

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

March 27, 2026

**Dr. Daniel Warshafsky
Erik Hellsten
Dr. Donna L Reynolds**



Infectious Disease & Assessment Tools on Conflicting Guidelines



Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of
Family Physicians



Infectious Disease & Assessment Tools on Conflicting Guidelines

Moderator:

- **Dr. Eleanor Colledge**, Staff Physician, South East Toronto Family Health Team, Assistant Professor, Department of Family and Community Medicine, Temerty Faculty of Medicine, University of Toronto, Toronto, ON

Panelists:

- **Dr. Daniel Warshafsky**, Associate Chief Medical Officer of Health at the Office of the Chief Medical Officer of Health, Toronto, ON
- **Erik Hellsten**, Vice President, Information Strategy, Management & Analytics, Strategy, Planning, Privacy & Analytics, Ontario Health, Toronto, ON
- **Dr. Donna L Reynolds**, Assistant Professor, Clinical Public Health, Dalla Lana School of Public Health and Lecturer, Department of Family and Community Medicine, University of Toronto, Toronto, ON

Host:

- **Dr. Jobin Varughese**, OCFP President, Family Physician, Assistant Dean of Primary Care Education for the School of Medicine at Toronto Metropolitan University (TMU), Brampton, ON

Session slides will be available on the CTWWW website by the end of the day.

The Changing the Way We Work Community of Practice for Ontario Family Physicians has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 32 Mainpro+ Certified Activity 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

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. Stephanie Zhou (DFCM), Julia Galbraith (OCFP), Pavethra Yogeswaran (OCFP), Angeline Tan (OCFP), Reema Chaudhry (OCFP), Marisa Schwartz (DFCM), Erin Plenert (DFCM)

Previous webinars & related resources:

<https://dfcm.utoronto.ca/past-changing-way-we-work-community-practice-sessions>

Self-learning program

The session materials, including recordings, tools, and resources are available as self-learning modules.

This one-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 80 credits.

To participate in this self-learning:

- Select the dates/sessions you wish to participate in. You are welcome to complete as many sessions as you wish.
- Watch the video recording of the live session.
- Review the session tools and resources.
- Complete the self-learning post-session activity, click the button below.

[Complete self-learning activity](#)



Self-Learning Activity and Evaluation: COVID-19 Community of Practice for Ontario Family Physicians

By completing this Self-Learning Activity for the COVID-19 Community of Practice for Ontario Family Physicians, you are confirming that you have completed this activity.

*** 1. Attestation: I confirm that I have completed the COVID-19 CoP self-learning activity (video and resources). (If completing multiple session dates, please enter all that apply below**

ENTER DATE AS Month-Day-Year i.e. December 10, 2021)

Session Date(s):

Name:

Email:

*** 2. After reviewing this COVID-19 session material (video and resources), I have a question (s) regarding the content that needs clarifying.**

I have no questions

Question:

Missed a session? Want to earn credits?

The Self-learning Program lets you earn credits for watching past sessions.

Just click the link and fill out a 60s form!



Dr. Daniel Warshafsky – Panelist

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



Erik Hellsten – Panelist

Vice President, Information Strategy, Management & Analytics, Strategy, Planning, Privacy & Analytics, Ontario Health



Dr. Donna L Reynolds – Panelist

Assistant Professor, Clinical Public Health, Dalla Lana School of Public Health and Lecturer, Department of Family and Community Medicine, University of Toronto

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: **Erik Hellsten**
- Relationships with financial sponsors:
 - Grants/Research Support: N/A
 - Speakers Bureau/Honoraria: N/A
 - Others: N/A

- Faculty Name: **Dr. Donna L Reynolds**
- Relationships with financial sponsors:
 - Grants/Research Support: N/A
 - Speakers Bureau/Honoraria: Volunteer member of Canadian Task Force on Preventive Health Care (CTFPHC)
 - Others: N/A

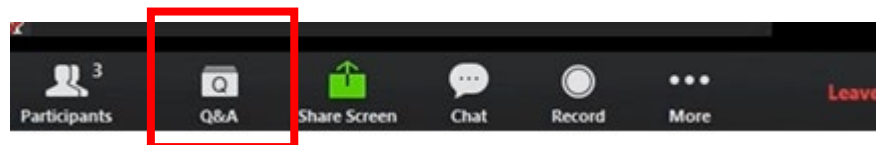
Speaker Disclosure

- 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 (Assistant Dean of Primary Care Education)

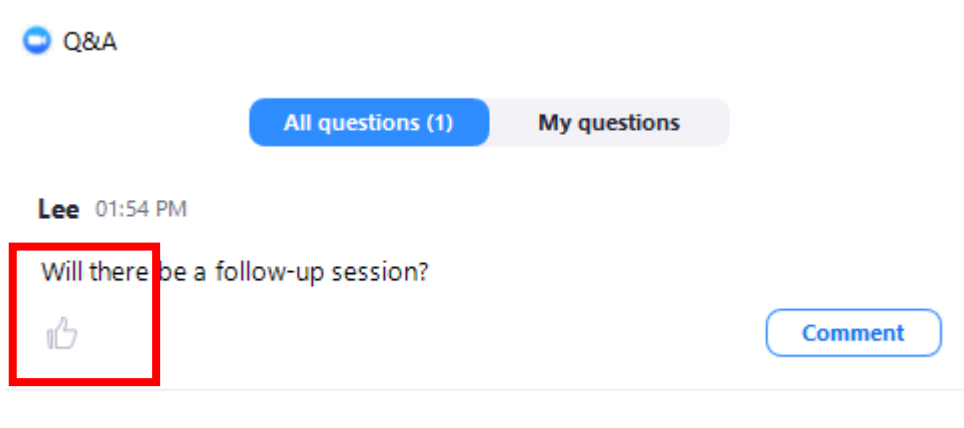
- Faculty Name: **Dr. Eleanor Colledge**
- Relationships with financial sponsors:
 - Grants/Research Support: N/A
 - Speakers Bureau/Honoraria: Ontario College of Family Physicians
 - Others: The Foundation for Medical Practice Education (McMaster University)

How to Participate

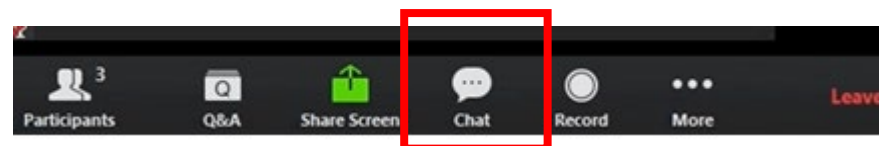
- All questions should be asked using the Q&A function at the bottom of your screen.



- 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.





Dr. Daniel Warshafsky – Panelist

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



Erik Hellsten – Panelist

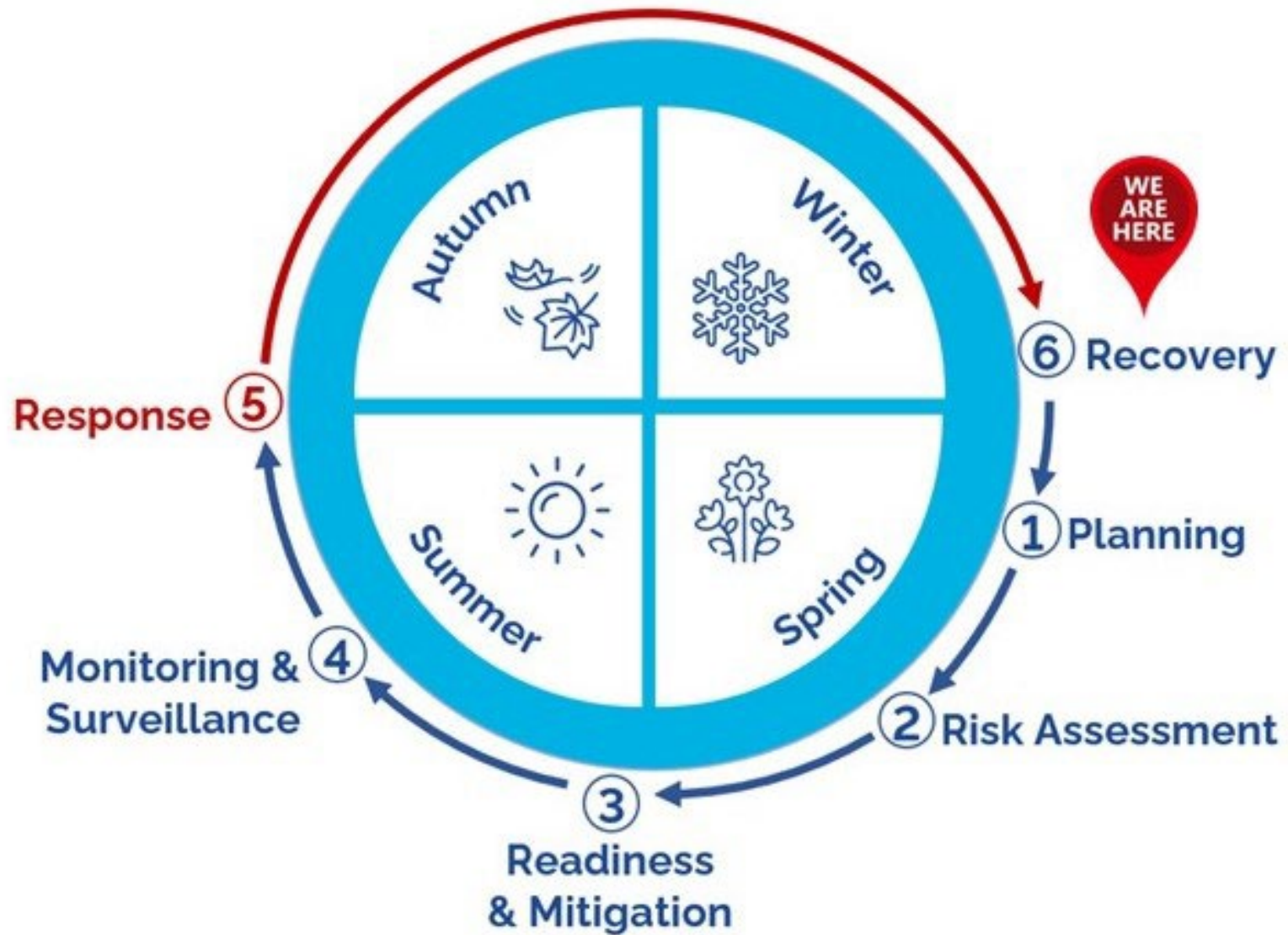
Vice President, Information Strategy, Management & Analytics, Strategy, Planning, Privacy & Analytics, Ontario Health



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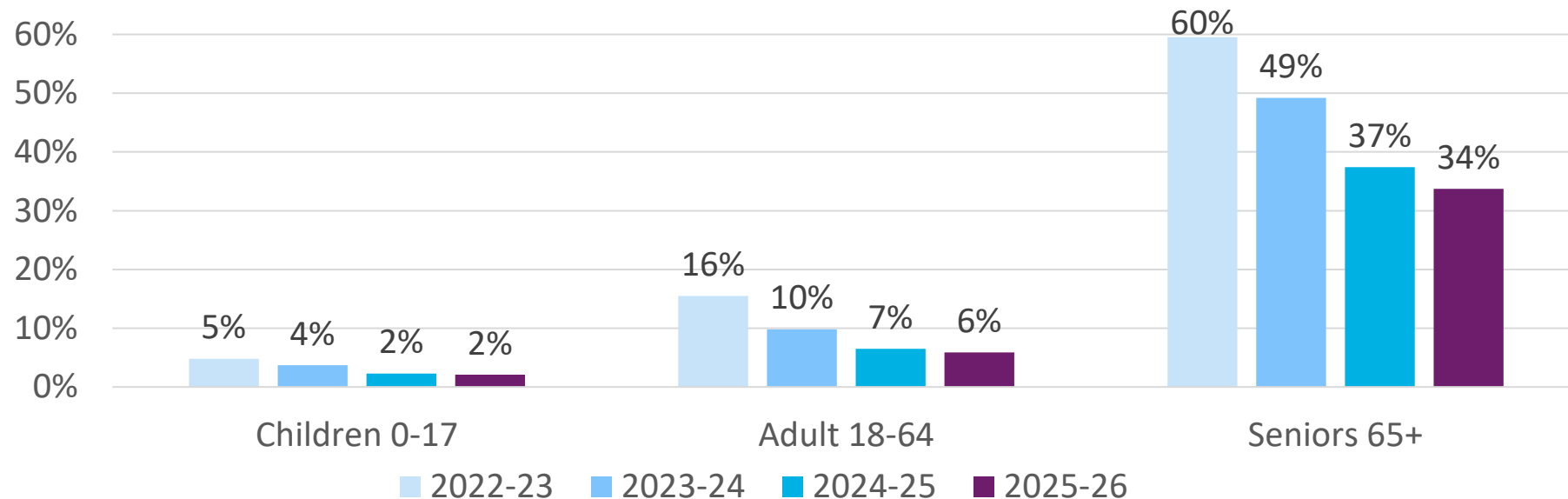
Preparedness Cycle



Respiratory Season Review: COVID-19 Vaccines

- Booster uptake for 2025/26 season was lower than in prior seasons across all age groups.
 - 51.4% of LTC residents (vs 54.8% for the same period a year ago) and 49.0% of RH residents (vs 50.7% for the same period a year ago) received a COVID-19 vaccination dose on/after September 22, 2025 as of March 9, 2026.
 - Booster uptake for the total population was 10.3%, down from 11.3% for the 2024/25 respiratory season. Coverage was highest among older Ontarians, with 33.7% of those aged 65+ receiving a COVID-19 vaccination dose.
 - Pharmacy channel administered 85.6% of 2025/26 respiratory season doses, which was similar (85.5%) to the 2024/25 season.

