



Close to Home: How to Leverage Your Relationship with Your PCP

Presented by: Ann Cabot, DO and Laurie Ann Maitland, DO, MPH

Alexis Crispino Kline:

Hello, everyone. Thank you all so much for being here with us tonight, and I hope that you and your community are doing well. We're delighted to share tonight's presentation, "Close to Home: How to Leverage Your Relationship with Your PCP". My name is Alexis Crispino Kline, and I'm the Director of Education and Healthcare Relations with the Multiple Sclerosis Association of America, and I'll be helping to guide tonight's conversation. I'll keep it brief before getting the evening started with just a few good-to-know's and housekeeping notes.

We'd like to extend a thank you to our program funding partners, Bristol Myers Squibb, Genentech and Greenwich Biosciences, as well as our booth sponsors, Genentech and Sanofi Genzyme. If you haven't already, please take a moment to visit the Virtual Display Hall.

I also wanted to take just a few moments to highlight some of the MSAA's free programs and services available to people living with MS nationwide. If you've connected with us before, you've probably spoken to them, the MSAA Helpline is staffed by trained and compassionate individuals who have a social services or counseling background and are familiar with MS. Helpline specialists can help assist people living with MS in their care community and identifying helpful MSAA program recommendations, as well as other resources available from the broader MS support community. I'll also note the MSAA cooling garment and equipment programs that are available to individuals who might be experiencing financial or insurance barriers to accessing the tangible items that can manage some of the symptoms of MS. Examples of products available through these programs include items such as cooling vests to help those experiencing heat sensitivity, and seated four-prong walkers for mobility support. We also have the MSAA MRI Access Program also for those who are experiencing financial barriers to accessing their cranial or C-spine MRI for diagnosis of MS or to track disease activity. For information about eligibility criteria, applications, or just more details about these and other MSAA programs, please visit us online at mysaa.org, pop us over an email or give us a call.

This disclaimer is just a friendly note that all information being shared today is for reference and informational purposes only and does not constitute formal medical recommendations. Please be sure to connect with your trusted care provider regarding the activities discussed.

I am now delighted and honored to introduce Dr. Ann Cabot and Dr. Laurie Ann Maitland. Dr. Ann Cabot is a neurologist and Director of the Multiple Sclerosis Specialty Care Program at Concord Hospital in Concord, New Hampshire, where they use a team approach to care for

people living with MS. She attended the University of New England College of Osteopathic Medicine in Bedford, Maine, and completed her residency and MS Fellowship at UMass Medical Center.

Dr. Laurie Ann Maitland is a family medicine physician and medical educator. She earned an MPH from Boston University School of Public Health, her medical degree from the University of New England Osteopathic Medicine and completed her postgraduate residency training at the Dartmouth Family Medicine Residency Program. She practices clinically and teaches both medical students and residents. She has a heart for the underserved, both domestically and internationally, and has traveled to Africa, Asia and Central America, providing medical care to those in need. All right, so that is it for our slide deck tonight. We are ready to get it started.

So without further ado, I am delighted to start the night by getting to know Dr. Cabot and Dr. Maitland a little bit better and specifically their connection to those who are living with MS in rural areas. Dr. Cabot, would you mind sharing with us first?

Dr. Ann Cabot:

No, not at all. I hope you can all hear me tonight. Thanks for joining me and my friends here tonight. And I want to, before we say anything, I just want to tell you how much I love the MSAA. I think two times today I sent patients to use the MRI Grant and another patient got a rolling walker from you guys. So thank you so much for all you do. Never mind all the other countless times we've used you. So thank you very much.

So I work in New Hampshire, and New Hampshire is a funny state because we are a long, skinny state and we have some very rural areas and we're not far from some bigger cities as well. We see patients who come from five minutes away, but we also have patients who travel two and a half hours to get to us. So being an MS center, I think the important thing in the community is to make sure that you really reach out and engage with all the other services that are available to you.

So a patient that lives right in New Hampshire has access to a lot of resources, right in Concord, I mean, where we're located or some of the other bigger cities. But if someone lives farther away, things always get more challenging. So no matter where the patient lives, working with a primary care is essential. But in the rural communities, it becomes incredibly essential. So I'm excited to have this program because I've never actually had the opportunity to formally recognize how much we appreciate our primary care colleagues, especially one like Laurie Ann, who has so much experience working with the underserved population.

Alexis Crispino Kline:

Thank you so much, Doctor. Cabot and we're so excited too, this is just such a great topic. And Dr. Maitland, I'll hand it over to you.

Dr. Laurie Ann Maitland:

Great. Thanks so much for having me tonight. I am a family medicine physician, so although I do see some patients with MS, most of my patients do not have MS, but you know, when I encounter a patient with MS, it's really important to me to know, usually I call Dr. Cabot, but you know, it's really important to have connections in the specialist community.

But, to back up a little bit, my connection to rural settings started really, you know, when I was a kid and watched my grandparents not have access to care that they needed because they lived

in rural upstate New York, and that interest continued when I went to medical school and realized that I was best suited to practice medicine in rural settings or certainly underserved settings. And so I was very thankful to have something called a National Health Service Corps scholarship. So basically, the National Health Service Corps, which is a government organization, helped me go to medical school and I promised in turn to practice in an underserved area.

So that's what I did for the first 15 years of my practice in rural Maine and rural New Hampshire, and I agree with Dr. Cabot, you know, when you practice rurally, getting your patients even enough primary care, there weren't enough of us to go around. So you know, to really have patients with a lot of needs that require specialty care was a huge, huge challenge, and my patients sometimes weren't able to access that care and they were stuck with me, so I need people like Dr. Cabot on speed dial to handle things.

But I would say now, I don't live in an urban area, but I would say I have a lot of rural patients, but more suburban. But my love and learning to practice rural medicine started even before medical school.

Alexis Crispino Kline:

That's really fantastic. It definitely sounds like both of your professional and personal paths have really guided the way that you've approached your treating and working with patients. So thank you both so much for that. I guess for our next question, that we wanted to talk about, is Dr. Cabot, would you mind describing a little bit more about your role as a neurologist specifically?

