COVID-19 Community of Practice for Ontario Family Physicians

June 7, 2024

Dr. Daniel Warshafsky
Dr. Neil Naik

Infectious Disease and Management of Obesity
Infectious Disease and Management of Obesity

Moderator:

• Dr. Ali Damji, Mississauga, ON

Panelists:

• Dr. Daniel Warshafsky, Toronto, ON
• Dr. Neil Naik, Waterloo, ON

Host:

• Dr. Mekalai Kumanan, Cambridge, ON

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

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

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

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

A community of practice for family physicians during COVID-19

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

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

Disclosure of Financial Support

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

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.

Potential for conflict(s) of interest:

N/A

Previous webinars & related resources:

https://www.dfcm.utoronto.ca/covid-19-community-practice/past-sessions
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Associate Chief Medical Officer of Health at the Office of the Chief Medical Officer of Health

Dr. Neil Naik – Panelist
Assistant Clinical Professor, University of Waterloo; Family Physician, Waterloo, Ontario

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Family Physician, Two Rivers Family Health Team
Speaker Disclosure

- Faculty Name: **Dr. Neil Naik**
- Relationships with financial sponsors:
  - **Grants/Research Support:** N/A
  - **Speakers Bureau/Honoraria:** Ontario College of Family Physicians, Baysil Inc, Amgen, Pfizer, Abbott, Novo Nordisk, AstraZeneca, Boehringer-Ingelheim, Canada Health Infoway, eHealth Centre for Excellence, McMaster University, OHIP, Kenora Health, Kitchener-Waterloo Academy of Medicine, Cancer Care in the Waterloo Wellington Region, Lush Woodcraft, The Canadian Collaborative Research Network (“CCRN”), Bayer, Chillwall AI, University of Waterloo, Topology Health, Khure Health, Ontario Health
  - **Advisory boards:** Amgen, Pfizer, Aralez, Abbott, Abbvie, AstraZeneca, Boehringer-Ingelheim, Eli Lilly, COVIS, eHealth Centre for Excellence, KW4 Primary Care Council, Canada-Africa Community Health Alliance, Waterloo Integrated Renal Program Council, Online Appointment Booking Provincial Advisory Committee, Lupin Pharmaceutical, Waterloo-Wellington Therapeutic Endoscopy Committee, Ontario Medical Laboratory Network for Connected Care, Ontario Primary Care Council
  - **Others:** Cloud Dx, Alphabet, Apple, Qualcomm, Johnson & Johnson, Aetna Insurance, RGAX Insurance, LSK Technologies, HealthTii Inc, Communitech, KW4 Ontario Health Team, Grand River Hospital Foundation, Orion Biotechnology, Glucoin, Sunlife Insurance, SanctuaryAI, AIoT, Bird&be, Tactico, FluidAI, FirstHx, Grand River Hospital Foundation, Canada Africa Community Health Alliance (CACHA), Intellijoint
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  - Relationships with financial sponsors:
    - Grants/Research Support: N/A
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    - 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.
Dr. Daniel Warshafsky – Panelist
Associate Chief Medical Officer of Health at the Office of the Chief Medical Officer of Health

Dr. Neil Naik – Panelist
Assistant Clinical Professor, University of Waterloo; Family Physician, Waterloo, Ontario
COVID
COVID-19 Spring Vaccination Campaign

• In alignment with NACI, individuals who are at increased risk of severe illness from COVID-19 may receive an additional dose of an XBB COVID-19 vaccine in Spring 2024. The Ontario Spring COVID-19 vaccine campaign will run from April to June 2024.

• The Ministry of Health is recommending that the following individuals receive an additional dose this spring:
  • Adults 65 years of age and older
  • Adult residents of long-term care homes and other congregate living settings for seniors
  • Individuals 6 months of age and older who are moderately to severely immunocompromised (due to an underlying condition or treatment)
  • Individuals 55 years and older who identify as First Nations, Inuit, or Metis and their non-Indigenous household members who are 55 years and older
Long-Term Care (LTC) Home Residents

Total LTC residents vaccinated with spring dose

20,002

% all LTC residents with spring dose

26.8%

Change from previous report:
+3,318 residents
+4.5 % points

LTC residents who received a Fall 2023/24 dose
(From September 12, 2023 to March 31, 2024):
45,290 (61.6%)

% LTC residents with a dose in the last 6 months

33.8%
Retirement Home (RH) Residents

Total RH residents vaccinated with spring dose

8,389

% all RH residents with spring dose

14.2%

Change from previous report:
+2,137 residents
+3.7 % points

RH residents who received a Fall 2023/24
(From September 12, 2023 to March 31, 2024):
37,563 (63.4%)

% RH residents with a dose in the last 6 months

19.4%
Updated OH Guidance: Mild to Moderate COVID-19

• **Risk Factors Associated with More Severe COVID-19 Outcomes Where Antiviral Therapy is RECOMMENDED**
  - Age (65 years and older, regardless of vaccine status, with no other risk factors)
  - Immunocompromised status (18 and older, regardless of vaccine status or prior COVID-19 infections)

• **Risk Factors Associated with More Severe COVID-19 Outcomes Where Antiviral Therapy MAY BE CONSIDERED**
  - Vaccination status (have never received a COVID-19 vaccine)
  - Certain medical conditions

*Treatment decisions should be individualized based on the prescriber's assessment of patient risk because not all medical or social vulnerabilities carry the same risk. Refer to Ontario Health guidance and resources at: [https://www.ontariohealth.ca/providing-health-care/clinical-resources-education/covid-19/treatment](https://www.ontariohealth.ca/providing-health-care/clinical-resources-education/covid-19/treatment)*
Coverage and Access for Paxlovid® in Community

• Effective May 17, 2024, Paxlovid® is listed Ontario Drug Benefit (ODB) Formulary with Limited Use (LU) criteria for ODB-eligible adults (18 years+) with a positive COVID-19 test (PCR or RAT) and symptoms within the past 5 days who are:
  - 65 years and older, regardless of risk factors or number of vaccine doses [673]
  - Immunocompromised, regardless of age or number of vaccine doses [674]
  - Have 1 or more risk factors (e.g. medical conditions) for severe COVID-19 [675]
  
  REMINDER: Prescribers must indicate the appropriate LU code on the prescription.

