360 Degree Advocacy: A Model for High Impact Advocacy

In a Rapidly Changing Healthcare Marketplace

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Abstract

In an era of rapid changes in the healthcare marketplace the specialty of clinical neuropsychology faces a substantial increase in advocacy challenges. These include maintaining both access to services and a favorable practice climate as new healthcare structures and payment models evolve. The issue of regional variability complicates an effective response to these challenges from national professional organizations. One response to the challenge of regional variability is to strengthen our national organizations’ capacity to engage in coordinated and effective advocacy, and to partner with state and regional neuro/psychological associations. The Inter-Organizational Practice Committee (IOPC) was formed in 2012 to meet this need. The IOPC has developed a model of 360 Degree Advocacy that coordinates local, regional and national resources for high impact, efficient advocacy. This paper describes the 360 Degree Advocacy model, and walks readers through an example of the model in action, successfully responding to a threat to patient access and practice climate with a regional Medicare carrier.

Key words: Advocacy, Neuropsychology, Healthcare Reform
360 Degree Advocacy: A model for high impact advocacy

In a rapidly changing healthcare marketplace

In an era of rapid changes in the healthcare market, the specialty of clinical neuropsychology faces a substantial increase in advocacy challenges. These include maintaining both *access to services* and a *favorable practice climate* as new healthcare structures and payment models evolve. Access issues include insuring high quality neuropsychological and psychological services are incorporated into coverage plans and integrated structures. Practice climate issues include defending and advancing the scope of practice (e.g. the doctoral degree as the minimum requirement for neuropsychological assessment) and ensuring reimbursement aligns appropriately with services. Howe, Sweet & Bauer (2010) cogently laid out the rationale for vigorous advocacy for the profession, pointing out that even if neuropsychologists are willing to accept the status quo, weak advocacy might result in losing the status quo. Their call for an “advocacy troop surge” is particularly relevant in the present climate where the status quo is being swept away in many federal, state, and regional healthcare reform initiatives.

Unfortunately, the complex web of national, regional, and state healthcare funding and regulation complicates an effective response to these challenges from national professional neuropsychology organizations (The American Academy of Clinical Neuropsychology/ American Board of Clinical Neuropsychology [AACN/ABCN], the American Psychological Association Practice Organization [APAPO], The Society for Clinical Neuropsychology [Division 40 of the American Psychological
Association, D40], the National Academy of Neuropsychology [NAN], and the American Board of Professional Neuropsychology [ABN]).

For example, a national professional organization that wanted to ensure that the doctoral degree is the minimum level of education for providing neuropsychological assessment services would face 50 sets of state regulations, statutes, and licensing board rules, as well as multiple regional Medicare Administrative Contractor rules, and national insurance carrier policies. For this reason, rolling out a single, “cookie cutter” approach to advocacy would result in a mismatch between many local laws/ regulations and the national strategy. Similarly, national professional organizations have a finite capacity to effectively track and monitor changes in state/ regional legislation and regulations that reduce access to services for patients, restrict scope of practice, or lower reimbursement.

One response to the challenge of regional and state variability is to strengthen neuropsychology’s national organizations’ capacity to engage in effective advocacy. The Inter-O rganizational Practice Committee (IOPC) was formed in 2012 for this reason. The group has been successful in achieving its mandate of coordinating advocacy responses by all of the major national neuropsychology organizations to increase impact and avoid inefficient duplication.

Another very important response to the problem of regional and state variability is to more effectively coordinate the existing network of regional neuropsychological societies and State, Provincial and Territorial Psychological Associations (SPTAs). The IOPC proposes a model of 360 Degree Advocacy that can be used as a roadmap to coordinate local, regional and national resources for high impact, efficient advocacy.
This paper will describe the 360 Degree Advocacy model, and present an example of the model in action.

