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<td>Creation of draft document</td>
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**Distribution**

The document has been distributed to the following individuals, groups, committees and/or organizations:

- NAC³
- Consultation participants
- FQR initiative participants
- FMRAC
EXECUTIVE SUMMARY

The National Assessment Collaboration (NAC) is working with Practice Ready Assessment (PRA) programs across the country to streamline the evaluation process used for International Medical Graduates (IMGs) who seek a licence to practise medicine in Canada by developing or adopting the tools necessary for a pan-Canadian PRA process. This process, as it is envisioned, will meet the Medical Regulatory Authorities’ (MRAs) provisional licensure requirements for a competency-based, pre-practice assessment in Canada.

An environmental scan was undertaken to review existing PRA processes, identify complementary initiatives as opportunities for collaboration and explore the envisioned pan-Canadian PRA process with various stakeholders. Cross-jurisdictional stakeholder consultations form the basis of the NAC PRA Environmental Scan.

Current Environment

Seven jurisdictions currently offer formal PRA processes in either or both of family medicine and other specialties. The processes encompass everything from pre-screening eligibility requirements of credentials and experience to assessment prerequisites to point-in-time and over-time assessments.

The variation across PRA processes is highlighted in an overview (Appendix G.6) that should be used to identify potential focus areas for a pan-Canadian process and to explore stakeholders’ tolerance for flexibility within a common approach.

Within the Canadian stakeholder landscape of IMG-related initiatives for entry into residency and entry to practice, complementary initiatives exist that need to be considered in context of the NAC PRA as multiple opportunities for collaboration exist:

1. Potential for a governance structure within the Federation of Medical Regulatory Authorities of Canada (FMRAC) Working Group on Assessment and Supervision (WGAS)
2. Expert assistance in defining competency requirements for PRA with certification colleges and from current PRA programs
3. Partnerships with certification colleges for determining appropriate, context-specific assessment tools
4. Cross-organization benchmarking assistance from certification colleges and current PRA programs

Future Environment

Through stakeholder consultations, appetite is solidifying for a pan-Canadian PRA process that would meet the expectations of MRAs and ensure the mobility of IMG physicians within the Agreement on Internal Trade (AIT). Stakeholder interests run from a commitment to deliver existing processes to building a pan-Canadian process to making use of processes from other jurisdictions where the capacity to develop and maintain an independent process is not feasible.

Benefits of a common pan-Canadian process include clarifying the alternate pathway route across jurisdictions, gaining confidence that the same acceptable minimal standard for practice readiness is being set across Canada, increasing the legal defensibility of current processes and obtaining the efficiencies of scale that can be realized with common toolkits and cross-jurisdictional collaboration.

A pan-Canadian PRA process must be implementable across jurisdictions where capacity permits, allow some jurisdictional autonomy within the common process and be achievable within jurisdictional funding and human resource capacities. The vision for a pan-Canadian process must allow for variance in the frequency of assessments and in the location of over-time assessments.

Philosophical differences will need to be explored to reach general agreement on an acceptable level of practice readiness, to define types of IMGs (i.e., IMGs with credentials and known training) and to compile an appropriate assessment toolkit for each type of IMG and area of physician need (i.e., assess all IMGs with point-in-time and over-time assessments?) Currently, there is agreement that a practice-ready route
would apply to any IMG not meeting full licensure requirements including Canadians Studying Abroad (CSAs) who have completed their postgraduate medical education before returning to Canada.

Studies are needed to both inform and validate the pan-Canadian PRA route. The studies should consider process reviews, assessment tools, current process tools and outcomes, establishing a minimal standard and ongoing monitoring of the assessment process itself.

**Pan-Canadian Approach**

Through the consultations, several expectations were articulated. Finding the right balance between objectives and required changes, engaging the right subject matter experts and making use of the expertise that exists within the Canadian assessment environment are critical examples.

**Potential Direction**

The scope of what direction NAC should take was explored. There was general agreement that NAC should proceed with the development of a pan-Canadian PRA route that spans activities between pre-screening policy and assessments to assessment-based decisions regarding candidate readiness to practise. This work will likely include the validation of competencies to be assessed, alignment of policies and practices and formalization of a common PRA framework. This work should be supported by research studies that focus on the comparability and accuracy of common tools and overall processes, adoption or development of a common toolkit and the establishment of a common infrastructure where required.

The initial focus areas for a pan-Canadian PRA framework should be critical needs, and during the scan the most common need identified was for family medicine/primary care practitioners.

Where possible, existing committee or organization structures could be used including:

- National Assessment Central Coordinating Committee (NAC³) with oversight for the approach and outcomes of a pan-Canadian PRA route
- Medical Council of Canada (MCC) to coordinate, facilitate and manage the development of the framework
- PRA Steering Committee to direct the initiative and its sub-elements with representation from MRAs
- Working groups to provide input into various sub-elements (e.g., Advisory Council of International Medical Graduate Assessment Programs [ACIMGAP] for policy review and practical experience, jurisdictional funders as a consultation group regarding the financial feasibility of the pan-Canadian framework across jurisdictions)
CONTEXT

BACKGROUND

Since the report of the IMG Task Force in 2004, it has been accepted that Canada has a fragmented approach to assessing and integratingIMGs. As many listed medical schools around the world have curricula and/or monitoring processes that are unknown to medical authorities in Canada, MRAs rely on internal assessment processes to provide sufficient information about a candidate to determine his or her readiness to enter clinical practice in Canada. A consensus has emerged that assessments of medical knowledge and clinical skills are not sufficient and that potential practitioners should be objectively observed in a realistic clinical environment as well.

Through the NAC, the NAC has made progress on implementing some of the key recommendations of the IMG Task Force. The overarching objective of NAC is to streamline the evaluation process for IMGs who seek a licence to practise medicine in Canada.

Accomplishments of the past eight years include:

- Development of a national research program and evaluation of IMG strategy
- Implementation of governance structures that can support a pan-Canadian IMG licensure process
- Use of new assessment tools with a focus on over-time observations and on point-in-time assessments of knowledge and clinical skills (e.g., mini-clinical evaluation exercise [mini-CEX], multisource feedback [MSF] and therapeutics examinations)
- Implementation of an assessment tool for screening IMGs for entry into Canadian postgraduate training programs (i.e., NAC Objective Structured Clinical Examination [OSCE])

In the next stage in the NAC commitment to streamline the evaluation process for IMGs, the focus shifts to the development and/or adoption of a pan-Canadian PRA process. This process, as it is envisioned, will meet the provisional licensure requirements of MRAs for a competency-based, pre-practice assessment in Canada.

The NAC PRA Environmental Scan was funded by Health Canada with in-kind support from MCC.

THE ENVIRONMENT/LANDSCAPE

Jurisdictions – Response to Physician Resource Needs

Efforts within the Canadian health-care system over the past few years have focused on the physician shortage situation that exists in many communities; a topic that is also of interest to the media.

When discussing physician resources as part of the health system, care must be exercised in speaking about the type of physicians required (i.e., family physicians or other specialists) and about the geographic location of the areas of need (i.e., urban, rural or remote areas within a jurisdiction).

As explained in the “Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications” (Forum of Labour Market Ministers, HRSDC, 2009), Canada relies on a community of foreign-trained physicians who immigrated to Canada to serve a growing and culturally diverse population. Of the approximately 250,000 immigrants who come to Canada annually, a proportion is internationally-trained doctors. About 25% of Canada’s medical practitioners are IMGs and this will likely be true in the future.

The expectation is that immigration to Canada will continue according to the current human capital model, federal plans and population need projections. IMGs will continue to fill the gaps to meet the
needs of the Canadian public. While some jurisdictions continue to identify the need for physicians in underserviced areas, others are experiencing distribution issues.

**Terminology – ‘Entry to Practice’ and ‘Practice Ready’**

‘Entry to practice’ generically refers to the process of a physician being permitted to commence medical practice. In the context of IMG assessment, the term is used in reference to an assessment designed to determine if an IMG has the requisite competencies to enter unsupervised or supervised medical practice or if they should use an alternate pathway that may include residency training.

‘Practice ready’ is an indication to an MRA that an IMG is qualified to enter medical practice in the capacity of a most responsible physician (MRP) under a provisional medical licence. There is an expectation that supervision and summative assessment will be a final prerequisite to attaining full medical licensure.

**IMG – Pathways to Licensure**

Currently, there exist three general routes for IMGs to enter into practice in Canada from a screen based on their credentials. The options are:

1. Obtain licensure – as credentials meet Canadian standards (i.e., IMG holds credentials accredited by the College of Family Physicians of Canada [CFPC] or the Royal College of Physicians and Surgeons of Canada [RCPSC]) or another jurisdiction has licensed the physician, etc.

2. Enter a supervised or unsupervised practice program for IMGs – as credentials indicate the IMG has completed acceptable postgraduate training and/or has been a practising physician outside of Canada

3. Complete Canadian postgraduate training – as credentials indicate the IMG does not have sufficient postgraduate training

In 2010, at least 393 IMGs across Canada were granted a provisional licence. A breakdown of the number of IMG physicians who obtained a provisional licence across the jurisdictions is included in Appendix C. Of note, five of the 13 jurisdictions in Canada licensed the majority of IMGs.

![Figure 1 2010 Provisional Licences Granted Across Jurisdictions](image)

**Practice Ready Assessment Processes**

Currently, seven jurisdictions in Canada offer formal PRA processes for IMGs in family medicine and/or other specialties. These processes collectively encompass a robust combination of assessment tools used to evaluate abilities that are essential for a physician to be deemed “practice ready”. The tools used include both “point-in-time” examinations and “over-time” evaluation periods to determine if an IMG is qualified to enter medical practice as an MRP under a provisional medical licence.

Formal PRA processes exist today in two broad physician skill areas:

- **Family physicians**: Newfoundland and Labrador, Nova Scotia, Quebec, Manitoba, Saskatchewan and Alberta
- **Other specialties**: Quebec, Ontario, Manitoba and Alberta
**Purpose of the NAC PRA Initiative**

A pan-Canadian PRA process is being explored by the NAC within an environment of multiple and often multi-role stakeholders. These groups operate in a Canadian system for medical licensure and for physician assessment and supervision.

**The Stakeholders**

Various stakeholder organizations come together to ensure that the physician supply is adequate and that the assessment and licensing system functions appropriately. Key players from a PRA perspective include:

- MRAs in their role to regulate the practice of medicine
- Provincial Ministries of Health (MoH) and Regional Health Authorities (RHA) as funders with a vested interest in meeting community needs for physicians in underserviced areas
- PRA programs and, while involvement by jurisdiction varies, this represents a cross-section including funded programs, medical schools and, in some cases, the MRAs themselves

Appendix D provides an overview of the general roles of these stakeholders.

**Frameworks**

The FMRAC Working Group on Registration sought to standardize the requirements and processes used by provincial and territorial MRAs for registration and licensure. The MRAs collectively defined and agreed to standards for medical registration in Canada, including standards for issuing provisional and full licences.

The standard for issuing a provisional licence is important to the development of a pan-Canadian PRA process for two reasons:

1. Consensus on the minimum standard for eligibility to a PRA process and eventual mobility is necessary to satisfy AIT
2. Solidifies the requirement for a competency-based, pre-practice assessment in Canada for both family physicians and other specialists

For a detailed description of the current standards for the issuance of a provisional licence, refer to Appendix E.

The FMRAC WGAS is continuing efforts to define acceptable processes for assessment, supervision and the final evaluation of physicians who do not hold a full, unrestricted licence. The work of this group focuses on aligning the different approaches of 13 jurisdictions to develop a common, national standard for pre-practice assessment, supervision in practice and a final summative assessment of physicians leading to full licensure. The principles of the work being explored are depicted in the process flow below.

![Process Flow](image)

**Figure 2 Principles of WGAS Work**

This work is of particular importance to a pan-Canadian PRA process:

1. Solidifies the need for competency-based assessment for pre-screening and post-screening
2. Establishes the need for PRA to determine whether a candidate has the necessary knowledge, clinical skills and professional characteristics to practise medicine safely in Canada while under supervision
APPROACH

The NAC<sup>3</sup> contribution to establishing a pan-Canadian system depends on following a sequence of steps:

1. Complete the analyses of assessment programs currently active in Canada for IMG physicians identifying commonalities and differences
2. Propose an acceptable pan-Canadian process for evaluating readiness for practice
3. Identify a delivery model to be used for the process
4. Develop the required policies, guidelines, procedures and the training and assessment tools

ENVIRONMENTAL SCAN – ANALYSES APPROACH

The environmental scan gathered information about currently active Canadian programs for IMG physicians’ entry to practice. The approach focused on establishing a baseline of information from the existing programs performing some form of PRA.

To initiate the scan, the general approach was defined and expectations established with the NAC<sup>3</sup> in November 2011. An informal review of published material regarding programs, processes, etc. was performed and used to refine the structure for discussions and information collection.

Stakeholder consultations occurred from January to March 2012 and included three main types of information gathering:

- Multi-organizational participation within all jurisdictions
  - Those with PRA processes – discussion focused on current state and future directions
  - Those without PRA processes – discussion focused on context and future directions
- Complementary initiatives – discussions either directly or indirectly related to the assessment of physicians for entry into practice
- Participants and other stakeholders – discussions focused on awareness and exploration of opportunities for future involvement

Session outputs in the form of informal discussion notes, in addition to the program and complementary initiative summaries, were validated by specific jurisdictional or organizational representatives to ensure the general accuracy of information gathered.
ENGGAGEMENT

As the environmental scan explored PRA in context of a pan-Canadian process, stakeholder responses were grouped informally by respective roles within a process framework. Details on stakeholders involved during the consultation are included in Appendix B.

Table 1 Stakeholders by Category

<table>
<thead>
<tr>
<th>Stakeholder Category</th>
<th>Description</th>
<th>Consultations</th>
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<tbody>
<tr>
<td>Driver</td>
<td>Require an assessment to grant provisional licence or certification respectively</td>
<td>MRAs, FMRAC, RCPSC</td>
</tr>
<tr>
<td>Delivery</td>
<td>Actively engaged in the delivery of a program to assess an IMG’s readiness for entry to practice</td>
<td>IMG programs/processes (with and without PRA)</td>
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<tr>
<td>Funder</td>
<td>Contributes to the process to assess an IMG through direct or indirect funding, allocations of resources to the process</td>
<td>Provinces and Territories, Regional Health Authorities</td>
</tr>
<tr>
<td>Participants</td>
<td>Involved in the process as either a receiver of services within a program or plays a key role in supporting the delivery of the process</td>
<td>Practising physicians (supervisors and mentors of programs) through anecdotal feedback (IMGs were not actively engaged in the scan, though a focus group is planned once the framework is established)</td>
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<tr>
<td>Other</td>
<td>Potential mechanisms for engagement throughout implementation (stakeholders with complementary initiatives or NAC stakeholders not actively engaged in delivery of PRA)</td>
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**Practice Ready Assessment Concepts**

In establishing the framework for discussion for NAC PRA, we focused on foundational material. The IMG Pathways to Licensure Proposal (Dr. Ian Bowmer) recommends a series of assessments that could be administered sequentially with common screening tools used to pre-screen and direct IMGs into two potential routes to practise in Canada: either a residency or a practice-eligible route.

**Screen**

- Assessment of training and practice (including practice currency)
- Source verification
- Basic screening of medical knowledge (i.e., computer-based assessment such as the MCC Evaluating Examination [MCCEE] or the MCC Qualifying Examination [MCCQE] Part I)

**Clinical Assessment**

- Clinical skills, communication, the integration of information and the development of a plan as well as therapeutics can be assessed in a clinical examination such as the NAC Examination
- The NAC Examination design is based on the deficits in the clinical ability of some IMGs entering postgraduate education; these deficits were identified through focus groups with residency program directors and include basic clinical skills, communication with patients and pharmacotherapy

**Training Required**

- Based on screening and clinical assessment, IMG candidate requires further postgraduate training plus experience in the Canadian context and an orientation to the Canadian system
- Entry into residency education is a competitive process where program directors make a judgment on entry using a comprehensive application file, including any screening assessment results
- A three-month clerkship/assessment/education is an option within this route in some jurisdictions

**Practice Eligibility Route**

- Candidates are selected to enter this route based on their credentials, recent clinical experience and performance on assessments to date; this route is limited and program opportunities vary
- Given funding limits and PRA opportunities, only those who exceed minimum requirements are selected
- A period of observed clinical practice usually requires a summative assessment using specific tools such as the mini-CEX, MSF and case-based discussion (CBD); these assessments are used to determine if an IMG is granted a provisional licence
- The standard for entry into practice would be based on a composite of the knowledge tests (e.g., MCCEE, MCCQE Part I) and/or the performance on the NAC Examination

**Licensure**

- A final decision point that may include the ability to award a full licence or extend the provisional licence

---

**Figure 4 Proposed Screening Pathway**

**Table 2 Pathway Descriptions**
Guiding Principles

Basic principles have been established by the NAC\(^3\) related to collaboration, process and assessment tools. The principles incorporate lessons learned and key tenets from the NAC\(^3\) experience of implementing a pan-Canadian examination for use by program directors selecting IMGs for residency. The principles established in 2005 through Maguire’s “A Process for Assessing International Medical Graduates” are also reflected in this report. Appendix F contains a list of PRA principles established in the Maguire report.

Table 3 Guiding Principles

<table>
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<td>• Alternate pathways, with national mobility (portability)</td>
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<tr>
<td>• Centrally-supported and regionally-delivered</td>
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<tr>
<td>• Build on existing provincial and regional IMG assessment processes, and those under development or planned</td>
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<td>• Common pricing for IMGs with the opportunity for different funding models by jurisdiction</td>
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<td>• IMGs for practice ready assessment include new graduates who have completed postgraduate training and practising physicians</td>
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<td>• Standards for provisional licensure should be comparable to Canadian-trained physicians</td>
</tr>
<tr>
<td>• Granting licences and certification - MRAs retain the right to grant licences to practise within their own jurisdictions; certification remains with the RCPSC, CFPC and CMQ</td>
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<table>
<thead>
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<th>Tools</th>
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<td>• Practice-ready clinical knowledge and skills assessments are standardized and reflect MCC, RCPSC and CFPC requirements</td>
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Data Gathering

Data gathering explored commonalities and differentiating factors in existing programs and processes, as well as complementary initiatives already underway.

Program

| Area of Need / Scope | Involved in Delivery | Funding Sources |

Process

| PRA Steps | Roles & Responsibilities | Tools & Training |

Assessment Activities

- Pre-Practice Assessment
- Eligibility
- Point-in-Time Assessment
- Orientation Assessment
- Provisional License

Physician Support

- Sponsorship
- Orientation
- Mentorship

Infrastructure

Complementary Initiatives

| Purpose | Scope | Linkage | Timelines | Composition | Opportunities |

Understanding of jurisdictional programs and processes within a larger framework to facilitate dialogue going forward.

Focusing on the activities and steps used within existing processes from eligibility criteria to assessment tools used and decision making approaches.

Highlighting the multiple stakeholders within a jurisdictional process and the tools and training used for assessors.

Exploring the supports in place for IMG candidates going through the PRA process from linking sponsorship to contextual-based assessments and orientation approaches.

Recognizing the infrastructures needed to support PRA processes.

Identifying other related activities that may need to be considered or opportunities for sharing responsibilities or activities in moving forward.

Figure 5 PRA Data-Gathering Strategy

**CURRENT ENVIRONMENT**

The PRA findings are based on a series of information gathering steps ranging from informal reviews of available published program information to formal Canadian jurisdictional and stakeholder consultations. The findings are organized to:

- Highlight the current situation for entry to practice through a provisional licence with a focus on PRA processes, their commonalities and differences
- Identify initiatives that are currently underway or planned that overlap or complement the pan-Canadian process envisioned by NAC
- Explore initial interest and considerations for a potential pan-Canadian NAC PRA process
PRA LANDSCAPE

Areas of Need

The areas of need vary by jurisdiction. There is a common need for rural/remote family physicians with the Territories requiring physicians in most disciplines, though various solutions are in place to support areas most in need. Consideration should be given to the severity of the impact in rural or remote communities when a physician resource is lost due to illness or mobility as compared to the impact in an urban environment.

Table 4 Areas of Need

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<th>PEI</th>
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IMGs

Attracting IMGs to a jurisdiction occurs primarily from within Canada with the exception of some overseas efforts in targeted medical specialties. An overseas approach adds complexity to the assessment process delivery constraints (i.e., timeframe restrictions).

Provisional Licensure Route – Estimated Volume

In 2011, approximately 300 IMG physicians were assessed through the existing PRA programs. A breakdown by jurisdiction is included in Appendix G.1. The PRA need is expected to increase over the next five years across Canada as the requirements take effect for a competency-based assessment falling under the standards for provisional licensure.

Figure 6 Estimated Volume of PRA over five years by Speciality Area

Note: At time of preliminary report distribution, engagement in consultations with Nunavut had not occurred.
Current Programs or Processes
The processes used to determine if an IMG is ready for entry to practice vary across jurisdictions but generally fall within two categories:

- Credential review only
  - IMG candidates have acceptable, comparable credentials that meet Canadian standards OR
  - Evaluation and assessment programs are limited or absent due to capacity issues
- PRA process that encompasses a credential review, a point-in-time examination and/or an over-time assessment
  - Specific IMG PRA programs have been developed in response to a combination of underserviced community needs and, in some cases, political and community pressure for physicians

In jurisdictional processes based solely on credential reviews, the activity includes a detailed review of IMG candidates’ credentials, training and practice experiences to decide if these meet the standard for provisional licensure. A breakdown of the range of entry into practice decision-making for provisional licensure is included in the table below.

Table 5 Decision-Making Processes for Provisional Licensure by Province

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<td>Point-in-Time</td>
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As the purpose of the environmental scan is to gather information about programs currently active in Canada for IMG physicians’ entry to practice, the following sections provide an overview.

Formal PRA Processes Overview
Currently, seven jurisdictions provide PRA processes with similar mandates and purposes. These seven jurisdictional processes are used to determine if an IMG is capable or not of entry to practice through provisional licensure. The processes are offered for family physicians or other specialty physicians, with Quebec, Manitoba and Alberta offering processes for both.

Table 6 Formal PRA Processes by Specialty across Provinces

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<thead>
<tr>
<th></th>
<th>NL</th>
<th>NS</th>
<th>QC</th>
<th>ON</th>
<th>MB</th>
<th>SK</th>
<th>AB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Medicine</strong></td>
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<td>✓</td>
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<td><strong>Other Specialties</strong></td>
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<td>✓</td>
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<td>✓</td>
</tr>
</tbody>
</table>

2 Over-time assessment occurs after a defined licence is granted.
Of note are the differences in assessment activities covered under various jurisdictional processes for provisional licensure. Most programs “finish” prior to provisional licensure with two exceptions; in Nova Scotia where supervised practice post-provisional licensure is covered under the program scope for family medicine, and in Alberta where supervised practice assessments occur after provisional licensure for both family medicine and other specialists. Refer to Appendix G.2 for an overview of the assessment activities covered by the various programs.

