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International Medical Graduate Assistance Program: Report to the Minnesota Legislature

FEBRUARY 2017

MDH Minnesota Department *of* Health
OFFICE OF RURAL HEALTH & PRIMARY CARE

International Medical Graduate Assistance Program: Report to the Minnesota Legislature

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Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

February 6, 2017

The Honorable Matt Dean
Chair, Health and Human Services Finance
401 State Office Building
100 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

The Honorable Joe Schomacker
Chair, Health and Human Services Reform
509 State Office Building
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The Honorable Michelle Benson
Chair, Health and Human Services Finance and Policy
Minnesota Senate, Room 3109
95 University Avenue West
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The Honorable Jim Abeler
Chair, Human Services Reform Finance and Policy
Minnesota Senate, Room 3215
95 University Ave West
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Honorable Chairs:

I am pleased to present this annual report of the International Medical Graduate (IMG) Assistance Program, as required by statute.

In the last year, MDH and stakeholders continued building on a strong foundation. The IMG Assistance Program and the University of Minnesota filled the first state-supported residency spots for immigrant physicians with highly qualified immigrant physicians, and MDH continued working with stakeholders to speed the path for immigrant physicians into medicine and related health careers.

This year, Minnesota was recognized by the White House Task Force on New Americans as the first state to implement a comprehensive program to integrate immigrant medical graduates into the physician workforce, making a unique contribution to address pressing issues like healthcare disparities, workforce shortages and rising health care costs.

The future holds many uncertainties for Minnesota's immigrant and refugee communities, including the possibility that major policy changes at the federal level will significantly curtail participation in this program. Currently, the largest cohort of immigrant medical graduates working in Minnesota hold a federal J1 student visa or temporary H1-B visa. As noted on page 18, foreign medical residents comprise a substantial share of participants and there could be a noticeable and detrimental effect on access to health services for their communities if major changes to federal immigration policies are enacted curtailing legal immigration.

I thank you for your commitment to the Minnesota and all who live here. I welcome your questions and thoughts on how we can work together to strengthen Minnesota's health workforce.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Sincerely,

Edward P. Ehlinger, M.D., M.S.P.H.
Commissioner
P.O. Box 64975
St. Paul, MN 55164-0975

Acknowledgements

MDH staff would like to thank the members and chair of the International Medical Graduates Assistance Program Stakeholder Group and other key partners for their dedication and collaboration. So many continue to give so much, all on a volunteer basis and all in the spirit of helping our state break new ground in expanding health access and health equity.

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Executive Summary

Pursuant to Minnesota Statutes, Section 144.1911, the Minnesota Department of Health, in collaboration with a multidisciplinary stakeholder group, implemented the International Medical Graduates (IMG) Assistance Program to address barriers to practice and facilitate pathways to assist immigrant IMGs with integrating into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state. The Program works to provide a range of services to IMGs, from initial career planning and United States Medical Licensing Exam preparation through residency application assistance and residency funding. Detailed information about the IMG Assistance Program is available on the IMG Assistance Program website.

Activities to Date

MDH implemented the following program as required by the Legislature:

- **Program Administration:** The program is implemented in consultation with a variety of stakeholders including representatives from state agencies (the Board of Medical Practice, the Office of Higher Education, Minnesota Department of Employment and Economic Development), the health care industry, Minnesota Academy of Physician Assistants, community-based organizations, higher education, and the International Immigrant Medical Graduate (IIMG) community.

- **Program Components**

  1. **Roster:** The program has developed an initial database of 148 physicians. As the program becomes more established the number of IIMGs on the roster is expected to grow. It is estimated that there are approximated 250-400 IIMGs living in Minnesota.

  2. **Collaboration to address barriers to residency:** A major barrier to residency is the recency of the year of graduation from medical school. Stakeholders surveyed primary care residency program directors at the University of Minnesota and all residency program directors reported that they would be willing to relax the requirement relating to the year of graduation if the applicant demonstrated that they passed a rigorous clinical assessment and participated in an in-depth clinical experience in the U.S.

  3. **Clinical Assessment:** MDH entered into a contract with the University of Minnesota's Simulation Center to develop and conduct clinical assessments of program participants.

4. **Career Guidance and Support:** MDH entered into grant agreements with two nonprofit agencies, WISE/NAAD partnership (St. Paul) and Workforce Development Inc. (Rochester) to provide career guidance and support for program participants.

5. **Clinical Preparation and Experience:** MDH and stakeholders have developed the policies and procedures for the clinical preparation and experience. The University of Minnesota was awarded grant funding to provide clinical preparation for IIMGs.

6. **Dedicated Residency Positions:** MDH issued an RFP in 2016 and selected the University of Minnesota Pediatric Residency Program and Hennepin County Medical Center Internal Medicine Residency Program.

7. **Study of possible licensure changes:** In consultation with Minnesota Board of Medical Practice and other stakeholders, MDH studied changes necessary in the health professional licensure and regulation to ensure full utilization of immigrant international medical graduates into the Minnesota health care delivery system and narrowed the options to two recommended proposals – an IMG integration license and an amendment in the medical practice act to include an exemption for primary care in a rural or underserved area. These licensure options are necessary, will integrate qualified IMGs into the health care delivery system without the time and expense of residency, and are consistent with health equity priorities. At this time there are several issues that require additional steps to complete before these proposals will be able to be implemented completely.

Conclusion and Recommendation

Minnesota has been recognized as the first state in the nation to implement a comprehensive program to integrate IMGs into the physician workforce, taking an important first step to realize the potential of these uniquely qualified professionals to address pressing issues like healthcare disparities, workforce shortages and rising health care costs.

In the last year, MDH and stakeholders have made great strides in building on a strong foundation for the IMG Assistance program by engaging additional stakeholders, working across state agencies, issuing grants, and developing programmatic policies and procedures. This program is positioned to have great impact, although it currently lacks the capacity to reach the majority of IIMG's in Minnesota and those likely to arrive in the future. To expand the reach of the program, MDH will continue to explore options for additional resources through foundations and other sources and develop options for alternative careers for IIMGs to integrate into the health delivery system. MDH will also conduct the necessary research to address the issues remaining to implement the alternative licensing options identified in #7 above, and MDH recommends that once addressed, alternative licensing options such as those discussed above be established.

Introduction

In 2015, the International Medical Graduates (IMG) Assistance Program (Minnesota Statutes, 144.1911) began to address barriers to practice and facilitate pathways to assist immigrant IMGs 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. This annual report summarizes the progress of IMG integration activities in 2016, and includes recommendations on actions needed for continued progress.

In collaboration with a multidisciplinary stakeholder group, community organizations, contractors, medical schools and medical residency programs, the IMG Assistance Program works to provide the following services (see Appendix B for the continuum of services):

- Gateway and Navigation (career planning and navigation, United States Medical Licensing Exam preparation and certification of graduation from foreign medical school)
- Foundational Skill Building (medical English training, orientation to U.S. health care system, medical IT/typing skills training)
- Clinical Assessment
- Clinical Preparation (clinical instruction, clinical experience, letters of reference)
- Clinical Certification
- Residency Application Assistance
- Residency positions

Detailed information about the IMG Assistance Program is available on the IMG Assistance Program website.

Background

The challenge of integrating foreign-trained physicians into the health care workforce is complex and long-standing. In Minnesota, the issue gained urgency as policy makers sought to address several major issues facing the state:

- Shortages in the supply of physicians
- An aging and diversifying population
- Persistent health disparities
- Rising health care costs

A Task Force chartered by the 2014 legislature concluded that integrating more immigrant physicians into Minnesota's health workforce could help address each of these issues, based on the following findings:

1. **The physician workforce does not mirror the state's racial and ethnic composition and most of Minnesota's largest immigrant and refugee communities are underrepresented.**

2. **Minnesota is home to an estimated 250-400 unlicensed immigrant physicians, almost all of whom are interested in entering medical practice or other health careers in Minnesota.**

    - Unlicensed immigrant physicians residing in Minnesota are from more than 37 countries and speak over 30 languages.
    - Over half of respondents to a state survey were eligible to apply for medical residency, but only a small minority (17 percent) had been accepted into a residency program.

