Changing the Way We Work Community of Practice for Ontario Family Physicians

April 4, 2025

Dr. Daniel Warshafsky
Dr. Mariam Hanna
Dr. Vanessa Redditt
Dr. Doug Gruner

Infectious Disease, Penicillin Allergy (De)labelling & Newcomer Care Resources

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of Family Physicians

Infectious Disease, Penicillin Allergy (De)labelling & Newcomer Care Resources

Moderator:

- Dr. Eleanor Colledge, CPD Program Director, University of Toronto and Family Physician, South East Toronto Family Health Team, Toronto, ON

Panelists:

- Dr. Daniel Warshafsky, Toronto, ON
- Dr. Mariam Hanna, Burlington, ON
- Dr. Vanessa Redditt, Toronto, ON
- Dr. Doug Gruner, Ottawa, ON

Host:

- Dr. Jobin Varughese, Brampton, ON

The Changing the Way We Work 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.

Please note that due to changes to the Cert+ platform, there will be delays in credits being applied to your account.

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

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

- Identify the current best practices for delivery of primary care 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. Jobin Varughese (OCFP), Dr. Ali Damji (DFCM), Dr. Eleanor Colledge (DFCM), Dr. Harry O'Halloran, Julia Galbraith (OCFP), Pavethra Yogeswaran (OCFP), Marisa Schwartz (DFCM)

Previous webinars & related resources:

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

Dr. Daniel Warshafsky – Panelist

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

Dr. Mariam Hanna – Panelist

Pediatric Allergy, Asthma, and Immunology Specialist, Halton Pediatric Allergy Clinic

Dr. Vanessa Redditt – Panelist

Family Physician, Crossroads Clinic, Women's College Hospital

Dr. Doug Gruner – Panelist

Family Physician, Bruyère Family Medicine Centre, OCFP Board Director

Speaker Disclosure

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

- Faculty Name: **Dr. Mariam Hanna**
- Relationships with financial sponsors:
    - Grants/Research Support: DBV, Dermavant, Arcutis, ALK, Sanofi, Dominica, Horizon, Leo-Pharma
    - Speakers Bureau/Honoraria: Ontario College of Family Physicians, COVIS, ALK, Regeneron, Pfizer
    - Membership on advisory boards: ALK, Arcutis, Incyte
    - Others: N/A

Speaker Disclosure

- Faculty Name: **Dr. Vanessa Redditt**
- Relationships with financial sponsors:
    - Grants/Research Support: N/A
    - Speakers Bureau/Honoraria: Ontario College of Family Physicians, Health Commons Solutions Lab (at Sinai Health; non-profit population health lab)
    - Membership on advisory boards: N/A
    - Others: N/A

- Faculty Name: **Dr. Doug Gruner**
- Relationships with financial sponsors:
    - Grants/Research Support: N/A
    - Speakers Bureau/Honoraria: Ontario College of Family Physicians
    - Membership on advisory boards: N/A
    - Others: N/A

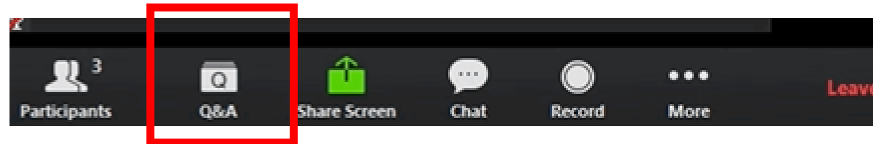
Speaker Disclosure

- Faculty Name: **Dr. Jobin Varughese**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: Toronto Metropolitan University, School of Medicine (Interim Assistant Dean of Primary Care Education), William Osler Health System (Associate Vice President of Academics)

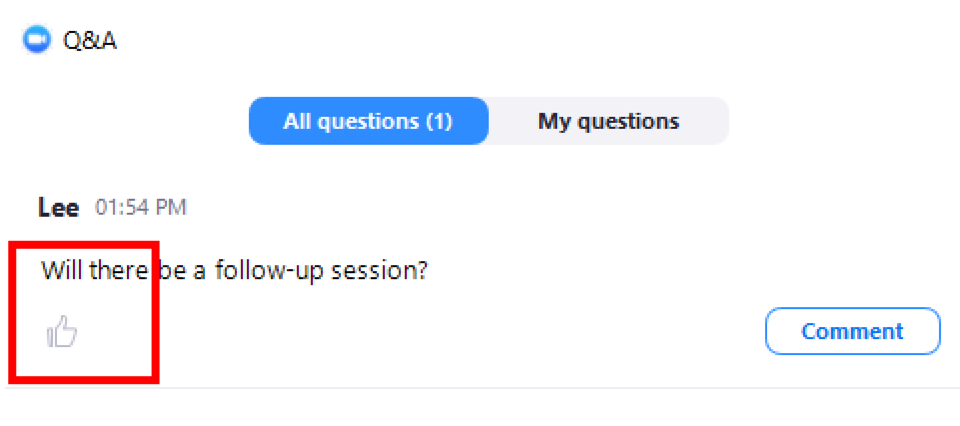
- Faculty Name: **Dr. Eleanor Colledge**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: The Foundation for Medical Practice Education (McMaster University)

How to Participate

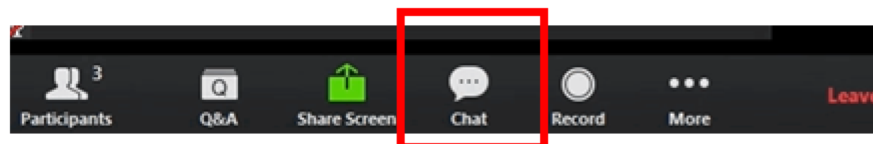
- All questions should be asked using the Q&A function at the bottom of your screen.



- 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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Infectious diseases update & Introduction to AMR/Penicillin allergy de-labelling

Changing the Way We Work CoP

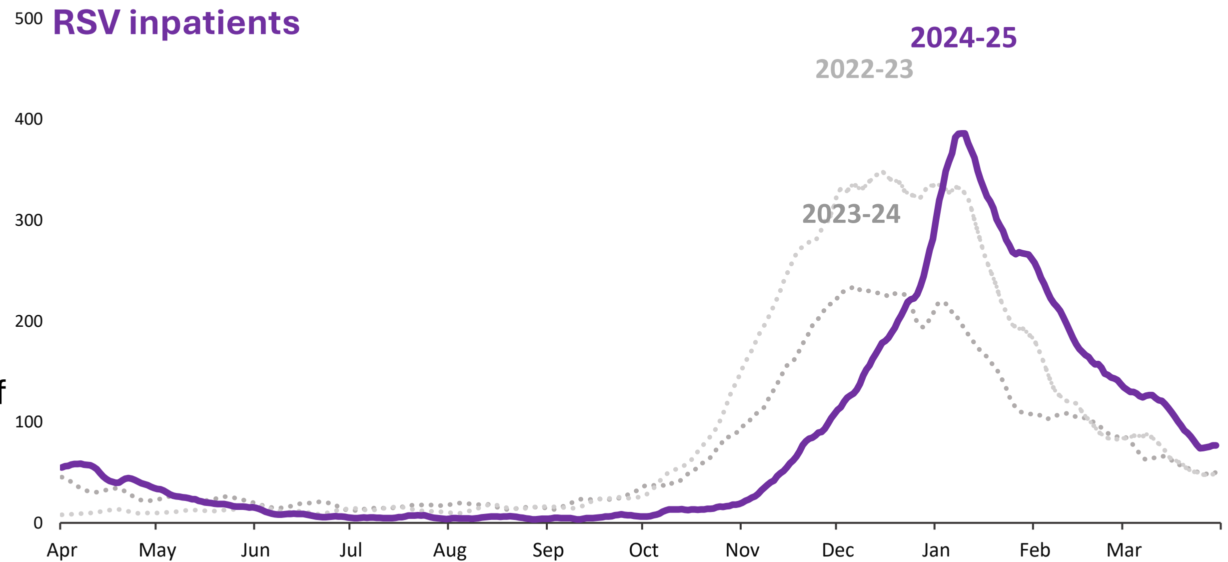
Dr. Daniel Warshafsky
Office of the Chief Medical Officer of Health