• For non-ODB Program recipients (e.g., individuals with private insurance or who pay out of pocket), Paxlovid® will not be publicly funded and usual and customary process will apply, once the remaining provincial supply of Paxlovid® expires at end of May.

• If a patient cannot afford the cost of a medication out-of-pocket, they may be eligible for the Trillium Drug Program (TDP). Where applicable, TDP can provide reimbursement retroactive to the enrollment date and process urgent applications.
Access to Testing

Rapid antigen tests (RATs)
• Health care providers can continue to order free rapid antigen tests (RATs) to provide to patients. Please order via PPE Supply Portal (must be registered for the Provincial Antigen Screening program – easy online application).
• RATs may also be available through participating pharmacies and public health units.

PCR tests
• Authorized providers may order publicly-funded PCR testing for eligible patients using the Public Health Ontario COVID-19 and Respiratory Virus Test Requisition form For help filling out the form use these instructions.
• Some pharmacies also continue to provide PCR testing (not available in all regions), see https://www.ontario.ca/covidtestinglocations for participating locations.
Meningococcal Disease
Clinical Illness

• Clinical illness associated with invasive meningococcal disease (IMD) usually manifests as meningitis, meningococcemia or both

• The case fatality ratio (CFR) is between 8% and 15%, with the CFR of meningococcemia as high as 40%.

• Symptoms include:
  • sudden development of fever
  • drowsiness
  • irritability or agitation
  • intense headache
  • nausea
  • vomiting
  • stiff neck and
  • Photophobia

• Most commonly, invasive disease results in meningitis and/or septicemia, in addition to a characteristic non-blanching petechial or purpuric rash.
Chemoprophylaxis should be offered to all persons having close contact with an IMD case during the infectious period (seven days before onset of symptoms in the case to 24 hours after initiation of effective treatment) regardless of their immunization status:

- Household contact of a case;
- Children and staff in contact with the case in child care settings;
- Persons who have direct nose or mouth contamination with the case’s oral/nasal secretions such as through kissing on the mouth, shared cigarettes, toothbrushes, eating utensils, drinking bottles;
- Health care workers (HCWs) who have had intensive unprotected contact (without wearing a mask) with an infected person such as in intubation, mouth-to-mouth resuscitation, or closely examining the oropharynx;
- Persons who share sleeping arrangements with the case; and
- Airline passengers sitting immediately on either side of the case, but not across the aisle, when the total time spent aboard the aircraft was at least hours.
<table>
<thead>
<tr>
<th>Drug</th>
<th>Age of Infants, Children, and Adults</th>
<th>Dosage (Dose, route, frequency)</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rifampin</td>
<td>&lt; 1 month</td>
<td>5mg/kg, oral, q12h x 2 days</td>
<td>• Can interfere with efficacy of medications including oral contraceptives, anticonvulsants and anticoagulants</td>
</tr>
<tr>
<td></td>
<td>≥ 1 month</td>
<td>10mg/kg, oral, q12h x 2 days</td>
<td>• Can stain contact lenses</td>
</tr>
<tr>
<td></td>
<td>Adults</td>
<td>600mg, oral, q12h x 2 days</td>
<td>• Not recommended for pregnant women</td>
</tr>
<tr>
<td>Ceftriaxon</td>
<td>&lt; 15 years</td>
<td>125mg, IM, single dose</td>
<td>• Safe for pregnancy</td>
</tr>
<tr>
<td></td>
<td>≥ 15 years</td>
<td>250mg, IM, single dose</td>
<td></td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td>Adults</td>
<td>500mg, oral, single dose</td>
<td>• Not used in communities where fluoroquinolone-resistant strains of <em>N. meningitidis</em> have been detected</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Not recommended for pregnant women</td>
</tr>
</tbody>
</table>
Hajj 2024

• Umrah is an Islamic pilgrimage to Mecca, Kingdom of Saudi Arabia, that can be performed any time in the year; the Hajj is an annual Islamic pilgrimage this year taking place June 14–19, 2024.

• Since April 2024, 12 cases of meningococcal disease linked to Saudi Arabia travel for Umrah have been reported to national public health agencies in the United States (5 cases), France (4 cases), and the United Kingdom (3 cases).