3. **Immigrant physicians face a range of barriers, with the following most significant:**

    - *Growing competition for limited residency spots*: While 95 percent of seniors in U.S. medical schools get into medical residency, most immigrant physicians do not. This competition will get even tougher with the "residency bottleneck": increasing numbers of medical graduates competing for a capped number of residency slots
    - *"Recency" of graduation from medical school*: Most U.S. residency programs consider only those who have recently graduated from medical school (within 3-5 years). Consequently, many of the most highly qualified immigrant physicians – those who have practiced extensively since medical school – are essentially disqualified at this point in the path to licensure.
    - *Lack of recognized clinical experience*: Most American residency programs prefer or even require that applicants have clinical experience acquired in the U.S., but such

hands-on experience is nearly impossible to obtain outside of medical school or residency.

- *Complexity and costs of testing and other steps needed to qualify for residency*: Foreign-trained physicians often need assistance in English proficiency, exam preparation and navigating the path to licensure. Assistance programs are crucial, but will continue to have only limited success if other structural barriers go unaddressed.

The Task Force concluded that Minnesota has a valuable and underused resource in its population of immigrant physicians, many of whom stand willing and qualified to serve as primary care providers in rural and underserved communities of the state. It also concluded that Minnesota could effectively address the obstacles faced by those physicians if it undertook strategic, coordinated, public-private action. When implemented, these strategies could produce a larger and more diverse primary care workforce capable of reducing both health disparities and health costs in Minnesota.

The subsequent 2015 law reflected many of the recommendations by the Foreign-Trained Physician Task Force. The Task Force report provides additional background on the rationale, policy drivers and potential of the new program. Additional background information is available on the Task Force website.

Definitions

International Medical Graduates (IMGs) are defined as individuals who obtained their basic medical degree outside the U.S. and Canada.[1] IMGs in the U.S. include several distinct subsets: (1) U.S.-born citizens who obtained their medical degree overseas (most commonly in the Caribbean or Central America); (2) foreign-born individuals who reside in the U.S. on non-immigrant visas (such as J-1, O-1 or H1-B visas) and (3) immigrants to the U.S. classified as either permanent residents ("green card" holders), U.S. citizens, asylees or refugees.

Pursuant to its statute, the IMG Assistance Program focuses specifically on category (3), herein referred to as Immigrant IMGs (IIMGs), and specifically IIMGs not licensed to practice medicine in the U.S.

[1] Educational Commission for Foreign Medical Graduates. Definition of an IMG. Available from: http://www.ecfmg.org/certification/definition-img.html. As the ECFMG notes, it is the location of the medical school that determines whether the physician is an IMG. Hence, if a non-U.S. citizen obtains their degree in the U.S., s/he is not considered an IMG.

2016 Activities and Update

The International Medical Graduates (IMG) Assistance Program is the first multi-component state program in the U.S. to assist immigrant international medical graduates (IIMGs) in integrating into the health delivery system. As such, much of the work in 2016, its second year, has consisted of continuing to build on a strong foundation and establishing program elements with an eye to maximum long-term impact and value for the state of Minnesota. The program has accomplished much in its second year and is well-positioned to help integrate growing numbers of IIMGs in their quest to serve in Minnesota's health care system.

Program Administration

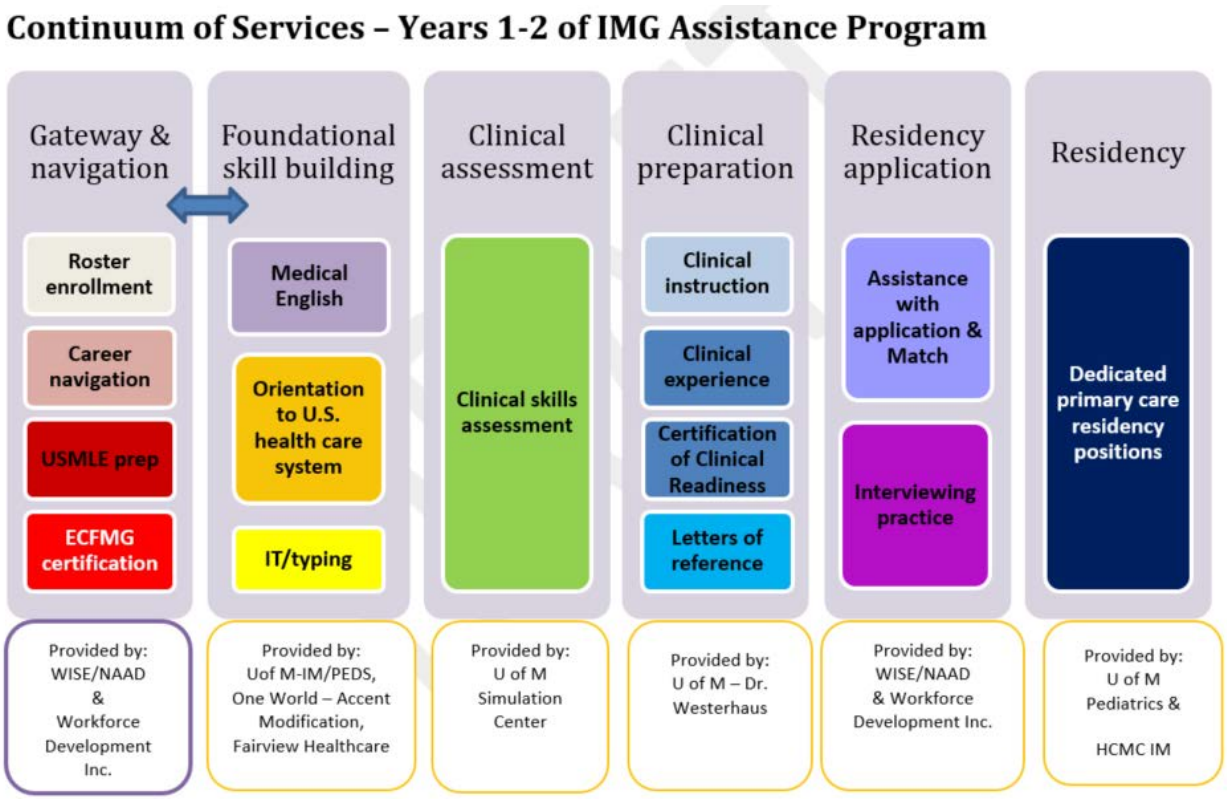
The program is being implemented in consultation with a variety of stakeholders, guided by an a highly engaged advisory stakeholder group that builds on the success of the 2014 Task Force, which brought together an unprecedented combination of individuals and organizations. The membership of the stakeholder group includes representatives from state agencies including the Board of Medical Practice and the Office of Higher Education, the health care industry, associations including the Minnesota Academy of Physician Assistants, community-based organizations, higher education, and the IIMG community. (See Appendix D: Roster of stakeholder group). The IIMG Assistance Program Stakeholder group meets quarterly and has subgroups or workgroups which meet in between the quarterly meetings. The workgroups are:

- Clinical Assessment and Experience
- Nonphysician Professions
- Licensing
- Fundraising

These work groups include additional stakeholders beyond those serving on the overall advisory group, and include additional representatives from the Minnesota Medical Association and Board of Medical Practice.

Program Components

The IMG Assistance Program provides a comprehensive range of related services to immigrant physicians, visualized in the diagram below and discussed in this section.



