Table of Contents and Introduction to Part III

Introduction to Part III & Part IV

Part III contains materials related to the tasks undertaken by the MLE Subcommittee. In some cases, these additional materials may provide a comprehensive picture of the report or task compared to the shorter summary in Part II. Throughout this report the Subcommittee has referred to projects, charts, or pertinent items introduced over the years, and in those circumstances the chart, letter, or timeline here may be a beneficial reminder.

Part IV contains the presentations given by the MLE Subcommittee at regional and national conferences since the fall of 2012. The presentations in the folder are listed in chronological order. There are two versions of Part IV material. One version is the power point slides, and the notes or script used is included. The second version contains paper copies of all the slides in each presentation. The slides and paper version are in separate folders.

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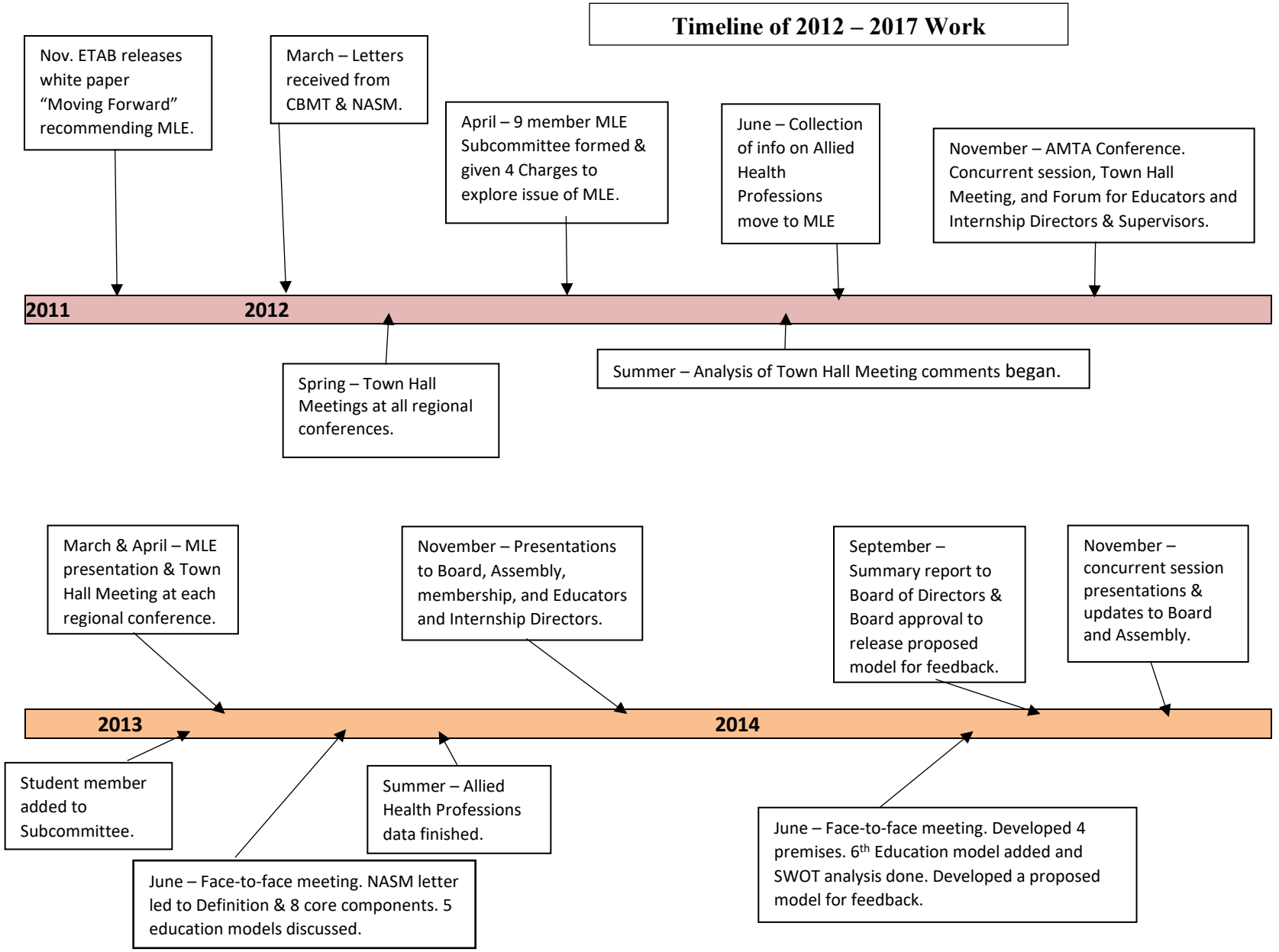
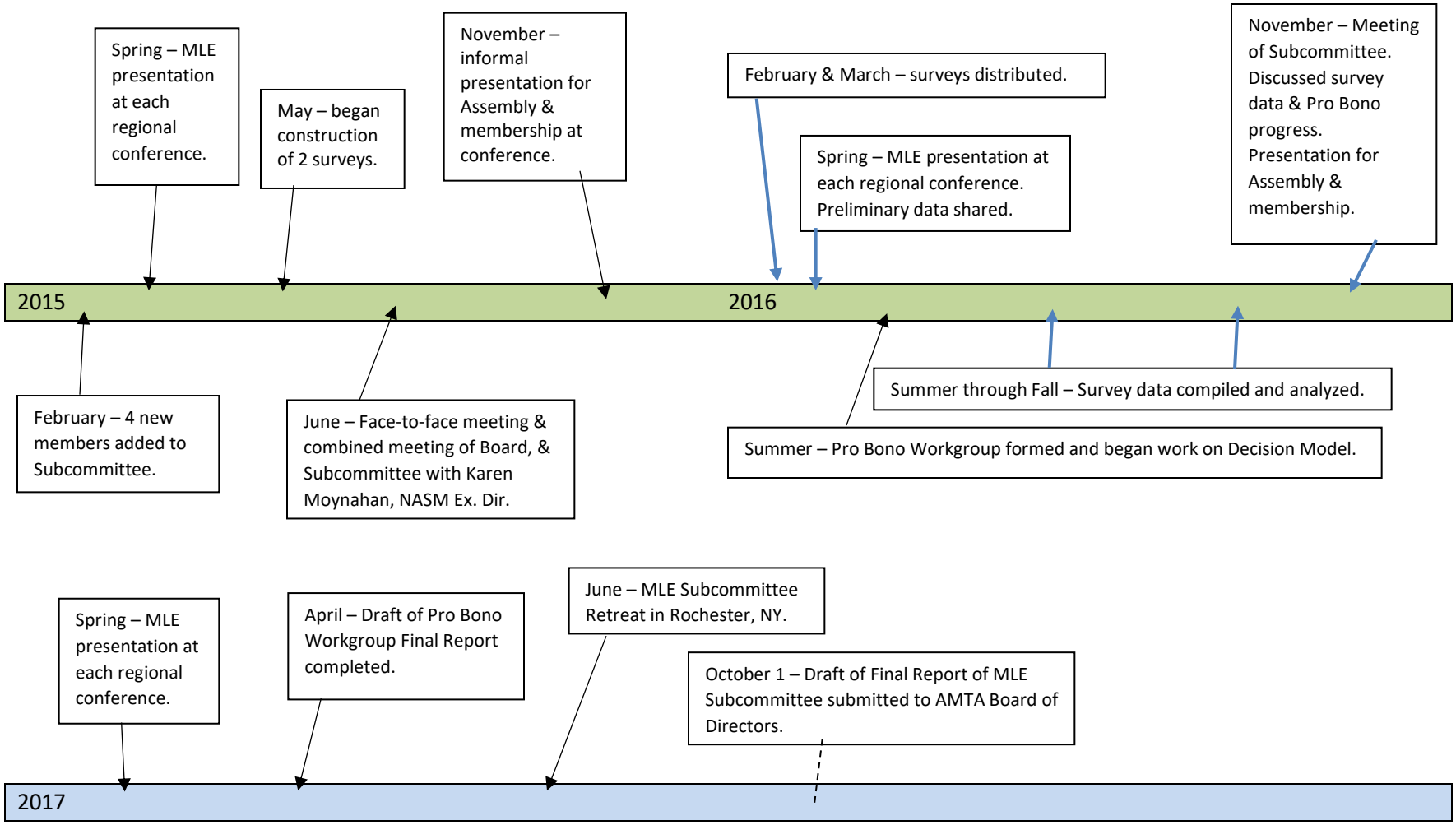

Timeline of 2012 – 2017 Work
Nov. ETAB releases white paper "Moving Forward" recommending MLE.
March – Letters received from CBMT & NASM.
April – 9 member MLE Subcommittee formed & given 4 Charges to explore issue of MLE.
June – Collection of info on Allied Health Professions move to MLE
November – AMTA Conference. Concurrent session, Town Hall Meeting, and Forum for Educators and Internship Directors & Supervisors.
2011
2012
Spring – Town Hall Meetings at all regional conferences.
Summer – Analysis of Town Hall Meeting comments began.
March & April – MLE presentation & Town Hall Meeting at each regional conference.
November – Presentations to Board, Assembly, membership, and Educators and Internship Directors.
September – Summary report to Board of Directors & Board approval to release proposed model for feedback.
November – concurrent session presentations & updates to Board and Assembly.
2013
2014
Student member added to Subcommittee.
June – Face-to-face meeting. NASM letter led to Definition & 8 core components. 5 education models discussed.
Summer – Allied Health Professions data finished.
June – Face-to-face meeting. Developed 4 premises. 6th Education model added and SWOT analysis done. Developed a proposed model for feedback.