COVID-19 Seasonal Coverage by Age Group

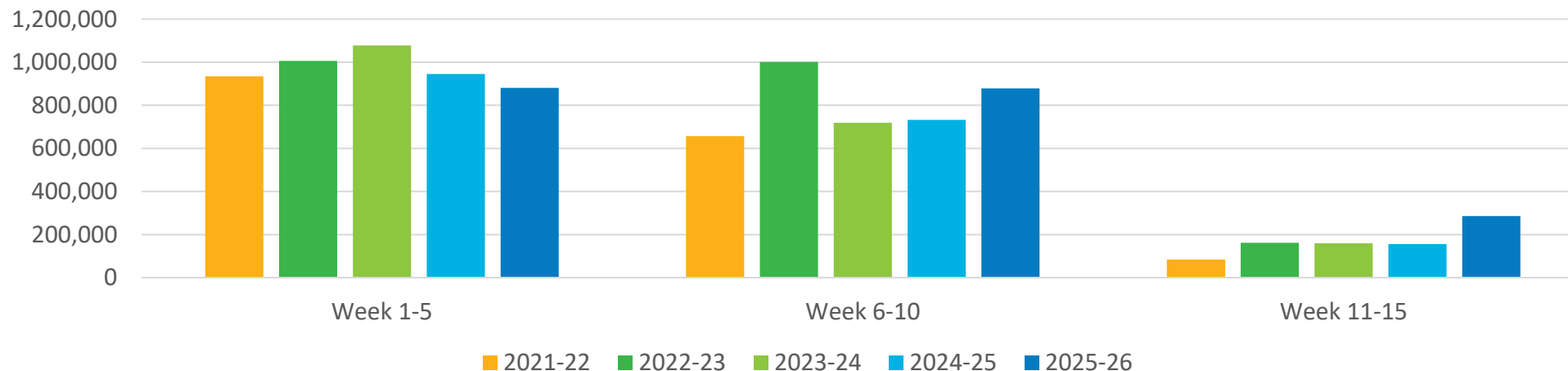


All channels. As of Mar 11, 2026

Respiratory Season Review: Influenza Vaccines

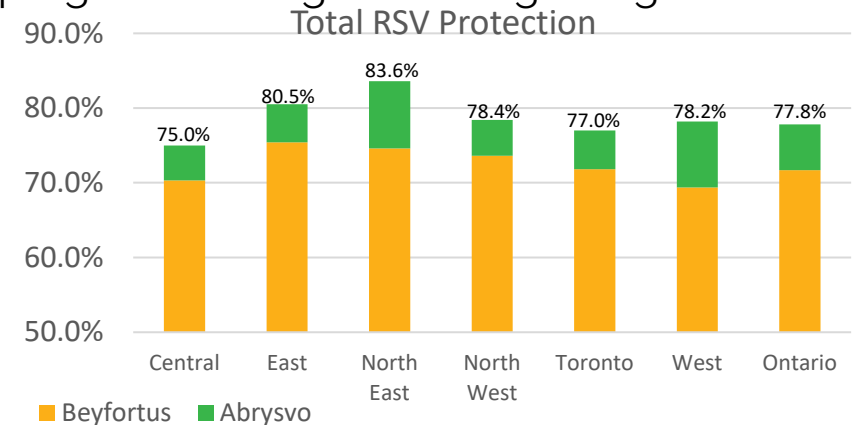
- There were nearly 2.1M doses administered in pharmacy, the highest since 2022/23 season, and an additional 850k by primary care.
 - 48% of influenza vaccines administered were to those aged 65 and older.
- In the last four seasons, 46-55% of influenza vaccines in pharmacy were administered in the first five weeks of the program (end October/early November).
 - In 2025/26, administration was trending behind in prior years up until that point.
- Influenza positivity in Ontario started to increase rapidly in early November (week 6 of the flu vaccine program), resulting in increases of administration versus three of the past four seasons.
- In early December (week 10 of the flu vaccine program), media reported on three deaths of children in Ontario due to influenza. In the past four seasons, vaccine administration has declined every week after peaking in late October/early November. In 2025/26, for two weeks in early December, administration increased vs the prior weeks.

Cumulative Influenza Vaccine Administration
(Pharmacy Channel Only)



Respiratory Season Review: RSV Vaccines

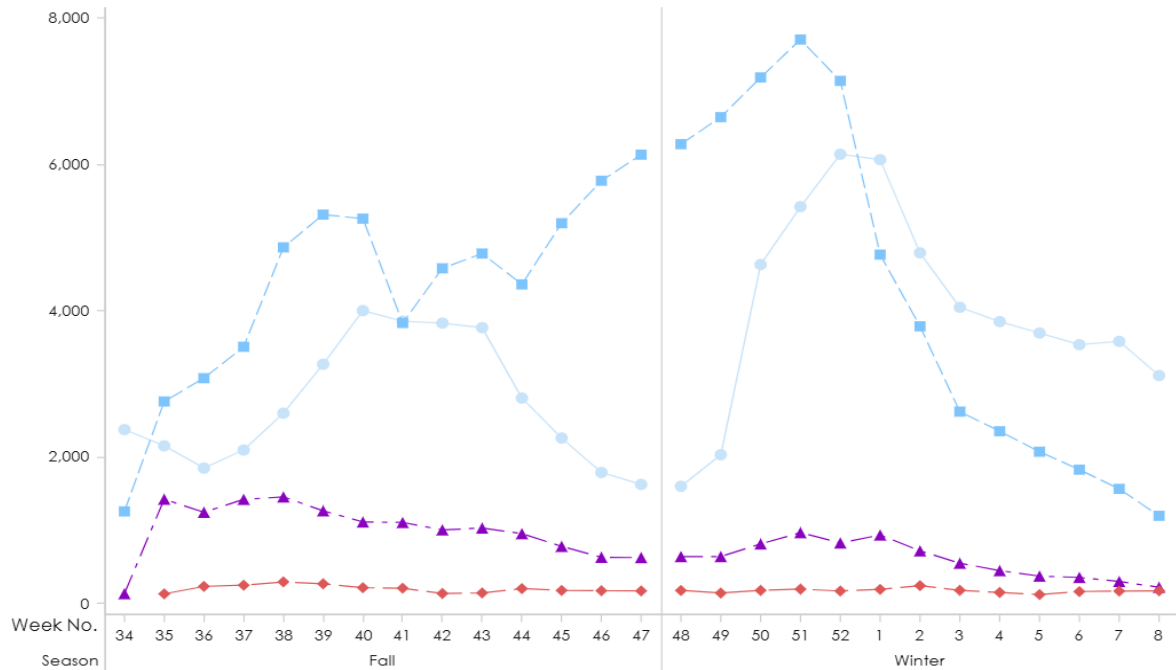
- Adult RSV: Ontario expanded the adult RSV program to include all adults aged 75 and older for 2025-26 season. The infant Beyfortus program continued, with vaccine starting at the beginning of October, a month earlier than last year.
 - ~467k RSV doses distributed to PHUs (+380k vs last season) with ~423k distributed to health care providers (+341k vs last season)
 - Both LTCH and RH saw decreases in distribution, which was expected as the vaccine provides multi-year protection. There were ~21k distributed to LTCH (-1k vs last season) and ~7k distributed to RHs (-8k vs last season).
 - LTCH survey results are coming on April 2026.
- Infant RSV: 2025-26 was the second season administering Beyfortus, with the program starting at the beginning of October, approximately a month earlier than the start of the 2024-25 season.
 - Beyfortus: 121,868 doses were distributed to health care providers (-2.5% vs last year).
 - Among infants with valid RSV immunization information recorded with BORN, 72% of infants born in hospital from October 2025-February 2026 received Beyfortus (+2.3pts vs last year).
- Including parents who received Abrysvo more than two weeks before birth and when the infant was not high risk, a total of 77.8% of infants born in hospital from October 2025-February 2026 had protection from RSV.
 - Between Nov 2024-Feb 2025, 1,097 (out of 31,505 = 3.5%) parents declined Beyfortus as they received Abrysvo more than two weeks before birth and when the infant was not high risk.
 - Between Oct 2025-Feb 2026, 2,078 (out of 50,780 = 4.1%) parents declined Beyfortus as they received Abrysvo more than two weeks before birth and when the infant was not high risk.



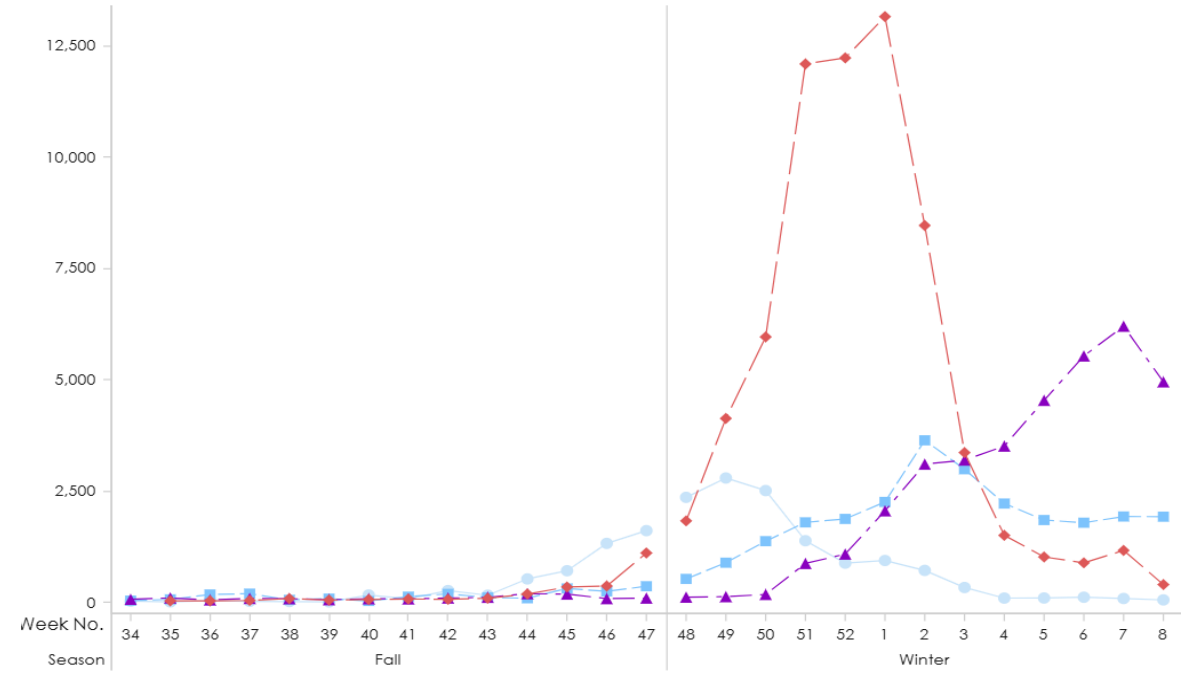
Respiratory Season Review: Therapeutics

- Pharmacies were given authority to prescribe Paxlovid in December 2022 and Tamiflu in December 2023.
- Paxlovid dispensing for the 2025-26 season was lower than in prior years due to change in drug coverage in May 2024, resulting in fewer individuals being eligible for provincially-funded treatment, change in testing availability and a less severe COVID-19 season.
- Increased Tamiflu dispensing (all prescribers) in 2025-26 is consistent with an early influenza peak and more severe season vs prior years.