[Insert figure 1, 360 Degree Advocacy Model, about here]

Figure 1. 360 Degree Advocacy Model

Legend:  IOPC= the Inter Organizational Practice Committee; SPTAs= State, Provincial, or Territorial Associations; National NP Orgs=National Neuropsychological Organizations, which include the American Academy of Clinical Neuropsychology/American Board of Clinical Neuropsychology, the National Academy of Neuropsychology, The Society for Clinical Neuropsychology (Division 40 of the American Psychological Association), the American Board of Professional Neuropsychology; APAPO= the American Psychological Association Practice Organization. Regional NP Orgs= Regional Neuropsychology Organizations.

Key Players in the 360 Degree Advocacy Model
Inter Organizational Practice Committee (IOPC)

Each of the IOPC member organizations have well-seasoned, active volunteer practice advocacy committees that advocate for good patient care and fair treatment of practitioners. The IOPC is a committee of the practice and advocacy chairs of the American Academy of Clinical Neuropsychology, the National Academy of Neuropsychology, The Society for Clinical Neuropsychology (Division 40 of the American Psychological Association), the American Board of Professional Neuropsychology, and the American Psychological Association Practice Organization. These organizations formed the IOPC in 2012\(^9\) in order to coordinate national practice advocacy efforts. Each national neuropsychology organization that had an active practice and advocacy committee appointed the chair of that committee as a delegate to the IOPC. Organizational leaders acknowledged that each of the member organizations has overlapping, but not completely aligned interests and organizational structures that shape their stance on, and approach to, important issues. The IOPC multi-organizational structure allows for coordination of advocacy efforts on topics of mutual concern, while at the same time retaining the individual organizations’ autonomy in determining the direction of their own organizational priorities.

At the time the IOPC was founded, practice and advocacy chairs of the national neuropsychology organizations recognized that while the advocacy needs of the field were rapidly increasing in the context of healthcare reform and consolidation of the healthcare industry, advocacy resources were being used inefficiently. For example, AACN might create a work group to address an advocacy issue, only to find after several

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\(^9\) The American Psychological Association Practice Organization joined the IOPC in 2013.
months of work that NAN already had a well-established work group that had put considerable time into the issue. Similarly, ABN’s practice committee might devise an advocacy strategy only to discover that Division 40 had tried that strategy, found that it was ineffective, and succeeded in an alternative strategy. Organizations were not replicating others’ successful advocacy efforts, thus wasting scarce volunteer resources.

Additionally, IOPC practice and advocacy chairs recognized that most national advocacy efforts were reactive rather than proactive. Insurance, legislative, or regulatory crises would emerge, and practice and advocacy chairs would mobilize resources to try to affect a favorable outcome. This response left few resources for pro-active advocacy work. In the first several meetings, IOPC delegates asked the question, “What are the practice and advocacy needs of the neuropsychology community, and how can our national organizations work in concert to proactively achieve those goals?” Creation of the Neuropsychology and Healthcare Reform Web Toolkit (neuropsychologytoolkit.com) is one example of the IOPC’s proactive advocacy agenda. Ensuring that the perspectives and agenda of neuropsychology are represented on key regulatory committees in every state is another proactive IOPC objective.

**State, Provincial and Territorial Psychological Associations (SPTAs)**

State legislators and regulatory bodies often create, re-interpret and revise existing laws and regulations that govern healthcare. Lawmakers and administrators look to state level provider organizations for input when considering changes in laws and regulations. This is one reason that SPTAs are powerful advocacy partners for clinical neuropsychologists. Additionally, SPTAs typically have paid staff such as directors of professional affairs and lobbyists who are familiar with the state level governmental and
industry decision makers, and who groom interpersonal relationships with them. SPTAs are often the single voice that state regulators and legislators respond to, due to their long history of providing a unified voice for the profession within the state.

Many neuropsychologists do not belong to their SPTAs, considering it an organization for “clinical psychologists” rather than neuropsychologists. They may also not belong to the American Psychological Association (or the APAPO) for similar reasons, feeling more comfortable within a national organization that more narrowly addresses their specialty. However, due to size and resources, the State Psychological Association is typically neuropsychologists’ most powerful ally for effecting legislative and organizational change in their state.

