

Guidance for clinical assessment centres: Clinical support for COVID-19, febrile respiratory and influenza-like illness

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Purpose of this document: This document was developed by Ontario Health and is intended to support clinical assessment centers to implement an expanded scope of clinical services.

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Introduction

As a response to the Omicron surge in December 2021 and the availability of COVID-19 therapeutics in early 2022, Ontario Health worked with many COVID-19 assessment centres to expand their scope to include clinical services to support people with known or suspected COVID-19 infection. These expanded sites are known as COVID-19 clinical assessment centres (CACs). CACs were modeled on the COVID-19, cough and flu clinics and other influenza-like illness clinics established in the fall of 2021.

As of fall 2022, Ontario is experiencing a significant increase in COVID-19 and other respiratory illnesses, including influenza and respiratory syncytial virus (RSV). This has led to a rise in emergency department visits and hospitalizations for these febrile respiratory and influenza-like illnesses (hereafter referred to as expanded influenza-like illnesses [expanded ILIs]), particularly in children.

Prioritizing the community-based care of patients with febrile respiratory symptoms is crucial to keep patients safe and healthy, mitigate the strain on emergency departments and prevent hospitalizations. In November 2022, Ontario Health confirmed that CACs can assess patients with COVID-19 and expanded ILI symptoms. Furthermore, Ontario Health requested CACs to plan for the following, where feasible and appropriate:

- Assessing patients presenting with ILI, cough, and cold symptoms, including pediatric patients
- Expanding after-hours coverage
- Partnering with primary care to support expansion of service hours and locations

The CACs are intended to provide timely clinical services to support Ontarians with known or suspected infection with COVID-19 and/or expanded ILI symptoms while conserving needed capacity in Ontario's emergency departments and hospitals. The CACs are an additional point of access for Ontarians in the community to receive care for COVID-19 and expanded ILI given the burden of illness and the backlogs of care and health and human resource capacity issues in existing primary and community care sectors.

This updated guidance outlines the following:

- The target patient population
- A set of planning recommendations to support equity in access
- The common elements of CACs that care for COVID-19 and expanded ILIs

Each CAC should incorporate strategies to support equity in access for populations with the greatest need, as well as the four key elements in their processes (as outlined below). A list of resources to support disposition planning is provided in the Appendices.

Target patient population

The CACs are intended for adult and pediatric patients with:

- Known or suspected COVID-19 and/or other expanded ILIs, particularly those who have **moderate or worsening symptoms who cannot manage safely at home**; or
- Those with milder symptoms who are at higher risk of severe disease and may require access to COVID-19 PCR testing and/or therapeutics that are not otherwise available through existing care pathways.


Patients can either self-refer or be referred by a health care professional (i.e., primary care clinician, pharmacist, public health staff, Health Connect Ontario nurse).

CACs are also an avenue of care for patients with ILI who do not have a regular primary care clinician.

The CACs are **not intended**:

- To replace the health care provided through existing primary and community care options, including the patient's primary care clinician, walk-in clinics, and Health Connect Ontario.
- For patients with mild COVID-19 and/or expanded ILI symptoms who are self-isolating and self-monitoring at home and/or who can be monitored safely in the community with support by their primary care clinician.
- For patients with severe COVID-19 and/or expanded ILI symptoms, who must be directed to call 911 or go directly to the emergency department.

Target patient population for CACs

<p>Mild symptoms of COVID-19 and/or expanded ILI* – patients can self-isolate and self-monitor at home.</p> <ul style="list-style-type: none"> • Fever and/or chills lasting ≤ 5 days (in adults and infants > 3 months)** • Cough (not related to other causes) • Mild shortness of breath • Decrease or loss of taste or smell • Muscle aches/joint pain • Extreme tiredness • Sore throat • Runny or stuffy/congested nose • Headache • Nausea, vomiting and/or diarrhea • Abdominal pain (not related to other causes) • Pink eye (not related to other causes) • Decreased appetite (young children only) 	<p>Moderate or worsening symptoms or as advised by a health care professional</p> <p style="text-align: center;">AND/OR</p> <p>Patient at higher risk of severe outcomes who requires access to outpatient assessment or therapeutics that are not otherwise available through their primary care clinician</p> <p style="text-align: center;"></p> <p>Target patient population for CACs</p>	<p>Severe symptoms* – direct patient to call 911 or go directly to nearest emergency department</p> <p>In adults:</p> <ul style="list-style-type: none"> • Severe difficulty breathing • Severe chest pain • Feeling confused • Losing consciousness <p>In children:</p> <ul style="list-style-type: none"> • Severe chest wall indrawing • Grunting, nostril flaring • Central cyanosis • Presence of any other danger signs (e.g., inability to breastfeed or drink, lethargy, reduced level of consciousness) • Reduced urinary output, fewer than 5 wet diapers per day • Concerning vitals (including oxygen saturation $< 95\%$) • Fever with rash • Seizure or convulsions • Increasing parent concern • Fever in an infant < 3 month** • Signs and symptoms of multisystem inflammatory syndrome in children (MIS-C)
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*The lists of mild and severe symptoms and direction for patients are consistent with [Ontario’s COVID-19 self-assessment tool](#) (updated October 2022)

