

# Study of Outcomes of Intensive Care

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## Conference presentations from this thesis

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### **Abstract**

Many studies show long-term outcome following critical illness involves reduced physical function, increased psychological symptoms, neuropsychological impairment and reduced quality of life compared with population norms. It is assumed these are a direct consequence of critical illness and critical care therapies.

The STudy of Outcomes of Intensive Care (STOIC) was designed to compare the long-term functional, neuropsychological and psychosocial recovery of intensive care unit (ICU) survivors (ICU patients) with non-intensive care, acute-care hospitalised controls. Secondary aims include identifying variables which predict outcome (for ICU patients only) at two years after ICU discharge.

Seventy-one survivors from two mixed medical-surgical ICU populations and seventy-two age- sex- matched non-ICU acute-care hospitalised controls, (selected from same hospital populations) were consecutively recruited at unit discharge. A broad test-battery incorporating standardised objective and subjective tests to measure functional, psychosocial, neuropsychological impairment together with patient self-report was used at six timepoints, across a two year period. Face-to-face, semi-structured interviews were conducted.

Data was analysed using mixed model regression. Thematic analysis drew subject themes from patient narratives. Pearson correlations were calculated to inform selection of variables for outcome prediction.

Preadmission scores reflect a state of chronic disability for both ICU patients and controls. Neither group reach complete functional independence during the study period. High levels of functional impairment are seen among controls, ranging between 56 - 85%. At two years following discharge mean functional test scores for both groups remain below preadmission levels.

Comparatively, ICU patients display lower levels of community integration throughout the study period.

There were no cases of Post-Traumatic Stress Disorder identified with both groups displaying low levels of anxiety and depression. Neuropsychologically, neither group achieved scores in the normative average range. A higher proportion of the ICU group were cognitively impaired at each time point. At two years following discharge, 21% of ICU patients and 16% of controls remain impaired in verbal, working memory. Several baseline variables were strongly correlated with impairment and mortality two years after unit discharge. Significant predictors include years of education, Mini Mental State Examination, Community Integration Questionnaire, Functional Independence Measure, and Charlson Age Comorbidity Index.

This study unexpectedly uncovers high levels of impairment for a non-ICU acute-care hospital population which have not previously been acknowledged whilst also demonstrating a correlation of high impairment among ICU patients. Baseline variables are capable of predicting clinically relevant outcomes two years after discharge. Clinicians, patients and carers are benefitted with the research of this paper, to be further informed of the possible after-effects associated with treatment for critical illness.

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And to my family and my children; those for whom my heart beats.

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## Contents

Chapter	CONFERENCE PRESENTATIONS	Page 2
	ABSTRACT	3
	ACKNOWLEDGEMENTS	5
	LIST OF TABLES AND FIGURES	8 - 12
	LIST OF APPENDICES	13
	ABBREVIATIONS	15
1	INTRODUCTION	17
2	BACKGROUND	24
	Health related quality of life Functional Outcome Neuropsychological Outcomes Psychosocial Outcomes Social and Economic Outcome of Critical Illness Study Methodology Pathogenesis of Post Intensive Care Syndrome ICU Re-admission Outcome Prediction Narrative / Thematic Analysis	
3	Participants Materials Test Battery Procedures Analytical Approaches Data Variables	45
4	RESULTS	67
	Demographic Characteristics Admission Characteristics	

	Return to Work	
	Prediction Analysis	
	Thematic Analysis	
	Test Incompletion	
5	DISCUSSION	156
	Demographic Factors	
	Test Scores	
	Test Outcomes	
	Summary of Outcomes	
	Diagnostic Subgroup Analysis	
	Conclusion of Subgroup Analysis	
	Narrative Thematic Analysis	
	Prediction Analysis	
6	CONCLUSION	169
	Test Battery	
	Demographics	
	Functional Outcome	
	Quality of Life	
	Psychosocial Outcomes	
	Narratives	
	Study Limitations	
	Further Research	
	REFERENCE LIST	180
	APPENDICES	191

Correlations between Critical Care Treatments and Outcomes

**Test Outcomes** 

Test Scores for Diagnostic Subgroups

**Defining Level of Impairment** 

	LIST OF TABLES	
Table	Title	Page
Table 1.0	Inclusion / exclusion criteria	46
Table 2.0	Test Battery Key	56
Table 3.0	Schedule of events	62
Table 4.0	Data variables	66
Table 5.0	Background characteristics	71
Table 6.0	APACHE 3 admission diagnoses-ICU patients	73
Table 7.0	Principal diagnoses-controls surgical	74
Table 8.0	Principal diagnoses-controls medical	76
Table 9.0	In-hospital interventions & comorbidities	77
Table 10.0	Unadjusted correlations among ICU intervention variables for ICU patients	78
Table 11.0	Unadjusted correlations among ICU intervention variables and cognitive test outcomes for ICU patients	79
Table 12.0	Functional Independence Measure Effect over Time	82
Table 13.0	Digit Span Test Effect over Time	83
Table 14.0	Digit Span Task (Freq; %)	84
Table 15.0	Letter Number Sequence Effect over time	85
Table 16.0	Letter Number Sequence (Freq; %)	86
Table 17.0	z score interpretation	87;88
Table 18.0	Trailmaking B Effect Over Time	88
Table 19.0	Stroop Task Test Effect over time	90
Table 20.0	Impact of Events Scale – Revised (Total) Effect Over Time	91
Table 21.0	Impact of Events Scale – Revised (Freq; %)	92
Table 22.0	Impact of Event Scale – Revised (Component: Avoidance) Test Scores and Effect over Time	93
Table 23.0	Impact of Events Scale – Revised (Component Hyperarousal) Test Scores and Effect over Time	94
Table 24.0	Impact of Events Scale-Revised (Component: Interruptions) Test Scores and Effect over Time	95
Table 25.0	Hospital Anxiety and Depression Scale Effect over Time	96
Table 26.0	Community Integration Questionnaire Effect over Time	97
Table 27.0	SF-36v2 Physical Component Score Effect over Time	99

Table 28.0	SF-36v2 Physical Component Score (Freq; %)	101
Table 29.0	SF-36v2 Mental Component Score Effect over Time	102
Table 30.0	SF-36v2 Mental Component Score (Freq; %)	103
Table 31.0	Change SF-36v2 BP per month	104
Table 32.0	Change SF-36v2 GH per month	105
Table 33.0	Change SF-36v2 MH per month	106
Table 34.0	Change SF-36v2 PF per month	107
Table 35.0	Change SF-36v2 RE per month	108
Table 36.0	Change SF-36v2 RP per month	109
Table 37.0	Change SF36v2 SF per month	110
Table 38.0	Change SF36v2 VT per month	111
Table 39.0	Outcome among diagnostic subgroups	113
Table 40.0	Outcome measures impairment descriptors	123
Table 41.0	Impairment at 24 months (%)	124
Table 42.0	Digit Span Task (Freq; %) at 24 months	125
Table 43.0	Letter Number Sequence (Freq; %) at 24 months	126
Table 44.0	SF36v2 Physical Component Score (Freq; %) at 24 months	128
Table 45.0	SF36v2 Mental Component Score Impairment (Freq;%) at 24 months	129
Table 46.0	Residential Support Impairment (Freq; %) at 24 months	131
Table 47.0	SF36v2 Mobility Impairment Score test Scores for subgroups	132
Table 48.0	Days off work	133
Table 49.0	Controls work capacity	135
Table 50.0	ICU patients work capacity	135
Table 51.0	Predictors and outcomes	137
Table 52.0	Premorbid predictors of impairment	139
Table 53.0	Premorbid predictors of death	140
Table 54.0	One month predictors of impairment	141
Table 55.0	One month predictors of death	142
Table 56.0	Narrative themes	152
Table 56.1	Narrative recovery trajectories	153

Table 57.0	Reasons for test incompletion	155
Table 58.0	Test outcome Predictors and Outcomes	161
Table 59.0	Incidence of impairment at 24 months (%)	162
Table 60.0	Premorbid and one month predictors of impairment at 24 months	165
Table 61.0	Premorbid and one month predictors of death at 24 months	166

	LIST OF FIGURES	
Figure	Title	Page
Figure 1.0	Study recruitment schema	69
Figure 2.0	Functional Independence Measure ICU patients and Controls recovery over time	81
Figure 3.0	Digit Span Test Outcomes	83
Figure 4.0	Letter Number Sequence Test Outcomes	85
Figure 5.0	Trailmaking B Test outcomes - z scores	86
Figure 6.0	Trailmaking B Test outcomes - seconds	87
Figure 7.0	Stroop Task Outcomes - z scores	88
Figure 8.0	Stroop Task Test Outcomes	89
Figure 9.0	Impact of Events Scale – Revised (Total) Test Outcomes	91
Figure 10.0	Impact of Events Scale – Revised (Component: Avoidance Test Outcomes)	93
Figure 11.0	Impact of Events Scale – (Component: Hyperarousal)	94
Figure 12.0	Impact of Events Scale-Revised (Component: Interruptions) Test Outcomes	95
Figure 13.0	Hospital Anxiety and Depression Scale test Outcomes	96
Figure 14.0	Hospital Anxiety and Depression Scale – Anxiety Subscale Test Outcomes	97
Figure 15.0	Hospital Anxiety and Depression Scale – Depression Subscale Test Outcomes	98
Figure 16.0	Community Integration Test Outcomes	99
Figure 17.0	SF-36v2 Physical Component Score Test Outcomes	100
Figure 18.0	SF-36v2 Mental Component Score Test Outcomes	101
Figure 19.0	SF-36v2-BP (Bodily Pain)	102
Figure 20.0	SF-36v2-GH (General Health)	103
Figure 21.0	SF-36v2-MH (Mental Health)	104
Figure 22.0	SF-36v2-PF (Physical Functioning)	105
Figure 23.0	SF-36v2-RE (Role Emotional)	106
Figure 24.0	SF-36v2-RP (Role Physical)	107
Figure 25.0	SF-36v2-SF (Social Functioning)	108
Figure 26.0	SF-36v2-VT (Vitality Component) Test Scores	109
Figure 27.0	Digit Span Task Outcomes for subgroups	110

Figure 28.0	Letter Number Sequence Test Outcomes for subgroups	115
Figure 29.0	Stroop task Test Outcomes for subgroups	119
Figure 30.0	Trailmaking B Task Test Outcomes for subgroups (seconds)	117
Figure 31.0	SF-36v2 Mental Component Score Test Outcomes for subgroups	118
Figure 32.0	Community Integration Questionnaire Test Outcomes for Subgroups	119
Figure 33.0	Functional Independence Measure Test Outcomes for Subgroups	120
Figure 34.0	SF-36v2-PCS Test Outcomes for Subgroups	121
Figure 35.0	Impact of Events Test Outcomes for Subgroups	122
Figure 36.0	Digit Span Impairment over time (controls and ICU patients	125
Figure 37.0	Letter Number Sequence Impairment over time (controls and ICU patients)	126
Figure 38.0	SF-36v2 Physical Component Score Impairment over time (controls and ICU patients)	127
Figure 39.0	SF-36v2 Mental Component Score Impairment over time (controls and ICU patients)	129
Figure 40.0	Social Impairment over time (controls and ICU patients)	130
Figure 41.0	Mobility Impairment over time (controls and ICU patients)	132

#### LIST OF APPENDICIES **Appendix** Title Page Appendix 1.1 Functional Independence Measure (Recovery over Time) 191 Digit Span Task (Recovery over Time) 192 Appendix 1.2 Letter Number Sequence (Recovery over Time) 193 Appendix 1.3 194 Trailmaking Task - B (Recovery over Time) Appendix 1.4 195 Appendix 1.5 Stroop Task (Recovery over Time) Appendix 1.6 Impact of Events Scale – Revised (Total) (Recovery over Time) 196 197 Hospital Anxiety and Depression Scale Task (Recovery over Time) Appendix 1.7 Hospital Anxiety and Depression Scale – Anxiety Subscale (Recovery over Time) 198 Appendix 1.8 Hospital Anxiety and Depression Scale – Depression Subscale (Recovery over Time) 199 Appendix 1.9 Appendix 1.10 Community Integration Questionnaire (Recovery over Time) 200 SF-36v2 Physical Component Score (Recovery over Time) 201 Appendix 1.11 Appendix 1.12 SF-36v2 Mental Component Score (Recovery over Time) 202 Appendix 1.13 SF-36v2-BP (Bodily Pain) Test Scores (Recovery over Time) 203 Appendix 1.14 SF-36v2-GH (General Health) Test Score (Recovery over Time) 204 Appendix 1.15 SF-36v2-MH (Mental Health) Test Scores (Recovery over Time) 205 SF-36v2-PF (Physical Functioning) Test Scores (Recovery over Time) 206 Appendix 1.16 SF-36v2-RE (Role Emotional) Test Scores (Recovery over Time) 207 Appendix 1.17 Appendix 1.18 SF-36v2-RP (Role Physical) Test Scores (Recovery over Time) 208 Appendix 1.19 SF-36v2-SF (Social Functioning) Test Scores (Recovery over Time) 209 SF-36v2-VT (Vitality Component) Test Scores (Recovery over Time) Appendix 1.20 210 Mini-Mental State Examination Test Scores Appendix 1.21 211 Appendix 1.22 Trailmaking Task - B Test Scores 212 Appendix 1.23 Stroop Task z Scores 213 Impact of Event Scale – Revised (Component: Avoidance) Test Scores Appendix 1.24 214 Appendix 1.25 Impact of Events Scale – Revised (Component Hyperarousal) Test Scores 215 Appendix 1.26 Impact of Events Scale-Revised (Component: Interruptions) Test Scores 216

Appendix 2.1	Digit Span Task Score for subgroups	217
Appendix 2.2	Letter Number Sequence Test Scores for subgroups	218
Appendix 2.3	Stroop Task Test Scores for subgroups	219
Appendix 2.4	Trailmaking Task - B Test Scores for subgroups (seconds)	220
Appendix 2.5	SF-36v2 Mental Component Score Test Scores for subgroup	221
Appendix 2.6	SF-36v2 Physical Component Score test Scores for subgroups	222
Appendix 2.7	Impact of Events-Revised Test Scores for subgroups	223
Appendix 2.8	Hospital Anxiety and Depression Test Scores for subgroup	224
Appendix 2.9	Community Integration Questionnaire Test Scores for subgroup	225
Appendix 2.10	Functional Independence Measure test Scores for subgroups	226
Appendix 2.11	Statistical significance of diagnostic subgroups	227
Appendix 3.1	Social Impairment (Freq; %)	228
Appendix 3.2	Mobility Impairment (Freq; %)	229
Appendix 4.1	Premorbid indicators of impairment at 24 months	230
Appendix 4.2	Premorbid indicators of death at 24 months	231
Appendix 4.3	One month indicators of death at 24 months	232
Appendix 4.4	One month predictors of impairment at 24 months	233
Appendix 5.1	Employment status (Controls)	234
Appendix 5.2	Employment status (ICU Cases)	235
Appendix 6.0	Protocol for semi-structured interviews	236
Appendix 7.0	Protocol for test administration	237
Appendix 8.0	Technical appendix	238
Appendix 8.1	Predictors of impairment	239
Appendix 8.2	Mixed-model regression	240

## List of Abbreviations

ACT	Adult Changes in Thought Study	LOS	Length of stay
ADL	Activities of Daily Living	MASS	Mean Age Scaled Score
APACHE	Acute Physiology & Chronic Health Evaluation	MCS	SF-36v2-Mental Health Component
ARDS	Acute respiratory distress syndrome	МН	Mental Health
ASS	Age Scaled Score	MMSE	Mini Mental Health Examination
ВР	Bodily Pain	NART	National Adult Reading Test
CACI	Chronic age and comorbidity index	PCID	Post critical illness disease
CI	Confidence Interval	PCS	SF-36v2 -Physical Health Component
CAM-ICU	Confusion Assessment Method for ICU	PF	Physical Function
ccu	Critical Care Unit (used interchangably with ICU)	PICS	Post Intensive Care Syndrome
CIQ	Community Integration Questionnaire	POCD	Post-Operative Cognitive Dysfunction
DS	Digit Span	POMS	Profile of Mood States
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4th Edition	РТА	Post Traumatic Amnesia
FIM	Functional Independence Measure	PTSD	Post Traumatic Stress Disorder
FSIQ	Full Scale Intelligence Quotient	QOL	Quality of Life
GH	General Health	RE	Role Emotional
GOS	Glasgow Outcome Scale	ROD	Risk of death
HADS	Hospital Anxiety and Depression Scale	RP	Role Physical

HADS-A	Hospital Anxiety and Depression Scale-Anxiety	SD	Standard deviation
HADS-D	Hospital Anxiety and Depression Scale-Depression	SF	Social Function
HRQoL	Health Related Quality of Life	SF-36v2	Short Form 36 version 2
ICU	Intensive Care Unit (used interchangably with CCU)	SIP	Sickness Impact Profile
ICU patient	Participant admitted to a ICU unit; used interchangeably with case	SNST	Stroop Task
ICUAW	Intensive Care Unit Acquired Weakness	SOFA	Sequential Organ Failure Assessment
IES-R	Impact of Events Scale-Revised	STOIC	Study of outcomes of intensive care
IQ	Intelligence Quotient	TMT-A	Trailmaking Task - Test A
LNS	Letter Number Sequence	TMT-B	Trailmaking Task - Test B

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### **CHAPTER 1**

### Introduction

Consideration of issues such as quality of life and physical disability often influence decisions surrounding treatment limitation. The burden of the illness whilst borne directly by patients, often flows on to their families and health and social service providers within the community. Uncertainty of patient outcomes after critical illness raises the issue of whether current treatments are providing acceptable outcomes, and questions the wisdom of the high investment in such treatment resourcing.<sup>1</sup>

### Background to the problem

Historically, the discipline of Critical Care Medicine arose though times of epidemics and war, where the main focus were the management of ventilation support, resuscitation, shock and major trauma. Today the focus of health care delivery for critically-ill patients still lie in acute life-threatening conditions but the battle lines are not so clearly defined. While the threat of war and pandemics still exist, contemporary critical illness is borne, in the main from the multiplicity of acute on chronic illness.

This not so subtle change of critical care focus from treating victims of war and epidemic to maintaining an increasingly aging, chronically sick population means the need for improving clinical effectiveness and cost-efficiency is becoming increasingly apparent. From the days of 'saving a life no matter the cost', we are now struggling to intelligently devise processes to equitably limit life-saving efforts. Albeit shrouded by increasing fiscal constraint, 'patient treatment limitation orders' aims for informed admission to critical care units. Difficult treatment decisions once made solely by Intensivists are now being balanced by realistic lay public expectations. Healthcare providers are now mandated to partner with consumers to make decisions together.<sup>2,3</sup>

Arguably the expectation of first-world health care for most consumers, conjures up images of open-access to unlimited numbers of highly technologically advanced critical care units, serviced by the very best and brightest and committed health care professionals. There has

been very little consultation or thought devoted to equipping patients and families with meaningful information regarding long-term outcomes. While the 'patient focus' idealology has been part of the hospital mission statement, there remains very little shared decision making or consumer involvement in the provision of critical care. While there is increased administrative pressure to optimise critical care beds, currently we do not hold an instrument which can predict morbidity of survivors of critical illness. With research showing high mortality rates and associated long-term impairments, it is the survivor who questions the value-for-service against quality of life. Survivors are concerned with real-life outcomes, how they and their families are able to live with the consequences of critical illness knowing a significant social cost is also carried by the greater community.

Similarly physicians and researchers are struggling, still heavily relying on mortality prediction models at unit admission and hospital discharge or at 28 days following admission, to help triage,<sup>4</sup> clarify treatment recommendations and assess outcome.<sup>5,6 7</sup> Only recently have clinicians questioned their actions in regard to the quality of life of patients and families, long-term. Providing life-saving treatment to patients without knowing their long-term outcome may not be providing appropriate care.

Consequently, long-term outcome information is not only fundamental if we intend to invite consumers to make informed decisions to accept or forego life sustaining treatment. In order to meet these challenges of critical-socio health reform, higher standards of health literacy are required by the patient, the medical community, the legal fraternity, health administrators and policymakers. The evolving context of critical health care mandates the blue-print for standardised outcome measurement design.

Previous research undertaking long-term follow-up of ICU patients have been criticised for such inconsistencies as varying test batteries, use of invalidated instruments, inconsistent follow-up timepoints, and patient populations and study design, including lack of control groups with lack of evidence of premorbid function. In 1997 Ridley<sup>8</sup> conducted a meta-analysis of outcome measures for adult critical care. It was concluded that it was impossible to reach a valid and reliable overview of the recovery of survivors of critical illness from the existing literature. Despite Ridley's observation of the difficulties comparing across studies, to date there is no standardised and validated procedure for monitoring patient progress

over time that enables the mapping and long-term recovery and the needs of the survivors of critical illness.

The diverse range of results in the literature highlights the lack of standardised approach. Research shows that survivors of critical care treatment suffer "post intensive care syndrome" (PICS). This consists of wide variability of deficits across functional, 10,11 neuropsychological 12-18 and psychosocial 19,20 domains with associated diminished quality of life. 12,21-25 There is no accepted definition of what constitutes critical illness or PICS, whether it is a chronic state of disability or merely a temporary state of dysfunction. Nor is PICS isolated to one specific diagnostic subgroup 18 or specific diagnostic criteria; yet studies into PICS describe a similar pattern of deficit.<sup>3</sup> Following critical illness, a high proportion of survivors suffer dramatic weight loss and weakness, are often unable to think, care for themselves independently, and subsequently endure long-term unemployment and isolation. Symptoms often persist for many years, resulting in a chronic state of disability, a state resembling a moderate form of dementia. 18 This is accompanied by an enormous emotional and physical burden for both patients and their relatives. Kress<sup>1</sup> also acknowledges that a downward trajectory of functional disability, whilst may be exacerbated by critical illness, may be predominantly driven by progression of underlying chronic disease. In which case, admission to ICU may not alter their ultimate outcome and may potentially induce greater disability or impairment.

The term PICS has been loosely derived from studies of varying methodologies, populations and levels of evidence. When designing a study battery for survivors of critical illness, a global assessment incorporating the complexity of critical illness sequelae, accounting for the cofounders such as diversity of ages, comorbidities and social supports is required. It has been suggested the strongest studies which measure outcome, methodologically, are those where self-report measures are used in conjunction with standardised clinical interview. <sup>26</sup>

This approach ensures a patient-centred approach superimposed on an inventory of standardised criteria and symptom severity. Comparing the outcomes of survivors of critical illness with hospitalised controls (who have not experienced critical illness) is important for the generation of accurate recovery curves surrounding illness rather than recovery curves of healthy general community populations. The wide variability of deficit in outcomes among

survivors, suggest PICS may be an extension of symptoms superimposed on a population already in a state of physical and psychological distress, but this is not proven. Very few studies use the hospitalised patient as a control population, the majority using normative data or other critically ill diagnostic subgroups. The importance of a control group is highlighted by Johnson<sup>27</sup> stating without the controls, studies may erroneously over or under emphasise trends.

While there has been criticism of test batteries for incorporating instruments not validated among ICU patients and lack of consistency of follow-up methodology<sup>7</sup> it perhaps is a reflection of the phases of outcome measurement development. Long-term outcome measurement evolved initially among disease-specific populations, such as Acute Respiratory Distress Syndrome (ARDS)<sup>14,28</sup> which incur difficulties when applied to heterogeneous, general critically ill populations. A process for measurement is best achieved if it is built on fundamental themes signified relevant to survival and adaptation by this population. Understanding how patients and carers adapt their lives according to chronic disability seems essential in achieving a complete test battery which is pertinent and truly reflective of their experience. Methods such as symptom scaling, neuropsychological testing and narrative analysis are acknowledging a state of enquiry which cannot be currently universalised, where the comparative standard is not yet fixed.

Exactly what long-term outcome means and the ideal timepoints including the period of follow-up have been contested. Ridley<sup>19</sup> suggests that survivors of critically illness should be followed-up until their survival curves match those of a comparable or general population, estimated 1-4 years duration. From this, a plethora of studies of varying lengths and methodologies have emerged. Acknowledging studying long-term follow-up is logistically difficult, prohibitively expensive and often plagued with high attrition rates, the critical care community still calls for a universally sustainable, standardised outcome methodology. Currently there is no standardised process for follow-up.

### Justification of the research

This study adds to the body of literature surrounding long-term outcomes after critical illness. It provides a broad description of morbidity, across functional, neuropsychological

and psychosocial domains. Patient self-report helps characterise recovery during the first 24 months following critical care discharge. Recruiting non-ICU acute-care hospitalised controls places the ICU patient onto an illness continuum acknowledging the existence of chronic states of ill-health and hospitalisation. Providing this controlled comparison will accurately define the as yet unresearched non-ICU, acute-care hospitalised population. It will also help determine if critical illness truly promotes the development of new cognitive impairment <sup>29</sup> or discover if the cognitive impairment is merely an extension of an unrecognised occult epidemic, surrounding chronic ill-health.

Predicting long-term outcome on admission will provide far reaching benefits on many levels. This study will assist patients and families make informed treatment choices to ensure appropriate care. Conversely, it will assist clinicians reduce the occurrence of inappropriate care, (being either unwanted or unnecessary). 30-32 Allocating limited resources to target early interventional rehabilitation will produce clinically and cost effective outcomes. These study findings will inform and potentially change current practice.

This study aims to:

### **Study Primary Aims**

- Determine the incidence of functional, neuropsychological and psychosocial impairment of patients surviving critical illness 24 months following ICU discharge;
- Determine the level of functional, neuropsychological and psychosocial impairment of patients surviving critical illness over a 24 month period following ICU discharge;
- Track the functional, neuropsychological and psychosocial recovery of patients surviving critical illness over a 24 month period following ICU discharge.

### **Secondary Aims**

 Determine baseline variables associated with outcome (not impaired, impaired and death) 24 months following ICU discharge; Examine common themes and characterise the subject's recovery during the first
 24 months following ICU discharge.

### Outline of the study chapters

In order to address the above study aims, this thesis have been divided into 6 chapters; introduction, background, methods, results, discussion and conclusion.

The main aim of the background chapter is to provide a thorough, narrative review of the literature highlighting the current context and significance surrounding issues relating to the recovery of intensive care survivors. These include issues relating to long-term study methodology; including the lack of a standardised test battery or time points. Many areas of deficits are discussed, including physical, neuropsychological and psychosocial impairments which are widely cited as common impairments in the critical care survivors. Study instruments are also discussed and reviewed. The literature reviewed, informed the current study design.

Chapter 3 describes the study model incorporating all areas of study methodology, procedural and analytical. Being a study of long term outcomes, it was important to incorporate instruments used locally and internationally, and possible, all instruments used are validated in the area of critical care. This chapter also outlines the control population; the recruitment of age- sex- non-ICU acute care hospitalised controls provides a novel approach in this area of research. Follow-up timelines are outlined and importantly, highlights the use of the premorbid (retrospective) data collection. Methods for statistical analysis are outlined in this chapter, incorporating descriptive statistics, mixed model analysis and predictive modelling. Narrative analysis and narrative trajectory analysis are described.

Chapter 4 outlines all results generated, detailing descriptive demographic characteristics and analyses. Extensive results are framed for the overall functional, neuropsychological and psychosocial recovery trajectories over a 24 month period. These include narrative,

thematic analyses and further, narrative trajectories which enhances the richness of the study data.

Chapter 5, the discussion, places the study's novel data into the context of the current body of research. Finally Chapter 6 provides an overall summary of all factors and issues identified with recommendations for potential areas of further research.

### **CHAPTER 2**

### Background

#### Search Methods

This literature review examined results, their relevance and utility in ICU and non-ICU, acute-care hospitalised patients. Relevant papers were identified and retrieved from a search using the bibliographic databases Medline, EMBASE, Cochrane Library, CINAHL, PsycINFO. Personal files and the reference lists of relevant review articles were hand-searched. The following search strategy was used. All terms (incorporating the Glossary of Terms) were mapped to the appropriate MeSH/EMTREE subject headings and "exploded", using, for example, ("intensive care units" or "critical care" OR "critical illness"). Search results were filtered for English-language. There were no limits regarding publication dates.

The literature review in this thesis employs a 'narrative' approach. This narrative review examines the evidence surrounding the functional, psychosocial and neuropsychological recovery of ICU survivors and non-ICU acute-care hospitalised controls across the pre-hospital to post-hospital continuum of illness. It reviewes the current evidence base for assessing a very wide range of factors; physical function, quality of life, psychosocial problems including anxiety and depression, community integration and neuropsychological measures relevant in these populations, intensive care unit utilisation, mortality, study methodology including time-points and study design.

To incorporate a thorough review of the literature across so many study areas within such an extensive study, lends to a narrative approach. The narrative review style allows for a more integrated overview, with a flow which incorporates all systematic literature reviews published within individual study areas. As with all literature reviews however, it is never possible to be certain that all studies are included as, for example, often negative studies are not published; authors, editors and reviewers being more inclined to give priority to large and/ or positive trials. However, all land-mark papers, systematic reviews / meta-analyses have been included and discussed.

Literature surrounding the outcomes of survivors of critical illness shows survivors commonly suffer ongoing cognitive, psychological and physical impairment. Over twelve years ago the European Society of Intensive Care Medicine recognised the importance of long-term follow-up of ICU patients recommending Health-Related Quality of Life (HRQoL)<sup>6,33</sup> as an all-encompassing endpoint, yet highlight the need for further methodological research in the area of long-term outcomes. A decade on, many authors have listed an extensive range of long-term impairments, broadly profiled as PICS. Currently no diagnostic criteria or universal definition exists or a standard to measure its outcome. Broomshead and colleagues<sup>10</sup> agree, emphasising this outcome data is urgently needed at all levels, by the individual, the healthcare system and society in general. Today the same fundamental problems of instrument design, insensitivity, validity<sup>7,34</sup> and study methodology<sup>35,36</sup> remain.

The majority of studies of long-term outcomes incorporate low-level evidence, predominantly observational studies. Systematic reviews surrounding quality of life highlight such challenges and limitations as inconsistent methodological frameworks, small sample sizes with high loss to follow-up. Such factors reduce the generalizability of results and may lead to inaccurate inferences.

Currently, the central tenet of PICS is the presence of a diverse range of deficits across physical, neuropsychological and psychological domains with variable rates of recovery. Cognitive assessments of PICS sufferers describe impairments to attention 14,16,40-42 memory, 14,16,40,42-45 executive function, 14,16,41,42,46,47 mental processing speed, 14,16,41,43,46,47 visuospatial ability 14,16,43 41,48 and general cognitive decline. 14,16,41,44,46 Functional impairment in PICS includes weight loss, reduced muscle mass, myopathy and polyneuropathy, often termed critical illness polyneuromyopathy (CIPM) 49-51 resulting in muscle wasting and fatigue. 52,53 Intensive care unit acquired weakness (ICUAW) broadly describes generalised weakness and muscle wasting, which can manifest itself as difficulty performing activities of daily living. 51,54 Kress¹ describes a spectrum of muscle, nerve and brain dysfunction directly attributable to critical illness and associated therapies. Psychological impairment commonly incorporates anxiety, depression, 55,56,57,58 delirium and post-traumatic stress disorder (PTSD). 19,26

PICS is not isolated to one specific diagnostic subgroup. Patients suffering severe sepsis<sup>17</sup> multiple organ dysfunction,<sup>59,60</sup> ICU re-admission<sup>61</sup> and ARDS<sup>28,62-64</sup> describe the same pattern of physical and psychological deficit that persist after hospital discharge.<sup>39</sup> The outcome information derived from specific patient cohorts has limited applicability to the general, heterogeneous population.

The varying study methodologies make drawing across-study comparisons from the literature surrounding the outcome of ICU patients difficult. It is essential to design a test battery which is sensitive enough to detect the slightest impairment. 65 Currently the critical care outcome literature is based on studies with varying test batteries incorporating varied follow-up time points, homo- and heterogeneous patient populations and variable study design, including lack of control groups or evidence of premorbid function. <sup>6,7,37,66</sup> Variation between examiners, testing environments and residual effects of medications are factors which should be acknowledged and minimised. The literature includes a mix of subjective and objective tests and the use of invalidated instruments within the critically ill population. Wider considerations such as cultural and language diversity, floor and ceiling effects of tests, test sensitivity or the selection of parameters for evaluating tests, statistically or clinically, as a research community has not yet been decided. Practice effects of neuropsychological tests are often not considered (or declared) when planning or reporting test versions or the potential effects of intervals between test sessions in longitudinal studies. Currently there is no general consensus of appropriate timeframes for follow-up of survivors of critical illness.

Baseline or premorbid function is necessary to comparatively detect ongoing improvement or deterioration. <sup>65</sup> Dowdy and colleagues <sup>37</sup> stress in their meta-analysis, concerns regarding the lack of studies with true baseline data or data prior to ICU admission, highlighting the difficulty when interpreting decrements at follow-up. Ridley <sup>8</sup> argues follow-up timelines may be too short for a reliable assessment of the recovery and often a longer time is needed to get accustomed to new disabilities or states of impairment. <sup>7</sup>

Health related quality of life (HRQoL) broadly reflects the causal influence of physical, psychological and cognitive components. Much of the early outcome work in ICU patients is derived from the ARDS population. One of the first studies of HRQoL in ICU patients was conducted in this population, <sup>67</sup> assessing HRQoL 3, 6 and 12 months after discharge. Despite recovery of lung function patients described impairments in HRQoL that persisted to 12 months and remained below levels of the normative, healthy population. Similarly, Jackson <sup>15</sup> showed the majority of his ARDS population had a moderate decline in HRQoL within the first year after discharge, followed by a long-term improvement. Notably, in those patients with a ICU stay of longer than two weeks, HRQoL at 12 months has been shown to be comparable to that of short-stay patients. <sup>15</sup>

Studies comparing the HRQoL in the general critical care population with a matched general population report clinically meaningful and statistically significant deficits (greater than 5 points) across all eight domains of the Short Form 36 Questionnaire (SF-36), in ICU survivors. 8,25,60,68, 69-71 However when comparing preadmission HRQoL (studies use proxy or retrospective data) to HRQoL 12 months post ICU discharge, there is clinically meaningful improvement (greater than 5 points) across all domains except for the General Health (GH) domain.<sup>8,12,25,72</sup> Only Role Physical (RP), Social Functioning (SF), Role Emotional (RE) show an initial clinically meaningful (>5-point) decrease at one month 25,72 before showing improvement. General Health perception did not show any clinically meaningful change throughout the 12 month study period, within any study. Hopkins<sup>47</sup> concludes the improvements in quality of life are uneven and are time and domain-specific. Although quality of life scores improve with time in most longitudinal studies, these often do not equate to clinically meaningful changes in function.<sup>34</sup> Studies assessing HQoL after critical care show clinically meaningful deficits<sup>37</sup> which improve over time<sup>7,68</sup> though long-term, health across these domains are worse than before admission 20,73,74 and also worse compared with general population norms.<sup>58</sup>

Many studies have since assessed quality of life at 6,<sup>22,23</sup> 9,<sup>25</sup> 12,<sup>11,58,60</sup> 18,<sup>75</sup> 24 months<sup>20</sup> and longer.<sup>69,76</sup> The deterioration in the patient's quality of life after ICU discharge found in most studies, occurred due to the physical impact of critical illness; finding that survivors were

unable to accomplish even the simplest of tasks without exhaustion due to such factors as muscle wasting, fatigue and impaired mobility. Kvale and colleagues<sup>20</sup> followed 346 ICU patients with an ICU length of stay of 24 hours or more, finding that six months post-discharge 32.4% were unable to continue pre-admission activities, 25% were unable to independently care for themselves, and 64.7% were unemployed, three times pre-admission levels. The authors found the most frequently diminished areas of health-related quality of life were those relating to work, recreation and sleep.

Interpreting recovery is complex. HRQoL is influenced by the patient's prior health status and their expectations for a return to premorbid functional status. Assessing HRQoL uncovers complex interactions. For instance, a patient who has sustained debilitating illness, but prior to the illness lived a sedentary life may report a more favourable outcome compared with a previously active person. Many patients suffer chronic disability and therefore carry a fixed degree of dysfunction prior to ICU admission. Wehler<sup>12</sup> and Graf<sup>25</sup> have shown that general ICU survivors who suffered multiple organ dysfunction have significantly lower (worse) SF-36 scores at baseline prior to admission (using retrospective patient or proxy responses) than population norms due to a higher burden of comorbid disease. At six month follow-up, 83-90% of survivors had regained their previous HRQoL and 94% were living at home with their families.<sup>12</sup>

Hospital mortality of survivors of critical illness in Australia and New Zealand is 16.1%, a decrease of 4% over 11 years. Thowever little is known about the long-term outcome or quality of life in the Australian and New Zealand intensive care survivor population. Brooks and colleagues concluded that 63% experienced poorer quality of life and more anxiety at 16 months post ICU discharge. Hackett conducted an Australian / New Zealand study looking at outcomes after one year in patients with subarachnoid haemorrhage (SAH) using the SF-36. It was concluded a high proportion of long-term survivors of SAH experience ongoing deficits in high level neuropsychological functioning. This data was derived from a highly selected series of patients, often excluding those who were most severely impaired. Denehy and colleagues studied physical function among survivors of an ICU admission greater than 5 days and demonstrated high levels of inactivity, with the majority not meeting international recommendations regarding physical activity.

#### **Functional Outcome**

A poor HRQOL is often a reflection of a poor functional outcome. Many studies cite physical function as a commonly occurring impairment suffered following critical illness. Hayes and colleagues<sup>7</sup> saw physical functional status diminish during the first few months among survivors after critical care discharge with 40% losing more than 10kg body weight. They concluded that body weight may return to pre-admission levels between six and twelve months. Some degree of dependency in activities of daily living persisted in about half the survivors. Hough<sup>82</sup> looked at ICUAW, myopathy and neuropathy and steroids within the persistent lung injury and found 34% of patients developed neuropathy during hospitalisation, however this study failed to provide any long-term study follow up. Subsequent studies evaluating ICUAW and neuromuscular blockers (cisatracurium)<sup>83</sup>have looked at ICUAW as a secondary outcome, concluding there was no difference between the two groups in the area of muscle strength. Sidiras and colleagues<sup>51</sup> assessed physical function among 37 critically ill survivors at hospital discharge and at 8 months after discharge. The authors concluded the impact of ICUAW was greatest in the short-term, having a significantly longer ICU and hospital stay. Functional impairment when assessed using the Functional Independence Measure (FIM), 84 showed immediate deficits in functional ability with improvement at the eight month time point. The authors concluded ICUAW has a negative functional impact, prolonging their hospitalisation. Wehler<sup>12</sup> reports higher scores of impairment in the mental profiles than the physical profiles with 20% of ARDS survivors meeting standard self-reported criteria for PTSD.

To accurately meter the diverse range of functional effects related to critical illness, the STOIC study incorporates a functional measure while assessing quality of life. The current study uses validated tools over a longitudinal period of follow-up which allows adequate rehabilitation and recovery following discharge.

### **Neuropsychological Outcome**

Both HRQOL and functional outcomes are influenced by cognitive function. The mechanisms surrounding the prolonged neuropsychological impairment seen among survivors of critical care are poorly understood<sup>18</sup> but are likely multiple with evidence suggesting sepsis,<sup>17</sup>

delirium $^{15, 85}$  hypoxaemia,  $^{14,86,48,87,88}$  glucose dysregulation, $^{48}$  coagulopathic derangements, $^{14,89}$  systemic inflammation  $^{90}$  and the effects of sedatives and narcotics  $^{91}$  among other factors.

In the neuropsychological domain, founding work by Hopkins, Weaver and Pope<sup>14</sup> showed large cognitive deficits in ARDS survivors. In a cohort of 55 ARDS patients after mechanical ventilation, 100% of patients had unfavourable cognitive sequelae at hospital discharge reducing to 30% at one year, demonstrating cognitive dysfunction in the domains of memory, attention and concentration and later, processing speed and executive function. Further work by these researchers <sup>44</sup> found that after two years there was improvement however 70% of the cohort continued to perform 1.5 *SD* below normative population value. They also found high levels of anxiety and depression and PTSD.<sup>92</sup>

In the ARDS literature Rothenhausler<sup>40</sup> studied a cohort of 46 ARDS survivors, finding 25% suffered cognitive impairment (deficits were noted in the area of speed of information processing) and disability 6 years following hospital discharge and as a consequence, only 46% were able to return to full-time employment. Suchyta<sup>42</sup> also studied a cohort of ARDS survivors with sepsis for a mean of six years following hospital discharge. They found cognitive impairment in 75% of survivors. Subsequently other investigators have confirmed that ICU survivors are at high risk for cognitive impairment that may persist years after recovery from critical illness. Al-Saidi<sup>45</sup> assessed neuropsychological function prospectively in a cohort of 87 ARDS survivors following ICU discharge, finding 20% rated their memory as poor, with the majority unable to return to work.

Marquis<sup>41</sup> compared outcome of 33 ARDS survivors with other critically ill patients in a case-controlled study. At one year the ARDS patients were significantly more impaired in areas of executive function, mental processing speed, and attention than critically ill controls. The authors proposed factors such as the disease process or the ICU treatment course were contributors to the impairment.

Sukantarat and colleagues<sup>46</sup> further add to the literature, describing an association between critical illness and long-term cognitive impairment. They studied a cohort of 51 ICU survivors at 3 and 9 months after ICU discharge, finding 35% had impaired executive function at 3

months, improving at 9 months, however remaining impaired when compared to population norms. The study comparatively measured executive dysfunction and intellectual ability. The authors proposed the executive dysfunction was likely due to generalised brain injury rather than focal frontal lobe damage, usually associated with executive function.

Larson<sup>93</sup> examined 78 ARDS survivors, specifically assessing the relationship between ICU recall and cognitive function. The mean age of the cohort was 45 years and the study battery consisted of standardised neuropsychological tests, together with structured interview. The battery was administered to all survivors at hospital, and one and two years following hospital discharge, assessing general intelligence, attention, verbal and visual memory, processing speed, executive function and visuospatial abilities. Approximately 24% had no recall of their ICU experience and found there was greater magnitude of cognitive sequelae in the no-ICU recall group at hospital discharge, one and two year follow-up; scoring significantly worse in areas of general intellectual function, executive function, processing speed and verbal memory.

An episode of cognitive impairment may result in new and often persistent disability, in some cases even resembling dementia. <sup>13,15, 17, 18</sup> Studies to date indicate that cognitive function improves during the first 6 to 12 months after hospital discharge and remains consistent and disabling for up to 6 years after discharge. <sup>94</sup> This suggests that while some recovery occurs initially, chronic cognitive impairments persist in many patients.

Cognitive impairment has been reported extensively in the post-operative and anaesthesia population, commonly termed post-operative cognitive dysfunction (POCD). POCD broadly describes a range of impairments of memory, learning, attention and processing speed, traits similar to those described in PICS. A meta-analysis of POCD among elderly surgical orthopaedic patients found no evidence of impairment, when compared with controls at 3 to 6 months post surgery. When examining the effects of anaesthetic agents and the incidence of POCD, results of a meta-analysis of twenty-one studies found no statistical significance of the association of general anaesthesia and POCD.

The association of cognitive dysfunction in patients following cardiac surgery is well documented with a reported incidence of 20 - 35% persisting for several months after surgery, thought to be associated with the effects of cardiopulmonary bypass during surgery. <sup>97, 98,99, 100</sup> Novel results reported by Rodig and colleagues <sup>101</sup> showed cardiac and noncardiac surgery patients self-reported significantly more cognitive impairment following surgery than pre-operatively.

To accurately meter the diverse range of neuropsychological effects related to critical illness, the STOIC study incorporates a broad test battery which assesses short-term working memory and executive function.

# **Psychosocial Outcome**

Functional and neuropsychological impairment is often reflected in a poor HRQOL<sup>7</sup> and may be manifested in a multiplicity of psychological impairments or distress. Psychological problems associated with critical care have been widely reported, especially in the areas of delirium, anxiety, depression and post-traumatic stress. 102-104

#### Delirium

Patients being supported by a ventilator receive numerous psychoactive medications for sedation and analgesia plus neuromuscular blockade to increase their comfort and tolerance of treatment modalities during the ICU stay. These medications, along with underlying comorbidities, advancing age, and factors such as multiple-system illnesses place ICU patients at extremely high risk for delirium.<sup>18</sup> Severe psychological upset may present as nightmares and delusions and such consequences of critical illness may impinge on the quality of life.

Girard<sup>13</sup> studied delirium duration and long-term cognitive impairment. They showed an association between delirium and cognitive impairment in a study of 126 mechanically ventilated medical intensive care unit with an average age of 61 years. Using the Confusion Assessment Method for ICU (CAM-ICU) at 3 and 12 months post discharge, the duration of delirium was independently associated with long-term cognitive impairment; an increase in delirium of 1 to 5 days was associated with decline of almost seven points in the cognitive

battery mean score at 12 month follow-up (p = 0.03). Girard proposed it is possible that a significant proportion of the patients studied in non-ICU cohorts had undiagnosed dementia or mild cognitive impairment, a syndrome thought to be a precursor to dementia  $^{105}$  or a progression of pre-existing disease. Delirium has been proposed as a marker of impaired brain reserve attributable to chronic disease or subclinical dementia among older patients.  $^{106}$  Pandaharipande  $^{18}$  found in a study of adults with respiratory failure or shock, that 74% developed delirium during their hospital stay. They found 34% of older and 24% of younger patients measuring cognitive impairment 2 SD below the population mean at 12 months; describing this level of impairment as similar to patients with moderate dementia.

# Anxiety, Depression

Critical illness and ICU treatments expose patients to many stressors including respiratory insufficiency, discomfort with endotracheal tube suctioning, administration of exogenous catecholamines and delirium with associated psychotic experiences, all within the context of a limited ability to communicate and reduced autonomy. ICU survivors also face significant physical limitations during recovery. From these experiences, the symptoms of anxiety and depression are a potential concern in ICU survivors. Anxiety and depression following critical illness negatively impacts HRQOL<sup>107</sup> and delays return to work. ICU survivors.

The reported prevalence of anxiety and depressive problems in ICU survivors ranges from 12 to 43% for anxiety 58,109 and between 10 and 30% for depression. 55-58,109 In examining anxiety and depression in patients with acute lung injury, 3 months after discharge Dowdy and colleagues 37 identified risk factors and predictors of preadmission depression, alcohol dependence, female sex, younger age and presence of cognitive sequelae. Davydow 103 examined the relationship between admission to the ICU and subsequent depression in pre-existing cohort of 3596 patients with diabetes in the pathways epidemiologic follow-up study of the group health cooperative. Of this cohort 98 patients were admitted to ICU and had completed premorbid assessments and assessment after ICU. Among these patients the point prevalence of probable major depression using the Questionnaire-9 was 14% compared with 6% in those without an ICU admission.

Davydow and colleagues<sup>102</sup> conducted a systematic review of depression in general intensive care unit survivors. Of the fourteen studies eligible studies, the prevalence of 'clinically significant' depression was 28% (n = 1213). The authors found that while age, sex, severity of illness at ICU admission were not consistent risk factors of post-ICU depression, early post-ICU depressive symptoms were a strong risk factor for subsequent depressive symptoms. They also conclude post-ICU depressive symptoms were associated with substantially lower HRQOL.

McKinley and colleagues<sup>78</sup> used the IES-R and SF-36 (MCS) to measure impaired mental health, anxiety, depression, stress and psychological distress. They found female gender, younger age and sleeping problems were associated with impaired psychological outcomes.

#### Post-Traumatic Stress Disorder

The diagnosis of acute PTSD, defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV)<sup>110</sup>,includes a set of symptoms experienced for at least one month and includes symptoms of dissociation, intrusion, avoidance and hyperarousal. Greater than one month yet less than three months defines acute PTSD and greater than three months terms chronic PTSD. Two reviews estimate that 5 – 64% of critical care patients may develop either PTSD or its associated symptoms that may endure for a number of years. However the studies reporting on the rates of PTSD and PTSD symptoms in ICU survivors vary considerably in their case mix, demographic variables and method and timing of PTSD assessment. A meta-analysis by Griffiths and colleagues confirms existing research that severity of illness does not appear to be predictive of the development of PTSD.

High levels of anxiety and the development of PTSD are recognised as significant problems occurring following an ICU admission<sup>55,111,112,40,113</sup> and may compromise patient recovery. These traumatic memories consist of clear and vivid recall of emotionally relevant experiences such as hallucinations and nightmares<sup>111,114</sup> but relatively little recall of factual events during their ICU stay.<sup>114,115</sup> It has been suggested by Schelling<sup>111</sup> that the number of adverse memories that patients can recall of the ICU is predictive of risk for PTSD. Jones<sup>55</sup>

hypothesised that even fragmentary explicit memories of real events in the ICU may reduce the emotional impact of delusional memories, by allowing the patient to question the reality of the delusions<sup>114</sup> and be protective against the development of PTSD-related symptoms.

Memories of vivid nightmares, hallucinations and paranoid delusions were prominent in a number of studies with patient recalling little to no memories for factual memories (such as suctioning). <sup>116</sup> Associations between delusional memories and psychological distress of ICU survivors have been mainly attributed to the strong vividness, long duration and high emotional content of these memories when compared with memories of real events. <sup>117,118</sup>

PTSD often coexists and interacts with anxiety and depression, and contributes to delayed recovery, suboptimal functional outcome, poor quality of life, sleep disorders and feelings of being detached from others. Four studies support the association between delusional memories and PTSD related symptoms while two studies support the association between delusional memories and anxiety and depression. 55,123

Several observational studies have found sedative exposure in the ICU to be an independent predictor of PTSD symptoms after critical illness. <sup>120,124-126</sup> Pandharipande <sup>127 128</sup> found that midazolam and other benzodiazepines promote ICU delirium, a leading candidate risk factor for PTSD after critical illness. Heavy sedation has found to be an independent risk factor for delirium. <sup>128</sup>

Treggiari and colleagues<sup>129</sup> conducted the first randomised controlled trial recruiting 137 patients to examine the psychological outcomes after mechanical ventilation among ICU patients with protocol-driven light versus deep sedation and found those in the light sedation group were less likely to report adverse psychological outcomes which confers the benefits of light sedation without causing psychological complications.

To accurately meter the diverse range of psychosocial effects related to critical illness, the STOIC study measures anxiety, depression, post-traumatic stress and levels of home and community integration.

Social and Economic Outcome of Critical Illness

Studies show surviving critical illness is often the start of prolonged rehabilitation, financial hardship and caregiver burden. ICU patients may experience a deterioration of quality of life after returning home increased mobility problems, pain and anxiety and depression, with families providing the ongoing care. Family members suddenly become informal carers; relationships are altered, often fuelled with financial strain and difficulty.

Economic consequences and burden is derived in the main, from ongoing post-hospital care. This can range from the need for long-term mechanical ventilation, the requirement of long-term acute-care, rehabilitation or skilled nursing facilities. Both authors highlight factors fundamental to cost projection models, in the area of post hospital care. These include the ability to perform activities of daily living and hospital readmission. Functional ability and levels of independence are important variables when considering the economic consequences of survivors of critical illness.

Daly and colleagues<sup>133</sup> found over 40% of their sample of patients who required mechanical ventilation for more than three days required rehospitalisation. Implementing a multidisciplinary plan of ongoing care reduced the length of rehospitalisation stay by more than five days, with an estimated associated cost saving of \$481,811.

Studies designed to reduce the economic burden associated with critical care survival focus on implementing such strategies as reducing physical debility by reducing sedation whilst in ICU<sup>134</sup> and increased early mobilisation. <sup>135,136</sup> Needham<sup>134</sup> showed by reducing sedative and analgesic doses while in ICU saw a reduction in number of cases of delirium (by 32%), a significantly higher level of function and a reduction in ICU and hospital days of 2.1 and 3.1 fewer days, respectively.

# Return to work

Return to work is a proxy measure of functional status. It is a single-item global measure that has been used in many studies but does not appear to have a consistent format. In all papers  $^{121,137-141}$  the mean ages of the participants ranged from 23 - 74 years with a ratio of male participants ranging from 29 – 86%. General ICU patients were followed-up in

13 papers and trauma survivors in eight. Construct validity was assessed in relation to age in 6 studies; 3 studies finding a statistically significant relationship and 3 failing to do so.

MacKenzie<sup>145</sup> also examined the relationship with gender, marital status and education. They found a significant association with education, but not with gender or marital status. Criterion validity was assessed by comparison with measures of impairment including the Glasgow Coma Scale (GCS) and mental functional status assessed using the Profile of Mood States (POMS), neuropsychological function assessed using the Trail Making Test - Trail A (TMT-A) and health-related quality of life assessed using the Sickness Impact Profile (SIP). Statistical significant associations were found with each measure (except for one dimension of the POMS in the study by Stambrook and colleagues<sup>146</sup>). None of the papers reported reliability. The responsiveness of the measure was not systematically assessed in any paper.

Hurel and colleagues<sup>23</sup> noted that employment status remained unchanged in 80% of subjects. However, there was a significant change in the level of work activity or employment capacity, from prior to after critical care. There was an in increase in the number of retired survivors and those on sick leave, and a decrease in the number of survivors in full- or part-time employment. Kriwanek and colleagues<sup>147</sup> showed that worsened employment status was noted by 25% of respondents in their study. MacKenzie and colleagues<sup>145</sup> noted that at one year following discharge, 17% of their patients were unable to work with Alho and Rokanen<sup>148</sup> reporting that 68% of their patients who were capable of returning to work had done so. Broome and colleagues<sup>149</sup> showed that 80% of individuals had been working before admission to critical care and of these, 70% had returned to work

within 10 months of discharge on average. Rowan<sup>142</sup> noted that 35% of survivors reported working full- or part-time before admission but of these, 42% were not working 6 months after discharge from critical care.

Overall, a fairly consistent pattern emerges. In the 16 studies that reported on the change in employment status, 11 found that over 70% of those in work before their critical care episode had returned to work. In some studies, the proportion resuming work was as high as 85-90%. In contrast, in some studies, work resumption proportions were as low as 45-55%, however these studies were predominantly of trauma victims.

Griffiths<sup>104</sup> showed at 12 months after discharge there is up to a 50% reduction in the number of patients who reported employment as their sole source of income. Families also report negative impacts financially and in the areas of employment up to 12 months following discharge.<sup>104</sup>

#### Residence

No attempt was made to identify the measurement properties of this single-item global measure outside critical care. Like 'return to work' this measure lacks a standardised format. There were 18 studies that reported using a place of residence as an outcome measure.  $^{150-152,153,137}$  The mean age of participants ranged from 44 - 88 years with 47 – 75% of participants being male. Six studies reported on follow-up at 6 months and 12 months. Ten papers reported measuring this outcome at several time points. Two papers made reference to the assessment of construct validity  $^{67,154}$  using the ages of patients, although neither paper explicitly tested for this type of validity. There were no attempts to assess criterion validity. There was no evidence for the assessment of reliability.

Residence and return to work are proxy measures that assume that those participants who have not reached a sufficient level of functional recovery are more likely to be institutionalised or to live at home with assistance and not able to return to work compared with those who have made a better recovery. There were 18 studies that reported using a place of residence as an outcome measure for critically ill patients. <sup>137,150,152,153</sup>

## Study Methodology

## **Timepoints**

The ideal timepoints for follow-up varies widely and is contested. Ridley<sup>8</sup> suggests that critically ill patients should be followed-up until their survival curves match those of a comparable / general population, estimating between one and four years. Drawing guidance from the largest study of quality of life in intensive care survivors, Niskaranen<sup>155</sup> and colleagues studied a cohort of 12 180 patients and found approximately 2 years was

needed for survival to parallel to that of the general population. Larson<sup>93</sup> also showed ARDS survivors showed significant group differences in general intellectual functioning, executive function, processing speed, and spatial skills at hospital discharge, resolving between the first and second year follow-up.

# Premorbid / baseline factors

There are few studies which have gathered premorbid or baseline data prior to critical care admission in the area of cognitive function. Unlike functional and HQoL measures, cognitive test data cannot be obtained retrospectively or via proxy. Three studies <sup>9,17,156</sup> cite baseline data which allows a true control for pre-existing decrements.

Ehlenbach<sup>9</sup> evaluated the risk of incident dementia among 2,929 survivors of critical illness and acute hospitalisation, 65 years and older, not living in a nursing home at baseline. Their cohort was a subset drawn from the Adult Changes in Thought Study (ACT), a population based longitudinal study of aging and dementia. Patients were followed for approximately 6 years with cognitive screening performed using the Cognitive Abilities Screening Instrument. Of the ACT cohort, 1,601 had no hospitalisations, 1,287 subjects had one or more noncritical illness hospitalisations and 41 subjects with one or more critical illness hospitalisations. They discovered that acute care and critical illness hospitalisations were independently associated with incident dementia, (almost double for critical illness hospitalisation), compared with participants who did not required hospitalisation. Additionally global cognitive decline was more common among participants requiring acute care hospitalisation. While the authors recognise such study limitations as the lack of a gold standard definition of what constitutes critical illness, lack of standardised study methodology and loss to follow-up of ICU patients (numbers not reported), this study found an important association between acute care and critical illness hospitalisations with greater cognitive decline.

Iwashyna<sup>17</sup> studied the survivors of severe sepsis in older adults, within the same ACT cohort drawing additional links to Medicare data. The cohort consisted of 1194 patients with a mean age at hospitalisation of 76.9 years. Patients were followed for 8 years prior to severe

sepsis and 8.3 years afterwards. Severe sepsis was independently associated with substantial and persistent new cognitive impairment and functional disability among survivors. In fact severe sepsis is independently associated with a tripling in the odds of moderate to severe cognitive impairment and the acquisition of 1.5 new functional limitations in patients with no, mild or moderate pre-existing functional limitations after controlling for baseline function and trajectory. They noted a substantial worsening in the trajectory relative to before their sepsis hospitalisation and surprisingly, the negative effects of severe sepsis were greater in those patients with better baseline physical functioning. In those with no limitations before sepsis, a mean 1.57 new limitations and for those with mild to moderate limitations before sepsis, a mean of 1.50 new limitations were seen. In contrast, nonsepsis general hospitalisations were associated with fewer new limitations.

Barnato<sup>156</sup> used the population-based longitudinal cohort study of Medicare recipients to investigate the association of mechanical ventilation and disability. The parent study conducted in person interviews four times each year for 4 years including a mobility difficulty score and weighted activates of daily living (ADL) score. The patients were 65 and older and living in the community with pre hospitalisation and post hospitalisation interview. Survivors of hospitalisation with or without mechanical ventilation had similar levels of disability. The level of disability within both hospitalised groups was significantly greater than those who were not hospitalised. In adjusted analyses mechanical ventilation was associated with a 30% greater disability in ADL and a 14% greater disability in mobility.