Spring – MLE presentation at each regional conference.
May – began construction of 2 surveys.
November – informal presentation for Assembly & membership at conference.
February & March – surveys distributed.
Spring – MLE presentation at each regional conference. Preliminary data shared.
November – Meeting of Subcommittee. Discussed survey data & Pro Bono progress. Presentation for Assembly & membership.
2015
2016
February – 4 new members added to Subcommittee.
June – Face-to-face meeting & combined meeting of Board, & Subcommittee with Karen Moynahan, NASM Ex. Dir.
Summer through Fall – Survey data compiled and analyzed.
Summer – Pro Bono Workgroup formed and began work on Decision Model.
Spring – MLE presentation at each regional conference.
April – Draft of Pro Bono Workgroup Final Report completed.
June – MLE Subcommittee Retreat in Rochester, NY.
October 1 – Draft of Final Report of MLE Subcommittee submitted to AMTA Board of Directors.
2017

Allied Health Comparison Chart – Questions & Responses from Selected Professions - Updated 10-04-17

	Art Therapy	**Child Life**	**Counseling**	**Nursing**
1. What prompted the move to the graduate (Master's or Doctorate) degree level for entry into the field?	The entry level to the field has always been the Masters.	To be in alignment with other allied health professions and have increased credibility. There is a need to change how easy it is to become a CLS, to raise standards, and to have a research-base driven by those in the CL profession. (see Notes)	No undergraduate degree for Mental Health or Rehabilitation counseling, master's is the requirement. Mental Health counseling established in the 1970s.	Registered Nurses (RN)s must be licensed Three education paths: 1. Bachelors of Science Degree in Nursing (BSN) 1. Associate Degree in Nursing (ADN) 2. Diploma from an approved nursing program Master's not required for practice.
2. What challenges were encountered?	1971 – 3 graduate programs. Were still a number of UG programs and certificate programs. 1979 - Majority of programs (41) were UG & were 22 graduate.	There are currently 58 specific academic programs that are CL compliant and there is a concern about programs closing as new standards are created. It's currently in the process of development so it is not yet clear what additional challenges will be encountered.		
3. What was the timeline for this move and how long did it take to make the transition to the advanced degree?	AATA formed in 1971. The Master's degree was established as entry level in 1971.	2013 - Committees organized. 2025 – All Certified Child Life Specialists must have masters from accredited program. 12 years	No move required from undergrad to graduate degree.	
4. How did the move to the graduate degree level affect clinical aspects of education such as internships? What is the training model?	At the Masters level students complete 600 hours of supervised clinical experiences. To become a Registered AT they must complete 1000 hours of supervised work beyond the Masters.		Mental Health Counseling-60 credit graduate degree that includes supervised fieldwork. Rehabilitation Counseling-48-60 credit degree with 150 hours of field work; internship is 600 hours across 2 semesters.	All programs include supervised clinical experience in hospital departments.
5. In what major/significant ways	Uncertain			

did the move to the graduate degree level change professional clinical practice?				
6. A) Number of professional members? B) Number of professionals in the field who are not members of the membership/professional organization?	Number of members=5,000. No information on # of professionals who are not members.	A = 5,000 members B = 70%	A = 54,000 American Counseling Association members In 2008 it was estimated there were 100,000 Mental Health Counselors	A = 500,000 B = unknown
Notes	Undergrad programs are considered prep programs. Master's is a 2-year program with 21 credits in art therapy and 12 in psychology.	From their document: "The task force anticipates that this advanced degree requirement will yield more child life-specific research, supported by child life-specific graduate level coursework, and provide students with leadership training and opportunities. It is expected that focusing the master's degree in child life will promote credibility and recognition for the field within the health care community and aid in establishing the role of child life specialists as highly trained professionals."		Advanced Practice Registered Nurses (APRNs). Requires at least a Master's Degree. APRN may work independently or in collaboration with physicians, provide primary care, or prescribe medications

	Occupational Therapy	**Physical Therapy**	**Social Work**	**Speech & Language Pathology**
1. What prompted the move to the graduate (Master's or Doctorate) degree level for entry into the field?	1986-AOTA Ex. Board 1st suggested move to post-bachelor's was best for the profession; no action due to shortage of OTs. 1998-the "demands, complexity, and diversity of contemporary OT practice . . . standards best achieved in post-baccalaureate degree." Other reasons: maximize contribution; take a leadership role; "being able to sit at the table."	Many reasons, including desire to be autonomous, acceptance by insurance and creating one type of degree. 1999 resolution to move to post-bachelor's stated in "order to meet needs of a more comprehensive and complex practice."	Master's Degree came first. Demand for Social Workers prompted addition of BSW. BSW is *minimum* requirement for entry into the profession. Many positions require an advanced degree.	ASHA felt the body of knowledge was such that the move to post-bachelor's was needed. Currently, Medicare and Medicaid only reimburse for services from a Master's level SLP
2. What challenges were encountered?	At the time were 130 programs, & only 4 at doctorate level, rest were master's and bachelor's. 4 programs closed. Professional org. made decision but the accreditation agency had to be convinced. Were concerns about having enough time make the change and having enough practitioners to meet demand. Was controversial at the time.	Initially there was a decade of strong opposition from members and educational institutions. Were also concerns about having numerous types of degrees and about the credentials of currently practicing PT's.	Defining the curriculum for BSW and MSW and delineating the scope of practice.	
3. What was the timeline for this move and how long did it take to make the transition to the advanced degree?	1986 - The Exec. Board recommended change. 1999 – mandate passed to stop accrediting bachelors programs. January 2007 – mandate took effect 21 years	1979 - First Resolution to move to a post-bachelor's level. 1988 - Resolution abandoned. 1999 - Resolution revived. 2002 - All education programs must be post-bachelor's. 2015 - All education programs must be for DPT. More than 20 years	1950s - MSW curriculum evolved. 1969 - BSW recognized, and those with BSW were allowed to join NASW (membership organization). At least 10 years.	1952 - Bachelor's was entry level for SLP. Students completed 275 practicum hours. 1993 - Master's degree required with 375 practicum hours
4. How did the move to the graduate degree level affect clinical aspects of education such as internships?	Clinical training stayed the same at master's as bachelors had been – 24 weeks, full time experience.	Either the Doctorate of Physical Therapy (DPT) or Master of PT (MPT) is the current entry level degree. By 2015 all accredited	MSW students complete 900 hours of supervised field practicum (work). BSW complete 400 hours of supervised field practicum..	ASHA has education and university accreditation standards and guidelines. A master's degree or higher is required. Students must

What is the training model?	Currently fieldwork consists of Level I and Level II experiences. No specific number of hours required for Level I. Programs set objectives for Level I fieldwork; students must demonstrate skill level and completion of objectives. Observation and selected participation occurs. For Level II Fieldwork, the Standards require a minimum of 24 weeks full-time.	educational programs need to be DPT programs. Typical DPT program is 3 years. Curriculum is 80% classroom and lab and 20% clinical education. PT student spend an average of 27.5 weeks in their final clinical.		complete a 400 hour supervised clinical experience. 25 of the hours are spent in clinical observation, and 375 hours are in direct client/patient contact. Degree program includes a minimum of 75 semester credits, including at least 36 at the graduate level.
5. In what major/significant ways did the move to the graduate degree level change professional clinical practice?	It did increase stature and opportunity for leadership and policy roles. This is the biggest issue in the current debate on whether or not to move to the doctorate. "If we hadn't made the move we would be left out." Now they are on par educationally with other members of the health care team.	They wanted to be the same as a MD, DDS, PharmD, so a DPT was established to gain that stature.	BSW defined as a generalist degree and MSW incorporates a concentration. Those with MSW can provide direct service or be in private practice. Those with BSW can assess and intervene in problems of individuals, families, groups, etc. They are licensed.	
6. A) Number of professional members? B) Number of professionals in the field who are not members of the membership/professional organization?	A = 44,000 B = 50% Has been reported there was little "impact on membership."	A = 80,000 B = According to the Bureau of Labor Statistics there are approximately 198,000 Physical Therapists, which would mean their membership level is lower than 50%.	A = 140,000 (total membership) B = unknown	A = As of December 31, 2012: 166,739 ASHA members B = An SLP can be licensed in their state with or without ASHA CCC credential. It is unknown how many are practicing/licensed but not members.
Notes			National Association of Social Workers All States and the District of Columbia have some licensure, certification, or registration requirement, but the regulations vary. Although a bachelor's degree (BSW) is sufficient for entry into the field, an advanced degree has become the standard for many positions.	Bachelor's degree is considered pre-professional, and those with undergrad degree can only function as technicians or aides.

	Therapeutic Recreation	Australian Music Therapy Association	Canadian Association for Music Therapy	American Music Therapy Association
1. What prompted the move to the graduate (Master's or Doctorate) degree level for entry into the field?	Bachelor's is entry level Therapeutic recreation specialists have not ruled out a master's level entry, but they are moving at a slower pace.	1996 - The National Registration and Education Board overhauled the educational requirements. By 2006 all four universities up-graded the graduate diploma courses to Master's coursework degrees. Master's is now the entry level.	Bachelor's is entry level degree. Move to a master's entry level is under consideration. Two programs (1/3 of their educational programs) in Ontario province are moving to master's level.	Bachelor's is the entry level degree. Master's may be required in certain work settings.
2. What challenges were encountered?	Discussing what the curriculum should be since they have two types of accreditation for the curriculum: parks and recreation, and Health Sciences. Educational enrollments have increased attributed to the affordability of the bachelor's degree and professionals getting jobs in this economy.	Two of the 4 educational programs (offering only the master's) have or are closing by 2014.		
3. What was the timeline for this move and how long did it take to make the transition to the advanced degree?		1978 - A 4 year undergraduate degree established. 2005-2006 – All 4 universities merged their undergrad and Master's programs resulting in "a coursework Master's program." The bachelor's in music therapy was eliminated. Students earn a bachelor's in music and take no music therapy courses as undergrad.		
4. How did the move to the graduate degree level affect clinical aspects of education such as internships? What is the training model?		Students complete four clinical training (practicum) placements. Internship is 1040 hours and is done during course work.	In a series of practicum courses, students complete 200 preclinical hours followed by a 1000 hour supervised internship after coursework.	A total of 1200 internship hours are required. At least 180 hours need to be pre-internship (practicum) hours and at least 900 hours completed in the internship.

5. In what major/significant ways did the move to the graduate degree level change professional clinical practice?				
6. A) Number of professional members? B) Number of professionals in the field who are not members of the membership/professional organization?	A = 2,100 in 2009 B = According to the U.S. Department of Labor, Bureau of Labor Statistics, in 2006 there were approximately 25,000 recreational therapists	A = 481 RMT's B = 0. To be an RMT and eligible to practice music therapy you have to be a member of the organization.	A = 850	A=as of May 2013 were 1800 professional members B=As of May 2013 there were 5,600 active certificants.
Notes	70% of their professionals have bachelor's degree, 30% have master's degree.	Typically a Masters student's undergraduate degree is a Bachelor of Music, but other undergraduate qualifications are accepted if the individual's musicianship is sufficiently high. Students can earn their degree in an on-campus or blended-learning program. Membership numbers in AMTA are reported to be increasing.	CAMT organized in 1974. Prior, there were several hundred MTs working across Canada. Credential is MTA-Music Therapist Accredited. Either Bachelor's level or Master's level MT can qualify for credential.	

Sources used to compile this information are listed in the References.

THE CERTIFICATION BOARD
FOR MUSIC THERAPISTS

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March 9, 2012

Cynthia Briggs, PsyD, MT-BC, Co-Chair, Education and Training Advisory Board
James Borling, MM, MT-BC, Co-Chair, Education and Training Advisory Board
American Music Therapy Association
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Dear Cynthia and Jim,

The Certification Board for Music Therapists (CBMT) appreciates receiving the two advisories created by the Education and Training Advisory Board (ETAB) regarding Master's Level Entry into the profession. We agree this change will have significant impact for CBMT as the credentialing body and appreciate our input being sought. Open and forthright communication between organizations an among our constituents, the members of the American Music Therapy Association (AMTA) and CBMT certificants, will encourage more involvement as the issues related to this important discussion are further explored. We applaud the openness of the process and that sufficient time has been allowed to solicit feedback from interested parties through question-and-answer segments on the AMTA website and Town Hall meetings at the regional conferences.

After reviewing the advisories from the ETAB related to Master's Level Entry into the profession, and reflecting on our mission and accreditation standards by which we must abide, we are reminded that certification programs such as CBMT are focused on measuring competency in professional practice. Certification industry standards and the National Commission for Certifying Agencies (NCCA) Standards for the Accreditation of Certification Programs expect us to maintain some distance from educational decisions and educational accrediting and approval bodies. For this reason, CBMT will refrain from issuing an official position on the matter at this time. However, we do believe this is an important discussion for our certificants and are interested in learning how MT-BCs who are currently not AMTA members can learn about the plan and participate in the process. If you would like to provide information to CBMT certificants about the discussion, we can email it to them prior to the regional conferences. It might encourage AMTA involvement and membership renewal if they are interested in becoming a part of the discussion.