Dr. Ann Cabot:

Absolutely, yeah, no problem. So I think, you know, a lot of patients come with many different neurological conditions. When someone has MS, it can be a very easy diagnosis or it can take a long time to diagnose them. So it's a very heterogeneous population. So my subspecialty training is in multiple sclerosis, so most of my patients have MS. So we have over 1000 patients that we care for in our clinic. And so my role is really limited to that, the care of those patients or patients that have diseases that are similar to MS, so other diseases or abnormal imaging. So that's our role.

And then I think the important part is to take care of the whole patient. This has always been a big passion of mine, even before going to medical school, I've always loved the idea of, you know, taking care of the whole person because if we only take care of the MS and we forget that the person has a broken foot or their depression is really bad or they have heart disease or, you know, there are other things that we're not addressing, we're not really taking care of the whole patient.

So I think the collaborative approach that is needed is incredibly important. So really, my main role is to appropriately diagnose and treat patients with MS. We're extremely lucky because we have so many different options for patients right now, and then to really sift through all the symptoms of MS. Make sure our patients know that they're not just someone with MS, that they're a whole person and that we can really nail out these symptoms if they're willing to work on it and then to work with all of the other subspecialties.

And we can get into that in a little, a little further. But I feel like my role is really like a spoke in a wheel, you know, the patient is in the middle of the wheel, and we're just trying to help them get all of these pieces put together. And, you know, I think that can really help them be the healthiest they can be, but we cannot do it without collaborating with our partners. And when you live in a rural area, the challenges that people face are just exponential.

Alexis Crispino Kline:

Thank you so much. Absolutely. And so I guess, Dr Maitland, could you tell us a little bit more about your role and how you might approach treatment planning or supporting someone that's living with MS who might be seeing you primarily?

Dr. Laurie Ann Maitland:

Sure. You know, I was thinking as Dr. Cabot was talking, you know, so I'm actually the opposite. I'm the... as a family physician, I'm broadly trained and I like to say "womb-to-tomb", right? So I take care of women who are pregnant. I take care of children, young adults, adults, geriatrician, geriatric patients and so on. So when Dr. Cabot described the spoke in the hub, I actually see myself in the hub with the patient, right? And helping them get out to all those spokes.

And you know, while I love that, because I really love literally knowing the entire patient, and not just the patient, one of the things that drew me to family medicine is I think of all my patients in the context of their family, right? Like they don't even realize, but I tell my patients, especially patients who I take care of the entire family, so I may take care of, you know, the grandparents, then the next generation, then the kids. And I left New Hampshire just in time for them to get pregnant and have babies because, you know, I'm in denial that I'm that old.

But that's really important because if I have a patient with MS, I mean, let's face it, most of my patients do not have MS. MS is a... well, probably not rare to Dr. Cabot and to you guys, because that's what you see. But to me, you know, and I'm going to be thankful for that, right? I'm going to be thankful that it's a rare disease. But when I do see it and help take care of those patients, I also have the privilege generally of taking care of their children, or maybe their sister, maybe their brother.

But we know that, I mean, although men do have MS, you know, I see it a lot more in women. So I think the difference for me is when I'm taking care of a patient completely holistically, I'm taking care of their diabetes and hypertension and cholesterol problems, depression, insomnia, knowing what they come to the table with is really important because that helps me look for it in their children.

Like one of my MS patients right now, I take care of her children and they are getting to be young adults, and so when they come in the office with a complaint that could be MS, I take it very seriously because I understand that those things are connected and genetic. But my, I would say my role right now, I live probably an hour and a half from a tertiary care center, so most of my patients right now, see a neurologist at the tertiary care center.

But what I would say, and we can get into this later, the most common model is specialists come to the small hospitals, right? So if you live within an hour or so of a big tertiary care center, big hospital, a lot of the times various specialists will actually travel once a month, maybe twice a month to the smaller outlying hospitals. And then you send your patients there for care. We don't have that. My patients have to travel an hour. So I would really like to see and I would be willing to participate more in their care, and we can talk a little bit about what that might look like as the night goes on.

Alexis Crispino Kline:

Yeah, that's really fantastic. And that really does bring us to kind of that next thought is if you can think of ways, Dr. Maitland or Dr. Cabot, the ways that you guys might collaborate if you, Dr.

Maitland, are seeing your patients more frequently and maybe ways that you might communicate things or share information.

Dr. Ann Cabot:

Yeah. So I can actually give you a great example. So we see the patients typically twice a year, three times a year, depending on their needs. And then I'll send a note to the patient's primary care to say, Hey, this is what we talked about today, this is the treatment plan, this is how the MRI looked, this is what the exam showed, you know, the symptoms that we're working on. But let me tell you about some symptoms, because the hard part about MS is a lot of those symptoms that patients have, you can blame it on MS, which makes it really easy. Right? So if someone's tired, number one complaint of MS, it's very easy to say, Oh, she's tired because she has MS. Or someone has stiffness, you can say, Oh, it's really, you know, they're stiff because they have MS. So, but we have to think of the whole person.

So are they tired because they're not sleeping or are they tired... So this is where finessing it with your primary care becomes so important. And a lot of times I'll have patients who say, Well, Dr. Cabot I see you more than I see my primary care, which is possibly true, right? But in a rural area where you know, they're not seeing me quite as often because the ride is terrible or the transportation is difficult, I know we have to rely on the primary care.

So sometimes the primary care and I will call or text or email. You know, we don't email patients names, so we have to do it all, like through the electronic medical record, usually on the phone. But it is really helpful. So if I know the primary care already and they know me, we both know the patients, then we can both say, OK, their tired. Have... are they sleeping? Is their B12? Okay, are they exercising? Is there any other medical condition that can be causing this fatigue? What else? You know, how much are they doing for exercise? What are the things that are getting in the way? And then they can help us figure out, is this fatigue MS fatigue? And that's a great sort of general symptom of MS, that, you know, I'm tired at the end of the day sometimes, and so are you, and so are other people with MS, And some of my MS patients aren't tired.

