ADHD in Practice: Treatment & Management for Family Physicians

PANELISTS

Dr. Joan Flood • Dr. Devon Shewfelt

WITH

Dr. Stephanie Zhou • Dr. Carrie Bernard

Ontario College of Family Physicians — *Thriving Family Physicians in a Healthy Ontario*

Family & Community Medicine, University of Toronto | Mental Health and Addictions

Please introduce yourself in the chat!

Your name,
Your community,
Your X (Twitter) handle

Interested in becoming a speaker at our CoPs?
Send us an email with your name & topic(s) of interest to
practisingwell@ocfp.on.ca

@OntarioCollege
#PractisingWell

Your Panelists: Disclosures

Dr. Joan Flood

Relationships with financial sponsors (including honoraria):

- CoP Speaker - OCFP Practising Well
- Speaker's fees- Elvium, Humber River Health, Janssen-Ortho, Knight, Kye, Otsuka, Takeda
- Advisory boards- Elvium, Kye, Otsuka
- Advisory council- CADDRA — the Canadian ADHD Resource Alliance

Dr. Devon Shewfelt

Relationships with financial sponsors (including honoraria):

- CoP Speaker - OCFP Practising Well
- Peer Mentor- OCFP Peer Connect
- Clinical Lead on ADHD in Adults Tool- Centre for Effective Practice
- Medical Director- Thames Valley Family Health Team
- Speaker- OMA
- Leadership work- MLOHT/MLPCN

Disclosures

Dr. Stephanie Zhou @stephanieyzhou

Relationships with financial sponsors (including honoraria):

•Ontario College of Family Physicians – Practising Well Scientific Planning Committee
•Ontario Medical Association – Honoraria for practice management lectures
•Department of Family and Community Medicine (University of Toronto), Dept of Medical Imaging, Dept of Ob/Gyn for practice management lectures
•Toronto Public Health – Board of Directors Member
•McMaster University, Queen's University, McGill University, Toronto Metropolitan University, OntarioMD & Dr. Bill, Canadian Society of Allergy & Immunology, Canadian Fertility & Andrology Society, and Women in Academic Medicine - Honoraria for teaching financial literacy, billing, and practice management.

Dr. Carrie Bernard

Relationships with financial sponsors (including honoraria):

- Ontario College of Family Physicians
- University of Toronto – Stipend for role in the Division of Mental Health and Addictions
- Ontario College of Family Physicians – Practising Well Scientific Planning Committee
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- Membership on Advisory boards or speakers' bureaus:
- College of Family Physicians of Canada – Past President of the Board of Directors

Mitigating Bias

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Potential conflicts

N/A

Mitigating potential bias

The Scientific Planning Committee (SPC) has control over the choice of topics and speakers.

Content has been developed according to the standards and expectations of the Mainpro+ certification program.

The program content was reviewed by the SPC.

Practising Well Self-Learning Program

The Practising Well CoP is certified for self-learning credits!

Earn **1-credit-per-hour** for reviewing the recording and resources from **past CoP sessions**. The self-learning program is certified for up to 63 Mainpro+ credits.

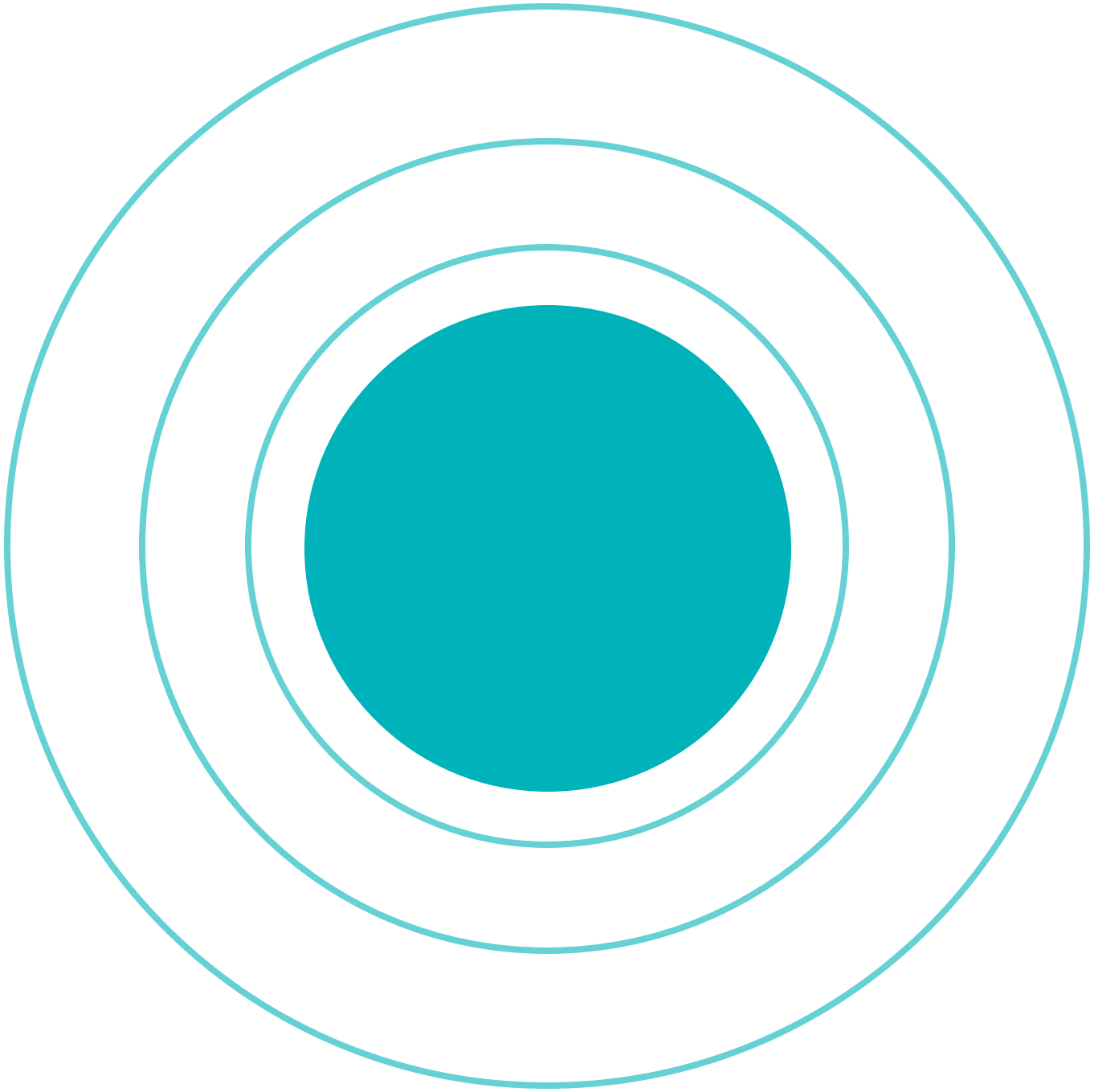
Learn More and Participate

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.



