NATIONAL NEWCOMER NAVIGATION NETWORK

RÉSEAU NATIONAL DE NAVIGATION POUR NOS NOUVEAUX ARRIVANTS

“A Missing Part of Me:”

A Pan-Canadian Report on the Licensure of Internationally Educated Health Professionals

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EXECUTIVE SUMMARY

Canada's health care system is understaffed and facing both recruitment and retention challenges. As part of a wider health human resources (HHR) strategy, the National Newcomer Navigation Network (N4) is investigating internationally educated physicians and nurses as a key demographic to help meet staffing needs. This report explores the barriers that internationally educated health professionals (IEHPs) experience on their path to licensure in Canada, as well as some facilitating factors. The research is the result of 76 individual and organization stakeholder visits during 2022 and provides a snapshot of the everyday realities of frontline and lived experience professionals at this time.

In parallel to this work, N4 has developed recommendations for internationally educated nurses and internationally trained physicians, and a toolkit for employers seeking to employ them. These tools are linked below.

Through consultation with a wide range of stakeholders, the N4 team discovered that the following overarching, pan-Canadian barriers are contributing to the challenges in quickly licensing and onboarding IENs and ITPs:

- A complex immigration system at both provincial and federal levels
- Difficulties with system navigation and finding the correct, personalized pathway
- A dearth of information to inform decision-making pre- and post-arrival in Canada
- Challenges with interprovincial mobility, leading to competition between provinces
- The high cost of licensure exams, assessments, and documentation
- Lack of opportunities for both IEHPs and Canadians to build cultural competency and facilitate IEHP integration
- Discrimination based on country of origin, ethnicity, language, and resulting poor mental health and wellbeing
- Language exams which are expensive, do not prioritize vocational knowledge, and produce results valid for only two years

For ITPs, pathways were narrowed by a lack of residency spots and lack of capacity in provincial Practice-Ready Assessment programs. Stringent recency of practice requirements were a barrier, forcing physicians to return to their home country to practice or try to build informal networks in Canada to find Canadian experience. ITPs reported a lack of customizable training and bridging options

For IENs, bottlenecks at the credential assessment and bridging stages were a reported issue. As well, registered nurses experienced a deskilling into practical nursing or unregulated care roles.

However, there are also some promising facilitators that can be explored by organizations and policy makers, including:

- A strong commitment from provinces to funding system navigators who are experts in IEHP licensure, and who can move IEHPs through the right pathways to practice
- Integration of immigration pathways with licensure so that IEHPs are directly connected with foreign credential recognition and training at arrival
- Additional mentorship and peer support to improve mental health and wellbeing
- More information pre-arrival about pathways and requirements, which would include the ability to complete parts of the licensure process in parallel with immigration

Ultimately, the equitable and efficient licensure of IEHPs is a team effort requiring the input of parties from the provincial to the federal level, and the injection of sustainable, sufficient funding.

The companion documents to this report are recommendations documents for internationally-trained physicians and internationally-educated nurses, and a recruitment and retention toolkit for employers. These resources are forthcoming on the N4 website in spring 2023.

INTRODUCTION

Canada's healthcare system is experiencing an unprecedented set of challenges across the continuum of care. Already-stressed systems are taxed by the increased healthcare needs of an aging population, a generation of physicians and nurses reaching retirement age, and the additional, ongoing pressures of COVID-19 pandemic. In a study of healthcare workers by the Conference Board of Canada, 97% of respondents indicated that understaffing was a challenge.[1] Understaffing puts additional pressure on healthcare workers, negatively impacting mental health, decreasing the quality of care that can be provided, and leading to burnout. As a result, 57% of respondents in the same study said that they had considered leaving their healthcare profession in the past year.[2]

This crisis has led to a flurry of policy, research and advocacy surrounding health human resources and the need for change in Canada's healthcare system. Among the many promising strategies set forth in health human resources policy recommendations, recruitment and retention are priorities. As part of any healthcare recruitment effort, one group stands out as under-utilized—internationally-educated healthcare professionals (IEHPs).[3]

Canada already draws significantly upon foreign-born, foreign-trained professionals to support the healthcare needs of Canadians. In fact, 25% of healthcare and social services professionals were born outside Canada, and this number is particularly high (33%) in unlicensed health professions like nurse aides, orderlies, and patient service associates.[4] For highly qualified licensed professionals like physicians and nurses, employment prospects are less rosy. OECD data gathered in 2016 showed that only 37.7% of foreign born, foreign trained physicians and 38.3% of foreign born, foreign trained RNs were working in their trained profession in Canada. And yet, the need for their skills has never been greater. Barriers to enter into Canadian practice are numerous and profoundly difficult to navigate.[5] [6] Many skilled and experienced physicians and nurses spend many years and tens of thousands of dollars trying to work their way through a licensure process that, all too often, ultimately shuts them out of practice. The title of this report was drawn from a lived experience interview with a foreign-trained physician who had spent 12 years trying to achieve licensure in Canada and ultimately worked with a local refugee clinic in an interpretation and patient navigation capacity. She described being a physician as intrinsic to her identity and her wellbeing.

In 2022, the National Newcomer Navigation Network (N4) was tasked by Immigration, Refugees and Citizenship Canada (IRCC) with mapping the challenges and barriers to licensure for IEHPs. The focus of this one-year project was physicians and nurses, reflecting the current urgent need for these professionals.[7] Over the course of a year, the N4 Community of Practice developed two recommendation reports (one for nurses, one for physicians) through a series of working groups, and an employer toolkit following consultations with employers and health authorities.

This work was supported by ongoing stakeholder outreach and research, captured in this report. N4 began a series of semi-structured interviews with subject matter experts and people with lived experience. Over the course of nine months (May 2022 to January 2023), N4 interviewed 74 stakeholders working along the pathway from immigration to optimal employment: regulators, employers, licensing bodies, educational institutions, accreditation specialists and bridging programs, and people with lived experience as IEHPs. This report is a thematic analysis of those interviews, providing a snapshot of the difficult road to licensure for nurses and physicians who come to Canada hoping to practice in their fields. The experiences of the many players in this complex game are triangulated to highlight for the reader the challenges and barriers that IEHPs face, and to provide context for a suite of recommendations that can mitigate or eliminate those barriers.

