COVID-19 Community of Practice for Ontario Family Physicians

October 6, 2023

Dr. Zain Chagla
Dr. Elizabeth Muggah

Update on COVID-19, influenza and RSV vaccines

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of Family Physicians

Update on COVID-19, influenza and RSV vaccines

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. Elizabeth Muggah, Ottawa, 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.

Wab Kinew becomes Canada's 1st First Nations premier of a province

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. Tara Kiran (DFCM), Dr. Mekalai Kumanan (OCFP); Dr. Ali Damji (DFCM), Dr. Harry O'Halloran, Kimberly Moran (OCFP), Mina Viscardi-Johnson (OCFP), 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

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President, Ontario College of Family Physicians
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Speaker Disclosure

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

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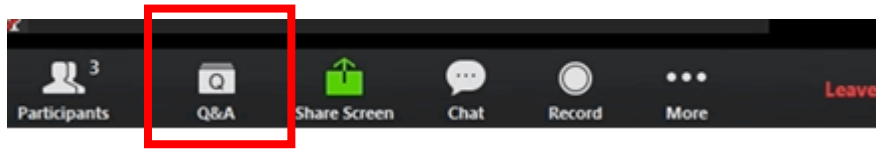
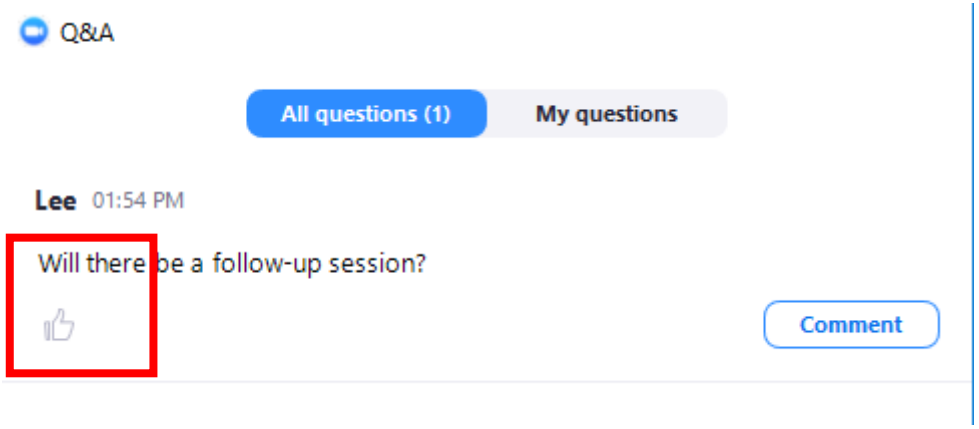
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: N/A

How to Participate

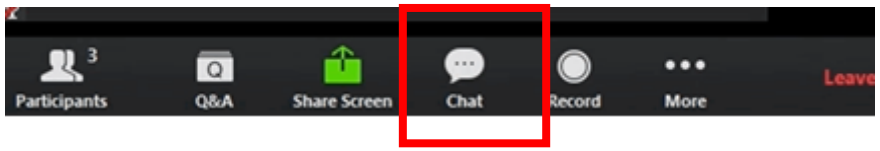
- All questions should be asked using the Q&A function at the bottom of your screen.



- Press the thumbs up button to upvote another guests 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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Objectives

- COVID Vaccine update
- RSV Vaccine – evidence and considerations
- Paxlovid
- Office Infection Control

COVID-19 vaccines

Fall 2023 Update

- Beginning in the fall of 2023 for those previously vaccinated against COVID-19, NACI recommends a dose of the XBB.1.5-containing formulation of COVID-19 vaccine for individuals in the authorized age group if it has been at least 6 months from the previous COVID-19 vaccine dose or known SARS-CoV-2 infection (whichever is later).
- Immunization is particularly important for those at increased risk of COVID-19 infection or severe disease, for example:
  - Adults 65 years of age or older;
  - Residents of long-term care homes and other congregate living settings;
  - Individuals with underlying medical conditions that place them at higher risk of severe COVID-19;
  - Individuals who are pregnant;
  - Individuals in or from First Nations, Métis and Inuit communities;
  - Members of racialized and other equity-deserving communities;
  - People who provide essential community services

Figure 1. Neutralizing Antibodies After a Booster Dose of XBB.1.5-Containing Monovalent and Bivalent Vaccines Against XBB.1.5, XBB.1.16, BQ.1.1 and BA.4/5 Variants and Ancestral SARS-CoV-2 (D614G)

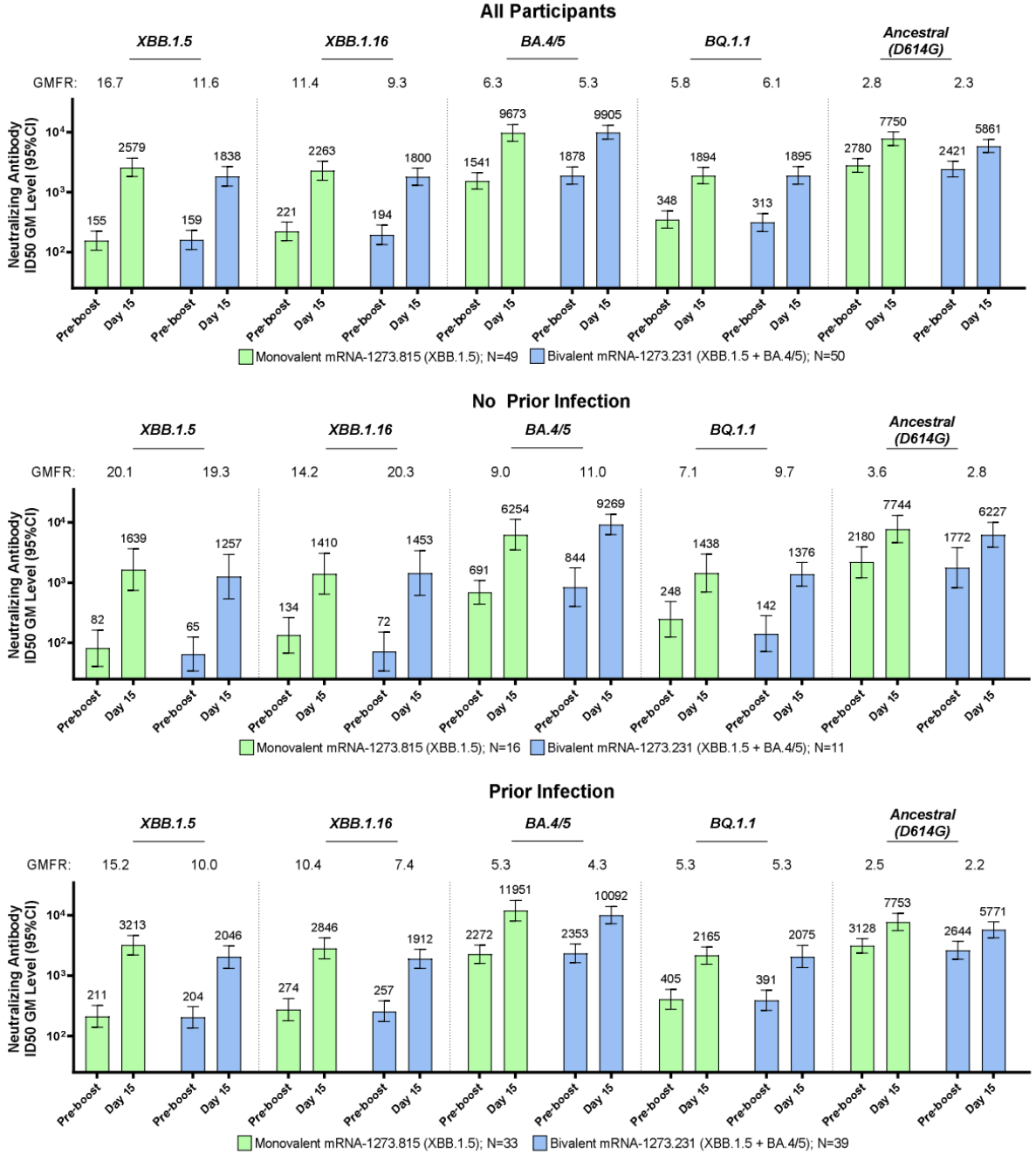


Figure 2. Analysis of Neutralizing Antibody Titers Against Ancestral SARS-CoV-2 (D614G) and BA.4/BA.5, XBB.1.5, XBB.1.16, XBB.2.3.2, EG.5.1, FL.1.5.1 and BA.2.86 Variants in a Randomly-selected Subset of Participants Who Received Monovalent mRNA-1273.815

