Long-term cardiovascular risk prediction in the emergency department: a mixed-methods study protocol

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ABSTRACT

Introduction Cardiovascular disease (CVD) remains one of the leading causes of preventable death in Europe, therefore any opportunity to intervene and improve care should be maximised. Known CVD risk factors are routinely collected in the emergency department (ED), yet they are often not acted on. If the risk factors have prognostic value and a pathway can be created, then this would provide more holistic care for patients and reduce health system inefficiency.

Methods and analysis In this mixed-methods study, we will use quantitative methods to investigate the prognostic characteristics of routinely collected data for long-term CVD outcomes, and qualitative methods to investigate how to use and implement this knowledge. The quantitative arm will use a database of approximately 21 000 chest pain patient episodes with a mean follow-up of 7.3 years. We will use Cox regression to evaluate the prognostic characteristics of routinely collected ED data for long-term CVD outcomes. We will also use a series of semi-structured interviews to co-design a prototype care pathway with stakeholders via thematic analysis. To enable the development of prototypes, themes will be structured into a logic model consisting of situation, inputs, outputs and mechanism.

Ethics and dissemination This work has been approved by Research Ethics Committee (Wales REC7) and the Human Research Authority under reference 19/WA/0312 and 19/WA/0311. It has also been approved by the Confidentiality Advisory Group reference 19/CAG/0209. Dissent recorded in the NHS’ opt-out scheme will be applied to the dataset by NHS Digital. This work will be disseminated through peer-review publication, conference presentation and a public dissemination strategy.

Trial registration number ISRCTN41008456.

INTRODUCTION

The opportunity for long-term cardiovascular risk prediction in the emergency department

Cardiovascular disease (CVD) remains the leading cause of premature death in Europe.1 It is estimated that if population-based primary prevention reduced mean blood pressure and cholesterol by 10%, it would reduce the incidence of major CVD by 45%.2 There is an enormous human and economic cost associated with CVD. There are approximately 7 million people living with CVD in the UK, and it is responsible for one-quarter of all UK deaths and costs the UK £19 billion per year.14

While in the emergency department (ED), all patients with suspected acute coronary syndrome (ACS) will have vital signs recorded on admission, and 19/WA/0311. It has also been approved by the Confidentiality Advisory Group reference 19/CAG/0209. Dissent recorded in the NHS’ opt-out scheme will be applied to the dataset by NHS Digital. This work will be disseminated through peer-review publication, conference presentation and a public dissemination strategy. Protocol version V1.0—7 June 2021.

Strengths and limitations of this study

► A pathway to quantify and address long-term cardiovascular risk is potentially valuable in acute care settings as it would promote holistic patient care and improve long-term health outcomes.
► The quantitative arm of the study will examine the prognostic value of routinely collected data in the emergency department for long-term cardiovascular outcomes.
► The qualitative arm of the study aims to co-design a care pathway to use the information from the quantitative arm in a way that is acceptable to all stakeholders and is therefore easily implemented.
► A retrospective cohort study can suffer from more bias than a prospective study, including selection, information and confusion bias; however, it enables a timely answer and can highlight key areas to be followed up by prospective work.

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problems, it also presents opportunities. Patients who do not see their GP frequently are more likely to attend the ED, whose staff are therefore interacting with a portion of society underserved by primary care. Furthermore, in the drive for National Health Service (NHS) system-wide efficiency, we must maximise the use of each patient interaction with the health service. Considering the large amount of data already collected and stored routinely from the ED around the UK, this presents an ideal opportunity to predict and intervene in cardiovascular risk. Preventative medicine is not a new concept to emergency medicine (EM), and it has been researched and implemented successfully before. Furthermore, patients expect clinical staff in the acute care setting to have tools to inform them of their long-term CVD risk. It has also been demonstrated that such encounters represent teachable moments, where patients are more likely to accept advice about modifiable risk factors.

In a pilot trial comparing a clinical prediction model (CPM) with standard care for diagnosing acute myocardial infarction (AMI), we evaluated patient satisfaction regarding using the CPM as a rule-in/rule-out decision aid. While overall satisfaction was high (mean overall score 3.78/5), patients gave lower ratings (mean 2.78/5) for “advice you got about ways to avoid illness and stay healthy”. Patients are dissatisfied with an approach that simply informs them that they ‘do not have ACS’ but that does not address future cardiovascular risk. This sentiment was echoed by two patient groups and became an unexpected theme in a recent qualitative study of ED patients. While such tasks may previously have fallen to inpatient teams, the widespread use of early rule-out strategies means that emergency physicians must increasingly bear responsibility for informing patients of their future risk.

