Hearing on the Impact of Occupational Licensing on Upward Mobility and Opportunities for Entrepreneurship and Innovation for Californians.

Culver City Mike Balkman City Council Chambers

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Thank you Chairman Nava and members of the Little Hoover Commission. My name is José Ramón Fernández-Peña. I am the founder and director of the Welcome Back Initiative, and the associate chair of the Department of Health Education at San Francisco State University. I am also representing IMPRINT, a national coalition of agencies working on immigrant professional integration. And, I am a foreign medical graduate. Thank you for the invitation to speak on this important topic.

My testimony will focus on the impact that the State's occupational licensing processes have on immigrant health professionals. What I will share with you today is based on the experience we have accrued over the past 15 years working with immigrant health professionals.

Background

In 2002 the Institute of Medicine first reported and later on the Sullivan Commission and others confirmed that the lack of diversity in the health workforce was an important contributing factor to racial and ethnic health disparities. This lack of ethnic, cultural, and linguistic parity between the health workforce and the population it serves is strikingly apparent in California, where for example, 37% of the population is Latino and only five percent of the doctors, eight percent of the nurses, and seven percent of the dentists are Latinos.

In addition to this problem, California faces serious shortages in the health workforce along with an insidious mal-distribution of the health workforce. The California Public Policy Institute projects that our state will need 500,000 new health workers by 2020. These projected shortages are already apparent in the areas of mental health, oral health, and in the number of laboratory technicians, and pharmacists to name a few. In regards to primary care, only 16 of California's 58 counties have the minimum suggested rate of 60-80 primary care providers per 100,000. Last, but certainly not least, the Association of Schools of Public Health predicts a deficit of 250,000 public health workers by 2020.

The rich diversity of the state is becoming more and more apparent among the fastest growing segment of the population: seniors 65 and over. It is estimated that by 2025 the number of Asians over 65 will increase by 65% and the number of Latinos over 65

will increase by 85%. In total, 48% of the seniors in California will be non-white by 2025.

Since the implementation of the Affordable Care Act (ACA), millions of California residents now have some form health insurance. And many of those who are not eligible for ACA insurance may have some form of coverage through the "Healthy California" program. This has significantly increased access to health services across the state.

As California and the US face this situation, the Migration Policy Institute estimates there are 1,700,000 foreign-born, college-educated California residents. Of these, over 400,000 are working in low-skilled jobs or are unemployed. Many of these are presumed to have been health professionals in their countries of origin.

The Welcome Back Initiative

The Welcome Back Initiative was founded in 2001 in partnership between San Francisco State University and City College of San Francisco with the intent of connecting the un-tapped pool of immigrant health professionals residing in California and the need for a health workforce that better reflects the linguistic and cultural diversity of our State.

In the process of developing the program, my staff and I spent a significant amount of time in Sacramento meeting with the leadership of all the health professions licensing boards to understand the licensing requirements for each profession in order to effectively convey this information to our participants. Ensuring that our participants meet the standards for licensure has been a top priority for our program.

Since then, the Welcome Back Initiative (WBI) has grown tremendously and currently includes 11 centers in 10 states, from California to Maine. Together, the centers have identified over 14,000 foreign-trained health professionals (FTHPs) -primarily physicians, nurses and dentists- from 167 countries. Seventy-two percent are women, and 66% were not working in the health sector when we meet them for the first time. Typically, those working in the health sector are grossly under-employed, (for example physicians working as medical assistants or nurses working as certified nursing assistants). Half of them have been in the US less than three years. California is home to 11,800 of these individuals.

The WBI model of service is a highly individualized approach where we work with each participant to assess their personal, educational, and professional experience in order to be able to effectively guide them through the steps needed to enter the US health workforce. In addition, the WBI has developed curricula specifically tailored to this population: an accelerated, health-focused English as a Second Language curriculum ("The English Health Train"), and a course entitled "Introduction to the US Health

System", which was developed to familiarize our participants with our rather complex and unique system.