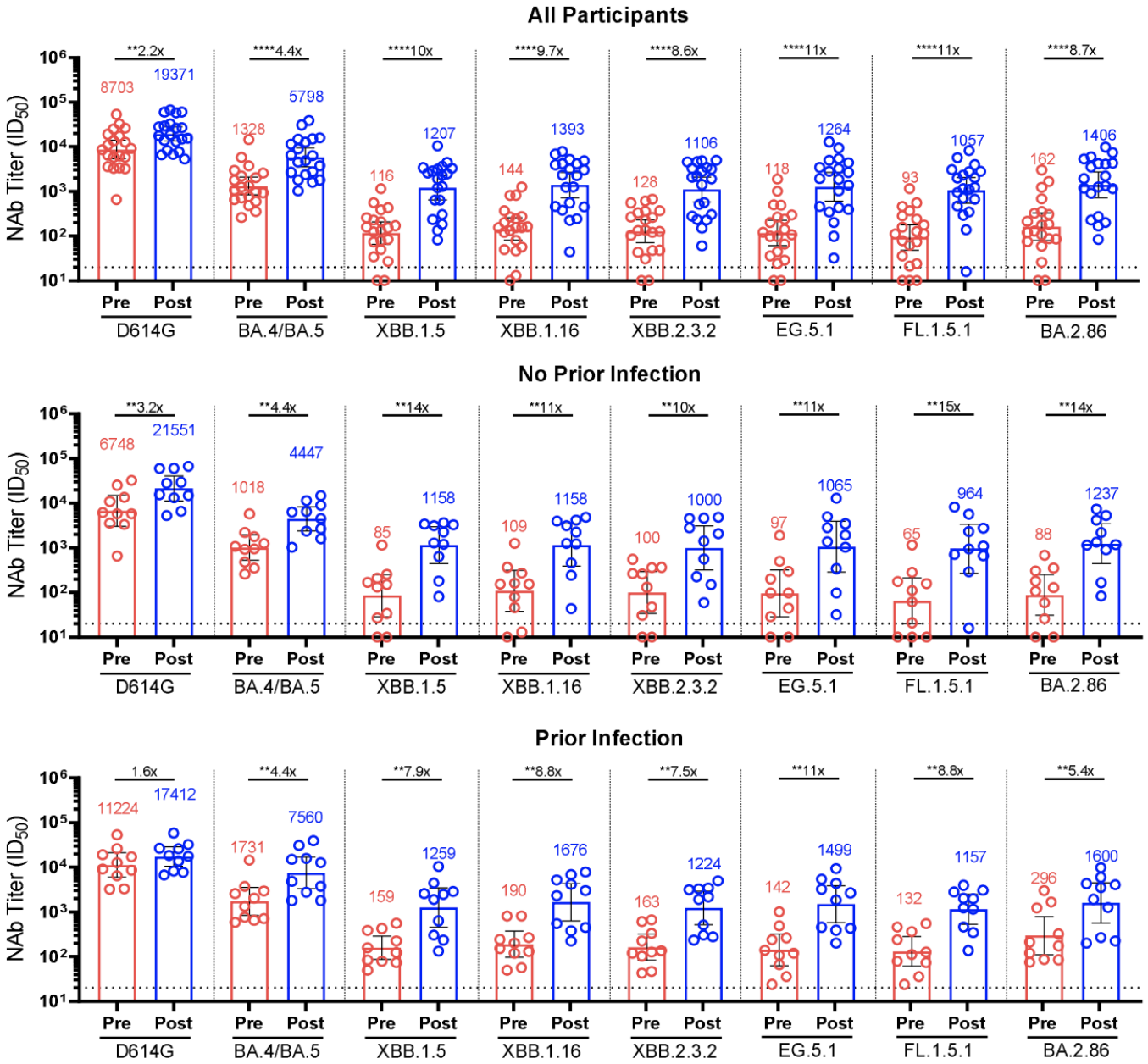


Table 2. Effectiveness against severe COVID-19 of a second booster dose of the bivalent (original/BA.4–5) mRNA vaccine relative to a first booster dose of an mRNA vaccine received ≥120 days earlier, by time since prior infection, Italy, 12 September–11 December 2022 (n = 11,190,209)

Toggle display: Open fullscreen

Time since prior infection	First booster dose since ≥120 days (reference)		Bivalent second booster dose (original/BA.4–5)		rVE	
	n events	Rate per 100,000 PD	n events	Rate per 100,000 PD	%	95% CI
Primary analysis						
No prior infection	18,594	2.60	413	1.54	59.4	55.1 to 63.3
≥40 weeks	433	1.93	17	0.93	61.6	37.5 to 76.3
27–39 weeks	494	1.37	26	0.76	61.7	43.1 to 74.2
17–26 weeks	507	0.52	18	0.73	10.0	−44.0 to 43.8
Sensitivity analysis[a]						
No prior infection	13,879	1.94	308	1.15	61.5	56.7 to 65.8
≥40 weeks	322	1.43	13	0.71	61.6	33.1 to 78.0
27–39 weeks	353	0.98	17	0.50	65.8	44.3 to 79.0
17–26 weeks	366	0.38	14	0.57	8.5	−56.1 to 46.4

CI: confidence interval; COVID-19: coronavirus disease; PD: person days; rVE: relative vaccine effectiveness.

[a] Sensitivity analysis based on a more specific definition of severe COVID-19, including death and only admission to a hospital unit usually used for COVID-19 patients (i.e. intensive care unit, semi-intensive care unit, pulmonary unit, infectious and tropical diseases unit or general medicine unit). A total of 5,230 (25.5%) of the 20,502 severe cases identified in the primary analysis were classified as non-severe in the sensitivity analysis.

Table 1: Use of Moderna XBB.1.5 mRNA COVID-19 vaccine

Unvaccinated Individuals		
	Recommended Interval[1]	**Minimum Interval**[2]
6 months – 4 years	Moderna XBB.1.5 (25 mcg) • 2 dose schedule • 2nd dose, ***56 days*** after 1st dose	Moderna XBB.1.5 (25 mcg) • 2 dose schedule • 2nd dose, ***28 days*** after 1st dose
5 – 11 years	Moderna XBB.1.5 (25 mcg) - 1 dose schedule	
[3]12 years +	Moderna XBB.1.5 (50 mcg) – 1 dose schedule	
Previously Vaccinated Individuals		
	Recommended Interval[1]	**Minimum Interval**[4]
6 months – 11 years	Moderna XBB.1.5 (25 mcg) • **6 months (168 days)** after last dose or confirmed SARS-CoV-2 infection	Moderna XBB.1.5 (25 mcg) • **3 months (84 days)** after last dose or confirmed SARS-CoV-2 infection
12 years +	Moderna XBB.1.5 (50 mcg) • **6 months (168 days)** after last dose or confirmed SARS-CoV-2 infection	Moderna XBB.1.5 (50 mcg) • **3 months (84 days)** after last dose or confirmed SARS-CoV-2 infection

Pfizer vaccine
0.5 – 5 years
Primary – 3mcg IM at day 0, 21, > 8 weeks
Booster – 3mcg IM x 1

