
# CITIZEN ADVISORY GROUP MEETING REPORT

## SATURDAY, OCTOBER 21, 2017

**College of Physiotherapists of Ontario Offices**
**800 – 375 University Ave, Toronto ON M5G 2J5**

**10:00 a.m. – 4:30 p.m.**

**Facilitator: Misha Glouberman**

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# WELCOME AND OPENING EXERCISES

The meeting was opened by Misha Glouberman, who welcomed the attendees and introduced Lisa Pretty, Citizen Advisory Group Partnership Chair and Communications Director of the College of Physiotherapists of Ontario.

Lisa gave a brief overview of purpose of the Citizen Advisory Group (CAG). The Group was initiated almost two years ago by the College of Physiotherapists of Ontario to provide a way to connect with the public. Building on the success of that College, a partnership of nine Colleges (of the 26 health regulatory Colleges in Ontario) was formed and the Citizen Advisory Group was expanded.

Colleges' governing Councils are made up of professionals, appointed public members, and sometimes representatives of educational programs. The public members are important, but it is important, too, for Colleges to hear directly from patients and caregivers who have hands-on experience with the healthcare system in Ontario. Colleges need to hear directly from patients or their caregivers about their experience.

CAG members were reminded that Colleges exist to protect the public interest. The conversations held with the Citizen Advisory Group have tremendous value for health regulatory Colleges as the Colleges serve their role as protectors of the public interest, ensuring healthcare professionals provide safe, competent, and ethical care.

Participants formed small groups and were assigned warm-up topics for discussions as the meeting began.

**OPENING EXERCISES**

Participants were asked for their thoughts about why they were at this session. Feedback included the following:

- improving patient experience
- looking for positive change
- making a change outside this group
- hearing other perspectives
- understanding boundaries of right/wrong
- advocating for those who don't have a voice
- understanding the expectations of the people who brought us together

Participants were then asked to share their thoughts about what would be important to remember throughout the day. The following was offered:

- respect for others' opinions and diversity of opinions
- lots of opportunity for discussion and good use of time
- having opinions heard and things actually happening because of the opinions that were shared
- validation that opinions are considered and taken seriously, not just "for the record"
- serving the needs of the Colleges as well as the needs of the group
- important to be heard and valued

**CONFIRMATION OF CONFIDENTIALITY**

It was agreed by all that participants are accountable for respecting what goes on at this meeting and that they will appropriately maintain confidentiality of all parties, including sharing information from work with other organizations or personal situations. It was also agreed that it is helpful to share what happens at CAG meetings, generally, in the spirit of transparency and openness, a value that is also held by Colleges.

A policy of "We are all adults" was formed: if something is confidential, it should be carefully shared and noted to be confidential, and CAG members should not share names or situations that could identify an individual outside of the meeting.

The reports from CAG meetings will be public documents, but comments and discussions will not be attributed to any particular person.

**CONFIRMATION OF TOPICS**

**Definition of a Patient:** Sponsored by College of Occupational Therapists of Ontario, College of Physiotherapists of Ontario, and Ontario College of Pharmacists

**Quality Assurance Programs**: Sponsored by College of Naturopaths of Ontario and College of Physiotherapists of Ontario

# DEFINITION OF A PATIENT

The definition of a "patient" has become even more important to all health regulatory Colleges since the introduction of Bill 87, *the Protecting Patients Act, 2017* which has a focus on protecting patients from sexual abuse by healthcare professionals. Defining a patient too broadly or too narrowly could cause problems, and there are serious consequences for a healthcare professional who enters into a physical relationship (defined by the legislation or more strictly by individual Colleges) with a "patient".

## GENERAL INPUT FROM THE CITIZEN ADVISORY GROUP

**Why does getting the definition of "patient" right matter?**

- For vulnerable patients, an encounter with a healthcare professional could become uncertain and unsafe.
- The public assumes that it is a "safe space" with a healthcare professional and if the professional steps outside that "space", it could be traumatic.
- Some patients might "manipulate" the situation.
- Ambiguity of boundaries: what is the cut-off of time – is it a five-minute encounter with a one-hour interaction?
- Having a clear definition is important.
- The professional might feel they are hemmed in (e.g., they can't hug anyone) and/or they are afraid to give advice or may be construed in giving advice to avoid a "patient" relationship.
- Would the creation of a "contract" between patients and healthcare professionals be helpful? It could outline what is allowed, like a consoling hug or culturally appropriate kisses on both cheeks.
- Too narrow a definition is positive for health professionals as they are more protected but there is a downside for patients.