Your Panelists

Dr. Joan Flood

Dr. Devon Shewfelt

ADHD in Practice: Treatment & Management for Family Physicians

ADHD Management

A multimodal approach

Education & Understanding

On the part of patient, family, school/workplace

Psychosocial Supports

At home, school/work & in the social milieu

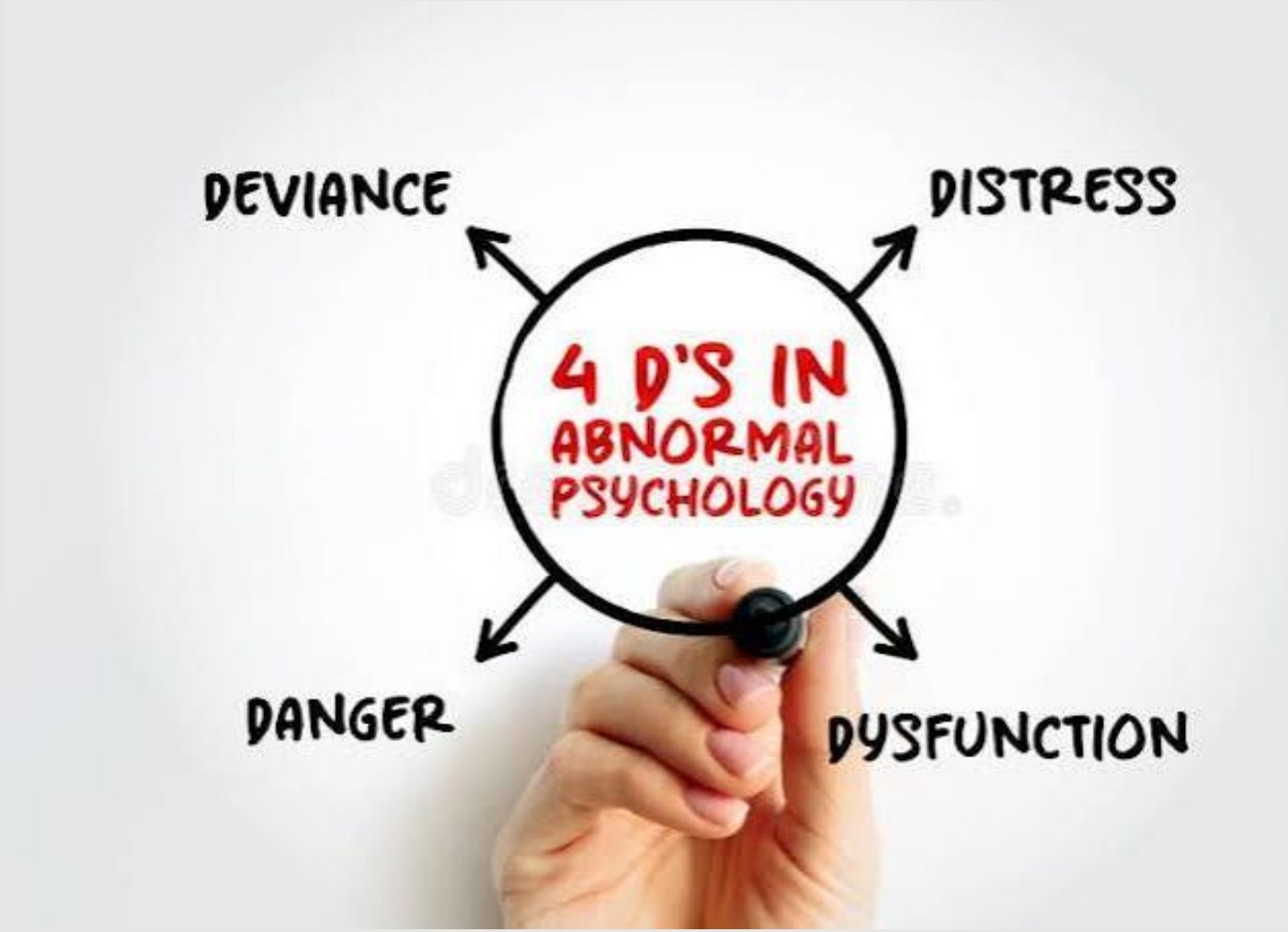
Medication

To correct the neurobiological deficits of ADHD

Learning Objectives

Review of ADHD management
including concurrent disorders

How to support your patient with
both psychosocial & medical modalities



Concurrent Disorders w ADHD

Anxiety/ Depression w ADHD

Stimulant Therapy?

- YES – Ensure Stimulants optimized THEN treat as usual

NO:

- Good – Improve Serotonin AND Norepinephrine/Dopamine
  - Buproprion
  - SNRIs – Duloxetine, Venlafaxine, Levomilnacipran
  - Vortioxetine
- Less Good – Improve Serotonin NOT Norepinephrine/Dopamine
  - SSRIs

DEMAND (COGNITIVE OR EMOTIONAL) VS GAS IN THE TANK (NE & D)

Treating ADHD: Pills and Skills

Fill the Tank

- Medication Therapy
- Exercise
- Diet/Nutrition
- Early Morning Sunlight
  - 10-20minutes within 1 hour of waking
- Cold Shower/Plunge
- Sleep Hygiene
- Known Activities***

Reduce the Emotional Demand

- DBT (Dialectical Behavioral Therapy)
- CBT (Cognitive Behavioral Therapy)
- ACT (Acceptance and Commitment Therapy)
- Mindfulness Therapy
- Free: OSP (Ontario Structured Psychotherapy), BounceBack, One Stop Talk (<18yo)
- PsychologyToday.com – Filters
  - Ex. ADHD, DBT/CBT vs. Coaching
- CADDAC – Centre for ADHD Awareness Canada

Reduce the Cognitive Demand

- AI (ChatGPT, Gemini) searches:
  - “I am 39yo Family physician with ADHD and I’m struggling with….”

