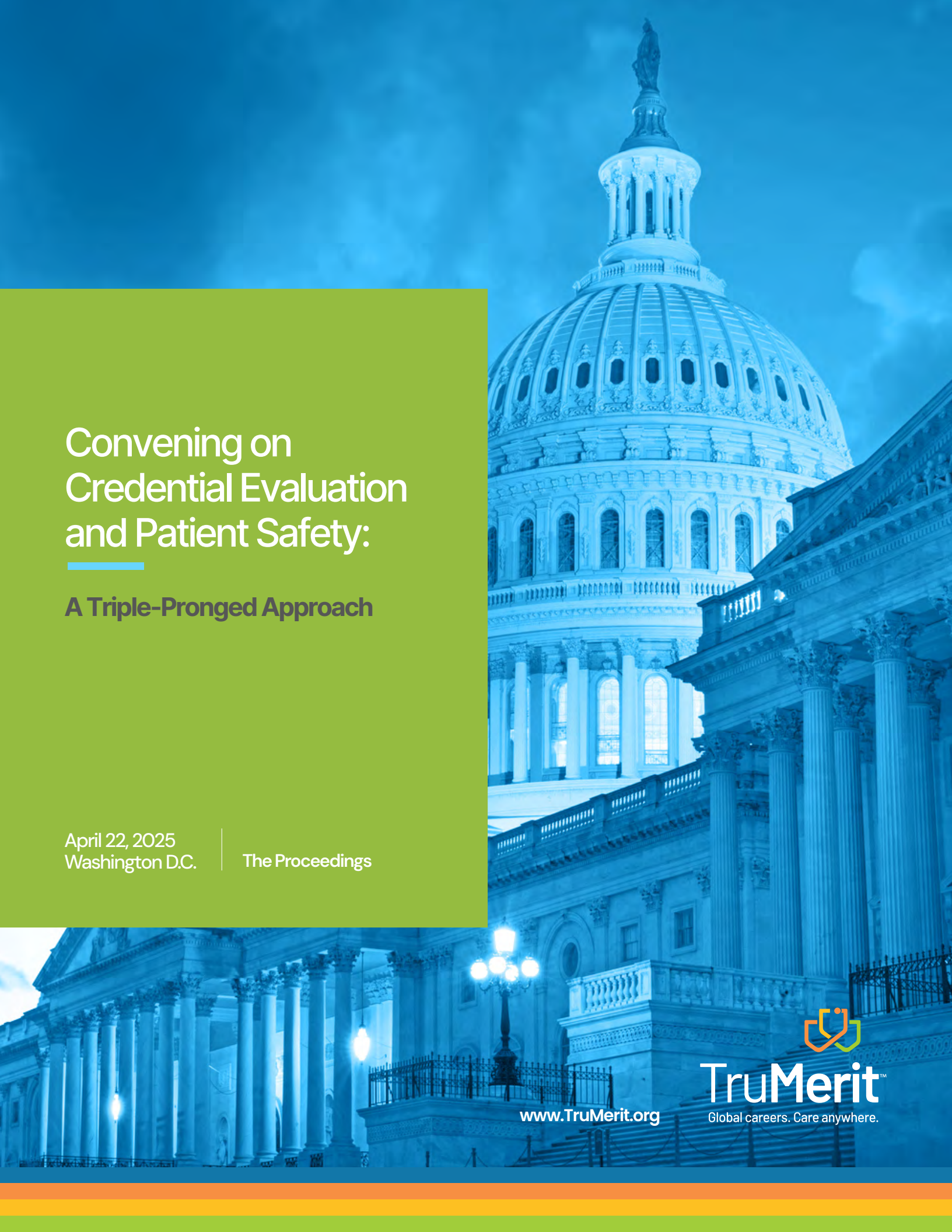

Convening on Credential Evaluation and Patient Safety:

A Triple-Pronged Approach

April 22, 2025
Washington D.C.

The Proceedings

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Foreword

At TruMerit, our mission has always been rooted in a singular, unwavering commitment: to protect the public by ensuring that only qualified, competent health professionals enter and thrive within the U.S. healthcare system. The April 2025 Convening on Credential Evaluation and Patient Safety was born from this commitment—a recognition that safeguarding patient well-being begins long before a clinician steps into a hospital or clinic. It begins with how foreign-educated health professionals are evaluated, supported, and empowered to serve the people they care for.

This Convening was not just a gathering of experts; it was a call to action. TruMerit brought together leaders from regulatory bodies, government agencies, healthcare institutions, academic organizations, and credentialing authorities to confront a critical question: how can we better ensure that foreign-educated health professionals are not only qualified on paper but are fully prepared to deliver safe, effective care in the U.S.?

We chose to focus on three foundational pillars—education comparability, English language proficiency, and authenticity of credentials—because each represents a vital safeguard in the credentialing process:

- **Education comparability** ensures that a health professional's training aligns with U.S. standards, not just in structure but in substance. It is the bedrock of clinical competence and professional readiness.

- **English language proficiency** is essential for clear, compassionate communication with patients, families, and care teams. It is not merely a technical skill—it is a matter of safety, trust, and dignity.

- **Authenticity of credentials** protects the system from fraud and deception. It ensures that those who care for our communities are who they say they are, with the qualifications they claim to hold.

These focus areas fill a longstanding void in the credentialing industry. Too often, evaluations have emphasized equivalency over comparability, test scores over real-world communication, and document collection over document verification. Our Convening challenged these norms and charted a new path—one that is more rigorous, more equitable, and more attuned to the realities of modern healthcare.