Weekly Paxlovid Dispensed in Pharmacy



Weekly Tamiflu Dispensed in Pharmacy



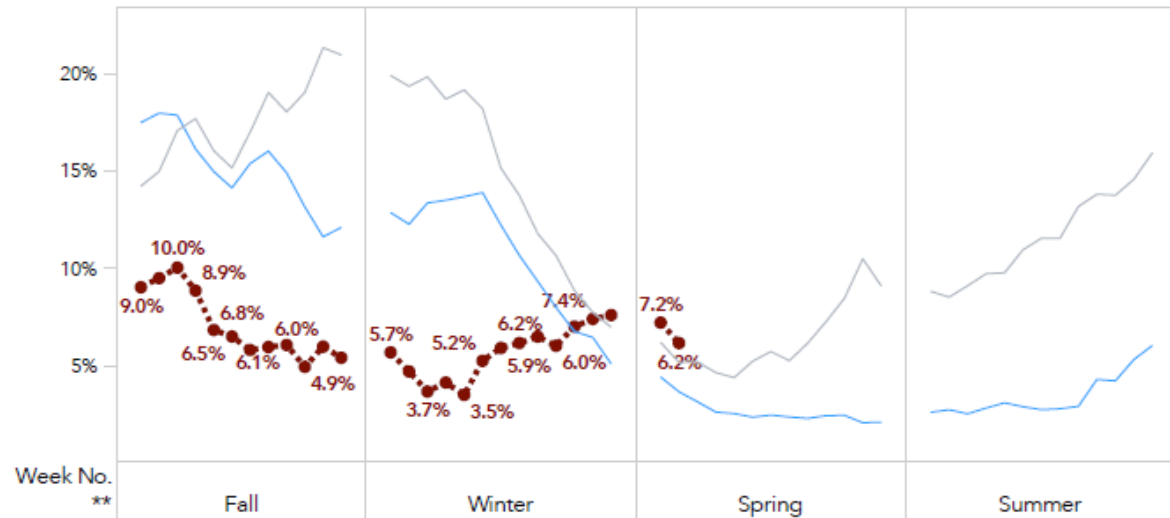
Respiratory Season

—●— 2022/23 —■— 2023/24 —▲— 2024/25 —◆— 2025/26

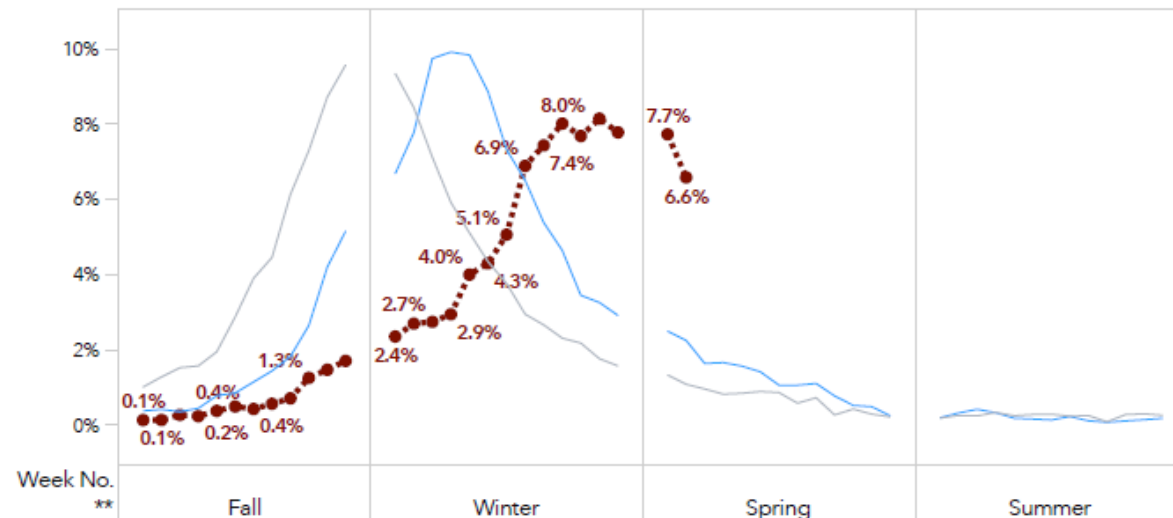
Respiratory Percent Positivity: 2025/26

●●●●● 2025/26 — 2024/25 — 2023/24

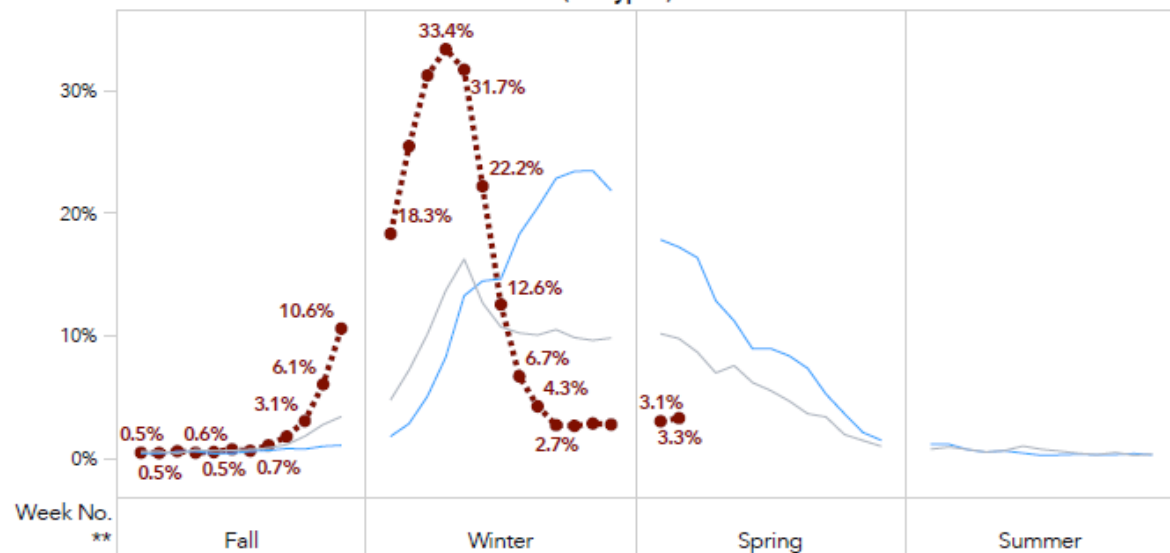
COVID-19



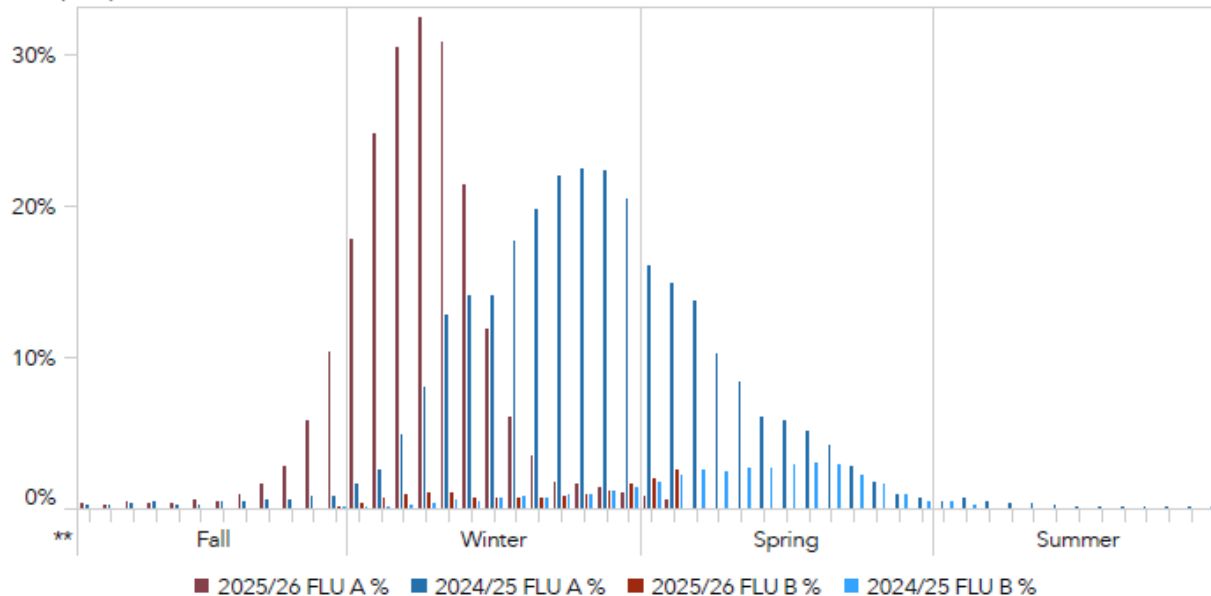
RSV



FLU (All types)



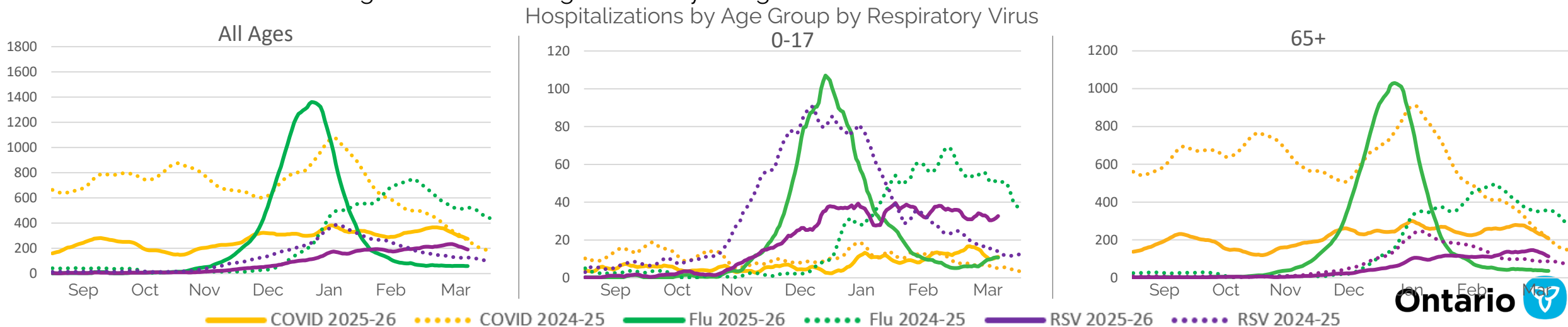
FLU (A/B)



Note: Numbers on the graphs are up to the latest complete week of data (up to Saturday) for seasonal comparisons. As such, they may be slightly different than the numbers presented on summary table, which are the most recent data available.