• Make sure you are vaccinated with a quadrivalent (ACYW) meningococcal vaccine before travelling, as required by Saudi Arabia.
Meningococcal Schedule in Ontario

Age 1
Men-C-C (Menjugate, NeisVac-CTM)

Grade 7
Men-ACYW (Menactra®, Menveo™, Nimenrix®)

High risk
2 months to 17 years - Men-B (Bexsero)
9 months+ Men-ACYW

- Acquired complement deficiencies (e.g., receiving eculizumab)
- Asplenia (functional or anatomic)
- Cochlear implant recipients (pre/post implant)
- Complement, properdin, factor D or primary antibody deficiencies
- HIV
MPOX
Mpxo Vaccine Guidance

• NACI (May 24, 2024) - **Interim guidance on the use of Imvamune® in the context of a routine immunization program**

• Ministry guidance changes – upcoming:
  o **Co-administration**: Imvamune® can be given concurrently (i.e., same day) or at any time before or after other live or non-live vaccines.
  o **Booster doses**: not recommended for individuals who have completed the 2-dose series of Imvamune®, except for lab workers who have continued occupational exposure.
  o **High-risk criteria**: provincial guidance revision to align with NACI
  o **Healthcare workers**: Imvamune® is not routinely recommended for healthcare workers, including those serving populations at high risk of mpxo, with the exception of post-exposure vaccination
  o **Pediatric populations**: Off-label use in pediatric populations is recommended for those meeting the criteria for post-exposure vaccination and may be offered at their clinician’s discretion.
Vaccination Reminder

• Please continue to vaccinate high-risk individuals with a 2-dose series of Imvamune®.

• Ensure those who have received one dose receive their second dose for optimal protection.
How you’re making a difference

How can we effectively treat and support our patients
Global prevalence of obesity
Among adults

764 million people live with obesity

Obesity is recognized as a disease and a health issue

Obesity is associated with multiple comorbid conditions and increased mortality

Life expectancy decreases as BMI increases

- Normal BMI
  - 80%
- BMI 35–40 kg/m²
  - 60%
- BMI 40–50 kg/m²
  - 50%

Once complications develop, their care becomes much more challenging.
Excess weight promotes cardiovascular disease via multiple mechanisms

BMI

Blood pressure

Blood glucose

Insulin resistance

Blood lipids

Inflammation*

Atherosclerosis:
- Adhesion molecule expression
- Foam cell formation
- Smooth muscle proliferation
- Fatty material and cholesterol deposited in arterial lumen, forming plaques which can narrow the lumen and hinder blood flow

Thrombosis:
- Blood vessels become less pliable and plaques can eventually rupture
- Can lead to MI, stroke or PAD

BMI, body mass index; CRP, C-reactive protein; CV, cardiovascular; IL, interleukin; MI, myocardial infarction; PAD, peripheral arterial disease; TNF, tumour necrosis factor alpha.
There is more happening than just simply appetite suppression.
What happens in your cells?

<table>
<thead>
<tr>
<th></th>
<th>5% Weight loss</th>
<th>11% Weight loss</th>
<th>16% Weight Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrahepatic triglyceride content</td>
<td>+</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td>Intra-abdominal adipose tissue</td>
<td>+</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td>Adipose tissue insulin sensitivity</td>
<td>+</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Liver Insulin Sensitivity</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Muscle insulin sensitivity</td>
<td>+</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td>Beta cell function</td>
<td>+</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td>Adipose tissue biology*</td>
<td></td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Inflammatory markers</td>
<td></td>
<td>+</td>
<td>++</td>
</tr>
</tbody>
</table>

Energy balance is regulated by the brain through various sources of input.

- Energy intake
- Energy expenditure

Hedonic input: Increased palatability or pleasure

Environment: Inactive lifestyle, smoking cessation, psychosocial factors

Adipose tissue
Pancreas
Gut
Genetics
Medications

The role of the brain in controlling appetite

Thoughts

Behavioural interventions empower sustainable behaviours in controlling eating

Feelings

Cognitive feedback
Self-regulatory processes influencing eating

Hedonic eating
Controlled by the brain’s reward system

Homeostatic eating
Controlled by endocrine feedback signals

The neuro-hormonal actors involved in energy homeostasis


ARC, arcuate nucleus; CCK, cholecystokinin; CHO, carbohydrates; DMH, dorsomedial hypothalamic nucleus; GLP-1, glucagon-like peptide 1; LH, lateral hypothalamus; NAcc, nucleus accumbens; NTS, nucleus tractus solitarius; OXM, oxyntomodulin; PA, physical activity; PP, pancreatic polypeptide; PVN, paraventricular nucleus; PYY, peptide YY; REE, resting energy expenditure; TEF, thermic effect of food; VMH, ventromedial hypothalamic nucleus; VTA, ventral tegmental area.

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**Diagram Notes:**
- Adiponectin, Leptin, Ghrelin, PYY, Insulin, Amylin, OXM, CCK, GLP-1, CHO, Fat, Protein, NAcc, Amygdala, VTA, Hypothalamus, Prefrontal cortex, Brainstem, Total energy expenditure (REE, TEF, PA), Food intake, Stomach, Small intestine, Portal vein, Pancreas, Liver, Taste, Ghrelin, PYY, OXM, GLP-1.
Maintenance of weight loss is challenging

Mean weight change (%)

Years after intervention

Pre-treatment  Post-treatment  1  2  3  4  5

Stalonas (1984)
Schwarzfuchs (2012)
Olszanecka-Glinianowicz (2012)
Vogels (2005)
Cooper (2010)
Pekkarinen (1997)
Wadden (1989)
Hensrud (1994)
Hunger increases in response to weight loss

- 50 individuals with overweight/obesity lost weight on a 10-week very low energy diet
- Appetite was measured using VAS scores at 0, 10 and 62 weeks

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*p<0.001, §p=0.008, †p=0.09 vs mean at baseline (week 0).
ITT, intention to treat; VAS, visual analogue scale.
Persistent metabolic adaptation following weight loss

Body weight

-58 kg
+41 kg

Resting metabolic rate

-610 kcal/day
-704 kcal/day

Metabolic adaptation*

-499 kcal/day

Data represent standard deviation. Data are for 14/16 participants in the 30-week Biggest Loser weight loss competition. Defined as the residual resting metabolic rate after adjusting for changes in body composition and age.

