SGFP
GENERAL & FAMILY PRACTICE

Building Tools & Structures: Modernizing Specialty Access & Collaboration

Discussion Paper

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

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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.

EXECUTIVE SUMMARY

Ontario is investing in operational tools and programs to improve specialty access and relieve administrative burden for physicians: central intake, standardized referral forms, e-referral, e-consult, and care pathways. These tools are valuable, but the structures to ensure accountability and usability for physicians (i.e., the primary users) are not in place. Although structures for the current access initiatives do exist, they are not transparent to family physicians or system partners, including how clinical representatives are selected or to whom they are accountable.

Without clear and visible governance, these initiatives risk becoming costly projects that fail to meet the needs of end-users, or worse, duplicating and conflicting with one another. The result is inequity for patients, administrative burden for family physicians, strained relationships with consulting specialists, and wasted resources.

SGFP supports the Primary Care Act and its six objectives of **province-wide, connected, convenient, inclusive, empowered**, and **responsive care**. We share the province's commitment to achieving these goals for Ontarians. This paper outlines a key structural requirement for delivering on the objective of **connected** care.

The Section on General & Family Practice (SGFP) is proposing a solution: **embed these specialty access operational tools and programs within a governance structure that establishes oversight and supports implementation**. A provincial framework is needed to integrate specialty access initiatives under one umbrella, embed physician leadership at every level, and ensure equity across regions. With clear governance, accountability, and alignment, Ontario can transform fragmented projects into a sustainable system that delivers for patients and physicians alike.

Our proposal defines a structure including:

- Tri-lateral governance through a **Provincial Specialty Access Committee** (OMA/SGFP, Ministry of Health, Ontario Health).
- **Coordinated project groups** to align intake, forms, consults, referrals, and pathways.
- **Provincial specialty working groups** to adapt standards to each discipline.
- **Regional specialty working groups** to operationalize solutions locally.

By building these structures to support the design and implementation of the operational tools, Ontario can modernize specialty access, reduce administrative burden, strengthen collegiality between family physicians and consulting specialists, and make the projects themselves more efficient and coordinated, ultimately improving access and care for patients across the province.

INTRODUCTION

Connected care is a priority of the government and embedded as seen in both the *Your Health: A Plan for Connected and Convenient Care* and the *Primary Care Act, 2025 (S.O.2025, c.8)*. Yet family physicians and consulting specialists across Ontario continue to face mounting challenges in accessing and collaborating with one another.

The current approach relies heavily on creating operational tools including, central intake, standard referral forms, e-referral, e-consult, and care pathways. These tools are important, but without strong, collaborative governance structures and implementation support they risk fragmentation, inequity, and inconsistent uptake. Ontario's system is designed to produce the results it currently delivers: uneven access, downloading of work, and blurred role boundaries. To change the results, we must change the design.

A Note on Terminology:
This paper uses the term "consulting specialists" to include all physicians who provide consultative care, including family physicians. This definition is intentionally inclusive and reinforces that consultative roles are shared across family medicine, medical, surgical and diagnostic specialties.

This paper is not about fault. Every system is designed to produce the results it delivers and Ontario's specialty access challenges are largely systemic, not individual. SGFP's position is that specialty access must be modernized through structured, collaborative solutions that work for both family physicians and consulting specialists*.

Ontario's Primary Care Act: Shared Objectives

The SGFP acknowledges the Primary Care Act and its six objectives for a *province-wide* system that is *connected*, *convenient*, *inclusive*, *empowered* and *responsive*. We share the province's commitment to achieving these goals for the people of Ontario and are committed to working in partnership to realize them.

This paper outlines a key structural requirement for achieving the objective of *connected care*, offering a governance approach that strengthens alignment across tools, pathways and system partners.

The audience for this paper includes:

- **Family physicians**, who have asked us for solutions aligned with frontline needs.
- **Consulting specialists**, invited into dialogue toward mutually beneficial solutions.
- **Ministry of Health** and **Ontario Health**, whose support is essential to make recommendations a reality.

In this paper we will briefly outline the "what" - the operational tools and programs already underway. The majority of this paper will focus on the "how" - the structures required for uptake, efficiency, and sustainability. SGFP's advocacy emphasizes physician leadership, accountability and equity as the foundation for modernizing specialty access in Ontario.

