COVID-19 Community of Practice for Ontario Family Physicians

April 26, 2024

Dr. Allison McGeer
Dr. Joan Flood

Infectious Disease Updates and Approaching ADHD

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of
Family Physicians

Infectious Disease Updates and Approaching ADHD

Moderator:

- Dr. Ali Damji, Mississauga, ON

Panelists:

- Dr. Allison McGeer, Toronto, ON
- Dr. Joan Flood, Toronto, ON

Host:

- Dr. Mekalai Kumanan, Cambridge, ON

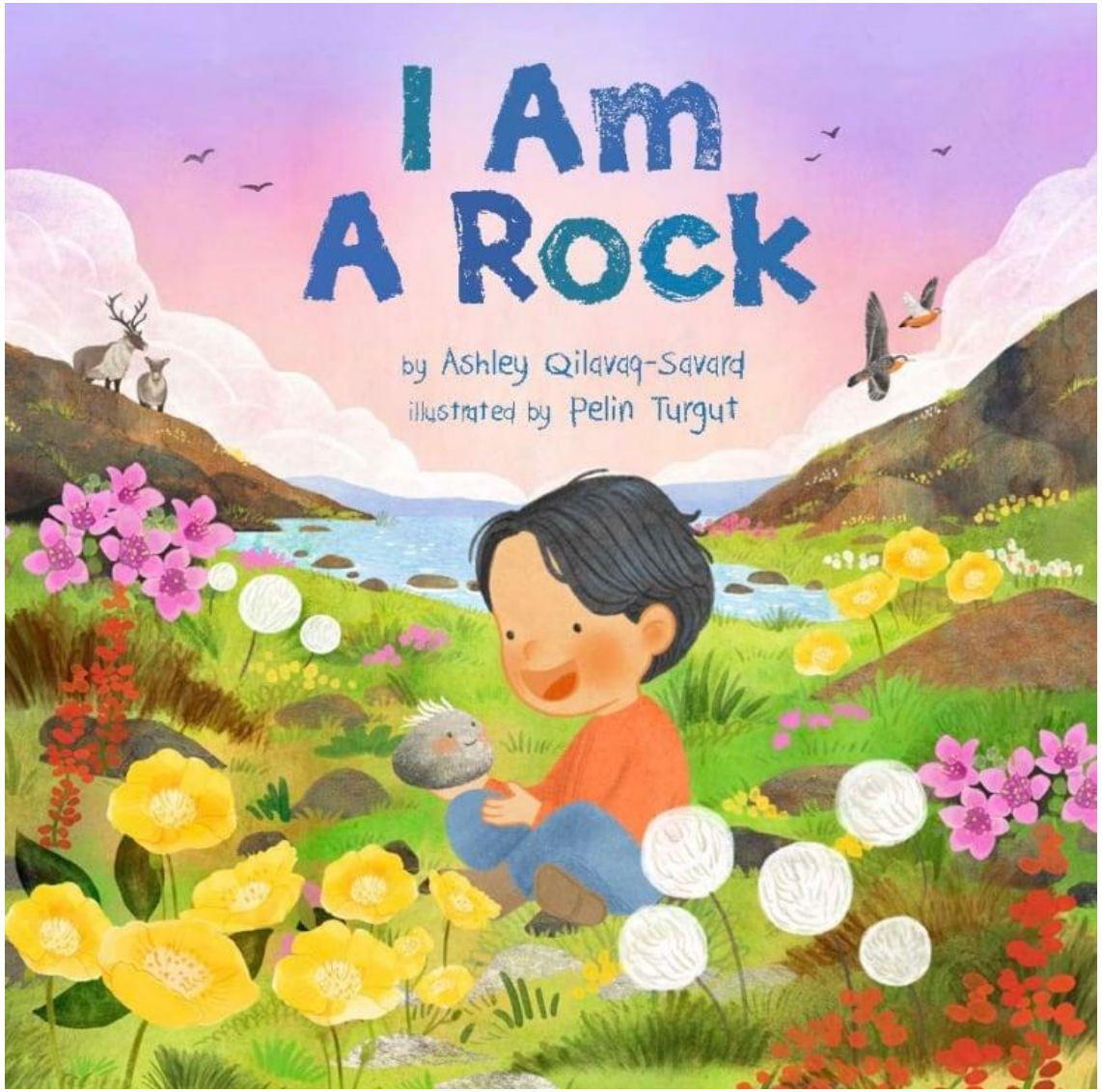
The COVID-19 Community of Practice for Ontario Family Physicians is a one-credit-per-hour Group Learning program that has been certified for up to a total of 32 credits.

Land Acknowledgement

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

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

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



13 Canadian books to read for Earth Day 2024:

https://www.cbc.ca/books/13-canadian-books-to-read-for-earth-day-2024-1.7180913

Changing the way we work

A community of practice for family physicians during COVID-19

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

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

Disclosure of Financial Support

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

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

Mitigating Potential Bias

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

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

Previous webinars & related resources:

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

Dr. Allison McGeer – Panelist

Infectious Disease Specialist, Mount Sinai Hospital

Dr. Joan Flood – Panelist

Family Physician & Board Member of CADDRA,
the Canadian ADHD Resource Alliance

Dr. Mekalai Kumanan – Host

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President, Ontario College of Family Physicians
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Speaker Disclosure

- Faculty Name: **Dr. Allison McGeer**
- Relationships with financial sponsors:
  - Grants/Research Support: Pfizer, SanofiPasteur, CIHR, CITF, PSI, PHAC, CIRN, Appili Therapeutics
  - Speakers Bureau/Honoraria: Moderna, Pfizer, AstraZeneca, Novavax, SanofiPasteur, GSK, Merck, Roche, Seqirus
  - Others: N/A

- Faculty Name: **Dr. Joan Flood**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians, Elvium, Janssen-Ortho, Kye, Otsuka, Takeda
  - Others: CADDRA – the Canadian ADHD Resource Alliance (board member)

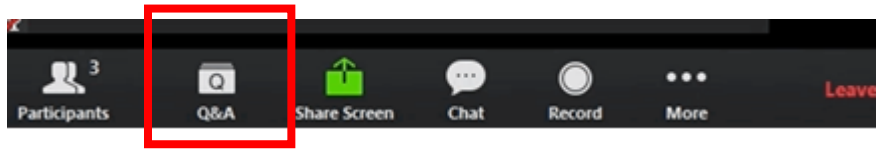
Speaker Disclosure

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

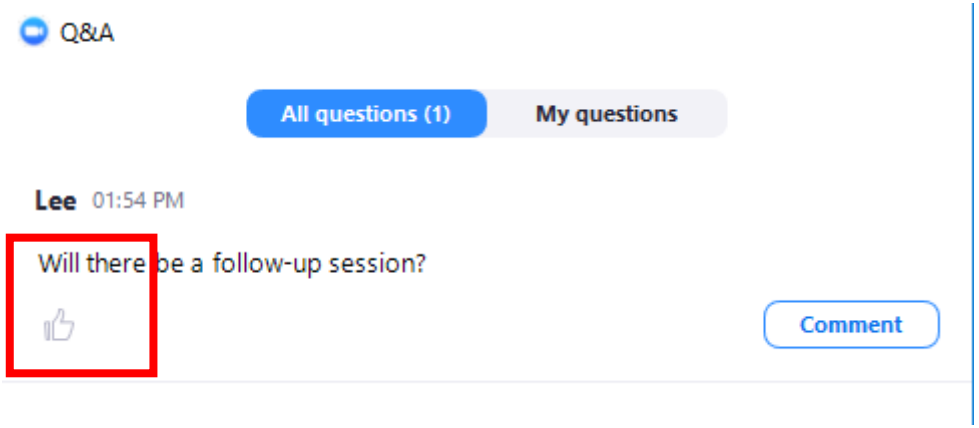
- Faculty Name: **Dr. Ali Damji**
- Relationships with financial sponsors:
  - Grants/Research Support: N/A
  - Speakers Bureau/Honoraria: Ontario College of Family Physicians
  - Others: N/A

How to Participate

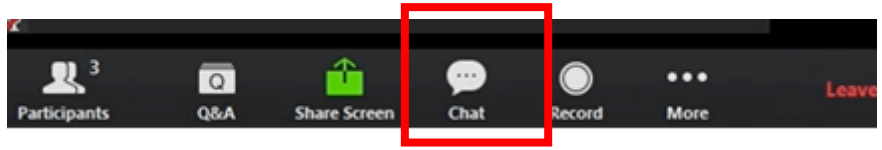
- All questions should be asked using the Q&A function at the bottom of your screen.