**Fever in children:

- Infants < 1 month with a fever need to be assessed in the emergency department; those 1-3 months require an urgent clinical assessment.
- A fever lasting up to 5 days in an otherwise well child is being observed in the current environment and is not itself a cause for concern.
- A biphasic fever, where a fever returns after being gone more than 24 hours, requires clinical assessment as it may be an indication of worsening or new infection.

Planning recommendations to support equity in access to CACs

These recommendations are strongly encouraged as a starting point in the planning for CACs to support equity in access for populations with the greatest need:

- Work with community partners (including community agencies and local ambassadors) to address barriers to access (e.g., appointment types – walk-in vs. scheduled, hours of operation, cultural safety, considerations for people living with disabilities)
- Connect patients with available wraparound supports (e.g., consider CHCs/FHTs offering “virtual team support”, access to PPE or community supports, referral to [Indigenous Primary Health Care Organizations](#) for culturally appropriate care)
- Consider how you will monitor whether populations with the greatest need in your community are accessing CACs and modify your approach as needed

Common elements of CACs that care for COVID-19 and expanded ILIs

Each CAC should include these four elements in their processes.

1. Patient intake, data collection and reporting

The CAC is responsible for patient intake, data collection and reporting. CACs should:

- Maintain a telephone-based and/or website intake process that allows eligible patients to self-refer and make an appointment within 24 hours. Ideally online appointment booking should be implemented.
- Maintain an intake process that allows health care professionals (e.g., primary care, public health, pharmacist, Health Connect Ontario) to refer eligible patients and arrange an appointment within 24 hours.
- Register patients on arrival.
- Collect data as directed by Ministry of Health and Ontario Health.
- Where possible, collect patient reported data according to best practices, including experience and outcomes measures.
- Report data regularly to Ministry of Health and Ontario Health as directed.

2. Assessment, appropriate testing, and diagnosis

Patients are assessed and diagnosed by an appropriate health professional (e.g., physician, nurse practitioner, registered nurse, registered practical nurse, paramedic). The assessment may include oxygen saturation, vital signs, and identifying relevant risk factors/comorbidities.

Patients may be tested for **COVID-19** using a molecular or antigen test, if appropriate, following the [provincial testing guidance](#). Rapid molecular testing instruments (ID Now) for COVID only are available to CACs by

contacting covid19testing@ontariohealth.ca.

Eligibility for PCR testing for **other respiratory viruses (i.e. influenza, RSV)** in Ontario is limited and not intended for use in ambulatory settings. Current eligible populations include:

- Symptomatic children (<18 years) seen in the emergency department
- Symptomatic hospitalized patients (ward and ICU/CCU)
- Symptomatic health care workers/staff in institutional settings (non-outbreak)
- Specimens from the first four symptomatic individuals (including health care workers/staff) in an outbreak that request respiratory virus testing

For details, refer to Public Health Ontario's [respiratory testing eligibility criteria](#) for non-COVID-19 illnesses.

Additional onsite testing may be considered and could include rapid strep testing and/or direction for patients to obtain blood tests or chest x-rays.

The CAC should use **existing laboratory pathways, which may be either through the affiliated hospitals or in the community**.

CACs must ensure appropriate follow-up of any testing performed.

3. Actions following diagnosis, including treatment

Treatment and disposition planning will require clinical expertise and judgement of the health professional(s) involved in the assessment of the patient.

Disposition planning

The CAC is responsible for disposition planning for the patient, which may include handover of the patient and/or creation of a follow-up plan for patients at higher risk either with their primary care clinician or back to the CAC.

CACs should be familiar with the scope of practice of the nearest emergency department(s) they will rely on, including their preferred method of handover of clinical information. CACs should also have a plan for the emergency transportation of unstable patients by paramedics through use of the 911 system (refer to [Appendix A](#) for more information on who to refer or transfer emergently).