Struggle to Get Things Done

Struggle to Get Started/Finished or Stay Focused

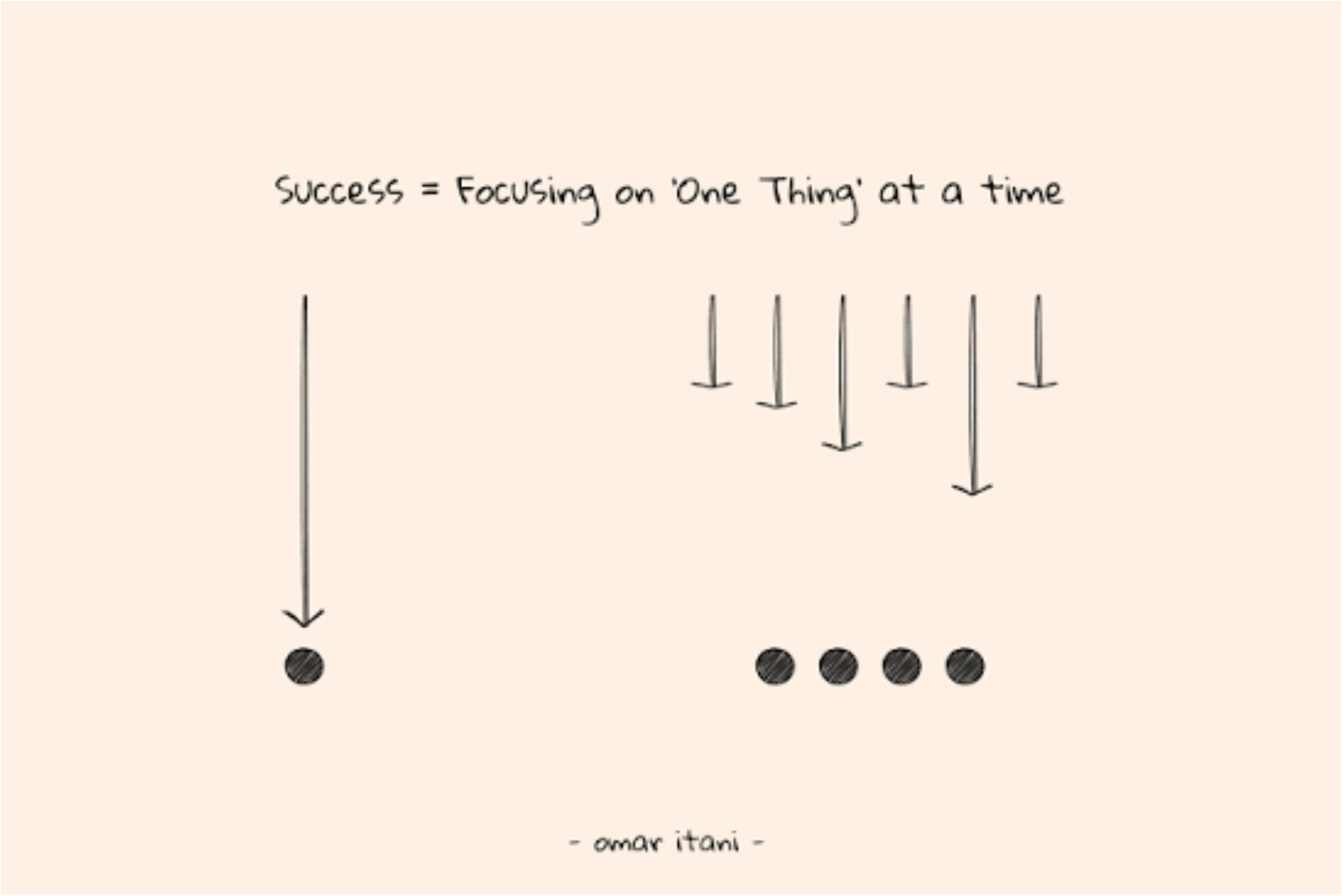
Struggle to Get Started

Struggle to Get Started

Struggle to Get Finished

Struggle to Stay Focused: Pomodoro Technique

Struggle to Stay Focused: One Thing At A Time



When Is Medication Indicated?

Confirmed diagnosis

Not just a symptom checklist — a real diagnostic workup first.

Severity / impairment threshold

When impairment is moderate-severe, or when psychosocial/behavioural approaches alone haven't cut it.

Consider contraindications & cautions

Cardiac history, active substance use disorder, psychiatric comorbidities — check before you pick an agent.

Stimulant vs Non-Stimulant: The General Idea

Stimulants

Methylphenidate- and amphetamine-class. First-line: largest effect sizes, fastest onset, most robust evidence base.

Non-Stimulants

Atomoxetine, viloxazine, guanfacine/clonidine ER. Second-line — or when stimulants are contraindicated/not tolerated, or there's a tic disorder / substance-use concern.

Same-day

stimulant onset — titratable within days

Up to 12 weeks

for full non-stimulant effect

Why "Stimulants"?

They boost synaptic dopamine and norepinephrine — via reuptake inhibition and/or release — which increases central nervous system arousal and activity.

That’s the "stimulation" — CNS/neurotransmitter effect. Not a behavioural "hyping up" of the patient. Worth naming out loud, since it’s a common patient and parent misconception.

Titration Principles

Start low, titrate to effect and tolerability

Not to a fixed target dose — response is individual and isn't well predicted by weight or age.
Medications should be taken daily – no drug ‘holidays’ or days off.

Reassess regularly

Efficacy (symptom + functional improvement), side effects (appetite, sleep, mood, cardiovascular), and coverage across the day.

Give each dose an adequate trial before switching

About a week per step is reasonable before calling a response inadequate.

Don't start a patient on a low dose and hand them a 2-month supply!