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



- Please use the chat box for networking purposes only.



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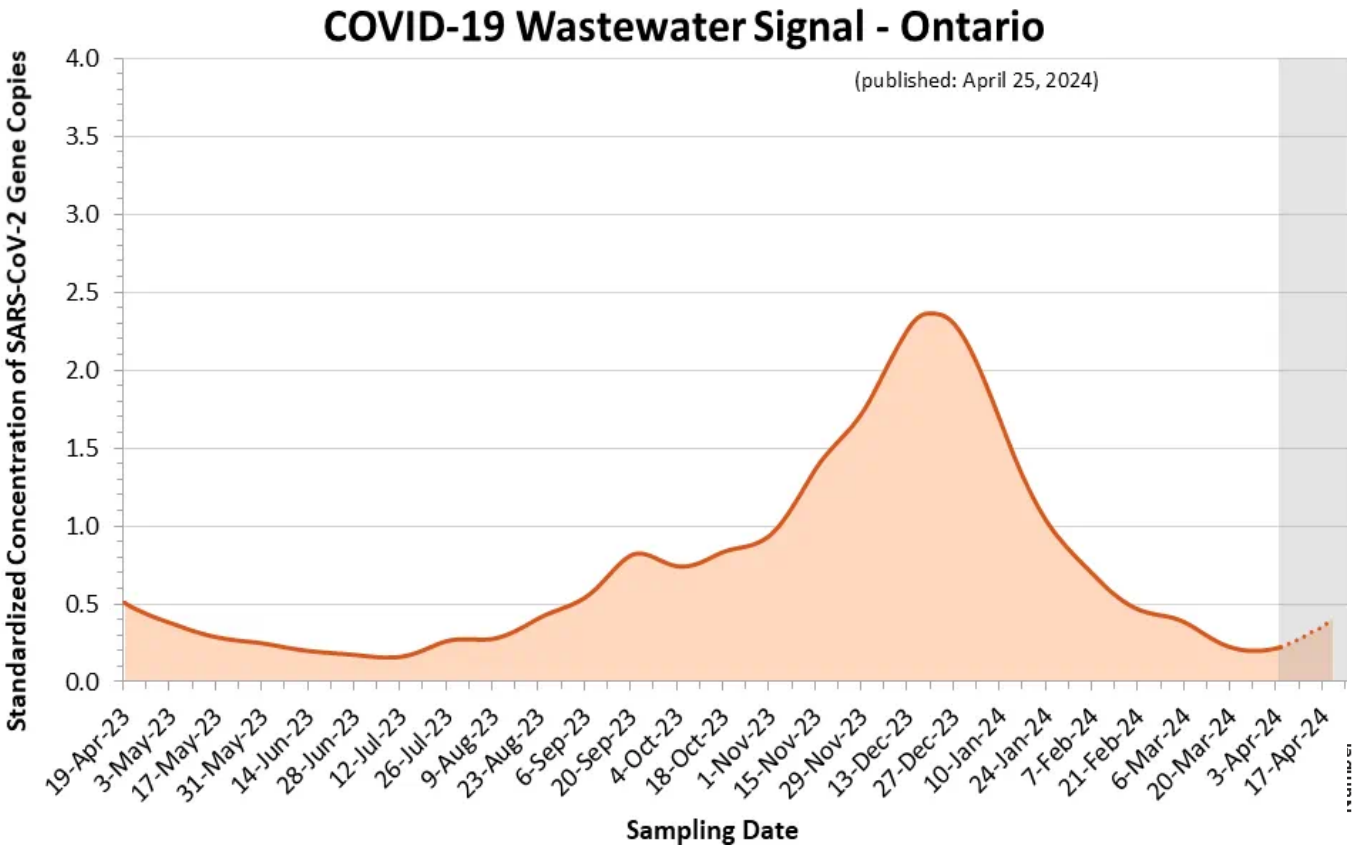
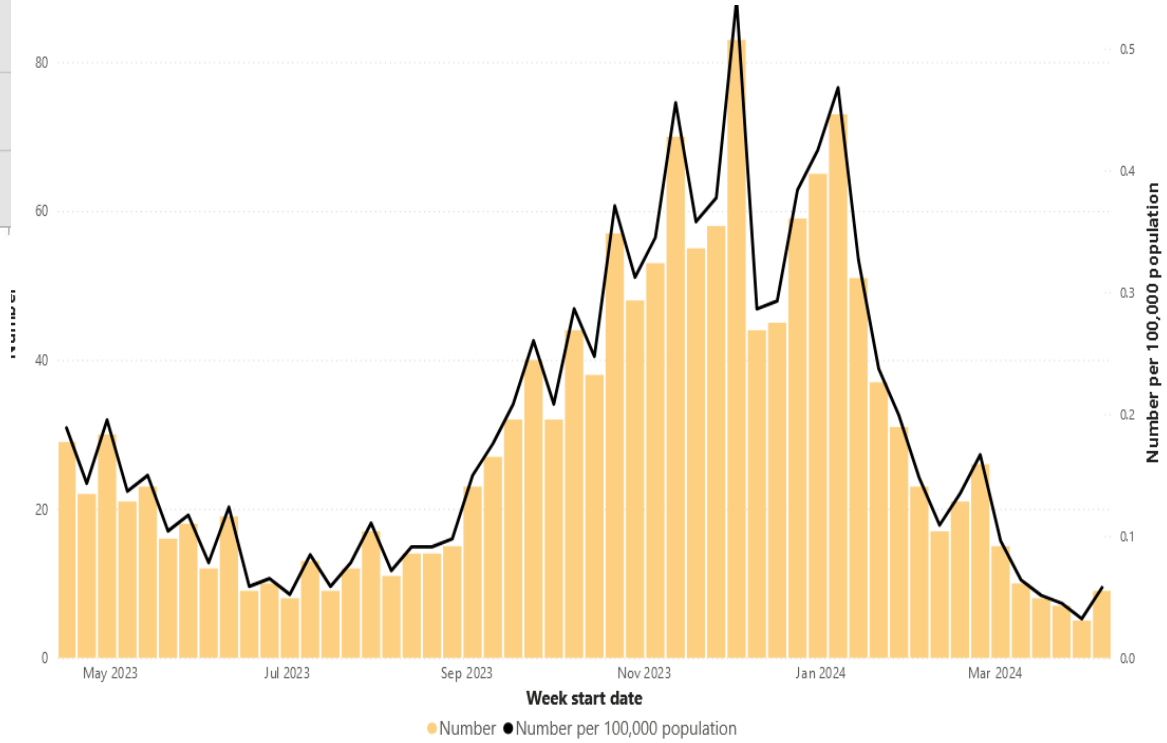
COVID indicators