When it comes to foreign-educated nurses and allied health workers, the real objectives of our work are about more than gatekeeping—they are about guidance. By setting clear, fair, and evidence-based standards, we help these professionals succeed. We recognize their potential, honor their training, and support their transition into a new healthcare culture. In doing so, we strengthen the workforce and, most importantly, protect the patients they serve.

This report captures the insights, challenges, and commitments that emerged from our Convening. It is both a reflection of where we are and a roadmap for where we must go. We invite all stakeholders to join us in this journey—because public protection and professional success are not opposing goals. They are, in fact, two sides of the same promise.

Peter Preziosi, PhD, RN, CAE
President & Chief Executive Officer
TruMerit

Julia To Dutka, EdD
Chief, Global Health Workforce Development Institute
TruMerit

Proceedings overview

Rick García, PhD, RN, CCM, FAAOHN, FNYAM, FAADN
Chief Executive Officer of the Organization for Associate Degree Nursing (OADN)

The April 2025 Convening, co-hosted by TruMerit (formerly CGFNS International) and Fragomen, brought together diverse stakeholders, including regulatory bodies, federal agencies, academic leaders, healthcare employers, and language assessment experts. They reaffirmed their shared responsibility in protecting the healthcare professions and the public through rigorous credentialing practices. Discussions focused on three primary areas: English language proficiency (ELP), educational comparability, and preventing fraud in international credential evaluation.

Participants acknowledged that effective communication in healthcare is non-negotiable. However, inconsistencies in English language proficiency cut scores and a lack of concordance across various assessment tools have raised concerns. These gaps potentially place patients at risk and compromise workforce quality. The group proposed establishing interim, consensus-based cut scores and initiating a healthcare-specific standard-setting study to create consistent, empirically validated benchmarks.

On educational comparability, the Convening highlighted the need to evolve from equivalency-based evaluations toward more meaningful comparability assessments. This shift would allow for a deeper understanding of global educational systems while maintaining the high standards expected in U.S. healthcare practice. Attendees supported refining evaluation methodologies so that they recognize international diversity without compromising patient safety.

The third and final area centered on eliminating fraud in credential evaluation. Fraudulent transcripts, misrepresented licenses, and falsified experience documents continue to threaten public trust. A shared sense of urgency led to proposed solutions including the adoption of advanced technologies, increased cross-border collaboration, and standardized protocols to detect and prevent fraud before it reaches the licensure stage.

The expected outcomes of this Convening include stronger collaboration among professional state boards, credentialing organizations, and employers; a unified approach to English language standards; and a commitment to updating credential evaluation processes in response to research and evolving regulatory needs. Attendees agreed that fraud prevention is not only a technical challenge but a moral imperative that demands transparency, accountability, and collective action.

Ultimately, the Convening served as a clarion call for professional state boards and allied partners to lead in safeguarding the profession. By aligning policies, investing in modern tools, and strengthening interagency cooperation, communities of interest reaffirmed their role as gatekeepers of patient safety—and champions of a fraud-free healthcare workforce.

PANEL 1: English Language Proficiency for Credentialing Excellence: The Hidden Dimension of Practice Competency for Migrating Nurses and Other Health Professionals

Facilitated by Julia To Dutka, Chief, Global Health Workforce Development Institute TruMerit. Panelists were Tracy Wallowicz, MLS, Senior Vice President, Regulatory Affairs and Chief Communications Officer, Intealth; and Jonathan Schmidgall, Senior Research Scientist, ETS Research Institute.

Introduction
Julia To Dutka, EdD
Chief, Global Health Workforce Development Institute
TruMerit

The United States has been built on the backs of immigrants. Regardless of their backgrounds, they brought with them unique talents and skills and an indefatigable human spirit to help build our communities across the land and to make us what we are today.

Today's immigrant health professionals are no exception. Having been educated and trained for specific professional roles in foreign countries, they have found their way to the United States to meet health workforce needs. According to 2021 data from the U.S. Census Bureau, of the 15,240,000 health workers employed in the country, 2,775,000 were immigrants, representing 15.7% of the total. A further breakdown reveals that of the 3,417,000 registered nurses in the U.S., 546,000 were migrants, representing 16% of the total registered nurse workforce.

The Migration Policy Institute's analysis of the 2021 data shows that the distribution of migrant health workers was not even across the states. The highest concentration was in New York, where 37% of health workers were migrants, followed by California with 35%, New Jersey with 32%, Florida with 30%, Maryland and Hawaii with 26% each, and Nevada with 24%.

These data are reason enough for us to focus on how best to evaluate the knowledge and skills as well as the English language proficiency of these migrating health workers as they seek to join the U.S. health workforce. Comparability of education is foundational to determining eligibility for practice, but effective communication is at the center of safe patient care. Evaluating English language proficiency for professional practice is a recurring theme that requires our attention. It is an assessment area that has not been studied with the rigor and scientific evidence that it deserves. The English language proficiency panel that was assembled here will help us begin this dialogue.

International medical graduates and English proficiency

Tracy Wallowicz, MLS
Senior Vice President, Regulatory Affairs and Chief Communications Officer
Intealth

International medical graduates (IMGs) are an indispensable part of the U.S. physician workforce, comprising approximately 25% of practicing physicians in the country. Their contributions are especially critical in underserved areas, where access to care often hinges on the presence of globally trained physicians.

Who are IMGs?
An IMG is a physician who obtained their basic medical degree from a medical school located outside of the United States and Canada. As of July 1, 2025, graduates of Canadian medical schools will also be categorized as IMGs under Educational Commission for Foreign Medical Graduates (ECFMG) standards.

