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ORIGINAL PAPER

# Integrating Immigrant Health Professionals into the U.S. Healthcare Workforce: Barriers and Solutions

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## Abstract
Internationally educated immigrant healthcare workers face skill underutilization working in lower-skilled healthcare jobs or outside healthcare. This study explored barriers to and solutions for integrating immigrant health professionals. Content analysis identifying key themes from semi-structured qualitative interviews with representatives from Welcome Back Centers (WBCs) and partner organizations. 18 participants completed interviews. Barriers facing immigrant health professionals included lack of access to resources, financial constraints, language difficulties, credentialing challenges, prejudice, and investment in current occupations. Barriers facing programs that assist immigrant health professionals included eligibility restrictions, funding challenges, program workforce instability, recruitment difficulties, difficulty maintaining connection, and pandemic challenges. Long-term program success depended on partner networks, advocacy, addressing prejudice, a client-centered approach, diverse resources and services, and conducting research. Initiatives to integrate immigrant health professionals require multi-level responses to diverse needs and collaborations among organizations that support immigrant health professionals, healthcare systems, labor, and other stakeholders.

**Keywords** Immigrant health workers · Health workforce · Health professional recruitment · Health workforce diversity

## Background

Immigrants are a critical part of the U.S. health workforce, employed in a vast array of occupations. Healthcare has been among the fastest growing sectors of the economy for employment, with the U.S. Bureau of Labor Statistics predicting 13% growth from 2021 through 2031 [1]. Immigrants are expected to continue in the future to play a significant role in U.S. healthcare [2, 3]. In 2018, 15.6% of healthcare practitioners and technical occupations and 22.4% of healthcare support workers were immigrants [2]. Relative to their representation in the general population, immigrants make up disproportionate shares of both lower- and higher-skilled healthcare workers in some occupations. For example, they accounted for 28% of physicians and surgeons and 38% of home health aides [2]. Still, large numbers of immigrant college graduates in healthcare face skill underutilization and are unemployed or work in lower-skilled jobs. An estimated 263,000 refugees and immigrants with four-year degrees or higher in a health field are sidelined in the U.S. by unemployment and underemployment [2, 4, 5]. Noncitizens appear to be at a particular disadvantage [6]. This brain waste is particularly tragic amid the pandemic when immigrant talents could have been tapped to provide care to patients with COVID-19 [5].

Migration provides migrants access to economic resources and education while driving economic growth and local vitalization in host countries [7, 8]. Migration can particularly empower immigrant women and improve their status and autonomy [9]. At the same time, immigrants increase host countries' economic growth through employment, higher demand for goods and services, and contribution to gross domestic product [10]. The COVID-19 pandemic has highlighted the importance of essential workers, including healthcare providers and staff, many of whom are immigrants [6]. Despite representing a large proportion of the U.S. health workforce, our knowledge about the characteristics of immigrants who are healthcare workers is limited [11]. For example, available data sources do not always allow us to determine whether immigrants obtained relevant healthcare education and work experience in the

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U.S. or abroad, as is the case for allied health workers and nurses [4].

Little documentation exists about immigrants' occupational preferences in the U.S. and the barriers they may face, including language, credential recognition, and others [12–14]. There is increased awareness of the underutilization of immigrants' education and skills when they are employed in occupations, whether in healthcare or other sectors, that require less education than the immigrants have attained [2, 15–19]. Immigrants' jobs often underutilize their qualifications, resulting in underemployment, and face higher threat of unemployment relative to citizens [20–22]. Prejudices and discrimination against immigrants lead to poor employment outcomes and decrease the return on immigrants' investment in education compared with non-immigrants [17, 23]. Prior studies suggest that in contrast to immigrants who are naturalized U.S. citizens, noncitizen healthcare workers—who are more concentrated in occupations that are lower-paying or require fewer skills [4]—especially face vulnerabilities both socially and in the labor market. Immigrant healthcare professionals face barriers in translating credentials and previous experience from their home countries when seeking U.S. jobs that match their education [24]. Underutilizing immigrant skills has economic and social costs, including forgone earnings and tax payments. Over time, skills and education decay, affecting immigrants' ability to earn wages sufficient to support their families [15].

