REPORT:

CITIZEN ADVISORY GROUP MEETING

Saturday, February 8, 2020

Citizen Advisory Group
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9:30 am—3:50 pm

AGENDA ITEMS

CPSO Council President, Dr. Brenda Copps
Dr. Brenda Copps will meet with the Citizen Advisory Group to acknowledge their contributions to health-care regulation.

Item 1: **Physicians and Surgeons (CPSO): Complementary / Alternative Medicine**
We are interested in your thoughts about medical doctors (physicians) who provide complementary/alternative medicine (CAM) as part of their practice. In particular, we want to better understand what patients and caregivers think about CAM, and what our approach should be to regulating physicians who provide CAM.

Item 2: **Pharmacists (OCP): Pharmacists Prescribing for Minor Ailments**
We are seeking feedback, from the public's perspective, on the proposed expansion of pharmacist practice that would allow pharmacists to prescribe medications for certain minor ailments. This change was directed by the Minister of Health in May 2019, among other changes to expand scope of practice for pharmacists.

LUNCH BREAK

Item 3: **Dental Hygienists (CDHO): Proposed Changes to Registration Categories**
Transparency in the public interest means that the Public Register accurately describes the scope of practice of a Dental Hygienist. As such, the Registration Committee is thinking about renaming the Certificates of Registration as they will appear on the Public Register.

Item 4: **Dental Hygienists (CDHO): Exam Requirements for Entry to Practice**
The College wishes to protect and hold the confidence and trust of the public. Dental Hygienists cannot practice in Ontario until they are registered with the CDHO. How should Dental Hygienists demonstrate entry to practice competency before entering the profession? Is it fair practice to treat those who receive their education outside of North America differently than those who receive their education in Canada?

Item 5: **Audiologists and Speech-Language Pathologists (CASLPO): CASLPO Complaints Process and Information**
In support of the College's public protection mandate, CASLPO has information about the complaints process on our website. This information explains how to file a complaint, describes the complaints process as well as the possible outcomes. CASLPO staff are seeking feedback and suggestions from the CAG to enhance the quality and clarity of this information.

CITIZEN ADVISORY GROUP (CAG) REPORT
Saturday, February 8, 2020
Facilitator: Misha Glouberman

The session was called to order at 9:30 a.m. with welcoming comments and an outline of the day's program.

Dr. Brenda Copps, the College of Physicians and Surgeons (CPSO) Council president, met with the CAG to acknowledge their contributions to health-care regulation.

Members convened in small groups to meet fellow members and provided initial comments and feedback about previous CAG meetings, including:

- They enjoyed meeting different members, and hearing about their experiences and insights
- All members' opinions are relevant
- The CAG has made a difference in health-care regulation and is hearing evidence of it
- The forum provides an opportunity to learn about the different colleges and how they work
- Both positive and negative feedback is expressed at each meeting
- This group helps to represent the interests of unrepresented people in Ontario
- It is positive to see diversity in the group and this should continue to be a priority

PAST CONSULTATION UPDATE: COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO (CPSO)

CAG members heard an update from the CPSO about the impact of the most recent CAG meeting:

Advertising (CPSO)
The CPSO reported that a draft *Advertising* policy has been developed which was informed by the discussion and feedback provided by the CAG at the November 2, 2019 meeting. The CPSO heard from the CAG that while advertising can offer helpful and educational information, there are potential risks to patients and caregivers where advertising is not properly regulated. The draft *Advertising* policy aims to strike a balance between allowing advertising with information patients may need to make decisions about their healthcare, and ensuring advertising is appropriate and accurate.

The draft *Advertising* policy and companion *Advice to the Profession* document were approved by CPSO Council in March 2020 and have been released for public consultation. The CPSO encouraged the CAG to provide their feedback to the consultation to help further refine the draft *Advertising* policy going forward.

