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Critical illness outcome study: an observational study of protocols and mortality in intensive care units

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Abstract: Individual intensive care unit (ICU) characteristics including staffing, expertise, continuity, and team structure, have been associated with patient outcomes. Separately, some aspects of care in ICUs have been implemented through treatment protocols. The United States Critical Illness and Injury Trials Group-Critical Illness Outcomes Study (USCIITG-CIOS) was designed to determine whether the extent of protocol use in ICUs is associated with hospital survival in a large number of US ICUs. Here, we describe the study protocol and analysis plan approved by the USCIITG-CIOS steering committee. USCIITG-CIOS is a prospective, observational, ecological, multicentered study of mixed ICUs in the US. The data to be collected include organizational information for the ICU (eg, protocol availability and utilization, multidisciplinary staffing assessment), and patient level information (eg, demographics, acute and chronic medical conditions). The primary outcome is all-cause hospital mortality, with the objective being to determine whether there is an association between protocol number and hospital mortality for ICU patients. USCIITG-CIOS is powered to detect a 3% difference in crude hospital mortality between high-protocol and low-protocol use ICUs, dichotomized according to protocol number at the median. The analysis will utilize multivariable regression approaches to adjust for outcome clustering by ICU, with secondary linear analysis of protocol number and mortality and a variety of a priori planned ancillary studies. We anticipate at least 60 ICUs participating in USCIITG-CIOS to enroll approximately 6000 study subjects. USCIITG-CIOS is a multicenter study examining the effect of ICU protocols on patient outcomes. These results will inform our understanding of the relationship between protocol availability, use, and patient outcomes in the ICU. Given the shortage of intensivists worldwide, the results of USCIITG-CIOS can be used to promote more effective and reproducible ICU care and outcomes.

Keywords: intensive care, critical care, outcomes, protocols, organization

Introduction
Critically ill patients are managed in intensive care units (ICUs) that contain limited, focused clinical resources and high-intensity nurse and physician staffing. While ICUs were initially developed to care for all patients with high acuity illness on a single hospital ward, they have evolved over the past 50 years to include units for patients with general respiratory failure or those with more narrowly defined illnesses or injuries in subspecialty ICUs.1 Anecdotal and published reports indicate that there is wide variation in the organization and structure of these units. For example, variation has been documented in physician staffing, hours of staffing, the presence and role of medical directors, and the presence of multidisciplinary rounding teams.2–5 Heterogeneous care provided to ICU patients may be related in part to patient differences or a lack of
medical consensus. However, some of this variation in care may be related to the general characteristics of the ICU itself and the practitioners who work there. ICU factors previously shown to be associated with practice variation include ICU type (general or specialty), location, and the training of the lead physician.6,7 Whether this heterogeneity leads directly to worse outcomes (cause and effect) remains to be proven; however, variation in patients admitted to specialty ICUs that do not match their particular diagnosis appear to fare worse, suggesting that familiarity and possible standardization of care may influence patient outcomes.7–9

One method for reducing unwanted variance in clinical practice is the use of treatment protocols to drive care for patients meeting specific criteria.10 There is little information on whether differences in processes of care (previously attributed to ICU organization and structure) might be related to the use of protocol-based care. For instance, high-intensity ICU organization has been shown to be associated with higher likelihood of evidence-based delivery of low tidal volume ventilation to acute lung injury patients.8 However, the presence of a protocol has also been linked to more frequent use of a desired process of care11 and therefore is likely to be associated with improved patient outcomes. As a result, it is logical to expect that a greater number of protocols is associated with a reduction in unwanted practice variation and thereby improved outcomes independent of ICU organization. The United States Critical Illness and Injury Trials Group (USCIIT Group) designed the Critical Illness Outcomes Study (USCIITG-CIOS) to test the hypothesis that the number of protocols influences hospital mortality.

Additionally, this study will determine the prevalence of protocols in 60 ICUs in the US.

