Clinical Training Assessment Taskforce Update

The Clinical Training Assessment Taskforce (CTAT) was charged with developing competency-based assessment guidelines for the clinical training of genetic counseling students and integrating suggestions from genetic counselor stakeholders related to clinical training.

CTAT began our work by analyzing benefits and limitations of the current system of assessment of clinical training within genetic counseling, specifically by examining the requirement that each student complete at least 50 "core" cases across a range of practice areas, with minimum of 45 conducted in-person. This requirement was evaluated by exploring the correlation between the number of core cases and exam pass rate, as exam performance was viewed as the sole objective, standardized measure of competence. Initial analysis of 2017 RCS data showed no correlation; however, this dataset was limited and the Taskforce agreed it was important to test for this correlation across data from more programs.

To compare clinical training in genetic counseling to other healthcare professions, we reviewed clinical requirements and accreditation standards in other medical fields. While there was minimal literature on alternative clinical training models, there was some support for the efficacy of milestones for developing competence during medical school. Milestones were noted to focus on achievement of competencies rather than a prescribed amount of time in clinic, thus serving as an example of competency-based assessment applied to clinical training. With regard to accreditation, there was great variability of standards of clinical training and assessment across healthcare professions. Relevant standards were quite broad and often centered on accumulating a specified number of clinical hours. There was some evidence that more hours in clinic correlated with a higher pass rate for credentialing exams.

To reach a shared understanding of competency-based education and appraise competency-based assessment alternatives, we reviewed literature on competency-based education in healthcare, with special attention to competency-based assessments of clinical competence. This review generated a working definition of competency-based education as training that is "fundamentally oriented to graduate outcome abilities and organized around competencies" (Frank et al., 2010). The emphasis on competency-related outcomes was accompanied by strong need for robust assessment tools, which must be "integrated and cumulative, cover professional formation as well as formal knowledge and clinical performance, and include formative feedback, guidance, and mentoring as well as summative certification of competence at each level of development" (Morcke, Dornan & Eika, 2013). The imperative to couple competency-based assessments with training and support for assessors was reiterated throughout this literature. While it was evident that effective implementation of competency-based education is dependent on robust assessment, there was no apparent, universal standard or template for assessing competence, and only minimal evidence of efficacy of existing methods.

The above investigations informed a debate on the utility of the 50 core case requirement, namely in what ways is the core case requirement useful and/or problematic, and is it a measure of competence? To better understand what the core case number was measuring and how reflective the core case number is of competence, we constructed and disseminated a survey to collect program directors' perspectives on strengths, challenges, and omissions of current standards of clinical training in genetic counseling; the 50 core case requirement and the

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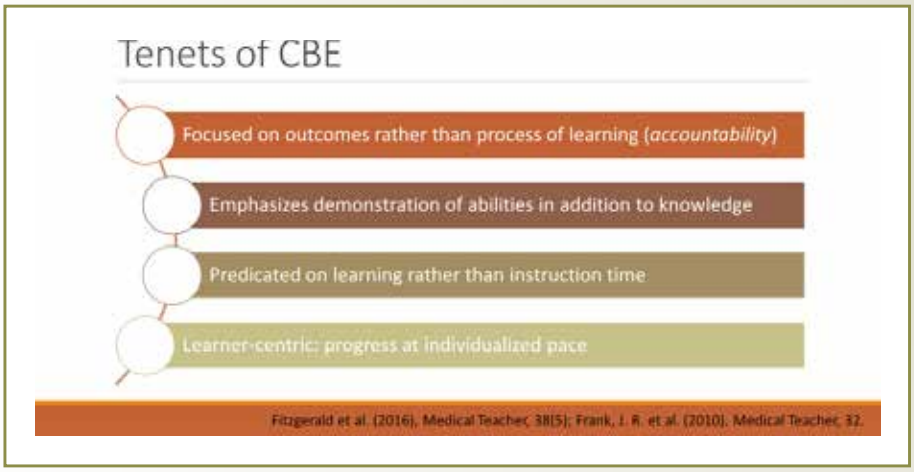
nature of its connection to competence; and clinical training assessment methods. The survey was open for five weeks at the beginning of 2018 and garnered 27 responses. Five programs also shared student-level deidentified core case numbers and exam performance data, and four shared their clinical training assessment forms.



CTAT met to integrate statistical analyses of a larger dataset of core case and exam data and qualitative analyses of responses to our survey and the Standards survey. Our findings were as follows:

1) Empirical evidence and stakeholder feedback concluded neither the number of cases nor the overall number of fundamental counseling roles performed predicts competence as defined by board exam performance.
2) Stakeholder feedback supports the retention of a minimum threshold for exposure to non-simulated clients, in diverse practice settings, with a variety of indications.
3) Stakeholder feedback supports inclusion of a broader range of service delivery models as part of Clinical Training. Furthermore, empirical data suggest increased amount of alternate service delivery models do not negatively impact board exam performance.
4) Stakeholder feedback and empirical evidence do not support requiring the distribution of core cases to align with the practice analysis. Furthermore, the practice analysis and the PSS are not designed for this purpose.
5) Review of competency-based education literature supports the adoption of this approach by ACGC.
6) Review of competency-based education literature did not identify an existing tool to assess competence in genetic counseling trainees, supporting a recommendation for the creation of a competency-based assessment tool and related utilization training.
7) Recognition that at this time, the only standardized assessment of clinical competence is ABGC board performance, which is post-graduation, and therefor problematic for assessing competence prior to/at the time of graduation.

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CTAT's discussions arrived at consensus that clinical training – like all components of a program – should support development of the PBCs. Since we are fortunate to have a set of well-defined competencies, we noted genetic counseling training is well positioned to apply CBE concepts to our clinical training model. In CBE, progress toward competence is not measured or achieved by completing a minimum number of hours, but rather by demonstrating abilities across a variety of settings – our recommendations were crafted to reflect these principles. Finally, our specific recommendations were provided to the Board on changes to the standards which aligned with our findings and tenets of competency-based education and assessment. The Board reviewed these changes and forwarded them to the Standards Committee for consideration and inclusion in the comprehensive review. (For more information on the Standards revision process see page 5.)

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