

Standards of Accreditation Revisions

FAQs

Section A

A1.1.3

Question: Does “should execute” a MOU apply only to clinical rotation placements, or is this meant to extend to other activities, such as a GC at a local hospital volunteering to help mentor a student thesis/capstone project, without any direct contributions from his/her employing hospital to the patient data set, data analysis or other activities?

Answer: This applies to more than clinical placements; it is also strongly encouraged when other institutions contribute to the program. With regards to this question, ACGC is not requiring affiliation agreements or MOUs, A1.1.3 states that we strongly encourage their use to protect the programs. Point C which is related to the MOU states if formal affiliation agreements are not required, then programs should execute.

From the introduction in the Standards document: Where the term “should” is used, the item is still required, but variation will be considered based on specific institutional policies and/or critical program needs.

A2.1

Question: Why is a medical director no longer a required program leadership position?

Answer: This change was made to allow for more flexibility in program leadership structure. The titled roles for additional leadership positions have been changed to better capture the fact that these roles are designed to complement and support the program director. ACGC strongly supports the collaborative relationships genetic counselors have with medical geneticists and other health professionals. Programs may include a medical director as an additional leadership position at their discretion (See Additional Leadership Positions Standard A2.3).

To ensure the continued valuable contributions medical geneticists can provide program leadership, a medical geneticist was made a required member of the Advisory Board (See Standard C1.4).

A2.2

Question: A.) Do A.2.2.2h and A.2.2.2i apply to the Program Directors already named on the New Program applications? This is a question of trying to understand when “becoming a program director for the first time” applies.

B.) Does becoming a program director for the first time refer only to individuals with no program leadership experience (i.e. have never been an Assistant Program Director), or also those who have been an Assistant Program Director, but never a Program Director? The main point of clarification here is that there doesn't seem to be a path for Assistant Program Directors to rise. Meaning, they need three years of experience, but there isn't a patient-facing requirement. They also aren't required to have experience supervising (whereas first time program directors are). A genetic counselor could theoretically qualify to be an APD, hold that role for many years and not be eligible for promotion. It would be helpful for someone to clarify that logic. Of course, this would be simpler if APD experience counts toward program director experience.

Answer: A.) PD qualifications apply to all individuals named as a PD for programs. Anyone new to the PD role will need to meet Standards A2.2.2h and A2.2.2i.

B.) Clinical supervision is a major component of a training program and the PD must have experienced providing clinical supervision to genetic counseling students.

Candidacy applications may be accepted in which the PD is still acquiring the required qualifications. However, the PD must have met the PD qualifications prior to submission of the New Program application. In the candidacy application programs must submit a detailed plan for the PD to acquire the required qualifications in the time frame needed. Prospective PDs are not allowed to continue to work to meet qualifications in the time before students' matriculate; the qualifications must be met to be granted Accredited, New Program Status.

The PD qualifications listed in A2.2.2 applies to all individuals regardless if previously an APD.

A2.2.2

Question: Why are the program director/co-director qualifications more rigorous?

Answer: The program director must provide effective program leadership, which requires experience and skills in genetic counseling as well as in postsecondary education, administration, and supervision. First-time program directors may not have an equivalent depth of experience in these areas, so additional hours dedicated to training in postsecondary education and student supervision are now included. The new standard aligns program directorship qualifications with the best practices of other allied health graduate programs and provides an objective way to ensure consistency in these areas across graduate programs. To ensure ongoing competency, the standard now includes the maintenance of ABGC certification and the requirement to document training or other experiences related to leadership, professional development, management, scholarly activities, mentoring, academic advising, and andragogy.

A2.2.2(d)

Question: Does telemedicine experience count toward the minimum of three years in a patient-facing role?

Answer: Yes.

A2.2.2(i)

Question: First time PD's must have supervised at least 5 GC students for a minimum of 500 contact hours within the last 10 years. Can 'contact hours' be better defined e.g. face to face, or defined by a programs rotation description e.g. a student participates in a clinic for 5 weeks @ 20 hours per week?