1 Conference Board of Canada, "Views From the Front Line: Taking the Pulse of Canada's Healthcare Professionals."
2 Conference Board of Canada.
3 Health Canada, "Summary Report of the Health Human Resources Symposium."
4 Caroline Ewen, Joan Atlin, and Karl Flecker, "Addressing the Underutilization of Internationally Educated Health Professionals in Canada."
5 Alka Sood, "A Study of Immigrant International Medical Graduates' Re-Licensing in Ontario."
6 Andrea Baumann, Jennifer Blythe, and Dana Ross, "Internationally Educated Health Professionals."
7 Based on feedback from our working groups and professionals with lived experience, we chose to use the title 'internationally trained physician (ITP)' rather than the more widely used 'international medical graduate (IMG).' This reflects the fact that physicians coming to Canada are not new graduates but often experienced professionals with advanced training and work histories.

METHODOLOGY

The first step in the stakeholder interview process was leveraging N4's sizeable network of health, settlement, and academic professionals to find promising contacts with experience with IEHPs. A coordinated stakeholder outreach plan involved emails introducing contacts to the project and setting up meetings. Between May and September 2022, the N4 team conducted 57 site visit meetings via Zoom or Microsoft Teams for the core research. A further 17 meetings took place between October 2022 and January 2023, and parts of these were used to supplement observations from the initial data set. Each visit took between 30 and 90 minutes, and was structured with introductions, a presentation from N4 and then a facilitated discussion touching on key areas of the IEHP licensure and pipeline process. Notes taken by N4 staff were collated and sent to the site visit attendees for validation; some attendees chose to add, edit, or correct as needed. Attendees were informed that the notes from the site visits would be later analyzed and used in an anonymized format in this report. No attendees chose to withdraw consent from this process.

Over the course of these virtual site visits, the team spoke with a diverse group of stakeholders. In addition to internationally trained doctors and nurses, the team interviewed executive directors, program managers and coordinators, research professionals, analysts, policy experts and academics, teachers, trainers and educators, allied health members, navigators, cultural brokers and settlement professionals. See Appendix 1 for the full breakdown of organizations and participants. The questions and conversation topics used in these semi-structured meetings can be found in Appendix 2.

On September 10, 2022 the notes from the first series of 57 visits were entered into nVivo, and the researcher coded the data using a combined deductive and inductive codebook. Results were compared and some disambiguation of codes and coding choices created a final qualitative analysis by key themes.

PAN-CANADIAN OUTREACH BY N4 BETWEEN 2019 AND 2022

LIMITATIONS

This study was time-bounded, lasting one fiscal year. The stakeholder engagement period was necessarily brief. There were limited opportunities for extensive follow-up with interviewees after the first one-hour interview. Initial interviewees were drawn from existing N4 contacts. At each interview, the N4 team asked if there were other organizations or individuals who should be interviewed for the project. This snowball sampling method was effective and generated many additional leads. However, this may have excluded voices who are less connected, working through unofficial channels, or marginalized.

Funding for this project was provided by IRCC to address a specific mandate. Northern communities and Quebec were not included in this mandate.

PAN-CANADIAN CHALLENGES

IMMIGRATION

Immigration is a complex system which presents multiple barriers along an IEHP's journey to full licensure. During the research process, lived experiences and responses from organizations were paired with an analysis of the legal situation from a lawyer specializing in internationally trained physician (ITP) immigration. The following themes emerged.

First, the differences between federal and provincial immigration pathways are not clear to immigrants prior to their arrival to Canada. There are several streams at each level of government, each with their own complicated requirements. There is also a lack of continuity between entry into Canada as a skilled worker, and subsequent entry into a skilled profession. The Canadian immigration system targets, through the skilled worker stream, individuals with skills and training that are needed in Canada. However, many respondents reported a disconnect between approval (obtaining permanent residence based on work experience as an IEHP) through the Federal Skilled Worker Program and approval (licensure/eligibility) to practice as a physician or a nurse. One respondent working for a national body put the problems facing IEHPs plainly: "We advertise that we need them, but when they arrive the process is very convoluted." In a different interview, an ITP with lived experience echoed this, saying, "It's challenging when you come in as a skilled worker, but that skill is not being used."

Some provinces (British Columbia, Nova Scotia) have provincial nominee programs which include targets immigration numbers of healthcare workers. These programs offer a pathway to permanent residence and licensure for healthcare workers including navigation and immigration guidance, but the IEHP must have a job offer from a health authority in order to be eligible for the stream. This program is not open to IEHPs who are already in-country and trying to become licensed in their profession.

In other cases, ITPs are cleared to come and practice on a temporary basis in Canada with employer specific work permits. However, they later find that they may be classed as 'self-employed' under the provincial nominee programs and the Federal government based on the complexities of how physicians are funded and paid (fee for service). This can then hinder their application for permanent residency. The Federal government announced changes to how physicians would be assessed under the Skilled Worker Program in fall 2022 but at the date of publication has not updated their internal guidance accordingly.[8]

Second, employers report being keen to utilize the skills and experience of IEHPs. Provinces also see the immediate need, and in some cases have developed particular streams or navigation programs to move IEHPs (usually nurses) directly through the licensure process and into paid employment in the healthcare field. However, some participants connected with employment reported a disconnect between their desire to employ IEHPs and their ability to assist with navigating provincial and federal immigration processes. Employers did not feel competent to assist

8 Immigration, Refugees and Citizenship Canada Immigration, "Canadian Experience Class (CEC)."

with immigration issues, and there was concern that a misstep in this area would have legal consequences for both the IEHP and the employer. N4's employer toolkit discusses some of these challenges in more depth.

There is a further disconnect between the various immigration processes in that most employers require a Labour Market Impact Assessment (LMIA) in order to employ foreign physicians and nurses. To provide this, employers undertake a laborious and expensive recruitment process for occupations that are known to be in high demand and where it is known there are substantial labour shortages. For clinics and hospitals recruiting physicians, these organizations are put in a position where they are undertaking to be the employer of a foreign worker who will not be considered an employee.

Third, in navigating these streams, IEHPs frequently came up against interactions between immigration streams, job status and required permitting that excluded them from entry into programs or jobs. For many training or bridging programs, one must be a permanent resident or citizen. For example, one nurse expressed that internationally educated nurses (IENs) who come to Canada through the Live-In Caregiver were not eligible for some pathways and programming which would later allow them to be licensed as a nurse in Canada. She felt that caregivers were trapped in low paid care work, without suitable options to move into their healthcare field later.