PATIENT-CENTRED ELEMENTS OF SPECIALTY ACCESS

Patients must be at the centre of any reform to specialty access. For them, the experience of care is shaped not by the existence of tools, but by how those tools are connected, governed and made usable. When systems are fragmented, patients face delays, duplication and confusion. When structures are clear, patients experience transparency, equity and continuity across their care journeys.

Putting patients at the centre means ensuring reforms reflect their priorities. The following elements are essential to a patient-centred system:

Single Digital Platform
Patients should have one clear entry point to view referrals and specialty access, rather than multiple overlapping systems. This is especially necessary for patients that see multiple specialists for their care. This reduces confusion, prevents duplication and ensures equity across regions.

Transparency and Tracking
Patients should be able to see where their referral is at every step of the process, much like tracking an online shopping order. This visibility reduces anxiety, builds trust and empowers patients to engage more confidently in their care.

Equity of Access
Structures must ensure that patients in rural, remote and underserved communities have the same access as those in urban centres. Central intake and standardized referral forms are key enablers of fairness.

Equity also requires that patients encounter no barriers related to technical know-how, language, culture, education or physical ability when using digital platforms or referral systems. The system must offer navigation supports and accessible design to ensure all patients can participate fully.

No-Cost Access
Patients should not face fees to access digital platforms or referral systems. Specialty access must remain a publicly funded service, consistent with Ontario's commitment to universal healthcare.

Provincial Consistency
Patients do not experience care within the boundaries of Ontario Health Teams or administrative regions, they cross them constantly. A provincial approach is essential to ensure that specialty access is seamless, consistent and equitable no matter where patients live or seek care.

THE CURRENT STATE OF IMPROVING SPECIALTY ACCESS: THE "WHAT"

Ontario's current efforts to improve specialty access focus on a series of operational projects. All of the work listed below is actively underway at various stages of design and implementation, with a shared desire to accelerate the implementation. Outlining these initiatives provides the context for SGFP's proposal to build the structures that will connect and sustain them. They include:

Central Intake
Designed to provide a single, standardized entry point for referrals, central intake aims to reduce inequities in patient access, streamline administrative work, and ensure patients are directed to the most appropriate professional or service based on patient choice of professional or first available.

Referral Forms Standardization
Led by clinical experts, this project focuses on the content of referral forms, ensuring that the information required is consistent, usable, and aligned across specialties. Without standardized forms, electronic platforms risk duplication, conflicting requirements and inefficiency for physicians.

E-Referral
A digital platform that replaces paper and fax-based referrals with secure electronic submissions. E-referral seeks to improve efficiency, reduce lost referrals, and allow physicians and patients to track referral status.

E-Consult
Provides family physicians with timely advice from consulting specialists without requiring a full referral. Synchronous e-consults (real-time phone or video) and asynchronous e-consults (secure written exchanges) both aim to reduce unnecessary referrals, improve collegiality and support continuity of care.

Care Pathways
Evidence-based protocols that outline recommended steps for managing specific conditions. Care pathways clarify roles, improve consistency across providers, and ensure patients receive high-quality care regardless of geography while recognizing there may be good reasons for following other than recommended steps in particular patient situations.

The Future State: How Integrated Specialty Access Tools Could Work Together in Practice

Dr. Joy is a family physician caring for a patient with a complex condition. He begins with an integrated clinical decision support tool, embedded in the EMR, which draws on provincially developed and locally customized guidance. After several weeks of trying the recommended diagnostic and treatment options without success, he turns to the e-consult platform for asynchronous advice. Within hours, a consulting specialist responds, confirms that he has exhausted the reasonable options, and suggests one additional patient specific approach. She advises that if this final option fails, a referral is appropriate.

When the additional option is unsuccessful, Dr. Joy initiates a referral using the standardized provincial form within the fully integrated ereferral platform. The referral is easily populated and then automatically routed to central intake, and on the referral form he notes the patient's preference to see the first available consulting specialist.

Within minutes, both Dr. Joy and the patient receive confirmation that the referral has been submitted. From there, they both digitally track its progress through each step of the process, much like following the status of an online shopping order, creating transparency, predictability, ease and confidence for everyone involved.

Consultant–Family Physician Task Transfers

Alongside these operational initiatives, consultant–family physician task transfers remain a persistent challenge for many family physicians. Although downloading from specialists is a significant concern, family medicine also recognizes that our own referrals can be inconsistent or incomplete, thus structures are needed that support improving referral quality across the board.