For an overview of the current PRA processes by jurisdiction including focus, delivery and funding sources, refer to Appendix G.3.

Collaboration - Multi-Stakeholder Processes

PRA processes engage multiple stakeholders and delivery mechanisms within each jurisdiction. The primary responsibility of the processes resides with the MRA or a university-affiliated IMG program. In all processes, there are strong linkages with the university or academic environments that make use of academic infrastructures to support the assessment. MRAs, where they are not owners of the process, are usually involved in the up-front credentialing and eligibility determination as the outcome of a successful assessment would be some form of licensure. Within Ontario, the MRA is only involved at the point of determining provisional licensure once the assessment is complete.

Where sponsorship is a critical component of the process, additional stakeholders participate to select physicians to fill underserviced community areas. Regional Health Care Authorities and sponsors (i.e., a family physician at a clinic in Alberta) are actively involved in the process. Their involvement ranges from preliminary screening of IMG candidates to placement and orientation.

Funding

All PRA programs operate under a cost-recovery model; however, the financial contributors to the process vary. The majority of the programs are funded through their respective jurisdictional Ministries of Health or other provincial programs. Provincial funding can be direct Ministry of Health funding or indirect through provincial IMG programs or hospital health authorities or individual or group practices. In the Newfoundland and Nova Scotia programs, candidates pay for a portion of the point-in-time assessment costs along with the MRA and the university. Where over-time assessments are used, there is no indication that candidates contribute to or offset the incurred cost across all jurisdictions.

In processes where there are strong linkages between job opportunities (i.e., sponsorship) and PRA, a return-of-service agreement is common. These range from two to four years where the IMG physician is required to complete the contract. In a few cases, RHAs or sponsors seek to recoup the investments in the assessment costs from the candidate where a return-of-service agreement is not used; however, this is exceptional.

Capacity

As program capacity varies significantly, a pan-Canadian process could assist with maximizing available spaces and infrastructure. In all jurisdictions, there are capacity restrictions on physical and human resources. In part, this has been created by the increasing number of postgraduate training spaces without a corresponding increase in university faculty to support the workload. The human resource limitations exist in academic university settings and community-based settings.

The type of assessor required is an important capacity constraint. For example, recruiting sufficient family medicine assessors can be a challenge, a constraint that can be eased with generalized recruitment efforts. The common challenge might be alleviated if general assessor recruitment and training were used across programs. Of interest, specialty-based assessment programs have a more variable capacity.

Frequency

The frequency of assessment varies from delivering “as-needed” or “on demand” assessments to scheduled application and assessment windows of one to three times per year. The variation in frequencies is observed within both family medicine and other specialty programs and is independent of
the assessment location. The variation does not depend on academic environments, etc. For example, the Ontario PRA program for specialties is delivered once per year whereas Quebec, Manitoba and Alberta offer their assessments on an as-needed basis while making use of academic environments. Family medicine programs are similarly different with Newfoundland and Labrador, Quebec and Alberta offering assessments on an as-needed basis and Nova Scotia, Manitoba and Saskatchewan offering processes on a scheduled basis. For an overview of the PRA processes timeline by jurisdictions, refer to Appendix G.4.

**Process Supports**

**Orientation**

All programs incorporate some form of orientation. The degree of formality, length and content of orientations differ. Common elements include orientation to the Canadian and jurisdictional environment, the assessment program or tools, Canadian society, interacting with other health-care professionals and team-based environments, and contract, legal and ethical issues. A common goal of orientation is to increase the probability of success for a skilled and competent candidate. Orientation components can span days or weeks. In cases where a less formal orientation occurs, other supports are available to IMGs.

**Consultation**

Access to staff resources for queries is offered within most programs. For example, the Newfoundland and Nova Scotia programs provide frequent opportunities to discuss progress and issues. Most government IMG programs and other associations provide assistance with finding temporary residences, relocation, counselling and subsidizing or covering living expenses during the assessments.

**Assessor Support and Training**

A critical component is the support and training provided to assessors. This support usually entails information sessions, documentation support, episodic contact and follow-up throughout the assessment.

Various training models exist with varying levels in the degree of formality. The amount of training and support provided depends on where the assessment occurs. When assessments are held in a community-based environment, assessor training ranges from handbooks and manuals to interactive strategies such as attending workshops. Where the assessors are academic staff, training supports are less formalized and are delivered through existing faculty development processes.

The programs reviewed in the following section have been separated into family medicine and other specialties to highlight commonalities and variations. In some jurisdictions, there is a clear distinction between the two groups; in other cases, the same process is used for both family medicine and other specialties.

Appendix G.5 contains overview information regarding specific jurisdictional processes. Appendix G.6 contains a summary of commonalities and variations between existing processes against the PRA data-gathering strategy.

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**Family Medicine**

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**Eligibility**

All family medicine PRA programs require, at minimum, a Doctor of Medicine (MD) degree and the MCCEE. Some programs require additional assessments such as the MCCQE Part I and language proficiency results. Where language proficiency is a requirement, the Test of English as a Foreign Language (TOEFL) is the common assessment tool result.

All family medicine programs require sponsorship. Sponsorship is used as either an eligibility factor or after point-in-time assessment and prior to over-time assessment. Sponsorship as an eligibility requirement occurs in Newfoundland, Quebec, Saskatchewan and Alberta. In these jurisdictions, the activities related to the application, screening and selection of an IMG serve to reinforce the pre-screening through additional
credential and experience reviews, plus an interview and selection process between the IMG and the potential employer.

Requirements for postgraduate training and evidence of practice differ. However, there appears to be a pattern, whereby less postgraduate training is required if there is a greater emphasis on years of practice experience. Generally, with two years of postgraduate training, the requirement for evidence of practice ranges from one to two years; with one year of postgraduate training, the requirement for evidence of practice ranges from one to three years.

The variability within the overall eligibility component appears to be in line with the FMRAC Standards for Registration for Provisional Licensure.

**Program Governance**

The MRA plays a critical role in determining the minimum eligibility requirements for the processes. An IMG who is successful during the assessment ultimately needs to be licensed. The involvement of the MRA provides the successful IMG candidate with clear expectations of licensure up front. How the selection decision is made varies. Two common approaches are used. IMG candidates are ranked based on assessment scores or selected based on a blend of a subjective reviews from one or a combination of stakeholders (the RHA, province, university sponsor and/or the MRA).

**Assessment Types**

The types of assessment vary; either point-in-time or over-time assessments or a combination of both are used. Point-in-time assessments occur in an examination-type setting and are centralized within the specific jurisdiction. Over-time assessments take place in a community-based location or alternate setting.

In all processes, over-time assessments occur before provisional licensure with two exceptions:

- Nova Scotia uses an observed, in-practice assessment following defined license (provisional license)
- Newfoundland combines point-in-time training and over-time assessment

<table>
<thead>
<tr>
<th>Assessment Type</th>
<th>NL</th>
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<th>QC</th>
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<td>Family Medicine</td>
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<tr>
<td>Point-in-Time</td>
<td>✓</td>
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<tr>
<td>Over-Time</td>
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</table>

In general, two types of decision-making occur after these assessments:

- A structured judgement approach is used to indicate a pass/fail type of decision based on the assessments and defined standards
- A broad-based judgement approach is used to review the assessments and a discussion-based decision follows

**Assessment Tools**

Where point-in-time assessment tools are used, the assessment period generally ranges from two to three days. The tools used include:

- Medical knowledge – multiple-choice questions (MCQ), therapeutics
- Clinical skills – OSCE, structured office interview, standardized patient encounters

Generally, the over-time assessment period ranges from three to six months with outliers of two to 52 weeks. A two-week, over-time assessment is used in the Alberta program where candidates have “known” credentials, experience and acceptable postgraduate training (i.e., IMG candidates from the United Kingdom, some areas of Australia, etc.). A 52-week, over-time assessment is used in Nova Scotia where the assessment occurs following provisional licensure. Saskatchewan’s pilot PRA program has eight weeks, but exploration is underway to determine the appropriate length of over-time assessment.
There appears to be a pattern between the screening requirements and assessment length. For example, where higher eligibility requirements exist, the assessment length appears to be shorter.

Across all programs, if candidates fail one component of the assessment, they are removed from the program. In some programs, an IMG may be removed from the process early if the IMG is deemed either clearly not ready or clearly practice-ready.

Where the over-time assessment occurs in an academic environment, similar tools are used for IMGs and CMGs in postgraduate training routes. All processes use some form of MSF and evaluation reports. A subset of the programs specifically indicated that mini-CEX, CBD and chart reviews are used.

**Other Specialties**

### Eligibility

While there is significant variation in program eligibility, all other specialty PRA processes require, at minimum, an MD and the MCCEE; Ontario also requires the MCCQE Part I. In some programs, additional assessments (i.e., MCCQE Parts I and II) are preferred.

Proof of language proficiency through assessment is required in Quebec and Manitoba. TOEFL results are used for English language assessment; Office québécois de la langue française (OQLF) is used for French language proficiency. In Manitoba, candidates must also demonstrate that their practice experience occurred in an English-speaking environment.

All other specialist PRA processes, with the exception of Ontario, require sponsorship either as a criteria for eligibility or prior to the start of the over-time assessment. Sponsorship as an eligibility requirement occurs in Quebec and Alberta. The activities related to the application, screening and selection of an IMG serve to reinforce the pre-screening through additional credential and experience reviews as well as interviews with, and selection by, the potential employer.

The highest degree of variation in eligibility exists for postgraduate training, evidence and currency of practice and specialist certification.

**Table 8 Eligibility Requirements for Non-Family Medicine Specialties by Province**

<table>
<thead>
<tr>
<th>Aspect of Eligibility by Jurisdiction</th>
<th>Postgraduate Training</th>
<th>Evidence &amp; Currency of Practice</th>
<th>Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>QC</td>
<td>Four-six years</td>
<td>12 months within the last two years</td>
<td>Specialty certificate</td>
</tr>
<tr>
<td>ON</td>
<td>Must be Board certified</td>
<td>Experience within last five years</td>
<td>Specialty certificate (Board certified)</td>
</tr>
<tr>
<td>MB</td>
<td>Over two years or highest qualification in specialty field (RCPSC durations)</td>
<td>Practice experience within an English-speaking environment</td>
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</tr>
<tr>
<td>AB</td>
<td>Three-four years</td>
<td>Three years discipline-specific practice</td>
<td></td>
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</table>

### Program Governance

The MRA plays a critical role in determining the minimum eligibility requirements for the programs. An IMG who is successful during the assessment will be licensed and MRA involvement provides the IMG candidate with clear expectations of licensure up front.

There is variability as to which organization decides if an IMG is eligible for the PRA process: a Sponsor (Alberta) or committee structure (Quebec), government through their initial screening of the candidate.
and linkage to potential positions through strong sponsorship requirements (Manitoba) and a program (CEHPEA) or program directors (Faculties of Medicine).

Assessment Types
Over-time assessments are common across all processes with Ontario also performing point-in-time assessments. Point-in-time assessment occurs in a centralized examination site and over-time assessments are in an academic-based setting or an approved or accredited community-based setting (i.e., hospital setting with trained assessors).

Table 9 Assessment Format for Other Specialties by Province

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<tr>
<th>Assessment Type</th>
<th>QC</th>
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<th>MB</th>
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<tr>
<td>Other Specialties</td>
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<tr>
<td>Point-In-Time</td>
<td>✓</td>
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<tr>
<td>Over-Time</td>
<td>✓</td>
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Assessment Tools
The point-in-time assessment used by Ontario includes assessing specialty medical knowledge with an MCQ examination and assessing clinical skills with an OSCE. Successful candidates in the Ontario process are directed towards interviews for assessments performed within faculties of medicine.

Generally, the over-time assessment period ranges from three to twelve months. The duration of the four programs varies from fixed lengths of 13 weeks to three months and six months to Manitoba’s variable over-time assessment length based on specialty (i.e., three months for urology, 12 months for psychiatry). To note, the Alberta program covers both pre- and post-provisional licensure assessments.

All over-time assessments require direct observation of clinical and communication skills. Common tools used include MSF and evaluation reports. A subset of the programs specifically indicated that they use mini-CEX, CBD and chart reviews.

Observation Summary – Process Learning
Throughout the consultations, challenges were identified and are summarized here in general themes. Some of the challenges are not directly related to assessment although any solutions that are implemented may be useful to a pan-Canadian PRA process.

Physician Supply, Retention and Distribution
PRA needs to be considered within the context of the broader goals of attracting and retaining a physician to serve a community’s needs. Workplace, recruitment and retention needs must be aligned with PRA providing a competency-based assessment to ensure a physician is capable of independent practice. A successful community placement depends on the processes working together.

Resourcing and Maintaining
With changes or turnover in various settings, support needs to be available for assessors, IMGs, assessor trainers and sponsors. Programs often assist in resolving cultural clashes between IMG candidates and their assessors. Ensuring equal use of the PRA route across health-care centres, ensuring the program is understood and still required and ensuring human resources planning to support the programs in place are all necessary.
Cost Management

The selection of assessment processes needs to take into account the benefit of the tool (increased decision-making reliability) balanced against the financial and human resource time costs. In addition, the alignment of tools and program schedules must be considered together within the context of any existing program. Of note, developing content for knowledge and skills examinations is typically a significant cost consideration.

Location

Where assessments occur in a community-based environment, it is important to find the right place to assess a candidate. Candidates should be assessed in a context or setting similar to that in which they will be practising. Finding a location and an assessor with the desired skill set can pose logistical challenges. Delivering PRA is more than an assessment challenge; logistical solutions are critical to successful delivery.

Holistic planning occurs within the programs. Balancing the time commitments and expectations of assessors is one part and taking into account the roles and time commitments of all professionals who are participating in the evaluation process is equally important.

A strong advocate for IMG PRA within the academic environment (i.e., as exists in Manitoba) can make a significant difference in the successful delivery of assessments that occur within an academic setting.

Expectations

Expectations regarding roles and responsibilities, expected outcomes and available supports need to be clarified for the assessor, the IMG and program staff. Frequent ongoing communications through process documentation and administration coordination are necessary to ensure expectations are reinforced and monitored for both the IMG and the assessor. Knowing what the PRA process will and will not do, knowing the purpose and the time frame, is essential for the IMG who is being assessed. While assessors tend to be reasonably reimbursed, they also need to be clear on the expected time commitment. IMGs tend to require more time as compared to CMGs; program staff need to anticipate and appreciate this difference.

Complementary Initiatives

One purpose of the environmental scan is to establish a baseline understanding of the various initiatives that currently exist in the IMG landscape. A representation of the landscape is depicted in Figure 7 and is followed by high-level descriptions of the purpose for each initiative.
Foreign Qualifications Recognition (FQR) Initiative

As part of the Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications, this initiative seeks to improve foreign qualifications recognition systems in Canada, including qualification assessment and recognition practices.

NAC PRA

To recommend and support the adoption and maintenance a pan-Canadian assessment process to determine whether or not an IMG is capable of entry into provisional practice and includes the up-front screening used to direct an IMG to a residency pathway.

FMRA Working Group on Registration

To standardize, to the greatest extent possible, the various practices used by the provincial and territorial MRAs for registration and licensure.

FMRA Working Group on Assessment and Supervision

To draft principles, acceptable methods and processes for assessment and supervision and final evaluation of physicians who do not hold a full, unrestricted licence.

Manitoba Practice Assessment Program (MPAP)

To develop a process to assess physicians in their practice settings that enables the College of Physicians and Surgeons of Manitoba (CPSM) to make a decision about granting registration to candidates moving from provisional to full licence in cases where physicians have not yet achieved final certification.

RCPSC Practice Eligible Route (PER) – Route B

RCPSC’s exploration of the practice eligible route for IMGs will provide the opportunity to have all physicians working as specialists measured against national standards. PER attempts to remove the barrier of a certification examination for licensed specialists who have been competently practising in their specialty for over five years. PER Route B will be an alternate but rigorous assessment of knowledge, skills and judgment through an in-practice assessment.

CFPC Practice Eligible Route (PER)

CFPC’s exploration of the practice eligible route for IMGs will provide the opportunity for those physicians already working as family medicine specialists to obtain certification through an alternate pathway that does not require writing the CFPC certification examination.

CMQ Specialist Certification Route

CMQ’s specialist certification route is available to IMGs who have worked for a period of five or more years under a restricted permit. The route to certification is not through examination, but rather is based on the IMG’s time spent under supervision through the restricted permit environment and a review of credentials and training related to his or her specialty.

The format and scope of a point-in-time clinical inspection comparing CMGs and IMGs may be a useful framework from which to assess existing PRA programs. Ultimately, assessing differences in practice quality of IMGs who have been provisionally licensed under different programs may be a useful lens under which to benchmark existing programs.

Society of Rural Physicians of Canada

The Society of Rural Physicians of Canada (SRPC) is the national voice of Canadian rural physicians. The SRPC’s mission is to provide leadership for rural physicians and to promote sustainable conditions and equitable health care for rural communities. Internally, SRPC has informally discussed the need for assessment for rural environment practice. While discussions are currently at the “ideas” stage within SRPC, the scope may include some form of PRA for rural environments.
The SRPC is interested in being involved in NAC PRA with regard to determining whether to explore assessment for rural environments and to provide input into the competencies to be assessed for rural environment practice. In addition, there may be an opportunity to make use of the SRPC membership as a potential source of preceptor/assessor recruitment for rural, community-based assessments.

The existing PRA initiatives are all possible collaborators with NAC PRA. Categories below are collaboration opportunities in the activities, requirements, assessment tools being considered and where information sharing is appropriate.

<table>
<thead>
<tr>
<th>Complementary Initiative</th>
<th>Partnering/ Collaborating Opportunities</th>
<th>Awareness/ Information Sharing</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Governance</td>
<td>Competency/ Licensure Requirements</td>
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<tr>
<td>FMRAC Working Group on Registration</td>
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<tr>
<td>FMRAC WGAS</td>
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<td>✓</td>
</tr>
<tr>
<td>MPAP</td>
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<td></td>
</tr>
<tr>
<td>RCPSC PER – Route B</td>
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<td></td>
</tr>
<tr>
<td>CFPC PER</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>CMQ</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>SRPC</td>
<td>✓</td>
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</tbody>
</table>

To consider the potential for collaboration across initiatives going forward in the context of NAC PRA, refer to Appendix H.1 and H.2 for highlights and for further details about the complementary initiatives including scope, timeline and resources involved.

In addition, the models proposed by the FMRAC WGAS, the IMG Pathways Model, current PRA processes and envisioned pan-Canadian PRA processes are aligned in their frameworks as identified in Appendix I.

**FUTURE ENVIRONMENT**

The future environment was discussed within each jurisdiction and by stakeholder groups. Policy discussions included the Standards for Issuance of Provisional Licensure and Full Licensure, the FMRAC WGAS and the IMG Pathways Model.

The ideal of a pan-Canadian PRA framework was seen to be a natural evolution of the processes that have been created in each jurisdiction to meet the principles driven by AIT. A pan-Canadian PRA framework with common standards that meet the minimal requirements of MRAs would realize the aim of enabling IMG mobility across Canada once full licensure (and possibly provisional licensure) is obtained.

**INTEREST GOING FORWARD**

A pan-Canadian process was consistently supported; however, participation ranged from those who would:

- Continue to deliver PRA processes that meet the minimal standard; they would participate in the development of the framework to establish comparable rigour in processes
• Plan to deliver PRA processes that would meet the minimal standard; they would participate in the development of the framework
• Be involved from an information awareness perspective and would:
  • Partner with other jurisdictions’ assessment programs
  • Utilize other jurisdictional assessment processes when credentialing processes become insufficient to screen for entry into practice

![Support for Pan-Canadian Process](image)

What general understanding needs to be put in place regarding jurisdictions that decide to rely on credential-only routes for licensure?

Should the pan-Canadian Practice Ready Assessment framework or other initiatives establish guidelines in these cases for credential-only pathways for licensure?

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**BENEFITS AND CONCERNS WITH A COMMON PROCESS**

**Intended Benefits**

In exploring the benefits of a common, pan-Canadian process for practice-ready decision-making, IMG, MRA and program efficiency perspectives were considered.

**IMG**

A common process would clarify the requirements and process for entry-to-practice pathways. A common process would enable stakeholders to concisely communicate a single model for PRA and identify unique requirements against a common standard.

**MRA**

MRAs would gain assurance there is one accepted, minimal standard for practice readiness set across the country. Specifically, there would be no lowering of the bar in certain areas to meet local needs for physicians. A standard assessment of IMGs through practice readiness conforms to AIT principles.

**Public Health Care System**

Establishing a common standard of PRA with rigorous assessment filters for IMGs who seek provisional licensure could alleviate resource drains in the health-care system once the physician is licensed.

**PRA Processes**

In general, a common process would increase public confidence in the jurisdictional practices and strengthen legal defensibility of licensure decisions. A common process would assist with standardization across the Canadian system, which includes Citizenship and Immigration Canada (CIC) rules and harmonizing processes, tools and decision-making.

Standardization of tools implies a common toolkit for pre-entry before evaluation begins, and a common method of documenting findings and reports to IMGs. Validated, secure examination content could be centrally developed, as could ongoing content improvements and maintenance of content banks.
Pan-Canadian IMG management could leverage the resources of the common elements to benefit the IMG. For example, candidates who cannot be accommodated in one jurisdiction could be assessed elsewhere with assurance of comparability. In addition, there exists the potential to manage point-in-time assessments (as part of pre-screening or an assessment filter) more collaboratively and consistently.

Through a pan-Canadian process, provinces and territories could find similar contexts in other jurisdictions to resolve conflicts between sponsor and assessment interests. Where sub-specialty spots or assessment skill sets do not exist in local academic or community settings, smaller jurisdictions or those who have capacity issues in some areas have an interest in contracting with larger programs to assess the more complex, smaller subspecialties on their behalf.

Common orientation materials and training on assessment tools that represent best practices are of interest to different stakeholders. Access to other programs has appeal, both from jurisdictions that currently deliver programs and for those that do not and do not intend to deliver a program.

**Common Process Concerns or Issues**

There are concerns regarding the buy-in, implementation and maintenance of a common process that are included in this environmental scan. The concerns raised should not be considered as barriers to a common process, but rather provide guidance for implementation planning. The concerns are listed in no particular order and are samples of concerns raised about how to move forward.

Specific concerns regarding the assessment tools and other practical implementation elements will need to be explored further once the general framework for a pan-Canadian process is articulated from a change management perspective.