Fothergill E et al. Obesity (Silver Spring) 2016;24:1612–19.
Greater weight loss leads to improved health outcomes

Towards greater weight loss and overall health improvement

- Prevention of T2D
- Cardiovascular disease
- OSAS
- T2D remission

- NAFLD
- Urinary stress incontinence
- GERD
- CV mortality

- PCOS
- NASH
- Knee OA
- HFpEF

- Hypertension
- Dyslipidaemia
- 0–5%
- 5–10%
- 10–15%
- >15%

- Hyperglycaemia
- Cardiovascular disease
- Urinary stress incontinence
- T2D remission

CV: cardiovascular; GERD: gastro-oesophageal reflux disease; HFpEF: heart failure with preserved ejection fraction; NAFLD: non-alcoholic fatty liver disease; NASH: non-alcoholic steatohepatitis; OA: osteoarthritis; OSAS: obstructive sleep apnoea syndrome; PCOS: polycystic ovary syndrome; TG: triglycerides.

Diagnosis of Obesity: Then vs. Now

- **NEW**
  - Ask permission
  - Assess readiness for change
  - Measure height, weight, BMI, and waist circumference
  - Establish comprehensive history to identify root causes of weight gain
  - Measure BP, fasting glucose/A1C, lipid profile, and ALT screen
  - EOSS

**HCPs are encouraged to:**

- Prioritize involving the patient in the decision-making process
- Focus on a holistic approach to health
- Use appropriate measurements that are focused on health behaviours in all patients
- Address the root causes of obesity

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Approaching the conversation about weight with your patients: **Explore readiness for change**³⁻⁴

This is essential to success, as initiating change when patients are not ready can result in frustration and impede future efforts.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Patient mindset</th>
<th>Practitioner task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-contemplation (not ready)</td>
<td>No intention of changing behaviour in the foreseeable future (within 6 months).</td>
<td>• Increase perception of the risks and problems with current behaviours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provide harm reduction strategies</td>
</tr>
<tr>
<td>Contemplation (getting ready)</td>
<td>Aware that a problem exists and is seriously thinking about starting to overcome it (within 6 months).</td>
<td>• Help identify reasons for change/risks of not changing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increase patient confidence in ability to change</td>
</tr>
<tr>
<td>Preparation</td>
<td>Intending to act in the next month.</td>
<td>• Clear goal-setting and development of realistic plan for change</td>
</tr>
<tr>
<td>Action</td>
<td>Modifies behaviour, experiences, or environment to overcome the problem.</td>
<td></td>
</tr>
<tr>
<td>Maintenance (sticking to it)</td>
<td>Works to prevent relapse and consolidate the gains attained during action.</td>
<td>• Help identify and use strategies to prevent relapse</td>
</tr>
</tbody>
</table>

Approaching the conversation about weight with your patients: **Create a weight-friendly practice**¹

**Facilities:** Easily accessible, wide doors, large restrooms, floor-mounted toilets

**Waiting room:** Sturdy and armless chairs, appropriate reading material

**Exam room:** Appropriately sized gowns, scales over 350 lbs/160 kg, wide and sturdy exam tables, extra-large blood pressure cuffs, long-handled shoe horns, large stepping stools

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Obesity management is about improving health and well-being, not just managing weight

Many patients see significant improvements in health and well-being even with modest reductions in weight.

The patient’s “best” weight may never be an “ideal” weight.

- A “healthy range” BMI is not a realistic goal for many patients.
- Help patients set weight targets based on the “best weight” they can sustain while still enjoying their life and reaping the benefits of improved health.

Treatment “success” can be defined in multiple ways¹

- Better quality of life
- Prevention of further weight gain
- Modest weight loss (5%)
- Greater self-esteem
- Improved overall health (metabolic, mechanical, mental)
- Maintenance of the patient’s “best” weight
- Higher energy levels

Recommended classification of BMI

BMI is not a tool for identifying adiposity-related complications. Integration of both BMI and waist circumference into a clinical assessment may identify people at higher risk of obesity better than either alone (particularly at BMI of 25–35 kg/m²).\(^1\,^2\)

<table>
<thead>
<tr>
<th>Category</th>
<th>BMI (kg/m²)</th>
<th>Category</th>
<th>BMI (kg/m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian, Euroid, and North American ethnicity</td>
<td></td>
<td>South-, Southeast-, or East-Asian ethnicity</td>
<td></td>
</tr>
<tr>
<td>Underweight</td>
<td>&lt; 18.5</td>
<td>Underweight</td>
<td>&lt; 18.5</td>
</tr>
<tr>
<td>Healthy weight</td>
<td>18.5–24.9</td>
<td>Healthy weight</td>
<td>18.5–22.9</td>
</tr>
<tr>
<td>Overweight</td>
<td>25–29.9</td>
<td>Overweight—At risk</td>
<td>23–24.9</td>
</tr>
<tr>
<td>Obesity Class 1</td>
<td>30–34.9</td>
<td>Overweight—Moderate risk</td>
<td>25–29.9</td>
</tr>
<tr>
<td>Obesity Class 2</td>
<td>35–39.9</td>
<td>Overweight—Severe risk</td>
<td>≥ 30</td>
</tr>
<tr>
<td>Obesity Class 3</td>
<td>≥ 40</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Edmonton Obesity Staging System\textsuperscript{1-3}

Rather than BMI, the Edmonton Obesity Staging System (EOSS) ranks the severity of obesity based on a clinical \textit{assessment of weight-related health issues and quality of life} to better guide clinical decision-making.


