Co-Evaluation and Interdisciplinary Management of Headache

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Disclosures

- Neither presenter has any relevant disclosures

Learning Objectives

- Participants will be able to describe the principles and methodology of biopsychosocial assessment of headache patients.

- Participants will be able to name at least 3 tangible benefits of headache co-assessment.

- Participants will be able to recommend appropriate interventions for persistent headache.

Presentation Overview

- Overview of the Biopsychosocial Model
- Distinction between Multi-Disciplinary and Interdisciplinary Care
- Overview of Interdisciplinary Headache Assessment
  - Neurological/Biomedical Factors
  - Psychosocial Factors
- Case Examples

Overview of the Biopsychosocial Model

- Generally attributed to George Engel
  - Roy Grinker actually predated Engel's work
- Initially a response to the biomedical vs. psychological argument in psychiatry
- Criticized both the *reductionist* and *exclusionist* conceptualizations of disease
- Suggested that biochemical abnormalities are necessary <u>but not sufficient</u> for the occurrence of the human experience of disease

(Ghaemi, 2009; Engel, 1977)

Disease vs. Illness

- "Disease" – Refers to an objective bodily event that involves disruption of specific body structures or organ systems caused by pathological, anatomical, or physiological changes

- "Illness" – Refers to a subjective experience or self-attribution that a disease is present, resulting in physical discomfort, emotional distress, behavioral limitations, and psychosocial disruption

Interdisciplinary Care and its Relevance to Headache Outcomes

- Collaborative care improves outcomes in conditions that requires self management, most especially chronic pain and chronic headache

- Collaborative care is particularly effective when conditions are accompanied by comorbid psychopathology

Kroenke, 2014; McGregor M, et al. J Ambul Care Manage. 2011;34:152-162.

"Interdisciplinary" vs. "Multidisciplinary"

- Terms are often incorrectly used interchangeably
- "Multidisciplinary" simply means numerous disciplines
- "Interdisciplinary" means that they're actually working together

(Gatchel RJ, et al. Am Psychol. 2014;69:119-130)

Typical Barriers to Collaborative Care

- Provider Location
- Finances, lack of reimbursement
- Schedule Coordination
- Patient Resistance
- Clinician Anxiety
- Personality

The Joys of Co-Assessment

- Innovative Model where multiple providers assess patient simultaneously

- Effectively addresses barriers:
  - Provider Location
  - Schedule Coordination
  - Patient Resistance
  - Clinician Anxiety

Elements of a Complete Interdisciplinary Headache Assessment

- Evaluation of headache in addition to general history
  - Neurologic and Medical “Red Flags”
  - 1 or more headache types

- Physical examination and medical record review

- Psychosocial Evaluation (including how pain is impacting relationships and family, signs of depression, anxiety, suicidal thoughts)

Elements of a Complete Interdisciplinary Headache Assessment

- PMP Review
- Screening Tools
  - PHQ-9, GAD-7, MIDAS, Headache Diary, ISI
- Urine Toxicology when appropriate
- Risk Assessment

Elements of a Complete Interdisciplinary Headache Assessment

- Individualized written treatment plan including functional goals.
  - Specific, Measurable, Achievable, Realistic, and Time-bound Goals

- Consultation with additional specialists when indicated (e.g., sleep specialist, physical therapy, dental, psychiatry, optho)

Interdisciplinary Care

- Why is it so important for headache patients specifically?
  - Headache is an *ongoing* illness and not simply a disease.
    - For example…

Headache Severity Progression

- Attack frequency
- Stressful life events and psychiatric comorbidity
- Effects of childhood maltreatment; physical, sexual, emotional abuse
- Medication and caffeine overuse
- Obesity
- Snoring and sleep apnea

Smitherman, Maizels, & Penzien, 2008

Psychological Issues Relevant to All Patients

- Assessment of cognitive factors
- Patient interest in medical treatment
  - beliefs/attitudes about illness /treatment
- Monitoring and managing triggers
- Treatment Adherence
  - 50%-70% of patients fail to optimally use medications
- Potential role for adjunctive behavioral treatment (e.g., biofeedback, relaxation, CBT)
  - Tension Type & Migraine