Answer: 500 hours was selected because that is a commonly used reference for social work and psychology.

1 contact hour is equivalent to 1 hour of student fieldwork supervision via video conference, telephone or in person (e.g., either direct observation, case preparation discussion, feedback to students, assessment of student-patient standardized encounters, case conference)

What does not count: email conversations, reviewing letters, teaching a class, course directorship, research hours, office hours. As it is possible that Program Leadership positions (Std A2.3) do not allow for direct fieldwork supervision of students, demonstration of activities related to Standards C.3.2.5., C.3.2.6 and C.3.2.7 will be considered to meet this Standard requirement for these individuals only.

A2.2.2(j)

Question: How should 'training' in teaching methodology be documented? As a PD in a developing program, I am currently registered for several teaching workshops for professors at my institution as well as a week-long course development course (40 hrs.) in the summer. Does this suffice? And how should this be documented?

Answer: Yes, the work that you reference is sufficient. For examples teaching workshops; conferences focused on pedagogy/andragogy; online curricular design courses, etc. are all potential ways to meet the required qualifications. There are a variety of ways to meet training in teaching methodology. The course name and transcript or proof of attendance is sufficient.

In addition, CEU hours at NSGC, AGCPD events would count towards this if related to the topics.

A2.3

Question: A.) Re: additional program leadership titles. Do the titles have to match exactly as written in the standards?

B.) If the person in the additional leadership position is not a CGC, then would this person be able to serve as a designated acting/interim PD in the event of an unexpected LOA of the PD?

C.) If the program has a medical director can that be counted as the additional leadership position?

Answer: A.) In order to prevent confusion and to clearly document that the program meets the Standard, it is best to use the leadership titles suggested in the Standard. Another option is to provide the rationale for the program's choice of title and how that relates to the title recommended in the Standard.

B.) No

C.) Yes

A2.6.1

Question: Supervision Qualifications: A.) "Documented preparation in fieldwork supervision". Please define: what qualifies as suitable preparation? How and by whom is this to be documented? Is supervision training an annual requirement?

B.) The new standards allow flexibility for the 50 required participatory cases, require supervision by a certified genetic counselor, and require cases take place in a variety of diverse settings that may include clinical, laboratory, research, industry, and/or other environments (B3.1.4). In A2.6.1b, however, it is stated that a fieldwork supervisor must have 1 year experience as a clinical genetic counselor (not just 1+ year of experience in their area of expertise and documented preparation in supervision). Does the word "clinical" in this situation also apply to laboratory genetic counselors who have been trained in supervision? It doesn't seem that a year of clinical experience would be the key driver of their qualification.

C.) Similarly "At least one year of clinical GC experience." How is "clinical" being defined by ACGC? Does this mean only "direct patient care" or would "laboratory genetic counseling" be acceptable? Or those who have provided telehealth services?

D.) Programs must assess and document the credentials and qualifications of those who will be supervision...How? Confirming they are in the ABGC database? Getting their CV?

Answer: A.) Preparing supervisors for teaching and training genetic counselors is an expectation of all student practicums regardless of the specialty. It would seem appropriate for program leadership to document the training. This would seem to be a topic that PDs might work together on to sort out the best way to support and train student as supervisors.

Examples could be supervision workshops, online webinars, mentoring with colleague. Training does not need to be annual, but the program must be able to show that they are supporting and training their supervisors.

B.) The word clinical is not meant to exclude laboratory genetic counselors. This better stated as fieldwork, we will make that change.

C.) same as above, it was not meant to be exclusive.

D.) Yes, as programs may have individuals who are not genetic counselors supervise in some fieldwork experiences, it would seem prudent for programs to know the qualifications of the individuals who are supervising their students. Obtaining CV's is likely sufficient, but could include current license status, certification, or what-ever might apply for current professional status relative to the supervisor. This is meant to allow students to know who they are being supervised by and for programs to fully document the student experience.