Ultimately lived experience interviewees expressed that had they known more about the licensure process in Canada, they might have made different choices or chosen not to come to Canada at all. The immigration process was considered one of the most stressful and opaque elements of their licensure journey. Public information was sorely lacking, and what was available was reported to be inadequate, confusing, and inapplicable to many IEHPs. Tellingly, no respondents in this research could identify any facilitators to the immigration process other than the assistance of a qualified, specialized lawyer.

Immigration lawyers have recommended the creation of a new LMIA exempt work permit for physicians under the IMP: Significant Benefit category. This pathway could require an Educational Credential Assessment by the Medical Council of Canada (MCC) and language testing which could be aligned with the provincial licensing requirements. This pathway, like the caregiver pathway, could have its own dedicated permanent residence stream. Immigration lawyers have recommended that IRCC, the provincial governments, and Employment and Social Development Canada (EDSC) provide clear written guidance to officers, employers, and physicians on the eligibility requirements for hospitals and physicians for LMIAs and permanent residence under the various pathways to permanent residence.

SYSTEM NAVIGATION

IEHPs and those working with them expressed a profound frustration at the challenges of navigating the licensure process from immigration and employment. Each individual stakeholder in the process presents information about their part of the process: immigration websites, licensing bodies, health systems and employers. The struggle respondents identified was linking those disparate pieces together into a cohesive, individualized pathway, and understanding eligibility for different pathways and processes. Some processes are provincial, and some are federal. Eligibility could be based on something clear (like country of origin or immigration status) or on something more complex (specific training rotations, years in a certain type of educational program, or language skills). Each jurisdiction has slightly different pathways, processes and requirements.

For an IEHP outside the country, choosing a province in which to live and work requires an overview of all the available options, as well as their likelihood of licensure in the province, and a sense of whether they will be eligible to practice there. An understanding of the immigration options available and whether or not any given provincial nominee program would move them directly into the licensure pathway would also be important. There is currently no centralized information bank, nor a central bank of advisors or navigators who could assist with decision-making.

For an IEHP in the country who has connected directly with a settlement agency, there are often some supports available. Career navigators working in settlement programs do exist, and often work with internationally trained professionals from all of Canada's regulated professions. However, the physician pathway in particular can be very complex. In their job capacity, navigators stated that they do not always have a complete understanding of all the regulated professions' pathways and healthcare workers tend to have the most complexity and the most need for specialist navigation. Some provinces report navigation programs for healthcare workers which

are linked directly to health systems, and therefore to hiring. These pathways exist in Nova Scotia and British Columbia for IENs, and during this research the research team heard that other provinces consider this model a best practice to emulate. It is notable, however, that expedited immigration pathways can require that the individual already have a job offer, which limits effectiveness for people already in the country.

MENTAL HEALTH AND WELLBEING

IEHPs and people who work closely with them expressed that medicine is a vocation, and that the inability to continue to practice medicine can lead to significant distress. IEHPs were described as becoming "depressed and distressed" by the licensure process in Canada. Both the length and complexity of the process, as well as the low chances of success, were indicated as causing this distress. This is also well-documented in literature.[9]

One individual who worked closely with IEHPs reported that while unofficial social channels like IEHP Facebook or WhatsApp groups could be useful for information sharing and support, they could also add to distress experienced by IEHPs. This was because friends, family and network members who had been through the licensure process unsuccessfully could be negative about it and impact prospective licensee's confidence and viewpoint. The suggested remedy to this was to lean on navigators, who could provide up to date information.

It was identified that for both nurses and physicians, a long and opaque credential assessment and licensure process could undermine a person's confidence in their abilities and suitability to practice. As one individual involved in a nursing pathway told us, "We don't want to undermine people's confidence because it's so key to being a successful health professional." This shows an understanding that the processes that Canada has established for IEHPs may be serving them poorly both from a time and effort perspective, but also in terms of their ability to begin their Canadian careers from a place of confidence and mastery.

CULTURAL COMPETENCY

In lived experience interviews, ITPs and IENs expressed that they and others had experienced cultural barriers to practice. 'Cultural barriers' was a term frequently used to encompass many different challenges. It could mean differences in cultural or communication norms, in medical communication around issues like patient consent, privacy, disclosure or the relationship between professional and patient. It also referred to learning Canadian examination and interview skills and the issues of 'cultural fit' in the workplace. It was also used in reference to adjustment issues surrounding life in Canada: the differences between low-context and high-context cultures, coping with mental health challenges during training (and particularly during residency), and interacting with peers and colleagues.

Some organizations in Canada provide orientation and training to IEHPs to assist with integrating into Canadian society and understanding cultural and ethical norms in the health care system. Strategies like showing ITPs a mock Objective Structured Clinical Examination (OSCE) have been deployed to demonstrate doctor-patient interaction.

However, less often reported were strategies to increase the cultural competency of Canadians. One interview discussed in depth the challenges ITPs can experience in residency—unconscious bias from supervisors and peers, a lack of appreciation for different life experiences, peers and patients struggling to understand or respect English spoken with an accent. The research team also heard about elevated likelihood of racism or discrimination in rural areas, where the majority of the population are Canadian-born and rarely exposed to newcomers, and internationally educated professionals are consequently a very small minority. For rural and remote recruitment and retention, education in cultural competency and a strong onboarding process were identified as key to ensuring that IEHPs can build a rewarding, long-term career in small population centres.

INTERPROVINCIAL MOBILITY

For both nurses and physicians, the pathways and requirements for licensure differ between provinces. Some provinces are perceived to have additional requirements for licensure and therefore to obtain. Through interviews, it was clear that some provinces struggled to retain physicians and nurses who had trained or become licensed there—they may choose a province for perceived ease of licensure with an ultimate goal to relocate to another for various personal reasons. This interprovincial competition impacts other elements of health human resource planning and creates inefficiencies through requiring individuals to re-license in a different province before they start practicing.

9 Aisha Lofters et al., "'Brain Drain' and 'Brain Waste.'"

Program leads for various licensure and employment initiatives expressed frustration about the challenges of retaining ITPs and IENs in their province after program completion. One program lead indicated frustration among nursing preceptors who invest in the mentorship of IENs, knowing that some IENs came from out of province to take the program and were likely to leave once they had finished.