**Methods**

**Study design**

To test the hypothesis that the number of protocols used in an ICU is associated with hospital survival, the USCIIT group has organized a large prospective observational study of ICU patients. Initial ICUs will be selected from a range of institutions participating in USCIIT group and other collaborative groups. After recruitment, physicians familiar with each ICU will be asked to fill out a structured assessment of protocol use and general unit characteristics, including physician and nursing staffing, the presence of electronic medical records and computerized order entry. This survey will determine both the presence of a priori defined care protocols and how they are utilized. In addition, respondents will have the opportunity to report self-determined protocols. Clinical characteristics and outcomes of a series of patients in these same ICUs will then be recorded (Figure 1).

At the time of initial planning, several important substudies were integrated into the overall study design, ie, ICU staffing patterns, the presence of electronic medical records, and continuity of care measurements. Adherence to specific care protocols and their relationship to disease-specific outcome will also be determined (Table 1).

**Site recruitment and communications**

Because health care delivery systems and intensive care units vary between countries, we sought to identify at least 60 ICUs...
in the US only. Sites will be initially petitioned by review of publications from active critical care investigators in the US, word-of-mouth at international critical care meetings, and direct communication with previous collaborators. Specific communication was sent to representatives of the USCIITG-CIOS and Surviving Sepsis Campaign institutions. Both academic and nonacademic ICUs were approached, regardless of specialty (eg, medical, surgical, cardiac, neurologic, trauma) and case-mix (eg, cancer). Follow-up calls provided a more detailed discussion between a USCIITG-CIOS principal investigator and the local contact at the site. During this semistructured interview, local ICU structure referral patterns, prior clinical research experience, the USCIITG-CIOS study protocol, anticipated workflow, workload, expectations, and site principal investigator rights were discussed. Interested sites were provided with basic Institutional Review Board application materials and ultimately access to the USCIITG-CIOS web interface. Over 70 sites progressed to phone interview, with all sites committing to data collection and study protocol requirements being invited to participate. Only two sites were excluded due to inability to obtain Institutional Review Board approval.

Communication between the principal investigators and individual site investigators is logistically complex. Formal communication from the USCIITG-CIOS principal investigators to site investigators will begin at the time of first subject recruitment through a variety of media. These include face-to-face meetings, conference calls, and electronic LISTSERV communications (Figure 2). Regularly scheduled emails will provide updates on recruitment status, deadlines, and overall study progress. Intersite communication is encouraged. Site-specific queries will be handled by the principal study investigators via electronic communication. Final participating sites are listed in Appendix A.

**Study subject and human subject protections**

Each site will be asked to screen census registers weekly to enroll new ICU patients. Sites are permitted discretion in choosing survey days and encouraged to rotate days to ensure variation in sampling. Study subjects are defined as adult patients occupying a bed in the study ICU at 8 am on each survey day. Subjects were excluded if they were <18 years of age or had been previously enrolled into USCIITG-CIOS. Enrollment days will not be continuous in order to facilitate subject enrollment without duplication. A minimum of 100 subjects was targeted for enrollment from each study ICU (Figure 3).

Because the exposure of interest (indigenous clinical care protocols) will be by definition, the baseline practice of any individual unit, and these practices will not be altered by study participation, any variation across study sites is considered local “usual care”. In addition, this study was designed to collect all patient information devoid of personally identifiable indicators. As a result, local institutional review boards will be petitioned for a waiver of consent.
Sample size

The primary objective of this study is to determine if a difference in hospital mortality exists between highly protocolized ICUs and those with fewer or no protocols. Because no threshold number of protocols could be proposed from prior work, we chose to divide ICUs into two groups defined by the median number of protocols observed in our sample of ICUs (median to be determined). We estimated that the minimal significant difference in unadjusted mortality outcomes would be 3% between ICU with a “higher” and “lower” number of protocols. Based upon average mortality from surveys of individual ICUs, we assumed that the group...
of ICUs with a lower number of protocols would have a baseline hospital mortality of 15%. Ignoring clustering by ICU, we would require 2791 participants per study group to detect a 3% absolute difference in hospital mortality, with 90% power and a significance level of 0.05. We plan to engage at least 60 centers to accrue 6000 evaluable patients. We anticipate that one year will be required to enroll the requisite number of subjects.