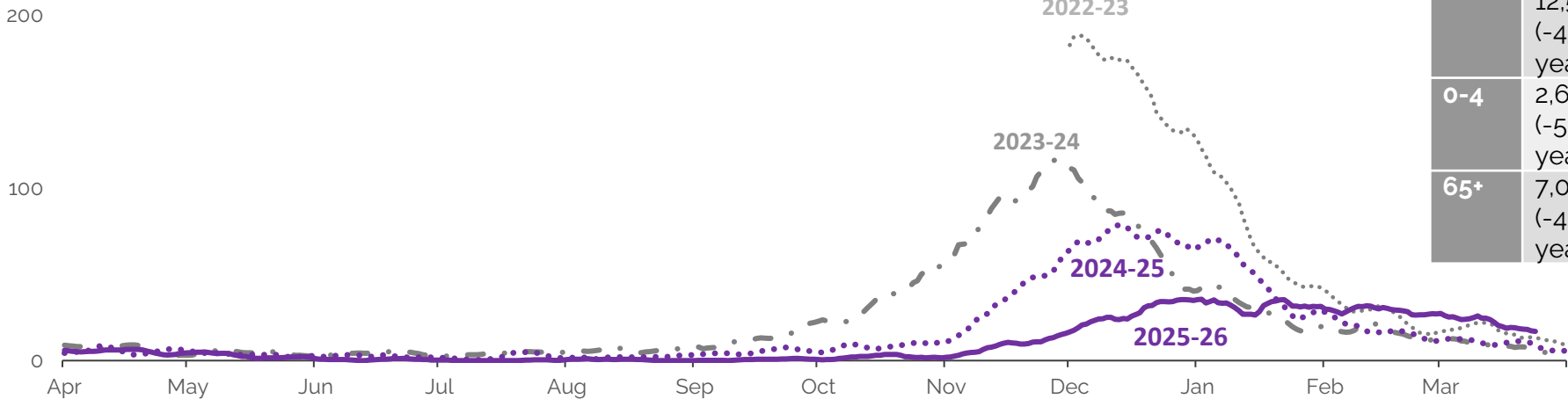
Respiratory Season Review: Hospitalizations

- While the system was strained, given preparations and mitigations, there was no major provincial impact on hospital surgical output.
- In January 2026, the combination of high levels of ALC, maintenance of maximum surgical output and high levels of influenza hospitalizations contributed to a peak of 112% in provincial med-surg occupancy levels in mid-January. Although hospital occupancy has declined slightly as respiratory admissions have decreased, occupancy levels remain high at 105% (Mar 11).
 - COVID-19: hospitalizations never reached the heights of the past three respiratory seasons, potentially driven by influenza dominance. There was no significant post-holiday wave like the past few years, although hospitalizations in March 2026 are similar to March 2025 with uncertainty on whether there could be a spring wave due to a quieter winter.
 - Influenza: hospitalizations were the highest since at least 2017-18, with the influenza starting much earlier than last year. The cumulative burden on hospitals for influenza is expected to be similar to 2024-25 given last season peaked in February.
 - RSV: pediatric hospitalizations peaked in mid-January, much later than in the past three seasons. Likely thanks to Beyfortus, hospitalizations among infants never reached the levels of the past three seasons. Due to the later start of RSV season, with a mid-February peak for seniors, hospitalization among seniors is only now surpassing last year's numbers, but it is unlikely that the cumulative burden among seniors will be higher than a year ago.



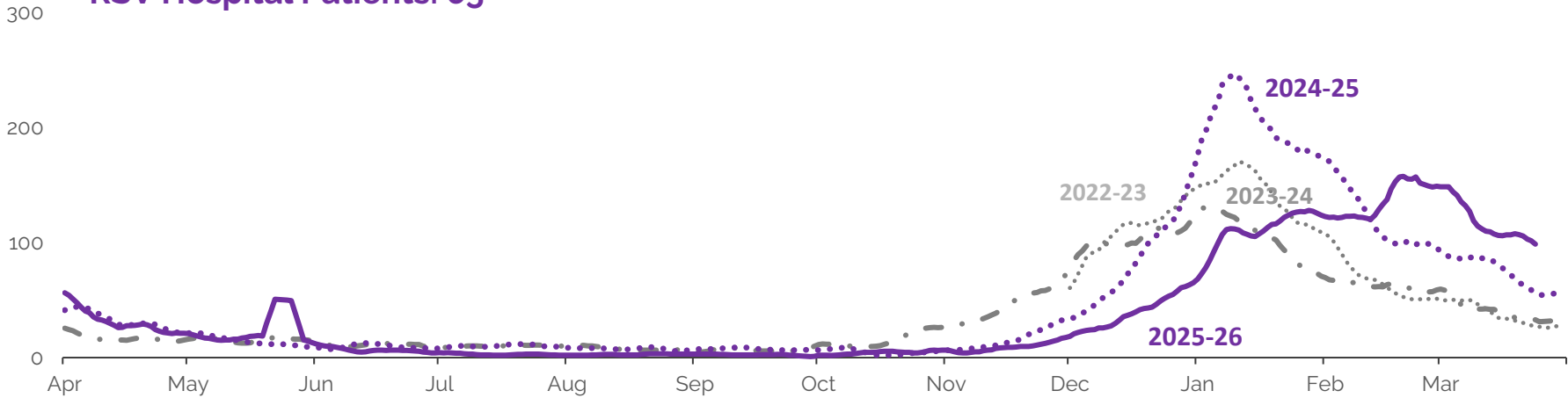
Hospitalization Comparison by Age: Kids (0-4) and Seniors (≥65) make up over 80% RSV hospital census. Lower hospitalization in current season partly due to lower community spread and likely successful vaccination efforts.

RSV Hospital Patients: 0-4



Total	2025-26	2024-25	2023-24
	12,547 (-43% vs prior year)	21,939 (+9% vs prior year)	20,093
0-4	2,656 (-51% vs prior year)	5,380 (-27% vs prior year)	7,403
65+	7,055 (-42% vs prior year)	12,151 (+29% vs prior year)	9,410

RSV Hospital Patients: 65+



Peak	0-4	65+
2022-23	201 (Dec 1)	182 (Jan 9)
2023-24	124 (Nov 23)	144 (Jan 1)
2024-25	89 (Dec 10)	279 (Jan 7)
2025-26	42 (Jan 16)	180 (Feb 17)

DRAFT FOR DISCUSSION PURPOSES

Extension of RSV Season

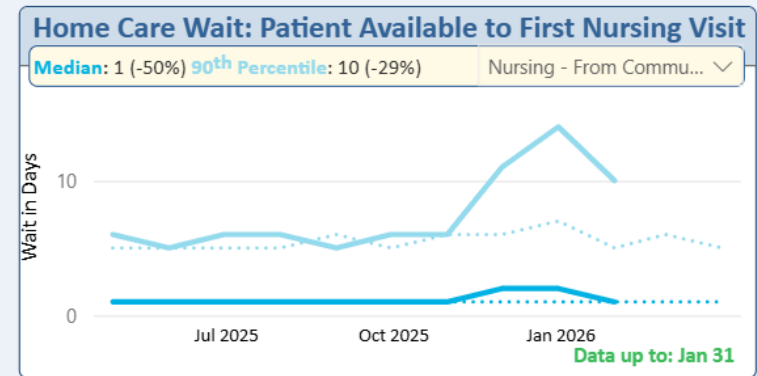
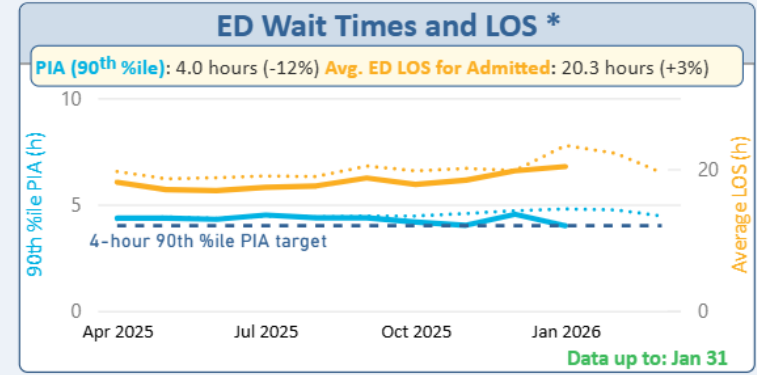
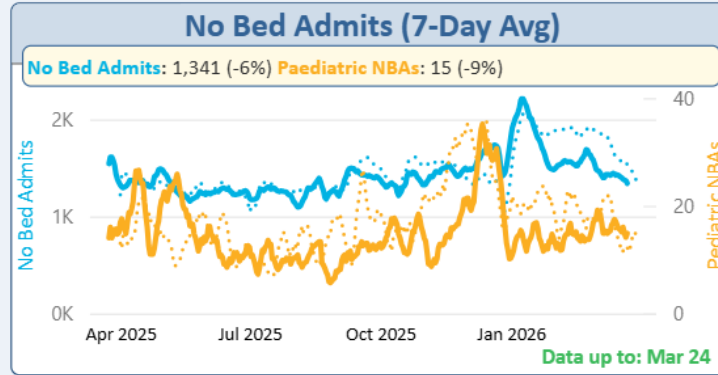
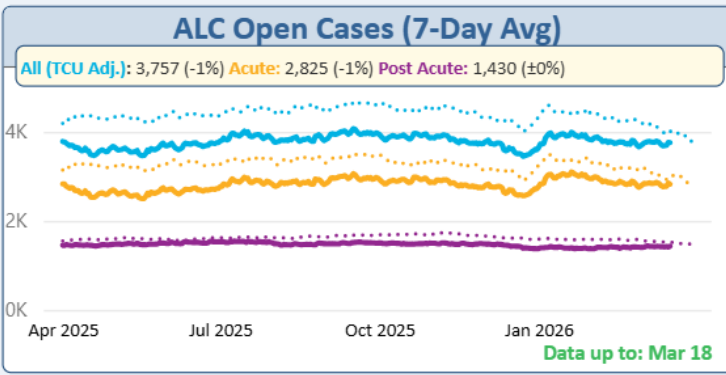
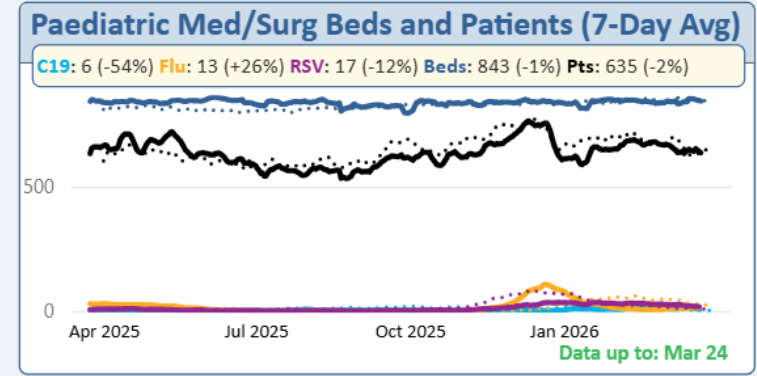
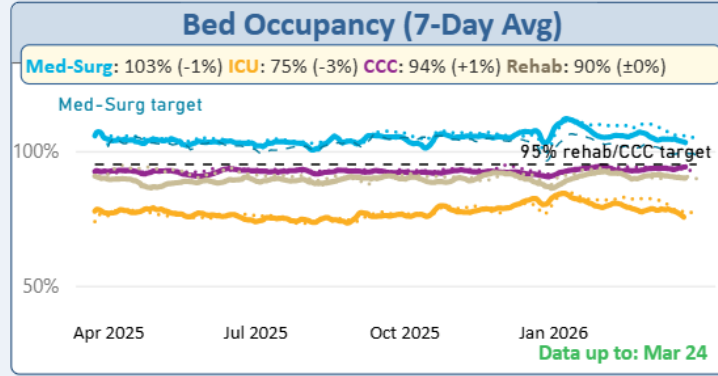
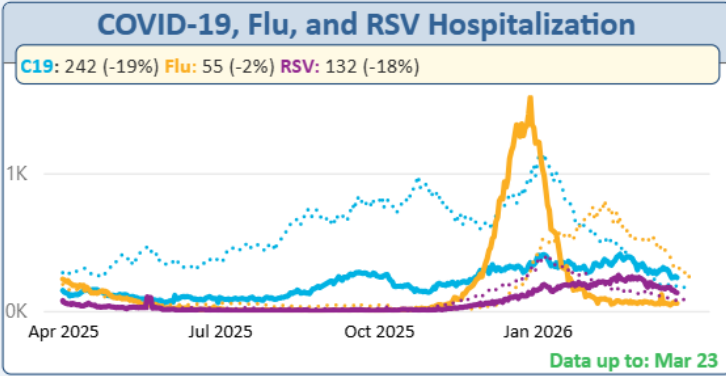
Based on epidemiological data (percent positivity and hospitalizations), community transmission of RSV is ongoing. Despite RSV positivity in Ontario having peaked among young children the week of January 18, positivity is variable across the province and overall remains high, particularly among infants and children.