### Table 11 Themes for Consideration

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
<th>Consideration for NAC</th>
</tr>
</thead>
</table>
| Interest, Participation & Will     | Getting agreement from all players in principle may be feasible, but once the practical implementation elements are on the table, there will be issues with the details.  
If not all jurisdictions are involved equally, the participating jurisdictions are investing a large amount of money into candidates who may be recruited to other non-participating jurisdictions; is this fair?  
What is the tolerance for some jurisdictions to “opt-out” of running or using another program for PRA? How would this impact other jurisdictions (ethical inter-provincial recruitment with the need for an IMG to be mobile)? | Pan-Canadian support by jurisdictions is necessary to go forward.  
Having critical mass/representation for all the jurisdictions is necessary.  
What happens if jurisdictions opt-out?  
Strategize how the process, with respective investments, can be protected in context of AIT. |
<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
<th>Consideration for NAC</th>
</tr>
</thead>
</table>
| Common & Autonomy Balance – Politically Charged Environment | Jurisdictions have different needs and resources, differing focuses on areas of need (urban, rural, remote – from family physicians across all domains to family physicians in geriatric care to other specialties) and differing levels of finances and human resources to support a PRA process from assessors, to assessment locations, to availability of program supports. | Can there be some jurisdictional autonomy within a pan-Canadian process?  
If jurisdictions have substantially different needs, can they be accommodated within a common process?  
The jurisdiction’s community physician resource needs may trump the need for a common process. How can this be managed and respected? |
| Concepts – Make Sure We Agree              | CSAs should not be treated any differently than immigrant IMGs.  
Common processes should be the norm with a few managed and documented exceptions. | What is the ideal, what is the minimal standard for the two groups? |
| Common & Flexible Process                  | What is done needs to be common enough to be acceptable, but not so restrictive that it cannot be maintained in all jurisdictions.  
Government buy-in is critical and financial/resource requirements cannot be impractical.  
Some variation in how PRA might be conducted in each jurisdiction could occur as long as it does not jeopardize the assurance that an IMG assessed in any province would be eligible for provisional registration in all jurisdictions. This could be acceptable so long as comparability of assessments could be demonstrated (i.e., the period of observed practice might vary in length as long as the assessment or assessment tools were comparable). | The process needs to be achievable across jurisdictions and take into account funding and resource capacities.  
A common process must maximize standards in areas such as terminology, definitions and tools, yet allow for some flexibility (i.e., exempt from a specific part of the assessment if the candidate is a “known quantity” vs. unknown).  
Funding models should be fairly aligned; however, jurisdictions retain the right to subsidize in their own areas and implement return-of-service contracts.  
Ethical jurisdictional recruitment to be considered both overseas and within Canada, albeit respecting AIT mobility intentions. |
| Jurisdictions Were Not Waiting for NAC     | Respect jurisdictional needs and capacities; no one was waiting for NAC to implement jurisdictional processes, so different models have been implemented. In some jurisdictions, assessments are seen as a fast-track program so point-in-time assessment requirements will compromise existing timeliness. In others, more robust, sequential programs from point-in-time to over-time assessments have been implemented. | Identify strong value systems in existing program and retain them in a common process.  
If considering an ideal framework, time needs to be given to manage the change and address individual implementation requirements. |
<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
<th>Consideration for NAC</th>
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</thead>
<tbody>
<tr>
<td>Development of a pan-Canadian Process – Great Idea but How?</td>
<td>How will we pay for whatever it is we’re envisioning? Jurisdictional funding envelopes are not expected to grow; we can benefit from the development of a pan-Canadian standard and use of same, but what does this mean?</td>
<td>What general support can be provided to at least offset the development costs of a pan-Canadian framework (i.e., resources, studies, etc.)? Leverage existing funding and direct a portion into a common process.</td>
</tr>
</tbody>
</table>
| Difference in Philosophies – Makes Things Interesting                | Differences in perspectives on IMG practice readiness, objectives of processes through to the assessment tools used include:  
  - No such thing as a practice ready IMG vs. those who firmly believe that IMGs can be practice ready  
  - Different kinds of IMGs [i.e., known to unknown where known is confidence in training (US, UK, Australia, etc.) vs. all IMGs need to go through the same filter route]  
  - Must have exams to filter PRA vs. have an exam to sort candidates into differing IMG pathways (residency, practice-ready, etc.)                                                                 | Expect philosophical differences about the process. Clearly identify and discuss ideas and preconceptions and define scope accordingly. Either address differences through research and project work or focus on an assessment toolkit.                                                    |
| Frequency of Assessments                                             | Individual jurisdictions currently determine how often to run the program cycle. Account for varying capacities to assess and for jurisdictional reliance upon IMGs for meeting physician needs is important. Of note, there are more restrictions on frequency of point-in-time assessments than for in-practice assessments. | Any tools used in the common toolkit will need to be maintained in a manner that takes into account the assessment windows for standard elements.                                                                                                                                  |
| Over-Time Assessment                                                | Where will IMG assessment spots be found as access to academic environments become more challenging due to the expansion of Canadian medical schools and the ripple effect being felt in postgraduate training? At this stage, the number of residency spots available is seen as “stable”.  
  How can over-time assessment occur in smaller communities where back-up is limited? Finding assessors is a challenge and finding funding might pose problems.  
  Thinking about where point-in-time assessments occur seems flexible so long as the assessment meets the needs of various program schedules, but when or where over-time assessment occurs is open to debate.  
  - Academic vs. community  
  - In jurisdiction vs. “outsourced” to another jurisdiction with capacity AND similar assessment context                                                                 | Principles of over-time assessment need to be established; where the assessment occurs can be variable as long as it meets the minimum requirements. Funding over-time assessment may be more difficult for some jurisdictions. How can funding for over-time assessments be freed up to encompass a common pre-screening process with point-in-time assessment tools? Is over-time assessment needed for all IMG PRA candidates or is it to be used only for “borderline” practice-ready candidates? |
<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
<th>Consideration for NAC</th>
</tr>
</thead>
</table>
| Assessors                             | Who is the right assessor if over-time assessment cannot occur in an academic environment?  
In an environment of peer-based assessment, why aren’t IMG assessors used more often?                                                 | Explore requirements for assessors; perhaps actively recruit IMGs who can assess as long as any perceived or actual conflict of interest is negated. |
| After Unsuccessful PRA Attempt        | Not all jurisdictions have the resources or capacity to redirect unsuccessful IMGs to other pathways or bridge unsuccessful candidates beyond the IMG residency programs.                                          | There needs to be concrete outage points and perhaps linkages to other pathways.  
Clarity in consequences for unsuccessful IMGs is needed.                                                                                                                                 |
| Awareness of Impact of Common – Primary Concerns | Loss of physician resources is of paramount importance in smaller jurisdictions as there is a concern over losing candidates to ‘more desirable areas’ and the ability to retain physicians may be problematic.  
‘Competition’ amongst smaller and larger jurisdictions exists today and will not be solved through a pan-Canadian PRA; however, PRA processes are seen as a factor in attracting and retaining physicians. | Success of jurisdictions’ programs to recruit and retain physicians will be a key factor in alleviating these concerns with a pan-Canadian PRA process.  
Jurisdictional governments may need to recognize that additional emphasis on recruitment/retention will be needed, as well as the possibility of invoking return-of-service agreements if government covers some portion of assessment costs. |
| Approach is Critical to Buy-in and Success | Approach will be critical to making a pan-Canadian process work. Consultation will be important as will cross-jurisdictional communications and discussions.                                                  | What is the approach; would a “building block” approach work starting with the “simpler” items for agreement before tackling the more challenging issues? |
A PAN-CANADIAN FUTURE MODEL

In exploring the future model(s) identified in Appendix J, cross-jurisdictional perspectives were gathered. Discussions ranged from general themes relating to the common process principles to specifics or criteria regarding the assessment framework used.

The envisioned assessment process is anchored to the general outcome of a PRA process. In essence, a patient should expect the same quality of care from a provisionally-licensed physician who has gone through PRA as he or she would expect and receive from a fully-licensed physician; this is the standard for the future model.

Throughout the consultations, common themes were identified. These included qualifying the term PRA to pre-provisional licensure PRA (the term ‘practice-ready’ is used for a variety of purposes) and the desire for an acceptable, rather than ideal, process. This desire for an acceptable process relies on other mechanisms in place to monitor the practice of all physicians post-provisional licensure (including CMGs).

A PRA process must meet the needs of the public, MRAs and IMGs. To assess an IMG physician’s skills, a holistic view is needed that encompasses communication, culture change, medical knowledge, clinical skills and the context or geographic-specific knowledge.

The general pan-Canadian PRA framework consists of two key steps; selection of candidates eligible to enter a PRA route and an assessment step to ensure the IMG candidate is indeed ready for provisional licensure.

The screening mechanism will consider candidate credentials and practice experience along with point-in-time screening assessments of medical knowledge, language proficiency, etc.

After screening, the assessment filter consists of an over-time assessment of observed in-practice performance. Some point-in-time assessments may become screening mechanisms.

Figure 9 Screening for PRA
The following table represents the cross-jurisdictional perspectives gathered during consultations with specific NAC considerations highlighted.

### Table 12 Cross-Jurisdictional Perspectives

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
<th>Consideration for NAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>The process to be developed must be fair, transparent and objective. The concept of a screening mechanism and assessment filter is generally acceptable. Currently, there are variations in when point-in-time assessment occurs (i.e., as a screening element or as part of the assessment filter).</td>
<td>Which IMG credentials meet the requirements for the PRA route?</td>
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<td></td>
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<td>What type of sponsorship should be at the front end?</td>
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<tr>
<td></td>
<td></td>
<td>And for the filtering component? This decision may drive screening requirements.</td>
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<td></td>
<td></td>
<td>MRAs need to play an important role in a pan-Canadian process. Are they the ultimate decision makers?</td>
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<tr>
<td>How</td>
<td>Various model options were discussed ranging from establishing a general framework to some form of accreditation of existing and future programs. Program accreditation by certifying bodies and MRAs?</td>
<td>Establish framework or accreditation of programs.</td>
</tr>
<tr>
<td>Program accreditation by certifying bodies and MRAs?</td>
<td>A PRA program accreditation framework is a possibility as it would promote comparability of programs while respecting the autonomy and needs of different jurisdictions and different frameworks for how PRA is delivered.</td>
<td>Framework</td>
</tr>
<tr>
<td></td>
<td>• Framework established for accreditation</td>
<td>• MRAs establish objectives for process and competencies to be assessed in collaboration with certification body</td>
</tr>
<tr>
<td></td>
<td>• Standards built around whether or not a reasonable assessment activity is in place with adequate supervision, etc.</td>
<td>• Programs collectively determine how competencies should be assessed with supporting studies</td>
</tr>
<tr>
<td></td>
<td>• Accredited program meets expectations with a final assessment that ensures confidence that a given physician is capable</td>
<td>• Develop common framework/tools</td>
</tr>
<tr>
<td></td>
<td>• Measure process and outcomes</td>
<td>• Each program implements changes as required</td>
</tr>
<tr>
<td></td>
<td>• Accredit assessment sites by program</td>
<td>Accreditation Issues</td>
</tr>
<tr>
<td></td>
<td>• Community-based assessment sites could be accredited</td>
<td>• Who would accredit programs?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Who would perform audits of programs for continuing accreditation purposes, etc.?</td>
</tr>
<tr>
<td>Delivery Models</td>
<td>Point-in-time assessments are an area to consider for centralized assessment tool development and delivery.</td>
<td>Regardless of the approach decided upon, there is recognition that each jurisdiction will need to build confidence in other jurisdictional programs and have confidence in their own.</td>
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<tr>
<td></td>
<td></td>
<td>What is the scope of PRA?</td>
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<td></td>
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<td>Is the capacity and needs management in scope of the NAC role (i.e., managing cross-Canada assessment needs with capacity restrictions in jurisdictions) and what would this look like?</td>
</tr>
<tr>
<td>Element</td>
<td>Description</td>
<td>Consideration for NAC</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Location of PRA Processes</td>
<td>In areas with less of a link to an academic environment, there should be more assistance and training for the assessor to help ensure the IMG’s skills are comparable.</td>
<td>May be a need for guidelines around standards – what type of IMG and where assessment occurs. Guidelines could vary from geographic locations (urban, rural, remote) to assessor type (faculty, academic, physician) and assessment environment (academic, community).</td>
</tr>
<tr>
<td>What to Assess</td>
<td>Assessments are appropriate to practice context. Any assessment or eligibility or standards for what it takes to be practice ready would define the competencies for safe independent practice. Assessment needs to be focused on the practice for which the individual is being recruited.</td>
<td></td>
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<tr>
<td></td>
<td><strong>Principles-based framework</strong></td>
<td>Considering that, at some point, the candidate will obtain full licensure and will be mobile, what is the requirement to ensure that the broadest skillset is covered for assessment vs. assessing a candidate for a specific scope of practice? How prescriptive does the pan-Canadian framework need to be in context of how things work?</td>
</tr>
<tr>
<td></td>
<td>Standardization of key aspects of assessment is needed for a pan-Canadian process. For example, definition and agreement on the qualifications and characteristics of assessor(s), the importance of access to multiple assessors, of up-to-date assessors with experience providing feedback, of assessors who are practising to acceptable standards and the scope of patient problems to be seen.</td>
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<tr>
<td></td>
<td><strong>Flexibility</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>How much variation and flexibility will exist within a pan-Canadian framework? Can a step be omitted? For example, if pre-screening or point-in-time assessments are effective, do top candidates need an over-time assessment? Would only borderline candidates need an over-time assessment?</td>
<td></td>
</tr>
<tr>
<td>Eligibility</td>
<td>Can anyone enter a PRA program? There are differing opinions on how open PRA should be. A degree of filtering usually occurs with the sponsor. Current thinking is that all IMGs who meet the requirements would go to PRA (including CSAs). Candidates must meet the Standards for Issuance for Provisional Licensure and perhaps include:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Actual IMG practice experience</td>
<td>Are the requirements for sponsorship as part of eligibility a component of the pan-Canadian framework or should this be managed within the jurisdiction?</td>
</tr>
<tr>
<td></td>
<td>• Language proficiency level</td>
<td></td>
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<tr>
<td></td>
<td>There is divergent thought on minimal levels of postgraduate training; however, various perspectives are included within the postgraduate training specifications for provisional licensure for family medicine and other specialties.</td>
<td></td>
</tr>
<tr>
<td>Element</td>
<td>Description</td>
<td>Consideration for NAC</td>
</tr>
<tr>
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</tr>
<tr>
<td>Pre-Screening</td>
<td>Rigorous pre-screening is important to clearly establish a candidate’s skill level before investing more time. Consideration for the different types of PRA that are required based on the physician’s training is needed. For example, does a candidate from an Australian medical school certified as ‘equivalent to Canadian medical schools’ need to go through the entire PRA process? There may be opportunities to work together more closely on the pre-screen elements.</td>
<td>In context of the Standards for Issuance for Provisional Licensure and considering fairness, etc., can a pan-Canadian program differentiate between known and unknown IMG training programs? Can there be levels of pre-screening and other assessments; can some screening steps be skipped?</td>
</tr>
<tr>
<td>Point-in-Time</td>
<td>There is agreement that assessment tools should be standardized across the country and maintained collectively. Work to be done includes analyzing and proposing how existing screening tools could be used as program elements so to avoid duplicating work that has already been done. Issues exist around timing and locale of assessments. (Note: MCC Assessment Review Task Force [ARTF] recommendations indicate this as well.)</td>
<td>What is the purpose of the MCCEE? Could it be changed to focus on family medicine and other top specialty topics? Should the MCCQE Part I be delivered outside of Canada? How can we use the NAC Examination? Should we compare the strengths and weaknesses of existing tools?</td>
</tr>
</tbody>
</table>
| Over-Time            | **Length of time & frequency – viewpoints differ**  
Competency-based assessment doesn’t have to have a defined set of time; however, one needs to be confident that the competencies are assessed.  
It is difficult to differentiate between formative and summative assessment with over-time assessments. | Does setting a period of time for the over-time assessment make sense? Does a common process include having an over-time assessment with direct observation without some strengths/weaknesses assessment? Is there the potential to identify strengths and weaknesses and then focus the assessment on the weaknesses for a pass/fail decision? Tools must meet best practice standards and be monitored for validity in the PRA process. |
| Consent to Share Information | Once a decision is made, the information needs to be shared across jurisdictions. There is a notion of enduring consent to share information (i.e., PRA results should be on file with PCRC and any red flags from one jurisdiction should not be hidden from other jurisdictions should a physician attempt licensure in different jurisdictions.) | Consent to share PRA results needs to be taken into account to ensure access across jurisdictions. |
### Element | Description | Consideration for NAC
--- | --- | ---
**Appeals** | Standardized appeal processes are required within a pan-Canadian PRA process, primarily to ensure consistency of appeal-related decision-making. This could cover who hears the appeals to how appeal information is shared across jurisdictions. | How much of the appeal process needs to be standardized? Process activities, timelines, grounds, appeal bodies, decision-making and communication? Who would hear the appeal at the onset or once precedents have been established? |
**Orientation** | In provisional licensure, cultural elements cannot be overlooked. Orientation should focus on how to interact with other health professionals in the Canadian context including non-medical professionals. Training elements within orientation or observed in-practice assessment bear consideration; common gaps are cultural acclimatization and communications. | Orientation should be integrated into the pan-Canadian PRA processes. The ultimate goal is to select the right physicians with the right skills to enable them to serve the public; as such, a level playing field is important. |

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**Benchmark Comparison**

Formal benchmarking has not occurred across the existing processes. There was general consensus on the need for benchmarking in a pan-Canadian PRA process. This might mean benchmarking activities, tools and outcomes of existing processes and then identifying, understanding and adapting best practices as a pan-Canadian model. Benchmarking may include the following:

- Establishing evidence-based standards using CMGs and immigrant IMGs for proposed common assessments.
- Exploring the current state of program tools and best practices for future adoption.
- Guiding tool use and decision-making processes as well as providing recommendations on assessment tools and the sequencing of their use to support sound, practice-ready decision-making.
- Aligning future state best practices against international processes in similar fields or different industries.
- Monitoring tools to ensure they are used for their intended purpose within the pan-Canadian process.
## Proposed Approach & Discussion

### Approach

The proposed approach for defining, designing and implementing a pan-Canadian PRA framework for provisional licensure is as follows:

<table>
<thead>
<tr>
<th>WHAT: Scope &amp; Model</th>
<th>HOW: Analysis &amp; Design/Transition Planning</th>
<th>DO: Implement &amp; Monitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Goals &amp; outcomes validation</td>
<td>• Opportunity assessment &amp; prioritization</td>
<td>• Implementation</td>
</tr>
<tr>
<td>• Governance structure for the work</td>
<td>• Determine scope of standard</td>
<td>• Detailed plan</td>
</tr>
<tr>
<td>• Environmental scan - baseline</td>
<td>• Set policies</td>
<td>• Funding</td>
</tr>
<tr>
<td>• Scope or focus for work</td>
<td>• Create procedures</td>
<td>• Analysis &amp; design</td>
</tr>
<tr>
<td>• Formulation of pan-Canadian process</td>
<td>• Develop training materials</td>
<td>• Development</td>
</tr>
<tr>
<td>• Change impact assessment/strategy</td>
<td>• Select assessment tools</td>
<td>• Test/train</td>
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<tr>
<td></td>
<td>• Examine predictors (research)</td>
<td>• Implement – roll out</td>
</tr>
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<td></td>
<td>• Plan &amp; sequence</td>
<td>• Monitor and assess</td>
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</tbody>
</table>

Figure 10 Approach to Pan-Canadian PRA

Appendix K outlines a potential high-level approach to a future model.

### Points for Discussion

The following points of discussion outline areas that require consideration, prior to developing specific recommendations for moving forward. The discussion areas are grouped into four broad themes and are in no particular order. These areas will be brought forward as design considerations.

#### Principles

What is the preferred approach for a pan-Canadian PRA process, taking into consideration:

- The broader need of jurisdictions to attract and retain physicians to serve various communities’ needs
- That the process enables a MRA to make a decision about granting a provisional licence
- That the process requires multiple assessment approaches that not only identify candidates who have the best chance at success but are also cost-effective

Are there common themes that serve as guiding principles?

- Recognize and be sensitive to political and resource-strained jurisdictions
- Recognize the jurisdictions’ varying needs
- Maintain acceptability and standardization across jurisdictions
- Implementation will require collaboration
- Clearly identify differences
- Benefit of the tool (increased decision-making reliability) or activity should be balanced against the financial and human resource time costs
- Use centrally-coordinated approaches where possible and build on each other’s processes
Governance

Who needs to be involved in guiding a pan-Canadian PRA process?

- Who needs to be involved in defining or guiding the requirements for a competency-based assessment?
  - Should CFPC, RCPSC and CMQ be involved in defining the competencies as they set the standard for certification?
- Who will decide if the pan-Canadian PRA process is acceptable?
- Who should be involved in partnering on assessment research and development?
- What role could the FMRAC WGAS play in the initiative?
- What role can the postgraduate training programs play in considering “over-time” best practices and assessor training toolkits?
- Should the SRPC be engaged in NAC PRA discussions; if so, how?

<table>
<thead>
<tr>
<th>Table 13 Potential Roles</th>
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<tbody>
<tr>
<td>Oversight</td>
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<tr>
<td>Initiative Delivery/Coordination</td>
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</tbody>
</table>
| Steering Committee | Actively engaged in the oversight of the pan-Canadian PRA process with representation from MRAs and PRA program resources
Potential to make use of the FMRAC WGAS with enhancements depending on the scope of the framework (during initial stages) |
| Working Groups | Developed to participate in discussions and address the deliverables and tasks at hand
Research working group to design and run benchmark studies with a view to providing recommendations to MCC and the PRA Steering Committee on current assessment tools
Policy & implementation working group – ACIMGAP to develop and validate framework policies with representation from MRAs and existing or planned programs
Jurisdictional sounding board – jurisdictional funders to ensure framework is sound from an ongoing investment perspective |

Scope

Should the first focus be based on one or all of the following:

- Development of a common framework for all specialty areas
- Cross-jurisdictional common needs (as in servicing physician under-serviced populations)
- Common location(s) of need (i.e., rural and remote areas)
- Alignment of efforts with complementary stakeholder initiatives (i.e., CFPC’s exploration into the practice eligible route for certification without examination)

What is the scope of the design and development of NAC PRA initiative?

