Underserved Populations in Headache Medicine

Saturday 6/23/12

In attendance:

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Joanna Katzman Jkatzman@salud.unm.edu
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J. Katzman

- Challenge seems with headache, more than any other subspecialty in Neurology, tremendous waiting list.
- Most of the time if you have a movement disorder specialist, you can see the movement disorders patients that you need to see (i.e. muscular dystrophy patient).
- Not the same with chronic headache sufferers, goal might be to get to the underserved and train primary docs to get up to speed, to at least to see the 80%.
- At JK's university, get many referrals. If primary care doc could just learn 30% more then they could at least begin the process of treating the patients a little bit before they reach the specialists.

H. O'Brien

- Interested in hearing the feedback.
- Some challenges she faces is that the primaries don't want to hear from the specialists, they think they are doing ok.

H. O'Brien

Intro/Opening:

- Go over what they did at last meeting (Last time met was in Arizona)
- At last meeting, tried to figure out where the need was as far as trying to reach out to the underserved areas
- Two sites selected: Washington and location on the West Coast
- Also talked about trying to devise a way to develop a questionnaire to measure what impact the resources/what has been provided has on helping the underserved
- Solicit advice from Joanna Katzman since she is familiar with working with underserved populations
- In Cincinnatti, it's an academic center, and they see people of all demographics, there is an underserved population, but when help and resources are offered, there is push back from the primary docs.
    - They are ok with treating headaches and feel they understand how to treat headaches
    - But when there is a difficult patient they just send them to the academic center.
    - At the headache center they don't turn anyone away but there is a need because often times the patients are not adequately treated.

J. Katzman

- Agrees with HO…In her experience, the primary care doc is overburdened with chronic disease issues and don't have for the chronic migraneur, so they're refilling their triptans, patients are now having medication overuse headaches. Or they are re- filling rescue opiates, and now patients are having dependence and other associated issues with opiates as well as anxiety and depression.
- Primary care doc is not able to take care of chronic conditions (hypertension, diabetes, heart disease)
- Primary care docs don't have confidence/the pearls to know about the resources and what's out there in terms of migraine.

- What are best practices on how to diagnose migraine?
- What are best practices on how to diagnose headache?
- What are some things to look for in the clinical exam?
- What might you want to consider doing before the patient is referred to the specialist?
- It might be 3 months before the patient gets to the specialist so are there some things the Primary doc can do to get the patient on a better path before the patient sees the specialist?

H. O'Brien

Asked if there are materials that are put together and sent to primary care docs

J. Katzman

Staff at JK's university offer/make themselves available to federally qualified health centers, VA hospitals, clinics where real cases are presented over video technology once a week at a lunch hour. Most of the time it reflects a case that's very similar to a case everyone else has. That's the beauty of it…they're reviewing a case that everyone has come across at least 5-10 times.

- Talk about the interdisciplinary aspects about what could be confounding
- Talk about the differential diagnosis and the examination (everyone is on video) so the primary care physician or mid-level therapist, whoever's calling in, can talk about the diagnosis
- Has a formal didactic curriculum
- Curbside consultation – Those that can connect on video can call over the phone and get their cases presented. The patient doesn't have to wait to be seen and the primary care physician gets their question answered, in a timely manner (within that week)
- If the case is difficult, then JK/staff will see the patient in clinic
- Program is approx. 25 minute segments (some topics below):
  - What are some best practices/preventative treatments for migraine?
  - Formal curriculum, mainly didactic/Case-based learning
  - Free continuing medical education (CME) credits. For every our that they call in they get free CME (so if they are calling from a rural site, they don't have to spend money traveling to Los Angeles for example, to attend AHS)
- Funding
  - Originally when it started 8 years ago, it was funded thru the state of New Mexico, the VA health services, Robert Wood Johnson grants, then thru AHRQ
  - Slowly lost state funding then VA saw beauty of this (b/c of Hepatitis C and diabetes clinics doing this all similarly) so now the VA is replicating this specifically for pain and headache. The Department of Defense is doing this. The VA is now contracting with JK's group
  - Insurance Companies (with Healthcare Reform) are now giving money to this effort b/c they are seeing the benefit of if the doctor gets consultation from the program early, then the patient is getting treatment much earlier than they would, instead of having to wait months for consultation.
    - ❖ The doctor gets paid $100 thru Medicaid if they present a patient to the project.
    - ❖ Project is reaching out to insurance companies
    - ❖ Project Echo just got an $8 million dollar CMI Clinical Innovation Grant to do this for complex care thru Centers for Medicare and Medicaid