For some years, organizations in Canada have advocated for single licensure for physicians and nurses.[10] For physicians, freer movement to practice in different provinces would assist with the provision of family doctors in rural and remote areas, as well as allow a flexible response to pandemics. There seem to be administrative and data collection processes already in place that would assist with this. Many organizations and jurisdictions have already bought into the Medical Identification Number for Canada (MINC) system for issuing a single identification number to physicians, including ITPs once their credentials have been validated by MCC. For nurses, it was clear that in provinces where practical and registered nurses were licensed through the same body, a single nursing number was a helpful administrative strategy for moving people efficiently if their career path led from LPN to RN. These strategies could be expanded so that all provinces have a consistent, portable licensure process, as in countries like Australia.

COST

During interviews with IEHPs with lived experience, cost emerged as one of the key, defining barriers to licensure. Financial challenges were exacerbated where individuals needed to balance their journey to licensure with childcare. This particularly affected women, leading to further gender inequity. Participants in site visits expressed these financial issues in several different ways.

First, the cost of exams, travel, administrative and application fees was high for both physicians and nurses. Although respondents tended to shy away from providing exact numbers regarding costs of licensure because it varies between applicant and province, it is possible to understand the financial challenges from a few illustrative examples and personal experiences. We heard from one organization that for physicians, $5000-$6000 per exam was typical. In Nova Scotia, an ITP trained at a recognized institution and with equivalency can move through a shortened process including a six-month bridging program at a cost of about $7500. These numbers are in line with those given by an ITP in Alberta, who totaled all her examination and administration costs for one attempt at a residency position at about $6500. The situation is financially taxing for RNs, too. In BC, it can take $25,000 out of pocket and four years to go through the complete process to become an RN. One nursing organization executive in Manitoba reported that they had recently been talking with a group of IENs who had spent $500 for an application, $500 for an English test, and $1000 for a clinical competency test, all while working minimum wage 'survival jobs' to support themselves.

Second, the ability to cover costs was limited by the kinds of work that the individual could get without full licensure. Nurses were more likely to report being able to work as a healthcare aide or a personal support worker while working towards their RN licensure; additionally, some employers provided practical support for this pathway. Respondents expressed that the longer an IEHP was not working in their profession and instead working a 'survival job', the harder it became to get back on track to licensure. There is a felt need for interventions and opportunities at the start of the process before IEHPs fall into low-paid, low-skilled work.

In British Columbia and Manitoba, bursaries are available for IENs moving through the licensure process. These have been implemented in response to the urgent need for IENs in the Canadian healthcare system. Additionally, microlending organizations exist which serve IEHPs. Windmill works across the country, and there are several organizations with the model of SEED Winnipeg, which provide small loans to physicians and nurses to allow them to upskill, take exams, support their families, and move towards full licensure. Such micro-lending organizations reported offering up to $15,000 in loans to IEHPs trying to get licensure. This funding could be used for career development and licensure requirements like exams, living costs while studying, and accreditation fees.

10 'Many of the country's largest medical organizations, including the SRPC, the Canadian Medical Association (CMA), Resident Doctors of Canada (RDoC), and the Canadian Federation of Medical Students (CFMS), are in favor of a national medical license in some form.' (Joshua Tepper, Ryan Hinds, and Bernard Ho, "Is It Time to Implement One National License for Canadian Doctors?")

LANGUAGE

Each province has its own standards and process for ensuring that internationally trained doctors and nurses have the necessary language skills to practice safely. Patient communication is key to a safe experience, and this was reiterated to the research team by stakeholders from many different sectors.[11] However, respondents also revealed very real and solvable inequities and barriers in the language testing process.

There are a number of possible language tests available. Not all the exams were considered equally suitable for purpose. IELTS is the most commonly accepted language evaluation, with the OET and the CELBAN also available and accepted variably by different provinces. Several interviewees working in navigation roles stated that IEHPs should take language exams that assess their ability with vocational terminology and situations. The academic version of the IELTS was considered excessive, non-specific and, in some cases, inconsistent and unfair.

An academic IELTS assessment is valid for two years, after which the applicant must get retested at additional time and cost. In some cases, interviewees reported that language tests were needed at multiple points in a long licensure process but that the tests could expire during that process. For example, one individual discussed the challenges for nurses in British Columbia, who were often required to take a year-long bridging program. Bridging program spots were limited and there was a waitlist of a year for the program. By the time the prospective nurse had applied for credential assessment including an English language test, received an assessment, waited to attend the program, and graduated, their language test would have expired, and they would have to retake the IELTS to move on to licensure.

In Alberta, the OET is now accepted for physician licensure. It is a vocational test, focusing on terminology and language typically used in day-to-day healthcare settings. For nurses, the CELBAN is a Canadian, profession-specific language assessment that was developed by the Centre for Canadian Language Benchmarks and Touchstone Institute. CELBAN is new and there are, as yet, fewer preparatory resources for nurses aiming to take it. That limitation aside, it has been well-received and was reported as a positive step in several site visits.

INFORMATION

Finding, assessing, verifying, understanding, and navigating information were serious challenges for IEHPs. From pre-arrival to employment, people struggled to receive up-to-date, accurate, specific, and personalized information that would guide them through the complex pathways to licensure in their provinces of choice. This included information about exams, practice requirements, costs, timelines, and where to go to seek additional navigation if needed. There were a number of reasons why they could not access this information as and when needed.

Most information is online. Digital literacy levels and information-seeking strategies in other countries are sometimes different than in Canada. People do not know how to validate information from Canadian sources, and may not have, or have had, consistent internet access that would allow provide that digital experience. In the absence of official navigational guidance, informal information networks have proliferated. In some cases, they can be valuable in terms of peer support and wellbeing. However, misinformation and inaccuracies are commonly reported. Many sources shared with us their concerns that ITPs and IENs are not receiving accurate or up to date information through informal channels but were at a loss to understand how to access those individuals and help them navigate the process.

For refugees, it is even harder to find information about licensure. Most pathways in Canada seem to operate under the assumption that prospective candidates are either permanent residents or Canadian citizens. The small number of lived experience interviews the research team undertook with former refugees indicated that their search for the right resources and programs was particularly difficult and, due to their personal circumstances, could not begin before they entered Canada.

Information changes often, and there are no central, validated, regularly updated hubs which provide a view of the full pathway to licensure and employment. Many individual organizations reported that they had worked had to put their organization's information online, and often had worked in consultation with groups of IEHPs on making it understandable and useful. However, the full pathway often remained a mystery to IEHPs. Our respondents frequently referenced the difficulties understanding interprovincial differences, eligibility

11 Cat Goodfellow and Christine Kouri, "Pan-Canadian Standards for Healthcare Equity: The Case for Provincial Interpretation Services."

for pathways for licensure, and finding opportunities for healthcare-adjacent jobs and funding in the form of loans or bursaries. On the other side of the table, institutions and employers are often unaware of pre-arrival and immigration challenges, which creates barriers to supporting IEHPs to the pathway to employment.