In further reviewing the information provided, assuring accurate information is conveyed to all stake holders is paramount. Currently, there are several question/answer segments on the website that imply CBMT has developed a plan for the future. The answer we reference states:

> "Similar to the time when the profession moved into the board certification system, there will be a process for therapists to transition into this system without having to complete new requirements. This shift to master's level entry will not require that currently certified therapists go back to school to earn advanced degrees."

While that statement may in fact be the final outcome, it is premature to suggest what CBMT's future policies will be. We cannot guarantee what CBMT's response would be until we understand AMTA's decision and implementation plan, and we would not want individuals making decisions based on false assumptions. We would respectfully request that care be given when responding to questions about what may or may not happen with CBMT and the credentialing program if and when new AMTA standards are adopted. At that time, CBMT would look at the impact on the current MT-BC program and develop a plan to phase in the changes.

We can say that typically a certification organization would follow an education accreditation decision and the customary approach would be to apply the Master's requirement only to future candidates, not retroactively to current bachelor MT-BCs. At this time, we can reassure people about these common industry practices but we cannot make any concrete statements until the results of the AMTA process are finalized.

We wish you well as you deliberate these changes and the implications they have for the future of music therapy education and training. Please contact us if you have any questions or clarifications prior to the regional conferences, or if you would like us to provide information about the process to our certificants.

Thank you again for the opportunity to offer feedback.

Sincerely,

Jacqueline C. Birnbaum

Jacqueline Birnbaum, MSEd, MA, LCAT, MT-BC
CBMT Chair

Joy S. Schneck

Joy S. Schneck, MM, MT-BC
Executive Director

cc: Andrea H. Farbman, EdD, AMTA Executive Director
Mary Ellen Wylie, PhD, MT-BC, AMTA President

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March 14, 2012

Andrea H. Farbman
Executive Director

Jane P. Creagan
Director of Professional Programs
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Dear Executive Director Farbman and Director Creagan:

Thank you for providing information and a briefing to Karen P. Moynahan and me regarding the recent reports of the AMTA Education and Training Advisory Board (ETAB). It is always good to see professions look to their future with goals for advancement in the terms closest to their work. The materials provided show evidence of thought, analysis, and concern about the structure of preparation for music therapy, and make proposals for an eventual change of the professional entry-level degree from baccalaureate to master's.

As you requested, I write to provide a set of analytical points addressed in our discussion. In doing so, it is important to make clear that these are not official positions of NASM, but rather staff reflections based on knowledge and experience gained over the years. The remarks below are consultative in nature and intended to support the music therapy profession and the work of AMTA. Official positions of NASM are found in the NASM *Handbook* and in other published materials of the Association that are revised and amended from time to time through Association procedures.

It is also important to state that NASM wants to see the music therapy profession continue to grow and gain support among all the constituencies important to its work. Therefore, in a strategic sense, we see two basic questions: 1) if change is desirable, after full reflection and consultation, what is the specific nature of the change to be made and 2) how can the change decided upon be made operational without producing the kinds of unintended consequences and collateral damage that could harm the larger effort of the profession, especially over the long term? Question 2 deals with issues that are outside the essence of a specific eventual decision about change of level or the development of multiple levels. This means seeing the change of level question as one piece of a larger puzzle, the other pieces of which need as careful an analysis as the original levels question received. Below please find several points recommended for consideration as AMTA continues to explore this issue. These points are not arguments for or against any particular change, but rather point to realities in the context within which any changes will be considered.

1. The music therapy profession needs to maintain a good rapport with administrative leaders in institutions of higher education. This includes administrative leaders in music, but also leaders at the

provost and presidential levels. Our experience over many years tells us that there is general concern at institutional administrative levels about the movement of credential eligibility qualifications from one degree level to another. Further, these concerns are heightened when the movement from undergraduate to graduate makes local programs more expensive, as has happened already in a number of allied health professions. The basic choice for an institution is to pay the extra costs under what is often perceived as duress, or to cancel the program. The greater the financial pressures, the more the incentive to simply cancel.

The situation is more acute when a profession appears to force change that leaves no alternative or fails to provide a reasonable transition period. Institutional-level administrators often express concerns and frustrations that a change of this kind 1) intrudes on pre-determined multi-year budget plans, 2) accomplishes little beyond offering a graduate degree for what has been traditionally undergraduate-level work, and 3) is yet another example of "credential creep" intended to reduce the number of practitioners in a profession. One may disagree with these and other negative views, but there is a reality to face: these views can be held by large numbers of individuals who hold decision-making authority over whether programs will continue or be cut.

Another issue here is the perceptions that academic administrators have of the music therapy profession. Even if an institution agrees to a particular change, a residue of general disrespect is not good for the profession or for that institution's program as budget and other decisions are made year after year. It helps to remember that presidents and provosts talk with each other, especially about problems or issues they find vexing. It would not be good for music therapy to become the object of general negative attention among institutional leaders.

2. The music therapy profession needs to have a sufficient number of programs to prepare the number of music therapists needed to serve current and developing needs in the field. The proposed change must be carefully considered in this regard, and not just in terms of numbers of education and training programs, but also in terms of actual credential-eligible graduates.

   Couple the issues raised in item 1. with the typical eventuality that graduate programs have lower enrollments than undergraduate programs. A question arises: if every program now approved and accredited became a graduate program, would the aggregate number of graduates still be sufficient? Would the number of graduates go down even if the number of programs remained the same? Such a result is possible because of the higher costs for institutions and for students. These considerations raise others: if there is a growing need for music therapy services and fewer music therapists to address those needs, risk increases that the proposed change will create a vacuum for others to fill. There are also ramifications for the numbers of professional music therapists supporting AMTA and the multi-faceted support it will provide the profession over the next decade and beyond.

3. The music therapy profession needs to maintain conditions of comity and mutual support among qualified practitioners. Perceptions or realities regarding disenfranchisement usually produce vitiating conditions. At times these conditions produce lasting divisions, an unfortunate prospect for AMTA and those who support its work. It would be tragic to see the profession divide against itself even temporarily.

4. The music therapy profession needs a sufficient number of institutions to continue offering music therapy education and training programs that produce eligibility for career entry. It is our understanding that about 50% of the approved and accredited music therapy programs currently offer graduate degrees in music therapy. Some institutions offering undergraduate programs do not have authority or a charter to offer graduate degrees. Given economic and other contextual issues, the chances are small that a large number of these baccalaureate-only institutions will seek graduate-

degree-granting authority to continue a single credential-eligible program in music therapy. Such a change requires large expenditures of time and money to seek multiple approvals, and includes approval at the institutional and specialized accreditation levels that in turn require additional resources of all kinds.

It is probable that current master's degrees in music therapy would need to be changed and lengthened to develop the competencies required. Questions arise concerning how easy it would be for master's degree-granting institutions to do so, or how fast such a transition could occur.

Institutions offering baccalaureate degrees in music therapy within institutions that have graduate programs in other fields would have the challenge of convincing the institution to make a considerable investment and incur perennially higher costs to establish a graduate degree in music therapy.

There is also the question of institutional qualifications to serve on graduate faculties. Many require doctorates and significant publication activity.

The picture presented here is complex, and it seems to indicate caution lest any decision taken reduce the aggregate institutional capacity to develop the numbers of practitioners needed.

5. The music therapy profession needs the continuing understanding and support of administrators of music programs in higher education. Music administrators work in relationship to the efforts of the music unit, but also in relationship to the larger institution and its administration. Therefore, all the issue categories previously mentioned are of concern to music administrators. We cannot stress enough the difficulties many experience due to the continuing economic situation. All resource allocations are hard to maintain, across the board budget cuts keep coming without respite, and new resources are extremely hard to obtain. Any change plan that does not take a realistic assessment of the current situation into account courts an unpredictable loss of support among those needed as allies if change is to be made that does not risk damage to the field.

   Another set of issues of concern to music administrators is exemplified by the hypothetical question about undergraduate pre-requisites for entry into a master's-level entry program. For example, if the pre-requisites did not include an undergraduate degree developing musical preparation equivalent to what is now expected after four years of professionally oriented undergraduate study, how would one support the argument that the master's-level credential is more advanced? Or that one is not now giving graduate credit for undergraduate-level work? Or, that developing competencies in the prerequisites at the post-baccalaureate level extends the time in school and the costs to students and the institution? Whatever the ultimate disposition on these and similar questions, there are many policy and operational ramifications for each specific institution. If not worked out carefully in consultation with those affected, these ramifications can reduce the prospects for consensus or slow its development considerably both within an institution and among the set of institutions offering music therapy degrees.

6. The music therapy profession needs to take into account realities about the relationships between possible credential-level change and NASM accreditation of undergraduate and graduate music therapy programs. As has been the case in the past, NASM music therapy standards can be changed through the procedures and processes of the Association that at the end include a vote by delegates representing member institutions. However, no matter what NASM may or may not develop or recommend, delegates will interact with standards change proposals and ultimately vote according to the wishes and positions of their institutions. The connections of this matter with those discussed previously are clear. Consensus often takes time to build, and normally people will not vote against

what they perceive to be their immediate best interest. Therefore, a high degree of consensus is essential. Further, for several reasons, NASM would do what is necessary to avoid either using or being perceived as using its accreditation authority to force institutional change as an agent of a particular profession. Besides being inappropriate, in the past such actions in other fields have magnified the problems outlined in item 1. above.

The above points should not be construed as arguing for a perpetual or long-term status quo. They are not intended to argue against considerations of change. Instead, they are intended to point out the critical importance of advancing the music therapy profession while taking great care not to damage elements needed for its success.

Are there ways to address the problems identified in the ETAB report that minimize the risks associated with a change from the current entry level structure to a new one, perhaps not necessarily the current proposal in its present form? Surely the answer is, yes. Are there ways to deal with the problematic issues, such as those listed in the six points above, and address the concerns listed in the ETAB report? Again, the answer is yes if many thoughtful decisions are taken over time. The keys are an understanding of the big picture, the elements within it and their relationships; dedication to realistic analyses; flexibility; creativity in matching decisions to goals perhaps in non-traditional ways; patience to develop needed consensus within and across the various constituencies involved; and constant diplomacy. Especially in these times, keeping anxieties low is one of the most important goals of all. One way to do this is to keep working the problem in all its dimensions, not fixing too early on a specific solution and determining that that solution is the sole measure of success or failure. Reality will conquer any solution that does not take reality into account.

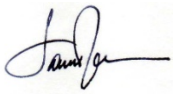
During our discussion, we recommended that AMTA develop a list of conditions that the music therapy profession absolutely must maintain in order to sustain and develop its efforts over time. These are essentials, not just desirables. A list of ten or so items can then be used as the basis for evaluating any proposal in terms of the extent to which it risks damage to the maintenance of that condition. Some of the six points mentioned above as opening sentences might be in such a list (along with more foundational issues, e.g., maintaining a codified body of knowledge and skills that defines the meaning of music therapy and sets the requirements for the preparation of practitioners). Doing something of this kind could be helpful in managing risk comprehensively, perhaps the most important goal for any organization in these times. Move and advance, but do so in an organizational culture that focuses on understanding and managing risk, and you will find a way forward that works on many levels and for many people.