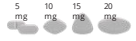
Women and ADHD

- **Estrogen facilitates dopamine transmission**
- **Low estrogen points in a women's lifespan (pre-menstrual, post-partum, menopause) can increase ADHD symptoms**
- **Give a top up dose of stimulants to women who note increased impairment**

Women are often overlooked or misdiagnosed as having anxiety & depression – it is important to know if that anxiety/depression is related to ADHD impairments that affect their ability to meet expectations

CADDRA GUIDE TO ADHD PHARMACOLOGICAL TREATMENTS IN CANADA

MAY 2026

Children & Adolescents (ages 6-17)	Adults (ages 18+)	Medications & Illustrations (Images not true to size. Size may vary according to mg dose)		Delivery	Duration of action1	Starting dose2	Release mode Immediate/Delayed (%)	Dose titration per product monograph3
AMPHETAMINE-BASED PSYCHOSTIMULANTS								
First Line	First Line	Adderall XR®	Capsules 5, 10, 15, 20, 25, 30 mg 	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 (6-12)	First Line	Dyanavel XR®	Chewable Tablets 5, 10, 15, 20 mg 	Chewable tablets Note: 5 mg is scored LiquiXR®	~ 13 h	2.5 or 5 mg	Unavailable	▲2.5 mg to 5 mg per day every 4 to 7 days Max. dose/day: Children (6 - 12) & Adults = 20 mg
First Line	First Line	Vyvanse®	Capsules 10, 20, 30, 40, 50, 60, 70[4] mg  Chewable Tablets 10, 20, 30, 40, 50, 60 mg 	Can be diluted in liquid or sprinkled Tablets should be chewed thoroughly Prodrug	~ 13-14 h	20-30 mg q.d. a.m.	Not Applicable	▲10-20 mg by clinical discretion at weekly intervals Max.dose/day: All ages = 60 mg
Second Line	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	First Line	Biphentin®	Capsules 10, 15, 20, 30, 40, 50, 60, 80 mg 	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	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	First Line	Foquest®	Capsules 25, 35, 45, 55, 70, 85, 100 mg 	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
First Line (6-12)	Second Line	Jornay PM™	Capsules 20, 40, 60, 80, 100 mg 	Can be sprinkled Delayed onset of action: 8-10 h	~ 12 h	20 mg q.d. p.m.	0/100	▲20 mg weekly Max. dose/day: Children (6-12) = 100 mg/day
First Line (6-12)	Second Line	Quillivant® ER	Chewable Tablets 20, 30, 40 mg  Powder for Oral Suspension 300, 600, 750, 900 mg/bottle 	Chewable tablets Note: 20 & 30 mg tablets are scored Oral Suspension (5 mg per ml)	~ 8-12 h ~ 12 h	20 mg q.d. a.m. 20 mg q.d. a.m.	30/70 20/80	▲10 mg, 15 mg, or 20 mg weekly Max. dose/day: Children (6-12) = 60 mg Note: Quillivant® ER Oral Suspension and Quillivant® ER Chewable Tablets are not interchangeable
Second Line	Second Line	Methylphenidate short-acting Tablets 5 mg (generic) 10, 20 mg (Ritalin®) Ritalin® SR Tablets 20 mg		Scored Tablet Wax Matrix Preparation	~ 3-4 h ~ 8 h	5 mg b.i.d. to t.i.d. Adult: 20 mg q.d.	100/0 100/0	▲5-10 mg at weekly intervals Max. dose/day: All ages = 60 mg
NON-PSYCHOSTIMULANT - SELECTIVE NOREPINEPHRINE REUPTAKE INHIBITOR								
Second Line	Second Line	Atomoxetine	Capsules 10, 18, 25, 40, 60, 80, 100 mg	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: All ages = 1.4 mg/kg/day or 100 mg
NON-PSYCHOSTIMULANT - SELECTIVE ALPHA-2A ADRENERGIC RECEPTOR AGONIST								
Second Line	Other Option	Intuniv XR® (Guanfacine XR)	Extended Release Tablets 1, 2, 3, 4 mg 	Needs to be swallowed whole to keep delivery mechanism intact	Up to 24 h	1 mg q.d. (q.a.m. or q.h.s.)	Not Applicable	▲Maintain dose for a minimum of 7 days before adjusting ≤ 1 mg/weekly Max.dose/daymonotherapy: Children = 4 mg Adolescents = 7 mg Max. dose/day (as adjunctive therapy to psychostimulants): Children & Adolescents = 4 mg

[1] Pharmacokinetic and pharmacodynamic responses vary from individual to individual. The clinician must use clinical judgement 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 from product monographs. CADDRA recommends usually starting with 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.*

Canadian ADHD Practice Guidelines Medication Classification

First Line

Long-acting psychostimulants (amphetamines and methylphenidate) with Health Canada approval for patient's age group.

Second Line

- Long-acting psychostimulants (amphetamines or methylphenidate) with Health Canada approval for other age groups, but not patient's age group.
- Short/intermediate-acting psychostimulants (amphetamines or methylphenidate).
- Non-stimulant medications approved for the age group.

Third line

No options listed in the table - see Guidelines full text. Medication treatments with limited evidence, significant side-effects or off-label status.

Other Options

Medication treatments based on clinical experience but overall trial data is heterogeneous and pooled data is not significant for the age group.

Abuse Potential

Longer-acting stimulants tend to have lower abuse potential than shorter-acting formulations. Non-stimulant formulations have no abuse potential.

Generics

Generic formulations of methylphenidate, amphetamine, atomoxetine and guanfacine XR products have received Health Canada approval. Prescribers are encouraged to use clinical judgement when medication formulation changes to a generic medication as individual patients may respond differently; clinical response and side effects profile should be monitored.

Pharmacotherapy Treatment

Pharmacotherapy should be considered after thorough assessment and alongside a comprehensive treatment plan, including psychosocial intervention.