- Is it an end-to-end process from point of pre-screening to assessment-based decisions regarding a candidate’s practice readiness?
- Does it include activities such as:
• Establishment of a common PRA framework
  • Alignment of policies, practices and documentation
• Research studies to focus on the comparability and rigour of common tools, supports and outcomes
• Adoption of a common toolkit including point-in-time and over-time assessments
  • Validation or formulation of competencies to be assessed
• Development or use of common infrastructure elements where feasible
• Common orientation, assessor and IMG supports

What is the implementation process?
• What are the considerations that would influence implementation in addition to respective jurisdictional timetables and capacities for integrating change?
• Should there be a centralized oversight role on the implementation of a pan-Canadian process or should it fall to jurisdictional organizations to facilitate implementation?
• What is the financial and human resource support required to transition current processes to a pan-Canadian process?

How can the pan-Canadian process facilitate capacity sharing across jurisdictions?
• Is the ability to maximize available spaces and infrastructures a component of a common process?
• What needs to be considered to facilitate capacity sharing (i.e., similar assessment contexts)?

Approach
How should jurisdictions that plan to utilize the pan-Canadian process, but not deliver a process, be engaged?
• What type of representation should be available to these jurisdictions on various working groups, etc.?
• What types of communications or engagement will be needed regarding process development and decision-making?

What opportunities exist for indirect benefits if we proceed with a pan-Canadian process?
• How could the work undertaken under the initiative assist current underserviced areas?
• An identified opportunity is an inventory and analysis of current programs for the territories and other provinces without assessment processes. Are there any other opportunities that need consideration?

What will be the decision process for common process concerns or issues?

Concerns or issues with:
• Standards, policies and/or guidelines
• Assessment tool selection
• Standard setting

Is an accreditation process an approach that should be considered?
• Is accreditation of the assessment process something that should be explored?
• Who would be positioned to best perform this role (i.e., through certification bodies and/or MRAs)?
• Are there benefits to considering this as an approach in addition to enabling the gathering and measurement of program comparability while respecting the autonomy and needs of different jurisdictions?
• Activities could include:
  • Establishing a framework for accreditation
  • Development of standards around whether or not a reasonable assessment activity is in place with adequate supervision, etc.
What is the degree of flexibility envisioned within a pan-Canadian process?

- Will variation be acceptable regarding the type of IMG that is being assessed (known credentials compared to unknown credentials)?
- Can components of the process be optional or mandatory?

**Next Steps**

**Immediate**
- PRA Environmental Scan finalization
- Secure funding from Available Sources
- Establish/formalize Steering Committee & Terms of Reference

**Short-Term Direction**
- Approve charter to guide the design of a pan-Canadian PRA process
  - Establish high-level plan and budget
  - Plan and implement research studies
    - Inform the framework process, tools and policies

**Medium-Term Targets**
- Pan-Canadian process framework finalized
  - Policy
  - Orientation
  - Training Tools
  - Centralized and regional components
  - Monitoring
  - Evaluation of program success

Figure 11 Next Steps
## APPENDIX A: GLOSSARY AND ACRONYMS

<table>
<thead>
<tr>
<th>TERM</th>
<th>DEFINITION</th>
<th>REFERENCE</th>
</tr>
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<tbody>
<tr>
<td>AFMC</td>
<td>Association of Faculties of Medicine of Canada – A national organization that facilitates the information sharing and learning among Canadian medical schools; AFMC works to represent and support the mandates of Canadian medical faculties – research, medical education, clinical care with social accountability</td>
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<tr>
<td>Assessor</td>
<td>A person who evaluates and makes decisions regarding a candidate’s performance</td>
<td></td>
</tr>
<tr>
<td>Candidate</td>
<td>Refers to the IMG physician who attempts a PRA process</td>
<td></td>
</tr>
<tr>
<td>CanMEDS</td>
<td>Canadian Medical Education Directives for Specialists – A framework of competencies that act as a guide to the essential abilities physicians need for optimal patient outcomes; the framework defines the competencies needed for medical education and practice and are organized thematically around seven key physician roles: medical expert, communicator, collaborator, manager, health advocate, scholar and professional (within this document “CanMEDS” refers to both CanMEDS and CanMEDS-FM)</td>
<td>FMRAC WGAS</td>
</tr>
<tr>
<td>CAPP</td>
<td>Clinician Assessment for Practice Program – Nova Scotia PRA program</td>
<td></td>
</tr>
<tr>
<td>CFPC</td>
<td>College of Family Physicians of Canada – Sets the highest standards for family medical education in Canada; a professional organization responsible for establishing standards for the training, certification and lifelong education of family physicians and advocates on behalf of the specialty of family medicine, family physicians and their patients</td>
<td></td>
</tr>
<tr>
<td>CLBA</td>
<td>Canadian Language Benchmark Assessment</td>
<td>Citizenship and Immigration Canada</td>
</tr>
<tr>
<td>CMA</td>
<td>Canadian Medical Association – Voluntary association of physicians acting as national “voice of the medical profession” in Canada; lobbies for and promotes a variety of physician and public interest objectives</td>
<td></td>
</tr>
<tr>
<td>Credentials</td>
<td>Documented evidence of status; in context, credentials would include medical diploma, postgraduate training, etc.</td>
<td></td>
</tr>
<tr>
<td>CSAT</td>
<td>Clinical Skills Assessment and Training – Newfoundland and Labrador PRA program</td>
<td></td>
</tr>
<tr>
<td>Eligibility</td>
<td>Stipulated requirements for consideration for entry into PRA program</td>
<td></td>
</tr>
<tr>
<td>Entry to Practice</td>
<td>Generically, this term refers to the process of a physician being permitted to commence medical practice; in the context of IMG assessment, the term is used in reference to an assessment designed to determine if an IMG has the requisite competencies to enter medical practice as an MRP</td>
<td></td>
</tr>
<tr>
<td>TERM</td>
<td>DEFINITION</td>
<td>REFERENCE</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>FMRAC</td>
<td><strong>Federation of Medical Regulatory Authorities of Canada</strong> – A national organization and the privileged voice, both nationally and internationally, of the provincial and territorial medical regulatory authorities; FMRAC considers, develops and shares positions and policies on matters of common concern and interest</td>
<td>FMRAC Agreement on National Standards for Medical Registration in Canada</td>
</tr>
<tr>
<td>Full Licence</td>
<td>A medical licence that is subject to no terms, limitations, conditions or restrictions</td>
<td>FMRAC Agreement on National Standards for Medical Registration in Canada</td>
</tr>
<tr>
<td>IMG</td>
<td><strong>International Medical Graduate</strong> – Physicians who obtained their initial medical degree outside of Canada (the NAC PRA IMG also has postgraduate training outside of Canada)</td>
<td>CAPER – The National IMG Database Report &amp; MCC</td>
</tr>
<tr>
<td>IMGACL</td>
<td><strong>IMG Assessment for Conditional Licensure</strong> – Manitoba Practice Ready Assessment program for family medicine</td>
<td>CPSM</td>
</tr>
<tr>
<td>MCC</td>
<td><strong>Medical Council of Canada</strong> – A national organization with a mandate to establish a national medical credential that is acceptable to all MRAs for medical licensure purposes</td>
<td>CPSM</td>
</tr>
<tr>
<td>MCQ</td>
<td>Multiple-choice question</td>
<td>CPSM</td>
</tr>
<tr>
<td>Mentor</td>
<td>A person who acts as a counsellor</td>
<td>CPSM</td>
</tr>
<tr>
<td>MRA</td>
<td><strong>Medical Regulatory Authority</strong> – Provincial or territorial organizations that regulate the practice of medicine</td>
<td>CPSM</td>
</tr>
<tr>
<td>MRP</td>
<td><strong>Most Responsible Physician</strong> – A physician who has final responsibility and is accountable for the medical care of a patient</td>
<td>FMRAC Working Group on Assessment and Supervision</td>
</tr>
<tr>
<td>NRSAP</td>
<td><strong>Non-Registered Specialist Assessment Program</strong> – Manitoba Practice Ready Assessment program for specialists</td>
<td>CPSM</td>
</tr>
<tr>
<td>Orientation</td>
<td>An introduction as to guide one in adjusting to the program, Canadian health-care system, etc.</td>
<td>CPSM</td>
</tr>
<tr>
<td>OSCE</td>
<td><strong>Objective Structured Clinical Examination</strong></td>
<td>CPSM</td>
</tr>
<tr>
<td>Over-Time Assessment</td>
<td>An evaluation of skills, knowledge and/or competencies that occurs over an extended period of time, usually with direct observation; in context, this would include assessment of a physician in a clinical setting using a variety of assessment tools (i.e., mini-CEX, MSF)</td>
<td>CPSM</td>
</tr>
<tr>
<td>PCRO</td>
<td><strong>Physician Resource Coordination Office</strong></td>
<td>Health Employment Manitoba</td>
</tr>
<tr>
<td>PGT</td>
<td><strong>Postgraduate Training</strong> – Clinical training programs certified by RCPSC or CFPC</td>
<td>CPSM</td>
</tr>
<tr>
<td>PPAP</td>
<td><strong>Provincial Physician Assessment Program</strong> – Alberta PRA program</td>
<td>CPSM</td>
</tr>
<tr>
<td>PRA</td>
<td>Practice Ready Assessment – An alternate pathway (process or program) that allows physicians meeting the requirements (i.e., previous practice experience or who have completed non-Canadian PGT) to be assessed to determine their readiness to enter directly into practice under a provisional licence</td>
<td>CPSM</td>
</tr>
<tr>
<td>TERM</td>
<td>DEFINITION</td>
<td>REFERENCE</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Practice-Ready Physician</td>
<td>An indication that an IMG is qualified to enter medical practice in the capacity of an MRP with an expectation of supervision and summative assessment required to attain full medical licensure</td>
<td>FMRAC Agreement on National Standards for Medical Registration in Canada</td>
</tr>
<tr>
<td>PRAP</td>
<td>Practice Ready Assessment Program – Ontario PRA program</td>
<td>FMRAC Agreement on National Standards for Medical Registration in Canada</td>
</tr>
<tr>
<td>Provisional Licence</td>
<td>A medical licence subject to terms, limitations, conditions or restrictions (including, but not limited to, further examinations, assessment and/or supervision), whether or not this information appears on the public register</td>
<td>FMRAC Agreement on National Standards for Medical Registration in Canada</td>
</tr>
<tr>
<td>CMQ-RPR</td>
<td>CMQ Restrictive Licence – Ready to Practice Route – Quebec PRA process</td>
<td>FMRAC Agreement on National Standards for Medical Registration in Canada</td>
</tr>
<tr>
<td>RCPSC</td>
<td>Royal College of Physicians and Surgeons of Canada – Sets the highest standards for specialty medical education in Canada and responsible for the training, certification and life-long learning for specialist physicians and promotes sound health policy</td>
<td>FMRAC Agreement on National Standards for Medical Registration in Canada</td>
</tr>
<tr>
<td>RHA/RHCA</td>
<td>Regional Health Authority/Regional Health Care Authority</td>
<td>FMRAC Agreement on National Standards for Medical Registration in Canada</td>
</tr>
<tr>
<td>SIPPA</td>
<td>Saskatchewan International Physician Practice Assessment – Saskatchewan PRA program</td>
<td>FMRAC Agreement on National Standards for Medical Registration in Canada</td>
</tr>
<tr>
<td>Sponsor</td>
<td>An individual or organization holding a position they wish for an IMG to occupy</td>
<td>FMRAC Agreement on National Standards for Medical Registration in Canada</td>
</tr>
<tr>
<td>Sponsorship</td>
<td>Used in context of someone having a job/position to occupy if successful through the PRA process</td>
<td>FMRAC Agreement on National Standards for Medical Registration in Canada</td>
</tr>
<tr>
<td>Supervision</td>
<td>Supervision is the act of overseeing the practice of a candidate; the nature, frequency, level and duration of interaction between supervisor and candidate will depend on the practice objectives of the supervisory arrangement defined by the MRA</td>
<td>FMRAC Agreement on National Standards for Medical Registration in Canada</td>
</tr>
</tbody>
</table>
## APPENDIX B: INFORMATION SOURCES

### Consultations

<table>
<thead>
<tr>
<th>JURISDICTION/ORGANIZATION</th>
<th>REPRESENTATIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newfoundland and Labrador</td>
<td>Elizabeth Bannister (Memorial), Carl Sparrow (CSAT &amp; MRA rep), Larry Alteen (Newfoundland Health and Community Services)</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>Cyril Moyse (CPSPEI), Richard Wedge (Medical Director)</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>Gus Grant (CPSNS), Sandra Taylor (CPSNS), Gwen MacPherson (CPSNS), William Lowe (CPSNS), Lynda Campbell (NS Department of Health), Robert Maudsley (CPSNS), Bruce Holmes (Dalhousie)</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>Edmund Schollenberg (CPSNB)</td>
</tr>
<tr>
<td>Quebec</td>
<td>Yves Robert (CMQ), Ernest Prégent (CMQ), Sylvie Leboeuf (CMQ), Isabelle Savard (Ministry of Health), Karine Huard (Ministry of Health)</td>
</tr>
<tr>
<td>Ontario</td>
<td>Rocco Gerace (CPSO), Dan Faulkner (CPSO), Jeff Goodyear (Ontario Ministry of Health), Lee Tregwin Goodyear (Ontario Ministry of Health), Anne Marie Crescenzi (CEHPEA), Murray Urowitz (CEHPEA), Arin De Fazio (CEHPEA), Arthur Rothman (CEHPEA)</td>
</tr>
<tr>
<td></td>
<td>COFM: Mark Walton (McMaster), Sal Spadafora (Toronto), Caroline Abrahams (Toronto), Dan Faulkner (CPSO), Risa Bardman (CPSO), Ross Walker (Queen's Chair), Jolanta Karpinski (Ottawa), Maureen Morris (Western), Cathy Cervin (NOSM), Jennifer Fawcett (NOMS), Vishal Bhella (PAIRO [Professional Association of Interns &amp; Residents of Ontario]), Jonathan DellaVedova (PAIRO), John Centofanti (PAIRO), Frances Lamb (COU [Council of Ontario Universities]), Sharon McNickle (COU), Michelle Cyr (COU)</td>
</tr>
<tr>
<td>Manitoba</td>
<td>William Pope (CPSM), Anna Ziomek (CPSM), Maxine Miller (CPSM), Jo-El Stevenson (CPSM), Marilyn Singer (University of Manitoba), Brooke Ballance (Manitoba Health)</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>Karen Shaw (CPSS), Barb Porter (CPSS), Shaylene Salazar (Saskatchewan Health), Ingrid Kirby (Saskatchewan Health), Adrienne Hagen Lyster (Saskatchewan Health), Penny Davis (Univ. of Saskatchewan), Dennis Kendel (FQR Observer)</td>
</tr>
<tr>
<td>Alberta</td>
<td>Ken Gardener (CPSA), Erin Anderson (CPSA), Farah Jamil (Alberta Health and Wellness), Cindy Gerdes (Alberta Health Services), Terry Gallamore (Alberta Health Services), Maureen Topps (AIMG), Patrick Yu (FQR Observer), Jolanta Slaska (FQR Observer)</td>
</tr>
<tr>
<td>British Colombia</td>
<td>Heidi Oetter (CPSBC), Rodney Andrew (UBC), Sharon Hall (UBC), Libby Posgate (BC Ministry of Health), Bev MacLean-Alley (BC Ministry of Health), John Mabbott (Health Match BC)</td>
</tr>
<tr>
<td>Northwest Territories</td>
<td>Samantha Van Genne (Registrar, Professional Licensing, Department of Health and Social Services)</td>
</tr>
</tbody>
</table>
JURISDICTION/ORGANIZATION | REPRESENTATIVES
---|---
Yukon | Fiona Charbonneau (Community Services, Registrar), Laurel Miller-Wright (Community Services, Assistant Registrar), Brian Kitchen (Health and Social Services), Charlene Beauchemin (ADM, Community Services), Sherri Wright (ADM, Health Services), Kim Dalhan (Health and Social Services), Skylan Parker (Health and Social Services), Dave Sloan (Education), Robert Bousquet (YMC and GP), Bruce Beaton (Chair, YMC), Ruth Koenig (Assistant Registrar, Health Practitioners), Carol Cameron (A/YMC, Coordinator)
MCC | Ian Bowmer, Krista Breitlaupt
CFPC | Francine Lemire, Paul Rainsberry
RCPSC | Tim Allen, Emily Stephenson
AFMC | Steve Slade
FMRAC | Fleur-Ange Lefebvre, Dan Faulkner (WGAS)
CMA | Todd Watkins (Council on Education and Development)
Society of Rural Physicians of Canada | Lee Teperman
Health Canada | Liz Hong-Farrell (HC), David Jones (HC), Emmy Mukasa (AB), Patrick Yu (AB), Dennis Kendel (SK)

Data Sources
AFMC, CAPER National IMG Database: Linda Bourgeois
CMA: Lynda Buske, Tara Chauhan

Papers
Proposal: Assessing International Medical Graduates for Entry Into Practice (Ian Bowmer, September 2011)

Process Information

<table>
<thead>
<tr>
<th>PROCESS MATERIAL</th>
</tr>
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</table>
| NL – CSAT | 2011 Yearly CSAT Report
CSAT Appeal Letter
IEHP Assessment – Final Report
Sample Results Report |
| NS – CAPP | CAPP Candidate Final Report, CAPP Progress Report
CAPP Statistics – December 2011
Assessment of International Medical Graduates and Their Integration into Family Practice: The Clinician Assessment for Practice Program |
| QC – PRA Process | IMG – Examination Outcomes for International Medical Graduates
IMG Pathways Overview |
| MB – IMGACL & NRSAP | Internal Review – Self-Study Manitoba IMG Program
External Review – University of Manitoba IMG Program
Manitoba Orientation Schedule |
### PROCESS MATERIAL

<table>
<thead>
<tr>
<th>Region</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>SK – SIPPA</td>
<td>Saskatchewan-Based Program to Assess Foreign-Trained Family Physicians Overview</td>
</tr>
</tbody>
</table>
| AB – PPAP | Applicant and Sponsor Family Medicine Manuals  
Applicant and Sponsor Specialist Manuals  
Practice Supervisor Agreement  
Preliminary Clinical Assessor Agreement |
| RCPSC | RCPSC PER Guidebook, Report, FAQ – Routes to Specialty Certification |

### ONLINE RESOURCES

<table>
<thead>
<tr>
<th>Region</th>
<th>Description</th>
</tr>
</thead>
</table>
[https://www.med.mun.ca/pdcs/services/csat.asp](https://www.med.mun.ca/pdcs/services/csat.asp) |
| ON – PRAP | [http://www.cephpea.ca/examinations/PRA/index.htm](http://www.cephpea.ca/examinations/PRA/index.htm) |
| AB – PPAP | [http://www.cpsa.ab.ca/Services/ace/practicereadiness/overview.aspx](http://www.cpsa.ab.ca/Services/ace/practicereadiness/overview.aspx) |
## APPENDIX C – IMG PROVISIONAL LICENSURE OVERVIEW

Table 14 Past Provisional Licences Granted

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>2010 Family Medicine</th>
<th>2010 Other Specialties</th>
<th>2011 Family Medicine</th>
<th>2011 Other Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>NL</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEI</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NS</td>
<td>17</td>
<td>32</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>NB</td>
<td>4</td>
<td>6</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>QC</td>
<td>9</td>
<td>62</td>
<td>20</td>
<td>57</td>
</tr>
<tr>
<td>ON</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>MB</td>
<td>25</td>
<td>19</td>
<td>31</td>
<td>11</td>
</tr>
<tr>
<td>SK</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>9</td>
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<tr>
<td>AB</td>
<td>8</td>
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<td></td>
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<tr>
<td>BC</td>
<td>68</td>
<td>116</td>
<td>50</td>
<td>87</td>
</tr>
<tr>
<td>NU</td>
<td>0</td>
<td>0</td>
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<tr>
<td>NWT</td>
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<tr>
<td>YK</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>156</strong></td>
<td><strong>237</strong></td>
<td><strong>123</strong></td>
<td><strong>192</strong></td>
</tr>
</tbody>
</table>

### Notes

1. MRAs were asked to identify:
   - How many provisional licences (or similar licences with different names) were granted by your medical regulatory authority in 2010 and 2011 to IMGs? Of these, how many underwent a practice-ready assessment?

   - IMGs for the purposes of the NAC-PRA scan are physicians who
     - completed their MD outside of Canada
     - complete their PG training outside of Canada and did not take any Canadian PG training

2. At time of report finalization, information was not available.

3. Of the provisional licences granted in Nova Scotia, assessments were used for the A portion, and the breakdown is as follows
   - 2010 - 5 FM Assessments; 1 Other Specialty Assessment;
   - 2011 - 7 FM Assessments

4. CPSNB had to change the old numbers as highlighted. It has always defined IMG based on medical school alone, but this also excludes those with Canadian training as per the definition.

5. QC: The difference between 2011 data between provisional licences granted and potential PRA volume is explained by the fact that some provisional licences are granted through academic recruitment (which requires no competency-based assessment). Assessments made in 2010 are as follows: FM/GP: 9 and OS: 26, for a total of 35.
ON: Only 2 licences of the NAC-PRA type were issued by CPSO in 2010 and 2011, a reflection of the temporary cessation by CEHPEA in 2009-10 of new candidates into its PRA stream. Since inception in 2002 of the PRA stream in Ontario, CPSO has issued approximately 125 NAC-PRA type licences, but almost all of these issuances occurred from 2002 to 2008.

“ACGME Trained/US Board-Certified IMG Candidates”: It should be noted that the CPSO offers a provisional licence pathway for US Board certified and ACGME residency trained IMGs (“Pathway 4” for short). This pathway has had strong IMG uptake, with 66 licences issued in 2009 and 45 in 2011. However, it does not involve a practice-ready assessment of the NAC-PRA type. It requires a period of supervised practice followed by a summative practice assessment.