Furthermore, there is evidence that algorithms used to risk stratify patients with suspected ACS can also be predictive of long-term CVD. Farkouh et al demonstrated that patients with acute chest pain who were deemed to be at high risk of in-hospital complications had an HR of 2.45 (95% CI 1.67 to 3.58) for cardiovascular and cerebrovascular events at a medium follow-up of 7.3 years.

In primary care, the QRISK-2 (or QRISK-3) tool is routinely used to predict patients’ 10-year risk of CVD. If the 10-year risk exceeds 10%, the National Institute for Health and Care Excellence recommends that statin therapy should be considered. A range of other measures (advice on smoking cessation, weight loss, diet, exercise and review of comorbidities) should also be undertaken.

This tool could potentially be used in the ED because most of the data required to calculate QRISK-2/QRISK-3 are already routinely collected. This could identify patients at high risk of CVD who would otherwise have been unidentified.

We aim to assess the prognostic value of routinely collected ED data for long-term cardiovascular outcomes. We will also examine the optimal method for deploying this knowledge with a co-designed clinical pathway created through qualitative methods. Due to the potential to take advantage of the teachable moment among patients with suspected AMI, we will focus our investigations on this population. The care of patients with suspected AMI has evolved from a plethora of biomarkers assays to high-sensitivity troponins, and then to include CPMs. Each of these brought incremental improvements in the clinical diagnosis of AMI, and may have different long-term prognostic characteristics. We will focus our investigation on each of these diagnostic innovations.

METHODS
We will use quantitative methods to ascertain the prognostic value of routinely collected data for long-term CVD outcomes. The outcome data will be retrieved from NHS Digital’s data repository. Given the age of the data being linked, this will primarily be a limited scale feasibility study with exploratory analysis of the prognostic characteristics of the data. We will also use qualitative methods (via semi-structured interviews) to co-design a care pathway to be deployed in future to intervene and modify risk if individuals are noted to be at high risk of long-term CVD.

QUANTITATIVE ARM
Study arm design and study setting
We will use routinely collected data from patients attending the ED at Manchester Royal Infirmary (MRI) in the last 10 years. Patients with suspected AMI will be included. MRI has an annual ED attendance of 104 449, an inpatient capacity of 1721 beds and is a major trauma centre.

Study population
We will include patients who presented to the ED during three separate 12-month periods. Due to resource constraints only 3 years of data were accessible, so they were chosen to coincide with new diagnostic innovations (high-sensitivity troponin and a CPM) and a base line cohort to enable 10-year follow-up (box 1).

Sample size
We conducted a sample size calculation based on sample size methodology by Riley et al. We estimated that our Cox regression would have 10–20 candidate predictors, however this is dependent on the availability of data which is not yet known. We also estimated mean follow-up

Box 1 Cohorts that constitute the study population
1. 1 January 2009 to 31 December 2009: selected to enable 10-year follow-up.
2. 1 November 2011 to 31 October 2012: selected to coincide with the implementation of a high-sensitivity cardiac troponin assay.
3. 1 July 2016 to 30 June 2017: selected to coincide with the implementation of a digital clinical prediction model (troponin-only Manchester acute coronary syndromes).
to be 7.3 years and the other sample size calculation inputs were calculated from the derivation of QRISK-3. The minimum sample size for 10 candidate predictors was calculated to be 3255, and for 20 candidate predictors 6509 participants. Given that we expect the cohort to consist of >20000 participants, we believe that we will have sufficient data.

Data collection
We will include patients identified from the electronic patient record at MRI and collated with local biochemistry and coded diagnosis datasets. This will then be cross-referenced with NHS Digital’s Hospital Episode Statistics database (table 1).

Outcome variables
We will examine the primary outcome of CVD defined as angina pectoris, myocardial infarction, coronary artery revascularisation, ischaemic heart disease, atraumatic stroke and transient ischaemic attack and cardiovascular mortality. International Classification of Diseases-10 outcomes include I20-24, I60-64 and G45.9, and Office of Population Censuses and Surveys intervention version four codes include K40-50, K63 and K75.

Analysis
The incidence of cardiovascular outcomes and measures of data completeness (including the success of data linkage) will be summarised using descriptive statistics. We will use multiple imputation and also test the diagnostic plots of the algorithms to ensure convergence.