5-11 years
Primary + Booster – 10 mcg IM x 1

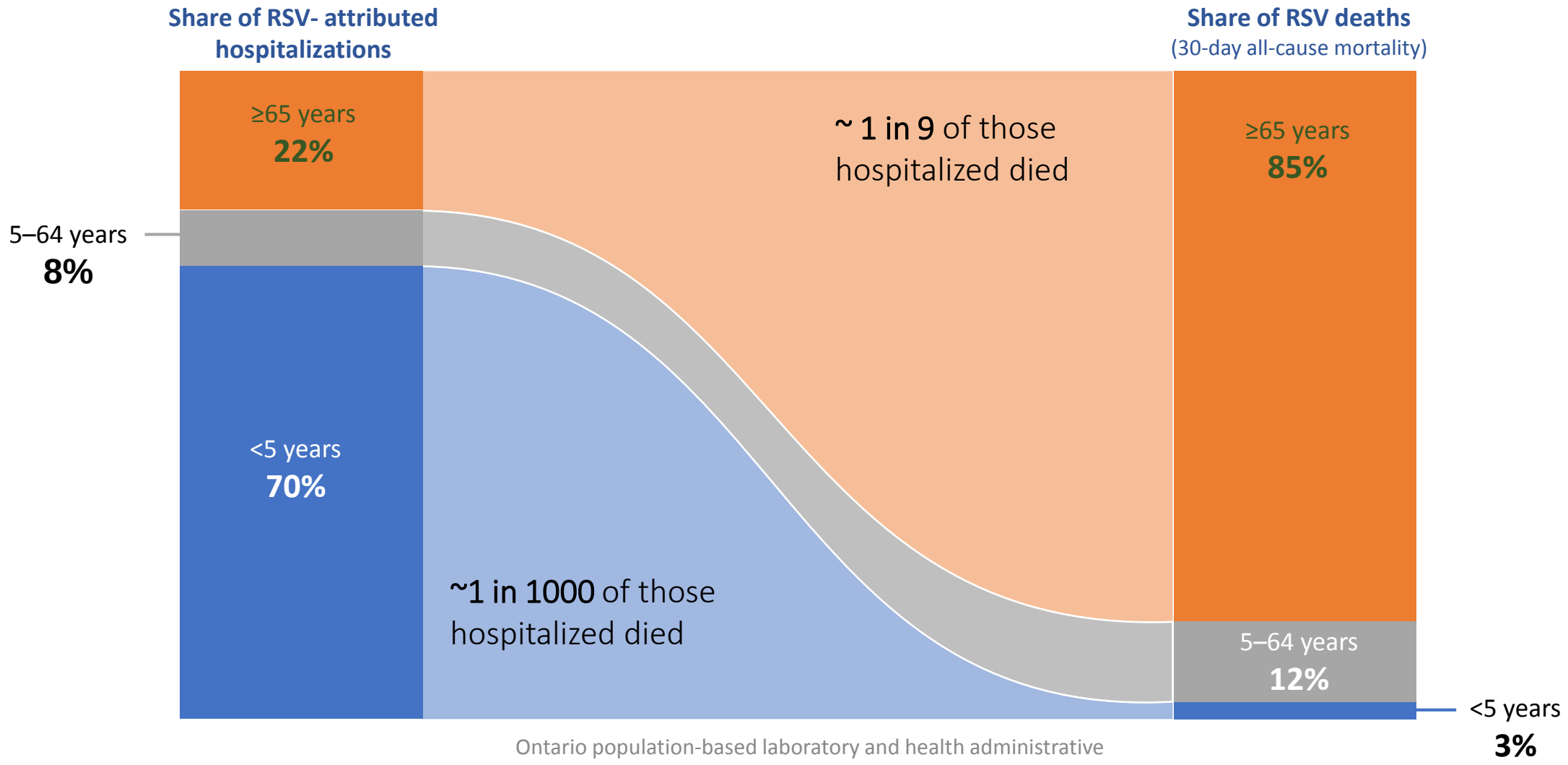
12+ years
Primary + Booster – 30mcg IM x 1

Note - Primary series for 12-29 year olds is still preferred for Pfizer vaccine

RSV Vaccine

- Data from Ontario show that older adults make up a disproportionate number of RSV-attributed deaths

Core content



Ontario population-based laboratory and health administrative data, 2010/2011–2018/2019 respiratory virus seasons. From: Hamilton MA, et al. Influenza Other Respir Viruses. 2022;16(6):1072-1081.

Economic burden of RSV in older adults

RSV in older adults causes a sizeable economic burden in Canada

- A study by Rafferty (2022) examining RSV-attributable **costs** for laboratory-confirmed cases in Alberta determined[1];

$12,713 CAD cost per RSV case within the first **30 days** following diagnosis across all age groups

In 65-79 YOA: **$17,507 CAD**
In >80 YOA: **$13,746 CAD**

$40,028 CAD cost per RSV case at **365 days** following diagnosis across all age groups

In 65-79 YOA: **$96,271 CAD**
In >80 YOA: **$71,773 CAD**

Inpatient costs accounted for **70 and 64% of total costs** at 30 and 365 days, respectively.

- Costs were estimated from the healthcare perspective and did **not consider societal or personal** costs associated with RSV infection
- Therefore, presented cost estimates are likely an **underestimate of** the actual cost burden of an RSV case to the health system, given indirect costs are not considered

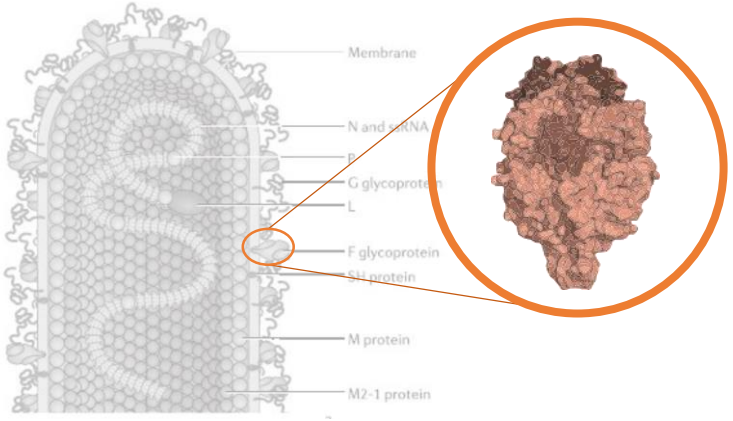
1. Rafferty E, Paulden M, Buchan SA, Robinson JL, Bettinger JA, Kumar M, Svenson LW, MacDonald SE; Canadian Immunization Research Network (CIRN) investigators. Evaluating the Individual Healthcare Costs and Burden of Disease Associated with RSV Across Age Groups. Pharmacoeconomics. 2022 Jun;40(6):633-645. doi: 10.1007/s40273-022-01142-w. Epub 2022 May 13. PMID: 35553028; PMCID: PMC9130187.

• AREXVY combines a recombinant RSV-PreF3 antigen

Core content

ANTIGEN

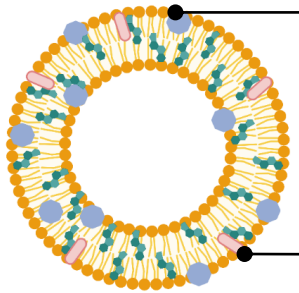
RSV-F stabilized in the prefusion state (120 µg)



The RSV-F antigen target is highly conserved between RSV-A and RSV-B subtypes[1]

ADJUVANT

AS01E adjuvant system: liposomes containing two immunostimulants that boost RSV-specific T-cell response[1,2]



Same adjuvant ingredients as the recombinant shingles vaccine Shingrix, with half the amount of MPL and QS-21[2,3]

Image of RSV adapted from: Battles MB, McLellan JS. Nat Rev Microbiol. 2019;17(4):233-245; Image of RSV-F reproduced from: Graham BS, et al. Curr Opin Immunol. 2015;35:30–38, with permission from Elsevier.