COUNTRY OF EDUCATION

The speed and ease of navigating pathways to licensure varies by country of education, according to site visit discussions. Some of these differences are built into the pathways. For example, the jurisdiction-approved route for physicians expedites the route to licensure via examination provided the physician's education comes from an approved list of countries, training jurisdictions, specialties/subspecialties, and trained within certain dates.[12] This was believed by some respondents to offer a simple licensure process to anyone from a list of countries (this pathway will soon be phased out by the Royal College in favour of an expanded Practice Eligibility Route.[13]). It was also noted that country of experience is irrelevant in consideration for licensure; only the country of education is considered. For example, a physician educated in Australia and later also licensed to practice in Ukraine would be considered for the jurisdiction-approved route in Canada. Meanwhile, a person educated in Ukraine but then licensed in Australia would not be. Meeting the criteria for licensure in an approved jurisdiction does not make a physician eligible for licensure in Canada, although the approved jurisdictions are considered to teach and practice medicine to a comparable standard. This was confusing and frustrating to ITPs who had successfully earned licensure in another English- or French-speaking country with similar practice requirements.

In other cases, there are 'soft' barriers or facilitators to IEHPs from various countries. A good example comes from the National Nursing Assessment Service, the credential recognition service for IENs. In order to get their credentials recognized, nurses must submit their documents through NNAS for verification. Some of these documents must come directly from institutions in their home countries. The research team heard that institutions in India and the Philippines (both major sources of IENs for Canada) are highly effective at providing the documents quickly and in translated format. For these nurses, there is little delay in their application. Countries in parts of the Middle East were identified as being less timely in releasing information, particularly if they had been employed on a contract basis. Nurses who come to Canada from these countries are more likely to experience processing delays at the credential verification step. Nurses who come from countries currently experiencing political conflict may have a very different experience again as their home institutions cannot provide necessary documentation. In several site visits, participants talked about the administrative difficulties faced by IEHPs who come to Canada as refugees.

Another barrier based on country or area of origin was racism and discrimination. One ITP who had trained in West Africa and worked in the UK shared that one's accent can create challenges. He suggested that speaking "African accented English" led people to assume that he wasn't a strong English speaker despite his years of English-speaking work history. Other discriminatory barriers to IEHPs' integration and licensure based on country of origin shared briefly with the research team were the perception by Canadians that Canadian medical education is 'elite'; systemic racism in healthcare; underrepresentation of people of colour in medical program leaderships leading to a lack of cultural understanding of IEHPs; and poor pedagogical fit in bridging and training programs designed for Canadian educational contexts.

12 The countries which have approved jurisdictions are Australia and New Zealand, Hong Kong, Singapore, South Africa, Switzerland, the United Kingdom and Ireland.
13 Royal College, "Highlights from Royal College Council (Feb. 2019)."

INTERNATIONALLY TRAINED DOCTORS

PRACTICE REQUIREMENTS

Practice requirements were a key barrier reported during the research process. Almost every physician interviewed for this research indicated that the timing and location of their practice experience had at some point caused stress, inconvenience, and barriers to the licensure process. Licensing bodies require that ITPs who wish to become licensed in Canada have practiced as a physician recently (typically within the last three or five years). The duration of the licensure process in Canada almost guarantees that some applicants' recency of practice will expire unless they practice in another country in the interim. Lived experience interviews revealed that, where financially possible, ITPs would return to their home countries to practice in order to maintain their recency of practice. For those who are working survival jobs, have family commitments, or who cannot return to their home countries, this is an impossible requirement to meet.

Similarly, ITPs encountered the paradox of Canadian experience. This is a highly desirable element for residency or fellowship applications. Canadian experience in this context means a suitable kind of medical professional experience. Not all healthcare jobs count towards Canadian experience. One potential option to gain healthcare experience is through a regulated clinical assistant program available in Alberta, British Columbia and Manitoba. Foreign-trained physicians can provide mid-level care under the supervision of a physician supervisor as part of a medical or surgical team. ITPs can in this way gain hands-on patient experience in Canada. However, program spots are limited and, as one interviewee pointed out, do not automatically lead to licensure.

In both cases, ITPs felt that there was a lack of respect for their previous experience in healthcare. Pre-Canadian experience does not meaningfully contribute towards requirements for practice in Canada, and an experienced physician essentially begins with a slate as blank as a newly qualified physician. The systemic undervaluing of international medical experience railroads mid-career ITPs into pathways to practice which are redundant and sends them down professional dead ends in the pursuit of Canadian experience.

PRACTICE-READY ASSESSMENT AND RESIDENCY PATHWAYS

Outside of the jurisdiction-approved route (which validates the education of ITPs from seven jurisdictions), ITPs predominantly come into Canadian practice through the Practice-Ready Assessment (PRA) program, or through completing a residency.

The residency application process for ITPs is effectively the same as that for Canadian graduates, but the ITP and Canadian pools of spots are different (except in Quebec). ITPs do not directly compete with Canadian graduates in the first round of selections through Canadian Resident Matching Service (CaRMS). Instead, their own pool consists of seats allocated to ITPs by educational institutions and provincial governments. This allows Canadian medical graduate data, which is a known quantity, to be used for forecasting what specialties are needed in what quantities. ITPs are then left with a pool of residencies that fill needed gaps. These are largely in family medicine. ITPs were disappointed and frustrated by the lack of choice and diversity of specialty in the residency process. Moreover, while most Canadian graduates will receive a residency, the disparity between applicants and spots for ITPs means that only about a quarter will successfully match in any given year.[14] Canadians who study medicine abroad and then return to Canada for a residency will compete with foreign-born, foreign-trained ITPs for these seats. Canadians who studied abroad were perceived to have a number of cultural, social, and legal advantages which would make them more likely to win one of these coveted spots. However, CaRMS no longer provides data on the difference in success rates between ITPs and Canadian studying abroad so this cannot be verified with recent, high-quality data.