We will conduct a prognostic factor study for suspected CVD risk factors using a cox proportional hazard model to adjust for other co-variates. We will examine outcome data for CVD disease at 10-year (2009 data), 9-year (2011 data) or 4-year (2016 data) CVD onset. We will assess that the proportionality assumption holds and will apply time-varying interactions if not. In such an instance, we will consider flexible parametric survival models as alternatives. Although our sample is large enough to include all available covariates, we will consider various methods to reduce the number of parameters and make the tool easier to use (clinical judgement, collinearity, poor data quality or very high level of missingness).

We will quantify discrimination (ability to differentiate cases from controls) using C statistic. We will assess calibration (agreement between the observed and expected event rates) with flexible calibration plots, and calibration intercepts/slopes.

Using the 2011/2016 datasets, we will assess the prognostic value (in terms of calibration and discrimination) of high-sensitivity troponin T to predict cardiovascular events, using the aforementioned measurements. Then using the 2016 dataset we will assess the prognostic value of the troponin-only Manchester acute coronary syndromes acute chest pain algorithm to assess 4-year cardiovascular events.

We will also seek to externally validate other long-term cardiovascular risk prediction models that are available, such as the Framingham score and QRISK-3.

Qualitative arm
Study setting
The qualitative study will seek to co-design a care pathway for long-term CVD in the ED. We will conduct two waves of semi-structured interviews to produce this. In the first wave of interviews, we aim to induct the design of potential solutions, this will be conducted according to the topic guide in the online supplemental material. The analysis will be mapped to a logic map, which in turn will be used to develop prototype care pathways. In the second wave of interviews, we will present prototype care pathways developed from the ideas of the first wave. We will invite feedback on prototype solutions developed from the first wave, seeking to illicit the participants’ perspectives on the benefits or challenges of the different approaches. Specific feedback will be invited against the implementation outcome variables highlighted by Peters et al (acceptability, adoption, appropriateness and feasibility).

Table 1 Data variables to be collected

<table>
<thead>
<tr>
<th>Source</th>
<th>Outcome data</th>
<th>Predictor data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local EPR</td>
<td>Index event date time</td>
<td>Age</td>
</tr>
<tr>
<td>Local EPR</td>
<td>Index event ICD-10 codes</td>
<td>Gender</td>
</tr>
<tr>
<td>Local EPR</td>
<td>Index event ICD-10-OPCS codes</td>
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<tr>
<td>NHSD</td>
<td>Subsequent event date time</td>
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<td>Subsequent event ICD-10 codes</td>
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<td>NHSD</td>
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<td>Time of departmental events</td>
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<td>NHSD</td>
<td>Subsequent event treatment specialty</td>
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<tr>
<td>NHSD</td>
<td>Date of death</td>
<td>T-MACS data</td>
</tr>
<tr>
<td>NHSD</td>
<td>Cause of death</td>
<td>Rural/Urban indicator</td>
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<tr>
<td>NHSD</td>
<td></td>
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</tr>
</tbody>
</table>

T-MACS diagnostic algorithm includes BP, sweating, crescendo angina, ECG ischaemia, troponin, pain radiating to the right arm or shoulder. BP: blood pressure; EPR, electronic patient record; ICD, International Classification of Diseases; NHSD, NHS Digital; T-MACS, troponin-only Manchester acute coronary syndromes.


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The semi-structure interviews will be digitally recorded, transcribed and analysed according to multigrounded theory described by Goldkuhl and Cronholm.25 This enables a mixture of deductive and inductive reasoning, using ‘pure’ grounded method to deduct and existing theory to induct creating a more robust analysis as a whole. The transcribed audio will be analysed using thematic analysis,26 while also mapping against a logic model. This model will follow the situation, inputs, outputs and mechanism format.27 After this inductive process, we will deduct further iterations to the logic model by inviting feedback in the second wave of interviews, as demonstrated by Smith et al.28 In this second wave of interviews, we will also invite feedback on prototype care pathways drawn from the initial logic model by trial steering committee.

It is also intended to use an evidenced based co-design approach to develop the care pathway.29 This encompasses four stages: capture, understand, improve and measure. The ‘capture’ phase is where ideas are generated and prominent issues for resolution are condensed, then in the ‘understand’ phase the selected issues are extensively mapped. In the ‘improve’ phase, solutions are conceived to the issues in the first phases then in the ‘measure’ phase the implementation of the proposed solution is checked for improvement. This research will encompass the capture, understand and improve phase. The measure phase is a focus for future research.