Some neuropsychologists have expressed frustration with their SPTAs, feeling that the organization does not appropriately focus on the concerns of the neuropsychology community and, in some cases, actually worked contrary to the interests of neuropsychologists. This may be an accurate appraisal of their SPTA’s current strategic plan or activities. However, becoming active constituents of the SPTA by paying member dues, joining advocacy committees, and running for the board of directors is a highly effective way to change their SPTA’s focus to include the needs of the neuropsychology community and remains the most effective way to effect change in most cases. It is difficult, if not impossible, to impact change as outsiders.

State/regional neuropsychology societies

Many states have active neuropsychology societies (visit neuropsychologytoolkit.com for a list compiled by the IOPC). Some of these have formal ties to SPTAs. Others were formed when neuropsychologists broke off from their
SPTA in order to focus more clearly on the interests and advocacy needs of neuropsychologists. This was the case recently with the New York State Association of Neuropsychologists (NYSAN) and decades ago with the Massachusetts Neuropsychological Society (MNS).

Some state/ regional neuropsychology groups have pursued policy change without collaboration with the state societies, partially because of substantial differences in interpretations of the scope of practice. For example, in New York the state psychological association did not support the use of testing technicians (Festa, Barr, & Pliskin, 2010).

In contrast, other state associations have been very responsive to neuropsychology. For example, North Carolina neuropsychologists partnered with the North Carolina Psychological Association (NCPA) to open up and revise state law to allow neuropsychological assessment to be covered for a full range of medically necessary diagnoses rather than just behavioral health diagnoses. The North Carolina Neuropsychological Society, was formed on the anniversary of NCPA 50th anniversary to move rapidly on specific areas of advocacy and the two groups frequently work together on issues of mutual concern.

The degree to which regional neuropsychological societies focus on advocacy varies. Many of the societies initially organized around education or research interests and may or may not have evolved their mission to include professional affairs. Some of the societies have well-developed professional affairs committees and have hired lobbyists to further their legislative and regulatory agendas. Typically, though, the relatively small size of the societies, dictated by the number of neuropsychologists in a
state, means that the regional neuropsychology societies are limited in their advocacy resources. For this reason, SPTAs and regional neuropsychological societies frequently work closely together when common advocacy issues arise. For example, the Massachusetts Neuropsychological Society has a formal joint advocacy committee with the Massachusetts Psychological Association that has been effective in addressing state level issues. Successfully adding language to Massachusetts’ healthcare reform law compelling insurance companies to make medical necessity criteria sets transparent was a recent win for both the state psychological association and neuropsychological society.

Joining a state or regional neuropsychology society is an effective way for neuropsychologists to stay informed about and take action on local practice and advocacy issues.

**The American Psychological Association Practice Organization (APAPO)**

The APA has created the APAPO in order to legally engage in advocacy on behalf of the professional practice of psychology without IRS restrictions. This means that the APAPO can use its resources to directly promote the professional interests of psychologists in legislative and regulatory arenas, and the healthcare marketplace. The APAPO’s full time, multi staffed legal team, government relations department, and public relations department actively identify and advocate for federal level practice issues. They also consult with SPTAs in order to bring national caliber advocacy and resources to state level efforts. None of the national neuropsychology organizations come close to having the advocacy resources of the APAPO. Therefore, when the APAPO joined the IOPC in 2013, access to their extensive legal team, regulatory experts,
government relations and public relations staff substantially increased the IOPC's capacity to deliver high impact advocacy.

Being a member of APA does not automatically include membership in the APAPO. A separate practice assessment, based on practice income, is levied to join APAPO. As members of Division 40 pay their practice assessment in greater numbers than most other APA divisions (Personal communication APAPO, Practice Directorate, 2013), the needs and concerns of neuropsychologists are squarely on the radar of the APAPO. APAPO leadership is sensitive to the needs of the neuropsychology community, and neuropsychologists who pay their practice assessment benefit from APA’s advocacy resources.