As a result, the RSV prevention program for infants and high-risk children will extend into April.

Healthcare providers should continue to administer immunizations to [eligible infants and children](#) until the ministry circulates communication to mark the end of the 2025/26 program.

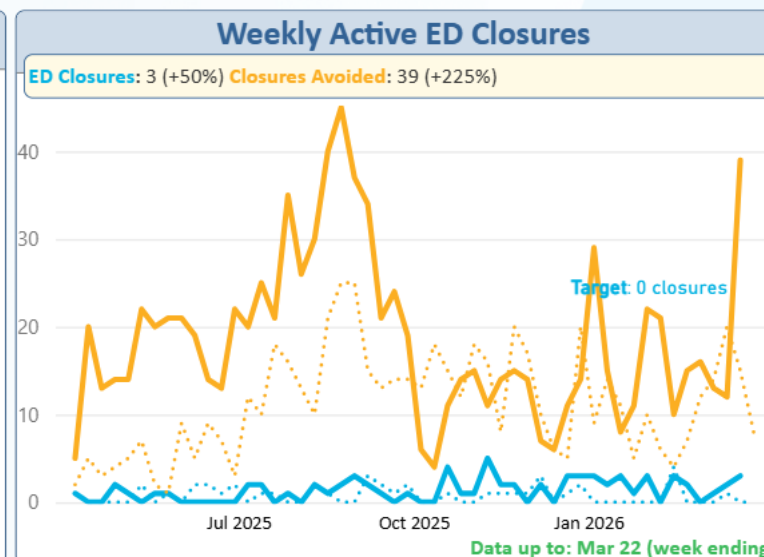
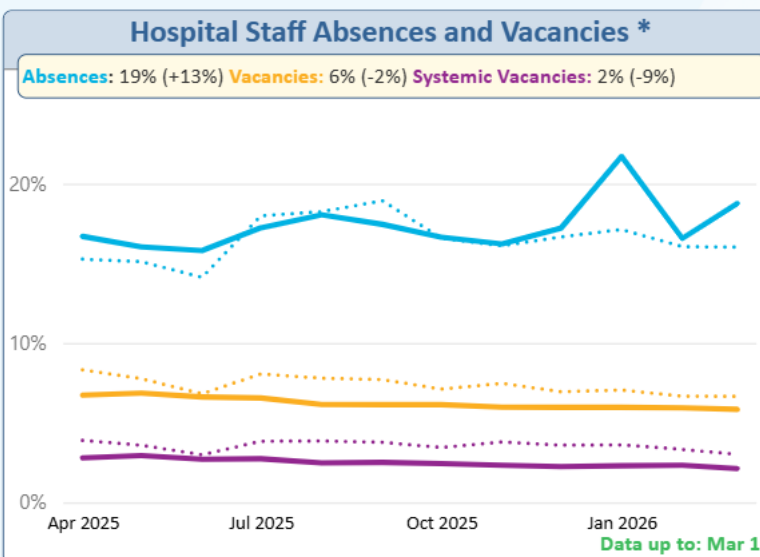
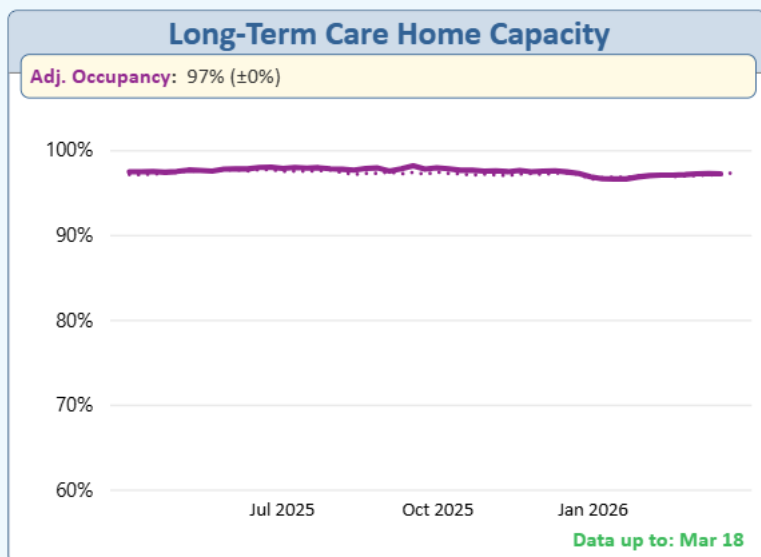
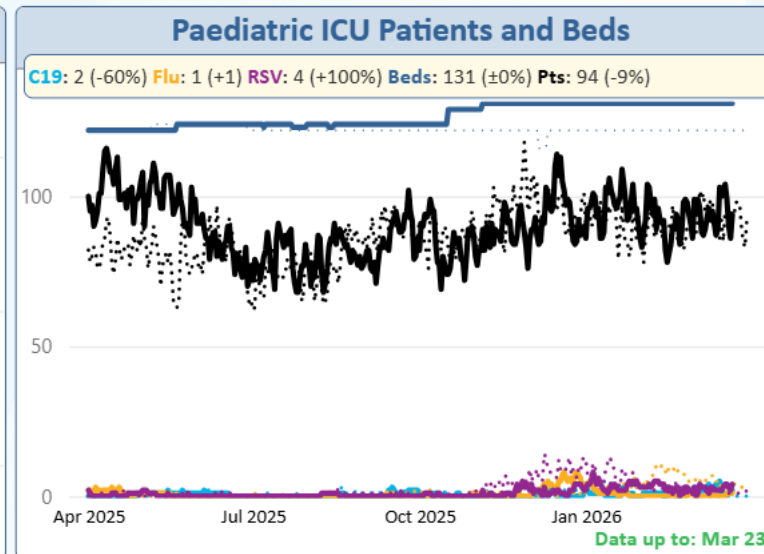
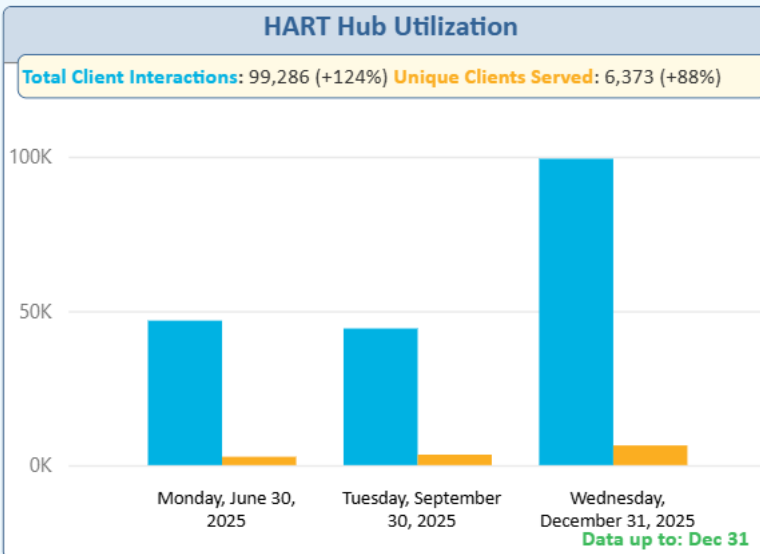
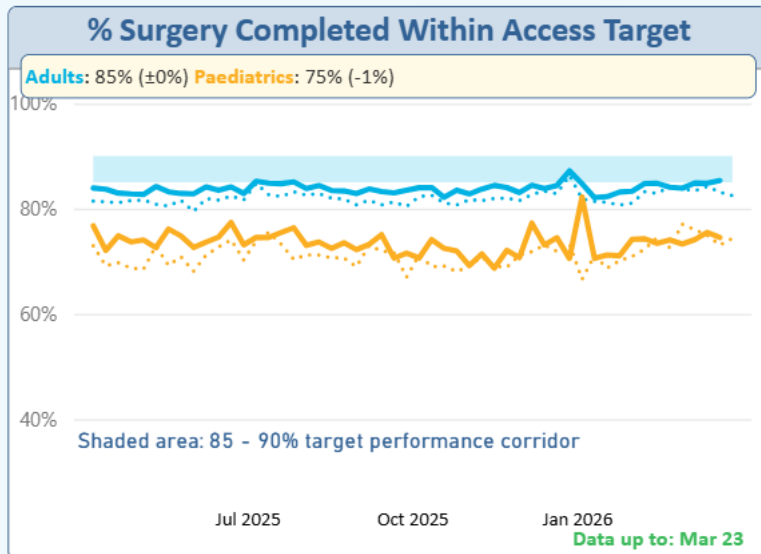
The decision to administer maternal vaccination should take into consideration the timing of administration during pregnancy (i.e. between 32-36 weeks gestation) and the upcoming timing for the end of the season.

Guidance for the 2026/27 program will be provided leading up to the fall and will include recommendations for those infants and children who receive RSV protection late this season.



* Brackets in yellow boxes for these tiles indicate % changes from previous month; all other charts show changes from previous week.

Disclaimer: This data has been prepared to support situational awareness and system planning and should be disseminated only to those individuals who require it. Please do not use this information, either alone or with other information to identify an individual. This includes attempting to decrypt information that is encrypted, attempting to identify an individual based on encrypted information, and attempting to identify an individual based on prior knowledge.



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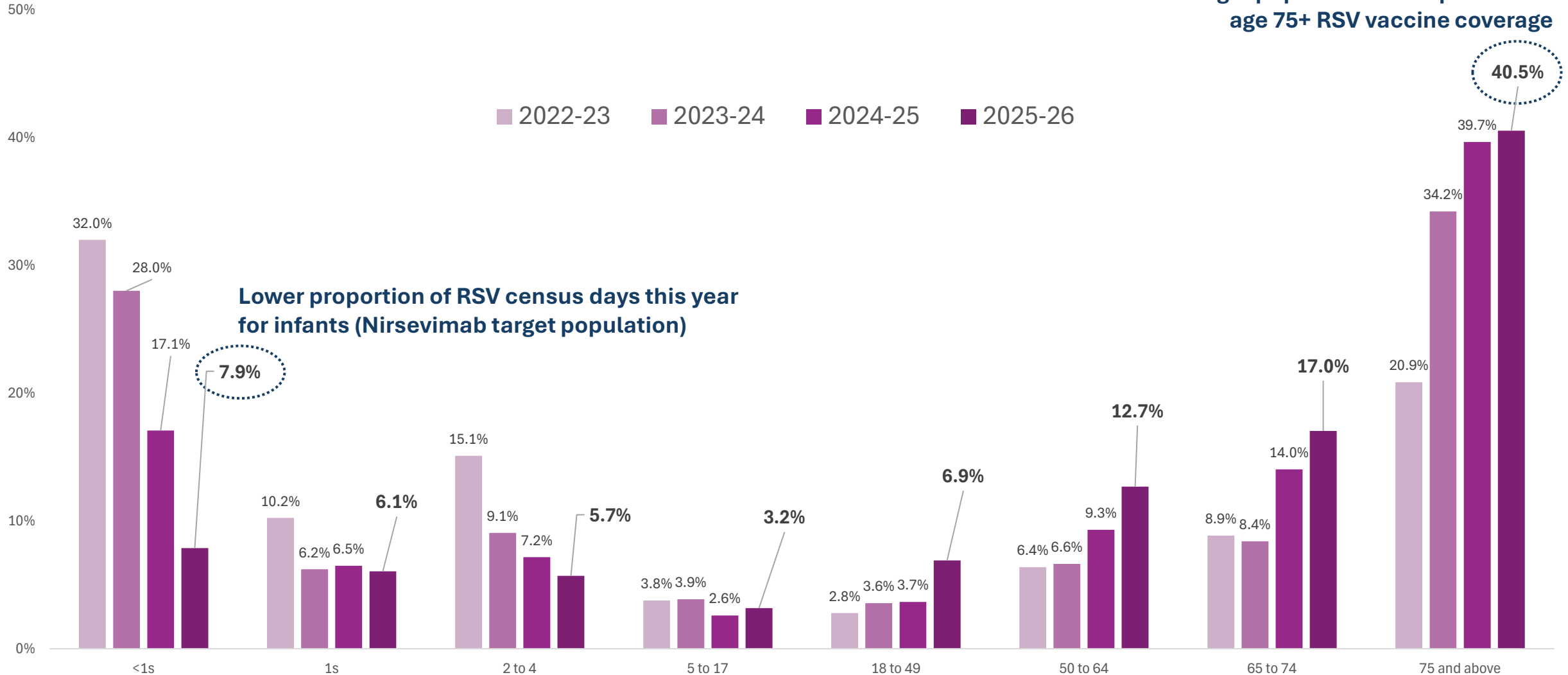
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Monitoring RSV census data for signals of immunization impacts:

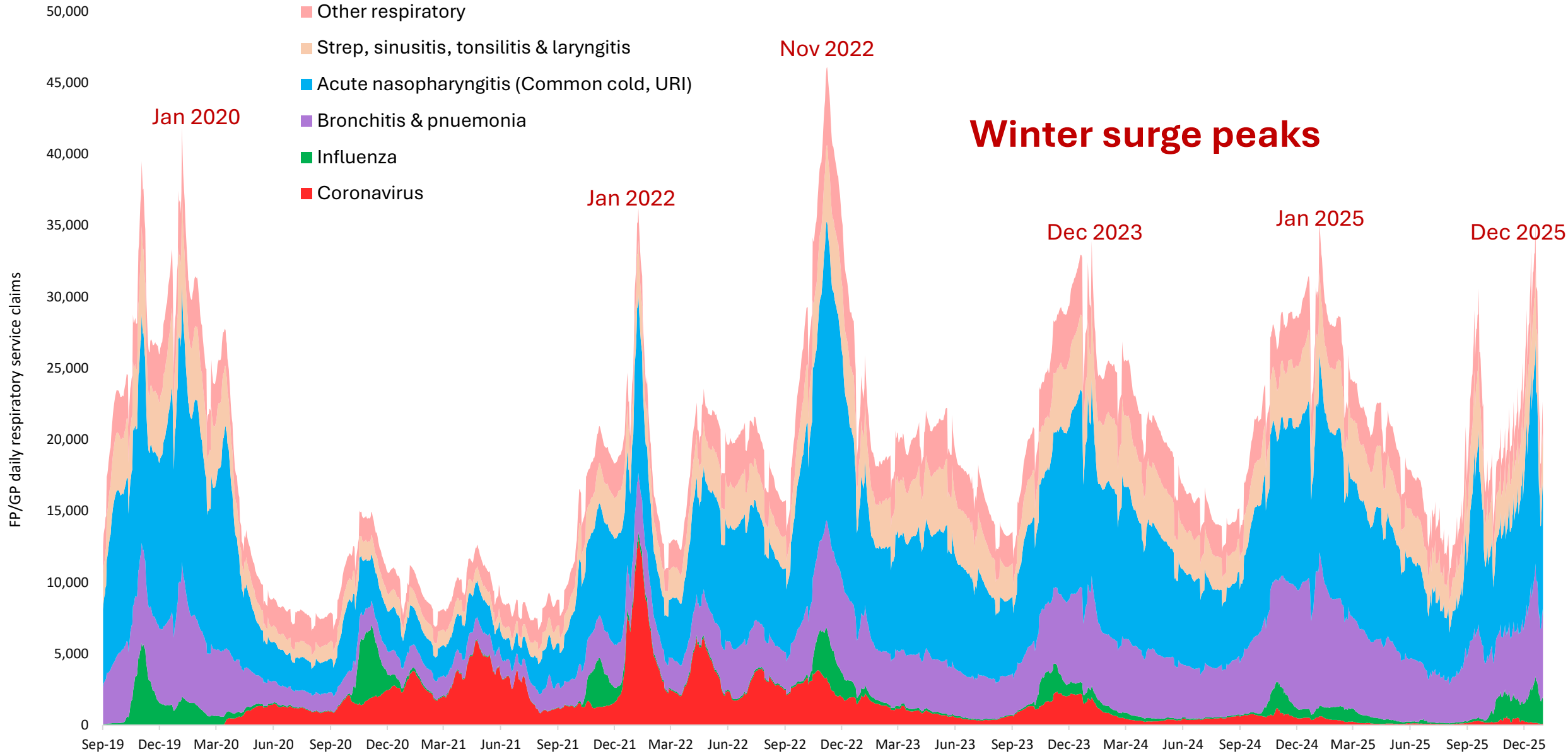
Comparing RSV hospital days 2022-23 – 2025-26 by age group

Total RSV hospital census days

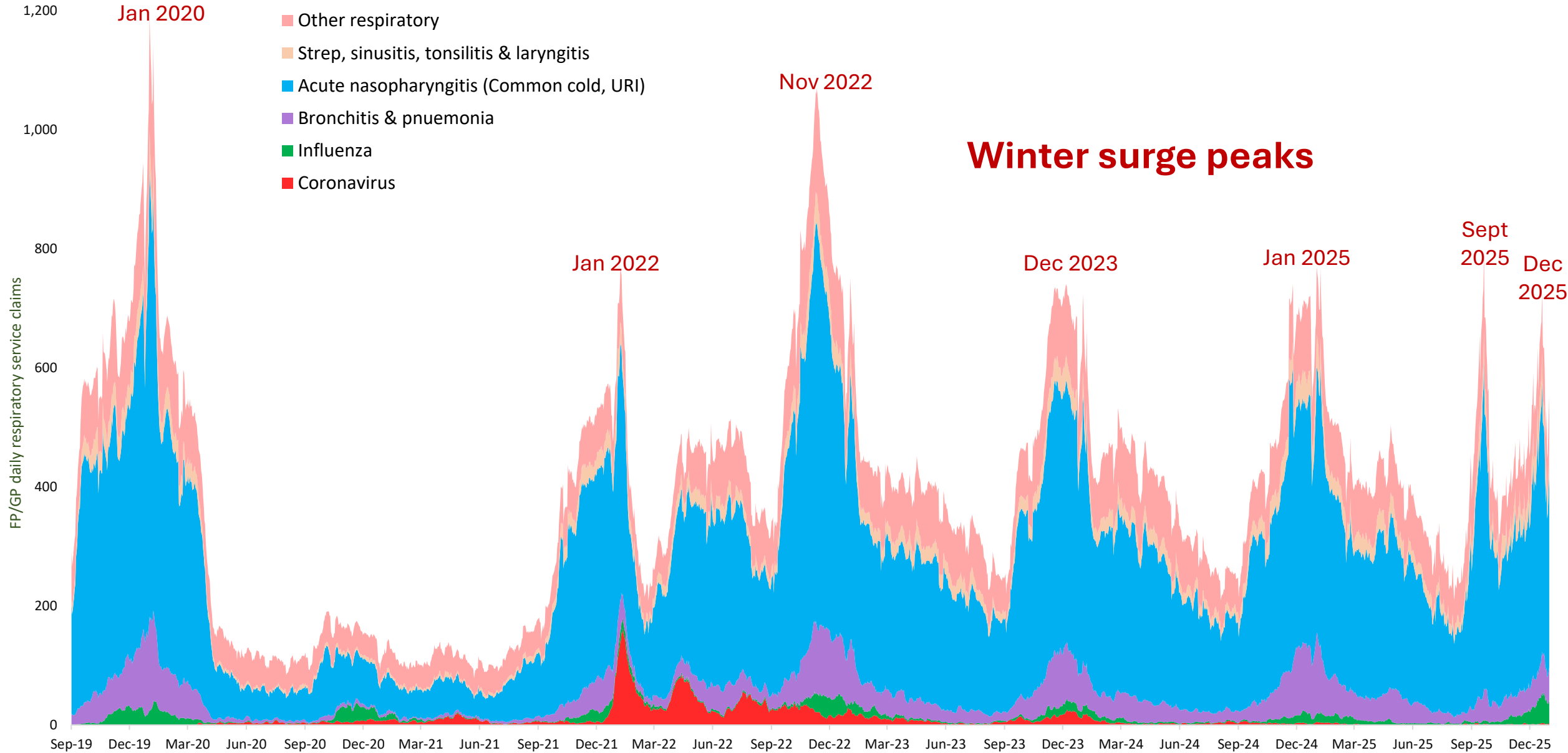
Each year's RSV wave measured from date 30 RSV hospitalizations reached to 97 days afterward (for comparison with current 2025-26 data)



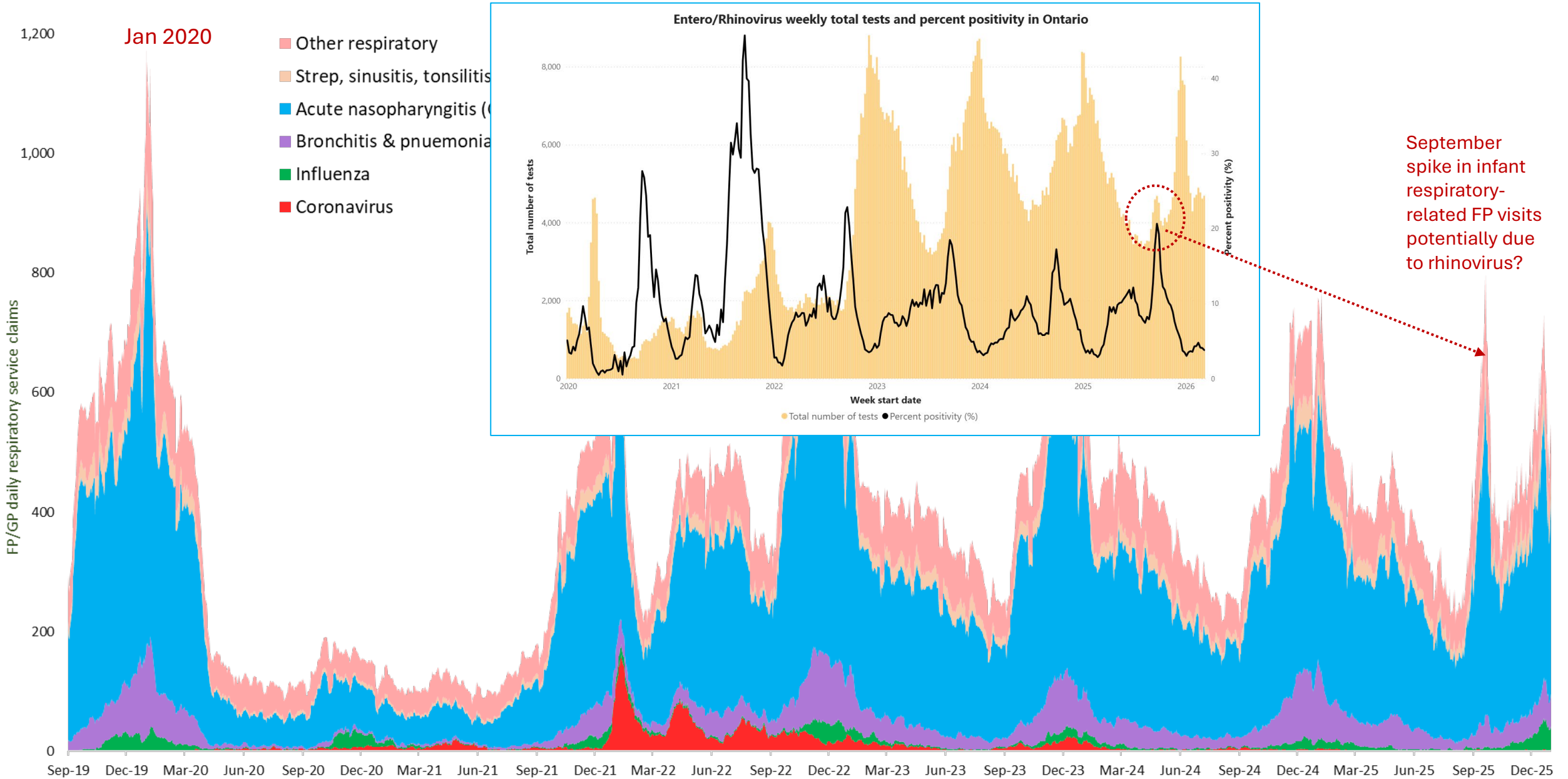
Daily FP / GP Visits for Respiratory-Related Diagnoses: All Ages