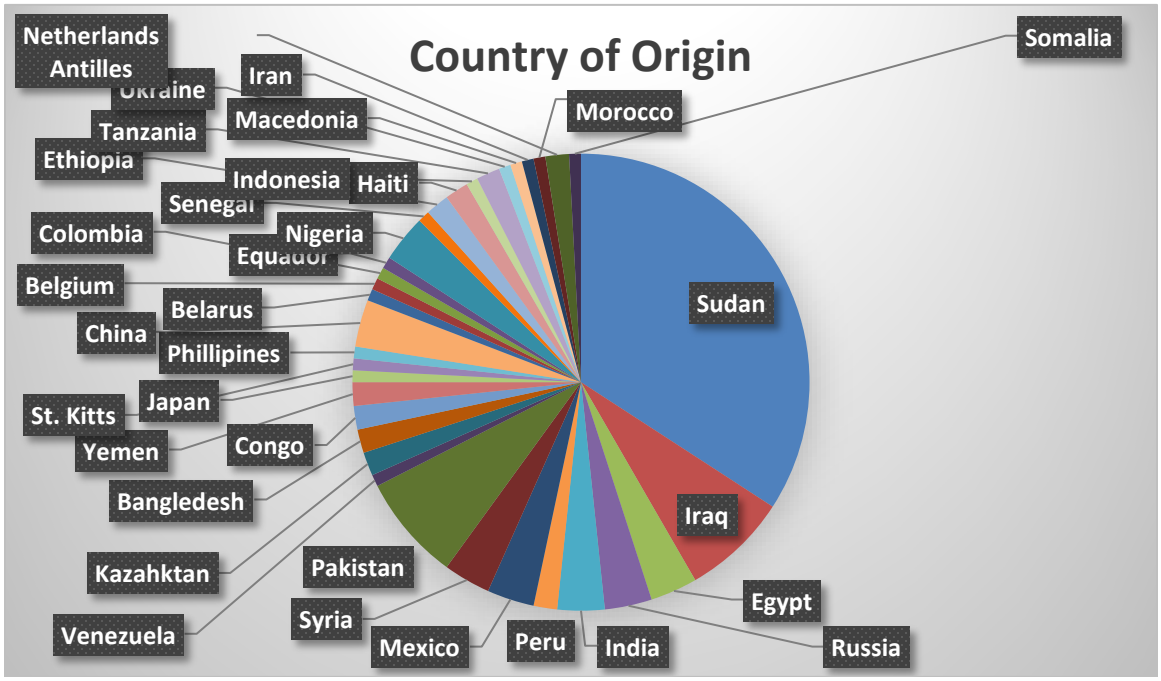
1. Roster

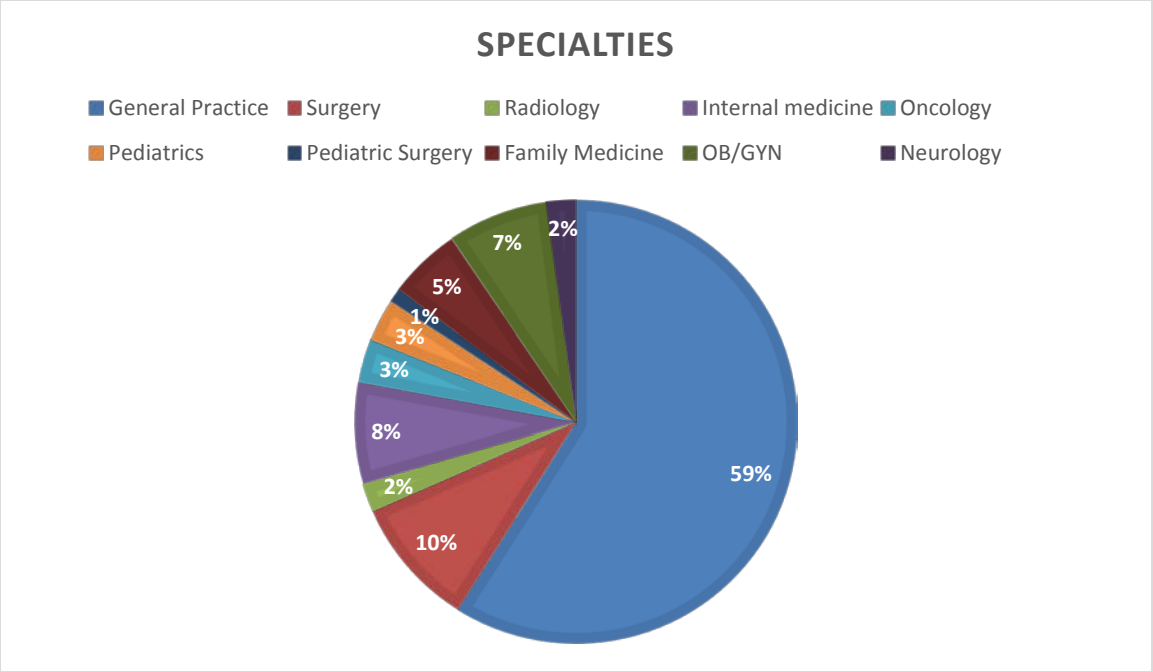
Legislative charge: [D]evelop and maintain, in partnership with community organizations working with international medical graduates, a voluntary roster of immigrant international medical graduates interested in entering the Minnesota health workforce to assist in planning and program administration, including making available summary reports that show the aggregate number and distribution, by geography and specialty, of immigrant international medical graduates in Minnesota.

It is estimated that Minnesota is home to approximately 250-400 immigrant physicians who are not able to practice here because of barriers to licensure. This estimate was made without the benefit of any official, ongoing count of the total number of unlicensed immigrant physicians living in the state, which led to the recommendation that a centralized, voluntary roster of those interested in entering the Minnesota health workforce be created to provide better and more consistent information about the pool of immigrant physicians in the state and their qualifications and interests, which could in turn guide planning and program administration for maximum impact.

Progress to date

With the help of community organizations, the new IMG program has developed an initial database of 148 immigrant physicians currently interested in entering the Minnesota health care workforce. Of those, 72 IMGs live in Rochester and the surrounding cities and 76 IMGs live in the Twin Cities metro area. There are an estimated 200 – 250 additional immigrant physicians living in Minnesota who are not yet part of the roster.





The next step is to continue updating the current roster as more IMGs actively engage in pursuing medical careers through the IMG Assistance Program. The goal is for the roster to serve as a formal source of information on health professionals who have unique skills such as competency in particular cultures, specific language skills, etc., that would be available to potential pre-residency employers, residency and PA programs. It would also serve as a platform for identifying and working with immigrants in other health occupations.

2. Collaboration to address barriers to residency

Legislative charge: [W]ork with graduate clinical medical training programs to address barriers faced by immigrant international medical graduates in securing residency positions in Minnesota, including the requirement that applicants for residency positions be recent graduates of medical school.

As described in more detail in the 2014 Task Force report, one of the main reasons immigrant physicians struggle to secure a medical residency is out of their control: most U.S. residency programs consider only "recent" graduates from medical school, typically requiring graduation within three to five years of application to residency. As a result, some of the most highly qualified immigrant physicians – those who have practiced extensively since medical school – are essentially disqualified at this point in the pathway to licensure.

> *"…Most U.S. residency programs consider only 'recent' graduates from medical school…. [S]ome of the most highly qualified immigrant physicians – those who have practiced extensively since medical school – are essentially disqualified at this point in the pathway to licensure.*

The 2014 Task Force learned that the primary rationale for these "recency" guidelines is the need for residents to be as up-to-date as possible on medical knowledge, treatment methods and protocols, and technology, particularly given how swiftly the health care field is changing. The 2014 Task Force concluded these valid concerns could be addressed in new, more effective ways that would benefit residency programs and immigrant physicians alike, and that these innovations alone could go a long way toward integrating more immigrant physicians into the health workforce.

Progress to date

As indicated earlier, one of the workgroups of the Advisory Stakeholder group is Clinical Assessment and Clinical Preparation. Collaborating with clinical medical training programs to address the recency issue falls within the purview of this workgroup.

As an initial step, the workgroup conducted a survey of all the primary care residency program directors in the state and asked:

1. Does your program eligibility include:
    - Graduation for medical school within five years of date of program application and;
    - U.S. clinical experience?
2. Under what circumstances are you willing to relax those requirements?

The responses confirmed that a majority of the programs require applicants to have graduated from medical school within the last five years. One program requires applicants to have graduated from medical school within the last five years *or* practiced medicine within the last three years. Two programs evaluate the year of graduation on a case-by-case basis. However, they reported that the applications of those who graduated from medical school more than five years ago are under increased scrutiny.

All residency program directors reported that they would be willing to relax the requirement relating to the year of graduation if the applicant demonstrated that they passed a rigorous clinical assessment and participated in an in-depth clinical experience in the United States.

We also learned that all residency program directors value IMGs and the cultural competencies IMGs add to the practice of medicine in Minnesota. Many work with IMGs. However, they generally work with IMGs who are on J-1 or H1-B visas and not IMGs who have immigrated to Minnesota (the focus of this program). The J-1 visa is a non-immigrant visa issued by the United States to scholars, professionals or others to participate in cultural exchange in the U.S., including obtaining medical training. An H1-B visa is also a non-immigrant visa issued by the United States to high skilled workers. It allows U.S. employers to temporarily employ foreign workers for specialty occupations. Both visas require a sponsor and are costly to obtain.

MDH implemented contracts or grant agreements for the clinical assessment and clinical experience program (described below) and will continue to work with the residency program directors to ensure that its components meet their requirements of rigorous and in-depth.