Depending on the patient's condition and risk of clinical deterioration, disposition options may include:

- Home with self-monitoring ([Who can be managed at home?](#))
- For COVID-19: Home with COVID-19 remote care monitoring, as available in your region (e.g., programs offered through home and community care, programs offered through primary care clinician such as [COVID@Home](#) Monitoring for Primary Care).
- Where possible, direct to inpatient COVID-19 unit if available ([Who should be hospitalized?](#))
- Direct to emergency department for further investigation (refer to Appendix A).

Patient-facing resources to support discharge planning for adults and children are available in the Appendices.

Therapeutics

Depending on the patient's diagnosis, risk for severe disease, and other clinical factors, treatment options may include:

- **COVID-19 therapeutics** including:
 - [Nirmatrelvir/ritonavir \(Paxlovid\)](#)
 - Remdesivir (reach out to Ontario Health regional contacts listed in [Appendix F](#) for information on access pathways for outpatients)For more information, visit:
 - Ontario Health's COVID-19 [therapeutics resources](#)
 - Centre for Effective Practice's [overview of available COVID-19 therapeutics](#)
- **Influenza therapeutics:** Oseltamivir (Tamiflu) and zanamivir (Relenza) are available for outpatient treatment of influenza in select patients at higher risk of complications or influenza and/or have severe, complicated or progressive illness as per [Public Health Ontario \(2022\)](#) and [AMMI Canada \(2019\)](#) guidance.
 - Treatment should be guided by clinical judgement and commenced as soon as possible (ideally < 48 hours). Refer to AMMI Canada Figures A and B for treatment algorithms for adults.
 - For **child and youth treatment** algorithm refer to AMMI Canada Figures C.1. Note that for children with mild influenza illness who are otherwise healthy, antiviral treatment is not routinely recommended.
 - For guidance on **prophylaxis and/or treatment of close contacts** of suspected or lab-confirmed influenza refer to AMMI Canada Figure D.1. Early treatment (i.e., before symptoms) may be considered for the very highest risk household contacts of lab-confirmed influenza cases as soon as possible after exposure.
 - **Dosing** based on age, weight and renal function are found in Table 2 and 3 of the [AMMI Canada \(2019\) guidelines](#).
 - Starting November 30th 2022 there will be [an updated LU Code](#) for the use of oseltamivir (Tamiflu) for the treatment of influenza in those at high risk of complications, consistent with the PHO Guidance.
- **Antibiotics** may be required for the treatment of presumed bacterial infections. Refer to [Choosing Wisely Canada's website](#) for the judicious use of antibiotics and patient education materials, including a "viral prescription".
- [Provide advice on antipyretic \(i.e., acetaminophen and ibuprofen\) treatment/formulations](#) for children, including local identification of compounding pharmacies, and the dosing options for [splitting/crushing adult tablets](#).

Additional tools and resources to support treatment are provided in the Appendices.

4. Follow-up care

The CAC is responsible for the creation of a follow-up plan for patients at higher risk either with their primary care clinician or back to the CAC. Elements of follow up care are listed below.

- Provide **discharge instructions to patients** (refer to the Appendices for tools and resources to support follow up care).
- Maintain a process to **hand over and follow up care to primary care** and if indicated, home and community care – with appropriate communications, including a discharge summary note for primary care (discharge note should include whether medications were adjusted)
- For **those without access to primary care clinician**, provide information about follow-up options (e.g., [Health Connect Ontario](#), nearest walk-in clinic, any other relevant supports) and/or connect patient with primary care options in the community
- For those patients who **require further investigation or treatment**, maintain a process to direct appropriate patients to nearest emergency department
- If directly providing therapeutics like Paxlovid, provide appropriate follow-up care to monitor for side effects for the course of the treatment
- Provide **direction on preventive care and risk reduction strategies** including: the [use of masks/isolation within the household](#), when/where to obtain [COVID-19](#) and/or [influenza vaccination](#) and/or how access to the [RSV prophylaxis program for high-risk infants](#).

Appendices: Resources to support disposition planning for CACs

This section links to existing clinical tools and resources that may assist in assessment, treatment, and disposition planning for patients with suspected or confirmed COVID-19 or expanded ILIs visiting a CAC.

Assessment, treatment, and disposition planning will require clinical expertise and judgement of a patient's condition and risk of clinical deterioration.