$AS01_E$, Adjuvant System 01_E (25 µg Quillaja saponaria Molina, fraction 21, 25 µg 3-O-desacyl-4'- monophosphoryl lipid A, combined in a liposomal formulation)

1. Graham BS et al. Curr Opin Immunol 2015;35:30–38. 2. AREXVY (RSV vaccine recombinant, AS01E adjuvanted). Product Monograph. Mississauga, ON: GlaxoSmithKline Inc; Aug 2023. 3. SHINGRIX (herpes zoster vaccine). Product Monograph. Mississauga, ON: GlaxoSmithKline Inc; Nov 2022.

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Respiratory Syncytial Virus Prefusion F Protein Vaccine in Older Adults

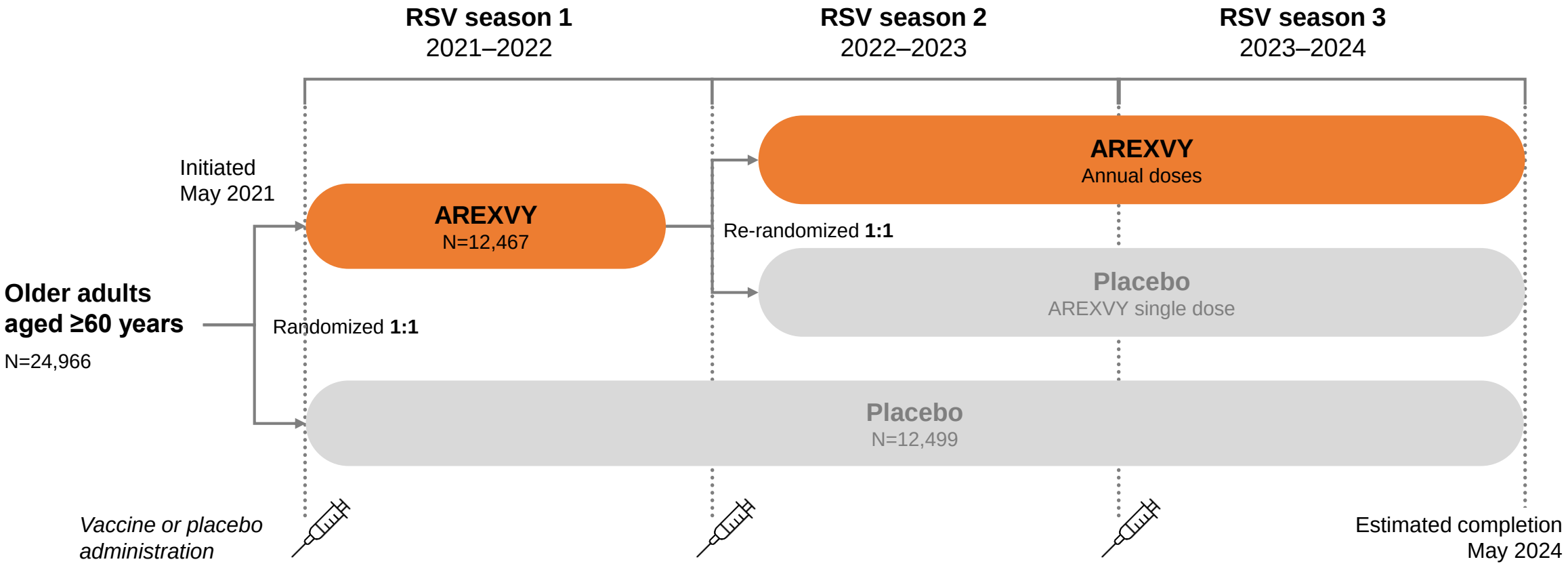
A. Papi, M.G. Ison, J.M. Langley, D.-G. Lee, I. Leroux-Roels, F. Martinon-Torres, T.F. Schwarz, R.N. van Zyl-Smit, L. Campora, N. Dezutter, N. de Schrevel, L. Fissette, M.-P. David, M. Van der Wielen, L. Kostanyan, and V. Hulstrøm, for the AReSVi-006 Study Group*

Papi A, et al. N Engl J Med. 2023;388(7):595–608.

- AReSVi-006: AREXVY pivotal efficacy study spanning 3 RSV seasons

Core content

Phase 3, randomized, placebo-controlled, observer-blind, multi-country study



Primary endpoint:
Vaccine efficacy against RSV-LRTD after 1 RSV season

Confirmatory secondary endpoint:
Vaccine efficacy of a single dose against RSV-LRTD after 2 seasons and vaccine efficacy after annual revaccination

Papi A, et al. N Engl J Med. 2023;388(7):595–608.

- AReSVi-006 enrolled adults ≥60 years old, including those with chronic medical conditions

Core content

- Key inclusion criteria

- Males and females
- **≥60 years of age** at first RSV vaccination
- Living in the general community or a long-term care facility
- Participants **with chronic conditions** such as diabetes, hypertension or cardiac disease (with or without specific treatment) must have been assessed as **medically stable**

- Key exclusion criteria

- Any confirmed or suspected **immunosuppressive or immunodeficient condition** resulting from disease or immunosuppressive/cytotoxic therapy, based on medical history or physical examination (no laboratory testing required)
- **Serious or unstable chronic illness**
- Administration of **long-acting immune-modifying drugs, immunoglobulins and/or any blood products or plasma**
- **Chronic administration** (>14 consecutive days) of **immunosuppressants or other immune-modifying drugs** within 90 days of the first study vaccination

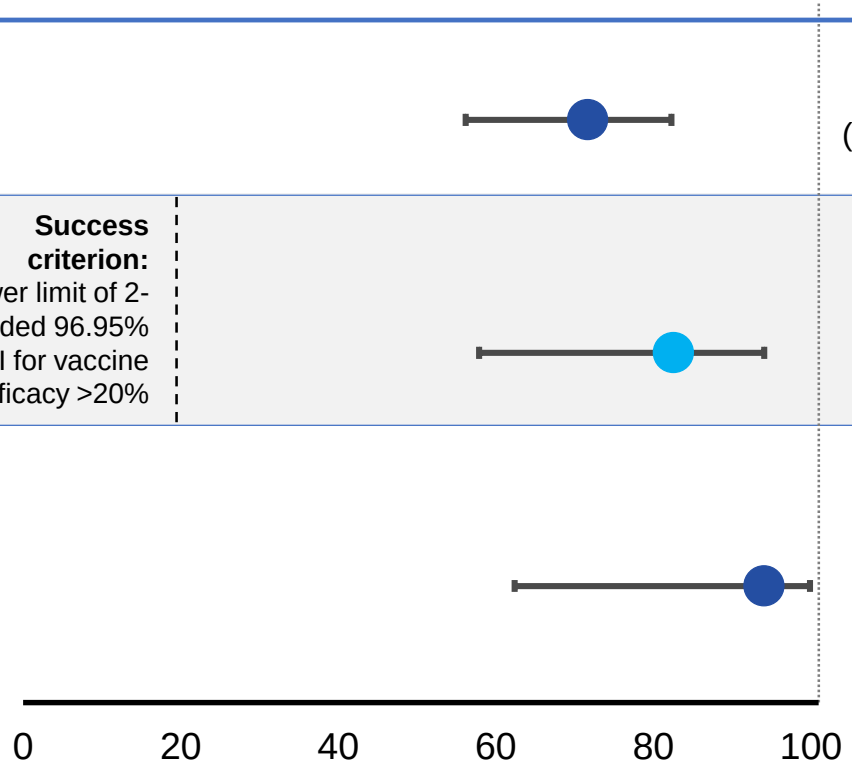
Papi A et al. N Engl J Med 2023;388(7):595–608 (publication and supplementary appendix)

Patient demographics

- One dose of AREXVY is highly efficacious across a broad spectrum of RSV-associated disease

Core content

RSV-confirmed:	Number of events: AREXVY N=12,466	Number of events: Placebo N=12,494	Vaccine efficacy (CI*)
ARI Acute respiratory infection	27	95	**71.7%** (56.2, 82.3)
PRIMARY ENDPOINT **LRTD** Lower respiratory tract disease	7	40	**82.6%** (57.9, 94.1)
Severe LRTD Severe lower respiratory tract disease	1	17	**94.1%** (62.4, 99.9)