CADDRA

CANADIAN ADHD RESOURCE ALLIANCE

www.caddra.ca

Biphentin, Foquest – double coated beads

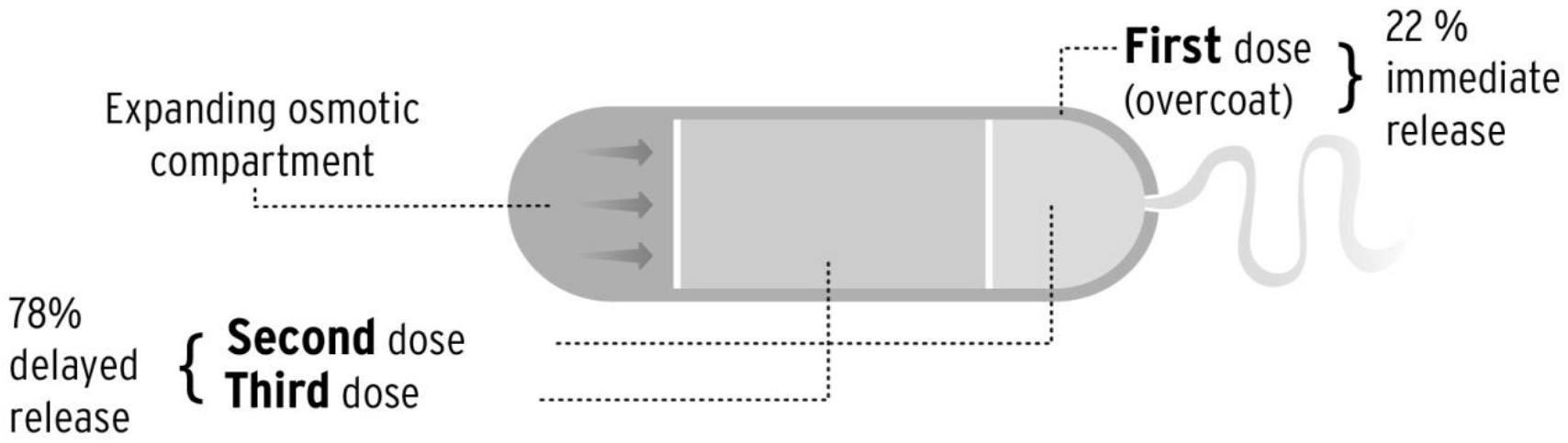
Biphentin®: 8–10 hours

Foquest®: 16 hours

Concerta (OROS Delivery System)

Osmotic-Controlled Release Oral Delivery System (OROS)
**Generic copies do NOT have this formulation although SUN pharma are coming out with a similar product this fall*

Concerta ® : 12 hours



Quillivant ER — Indicated for Children

- Ion-exchange resins with micron-sized MPH-resin particles and variable coatings that gradually dissolve over 8–12 hours
- Available as a liquid (banana) or chewable tablet (cherry), which have different delivery profiles

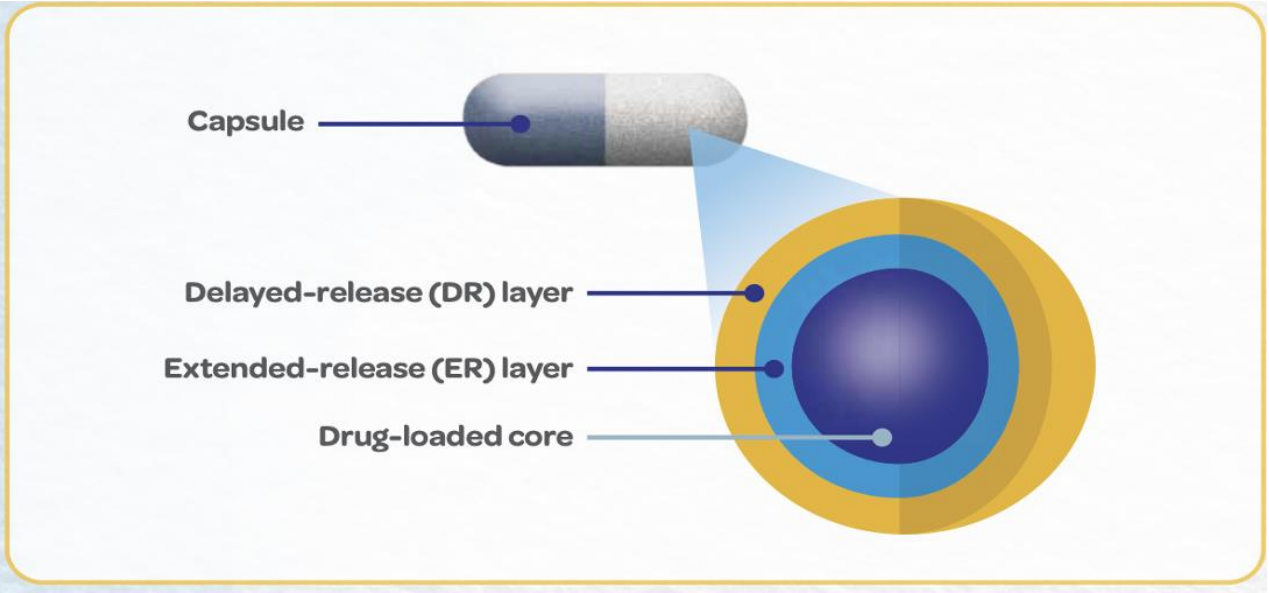
Quillivant ER ® - 8-10 hours -tablet
10 – 12 hours - liquid
* not interchangeable

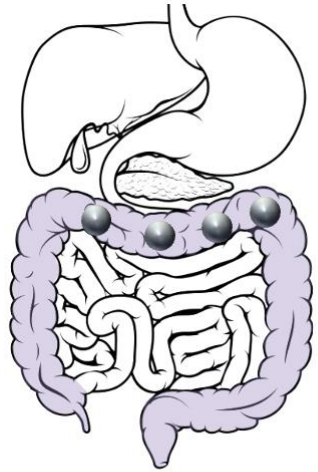
1. Herman B et al. Poster presented at the 2019 APSARD Annual Meeting, Washington, DC, 18-20, 2019; 2. Kando JC, King TR, Pardo A. A novel, modified release drug delivery technology containing amphetamine and methylphenidate ion-exchange complexes. Poster presented at: American Psychiatric Association Annual Meeting; May 1-3, 2021

Jornay PM: Colon-Targeted, Delayed-Release Delivery

Approved ages 6–12. Taken at bedtime — the capsule is coated and takes 8–10 hours to dissolve, so medication is on board as the child wakes.