So having that primary care to be like, let's rule out other things that can cause fatigue, and then let's talk about, well, how we can get you out of this fatigue, I think can be so helpful. So that's just one example of how... I can't tell you how many times patients have come to me and said, you know, I had, I had a belly pain. I went to the emergency room and they told me it was my MS. I'm like, "What"! So you know, you know, so I think it is really awesome to feel free to call each other.

And I think that's what Dr. Maitland has always been really good at collaborating with specialists because that's what she does, and I think a lot of primary care providers are very happy to do the same thing. And sometimes it's a nurse practitioner or a PA, especially in a rural area. So it's always great for them to hop on the phone and to leave a message with the neurologist and tell them they can call them back. So that's one example. There are so many.

Dr. Laurie Ann Maitland:

I agree, I think I think too many times patients actually don't see their doctors as a team. They see them as completely separate. You know, I'm going to see Dr. Cabot or whoever for my MS, and they may see me and not tell me, Oh, I had a flare. I've had lots of flares. Oh, guess what? My medication got changed. And, when I practiced near Dr. Cabot, I always got a note, but...

Dr. Ann Cabot:

I rat them out.

Dr. Laurie Ann Maitland:

Well, we worked for the same hospital system, right? So now I already said we don't have an MS specialist in my community, so I'm relying on someone that I don't know an hour away to send me their documentation. And I would say most of the time, I don't get it. So then the other barrier is their neurologist is nameless, faceless to me, and it's not always easy to cold call people because you're not sure what you're going to get on the other end of the phone. Are they going to want to talk to me? Are they not or are they collaborative or are they not? But I would say we need to do better. We need to really try. We need to pick up the phone and we're all busy. So that's definitely a barrier.

Dr. Ann Cabot:

Yeah, I think the patient can also help with that because I have patients who are proactive, who see doctors and lots of different medical systems and they'll be like, my doctor didn't get your note, didn't get your note, whatever. So I think it's always "empower the patient to help you" is really important. So as patients are listening tonight, they can help us by saying, Hey, did you get that note? Are you up to date on the MS care? Did you know I just got diagnosed with diabetes? And to be honest, a lot of patients now with the portals and the email systems that the patients can use, I think that streamlined the care so much and made it so much better.

Dr. Laurie Ann Maitland:

Well, you also, you know, the notes and the information should go both ways. Right. And I think too many times a PCP just expects all the specialist's notes, when we should be doing a better job if we want sort of seamless care is to send a note, you know?

Dr. Ann Cabot:

Yeah, it's probably one in a hundred primary care that sends me the note. I'm not...

Dr. Laurie Ann Maitland:

I'm probably one of them.

Dr. Ann Cabot:

Oh no, I think that's normal because the primary care in my mind is sort of the quarterback, right? They take all of it and sort of help the patient like you said, you know, that's how I always think of it like a quarterback.

Dr. Laurie Ann Maitland:

So, the other thing I was going to say is, I literally am not thankful for anything COVID related at all except telemedicine. So before COVID, and you patients out there may notice that, you know, before COVID, doctor wasn't calling me, except for Dr. Cabot, I know she calls her patients a lot. I've actually been with her when she calls patients, when she's on vacation. So, but, you know, prior to COVID... And here's the thing - we're super busy, and it's not at all about money, I do not want to come across that way at all, but there was not a mechanism whereby a doctor could call a patient and bill for it. Or, not bill the patient, but bill the insurance company and just you know, any of you who have engaged with a lawyer, every time you talk to the lawyer, the lawyer's secretary, anybody - they bill. OK, that's not been so in medicine.

So we, generally, who do we get to call you? Our nurse. So what COVID has done is it's opened the doors and allowed us to call patients on the phone in secure ways, that was the other problem, the telephone calls weren't secure and the video calls were insecure. So. Some follow up visits are really amenable to having it done via video, right, I mean, there are lots of times if, say for example, the neurologist said, You know, I, we share a patient who has depression, right? And I'm managing the depression because I should manage the depression. I know the patient well. My patients see me the most, you know, rather than their specialists. And I started them on a medication or changed their medication. I don't necessarily need to see them physically and follow up. I could just talk to them on video or by phone, you know, Hey, how are you doing since we increased that medication? It's time efficient for me, and it's very patient friendly so that patients don't have to travel an hour or travel 15 minutes or get in their car when that might be tough.

And so I think that one of the things that I'd like to see more is collaboration with telehealth, and I could really see something like if a patient is visiting me and we want to talk about their MS or I'm not sure if what they're talking, the complaint they have is MS related, it would be really nice, maybe not at that moment, but to say, Hey, let's book a three way appointment with the patient, with me and the specialist. Wouldn't that be awesome?

Dr. Ann Cabot:

That's a great idea? Yeah. Mind blown.

Dr. Laurie Ann Maitland:

And I know, you know.

Dr. Ann Cabot:

Yeah, that's the next teleconference.

Alexis Crispino Kline:

Yeah, like on that same track, and we'll get to really dig into telehealth again, but I think one of the things that both of you really mentioned is how important that collaboration between a neurologist and a primary care provider might be, but also is the patient living, or the person living with MS being at the central and vital role of helping connect everybody. And so do you think that there's things that maybe people living with MS or care communities that you guys work with that you think could help bridge some of those communication or connection gaps between different providers when you're living in a rural area?

Dr. Ann Cabot:

Yeah. So I actually was thinking about a couple of my patients who live in pretty difficult, far away, difficult situations, mobility issues, a lot of mobility issues, not a lot of resources. I think we do get spoiled when we live near, like, I live in a suburban area. There's kind of a good sized hospital. There's a lot of services around us. But if the patient doesn't tell us what's going on, I don't know.

So some of our patients are so stoic and so amazing. But if I don't know that they're having trouble getting their groceries, getting social work care, because to be honest, those resources, we think they're stretched here in Concord, they're worse up north and rural areas west of us.