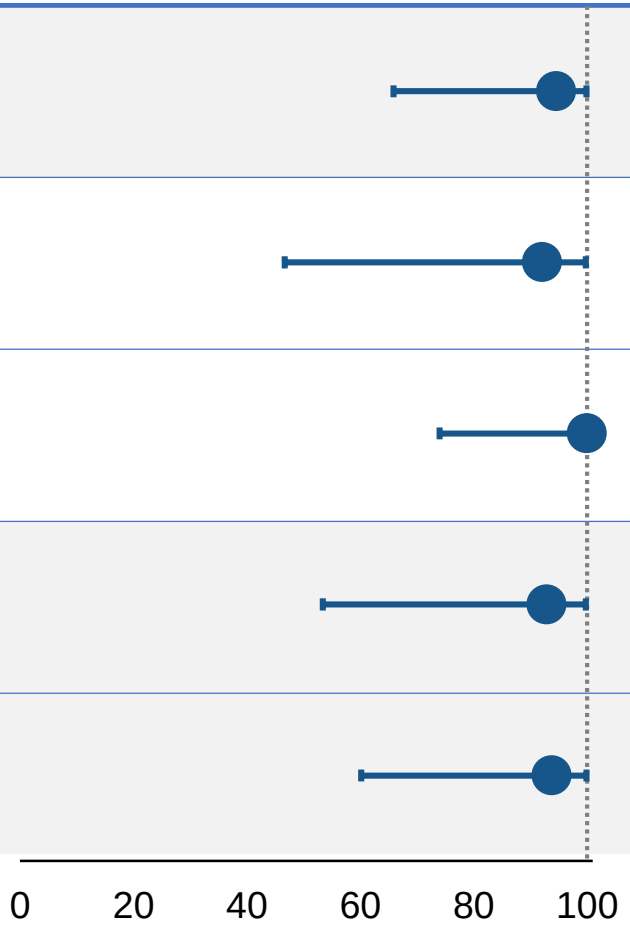


CI, confidence interval.
*95% CI for RSV ARI and RSV confirmed severe LRTD; 96.95% CI for RSV confirmed LRTD
Papi A et al. N Engl J Med 2023;388(7):595–608.

- AREXVY is highly efficacious in older adults at increased risk of severe RSV disease, including those with comorbidities

Core content

	Number of events		**Vaccine efficacy** (95% CI) **against RSV-LRTD**
	AREXVY N=12,466	*Placebo N=12,494*	
≥1 pre-existing comorbidity of interest	1	18	**94.6%** (65.9, 99.9)
≥1 cardiorespiratory condition	1	12	**92.1%** (46.7, 99.8)
≥1 endocrine metabolic condition	0	13	**100%** (74.0, 100)
Pre-frail	1	14	**92.9%** (53.4, 99.8)
70–79 years of age	1 / 4,487	16 / 4,487	**93.8%** (60.2, 99.9)



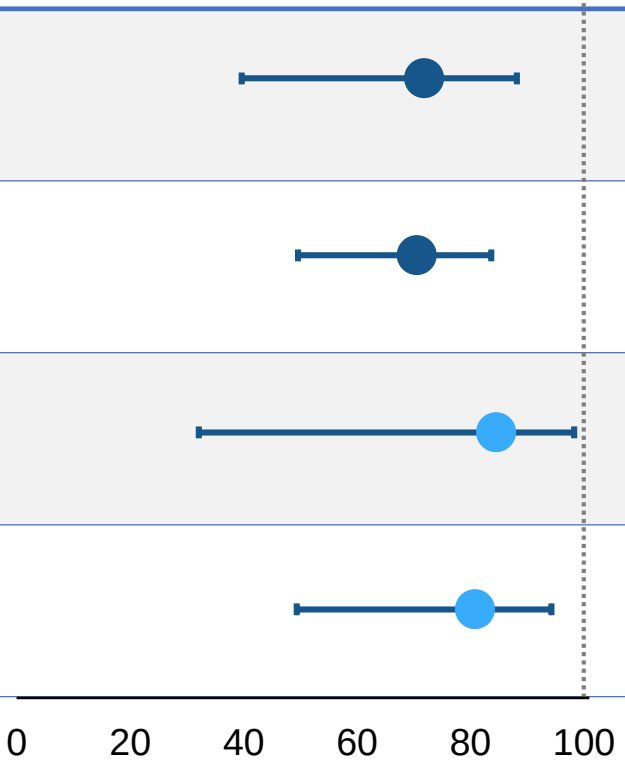
CI, confidence interval; LRTD, lower respiratory tract disease.

Papi A et al. N Engl J Med 2023;388(7):595–608.

- AREXVY provides a similar level of protection against RSV-A and RSV-B

Core content

		Number of events: AREXVY N=12,466	Number of events: Placebo N=12,494	Vaccine efficacy (95% CI)
ARI	RSV-A acute respiratory infection	9	32	71.9% (39.7, 88.2)
ARI	RSV-B acute respiratory infection	18	61	70.6% (49.6, 83.7)
LRTD	RSV-A lower respiratory tract disease	2	13	84.6% (32.1, 98.3)
LRTD	RSV-B lower respiratory tract disease	5	26	80.9% (49.4, 94.3)



Two thirds of RSV-LRTD cases were associated with RSV-B

ARI, acute respiratory infection; LRTD, lower respiratory tract disease.

Papi A et al. N Engl J Med 2023;388(7):595–608.

• AREXVY produces durable vaccine efficacy against RSV-LRTD over 2 RSV seasons

Core content

Efficacy of 1 dose of AREXVY against RSV-associated disease among adults aged ≥60 years

Efficacy evaluation period	RSV-associated LRTD	RSV-associated medically attended* LRTD *(post-hoc analysis)*
Season 1	**82.6%** (57.9–94.1)	**87.5%** (58.9–97.6)
Combined seasons 1 and 2 (interim)	**74.5%** (60.0–84.5)	**77.5%** (57.9–89.0)

No recommendation for a booster at this time

Future data will inform optimal timing of revaccination

Efficacy up to 18 months after was vaccination was shown:

- in the overall population
- against both RSV-A and RSV-B subtypes
- across all age groups
- in participants with comorbidities
- against severe LRTD

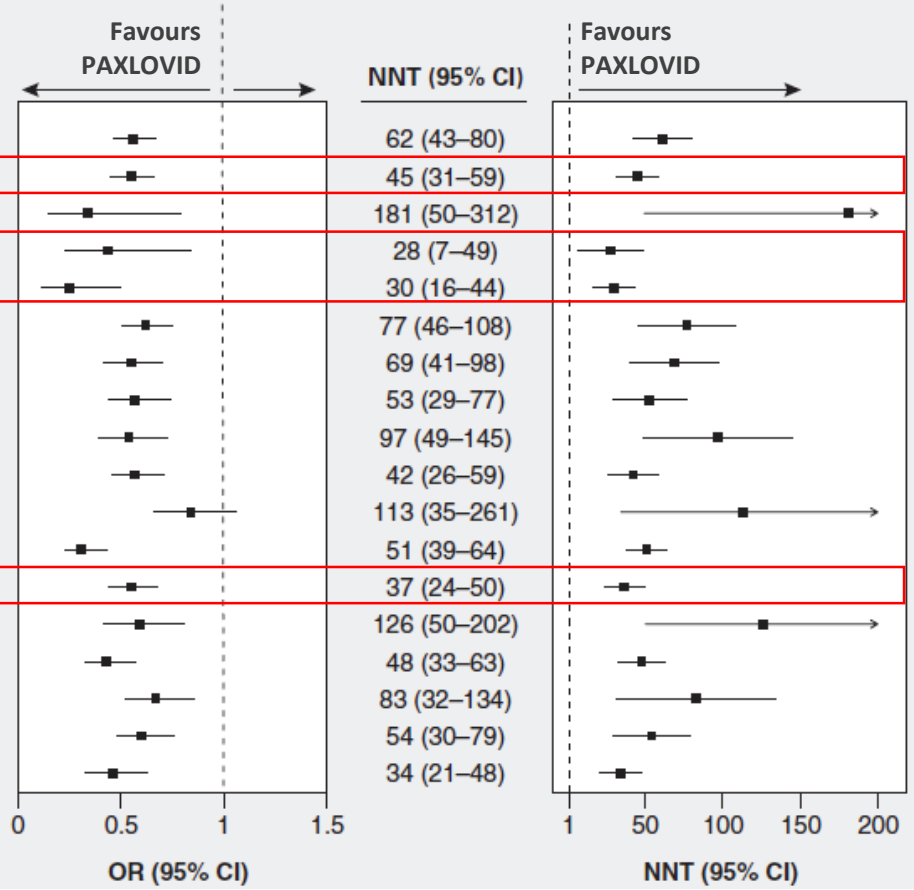
*LRTD prompting any health care visit.
LRTD, lower respiratory tract disease.