This study explores systemic barriers that affect the career progression of health professionals immigrating to the U.S. who received their healthcare education abroad (hereafter referred to as "immigrant health professionals") and best practices for overcoming those barriers. It answers three main questions: [1] What factors keep immigrant health professionals from working in healthcare jobs that match their education and skills? [2] What barriers do programs serving immigrant health professionals encounter in implementing and providing services to assist this population in pursuing healthcare careers in the U.S.? [3] What strategies for success and promising practices can be used by WBCs and their partners to serve this population? The findings from this study will help policymakers and workforce planners develop targeted programs and investments to maximize the potential of immigrant health professionals' contributions to U.S. healthcare.

## Methods

We conducted semi-structured qualitative interviews with one or two staff representatives from Welcome Back Centers (WBCs) around the country. The Welcome Back Initiative was started in 2001 in California, growing to a high of ten WBCs around the U.S. to help immigrant health workers maximize their untapped skills. The Initiative provides services to help immigrants achieve recognition of qualifications they bring from countries of origin and support fulfillment of other requirements to obtain U.S. health occupation credentials [25]. We also reached out to labor and industry partner organizations of one WBC, the Puget Sound WBC located at Highline College in Des Moines, WA, which has coordinated efforts with these partners to develop career pathways for immigrant health professionals. The University of Washington's Human Subjects Division approved the study.

### Participants

We contacted leaders of all nine WBCs in operation in early 2021 (one each in Colorado, Massachusetts, Maine, Maryland, New York, Pennsylvania, Rhode Island, and two in Washington) up to 5 times requesting an interview. Most WBCs are based in community colleges and work with community partners. We also reached out to labor and industry partners of the Puget Sound WBC involved in a project to accelerate career advancement for immigrant health professionals, address workforce shortages, and advance health equity by diversifying the health workforce. Partner organizations included Cascade Behavioral Health Hospital; Kaiser Permanente Washington; St. Anne Hospital, part of Virginia Mason Franciscan Health; Service Employees International Union (SEIU) Healthcare 1199NW; and the SEIU Healthcare 1199NW Multi-Employer Training and Education Fund. Leaders participated in the interviews, occasionally including client-facing staff.

### Data Collection

Our study team developed an interview guide (provided in the Appendix) in collaboration with the Puget Sound WBC to ensure the relevance and comprehensiveness of the questions to meet study goals. We tailored questions as appropriate to the type of interviewee organization (education, healthcare employer, labor union, and funding organization). We documented interviews using typewritten notes and audio recordings with consent from the participants.

### Analysis

We used NVivo qualitative analysis software (version 11) to identify key themes through a directed content analysis. Author MA with expertise in qualitative research methodology led the first round of coding by deriving and applying themes to relevant text in the transcripts. We developed coding categories based on the topics of the interview guide. Authors MA and DP met regularly to review the coding, develop emergent themes, and reach consensus. We

synthesize the findings according to themes that answer our three study questions.

# Results

A total of 18 personnel from 8 of 9 WBCs and all 5 Puget Sound WBC partner organizations participated in 13 interviews from February through May 2021. We organize this summary of study findings based on the three study questions of interest, describing the themes in no particular order that pertain to each question. Table 1 provides illustrative quotes for each theme.

## What are key factors that keep immigrant health professionals from working in fields in which they are educated or drive them toseek jobs that do not take full advantage of their education and training?

### Lack of Access to Opportunities and Resources

Immigrants may experience limited access to opportunities, information, and other resources (e.g., professional networks, internships) that allow them to pursue in the U.S. the health career for which they were educated in their country of origin.

### Financial Constraints

Immigrant health professionals may face financial constraints, such as the need to support family, that do not allow them to afford costs including English language courses and exams required for obtaining health professional credentials.