We will construct a logic model of potential care pathways from our initial interviews using the situation-inputs-outputs-mechanism-outcome definition.

Coding and thematic analysis sensitivity analysis
Two separate clinical academic EM researchers will code a sample of the transcripts independently to ensure that no themes are misinterpreted or omitted. Each researcher will be blinded to the process and if conflicting codes are identified then a third researcher will adjudicate. This will ensure the transferability of the findings.

Sample size calculation
The interviews will continue until data saturation is achieved. Data saturation will be defined as a no new emerging themes and will be adjudicated by the researchers coding the transcripts. We anticipate that this is likely to occur by the end of the work packages but will continue if deemed necessary.

Ethics and dissemination
This study has received approval from the National Research Ethics Service and the confidentiality advisory group (references 19/WA/0312, 19/WA/0311 and 19/CAG/0209).

We will publish the results of our study in peer-reviewed journals. This mixed-methods co-design approach is in keeping with the Medical Research Council’s complex intervention guidelines, we believe that this will increase the implementation of our findings.30

We will present the findings of our research at international conferences and develop a public engagement strategy in collaboration with our patient groups.

DISCUSSION
Risk prediction is not a new concept to the ED. In the short-term, we already use tools to identify those patients who are at high risk of complications (eg, 30-day major

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**Table 2 Inclusion and exclusion criteria for semi-structured interviews**

<table>
<thead>
<tr>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
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<tr>
<td>Participant belongs to an identified stakeholder group. Patient with suspected cardiac chest pain deemed low risk by local care pathway.</td>
<td>Patient with suspected cardiac chest pain deemed moderate or high risk by local care pathway.</td>
</tr>
<tr>
<td></td>
<td>Participant not fluent in English language.</td>
</tr>
<tr>
<td></td>
<td>Participant unwilling to take part.</td>
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</table>

Stakeholders include emergency medicine consultants, general practitioners, acute care nurses and patients with chest pain.
adverse cardiac events in patients with acute coronary syndromes\(^1\), CURB-65 and community-acquired pneumonia\(^2\) and ABCD-2 score\(^3\). However, we are becoming increasingly responsible for identifying long-term complications, for example, using CHA2DS2-VASc in new-onset atrial fibrillation.\(^4\)

EM physicians act on red flags for other conditions as part of routine care, such as a shadow on a chest radiograph that may be a small cell carcinoma and therefore lead to the patient’s death in 6 months. So why ignore cardiovascular risk factors that could do the same? Previously, this may have been due to ED-measured hypertension being negated as ‘white coat’ hypertension, however more recent studies have suggested that 50% of patients who are found to be hypertensive in the ED have persistent hypertension at follow-up.\(^35\)\(^36\) Our quantitative analysis will add to the evidence base for the prognostic value of cardiovascular risk factors that are identified in the ED.

There is increasing concern for EM as it is perceived by some to be a service in crisis due to ever-increasing demand.\(^37\) A conceivable consequence of the pathway we proposed is that it could exacerbate this issue by propagating the idea that EM is a solution for all conditions and their presentations. However, across our patient and public involvement group there was broad support for this proposal primarily due to the efficiency and its ability to reach otherwise inaccessible patients. Furthermore, the opportunity for preventative medicine in the ED has been highlighted previously.\(^38\) We expect this topic to be explored in qualitative arm of this work, and a potential middle ground to be found where the hard-to-reach patients can be helped but the perception of EM is not adversely affected.

This multifaceted research project seeks to improve CVD care in the acute setting by answering two questions: (1) can routinely collected ED data predict long-term CVD and (2) how should long-term CVD advice be given in the acute care setting? If successful, this study would present a method for an efficiency in the healthcare system, where each patient interaction is seized on to provide the greatest value to the individual and to the NHS.

**REFERENCES**

Open access


20 Riley RD, Van Calster B, Collins GS. A note on estimating the Cox-Snell R² from a reported C statistic (AUROC) to inform sample size calculations for developing a prediction model with a binary outcome. Stat Med 2021;40:859–64.