The role that APAPO and APA have had in the Current Procedural Terminology (CPT®) coding system is an excellent example of the critical nature of the groups’ activities on behalf of the practice of neuropsychology, and the type of advocacy skill they bring to the IOPC. Randy Phelps, Ph.D., Senior Advisor for Healthcare Financing and his staff at the APA analyzes each CPT issue at the micro and macroscopic levels to make sure not only that psychology is well represented in the coding process but also that key players appreciate the importance of behavioral health in the larger healthcare arena.

The CPT coding system was developed by the American Medical Association (AMA) in 1996 and is under contract with the Center for Medicare and Medicaid Services (CMS). The CPT process is maintained by the 17 member CPT Editorial Panel, which meets three times a year to discuss issues associated with new and emerging technologies as well as difficulties encountered with procedures and services and their relation to CPT codes. There are over 120 medical and allied health specialties that
attend the meetings as observers/participants. The APA/ APAPO facilitated a neuropsychologist, Dr. Antonio E. Puente, working on the panel in 1992. Additionally, 18 nonmedical specialties (including the APA) comprise a Health Care Professionals Advisory Committee (HCPAC), which provides two voting members of the 17 member Editorial Panel. Dr. Puente is currently serving his second four-year term on the editorial panel. Dr. Neil Pliskin, another neuropsychologist, was selected to replace Puente as the representative on the AMA HCPAC. As a consequence, neuropsychology is in the enviable situation of having 2 of their own out of less than 140 professionals in the national body responsible for developing health care policy and payment.

The CPT process becomes vitally important for any specialty seeking third party reimbursement for new or existing services and procedures. In order to obtain new codes, the clinical efficacy of that service must be established and documented in peer-reviewed scientific/professional literature. Each of the 120 plus societies has a distinct role in helping other group representatives understand the role of their professional members. Further, as part of CPT process, APA staff study, research and put large number of hours, staff and volunteer, as well as financial resources to ensure that the service proposed by the professional community is empirically supported.

The CPT process gives health care providers and their specialty societies a voice in shaping the future of healthcare delivery. Indeed, new healthcare trends envisioned by the Affordable Care Act (i.e., integrated/embedded services) will be actualized through the AMA/CPT process. However, it can take anywhere from 2 to 12 years for new codes to be developed and approved, making the AMA/CPT process critical to the future of healthcare and for specialties like neuropsychology.
The Individual Neuropsychologist

Howe et al. (2010) articulated reasons why many neuropsychologists have not yet become involved in advocacy. These include the perception that advocacy issues do not directly affect ones’ practice (“not in my backyard”), others will take care of advocacy effectively (“bystander effect”), there is nothing wrong, so there is no need to take action (“ostrich effect”), and the perception that advocacy efforts go nowhere (“I can’t make a difference so why bother?”) In addition, many neuropsychologists are not sure how to get involved. Bauer (2006) introduced a clever diagnostic term for the lack of understanding of a clear pathway for advocacy, “advocagnosia.” To be fair, many neuropsychologists have become involved at one point in their career and been frustrated by a lack of effectiveness of advocacy strategies. The 360 Degree Advocacy model offers a clear pathway for individual participation in advocacy.

Traditional roles that individual neuropsychologists play in advocacy include being dues paying members of national, state, and regional neuro/psychology organizations, committee members and organization leaders, financial contributors to Political Action Committees and foundations for evidence based research, responders to specific calls to grassroots action campaigns, and public speakers about the profession (e.g., Attix & Potter, 2010; Howe et al., 2010; Goldstein 2010). In addition, the 360 Degree Advocacy model offers two additional roles, “on the ground eyes and ears” and 360 Degree Advocacy team member.