- [Appendix A. When to refer or direct transfer to the emergency department or inpatient COVID-19 hospital setting \(adults and children\)](#)
- [Appendix B. Home with self-monitoring or COVID-19 remote care monitoring](#)
- [Appendix C. Patient self-management and self-monitoring resources](#)
- [Appendix D. Provincial testing guidance for COVID-19, Influenza and RSV](#)
- [Appendix E. Outpatient treatments for COVID, febrile respiratory illness and Influenza](#)
- [Appendix F. Other local supports available](#)

Appendix A. When to refer to the emergency department or direct transfer to inpatient hospital setting

Adults

The table below describes signs and symptoms in adults that may indicate that direct transfer to the emergency department or to inpatient hospital setting is required. Note that the constellations of signs and symptoms, progression of the patient’s illness over time, and additional risk factors are considered together to determine best setting to meet care needs. Use your clinical judgement.

CACs should familiarize themselves with the nearest emergency department(s) and their scope of practice (i.e. do they care for adult, pediatric or both populations). Ideally the CAC will establish with the emergency departments they will rely on what is the preferred method of handover of clinical information when patients are sent to the emergency departments – by phone call (to the physician on duty or triage nurse), fax or written note to accompany the patient. Patients in acute distress or with unstable vital signs should be transported by paramedics through use of the 911 system. In other cases, a discussion with the patient/family should verify they have a safe mode of transport and clear understanding of where they are going and the need to attend immediately.

Signs and symptoms of severe illness in adults (see below for children)

Signs	Symptoms
<ul style="list-style-type: none"> Heart rate > 110 bpm, respiratory rate > 24 breaths per minute, oxygen saturation (SpO2) consistently ≤ 92% on room air, and/or consistently reducing/downward trend in SpO2 over time <p><i>Note: if patient has underlying lung disease with documented low normal SpO2 baseline, take this into consideration. Respiratory rate can also be affected by anxiety.</i></p> <ul style="list-style-type: none"> Severe shortness of breath at rest (e.g., breathlessness, respiratory rate > 30 breaths per minute despite normal SpO2) Blue lips or face Hemoptysis (coughing up blood) Cold, clammy, or pale mottled skin Syncope Decreased oral intake or urine output (dehydrated and needing intravenous fluids) 	<ul style="list-style-type: none"> New-onset confusion, difficult to rouse, reduced level of consciousness Pain or pressure in chest Increasing significant fatigue (can be a marker for hypoxemia with absence of dyspnea) Severe difficulty breathing

Additional risk factors for adults:

- Over 65 years of age
- Comorbidities
- Immunocompromised
- High frailty
- Lack of support at home to manage own care

Additional risk factors in pregnancy ([World Health Organization, 2020](#)):

- Increasing maternal age
- High body mass index
- Non-white ethnicity
- Chronic conditions
- Pregnancy-specific conditions such as gestational diabetes and pre-eclampsia

Sources and additional information:

- Hamilton Family Medicine (HFAM): [Assessment, Monitoring and Management of COVID¹](#): 5. When to Refer to ED and Who to Call for Acute Care Advice
- Centre for Effective Practice: [Outpatient management of patients with COVID-19](#)
- World Health Organization: [Living Guidance for Clinical Management of COVID-19](#)
- Speak Up Ontario: [Resources for Health Care Providers](#) (for resources to support advance care planning, goals of care, and person-centered decision making; discuss patient goals of care and ensure joint decision-making regarding transfer to ED)

Children

The table below describes signs and symptoms in children that indicate that direct transfer to the emergency department or to inpatient hospital setting is required. Note that the constellations of signs and symptoms, progression of the patient's illness over time (if history can be obtained), and additional risk factors are considered together to determine best setting to meet the patient's care needs. Use your clinical judgement.

Please refer to the notes under "Adults" above for notification of the Emergency Department and considerations in transport.

Severe symptoms – direct patient to call 911 or go directly to nearest emergency department

- Severe chest wall indrawing
- Grunting, nostril flaring
- Central cyanosis
- Presence of any other danger signs (e.g., inability to breastfeed or drink, lethargy, reduced level of consciousness)

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- Reduced urinary output, fewer than 5 wet diapers per day
 - Concerning [vitals](#) (including oxygen saturation <95%)
 - Fever with rash (particularly purpura, petechiae, blistering)
 - Seizure or convulsions
 - Increasing parent concern
 - Fever in an infant < 3 months*
 - Symptoms of [multisystem inflammatory syndrome](#) (i.e. abdominal pain, vomiting; rash (any type), hemodynamic shock or hypotension, conjunctivitis, diarrhea, other cardiac abnormalities (e.g., pericardial effusion, myocarditis), diarrhea, oral cavity changes (e.g., dry/cracked lips, strawberry tongue); and swelling in extremities).