The numbers indicated represent those physicians who were granted a provisional licence upon initial registration. Other physicians were initially registered on another form of licensure and then were converted to a provisional licence. For information purposes, the breakdown of information for physicians in the latter scenario was:
- 2010 - 3 Family Physicians, 5 Other Specialties
- 2011 - 29 Family Physicians, 10 Other Specialties

CPSA/Alberta – Legislative change in practice registers. Unable to report numbers.
## Appendix D – PRA Stakeholder Roles Overview

<table>
<thead>
<tr>
<th>Organization</th>
<th>Description</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requirements &amp; Acceptance</strong></td>
<td>A national organization and the privileged voice, both nationally and internationally, of the provincial and territorial medical regulatory authorities; FMRAC considers, develops and shares positions and policies on matters of common concern and interest.</td>
<td>Facilitate consensus with MRAs on model</td>
</tr>
<tr>
<td>FMRAC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRAs</td>
<td>Provincial or territorial organizations to regulate the practice of medicine</td>
<td>Define the “what” of PRA, ultimate approvers of the competency-based assessment through their support and acceptance of PR decisions</td>
</tr>
<tr>
<td><strong>Funder – During Development</strong></td>
<td>Health Canada is the federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances. The Health Human Resources Policy Division (HHRPD) is Health Canada’s focal point for health human resource (HHR) issues associated with physicians, nurses (in collaboration with the Office of Nursing Policy) and other regulated health professionals; main activities include policy development and provision of advice related to identified HHR priorities, and program management for HHR strategy initiatives</td>
<td>Potential funders for the pan-Canadian practice ready assessment development work</td>
</tr>
<tr>
<td>Health Canada</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Funders</strong></td>
<td></td>
<td>Fund jurisdictional IMG programs/assessments; source of information for physician resource needs</td>
</tr>
<tr>
<td>Provincial/Territorial Ministries of Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
<td>Role</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
<td>------</td>
</tr>
<tr>
<td>Regional Health (Care) Authorities</td>
<td>Involved in the oversight of primary care in jurisdictions</td>
<td>Involved in the delivery of health care services within a jurisdiction; varying levels of involvement in PRA</td>
</tr>
<tr>
<td>IMG Programs/Processes</td>
<td>Responsible for the delivery, maintenance of current IMG PRA processes within jurisdictional frameworks</td>
<td>Determine “how” the pan-Canadian PRA process will work, as subject matter experts</td>
</tr>
<tr>
<td>CFPC</td>
<td>Sets the highest standards for family medical education in Canada; a professional organization responsible for establishing standards for the training, certification and lifelong education of family physicians and advocates on behalf of the specialty of family medicine, family physicians and their patients</td>
<td>Competency input</td>
</tr>
<tr>
<td>RCPSC</td>
<td>Sets the highest standards for specialty medical education in Canada and responsible for the training, certification and lifelong learning for specialist physicians and promotes sound health policy</td>
<td>Competency input</td>
</tr>
<tr>
<td>MCC</td>
<td>A national organization with a mandate to establish a national medical credential (LMCC) that is acceptable to all MRAs for medical licensure purposes</td>
<td>Support the direction of NAC through the coordination of the initiative</td>
</tr>
<tr>
<td>AFMC</td>
<td>A national organization that facilitates the information sharing and learning among Canadian medical schools; AFMC works to represent and support the mandates of Canadian medical faculties – research, medical education, clinical care with social accountability</td>
<td>Conduit to engagement with all medical schools</td>
</tr>
<tr>
<td>Organization</td>
<td>Description</td>
<td>Role</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medical schools - Universities</td>
<td>Faculties of medicine who train physicians</td>
<td>Source of evaluation expertise that will be required to assess the current clinical competence of IMGs seeking direct entry to practice</td>
</tr>
<tr>
<td>CMA</td>
<td>Voluntary association of physicians; acting as a national “voice of the medical profession” in Canada, lobbies for and promotes a variety of physician and public interest objectives</td>
<td>Potential to assist in the implementation of the assessment strategy in each jurisdiction by encouraging their community based members to serve as assessors and/or mentors for IMGs</td>
</tr>
<tr>
<td>PTMA</td>
<td>The PTMAs are the provincial/territorial “locals” of the CMA and are focused almost exclusively on physician advocacy work and are the closest thing to a “doctor’s union”; they negotiate professional compensation arrangements for doctors with their respective provincial governments</td>
<td></td>
</tr>
<tr>
<td>ACIMGAP</td>
<td>Provides the opportunity for the effective exchange of information regarding existing IMG assessment programs. Formed to support information sharing during the NAC entry into residency examination</td>
<td>Engaged in the development of a pan-Canadian process as individual processes may be required to adjust elements of the process</td>
</tr>
<tr>
<td>ACHDHR</td>
<td>Provides policy and strategic advice to the Conference of Deputy Ministers of Health on the planning, organization and delivery of health services including health human resources</td>
<td>Consulted to ensure framework is financially viable from an ongoing maintenance perspective</td>
</tr>
<tr>
<td>NAC³</td>
<td>Alliance of Canadian organizations seeking to streamline the evaluation process through which an IMG navigates on the path to obtaining a licence to practise medicine in Canada</td>
<td>Oversight and accountability for the pan-Canadian framework</td>
</tr>
</tbody>
</table>
## Appendix E – FMRAC – Standard for the Issuance of a Provisional Licence

<table>
<thead>
<tr>
<th>Element</th>
<th>Family Physicians</th>
<th>Other Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Degree</td>
<td>1. MD degree (WDMS 2000 or IMED) or Doctor of Osteopathic Medicine (U.S.); and</td>
<td>1. MD degree (WDMS 2000 or IMED) or Doctor of Osteopathic Medicine (U.S.); and</td>
</tr>
<tr>
<td>Examinations</td>
<td>2. At minimum the MCCEE; preferably the MCCQE Part I N.B.: this does not apply to physicians with academic appointments (see Exemptions); and</td>
<td>2. MCCEE or MCCQE Part I N.B.: this does not apply to physicians with academic appointments (see Exemptions); and</td>
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<td>Training</td>
<td>3. (a) Satisfactory completion of at least four years of discipline-specific postgraduate training in a program accredited by a national postgraduate training authority; and (b) A verifiable document of completion of specialist training by the national postgraduate training authority, referred to above; or If a verifiable document is not issued or available, then has been recognized as a specialist authorized to practice independently in the country where the postgraduate training was completed; and</td>
<td>3. (a) Satisfactory completion of at least four years of discipline-specific postgraduate training in a program accredited by a national postgraduate training authority; and (b) A verifiable document of completion of specialist training by the national postgraduate training authority, referred to above; or If a verifiable document is not issued or available, then has been recognized as a specialist authorized to practice independently in the country where the postgraduate training was completed; and</td>
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<tr>
<td>Assessment</td>
<td>4. A competency-based, pre-practice assessment in Canada (to be defined by the Working Group on Assessment and Supervision).</td>
<td>4. A competency-based, pre-practice assessment in Canada (to be defined by the Working Group on Assessment and Supervision).</td>
</tr>
</tbody>
</table>

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3 This represents an overview of the standards as of January 2012; it should be noted that further detail refinement continues.
**APPENDIX F – PRA PRINCIPLES**

Based on the Principles Established in the 2005 report by T. Maguire’s *A Process for Assessing International Medical Graduates (IMGs)*:

- **Equivalent standards for the IMG**
  - The standards applied to IMGs should be equivalent to the standards applied to graduates of Canadian medical schools with the caveat that the standards applied will need to acknowledge differences in cultural competencies and knowledge of the Canadian healthcare system.

- **Assessment tool(s) should be fair, efficient and reflect best practice**
  - While the requirements of licensure can be broad, the assessment tools for minimal competency are subject to the “Standards for Educational and Psychological Tests”, published by the American Psychological Association, the American Education Research Association, the National Council on Measurement in Education and the current research literature on assessment in the professions.

- **Decision-making autonomy separate from assessment process**
  - Provincial regulatory authorities retain the right to grant licences to practise within their own jurisdiction.
  - Certification is the responsibility of the RCPSC and CFPC.

- **Assessment for provisional licensure**
  - Practice-ready IMGs may receive licences that are restricted and that the practice-ready group will require an efficient assessment strategy that checks their skills, then moves them toward licensure.
  - This may also require specific but truncated orientation through courses and monitored experience, but in general the time requirements will be brief and significantly less than a residency in one of the specialty programs.

- **A valid determination of practice-ready clinical skills**
  - Involves both standardized assessments and performance assessments carried out in a context similar to the context in which the candidate will practise.
  - If the process is to be consistent and coherent, it must be administered by an appropriate organization; this organization will be required to develop and validate instruments, organize assessments and placements, maintain records, provide the necessary information and guidance for candidates, monitor standards, and ensure that the entire process is fair, efficient and reflects best practices.

- **Build off current successes**
  - Currently, there are provincial and regional IMG assessment procedures in existence or under development.

- **Ensure appropriate linkages**
  - For candidates nearer the ‘practice-ready’ end of the continuum, assessment and education are closely linked; it is assumed that any kind of monitored practice will involve feedback for improvement purposes as well as an evaluation of readiness to undertake independent practice.
### APPENDIX G.1 – CURRENT ENVIRONMENT – IMG PRA VOLUMES

#### Table 15 Estimated pan-Canadian PRA Volumes

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#### Table 16 Estimated Jurisdictional PRA Volumes

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Future PRA Volume

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Notes
MRAs were asked to assist in identifying the projected volume of NAC PRA assessments that are likely to be performed in their respective jurisdiction over the next five years in context of:

- 2011 actual volume and estimated trends
- Anticipated increases/decreases resulting from jurisdictional physician need areas (HHR) that may utilize IMG physicians of which there is an awareness of same
- Implementation of the FMRAC Standards for the Issuance of a Provisional Licence that requires a competency-based assessment (PRA) prior to a MRA granting a provisional licence

Trend estimates based on preliminary data collection during consultations January – March 2012.

At time of report finalization, specific information was not confirmed; however, similar trends are expected.

Range provided was between 5-10.

Initial discussions with the SK government have been initiated to create/fund a program for other specialists. It will take several years to have an assessment program in place for other specialist physicians hence the volume anticipated to start in 2014.

Numbers will not change as NU does not have the capacity for IMG assessments.

This is a best estimate of the need for IMG pre-licensure assessment. The Limited (formerly Special) Licence program has been closed over the past couple of years. That said, it could reopen at any time with a subsequent need for assessment programs (as the Yukon Medical Council now has the authority, under the recently amended legislation, to require pre- and post-licensure assessment).
APPENDIX G.2 – CURRENT ENVIRONMENT – JURISDICTIONAL PROGRAM “SCOPES”
## Appendix G.3 – Current Environment – Existing Program Dashboard

| Program | Description | IMG Candidate Location | Area of Need | Involvement in Delivery of Process (Application to PR Decision) | Process Funding Breakdown (Estimates to demonstrate proportion only; Note: P/T broken down in RHA & MoH) | Volume/Year | Process Capacity |
|---------|-------------|------------------------|--------------|---------------------------------------------------------------|---------------------------------------------------------------------------------|-------------|----------------|}
<p>| CSAT    | CSAT program assesses qualified IMGs for provisional licensure purposes. The program consists of the evaluation of medical knowledge, clinical skills and integrates a training element prior to the re-assessment step to establish if the IMG is ready for entry into provisional licensure practice. | In Canada | ✓ Family medicine &lt;br&gt; ✓ Rural | <img src="chart.png" alt="NRLD-CSAT" /> | <img src="chart.png" alt="NRLD-CSAT" /> | Ideal is 16, typically 18-22 | 20 |
| CAPP    | To evaluate IMG physicians who may be ready for entry into family practice without additional formal residency training in Canada, with a view to recommend the candidate for provisional licensure or not. | In Canada | ✓ Family medicine &lt;br&gt; ✓ Rural | <img src="chart.png" alt="NS - CAPP" /> | <img src="chart.png" alt="NS - CAPP" /> | 36 | 38 |</p>
<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>IMG Candidate Location</th>
<th>Area of Need</th>
<th>Involvement in Delivery of Process (Application to PR Decision)</th>
<th>Process Funding Breakdown</th>
<th>Volume/Year</th>
<th>Process Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>IRA - Process Quebec</td>
<td>To determine whether an IMG applicant recruited to meet specific physician human resource needs where sponsorship by a health establishment is required, meets the provisional licensing (restrictive permit) requirements of the CMQ and the assessment includes an evaluation period.</td>
<td>In Canada/Overseas</td>
<td>✓ Family medicine ✓ Specialties ○ Rural ○ Urban</td>
<td>QC □ MRA □ Academic □ Provincial Government</td>
<td>QC □ MRA □ Academic □ Provincial/Regional Health Care Authority □ Provincial Government □ Sponsor □ Potential Future Employer □ Candidates</td>
<td>81</td>
<td>As needed</td>
</tr>
<tr>
<td>Practice Ready Assessment Program (PRAP)</td>
<td>To facilitate entry to practice for internationally educated health professionals (including physicians). This includes assessing IMGs to ensure they meet Canadian standards and provide orientation programs to training and practice in Canada.</td>
<td>In Canada</td>
<td>○ Family medicine ✓ Specialties ○ Rural ○ Urban</td>
<td>QC □ MRA □ Academic □ Provincial Government</td>
<td>ON - PRAP □ MRA □ Academic □ Provincial/Regional Health Care Authority □ Provincial Government □ Sponsor □ Potential Future Employer □ Candidates</td>
<td>Variable</td>
<td>Point-in-time assessment unlimited Supervised clinical assessment variable</td>
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<tr>
<td>MB - IMGACL</td>
<td>To facilitate entry to practice for family medicine/general practitioners through an assessment route that provides qualified IMGs the opportunity to practice in Manitoba, and to provide communities in Manitoba with internationally-trained physicians willing to practise in rural regions.</td>
<td>In Canada</td>
<td>✓ Family medicine ✓ Rural</td>
<td>MB - IMGACL □ MRA □ Academic □ Provincial/Regional Health Care Authority □ Provincial Government □ Sponsor □ Potential Future Employer □ Candidates</td>
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<td>Program</td>
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<td>Area of Need</td>
<td>Involvement in Delivery of Process (Application to PR Decision)</td>
<td>Process Funding Breakdown (Estimates to demonstrate proportion only; Note: P/T broken down in RHA &amp; MoH)</td>
<td>Volume/Year</td>
<td>Process Capacity</td>
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</tr>
<tr>
<td>Non-Registered Specialist Assessment Program (NRSAP) <em>Manitoba</em></td>
<td>To facilitate entry to practice through an assessment route which provides qualified IMGs the opportunity to practice in Manitoba, and to provide communities in Manitoba with internationally-trained physicians willing to practice in underserviced fields of medicine.</td>
<td>In Canada</td>
<td>✓ Specialties</td>
<td>✓ Urban</td>
<td>✓ Rural</td>
<td>MB - NRSAP [MRA] [Academic] [Prov.(MoH/RHCA)] [Program]</td>
<td>MB - NRSAP [MRA] [Academic] [Prov.(MoH/RHCA)] [Program]</td>
</tr>
<tr>
<td>Saskatchewan International Physician Practice Assessment (SIPPA) <em>Saskatchewan</em></td>
<td>Assesses IMG applicants for readiness for independent family practice under provisional licensure to meet the urban and rural need for physicians in the jurisdiction.</td>
<td>Overseas</td>
<td>✓ Family medicine</td>
<td>✓ Specialties</td>
<td>✓ Rural</td>
<td>✓ Urban</td>
<td>SK - SIPPA [MRA] [Academic] [Prov. Government] [IMG Program]</td>
</tr>
<tr>
<td>Provincial Physician Assessment Program (PPAP) <em>Alberta</em></td>
<td>To determine whether applicants are ready to enter independent practice (for provisional licensure) in Alberta through assessment of applicant’s clinical knowledge and skills.</td>
<td>In Canada/Overseas</td>
<td>✓ Family medicine</td>
<td>✓ Specialties</td>
<td>✓ Rural</td>
<td>✓ Urban</td>
<td>AB - PPAP [MRA] [Academic] [Prov.(MoH/RHCA)] [Program]</td>
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<td>Program</td>
<td>Description</td>
<td>IMG Candidate Location</td>
<td>Area of Need</td>
<td>Involvement in Delivery of Process (Application to PR Decision)</td>
<td>Process Funding Breakdown (Estimates to demonstrate proportion only; Note: P/T broken down in RHA &amp; MoH)</td>
<td>Volume/Year</td>
<td>Process Capacity</td>
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<tr>
<td>BC</td>
<td>To determine whether applicants are practice-ready for provisional licensure, the program is in its inception stages and scope is under development. Involvement and funding breakdowns are point-in-time estimates.</td>
<td>Likely in Canada</td>
<td>✓ Family medicine</td>
<td>BC - Future &lt;br&gt; - MRA &lt;br&gt; - Academic &lt;br&gt; - Prov.(MoH/R HCA) &lt;br&gt; - Program</td>
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## APPENDIX G.4 – CURRENT ENVIRONMENT – EXISTING PROGRAM TIMELINES

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* This denotes SIPPA’s program period intakes.

### Other Specialties

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<td>Once per year</td>
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As needed
## Appendix G.5 – Current Environment – Program Overviews

<table>
<thead>
<tr>
<th>Reference</th>
<th>PRA Process Overview</th>
</tr>
</thead>
</table>
| G.5.1     | Clinical Skills Assessment & Training (CSAT)  
            Newfoundland & Labrador |
| G.5.2     | Clinician Assessment for Practice Program (CAPP)  
            Nova Scotia |
| G.5.3     | PRA Process  
            Quebec |
| G.5.4     | Practice Ready Assessment Program (PRAP)  
            Ontario |
| G.5.5     | IMG Assessment for Conditional Licensure (IMGACL)  
            Manitoba |
| G.5.6     | Non-Registered Specialist Assessment Program (NRSAP)  
            Manitoba |
| G.5.7     | Saskatchewan International Physician Practice Assessment (SIPPA)  
            Saskatchewan |
| G.5.8     | Provincial Physician Assessment Program (PPAP)  
            Alberta |
### G.5.1 - Jurisdiction and Program:

**Newfoundland & Labrador**

**Clinical Skills Assessment & Training (CSAT)**

**Focus:**

Family physician - Rural

**Purpose:**

To evaluate IMG physicians for provisional licensure as a response to the need to recruit physicians for rural Newfoundland and Labrador. At the time of inception (1998), many of the physicians applying for employment needed further enhancement of their skills to meet licensure requirements.

**Program Highlights:**

- Assessment, training/assessment of 25 weeks, re-assessment pre-provisional licensure
- Point-in-time assessments - two-day (pre-licensure) assessment leading to an educational licence upon passing
- Over-time assessment through training and evaluation – 25-week assessment course tailored to candidate needs
- Point-in-time re-assessment
- Orientation throughout the program, training is a differentiator for this program

**Candidate assessment costs:**

- Candidate pays $3,000 for the assessment + payment of preceptor costs during training assessment - ~$12,500 (25 weeks*$500) before provisional licensure granted

### Process Overview

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<tr>
<th>Step</th>
<th>Description</th>
<th>Involved/Responsible</th>
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</thead>
</table>
| Prerequisite | • Applicants applying for a licence for entry to practice who are assessed as ineligible may be eligible to enter CSAT; if determined candidate is eligible, candidate is provided with an application form  
• Must have MCCEE | MRA |
| Application | • Provide evidence of eligibility and a Regional Health Care Authority must officially sponsor the candidate before the formal examination begins and must be willing to receive the candidate if successful (upfront sponsorship linkage)  
• The candidate applies for specific CSAT position postings and recruiting officers select candidates for positions | RHCA |

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[Diagram and table content as per the original document]
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<tr>
<th>Step</th>
<th>Description</th>
<th>Involved/Responsible</th>
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</thead>
</table>
| Eligibility | • Completed 12-month rotating internship (minimum of eight-week rotation in each of medicine, surgery, pediatrics and an eight-week rotation in either OBGYN or psychiatry)  
• Training must be within three years of last practice  
• Pass on MCCEE with minimum passing score set  
• Meet English fluency policy  
• Reference checks performed | MRA |
| Decision Making | • MRA determines eligibility for CSAT  
• RHCA selects candidates for positions | MRA/RHCA |
| Orientation | • Orientation on Canadian health care/medical system, cultural elements and how to interact with other health professionals in the Canadian context  
• Two-hour meeting with CSAT Director to orient candidate to the program  
• RHCA conducts a two-day business orientation session | Varied |
| Stage 1 – Assessment | Throughout the assessment a residence and meal plan is offered:  
• Day 1 – MCQ, structured oral interview, meeting with CSAT Director (includes orientation to the program)  
• Day 2 – Therapeutic assessment and standardized patient encounters | University |
| Decision | • Scoring of the examinations takes one-two months to mark (double marking, etc.), multiple review points  
• Results reviewed by committee of physician assessors  
• Candidate can appeal on process, not content  
• If successful, candidate proceeds to training assessment once sponsor secured | Academic Advisory Committee (recommendation)/CPSNL (final decision) |
| Sponsorship | • Sponsorship may not always be monetary, it may be the “promise” of a position if successful | RHCA |
| Stage 2 – Training & Assessment | • Assessment course tailored to the candidate’s needs (25 weeks, can go to 32 weeks with up to one element of training repeated if required)  
• Training position offered and assigned a preceptor  
• In-training evaluation reports used | CSAT |
| Stage 3 – Reassessment | • Summative focused reassessment on all or a portion of the assessments in the assessment stage (i.e., MCQ, etc.)  
• Final assessment typically done in another region from where they are practicing | Academic Advisory Committee (recommendation)/CPSNL (final decision) |
| Decision Making | Results to Academic Advisory Committee and meeting with RHCA:  
• If successful, MRA notified and provisional licence granted  
• If not successful, process stops and the candidate is required to pay back funds for accommodation and meals during the training process (the refund is appealable) | Academic Advisory Committee (recommendation)/RHCA (decision)/CPSNL (licensing decision) |
G.5.2 - Jurisdiction and Program:
Nova Scotia
Clinician Assessment for Practice Program (CAPP)

Purpose:
To evaluate IMG physicians who may be ready for entry into family practice without additional formal residency training in Canada, with a view to recommend the candidate for provisional licensure, or not.