“On the ground eyes and ears.” As Howe et al. (2010, p. 375) articulated, “Most critical decisions that affect neuropsychological practice are made by non-neuropsychologists.” An insurance company may decide to reduce access to assessment
services, or a behavioral health integration committee may be forming in a state without representation from the neuropsychology community. The likelihood of the relatively small group of active national organizational leaders catching all the instances in which practice, research, or patient access issues emerge for neuropsychology is low. Identifying those instances is most often a result of individual neuropsychologists being vigilant within their academic/medical institutions, at interdisciplinary conferences, and in the course of their practices in all 50 states. When thousands of practicing neuropsychologists across the country take on the role of “on the ground eyes and ears” for their professional organizations, the likelihood of successfully identifying advocacy opportunities improves dramatically.

In the 360 Advocacy model, when a neuropsychologist identifies an advocacy challenge, he/she brings the issue to his/her national neuropsychology organizations’ practice committee. The committee contact either informs the individual about ongoing advocacy efforts in that area, or if the issue is new, refers the issue to the IOPC and the below described 360 Degree Advocacy model is triggered.

**360 Degree Advocacy Team member.** Another role for individual neuropsychologists in the model is as a participant or an expert on a 360 Degree Advocacy team. As described below, the 360 Degree Advocacy teams are populated with individuals who are directly affected by an advocacy issue (for example a neuropsychologist seeking provider status with a particular state Medicaid program), state level SPTA and regional neuropsychology organization leadership, and national experts who bring experience from previous advocacy efforts. The structure of the 360 Degree Advocacy team ensures that individuals who are highly motivated to provide
boots on the ground resources are paired with individuals who already know the ropes of the issue, as well as state and regional organization leadership, and national legal / government affairs staff.

**Coordinating Local and National Efforts**

State level government agencies are often mandated to receive input from local provider communities. The presence of state level provider organizations (SPTAs and state/regional neuropsychology societies) signals to the agencies that they are hearing the voice of local providers (e.g. Allen, Pennington & Keysor, 2008; “Advocacy Strategies”, 2013). Input from state level provider organizations, *in combination* with input from national organizations, reassures state agencies that they are hearing legitimate local provider concerns, and impresses them with the backing and support of major national organizations. There are clearly times when both local and national efforts need to be blended to achieve a desired goal. The recent IOPC effort to encourage individual neuropsychologists to contact their congress people in support of the legislation that includes psychologists in the Medicare definition of physician is one example of this.

**360 Degree Advocacy Model**

The 360 Degree Advocacy model provides a structured method of coordinating advocacy efforts, by sharing best practices from previous, similar advocacy efforts, and placing individuals with experience from previous successful efforts on a 360 Degree Advocacy team. The team composition facilitates rapid action by including key state/regional organizational decision makers from the beginning. While many advocacy efforts stall while a plan of action developed by a group of advocates is “sold” to leadership of SPTAs or regional neuropsychological societies critical for its
implementation, the 360 Degree Advocacy team composition creates “buy in” from the beginning as organizational leaders actively participate in developing the plan.

The 360 Degree Advocacy model is activated when a neuropsychologist learns of a critical practice or advocacy issue. The neuropsychologist informs the practice and advocacy committee of his/her national neuropsychology organization (e.g., AACN or NAN). The matter is discussed in committee and if appropriate the practice and advocacy chair (who is also a delegate to the IOPC) refers the issue to the IOPC.

IOPC delegates share information about current or past advocacy efforts in the area of concern. In this way, the IOPC identifies previously successful advocacy efforts carried out in parallel circumstances in other areas of the country. The IOPC recruits neuropsychologists who participated in other advocacy efforts to participate on a 360 Degree Advocacy team, along with local neuropsychologists (typically those individuals who brought the issue to attention) and SPTA/ regional neuropsychology leaders. State level providers carry out action with input from the 360 Degree Advocacy team. The result is a rapid advocacy response, using best national practices, with buy in and “boots on the ground resources” from local clinicians and state level leaders. The model can also be triggered when a SPTA, regional neuropsychology association, or national neuropsychology organization learns of a practice, access, or legislative threat or opportunity.