## SCENARIOS WITH OCCUPATIONAL THERAPISTS (OTS)

**SCENARIO 1:**
*A woman goes to a store to find information about installing safety rails in the bathtub to prevent a fall. The salesperson at the store is an occupational therapist (OT). Is the woman a patient of that OT?*

**Majority vote – not a patient**

CAG reasons why the woman is not a patient:

- Professional sales capacity – not doing OT work there
- The individual did not identify themselves as an OT.
- The woman was not seeking OT supplies.

- The woman did not ask specific questions about her individual needs; therefore, she was not getting OT advice.

CAG reason the woman is a patient:
- An OT is professional; the woman is seeking information about the installation of safety rails. She is seeking advice from a professional. This is the type of advice an OT would dispense.

CAG members who did not vote:
- Was the salesperson hired as an OT?
- If the salesperson is an active member, then she would be held to the standards of her profession.
- Was the OT acting as an OT in the store? Without knowing the type of information noted above, it is hard to answer.

**SCENARIO 2:**
*If a person attends a drop-in education session on arthritis run by an OT in a local community centre, are they a patient/client?*

**Majority vote – not a patient**

CAG reasons why the woman is not a patient:
- They are holding an information session, not providing treatment.
- In a room with 200 people with an OT presenting about OTs, it doesn't make the attendee a patient.
- If a healthcare professional tweets, would all Twitter followers be patients?
- The contact is not direct or individualized.
- This is education and not therapy and, while OTs do provide education, it doesn't apply to a group like this. Individualized education might change things.

CAG reason the woman is a patient:
- The OT is giving a service and providing information, as well as giving professional information to do with the profession. As a professional, if you gave wrong information, that would have an impact (e.g., generate a complaint). There is professional accountability.

Additional comments:
- With 200 people in the room, would that be 200 patients?
- "Direct" care implies one-on-one (although there were varying opinions expressed that this is acceptable).
- If the therapist gives information and if something goes wrong, they are responsible. This is a drop-in session, though, and that might make a difference.
- The drop-in format is anonymous; if it's a conference with sign-in, names provided, opportunity for follow up, etc., there is direct correlation between giving advice.

- How does the patient identify? Do they identify as a patient? If they do, the healthcare professional must treat them as a patient.

**SCENARIO 3:**
*A grade one student is receiving occupational therapy services at school in the classroom. Is the student's parent a patient?*

**Majority vote – a patient**

CAG reasons why the parent is a patient:
- The 6-year old child is a minor, not responsible.
- The student cannot make decisions by him/herself.
- The parent is accessing the services of the OT to help their child; they are the "client".

**SCENARIO 4:**
*A man is receiving services in the hospital as an in-patient, following a stroke. Is the man's daughter considered a patient? Does it matter if the patient is able to make decisions on his own or if he requires his daughter to make decisions for him?*

**Majority vote – the daughter is a patient if the father can't make decisions/if the daughter is not making the healthcare decisions for the father (i.e., does not have power of attorney), she is not the patient**

CAG reasons why the daughter is a patient:
- If the man can make decisions on his own, he is not the patient.
- Under the current definition, the patient may be a family member (i.e., the daughter).
- It doesn't matter whether the patient can make their own decisions because if the daughter is integral to the care team, she is a "patient".
- An OT cannot share confidential information with someone who hasn't been given a right to receive that information by the patient. There are rules of law about that.
- You can't date anyone who is part of the care team.

CAG reasons why the daughter is not a patient:
- If you give another person power to make decisions and the OT recommends something and your daughter, who doesn't have that power, disagrees, it could get "murky". And then what if the OT wanted to date the daughter?
- Unless there is some kind of formal relationship between the client and family involved with their consent, there is no personal connection.
- As an example, if you go with a friend to a doctor's appointment, the friend is not a patient.

Additional comments:

- How the patient chooses their caregiver team is a separate question. A professional should not be allowed to have a relationship with a member of a caregiver team who can make decisions for the patient.