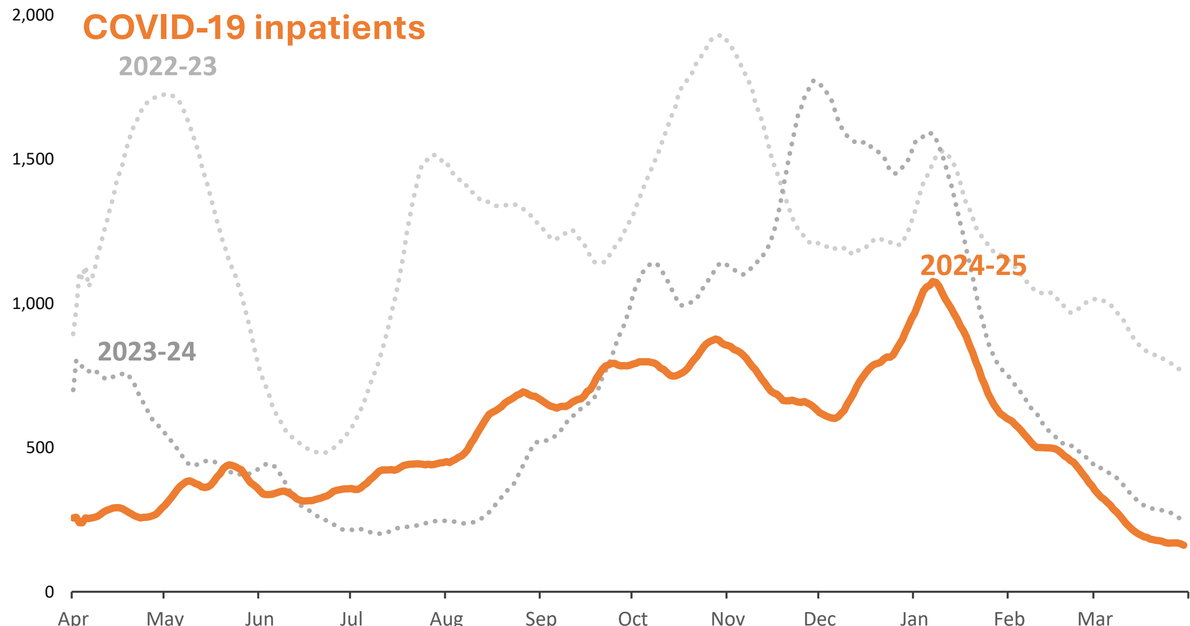
April 4, 2025

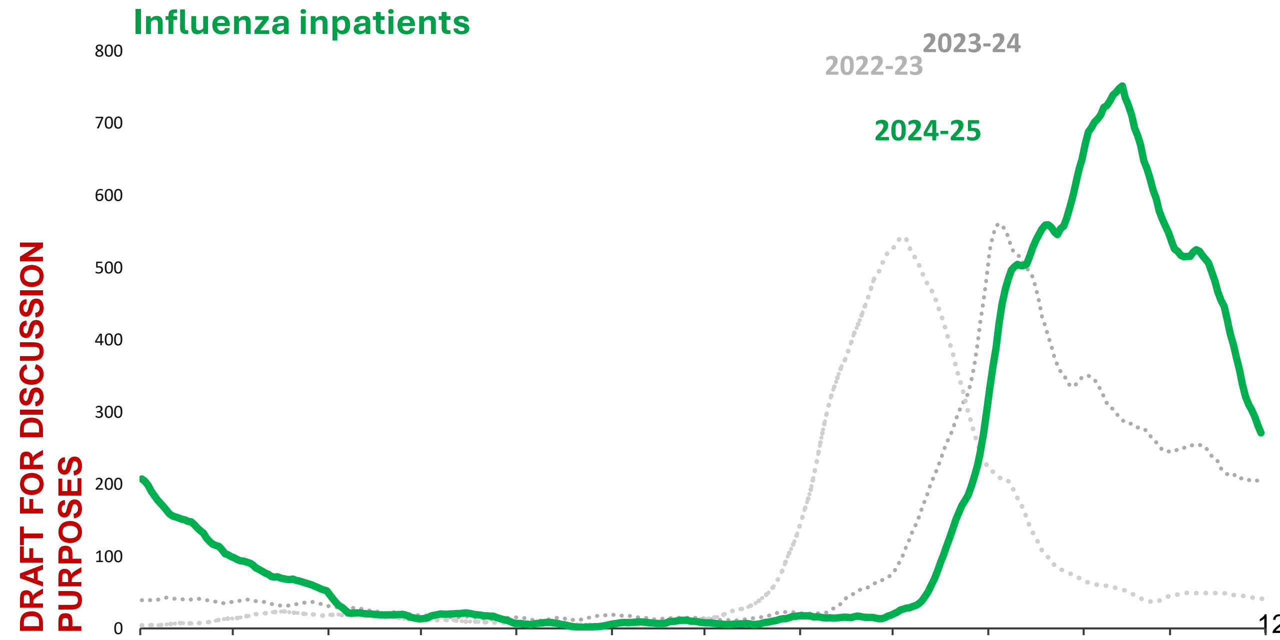
Ontario 2024-25 respiratory season hospitalizations to date vs. previous years

Data: I9 hospital census data as of March 30, 2025

- **RSV** pediatric hospitalizations peaked in mid-December and never reached levels from past two seasons. Among seniors, hospitalizations was the highest in three seasons, with a peak day for cases among 65+ this season that was nearly double the peak day for cases among 65+ in 2023-24.
- **Influenza** hospitalizations were the highest since 2017-18. In the latter part of respiratory season, there were more patients in hospital with influenza than COVID-19, a first. Activity peaked in late February. But, influenza B, which starts later and runs at lower levels than influenza A, rose through March.
- **COVID-19** hospitalization trends generally followed last year's, with early fall and post-holiday peaks. Cases never reached the heights from the last two seasons. Although not as severe as past seasons, COVID-19 still represents roughly 60% of all respiratory virus cases in hospital.