Focus:
Family physician - Rural

Program Overview

Process Overview

Eligibility
- Cannot be out of practice for any more than the last 5 years
- MCCQE Part I preferred
- Have training & clinical practice experience which consists of either 1 year rotating internship & have at least 2 years of licensed clinical practice experience OR 2 year training program equivalent to family medicine & have at least 1 year of licensed clinical practice experience

Credentials & Experience
- Referred by MRA
- Medical diploma
- Evidence of PGT
- MCCQI Part I preferred

Stage 1 Assessment
- Medical Knowledge Assessment
  - Part A: Therapeutics
- Clinical Skills Assessment
  - OSCE

Assessment Outcome
- Part A: MRA Credential Committee considers Part A report
- Part B: Sponsor identified (DHA)
- Part C: Mandatory orientation program
- CME identified & plan developed

Supervised Practice
- Part B: First year in practice with physician supervisor (teaching, supervision, assessment) then transition to supervision risk
- Under contract through Department of Health
- Orienteer assessment – external – at 4-6 months
- Patient feedback survey at 10 months
- Assessed after 13 months
- CME activities reviewed, new needs identified if applicable

Assessment Outcome
- Part A: MRA Credentials Committee determines continuation, additional follow up required
- Part B: MSC at 18 months
- Re-assessment as necessary

Full License

Step Description Involved/Responsible
Prerequisite
- Must have MCCE & MCCQE Part I
Candidate
Application
- Applies to CPSNS and eligibility requirements verified by MRA:
  - Condition of application is that successful candidates will practice in a rural area
MRA
Eligibility
- Cannot be out of practice for any more than the last five years
- Pass MCCE & MCCQE Part I
- Have training and clinical practice experience consisting of:
  - One year rotating internship AND have at least two years of licensed clinical practice experience OR
  - Evidence of a two-year training program equivalent to family medicine AND have at least one year of licensed clinical practice experience
MRA
<table>
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<tr>
<th>Step</th>
<th>Description</th>
<th>Involved/Responsible</th>
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</table>
| CAPP Registration        | • CAPP sends referred candidates the application form with the intention of verifying previous medical experience and history, fee deposits, etc.  
                             • There is a maximum of two attempts at Part A of the assessment and the IMG cannot be out of clinical practice for more than five years for both attempts | Program (MRA)                        |
| Part A – Assessment      | • Day 1 – Therapeutics examination, afternoon orientation  
                             • Day 2 – OSCE | University                           |
| Orientation              | Orientation to the examination process is included at point of application and prior to the examination window  
                             • OSCE orientation is integrated into the Part A assessment | MRA/University                      |
| Decision                 | Scoring of the assessments within a week and clinical scores are weighted more heavily than therapeutics scores.  
                             • Report focuses on assessment of strengths and weaknesses and is provided to both the candidate and credentials committee (about 60 days from assessment to report)  
                             • Credentials Committee makes decision to offer a defined license  
                             • Documents must be source verified  
                             • Orientation session completion  
                             • Sponsor and supervisor secured  
                             • Four-year contract is signed | MRA Credentials Committee          |
| Orientation              | Mandatory five-day orientation:  
                             • Canadian health-care system  
                             • Contract information, legal/ethical issues  
                             • Mentoring program  
                             • CME session, etc. | MRA and others                      |
| Site Visits – Sponsorship/Mentorship | • Sponsor (i.e., Medical Director/Chief of Staff) identified through Provincial Department of Health and Provincial District Health Authorities  
                             • Visit rural areas, candidates interviewed by districts and districts offer positions | Province                            |
| Part B – Supervised Practice | • Reports with decreasing frequency if performance satisfactory (self-assessments, supervisor reports)  
                             • At four-five months, external assessor performs a half-day practice audit; at 10 months, a patient feedback survey is completed  
                             • Culminates in a final report by the CAPP physician, assessor/supervisor, CME; goes to Credentials Committee to review and address concerns | MRA/Province (contract)/Sponsor/Assessor |
| Part C – Post Mentorship | Independent practice with supporting systems if issues in Part B remain unaddressed and includes MSF at 18 months and any reassessments required, semi-annual reports, etc. | MRA/Sponsor Supervisor |
### G.5.3 - Jurisdiction and Program:

<table>
<thead>
<tr>
<th>Quebec - Restrictive License – Ready to Practice Route</th>
<th>Focus:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose:</strong> To determine whether an IMG applicant recruited to meet specific physician human resource needs where sponsorship by a health establishment is required, meets the provisional licensing (restrictive permit) requirements of the CMQ and the assessment includes an evaluation period. The evaluation period is also used for France MD; however, for these candidates, sponsorship is not required and the applicant undergoes an adaptation period (rotations with an evaluation period.)</td>
<td><strong>Family Medicine/Specialists</strong></td>
</tr>
</tbody>
</table>

#### Program Highlights:
- Offered throughout the year
- Sponsorship required up front for IMGs (with the exception of France MD/PGT candidates)
- Three-month clinical assessment in an academic or accredited environment
- Over-time clinical assessment in a hospital setting only (for five years)
- Post-provisional licensure the physician works in a hospital/hospital-linked environment

#### Candidate Assessment Costs:
- No candidate assessment costs; Ministry of Health pays for assessment

### Process Overview

#### Credentialing & Program Eligibility
- Medical diploma
- 2 years postgraduate clinical training (family medicine or 4-6 years specialty)
- Years postgraduate training
- French language testing (OQLF)
- Medical Knowledge Assessment
- USMLE2 or ECFMG certificate
- Agreement covers 29 specialties for which the training is deemed equivalent
- If specialty – certification in France
- Actively working in France over past 2 years
- Link with l’Ordre des médecins de France

#### Evaluation Rotation
- 13 weeks of assessment
- Week 1 – Orientation – adaptation
- Assessment process/tools development by department(s) of assessment – vary by locations but align with PGT evaluation tools
- Evaluation tools used include:
  - Evaluation reports that cover
  - Direct observation
  - Clinical assessment skills
  - Communications with others

#### Adaptation Rotation with Evaluation
- 13 weeks of assessment
- Week 1 – Orientation – adaptation
- Assessment process/tools development by department(s) of assessment – vary by locations but align with PGT evaluation tools
- Evaluation tools used include:
  - Evaluation reports that cover
  - Direct observation
  - Clinical assessment skills
  - Communications with others

### Step | Description | Involved/Responsible
---|---|---
**Prerequisite** | MCECE or USMLE2 or ECFMG certificate; French language proficiency | Candidate
**Sponsorship** | Ministry of Health through RSQ screens candidate CVs and determines if there is a need within the health-care system for their specific skill set.  
- CVs circulated to health-care providers (i.e., hospitals, long-term care facilities) to determine a potential match  
- Health-care provider may interview the candidate and determine that they are still interested in the candidate.  
- Candidates who obtain a sponsor proceed to the MRA eligibility process for the route.  
**Note:** France MD candidates do not need to secure a sponsor prior to applying for a restrictive permit within jurisdiction. | RSQ (MoH), hospitals
<table>
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<tr>
<th>Step</th>
<th>Description</th>
<th>Involved/Responsible</th>
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</table>
| Eligibility                 | MRA reviews the eligibility requirements and determines, that if the candidate is successful through the assessment program, a restricted permit would be granted  <ul>  - Medical diploma  
   - Two years PGT (family medicine) or training in a specialty equivalent as to what is expected in Canada, and certification in the specialty  
   - French language proficiency  
</ul> | MRA                                   |
| Decision Making             | Candidates who meet the requirements and have a sponsor proceed in the process                                                                                                                                   | MRA                                   |
| Evaluation Period (or Adaptation Period with Evaluation for France MD & PGT candidates) | Assessment period (13 weeks)  
  - First week being an orientation/adaptation period  
  - Candidates are assessed by trained assessors within a CMQ-accredited training environment with faculty links  
  - Evaluation period does not occur in the sponsor hospital and the location of the evaluation is chosen based on similar environment to that of the sponsor organization  
For family medicine the assessment centres on three components:  
  - Hospitalization  
  - Patient follow-up  
  - Emergency  
Performance is assessed using tools available to PGT assessors and is assessed at the level expected of a resident upon completion of training  
For other specialities, the candidates may also be exposed to practice in the emergency room, operating room, outpatient clinic, hospital floors as well as participation in other activities (i.e., on-call activities) | Assessor in practice environment |
| Decision                    | The assessor provides CMQ with the evaluation report and a CMQ committee determines whether or not to issue the requested restrictive permit                                                                            | MRA                                   |
| Post-provisional licensure  | Within the jurisdiction, physicians under a restrictive license are linked to supervisory structures within the public health-care system; as such, supervision does occur while the physician practises independently                        | Organizations                         |
G.5.4 - Jurisdiction and Program:

**Ontario**
*Practice Ready Assessment Program (PRAP)*

**Purpose:**
To facilitate entry to practice for internationally educated health professionals. This includes assessing IMGs to ensure that they meet Canadian standards and providing orientation programs to training and practice in Canada.

**Program Highlights:**
- Point-in-time assessment offered through CEHPEA in the specific specialty for medical knowledge and clinical skills
- Over-time assessment (six-month assessment in supervised clinical setting in Ontario medical school)
- Orientation component

**Candidate assessment costs:**
- Candidate pays ~$2,700 for point-in-time assessment (in addition to $200 application fee) excluding the supervised clinical setting assessment provided by the medical school through funding by the province

**Process Overview**

**Credentialing & Approval**
- Medical degree & medical degree transcripts
- Experience in an independent professional practice within the last 5 years
- Letter from medical board, university or hospital confirming appointment
- Letter from local licensing authority confirming location of practice & duration of licence
- Specialty certificates (Board Certified)
- Proof of medical licensure
- Curriculum vitae
- Proof of Canadian legal status Assessments
- MCCEE
- MCCQE Part I

**Assessment**
- Medical knowledge
  - Specialty-specific written examinations
- Clinical Skills
  - Specialty-specific clinical examination

**Orientation**
- Process (Exams)

**Supervised Clinical Assessment (ON Medical School)**
- 6 month assessment in a supervised clinical setting at a medical school in the province of Ontario
- Ensure that candidate is ready for practice in an Ontario setting

**Assessment Outcome**
- Pass/Fail decision
  - Pass – proceed to interview for supervised clinical assessment

**Interview**
- With programs
- Selected or not

**Assessment Outcome**
- Pass/Fail decision for PRA
  - If fail, training opportunities (if applicable) are noted or candidate directed to PGY4-5

**Provisional Licence**

**Step Description**

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<th>Step</th>
<th>Description</th>
<th>Involved/Responsible</th>
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| **Prerequisite** | • MCCEE, MCCQE Part I  
                      • Applications only accepted for PRA route where there are identified IMG PRA positions available within the supervised clinical assessment environment, through the Council of Faculties of Medicine in Ontario | CEHPEA               |
| **Application** | Available positions (i.e., at least one position available) in a specific specialty area are posted | CEHPEA               |
| **Eligibility** | • Medical degree and board-certified in their home jurisdiction in which there is a specialty opening  
                      • Must have been in practice within the past five years  
                      • Evidence through letters from medical board, university, or hospital confirming appointment and from local licensing authority confirming location of practice and duration of licence | CEHPEA               |
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<th>Step</th>
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<tbody>
<tr>
<td>Decision Making</td>
<td>Those candidates who meet the eligibility criteria are accepted into the first stage of assessment</td>
<td>CEHPEA</td>
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</table>
| Stage 1 – Assessment | - Written & clinical examinations  
- Written examinations are either purchased from national or international testing organizations or created in-house using Ontario university professors  
- Clinical examinations are all created in-house using Ontario university professors                                                                 | CEHPEA               |
| Decision             | - Pass/fail decision made on point-in-time assessments; must pass both to be successful  
- If successful, eligible for an interview with the program directors who manage the supervised clinical assessment portion of the program, or their designates  
- Examination results are valid for three years  
- Summary report of written examination is available free of charge as part of results notification and includes a summary of examiner comments highlighting areas of weakness or unsatisfactory performance  
- If unsuccessful, candidate would need to re-apply in the next cycle when the specialty has an available position within Ontario medical schools (i.e., next iteration) | CEHPEA               |
| Interview            | Candidates are invited for interviews by program directors facilitated by CEHPEA                                                                                                                                 | University           |
| Stage 2 – Supervised Clinical Assessment | Six-month assessment in an Ontario medical school supervised clinical setting                                                                                                                                 | University           |
| Orientation          | Orientation to Training and Practice in Canada (OTPC) is offered by CEHPEA and is compulsory for candidates who have been accepted for specialty residency training program:  
- Three weeks in duration  
- Covers patient-centred interview process, documentation, collaboration and other aspects of the Canadian medical system prior to beginning residency | CEHPEA               |
| Decision             | Decision is made regarding candidate’s practice readiness                                                                                                                                                   | Program Director     |
| Candidate Outcome    | - If deemed practice-ready, may proceed to apply for registration with MRA  
- If deemed lacking in a particular area but seen to be trainable, a postgraduate training education experience is prescribed, with a maximum of two years of funding  
- If lacking overall, candidate dismissed from the program | CEHPEA               |
**G.5.5 - Jurisdiction and Program:**

**Manitoba**
**IMG Assessment for Conditional Licensure (IMGACL)**

**Purpose:**
To assess if a physician is practice-ready in family medicine who has completed medical school, a residency and who has practice experience in another country; established in 2007. Offers an accelerated route to licensure. Successful candidates receive conditional (provisional) licensure to begin independent practice.

**Focus:**
Family medicine – Rural

**Program Highlights:**
- Two-stage assessment pre-provisional licensure – point-in-time and over-time
- Multiple screening points (filters) throughout the process
- Candidate interviews in interested regions and sponsorship required during orientation and assessment
- Physicians must work in an underserviced area of Manitoba for a return of service
- If successful in assessment, candidate works in sponsoring region with the support of a mentor

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**Process Overview**

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<th>Step</th>
<th>Description</th>
<th>Involved/Responsible</th>
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</table>
| Program Eligibility | - MCCEE and MCCQE Part I, English language proficiency (TOEFL)  
- Be eligible for conditional (provisional) registration to the CPSM  
  - Be a graduate from an approved faculty of medicine  
  - Completed an assessment process acceptable to the College (once completed PRA)  
  - Passed the MCCEE and MCCQE Part I OR MCCQE Part II OR both (LMCC)  
  - Completed one of the following postgraduate clinical training requirements:  
    - Two years acceptable postgraduate clinical training  
    - One year acceptable postgraduate clinical training, at least three years practice experience in the preceding five-year period and completed an acceptable orientation program  
    - Be issued a certificate from the Minister of Health stating that the physician is required to provide medical services in a specified community or practice setting | IMG Program |
| Application | - Selection committee conducts preliminary screening of applications and provides a file score  
- Raking determined by quality of Canadian health-care experience, completion of MCCEE and MCCQE Part I, reference quality | IMG Program |
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<th>Description</th>
<th>Involved/Responsible</th>
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<tr>
<td><strong>Decision Making</strong></td>
<td>• Candidate must register with the PRCO who work with the candidate to facilitate employment</td>
<td>IMG Program</td>
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</tbody>
</table>
| **Conditional Registration** | • Selection committee short lists candidates based on the written application  
  • Candidates are invited to apply for conditional registration by the CPSM                                                                                                                          | CPSM                                  |
| **CAPE Assessment**     | Three-day assessment measuring the performance of an applicant against provincial standards for primary care physician practice:  
  • MCQs (150 questions for core knowledge), therapeutics assessment (17 short clinical scenarios)  
  • At least two structured oral interviews and up to four common primary care clinical scenarios discussing history, physical exam, differential diagnosis and management plans (including investigation, treatment, monitoring and follow-up)  
  • Clinical comprehensive encounter (nine standardized patients, 15 minutes each)   | Clinical Assessment Programs          |
| **Decision Making**     | Best score on written application and CAPE assessment proceed to the interview stage                                                                                                                                                     | IMG Selection Committee               |
| **Interview**           | • Standard in-person interview, using structured questions for about 30 minutes, includes questions related to professional experiences, but does not test medical knowledge  
  • Testing for effective communication skills, critical thinking skills, adaptability, collaborative skills and experience, understanding of Canadian/Manitoba health-care system | Resident Training Committee          |
| **Decision Making**     | Admission to the final stage of the program is based on the cumulative results  
  • Written application (10%), CAPE results (50%), interview (40%)                                                                                                                                                     | IMG Selection Committee               |
| **Sponsorship**         | • Once accepted in the final stage, candidates must obtain a sponsor in Manitoba and the sponsor may be a Manitoba Regional Health Authority, hospital or a private clinic  
  • Candidate is paid during the assessment and orientation period                                                                                                                                         | PRCO                                  |
| **Orientation**         | Mandatory, four-week orientation program designed to assist IMGs in achieving a timely integration into the system (runs twice per year):  
  • Overview of Canadian health-care system, role of physicians, patient-centred approach and team-based practice environments  
  • Explore the model that highlights the typical Canadian learning setting and differences IMGs may experience  
  • Training in patient-centred interviewing, social-cultural training and ethics                                                                                           | Faculty of medicine/PRCO/CPSM/RHAs    |
| **Clinical Assessment** | • Three four-week segments including eight weeks of primary care clinics and four weeks of emergency in rural Manitoba outside of the sponsoring RHA area  
  • Assessment may occur in different sites and each rotation is covered by a trained assessor  
  • Assessed by preceptor, patients, medical colleagues and co-workers using:  
    • Interim assessment evaluation report, mini-CEX  
    • Co-worker questionnaires, patient questionnaires, medical colleague questionnaires, self-assessment questionnaires  
  • Pass/fail determined by assessors or committee depending on the structure of the assessing clinic or hospital                                                                 | Assessors                              |
| **Decision Making**     | Final evaluation is provided by individual assessors or by committee, failure in one rotation results in dismissal from the program  
  • At successful completion of the three rotations, a letter of program completion is provided to CPSM                                                                                     | IMG Program                           |
**G.5.6 - Jurisdiction and Program:**

**Program Established in 1999.**

**Purpose:** To assess if a physician who has completed medical school, a residency and who has practice experience in another country, is practice ready in a specialty.

**Pre-Step Process Overview:**

<table>
<thead>
<tr>
<th>Program Highlights:</th>
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<tbody>
<tr>
<td>• Strong linkage to areas of need with upfront job offer before assessment begins</td>
</tr>
<tr>
<td>• Credentialing and interviews are used as pre-screening, program consists solely of over-time assessments</td>
</tr>
<tr>
<td>• Makes use of existing assessment infrastructure, similar to PGYS</td>
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<tr>
<td>• Varying lengths of clinical assessment depending on specialty area</td>
</tr>
</tbody>
</table>

**Process Overview:**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>Be eligible for conditional (provisional) registration by CPSM:</td>
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<tr>
<td>• Be a graduate from an approved faculty of medicine</td>
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</tr>
<tr>
<td>• Completed an assessment process acceptable to the College <em>(once completed PRA)</em></td>
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</tr>
<tr>
<td>• Passed the MCCEE</td>
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<tr>
<td>• Completed one of the following postgraduate clinical training requirements for practice in a specialty field:</td>
<td></td>
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<tr>
<td>• The highest qualification in a specialty field where the length of training is of equal duration to that required by RCPSC, which would entitle the physician to obtain a licence limited to the specialty training field</td>
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</tr>
<tr>
<td>• Two years acceptable postgraduate clinical training that would entitle the physician to obtain a licence limited to the specialty training field</td>
<td></td>
</tr>
<tr>
<td>• Be issued a certificate from the Minister of Health stating that the physician is required to provide medical services in a specified community or practice setting</td>
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<tr>
<td>• Receive confirmation of eligibility from CPSM</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Prerequisites</th>
<th>Program Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical diploma</td>
<td></td>
</tr>
<tr>
<td>• 2 years PGY OR</td>
<td></td>
</tr>
<tr>
<td>• Highest qualification in a specialty field where length of training = duration required by RCPSC</td>
<td></td>
</tr>
<tr>
<td>• Practice experience in an English-speaking environment</td>
<td></td>
</tr>
<tr>
<td>• TOEFL</td>
<td></td>
</tr>
<tr>
<td>• MCCEE with a preference if complete MCCQE Part I &amp; MCCQE Part II</td>
<td></td>
</tr>
<tr>
<td>• Confirmation of conditional registration eligibility</td>
<td></td>
</tr>
<tr>
<td>• Application for job screened in</td>
<td></td>
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<tr>
<td>• Skills (communication, critical thinking, collaboration)</td>
<td></td>
</tr>
<tr>
<td>• Adaptability</td>
<td></td>
</tr>
<tr>
<td>• Experience</td>
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<tr>
<td>• Job offer</td>
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<tr>
<td>• Final evaluation of clinical assessment</td>
<td></td>
</tr>
<tr>
<td>• Provisional Licence</td>
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</tbody>
</table>

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<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Involved/Responsible</th>
</tr>
</thead>
</table>
| Job Posting, Application & Sponsorship | • Available specialist positions posted through PRCO, candidate applies  
• Candidate CVs and scores reviewed by PRCO  
• If screened in, reviewed by Screening Panel (IMG Program, Department of Assessment, VP Medical from sponsoring RHA)  
• Short-listed candidates proceed through to interviews | PRCO                |
| Interview                | Interviewed by Screening Panel and PRCO representative                                                                                                                                             | PRCO                |
| Decision Making          | If successful, candidate is offered a job from a RHA or private clinic                                                                                                                               | RHA                 |
| Assessment               | • Conducted in university-affiliated hospitals that correspond to the physician’s area of specialty  
• Brings together assessing departments, CPSM and the IMG program  
  • Each department develops own evaluation criteria and determines the time frame required to assess the candidate  
  • Assessment periods range from three – twelve months  
• Where possible, evaluation occurs in a university hospital or clinic separate from the sponsor  
• Candidates evaluated at the level of a PGYS resident | Department of Assessment |
| Decision Making          | • Final evaluation of the candidate is through the evaluating department  
• Termination of an assessment can occur after a period of one month if the assessing department determines the candidate is clearly unsuitable  
• At successful completion of the rotations, a letter of program completion is provided to CPSM | IMG Program          |
### G.5.7 - Jurisdiction and Program:

<table>
<thead>
<tr>
<th>Saskatchewan Saskatchewan International Physician Practice Assessment (SIPPA)</th>
</tr>
</thead>
</table>

### Purpose:

To evaluate IMG physicians who may be ready for entry into family medicine with a view to recommend the candidate for provisional licensure, or not, to meet the urban and rural need for physicians in the jurisdiction.

### Focus:

Family Medicine – Rural and Urban

### Program Highlights:

- Offered three times per year:
  - Program elements occur pre-provisional licensure
  - Point-in-time assessment to qualify to proceed to a clinical field assessment
  - Over-time assessment through clinical field assessment
  - Orientation supports throughout assessment program
- Following a pilot review, the program is operational as of May 2012
- Currently, physicians from countries whose postgraduate training is fully recognized by the MRA require a six-week clinical field assessment; all others require 12 weeks

### Candidate assessment costs:

- No candidate assessment costs during pilot stage, candidate fees to be determined
- IMGs compensated throughout assessment period with an honorarium (i.e., ~$1,000/week) and receive accommodation

### Process Overview

#### Step A - Assessment

<table>
<thead>
<tr>
<th>Description</th>
<th>Involved/Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Knowledge</strong></td>
<td>MCQ (EPAK)</td>
</tr>
<tr>
<td><strong>Short answer</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Therapeutics</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Pre IMG Arrival**

- Applicant applies for positions & RHA selects potential physician
- Must have an offer to practice from an RHA
- Immigration process/ work permit & visa

**Sponsorship**

Candidates are recruited by health region or provincial recruitment agency through posting; RHA screens candidates based on currency of practice, scope of practice, etc.

**Eligibility**

- Be eligible for licensure with CPSS:
  - Have passed MCCEE
  - Have offer to practice from one of the RHAs and be prepared to participate in a two-year return of service agreement

**Assessment Outcome**

- Successful move to clinical field assessment
- Granted privileges of a medical resident

**Clinical Field Assessment**

- Occurs in a similar practice environment to which the physician will be practising, through the College of Medicine/RHA.
- Assesses communication skills, etc.