3. Clinical assessment

Legislative Charge: [D]evelop a system to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program.

The current system of certification from the Educational Commission on Foreign Medical Graduates (ECFMG), needed for admission to residency and for licensure, requires that IMGs pass a part of the United States Medical Licensing Exam (USMLE) that assesses a medical graduate's clinical skills. However, the 2014 Task Force heard repeatedly – including from residency program directors directly – that ECFMG certification alone does not give them enough information about a candidate's clinical aptitude to know if they will succeed in a U.S. medical residency program. The Task Force therefore recommended, and the IMG Program Assistance program provides, that Minnesota develop a standardized assessment and certification program that would assess the clinical readiness of immigrant physicians, and therefore allow IIMGs to compete more fully with U.S. medical graduates for limited residency spots.

Progress to date

As noted above, one of the workgroups of the Advisory Stakeholder group is the Clinical Assessment and Clinical Preparation group. In designing this component of the IMG program, staff studied the Interprofessional Education and Resource Center (IERC) and Academic Health Center (AHC) Simulation Center at the University of Minnesota. Staff there conduct simulations designed to meet assessment needs for professional accreditation as well as develop and promote interprofessional education and collaborative practice, and foster the development of

clinical skills and patient communication. (http://www.simulation.umn.edu/about) Staff also has past experience conducting assessments for IMG's in collaboration with the University of Minnesota's Preparation for Residency Program which ended in 2012.

MDH has finalized a contract with the University of Minnesota Simulation Center to develop and implement a Minnesota IIMG Assessment. The Simulation Center will conduct a clinical assessment of 15 IMGs during 2017, and will provide a report to MDH with a copy to the person assessed on their strengths and weaknesses, and that assessment report will inform the clinical preparation experience.

4. Career guidance and support

Legislative Charge:

- *The commissioner shall award grants to eligible nonprofits organizations to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce.*
- *The commissioner shall award the initial grants under this subdivision by December 31, 2015.*

Practicing medicine in the U.S. requires a wide range of skills and knowledge, some specific to the rapidly changing and highly complex American health care system. Even immigrant physicians with extensive clinical skills and experience overseas have much to learn in order to qualify for residency and practice effectively in the U.S. In addition to passing the rigorous and highly technical USMLE licensing exams required for ECFMG certification, they must demonstrate to residency programs that their English proficiency, technological skills and understanding of U.S. medical culture make them qualified to train successfully in a graduate clinical setting and beyond.

The Task Force examined existing programs, including the Foreign-Trained Health Care Professionals program funded by the legislature in three of the last ten years and administered by the Minnesota Department of Employment and Economic Development (DEED), that seek to support IMGs with career navigation, language assistance and test preparation. It concluded that such programs are a key component of integrating immigrant physicians into the health workforce, but will have a far greater impact if they work in concert with other key partners (including the medical education system, health care providers and employers, and regulatory bodies) and if key barriers on the pathway can be addressed (including opportunities for clinical experience and mechanisms for assessing clinical readiness)**.**

The Task Force's recommendations therefore proposed, and the new program provides, for continuing support for these foundational programs, but doing so within a coordinated statewide system.

Progress to date

In the interests of interagency coordination, DEED and MDH executed an interagency agreement that transferred from DEED to MDH most of the $200,000 DEED was allocated by the 2015 legislature for its Foreign-Trained Health Care Professionals. This will leverage the funds at MDH for these activities.

Staff and work group members also concluded that the program should expand traditional career guidance and support to also include trauma support and coaching. Many of the immigrant IMGs did not plan to leave their countries of origin but rather have uprooted their

families, lost their physical belongings, professions and a sense of self-worth due to political persecution, civil unrest or war. As a result, they have experienced significant trauma. This is further compounded by the disappointment of loss of the ability to use their skills and talents in their new home. Many have tried for years to enter the health workforce and are experiencing failure to reach goals for the first time in their lives. Many hold on at all cost to the dream of practicing medicine. While this is an option for some, others could add value to the health workforce in Minnesota by considering other alternatives including working in public health or in the Physician Assistant (PA) profession. Part of the problem is that they are not fully aware of these opportunities and what they entail. Combining trauma support and coaching, including information on alternative career pathways, is essential in helping IMGs deal with past trauma and providing the necessary information and tools to help them make informed professional decisions.

Many international medical graduates did not plan to leave their countries of origin but rather have uprooted their families, lost their physical belongings, professions and a sense of self-worth due to political persecution, civil unrest or war. As a result, they have experienced significant trauma. This is further compounded by the disappointment of loss of the ability to use their skills and talents in their new home.

The Women's Initiative for Self Empowerment, in collaboration with New American Alliance for Development, (St. Paul) and Workforce Development Inc (Rochester) are delivering career guidance and support services to IIMG program participants. Their services include USMLE exam support, support for technology proficiency, Medical English proficiency training, electronic medical record training, life coaching, accent modification training, and weekly support groups. The agencies are serving a total of 148 participants.

These agencies will also continue counseling IMG's about the alternative pathway of providing healthcare as Physician Assistants (PA). Many IMG's come from countries where the PA profession is not an established profession. MDH is in conversations with Fairview Medical Center, St. Catherine's University and Augsburg College about collaborating to facilitate opportunities for IMGs to improve their chances of admission to a PA education program.

In 2017, MDH will issue another RFP to provide additional funding to continue these services.

5. Clinical preparation and experience

Legislative Charge:

- *The commissioner shall award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency.*
- *The policies and procedures for the clinical preparation grants must be developed by December 31, 2015, including an implementation schedule that begins awarding grants to clinical preparation programs beginning in June of 2016.*

The 2014 Task Force concluded another major reason immigrant physicians are not accepted into residency programs, and also one largely out of their control given the current system, is a lack of hands-on clinical experience in the U.S. Most American residency programs give preference to applicants with clinical experience acquired in the U.S. or Canada. However, such hands-on experience with patients is nearly impossible to obtain outside of U.S. medical school or residency. This led to the recommendation, and resulting law, calling for a state grant program to support clinical training sites in providing hands-on experience and other preparation for Minnesota immigrant physicians needing additional clinical preparation or experience to become certified as ready for residency.

Progress to date

The Clinical Assessment and Clinical Preparation work group has been working to develop the policies, procedures, evaluation and outcomes for a grant program to support clinical preparation.

The group studied two basic types of clinical preparation: UCLA International Medical Graduate Program and the former University of Minnesota Preparation for Residency Program (PRP). The program at UCLA is narrowly tailored to serve only Spanish speaking IMGs who graduated from an international medical institution within the last four years. The PRP program was a broader program.

Based on its study of those programs, the Advisory stakeholder group adopted the following policies:

1. The Clinical Preparation should serve a broad range of IIMGs and should not be limited to specific languages, ethnicities or year of graduation for medical school.
2. A prerequisite for the clinical preparation should be the new Minnesota clinical assessment.
3. The length of the clinical preparation should be based on the outcome of the clinical assessment. Standard preparation time is 6 months. A high pass on the assessment should result in a shorter preparation time and a low pass, a longer preparation time. Individuals who fail the assessment will be counseled on possible alternative opportunities.
4. After the clinical preparation, an IIMG will be required to participate in a post-assessment conducted by an assessment preceptor.

5. Passing the post-assessment will result in a certificate of clinical readiness.

The University of Minnesota has been awarded grant funds to implement the clinical preparation program. This first year will include planning and developing curriculum, recruitment guidelines and creating a cadre of mentors. Beginning in June 2017, the University of MN will accept four to six participants for a six month, 40 hour per week clinical experience.

6. Dedicated residency positions

Legislative Charge: The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state.

A key requirement for medical licensure in Minnesota is graduate clinical medical training in a U.S. or Canadian residency program accredited by a national accrediting organization approved by the state Board of Medical Practice. With rare exceptions, immigrant physicians are required to complete at least two years of such training, typically in a residency program, regardless of whether they completed similar clinical training outside the U.S.

Obtaining such a position, however, is a difficult feat for a variety of reasons. One is the sheer number of medical graduates vying for an essentially static number of residency positions. Medicare funding for residency training (which covers about 25 percent of GME costs in the U.S.) has been capped at the number of slots that existed in 1997, and funding by Medicare is less than what it costs to provide care and training, according to the Metro Minnesota Council on Graduate Medical Education. Even as the number of slots remains capped, however, the number of medical school graduates is increasing as many schools expand enrollments in anticipation of the physician shortages. Sometimes referred to as the "residency bottleneck," this is a major reason cited by both the University of Minnesota and Mayo medical schools for why they do not plan to expand their medical school class sizes.