A2.6.1b

Question: Why is it now required that fieldwork supervisors have at least one year of experience?

Answer: To be a competent supervisor, an individual must have knowledge and skills specific to clinical supervision and must also be competent in the area(s) of clinical practice. In the absence of an evaluative tool to measure genetic counselor competence in these areas, "years of experience" is often used as a proxy. Benner's Stages of Clinical Competence suggest that "competence" is evident at Stage 3 and that "employees in this area usually have 2-3 years of experience in the given area or skill."¹ The new standard, which requires clinical supervisors to have one year of experience, balances the need for maturation of clinical proficiency with the demand for available fieldwork supervisors.

A3.2.2

Question: A.) Programs are expected to develop strategies to promote applications from underrepresented populations... What qualifies as underrepresented? Is it underrepresented in GC, or underrepresented within our graduate school/medical school? There is likely overlap, but it is easier to access diversity recruitment mechanisms when a program aligns with their home institution. Are there metrics we will be measured by and what would be the consequences if our recruitment efforts are not successful?

¹ Benner, P. E. (1984). *From novice to expert: Excellence and power in clinical nursing practice* (pp. 13-34). Menlo Park, Calif.: Addison-Wesley Publishing Company.

B.) We can document outreach activities to health career fairs, schools, etc. with high minority status, but are we required to have them sign a sheet and indicate their race?

Answer: A.) The way to record efforts at recruitment for under-represented populations is not mandated by ACGC. There are many measures of this statistic and it would seem reasonable to use the measure employed at the sponsoring institution of the program.

This Standard is meant to ask programs to document their efforts to increase diversity within their student population. There are no metrics that programs will be judged against. It is not legal to require quotas.

B.) This standard is meant to document the program's effort to reach out to under-represented populations.

The activities that are mentioned would indicate compliance with the standard. The fact that they are held in 'high minority' school is an example that provides the necessary information.

A3.2.2b

Question: Why are cumulative board examination pass rates, attrition rates, and employment rates required to be published on the program's website?

Answer: Success with respect to student achievement is at the heart of accreditation. In the interest of transparency, accrediting agencies that are recognized by the Council on Higher Education Accreditation (www.chea.org) or that seek such recognition require the institutions and programs they accredit to make available to the public evidence of student success, including board pass rates, attrition rates, and job placement rates.

A3.2.7

Question: Program leadership records/evaluation. For faculty that teach 1 or 2 courses, are course evaluations sufficient, or do they need to be evaluated by the PD's in some other way?

Answer: Course evaluations are sufficient. Meeting the Standard requires that a program indicate the process for how the results of the evaluation will be reviewed by the PD and discussed with the faculty, if problem issues are identified.

Section B

B1.2

Question: For traditional didactic courses, is this standard met by a syllabus that outlines learning objectives, assessment modalities (exams, assignments), and course grading policies? Minimum course grades required for courses to count toward the

M.S. degree are typically published in the Student Handbook, not in individual course syllabi, since there may be non-GC students in some courses.

Answer: Yes.

B1.4

Question: The program must demonstrate education adequacy and equivalency of.....fieldwork experiences when conducted at geographically separate locations - In what format should this be demonstrated? Is it sufficient to continue to document the number of cases seen at each site?

Answer: Number and type of cases is fine

B1.5

Question: Annual review and subsequent update syllabi: is it expected that syllabi will be changed every year regardless of evaluations and effectiveness?

Answer: No, change is not expected if the courses and syllabi remain effective.

B2.1.2f

Question: RE: instructional content about test ordering—what is meant by liability implications?

Answer: Liability = The legal implications that a provider assumes when he/she orders a test: the appropriate test is ordered, test result is interpreted for the patient, implications of the result are discussed and follow up is initiated relative to the result. Liability content will also include training students to understand the state test order laws/regs; licensure, etc.