### Difficulties with Language Proficiency

English language requirements for credentialing in some health occupations can present a prohibitively high hurdle, and at times, immigrant health professionals lack sufficient English competency.

### Credential Verification Challenges

Immigrant health professionals can encounter difficulties in obtaining education records from their home countries or verifying their records with credentialing bodies.

### Racism and Prejudices

Immigrants often face biases due to systemic racism and what was described as an “elitist mentality” that favors U.S.-based education. As people of color often working in lower-paying jobs where they are perceived to have lower education, at times due to their accents, immigrants face multifold prejudices.

### Investment in Current Occupations

Immigrants may not want to return to their former healthcare careers when their current occupations afford them satisfactory income or comfort, when nearing retirement, or when facing high barriers to career entry.

## What have been barriers to implementation of programs or initiatives to assist immigrant health professionals?

### Eligibility Restrictions

Some initiatives and programs restrict eligibility to immigrants living in the state where the program is located, specific immigration statuses, or to certain categories of workers based on employment in partner organizations or union membership.

### Funding Challenges

Some WBCs experience inconsistent funding levels due to changes in the funding environment or funders’ desires for immediate return on investment that contribute to shorter-term funding horizons.

### Program Workforce Instability

A program or partner organization’s workforce may be unstable due to reliance on volunteers, turnover in leadership, or staff attrition due to loss of funding.

### Recruitment Difficulties

WBCs do not always have direct access to immigrant health professionals that could benefit from program services and must therefore rely on intermediaries for recruitment (e.g., word of mouth, employers) who themselves may not be able to identify interested and eligible persons. Some immigrant health professionals may be difficult to reach through channels such as email or because of limited employer

**Table 1** Integrating Immigrant Health Professionals into the U.S. Healthcare Workforce: Illustrative Comments by Key Questions and Themes

| **What are key factors that keep immigrant health professionals from working in fields in which they are educated or drive them to seek jobs that do not take full advantage of their education and training?** |
|---|
| *Lack of access to opportunities and resources* |
| Some are fearful of their security, not knowing what they can do with a little more help. Lack of knowledge of alternatives |
| Lack of professional connections—need to rebuild network, difficult to do here |
| *Financial constraints* |
| People need to work, they take anything they can. The need to provide for family back at home and here |
| The financial barrier—transcripts have to be evaluated, there are exams they have to take. Physicians have to take multiple steps, it's costly. They look toward resources that can help them do that. Some don't have the resources |
| *Difficulties with language proficiency* |
| We absolutely agree that folks need to speak English, feel comfortable, but the [English language] test they're asked to take is above the requirement to get into a US nursing school |
| People tend to go into entry-level positions that don't require a high level of English, planning to improve. But that can be a barrier itself, not getting the English they need, or running into systemic barriers |
| *Credential verification challenges* |
| Other barriers: in war-torn countries, they just can't get their transcripts. There's not much we can do about that. Sometimes the university no longer exists or won't release it. We've had people fly back to country to get their transcript |
| Different countries are questioned [regarding education credentials] more than others are. With [credential verification entity], there is a validation process with the licensing that's taking additional time, "to ensure authenticity." We've been working with the same person for many years. The change is incongruent with the past |
| *Racism and prejudices* |
| Lack of openness from top management. That bias against workers who are internationally trained. I believe there is sometimes not even the chance to get hired |
| Our population in allied health is pretty diverse. We talk about disparities and racism in the class that I teach. The conversation has changed. They are feeling it a lot more. They're more hesitant to put themselves in a position where they might not get a job because of racism |
| Investment in current occupations |
| One participant after a year of study, we sent her to a hospital…She went back to the hospital as CNA. She wanted to be a nurse, but she didn't pass. She felt OK not being an RN… |
| I know one specific LPN who works in clinic and I think she was saying she's near retirement, so she didn't want to pursue furthering her career |
| **What have been barriers to implementation of programs or initiatives to assist immigrant health professionals?** |
| *Eligibility restrictions* |
| I get a lot of inquiries from other states. Depending on my time, funding, I try to feel out that conversation. Sometimes I'm not always able to help that person, depending on the source of funding. It also depends on the profession. With nursing, it varies state by state, and I'm not always able to help if it's another state |
| The person must live in [my state] and have been educated as a nurse |
| *Funding challenges* |
| I think the biggest systemic barrier for us is we have some local funding sources, but having them see the value in funding services that support this group is difficult. There's not an immediate return on investment |
| We approached a foundation here to help us develop a revolving loan. The reason we only have about 100 a year is that our funding won't allow us to offer more financial aid. For sustainability, I wish we had a financial organization to help us expand |
| *Program workforce instability* |
| It's not the same working as a volunteer as when you have dedicated staff. It's a challenge with volunteers |
| Since we lost our funding, we lost our educational case manager…One of the key things is the educational case manager, they spend a lot of time [with service recipients]—what are your goals, what is reasonable, specific pathways, and parallel pathways while getting license… |
| *Recruitment difficulties* |
| Mostly word of mouth, past participants. We don't get a lot of referrals from local workforce system |
| I'm glad that we don't, to be honest. I don't think they have a full picture of what we do. We had a lot of people reach out to us who were very confused about services offered, often not the type of program they were looking for |
| Employers are the first link. How do you talk to your employees? Newsletters, postcards. Our barrier is just getting the word out. Just showing an interest—you don't have to sign up for anything—just meet with us. A lot of these costs would be paid for them, they wouldn't have to go back to school |