Melgar M, et al. MMWR Morb Mortal Wkly Rep 2023;72:793–801.

COVID Treatments

Primary outcome analysis and subgroups

Subgroup	PAXLOVID weighted, %	Unexposed weighted, %	OR (95% CI)	NNT (95% CI)
Primary analysis	2.1	3.7	0.56 (0.47–0.67)	62 (43–80)
Age ≥ 70 yr	2.8	5.0	0.55 (0.45–0.66)	45 (31–59)
Age < 70 yr	0.3	0.8	0.34 (0.15–0.79)	181 (50–312)
No vaccine	3.0	6.6	0.44 (0.23–0.84)	28 (7–49)
Vaccine doses: 1–2	1.1	4.4	0.25 (0.12–0.50)	30 (16–44)
Vaccine doses: 3 or more	2.2	3.5	0.62 (0.51–0.75)	77 (46–108)
Last vaccine dose: 14–179 d	1.8	3.2	0.55 (0.42–0.70)	69 (41–98)
Last vaccine dose: 180 or more d	2.6	4.5	0.57 (0.44–0.74)	53 (29–77)
Comorbidities: 3 or more	1.2	2.3	0.54 (0.39–0.73)	97 (49–145)
Comorbidities: < 3	3.3	5.7	0.57 (0.46–0.71)	42 (26–59)
Long-term care resident	4.7	5.6	0.84 (0.66–1.06)	113 (35–261)
Not in long-term care	0.9	2.9	0.31 (0.23–0.43)	51 (39–64)
OST risk group: high	3.5	6.2	0.55 (0.44–0.68)	37 (24–50)
OST risk group: standard	1.1	1.9	0.59 (0.42–0.81)	126 (50–202)
April to June 2022	1.6	3.7	0.43 (0.33–0.57)	48 (33–63)
July to August 2022	2.6	3.8	0.67 (0.52–0.86)	83 (32–134)
DDI level 2	2.9	4.8	0.60 (0.48–0.76)	54 (30–79)
No DDI	2.6	5.5	0.46 (0.33–0.63)	34 (21–48)



CI, confidence interval; DDI, drug-drug interaction; NNT, number needed to treat; OR, (weighted) odds ratio; OST, Ontario COVID-19 Science Advisory Table.

Schwartz KL, et al. *CMAJ* 2023;195:E220–E226.

Table 4. Risk of hospitalization among outpatient with high-risk of progression to severe COVID-19 who received nirmatrelvir/ritonavir prescription compared to controls

		Before Propensity Score Matching			After Propensity Score Matching					
	Group	Population	Hospitalizations		Population	Hospitalizations		Adjusted Poisson regression with robust error variance[a]		
		N	N	%	N	N	%	RR	CI 95%	P-value
All (incomplete and complete primary vaccination)	Control	242,337	8,293	3.42	8,402	966	11.50	1		
	Treated	16,601	356	2.14	8,402	299	3.56	0.31	0.28; 0.36	<0.001
Incomplete primary vaccination[b]	Control	18,123	1,054	5.82	4,701	631	13.42	1		
	Treated	12,699	62	0.49	4,701	27	0.57	0.04	0.03; 0.06	<0.001
Complete primary vaccination (All)[c]	Control	224,214	7,239	3.23	3,665	309	8.43	1		
	Treated	3,902	294	7.53	3,665	276	7.53	0.93	0.78; 1.08	0.321
• Last vaccine dose ≤ 6 months	Control	139,544	4,987	3.57	2,688	227	8.44	1		
	Treated	2,864	223	7.79	2,688	213	7.92	0.97	0.81; 1.15	0.718
• Last vaccine dose > 6 months	Control	84,670	2,252	2.66	885	97	10.96	1		
	Treated	1,038	71	6.84	885	60	6.78	0.62	0.46; 0.83	0.001
• Less than 70 years (All)	Control	183,690	2,037	1.1	1,869	63	3.4	1		
	Treated	2,137	81	3.8	1,869	74	4.0	1.20	0.87; 1.65	0.269
• Less than 70 years (last dose ≤ 6 months)	Control	105,265	1,136	1.1	1,231	40	3.3	1		
	Treated	1,436	56	3.9	1,231	48	3.9	1.20	0.81; 1.81	0.361
• Less than 70 years (last dose > 6 months)	Control	78,425	901	1.2	579	16	2.8	1		
	Treated	701	25	3.6	579	20	3.5	1.31	0.68; 2.49	0.418
• 70 years and older (All)	Control	40,524	5,202	12.8	1,678	261	15.6	1		
	Treated	1,765	213	12.1	1,678	199	11.9	0.75	0.63; 0.88	0.001
• 70 years and older (Last dose ≤ 6 months)	Control	34,279	3,851	11.2	1,388	181	13.0	1		
	Treated	1,428	167	11.7	1,388	161	11.6	0.89	0.73; 1.08	0.240
• 70 years and older (Last dose > 6 months)	Control	6,245	1,351	21.6	253	58	22.9	1		
	Treated	337	46	13.7	253	30	11.9	0.50	0.34; 0.74	<0.001
• Severely immunocompromised (All)	Control	2,012	452	22.5	519	95	18.3	1		
	Treated	524	63	12.0	519	62	12.0	0.66	0.50; 0.89	0.005
• Severely immunocompromised (Last dose ≤ 6 months)	Control	1,502	334	22.2	369	78	21.1	1		
	Treated	375	44	11.7	369	43	11.7	0.58	0.41; 0.81	0.001
• Severely immunocompromised (Last dose > 6 months)	Control	510	118	23.1	139	32	23.0	1		
	Treated	149	19	12.8	139	19	13.7	0.61	0.37; 0.99	0.047

IPAC in the office

Table 2: Routine Practices for Risk Periods

Routine Practices for Respiratory Viruses	High Risk Period	Non-High Risk Period
HCW Masking for direct patient care	Recommend	Situational^^
HCW Masking in inpatient clinical areas	Strongly consider^	Situational^
HCW Masking in outpatient clinical areas	Consider^	Situational**
HCW Masking in non-clinical areas (i.e., no patient care activities performed/delivered)	Consider*	Situational**
Eye protection when within 2 metres of an asymptomatic patient	As per Personal Risk Asessement (Routine Practices)	As per Personal Risk Asessement (Routine Practices)
Asymptomatic Patient masking†	Recommend when ambulatory. Consider when in bedspace while receiving care.	Situational†††
Visitor/essential caregiver masking in clinical areas	Recommend††	Situational**

Table 1: Framework for Transmission Risk Periods

Indicator	High Risk Period	Non-High Risk Period
Respiratory virus outbreaks in health care facilities	Frequent and ongoing	Infrequent or baseline
Hospitalizations and ICU admissions*	High and /or upward trajectory	Baseline and stable
Community transmission**	High and /or increasing	Low to moderate and stable

*Secondary to acute respiratory virus infection. May include local or provincial context depending on organization. Metrics to consider as a proxy for disease severity include hospitalized cases or daily number of hospitalizations per 100 000 community population