The Obesity Canada Clinical Practice Guidelines provide recommendations on how to effectively manage obesity according to the patient’s EOSS stage.
Laboratory and diagnostic tests to consider in the assessment of patients with obesity

Consider for most patients

- A1C, serum glucose
- Electrolytes, renal function (creatinine, eGFR)
- Total cholesterol, HDL- and LDL-cholesterol, triglycerides
- Alanine aminotransferase (ALT)
- Screening for obstructive sleep apnea (e.g., STOP-BANG questionnaire)
- Age-appropriate cancer screening

Consider only if clinically indicated

- Complete (full) blood count
- Thyroid stimulating hormone/thyroid function tests
- Uric acid
- Assessment of iron (TIBC, % saturation, serum ferritin, serum iron)
- Vitamins B12 and D levels
- Urinalysis
- Urine for albuminuria

Women with obesity and symptoms of PCOS

- LH, FSH, total testosterone, DHEAS, prolactin, and 17 hydroxyprogesterone levels

HDL, high-density lipoprotein; LDL, low-density lipoprotein; TIBC, total iron binding capacity; PCOS, polycystic ovary syndrome; LH, luteinizing hormone; FSH, follicle stimulating hormone; DHEAS, dehydroepiandrosterone.

Understanding the treatment options available

The three pillars of obesity management that support MNT and physical activity

**PSYCHOLOGICAL INTERVENTION**

Criteria: Any person undergoing obesity management

**PHARMACOLOGICAL THERAPY**

Criteria: BMI ≥ 30 kg/m² or ≥ 27 kg/m² with obesity-related complications

**BARIATRIC SURGERY**

Criteria: BMI ≥ 40 kg/m² or ≥ 35–40 kg/m² with an obesity-related complication or ≥ 30 kg/m² with poorly controlled type 2 diabetes*

* Eligibility for bariatric surgery may vary by province.

Addressing any root causes of obesity/contributors to obesity is an essential component of obesity management (refer to the 4M framework).
Phenotype-guided antiobesity pharmacotherapy!!!
Four obesity phenotypes

- **Hungry brain**: Satiation – Knowing when the meal is over
- **Hungry Gut**: Satiety – Ability to not eat in periods between meals
- **Emotional Hunger**: Emotional/Reward – Regarding in response to negative/positive emotions
- **Slow burn**: Energy Expenditure – Base metabolic rate + Overall activity level
Differences in phenotypes vs those not categorized

• the hungry brain group consumed 62% more calories prior to reaching fullness;
• the emotional hunger group reported 2.8 times higher levels of anxiety;
• the hungry gut group emptied the stomach contents 31% faster; and
• the slow burn group had 12% lower predicted REE when compared with the other groups of obesity

1. Abnormal satiation (“hungry brain”): phentermine-topiramate extended release at a dose of 7.5/46 mg daily or lorcaserin at 20 mg daily (patients were told to discontinue in February 2020 based on U.S. Food and Drug Administration [FDA] recall);

2. Abnormal hedonic eating (“emotional hunger”): oral naltrexone/bupropion sustained release at a dose of 16/180 mg twice daily;

3. Abnormal satiety (“hungry gut”): liraglutide 3 mg subcutaneous daily; or

4. Low predicted energy expenditure (“slow burn”): phentermine 15 mg daily plus increased resistance training.

What...

- PG pharmacotherapy for obesity management improves weight loss outcomes. (A) Percentage of patients achieving levels of weight loss after 1 year of either non-PG (n = 228) or PG (n = 84) treatment. (B) The average percentage of total body weight loss from BSL in non-PG (red circles) and PG (blue squares) treatment at 3, 6, and 12 months. **P < 0.01, ***P < 0.001. BSL, baseline; PG, phenotype guided.

### Completed

<table>
<thead>
<tr>
<th>STEP 1</th>
<th>STEP 2</th>
<th>STEP 3</th>
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<tbody>
<tr>
<td>Weight management</td>
<td>WM in T2D</td>
<td>WM with IBT</td>
<td>Sustained WM</td>
<td>Long-term WM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 6</th>
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<th>STEP TEENs</th>
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<tr>
<td>East Asian trial</td>
<td>China, Brazil, Korea, Hong Kong MRCT</td>
<td>H2H vs liraglutide</td>
<td>Reversal of pre-diabetes</td>
<td>WM in adolescents</td>
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</table>

<table>
<thead>
<tr>
<th>SELECT</th>
<th>STEP HFpEF</th>
<th>STEP HFpEF DM</th>
<th>STEP 9</th>
<th>STEP 11</th>
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</thead>
<tbody>
<tr>
<td>Obesity and HFpEF</td>
<td>Obesity and HFpEF with T2D</td>
<td>Semaglutide in knee OA</td>
<td>Obesity in Korea/Thailand</td>
<td></td>
</tr>
</tbody>
</table>

### Ongoing

<table>
<thead>
<tr>
<th>STEP Young</th>
<th>STEP UP</th>
<th>STEP UP T2D</th>
</tr>
</thead>
<tbody>
<tr>
<td>WM in children and adolescents</td>
<td>WM with 7.2 mg</td>
<td>WM with 7.2 mg in T2D</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STEP 12</th>
<th>POSEY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity in Mainland China/Taiwan</td>
<td>US employer trial</td>
</tr>
</tbody>
</table>

**Notes:**
- **CVOT:** cardiovascular outcomes trial; **HFpEF:** heart failure with preserved ejection fraction; **H2H:** head-to-head; **IBT:** intensive behavioural therapy; **MRCT:** multi-regional clinical trial (including China and ≥1 additional East Asian country); **OA:** osteoarthritis; **WM:** weight management.
- Data on file; Clinicaltrials.gov. (Accessed 20 Jan 2023)
Weight loss across STEP trials

