COVID-19 Community of Practice for Ontario Family Physicians

March 22, 2024

Dr. Zain Chagla
Dr. Daniel Warshafsky
Dr. Susan Goldstein

Infectious Disease Updates and Management of Menopause

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of Family Physicians

Infectious Disease Updates and Management of Menopause

Moderator:

- Dr. Ali Damji, Division Head, Primary Care, Trillium Health Partners and Family Physician, Credit Valley Family Health Team, Mississauga, ON

Panelists:

- Dr. Zain Chagla, Hamilton, ON
- Dr. Daniel Warshafsky, Toronto, ON
- Dr. Susan Goldstein, Toronto, ON

Host:

- Dr. Mekalai Kumanan, Cambridge, ON

The COVID-19 Community of Practice for Ontario Family Physicians is a one-credit-per-hour Group Learning program that has been certified for up to a total of 32 credits.

Land Acknowledgement

We acknowledge that the lands on which we are hosting this meeting include the traditional territories of many nations.

The OCFP and DFCM recognizes that the many injustices experienced by the Indigenous Peoples of what we now call Canada continue to affect their health and well-being. The OCFP and DFCM respects that Indigenous people have rich cultural and traditional practices that have been known to improve health outcomes.

I invite all of us to reflect on the territories you are calling in from as we commit ourselves to gaining knowledge; forging a new, culturally safe relationship; and contributing to reconciliation.

Changing the way we work

A community of practice for family physicians during COVID-19

At the conclusion of this series participants will be able to:

- Identify the current best practices for delivery of primary care within the context of COVID-19 and how to incorporate into practice.
- Describe point-of-care resources and tools available to guide decision making and plan of care.
- Connect with a community of family physicians to identify practical solutions for their primary care practice under current conditions.

Disclosure of Financial Support

This CPD program has received in-kind support from the Ontario College of Family Physicians and the Department of Family and Community Medicine, University of Toronto in the form of logistical and promotional support.

Potential for conflict(s) of interest:
N/A

Mitigating Potential Bias

- The Scientific Planning Committee has full control over the choice of topics/speakers.
- Content has been developed according to the standards and expectations of the Mainpro+ certification program.
- The program content was reviewed by a three-member national/scientific planning committee.

Planning Committee: Dr. Mekalai Kumanan (OCFP), Dr. Ali Damji (DFCM), Dr. Eleanor Colledge (DFCM), Dr. Harry O'Halloran, Julia Galbraith (OCFP), Pavethra Yogeswaran (OCFP), Marisa Schwartz (DFCM), Erin Plenert (DFCM)

Previous webinars & related resources:

https://www.dfcm.utoronto.ca/covid-19-community-practice/past-sessions

Dr. Zain Chagla – Panelist

Twitter: @zchagla

Co-Medical Director Infection Control and Head of Infectious Diseases Service, Infectious Disease Physician, St. Joseph's Healthcare Hamilton

Dr. Susan Goldstein– Panelist

Family Physician and Menopause Society Certified Practitioner

Dr. Daniel Warshafsky – Panelist

Associate Chief Medical Officer of Health at the Office of the Chief Medical Officer of Health

Dr. Mekalai Kumanan – Host

Twitter: @MKumananMD

President, Ontario College of Family Physicians
Family Physician, Two Rivers Family Health Team
Deputy Chief of Family Medicine, Cambridge, ON

Speaker Disclosure

- Faculty Name: **Dr. Zain Chagla**
- Relationships with financial sponsors:
  - Grants/Research Support: Merck, Pfizer, Roche, Gilead
  - Bureau/Honoraria: Ontario College of Family Physicians
  - Advisory boards or speakers' bureaus: Pfizer, Moderna, Novovax, Avir, GSK, Gilead, AstraZeneca, Roche, Paladin, Takeda, Merck
  - Others: N/A

- Faculty Name: **Dr. Susan Goldstein**
- Relationships with financial sponsors:
  - Grants/Research Support: Canadian Menopause Society
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians, Canadian Menopause Society
  - Advisory boards or speakers' bureaus: Astellas, Bayer, Biosyent, Esai, Knight, Pfizer, Astellas, Biosyent, Pfizer
  - Others: N/A

- Faculty Name: **Dr. Daniel Warshafsky**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: N/A
  - Others: N/A

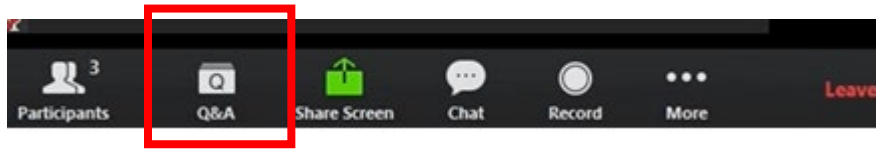
Speaker Disclosure

- Faculty Name: **Dr. Mekalai Kumanan**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: Deputy Chief of Family Medicine, Cambridge Memorial Hospital

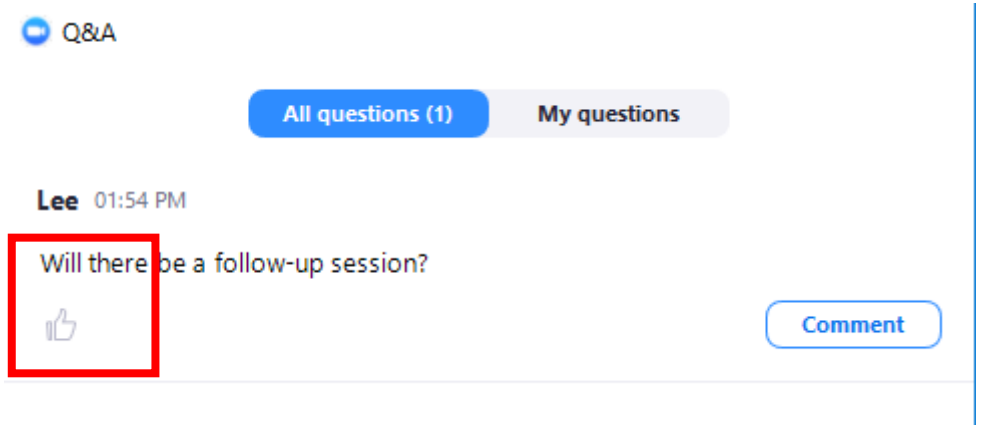
- Faculty Name: **Dr. Ali Damji**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: N/A

How to Participate

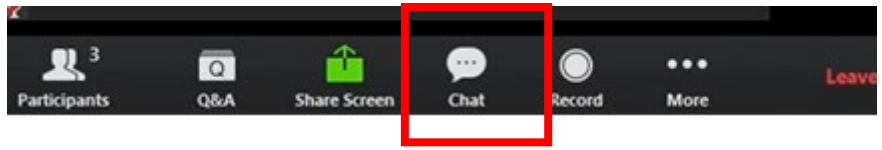
- All questions should be asked using the Q&A function at the bottom of your screen.



- Press the thumbs up button to upvote another guest's questions. Upvote a question if you want to ask a similar question or want to see a guest's question go to the top and catch the panels attention.



- Please use the chat box for networking purposes only.



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Associate Chief Medical Officer of Health at the Office of the Chief Medical Officer of Health

Respiratory and Measles Update

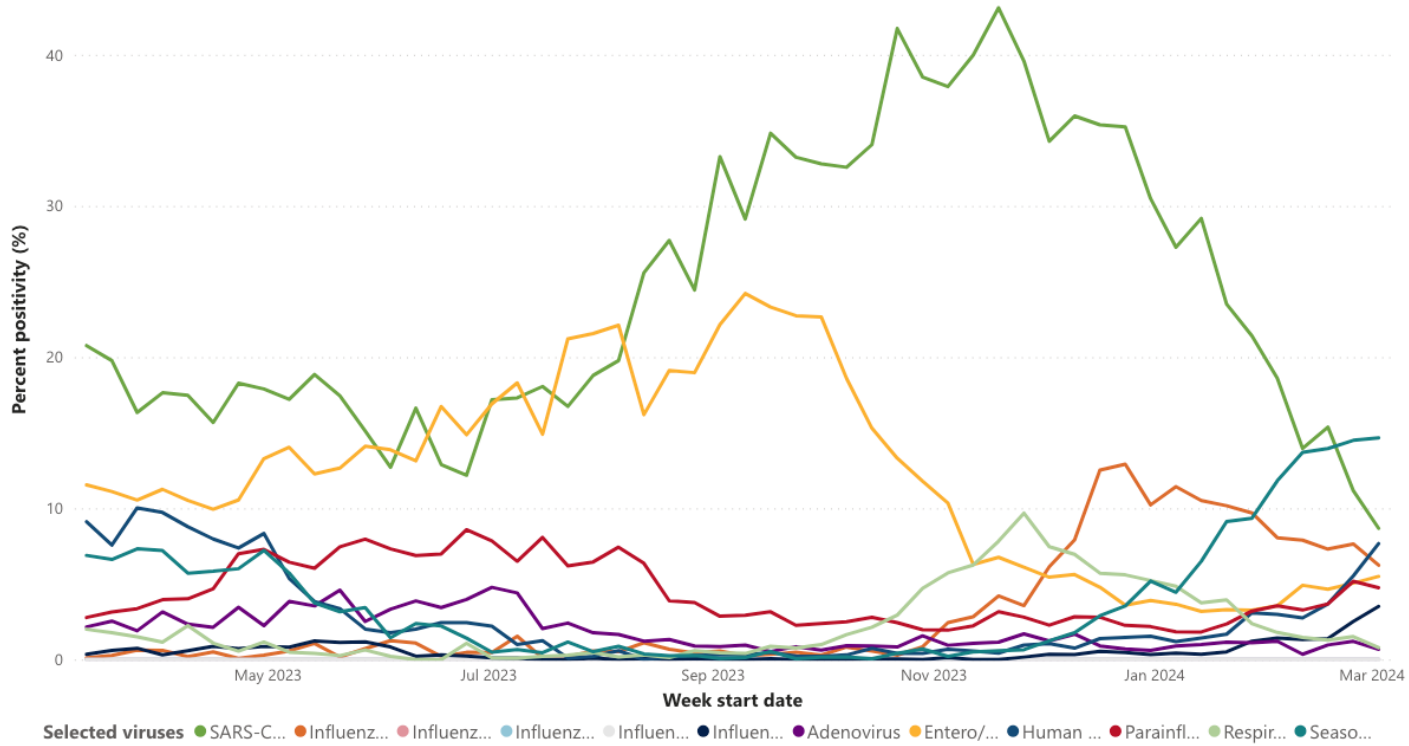
Zain Chagla

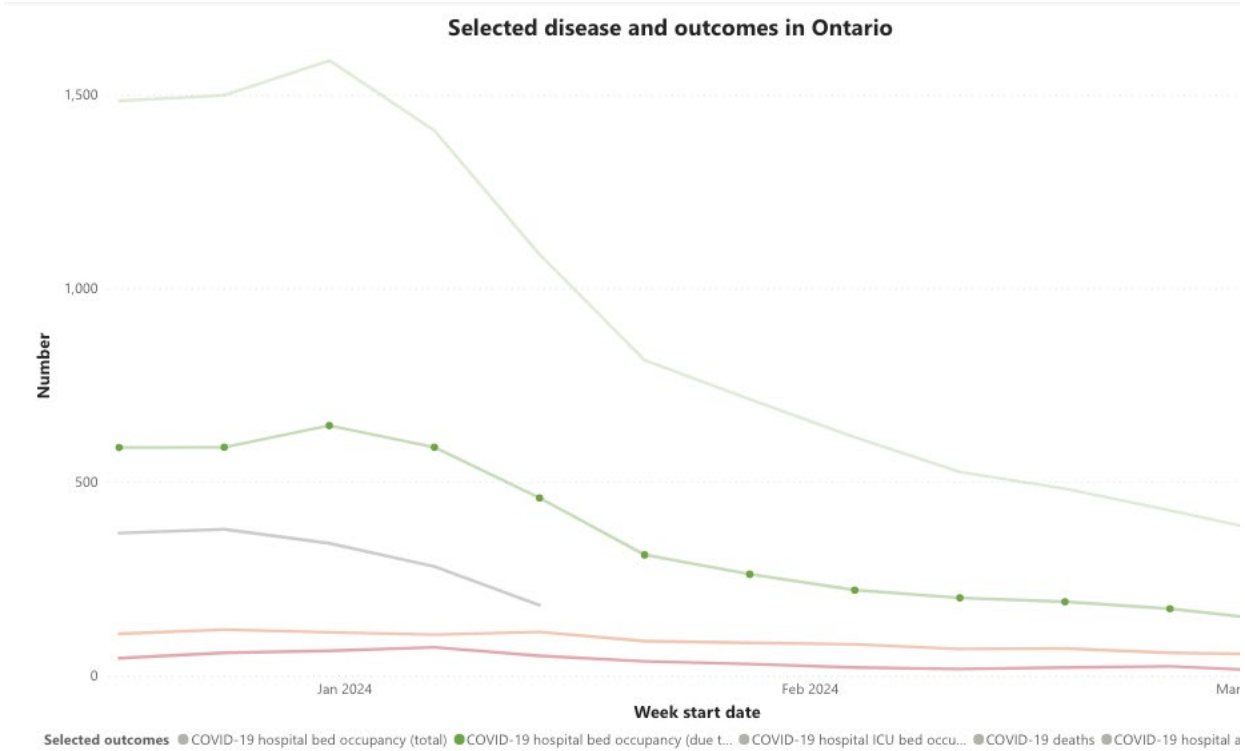
March 22, 2024

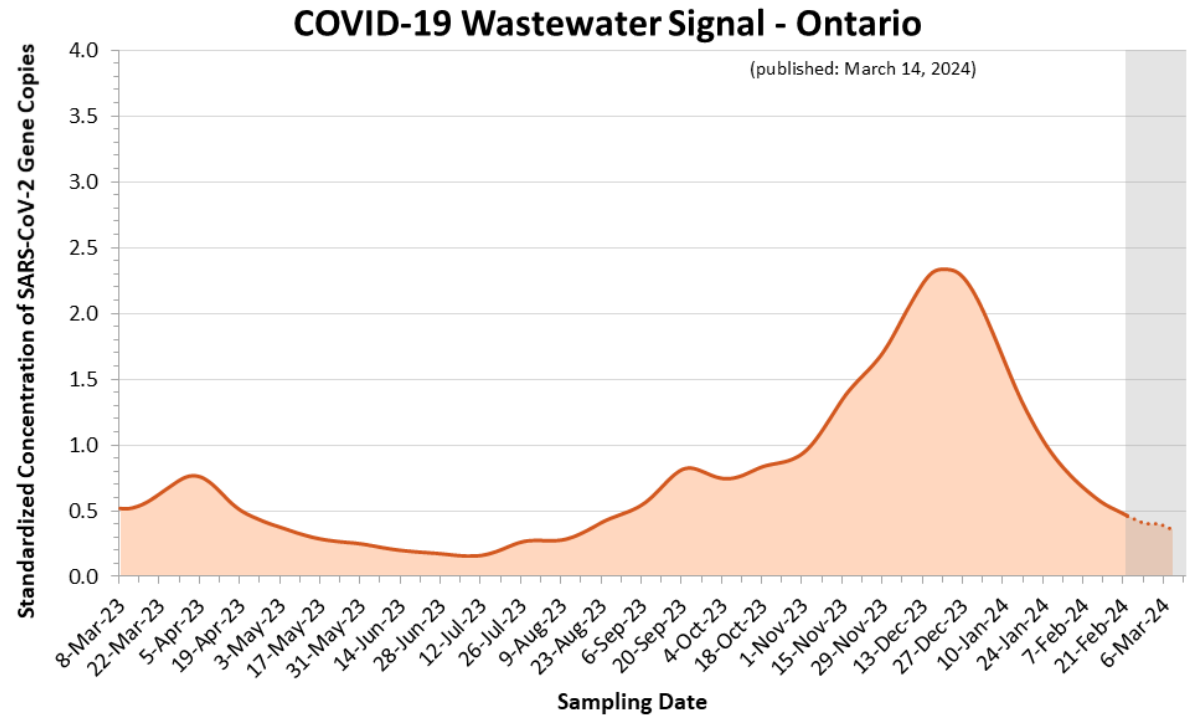
Respiratory virus activity

Virus	Percent positivity (%)
Adenovirus	0.7%
COVID-19	5.2%
Entero/Rhinovirus	4.6%
Human metapneumovirus	4.4%
Influenza A	5.1%
Influenza B	3.8%
Parainfluenza (all types)	2.6%
Respiratory syncytial virus	0.9%
Seasonal human coronavirus	8.3%