While the IMG designation relates to where a medical degree is earned, IMGs fall into two primary categories:

- **Foreign Citizen IMGs (~70% of IMGs):** These individuals usually apply to ECFMG as medical school graduates and must obtain a visa, most commonly the J-1 or H-1B, for graduate medical education (GME). Their path to U.S. practice tends to be longer and more complex due to immigration and credentialing requirements.

- **U.S. Citizen IMGs (~30% of IMGs):** These applicants are U.S. citizens who pursued medical degrees abroad, often in the Caribbean or Eastern Europe. They usually apply to ECFMG as students and do not need visas, making their transition to GME more aligned with that of U.S. medical school graduates.

Why English proficiency matters
While academic qualifications and clinical acumen are essential, strong English communication skills are equally critical for the safe and effective practice of medicine in the United States. English proficiency supports success in four key domains:

1. Team-based care
U.S. healthcare is inherently collaborative. Physicians work in close coordination with nurses, pharmacists, specialists, social workers, and other team members. Fluent and confident communication is vital, particularly during high-stakes interactions like patient handoffs, emergency care, and multidisciplinary rounds.

Even minor miscommunications can delay treatment, compromise care quality, or create friction within teams operating under intense pressure.

2. Patient safety and rapport
Clear, empathetic communication directly impacts clinical outcomes. Misunderstandings caused by language barriers can lead to medical errors, misdiagnoses, or ineffective treatment plans. This not only endangers patients but also introduces legal and reputational risks to physicians and institutions.

Additionally, establishing trust with patients requires more than just accuracy, it demands emotional nuance. Rapport, bedside manner, and shared decision-making all depend on the ability to connect in a shared language.

3. Well-being and integration
Language barriers can foster professional and personal isolation. When IMGs feel unable to fully express themselves or feel misunderstood by colleagues, they may experience diminished confidence, imposter syndrome, or burnout.

Conversely, strong communication skills can be a bridge to belonging. They allow IMGs to build social and professional networks, seek mentorship, and establish a sense of community—both inside and outside the workplace.

4. Academic and clinical performance
Residency and fellowship training programs in the United States are academically rigorous and heavily communication driven. IMGs must participate in didactic sessions, journal clubs, case presentations, and bedside teaching, all while preparing for licensing exams such as USMLE Step 3.

English fluency is key to mastering medical terminology, understanding complex material, and demonstrating clinical competence during assessments and evaluations.

Supporting the future of U.S. healthcare
As the global health workforce continues to evolve, the importance of language proficiency among IMGs cannot be overstated. It is not merely a technical skill—it is a cornerstone of safe, inclusive, and high-quality care.

By ensuring that IMGs have the communication skills they need to thrive, we are not just supporting individual physicians, we are strengthening the entire U.S. healthcare system.

Considerations for setting language proficiency score requirements for healthcare professionals.

Jonathan Schmidgall
Senior Research Scientist
ETS Research Institute

Communication skills are needed for safe and effective healthcare. Comprehension skills (reading, listening) are required for understanding medication dosages, patient histories, and other critical functions. Speaking skills are essential for communicating instructions and information to patients and colleagues. Poor communication skills can lead to patient anxiety, mistrust, and noncompliance.

Language proficiency assessments can be designed and demonstrated to provide reliable, fair, and valid measures of communication skills. Since language proficiency is a complex construct (i.e., a set of interrelated knowledge, skills, and abilities), the challenge for assessment is to find the right balance between defining and measuring the construct in a practical vs. comprehensive manner.

Communicative competence is typically defined and operationalized in language assessment as the use of receptive (reading, listening) and/or productive (speaking, writing) skills for a functional purpose. Communicative skills draw upon underlying language knowledge (e.g., vocabulary, grammar, discourse, pragmatics) and other enabling skills (e.g., pronunciation) to facilitate production or comprehension of language —often in interaction—in a communicative context. A real-world communicative context typically includes cultural, social, and situational norms that influence the appropriateness and effectiveness of language use.

Even if different tests measure the same skill in a similar manner, they can vary in terms of their precision. In assessment, precision can refer to the how "fine-grained" the measurement and corresponding score scale is designed to be, as well as the degree to which it produces scores that are consistent or reliable. For example, the score scales of two tests may cover comparable ranges of proficiency (e.g., beginner

to advanced) but vary in the extent to which levels or degrees of proficiency can be meaningfully distinguished across this range (e.g., a 10-point score scale vs. a 40-point score scale with comparable levels of reliability).

In practice, however, different tests tend to measure slightly different ranges of proficiency. Some tests are designed to measure a wide range of proficiency (e.g., from basic to advanced), while others are designed to target more specific proficiency levels (e.g., high-intermediate to advanced). Measuring a wider range of proficiency typically involves sacrificing some precision, increasing testing time and/or the number of items administered, or the use of more sophisticated assessment methods; consequently, it's important to consider all these tradeoffs when considering which assessment is best suited for a particular purpose.

These differences can make it challenging or even inappropriate to directly compare the scores of different language tests, even when they purport to measure similar skill(s). Comparability and c oncordance research is conducted to establish fairer and more accurate comparisons between scores on tests that measure similar skills, but ultimately a more particular type of research is needed to justify the use of test score requirements for high-stakes decisions.

Standard setting creates evidence-based thresholds for competency

Standard setting is the process of establishing cut scores on a test that differentiates "adequate" from "inadequate" proficiency for a particular purpose.