Given this need for additional residency spots and the unique qualifications many IIMGs bring to serve the fastest growing segments of the state's population and their willingness to serve in rural and underserved communities, the IMG Program includes grants to establish new residency slots dedicated specifically to immigrant physicians. The 2015 legislature appropriated one-time funds to MDH to support a limited number of residency positions dedicated to immigrant IMGs. The enabling legislation also established a revolving international medical graduate residency account to accept funds from the public and private sectors to sustain grants for dedicated residency positions. In addition to the commitment to serve in a rural or underserved community for at least five years, an IIMG accepted by a residency program into a residency position funded by this grant program is required to pay the lessor of $15,000 or ten percent of their annual compensation into the revolving account for five years, beginning in the second year of post residency employment.

Progress to date

Last year the University of Minnesota Pediatric Residency Program was approved for funding one residency position. Its program included:

- An assessment-based recruitment process.
- A preliminary preparation period with more targeted and mentored orientation.

- A training program with additional retention and career preparation activities through mentorship.

The residency program interviewed 18 out of 36 applicants and, based on the quality of applicants, selected/ ranked four applicants to participate in the program. However two applicants ranked other residency programs higher than the University of Minnesota Pediatric Residency program. Ultimately, the Pediatric Residency enrolled two residents. (The residency selection process requires both the program's ranking and the applicant's ranking to match for enrollment.) Funding from the IMG Assistance Program only supported one resident; based on the quality of the selected candidate, the University of Minnesota chose to fund the other itself. Currently, both residents are performing very well in the program.

MDH also issued an RFP in 2016 for the second round of funding. Two programs, the University of Minnesota Pediatric Residency Program and Hennepin County Medical Center Internal Medicine Residency Program applied for funding.

Staff has conducted the initial analysis of both proposals and recommends IIMG funding residency positions at both programs. The next step is to finalize the grant agreements and work with both programs regarding recruitment.

7. Study of possible licensure changes

The IMG Assistance Program's authorizing statute charges the commissioner of health to study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system and to include recommendations in this annual report due January 15, 2017.

Accordingly, MDH, the Board of Medical Practice and other stakeholders worked together during 2016 to identify licensing and regulatory options needed to ensure full utilization of immigrant international medical graduates into the Minnesota health care delivery system. Current law and regulation generally allows international medical graduates (IMGs) to apply for licensure only after at least two years of U.S. graduate medical education (medical residency). As noted in this report, few immigrant IMGs have been able to obtain residency slots, and although the IMG Assistance Program is making progress increasing the number of immigrant IMGs getting into residency, the numbers are still small. For qualified and experienced immigrant physicians, repeating residency is costly and time consuming, and delays their ability to contribute to Minnesota's primary care needs or resume their medical careers.

MDH and stakeholders worked to identify new licensing options that would provide a path to licensure for qualified and experienced immigrant IMGs that would put their skills to work meeting high priority primary care needs, while including assurances and protections that patient safety expectations are met as newly licensed physicians enter practice in Minnesota.

MDH, the Board of Medical Practice and other stakeholders reviewed the medical practice act, reviewed programs in other states and studied possible changes to the medical practice act.

Contemplating professional licensing changes is often contentious. Over the course of several months, all participants worked diligently to identify practical barriers, reconcile strongly held and widely divergent positions, and develop options to address and respond to in considering licensure options. The discussions touched on a number of sensitive issues; some individuals in licensure group meetings expressed the view that immigrant physicians are a special interest group that should be required to meet all licensing requirements in the current law. Similarly, some participants felt that if new paths to licensure are provided to immigrant physicians, inquiries and expectations will increase from others requesting variances from the current process, and that this will increase the workload of the Board of Medical Practice.

In response, MDH staff and other participants noted that immigrant physicians have a unique potential to contribute to improving health equity in Minnesota, and that this potential is a central basis of the IMG Assistance Program, which was established "to address barriers to practice and facilitate pathways to assist immigrant international medical graduates 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."

The group also discussed the idea that negative consequences may occur if changes are made to licensing requirements without explicitly addressing all potential contingencies, and that changes should not be recommended until provisions for preventing all potential negative consequences are identified and included in recommendations. MDH noted that current law does not address all potential aspects of the supervision and practice of traditional residents and physicians, which are the responsibility of training sites and employers.

The group studied several strategies and a wide range of potential recommendations before settling on two proposals to address issues raised during discussion: An IMG Primary Care Integration License and an amendment to the medical practice act to include an exemption for practice in primary care in a rural or underserved area.

I. **IMG Primary Care Integration License**. This option would license certain experienced immigrant IMGs to practice primary care in rural or underserved urban areas upon meeting eligibility requirements and obtaining an employment contract.

Eligibility for the **IMG Primary Care Integration License** would include:

1. IMG registers with MDH;
2. IMG demonstrates that s/he has a minimum of seven years of prior medical practice including residency and fellowships; **Observerships do not qualify.**
3. IMG passes USMLE step 1, 2 and 3 within three attempts; becomes ECFMG certified;
4. IMG participates in clinical assessment at U of M; participates in six months of clinical experience; undergoes post assessment with an established assessment service provider

similar to the Physician Assessment and Clinical Education (PACE) program or the Center for Personalized Education for Physicians (CPEP) – receives a certificate of clinical readiness to practice medicine.

5. IMG obtains employer sponsorship. Employer must provide supervision and mentorship outlined in a supervision agreement. Employer must be in "rural" or "underserved" community as defined by Minnesota Statutes, section 144.1911. Scope of practice limited to primary care as described in Minnesota Statutes, section 144.1911;
6. Once sponsorship is obtained, IMG applies for an IMG integration License – a restrictive license renewable annually with recommendation to renew from employer.

The proposal would allow for the licensee to apply for an unrestricted license after four years of successful renewals (five years total of effective practice). It would also allow the Board to take disciplinary action against the licensee and supervisor for violations of the limitations on the license.

Creation of this alternate license would be an efficient process – it allows objectively qualified physicians into the system quickly to address issues of health disparities and primary care shortages. It does not require additional residency positions. In addition, it is cost effective. The cost of retraining IMGs in a residency program is approximately $300,000 to $400,000. While there would be funding needs for clinical experience and post assessment, as well as funding needs for Board of Medical Practice capacity, those needs would be far less than the cost of residency.

Several steps remain to be completed before this option would be ready to implement. This effort depends on identifying and securing the commitment of a suitable assessor. Currently the Board of Medical Practice uses national assessment centers to assess physicians in the disciplinary process. During 2017 MDH plans to approach these national assessment centers to explore their interest and capacity to assess candidates for the proposed IMG Primary Care Integration License.

In addition, MDH will work to confirm the employability of IMGs with this proposed restricted license. To be eligible for board certification, a physician must complete residency in the U.S. Any IMG licensed under this proposal would thus not be eligible for board certification. As such, employers may face a barrier in being reimbursed for the services rendered by "unboarded" physicians. During 2017 MDH plans to document current reimbursement policies related to board certification with the Department of Human Services, health plans and insurance companies. MDH contacted several potential employers during 2016 to discuss their interest in and ability to employ "unboarded" physicians, and during 2017 MDH will survey additional employers, specifically clinics which provide services to uninsured persons, to determine if they would employ unboarded physicians.

Further, Minnesota is a member of the Federation of State Medical Boards and has adopted legislation implementing the Interstate Medical Licensure Compact. The Interstate Medical

Licensure Compact provides an expedited pathway to licensure for qualified physicians who wish to practice in multiple states. The concern was raised whether this restricted license would impact the Interstate Medical Licensure Compact. Initial research revealed that IMGs licensed under the proposed licensure would not be eligible to participate in the Compact process and Minnesota adoption of license variations would not affect other compact states. However MDH is eager to share this proposal with the Federation of State Medical Boards and obtain further feedback.