Weekly total tests, positive tests, or percent positivity for selected viruses in Ontario (PHO Laboratory data)




Selected disease and outcomes in Ontario
1,500
1,000
500
0
Number
Jan 2024
Feb 2024
Mar
Week start date
Selected outcomes
COVID-19 hospital bed occupancy (total)
COVID-19 hospital bed occupancy (due t...
COVID-19 hospital ICU bed occu...
COVID-19 deaths
COVID-19 hospital a


COVID-19 Wastewater Signal - Ontario
(published: March 14, 2024)
Standardized Concentration of SARS-CoV-2 Gene Copies
4.0
3.5
3.0
2.5
2.0
1.5
1.0
0.5
0.0
8-Mar-23
22-Mar-23
5-Apr-23
19-Apr-23
3-May-23
17-May-23
31-May-23
14-Jun-23
28-Jun-23
12-Jul-23
26-Jul-23
9-Aug-23
23-Aug-23
6-Sep-23
20-Sep-23
4-Oct-23
18-Oct-23
1-Nov-23
15-Nov-23
29-Nov-23
13-Dec-23
27-Dec-23
10-Jan-24
24-Jan-24
7-Feb-24
21-Feb-24
6-Mar-24
Sampling Date

Spring Immunization Campaign

- Provincial recommendations for Spring
  - Starting in the spring of 2024, NACI recommends that the following individuals who are at increased risk of severe illness from COVID-19 may receive an additional dose of XBB.1.5 COVID-19 vaccine:
    - Adults 65 years of age and older
    - Adult residents of long-term care homes and other congregate living settings for seniors
    - Individuals 6 months of age and older who are moderately to severely immunocompromised (due to an underlying condition or treatment)
    - Individuals 55 years and older who identify as First Nations, Inuit, or Metis and their non-Indigenous household members who are 55 years and older
  - Recommended interval of 6 months post infection/last vaccine (3 months minimum)

Other Immunizations

- RSV Vaccines
  - GSK (Arexvy) – for >= 60
  - Publicly funded vaccine program
    - living in long-term care homes
    - living in Elder Care Lodges
    - residents of retirement homes licensed to provide dementia care
    - patients in hospital receiving alternate level of care (ALC)
    - patients receiving hemodialysis or peritoneal dialysis
    - recipients of solid organ or hematopoietic stem cell transplants
    - individuals experiencing homelessness
    - individuals who identify as First Nations, Inuit, or Métis
  - Pfizer (Abrysvo)
    - >= 60
    - Pregnant individuals between weeks 32-36
    - Approved but not available yet commercially
- Both have 2 full seasons data suggesting > 70% efficacy against moderate RSV

Measles

Figure 1. Number of reported measles cases from July to December 2023, WHO [1]

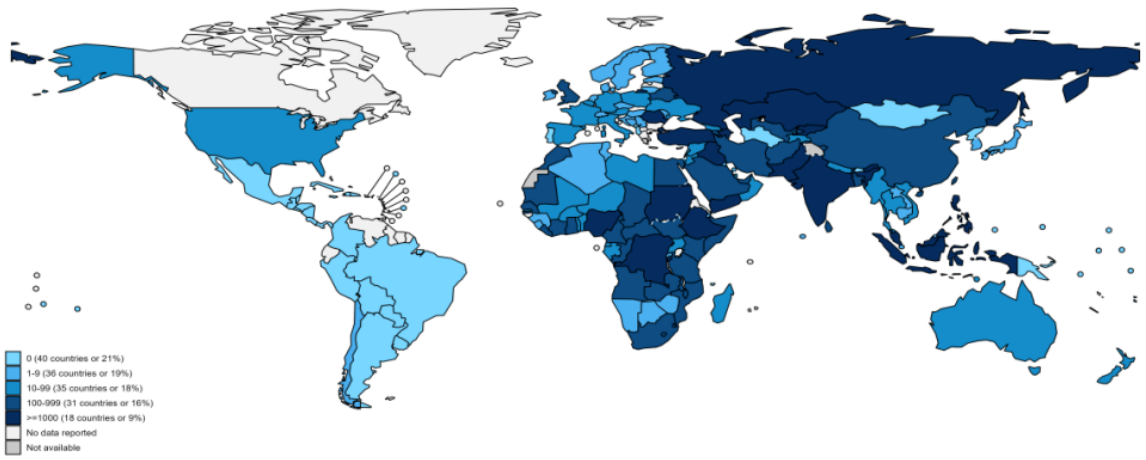
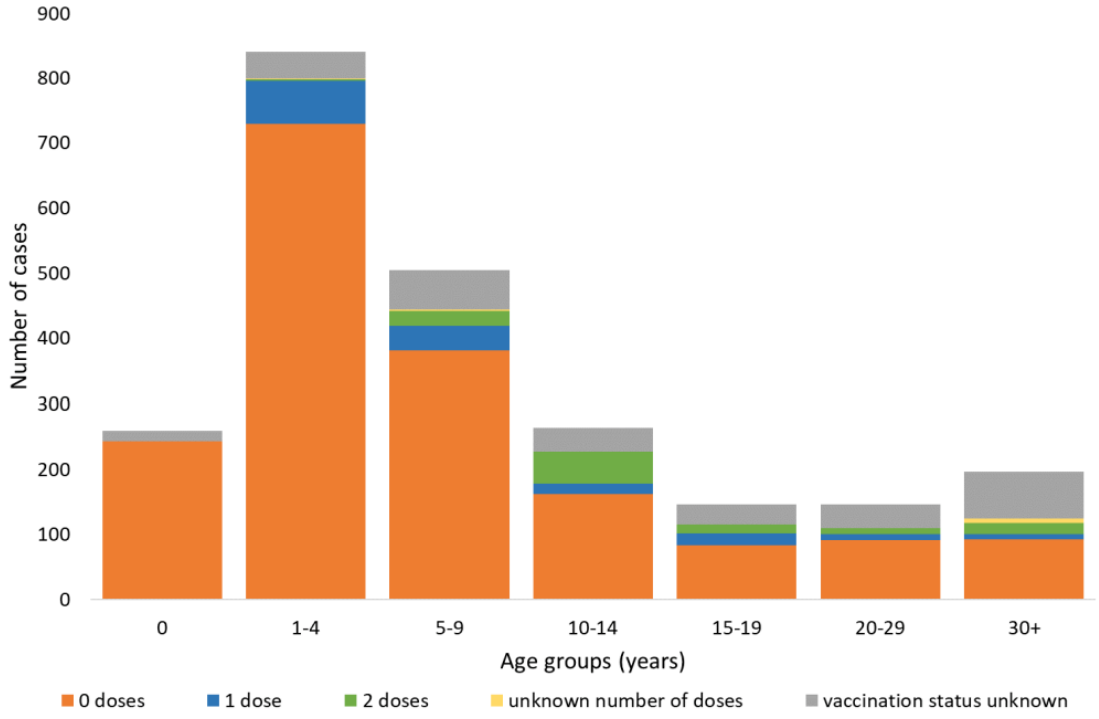
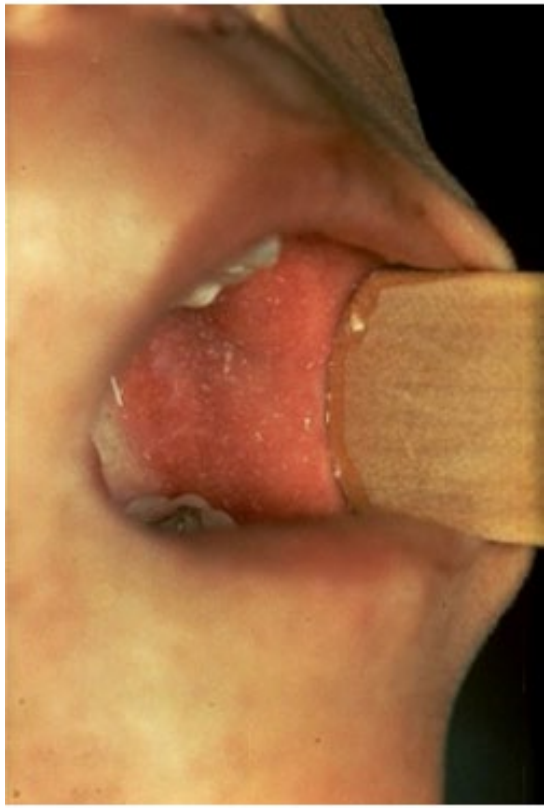


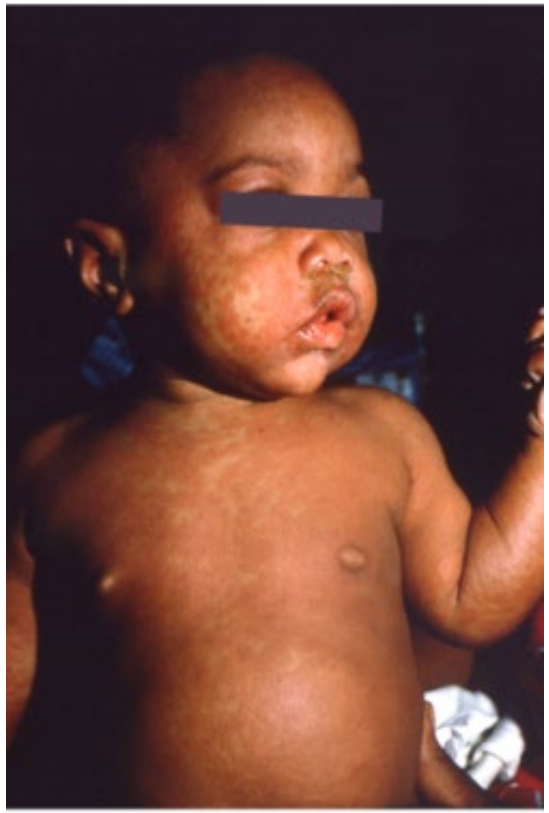
Figure 4. Number of measles cases reported to TESSy by age group and vaccination status, EU/EEA countries, 1 January 2023 to 31 December 2023

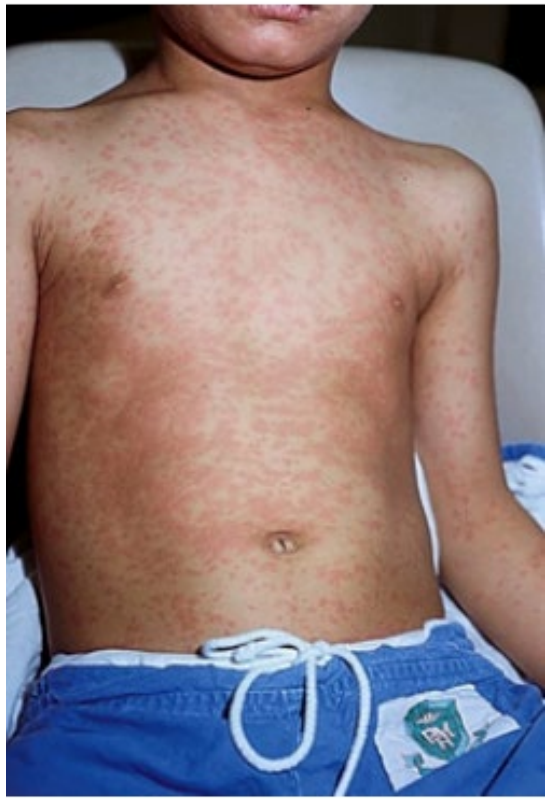


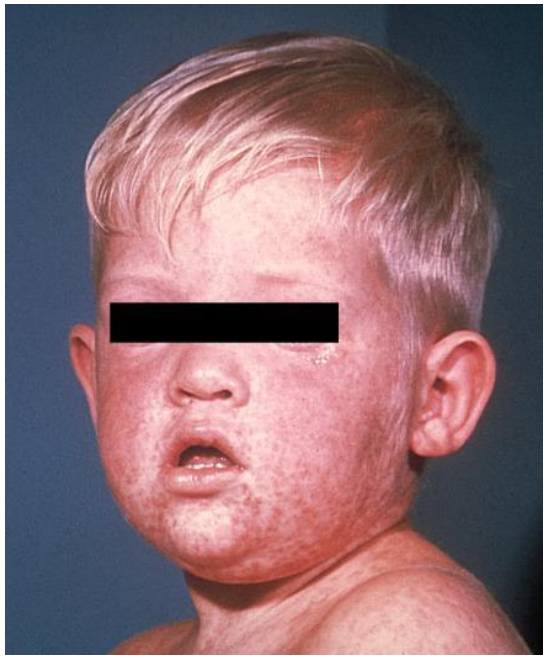
Clinical Presentation

- Prodrome 7-21 days after infection (infectious post day 5)
  - Fever, Malaise, Cough, Coryza, Conjunctivitis
  - Koplic spots 2-3 days post symptom onset
  - Maculopapular rash 3-7 days after prodrome (14 days after infection) – typically starts on the face, down to the trunk/arms/legs
  - Of note – post vaccination measles may have variable rashes and milder clinical course









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Infection Prevention in Practice

journal homepage: www.elsevier.com/locate/ipip

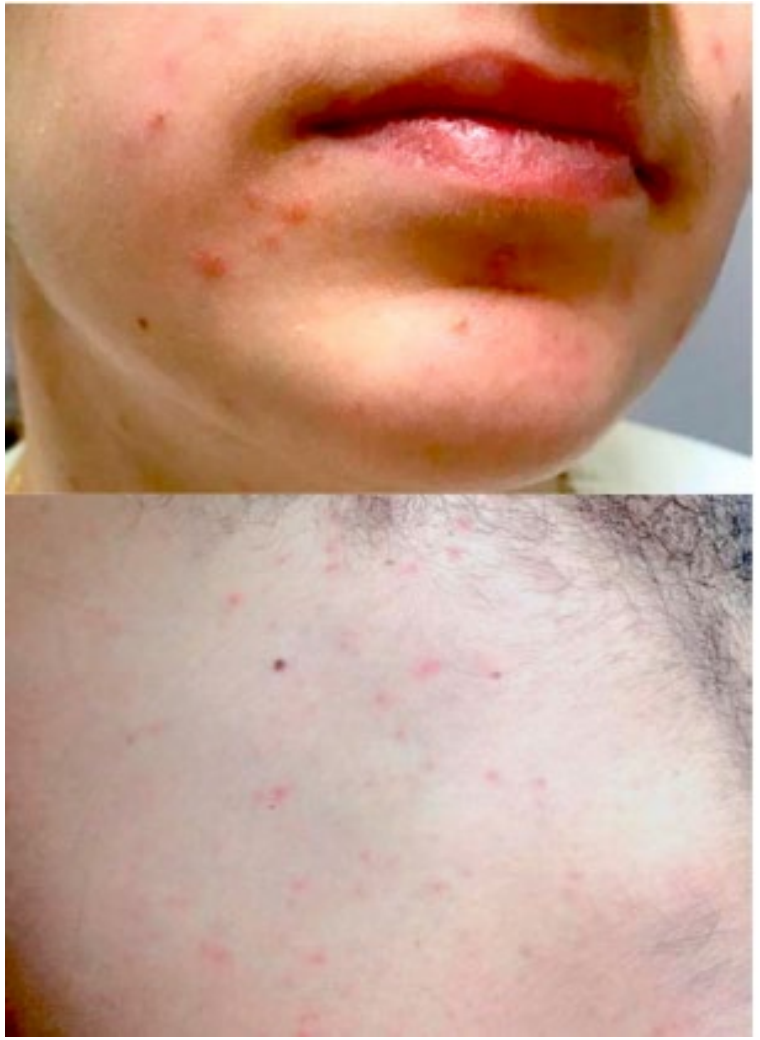
A challenging modified measles outbreak in vaccinated healthcare providers