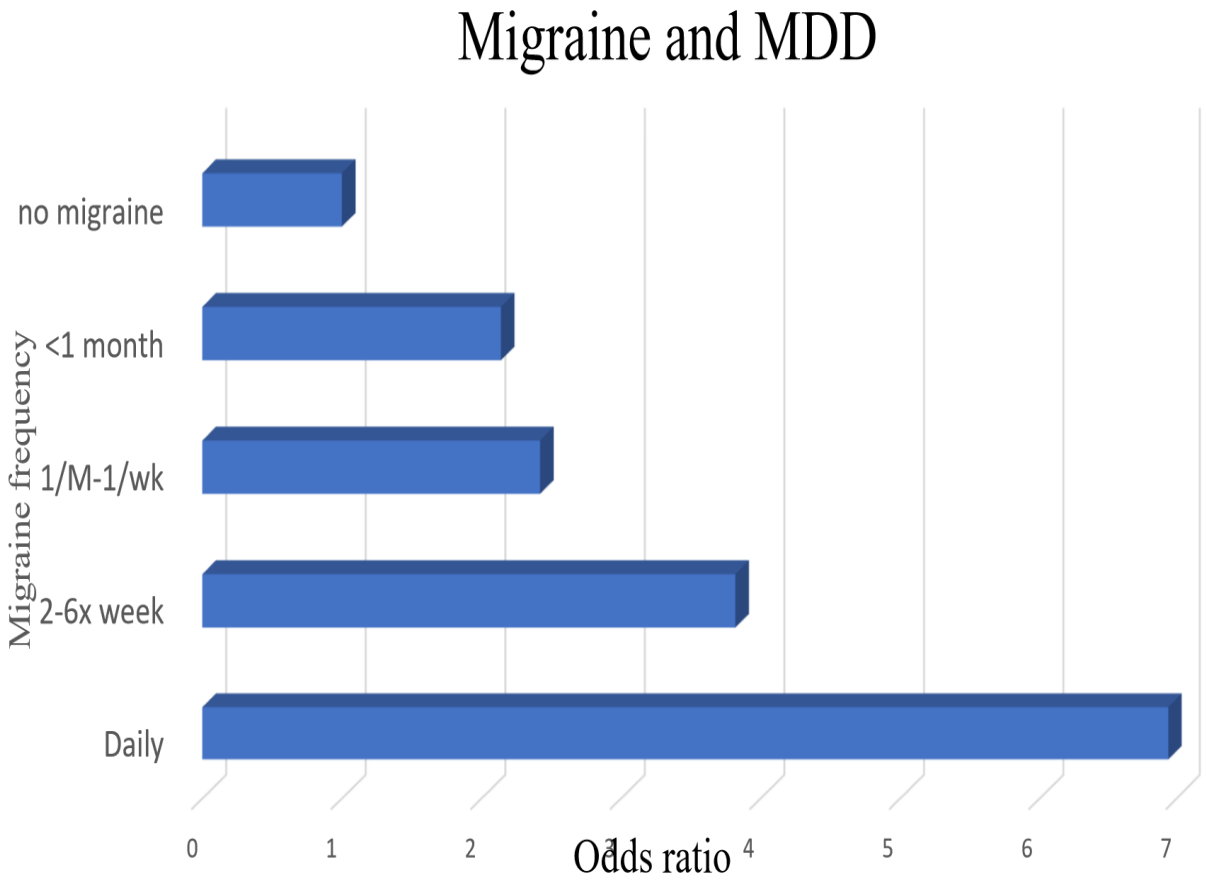
(Nicholson, 2010)

Indicators for behavioral treatment

- Presence of psychiatric co-morbidity
- Difficulties coping with headache
- Sleep Problems
- Managing Stress and Reducing Arousal
- Medication Overuse/Misuse
- History of Trauma/Abuse
- Work Loss and Disability

(Andrasik, Buse, & Grazzi, 2009)

Brazilian Adult Health Study



(Baskin, 2017; Goulart, A, Santos, I, et al. Headache 2014;54:1310-1319)

Comorbid Psychiatric Disorders

Prognosis for Refractory Headache 8-year follow-up of adolescents & young adults N=100

Multiple disorders	57% same or worse	29% improved	14% HA-free
Single disorder	15% same or worse	46% improved	39% HA-free
No psych disorder	7% same or worse	53% improved	40% HA-free