**Study outcomes and data collection**

The primary outcome for the USCIITG-CIOS study is hospital mortality. Secondary outcomes are ICU mortality, discharge location, hospital ICU length of stay, and duration of mechanical ventilation. Observations will be recorded using two separate questionnaire case report forms, ie, one for ICU structural data and one for patient-level data. Each participating ICU will complete a structural questionnaire prior to enrolling subjects. The structural questionnaire includes 79 questions in seven sections, comprising general information, bed count, utilization, staffing, rounding practices, team work tools, and ICU protocols (Table 2). A “protocol” will be defined using the Medline MeSH subject heading as “precise and detailed plans for a regimen of therapy”. Investigators will be left to determine whether local practice was guided by a protocol, but additional questions will be asked to determine how the protocol was activated and how its recommendations were implemented. Guidance for the survey will be provided in the distributed operations manual. After the structural questionnaire is deemed complete, the site will be allowed to enroll subjects.

Enrollment days will be chosen randomly, with 5–10 days between enrollments to allow for patient turnover. A case report form will be completed for all patients receiving care in an ICU on the day they meet the enrollment criteria. The case report form includes 136 items organized into nine sections, comprising demographics, illness severity, organ failure data, mechanical ventilation, medications, treatment issues, diagnoses, infections, and outcomes (Table 3). Records will be reviewed on the day of enrollment and periodically thereafter until the time of discharge to obtain appropriate treatment and follow-up data. Admission data on mechanical ventilation and medications will be recorded from 8 am on the day of enrollment. All other data are based on the 24-hour period prior to enrollment (Table 3).

Patient charts will be reviewed for documented chronic organ insufficiency and the circumstances leading to ICU admission. These categorizations and their definitions will be recorded according to Acute Physiology and Chronic Health Evaluation II definitions. Researchers are not permitted to interpret records; diagnoses recorded in the case report form are all based upon physicians’ or other practitioners’ notes recorded in the patient’s chart. The presence of chart documentation and consult notes will be recorded in order to quantify the number of disciplines involved in each patient’s care. These notes will be defined as identifying a specific service by the title of the chart entry. Data on infections will be completed based on progress notes from the day of enrollment and the most recent laboratory data. Outcome data will be completed after the patient is discharged from

<table>
<thead>
<tr>
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<th>Number of questions</th>
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<td>Categorical and numerical</td>
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<tr>
<td>Infections</td>
<td>6</td>
<td>Categorical</td>
<td>24 hours prior to enrollment</td>
</tr>
<tr>
<td>Outcomes</td>
<td>9</td>
<td>Categorical</td>
<td>Values recorded after discharge</td>
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Notes: Instruments and definitions used within the survey include the following severity of illness, Acute Physiology and Chronic Health Evaluation II; organ failure, Sequential Organ Failure Assessment; coagulopathy, International Normalized Ratio >1.5, partial thromboplastin time >2× control or platelets <50,000; hypotensive, mean arterial pressure <65 mmHg, systolic blood pressure <90 mmHg, or drop in systolic blood pressure of >40 mmHg despite 2 L fluid given; delirium, Confusion Assessment Method for the Intensive Care Unit, Intensive Care Delirium Screening Checklist, Nursing Delirium Screening Scale; stress dose steroids, hydrocortisone ≥200 mg/day or equivalent dose of other corticosteroids.
the hospital. Discharge location includes detail about hospital type if the patient is discharged to another inpatient facility. The presence of mechanical ventilation, renal replacement therapy, or limitation-of-care orders at hospital discharge will also be documented.