**SCENARIO 5:**
*An OT is asked by an insurance company to complete a review of a young man's health record to determine what health care services may be required in the future. If the OT never meets the individual in person, is the individual a patient of that OT?*

**Vote split: 1/3 for "patient", 1/3 for "not a patient", 1/3 "not sure"**

CAG reasons why the person is a patient:
- If the OT has had access to a patient's personal information, it would be invasive to have a romantic relationship. Dating someone who has access to your personal information seems to be a power imbalance.
- A regular dating relationship may not reveal the personal information that would be found out through the review of health records.
- Could be other information be found out, such as whether the person has lots of insurance coverage? There is a lot at stake and there could be complications.
- If the OT is reviewing the file in the office (and not with the patient in person), they still have all the information; consider that with Telehealth, healthcare professionals are "meeting" you on screen, which is like an in-person interaction.

CAG reasons why the person is not a patient:
- What service did they provide to the patient?
- Is the identity actually identified? It was suggested that it was just broad demographics.
- The client is the insurance company – it hired the OT, not the person whose file is being reviewed.
- If the patient information was anonymized, that makes a difference.

Additional comments:
- Some healthcare providers share cases with each other to provide professional guidance. In this case, if the OT is working for the insurance company, and they go to their peer group to share ideas there are other issues to consider.
- Does the definition of a patient need to be different for different professions?

**SCENARIO 6:**

*An OT runs a weekly group for individuals living with mental health conditions, if the OT only sees the individual in a group setting, is the individual a patient?*

**Unanimous vote – a patient**

CAG reasons why the person is a patient:
- They are the direct recipient of service. (Why did COTO think this was tricky?)

## SCENARIOS WITH PHARMACISTS

**General discussion:**
- "I want all the rights of a patient during those five minutes with a healthcare professional, but waiting a year to date someone I'm attracted to seems too long."
- Consider two definitions: one that applies solely to sexual relationships and one that applies to everyone else. But defining "patient" into two different categories could be problematic (i.e., situations where there is some sliding from one to another).
- Colleges need to educate their members and the public about patient relationships to have it clearly known to all parties.
- For both for the healthcare professional and the public, there needs to be clarity.
- Consider a discussion on sexual relationships versus who is a patient.
- Health care professionals need to have a higher level of duty.
- Is it not just about sexual consent? Does it mean, for example, a patient can't go for coffee with their pharmacist? There is confusion between a sexual relationship and a personal relationship and boundary issues and makes the "patient" definition more difficult.
- Is it feasible that Colleges could have two definitions? Should there be 26 definitions among the Colleges or one for all?
- In small towns, where there is one pharmacy, that makes it tough for the pharmacist.
- If a pharmacist gives information about a medication, in almost all situations, the person getting the information would be a patient. If a pharmacy technician just takes direction, doesn't have access to records, and just supports a transaction, in almost all situations, the person getting the medication would not be a patient.
- Some CAG members saw the personal relationship rule as reasonable and others thought it was extreme.

### SCENARIO 1: AT THE COUNTER, FORMAL CONSULTATION WITH A PHARMACIST

*You arrive at the pharmacy and approach the counter where you are greeted by a pharmacy staff member. You are not sure if it is a pharmacist or pharmacy technician. You explain that you have some questions about the medication you've been given from that pharmacy and would like to discuss it with someone. The staff member calls a pharmacist to the counter to speak with you. After a brief 3-minute discussion and after having your questions answered, you complete your visit to the pharmacy.*

*In this scenario, would it be reasonable to say that you are a patient of the pharmacy professional you interacted with? If yes, why? If no, why not? What about if you interacted with more than one professional, such as when the pharmacy technician welcomed you and requested the pharmacist to talk to you for a consultation: would you consider yourself to be a patient of the technician too, or just the pharmacist who provided the consultation? If yes, why? If no, why not?*