Studies demonstrated that previously healthy patients who suffer critical illness tend to suffer greater deterioration in their HRQoL than individuals who had a lower HRQoL status prior to ICU admission.<sup>24</sup> <sup>11,12</sup> These studies lead to the conclusion that health-related quality of life is influenced by premorbid health status or symptom load as well an individual's expectations for recovery. Dowdy<sup>37</sup> conclude in their review of the literature that age and severity of illness are predictors of physical functioning among ICU patients.

## **Pathogenesis of PICS**

Emerging from the literature is a shift towards identifying the cause of PICS <sup>52,157,158</sup> while the mission to construct a universal test battery and validate instruments has been surpassed by

and large. Prognosticating the pathogenesis of PICS<sup>52,157,158</sup> has given rise to the consideration of possible factors including co-morbidities and chronic disease <sup>12,157</sup>, malignancy, <sup>159</sup> duration of mechanical ventilation (greater than 50 days), <sup>160</sup> maximum Acute Physiology & Chronic Health Evaluation (APACHE) II score, length of ventilation, the number of surgical revisions, number of failing organs, <sup>157</sup> the duration of catecholamine therapy, <sup>161</sup> ICU re-admissions <sup>61</sup> and advanced age. <sup>162</sup>

## **Elderly**

Multiple studies have examined the impact of age on outcome following critical care. <sup>9</sup> The literature suggests that age alone has little or no important effect on outcome from critical illness, with the exception of severe closed head injury and out-of-hospital cardiac arrest. However, Ridley <sup>163</sup> notes the presence of chronic disease is a major factor to consider when studying populations and longitudinally, age will influence quantity or quality or survival. In those patients with a prolonged ICU stay requiring more than two weeks ICU admission, HRQoL at 12 months has been shown to be comparable to that of short-stay patients. Similarly, Garrouste-Orgeas agrees, stating projected outcomes should be based on physiological rather than chronological age. Currently, within this specific ICU subpopulation, existing studies carry bias making it more difficult to draw across study comparisons. Factors causing bias include selected ICU admission of the 'most-well' and exclusion of older patients from ICU admission based on age alone, the effect of social isolation and institutionalisation. Relevant outcomes, taking into consideration premorbid function is important to accurately reflect overall outcomes.

#### **ICU Re-admission**

Patients who are re-admitted to ICU are identified as a high-risk group in terms of hospital mortality, length of stay and resource utilisation. Conlon<sup>61</sup> studied 73 patients who survived their first ICU stay and were re-admitted during the study period. Using telephone interview they administered two functional outcome measures, the Glasgow Outcome Scale (GOS) and Karnofsky Index. Between 2 and 3 years after discharge, 43.8% of the cohort was followed-up. Of these, all showed moderate disability, that is were able to function independently but not return to work. Jones<sup>164</sup> found there were no between-group differences for

demographic variables, hospital length of stay, ICU length of stay, indices of illness severity, oxygen tension and inspiration variables, days receiving sedative, narcotic or paralytic medications, or estimated premorbid intelligence levels and outcome. The authors conclude these variables do not account for the group differences in group performances in cognitive performance.

The high economic cost associated with ICU and hospital readmission has been noted<sup>1</sup> with disease management programs being designed primarily to reduce the incidence and length of subsequent hospital readmission. <sup>133</sup> Daly and colleagues <sup>133</sup> showed a reduction of a more than a five day mean among a cohort of patients who required mechanical ventilation for greater than three days. This study showed a cost saving of greater than \$480,000.

#### **Outcome Prediction**

Determining the patient's risk of developing physical, cognitive and psychosocial (non-physical<sup>1</sup>) morbidity is important to enable comprehensive rehabilitation to start as early as clinically possible. The National Institute for Health and Clinical Excellence<sup>3</sup> instituted such tools as the short and comprehensive clinical assessment to identify patients who are at risk of developing physical and non-physical morbidity. These were constructed based on best-available evidence and clinical expertise however authors state there is no evidence indicating screening assessment tools improve outcomes (physical morbidity, cognitive dysfunction, swallowing and communication difficulties) among adults who have received critical care. However, based heavily on professional clinical judgement, the NICE clinical guideline endorsed a 'Care Pathway' to individualise and inform and guide post critical care outcome.

Kress and Herridge<sup>1</sup> discuss a 'spectrum' of clinical phenotypes for functional recovery citing precursors as prolonged mechanical ventilation and the very elderly. Chelluri<sup>150</sup> and Coombes<sup>165</sup> both note similar findings. These studies indicate poorer outcomes were associated with older age and greater comorbid illness.

## **Narrative / Thematic Analysis**

Fundamental and relevant themes of survival and adaptation are often captured in the patient's narrative. By asking patients how they orientate their lives according to things that matter and to understand their process of adjustment to chronic disability, seem fundamental when measuring outcome. Thematic analyses also aim to reveal new patient perspectives that are unlikely to appear in standard questionnaires or health-related quality of life instruments. Using open-ended questions patients were asked to identify any problems is an attempt to derive understanding directly from the participant data. Narrative interview has been used to elicit people's stories and perspectives of being in the ICU. <sup>166</sup>, <sup>167,168,169, 117, 118</sup> Narratives (and tools such as diaries) assist patients re-visit the critical care experience, often found struggling to decipher which experience was factual or unreal. <sup>117</sup>

Intensive care survivors often experience vivid dreams and delusions after discharge. Ely <sup>170</sup> and McNicoll<sup>171</sup> confirm the prevalance of delirium is high among ICU survivors and postulate the rate to be up to 80% of ventilated patients. 'Constructing the illness narrative' helps survivors piece in the missing gaps around their ICU experience, after waking from extended period (days to weeks) from sedation.

The literature indicates that PICS is associated with variable deficits across physical, cognitive and psychological domains. To account for this heterogeneity of physical, functional and psychological disability, research must consider the whole disease-treatment pathway, encompassing the admitting diagnosis, co-morbidities, organ dysfunction, effect of ICU treatment and interventions, the patient's adjustment ability and the process of ongoing supportive care. It has been suggested the strongest studies which measure outcome, methodologically, are those where research uses self-report measures in conjunction with standardised clinical interview. This approach ensures a patient-centred approach to accurate diagnosis based on an inventory of standardised criteria plus symptom severity. The current study assess long-term outcome using a battery of objective and subjective tasks, including narrative, thematic analysis.

In conclusion, the literature suggests much variability across long-term follow-up study methodologies of critical care survivors. There is considerable variability in the literature in

the test batteries used to assess function, the nature of the populations being assessed, the type of instruments used, and in the time intervals used in longitudinal follow-up. Research to date indicates that while the greatest deficits are seen immediately following ICU discharge, survivors are seen to parallel to normative population data for up to 24 months. To achieve a true comparative baseline for recovery, premorbid (baseline) data is necessary. This thesis reports the results of a study that tracks patients from baseline (gathering retrospective baseline data), extending follow-up to 24 months after ICU discharge. A consecutive recruitment, general ICU population is utilised, using validated instruments where possible. This will ensure this study data are comparable with other studies and yet provide a baseline novel data set. Narrative analysis and narrative trajectories add to the richness of the data, building upon and humanising the outcome data.

# **CHAPTER 3**

# Methods

# **Participants**

This longitudinal, observational, controlled, cohort study was designed to examine the functional, psychosocial and cognitive morbidity experienced by patients following critical illness.

From April through October 2006, 143 patients were recruited from two metropolitan hospitals, (one the sole tertiary referral centre) in Southern Tasmania. The cohort consisted of 71 survivors of critical illness from a mixed medical-surgical population, and 72 patients from both medical-surgical acute-care wards who did not experience critical illness controls. Both study ICUs were general medical and surgical ICUs.

Intensive care survivors were recruited consecutively on ICU discharge after which a restricted random sample of controls was matched by age and sex. Due to the high mortality rate among ICU patients, an expansion cohort was recruited, with an additional 10 individuals recruited in December 2007 to enable a dataset of fifty patients in each arm with complete 24 month outcome data. The consecutive enrolment strategy was again used. The aim was achieve a 2:1 match, that is, 1 ICU patient matched to 2 controls however due to financial constraints, a 1:1 match was used.

Inclusion criteria specified patients were to be  $\geq$  18 years of age, ICU patients requiring an ICU admission of  $\geq$  48 hours, APACHE II Physiological Component Score  $\geq$  10, and must reside within 90 minutes travel from the recruitment site. Controls were required to have had a medical or surgical acute-care ward admission  $\geq$  48 hours with no current ICU admission and must reside within 90 minutes travel from the recruitment site. We excluded patients who: failed to provide informed consent; who were unable to communicate with examiners because of sensory deficits or limitation in the use of English; neurosurgical patients, sustained a traumatic brain injury and were in a state of Post Traumatic Amnesia (PTA); and patients who were unlikely to survive 72 hours. (Table 1.0). As this study was an

observational study, all patients received standard care. Standard care patient's received was selected by their attending clinician and was based on current practice in their hospital.

Table 1.0 Inclusion / exclusion criteria					
Inclusion Criteria	Exclusion Criteria				
ICU patients	ICU patients Controls				
≥ 18yrs		Failure to provide			
	informed consent				
	Acute-	Subjects who are unable to			
APACHE II	care ward	communicate with			
Physiological  Component Score ≥ 10	admission	examiners because of			
	≥ 48 hours	sensory deficits or			
	(no ICU	limitation in the use of			
	admission)	English.			
ICU admission ≥ 48		Neurosurgery patients			
hours		rearosurgery patients			
	Patients with traumatic				
Reside within 90 minutes travel		brain injury, who are in a			
		state of Post Traumatic			
nom redutinent site	Amnesia (PTA)				
	Death imminent within 72				
	hours				

# Materials

Currently there is no validated and standardised test battery to evaluate the outcome of survivors of critical illness. For this study, a battery of tests was designed for face-to-face assessment of recovery of a heterogeneous group of ICU patients. Study design was informed by the outcome literature and aimed to maintain a standardised approach as much as possible (Tables 2.0; 3.0). Domains evaluated included functional, psychosocial and neuropsychological outcome. Assessments consisted of standardised objective and subjective instruments, (validated for use in the ICU patient population where possible), demographic, lifestyle questions and patient transcripts, themed to accurately reflect the patient's experiences. A global neuropsychological assessment measured visuo-conceptual, perceptual speed, cognitive flexibility, attention and task alternation, executive function and verbal working memory. Tasks with alternate versions were used where possible to minimise practice effects. Physical recovery assessed functional skills used for activities of daily living together with the patient's subjective assessment of their physical function. The

psychosocial domain considered levels of anxiety and depression, post-traumatic stress symptoms, the level of home and community integration together with the patient's subjective assessment. Timepoints were premorbid (retrospective data collected at the 1 month time point), 1, 3, 6, 12 and 24 months after discharge from critical care (ICU patients) and hospital (controls). Research personnel were trained in test administration to ensure a standardised approach, each taking approximately one hour in duration.

Information collected at each time point included demographic, lifestyle questions and patient narratives which were themed to accurately reflect the patient's experiences. Face-to-face, semi-structured interviews were conducted at each time point.

#### **Test Battery**

#### Functional Measures

Physical functional recovery was an assessment of functional skills used for activities of daily living, and was assessed using the FIM, together with the patient's subjective assessment of their physical function, as a component score of quality of life measure Short Form-36 version 2 (SF-36v2) Physical Component Score (PCS). Additional lifestyle measures which reflect clinical meaning include mobility impairment, residential support and return to work. These criteria are used in current health care planning. In this study, Residential Support is defined as inpatients of acute care, inpatients of acute rehabilitation unit, nursing home residents or people living at home with a carer. Mobility Impairment is defined as patients hospitalised or people who are house mobile only. Employment capacity or Return to Work, reflects the patient's occupation (retired, employed, unemployed, and student), capacity (≥ 35 hours per week, < 35 hours per week, unemployed, disability pension) and employment status which reflect casual, permanent or self-employed status.

# • Functional Independence Measure

The FIM provides a valuable metric which measures progress of functional skills used for ADL. 84 It assesses 18 ADL themes, including 13 motor items and five cognitive items, each scored on a seven point ordinal scale. Motor items cover personal care, sphincter control, mobility and locomotion. Cognitive items cover communication and social cognition. It is used extensively in Australia within areas of occupational therapy and rehabilitation medicine. 172 National data collected for rehabilitation medicine benchmarking and have shown acceptable levels of reliability and validity. 173 Dennis and colleagues<sup>174</sup> employed the FIM during a six month follow-up of Australian ICU patients concluding premorbid physical recovery was achieved within six months. This study use levels of impairment as used by Baguley <sup>175</sup> consisting of three categories: maximal assistance (score 18-54), indicating a mean FIM item score of three or less; moderate assistance (score 55-107), indicating a mean FIM item score of 4 or 5; and independent (score 108-126), indicating a mean FIM item score of 6 or more. These scores were based on hospital discharge FIM scores. This study considers the lower level of independence of 108 as the definition of impairment. Elliott and colleagues warns within a review of instruments used in assessing physical function and activity for survivors of critical illness of possible ceiling effects.

## • Short Form Questionnaire 36 version 2

Quality of life, as measured by the SF-36v2<sup>177</sup> has been used in a wide range of post-critical care outcome studies.<sup>58, 137</sup> It is one of the strongest of the existing generic measures and has been validated extensively,<sup>6,7,37</sup> The questionnaire has evidence of validity among ICU patients.<sup>59</sup>

The SF-36v2 is a 36-item multipurpose health survey that measures overall health, functional status and mental status. It measures 8 domains: physical functioning (PF), role limitations due to physical problems, bodily pain (BP), general health perceptions, energy/vitality (VT), social functioning (SF), role limitations due to emotional problems and mental health (MH), equating to two summary scales; physical component score (PCS) and mental component score (MCS). The most recent version of the survey<sup>177</sup> contains 11 questions, most consisting

of structured Likert-type responses. The improvements were introduced to correct deficiencies identified in the original version.

Current scoring recommendations are that the scores be standardised to a 0-100 range, converting the lowest possible score to 0 and the highest to 100. Scores are norm-based, mean = 50, SD = 10. When interpreting scores, 50 is considered average; 0-49 is below average; 51-100 is above average. Clinical significance is a five point improvement or decline in scores.

Factor analysis has validated the existence of eight scales which fall into either the Physical or Mental Health Components. In regards to construct validity, PF has been shown to be the best around measure of physical health and mental health is the most valid measure of mental health. Many reliability and validity<sup>178</sup> studies have been conducted on the SF-36 and in most, reliability coefficients have been greater than 0.70. Analyses have also produced evidence of content, concurrent, criterion, construct and predictive validity. Individual scales and summary measures have been useful in screening and measuring aspects of specific diseases and conditions.

The SF-36 has been used in a wide range of disease-related studies and can be useful in comparing the effects of different conditions or on individual or comparing patients to individuals in the general population. It can also be used in repeated measures of the same patients over time. It has been well validated in health service studies. <sup>179,180</sup> In the area of critical care, the SF-36v2 has been used extensively among varied cohorts including general medical, acute lung injury and ARDS patients. <sup>11,25,38,48,112,181,182</sup> Across these studies the mean SF-36 scores fell within ranges of 12 points or less for six domains and 20 points or less for the role physical and social functioning, indicating this population had significantly lower quality of life (QOL) versus a matched population norms in all domains. Deficits were greatest in the four physical domains, PF, RP, bodily pain (BP) and GH perceptions.

Additional lifestyle measures which reflect clinical meaning include Return to Work,
Residential Support and Mobility Impairment. These criteria are factors which are used in
current health care planning.

# Return to Work

Return to work is a proxy measure of functional status. It is a single-item global measure that has been used in many studies but does not appear to have a consistent format. In this study, the return to work capacity reflects the patient's occupation (retired, employed, unemployed, and student), capacity (≥ 35 hours per week, < 35 hours per week, unemployed, disability pension) and employment status which reflect casual, permanent or self-employed status.

#### • Residential Support

In this study, Residential Support impairment is defined as inpatients of acute care, inpatients of acute rehabilitation unit, nursing home residents or people living at home with a carer.

# • Mobility Impairment

Mobility Impairment is defined in this study as patients hospitalised or people who are house mobile only.

# • Psychosocial Measures

To measure psychosocial recovery, this study uses instruments which are validated within the ICU population where ever possible and where this is not possible, incorporate instruments which are used clinically.

The psychosocial domain considered levels of anxiety and depression, assessed using the Hospital Anxiety and Depression Scale (HADS), post-traumatic stress symptoms, assessed using the Impact of Events Scale (Revised) (IES-R), the level of home and community integration assessed using the Community Integration

Questionnaire (CIQ). The patient's subjective assessment was assessed using the SF-36v2 Mental Component Score (MCS).

# • Hospital Anxiety and Depression Scale

The HADS <sup>183</sup> is a self-assessment instrument developed to screen for mood disorders of anxiety and depression in non-psychiatric patients. The scale comprises of 14 items that are divided into two subscales, for which the participant rates each item on a four-point scale. The score range is 0 - 42, the higher the score, the greater the level of anxiety and depression symptoms. One scale contains seven items on depression, subscale scores range between 0 - 21, higher scores greater symptoms of depression and the other seven items on anxiety, subscale scores range between 0 - 14, higher scores greater symptoms of anxiety.

The HADS has been validated in the critical care population.  $^{56,58,109,184}$  The reported prevalence of anxiety and depressive problems in ICU survivors ranges from 12-43% for anxiety and 10-30% for depression.  $^{58,109}$  For the presence of depression, anxiety or both, the cut-off level of 19, as recommended by Spinhoven was used. For the subscales anxiety or depression, the cut-off values of 11 or more were applied. Score interpretation is defined as 7or less = non-case; 8-10 = doubtful case; 11 or more = definite case.

# • Impact of Events Scale – Revised

The IES-R <sup>187</sup> provides a dimensional assessment of PTSD. Participants specify the frequency with which they have had intrusion-, avoidance-, and hyperarousal- related thoughts in the previous 7 days on a Likert scale. The IES-R an extension of Horowitz's IES<sup>188</sup> is a valid, 15-item, self-report disease-specific measure which assesses levels of subjective post-traumatic psychological distress and which provides specific measures of event intrusion, event-related avoidance and even-related hyperarousal, the key elements of post-traumatic stress disorder. The scores for the intrusion component of the scale range from 0 - 24, for the avoidance component, 0-32 and hyperarousal 0 - 24 with a total score between 0-88. The higher the score, the greater the level of distress indicated. For the identification of coping disorders, scores above the cut-off point of 35 were classified as a high level of PTSD-related symptoms.<sup>189</sup>

Weiss and Marmar<sup>190</sup> report the IES-R showed high internal consistency, with coefficient alphas ranging from 0.87 - 0.92 for intrusion, 0.84 - 0.85 for avoidance and 0.79 - 0.90 for hyperarousal. Test-retest correlation coefficients ranged from 0.57 - 0.94 for intrusion, 0.51 - 0.89 for avoidance and 0.59 - 0.92 for hyperarousal. The IES-R has been used in numerous studies of ICU survivors<sup>26</sup> with a wide variety of adult populations and has proved valuable in documenting the course of posttraumatic phenomena over time.<sup>191</sup> The STOIC case level for posttraumatic stress symptoms with a high probability of PTSD was a positive IES-R together with a case level of HADS – anxiety or depression of  $\geq$ 11.

# Community Integration Questionnaire

The CIQ <sup>192</sup> is intended as a brief, general, reliable measure of an individual's level of integration into the home and community and is used widely in brain injury populations. The CIQ was developed for patients with traumatic brain injury and they suggest as the CIQ does not encompass all possible indicators of integration it is recommended it be used in conjunction with assessments of impairment, disability, environmental barriers and demographic descriptors. Most of the questions are directed at how the individual performs a specific activity within the household or the community. Responses usually indicate that the individual performs the activity alone, with another person or that the activity is typically performed by someone else. For some responses, the individual being assessed may find it difficult to decide which response fits best with how a particular activity is performed. The score range is 0-29, impairment classified as  $\leq 6$ . Community Integration Questionnaire Impairment  $\leq 6$  (Score range 0-29; mean 11~SD~5.0).

#### Neuropsychological Measures

Neuropsychological measures of global neuropsychological functioning incorporated in this test battery included assessment of auditory and working memory using the Letter Number Sequence (LNS) and the Digit Span (DS), and assessment of attention and information processing speed using the Trailmaking Task—Test B (TMT-B). Executive

function measures a range of executive abilities, such as planning, organisation, problem solving and non-verbal reasoning ability using the Stroop Task (SNST). Validated tests were used where possible. Weak evidence only exists for test validation (among ICU patients) for the Mini-Mental State Examination (MMSE)<sup>193,194</sup> TMT<sup>138,140,193,195</sup> and the HADS.<sup>55-58</sup> Demographic details including occupation, mobility, activities of daily living (ADLs), social situation, social supports, weight, alcohol and illicit substance consumption, medical and allied health services accessed after discharge, were collected and are detailed.

# • Mini Mental State Examination

The MMSE is a brief screening test of cognitive mental state  $^{196}$  which has the ability to distinguish between organic and functional psychiatric illness. The MMSE was originally designed for use with neurogeriatric patients, and comprises two parts (verbal and performance). The maximum score on the verbal subscale is 21 and, on the performance subscale, 9 with an overall score of 30. Lower scores,  $\leq$  23 represent cognitive malfunction, indicating probable dementia. The MMSE assesses orientation, registration, attention and calculation, visuoconstruction, recall and language. Criterion validity against the Wechsler Adult Intelligence Scale,  $3^{rd}$  edition (WAIS-III) $^{197}$  found significant association between the two measures. Inter-rater and test-retest reliability were satisfactory; 0.83 to 0.98. Two studies in critical care used this measure.  $^{193,194}$  One study was based on trauma and the other on liver- or heart- transplant patients with mean ages between 36 and 46 years. There was no assessment of validity, reliability or responsiveness in either paper. The test is interviewer administered and takes approximately five minutes to administer. In this study, patients were deemed fit for neuropsychological tests by achieving a score greater than 24.

## • National Adult Reading Test

An estimate of premorbid Intelligence Quotient (IQ) was obtained using the National Adult Reading Test (NART)<sup>198</sup>. This requires the participant to pronounce 50 short words of irregular pronunciation and can be used to provide an estimate of premorbid IQ as NART performance is largely resistant to the effects of neurological and psychiatric disorder. <sup>199-201</sup>

# • <u>Letter Number Sequence Task</u>

The Letter-Number Sequencing subtest of the Weschsler Adult Intelligence Scale  $3^{rd}$  edition (WAIS-III)  $^{197}$  is a well-standardised, brief test of auditory working memory. It tests the subject's ability to hold on to concurrent strings of numbers and letters. It has parallel versions, allowing re-test without use of the original test stimuli. *ASS* were calculated, higher scores show increased capacity with impairment classified as  $ASS \le 4$ , a level that is 2 *SD* below the mean. There is no published evidence of the LNS being used with ICU patients.

#### Digit Span Task

The Digit Span subtest of WAIS-III<sup>197</sup> is a standardised measure of auditory-verbal short-term memory span requiring the subject to immediately recall an increasing sequence of numerical digits in forward and in reverse order. It has parallel versions, allowing re-test without use of the original test stimuli. Age scaled scores (ASS) were used, higher scores show increased capacity with impairment classified as an ASS  $\leq$  4, a level equivalent to 2 *SD* below the mean ASS. There is no published evidence of the DS being used with ICU patients.

# <u>Trailmaking Task – Test B</u>

Trailmaking Task-Test B is a visual-motor attention task measuring executive function and is comprised of two separate trails, part A and part B. <sup>202</sup> The TMT-B is a visual motor attention test that requires the subject to shift attention between two sets of stimuli and alternately sequence, a series of numbers and letters. Performance of TMT-B is dependent on various cognitive abilities, including visual-conceptual, perceptual speed, cognitive flexibility, attention and task alternation. Parallel test versions were used to minimise practice effects. <sup>65</sup> Four studies of critically ill patients were reported using the TMT. <sup>138,140,193,195</sup> The mean ages of participants ranged from 23-46 years, each paper reported on different populations within critical care. Three papers reported administering the TMT-B at 6 months and two papers at 12 months. Two papers administered the TMT-B at multiple time points. There is no evidence for the assessment of reliability or responsiveness in any of the papers reviewed.

# Stroop Task

The SNST<sup>203</sup> assesses verbal executive function, specifically selective attention, response inhibition, and information processing speed. The SNST requires the subject to suppress an automatic response (word reading) and generate a non-automatic response (colour naming), where the stimuli are colour words in different ink colours. A relative increase in time taken to perform the incongruent task compared with a simple word reading task is referred to as "the interference effect" and is considered a general measure of cognitive flexibility and control or executive functioning. These abilities decline with age and in dementia which has made the SNST a widely used test to evaluate various groups of patients with borderline established or altered brain pathology such as raised intracranial pressure. <sup>204,127</sup> The time taken to complete the task is measured in seconds, with higher scores equating to greater deficit. Study scores are displayed as a ratio of Stroop 3 to Stroop 2.

Table 2.0 Test Battery Key						
		Mel	ropsychological Tests		Section 201	
Mini-Mental State Examination	Folstein, Folstein & McHugh (1975) Ref: #156	A brief 30-point tool assessing mental status	Global measure of orientation, registration, attention and calculation, visuoconstruction, recall and language.	Riether et al (1992); Frutiger et al (1991)	Higher score is better Maximum score 30; Cognitive testing cut-off ≤ 24; <24 possibly indicative of dementia	
National Adult Reading Test	Nelson (1982) Ref: #158	The patient to pronounce irregular written words.	Pre-morbid intelligence	Griffiths et al (2007)	Higher score is better, Number of errors on the NART connects to FSIQ (full scale IQ)	
Digit Span	Wechsler (1997) Ref: #157	Determines the longest strings of digit, both forwards and in reverse order, that can be held in working memory.	Verbal working memory	Not validated in ICU patients	Higher score is better; Raw scores age- sex- adjusted to form z scores; Mean=10 SD 3; Clinical impairment are 2 SD below the mean or ≤ 4.	
Letter number sequence	Wechsler (1997) Ref: #157	Brief auditory divided attention task; measures working memory ability to hold on to concurrent strings of numbers and letters.	Executive function	Stanton et al (1983); Uzell et al (1987)	Higher score is better Raw scores age- sex- adjusted to form z scores; Mean=10 SD 3; Clinical impairment are 2 SD below the mean or ≤ 4.	
Trailmaking B Test	Reitan (1958) Ref: #162	A visual motor attention task that shifts attention between two sets of stimuli. Examines a patient's ability to search for, and alternately sequence, randomly positioned numbers and letters	Assesses visual- conceptual, perceptual speed, cognitive flexibility, attention and task alternation	Riether et al (1992); McKee et al (1997)	Higher score is worse Raw scores in seconds	
Stroop Test	Stroop (1935) Ref: #163	Visual cognitive inhibition	A general measure of cognitive flexibility and control or executive functioning.	Not validated in ICU patients	Higher score is worse Raw scores in seconds	

Table 2.0 Test Battery Key (Continued)

Psychosocial Tests					
Impact of Event Scale-Revised	Weiss and Marmar (1997) Ref: #178	15-item, self-report disease-specific measure	Assesses levels of subjective post-traumatic psychological distress providing specific measured subscales: of event intrusion (0-32), event-related avoidance (0-32) and event-related hyperarousal (0-24). IES-R score: sum of subscales (0-88).	Eddleston et al (2000); Jones et al (2001); Scragg et al (2001); Cuthbertson et al (2004)	Higher score is worse ≥ 24 PTSD clinical concern; ≥ 33 probable PTSD; ≥37 severe PTSD
Hospital Anxiety and Depression Scale	Snaith (2003) Ref: #182	The scale comprises of 14 items that are divided into two subscales-each item rated on a four-point scale. Contains 7 items on depression and 7 on anxiety.	Screening tool for anxiety and depression.	Friman et al (1976); Lund et al (1985); Rowan (1992)	Higher score is better Individual anxiety and depression scores ≤7 = non-case; 8-10 = doubtful case; ≥11 = definite case
SF-36v2	Ware et al SF-36 (Ware 1993); QualityMetric Incorporated and Medical Outcomes Trust (2000) Ref: #165	Generic 36-item Quality of Life questionnaire	A multipurpose health survey that measures 8 domains overall health status, functional status emotional and mental health	Chrispin et al (1997); Ridley et al (1997)	Higher score is better 50 is average; 0-49 is below average; 51-100 is above average
Community Integration Questionnaire	Willer et al (1993) Ref: #177	Questions are directed at how the individual performs a specific activity within the household or the community.	A brief 15 question measure of level of integration into the home and community. 3 subscores home, social integration & productivity	Not validated in CCU patients. Designed for use following traumatic brain injury.	Higher score is better Total score range 0-29

**Table 2.0** Test Battery Key (*Continued*)

			Functional Measure		
Functional Independent Measure	Australasian Rehabilitation Outcomes Centre (2005) Ref: #171	18-item ordinal scale measures disability; motor domain consists of 13 items, cognitive domain consists of 5 items on a score from 1-7; 7=complete independence; 1=total assist	Measures the functional abilities of patients during rehabilitation	Used with all diagnosis within a rehabilitation population	Higher score is better Scores range from 18-126; physical items can be scored separately from cognitive items. Low scores most likely require discharge to facility; greater scores associated with home discharge.

# • Patient narrative

Narrative interview were used to elicit people's stories and perspectives of being in the ICU; to derive understanding directly from the participant data. The patient transcripts reliably represent the participants' experiences with subjectivity of the researcher minimised as much as possible. The aims of the interview were to capture and understand the lived experience of critical illness and the patient variation of the overall experience. Narrative, thematic analysis has been used in conjunction with standardised clinical interview to increase methodological rigour. This patient-centred approach complements the inventory of standardised criteria and symptom severity. Patient narratives were collected at each timepoint, one-to-one, face-to-face by experienced qualitative researchers unconnected to the patient's hospital care. Narrative interviews were conducted at each timepoint, 1, 3, 6, 12 and 24 months following discharge.

Interviews commenced with researchers asking patients to talk about their experience of critical illness and how it affected their life in any way they felt was important. After the narrative, researchers followed up themes patients raised using specific semi-structured probe questions to gain clarification if required (Appendix 8.0). Interviews were then transcribed verbatim into a computer word document and then coded separately. The transcription included pause and emphasis of words. Coding in this way provided a snapshot of the language used by the participant groups. The patient transcripts reliably represent the participants' experiences with subjectivity of the researcher minimised as much as possible. A thematic approach to analysis looks for patterns, meaning and potential points of interest in the data that maintains an honest interpretation by constant reference to the raw data source. <sup>206</sup>

## Thematic analysis

A thematic approach to analysis was used to ascertain themes from the patient narratives, looking for patterns, meaning and potential points of interest in the data that maintains an honest interpretation by constant reference to the raw data source.<sup>206</sup> A deductive method

of thematic analysis is one which investigates the transcripts and aims to interpret the data by looking beyond the descriptions given, to identify the meaning and implications arising from them.

Two researchers, blinded to patient characteristics, each independently scrutinised the same data transcripts. Interviews were systematically coded, extracting the most significant statements using a modified grounded theory approach so that data were explored for well-established as well as emergent themes. Second stage coding identified patterns from the initial first stage, until no new codes were found. During analysis meetings independently formulated meanings were discussed until agreement was reached. The resultant development of principle-overarching themes (constructs) was generated through a transparent process that can be traced back to the data found in the text and across multiple participant groups. Through this consensus process, overarching constructs were generated through a transparent process. The constructs of 'Physical Incapacity', 'Isolation' and 'Advice and Reassurance' were used as the narrative thematic framework.

From this framework, narrative trajectories were formed. To create longitudinal, trajectories of the narrative data, each narrative construct was placed into a trajectory framework 207-209 and categorised as 'positive', 'negative', 'mixed' or 'neutral.' The narrative constructs of physical incapacity, isolation and advice and reassurance were used. Each transcript was coded for positive, negative, mixed or no change on each theme. If the number of positive theme items clearly outnumbered the negative, the trajectory was coded as 'positive.' Conversely, if the number of negative theme items clearly outnumbered the positive, the trajectory was coded as 'negative.' If the number of negative and positive theme items were roughly equal, the trajectory was categorised as 'mixed;' and if no clear change was observed over time in the majority of theme items, the trajectory was categorised as 'neutral.' Although we structured coding by using three constructs, scientific and clinical judgement and discussion among coders and interviewers was a key part of the analytic process.

#### **Procedures**

#### Recruitment

The researcher screened consecutive discharges from ICU's at both sites daily and following recruitment of ICU patients, matched controls from general medical and surgical wards for inclusion into the study. The patient and the nominated next-of-kin were approached by the researcher and were provided with a verbal explanation of the study. A written plain language information statement was also provided, time given for consideration, and all questions answered, after which the patient or next-of-kin gave written consent. The researcher introduced themselves to the patient, briefly explained the study and gave the patient a study information brochure prior to discharge. Consent for a follow-up phone call was obtained at this time after which the researcher contacted the patient by telephone 1 - 2 weeks post discharge. At this time the study was detailed and the first interview scheduled. The first interview was often conducted in the patient's home as the majority of patients suffered debility.

As the study focus was examining meaningful clinical outcomes of disease, it was expected that patients with poor outcome would be identified. The study involved the collection of information of a personal nature and researchers were sensitive to the needs, comfort and were respectful of possible participant dysfunction. There was a protocol of support systems for researchers to follow if participants requested help and was considered the duty of care as part of Good Clinical Practice Guidelines. Patients were referred, if necessary to their General Practitioner for further follow-up and review.

#### Timeline

Study assessments were conducted by trained researchers (blinded to the disease status of each participant) at 1, 3, 6, 12 and 24 months post discharge. Retrospective premorbid data was collected at 1 month time point, using tasks which have been validated for this purpose (Table 3.0). Researchers were trained to conduct the interview, administer and score the tests by a neuropsychologist, guided by the study protocol and procedures. All

interviews were conducted face-to-face, in a quiet environment using a semi-structured format, lasting approximately one hour. Follow-up contact for participants consisted of a phone call / letter, one week prior to the scheduled reviews.

Month	Baseline	1	3	6	12	24
MMSE	x					
NART	х					
Digit Span Task		Х	Х	Х	Х	Х
LNS		Х	Х	Х	Х	Х
ТМТ-В		Х	Х	Х	Х	Х
SNST		Х	Х	Х	Х	Х
IES-R		Х	Х	Х	Х	Х
HADS		Х	Х	Х	Х	Х
SF-36V2	×	X	Х	Х	Х	Х
CIQ	Х	Х	Х	Х	X	Х
FIM	X	Х	Х	Х	Х	Х
Mobility, Residence,						
Return to Work	x	X	Х	Х	X	х
Demographics	X	Х	Х	Х	Х	Х
Patient narrative	X	Х	Х	X	Х	х
Mortality		Х	Х	X	X	х

#### Informed consent

At enrolment into the study, written informed consent was obtained from patients or their authorised surrogates. If consent obtained from a surrogate, written informed consent was obtained from the patient once competent. The STOIC study was approved by the Ethics Committee and hospital Management Boards (June 2005, Ethics Reference: H8250) in accordance with National Health and Medical Research Ethical guidelines.

## Data handling

It was emphasised that security and confidentiality of information would be maintained at all times. Every attempt was made to treat information gathering in a sensitive and

appropriate manner. The comfort and dignity of the participant was maintained throughout this process.

Data was collected and scored by researchers in hard copy, after which test scores were reviewed by a neuropsychologist and entered onto a database by a data entry employee onto a secure Filemaker Pro V7 database. All data and scores imported as electronic files underwent filtering, validity and range checks before being included. Data cleaning was performed prior to analysis.

# • Data sources / measurement

Retrospective baseline data was collected from the patient together with their nominated carer, using instruments validated for this purpose and included the FIM, SF-36v2 and CIQ at one month time point. Subjective problems experienced prior to admission were also collected. Prospective data was collected relating to the participant's functional, psychological, cognitive and social situation at all other timepoints out to 24 months (Table 2.0). Outcome assessments were assessed with standardised instruments and self-report measures, only some of which have been validated for use in critical care research. Clinical data relating to medical history and current admission were collected from the patient's medical record and hospital information system.

**Analytical Approaches** 

#### Statistical analysis

Being a pilot study, apriori calculation of the sample size required for attaining statistical significance was not calculated. Admission numbers from the Level 3, tertiary referral centre, for the year 2009-2010, was 840 ICU admissions with 6.2% in-unit mortality. Based on these previous unit admission numbers, study recruitment targets were deemed realistic and achievable. Every attempt was made to minimise post-recruitment exclusions. Study numbers show no loss to follow-up except attrition due to death (Figure 1.0), across both groups at the 24 month time-point. Linear mixed models were used to compare outcomes

for ICU patients and controls at six sampling times using a battery of functional, neuropsychological and psychosocial tests. This method allows for the correlation structure of repeated measures of individuals, and missing data points. Patient group (case or control) and sampling time were treated as fixed effects, whilst individual effects were assumed to be random. The Kaplan-Meier method was used to generate time to event curves. Within the context of the interpretation of outcome measures, statistically significant results are reported and results are interpreted as to their clinically meaningful or real benefit.

Post hoc subgroup analysis was undertaken within four specified subgroups. Diagnostic subgroups included 'sepsis,' 'neoplasia,' 'trauma' and 'other'. T-tests were used to assess for statistical significance where group size allowed. This enabled further examination of the heterogeneous, medical-surgical population, for trends which may show specificity.

Pearson correlations among test outcomes and clinical data (prognostic variables) were calculated to assess for strong associations among factors and to inform selection of variables for prediction of outcomes. Group differences were used in this population as there is high variability in each.

Linear regression was used to determine the utility of pre-morbid and in-hospital and descriptive measures as predictors of mortality or cognitive and functional outcomes 24 months after admission.

Mixed model regression was used to generate test outcomes to examine group by time, age by time and sex by time analyses of cases, controls and subgroup of survivors within these.

Results were adjusted for age and sex to remove effects on task performance.

Thematic analysis was used to analyse patient narrative's looking for patterns, meanings and potential points of interest in the data. At each study time point, patient narratives were transcribed, at the end of each interview. Thematic analysis was used in an attempt to derive understanding directly from the participant data. Narrative, thematic analysis has been used in conjunction with standardised clinical interview to increase methodological rigour<sup>24</sup>. This patient-centred approach complements the inventory of standardised criteria and symptom severity. Interrater reliability was not established.

Outcomes were profiled as 'not impaired', 'impaired' and 'deceased'. Levels of impairment were defined for six outcome measures which together reflect a broad and clinically relevant picture. Outcomes included quality of life components, PCS and MCS, DS, LNS, Mobility and Social Impairment. Recovery curves for levels of impairment within each outcome were analysed and linear mixed models were used to compare outcomes for ICU patients and controls at the six sampling times against the battery of functional, cognitive and psychosocial tests.

Univariate analyses showing significance were then used to inform a multivariable model (adjusting for multicollinearity, age and sex), to form a battery of tests which show significant relationships for the relative risk of impairment and death for ICU patients at 24 months. Mixed model regression applied premorbid and one month predictors to show outcomes of impairment and death at 24 months.

## **Data variables**

Data variables included a broad set of demographic, clinical and outcome variables as below. These were collected with consent, from the medical record, including clinical and medication charts. All pathology results were accessed and validated via the electronic data system and entered onto the study database. APACHE and Sequential Organ Failure Assessment (SOFA) scores were calculated via electronic calculators and scores entered onto the study database (Table 4.0).

Table 4.0 Data vari	ables from medical history		
Demographics	age	Clinical outcomes	dialysis days
	marital status	ICU	ventilation days
	dependents		adverse events
	postcode		readmisison to CCU within 72 hours
	occupation, status, capacity		APACHE II and III on admission
Clinical outcomes	medical history		daily SOFA scores
(Preadmission)	medication history		neuromuscular blockers (mg/day)
	chronic diseases		narcotics (mg/day)
	dementia		sedatives (mg/day)
		Prospective	
	chronic neurologic disease	outcomes	days
	chronic neuromuscular disease		ICU
	psychiatric disorders		acute care
	depression		rehabilitation
	chronic drug abuse		discharge destination
	chronic alcohol abuse		mortality
Clinical outcomes	dialysis days		ICU discharge
ICU	ventilation days		hospital discharge
	adverse events		one month
	readmisison to CCU within 72 hours		three months
	APACHE II and III on admission		six months
	daily SOFA scores		12 months
	neuromuscular blockers (mg/day)		24 months
10	narcotics (mg/day)		
	sedatives (mg/day)		

# **CHAPTER 4**

# Results

Study results will be presented to address the study aims.

# Primary aims:

- 1. Track the functional, neuropsychological and psychosocial recovery of patients surviving critical illness over a 24 month period following ICU discharge;
- Determine the incidence of functional, neuropsychological and psychosocial impairment of patients surviving critical illness 24 months following ICU discharge;
- 3. Determine the level of functional, neuropsychological and psychosocial impairment of patients surviving critical illness over a 24 month period following ICU discharge;

# Analyses:

- Descriptive demographic characteristics including hospital interventions;
- Test scores (mean, SD), ICU patients and controls at each time point (survivors, deceased);
- Mixed model analysis of ICU patients and controls, sorted by mortality, case by time,
   sex and age effects (Coefficient; CI; p value) using linear regression;
- Test scores and subgroup analysis, grouping ICU patients and controls sorted into four diagnostic related groups post-hoc – 'sepsis', 'trauma', 'neoplasia' and 'other' (mean; SD; p value);

• Frequency (%) ICU patients: Controls; Not impaired, Impaired and Deceased;

# Secondary aims:

- Determine baseline variables associated with outcome (not impaired, impaired and death) 24 months following ICU discharge;
- 2. Examine common themes and characterise the subject's recovery during the first 24 months following ICU discharge.

Analyses:

- Predictors of morbidity and mortality significant univariates were then used to
  inform a multivariable model (adjusting for multicollinearity, age and sex), to form a
  battery of tests which give the relative risk of impairment and death for ICU patients
  at 24 months;
- Patient narrative, thematic analysis

Figure 1: Study Recruitment Schema

Total ICU patient population Apr 2006-Oct 2006

N=753

ICU patients excluded:

LOS ICU ≤48hrs 339 APACHE II physiological component score ≤10

Death imminent <72hrs

28

5

Located >90mins from hospital 48
Language difficulties 2
Traumatic brain injury / neurosurgical procedure / cognitive failure 49
Age <18 23

Refused to participate\*

N = 682

Participating ICU patients

N = 71

Age-sex-matched

surgical and medical controls

N = 72

1 Month: Lost to follow-up

Cases N = 0 Controls N = 0 Participating ICU patients

1 Month post ICU discharge N = 71 (100%) Participating Controls

1 Month post hospital discharge

N = 72 (100%)

1 Month - mortality:

Cases N = 0 Controls N = 0

3 Month: Lost to follow-up

Cases N = 0 Controls N = 0 Participating ICU patients

3 Month post ICU discharge N = 68 (95.8%)

Participating Controls

3 Month post hospital discharge N = 69 (95.8%)

3 Month - mortality :

Cases N = 3Controls N = 3

6 Month: Lost to follow-up

Cases N = 0 Controls N = 0 Participating ICU patients

6 Month post ICU discharge N = 66 (92.9%) Participating Controls 6 Month post hospital

> discharge N = 67 (93.0%)

6 Month - mortality:

Cases N = 2 Controls N = 2

12 Month: Lost to follow-up

Cases N = 0 Controls N = 0 Participating ICU
patients
12 Month post

12 Month post ICU discharge N = 61 (85.9%)

Participating Controls

12 Month post hospital discharge N = 65 (90.3%) 12 Month mortality :

Cases N = 5 Controls N = 2

24 Month: Lost to follow-up

Cases N = 0 Controls N = 0 Participating ICU patients 24 Month post ICU discharge N = 58 (81.7%)

Participating Controls 24 Month post hospital discharge

N = 63 (87.5%)

24 Month mortality :

Cases N = 3 Controls N = 2

<sup>\*</sup>Refused to participate due to 'tiredness', 'unwell' or 'anxiety'

## **Demographic Characteristics**

From April through October 2006, 143 patients were recruited from two centres in Southern Tasmania, one being the sole tertiary referral hospital in Tasmania. The cohort consisted of 71 survivors of critical illness from a mixed medical-surgical population, and 72 controls, patients from general medical and surgical acute-care wards who did not experience critical illness. ICU patients were recruited consecutively on ICU discharge after which a restricted random sample of controls was matched by age and sex (Figure 1.0).

Both groups were very similar at baseline (Table 5.0). Data show the mean age of ICU patients was 62.1 years (*SD* 16.4) and controls 61.7 years (*SD* 17.3). Fifty-four percent of ICU patients were male compared with 57% of controls. The levels of education show similar numbers of ICU patients and controls holding primary, secondary and tertiary levels of education. Full Scale Intelligence Quotient (FSIQ) scores, an estimate of premorbid I.Q. show both groups are of average intelligence, (mean; SD) ICU patients 104 (13.9) and controls 107 (14.7). Occupation also show both groups very comparable, with 55% of ICU patients retired compared with 51% of controls. With regard to employment status, 21% of ICU patients and 19% of controls were employed, with 1% of controls and none of the ICU patients, being unemployed. A total of 49% of ICU patients were receiving social support on admission, compared to 32% of controls, including 17% of ICU patients being hospitalised prior to ICU admission.

The Charlson-Age Comorbidity Index (CACI) show similar weights of comorbid medical conditions. ICU patients were more independent, scoring higher FIM scores and reported higher physical component quality of life. Controls had reduced mobility, 10% being house mobile versus 4% of cases. Still, controls showed a higher level of integration at home and in the community.

7 (17.3) 7	N ICU
(500)	'1 62.1 (16.4)
· ·	'1 38 (53.5)
	'1 22 (31)
7 (14.7) 5	2 104 (13.9)
7 (3.69) 6	27.9 (3.80)
7 (17.8) 4	8 21.6 (14.3)
6 (2.87) 7	2.23 (2.11)
7 (3.55) 7	1 4.24 (2.97)
NA 71	19.0 (8.0)
NA 59	
NA 71	
NA 71	
NA 71	, ,
NA 71	
15 7	
5 7	
7 7	
45 7	
2 (63) 7	
7	
0	2 (3)
0	0
0	0
2 (18)	14 (20)
(11)	4 (6)
3 (5)	2 (3)
) (61)	47 (67)
3 (5)	1 (1)
L (2)	0
(10%) 7:	
7:	• •
2 (18)	9 (13)
3 (19)	15 (21)
i (51)	39 (55)
5 (7) 2 (3)	7 (10) 1 (1)
	0
l (1) 7:	
3 (25)	18 (25)
) (56)   (10)	40 (56)
(19)	13 (18)
? (31) 7(	, ,
2 (3)	1(1)
5 (7)	8 (11)
! (17)	6 (9)
0	12 (17)
0	2 (3)
5 (4)	6 (9)
	3 (4)
	57 (80)
	9 (13)
. (1)	2 (3)
	71 (10) (78) (10) (10)

Table 5.0 (continued)	N	Controls	N	ICU
Tobacco	67	3 (5.5)	70	6 (8.6)
Cannabis	71	0	70	2 (2.9)
FIM, mean (SD)	72	119 (14.2)	71	121 (14.3)
CIQ, mean (SD)	70	35.7 (16.2)	71	16.8 (4.63)
SF36v2 PCS	67	38.5 (13.7)	70	45.7 (13.5)
SF36v2 MCS	67	49.2 (13.9)	70	53.8 (11.0)

FIM Functional Independence Measure: Score range 18-126; <108 = impairment; CIQ Community Integration
Questionnaire: Score range 0-29, <6.2 = impairment; SF36v2 PCS Physical Component Score: Score range 0-100, mean, (SD) 50 (10); SF36v2 MCS Mental Component Score: Score range 0-100, mean, (SD) 50 (10).

## **Admission characteristics**

APACHE 3 diagnoses indicate (Table 6.0) that pneumonia accounted for over 25% of case admissions (aspiration 9.86%, bacterial 14.08% and viral 1.41%), sepsis 19.71% and cardiac surgery 19.71%. Of note, study inclusion criteria show recruited cardiac surgery patients had an ICU length of stay of greater than 48hrs with an APACHE II physiological component score greater than 10 describing the more complex rather than routine cases. It is worth noting cardiac arrest occurred in four cases (5.63%) and one (2.5%) control. While both cardiac surgery and cardiac arrest diagnosis may suggest hypoxic brain injury and associated impaired cognitive function, inclusion criteria required a MMSE score of greater than 24, before patients in these groups were deemed testable. Data shows these scores were attained with mean MMSE score of 28.7 (SD 3.69) for cases and 27.9 (SD 3.80) for controls (Table 1). Control admission data show 37.5% of controls principal admission diagnosis was cardiac related with 33% of having received a general anaesthetic. Three control patients were admitted to ICU during their hospital admission however length of ICU stay was less than 24 hours, two patients receiving routine post-op care and one with acute pulmonary oedema (Table 7.0; 8.0).

Ensuring a heterogeneous and representative, mixed medical-surgical population within both groups, meant excluding as few as participants as possible. This was achieved by employing an inclusion criterion of MMSE score of 24 or more. All consecutive patients discharged from ICU participants achieved this, were therefore deemed testable and recruited.

Table 6.0. Apache 3 admission diagnosis-ICU		
patients		
Admission Diagnosis	Freq	Percent
Acute Myocardial Infarction (NonOperative)	1	1.41
Aspiration Pneumonia (NonOperative)	7	9.86
Bacterial Pneumonia (NonOperative)	10	14.08
Burns (NonOperative)	1	1.41
CABG with valve repair or replacement	3	4.23
COPD (NonOperative)	2	2.82
Cardiac Arrest (NonOperative)	4	5.63
Cardiomyopathy (NonOperative)	1	1.41
Cellulitis/soft tissue infection (PostOperative)	1	1.41
Congestive Heart Failure (NonOperative)	1	1.41
Coronary Artery Bypass Graft	10	14.08
Dissecting Aortic Aneurysm (PostOperative)	1	1.41
Drug overdose (NonOperative)	2	2.82
GI Neoplasm (PostOperative)	2	2.82
GI Obstruction (NonOperative)	1	1.41
GI Obstruction (PostOperative)	1	1.41
GI Perforation/rupture (PostOperative)	3	4.23
GI Vascular ischemia resection surgery	1	1.41
Mechanical Airway Obstruction (NonOperative)	1	1.41
Multiple trauma excluding head (NonOperative)	3	4.23
Peritonitis (PostOperative)	2	2.82
Renal Neoplasm (PostOperative)	1	1.41
Seizure (NonOperative)	1	1.41
Sepsis of Urinary tract origin with sho	1	1.41
Sepsis other than urinary (NonOperative)	2	2.82
Sepsis with shock other than urinary tract	3	4.23
Valvular Heart Surgery (PostOperative)	4	5.63
Viral Pneumonia (NonOperative)	1	1.41
Total	71	100

Table 7.0. Principal diagnoses surgical controls

Admission diagnosis	Operation	Freq (%)	Anaesthetic type	ICU admission (Y/N)	Reason for ICU admission
Surgical Controls acute abdomen	appendicectomy	1 (3.12)	GA	N	NIL
acute choecystitis	NIL	1 (3.12)	NIL	N	NIL
acute ischemic gangrenous right	right below elbow	1 (3.12)	GA	N	NIL
hand bilateral varicose veins	amputation bilateral high ligation and stripping varicose veins	1 (3.12)	GA	N	NIL
bowel cancer	laparotomy, subtotal colectomy, open	1 (3.12)	GA	Υ	acute pulmonary oedema
cancer gall bladder	cholecystectomy NIL	1 (3.12)	NIL	N	NIL
cellulitis left leg	NIL	1 (3.12)	NIL	N	NIL
cholelithiasis with cholodocolithiasis	laparoscopic cholecystectomy	1 (3.12)	GA	N	NIL
cholodocolithiasis	ERCP	1 (3.12)	GA	N	NIL
Chron's disease	reversal of ileostomy	1 (3.12)	GA	N	NIL
colorectal carcinoma	right hemicolectomy, bilateral salpingoopherec	1 (3.12)	GA	N	NIL
diverticulitis with rectal bleed	tomy NIL	1 (3.12)	NIL	N	NIL
elective right hemicolectomy	right hemicolectomy	1 (3.12)	epidural	N	NIL
enterocutaneous fistula, anterior	incision and drainage	1 (3.12)	GA	N	NIL
wall cellulitis ischaemic heart disease	coronary artery bypass grafts	2 (6.25)	GA	Υ	routine post-op care
left buccal adenocystic cancer	excision left buccal adenocystic	1 (3.12)	GA	N	NIL
left mastectomy	cancer left mastectomy	1 (3.12)	GA	N	NIL

Table 7.0. (Continued)	Operation	Freq (%)	Anaesthetic type	ICU admission (Y/N)	Reason for ICU admission
Non-Hodgkin's lymphoma	biopsy	1 (3.12)	GA	N	NIL
pancreatitis	NIL	2 (6.25	NIL	N	NIL
pelvic cyst drainage and repair incisional hernia	pelvic cyst drainage and repair incisional hernia	1 (3.12)	GA	N	NIL
pre sacral abscess	CT guided pre sacral abscess drainage	1 (3.12)	GA	N	NIL
reversal of colostomy	reversal of colostomy	1 (3.12)	GA	N	NIL
reversal of loop colostomy	reversal of loop colostomy	1 (3.12)	GA	N	NIL
right ankle fracture	open reduction and internal fixation	1 (3.12)	GA	N	NIL
right transverse process fractures, rib fractures	nasal laceration repair, split skin graft, wound washout	1 (3.12)	GA	N	NIL
sepsis following fundoplication surgery	fundoplication	1 (3.12)	GA	N	NIL
sigmoid cancer	recto-sigmoid resection	1 (3.12)	GA	N	NIL
small bowel obstruction band adhesion	laparotomy, division of band adhesion	1 (3.12)	GA	N	NIL
unhealing left index toe ulcer	amputation left index toe, angiogram	1 (3.12)	GA	N	NIL

Seventy-one ICU patients and seventy-two controls were consecutively recruited at discharge. Statistically, a 2:1 match was the aim, that is, 1 ICU patients each matched to 1 medical and 1 surgical control however due to financial constraints, a 1:1 match was used. ICU patients were consecutively recruited at ICU discharge, after which sex-matched controls were randomly selected within a five year age range of cases. Both medical and surgical controls were representative of medical and surgical acute-care admissions, at this time.

<b>Table 8.0</b> . Principal diagnoses medical controls  Principal admission diagnosis	Freq (%) (N=40)
acute coronary syndrome	3 (7.5)
acute myocardial infarction with VF arrest	1 (2.5)
amyloidosis	1 (2.5)
asthma	2 (5)
atrial flutter	1 (2.5)
atypical chest pain	2 (5.0)
chest pain and dyspnoea	1 (2.5)
chron's disease	1 (2.5)
confusion	1 (2.5)
congestive cardiac failure	4 (10)
coronary artery disease	1 (2.5)
dermatitis right leg	1 (2.5)
diverticular abscess	1 (2.5)
exacerbation chronic obstructive airways disease	1 (2.5)
forefoot cellulitis	1 (2.5)
fracture lumbar vertebrae	1 (2.5)
general deterioration	1 (2.5)
heart failure	1 (2.5)
infective exacerbation chronic obstructive airways disease	1 (2.5)
metastatic cancer	1 (2.5)
myocardial ischaemia	1 (2.5)
non cardiac chest pain	1 (2.5)
non healing leg wound	1 (2.5)
pancreatic pseudocyst and pancreatitis	1 (2.5)
pericarditis	1 (2.5)
pneumonia	1 (2.5)
recurrent falls	1 (2.5)
respiratory failure, pneumonia	1 (2.5)
spontaneous pneumothorax	1 (2.5)
stabilisation of blood sugar levels	1 (2.5)
ulcerative colitis	1 (2.5)
unstable angina	2 (5.0)

Data relating to admission (Table 9.0) show ICU patients had a mean ICU length of stay (LOS) of 5.9 days and 29 hospital days compared with the controls mean LOS of 7.5 days. Ninety-three percent ICU patients were intubated and 42% of ICU patients had at least one episode of severe sepsis. Twenty-three percent of ICU patients suffered chronic obstructive airways disease and obstructive sleep apnoea (almost 9% smokers) compared with 14% of controls. Hypertension was also common among both groups although 6% more frequent among ICU patients. Even so, equal numbers had a diagnosis of cardiovascular disease. There were a higher proportion of controls with diabetes occurring in 31% of controls and only 24% among ICU patients. Other comorbidities were equally weighted within both groups. Comorbidities which may influence testing outcomes were cerebrovascular accident, dementia/delirium, head injury, depression, psychiatric illness and chronic alcohol and drug abuse also were equally weighted between both groups. Data relating to doses of Morphine,

Midazolam and Propofol were not collected for controls as doses were considered incidental.