*Fever in children:

- Infants < 1 month with a fever need to be assessed in the emergency department; those 1-3 months require an urgent clinical assessment.
- A fever lasting up to 5 days in an otherwise well child is being observed in the current environment and is not itself a cause for concern.
- A biphasic fever, where a fever returns after being gone more than 24 hours, requires clinical assessment as it may be an indication of worsening or new infection

Sources and additional information:

- HFAM: [Assessment, Monitoring and Management of COVID](#): 5. When to Refer to ED and Who to Call for Acute Care Advice & 11. Pediatric Assessment and Referral
 - [Paediatric COVID-19 Assessment Tool](#) (*note that each region will have their own specific access to specialized consults*)
- Centers for Disease Control and Prevention: [Information for Pediatric Health Care Providers](#)
- CHEO: [Deciding to come to the Emergency Department](#)
- Canadian Pediatric Society: [The acute management of COVID-19 in pediatrics \(spring 2021 update\)](#)
- National Institutes of Health: [COVID-19 Treatment Guidelines, Special Considerations in Children \(updated August 2022\)](#)
- Public Health Ontario (June 2022): [Pediatric Post-acute COVID-19 Syndrome \(PACS\) and Multisystem Inflammatory Syndrome in Children \(MIS-C\) – What We Know So Far](#)

Appendix B. Home with self-monitoring or COVID-19 remote care monitoring

Risk stratification can help to determine if self-monitoring or COVID-19 remote care monitoring program is more appropriate. Patients over 60 years of age, those with medical comorbidities, those with social safety net flags, or patients with symptom deterioration are higher risk and will require frequent monitoring.

Formal-at home remote monitoring programs are only available for patients with COVID-19, and most are only available for adults. Access to and admission criteria for these COVID-19 remote monitoring will vary regionally and between remote care monitoring programs. CACs will need to be aware of local monitoring programs, including those that are primary care team-based. Visit [this Ontario Health webpage for a list of monitoring programs](#), including eligibility criteria and referral information.

In general patients with the following presentation can be considered for return to home with self-monitoring or a formal COVID monitoring program.

- Have only mild to moderate uncomplicated COVID-19
- Have an SpO₂ > 93% in adults and ≥95% in children
- Stable vitals including respiratory rate (visit PedsCases' [Pediatric Vital Signs Reference Chart](#))
- Show no signs of respiratory distress
- Able to stay well hydrated
- Have access to appropriate resources and social supports to manage at home (including access to food and other necessities, a caregiver, or home care if required,
- If indicated, have ability to measure own SpO₂ with pulse oximeter. Primary care organizations can submit a request for monitors by completing [this ordering form](#).

Sources and additional information:

- HFAM: [Assessment, Monitoring and Management of COVID](#): 6. Monitoring and Follow-up, Risk Stratify Patient
- Information on assessing pre-existing medical conditions:
 - HFAM: [Respiratory conditions \(COPD, asthma\)](#)
 - Canadian Cardiovascular Society: [COVID-19 Resources](#)
 - [RX Files Handout: Type 2 diabetes and sick days: Medications to pause](#)
 - Government of Canada: [People who are at risk for more severe disease or outcomes from COVID-19](#)

Appendix C. Patient self-management and self-monitoring resources

Resources related to COVID-19

- Public Health Ontario:
 - [How to self-isolate](#)
 - [Self-isolation: Guide for caregivers, household members and close contacts](#)
 - [Multilingual COVID-19 resources](#)
- [Confused about COVID](#) (U of T Department of Family and Community Medicine and Ontario College of Family Physicians) multiple patient resources including:
 - [I think I have COVID. When should I call my doctor?](#)
 - [I'm pregnant. How can I keep safe? What should I do if I get COVID?](#)
 - [My child has covid what should I know?](#)
- HFAM:
 - [COVID-19 Guide for Patients](#) (includes patient information including illness course, self-care and monitoring and use of pulse oximeter instructions)
 - [Translated Guides for COVID Patients Being Monitored at Home](#) (available in several languages)
 - [Translated Pulse Oximeter Patient Instructions](#) (available in several languages)