**Assessment Outcome**

- Remediation steps noted but no training offered

**Provisional Licence**

- Offered three times per year:
  - Program elements occur pre-provisional licensure
  - Point-in-time assessment to qualify to proceed to a clinical field assessment
  - Over-time assessment through clinical field assessment
  - Orientation supports throughout assessment program

- Following a pilot review, the program is operational as of May 2012
- Currently, physicians from countries whose postgraduate training is fully recognized by the MRA require a six-week clinical field assessment; all others require 12 weeks

### Step B - Clinical Field Assessment

- Orientation to health-care systems (i.e., roles of MRA)
- Orientation to clinical systems & examination processes

- Assessment Outcome
  - Remediation steps noted but no training offered

- Provisional Licence

---

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<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Involved/Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Immigration</strong></td>
<td>Program provides candidates with assistance to complete the immigration process (i.e., work permit/visa); work permits are 18 weeks in duration</td>
<td>Program</td>
</tr>
<tr>
<td><strong>Decision Making</strong></td>
<td>• Based on eligibility requirements being met, including the offer to practise, candidates may proceed through the assessment portion of the program; Unsuccessful candidates have a maximum of two attempts to apply to the program with one year in between application attempts</td>
<td>RHA/CPL at College of Medicine</td>
</tr>
<tr>
<td><strong>Orientation</strong></td>
<td>Centralized orientation spans 10-14 days: • Orientation to the community • Record keeping practices • Patient-centered care • Cultural issues • Learning and practice resources • Boundaries • SIPPA examinations</td>
<td>Program</td>
</tr>
<tr>
<td><strong>Step A – Assessment</strong></td>
<td>• Therapeutics and MCQ (EPAK) for medical knowledge • OSCE for clinical skills</td>
<td>University</td>
</tr>
<tr>
<td><strong>Decision</strong></td>
<td>• Third-party results analysis with pass/fail or successful/not successful decision • Successful candidates proceed to next stage of orientation • Unsuccessful candidates are assisted by the recruitment agency to return home</td>
<td>Third party</td>
</tr>
<tr>
<td><strong>Orientation</strong></td>
<td>Orientation is provided to the health-care system within jurisdiction</td>
<td>Program</td>
</tr>
<tr>
<td><strong>Step B Clinical Field Assessment</strong></td>
<td>• Eight-week field assessment occurs in community similar to the environment being recruited for • Placement based on availability of assessors who provide direct supervision and evaluation by physician assessors of actual patient interactions • First week is orientation-based in nature (no formal assessments occur during this time) • Remaining five or 11 weeks encompass a global review of practice to cover communication skills, information gathering, learning techniques, prescribing, case management, etc. • Five mini-CEX records of patient interactions per week (total of 25 or 55 assessments) • MSF (peers, colleagues, patients, self and supervisor participation) • In-training evaluation report for overall performance evaluation (including a FITER)</td>
<td>Clinical Setting</td>
</tr>
<tr>
<td><strong>Decision Making</strong></td>
<td>• Pass/fail or successful/unsuccessful decision based on psychometric analysis • If successful, educational licence ends and candidates are provided a provisional licence • If unsuccessful, candidates’ return home is facilitated by recruitment agency and must wait 12 months before reapplying</td>
<td>University</td>
</tr>
</tbody>
</table>
G.5.8 - Jurisdiction and Program:
Alberta Provincial Physician Assessment Program (PPAP)

Focus:
Family Medicine/Specialists – Rural/Remote and Urban

Purpose:
To determine whether applicants are ready to enter independent practice (for provisional licensure) in Alberta through assessment of applicants’ clinical knowledge and skills.

Program Highlights:
Offered throughout the year:
- Credentials review determines eligibility for a practice-based preliminary clinical assessment that occurs before the granting of an independent licence
- The program includes a supervised practice assessment component that occurs after the granting of an independent licence

Candidate assessment costs:
- No candidate assessment costs; sponsor organization pays for assessment (MRA program runs on a revenue neutral/cost recovery model)

Process Overview

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Involved/Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prerequisite</td>
<td>Program eligibility determined by provisional licensure requirements and includes the MCCEE</td>
<td>Candidate</td>
</tr>
<tr>
<td>Sponsorship</td>
<td>• Sponsorship open to individual members, clinics, health-care facilities, health authorities • Sponsor must have a position being recruited to fill and must cover assessment costs • Position identified and sponsor identifies IMG who may meet the position requirements</td>
<td>Clinics/ independent physicians/AHS</td>
</tr>
<tr>
<td>Eligibility</td>
<td>MRA reviews IMG to determine if the candidate meets requirements for full licensure; if not, determine if eligible for the PRA program and recommends which assessment parts require completion and estimated length of time • If candidate is eligible for licensure, they need to secure a sponsor • If sponsor is anyone other than AHS, AHS’ approval needs to be obtained (ties recruitment to privileging to need) • Proof of English language proficiency</td>
<td>MRA</td>
</tr>
<tr>
<td>Step</td>
<td>Description</td>
<td>Involved/Responsible</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Decision Making</td>
<td>Program begins when minimum requirements are met and sponsorship is confirmed</td>
<td>MRA</td>
</tr>
<tr>
<td>Orientation</td>
<td>Orientation is informally performed by sponsors with varying levels of occurrence and subjects covered</td>
<td>Sponsor</td>
</tr>
</tbody>
</table>
| Part A – Preliminary Clinical Assessment | - Two weeks to three months  
- Assessed by trained assessors but not in the location the applicant is being recruited to (where possible)  
- Candidate works in a clinical domain chosen based on what they are applying to do (i.e., rural family physician, general internist in a hospital, etc.)  
- Assessment is to determine if the applicant has the appropriate clinical knowledge, skills and professionalism to practise safely in independent practice and uses CanMEDS Roles  
- Length varies depending on how “known” the candidate’s credentials are  
- Family medicine assessment may span two weeks if from accredited family medicine program through CFPC (i.e., Australia, UK, Ireland) or otherwise up to three months  
- Specialists assessment lasts three months  
- Assessment can be ended early:  
  - If the candidate is not ready, with clear and significant gaps in knowledge (assessment is terminated)  
  - If the candidate is clearly ready  
- Using an electronic competency-based achievement system (ECBAS)  
- Assessor rates whether or not the candidate’s independent practice standard has been observed, inferred, across CanMEDS Roles and clinical problems, procedural skills, etc. | MRA/Assessor          |
| Decision                    | - Pass/fail decision made  
- If pass, candidate is given a provisional licence, subject to continuing in Part B of the program (monitoring/supervision post-provisional licensure) | MRA                  |
| Part B – Supervised Practice Assessment | - Supervisor assigned, mix of tools used  
- Assessment occurs in the location they are recruited to and supervision is less rigorous than Part A  
- Assessment runs for about three months and frequency of assessments is set according to the assessors discretion  
- No formal assessor training is provided; however, a manual is provided and assessment support is made available | MRA                  |
| Decision Making             | - Pass/fail decision  
- If failed, can reapply for entire process with evidence of appropriate remedial intervention | MRA                  |
# Appendix G.6 – Current Environment – PRA Process Comparison

**Green**
- Commonalities across elements
- Variation is perceived to be neutral
- Allows for regional variation

**Yellow**
- Some commonalities
- Adjustments perceived to be minor - medium

**Red**
- Significant variation
- Adjustments/changes perceived to be medium - high

<table>
<thead>
<tr>
<th>Comparison/Element</th>
<th>Family Medicine</th>
<th>Specialties</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NL-CSAT</td>
<td>NS-CAPP</td>
<td>QC</td>
</tr>
<tr>
<td>Program/Process</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician need being served</td>
<td>Rural</td>
<td>Rural</td>
<td>Rural</td>
</tr>
<tr>
<td>IMG pool/recruitment</td>
<td>Canada</td>
<td>Canada</td>
<td>Canada</td>
</tr>
<tr>
<td>Frequency of program</td>
<td>As needed</td>
<td>Once per year</td>
<td>As needed</td>
</tr>
<tr>
<td>Annual program capacity</td>
<td>16</td>
<td>38</td>
<td>Variable</td>
</tr>
<tr>
<td>Actual volume (2011)</td>
<td>18-22</td>
<td>36</td>
<td>28</td>
</tr>
<tr>
<td>Delivery involvement</td>
<td>Univ./MRA/ RHA</td>
<td>MRA/Univ.</td>
<td>MoH/MRA/ Univ.</td>
</tr>
<tr>
<td>Funding</td>
<td>Mixed incl. IMG</td>
<td>Mixed incl. IMG</td>
<td>Province/ MRA</td>
</tr>
</tbody>
</table>

¹ The breakdown between Family Medicine and Other Specialties is an estimated breakdown of the 154 assessments performed in Alberta as historical information was not captured to differentiate by specialty area.
<table>
<thead>
<tr>
<th>Comparison/Element</th>
<th>Family Medicine</th>
<th>Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NL-CSAT</td>
<td>NS-CAPP</td>
</tr>
<tr>
<td>Process Elements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program eligibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MD</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>PGT</td>
<td>1 year</td>
<td>1-2 yrs</td>
</tr>
<tr>
<td>Evidence of practice</td>
<td>3 yrs</td>
<td>1-2 yrs</td>
</tr>
<tr>
<td>Evidence of practice</td>
<td>3 yrs</td>
<td>1-2 yrs</td>
</tr>
<tr>
<td>MCCEE</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>MCCQE Part I</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Language proficiency*</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sponsorship</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Program selection**</td>
<td>Min. Eligibility Rqmts.</td>
<td>MRA</td>
</tr>
<tr>
<td>Other Rqmts.</td>
<td>RHA</td>
<td>RHA</td>
</tr>
<tr>
<td>Assessment Types</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Point-in-Time</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Over-Time</td>
<td>Yes, includes training, Yes, but post-provisional</td>
<td>Yes, Yes, Yes</td>
</tr>
<tr>
<td>Location</td>
<td>Community</td>
<td>Community</td>
</tr>
<tr>
<td>Decision Making***</td>
<td>Broad-based judgment, Broad-based judgment</td>
<td>Structured judgment, Structured judgment</td>
</tr>
<tr>
<td>Supports</td>
<td>Sponsorship</td>
<td>(up front)</td>
</tr>
<tr>
<td>Orientation</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Assessor Supports</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Assessor Training</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IMG Supports</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Assessment tools

#### Point-in-Time

<table>
<thead>
<tr>
<th>Medical knowledge</th>
<th>Family Medicine</th>
<th>Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MCQ</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>TPx</strong></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Clinical</strong></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>SOI</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>SPE</strong></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

#### Over-Time

<table>
<thead>
<tr>
<th>Length</th>
<th>25 wks</th>
<th>52 wks (post prov. lic.)</th>
<th>13 wks</th>
<th>12 wks</th>
<th>6-8 wks</th>
<th>2 wks – 3 mnths</th>
<th>13 wks</th>
<th>6 months</th>
<th>3-12 months</th>
<th>3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tools</strong></td>
<td>MSF/ Evaluation reports</td>
<td>MSF/ Practice audits</td>
<td>Evaluation reports</td>
<td>MSF/Mini-CEX/ Evaluation reports</td>
<td>MSF/Mini-CEX/ Evaluation reports</td>
<td>MSF/ Evaluation reports/CBD/ Chart reviews</td>
<td>Evaluation reports</td>
<td>Evaluation reports</td>
<td>MSF/Mini-CEX/ Evaluation reports</td>
<td>MSF/ Evaluation reports/CBD/Chart reviews</td>
</tr>
</tbody>
</table>

* Language proficiency assessments are part of CIC processes; however, process utilizes the results.
** Program selection is usually a collaborative activity taking into consideration the minimum eligibility requirements, screening tools used and/or application processes for physician need areas.
*** Structured judgment is generally used to indicate a "pass/fail" decision based on the assessments and defined standards whereas broad-based judgment is generally used to indicate a review of the assessments and discussion as to the decision.
APPENDIX H.1 – COMPLEMENTARY INITIATIVES OVERVIEW

<table>
<thead>
<tr>
<th>Complementary Initiative Highlight</th>
<th>In Context of NAC PRA</th>
<th>Involvement Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Foreign Qualifications Recognition Initiative</strong></td>
<td>Part of the Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications, this initiative seeks to improve foreign qualifications recognition systems in Canada, which include qualification assessment and recognition practices.</td>
<td>In context of NAC PRA, the initiative seeks to identify areas for potential collective action that will better inform IMGs' understanding of the licensure pathway process and optimize their progress through entry into practice.</td>
</tr>
<tr>
<td><strong>National Assessment Collaboration Practice Ready Assessment</strong></td>
<td>To implement (develop or adopt) and maintain a pan-Canadian assessment process to determine if an IMG is capable or not of entry into provisional practice.</td>
<td>The process designed and decision made must be acceptable to all MRAs to assure public safety and ensure the successful IMG’s mobility and portability.</td>
</tr>
<tr>
<td><strong>FMRAC Working Group on Registration</strong></td>
<td>To standardize, to the greatest extent possible, the various practices used by the provincial and territorial medical regulatory authorities for registration and licensure.</td>
<td>With the intention of achieving uniformity of purposes and procedures to facilitate labour mobility, it is within this future environment that NAC PRA is being envisioned.</td>
</tr>
<tr>
<td>Complementary Initiative Highlight</td>
<td>In Context of NAC PRA</td>
<td>Involvement Area</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>FMRAC Working Group on Assessment &amp; Supervision</strong></td>
<td>Activities related to moving from 13 approaches to a common national standard for pre-practice assessment, supervision in practice and final summative assessment of physicians leading to full licensure. Work is critical to accepting the NAC PRA pan-Canadian process.</td>
<td>Potential Steering Committee</td>
</tr>
<tr>
<td>To draft principles, acceptable methods and processes for assessment and supervision and final evaluation of physicians who do not hold a full, unrestricted licence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Manitoba Practice Assessment Program</strong></td>
<td>To perform an in-practice assessment for physicians moving from a provisional to full licence. This initiative falls within the framework of the FMRAC Working Group on Assessment and Supervision. Opportunity to ensure alignment of tools and look for avenues to collaborate within the assessment continuum.</td>
<td>Cooperate on tool selection; specifically, the process and tools used for in-practice assessment as this may be similar to the over-time assessment in context of PRA.</td>
</tr>
<tr>
<td>To develop a process to assess physicians in their practice settings to enable the College to make a decision about granting registration to these candidates; moving from a provisional to full licence, in cases where physicians have not yet achieved final certification for a variety of reasons.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Royal College Practice Eligible Route – Route B**                                                                                          | To certify physicians practising as specialists across Canada and licenced to do so under the MRAs. Opportunity to ensure alignment of tools and look for avenues to collaborate within the assessment continuum. | Input into competencies  
Cooperate on tool selection                                                                                                    |
| PER will provide an opportunity to have all physicians working as specialists to be measured against national standards. PER will attempt to remove the barrier of a certification examination for licensed specialists who have been competently practising their specialty for over five years. PER Route B is an alternate, but rigorous assessment of knowledge, skills and judgment through an in-practice assessment. |                                                                                                                                                                                                                       |                                                                                                                                                                     |
| **College of Family Physicians – Practice Eligible Route**                                                                                   | In-practice assessment tools, competencies demonstrated by family physicians and implementation approaches to be considered in context of NAC PRA. Opportunity to ensure alignment of assessment tools and explore the avenues to collaborate within the assessment continuum. | Input into competencies  
Cooperate on tool selection                                                                                                    |
<p>| CFPC’s exploration of the Practice Eligible Route for IMGs will provide the opportunity to have all physicians working as Family Medicine specialists obtain certification through an alternate pathway that does not require writing the CFPC certification examination. |                                                                                                                                                                                                                       |                                                                                                                                                                     |</p>
<table>
<thead>
<tr>
<th><strong>CMQ – Route to Specialist Certification</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CMQ’s Specialist Certification route is available to IMGs who have worked for a period of five or more years under a restricted permit.</td>
<td>Route to certification is not through examination rather based on the IMG’s time spent under five years of supervision through the restricted permit environment and a review of credentials and training related to his or her specialty. The format and scope of the point-in-time clinical inspection between CMGs and IMGs may be a useful framework from which to assess existing current PRA processes. Ultimately, differences in practice quality of IMGs who have been provisionally licensed under different programs may be a useful lens through which to benchmark existing programs.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Society of Rural Physicians of Canada</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Internally, the Society has informally discussed the need for assessment for rural environment practice. While discussions are currently at the “ideas” stage within the Society, the scope may include some form of practice ready assessment for rural environments.</td>
<td>The SRPC is interested in being involved in NAC PRA in the context of determining whether to explore assessment for rural environments and to provide input into the competencies to be assessed for rural environment practice (i.e., what makes the environment different, what are the competencies and requirements for family physicians and other specialists, etc.) In addition, there may be an opportunity to make use of the SRPC membership as a potential source of preceptor/assessor recruitment for community-based assessments in a rural context.</td>
<td>Input into competencies Network of rural physicians as potential preceptors</td>
</tr>
</tbody>
</table>
## Complementary Initiative

<table>
<thead>
<tr>
<th>Complementary Initiative</th>
<th>Foreign Qualifications Recognition – Entry into Practice Pathway</th>
<th>Owner</th>
<th>Health Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose:</strong></td>
<td>As part of the Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications, this initiative seeks to improve foreign qualifications recognition systems in Canada, which include qualification assessment and recognition practices. In context of NAC PRA, the initiative seeks to identify areas for potential collective action that will better inform IMGs’ understanding of the physician licensure pathway process and optimize their progress through entry into practice. Analysis and action plan development activities are conducted through the Physician Task Team, consisting of representatives from provincial/territorial governments and co-led by the Government of Alberta and Health Canada.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Scope:</strong></td>
<td>To aid IMGs to become licensed to practise medicine in Canada, the Foreign Qualifications Recognition initiative is undertaking stakeholder consultations to identify priority areas of action for the physician occupation. For this component, the areas span from point of information sharing about the full pathway to an IMG’s entry into practice and pre- and post-licensure and include assessment practices, training, orientation and workplace integration programs, etc. Analysis for the Entry into Practice Pathway is complemented by the work previously done for the Entry to Residency Pathway. Note: The FQR work does not go beyond the identification of priority action areas. Once areas have been identified, it is up to individual governments and organizations to review their partnerships, available funding and funding mechanisms to see what makes sense and what can be done on any of the action areas.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NAC Linkage:**
The practice ready assessment focus within NAC augments the information-gathering for the overall FQR initiative.

**Timeline:**

- 2012
  - Survey and analysis for entry to practice pathway
  - Stakeholder consultation(s)
  - Identification of priority action areas
- **End 2012**
  - Submission of Physician Task Team final report on priority action areas for full physician pathway
- **2013+**
  - Individual governments and organizations to review their partnerships, available funding and funding mechanisms to implement action areas

**Approach:**

- Survey of jurisdictional practices for entry into practice
- Consultation to identify focus areas
- Identify opportunities for action
- Prioritization

**Opportunities for Alignment:**

- NAC PRA environmental scan to identify other areas to FQR that are not “in scope” of assessment but may be components of the larger vision
- Review of FQR survey to identify common themes or potential conflicts of information

**Working Group Composition:**

- Emmy Mukasa, (Gov of AB, PTT Co-lead)
- David Jones (HC – PTT Co-lead)
- Patrick Yu (Gov of AB)
- Eileen May (Gov of MB)
- Angel De Paz (Gov of MB)
- Roseline Pelletier (Gov of NB)
- Jan Kutcher (Gov of NS)
- Stella Juma-Anderson (Gov of SK)
- Ingrid Kirby (Gov of SK)
- Liz Hong-Farrell (HC)
- Libby Posgate (ACHDHR)
- Beth McGinnis (ACHDHR)
- Anik Beaudry (CIC)
- Erin Wheal (CIC)
- Colin Kok (HRSDC)
- Nicole D’Avignon (HRSDC)
- Mark Roe (HRSDC)
- Kim Dalgleish (HRSDC)
<table>
<thead>
<tr>
<th>Complementary Initiative</th>
<th>NAC Practice Ready Assessment</th>
<th>Owner</th>
<th>National Assessment Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose:</strong></td>
<td>To implement and maintain a pan-Canadian assessment process to determine if an IMG is capable or not of entry into provisional practice. The process designed and decision made must be acceptable to all MRAs to assure public safety and ensure the successful IMG’s mobility and portability within Canada.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Scope:</strong></td>
<td>The scope of this initiative spans the design, development/adoption of a pan-Canadian process for PRA that includes the:</td>
<td></td>
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<tr>
<td></td>
<td>• Integration of this work within NAC structures</td>
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<td></td>
<td>• Completion of the analysis of existing IMG programs and exploration of the future state</td>
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<td></td>
<td>• Benchmarking on current programs and future model from a process, tool and eventually an outcome perspective</td>
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<tr>
<td></td>
<td>• Design of an acceptable pan-Canadian PRA process based on the scope and model envisioned</td>
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<tr>
<td></td>
<td>• Analysis and design including transition planning for the scope of the process</td>
<td></td>
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<tr>
<td></td>
<td>• Development or adoption of assessment tools, predictors, policies and training to support the process</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>• Implementation of the process and structures to support the ongoing monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NAC Linkage:</strong></td>
<td>NAC PRA links to the overall National Assessment Collaboration to streamline the evaluation process used for IMGs who seek to obtain a licence to practise medicine in Canada.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Timeline:</strong></td>
<td>![Timeline Diagram]</td>
<td></td>
<td>![Approach Diagram]</td>
</tr>
<tr>
<td><strong>Opportunities for Alignment:</strong></td>
<td>• NA</td>
<td></td>
<td>![Next Steps Diagram]</td>
</tr>
<tr>
<td><strong>Steering Committee Composition:</strong></td>
<td>![Committee Members]</td>
<td></td>
<td>![Committee Members]</td>
</tr>
<tr>
<td><strong>Approach:</strong></td>
<td>• Environmental scan of programs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Design a pan-Canadian process</td>
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<tr>
<td></td>
<td>• Develop or adopt standards for common use</td>
<td></td>
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<tr>
<td></td>
<td>• Implement and monitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Next Steps:</strong></td>
<td>• Present environmental scan to NAC³</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Obtain direction on next steps</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Steering Committee Composition:</strong></td>
<td>![Committee Members]</td>
<td></td>
<td>![Committee Members]</td>
</tr>
<tr>
<td><strong>2013</strong></td>
<td>![2013 Process]</td>
<td></td>
<td>![2013 Process]</td>
</tr>
</tbody>
</table>

³: Please refer to the actual document for the most accurate timeline and approach details.
### Complementary Initiative