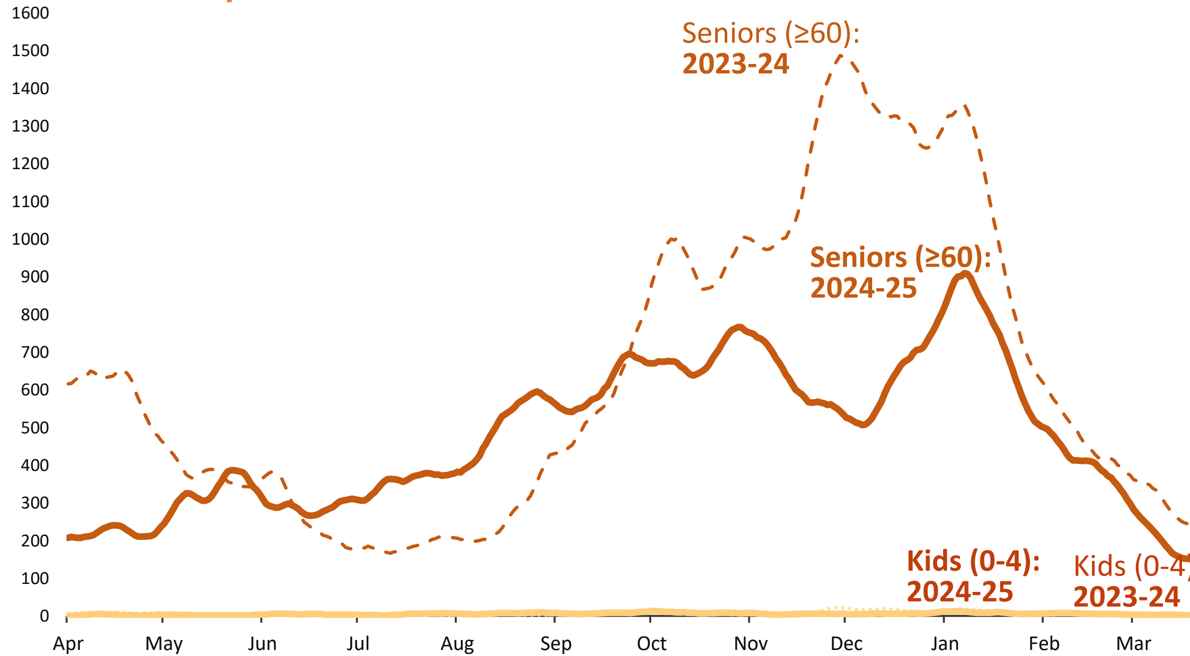
DRAFT FOR DISCUSSION PURPOSES

Ontario 2024-25 respiratory season hospitalizations by age group

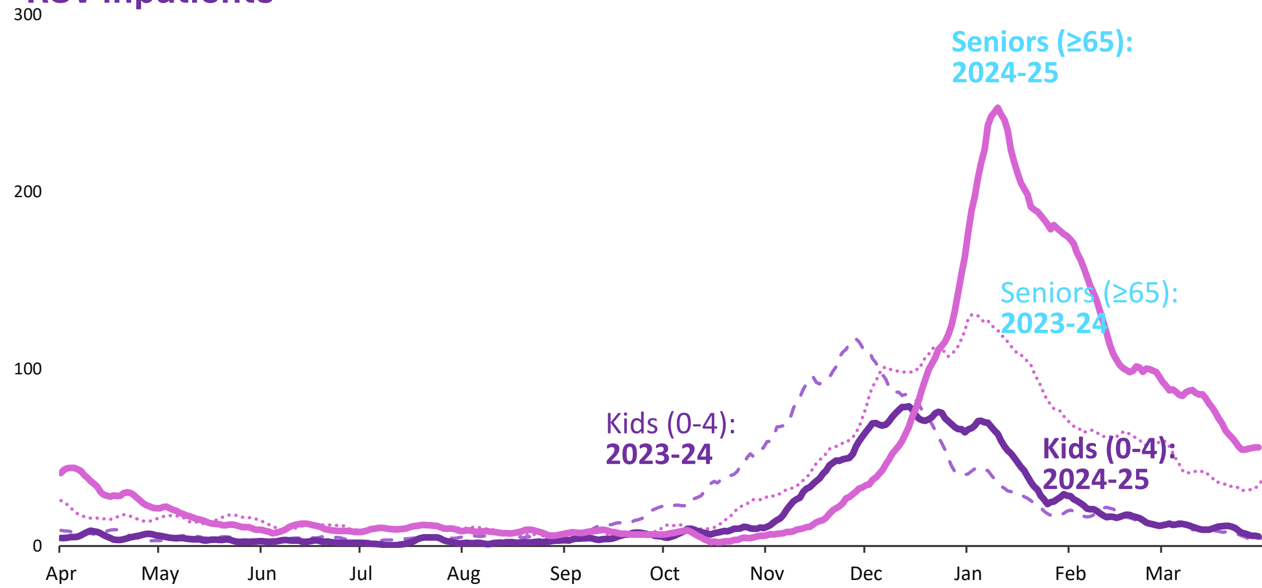
Data: I9 hospital census data as of March 30, 2025

- **RSV** 80+% of cases are among 0-4 year olds and 65+. 2024-25 followed similar trends from past years, with 0-4 year old cases starting first followed later by those age 65+.
- **Influenza** seniors represented 2/3 of all hospital cases. Cases among children sometimes lingers in late winter/early spring with rise of Influenza B activity, although at much lower volumes than peak respiratory season activity.
- **COVID-19** hospitalization is dominated by those aged 60+, with 85% of cases being from that group. All age groups generally follow same trend. Only 1% of hospitalizations are among patients 0-17.