In the context of medical communication, a standard-setting study could be used to determine the minimum level of proficiency needed to safely and reliably perform job tasks. In a standard-setting study, researchers convene a panel of subject matter experts and use a systematic, judgment-based procedure that produces a minimum required score (or cut score). The process and rationale for the cut score are clearly documented and the validity can be established.

When we want to use test scores to inform important decisions such as hiring and promotion, it is crucial to have a principled basis for setting competency thresholds. A decision-maker can utilize scores from a high-quality assessment that measures the skill(s) they care about, but without referencing appropriate competency thresholds the use of scores may produce unintended, negative outcomes. The purpose of standard setting is to provide a principled, evidence-based approach for establishing competency thresholds.

The cut scores recommended by a standard-setting study may be further adjusted to reflect a more stringent or lenient approach to skill requirements. When more stringent score requirements are adopt-ed, decision-makers can have more confidence that recruited healthcare professionals can cope with the English language demands of providing care; unfortunately, there's also an increased likelihood that some healthcare professionals whose English proficiency was sufficient for providing care might be excluded. When more lenient score requirements are adopted, decision-makers are likely to have access to a larger pool of applications from which healthcare professionals can be recruited; however, some of these professionals may have difficulty coping with the English language demands of providing care.

Summary

When English skills are needed to support safe and effective healthcare, language proficiency assessments can measure the communicative skills needed. Differences in language test design (including the nature of the skills measured, range of proficiency targeted, and precision of the score scale) and test quality (reliability, validity, fairness) lead to challenges in score comparability; these can be addressed through

concordance studies and research-based comparison tables. Regardless, effective use of assessment is predicated on using scores appropriately for purpose. Standard-setting research creates evidence-based thresholds for competency.

PANEL 2: Education Comparability and Cultural Context

The concept and purpose of education comparability in credentialing was explored during the second panel of the Convening. The panel was facilitated by Jason Richter, Project and Product Champion, Global Health Workforce Development Institute, TruMerit. Panelists providing their unique insights on documenting learning were Julia Funaki, Director, International, American Association of Collegiate Registrars and Admissions Officers (AACRAO), and Mary Romanello, Director, Accreditation, American Physical Therapy Association, Commission on Accreditation in Physical Therapy Education (CAPTE).

Degrees of difference: Rethinking global credentialing

Jason Richter, BA
Project and Product Champion, Global Health Workforce Development Institute
TruMerit

In a rapidly globalizing world, we must begin by asking ourselves a fundamental question: Why are we evaluating credentials in the first place? The answer is not as simple as checking a box or validating a transcript.

Credential evaluation is deeply tied to purpose, and that purpose differs depending on the pathway. Whether for academic admissions, immigration, licensure, employment, or certification, each context requires its own kind of validation. Each carries significant consequences for the individual seeking opportunity and mobility. Therefore, the purpose behind credential evaluation is foundational to how we interpret and apply our judgments.

Historically, we have leaned heavily on equivalency, asking whether credit hours, grades, or degree titles match. This provides a baseline but only scratches the surface. Comparability pushes us further: Does the curriculum in question prepare learners in a similar way? Does it meet the same learning objectives or align with similar expectations? Beyond that, competency assessment brings us to the heart of professional practice. It asks the most crucial question of all: Can this person do what is expected in a real-world clinical or workplace setting?

These are not isolated steps but layers within a broader continuum of readiness. We must evolve beyond treating them as separate checkboxes and begin to see them as interconnected components that together reflect the true capability of a professional. The shift from inputs to outputs, from how much time someone has spent in a classroom to what they can actually do, is redefining how we understand credentials.

Degree titles can no longer serve as reliable proxies for professional readiness. We are seeing rapid growth in micro-credentials that assess targeted skills and macro-credentials that reflect broad, integrated standards of professional practice. This evolution allows for flexibility while ensuring that assessments remain rooted in real, observable knowledge and skill.

At TruMerit, we advocate for a nuanced, dialog-driven approach to global credentialing. Rigid formulas and static checklists no longer suffice in a world as diverse and dynamic as ours. Instead, we must adopt a hybrid

model that values both quantitative data and contextual understanding, both numbers and narratives. The global healthcare workforce is too varied and too complex for one-size-fits-all solutions.

Let us think of our credentialing tools not as blunt instruments but as members of an orchestra. Each has its own strengths, but harmony is only achieved when they are used together—wisely, skillfully, and intentionally. Let's not just evaluate credentials, let's reimagine them. Let's envision a credentialing system that meets individuals where they are—one that reflects the complexity of global education systems and validates the academic achievements, theoretical knowledge, and demonstrated competencies of the healthcare workforce whether they practice in a rural village or on the global stage. And above all, let us never forget who stands to benefit the most: the patients whose care depends on the skill and readiness of the professionals we credential.

This is not just a technical process. It's a human one—and one that is necessary to truly fulfill the vision of providing care… anywhere.

The functional role of transcripts in global health workforce development: Bridging education comparability and cultural context

Julia Funaki
Director, International
American Association of Collegiate Registrars and Admissions Officers (AACRAO)

Introduction

Global health workforce challenges fundamentally center on a critical question: How do we better understand and quantify the full scope of education and experience that healthcare workers have undertaken—both formal and informal? This challenge extends beyond healthcare to all learners seeking recognition for their diverse educational pathways. Drawing from AACRAO's century-long expertise in credential evaluation and learning mobility, this contribution explores how transcript functionality can address these quantification challenges, particularly as TruMerit has engaged our expertise to support their patient safety and global health workforce development initiatives.