DISCUSSION ITEMS

ITEM 1: CPSO – COMPLEMENTARY/ALTERNATIVE MEDICINE (CAM)

ISSUE A: CAM

1. **What are the risks and benefits of physicians providing CAM?**

   - Worry about the cost for a patient who is being charged for a service (i.e. could be financial gain for physician)
   - Clarity: for example, is the doctor a "doctor of naturopathy"? What kind of care are they talking about (e.g. traditional, complementary)? Where is the distinction to the patient? Is the model moving towards being less evidence-based? Where does it fit in more broadly?
   - Not clear what the costs to the system are of physicians providing these treatments. Seems unclear when a decision would be made to stop providing treatment because it isn't working, when there isn't clear evidence for its effectiveness and the physician may be profiting. Are there clear guidelines around this?
   - The profit motive tinkers with the relationship between the doctor and patient
   - There is a conflict between two modalities (conventional and alternative medicines). There are different therapies and patients need to know the distinction between them. Could be a conflict of interest in a way – a patient is likely seeking CAM treatment because conventional medicine has failed them, so why would they want to receive alternative treatment from a conventional physician
   - The practitioner should be clear to the patient about what they are doing (e.g. conventional, alternative, or science-based, etc.)
   - How is the doctor held accountable for the alternative medicine approach (e.g. when practicing conventional medicine, they need to be licensed to do so – would the same be true for providing alternative medicine?)
   - Having one person in a clinic responsible for all care is beneficial to patients but there are also considerations with other factors such as other patients and their treatments
   - Physicians should be aware of patients' choices and needs
   - Group feedback: Risks outweigh benefits: 8; Benefits outweigh risks: 4

2. **If your current physician provides CAM treatments and recommends a CAM treatment to you, what information would you want to know before accepting/rejecting their recommendation to undergo a CAM treatment?**

   - Skillset: "I want to know they know what they are doing (e.g. acupuncture)"
   - Anecdotal evidence (e.g. treatment of another patient with similar symptoms)
   - Opt-in/opt-out: when patients register, physicians could consider adding a section to the patient consent form stating whether you wish to be informed about alternative therapies or not. For example, "here we provide alternative medicine – do you want to access it or not?"
   - Patient needs to know the implications
   - Scientific evidence is important (e.g. trials on complementary evidence: "show me some studies")
   - The patient should be told the cost per session or an estimate of how many sessions are being recommended

- The patient would want to know if there are any side-effects
- How often does the doctor provide this service? Should I go to a practitioner who does this all the time?
- Could create stratification (e.g. who can afford the service, as these therapies can be expensive and some people may not have access)
- Needs to be a process so that when a prescription is given and the patient has an adverse reaction, they can complain about it if they want to
- Needs to be accountability for the individual who provides the service

ISSUE B: EVIDENCE

1. **If your physician was recommending you undergo a CAM treatment, what would you want to know, if anything, about the evidence that supports the treatment?**

   - What would the public health agency of Canada or similar agency would tell me as a patient or consumer about, for example, alternative medicine, which works in a different way?
   - What trials were done? Were they randomized? The average person may not even know to ask about this, or may want to know different things
   - Is the evidence for it only based on word-of-mouth/anecdotal information?
   - Is my doctor knowledgeable about this? Physicians providing these treatments should be held to a higher standard – don't know if a physician has the same level of training in that particular modality as a CAM practitioner would have
   - The practitioner has to justify why they are recommending this type of treatment
   - Is the merger intended to control the alternative therapies? Why are we trying to do this? Is it motivated by monetary considerations?
   - Is there a responsibility for the doctor to provide the patient with and to discuss the evidence against it (e.g. side effects, a study shows it is ineffective)?
   - Being provided with a balance of information is in the patient's best interests in helping them make a decision
   - What are the lasting effects of the treatment? Is it experimental? Is it new or has it been used for a period of time? How long does it take to work?

2. **Do you think physicians should recommend treatments that they believe will be helpful, but which are not supported by the available evidence (either because research has not been undertaken or because the available evidence suggests that the treatment is not effective)?**

   - Is there abuse of power?
   - Keep alternative medicine and physicians separate; both can't be done at the same time; there is a need to recognize what the patient is there for (normal or alternative medicine); a big issue will be cost implications
   - Group feedback:
     - Half the room: no
     - Reasons: if you do not need it to be based on evidence then can be completely based on a whim; need to understand what the standards of practice on this would look like, seems like basically anything could then be suggested

- Consider the vulnerability of the patient: power imbalance; patients who may wish to receive a CAM treatment from a practitioner and not their physician could feel that saying so might damage their relationship with the doctor
- Broader shift in philosophical thinking – medical treatments not needing to be either/or conventional or alternative: not operating in silos
- Comes down to whether the doctor might profit from the recommendation
- Could be more attractive to people who would go out and do their own research if they had that capability. If the patient doesn't speak English or is otherwise disadvantaged, they may not be able to access additional information
- If there is trust in the doctor, that would help (e.g. rapport, length of time that the physician has been seeing the patient). It could be a problem for disadvantaged people who do everything their doctor suggests
- What is the implication of specialists recommending treatment based on some logic or personal history in treating patients who report success, rather than evidence?