**Majority vote – patient of the pharmacist / not a patient of the pharmacy technician**

CAG reasons**:**

- Considerations need to be given to whether the scenario was related to medication they previously got from that pharmacist.
- The individual is not a patient of the pharmacy technician because the interaction was more upfront customer service and not about providing pharmacy service.
- In some large pharmacies, there is a variety of staff everyone needs to be considered part of the pharmacy team who has access to patients; the person in this scenario then would be a patient of the pharmacy technician.
- People could be considered patients/clients of a "pharmacy". The person is a patient but a patient of whom? Does use of the term "client" or "patient" matter?
- The person wasn't provided with a service, as the technician just directed information and had no access to records.
- Consider where a person walks in and describes a rash to the pharmacy technician, who then refers them to the pharmacist to ask a question; they haven't offered advice but have been exposed to the patient's medical information. They would be a patient as opposed to a situation when the person asks a simple question when no relationship. There is a need for a clear line to be drawn for the definition of a "patient" when a pharmacy technician is dealing with dozens of patients. The counter may help to draw a line – are they behind it or in front of it? That could be a clear line.
- When a drug is explained to a person, is it the pharmacist who explains it? Pharmacy technicians can fill the prescriptions, but can they discuss it with the patient? It was noted that if pharmacy technicians do not discuss the medication, the person getting the medication would not be a patient.
- Pharmacists and pharmacy technicians are under a regulatory body whose rules they have to abide by, and under that umbrella, there are ethical things they have to adhere to, like not having a sexual relationship with anyone who could be construed to be a "patient".

**SCENARIO 2: IN THE AISLE, INFORMAL CONSULTATION**

*You visit a pharmacy and are looking at common pain killers available without a prescription off the shelf. You are not sure about the difference between ibuprofen and acetaminophen and have a question about which would be the best product for you. You see someone from the pharmacy walking down the aisle towards you and stop him/her to ask the question. The staff member (you are not sure if it is a technician or pharmacist) provides you basic information about the differences of the two medicines and how they are typically used and you feel satisfied with the answer. You then make your way to the cashier to complete your purchase.*

*In this scenario, would it be reasonable to say that you consider yourself to be a patient of the pharmacy professional you interacted with? If yes, why? If no, why not? Is there anything about this situation that would need to change to make you feel like you were a patient?*

**Vote – split between patient and not a patient of pharmacy professional**

CAG reasons:

- Not an established patient/pharmacist relationship for this type of interaction.
- Over-the-counter assistance was provided and it is a coincidence that the individual was seeking the opinion of a licensed professional. (It could have been anyone but a stock person shouldn't be answering drug-related questions and should help the person find a pharmacist.) It would not be a patient.
- Pharmacists should be identifiable with their "little white jackets"; people would go to the counter for advice if they needed it. These would be patients.
- Is there a difference between something being prescribed and buying something off the shelf when it comes to pharmacists' duties?
- The customer doesn't know if the person walking by is a pharmacist.
- If a person explained products to a customer, the customer would likely make a decision based on that. That would be a patient.
- It doesn't matter if the medication is over-the-counter or prescription; the person interacting with the public has to have knowledge and people would be patients when they get information about medication.
- "It feels draconian to tell someone (a pharmacist) they can't date a person if they've answered a question about aspirin."
- You should consider that you are a patient of everyone on the "team" who has access to your information.
- It might be a "patient relationship" if a pharmacist uses his/her knowledge to give information about aspirin, but it did not seem appropriate to prevent a relationship evolving with just this interaction.

**SCENARIO 3—NOT YOUR 'REGULAR' PHARMACIST**

*You've just visited an after-hours walk in clinic and received a prescription that you'd like to have filled right away. Your regular pharmacy is closed and so you visit a nearby pharmacy to have your medication dispensed. You have no questions for the pharmacy staff. You are dispensed the medication and are provided a review of the medication including instructions on how to take the medicine and receive summary of potential side effects before you leave. You complete the visit to the pharmacy and plan to update your regular pharmacist the next time you visit him/her.*

*In this scenario, would it be reasonable to say that you consider yourself to be a patient of the pharmacy professional you interacted with even if it isn't your regular pharmacist/pharmacy? If yes, why? If no, why not?*

**SCENARIO 4—THE CALL**

*Same scenario as above, except that instead of visiting the pharmacy to dispense medication, you call the pharmacy for an over the phone consultation about a prescription medication that was given to you by your regular pharmacist (who is currently not available). The staff member who answers gets the basic details from you but then asks the pharmacist to speak to you to help answer your questions. After a 2 minute conversation, you feel you have the information you need and thank the pharmacist for his/her time and conclude the call. You plan to update your regular pharmacist when you see him/her next. In this scenario, would it be reasonable to say that you would consider yourself to be a patient of the pharmacy professional you interacted with over the phone, even if it isn't your regular pharmacist? If yes, why? Both professionals or just the pharmacist who provided the consultation? If no, why not?*

The above scenarios were felt to have been addressed in the earlier comments. No additional input was provided into these scenarios specifically.