B3

Question: How does ACGC define... “Must regularly” train, orient, evaluate and communicate with its supervisors? Are specific formats and/or frequencies of these activities specified?

Answer: How a program conducts orientation, training, evaluations and assessments are at the discretion of the program, program leadership, and perhaps the Advisory Board. However, supervisor training and readiness are considered essential for strong student fieldwork experiences.

B3.1

Question: Is there a limit to the number of ‘participatory fieldwork cases’ that can be obtained by telemedicine (old standards limited that number to 5) i.e. minimum or

maximum? Or to expand the question further-please provide clarification on the maximum number of participatory cases that can be telehealth, telephone, group counseling scenarios, etc.?

Answer: The Standards no longer list specific case numbers for the various counseling methodologies. The key is diversity in the different types of experiences as students will need to be prepared for a variety of ways in which they might interact with clients in practice. The focus is to be on achieving the practice-based competencies for each student through the participatory cases they experience.

B3.1.1

Question: Several questions were raised about the use of simulated vs non-simulated patients: A.) What is the definition of simulated: role plays with other GC students, SP's at designated simulation centers or actors who are trained by the MSGC program to work with students.

B.) A philosophical/rhetorical/language question re: "*Client can refer to a simulated or non-simulated patient and/or research participant*". This feels disrespectful that the "real patients" are referred to as the non-simulated patients and are listed after the simulated patients. This language is preferable because it honors the patients we see with health concerns.

Answer: The Board recognized that the term "standardized" rather than simulated more correctly describes current educational use of individuals in a trained patient role.

A.) Standardized patients are used in the training of many health professionals. It refers to either designated simulation centers or actors who are trained to play the role of a patient and engage with the learner in a controlled patient encounter. GC student role play is not considered to meet the definition of a 'standardized patient' encounter. Research participants may be used for participatory cases, if the trainee is providing clinical genetic counseling services although within a research protocol. This does not include, for example, consenting individuals to participate in a research protocol or clinical trial.

B.) Thank you for your thoughtful reading of the Standards. There was no disrespect intended. We agree with the suggestion to change the language. Revised standard B3.1.1: Client can refer to individuals seen in a clinic setting; as standardized patients; or in certain research participant encounters.

B3.1.2

Question: Why do the standards related to clinical training require a minimum of 50 participatory cases, with at least 40 of these 50 participatory cases required to be with

individuals being evaluated for risk of, or affected by, diverse genetic conditions across the lifespan (i.e., non-simulated patients; not a research participant)?

A.) Presumably a pregnant client who is herself unaffected but is being seen for indications such as AMA, abnormal NIPT, abnormal U/S or similar prenatal indications counts among the “at least 40” cases, even though the risk being evaluated in these cases is for the fetus to be affected by a genetic condition? We are asking this only because ABGC introduced the “affected” language many years ago, i.e. the requirement that a certain proportion of clients had to be “affected” with a condition/phenotype, specifically to ensure that students were not seeing an overabundance of prenatal cases for their 50 case logbooks, since pregnant clients were typically not affected with anything themselves.

B.) Is teratology risk assessment/counseling included in this?

Answer: ACGC referred to the work of the Clinical Training Assessment Taskforce (CTAT) to develop the clinical training requirements: https://www.gceducation.org/wp-content/uploads/2020/01/Clinical-Training-Assessment-Taskforce-Update-Published-in-ACGC-17-18-Annual-Report_V2.pdf

While CTAT found that the number of cases does not predict competency as defined by board exam performance, stakeholder feedback supported the retention of a minimum threshold for exposure to patients/clients, in diverse practice settings and with a variety of indications.

Moreover, the review of competency-based education literature did not identify an existing tool to assess and determine clinical competency in genetic counseling trainees, and such a tool would be necessary for the implementation of a competency-based approach. CTAT found no viable alternative approaches that would eliminate the need for a minimum number of required cases. CTAT also noted that the profession has a set of well-defined practice-based competencies (PBCs) and that clinical training and all components of a program should support trainees’ development of the PBCs.