A structured, physician-led governance model would provide a systematic way to identify, assess, and address these issues. Within care pathway development and other collaborative processes, family physicians and consulting specialists can jointly determine where work is best situated, ensuring tasks align with scope, capacity and patient needs. Embedding this decision-making within the proposed framework also creates a foundation for mutual accountability, enabling both sides to uphold shared expectations and strengthening the relationships that support high-quality, coordinated care.

THE MISSING PIECE: THE "HOW"

Ontario has begun building the tools and programs to improve specialty access: central intake, referral form standardization, e-referral, e-consult and care pathways. But tools and programs alone cannot effectively deliver the outcomes patients and physicians need. Without structures to guide their use, they risk becoming fragmented, duplicative, or unusable.

Although structures for the current access initiatives do exist, they are not transparent to physicians or system partners. It is unclear who the clinical representatives are, how they are selected, or to whom they are accountable. The work also lacks a clear implementation plan that outlines how tools will be rolled out, supported and evaluated across regions. This lack of visibility limits trust and makes it difficult for users to understand how decisions are made or how the various projects relate to one another. A visible, coordinated governance framework would allow users to understand how initiatives fit together, how decisions are made and how accountability is upheld.

> ***"A visible, coordinated governance framework would allow users to understand how initiatives fit together, how decisions are made and how accountability is upheld."***

To be effective, these operational tools must sit within a governance structure that connects them into a coherent system. Clear frameworks and leadership mechanisms ensure tools are aligned, equitably accessed, and sustainably supported. This is what will create lasting solutions, embedding accountability so reforms work for physicians and patients alike.

SGFP's position is clear: operational tools must be paired with structures that provide oversight, integration and physician leadership. This means:

- Tri-lateral oversight and accountability (OMA-SGFP, Ministry of Health, Ontario Health).
- Purposeful integration of specialty access projects under one umbrella structure.
- End-user engagement: physicians highly involved in planning and implementation.
- Peer-to-peer accountability: bringing colleagues along in the adoption journey.
- Local accountability: regional structures to ensure implementation.

FORMAL ACCOUNTABILITY FOR FAMILY MEDICINE

We recognize that accountability can be a tricky concept, so we want to be clear about what we mean in the context of this discussion paper.

In this framework, accountability refers to family physicians serving in formal system roles; roles that are either appointed or employed, with accountability upward to an organization, or elected, with accountability outward to their peers. SGFP recommends a balanced mix of all three, ensuring that no single pathway dominates and that the system benefits from both organizational oversight and peer-conferred legitimacy.

In all cases, representatives hold clear mandates, defined expectations and transparent reporting relationships. This ensures that those shaping the tools and standards are meaningfully connected to the clinicians who must use them, and that their authority is grounded in legitimate, visible processes.

We also acknowledge that family medicine in the province currently lacks sufficient structures to support this kind of formal accountability, and that strengthening these mechanisms is important work. SGFP has begun addressing this in our discussion paper on Primary Care Networks (PCNs), but that broader system-building effort is beyond the scope of this paper.

The Current Reality

Dr. Singh brings exceptional clinical expertise and deep system insight to provincial specialty access work. When she is invited to participate, her contributions genuinely shape decisions. But she does so as an individual clinician, not from a formal, accountable provincial role.

She is helping to build the system, yet she is not elected, appointed, or connected to a mandate that ties her work to the broader family medicine community. Her influence depends on personal invitation rather than transparent, legitimate processes.

The Future State

In a unified provincial structure, Dr. Singh serves in a formal, accountable role with a clear mandate and transparent reporting relationships. She is appointed or elected through a visible process, supported by the peers she represents and connected to the broader family medicine community. Her clinical expertise is no longer offered informally or by invitation. it is embedded in the system's design.