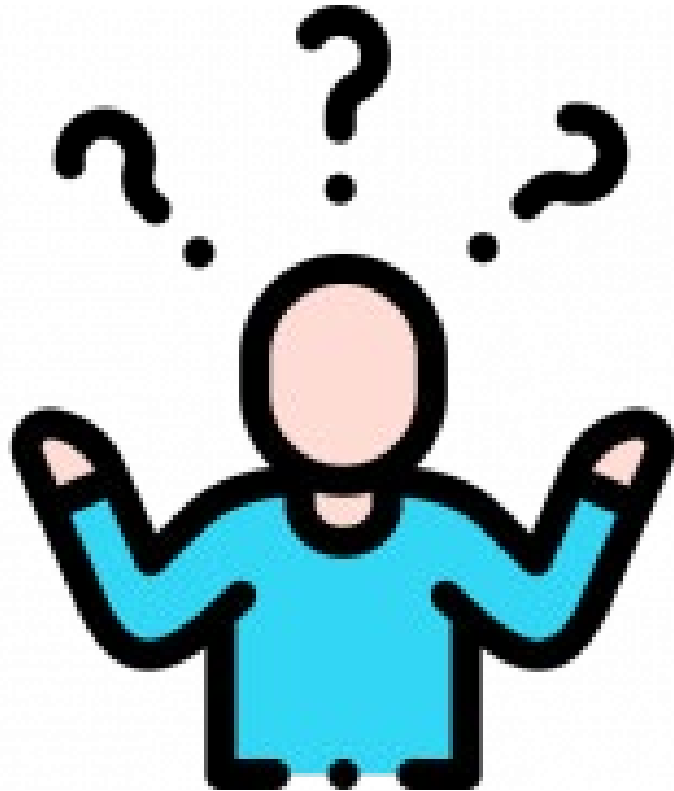
Daily FP / GP Visits for Respiratory-Related Diagnoses: **Under 1s**



Daily FP / GP Visits for Respiratory-Related Diagnoses: **Under 1s**



Conflicting Guidelines: Why and Tools to Choose?



Donna L Reynolds

MD, MSc, FCFP, FRCPC

OCFP/DFCM, March 27, 2026

Disclaimers/Interests

1. Worked on a lot of CTFPHC guidelines
2. Published articles on preventive health care & screening
3. Interest in how evidence is used and misused to affect our practice
4. This presentation is not on behalf of the CTFPHC



Conflicting guidelines:

Why?



Is it a problem?

Isn't it all using the same evidence?

Objectives

1. Identify features that suggest a **quality guideline**:

–**Relevant**

–**Trustworthy**

- methodologically sound
- unbiased judgements



2. Use a tool, quickly **appraise** guidelines for consideration

3. Recognize why guidelines with primary care involvement may differ from those of specialist and advocacy groups

Screening for abdominal aortic aneurysms in Canada: 2020 review and position statement of the Canadian Society for Vascular Surgery

Varun Kapila, MD
Prasad Jetty, MD, MSc
Doug Wooster, MD
Vic Vucemilo, MD
Luc Dubois, MD, MSc;
on behalf of the Canadian
Society for Vascular Surgery

Accepted Sept. 18, 2020

Correspondence to:
V. Kapila
Canadian Society for Vascular Surgery
PO Box 58062
Ottawa ON K1C 7H4
varun.kapila@utoronto.ca

Cite as: *Can J Surg* 2021 September 1;
64(5). doi: 10.1503/cjs.009120

Abdominal aortic aneurysms (AAAs) remain a major risk to patients, despite level 1 evidence for screening to prevent rupture events and decrease mortality. In 2007, the Canadian Society for Vascular Surgery (CSVS) published a review and position statement for AAA screening in Canada. Since that publication, there have been a number of updates in the published literature affecting screening recommendations. In this paper, we present a review of some of the controversies in the AAA screening literature to help elucidate differences in the various published screening guidelines. This article represents a review of the data and updated recommendations for AAA screening in the Canadian population on behalf of the CSVS.

Les anévrismes de l'aorte abdominale (AAA) continuent de poser un risque majeur pour les patients, malgré des données probantes de niveau 1 à l'appui du dépistage pour prévenir les ruptures et réduire la mortalité. En 2007, la Société canadienne de chirurgie vasculaire (SCCV) a publié une revue et un énoncé de position sur le dépistage de l'AAA au Canada. Depuis lors, plusieurs mises à jour ont paru dans la littérature et elles ont un impact sur les recommandations relatives au dépistage. Dans le présent article, nous présentons une synthèse de quelques controverses soulevées dans la littérature sur le dépistage de l'AAA afin d'expliquer les différences entre les diverses lignes directrices publiées à ce sujet. Cet article propose au nom de la SCCV une revue des données probantes et des recommandations à jour sur le dépistage de l'AAA dans la population canadienne.

Richard Ward, MD, and Wendy Whyte, MD, MSc

in adults

ampbell,

or the
of

D.^c

primary care

Nicolas Dugré,

McKay, Lyne Cloutier 6

Recommendation

Canadian Task Force on Preventive
CMAJ September 11, 2017 189 (36) E113

Family Physician October 2023; 69 (1)

UIC

A

Gordon A

Milan Gu

Alexander

Ru

Pat

Hypertension
in primary

Rémi Goupil,
Ernesto L. S
CMAJ May

Example of AAA screening for women

CTFPHC (2017) Guideline

We recommend not screening women for AAA (strong recommendation; very low quality of evidence).

CVSC (2021) Position/ Consensus Statement

We suggest one-time screening U/S for all women aged 65-80 years with a history of smoking or CVD (grade 2c [weak, low quality] evidence).

Ontario AAAS Guideline (2025)

Women turning 65 will receive a letter inviting them to get screened for AAA

Recommended for women aged 65-80, especially those who smoke, family history of AAA, or history of CVD

2 Key Components of Quality Guidelines

Relevance

You

Your
Patients

Your
Practice

Trustworthy

Standardised
Methods

Unbiased
Judgements

4 Tools



1. AGREE II

2. G-TRUST

= Guideline Trustworthiness, Relevance, and Utility Scoring Tool

- Relevance
- Evidence
- Interpretation

3. ECRI TRUST Scorecard

= Transparency and Rigor Using Standards of Trustworthiness

4. Simplified G-TRUST

Simplified G-TRUST



➤ Methods (not content)

➤ 3 questions:

–**Relevance**: *Is this guideline useful & applicable in my practice?*

–**Confidence**: *What is the factual basis of the recommendations, & is this transparent?*

–**Interpretation**: *Do I trust those who interpreted the evidence & made the recommendations?*

➤ “Kill switch”

Simplified G-TRUST

Relevance

- Is this guideline useful and applicable in my practice?

If no...STOP!

Are the patient population and context

guidelines address patient-oriented outcomes?













Are the recommendations clear, actionable and feasible?

Has time needed to treat been considered?

TNT calculator at Choosing Wisely:

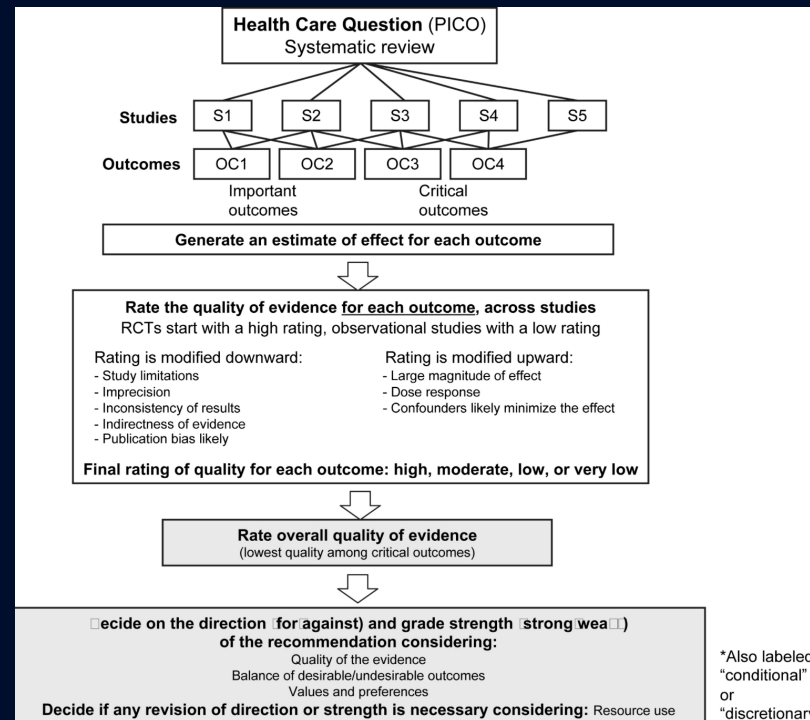
<https://choosingwiselycanada.org/primary-care/easing-workload/#resources>

Relevance: How do they stack up?

	CTFPHC	CVSC	OAAAS
Are the patients, population, and context similar to mine?			
Do the guidelines address patient-oriented outcomes?			
Are the recommendations clear, actionable and feasible? (e.g., for SDM)			
Has time needed to screen/treat/feasibility been considered?			

Trustworthiness:

Standardised Methods (& some background)



3 methodological advances:

1. GRADE

A standardised *approach* for Grading of Recommendations Assessment, Development, & Evaluation

- Rate **QUALITY** of evidence
 - Grade **STRENGTH** of recommendations
-

2. US Institute of Medicine

Criteria for developing **trustworthy** guidelines

3. GIN (Guidelines International Network)

Managing **conflicts of interest**



US Institute of Medicine 2011: To be trustworthy



CLINICAL PRACTICE
GUIDELINES
WE CAN TRUST

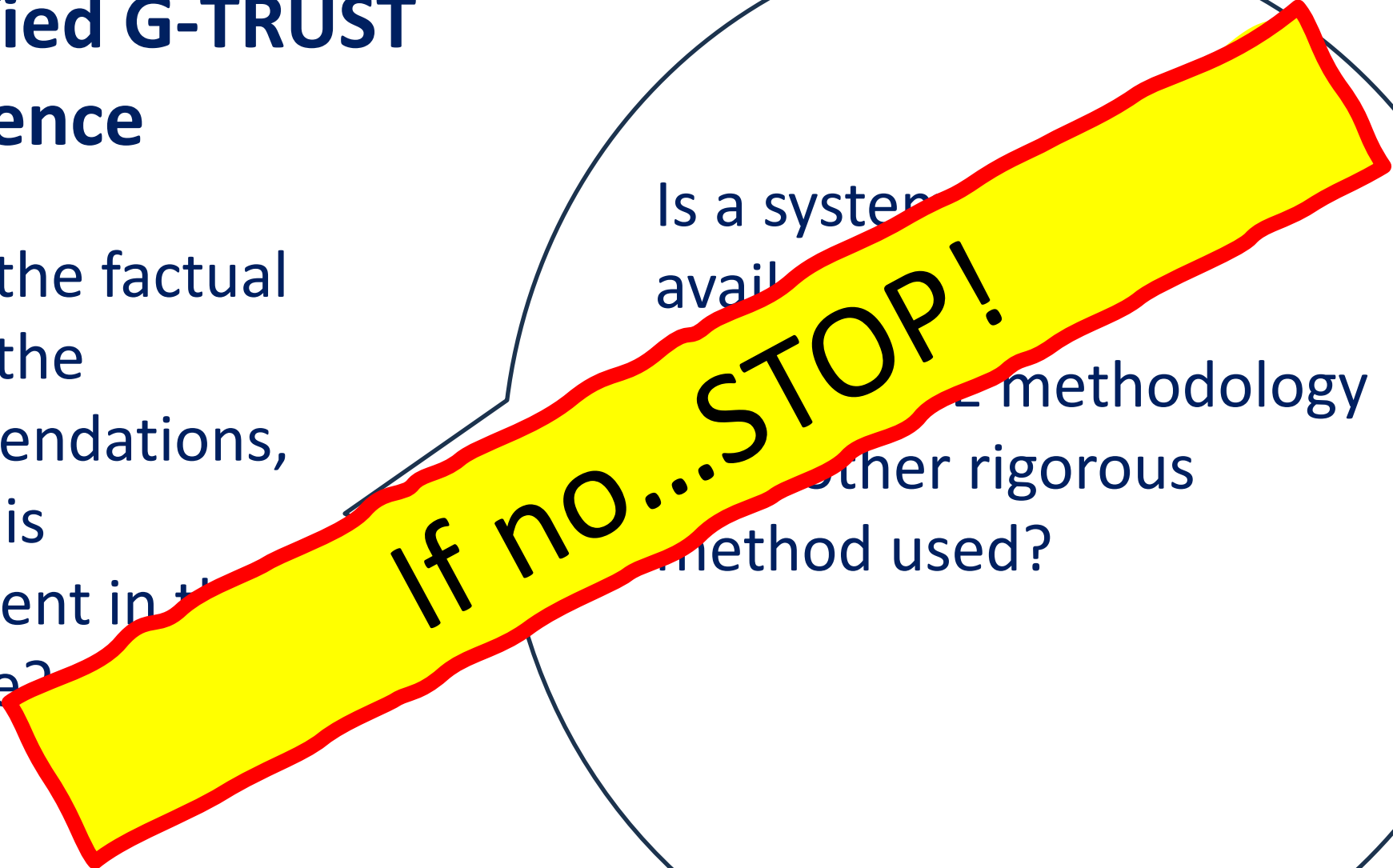
INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