[Insert figure 2, 360 Degree Advocacy Team, about here]

Figure 2. 360 Degree Advocacy Team
Legend:  SPTA= State, Provincial, or Territorial Association; AACN= the American Academy of Clinical Neuropsychology/American Board of Clinical Neuropsychology; NAN= the National Academy of Neuropsychology; D40= Division 40 (Society for Clinical Neuropsychology) of the American Psychological Association; ABN= the American Board of Professional Neuropsychology; APAPO= the American Psychological Association Practice Organization

360 Degree Model in action: Medicare patients’ access to neuropsychological services.

Though several examples of the 360 Degree Advocacy model could be provided, one in particular, the IOPC’s advocacy for adequate Medicare coverage of neuropsychological services in Florida, Puerto Rico, and the Virgin Islands, will be highlighted due to its potential national impact, the rapidity of the coordinated efforts and the impact of the collaboration.

Statement of the Problem
In June of 2013, First Coast Services, Inc., the regional Medicare carrier for Florida, Puerto Rico, and the Virgin Islands, announced that it was revising its local coverage determination (LCD) for neuropsychological services. Announcements of an LCD draft go directly to Medicare providers through alerts and through the Medicare Administrative Carrier websites. Alterations to the number of hours considered typical for neuropsychological assessment, which ICD-9 codes would demonstrate medical necessity, and the scope of neuropsychology services, were among the proposed changes in the LCD draft that was released. Regarding the latter, the new LCD included language that might restrict neuropsychologists from integrating results from mood and personality instruments, “Neuropsychological testing does not rely on self report measures such as the Minnesota Multiphasic Personality Inventory 2 (MMPI-2), rating scales such as the Hamilton Depression Rating Scale, or projective techniques such as the Rorschach or Thematic Apperception Test (TAT).” The LCD also included ambiguous language that appeared to potentially restrict reimbursement for feedback sessions, “The psychological/neuropsychological testing codes should not be reported by the treating physician for only reading the testing report or explaining the results to the patient or family. Payment for these services is included in the payment for other services rendered to the patient, such as evaluation and management services.”

Medicare coverage determination is a regional rather than national, issue. Although Medicare is a national program, federal law requires the national Center for Medicare and Medicaid Services (CMS) to contract with regional carriers to handle claims and determine how services will be covered at local levels. Each regional carrier has a medical director who sets coverage policies, assisted by a regional Carrier Advisory
Committee (CAC) made up of physicians and other practitioners. They regularly review LCDs and solicit input at the local level to determine the local standard of care. The LCDs are announced regionally and affect only practitioners in the specific region covered by the regional carrier.

**Trigger of the 360 Degree Advocacy model**

Announcements from First Coast alerted several local neuropsychologists covered in the First Coast region to the proposed changes in local coverage of neuropsychological services. The local clinicians notified their national neuropsychology organizations. In this case, they alerted all of the national neuropsychology organizations, including AACN, NAN, Division 40, and ABN.

**Referral to the IOPC**

Alerts of the proposed First Coast restriction of access to neuropsychology services came to the IOPC through the practice and advocacy committees of all four of the member organizations. The IOPC determined that this was an issue of considerable significance to the Neuropsychology communities of Florida, the U.S. Virgin Islands, Puerto Rico. And, as one region’s Local Coverage Determinations are frequently cited in drafts of other region’s LCDs, the IOPC determined that the issue might have “a ripple effect” of national consequences, were an unfavorable LCD draft to be accepted by First Coast.

**Review of previously successful efforts**

One of the benefits of the IOPC is the opportunity to share information about whether previous advocacy efforts have been carried out in other regions of the country, and to clarify which of those advocacy strategies have been effective. Discussion among
IOPC members revealed that two other regional Medicare carriers had recently revised their Neuropsychology LCDs: National Heritage Insurance Company (NHIC), the carrier for five Northeast states, and Wisconsin Physicians Service (WPS), the carrier for Illinois, Wisconsin, and Michigan. In both cases, neuropsychologists successfully advocated for more favorable LCD language, improving access and practice climate issues. The WPS experience involved active input from AACN, NAN, and Division 40, and led to the creation of a model national neuropsychology LCD (Braun et. al., 2011).