Table 9.0. In-hospital interventions and comorbidities. Numbers are mean (SD) or number (%). ICU Test Control Mean (SD) Ν Mean (SD) Ν This admission Arterial line 72 0 71 69 (97%) Cardiac arrest 72 0 67 8 (12%) Central line 72 1 70 70 (100%) Arrhythmia 72 1 (1%) 64 22 (34%) 25 (40%) Episode of sepsis (severe 72 0 62 sepsis) Haemofiltration 72 0 70 5 (7%) Mechanical ventilation 72 71 150.9 (151.9) 1 (hours) ICU day number 72 1 63 5.9 (5.5) Insulin therapy 72 0 0 Intercostal catheter 72 0 70 18 (26%) Intra-aortic balloon pump 72 0 70 5 (7%) 72 0 70 Intra-cranial pressure 0 monitor Intubation 72 0 71 66 (93%) 72 0 71 3 (4%) Laparotomy Number of septic episodes 71 (severe sepsis) 0 0 39 (58%) 19 (28%) 1 0 0 6 (9%) 2 0 3 (5%) 3 or more PA catheter 72 0 71 22 (31%) Medical history 72 CABG valve surgery 0 70 2 (3%) 72 Carcinoma 13 (18%) 71 5 (7%) 72 71 Cardiac arrest 0 1 (1%) 72 71 Cardio-respiratory arrest 0 0 72 10 (14%) 71 16 (23%) COAD OSA 72 Hypoxic insults 71 0 0 (Pao2/FIO2<200) 72 70 Incontinence 1 (1%) O 72 2 (3%) 71 2 (3%) Obesity 72 4 (6%) 5 (7%) 71 Respiratory arrest 72 2 (3%) 69 1 (1%) Type 1 diabetes 72 20 (28%) 71 16 (23%) Type 2 diabetes 72 9 (13%) 71 5 (7%) Alcohol abuse 72 24 (33%) 71 23 (32%) Cardiovascular disease 72 2 (3%) 71 3 (4%) Chronic drug abuse Chronic neurologic disease 72 1 (1%) 70 CVA or hemiparesis 72 4 (6%) 70 10 (14%) Depression 72 7(10%) 71 10 (14%) Head injury 72 1 (1%) 70 0 Table 9.0 (continued) Chronic heart failure 72 1(1%) 71 5 (7%) Chronic renal failure 72 3 (4%) 71 3 (4%) Dementia / delirium 72 1 (1%) 71 0 Hypertension 72 27 (38%) 71 31 (44%)

0

71

2 (3%)

72

Psychiatric disorder

Seizures	72	2 (2%)	70	3 (4%)
Spinal cord injury	72	1 (1%)	71	1 (1%)
Apache 2		NA	71	19.0 (8.0)
Apache 2 ROD		NA	59	0.34 (0.25)
Apache 3		NA	71	67.2 (27.8)
Apache 3 ROD		NA	71	0.23 (0.24)
SAPS 2		NA	71	39.9 (14.9)
SAPS 2 ROD		NA	71	0.29 (0.24)
Days in ICU		NA	71	9.3 (7.2)
Days in hospital	72	7.5 (5.2)	71	29.1 (30.9)
Ventilation (hours)	İ			
Invasive		0	71	151 (152)
Non-invasive	1	0	71	3.4 (9.2)
Morphine (mg)		0	71	358 (754)
Midazolam (mg)	1	0	71	396 (861)
Propofol (mg)		0	71	7669 (10958)
Noradrenaline (mg)		0	71	34.4 (50.6)
SOFA total		NA	71	7.8 (2.1)
Days before death	72	492.5 (470.2)	22	616 (491)

#### **Correlations between Critical Care Treatments and Outcomes**

Unadjusted correlations between ICU treatments, severity scoring criteria and positive coefficients show strong relationships. Strongly significant relationships exist between Days in ICU and noradrenaline (mg) and SOFA score. This means as the Days in ICU increase, the amount of noradrenaline (mg) increased by a coefficient of 0.269 (p < 0.05) and the total SOFA score increased by a coefficient of 0.871 (p < 0.0001). Similarly as the hours of invasive ventilation increased, so did noradrenaline (mg), the SOFA score and the days in ICU. As the number of septic episodes increase (per patient) so does the SOFA score, days in ICU and hours of ventilation. (It should be noted, associations between SOFA and APACHE scores and noradrenaline (mg) were not analysed further as noradrenaline is a score component). Positive relationships between these parameters reflect a clinical reality. Each parameter is commonly used as a clinical indicator of patient acuity so an increase of one parameter would be expected to be reflected similarly in the others (Table 10.0).

Table 10.0.         Unadjusted correlations among ICU intervention variables for ICU patients.	

Parameter	Noradrenaline	SOFA total	Days in ICU	Invasive ventilation (hrs)	Apache 3 ROD
Days in ICU	0.269*	0.871****	~		
Invasive ventilation (hrs)	0.284*	0.871****	0.962****	~	
Apache3 ROD	~	0.102	-0.008	0.0031	~
Number septic episodes	0.198	0.267*	0.267*	0.343**	0.105

<sup>\*&</sup>lt;0.05 \*\*<0.01 \*\*\*<0.001 \*\*\*\*<0.0001 ~ not analysed

## Correlations between critical care treatments and outcomes at each timepoint

Unadjusted correlations among ICU treatment variables, severity scoring criteria and cognitive outcome tasks at each time-point show significant relationships. Noradrenaline is used clinically as a component of or individual indicator of severity of illness in the APACHE 3 and SOFA scores. Clinically, as the mean dose of noradrenaline is increased, the severity of illness increases and outcomes would be expected to be worse. The APACHE 3 score and SOFA score are mortality prediction tools currently used in critical care; higher scores equating to higher mortality. Again as severity of illness increases, clinical outcomes would be expected to be worse. Study data confirms these relationships (Table 11.0).

Table 11.0. Unadjusted correla	tions among	a ICII into	ruantian va	riables and
cognitive test outcomes for ICL	_		vention vu	nubles unu
	Stroop 3	TMT	DS	LNS
Noradrenaline (mg)				
1 month	0.217	0.256	-0.036	-0.225
3 months	0.095	0.347*	-0.167	-0.176
6 months	0.197	0.342*	-0.177	-0.300*
12 months	0.285*	0.103	-0.177	-0.261*
24 months	0.261	0.247	0.042	-0.033
SOFA score				
1 month	0.084	0.036	-0.067	-0.010
3 months	-0.011	0.093	-0.014	0.09
6 months	0.104	0.174	-0.153	-0.071
12 months	0.09	0.227	-0.066	0.0002
24 months	0.126	0.299*	-0.004	0.002
Days in ICU				
1 month	-0.050	-0.058	0.075	0.023
3 months	-0.161	0.0004	0.059	0.142
6 months	-0.023	0.164	-0.025	0.075
12 months	-0.078	0.216	-0.059	0.102
24 months	-0.010	0.224	-0.020	0.026
Ventilation hours				
1 month	-0.114	-0.103	0.035	0.013
3 months	-0.178	-0.036	-0.008	0.136
6 months	-0.096	0.147	-0.076	0.09
12 months	-0.091	0.232	-0.079	0.093
24 months	-0.040	0.216	0.034	0.032
APACHE 3 ROD				
1 month	0.230	0.348	0.184	-0.111
3 months	0.293*	0.054	-0.076	-0.216
6 months	0.085	0.092	-0.028	-0.234
12 months	0.262	0.135	0.023	-0.149
24 months	0.348*	0.350*	-0.081	-0.053

#### ICU variables of significance

#### Noradrenaline

Data shows significant relationships between noradrenaline and the TMT, the LNS and the SNST across the study period. Correlations between noradrenaline and the TMT at 3 and 6 months show as milligrams of noradrenaline increase, the TMT mean score increases (worsens). At 6 and 12 months, as milligrams of noradrenaline increase, the LNS mean score decreases (worsens). Finally, at 12 month time point, as milligrams of noradrenaline increase, the SNST mean score increases (worsens).

#### SOFA score

A significant relationship exists between the SOFA score and the mean TMT at 24 months which indicates as the mean SOFA score increases, the mean TMT increases (worsens).

## APACHE3 ROD

Data shows relationships between the APACHE 3 risk of death (ROD) score and the mean SNST scores at three and the SNST mean score and TMT mean score at 24 months. This indicates, at three month time point, as the APACHE 3 ROD mean score increases, the SNST mean score increases (worsens). Similarly at 24 months, as the APACHE 3 ROD mean score increases, the SNST mean score increases (worsens). Also at 24 months, as the APACHE 3 ROD mean score increases, the TMT mean score increases (worsens).

#### **Test Outcomes**

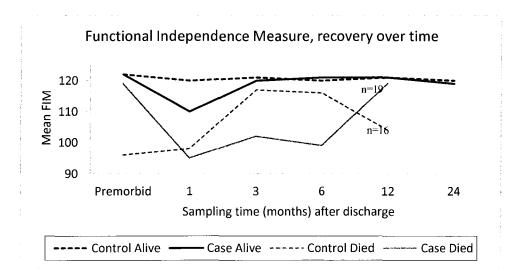
This following section describes the functional, cognitive and psychosocial outcomes of both groups.

#### **Functional Outcomes**

In this study, functional outcome describes the ability of a person to perform the functional skills used for activities of daily living. Functional outcome was measured using the FIM. The FIM is used extensively in Australia within areas of rehabilitation medicine to monitor overall

functional capacity and to monitor changes in patient condition. It provides a valuable metric which measures progress of functional skills used particularly for ADL's. The higher the FIM score the higher the functional capacity. The score range is between 18 and 126, with impairment classified, in this study, as scores < 108. 175

Results of the FIM show overall ICU patients and controls score similarly at all timepoints, with both groups holding the same level of function pre admission. Interestingly, neither group score 126, full functional independence, at any stage throughout the study period. At 1 month the mean scores for surviving ICU patients drop to impaired levels not recovering to premorbid levels until 12 months. Surviving control mean scores, however, dip very mildly at one month, quickly recovering to exceed premorbid values at 3 months. Standard deviation of data throughout all timepoints (except time point 12 months) for ICU patients, uncover impairment. Surviving controls show impairment at the premorbid and one month time points only. Deceased patient scores show lower values compared to survivors particularly deceased controls yet both deceased groups recover to the premorbid level before death (Figure 2.0, Appendix 1.1).



**Figure 2.0** Functional Independence Measure - ICU Cases and Controls recovery over time (A higher score denotes improvement)

Analysis was performed using mixed model regression. Due to deceased patients showing an altered recovery curve compared with survivors, analysis was performed on both, survivors only and the cohort as a whole. Data show ICU patients have a significantly lower level of physical function (FIM score) at each time point relative to controls (Coefficient, -0.056; CI, -

0.112 to -0.001;  $p \le$  0.002; all ICU patients, and Coefficient -0.061; CI, -0.114 to -0.009;  $p \le$  0.021; age, sex adjusted, ICU survivors only).

Similarly, comparing age related data as a patients' mean age increases, the functional outcome mean scores decrease (worsen) at each time point relative to younger patients (Coefficient, -0.123; CI, -0.235 to -0.012;  $p \le 0.029$ , all older patients and Coefficient, -0.128; CI, -0.208 to -0.047;  $p \le 0.002$  for older survivors only, sex adjusted) (Table 12.0).

Table 12.0 Functional Indep	oendence Measure Effect	over Time		
Functional Impairment	Coefficient	р	Coefficient	р
Measure (FIM)	(95% CI)	value	(95% CI)	value
	Time x Case		Age x Time	
Survivors	-0.061	0.021	-0.128	0.002
	(-0.114 to -0.009)		(-0.208 to -0.047)	
All	-0.056	0.002	-0.123	0.029
	(-0.112 to -0.001)		(-0.235 to -0.012)	

#### **Neuropsychological Outcomes**

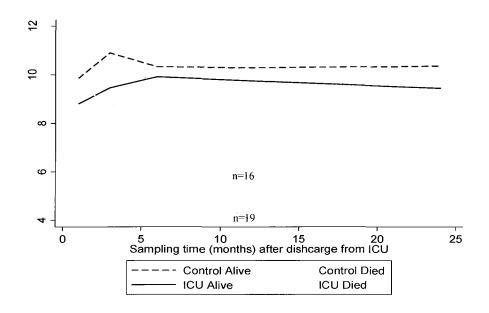
#### • Mini Mental State Examination

Prior to neuropsychological testing, patients were screened using the MMSE. The MMSE is a very brief screening test of cognitive mental state, commonly used to screen for dementia. Patients were deemed cognitively fit for neuropsychological testing if achieved a MMSE score greater than 24. Looking at test outcomes for each group, the mean MMSE was similar for both groups. All participants scored above the minimum testing requirement of 24 (Appendix 2.0).

#### Digit Span

The DS is a standardised measure of auditory-verbal short-term memory. Age scaled scores were used to remove effect of age on task performance. Higher scores show improvement with impairment classified as  $ASS \le 4$ , two standard deviations below the mean ASS. ICU patients do not ever achieve the mean normative score. Among survivors, data show controls mean scores were higher (improved) with a higher sustained level of recovery from

day 28 throughout 24 months. The pattern or shape of recovery curves were very similar for ICU patients, however, the mean score for ICU patients being always lower than controls. Both groups exceed day 28 scores at three months with scores plateauing at six months. Controls reach the mean normative score range of ≥ 10 and plateau. Deceased patient test curves (both groups) differ from both survivor and total cohort curves with scores being lower with a gradual decline prior to death (Figure 3.0, Appendix 1.2). Overall, mixed model analysis shows no statistical significance between groups and recovery over time (Table 13.0).



**Figure 3.0** Digit Span Test Outcomes - ICU Cases and Controls recovery over time (A higher score denotes improvement)

Digit Span (scaled	Case x Time	<i>p</i> value
score)	Coefficient	
	(95% CI)	
Survivors	0.008	0.727
	(-0.038 to 0.055)	
All	0.008	0.705
	(-0.037 to 0.055)	

Among ICU patients, the incidence of impairment on the DS increases at each time point, trending up from 13.64% at one month to 17.39% (peaking) at 24 months. The incidence of

impairment for controls remains fairly steady, seeing a gradual trend for improvement from six months on (Table 14.0).

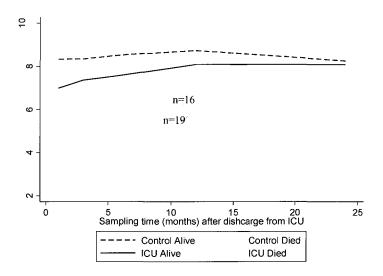
DS	ICU	J			Controls	
from discharge (months)	Not impaired	Impaired	Dead	Not impaired	Impaired	Dead
1	57	9	0	63	6	0
	(86.36)	(13.64)	(0.00)	(91.30)	(8.70)	(0.00)
3	55	10	3	56	5	3
	(80.88)	(14.71)	(4.41)	(87.50)	(7.81)	(4.69)
6	53	9	6	51	9	6
	(77.94)	(13.24)	(8.82)	(77.27)	(13.64)	(9.09)
12	46	10	10	51	9	7
	(69.70)	(15.15)	(15.15)	(76.12)	(13.43)	(10.45)
24	44	12	13	50	8	10
	(63.77)	(17.39)	(18.84)	(73.53)	(11.76)	(14.71)

(An increase in mean DS score denotes improvement)

## • <u>Letter Number Sequence</u>

The LNS is an auditory-verbal, working memory task which measures executive function. The LNS task is similar to the DS however is deemed to be more sensitive due to the executive function component. Age scaled scores are used to remove effect of age on task performance. Higher scores show increased capacity or improvement with impairment classified as ≤ 4, two standard deviations below the mean ASS. Neither group, at any time point, achieve a mean normative score. Among both groups, 1 month scores are the lowest (worst performance). Both groups exceed their 1 month scores at 3 months and plateau at 6 months. Among survivors, both ICU patients and controls begin to show improvement by 6 months with ICU patients plateauing and sustaining this level. Not surprisingly, controls score higher than ICU patients throughout the two year study period. Where ICU patients sustain a plateaued recovery curve, controls show an ongoing deteriorating trend out to (and beyond) 24 months; although never to drop to levels as low as case score level. Deceased patients show very different recovery curves among both groups, with scores being lower with a gradual decline prior to death. Standard deviations uncover impairment

for survivor ICU patients at 3 months and at all timepoints for deceased cases and 1 month and 3 months for deceased controls (Figure 4.0, Appendix 1.3). Mixed model regression analysis shows, for a one unit increase in LNS mean score, ICU patients increased by a coefficient (factor) of 0.059 (CI, 0.003 to 0.112;  $p \le 0.035$ ) and 0.054 (CI, 0.000 to 0.109;  $p \le 0.049$ ) respectively relative to controls (age, sex adjusted). Therefore ICU patients' mean scores increase (improve) in executive function at each time point relative to controls (Table 15.0).



**Figure 4.0.** Letter Number Sequence Test Outcomes - ICU Cases and Controls recovery over time (A higher score denotes improvement)

Letter Number Sequence (scaled	Case x Time Coefficient	<i>p</i> value
score)	(95% CI)	
Survivors	0.054	0.049
	(0.000 to 0.109)	
All	0.059	0.035
	(0.003 to 0.112)	

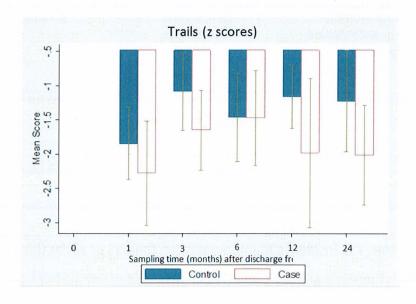
Among ICU patients, the incidence of impairment on the LNS peaks at the 3 month time point after which there is a gradual reduction in incidence of impairment out to 24 months. The incidence of impairment for controls follows a similar trend with incidence much higher than expected for controls, (almost 30% at one month), however remain lower than ICU patients throughout (Table 16.0).

Table 16.0. Letter Number Sequence (Freq; %)							
ICU				Controls			
from discharge (months)	Not impaired	Impaired	Dead	Not impaired	Impaired	Dead	
1	42 (65.63)	22 (34.38)	0 (0.00)	46 (70.77)	19 (29.23)	0 (0.00)	
3	37 (54.41)	28 (41.18)	3 (4.41)	40 (68.97)	15 (25.68)	3 (5.17)	
6	38 (57.58)	22 (33.33)	6 (9.09)	37 (61.67)	17 (28.33)	6 (10.00)	
12	40 (61.54)	15 (23.08)	10 (15.38)	40 (66.67)	13 (21.67)	7 (11.67)	
24	39 (59.09)	14 (21.21)	13 (19.70)	42 (67.74)	10 (16.13)	10 (16.13)	

(Impairment ≤ 4; an increase in mean LNS score denotes improvement)

# Trailmaking Task – Test B

The TMT is a timed task assessing visual-conceptual, perceptual speed, cognitive flexibility, attention and task alternation. The raw test scores were converted to z scores which showed high levels of impairment (Figure 5.0, Table 17.0, Appendix 1.4). Raw test scores have been used to describe outcome only. Results as z scores, are presented below.



**Figure 5.0**. Trailmaking B Task z score Outcomes - ICU Cases and Controls recovery over time (A lower score denotes improvement)

Table 17.0. z score interrpretation

>3.0		Very superior
1.4 - 2.5	=	Superior
0.7 - 1.3	=	High average
0.60.6	=	Average
-0.71.3	=	Low average
-1.41.9	=	Borderline
< -2.0	=	Clinically impaired

Raw study scores are displayed in seconds with no specified level of impairment (Appendix 1.4). Throughout the study period, among survivors, ICU patients show higher scores or greater impairment with both groups peaking at 1 month, the time point of greatest impairment. Both groups improved at 3 months, after which, controls then plateau out to 24 months. ICU patients also plateaued until 12 months after which there is an ongoing upward trajectory, denoting deterioration, continuing to (and possibly past) 24 months. Deceased patient scores (both groups) are considerably higher (worse) than that of the total cohort at day 28, indicating much higher levels of impairment after which drop to below initial testing levels at time of death (Figure 6.0).

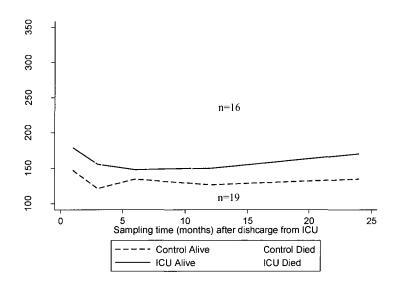


Figure 6: Trailmaking B Task Outcomes - ICU Cases and Controls recovery over time (A lower score denotes improvement)

Mixed model regression analysis shows strong significance between groups recovery over time. As patients' mean age increase levels of executive cognitive impairment increase at each time point relative to younger patients (Coefficient, 2.065; CI, 1.275 to 2.854;  $p \le 0.001$ ;

all older patients, and Coefficient, 1.850; CI, 1.051 to 2.652;  $p \le 0.001$ ; older survivors only, sex adjusted) (Table 18.0).

Table 18.0 Trailmaking B Effect of Age over Time				
Test	Age x Time	<i>p</i> value		
Trailmaking (sec)	Coefficient			
	(95% CI)			
Survivors	1.85	0.000		
	(1.051 to 2.652)			
All	2.065	0.000		
	(1.275 to 2.854)			

# Stroop Task

The SNST is a timed task and measures cognitive flexibility and control and executive functioning. Similar to the TMT, scores were converted to z scores and results showed extraordinarily high levels of impairment (Figure 7.0, Table 17.0, Appendix 1.5).

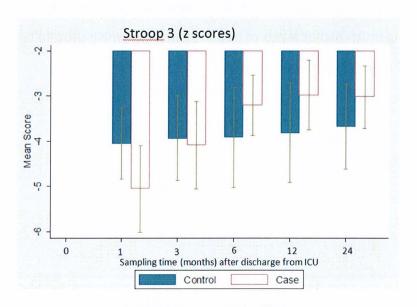
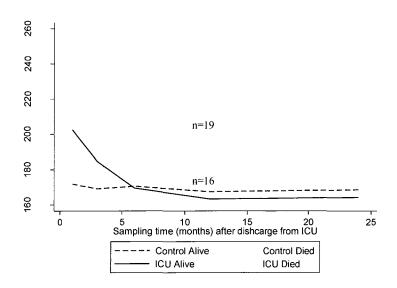


Figure 7.0 Stroop 3 (z scores) - ICU Cases and Controls recovery over time

Table 17.0. z score interrpretation						
>3.0		Very superior				
1.4 - 2.5	=	Superior				
0.7 - 1.3	=	High average				
0.60.6	=	Average				
-0.71.3	=	Low average				
-1.41.9	=	Borderline				
< -2.0	=	Clinically impaired				

The SNST is a general measure of cognitive flexibility, control, mental flexibility and executive function. Study scores are displayed as a ratio of Stroop 3 - Stroop 2 scores with no specified level of impairment (Appendix 3.2). Among survivors, results show highest scores (greatest impairment) for ICU patients at 1 month and improve considerably at time point 3 months to plateau to levels (below controls) sustained out to 24 months. Highest scores and greatest impairment also occur for controls at 1 month although generally remain constant throughout the study period, resting at a higher level to ICU patients. Similar curves of recovery are evident among both survivor groups, with ICU patients and control scores equilibrating after 12 months. Deceased control scores are much higher (worse) than deceased ICU patients (also much higher than overall cohort) with scores decreasing at 3 months although continue to remain much higher than other groups until death (Figure 8.0). Using mixed model regression analysis for a one unit increase in SNST Ratio mean score, older patients' scores increased (worsened) by a coefficient (factor) of 0.009 (CI, 0.004 to 0.013;  $p \le 0.001$ ) and 0.008 (CI, 0.004 to 0.013;  $p \le 0.001$ ) respectively relative to younger patients (sex adjusted). Therefore as patients' mean age increases, cognitive executive function worsens at each time point relative to younger patients (Table 19.0).



**Figure 8.0**. Stroop Task Test Outcomes - ICU Cases and Controls recovery over time (A lower score denotes improvement)

Table 19.0. Stroop Task Age over Time					
Test Coefficient (95%; CI)					
Stroop 3 ratio	Age x Time	p value			
Survivors	0.008 (0.004 to 0.013)	0.000			
All	0.009 (0.004 to 0.013)	0.000			

## **Psychosocial Outcomes**

## Impact of Events Scale – Revised

The IES-R provides a dimensional assessment of PTSD related symptoms. Participants specify the frequency with which they have had avoidance-, intrusion-, and hyper- arousal related thoughts over the preceding seven days. The higher the score is indicative of greater the level of distress, with the total score ranging from 0 - 88. Among survivors, the data indicates that ICU patients have a higher mean score at 1 month which is sustained through to 6 months. Scores decrease sharply by 12 months (improve) and continue until falling to almost match controls at 24 months. Data standard deviation uncovers higher levels of impairment. Controls mean scores are much lower at one month correcting to plateau at six months and

by 24 months show no measurable level of PTSD. ICU patient test scores also drop to negligible levels by 24 months. Data for the deceased ICU patients display similar high levels to the overall cohort, and then dip before peaking again at very high levels at 24 months. However, it needs to be noted that this data is derived from very small numbers. (Figure 9.0, Appendix 1.6).

Mixed model regression analysis outcomes show ICU patients achieve lower scores (greater improvement) in distress symptoms at each time point relative to controls (Coefficient, - 0.348; CI, -0.588 to 0.108; p = 0.004, all cases and Coefficient, -0.350; CI, -0.589 to 0.111; p = 0.004, survivor cases only, age, sex adjusted) (Table 20.0).

Additionally, comparing sex related data for a one unit increase in the mean IES-R total score, female patients and surviving female patients increased by a coefficient (factor) of 2.853 (CI, 0.205 to 5.502; p = 0.035) and 2.630 (CI, -0.049 to 5.310; p = 0.054) respectively

relative to male patients (age adjusted). Therefore female patients showed higher levels of distress symptoms related to PTSD at each time point relative to male patients.

Comparing age related data as patients' mean age increases, distress symptoms decrease (improve) relative to younger patients (Coefficient, -0.161; CI, -0.239 to 0.084;  $p \le 0.001$ , all older patients, and Coefficient, -0.153; CI, -0.231 to 0.076;  $p \le 0.001$ , older survivors only, sex adjusted).

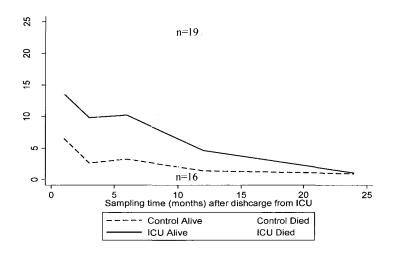


Figure 9.0. Impact of Events Scale – Revised (Total) Test Outcomes ICU Cases and Controls recovery over time

(A lower score denotes improvement)

<b>Table 20.0.</b> Impact of Events Scale – Revised (Total) Effect Over Time						
Test IES	Coefficient	р	Coefficient	р	Coefficient	p value
TOTAL	(95%; CI)	value	(95%; CI)	value	(95%; CI)	
	Case x Time		Age x Time		Sex x Time	
Survivor	-0.350	0.004	-0.153	0.000	2.630	0.054
S	(-0.589 to -		(-0.231 to -		(0.049 to 5.310)	
	0.111)		0.076)			
All	-0.348	0.004	-0.161	0.000	2.853	0.035
	(-0.588 to -		(0.239 to -0.084)		(0.205 to 5.502)	
	0.108)					

The incidence of IES-R impairment (symptoms of distress related to the event) for both groups, were highest for both groups at the one month time point. The incidence within both groups drop dramatically with no impaired within either group at 24 months (Table 21.0.

Table 21.0. Impact of Events Scale – Revised (Freq; %)							
ICU					Contr	ols	
From discharge (months)	Not impaired	Impaired	Dead	Not impaired	Impaired	Dead	
1	58 (82.86)	12 (17.14)	0 (0.00)	65 (91.55)	6 (8.45)	0 (0.00)	
3	61 (85.92)	7 (9.68)	3 (4.23)	64 (94.12)	1 (1.47)	3 (4.41)	
6	60 (85.71)	4 (5.71)	6 (8.57)	62 (88.57)	2 (2.86)	6 (8.57)	
12	56 (80.00)	4 (5.71)	10 (14.29)	61 (87.14)	2 (2.86)	7 (10.00)	
24	58 (81.69)	0 (0.00)	13 (18.31)	59 (85.51)	0 (0.00)	10 (14.49)	

(A decrease in mean IES-R total mean score denotes improvement)

## • <u>Avoidance Component</u>

Avoidance is one of three components of the IES-R. The avoidance component has a total score range between 0-32, the higher the score, the greater the level of avoidance symptoms. ICU patients display much higher levels of avoidance compared with controls at all timepoints, with no overlap of standard deviation at three and six months. This component illustrates a high level of distress among cases which is sustained to six months and then decreases largely by 12 months and further at 24 months. Scores were more moderate for controls and similarly to cases, both display a trajectory of improvement out to 24 months which possibly may continue (Figure 10.0, Appendix 3.3).

Using mixed model regression analysis ICU patients' symptoms of Avoidance decreased (improved) relative to controls (Coefficient, -0.138; CI, 0.221 to -0.055; p = 0.001 for all cases and Coefficient, -0.137; CI, 0.2, for survivor cases only, age, sex adjusted) (Table 22.0).

Comparing age related data, as mean age increases, Avoidance symptoms related to PTSD decrease (improve) relative to younger patients (Coefficient, -0.059; CI, 0.088 to -0.031;  $p \le 0.001$ , older survivors only, sex adjusted).

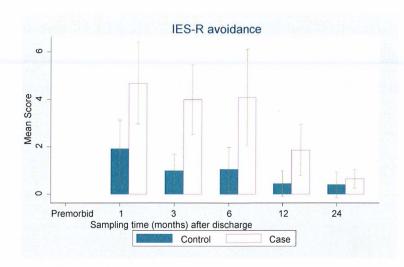


Figure 10.0. Impact of Events Scale – Revised (Component: Avoidance Test Outcomes)

ICU Cases and Controls recovery over time

(A lower score denotes improvement)

Table 22.0. Impact of Event Scale – Revised (Component: Avoidance) Effect over					
		Time			
Impact of	Coefficient	р	Coefficient	p value	
Events	(95%; CI)	value	(95%; CI)		
(Avoidance)	Case x Time		Age x Time		
Survivors	-0.138	0.001	-0.059	0.000	
	(0.221 to -0.055)		(0.088 to -0.031)		
All	-0.137	0.001			
	(0.221to -0.054)				

# • Hyperarousal Component

Hyperarousal is the second component of the IES-R. The hyperarousal component comprises a total score range between 0-24, the higher the score, the greater the level of Hyperarousal symptoms. ICU patients display higher levels of hyperarousal compared with controls at all timepoints although standard deviations overlap for all but for time point six months. Controls show much levels of avoidance with both groups dropping to negligible levels by 24 months. (Figure 11, Appendix 3.4).

Using mixed model regression analysis, ICU patients' symptoms of hyperarousal increased (worsened) relative to controls (Coefficient, 1.731; CI, 0.628 to 2.834; p = 0.002, age, sex adjusted). It is notable there was no statistical significance in case by time effect of surviving ICU patients.

Comparing age related data (excluding deceased) at all timepoints, as patients mean age increases, hyperarousal symptoms related to PTSD decreased (improved) relative to younger patients (Coefficient, -0.042; CI, -0.064 to -0.020;  $p \le 0.001$ , all older patients and Coefficient, -0.042; CI,-0.064 to 0.019;  $p \le 0.001$ , older survivors only, sex adjusted) (Table 23.0).

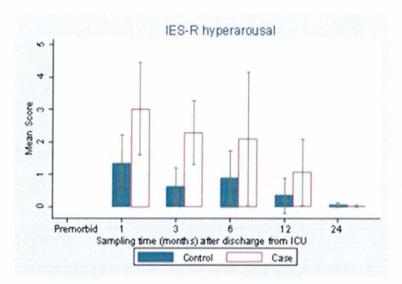


Figure 11.0. Impact of Events Scale – (Component: Hyperarousal)
ICU Cases and Controls recovery over time
(A lower score denotes improvement)

**Table 23.0.** Impact of Events Scale – Revised (Component Hyperarousal) Effect over Time

Impact of	Coefficient	р	Coefficient	p value
Events	(95%; CI)	value	(95%; CI)	
Hyperarousal	Case x Time		Age x Time	
Survivors	-0.079	0.06	-0.042	0.000
	(0.163 to 0.004)	3	(-0.064 to -0.019)	
All	1.731	0.00	-0.042	0.000
	(0.628 to 2.834)	2	(-0.064 to -0.020)	

# • Interruptions Component

Interruptions are the third component of the IES-R. The interruptions component has a total score range between 0-24, the higher the score, the greater the level of interruption symptoms.

The same pattern exists in this component for both groups with higher levels for both groups at day 28, dropping steadily, particularly at 12 months, down to negligible levels at 24

months. Again, scores are much higher for ICU patients at all timepoints, with no overlap in standard deviation at three months. At 24 months ICU patients' scores drop lower than controls (Figure 12.0, Appendix 3.5).

Using mixed model regression analysis, ICU patients' symptoms of interruptions related to PTSD decrease (improve) relative to controls (Coefficient, -0.132; CI, -0.220 to -0.043; p = 0.003, all cases and Coefficient, -0.132; CI, -0.220 to -0.044; p = 0.003, ICU patient survivors only, age, sex adjusted) (Table 24.0).

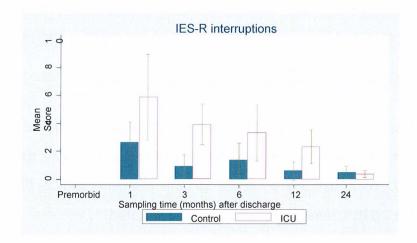


Figure 12.0. Impact of Events Scale-Revised (Component: Interruptions) Test Outcomes
ICU Cases and Controls recovery over time
(A lower score denotes improvement)

<b>Table 24.0.</b> Impact of Events Scale-Revised (Component: Interruptions)  Effect over Time					
Impact of Events Interruptions	Coefficient (95%; CI)	p value			
Case x Time					
Survivors	-0.132	0.003			
	(-0.220 to -0.044)				
All	-0.132	0.003			
	(-0.220 to -0.043)				

## Hospital Anxiety and Depression Scale (HADS)

The HADS is a screening tool developed to measure mood disorders of anxiety and depression in non-psychiatric patients. The total score range is 0 - 28, the higher the score, the greater the level of anxiety and depression symptoms. Among survivors, study data

show both groups show very similarly shaped recovery curves. Both groups of survivors show greatest scores (highest levels of anxiety and depression) at 1 month. Surprisingly, controls show higher levels of anxiety and depression than ICU patients. Both groups show an improving trend (scores declining) with both groups plateauing at 12 months and continuing to drop (improve) through to 24 months (and beyond). ICU patients peak slightly at day 28 however they plateau out to 24 months (Figure 13.0, Appendix 1.7).

Mixed model regression analysis show ICU patients' symptoms of anxiety and depression decrease (improve) at each time point relative to controls (Coefficient, -0.914; CI, -0.168 to -0.014; p = 0.020 for all ICU patients and Coefficient -0.090; CI, -0.165 to -0.014; p = 0.020, survivor cases only, age, sex adjusted, Table 25.0).

Mixed model regression analysis show, within sex related data, female patients score higher levels of anxiety and depression (worse) at each time point relative to male patients (Coefficient, 3.548, CI, 0.427 to 6.669; p = 0.026, all female patients and Coefficient, 3.766, CI, 0.653 to 6.879; p = 0.018, female survivors only, age adjusted).

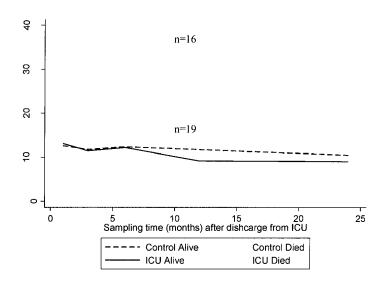


Figure 13.0. Hospital Anxiety and Depression Scale test Outcomes ICU Cases and Controls recovery over time

(A lower score denotes improvement)

Table 25.0. Hospital Anxiety and Depression Scale Effect over Time						
Test HADS TOTAL	Coefficient $p$ value (95%; CI)		Coefficient (95%; CI)	p value		
	Case x Time		Sex x Time			
Survivors	-0.090	0.020	3.766	0.018		
	(-0.165 to -0.014)		(0.653 to 6.879			
All	-0.914	0.020	3.548	0.026		
	(-0.168 to -0.014)		(0.427 to 6.669)			

## Hospital Anxiety and Depression Scale - Component Scores

As HADS subscales (component) data were not used in the predictor model, comparator survivor and deceased patient groups, together with effect over time were not analysed.

## Hospital Anxiety and Depression Scale-Anxiety subscale (HADS-A)

The HADS-A is a self-assessment screening tool for symptoms of anxiety. Subscale scores range between 0 - 14, higher scores greater symptoms of anxiety. Both ICU patients and controls scores were similar at day 28 decreasing at three months however peaking at six months before again trending down out to 24 months, at which point ICU patients' level of anxiety was less than controls. This trend in recovery may continue to improve past 24 months. Deceased patient scores are similar to total cohort scores, with deceased case scores lower (Figure 14.0, Appendix 1.8).

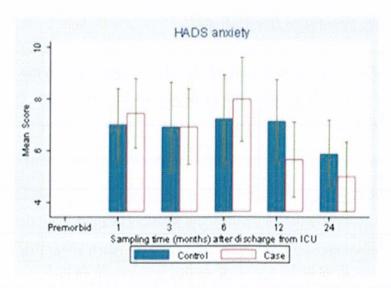


Figure 14.0. Hospital Anxiety and Depression Scale – Anxiety Subscale Test Outcomes ICU Cases and Controls recovery over time

(A lower score denotes improvement)

## Hospital Anxiety and Depression Scale – Depression Subscale (HADS-D)

The HADS-D is a self-assessment screening tool for symptoms of depression. Subscale scores range between 0 - 14, higher scores greater symptoms of depression. Difference in mean scores between ICU patients and controls were greater however levels of depression overall lower at each time point than for anxiety. Levels of depression for both groups were highest at day 28, slowly decreasing towards 24 months. Generally after six months both groups show a trend of recovery towards 24 months with possible ongoing improvement. Test scores indicate the low levels of depression remained fairly constant overall for both groups (Figure 15.0, Appendix 1.9).

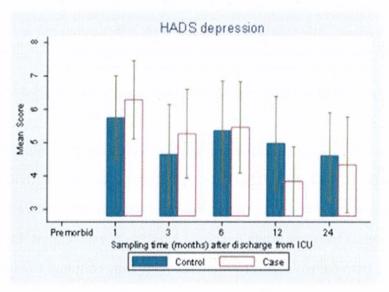


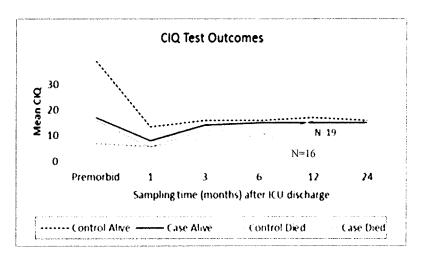
Figure 15.0. Hospital Anxiety and Depression Scale – Depression Subscale ICU Cases and Controls recovery over time (A lower score denotes improvement)

#### Community Integration Questionnaire

The CIQ is a brief measure of an individual's level of integration into the home and community with a score range of 0-29, with impairment defined as a score  $\leq 6$ ). Among survivors, recovery curves are similar for both groups. ICU patients have lower scores (worse) compared with controls, (particularly at premorbid time point) throughout the study period, indicating less integration. Both groups plateau at 6 months with cases showing a slight trend of deterioration at 24 months and possibly beyond. Both deceased groups display very different recovery curves to survivors with much lower test scores throughout the study period, reflecting less integration. (Figure 16.0, Appendix 1.10).

Using mixed model regression analysis, ICU patients' community and home integration decrease (deteriorate) relative to controls at each time point (Coefficient, -0.139; CI, -0.192 to -0.085;  $p \le 0.001$  for all ICU patients and Coefficient, -0.134, CI, -0.186 to -0.082;  $p \le 0.000$ , ICU patient survivors only, age, sex adjusted, Table 26.0).

Comparing age related data as patients mean age increases, anxiety and depression symptoms decreased (improved) relative to younger patients (Coefficient, -0.139; CI, 0.192 to -0.085;  $p \le 0.001$  for all older patients and Coefficient, -0.134; CI,0.186 to -0.082; p=0.000 for older survivors only, sex adjusted) .



**Figure 16.0.** Community Integration Test Outcomes - ICU Cases and Controls recovery over time (A higher score denotes improvement)

<b>Table 26.0.</b> Cor Effect over Time	nmunity Integration Qเ	iestionnaire
Community	Coefficient	<i>p</i> value
Integration	(95% CI)	
Questionnaire	Age x Time	
(CIQ)		
Survivors	-0.134	0.000
	(-0.186 to -0.082)	***
All	-0.139	0.000
	(-0.192 to -0.085)	

## Short Form Questionnaire-36v2

The SF-36v2 is a 36-item multipurpose health quality of life survey that measures overall health, functional status and mental status. It measures 8 domains: role limitations due to physical problems, bodily pain, general health perceptions, energy/vitality, social

functioning, role limitations due to emotional problems and mental health, equating to two summary scales; physical component score and mental component score. Score range is 0 - 100 with impaired classified as  $\leq 45$ .

## • Physical Component Score

Among survivors, premorbid values show ICU patients perceive a higher level of physical health compared with controls although at day 28 both groups drop, before plateauing at three months at similar levels to controls though never regain premorbid levels. Control curves show deterioration from six months continuing to 24 months and possibly beyond. ICU patients drop markedly at 3 months, only reaching control levels at 12 months. The recovery curves of both deceased groups are distinctly different to those of survivors and have substantially lower scores at all timepoints indicating very low perceived levels of physical health. (Figure 17.0, Appendix 1.11). Using mixed model regression survivor ICU patients' quality of life PCS decrease (deteriorate) at each time point relative to survivor controls (Coefficient, -0.350; Cl, -0.463 to -0.236;  $p \le 0.000$ , age, sex adjusted, Table 27.0).

Comparing age related data as patients mean age increases, quality of life PCS decreased (deteriorated) at each time point relative to younger patients (Coefficient, -0.349; CI, -0.459 to -0.000; p=0.000 for all older patients and Coefficient, -0.349; CI,-0.462 to 0.236; p=0.001 for older survivors only, sex adjusted).

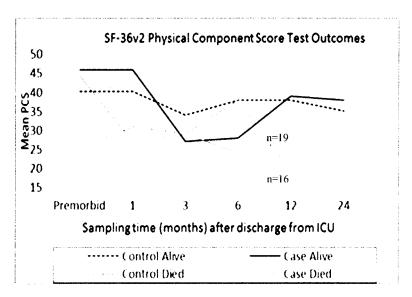


Figure 17.0. SF-36v2 Physical Component Score Test Outcomes ICU Cases and Controls recovery over time (A higher score denotes improvement)

<b>Table 27.0.</b> SF-36v2 Physical Component Score Effect over Time					
SF-36v2	Coefficient	р	Coefficient	<i>p</i> value	
PCS	(95% CI)	value	(95%;CI)		
	Case x Time		Age x Time		
Survivors	-0.350	0.000	-0.349	0.000	
	(-0.463 to -0.236)		(-0.462 to -0.236)		
All			-0.349	0.000	
			(-0.459 to 0.000)		

Surprisingly, 70% of controls were impaired at the premorbid time point, compared with 40% of cases. The incidence of PCS impairment among both groups is highest at the one month time point after which both groups show a trend of improvement out to 24 months. At 24 month time point, almost 48% of ICU patients are impaired while the incidence of impairment among controls at 24 months is exceeds 56% (Table 28.0)

	SF-36v2 PCS ICU			SF-36v2 PCS Controls		
from discharge (months)	Not impaired	Impaired	Dead	Not impaired	Impaired	Dead
Preadmission	40 (57.14)	30 (42.86)	0 (0.00)	19 (28.36)	48 (71.64)	0 (0.00)
1	4 (5.71)	66 (94.29)	0 (0.00)	10 (14.93)	57 (85.07)	0 (0.00)
3	19	49	3	21	38	3
	(26.76)	(69.01)	(4.23)	(33.87)	(61.29)	(4.84)
6	20	44	6	22	36	6
	(28.57)	(62.86)	(8.57)	(34.38)	(56.25)	(9.38)
12	22	39	10	20	37	7
	(30.99)	(54.93)	(14.08)	(31.25)	(57.81)	(10.94)
24	24	34	13	17	35	10
	(33.80)	(47.89)	(18.31)	(27.42)	(56.45)	(16.13)

# • <u>Mental Component Score</u>

Overall, among survivors, both groups score similarly at all timepoints, plateauing between 3 and 6 months and maintaining this level out to 24 months. ICU patients have a slightly higher level of MCS than controls at all timepoints, perceiving a higher level of mental health and

continue to maintain a higher score out to 24 months (Figure 18.0, Appendix 1.12). Using mixed model regression sex related data show female patients score lower MCS levels relative to male patients (Coefficient, -4.428; CI, -8.488 to -0.369; p=0.032, age adjusted, Table 29.0).

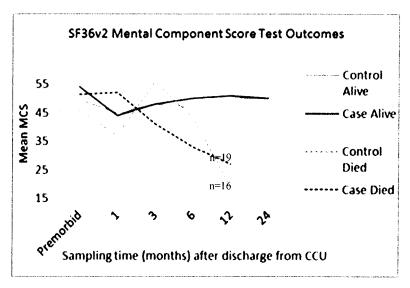


Figure 18.0. SF36v2 Mental Component Score Test Outcomes

ICU Cases and Controls recovery over time

(A higher score denotes improvement)

<b>Table 29.0</b> SF-36v2 Mental Component Score Effect over Time				
SF36v2 MCS	Coefficient (95% CI) Sex x Time	p value		
Survivors	-4.428 (-8.488 to -0.369)	0.032		

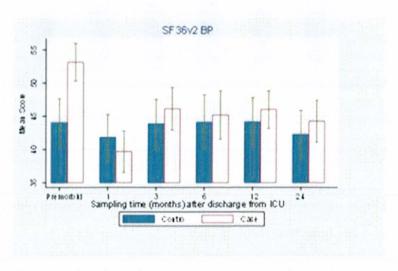
The highest incidence of impairment for the MCS for both groups is the one month time point, with ICU patients showing 50% impairment and controls comparatively less although high levels of incidence with almost 42% impaired. However at 24 months, the incidence of impairment among cases drops lower than controls, with 18% of ICU patients still impaired and almost 26% of controls impaired (Table 30.0).

<b>Table 30.0</b> SF36v2 Mental Component Score (Freq; %)						
SF-36v2 MCS ICU			SF-36v2 MCS Controls			
from discharge (months)	Not impaired	Impaired	Dead	Not impaired	Impaired	Dead
PREMORBID	59 (84.29)	11 (15.71)	0 (0.00)	49 (73.13)	18 (26.87)	0 (0.00)
1	35 (50.00)	35 (50.00)	0 (0.00)	39 (58.21)	28 (41.79)	0 (0.00)
3	42 (59.15)	26 (36.62)	3 (4.32)	38 (61.29)	21 (33.87)	3 (4.84)
6	44 (62.86)	20 (28.57)	6 (8.57)	41 (64.06)	17 (26.56)	6 (9.38)
12	46 (64.79)	15 (21.13)	10 (14.08)	39 (60.94)	18 (28.13)	7 (10.94
24	45 (63.38)	13 (18.31)	13 (18.31)	36 (58.06)	16 (25.81)	10 (16.13

## • Short Form Questionnaire - 36v2 Factor scores

# • SF-36v2- Bodily Pain (BP)

Examining test scores at each time point from premorbid time point through to 24 months, cases perceive a higher level of bodily pain at premorbid time point which reduces at one month although again climbs and plateaus at 3 months. The BP component measured by controls was constant throughout the study period dipping slightly at 1 month, although also plateauing after 3 months (Figure 19.0, Appendix 1.13).



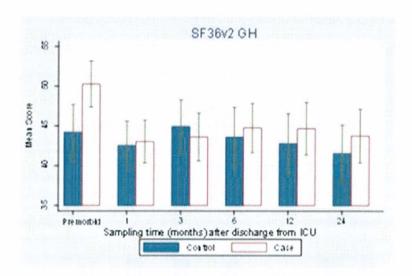
**Figure 19.0.** SF36v2-BP (Bodily Pain) Test Scores - ICU Cases and Controls recovery over time (A higher score denotes improvement)

There is no statistical significance between groups during the recovery of ICU patients and controls within the BP subgroup (Table 31.0).

Table 31.0	<b>)</b> . Change in Si	F-36v2 l	BP score over the 2-year study period
SF-36v2 subgroup	Controls	ICU	<i>p</i> -value
ВР	0.24	0.14	0.350

### • SF-36v2-General Health

Examining test scores at each time point from premorbid time point through to 24 months, show ICU patients regard they have a higher level of GH compared with controls at premorbid time point dipping sharply at day 28 closer to control levels and then plateauing to 24 months. The level of perceived GH for controls is much lower at premorbid time point, and although dip slightly at day 28 exceed premorbid levels by 3 months however after which subtly fall lower than ICU patients consistently from six months through to 24 months (Figure 20, Appendix 1.14).



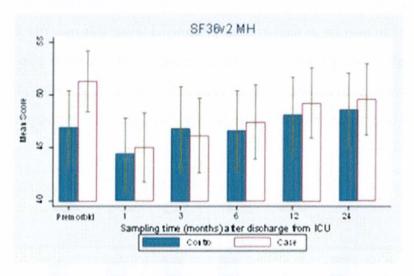
**Figure 20.0.** SF36v2-GH (General Health) - ICU Cases and Controls recovery over time (A higher score denotes improvement)

There is no statistical significance between groups during the recovery of ICU patients and controls within the GH subgroup (Table 32.0).

Table 3	<b>2.0.</b> Change	in SF	36v2-GH score over the 2-year study period
SF-36v2 subgroup	Controls	ICU	<i>p</i> -value
GH	0.24	0.15	0.28

# • SF-36v2-Mental Health

Based on test scores, ICU patients perceive a higher level of MH compared with controls at premorbid time point falling sharply at day 28 to levels closer to controls however recovery curves show an ongoing upward trajectory out to 24 months. Although ICU patients do not regain their premorbid level of perceived MH during the 24 month study period the trajectory suggests one of ongoing improvement. The control group's perceived MH likewise dips at day 28 although not as sharply as cases at the same time point and likewise continue to steadily improve out to and possibly past 24 months (Figure 21, Appendix 1.15).



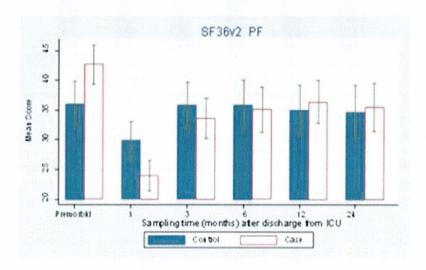
**Figure 21.0.** SF-36v2-MH (Mental Health) - ICU Cases and Controls recovery over time (A higher score denotes improvement)

There is no statistical significance between groups during the recovery of ICU patients and controls within the MH subgroup (Table 33.0).

<b>Table 33.0.</b> Change in SF-36v2 MH score over the 2-year study period									
SF-36v2	Controls	ICU	<i>p</i> -value						
subgroup									
МН	0.38	0.35	0.772						

# • SF-36v2-Physical Functioning

Examining test scores at each time point from premorbid time point through to 24 months, ICU patients show higher test scores at premorbid time point compared with controls dropping dramatically at day 28. By the 3 month time point test scores show an improvement with continuing improvement to 24 months, however ICU patients do not ever regain their premorbid test scores within the 24 months, showing that ICU patients do not perceive their PF to ever be as high as their premorbid level. This may merely be indicative of potential bias when asking patients to reflect retrospectively. Controls also perceive a reduction in physical functioning at day 28 reflected by lower test scores although recovering well to premorbid levels by three months (Figure 22.0, Appendix 1.16).



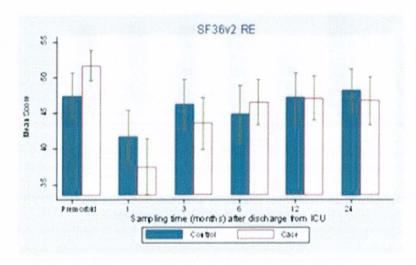
**Figure 22.0.** SF-36v2-PF (Physical Function) - ICU Cases and Controls recovery over time (A higher score denotes improvement)

The recovery of physical function (PF) between ICU patients and controls was statistically significant (Table 34.0).

<b>Table 34.0.</b> Change in SI st	F-36v2 –PF so udy period	ore over	the 2-year
SF-36v2 subgroup	Controls	ICU	<i>p</i> -value
PF	-2.85	-3.06	0.024

## • SF-36v2-Role Emotional

Examining test scores at each time point from premorbid time point through to 24 months show at the premorbid time point, ICU patients scoring more highly in the area of RE than controls. Both group scores drop dramatically at day 28 with controls showing recovery to premorbid levels by 3 months, continuing to improve and exceeding premorbid levels at 24 months, with the potential for continued improvement past 24 months. Recovery for ICU patients is more gradual, with test scores showing gradually recovery by 3 months and plateau at 12 months. ICU patients so not ever perceive they regain premorbid levels in the area of emotional health (Figure 23, Appendix 1.17).



**Figure 23.0** SF-36v2-RE (Role Emotional) - ICU Cases and Controls recovery over time (A higher score denotes improvement)

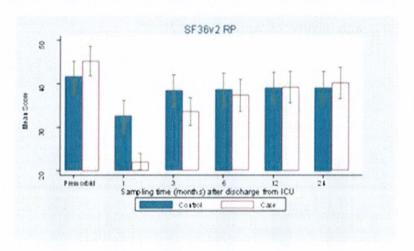
There is no statistical significance between groups during the recovery of ICU patients and controls within the RE subgroup (Table 35.0).

**Table 35.0.** Change in SF-36v2 RE score over the 2-year study period

	AND DESCRIPTION OF THE PERSON		
SF-36v2	Controls	ICU	<i>p</i> -value
subgroup			
RE	-2.07	-2.12	0.679

#### SF-36v2-Role Physical

Examining test scores at each time point from premorbid time point through to 24 months show ICU patients dip very sharply at day 28 in response to the effects of critical illness, to a much greater degree compared with control test scores. Recovery is evident by 3 months with scores continuing to increase out to 24 months, however ICU patient scores do not ever match premorbid levels within the 24 month study period. This shows the potential for further recovery past 24 months. Controls adopt the same pattern of recovery with a more modest drop in scores at day 28. Recovery is seen at 3 months however RP test scores plateau at this point and do not regain their perceived premorbid levels of RP function (Figure 24.0, Appendix 1.18).



**Figure 24.0.** SF-36v2-RP (Role Physical) - ICU Cases and Controls recovery over time (A higher score denotes improvement)

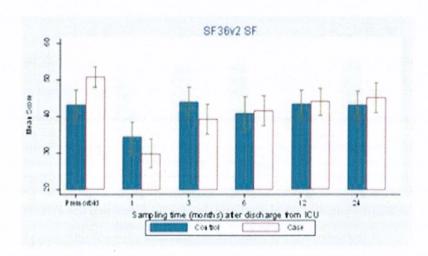
There is no statistical significance between groups during the recovery of ICU patients and controls within the RP subgroup (Table 36.0).

Table 36.0. Change in SF-36v2 RP score
over the 2-year study period

SF-36v2	Controls	ICU	<i>p</i> -value
subgroup			
RP	-5.90	-6.28	0.000

#### • SF-36v2-Social Function

Based on test scores at each time point from premorbid time point through to 24 months show ICU patients perceive a higher level of SF at the premorbid time point compared with controls. Both groups test scores drop at day 28 with ICU patients showing a trajectory of continued recovery out to 24 months. The levels of perceived premorbid SF are not regained during the 24 months study period however the ICU patient trajectory show cases potentially may continue to improve out past 24 months. Controls show recovery to premorbid levels by 3 months after which they plateau, with no further improvement in their perceived SF past 3 months (Figure 25.0, Appendix 1.19).



**Figure 25.0**. SF-36v2-SF (Social Functioning) - ICU Cases and Controls recovery over time (A higher score denotes improvement)

at 3 months to similar levels of controls. ICU patients do not show recovery in either component score back to premorbid levels within the 24 month study period. Control curves show deterioration from six months continuing out to 24 months. ICU patients have a slightly higher level of MCS than controls and continue to maintain a higher score out to 24 months.

**Test Scores for Diagnostic Subgroups** 

- 1. Sepsis
- 2. Neoplasia
- 3. Trauma
- 4. Other

Data was sorted into the diagnostic subgroups of 'sepsis', 'trauma' 'neoplasia' and 'other', to examine significance of test outcome among specific diagnostic groups. Test scores and recovery curves include combined data of both survivors and deceased scores (Appendix 4.1 – 4.11). Significance between groups is calculated using independent-samples t-test. Patient numbers within each diagnostic subgroup vary. Overall sample sizes of diagnostic subgroups are small, with trauma and neoplasia considered too small to analyse (< 10 participants). Discussion will only include the statistically significant subgroups, being the sepsis diagnostic group using the DS, LNS, TMT, SNST, SF36v2 MCS, CIQ and FIM and the 'other' diagnostic subgroup using the SF-36v2 PCS and IES-R. Mean scores are displayed in Appendices 4.1 – 4.11.

# Sepsis subgroup

The sepsis diagnostic subgroup shows significance between group recoveries for the DS, LNS SNST, TMT, MCS, CIQ and FIM tasks while the 'Other' subgroup shows significance between groups for the TMT, PCS and IES-R tasks (Table 39.0).

Table 39.0. Outcome among diagnostic subgroups

Diagnostic	LNS	LNS	DS	DS	STROOP	SNST	TMT	TMT	MCS	MCS	PCS	PCS	CIQ	CIQ	HADS	HADS	IES-R	IES-R	FIM	FIM	N	N	
subgroup	traj	(p)	traj	(p)	traj	(p)	traj	(p)	traj	(p)	traj	(p)	traj	(p)	traj	(p)	traj	(p)	traj	(p)	control	case	
SEPSIS	$\downarrow$	0.000	$\downarrow$	0.000	$\downarrow$	0.004	$\downarrow$	0.001	$\uparrow$	0.004	~	0.342	$\downarrow$	0.048	~	0.291	~	0.415	$\downarrow$	0.025	15	29	
OTHER	~	0.420	~	0.276	~	0.090	J	0.006	~	0.278	J	0.025	~	0.402	~	0.081	<b>1</b>	0.017	~	0 149	45	32	

 $<sup>\</sup>uparrow$  improving trajectory;  $\downarrow$  declining trajectory;  $\sim$  not significant

### • Sepsis subgroup - Digit Span

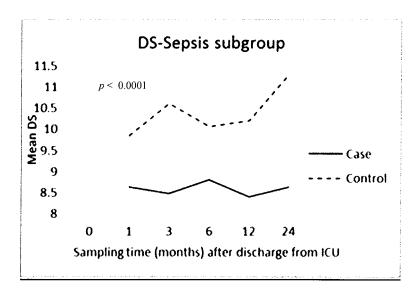


Figure 27.0. Digit Span Task Outcomes for subgroups ICU Cases and Controls recovery over time (A higher score denotes improvement)

The sepsis subgroup shows strong statistical significance of DS test outcome when comparing the recovery of ICU patients and controls. Mean test scores are lower for ICU patients (worse outcome) compared with controls. ICU patients show worse outcome in the sepsis subgroup in the area of verbal memory. Recovery curves for sepsis shows ongoing improvement in mean scores throughout the 24 month period. Recovery curves in the sepsis subgroup are very similar as seen in the overall survivor DS task and LNS sepsis subgroup. Clinically there is no evidence of impairment (≤4) within mean test scores for ICU patients or controls (Figure 27.0).

# • Sepsis subgroup - Letter Number Sequence

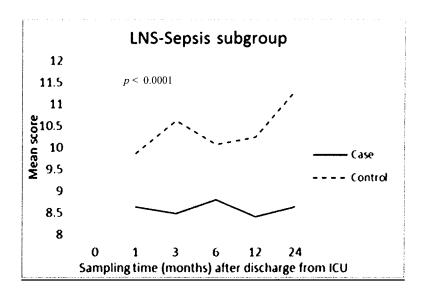


Figure 28.0. Letter Number Sequence Test Outcomes for subgroups ICU Cases and Controls recovery over time

(A greater score denotes improvement)

For the test outcome of LNS, only sepsis shows statistical significance, showing an ongoing trajectory of improvement at 24 months among ICU patients and controls. Mean test scores are lower for ICU patients compared with controls in the sepsis subgroup. Recovery curves for ICU patients and controls show an ongoing improvement throughout the 24 month study period for sepsis. This follows a similar pattern as seen in the DS task. Both tasks measure verbal working memory however the LNS also contains an executive function component increasing the test sensitivity to cognitive decline. Similarity of recovery curves of the sepsis subgroup to the overall survivor recovery curves is evident, also seen with the DS task. Clinically, mean test scores do not uncover any clinical impairment ( $\leq$  4) for ICU patients or controls. ICU patients show worse outcome in the sepsis subgroup in the area of verbal memory and executive function (Figure 28.0).