Please let us know if we may provide further assistance at this time, and please let us know whenever we may provide further information and analysis.

We look forward to continuing consultations as your discussions proceed.

With best regards, I remain

Sincerely yours,



Samuel Hope
Executive Director

SH:sy

Appendix C
Education Models, Proposed Model, and SWOT Analyses

- **MODEL #1. One institution – Bachelor's leading to a required Master's degree in Music Therapy**

The Bachelor's degree in Music Therapy would be phased out, and prerequisite courses would be included in another baccalaureate degree in music. Institutions could incorporate at the undergraduate level the prerequisite courses for admission to the Master's degree in music therapy. Such courses would be completed before enrolling in the advanced level courses offered in the Master's degree program.

- **MODEL #2. Two institutions – Bachelor's program formally affiliated with Master's program; Master's required**

Institutions that currently have only an AMTA-approved bachelor's degree program in music therapy could continue to offer undergraduate courses in basic foundations of music therapy. This would prepare students for admission to master's degree programs. The undergraduate institution would not offer a baccalaureate degree nor a concentration titled "music therapy." Undergraduate programs could develop educational affiliation agreement(s) with one or more institutions that offer AMTA-approved master's degree programs enabling students to be accepted for admission to affiliated graduate program(s) with few or no deficiencies. This model could provide a smooth transition for students wanting to obtain the master's degree in music therapy and eligibility to sit for the Board Certification Exam.

- **MODEL #3. Master's degree in Music Therapy is entry level degree for the profession**

The master's degree as the entry level into the profession must be comprised of courses that address current AMTA Professional Competencies as well as some of the current AMTA Advanced Competencies. Prerequisites for this program are: 1) Bachelor's degree in music; 2) Functional music skills in piano, voice, guitar, percussion; 3) Intro to Music Therapy with observation of music therapy session; and 4) General, Developmental & Abnormal Psychology courses. Students (with a degree in music or in another field) who enter a degree program without the prerequisite courses in clinical foundations, music foundations, or an introduction to the profession would complete courses to remediate these deficiencies. Such remedial courses would not count toward those required for the master's degree in music therapy.

- **MODEL #4. Two-tiered process – Bachelor's earned and eventual Master's in Music Therapy required**

Students earning a bachelor's degree (titled a Bachelor's in Music Therapy or a Bachelor's in Human Services) would have provisional entry level certification and would practice at an entry level. The curriculum would consist of courses currently taught in the undergraduate program. To continue to practice as a music therapist and have advanced certification, a master's degree is required and the student would have a number of years (10 years suggested) to earn a master's degree in music therapy. This model is similar to that of a beginning teacher receiving a provisional teaching certificate initially and then eventually earning a professional certificate.

- **MODEL #5. Bachelor's in Music Therapy is entry level degree (current model)**

Students earn a Bachelor's degree in Music Therapy after 4-4.5 years on campus followed by approximately a 6 month internship, total of 4.5-5 years. Completion of the degree (and internship) is

required before the student can obtain the credential and work as a professional music therapist. Knowledge, skills and abilities in music therapy, music, and human behavior and development are the focus of these years. Experience is gained in pre-internship (clinical practicum) and internship work.

- **MODEL #6. Pre-Music Therapy Bachelor Degree leads to Required Master's in Music Therapy**

Foundational music courses—Introduction to MT; Music Therapy Seminar (senior course with observation and possibly a small amount of supervised clinical exposure); Psychology of Music; study of piano, guitar, and voice—and non-music courses (General Psychology, Abnormal Psychology, Human Anatomy/Lab, Statistics) would be taken in the undergraduate program. This **would not** be a "minor" in music therapy. Psychology, Anatomy and Statistics requirements would be completed prior to entering a master's program. The Master's Degree would include music therapy courses with different populations, courses in research, assessment, ethics, improvisation, neuroscience, along with clinical practicum experiences, a specialization, and a final project/thesis. Students would complete guitar and piano proficiency as part of graduate requirements. Clinical experience would remain 1200-1300 hours but would be divided differently.

Proposed New Education and Clinical Training Model
Updated June 2015

Proposed New Model **AMTA-approved[1] Bachelor's Degree in Music – the Major or Concentration is Pre-Music Therapy[2]** (Recommended range of semester hours: 120-130)	**Proposed New Model** **AMTA-approved Master's Degree in Music Therapy leading to Eligibility for Board Certification Examination** (Recommended range of semester hours 48-60)
Core Music Training in: Music theory & aural skills, Ensembles, Music History, World Music, Conducting & Orchestration/Arranging, Primary instrument/voice study to the level of senior recital (7-8 semesters of study)	**Pre-competence[4] for entrance into the Master's program:** Competence in applied music (instrument) skills Competence in functional music skills
Functional Musicianship (Music Foundations Content Areas): Voice, piano, guitar, percussion classes; a Variety of genres and styles taught; Intro to songwriting/composition; Intro to improvisation; Music technology included in various instructional settings	**Music Foundations Content Areas:** Clinical improvisation Clinical composition/songwriting Receptive MT Re-creative MT
Core of MT training: Intro to MT, including study of the Code of Ethics and Standards of Practice[3] Psych of music, including intro to music and the brain MT lab classes that include observation, assisting, leadership training, song leading. When these are offered will need to be specified (100 hours of observation, etc. recommended)	**Music Therapy Content Areas:** Advanced Psych of Music (Music Neuroscience) Research in MT History and philosophy of MT Clinical populations and techniques Theories/approaches/frameworks of MT Ethics Therapeutic relationship Thesis/project Standards of Practice including: Assessment, Treatment planning, Implementation, Documentation, Evaluation, and Termination Practica/internship(s) (1200 hours recommended)
Non-music courses/areas of study: Human growth and development Anatomy and physiology General and abnormal psychology Biology Exceptional children	**Related Content Areas:** Verbal therapy and counseling skills Statistics Research methodologies: qualitative, quantitative, mixed, IRB Psychopathology/DSM 5

[1] The degree programs would need to be adequately staffed and approved by AMTA.
[2] Whether this is a BA, BM or BS degree needs to be determined later.
[3] Courses need to signal what is the first step in becoming a music therapist.
[4] To be evaluated by campus faculty.

SWOT Analysis of a Proposed Master's Level Entry Model

SWOT (strengths, weaknesses, opportunities, threats) Analysis
of the Proposed Undergraduate-Graduate Music Therapy Educational Model

8-27-14

STRENGTHS: (internal, positive factors)

- Longer time to develop musicianship/functional musical skills
- Expanded educational time contributes to maturity of entry level therapist
- UG coursework will focus on functional and applied music skill along with preparatory skill development; enables student to focus on these foundational skills separately vs. simultaneously
- G coursework will focus on therapeutic and music therapy skill development
- Clinical training will begin with observation assisting, and non-MT music leading in UG and will be fully integrated into G level courses; this model allows room to explore ways to integrate the internship experience
- G level work can generate more research to contribute to evidence-based practice
- Transfer or equivalency students can complete pre-MT degree and go on to earn Master's
- Resources – we already have UG and G programs as well as internships in place
- There are already UG programs interested in establishing pre-MT degrees
- New undergrad programs approved this year as well as schools planning to submit degree applications have stated that moving to master's would not be a problem for them
- May increase retention of music therapists over the long-term and prevent burnout since MT's will be better trained which could counter the fear of a decreased workforce
- Retention of music therapists over the long term could provide increase in AMTA membership
- Practicing MTs will have greater level of skill and knowledge entering the field

OPPORTUNITIES: (external, positive factors)

- Professional practice of Master's level MT may set us apart from other musicians claiming to provide therapeutic music
- We will provide better quality of services to the clients we serve
- Some employers prefer MTs with Master's degree now for employment. We are seeing this in mental health job announcements.

WEAKNESSES: (internal, negative factors)

- Students cannot work as a professional MT-BC between UG and G degree programs and will not be able to bring experiences gained from work to their G program
- Financial hardship created without the possibility to work after UG as a professional music therapist or while pursuing G
- May be difficult for UG students to identify with a "pre" major
- Pre-MT students may earn the UG degree, but not the G degree, and could join ranks with labor substitutes (those using music without the MT-BC)
- Campuses may be challenged if they need to modify UG curriculum or degree program, G curriculum or degree program, meet new staffing needs, or recruit at the UG level
- Internships may need to modify for G level students
- Internship credits will be at the graduate credit price
- Additional years in school to get degree and credential will increase cost to students and may create more financial barriers than we already have
- Added time to get degree and credential may contribute to burnout
- Additional time and cost may reduce # of MTs entering workforce each year
- Impact of above point on diversity within the field. Labor analysts say that limited access to profession through increased credentialing will have impact on new potential recruits, the underrepresented and disadvantaged individuals.
- Void created by lack of music therapists may be filled by lesser trained therapeutic musicians
- There may be competition due to limited numbers of G programs as well as internships

THREATS: (external, negative factors)

- Campuses currently offering degrees will need to be notified in a timely fashion and then will need to act to bring about change in a timely fashion
- Proposed changes will need to be approved by NASM Assembly.
- AMTA will need to work with CBMT to determine if change impacts Scope of Practice
- On-line Master's in MT programs may need to change or revise curriculum

▪ After earning a Master's the MT will be able to acquire true specializations or advanced practice training ▪ Well-trained MTs may contribute to projected need for healthcare workers ▪ UG and G degree programs will be approved by AMTA ▪ CBMT retains one Scope of Practice although it may need to be adjusted to accommodate entry level clinician with Master's ▪ We have a good working relationship with CBMT, e.g. State Recognition Plan ▪ Individuals or others within and outside of MT can provide specialized training for music therapists ▪ Employers, the public, and other healthcare professionals will need to be educated about the new level for entry into the profession ▪ Changes that affect MT have and are taking place: state regulation; positive publicity about benefits of MT (Gifford's recovery); other allied health professions have moved to the G level for entry into the profession ▪ There may be an increase in UG pre-MT programs since this is already a trend and new G programs may result due to the demand	▪ Campuses may refuse to change to new UG degree and/or add G degree resulting in closure of programs ▪ Universities prefer having undergrad programs that lead to a credential. AMTA will have to convince UG administrators of the necessity of going to the MLE and that AMTA is not just "leveling up" the Bachelor's degree ▪ Fewer MTs entering workforce each year may reduce CBMT certificant and AMTA membership numbers resulting in fewer clients having access to beneficial services ▪ Expectations are employers will pay higher wages for Master's level MTs, and if they cannot or will not, employers may turn to labor substitutes ▪ Competition for jobs with lower wage therapeutic musicians. ▪ Competition from creative arts therapists, other musicians or other allied health professions will continue and MTs need to know how to talk with administrators and organizations about the risks of lesser-trained musicians providing services ▪ Risk analysis needed to outline potential financial impact on AMTA and gather trend data ▪ We may be challenged to get full support from membership and from administrators of educational programs and clinical training programs.