So if I don't know, like... and it's OK to share that with us, so it's OK to like, say, listen, I am... and that usually only comes out in the appointment, right? So sometimes they'll be like, you

know, I'm really having trouble getting, you know, someone to come in and help me if I need assistance, "I'm not able to get out of my house" is something I hear. I don't have, like, they qualify for assistance in the house, but there's not enough people. You know, there's nobody to work, or they can't get PT and OT.

So I really that's what I'm like, Ro, I need to call the PCP and see if in this area there are services that I don't know about. So honestly, this is where the MSAA and the MS Society have also come in really helpful because you guys have done a nice job helping patients access things that they might not have been able to access before, including grants and finding funding for stuff. But gosh, like even ordering an MRI becomes a hassle for these poor people because they either have to drive for two hours to get it, or they have to go to a local one that might not be as good a quality.

So those are the cases where I just hope that their excellent PCP doesn't retire or leave because, like Laurie said, then we're in trouble because we don't even have enough primary care doctors. So those are the things I think patients can do is to make sure they write things down.

And you guys have an amazing app that they can track things in, so they can track their symptoms. They can electronically send those things to us if the hospital links up, and I hope ours will. But I think those kind of things are awesome trying to make sure that these people have the resources that, you know, honestly, even, like, if we could get someone out of the house to get to the grocery store, like things like that, that seems so simple, when the grocery store is 30 miles away, it's a whole different story, right?

So I think that's really where we're running into how rural is rural, and we see some really rural people. And the telehealth has made this so much better if they have Wi-Fi, so that's another obstacle. But it's definitely better and I'm very grateful.

I had two patients today, one got COVID and I was like, Do not come to my office. And but he had his visit on video and another patient was like, I feel really good, but I know we need to go over a few things. So we did our visit on video. It was excellent. She was an hour and a half away. He was sick. We don't want COVID in the office. I couldn't be more grateful.

Alexis Crispino Kline:

That's fantastic.

Dr. Ann Cabot:

Yeah.

Dr. Laurie Ann Maitland:

Dr. Cabot, you're speaking my language. I, as mentioned in my bio, one of the things that I really love are underserved and overlooked people, and that doesn't just happen in rural areas. It happens in urban, suburban, it happens everywhere. But you know, in rural areas, you know, 20% of the U.S. population lives in rural areas, but only 10% of physicians in the United States practice in rural America. And most of those are not uber specialists like Dr. Cabot, they're generalists like me who may not come to the table... We know, we learned MS school, we know what it is, we know what to look for, but we don't know the latest drug that came down the pike because we have to know about all the diabetes.

Dr. Ann Cabot:

And nor should you, right?

Dr. Laurie Ann Maitland:

Hypertension, you know, high blood pressure medication and all of that. But it doesn't, it's not an excuse to not sort of keep up where we can and how we can. And one of the things I wanted to mention when we talk about... I just mentioned this term called social determinants of health, and I'm sorry, I didn't explain what that means. What that means is all the social things that impacts a person's health, right?

Not just people that have MS, but many other problems as well. So those are the social things like what's your housing like? What's your access to food? Many people in rural areas... What's funny is they grow the food like for the rest of us in the U.S., but they don't really have access a lot of times to fresh foods. Not just because of transportation, but because, you know, like Dr. Cabot said, that the grocery store is 30 minutes away, but the convenience store that's attached to the gas station, that's ten minutes away, they can get to. So what do they eat? Food that's not healthy. What happens? Their body's not as healthy, which impacts their MS and diabetes and whatever else they have.

So I don't know if you folks out there have a pen and a piece of paper, but one of the things that I do give to my patients, there is a website called Neighborhood Navigator. So if you just Google Neighborhood Navigator, it will come up and you click on it and it will bring up a box that says, enter your zip code. So like Concord, it's 03301, OK. You enter the zip code and then it's going to say, give you a whole bunch of "what are you having trouble with?", transportation, food, housing, domestic violence, whatever it is, and it'll give you a drop down so you can actually see the services... Dr. Cabot is Googling it right now.

Dr. Ann Cabot:

You knew I was. You knew I was. How did I not know about this?

Dr. Laurie Ann Maitland:

But it's an awesome... and most states have some sort of... that's a national thing, but like, I know there's like 211. There are a whole bunch of websites that you can go to, even as a patient. I do it as a physician. But yes, Dr. Cabot, I make it my job to know what resources...

Dr. Ann Cabot:

And that's what we rely on. Like without a good primary, if my patient comes in with obesity and thinks they're knee pain is from their MS and I need someone to help them with their orthopedic issues, then we need to get the full discussion, like we need to talk about exercise and how the best way to treat your knee pain and how to help you with your diet. And and we try to do all those things and we do have a lot of those resources. And again, a lot of our classes are now on Zoom, like our mindfulness class is on Zoom and our yoga class is on Zoom and everything like that.

But you still need someone to lay hands on you and check you out and have that one on one. And that's where that rural person can make so much help. So I think it's really trying to figure out, like Laurie said, like, how do we keep these people in the loop, in the loop, so they don't feel like they're alone. They're never alone.

Dr. Laurie Ann Maitland:

I would say, keep your PCP in the loop, too. I want to know, don't just consider your MS care separate from what I do because I need to know, you know, if you're having a flare, what is your flare like? You know, it helps me understand my other patients with MS. So keep keep your PCP in the loop. They really do want to know, even though we've got only ten or 15 minutes to see you, sneak it in there. Let us know what's happening.

And, I like to know who is your your specialist. Do you like them or are they kind? And I write a list of people that I refer my patients to and a list of people I don't refer my patients to. And I won't know if patients don't tell me their experience.

Dr. Ann Cabot:

And I think the other thing that patients can do, and that is that I am not a good primary care provider and I don't even pretend to be.

Dr. Laurie Ann Maitland:

Make sure you have one. Right?

