Headache and Facial Pain Section Strategic Plan

I. Introduction

a. Headache and Facial Pain (headache medicine) is a section concerned with the diagnosis and treatment of head and face pain. Its scope includes the diseases or categories of disease causing central and peripheral disturbance of structures or functions.

b. There are two main components of headache and facial pain: primary headache and secondary headache or face pain. Primary headache is defined as a head syndrome with associated symptoms and/or signs whose historical occurrence or phenomenology occurs in the absence of intracranial or systemic pathology. Some examples of treated primary headache are: migraine, tension-type headache, cluster headaches of short duration, and other headaches unassociated with structural abnormalities of the brain. Secondary head or face pain is defined as a head or face pain syndrome with or without associated symptoms and/or signs whose historical occurrence or phenomenology occurs in temporal association with intracranial, extra-cranial, or systemic pathology.

c. The purpose of the headache and facial pain strategic plan is to help the section outline its current and future plans and allow AAN key users to be aware of the section’s unique goals. In this document is a brief history of the section, the current status, and long and short-term visions and goals. All of these combined will serve as the framework for the strategic plan.

II. Background/History of Subspecialty or Section

a. Before the 1930s and 1940s, there were not many pioneers interested in the field of headache. It was not until Harold G. Wolff of Cornell Medical Center began research in headache medicine that the specialty was put on the map. He is arguably the father of modern experimental migrainology. Some other early pioneers were Baynard Horton of the Mayo Clinic and Charles Kunkle of the Maine Medical Center who were instrumental in describing clinical aspects of cluster headache in the 1950s. Arnold Freedman set up the first comprehensive academic headache center at Montefiore Hospital during the 1950s and 1960s. Even though these pioneers made great contributions to the field of headache, it was not until John Graham, a Boston internist, spent four decades writing and teaching about caring for patients with chronic headache. It was not until the late 1960s that the first professional headache society was established, ironically not by neurologists in the field. Over the next thirty years, the American Association for the Study of Headache became the dominant organization solely dedicated to scientific, clinical, and core aspects of headache disorders. Both Drs. Freedman and Graham served as presidents of the association after its inception. In 1981, the International Headache Society was formed to promote research and set-up clinical studies and quality-of-care guidelines. The most important achievement of this society is its well-accepted Classification and Criteria for Diagnosis of Headache Disorders.

b. It was not until 1993 that members of the AAN began attempting to organize a separate section on headache and facial pain. There were several courses offered in the field of headache at the Annual Meeting since the 1980s, which were well received. This prompted the interest of having a section. In addition to the growing interest in courses offered, there was rapid expansion of knowledge in established migraine and related disorders as
biologically-based and possibly treatable. Dr. Ninan T. Mathew, with the help of George Sands, took the initiative in collecting signatures from interested members and formalizing the bylaws. The Executive Board of the AAN approved the formation of the section in 1993 and its first meeting was held at the 1994 Annual Meeting in Washington, D.C. George Sands was elected as the first chair of the section. From 1994 to 1998, the section membership grew to over three hundred. Membership grew to 429 in 2004, and has declined slightly and remained steady around 380 in June 2008.

c. There are many pertinent journals and societies related to headache and facial pain. Some of the more prominent other headache societies are: the American Headache Society, the International Headache Society, the American College of Allergy, Asthma, and Immunology, and the National Headache Foundation. Some of the prominent journals published in the field of headache are: The Journal of Head and Face Pain, the Migraine Headache Journal, the American Headache Society Journal, the Cephalalgia Journal, and the Pain Journal.

d. In 2004, the headache and facial pain section applied for subspecialty from the United Council for Neurologic Subspecialties (UCNS). The goal of the UCNS is to accredit training programs in neurologic subspecialties like headache and to certify competence in physicians who have completed an accredited training program, with the goal of enhancing the quality of training benefiting both physicians and patients.