ISSUE C: EXPERIMENTAL AND/OR INNOVATIVE MEDICINE

1. If your physician recommended that you undergo an "experimental" and/or "innovative" medical treatment, such as a platelet-rich plasma (PRP) injection, what information would you want your physician to provide to you about it?

- It would be useful to know the theoretical research as to why it might work
- Is there any recourse for the patient if it doesn't work? Could they get their money back? Is it covered by the Ontario Health Insurance Program (OHIP) and if there are side effects, would these also be covered and how would they be addressed?
- If a patient is being given both traditional and alternative options, which is better? What are the traditional medicine options?
- What does "experimental" mean (e.g. what phase is it in)?
- It would be advantageous to have a better understanding of the approval process
- Is it approved in Canada? If it's considered an experimental treatment in Canada, would the patient have to go elsewhere to get it? If the patient comes back to the practitioner after receiving treatment elsewhere, would they pay for it? If the patient ends up in the hospital, would it be covered?
- Why is this experimental treatment being recommended?
- Is coercion or manipulation involved (e.g. using patients to further the research on the treatment)?

2. Given that "experimental" and/or "innovative" medical treatments share some common features with CAM, including an absence of clear scientific evidence, should the CPSO regulate these treatments in the same way it regulates CAM? Why or why not?

If you feel the CPSO should regulate these types of treatments differently from CAM, how should they be regulated, if at all?

- Should experimental or innovative medical treatments be regulated differently?
  - Unanimous: "yes"

- Risk associated with biological or pharmalogical treatment is higher than with conventional medicine
- Cost to patient: if they pay for it, they need to know they are getting the highest quality
- If it's experimental, is there a cost to the patient? Perhaps a pharmaceutical company is paying for it or there are grants – is there a cost or not?
- Alternative medicine is newer so it is likely more expensive – or is it dependent on the condition?
- Regulate in a way that is safe. Encourage it as we don't want to stop innovation. We want enough flexibility that innovation is not stifled
- The College has a responsibility to assess physicians providing experimental treatments
- It is not *necessary* for physicians to be providing CAM, but it is necessary for physicians to innovate/experiment in order to move medicine forward

ITEM 2: ONTARIO COLLEGE OF PHARMACISTS (OCP) – PHARMACISTS PRESCRIBING FOR MINOR AILMENTS

QUESTIONS:

Show of hands:

1. **Do you often visit a pharmacy for yourself, or on behalf of a family member or someone else such as a friend?**
    - Majority: yes (11 out of 12)
2. **When you visit a pharmacy, do you always or often go to the same pharmacy? If not, why?**
    - Majority: yes
    - Majority consider their pharmacist as one of their important healthcare providers
    - Trust in their pharmacist as they retain patient records
    - Continuity of care
    - Security/confidence of patient information going to the same healthcare providers

Questions for Discussion:

1. **Given the government's stated goal to increase access to care related to common and minor conditions in the community to relieve pressure on emergency departments, which minor ailments on this list would be of most benefit to patients? Are there other minor ailments that should be included on the list?**
    - Minor ailments that could be beneficial in having pharmacists being able to prescribe it:

"YES" GROUP:	"NO" GROUP:
• Urinary tract infection (UTI): 10 • Dermatitis: 4 • Insect bites: 7 • Pink eye: 8 • Acne: 6 • Allergic rhinitis: 1 • Candidal stomatitis: 0 • Canker sores: 0 • Cold sores: 5 • Hemorrhoids: 9 • Yeast infection: 4 • Dysmenorrhea: 1 • Muscle strains and sprains: 0 • Impetigo: 1 • Nausea and vomiting of pregnancy: 4 • GERD: 1 • Pinworms and threadworms: 0 • Lyme disease, post-exposure prophylaxis: 2	• Urinary tract infection (UTI): 0 • Dermatitis: 1 • Insect bites: 0 • Pink eye: 1 • Acne: 1 • Allergic rhinitis: 1 • Candidal stomatitis: 1 • Canker sores: 1 • Cold sores: 1 • Hemorrhoids: 1 • Yeast infection: 2 • Dysmenorrhea: 2 • Muscle strains and sprains: 8 • Impetigo: 2 • Nausea and vomiting of pregnancy: 8 • GERD: 9 • Pinworms and threadworms: 10 • Lyme disease, post-exposure prophylaxis: 8

Feedback:

- Some conditions are easy to recognize
- Simple to treat, easy to identify; if not treated quickly, can get worse quite quickly
- Do not require follow-up or lab tests
- Some conditions require time-sensitive treatment (i.e. needs a quick solution)
- Something contagious or something which needs to be treated really quickly (e.g. UTI) can become very serious very fast
- Pharmacists should not assess something that is hard to assess
- Takes pressure off the system by being able to assess
- Lyme disease is hard to assess and is fast-acting; if you can prevent it that's good
- Treatment should be low risk

The advantages/disadvantages of going to your pharmacist include:

- Quicker service
- Not sitting in a waiting room with sick people
- For people visiting areas from out-of-town, they can access a pharmacy
- Saves the system money (cost-effective)
- Fast pain relief
- Allows people to act faster on problems (i.e. get treatment if otherwise there would be no treatment provided)
- Helpful for medications that are covered under the Ontario Drug Benefit (ODB) for which a prescription is needed (e.g. over-the-counter medication)
- Lower income people have options (equity advantages for disadvantaged people or they don't have a doctor)
- If there is a fee for the patient in getting the prescription from a pharmacist, patients would not want to pay
- In a pharmacy, consider the need for privacy and sensitivity for some conditions, including the notion that there is no place to talk, assess, etc.
- Concern was expressed about the little time for interaction between pharmacists and the members of the public (i.e. that there is no time for the pharmacist to go through the variables of conditions, etc.)
    - Is there enough time allocated to the patient/pharmacist being able to have verbal interaction?
- Potential collusion with pharmaceutical companies: would pharmacies see it as opportunity to make money?
    - From a sales perspective, the pharmacist may be offering a more expensive medication option (e.g. if a pharmacist could be getting a financial incentive to prescribe a medication than not prescribing a medication)
    - Option for the patient to get brand or generic medication would be positive (if feasible)
- Concerns/worries about the over-prescribing of antibiotics (e.g. not for UTIs)
- Concerns surrounding people pharmacy-hopping
    - What would happen if a person goes to various pharmacies and asks for the medication (e.g. there is a danger of over prescribing)?
    - It was noted that there are no clear answers yet on how this will be tracked
- Musculoskeletal conditions (MSK) requires x-raying; some conditions such as strains can be easily mis-assessed

- Will there be more ailments assigned to the pharmacists?
    - Concern was expressed about the expansion of scope of practice for pharmacists and possibly overlapping with physicians
- Are pharmacists overburdened?
- How would a physician know their patient goes to a pharmacist for a minor ailment, and if that patient is not connected to a physician, how will they know when to follow up?

2. If you were able to see a pharmacist for one of these minor ailments, would you go there? Why or why not?

Pros:

- Equity is quite important
    - A patient would be able to visit a pharmacist and potentially be prescribed a medication they need that is covered under the publicly funded drug program, rather than paying for an over-the-counter treatment
- May want to get treatment faster for those who don't want to wait to see a doctor
- Quick
- Saves the system some money
- Convenient for the public if they are out-of-town and not close to their primary care provider
- Quick pain relief
- Don't have to wait in a room with sick people

Cons:

- Sensitivity for privacy
- Potential collusion with pharmaceutical companies (i.e. the possibility of offering financial incentives to choose a brand name medication rather than a generic medication)
- Not enough time to talk in the store setting
- Could potentially damage a patient's relationship with their physician, who may not be supportive of their patient seeing a pharmacist rather than their physician for a minor ailment
- Will the patient have to pay for a consultation?
- Is there enough time to get the patient history in a busy pharmacy?

Other comments raised by CAG members during this discussion included questions regarding possible medication and pharmacist fees (i.e. how the service will be paid for or funded?)

3. What would you expect as part of your experience as a patient seeking help for a minor ailment?

- Second pharmacist or dedicated person to deal with prescribing for minor ailments: lineups at the pharmacy might get long as they are already doing prescriptions; might want more staff
- Ensure there is clear indication as to who can give an assessment and who can be dispensing
- There needs to be a list of ailments and the pharmacist/pharmacy assistant must have the knowledge, skills, and judgment to assess the condition
- Ensure there is space for consultation (e.g. private room)
- Allocate a certain amount of time (i.e. should not be rushed)
- Tracking system (e.g. government database) to show how many times a patient visits a pharmacy and should link back to the family doctor and/or another pharmacist

- Information provided on the potential side effects of the medication, how to take the medicine, are there any warnings, and if the condition persists, to see a physician
- A one-page description of the condition would be beneficial, along with the other information provided with the medicine
- The pharmacist should be asking pertinent questions on the person's medical history (e.g. have you seen a doctor for this?)
- List of drugs covered under OHIP given to patient
- The pharmacist should be appropriately trained to advise the patient regarding the assessment
- Would the patient/pharmacist relationship damage the patient's relationship with their doctor?