SWOT Analysis of Current Bachelor's Level Entry Model

NOT moving to the MLE (Remain BLE)

8-30-14

STRENGTHS: (internal, positive factors) • Academic programs will not be at risk for closing • Clinical training model will not need to change • Will continue with the same number of MTs entering the field since BLE enrollment is more than MLE • MTs will be able to attain professional clinical experience prior to getting a master's degree (when moving to Advanced level of practice) • Less years in academia = decreased cost • AMTA/CBMT/NASM already have resources in place for this model	**WEAKNESSES:** (internal, negative factors) • The musicianship and functional music skills may continue to be underdeveloped in some entry-level MTs • We will continue to have to put all the coursework and internship (clinical and non-clinical) into 4.5 years as knowledge base continues to grow (there will be more to teach in the future) • Some BLE students may not be mature enough for the role of therapist in certain clinical situations • Graduating at the BLE and discovering one's limited skill base may lead to burnout and leaving the profession • This model may have to be revamped or revised to sufficiently provide quality MT services in a rapidly changing world
OPPORTUNITIES: (external, positive factors) ▪ No need to drastically change AMTA education & clinical training documents ▪ AMTA/CBMT can maintain primary strategic priority toward state recognition ▪ Students will be able to start career after the BLE, enhancing the marketability of the degree ▪ Specialized trainings may continue to grow and expand as more MTs are demanding additional training in certain areas	**THREATS:** (external, negative factors) ▪ Ability of various client populations to access quality treatment may be impaired by MTs entering the work force who will not have the adequate clinical and musicianship skills ▪ Undergraduate level does not elicit research which may hinder evidence-informed practice ▪ The strong musicianship of other therapeutic music practitioners may result in MTs losing potential positions to these practitioners ▪ MTs with only BLE training may not be able to serve as primary therapists in some agencies and institutions ▪ Could potentially "lose" some MTs who choose to get a Master's in another related health profession such as SLP, counseling, etc. ▪ Public may continue to be confused by differences between BLE, MTs who have a graduate degree in MT, and Master's Equivalency MTs ▪ There may continue to be "pre-MT programs" being developed in various places with AMTA unable to monitor curriculum and quality ▪ The number of professionals may continue to remain even without some kind of change…need to figure out what the primary reason for MTs leaving the profession ▪ There may not be another opportunity for MT to move to MLE (which will already be a long process) and by then, it could be too late

Appendix D
Chart #1: Ranking of Top 6 Reasons by Group

Reasons to <u>Support</u> MLE	PDs	FFMs	NR Sup.	UA Sup.
1. There is presently concern about the quality of graduating music therapy students.			6.	6
2. Moving the profession to MLE has the potential to produce higher quality music therapists.	1.	1.	1.	2.
3. Obtaining a 48-60 hours Master's degree is consistent with the requirement of related allied health fields.	2.	4.	3.	1.
4. The level of education offered by MLE has the potential to improve students' understanding of the therapeutic process.	3.	3.	4.	4.
5. A pre-music therapy undergraduate degree can focus more on musical skills: those skills can then be further enhanced at the graduate level.	6.			
6. Graduate level students may demonstrate greater professional maturity in their clinical work.	5.	5.	5.	5.
7. Move to MLE may create the ability to produce more research.				
8. MLE may allow for a greater depth of clinical skills that will benefit the clients.	4.	2.	2.	3.
9. Master's level professional practice may set music therapists apart from other non-credentialed musicians claiming to provide therapeutic music.				
10. After earning a Master's degree, music therapists will be able to acquire specializations or advanced practice training.				
11. As the requisite body of knowledge increases, it can be more effectively addressed through training, which continues into a graduate level degree.		6.		
12. Other, please explain.				

Respondents were also asked to identify, from a list of 12 options, the top 6 reasons for not supporting the MLE. Those statements receiving a rank of 1 through 6 are listed below in Chart #2.

Chart #2: Ranking of Top 6 Reasons by Group

Reasons to <u>Not Support</u> MLE	PDs	FFMs	NR Sup.	UA Sup.
1. MLE may result in higher educational expenses by adding two more years of graduate tuition.	2.	3.	1.	2.
2. MLE appears to be an extension of the Bachelor's degree and would simply be moving undergraduate training to the graduate level.	1.	1.	5.	3.
3. After obtaining the pre-music therapy Bachelor's degree, students could choose to pursue non-music therapy graduate degrees, which could result in a decreased MT workforce.				
4. Many state legislatures are requiring universities to focus on providing educational programs that lead directly to employment, which puts programs that cannot provide a Master's option at risk.				
5. Non-credentialed individuals calling themselves "music therapists" may rise to fill employment voids caused by the increased length of time required to obtain the MT-BC.				6.
6. The increase from a 40 to a 48-60 hour Master's program is concerning.				
7. It seems that moving competencies currently at the undergraduate level to the graduate level may result in the Master's not being an advanced degree.	4.	2.		
8. There are no guarantees that Master's level MTs would earn higher incomes than present Bachelor's MT-BCs.	5.	4.	2.	5.
9. There is no guarantee that a MT with a graduate degree would be any more effective than someone with an undergraduate degree.	3.		4.	
10. If no clinical skills training occurs during undergraduate coursework (as described in some of the proposed models), it would be difficult to assess if a student is suited for therapeutic work at the graduate level.		6.	3.	
11. The present undergraduate degree is adequately training competent music therapists.	6.	5.	6.	1.
12. Other, please explain.				

Appendix E

American Music Therapy Association
Decision Analysis: Process and Results
6/4/17

Submitted by
Mary Ellen Wylie, Chair, MLE Subcommittee; Jane Creagan; Amy Furman; Bryan Hunter;
Angie Snell; and Adam Clark, Volunteer, Pro-Bono Analytics

1. Executive Summary

The mission of the American Music Therapy Association is to advance public awareness of the benefits of music therapy and increase access to quality music therapy services in a rapidly changing world. The American Music Therapy Association (AMTA) promotes development of the therapeutic use of music in rehabilitation, special education, and community settings[1]. As the professional organization for music therapists, AMTA wants to ensure that music therapy education is aligned with future needs of the profession. It was proposed that entry level into the profession of music therapy move from the Bachelor's degree level to a Master's degree. The AMTA Board of Directors sought the assistance of an analytics coach to help define the issue, identify relevant data, and develop a decision model to support an informed decision that was in the best interest of their members and the general public seeking music therapy services.

It was assumed the Multiple Objective Decision Analysis method, facilitated by a volunteer from the Institute for Operations Research and Management Science (INFORMS) Pro-Bono Analytics program, would provide a viable approach for investigation of the issue. It was also assumed a subset of the MLE Subcommittee would be the group working weekly for approximately six months to build a Decision model.

The full team (see list of names above) was in place in midsummer 2016 and finished in spring 2017. The analysis focused on two alternatives: the current Bachelors Level Entry (see p. 17) and the proposed Master's Level Entry (see p. 18). One outcome of this investigation was the identification of eight characteristics or features, related to music therapy education, that articulated the challenges faced when considering an educational change. Another outcome was the final score on the Master's Level Entry (MLE) alternative was higher than the final score for Bachelor's Level Entry.

One limitation of this project was the final scores were based solely on input and the votes of the five music therapy members of the work group. Other factors possibly limiting the outcomes were that the volunteer coach needed to be educated about the profession of music therapy and the education of music therapists, and all work was done via conference call.

[1] http://www.musictherapy.org/about/amta/ as of 21 Aug 2016

2. Background

The mission of the American Music Therapy Association is to advance public awareness of the benefits of music therapy and increase access to quality music therapy services in a rapidly changing world. AMTA is committed to the advancement of education, training, professional standards, credentials, and research in support of the music therapy profession. AMTA supports members in their service to clients and strives to increase awareness and recognition of music therapy at local, state, national and international levels.

The Association provides resources for members and the general public along with efficacy, advocacy, and professional development for members. The Association seeks to expand access to services, including increasing the number of credentialed music therapists who can meet the demand for the growing number and diversity of those persons needing service.

AMTA strives to improve and advance the use of music, in both breadth and quality, in medical, educational, and community settings for the betterment of the public health and welfare by:

- Establishing, maintaining, and improving standards for the education and training of music therapists;
- Establishing, maintaining, and improving standards of treatment and service in music therapy;
- Establishing, maintaining, and improving standards of ethical conduct for music therapists;
- And encouraging, developing, and promoting research, both theoretical and applied, in music therapy.

Candidates for Music Therapy Board Certification must have successfully completed the academic and clinical training requirements for music therapy, or their equivalent as established by the AMTA.

3. Methodology

Kirkwood's[2] text provides an accessible description of Multiple-Objective Decision Analysis. The Wikipedia[3] page on Multiple Criteria Decision Analysis also explains the method, but is not as accessible to the general audience. The method used in this project consisted of 7 steps, as described in Table 1.

Table 1: Decision Analysis Steps

	Step	Description
1	Define the Fundamental Objective	Like many strategic projects, the first step is to make sure that everyone's effort and expectations are aligned to the same goal. During this step, the project team defines the terms and records the assumptions.

[2] Kirkwood, C. W. 1997. Strategic Decision Making: Multiple-Objective Decision Analysis with Spreadsheets. Duxbury Press, Belmont, CA.

[3] https://en.wikipedia.org/wiki/Multiple-criteria_decision_analysis

2	Define the Measures	During this step, the team determines the characteristics that describe the differences in the possible alternatives. These characteristics will be referred to as measures throughout this document. If every alternative is expected to score about the same on a measure, then that measure does not help discriminate the better choice. By focusing on measures that are expected to vary among the alternatives, the team starts to shape the boundaries of the decision space.
3	Define the Scoring Methods	The team creates a scoring method for scoring how well an alternative performs for each of the measures discovered in step 2.
4	Weighting the Measures	Not all measures carry the same importance in the final decision. Once we know how the measures are defined, we can determine a weighting for each of the measures that will be applied when scoring the alternatives. For this project, we will rank-order the measures while considering the variation in the measure's definition. The Rank-Ordered-Centroid method will be used to calculate the weights from the ranked list.
5	Define the Alternatives	Now that we know how to score the alternative, using the results of steps 2-4, we can start gathering data on the characteristics of the alternatives. Perhaps when looking at the decision model we even discover new alternatives that were not considered before.
6	Model the Decision	Each alternative is scored on each measure (typically a value between 0-100). For each alternative, the scores are combined using a weighted average using the weights from Step 4. This provides a single score for each alternative. The final score for each alternative shows the relative total-value for each one.
7	Sensitivity Analysis	To determine if the final solution is robust against the model, use the decision model to determine if a 5-10% change in any value would lead to a different decision. If so, then the team can apply further resources to those numbers to make sure they represent the decision space accurately.

4. Analysis

In mid-summer 2016, the Pro Bono Workgroup started with step 1 of the decision analysis methodology. They were asked to provide the ideal characteristics of a successful education program, and its impact on music therapy professionals. The fundamental objective statement was crafted from the list of ideal characteristics:

The goal of the Pro Bono Workgroup is to ensure that credentialed music therapy professionals are skilled musicians and competent clinicians with the required theoretical understanding to apply music therapy to the best benefit of the client in the ever-innovating field of music therapy, while not levying undue financial burden on the practitioner, client or other stakeholders.