III. Current State of the Subspecialty

a. Patient care/practice

Headache patients are the largest group of patients continuously followed in Neurology practice. Though primary care physicians are usually the first contact points for these patients, many seek neurologic consultation when their condition proves more complex or refractory to standard modalities. These patients are usually transferred to a general neurologist but many eventually seek a more advanced practitioner of Headache Medicine. The modalities available to the Headache Medicine practitioners include medications, psychological and behavioral modalities, dental and myofascial treatments, denervation therapies, infusions in outpatient and inpatient settings and neurosurgical procedures. It is crucial for the practitioner of Headache Medicine to be aware of the indications for these modalities. The publication of the US Headache Guidelines and the upcoming revision provide evidence base for this type of decision making. Access to specialists and subspecialists remains sporadic in many locations and migraine remains a well recognized source of personal and social disability. Practice standards are applied variably and the subspecialist in Headache Medicine quickly becomes oversubscribed by patients with many unmet needs both diagnostically and therapeutically. Raising the standard for diagnosis has not been demonstrated and applying effective therapies remains a challenge, compounded by access issues generated by high costs and restrictions from managed care. The search for newer, safer and affordable therapies is slow and major roadblocks exist at all levels of health care systems bi and small.

b. Research

The state of research in Headache Medicine mirrors same challenges present for the practice and teaching of Headache Medicine. Grossly underfunded by NIH, the last 2
decades were dedicated to pharmaceutical clinical trials and spin-offs from those therapies. Responding to this need, the Section participated in initiatives partnering with the American Headache Society in efforts culminating in Headache on the Hill, modeled after the proven success of Neurology on the Hill. This has resulted in report language in a house bill, but there is still no guarantee of improved funding for basic or clinical intramural research. Competing for a limited talent pool of young researchers, academic departments are hesitant to invest resources in HM. The Graham-Wolfe award is a visible sign of the dedication of the Academy to improving this state and additional awards are now being proposed for early career researchers, though none have yet been given to member of the Section.

c. Education

In 2003, President Robert Daroff (AHS) made a formal request to the Academic Section to develop a headache fellowship with the long term goal of developing accreditation for training programs. Chairman James Couch (American Academy of Neurology {AAN} Headache and Facial Pain Section) endorsed and encouraged fellowship training and recommended consideration for broader recognition of headache practitioners. Simultaneous with this the AAN, American Neurological Association, Association of University Professors of Neurology, Child Neurology Society and Professors of Child Neurology formed the United Council for Neurologic Subspecialties (UCNS) whose mandate was to develop mechanisms for accreditation and credentialing. The AHS, with its co-sponsor the AAN Section, applied for recognition and in March 2005 our application was approved. The new subspecialty area was born. In September 2006 the first examinations were administered and 105 diplomates of Headache Medicine received certificates. That same year 7 programs were approved for accredited fellowships. The third exam has just been given. The pass rate on the first 2 was 99% with 165 diplomates certified. Eleven programs are accredited. The section has NOT been an active marketer for either certification or accreditation, but has kept its members up to date on the data. A future direction should include, in the very short term, an aggressive plan to enroll more fellowship programs in order to move towards an ACGME accreditation and ABMS recognition.

d. Medical Economics issues

In the last 2 section meetings, it was proposed that a P4P project begin. This has not been acted upon. It remains a goal of the current Chair to continue an initiative to define the goals of a Headache Medicine P4P. Coding education has been undertaken at the AHS, but is not a formal part of any plan for the section at this time.

e. Legislative Issues

Legislative issues have recently become more of a focus with regards to NIH funding (above). A historical liaison with the Pain Care Coalition (PCC; a diverse coalition of consumers, practitioners, scientists, etc) and AHS has been established and will be strengthened. One of the officer’s states: “The AAN hasn’t really represented the headache issue very well and haven’t utilized the potentially strong linkage within the legislative efforts of AHS and PCC. Many members of the section participated in Neurology on the Hill and Headache on the Hill in the past. The current legislative agenda includes a bill in process entitled THE PAIN CARE POCLICY ACT with past
accomplishments including the passage in 2008 of the MILITARY PAIN CARE and VETERANS PAIN CARE Acts. The NATIONAL PAIN CARE POLICY ACT of 2009 has been reintroduced.