For ITPs who have the educational and practice requirements, a PRA is a much more expedient route to licensure. Places are limited to 7 provinces with a total of approximately 120 spots per year across Canada. The PRA stream is primarily aimed at meeting the need for family physicians in rural and remote areas.[15] Practice options are therefore limited; specialists who trained abroad will effectively need to move into a

14 For example, 439 people matched through the IMG residency stream in 2022, and 1395 applied but did not match. (Caroline Ewen et al., "Expanding Pathways to Licensure for Internationally Trained Physicians in Ontario: How to Get There and Why It Matters.")
15 Viren Naik, "A Pathway to Licensure for Internationally Educated Physicians."

different area of medicine, which many respondents found a frustrating trade-off.

Following a successful PRA or residency match, ITPs may be required to sign a Return of Service (ROS) agreement which typically places them in an area in need of a family physician. Thisis not a requirement for Canadian trained physicians. This is a key strategy for staffing rural and small locations. Opinions were divided on the topic of ROS agreements. Many ITPs indicated (and Internationally Trained Physicians of Ontario (ITPO) research confirms) that they had a willingness and ability to work in small and rural practice.[16] Some respondents pointed out that agreements of this type are used in many countries and are not a foreign concept to a lot of the physicians signing them. However, there was also criticism of this strategy on two main grounds. First, some ITPs and other participants felt that because there are so few pathways to practice in Canada, that ITPs would sign these agreements because they had no other choice if they wanted to become licensed physicians. Indeed, ROS agreements have been recently challenged in courts, such as in British Columbia, on the grounds that they limit an ITP's Charter right to freedom of movement.[17] Second, as in residency program choices, ITPs felt that there were few options to practice in the specialty or subspecialty in which they had been trained and practiced.

BRIDGING AND TRAINING

Generally, there were fewer bridging programs available for physicians than nurses. A PRA or residency seemed to be considered to cover the required re-training or bridging. As mentioned above, Nova Scotia does use a six-month bridging program to move physicians into practice. In semi-structured interviews and working groups, participants acknowledged there were potential avenues for new bridging or training programs that were not being explored.

More common was the practice of training in topics like the Canadian healthcare system, 'soft skills' and cultural competence. There are many programs available to physicians. They vary by province and are administered by settlement organizations, educational institutions and both for-profit and non-profit groups. There is no federal standard for quality, duration or content, and no accreditation process. The quality of the programs therefore varies. In some cases, they are very costly and offered by organizations working on a for-profit basis. The opinions of ITPs on these programs seem to vary as much as the programs themselves. N4 heard of some cases where ITPs were satisfied with good additional education on the Canadian healthcare system and the skills required to succeed. Others reported spending a significant amount of money on a program that they hoped would make them more competitive on the job market but had ultimately not helped.

A noted challenge was the lack of consistent alignment between the regulatory authorities, educational institutions, and practice pathways. Ideally, participants wanted to receive a referral to a training program that was recognized by regulators, filled a specific, identified knowledge gap, and would move them further down the pathway to licensure. Lacking such clear guidance, ITPs were left vulnerable to for-profit institutions and ended up wasting time and money on training programs that were not required.

16 Internationally Trained Physicians of Ontario (ITPO), "ITPs: A Diverse, Underutilised Skilled Health Human Resource."
17 Canadian on Paper, "Lawsuit – Canadian On Paper Society for Immigrant Physicians Equality."

INTERNATIONALLY EDUCATED NURSES

PATHWAYS TO RN

Unlike physicians, IENs who qualified as RNs in their home country have more opportunity to work in a nursing-adjacent role, or as a registered/ licensed practical nurse (RPN/LPN), while they work towards their RN in Canada. Through the research process, we heard from many different stakeholders and nurses themselves that it is common to begin work as an RPN/LPN or in an unregulated health care aide role while they complete the NCLEX or fill in education gaps through a bridging program. This pathway varies between provinces.

For example, in Nova Scotia and British Columbia, the nursing regulator regulates both LPNs and RNs, and actively recommends the LPN pathway, when appropriate, to get an IEN licensed and working faster. Because the regulatory body is combined, the nurse has one license number which will stay with them if they move from LPN to RN. Elsewhere in Canada, these processes are siloed because they are regulated by different colleges, resulting in an additional organization to navigate towards licensure as an RN.

Across Canada, organizations have made efforts to make this pathway clear or more accessible. In British Columbia, a 'triple track' assessment process checks an IEN's education against the Canadian requirements to be a PSW, an LPN and an RN. This practice allows the IEN to learn precisely where they stand in relation to Canadian scopes of practice. In Manitoba, the College of LPNs has mandatory membership for students which allows for the regulation of student employees. They can take on a work placement rather than a clinical competency exam; a model which is in the process of expanding to encompass IENs working in healthcare in non-medical roles like housekeeping. These IENs, once connected to the College of LPNs, can be placed in small and rural communities, and supervised by existing staff as they build Canadian experience, potentially improve their vocational language skills, and have their nursing skills assessed.

Employers are key players in this pathway. It was identified that when successful, the PSW to RPN/ LPN to RN pathway was a win-win situation, allowing employers to recruit and retain staff and IENs to gain experience and move to an RN role. On the other hand, participants also cautioned the challenges of moving nurses effectively through this pathway and ensuring they didn't become 'stuck' as PSWs indefinitely. At a systems level, we heard that moving IENs to RN roles left vacancies at the more difficult to recruit LPN and PSW roles, creating a potential conflict of interest to advance their skills towards a lesser needed one. And, both research and lived experience interviews indicated that, overall, it is a problem to expect IENs who have a lot of training and experience to start as PSWs when their foundational nursing skills are strong. There can be a 'deskilling' effect in these cases, which leads to brain waste.[18]

CREDENTIAL ASSESSMENT

Credential assessment for IENs in Canada is currently offered through a single point of entry: the National Nursing Assessment Service (NNAS). NNAS collects an IEN's documentation (education, identification, language test and details of their experience) and sends it to a third party in the USA. After document verification, NNAS generates a report which the IEN can take to a provincial licensing body and use to confirm their eligibility to practice in Canada.[19]

NNAS data shows that most nurses (between 80% and 90%) receive their report within the stated 12-week timeframe. Some nurses in lived experience interviews indicated that their reports, or the reports of people they knew, took longer. There seemed to be a general and pervasive sense that the process was opaque, hard to understand, or non-communicative. Nurses described the process as stressful as it requires institutions in their home country to respond to requests for documents. In some cases, those institutions were not able to provide documents due to social upheaval associated with conflict. For these nurses there are few avenues for moving forward in the licensure process. The exception would be the

18 B. Salami, S. Meherali, and C. L. Covell, "Downward Occupational Mobility of Baccalaureate-Prepared, Internationally Educated Nurses to Licensed Practical Nurses."