Jornay PM® ~12 hours
*higher dose, longer duration





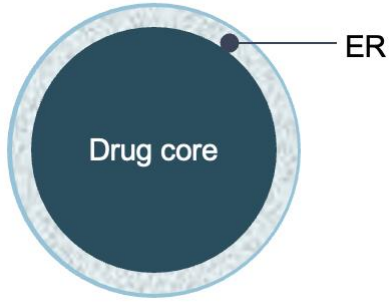


Image shared with permission Knight pharma

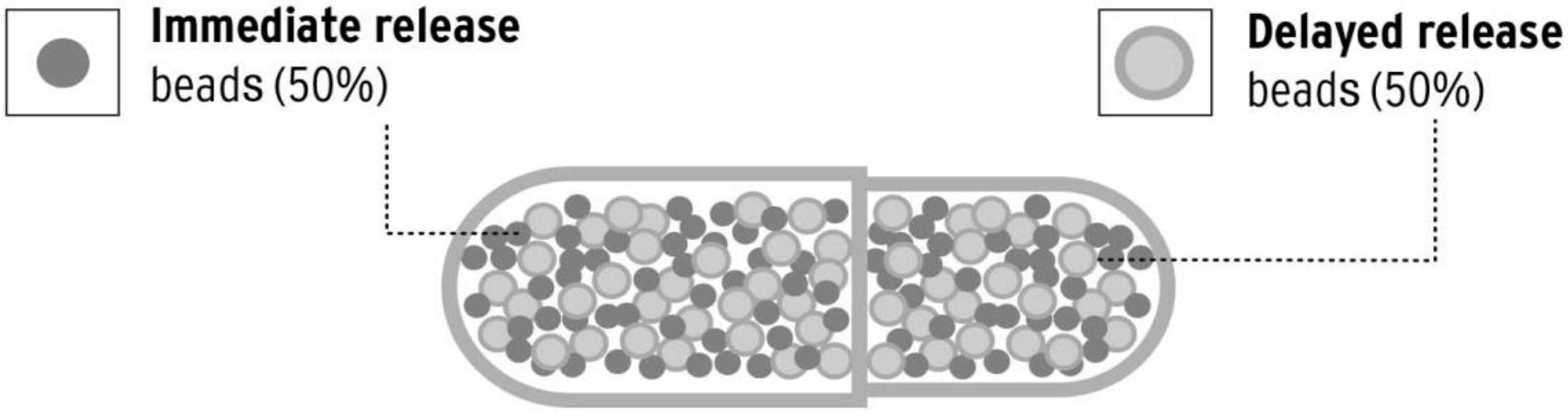
Ileum → Cecum	→ Ascending colon	→ Transverse colon	→ Descending colon
8–11h	**~14h**	**—**	**~20h**
Beads enter cecum	Peak dissolution	Dissolution slows	Dissolution complete

1. Data on File. Ironshore Pharmaceuticals & Development, Inc. Patent # 8,927,010 (Compositions MPH) patent application # 14/230,053. 2. Childress AC, et al. *J Child Adolesc Psychopharmacol*. 2018;28(1):10-18.
3. Watts PJ, et al. Drug Dev *Ind Pharm*. 1997;23(9):893-913. 4. Davis SS, et al. *Int J Pharm*. 1984;21(2):167-177. 5. Coupe AJ, et al. *Pharm Res*. 1991;8(3):360-364.

Adderall XR

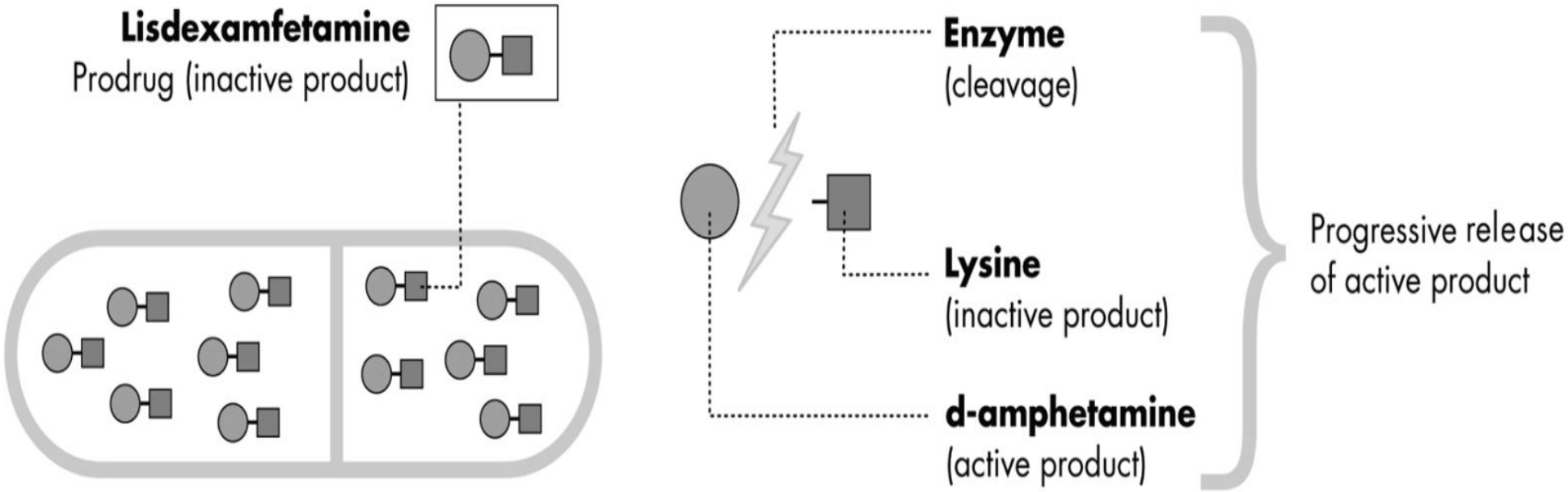
Amphetamines are thought to block the reuptake of norepinephrine and dopamine into the presynaptic neuron and increase the release of these monoamines into the extraneuronal space, thereby increasing these neurotransmitters' availability in the synaptic cleft.