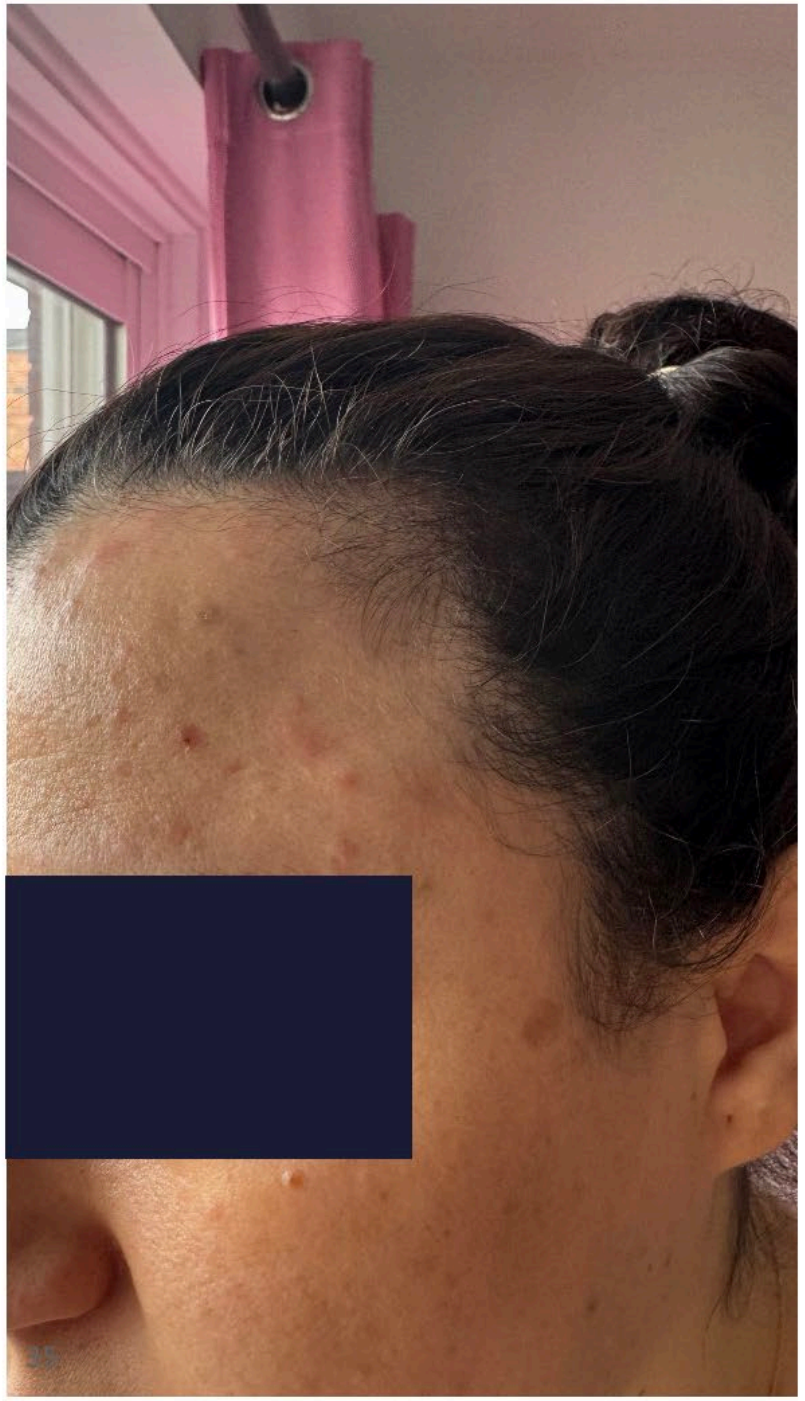
Omar Zmerli [a,b], Amanda Chamieh [a,b,d], Eliane Maasri [c], Eid Azar [a,b], Claude Afif [a,b,*]

Table II
Characteristics of documented classic/modified measles among healthcare professionals during the April 2018—June 2018 outbreak

Case	Vaccination status*	Date of rash appearance	IgG titre (mIU/mL)	Symptoms†						Diagnosis
				Fever	Cough	Coryza	Conjunctivitis	Maculopapular rash	Pinpoint/ Vesicular rash	
CA	+	19-Jun-2018	364.6	+	+	−	+	+	−	**Classic measles**
A	+	30-Apr-2018	>5000	+	−	−	−	−	+	**Modified Measles**
B	+	30-Apr-2018	2003	+	+	−	−	−	+	**Modified Measles**
C	+	3-May-2018	>5000	+	−	−	−	−	+	**Modified Measles**
D	+	5-May-2018	24.4	+	−	−	−	−	+	**Modified Measles**
E	+	5-May-2018	−	+	−	−	−	−	+	**Modified Measles**
F	+	7-May-2018	>5000	+	−	+	−	−	+	**Modified Measles**
G	+	19-Jun-2018	>5000	+	−	−	−	−	+	**Modified Measles**
H	+	−	−	+	−	−	−	−	−	**Modified Measles**

* +: Vaccinated; -:Not Vaccinated; ?: Unknown Status; † +: Present; -: Absent; Fever: >38.9°C.





Testing

- Diagnosis made by a combination of
  - Nasopharyngeal swab OR throat swab PCR AND
  - Urine PCR AND
  - Serology (IgM / IgG)
- **Very important all 3 are collected**
- Processed through PHO – contact local public health unit if suspect cases
- Viral swabs – some media expired (acceptable for other resp viruses) – please ensure that unexpired media is available

Infection Control

- All health care workers should have documented immunity to measles (2 doses OR history of lab confirmed infection OR serologic evidence of immunity regardless of year of birth)
  - Only HCW with presumptive immunity should care for measles cases
- All HCW should wear fit tested seal checked N95 respirator when entering the room or caring for measles.
  - If possible use Airborne infection isolation room
- Additional PPE based on point of care risk

Infection Control

- Hospital ED/Urgent Care may present a significant challenge for transmission, contact tracing, and clustering of vulnerable patients
- Patients can be tested in office – tips include
  - Scheduling (end of day)
  - Hand Hygiene and Mask patient if tolerated
  - Place patient in single room immediately and close door
  - Curtail patient movement unless otherwise necessary
  - When patient leave, close room. If not appropriate air exchanges, then 2-hour closure with cleaning.
  - Tell patients to isolate while laboratory results are pending – infectious 4 days prior to rash to 4 days post rash (avoid all non household contacts and high-risk individuals)

Post Exposure Prophylaxis

- Susceptible infants 0-6 months old
  - Intramuscular IG/Measles IG up to 6 days
- Susceptible immunocomp infants 6-12 months old
  - MMR up to 72 hours, IMIG/Measles IG 72h to 6d
- Susceptible immmunocomp 12 months and older
  - MMR up to 6 days (only effective within 72 hours)
- Susceptible pregnant or moderate to severe immunocompromise
  - IVIG up to 7 days
- Confirmed immunity – no prophylaxis

Table 1: Summary of updated measles post-exposure prophylaxis recommendations for susceptible contacts

Population	Time since exposure to measles	
	≤ 72 hours	73 hours-6 days
Susceptible infants 0-6 months of age	IMIg (0.5 ml/kg)[a,b]	
Susceptible immunocompetent infants 6-12 months of age	MMR vaccine[a]	IMIg (0.5 ml/kg)[b]
Susceptible immunocompromised[c] individuals 6 months of age and older	IVIg (400 mg/kg) or IMIg (0.5 ml/kg), limited protection if body weight ≥ 30 kg[d]	
Susceptible immunocompetent individuals 12 months of age and older	MMR vaccine	MMR vaccine[e]
Susceptible pregnant individuals[f]	IVIg (400 mg/kg) or IMIg (0.5 ml/kg), limited protection if body weight ≥ 30 kg[d]	

https://www.ontario.ca/files/2024-03/moh-measles-appendix-en-2024-03-19.pdf

Prevention – Ontario Publicly Funded Immunization Schedule

- MMR at >= 1 year of age, MMRV at 4-12
  - High risk vaccine program
    - 6-11 months (infants travelling to areas where disease is of concern – still need full series)
    - >= 26 years of age – in those who have received 1 dose of vaccine and are eligible to receive a second dose
      - HCW
      - Post secondary students
      - Travel
      - Based on clinical judgment
- Minimum interval between vaccines is 4 weeks – 1 month (if not using MMRV)
- Who to focus on – kids! Highest risk, and least likely to be immune

Ministry of Health

Mpox

March 2024 Update

Ontario

Key Messages

1. Consider **Mpox on your differential diagnosis** when seeing patients

2. If your clinical suspicion is high enough to consider Mpox testing…
    - **Consider proactively informing your local public health unit**
    - **Offer opportunistic STI testing** +/- start your patient on HIV PrEP if eligible

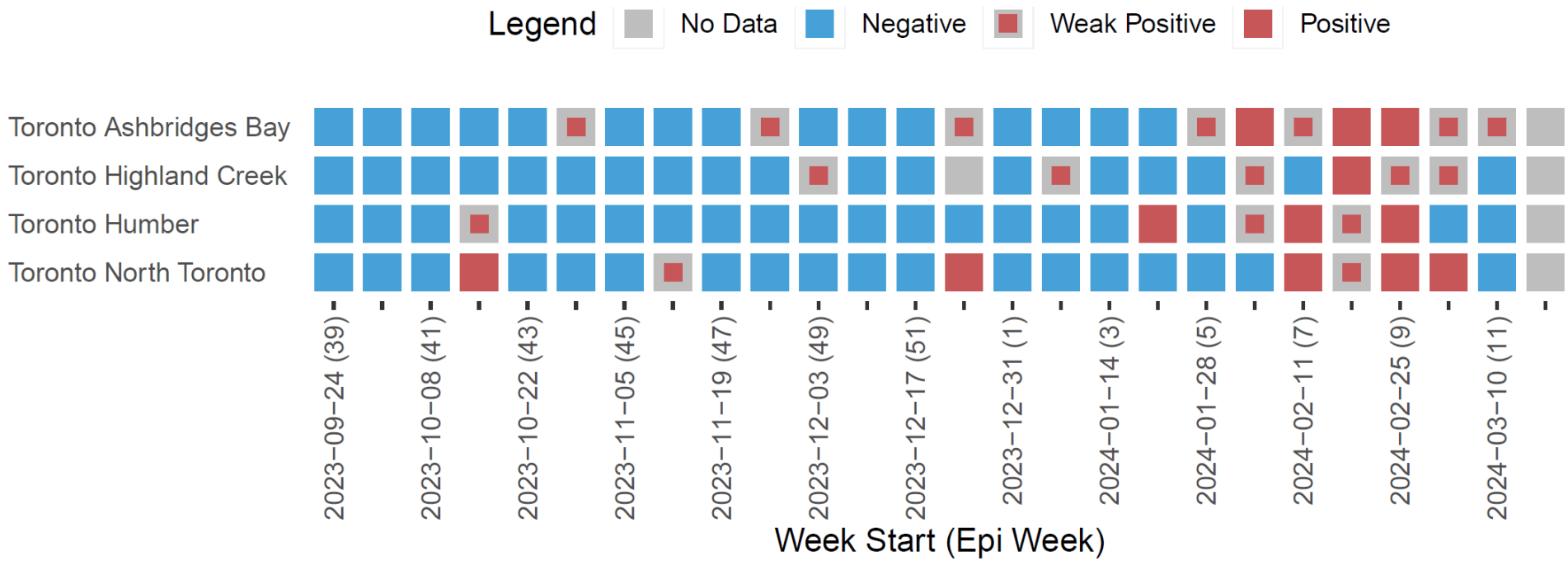
3. Recommend your patients to get **vaccinated with Imvamune®** if they are eligible
    - PrEP is available through sexual health clinics or your local public health unit
    - PEP should be offered to those with a recent high-risk exposure

Ontario

Epidemiology of Mpox in Ontario

As of March 20, 2024:

- There have been **28 laboratory-confirmed mpox cases reported in Ontario between January 1 and March 20, 2024**. For reference, in 2023 a total of 33 laboratory-confirmed mpox cases were reported in the province.
    - Of the 28 confirmed mpox cases, **27 are male and one is female** (known epidemiological link to a confirmed case in a male). The **median age is 36.5 years** (range 19 to 53 years).
- **Most (22/28) of the confirmed mpox cases reside in Toronto**; Ottawa has four cases (two are epi-linked with travel to Mexico) and Halton Region and Peel Region each have one case.
- Of those with at least one risk factor reported (17/28), **the most common risk factors are sex with same sex, new/multiple sexual contacts, anonymous sex, met contact through internet.**
- The majority of cases (91.5%) since January 1, 2023 have been **unvaccinated** or have only had 1 dose of Imvamune® vaccine.


Legend
No Data
Negative
Weak Positive
Positive
Toronto Ashbridges Bay
Toronto Highland Creek
Toronto Humber
Toronto North Toronto
2023–09–24 (39)
2023–10–08 (41)
2023–10–22 (43)
2023–11–05 (45)
2023–11–19 (47)
2023–12–03 (49)
2023–12–17 (51)
2023–12–31 (1)
2024–01–14 (3)
2024–01–28 (5)
2024–02–11 (7)
2024–02–25 (9)
2024–03–10 (11)
Week Start (Epi Week)

Ontario

When should I consider Mpox in my patient?

Monkeypox is a viral disease with symptoms similar to smallpox but clinically less severe

It is characterized by the following symptoms:

Initial symptoms

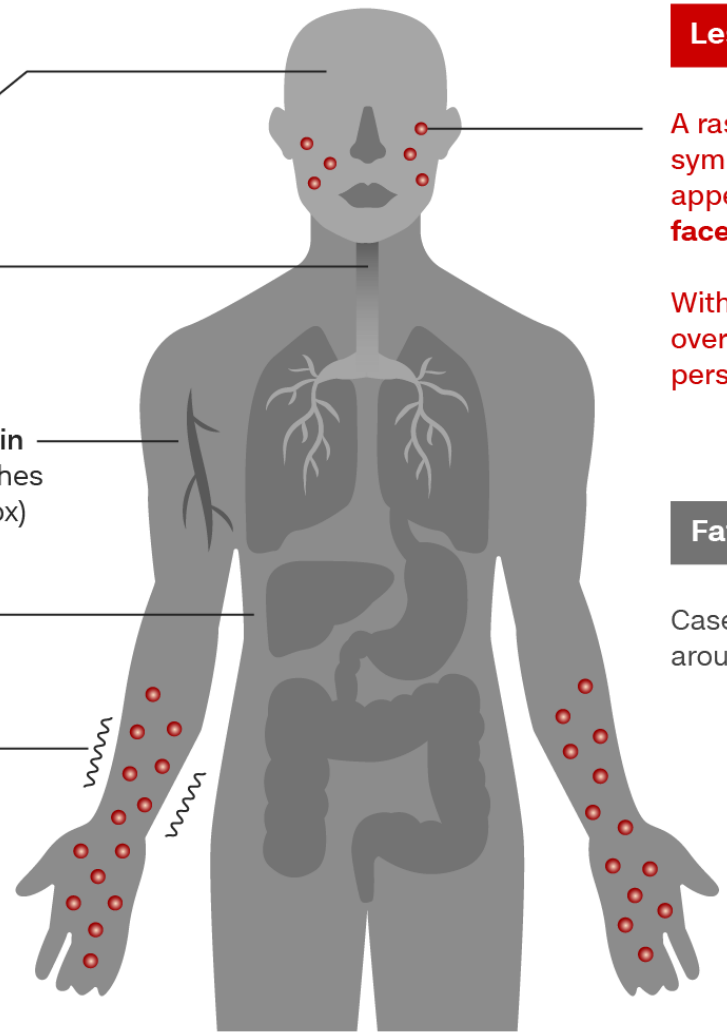
Fever and headache

Sore throat and cough

Swollen lymph nodes in the **neck, armpits** or **groin** (this symptom distinguishes monkeypox from smallpox)

Back pain and muscle aches

Lack of energy



Lesions

A rash follows the initial symptoms. Painful lesions can appear anywhere, including **face, arms** and **legs**.