Supplementary Table 1

<table>
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<th>Data category</th>
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<td>Source(s) of monetary or material support</td>
<td>Royal College of Emergency Medicine &amp; National Institute of Health Research</td>
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<tr>
<td>Primary sponsor</td>
<td>University of Manchester, United Kingdom</td>
</tr>
<tr>
<td>Contact for public queries</td>
<td>Charlie Reynard [<a href="mailto:charlie.reynard@manchester.ac.uk">charlie.reynard@manchester.ac.uk</a>]</td>
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<tr>
<td>Contact for scientific queries</td>
<td>Charlie Reynard [<a href="mailto:charlie.reynard@manchester.ac.uk">charlie.reynard@manchester.ac.uk</a>]</td>
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<td>Key inclusion and exclusion criteria</td>
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<tr>
<td></td>
<td>Sexes eligible for study: both</td>
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<tr>
<td></td>
<td>Accepts healthy volunteers: no</td>
</tr>
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<td></td>
<td>Inclusion criteria: adult patient (≥ 18 years), patient attended Emergency Department with chest pain</td>
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<tr>
<td></td>
<td>Exclusion criteria: Patient has opted out of research</td>
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<td>Study type</td>
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<td>Population: Patient attended between (a) January 1st, 2009 to December 31, 2009, (b) November 1st 2011 – October 31st 2012 (c) July 1st, 2016 – June 30th, 2017</td>
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<tr>
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<td>Primary purpose: identify the prognostic value of routinely collected data for cardiovascular disease</td>
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Data category | Information
--- | ---
Prognostic factor study

Date of first enrolment | September 2019 (study started)
Target sample size | 21,000

Recruitment status | Data linkage in process

Primary outcome(s) | Major adverse cardiovascular event - defined as angina pectoris, myocardial infarction, coronary artery revascularisation, ischaemic heart disease, atraumatic stroke, and transient ischaemic attack and cardiovascular mortality

**Data management**

Qualitative study – data will be anonymised and securely stored on servers at the University of Manchester.

Quantitative study – data will be stored in the Data Safe Haven at the University of Manchester. This is a physically and digitally secure environment, allowing named user access only, gated entry and exit, and advanced auditing capabilities. The data will be pseudo-anonymised and later fully anonymised once the analysis is complete.

**Sponsor Contact Details**

**Trial Steering Committee**

Dr Charles Reynard
Professor Richard Body
Dr Brian McMillan
Dr Glen Martin
Professor Evan Kontopantelis
Dr Anisa Jafar
Professor Anthony Heagerty
2 x Lay representatives.
Topic Guide

Thank you for attending today and taking the time out of your schedule. The session ought not to last more than 30 – 45 minutes.

Before starting I would just like to remind you to avoid identify yourself whilst we record the audio of this session.

We are going to run through a patient journey to try and discover what more we might be able to do for patients in the ED.

Today I would like to explore what we can do for patients who attend the emergency department with chest pain but have a heart attack excluded. We have been told by previous patient groups that they are often left feeling dissatisfied at this abrupt end of care, many are left wanting more information particularly about long term risk.

Do you have any experience of patients with chest pain?

Sometimes in patients who present with chest pain we look to rule out a heart attack with serial blood tests and an ECG. After some time, when the results are all in, we can sometimes exclude a heart attack.

Beyond the message that a heart attack has been ruled out, is there more that can be done?

What about long-term heart health (cardiovascular disease)?

- mention teachable moment and prognostic strength of classic primary care risk factors

A common risk factor for long term heart health is high blood pressure, if this patient had a high blood pressure what should we do for them in the ED?

- High cholesterol - smoking, kidney disease – diabetes
- blood scavenging
- medication
- lifestyle advice

Out of all the things we have mentioned, what would you focus on to capitalise on this teachable moment?

- How long would you envisage this taking?
- What would be the best way to communicate this?
There are medications available to treat some of these risk factors, how could we guide patients towards them?

- Who prescribes
- What about ED/specialist nurse/pharmacist/GP
- Who follows up (quote Southampton GP f/u RCT)

Do you have any experience with acute care / ED / A&E trying to help long term health

- This could have been in any number of form of lifestyle advice/ smoking / alcohol / diet/
  blood pressure / diabetes
- What went well/badly

Where does the onus of clinical responsibility lay to act, if these long term predictors are identified in ED?

- Primary care vs secondary care
- How can we improve the interaction between primary and secondary care
- Patient vs clinician vs system

Finally I would to briefly discuss like the current pandemic, of the opinions your have expressed how much do you think they are effected by the current situation?

- What would you do- Differing risk thresholds – fear of hospitals – wait and see approach
- How do you think patient’s behaviour has changed to seeking medical attention?