An Advisory Committee Statement (ACS)
National Advisory Committee on Immunization (NACI)

Guidance on the use of COVID-19 vaccines during the fall of 2024

Public Health Agency of Canada / Agence de la santé publique du Canada

Canada

Recommendations

- **SHOULD** be vaccinated:
  - Adults >65 yrs of age
  - Residents of LTC/congregate living
  - Individuals with co-morbidities placing them at higher risk
  - Individuals who are pregnant
  - Individuals from First Nations, Métis and Inuit communities
  - Members of racialized or other equity deserving communities
  - Essential service providers

- **MAY** be vaccinated
  - all other individuals 6 months of age and over

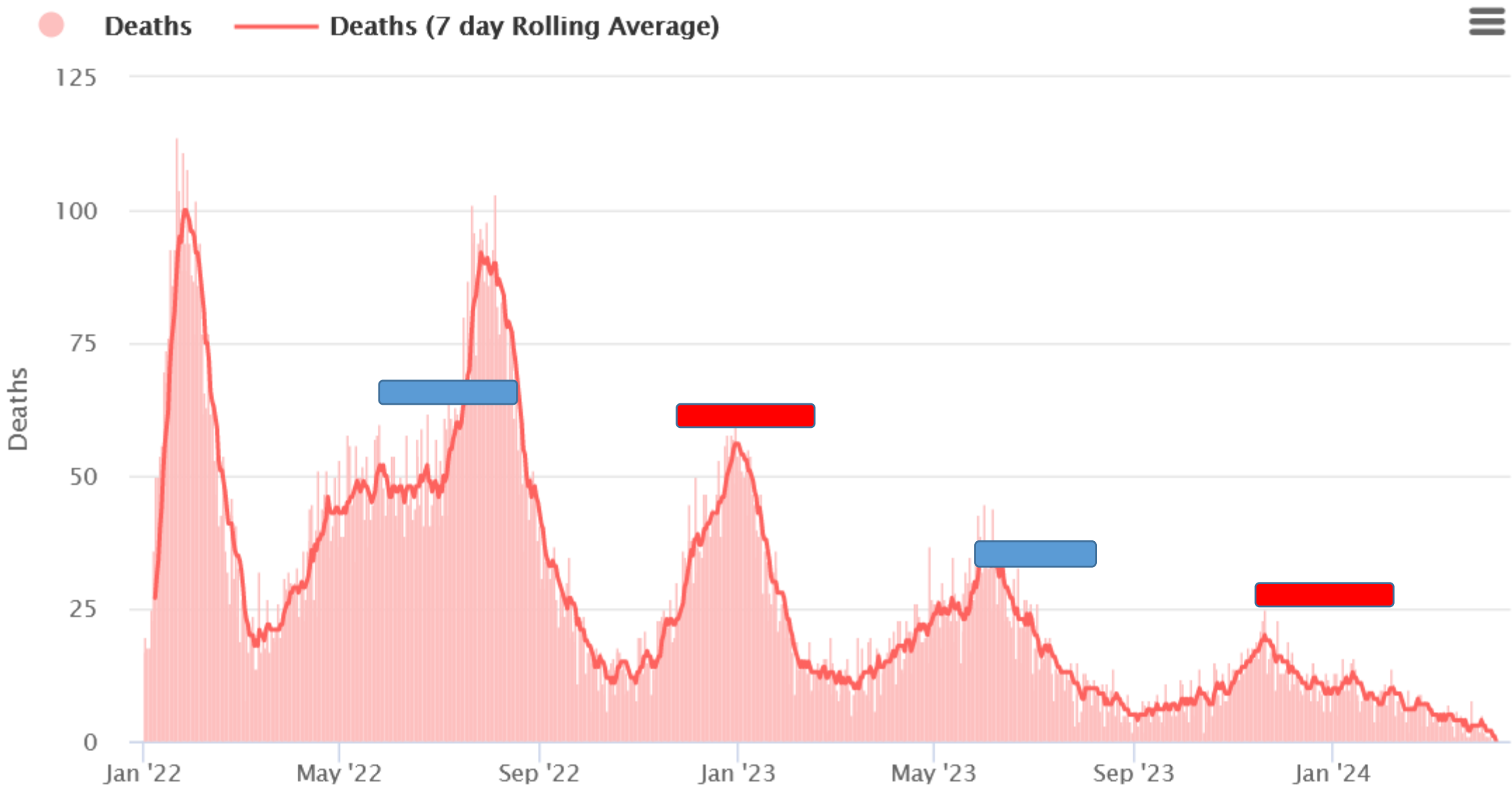
Other notes:

- NACI
  - Cost effectiveness for adults 65 and over: $8099/QALY (all eligible $12,518)
  - Clear minimum interval of 3 months
  - Co-administration with influenza/pneumococcal/shingles vaccines OK

- FDA meeting for strain selection for 2024 fall COVID-19 vaccines is May 16, 2024
- New US NASEM report on COVID-19 vaccine safety

https://www.fda.gov/advisory-committees/advisory-committee-calendar/vaccines-and-related-biological-products-advisory-committee-may-16-2024-meeting-announcement#event-information
https://nap.nationalacademies.org/read/27746/chapter/1

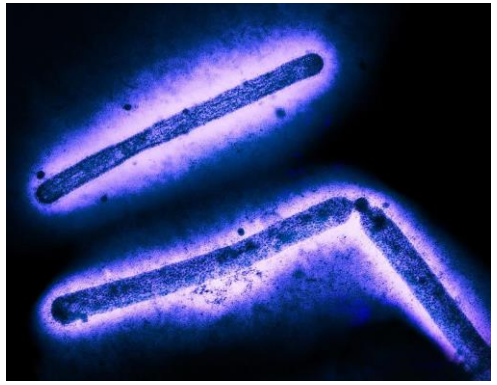
COVID-19 associated deaths, Australia, 01 Jan 2022 to 10 Apr 2024