In step 2, *Define the Measures*, the list of ideal characteristics was used as the list of measures. Eight measures were developed that the team felt captured the nuances between the two alternatives. Three of these measures focused on describing the potential benefits of a possible change in educational preparation and the other five focused on describing the potential costs of a possible change in educational preparation. These measures are briefly described in Table 2. The team found it useful to refer to the measures by using the section number that describes that measure in detail (e.g., Section 4.1 describes the Musical Skills Competency measure).

Table 2: Characteristics of Education Programs

	Measure	Comments
4.1	Music Skills Competency	Students must be skilled musicians
4.2	Clinical Skills Competency	Students must have the practical clinical skills from a process oriented program
4.4	External Perceptions	The program must be supported by the stakeholders, including clinicians, campuses, employers and supervisors
4.5	Financial Burden	The cost program must be financially feasible
4.6	Length of Program	The length of the program must be commensurate with the body of knowledge
4.7.a	Access to Qualified Education Programs: Education Positions	The program must be accessible to interested students
4.7.b	Access to Qualified Education Programs: Geography	The program must be accessible across the geographic regions
4.8	Changes in cost of Music Therapy care to the patients and stakeholders	The financial cost of the degree to the graduate must not cause external stakeholders to bear a bigger burden

In Step 3, *Define the Scoring Method*, the team created a scale that would provide a way to score the measures for each alternative. Further details on the measures are provided in the sections below.

4.1 Music Skills Competency

A good educational program must ensure that certified music therapists are skilled musicians.

The survey of music therapy intern supervisors showed that the supervisors rated the quality of interns' functional musicianship at the beginning of internship as just over Average (3.18 on a 1.0 to 5.0 scale). Opinions differ as to whether or not average functional music skills are sufficient at the beginning of internship. Increasing the length and rigor of the academic program may allow for the growth of the students' functional musical proficiency.

Educational requirements that demand rigor enable musicianship to improve and are more valuable than those that do not. For the purpose of this measure, an educational program's requirements can be binned into one of two categories as shown below (see Appendix B for additional discussion of scoring this item).

	Description	Score
Increases Confidence	Educational program's length and rigor increases confidence that students will have excellent functional musicianship upon graduation.	100
Continuing Trends	Educational program's length and rigor maintains historical trends with average functional musicianship.	0

Music Therapists treat patients with music, so musical skills are critical to the success of the profession. For this reason, this measure was ranked near the top of all of the measures. Furthermore, this measure was ranked lower than only one other measure (4.2 Clinical Skills Competency) in which strong music skills are applied clinically. The Rank-Ordered Centroid (ROC) method states that the second-ranked measure has a weight of 0.21.

4.2 Clinical Skills Competency

A good educational program must ensure that certified music therapists are skilled music therapy clinicians. Educational requirements must ensure that the there is a consistency between different programs across the country and that these programs provide clinicians with the practical application of music therapy in a process oriented environment.

Data from the Certification Board for Music Therapist (CBMT) shows a decline in the pass rate for first-time test takers over the last 10 years. The test was extensively revised in 2015 with new domains, a change in content, and a higher standard passing rate (from 91 to 95 of 130 questions). The reasons for decline are likely complex but may include an increase in the Music Therapy body of knowledge or that the breadth of information needed to pass the exam is not being taught consistently. As of the first quarter of 2017, the pass rate for first time test takers is 75%. In the last decade, there has been an approximate decline of 9.5%.

Increasing the requirements of the academic programs may improve the pass rate for the Certification Board for Music Therapists exam and lead to better clinical skills. For the purpose of this measure, an educational program's requirements can be binned into one of four categories as shown below.

	Description	Score
Greatly Enables Improved Clinical Competency	Educational program's length and rigor provides GREAT confidence that students will have EXCELLENT clinical skills with HIGH likelihood of passing board certification.	100
Enables Improved Clinical Competency	Educational program's length and rigor provides confidence that students will have GOOD clinical skills with GOOD likelihood of passing board certification.	80
Enables Clinical Competency	Educational program's length and rigor provides confidence that students will have AVERAGE skills with likelihood of passing board certification.	50
Does not provide confidence in Clinical Competency	Educational program's length and rigor DOES NOT provide confidence that student will have the skills to pass board certification.	0

One of the many roles of the American Music Therapy Association is to ensure that students pass the certification exam. Therefore, the student's ability to pass the exam and become a Music Therapist is critical to the success of the profession. For this reason, this measure was ranked as the most

important of all of the measures. The Rank-Ordered Centroid method states that the highest-ranked measure has a weight of 0.34.

Section 4.3

Section 4.3 was removed. The labeling of the remaining sections was not changed because the team found it useful to use the section numbers to refer to the measures. Previously, section 4.3 described a measure that was focused on the need for the education program to be flexible. While program flexibility is very important, the team later decided that the characteristic was already covered in 4.2 and thus removed 4.3 as a redundant measure.

4.4 External Perceptions

A good educational program must have a favorable reputation. The program requirements should have support from all of the stakeholders, to include: the clinicians, the campuses, the employers, the supervisors and the other allied health professionals. These stakeholders should feel that the program requirements favorably affect the profession's prestige and reputation. The team considered that increasing the education program requirements may lead to an increase in the prestige and reputation of the Music Therapy profession.

On the other hand, it is possible that some educational programs would provide the same basic curriculum, but just move to a Master's program – a technique referred to as "leveling-up." Leveling-up means a program would not undergo any real change and thus may not support increasing the prestige and reputation of the Music Therapy profession. Processes/oversight must be in place to ensure that any increase in education requirements is taken seriously by the programs and not simply leveling-up.

For the purpose of this measure, the educational programs can be binned into one of three categories as shown below.

	Description	Score
Possible Increase	Educational program's reputation among clinicians, campuses, employers and supervisors may increase due to increased education requirements.	100
Historical Norms	Educational program's reputation among clinicians, campuses, employers and supervisors are consistent with historical norms.	50
Possible Decrease	Educational program's reputation among clinicians, campuses, employers and supervisors is perceived as leveling-up the academic requirements.	0

Some members feel that adopting a Master's Level Entry places Music Therapy on equal footing with other creative arts therapy degrees, possibly improving external perceptions of the profession. Additionally, the team expressed a strong desire to ensure that any increase in requirements not be perceived as leveling-up. These two factors ranked the measure as fourth. This measure barely surpassed being ranked as third by a 3-2 vote. One of the factors considered in the dissent argument was that reputation may matter less if there are not enough academic slots for the students. The Rank-Ordered Centroid method states that the fourth highest-ranked measure has a weight of 0.11.

4.5 Financial Burden

A good educational program must not be too costly for potential practitioners.

The cost of a four-year degree and how much debt the student must endure is dependent on a wide array of factors. Since the ability of the student to afford a degree is not within the control of the AMTA, this measure will focus only on the overall costs of the programs.

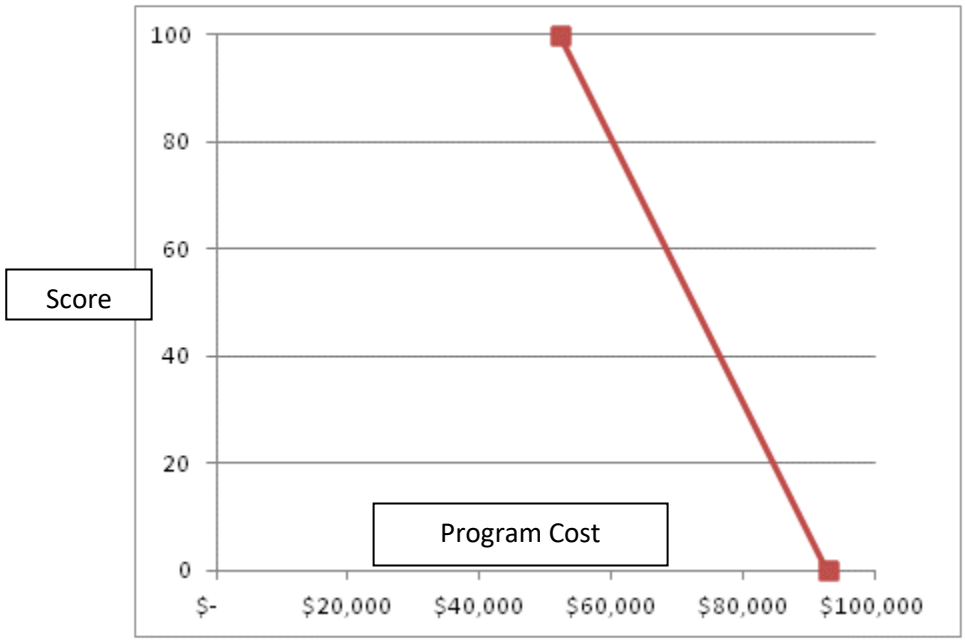
In contrast to the other measures, this characteristic will be measured quantitatively. That is, it will be measured using a mathematical relationship that can be depicted with a graph. Every dollar increase in the cost of the program to the student reduces the score of the program against this measure.

To develop the quantitative measure, the team had to pick a lower cost mark (the point at which a lower program cost does not increase the score) and a higher cost mark (the point at which a higher program cost remains at a score of zero). The program cost for any alternative should be a weighted average of the average in-state costs and out-of-state costs. The table below shows how the costs are calculated for two programs.

Program	Average In-State	Average Out-of-State	Average Program Cost[4,5]
Four-year Degree[6]	$37,640	$95,560	$52,120
Additional Cost of Two-year MT Master's	$37,968	$48,878	$40,695
Total Cost of both four-year degree and MT Master's degree	$75,608	$144,438	$92,815

The program costs from these two programs represent the lower and higher cost marks as shown in the figure below.

[4] The percentage of students paying out-of-state tuition varies among universities, but many universities limit out-of-state students to around 25% of total students.
[5] According to www.trends.collegeboard.org/college-pricing, at private four year schools few students, if any, pay the advertised tuition (with the exception of international students). The national average discount rate is 57%, meaning students pay, on average, 43 cents per dollar of the advertised tuition rate.
[6] https://bigfuture.collegeboard.org/pay-for-college/college-costs/college-costs-faqs



The money management site Mapping Your Future[7] states that a healthy ratio of student loan debt to projected income be no more than 0.08[8]. From AMTA's 2016 Workforce Analysis, the average salary of a music therapist during their first 1- 5 years was $42,000 and 6-10 years $48,000. A reasonable student loan debt over the total program for a gross annual salary of between $42,000 and $48,000 would be between $25,220 and $28,824, respectively[9]. Other sites suggest that total student loan debt at graduation should be less than the annual starting salary. If the total student debt is less than the annual income, one should be able to pay back the loan in 10 years or less. If debt exceeds income, there is likely to be a struggle to make loan payments[10].

Respondents to the MLE survey cited the additional financial burden of reaching higher levels of education as a concern. The team did not feel that the cost of higher education was within AMTA's power to change. Some colleges may offer online degrees or try other approaches to mitigate the cost of additional education. This measure was ranked as the lowest in importance of all of the measures, with a ranking of eighth. The team voted 3-2 for this measure to be ranked below seventh. The Rank-Ordered Centroid method states that the eighth highest-ranked measure has a weight of 0.02.