Two stakeholders groups that participated in the process brought subjects to the discussion of importance to their organizations. The Minnesota Academy of Physician Assistants' (MAPA) raised the possibility that creating a "sponsored or supervised" restricted IMG integration license for IMGs might create professional role confusion for healthcare systems and patients, specifically how physicians with a primary care integration license would be similar to or vary from the PA profession, unless this license and the entire process is clearly defined. The Minnesota Medical Association's physician member who participated in the process contributed to developing this option; an MMA staff member reported at a public meeting that the association is currently opposed to a "tiered" licensure system. Further discussion is needed with both MAPA and MMA to clarify and address these concerns.

II**. Immigrant IMG license to practice primary care in rural or underserved urban areas with one year of graduate medical education.** Under current law (Minnesota Statutes, section 147.037) the Medical Practice Act allows licensing of IMGs if they have two years of graduate medical education (residency), but the statute includes several exemptions that allow licensure with one year of graduate education. This proposed option would add an exemption for practicing primary care in a rural or underserved area, as follows:

The board may exempt a requirement for more than one year of residency, if the applicant has completed at least one year of an accredited residency program and if the following conditions are met:

(a) The applicant meets all other qualifications for a medical license.

    (i) The applicant submits satisfactory proof that issuance of a license based on the waiver requirement of more than one year of residency will not jeopardize the health, safety, and welfare of the citizens of this state. Satisfactory proof would include participation in clinical assessment at the University of Minnesota; participation in six months of clinical experience and post assessment with an established assessment service provider similar to PACE or CPEP – receipt of certificate of clinical readiness to practice medicine (Meets level 5 of the 4 selected general milestones of the next accreditation system); and

(b) The applicant submits proof – such as an employment contract - that he or she will enter into the practice of medicine in primary care in a rural or underserved community as defined by Minnesota Statutes, section 144.1911 immediately upon obtaining a

license to practice medicine based upon a waiver of the requirement for more than one year of residency.

(i) A license issued on the basis of this exemption shall be subject to the limitation that the licensee continue to practice primary care in a rural or underserved community as defined by Minnesota Statutes, section144.1911 and such other limitations, if any, deemed appropriate under the circumstances, which may include, but shall not be limited to, supervision by a medical practitioner, training, education, and scope of practice. After two years of practice under a limited license issued on the basis of a waiver of the requirement of more than one year of residency, a licensee may apply to the Board for removal of the limitations. The Board may grant or deny such application or may continue the license with limitations.

(ii) The Board shall take disciplinary action against a license granted on the basis of this exemption of the requirement of more than one year of graduate medical education for violation of the limitations on the license.

The benefits and concerns of this proposal mirrors the benefits and concerns of the first proposal as discussed above.

In summary, these licensure options offer important new routes to integrate qualified IMGs into the health care delivery system without the time and expense of residency, and are consistent with health equity priorities. At this time there are several ancillary issues that need to be addressed before it will be practical to implement these proposals fully. These issues are noted above and in Appendix D. The most pressing are to confirm the availability of the objective assessment required for Option a. above and to confirm that employment would be available to those with these license types. MDH will conduct the necessary research to address these ancillary issues, and MDH recommends that once addressed, alternative licensing options such as those discussed above be established.

Conclusion and Recommendations

Minnesota has been recognized as the first state in the nation to implement a comprehensive program to integrate immigrant medical graduates into the physician workforce, taking an important first step to realize the potential of these uniquely qualified professionals to address pressing issues like healthcare disparities, workforce shortages and rising health care costs.

In 2016 MDH and stakeholders made continued strides in building on a strong foundation for the IMG Assistance Program by engaging additional stakeholders, working across state agencies, issuing grants, and developing programmatic policies and procedures. This program is positioned to have great impact in lowering healthcare costs by increasing the use of primary care; eliminating healthcare disparities through diversifying the healthcare workforce with culturally and linguistically appropriate care; and increasing the number of physicians in rural and underserved areas of the state.

However, as implementation begins and the program's limited resources are committed, MDH also realizes the limited reach the program may have, given the number of IIMGs in Minnesota and those likely to arrive in the future. To expand the reach of the program, MDH will continue to explore options for additional resources through foundations and other sources, develop options for alternative careers for IIMGs to integrate into the health delivery system, and work with stakeholders to establish an alternative licensure process.

As legislatively required, MDH, the Board of Medical Practice and other stakeholders explored options for changes to the medical practice act to ensure full utilization of IMGs in the Minnesota health care delivery system and identified new licensing options that would provide a path to licensure for qualified and experienced immigrant IMGs that would put their skills to work meeting high priority primary care needs while including assurances and protections. At this time there are several ancillary issues that need to be addressed before it will be practical to implement these proposals fully.

MDH and stakeholders look forward to implementing the next steps detailed above and implementing additional strategies. MDH will also conduct the necessary research to address the issues remaining to fully implement the alternative licensing options identified in section 7 above, and MDH recommends that once addressed, alternative licensing options such as those discussed above be established.

Appendices

A. IMG Assistance Program Legislation
B. Continuum of Services
C. Advisory Stakeholder Group Membership
D. Potential Recommendations

Appendix A: IMG Assistance Program Legislation

2015 Minnesota Session Laws, Chapter 71, Article 8, Section 17

144.1911 INTERNATIONAL MEDICAL GRADUATES ASSISTANCE PROGRAM.

Subdivision 1.**Establishment.**

The international medical graduate assistance program is established to address barriers to practice and facilitate pathways to assist immigrant international medical graduates 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.

Subd. 2. **Definitions.**

(a) For the purposes of this section, the following terms have the meanings given.

(b) "Commissioner" means the commissioner of health.

(c) "Immigrant international medical graduate" means an international medical graduate who was born outside the United States, now resides permanently in the United States, and who did not enter the United States on a J1 or similar nonimmigrant visa following acceptance into a United States medical residency or fellowship program.

(d) "International medical graduate" means a physician who received a basic medical degree or qualification from a medical school located outside the United States and Canada.

(e) "Minnesota immigrant international medical graduate" means an immigrant international medical graduate who has lived in Minnesota for at least two years.

(f) "Rural community" means a statutory and home rule charter city or township that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

(g) "Underserved community" means a Minnesota area or population included in the list of designated primary medical care health professional shortage areas, medically underserved areas, or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Subd. 3. **Program administration.**

In administering the international medical graduate assistance program, the commissioner shall:

(1) provide overall coordination for the planning, development, and implementation of a comprehensive system for integrating qualified immigrant international medical graduates into the Minnesota health care delivery system, particularly those willing to serve in rural or underserved communities of the state;

(2) develop and maintain, in partnership with community organizations working with international medical graduates, a voluntary roster of immigrant international medical graduates interested in entering the Minnesota health workforce to assist in planning and program administration, including making available summary reports that show the aggregate number and distribution, by geography and specialty, of immigrant international medical graduates in Minnesota;

(3) work with graduate clinical medical training programs to address barriers faced by immigrant international medical graduates in securing residency positions in Minnesota, including the requirement that applicants for residency positions be recent graduates of medical school. The annual report required in subdivision 10 shall include any progress in addressing these barriers;

(4) develop a system to assess and certify the clinical readiness of eligible immigrant international medical graduates to serve in a residency program. The system shall include assessment methods, an operating plan, and a budget. Initially, the commissioner may develop assessments for clinical readiness for practice of one or more primary care specialties, and shall add additional assessments as resources are available. The commissioner may contract with an independent entity or another state agency to conduct the assessments. In order to be assessed for clinical readiness for residency, an eligible international medical graduate must have obtained a certification from the Educational Commission of Foreign Medical Graduates. The commissioner shall issue a Minnesota certificate of clinical readiness for residency to those who pass the assessment;

(5) explore and facilitate more streamlined pathways for immigrant international medical graduates to serve in nonphysician professions in the Minnesota workforce; and

(6) study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system. The commissioner shall include recommendations in the annual report required under subdivision 10, due January 15, 2017.

Subd. 4. **Career guidance and support services.**

(a) The commissioner shall award grants to eligible nonprofit organizations to provide career guidance and support services to immigrant international medical graduates seeking to enter the Minnesota health workforce. Eligible grant activities include the following:

(1) educational and career navigation, including information on training and licensing requirements for physician and nonphysician health care professions, and guidance in determining which pathway is best suited for an individual international medical graduate based on the graduate's skills, experience, resources, and interests;

(2) support in becoming proficient in medical English;

(3) support in becoming proficient in the use of information technology, including computer skills and use of electronic health record technology;

(4) support for increasing knowledge of and familiarity with the United States health care system;

(5) support for other foundational skills identified by the commissioner;

(6) support for immigrant international medical graduates in becoming certified by the Educational Commission on Foreign Medical Graduates, including help with preparation for required licensing examinations and financial assistance for fees; and

(7) assistance to international medical graduates in registering with the program's Minnesota international medical graduate roster.