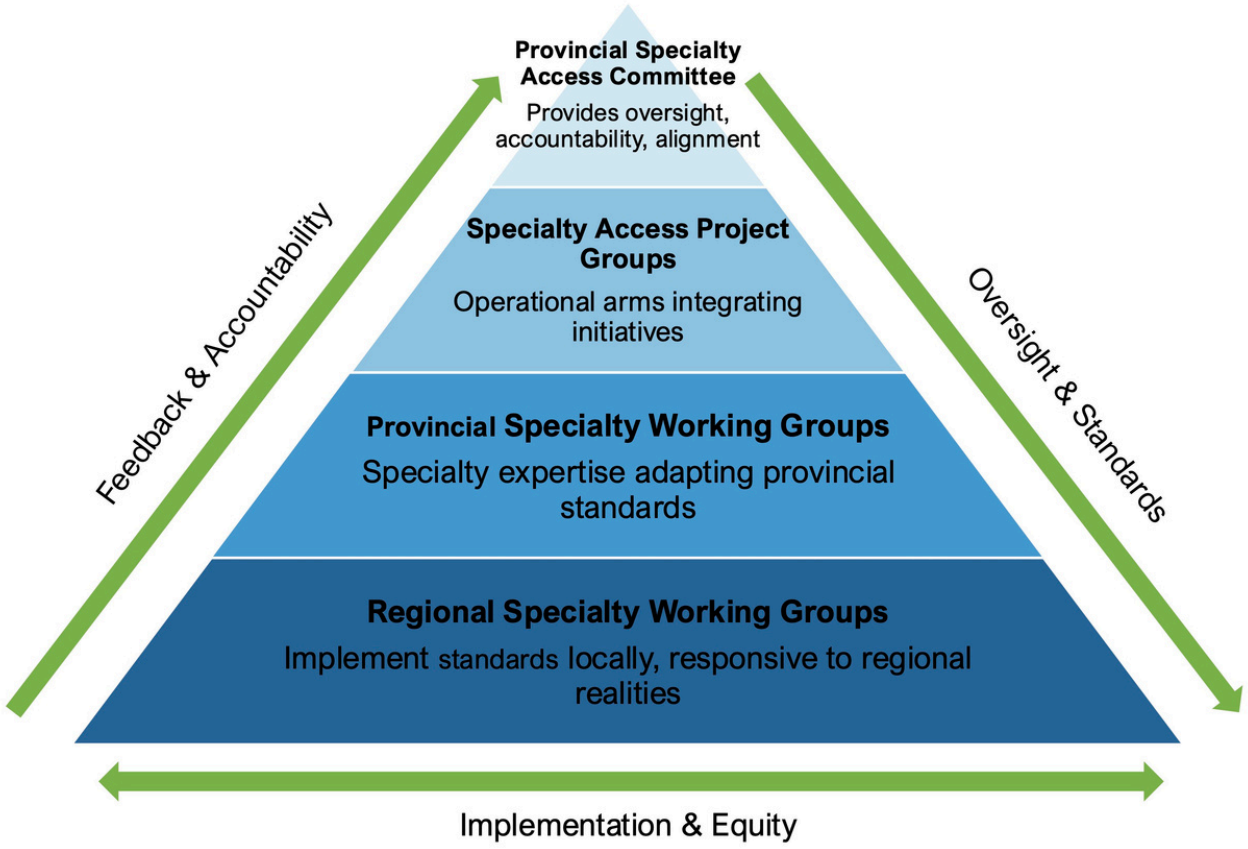
From this position, Dr. Singh helps guide all specialty access work as part of a coordinated structure. She collaborates with consulting specialists, shapes standards and tools with legitimacy, and draws on additional expertise as needed. Her leadership is stable, trusted and grounded in real clinical practice.

PROPOSED STRUCTURE

SGFP's proposed framework is built on four interconnected layers that move from provincial oversight to regional implementation:

1. **Provincial Specialty Access Committee (PSAC)** – A tri-lateral governance body providing oversight, accountability, and alignment across the province.
2. **Specialty Access Project Groups** – Coordinated provincial projects (central intake, referral forms, e-referral, e-consult, care pathways) that function as arms of the framework.
3. **Provincial Specialty Working Groups** – Specialty-specific forums that adapt provincial standards to the realities of each discipline.
4. **Regional Specialty Working Groups** – Local structures that operationalize provincial standards within Ontario Health's six regions, ensuring responsiveness to local realities.

Together, these layers ensure that operational tools are not siloed but part of a connected, accountable system that embeds physician leadership and equity at every level.



Family Physician Leadership: In the long term, family physician representation across all layers should include elected leaders from a mature PCN governance structure (at the upper layers) and appointed leaders from PCNs at the lower layers of the structure. The SGFP's September 2024 discussion paper, *Optimizing Primary Care Networks in Ontario*, proposes a model for such a provincial PCN structure. As this structure does not yet exist, elected SGFP leaders are suggested to serve as the current mechanism for accountable family physician representation. This is an interim approach intended to ensure legitimacy and continuity until PCN-based leadership is established.

