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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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Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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 colleagues¹ 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 Mehta² 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 3 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.³ 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 al⁴ 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). Were measures of variation between bedside nurses determined prior to the study? Was consideration given to additional measurements for level of sedation prior to the study? Also, could a high turnover of PICU nurses have led to a relatively inexperienced workforce responsible for sedation assessments? Do the authors have any further data that may offer insight into how turnover or experience may have confounded the study?

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2. Mehta S. Protocolized sedation in critically ill children. *JAMA*. 2015;313(4):363-364.
3. Balas MC, Vasilevskis EE, Olsen KM, et al. Effectiveness and safety of the awakening and breathing coordination, delirium monitoring/management, and early exercise/mobility bundle. *Crit Care Med*. 2014;42(5):1024-1036.
4. Curley MAQ, Harris SK, Fraser KA, Johnson RA, Arnold JH. State Behavioral Scale: a sedation assessment instrument for infants and young children supported on mechanical ventilation. *Pediatr Crit Care Med*. 2006;7(2):107-114.

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.¹ 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 κ score for the SBS was 0.87 (95% CI, 0.83-0.91). Any PICU falling 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 studies² 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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Conflict of Interest Disclosures: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Matthay reported receiving personal fees for serving as chair of a data and safety monitoring board for Roche-Genentech and as a consultant for Cerus, Quark Pharmaceuticals, Biogen, and GlaxoSmithKline. No other disclosures were reported.

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

To the Editor In their Viewpoint, Dr Sisti and colleagues¹ addressed the need for expanded and cost-effective care options for people living with serious mental illness. As the authors pointed out, closing state psychiatric hospitals made prisons the new institutions. Although the authors noted that the best option for a person with serious mental illness is "assisted treatment in the community," they appear to believe that current community-based programs are inadequate for the most seriously ill.

Community mental health programs need to take some responsibility for these failures and for the inability to provide adequate services to enough people with the most serious mental health problems. I believe that this failure has been partially attributable to a loss of focus on the most seriously ill, coupled with inadequate funding. But more funding is not the only answer. Serving the neediest individuals in more effective ways is necessary.

Since 1948, Fountain House has served thousands of people living with the most serious forms of mental illness through a partnership model (not a peer-only model, as suggested in the Viewpoint) between members and professionally trained staff. Fountain House provides the "safety" and "sanctuary" Sisti and colleagues attributed to asylums but has also adopted a 3-part approach needed to assist patients in rejoining mainstream society: a psychiatrist trained in psychopharmacology, a primary care physician, and a supportive environment that offers hope and opportunity. People living with serious mental illness, specifically schizophrenia, experience a 22.3% rate of hospital readmission.² At Fountain House, our hospital readmission rate is 10%. For less than the cost of a 2-week stay in a psychiatric hospital, Fountain House provides members with housing, community support services, and access to medical and psychiatric care for an entire year.

The authors' call to action could not come at a more important time. New York is witnessing the largest shift in funding since deinstitutionalization, transitioning to Medicaid and Medicare funding and in the process seeing major reductions in state government funding. I urge the authors to reconsider the value of cost-effective, community programs that focus exclusively on people with serious mental illness.

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Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

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To the Editor Dr Sisti and colleagues¹ argued that "[t]he financially sensible and morally appropriate way forward [regard-