ITEM 3: COLLEGE OF DENTAL HYGIENISTS OF ONTARIO (CDHO) – PROPOSED CHANGES TO REGISTRATION CATEGORIES

The five proposed categories of registration:

- RDH Clinical Practice (replaces General)
- RDH Non-Clinical Practice (new category)
- RDH Temporary (new category)
- RDH Non-practising (replaces Inactive)
- RDH Authorized for Restorative Practice (replaces Specialty)

Feedback:

Overall, a straw poll showed that almost all members indicated a high level of confusion with respect to the proposed registration categories. Questions were noted such as:

- Would an individual would get the same certificate in going from practice to non-clinical?
- Does it involve the same amount of education?
- Is "clinical" or "educator" giving a good enough description as to what a dental hygienist does?
- It is not clear there are different levels of education required

1. RDH Clinical Practice (replaces General)

- Are the descriptions clear?
- Comments:
    - RDH Clinical Practice is pretty clear but the word "clinically" is not clear to members of the public – needs fine-tuning to the language
    - Add the word "dental"
    - Have to be specific about what is to be expected by the public (e.g. Registered Dental Hygienist)
    - Consider "practising" dental hygienists
    - Would this description be unclear to most people?
    - While "clinical" can be confusing to the public, patients do not care about the distinctions
        - Group feedback: matters a lot: 3; not for it: 9
    - With respect to the terms/descriptions above, "RDH – Clinical Practice" has more "yes" support
    - Consider "general practice" or "RDH – Practitioner," which might make more sense

2. RDH – Non-Clinical Practice (new category)

- Supported/not supported: 50/50
- It is about practising
- Use of the word "Clinical" is appropriate (it's "okay")
- Consider case-by-case (e.g. administrative practice, education practice), and naming what they do (e.g. education)
- "Clinical" and "practice" mean the same things
- Non-practising wording: the members were divided in their opinions

3. RDH – Temporary (new category)

- In assessing the description and whether the name captured it, the majority of members were unclear and said it was confusing
- The word “Visiting” in the name might clarify it more

4. RDH – Non-practising (replaces Inactive)

- Suggestion to label it as: “RDH – Non-practising”
- Able to use title but do not practise, retired, on leave, on break
- With respect to the description, the majority felt the following title was better: “RDH-Non-practising”

5. RDH – Authorized for Restorative Practice (replaces Speciality)

- Description clear (majority agree)
- Title is a bit long

ITEM 4: CDHO – EXAM REQUIREMENTS FOR ENTRY TO PRACTICE

The group provided the following feedback regarding the current entry-to-practice requirements and what examinations should be required for entry-to-practice.

- Is accreditation enough across Canada? There should be Canadian-wide national standards of practice and include a written and clinical exam. There should be a qualified and objective examiner
- Majority support was expressed for having a clinical examination – including physically doing the work in order to ensure they have a level of practice, and proof of their practising skills, which seems more important than the clinical examination
- The national clinical exam would hold them all to the same standard; provincial jurisdictions is the problem
- There is a quality assurance (QA) process for registered dental hygienists (e.g. practice requirements, new technologies in the field, specified hours for their continuing education [CE])
- Strong feelings were expressed by the members that clinical exams need to be taken; it opens their eyes to what they work in and also will put them in the right category
- The public doesn't know that their dental hygienist did not have to do a test and it is highly desirable to have clinical examinations
- There is currently no clinical examination in Ontario
- Different requirements for out of country candidates. There is no national clinical exam if you are from an accredited institution (e.g. US)

Asked whether the standards should be relaxed, it was unanimously agreed that it is in the public interest that they should not be relaxed and there are no advantages to dropping the need for exams. Testing members' skills is also desirable.