Primary analysis and other statistical considerations
The primary objective of this study is to determine whether an association exists between the number of ICU protocols and hospital mortality for ICU patients. The primary outcome for this study is hospital mortality. As described above, we plan to divide ICUs into two groups based upon the median number of protocols observed in the entire sample of ICUs (n = 30 as having a higher number of protocols and n = 30 as having a lower number of protocols). We will first compare the simple means of the hospital mortality rates between the two predefined groups of ICUs using standard techniques.13 Secondly, we will perform an adjusted analysis controlling for physiologic severity of illness and other potentially confounding variables. Specifically, we will use logistic regression techniques with generalized estimating equations, a compound symmetry matrix14 and a robust variance estimate to adjust for clustering of hospital mortality by ICU. In a secondary analysis, we will characterize the relationship between the number of protocols as a continuous variable and hospital mortality using regression splines15 within the context of multivariable logistic regression with generalized estimating equations.

Data quality and management
Prior to data collection, the principal investigators developed an operations manual to ensure intersite reliability. The operations manual includes selected definitions for questionnaires as well as guidelines for data collection. The operations manual will be maintained and revised as needed by the principal investigators, and distributed to sites as revisions are made. Frequent communications will be sent electronically that include clarifications of the operations manual, discussion of Institutional Review Board approval process, and suggestions regarding data collection. The primary investigators review the structural questionnaire at each site prior to allowing subject enrollment.

All patient data will be recorded on paper case report forms and then entered into an online database maintained by Johns Hopkins University. The database was designed to prevent entry of duplicate patients in the following ways. First, the database will create a unique patient identifier for each new patient based on the demographic information provided. This demographic information will be then compared with enrollees. Subjects with an exact match on five independent variables (gender, age, race, height, and weight) will be blocked from entry. During data entry, computer decision support identifies missing, inconsistent, or out-of-range data. A data error query will be produced and either resolved within the data center by individual, manual review, or returned to the local investigator for resolution. Finally, the database ensures that data is entered in structured formats to facilitate calculation of the APACHE II and Sequential Organ Failure Assessment scores.

Discussion
We have developed a large collaborative US study to investigate the effect of the number of protocols used in an intensive care unit on hospital mortality. There are many factors that influence outcomes in individual ICUs. These factors can include local referral patterns,16–18 patient-specialty ICU type match,7 case-volume,8 staffing characteristics, and expertise.2,3 Presumably, these superficial characteristics belie some variation in the ability to identify or treat important medical issues. Protocols have been used to reduce unwanted practice variation. Protocol-driven interventions in the ICU have improved targeted process measures and disease-specific outcomes,19 but the association between the number of protocols and general outcome across diverse patient groups has not been studied. In this multicenter prospective study, we test the hypothesis that there is an association between the amount of protocol-driven practice in a given ICU and outcome.

There is a significant evidence base that should influence ICU practice. Noteworthy practices include transfusion management,20,21 sedation and analgesia,22 and ventilator weaning.23,24 Additionally, condition-specific practices like the use of low tidal volume ventilation in acute lung injury patients25 or aggressive treatment of septic shock have improved mortality in these diseases.26 Given that these are common ICU conditions and treatments, adopting these practices effectively could improve outcomes across larger populations of general critically ill patients independent of their admitting problem. Despite knowledge of these interventions and their beneficial consequences, evidence suggests these practices are still only variably applied.27–32

Nonadherence to recommended protocols can be related to knowledge deficits, distractions33 or a lack of access to evidence at the point of care.34 Knowledge of these barriers has led to the development of simple checklists for ICU teams associated with increased adherence.35–39
to use to identify treatment goals, but their ability to improve adherence is dependent on knowledge of a mechanism to effect these goals. Protocols can provide operational definitions for the delivery of evidence-based therapy and accordingly increase a practitioner’s ability to understand how to apply a specific practice. When clear and readily available, protocols should improve outcomes in a variety of ways, particularly if baseline adherence to desired practice is low. In some settings, these protocols may improve the efficiency of decision-making or allow the responsibility for the decision to be shifted to appropriate team members.