[7] https://mappingyourfuture.org/paying/debtwizard/
[8] The calculations do not take into consideration the individual's amount of credit card or other debt.
[9] Assumes an interest rate on student loan payments of 6% paid over 10 years
[10] http://www.bankrate.com/finance/college-finance/how-much-college-debt-is-too-much-1.aspx

4.6 Length of Program

Longer academic programs increase the burden on the student and future professionals. This measure captures the negative impact to the student of longer programs of study.

The burden of any additional time commitment may manifest itself in ways beyond the direct impact to the student. It is possible that higher-level programs will be harder to fill, as students may not be willing or able to continue past undergraduate programs. If there is a shortfall in students, then some client stakeholders may turn to alternative work force substitutes to meet the need, which would hurt the reputation of the profession. Also, there is a possibility that graduate students may face a higher level of burn-out, leading to the same downside for the profession.

For the purpose of this measure, the educational programs can be binned into one of two categories as shown below.

	Description	Score
4-5 Years	Students would not incur any additional time burden over the length of the academic program.	100
6-7 Years	Students must incur additional commitment and time burden, possibly increasing attrition and/or burn-out.	0

This measure was ranked as the sixth highest in importance of all of the measures, with a ranking of six. The measure's importance was ranked higher than 4.7.b (Geographic Access) by a 3-2 vote because AMTA has more influence in the length of the program than it does over geographic access. The measure's importance was ranked below 4.8 (Stakeholder Burden) by consensus because the profession as a whole would likely suffer from unfavorable Stakeholder Burden. The Rank-Ordered Centroid method states that the sixth highest-ranked measure has a weight of 0.05.

4.7 Access for Professionals to Qualified Education Programs

A good educational program must be accessible to as many potential professionals as possible from diverse backgrounds including geographic region, socio-economic status, race, gender, and other protected groups. The team addressed each of the issues separately.

Ultimately, this measure was divided into two measures to capture the aspects of diversity that may be impacted by this decision. 4.7.a measures the access of students to programs by considering the number of available student slots across all of the programs. 4.7.b measures the access of students to programs by considering how well the programs are spread across the nation. Measure 4.5 (Financial Burden) and measure 4.6 (Length of Program) cover the concern about socio-economic diversity. The concern of ensuring diversity across race, gender and other protected groups is not predicted to vary across the two alternatives and thus not measured.

Measures 4.7.a and 4.7.b are discussed in the next sections.

4.7.a Student Positions Available

There should be enough graduate level opportunities to place all of the bachelor's level students in a program. When the 2016 MLE survey was administered there were 73 programs offering Music Therapy at the Bachelors level and 38 programs offering Music Therapy at the Master's level. In the survey, 33 of the 38 program directors answered questions about caps on student enrollment at the Master's level. Of these 33 programs, nine stated their Master's program had a cap leaving 24 programs that do not have a cap. In addition, 19 schools indicated a Master's program was in development. Will this level be sufficient if AMTA were to expand the program requirements? As of April 2017 there are 74 programs offering a Bachelor's and 39 offering the Master's. For a further breakdown of Music Therapy programs, see appendix A.

Additionally, some states have policies and restrictions dictating how colleges and universities can add graduate programs. AMTA has very little influence on these policies but recognizes that there can be barriers to opening new or expanding current programs. Generally, there should be sufficient time for programs to determine their path forward before full implementation if AMTA chooses to expand the program requirements.

This measure is structured to capture the desire for there to be enough spots for students in whichever program the association chooses.

Description	Score
There are enough openings (graduate or undergraduate) to place **more than 75%** of students in academic programs.	100
There are enough openings (graduate or undergraduate) to place **less than 75% but more than half** of students in academic programs.	50
There are enough openings (graduate or undergraduate) to place **less than half** of students in academic programs.	0

This measure was ranked as the third highest in importance of all of the measures. The measure's importance was ranked below measures 4.2 and 4.1 (Clinical Competency and Musical Competency), respectively because the focus of AMTA has to be the ability of the clinicians to deliver quality care. The measure's importance was ranked higher than 4.4 (Reputation) by a 3-2 vote because of the risk to the profession of clients reaching for workforce substitutes if there are not enough clinicians. The Rank-Ordered Centroid method states that the third highest-ranked measure has a weight of 0.15.

4.7.b Geographical Access

Locations of academic programs should be spread across all geographical areas and not limit access to interested students. AMTA does not have control over whether or not an institution chooses to

offer a Music Therapy program, but the team expressed concern that the decision to expand program requirements could have a disproportionate effect across regions.

For the purpose of this measure, the geographic accessibility of the programs can be binned into one of two categories as shown below.

Description	Score
Academic programs are accessible to students across geographic regions.	100
Academic programs are in limited geographic locations.	0

This measure was ranked as the second lowest in importance of all of the measures, with a ranking of seven. There was a strong feeling that the importance of this measure should tie with 4.6 (Length of Program), but it was ultimately placed below 4.6 by a 3-2 vote, citing the AMTA members' strong concern about increasing the time requirement of the Music Therapy curriculum. The Rank-Ordered Centroid method states that the seventh highest-ranked measure has a weight of 0.03.

4.8 Cost of Music Therapy care to the patients and stakeholders

A good educational program must help practitioners maintain a reasonable cost to patients and other stakeholders. Will a MLE program cause people to seek workforce substitutes if the cost of music therapy services increase?

This characteristic measures the impact of the potential increase in cost to stakeholders. This measure also considers the risk of stakeholders seeking less expensive workforce substitutes.

For the purpose of this measure, the increased stakeholder burden can be binned into one of two categories as shown below.

Description	Score
Cost of music therapy services remain on historical trends and are not likely to increase the number of clients and employers utilizing less expensive workforce substitutes.	100
Increased cost of music therapy services may increase the likelihood of clients and employers utilizing less expensive workforce substitutes.	0

This measure was ranked as the fifth highest in importance of all of the measures, with a ranking of five. This measure was ranked below 4.4 (External Perceptions) by a 3-2 vote. Avoiding the perception that the program is leveling up (in 4.4) was assessed to be more important to avoiding a situation where clients might utilize less expensive workforce substitutes. There was also discussion about other ways to avoid workforce substitutes. The Rank-Ordered Centroid method states that the fifth highest-ranked measure has a weight of 0.08.

5. Weighting the Measures

The various measures impact the total value of the academic program in different ways. The team developed weights for the measures using a two-step process. First, the team used pair-wise comparisons to rank the measures from most to least impactful. Next, the team used the Rank-Ordered Centroid[11] to assign weights to the measures.

The final ranking of the measures, along with the calculated weights, are shown in Table 5.1 below. Explanations for the rankings are provided in the previous section.

Ranking	Measure	Weight
1	4.2: Clinical Skills Competency	0.3397
2	4.1: Music Skills Competency	0.2147
3	4.7.a: Student Positions Available	0.1522
4	4.4: External Perceptions	0.1106
5	4.8: Cost of Care to Stakeholders	0.0793
6	4.6: Length of Program	0.0543
7	4.7.b: Geographic Access	0.0335
8	4.5: Financial Burden	0.0156

6. Alternatives

The Pro-Bono Analytics/AMTA group considered two alternatives: changing the recommended academic program to have Master's Level Entry (MLE) or not making the change and keeping a Bachelor's Level Entry.

6.1 Bachelor's Level Entry (BLE)

The Bachelor's Level Entry or BLE signifies a student has completed a 4-year Bachelor's degree program from an institution accredited by the National Association of Schools of Music (NASM) and approved by the American Music Therapy Association (AMTA). Approximately 120 credits are completed in the study of music, music therapy, supporting courses such as psychology, and general education. A music therapy internship is the final component of the degree, and a student must complete 1200 clinical training hours prior to being awarded the degree. After earning the degree, the student is then eligible to sit for the Certification Exam, and upon successful completion of the exam earns the credential MT-BC, Music Therapist-Board Certified.

[11] https://www.vcalc.com/wiki/MichaelBartmess/Rank+Order+Centroid

6.2 Master's Level Entry (MLE)

The Master's Level Entry or MLE signifies that a student has completed a 4-year Bachelor's degree program from an institution accredited by NASM and approved by the AMTA prior to completing a 2-year Master's degree program at a program accredited by NASM and approved by AMTA. The number of credits for the Bachelor's degree is the same, but in this model students study music, supporting courses such as psychology, general education, and preparatory music therapy courses. Completion of an internship is not required at the Bachelor's level. Upon completion of the Bachelor's degree and successfully meeting Master's program entry requirements, the student begins graduate studies, completing courses in clinical skills, foundations of music therapy, research, special populations, and functional music skills. Required internship hours are completed at an approved site. Upon completion of 48-60 credits, a student earns a Master's degree and is eligible to sit for the Certification Exam. Upon successful completion of the exam, a student earns the credential MT-BC, Music Therapist-Board Certified.

6.3 Scoring the Alternatives

Both alternatives were scored against each measure at the same time. Once both alternatives were scored against a measure, the team then considered the next measure. This process allowed the team to remain consistent in how it applied the scoring across the alternatives.

- For measure 4.1 (Music Skills Competency), there was general agreement that the BLE should score as "continuing trends." There was much more discussion about whether or not the MLE should score as "increases confidence." It was noted that under the MLE, incoming Master's students may be music majors with a greater depth of music skills, but not necessarily more time with the functional instrument skills. This increase in time for focus on music skills may not always translate to better functional music skills. Still, the extra time given to students should allow for increased confidence that graduates may have excellent functional musicianship. The yellow 'sticky notes' in the following table show where the alternatives scored on this measure.

	Description	Score
Increases Confidence	Educational program's length and rigor increases confidence that students will have excellent functional musicianship upon graduation.	100 **MLE**
Continuing Trends	Educational program's length and rigor maintains historical trends with average functional musicianship.	0 **BLE**

- For measure 4.2 (Clinical Skills Competency), the BLE was assigned to the third (of four) categories. It was noted that approximately 75% of first-time test takers pass the board certification today, which indicated that the fourth category does not describe the BLE. The MLE may enable students to develop greater clinical competency, but the degree of improvement was not clear. Thus, the MLE was binned into the second category 'enables improved clinical competency.' The yellow 'sticky notes' in the following table show where the alternatives scored on this measure.