IV. PATIENT CARE

A. Strengths
1. Strong National Societies
   a. American Headache Society
   b. National Headache Foundation
2. Guidelines
3. Patient Advocacy
   a. relatively small but vocal
      1. www.helpforheadaches.com
      2. www.migraines.org
      3. others

B. Weaknesses
1. Primary care practice standard
2. Access to and cost of medication
3. General neurology
4. Disparity of and access to specialty care

C. Opportunities for growth
1. Improve treatment guidelines and active use
2. Develop partnerships with agencies, payers and PhARMA
3. Improve training of residents
4. Work with government to improve access

D. Threats to achieving goals
1. Lack of resources
2. Competition with other disease area for attention of agencies, etc.
3. Limited access to training

E. Current status of AAN
1. Quality standards mechanism is in place
2. Revised guidelines pending (Silberstein)
3. Legislative initiatives (Saper)

RESEARCH

A. Strengths
1. Small but committed group of researchers
2. Compatible international community
3. Legislative Advocacy
4. Academic faculty and fellowships

B. Weaknesses
1. Poor funding from government and foundations
2. Historical reliance upon funding from PhARMA
3. Lack of academic support for research fellowships
4. Small but committed group of researchers

C. Opportunities for growth
1. Improve funding
2. Develop quality and ethical partnerships with agencies, payers and PhARMA
3. Improve training of fellows
4. Work with government to improve funding
D. Threats to achieving goals
1. Historical lack of knowledge amongst national academic leadership
2. Lack of resources
3. Competition with other disease area for attention of agencies, etc.
4. Limited access to training fellows
5. AAN policy on international membership

E. Current status of AAN
1. Scientific fellowships
2. Scientific presentations at Annual meeting
3. Legislative initiatives and funding requests including NOH, HOH (Shapiro)

EDUCATION
A. Strengths
1. Small but committed group of educators
2. Co-membership with others all ready developing initiatives
   a. American Headache Society
   b. UCNS
3. Accredited fellowships: UCNS
4. Resident and medical student education (III.A.2.a)

B. Weaknesses
1. Primary care education
2. General neurology education
3. Reliance upon PhARMA for dissemination

C. Opportunities for growth
1. Curriculum change
2. Develop programming for medical schools
3. Improve training of residents
4. Funding for fellowships

D. Threats to achieving goals
1. Lack of resources
2. Competition with other disease area for attention of agencies, etc.
3. Limited access to training

E. Current status of AAN
1. Co-sponsor of UCNS
2. Resident and medical student programming (with AHS)

ECONOMICS
A. Strengths
1. Strong National Societies
   a. American Headache Society
   b. National Headache Foundation
2. Guidelines
3. High prevalence disorders and referral base

B. Weaknesses
1. Payer mix
2. Disabled population
3. Lack of procedures
4. Weakening of PhARMA commitment to research

C. Opportunities for growth
1. Improve treatment guidelines and active use
2. Develop partnerships with agencies, payers and PhARMA
3. Improve training of residents
4. Work with government and payers to improve reimbursement

D. Threats to achieving goals
1. Lack of resources
2. Competition with other disease area for attention of agencies, etc.
3. Limited access to payers

E. Current status of AAN
1. Quality standards
2. Legislative initiatives (Saper) and lobbying

LEGISLATIVE
A. Strengths
1. Strong National Societies
2. Section membership
3. Patient Advocacy

B. Weaknesses
1. Public perception of disease area
2. Disparity of and access to specialty care

C. Opportunities for growth
1. Improve communication with officials and legislators; e.g. PCC
2. Develop partnerships with agencies, payers and patient advocacy groups
3. Headache on the Hill
4. Work with PAC

D. Threats to achieving goals
1. Lack of knowledge (public and private) of burden of disease
2. Competition with other disease areas, especially Pain, for attention
3. Limited access to legislators

E. Current status of AAN
1. PAC
2. Headache on the Hill
3. Pain Care Coalition (Saper/Freidman)

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<td>Threats</td>
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V. Specific Vision, Goals and Objectives for the Subspecialty/Section: Headache and Face Pain