Dr. Ann Cabot:

Like I see my own primary care. I never even tell my primary care other doctors that I'm a doctor because I want to be a patient when I'm a patient. But if someone had strep throat or pneumonia or... like Dr. Maitland is going to be on top of what's the best way to treat your hypertension today. Whereas I looked at that 20 plus years ago, so you do not want me, unless I have recently googled it, which is another thing you don't want. You want your hypertension treated by the best person, you want your MS treated by the right person. You want your physical therapist to be the right person. You need your weight loss specialist to be the right person. You need your orthopedist to be the right person, your urologist to be the right person. You know, there's a team approach here, but really, I think that that's important for the patient to know is that if they have these things, that it is so nice to partner up with your PCP.

I feel a sense of relief when I know someone has a good PCP. I just feel like, OK, we've got your mammograms covered. We know you got your colonoscopy done. I don't want to take all this care of you and then find out you didn't have your colonoscopy done and you could have saved yourself.

Dr. Laurie Ann Maitland:

And you know what? I will say that I find that patients who have complicated medical issues, they're doctored out, you know, so the thing they're going to give up is their preventative care. Yes. And so, you know, getting your mammogram and your colonoscopy and a pap smear, you know those things. Don't forget about them because, you know, those are really important and can actually prevent you from getting another chronic illness that's just going to make your MS harder. You know, so get your preventative care. So really, really important.

Dr. Ann Cabot:

Yeah. So I depend on that and we even document it in our notes now, you know, last time you saw your PCP kind of thing because we have realized over time that some people will be like, Well, it's been a couple of years... and I'm like, do you not know? And a lot of people would be like, I don't know who it is because they've changed so much. Do you think that Dr Maitland?

Dr. Laurie Ann Maitland:

Oh, yeah, absolutely. Yeah. And I'll put a plug in for family medicine because if you see a family medicine physician, we can do your pap smears. We can do everything. So I see women who will just have an OB-GYN, but they don't have, you know, a primary care physician. And yes, you can have both. You can have a family doc or an internal medicine doc and an OB-GYN to take care of pap smears and such.

But you could have one stop shopping with somebody who is really going to try to get to know you well, like a family doc. That's what I do. I'm a family medicine educator. I try to teach my residents and medical students that you want to take full care of the patient you want to be responsible for being that quarterback that Dr. Cabot talked about.

Alexis Crispino Kline:

And I guess just in hearing your conversations, you guys have such a great report. And I wonder if, and this is a little bit off the script, but I'm curious if sometimes people might have doctors or a provider that they see that they don't gel with. And I think it's... Is it OK to change doctors or think that, you know, I have a different style of approaching my wellness and sometimes that can be hard or people don't know if they can do that? Is that something...?

Dr. Ann Cabot:

I think that's true for a specialist as well? Like I tell patients, not every shoe fits. Like I am not going to be everybody's doc, like they're going to see me and they're they're going to want to move on. And I totally respect that. I also respect a second opinion, if they want a second opinion. I think that's awesome, actually, because there's so many opinions, you know, especially neurologists will have two neurologists and ten different opinions on the same subject.

So. And I have had patients that feel like, Well, my doctor left and now I'm assigned to this new person, I'm not sure I know if I like this new person. I would say this, and I've learned this from my patients, give that person a couple tries before you dump them because maybe you loved your old primary care so much and you were still a little annoyed that they left that you were sort of angry at them. And I have seen that, and they're like, Oh, this person's actually great, you know, so you're just so used to, you know? Like, I think when my doctor retired, my primary care provider retired, I was like, Harrumph! And I saw the new person. I was like, Well, she's alright. And then I thought, I love her. You know what I mean?

So it was just a matter that not every shoe has to fit and you're telling your doctor... I had a patient today, we were talking about, you know, a gentleman who was talking about sexual dysfunction - that can be awkward for your patients when they have to talk about that, male or female. And I think if you already know the patient, it's so much easier. But, you know, I think those are exactly the circumstances where you're like, I don't feel comfortable. Give it another try. But if it's not working out, see what else is going on. Now in a rural community, there may not be anybody else. Right?

Dr. Laurie Ann Maitland:

That's what I was thinking that sometimes, you know, I've been in communities where I was, maybe not the only one. I felt like I was the only one, but maybe one of two, right? And I was the only female. So, you know, I got all the female issues, you know? So, but yeah, so I think it's absolutely.. I mean, I view the relationship with your PCP, i.e. me, really important and, you know, if there is something that's bothering you, you know, I think we're all conditioned that, oh, you know... I don't have a right to bring that up. I mean, of course, you want to be respectful and

things like that. And sometimes it's not an issue with the physician, but it's an issue with the office or the nurse.

You know, I mean, within reason, we all sort of just accept some inefficiencies and some things that we just can't change. But if it's really obstructing your care, meaning that you're not going to go in because it's so unpleasant, I bet your doctor wants to know that. I would want to know that. And I say I can't fix everything. But, but thank you for telling me, and maybe we can make a change in the office. Maybe we can't and we're not the the the the office for you, but I definitely would say it is appropriate, appropriate to change.

Some offices will have, you know, you can't doctor switch within a certain office. You would have to leave and go to a different office. Who knows? But I agree with Dr. Cabot. Give them a few tries. Talk to them if things aren't going well and see if you can come to an understanding and if you can't, you have to move on.

Dr. Ann Cabot:

Don't feel bad. This is your health care. There's nothing more important, so nothing more important. So if it's not working, move on. I love when patients are like, I'm not trying... I love the second opinion, but I'm all for it, you know? And if someone else seems to help... because it really is about trying to get you going and if someone else has a better message that fits with you or you just jive with them, but I'm pumped for them. Like all we want is... all we want is for our patients to do better. That's all we want. So we give them the tools and those tools aren't working, we beg the PCPs for their tools. You know, we go back and forth, but there's so many opportunities there. But if it's not working, move on.

