of AI scribe into their practice.

## The Cost of the Status Quo: Why This Demands Urgent Action

Our current approach to innovation is actively undermining the system it's intended to support:

- **Failed Investments & Fragmented Care**: We are investing in powerful tools like **Health811** that remain disconnected from primary care. Instead of acting as an integrated Digital Front Door, it risks becoming another silo that fragments care, confuses patients, and bypasses the Patient's Medical Home.
- **Guaranteed Adoption Failure**: By ignoring the reality of clinical workflow, we are ensuring our digital investments fail. Physicians will not and cannot adopt tools that add clicks, create noise, or force them to change how they work without a clear, immediate benefit.

- **Stifled AI Innovation**: We are hobbling our own technology sector. By denying vendors a safe, physician-guided framework to train AI on real-world data, we are ensuring that the smart inbox sorters and decision-support tools we buy will not work, requiring costly rework and delaying real progress.

## The Solution: A Workflow-First Approach to Innovation

To get buy-in, innovation must be invisible at first. New tools must be integrated on the **back end**—showing clear benefits to the physician before asking them to change their workflow. This low-risk, high-value approach builds clinician confidence before scaling to more complex clinical decision support.

1. **Integrate First, Change Later**: New tools must plug into current workflows. Physicians must see the benefits (e.g., a cleaner inbox, a pre-populated form) before they are asked to click a new button.
2. **Create a Digital Transformation Workforce**: We must fund a provincial team of practice facilitators—change management experts who provide hands-on, in-clinic support to help teams adapt and optimize tools.
3. **Build a Real-World AI Sandbox**: We need a new, **physician-led governance framework** (as described in **Pillar 1**) that allows vendors safe, reasonable access to data to build and validate tools. This de-risks innovation and ensures the smart tools we buy actually work.

## Our Recommendation: Four High-Impact Actions

To de-risk our digital investments and finally achieve meaningful adoption, we urge the government to:

1. **Mandate Workflow-First Integration**: Prohibit the rollout of any new provincial tool that does not integrate invisibly with existing EMRs. New tools should undergo simulation and rigorous testing within a living laboratory to ensure seamless integration and minimal workflow disruption. New tools must deliver value before they demand change.

2. **Fund a Provincial Practice Facilitator Workforce:** Establish a dedicated team, funded through a trusted delivery partner, to provide hands-on QI and change management support directly to clinics, ensuring no clinic is left behind.
3. **Establish a Physician-Guided AI Sandbox**: Create a formal governance body that allows vendors to safely use data for AI tool development, ensuring real-world usability and accelerating our tech ecosystem.
4. **Immediately Integrate Health811:** Make it a priority to connect Health811 to the provincial digital attachment registry and EMRs, ensuring it supports, rather than fragments, primary care services.

# PILLAR 6: FIX THE INTERFACE: A PRAGMATIC, PHYSICIAN-LED PLAN FOR PATIENT ACCESS

Patient access to their own health information is no longer a nice to have. It is a core expectation—8 in 10 patients want it—and a key objective of Ontario's Primary Care Act and an OurCare Standard of what everyone in Canada should expect from primary care.

Yet, Ontario's current approach is a chaotic failure. We have a fragmented system of incomplete hospital portals, pay-for-access lab sites, and clinical viewers that were never designed for patients. This has created a crisis of public expectation, and **family physicians are bearing the brunt of it**. We have become the **unpaid default interpreters** and manual messengers for a broken digital system, fielding endless calls to procure and explain results that patients should be able to see themselves.

While pockets of Ontario have patient access to some of their own health information, when it comes to patient access through a single provincial patient portal, Ontario is following other provinces in Canada that have this fully implemented. Saskatchewan followed their western neighbours and recently celebrated the five-year anniversary of MySaskHealthRecord. Citizens can access via a mobile app or desktop their clinical visit history, lab test results, medical imaging, prescription history, immunization history, select clinical documents, and surgical procedure information, and 58% of residents have quickly adopted it. Saskatchewan is one of the provinces leading in patient access to digital health information available via a patient portal. Ontario physicians have valid questions and concerns but patient access can be accelerated using a physician-led approach and leveraging the wisdom and lessons learned from physician organizations from other jurisdictions both within Canada and around the world to make this a rapid reality.

## The Cost of the Status Quo: Why This Demands Urgent Action

Simply turning on the taps without a plan will be a catastrophe. It will overwhelm clinics, increase patient anxiety, and erode trust in the system.