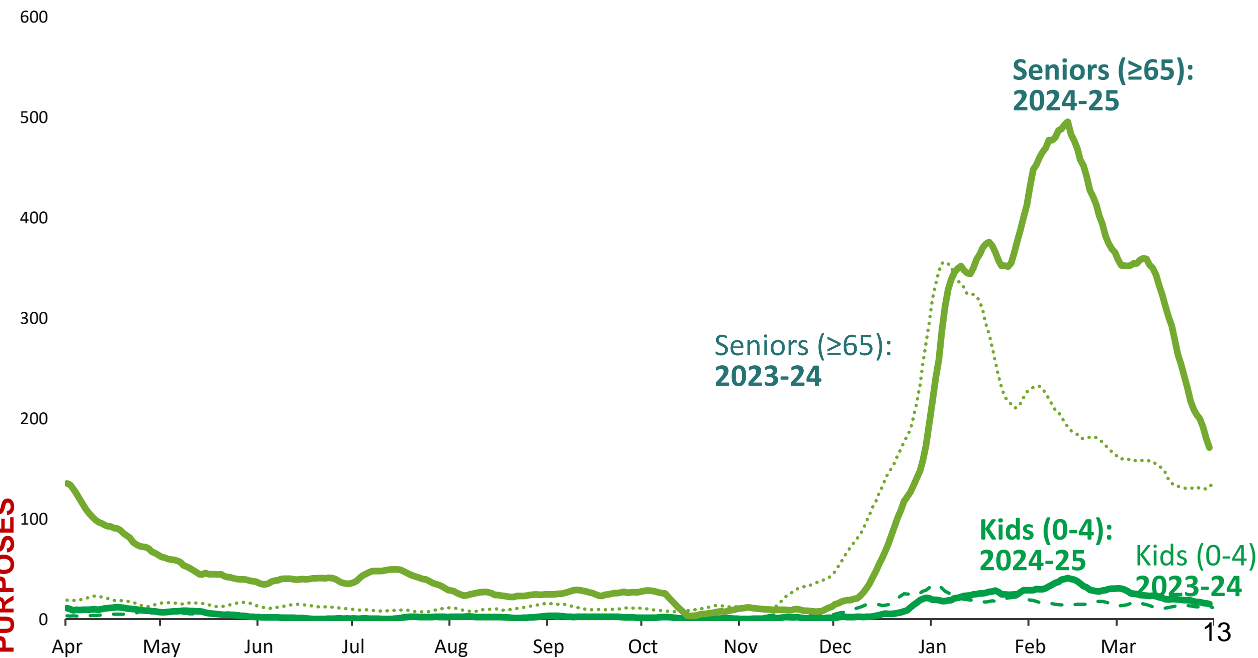
COVID-19 inpatients



RSV inpatients

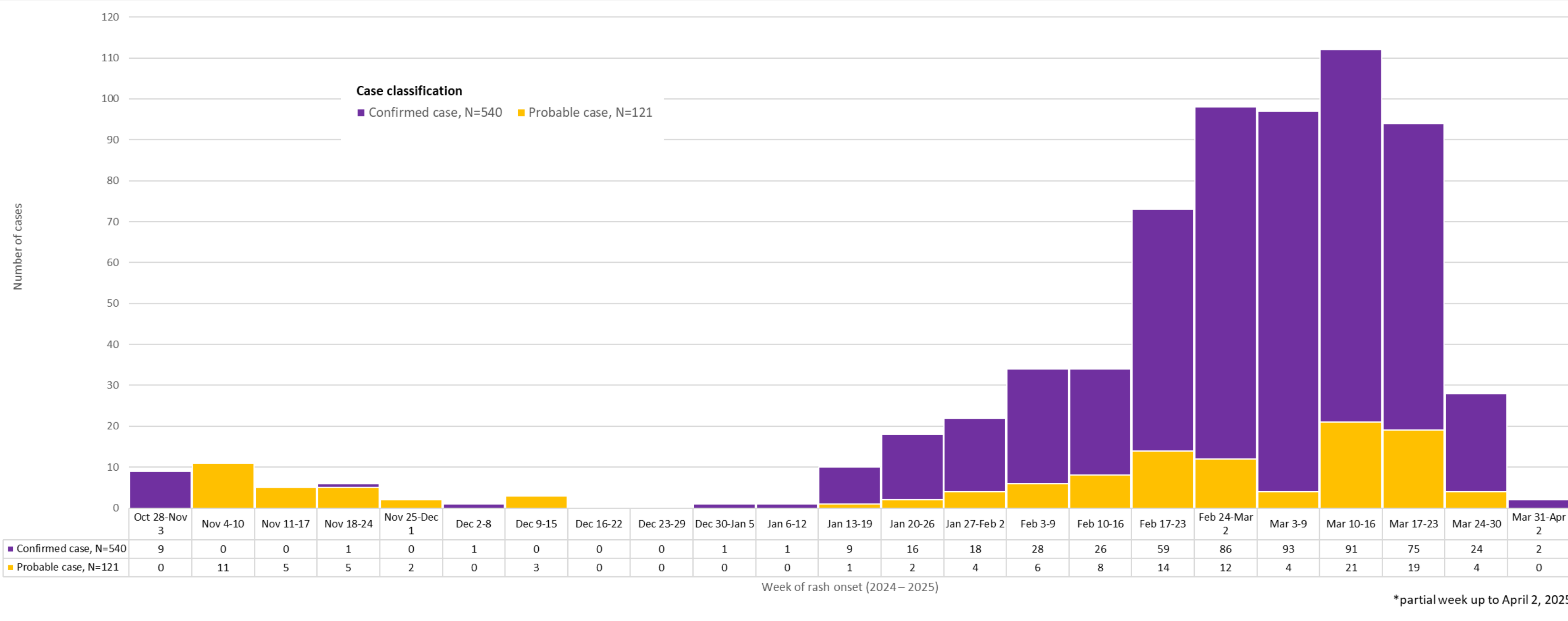


Influenza inpatients



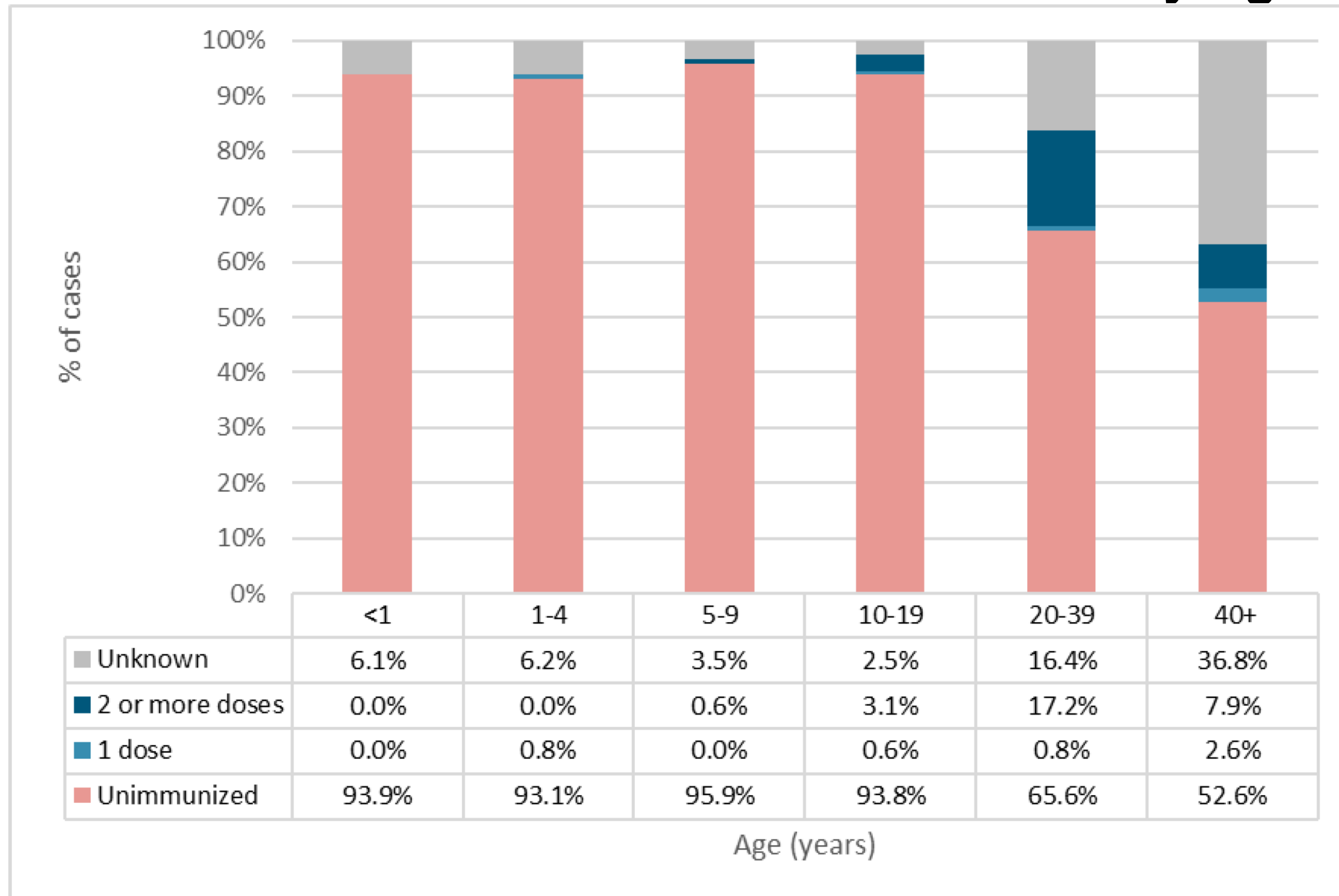
DRAFT FOR DISCUSSION PURPOSES

Measles Outbreak Cases by Week of Rash Onset and Case Classification: Ontario, October 28, 2024 – April 2, 2025



	Oct 28-Nov 3	Nov 4-10	Nov 11-17	Nov 18-24	Nov 25-Dec 1	Dec 2-8	Dec 9-15	Dec 16-22	Dec 23-29	Dec 30-Jan 5	Jan 6-12	Jan 13-19	Jan 20-26	Jan 27-Feb 2	Feb 3-9	Feb 10-16	Feb 17-23	Feb 24-Mar 2	Mar 3-9	Mar 10-16	Mar 17-23	Mar 24-30	Mar 31-Apr 2
Confirmed case, N=540	9	0	0	1	0	1	0	0	0	1	1	9	16	18	28	26	59	86	93	91	75	24	2
Probable case, N=121	0	11	5	5	2	0	3	0	0	0	0	1	2	4	6	8	14	12	4	21	19	4	0

Immunization Status of Measles Outbreak Cases by Age Group



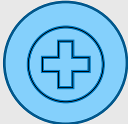
	<1	1-4	5-9	10-19	20-39	40+
Unknown	6.1%	6.2%	3.5%	2.5%	16.4%	36.8%
2 or more doses	0.0%	0.0%	0.6%	3.1%	17.2%	7.9%
1 dose	0.0%	0.8%	0.0%	0.6%	0.8%	2.6%
Unimmunized	93.9%	93.1%	95.9%	93.8%	65.6%	52.6%

Ontario

Public Health Unit	Case Count as of April 2	Change in Case Count Since March 26	Rate per 100,000 Population as of April 2
Southwestern Public Health	296 (44.8%)	43	124.9
Grand Erie Public Health	119 (18.0%)	3	40.4
Huron Perth Public Health	73 (11.0%)	18	46.8
Chatham-Kent Public Health	43 (6.5%)	4	39.5
South East Health Unit	36 (5.4%)	1	6.1
Windsor-Essex County Health Unit	30 (4.5%)	7	6.7
Region of Waterloo Public Health and Emergency Services	14 (2.1%)	12	2.1
Middlesex-London Health Unit	12 (1.8%)	0	2.1
North Bay Parry Sound District Health Unit	11 (1.7%)	0	8.3
Niagara Region Public Health	10 (1.5%)	0	1.9
Grey Bruce Health Unit	9 (1.4%)	0	4.8
Lambton Public Health	6 (0.9%)	0	4.4
Wellington-Dufferin-Guelph Public Health	2 (0.3%)	1	0.6
Ontario	**661 (100.0%)**	**89**	**4.2**

The Burden of Antimicrobial Resistance to Ontario's Health Care System

AMR is a growing threat in Ontario, posing a significant risk to patients and costs to the health care system, which could impact the investments in system capacity the government has made to address gaps across the system. Coordinated action is required to mitigate health and economic impacts



Increased Illness and Death

- **6 Ontarian lives lost per day due to AMR (2018)**
- Bloodstream infections in Ontario caused by AMR bacteria increase odds of death by 30% compared to bacteria that are susceptible to antibiotics.

Health Care Costs and Economic Impacts

- **Costs $18,000 more** to treat a patient with an AMR infection than without an infection. In 2018, treating AMR **cost Ontario hospitals $520 million**. By 2050, this will increase to $2.8 billion without action.
- In 2018, AMR **reduced Ontario's economy by $760 million.** This will **increase to $147 billion by 2050** without action.

Health System Capacity and Demand

- **AMR infections require more treatment, longer hospital stays and more care by hospital staff**. Since 2018, rates of bacteria (MRSA, VRE and COP) in Ontario hospitals have been increasing (see Appendix I). Ex. Incidence rates of MRSA and VRE increased in 2022 compared with 2021, rate of CPO nearly doubled from 2021 to 2022.

Preventable Harm to Vulnerable Populations

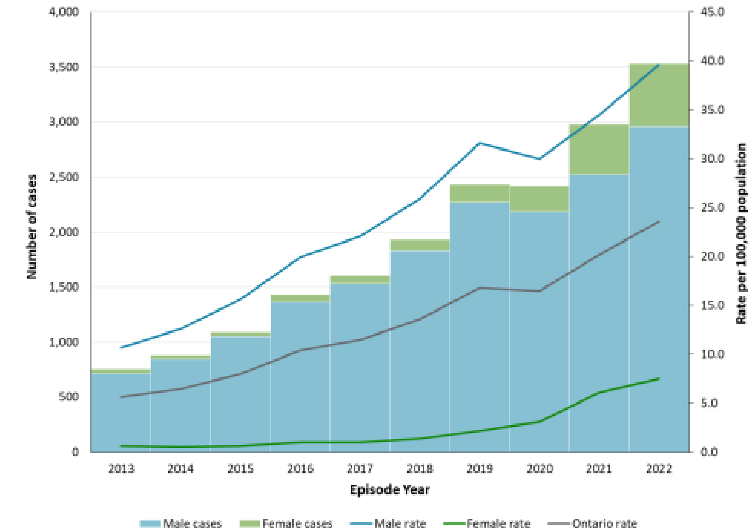
- **Residents in Ontario long-term care homes with higher antibiotic use experience more harm** (ex. 24% increased risk of Clostridioides difficile infection, allergic reactions and antibiotic-resistant organisms)