Alexis Crispino Kline:

Yeah. Thank you so, so much. So just another person... We've kind of talked a lot about specialists and a person living with MS, and then there might be one other central person that's there with them and that's care partners. And so I think especially maybe people who are living in rural areas the way that their care partners might be a part of this partnership, and should they be a part of this partnership in this journey?

Dr. Ann Cabot:

So I can tell you in rural areas, I think the care partners bear a heavy burden. They might not have the social supports that we have in other communities. It depends on, you know, again, MS is very heterogeneous. Many, many of our MS patients, you will never know they have MS and a small percentage of them may have a lot of disabilities.

So for the patients with more severe disabilities, I think those patients that are in rural areas, their care partners need a lot of support because they have very few support systems. Unless they have family, they have very few support systems in place. And I think this is all across the states. And again, it could be in the cities as well. But but at least we have some other services within our, you know, 25 mile range and all these other things.

So this is what breaks my heart. I can't stop thinking about these people because I think both of... a lot of times these patients and their care partners are so, just beautiful people who just care about each other so much and they're working so hard to keep it all together. And they might just need a few things like a little better ramp or a little this or that, you know, to make the house a little more, a little easier to navigate. And that's where, that's where, I think the PCP is so helpful - if we could get a visiting nurse out. Can we get the visiting nurse out to do a home

safety check? Make sure the patient's not falling, get handicapped rails. Is there like a Boy Scout club that helps build ramps or some kind of... A lot of times the PCPs will know that. Sometimes there are charitable organizations, various religious institutions that are very happy to help out in those communities, but it's almost always community based. But what I don't want is patients not to look, and sometimes the social workers can't find much either. So I want them to keep reaching out to the community and leaning on each other.

And I'm hoping that's where this video stuff can really help, because if I could get, you know, the care partner and the patient in a rural community to take our mindfulness based stress reduction class, and they enjoy it and it's free and they win, I'm happy. So I'm hoping that this is where the care partner stuff can do it. And I think you guys have done a very good job helping put out some resources for care partners too.

Dr. Laurie Ann Maitland:

Yeah, I would I would say too, I see care partners in a couple of roles. Number one, when they come in to the office... Well, I ask all my patients, please... and I can print it out from electronic medical record, I want you to carry in your wallet a medication list and update it when people give you different medications, and a problem list, like what are your medical problems. And don't forget about the little stuff and keep that.

And so sometimes I, not just with MS, but patients whose spouse is their care partner for complex other medical issues, I sort of make them the scribe, you know, and I say, you know, write this down because I want you to make sure that when you go to the specialist that you're asking these questions.

And then I would also see another huge role for the care partner is to keep themselves healthy. We see that with other chronic diseases such, you know, we talk about Alzheimer's all the time. You know, if you are not keeping yourself healthy, I don't mean just physically but emotionally. You know, that's when we're not a good support is when we're just, you know, focusing on the other person, which of course, you need to do what you can, but you're not going to be what they need if you're not taking care of yourself.

And you know, I have the privilege a lot of times of being the doctor of the person with complex medical issues, for example MS, and the spouse. So there are many times where I'm seeing the spouse alone because they're also my patient, and it gives me the opportunity to say, you know, how's it going? And they might tell me something that I can help them with that they wouldn't say in front of their partner because, you know, for a whole host of reasons. So, you know, keep yourself healthy if there are any care partners listening to us out there.

Dr. Ann Cabot:

Yeah, and take advantage of some of the wonderful programing that's out there, that's online too, to help reduce stress and keep you healthy. Thank you, Laura. I think that that's probably the most well said.

Alexis Crispino Kline:

Thank you, guys, both so much and such great, great information, and you know, we had a couple of more topics to touch on, but we've also received some really wonderful questions.

And so I'm wondering if I can start posing some of those questions to you guys. So, one of the first questions we came in was for both of you guys, and it goes: Sometimes I feel like I'm starting from the beginning when I talk to a PA, nurse or other health care provider at my doctor's office. I know my doctors are busy and I can't always talk to them when I have a question, but it's almost like no one reads the notes about my treatment plan. It's pretty exhausting getting every PA and nurse I speak to on the phone up to speed. What can I do to make sure that everyone is on the same page in terms of where I am with my care so they can accurately answer my questions?

Dr. Ann Cabot:

Hmm. That's a good question. So I would hope, you know, when a person sends a message in, if it's an email, in our office, I know that the nurses will look at the last office note so that they have some background. And usually, this may not happen in a bigger office though, usually in an office like ours, where I'm the only MS specialist, I have one PA that works with me and a couple of nurses. So usually the same nurse will answer the string, right? So if one person calls, that nurse will kind of keep that patient until the problem is solved.

So let's say someone calls and they have new numbness and tingling. We know they have MS and they're on Drug X and they've been doing well, and this is when their last MRI was. So what we do is we have a standard triage note and in it it says, you know, ask the patient this. And so they've already checked it off. Like patient is on Drug X, this is the last MRI, these are the last labs. Make sure to ask the patient this. So then you ask the patient, do they have a fever, do they feel sick, have they been exposed to COVID, have they been vaccinated... so like a whole list of things. It asks about sleep, it asks about bladder, it asks about...

So it's a very standardized thing so that, you know, hopefully by the time the person is calling or emailing you back, they have a little understanding, but they're never going to know as much as the patient does. So the patient might want to just quickly summarize if they're sending an email, say, Hi, this is Stephanie. I don't know if it really is Stephanie, I don't know her name, I have MS, I'm on this drug. I've been on it for this long, the last MRI is here, my last labs are here. Here's my problem.

And that... the patient might make it a little easier if they... they could even like, copy and paste something that they put in their emails all the time. I like the email system because it gives the nurse a chance to sort of look at stuff before they call you back. And a lot of times they'll read the message and call you back, or they'll read the message and email you back, depending on the complexity.

But I do, I agree It is hard to keep a lot of things straight, and MS has a lot of moving parts. So I think if you wanted to make it simple for them, you could cut and paste your own little quick summary of like, this is my quick MS review. Here's my problem. What is the actionable item I'm hoping to get out of this. Like, what do we want to try to make better. And then they can like, talk to the doc, because what usually happens is they talk to the doctor and then they call you back, because the doctor is seeing patients in clinic during the day. So that's really what I would do if I were the patient.