Resources for managing fever and respiratory illness in children

- CHEO:
 - [Care for fever at home](#)
 - [Cough and colds](#)
 - [Bronchiolitis](#)
 - [Croup](#)
- Sick Kids:
 - [Fever](#)
 - [How to safely use acetaminophen or ibuprofen tablets by mouth for children](#)
- Canadian Pharmacists Association and Children's hospitals: [Information for families and caregivers on children's fever and pain medication](#)
- Ontario College of Family Physicians: [Caring for kids with respiratory illness at home](#)

Appendix D. Provincial testing guidance for COVID-19, influenza and RSV

Guidance from the **Ministry of Health**:

- [COVID-19 Provincial Testing Guidance \(October 2022\)](#)

Guidance from **Public Health Ontario**:

- [Respiratory viruses \(including seasonal Influenza and respiratory syncytial virus \(RSV\)\)](#)

Appendix E. Outpatient treatments for COVID-19, febrile respiratory illness, and influenza

Treatment for COVID-19:

- Ontario Health: [Access to COVID-19 antiviral treatment \(Paxlovid\)](#)
- HFAM: [Assessment, Monitoring and Management of COVID](#): 7. Management
- Ontario COVID-19 Drugs and Biologics Clinical Practice Guidelines Working Group: [Therapeutic Management of Adult Patients with COVID-19](#)
- Centre for Effective Practice: [Recommended drugs for patients with mild COVID-19](#)
- Ontario College of Family Physicians: [Regional sites offering remdesivir and Paxlovid](#)

Treatment for seasonal influenza:

- Public Health Ontario (2022): [Antiviral Medications for Seasonal Influenza](#)
- AMMI Canada (2019): [Use of antiviral drugs for seasonal influenza: Foundation document for practitioners—Update 2019](#)
- Canadian Paediatric Society (2018): [The use of antiviral drugs for influenza: Guidance for practitioners](#)
- Centre for Effective Practice: [Managing fall/winter season in primary care - Therapeutics](#)
- Ministry of Health: [Ontario Drug Benefit Formulary/Comparative Drug Index](#) (information on Limited Use codes)

Treatments for other respiratory illnesses:

- Choosing Wisely Canada (2022): [Antibiotics](#) (their judicious use, as well as patient education materials including a “viral prescription”)
- Canadian Pediatric Society (2021): [Management of acute asthma](#)
- The Centre for Evidence-Based Medicine: Guidance on [differentiating viral from bacterial pneumonia](#)

Appendix F. Other local supports available

Ontario Health regions may share additional supports available locally, including:

- Specialist consult supports (e.g., GIM, palliative care specialist, respirologist etc.), including through e-consult
- Additional local supports for patients (home care, food bank or food delivery services through volunteer organizations, palliative care supports, mental health supports)
- Through **Health Connect Ontario**, patients can access non-urgent health advice from registered nurses 24/7 via telephone (811) or online chat at ontario.ca/HealthConnectOntario.
- The Centre for Effective Practice has [a list of local services](#), including assistance for isolated people, diagnostic centres, financial services, food, home care, home equipment, mental health services, and pharmacies, broken down further by region where applicable.

Please find below a list of contacts by region.

Ontario Health Regional Contacts

Central	Mira Backo-Shannon (Mira.Backo-Shannon@ontariohealth.ca) David Pearson (David.Pearson@ontariohealth.ca)
East	Farrah Hirji (Farrah.Hirji@ontariohealth.ca) Lesley Ng (Lesley.Ng@ontariohealth.ca)
Toronto	Rose Cook (Rose.Cook@ontariohealth.ca) Shama Malik (Shama.Malik@ontariohealth.ca) Leona Pereira (Leona.Pereira@ontariohealth.ca)
West	Emily Christoffersen (Emily.Christoffersen@ontariohealth.ca) Karen M. Bell (Karen.M.Bell@ontariohealth.ca) Heather Byrnell (heather.byrnell@ontariohealth.ca) Tammy Meads (tammy.meads@ontariohealth.ca) Jennifer Mills Beaton (jennifer.millsbeaton@ontariohealth.ca) Ontario Health West Primary Care Clinical Leads: <ul style="list-style-type: none"> • Dr. Gord Schacter, Erie St. Clair (gschacte@uwo.ca) • Dr. Paul Gill, South West (paul.gill@medportal.ca) • Dr. Sharon Bal, Waterloo Wellington (sharon.bal@medportal.ca) • Dr. Scott Elliott, Hamilton Niagara Haldimand Brant (scotthelliott@sympatico.ca)
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