CADTH:
coverage recommendation today

Provincial recommendation:
?2nd week May

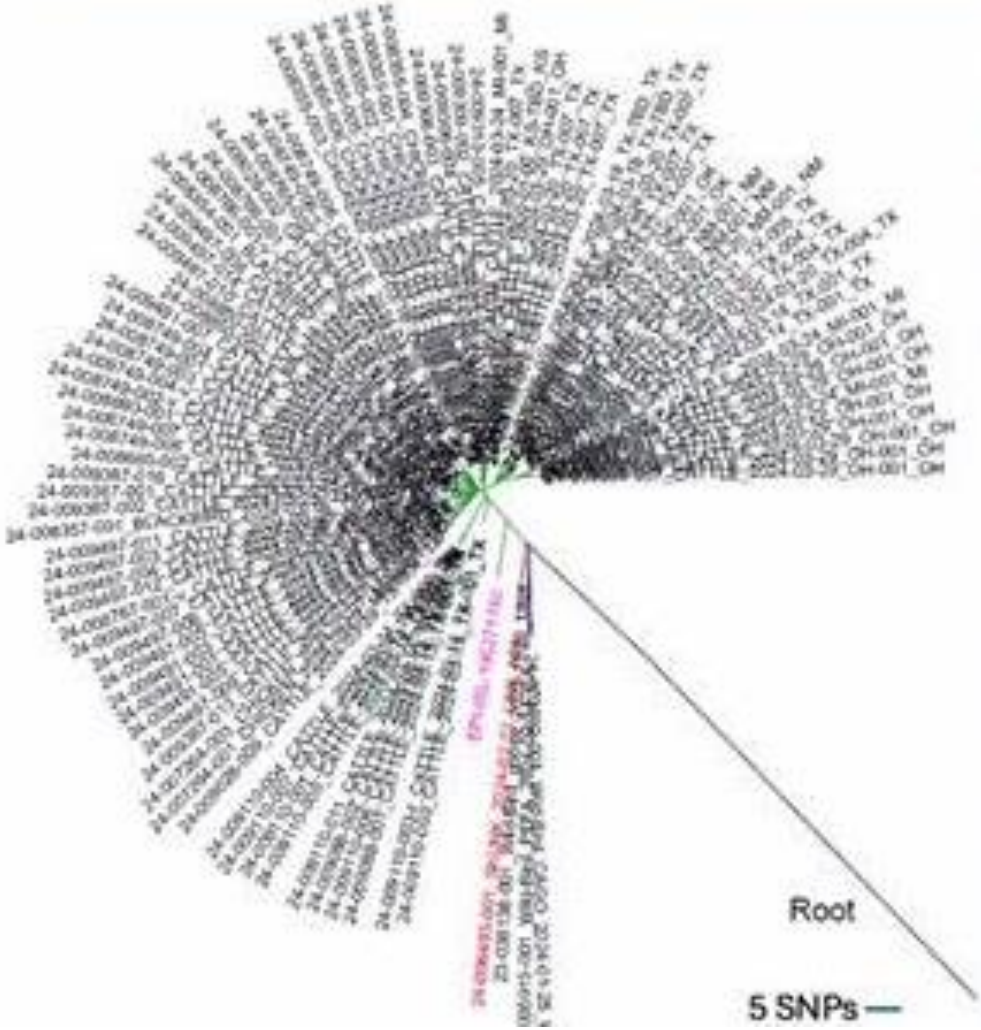
H5N1 and cows?



Phylogenetic tree of cattle isolates

Genotype B3.13 Cattle Detections

- No significant changes compared to other genotypes
- Similarity between viruses indicates clonal expansion versus different independent introductions
- Distinct ancestral branch related to dairy detections (common ancestor)
- Independent analysis by ARS supports a single introduction, currently estimated in early February 2024



Congratulations Dr. Allison McGeer!

- One of Canada's most trusted policy advisors in the field of infectious disease.
- Expertise was integral to combatting emerging infections including:
  - 2003 SARS pandemic
  - MERS outbreak in Saudi Arabia
  - Ebola outbreak in West Africa
  - COVID-19 pandemic

Ministry of Health Announcement: Admin burden

On April 24, the Minister of Health announced two changes to address the overwhelming administrative burden family doctors are facing:

- Employers will no longer require sick notes to be provided by a health care practitioner for absences of three days or less.
- A new pilot program that will test the use of an AI scribe with +150 primary care providers.

Vaccine Injury Support Program

Eligibility Criteria

All of the below criteria must be met in order to submit a successful claim.

Authorized Vaccine

Any person receiving a Health Canada authorized vaccine.

Time Frame

Claims can be filed within three years after the date of vaccination, date of death or date when an injury first becomes apparent.

Injury Reported

Injury reported to health care provider.

Eligibility Date

Date of vaccination was on or after December 8, 2020.

Administered in Canada*

The vaccine was administered in Canada.

*Exceptions apply

Serious and Permanent

The injury is serious and permanent or has resulted in death.

What does this mean for family physicians?

- Eligible patients or their representatives may ask about their eligibility for the program
- If your patient submits a claim, you will be asked to complete a medical assessment form
- You may be asked to provide additional medical records by VISP

For more information about the program, eligibility and the claims process: Vaccine Injury Support Program

ADHD – Myths, Pearls & Random Thoughts

Dr. Joan Flood

The Possibilities Clinic

A quick review – the facts.

- **ADHD is a neurodevelopmental disorder, usually genetic in origin:**
- MRI studies show volumetric decreases in cerebrum and cerebellum
- Delayed cortical thinning and maturation of the cerebral cortex in youth
- Abnormal connections in the corticolimbic system
- ***Pearl: These are the same areas that are affected by cannabis use***
- Impaired synaptic release of dopamine (attention) & norepinephrine (emotional/motor regulation) – medications target this acting as reuptake inhibitors

ADHD & Public Health

ADHD is linked to increased adverse consequences in nearly every major domain of life activity studied to date (Barkley & Fischer, 2018)

Increased accidental & self-inflicted injuries, motor vehicle accidents, obesity, tobacco, alcohol, and marijuana use, dental caries; sedentary behavior, low rates of exercise, sleeping problems, migraines, poor nutrition

Barkley found in a long-term follow-up study that adults with ADHD have a 12.7-year decrease in Estimated Life Expectancy

Less education, less annual income, greater consumption of alcohol and tobacco, diminished sleep, and poorer overall health status relative to the control group – plus behavioural traits – impulsivity, poor inhibition – all play a factor

What Individuals with ADHD Experience

ADHD : Attention-deficit/hyperactivity disorder

Bjerrum MB, et al. JBI Database Syst. Rev. Implement. Rep. 2017;15(4):1080-1153

How to Diagnose in 15 minutes

So, you can't diagnose ADHD in 15 minutes – but you can diagnose in 4 x 15-minute appointments

1. The patient is concerned: Get a history of the symptoms, impairments and how long it has been going on. Provide rating scales (**SNAP, ASRS, WFIRS**) & resources (**caddac.ca, ADDitudemagazine.com**). Ask them to bring in grade school report cards. Tell the patient you will need to see them for a few appointments to ascertain if they have ADHD.

2. Second appointment – review **history, family history, educational and occupational history, current impairments**. Tell the patient you will review their questionnaires.

How to Diagnose in 15 minutes x 4 appts…

- 3. Meet with the patient and **educate** about ADHD: options for treatment and psychosocial supports, accommodations for school, medical and co-morbid diagnoses, need for daily medication.

- 4. If you are satisfied with the validity of the diagnosis, start meds. **Explain treatment options to patient** – only long-term meds, no short-acting meds. Different stimulants, duration of action, specific indications (e.g. Vyvanse is also indicated for binge eating disorder), titration and need for regular follow-up and measurement of BP/HR.

Myth: the gold standard for diagnosis is a psychological assessment

NOOOO!!!

The gold standard is like all psychiatric diagnoses – a thorough history supported by collaborative information from rating scales, family members, school records.

Key Questions to help tease out ADHD in Adults

- Have you had long-standing and consistent problems with attention & distractibility?
- Have your current complaints (of executive dysfunction) been present over the last 10 -20 years?
- If I could see you in the classroom, you were in as a child, what would you be like?
- ***Pearl – do they have a 'PDF file = procrastination, distractibility, forgetfulness'?***

Katzman et al, BMC Psychiatry. 2017.

Comorbidities

ADHD rarely occurs in isolation

Anxiety, Depression, Substance Use, Bipolar Disorder, Borderline Personality Disorder, Autism, Learning Disorders, PTSD..

Pearl: Keep in mind that you may see the co-morbidity before you realize that the underlying diagnosis is ADHD – they may be depressed or anxious because of their failures and inability to keep up in life

50% to 90% of children and 85% of adults with ADHD have at least one comorbid condition

CADDRA. Canadian ADHD Practice Guidelines, 4.1 Edition, 2020;
*Based on faculty expert opinion and experience

Clinical situations:

- My patient used to abuse cannabis – so I can’t use stimulants
- My patient is middle-aged and hypertensive – so I can’t use stimulants
- My patient is partying on the weekend – so they should skip their meds
- My patient only needs meds for school/work days – so drug ‘holidays’ are a good idea
- My patient is over 60 - they've gotten this far so why does it matter?