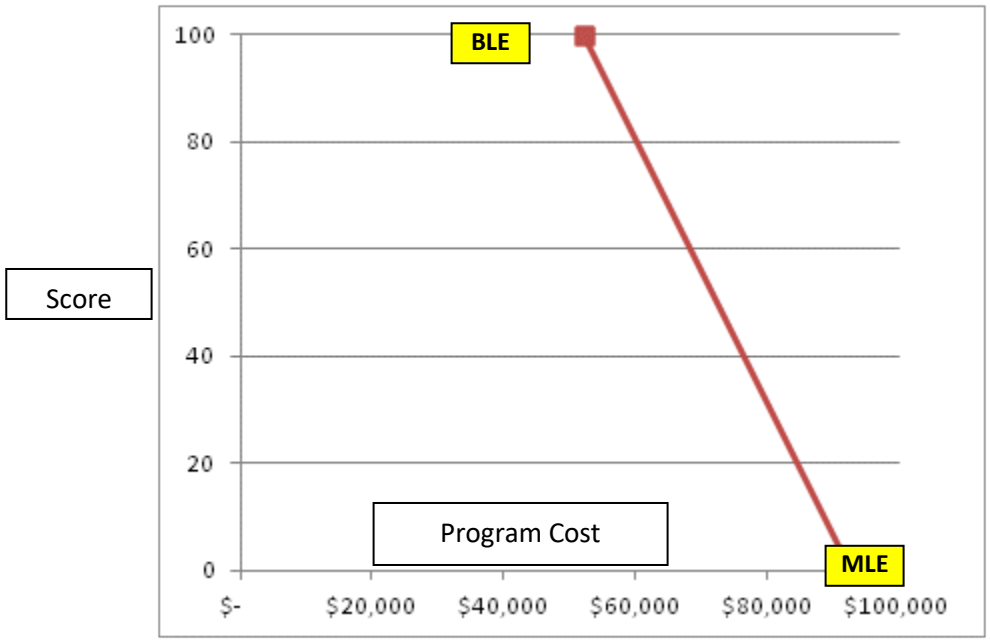
	Description	Score
Greatly Enables Improved Clinical Competency	Educational program's length and rigor provides GREAT confidence that students will have EXCELLENT clinical skills with HIGH likelihood of passing board certification.	100
Enables Improved Clinical Competency	Educational program's length and rigor provides confidence that students will have GOOD clinical skills with GOOD likelihood of passing board certification.	80 **MLE**
Enables Clinical Competency	Educational program's length and rigor provides confidence that students will have AVERAGE skills with likelihood of passing board certification.	50 **BLE**
Does not provide confidence in Clinical Competency	Educational program's length and rigor DOES NOT provide confidence that student will have the skills to pass board certification	0

- For measure 4.4 (External Perception), the team felt that AMTA would not support even the appearance of leveling-up, thus, neither the BLE nor MLE were to be binned in the third category (possible decrease). The second category described historical norms and thus was used to score the BLE. Some music therapists feel the MLE could provide an increase in external perceptions, so it was binned into the top category.

	Description	Score
Possible Increase	Educational program's reputation among clinicians, campuses, employers and supervisors may increase due to increased education requirements.	100 **MLE**
Historical Norms	Educational program's reputation among clinicians, campuses, employers and	50 **BLE**

	supervisors are consistent with historical norms.	
Possible Decrease	Educational program's reputation among clinicians, campuses, employers and supervisors is perceived as leveling-up the academic requirements.	0

- For measure 4.5 (Financial Burden), the measure was quantitative so a formula was used to calculate the alternative's score directly from the data in the table and chart form in section 4.5. Since the cost of the BLE and the cost of the MLE were used to create the boundaries of the measure, the resulting scores are 100 and 0, respectively. The yellow 'sticky notes' in the following figure show where the alternatives scored on this measure.



- Measure 4.6 (Length of Program) was designed specifically to address the two alternatives. The BLE requires approximately 4-5 years of study, while the MLE would require approximately 6-7 total years of study. The yellow 'sticky notes' in the following table show where the alternatives scored on this measure.

	Description	Score
4-5 Years	Students would not incur any additional time burden over the length of the academic program.	100 **BLE**
6-7 Years	Students must incur additional commitment and time burden,	0 **MLE**

possibly increasing attrition
and/or burn-out.

- For measure 4.7.a (Student Positions Available), the BLE was assigned to the top category because today there are sufficient spots for all interested students. Assigning the MLE alternative was more difficult as the AMTA does not have control over the addition or size of Master's level programs. Currently, there are 74 programs offering a Bachelors and 39 schools offering a Master's degree[12]. If the programs do not grow, and the number of MT students remains constant, then the category that best describes the MLE is the second bin (there are sufficient spots for between 50% and 75% of the students). However, it is noted that this is the lower-end of the estimate as new programs are likely. The yellow 'sticky notes' in the following table show where the alternatives scored on this measure.

Description	Score
There are enough openings (graduate or undergraduate) to place **more than 75%** of students in academic programs.	100 **BLE**
There are enough openings (graduate or undergraduate) to place **less than 75% but more than half** of students in academic programs.	50 **MLE**
There are enough openings (graduate or undergraduate) to place **less than half** of students in academic programs.	0

- For measure 4.7.b (Geographic Access), both alternatives are best described by the top bin as there are currently undergraduate and Master's programs available in each of AMTA's seven regions. For more detailed data, see Appendix A. The yellow 'sticky notes' in the following table show where the alternatives scored on this measure.

Description	Score
Academic programs are accessible to students across geographic regions.	100 **BLE** **MLE**
Academic programs are in limited geographic locations.	0

- For measure 4.8 (Cost of Care to Stakeholders), the BLE is best described by the top category that states "remain on historical trends." The MLE is best described by the bottom category that states "may increase the likelihood of clients and employers utilizing less expensive

[12] 2017 AMTA Data

workforce substitutes." The yellow 'sticky notes' in the following table show where the alternatives scored on this measure.

Description	Score
Costs of music therapy services remain on historical trends and are not likely to increase the number of clients and employers utilizing less expensive workforce substitutes.	100 BLE
Increased cost of music therapy services may increase the likelihood of clients and employers utilizing less expensive workforce substitutes.	0 MLE

In summary, the scores obtained by each of the alternatives are shown in the table below. These are the non-weighted scores.

Measure	BLE Score	MLE Score
4.1: Music Skills Competency	0	100
4.2: Clinical Skills Competency	50	80
4.4: External Perceptions	50	100
4.5: Financial Burden	100	0
4.6: Length of Program	100	0
4.7.a: Student Positions Available	100	50
4.7.b: Geographic Access	100	100
4.8: Cost of Care to Stakeholders	100	0

6.4 Total Scores

To find the final scores for each alternative, we took the weighted average of the scores, as shown in the following table.

Ranking	Measure	Weight	MLE	BLE
1	4.2: Clinical Skills Competency	.34	80	50
2	4.1: Music Skills Competency	.21	100	0
3	4.7.a: Student Positions Available	.15	50	100
4	4.4: External Perceptions	.11	100	50
5	4.8: Cost of Care to Stakeholders	.08	0	100
6	4.6: Length of Program	.05	0	100
7	4.7.b: Geographic Access	.03	100	100
8	4.5: Financial Burden	.02	0	100
		Total Score	**71**	**56**

An alternative's total score can be interpreted as the relative value, with higher scores being more preferred than lower scores. In this model, since the MLE has a higher total score, it would be the outcome. Other alternatives were not evaluated.

1. Sensitivity Analysis

The final step in decision analysis is to determine where the model is sensitive to errors. For example, during the model creation, the team may not be fully comfortable with a specific weight or a score. The sensitivity analysis will show just how much the weights and scores can vary before the outcome would change. The sensitivity analysis intends to show where errors could impact the final outcome. While the analysis showed a few spots where an error would have changed the outcome, the team feels confident that those parts of the model are accurate enough. This model was weighted by a team of five individuals, it may be that a different set of individuals would weight the measures differently.

7.1 Sensitivity to Rankings/Weights

During the weighting step, we rank-ordered the measures and then used the Rank-Ordered Centroid algorithm to calculate the weights. For each measure, we examined if moving each of the measures up or down from their original ranking would change the outcome. The results from moving each measure up/down one place in the rank-ordered list showed that the outcome does not change. For example, measure 4.4 (External Perception) is ranked fourth in the original ranking, and had the team made a mistake and ranked 4.4 as either third or fifth in the ranking, the outcome is still the MLE.

Next, we examined if moving each of the measures up or down two spots in the rank-ordered list would change the outcome. If a measure should be two spots up or down on the rank-ordered list, then that suggests larger errors were made and is unlikely. The model showed sensitivity to the large change in the rank-ordered list only with measure 4.7.a (Student Positions Available). Measure 4.7.a was ranked as third most important in the original rank-ordered list. If 4.7.a was changed to be the most important measure, then the outcome would change. The team felt comfortable that 4.7.a is not the most important measure.

7.2 Sensitivity to Scores

Sensitivity analysis also checks to see how the outcome would change if the alternatives scored differently. For each alternative, the scores on each measure were varied one at a time across all of the possible scores. The model showed sensitivity in only a few areas, which are described below.

If the MLE scored in the bottom category for either 4.1 (Music Skills) or 4.2 (Clinical Skills), then the outcome would change. While there was some uncertainty in how the MLE should score on measure 4.2, the team felt comfortable that the MLE alternative should not score in the bottom category for either measure.

If the BLE scored in the top category for either 4.1 (Music Skills) or 4.2 (Clinical Skills), then the outcome would change. Again, while there was some uncertainty in how the BLE should score on measure 4.2, the team felt comfortable that the BLE alternative should not score in the top category for either measure.

Appendix A

As of April 2017, there are 74 programs offering a Bachelor's level degree (41 with just the Bachelor's level and 33 with both a Bachelor's and Master's). At the Master's level 39 schools offer a Master's program (6 with just a Master's and 33 with both a Bachelor's and Master's). The following table shows the education programs by region.

Table A.1: Education Programs by Region

Education Programs by Region	Bachelor's Level Programs	Master's Level programs
NEW ENGLAND REGION	2	2
MID-ATLANTIC REGION	16	12
SOUTHEASTERN REGION	15	7
SOUTHWESTERN REGION	7	2
GREAT LAKES REGION	18	7
MIDWESTERN REGION	9	6
WESTERN REGION	7	3

Appendix B

Five members of the Pro Bono Workgroup utilized two conference calls to update and educate the nine members of the MLE Subcommittee not involved in the Pro Bono work. There was significant, yet healthy, discussion and debate among members of the Subcommittee regarding the descriptors developed for measure 4.1, Music Skills Competency, as well as the use of the 100 to 0 scoring range, and the use of two bins. Most attention was directed toward the scoring range and number of bins used for this measure. The main points raised were:

- Suggestion that three bins be used with this measure; some Subcommittee members supported that idea and other members did not feel more bins were needed.
- Suggestion that the BLE could be assigned to a middle bin with a score of 50; some Subcommittee members supported this idea while other members did not support creating a middle bin.

Needing further clarification or information, we asked Adam Clark, our Pro Bono coach, to explain the scoring range and use of two bins. He replied with the following explanation:

> Typically, 0 and 100 are used as the minimum and maximum scores for a measure. Mathematically, this translates to the condition where a 0 score gets none of the measures 'weight' and a maximum score receives all of the measure's 'weight'. These book-ends, if you will, of the score should represent the swing you expect to see in the alternatives. So, the minimal score should be worded to describe the least acceptable alternative, and the maximal score should be worded to describe the alternative where more of the measure is not important. Then later, once the alternatives are fully defined, hopefully, there is a bin that best describes the alternative. Let's say we had many alternatives, it is not necessary for one of the alternatives to actually be binned in the book-end bins. In the case of measure 4.1, we did not make any intermediate bins, though we could have.

The discussion transitioned to remarks about what level of functional music skills are expected of interns at the beginning and end of the internship, and do we want interns to have fully developed functional music skills by the time of the internship, or do we want internship directors to develop those skills during the internship? We realized the discussion of functional music skills was complicated and incomplete at this point. Some members of the Pro Bono Workgroup were opposed to any change to the scoring range or number of bins, because if one measure was changed ultimately all the other measures would need to be re-examined in order to remain true to the Decision Model process. Rather it was agreed that this Appendix would be used to provide additional information about working with the scoring process of this measure.