Alexis Crispino Kline:

They can keep it in the notes, on the phone or on their computer.

Dr. Ann Cabot:

That's a perfect idea. Yeah. And just update it as necessary. Say this is my... here's my short story. This is the problem. And sometimes the problem could be I have weakness. I've been weak for ten years, but it seems worse, right? So it just may be like something's a little different.

But hopefully that will make it a little easier for you and easier for the office, because the problem is, everybody's trying to take good care of you, but you have to advocate for yourself these days. I have, I would say, like, you really do, have to be your best advocate.

There's a bunch of apps online. MS Association of America has a nice one, a symptom tracker. That would be something that would be really easy to bring to your appointments and be like, here's my symptom tracker.

Alexis Crispino Kline:

My MS Manager.

Dr. Ann Cabot:

Yup. So that thing's great. Some people just come in with a piece of paper and a list of questions. I love it.

Alexis Crispino Kline:

So... Dr Maitland, did you have anything that you wanted to add?

Dr. Laurie Ann Maitland:

Not really. I think it's a little bit different for me. Well, I wish we had the emails thing, we don't, but then that would be one more thing for me to do.

Dr. Ann Cabot:

And some people don't use it because of that. They're like, it's exhausting and I get like 100 miles a day. Yes, it's true. You know, I got to get back online and answer them now.

Dr. Laurie Ann Maitland:

Yeah. And I guess while I understand and I'm empathetic to what the question was asking, I mean, really, I agree with Dr. Cabot, you're the one that knows your story the best and sometimes you just have to tell it, you know, and if you have it succinct, that's the best way. My office is crazy because we literally have, because it's a training institution for new, graduated physicians before they go out into practice. Most of you know those are residents and we've got 27 of those and we've got like twelve faculty. We've got like at any one time, 40 very, very part time doctors in the office. So you want to... So don't call our office. You'll be very unhappy. Yes. Start with your neurologist.

Dr. Ann Cabot:

Yeah, the symptom trackers are awesome, and the managers are awesome. I like the idea of keeping the phone notes too. That's a really good idea.

Alexis Crispino Kline:

Thank you guys so much.

Dr. Ann Cabot:

Great question, too, because I think we all deal with that.

Alexis Crispino Kline:

And we have another really good one, too. This is from the care partner: So my family member has MS and is having mobility issues. Aside from their primary care doctor and the neurologist, what other specialist or service might we consider? We live about an hour away from the closest doctor, so just getting to appointments can be a little difficult.

Dr. Ann Cabot:

Exactly. So, and the hard part is, with mobility, we do like to lay our hands on you. We want to see walk. We want to see how tight the muscles are. We want to see what the strength is like. So that's a little trickier. So when it comes to mobility, we do usually use a team approach.

So there may be a really good physical therapist near you, even if there isn't a very good orthopedist or something like that. Now, a good physical therapist can also work with your neurologist, so they can lay hands on you. Let's say they're 15 minutes away. Then they generate a report saying, Here's what the strength was. Here's what the spasticity was. Here's what the walking looked like. What I recommend... So then what the physical therapist does is they say, I think they would do really well with like a little leg brace, maybe an AFO, an ankle foot orthosis, or maybe a single point cane, or maybe they need a rolling walker, or something like that, but they give their recommendations.

The other person we can send out are visiting nurses. So visiting nurses are like the army of awesomeness. They are just the best people in the whole world. I want to hug them every time I get a note because they go to your home when people can't travel and they can do in-person assessments, they can do PT and OT in home if patients can't get out. So they are, they are amazing. So I think the first thing to do is if your family member's having mobility issues, is home safety evaluation, which is done by visiting nurses so they can make sure the home is safe. Sometimes it's as simple as moving the throw rugs and putting a bar in. It doesn't have to be complicated.

And then a mobility evaluation with physical therapy, and then physical therapy... like I had physical therapy call me this week and be like, this patient is not doing well. You know? And so we started the whole process to like... because the patient hadn't come to the office. They hadn't been in for a really long time because of transportation issues, and she didn't have the internet. It was a disaster. So visiting nurse, PT went in... saved the day.

So maybe there's resources like that, that you do your primary care or your neurologist can start the process, and a lot of times the primary care knows the best PT right around. So hopefully that will help. I hope that helps you. And the MSAA will give you walkers if you need them. Like the rolling kind with the seat and the brakes and the handbrakes, nice colors and everything.

Dr. Laurie Ann Maitland:

And that's the other thing, I would make sure that you know what services you qualify for, what you can get, even insurance, probably if, you know, some patients with MS are disabled, right, they're on disability, so when you're on disability, you get Medicare and sometimes you qualify for Medicaid, sometimes you don't but pay attention because your state, sometimes every once in a while, will have Medicaid expansion.

So if you're watching the news and you hear the term Medicaid Expansion, that is your time. Maybe you didn't qualify last year, the year before, but you might now. So don't forget about

making sure that you have the variety of insurances that you might qualify for and services you might qualify for.

Dr. Ann Cabot:

Yeah. And I think that MSAA has some resources, right? For patients when they have questions about insurance because I do not know all the answers about insurance and I feel really bad about that, but I cannot keep up.

So I tell people, go see, are you down from here? Go see her. Yeah, yeah. But if she can help you?

Alexis Crispino Kline:

Yeah, we'll try and help.

Dr. Ann Cabot:

At least point you in the right direction.

Alexis Crispino Kline:

Mm Hmm. That's great. Thank you both so much for that feedback. Great questions. Yeah, so good. And I guess one thing I'm really curious about, too, is we're talking about the mobility and transportation. How do you guys see your respective roles approaching telehealth now that that's an option? So in your role with your patients or who you're seeing, how you might use telehealth, or if you'd like to use telehealth in the future?