Semaglutide 2.4 mg once-weekly in participants with overweight or obesity

<table>
<thead>
<tr>
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<th>STEP 5</th>
<th>STEP 8</th>
<th>STEP 2</th>
<th>STEP 6</th>
<th>STEP 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight management</td>
<td>Weight management with IBT</td>
<td>Sustained weight management</td>
<td>Long term weight management</td>
<td>Head-to-head vs. liraglutide 3.0 mg</td>
<td>Weight management in T2D</td>
<td>Weight management in East Asians (includes T2D)</td>
<td>Weight management in Asians (includes T2D)</td>
</tr>
<tr>
<td>Baseline BW</td>
<td>105.3 kg</td>
<td>105.8 kg</td>
<td>107.2 kg</td>
<td>96.1 kg</td>
<td>106.0 kg</td>
<td>104.5 kg</td>
<td>99.8 kg</td>
</tr>
</tbody>
</table>

**In-trial:** Evaluates the treatment effect under the time from randomization to the last contact with a trial site, regardless of any discontinuation.

- **Semaglutide 2.4 mg**
- **Semaglutide 1.7 mg**
- **Liraglutide 3.0 mg**
- **Placebo**

Change in body weight from baseline (%)

-20 -16 -12 -8 -4 0 4 8

**SEMAGLUTIDE 2.4 MG VS. PLACEBO**

*Statistically significant vs. placebo.* † Statistically significant vs. liraglutide 3.0 mg.

2. Davies et al. Lancet, 2021; doi.org/10.1016/S0140-6736(21)00213-0;
5. Garvey et al. Nat Med 28, 2083–2091 (2022);
6. Kadowaki et al. The Lancet Diabetes & Endocrinology 2022.;
# Change in body composition (DXA)

## STEP 1

<table>
<thead>
<tr>
<th></th>
<th>Semaglutide 2.4 mg</th>
<th>Placebo</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline</strong></td>
<td><strong>42.1</strong></td>
<td><strong>52.4</strong></td>
</tr>
<tr>
<td><strong>Week 68</strong></td>
<td><strong>33.7</strong></td>
<td><strong>47.1</strong></td>
</tr>
<tr>
<td><strong>Lean body mass (kg)</strong></td>
<td><strong>43.3</strong></td>
<td><strong>51.5</strong></td>
</tr>
<tr>
<td></td>
<td><strong>41.9</strong></td>
<td><strong>49.7</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th><strong>Total fat mass (kg)</strong></th>
<th><strong>Total Lean body mass (kg)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Semaglutide 2.4 mg</strong></td>
<td><strong>ETD: -7.0 kg</strong></td>
<td><strong>ETD: -3.4 kg</strong></td>
</tr>
<tr>
<td><strong>Placebo</strong></td>
<td><strong>95% CI: [-9.79;-4.19]</strong></td>
<td><strong>95% CI: [-4.74;-2.13]</strong></td>
</tr>
</tbody>
</table>

- Total fat mass: Observed data for the in-trial period; Estimated data for the treatment policy estimand.
- CI, confidence interval; DXA, dual energy x-ray absorptiometry; ETD, estimated treatment difference.


---

|                  | Semaglutide 2.4 mg | Placebo |

- **Total Lean body mass (kg):**
  - Mean baseline: 52.1 kg

- **ETD:**
  - -3.4 kg
  - 95% CI: [-4.74;-2.13]
• 15 week program
• 5 hours of one-on-one video access to registered dietitians
• work on knowledge translation and motivation through collaborative goal setting
• Goals around
• dietary modification
• increased physical activity
• improved health promoting behaviours (for instance the goal of not missing a dose of a prescribed medication) will be monitored by Constant Health’s certified wellness coaches
• Embedded food diary and recipe search engine that can accommodate a patient’s preferred diet – from low-fat to keto and anything and everything in between.

https://www.constanthealth.ca/doctor
Other Resources

- Canada’s Food Guide
  - Food guide snapshot – Other languages - Canada.ca
  - Make healthy meals with Canada’s food guide plate - Canada’s Food Guide – tips, snack video
- Home - Unlock Food – Dietitian –
  - developed site with general and specific healthy eating and nutrition topics, meal planning, ideas for protein, fibre sources, snacking, seniors, children etc; how to find a dietitian.
- Diabetes Menu Plan for Prevention and Management - Unlock Food -
  - sample mealplan for diabetes (M,F) and to help with portion control/balance for all patients
- information.
- Diabetes Canada | Clinical Practice Guidelines - Patient Resources –
  - note the various tools in different languages to support those where English is not their first language.
- Diabetes (diabetestoolbox.ca)
  - credible site for lifestyle management of diabetes/weight.
- Bust the Bias videos - Obesity Canada
  - short videos to help bust the bias of obesity
- Blog | My Weight What To Know –
  - great tips, videos to support healthy living, good nutrition, commentary about obesity as a chronic disease and how dieting doesn’t work. My Weight Action Plan | My Weight What To Know – personalized action plan
- Nutritional Documents – Macklin Method | Patient –
  - nutrition tools to help implement the concepts of treating obesity as a chronic disease (metabolism, setting up a food diary to determine when, why and how we eat, portions and healthy meal planning, snack ideas, calorie content of common foods)
- Obesity CARE Service (obesity-care.ca) –
  - videos to help reduce the bias around weight (what is obesity?) and to learn about the factors impacting the appetite system.
Primary Strategy to preserve lean mass during weight loss

- **Target an appropriate energy deficit**: Individualized, however targeting 1-2 lb weight loss per week is likely ideal.
- **Promote adequate protein intake**: Can be from a combination of foods/supplements.
- **Resistance training**: Weight lifting, resistance bands, body weight exercises, etc.
Recommendations vary