**Table 1** (continued)

| |
|---|
| *Difficulty maintaining connection* |
| For those that move out of state, it's hard to follow up. I try from time to time. For those in state, I find a lot of them are from this area, tend to stay in this area |
| It's really a long process. Nothing is fast. Sometimes people talk to us and then a year or two later come back |
| *Pandemic challenges* |
| Some are so overwhelmed with work right now that they can't take on another thing. Some people don't have the additional bandwidth, working for employers dealing with the pandemic on a daily basis. Working full time, kids at home learning, little capacity |
| Zoom has made it tougher to connect, especially people who just met each other |
| **What ingredients are needed for long-term success and sustainability of this initiative? Are there promising practices or recommendations you would share with others doing this work?** |
| *Building a network of partners* |
| Making relationships with organizations so you can see exactly where you fit and can fill a particular gap. There are a lot of siloes, but still organizations are willing to work with others and not duplicate services |
| Connecting with the larger network of WBCs has been huge. So incredibly helpful to talk with my colleagues in New York or Massachusetts who only serve nurses—helps me learn best practices, so you're not on your own |
| *Engaging in advocacy* |
| On a national level we need to get together and create an agenda of the policy issues we want to tackle. They're the same in many states. Why can't professionals come and challenge an exam… There are a lot of policy, regulatory, procedural changes I'd like to see |
| Engaging licensing boards has been huge, for example, the nurses. We were in the right place at the right time, they were frustrated with dealing with one organization [for credential evaluation], trying to change some attitudes |
| *Addressing prejudice and racism* |
| Seems everyone is figuring out how not to be racist now, looking at practices, trying to do something. I think we still have a long ways to go |
| Quality of care is working with someone in same language |
| *Using a client-centered approach* |
| You may be focused on the license but this person doesn't have a home, or can't pay electricity. I think it's a deep concept. The staff that helps them is critical. Sometimes it's just listening. Sometimes they just need a little word that says you can do it. That little touch |
| One thing we know is that the individualized aspect of the program is really critical…The funding needs to provide individualized support in the long term and give that kind of flexibility |
| *Offering diverse resources and services* |
| We make use of people who have been successful to find out what they've done. We use volunteer experience, also potentially a mentor at the site. Observing, job shadowing, getting a sense of the differences of how health care is delivered…getting hands on patient care. They can incorporate it into personal statement, use in interview questions. It gives them more credibility that they have an understanding of how to provide care here |
| Doctors, nurses, engineers want to know what to do. I had to go learn licensing for all these professions. I've developed a series of licensing guides |
| *Conducting research* |
| We're trying to pass a bill to do a study of internationally trained professionals more generally. We need more data. That can open up the conversation, and what things can we change? We're missing out on a group of talented folks |
| I hope we can continue to expand our efforts to figure out what is stopping people from coming forward to build a more robust system for these individuals. They're not going away, and we could benefit from them |