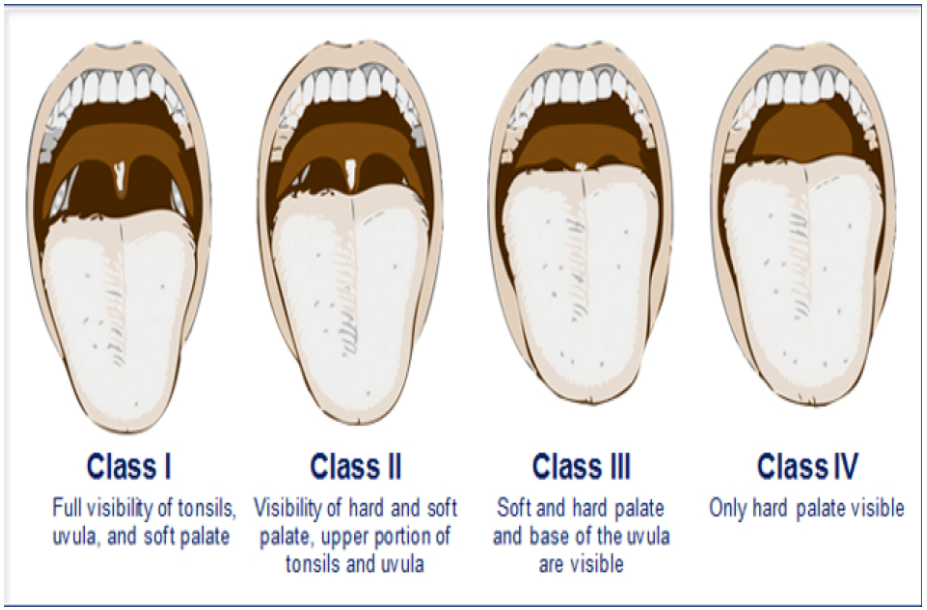
(Baskin, 2017; Guidetti V, Galli F et al: Cephalalgia 1998;18:455-462)

Case 1

- 55 year old man with hx significant for hypertension and GERD, presenting with daily headaches for the last 20 years.
- Headache was holocephalic, no associated symptoms, worse in the morning
- On review of symptoms, endorsed daytime sleepiness/napping
- Questionnaires:
    - PHQ-9: WNL
    - GAD-7: WNL
    - ISI: ALARMING

Case 1 Cont.

- Relevant Physical Exam Findings:
  - Neurological Exam WNL
  - Prior neuroimaging reassuring
  - Mallampati IV