19 At time of writing, NNAS is currently undergoing a process to streamline their credential assessment and provide additional navigation support to their clients.

Gateway Alternative Credential Program offered by World Education Service, which works to find ways of validating the credentials of individuals from seven countries which have experienced recent conflict.[20]

BRIDGING PROGRAMS

The defining feature of feedback about bridging programs for IENs was that they were important in theory but that there were implementation and capacity challenges in practice. The research team heard that capacity was not meeting demand, and that programs came and went as funding was found and then lost. This compounded systems navigation problems for nurses, who could not rely on a program that they had heard about being available when it was time for them to take it.

Mandatory bridging programs were also considered an important area to improve because they created bottlenecks in the licensure process. In some cases, a long waitlist or program could mean that the nurse's language exam results expired before they could return to their provincial licensing body to apply for a license (this was a particular barrier in Manitoba.) There were questions asked about the approach taken towards bridging in the current state, which takes the philosophy that nurses should be individually assessed and provided with an individualized program. Although in other areas of nurse licensure an individualized approach was welcomed, some participants felt that it created roadblocks for nurses in bridging which could be resolved by a more general program which focused on the Canadian context and ethics. Participants also suggested that virtual programming could expedite some kinds of bridging for nurses who were not yet in country, and later discussion with the N4 Community of Practice IEN Working Group did confirm that this is a viable option following the virtualization of much educational programming during COVID-19.

At the national level, the research team heard from more than one national body that there was a lack of nationwide standardization, leaving the door open for private enterprises to provide low quality or even predatory programming. Accreditation was considered a desirable strategy, but one that would take time to implement and roll out nationally. Accreditation could also require that institutions consider the pedagogical context of foreign-trained nurses and include clinical elements that respected the experience of the IENs rather than focusing on delivering information in the classroom. One hospital reported much success using a simlab environment to train IENs on equipment and procedures that are common in Canada but not in other parts of the world. And, as in other areas of the licensure process, mentorship was considered a useful tool to enhance participant learning in a bridging program.

FACILITATORS AND PROMISING PRACTICES

Although interviewees focused on the many and complex barriers to IEHP licensure, there were many promising practices and facilitating factors identified as well. The barriers to practice were considered to be universal. By contrast, many programs and practices are limited in scope and geography, with practitioners working in silos unable to share their expertise across the country. In this section, we discuss some of the many initiatives and strategies taking place across Canada. This could offer potential pan Canadian direction for institutions, health care professionals, the settlement sector, recruiters, navigators and IEHPs themselves. This section should be read in conjunction with the N4 Recommendation Reports for ITPs and IENs, which present specific avenues for change and signpost to practices which are already in use.

PERSONALIZED NAVIGATION

There was a strongly felt need by participants for personalization and specificity when it came to navigating IEHPs through the licensure process. Participants reported that a flowchart or guidance documentation could only indicate the most common or standard pathways. Many IEHPs who successfully received licensure stated that they had self-advocated for waiving language requirements, found their own peer or mentor support, or were supported by a skilled navigator regarding the the pathway. Having an individualized plan based on the specifics of their education, training and licensure requirements was the key factor in getting a license. People who had to rely on a generalized information source tended to struggle and pursue strategies only to find doors were closed to them.

20 At present, the Gateway Program works with individuals from Afghanistan, Eritrea, Iraq, Syria, Turkey, Ukraine, and Venezuela.

It was suggested that a centralized pan Canadian information hub would be useful in tracking changes to requirements in a user-friendly manner as an alternative to the current use of informal information that is not accurate. The hub, respondents suggested, should be a source of information that all navigators and newcomer serving professionals could use to understand the current state of ITP and IEN licensure, and assist IEHPs accordingly.

Settlement organizations play an important role in navigation. Settlement professionals who participated in this research also spoke about the need for clear and up to date information. This was because many organizations did not have separate navigators for different professions. A settlement worker (especially in a smaller organization) may be required to help immigrants navigate all of Canada's unregulated and regulated professions, and would not necessarily be able to build specific expertise in one area. Specialist organizations serving IEHPs have deeper knowledge but were more likely to report expertise in one province. A central hub was identified as a facilitator to intersectoral partnerships between settlement and other organizations. Partnerships would allow organizations to refer out for various needs (career coaching, job searching, additional navigation, social and family need, financial support and bursaries) and better integrate the licensure and job searching process into other settlement services.

MENTORSHIP AND PEER SUPPORT

ITPs and IENs were vocal about the importance of the right kind of social supports. Mentors who were licensed IEHPs were particularly sought after. Indeed, we spoke with several ITPs who were now licensed and working in Canada, and the majority of them said that they were informally mentoring newcomer ITPs. Programs like the Supervised Practice Experience Partnership (SPEP), available in several provinces, can provide mentorship opportunities both professionally through a nurse preceptor but also through other program staff. SPEP staff interviewed in Ontario indicated that they understood the benefit of helping IENs integrate socially, find housing, link up with IEN serving organizations, and generally develop nursing-related soft skills.

PRE-ARRIVAL ACTIVITY

A comprehensive scoping review of IEHP literature found that "the circumstances surrounding IEHPs' immigration influence the type of activities they undertake prior to immigration [...] some IEHPs have significant time and ability to plan their move to Canada, and others, like refugees, move with little preparation."[21] For N4 research participants who had planned to move to Canada, the lack of pre-arrival preparatory information and resources created a knowledge gap which led to avoidable inefficiencies in the timeline from arrival in Canada to licensure. There was a noted interest in the idea of online, proctored exams, for example, so that IEHPs could arrive in-country with their exam results in hand.

A general trend in this research, and in the N4 CoP working groups, was a shift towards using virtual and online methods of assessment and examination so that parts of licensure processes could be completed pre-arrival. This shift was accelerated by the COVID-19 pandemic and the resulting widespread social validation of online education and assessment methods. In British Columbia, the assessment of internationally trained psychiatric nurses was moved to a virtual setting, because they were not required to physically interact with a patient actor to be assessed in practice.

The MCC also informed the research team that some of their services have recently been centralized to remove barriers, including providing a service desk to answer pre-arrival questions, and providing letters to support Express Entry applications. Such initiatives oriented towards pre-arrival support could streamline the in-country licensure process. This is a vital step towards reducing time spent supporting a family, maintaining recency of practice, sitting on waitlists, and keeping language evaluations current.