engagement. Finally, immigrant health professionals may not understand how programs can help them and therefore not participate.

## Difficulty Maintaining Connection

Because immigrant health professionals may be overwhelmed with home or work responsibilities that prevent consistent engagement or a linear pathway to career progression, some programs may lose connection with program participants before they have achieved their goals.

## Pandemic Challenges

COVID-19 exacerbated some of the above challenges due to limited in-person connections and competing demands, such as homeschooling children.

### What ingredients are needed for long-term success and sustainability of this initiative? Are there promising practices or recommendations you would share with others doing this work?

#### Building a Network of Partners

Building a network of partners with shared goals—employers, community colleges, health profession education programs, unions, other WBCs, and other immigrant-serving community organizations—is crucial.

#### Engaging in Advocacy

Many WBC personnel participate in state and federal advocacy for regulatory changes to increase immigrant participation in health careers. Desired changes include using discriminatory impact statements in legislation, applying uniform credentialing rules and requirements among states, allowing more than one organization within a state to verify credentials, creating alternative licensure for foreign-educated physicians to work under licensed physicians, and increasing opportunities for incumbent workers to access education and services to advance their careers.

#### Addressing Prejudice and Racism

Some participants called for action to eliminate stigma associated with foreign-educated providers through anti-racist education, using an asset-based approach that expands notions of healthcare quality to include care provided by native speakers of immigrant communities' languages, challenging the view that non-native speakers of English pose a threat to patient safety, and promoting inclusion of immigrant workers as a strategy to address social determinants of health.

#### Using a Client-Centered Approach

Many initiatives used an individualized case management approach by providing flexible programs that work with the immigrants wherever they are in their transition to a U.S. health career and including coaching by a career counselor that maintains a personal touch. To be client-centered, it is essential to be realistic and frank about expectations while giving hope, building trust, keeping efforts based in the community, bringing participants to the table, and employing passionate staff. A few initiatives used cohort models to foster peer support as participants progressed through a defined program.

#### Offering Diverse Resources and Services

Interviewees reported that successful WBCs develop a diverse set of resources to meet multiple needs, including an extensive knowledge base about varied career pathways, career licensing guides, and a robust network of volunteers. WBCs offer a broad range of services such as training or connecting immigrants to work experiences (e.g., apprenticeships, fellowships, or healthcare jobs), English language proficiency courses, and activities to increase immigrants' familiarity with U.S. culture in general and in healthcare. Some WBCs provide financial support including scholarships or stipends to help cover expenses such as courses, exams, and licensing.

#### Conducting Research

Interviewees noted that more research on immigrant pathways in healthcare careers would assist them to better understand the landscape and examine barriers, such as by surveying immigrant health professionals on their experiences.

## Discussion

To our knowledge, our study is the first examination of the barriers affecting the career progression of immigrant health professionals and best practices for overcoming those barriers. Diverse immigrant workers experience various resource barriers and bring different career motivations. Programs serving these potential healthcare workers attempt to address these challenges but also face their own challenges.