# Sepsis subgroup - Stroop Task

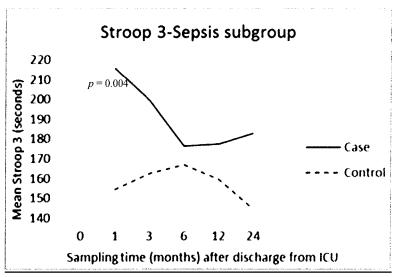


Figure 29.0. SNST task Test Outcomes for subgroups ICU Cases and Controls recovery over time (A lower score denotes improvement)

Within the SNST outcomes, sepsis shows strong statistical significance when comparing outcomes of ICU patients and controls. Recovery curves are distinctly different within this subgroup to the overall survivor study cohort, with ICU patients showing worse outcome throughout the 24 month study period, with a deteriorating trajectory. Cohort survivor ICU patient curves improve and supersede controls at 6 months after which both plateauing between 6 and 12 months with a slight trajectory of deterioration out to 24 months. ICU patients show higher test scores (worse outcome) in the sepsis group. Differences may be the direct effect of increased homogeneity, small numbers or skewing caused by deceased patients (Figure 29.0). ICU patients show worse outcome in sepsis subgroup in the area of executive function, specifically multitasking.

# • Sepsis Subgroup - Trailmaking B Task

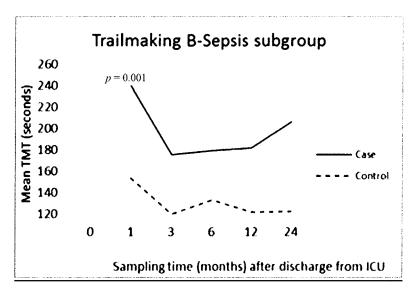
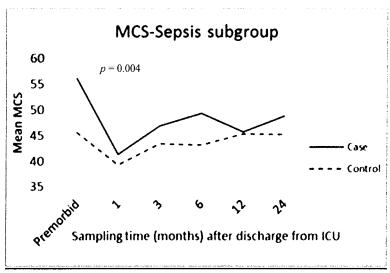


Figure 30.0. Trailmaking B Task Test Outcomes for subgroups (seconds)
ICU Cases and Controls recovery over time
(A lower score denotes improvement)

Within the TMT, the sepsis subgroup only shows statistical significance. There is wide variation of test scores and recovery curves for both ICU patients and controls. ICU patients are seen to achieve higher mean test scores (worse outcome) compared with controls. Recovery curve of the sepsis subgroup closely aligns with the recovery curve seen in the overall TMT survivor cohort. ICU patients show lower mean test scores (worse outcome) in sepsis subgroup in the area of executive function than controls (Figure 30.0.)

# • Sepsis Subgroup – SF-36v2 (Mental Component Score)



**Figure 31.0.** SF36v2 MCS Test Outcomes for subgroups - ICU Cases and Controls recovery over time; (A higher score denotes improvement)

Within the SF-36v2 MCS, the sepsis subgroup only shows statistical significance. Mean test scores are similar for cases and controls. Sepsis subgroup shows a trajectory of improvement at 24 months. Mean test scores show clinical impairment ( $\leq$  45) for ICU patients prior to admission. Clinically meaningful improvement occurs by 1 month for ICU patients of sepsis subgroup which is sustained to 24 months. Control mean test scores of sepsis subgroup marginally improve and plateau from the 6 month time point, sustained to 24 months (Figure 31.0).

### • Sepsis Subgroup - Community Integration Questionnaire

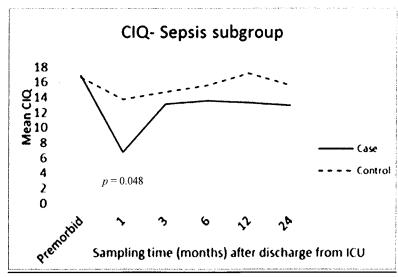


Figure 32.0. Community Integration Questionnaire Test Outcomes for subgroups ICU Cases and Controls recovery over time

(A higher score denotes improvement)

The subgroup, sepsis show strong statistical significance of CIQ test outcome when comparing the recovery of ICU patients and controls. Test scores show higher mean scores for controls compared to ICU patients throughout the 24 month study period. Both ICU patients and controls improve at 1 month after which scores plateau for both out to 24 months. Neither groups show clinical impairment (<6) at any time point throughout the study period. Recovery curves compare with the survivor CIQ study cohorts however subgroup recovery curves show lower levels of community independence at the premorbid timepoint for both groups. ICU patients show worse outcome than controls in the subgroup of sepsis (Figure 32.0).

### Sepsis Subgroup - Functional Independence Measure

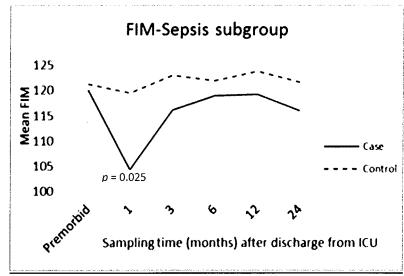


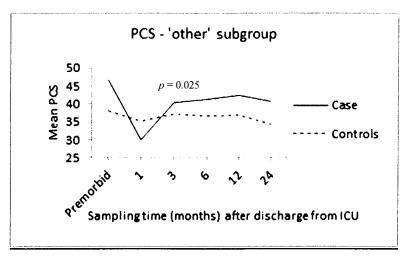
Figure 33.0. Functional Independence Measure test Outcomes for subgroups ICU Cases and Controls recovery over time

(A higher score denotes improvement)

The subgroup, sepsis show strong statistical significance of FIM test outcome when comparing the recovery of ICU patients and controls. Mean test scores remain lower (worse) for ICU patients than controls throughout the entire study period. ICU patients show clinical impairment at premorbid time point (<108) after which there is noted improvement at 1 month however the recovery curve shows a negative trajectory at 24 months. Controls mean test scores are considerably higher at premorbid time point, after which plateau and are sustained throughout the study period. Recovery curves are comparatively similar to the survivor FIM study cohorts however subgroup recovery curves show lower levels of functional independence at the premorbid time point for both controls. ICU patients show worse outcome than controls in the subgroup sepsis (Figure 33.0).

# Other subgroup

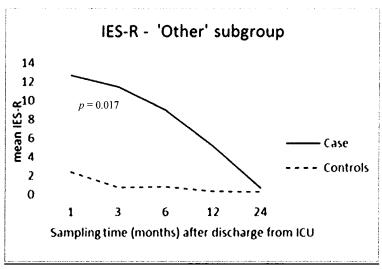
• Other subgroup – SF-36v2 (Physical Component Score)



**Figure 34.0**. SF-36v2 PCS Test Outcomes for subgroups ICU Cases and Controls recovery over time (An increase in SF36v2 PCS mean score denotes improvement)

The PCS recovery curves within the Sepsis subgroup show mean test scores for controls show clinical impairment (≤ 45) prior to admission. Clinically meaningful improvement occurs by one month for ICU patients of sepsis subgroup which is sustained to 24 months. Both group test scores worsen at the 1 month time point with only marginal improvement for controls out to 24 months. ICU patients do show improvement at 6 and 12 month timepoints however show an ongoing trajectory of deterioration at 24 months. Neither group achieve premorbid levels of PCS recovery (Figure 34.0).

# • Other Subgroup - Impact of Events - Revised



**Figure 35.0**. Impact of Events-Revised test outcomes for subgroups – mean score (A lower score denotes improvement)

The only subgroup to show statistical significance in IES-R outcome recovery between ICU patients and controls is the 'other' subgroup. Recovery curves show a gradual but definite improving recovery for ICU patients out to 24 months. Control test scores are much lower (better) than ICU patients and plateau to almost negligible levels from 1 month, sustained through to 24 months. ICU patients show higher levels of PTSD related to the episode of illness than controls. The ICU patient recovery curve reflects the gradual reduction in perceived stress in relation to the episode of illness (similar to the study survivor cohort) there is a matching of control recovery curve at 24 months. ICU patients show higher levels of PTSD related to the episode of illness in the 'other' subgroup (Figure 35.0).

# Defining Impairment

Holding an understanding of the outcome and recovery curves of ICU patients and controls overall, the effects over time and recovery curves of subgroups it was time to interrogate the ICU patient data to start prediction analyses. Methodically decisions were made in relation to:

- level of outcome
- defining level of impairment
- identify predictors of morbidity and mortality (Table 40.0)
- define the clinically relevant outcome measures

Significant univariates were used to inform a multivariable model (adjusting for multicollinearity, age and sex), to form a battery of tests which give the relative risk of impairment and death for ICU patients at 24 months.

### **Defining level of impairment**

Impairment was defined for a group of outcome measures aimed to reflect a clinically meaningful overview of recovery. Levels of impairment are derived from validated sources.

<b>Table 40.0.</b> Outcome measures impairment descriptors
24 month OUTCOME MEASURES
(Impaired)
Letter Number Sequence (LNS) - Impairment ≤ 4
Digit Span (DS) – Impairment ≤ 4
SF-36v2 Physical Component Score (PCS) Impairment ≤45
SF-36v2 Mental Component Score (MCS) Impairment ≤ 45
Residential Support
<ul> <li>Inpatient acute care</li> </ul>
<ul> <li>Inpatient rehabilitation unit</li> </ul>
<ul> <li>Living at home with carer</li> </ul>
Nursing home resident
Mobility Impairment
<ul> <li>Hospitalised</li> </ul>
House mobile

The DS and LNS levels of impairment are defined as recommended by WAIS-III <sup>197</sup> as two standard deviations below the norm. PCS and MCS impairment are defined by authors Ware et al 1992 as scores or 45 or less. Residential support and mobility impairment are clinically relevant levels at which require moderate levels of carer support. Frequencies of impairment for each outcome measure are presented in following graphs (Table 40.0). ICU patients show increasing impairment from baseline to 24 months across all outcomes except for LNS which shows 34% impaired at baseline (1 month) dropping to 21at 24 months. PCS and MCS component baseline scores reflect premorbid values, showing participants regard their quality of life, across both physical and mental domains worse at 24 months than prior to admission. Social support show greater than four times more impaired at 24 months than baseline (prior to admission) and mobility impairment also show greater numbers of impaired at 24 months (Table 41.0).

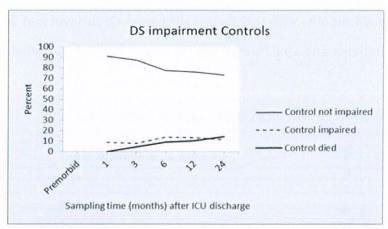
Controls however show an improvement or reduction in number of impaired at 24 months across all domains except in the DS which shows a slight increase in the number of impaired at 24 months. The level and number of impaired across all domains for controls were considerably higher than anticipated, anticipating the acute-care patient cohort as a controls group who would exhibit normative scores. At baseline (1 month) almost 30% of controls were impaired; canvassing scores greater than two standard deviations below normative levels. Physical component quality of life scores show greater than 70% of controls regarded their physical quality of life impaired prior to admission.

Table 41.0. Impaired at 24 months (%)										
	Baseline Impaired ICU (%)	24 month Impaired	Baseline Impaired controls	24 month Impaired	Baseline inter- group	24 month intergroup Difference (%)				
LNS	34.38	ICU (%) 21.21	(%)	controls (%) 16.13	Difference (%)	4 27				
DS	13.64	17.39	29.23 8.70	11.76	5.15 4.94	4.27 5.63				
SF-36v2 PCS SF-36v2	42.86 15.71	47.89 18.31	71.64 26.87	56.45 25.81	28.78 11.16	8.56 7.5				
MCS Social	2.86	9.86	6.06	0.00	3.20	9.86				
Support Mobility Impairment	4.23	7.04	10.45	3.17	6.22	3.87				

#### Digit Span

Although overall ICU patients show higher numbers of impaired DS at each time point compared with controls throughout the whole study period, both groups show a very similar trend throughout the study period, with the proportion of impaired being equivalent. At 24 months, the proportion of impaired ICU patients continue to increase whereas the proportion of impaired controls appear to gently plateau although numbers remain higher than day 28 levels in both groups. Of survivors, at 24 months, there were 21.43% ICU patients and 13.79% controls impaired. Both ICU patients and controls show a steady decline in unimpaired patients throughout the study period, although is greater among ICU patients. Given the LNS and DS are both cognitive tasks measuring verbal working memory, what is noticeable is from day 28 through to six months, the LNS show double the number of

impaired patients than the DS across both groups. One difference perhaps can be attributed to the LNS also measuring executive function, making it more sensitive to general cognitive impairment than the DS in this population (Figure 36.0, Table 42.0).



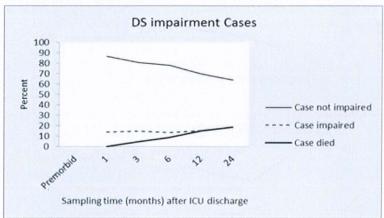


Figure 36.0 Digit Span Impairment over time (ICU cases and controls)

Table 4	<b>2.0.</b> Digit Span (I	requency of I	Impaired at	24 months)
	Impaired	Impaired	Impaired	Impaired
	ICU (total)	(survivors)	controls (total)	controls (survivors)
DS	17.39	21.43	11.76	13.79

# Letter Number Sequence

Overall ICU patients show higher numbers of LNS impaired at each time point, across the study period with both groups showing similar recovery curves. Recovery curves deviated at 3 months with the proportion of impaired ICU patients increasing at 3 months before

assuming a downward trend, almost matching the level of impaired controls at 24 months. Proportionally, the number of unimpaired remains relatively steady within both groups. While ICU patients show a slight decrease in numbers of unimpaired at 3 months, overall the trend remains static throughout the 24 month study period. Controls show a very slight downward trend at 24 months with slightly less deceased. Of survivors, at 24 months, there were 22.22% ICU patients and 19.23% controls impaired (Figure 37.0, Table 43.0).

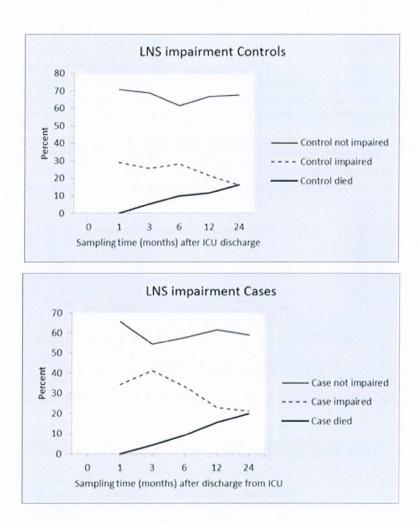


Figure 37.0. Letter Number Sequence Impairment over time (ICU cases and controls)

Table 4	<b>3.0.</b> Letter Numb a	er Sequence at 24 months)		of Impaired	
	Table 45.0. LN	S % Impaired	at 24 mont	hs	
	Impaired ICU (total)	Impaired ICU (survivors)	Impaired controls (total)	Impaired controls (survivors)	
LNS	20.28	22.22	16.94	19.23	

#### • SF-36v2-Physical Component Score

The SF-36v2 PCS show very high numbers of impaired ICU patients and controls throughout the study period. At premorbid time point, controls show 71.64% and cases, 42.86% impairment of their total samples. Both impaired ICU patients and controls increase sharply at 1 month, seeing the number of ICU patients double to 94.29% and 85% controls. Both groups displayed a reduction in numbers of impaired at 24 months, the downward trend more acute for controls across the study period. The proportion of unimpaired dip sharply at 1 month within both groups however ICU patients show a slight downward trend across the study period, whereas controls display a definite upward trend out to 24 months. Of survivors, at 24 months, there were 58.62% ICU patients and 67.30% controls impaired (Figure 38.0, Table 44.0).

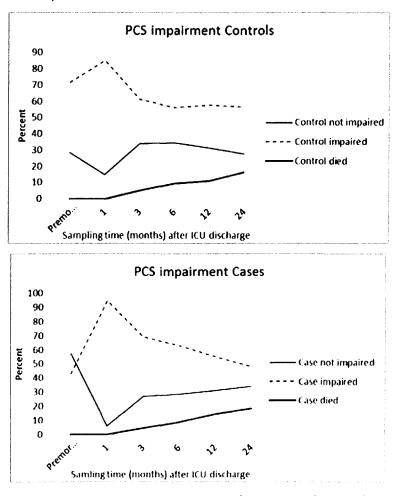
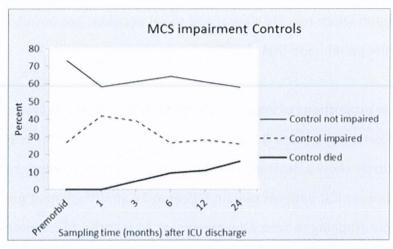


Figure 38.0. SF-36v2 PCS Impairment over time (ICU cases and controls)

**Table 44.0.** SF-36v2 PCS (Frequency of Impaired at 24 months) % Impaired at 24 months **Impaired Impaired Impaired Impaired** ICU ICU controls controls (total) (survivors) (total) (survivors) SF-36v2 PCS 47.88 58.62 56.45 67.30

#### SF-36v2-Mental Component Score

Proportionally, the number of impaired in the area of MCS within both groups are by far less than seen in the Physical Component Score, however, groups show similar trends across the study period. Controls show a greater number of impaired at the premorbid time point with both groups increasing sharply at the 28 day time point (number of ICU patients double to exactly match the number of unimpaired at 50%). Both groups show a downward trend and reduction in numbers of impaired at 24 months, with controls returning to premorbid levels, and ICU patients not achieving this within the 24 month study period. ICU patients show a greater proportion of unimpaired at premorbid time point, although drop by 30% (compared to controls who drop by approximately 15%) at 1 month. Overall, both ICU patients and controls show a downward trend in numbers of unimpaired throughout the study period, with cases approximately 21% less and controls 15%. Of survivors, at 24 months, there were 22.41% ICU patients and 30.77% controls impaired (Figure 39.0, Table 45.0).



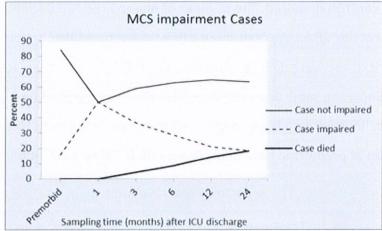


Figure 39.0. SF-36v2 MCS Impairment over time (ICU cases and controls)

	% Imp	aired at 24 m	onths	
	Impaired ICU (total)	Impaired ICU (survivors)	Impaired controls (total)	Impaired controls (survivors)
SF-36v2 MCS	18.30	22.41	25.8	30.77

# Social support

Residential support was included as a secondary indicator or lifestyle measure, based on living arrangements and support required. Frequencies are derived from the defining classification criteria of acute care inpatient, inpatient of a rehabilitation unit, living at home with carer or a nursing home resident. All were deemed to be indicative of an increased level

of dependence upon which real life clinical and social decisions are based, for the health care team as well as the patient and their family.

Data show similar proportions of impaired within both groups at the premorbid time point after which, ICU patients increase by approximately 35% (controls 4%) at 1 month. Both ICU patients and controls show a declining trend in proportion of impaired across the 24 month study period, however ICU patients remain higher at 24 months than at premorbid time point and controls dropping to zero. Of survivors, at 24 months, there were 12.07% ICU patients and 0% controls impaired. The number of unimpaired ICU patients is seen to decrease sharply at day 28 and overall show a downward trend throughout the study period. Still, at 24 months, there were 17% fewer unimpaired ICU patients than at premorbid time point. Controls show the same downward trend in the proportion of unimpaired across the 24 month period, however to a lesser degree, showing approximately 10% fewer unimpaired at 24 months than at premorbid time point (Figure 40.0, Table 46.0; Appendix 5.1).

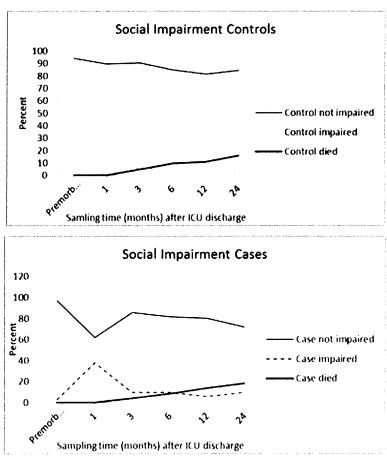


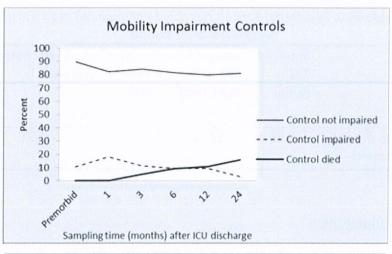
Figure 40.0. Residential Support Impairment over time (ICU patients and controls)

<b>Table 46.0.</b> Residential Support (Frequency of Impaired at 24 months) % Impaired at 24 months									
	Impaired ICU	Impaired ICU	Impaired controls	Impaired controls (survivors)					
	(total)	(survivors)	(total)						
Residential Support	9.85	12.07	0.00	0.00					

#### Mobility Impairment

Mobility Impairment, similar to Residential support was included as a secondary indicator or lifestyle measure, based on the level of mobility; defined as house mobile or hospitalised. Both were deemed to be indicative of an increased level of dependence upon which real-life clinical and social decisions are based. These measures were also included as it is such real-life parameters which are of most use to patients and their families.

The proportion of impaired participants in both groups, spiked sharply at day 28 although both ICU patients and controls show a similar downward trend throughout the study period. At 24 months, the proportion of impaired ICU patients remain higher than at premorbid levels however the proportion of impaired controls drop below premorbid levels. Of survivors, at 24 months, there were 8.62% ICU patients and 3.17% controls impaired. There were proportionally higher numbers of unimpaired ICU patients at premorbid time point, seen to trend down where at 24 months, there were over 20% fewer unimpaired ICU patients. Controls also show the downward trend in unimpaired throughout the 24 months, however at 24 months, there were approximately 9% fewer unimpaired participants than at premorbid time point (Figure 41.0, Table 47.0; Appendix 5.2).



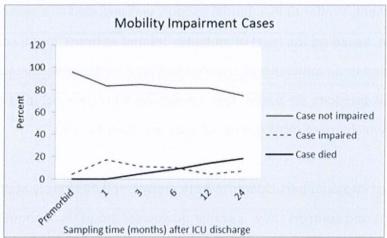


Figure 41.0. Mobility Impairment over time (ICU cases controls)

**Table 47.0.** Mobility Impairment (Frequency of Impaired at 24 months)

	%	Impaired at 2	24 months	PO TE STORY TO A SPO.
	Impaired ICU (total)	Impaired ICU (survivors)	Impaired controls (total)	Impaired controls (survivors)
Mobility Impairment	7.04	8.62	3.17	3.77

### Return to Work

The functional consequences to the ICU survivor can be severe. To the survivor and the community, successful return to work often signifies a successful recovery while a failure to return to work or changes in patterns of employment signifies failure of

an otherwise successful recovery. The status of return to work has profound consequences to the individual and family, both economic and psychosocial. The outcome measure of work capacity is a reflection of one aspect of the social cost of illness. There is much inter-study variability within the literature with this outcome. Consistently studies show with ICU patients that work status often changes throughout the first year, with a decrease in the number of survivors in full-or part-time employment. <sup>23, 147</sup>

# Days off work

ICU patients had a much higher rate of time off work compared with controls. The ICU patient rate of sick leave was very similar at 3 months as was for 1 month. Rates surprisingly increased over three fold, at 6 month time point after which reduced at 12 months with only 6 days recorded overall at 24 months. Controls took much lower levels of leave overall, with highest levels recorded at 1 month time point although again increasing at 6 months, falling to zero days at 12 and 24 months (Table 48.0; Appendix 7.0)

Table 48.0 Days off work									
Test		Control		ICU					
Days off work	N	Mean (SD)	N	Mean (SD)					
Preadmission	9	1.6 (4.7)	13	13.8 (49.9)					
1 month	14	15.4 (17.6)	18	27.8 (40.4)					
3 months	10	9 (28.4)	17	54.6 (54.4)					
6 months	9	20 (60.0)	15	97.3 (94.4)					
12 months	7	0	13	74.2 (88.2)					
24 months	1	0	4	6.0 (12.0)					

The mean age of the study cohort was 61.7 years with the majority (greater than 70%) of participants within both groups' retirees. Subsequently numbers of employed /unemployed/ students were very small which may skew analyses. Both groups show a reduction in the number of employed over the 24 month study period; for controls a reduction from 13 people employed at baseline (prior to admission) to 6 employed at the 24 month time point.

Numbers of unemployed were negligible within controls cohort, dropping from 1 to 0. Unemployed ICU patients increased at 24 month time point, going from 0 to 2 cases.

Closer examination of the work capacity data (Tables 49.0, 50.0) indicates that of those employed, there was a reduction in the hours worked per week within both groups. The number of controls who worked 35 hours or more per week decreased by 5.5% (4 people) from baseline (prior to admission) to 24 months with the number of people classified as working less than 35 hours per week increasing from 2 to 3 ICU patients. ICU patients show a reduction in numbers working 35 hours or more each week of 5% (3 people) from baseline (prior to admission) compared to the 24 month time point, while concurrently showing an increase from 5.08 - 8.47% (three to five people) at 24 months. Numbers of unemployed were negligible within both groups, with number of unemployed ICU patients increasing from 0 to 2 at 24 months.

								Table	49.0. (	CONTROLS WO	RK CAP	ACITY							
		≥35		< 35		Age		Disability						Sicknes		Not		Retired/Home	
Episode		hrs/w		hr/w		Pension		Pension		Unemployed		Student		S		Stated		duties/not in	
number	N	k (N)	% _	k (N)	%	(N)	%	(N)	%	(N)	%	(N)	%	Benefit	% _	(N)	%	labour force	%
PREMORBID	59	12	20.34	2	3.39	35	59.32	6	10.17	1	1.69	2	3.39	1	1.69	0	0.00	43.00	72.88
1	59	2	3.39	3	5.08	35	59.32	8	13.56	1	1.69	2	3.39	7	11.86	1	1.69	50.00	84.74
3	56	5	8.93	5	8.93	33	58.93	8	14.29	1	1.79	2	3.57	2	3.57	0	0.00	44.00	78.57
6	56	7	12.50	5	8.93	31	55.36	9	16.07	0	0.00	2	3.57	2	3.57	0	0.00	43.00	96.43
12	56	8	14.29	4	7.14	32	57.14	9	16.07	0	0.00	2	3.57	1	1.79	0	0.00	43.00	76.78
24	54	8	14.81	3	5.56	31	57.41	10	18.52	0	0.00	2	3.70	0	0.00	0	0.00	41.00	75.93

									able 50.	O. ICU WORK	CAPACI	TY							
	-													Sicknes				Retired/Home	
		≥35		< 35		Age		Disability						s		Not		duties/not in	
Episode		hrs/w		hr/w		Pension		Pension		Unemployed		Student		Benefit		Stated		labour force	
number	N	k (N)	%	k (N)	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)	%	(N)	%
PREMORBID	59	11	18.64	3	5.08	35	59.32	6	10.17	0	0.00	1	1.69	0	0.00	3	5.08	44	74.57
1	59	3	5.08	1	1.69	38	64.41	7	11.86	1	1.69	0	0.00	8	13.56	2	3.39	54	91.52
3	56	6	10.17	3	5.08	38	64.41	6	10.17	1	1.69	0	0.00	5	8.47	0	0.00	49	83.04
6	56	10	16.95	2	3.36	38	64.41	6	10.17	1	1.69	0	0.00	2	3.39	0	0.00	46	77.97
12	56	10	16.95	4	6.78	38	64.41	5	8.47	2	3.39	0	0.00	0	0.00	0	0.00	43	72.88
24	54	8	13.56	5	8.47	40	67.80	4	6.78	2	3.39	0	0.00	0	0.00	0	0.00	44	74.57

Employment status show numbers within groups of casual and permanent employees also very small, with no trend evident. Overall ICU patients had a much higher rate of time off work after discharge compared with controls. The rate of sick leave among ICU patients was very similar at three months as was for day 28. Rates surprisingly increased three fold at 6 month time point for ICU patients after which appeared to reduce at 12 months with only six days recorded overall between 12 and 24 months. Controls took much lower levels of leave overall, with highest levels at 1 month although again increasing at 6 months, falling to zero days at 6 – 12 month and 12 - 24 month periods.

### **Prediction Analysis**

Holding a tool which enables clinicians to predict a patient's outcome at 24 months after discharge from the ICU will have high utility. It will assist patients and families make informed treatment choices knowing of their likely long-term outcome. It will help inform health care teams (both the critical care through to rehabilitation teams) help allocate effectively their limited numbers of beds to those with the greatest need and those who potentially show best long-term outcome.

Predicting impairment or death at 24 months after ICU discharge prior to admission or at one month after admission was a secondary aim. A predictor, when applied to mixed model regression uncovered multiple, significant relationships of impairment and or death, for cases at 24 months. Univariate analysis provided the necessary information to enable the informed selection of a set of predictors and outcomes to progress the area of prediction analysis. From the univariate analysis, mixed model regression analyses showed statistically significant relationships to study outcomes (Table 51.0).

Outcome measures include cognitive tasks, the LNS and DS (verbal memory / executive function), quality of life component scores (PCS, MCS), residential support, and mobility impairment. Impairment is defined as previously. Premorbid predictors include the FIM, CIQ, both performed retrospectively, years of education and CACI. One month predictors include the FIM, CIQ, APACHE 3 ROD and the MMSE. Tables 52.0 and 53.0 show results of mixed model regression using the listed predictors and outcome measures. Prediction was based on premorbid and one month. Using mixed model regression relative risk ratios were

calculated (95% CI) against each outcome measure, for the morbidity and mortality outcomes of impairment and death.

Tab	Table 51.0. Predictors and Outcomes							
PREDICTORS (Premorbid & 28 day)	24 month OUTCOME MEASURES (Impaired and Death)							
Functional Independence Measure (FIM)	Letter Number Sequence (LNS) - Impairment ≤ 4							
Community Integration Score (CIQ)	Digit Span (DS) – Impairment ≤ 4							
Years Education	SF36v2 Physical Component Score (PCS) Impairment ≤ 45							
Charlson Age Comorbidity Index (CACI)	SF36v2 Mental Component Score (MCS) Impairment ≤ 45							
APACHE 3 Risk of Death (ROD)	Residential Support							
Mini Mental State Examination (MMSE)	Mobility Impairment  • Hospitalised  • House mobile							

# Prediction analysis results discussion

### Premorbid predictors and outcome

Of the premorbid predictors, years of education shows a strong association for mobility impairment at 24 months (RRR 0.539; p = 0.023). This indicates for a one unit increase in years of education, the risk of mobility impairment decreases by 46.1%. Years of education also proves to be a strong predictor of death at 24 months. For a one unit increase in years of education, the relative risk of death (measured by LNS, DS, PCS, residential support and mobility impairment) all decrease between 17.3 - 29.3% at 24 months after discharge from critical care. In clinical terms, greater the years of education, the risk of death decreases at 24 months after discharge from critical care.

The premorbid FIM score proves to be a strong predictor of death at 24 months. The FIM, a measure of functional outcome, describes the ability of a person to perform the functional skills used for activities of daily living. When interpreting scores, as the FIM score improves the greater functional independence. For a one unit increase in the premorbid FIM score, the relative risk of death (measured by LNS, DS, PCS, MCS, residential support and mobility impairment) all decrease between 5.6 - 16.6% at 24 months after discharge from critical care. In clinical terms, as functional independence improves, the risk of death decreases at 24 months after discharge from critical care.

The premorbid CACI scores also prove to be a strong predictor of death at 24 months. The Charlson Age Comorbidity Index is a tool designed to predict mortality based on comorbidities. When interpreting scores, an increase in the CACI score indicates the greater level of comorbidities. For a one unit increase in the premorbid CACI score, the relative risk of death (measured by LNS, DS, PCS, MCS, Residential Support and Mobility Impairment) all increase between 31.3 – 53.1% at 24 months after discharge from critical care. In clinical terms, as comorbidities increase, the risk of death increases 24 months after discharge from critical care.

The Community Integration Questionnaire (CIQ) is a brief measure of an individual's level of integration into the home and community. When interpreting scores, as the CIQ score improves, the greater the integration. Data shows for a one unit increase in the premorbid CIQ score, the relative risk of death (measured by LNS, DS, PCS, MCS, and residential support and mobility impairment) all decrease between 10.3 - 51.1% at 24 months after discharge from critical care. In clinical terms, the greater the home and community integration, the risk of death decreases 24 months after discharge from critical care. (Tables 52.0, 53.0)

**Table 52.0** Premorbid predictors of impairment

Predictor	Outcome	Effect	RRR (%)	Р
(impairment)	Measure			value
premorbid				
FIM	LNS	~	0.996	0.719
	DS	~	1.006	0.793
	PCS	~	0.999	0.918
	MCS	~	1.006	0.712
	Social Impairment	~	1.275	0.371
	Mobility Impairment	~	0.991	0.683
CIQ	LNS	~	0.960	0.260
	DS	~	1.025	0.557
	PCS	~	0.989	0.598
	MCS	~	0.986	0.651
	Social Impairment	~	1.066	0.399
	Mobility Impairment	~	1.015	0.849
Years Education	LNS	~	0.913	0.298
	DS	~	0.840	0.108
	PCS	~	1.005	0.891
	MCS	~	0.934	0.282
	Social Impairment	~	0.688	0.086
	Mobility Impairment	$\uparrow$	0.539 (46.1)	0.023
CACI	LNS	~	0.965	0.666
	DS	~	0.868	0.179
	PCS	~	0.989	0.589
	MCS	~	0.898	0.127
	Social Impairment	~	1.001	0.991
	Mobility Impairment	~	0.915	0.585
↑ pos	itive effect ; $\downarrow$ negative	effect; ~ n	ot significant	

**Table 53.0** Premorbid predictors of death

Predictor (death) premorbid	24 month outcome measure	Effect	RRR (%)	p value
FIRA	LNC		0.032 (6.0)	0.000
FIM	LNS	<b>↑</b>	0.932 (6.8)	0.000
	DS	<b>↑</b>	0.941 (5.9)	0.000
	PCS	<b>↑</b>	0.946 (5.4)	0.002
	MCS	<b>↑</b>	0.956 (4.4)	0.000
	Social Impairment	<b>↑</b>	0.953 (4.7)	0.000
	Mobility Impairment	$\uparrow$	0.940 (6.0)	0.000
CIQ	LNS	$\uparrow$	0.897 (10.3)	0.003
	DS	$\uparrow$	0.875 (12.5)	0.002
	PCS	$\uparrow$	0.489 (51.1)	0.420
	MCS	$\uparrow$	0.891 (10.9)	0.006
	Social Impairment	$\uparrow$	0.895 (10.5)	0.001
	Mobility Impairment	$\uparrow$	0.893 (10.7)	0.001
Years Education	LNS	<b></b>	0.827 (17.3)	0.049
	DS	$\uparrow$	0.813 (18.7)	0.029
	PCS	$\uparrow$	0.707 (29.3)	0.037
	MCS	~	0.882	0.111
	Social Impairment	$\uparrow$	0.851 (14.9)	0.047
	Mobility Impairment	$\uparrow$	0.819 (18.1)	0.031
CACI	LNS	$\downarrow$	1.531 (53.1)	0.000
	DS	Ţ	1.333 (33.3)	0.000
	PCS	<u>,</u>	1.313 (31.3)	0.000
	MCS	Ţ	1.313 (31.3)	0.000
	Social Impairment	Į.	1.334 (33.4)	0.000
	Mobility Impairment	<b>V</b>	1.337 (33.7)	0.000
↑ pos	itive effect ; $\downarrow$ negative	effect; ~ n	ot significant	

**Table 54.0** One month predictors of impairment

Predictor	Outcome	Effect	RRR (%)	P
(impairment)	Measure			value
1 month				
FIM	LNS	~	0.990	0.440
	DS	~	0.997	0.844
	PCS	~	1.003	0.581
	MCS	~	1.000	0.970
	Social Impairment	~	0.968	0.095
	Mobility Impairment	~	0.977	0.312
CIQ	LNS	$\uparrow$	0.933 (6.7)	0.048
	DS	~	0.942	0.128
	PCS	~	1.006	0.961
	MCS	~	1.023	0.423
	Social Impairment	~	0.956	0.523
	Mobility Impairment	~	1.008	0.897
MMSE	LNS	~	0.902	0.083
	DS	$\uparrow$	0.795 (20.5)	0.000
	PCS	~	0.967	0.108
	MCS	~	1.031	0.557
	Social Impairment	~	0.933	0.346
	Mobility Impairment	$\uparrow$	0.866 (13.4)	0.045
APACHE 3 ROD	LNS	~	1.416	0.641
	DS	~	2.100	0.401
	PCS	~	1.188	0.623
	MCS	~	2.407	0.256
i	Social Impairment	~	6.710	0.079
	Mobility Impairment	$\downarrow$	2.950 (295)	0.013
↑ positive effect	; $\downarrow$ negative effect; $^{\sim}$ no	ot significa	nt	

**Table 55.0** One month predictors of death

Predictor	Outcome	Effect	RRR (%)	Р
(death) 1	Measure			value
month				
FIM	LNS	$\uparrow$	0.834 (16.6)	0.001
	DS	$\uparrow$	0.923 (7.7)	0.000
	PCS	$\uparrow$	0.944 (5.6)	0.000
	MCS	$\uparrow$	0.921 (7.9)	0.000
	Social Impairment	$\uparrow$	0.936 (6.4)	0.000
	Mobility Impairment	$\uparrow$	0.913 (8.7)	0.000
CIQ	LNS	$\uparrow$	0.919 (8.1)	0.014
	DS	$\uparrow$	0.906 (9.4)	0.004
	PCS	$\uparrow$	0.863 (13.7)	0.001
	MCS	$\uparrow$	0.750 (25.0)	0.001
	Social Impairment	$\uparrow$	0.892 (10.8)	0.001
	Mobility Impairment	$\uparrow$	0.895 (10.5)	0.001
MMSE	LNS	~	0.976	0.821
	DS	~	1.001	0.987
	PCS	~	1.008	0.917
	MCS	~	1.025	0.702
	Social Impairment	~	1.034	0.668
	Mobility Impairment	~	1.023	0.796
APACHE 3 ROD	LNS	~	2.083	0.388
	DS	~	1.001	0.987
	PCS	~	1.008	0.917
	MCS	~	1.025	0.702
	Social Impairment	~	1.034	0.668
	Mobility Impairment	~	1.023	0.796
↑ pos	sitive effect ; $\downarrow$ negative	effect; ~ n	ot significant	1

#### One month predictors and outcome

At one month, data shows for a one unit increase in the CIQ score, the relative risk of LNS impairment decreases and the risk of death, (measured by LNS, DS, PCS, MCS, residential support and mobility impairment) all decrease 24 months after discharge from critical care. In clinical terms, the greater the home and community integration the risk of LNS impairment (verbal working memory and executive function) decreases; as does the risk of death, 24 months after ICU discharge.

The MMSE is widely used as a general screening measure of cognitive mental state and dementia. When interpreting scores, an increase in the MMSE score indicates an

improvement in general cognition. Study data shows for a one unit increase in the one month MMSE score, the relative risk of DS and mobility impairment decreases 24 months after ICU discharge.

The APACHE 3 is a severity-of-disease classification system used to predict mortality at ICU discharge. The higher the Apache 3 score, the greater the severity of disease. Study data shows for a one unit increase in the APACHE 3 R.O.D. the relative risk of mobility impairment increases (RRR 2.95; p = 0.013), almost triples at 24 months after discharge from ICU.

Finally, the premorbid FIM score is a strong predictor of death as is the one month FIM score, which proves to be a strong predictor of death at 24 months after ICU discharge. This effect not only holds but becomes stronger at one month time point. For a one unit increase in the one month FIM score, the relative risk of death (measured by LNS, DS, PCS, MCS, residential support and mobility impairment) all decrease 24 months after ICU discharge. (Tables 54.0, 55.0)

#### Thematic Analysis

A thematic approach to analysing narratives was used to look for patterns, meaning and potential points of interest in the data and ensures an honest interpretation is maintained through the by constant reference to the raw data source. Both ICU patients and controls discussed their perceptions, experiences and memories of their illness experience at each time point. Often patients and families diarised their thoughts and any questions throughout the illness episode and could directly refer to these. Narratives are subjective and may be influenced and altered with time. Narratives contained both factual and emotional memories, some explicit often chronologically pieced together. ICU patients often turned narratives of fear into comedy or stories depicting themselves in control, in an attempt to normalise the experience for themselves and others. Many could not recall or understand much of their time in the critical care unit and consequently would construct stories in an attempt to share their experience without feeling uncomfortable and concerned. Narrations were broadly themed incorporating physical incapacity, isolation and advice, and reassurance.

Physical incapacity for cases comprised of statements surrounding weakness, tiredness, and debility, loss of balance and stamina, and pain. Isolation, often incorporating cognitive deficits such as poor concentration and memory, panic attacks, feeling like 'they're going slow', loneliness and recurring memories of critical care overlay their fear of being a burden to their families physically, emotionally and financially. Ongoing physical incapacity would build hopelessness, frustration and despair among survivors of critical illness. Very few survivors knew of, or participated in community physiotherapy or occupational therapy services.

'In intensive care I had a nurse and twice daily visits from physiotherapists and OT's. The physio spent a lot of time with me doing exercises with my hands, legs and feet. When I got to the ward, I saw a physio twice during the first five days. There is no physio on weekends. The OT came one day and worked on helping me to try and sit up. There was not enough staff to lift me and they could not locate a lifting frame so I stayed in bed. I feel this made me go backwards as I was so weak I stayed in bed the whole time laying dawn. I knew I was not improving and was getting distressed about it because I wanted to go home.'

'One day two physios and my OT came and helped me to walk on a walking frame. After that I never saw a physio or OT again. It was as if they had ticked that box that I was on my feet and no longer needed any rehabilitation.'

'I remember being transferred from the critical care unit to the ward and because I am only young, you know, only 28 [years old] the nurses didn't understand how weak I was. I think I lost about 12 kgs over two and a half weeks... The nurses would tell me to get up and walk to the toilet but I was so weak, I couldn't. I fell over twice... I was scared to get up by myself'

Physical recovery was gradual. The impact of weakness, pain and exhaustion forced survivors to adapt to managing with their new disabilities.

'I don't have any energy anymore. I am just so tired, I just don't have the strength to eat let alone walk down to the shops at the end of the block anymore...My doctor told me my scan looked worse and there was no operation I could have as it has spread. My daughter drops in when she can, she's just so busy...They say I have to start chemo next week [crying].'

'My life has changed; I didn't know it would be like this [tired, strained stare]. I can't go out to lunch with my friends as I fear my bag will leak or burst. I am up many times every night with cramps. I smell, my skin is flaking off and hair falling out. I have to walk with a frame. '

'I still have problems with my wounds, they are just not healing. I have such a lot of pain from these pressure sores on the back of my heals that I can't even wear shoes or walk any further than around here [gesturing].'

'I can't drive or really get around with this [orthotic] boot and no way can I walk all that way to the [hospital] for them diabetes appointments. The lady at the hospital gets really mad that I don't turn up but I haven't even got any money for food. '

'At the moment I can't get to the toilet fast enough, I'm so weak and can't walk by myself so end up soiling my pants as I keep having diarrhoea [pause, breath, blink back tears] I feel I have lost all self-respect.'

Often as a result of the physical incapacity, survivors became isolated, unable to keep up mentally or physically. The physical and mental exhaustion together with factors such as loss of balance and pain saw survivors become socially isolated with families adopting a protective role; often becoming gatekeepers.

'I remember one day the nurse was watching this TV show on the TV above my bed and I couldn't move or talk cause of that breathing tube. I remember it was Bathurst and you know..suddenly one of the cars burst into flames. You know, I was lying there with all those burns and couldn't move and in a lot of pain and I cried hard inside cause I felt for the driver. The nurse didn't even blink, he didn't understand.'

'I remember all of a sudden people talking about me, they were yelling across the room, 'we're going to exterminate [name] now'...I thought well, [with a laugh] I've trusted them so far. I was real scared, they talked so fast I couldn't understand...suddenly I was sat bolt upright in the bed and they wrenched this thing out of my throat...' 'It was such a terrible time I wanted to leave but they wouldn't let me. I felt everyone was plotting against me. I could see people looking at me, walking past me, staring and talking about me and then turning away to plot...I was scared, I struggled to get away, I wanted to yell and they come close and force me down. I didn't want to be there. They were trying to kill me. I saw a priest just waiting in the room. I looked around and saw other dead bodies lying in the room...'

'I still remember the black shapes of the evil spirits flying over my bed. They were swooping over my bed trying to eat my flesh.'

Discharge from the ICU signifies a stage of recovery when patients no longer require intensive care support. Transfer from the critical care to the ward environment has been described by survivors as a time of heightened anxiety, fear and confusion. In the intensive care unit, survivors become accustomed and reassured to have nurses and doctors always in sight. Intensive unit discharge brings the loss of one-to-one nurse-patient ratios, with patients now entering the very different environment of a busy general ward.

'I can't remember much but I remember it was so busy, people always asking me things I didn't know. They spoke so fast I couldn't keep up. I couldn't understand them. I didn't know what day it was or really where I was.'

Patients perceive ICU-ward transfer as one of rapid transition. After the ICU nurse transferred the patient to the ward, the patient would not see the ICU, ICU nurse or have any reference to their critical illness experience again. Survivors perceive that ward nurses have very limited insight and understanding of the patient's critical illness journey, feeling it has very little relevance to their plan of care on the ward. Immediately the survivor feels isolated and frightened as they suffer pervasive memories of critical care. They describe feeling disorientated to time and place and often did not understand (or have) a plan of care. At this stage in recovery, survivors have very limited knowledge of their diagnosis, treatment or prognosis.

'Can you show me where I was in intensive care? I just want to see if I can piece it all together, what went on. I remember a lot of bits but I don't know if I dreamed it.'

Weak, incapacitated, unable to stand or walk, feed themselves, many found themselves alone in a single room. The transition to the ward was sudden and dramatic. The survivors' working memory and executive function (ability to multitask, problem solve, short term memory) were greatly impaired at this time. They did not have the capacity to make simple decisions, understand simple statements or fill in a menu. The state of cognitive impairment continues months after ICU discharge. Survivors describe the day-to-day impact of their new disability.

'Can you tell me what is wrong with me? I just can't keep up anymore...[ in tears] I can't look after my kids, I just can't seem to keep up with them. They're noisy and I can't do things quickly anymore, my mind is blurry, going in slow motion, it's all just so confusing. At work my boss has been great and has let me come back to work part-time. I'm working three days a week but it's still really hard and all going wrong. It's all so fast and confusing, and I know I'm making mistakes but I can't seem to understand what people want. My friends at work ask me how I am...I look just the same, they say...they don't understand...I can't explain it as like a funny one-liner so I smile and don't bother. I feel really depressed and down all the time. Will it always be this way?'

'Do you have my file? Can you tell me what happened, how I came to be admitted? They took me off the machine and sent me home that afternoon with my cut up clothes in a brown paper bag. They said I discharged myself. I can't remember doing that [crying].'

'I'm just so worried about being a strain on my husband [pause, shaking head] he's not young and shouldn't have to get up and change me through the night, every night.'

I run a roofing business and keep forgetting to order the materials for the jobs and can't coordinate them for the right day and times. My mum has come in and is helping me manage things.

However recurrent statements reflect, a quiet sense of gratitude and overwhelming appreciation for life.

'I feel I appreciate everything so much more now [pause]. Nothing worries me [smile]. I am just so glad to be alive [smile with tears].'

The themes of advice and reassurance uncovered patient frustration on many levels. They include lack of information about their illness episode with patients often searching to understand what had gone on while they had been sedated or unconscious. Patients felt there was a lack of acknowledgement and understanding of their critical illness by other health care professionals outside of critical care, with no one able to give accurate advice or reassurance about problems experienced or able to assist with making achievable ongoing plans of care. Many describe the journey out of the critical care unit sudden and disjoint with the lack of organised health planning causing survivors to feel their recovery was going backwards. All survivors who were employed prior to the critical illness found returning to work very difficult. There was lack of advice around the appropriate time to return and the capacity. All had problems managing their prior workload, expressing feelings of failure and doubt about their capability. All endured difficulty integrating with colleagues.

'We have had no follow-up since leaving hospital you know [pause]. The GP doesn't know what to do [pause] doesn't seem to understand my problems or give me any answers [frown, turns away]. I feel abandoned. We have to try and figure it out by ourselves.'

'How long will it take for her to be back to normal [husband referring to wife, the patient]? I really have never learned to cook cause it was always [wife's] job.. I have figured out this routine I follow everyday [exhausted sigh]. I get her up and showered by seven, and then I put all the wet sheets I've changed through the night into the machine then make her breakfast. She eats so little but I force her to eat more [wry smile from patient]. Then I put her on the couch in the sun while I clean up the house. At ten o'clock I make sure she marches three laps around the backyard with her walker. Our GP has changed all her tablets and now I don't know what any of them are for. It's been eight weeks now, how much longer will she be like this? [looking around the kitchen] How long do you reckon it takes to boil an egg for a salad?'

'My husband now travels without me as I am just not strong enough and now I have all these problems. He is away for three months at a time and I have to find ways of coping out here on the farm by myself.'

Often roles and relationships change with the impact of critical illness often borne by the whole family unit. Survivors often describe relationship strain as the critical illness defines their sense of self.

'Yeah she's [name] eight months pregnant and our [older child] is just two. I try and concentrate on my work but can't seem to do anything I could before. I have started drinking abit. The business is going further and further down and I won't be able to pay the rent for my office soon. I find it hard to quote for jobs and can't manage to draw plans anymore. She [wife] is always very tired, she has had to take on extra work and when she gets home she has to look after our son as I can't by myself. He [son] is just so noisy all the time that I don't like being around them. We used to argue but now we really don't talk much at all, I feel uncomfortable around her. She thinks I am just another child she has to look after. It will be a relief if she leaves me.'

'Since my accident my boy [10 year old] won't leave my side. The teachers say he's muckn around at school. You know he saw them drag me out of the car...now all I can do is sit in this chair for couple hours each day...rest of the time I'm in bed.'

'My family is smothering me. He [husband] won't leave me, telling me to eat more, pushing me to rest and sleep like I'm going to fall over and break.'

'Yes, it's good to be home with her [wife]. If I couldn't be home looking after her then there would be no point to me living.'

#### Themes for controls

Physical incapacity

Control narratives were also grouped under the same themes. The themes were common between groups with controls often themes however the severity of with pain and weakness also common problems, however to a lesser degree.

'I still have problems with my wounds, they are just not healing. I have such a lot of pain from these pressure sores on the back of my heals that I can't even wear shoes or walk any further than around here [gesturing].'

'I am a lot weaker since my surgery and fear falling in the shower.'

#### Isolation

The theme of isolation consisted of financial problems, transport problems and issues with logistics of getting to hospital appointments; feeling depressed and often also endures relationship strains between partners and carers.

'My husband gives me no consideration. I was trying to sleep last night and he was watching the soccer on T.V. all night which kept me awake.'

## Advice and reassurance

Advice and reassurance consisted of such issues as lack of information about their illness and prognosis, problems with the transition back to work.

'We are due to move house next week and I worry how things will go. I worry about the contracts and sale of the house.'

'I still experience a lot of pain and am unsure of which of these tablets I should be taking.'

Controls are seen to commonly suffer lack of information regarding their condition, transport problems (attending clinic appointments) as are restricted with driving, they fear being a burden and are often frustrated with carer's lack of consideration and support. These problems are not in isolation but coupled with physical problems most commonly listed as changes in bowel habits, leg cramps poor wound healing, pain and immobility. Controls do not highlight any cognitive problems. Comparison between groups shows a greater number of problems for cases with greater diversity. There were neither critically ill survivors nor carers who felt they were prepared to deal with the new disabilities and impairments and some even reported that their complaints to physicians were dismissive.

Themes are derived from patient transcripts which reliably represent the ICU patients and controls recovery experience (Table 56.0). Controls experiences were also grouped under the same themes, with pain and weakness also common problems, however to a lesser degree. The theme of isolation consisted of financial problems, transport problems and issues with logistics of getting to hospital appointments, feeling depressed and a burden. Advice and reassurance consisted of such issues as lack of information about their illness and prognosis, problems with the transition back to work and often also endure relationship strains between partners and carers.

**Table 56.0.** Themes derived from patient transcripts which reliably represent the case and controls recovery experience.

Constructs	ICU themes	Control themes
Physical Incapacity	Lack of balance and strength, limiting mobility.	Weakness
	Weakness and lack of endurance	Pain
	Tiredness	Immobility
	Breathlessness	Poor wound healing
	Pain	Altered bowel habits
	Poor wound healing	
	Problems sleeping	
	Nightmares	
	Hearing problems / loss; problems	
	communicating	
	Embarrassed at altered body image	
Isolation	Pervasive memories of critical care	Financial difficulties
	Altered perspective to illness,	Transport problems, difficulty
	renewed appreciation of life	getting to clinic appointments as
		cannot drive, public transport not
		suitable, taxi expensive
	Financial problems	Feeling depressed
	Loneliness and isolation	Fear of being a burden
	Critical illness defining the sense of self	
	Fear of being a burden	
	Recall of traumatic events	
	consistent with PTSD	
	Poor concentration	
	Panic attacks	
	Poor memory	
Advice and	Lack of discharge follow-up and	Lack of information about illness
Reassurance	ongoing support	and prognosis
	Carers uninformed, limiting	Relationship strain and change
	independence and restricting	
	recovery	
	Ability to cope with disability	Difficulties returning to work
	Relationship strain and change	
	Difficulties returning to work	

As an extension to this analysis and to create longitudinal trajectories of the narrative data, the overall construct trajectory was categorised as 'positive', 'negative', 'mixed' or 'neutral.' Categorisations or themes were based on 3 constructs, physical incapacity, isolation and advice and reassurance. Each transcript was coded for positive, negative, mixed or no change on each theme. (Table 56.1)

Table 56.1. Narrative recovery trajectories over 24 months, ICU patients and controls (Freq; %)											
	Trajectory type										
Themes		Posi	tive		Negative		Mixed		Neutral		
	ICU patient (n)	Control (n)	ICU	Control	ICU	Control	ICU	Control	ICU	Control	
Physical incapacity	71	72	0 (0)	63 (87.5)	61 (85.9)	2 (2.8)	3 (4.2)	5 (6.9)	7 (9.9)	2 (2.8)	
Isolation	71	72	11 (15.5)	67 (93.1)	23 (32.4)	0 (0)	30 (42.2)	5 (6.9)	7 (9.9)	0 (0)	
Advice and reassurance	71	72	9 (12.7)	70 (97.2)	17 (24)	0 (0)	1 (1.3)	0 (0)	44 (62)	2 (2.8)	

#### Narrative trajectories

Across the construct of physical incapacity, ICU patient narratives were predominantly classified as negative (86%), neutral (9.9%) and 4.2% of narratives were classified as mixed. Comparatively, 87.5% of controls were classified as a positive trajectory, 7% mixed and almost 3% equally neutral or negative. Throughout the 24 month period, ICU patients regarded physical incapacity (Table 56.0) incorporating themes such as lack of balance and strength, weakness and lack of endurance, as factors which continued to impact causing a negative affect across the study period. Additionally, almost 10% of ICU patients show neutral or no change to themes within this construct which shows no clear change to these themes. Controls show the inverse, a positive trajectory throughout the study period. While highlighting themes of weakness and pain, these themes improved across the 24 month period. Comparing the narrative trajectories to the quantitative data, physical function, as measured by the FIM show a much slower recovery for ICU survivors, re-claiming premorbid levels by 12 months however do ever reach full physical function before showing a downward trajectory. Controls are seen to exceed premorbid levels by the 3 month time point, reflected within the positive narrative trajectory. Considering the HRQOL physical component score, while trajectories may show a similar pattern of recovery, ICU patients display greater deterioration across each time point compared to controls, also consistent with narrative trajectories.

Considering the construct of isolation, ICU patient narratives were predominantly mixed (42%) with only 15% classified as positive trajectories. Themes within this construct include memories of the ICU experience, financial problems, loneliness, poor concentration, memory among others. Controls show a positive trajectory of 97% across the 24 month period and while there are some common themes between ICU patients and controls,

(financial problems, fear of being a burden), it appears these correct quickly, becoming predominantly a positive trajectory across the 24 month period. While considering quantitative data, the HRQOL mental component score, ICU patients show higher levels of quality of life compared with controls however do suffer higher levels of neuropsychological impairment, reflected across the Stroop, Trailmaking Task and Letter Number Sequence. Psychosocially, while ICU patients do display lower levels of anxiety and depression compared with controls, they show high levels of post-traumatic stress associated symptoms. The narrative analysis trajectory informs the study of the ongoing impact of symptoms related to the neuropsychological impairment and post-traumatic stress associated symptoms among ICU survivors.

Finally within the construct of advice and reassurance, the narrative trajectories for ICU patients are dispersed between a neutral trajectory, 62% showing there was no clear change across the 24 month period, 24% negative and almost 13% positive. Controls show a strongly positive trajectory across the 24 month period (97%). ICU patients cite such themes as lack of information and ongoing support for both themselves and carers which they regard impede their recovery. The neutral narrative trajectory shows little change, if not increasing dissatisfaction (negative trajectory) in this area of support, advice and reassurance.

Quantitative data in the area of community integration for both ICU patients confirms this, showing a moderated recovery, never reaching the premorbid level of community integration across the study period. Controls show a strongly positive narrative trajectory which reflects either greater access to advice and reassurance or perhaps cited themes, such as returning to work and relationship change and strain, were on a lesser scale. Community integration recovery trajectories for controls show improvement by 3 month time point.

#### **Test incompletion**

Finally, reasons for test incompletion must be discussed not only for reasons of study rigour but this additional information may highlight further areas where patients perhaps encountered problems (Table 57.0). Researchers documented at each interview reasons why test batteries were unable to be completed under the heading of 'physical inability', 'poor cognition' (MMSE<24) and 'refusal'. Early time points see a high level of physical inability among ICU patients, showing patients were physically exhausted and a low level of physical

endurance. The number of ICU patients who refuse increase during the study which may indicate familiarity of the test battery and deciding to opt out due to such factors as distress due to low levels of achievement or mental exhaustion. Phone interviews were classified as refusal. Each interview required approximately one hour so physical and mental exhaustion is factors to be considered when designing an extensive test battery for this cohort.