A.) At least 40 of the 50 required participatory cases must be with individuals being evaluated for risk of or affected by diverse genetic conditions across the lifespan (i.e., patients; not individuals who are being consented to research; and not standardized patients).

B.) Yes, teratology risk assessment is included.

B3.1.3

Question: There is a concern that MD’s can no longer supervise for cases counted in the ‘required participatory fieldwork cases’. This significantly limits pediatric/general genetics sites in many areas. Many MD geneticists’ practice “genetic counseling”

without a genetic counselor on staff and students under their supervision have been able to develop their skills just the same. Can ACGC clarify the logic behind this decision?

Answer: The ACGC has moved to recognize genetic counselors as the professional best equipped to educate genetic counselors. We have reached the professional place where genetic counselors assume responsibility for the training of genetic counselors. Geneticists may still sign off on non-required participatory cases. ACGC recognizes that students need to learn genetic counseling skills specifically as they apply to families with children affected by genetic disease.

B3.1.4

Question: A.) Please confirm that “may include” means that participatory encounters can just include clinical cases.

B.) Some, but not all, of our major specialties utilize telemedicine in addition to face-to-face visits --- as long as students gain telemedicine experience in some of their specialties (e.g. pediatrics and cancer, but not prenatal or adult), does that satisfy this standard?

C.) How is telephone service delivery being defined? Does this mean that the entire session must be conducted via telephone (such as for a teratogen line inquiry) for it to count, or does this mean that some components of the case can be conducted by telephone (e.g. pre-clinic contact by student to clarify understanding of the visit and what to expect, post-clinic telephone call to discuss results of testing), while others are face-to-face?

D.) Re: use of multiple service delivery modes-if student’s complete review of systems, family histories and HPI over the phone is that considered a type of service delivery? The same can be asked about f/u counseling regarding test results. Under prior standards we would not count these in the log roles assumed as they were not face to face.

E.) Does every student need experience in multiple service delivery models? Or as an aggregate?

F.) What is considered a case in settings such as industry/ other?

Answer: A.) There must be diverse settings, but the require participatory cases can be just clinical.

B.) Yes, it satisfies the Standard. A student does not need to gain experience in every mode of service delivery in every fieldwork experience. This applies across all fieldwork experiences as a total.

C.) Telephone service delivery is not defined as many counselors employ a variety of telephone encounter modalities and deliver a variety of counseling encounters in the various modes. The important aspect of the fieldwork encounter is tying the student's experience to practice-based competencies. For example, a face-to-face initial visit and a telephone FU would count.

D.) These may be counted as logbook roles as long as the experience is tied to the accomplishment of practice-based competencies within the fieldwork experience framework at your program.

E.) This is an individual student requirement as students need to be prepared to practice in the wide variety of practice settings that now exist.

F.) There are many industry settings, such as commercial lab settings, in which the student may have a consumer encounter.

Participatory cases need to involve the student interacting with a "client."

Non-participatory cases may include broader experiential encounters that lead to the development of PBCs, such as variant interpretation or consulting with clinicians regarding laboratory test results.

B3.1.5

Question: A.) What does ACGC define as "sufficient" opportunities in each of the main specialties --- i.e. is there a minimum number of opportunities in each specialty that must be provided?

B.) What does ACGC define as "no one specialty dominating"? E.g. in the current 2013 standards, Prenatal is expected to encompass 40% of the core cases, while Cancer and Pediatrics are expected to encompass 25% each, with Adult 10%. Under the new standard, would 40% be flagged as dominating, as it is certainly quite a bit higher than 25%? Or would dominating be 51% --- or something else? Would it depend on the specialty --- e.g. ACGC would consider it acceptable for Prenatal or Cancer cases to constitute 40-50% (or more) of a students' participatory cases, but penalize a program if 40-50% of the cases were in Adult or Pediatrics? As currently written, this allows way too much subjectivity by ACGC, when it comes time for rendering reaccreditation decisions.