1 Provincial Governance Structure: The Provincial Specialty Access Committee (PSAC)

The Provincial Specialty Access Committee (PSAC) is the apex of the framework. Positioned at the top, it provides oversight, accountability and alignment across all specialty access initiatives.

Membership:

- Tri-lateral representation from the Ontario Medical Association (family medicine, consulting specialties), Ministry of Health and Ontario Health.
- Family physicians and consulting specialists in leadership roles to ensure and balance frontline and system perspectives.

Mandate:

- Set provincial standards for specialty access projects.
- Ensure projects are connected and aligned, avoiding duplication or conflict.
- Guarantee equity across regions and specialties.
- Monitor implementation and performance.
- Report publicly to maintain transparency.

Accountability:

- A designated Ministry lead responsible for ensuring the work is advanced and coordinated.
- All other members accountable through the trilateral structure, reporting collectively to the three partner organizations.

2 Specialty Access Project Groups

These groups form the first operational arms of the framework. They consolidate ongoing initiatives under one umbrella, ensuring integration and preventing siloed solutions.

The projects include: central intake; referral forms standardization; e-referral; e-consult; care pathways.

Membership:

- Family physicians and consulting specialists.
- Ministry of Health and Ontario Health leadership.
- Project leaders.

Mandate:

- Build out the project according to its objectives.
- Align with other projects to ensure interoperability.
- Report quarterly to PSAC with progress, challenges and recommendations.
- Engage provincial specialty working groups to capture discipline-specific input.
- Document equity impacts (urban vs. rural, practice size, patient demographics).
- Foster dialogue and relationship-building between family physicians and specialists.

Accountability:

- Each project group reports directly to PSAC, ensuring oversight and alignment.
- Outputs must be documented, transparent and shared across projects to prevent duplication.

3 Provincial Specialty Working Groups

These groups provide the specialty-specific expertise needed to adapt provincial standards into workable solutions. Positioned in the middle layer of the framework, they ensure that family medicine and each specialty's unique realities are reflected in the design and implementation of every tool and program.

Membership:

- Consulting specialists from the relevant specialty (e.g., orthopedics, cardiology, dermatology, etc.).
- Family physician representatives to align with primary care workflows and ensure a workflow-first approach.
- Project leads from the specialty access projects.
- Ontario Health and Ministry of Health liaisons.

Mandate:

- Interpret provincial standards through the lens of each specialty.
- Identify specialty-specific challenges (e.g., surgical waitlists, diagnostic bottlenecks).
- Co-design solutions that balance family physician and specialist needs.
- Advise project groups on feasibility, workflow integration and equity impacts.
- Support provincial rollout while respecting specialty nuances.
- Provide feedback loops to PSAC, highlighting successes, barriers and adjustments needed.

Accountability:

- Report to the Specialty Access Project Groups, ensuring operational alignment.
- Ensure recommendations are transparent, documented and shared across specialties to promote cross-learning.
- Maintain alignment with PSAC's provincial standards and equity goals, reinforcing the trilateral governance structure.

4 Regional Specialty Working Groups

These groups form the final layer of the framework. They operationalize provincial standards within Ontario Health's six regions, ensuring solutions are responsive to local realities while maintaining consistency across the province.

Membership:

- Consulting specialists practicing in the region.
- Family physician representatives PCN structures where they exist, otherwise SGFP.
- Regional Ontario Health leadership and administrators.
- Project group liaisons to connect regional work back to provincial initiatives.

Mandate:

- Implement provincial specialty approaches (intake, consults, e-referral, pathways) within the regional context.
- Identify local barriers and enablers (hospital capacity, rural geography, digital infrastructure).
- Adapt provincial standards to reflect regional realities while preserving equity.
- Facilitate relationship-building between local family physicians and consulting specialists.
- Provide feedback loops to Provincial Specialty Working Groups and Project Groups.
- Monitor regional performance (wait times, consult turnaround, pathway adherence).

Accountability:

- Report to the corresponding Provincial Specialty Working Group.
- Consolidate outputs for escalation to Project Groups and ultimately to PSAC.

ENABLERS OF SUCCESS

SGFP has identified enablers of system change in other papers; this section highlights those most critical to ensuring specialty access reforms are adopted, sustained, and aligned with physician and patient needs.

Primary Care Networks (PCNs)
PCNs strengthen family physician leadership and accountability by embedding specialty access initiatives within organized primary care structures. They provide the foundation for local physician engagement, peer-to-peer accountability and anchoring patients in their medical home.