The organizational structure of an intensive care unit has been linked to adherence to evidence-based ventilator management for acute lung injury patients. Our study will attempt to describe whether one potential mechanism for this effect is the use of protocols. The systematic adoption of protocols, using presence of a higher number of protocols as a proxy, should be associated with improved outcomes because it marks an underlying multidisciplinary culture that defines unwanted practice variation. Alternately, if a specific ICU cares for a high proportion of patients where these practices apply (like sepsis or acute lung injury) then protocols could directly improve practice and outcome. Finally, a higher number of protocols could simply increase the likelihood of having the “right” protocols in place. In any case, the observation that the number of protocols is associated with outcome could have important implications for the appropriate design and structure of ICU care teams particularly when the human resources needed to develop multidisciplinary teams are limited.

The novelty of our study is that it addresses a unique topic in critical care medicine that could not be easily studied in a prospective randomized design. It is clear that multidisciplinary teams improve outcomes in ICUs, but the mechanism by which this occurs is not known. By studying protocol use in general, we are analyzing an approach to care standardization and not the practices themselves. Strengths of our study design include a broad array of ICUs of mixed type and the explicit description of their coverage model and care practices. In addition, data collection was designed not only to quantify protocols but also to record the area of practice they are designed to impact. We record data about how the particular protocol is activated (standing order, individual activation) to understand where in the process of clinical decision-making these support tools exist. Finally, by collecting important clinical data we can generate inferences about what proportion of patients in an individual ICU would have been a candidate for protocol-driven care and appropriately risk-adjust all outcomes.

There are several potential limitations to this study. By including a broad array of ICU types, we may lose the ability to determine the importance of individual care protocols that impact a small proportion of our study patients (eg, ventriculostomy management). Second, because we primarily measure outcome as hospital mortality, we may lose the ability to detect benefit from care protocols that have a greater impact on morbidity than mortality. Examples of these types of treatments include sedation practice and mobility protocols. It is possible that the way in which a protocol is activated is important to its ability to affect outcomes. Because we are only collecting survey data about how protocols are utilized, we lack the ability to comment on whether individual units enact their stated practice. Additionally, we do not review the content of each protocol so we cannot exclude the possibility that the protocols are incorrect or not explicit enough. Ideally, this question could be tested by a cluster randomized trial of protocol-driven general care, but the resources to perform this study and the ethics behind it, could be prohibitive barriers. Lastly, it is possible that we may fail to observe improved outcomes in general ICU patients simply because the “right” protocols have not been developed yet. We believe this is unlikely given the temporal improvements in ICU outcomes that have been observed with time and the magnitude of effect seen in homogenous patient groups; however, this is still a possibility.

Our analysis also may be confounded by not accounting for clustering by ICU in our original sample size calculations. Controlling for this necessitates accounting for the coefficient of variation of the actual mortality between study ICUs, an additional unknown. If we were to now take this into account, we would likely trade more rigorous analysis for less power to detect the expected 3% difference in hospital mortality (assuming the coefficient of variation for hospital mortality is >0.1, Figure 4). While our intent is to enroll 6000 participants across 60 ICUs, we plan to monitor longitudinally the observed coefficient of variation for hospital mortality to obtain a better understanding of the magnitude of this potential effect.

In closing, this study will examine the association between the number of care protocols and patient outcome. Further, it will provide a number of important ancillary studies, include an ability to begin to identify what protocol characteristics determine improved practice and a relative weighting of the impact of specific protocols by ICU specialty. This new knowledge in turn can inform design of information systems to automate when possible those practices that have the greatest positive impact on outcomes and costs. This study
will generate important information that can be used in the near term by unit and hospital medical directors to inform ICU organization, and in the longer term to determine bridge strategies to improve ICU outcomes in a resource-limited environment.

Acknowledgment

We acknowledge the leadership of the USCIITG in facilitating the execution of this study and providing invaluable advice on protocol development and execution.

Disclosure

None of the authors report that they have a significant financial or other competing interest related to the content of this manuscript.

References


Appendix
Participating centers, listed in alphabetical order by state. The principal investigator’s name appears first, then all others are listed in alphabetical order per site.

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Protocols and ICU mortality

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Abbreviation: PI, principal investigator.