Our findings align with and expand on previous literature on factors that impact immigrants' employability. Batalova, Fix, and Creticos showed limited English proficiency doubled the likelihood of working in unskilled jobs [22]. Our study showed that some immigrants find unjustified requirements for proof of English proficiency (e.g., difficult general English tests vs. specific medical language proficiency tests) challenging. We further showed that the perception of the lack of English proficiency, whether well founded or based on a bias against people speaking in a non-American accent, is a major barrier for immigrants attaining jobs or being perceived as competent in their roles. It has been documented that labor market involvements of immigrants are also determined by both institutional and informal social dynamics [7]. Our study showed immigrants lacking access to opportunities such as professional networking, contributing to staying on the margins. On occasions, the attitudes and openness of people in leadership positions toward immigrants can make the environment welcoming or hostile toward employing immigrants. Being vulnerable, migrants, especially women, are at greater risk for exploitation [9], which may influence available work choices. Our

participants recognized immigrants' and refugees' vulnerabilities, whether due to financial constraints, family constraints, or limited access to resources. In addition to these challenges, our work emphasizes how policies can create barriers as well as how prejudices and concealed racism are potential forces that make the career pathway harder. Faced with barriers to healthcare careers and more welcoming opportunities elsewhere, some immigrant health professionals choose jobs in other sectors, a loss of healthcare human capital for both the societies that educated them and the U.S.

Immigrants do not simply respond to preexisting demand for particular kinds of labor; they can create demand for their labor by constructing new markets [7]. Immigrant communities need healthcare providers that are mindful of their cultures. Our work suggests that valuing the cultural knowledge immigrant healthcare professionals offer may be in tension with prejudice held by employers or other providers, sometimes masked behind expressions of concern for provider qualifications and patient safety. At the same time, non-immigrant providers who may not look like the patients they care for and who may even harbor prejudices against these patients are presumed to provide better care. Our health system emphasizes the need for English proficiency in providing care to English-speaking individuals while being content with interpreted services when providing care for other communities. Prioritizing English to the exclusion of other languages represents a missed opportunity to nurture members of immigrant communities so that they can provide care in patients' native languages. Evidence that patient-provider social concordance (sharing characteristics such as race or language) results in better care (26) likewise suggests that immigrants who speak their community's native language and understand the culture can best respond to this market need. Addressing the needs of all parties will require providing opportunities for immigrant healthcare workers to develop needed capacities while recognizing their assets and respecting their dignity.

Our findings point to four requirements for facilitating internationally educated health professionals' pursuit of occupations that make full use of their abilities. First, initiatives to address barriers must be carried out at multiple levels—individual, interpersonal, organizational, community, and societal. Second, initiatives must engage both immigrant workers and their communities in determining appropriate solutions. Third, government and professional regulatory bodies' actions can lead to policies and rules that pave an easier path to integrating internationally educated professionals while promoting standards that ensure high-quality care for all patients. Fourth, many immigrants live in states without the kinds of services that WBCs provide; similar initiatives would need to be expanded to tap into the full potential of immigrants nationwide.

Study limitations include that we did not engage immigrants who were recipients of WBC services, though all study participants had worked closely with immigrants and refugees, some having personal experience of the immigration process. We were also unable to gauge the success of strategies described in facilitating immigrant career transitions. Though we interviewed leaders from all participating WBCs, inclusion of more client-facing staff might have uncovered additional information. Finally, we conducted this study during the pandemic, and its eventual impact on these programs is unclear, though remote learning opportunities created during the pandemic have the potential for sustaining and expanded access to some program services.

This study's strengths include that we interviewed all but one WBC in the U.S. and frequently spoke with more than one person from each organization, providing insights with applicability across the U.S., not only in one state or region. Our qualitative methods allowed for an open and in-depth exploration of the study topics, and interviewees were frequently highly motivated and passionate to share their experiences in serving immigrants.

Future work should focus on understanding the experiences of immigrants and refugees in the healthcare workforce, including but not limited to different groups' specific pathways (e.g., by immigration status, by profession, etc.). This exploration would help to identify immigrants' needs and ways to support their aspirations. Further, research should examine the extent to which immigrants prepared for and desiring to pursue healthcare careers are working in other occupations as well as optimal strategies to support them. This information will not only help immigrants actualize their aspirations but also provide benefits to their communities.