H. O'Brien

- Commented that the NIH is very interested in funding pain disorders and helping to educate on pain

J. Katzman

- Most complex care patients have chronic pain with headache
- Most are underserved

L. Charleston

- Wanted to remind group that goals should be attainable, and that the will be able to work on as a group
- Minorities won't benefit from program like JK's b/c they don't even go to primary doc/seek medical attention
- Figure out a way to educate community
    - Example: Have short interview with American Urban Radio Network
    - Result: Opportunity to talk about headache disorders, gets the ball rolling

S. Broner

- Suggests a direct/2-pronged approach (to get information to primary care docs whether thru residency programs and training them to treat the basics)
    - Educate people
    - Then combine with program so that the people that are listening and the educational campaign then gets linked to the primary care doc who now knows how to take it

K. Digre

- Compares program to the Stoke Campaign…i.e. Teaching patients that if you're having symptoms of a stroke, get to the emergency room, it can be treated like a heart attack now.

S. Broner

- The Chronic Migraine Campaign is doing stuff similar to that (Allergan)
- In terms of doing it with a local project, you can get people coming in more #s, but docs don't know how to take care of them and the system is getting overwhelmed
- Struggle is with doing public education programs vs education doctors. Can't really be combined into one project

L. Charleston

- Mentioned article demystifying headaches…when do you need to go see a physicians. Patients aren't going to seek a physician, when they do, their symptoms are now severe
- In Grand Rapids, MI, there was a good response when LC did some headache advocacy
    - The HUB (people in the community can call in or visit) – public approach
    - Did not see a lot of underrepresented patients, was older population b/c it was advertised in newspaper
    - Some patients in underserved population are not getting info because they don't read paper for information
    - Find the right venue get word out (music, newspaper, YouTube, etc) – think outside the box
    - Get AHS behind project to get word out
- Need to understand WHY they are underserved
    - Part of the reason why they are underserved, they are not going to seek medical attention
    - When they come seek medical attention, there is mistrust with the medical community

J. Katzman

- Her org serves Native Americans and Hispanics
- Population is primarily in Albuquerque, but most are isolated, live in rural areas
- Distances to travel are so great

K. Digre

- Asked how can we figure out barriers for underserved populations to get information or care

S. Broner

- Suggests we do something that's been talked about but not done yet, which is get the epidemiology study
    - Get data from physicians and identify available knowledge in most areas that need to be solicited including:
        - Socio-economic breakdown
        - Racial breakdown
        - Location of headache specialists
        - Lack of representation sources
        - Couple with cultural barriers to care to be most effective
    - Known issues: doctor supply is lacking; educational supply

L. Charleston

- Need to figure out how to get to that population (b/c they are not "picking up the paper")
- Says there is literature on "Mistrust"…i.e. "Late identification of cluster headaches, particularly in African American women"
- Another paper: "Less likely to receive preventive medication"
- While looks at a subset of population, but when extrapolated to entire populations, there are many similarities
- As a section, need to do outreach initially!

H. O'Brien

- Need to look at demographics of area
- Mirror what stroke team did…Go to barbershops and churches for outreach
- Starting to make inpact in outcomes of stroke

Action Items:

Meet at Scottsdale (each to think about demographics)

Set up teleconference (Andrea)