Within 2-3 weeks lesions scab over and resolve. After this a person is no longer contagious.

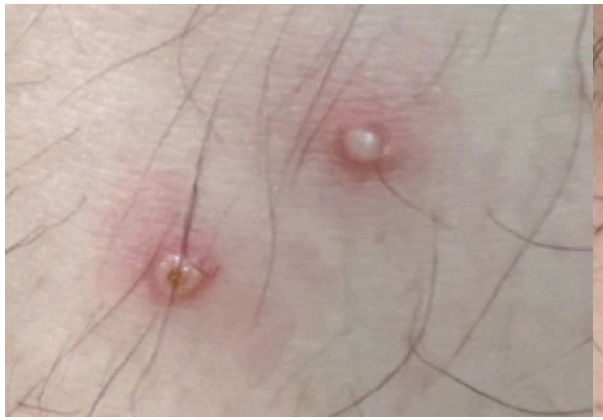
Fatality risk

Case fatality ratio has been around **3% to 6%** in recent times.

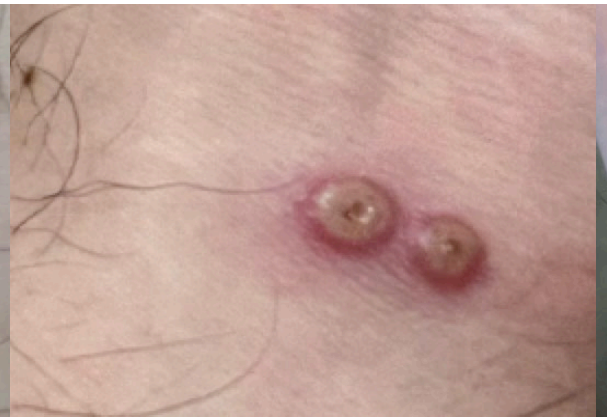
Source: Centers for Disease Control and Prevention, World Health Organization
Graphic: Natalie Leung, CNN

Ontario

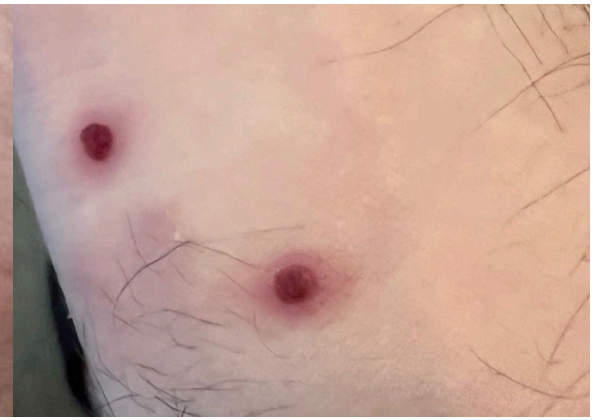
Progression of Mpox lesions



pustular



“central umbilication”

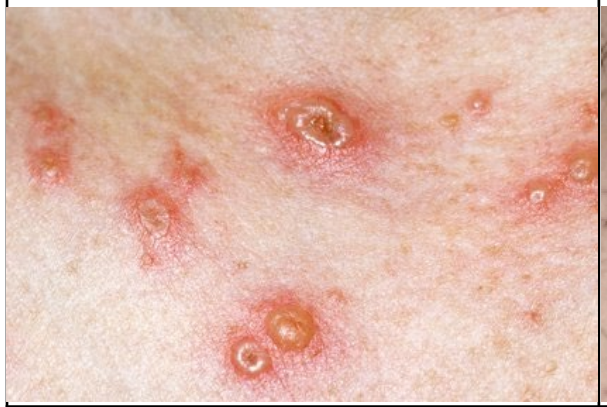
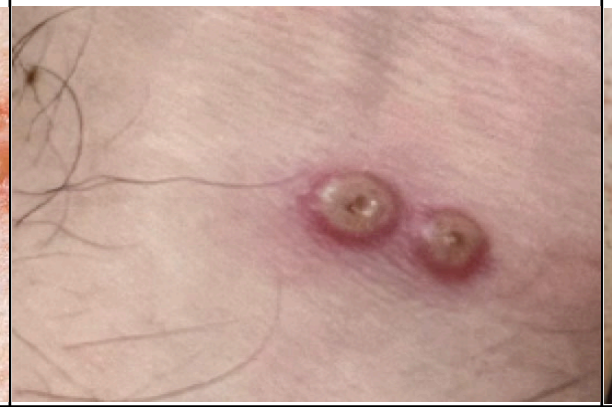
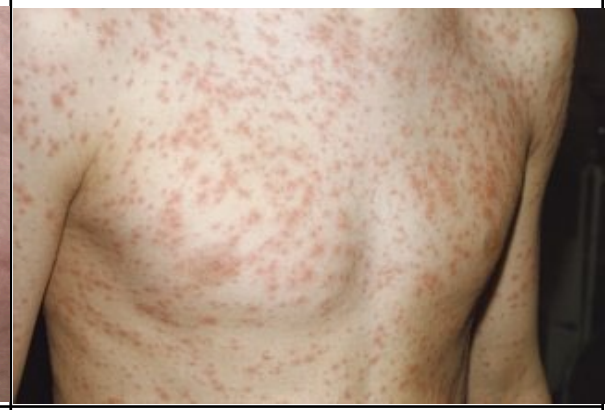
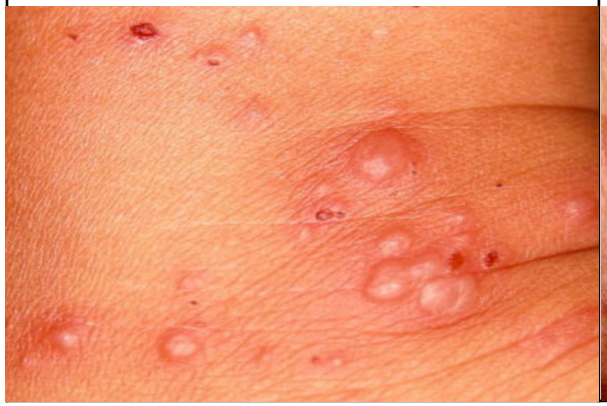
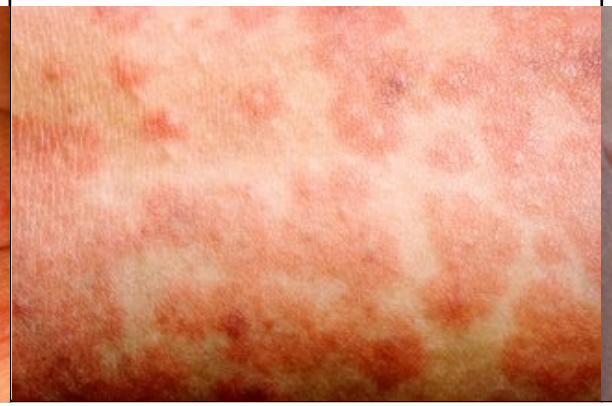
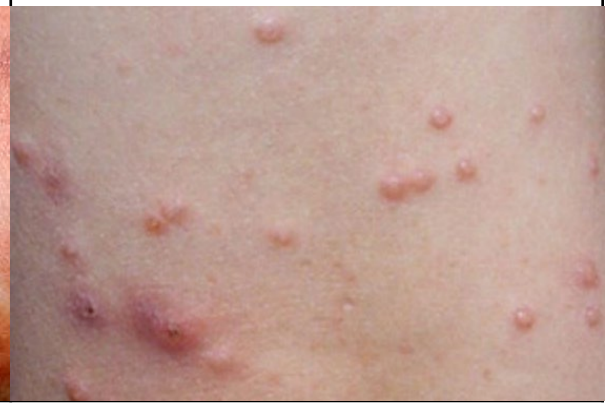


crusting

The rash can last for 2–4 weeks and progresses through the following stages: macules, papules, vesicles, pustules, and finally crusts/scabs which then falls off with new skin formed underneath

Ontario

Comparison of lesions

Chickenpox	Mpox	Rubella
		
Hand, Foot and Mouth	**Measles**	**Molluscum Contagiosum**
		

Ontario

What should I do when I suspect my patient might have Mpox?

Infection Prevention and Control!!!

(Hint: it's the same as for COVID-19)

- Place the individual in a **single-patient room**, with the door closed
  - Inpatients should be placed in a single-person room with a dedicated bathroom
- **Use recommended personal protective equipment (PPE):** gloves, gown, eye protection, and a fit-tested and seal-checked N-95 respirator
  - Ensure patients wear a well-fitting **medical mask**
  - Don't forget about **hand hygiene**
- **Perform routine environmental cleaning and disinfection**
  - Ensure all horizontal surfaces that may be touched by the patient and equipment that may have been used by or shared between patients are cleaned and disinfected after every use
  - No need for terminal cleaning or fallow time

Ontario

Testing for Mpox in the Clinic

- **All patients presenting with a compatible clinical illness where Mpox is suspected should undergo laboratory testing**
    - Test is a **PCR test** and is performed at Public Health Ontario Laboratories only at this time
- Also consider offering **opportunistic STI testing** when you are considering Mpox testing - i.e., chlamydia, gonorrhea, syphilis, and HIV testing – **and starting HIV PrEP**.

Ontario

Management of Mpox

- Typically **self-limiting illness in 2-4 weeks**
- Treatment is **primarily supportive** with the goal of symptom alleviation
  - Fever, pruritus, hydration, stool softeners, etc.

- A VERY limited amount of antiviral medication **(Tecovirimat or TPOXX ®)** is available in Ontario for in severe Mpox illness
  - A very strict eligibility criteria given limited supply
  - Off-label use upon clinician request – requires Ministry approval for dispensation
  - If you're thinking your patient needs antiviral medication, you really should really be thinking about consulting ID

PLATINUM-CAN – Placebo-controlled randomized trial of tecovirimat in non-hospitalized patients with Mpox: Canadian Feasibility Study

Ontario

What to counsel your patient

- At this time, all confirmed and probable cases of Mpox should **self-isolate at home** during the period of communicability – i.e., from the onset of the rash until the lesion scabs have fallen off and new intact skin has formed below
  - At home, stay in a **separate room/area** away from other household members if possible and use a separate bathroom if available/feasible
  - **Avoid contact with others**, especially those at higher risk of severe Mpox illness, including immunosuppressed people, pregnant people, and children younger than 12 years of age
  - **Avoid leaving the home** unless necessary (e.g., to seek essential medical care, mental health walks)
  - **Avoid non-essential household visitors**
  - **Wear a mask for source control** (medical mask preferred), especially if respiratory symptoms are present
  - **Cover skin lesions** as much as possible (e.g., bandages, long sleeves, long pants)
  - **Avoid contact with animals**, including household pets

What can public health do for you (for Mpox)?

- Mpox infection is a **reportable disease in Ontario** as of June 2022
    - Yes, labs will report the positive results to public health, but as with all other reportable diseases, **you as the clinician should consider proactively calling public health** to let them know of a case if you feel that the clinical suspicion for the disease and the risk of transmission to others is sufficiently high

- **Public health will follow up with cases** during their isolation period to provide guidance, identify potential barriers/resources to support effective isolation, and initiate contact tracing
    - Ending of the self-isolation period should be assessed on an individual case basis and in consultation with the public health

Ontario

Mpox vaccine

(Imvamune®)

Pre-exposure prophylaxis vaccine eligibility criteria (updated)

1. Two-spirited, non-binary, trans- or cis-gender individuals who self-identify or have sexual partners who self-identify as belonging to the gay, bisexual and other men who have sex with men (gbMSM) community AND at least one of the following:
    - Have received a diagnosis of STI in the past year;
    - Have had 2 or more sexual partners or may be planning to;
    - Have attended venues for sexual contact (i.e., bath houses, sex clubs) or may be planning to, or who work/volunteer in these settings; or
    - Have had anonymous sex (e.g., using hookup apps) or may be planning to; and/or
    - Are a sexual contact of an individual who engage in sex work.
2. Any individual who engages in sex work or may be planning to.
3. Household and/or sexual contacts of those identified for pre-exposure vaccination eligibility above **and** who are moderately to severely immunocompromised or pregnant.
4. **PEP**: offered to individuals *after* a recent high-risk exposure to a known case
    - **A single dose** of PEP should be offered ideally within 4 days (up to 14 days) from the date of last exposure

Ontario

Key Messages

1. Consider **Mpox on your differential diagnosis** when seeing patients

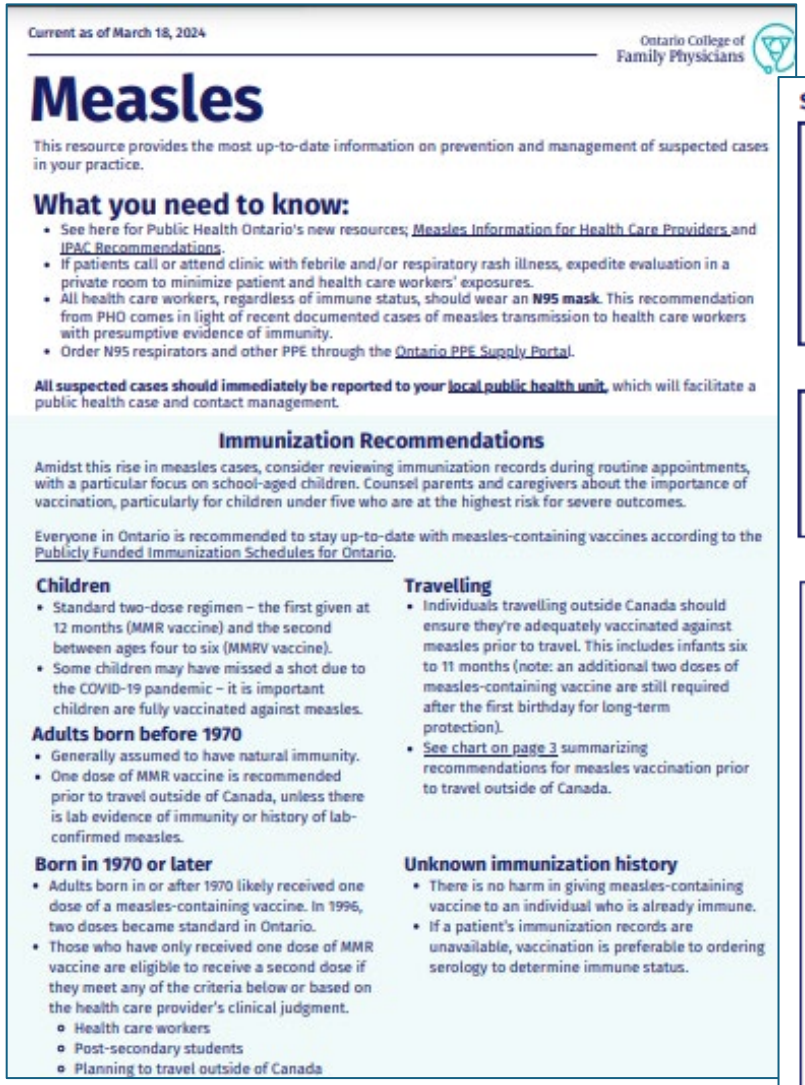
2. If your clinical suspicion is high enough to consider Mpox testing…
    - **Consider proactively informing your local public health unit**
    - **Offer opportunistic STI testing** +/- start your patient on HIV PrEP if eligible

3. Recommend your patients to get **vaccinated with Imvamune®** if they are eligible
    - PrEP is available through sexual health clinics or your local public health unit
    - PEP should be offered to those with a recent high-risk exposure

Ontario

Resources to support your practice

Measles



Current as of March 18, 2024

Ontario College of Family Physicians

Measles

This resource provides the most up-to-date information on prevention and management of suspected cases in your practice.