C.) B3.1.5 RE: cases must represent as being across multiple practice areas with no one specialty area dominating. Can this be clarified? Does "no one specialty dominating" mean that two could dominate, or that there should be an equal distribution across the four specialties? IF a student is really interested in a particular area they may choose an

elective credit to do more in that area....this will automatically skew their numbers. How is this accounted for? Or will students need to be denied the extra opportunity or told not to log these cases? It is important to know that this variable interpretation is acceptable.

D.) Please clarify whether only certain categories of research participants fully count or not in the 50 required participatory cases e.g. those who are healthy and not at risk for a certain condition vs. those at risk/affected with.

E.) Do we need separate tracking forms for Field work experiences and clinical rotations if both can count toward participatory cases?

Answer: A.,B.) The Standards no longer list specific case numbers for the various counseling methodologies. The key is overall diversity in the different types of experiences as students will need to be prepared for a variety of ways in which they might interact with clients in practice. The focus is to be on ensuring that each student achieves the practice-based competencies through the variety of participatory cases they experience and in different practice areas.

C.) Variable interpretation is acceptable, however at this time training should prepare students to practice in a wide variety of specialty areas using a variety of service delivery methodologies.

D.) A specific type of research participant is not specified. Research participants may be used for participatory cases, if the trainee is providing clinical genetic counseling services to the individual even though within a research protocol.

E.) Fieldwork experiences include clinical rotations.

B3.3

Questions: RE: ensuring number and variety of experiences is equitable. Is this saying that each student should have the opportunity to do every rotation? Or just that efforts should be made to be equitable? Can ACGC provide an example of what structure would and would not meet this standard?

Answer: There are a variety of ways in which a program may meet this Standard. Equitable means that each student is given a chance to experience a diversity of settings and a variety of service delivery modes without an overload of one type of experience to the loss of other experiences. Each student is not expected to have the exact same fieldwork experiences.

B3.6.3

Question: A.) No minimum level of participation is specified that defines what constitutes a participatory case. Presumably, purely observations are not considered participatory?

B.) The list of documentation elements specifies “PBC(s) addressed” --- is the intent that every single PBC that is demonstrated, even in a small way, during each participatory case be formally recorded in some way? If so, is this expected to be at the level of just the 4 Domains, or the 22 PBCs (main PBC, as bolded in the PBC document), or down to an even more discrete level within each PBC (i.e. the lettered examples under each of the 22 PBCs)? Would it suffice to have the PBC’s be the identified learning objectives for clinical fieldwork?

C.) Also, are there repercussions if a category is not checked a certain number of times- if so, is there a certain number of times it must be checked to ‘count’. Some PBC’s are not relevant to clinical care e.g. effectively give a presentation on genetics or demonstrate understanding of the research process.

D.) Lastly, is there any evidence that checking these boxes identifies a better or more robust learning experience, or that the number of times they are checked says something about competence of the learner?

E.) Will the next RCS allow for the inclusion of the broader categories of ‘participatory experiences’? This is an important clarification to make sure we are documenting things appropriately for graduating students.

A2.) Please clarify what would constitute a healthcare provider being a client. If this is intended to be in a laboratory setting where a GC student takes a phone call from an HCP, then are there certain elements of the inquiry/discussion that a student would have to complete for this to “count” as a participatory case, or does a quick/straightforward 1 minute phone call about a lab result count as a case?

B2.) A “healthcare provider” is considered a client here, but was removed from section B3.1.1 in the draft for public comment.

Answer: A.) Correct

B.) Programs are expected to document to the 22 PBCs. The detail provided in the PBCs are meant to be examples and suggestions as to how one may achieve or demonstrate competency for that PBC. A program could use the PBCs as learning objectives should they choose; however, this is currently not an expectation.