CADDRA GUIDE TO ADHD PHARMACOLOGICAL TREATMENTS IN CANADA - NOVEMBER 2022

	Medications & Illustrations		Delivery	Duration of action[1]	Starting dose[2]	Release mode Immediate/ Delayed (%)	Dose titration per product monograph[3]
AMPHETAMINE-BASED PSYCHOSTIMULANTS							
First Line	Adderall XR®	Capsules 5, 10, 15, 20, 25, 30 mg 	Granules can be sprinkled	~12 h	5-10 mg q.d. a.m.	50/50	▲5-10 mg at weekly intervals Max. dose/day: Children = 30 mg Adolescents & Adults = 20-30 mg
First Line	Vyvanse®	Capsules 10, 20, 30, 40, 50, 60, 70[4] mg  Chewable Tablets 10, 20, 30, 40, 50, 60 mg 	Capsule content can be diluted in liquid or sprinkled Chewable tablets should be chewed thoroughly	~13-14 h	20-30 mg q.d. a.m.	Not Applicable (Prodrug)	▲10-20 mg by clinical discretion at weekly intervals Max. dose/day: All ages = 60 mg
Second Line	Dexedrine®	Tablets 5 mg  Spansules 10, 15 mg 	Scored Tablet Beaded Formulation	~4 h ~6-8 h	Tablets = 2.5 to 5 mg b.i.d. Spansules = 10 mg q.d. a.m.	100/0 50/50	▲5 mg at weekly intervals Max. dose/day: (q.d. or b.i.d.) Children & Adolescents = 20-30 mg Adults = 50 mg
METHYLPHENIDATE-BASED PSYCHOSTIMULANTS							
First Line	Biphentin®	Capsules 10, 15, 20, 30, 40, 50, 60, 80 mg 	Granules can be sprinkled	~10-12 h	10-20 mg q.d. a.m.	40/60	▲10 mg at weekly intervals Max. dose/day: Children & Adolescents = 60 mg Adults = 80 mg
First Line	Concerta®	Extended Release Tablets 18, 27, 36, 54 mg 	Osmotic-Controlled Release Oral Delivery System (OROS®)	~12 h	18 mg q.d. a.m.	22/78	▲18 mg at weekly intervals. Max. dose/day: Children & Adolescents = 54 mg Adults = 72 mg
First Line	Foquest®	Capsules 25, 35, 45, 55, 70, 85, 100 mg 	Granules can be sprinkled	~13-16 h	25 mg q.d. a.m.	20/80	▲10-15 mg in intervals of no less than 5 days Max. dose/day: Children & Adolescents = 70 mg Adults = 100 mg
Second Line	Methylphenidate short-acting	Tablets 5 mg (generic) 10, 20 mg (Ritalin®) 	Scored Tablet	~3-4 h	5 mg b.i.d. to t.i.d.	100/0	▲5-10 mg at weekly intervals Max. dose/day: All ages = 60 mg
	Ritalin®SR	Tablets 20 mg 	Wax Matrix Preparation	~8 h	Adult: 20 mg q.d.	100/0	
NON-PSYCHOSTIMULANT - SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR							
Second Line	Strattera® (Atomoxetine)	Capsules 10, 18, 25, 40, 60, 80, 100 mg 	Capsule needs to be swallowed whole to reduce GI side effects	Up to 24 h	Children & Adolescents: 0.5 mg/kg/day Adults = 40 mg q.d. for 7-14 days	Not Applicable	Maintain dose for a minimum of 7-14 days before adjusting: Children = 0.8 then 1.2 mg/kg/day 70 kg or Adults = 60 then 80 mg/day Max. dose/day: 1.4 mg/kg/day or 100 mg
NON-PSYCHOSTIMULANT - SELECTIVE ALPHA-2A ADRENERGIC RECEPTOR AGONIST							
Second Line	Intuniv XR® (Guanfacine XR)	Extended Release Tablets 1, 2, 3, 4 mg 	Pills need to be swallowed whole to keep delivery mechanism intact	Up to 24 h	1 mg q.d. (morning or evening)	Not Applicable	Maintain dose for a minimum of 7 days before adjusting by no more than 1 mg increment weekly. Max. dose/day: Monotherapy: 6-12 years = 4 mg, 13-17 years = 7 mg As adjunctive therapy to psychostimulants: 6-17 years = 4 mg

Illustrations do not reflect actual size of pills/capsules. Longer-acting stimulants tend to have lower abuse potential than shorter-acting formulations. Non-stimulant formulations have no abuse potential.
[1]Pharmacokinetic and pharmacodynamic responses vary from individual to individual. The clinician must use clinical judgment as to the duration of efficacy and not solely rely on reported values for PK-PD and duration of effect. [2]Starting doses in table are taken from product monographs. CADDRA recommends usually starting with the lowest dose available. [3]For specific details on how to start, adjust and switch ADHD medications, clinicians should refer to the Canadian ADHD Practice Guidelines (www.caddra.ca). [4]Vyvanse 70 mg is an off-label dosage for ADHD treatment in Canada. Original version of this sheet developed by Dr. Annick Vincent in collaboration with Direction des communications et de la philanthropie, Laval University. Access provincial and federal formulary information at tinyurl.com/uf3mxrl

CADDRA

Guide to ADHD Psychoeducation

What is ADHD?

Attention Deficit Hyperactivity Disorder is a neurodevelopmental condition with symptoms existing along a continuum from mild to severe. It occurs across the life span.

How is ADHD Treated?

Treatment should be **multimodal.** Incorporating different interventions, such as education, medication, and behavioral modifications/motivational interviewing/ psychotherapy, produces a better outcome.

Treatment must be collaborative among the physician, the patient, and the family. It should be targeted to each individual's needs and goals, which may change over time.

Two important components of a multimodal approach:

PSYCHOEDUCATION

Psychoeducation should be the first intervention. Educating the family/ patient about ADHD (symptoms, functional impairment, possible comorbidities and treatment) will ensure a more successful outcome.

PSYCHOSOCIAL INTERVENTIONS

Psychosocial interventions can reduce impairments associated with ADHD symptoms and improve overall quality of life. Interventions can be **cognitive** or **behavioral**.

Psychoeducation

Discover

- What does the individual/ family know about ADHD?

Demystify

- Myths about ADHD
- Diagnosis and assessment processes

Instill Hope

- Evidence-based treatments and interventions **do** exist and **will** promote a positive outcome

Educate

- Importance of combining pharmacological and psychosocial interventions
- Risks and benefits

Empathize

- Acknowledge feelings of discouragement, grief, and frustration.