**Table 57.0.** Reasons for test incompletion

UNABLE TO COMPLETE COGNITIVE TESTS			CONTROL		ICU patients			
	N	PHYSICAL	POOR	REFUSED	N	PHYSICAL	POOR	REFUSED
		INABILITY	COGNITION			INABILITY	COGNITION	
Preadmission	13	4	8	1	48	21	10	17
1 month	13	4	8	1	48	21	10	17
3 months	18	5	13	0	37	7	9	21
6 months	19	4	8	7	37	10	5	22
12 months	16	3	10	3	36	0	8	28

# Chapter 5

# Discussion

# **Study Summary**

With advances in critical care medicine, a higher proportion of patients are now surviving ICU admission.<sup>6</sup> With this increase in survival, critical care research has begun focusing on long-term outcomes of ICU survivors, including physical function, mental health, HRQoL and cognitive outcomes.<sup>10,37,38</sup> Critical illness and associated therapies expose patients to enormous stressors. <sup>102</sup> ICU survivors may face significant physical limitations<sup>6</sup> which predispose them to depressive symptoms, which may impact their HRQoL<sup>94</sup> and capacity to return to work.<sup>108</sup> Increasingly, attention has been focused on the effect critical illness may have on cognitive functioning and impairment.<sup>19,94</sup>

ICU outcome literature has demonstrated marked variability in the reported physical, neuropsychological and psychosocial disability among survivors <sup>14,16,40-43,45,46,51,55,56</sup> This is not surprising given such factors as the heterogeneous population, the varied follow-up time points, incompleteness of follow-up and the lack of independent assessors. <sup>6-8,37,39</sup>

The present study followed the longitudinal trajectory of two groups (ICU survivors and controls) using a study methodology that is consistent with current evidence, <sup>35,36</sup> describing outcomes based on a battery of tests that are validated in this population. The scale and completeness of follow-up data adds novel data and addresses some of the recognised limitations of the current critical care outcomes literature.

# Key findings

- This study profiled and tracked the recovery of a group of non-ICU, medical and surgical acute care patients. This group acted as a control group for the ICU survivors.
   Very few studies use the acute care hospitalised patient as a control population.<sup>9</sup>
- The control group showed unexpected high levels of impairment, particularly across the neuropsychological domain. Long-term recovery trajectories across all domains

show similar levels of impairment among controls to those seen among ICU survivors. With comparable levels of impairment amongst both groups, study data arguably questions the implication of critical illness and critical care therapies as the causation of long-term impairment among survivors. Critical care research may have erroneously over emphasised the implication of critical care therapies;<sup>27</sup> with long-term impairment explained as more one of a continuum of pre-existing impairment.<sup>176</sup>

- Few studies have gathered premorbid or baseline data prior to critical care admission. 9,17,210 This study provides a baseline data set which uncovers the profile of two parallel groups, both suffering similar levels of comorbidities and chronic illness, requiring social health support. This study provides important novel epidemiological information detailing previously unrecognised high levels of chronic ill-health across functional, neurocognitive and psychosocial domains. This data highlights the need for management, support and investment of primary health care resources.
- Study literature broadly cites a period of up to 4 years for the recovery of the critical care survivor and longer across many domains. <sup>21,29,48</sup> This study shows trajectories of recovery across functional, neuropsychological and psychosocial domains reach maximum recovery between 3-12 months, after which trajectories plateau or show deterioration. This information provides a sound methodological prototype for further studies, providing the consistency for future study design in long-term outcomes which is urgently needed. <sup>10,211</sup>
- The addition of the narrative trajectory is relatively novel in ICU research<sup>78,176</sup> and provides meaning of the journey of survivors and a focus for a responsive health care system to support optimal recovery.<sup>78,176</sup>
- This study has provided a multivariate model based on criteria at premorbid and 1
  month timepoints, which has the ability to predict those with impairment at 2 years
  following discharge. This work provides the research community fundamental

information for further risk stratification which will help distinguish between patients who can regain independence and those who will not.

Study outcomes will be discussed in detail, addressing the study aims.

# **Primary Aims**

- Determine the incidence of functional, neuropsychological and psychosocial impairment of patients surviving critical illness 24 months following ICU discharge;
- Determine the level of functional, neuropsychological and psychosocial impairment of patients surviving critical illness over a 24 month period following ICU discharge;
- Track the functional, neuropsychological and psychosocial recovery of patients surviving critical illness over a 24 month period following ICU discharge.

## **Secondary Aims**

- Determine baseline variables associated with outcome (not impaired, impaired and death) 24 months following ICU discharge;
- Examine common themes and characterise the subject's recovery during the first
   24 months following ICU discharge.

# Study outcomes

Despite a slightly older and sicker critical care population when compared to the Australian critical care population published by Moran in 2008,<sup>77</sup> the incidence of functional impairment was comparable to the study literature.<sup>39</sup> Prior to hospitalisation both ICU survivors and controls reported physical impairment and functional quality of life to be lower than norm referenced average levels. ICU survivors were more physically independent,

which may reflect the impact of a rapid onset of critical illness, rather than a slower, more chronic state of illness, as seen among controls.

Study scores are reflected as a poorer quality of life within the patient narratives and thematic analysis. ICU survivors describe similar themes to those identified by Cuthbertson<sup>176</sup> as a state of physical incapacity, which incorporates lack of balance, strength, weakness, lack of endurance, tiredness and pain. Compared to controls, the immediate impact of an illness with greater severity (critical illness) is reflected in both the objective and subjective test scores.

Neuropsychological impairments after critical illness are seen to affect multiple cognitive domains and many critical care survivors face significant brain-related morbidity. <sup>13,15,17,39</sup> An episode of cognitive impairment may result in new and often persistent disability, in some cases even resembling dementia. <sup>13,15,17,18</sup> In this study, neither group attained neuropsychogical scores in the normative range throughout the 24 month study period, with controls having a lower incidence at the 3 month and 24 month timepoints. While such levels of impairment have been reported for ICU survivors, <sup>14,16,40,41,46</sup> such high levels of impairment among controls have not been previously reported. Existing evidence suggests that older adults without dementia at baseline found that those who underwent an acute illness hospitalisation or a critical illness hospitalisation had a greater likelihood of cognitive decline than did those who were not hospitalised. Such impairment for a general acute care hospital population has not been previously acknowledged and now must be given consideration.

ICU survivors also face significant physical limitations during recovery which predispose them to depressive symptoms. Psychological problems associated with critical care have been widely reported, especially in the areas of delirium, anxiety, depression and PTSD. The reported prevalence of anxiety and depressive problems in ICU survivors ranges from 12 to 43% for anxiety and between 10 and 30% for depression. This was not reflected in this study data, revealing very low levels of symptoms of PTSD, anxiety and depression. This is perhaps reflective of recent changes in practice to less sedation and more physical activity whilst in ICU. 1,125

Research indicates that previously healthy patients who suffer critical illness tend to suffer greater deterioration in their HRQoL than individuals who had a lower HRQoL status prior to ICU admission as HRQoL is influenced by the patient's prior health status as well as their expectations for a return to premorbid functional status.<sup>24</sup> A rapid onset of critical illness gives insufficient time to prepare or adjust for the new state of incapacity. Controls appear to have endured a slower onset, chronic state of physical illness and report a lower quality of life prior to admission.

The literature shows cognitive impairment in ICU survivors includes a wide range of impairments, predominantly in the areas of memory <sup>14,16,40-42</sup> and executive function.  $^{14,16,40,42,44,46}$  Levels range between 30 - 90% at three months improving to approximately 41% at 6 months with further improvement at 9 months however remaining impaired when compared to population norms. 46 48 Studies to date indicate that cognitive function improves during the first 6 - 12 months after hospital discharge and remains consistent and disabling for up to 6 years after discharge. <sup>212</sup> This suggests that while some recovery occurs initially, chronic cognitive impairments persist in many patients. This is supported by the data; results of the present study indicate that neither group attained scores in the normative average range throughout the 24 months. In this study, throughout all cognitive tasks, ICU survivors displayed higher levels of deficit throughout the study period with a lower level of recovery across the 24 month study period, compared to controls. While such levels of impairment were expected for ICU survivors, such high levels of impairment were not for controls. Further, executive function, information processing speed and visual-motor attention test performance of ICU survivors in this study is below test performances of other patient groups reported in the literature. 14,16,40,42,44,46

The completeness of the dataset has provided a highly detailed trajectory of the sequelae of critical illness and its severity in comparison to acutely hospitalised patients. Furthermore, the completeness of the dataset has facilitated the development of a predictive model which provides variables at the premorbid and 1 month time points which predict impairment and death of ICU survivors at 24 months. This data will inform clinicians of patient's long-term outcome. Early identification of patients who are at high risk of long-term impairment will assist patients and families to make informed treatment choices and will also assist the

clinical team to coordinate care across the continuum and between settings to maximise recovery.

## **Prediction Analysis**

Currently there is no single instrument which can reliably predict long-term morbidity or mortality of survivors of critical illness. The results of this study identify potential variables that predict items risk of clinical impairment and death at 24 months following discharge from critical care.

Predicting impairment or death at 24 months after ICU discharge prior to admission or at 1 month after admission was a secondary aim for this study. Outcome was stratified at 24 months as 'not impaired', 'impaired' and 'deceased'. Impairment was defined as outlined in Table 58.0. The impairment descriptors are clinically relevant parameters which reflect day-to-day function and patient outcome.

**Table 58.0.** Test Outcome predictors and outcome

PREDICTORS (Premorbid & 28 day)	24 month OUTCOME MEASURES (Impaired and Death)				
Functional Independence Measure (FIM)	Letter Number Sequence (LNS) - Impairment <u>&lt;</u> 4				
Community Integration Score (CIQ)	Digit Span (DS) – Impairment <u>&lt;</u> 4				
Years Education	SF-36v2 Physical Component Score (PCS) Impairment < 45				
Charlson Age Comorbidity Index (CACI)	SF-36v2 Mental Component Score (MCS) Impairment < 45				
APACHE 3 Risk of Death (ROD)	Social Impairment Inpatient acute care Inpatient rehabilitation unit Living at home with carer Nursing home resident				
Mini Mental State Examination (MMSE)	Mobility Impairment <ul><li>Hospitalised</li><li>House mobile</li></ul>				

The levels of impairment among ICU patients and controls at 24 months were comparably high, with cases showing higher levels of impairment across all tasks excluding the subjective component measures of quality of life. (Table 59.0)

Table 59.0. Incidence of impairment at 24 months (%)

	Impaired	Impaired	Impaired	Impaired
	ICU	ICU	controls	controls
	(total)	(survivors)	(total)	(survivors)
LNS	20.28	22.22	16.94	19.23
DS	17.39	21.43	11.76	13.79
SF-36v2 PCS	47.88	58.62	56.45	67.30
SF-36v2 MCS	18.30	22.41	25.8	30.77
Residential Support	9.85	12.07	0.00	0.00
Mobility Impairment	7.04	8.62	3.17	3.77
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Statistically significant premorbid and 1 month univariate 'predictors' were applied in a mixed model regression. From the univariate analysis, mixed model regression analyses showed statistically significant relationships to study outcomes (Tables 60.0, 61.0; Appendix 6).

#### Impairment prediction

Significant premorbid predictors of impairment at 24 months include Years of education, MMSE, FIM, APACHE 3 ROD and the CIQ.

# Years of education

Years of education was found to be a significant premorbid and 1 month predictor of mobility impairment (defined as being hospitalised or house mobile) at 24 months. This means that for each unit increase in years of education, the risk of mobility impairment *decreases* by a RRR of 0.539 or 46.1% at 24 months after discharge. The positive association between education and health has been well established in areas of health lifestyle 213 socioeconomic status 214 and social-psychological resources. 215 The well-educated are more

likely to be employed full-time with high incomes which in turn give a greater sense of control over their lives and their health. They are more likely to make positive health choices, such as not smoke, drink moderately and exercise<sup>215</sup>. Authors conclude that high educational attainment improves health directly and indirectly, such as work and economic conditions.<sup>215</sup>

#### • Mini Mental State Examination

A similar relationship exists between MMSE and a reduction in impairment of mobility impairment. The MMSE is widely used as a general screening measure of cognitive mental state and dementia. An increase in the MMSE performance indicates an improvement in general cognition. An association between reduced cognitive function and mobility impairment has been widely reported. McGough<sup>216</sup> found the prevalence of functional mobility limitations and falls is higher in people with dementia compared with cognitively healthy older adults, and both are associated with gait and motor impairments.

The results of the present study indicate that improved MMSE performance is associated with an improvement in Digit Span, (a task measuring verbal short term memory) at 24 months.

#### APACHE 3 Risk of Death

APACHE 3 ROD (severity of illness assessment) also shows strong predictive relationship with mobility impairment at 24 months. For every unit increase in APACHE 3 risk of death (worsening) mobility impairment triples at 24 months. ICU acquired weakness is a syndrome encompassing myopathic, neuropathic and atrophic changes, which clinically presents as profound weakness. Mortality is higher in those with a diagnosis of ICU acquired weakness<sup>217</sup> and may demonstrate a link between ICU acquired weakness and severity of illness, rather than ICU acquired weakness being a direct cause of mortality.<sup>217</sup> ICU-acquired weakness is a complication of critical illness associated with worse clinical outcomes and functional decline in survivors.

## Community Integration Questionnaire

The results of the present study indicate that CIQ performance at 1 month is a significant predictor of later function.

The level of home and community integration predicts LNS outcome. For each unit increase in the CIQ score, the relative risk of LNS impairment (verbal working memory) decreases with integration. Zunzunegui and colleagues<sup>218</sup> also found as association between cognitive decline and community integration. The authors show that few social ties, poor integration, and social disengagement are risk factors for cognitive decline among community-dwelling elderly persons.

For a one unit increa	ase in the mean score	of (premorb	id pred	lictor) the re	lative risk of (outcom	e) <b>impairment</b>	increases o	or decre	ases by %
Premorbid predictor	Outcome	Trend	%	(p value)	1 month predictor	Outcome	Trend	%	(p value)
Years of Education	Mobility Impairment	decreases	46.1	0.023	MMSE	DS Mobility	decreases	20.5	0.000
						Impairment	decreases	13.4	0.045
					CIQ	LNS	decreases	6.7	0.048
APACHE 3 ROD	Mobility Impairment		295	0.013					

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For a one unit increase in the mean score of	of (premorbid predictor) the relative risk of (out	rome) death increases	or decreases by %

Premorbid predictor	Outcome	Trend	%	(p value)	1 month predictor	Outcome	Trend	%	(p value)
Independence	Letter Number				Independence	Letter Number			
Measure	Sequence	decreases	6.8	0.000	Measure	Sequence	decreases	16.6	0.001
	Digit Span	decreases	5.9	0.000		Digit Span	decreases	7.7	0.000
	Physical Component	decreases	5.4	0.002		Physical	decreases	5.6	0.000
	Mental Component	decreases	4.4	0.000		Mental	decreases	7.9	0.000
	Social Impairment	decreases	4.7	0.000		Social Impairmer	decreases	6.4	0.000
	Mobility Impairment	decreases	6.0	0.000		Mobility	decreases	8.7	0.000
Community					Community				
Integration	Letter Number				Integration	Letter Number			
Questionnaire	Sequence	decreases	10.3	0.003	Questionnaire	Sequence	decreases	8.1	0.014
	Digit Span	decreases	12.5	0.002		Digit Span	decreases	9.4	0.004
	Physical Component	decreases	51.1	0.042		Physical	decreases	13.7	0.001
	Mental Component	decreases	10.9	0.006		Mental	decreases	25.0	0.001
	Social Impairment	decreases	10.5	0.001		Social Impairmer	decreases	10.5	0.001
	Mobility Impairment	decreases	10.7	0.001		Mobility	decreases	10.8	0.001
Years of Education	Letter Number	decreases	17.3	0.049					
TOOL DO LOUDGE TO	Digit Span	decreases	18.7	0.029					
	Physical Component	decreases	29.3	0.037					
	Social Impairment	decreases	18.1	0.047					
	Mobility Impairment	decreases	14.9	0.031					
Charlson	Letter Number								
Comorbidity Index	Sequence	increases	53.1	0.000					
	Digit Span	increases	33.1	0.000					***
	Physical Component	increases	31.3	0.000					
	Mental Component	increases	31.3	0.000					
	Social Impairment	increases	33.4	0.000					
	Mobility Impairment	increases	33.7	0.000					·. ·
				_					

Table 61.0. Premorbid and one month predictors of death at 24 months

# **Death prediction**

Significant premorbid predictors of death at 24 months include Years of education, FIM, CIQ, and the CACI.

# Years of education

Years of Education are a strong predictor of death. As years of education increase, the relative risk of death measured using Mobility Impairment, the DS, the LNS, the PCS and Residential Support decrease.

#### • Functional Independence Measure

The outcome effect of the premorbid physical functional predictor, the FIM shows a broad effect on outcome at 24 months. As FIM scores increase (physical function improves) the relative risk of death for all outcomes decrease. This effect not only holds but becomes stronger at the 1 month time point.

## • Community Integration Questionnaire

Socially, premorbid and 1 month CIQ scores also show a broad significant effect across all outcome measures in relation to predicting death. In particular for every unit increase in CIQ scores the relative risk of death for the PCS decreases by 51%. This predictor item holds its statistical significance at 1 month, with the relative risk for death decreases across all outcome measures at levels between 8 - 25% at 24 months. The relative risk of death for the MCS is seen to decrease by half as the CIQ increases.

#### • Charlson Age and Comorbidites Index

Finally, the effect of comorbidities shows a very strong effect. With every unit increase in the mean CACI score (indicating greater comorbidities) the relative risk of death across all outcomes measures increases between 30 - 50%.

#### Significance of prediction analysis

It has only been relatively recently that the long-term consequences of critical illness have been considered. For many, discharge from critical care signifies the start to recovery of functional, neuropsychological and psychosocial problems. Currently we cannot predict those patients who will lead a short and straight-forward recovery or those who will endure long-term problems and may need substantial help. What is now clear is that many ICU patients are discharged home and are likely to incur many problems which will lead to a poor quality of life. These problems cause ripple on effects to families and society in general and consequently, rehabilitation after critical illness has been classified as a major public

health issue by the National Health Service.<sup>3</sup> In response, the NICE clinical guidelines<sup>3</sup> were formulated to assist clinicians in assessing and standardising practices after critical illness.

In this study prediction analyses provides variables at the premorbid and 1 month time points which predict impairment (definition was predetermined, Table 55) and death at 24 months. This data will inform clinicians of patient's long-term outcome. Holding information which allows early identification of patients who require early intensive rehabilitation is important on the individual and social level. Rehabilitation is often fundamental in enhancing patients' functional independence and play an important role in assisting with the patient's return to the community and home.

Early identification of patients who are at high risk of impairment will assist the rehabilitation team coordinate care across the continuum and between settings.

This assists maximising independence between setting and at different stages of recovery and minimising ongoing health care needs of this population.

Information relating to risk of clinically meaningful impairment and death, long-term, will assist patients and families to make informed treatment choices. We now hold accurate data which describes the recovery curves and long-term trajectory of the survivor of critical illness.

## Conclusion

This study has demonstrated novel and supporting evidence for the functional, neuropsychological and psychosocial recovery of ICU survivors compared with the existing literature. It has also revealed a much greater impaired profile for non-ICU medical and surgical acute care hospitalised patients, exhibiting a sicker and poorer baseline and recovery than expected.

# Chapter 6

# Conclusion

#### **Test Battery**

A broad test-battery incorporating standardised objective and subjective tests to measure functional, psychosocial, neuropsychological impairment together with patient self-report was used at 6 timepoints, over a 2 year period. Face-to-face, semi-structured interviews were conducted, which included narrative analysis. Tests, validated for use in ICU patients were used wherever possible.

It was important to design a heterogeneous study to accurately describe the recovery of the ICU survivor from a general medical, surgical unit rather than focusing on a homogeneous diagnostic group with limited capacity for generalisation to the general ICU population. The study did not suffer any loss to follow-up among the 143 participants throughout the study period, excluding attrition due to death.

The recovery of survivors of critical illness shows physical functional, neuropsychological and psychosocial impairment, of varying degrees, consistent with the literature. Points of note include:

## **Demographics**

- Preadmission, both groups were physically impaired to some degree and consider their functional quality of life below normative levels;
- The ICU patient profile show a sicker demographic prior to admission with almost 50 percent receiving social support and 17% of ICU patients hospitalised prior to ICU admission;

- However ICU patients were more physically independent and report higher levels of quality of life prior to admission compared with controls;
- Preadmission, the control profile was largely a group with a degree of functional deficit, reduced mobility, receiving community services although were still living at home and showed a higher level of integration at home and in the community.

#### **Physical Functional Outcome**

- Neither group score full functional capacity at any stage throughout the study period;
- Both groups show greatest deterioration in scores at the one month time point,
   reflecting the impact of the immediate illness episode and show recovery between 3 and 6 months;
- Controls reach maximum recovery and then plateau at 3 months after which show a trajectory of decline out to 24 months;
- ICU patients take longer to recover, achieving their maximum recovery reaching 12 months after which also showing a trajectory of decline at 24 months.

#### Quality of life

 Throughout the 24 month study period, both groups show gradual improvement to 12 months however do not ever perceive their physical function to be as high as the preadmission levels. The MCS trajectory is one of ongoing improvement at 24 months.

#### **Neuropsychological Recovery**

#### Verbal working memory

- Recovery curves for the DS show both ICU patients and controls show a similar pattern, achieving maximum recovery by 3 - 6 months after which both groups show a trajectory of decline at 24 months;
- Cognitively, overall ICU patients suffer higher levels of working memory deficit throughout the study with a lower level of recovery which is less sustained;
- ICU patients do not achieve normative scores at any time point for the DS or LNS,
   with older ICU patients showing worse verbal working memory.

# Executive function

- Recovery curves for the TMT, for both groups show maximum recovery by 6 months, after which the trajectory for ICU patients, at 24 months shows deterioration while controls continue to plateau;
- The SNST shows maximum recovery occurring later, between 6 12 months after which both groups show a plateauing trajectory.

## Psychosocial outcome

- There were no screened cases of PTSD symptoms in this study;
- ICU patients show low incidence of PTSD associated stress with scores improving to match controls, dropping to negligible levels by 24 months;

- The IES-R show controls score negligible levels of PTSD associated distress;
- Study data show both groups display low levels of deficit in the area of anxiety and depression throughout the study;
- Overall in this study up to 17% of ICU patients and 8% of controls displayed clinically elevated anxiety and depression (HADS) related to distress of the episode of illness.
   However, the level of clinically elevated anxiety and depression declined rapidly, with no evidence of anxiety or depression in either group at 24 months;
- ICU patients show slightly higher levels of anxiety and depression, particularly among females.

# Narratives confirm:

- Comparison between groups shows greater incidence and higher severity of problems for ICU patients with greater diversity;
- In the psychosocial domain, most common themes for ICU patients include physical weakness, fatigue, poor balance and strength;
- They felt unsupported immediately once discharged from the ICU. They found they
  were a lack of community support and service, lack of information, advice and
  reassurance resulting in loneliness, isolation and an inability to cope. ICU patients
  describe the majority of clinicians (from acute-care through to their General
  Practitioner) as dismissive of their problems and concerns;
- ICU patients feel ill-equipped and frightened to cope on the hospital wards. They
  regard there generally is lack of appreciation of the critical illness experience. They
  cite upon ICU discharge, there is a lack of ongoing rehabilitation, such as
  physiotherapy, occupational therapy;

- ICU patients perceive a low level of ongoing support, especially within the
  community, showing low levels of participation in community occupational /
  rehabilitation / allied health services. ICU patients believe their General Practitioners
  may be unaware of community based programs or regard them as unnecessary;
- ICU patients describe being unable to concentrate and describe poor memory function, many suffering panic attacks;
- Neither critically ill survivors nor carers felt they were prepared to deal with the new disabilities and impairments;
- Controls describe lack of information regarding their health condition, prognosis or recovery;
- Controls site transport problems (attending clinic appointments) as a significant and common problem due to driving restrictions;
- Controls are frustrated with their carer's lack of consideration and support.
- Controls cite transient physical problems such as changes in bowel habits, leg cramps poor wound healing, pain and immobility. Controls do not highlight any cognitive problems;
- Themes reflect a concerning level of patient frustration with the current systems and raise concerns for the ongoing management of patients following critical illness.

# Significance of outcomes

- Information surrounding recovery, outcome and impairment will influence immediate and ongoing patient treatment and care, and will have significance for future critical care health modelling. Understanding long-term recovery of intensive care survivors is needed to assist clinicians, patients, families and policymakers judge the clinical and economic benefits of new interventions and ensure provisions for suitable rehabilitation. Recovery outcomes will inform and strengthen the health literacy of patients and families, assisting in their decision making process.
- Using non-ICU, acute-care hospitalised controls is relatively novel in the area of critical care outcome research, with the majority of controlled studies recruiting control cohorts from either parallel critically-ill patient groups or controlling data within community norms. An acute-care hospitalised cohort was used to control for the effect of acute illness on the outcome of the critically ill survivor. Study data show impairment (to a lesser degree) among non-ICU general medical and surgical acute-care hospitalised controls, existing prior to admission. The literature details physical, psychosocial and cognitive deficits following critical illness, however there is very little published detail of the pre-existing level of impairment which chronically exists among acute-care hospitalised controls. These results perhaps reflect higher levels of incapacity and chronic disease existing in the community than previously acknowledged. This suggests that long-term impairment seen after critical illness may not totally be directly attributable to the critical illness episode. Acute-care hospitalised controls and ICU survivors may be suffering a chronic state of disability, upon which the critical illness episode is superimposed. This information is vital to accurately inform the design of the health planning framework for the health model to be sustainable.
- Cognitive impairment was not isolated to ICU patients. Study data show acute-care hospitalised controls suffered high levels of cognitive deficit compared to ICU patients.

- Study data confirms follow-up of between 3 and 12 months will show maximal recovery across all physical functional, psychosocial and cognitive domains. This data will inform future longitudinal studies, recognising follow-up is costly and loss to follow-up is notoriously high for long-term longitudinal follow. Being able to define the required length of follow-up is finally working towards a standardised test battery.
- The incidence of delirium is well documented in the critical care literature. Delirium has been cited to occur in up to 80% of ICU patients and may contribute to morbidity and mortality in the ICU.<sup>219</sup> Although delirium is recognised as a significant factor which may predispose ICU patients to PTSD and long-term cognitive deficits, it was not able to be measured in this study as delirium was not routinely measured in the critical care units at the time the study was conducted. However, it is recommended that all ICU patients be monitored using a validated delirium assessment instrument.
- Secondary outcome measures have been incorporated as outcomes for this study. These include social support, mobility impairment and return to work. These criteria were included to describe real-life situations upon which day-to-day health and service support services are allocated. These have important implications for such services including general practice, community nursing, rehabilitation, physiotherapy, occupational medicine and employers as they provide ongoing support for survivors of critical illness. Holding knowledge of the high level of deficit among acute-care hospitalised patients may alert clinicians to ensure appropriate services are in place to support a population previously thought to be independent. A comprehensive approach medical and psychosocial eventually entailing adequate vocational rehabilitation with supported employment can improve outcomes.

#### **Utility of Prediction analysis**

Having the capacity to predict the two year outcome of critically ill patients at unit admission will potentially change the model of critical care treatment. It has high utility for clinicians

and invaluable for patients and their families. Critical care beds are a scarce resource and a tool of predication will assure effective use of the beds.

A prediction tool will therefore ensure patients who choose not accept the long-term deficits or limitations or poor quality of life make an informed treatment limitation order with the knowledge that their quality of life may be poorer.

## **Study Limitations**

- This is a small pilot study conducted at two metropolitan hospitals (one a tertiary referral centre) in southern Tasmania. Currently Tasmania has the nation's highest unemployment rate which may result in a sample of a lower socioeconomic status than the wider Australian population, which may cause study bias.
- Delirium was not measured in this study as this was an observational study and delirium was not routinely measured in the critical care units at the time the study was conducted. The levels of PTSD symptoms measured by the IES-R were overall low to moderate levels.
- Positive outcomes were not measured. ICU patients, in particular, relayed a
  heightened sense of the value and meaning of life, often changing their outlook
  after critical illness. The capacity to capture positive outcomes was only reflected in
  the thematic analysis. Positive outcomes may have an impact on and create bias
  among such measures as quality of life, anxiety and depression and premorbid task
  scores.
- MMSE should have been administered prior to each time point to assess for general cognitive decline.
- Study design and study rigor was limited by financial constraints. The ideal design of a 'controlled' study (whereby a 2:1 match exists with 1 ICU patient matched to 2

controls) could not be achieved. This ensures that each and every control patient has a match. However, the adopted design still achieved study rigor.

- Unplanned critical care unit readmissions which have shown to increase mortality
  and longer length of hospital stay<sup>220</sup> have not been displayed nor factored into the
  study analyses due to small numbers. Data show one study participant (ICU patient)
  was readmitted to the ICU twice, within the 2 year study period.
- Administration of the test battery required approximately one hour to complete. While participants were offered rest breaks it was acknowledged interviews were mentally and physically tiring. Fatigue was highlighted by participants to be one of their primary problems, especially during the early stages of recovery. The length of interview may have contributed to participant fatigue. This perhaps contributed to the number of incomplete tasks within the test battery (participants noted as refusing some tasks) and perhaps poor test scores. This is a methodological factor of study design which should be a considered in future study design.
- Premorbid values, measured retrospectively, may show bias and inaccuracy.
- The control cohort consists of 16.25% cardiac related diagnostic groups. While this is
  acknowledged to be a high percentage of the total control cohort and may cause
  some study bias, it is also a true reflection of the current epidemiology of
  cardiovascular disease and representative of the restricted random sample.
- Five ICU patients listed as 'refused to participate' did so based on either reasons of 'tiredness,' 'unwell,' or 'anxiety'. This is a potential area of study bias, as these ICU patients possibly incurred higher levels of deficit.
- Three control patients were admitted to ICU during their hospital admission;
   however length of ICU stay was less than 24 hours, two patients receiving routine

post-op care and one with acute pulmonary oedema (Table 3 & 4). The patient who was readmitted to ICU during their current admission was not re-enrolled.

• Timepoints for the groups differed; for controls it was from hospital discharge; for cases from critical care discharge. Given the 3-week mean difference in hospital length of stay (29 versus 7.5 days) this may be a systematic measurement bias.

#### In conclusion:

- Greatest deficits existed among ICU survivors which were sustained across the study period which is consistent with the outcome literature;
- Preadmission scores reflect a fixed degree of dysfunction or a state of chronic disability prior to admission for both ICU patients and controls. Of concern is the high level of functional impairment seen among controls throughout the study, ranging between 56 – 85%;
- This study show high levels and incidence of physical and cognitive impairment for controls between 7.81 - 29.23% throughout the study period. Such impairment for a general acute-care general hospital population was previously unknown and must be now given consideration;
- This study confirms the highest levels and incidence of functional, neuropsychological and psychosocial deficits occurs one month after ICU discharge;
- Levels of anxiety and depression are not as high as those cited in the literature.

### **Further research**

• Further work on the predictor index is required to formulate into a tool for clinical use. Defining specific outcome (levels of impairment) with predictor test scores is

required to extend and refine the spectrum of impairment among ICU patients. This will then enable clinicians to not only identify patients who require immediate and additional ongoing rehabilitation but perhaps identify non-ICU acute care patients at risk of deterioration.

## References

- 1. Kress J, Herridge M. Medical and Economic Implications of Physical Disability of Survivorship. Crit Care Med 2012;33:339-47.
- 2. Australian Commission on Safety and Quality in Health Care. Vital Signs 2013: The State of Safety and Quality in Australian Health Care. Sydney, Australia: Commonwealth of Australia; 2013.
- 3. National Institute for Health and Clinical Excellence. NICE clinical guideline 83: Rehabilitation after critical illness. In: Practice CfC, ed. London: NHS; 2009:1-91.
- 4. Garrouste-Orgeas M, Boumendil A, Pateron D, al e, Group I-C. Selection of intensive care unit admission criteria for patients aged 80 years and over and compliance of emergency and intensive care unit physicians with the selected criteria: an observational, multicenter, prospective study. Crit Care Med 2009;37:2919-28.
- 5. ATS. fair allocation of intensive care unit resources. American Journal of Respiratory and Critical Care Medicine 1997;156:1282-301.
- 6. Angus D, Carlet J. Surviving intensive care: a report from the 2002 Brussels Roundtable. Intensive Care Med 2003;29:368-77.
- 7. Hayes J, Black N, Jenkinson C, et al. Outcome measures for adult critical care: a systematic review. Health Technol Assess 2000;4:1-111.
- 8. Ridley S, Crispin P, Scotton H, Rogers J, Lloyd D. Changes in quality of life after intensive care: comparison with normal data. Anaesthesia 1997;52:195-202.
- 9. Ehlenbach W, Hough C, Crane P, et al. Association Between Acute Care and Critical Illness Hospitalisation and Cognitive Function in Older Adults. JAMA 2010;303:763-70.
- 10. Broomhead L, Brett S. Clinical Review: Intensive care follow-up-what has it told us? Crit Care 2002;6:411-7.
- 11. Herridge M. One year outcomes in survivors of acute respiratory distress syndrome. NEJM 2003;348:683 93.
- 12. Wehler M, Geise A, Hadzionerovic D, et al. Health-related quality of life of patients with multiple organ dysfunction: Individual changes and comparison with normative population. Crit Care Med 2003;31:1094-101.
- 13. Girard T, Jackson J, Pratik P, et al. Delirium as a predictor of long-term cognitive impairment in survivors of critical illness. Crit Care Med 2010;38.
- 14. Hopkins R, Weaver L, Pope D, Orme J, Bigler E, Larson-Lohr V. Neurophysicological sequelae and impaired health status in survivors of severe acute respiratory distresss syndrome. Am J Respir Crit Care Med 1999;160:50-6.
- 15. Jackson J, Gordon S, Hart R, Hopkins R, Ely E. The association between delirium and cognitive decline: a review of the empirical literature. Neuropsychol Rev 2004;14:87-98.
- 16. Jackson J, Hart R, Gordon S, et al. Six-month Neuropsychological outcome of medical intensive care unit patients. Critical Care Medicine 2003;31:1226-34.
- 17. Iwashyna T, Ely W, Smith D, Langa K. Long-term cognitive impairment and functional disability among survivors of severe sepsis. JAMA 2010;304:1787-94.
- 18. Pandharipande P, Girard T, Jackson J, et al. Long-Term Cognitive Impairment after Critical Illness. The New England Journal of Medicine 2013;369:1306-16.
- 19. Jackson J, Hart R, Gordon S, Hopkins R, Girard T, Ely E. Post-traumatic stress disorder and post-traumatic stress symptoms following critical illness in medical intensive care unit patients: assessing the magnitude of the problem. Crit Care 2007;11.
- 20. Kvale R, Ulvik A, Flaatten H. Follow-up after intensive care: a single centre study. Intensive Care Med 2003;29:2149-56.
- 21. Griffiths R, Jones C. Intensive care aftercare. Oxford: Butterworth Heinemann; 2002.

- 22. Granja C, Teixeira-Pinto A, Costa-Pereira A. Quality of life after intensive care-evaluation with EQ-5D questionnaire. Intensive Care Med 2002;28:898-907.
- 23. Hurel D, Loirat P, Saulnier F, Nicolas F, Brivat F. Quality of life 6 months after intensive care: results of a prospective multicentre study using a generic health status scale and a satisfaction scale. Intensive Care Med 1997;23:331-7.
- 24. Wehler M, Martus P, Geise A, et al. Changes in quality of life after medical intensive care. Intensive Care Med 2001;27:154-9.
- 25. Graf J, Koch M, Dujardin R, Kersten A, Janssens U. Health-related quality of life before, 1 month after and 9 months after intensive care in medical cardiovascular and pulmonary patients. Crit Care Med 2003;31:2163-9.
- 26. Griffiths J, Fortune G, Barber V, Young J. The prevalence of post traumatic stress disorder in survivors of ICU treatment: a systematic review. Intensive Care Med 2007;33:1506-18.
- 27. Johnson T, Monk T, Rasmussen L, Abildstrom H, Houx P, al. e. Postoperative Cognitive Dysfunction in Middle-aged Patients. Anesthesiology 2002;96:1351-7.
- 28. Hopkins R. Brain imaging, neurocognitive sequelae and health related quality of life following acute respiratory distress syndrome. In: (ed)Recent research developments in respiratory and critical care medicine. Kerala2001.
- 29. Herridge M. Disability after Critical Illness. New England Journal of Medicine 2013:1367-9.
- 30. Palda V, Bowman K, McLean R, Chapman M. 'Futile' care: do we provide it? Why? A semistructured, Canada-wide survey of intensive care unit doctors and nurses. J Crit Care 2005;20:207-13.
- 31. Giannini A. Physicians' perceptions and attitudes regarding inappropriate admissions and resource allocation in intensive care setting. Br J Anaesth 2005;96:57-62.
- 32. Ward N, Teno J, Curtis J, Rubenfeld G, Levy M. Perceptions of cost constraints, resource limitations, and rationing in United States intensive care units: results of a national survey. Crit Care Med 2008;36:471-6.
- 33. Rubenfeld G. Interventions to improve long-term outcomes after critical illness. Curr Opin Crit Care 2007;13:476-81.
- 34. Ramsay P. Health-related quality of life: implications for critical care interventional studies and why we need to collaborate with patients. Current Opinion in Critical Care 2011;17:510-4.
- 35. Guyatt G, Ferrans C, Halyard M, et.al. Exploration of the value of health-related quality-of-life information from clinical research and into clinical practice. Mayo Clin Proc 2007;82:1229-39.
- 36. Rapkin B, Schwartz C. Toward a theoretical model of quality-of-life appraisal: implications of findings from studies of response shift. Health Qual Life Outcomes 2004;21:14-26.
- 37. Dowdy D, Eid M, Sedrakyan A, et al. Quality of life in adult survivors of critical illness: a systematic review of the literature. Intensive care Medicine 2005;31:611-20.
- 38. Dowdy D, Eid M, Dennison C, et al. Quality of life after acute respiratory distress syndrome: a meta-analysis. Intensive Care Med 2006;32:1115-24.
- 39. Winters B, Eberlein M, Leung J, Needham D, Pronovost P, Sevransky J. Long-term mortality and quality of life in sepsis: A systematic review. Crit Care Med 2010;38:1276-83.
- 40. Rothenhausler H, Ehrentraut S, Stoll C, Schelling G, Kapfhammer H. The relationship between cognitive performance and employment and health status in long term survivors of the acute respiratory distress syndrome: results of an exploratory study. Gen Hosp Psychiatry 2001;23:90-6.
- 41. Marquis K, Curtis J, Caldwell E, et.al. Neuropsychological sequelae in survivors of ARDS compared with critically ill control patients. Am J Respir Crit Care Med 2000;161:A383.

- 42. Suchyta M, Hopkins R, White J, et.al. The incidence of cognitive dysfunction after ARDS. Am J Respir Crit Care Med 2004;169:A18.
- 43. Hopkins R, Weaver L, Chan K, Orme J. Quality of life, emotional and cognitive function following acute respiratory distress syndrome. J Int Neuropsychol Soc 2004;10:1005-17.
- 44. Hopkins R, Weaver L, Collingridge D, Parkinson R, Chan K, Orme J. Two year cognitive, emotional and quality of life outcomes in acute respiratory distress syndrome. Am J Respir Crit Care Med 2005;171:340-7.
- 45. Al-Saidi F, McAndrews M, Cheung A, et.al. Neuropsychological sequelae in ARDS survivors. Am J Respir Crit Care Med 2003;167:A737.
- 46. Sukantarat K, Burgess P, Williamson R, Brett S. Prolonged cognitive dysfunction in survivors of critical illness. Anaesthesia 2005;60:847-53.
- 47. Hopkins R, JAckson J, Wallace C. Neurocognitive impairments in ICU patients with prolonged mechanical ventilation. International Neuropsychological Society 33rd Annual Meeting; 2005. p. 60.
- 48. Hopkins R, Brett S. Chronic neurocognitive effects of critical illness. Current Opinion in Critical Care 2005;11:369-75.
- 49. De Jonghe B, Bastuji-Garin S, Durand M, Malissin I, Rodrigues P, al. e. Respiratory weakness is associated with limb weakness and delayed weaning in critical illness. Crit Care Med 2007;35:2007-15.
- 50. Kritikos S, Angelopoulos E, Siafaka A, et al. Predisposing factors for critical illness polyneuromyopathy in a multidisciplinary intensive care unit. Acta Neurol Scand 2008;118:175-81.
- 51. Sidiras G, Gerovasili V, Pataski I, et al. Short and long term outcomes of ICU acquired weakness. Health Science Journal 2013;7:188-200.
- 52. Herridge M. Long-term outcomes after critical illness: past, present, future. Current Opinion in Critical Care 2007;13:473-5.
- 53. Herridge M. Long-term outcomes after critical illness. Current Opinion in Critical Care 2002;8:331-6.
- 54. Hough C, Steinberg K, Taylor Thompson B, Rubenfeld G, Hudson L. Intensive care unit-acquired neuromyopathy and corticosteroids in survivors of persistent ARDS. Intensive Care Med 2009;35:63-8.
- 55. Jones C, Griffiths R, Humphris G, Skirrow P. Memory, delusions and the development of acute posttraumatic stress disorder-related symptoms after intensive care. Crit Care Med 2001;29.
- 56. Cuthbertson B, Hull A, Strachan M, J S. Post-traumatic stress disorder after critical illness requiring general intensive care. Intensive Care Medicine 2004;30:450-5.
- 57. Scragg P, Jones A, Fauvel N. Psychological problems following ICU treatment. Anaesthesia 2001;56:9-14.
- 58. Eddleston J, White P, Guthrie E. Survival, morbidity, and the quality of life after discharge from intensive care. Crit Care Med 2000;28:368-77.
- 59. Heyland D, Hopman W, Coo H, Tranmer, J, McColl M. Long-term health-related quality of life in survivors of sepsis. Short Form 36: A valid and reliable measure of health-related quality of life. Crit Care Med 2000;28:3599-605.
- 60. Pettila A, Kaarlola A, Makelainen A. Health-related quality of life of multiple organ dysfunction patients one year after intensive care. Intensive Care Med 2000;26:1473-9.
- 61. Conlon N, O'Brien B, Herbison G, Marsh B. Long-term functional outcome and performance status after intensive care unit re-admission: a prospective survey. Br J Anaesth 2008;100:219-23.
- 62. Longo C, Heyland D, Fisher H, al. e. A long-term follow-up study investigating health-related quality of life and resource use in survivors of severe sepsis: Comparison of recombinant human activated protein C with standard care. Critical Care 2007;11:R128-R39.

- 63. Cook W, Eddleston J, Conway D, al. e. Quality of life in ICU survivors with severe sepsis who received Activated Protein C. Crit Care 2007;7.
- 64. Hofhuis J, Spronk P, van Stel H. The impact of severe sepsis on health-related quality of life: A long-term follow-up study. Anaesth Analg 2008;107:1957-64.
- 65. Rasmussen LS, Larsen K, Houx P, et al. The assessment of postoperative cognitive function Acta Psychiatrica Scandinavica 2001;45:275-89.
- 66. Heyland D, Guyatt G, Cook D, et al. Frequency and methodologic rigor of quality-of-life assessments in the critical care literature. Crit Care Med 1998;26:591-8.
- 67. McHugh G, Havill J, Armstead S, Ullal R, Fayers T. Follow-up of elderly patients after cardiac surgery and intensive care unit admission. NZ Med J 1997;100:432-5.
- 68. Wehler M, Geise A, Hadzionerovic D, et al. Health-related quality-of-life of patients with multiple organ dysfunction: individual changes and comparison with normative population. Crit Care Med 2003;31:1094-101.
- 69. Kaarlola A, Pettila V, Kekki P. Quality of life six years after intensive care. Intensive Care Med 2003;29.
- 70. Vedio A, Sherbourne C. The Mos 36-item Short-Form Health Survey (SF-36) conceptual framework and item selection. Med Care 1992;30:473-83.
- 71. Flaaten K, Kvale R. Survival and quality of life 12 years after ICU. A comparison with the general Norwegian population. Intensive Care Med 2001;27:1005-11.
- 72. Kleinpell R. Exploring outcomes after critical illness in the elderly. Outcomes Manag 2003;7:159-69.
- 73. Chaboyer W, Elliot D. Health-related quality of life of ICU survivors: Review of the literature. Intensive and Critical Care Nursing 2000;16:88-97.
- 74. Fildissis G, Zidianakis V, Tsigou E, Koulenti D, Katostaras T, et.al. Quality of life outcome of critical care survivors eighteen months after discharge from intensive care. Croat Med J 2007;48:814-21.
- 75. Garcia Lizana F, Peres Bota D, De Cubber M, Vincent J. Long-term outcome in ICU patients: what about quality of life? Intensive Care Med 2003;29:1286-93.
- 76. Flaatten K, Kvale R. Survival and quality of life 12 years after ICU. A comparison with the general Norwegian population. Intensive Care Med 2001;27:1005-11.
- 77. Moran J, Bristow P, Solomon P, George C, Hart G, Australian and New Zealand Intensive Care Society Database Management Committee. Mortality and length-of-stay outcomes, 1993-2003, in the binational Australian and New Zealand intensive care adult patient database. Crit Care Med 2008;36:46-61.
- 78. McKinley S, Aitken L, Alison J, et al. Sleep and other factors associated with mental health and psychological distress after intensive care for critical illness. Intensive Care Med 2012;38:627-33.
- 79. Brooks R, Kerridge R, Hillman K, Bauman A, Daffurn K. Quality of life outcomes after intensive care. Comparison with a community group. Intensive Care Medicine 1997;23:581-6.
- 80. Hackett M, Anderson C. Health outcomes 1 year after subarachnoid hemorrhage: An international population-based study. The Australian Cooperative research on Subarachnoid Hemorrhage Study Group. Neurology 2000;55:658-62.
- 81. Denehy L, Berney S, Whitburn L, Edbrooke L. Quantifying physical activity levels of survivors of intensive care: a prospective observational study. Phys Ther 2012;92:1507-17.
- 82. Hough C, Herridge M. Long-term outcome after acute lung injury. Current Opinion in Critical Care 2012;18:8-15.
- 83. Papazian L, Forel J, Gacouin A, et.al. Neuromuscular blockers in early acute respiratory distress syndrome. NEJM 2010;363:1107-16.
- 84. Uniform Data Set for Medical Rehabilitation. The clinical guide for the uniform data set for medical rehabilitation (including the FIM Instrument). Buffalo, NY: State University of New York at Buffalo; 2009.

- 85. Girard T, Jackson J, Pandharipande P, Thompson J, Shintani A, Ely E. Duration of delirium as a predictor of long-term cognitive impairment in survivors of critical illness. Am J Respir Crit Care Med 2009;179:A5477.
- 86. Stuss D, Peterkin I, Guzman D, al. e. Chronic obstructive pulmonary disease: Effects of hypoxia on neurological and neuropsychological measures. J Clin Exp Neuropsychol 1997;19:515-24.
- 87. Incalzi R, Chiappini F, Fuso L, al. e. Predicting cognitive decline in patients with hypoxaemic COPD. Respir Med 1998;92:527-33.
- 88. Hopkins R, Gale S, Johnson S, et.al. Severe anoxia with and without concomitant brain atrophy and neuropsychological impairments. J Int Neuropsychol Soc 1995;1:501-9.
- 89. Eideleman L, Putterman D, Putterman C, et.al. The spectrum of septic encephalopathy: definitions, eitiologies and mortalities. JAMA 1996;275:470-3.
- 90. Elenkov I, Iezzoni D, A D, Harris A, Chrousos G. Cytokine dysregulation, inflammation and well-being. Neuroimmunomodulation 2005;12:255-69.
- 91. Pandharipande P, Pun B, Herr D, al. e. Effect of sedation with dexmetetomidine vs lorazepam on acute brain dysfunction in mechanically ventilated patients: The MENDS randomised controlled trial. JAMA 2007;298:2644-53.
- 92. Schelling G, Stoll C, Kapfhammer H, al. e. The effect of stress doses of hydrocortisone during septic shock on posttraumatic stress disorder and health-related quality of life in survivors. Crit Care Med 1999;27:2678-83.
- 93. Larson M, Weaver L, Hopkins R. Cognitive sequelae in acute respiratory distress syndrome patients with and without recall of the intensive care unit. USA: Cambridge University press; 2007.
- 94. Hopkins R, Jackson J. Long-term Neurocognitive Function After Critical Illness. CHEST 2006;130:869-78.
- 95. Mason S, Noel-Storr A, Ritchie C. The impact of general and regional anaesthesia on the incidence of post-operative cognitive dysfunction and post-operative delirium: a systematic review with meta-analysis. J Alzheimers Dis 2010;22:67-79.
- 96. Scott JE, Mathias JL, Kneebone AC. Postoperative cognitive dysfunction after total joint arthroplasty in the elderly: a meta-analysis. J Arthroplasty 2014;29:261-7.
- 97. Borowicz L, Goldsborough M, Selnes O, McKhann G. Neuropsychologic change after cardiac surgery: a critical review. Journal of Cardiothoracic and Vascular Anaesthesia 1996;10:105-12.
- 98. McKhann G, Goldsborough M, Borowicz L, al. e. Cognitive outcome after coronary artery bypass: a one-year prospective study. Annals of Thoracic Surgery 1997;63:510-15.
- 99. Bruggermans E, Van Dijk J, Huysmans H. Residual cognitive dysfunction at 6 months following coronary bypass graft surgery. European Journal of Cardiothoracic Surgery 1995;9:636-43.
- 100. Robinson M, Blumenthal J, Burker E, Hlarky M, Reves J. coronary artery bypass grafting and cognitive function: a review. Journal of Cardiopulmonary Rehabilitation 1990;10.
- 101. Rodig G, Rak A, Kasprzak P, Hobbhahn J. Evaluation of self-reported failures in cognitive function after cardiac and noncardiac surgery. Anaesthesia 1999;54:826-30.
- 102. Davydow D, Gifford J, Desai S, Bienvenu O, Needham D. Depression in general intensive care unit survivors: a systematic review. Intensive Care Medicine 2009;35:796-809.
- 103. Davydow D, Hough C, Russo J, et.al. The association between intensive care unit admission and subsequent depression in patients with diabetes. Int J Geriatr Psychiatry 2011;21:311-5.
- 104. Griffiths J, Hatch R, Bishop J, et al. An exploration of social and economic outcome and associated health-related quality of life after critical illness in general intensive care unit survivors: a 12-month follow-up study. Crit Care 2013;17.

- 105. Peterson R, Smith G, Waring S, et.al. Mild cognitive impairment: clinical characterisation and outcome. Arch Neurol 1999;56:303-8.
- 106. Francis J, Kapoor W. Prognosis after hospital discharge of older medical patients with delirium. J Am Geriatr Soc 1992;40:601-6.
- 107. Wells K, Hays R, Burnam M, et al. The functioning and well-being of depressed patients: results from the Medical Outcomes Study. JAMA 1989;262:914-9.
- 108. Zatzick D, Jurkovich G, Rivara F, et al. A national study of posttraumatic stress disorder, depression and work and functional outcomes after hospitalisation for traumatic injury. Ann Surg 2008;248:429-37.
- 109. Scragg P, Jones A, N F. Psychological problems following ICU treatment. Anaesthesia 2001;56:9-14.
- 110. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 4th edition, text revision ed. Arlington, VA2000.
- 111. Schelling G, Stoll C, Meirer M, al. e. Health-related quality of life and posttraumatic stress disorder in survivors of adult respiratory distress syndrome. Crit Care Med 1998;26:651-9.
- 112. Schelling G, Richter M, Roozendaal B, et al. Exposure to high stress in the intensive care unit may have negative effects on health-related quality-of-life outcomes after cardiac surgery. Crit Care Med 2003;31:1971-80.
- 113. Deja M, Denke C, Weber-Carstons S, et al. Social support during intensive care unit stay might improve mental impairment and consequently health-related quality of life in survivors of severe acute respiratory distress syndrome. Crit Care 2006;10.
- 114. Jones C, Griffiths R, Humphris G, al e. Disturbed memory and amnesia related to intensive care. Memory 2000;8:79-94.
- 115. Jones J, Hoggart B, Withey J, Donaghue K, Ellis B. What the patients say: A study of reactions to an intensive care unit. Intensive Care Med 1979;5:89-92.
- 116. Jones C, Griffiths R, Macmillan R, al. e. Psychological problems occurring after intensive care. Br J Int Care 1994;2:46-53.
- 117. Lof L, Berggren L, Ahlstrom G. Severely ill ICU patients recall of factual events and unreal experiences of hospital admission and ICU stay 3 and 12 months after discharge. Intensive and Critical Care Nursing 2006;22:154-66.
- 118. Roberts B, Chaboyer W. Patients' dreams and unreal experiences following intensive care unit admission. Nursing in Critical Care 2004;9:173-80.
- 119. Ballenger J, al. e. Consensus statement on posttraumatic stress disorder from the International Consensus groups on Depression and Anxiety. The Journal of Clinical Psychiatry 2000;61:60-6.
- 120. Jones C, Backman C, Capuzzo M, al. e. Participants of post-traumatic stress disorder following intensive care: A hypothesis generating study of diversity of care. Intensive Care Med 2007;33:978-85.
- 121. Weinert C, Sprenkle M. Post-ICU consequences of patient wakefulness and sedative exposure during mechanical ventilation. Intensive Care Med 2008;34:82-90.
- 122. Granja C. Patients' recollections of experiences in the intensive care unit may affect their quality of life. Critical Care 2005;9:R96-R109.
- 123. Ringdal M, al. e. Outcome after injury: Memories, health-related quality of life, anxiety and symptoms of depression after intensive care. Journal of Trauma 2009;66:1226-33.
- 124. Nelson B, Weinert C, Bury C, et.al. Intensive care unit drug use and subsequent quality of life in acute lung injury patients. Crit Care Med 2000;28:3626-30.
- 125. Kress J, Gehlbach B, Lacy M, al. e. The long-term psychological effects of daily sedative interruption on critically ill patients. Am J Respir Crit Care Med 2003;168:1475-61.
- 126. Girard T, Shintani A, Jackson J, al. e. Risk factors for posttraumatic stress disorder symptoms following critical illness requiring mechanical ventilation: A prospective cohort study. Crit Care 2007;11.

- 127. Pandharipande P, Cotton B, Shintani A, al. e. Prevalence and risk factors for development of delirium in surgical and trauma intensive care unit patients. J Trauma 2008;64:34-41.
- 128. Pandharipande P, Shintani A, Peterson J, al. e. Lorazepam is an independent risk factor for transitioning to delirium in intensive care unit patients. Anesthesiology 2006;104:21-6.
- 129. Treggiari M, Romand J, Yanez N, Deem S, et.al. Randomised trial of light versus deep sedation on mental health after critical illness. Crit Care Med 2009;37:2527-34.
- 130. Foster M, Chaboyer W. Family carers of ICU survivors: a survey of the burden they experience. Scandinavian Journal of Caring Sciences 2003;17:205-14.
- 131. Unroe M, Kahn J, Carson S, al e. One-year trajectories of care and resource utilisation for recipients of prolonged mechanical ventilation: a cohort study. Ann Intern Med 2010;153:167-75.
- 132. Cox C, Carson S, Govert J, Chelluri L, Sanders G. An economic evaluation of prolonged mechanical ventilation. Crit Care Med 2007;35:1918-27.
- 133. Daly B, Douglas S, Kelley C, O'Toole E, Montenegro H. Trial of a disease management program to reduce hospital readmissions of the chronically critically ill. CHEST 2005;128:507-17.
- 134. Needham D, Korupolu R, Zanni J, al e. Early physical medicine and rehabilitation for patients with acute respiratory failure: a quality improvement project. Arch Phys Med Rehabil 2010;91:536-42.
- 135. Schweickert W, Pohlman M, Pohlman A, as e. Early physical and occupational therapy in mechanically ventilated, critically ill patients: a randomized controlled trial. Lancet 2009;373:1874-82.
- 136. Morris P, Griffin L, Berry M, et al. Receiving Early Mobility During an ICU Admission Is A Predictor of Improved Outcomes In Acute Respiratory Failure. Am J Med Sci 2011;341:373-7.
- 137. Yinnon A, Zimran A, Hershko C. Quality of life and survival following intensive medical care. QJ Med 1989;71:347-57.
- 138. Stanton B, Jenkins C, Denlinger P, Savageau J, Weintraub R, Goldstein R. Predictors of employment status after cardiac surgery. JAMA 1983;249:907-11.
- 139. Bell D, Turpin K. Quality of life at three months following admission to intensive and coronary care units. Clin Intensive Care 1994;5:276-81.
- 140. McKee M, Schemitsch E, Vincent L, Sullivan I, Yoo D, Gruen G. The effect of a femoral fracture on concomitant closed head injury in patients with multiple injuries. J Trauma 1997;42:1041-5.
- 141. Schuster H. Intensive care in old age. Med Klim 1991:86:473-81.
- 142. Rowan K. Outcome comparisons of intensive care units in Great Britain and Ireland using APACHE II method. Oxford: University of Oxford; 1992.
- 143. Grotz M, Hohensee A, D R, Wagner T, et.al. Rehabilitation results of patients with multiple injuries and multiple organ failure and long-term intensive care. J Trauma 1997;42:919-26.
- 144. Doepel M, Eriksson J, Halme L, Kumpulainen T, Hockerstedt K. Good long term results in patients surviving severe acute pancreatitis. Br J Surg 1993;80:1583-19.
- 145. MacKenzie E, Siegel J, Shapiro S, Moody M, Smith R. Functional recovery and medical costs of trauma: an analysis by type and severity of injury. J Trauma 1988;28:281-95.
- 146. Stambrook M, Moore A, Peters L, Deviaene C, et.al. Effects of mild, moderate and severe closed head injury on long-term vocational status. Brain Injury 1990;4:183-90.
- 147. Kriwanek S, Armbruster C, Dittrich K, Beckerhinn P, et.al. Long-term outcome after open treatment of severe intra-abdominal infection and pancreatic necrosis. Arch Surg 1998;133:140-4.