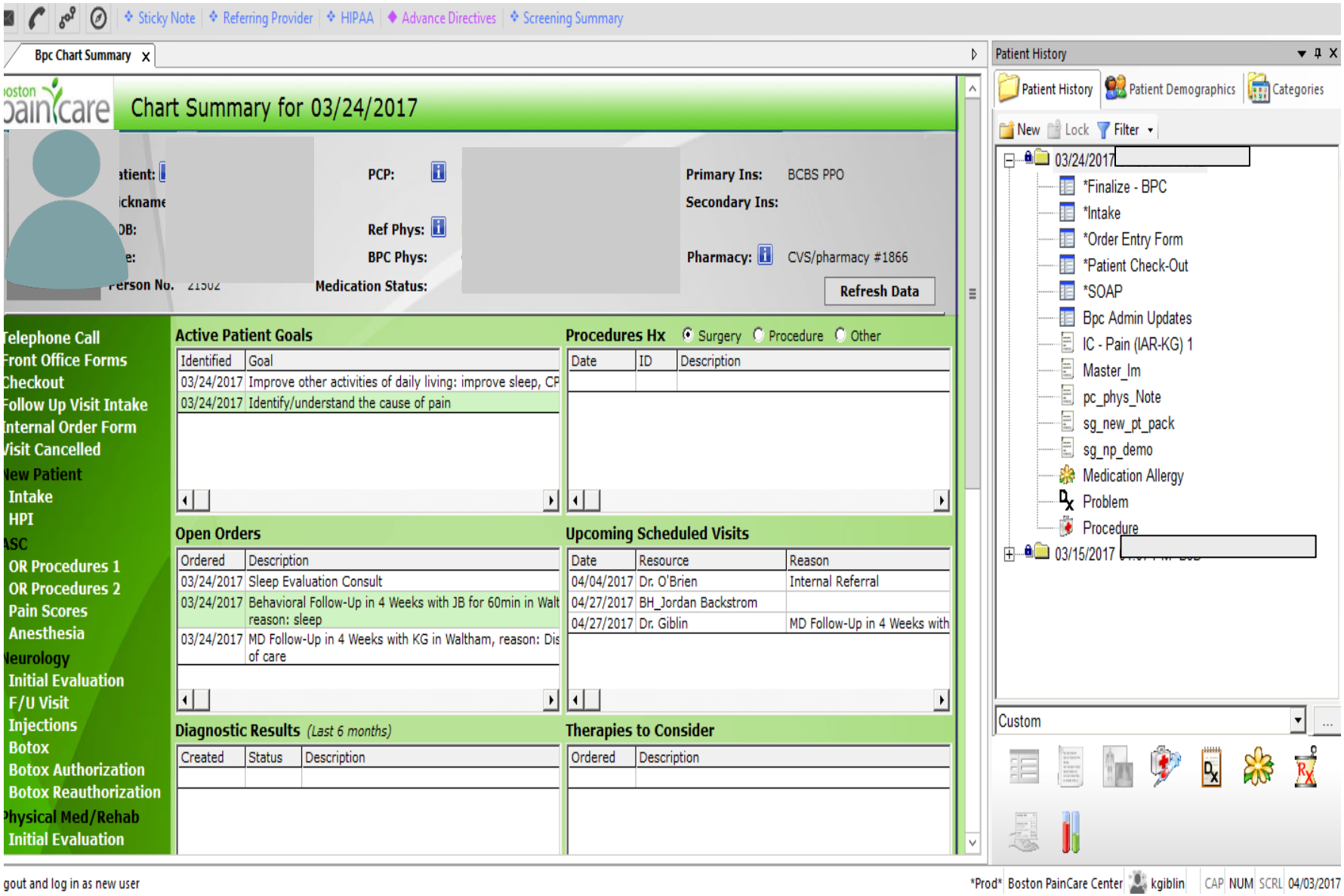


On further questioning:
distant dx of OSA, non-adherent with CPAP

…. Diagnosis?

Case 1 Cont.

- Diagnosis:
  - headache secondary to sleep apnea
- Immediate Intervention and POC
  - Brief CBT-I intervention focused on sleep hygiene
  - Referral to sleep specialist
    - Recommended CPAP adherence
    - Potential oral splint therapy
  - 4 week neurological and psychological follow up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BPC Phys:
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Secondary Ins:
Pharmacy: CVS/pharmacy #1866
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Front Office Forms
Checkout
Follow Up Visit Intake
Internal Order Form
Visit Cancelled
New Patient
Intake
HPI
ASC
OR Procedures 1
OR Procedures 2
Pain Scores
Anesthesia
Neurology
Initial Evaluation
F/U Visit
Injections
Botox
Botox Authorization
Botox Reauthorization
Physical Med/Rehab
Initial Evaluation
Active Patient Goals
Identified
Goal
03/24/2017
Improve other activities of daily living: improve sleep, CP
03/24/2017
Identify/understand the cause of pain
Procedures Hx
Surgery
Procedure
Other
Date
ID
Description
Open Orders
Ordered
Description
03/24/2017
Sleep Evaluation Consult
03/24/2017
Behavioral Follow-Up in 4 Weeks with JB for 60min in Walt
reason: sleep
03/24/2017
MD Follow-Up in 4 Weeks with KG in Waltham, reason: Dis
of care
Upcoming Scheduled Visits
Date
Resource
Reason
04/04/2017
Dr. O'Brien
Internal Referral
04/27/2017
BH_Jordan Backstrom
04/27/2017
Dr. Giblin
MD Follow-Up in 4 Weeks with
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Created
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Description
Therapies to Consider
Ordered
Description
Patient History
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*Intake
*Order Entry Form
*Patient Check-Out
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Medication Allergy
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Procedure
03/15/2017
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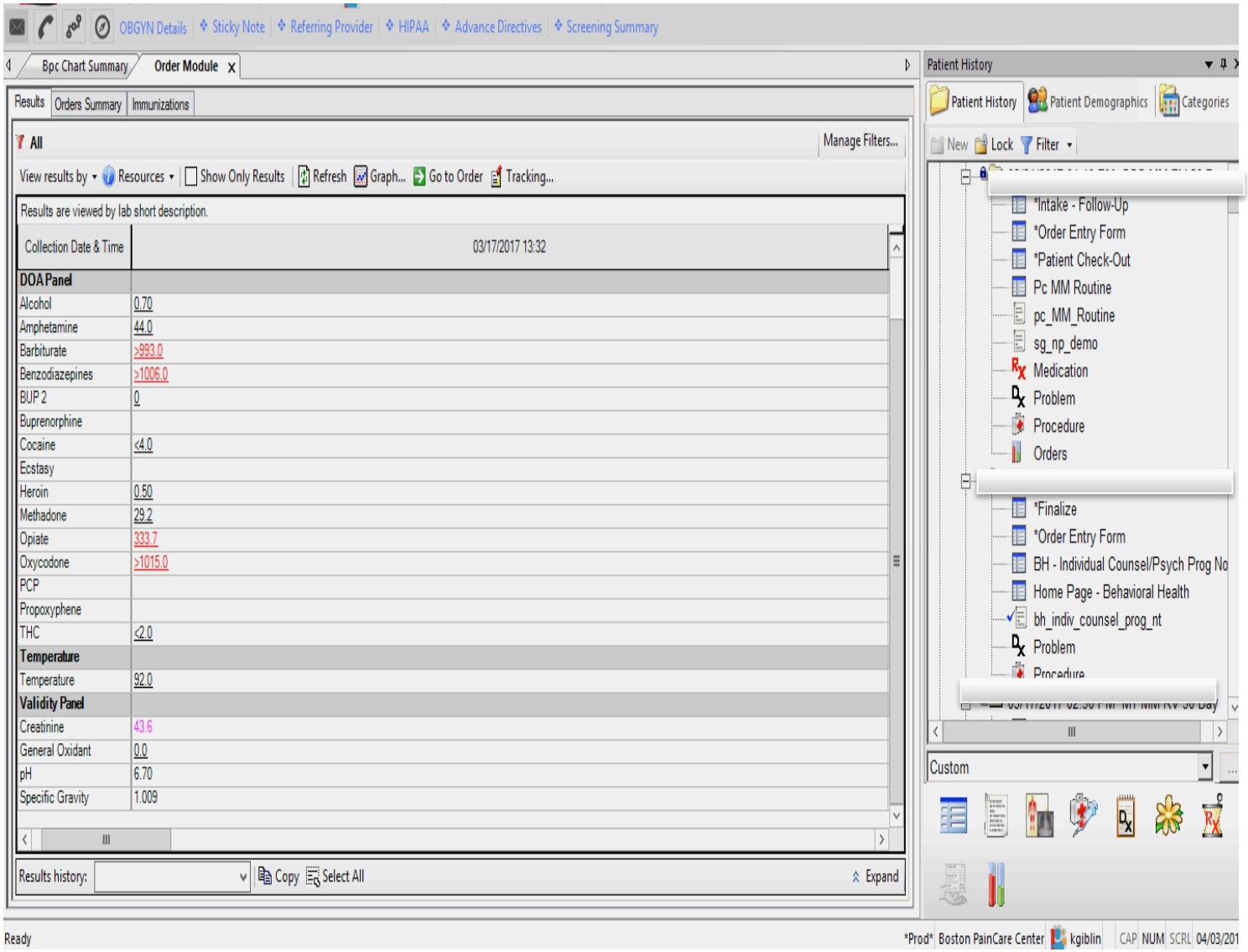
Case 2