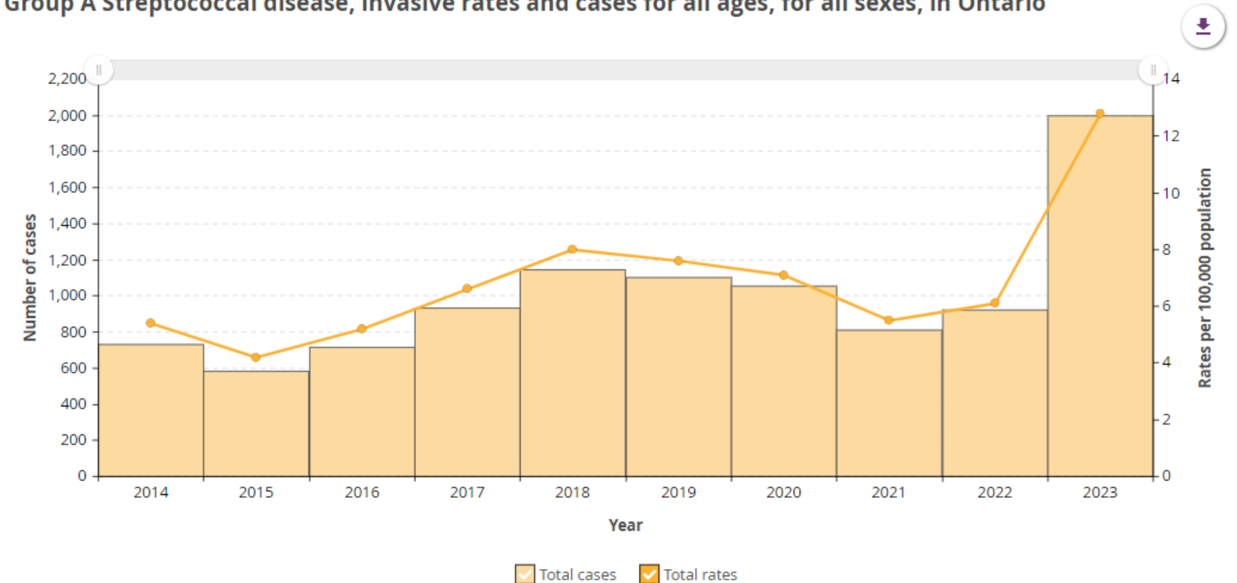
The AMR burden **impacts all sectors of the health care system**, including **hospitals** (prolonged stays, increased risk of HAIs), **long-term care** (high antibiotic use, high infection rates), **home care** and in the **community** (high antibiotic use, high need for education for patients and families on proper use).

Ontario

The role of penicillin allergy de-labelling in antimicrobial stewardship

- Penicillins are the first-line treatment for many serious infections, some of which are increasing in incidence in Ontario & Canada:
    - **Syphilis**: penicillin G benzathine (Bicillin L-A)
    - **Intrapartum GBS prophylaxis:** penicillin G or ampicillin
    - **Invasive and non-invasive group A streptococcal disease:** penicillin and amoxicillin
    - Other common infections caused by *Streptococcus pneumoniae* (community acquired pneumonia, acute otitis media)





OMA section on
ALLERGY AND CLINICAL IMMUNOLOGY

Pathways to Appropriate Penicillin Allergy (de)Labelling:

Support tool for primary care physicians developed by the OMA Section on allergy

Allergy & Clinical Immunology

Seven Things Clinicians and Patients Should Question
by
Canadian Society of Allergy and Clinical Immunology
Last updated: August 2021

Don't order non-beta lactam antibiotics in patients with a history of penicillin allergy, without an appropriate evaluation.

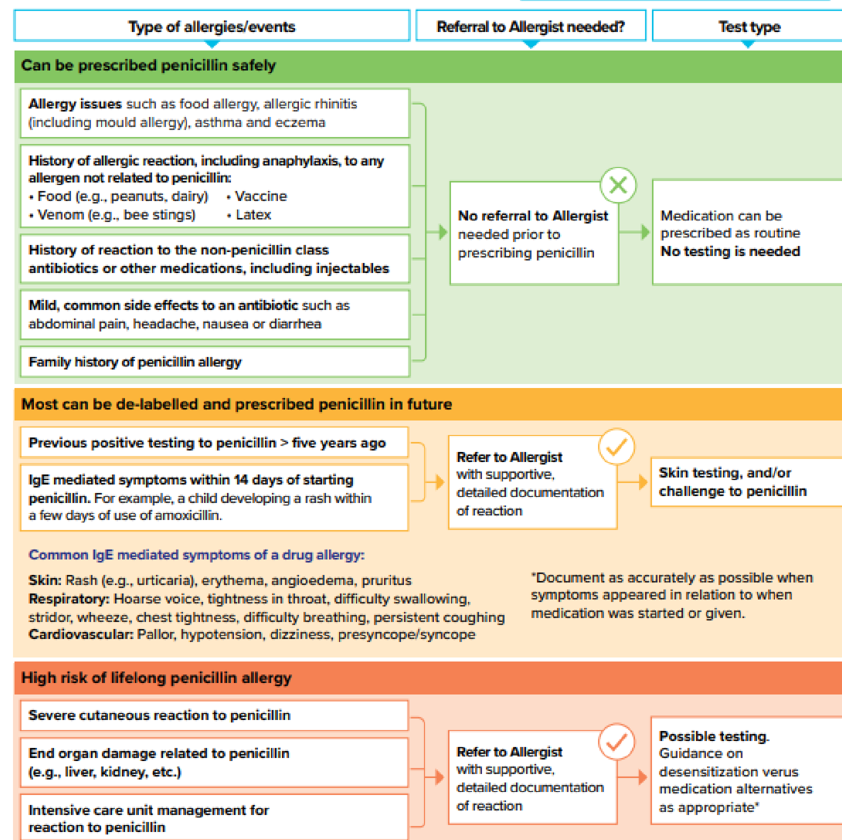
While a history of penicillin allergy is self-reported by approximately 6-25% of patients, most are able to tolerate penicillin. In those with penicillin allergy, it may remit over time. Patients deemed 'penicillin-allergic' are more likely to: be treated with broad-spectrum alternative antibiotics (such as vancomycin, quinolones and clindamycin); experience longer hospital stays; and develop complications such as infections with methicillin-resistant Staphylococcus aureus, vancomycin-resistant Enterococcus, and Clostridium difficile. IgE-mediated penicillin allergy can be evaluated through skin testing or graded oral challenge.

Pathways to Appropriate Penicillin Allergy (de)Labelling:

Support tool for primary care physicians developed by the OMA Section on allergy

This tool reflects the current evidence, guidance and recommendations for penicillin allergy labelling in patients with suspected and/or confirmed allergies. This knowledge has evolved drastically over the past 10 years.

Did you know?
More than 80 per cent of patients with a suspected penicillin allergy may be safely de-labeled. This number is closer to 95 per cent in children.



*Consider retesting sooner if clinical need for this class of medications sooner, or if testing conducted outside of Canada without any history of use of these antibiotics.

Common questions

Why are penicillin allergies over-diagnosed?
Most antibiotic reactions are not caused by the medication itself. Infections or drug-bug interactions are more common causes, which is why each reaction should be evaluated.

How is penicillin allergy tested for?
Some patients, depending on history and risk factors, can proceed directly to an oral challenge under medical observation. Other patients may require additional testing to determine if an oral challenge can be pursued.

What should I do if a patient develops serum sickness like reaction while on amoxicillin?
Document symptoms carefully for referral. An allergist will assess the appropriateness and risks/benefits of an oral challenge.

Penicillin and cephalosporin allergies

- **Cross-reactivity is no longer a concern**: Past reports of high cross-reactivity were from the 1980s and were because cephalosporins had contamination issues with penicillin antibiotics in production. True cross-reactivity is very low.
- **Risk of cephalosporin allergy is low**: In those with a true penicillin allergy, there is about a two per cent risk of cephalosporin allergy. For those with a self-reported (unconfirmed) penicillin allergy, the risk is about one per cent (the same as the general population)
- **A similar chemical structure doesn't typically contribute to allergy**: Amoxicillin and penicillin do not have similar side chains to cefazolin. Although penicillins and cephalosporins share a beta lactam ring structure, it is rarely the cause for allergy to either of these medications.

Connecting with an Allergist

✓ Refer patients with **cutaneous or systemic symptoms** affecting airway, breathing, or circulation (e.g. angioedema, hives, wheezing, hypotension, tachycardia, loss of consciousness). Refer these patients sooner rather than later, as diagnosis relies on patient history and recall.

✗ **Do not refer** for antibiotic-related side effects (e.g., nausea, diarrhea)—these are not allergic reactions and require only reassurance

How can I find an allergist to refer to?

The Canadian Society of Allergy and Clinical Immunology (CSACI) provides a geographic look-up service.

What should I include in a referral to an Allergist?

Please include the following information with your referral:

- Details of the reaction of concern the patient had, including timing and symptoms
- What penicillin antibiotic they received (if applicable)
- Full past medical history and medication list

Can I get advice about possible penicillin reactions from an Allergist without referring my patient?

Yes, you can get advice from an Allergist through:
- Ontario eConsult
- Ontario Telemedicine Network

A referral should include all relevant information, including the patient's allergy or condition, medical history and any drugs they are taking.

You can use these services when you have a general question or a question about a patient who does not require a referral (refer to page one for more details).

