aspirin use based on data collected at baseline and at additional time points prior to hospitalization for pneumonia if these data were available. Aspirin use was similar between the 2 groups, suggesting that confounding by unaccounted aspirin use is unlikely.

We agree with the authors that advanced age is an important risk factor for CVD after pneumonia. This is supported by the substantial difference in incident CVD after hospitalization for pneumonia between the 2 cohorts that we analyzed (CHS: mean age of 73 years and 10-year risk of 35% for CVD vs ARIC study: mean age of 55 years and 10-year risk of 16.5% for CVD). In regard to their point about the severity of pneumonia being an important risk factor for subsequent CVD, we also agree that previous studies support this concept. However, our study was not designed to address this question. Instead, we chose to perform a stratified analysis by pneumonia severity to determine whether the association between hospitalization for this infection and increased risk of CVD was present in cases of both severe and nonsevere pneumonia.

We agree with Violi and colleagues that randomized clinical trials of interventions to reduce CVD after hospitalization for pneumonia are needed, and that older adults with severe pneumonia would be a high-risk group in which these interventions could demonstrate benefit.

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Sedation Protocol for Critically Ill Pediatric Patients

To the Editor In the Randomized Evaluation of Sedation Titration for Respiratory Failure (RESTORE) trial, Dr Curley and colleagues found that a nurse-implemented, goal-directed sedation protocol for children undergoing mechanical ventilation for acute respiratory failure did not reduce the duration of mechanical ventilation compared with standard of care. In an accompanying Editorial, Dr Mehta raised the question of whether a low adherence rate to a complex protocol (71%-100%) or a difference in administered drugs with bioaccumulation between the groups contributed to the null findings. This large randomized clinical trial of sedation using a bedside protocol in critically ill children may have been confounded by an intervention group who were younger and less sick and who received more frequent assessments.

Previous work in adult critical care has demonstrated fewer days of mechanical ventilation through the use of a multidisciplinary team bundle approach to care based on an ABCDE (awakening and breathing coordination, delirium monitoring/management, and early exercise/mobility) protocol. This approach has allowed patients to be more awake to participate in early mobility and physical therapy, potentially minimizing myopathy acquired in the intensive care unit and reducing time spent receiving mechanical ventilation.

Previous work by Curley et al has demonstrated that the State Behavioral Scale (SBS) has an interrater reliability score of 0.44 to 0.76 in younger patients. I question whether the authors’ null findings may result from the variation between bedside nurses or between different centers because the unit of randomization was the pediatric intensive care unit (PICU).

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In Reply Dr Remy is concerned that null findings of the RESTORE clinical trial may have been the result of the cluster randomized design leading to variation in sedation assessments between bedside nurses and among different centers. Remy asks whether measures of variation between bedside nurses were determined prior to the study, whether additional sedation measures were considered, and whether nurse turnover or experience could have confounded study results.

During the RESTORE start-up phase, all PICUs implemented the SBS as a unit-based standard of care. The SBS was selected because it was the only valid and reliable sedation assessment instrument specific for intubated pediatric patients. The weighted κ scores of 0.44 to 0.76 noted by
Remy were drawn from the instrument development study and reflect scores associated with the 7 dimensions of the instrument but not the total instrument. In the RESTORE trial, all physicians and nurses received training and were required to successfully complete a posttest prior to enrolling patients. We established interrater reliability checks on the SBS and monitored interrater reliability throughout the trial in both intervention and control PICUs. The overall k score for the SBS was 0.87 (95% CI, 0.83-0.91). Any PICU failing below 80% agreement implemented a quality improvement plan and the interrater reliability was rechecked.

As noted in our article and in the supplementary materials, sedation assessments were completed more frequently in the intervention compared with control PICUs, presumably because the data were used by the intervention PICUs to target sedation. Adherence to sedation assessment elements in our protocol was high; the daily SBS target was prescribed on 98% of intubation study days and achieved 95% of the time in intervention patients.

We have no data on how nurse turnover or experience may have confounded the RESTORE study. As noted in our supplemental materials, the experience level of the PICU nursing workforce was good, with a median of 6.2 years (interquartile range, 5.1-8.3 years) across sites, and most nurses had bachelor’s degrees (median, 80%; interquartile range, 74%-90% across sites). In addition, we had few protocol deviations stemming from enrolled patients receiving care from a nurse who was not trained in using the RESTORE protocol. Clinical trials and observational studies may differ in their conclusions for the reasons that Remy cites, and there may be additional bias introduced in observational studies that may be difficult to identify, as well as the inherent differences between a toddler with acute respiratory failure and a 50-year-old adult with a medical or surgical problem.

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Expanding Long-term Care Options for Persons With Serious Mental Illness

To the Editor Dr Sisti and colleagues’ argued that “[t]he financially sensible and morally appropriate way forward [regard-