**Other comments:**

- To a regulator, it seems reasonable that if it is a patient interacts socially, regularly, with their healthcare profession, that professional should discharge the patient. (Half of the CAG agreed.)
- A diversity of opinion on friendships with a patient were noted. ("It's all good until things go wrong.")

# CONTINUING COMPETENCY AND QUALITY ASSURANCE

## PROFESSIONAL DEVELOPMENT AND CONTINUING EDUCATION FOR REGULATED HEALTH PROFESSIONALS: EXPECTATIONS FROM THE PUBLIC ABOUT A QUALITY ASSURANCE PROGRAM

A brief introduction about quality assurance (QA) programs, which includes mechanisms to ensure healthcare professionals are able to offer the delivery of safe, competent, and ethical care to Ontarians. All healthcare professionals need to participate in some sort of QA program. These can include continuing education requirements, peer assessments, practice assessments, and more. QA programs are generally focused on ensuring practitioners provide safe, competent and ethical care throughout their careers. They are not focussed on quality improvement per se, but moreso on quality assurance and control. All Colleges have quality standards and Colleges monitor their members: who is performing appropriately and who is under-performing. Different Colleges have different programs in place.

### FEEDBACK ON CONCERNS AND EXPECTATIONS REGARDING RECEIVING SAFE, COMPETENT, AND ETHICAL CARE:

- Regarding continuing education (CE) credits, what stops someone from going to a course and then not considering what was presented to make changes things in their practice? Consider making healthcare professionals agree to use new practices when appropriate.
- "It is hard for a participant to fail a CE course." What measures to guarantee learning actually took place are there?
- Continuity and consistency of programs are concerns.
- Even with the healthcare professional having a diploma, a patient wouldn't care about that or if they had their education updated. ("I am only concerned about my daily interaction with my physiotherapist, and how they treat me is what I care about.")
- "Some people say you should change your doctor every seven years. When someone gets his license and starts practising, new stuff comes out and he's too busy in his practice to address them. Where do you find the balance – the patient wants quality of care?"
- It would be good if patients could look up what courses the healthcare professional has actually taken and what kind of education it is (i.e., the patient would want to know if it is a continuous program/course or not). There should be clear information for patients about what to expect in terms of healthcare providers taking courses and being trained.
- A patient's concern is if the treatment they're receiving is effective. Is the professional competent and is what they're doing working?

### Poll of Issues Raised – By Votes Received

10 Transparency
13 Therapy effective
2 Can't fail a course
2 Care more about personal relationship
4 Take a course but don't change
5 Continuity of service

**FEEDBACK REGARDING WHAT A COLLEGE CAN DO:**

- The job of Colleges is to enforce a standard.
- Charter of patient rights could be considered, e.g., patient-focused information re. minimum care they can expect, the training the member has taken, etc.
- The healthcare professional could give statistics on the proposed treatment and its effectiveness (i.e., some information on effectiveness of certain treatments, procedures, etc.). Require statistics on patient results and share them broadly with Colleges collecting that type of information. Different professions could provide information on treatments and their effectiveness.
- OHIP only pays for a standard 10 treatments for many funding blocks; how is this effective and what if the healthcare professional cannot complete their required treatments in that time? Who is responsible for ensuring patients receive the care they need? Concern was expressed about efficacy of treatment, i.e., updating of skills might not be what the patient cares about.
- Patients need to receive benchmarks and targets regarding their treatment plans.
- The peer assessments and self-assessments that Colleges execute should focus on the effectiveness of the care the professionals are providing, i.e. improvement should be seen.
- Colleges could survey patients on the effectiveness of the care being provided and the quality of the treatment plans.
- Make every healthcare professional complete an understandable “form”, or treatment plan, for the patient (i.e., diagnosis, here’s what we’re going to do and the expectations).
- Colleges should be an ombudsman in case of client concerns, taking patients’ questions seriously, providing direction, and indicating how they will investigate/report back to the patient. Treat patients as a “customer” if the public interest is truly their concern.

**Poll of Issues Raised – By Votes Received**

12 College surveying patients on efficacy
8 Clear treatment plan
6 Sharing how effective treatments are
4 Ongoing development through peer and self assessment
3 Poster explaining expectations for patient
3 Enforcing standards
1 Ombudsman on concerns
1 Mandating appropriate treatment length

**NATUROPATHS: CONTINUING EDUCATION AND KEEPING SKILLS CURRENT**

The CAG was provided with an overview of the current strategies used by the College of Naturopaths of Ontario for its QA program:

- Every year, the member does a self-assessment to identify areas for improvement and the member creates a learning plan to show how they are going to improve, e.g., conferences, online courses, self-study.
- Every 3 years, the member submits CE activities (30 credits of core clinical skills and 40 hours of self-directed CE).
- Every 5 years, the College randomly selects members for peer assessment and plans for improvement are created.