**Metrics to consider as a proxy for community transmission include:

1. Community positivity rates
2. Staff metrics including staff positivity rates and/or absenteeism
3. Wastewater surveillance trends

Return to work

- Ideally isolate for 10 days, minimum 5
- If mission critical consider return to work early – 24 hours fever free, symptoms improving
  - Prioritize people closest to 5-10 day mark
- For people who are within contagious period – well fitted mask at all times with others, provide safe environments for unmasking (eating etc) in isolation
- Many not being tested for COVID – for ARI - 24 hours fever free, symptoms improving, reinforce mask guidance as above

Supporting Family Doctors In Practice

Fall 2023

Ontario College of Family Physicians

Leaders for a healthy Ontario

October 6, 2023

Clarifying CPSO Advice

- You told us that unnecessary and inappropriate burden was being placed onto family doctors and your practice.
- You asked for clarification on CPSO advice. We took action to seek clarification from the CPSO.
- Visit ‘Advice to the Profession: Continuity of Care’

CPSO clarifies advice in two policies to bolster collaboration

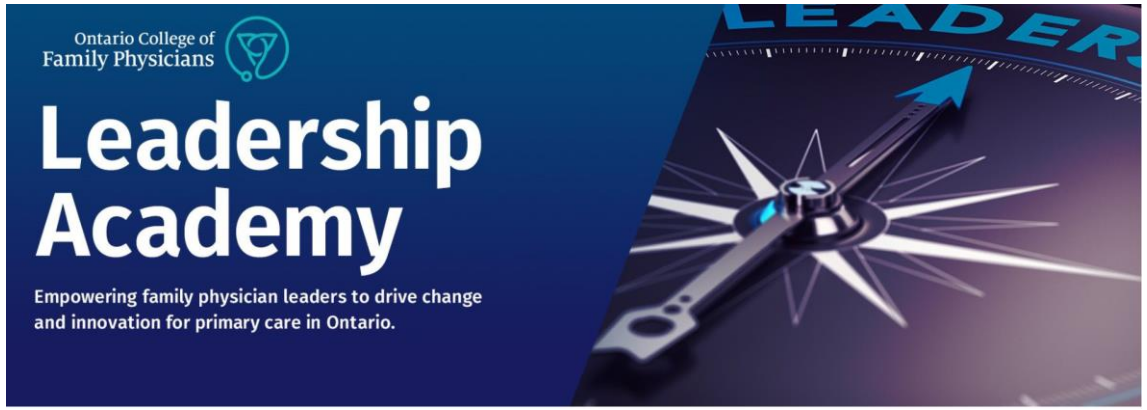
Primary Care Networks & OCFP Leadership Academy

Primary Care Networks

- 12 OHTs will be supported to accelerate OHT progress and impact and Primary Care Networks (PCNs) will be a necessary building block in that process.

OCFP Leadership Academy

- Applications for the second cohort are now open!
- Virtual and in-person learning, running from February 2024 to December 2024.

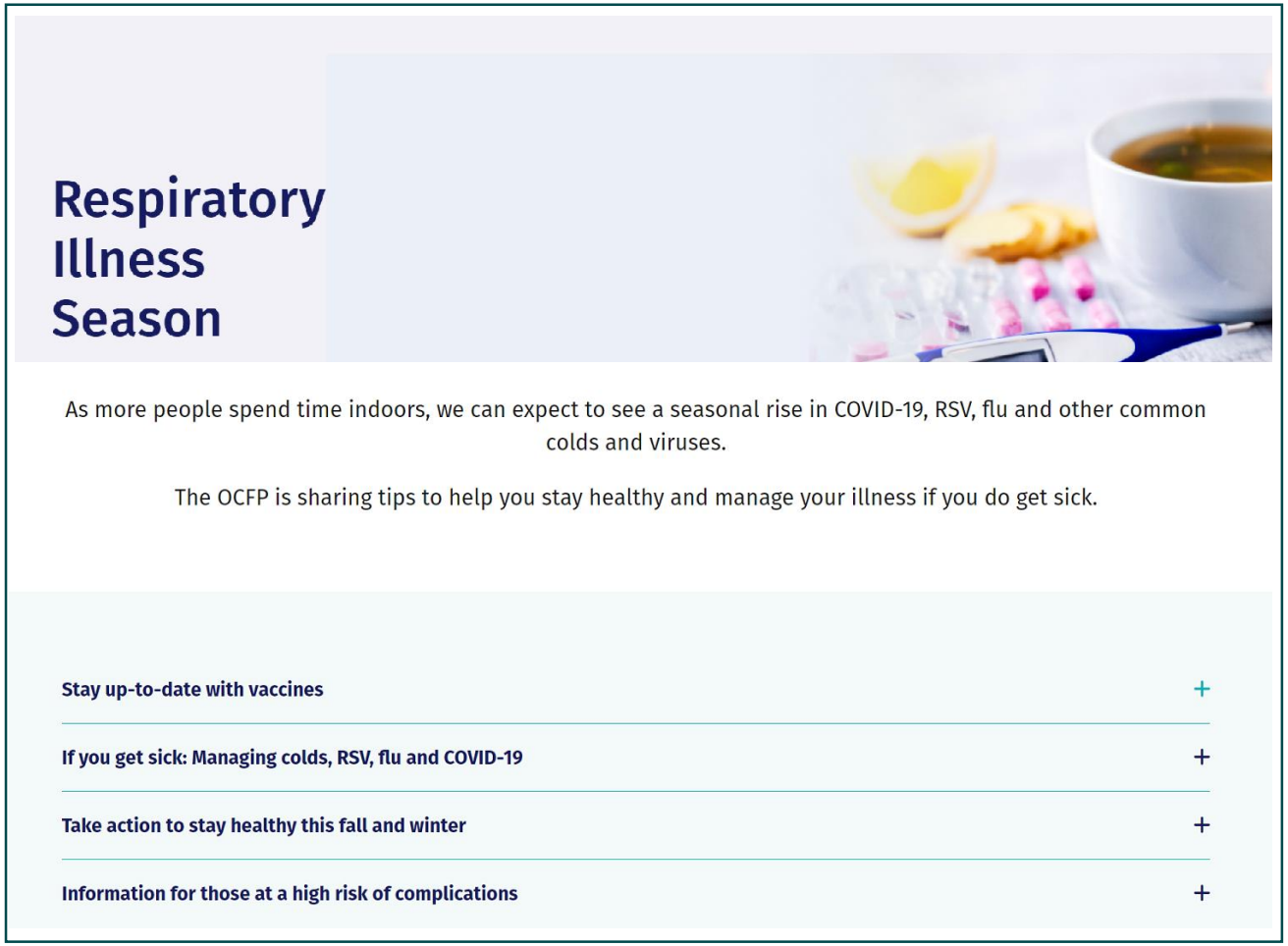


Future OCFP Leadership Academy alumni will be well-equipped to lead Primary Care Networks.

Reminder: Respiratory Illness Resources

Resources available at:

StayHealthyOntario.ca



Respiratory Illness Season

As more people spend time indoors, we can expect to see a seasonal rise in COVID-19, RSV, flu and other common colds and viruses.

The OCFP is sharing tips to help you stay healthy and manage your illness if you do get sick.

- Stay up-to-date with vaccines +
- If you get sick: Managing colds, RSV, flu and COVID-19 +
- Take action to stay healthy this fall and winter +
- Information for those at a high risk of complications +

Primary Care: Supports for the Fall/Winter Respiratory Season

Dr. Liz Muggah

Senior Clinical Advisor, Primary Care

6 October 2023

Ontario Health

Snapshot

- Volume of primary care visits (OHIP) has recovered to pre-pandemic levels
- Anticipate further increase in demand through the fall
- Recognize and value primary care's critical role in preventing and caring for febrile respiratory illness
- Ontario Health will be sending out an operational direction for the whole health system and separately a primary care memo with resources

Ontario Health resources and supports related to the primary care of respiratory illness

Access to Ontario Health Clinical Services – Health811

For non-urgent health inquiries and questions, including those regarding respiratory illnesses, Ontarians can access Health811:

- Available 24/7 by calling 811 (TTY: 1-866-797-0007)
- Live online chat at ontario.ca/health811 (French: ontario.ca/sante811)
- Translation for the phone service is available in over 200 languages

Services offered through Health811:

- 24/7 access to health advice from registered nurses
- Assistance locating health services, including virtual urgent care
- Online symptom assessment tool
- Advice from registered dietitians, lactation consultants, smoking cessation coaches
- Free FIT kits for colorectal cancer screening

Regional Virtual Urgent Care Programs

- Regional virtual urgent care programs, staffed by nurse practitioners, are available for individuals without a primary care clinicians or those unable to reach their clinician.