- 148. Alho A, Rokkanen P. Recovery of patients after intensive care for blunt injuries. Ann Chir Gynaecol Fenniae 1973;62:64-8.
- 149. Broome A, Eisen G, Harland R, Collins B, Meyers W, Pappas T. Quality of life after treatment for pancreatitis. Ann Surg 1996;223:665-72.
- 150. Chelluri L, Im K, Belle S, al e. Long-term mortality and quality of life after prolonged mechanical ventilation. Critical Care Medicine 2004;32:61-9.
- 151. Chelluri L, Pinsky M, Donahoe M, Grenvik A. Long-term outcome of critically ill elderly patients requiring intensive care. JAMA 1993;269:3119-23.
- 152. Dardaine V, Constans T, Lasfargues G, Perrotin D, Ginies G. Outcome of elderly patients requiring ventilatory support in intensive care. Aging Clin Exp Res 1995;7:211-7.
- 153. Battistella F, Din A, Perez L. Trauma patients 75 years and older: long-term follow-up results justify aggressive management. J Trauma 1998;44:618-23.
- 154. Zaren B, Hedstrand U. Quality of life among long-term survivors of intensive care. Crit Care Med 1987;15:743-7.
- 155. Niskanen M, Ruokonen E, Takala J, Rissanen P, Kari A. Quality of life outcomes after prolonged intensive care. Crit Care Med 1999;27:1132-9.
- 156. Barnato A, Albert S, Angus Dea. Disability among elderly survivors of mechanical ventilation. Am J Respir Crit Care Med 2011;183:1037-42.
- 157. Hartl W, Wolf H, Schneider C, Kuchenhoff H, Jauch K. Acute and long-term survival in chronically critically ill surgical patients: a retrospective observational study. Crit Care 2007:11.
- 158. Williams S, Williams C, Zimmerman S, et al. Characteristics Associated With Mobility Limitation in Long-Term Care Residents With Dementia. The Gerentologist 2005;45:62-7.
- 159. Staudinger T, Stoiser B, Mullner M, et al. Outcome and prognostic factors in critically ill cancer patients admitted to the intensive care unit. Crit Care Med 2000;28:1322-8.
- 160. Gracey D, Naessens J, Krishan I, Marsh H. Hospital and posthospital survival in patients mechanically ventilated for more than 29 days. Chest 1992;101:201-14.
- 161. Friedrich J, Wilson G, Chant C. Long-term outcomes and clinical predictors of hospital mortality in very long stay intensive care unit patients: a cohort study. Crit Care 2006;10:R59.
- 162. Williams T, Dobb G, Finn J, SA W. Long-term survival from intensive care: a review. Intensive Care Med 2005;31:1306-15.
- 163. Ridley S. Quality of life and longer term outcomes in evaluating critical care using health services research to improve quality: Springer; 2000.
- 164. Jones C, Griffiths R. Identifying post intensive care patients who may need physical rehabilitation. Clinical Intensive Care 2000;11:35-8.
- 165. Combes A, Costa M, Trouillet J, et al. Morbidity, mortality and quality-of-life outcomes of patients requiring  $\geq$  14 days of mechanical ventilation. Crit Care Med 2003;31:1373-81.
- 166. Herbst A, Drenth C. The Intensity of Intensive Care: A Patient's Narrative. Global Journal of Health Science 2012;4.
- 167. Egerod I, Christensen D. Analysis of patient diaries in Danish ICUs: a narrative approach. Intensive and Critical Care Nursing 2009;25:268-77.
- 168. Egerod I, Christensen D, Schwartz-Nielson H, Agard A. Constructing the illness narrative: A grounded theory exploring patients' and relatives' use of intensive care diaries. Crit Care Med 2011;39.
- 169. Shinotsuka C, Salluh J. Perceptions and practices regarding delirium, sedation and analgesia in critically ill patients: a narrative review. Revista Brasileira de Terapia Intensiva 2013;25.

- 170. Ely E, Inoute S, Bernard G, al. e. Delirium in mechanically ventilated patients: Validity and reliability of the Confusion Assessment Method for the intensive care unit (CAM-ICU). JAMA 2001;286:2703-10.
- 171. McNicoll L, Pisani M, Zhang Y, et.al. Delirium in the intensive care unit: occurrence and clinical course in older patients. J Am Geriatr Soc 2003;51:591-98.
- 172. Mauthe R, Haaf D, Hayn P, Krau J. Predicting discharge destination of stroke patients using a mathematical model based on six items from the Functional Independence Measure. Arch Phys Med Rehabil 1996;77:10-3.
- 173. Cohen M, Marino R. The tools of disability outcomes research functional status measures. Arch Phys Med Rehabil 2000;81:521-9.
- 174. Dennis D, Hebden-Todd T, Marsh L, Cipriano L, Parsons R. How do Australian ICU survivors fare functionally 6 months after admission? Crit Care Resusc 2011;13:9-16.
- 175. Baguley J, Nott M, Howie A, et al. Late mortality after severe traumatic brain injury in New South Wales: a multicentre study. MJA 2012;196:40-5.
- 176. Elliott D, Denehy L, Berney S, Alison J. Assessing physical function and activity for survivors of a critical illness: A review of instruments. Australian Critical Care 2011;24:155-66.
- 177. Ware J, Snow K, Kosinski M. SF 36 Version 2 health survey: manual and interpretation guide: Quality Metric Incorporated; 2000.
- 178. McHorney C. Health status assessment methods for adults: Past accomplishments and future challenges. Annu Rev Public Health 1999;20:309-35.
- 179. Brazier J, Harper R, Jones N, al. e. Validating the SF36 survey questionnaire: New outcome measure for primary care. British Medical Journal 1992;305:160-4.
- 180. Garrat A, Ruta D, Abdalla M, Buckingham J, Tussell I. The SF36 health survey questionnaire: An outcome measure suitable for routine use within the NHS? British Medical Journal 1993;306:1440-4.
- 181. Cuthbertson B, Roughton S, Jenkinson D, MacLennan G, Vale L. Quality of life in the five years after intensive care: a cohort study. Critical Care 2010;14.
- 182. Davidson T, Caldwell E, Curtis J, Hudson L, Steinberg K. Reduced Quality of Life in Survivors of Acute Respiratory Distress Syndrome Compared With Critically Ill Control Patients. JAMA 1999;281:354-60.
- 183. Zigmond A, Snaith R. The Hospital Anxiety and Depression Scale. Acta Psychiatrica Scandinavica 1983;67:361-70.
- 184. Jones C, Griffiths R, Humphris G, Skirrow P. Memory, delusions, and the development of acute posttraumatic stress disorder-related symptoms after intensive care. Crit Care Med 2001;29:573-80.
- 185. Spinhoven P, Ormel J, Slockers P, Kempen G, et.al. A validation study of the Hospital Anxiety and Depression Scale (HADS) in different groups of Dutch subjects. Psychol Med 1997;27:363-70.
- 186. Zigmond A, Snaith R. The Hospital Anxiety and Depression Scale. Acta Psychiatrica Scandinavica 1983;67:361-70.
- 187. Weiss D, Marmar C. The Impact of Event Scale-Revised. New York: Guilford Press; 1997.
- 188. Horowitz M, Wilner N, Alvarez W. Impact of Events Scale: A measure of subjective distress. Psychosom Med 1979;41:209.
- 189. Neal L, Busuttil W, Rollins J, Herepath R, Strike P. Convergent validity of measures of post-traumatic stress disorder in mixed military and civilian population. J Trauma Stress 1994;7:447-55.
- 190. Weiss D, Marmar C. The Impact of Event Scale-Revised. Assessing psychological trauma and PTSD. New York: Guilford Press; 1997.
- 191. Rothbaum B, Foa E, Riggs D, Murdock T, Walsh W. A prospective examination of post-traumatic stress disorder in rape victims. Journal of Traumatic Stress 1992;7:669-90.

- 192. Willer B, Rosenthal M, Kreutzer S, Gordon A, Rempel R. Assessment of community integration following rehabilitation for traumatic brain injury. Journal of Head Trauma 1993:8.
- 193. Riether A, Smith S, Lewison B, Cotsonis G, CM E. Quality-of-life changes and psychiatric and neurocognitive outcome after heart and liver transplantation. Transplantation 1992;54:444-50.
- 194. Frutiger A, Ryf C, Bilat C, et al. five years follow-up of severely injured ICU patients. J Trauma 1991;31:1216-26.
- 195. Uzell B, Langfitt T, Dolinskas C. Influence of injury severity on quality of survival after head injury. Surg Neurol 1987;27:419-29.
- 196. Folstein M, Folstein S, McHugh P. "Mini-mental state": A practical method for grading the cognitive state of patients for the clinician. J Psychiatric Res 1975;12:189-98.
- 197. Wechsler D. Wechsler Adult Intelligence Scale. Third Edition ed. San Antonio: Psychological Corporation; 1997.
- 198. Nelson H. National Adult Reading Test (NART): Test Manual: Windsor; 1982.
- 199. Crawford J, Besson J, Parker D, Sutherland K, Keen P. Estimation of premorbid intellectual status in depression. British Journal of clinical Psychology. 26 1987:313-4.
- 200. Crawford J, Parker D, Besson J. Estimation of premorbid intelligence in organic conditions. British Journal of Psychiatry 1988;153:178-81.
- 201. O'Carroll R. The inter-rater reliability of the National Adult reading Test (NART): A pilot study. British Journal of Clinical Psychology 1987;26:229-30.
- 202. Reitan R. Trail-making manual for administration, scoring and interpretation. Indianapolis: Indiana University Medical Centre; 1958.
- 203. Stroop J. Studies of interference in serial verbal reactions. Journal of Experimental Psychology 1935;18:643-61.
- 204. Lannoo E, Colardyn E, De Deyne C, Vandekerchove T, Jannes C, De Soete G. Cerebral perfusion pressure and intracranial pressure in relation to neuropsychological outcome. Intensive Care Med 1998;24:236-41.
- 205. Liamputtong P, Ezzy D. Qualitative research methods. 2nd edn ed. South Melbourne: Oxford University Press; 2005.
- 206. Braun V, Clarke V. Using thematic analysis in psychology Qualitative Research in Psychology 2006;3:77-101.
- 207. Singer B, Ryff C, Carr D, al e. Linking life histories and mental health: a person-centered strategy. Sociol Methodol 1998;28:1-51.
- 208. Morse J, Field P. Qualitative research methods for health professionals: Sage Publications; 1995.
- 209. Strauss A. Qualitative analysis for social scientists: Cambridge University Press; 1987.
- 210. Friedrich J, Wilson G, Chant C. Long-term outcomes and clinical predictors of hospital mortality in very long stay intensive care unit patients: A cohort study. Crit Care 2006;10.
- 211. Riether A, Smith S, Lewison B, Cotsonis G, Epstein C. Quality-of-life changes and psychiatric and neuocognitive outcome after heart and liver transplantation. Transplantation 1992;54:444-50.
- 212. Hopkins R, Jackson J. Assessing neurocognitive outcomes after critical illness: are delirium and long-term cognitive impairments related? Current Opinion in Critical Care 2006;12:388-94.
- 213. Schillinger D, Barton L, Karter A, Wang F, Adler N. Does Literacy Mediate the Relationship Between Education and Health Outcomes: Study of a Low-Income Population with Diabetes. Public Health Rep 2006;121:245-54.
- 214. Lynch S. Cohort and life-course patterns in the relationship between education and health: A hierarchical approach. Demography 2003;40:309-31.

- 215. Ross C, Wu C. The links between education and health. American Sociological Review 1995;60:719-45.
- 216. McGough E, Logsdon R, Kelly V, Teri L. Functional mobility limitations and falls in assisted living residents with dementia: physical performance assessment and quantitative gait analysis. J Geriatr Phys Ther 2013;36:78-86.
- 217. Corner E. Intensive care unit acquired weakness: measuring recovery from critical illness. JICS 2012;13:216-20.
- 218. Zunzunegui M, Alvarado B, Ser T, Otero A. Social Networks, Social Integration, and Social Engagement Determine Cognitive Decline in Community-Dwelling Spanish Older Adults. Journal of Gerontology: SOCIAL SCIENCES 2003;58B:S93-S100.
- 219. Girard T, Carson S, Pandharipande P, al. e. Modifying the incidence of delirium (MIND) trial: A randomised controlled trial of the feasibility, efficacy and safety of antipsychotics for the prevention and treatment of ICU delirium. Am J Respir Crit Care Med 2008;177.
- 220. Rosenberg A, Watts C. Patients Readmitted to ICUs. A Systematic Review of Risk Factors and Outcomes. CHEST 2000;118:492-502.

# APPENDICIES

## **APPENDIX 1.0 - TEST OUTCOMES**

Appendix 1.1. Functional Independence Measure (Recovery over Time)

FIM		All Control		All ICU		Survivor Control		Survivor ICU		Deceased Controls		Deceased ICU
	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)
Preadmission	72	119 (14.2)	71	121 (14.3)	64	122 (6.10)	59	122 (14.66)	8	96 (31.67)	12	119 (12.91)
1 month	72	117 (15.2)	72	108 (18.7)	64	120 (9.61)	59	110 (14.91)	8	98 (31.94)	12	95 (29.08)
3 months	65	121 (9.24)	68	118 (12.8)	62	121 (9.38)	59	120 (7.77)	3	117 (5.03)	9	102 (24.78)
6 months	64	121 (9.74)	65	119 (15.0)	62	120 (9.72)	59	121 (7.55)	2	116 (12.72)	6	99 (40.78)
12 months	63	122 (8.56)	61	122 (6.46)	62	121 (8.32)	59	121 (6.44)	1	104	2	120 (9.19)
24 months	60	121 (7.62)	60	119 (11.4)	60	120 (7.62)	59	119 (11.43)	0		0	

Score range 0-126. Increase in score denotes improved functional independence. Clinical impairment <108

**Appendix 1.2.** Digit Span Task (Recovery over Time)

Test Digit Span (Adj)		All Control		All ICU		Survivor Control		Survivor ICU		Deceased Control		Deceased ICU
	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)
Preadmission	0		0		0		0		0		0	
1 month	69	9.7 (2.80)	66	8.88 (3.16)	62	9.85 (2.80)	56	8.80 (3.05)	7	8.14 (2.41)	10	9.30 (3.83)
3 months	61	10.8 (3.45)	65	9.40 (3.66)	59	10.89 (3.46)	57	9.45 (3.52)	2	8.00 (1.41)	8	9.00 (4.81)
6 months	60	10.3 (3.51)	62	9.66 (3.04)	58	10.32 (3.56)	58	9.91 (2.94)	2	10.5 (0.70)	4	6.00 (2.00)
12 months	60	10.2 (3.69)	56	9.64 (3.07)	59	10.28 (3.67)	55	9.74 (3.00)	1	6.00	1	4.00 (2.00)
24 months	59	10.4 (3.53)	58	9.43 (3.15)	59	10.35 (3.52)	57	9.43 (3.17)	0		0	(=/

Increase in score denotes improved verbal memory. Below normal: 7-8
Clinical Impairment: ≤4

**Appendix 1.3.** Letter Number Sequence (Recovery over Time)

LNS (adj)		All Control		All ICU		Survivor Control		Survivor ICU		Decease d Controls		Deceased ICU
	N	Mean (SD)	N	Mea n (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)
Preadmission	0		0		0		0		0		0	
1 month	65	8.87 (3.7)	64	7.71 (3.0)	58	9.06 (3.7)	54	7.83 (3.1)	7	5.71 (2.36)	10	5.70 (2.58)
3 months	55	8.94 (3.7)	65	7.44 (3.7)	53	9.05 (3.7)	56	7.75 (3.8)	2	5.00 (1.41)	9	5.44 (4.00)
6 months	54	9.03 (4.1)	60	8.13 (3.3)	52	9.01 (4.1)	56	8.44 (3.2)	2	7.50 (2.12)	4	3.25 (2.50)
12 months	53	9.30 (3.9)	55	8.76 (3.4)	52	9.34 (3.9)	54	8.87 (3.4)	1	6.00	2	6.00 (4.24)
24 months	53	8.86 (3.6)	54	8.85 (3.9)	53	8.86 (3.6)	54	8.85 (3.9)	0		0	

Increase in score denotes improved verbal working memory. Below normal: 7-8 Clinical Impairment:  $\leq 4$ 

**Appendix 1.4.** Trailmaking B Task (Recovery over Time)

TRAILS (sec)		All Contro I		All ICU		Survivor Control		Survivor ICU		Deceased Controls		Deceased ICU
	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)
Preadmission	0		0		0		0		0		0	
1 month	65	162 (100)	53	192 (131)	58	146 (79)	44	178 (124)	7	292 (152)	9	256 (151)
3 months	53	120 (85)	54	154 (96)	51	121 (70)	47	155 (100)	2	335 (216)	7	146 (58)
6 months	53	136 (84)	51	154 (103)	51	134 (83)	47	147 (100)	2	175 (98)	4	224 (112)
12 months	52	129 (71)	48	149 (87)	51	126 (70)	46	149 (89)	1	230 (230)	2	124 (3)
24 months	52	135 (114)	47	172 (94)	52	134 (114)	46	170 (94)	0		0	

Decrease in score denotes improved executive function

**Appendix 1.5.** StroopTask (Recovery over Time)

Stroop Ratio	N	All Control Mean	N	All ICU Mean	N	Survivor Control Mean	N	Survivor ICU Mean	N	Deceased Controls Mean	N	
Preadmission	0	(SD)	0	(SD)	0	(SD)	0	(SD)	0	(SD)	0	(SD)
Freduillission	U		U		U		U		U		U	
1 month	6	0.97	54	1.19	58	0.97	46	1.18	5	252.80	8	215.38
	3	(0.42)		(0.54)		(0.42)		(0.58)		(69.29)		(73.54)
3 months	5	0.91	52	1.11	53	0.92	46	0.99	1	181	6	205.83
	4	(0.50)		(0.50)		(0.50)		(0.49)				(95.53)
6 months	5	1.01	49	0.95	50	1.00	47	0.94	2	184.5	2	182
	2	(0.57)		(0.71)		(0.58)		(0.73)		(0.71)		(56.56)
12 months	5	0.95	48	0.96	52	0.96	46	0.94	1	170.00	2	203.00
	3	(0.61)		(0.64)		(0.62)		(0.65)				(21.21)
24 months	5	0.86	46	0.90	52	0.86	46	0.90	0		0	
	2	(0.38)	_	(0.46)		(0.38)		(0.46)				

Decrease in score denotes improvement

**Appendix 1.6.** Impact of Events Scale – Revised (Total) (Recovery over Time)

IES (Total)		All Control		All ICU		Survivor Control		Survivor ICU		Deceased Controls		Deceased ICU
	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)
	0		0		0		0		0		0	
Preadmission												
1 month	71	5.90 (14.6)	70	13.6 (22.3)	64	6.54 (15.25)	59	13.59 (22.34)	7	0	11	13.54 (23.03)
3 months	65	2.52 (8.27)	68	10.2 (15.1)	62	2.64 (8.45)	59	9.81 (14.12)	3	0	9	12.66 (21.20)
6 months	64	3.33 (11.5)	64	9.50 (23.6)	62	3.24 (11.66)	59	10.22 (24.44)	2	6.00 (8.48)	5	1.00 (1.41)
12 months	63	1.40 (6.32)	60	5.28 (12.0)	62	1.41 (6.36)	58	4.65 (10.85)	1	0	2	23.50 (33.23)
24 months	60	0.95 (3.67)	60	1.05 (2.16)	60	0.95 (3.67)	59	1.06 (2.17)	0		0	

Score range: 0-88 Decrease in score denotes less likelihood of post-traumatic related stress

Appendix 1.7. Hospital Anxiety and Depression Scale Task (Recovery over Time)

HADS (TOTAL)		All Control		All ICU		Survivor Control		Survivor ICU		Deceased Controls		Deceased ICU
	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)
Preadmission	0		0		0		0		0		0	
1 month	72	12.75 (10.83)	70	13.72 (9.64)	64	12.57 (10.44)	59	13.06 (9.41)	8	14.12 (14.38)	11	17.27 (10.52)
3 months	65	11.55 (12.23)	68	12.19 (11.15)	62	11.75 (12.37	59	11.42 (10.63)	3	7.33 (9.45)	9	17.22 (13.75)
6 months	64	12.57 (12.14)	64	13.43 (11.22)	62	12.33 (11.72)	59	12.16 (10.45)	2	20.00 (28.28)	5	28.40 (9.78)
12 months	63	12.09 (11.56)	61	9.49 (8.90)	62	11.70 (11.24)	59	9.18 (8.85)	1	36.00	2	18.50 (6.36)
24 months	60	10.46 (9.41)	59	9.01 (9.19)	60	10.46 (9.41)	59	9.01 (9.19)	0		0	

Decrease in score denotes less anxiety and depression. Score range 0 – 42

**Appendix 1.8.** Hospital Anxiety and Depression Scale – Anxiety Subscale (Recovery over Time)

Test HADS ANXIETY		Control Alive		ICU Alive		Control Deceased		ICU Deceased
	N	Mean	N	Mean	N	Mean	N	Mean
		(SD)		(SD)		(SD)		(SD)
Preadmission	0		0		0		0	
1 month	72	7.00	70	7.44	64	6.93	59	7.10
		(5.98)		(5.63)		(5.83)		(5.55)
3 months	65	6.91	68	6.93	62	6.98	59	6.54
		(7.00)		(6.03)		(7.07)		(5.89)
6 months	64	7.22	64	7.98	62	7.12	59	7.49
		(6.86)		(6.52)		(6.71)		(6.46)
12 months	63	7.13	61	5.66	62	6.93	59	5.54
		(6.46)		(5.66)		(6.33)		(5.72)
24 months	60	5.87	60	5.00	60	5.86	59	4.88
		(5.08)		(5.20)		(5.07)		(5.15)

Decrease in score denotes less anxiety. 8-10: mild; 11-14: mod; 15-21: severe

**Appendix 1.9.** Hospital Anxiety and Depression Scale – Depression Subscale (Recovery over Time)

HADS DEPRESSION

I	DEPRESSION								
Test	t		Control		ICU		Control		ICU
			Alive		Alive		Deceased		Deceased
		N	Mean	N	Mean	N	Mean	N	Mean
			(SD)		(SD)		(SD)		(SD)
	Preadmission	0		0		0		0	
	1 month	72	5.75	70	6.29	64	5.64	59	5.96
			(5.34)		(4.93)		(5.13)		(4.82)
	3 months	65	4.65	68	5.26	62	4.77	59	4.88
			(6.04)		(5.51)		(6.12)		(5.14)
	6 months	64	5.36	64	5.45	62	5.20	59	4.67
			(5.97)		(5.49)		(5.73)		(4.71)
	12 months	63	4.97	61	3.84	62	4.77	59	3.6
			(5.61)		(4.05)		(5.43)		(3.92)
	24 months	60	4.60	60	4.33	60	4.6	59	4.13
			(5.07)		(5.56)		(5.06)		(5.38)
							·····		

Decrease in score denotes less depression. 8-10: mild; 11-14: mod; 15-21: severe

**Appendix 1.10.** Community Integration Questionnaire (Recovery over Time)

CIQ (TOTAL)		All Control		AII ICU		Survivor Control		Survivor ICU		Deceas ed Control		Deceased ICU
	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)
Preadmission	70	35.7 (16.07)	71	16.8 (4.63)	63	39 (17.6)	59	17 (4.4)	7	6.96 (6.91)	12	15.85 (5.50)
1 month	72	12.6 (6.72)	71	8.0 (6.25)	64	13.5 (6.4)	59	8 (6.2)	8	5.84 (5.14)	12	5.54 (5.89)
3 months	65	15.9 (6.35)	68	13.3 (6.06)	62	16 (6.2)	59	14 (5.7)	3	11.75 (8.51)	9	9.00 (6.79)
6 months	64	16.08 (6.55)	65	15.0 (5.77)	62	16 (6.2)	59	15 (5.4)	2	11.75 (16.61)	6	10.12 (6.68)
12 months	63	16.8 (6.59)	61	15.97 (6.43)	62	17 (6.3)	59	15 (6.5)	1	1	2	15.62 (0.88)
24 months	60	16.6 (6.47)	59	15.2 (6.87)	60	16 (6.4)	59	15 (6.8)	0		0	

Score range: 0-29; greater the score, greater the integration

**Appendix 1.11.** SF-36v2 Physical Component Score (Recovery over Time)

SF-36v2 PCS		All Control		All ICU		Survivor Control		Survivor ICU		Deceased Control		Deceased ICU
	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)
Preadmission	59	40.28 (13.27)	59	45.93 (13.47)	59	40.28 (13.26)	59	45.93 (13.47)	8	25.11 (9.39)	11	44.34 (14.04)
1 month	67	33.3 (12.0)	70	27.3 (10.0)	59	40.2 (13.2)	59	45.9 (13.47)	8	30.94 (14.42)	11	27.00 (10.69)
3 months	59	37.9 (13.2)	68	36.5 (13.0)	59	33.5 (11.7)	59	27.4 (9.95)	3	29.36 (15.18)	9	29.07 (12.30)
6 months	58	38.1 (14.8)	64	37.5 (14.5)	56	38.3 (13.05	59	27.6 (12.86)	2	37.65 (15.34)	5	23.46 (8.93)
12 months	57	36.8 (13.6)	61	38.6 (13.0)	56	38.1 (14.91)	59	38.6 (14.29)	1	18.60	2	26.75 (8.41)
24 months	53	35.5 (15.0)	60	37.6 (14.7)	53	35.4 (14.99)	59	37.8 (14.63)	0		0	

Score range: Clinically meaningful: mean < 50; > 10 point decrements in each domain. Higher score denotes improvement.

Appendix 1.12. SF-36v2 Mental Component Score (Recovery over Time)

SF-36v2 MCS		All Control		AII ICU		Survivor Control		Survivor ICU		Deceas ed Control		Deceased ICU
	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)
Preadmission	59	49.66 (13.22)	59	54.27 (10.42)	59	49.66 (13.22)	59	54.27 (10.42)	8	45.72 (19.29)	11	51.50 (14.14)
1 month	67	44.8 (14.5)	70	44.3 (14.7)	59	45 (14.1)	59	44 (14.9)	8	37.24 (16.11)	11	51.50 (14.14)
3 months	59	49.2 (15.2)	68	47.2 (16.1)	56	48 (15.3)	59	48 (15.7)	3	56.00 (11.11)	9	41.01 (13.75)
6 months	58	47.5 (15.3)	64	49.0 (14.0)	56	47 (15.0)	59	50 (13.4)	2	43.00 (29.55)	5	33.34 (11.40)
12 months	57	49.5 (12.8)	61	50.6 (13.6)	56	50 (12.2)	59	51 (13.0)	1	18.80	2	27.30 (6.22)
24 months	53	50.4 (11.1)	60	50.5 (14.1)	53	50 (11.1)	59	50 (13.9)	0		0	

Score range: Clinically meaningful: mean < 50; > 10 point decrements in each domain Impairment is considered <=45. Higher score denotes improvement.

Appendix 1.13. SF-36v2-BP (Bodily Pain) Test Scores (Recovery over Time)

SF-36v2 BP	Clin	Clinically meaningful: mean < 50; > 5 point decrements in each domain						
	N	All Control Mean (SD)	N	All ICU Mean (SD)	N	Survivor Controls Mean (SD)	N	Survivor ICU Mean (SD)
Preadmission	67	44.0 (14.7)	70	61.1 (69.1)	59	45 (14.5)	59	53 (12.2)
1 month	67	41.8 (14.2)	70	39.6 (13.0)	59	41 (13.9)	59	38 (12.6)
3 months	59	43.8 (14.2)	68	46.1 (13.4)	56	44 (14.2)	59	47 (12.5)
6 months	58	44.1 (15.8)	64	45.2 (14.6)	56	43 (15.8)	59	45 (14.4)
12 months	57	44.1 (13.8)	61	46.0 (11.1)	56	44 (13.5)	59	46 (11.1)
24 months	53	42.2 (13.3)	60	44.2 (12.2)	53	42 (13.2)	59	44 (12.1)

**Appendix 1.14.** SF-36v2-GH (General Health) Test Score (Recovery over Time)

SF-36v2 GH	Clin	Clinically meaningful: mean < 50; > 10 point decrements in each domain						
	N	All Control Mean (SD)	N	All ICU Mean (SD)	N	Survivor Control Mean (SD)	N	Survivor ICU Mean (SD)
Preadmission	67	44.2 (14.3)	70	50.3 (12.2)	59	45 (13.4)	59	50 (11.2)
1 month	67	42.5 (12.5)	70	43.0 (11.2)	59	43 (11.7)	59	44 (11.1)
3 months	59	44.9 (13.0)	68	43.6 (12.4)	56	45 (12.8)	59	45 (11.8)
6 months	58	43.6 (14.3)	64	44.7 (12.4)	56	43 (14)	59	46 (11.5)
12 months	57	42.8 (14.2)	61	44.7 (12.9)	56	43 (13.8)	59	45 (12.6)
24 months	53	41.5 (13.2)	60	43.7 (13.1)	53	41 (13.1)	59	44 (12.7)

Appendix 1.15. SF-36v2-MH (Mental Health) Test Scores (Recovery over Time)

SF-36v2 MH	2 MH Clinically meaningful: mean < 50; > 10 point decrements in each domain							
	N	All Control Mean (SD)	N	All ICU Mean (SD)	N	Survivor Control Mean (SD)	N	Survivor ICU Mean (SD)
Preadmission	67	46.9 (14.2)	70	51.3 (12.1)	59	47 (13.7)	59	51 (11.8)
1 month	67	44.4 (14.0)	70	45.0 (13.8)	59	45 (13.4)	59	45 (13.9)
3 months	59	46.9 (15.0)	68	46.2 (15.0)	56	46 (15.1)	59	47 (14.2)
6 months	58	46.7 (14.3)	64	47.4 (14.1)	56	46 (14.1)	59	48 (13.8)
12 months	57	48.1 (13.4)	61	49.2 (12.9)	56	48 (13.1)	59	49 (12.5)
24 months	53	48.6 (12.7)	60	49.6 (13.1)	53	48 (12.7)	59	49 (13.0)

**Appendix 1.16**. SF-36v2-PF (Physical Functioning) Test Scores (Recovery over Time)

SF-36v2 PF	Clini	Clinically meaningful: mean < 50; > 10 point decrements in each domain								
	N	All Control Mean (SD)	N	All ICU Mean (SD)	N	Survivor Control Mean (SD)	N	Survivor ICU Mean (SD)		
Preadmission	67	36.0 (15.7)	70	42.7 (14.2)	59	37 (15.1)	59	43 (13.5)		
1 month	67	29.8 (13.6)	70	24.0 (10.8)	59	30 (13.3)	59	24 (11.0)		
3 months	59	35.7 (15.4)	68	33.6 (14.2)	56	36 (15.5)	59	35 (13.6)		
6 months	58	35.8 (16.1)	64	35.1 (15.2)	56	36 (16.1)	59	36 (15.1)		
12 months	57	35.0 (16.0)	61	36.4 (14.0)	56	35 (15.8)	59	36 (14.0)		
24 months	53	34.6 (16.3)	60	35.5 (15.7)	53	34 (16.3)	59	35 (15.7)		

**Appendix 1.17.** SF-36v2-RE (Role Emotional) Test Scores (Recovery over Time)

SF-36v2 RE	Clinically meaningful: mean < 50; > 10 point decrements in each domain							
	N	All Control Mean (SD)	N	All ICU Mean (SD)	N	Survivors Control Mean (SD)	N	Survivor ICU Mean (SD)
Preadmission	67	47.4 (13.5)	70	51.7 (8.8)	59	48 (12.5)	59	52 (7.9)
1 month	67	41.7 (15.0)	70	37.5 (16.4)	59	42 (14.9)	59	38 (16.2)
3 months	59	46.3 (13.2)	68	43.6 (15.3)	56	46 (13.4)	59	45 (13.8)
6 months	58	44.9 (15.3)	64	46.5 (12.7)	56	45 (14.7)	59	47 (12.2)
12 months	57	47.2 (13.3)	61	47.1 (12.1)	56	47 (12.3)	59	47 (12.0)
24 months	53	48.3 (10.7)	60	46.8 (13.1)	53	48 (10.7)	59	47 (13.0)

**Appendix 1.18.** SF-36v2-RP (Role Physical) Test Scores (Recovery over Time)

SF-36v2 RP	Clinic	Clinically meaningful: mean < 50; > 10 point decrements in each domain							
	N	All Control Mean (SD)	N	All ICU Mean (SD)	N	Survivor Control Mean (SD)	N	Survivor ICU Mean (SD)	
Preadmission	67	41.4(15.3)	70	45.3 (14.3)	59	43 (14.4)	59	45 (14.4)	
1 month	67	38.7 (12.6)	70	37.2 (11.3)	59	32 (14.8)	59	22 (7.5)	
3 months	59	43.7 (15.0)	68	43.9 (13.9)	56	38 (14.1)	59	34 (12.9)	
6 months	58	43.7 (15.3)	64	43.7 (13.7)	56	38 (14.7)	59	38 (14.7)	
12 months	57	41.1 (15.3)	61	45.5 (13.1)	56	39 (12.9)	59	39 (14.3)	
24 months	53	41.0 (13.3)	60	42.5 (15.0)	53	39 (13.0)	59	40 (14.0)	

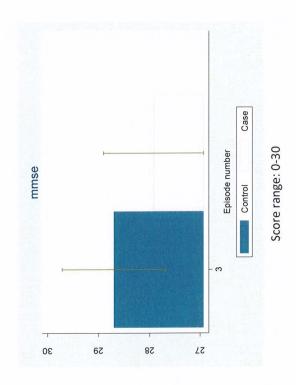
Appendix 1.19. SF-36v2-SF (Social Functioning) Test Scores (Recovery over Time)

SF-36v2 SF	Clinically meaningful: mean < 50; > 10 point decrements in each domain							
	N	All Control Mean (SD)	N	All ICU Mean (SD)	N	Survivor Control Mean (SD)	N	Survivor ICU Mean (SD)
Preadmission	67	42.9 (16.7)	70	50.7 (12.1)	59	44 (15.9)	59	51 (11.2)
1 month	67	34.2 (17.0)	70	29.8 (16.3)	59	35 (17.0)	59	29 (16.4)
3 months	59	43.9 (15.6)	68	39.3 (17.0)	56	43 (15.8)	59	40 (16.7)
6 months	58	40.7 (17. 57	64	41.5 (16.4)	56	40 (17.8)	59	43 (15.1)
12 months	57	43.1 (14.7)	61	44.0 (14.7)	56	43 (14.3)	59	44 (13.7)
24 months	53	43.0 (13.7)	60	45.2 (15.8)	53	43 (13.6)	59	45 (15.5)

Appendix 1.20. SF-36v2-VT (Vitality Component) Test Scores (Recovery over Time)

SF-36v2 VT	Clinica	Clinically meaningful: mean < 50; > 10 point decrements in each domain								
	N	All Control Mean (SD)	N	All ICU Mean (SD)	N	Survivor Control Mean (SD)	N	Survivor ICU Mean (SD)		
Preadmission	67	44.5 (14.9)	70	51.5 (12.6)	59	45 (14.8)	59	52 (11.7)		
1 month	67	38.7 (12.6)	70	37.2 (11.3)	59	39 (12.4)	59	38 (11.5)		
3 months	59	43.7 (15.0)	68	43.9 (13.9)	56	43 (14.9)	59	45 (13.4)		
6 months	58	43.7 (15.3)	64	43.7 (13.7)	56	43 (15.0)	59	45 (13.0)		
12 months	57	41.1 (15.3)	61	45.5 (13.1)	56	41 (15.1)	59	46 (12.6)		
24 months	53	41.0 (13.3)	60	42.5 (15.0)	53	41 (13.2)	59	42 (14.8)		

Appendix 1.21. Mini-Mental State Examination Test Scores (ICU cases and controls)



Appendix 1.22 Trailmaking B Task z scores

		ICU		Control
Months	N	(Mean;SD)	N	(Mean;SD)
1	53	-2.28	65	-1.84 (2.14)
		(2.76)		
3	54	-1.65	53	-1.08 (2.05)
		(2.14)		
6	51	-1.47	52	-1.46 (2.32)
		(2.47)		
12	47	-1.98	52	-1.16 (1.65)
		(3.70)		
24	47	-2.04	52	-1.23 (2.67)
		(2.49)		

Appendix 1.23. Stroop z scores								
-		ICU	Control					
Months	N	(Mean;SD)	N	(Mean;SD)				
1	54	-5.05 (3.52)	63	-4.04 (3.14)				
3	52	-4.09 (3.48)	54	-3.93 (3.41)				
6	49	-3.20 (2.32)	52	-3.92 (3.98)				
12	48	-2.98 (2.65)	53	-3.81 (3.99)				
24	47	-3.02 (2.37)	52	-3.68 (3.56)				

**Appendix 1.24.** Impact of Event Scale – Revised (Component: Avoidance) Test Scores

Impact of Events (Avoidance)	N	Control Mean (SD)	N	ICU Mean (SD)
Preadmission	0		0	
1 month	71	1.92 (5.14)	70	4.68 (7.23)
3 months	65	0.98 (2.86)	68	3.99 (6.09)
6 months	64	1.05 (3.71)	64	4.09 (8.09)
12 months	63	0.44 (2.15)	60	1.87 (4.20)
24 months	60	0.40 (2.10)	60	0.65 (1.51)

Score range 0-32; Decrease in score denotes less likelihood of post-traumatic related stress

**Appendix 1.25.** Impact of Events Scale – Revised (Component Hyperarousal) Test Scores

Impact of		Control		ICU
Events				
Hyperarousal				
	Ν	Mean	Ν	Mean
		(SD)		(SD)
Preadmission	0		0	
1 month	7	1.34	7	3.02
	1	(3.71)	0	(6.00)
3 months	6	0.62	6	2.29
	5	(2.37)	8	(4.09)
6 months	6	0.89	6	2.09
	4	(3.37)	4	(8.29)
12 months	6	0.35	6	1.07
	3	(2.14)	0	(4.02)
24 months	6	0.07	6	0.02
	0	(2.52)	0	(0.13)

Score range 0-20; Decrease in score denotes less likelihood of post-traumatic related stress

**Appendix 1.26.** Impact of Events Scale-Revised (Component: Interruptions) Test Scores

Impact of	N	Control	N	ICU
Events		Mean		Mean (SD)
Interruptions		(SD)		
Preadmission	0		0	
1 month	71	2.65	70	5.88
		(6.09)		(12.86)
3 months	65	0.92	68	3.90
		(3.31)		(6.06)
6 months	64	1.39	64	3.32
		(4.68)		(8.10)
12 months	63	0.60	60	2.35
	_	(2.62)		(4.70)
24 months	60	0.48	60	0.38
		(1.65		(0.99)

Score range 0-32; Decrease in score denotes less likelihood of post-traumatic related stress

# Appendix 2.0 Subgroup Test Scores

Appendix 2.1. Digit Span Task Score for subgroups

Test		Control		ICU
DIGIT SPAN ADJUSTED	N	Mean (SD)	N	Mean (SD)
SEPSIS				
1 month	14	9.86 (1.88)	25	8.64 (2.55)
3 months	13	10.61 (3.45)	25	8.48 (4.11)
6 months	14	10.07 (3.63)	25	8.80 (3.23)
12 months	14	10.21 (4.19)	22	8.40 (3.09)
24 months	13	11.38 (4.52)	22	8.63 (2.98)
TRAUMA				
I month	4	9.00 (3.74)	5	12.20 (3.11)
3 months	5	9.40 (3.36)	5	11.40 (5.94)
6 months	5	9.00 (3.67)	5	10.80 (4.44)
12 months	5	8.00 (2.65)	4	12.5 (3.11)
24 months	5	8.80 (2.77)	3	14.00 (2.00)
NEOPLASIA				
l month	7	10.29 (3.64)	4	8.75 (0.50)
3 months	6	13.33 (4.59)	4	8.25 (0.50)
6 months	6	13.83 (3.60)	4	8.75 (2.06)
12 months	6	13.33 (5.00)	4	9.00 (1.82)
24 months	6	12.33 (3.50)	4	8.25 (2.87)
OTHER				
I month	44	9.59 (2.89)	32	8.56 (3.56)
3 months	37	10.64 (3.22)	31	9.97 (2.90)
6 months	35	10.03 (3.20)	28	10.36 (2.59)
12 months	35	10.00 (3.14)	26	10.34 (2.81)
24 months	35	9.88 (3.11)	28	9.75 (3.09)

Increase in score denotes improved verbal memory. Below normal: 7-8 Clinical Impairment: ≤4

**Appendix 2.2.** Letter Number Sequence Test Scores for subgroups

Test		Control		ICU
LN SCORE ADJ	N	Mean (SD)	Ν	Mean (SD)
SEPSIS				
l month	14	8.5 (3.23)	24	6.08 (3.29)
3 months	13	8.07 (3.42)	24	6.29 (3.62)
6 months	14	7.93 (3.89)	24	6.45 (3.20)
12 months	13	9.00 (4.45)	23	7.04 (3.23)
24 months	13	8.53 (3.67)	21	7.71 (3.79)
TRAUMA				
I month	5	7.40 (2.79)	5	10.00 (3.08)
3 months	5	7.20 (2.68)	5	8.40 (5.27)
6 months	5	7.60 (2.05)	5	8.80 (5.63)
12 months	5	7.80 (3.63)	4	10.75 (2.06)
24 months	5	7.40 (2.30)	3	13.00 (1.00)
NEOPLASIA				
I month	7	9.86 (4.67)	4	6.00 (2.16)
3 months	6	11.17 (4.54)	4	5.25 (2.75)
6 months	6	11.67 (4.41)	4	5.50 (2.08)
12 months	6	9.83 (3.76)	4	5.25 (0.96)
24 months	6	10.33 (4.63)	3	5.00 (2.00)
OTHER				
I month	39	7.64 (3.29)	32	6.91 (2.65)
3 months	31	7.87 (3.35)	32	7.72 (2.96)
6 months	29	8.24 (3.68)	28	8.00 (2.85)
12 months	29	8.45 (3.36)	26	8.88 (3.10)
24 months	29	7.83 (3.49)	27	8.15 (3.49)

Increase in score denotes improved verbal working memory. Below normal: 7-8 Clinical Impairment:  $\leq 4$ 

**Appendix 2.3.** Stroop Task Test Scores for subgroups

Test		Control		ICU
STROOP 3	N	Mean (SD)	N	Mean (SD)
SEPSIS				
I month	14	154.43 (59.69)	22	215.55 (90.10)
3 months	13	162.62 (72.52)	21	199.48 (82.72)
6 months	14	167.07 (88.64)	21	176.24 (58.85)
12 months	14	159.64 (89.31)	21	177.57 (56.16)
24 months	13	144.69 (65.91)	19	182.95 (60.45)
TRAUMA				
I month	5	173.20 (55.18)	2	121.00 (12.73)
3 months	5	157.00 (53.30)	2	134.5 (24.75)
6 months	5	171.00 (85.14)	2	113.50 (12.02)
12 months	5	166.00 (93.56)	1	98.00
24 months	5	154.6 (40.76)	1	101.00
NEOPLASIA				
I month	7	187.57 (111.65)	4	231.75 (36.61)
3 months	6	140.17 (68.51)	4	244.50 (67.34)
6 months	6	142.50 (50.82)	4	203.75 (49.73)
12 months	6	152.83 (51.45)	4	217.50 (72.08)
24 months	6	171.33 (112.07)	4	166.75 (37.50)
OTHER				
I month	37	186.27 (67.13)	26	197.27 (87.57)
3 months	30	180.23 (70.57)	25	171.84 (67.87)
6 months	27	179.63 (79.34)	22	163.14 (61.60)
12 months	28	174.96 (80.05)	22	146.59 (54.48)
24 months	28	181.61 (79.38)	22	150.63 (43.38)

A decrease in score denotes improvement

Appendix 2.4. Trailmaking B Task - Test Scores for subgroups (seconds)

Test		Control		ICU
TRAILMAKING B	N	Mean (SD)	Ν	Mean (SD)
SEPSIS				
I month	14	153.50 (78.52)	22	239.73 (166.06)
3 months	11	119.91 (91.99)	22	175.73 (127.76)
6 months	14	132.79 (83.89)	23	178.96 (123.41)
12 months	14	121.64 (64.83)	21	181.67 (110.46)
24 months	13	122.08 (104.78)	19	206.37 (113.29)
TRAUMA				
I month	5	119.60 (62.00)	2	93.00 (33.94)
3 months	5	102.40 (85.46)	2	95.00 (49.49)
6 months	5	124.00 (89.22)	2	185.00 (190.91)
12 months	5	105.80 (52.32)	1	54.00
24 months	5	117.20 (56.37)	1	72.00
NEOPLASIA				
I month	7	133.43 (93.91)	4	161.50 (32.09)
3 months	6	106.83 (75.31)	4	156.75 (58.86)
6 months	6	133.50 (125.19)	4	155.00 (95.68)
12 months	6	96.00 (64.77)	4	157.75 (52.18)
24 months	6	135.00 (161.59)	4	136.50 (50.31)
OTHER				
I month	39	176.67 (110.47)	25	163.00 (95.56)
3 months	31	141.87 (86.68)	26	139.96 (66.37)
6 months	28	140.64 (77.03)	22	124.05 (66.09)
12 months	27	144.00 (77.64)	22	119.55 (51.89)
24 months	28	143.82 (119.81)	22	149.86 (73.41)

A decrease in score denotes improvement

Appendix 2.5. SF-36v2 Mental Component Score Test Scores for subgroup

Test		Control		ICU
SF-36V2 - MCS	N	Mean (SD)	N	Mean (SD)
SEPSIS				
Preadmission	15	45.61 (14.50)	29	56.08 (8.18)
l month	15	39.27 (13.92)	29	41.35 (16.39)
3 months	15	43.45 (15.81)	27	16.86 (15.34)
6 months	15	43.15 (15.96)	27	49.26 (14.22)
12 months	15	45.26 (11.46)	25	45.65 (15.28)
24 months	14	45.25 (11.12)	23	48.77 (14.49)
TRAUMA				
Preadmission	5	57.34 (2.73)	5	52.02 (6.62)
I month	5	49.80 (10.04)	5	44.20 (10.90)
3 months	5	56.09 (15.83)	5	39.36 (19.44)
6 months	5	45.46 (19.50)	5	45.58 (11.39)
12 months	5	55.21 (8.60)	4	54.31 (6.10)
24 months	5	55.06 (11.38)	4	47.68 (20.89)
NEOPLASIA				
Preadmission	7	48.1 (14.87)	4	61.60 (4.88)
I month	7	42.51 (19.07)	4	49.05 (10.79)
3 months	7	51.97 (15.30)	4	53.05 (8.70)
6 months	7	54.30 (11.76)	4	53.40 (16.75)
12 months	7	53.14 (12.81)	4	53.33 (8.07)
24 months	6	56.28 (5.12)	4	56.38 (9.92)
OTHER				
Preadmission	40	49.71 (14.33)	32	51.13 (13.45)
I month	40	46.72 (14.23)	32	46.30 (14.09)
3 months	32	50.25 (14.69)	32	48.05 (17.17)
6 months	31	48.43 (15.05)	28	48.74 (14.45)
12 months	30	49.73 (13.84)	28	54.19 (12.38)
24 months	28	50.82 (11.37)	28	52.18 (13.34)

Score range: Clinically meaningful: mean < 50; > 10 point decrements in each domain Impairment is considered <=45. Higher score denotes improvement.

Appendix 2.6. SF-36v2 Physical Component Score test Scores for subgroups

Test		Control		ICU
SF-36V2 - PCS	N	Mean (SD)	N	Mean (SD)
SEPSIS				
Preadmission	15	36.33 (13.37)	29	43.12 (13.66)
1 month	15	31.08 (9.44)	29	25.95 (8.87)
3 months	15	36.12 (12.89)	27	33.38 (13.01)
6 months	15	37.90 (13.68)	27	32.96 (12.61)
12 months	15	33.55 (14.64)	25	33.35 (11.47)
24 months	14	34.16 (17.12)	23	34.19 (12.67)
TRAUMA				
Preadmission	5	52.16 (13.37)	5	53.92 (6.96)
1 month	5	23.87 (7.93)	5	26.08 (4.77)
3 months	5	42.30 (14.97)	5	34.40 (8.64)
6 months	5	35.46 (17.55)	5	45.14 (16.11)
12 months	5	43.00 (13.81)	4	51.17 (7.79)
24 months	5	38.40 (15.81)	4	51.89 (4.10)
NEOPLASIA				
Preadmission	7	36.48 (15.00)	4	45.40 (16.91)
1 month	7	34.50 (11.16)	4	18.87 (6.38)
3 months	7	41.88 (15.18)	4	30.27 (2.08)
6 months	7	47.58 (15.28)	4	32.67 (15.13)
12 months	7	38.51 (14.95)	4	31.08 (10.74)
24 months	6	41.33 (14.82	4	25.95 (2.50)
OTHER				
Preadmission	40	37.91 (13.23)	32	46.75 (13.52)
1 month	40	35.06 (12.98)	32	29.85 (11.24)
3 months	32	37.19 (12.94)	32	40.24 (13.65)
6 months	31	36.46 (14.68)	28	41.10 (15.00)
12 months	30	36.90 (12.92)	28	42.46 (12.83)
24 months	28	34.36 (14.23)	28	40.56 (16.04)

Score range: Clinically meaningful: mean < 50; > 10 point decrements in each domain Impairment is considered <=45. Higher score denotes improvement.

Appendix 2.7. Impact of Events-Revised Test Scores for subgroups

Test		Control		ICU
IES TOTAL	N	Mean (SD)	N	Mean (SD)
SEPSIS				
1 month	15	12.33 (23.60)	29	14.83 (24.45)
3 months	15	6.47 (15.40)	27	
				8.66 (12.95)
6 months	15	11.13 (21.94)	27	C 02 (45 55)
1.2 magneths	15	2.00 (0.51)	25	6.03 (15.55)
12 months 24 months	15 14	2.80 (9.51)	25	6.64 (15.45)
	14	1.85 (6.13)	23	1.73 (2.87)
TRAUMA	-	4.20 (5.76)	F	10 40 /10 21)
1 month	5	4.20 (5.76)	5	10.40 (16.31)
3 months	5	5.20 (7.15)	5	11.20 (10.03)
6 months	5	3.40 (7.60)	5	6.66 (70.43)
12 months	5	6.60 (14.76)	4	1.25 (1.89)
24 months	5	4.20 (6.57)	4	1.25 (1.89)
NEOPLASIA				
1 month	7	15.28 (23.02)	4	16.00 (17.76)
3 months	7	1.86 (3.48)	4	9.50 (6.80)
6 months	7	0	4	2.75 (3.09)
12 months	7	0.28 (0.75)	4	1.75 (3.50)
24 months	6	0	4	0
OTHER				
1 month	44	2.41 (6.85)	32	12.65 (22.26)
3 months	38	0.74 (3.22)	32	11.40 (18.14)
6 months	37	0.78 (2.26)	28	8.96 (13.17)
12 months	36	0.31 (1.83)	27	5.14 (9.92)
24 months	35	0.29 (1.20)	28	0.64 (1.49)

Score range: 0-88 Decrease in score denotes less likelihood of post-traumatic related stress

Appendix 2.8. Hospital Anxiety and Depression Test Scores for subgroup

Test		Control		ICU
HADS TOTAL	N	Mean (SD)	N	Mean (SD)
SEPSIS				
1 month	15	12.60 (9.96)	29	
				16.62 (10.50)
3 months	15	15.40 (12.32)	27	
				12.11 (10.45)
6 months	15	14.13 (12.65)	27	
				14.96 (11.70)
12 months	15	15.80 (9.89)	25	12.80 (9.15)
24 months	14	12.43 (10.40)	23	10.83 (11.09)
TRAUMA				
1 month	5	11.80 (13.49)	5	9.4 (5.98)
3 months	5	8.60 (12.45)	5	19.00 (14.44)
6 months	5	15.80 (12.47)	5	13.80 (15.93)
12 months	5	13.40 (16.83)	4	4.25 (2.50)
24 months	5	8.20 (9.78)	4	4.00 (8.00)
NEOPLASIA				
1 month	7	14.71 (13.79)	4	17.5 (5.06)
3 months	7	7.71 (11.52)	4	13.50 (8.34)
6 months	7	6.14 (9.70)	4	13.00 (10.42)
12 months	7	10.42 (16.27)	4	10.50 (9.88)
24 months	6	5.33 (9.75)	4	9.75 (7.93)
OTHER				
1 month	45	12.60 (10.71)	32	11.31 (9.02)
3 months	38	11.13 (11.84)	32	11.03 (11.59)
6 months	37	12.72 (12.34)	28	11.96 (10.38)
12 months	36	10.69 (10.55)	28	7.14 (8.37)
24 months	35	10.88 (8.95)	28	8.14 (7.72)

Decrease in score denotes less anxiety and depression. Score range 0 – 42

Appendix 2.9. Community Integration Questionnaire Test Scores for subgroup

Test		Control		ICU
CIQ TOTAL	N	Mean (SD)	Ν	Mean (SD)
SEPSIS				
Preadmission	15	106.67 (349.83)	29	
				16.89 (4.28)
1 month	15	13.71 (6.12)	29	C 72 (F F 4)
	4-	=0 (0 . 0)		6.73 (5.54)
3 months	15	14.73 (6.13)	27	12.15 /5 (5)
6 months	15	1F F2 /F 70\	25	13.15 (5.65)
6 months	15	15.53 (5.79)	25	13.54 (4.96)
12 months	15	17.13 (6.19)	25	13.29 (5.78)
24 months	14	15.55 (6.37)	23	12.93 (6.31)
TRAUMA	14	13.33 (0.37)	23	12.93 (0.31)
Preadmission	5	22.65 (3.89)	5	18.75 (4.44)
1 month	5	11.20 (7.69)	5	4.80 (3.74)
3 months	5	18.20 (9.93)	5	10.75 (6.35)
6 months	5	16.40 (9.23)	5	13.95 (5.15)
12 months	5	18.50 (7.72)	4	22.13 (7394)
24 months	5	22.25 (6.49)	4	16.50 (11.13)
NEOPLASIA		, ,		, ,
Preadmission	6	14.25 (5.50)	5	14.8 (7.09)
1 month	7	12.67 (7.10)	5	11.60 (9.14)
3 months	7	14.96 (6.55)	4	13.76 (6.33)
6 months	7	16.21 (7.35)	4	14.36 (4.31)
12 months	7	14.42 (7.32)	4	10.38 (2.80)
24 months	6	15.16 (7.05)	4	14.44 (2.98)
OTHER				
Preadmission	44	16.06 (7.93)	32	16.83 (4.65)
1 month	45	12.48 (6.94)	32	9.20 (6.43)
3 months	38	16.25 (6.03)	32	13.99 (6.48)
6 months	37	16.24 (6.59)	29	16.82 (6.47)
12 months	36	16.94 (6.63)	28	18.28 (5.66)
24 months	35	16.58 (6.27)	28	17.12 (6.76)

Score range: 0-29; greater the score, greater the integration

Appendix 2.10. Functional Independence Measure test Scores for subgroups

Test		Control		ICU
FIM	N	Mean (SD)	N	Mean (SD)
SEPSIS				
Preadmission	15	121.20 (7.06)	29	
				119.97 (19.79)
1 month	15	119.53 (8.33)	29	
				104.27 (20.58)
3 months	15	123.00 (3.42)	27	
				116.14 (11.19)
6 months	15	121.93 (4.92)	27	
				118.89 (8.59)
12 months	15	123.80 (3.80)	25	119.24 (8.50)
24 months	14	121.64 (5.94)	23	116.00 (14.48)
TRAUMA				
Preadmission	5	126.00 (0)	5	124.40 (3.57)
1 month	5	112.00 (19.81)	5	99.20 (23.32)
3 months	5	120.40 (11.97)	5	116.20 (6.79)
6 months	5	120.20 (10.87)	5	121.40 (10.29)
12 months	5	120.80 (11.62)	4	126.00 (0)
24 months	5	122.40 (7.50)	4	126.00 (0)
NEOPLASIA				
Preadmission	7	122.42 (6.45)	5	120.40 (8.17)
1 month	7	121.14 (11.55)	5	98.40 (32.47)
3 months	7	116.86 (22.89)	4	118.50 (3.00)
6 months	7	116.43 (24.88)	4	119.25 (6.80)
12 months	7	118.57 (18.79)	4	117.75 (1.89)
24 months	6	122.67 (7.69)	4	118.75 (2.22)
OTHER				
Preadmission	45	118.51 (17.21)	32	122.63 (9376)
1 month	45	117.44 (17.01)	32	113.88 (11.62)
3 months	38	121.86 (6.13)	32	119.59 (15.27)
6 months	37	121.18 (5.97)	29	119.17 (20.62)
12 months	36	121.55 (6.64)	28	124.25 (3.29)
24 months	35	120.00 (8.37)	28	121.25 (9.47)

Score range 0-126. Increase in score denotes improved functional independence. Clinical impairment <108

**Appendix 2.11.** Statistical significance of diagnostic subgroups

Diagnostic										
subgroup				p valu	е					
	LNS	DS	STROOP 3	MCS	HADS TOT	CIQ TOT	PCS	FIM	N control	N case
SEPSIS	0.000	0.000	0.004	0.004	0.291	0.048	0.342	0.025	15	29
TRAUMA	0.014	0.000	0.000	0.033	0.331	0.126	0.231	0.368	5	5
NEOPLASIA	1.070	0.001	0.006	0.144	0.000	0.065	0.077	0.493	7	5
OTHER	0.420	0.276	0.090	0.278	0.081	0.402	0.025	0.149	45	32

# Appendix 3.0. Level of Impairment

Appendix 3.1. Social Impairment (Freq; %)

red Impaired 2 1) (2.86)	d Dead i	Not mpaired	Impaired	
2	d Dead i	mpaired	Impaired	
2		•	Impaired	
_	0 6			Dead
1) (2.86)		52		0
	(0.00)	93.94)	4 (6.06)	(0.00)
27	0	60	7	0
7) (38.03)	(0.00)	(89.55)	(10.45)	(0.00)
7	3	56	3	3
2) (9.86)	(4.23)	(90.32)	(4.84)	(4.84)
7	6	54	4	6
9) (9.86)	(8.45)	(84.38)	(6.25)	(9.38)
4	10	52	5	7
8) (5.63)	(14.08)	(81.25)	(7.81)	(10.94)
	13	53	0	10
3) 7 (9.86)	(18.31)	(84.13)	(0.00)	(15.87)
	, , ,	13	13 53	13 53 0

Appendix 3.2. Mobility Impairment (Freq; %)

	ICU				Controls	
from						
discharge	Not			Not		
(months)	impaired	Impaired	Dead	impaired	Impaired	Dead
	68	3	0	60	7	0
Preadmission	(95.77)	(4.23)	(0.00)	(89.55)	(10.45)	(0.00)
	59	12	0	55	12	0
1	(83.10)	(16.90)	(0.00)	(82.09)	(17.91)	(0.00)
	60	8	3	52	7	3
3	(84.51)	(11.27)	(4.23)	(83.87)	(11.29)	(4.84)
	57	7	6	52	6	6
6	(81.43)	(10.00)	(8.57)	(81.25)	(9.38)	(9.38)
	57	3	10	51	6	7
12	(81.43)	(4.29)	(14.29)	(79.69)	(9.38)	(10.94)
	53	5	13	51	2	10
24	(74.65)	(7.04)	(18.31)	(80.95)	(3.17)	(15.87)

# Appendix 4.0 Predictors of impairment

## Appendix 4.1. Premorbid indicators of 24 month impairment

# PREMORBID PREDICTORS OF IMPAIRMENT AT 24 MONTHS OUTCOME MEASURES

Predictor	LNS		DS		PCS		MCS		MOBILITY		SOCIAL	
	RRR	р	RRR	р	RRR	p	RRR	р	RRR	р	RRR	p
	(95%CI)	value										
	0.996		1.006		0.999		1.006		0.991		1.275	
FIM	(0.977 to 1.015)	0.719	(0.959 to 1.055)	0.793	(0.983 to 1.014)	0.918	(0.973 to 1.040)	0.712	(0.950 to 1.033)	0.683	(0.748 to 2.175)	0.371
	0.960		1.025		0.989		0.986		1.066		1.015	
CIQ	(0.896 to 1.030)	0.260	(0.943 to 1.114)	0.557	(0.950 to 1.029)	0.598	(0.927 to 1.047)	0.651	(0.917 to 1.239)	0.399	(0.870 to 1.184)	0.849
	0.913		0.840		1.005		0.934		0.539		0.688	
YRS EDN	(0.770 to 1.082)	0.298	(0.680 to 1.039)	0.108	(0.932 to 1.084)	0.891	(0.825 to 1.057)	0.282	(0.317 to 0.918)	0.023	(0.449 to 1.054)	0.086
	0.965		0.868		0.989		0.898		0.915		1.001	
CACI	(0.821 to 1.133)	0.666	(0.706 to 1.066)	0.179	(0.950 to 1.029)	0.589	(0.784 to 1.030)	0.127	(0.665 to 1.125)	0.585	(0.725 to 1.382)	0.991

# **Appendix 4.2.** Premorbid indicators of death at 24 months

### PREMORBID PREDICTORS OF DEATH AT 24 MONTHS

#### OUTCOME MEASURES

Predictor	LNS		DS		PCS		MCS		MOBILITY		SOCIAL	
	RRR	р	RRR	р	RRR	р	RRR	p	RRR	p	RRR	p
	(95%CI)	value										
	0.932		0.941		0.946		0.956		0.940		0.953	
FIM	(0.903 to 0.962)	0.000	(0.917 to 0.965)	0.000	(0.915 to 0.979)	0.002	(0.937 to 0.976)	0.000	(0.915 to 0.965)	0.000	(0.934 to 0.972)	0.000
	0.897		0.875		0.489		0.891		0.893		0.895	
CIQ	(0.834 to 0.964)	0.003	(0.805 to 0.952)	0.002	(0.246 to 0.973)	0.042	(0.821 to 0.966)	0.006	(0.835 to 0.956)	0.001	(0.836 to 0.958)	0.001
	0.827		0.813		0.707		0.882		0.819		0.851	
YRS EDN	(0.685 to 0.999)	0.049	(0.676 to 0.978)	0.029	(0.511 to 0.979)	0.037	(0.756 to 1.029)	0.111	(0.684 to 0.918)	0.031	(0.727 to 0.997)	0.047
	1.531		1.333		1.313		1.313		1.337		1.334	
CACI	(1.304 to 1.798)	0.000	(1.211 to 1.467)	0.000	(1.193 to 1.445)	0.000	(1.193 to 1.445)	0.000	(1.207 to 1.480)	0.000	(1.204 to 1.477)	0.000

# **Appendix 4.3.** One month indicators of death at 24 months

#### 1 MONTH PREDICTORS OF DEATH AT 24 MONTHS

#### OUTCOME MEASURES

Predictor	LNS		DS		PCS		MCS		MOBILITY	,	SOCIAL	
	RRR	р										
	(95%CI)	value										
	0.834		0.923		0.944		0.921		0.913		0.936	
FIM	(0.753 to 0.924)	0.001	(0.893 to 0.953)	0.000	(0.917 to 0.971)	0.000	(0.886 to 0.958)	0.000	(0.875 to 0.953)	0.000	(0.911 to 0.962)	0.000
	0.919		0.906		0.863		0.750		0.895		0.892	
CIQ	(0.860 to 0.983)	0.014	(0.848 to 0.968)	0.004	(0.790 to 0.942)	0.001	(0.631 to 0.891)	0.001	(0.836 to 0.958)	0.001	(0.833 to 0.954)	0.001
	2.083						2.213		1.754		1.893	
APACHE 3	(0.393 to		1.935 (0.332 to		1.700		(0.392 to		(0.303 to		(0.311 to	
R.O.D.	11.041)	0.388	11.267)	0.462	(0.377 to 7.661)	0.490	12.493)	0.368	10.149)	0.530	11.513)	0.488
	0.976		1.001		1.088		1.025		1.023		1.034	
MMSE	(0.794 to 1.200)	0.821	(0.818 to 1.225)	0.987	(0.863 to 1.176)	0.917	(0.901 to 1.166)	0.702	(0.857 to 1.222)	0.796	(0.886 to 1.207)	0.668

# **Appendix 4.4.** One month predictors of impairment at 24 months

# 1 MONTH PREDICTORS OF IMPAIRMENT AT 24 MONTHS OUTCOME MEASURES

					• •							
Predictor	LNS		DS		PCS		MCS		MOBILITY	•	SOCIAL	
	RRR	p		р	RRR	p	RRR	р	RRR	р	RRR	p
	(95%CI)	value		value	(95%CI)	value	(95%CI)	value	(95%CI)	value	(95%CI)	value
	0.990		0.997		1.003		1.000		0.977		0.968	
FIM	(0.965 to 1.015)	0.440	(0.967 to 1.027)	0.844	(0.991 to 1.015)	0.581	(0.972 to 1.029)	0.970	(0.933 to 1.022)	0.312	(0.933 to 1.005)	0.095
	0.933		0.942		1.006		1.023		1.008		0.956	
CIQ	(0.872 to 0.999)	0.048	(0.873 to 1.017)	0.128	(0.976 to 1.025)	0.961	(0.966 to 1.085)	0.423	(0.892 to 1.138)	0.897	(0.836 to 1.095)	0.523
			2.100				2.407				6.710	
APACHE 3	1.416		(0.371 to		1.188		(0.528 to		2.950		(0.801 to	
R.O.D.	(0.327 to 6.129)	0.641	11.877)	0.401	(0.597 to 2.363)	0.623	10.962)	0.256	(2.539 to 2.710)	0.013	56.163)	0.079
	0.902		0.795		0.967		1.031		0.866		0.933	
MMSE	(0.803 to 1.013)	0.083	(0.705 to 0.896)	0.000	(0.929 to 1.007)	0.108	(0.929 to 1.144)	0.557	(0.752 to 0.996)	0.045	(0.808 to 1.077)	0.346

# Appendix 5.0 Employment status

Appendix 5.1. Employment status (Controls)

			CON	rols I	EMPLOYN	IENT STA	TUS			<u> </u>	_
Episode number	N	Casual (N)	%	N/A (N)	%	Not stated (N)	%	Permanent (N)	%	Self- employed (N)	%
PREMORBID	59	5	8.47	44	74.58	0	0.00	9	15.25	1	1.69
1	59	2	3.39	52	88.14	0	0.00	4	6.78	1	1.69
3	56	5	8.93	44	78.57	0	0.00	6	10.71	1	1.79
6	56	6	10.71	42	75.00	0	0.00	7	12.50	1	1.79
12	56	6	10.71	43	76.79	0	0.00	6	10.71	1	1.79
24	54	4	7.41	41	75.93	0	0.00	6	11.11	2	3.70

**Appendix 5.2.** Employment status (ICU cases)

	CASE EMPLOYMENT STATUS										
Episode number		Casual (N)	%	N/A	%	Not stated	%	Permanent	0/	Self- employed	%
PREMORBID	N 59	Casual (N)	6.78	(N) 42	71.19	(N) 2	3.39	(N) 5	% 8.47	(N) 6	10.17
1	59	2	3.39	52	88.14	0	0	1	1.69	4	6.78
3	56	2	3.39	50	84.75	0	0	3	5.08	4	6.78
6	56	2	3.39	46	77.97	1	1.69	7	11.86	3	5.08
12	56	4	6.78	32	54.24	13	22.03	6	10.17	4	6.78
24	54	3	5.08	46	77.97	0	0.00	6	10.17	4	6.78

# Appendix 6.0. Protocol for semi-structured interviews

#### Introduction

I want to talk about your experience while you were sick and how your experience has affected your life — in any way you think is important. This includes the time before you came to hospital, your time in hospital and after you left the hospital, up until now. We are interested in finding out the things that makes your overall satisfaction with your daily life and functioning good or what makes it bad. But before we begin, I'd like to review a few things.