**FEEDBACK ON ASPECTS OF THE COLLEGE OF NATUROPATHS OF ONTARIO'S QA PROGRAM:**

- The majority agreed that the QA program was "sufficient" and approximately 1/3 were "reasonably okay" with what was presented.
- It is good that the member can self-assess and "zero in" on their own practice needs and specify their own training (i.e., focus on their own practice/needs).
- The College approval of courses is positive and sets a universal standard.
- Peer assessment is a good measurement tool but should be more frequent, perhaps no less than 2 ½ years.
- Self-assessment is good, but does the College look at efficacy? Is what the member says they are going to do actually working?
- Ongoing learning is important to ensure naturopaths are staying current.
- The College needs to ensure that a universal standard is applied to everyone.
- In general, self-assessment tools are viewed to be not too strong. Questions should be uniform, and the results should always be sent back to the College for review.
- The self-assessment can be skewed and is subjective and could be unreliable. Could there be a section for someone else to comment?
- There needs to be reliable statistics or data in addition to the self-assessment processes.
- Where is the voice of the patient in the self-assessment process (e.g., survey or College independently seeking input)?
- Peer assessments should be observed in the patient's environment. Some healthcare professionals think they are doing okay and having a peer assessment has real value in demonstrating the need to upgrade skills.
- Show collaboration of the professional with other professionals, which gives the patient confidence that the professional is keeping their skills up-to-date.
- A focus on outcomes needs to be considered.
- There should be random audits, similar to peer assessments.
- Audits should be risk based instead of random and not based on complaints which are lagging indicators.
- How does a College get a handle as to how effective the program is?

**Poll of Issues Raised – By Votes Received**

13 Input from patient
8 Desire for the self-assessment to go to the College
6 College reviews the self-assessment
3 More focus on outcomes
1 Self-assessment is too subjective
1 Meet with other professionals
0 More often conducting peer assessment
0 Self-assessment should be uniform

**Other Comments:**

- Unanimous support for random audits
- Majority agreed that Colleges should look at audits of higher-risk professionals, e.g., new practitioners, sole practitioners, people educated outside of Canada and with no Canadian experience
- Who is best qualified to select the appropriate training activities to meet learning needs?
- Majority agree that it would be helpful to have some degree of standardization. Professionals do need to be treated like adults.
- Since the College can't see everything every time, random drop-ins are very important to find out exactly what the professional is doing, i.e., is it up to standard?
- Good courses should be required to be taken.
- There was no consensus on the need for in-person training versus online, but the benefits of in-person training, e.g., asking question to bring clarity, were noted.

# WRAP UP

***What Went Well?***

- Great facilitator
- Group came together well
- Good synergy in the small group discussions; consider shifting groups one more time within the allotted schedule
- People were polite and built on others' ideas
- Open discussions, participants talked freely
- Good mix of patient backgrounds, healthcare, etc.
- Everyone had input
- There was space to disagree, which is important
- Good use of time: sense of accomplishment, views heard, College is listening and not taking over, which is important to the process
- Good food

***What can be done Differently?***

- More ethnically diverse group
- Provide pre-reading for all topics
- Provide materials sooner to the participants and with more time to review it
- Improve contact with the CAG
- Invitation process had a time lag in accepting the participants
- Voting process was limiting as it had only "top 2" priorities; consider a third priority, or a ranking system
- Spend more time with the broad group (but smaller) rather than breakout groups. It is hard to get collaboration with a large group and easier with sub-groups. Opinions varied about preferences for the broad group or smaller groups, with a but most people like the day's group size.
- It is still early to evaluate how effective the day was.

**CLOSING**

The process for invitations for future meetings and other opportunities for input was reviewed, noting that CAG member invitations are based on many factors, including having experience with the sponsoring CAG Partner Colleges' members (e.g., "Have you been a patient or caregiver of a physiotherapist who is sponsoring this meeting?"), geographic representation, other demographic permutations.

The participants were thanked for their participation and input.