To date, more than 2,000 participants have found employment in the health sector for the first time (1,500 in California), 800 have been able to move up their career ladder (560 in California), and 130 physicians have secured residency training slots (104 in California). Thousands more are actively engaged with our centers and moving forward. On average, their income increases by 255% from intake to discharge from our program.

Overview of the occupational licensing-related challenges faced by foreign-trained health professionals when seeking employment in California.

In addition to the individual-level barriers FTHPs face as they attempt to re-enter the health workforce (e.g. fluency in English, lack of time to redress educational deficiencies, etc.), there are three specific examples that, in our opinion, deserve a second look:

- A foreign-trained physician, regardless of his or her specialty or years of practice may not seek licensure in California as a physician assistant unless he or she "has completed an approved physician assistant training program".

- A foreign trained dentist may not seek licensure in California until he or she completes a two-year international dentist program with an average cost of $150,000.

- A foreign trained dentist may not seek licensure in California as a dental hygienist unless he or she "graduated from a program which has a minimum of two academic years of dental hygiene curriculum provided by a college or institution of higher education, the program of which is accredited by a national agency recognized by the United States Department of Education and/or an appropriate national voluntary agency".

In these three situations, we are failing to build on the educational and professional experience of foreign trained health professionals. In the absence of concrete evidence that would suggest that the creation of accelerated or advance-standing programs would in any way jeopardize patients' health, the rationale behind these provisions seems unreasonable.

The opportunity

Many foreign-trained immigrants living in the U.S. have backgrounds in high growth sectors such as health, finance, accounting, IT, engineering, management, and other fields. But, they need assistance finding their way back to their respective fields due to cultural, language and systemic barriers, as well as the challenges they face transferring

their professional certifications, academic credentials and training. Consequently, many foreign-trained immigrants are either underemployed or unemployed in the U.S. This "waste" of human capital is referred to as "brain waste."

Against this backdrop, U.S. employers report either a loss of productivity, a loss of revenue, and/or difficulty expanding their business because they are unable to fill key, skilled positions. In the specific case of the health sector, it is a lost opportunity to fill current and projected vacancies and to increase the cultural and linguistic diversity of the sector.

These three examples illustrate opportunities to capitalize on the experience of foreign trained health professionals:

Upon validation of their degree, foreign trained doctors may take the US Medical Licensure Exam (USMLE). When they pass these exams (all US graduates also take these exams), they may apply to residency training programs. The average cost of medical school in the US ranges between $197,192 at public schools to $267,936 for private schools; an average of $232,564. The Welcome Back Initiative has assisted 130 foreign trained physicians in securing residency training slots. The average cost of sending these individuals to medical school in the US would have been over $28M.

Upon validation of their degree, foreign trained nurses may sit for the nursing licensure exam (NCLEX). To ensure our nurses are ready for the exam, several Welcome Back Centers offer courses to prepare them. The average cost of an NCLEX prep exam ranges between $3000 and $8,000 per nurse. A typical class can take 25 students, for a total cost between $75,000 and $200,000. The average cost of recruiting a nurse ranges between $20,000 and $22,000. The equivalent cost for recruiting 25 nurses would be between $500,000 and $550,000.

Upon validation of their degree by a reputable US agency, a foreign trained pharmacist is eligible to take the exams to be licensed in the US. A US trained pharmacist completes a minimum of six years of education before they can sit for the licensure exams, an average cost savings of $63,000 if the degree is obtained at a public university or $122,000 at a private university. These costs are in addition to the cost of the undergraduate degree.

Alternatively, a foreign trained pharmacist may also, upon validation of his/her foreign credentials, take the pharmacy tech exam and be licensed for under $100.00. The cost of a pharmacy tech program in California ranges between $600 and $1,100.

As stated before, our participants typically increase their income by 255% once they reach their professional goals. Thus, professional integration translates into economic integration. It can also be inferred that economic integration leads to social and civic integration.

Models or best practices from other states or countries that California could consider adopting.