(b) The commissioner shall award the initial grants under this subdivision by December 31, 2015.

Subd. 5.**Clinical preparation.**

(a) The commissioner shall award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency. The grant program shall include:

(1) proposed training curricula;

(2) Associated policies and procedures for clinical training sites, which must be part of existing clinical medical education programs in Minnesota; and

(3) Monthly stipends for international medical graduate participants. Priority shall be given to primary care sites in rural or underserved areas of the state, and international medical graduate participants must commit to serving at least five years in a rural or underserved community of the state.

(b) The policies and procedures for the clinical preparation grants must be developed by December 31, 2015, including an implementation schedule that begins awarding grants to clinical preparation programs beginning in June of 2016.

Subd. 6. **International medical graduate primary care residency grant program and revolving account.**

(a) The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. No grant shall exceed $150,000 per residency position per year. Eligible primary care residency grant recipients include accredited family medicine, internal medicine, obstetrics and gynecology, psychiatry, and pediatric residency programs. Eligible primary care residency programs shall apply to the commissioner. Applications must include the number of anticipated residents to be funded using grant funds and a budget. Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires. Before any funds are distributed, a grant recipient shall provide the commissioner with the following:

(1) a copy of the signed contract between the primary care residency program and the participating international medical graduate;

(2) certification that the participating international medical graduate has lived in Minnesota for at least two years and is certified by the Educational Commission on Foreign Medical Graduates. Residency programs may also require that participating international medical graduates hold a Minnesota certificate of clinical readiness for residency, once the certificates become available; and

(3) verification that the participating international medical graduate has executed a participant agreement pursuant to paragraph (b).

(b) Upon acceptance by a participating residency program, international medical graduates shall enter into an agreement with the commissioner to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of postresidency employment. Participants shall pay $15,000 or ten percent of their annual compensation each year, whichever is less.

(c) A revolving international medical graduate residency account is established as an account in the special revenue fund in the state treasury. The commissioner of management and budget shall credit to the account appropriations, payments, and transfers to the account. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the account. Funds in the account are

appropriated annually to the commissioner to award grants and administer the grant program established in paragraph (a). Notwithstanding any law to the contrary, any funds deposited in the account do not expire. The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any grant issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the account, as well as the amount of the contribution provided; and

(3) a contributing entity may not specify that the recipient or recipients of any funds use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

Subd. 7.**Voluntary hospital programs.**

A hospital may establish residency programs for foreign-trained physicians to become candidates for licensure to practice medicine in the state of Minnesota. A hospital may partner with organizations, such as the New Americans Alliance for Development, to screen for and identify foreign-trained physicians eligible for a hospital's particular residency program.

Subd. 8.**Board of Medical Practice.**

Nothing in this section alters the authority of the Board of Medical Practice to regulate the practice of medicine.

Subd. 9.**Consultation with stakeholders.**

The commissioner shall administer the international medical graduates assistance program, including the grant programs described under subdivisions 4, 5, and 6, in consultation with representatives of the following sectors:

(1) state agencies:

(i) Board of Medical Practice;

(ii) Office of Higher Education; and

(iii) Department of Employment and Economic Development;

(2) health care industry:

(i) a health care employer in a rural or underserved area of Minnesota;

(ii) a health plan company;

(iii) the Minnesota Medical Association;

(iv) licensed physicians experienced in working with international medical graduates; and

(v) the Minnesota Academy of Physician Assistants;

(3) community-based organizations:

(i) organizations serving immigrant and refugee communities of Minnesota;

(ii) organizations serving the international medical graduate community, such as the New Americans Alliance for Development and Women's Initiative for Self Empowerment; and

(iii) the Minnesota Association of Community Health Centers;

(4) higher education:

(i) University of Minnesota;

(ii) Mayo Clinic School of Health Professions;

(iii) graduate medical education programs not located at the University of Minnesota or Mayo Clinic School of Health Professions; and

(iv) Minnesota physician assistant education programs; and

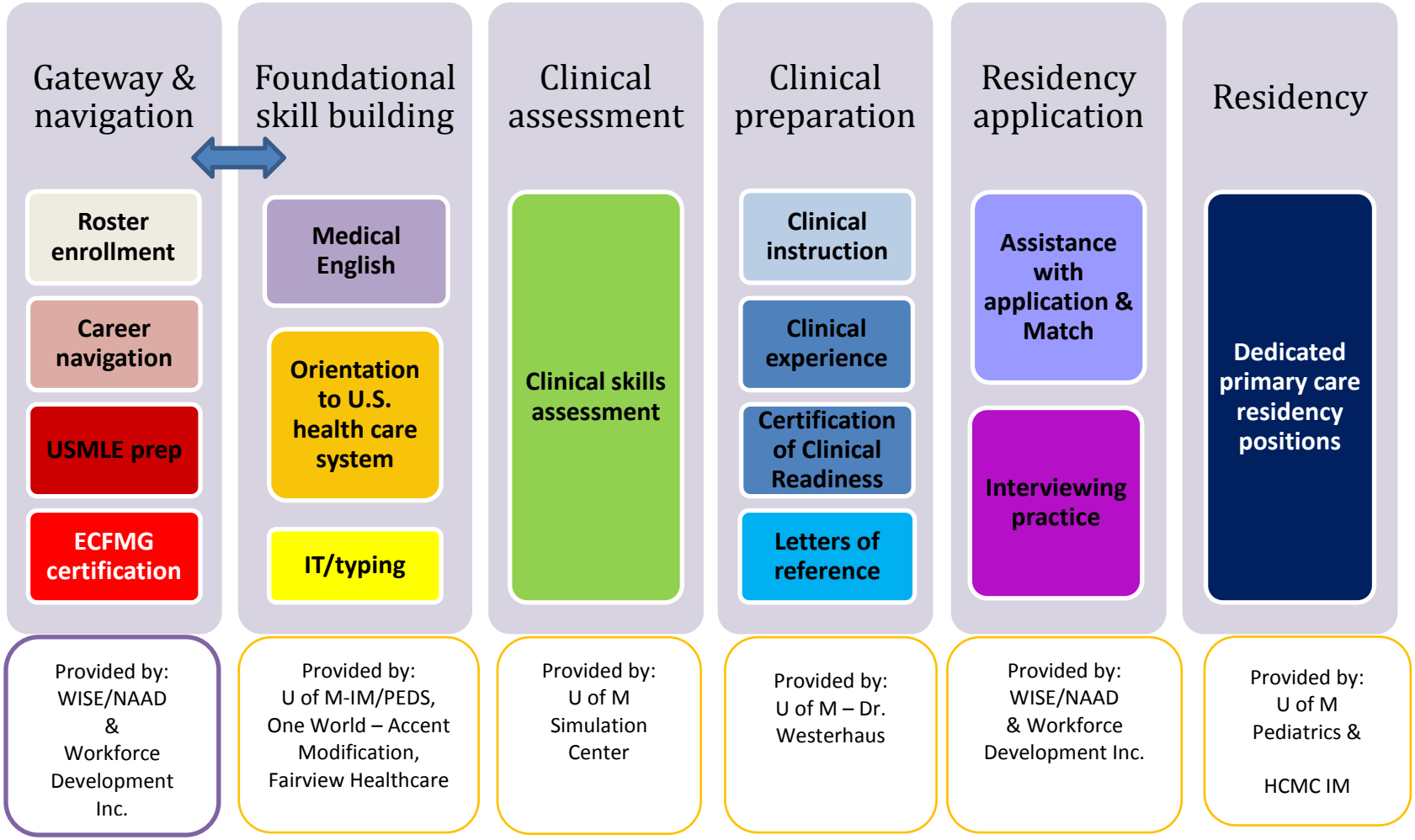
(5) two international medical graduates.

Subd. 10. **Report.**

The commissioner shall submit an annual report to the chairs and ranking minority members of the legislative committees with jurisdiction over health care and higher education on the progress of the integration of international medical graduates into the Minnesota health care delivery system. The report shall include recommendations on actions needed for continued progress integrating international medical graduates. The report shall be submitted by January 15 each year, beginning January 15, 2016.