The IOPC identified individuals who had experience successfully advocating for favorable neuropsychology LCDs. The question then became, “how can we assemble a team to help neuropsychologists in the First Coast region replicate that success?”

**Creation of the 360 Degree Advocacy Team and coordination between groups**

With both the NHIC and WPS regional Medicare carriers, the presence of local psychology and neuropsychology state leaders was critical to the success in revising their draft neuropsychology LCDs. Therefore, a goal of the IOPC advocacy strategy was to assemble a team that included state leaders from the First Coast Region, as well as individuals with experience in the issue from the national level who played a role in the WPS and NHIC LCD drafts. The IOPC also asked the individual practitioners from Florida, who originally contacted their national neuropsychology organizations, to participate in the 360 Degree Advocacy team. In addition, the IOPC asked the executive director of the Florida Psychological Association (FPA) and its President to join the effort. Neither the executive director, nor the president of FPA were neuropsychologists. However, both immediately embraced the opportunity to participate in the First Coast LCD workgroup.
The workgroup also included neuropsychologists who participated in the WPS, NHIC, and National Model LCD for Neuropsychology efforts, as well as members of the IOPC. The workgroup additionally contacted the SPTAs for Puerto Rico and the Virgin Islands.

[Insert figure 3, 360 degree advocacy team, First Coast about here]

Figure 3. 360 Degree advocacy team, First Coast

Legend: SPTA= State, Provincial, or Territorial Association; AACN= the American Academy of Clinical Neuropsychology/ American Board of Clinical Neuropsychology; NAN= the National Academy of Neuropsychology; D40= Division 40 (Society for Clinical Neuropsychology) of the American Psychological Association; ABN= the American Board of Professional Neuropsychology; APAPO=__________

10 The workgroup included Dr. Robert Porter, President of Florida Psychological Association, Ms. Connie Galleti, Executive Director of Florida Psychological Association, as well as neuropsychologists Dr. Michelle Braun, Dr. Teresa Deer, Dr. Seema Elcher, Dr. Randi Most, Dr. Karen Postal, Dr. Tresa Roebuck- Spencer, Dr. Michael Schoenberg and Dr. Michael Westerveld.
the American Psychological Association Practice Organization; Regional NP Organizations = Regional Neuropsychological Organizations

Resolution of the First Coast advocacy effort.

Utilizing the Model National Neuropsychology LCD, and the WPS and NHIC LCDs as templates, members of the First Coast 360 Degree Advocacy team drafted language changes to the First Coast LCD. The changes were directly informed by team members’ experiences in the state with First Coast, and the advocacy process with other Medicare carriers. The IOPC sent a letter signed by each member organization to First Coast outlining the new language as well as an explanation of the rationale for the changes. FPA sent a similar letter to First Coast. The workgroup also drafted a grassroots letter and sent it to psychologists in the three states/territories covered by First Coast via SPTA listserv and local neuropsychology networks. This resulted in over 60 individual letters sent by neuropsychologists in Florida to First Coast.

Outcome of First Coast Advocacy Effort

The IOPC 360 Degree Advocacy team efforts resulted in substantial improvement in the LCD for practicing clinicians. First Coast published a comment summary, which began with an acknowledgement of the input from the IOPC and grassroots letter writing campaign. “Comments 1-11 address the considerable input to various sections of the LCD received from the Inter Organizational Practice Committee (IOPC), a coalition of representatives of various entities tasked with coordinating national neuropsychology advocacy efforts. Regarding the IOPC recommendations received, the contractor acknowledges (First Coast, 2013) that an extensive number of letters and emails from various stakeholders across Florida were received in support of the IOPC’s suggested
changes to the policy.” Eight out of the 11 comments suggesting changes to LCD draft language that the 360 Degree Advocacy team submitted to First Coast were incorporated into the final LCD draft.