- **Physician Burnout**: A poorly designed portal will flood clinics with calls from patients who are confused or distressed by raw data they see without context. This wastes uncompensated physician time, reduces time for direct patient care and erodes the **relational continuity** that is proven to improve health outcomes and lower system costs.
- **Patient Harm & Inequity**: The current fragmented system creates confusion, mistrust, and inequitable access for those who can't navigate multiple complex portals.
- **Failing a Key Provincial Mandate**: We are failing to meet the public's demand and the Empowered objective of the Primary Care Act, while lessons from other jurisdictions show there is a better way.

## The Solution: A Pragmatic, Physician-Guided Rollout

We must get this right. The solution is not to simply dump raw data on patients. The solution is a **single, unified provincial portal**, co-designed with physicians, that is rolled out in a safe, staged, and step-wise manner, as seen in other provinces. This approach builds public trust while protecting clinics from an unmanageable surge in workload.

> With the rapid advancement of artificial intelligence technology, it will not be long before AI driven personalization can make patient portals more meaningful by tailoring information delivery, providing plain-language explanations, and supporting multilingual accessibility in a patient-centred manner.

## Our Recommendation: Four High-Impact Actions

To meet public demand without overwhelming the front lines, we urge the government to:

1. **Commit to a Single Provincial Portal in 2026**: Announce a firm deadline for a single, no-cost patient portal, built from existing data feeds.

2. **Mandate SGFP Co-Design at Every Phase**: Formally appoint the SGFP to the advisory body shaping this rollout. We must be at the table to ensure the system is safe and practical.

3. **Implement a Tiered Release Model to Manage Workload:**
   - **Immediate Release:** Start with low-anxiety data like routine labs, immunizations, medications and allergies. Learn the lessons from the many provinces that have already implemented this; it is not new work.
   - **Delayed Release:** Institute **mandatory time delays** for highly sensitive results (e.g., oncology, new diagnoses) to give physicians time to communicate with their patients first.

4. **Fund Patient Support Tools**: The portal **must** include provincially-funded, plain-language explanations of results, multilingual support, and secure caregiver proxy access. This is critical to reducing patient anxiety and preventing unnecessary clinic calls.

# AN URGENT CALL TO ACTION: THE PATH TO A UNIFIED SYSTEM

**The time for pilots and haphazard solutions is over. We call on the government to take immediate, decisive action on these foundational prerequisites.**

## Phase 1: Install the Groundwork (The Non-Negotiables)

**MANDATE CLINICAL EXPERTISE AT THE TOP**: Physicians need to be represented at the governance, vision and strategy level. Appoint at least two SGFP-nominated family physicians to the Ontario Health Data Council to embed real-world expertise at the source.

**MANDATE AND FUND DIGITAL READINESS**: Establish a Digital Infrastructure Stabilization Fund and mandate minimum standards for all clinics, including provincially-funded centralized cybersecurity and free, standardized training for all practice staff and Privacy Officers.

**MANDATE AN OPEN MARKET BY 2027**: Set a hard deadline for all EMR vendors to adopt modern, open APIs (like FHIR) to end vendor lock-in as a condition of operating in Ontario.

## Phase 2: Build the System (The Enablers)

- **ESTABLISH THE DIGITAL BACKBONE**: Mandate and fund a provincial Digital Attachment system that is fed directly by clinic EMRs as the single source of truth for all data routing.
- **ESTABLISH A PHYSICIAN-GUIDED AI SANDBOX FOR INNOVATION**: Create a formal governance body that allows vendors safe, reasonable access to data to build and validate real-world AI tools.
- **COMMIT TO A STAGED ONE PATIENT, ONE RECORD PORTAL**: Commit to a single provincial patient portal, co-designed with physicians and patients, that uses a Tiered Release Model (e.g., time delays for sensitive results) to protect physician workflow and prevent patient anxiety.

**A final note on Artificial Intelligence:**

AI must reinforce, not replace, the human connection at the heart of primary care. A patient-centred co-designed AI strategy should always measure success in terms of improved trust, understanding and relational continuity between a patient and their family physician.

# THE VISION: A SYSTEM THAT FINALLY WORKS

Fixing this foundation is the only way to achieve our shared goal: a high-performing, integrated health system aligned with the **Patient's Medical Home (PMH)** vision. This is the unified digital front door Ontario needs, one that is not just a piece of technology, but a new way of delivering care.

This new front door will be:

**POWERED TO support** the **Patient's Medical Home** vision.
**GOVERNED WITH family physicians**.
**CONNECTED VIA** mandated **Interoperability** standards.
**SECURED THROUGH** universal **Digital Readiness**.
**ACCESSED BY** a single, safe, staged **Patient Portal**.

This is the system that finally reduces physician burnout by streamlining referrals, automating data flow, and empowering patients. This is the only path to a modern, efficient, and fiscally responsible health system. We have provided the roadmap. This work is urgent, it is essential, and we must partner on this work and begin now.