- ✓ Based on a **systematic review** (e.g., GRADE)
- ✓ Follow **explicit & transparent** process that minimizes distortions, biases, & conflicts of interest
- ✓ Clear & logical explanations **connect interventions & health outcomes** (e.g., GRADE)
- ✓ Developed by a knowledgeable, multidisciplinary panel of experts & representatives from **key affected groups**
- ✓ Consider evidence on patient subgroups & preferences
- ✓ Reviewed when new evidence could modify recommendations

Simplified G-TRUST Confidence







What is the factual
basis of the
recommendations,
and is this
transparent in the
guideline?

Is a system
available
methodology
other rigorous
method used?



If no...STOP!

Confidence: How do they stack up?

	CTFPHC	CVSC	OAAAS
A systematic review is available			
A systematic approach was followed (e.g., GRADE)			

Examples of no published SR

Guidelines recommendations from:



- Canadian Cancer Society
- Many provincial/territorial guidelines
- Canadian Association of Radiologists - CAR Practice guidelines for breast imaging & intervention
- Canadian Urological Association: Prostate cancer screening and early diagnosis guideline
- Canadian Cardiovascular Society
- Osteoporosis Canada
- Diabetes Canada

Trustworthiness:

Unbiased Judgements: COIs & Perspectives
(& some background)



GIN Principles: Types of COI

Table. Types and Examples of Conflicts of Interest in Guidelines

Type of Conflict	Domains*	Examples
Direct financial	Direct payments for service Stock options	Payments to participate in a study on an intervention that is subject to a recommendation Consultancy for a manufacturer of a relevant technology/intervention Payment for lectures and meeting attendance in support of a technology/intervention Paid board memberships, patent applications, and research grants† Honoraria and gifts
Indirect‡	Academic advancement Clinical revenue streams Community standing Scientific interest	Having published on a topic that expresses an opinion on the effectiveness of an intervention or doing research on a topic that could be affected by a recommendation§ Being an acknowledged expert in the intervention Gaining clinical income from the recommendation Leadership or board or committee memberships Involvement with an advocacy group that may gain from a guideline Writing or consulting for an educational company Personal convictions or positions

* Not exclusive.

† From any source, whether restricted or unrestricted.

‡ Possibly leading to indirect financial gains.

§ For example, further funding decisions based on the direction and strength of a recommendation.

|| Political, religious, ideological, or other.



GIN key principles:

- Applies to everyone
- Avoid COIs
- Disclose COIs
- Balance
- COIs (
- No COIs
- direction
- Oversight

~50-80% of COI statements are incomplete

Principle 1: Guideline development groups should make all possible efforts to not include members with direct or indirect COIs.

Principle 2: The management applies to all members of a guideline development group, regardless of the discipline or stakeholders they represent. Management should use standardized forms for disclosure of interests and should disclose interests publicly, and these should be easily accessible to all members of the group and at regular intervals (e.g., at guideline development groups).

Principle 3: Guideline development groups should have no direct or indirect COIs. When direct or indirect COIs of a chair are disclosed, the chair should be replaced by another COI-free chair. COIs who leads the guideline panel should be disclosed to all members of the group. When relevant COIs and specific knowledge or expertise may be helpful, members with COIs may participate in discussion of individual topics, but there should be an appropriate balance of opinion among those sought to provide input.

Principle 4: No member of the guideline development group deciding about the direction or strength of a recommendation should have a direct financial interest in the guideline or a COI.

Principle 9: An oversight committee should be responsible for developing and implementing rules related to COIs.

Does industry support Canadian guideline developers/funders?

YES

NO

Alzheimer's Society of Canada
Canadian Association of Radiologists
Canadian Association for Studies of the Liver
Canadian Cancer Society
Canadian Cardiovascular Society
Canadian Pediatric Society
Canadian Rheumatology Association
Canadian Society for Vascular Surgery (?)
Canadian Urological Association

Colorectal Cancer Canada
Diabetes Canada
Liver Canada
Hypertension Canada
Obesity Canada
Osteoporosis Canada
Prostate Cancer Foundation
Society of Ob/Gyne of Canada
And more...

CTFPHC
PEER

Judgements:

Perspectives

Family Medicine & Specialist



Perspectives differ

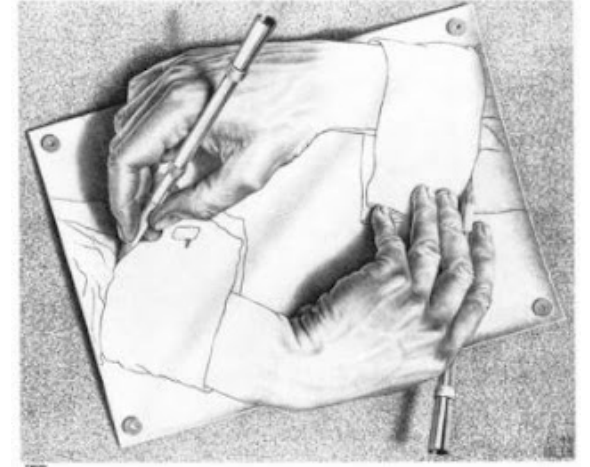
Family Medicine



Specialist care



For Guidelines...Perspectives matter



Specialists & Medical Societies

- Recommend more interventions
- Tend to minimize & underreport harms of screening
- More detection=better

➤ ***“My disease is the most important”***







Simplified G-TRUST Interpretation

Do I trust the people who interpreted the evidence and made the recommendations?

- Are the panel members free of conflicts of interest (including funding funders)?
- Have conflicts of interest been managed?
- Are the panel members diverse?



Interpretation: How do they stack up?

	CTFPHC	CVSC	OAAAS
Are the guidelines free of competing interests? Have conflicts of interest been managed?			
Are the panel members diverse?			

...and AAA Screening for women 65-80

Consider	Cdn Society for Vascular Surgery (2020)	CTFPHC (2017)
Relevance	<ul style="list-style-type: none"> ✗ Position statement ✗ Outcomes uncertain ✗ No tools ✗ No T/S 	<ul style="list-style-type: none"> ☑ 1,000 person diagram in absolute numbers & clinician tool ☑ Feasibility addressed
Interpretation	<ul style="list-style-type: none"> ✗ All a vascular surgery family do ✗ COLs –mngt uk 	<ul style="list-style-type: none"> ☑ 1/11 was a non-industry funded trial ☑ Diverse, varied background ☑ Wide interest holders review
Confidence	<ul style="list-style-type: none"> ✗ No systematic review ✗ Methods & processes not clear 	<ul style="list-style-type: none"> ☑ Systematic review ☑ GRADE

Next & Summary?



Other possibilities

- ECRI TRUST Scorecard
- AI
- Advocate for journals to require & publish independent guideline assessment
- Create Canadian trusted source for FPs (help wanted!)

Many guidelines conflict

Look for/Demand:

- Guidelines for primary care by primary care
- Clear methods
 - Systematic review
 - GRADE (or similar)
 - Patient-important outcomes in absolute numbers
- TNT/S
- No or managed conflicts of interest



Thank you



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.

March 30, 2026 | 1:30PM - 4:30PM

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learn more

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Health Equity Community of Practice for Family Physicians

April 30, 2026 | 12 P.M. - 1 P.M. EST

Caring for Adults with Intellectual and Developmental Disabilities



[Click here](#) or scan the QR code

Supports for Mental Health, Addictions and Chronic Pain

Find information to support the care you give patients – in a way that also considers your wellbeing.

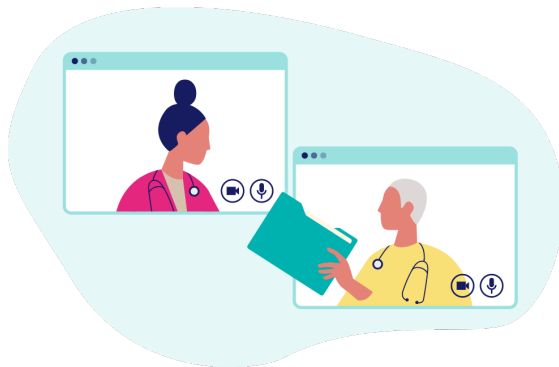
Community of Practice



[Return-to-Work Planning in Family
Medicine: Practical WSIB
Considerations \(April 22\)](#)

Peer Connect Mentorship

Receive tailored support to skillfully respond to challenges in your practice and earn Mainpro+ credits.



Topics Explored by Peer Learners:

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- Strategies to address work-life balance
- Supporting patients living with chronic pain and addiction challenges

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Care

When You Need It

No patient should be waiting without answers.

Together, we can build a system that gets patients the care they need, when they need it.

[Send a Letter to Your MPP](#)

[Spread the Word](#)



First Five Years Community of Practice

Our next First Five Years Community of Practice sessions:

From 7 – 8pm:

April 21, 2026: Patient management & setting expectations

May 19, 2026: Parental leave & practice management with young children

Register on the First Five Years CoP Website:



Contact us: dfcm.quality@utoronto.ca



Family & Community Medicine
UNIVERSITY OF TORONTO

The First Five Years Community of Practice is a one-credit-per-hour Group Learning program that has been certified for up to a total of 9 Mainpro+ credits.

RECENT SESSIONS

December 5	Infectious Disease & Current Public Health Issues	Dr. Daniel Warshafsky Dr. Kieran Moore
January 16	Infectious Disease & e-Referral Development	Dr. Alon Vaisman Dr. Stephen Pomedli
February 6	Infectious Disease & Best Practices for MSK Imaging	Dr. Allison McGeer Dr. Daniel Warshafsky
February 20	Infectious Disease & New Hypertension Guidelines Update	Dr. Daniel Warshafsky Dr. Vincent Ki
March 6	Infectious Disease & Supporting Healthy Aging in Women	Dr. Zain Chagla Dr. Margarita Lam Antoniades

Past Webinars, Slides, Self-Learning & More Resources:
<https://dfcm.utoronto.ca/past-changing-way-we-work-community-practice-sessions>

UPCOMING SESSIONS

Month	Date
April 2026	April 17
May 2026	May 1
May 2026	May 22

SAVE THE DATE

Registration links will be emailed to you closer to the date



Questions?

The webinar recording will be posted soon.

Session slides will be available by the end of the day:

<https://dfcm.utoronto.ca/past-changing-way-we-work-community-practice-sessions>

Our next Community of Practice: April 17, 2026

Contact us: ocfpcme@ocfp.on.ca

The Changing the Way we Work Community of Practice for Ontario Family Physicians has been certified by the College of Family Physicians of Canada and the Ontario Chapter for up to 32 Mainpro+ Certified Activity credits.

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