A Primary Care Team Approach for the Treatment of Headaches

Jennifer Bell, MD, Internist/Branch Chief
Briana L. Todd, PhD, Clinical Psychologist/Subject Matter Expert
Primary Care Behavioral Health, Psychological Health Center of Excellence

National VA/DoD Women's Mental Health Mini-Residency:
Building Clinical Expertise to Meet Women's Unique Treatment Needs
Crystal City, Virginia | August 28-30, 2018

Disclosures

- The views expressed in this presentation are those of the author and do not necessarily reflect the official policy or position of the Department of Defense, nor the U.S. Government
- This continuing education activity is managed and accredited by the Department of Veterans Affairs, Employee Education System (VA-EES)
- Drs. Jennifer Bell and Briana Todd and Psychological Health Center of Excellence (PHCoE) staff have no financial interest to disclose. Commercial support was not received for this activity

Learning Objectives

At the conclusion of this presentation, participants will be able to:

- Describe an integrative approach to the biopsychosocial assessment and behaviorally-based treatment of migraines
- Explain how Primary Care Clinicians (PCC) and Behavioral Health Consultants (BHC) can optimize care for patients with migraines through shared treatment planning and coordination of care

Note:

Behavioral Health Consultant (BHC) in the VA =

Internal Behavioral Health Consultant (IBHC) in the DoD

Case Example

A 26 year-old female presents to her primary care clinician (PCC) with the complaint of migraines. Initial onset was eight years ago. She previously managed her headaches with over the counter (OTC) ibuprofen and naps. This worked well while in school but the naps are incompatible with her new job. She is now taking ibuprofen "like candy." She shares that she needs some relief, but isn't sure what to do.

For the purposes of this presentation (only 25 minutes!) we will assume that there are no red flags and that the diagnosis of migraine is correct.

Sex Differences in Migraine

- Two to three times more prevalent in women (Vetcik et al., 2017)
- Women report: longer duration, increased recurrence, greater disability, longer recovery time (Vetvik et al., 2017)
- The burden of headache was highest in females 18-44 (Smitherman et al., 2013):
  - 3-month prevalence of migraine or severe headache was 26.1%
  - Head pain was the third leading cause of Emergency Department visits

Case Example, cont'd

The patient reports a migraine "like clockwork" the day before menses and once or twice a week, particularly if she doesn't sleep well or misses a meal

- She was given a "sleep hygiene" worksheet at a previous appointment but still doesn't get enough sleep a few times per week
- Meals times are inconsistent and outside of her control due to work schedule (early or noon meetings, stays late some days)
- She describes frustration and stress with her work, which she attributes to low productivity during headaches and the postdrome phase

Patient-Centered Care: Treatment Options

- Consider modifiable and non-modifiable triggers (e.g., food, activity, stress, menses)
- Consider appropriate treatment setting in a stepped-care approach
  - ❑ Primary care provider
  - ❑ Additional assets in primary care: BHC (VA)/IBHC (DoD), dietician or nutrition expert
  - ❑ Specialty care: neurology and specialty behavioral health
- Create a comprehensive treatment plan incorporating patient values and preferences

BHCs Support Self-Management with Behaviorally-Based Interventions

Intervention	Description
Education (Nicholson et al., 2011)	▪ Education about triggers ▪ Education of the role of stress and headaches
Tracking Triggers (Nicholson et al. 2011)	▪ Avoidable and manageable (e.g., alcohol, bright lights, foods) ▪ Unavoidable but manageable (e.g., stress, hunger) ▪ Hard to avoid and manage (e.g., hormones, weather changes, airplane travel)
Relaxation (Cho et al., 2017)	▪ Progressive muscle relaxation, diaphragmatic breathing, cue controlled
Cognitive Behavioral Therapy (CBT) (Cho et al., 2017)	▪ CBT tools to manage the physiological, cognitive, emotional, and behavioral response to life stressors and headaches

BHC Role

BHCs are appropriate to assist patients with migraines, including:

- Chronic migraines
- Non-responsive to medication
- Frequent emergency room visits
- Functional limitations due to headaches
- Preference for non-pharmacological approach
- Contraindications for medication (e.g., pregnancy, nursing)
- Medication overuse headaches

Is Treating the Insomnia an Option?

- Cognitive behavioral therapy for insomnia (CBT-I) has long demonstrated effectiveness and even superiority over hypnotics as a treatment for insomnia.[1] Wide-spread use is limited by shortage of trained providers and number of treatment sessions (Trauer et al, 2015)
- Brief behavioral treatment of insomnia (BBTI), a four-appointment protocol has demonstrated efficacy in treating insomnia (Buysse et al, 2011)
- Army IBHCs are trained in a five-appointment protocol adaptation of BBTI intervention for primary care. Two appointments may be done by telephone

Case Example, revisited

Biopsychosocial assessment: 26-year-old woman with migraines; triggers include sleep disturbance, work stress, menses, inconsistent meals

Evidence-based approach: research evidence, clinical expertise, and patient values and circumstances

Options are given to patient who selects/agrees with the following initial comprehensive treatment plan:

- Continue ibuprofen on day prior to menses as it has been effective for her menses-related symptoms (including minimizing or preventing her headache)
- Link with dietician to review and optimize diet based on scheduling challenges
- Link with BHC for assessment and behaviorally-based intervention

Coordination of Care:
PCC and BHC Shared Treatment Goals

- Coordinate treatment goals
  - PCC and BHC collaborate on initial and ongoing treatment goals with patient
  - Maintain shared expectations for patient
  - Patient hears consistent message
  - Multiple members of treatment team reinforce goal
- Consider future episode of care (e.g., insomnia or other relevant contributing condition) for additional concerns/treatment needs

Key Takeaways

- BHCs are available in primary care clinics to support a biopsychosocial approach to assessment and treatment of migraines
- Treatment goals are based on patient preferences and are shared between PCC and BHC
- BHCs provide behaviorally-based interventions to support a self-management/behavioral approach to migraines (with or without medication)
- BHCs can augment with future episodes of care for problems (e.g., insomnia, depression) associated with migraines

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Q & A

Jennifer Bell, MD

Jennifer.l.bell32.civ@mail.mil

Briana Todd, Ph.D.

Briana.l.todd.ctr@mail.mil