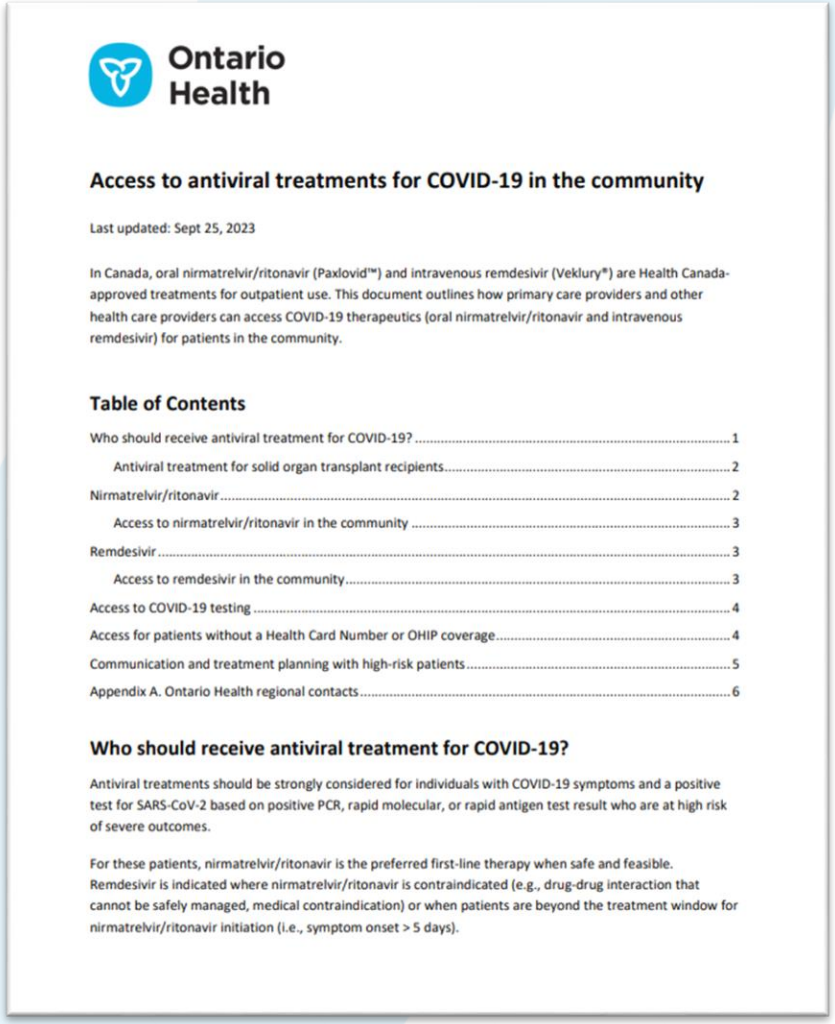
  - Central Region (Adult and Pediatric) - Oak Valley Health
  - Toronto Region (Adult) - Sunnybrook Health Sciences Centre/University Health Network
  - Toronto Region (Pediatrics) – SickKids
  - Toronto Region (Mental Health) - Centre for Addictions and Mental Health
  - East Region (Adult and Pediatrics) - Durham Community Health Centre
  - West Region (Adult) - St. Joseph's Healthcare Hamilton
  - West Region (Pediatrics) - London Health Science Centre

Access to PPE and Rapid Tests

- To help ensure a steady supply of PPE and rapid antigen tests to support your clinical needs:
  - Personal protective equipment (PPE) and essential supplies, including rapid antigen tests, continue to be accessible through the Provincial PPE Supply Portal (now managed by Supply Ontario)
  - New users can register for access to the portal

COVID-19 Treatment

- Ontario Health has released updated guidance for accessing antiviral treatments for COVID-19 in the community
- Paxlovid handout for patients available in 29 languages
- Information and referral process for remdesivir
  - Recommendations for Outpatient Use of Intravenous Remdesivir (Veklury) in Adults
  - Remdesivir infusion referral forms and procedures



Ontario Health

Access to antiviral treatments for COVID-19 in the community

Last updated: Sept 25, 2023

In Canada, oral nirmatrelvir/ritonavir (Paxlovid™) and intravenous remdesivir (Veklury®) are Health Canada-approved treatments for outpatient use. This document outlines how primary care providers and other health care providers can access COVID-19 therapeutics (oral nirmatrelvir/ritonavir and intravenous remdesivir) for patients in the community.

Table of Contents

Who should receive antiviral treatment for COVID-19?

Antiviral treatments should be strongly considered for individuals with COVID-19 symptoms and a positive test for SARS-CoV-2 based on positive PCR, rapid molecular, or rapid antigen test result who are at high risk of severe outcomes.

For these patients, nirmatrelvir/ritonavir is the preferred first-line therapy when safe and feasible. Remdesivir is indicated where nirmatrelvir/ritonavir is contraindicated (e.g., drug-drug interaction that cannot be safely managed, medical contraindication) or when patients are beyond the treatment window for nirmatrelvir/ritonavir initiation (i.e., symptom onset > 5 days).

Regional Support for Primary Care

Region	Contact	Regional Primary Care Leads
Toronto	Rose Cook	Dr. Danielle Martin
East	Dr. David Zelt	Dr. Alison Eyre Dr. Anna Chavlovski
West	Dr. Jennifer Everson	Dr. Paul Gill Dr. Gordon Schacter Dr. Sharon Bal Dr. Scott Elliott
Central	Dr. Mira Backo-Shannon	Dr. Sohal Goyal Dr. David Daien
North East and North West	Dr. Paul Preston	Dr. Stephen Cooper (North East) Dr. Lisa Habermehl (North West)

Dr. Liz Muggah
Senior Clinical Advisor, Primary Care

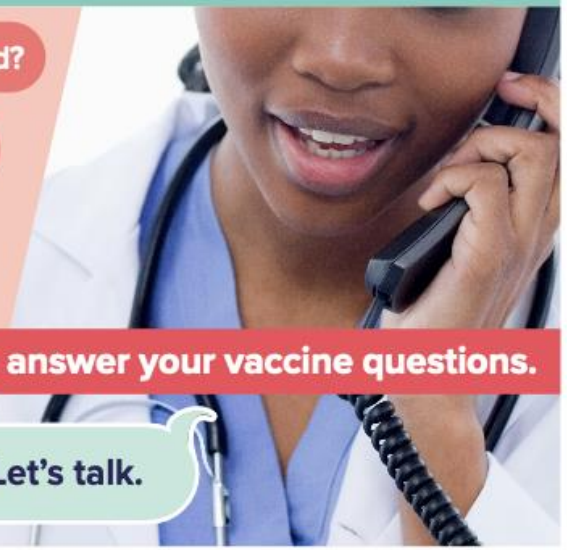
Elizabeth.Muggah@ontariohealth.ca

Wondering if you should get boosted this Fall?

What if I recently had Covid?

Is the booster Omicron-specific?

What about boosters for my kids?



Our doctors are here to answer your vaccine questions.

I can help. Let's talk.

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!

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

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

SHN SCARBOROUGH HEALTH NETWORK | VaxFacts+ CLINIC

Ontario College of Family Physicians

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Contact us at fms@ocfp.on.ca

REGISTRATION NOW OPEN!

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: October 27, 2023

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.

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of Family Physicians
Leaders for a healthy Ontario