What you need to know:

- See here for Public Health Ontario's new resources; Measles Information for Health Care Providers and IPAC Recommendations.
- If patients call or attend clinic with febrile and/or respiratory rash illness, expedite evaluation in a private room to minimize patient and health care workers' exposures.
- All health care workers, regardless of immune status, should wear an **N95 mask**. This recommendation from PHO comes in light of recent documented cases of measles transmission to health care workers with presumptive evidence of immunity.
- Order N95 respirators and other PPE through the Ontario PPE Supply Portal.

All suspected cases should immediately be reported to your local public health unit, which will facilitate a public health case and contact management.

Immunization Recommendations

Amidst this rise in measles cases, consider reviewing immunization records during routine appointments, with a particular focus on school-aged children. Counsel parents and caregivers about the importance of vaccination, particularly for children under five who are at the highest risk for severe outcomes.

Everyone in Ontario is recommended to stay up-to-date with measles-containing vaccines according to the Publicly Funded Immunization Schedules for Ontario.

Children

- Standard two-dose regimen – the first given at 12 months (MMR vaccine) and the second between ages four to six (MMRV vaccine).
- Some children may have missed a shot due to the COVID-19 pandemic – it is important children are fully vaccinated against measles.

Adults born before 1970

- Generally assumed to have natural immunity.
- One dose of MMR vaccine is recommended prior to travel outside of Canada, unless there is lab evidence of immunity or history of lab-confirmed measles.

Born in 1970 or later

- Adults born in or after 1970 likely received one dose of a measles-containing vaccine. In 1996, two doses became standard in Ontario.
- Those who have only received one dose of MMR vaccine are eligible to receive a second dose if they meet any of the criteria below or based on the health care provider's clinical judgment.
  - Health care workers
  - Post-secondary students
  - Planning to travel outside of Canada

Travelling

- Individuals travelling outside Canada should ensure they're adequately vaccinated against measles prior to travel. This includes infants six to 11 months (note: an additional two doses of measles-containing vaccine are still required after the first birthday for long-term protection).
- See chart on page 3 summarizing recommendations for measles vaccination prior to travel outside of Canada.

Unknown immunization history

- There is no harm in giving measles-containing vaccine to an individual who is already immune.
- If a patient's immunization records are unavailable, vaccination is preferable to ordering serology to determine immune status.

Screen Patient by Asking: Do you have symptoms of measles?

Fever | Cough | Conjunctivitis | Runny Nose | Koplik spots | Rash

- The infectious period for measles is four days before rash onset until four days after rash onset.
- Measles can resemble other viruses, including Mpox, varicella, and hand, foot and mouth disease.
- Symptoms generally start around 10 days after being exposed but can start anywhere from seven to 21 days after exposure and typically last for one to two weeks.
- The characteristic red maculopapular rash typically appears after three to seven days of initial symptoms.
- Rash first appears on the face and spreads downwards over the body, lasting five to six days.

Yes

Do you have risk factors for measles?

Recent travel | No/unknown immunity | Links to a known outbreak or case

Yes

Providing Care for Symptomatic Patients

When patients call for appointments with symptoms of febrile and/or respiratory rash illnesses, consider measles in differential diagnoses, particularly in patients returning from travel.

- Routine practices and airborne precautions are recommended.
- Only health care workers with presumptive immunity should care for a patient suspected of measles (two doses of measles-containing vaccine or lab evidence of immunity).
- All health care workers and staff should wear an N95 mask, regardless of immune status.
- Health care workers should also conduct a personal care risk assessment (PCRA) to determine whether additional PPE is recommended (e.g., gloves, gown, eye protection).

Patient flow

- Where possible, schedule symptomatic patients separately from other patients—ideally at the end of the day since no other patients should be placed in the same room for two hours afterwards.
- Require symptomatic patients to wear medical masks.
- Promptly isolate symptomatic patients in a negative pressure room, if available, or single patient room with the door closed.

For more guidance, refer to PHO's new Interim IPAC Recommendations.

Testing

Note: All suspect cases of measles should immediately be reported to your local public health unit. Do not wait for laboratory confirmation.

Collect samples for testing

- To optimize test turnaround time, ensure use of valid (non-expired) collection kits (if you require specimen collection supplies for your clinic, order through PHO).
  - Collect PCR nasopharyngeal / throat swab **AND** urine as well as diagnostic serology.
- If you cannot collect samples in your office, provide the patient with a requisition and refer to a lab for testing.
- If you are referring a patient for further assessment or diagnostic testing, advise the patient to contact the health care facility prior to arrival (if possible) so appropriate IPAC precautions can be implemented.

https://ontariofamilyphysicians.ca/wp-content/uploads/2024/03/measles-Final-2.pdf

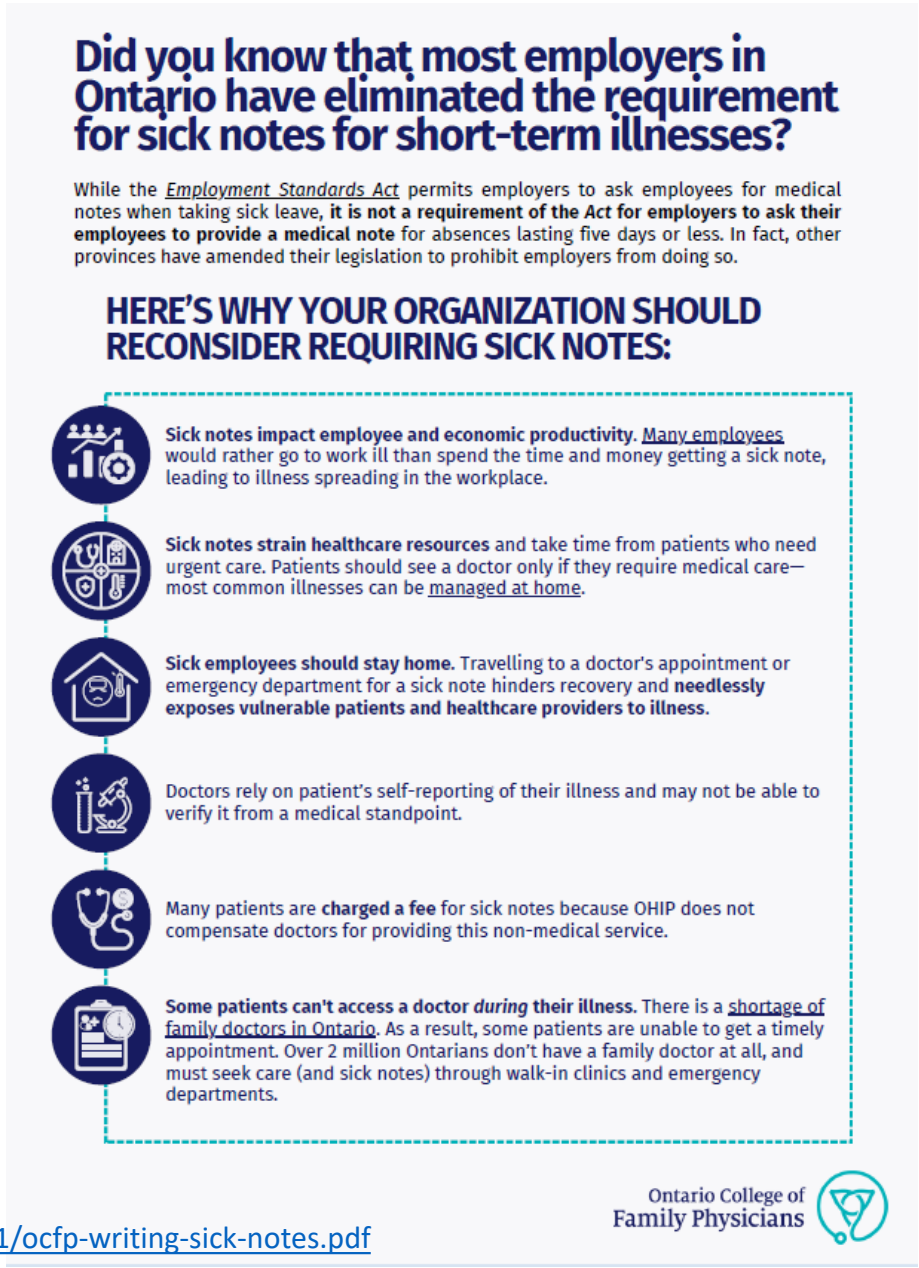
https://ontariofamilyphysicians.ca/supports-for-family-doctors/

Ontario College of Family Physicians

Resources to support your practice

Writing Sick Notes

To help educate employers on changing their policies, the OCFP has created this resource for use in your EMRs and clinic workflows for sick notes.



Did you know that most employers in Ontario have eliminated the requirement for sick notes for short-term illnesses?

While the *Employment Standards Act* permits employers to ask employees for medical notes when taking sick leave, **it is not a requirement of the *Act* for employers to ask their employees to provide a medical note** for absences lasting five days or less. In fact, other provinces have amended their legislation to prohibit employers from doing so.

HERE'S WHY YOUR ORGANIZATION SHOULD RECONSIDER REQUIRING SICK NOTES:

Sick notes impact employee and economic productivity. Many employees would rather go to work ill than spend the time and money getting a sick note, leading to illness spreading in the workplace.

Sick notes strain healthcare resources and take time from patients who need urgent care. Patients should see a doctor only if they require medical care—most common illnesses can be managed at home.

Sick employees should stay home. Travelling to a doctor's appointment or emergency department for a sick note hinders recovery and **needlessly exposes vulnerable patients and healthcare providers to illness.**

Doctors rely on patient's self-reporting of their illness and may not be able to verify it from a medical standpoint.

Many patients are **charged a fee** for sick notes because OHIP does not compensate doctors for providing this non-medical service.

Some patients can't access a doctor *during* their illness. There is a shortage of family doctors in Ontario. As a result, some patients are unable to get a timely appointment. Over 2 million Ontarians don't have a family doctor at all, and must seek care (and sick notes) through walk-in clinics and emergency departments.

Ontario College of Family Physicians

New

EMR-Integrate Sick note form for TELUS PS suites, OSCAR Pro and Accuro QHR

https://ontariofamilyphysicians.ca/supports-for-family-doctors/

https://ontariofamilyphysicians.ca/wp-content/uploads/2024/01/ocfp-writing-sick-notes.pdf

Ontario College of Family Physicians

Quick & Simple Menopause Management: Using the MQ6 tools

Dr. Susan Goldstein

Family Physician, Menopause Certified Menopause Practitioner

Assistant Professor

Department of Family & Community Medicine

University of Toronto

Susan.goldstein@utoronto.ca

March 22, 2024

WWW.MQ6.CA

MENOPAUSE MANAGEMENT TOOLS ©2023

WEBSITE CONTENT includes:

FOR Healthcare Professionals:
MQ6 Assessment tool
MQ6 Treatment algorithm (PDF)
Interactive online treatment decision App
EMR Templates for MQ6 assessment tool
Medication tables
Patient Counselling PDF
Overview of the updated findings of the WHI
FAQs
Academic references & Resources

"For Women*"
General Menopause Information
Tips for Health promotion, including
brain, bone and cardiovascular health

- Centered on 2017 CFP publication *
- Content and recommendations are **evidence-based & peer-reviewed** by a group of multidisciplinary national menopause experts
- Designed for use for both HCPs and patients

*Goldstein S. An efficient tool for the primary care management of menopause. Can Fam Physician. 2017 Apr;63(4):295-298

Assessing the menopausal patient: The Menopause Quick 6 Screen (MQ6)

Key questions to ask peri/menopausal women in assessing need for treatment

MQ6 Menopause Management Tools

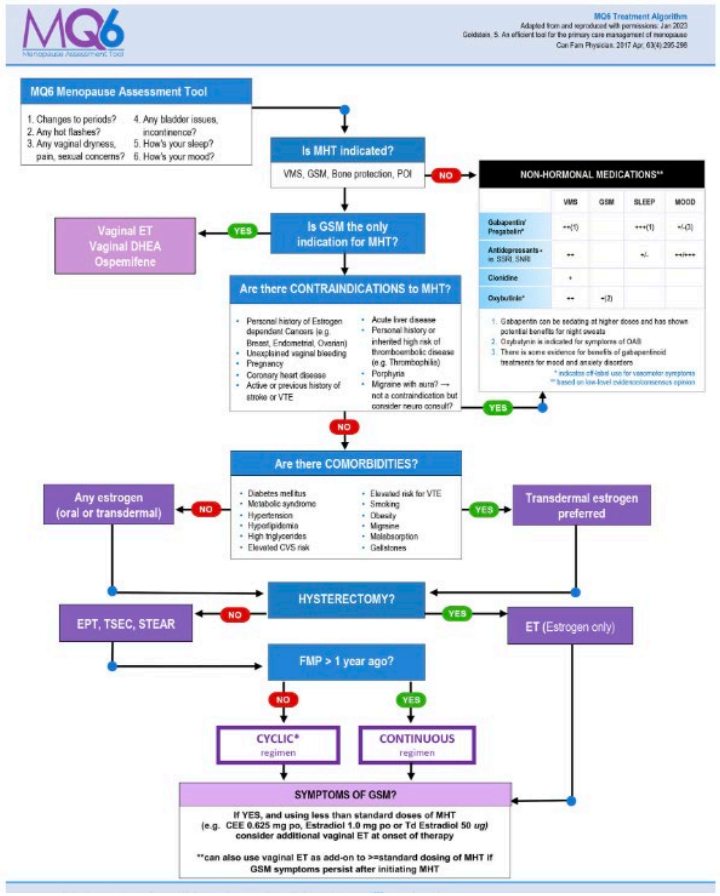
Validated Tool

1. Any changes in your periods? R/O PMB
2. Are you having any hot flashes?
3. Any vaginal dryness or pain or sexual concerns?
4. Any bladder issues/ incontinence?
5. How's your sleep?
6. How's your mood? Window of vulnerability

An efficient tool for the primary care management of menopause – Susan Goldstein, Canadian Family Physician Apr 2017, 63(4) 295-298

www.MQ6.ca
Treatment Algorithm/Decision Tool

Updated 2023!



[An efficient tool for the primary care management of menopause](#)
Susan Goldstein, Canadian Family Physician Apr 2017, 63(4) 295-298

DOL FOR HEALTHCARE PROFESSIONALS FO

- MQ6 Tool: Fillable Forms
- Interactive Treatment Algorithm
- Treatment Algorithm PDF
- Menopause Therapies ›
- Menopausal Health Promotion
- Resources
- Academic References

AC

INTERACTIVE TREATMENT ALGORITHM

The MQ6 treatment algorithm is a decision tool that allows the healthcare provider to utilize the answers to the MQ6 as a starti
a personalized menopausal treatment plan. The original algorithm has been amended and updated to reflect the most recent e
and available treatment options. A discussion explaining the rationale for the decisions in the algorithm can be found by review
journal article "An Efficient Tool for the Primary Care Management of Menopause".