- 1. Please be as honest as you can and say exactly what you think. Don't worry what I think or what your family or friends think.
- 2. I would like you to talk about your experience and feelings.

### General probe questions

- 1. Do you clearly remember all of your illness experience? If not, which parts are you unclear of? How does this make you feel?
- 2. How did your ICU / hospital experience affect you in good ways or bad ways? Why?
- 3. What are the most important things (and activities) that matter to you in your day-to-day life? How did your illness affect these?
- 4. Has your recovery gone as you expected? Why or why not?

### More specific probe questions

- 1. Have you noticed any problems that interfere with your daily routine?
- 2. Do you have any worries or concerns about any particular issue now?
- 3. Do you feel your emotions have been normal since your illness? Why or why not?
- 4. Has your thinking been clear since your illness?
- 5. How does it feel now that you are home after being in hospital? Is anything different?
- 6. Have any of your relationships changed in any way? If so why?

# Appendix 7.0 Protocol for test administration

## Mini-Mental State Examination (MMSE)

The MMSE is a measure of orientation to time and place, attention and concentration, language, constructional ability and immediate and delayed recall. It is commonly used to screen for cognitive impairment.

Administration Time Point: A score of  $\geq$  24 is required to commence neuropsychometric testing. If the subject scores < 24, please administer at the next timepoint for qualification of neuropsychomnetric testing.

Materials: Response form Pen

- 1. This is administered at the beginning of the baseline assessment.
- 2. Tell the patient you are going to ask them some questions to test their memory.
- 3. The response sheet gives clear instructions, however for question 8 clearly read the three instructions before giving the patient the piece of paper. This will enable you to examine the patients' ability to remember and execute three instructions.

TRAILMAKING B

This is a test of complex visual scanning and with a motor component hence success is

strongly influenced by motor speed and agility and is referred to as a mental tracking

working memory task. Visual scanning and tracking problems revealed on this test can give

the examiner an idea of how effectively the patient responds to visual array of any

complexity, follows a sequence mentally, deals with more than one stimulus or thought at a

time, or is flexible in shifting the course of ongoing activity.

Administration Time points: 1, 3, 6, 12 & 24 months

Materials:

Response form

Stopwatch

Pens

1. Tell the patient, "I am going to ask you to alternate between numbers and letters. I

will show you on this practice sample. There is a beginning and an end (point to both)

and I want you to join the dots without taking your pen off the paper. Starting with

your pen on 1 then you go to A, then 2-B and 3-C and so on. Can you complete this

sample?"

2. If the patient has difficulties explain again and demonstrate with the sample.

Tell the patient the task will be timed so they need to work as quickly as possible but

be accurate.

4. Watch the patient carefully and if they are off track you can tell them and guide them

in the right direction. If they are finding it difficult and you have corrected them

several times do not keep correcting them. If the test is invalid because the sequence

was not correct place the appropriate code on the page.

238

# TRAILMAKING B - SCORING

1. Write the time taken to complete in **seconds** on the demonstration page.

239

Digit Span - Forwards & Backwards

Forms A, B, & C

Digit Span is commonly used for measuring span of immediate verbal recall. Digits Forward and Digits Backward involve different mental activities however both depend on a short-term retention capacity. Digits backward is a more complex working memory task requiring manipulation of the material to be recalled.

Administration Time points:

Form A - 1 month; 12 months

Form C - 3 months;

Form B – 6 months, 24 months

Materials:

Response sheet

Pen

- 1. Inform the participant that you are going to read out a string of numbers.
- 2. When you have finished each string, they are asked to repeat the numbers back to you.
- 3. They will start of easy and get more difficult.
- 4. Start with item 1
- 5. Numbers are spaced 1 second apart and said in a monotone voice, dropping your voice on the last digit to indicate the end of the string.
- 6. Do not group numbers together.

- 7. Do not repeat any trials. If the patient asks for the items to be repeated tell the patient you cannot repeat them but can they recall any at all.
- 8. Discontinue when both levels of a trial are incorrect.
- 9. Attempt digits backwards even if the participants score 0 on forwards.
- 10. When the Digits Forward is completed then inform the patient you are now going to read some numbers but this time they are required to repeat them backwards. Provide an example, "If I say 9-3-2, then you say 2-3-9".
- 11. Discontinue when both trials of an item are incorrect.

## Digit Span - SCORING

- 1. Add up all items for Digit Forwards and Digits Backwards, add together and place in appropriate space.
- 2. is the last item where both trials are correct
- 3. String is the longest correct string (only need 1 string correct in the tow trials of the item). Count the numbers recalled in the string.

## Letter-Number Sequencing

Forms A, B, & C

Adminis	tration	Time	noints:
Aummi	uation	HIIIIE	politics.

Form A - 1 month; 12 months

Form C - 3 months;

Form B – 6 months, 24 months

Materials:

Response sheet

Pen

- Tell the patient you are going to say a group of numbers and letters. "After I say them
  I want you to rearrange them with the numbers first, in order, starting with the
  lowest number. Then tell me the letters in alphabetical order."
- 2. Use an example, "If I say B-7 then your answer should be 7-B, the number first and then the letter. If I say 9-C-3 then your answer should be 3-9-C."
- 3. Use Practice examples:

6-F (6-F)

G-4 (4-G)

3-W-5 (3-5-W) T-7-L (7-L-T)

1-J-A (1-A-

J)

- 4. Correct any practice items given incorrectly.
- 5. Do not repeat any items.
- 6. Discontinue after failure on all three trials of an item.

### National Adult Reading Test (NART)

The National Adult Reading Test (NART) is a commonly used instrument in estimating premorbid intelligence. The NART is a 50 item irregular word list thought to be relatively unaffected by neurological and psychiatric disorder. The NART provides clinicians and researchers with a measure of premorbid intellectual functioning rather than current cognitive ability. Establishing premorbid intellectual functioning is an important factor in the assessment of patients as it allows a clinician to assess the degree of impairment for an individual and therefore establish a realistic expectation of recovery.

Administration Time Points: Baseline assessment

Materials: NART record sheet

NART pronunciation sheet

NART tape (correct pronunciation sample for

interviewers)

- Tell the patient, 'I would like you to read this long list of words, they are difficult
  words and most people do not recognize many of them, so just have a guess, OK? Go
  ahead.'
- Responses should be reinforced, 'That's fine, good' is encouraging without being dishonest.
- Mark with a cross next to the words pronounced incorrectly.
- A ceiling of 14 incorrect responses in 15 consecutive responses can be implemented without significantly affected the accuracy of the test.
- If the patient becomes anxious allow them to stop and continue with other neuropsychometric tests. If the patient finds the test very difficult they can stop at the bottom of the first column. The WAIS vocabulary can be administered in place of

the NART for those patients who find it too difficult. It is preferable that the WAIS Vocabulary is administered at the baseline assessment. If this is not possible due to time constraints it can be administered at the next assessment. Please make a note of this on the pack cover sheet.

## **NART - SCORING**

- Incorrect responses are added together to give a NART error score.
- The NART error score can be used to yield an estimate of premorbid functioning by referring to the

WAIS-111 conversion form in the scoring folder.

Hospital Anxiety and Depression Scale (HADS)

The Hospital Anxiety and Depression Scale is a widely used self-report instrument designed

as brief assessment of anxiety and depression in non-psychiatric populations.

Administration Time points: 1, 3, 6, 12 & 24 months

Materials:

HADS response form

Fold the scoring section over as indicated on the form.

• Tell the patient, 'I would like you to complete this questionnaire about how you have

been feeling over the past week. Read each item below and underline the reply

which comes closest to how you have been feeling. Don't take too long over your

replies, your immediate reaction to each item will probably be more accurate than a

long, thought out response.'

The patient can fill this out alone. If they have difficulty understanding or reading

problems the tester can provide assistance.

245

## **HADS - SCORING**

- Unfold the scoring section and cross out the numbers corresponding to the patients' response.
- Add together all scores in the Anxiety column on both sides of the page and place the total in the

appropriate box. Follow this procedure for the Depression Scale also.

Score	Description
0-7	Normal
8-10	Mild
11-14	Moderate
15-21	Severe

Short Form Health Survey-36v2 (SF-36v2)

The SF-36v2 is a 36-item multipurpose health survey that measures overall health, functional

status and mental status. It measures 8 domains: physical functioning (PF), role limitations

due to physical problems, bodily pain (BP), general health perceptions, energy/vitality (VT),

social functioning (SF), role limitations due to emotional problems and mental health (MH),

equating to two summary scales; physical component score (PCS) and mental component

score (MCS). It contains 11 questions, most consisting of structured Likert-type responses.

Current scoring recommendations are that the scores be standardised to a 0-100 range,

converting the lowest possible score to 0 and the highest to 100. Scores are norm-based,

mean = 50, SD = 10. When interpreting scores, 50 is considered average; 0-49 is below

average; 51-100 is above average. Clinical significance is a five point improvement or decline

in scores.

Administration Time points: Premorbid, 1, 3, 6, 12 & 24 months

Materials:

Response sheet

Pen

Directions and domain definitions are included in the stimuli packs and in this

manual. It is preferable to read these to the patient on the first administration but

not at the other time points.

Administration for each time point:

Visit 1 Retrospective data. Administered at baseline or 1 month.

Ask the patient to answer the questions on the QOLI reflecting on

their life over the month PRIOR to the injury.

Ask the patient to answer the questions on the QOLI reflecting on 1 Month

their life over the month SINCE their injury.

247

- 3 Month Ask the patient to answer the questions on the QOLI reflecting on their life over the past month.
- 6 months Ask the patient to answer the questions on the QOLI reflecting on their life **over the past month.**
- 12 months Ask the patient to answer the questions on the QOLI reflecting on their life **over the past month.**
- 24 months Ask the patient to answer the questions on the QOLI reflecting on their life **over the past month.**

**Example: HEALTH:** Over the last month how important has your health been to your happiness? Over the last month how satisfied have you been with your health?

# Community Integrated Questionnaire (CIQ)

The CIQ is a questionnaire that was specifically designed as a telephone interview evaluating community integration.

Administration Time points: Premorbid, 1, 3, 6, 12 & 24 months

Materials: Questionnaire form

Pen

 Tell the patient, 'I would like you to answer some questions about everyday tasks like shopping, paying bills and leisure activities. Could you please colour in the circle next to the appropriate response.' Functional Independence Measure (FIM)

The FIM is a measure of disability not impairment. It measures what a person can actually do

at the time of assessment and it assess the need, type and amount of assistance ("Burden of

Care") required for a person with a disability to perform basic life skills effectively. The FIM

includes a seven-level scale that designates major gradations in behaviour from dependence

to independence

Administration Time points: Premorbid, 1, 3, 6, 12 & 24 months

Materials:

Response sheet

Pen

Some information regarding each section can be obtained throughout

the assessment, however some specific questions will need to be

asked to clarify circumstances.

Record the score which best describes the patients level of function

for every FIM item on the coding sheet.

The FIM score should reflect what the person usually does – actual not

capacity is recorded.

If differences in function occur in different environments or at

different times of the day, record the lowest score as the usual reason

for this is that the patient has not mastered the function. A discussion

with ward nurses (inpatient) or carers (outpatient) may be necessary

to resolve any queries.

If the If the patient does not perform the activity or would be put at

risk if tested, enter Level 1 – Total Assistance. For example, the patient

who requires a bed bath is scored 1 for Transfers: Tub or Shower.

When two helpers are required for the patient to perform activities

described in an item, score Level 1.

250

- Do not leave any FIM item blank.
- Do not enter 'N/A' for any FIM item.
- For the items Walk/Wheelchair, Comprehension and Expression, indicate the most usual mode in the small box. Do not place numbers in the small box.

#### FIM SCORING

#### **NO HELPER**

- 7 = Complete Independence (no help, no devices, safely, timely)
- 6 = Modified Independence

  (assistive device, safety or timeliness issues)

#### HELPER

#### Modified Independence

- 5 = Supervision, setup or standby prompting
- 4 = Minimal contact assistance or prompting(Subject does 75% or more effort)
- 3 = Moderate contact assisstacne or prompting(Subject does 50-74% of effort)

### Complete Independence

- 2 = Maximal contact assissatance or prompting (subject does 25-49% of effort)
- 1 = Total assistance
   (Subject does less than 25% of effort)

```
Appendix 8.1
         ***********
         4
                MIXED MODELS for test outcomes: Group x time
         **********
  use "ICU_ALL_data_CLEAN_v2", clear
   capture drop __0000*
  set more off
                 /* Generate terms for Mixed model analyses
                                                              */
   drop if episodenumber<=3
(429 observations deleted)
   gen case_time=case*sample_time
                                                      /* create interaction
  term for case and sample time
   gen sample_time_0=sample_time-1
                                                      /* start sample time
 at zero
   gen sample_time_0_case=sample_time_0*case
                                               /* interaction term
                                                                     */
   gen ln_time=ln(sample_time)
                                                      /* log time (linear m
   gen ln_time_case=ln_time*case
                                                      /* ln(time) interacti
 on */
                                                      /* sets 6 month sampl
   gen sample_time_6=sample_time-6
                   - can be used to compare changes relative to 6 months
 ing time to 0
   gen case_sample_time_6=sample_time_6*case
   ******
         SURVIVORS
   *****
 drop if died_study==1
(80 observations deleted)
  foreach var of varlist digitspanadiusted lnagescaledscore stroop_ratio trail
 s_inseconds ///
                sf36v2mcs sf36v2pcs iesravoidance iesrhyperarousal iesrinter
 ruptions ies_total ///
                hadstotal cig_total fim {
 2.
                   display
                   display "**************
 3.
                          "`var'"
 4.
                   display
                           ***************
                   display
                            var' case sample_time_0 ||
                                                      patientnumber:
 6.
                   xtmixed
                           `var' case sample_time_0 age sex_recode ||
                   xtmixed
 tnumber:
                   xtmixed `var' case sample_time_0 sample_time_0_case ||
 8.
 tientnumber:
                   xtmixed `var' case sample_time_0 sample_time_0_case age s
 9.
 ex_recode ||
              patientnumber:
10.
                   }
```

**	ж	**	**	*	*	**	×	**	**	**	**	×	*	×	×	**	**	×	ж	**	×	**
d	i	a	i	+	ς	n	а	n	а	d	i	п	S	+	e	d						
*																		*	*	*	*	*

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = -1105.7113
Iteration 1: log likelihood = -1105.7113

Computing standard errors:

Mixed-effects ML regress Group variable: patientr	sion number			er of obs er of grou		<del>=</del> =	462 118
			Obs	per group:	min avg max	=	3.9 4
Log likelihood = -1105.7	'113 			chi2(2) > chi2	:	= = 0	3.20 .2021
 digitspanadjusted   > val] 	Coef.	Std. Err.	z	P> z	[95%	Conf.	Inter
> 4714 sample_time_0  0 > 1707		.52381 .0118445 .3868786	-1.50 -0.97 27.29		-1.813 0343	7226	.239 .01 11.3
/ 1/0/							

Random-effects Parameters	Estimate	Std. Err.	[95% Conf.	<pre>Interval]</pre>
patientnum~r: Identity sd(_cons)	2.648711	.1993428	2.285456	3.069702
sd(Residual)	2.047069	.0780287	1.899709	2.20586
7,	1:1 2(01)	246 02		

LR test vs. linear regression: chibar2(01) = 216.83 Prob >= chibar2 = 0.0000

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0:  $\log \text{ likelihood} = -1096.0015$ Iteration 1:  $\log \text{ likelihood} = -1096.0015$ 

Computing standard errors:

Mixed-effects ML regression Group variable: patientnumber	Number of obs = Number of groups =	130
	Obs per group: min = avg = max =	3.9

wald chi2(4) = 3.79

Appendix 8 1_ICU_mixed_model_ Log likelihood = -1096.0015	Prob > chi2	= 0.4351		
digitspanadjusted   Coef. Std. Err. > val]	z P> z	[95% Conf. Inter		
case  8397317 .5238697 > 7034				
sample_time_0  010268 .0119145 > 3084	-0.86 0.389	03362 .01		
age  006262 .0155906 > 2951	-0.40 0.688	0368191 .024		
sex_recode   .2970337 .5385901 > 2651	0.55 0.581	7585836 1.35		
_cons   10.84604 .9750675 > 5714		8.934945 12.7		
Random-effects Parameters   Estimate				
patientnum~r: Identity   sd(_cons)   2.630619				
sd(Residual)   2.050208				
LR test vs. linear regression: chibar2(01)				
Performing EM optimization:				
Performing gradient-based optimization:				
<pre>Iteration 0: log likelihood = -1105.6091 Iteration 1: log likelihood = -1105.6091</pre>				
Computing standard errors:				
Mixed-effects ML regression Group variable: patientnumber	Number of obs = 467 Number of groups = 118			
	Obs per group:	$\begin{array}{ll} \text{min} = & 3 \\ \text{avg} = & 3.9 \\ \text{max} = & 4 \end{array}$		
Log likelihood = -1105.6091		= 3.40 = 0.3336		
digitspanadjusted   Coef. Std. Err.	z P> z	[95% Conf. Inte		
case  8968671 .577324	-1.55 0.120	-2.028401 .23		
> 46672 sample_time_0  0167809 .0166208	-1.01 0.313	0493571 .01		
> 57954 sample_time_0_case   .0107075 .0236839	0.45 0.651	0357122 .05		
> 71271 _cons   10.6138 .4050475 > 40768	26.20 0.000	9.81992 11.		

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Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH

Random-effects F						
patientnum~r: Ider	ntity     sd( cons)	2.649137				
	7	2.046394	.0780034	1.89	99082	2.20513
LR test vs. linear	regression:	chibar2(01)	= 216.99	9  Prob >=	chibar2	2 = 0.000
Performing EM opti	mization:					
Performing gradier	t-based opti	mization:				
Iteration 0: log Iteration 1: log	likelihood likelihood	= -1095.9407 = -1095.9407				
Computing standard	errors:					
Mixed-effects ML r Group variable: pa	egression tientnumber			er of obs er of grou		
			Obs p	per group:	min = avg = max =	3.
Log likelihood = -				chi2(5) > chi2		
digitspanadjusted > rval]	l Coef	. Std. Err	. Z	P> z	Γ95%	Conf. In
case		6 .577937				
> 07905 sample_time_0	01439	6 .0167924	-0.86	0.391	0473	085 .
> 85164 sample_time_0_case	.008309	8 .0238244	0.35	0.727	0383	852 .
> 50048 age	006279	4 .0155918	-0.40	0.687	0368	388
> 02428 sex_recode	.297221	8 .5386282	0.55	0.581	7584	702 1
> .8161	·	4 .9830262				
Random-effects P	arameters	Estimate	Std. Err.	[95%	Conf.	- <b></b> Intervalj
patientnum~r: Iden	tity   sd(_cons)	2.630915	.1992983	2.26	7912	3.05202
	+ (Residual)	2.049793	.0784752	1.90	1614	2.209519
LR test vs. linear	_	chibar2(01)	= 211.95	Prob >=	chibar2	= 0.0000
lnagescaledscore						

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = Iteration 1: log likelihood =	= -1082.586 = -1082.586		<u></u>	
Computing standard errors:				
Mixed-effects ML regression Group variable: patientnumber		Number o	of obs = of groups =	430 111
		Obs per	group: min = avg = max =	3.9 4
Log likelihood = -1082.586			2(2) = hi2 =	
lnagescaledscore   Coef. > al]	Std. Err.	z P> z	:	. Interv
 case  5629436				
> 144 sample_time_0   .0198756	.0140656	1.41 0.15	80076924	.0474
> 436 _cons   8.819655 > 667				
Random-effects Parameters	Estimate		[95% Conf. In	
patientnum~r: Identity   sd(_cons)				.380492
sd(Residual)	2.337066	.0925027	2.162618 2	.525586
LR test vs. linear regression:	chibar2(01)	= 186.27 Pr	ob >= chibar2 =	0.0000
Performing EM optimization:				
Performing gradient-based optim	nization:			
<pre>Iteration 0: log likelihood = Iteration 1: log likelihood =</pre>	-1082.3102 -1082.3102			
Computing standard errors:				
Mixed-effects ML regression Group variable: patientnumber		Number o Number o	f obs = f groups =	430 111
		Obs per	group: min = avg = max =	3.9
Log likelihood = -1082.3102			2(4) = hi2 =	
lnagescaledscore   Coef.	Std. Err.	z P> z	[95% Conf	. Interv

case  555540	ICU_mixed_model 8 .595712	_regressio -0.93 C		TECH -1.72311	5 .6120
> 332 sample_time_0   .019774	3 .0140664	1.41 0	.160 -	007795	3 .0473
> 438 age  004305	2 .0174935	-0.25 C	.806 -	038591	8 .0299
> 815 sex_recode   .45127	7 .6110484	0.74 0	.460 -	746355	9 1.64
> 891 _cons   8.86965	6 1.087285	8.16 0	.000	6.73861	6 11.0
> 007		· • • • • • • • • • • • • • • • • • • •		<b></b>	
Random-effects Parameters					
patientnum~r: Identity	-+				
sd(_cons)  sd(Residual)	-+			- <b></b>	
LR test vs. linear regression					
Performing EM optimization:					
Performing gradient-based op	timization:				
Iteration 0: log likelihood Iteration 1: log likelihood	d = -1080.6631 $d = -1080.6631$				
Computing standard errors:					
Mixed-effects ML regression Group variable: patientnumber	r	Numbe Numbe	r of obs r of grou	= ips =	430 111
		Obs p	er group:	min = avg = max =	3.9 4
Log likelihood = -1080.6631		Wald Prob	chi2(3) > chi2	= =	6.80 0.0786
lnagescaledscore   Coe > rval]					
case   -1.1237	777 .6600449	-1.70	0.089	-2.4174	141 .16
> 98874 sample_time_0  00803	155 .0199112	-0.40	0.687	04704	107 .03
> 10097 sample_time_0_case   .05500	086 .0279602	1.97	0.049	.00020	75 .10
> 98097 _cons   9.1061		19.25	0.000	8.1791	194 10.
> 03311					
Random-effects Parameters	Estimate	Std. Err.	[95%		
patientnum~r: Identity sd(_cons)	     2.901911			 7839	3.3849
	2.322605				

Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH LR test vs. linear regression: chibar2(01) = 188.79 Prob >= chibar2 = 0.0000 Performing EM optimization: Performing gradient-based optimization: log likelihood = -1080.3924
log likelihood = -1080.3924 Iteration 0: Iteration 1: Computing standard errors: Number of obs Number of groups Mixed-effects ML regression 430 Group variable: patientnumber 111 Obs per group: min = avg = 3.9 max = 4 Wald chi2(5) 7.34 Log likelihood = -1080.3924Prob > chi2 0.1963 lnagescaledscore | Coef. Std. Err. z P>|z|[95% Conf. Inte rval] case -1.115842 .6607698 -1.690.091 -2.410927 .17 92427 sample\_time\_0 | -.0080782 .0199116 -0.410.685 -.0471043 .03 09479 sample\_time\_0\_case | .0549366 .0279608 1.960.049 .0001346 .10 97387 -.0042218 .0175033 -0.240.809 -.0385276 .0 age | 30084 .4474983 0.73 sex\_recode | .6113927 0.464 -.7508094 1.6 45806 \_cons | 9.152608 1.097247 8.34 0.000 7.002044 11. > 30317 Random-effects Parameters | Estimate Std. Err. [95% Conf. Interval] patientnum~r: Identity sd(\_cons) | 2.893498 .2275016 2.480261 3.375585 sd(Residual) | 2.322642 .0919379 2.149259 2.510011 LR test vs. linear regression: chibar2(01) = 187.73 Prob >= chibar2 = 0.0000 \*\*\*\*\*\*\*\* \*\*\*\*\*\*\*\*

stroop\_ratio

Performing EM optimization:

Performing gradient-based optimization:  $\log likelihood = -276.33119$ 

log likelihood = -276.33119Iteration 1: Computing standard errors:

Mixed-effects ML regression Group variable: patientnumber

Number of obs 392 Number of groups = 102

				Obs per	group: min = avg = max =	3.8
Log likelihood	= -276.33119			Wald chi Prob > 0	2(2) = :hi2 =	2.39 0.3027
stroop_ratio	Coef.	Std. Err.	Z	P>   z	[95% Conf	. Interval]
case sample_time_0 _cons	.0024961  0038927   .9876004	.0889111 .0025186 .0662552	0.03 -1.55 14.91	0.978 0.122 0.000	1717664 008829 .8577425	.1767586 .0010435 1.117458
	ts Parameters	+				
patientnum~r: 1	sd(_cons)	.3982823	3 .03	61361	.3333969	.4757957
	sd(Residual)	.3993577	7 .01	66608	.3680025	.4333844
LR test vs. lin	near regression	: chibar2(01	L) =	103.19 Pr	ob >= chibar	2 = 0.0000
Performing EM o	optimization:					
Performing grad	dient-based opt	imization:				
Iteration 0: Iteration 1:	log likelihood log likelihood	= -269.1163 = -269.1163	38 38			
Computing stand	dard errors:					
Mixed-effects M Group variables	ML regression patientnumber			Number o Number o	f obs = f groups =	392 102
				Obs per	group: min = avg = max =	$\frac{1}{3.8}$
Log likelihood					2(4) = hi2 =	17.84 0.0013
stroop_ratio	Coef.	Std. Err.			[95% Conf	. Interval]
case sample_time_0 age sex_recode _cons	0327823 0039286 .0089969 .0485846 .4468092	.0834363 .0025174 .0024299 .0847706 .1513265	-0.39 -1.56 3.70 0.57 2.95	0.694 0.119 0.000 0.567 0.003	1963144 0088626 .0042344 1175628 .1502148	.1307498 .0010054 .0137595 .214732 .7434037
Random-effect	s Parameters	Estimate	Std	. Err.	[95% Conf.	Interval]
patientnum~r: ]	dentity	Ĭ			.3023808	
	sd(Residual)	+   .3992243	. (	01665	.3678891	.4332286
LR test vs. lir	lear regression	: chibar2(01	.) =	85.21 Pr	ob >= chibar	2 = 0.0000
Performing EM o	ptimization:	Page	. 0			

Performing gradient-based optimization:

log likelihood = -276.32268
log likelihood = -276.32268 Iteration 0: Iteration 1:

Computing standard errors:

Mixed-effects ML regression Group variable: patientnumber			er of obs er of grou			392 102
		Obs p	per group:	min = avg = max =		3.8 4
Log likelihood = -276.32268			chi2(3) > chi2	= =		2.41 4923
stroop_ratio   Coef.	Std. Err.			_	Conf.	Inte
case   .0092125 > 05935 sample_time_0  0035839 > 31885 sample_time_0_case  0006587 > 92323 cons   .9844478 > 12269	.1027473 .0034554 .0050465 .0705328	0.09 -1.04 -0.13 13.96	0.929 0.300 0.896 0.000	1921 0103 0105	3563 5497	.21 .00 .00

Random-effects Parameters	Estimate	Std. Err.	[95% Conf.	Interval]
patientnum~r: Identity sd(_cons)	.3983695	.036147	.3334651	.4759067
sd(Residual)	.3993241	.0166605	. 3679696	.4333504

LR test vs. linear regression: chibar2(01) = 103.20 Prob >= chibar2 = 0.0000

Performing EM optimization:

Performing gradient-based optimization:

log likelihood = -269.10646
log likelihood = -269.10646 Iteration 0: Iteration 1:

Computing standard errors:

Mixed-effects ML regression Group variable: patientnumber	Number of obs Number of groups	= =	392 102
	Obs per group: mir avç max	<b>)</b> =	$\begin{smallmatrix}1\\3.8\\4\end{smallmatrix}$
Log likelihood = -269.10646	wald chi2(5) Prob > chi2	= =	17.85 0.0031

Appendix 8 1_ICU_mixed stroop_ratio   Coef. Sto > rval]	d. Err.	z P> z	[95% Co	
case  0255421 .09	980071 -0	0.26 0.794	217632	4 .16
> 31735 sample_time_0_case  0007106 .00 > 91744 age   .0089992 .00 > 37626	050435 -0 024304 3	0.298 0.14 0.888 0.70 0.000 0.57 0.566	010595 .004235	6 .00 8 .01
> 47765 cons   .4432665 .15 > 39611 	534184 2	.89 0.004	.142571	9 .74
Random-effects Parameters   Esti-	imate Std.	Err. [9	95% Conf. In	terval] 
sd(_cons)   .364 sd(Residual)   .399				
LR test vs. linear regression: chibar				
**************************************				
Performing EM optimization:				
Performing gradient-based optimization	on:			
<pre>Iteration 0: log likelihood = -2222 Iteration 1: log likelihood = -2222</pre>	2.2158 2.2158			
Computing standard errors:				
Mixed-effects ML regression Group variable: patientnumber		Number of ob Number of gr	s = oups =	391 102
		Obs per grou	p: min = avg = max =	3.8 $4$
Log likelihood = -2222.2158		Wald chi2(2) Prob > chi2		
trails_inseconds   Coef. Std. > al]	Err. z	P>   z	[95% Conf.	Interv
case   25.98953 15.33				
> 124 sample_time_0   .6302743 .344				
> 623	11.1	5 0.000	102.1139	145.6

Appendix 8 1_IC	:U_mixed_model	_regressio	n_THESIS_TECH	4
Random-effects Parameters	Estimate	Std. Err	. [95% Co	nf. Interval]
patientnum~r: Identity sd(_cons)	72.00086			8 84.33464
sd(Residual)	54.58713	2.267428	50.3191	5 59.21712
LR test vs. linear regression:	chibar2(01)	= 190.22	L Prob >= chi	bar2 = 0.0000
Performing EM optimization:				
Performing gradient-based opti	mization:			
Iteration 0: log likelihood Iteration 1: log likelihood	= -2212.7013 = -2212.7013			
Computing standard errors:				
Mixed-effects ML regression Group variable: patientnumber		Numbe Numbe	er of obs er of groups	= 391 = 102
		Obs p	oer group: min avg max	$     \begin{array}{rcl}         & n & = & & 1 \\         & g & = & & 3.8 \\         & x & = & & 4     \end{array} $
Log likelihood = -2212.7013				= 27.78 = 0.0000
trails_inseconds   Coef.	Std. Err.	z F	P> z  [95%	% Conf. Interv
case   18.97738				
> 197 sample_time_0   .633075	.3450173	1.83	.067043	31465 1.309

trails_inseconds   > al]	Coef.	Std. Err.	z	P> z	[95% Conf.	Interv
case   > 197	18.97738	14.03321	1.35	0.176	-8.527216	46.48
	.633075	.3450173	1.83	0.067	0431465	1.309
	1.853866	.4082413	4.54	0.000	1.053728	2.654
	-3.83882	14.26093	-0.27	0.788	-31.78973	24.11
	18.44014	25.36572	0.73	0.467	-31.27575	68.15

Random-effects Parameters	Estimate	Std. Err.	[95% Conf.	. Interval]
patientnum~r: Identity sd(_cons)	64.42832	5.391925	54.68155	75.91241
sd(Residual)	54.61564	2.270659	50.34173	59.2524

LR test vs. linear regression: chibar2(01) = 153.65 Prob >= chibar2 = 0.0000

Performing EM optimization:

Performing gradient-based optimization:

log likelihood = -2221.9812
log likelihood = -2221.9812 Iteration 0:
Iteration 1:

Computing standard errors:

Appendix 8 1_ICU_mixe Mixed-effects ML regression Group variable: patientnumber	ed_model_regr	ression_THES Number of o Number of o	IS_TECH obs = groups =	391 102
		Obs per gro	oup: min = avg = max =	3.X
Log likelihood = -2221.9812		Wald chi2(3 Prob > chi2	3) = = =	6.67 0.0833
			·	
trails_inseconds   Coef. Si > rval]	td. Err.	z P> z	[95%	Conf. Inte
 case   21.1694 16				
> 24137 sample_time_0   .4064506 .4			25241	
> 37008 sample_time_0_case   .47301 .6				
> 25766				
_cons   126.1971 11 > .9504				
Random-effects Parameters   Est	imate Std.	Err. [	95% Conf.	Interval]
patientnum~r: Identity   sd(_cons)   72.	01098 5.8	30788 6	51.48186	84.34327
sd(Residual)   54.	54258 2.26	55593 5	0.27805	59.16882
LR test vs. linear regression: chiba	ar2(01) = 1	L90.50 Prob	>= chibar2	= 0.0000
Performing EM optimization:				
Performing gradient-based optimizati	on:			
<pre>Iteration 0: log likelihood = -221 Iteration 1: log likelihood = -221</pre>	.2.4892 .2.4892			
Computing standard errors:				
Mixed-effects ML regression Group variable: patientnumber		Number of o Number of g	bs = roups =	391 102
		Obs per gro	up: min = avg = max =	$\begin{smallmatrix}1\\3.8\\4\end{smallmatrix}$
Log likelihood = -2212.4892		Wald chi2(5 Prob > chi2	) =	28.20
trails_inseconds   Coef. St	d. Err.	z P> z	[95% (	Conf. Inte
case   14.40011 15 > .1645				
sample_time_0   .4202255 .4 > 51133	749blb 0	v.88 U.3/6	51068	322 1.3
	Page 12			

<pre>sample_time_0_ &gt; 02934</pre>	Append case	lix 8 1_I0 .44979	CU_mixed_mo 08 .6903	del_regi 192	ression_ 0.65	_THESIS_ 0.515	TECH 903	3526	1.8
> 52094	age	1.8517	94 .4083	24	4.54	0.000	1.05	1494	2.6
	code	-3.7998	05 14.263	56 -	0.27	0.790	-31.7	5587	24.
_	cons	20.728	06 25.611	.18	0.81	0.418	-29.46	5894	70.
> 92506 		<b></b>							
Random-effec								Interva	1]
patientnum~r:	Identii So	ty	64.4516						
		esidual)	+   54.572	2 2.2	68939	50.3	 0153	59.205	46
LR test vs. li			<b></b>					· <b></b> -	
************ sf36v2mcs ******									
Performing EM	optimiz	zation:							
Performing grad	dient-k	oased opt	imization:						
Iteration 0: Iteration 1:	log li log li	kelihood kelihood	= -1777.15 = -1777.15	14 14					
Computing stand	dard er	rors:							
Mixed-effects   Group variable	ML regr : patie	ression entnumber			Number Number	of obs of grou	ps =	4 1	57 15
					Obs pei	group:	min = avg = max =		3 .0 4
Log likelihood	= -177	7.1514				ni2(2) chi2	=	2. 0.24	81 60
sf36v2mcs	   !	Coef.		Z		[959	% Conf.	Interv	al]
case sample_time_0 _cons	1.1	18207 889086 18.314	2.052848 .0562518 1.576078	0.54 1.58 30.65	0.586 0.114 0.000	-2.90 021 45.2	05301 13429 22494	5.141 .1991 51.40	715 601 305
Random-effect	 ts Para	meters	Estimat	 e Std	 . Err.	[95%	Conf.	 Interva	 1]
patientnum~r:	50	y l(_cons)	9.89029	7 .81	37204	8.417	7383	11.620	- <b>-</b> 95
		esidual)	9.60290	8 .367	73977	8.909	9158	10.350	68
LR test vs. lin	near re	gression	chibar2(0	1) = 3	L39.11 F	rob >= 0	chibar2	= 0.00	00
Performing EM (	optimiz	ation:							
Performing grad	dient-h	ased onti	imization:						

Performing gradient-based optimization:

Iteration 1:	Appendix 8 1_ICU_mixed_model_regression_THESIS_TECH log likelihood = -1774.8317
iteration i.	10g 17ke1111000 = -1774.8317

Compu	ıtina	standard	errors:
COIIID	ıtılı	3 canuar u	CIIOI3.

Computing stand	dard errors:					
Mixed-effects   Group variable	ML regression : patientnumbe	r	Nu Nu	mber of o	obs = groups =	457 115
			Ob	s per gro	oup: min = avg = max =	4.0
Log likelihood	= -1774.8317		Wa Pr	ld chi2(4 ob > chi2	!) = ! =	7.55 0.1095
sf36v2mcs	Coef.	Std. Err.	z P	> z	[95% Conf	. Interval]
case sample_time_0 age sex_recode _cons	1.075444 .08876 .0505874 -4.42973 47.3159	2.014962 .0562493 .059008 2.071119 3.727484	0.53 0 1.58 0 0.86 0 -2.14 0 12.69 0	.594 - .115 - .391 - .032 -	2.873808 .0214866 .0650662 8.489048 40.01017	5.024697 .1990067 .166241 3704107 54.62164
Random-effect	s Parameters	   Estimate	Std. E	 rr. [	95% Conf.	Interval]
patientnum~r: ]		9.646313	.80171	 35 8	.196289	11.35286
	sd(Residual)	T				
LR test vs. lir	near regression	n: chibar2(01	.) = 132	.34 Prob	>= chibar2	2 = 0.0000
Performing EM o	optimization:					
Performing grad	dient-based op	timization:				
Iteration 0: Iteration 1:	log likelihood log likelihood	d = -1777.127 d = -1777.127	9			
Computing stand	lard errors:					
Mixed-effects M Group variable:	ML regression patientnumbe	r	Nur Nur	mber of o mber of g	bs = roups =	457 115
			Obs	s per gro	up: min = avg = max =	4.0
Log likelihood	= -1777.1279					2.85 0.4149
 sf36v2 > rval]	mcs   Coe	ef. Std. Er	r. z	P>   z	[95%	Conf. Inte
	ase   1.3650	561 2.34898	1 0.58	3 0.561	-3.238	257 5.
> 96958 sample_tim	ne_0   .10169	955 .081513	7 1.25	0.212	0580	685 .26
<pre>&gt; 14594 sample_time_0_c &gt; 63292</pre>	ase  02440	098 .11262	4 -0.22	0.828	2451	.488 .19
	ons   48.185	568 1.68359 Page		0.000	44.88	589 51.

			Estimate				
oatientnum~r:							
	sd(R	 esidual)	9.602253	.3673726	5 8	. 90855	10.34997
R test vs. 1	inear r	egression:	chibar2(01)	= 139.1	L4 Prob >:	= chibar2	2 = 0.0000
Performing EM	optimi	zation:					
Performing gra	adient-l	based optir	nization:				
teration 0: teration 1:	log la	ikelihood = ikelihood =	= -1774.8088 = -1774.8088				
Computing star	ndard e	rrors:					
		_				_	457
Mixed-effects Group variable	ML regi e: patio	ression entnumber		Numb Numb	per of obs per of gro	oups =	457 115
Mixed-effects Group variable	ML regi e: patio	ression entnumber		Numb	per of obs per of group	oups =	115 3 4.0
Mixed-effects Group variable Group variable Group variable	d = -177	74.8088		Numb Obs Wald Prob	per of group per group   chi2(5)   chi2	oups = avg = max = = = =	7.60 0.1799
og likelihood	d = -177  /2mcs	74.8088  Coef.		Numb Obs Wald Prob	per of group    chi2(5)   > chi2   P> z	oups =  o: min =     avg =     max =  = = = = [95%	7.60 0.1799 Conf. Int
og likelihood  sf36v rval] 	d = -177  /2mcs   +	74.8088  Coef.		Numb Obs Wald Prob	per of group   chi2(5)   > chi2   P> z	oups = o: min =     avg =     max =  = = = [95%	7.60 0.1799 Conf. Int
og likelihood	d = -177  /2mcs   + case	74.8088 	Std. Err.	Numb Obs Wald Prob . z 0.57	per of group   chi2(5)   chi2   chi2   chi2	oups = o: min = avg = max =  = = [95%	7.60 0.1799 Conf. Int
og likelihood 	d = -177  /2mcs   + case   ime_0	74.8088 	Std. Err.  5 2.31575  6 .0815087	Numb Obs Wald Prob . z 0.57	per of group   chi2(5)   chi2   chi2   chi2	oups = o: min = avg = max =  = = [95%3.2190583	7.60 0.1799 
og likelihood 	d = -177 	74.8088 	Std. Err.  2.31575  0.0815087  1126189	Numb Obs  Wald Prob	per of group   chi2(5)   > chi2   P> z      0.569   0.214	oups = o: min = avg = max =  = = [95%3.21905832448	7.60 0.1799 
og likelihood 	d = -177	74.8088 	Std. Err.  2.31575  0.0815087  1126189  0.0590085	Numb Obs  Wald Prob z  0.57 1.24 -0.21 0.86	per of group   chi2(5)   > chi2   P> z      0.569   0.214   0.831	oups = o: min = avg = max =  = = [95%3.219058324480650	7.60 0.1799 Conf. Int 

Random-effects Parameters	Estimate	Std. Err.	[95% Conf.	Interval]
patientnum~r: Identity sd(_cons)	9.64652	.8017008	8.196514	11.35304
sd(Residual)	9.601994	.3673431	8.908345	10.34965

LR test vs. linear regression: chibar2(01) = 132.37 Prob >= chibar2 = 0.0000

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = -1705.5686
Iteration 1: log likelihood = -1705.5686

Computing standard errors:

Mixed-effects ML regression	Number of obs =	457
Group variable: patientnumber	Number of groups =	115
	Ohe nor group, min -	2

Obs per group: min = avg = 4.0 max =

	wald chi2(2)	=	3.64
Log likelihood = -1705.5686	Prob > chi2	=	0.1617

sf36v2pcs	Coef.	Std. Err.	z	P> z	[95% Conf.	Interval]
case	1.119246	2.271993	0.49	0.622	-3.333778	5.57227
sample_time_0	0814429	.0441118	-1.85	0.065	1679005	.0050147
_cons	37.99033	1.687041	22.52	0.000	34.68379	41.29687

Random-effects Parameters	•	Std. Err.	<del>-</del>	Interval]
patientnum~r: Identity sd(_cons)	11.57619	.8460616	10.03123	13.35909
sd(Residual)				8.114007

LR test vs. linear regression: chibar2(01) = 285.13 Prob >= chibar2 = 0.0000

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = -1688.8474
Iteration 1: log likelihood = -1688.8474

Computing standard errors:

Mixed-effects ML regression	Number of obs =	457
Group variable: patientnumber	Number of groups =	115
	Obs per group: min =	3

avg = 4.0 max = 4

	Wald chi2(4)	=	42.48
Log likelihood = -1688.8474	Prob > chí2	=	0.0000

sf36v2pcs	Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
case	1.772278	1.967787	0.90	0.368	-2.084515	5.62907
sample_time_0	0817108	.0441043	-1.85	0.064	1681538	.0047321
age	3497509	.057637	-6.07	0.000	4627173	2367844
sex_recode	081618	2.022677	-0.04	0.968	-4.045992	3.882756
_cons	58.59957	3.625701	16.16	0.000	51.49333	65.70581

Random-effects Parameters	Estimate	Std. Err.	[95%	Conf.	Interval]
patientnum~r: Identity   sd(_cons)	9.83031	.7457977	8.47	2059	11.40632
sd(Residual)	7.527632	.2877925	6.98	34184	8.113366
LR test vs. linear regression: c	 hibar2(01)	= 219.52	Prob >=	chibar2	= 0.0000
Performing EM optimization:					
Performing gradient-based optimi	zation:				
<pre>Iteration 0: log likelihood = Iteration 1: log likelihood =</pre>	-1703.9445 -1703.9445				
Computing standard errors:					
Mixed-effects ML regression Group variable: patientnumber		Numbe Numbe	of obs of grou	ips =	457 115
		Obs pe	er group:	min = avg = max =	4.0
Log likelihood = -1703.9445					6.94 0.0737
sf36v2pcs   Coef.	Std. Err.	Z	P> z	[95%	
case  4900493	2.441556	-0.20	0.841	-5.275	412 4.2
> 95313 sample_time_0  1647057	.0636331	-2.59	0.010	2894	24303
> 99871 sample_time_0_case   .1588167	.0878919	1.81	0.071	0134	481 .33
> 10816 _cons   38.8252 > .2541	1.749473	22.19	0.000	35.3	963 42
			·		
Random-effects Parameters	 Estimate	Std. Err.	 95%]	Conf.	 Interval]
patientnum~r: Identity   sd( cons)					
sd(Residual)					
LR test vs. linear regression: c	 hibar2(01)	= 287.68	Prob >=	<b></b> chibar2	= 0.0000
Performing EM optimization:					
Performing gradient-based optimiz	zation:				
<pre>Iteration 0: log likelihood = Iteration 1: log likelihood =</pre>	-1687.212 -1687.212				
Computing standard errors:					
Mixed-effects ML regression	Page 17		of obs	=	457

Appendix 8 1_ICU_mixed_model_reg	ression_THESIS_TECH Number of groups = 115
	Obs per group: $min = 3$ avg = 4.0 max = 4
Log likelihood = -1687.212	Wald chi2(5) = 45.76 Prob > chi2 = 0.0000
 sf36v2pcs   Coef. Std. Err. > rval]	
case   .158048 2.160677	
	2.60 0.00928991104
	1.81 0.0700128962 .33
> 15723 age  3500139 .0576644 - > 69937	6.07 0.000463034123
	0.04 0.965 -4.053916 3.8
	6.25 0.000 52.28644 66.
+	55499 8.484788 11.41804
sd(Residual)   7.490538 .2	
LR test vs. linear regression: chibar2(01) =  ********************  iesravoidance  *****************  Performing EM optimization:  Performing gradient-based optimization:  Iteration 0: log likelihood = -1370.0935  Iteration 1: log likelihood = -1370.0934  Computing standard errors:	221.79 Prob >= Chibar2 = 0.0000
Mixed-effects ML regression Group variable: patientnumber	Number of obs = 481 Number of groups = 121
STOUP VALIABLE. PACTEMENTURBET	Obs per group: min = 3
Log likelihood = -1370.0934	wald chi2(2) = 35.90 Prob > chi2 = 0.0000
iesravoidance   Coef. Std. Err. z	P> z  [95% Conf. Interval]

case sample_time_0 _cons	Appendix 8 1_I   1.879528  102864   1.775374	CU_mixed_mod .525941 .0213128 .4261586	el_regr 3.57 -4.83 4.17	ression_TH 0.000 0.000 0.000	ESIS_TECH .848702 144636 .940118	1 21 52 38	2.910353 0610917 2.61063
Random-effec	ts Parameters	Estimate	Std	 . Err.	 [95% Cor	 nf.	 Interval]
patientnum~r:	1	+     2.196619	.2	 51262	1.755454	1	2.748654
	sd(Residual)	+   3.748045	.139	<b></b> 95731	3.484231		4.031834
	near regression				. – – – – – – –		
Performing EM	optimization:						
Performing gra	dient-based opt	imization:					
Iteration 0: Iteration 1: Iteration 2:	log likelihood log likelihood log likelihood	= -1351.581 = -1351.581 = -1351.581	8 5 5				
Computing stan	dard errors:						
Mixed-effects Group variable	ML regression : patientnumber			Number of Number of	obs groups	= =	477 120
				Obs per g		) =   =   =	4.0
Log likelihood	= -1351.5815			wald chi2 Prob > ch	(4) i2	=	56.88 0.0000
iesravoidance	Coef.	Std. Err.	Z	P> z	[95% Co	nf.	Interval]
sex_recode	1.939587  1040412  06014   1.20524   4.824645	.5052558	2.39	0.017	.214957	3	2.195524
Random-effec	 ts Parameters	   Estimate	 Std.	Err.	 [95% Con	 f. 1	 [nterval]
patientnum~r:	Identity	1.922779					
	sd(Residual)	+					
	near regression		<del></del>	· <del>-</del>			
Performing EM	optimization:						
Performing grad	dient-based opt	imization:					
Iteration 0: Iteration 1:	log likelihood log likelihood	= -1364.642 = -1364.642	<u>l</u> l				
Computing stand	dard errors:						
Mixed-effects   Group variable	ML regression : patientnumber			Number of Number of	obs groups	= =	481 121

Appendix 8 1_ICU	_mixed_model	_regressio Obs p	n_THESIS per group	_TECH : min = avg = max =	4.0
Log likelihood = -1364.6421					47.69 0.0000
iesravoidance   Coef.	. Std. Err.	z	P>   z	[95%	Conf. Inte
case   3.302866	5 .6778253	4.87	0.000	1.974	1353 4.6
> 31379 sample_time_0  0339131					
> 39164 sample_time_0_case  1397031					
> 57394 _cons   1.076878					
> 04926			<b>-</b>		
Random-effects Parameters	Estimate	Std. Err.	[95	% Conf.	Interval]
patientnum~r: Identity	2.21869			210 <i>1</i> 2	2 762491
sd(_cons)   					
LR test vs. linear regression:	. – – – – – – – – –			<del>-</del>	
Performing EM optimization:	CIII Dai 2 (01)	- 40.30	1100 /-	Ciribarz	- 0.0000
Performing gradient-based optim	nization:				
<pre>Iteration 0: log likelihood = Iteration 1: log likelihood = Iteration 2: log likelihood =</pre>					
Computing standard errors:					
Mixed-effects ML regression Group variable: patientnumber		Numbe Numbe	r of obs r of grou	ups =	477 120
		Obs p	er group	min = avg = max =	4.0
Log likelihood = -1346.3077					68.30 0.0000
iesravoidance   Coef.	Std. Err.	7	P> 7	Γ95%	Conf. Inte
case   3.350455					
> 33179 sample_time_0  0351081					
> 34294 sample_time_0_case  138512					88405
> 55355					

Appendix 8 1_IC age  05994	CU_mixed_model 47 .0145937	_regression_ -4.11	_THESIS_TECH 0.000088	547803
> 13416 sex_recode   1.204	11 .5052107	2.38	0.017 .21	3915 2.1
> 94305 _cons   4.1152	84 .9674323	4.25	0.000 2.21	9152 6.0
> 11417				
Random-effects Parameters	Estimate	Std. Err.	[95% Conf.	Interval]
<pre>patientnum~r: Identity</pre>	İ		1.518112	
sd(Residual)	+   3.707227	.1386056	3.44528	3.98909
LR test vs. linear regression	: chibar2(01)	= 27.75	rob >= chibar	2 = 0.0000
**************************************				
Performing EM optimization:				
Performing gradient-based opt	imization:			
Iteration 0: log likelihood Iteration 1: log likelihood Iteration 2: log likelihood	= -1338.3955			
Computing standard errors:				
Mixed-effects ML regression Group variable: patientnumber		Number Number	of obs = of groups =	481 121
		Obs pe	group: min = avg = max =	
Log likelihood = -1338.3954		Wald ch Prob >	ni2(2) = chi2 =	
iesrhyperarousal   Coef.	 Std Err	7 D		onf Interv
> al]				
case   .9056384				32 1.695
> 095 sample_time_0  0723138	.0213356	-3.39 0.0	001114130	080304
> 968 _cons   1.20041 > 185	. 3549939	3.38 0.0	.504634	1.896
Random-effects Parameters	Estimate	Std. Err.	[95% Conf.	Interval]
patientnum~r: Identity	ĺ		.7134654	
sd(Residual)	+			
LR test vs. linear regression	: chibar2(01) Page 2		Prob >= chibar2	2 = 0.0122