References

- Canadian Society of Allergy and Clinical Immunology (CSACI) Position Statement on beta lactam allergy, November 2020
- Canadian Society of Allergy and Clinical Immunology Podcast: The Allergist on Penicillin allergy, March 2025
- Choosing Wisely Canada: Allergy and Clinical Immunology, August 2021
- Canadian Pediatric Society Practice Point: Beta Lactam allergy, January 2020

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Can be prescribed penicillin safely

Allergy issues such as food allergy, allergic rhinitis (including mould allergy), asthma and eczema

History of allergic reaction, including anaphylaxis, to any allergen not related to penicillin:

- Food (e.g., peanuts, dairy)
- Vaccine
- Venom (e.g., bee stings)
- Latex

History of reaction to the non-penicillin class antibiotics or other medications, including injectables

Mild, common side effects to an antibiotic such as abdominal pain, headache, nausea or diarrhea

Family history of penicillin allergy

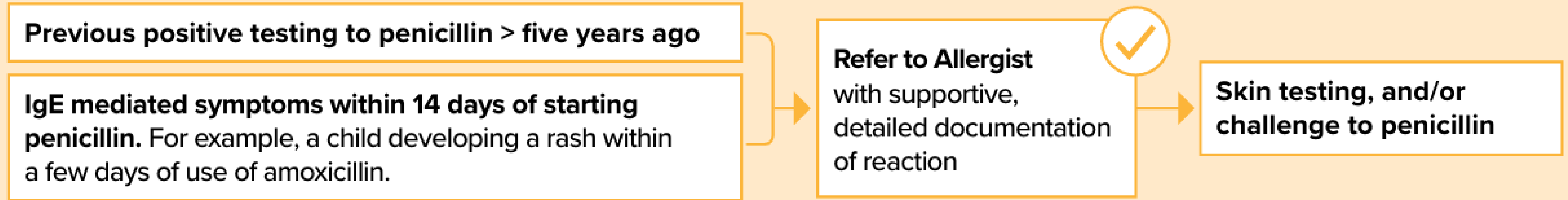
→

No referral to Allergist needed prior to prescribing penicillin

→

Medication can be prescribed as routine
No testing is needed

Most can be de-labelled and prescribed penicillin in future



Common IgE mediated symptoms of a drug allergy:

Skin: Rash (e.g., urticaria), erythema, angioedema, pruritus
Respiratory: Hoarse voice, tightness in throat, difficulty swallowing, stridor, wheeze, chest tightness, difficulty breathing, persistent coughing
Cardiovascular: Pallor, hypotension, dizziness, presyncope/syncope

*Document as accurately as possible when symptoms appeared in relation to when medication was started or given.

High risk of lifelong penicillin allergy

Severe cutaneous reaction to penicillin

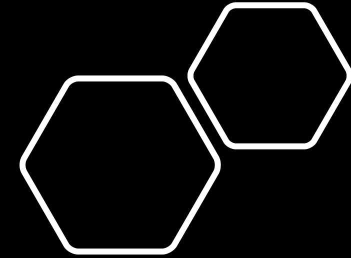
End organ damage related to penicillin (e.g., liver, kidney, etc.)

Intensive care unit management for reaction to penicillin

→ **Refer to Allergist** with supportive, detailed documentation of reaction

→ **Possible testing.** Guidance on desensitization verus medication alternatives as appropriate*

Penicillin and cephalosporin allergies



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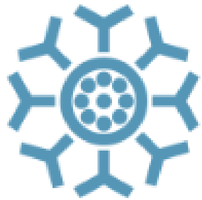
Access to Penicillin Allergy Advice through eConsult

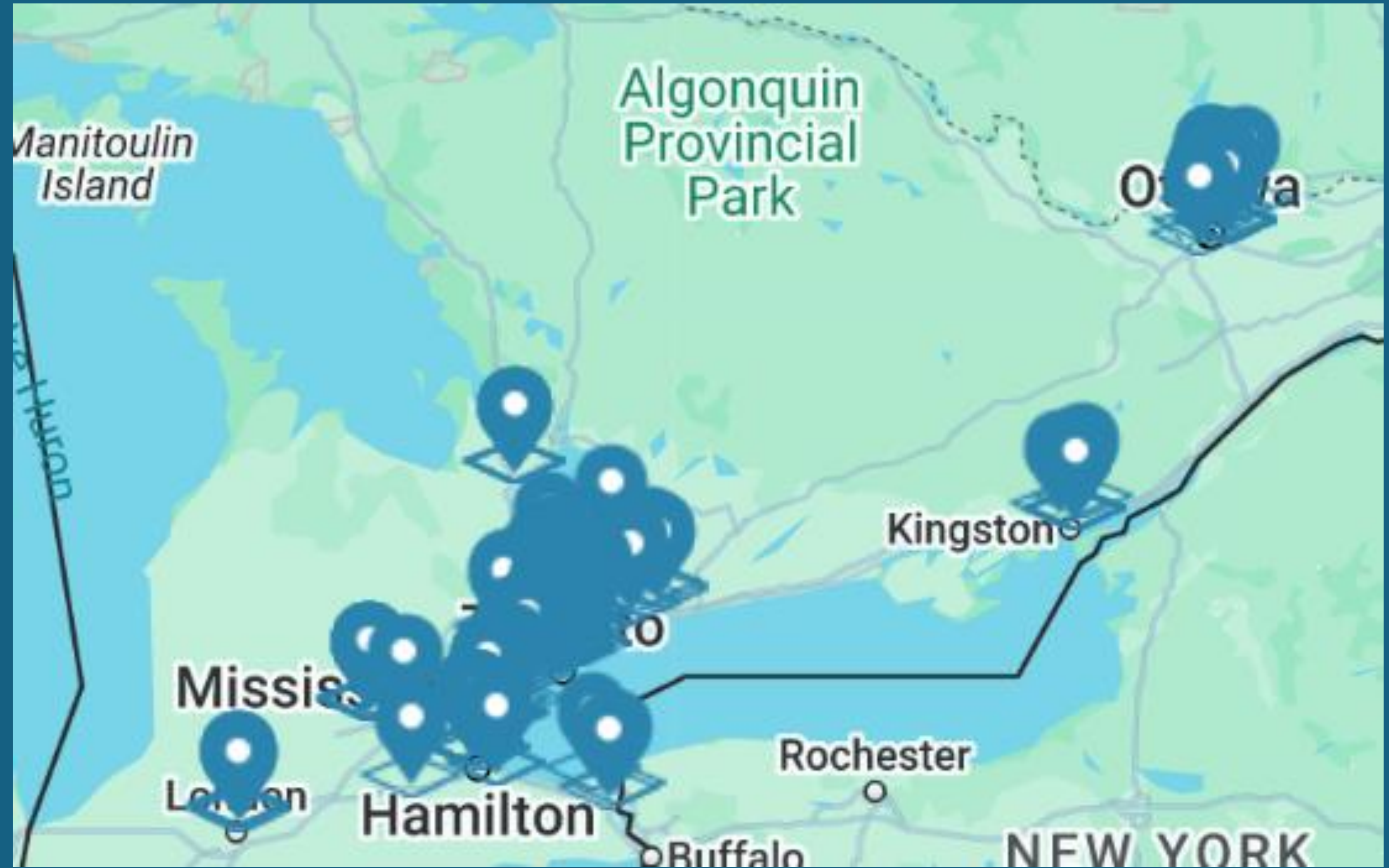
The Ontario eConsult Service, accessed on the OTNhub and a part of the ***Ontario eServices Program***, is a secure web-based tool, that allows physicians and nurse practitioners timely access to specialist advice.

The **Ontario eConsult Service, accessed on the OTNhub.ca**, offers easy and timely access to specialist advice, including questions related to Penicillin Allergy.

The Penicillin Allergy Provincial BASE™ eConsult Group is **now available** on the OTNhub:

Canadian Society of Allergy and Clinical Immunology





Questions

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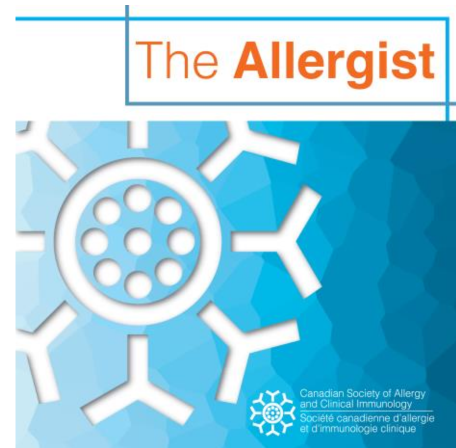


Introduction to Refugee Care in Canada

Vanessa Redditt, MD (she/her)
Crossroads Clinic, Women's College Hospital
Dept of Family & Community Medicine, University of Toronto

Doug Gruner, MD
Dept of Family Medicine, University of Ottawa
Board member, OCFP

www.un.org

Legal definition of refugee

1951 United Nations Geneva Convention Relating to the Status of Refugees:

- a person owing to a well-founded fear of being **persecuted**
- for reasons of race, religion, nationality, membership of a particular social group, or political opinion,
- is outside the country of their nationality, and is unable to or, owing to such fear, is unwilling to avail him/herself of the protection of that country

unhcr.org

Refugee categories in Canada

Resettled Refugees

Government Assisted Refugees (GARs) & Privately Sponsored Refugees (PSRs)