Encourage

- A strength-based approach
- Make more positive than negative comments
- Discourage criticisms

Recognize

- Appropriate behavior, whether observed or reported
- Goals achieved

Be Sensitive

- Ethnic, cultural and gender issues may shape the perception and beliefs about ADHD and its treatment

Motivate

- Nurture strengths and talents
- Encourage skills

Promote

- Regular exercise
- Consistent sleep hygiene
- Healthy nutrition routine

Humour

Humour can defuse awkward, tense situations and avoid or reduce conflict

Give Resources

- Websites
- Local community resources
- Book lists

CADDRA

For further information, please refer to the Psychosocial Interventions and Treatments chapter, Canadian ADHD Practice Guidelines at caddra.ca

Version: October 2016

Guide to ADHD Psychosocial Interventions

At Home

Instructional
- Make eye and/or gentle physical contact before giving one or two clear instructions. Have instructions repeated back, or confirm they were understood, before proceeding

Behavioral
- Use a positive approach and calm tone of voice. Teach calming techniques to de-escalate conflict
- Use praise, catch them being good (playing nicely)
- Set clear attainable goals and limits (homework and bedtime routines, chores) and connect them to earning privileges, special outings etc.
- Use positive incentives and natural consequences: *When you..., then you may...*
- Empathy statements can be useful, such as *I understand*
- Adults should model emotional self-regulation and a balanced lifestyle (good eating and sleep habits, exercise and hobbies)
- Choices should be limited to two or three options

Environmental
- Structure and routine are essential. Parents/partners must be united, consistent, firm, fair and follow through
- Encourage prioritizing instead of procrastination
- Post visual reminders (rules, lists, sticky notes, calendars) in prominent locations
- Use timers/apps for reminders (homework, chores, limiting electronics, paying bills)
- Keep labeled, different coloured folders or containers in prominent locations for items (keys, electronics).
- Find the work area best suited to the individual (dining table, quiet area)
- Break down tasks
- Allow movement breaks
- Allow white noise (fan, background music) during homework or at bedtime

At School

Instructional
- Keep directions clear and precise
- Get student's attention before giving instructions
- Check understanding and provide clarification as needed
- Actively engage the student by providing work at the appropriate academic level

Behavioral
- Provide immediate and frequent feedback
- Use direct requests – *when...then*
- Visual cues for transitions
- Allow for acceptable opportunities for movement- "walking passes"

Environmental
- Preferential seating
- Quiet place for calming down

Accommodations
- Chunk and break down steps to initiate tasks
- Provide visual supports to instruction
- Reduce the amount of work required to show knowledge
- Allow extended time on tests and exams
- Provide note taker or access to assistive technology
- Supports can include the CADDRA psychoeducational and accommodations template
- Request school support services

At Work

Accommodations
- Identify accommodation needs
- Provide CADDRA workplace accommodations template

Counsel
- Suggest regular and frequent meetings with manager and support collaborative approach
- Set goals, learn to prioritize, review progress regularly
- Identify time management techniques that work for the client, e.g. using a planner, apps
- Declutter and create a work-friendly environment

Tools
- Organizational apps and/or productivity websites caddra.ca/medical-resources/psychosocial-information

Relationships

- Understand the impact ADHD can have on relationships with partners, family, friends, teachers, peers and co-workers.
- Recognize and accept ADHD can cause unintended friction and frustration between parent and child as well as between partners (e.g. difficulties with self-regulation, time management difficulties)
- Learn how to listen and communicate effectively
- Organize frequent time to communicate (don't just talk) to discuss goals and plans (what works, what doesn't) within home, educational and work environments
- Schedule regular fun with family, partner, friends
- Practice relaxation and mindfulness techniques caddra.ca/medical-resources/psychosocial-information
- Stay calm, be positive, recognize/validate and celebrate strengths!

Other referrals may be needed:

- Psychologist
- Tutor, Family Therapist
- Parenting Programs
- Social Skills Program
- Organizational Skill Course
- Occupational Therapist
- Speech and Language
- Audiologist
- Learning Strategist
- ADHD Coach
- Vocational Coach

CADDRA

For further information, please refer to the Psychosocial Interventions and Treatments chapter, Canadian ADHD Practice Guidelines at caddra.ca

Version: October 2016

Pearls: Dextramphetamine

First off – this is NOT methamphetamine

Adderall and Vyvanse: are they equivalent???

So if my patient is on Adderall 30 mg, I'll switch to Vyvanse 30 mg…NO!!!

Pearls: Methylphenidate

Concerta – the generic is equivalent?? **NO!!!!**

Foquest – sleep and appetite side effects must be worse due to the long duration of action?? **NO!!!!**

It’s OK to crush these meds?? **NO!!!**

Common Errors in Treatment

#1 error in treatment – too low a dose of stimulant

#2 not recognizing **Rebound**: when too low a dose wears off too soon

Starting with an immediate release medication “to see if it works”

Opting to treat with SSRI’s/SNRI’s to address anxiety/depression even when it’s a secondary symptom or a consequence of unmanaged ADHD

Let’s try a second line med because it’s “safer” – buproprion, atomoxetine

Females with ADHD: An expert consensus statement. Susan Young et al, BMC Psychiatry. 2020; 20:404

MYTH: Women don't have ADHD

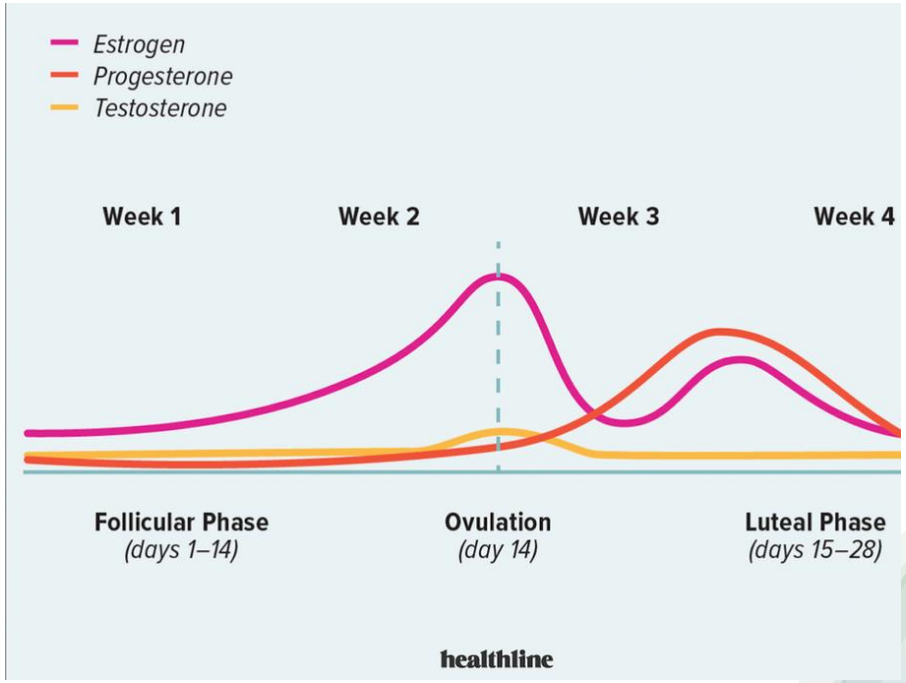
- The stereotype of the disruptive, defiant boy eclipses the recognition of ADHD in girls and women
- Clinical referrals for boys exceed those for girls approximately 3:1[1]
- The broad discrepancy in the ratio of males to females with diagnosed ADHD is at least in part due to **lack of recognition and/or referral bias in females**
- **The largest cohort presenting for assessment today is adult women who were missed in childhood!**