<table>
<thead>
<tr>
<th>Working Group on Registration</th>
<th>Owner</th>
<th>FMRAC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose:</strong></td>
<td>To standardize the various practices used by the provincial and territorial medical regulatory authorities for registration and licensure.</td>
<td></td>
</tr>
<tr>
<td><strong>Scope:</strong></td>
<td>To define and agree to standards for medical registration in Canada with participation from the 13 provincial and territorial medical regulatory authorities.</td>
<td></td>
</tr>
<tr>
<td><strong>NAC Linkage:</strong></td>
<td>As the initiative achieved agreement on the uniformity of purposes and procedures for licensing in an effort to facilitate labour mobility, NAC PRA is being envisioned within this agreement</td>
<td></td>
</tr>
<tr>
<td><strong>Timeline:</strong></td>
<td>2012 onwards</td>
<td>Approach:</td>
</tr>
<tr>
<td><strong>Opportunities for Alignment:</strong></td>
<td>NAC PRA processes will align with the standards.</td>
<td>Next Steps:</td>
</tr>
<tr>
<td><strong>Supplemental Information:</strong></td>
<td>FMRAC – Agreement on Standards for Medical Registration in Canada – November 2011</td>
<td></td>
</tr>
</tbody>
</table>

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### Standard for the Issuance of a Provisional License

<table>
<thead>
<tr>
<th>General Practitioners/Family Physicians</th>
<th>Other Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MD Degree (WDMS 2000 or IMED) or Doctor of Osteopathic Medicine (U.S.); and</td>
<td>1. MD Degree (WDMS 2000 or IMED) or Doctor of Osteopathic Medicine (U.S.); and</td>
</tr>
<tr>
<td>2. At minimum, the MCCEE, preferably the MCCQE Part I</td>
<td>2. MCCEE or MCCQE Part I</td>
</tr>
<tr>
<td>N.B.: this does not apply to physicians with academic appointments (see Exemptions); and</td>
<td>N.B.: this does not apply to physicians with academic appointments (see Exemptions); and</td>
</tr>
<tr>
<td>3. a) Satisfactory completion of a nationally approved, two-year, discipline-appropriate postgraduate training program with certification of satisfactory completion of training and of registration/recognition as a general practitioner/family physician within the jurisdiction; or</td>
<td>3. (a) Satisfactory completion of at least four years of discipline-specific postgraduate training in a program accredited by a national postgraduate training authority; and</td>
</tr>
<tr>
<td>b) Satisfactory completion of a postgraduate training program recognized by the College of Family Physicians of Canada; or</td>
<td>(b) A verifiable document of completion of specialist training by the national postgraduate training authority, referred to above; or</td>
</tr>
<tr>
<td>c) Satisfactory completion of at least one year of discipline-specific postgraduate training and three years of discipline-specific time in independent practice outside of Canada; and</td>
<td>If a verifiable document is not issued or available, then has been recognized as a specialist authorized to practise independently in the country where the postgraduate training was completed; and</td>
</tr>
<tr>
<td>4. A competency-based, pre-practice assessment in Canada (to be defined by the Working Group on Assessment and Supervision).</td>
<td>4. A competency-based, pre-practice assessment in Canada (to be defined by the Working Group on Assessment and Supervision).</td>
</tr>
<tr>
<td>Complementary Initiative</td>
<td>Working Group on Assessment and Supervision</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Purpose:</td>
<td>To draft principles, acceptable methods and processes for assessment and supervision and final evaluation of physicians who do not hold a full, unrestricted licence</td>
</tr>
<tr>
<td>Scope:</td>
<td>Activities related to moving from 13 approaches to a common, national standard for pre-practice assessment, supervision in practice and final summative assessment of physicians leading to full licensure. The objective of the pre-practice assessment is to determine if the candidate has the necessary knowledge, clinical skills and professional characteristics to practise medicine safely in Canada under supervision.</td>
</tr>
<tr>
<td>NAC Linkage:</td>
<td>From a NAC PRA perspective; the focus for alignment with this initiative is in the principles, acceptable methods and processes for pre-practice assessment:</td>
</tr>
<tr>
<td>Timeline:</td>
<td></td>
</tr>
<tr>
<td>Opportunities for Alignment:</td>
<td></td>
</tr>
<tr>
<td>Working Group Composition:</td>
<td></td>
</tr>
<tr>
<td>Supplemental Information:</td>
<td>FMRAC’s Working Group on Assessment and Supervision – “A Framework for Assessment and Supervision of General/Family Physicians for Provisional and Full Licensure – DRAFT” April 28 2010. The general framework was used to explore the future pan-Canadian process throughout the environmental scan.</td>
</tr>
</tbody>
</table>
### Complementary Initiative

<table>
<thead>
<tr>
<th>Manitoba Practice Assessment Program</th>
<th>Owner</th>
<th>CPSM &amp; University of Manitoba</th>
</tr>
</thead>
</table>

**Purpose:**

To develop a process to assess physicians in their practice settings to enable the College to make a decision about granting registration to these candidates, moving from a provisional licence to a full licence, in cases where physicians have not yet achieved final certification for a variety of reasons. The assessment process will be comprehensive, transparent and tailored to the specialty and practice setting.

Eligibility for the program will include physicians who:

- Have attempted either Part I and/or Part II of the MCCQE and/or have attempted to become certified by CFPC or RCPSC; and
- Are currently practising in Manitoba on the Provisional Register, and
- Have been in active practice in Manitoba for a period of two years (note: A review of the self-assessment reports must determine that sufficient data exist about the physician’s practice to complete an assessment).

**Scope:**

The scope of the work being undertaken includes the design, development, implementation, use and monitoring of:

- Overall MPAP purpose, goals and process
- Assessment components (self-assessment, surveys, on-site visit, interviews)
- Assessor selection process, assessor training and guides (to ensure consistency of approaches used across assessors on assessments, completion of assessment tools and report writing)

This initiative is supported by research activities in the following areas:

- Validation of the Manitoba Practice Assessment Program – May 2011 to December 2011
- A Pan-Canadian Inventory of Physician Assessment, Enhancement and Remediation Activities – May 2011 to December 2011
- Weighting CanMEDS Role and Competencies - October 2010 to January 2011

**NAC Linkage:**

The in-practice assessment has been designed using a blueprint based on the CanMEDS Roles and enabling competencies from both CFPC and RCPSC. For the assessment of practising physicians, it is highly appropriate as it reflects many aspects of professional life and performance. Specialty-specific competencies are identified by CFPC and RCPSC.

**Timeline:**

- Research
- Design work
- Program expected start date
- Spring 2012

**Approach:**

- Assessment design, eligibility determination
- Define MPAP assessment process/final report process (and appeals handling)
- Blueprint based on CanMEDS Roles/enabling competencies
- Implementation

**Opportunities for Alignment:**

- Process followed, assessment tools used
- Training of assessors/approach and scope

**Next Steps:**

- Observe and look for opportunities for schedule alignments (i.e., as inputs into NAC PRA or concurrent activities)

**Working Group Composition:**

- Marilyn Singer, Program Director
- Jose Francois, Associate Dean, CPD
- Jillian Horton, Assistant Director
- Brenda Stutsky, Program Advisor
- Robert Renaud, Psychometrician

**Supplemental Information:**

- Manitoba Practice Assessment Program Overview
  
### Practice Eligibility Route to Certification for Specialists (PER)

#### Purpose:
To certify physicians practising as specialists across Canada and licensed to do so under the MRAs. PER will provide an opportunity to have all physicians working as specialists to be measured against national standards. Currently, each jurisdiction has its own form of assessment with no set pan-Canadian standard. PER attempts to remove the barrier of a certification examination for licensed specialists who have been competently practising within their specialty for over five years. PER Route B is an alternate, but rigorous assessment of knowledge, skills and judgment through an in-practice assessment.

#### Scope:
The scope of PER includes the implementation of two types of assessment routes: Route A — current format specialty certification or Route B — context-based scope-of-practice examination/assessment conducted by peer assessors. The initial focus is on establishing what to assess to determine competency. The selection of the appropriate tools will follow.

#### Proposed Process Overview:

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Preliminary Application&lt;br&gt;Submit application based on PGT eligibility with a focus on scope of practice to ensure the candidate meets specialty committee requirements for entry into PER&lt;br&gt;Submit scope of practice document reviewed by a physician within RCPSC to determine if the applicant should proceed to the next step&lt;br&gt;Submit continuing professional development plan (MOC PER) that includes the physician self-assessment (scope of practice, self-identified gaps) - reviewed by a physician within the College &amp; if approved, the physician would register for MOC PER</td>
</tr>
<tr>
<td>2</td>
<td>Step 1 – Maintenance of Certification Component (MOC PER)&lt;br&gt;Two year commitment&lt;br&gt;Component tailored through MOC PER learning &amp; activities plan&lt;br&gt;Instrument of MOC PER &amp; A plans&lt;br&gt;Applicants must complete one full year of MOC PER before accessing Step 2 &amp; 3&lt;br&gt;PER Eligibility&lt;br&gt;Minimum of 5 years of active specialist practice, but 2 of which in Canada&lt;br&gt;Completion &amp; verification of all PGT requirements of the jurisdiction in which the training occurred &amp; have eligibility to practice&lt;br&gt;Minimum 48 months of PGT at least 36 of which must be directly related to the specialty&lt;br&gt;Proof of medical licence &amp; a confirmed Certificate of Professional Standing from the NRA (Canadian practice jurisdiction)</td>
</tr>
<tr>
<td>3</td>
<td>Step 2 – Credentials Route&lt;br&gt;Route A (if available)&lt;br&gt;Existing RCPSC certification examination&lt;br&gt;Route B (Practice-based assessment if available)&lt;br&gt;Written examination of fundamental knowledge of the specialty&lt;br&gt;Training assessors&lt;br&gt;In-practice structured oral examinations&lt;br&gt;Direct observation of practice&lt;br&gt;In-practice short-stimulated recall and/or chart reviews&lt;br&gt;Review of practice profiles &amp; outcome data&lt;br&gt;</td>
</tr>
<tr>
<td>4</td>
<td>Step 3 – Examination/Assessment Component&lt;br&gt;Route A (if available)&lt;br&gt;Existing RCPSC certification examination&lt;br&gt;Route B (Practice-based assessment if available)&lt;br&gt;Written examination of fundamental knowledge of the specialty&lt;br&gt;Training assessors&lt;br&gt;In-practice structured oral examinations&lt;br&gt;Direct observation of practice&lt;br&gt;In-practice short-stimulated recall and/or chart reviews&lt;br&gt;Review of practice profiles &amp; outcome data&lt;br&gt;</td>
</tr>
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</table>

#### Description:
The PER route establishes the eligibility for the stream to the assessment tools used to enable a Certification decision. The PER assessment of specialties includes three components:
- Individualized continuing professional development (CPD) plan – Maintenance of Certification Component (MOC PER)
- Credentials review and confirmation of eligibility criteria (i.e., source verification of PGT, current scope of practice review including feedback and multisource feedback from patients, colleagues and co-workers)
- Assessment
  - Route A – current format specialty certification
  - Route B – under development - context-based scope-of-practice assessment/examination conducted by peer assessors. Examples of tools being considered include:
    - Direct observation of care
    - Structured oral assessment based on practice and/or standardized cases
    - Chart-stimulated review and examination
    - Practice statistics and other performance indicators review
    - RCPSC validated test material

#### NAC Linkage:
The practice-based examination and assessment envisioned by the Practice Eligibility Route to Certification for Specialists Route B provide an opportunity to explore the competencies required for specialists and the assessment tools being proposed for use. Exploration as to the potential supporting infrastructure (resources, tools, etc.) required to deliver the alternate route should also be considered as there may be efficiencies of scale and maintenance to be gained.
### Complementary Initiative

**Practice Eligibility Route to Certification for Specialists (PER)**

<table>
<thead>
<tr>
<th>Timeline:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spring 2012</td>
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</tbody>
</table>

#### Opportunities for Alignment:
- Approach used to consult and define requirements for the assessment
- Assessment tools

#### Next Steps:
- Inform RCPSC of the NAC PRA initiative
- Explore opportunities to investigate assessment tools being proposed

#### Working Group Composition:
- Dr. Paul Bernstein - Obstetrics and Gynecology
- Dr. John Bohnen - General Surgery
- Dr. Paul Dagg - Psychiatry
- Dr. Moyez Ladhani - Pediatrics
- Dr. Grant Stoneham - Diagnostic Radiology
- Dr. Jeffrey Schaefer - Internal Medicine
- Dr. Michael Sullivan - Anesthesiology
- Dr. Robert Maudsley – Chair; Royal College/OE Associate Director
- Dr. Ken Harris - Royal College/OE Director
- Dr. Gary Cole - Royal College/OE Senior Researcher/Developer
- Emily Stephenson - Royal College/Manager, Credentials Unit, OE
- MRA Working Group (Note: one meeting held in early 2011, group to be revitalized winter/spring 2012)

#### Supplemental Information:
- The Practice Eligibility Route to Certification for Specialists (PER) November 2011
- Practice Eligibility Route to Certification – Frequently Asked Questions (FAQ)
- Guide – Practice Eligibility Route to Certification for Specialist – Overview and Application Forms – October 2011

### Approach:
- Determine competencies of a practising specialist
- Identify potential tools for assessment
- PER Route B
  - Pilot
  - Review for improvements and refinement opportunities
### Purpose:
Eligibility for Certification in family medicine is granted by the CFPC to those members who have either completed approved residency training in family medicine or become eligible for certification through a combination of approved training and practice experience. Once eligible, individuals may be granted certification either by successfully completing the certification examination in family medicine or through an alternate pathway. An alternate pathway currently offered by CFPC is the Alternative Route to Certification (ARC) and the application window ends in December 2012. ARC was implemented as a time-limited alternate pathway to certification and did not focus on an evaluation component. In addition, CFPC recognizes international credentials through accreditation and will continue to do so. There is a recognition that a Practice Eligible Route for Certification for primarily IMGs is required going forward.

### Scope:
With the ARC window closing, CFPC is exploring the practice eligible route for physicians currently licensed to practise in a Canadian jurisdiction. In context of NAC PRA, CFPC would explore an alternate to certification examinations for IMGs who have been granted a provisional licence; it is envisioned that an assessment protocol would be implemented in 2014.

The scope of the work includes exploring options based on requirements and best practices, design and development of the policies, tools and infrastructure required, as well as implementation and monitoring.

### Proposed Process Overview:

#### Step 1 – Practice Eligible Route for Certification

To be determined, core tenets would likely remain for candidates & are noted as follows:
- Possess a licence in good standing to practise family medicine independently in a province or territory of Canada or elsewhere
- Completed 12 months of relevant PGT
- Completed a minimum of 5 years of full-time, active family practice prior to application date
- Be in continuous, full-time active family practice for a minimum period of 2 years immediately preceding application date
- Remain in continuous full-time, active practice in Canada & maintain their licensure
- Provide references from two colleagues (known at least 2 years) who are licensed & in good standing in the same jurisdiction as the applicant

#### Step 2 – Examination Assessment

**Option A**
- CFPC certification examination

**Option B**
- Continuing Professional Development to ensure a learning culture & provide the candidate with learning benefits
  - In practice assessment
  - Chart audits supported by standard setting for what charts should look like compared to norms to identify outliers
  - Physician evaluations & observed care
  - Chart-stimulated recall against protocols
  - Formal orals – structured case discussions
  - Mini-pearl (self-audit, reflection) with assessment components
  - Review of clinical questions arising from patient encounters
  - Self-directed evidence-based practice assessments
  - Communications survey – matched questionnaires (patient & physician generated with third party analysis)

### Description:
Eligibility for the practice eligible route to family medicine certification would be reviewed in context of the framework envisioned through the FMRAC Working Group on Assessment and Supervision; however, core tenets would likely remain for candidates and are noted as follows:
- Possess a licence in good standing to practise family medicine independently in a province or territory of Canada or elsewhere
- Completed 12 months of relevant postgraduate medical training
- Completed a minimum of five years of full-time active family practice prior to application date and be in continuous, full-time, active family practice for a minimum period of two years immediately preceding application date
- Remain in continuous, full-time, active practice in Canada and maintain their licensure
- Provide references from two colleagues (known at least two years) who are licensed and in good standing in the same jurisdiction as the applicant
  - At least one letter of support must be from a member of the CFPC who holds certification in family medicine

While the options exploration is still in the planning stages, initial thoughts as to the in-practice assessment scope could include the following elements:
- CPD to ensure a learning culture and provide the candidate with learning benefits
- In-practice assessment such as
  - Chart audits supported by standard setting for what charts should look like compared to norms to identify outliers
<table>
<thead>
<tr>
<th>Complementary Initiative</th>
<th>Practising Physician Eligibility Route for Family Medicine – Practice Based Assessment</th>
<th>Owner</th>
<th>CFPC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Physician evaluations and observed care</td>
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<td>• Chart stimulated recall against protocols</td>
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<td></td>
<td>• Self-directed evidence-based practice assessments</td>
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<tr>
<td></td>
<td>• Communications survey – matched questionnaires (patient and physician generated with third-party analysis)</td>
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</tbody>
</table>

**NAC Linkage:** While practice-eligible candidates for this route for certification in family medicine are practising as physicians (i.e., with provisional or full licence), the tools and assessments used and the principles and method/approach to assessment may be considered in context of the NAC PRA “Observed (evaluated) In-Practice Clinical Assessment”. As the focus for many jurisdictions is the assessment for family medicine serving rural communities, efforts should be aligned.

**Timeline:**

<table>
<thead>
<tr>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning</td>
<td>Design and development of tools and supporting infrastructure</td>
<td>Practice eligible route for IMGs implemented</td>
</tr>
<tr>
<td>Options exploration</td>
<td>Policies</td>
<td>Monitoring and continuous improvement</td>
</tr>
<tr>
<td>Requirements and best practices consultation</td>
<td>Tasks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supporting infrastructure</td>
<td></td>
</tr>
</tbody>
</table>

**Approach:**

- Options exploration based on Family Medicine Certificant requirements and best practices
- Alignment/collaboration with other assessments (i.e., MRA provisional licensure to full licensure supervised practice and summative assessment steps)
- Design, development and implementation

**Opportunities for Alignment:**

- Partnering in assessment research, development and supporting tools (i.e., assessor training)
- Consultation/collaboration in the family medicine competencies to be demonstrated for provisional licensure and options for point-in-time and over-time (observation-based) assessments

**Next Steps:**

- Once direction is received as to the scope of the pan-Canadian process and initial focus areas, planning of activities should be shared to determine if alignment or sharing of resources is feasible

**Working Group Composition:**

- To be defined

**Supplemental Information:**

- NA
### Complementary Initiative

<table>
<thead>
<tr>
<th>CMQ Route to Specialist Certification</th>
<th>Owner</th>
<th>CMQ</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose:</strong> To provide an alternate path to certification and full licensure that does not require certification through examination.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Description:</strong> CMQ’s specialist certification route is available to IMGs who have worked for a period of five or more years under a restricted permit. To note, conversion of a restrictive permit (provisional licence) to a full permit after only one year of restrictive permit practice can only be done through certification examinations. &lt;br&gt; &lt;br&gt; The route to specialist certification after five or more years under a restricted permit is not through examination, but rather is based on applicants’ time spent under five years of supervision through the restricted permit environment and their training program and postgraduate training duration and content. &lt;br&gt; &lt;br&gt; An in-depth review of credentials and training related to their non-certified university training program and postgraduate training (in duration and content) is performed to determine if the program and training are equivalent to that required in Québec for family medicine or another specialty. The applicant’s program and training are assessed against RCPSC and CFPC training program elements.</td>
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<tr>
<td><strong>NAC Linkage:</strong> A professional inspection (peer review) was performed to assess the quality of the practice of IMGs with a restrictive permit. As an outcome from the assessment program, restrictive permit holders were globally deemed as competent as full permit holders. It was decided that no further assessment would be required as practice quality appeared to be sufficient. &lt;br&gt; &lt;br&gt; The format and scope of the inspection may be a useful framework from which to assess existing current PRA programs/processes to determine if there are differences in practice quality of IMGs who have been provisionally licensed under different programs.</td>
<td></td>
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</table>

### Complementary Initiative

<table>
<thead>
<tr>
<th>Rural Physician Assessment</th>
<th>Owner</th>
<th>Society of Rural Physicians of Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose:</strong> The Society of Rural Physicians of Canada (SRPC) is the national voice of Canadian rural physicians. The SRPC’s mission is to provide leadership for rural physicians and to promote sustainable conditions and equitable health care for rural communities. &lt;br&gt; &lt;br&gt; SRPC performs a wide variety of functions such as developing and advocating health delivery mechanisms, supporting rural doctors and communities in crisis, promoting and delivering continuing rural medical education, encouraging and facilitating research into rural health issues and fostering communication among rural physicians and other groups with an interest in rural health care.</td>
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<td><strong>Scope:</strong> Internally, the Society has informally discussed the need for assessment for rural environment practice. While discussions are currently at the “ideas” stage within the Society, the scope may include some form of practice ready assessment for rural environments.</td>
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<tr>
<td><strong>NAC Linkage:</strong> The SRPC is interested in being involved in NAC PRA in the context of determining whether to explore assessment for rural environments and to provide input into the competencies to be assessed for rural environment practice (i.e., what makes the environment different, what are the competencies and requirements for family physicians and other specialists, etc.) &lt;br&gt; &lt;br&gt; In addition, there may be an opportunity to make use of the SRPC membership as a potential source of preceptor/assessor recruitment for community-based assessments in a rural context.</td>
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APPENDIX I – FUTURE MODEL– PROCESS EXPECTATIONS ALIGNMENT

Practice Ready Assessment for Provisional Licensure – Aligned Models

- [Diagram of Practice Ready Assessment for Provisional Licensure – Aligned Models]

- [Table of Practice Ready Assessment for Provisional Licensure – Aligned Models]

- [Textual description of Practice Ready Assessment for Provisional Licensure – Aligned Models]

- [List of Key Points for Practice Ready Assessment for Provisional Licensure – Aligned Models]

- [Important Considerations for Practice Ready Assessment for Provisional Licensure – Aligned Models]

- [Conclusion of Practice Ready Assessment for Provisional Licensure – Aligned Models]
APPENDIX J – FUTURE MODEL– PRA PATHWAY SCREENING & ASSESSMENT FILTER

Eligible

Practice Ready Route

Sponsorship

Experience

Credentials

Screening assessments (main criteria)

Orientation

Point-in-Time Assessment

Over-Time Assessment

Common toolkit

Trained assessors

In similar context but not within sponsor environment

PRA Decision

Provisional Licensure

IMG PGT not in Canada and/or has practised outside of Canada

Standard decision & appeals process
APPENDIX K – FUTURE MODEL – POTENTIAL APPROACH

Plan

- Scope
- Focus area
- Approach
- Governance

Design Framework

- Common minimal standards
- Competency
- Eligibility
- Point-in-Time assessment
- Over-Time assessment
- Outcome/decisions
- Areas of flexibility/guidelines

Decide

- Research evidence based
- Infrastructure/support required
- Common policy/processes
- Coordination requirements
- Approach to implementation

Implement