The quantification challenge: Beyond course listings

The modern academic transcript, formalized in U.S. higher education since the 1920s, was designed for a different era when education followed predictable pathways. Today's global health workforce challenges expose the limitations of traditional transcript functionality:

The invisible learning problem: Healthcare workers often possess crucial competencies gained through informal education, community health initiatives, traditional healing practices, or emergency response experiences that never appear on formal transcripts. These "invisible" qualifications may be equally or more relevant to effective healthcare delivery than formal coursework.

Content vs. competency gap: Traditional transcripts list courses but fail to quantify what learners actually know and can do. A course titled "Community Health" might represent vastly different competencies depending on the educational context, clinical exposure, and practical application opportunities.

Experience quantification: Healthcare workers accumulate invaluable experience through practice, but current transcript models provide no systematic way to document, verify, and quantify this experiential learning alongside formal education.

Education comparability and cultural context: AACRAO's broader mission
The Education Comparability and Cultural Context panel highlighted how AACRAO's expertise in understanding and quantifying diverse educational experiences serves learners across all fields, with particular relevance to TruMerit's healthcare workforce initiatives:

Universal quantification challenges: Whether in healthcare, technology, or trades, learners worldwide face similar challenges in having their full educational experiences recognized. AACRAO's work addresses the fundamental question: How do we systematically quantify and communicate what learners know and can do, regardless of how they learned it?

Cultural context in learning recognition: Traditional transcripts often reflect Western educational models that may not capture the value of apprenticeship systems, community-based learning, or culturally specific knowledge transmission methods that are particularly relevant in global health contexts.

The comprehensive learner picture: Healthcare workers, like all learners, bring combinations of formal education, informal learning, work experience, and cultural knowledge that collectively define their qualifications. Current transcript systems fail to capture this comprehensive picture, creating barriers to workforce mobility and recognition.

Why this work matters: From healthcare to universal learning recognition
The quantification of diverse learning experiences represents one of the most critical challenges facing workforce development globally. In healthcare, this challenge directly impacts patient safety and access to care. When we cannot systematically understand and verify what healthcare workers know and can do—whether learned through formal education, community practice, or emergency response—we create barriers that can leave communities underserved while qualified providers remain unrecognized.

This challenge extends far beyond healthcare. Across all sectors, traditional credential systems fail to capture the full spectrum of human learning and capability. The COVID-19 pandemic highlighted how quickly individuals can acquire critical skills through non-traditional pathways, yet our systems for recognizing these competencies remain inadequate.

AACRAO's Learning and Employment Records (LER) initiative, including the LER Accelerator project's 25 pilot institutions, represents a systematic approach to this universal challenge. By developing interoperable, skills-based documentation systems, this work creates pathways for comprehensive recognition of learning regardless of how it was acquired.

Critical takeaways and future directions
Three key insights emerged from the Convening discussions that apply to learners across all fields, with particular relevance to TruMerit's healthcare workforce initiatives:

1. **Quantification as a foundation:** Understanding learner qualifications requires systematic approaches to quantifying both formal and informal educational experiences. This quantification challenge exists across all fields but is particularly critical in healthcare, where patient safety depends on accurate assessment of provider qualifications.

2. **Technology as a universal enabler:** Digital credential systems like LERs provide scalable solutions for documenting and verifying diverse learning experiences across cultural and educational contexts.

These systems can serve learners in healthcare and beyond, supporting workforce mobility and recognition globally.

3. **Partnership imperative:** Addressing learning quantification challenges requires collaboration between credential experts like AACRAO and domain specialists like TruMerit. This partnership model—combining educational credential expertise with field-specific knowledge—offers a pathway for better understanding and recognizing learner qualifications across all sectors.

As we advance toward more functional transcript models, we must ensure they serve the ultimate goal of accurate, comprehensive recognition of what learners know and can do. AACRAO's expertise in quantifying diverse educational experiences, developed through decades of work with learners across all fields, provides an essential foundation for TruMerit's healthcare workforce initiatives and similar efforts to understand and recognize the full scope of human learning and capability.

Measuring what matters: Education comparability and cultural context

Mary Romanello, PT, MS, PhD
Director, Accreditation
American Physical Therapy Association (APTA), Commission on Accreditation in Physical Therapy Education (CAPTE)

Introduction

The purpose of the presentation was to convey background on the Commission on Accreditation in Physical Therapy Education, or CAPTE, and provide participants with insight into how CAPTE applies its guiding documents, Standards and Required Elements for Physical Therapist Education Programs and CAPTE's Rules of Practice and Procedure.

About CAPTE

CAPTE is recognized by the U.S. Department of Education and Council for Higher Education Accreditation for entry-level physical therapist and physical therapist assistant education program accreditation in the United States. CAPTE is the entry-level education accrediting arm of the American Physical Therapy Association, has been an independent agency since 1977, and has been the sole recognized accreditor for physical therapy entry-level education programs since 1983. CAPTE is an active member of the Association of Specialized and Programmatic Accreditors.

As of June 2025, CAPTE has accredited 322 doctor of physical therapy programs and 390 physical therapist assistant education programs. These are programs holding Accreditation or Candidate or Accreditation status.

CAPTE comprises a broad representation from the higher education community, physical therapy clinical settings, and the public in its cadre of reviewers, panel members, and board members. This includes the cadre of program reviewers and the CAPTE Board of Commissioners. These individuals are guided in their decision-making by the CAPTE Standards and Required Elements and the CAPTE Rules of Practice and Procedure.