Hormonal influences in Female ADHD

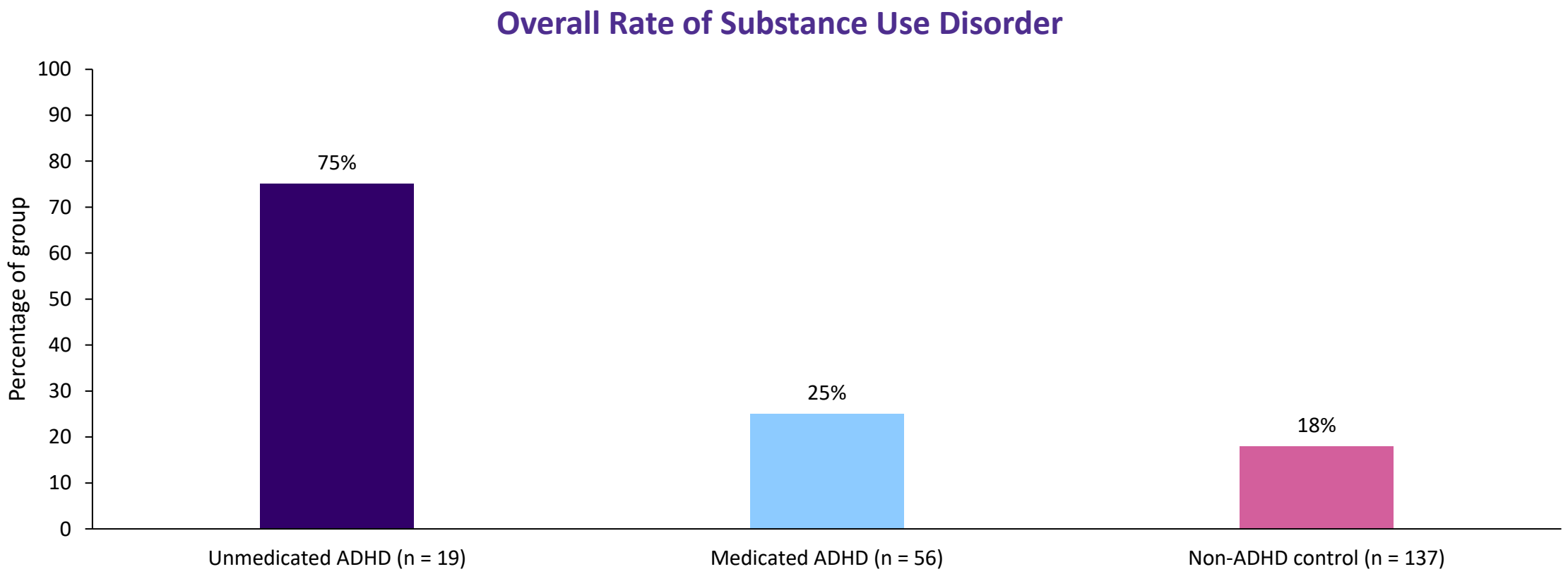
Estrogen plays a part in modulating cerebral dopamine receptors in the pre-frontal cortex (executive function), amygdala (emotion) & hippocampus (cognition/memory)

Dopamine is a central neurotransmitter in the establishment of executive function, emotional regulation & reward pathways. Poor dopamine transmission is causal in ADHD impairments.

A deficiency in estrogen (pre-menses, menopause) can further impair these functions contributing to increased mood & anxiety disorders, memory impairments, emotional regulation & worsening ADHD



MYTH: You Can't Treat an Addict & ADHD Meds cause addiction



Biederman, 1999

ADHD & Substance Use Disorder

Individuals with ADHD have a two-fold risk for substance abuse and dependence compared to those without ADHD

25% of Adults and 50% of Youth with SUD also have ADHD

They do not do as well, nor persist as long, in substance abuse treatment – so prevention is better than treatment!

Marijuana is the most abused agent followed by alcohol, cigarettes/vaping and other drugs

Canadian ADHD Resource Alliance. 2020. *Canadian ADHD Practice Guidelines, 4.1 Edition.* Toronto, ON: Canadian ADHD Resource Alliance

How to Treat ADHD and SUD

It is very convincing that treatment of ADHD BEFORE puberty curtails the tendency toward SUD as an individual matures

In the case of a patient with SUD and concurrent ADHD, treatment is more challenging

The ultimate success of substance use interventions may depend in large part on success in addressing their ADHD-related problems[1]

Encourage reduction of substance use and work with the patient to safely prescribe stimulants or start with atomoxetine

1. Hogue A, et al. *J Child Adolesc Subst Abuse* 2017;26:277
*Based on faculty expert opinion and experience

ADHD & Obesity

Cortese 2015: pooled prevalence for obesity (BMI>30) was 70% in adults with ADHD and 40% in children with ADHD

Further, the association between ADHD & obesity was significant for unmedicated **not** medicated individuals with ADHD – odds ratio of 1.43 vs. 1.00

Is obesity due in part to a 'reward deficiency syndrome' fueled by a need for dopamine?

ADHD and Diabetes – what do we know?

ADHD is largely influenced by genetics ***but*** **mothers with diabetes have a higher incidence of offspring with ADHD**

Kaiser Permanente Southern California hospitals reviewed over 300,000 births in 1995-2012 and discovered that

1. Children's exposure to gestational DM requiring antidiabetic medication had a **26%** greater ADHD risk
2. Type 1 DM exposure carried the greatest risk at **57%** followed by Type 2 DM at **43%**

With confounders (sociodemographic, smoking, alcohol..) controlled for, it appears that the intrauterine glycemic environment may play a role in the etiology of ADHD – why & how????

Xiang et al, 2018

ADHD & Type 2 Diabetes

Swedish National Registries (2018): Adults with ADHD showed an increased prevalence of T2DM at **3.9%** compared to those without ADHD at 1.6%

Taiwan National Health Insurance Research Database (2018): hazard ratio for ADHD teens **2.8** young adults **3.2** for T2DM

Removing confounders (atypical antipsychotic agents, other medical co-morbidities) overall HR was **2.8.**

In patients using ADHD medications, the hazard ratio was **0.90** for long term use

Resources:

- www.caddra.ca – Please become a member!! Lots of updates, accredited learning modules, ADHDLearn, ADHDTreat
- Fun & practical annual conference – September 27 – 29, 2024 Winnipeg
- www.caddac.ca – Non-profit organization that supports patients
- www.ADDitudemagazine.com – a treasure trove or articles and webinars for patients and professionals

CanTreatCOVID

Canadian Adaptive Platform Trial of Treatments for COVID in Community Settings

Who can participate?

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

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

Why participate?

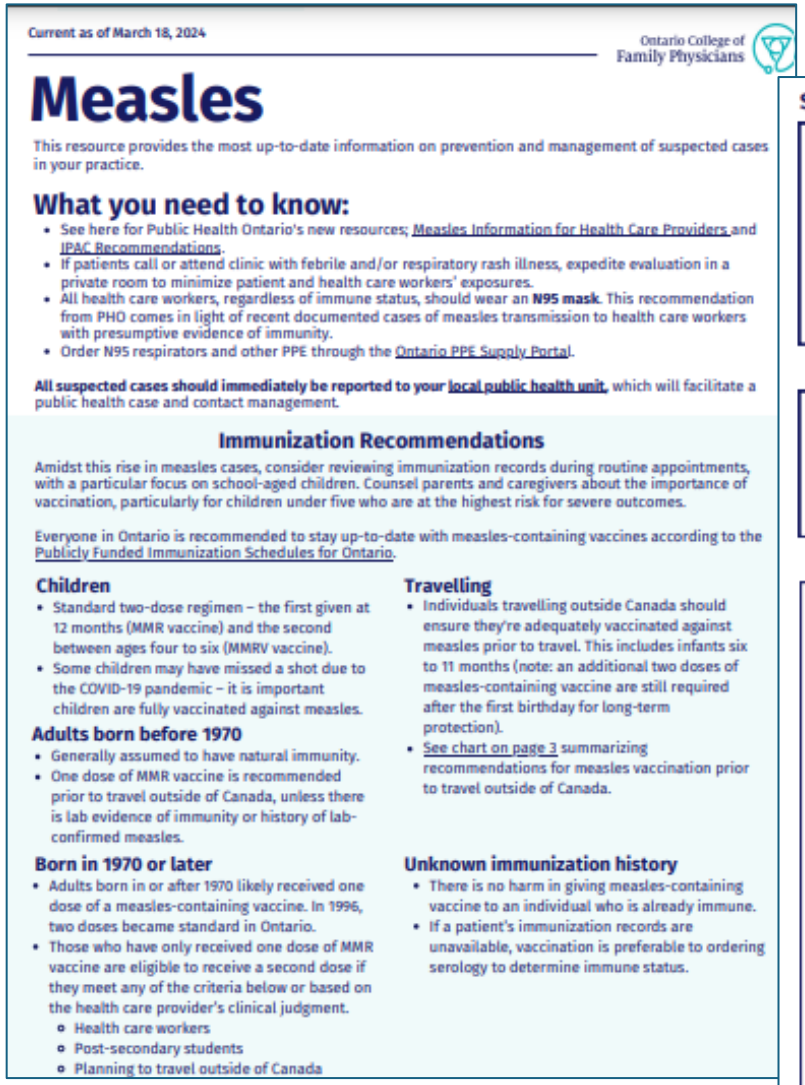
- Close monitoring
- Personalized care
- Contribution to medical research
- Participate online or by phone call