Change Management Supports
Structured resources and supports are required to guide adoption. Physicians and teams need practical tools, training and communication strategies to integrate new processes into daily workflows.

Physician Leadership
Embedded at every level of governance, provincial, specialty, and regional physician leadership ensures that reforms are grounded in clinical realities and maintain credibility with end-users.

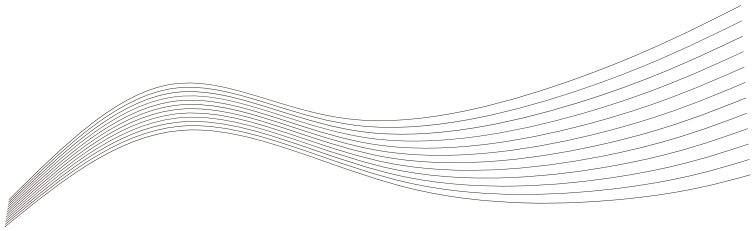
Digital Integration
A government-funded e-referral platform, paired with standardized referral forms and aligned with central intake, ensures interoperability and usability. Integration across tools prevents duplication, supports equity of access and embeds digital solutions as part of a system rather than isolated pilots.

Peer-to-Peer Engagement
Specialties must lead their colleagues through adoption. Peer-to-peer dialogue builds trust, reduces resistance and fosters shared accountability across disciplines.

Barrier-Free Technology
Technology must be provided at no cost to physicians. Removing financial barriers ensures equitable adoption across practice sizes and geographies and reinforces the principle that specialty access is a publicly funded service.

A Foundation for Continuous Monitoring and Adaptation

This framework not only supports the modernization of specialty access but also provides the structures needed to monitor, learn from and refine the projects outlined in this paper. By embedding governance, accountability, and physician leadership at every layer, it creates durable mechanisms that can guide ongoing implementation and ensure the work remains responsive to real-world experience. As new challenges and opportunities emerge, these same structures with clear roles, transparent reporting, and continuous feedback loops, position the system to adapt, evolve and strengthen collaboration across disciplines over time.



CONCLUSION & CALL TO ACTION

Ontario's specialty access challenges are systemic, not individual. Tools to improve specialty access are already being built, but without structures to guide their use, they risk fragmentation, duplication and uneven adoption. What is missing are governance frameworks and leadership mechanisms that embed accountability, equity and usability for physicians and patients alike.

SGFP is calling for:

- **Tri-lateral oversight and accountability** through government, Ontario Health, and the Ontario Medical Association.
- **Physician leadership** embedded provincially, by specialty, and regionally.
- **Integration of projects** under one coordinated framework to avoid duplication and conflict.
- **Patient-centred digital tools** that ensure transparency, equity and barrier-free access.
- **Continued focus on system enablers** such as Primary Care Networks, change management supports and peer-to-peer engagement.

By building these structures alongside operational tools, Ontario can modernize specialty access, reduce administrative burden and strengthen collegiality between family physicians and consulting specialists. Most importantly, it will fulfill the promise of equitable, transparent and sustainable care for patients across the province.

APPENDIX

Glossary of Terms

This glossary defines key terms used throughout the paper. It is intended to provide clarity and consistency by outlining the tools and concepts central to Ontario's specialty access initiatives.

Central Intake
A standardized process for receiving and triaging referrals to consulting specialists. Central intake systems aim to reduce inequities in access, streamline administrative work and ensure patients are directed to the most appropriate provider or service.

E-Referral
A digital platform that allows family physicians to submit referrals electronically to consulting specialists. E-referral systems improve efficiency, reduce paperwork and enable tracking of referral status. They are most effective when integrated with EMRs and central intake processes.

E-Consult
A secure digital tool that enables family physicians to seek advice from consulting specialists without a formal referral.
- Synchronous e-consults: Real-time interactions (e.g., phone or video).
- Asynchronous e-consults: Written exchanges through secure platforms.
E-consults reduce unnecessary referrals, improve timeliness of advice and foster collegiality between physicians.

Care Pathways
Evidence-based, standardized protocols that outline the recommended steps for managing specific conditions across the continuum of care. Care pathways clarify roles, improve continuity and ensure patients receive consistent, high-quality care regardless of location.

Downloading/Task Transfers
The practice of consulting specialists redirecting tasks back to family physicians that should remain with the specialist, either administrative or clinical responsibilities or both. Downloading increases workload, blurs role boundaries and can compromise patient safety.

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