- 48 year old woman with hx significant for gastric bypass, PTSD, anxiety, depression, “migraines,” presenting with daily headache pain.
- Headaches started in adolescence, initially catamenial, + phono/photo/N/V.
- Managed by PCPs with fioricet, Tylenol with codeine
- Age 35, HA became “constant.”
- Now 1-2 ED visits per month (IVF, opiates, mag)
  - Taking 2-3 tabs Fioricet daily, Tylenol with codeine 1 tab QHS. Also takes lorazepam QHS for sleep.

Case 2 Cont.

- Questionnaires:
  - PHQ-9: Moderately Depressed
  - GAD-7: Highly Anxious
  - ISI: Moderate
  - MIDAS: 21+, MIDAS Grade IV, Severe disability
    - Missing multiple work days (5+) and family activities due to headache
- Physical exam with taut, tender bands over cervicothoracic musculature, but normal cervical ROM, neurological examination
- Neuroimaging reassuring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HIPAA
Advance Directives
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Bpc Chart Summary
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Resources
Show Only Results
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Amphetamine 44.0
Barbiturate >993.0
Benzodiazepines >1006.0
BUP 2 0
Buprenorphine
Cocaine <4.0
Ecstasy
Heroin 0.50
Methadone 29.2
Opiate 333.7
Oxycodone >1015.0
PCP
Propoxyphene
THC <2.0
Temperature
Temperature 92.0
Validity Panel
Creatinine 43.6
General Oxidant 0.0
pH 6.70
Specific Gravity 1.009
Results history:
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Select All
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Patient History
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Categories
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Case 2 Cont.

- Additional Information:
  - PCP no longer willing to prescribe Tylenol w/ Codeine and Fioricet
- Diagnosis:
  - Hx of Migraine, now with Medication Overuse Headache, r/o rebound
  - Dual Diagnosis: Polysubstance Use Disorder, Depression/Anxiety, Chronic PTSD

Case 2 Cont.

- Recommendations and POC:
  - Inpatient vs. outpatient medication wean with subsequent outpatient Substance Abuse Treatment/CBT for Mood
  - MOH treatment: steroid pulse, initiation of migraine prophylactic (topiramate); sumatriptan SQ for abortive medication once HA became episodic
  - Ongoing follow up (MOH relapse 10% annually)

THANK YOU!

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Questions?

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