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

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

Resources to support your practice

Measles



Current as of March 18, 2024

Ontario College of Family Physicians

Measles

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

What you need to know:

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

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

Immunization Recommendations

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

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

Children

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

Adults born before 1970

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

Born in 1970 or later

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

Travelling

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

Unknown immunization history

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

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

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

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

Yes

Do you have risk factors for measles?

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

Yes

Providing Care for Symptomatic Patients

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

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

Patient flow

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

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

Testing

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

Collect samples for testing

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

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

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

Ontario College of Family Physicians

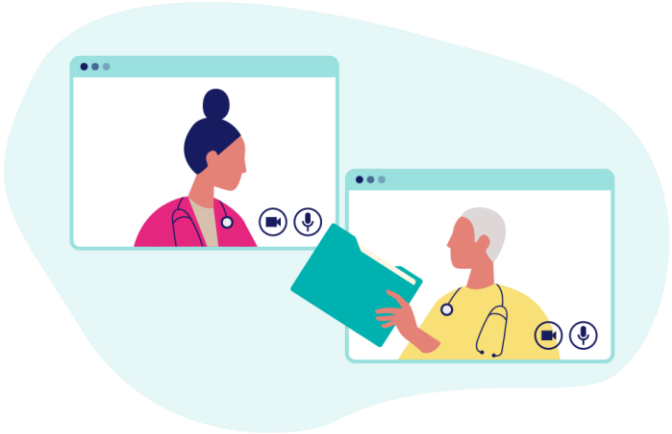
OCFP supports for Mental Health, Addictions and Chronic Pain

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:

- Emerging therapeutics amidst fat-shaming (May 22)
- Gender affirming care (June 26)
- Preventing burnout (July 24)



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

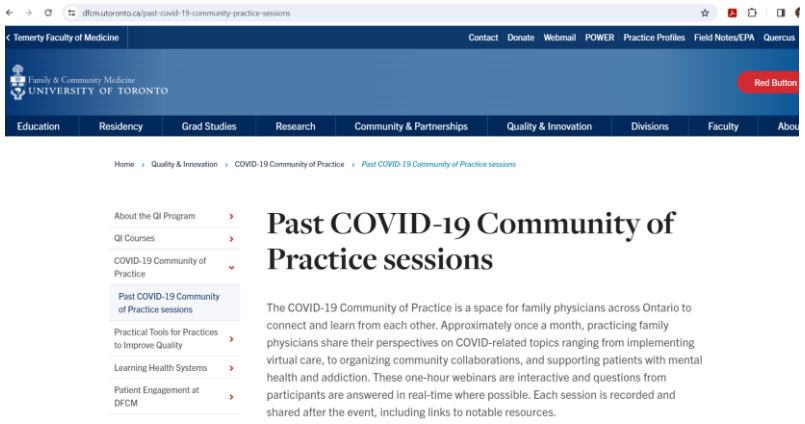
RECENT SESSIONS

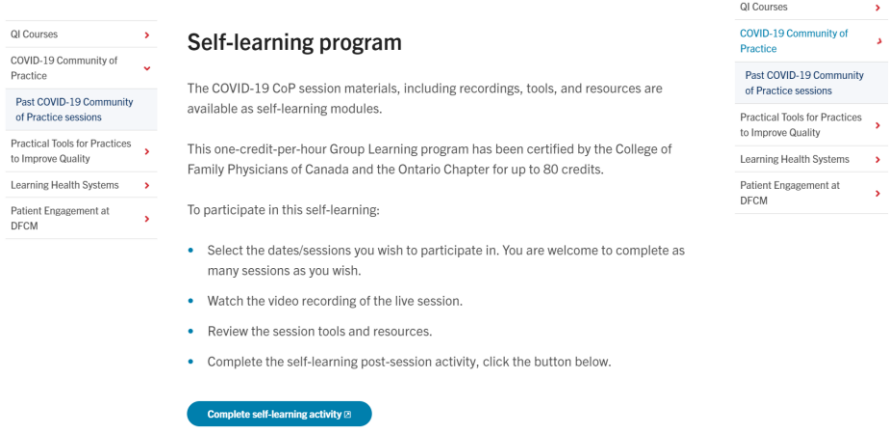
January 19	**COVID-19 Updates and Managing Respiratory Illness in Kids**	**Dr. Alon Vaisman** **Dr. Tasha Stoltz**
February 9	**Long COVID and Lipid Guidelines**	Dr. Kieran Quinn Dr. Michael Kolber
February 23	**COVID-19 and Measles Updates, and Supporting Primary Care**	Dr. Megan Devlin Dr. Elizabeth Muggah
March 22	**Infectious Disease Updates and Management of Menopause**	Dr. Zain Chagla Dr. Susan Goldstein Dr. Daniel Warshafsky
April 5	**Infectious Disease and Updates to Osteoporosis Canada Guidelines**	Dr. Gerald Evans Dr. Sid Feldman

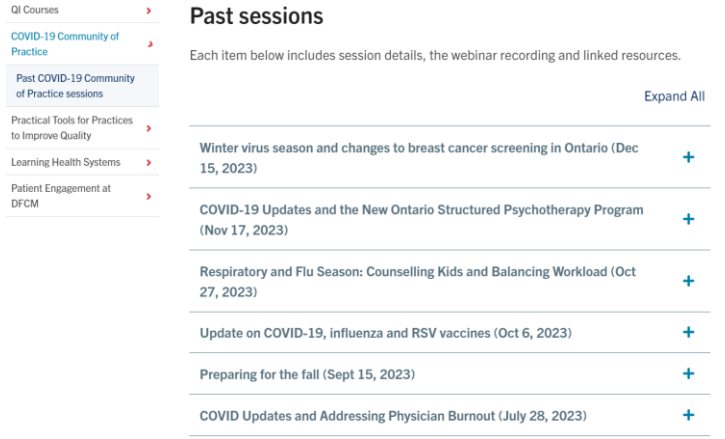
Previous webinars & related resources:
https://www.dfcm.utoronto.ca/covid-19-community-practice/past-sessions

Accessing Previous Sessions and Self-Learning

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







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 17, 2024

Contact us: ocfpcme@ocfp.on.ca

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

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

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

Family & Community Medicine
UNIVERSITY OF TORONTO

Ontario College of Family Physicians
Leaders for a healthy Ontario