Appendix B: Continuum of Services

Continuum of Services – Years 1-2 of IMG Assistance Program



Appendix C: Advisory Stakeholder Group

Stakeholder Group	Member
Board of Medical Practice	**Ruth Martinez** Executive Director Board of Medical Practice **Molly Shwanz** Supervisor, Licensure Unit Board of Medical Practice
Office of Higher Education	**Diane O'Connor** Deputy Commissioner Office of Higher Education
Dept. of Employment and Economic Dev	**Annie Welch** Senior Planner MN Department of Employment and Economic Development **Sarah Sinderbrand** Planner MN Department of Employment and Economic Development
Health care employer in rural or underserved area	**James Volk, MD** Chief Medical Officer Sanford Health
Health plan	**Julie Cole** GME Health Partners
MN Medical Association (MMA)	**Armit Singh, MD** MN Medical Association

Stakeholder Group	Member
MN Academy of Physician Assistants (MAPA)	**Leslie Milteer** President Minnesota Academy of Physician Assistants (MAPA)
Licensed physicians experienced in working with IMGs	**Edwin Bogonko, MD, Chair** Physician St. Francis Regional Medical Center Representative for the MN Medical Association
MN Assoc of Community Health Centers (MNACHC)	**Christopher Reif, MD** Director of Clinical Services Community University Health Care Clinic
University of MN	**James Pacala, MD** Associate Department Head University of Minnesota, Family Medicine & Community Health
Mayo School of Health Sciences	**Barbara Jordan** Administrator Mayo Clinic College of Medicine Office for Diversity
GME programs not at U or Mayo	**Meghan Walsh, MD** Chief Medical Education Officer Associate Medical Director Hennepin County Medical Center
PA education program	**Donna DeGracia** Curriculum Director/Academic Coordinator Master of PA Studies Program St. Catherine University, School of Health
Two IMGs	**Tedla Kefene** International Medical Graduate **Nadia Rini** International Medical Graduate

Appendix D: Advisory Stakeholder Group – Potential Recommendations

IMG Assistance Program –Stakeholder Advisory Group - Licensure Group

Potential Recommendations

Decision Making Criteria:

- Does recommendation require statutory changes?
- Is the recommendation controversial?
- Does it require new resources? Funding? Personnel? Etc.
- How much progress would it produce?
- What is the impact on health equity?

Timeline:

August: Work group meeting
September: Work group meeting, Finalize recommendation
October: Present recommendations to the stakeholder group
Present recommendations to BMP Policy/Planning Committee (October 12, 4:30pm)
November: Presentation to BMP Draft of Report which will include recommendations to legislators.
January: final report due

General note: There were statements in licensure group meetings that immigrant physicians are a special interest group that should be required to meet all licensing requirements in current law. Related statements were made that if new paths to licensure are provided to immigrant physicians, inquiries and expectations will increase from others requesting variances from the current process, and that this will increase the workload of the Board of Medical Practice.

In response it was noted that immigrant physicians have a unique potential to contribute to improving health equity in Minnesota, and that this potential is a central basis of Minnesota Statutes, section 144.1911, the International Medical Graduates Assistance Program, which was established "to address barriers to practice and facilitate pathways to assist immigrant international medical graduates 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." Among other provisions, Minnesota Statutes, section 144.1911 requires the Commissioner of Health to study, in consultation with the Board of Medical Practice and other stakeholders, changes necessary in health professional licensure and regulation to ensure full utilization of immigrant international medical graduates in the Minnesota health care delivery system, and to make recommendations to the legislature.

It was agreed that the need for new funds to cover any increased workload should be included in recommendations.

There was also discussion that negative consequences that may occur if changes are made to licensing requirements without explicitly addressing all potential contingencies, and that changes should not be recommended until provisions for preventing all potential consequences are identified and included in recommendations.

In response it was noted that current law does not address all potential aspects of the supervision and practice of residents and physicians, which are the responsibility of training sites and employers.

Proposals for consideration

Proposal	Pros/Cons
A. IMG Primary Care Integration License 1. IMG registers with MDH 2. IMG demonstrates that s/he has a minimum of 7 years of prior medical practice including residency and fellowships. **Obsersverships do not qualify.** 3. IMG passes USMLE step 1, 2 and 3 within 3 attempts; becomes ECFMG certified 4. IMG participates in clinical assessment at U of M; participates in 6 months of clinical experience; undergoes post assessment with an established assessment service provider similar to PACE or CPEP – receives a certificate of clinical readiness to practice medicine (Meets level 5 of the 4 selected general milestones of the next accreditation system) 5. IMG obtains employer sponsorship. Employer must provide supervision and mentorship outlined in a supervision agreement. Employer must be in "rural" or "underserved" community as defined by Minn Stat. 144.1911. Scope of practice limited to primary care as described in Minn Stat. 144.1911. 6. Once sponsorship is obtained, IMG applies for an IMG integration License – a restrictive license renewable annually with recommendation to renew from employer. 7. Participant can apply for an unrestricted license after 4 years of successful renewals (5 years total of effective practice) 8. The Board shall take disciplinary action against a licensee and supervisor for violations of the limitations on the license.	**Pros:** • Fast. Gets objectively qualified physicians into the system quickly. • Does not require residency positions. • Very cost effective. May need money for clinical post assessment and clinical experience. • Increases state revenue from new doctors paying taxes. • Helps with health disparities and primary care shortages **Cons**: • May require new level of effort for Board of Medical Practice and new revenue. • Doctors with this restricted license may get paid less than other doctors with a traditional unrestricted license. • #5, 6, 7. MAPA objected to these components prior to the passing of the 2015 legislation. Those objections and concerns are unchanged by the current writing. • MAPA's position is that creating a "sponsored or supervised" restricted IMG integration license for IMG physicians will create professional role confusion for healthcare systems and patients, specifically with regards to how they would be similar to or vary from the PA profession.

Proposal	Pros/Cons
	• Unless clearly defined, this could create confusion for who can supervise a PA during the restricted licensure periods and potentially after unrestricted license is obtained regarding proper PA/ Physician relationships. • Such a program will create potential challenges to full licensure by other professions as well. • Reimbursement and the ability to obtain liability coverage are unknowns. These issues have been identified in similar programs that sought to create alternative licensing categories– such as Missouri's Assistant Physician program. • Other physicians who would not meet minimum requirements will view this as arbitrary and preferential, and will demand equal opportunity under the law.

Proposal	Pros/Cons
B. Amend 147.037 to include Exemption for primary care in a rural or underserved area. The board may exempt any requirement for more than one year of approved graduate medical education, as set forth in the Physicians Practice Act, if the applicant has served at least one year of graduate medical education approved by the board and if the following conditions are met: (c) The applicants meets all other qualifications for a medical license (i) The applicants submits satisfactory proof that issuance of a license based on the waiver requirement of more than one year of approved graduate medical education will not jeopardize the health, safety, and welfare of the citizens of this state. Satisfactory proof would include participation in clinical	**Pros:** Similar to pros listed above **Cons:** B(b)(i) This sections has similar concerns to the above regarding clarity of licensure title and potential supervision of other professions such as nursing ,PAs Etc.

assessment at U of M; participation in 6 months of clinical experience and post assessment with an established assessment service provider similar to PACE or CPEP – receipt of certificate of clinical readiness to practice medicine (Meets level 5 of the 4 selected general milestones of the next accreditation system); and (d) The applicant submits proof – such as an employment contract - that he or she will enter into the practice of medicine in primary care in a rural or underserved community as defined by Minn stat. 144.1911 immediately upon obtaining a license to practice medicine based upon a waiver of the requirement for more than one year of graduate medical education. (i) A license issued on the basis of this exemption shall be subject to the limitation that the licensee continue to practice primary care in a rural or underserved community as defined by Minn stat. 144.1911 and such other limitations, if any, deemed appropriate under the circumstances, which may include, but shall not be limited to, supervision by a medical practitioner, training, education, and scope of practice. After two years of practice under a limited license issued on the basis of a waiver of the requirement of more than one year of graduate medical education, a licensee may apply to the Board for removal of the limitations. The Board may grant or deny such application or may continue the license with limitations. (ii) The Board shall take disciplinary action against a license granted on the basis of this exemption of the requirement of more than one year of graduate medical education for violation of the limitations on the license	