As an example of the changes, the final LCD language clarified that while physicians cannot use the neuropsychological testing codes for explaining an assessment report prepared by another provider, the performing provider can use the neuropsychological testing codes to bill for feedback sessions. As another example, the final LCD language clarified that although the time a patient takes to fill out a self report instrument cannot be included in the neuropsychological testing codes, the time a neuropsychologist spends integrating the self report measures into the diagnostic formulation can be billed under the testing codes.

Where comments were not incorporated, explanations that would be helpful to clinicians and their billing departments in clarifying billing procedures were offered in the published comments summary document. Accepted suggestions to the LCD included language that more accurately described psychological and neuropsychological assessments and the difference between the two, clarification that time integrating self report measures into neuropsychological evaluations is considered a covered service, clarification that feedback sessions by neuropsychologists, psychologists, or the performing provider are considered covered services, and increase in the number of codes considered medically necessary for neuropsychological assessment.

While First Coast did not add suggested clarifying language to the LCD about the number of hours typically required to perform a neuropsychological assessment, they published the following comment in response to the advocacy teams’ concerns that their
draft language describing “4-6 hours as typical and more than 8 requiring extra
documentation” was confusing. Their published comments will be helpful in addressing
potential post service audits. “When the contractor states that typically psychological
testing/neuropsychological testing may require four to six hours to perform (including
administration, scoring, and interpretation), it’s just indicating that this is the most
common length of time for these tests. The contractor recognizes that tests could last up
to eight hours and sometimes extended time is necessary. The emphasis intended is that
for testing time exceeding eight hours, medical necessity for the extended testing should
be documented in the report, since the provider could fall under medical review.”

**Summary of the 360 Degree Advocacy model in action**

In the First Coast advocacy effort, the 360 Degree Advocacy model was triggered
by individual practitioners who learned of a critical practice issue in their state. Those
individuals alerted national neuropsychology organizations, who referred the issue to the
IOPC. The IOPC identified previously successful advocacy efforts carried out in parallel
circumstances in other areas of the country. Neuropsychologists who participated in
those other advocacy efforts were pulled in to participate on a 360 Degree Advocacy
team, along with local neuropsychologists and SPTA leaders. The result was a rapid
response, with buy in from local clinicians and leaders, and a work product signed by
national neuropsychology organizations as well as the state psychological association.
The advocacy effort resulted in substantial changes to the LCD, and therefore to the
practice climate of neuropsychologists in the region.

**Conclusions**
Increasing clinical neuropsychology’s capacity for effective advocacy as a field is particularly important in this era of rapid changes in the healthcare market place. Decisions affecting access to neuropsychological services and the neuropsychology practice climate may have long lasting implications as new delivery structures and payment models are solidified. However, state-by-state variability in regulations and healthcare marketplaces makes it difficult for national professional organizations to recognize critical advocacy issues as they emerge, and to mobilize finite resources effectively. The 360 Degree Advocacy model allows national neuropsychology organizations to identify and address practice threats and advocacy opportunities with maximal impact and efficiency by sharing best practices and activating the existing network of state psychological associations and regional neuropsychological societies.

We encourage neuropsychologists to become active participants in the 360 Degree Advocacy model by reporting practice and advocacy issues to their regional and national neuropsychology organizations, with the intention of participating in the advocacy and solution process. In addition, the 360 Degree Advocacy model only works to the extent that practicing neuropsychologists are active in not only neuropsychology organizations but organizations that more broadly represent psychologists as a whole (SPTAs and APAPO). Paying dues, joining advocacy committees, and running for leadership positions in SPTAs and APA will ensure that those organizations will be active, enthusiastic participants in coordinated, state level advocacy efforts on behalf of neuropsychology.

References