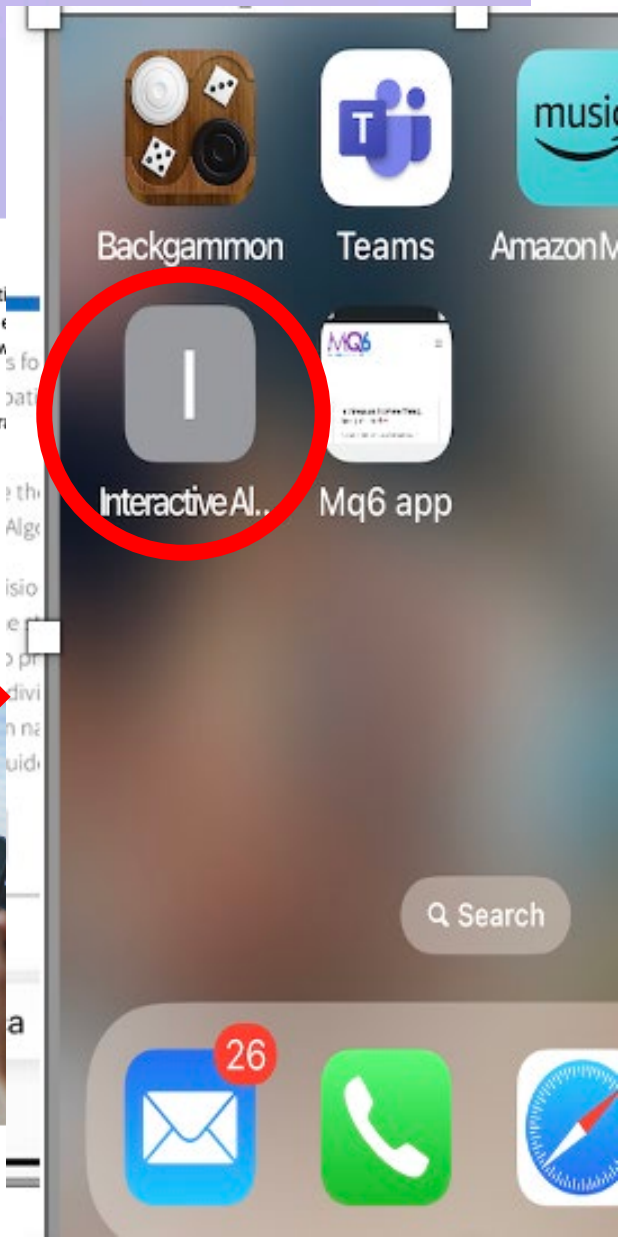
A printable PDF of the updated treatment algorithm can be found below, however you may choose to use the quick online inter
algorithm/decision tool here:

INTERACTIVE TREATMENT ALGORITHM

DOWNLOADING THE INTERACTIVE TREATMENT ALGORITHM "APP" TO YOUR DEVICE:

You can enjoy quick and easy access to this treatment decision tool by simply creating a ~~shortcut~~ or **bookmark** on the home page or screen of your device of choice, be it smartphone, tablet, iPad or computer. Creating a shortcut will provide for an app-like icon on your home screen and will take you directly to the first page of the decision tool for quick reference when providing clinical care. Click here for instructions. If at any time the shortcut stops working, please delete it (using the same steps you would use to delete any app from your mobile device) and re-add it using the steps provided.

You can also directly bookmark https://mq6.ca/interactive-algorithm/ in your browser of choice. Click here to download our easy-to-follow instructions.



MQ6 TREATMENT ALGORITHM/DECISION TOOL

INTERACTIVE TREATMENT ALGORITHM

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MQ6 TREATMENT ALGORITHM/DECISION TOOL

Choosing treatment options for your symptomatic menopausal patients can be challenging.

Click "Start" below to utilize the online MQ6 Interactive Treatment Algorithm.

Completing this online decision tool will quickly take you through the steps of the MQ6 treatment algorithm to provide recommendations for an individualized management plan based on national and international menopause guidelines.

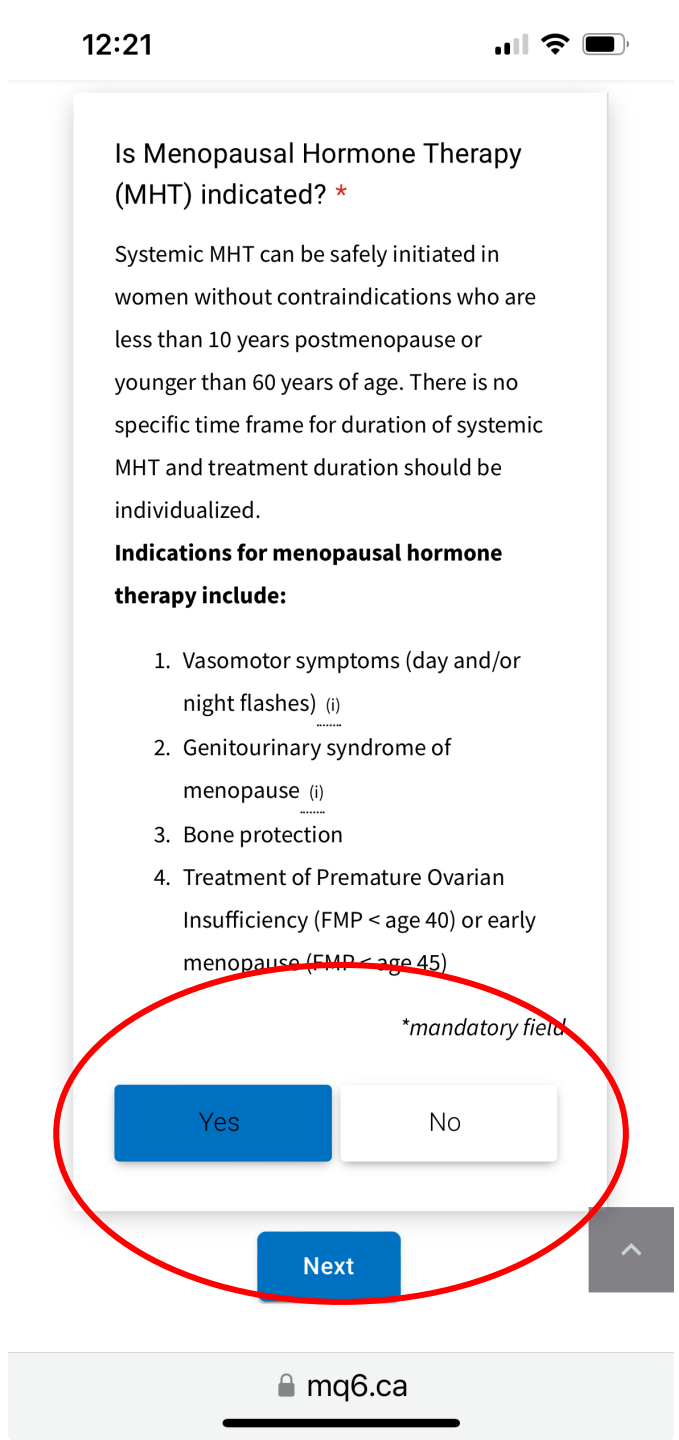
Start

1. Is MHT **indicated?**

- MHT Is safest when **initiated** *in appropriately selected* women
  - before age 60, **or**
  - within 10 years of FMP

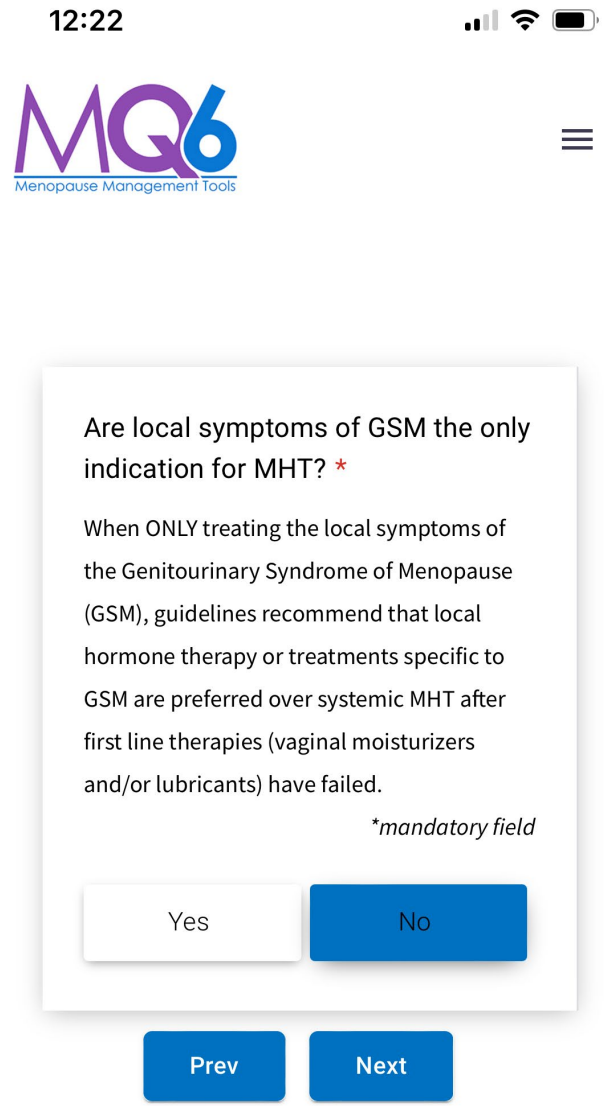
Indications for MHT:

- VMS
- GSM
- Prevention of Osteoporosis
- Rx of Early menopause/POI

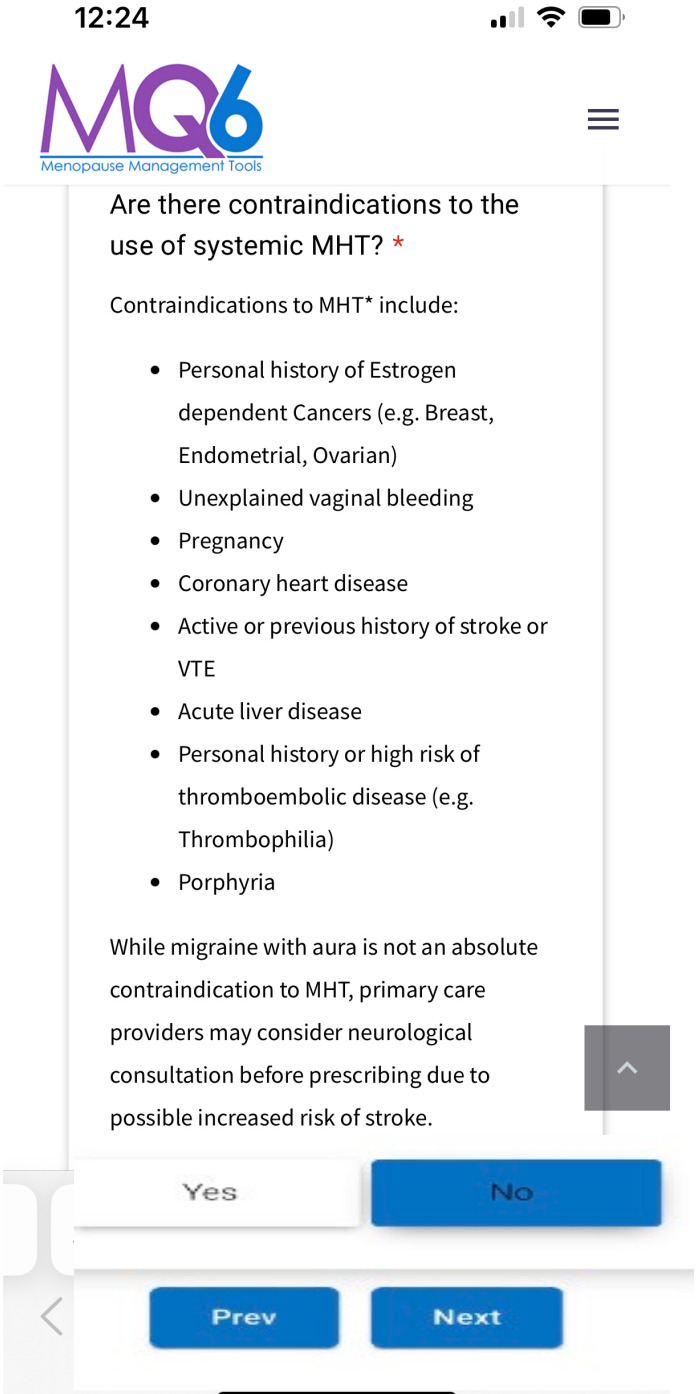


2. Is GSM the **only indication** for treatment?

IF YES:
Use locally acting GSM Treatments



3. Are there **contraindications** to systemic MHT?

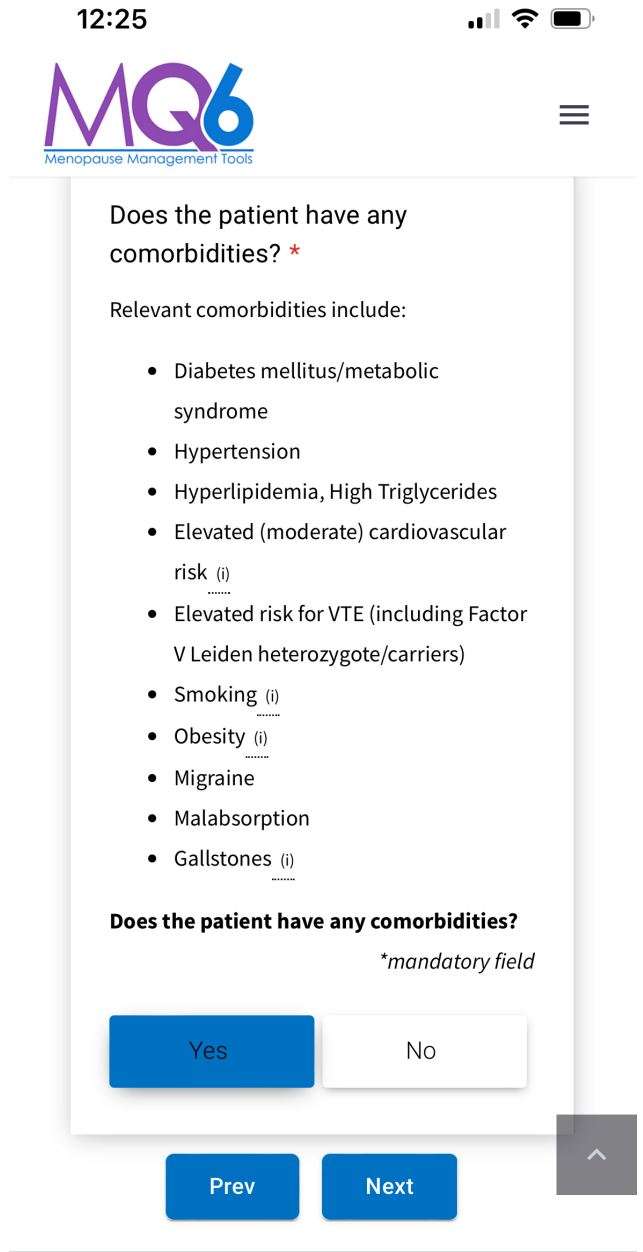


SOGC Guidelines: Managing Menopause, J Obstet Gynaecol Can. 2014 Sep;36(9):830-8.