As the White House report "Occupational Licensing: A Framework for Policymakers" recognizes, licensing regulations are sometimes an impediment for skilled immigrant professionals to work in fields related to their experience and training. We were delighted to be approached by the Little Hoover Commission in their effort to explore areas where occupational licensing requirements create an unnecessary barrier to labor market entry or labor mobility for foreign-educated immigrants. Our efforts to remove artificial barriers will result in improved economic opportunities and will support economic growth and prosperity in our state.

Minnesota

The Minnesota Department of Health is supporting the integration of international medical graduates (IMG) through the implementation of the International Medical Graduate Assistance Program. The Minnesota Legislature established this program, in 2015 Minnesota Session Laws, Chapter 71, Article 8, Section 17, to address barriers to practice and facilitate pathways to assist immigrant international medical graduates (IIMG) to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state. http://www.health.state.mn.us/divs/orhpc/img/

Massachusetts

A report by the Governor's Advisory Council for Refugees and Immigrants' (GAC), "Rx for Massachusetts' Economy and Healthcare System" was developed by a statewide Task Force on Immigrant Healthcare Professionals in Massachusetts and offers information and recommendations aimed at supporting the needs of immigrant and refugee medical professionals in achieving their full potential in the U.S. https://miracoalition.org/images/stories/gac_task_force_report_final-12.18.14.pdf

Washington

One America released "Reducing Brain Waste: Creating Career Pathways for Foreign-Educated Immigrants in Washington State" which details the impact brain waste has had on Washington State. To illustrate the barriers experienced by foreign-educated immigrants, the report takes a deeper look at nursing and teaching. As industries that are regulated by state law, those entering the nursing or teaching workforce must obtain state licenses in order to find employment in their respective industries. Despite years of investing in education or sometimes decades in the field, foreign-educated immigrants searching for a way to re-enter professional careers encounter one road block after another.

https://www.weareoneamerica.org/sites/weareoneamerica.org/files/OA.BrainWaste.final_.pdf

Canada, Bridging Program
The Gateway for International Professionals programs, offered through Ryerson University's G. Raymond Chang School of Continuing Education, are helping bridge the gap between education, experience, and employment. International professionals often come to Canada with a breadth and depth of experience and credentials that simply aren't recognized here. The Chang School offers bridging programs that accurately assess the skills of international professionals and provide them with the education and experience needed to succeed in the Canadian workplace at levels that correspond with their qualifications.
http://ce-online.ryerson.ca/ce/default.aspx?id=2672

Florida, Miami-Dade – No longer offered through college ·Miami Dade College established the Foreign Physician Alternative Certification Program (FOPAC), supported by the Department of Children and Families (Office of Refugee Services), the Florida Legislative Allocation and Blue Cross and Blue Shield, which provided orientation, assistance and training to foreign health care professionals living in the U.S. The FOPAC program offered two tracks. One provided foreign physicians the opportunity to train and study for licensure in the U.S. to work as practicing medical doctors. The other track aimed at retraining foreign-trained health professionals to obtain degrees in other in-demand medical careers, such as in nursing, medical lab technology, respiratory care, sonography and teaching.
http://www.mdc.edu/main/newsandnotes/2009/vol7-6/otherstories/foreignhealthcare.aspx

Recommendations

This situation can be addressed in many ways, most requiring new partnerships between educators, immigrant-serving organizations, state licensing boards, professional associations, and employers to: **a.** identify in-demand occupations and employers' workforce needs, **b.** assess the skills of the foreign-trained immigrant professionals, **c.** develop and adapt training models, and prepare these individuals for licensure. Examples include:

- Establish an inter-agency working group to examine licensing requirements and funding barriers for health professionals and provide flexibility for foreign-trained health workers to help fill gaps.

- Provide foreign-trained immigrant professionals with relevant networks, work experience and training in the U.S. required for licensure through mid-career apprenticeships, paid internships, and on-the-job training programs.

- Develop programs in partnership with postsecondary educational institutions to provide foreign-trained immigrants with credit towards degree attainment for work, other experience, and credentials gained abroad.

- Accelerate the completion of any additional training, including degree attainment required for U.S. licensure, saving participants time and money.

Thank you again for the opportunity to share with you our experience working with foreign-trained health professionals. I am happy to answer any questions.