CAPTE guiding documents

CAPTE develops and implements Standards and Required Elements and Rules of Practice and Procedure to foster improvement to elevate physical therapy education and practice. The CAPTE board conducts an

annual review of the commission's Rules of Practice and Procedure and follows these rules in conducting a review of the Standards and Required Elements at least every five years.

CAPTE Standards and Required Elements and Rules of Practice and Procedure are designed specifically for evaluating entry-level education programs. They are not designed to evaluate foreign-trained physical therapists. CAPTE refers foreign-trained therapists to the respective physical therapy state and jurisdictional regulatory bodies and to the Foreign Credentialing Commission on Physical Therapy to determine an individual's eligibility for licensure.

Expectations for entry-level programs

CAPTE Standards and Required Elements provide information on expected competencies individuals must demonstrate to graduate from an accredited program and be eligible for licensure in the United States. Expectations for physical therapist education curricula are outlined in Standard 7; clinical education in Standard 6; faculty requirements in Standard 4; and student outcomes in Standard 1.

Standard 7 outlines a curriculum framework that includes expected knowledge and skills students should demonstrate in basic sciences, clinical sciences, evidence-based practice, patient examination, evaluation, diagnosis, intervention, professional ethics, values, and responsibilities. Standard 6 elements require that students complete at least 30 weeks of full-time clinical experience that is supervised by a licensed physical therapist and that students participate in planned interprofessional learning activities. CAPTE expects programs to confirm that a student's performance, at a minimum, meets entry-level practice prior to graduation and that the program identifies the criteria by which assessment of the student's entry-level practice performance is measured.

CAPTE lays out expectations for education program faculty who are physical therapists. Each faculty member teaching in the entry-level program must demonstrate contemporary expertise in the areas in which they teach, maintain a current, unencumbered physical therapist license in the jurisdiction where the program is located, and participate in teaching, scholarship, and service. At least 50% of the core faculty must hold an academic doctoral degree.

The above-described expectations are designed to lead to programs demonstrating compliance with Standard 1, in which CAPTE expects that each Doctor of Physical Therapy program demonstrates student and program outcomes. At a minimum, programs must demonstrate that students graduate at a rate not less than 80%, show an ultimate pass rate of at least 85%, and that 90% of graduates who seek employment are employed within one year of graduation from the program.

Relevance to foreign-trained PTs seeking to practice in the United States

The Federation of State Boards of Physical Therapy uses the Coursework Tool to evaluate foreign education equivalency using CAPTE Standards and Required Elements as a benchmark. This includes verification that clinical experiences result in an applicant meeting entry-level practice criteria. After evaluation of program equivalency with U.S. physical therapy program standards, an individual trained in another country must pass the National Physical Therapy Exam and jurisdictional jurisprudence exam. State boards may require specific coursework based on gaps identified when comparing foreign education to CAPTE standards.

The American Physical Therapy Association's "A Vision for Excellence in Physical Therapy Education" outlines guiding principles for the domains of competence. These are a defined set of standard performance outcomes for learners across the learner continuum in physical therapy education.

These domains of competence correspond to CAPTE standards in the areas of:

- Foundational knowledge.
- Curriculum requirements.
- Evidence-based practice.
- Self-assessment and feedback.
- Communication skills.
- Professional behaviors.
- Safety.
- Clinical reasoning.
- Examination and intervention skills.
- Professional standards.

Overall, CAPTE Standards and Required Elements require program curricula to include students demonstrating (a) skill progression from basic to advanced, (b) readiness for clinical education, (c) entry-level practice skills prior to graduation, and (d) professional behaviors and attributes. Programs show how they achieve their outcomes through an articulated framework for assessment.

PANEL 3: Toward a Fraud-Free Environment

The role of credentials evaluation in combatting fraud, and the importance of working toward a fraud-free environment, were at the center of the third and final panel of the Convening on Credential Evaluation and Patient Safety. Facilitated by Emily Tse, Senior Director of Knowledge Management at TruMerit, the panel included Lori Scheidt, Executive Director of the Missouri State Board of Nursing, and Rick García, Chief Executive Officer of the Organization for Associate Degree Nursing (OADN).

Toward a fraud-free environment

Emily Tse, MPhil
Senior Director of Knowledge Management, Global Health Workforce Development Institute
TruMerit

Fraud, unfortunately, is an international, dynamic problem. The examples of Recto University in the Philippines and Operation Nightingale in the U.S. highlight the ease with which fraudulent credentials can now be produced and obtained. Recto University refers to an area in Manila where an array of fake documents, such as diplomas and transcripts, are bought and sold. In the instance of Operation Nightingale in 2023, the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG), the FBI, and the Department of Justice uncovered the sale and use of over 7,600 fake nursing qualifications. Many of these led to access to NCLEX, the national nursing licensure examination, state licensure, and employment that included positions both in registered nursing and practical/vocational nursing.

These examples underscore the importance of the review process of candidates for licensure and employment. In the case of internationally educated nurses, credential evaluation is a key component, as it helps determine the comparability of the nursing qualification obtained abroad to that in the U.S. However, the comparability assessment has no value if the credentials themselves are fraudulent. Working toward a fraud-free environment is the key to an accurate credentials review. Being able to determine that these health professionals have the necessary knowledge and skills to practice helps ensure patient safety.

To achieve a fraud-free environment, we must consider three issues. First, we must acknowledge the changing credentials landscape—that we are transitioning from a paper-oriented one toward a paperless one. While digital credentials are efficient, fast, and convenient, issues around security must be considered. Email spoofing, for example, illustrates how unsafe email is as a method of transmission and delivery.