21 Christine L. Covell, Elena Neiterman, and Ivy Lynn Bourgeault, "Scoping Review about the Professional Integration of Internationally Educated Health Professionals."

CONCLUSIONS AND FUTURE DIRECTIONS

Over the course of this research, the N4 team was struck by the depth, breadth and complexity of the barriers facing internationally educated physicians and nurses on their way to licensure in Canada. A frequent metaphor of the IEHP process was that of peeling back endless layers of an onion, with tears at every step. At every site visit, we asked about barriers and facilitators. Every time, the barriers far outweighed the facilitators and in many cases our respondents said they couldn't think of any facilitators. Despite these issues, both IEHPs and the organizations working with them remained committed to finding ways to navigate pathways and break down barriers for themselves and others.

For ITPs, pathways are limited in number and so competitive that only a fraction of these physicians successfully start on them every year. Mid-career ITPs are particularly poorly served by existing pathways, because not only must they repeat training and assessments, but they are likely to be tracked into family medicine rather than being able to continue to practice in their specialty or sub-specialty. IENs have more pathways into practice, but they experience a pervasive deskilling into practical nursing and even into unregulated care aide jobs.

Information is plentiful but hard to navigate and contaminated by misinformation and hearsay; informal networks are emotionally important but do not always keep up with changes to licensure requirements. A personalized navigation approach is the gold standard for moving individuals through the system to full licensure, but it is rarely available, and demand outstrips spaces in programs. Bridging and training programs come and go with funding and are so variable in quality and availability that they cause additional navigational issues for clients.

Throughout the course of the research, certain best practices which should be pan-Canadian emerged and are fully detailed in our Community of Practice Working Group Recommendations Reports and Employer Toolkit. We also heard about further avenues for work which would be helpful; more bridging and training opportunities that can be accessed online and completed in parallel with other parts of the immigration and credential evaluation processes; better linkage between the federal and provincial ministries that oversee immigration and regulators, to link IEHPs to navigational supports for the pathway to the licensure process. A scan of provincial legislation that governs healthcare regulatory bodies would assist in building accountability for change, as some legislation holds regulators responsible for ensuring physician supply.

Finally, this work is just one small part of a large ecosystem of other organizations who are working to alleviate healthcare staffing needs and make sure we are efficiently and equitably welcoming these competent, skilled, highly trained professionals to Canada.

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APPENDIX 1: LIST OF SITE VISITS

- Initial Round of Site Visits (May to September 2022)
- Alberta International Medical Graduates Association
- Alberta Network of Immigrant Women
- Association of Faculties of Medicine Canada
- Association of Registered Nurses of Manitoba
- Canadian Association for Long Term Care
- Canadian Association of Schools of Nursing
- Canadian Council for Practical Nurse Regulators
- Canadian Medical Association
- Canadian Nurses Association
- Capelle Kane Immigration Law
- Care4Nurses
- CaRMS
- CHEO Human Resources
- College of Physicians and Surgeons of Nova Scotia
- Doctors Nova Scotia
- Dr. Edward Cruz, Faculty of Nursing, University of Windsor
- Dr. Emmanuel Ajuwon
- Dr. Geraldine Balao
- Dr. Sarah Zia
- Dr. Sepideh Behroozan
- Dr. Shafi Bhuiyan, Dalla Lana School of Public Health
- Dr. Tanvir Turin Chowdhury, University of Calgary
- Dr. Vicki Esses, University of Western Ontario
- Dr. Zahra Fatehi
- Dr. Zubin Austin, University of Toronto
- Economic and Social Development Canada
- Faculty of Medicine, University of Manitoba
- Government of New Brunswick IEN Navigation Unit
- Health Canada
- Health Force Ontario
- Health Match BC
- Health Professional Regulators of Ontario
- HealthCareCAN
- Immigration Partnership Winnipeg
- Immigration, Refugees and Citizenship Canada
- Internationally Trained Physicians of Ontario
- Leah Geller
- Luma Qussay
- Medical Council of Canada
- Medical Council of Canada
- Medical Council of Canada, Practice-Ready Assessment Programs
- MOSAIC BC
- National Nursing Assessment Service
- Nova Scotia Practice Ready Assessment Program
- Nursing Community Assessment Services
- Office of the Fairness Commissioner
- PEGASUS Institute
- Ranika Singh
- SEED Winnipeg
- Success Skills Centre
- Sunnybrook Hospital
- Sura Harbi Al Azzawi
- The College of Family Physicians of Canada
- The Royal College of Physicians and Surgeons of Canada
- Touchstone Institute
- University of Manitoba Access Hub
- World Education Service

ADDITIONAL SITE VISITS (OCTOBER 2022 TO JANUARY 2023)

- Binny Law
- British Columbia College of Nurses and Midwives
- Canadian Federation of Nurses Unions
- Capacity and Health Workforce Planning Ministry of Health and Long-Term Care
- CAPER, Association of Faculties of Medicine of Canada
- Collège des médecins du Québec
- College of Physicians and Surgeons of BC
- Dr Leigh Chapman, Chief Nursing Officer, Health Canada
- Federation of Medical Regulatory Authorities of Canada (FMRAC)
- Immigrants Healthcare Support Network
- ISANS
- Kids Help Phone
- McMaster University
- New Brunswick Community College, School of Health and Wellness
- Nova Scotia Health
- Ontario Ministry of Health
- Windmill Microlending
- York University School of Nursing

APPENDIX 2: SEMI-STRUCTURED INTERVIEW QUESTION SET

Tell us about the IEHP work you have been involved with

How did you become involved in the field of IEHP licensure?

How do you facilitate IEHPs into the Canadian healthcare system?

What barriers exist that prevent IEHPs from entering the Canadian healthcare system?

Are you aware of any projects, tools or resources that have been developed to support the recruitment and retention of IEHPs?

Are you aware of any programs and initiatives that support IEHPs to support employment relevant to their training within your community or organization?

Where (or to whom) do you turn to for resources related to IEHPs? (as it relates to employment and/or recruitment and retention)

What resources and/or education would support your research and/or work related to IEHPs?

Are there any other stakeholders doing work or who have done work in this area we should connect with as we begin this project?

Based on what we have shared today, do you see any opportunities for collaboration or synergy with the work you are doing?

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