A. Short Term (over next 5 years)

1. Specific defined goals and targets
   a. **Practice Standards**: Implementation of upcoming revisions with definable outcome measures to insure success of improving dissemination and utilization
   b. **Research Funding**: To attain the goal of increased funding of basic and applied research
   c. **Medical Education**: To complete and disseminate vetted medical student and neurology resident curricula

   - Lack of resources
   - Competition with other disease areas for attention of agencies, etc.
   - Limited access to training

   - Lack of knowledge amongst academic leadership
   - Lack of resources
   - Competition with other disease areas
   - Limited access to training fellows
   - AAN policy on international membership

   - Lack of knowledge (public and private) of burden of disease
   - Competition with other disease areas, especially Pain, for attention
   - Limited access to legislators

   - Improve communication with officials and legislators
   - Develop partnerships with agencies, payers and patient advocacy groups
   - Headache on the Hill
   - Work with PAC

   - Lack of knowledge about disease area
   - Competition with other disease areas
   - Limited access to training fellows
   - AAN policy on international membership

   - Lack of knowledge (public and private) of burden of disease
   - Competition with other disease areas, especially Pain, for attention
   - Limited access to legislators
d. Legislative agenda: To continue support of initiatives including PCC and congressional and regulatory activity

e. Fellowship Training
   1. Increasing the number of UCNS accredited Headache Medicine fellowships
   2. Formalizing the review process for accreditation

f. International Membership: To define and implement the membership categories available to international experts

2. Operational strategies to achieve goals
   a. Practice Standards: To complete the headache guideline.
   b. Research Funding: To continue Headache on the Hill
   c. Medical Education: To complete a medical student and resident curriculum
   d. Legislative agenda: To continue administrative support for liaison to PCC
   e. Fellowship training
      1. Marketing of fellowships
      2. Task force and committee to establish documents and standards

f. International Membership: To identify appropriate individuals for new categories of membership in the Section

3. Specific action items for each goal
   a. Practice standards: To encourage AAN to validate and distribute a Quality Standard
   b. Research Funding: To promote an improved review process with the end goal of increasing the scientific competitiveness of grant submissions specific to areas of need and importance to understanding mechanisms and impact of primary and secondary headache including traumatic brain injury.
   c. Medical Education: Publication and marketing of curricula to medical and allied health schools
   d. Legislative agenda: To partner with Legislative Affairs committee of AAN
   e. Fellowship training:
      1. Revise and review the curriculum
      2. Establish a formal process for internal review prior to accreditation or re-accreditation of fellowship program

f. International Membership: Explore and engage the process underway at AAN

4. Role of AAN in achieving goals
   a. Practice Standards: Publication and distribution
   b. Research Funding: Administrative and financial support of Headache on the Hill and other initiatives
   c. Medical Education: see 3c
   d. Legislative agenda: Coordination
   e. Fellowship training
      1. Provide administrative support for the “review committee”

f. International Membership: AAN will lead the initiative to define International membership status

5. Benefit to AAN and sub-specialty in achieving goals
   a. Practice Standards: Continued leadership in Headache Medicine
   b. Research Funding: Establishing scientific leadership in Headache Medicine
   c. Medical Education: Insuring the importance of neurology in teaching Headache Medicine
   d. Legislative Agenda: Advancing legislation to improve Headache care and research
   e. Fellowship training: Insures the role of AAN and the Section as overseers of quality of training and credentials
f. **International Membership**: Creating partnerships with organizations and individuals

6. How will sub-specialty assess and address success/failure for each goal/area?
   a. **Practice Standards**: Success will be measured by definable metrics including P4P. (see below). The subspecialty will address failure by continuing to encourage research and education.
   b. **Research Funding**: Success will be measured in absolute funding dollars and percent of NIH budget dedicated to migraine and head pain research. The subspecialty will address failure by continued efforts to legislate and allocate funds.
   c. **Medical Education**: Success will be measured by formal or informal survey of teaching institutions utilizing the created materials. The subspecialty will address failure by reassessing needs of educators.
   d. **Legislative Agenda**: Legislation and regulations
   e. **Fellowship training**: Success will be measured by accounting the absolute numbers of programs establishing and/or maintaining accreditation. The subspecialty will address failure by aggressive communication with academic medical center leadership in neurology.
   f. **International Membership**: Success will be measured by the response of the international community to decisions made by the Academy. The subspecialty will address failure to establish appropriate categories by continued communication with the main stakeholders to include international experts and the AAN.