- Permanent resident
- OHIP + IFHP
- 1 year of financial and social support
  - GAR: Fed govt funding & settlement agency support
  - PSR: Private sponsors

Refugee Claimants

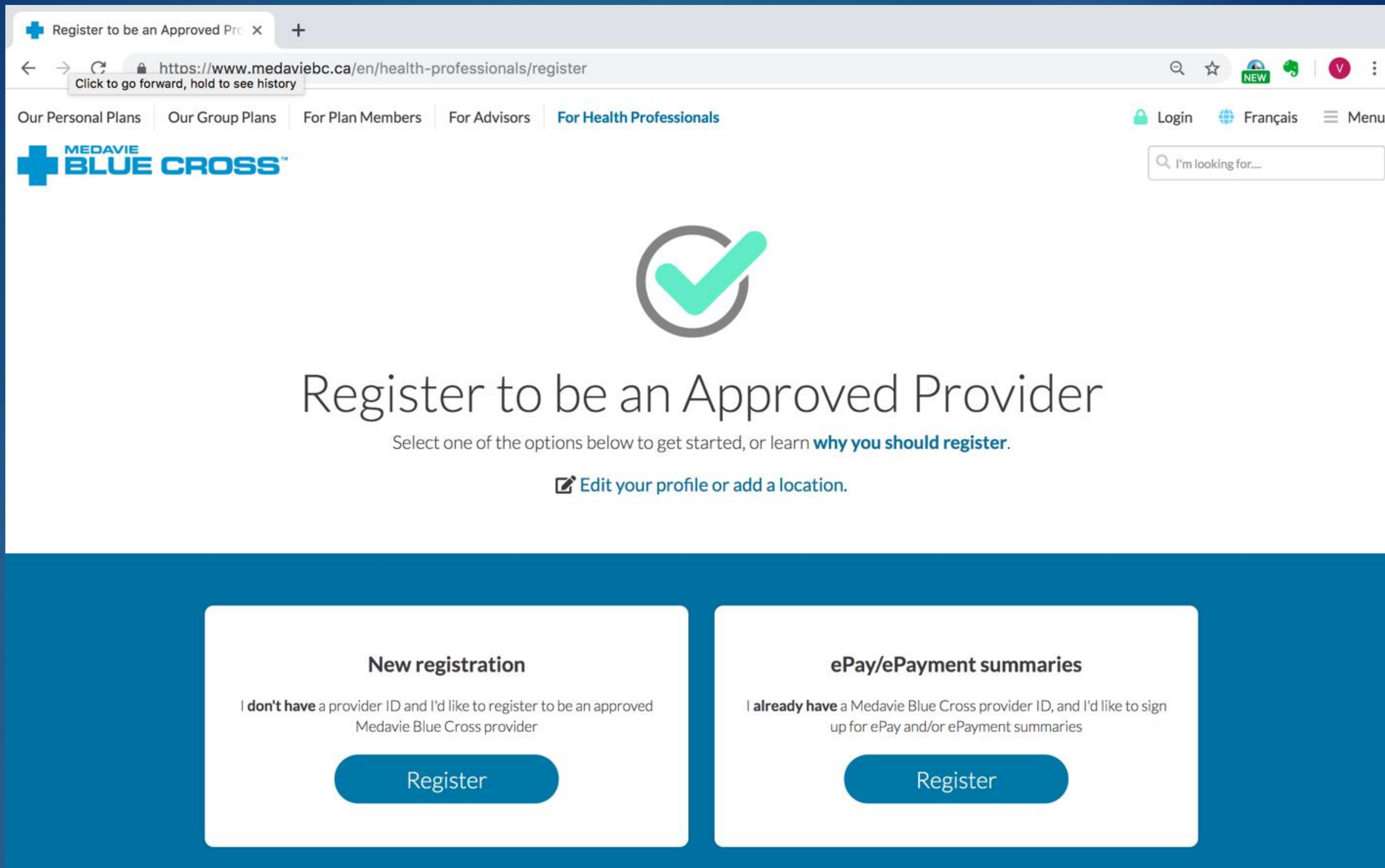
- Uncertain immigration status
- IFHP
- OW social assistance
- Shelter system
- Network of community organizations

Health Insurance for Refugees

unhcr.org

Interim Federal Health Program (IFHP)

- Temporary health care coverage for refugees
- **Basic coverage:** MDs&NPs/Diagnostics/Laboratory tests/hospitalizations *(similar to OHIP coverage)*
- **Supplemental services**
  - Medications
  - Emergency dental
  - Vision
  - Allied health: Physical therapy, counselling, etc
  - Medical devices: canes, wheelchairs, etc
- Coverage for 1 year for PSRs/GARs and until refugee claim accepted for claimants
- www.medaviebc.ca/en/health-professionals/resources



www.medaviebc.ca/en/health-professionals/register

Health Care Coverage for GARs/PSRs

- Provincial health card for basic coverage
- IFHP for supplemental services for 1 year

Photo: Settlement.org

PROTECTED - B

INTERIM FEDERAL HEALTH CERTIFICATE OF ELIGIBILITY

Family name:
Given name(s):
Date of birth:
Sex:
UCI:
Citizenship:
Application no.:

NOT VALID FOR TRAVEL
DOES NOT CONFER STATUS

Coverage: Effective Date: Valid Until:

SPECIMEN

I, the undersigned:

Canada

Health Care Coverage for Refugee Claimants

- **IFHP for ALL coverage:**
  - basic and supplemental

Refugee Health

msf.ca

GUIDELINES

CMAJ

Evidence-based clinical guidelines for immigrants and refugees

Kevin Pottie MD MClSc, Christina Greenaway MD MSc, John Feightner MD MSc, Vivian Welch MSc PhD, Helena Swinkels MD MHSc, Meb Rashid MD, Lavanya Narasiah MD MSc, Laurence J. Kirmayer MD, Erin Ueffing BHSc MHSc, Noni E. MacDonald MD MSc, Ghayda Hassan PhD, Mary McNally DDS MA, Kamran Khan MD MPH, Ralf Buhrmann MDCM PhD, Sheila Dunn MD MSc, Arunmozhi Dominic MD, Anne E. McCarthy MD MSc, Anita J. Gagnon MPH PhD, Cécile Rousseau MD, Peter Tugwell MD MSc; and coauthors of the Canadian Collaboration for Immigrant and Refugee Health

CMAJ 2011. DOI:10.1503/cmaj.090313

www.cmaj.ca/content/183/12/e824

Initial Intake

- Thorough History and Physical exam
- Screening
  - Infectious Disease
  - Chronic Disease
- Immunizations
- Mental Health
- Women's Health

Adapted from Pottie et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183(12): E284-E925

Infectious Disease Screening

- Hepatitis B: HBsAg, HBsAb HBcAb
- Hepatitis C
- Syphilis*
- HIV*
- Gonorrhea/chlamydia*
- Varicella serology (≥13yo)
- Strongyloides serology
- Schistosomiasis serology: endemic countries
- Latent TB screening (prioritize those at higher risk)

Adapted from Pottie et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183(12): E284-E925

Chronic Disease Screening

- Anemia: CBC
- Hb electrophoresis, as appropriate
- Lead level (<7yo)
- Age-appropriate DM and lipid screening
- Age-appropriate cancer screening

Adapted from Pottie et al. Evidence-based clinical guidelines for immigrants and refugees. *CMAJ* 2011;183(12): E284-E925

Helpful clinical resources

CCIRH Evidence-Based Preventive Care Checklist for New Immigrants and Refugees

REGION

SUB-SAHARAN AFRICA

Name ____ Date ____

Date of Arrival in Canada ____ Language(s) spoken ____

Country of Origin ____ Family Supports ____

Settlement/Refugee Claimant Worker ____ Refugee Claimant Hearing Date ____

	1st Visit	
	Date:	
Vital Signs	Ht: Wt: BP:	
Patient Health Concerns Address reason for visit Patient-centered approach		
Orientation	☐ Clinic appointments and health system	
Health History	Allergies, Current meds Previous Illness	B *Immunization status*
Psychosocial Assessment	Past education: Past occupation(s): Current housing: Migration/Displacement History:	A **Remain alert to possible PTSD but do not routinely screen for history of trauma** A **If linked to integrated program: Depression Screen** Document date of refugee claimants hearing
Education	☐ Nutrition screening & B *counseling (programs to promote breastfeeding)*	☐ **Screen for Unmet Contraceptive Needs/ Emergency Contraception** ☐ A **Home visitation for high risk mothers (infant <3)**
Physical Exam Important signs in immigrants from developing countries	☐ Focused examination to address patient's presenting complaint ☐ A **Remain alert for malaria* if fever from malaria zone**	
Problems/Plan	Plan and book follow-up visit	
Screening Investigations	☐ A **Mantoux Skin Test (TST)*** ☐ A **Hep B (sag/sab/cab)*** ☐ **Hep C antibody*** ☐ A **CBC with differential (children/females)** ☐ **Serology for Varicella*** ☐ A **HIV (endemic regions)*** ☐ A **Serology for Strongyloidiasis*** ☐ A **Serology for Schistosomiasis***	
Immunizations*	A **Children (Age Dependent):** ☐ **DPT-aP** ☐ **HPV** ☐ **MMR** ☐ **Varicella**	**Adults:** ☐ **DPT** ☐ **Varicella** ☐ **MMR**