C.) No

D.) ACGC requests that programs utilize the PBCs because they are currently the best indication of knowledge, skills, and actions that will be required of practicing genetic counselors. The PBCs were developed based on the practice analysis of what genetic counselors are currently doing as service providers in clinical practice. PBCs offer the student some assurance that the competencies that they are working to achieve do have actual relationship to clinical knowledge, skills and actions used by genetic counselors in practice. ACGC recognizes the limitations of the current knowledge base regarding competency-based education and its assessment of relevance to actual practice-based competency. It an area well-deserving of future research for the ongoing development of our professional and educational competencies.

E.) The June 2021 RCS will include this.

A2.) HCP were removed from B3.1.1, participatory cases. CTAT had initially included them in response to stakeholder feedback. This standard outlines what is needed for documentation of a case. Time is not one of them.

B2.) A HCP can be a client for ‘other supplementary’ fieldwork experiences.

B4.2.1

Question: Document credentials of people supervising supplemental experiences. With what? Their CV? Their name...transcripts?

Answer: Yes, as programs may have individuals who are not genetic counselors supervise in some fieldwork experiences, it would seem prudent for programs to know the qualifications of the individuals who are supervising their students. Obtaining CV’s is likely sufficient, but could include current license status, certification, or what-ever might apply for current professional status relative to the supervisor for programs to record for documentation of their students’ participatory experiences. This is meant to allow students to know who they are being supervised by and for programs to fully document the student experience.

B3.14/B3.15

Question: A.) Categorizing specialties based on the ages of the clients served, i.e. pediatric vs. adult, is becoming increasingly problematic as genetic testing in numerous medical specialties (e.g. Cardiology, Neurology, Hematology, Immunology, Ophthalmology, and many others) is driving the creation of many very interesting areas of specialty practice for genetic counselors that we should be encouraging students to pursue training in, as they are also in-demand by clinical and industry-based employers. However, depending on where the clinic it is based within an integrated medical system, the bulk of the patient’s students may have access to for these specialized indications may be in an adult facility that can only see patients older than

18 or a pediatric facility that can only see patients up to 18. The training objectives that programs are attempting to meet emphasize development of GC competency in the specialty area, e.g. cardiology, not the age of the patient, as the genetic counseling and testing approach to a 16 year old (counted by ACGC as a “pediatric” patient) is fundamentally the same (except for issues around testing of minors) as it is for an 18 year old (counted by ACGC as an “adult” patient). This has the potential to penalize students who want to pursue a specialty area such as cardiology or neurology as an elective, but risk having those cases cause their pediatric or adult distributions to become “unbalanced/dominant.”

B.) RE: representative of across the lifecycle. Can requirements around this be better defined? E.g. If a student is involved in a case involving a child where there is a physical exam for dx purposes and but they counsel parents about recurrence risks of the disorder-is this a pediatric, or pre-conception? Similarly, if they see an adult with a disorder and they describe natural history and recurrence risk is this pre-conception or adult? This may seem a straightforward clarification but if a logbook needs to have an evenly distributed spread across the lifecycle it will lead to variable interpretation.

Answer: A.) Your observation is part of the rationale for changing the expectation that a percentage or certain number of cases is required. That said, genetic counseling students at this time are still expected to be competent in all aspects of genetic counseling service provision. For example, pediatric cases allow the trainee to address the substantial rare disease population that may present in childhood and/or prenatally and so prepares genetic counselors for counseling around risk related fetal presentation. Graduate education that prepares genetic counseling students to be certified genetic counselors at this time still requires exposure to the wide variety of presentations of genetic disease over the lifetime.

B.) This Standard refers to an expectation that the genetic counseling student’s education address the issues and diagnoses that are experienced over the lifetime. The way in which students achieve this exposure is likely to vary depending on exactly the factors that you describe. The context of the visit and the variety of patients seen by the trainee may lead to the same encounter being “counted” differently for different students. The Standard does not mention that the experiences must be “evenly” distributed.