Adderall® XR: 10–12 hours



Vyvanse: Pro-Drug Mechanism

Vyvanse®: 12–13 hours



Dyanaval XR – children & adults

- Ion-exchange resins with micron-sized MPH-resin particles and variable coatings that gradually dissolve over 8–12 hours
- Available as a liquid (banana) or chewable tablet (cherry), which have different delivery profiles
- Tablets 5, 10, 15, 20 mg – will come out as a liquid in 2027

Dyanaval XR ® - 13 hours

1. Herman B et al. Poster presented at the 2019 APSARD Annual Meeting, Washington, DC, 18-20, 2019; 2. Kando JC, King TR, Pardo A. A novel, modified release drug delivery technology containing amphetamine and methylphenidate ion-exchange complexes. Poster presented at: American Psychiatric Association Annual Meeting; May 1-3, 2021

Second Line Medications

Important to optimize First Line meds before adding in second medications or switching medications – *don't presume that these meds have less risk!*

Atomoxetine (Strattera no longer on the market)

Member of the antidepressant family – it has a place in treating ADHD in stimulant non-responders and substance abusers – in general it is not nearly as effective in treating core ADHD symptoms – sometimes it works particularly well in autistic individuals – same cautions as for SNRIs and anti-depressants, can impact HR/BP

Intuniv XR is a very useful adjunct for emotional dysregulation and impulsive behaviours – *but it must be given every day as missed doses can cause serious rebound hypertension* – so only for children with reliable parents – use in reliable adults is off label but can be helpful

Clonidine is like Intuniv XR and can be helpful in sleep regulation – risk of rebound hypertension is not an issue

Coming Up…

Qelbree

Viloxazine – extended-release selective norepinephrine reuptake inhibitor
Knight Pharma – Health Canada approval 2024 – ages ≥6 years
Available 2026/2027

Simtriyo

Centenafadine – Otsuka Pharma – first-in-class norepinephrine, dopamine, and serotonin reuptake inhibitor (NDSRI)
2026 FDA new drug acceptance– children/teens/adults – Not yet approved by Health Canada

Side Effects

Loss of Appetite

Ensure a healthy, calorie-dense breakfast & fluids through the day – usually settles – aggravated by erratic use of meds – on/off days

Insomnia

Usually settles with good sleep hygiene & avoidance of 'screens' in the hour before bed
* erratic use of medication increases this side effect

Cardiovascular Effects

Increase in BP and pulse equivalent to running up a flight of stairs in most. Requires a cardiac history on intake and when prescribed to ensure no contraindications (long QT syndrome, arrhythmias, congenital cardiac disease, known hypertension, CV disease)

Rebound

As the medication wears off, there is often a period of irritability. This is important because when the dose is too low, this irritability may occur midday and is mistakenly interpreted as a medication failure by individuals, teachers and family members

Side Effects

Mood Changes

Occasionally, a patient will complain of feeling depressed or 'flat'. A change to another stimulant or second-line medication usually solves this problem unless they are truly depressed and then need treatment for depression as well.

Headaches

Usually transient and can be managed with Tylenol, Advil.

Tight Jaw

Usually settles in the first month – more common with Vyvanse.

Disability Tax Credit

Eligibility

ADHD isn't automatically disability-eligible — the Canada Revenue Agency does not approve the DTC based on diagnosis, but on functional restriction. To be eligible, one must suffer marked impairment in performing the basic activities of daily living. CRA is looking for a clear picture – examples are required.

Marked Restriction

ADHD is assessed under the "mental functions necessary for everyday life" category. The person must be markedly restricted 90% of the time, lasting over 12 months – even with appropriate therapy and medical treatment.

General Comments

Children who need caregivers, tutors, supportive personal & family therapy are more likely to be approved. Adults living and working independently are less likely to qualify. Concurrent disorders such as autism which compound the disabilities of ADHD are more likely to gain approval.

Disability Tax Credit

When assessing eligibility, think about how your patient is restricted in comparison to someone their age without their same restrictions. Are they unable to do an activity? Do they take longer to do an activity? Do they need support with an activity from others? If applying for a child, compare their functionality to their same age peers.

How often does this occur? Explain how a patient is restricted substantially all the time. Do they need any supervision? Do they use any assistive devices? What are examples that demonstrate how their daily life is affected? Compare their functionality to someone their age without restrictions. Do they take two or three times longer to do a task?

Beware companies that take a large commission from the patient's ultimate tax refund to process this file. The job of the documentation is yours and your patient should not be giving away the funds they are entitled to to a middleman.

Disability Tax Credit

https://ontariofamilyphysicians.ca/wp-content/uploads/2026/08/A-Medical-Practitioners-Guide-to-the-Disability-Tax-Credit-DTC.pdf

https://mydtc.dabc.ca/

These forms are very time consuming. To do a proper job often requires over an hour of time to review the chart, document the impairments and upload the information – beware, CRA does not save your work so you can go back to it later. Patients will often get up to $2,000 per year in tax refunds for every year the credit is approved, back-dated up to 10 years so be sure you get paid for this work!

Take Home Points

You can screen and assess for ADHD in your office – you treat depression & anxiety, don't you? Start with a couple of patients – see them for 3 – 4 brief visits and commit to treat them. It's not that difficult!

Treatment of ADHD is lifechanging and can alter the course of a lifetime.
Don't consider the risk of treating – ***consider the Risk of NOT treating!***

Resources

www.caddra.ca – The Canadian ADHD Resource Alliance – sets clinical practice guidelines & provides considerable teaching and support

www.caddac.ca

- supportive organization for individuals with ADHD – Canadian non-profit – good resources and programming (e.g., support groups, coaching)

www.ADDitudemagazine.com – a treasure trove of articles on all aspects of ADHD for patients and families – no cost, sign up for their email list (they won't spam you!)

Resources

Tools

Links to resources shared today will be sent to participants following the session.

Tools and Resources

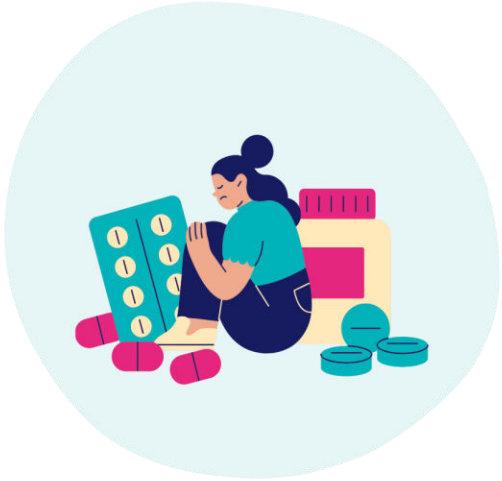
Resource Type	
Clinical Practice Guidelines, Teaching & Support	www.caddra.ca
Resources & Programming for Patients	www.caddac.ca
Articles for Patients & Families	www.ADDitudemagazine.com