B. Long Term (over the next 5-10 years)

1. Specific defined goals and targets
   a. **Relationships with other organizations in the Subspecialty** (AHS, IHS and NHF): To formalize a process for collaboration
   b. **Fellowship**: To accrue the minimum number of fellowships to move Headache Medicine, a recognized UCNS Neurologic Subspecialty Area (NSA) to ACGME accreditation and ABMS certification.
   c. **P4P**: To construct guidelines for reimbursement of Headache Medicine practices

2. Operational strategies to achieve goals
   a. **Relationships**: Maintenance of liaison non-voting directorship on the AHS BOT; to explore the rationale and feasibility of a similar position on the HIS; to define the relationship with NHF.
   b. **Fellowship**: Partnership with the UCNS marketing to address concerns of and decisions by Chairs of Neurology about Headache Medicine training programs
   c. **P4P**: Exploration of the process of P4P based on existing programs in neurology

3. Specific action items for each goal
   a. **Relationships**: Form a working group to define options for liaison, etc.
   b. **Fellowship**: Form a fellowship director committee to set an agenda and timeline for completion
   c. **P4P**: To form working groups to define the diagnostic and therapeutic parameters of a pay-for-performance scheme

4. Role of AAN in achieving goals
   a. **Relationships**: To provide staff support, guidance and regulatory assistance
   b. **Fellowship**: To continue to support UCNS and the education of Chairs and academic administrations
   c. **P4P**: To provide staff support, information technology and guidance necessary to prepare and implement the strategy

5. Benefit to AAN and sub-specialty in achieving goals
   a. **Relationships**: Enhanced visibility of AAN and the Section as leaders in the field with reduction of duplication of effort
b. **Fellowship**: Legacy  

c. **P4P**: Improved reimbursement and standard bearing

6. How will sub-specialty assess and address success/failure for each goal/area?
   a. **Relationships**: Success will be measured by enhanced satisfaction of members. The subspecialty will address failure by redirecting efforts to collaborate with those associations treating patients with headache  
   b. **Fellowship**: Success will be measured by attainment of ACGME/ABMS status. The subspecialty will address failure by exploring and repairing flaws in the process  
   c. **P4P**: Success will be measured by broad adoption of P4P (or its successor) for Headache Medicine. The subspecialty will address failure by a reactive process based on “reasons for non-adoption”.

VI. Summary/Concluding Statement

1. Summary of mission/vision/values for specialty
   a. **Mission**: To enhance the treatment of all patients with headache and face pain  
   b. **Vision**: To lead the practice, research and teaching of Headache Medicine  
   c. **Values**: To create and endorse excellence and professionalism in the practice of headache medicine

2. Global conclusion and assessment of sub-specialty’s place within the larger scope of AAN, other specialties, neurology in general and related fields (e.g. neurosurgery).
   a. **Headache Medicine is a core practice of neurology**.  
   b. Within the AAN it is the role of the Headache and Face Pain Section to:
      i. Provide a forum for active discussion of the science, practice and policies of the AAN with regards to the population at risk;  
      ii. Inform the education of all levels of trainees and practitioners to insure appropriate and professional behaviors regarding the practice of Headache Medicine  
      iii. Support the subspecialty while remaining mindful of the importance of Headache Medicine in the practice of general neurology  
   c. The greater good which can be served by a strategic process involving Headache Medicine will include  
      i. Enhanced re-imbursement for cognitive specialists in all areas of neurology  
      ii. Better definitions and skill training for non-neurologists when addressing primary and secondary processes responsible for head and face pain.

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