Section C

C2.1

Question: Why is a first-time board pass rate of 80% over a 3-year period the threshold below which the program must submit a plan for remediation?

A.) Student Performance on the ABGC Certification Exam: Is the 80% pass rate for ACGC exam an average of 3 years exams or for each year?

B.) Concerns about reporting 1st time pass rate (vs. cumulative): In some states that have licensure, the statute requires new genetic counselors “to take the next available exam in order to obtain a provisional license” thus the August exam in order to satisfy the state licensure rules. For other programs, they encourage students to wait until February to sit for the exam. This may provide an unfair disadvantage to students who do not have a choice about when to take the exam, but rather are forced to take the board exam in August. Could the board require that cohort information is provided to even out this discrepancy? Below is an eg. of the OT language: *The average pass rate over the 3 most recent calendar years for graduates attempting the national certification exam within 12 months of graduation from the program must be 80% or higher (regardless of the number of attempts). If a program has fewer than 25 test takers in the 3 most recent calendar years, the program may include test takers from additional years until it reaches 25 or until the 5 most recent calendar years are included in the total. Programs that did not have candidates who sat for the exam in each of the 3 most recent calendar years must meet the required 80% pass rate each year until data for 3 calendar years are available.*

Answer: The Standards Committee and CTAT had extensive discussions about defining a standard related to the ABGC Board Examination Pass Rate. A 3-year period was selected in order to include several years’ worth of graduate data to prevent issues that may arise due to small class cohorts. Since the passing score for the certification exam is an absolute criterion and not a comparative one, it stands to reason that this should work in a similar manner. Historically, the first-time pass rates for the ABGC Board Examination have been close to or more than 80%. Additionally, 80% is consistent with what is used for certification exams for other similar organizations.

If a program falls below this threshold, a remediation process is required as opposed to an automatic revoking of accreditation. This allows the program time to make modifications to its curriculum to address consistent deficiencies in specific categories.

A.) Average of 3 years.

B.) State licensure requirements are what they are, they should not be considered a disadvantage. The same is expected of other allied health professionals. The issue of first-time test takers is recommended by the Council for Higher Education Accreditation (CHEA) to provide complete transparency for students who are evaluating genetic counseling programs. ACGC is working to meet the standards of CHEA.

C2.5.1

Question: RE: documentation about fieldwork sites. Can ACGC elaborate on what this document would look like?

Answer: Program records of each fieldwork site are sufficient and should include: Patient volume, number of CGCs, space.

Section D

A.) For those programs approved in late 2018 or early 2019 by the previous standards and who have accepted their first cohort this August, will ACGC audit previous standards and new standards for the 2019-2021 period? For example, could we go ahead and shift our logbook cases to fieldwork experiences and track only PBC's? Or will we need to show fundamental counseling roles in addition to PBC's during this time? Or should we track both?

B.) Can we start implementing these changes now, acknowledging that this will be incremental and that we will be operating under the old standards in some areas and under the new standards in others? Also, acknowledging that this could vary between the first- and second-year cohorts...

C.) What are the deadlines for compliance for a developing program that intends to submit a candidacy application this fall and the new program application in May but has already recruited a PD based on previous standards? It appears that according to the compliance dates on the website, the new PD must meet the current standards at the time of the new program application. Is this accurate? Is there any accommodation for the new PD as long as they have a detailed plan to meet qualifications by 5/1/21, which would be prior to matriculation of the first class?

Answer:

A.) Shifting to the new Standards is acceptable.

B.) Shifting to the new Standards is acceptable.

C.) It is in the best interest of the program to map out a process as soon as possible for their PD to meet the new Standards and submit that with their Candidacy or to document how their Pd meets the Standard in the New Program application.

Miscellaneous

Question: Are there plans to create a separate biosketch form for PDs vs. teaching faculty?

Answer: Yes