META:PHI Needs Assessment Survey, August 2026

- META:PHI is funded by the Ontario Ministry of Health as the organizational hub of Ontario's Rapid Access Addiction Medicine (RAAM) Clinics. Our mission is to promote the delivery of high-quality care for people who use substances through education and clinical guidance, RAAM clinic support, and health system integration and advocacy.
- For the last several years META:PHI has offered monthly webinars in addition to an annual virtual conference, covering a range of topics related to substance use health. (Recorded sessions can be found on our website.)
- We are seeking input to ensure that future educational offerings continue to be relevant to health care providers from a variety of roles and practice settings in Ontario. Your input will help us strengthen our programming, build capacity and enhance our community of practice.
- Please complete this brief **Needs Assessment** (which should take no more than 5 minutes) by **September 14.**
- Jennifer Wyman, Clinical Program Lead, META:PHI Jennifer.wyman@wchospital.ca
- https://www.metaphi.ca/

META:PHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

Upcoming Community of Practice Events



Supporting Children & Youth with Substance Use Concerns in Primary Care

September 23rd, 2026
8:00am – 9:00am

Register Now

Children's Aid Society Reporting: Navigating Complex Decisions in Family Practice

October 28th, 2026
8:00am – 9:00am

Register Now

Ontario College of Family Physicians

OCFP Ask Me Anything (AMA) Webinar

Wellness in Family Medicine

August 27, 2026 | 6:00pm – 7:00pm

- Hear firsthand from experienced family physicians about navigating wellness, career development, work-life balance, and the transition into practice.
- Ideal for medical students, residents, and international medical graduates (IMGs) exploring a future in family medicine.

Register Now

Ontario College of Family Physicians

ONTARIO Osteoporosis Strategy

Clinical Application of the Long-Term Care (LTC) Fracture Prevention Recommendations for Frail Older Adults

At the end of this session, participants will be able to:

- Assess fracture risk using Fracture Risk Scale
- Apply evidence-based recommendations for fracture prevention in LTC
- Recognize challenges and barriers to implement the recommendations and use enablers.

September 4, 2026 | 12 PM – 1PM | Zoom

Free to attend. 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 1 Mainpro+ credit.

Registration now open

Scan to learn more

Ontario College of Family Physicians

The Children's Mental Health Workshop Series

Foundations of Children's Mental Health

Scan QR Code

October 7, 2026 | 1:30PM - 4:30PM | Virtual Workshop | Earn up to **3 credits**!

- Explore how to take a comprehensive psychosocial history specific to school-aged children and adolescents
- Identify common childhood presentations, including adjustment disorder, anxiety & depression, and review essential concepts related to ADHD
- Review early identification through use of evidence-based screening tools
- And More

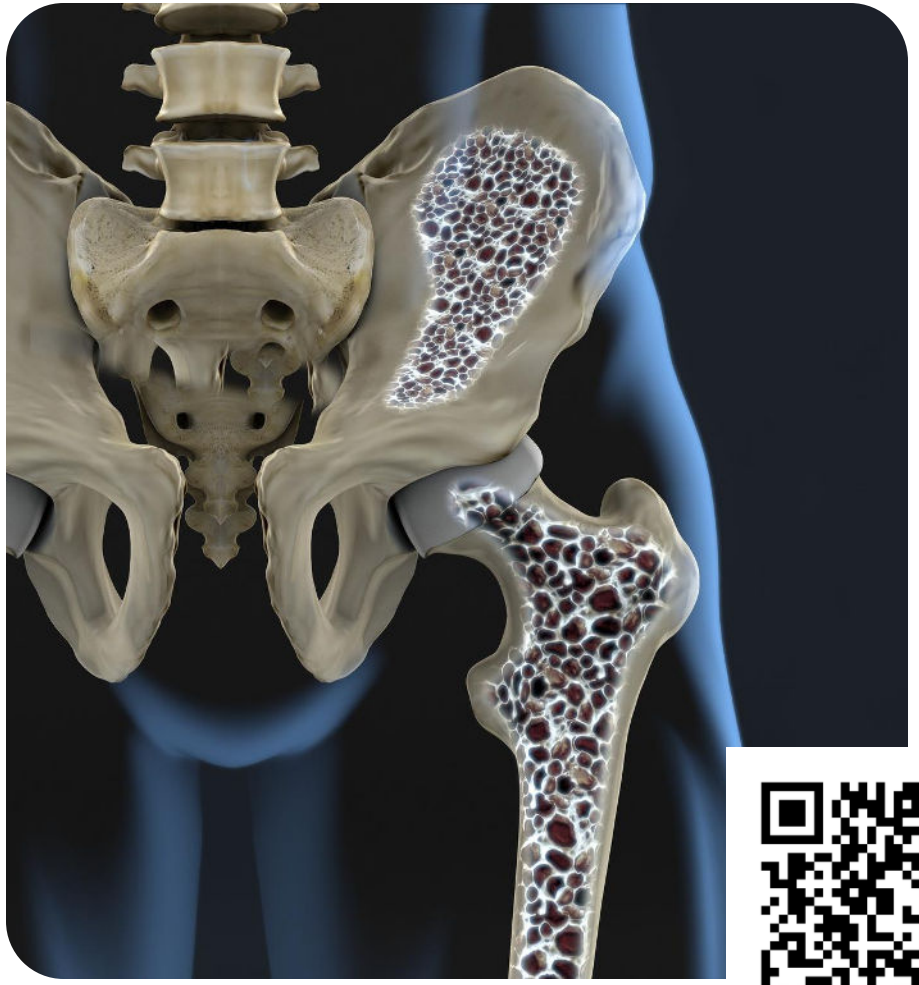
Price: $250 +HST

Register now

Ontario College of Family Physicians

ONTARIO Osteoporosis Strategy

Osteoporosis and Fracture Prevention Workshop



Participants will:

✓ Strengthen their approach to osteoporosis screening, risk assessment and treatment planning.

✓ Discover practical tools, resources and strategies that can be applied immediately in practice.

✓ Learn from expert faculty through interactive discussion, case studies and Q&A.

October 14 , 2026 | 12:00pm – 3:00pm
$195 + HST | Virtual

Earn up to 6 Mainpro+ credits!

Register Now

Scan for more info