- Target ~1.0 g protein/kg/day
  - Studies have shown 1.2-1.5 g / kg preserved more lead mass than 0.8g/kg in healthy middle-age and older adults
- CKD 3 patients
  - KDIGO guidelines suggest 0.5g/kg, but no more than 1.3g/kg. Favours plant based over animal sources
- Post-bariatric surgery patients
  - At least 60g/day post op or 1.1g/kg/day
Nutrient-stimulated hormone (NuSH)-based therapies in development

2022

GLP-1 RA

SEMAGLUTIDE - FDA

GIP / GLP-1 RA

MONTHLY GIP RA / GLP-1 RA

AMG133- PHASE 2

2023

TIRZEPATIDE – SURMOUNT – PHASE 3

2024

Amylin / GLP-1 RA

CAGRI-SEMA – PHASE 2

CAGRI-SEMA – REDEFINE - PHASE 3

2025

Glucagon / GLP-1 RA

SURVODUTIDE – PHASE 2

SURVODUTIDE – SYNCHRONIZE - PHASE 3

GIP / Glucagon / GLP-1 RA

PEMVIDUTIDE – PHASE 2

RETATRUTIDE – TRIUMPH - PHASE 3

Oral GLP-1 RA

ORFORGLIPRON – PHASE 2

SEMAGLUTIDE ORAL - OASIS – PHASE 3

DANUGLIPRON - ATTAIN – PHASE 3

DANUGLIPRON – PHASE 2

Modified slides from: Ania Jastreboff, MD, PhD, ToS Conference, Dallas, 2023
Retatrutide....

GIP/GLP-1/Glucagon Receptor Agonist
Orforglipron

Non-peptide GLP-1 RA
Design of the trial

Bimgrumab

an antibody that blocks activin type II receptors and stimulates skeletal muscle growth...
RCT: Effect of Bimagrumab vs Placebo on Body Fat Mass Among Adults With Type 2 Diabetes and Obesity

**POPULATION**
40 Men, 35 Women

Adults with BMI of 28-40, type 2 diabetes, glycated hemoglobin levels of 6.5%-10.0%, and stable body weight of 65-140 kg

Mean (SD) 60.4 (7.7) y

**INTERVENTION**
58 Individuals randomized and analyzed

27 **Bimagrumab**
Bimagrumab 10 mg/kg, up to a maximum of 1200 mg, in 5% dextrose solution, IV infusion over 30 minutes, every 4 wk for 48 wk (12 doses)

31 **Placebo**
5% dextrose solution, IV infusion over 30 minutes, every 4 weeks for 48 wk (12 doses)

**FINDINGS**
Total body fat mass decreased by 21% in patients receiving bimagrumab vs 0.5% in those treated with placebo (7.31 kg difference)

**SETTINGS / LOCATIONS**
9 sites, 8 in the US and 1 in Wales, UK

**PRIMARY OUTCOME**
Primary end point was least squares mean change from baseline in total body fat mass in kg at 48 wk

<table>
<thead>
<tr>
<th>End Point</th>
<th>Change (90% CI) [Participants, N]</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FM, kg</td>
<td>-7.49 (-8.33 to -6.64) [26]</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Secondary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lean mass, kg</td>
<td>1.70 (1.14 to 2.26) [26]</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Body weight, kg</td>
<td>-2.19 (-2.60 to -1.78) [26]</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>BMI</td>
<td>-0.05 (-0.06 to -0.04) [26]</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Waist circumference, cm</td>
<td>0.01 (0.00 to 0.02) [26]</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Waist-to-hip ratio</td>
<td>-0.66 (-1.14 to -0.18) [27]</td>
<td>0.08</td>
</tr>
<tr>
<td>HbA1c, %</td>
<td>0.10 (0.00 to 0.01) [21]</td>
<td>0.03</td>
</tr>
<tr>
<td>Matsuda Index</td>
<td>1.37 (0.31 to 2.43) [20]</td>
<td>.10</td>
</tr>
<tr>
<td><strong>Exploratory</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatic fat fraction, %</td>
<td>-4.60 (-6.07 to -3.12) [18]</td>
<td>.006</td>
</tr>
<tr>
<td>Week 24</td>
<td>0.23 (-1.61 to 2.08) [11]</td>
<td>.01</td>
</tr>
<tr>
<td>Week 48</td>
<td>-2.33 (-4.16 to -0.51) [5]</td>
<td></td>
</tr>
<tr>
<td>Abdominal SAT, L</td>
<td>0.97 (-1.17 to -0.56) [18]</td>
<td>.05</td>
</tr>
<tr>
<td>Week 24</td>
<td>0.14 (-0.65 to 0.57) [11]</td>
<td></td>
</tr>
<tr>
<td>Week 48</td>
<td>-0.19 (-1.30 to -0.26) [4]</td>
<td></td>
</tr>
<tr>
<td>Abdominal VAT, L</td>
<td>-1.40 (-1.69 to -1.20) [18]</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Week 24</td>
<td>0.22 (-0.03 to 0.48) [11]</td>
<td></td>
</tr>
<tr>
<td>Week 48</td>
<td>-0.61 (-1.05 to 0.30) [4]</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: BMI, body mass index (calculated as weight in kilograms divided by height in meters squared); FM, body fat mass; HbA1c, glycated hemoglobin; HOMA2, homeostasis model assessment; QUICKI, quantitative insulin sensitivity check index (calculated as 1/[log(thrashing insulin, mU/mL) + log(thrashing glucose, mg/dL)]; SAT, subcutaneous adipose tissue; VAT, visceral adipose tissue.

