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More coordinated care between physicians may improve lipid screenings in RA patients

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Patients with rheumatoid arthritis whose rheumatologists and primary-care physicians coordinate their care have a higher likelihood of being screened for hyperlipidemia, a key risk factor for coronary heart disease, according to new research findings presented this week at the 2016 ACR/ARHP Annual Meeting in Washington.

Rheumatoid arthritis (RA) is a chronic disease that causes pain, stiffness, swelling, and limitation in the motion and function of multiple joints. Though joints are the principal body parts affected by RA, inflammation can develop in other organs as well. An estimated 1.3 million Americans have RA, and the disease typically affects women twice as often as men.

Patients with RA have an increased prevalence for coronary heart disease (CHD). Some data suggests that RA patients are not being screened properly for hyperlipidemia, so researchers at the University of Alabama at Birmingham conducted a study to evaluate lipid testing patterns among RA patients. They looked at whether patients screened for hyperlipidemia received care from a primary-care physician (PCP), a rheumatologist or both.

The study was conducted to identify the extent of the screening and management gaps for hyperlipidemia among the RA patient population, said Iris Navarro-Millan, MD, Assistant Professor of Medicine at UAB and a lead author of the study.

"You could argue that screening for hyperlipidemia, a traditional risk

factor, should be addressed by primary-care physicians, but there are a number of patients with RA who only see a rheumatologist," she said. "Patients see a specialist for a comorbidity (in this case RA), and do not establish care with a PCP, and this results in gaps in standard of care, such as screening and management for hyperlipidemia. We decided to focus on hyperlipidemia because CHD is the most common cause of death among patients with RA. Therapies for RA also affect lipid profiles in these patients, which adds complexity to the issue of cardiovascular risk reduction in patients with RA."

The study linked commercial and public health plan claims data together from 2006 to 2010. Participants in the study were required to have at least 12 months of continuous medical and pharmacy coverage at baseline, have two or more physician diagnoses plus relevant DMARD and/or biologic prescriptions to categorize them as having RA, plus two years of follow-up. Excluded were patients with prevalent myocardial infarction (MI), stroke or CHD at baseline, or those who had a diagnosis of hyperlipidemia or were using hyperlipidemia medications at baseline.

The researchers organized the patterns of care at baseline as visited a PCP only, visited a rheumatologist only or visited both types of physicians. They used logistic regression to determine the how likely patients were to be screened for hyperlipidemia during two years of follow-up based on their pattern of care.The study measured hyperlipidemia screening in 13,319 RA patients, including 83 percent women. Twenty-six percent were between the ages of 41-60 and 74 percent were older than 65. Eighteen percent of the RA patients did not see a PCP at the 12-month baseline.

The results showed that 42 percent of patients seeing a PCP only were screened for hyperlipidemia, 40 percent of patients seeing only a rheumatologist were screened, and 47 percent of patients seeing both a PCP and rheumatologist were screened. After controlling for multiple

potential confounders, the researchers found that RA patients who received combined care had a 32 percent increase in the likelihood of being screened for hyperlipidemia.

Rheumatologists may not always consider hyperlipidemia screenings as part of RA patient care, the researchers concluded. Improved coordination of care between PCPs and rheumatologists could help RA patients get necessary cardiovascular screenings. The study's findings help raise awareness that the RA patient population is inadequately screened and managed for hyperlipidemia, said Dr. Navarro-Millan.

"Our goal is to develop an intervention that can facilitate communication between specialties with the goal of decreasing health care fragmentation and reduce CHD risk in these patients," she said. "We anticipate that patient activation and knowledge will be a key element for the success of such intervention, since patients with RA are less likely to be aware of their increased risk for CHD."

Provided by American College of Rheumatology

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