Dr. Ann Cabot:

I think it's awesome. I think that we do need to see once in a while. So don't be lazy. Some of my patients are perfectly capable of coming in and are like, Oh, this telehealth is so easy, I feel pretty good, so I'm not going to come in. So that's OK once in a while, OK? But I don't want people to slip through the cracks that way. I do feel like that that would be a misuse of it. So I had someone today who was just like, I didn't want to drive in to see you, I feel great. I was like, Oh, OK. Whatever.

But, it could be a... like to not have to spend the gas. Gas is so expensive is now and if you have to find a ride. But there are transportation services out there. Sometimes insurance will pay for this too. So again, what Dr. Maitland said about, you know, checking your insurance, that would be really great. But I hope telehealth is here to stay for these people because I could see you more often. And I think that might be nice. So somebody who used to only come once a year because traveling was such a burden, I might be able to check in on them, visually, check in on them, see what's going on.

Like, I had a patient the other day who had not been out of her house since COVID started, at all. Not once. but she was able with her video to show me how she has her house set up, how she stands and squats, how she's getting in and out of her chair, everything she was able to show me on video. I couldn't have done that two years ago.

Dr. Laurie Ann Maitland:

And there's a huge emotional benefit to that, you know, to seeing another face without a mask. Yeah, on video, we don't have to wear a mask. But yeah, so I know we're getting out of time. But in prep for this, I was learning a little bit about some other ways to do this with the triad of the patient, the PCP and the specialist in a rural area. And I don't know Dr. Cabot or Alexis, if

you have heard of something called the ECHO program, but it's moving knowledge not people. And so, for example, if Dr. Cabot and I work together and we were two hours apart and we shared a patient. Different specialists can teach the PCP how to, for example, treat a flare or, hey, if we get the infusion drug to you, can you manage the infusion? So teaching me the skills, I don't want to be a, you know, I'm a primary care physician, so it's not like I want to retrain as a neurologist. But are there things that I can do, like be Dr. Cabot's technician?

Dr. Ann Cabot:

Absolutely. And we do this all the time. So I have patients who will have a flare. We get the document as a flare. But they don't want to drive down for five days of I.V. steroids, or three days, or whatever it might be. And I call the primary care and we work with them and then they run the infusion.

Dr. Laurie Ann Maitland:

Right. The key is a willing PCP to learn something new, right? To learn something new for the benefit of the patient. We do it in psychiatry now all the time, because even more rare than an MS specialist is a psychiatrist in a rural area. So we, PCPs, do that care all the time, and there are training programs for us, so I'd love to see that in other specialty care.

But, so if you're interested look up ECHO, I don't know where all the audience is. It's a Robert Wood Johnson Foundation initiative, and it's, I don't know, all of the United States and global...

Alexis Crispino Kline:

...out of New Mexico.

Dr. Laurie Ann Maitland:

Yes, exactly. Yeah, I could see that fitting MS really well. So that's your next project, Alexis.

Dr. Ann Cabot:

Go Alexis.

Alexis Crispino Kline:

I got it. Well, you guys, that was just so wonderful. And we so, so appreciate it. And you know, we've hit our time. Listening to your wonderful, wonderful information. And I wonder if you guys each of you wouldn't mind sharing kind of a closing hope or note that you'd like to share with folks who might be watching tonight? Just anything, if you might like.

Dr. Laurie Ann Maitland:

Well, I guess I would say thank you for having me. It is, you know, I was excited to come and sort of talk. I was a little, at first, like, I don't remember a lot about MS, but you know it's great that I don't have to, you know, I don't have to know everything because I have you guys. And I guess for the patients out there, stay safe, COVID is still here. You know, I guess I won't go on the vaccine, wear a mask thing, but get a vaccine, wear a mask.

And, you know, get to know your PCP. Encourage your PCP to get to know your specialist. Be the love triangle. Be the match, be the, you know, match.com or whatever. What do you call like a match person?

Dr. Ann Cabot:

Your matchmaker.

Dr. Laurie Ann Maitland:

You're a matchmaker, right. Yeah. So thank you for inviting me into your world.

Alexis Crispino Kline:

Thanks for coming. We're so, so, so thankful to have you and, you know, that's such important information, and it's so great to hear from a PCP who is really connected and wants to be connected with patients and sometimes people, you know, they don't always get that feeling.

Dr. Ann Cabot:

And Laurie has unbelievable background. I'll brag for her. She's got a lot of background in rural medicine, and she's brave and wonderful and very caring about her patients. She loves her patients.

And I just would say, thank you Alexis, too, for having us. And my hope is that we can just every day make life for patients with MS just a little better, that we can engage our patients to help themselves, empower them to make their lives a little better. Some patients have a lot they have on their plate. Some of it has a lot to do with MS and some of it doesn't because we're all humans. But every day they do something a little better for themselves is absolutely awesome.

And your doctors have a lot of tools if you're willing to look for the help and the resources. So make sure you take advantage of the resources we give you and definitely stay safe out there. We care very much about you.

Alexis Crispino Kline:

Thank you both so, so much for those messages, and, you know, we'd like to thank everyone for joining us this evening. Of course, a special, special thank you to Dr. Cabot and Dr. Maitland for taking time out of their extremely busy schedules to be here with us and then also for our partners at Impact Education, who also help us to facilitate and host these patient education programs.

And so this will conclude our first in the series of Living Rural with MS - Close to Home: How to Leverage Your Relationship with Your PCP. We'd like to extend a thank you again to our funding partners Bristol Myers Squibb, Genentech, and Greenwich Biosciences, as well as our booth sponsors Genentech, Biogen, and Sanofi Genzyme. If you haven't already, please visit the Virtual Display Hall.

And finally, we ask if you could please be sure and complete our MSAA Patient Education Program survey, which will be linked in the chat box and it will pop up when the window closes. And completing this survey helps MSAA to guide future program topics and the efficacy of educational programs. Again, thank you all so much for joining us this evening, and we hope that you and your community are staying safe. Take care!