Feedback:

- There might be different standards from outside of North America; treat them differently
- Preferential treatment for US graduates is extremely unfair; does it have a gold standard?
- People who are immigrating to Canada have to do the testing so there should be some way to support them while they are going through the process (e.g. take away financial barriers)
- Encourage people from other countries; create resources to break down barriers for them – the resources are just for the testing so they are accredited
- National clinical test: if trained in Canada, the individual would need to do it
- People coming in shouldn't be treated otherwise
- Testing that it would be the same for all trained equally
- Applicants now need a diploma or degree in dental hygiene and it must be from an accredited school to be exempt from the clinical exam
- We actively want to have practitioners from around the world
- Outsiders should be subject to the same standards (e.g. national standard examination)

ITEM 5: COLLEGE OF AUDIOLOGISTS AND SPEECH-LANGUAGE PATHOLOGISTS OF ONTARIO (CASLPO) – COMPLAINTS PROCESS AND INFORMATION

1. Does the information clearly explain what to expect when the College investigates a complaint?

Feedback with respect to accessibility and ease of navigating the website to find information on the complaints process:

- Once you get to the website, it is very difficult to access information and navigate smoothly; the majority reported that they found it hard to find the desired information
- Navigation to the Complaints information could be included on the main website's page
- Have more prominent links to the complaints process
- Accessibility: hard to find the desired information, which would be considerably more frustrating for people who may have difficulty understanding and/or accessing it
- Include a big button on the Complaints page to directly submit a complaint; all other information on how to file a complaint can follow
- Make the infographic/complaint information easier to navigate (it is currently embedded and it is hard to find the information on how to file a complaint)
- If the user has already decided they want to file a complaint, they do not need all the extraneous information
- Too much information is provided – consider a video that gives instructions and does a short outline, step-by-step overview, etc.
- Most of the written materials are confusing
- Need to have alternative solution for hearing-deficient members of the public
- First page ("How to complain") is hard to find – difficult for a person to get to and or do what they set out to do when going to the website
- Complaint process: generally clear but bars to appeal (discipline and incapacity) are confusing; information about where to submit the complaint shows up on a different part of the webpage (i.e. read a chunk of content before coming back to the Complaints page)
- With regard to the College's infographic: there should be more clarity on how a complaint winds its way through the process

2. Do you know where/how to file a complaint with the College?

a. Generally yes, but difficult to find

3. Is there additional information you would need before contacting the College/filling a complaint?

Feedback:

- It is an arduous task: the complaint submission address/email and the information is too hard to find (e.g. there are too many steps to finding the information)
- It would be helpful to have some documents to guide the user in getting through the complaints process (e.g. information regarding response times for the complainant, investigation timelines, what information is needed from the complainant)
- Consider a checklist for the complainant (e.g. case number, telephone number for follow-up, etc.)
- Include a more prominent link to the Complaints Process PDF directly on the Complaints page

- The current diagram (infographic) is very confusing; consider breaking it into sections; however, language is very clear and reader friendly
- Capital letters are difficult to read – remove for legibility and accessibility
- “Incapacity” as a term may not be understood by everyone
- Consider having a patient review the content once revised

REFLECTIONS ON THE DAY

1. What went well?

- Inclusive – listened to other members' points of view; collective efforts were positive
- Everyone led the conversation, which was about the patient, which is for the community the CAG is representing
- Group discussion was very helpful and not too rushed
- Liked having different College representatives to clarify things; this is positive
- Having the CPSO Council President in a group to hear the discussion was positive and respectful (e.g. excellent feedback; validation of the group's work)
    - Support for doing this at the next meeting was noted
- Good time management: for the new members, it may have been a bit rushed in the morning and some of the questions were quite complex
- Alternative and complementary medicine topic was very interesting and there are many perspectives to consider (it was a bit rushed but understood that it is complicated topic)
- Integrated the new members well and they felt welcome – good reception and the opportunities for the new members to learn is positive (there were no exclusions)
- Did not feel any members had to censor their opinions (everyone open to other perspectives)
- Informative meeting package, but 50% thought it was bit long/too much reading
- Openness of the meeting room space is appreciated
- Moderator did appropriate and helpful re-framing for some people's comments
- Switched three times into smaller groups, which was a good way to meet new members
    - Support was noted for this and more breakout groups could be considered

2. What could be done differently?

- The session was a bit long
- Too much information provided by the Colleges for some agenda items
    - Perhaps having staff in with a group may have changed the direction and perhaps steered the conversation towards what the College is looking for
- Having better sense of the context of the issue (i.e. what the College is doing) might be useful
- Group breakout sizes were okay; adapt breakout group sizes as needed
- To encourage interaction with other members, think about how people are seated and mix them up in the future
- Shorter breaks and lunch time are preferable (earlier finish time)
- Stickier name tags for the members would be preferred

Adjournment

The members were thanked for their input and feedback, and the meeting was adjourned at 3:50 p.m.