## New Contribution to the Literature

Immigrant health professionals play essential roles in today's health system. Not only do immigrant health professionals help relieve workforce shortages, especially in under-resourced areas, they also bring awareness of and sensitivities to the needs and health challenges of their communities. Because the barriers to integration of immigrant health professionals are multi-faceted, initiatives to break down barriers must be multi-leveled to respond to diverse needs. Collaborations between organizations that support immigrant health professionals, healthcare systems, labor, and other stakeholders are essential to ensure that these professionals can attain fulfilling careers and that our communities can receive maximum benefits from their talents.

## Appendix

See Table 2.

**Table 2** Hospital Employees Education and Training Grant (HEET). Accelerated Pathways for Internationally Educated Professionals. Interview Guide

**Background on Program Participants**

We're interested in talking with you about immigrants who your WBC is assisting to understand the context of their employment and employment goals since they arrived in the U.S., how they progress, how the WBC and its partners are able to help them, and barriers and solutions

Could we begin with a description of your program participants?
What are their occupations when they come to you?
To what extent are they already working in health occupations vs. other occupations?
What kinds of prior healthcare experience or credentials do they have?
What are their demographic profiles (countries of origin, languages spoken, gender, age, education)? Legal status?
Other relevant characteristics?

What are the key factors that keep immigrants from working in fields in which they are educated, or drive them to seek jobs in fields that don't take full advantage of their education and training? (e.g., legal status, demographics, financial need, regulatory barriers to obtaining credentials in fields they're trained in, lack of access to education/opportunities, racism)

Are there typical health careers that WBC program participants tend to pursue?
Are there patterns by country of origin or by type of prior education (degree or credential)?
Does the sector they are already working in when they start receiving services from the WBC (health vs. other occupation) affect their opportunities for pursuing their chosen health career? If so, how does that matter?
What are typical settings where they end up working? Do they work with underserved patients? Speakers of languages other than English?

**Lessons Learned: Implementation Barriers and Solutions**

Have you conducted surveys of program participants to understand the impact of your program or to improve your services? What have you learned? Are there results we can access?

Based on the data you've collected [if applicable] and your experience, what ingredients are needed for successful implementation of the [*if applicable*: HEET] initiative?

What have been barriers to implementation of the [*if applicable*: HEET] initiative? How have you addressed those barriers?
Barriers to collaboration between educational institutions, non-profit organizations, employers, [if applicable: the Training Fund, and SEIU]?
Policy barriers/changes needed
Systemic/structural barriers
Resource barriers
Other?

**Value and Accomplishments of the Initiative**

What changes have been made at your educational institution or other educational institutions to meet the needs of internationally trained health professionals as a result of the WBC [HEET] initiative?
[if needed] for example, recognition of past experience or credentials, programs adapted or created to meet their needs

Which aspects of the [*if applicable*: HEET] initiative are showing success?

**Lessons Learned: Sustainability Barriers and Solutions**

What ingredients are needed for long-term success and sustainability of this initiative?

What are ways the initiative could be improved? What are barriers to sustainability? What resources are needed to improve the program?
Policy barriers/changes needed
Systemic/structural barriers
Resource barriers
Other?

[If not addressed previously] To what extent do you think discrimination or racism is a barrier to immigrant career progression or to achieving the objectives of your initiative more generally?

**Promising Practices**

[FOR OTHER WBCS (NOT PUGET SOUND WBC)] Are there any promising practices or recommendations you would share with others doing this work?
[FOR THE PUGET SOUND WBC ONLY] Based on what you've learned from the HEET initiative so far, what are promising or enabling policies, structures, practices, or resources that could be shared and adopted more broadly?
What aspects of the collaborations between educational institutions, non-profit organizations, and employers have worked well?
What more can this coalition of partners do to create change in this area?
Have employers shared their own successes and challenges reaching out to employees with other employers? Have others shared lessons learned with you?

**Closing**

Is there anything we haven't asked you that you think is important for us to know about this initiative?

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