Second, the source of the documents and maintaining the chain of custody are also important considerations. While accepting copies of records from the candidates may be most convenient, it is important that the documentation be received directly from issuing and/or validating authorities, where possible. Requiring primary source verification helps to ensure that educational and professional records are authentic and tamper-free.

Third, fraud can be committed along many data points. As such, it is important that rigorous checkpoints be established through the credential evaluation and review process. Inconsistencies are often revealed among the biodata, educational data, and professional data provided, especially when there is a lack of understanding of the details of another country's educational and nursing regulatory system. Credential evaluators, who are experts in these systems, play an important role in conducting rigorous cross-checks.

We must work toward a fraud-free environment, which entails having a secure electronic delivery mechanism, primary source verification, and rigorous data checkpoints. By protecting the integrity of the nursing profession, we are also safeguarding our healthcare system and protecting the public.

Safeguarding the profession and protecting the public
Rick García, PhD, RN, CCM, FAAOHN, FNYAM, FAADN
Chief Executive Officer of the Organization for Associate Degree Nursing (OADN)
Lori Scheidt
Executive Director of the Missouri State Board of Nursing

Having collectively served on five regulatory bodies, Rick García and Lori Scheidt each presented from their extensive regulatory experiences. They both stressed the relentless vigilance regulators must hold in their commitment to protecting the public and ensuring that no harm is done. As part of this mandate, nurse regulatory boards (NRBs) manage the licensure process as a frontline defense, to make certain that only those with the requisite knowledge and skills can enter the profession.

The licensure process includes confirming possession of an appropriate nursing qualification, conducting a background check, and certifying that the nurse successfully passed the licensure examination. Helpful tools include Nursys, the national database managed by NCSBN for the verification of nurse licenses, and FITS, the Falsified Identity Tracking System, also provided by NCSBN. They have assisted in the development of a number of these tools and guides for the regulatory community.

It was recognized that the licensure process must be a rigorous one. Where documentation is concerned, primary source verification is critical. Unfortunately, there can be complications that lead to nurses being unable to satisfy this requirement. Examples include natural disasters that impede their ability to secure the required official records, political conflict that may occur at the time, and personal and financial hardships. In these instances, it is up to the NRBs to determine what reasonable exceptions can be made.

The NRBs must strike a balance between mobilizing the nursing workforce and protecting the public. Another available tool is NCSBN's Nurse Licensure Compact (NLC), which facilitates a multi-state license

through establishing uniform licensure requirements. In the case of internationally educated nurses, this would include graduating from a nursing program that is recognized or approved by the appropriate authorities in the country of study, as well as passing an English proficiency examination, where applicable. At present, there are 43 members in the NLC, and it continues to grow.

Committed to protecting the public, NCSBN continues to provide support and guidance in detecting and combatting fraud. It has provided best practices and facilitated the reporting and monitoring of fraudulent activity, as well as notification by educational institutions, practice settings, and NRBs. Through these collective efforts with the nurse regulatory boards, we can work toward a fraud-free environment.

Contributions from Convening Participants

The Convening brought together representatives from regulatory bodies, government agencies, healthcare institutions, academic organizations, and credentialing authorities. The following perspectives have been offered by participants to highlight the themes discussed at the Convening.

Umamaheswari (Uma) Venugopal, MSN, RN, CCRN, NEA-BC
President
National Association of Indian Nurses of America (NAINA)

The National Association of Indian Nurses of America (NAINA) represents a vibrant and accomplished community of Indian nurses who bring clinical expertise, cultural humility, and unwavering commitment to patient care across the United States. These professionals often navigate complex credentialing, licensing, and recognition processes to enter the U.S. workforce. As a leading voice for Indian nurses in America, NAINA believes that fair, consistent, and culturally informed credentialing is not only critical for individual advancement but also essential for safeguarding public health and the integrity of our national health workforce.

At the recent TruMerit Convening, which centered on English language proficiency, educational comparability, and fraud mitigation, NAINA emphasized that credentialing practices must be rigorous yet equitable and transparent. We support strong English proficiency standards tied directly to real-world clinical communication, without disadvantaging qualified professionals from diverse linguistic backgrounds. Likewise, we advocate for credentialing processes that recognize the strength of India's nursing education within its cultural context, valuing collaboration with the diaspora organizations to build mutual understanding. Finally, we strongly support efforts to safeguard the integrity of the profession through fraud prevention but urge that verification processes remain accessible and respectful, ensuring ethical nurses are supported, not hindered, in their journey to contribute meaningfully to the U.S. healthcare system.

"Indian nurses bring world-class education, cultural fluency, and clinical expertise. As we continue to strengthen credentialing practices, we are proud to collaborate with stakeholders like TruMerit to ensure pathways that are transparent, equitable, and centered on quality and safety."

Gary Neale
Vice President Americas
OET (Occupational English Test)
OET would like to echo the importance of the topics covered at the Convening, particularly those discussed in the session on English language proficiency standards. As discussed by Jonathan Schmidgall from ETS,

there are scientifically agreed-upon procedures for comparing different tests. They require, first, an evaluation of the extent to which the tests are measuring the right things and measuring comparable things. In the case of OET, we have a test that measures the communication skills in English of healthcare professionals, making it the most appropriate English proficiency test for this context. This was affirmed by Tracy Wallowicz, who mentioned how OET is the sole test that Intealth (now the parent organization of ECFMG) uses to satisfy the clinical communication skills requirement for certification of international medical graduates (IMGs).