4. Are there **comorbidities**?

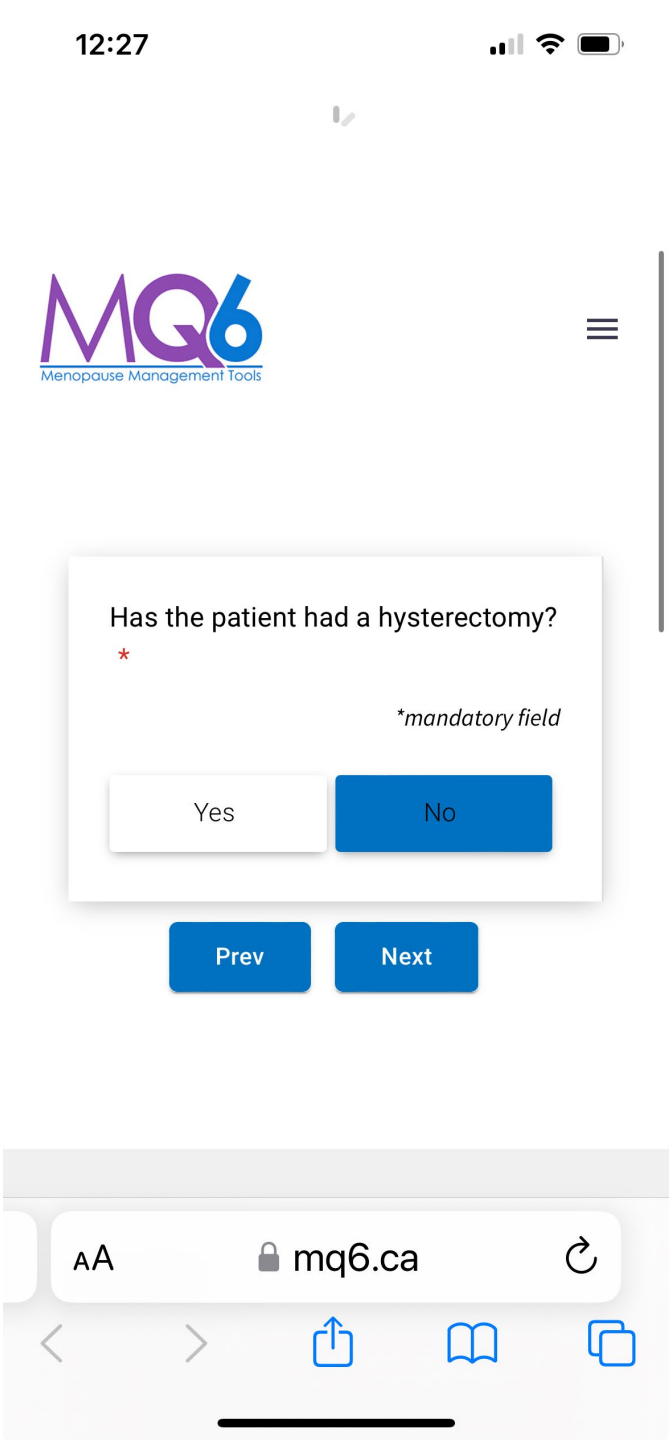
Diabetes mellitus/metabolic syndrome
Hypertension
Hyperlipidemia, High Triglycerides
Elevated (moderate) cardiovascular risk
Elevated risk for VTE
(includes Factor V Leiden heterozygote/carriers)
Smoking
Obesity
Migraine
Malabsorption
Gallstones

IF YES: recommend Transdermal Estrogen
Consider a less atherogenic progestogen
Ie. micronized Progesterone



5. Hysterectomy?

- Consider need for endometrial protection



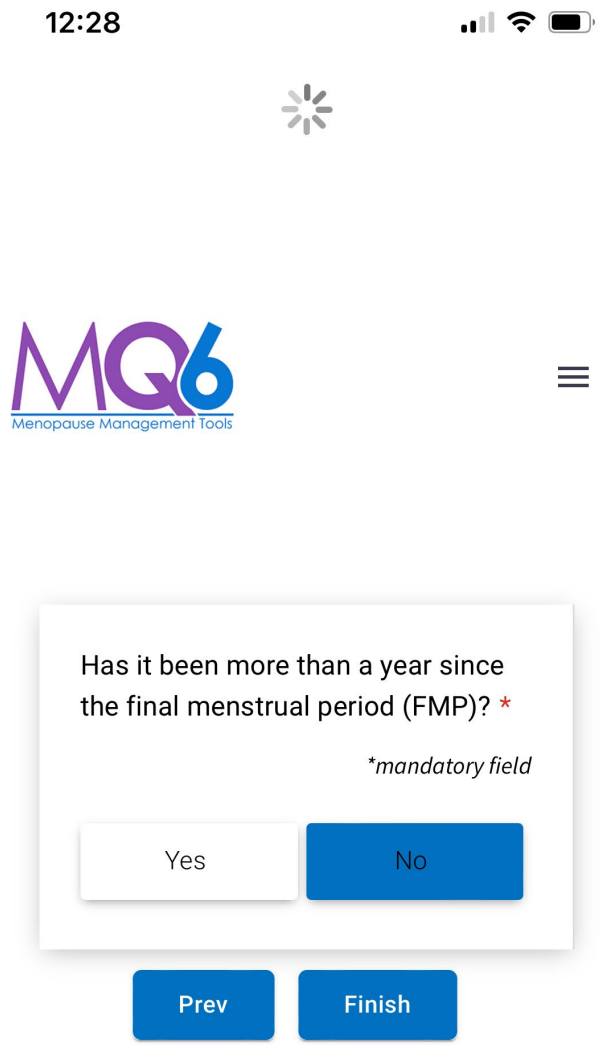
6. **FMP** more than a year ago?

<1yr: Postmenopausal

- Continuous regimen

>1yr: Perimenopausal

- Cyclic regimen



12:30

Based on the answers provided:

Treatment Recommendations for this Patient:

Consider prescribing

Any cyclic MHT regimen that contains a Transdermal Estrogen and provides endometrial protection

Click here for a table of treatment options

Rationale

This patient has comorbidities which suggest the use of transdermal estrogen therapy.

This patient requires endometrial protection.

The patient is *perimenopausal* and will likely have a better bleeding

Based on the answers provided:

Treatment Recommendations for this Patient:

Consider prescribing

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This patient has comorbidities which suggest the use of transdermal estrogen therapy.

This patient requires endometrial protection.

The patient is *perimenopausal* and will likely have a better bleeding profile if started on a cyclic regimen. Consider transitioning from a cyclic to a continuous regimen after one year.

Considerations

As hormones are still fluctuating during the perimenopause, while one may consider starting a continuous regimen, they may find that patients experience unexpected menstrual bleeding which can lead to non-adherence. For this reason guidelines recommend starting with a cyclic regimen for the first 12 months then attempting a switch to a continuous regimen.

MHT has been shown to improve glucose metabolism. If your patient's comorbidity is only type 2 diabetes mellitus and she is without other cardiovascular risk factors, evidence suggests that oral estrogen may be preferred.

Also consider: does this patient have symptoms of GSM?

If yes, and initiating treatment at lower than "standard doses"* of Estrogen, consider additional vaginal Estrogen Therapy (ET) at the onset of therapy after a trial of vaginal moisturizers +/- lubricants.

NB: one may also use vaginal ET as an add-on to >= standard doses if GSM symptoms persist after initiating MHT.

**examples of "standard doses" of Estrogen include:*

Oral conjugated equine estrogen .625 mg po od
Oral estradiol 1.0 mg po od
Transdermal estradiol 50 ug patch 2/week

MQ6 Interactive Algorithm Responses

1. Is Menopausal Hormone Therapy (MHT) indicated? **YES**
2. Are local symptoms of GSM the only indication for MHT? **NO**
3. Are there contraindications to the use of systemic MHT? **NO**
4. Does the patient have any comorbidites? **YES**
5. Has the patient had a hysterectomy? **NO**
6. Has it been more than a year since the final menstrual period (FMP)? **NO**

--

These are recommendations only. You must always rely on your clinical judgement and consider individual patient risk factors.

Restart Exit

Dr. Shesa Swettin

age 49 y/o for pap

MQ6:

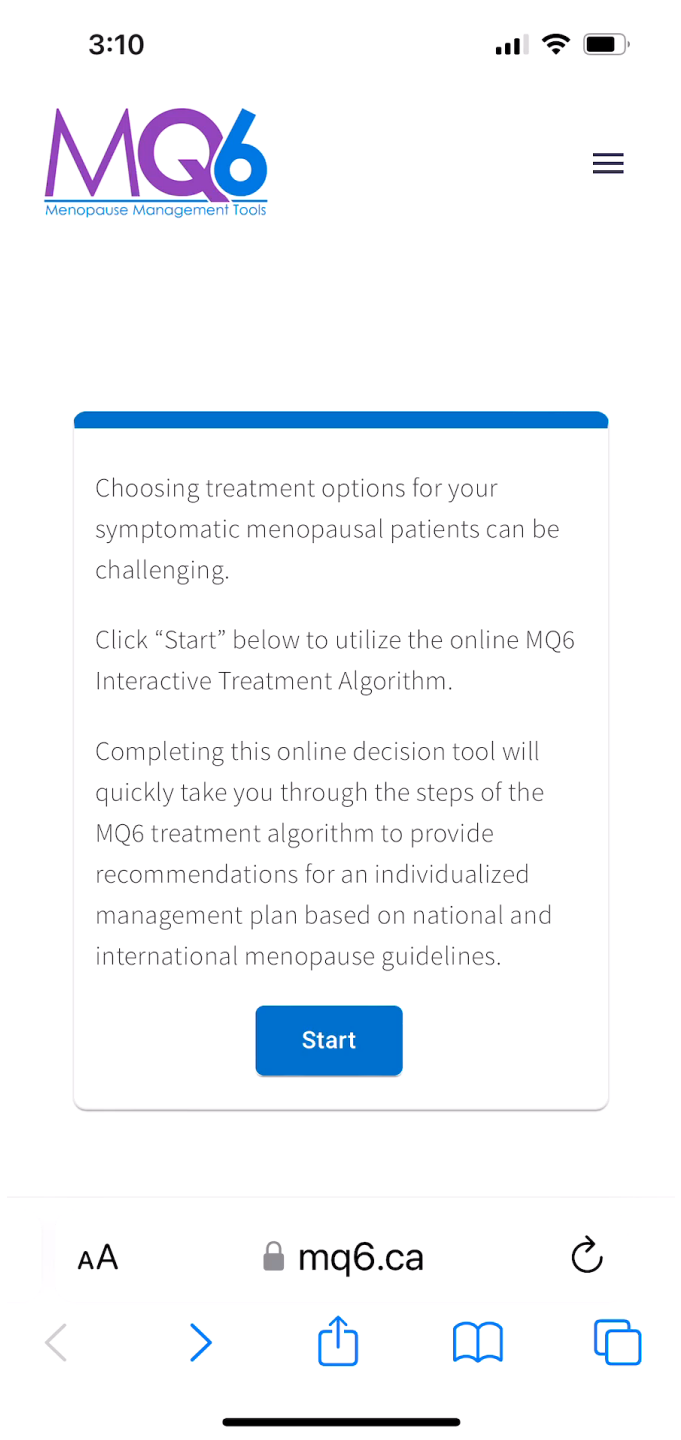
- LMP 8 MOS AGO
- VMS 7/10 day and night
- GSM: dry vagina/pain with sex
- Sleep interrupted by Vms
- Mood fine

Hx/Px: controlled HTn,

Labs: HbA1c=.57 LDL chol 2.8

mammo, pap utd

Sample Video of the MQ6 Assessment Tool



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The patient is *perimenopausal* and will likely have a better bleeding

AA mq6.ca

Cyclic MHT

Estrogen day 1-31 +
Progestogen 12-14 days a month

℞

Estradiol 37.5 mg patch 2/week

Micronized Progesterone

200 mg po od day 1-13 of the month

+

Vaginal E2 10 mcg pv nightly x 2 weeks

then 2/week

Anything else I need to know about **perimenopause**?

- CONTRACEPTION! --- MHT **does not** provide contraception

  Fertility persists:
  - 1 year post FMP in 50s
  - **2 years** post FMP in 40s !

<u>Requires Contraception:</u>

- Cyclic EPT: need backup (condoms)
- Estrogen + Prog IUS (eg. Mirena)
- low dose CHC if no contraindications

<u>Can't use Estrogen</u>

Progestogen alone-some benefit VMS

How to choose for the **postmenopausal** patient?

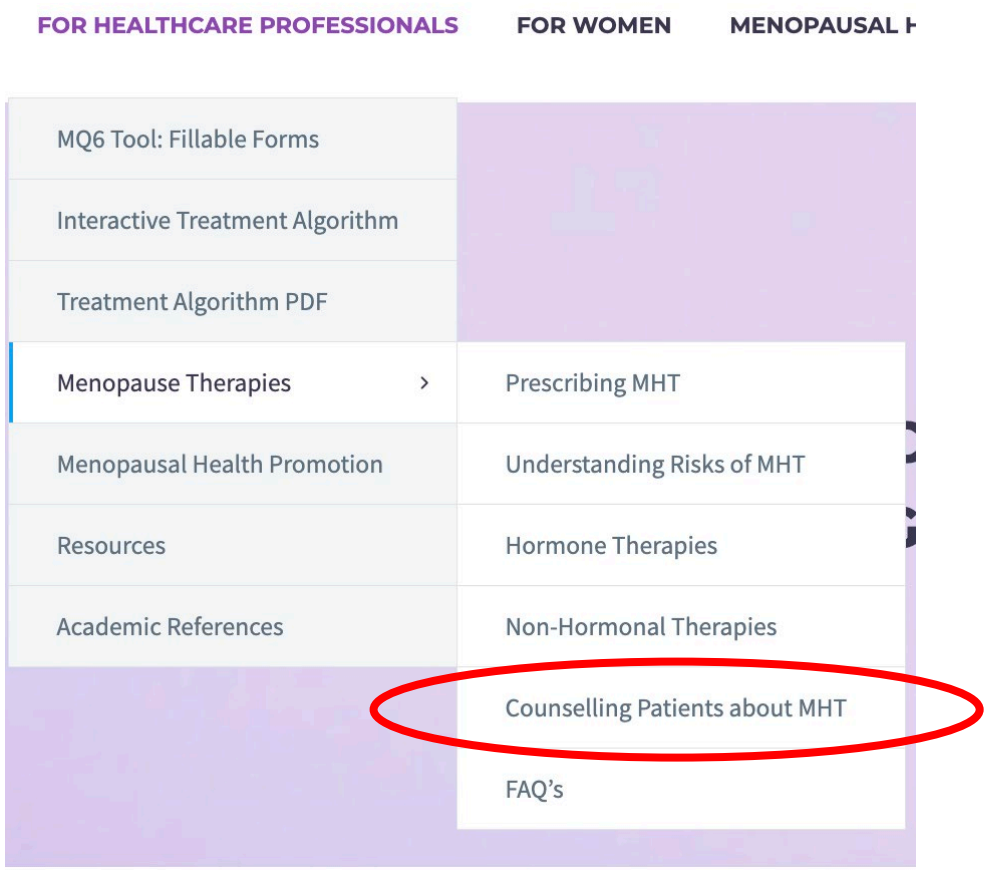
Options for **Postmenopause**:

- Continuous EPT
- Tissue specific products do not require additional progestogen
  - TSEC (CE/BZA)-Duavive®
  - STEAR (TIBOLONE)-Tibella®

Breast neutrality

More favourable bleeding profiles

Counselling Tool



MQ6 Menopause Assessment Tool

Here is a counselling tool you may use when initiating MHT in appropriately selected women:

- □ Menopausal Hormone Therapy (MHT) will likely be effective for your hot flashes and/or night sweats
    - □ Effects may take up to 4-8 weeks to work depending on dosage
    - □ We may need to adjust dosages
- □ MHT will provide bone protection to prevent osteoporosis while you are taking it
- □ You may also derive some benefit to symptoms of GSM such as vaginal dryness, urinary frequency or recurrent urinary tract infections
    - □ Depending on dose, we may need to add in additional treatments that act locally on the vaginal and urinary tissues
- □ You may also benefit with respect to joint pains, mood, sleep and quality of life
- □ The effect on libido is unpredictable
- □ There are some risks to consider:
    - □ There is a small "rare" increased risk of breast cancer (1/1000 women for EPT) after approximately 5 years of treatment
        - □ This risk may change based on product and regimen we choose
        - □ This risk is similar to that caused by 1-2 alcoholic drinks a day or being overweight/obese
        - □ Although more cases of breast cancer have been observed, the data indicates no increase in the # of deaths from breast cancer
    - □ There is an increased risk of blood clots in the first 1-2 years of treatment: the risk is about 1/1000 women
- □ When initiating MHT in women your age, MHT is safe for the heart and there is no appreciable increase in stroke risk or dementia
- □ Most MHT regimens are weight neutral, however weight gain is a normal effect of aging, so optimize your diet and exercise
- □ Common side effects include breast tenderness, bloating and mild headaches which usually settle within a few weeks With cyclic regimens you may see a small withdrawal bleed
- □ As VMS may last anywhere from 5-10 years or more, we will review and revisit indications for treatment annually

2A. COMBINED CONTINUOUS PRODUCTS

Estrogen (1A) and progestogen (1B) products may be combined to create a cyclic OR continuous EPT regimen or you may choose existing daily products which provide for continuous therapy.