a Change from baseline to week 48, unless otherwise noted, in the end point.
b This model has change from baseline FM in kilograms as the dependent variable and treatment group, time, and a time × treatment group interaction as fixed effects. Baseline FM and baseline BMI values were included in the model as covariates. Time was modeled as a categorical variable. An unstructured within-participant covariance was used.
## Activin receptor inhibitors

<table>
<thead>
<tr>
<th>Drug</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bimagrumab</td>
<td>• Monoclonal antibody that binds activin type II receptor (ACTRII)</td>
</tr>
<tr>
<td></td>
<td>• Phase 2 study in individuals with T2D</td>
</tr>
<tr>
<td></td>
<td>• BELIEVE study (Phase 2b): bimagrumab + semaglutide</td>
</tr>
<tr>
<td>Taldefgrobep</td>
<td>• Fusion protein that binds active myostatin, inhibits signaling through ACTRII</td>
</tr>
<tr>
<td></td>
<td>• Developed for Duchenne Muscular Dystrophy</td>
</tr>
<tr>
<td></td>
<td>• Completed pre-IND engagement with FDA for the indication of obesity</td>
</tr>
<tr>
<td></td>
<td>• Phase 2 obesity study with taldefgrobep is planned to start in 2024</td>
</tr>
<tr>
<td>SRK-439</td>
<td>• Myostatin inhibitor</td>
</tr>
<tr>
<td></td>
<td>• Initial focus on obesity</td>
</tr>
<tr>
<td></td>
<td>• Proof of concept study apitegromab + GLP-1 RA (phase 2 2024)</td>
</tr>
<tr>
<td></td>
<td>• Developed for Spinal Muscular Atrophy</td>
</tr>
</tbody>
</table>
Future Topics Poll Results
May 17 2024 CoP

- Medical management of obesity: 50% (140/280)
- Management of anxiety in youth: 49% (137/280)
- Use of newer medications in type 2 diabetes: 45% (125/280)
- COPD - Update on best treatment practices: 44% (124/280)
- Review of STI testing and treatments: 39% (110/280)
- Management of cannabis use disorder: 34% (94/280)
- Update on other tick borne illnesses: 29% (80/280)
- Cannabinoid medicine/use of psychedelics: 19% (52/280)
Register for Health Alerts – OHIP & PHO

INFOBulletin

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What are OHIP INFOBulletins?

OHIP INFOBulletins are communications from the Ministry of Health. The communications inform of payment, policy, program or software changes.

The information is intended primarily for members of the professional health care community or software developers.

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1. Enter your email address
2. Select INFOBulletin categories of your choice
3. Select the Subscribe button

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https://mailchi.mp/ontario/infobulletin-en

MyPHO

Register for MyPHO to save commonly accessed resources, select areas of interest to help us recommend content most relevant to you, access online learning, and subscribe to our mailings.

MyPHO Registration
https://account.publichealthontario.ca/signup.aspx

PHO News
https://www.publichealthontario.ca/en/About/News
Register for Health Alerts – Your Region

Simcoe Muskoka Public Health Updates
https://www.simcoemuskokahealth.org/JFY/HPPortal/ResourcesTools/RAVE-Collection-of-Contact-Information

Niagara Region Public Health Updates
https://www.niagararegion.ca/health/professionals/medical-advisories.aspx

Toronto Public Health Updates
https://www.toronto.ca/community-people/health-wellness-care/information-for-healthcare-professionals/archived-newsletters-for-health-professionals/subscribe-to-tph-updates/
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:

- 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
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

Why participate?

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

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

CanTreatCOVID is led by Dr. Andrew Pinto and supported by

CanTreatCOVID.org  1-888-888-3308  info@CanTreatCOVID.org
## Recent Sessions

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<th>Topic</th>
<th>Speakers</th>
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<tr>
<td>February 23</td>
<td>COVID-19 and Measles Updates, and Supporting Primary Care</td>
<td>Dr. Megan Devlin Dr. Elizabeth Muggah</td>
</tr>
<tr>
<td>March 22</td>
<td>Infectious Disease Updates and Management of Menopause</td>
<td>Dr. Zain Chagla Dr. Susan Goldstein Dr. Daniel Warshafsky</td>
</tr>
<tr>
<td>April 5</td>
<td>Infectious Disease and Updates to Osteoporosis Canada Guidelines</td>
<td>Dr. Gerald Evans Dr. Sid Feldman</td>
</tr>
<tr>
<td>April 26</td>
<td>Infectious Disease Updates and Approaching ADHD</td>
<td>Dr. Allison McGeer Dr. Joan Flood,</td>
</tr>
<tr>
<td>May 17</td>
<td>Infectious Disease and Practical Tips for Practice Management &amp; AI</td>
<td>Dr. Daniel Pepe Dr. Alon Vaisman Dr. Ali Damji</td>
</tr>
</tbody>
</table>

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

Self-learning program
The COVID-19 CoP 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 60 credits.

To participate in this self-learning:
• Select the CoP 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

Past sessions
Each item below includes session details, the webinar, recording, and linked resources.

- Winter weight season and changes to breast cancer screening in Ontario (Dec 15, 2020)
- COVID-19 Updates and the New Ontario Structured Psychosocial Program (Nov 17, 2020)
- Respiratory and Flu Season: Counselling Kids and Balancing Workload (Oct 27, 2020)
- Update on COVID-19, Influenza and RSV vaccines (Oct 6, 2020)
- Preparing for the Fall (Sept 15, 2020)
- COVID Updates and Addressing Physician Burnout (July 28, 2020)
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: June 21, 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.