● : Links to an interactive synopsis of available evidence and recommendations for the condition.
◆ : Links to the relevant section of the guidelines published in the Canadian Medical Association Journal.
▲ : Links to the recommendations on the map.
Evidence Link: A **Bold-CCIRHs Recommendations** B *Systematic Review Linked Evidence: US and Canadian Task Force Preventive Care.*

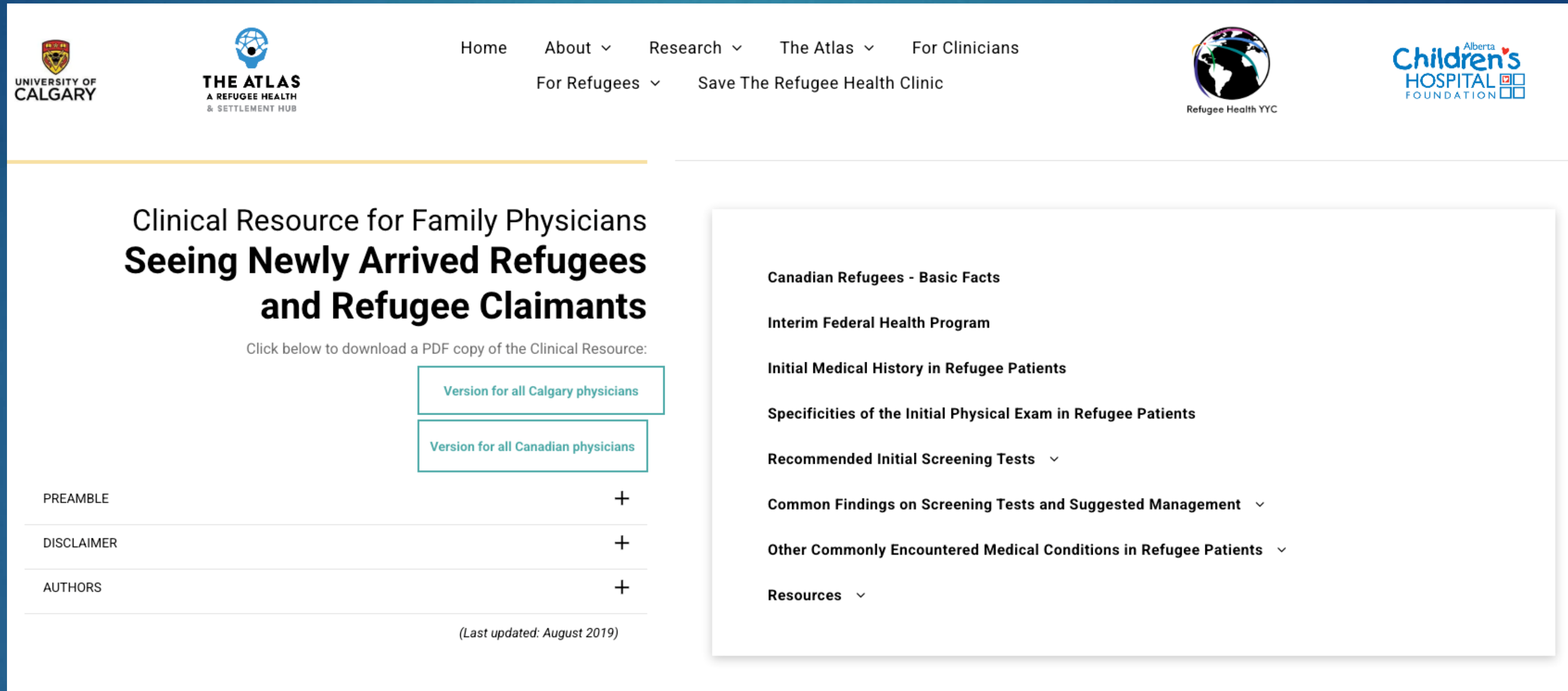
*See Resource Page
Disclaimer: Given the constantly evolving nature of evidence and changing recommendations, the preventative checklist is meant as a guide only.
Fair Use Authorization: See ccirhken.ca

uOttawa

Bruyère

https://ccirhken.ca/e-clinical-checklist-for-new-immigrants-and-refugees

Helpful clinical resources



https://blog.rh2c.org/for-clinicians

Immunizations

Adults:

- 1-2 MMR shots (2 if born after 1970)
- Primary series of Td-IPV (three shots), one of which should be a TdaP-IPV
- +/- Men-C-ACWY (based on age)

Children:

- (re)immunize if no records; catch up if records available

- Varicella:
  - *Check serology in those ≥13yo and vaccinate non-immune*
  - *Vaccinate all children <13yo*
- Hepatitis B:
  - *Offer vaccine to eligible non-immune*

Mental Health Issues in Refugees

Photo: unhcr.org

Stress and trauma may manifest in different ways at different points in the migration trajectory

People may need and want different supports

Photo: unhcr.org

Mental health strongly influenced by conditions of migration and resettlement

Focus on addressing social concerns

Photo: unhcr.org

Promoting Resilience

Safety	Learning English	Education
Recreation and exercise	Safe housing	Employment
Health care	Friendships and social connections	Financial stability

Thank you!
QUESTIONS?
Photo: UNHCR.org

Ontario College of Family Physicians

ONTARIO Osteoporosis Strategy

Osteoporosis and Fracture Prevention Workshop

What you'll gain:

- A **practical toolkit** with resources and video content to support you in your practice.
- **Expert insights** from facilitators sharing the latest updates from the 2023 clinical practice guideline.
- A **collaborative learning experience** designed specifically for family physicians.

April 30, 2025 | 1-4 p.m.

$195 + HST

3-credit-per-hour Mainpro+ certified

Scan to learn more

Registration now open

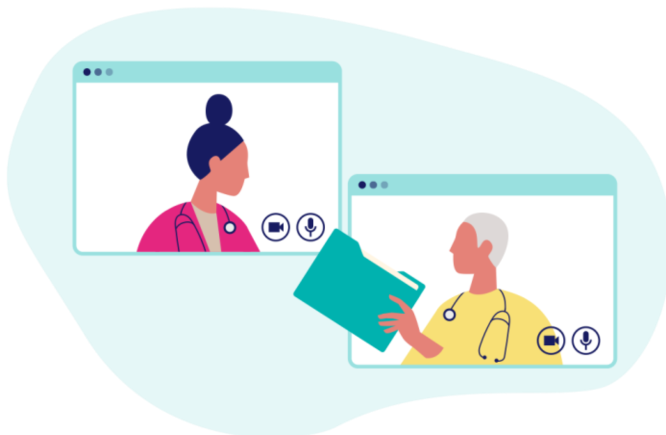
OCFP supports for Mental Health, Addictions and Chronic Pain

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:

- Indigenous cultural safety: Confronting anti-Indigenous racism and providing trauma-informed care (April 23)
- Supporting patients with ADHD and comorbidities (May 28)
- Navigating the Complexities of Opioid Prescribing for Chronic (June 25)



Peer Connect Mentorship

Receive tailored support to skillfully respond to mental health issues, address substance use disorders, and chronic pain challenges in your practice.

Join

RECENT SESSIONS

Date	Session	Speakers
November 15	**Infectious Disease & Diabetes Pharmacotherapy**	Dr. Daniel Warshafsky Dr. Gihane Zarifa
December 6	**Best of 2024 – Winter Virus Season & Menopause Revisited**	Dr. Janine McCready Dr. Sue Goldstein
February 21	**Infectious Disease & Navigating Ontario's Disability Support Program**	Dr. Alon Vaisman Dr. Mohamed Alarakhia Norma English
March 7	**Infectious Disease & HPV Cervical Screening Implementation**	Dr. Daniel Warshafsky Dr. Jonathan Isenberg Dr. Rachel Kupets
March 21	**Infectious Disease & Dermatology Treatments**	Dr. Gerald Evans Dr. Juthika Thakur

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

UPCOMING SESSIONS

Month	Date
May 2025	May 2 May 23
June 2025	June 6 June 27
July 2025	July 18

SAVE THE DATE

Registration link will be emailed to you closer to the date

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of Family Physicians
Leaders for a healthy Ontario

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: May 2, 2025

Contact us: ocfpcme@ocfp.on.ca

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

The Changing the Way we Work 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.

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