# APPENDIX A

## Comparison of Provincial Progress on Connected Care

| Provincial Digital Health | BC | AB | SK | MB | ON | QC | NS | PEI | NB | NF &L |
|---|---|---|---|---|---|---|---|---|---|---|
| Single Provincial EHR Viewer | ✓ | ✓ | ✓ | ✓ | ✓* | ✓ | ✓ | ✓* | ✓ | ✓ |
| Dispensed Rx | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |
| Immunizations | ✓ | ✓ | ✓ | ✓ | | ✓ | | | | |
| Lab Results | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ |
| Imaging | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | |
| Medical Reports | | ✓ | ✓ | | ✓ | ✓ | ✓ | | | |
| Allergies | | ✓ | | | ✓ | ✓ | | | | ✓ |
| ECG | | ✓ | | | | | | | | |
| Community Consultations | | ✓ | | | | | | | | |
| Community Encounters | ✓ | ✓ | | | | | | | | |
| 4 Chronic Diseases** | | | ✓ | | | | | | | |
| Single Patient EHR Viewer/Patient Portal | | ✓ | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ |

✓ Complete

✓ In-Progress

✓ Developing

*ON has three clinical viewers in progress toward one
*PEI has one CIS for 7 hospitals and one EMR for community
** SK: The CDM-Quality Improvement Program covers 4 chronic diseases and involves exporting flowsheet data electronically to eHealth for annual payment

Presently, Ontario is moving from three clinical viewers to one, and contributions from acute care sites vary. The Digital Health Drug Repository displays only publicly funded medications and pharmacy services, as well as all monitored drugs, in comparison to alldispensed medications in other provinces.

# APPENDIX B

## Provinces with Privacy Programs and Supports to Build Capacity for Community Practices

While hospitals and health authorities offer dedicated privacy training there is a need to provide privacy and privacy officer training and resources to community-based clinic teams members that support physicians. The following is scan of offerings that fill this gap.

### British Columbia:

Doctors of BC and the Doctors Technology Office partnered with the University of the Fraser Valley to provide medical offices assistants with the opportunity to learn how to protect patient information in their clinics at no cost. Doctors of BC also provides a BC Physician Privacy Toolkit.

### Alberta:

The Alberta Medical Association offers free online privacy training and resources for community based physicians and dedicated training for their teams. There is dedicated training for clinic and primary care network privacy officers that includes a privacy officer handbook, basic and advanced training modules as well as networking through the provincial clinic managers network.

### Saskatchewan:

The Saskatchewan Medical Association offers a privacy and security policy and procedure requirement checklist and a privacy and security requirement actions checklist as well as sample practice manuals.

### Manitoba:

Manitoba Health offers a free online training program for the provincial health information act available to physicians/trustees and individuals that work in healthcare. eChart Manitoba offers a handbook for site privacy officers.

### Ontario:

OntarioMD offers privacy and security online training and resources for healthcare professionals. The Office of the Information and Privacy Commissioner offers resources and a Privacy Management Handbook for Small Healthcare Organizations.

### Nova Scotia:

The Office of the Information and Privacy Commissioner of Nova Scotia offers training: a PHIA Essentials for Custodians, PHIA Basics for Staff and a Chief Privacy Officer Training and a PHIA Toolkit.

### Newfoundland and Labrador:

eDOCSNL has developed privacy and security documents to assist custodians and their staff in meeting their privacy and security responsibilities including manuals, templates and checklists.

### Prince Edward Island:

Health PEI offers privacy and access to PHI training videos, slideshows and resource documents as well as a toolkit containing a readiness checklist for managers and supervisors.

# APPENDIX C

## Connected Care Across Canada: Viewers and Patient Portals

**Provincial digital health clinical viewers and information available to healthcare providers and patients in select Canadian provinces.**

### British Columbia:

Provincial Health Services Authority Digital Health Initiatives and Care Connect, provincial EHR viewer
Health Gateway, provinicial patient portal

### Alberta:

Alberta Netcare Provincial EHR Data for healthcare providers
MyHealth Records, provincial patient portal
Alberta Health Services Connect Care, the common provincial clinical information system

### Saskatchewan:

eHealth Saskatchewan EHR Viewer for healthcare providers
MySaskHealthRecord, provincial patient portal

### Manitoba:

eChart Manitoba, EHR for healthcare providers

### Ontario:

Connecting Ontario Clinical Viewers for healthcare provideres

### Nova Scotia:

Nova Scotia Electronic Health Record (SHARE) for healthcare providers
Your Health NS provincial patient portal

### Newfoundland and Labrador:

Health eNL for healthcare providers
My Health NL provincial patient portal

### Prince Edward Island:

Provincial EMR, for healthcare providers
MyHealth PEI provincial patient portal