Once construct comparability has been determined, the next step in the process is to determine comparable score outcomes across tests. This is equally crucial because accepting scores that are too low or too high will have an adverse impact on the number and quality of healthcare professionals received into a healthcare system, with an impact on patient safety and public health. It is our view—validated by reports from the field—that the currently recognized scores across different English language tests are not, in fact, comparable. We are therefore grateful to Melissa Ryan Kemburu and the team at HRSA, who are taking a hard look at this issue and reevaluating the available academic evidence, to ensure that the accepted scores across tests are fair to healthcare professionals and right for the patients who will come under their care.

We hope that the standards established by the eventual HRSA position will be reviewed and considered by all state healthcare regulatory jurisdictions to ensure consistent minimum standards of relevant communicative skills across the U.S. healthcare workforce.

Gloria Lamela Beriones, PhD, RN, NEA-BC, FADLN
Immediate Past President
Philippine Nurses Association of America, Inc. (PNAA)

As a Filipino American nurse leader, I was invited to attend the TruMerit meeting in Washington, DC, April 22, 2025, the "Convening on Credentialing Evaluation and Patient Safety: A Triple-Pronged Approach." This meeting brought about plenty of personal reflection, being a migrant nurse in the United States myself. Since the early 1900s to the present, Filipino nurses have been an integral part of the U.S. healthcare system. It is estimated that over 150,000 Filipino nurses are working in the U.S. in various healthcare facilities but mostly in the hospitals.

My story and lived experiences, which resonate with many of my fellow migrant Filipino nurses, include my pre-arrival phase in the U.S., which started as a dream and served as strong motivation to come to this country to better myself personally and professionally. However, culture shock affects everyone who migrates and learns the U.S. nursing practice and lives in a country with a vastly different culture than what they grew up with.

My qualitative research study, "Adaptation Experiences of Internationally Educated Nurses Employed in the United States," showed ***adaptation barriers, both intrinsic and extrinsic.*** The intrinsic barriers to adaptation in nursing practice are being shy, timid, and sensitive while extrinsic barriers include language and communication, variation in nursing practice and technology, cultural difference, fear of healthcare lawsuits, and facing discrimination. The adaptation facilitators are intrinsic factors such as life-long learning,

determination to succeed, strong faith in God, and love of family while the extrinsic factors include support system from management, preceptor, educator, co-workers, family, and friends; thorough orientation and value of preceptor; interdisciplinary teamwork and partnership; utilization of evidence-based practice; and impact of NCLEX-RN on practice.

Filipino nurses new to the U.S nursing practice use adaptation strategies such as observing and listening to preceptor, educator, and co-workers; asking questions and engaging in hands-on practice; being a team player and having a positive attitude; embracing the value of life-long learning; building relationships and finding meaning in nursing practice; capitalizing on their personal traits and self-reflection. Filipino nurses are able to adapt, finding balance by overcoming barriers and contributing to the U.S. nursing practice.

Chloe Cannone
Director of U.S. Immigration
Shearwater Health

Attending the TruMerit Convening in D.C. was a great reminder of how many different organizations play a role in the journey to become a U.S. Registered Nurse and the great need for fully qualified and vetted healthcare professionals. For international nurses, specifically, it is encouraging to see how much care and thought are going into the agency's processes that set nurses up for success. From English testing to Boards of Nursing, these organizations are not just focused on meeting requirements but making sure they're truly prepared to thrive.

The agencies present shared real examples of ways they support nurses in being fully prepared clinically, educationally, and in their English proficiency. Nurses care for people at their most vulnerable, and it was clear that everyone in the room takes that responsibility seriously. The systems of licensure are not simply about completing a compliance checklist but about wholistically ensuring patient safety and long-term success for each nurse.

TruMerit continues to be a strong leader in this space, advocating for healthcare professionals, their patients, and the entire community supporting this process. This Convening helped create an opportunity for collaboration, which will lead to better outcomes for healthcare workers and for patients globally.

We are proud to support nurses and their healthcare community, both in their home countries as well as in the U.S., depending on where they choose to practice. Being in a room with others who are just as committed to their success was both energizing and inspiring.

Acknowledgements

TruMerit expresses sincere thanks to our colleagues who contributed to the Convening and these Proceedings.

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Tracy Wallowicz, MLS
Senior Vice President, Regulatory Affairs and Chief Communications Officer
Intealth

Appendix

The following program, position statements, and presentations can be found on and downloaded from the 2025 TruMerit DC Convening web page.

Convening Program Content

Position Statements

- English Language Proficiency Assessment
- Determining the Comparability of Education of Foreign Health Workers
- Toward a Fraud-Free Environment

Presentations

Panel 1: English Language Proficiency for Credentialing Excellence: The Hidden Dimension of Practice Competency for Migrating Nurses and other Health Professionals

- Percent of immigrant health workers in United States: U.S. Census Bureau 2021 data (Julia To Dutka)
- The case for English Language Proficiency—The view from the profession (Cheryl Peterson)
- International medical graduates and English proficiency (Tracy Wallowicz)
- Considerations for setting language proficiency score requirements for healthcare professionals (Jonathan Schmidgall)

Panel 2: Education Comparability and Cultural Context

- Degrees of difference: Rethinking global credentialing (Jason Richter)
- AACRAO: A legacy of integrity & expertise (Julia Funaki)
- Measuring what matters: Education comparability and cultural context (Mary Romanello)

Panel 3: Toward a Fraud-Free Environment

- Toward a fraud-free environment (Emily Tse)
- Safeguarding the profession: Protecting the public through credentialing and regulatory integrity (Rick Garcia)