Type of Continuous Combined Product	Starting doses*
Oral	
17β-estradiol + NETA oral (Activelle®, Activelle LD®)	1 mg E2/0.5 mg NETA daily 0.5 mg E2/0.1 mg NETA daily (LD) One tablet daily
17β-estradiol + drospirenone oral (Angeliq®)	1 mg E2/1 mg DRSP One tablet daily
Transdermal Patch	
17β-estradiol + NETA patches (Estalis® 140/50; 250/50)	140 mg NETA /50 mg E2 250 mg NETA/50 mg E2 One patch twice weekly
Custom Combined Regimen	
Combine an estrogen (oral or transdermal) from Table 1A with a progestogen from Table 1B to create EPT	Estrogen + Progestogen daily, or Estrogen daily + LNG-IUS (off-label)
Continuous MHT Options: no additional Progestogen	Doses
Selective Tissue Estrogenic Activity Regulator (STEAR)	
Tibolone (Tibella®)	2.5 mg tablet One tablet daily
Tissue Selective Estrogen Complex (TSEC)	
Conjugated estrogen (0.45 mg) + bazedoxifene (Duavive®)	0.45 mg CEE + 20 mg BZA One tablet daily

NON-HORMONAL TREATMENT OPTIONS**

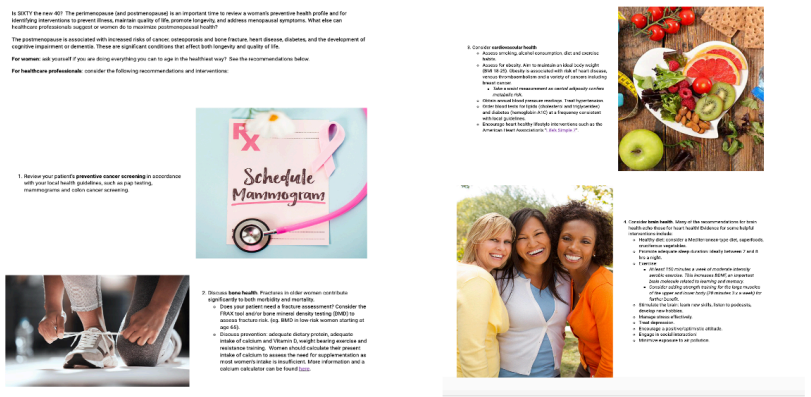
	Gabapentin/ Pregabalin*	Antidepressants* ie. SSRI, SNRI	Clonidine	Oxybutinin*
Vasomotor Symptoms	++(1)	++	+	++
GSM				+(2)
Sleep	+++(1)	+/-		
Mood	+/-(3)	++/+++		

1. *Gabapentin can be sedating at higher doses and has shown particular benefit for night sweats*
2. *Oxybutynin is indicated (on-label) for symptoms of overactive bladder (OAB)*
3. *There is some evidence for benefits of gabapentinoids on mood/anxiety*

FAQ'S

- How do I create and prescribe a combined cyclic MHT?
- Do I need to prescribe progesterone when prescribing vaginal estrogen therapy?
- How do I manage patients with early menopause (ie. LMP before age 45)
- My patient is asking for bioidentical hormones, what do I prescribe?
- I have an obese patient, are there special considerations?
- What if the HCP or the patient have breast concerns?
- My patient is complaining of libido problems?
- My patient is on a combined oral contraceptive. How would I know if she is in menopause?
- Will menopausal hormone therapy provide contraception?
- How do I dose Gabapentin for vasomotor symptoms?

MENOPAUSAL HEALTH PROMOTION



(c) MQ6 Menopause Management Tools

CANADIAN MENOPAUSE SOCIETY
SOCIÉTÉ CANADIENNE DE MÉNOPAUSE

Guidelines and References

- Canadian Menopause Clinical Practice Guidelines: JOGC 2021. NO. 422, a-f
- "The 2022 Hormone Therapy Position Statement of The North American Menopause Society" Advisory Panel. The 2022 hormone therapy position statement of The North American Menopause Society. Menopause. 2022 Jul 1;29(7):767-794.
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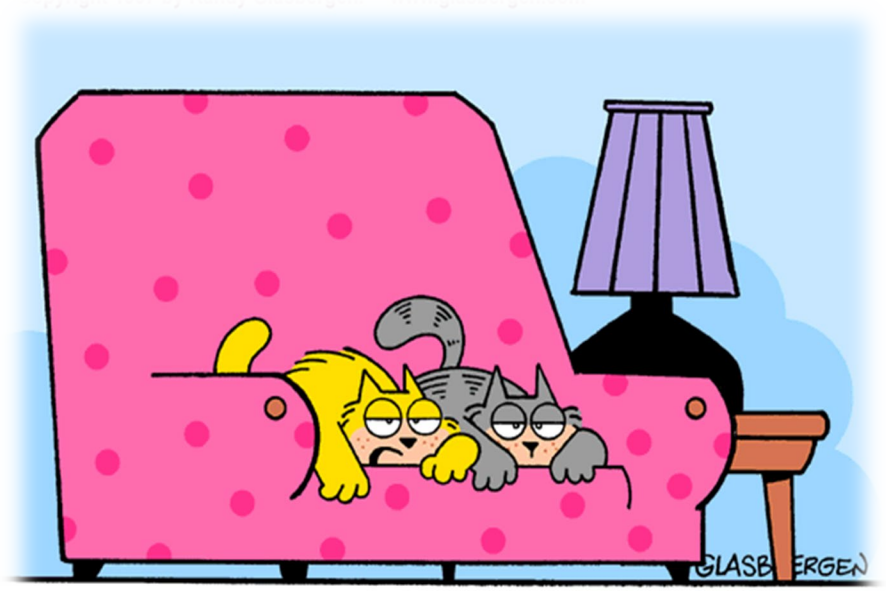
- Menopause and diabetes: EMAS clinical guide. Maturitas 2018 Nov:117:6-10.
- Joint position statement by the British Menopause Society, Royal College of Obstetricians and Gynaecologists and Society for Endocrinology on best practice recommendations for the care of women experiencing the menopause. Post reproductive health 2022. Vol 28(3):123-125
- IMS 2023 White Paper: Reproductive Milestones across the lifespan and and cardiovascular disease risk in women
- CMS Pocket Guide Menopause Management : A practical tool for healthcare professionals
- www.MQ6.ca

THANK YOU!

susan.goldstein@utoronto.ca



"Having nine lives is cool, but if I have to go through menopause again, forget it!"

Questions?

Wondering if you should get boosted?

Our VaxFacts+ Clinic will connect you with qualified doctors who understand that you may have questions or are looking for more information about COVID-19 vaccines. They are ready to talk, listen and help you get the facts.

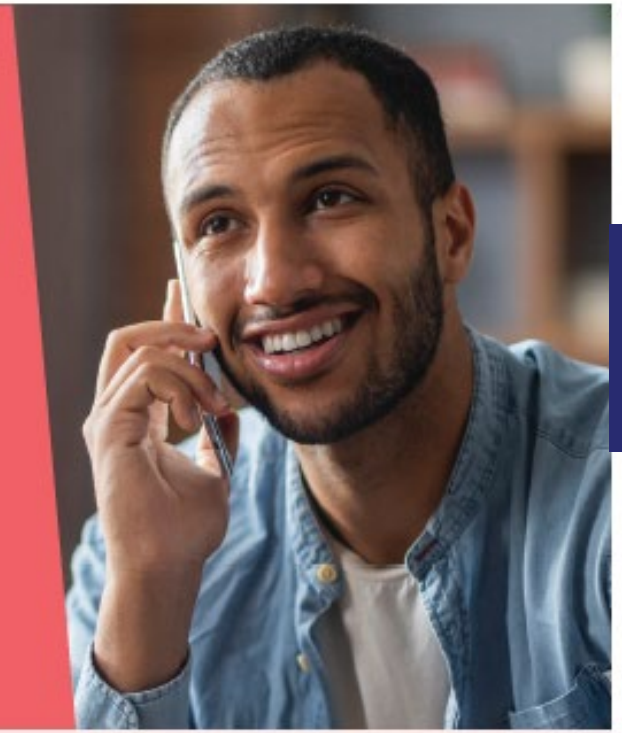
Schedule a one-to-one phone conversation.
BOOK ONLINE
shn.ca/VaxFacts

SHN
SCARBOROUGH HEALTH NETWORK

VaxFacts+
CLINIC

Questions about your health?

Speak with an expert physician!



Schedule a one-to-one phone conversation.

BOOK ONLINE:

shn.ca/VaxFacts

Our trusted doctors are here to listen and answer your questions about:

VACCINES

Including COVID-19, RSV, flu, immunizations

CANCER SCREENING

For colon, breast and cervical

PREVENTATIVE HEALTH COUNSELLING

For topics such as infectious diseases, health risk factors, and community resources

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SCARBOROUGH CENTRE FOR HEALTHY COMMUNITIES

CanTreatCOVID

Canadian Adaptive Platform Trial of Treatments for COVID in Community Settings

Who can participate?

- Adults who **tested positive for COVID** with symptoms starting within the last 5 days and
- aged 18-49 years with one or more chronic condition(s) **OR** aged 50+ years regardless of health status

Compensation: Healthcare providers - $40 for referring potentially eligible participants
Patients - up to $120 while in the study

Why participate?

- Close monitoring
- Personalized care
- Contribution to medical research
- Participate online or by phone call

1-888-888-3308 CanTreatCOVID.org info@CanTreatCOVID.org

CanTreatCOVID is led by Dr. Andrew Pinto and supported by CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada · Santé Canada Health Canada · Public Health Agency of Canada Agence de la santé publique du Canada

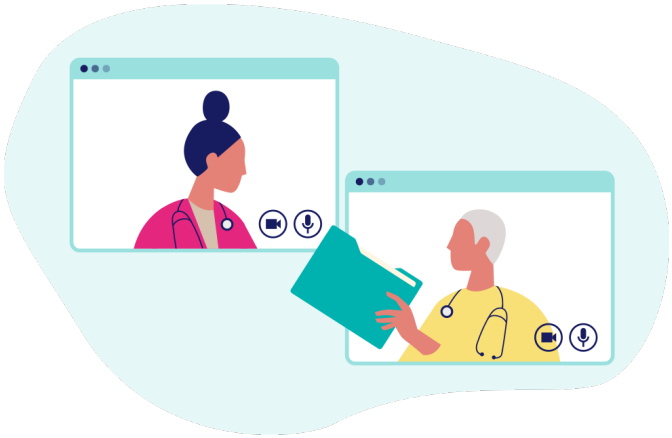
OCFP supports for Mental Health, Addictions and Chronic Pain

Mental health, addictions and chronic pain are challenging conditions. Find information to support the care you give patients – in a way that also considers your wellbeing.

Community of Practice

Join upcoming sessions:

- Caring for anxious patients (March 27)
- Managing alcohol use (April 17)
- Emerging therapeutics amidst fat-shaming (May 22)



Peer Connect Mentorship

Join a series of small group learning sessions designed for family physicians to celebrate their successes and address the obstacles they encounter in their practice. The deadline to register for a small group is **Friday, April 12, 2024.**

Sign Up

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Let’s shine a light on Ontario’s family doctors

Nominate a colleague or peer for an OCFP Award today!

Nomination Deadline is March 31, 2024

RECENT SESSIONS

September 15	**Preparing for the fall**	Dr. Kieran Michael Moore Dr. Daniel Warshafsky
December 15	**Winter virus season and Changes to breast cancer screening in Ontario**	Dr. Allison McGeer Dr. Jonathan Isenberg Dr. Anna M. Chiarelli Maggie Keresteci
January 19	**COVID-19 Updates and Managing Respiratory Illness in Kids**	Dr. Alon Vaisman Dr. Tasha Stoltz
February 9	**Long COVID and Lipid Guidelines**	Dr. Kieran Quinn Dr. Michael Kolber
February 23	**COVID-19 and Measles Updates, and Supporting Primary Care**	Dr. Megan Devlin Dr. Elizabeth Muggah

Previous webinars & related resources:
https://www.dfcm.utoronto.ca/covid-19-community-practice/past-sessions

Accessing Previous Sessions and Self Learning

Previous webinars & related resources

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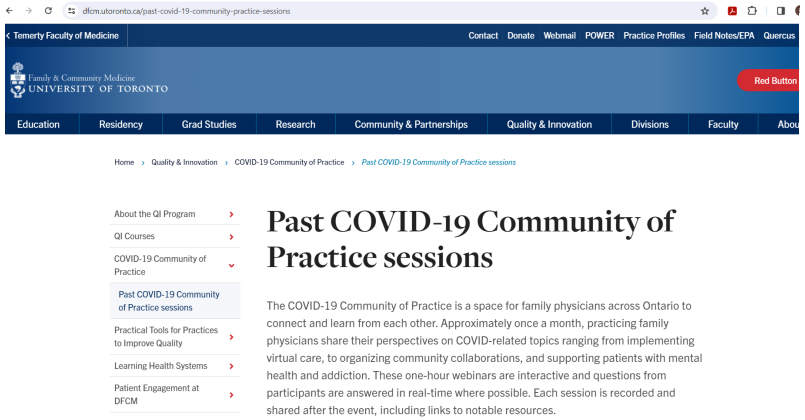

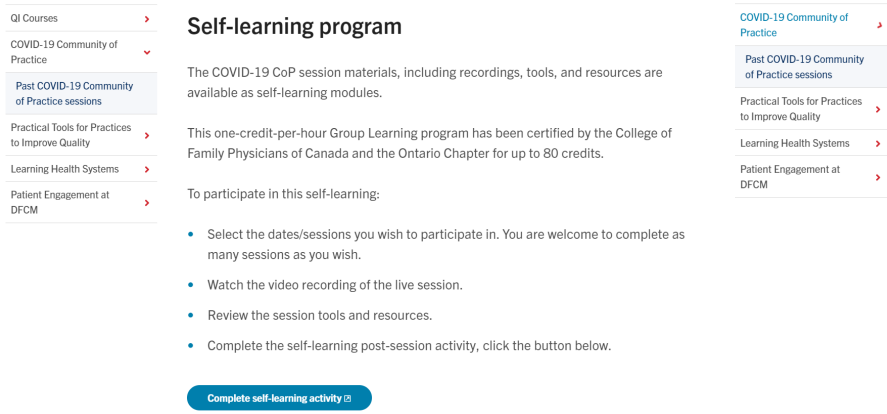

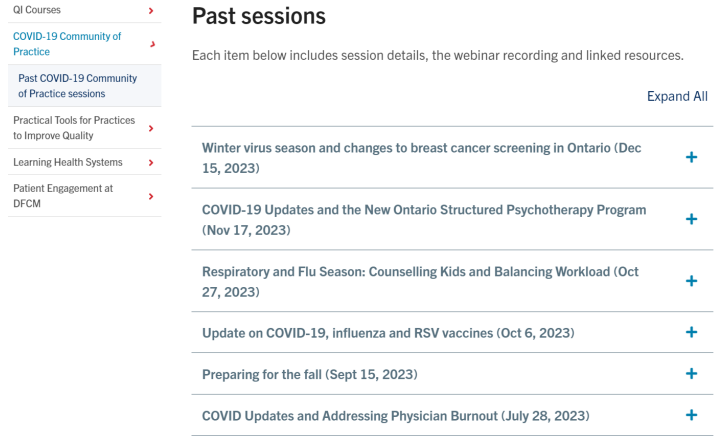

Questions?

Webinar recording and curated Q&A will be posted soon
https://www.dfcm.utoronto.ca/covid-19-community-practice/past-sessions

Our next Community of Practice: April 5, 2024

Contact us: ocfpcme@ocfp.on.ca

Visit: https://www.ontariofamilyphysicians.ca/tools-resources/covid-19-resources

The COVID-19 Community of Practice for Ontario Family Physicians is a one-credit-per-hour Group Learning program that has been certified for up to a total of 32 credits..

Post session survey will be emailed to you. Mainpro+ credits will be entered for you with the information you provided during registration.