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = -1322.5982
Iteration 1: log likelihood = -1322.3747
Iteration 2: log likelihood = -1322.3747

#### Computing standard errors:

Mixed-effects ML regression Group variable: patientnumber	Number of obs Number of groups	=	477 120
	•	n = g = x =	3 4.0 4
Log likelihood = -1322.3747	Wald chi2(4) Prob > chi2	=	31.30 0.0000

	 esrhyperarousal   al]	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interv
-	case	. 949034	.3839817	2.47	0.013	. 1964437	1.701
	624 sample_time_0   442	0732969	.0215069	-3.41	0.001	1154497	0311
	age	0422267	.011379	-3.71	0.000	0645291	0199

sex\_recode | .6203698 .3940182 1.57 0.115-.1518918 1.392 631 \_cons | 3.444423 .748553 4.60 0.000 1.977286 4.91 > 156

Random-effects Parameters | Estimate Std. Err. [95% Conf. Interval]

patientnum~r: Identity | sd(\_cons) | .9179568 .3410256 .4431967 1.901288

sd(Residual) | 3.7686 .1408251 3.502453 4.054971

LR test vs. linear regression: chibar2(01) = 2.11 Prob >= chibar2 = 0.0732

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = -1336.6588 Iteration 1: log likelihood = -1336.5892 Iteration 2: log likelihood = -1336.5891

Computing standard errors:

Mixed-effects ML regression Number of obs = 481 Group variable: patientnumber Number of groups = 121

> Obs per group: min = 3 avg = 4.0 max = 4

Log likelihood = -1336.5891	wald chi2(3) Prob > chi2	= =	20.20 0.0002
iesrhyperarousal   Coef. Std. Err	. z P> z	[95% Con	f. Inte
case   1.730356 .5912303 > 89146			
sample_time_0  0324165 .0298202 > 60299	-1.09 0.277	0908629	.02
sample_time_0_case  080909 .0424643 > 23195	-1.91 0.057	1641375	.00
_cons   .7958866 .4130484 > 05447			
Random-effects Parameters   Estimate	Std. Err. [95	 % Conf. Into	erval]
patientnum~r: Identity   sd(_cons)   1.17983	.2878247 .73	14167 1.9	903153
sd(Residual)   3.735292	.1390277 3.4	72504 4.0	17967
LR test vs. linear regression: chibar2(01)	= 5.39 Prob >=	chibar2 = (	0.0101
Performing EM optimization:			
Performing gradient-based optimization:			
<pre>Iteration 0: log likelihood = -1320.8581 Iteration 1: log likelihood = -1320.6529 Iteration 2: log likelihood = -1320.6529</pre>			
Computing standard errors:			
Mixed-effects ML regression Group variable: patientnumber	Number of obs Number of gro	= ups =	477 120
	Obs per group	: min = avg = max =	4.0 4
Log likelihood = -1320.6529	Wald chi2(5) Prob > chi2	= = (	34.87
iesrhyperarousal   Coef. Std. Err.	z P> z		. Inte
		.6214585	2.8
> 99734 sample_time_0  0337039 .0301841			
> 54558 sample_time_0_case  079633 .0428072			
> 42676 age  0421227 .0113799			01
> 98186 sex_recode   .6198159 .3940413			1.3
> 92123	<del>-</del>		5

> 65191	_cons	idix 8 1_IC   3.03705	U_mixed_mode 8 .7796742	_regressi 3.90	on_THES: 0.000	1.50	8924	4.
Random-eff	ects Par	rameters	Estimate	Std. Err	· [	 95% Conf.	Inte	 rval]
 patientnum~r	: Identi	 itv	.936763					
		+	3.750403			<b>-</b>		
			chibar2(01)					
*********** iesrinterrup *****	*****	***					- •	.0012
Performing E	M optimi	ization:						
Performing g	radient-	-based opti	mization:					
Iteration 0: Iteration 1:	log 1 log 1	likelihood likelihood	= -1392.1292 = -1392.1291					
Computing st	andard e	errors:						
Mixed-effect Group variab	s ML reç le: pati	ression entnumber		Numb Numb	er of ol er of gi	os = roups =		481 121
				Obs	per grou	up: min = avg = max =		3 4.0 4
_og likeliho	od = -13	392.1291		Wald Prob	chi2(2) > chi2	) = =	0.	28.52 0000
vall i			Std. Err.			_		
	case	1.612942	. 5385968	2.99	0.003	.55731	.17	2.6
> 8572 sample_t	ime_0	0997053	.0224766	-4.44	0.000	14375	87	0
> 5652 - 2468	_cons	1.880458	.4398088	4.28	0.000	1.0184	49	2.74
			 Fstimate					
oatientnum~r	: Tdenti	tv İ	Estimate 					
	S 	d(_cons)	2.198956					
			3.952896					
	1	oarection.	chibar2(01)	_ 32 0	2 Droh s	- chihar2	_ 0	0000

Performing gradient-based optimization:

```
log likelihood = -1376.6554
log likelihood = -1376.655
log likelihood = -1376.655
Iteration 0:
Iteration 1:
Iteration 2:
Computing standard errors:
                                           Number of obs
Number of groups
Mixed-effects ML regression
                                                                    120
Group variable: patientnumber
                                           Obs per group: min =
                                                                    4.0
                                                         avg =
                                                         max =
                                           Wald chi2(4)
                                                            =
                                                                 41.20
                                           Prob > chi2
Log likelihood = -1376.655
                                                                 0.0000
                                                           =
iesrinterruptions |
                    Coef. Std. Err. z P>|z|
                                                        [95% Conf. Inter
> val]
case
                   1.660601
                              .5177713
                                       3.21
                                                0.001
                                                        .6457882
 5414
   sample_time_0 | -.1008579
                              .0226574
                                        -4.45
                                                0.000
                                                        -.1452655
                                                                   -.056
 4503
                                                0.001
            age | -.0518768
                              .0153487
                                        -3.38
                                                        -.0819596
                                                                   -.021
> 7939
      sex_recode | .8076879
                              .5313587
                                        1.52
                                                0.129
                                                        -.233756
                                                                   1.84
          _cons | 4.622077
                             .9925272
                                                0.000
                                         4.66
                                                        2.676759
                                                                   6.56
> 7394
 Random-effects Parameters | Estimate Std. Err. [95% Conf. Interval]
patientnum~r: Identity
              sd(_cons)
                             2.01639
                                        .266481
                                                   1.556259
                                                              2.612565
             sd(Residual) | 3.968245 .1483695 3.687846 4.269964
LR test vs. linear regression: chibar2(01) = 25.06 Prob >= chibar2 = 0.0000
Performing EM optimization:
Performing gradient-based optimization:
Iteration 0:
             log likelihood = -1387.666
             \log likelihood = -1387.6659
Iteration 1:
Computing standard errors:
                                           Number of obs
Mixed-effects ML regression
                                                                   481
                                           Number of groups
Group variable: patientnumber
                                                                   121
                                           Obs per group: min =
                                                        avg =
                                                                   4.0
                                                        max =
                                           Wald chi2(3)
                                                                 38.05
                                           Prob > chi2
Log likelihood = -1387.6659
                                                                0.0000
```

Appe iesrinterruptions > rval]	Coe		. Z	P>   z	[95% (	
case > 51591	2.9730	03 .703374	4.23	0.000	1.5944	115 4.3
<pre>sample_time_0 &gt; 27327</pre>	03381	83 .0311971	-1.08	0.278	09496	.0
<pre>sample_time_0_case &gt; 64608</pre>	13349	.0444052	-3.01	0.003	22052	25904
_cons		01 .4913554				
Random-effects Pa						
patientnum~r: Ident	_					
sd(	Residual)	3.90431	.1453914	3.62	29499	4.199929
LR test vs. linear	regression	: chibar2(01)	= 35.07	' Prob >=	chibar2	= 0.0000
Performing EM optim	nization:					
Performing gradient	-based opt	imization:				
Iteration 0: log Iteration 1: log Iteration 2: log	likelihood likelihood likelihood	= -1372.3409 = -1372.3406 = -1372.3406				
Computing standard	errors:					
Computing standard Mixed-effects ML re Group variable: pat	*		Numbe Numbe	er of obs er of grou	= ups =	477 120
	*		Numbe	er of obs er of grou eer group:	ıps =	120 3 4.0
	gression ientnumber		Numbe Obs p Wald	er of grou	ups = min = avg = max =	120 3 4.0 4
Mixed-effects ML re Group variable: pat	gression ientnumber 372.3406		Numbe Obs p Wald Prob	er of group: er group: chi2(5) > chi2	ups = min = avg = max = =	120 3 4.0 4 50.41 0.0000
Mixed-effects ML re Group variable: pat Log likelihood = -1iesrinterruptions	gression ientnumber 372.3406	f. Std. Err	Numbe Obs p Wald Prob	chi2(5) > chi2 	ups = min = avg = max =  = = = = [95% C	120 3 4.0 4 50.41 0.0000 
Mixed-effects ML re Group variable: pat Log likelihood = -1  iesrinterruptions > rval]	gression ientnumber 372.3406 	f. Std. Err	Numbe Obs p Wald Prob 	er of group: chi2(5) > chi2 P> z	ups =  min = avg = max =  = = [95% C	120 3 4.0 4 50.41 0.0000  onf. Inte
Mixed-effects ML re Group variable: pat Log likelihood = -1 iesrinterruptions > rval] 	gression ientnumber  372.3406	f. Std. Err	Number Obs public wald Prober 2	chi2(5) > chi2 P> z	ups =  min = avg = max =  = = [95% C 1.6558	120 3 4.0 4 50.41 0.0000  onf. Inte 54 4.3
Mixed-effects ML re Group variable: pat Log likelihood = -1 iesrinterruptions > rval] 	372.3406	f. Std. Err 	Number Obs p  Wald Prob  . z  4.36  -1.11	chi2(5) > chi2 P> z  0.000 0.268	min = avg = max = = = = = = = = = = = = = = = = = = =	120  4.0 4  50.41 0.0000  onf. Inte 54 4.3 45 .02
Mixed-effects ML re Group variable: pat Log likelihood = -1 	372.3406	f. Std. Err 	Wald Prob z 4.36 -1.11 -2.96	chi2(5) > chi2 > chi2  P> z   0.000 0.268 0.003	min = avg = max = = = = = = = = = = = = = = = = = = =	120  3 4.0 4  50.41 0.0000 onf. Inte 54 4.3 45 .02 1804
Mixed-effects ML re Group variable: pat Log likelihood = -1 	gression ientnumber  372.3406	f. Std. Err 	Wald Prob z 4.36 -1.11 -2.96 -3.37	chi2(5) > chi2 > chi2  P> z   0.000 0.268 0.003 0.001	min = avg = max = = = = = = = = = = = = = = = = = = =	120 3 4.0 4 50.41 0.0000 onf. Inte 54 4.3 45 .02 1804 7902
Mixed-effects ML re Group variable: pat Log likelihood = -1 	gression ientnumber  372.3406	f. Std. Err	Wald Prob z 4.36 -1.11 -2.96 -3.37 1.52	chi2(5) > chi2 > chi2  P> z   0.000 0.268 0.003 0.001 0.129	min = avg = max = = = = = = = = = = = = = = = = = = =	120 3 4.0 4 50.41 0.0000 onf. Inte 54 4.3 45 .02 1804 7902 85 1.8
Mixed-effects ML re Group variable: pat Log likelihood = -1 iesrinterruptions > rval] case > 60769 sample_time_0 > 68985 sample_time_0_case > 45708 age > 15995 sex_recode > 48352 _cons > 40007	gression ientnumber  372.3406	f. Std. Err	Wald Prob  . z  4.36 -1.11 -2.96 -3.37 1.52 3.87	chi2(5) > chi2 > chi2 	min = avg = max = = = = = = = = = = = = = = = = = = =	120 3 4.0 4 50.41 0.0000 onf. Inte 54 4.3 45 .02 1804 7902 85 1.8 61 5.9

```
Appendix 8 1_ICU_mixed_model_regression_THESIS_TECH
 Random-effects Parameters | Estimate Std. Err. [95% Conf. Interval]
patientnum~r: Identity
              sd(_cons) |
                            2.040575
                                     .2629869
                                                 1.585079
                                                            2.626966
             sd(Residual) | 3.920335 .1465844 3.643309
                                                            4.218424
LR test vs. linear regression: chibar2(01) = 26.91 Prob >= chibar2 = 0.0000
******
Performing EM optimization:
Performing gradient-based optimization:
Iteration 0:
             \log likelihood = -1868.3447
            log likelihood = -1868.3443
log likelihood = -1868.3443
Iteration 1:
Iteration 2:
Computing standard errors:
                                         Number of obs
Mixed-effects ML regression
                                                                481
Group variable: patientnumber
                                         Number of groups =
                                                                121
                                         Obs per group: min =
                                                                  3
                                                      avg =
                                                                4.0
                                                      max =
                                         wald chi2(2)
                                                              29.87
Log likelihood = -1868.3443
                                         Prob > chi2
                                                             0.0000
   ies_total | Coef. Std. Err. z P>|z| [95% Conf. Interval]
______
 Random-effects Parameters | Estimate Std. Err. [95% Conf. Interval]
              patientnum~r: Identity
            sd(_cons) | 5.561398 .7177648 4.318433 7.162122
             sd(Residual) | 10.74178 .399971 9.985774 11.55502
LR test vs. linear regression: chibar2(01) =
                                        26.71 \text{ Prob} >= \text{chibar2} = 0.0000
Performing EM optimization:
Performing gradient-based optimization:
            \log likelihood = -1846.9414
Iteration 0:
Iteration 1:
            log likelihood = -1846.939
log likelihood = -1846.939
Iteration 2:
Computing standard errors:
                                         Number of obs
Number of groups
Mixed-effects ML regression
                                                                477
Group variable: patientnumber
                                                                120
                                         Obs per group: min =
                                                      avg =
                                                     max =
```

Log likelihood = -1846.939	Wald chi2(4) = 47.37 Prob > chi2 = 0.0000
ies_total   Coef. Std. Err.	z P> z  [95% Conf. Interval]
sex_recode   2.633227 1.367143	3.41 0.001 1.9378 7.159968 -4.52 0.0003988395157523 -3.91 0.00023164110768461 1.93 0.0540463244 5.312779 5.03 0.000 7.870543 17.91184
 Random-effects Parameters   Estim	nate Std. Err. [95% Conf. Interval]
patientnum~r: Identity	7904 .7339883 3.641687 6.560586
sd(_con3)   4.887 sd(Residual)   10.78	299 .4031074 10.02116 11.60273
LR test vs. linear regression: chibar2	(01) = 17.69 Prob >= chibar2 = 0.0000
Performing EM optimization:	
Performing gradient-based optimization	:
Iteration 0: log likelihood = -1864. Iteration 1: log likelihood = -1864. Iteration 2: log likelihood = -1864.	0941
Computing standard errors:	
Mixed-effects ML regression Group variable: patientnumber	Number of obs = 481 Number of groups = 121
	Obs per group: $min = 3$ avg = 4.0 max = 4
Log likelihood = -1864.0941	Wald chi2(3) = 38.96 Prob > chi2 = 0.0000
ies_total   Coef. Std. > rval]	Err. z P> z  [95% Conf. Inte
case   8.005675 1.86	9929 4.28 0.000 4.340681 11.
> 67067 sample_time_0  1001732 .084	8207 -1.18 0.2382664187 .06
> 60723 sample_time_0_case  3540856 .120	7391 -2.93 0.003590729911
> 74414 _cons   3.085906 1.30 > 46194	
Random-effects Parameters   Estim	ate Std. Err. [95% Conf. Interval]
patientnum~r: Identity   5.619	027 .708911 4.388048 7.195333 age 28

#### Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH sd(Residual) | 10.61657 .3953091 9.869375 11.42033 LR test vs. linear regression: chibar2(01) = 28.51 Prob >= chibar2 = 0.0000Performing EM optimization: Performing gradient-based optimization: log likelihood = -1842.8422 log likelihood = -1842.8405 log likelihood = -1842.8405 Iteration 0: Iteration 1: Iteration 2: Computing standard errors: Number of obs Number of groups Mixed-effects ML regression 477 Group variable: patientnumber 120 Obs per group: min = 4.0 avg =max =Wald chi2(5) 56.14 Log likelihood = -1842.8405Prob > chi2 0.0000 Coef. Std. Err. P> | z | [95% Conf. Inte ies\_total | Z > rval] -------4.46 0.000 case | 8.119422 1.820061 4.552168 11. 68668 -1.210.227 -.2720541 .06 sample\_time\_0 | -.1037705 .0858606 > 45131 sample\_time\_0\_case | -.350508 .1217189 -2.880.004 -.5890726 -.11 > 19434 -.1537548 .0394927 -3.890.000 -.231159 -.07 age | > 63506 sex\_recode | 2.630557 1.367237 1.92 0.054 -.0491778 5.3 > 10292 \_cons | 11.09638 2.634836 4.21 0.000 5.932197 16.

:	> 26056								
	<del>-</del>								
							<b></b>		
	Random-effects	Parameters	- 1	Estimate	Std. Err	^.	[95% Conf.	Interv	all

Raffuolii-effects Fafailleters	Lacinate	3tu. Lii.		Incervary
patientnum~r: Identity sd(_cons)	4.956145	.7225625	3.724314	6.595409
sd(Residual)	10.6597	.3985116	9.906556	11.47009

LR test vs. linear regression: chibar2(01) = 19.14 Prob >= chibar2 = 0.0000

\*\*\*\*\*

hadstotal

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0:  $\log \text{likelihood} = -1726.5316$ Iteration 1:  $\log \text{likelihood} = -1726.5316$ 

# 

Mixed-effects Group variable	ML regression : patientnumber	•		Number o Number o	f obs f groups	=	482 121
				Obs per	group: m a m	in = vg = ax =	4.0 4
Log likelihood							7.40 0.0248
hadstotal	Coef.	Std. Err.	Z	P> z	[95%	conf.	
	-1.16148  1028044   12.66438	1.575716	-0.74 -2.62 10.82	0.461 0.009 0.000	-4.2498 17984 10.33	328 453 704	1.926867 0257635 14.95836
					<b>-</b>		
Random-effec	ts Parameters	Estimate	std	. Err.	[95% Cd	onf.	Interval]
patientnum~r:	Identity sd(_cons)	7.941439	.63	11198	6.82948	37	9.234436
	sd(Residual)	+	2 .257	72619	6.42292	 27	7.432271
LR test vs. li	near regression	: chibar2(01	L) = [	182.20 Pr	ob >= chi	ibar2	2 = 0.0000
Performing EM	optimization:						
Performing grad	dient-based opt	imization:					
Iteration 0: Iteration 1:	log likelihood log likelihood	= -1701.693 = -1701.693	16 16				
Computing stand	dard errors:						
Mixed-effects M Group variable	ML regression : patientnumber			Number of	f obs f groups	=	478 120
				Obs per (	av	n = /g = ix =	4.0 4
Log likelihood	= -1701.6936			Wald chi2 Prob > ch	2(4) ni2	= =	12.40 0.0146
hadstotal	Coef.	Std. Err.	Z	P>   z	[95% C	onf.	Interval]
case sample_time_0 age sex_recode _cons	0901591 .0170933 3.767328	.0386274	-2.33 0.37 2.37	0.478 0.020 0.709 0.018 0.001	16586 072	74 83 79	1.93459 0144508 .1070165 6.879418 15.41596
Random-effect	s Parameters	   Estimate	Std.	Err.	[95% Co	nf.	 Interval]
patientnum~r: ]	Identity sd(_cons)	+     7.758977	. 599	96749	6.66832	 7	9.02801
	sd(Residual)	+		7662	6.28347	4	7.275186

LR test vs. linear regression: chibar2(01) = 180.63 Prob >= chibar2 = 0.0000

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = -1726.0887
Iteration 1: log likelihood = -1726.0887

Computing standard errors:

Mixed-effects ML regression	Number of obs	=	482
Group variable: patientnumber	Number of groups	=	121

Obs per group: min = 3 avg = 4.0max = 4

		wald chi2(3)	=	8.30
Log	likelihood = -1726.0887	Prob > chi2	=	0.0402

hadstotal   rval]	Coef.	Std. Err.	Z	P> z	[95% Conf.	Inte
case	4082983	1.767359	-0.23	0.817	-3.872259	3.0
> 55662	000202	0551037	1 20	0 220	1744270	0.4
sample_time_0   > 19138	066262	.0551927	-1.20	0.230	1744378	. 04
sample_time_0_case	0739493	.078518	-0.94	0.346	2278418	.07
> 99433	12 20462	1 224550	0.06	0 000	0 074027	14
_cons   > .7143	12.29462	1.234558	9.96	0.000	9.874927	14
~ ./ ± / J						

----

Random-effects Parameters		Std. Err.	[95% Conf.	Interval]
patientnum~r: Identity   sd(_cons)	7.945449	.611154	6.833529	9.238294
sd(Residual)			6.414583	7.422623

LR test vs. linear regression: chibar2(01) = 182.79 Prob >= chibar2 = 0.0000

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = -1700.8577
Iteration 1: log likelihood = -1700.8577

Computing standard errors:

Mixed-effects ML regression	Number of obs	=	478
Group variable: patientnumber	Number of groups		120
	Obs per group: mir avç max	g =	4.0 4

Page 31

Wald chi2(5)

14.09

Appendix 8 1_IC Log likelihood = -1700.8577		Prob	> chi2	=		0150
hadstotal   Coe	f. Std. Err.	Z	P>   Z	[95%	Conf.	
case  08156	26 1.735027	-0.05	0.963	-3.482	153	3.3
> 19027 sample_time_0  04043	71 .0544016	-0.74	0.457	1470	622	. 0
> 66188 sample_time_0_case  09977	.0770674	-1.29	0.195	2508	236	.05
> 12753 age   .0172	.0458941	0.38	0.707	0726	947	.10
> 72066 sex_recode   3.76678	1.588308	2.37	0.018	.6537	604	6.8
> 79813 _cons   9.19704 > 95741						
Random-effects Parameters						/al]
<pre>patientnum~r: Identity      sd(_cons)</pre>						
sd(Residual)	<del></del>					
LR test vs. linear regression	: chibar2(01)	= 181.71	Prob >=	chibar2	= 0.0	0000
*************** Ciq_total ******						
Performing EM optimization:						
Performing gradient-based opti	mization:					
Iteration 0: log likelihood Iteration 1: log likelihood	= -1438.9397 = -1438.9397					
Computing standard errors:						
Mixed-effects ML regression Group variable: patientnumber		Number Number	r of obs r of grou	= ups =		482 121
		Obs pe	er group	: min = avg = max =		4.0 4
Log likelihood = -1438.9397		Wald o	chi2(2) · chi2	= =	0.2	.96 274
ciq_total   Coef. S	Std. Err.	z P> z		5% Conf.	Inter	val]
case   -1.23659 . sample_time_0   .0244224 . _cons   16.21077 .	<b></b>					
Random-effects Parameters	Estimate	Std. Err.	[95%	6 Conf. I	interv	al]

patientnum~r:	Appendix 8 1_IC	CU_mixed_model	_reg	ression_TH	HESIS_TE	СН	
pacrenchum~r.	sd(_cons)	5.074748	.37	02536	4.3985	63	5.854882
	sd(Residual)	3.650959	.13	59645	3.3939	67	3.927411
LR test vs. li	near regression	: chibar2(01)	=	253.02 Pro	ob >= ch	ibar2	= 0.0000
Performing EM	optimization:						
Performing gra	dient-based opt	imization:					
Iteration 0: Iteration 1:	log likelihood log likelihood	= -1416.8464 = -1416.8464					
Computing stan	dard errors:						
Mixed-effects Group variable	ML regression : patientnumber			Number of	f obs f groups	=	478 120
				Obs per o	a		4.0 $4$
Log likelihood	= -1416.8464			Wald chiz Prob > ch	2(4) ni 2	=	29.27 0.0000
ciq_total	Coef.	Std. Err.	z	P> z	[95%	conf.	Interval]
case sample_time_0 age	-1.066886 .0260236 1342854 1.555673 23.46091	.8975183 -1 .0209226 1 .0266191 -5	.19	0.235 0.214 0.000	-2.82 0149 186	 599 839 458	.6922177 .0670311 0821129
_cons	23.46091	1.687254 13	.90	0.000	20.15	395 	26.76786
Random-effec	ts Parameters	Estimate +- <b></b>	Std 	. Err. 	[95% C	onf. 	Interval] 
patientnum~r:	Identity sd(_cons) 	   4.556441 	.34	37728 	3.9301	09	5.28259
	sd(Residual)			69542 	3.4032		3.94055
LR test vs. li	near regression	: chibar2(01)	= :	207.78 Pro	ob >= ch	ibar2	= 0.0000
Performing EM	optimization:						
Performing gradient-based optimization:							
Iteration 0: Iteration 1:	log likelihood log likelihood	= -1438.8299 = -1438.8299					
Computing stan	dard errors:						
Mixed-effects Group variable	ML regression : patientnumber			Number of Number of		=	482 121
				Obs per g	av	in = vg = ax =	4.0 4
Log likelihood	= -1438.8299			Wald chi2 Prob > ch	(3) ii2	= =	3.18 0.3643

#### Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH ciq\_total | coef. Std. Err. P> | z | [95% Conf. Inte Z > rvall -1.34case -1.434873 1.068642 0.179-3.529373 > 96268 sample\_time\_0 | .0147988 .0291972 0.51 0.612 -.0424267 .07 > 20244 sample\_time\_0\_case | > 08725 .0194701 .0415326 0.47 0.639 -.0619323 .10 .746422 \_cons | 16.30813 21.85 0.000 14.84517 17. > 77109 Random-effects Parameters | Estimate Std. Err. [95% Conf. Interval] patientnum~r: Identity 5.076223 .3703172 4.399916 sd(\_cons) | 5.856484 3.649587 .1359151 3.392688 3.925939 sd(Residual) | LR test vs. linear regression: chibar2(01) = 253.23 Prob >= chibar2 = 0.0000Performing EM optimization: Performing gradient-based optimization: log likelihood = -1416.7692 log likelihood = -1416.7692 Iteration 0: Iteration 1: Computing standard errors: Number of obs Number of groups Mixed-effects ML regression Group variable: patientnumber Obs per group: min = avg =4.0 max =Wald chi2(5) 29.41 = Log likelihood = -1416.7692Prob > chi2 0.0000 ciq\_total | Coef. Std. Err. Z P> | Z | [95% Conf. Inte > rval] \_\_\_\_\_ -1.240.214 -1.23424.993604 case -3.181668 . 7 > 13188 sample\_time\_0 | .0178312 .0295316 0.60 0.546 -.0400496 .07 > 57119 sample\_time\_0\_case | .0164378 .0418339 0.39 0.694 -.0655551 .09 > 84307 age -.1343124 .0266239 -5.040.000 -.1864944 -.08 > 21304 sex\_recode | 1.555772 .9213927 1.690.091 -.2501249 3.3

-----

1.70116

23.54534

\_cons |

13.84

0.000

20.21112

26.

61668

> 87955

Appendix 8 1_ICU_ Random-effects Parameters	_mixed_model_re Estimate S	egression_T td. Err.	HESIS_TECH [95% Conf.	Interval]
in a sub-construction of the s				
sd(_cons)    sd(Residual)	3.661035	1369183	3.402279	3.93947
LR test vs. linear regression:	chibar2(01) =	207.93 Pr	ob >= chibar	2 = 0.0000
***************** fim *******				
Performing EM optimization:				
Performing gradient-based optim	ization:			
<pre>Iteration 0: log likelihood = Iteration 1: log likelihood =</pre>	-1574.7851 -1574.7851			
Computing standard errors:				
Mixed-effects ML regression Group variable: patientnumber			f obs = f groups =	
		Obs per	group: min = avg = max =	$4.0\\4$
Log likelihood = -1574.7851		Wald chi Prob > c	2(2) = hi2 =	5.48 0.0647
fim   Coef. St	d. Err. z	P>   z	[95% Conf.	. Interval]
case  431994 1. sample_time_0  0617567 .0 _cons   121.7938 1.	439643 -0.30 266153 -2.32 040942 117.00	0.764 2 0.020 0.000	-3.253643 1139218 119.7536	2.389655 0095917 123.834
		- <b></b>		
Random-effects Parameters	Estimate S1			
patientnum~r: Identity   sd(_cons)	7.560329 .5	392442	6.57398	8.69467
sd(Residual)	4.67757 .1	L746838	4.347425	5.032785
LR test vs. linear regression:	chibar2(01) =	295.24 Pr	ob >= chibar2	2 = 0.0000
Performing EM optimization:				
Performing gradient-based optim	ization:			
<pre>Iteration 0: log likelihood = Iteration 1: log likelihood =</pre>	-1557.9393 -1557.9393			
Computing standard errors:				
Mixed-effects ML regression Group variable: patientnumber		Number o	f obs = f groups =	478 120
		Obs per	group: min = avg = max =	4.0

Appendix 8 1_ICU	_mixed_model	_regression	_THESIS_T	ECH	17.00
Log likelihood = -1557.9393		Prob :	chi2(4) > chi2	=	0.0019
fim   Coef. S1	d. Err.	z P> z	[95%	Conf.	Interval]
case  2556776 1. sample_time_0  061964 .0 age  1283738 .0 sex_recode  9867701 1cons   129.8607 2.	.385284 -0 )268308 -2 )410873 -3 ,421894 -0 ,597877 49	.18 0.854 .31 0.02 .12 0.000 .69 0.488 .99 0.000	4 -2.97 1114 2208 3 -3.77 0 124.	0784 5513 9034 3632 7689	2.459429 0093767 0478443 1.800092 134.9524
Random-effects Parameters	Estimate	Std. Err.	[95%	 Conf. I	nterval]
patientnum~r: Identity   sd(_cons)	7.207379	.5217254	6.254	043	8.306037
sd(Residual)	4.69572	.1761399	4.362	 877	5.053955
LR test vs. linear regression:	chibar2(01)	= 270.49	Prob >= c	hibar2	= 0.0000
Performing EM optimization:					
Performing gradient-based optim	nization:				
Iteration 0: log likelihood = Iteration 1: log likelihood =	-1574.7851 -1574.7851				
Computing standard errors:					
Mixed-effects ML regression Group variable: patientnumber			of obs of group		
		Obs pe		min = avg = max =	
Log likelihood = -1574.7851		Wald o Prob >	chi2(3) · chi2	=	5.48 0.1400
fim   Coef.					
case  4369989	1.538349	-0.28	0.776 -	-3.4521	07 2.5
> 78109 sample_time_0  0619997	.0374254	-1.66	0.098 -	13535	22 .01
> 13527 sample_time_0_case   .0004915	.053234	0.01	0.993 -	10384	52 .10
> 48282 _cons   121.7963	1.074443	113.36	0.000	119.69	04 123
> .9021			<b></b>		
Random-effects Parameters	Estimate	Std. Err.	[95% (	Conf. I	nterval]
<pre>patientnum~r: Identity</pre>	7.560389				
sd(Residual)		<del></del>			

Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH LR test vs. linear regression: chibar2(01) = 295.09 Prob >= chibar2 = 0.0000 Performing EM optimization: Performing gradient-based optimization: log likelihood = -1557.9392
log likelihood = -1557.9392 Iteration 0: Iteration 1: Computing standard errors: Mixed-effects ML regression Number of obs 478 Number of groups = Group variable: patientnumber 120 Obs per group: min = 4.0 avg = max =Wald chi2(5) 17.09 = Log likelihood = -1557.9392Prob > chi2 0.0043 coef. fim | Std. Err. z P > |z|[95% Conf. Inte > rvall case | -.2649294 1.489135 -0.180.859 -3.18358 2.6 53721 sample\_time\_0 | -.0624171 .0378844 -1.650.099 -.1366691 .0 11835 sample\_time\_0\_case | .0009089 .0536616 0.02 0.986 -.1042659 . 10 60836 age | -.1283753 .0410879 -3.120.002 -.2089061 -.04 > 78445 sex\_recode | -.986765 1.421913 -0.690.488 -3.773664 1.8 00134 \_cons | 129.8653 2.612492 49.71 0.000 124.7449 134 .9857 Random-effects Parameters | Estimate Std. Err. [95% Conf. Interval] patientnum~r: Identity sd(\_cons) | 7.207489 .5217714 6.254073 8.306249 sd(Residual) | 4.695697 .1761434 4.362848 5.053939 LR test vs. linear regression: chibar2(01) = 270.36 Prob >= chibar2 = 0.0000

\*\*\*\*\*\*\*\*\*\*\* \* ALL CASES \*\*\*\*\*

use "Marsden\_ICU\_ALL\_data\_CLEAN\_v2", clear

capture drop <u>0000</u>\*

set more off

```
Appendix 8 1_ICU_mixed_model_regression_THESIS_TECH
                  /* Generate terms for Mixed model analyses
    drop if episodenumber<=3
(429 observations deleted)
    gen case_time=case*sample_time
                                                           /* create interaction
   term for case and sample time
    gen sample_time_0=sample_time-1
                                                           /* start sample time
> at zero
    gen sample_time_0_case=sample_time_0*case
                                                  /* interaction term
    gen ln_time=ln(sample_time)
                                                           /* log time (linear m
 ode;)
    gen ln_time_case=ln_time*case
                                                           /* ln(time) interacti
 on */
    gen sample_time_6=sample_time-6
                                                           /* sets 6 month sampl
 ing time to O
                    - can be used to compare changes relative to 6 months
    gen case_sample_time_6=sample_time_6*case
   foreach var of varlist digitspanadjusted lnagescaledscore stroop_ratio trail
  s_inseconds ///
                  sf36v2mcs sf36v2pcs iesravoidance iesrhyperarousal iesrinter
 ruptions ies_total ///
                  hadstotal cig_total fim {
  2
                     display ""
display "***************
  3.
                     display "`var'"
display "*****************
  4.
  5.
                     xtmixed `var' case sample_time_0 || patientnumber:
  6.
                     xtmixed var' case sample_time_0 age sex_recode ||
                                                                         patien
 tnumber:
                     xtmixed `var' case sample_time_0 sample_time_0_case ||
 tientnumber:
                     xtmixed `var' case sample_time_0 sample_time_0_case age se
  9.
               patientnumber:
 x_recode ||
 10.
******
digitspanadjusted
   ****
Performing EM optimization:
Performing gradient-based optimization:
Iteration 0:
               log likelihood = -1153.7469
               \log likelihood = -1153.7469
Iteration 1:
Computing standard errors:
                                                Number of obs
Mixed-effects ML regression
                                                                            480
Group variable: patientnumber
                                                Number of groups
                                                                           129
                                                Obs per group: min =
                                                               avg =
                                                               max =
                                                Wald chi2(2)
                                                                          3.50
                                     Page 38
```

Appendix 8 1_ICU_mixed Log likelihood = -1153.7469		Prob > ch	i2 =	
digitspanadjusted   Coef. Std	. Err.	z P>  <i>z</i>		onf. Inter
case  8350017 .51 > 3973	47925 -1	.62 0.10	5 -1.84397	76 .17
sample_time_0  011223 .01 > 8938	57005 27	.17 0.00	0 9.72520	58 11.2
Random-effects Parameters   Est	imate Std	. Frr.	[95% Conf. ]	[ntervall
patientnum~r: Identity sd(_cons) 2.7	07692 .19	80045	2.346139	3.124963
sd(Residual)   2.0				
LR test vs. linear regression: chiba	r2(01) =	223.73 Pro	b >= chibar2	= 0.0000
Performing EM optimization:				
Performing gradient-based optimization	on:			
<pre>Iteration 0: log likelihood = -114 Iteration 1: log likelihood = -114</pre>	3.9688 3.9688			
Computing standard errors:				
Mixed-effects ML regression Group variable: patientnumber		Number of Number of	obs = groups =	476 128
		Obs per g	roup: min = avg = max =	$3.\overset{1}{\underset{4}{7}}$
Log likelihood = -1143.9688			(4) = i2 =	
digitspanadjusted   Coef. Std > val]				
case  8776711 .51				
> 3092 sample_time_0  0100703 .01				6 .01
> 3184 age  0090146 .01				9 .021
> 1438 sex_recode   .3351473 .520				8 1.36
> 7625 _cons   10.91742 .979				
> 3724				
Random-effects Parameters   Est	imate Std. Page 39	. Err.	[95% Conf. I	nterval]

Annendiv	R	1	TCH	mived	Labou	_rearession	THESTS	TECH
ADDENUIX	0		TCU	III I X E U	mouer	1 601 622 1011	ILESTS	I EU.H

Appendix 8 1_ICU_mixed_model_	regression_THESIS_TECH
patientnum~r: Identity   sd(_cons)   2.688682	.1979412 2.327415 3.106025
	.0778794 1.904405 2.209969
LR test vs. linear regression: chibar2(01) =	= 218.51 Prob >= chibar2 = 0.0000
Performing EM optimization:	
Performing gradient-based optimization:	
Iteration 0: log likelihood = -1153.6302 Iteration 1: log likelihood = -1153.6302	
Computing standard errors:	
Mixed-effects ML regression Group variable: patientnumber	Number of obs $=$ 480 Number of groups $=$ 129
	Obs per group: $min = 0.05$ avg = 0.7 max = 0.4
Log likelihood = -1153.6302	Wald chi2(3) = 3.73 Prob > chi2 = 0.2919
digitspanadjusted   Coef. Std. Err.	z P> z  [95% Conf. Inte
case  9463842 .5640612	
> 91554 sample_time_0  0168608 .0165845	
> 56443 sample_time_0_case   .011398 .0235822	0.48 0.6290348221 .05
> 76182 _cons   10.53789 .4031369 > 32803	
Random-effects Parameters   Estimate	Std. Err. [95% Conf. Interval]
patientnum~r: Identity   sd(_cons)   2.708011	.19802 2.346428 3.125313
sd(Residual)   2.047554	.0773949 1.901345 2.205005
LR test vs. linear regression: chibar2(01) =	223.86 Prob >= chibar2 = 0.0000
Performing EM optimization:	
Performing gradient-based optimization:	
<pre>Iteration 0: log likelihood = -1143.8972 Iteration 1: log likelihood = -1143.8972</pre>	
Computing standard errors:	
Mixed-effects ML regression Group variable: patientnumber	Number of obs = 476 Number of groups = 128
	Obs per group: min = 1

А	Appendix 8 1_I	CU_mixed_mod	le1_regress	sion_THES	IS_TECH avg = max =	3.7
Log likelihood =			Pr	ob > chi2	=	4.49 0.4814
 digitspanadjust		ef. Std. E	rr. z	P>   z	[95%	Conf. Inte
ca > 12329 sample_time	ase  96540		23 -1.7		-2.07	
> 82921 sample_time_0_ca > 55472	ase   .00897	776 .0237	22 0.3	8 0.705	037	5168 .0
> 11376	age  0090					1816 .02
> 67794 _cc > 89704	ode   .33527 ons   10.962	.986869	99 11.1	1 0.000	9.02	
Random-effects	s Parameters	Estimate	e Std. E	rr. [	95% Conf.	Interval]
patientnum~r: Ic	sd(_cons)	2.688906	5 .1979	56 2	.327612	3.106281
	sd(Residual)	2.051054	.07786	43 1	.903982	2.209486
LR test vs. line	ear regression	: chibar2(01	L) = 218	.59 Prob	>= chibar	2 = 0.0000
**************************************						
Performing EM op	otimization:					
Performing gradi	ient-based opt	imization:				
Iteration 0: 1 Iteration 1: 1	log likelihood log likelihood	= -1130.913   = -1130.913	35 35			
Computing standa						
Mixed-effects ML Group variable:	_ regression patientnumber		Nur Nur	mber of ol mber of g	bs = roups =	449 123
			Obs	s per gro	up: min = avg = max =	3. <sub>7</sub>
Log likelihood =						4.96 0.0838
lnagescaledscore		Std. Err.	Z	P> z	Г95% со	

Appendix 8 1_ICU_ case  8625739 > 622	_mixed_model .5742127	_regress -1.50	oion_TH 0.133	ESIS_TECH -1.988	01 .2628
sample_time_0   .0224689 > 685	.013886	1.62	0.106	00474	.049
_cons   8.750552 > 453	.4412843	19.83	0.000	7.8856	51 9.615
Random-effects Parameters	Estimate	Std. Er	rr. 	[95% Conf.	Interval]
patientnum~r: Identity   sd(_cons)   					
sd(Residual)	2.320554	.090724	41 	2.14938	2.50536
LR test vs. linear regression:	chibar2(01)	= 194.	.57 Pro	b >= chibar	2 = 0.0000
Performing EM optimization:					
Performing gradient-based optim	ization:				
<pre>Iteration 0: log likelihood = Iteration 1: log likelihood =</pre>	-1130.5386 -1130.5386				
Computing standard errors:					
Mixed-effects ML regression Group variable: patientnumber		Nun Nun	nber of nber of	obs = groups =	449 123
		Obs	s per g	roup: min = avg =	3.7
				max =	4
Log likelihood = -1130.5386		Wal Pro	ld chi2 bb > ch	(4) = i2 =	5.73 0.2205
lnagescaledscore   Coef.	 Std. Err.				
case  8492644 > 733					
	.0138881	1.60	0.109	004939	96 .0495
age  0073659 > 066	.0169761	-0.43	0.664	040638	.0259
sex_recode   .4798845 > 085	.5853169	0.82	0.412	667315	55 1.627
_cons   8.974368 > 265	1.075672	8.34	0.000	6.8660	09 11.08
		<del></del>			
Random-effects Parameters	Estimate	Std. Er	r.	[95% Conf.	Interval]
patientnum~r: Identity   sd(_cons)					
sd(_cons)   					
LR test vs. linear regression: (	<del> </del>				
LK Lest vs. Timear regression: (	CITIDALZ (OT)	= 193.	22 FLOI	) >= CIIIDdf2	: = 0.0000

# $\label{lem:condition} \mbox{Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH} \\ \mbox{Performing EM optimization:}$

Porforming	gradient-based	ontimization:
Periormina	uraurent-baseu	optimization:

Iteration	0:	log	likelihood	=	-1128.7105
Iteration	1:	log	likelihood	=	-1128.7105

### Computing standard errors:

Mixed-effects ML regression Group variable: patientnumber	Numb Numb	er of obs er of grou	= ps =	449 123	
		0bs	per group:	min = avg = max =	$3.7\\4$
Log likelihood = -1128.7105			chi2(3) > chi2	= =	9.43 0.0241
lnagescaledscore   Coef.	Std. Err.			[95% c	Conf. Inte
case   -1.425826	. 6326032	-2.25	0.024	-2.6657	'061
sample_time_0  0071683	.019709	-0.36	0.716	04579	.03
> 14607 sample_time_0_case   .0581167 > 22271	.0276079	2.11	0.035	.00400	.11
_cons   9.047758 > 95418	.4624684	19.56	0.000	8.1413	9.

Random-effects Parameters	Estimate	Std. Err.	[95% Conf.	Interval]
patientnum~r: Identity sd(_cons)	2.911847	.2201676	2.510779	3.376982
sd(Residual)	2.306323	.0901575	2.136217	2.489974

LR test vs. linear regression: chibar2(01) = 196.76 Prob >= chibar2 = 0.0000

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = -1128.3375
Iteration 1: log likelihood = -1128.3375

### Computing standard errors:

Mixed-effects ML regression	Number of obs	= =	449
Group variable: patientnumber	Number of groups		123
		in = /g = ax =	$\begin{array}{c} 1\\ 3.7\\ 4 \end{array}$
Log likelihood = -1128.3375	Wald chi2(5)	=	10.19
	Prob > chi2	=	0.0699

\_\_\_\_\_

### Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH

	ore   Coe				_		
 C	ase   -1.4125					3083	
> 20421 sample_tim	e_0  00734	.01971	-0.37	0.710	04	5972	.03
> 12897 sample_time_0_c	ase   .05809	04 .0276071	2.10	0.035	.003	9814	.11
> 21994	age  00726	86 .0169498	-0.43	0.668	040	4895	.02
> 59524 sex_rec	ode   .47878	25 .5843933	0.82	0.413	666	6073	1.6
> 24172 c	ons   9.266	21 1.082836	8.56	0.000	7.14	3891	11.
> 38853							
	s Parameters						
patientnum~r: I	dentity sd(_cons)	+     2.901451					
	sd(Residual)	+					
LR test vs. line							
**************************************	****						
Performing EM o							
Performing grad	•						
Iteration 0: Iteration 1:	log likelihood log likelihood	= -284.99002 = -284.99002					
Computing standa	ard errors:						
Mixed-effects MI Group variable:	L regression patientnumber			r of obs r of gro			406 110
			Obs pe	er group	: min = avg = max =		3.7 $4$
Log likelihood =	= -284.99002		Wald o	chi2(2) > chi2	<del>=</del> =	0.2	.53 820
stroop_ratio	Coef.	Std. Err.	z P> z	[9	5% Conf.	Inter	val]
case   sample_time_0   _cons	.0121019 003941 .9889318	.0858622 ( .0024895 - 2 .0649509 15	0.14 0.888 1.58 0.113 5.23 0.000	315 300 ) .86	561849 088203 616305	.180 .000 1.11	3888 9383 .6233
Random-effects	s Parameters	Estimate	Std. Err.	[95%	Conf.	Interv	 al]
patientnum~r: I	dentity sd(_cons)		.0352342	.33	33197 	.4720	117

	Appendix 8 1_1 sd(Residual)	CU_mixed_mode   .3970632	el_reg	ression_TH 16392	ESIS_TEC .366200	H 8	. 4305265
LR test vs. li	near regression	n: chibar2(01	) =	105.33 Pro	ob >= chi	bar2	= 0.0000
Performing EM	optimization:						
Performing grad	dient-based op	timization:					
Iteration 0: Iteration 1:	log likelihood log likelihood	d = -277.4196 d = -277.4196	8 8				
Computing stand	dard errors:						
Mixed-effects M Group variable	ML regression : patientnumbe	r		Number of Number of	obs groups	=	406 110
				Obs per g	av	n = g = x =	3.7 4
Log likelihood	= -277.41968			Wald chi2 Prob > ch	2(4) 112	=======================================	18.68 0.0009
stroop_ratio	Coef.	Std. Err.	 Z	P>   Z	95% C	onf.	Interval]
case sample_time_0 age sex_recode	0188792 0039338 .009194 .0350859	.0807454 .002486 .0023849 .0820457	-0.23 -1.58 3.86 0.43		17713 00880 .00451	73 63 97 07	
Random-effect	s Parameters	Estimate	Std	. Err.	[95% Coi	1f. I	nterval]
patientnum~r:	<pre>Identity     sd(_cons)</pre>	.3636983					
	sd(Residual)	.3966676	.01	63547	.36587	4	.4300531
LR test vs. lir	near regression	n: chibar2(01)	) =	88.10 Pro	b >= chil	oar2	= 0.0000
Performing EM o	optimization:						
Performing grad	lient-based opt	imization:					
Iteration 0: Iteration 1:	log likelihood log likelihood						
Computing stand	dard errors:						
Mixed-effects M Group variable:	ML regression patientnumber	,		Number of Number of	obs groups	= =	406 110
				Obs per g	roup: mir avç max	) = J = ( =	3.7 4
Log likelihood	= -284.98432			Wald chi2 Prob > ch	(3) i2	<b>=</b> <b>=</b>	2.54 0.4675
stroop_ra	ntio   Coe	ef. Std. Err Page		z P>	z  [9	 95% C	onf. Inte

Арре	ndix 8 1_IC	CU_mixed_mode	l_regressio	on_THESIS	S_TECH	
case > 12556 sample_time_0	•	.098935 .0034269		0.861		
<pre>&gt; 30271 sample_time_0_case &gt; 92407</pre>	00053		-0.11	0.915		
> 12195						
Random-effects Pa	rameters	Estimate	Std. Err	. [95	5% Conf. Inte	rval]
patientnum~r: Ident	itv	.3966291				
	Residual)	.397042	.016392	.36	61799 .43	05053
LR test vs. linear	regression	: chibar2(01)	= 105.3	4 Prob >=	= chibar2 = 0	.0000
Performing EM optim	ization:					
Performing gradient	-based opt	imization:				
Iteration 0: log Iteration 1: log	likelihood likelihood	= -277.41071 = -277.41071				
Computing standard	errors:					
Mixed-effects ML re Group variable: pat	gression ientnumber		Numb Numb	er of obs er of gro	s = oups =	406 110
			Obs	per group	o: min = avg = max =	3.7 4
Log likelihood = -2					= 0	
stroop_ratio	Coef		. z	P> z	[95% Conf	. Inte
 case		. 0944853				
> 28794 sample_time_0	003618	.0034227	-1.06	0.290	0103269	.00
> 30898 sample_time_0_case	00066	.0049785	-0.13	0.893	0104246	.00
> 90906 age	.00919	.0023852	3.86	0.000	.004522	.01
> 38719 sex_recode	.035118	.082053	0.43	0.669	1257025	.19
> 29983		.1522809			.1360681	

Random-effects Parameters | Estimate Std. Err. [95% Conf. Interval] patientnum~r: Identity

	Appen	dix 8 1_IC sd(_cons)	U_mixed_mode .3637466	l_regres .03359	sion_TH 012	ESIS_TECH .3035236	.435918	37
	sd(F	+ Residual)	.3966433	.0163	543	.3658505	.430027	'9
LR test vs. li	near r	regression:	chibar2(01)	= 88	3.12 Pro	b >= chiba	ir2 = 0.000	00
************ trails_insecon *****	ıds							
Performing EM	optimi	zation:						
Performing gra	dient-	-based opti	mization:					
Iteration 0: Iteration 1:	log l log l	likelihood likelihood	= -2336.5537 = -2336.5537					
Computing stan	dard e	errors:						
Mixed-effects Group variable	ML reç	ression entnumber		Nu Nu	ımber of ımber of	obs groups	= 40 = 11	
				Ob	s per g	roup: min avg max	= = = 3.	-
Log likelihood							= 4.8 = 0.089	3 3
trails_insecon > al]	ds	Coef.	Std. Err.	z	P> z	[95%	Conf. Inte	rv 
			15.16477					86
> 208 sample_time	_0	.5832612	.3508025	1.66	0.096	104	299 1.27	70
> 041			11.17943		0.000		815 152	. 3
		amotors				[05% Conf	Tntoryal	- 1
patientnum~r:		•	Estimate 					
	S	d(_cons)	74.22288	5.9068	77 	63.50335	86.75189	9
	sd(R	esidual)	55.84376	2.3036	46 	51.5064	60.54637	7
LR test vs. li	near r	egression:	chibar2(01)	= 185	.71 Prol	o >= chiba	r2 = 0.0000	Э
Performing EM	optimi	zation:						
Performing gra	dient-	based opti	mization:					
Iteration 0: Iteration 1:	log l log l	ikelihood ikelihood	= -2324.6956 = -2324.6956					
Computing stan	dard e	rrors:						
Mixed-effects Group variable	ML reg : pati	ression entnumber		Nu Nu	mber of mber of	obs = groups =	= 409 = 112	_
			D000 A		s per gi	roup: min :	= 1	L
			Page 4	1				

Appendix 8 1_IC	U_mixed_mode	l_regressio	on_THES	avg =	3.7
Log likelihood = -2324.6956				= =	
trails_inseconds   Coef.	Std. Err.	z	P>   z	[95% Co	onf. Interv
case   15.24345 > 159 sample_time_0   .5988361	13.69828	1.11		-11.6046	69 42.09
> 139 age   2.0679 > 451	. 4028395	5.13		1.27834	
sex_recode   -12.24019 > 279 cons   14.33476					
> 959 					
Random-effects Parameters	Estimate	Std. Err	· [	 95% Conf.	Interval]
patientnum~r: Identity   sd(_cons)	65.39863	5.421774	5	5.59057	76.93718
sd(Residual)	55.8524	2.303259	5	 1.51571	60.55416
LR test vs. linear regression:	chibar2(01)	= 148.09	9 Prob	>= chibar2	= 0.0000
Performing EM optimization:					
Performing gradient-based opti	mization:				
Iteration 0: log likelihood Iteration 1: log likelihood	= -2336.2664 = -2336.2664				
Computing standard errors:					
Mixed-effects ML regression Group variable: patientnumber		Numbe Numbe	er of ol er of g	bs = roups =	409 112
		Obs p	oer gro	up: min = avg = max =	$3.\overset{1}{\underset{4}{7}}$
Log likelihood = -2336.2664				) = =	
trails_inseconds   Coef	. Std. Err.	. Z	P> z	Γ95%	Conf. Inte
	9 16.61925				
sample_time_0   .330017 > 1.279	4 .4841838	0.68	0.495	6189	653
sample_time_0_case   .532204 > 07783	8 .7018383	0.76	0.448	843	373 1.9
	Page 4	8			

Random-effects Parameters	FStimate	<b>-</b> Std Frr.	[95% Conf Interval]

Random-effects Parameters	Estimate	Std. Err.	[95% Conf.	Interval
patientnum~r: Identity sd(_cons)	74.20187	5.903441	63.48834	86.7233
sd(Residual)	55.79739	2.301623	51.46383	60.49586

LR test vs. linear regression: chibar2(01) = 185.95 Prob >= chibar2 = 0.0000

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = -2324.4334
Iteration 1: log likelihood = -2324.4334

Computing standard errors:

Group variable: pacterialiser	Obs. non anount min	112
Mixed-effects ML regression Group variable: patientnumber	Number of obs = Number of groups =	409 112

trails_inseconds > rval]		Coef.	Std. Err.	Z	P> z	[95% Conf.	Inte
	+-						
case > 28858		10.30985	15.29555	0.67	0.500	-19.66888	40.
sample_time_0 > 05717		.3569069	.4840957	0.74	0.461	5919033	1.3
sample_time_0_case > 82621		.5080547	.7013225	0.72	0.469	8665122	1.8
age	1	2.065307	.402793	5.13	0.000	1.275848	2.8
> 54767 sex_recode > 01298	1	-12.22577	13.89758	-0.88	0.379	-39.46452	15.
_cons	1	16.90774	25.7836	0.66	0.512	-33.62719	67.

-----

Random-effects Parameters		Std. Err.	[95% Conf.	Interval]
patientnum~r: Identity     sd(_cons)	65.39758	5.419672	55.59303	76.93129
sd(Residual)	55.80646	2.301305	51.47345	60.50422

LR test vs. linear regression: chibar2(01) = 148.34 Prob >= chibar2 = 0.0000

\*\*\*\*\*\*

sf36v2mcs

> 44266

### Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = -1874.8926
Iteration 1: log likelihood = -1874.8926

Computing standard errors:

Mixed-effects ML regression Group variable: patientnumber	Number of obs Number of groups	=	479 127
	Obs per group: mir avo max	=	3.8 4
7.11. 7.11. 1. 40.74.000.6	wald chi2(2)	=	2.82

Log likelihood = -1874.8926

sf36v2mcs	Coef.	Std. Err.	z	P>   z	 [95% Conf.	Interval]
case	5357125	2.056316	-0.26	0.794	-4.566018	3.494593
sample_time_0	.0941027	.0567383	1.66	0.097	0171023	.2053078
_cons	48.24276	1.598177	30.19	0.000	45.11039	51.37513

Prob > chi2

Number of obs

0.2436

479

Random-effects Parameters	Estimate	Std. Err.	[95% Conf.	Interval]
patientnum~r: Identity sd(_cons)	10.34722	.8284659	8.84445	12.10532
sd(Residual)	9.755631	.3693739	9.057882	10.50713

LR test vs. linear regression: chibar2(01) = 143.89 Prob >= chibar2 = 0.0000

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = -1873.1938
Iteration 1: log likelihood = -1873.1938

Computing standard errors:

Mixed-effects ML regression

Group variable: patientnumber	Number of groups =	127
	Obs per group: min = avg = max =	3.8
Log likelihood = -1873.1938	Wald chi2(4) = Prob > chi2 =	0.20

sf36v2mcs	Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
case sample_time_0 age sex_recode _cons	5401894 .0947141 .0345554 -3.82433 47.86945	2.032297 .0567332 .0599717 2.076599 3.853315	-0.27 1.67 0.58 -1.84 12.42	0.790 0.095 0.564 0.066 0.000	-4.523418 0164809 0829869 -7.89439 40.31709	3.443039 .2059091 .1520977 .2457291 55.42181

Random-effects Parameters	Estimate	Std. Err.	[95%	 6 Conf.	Interval]
patientnum~r: Identity	10.1797				
sd(Residual)	9.754481	.3692832	9.	0569	10.50579
LR test vs. linear regression	: chibar2(01)	= 139.13	Prob >=	chibara	2 = 0.0000
Performing EM optimization:					
Performing gradient-based opt	imization:				
Iteration 0: log likelihood Iteration 1: log likelihood	= -1874.8905 = -1874.8905				
Computing standard errors:					
Mixed-effects ML regression Group variable: patientnumber		Numbe Numbe	r of obs r of grou	= ips =	479 127
		Obs p	er group:	min = avg = max =	3.8
Log likelihood = -1874.8905					2.83 0.4188
	f. Std. Err.	z	P> z	[95%	
	63 2.331431				7417 3.9
sample_time_0   .09016 > 18494	.0824923	1.09	0.274	0715	.25
sample_time_0_case   .0074	76 4436453				
	/6 .1136452	0.07	0.948	2152	2645 .23
> 02166 _cons   48.281 > .6172			0.948		
> 02166 _cons   48.281					
> 02166 _cons   48.281	25 1.702047	28.37	0.000	44.9	9453 51 
> 02166cons   48.2813 > .6172 Random-effects Parameters patientnum~r: Identity sd(_cons)	25 1.702047	28.37	0.000	44.9  Conf.	0453 51   Interval]
> 02166cons   48.2813 > .6172	25 1.702047 	28.37 	0.000  [95% 8.84	44.9  Conf. 	0453 51  Interval]  12.10432
> 02166cons   48.2813 > .6172 Random-effects Parameters patientnum~r: Identitysd(_cons)	25 1.702047 	28.37 	0.000  [95%  8.84 9.0	44.9  Conf.  2356  5813	12.10432 10.50763
> 02166cons   48.2813 > .6172 Random-effects Parameters patientnum~r: Identitysd(_cons)sd(Residual)	25 1.702047 	28.37 	0.000  [95%  8.84 9.0	44.9  Conf.  2356  5813	12.10432 10.50763

Computing standard errors:

Iteration 0:
Iteration 1:

log likelihood = -1873.1912
log likelihood = -1873.1912

Appendix 8 1_ICU_mixed_model_r Mixed-effects ML regression Group variable: patientnumber	- Number of obs	= 479				
	Obs per group	min = 1 avg = 3.8 max = 4				
Log likelihood = -1873.1912		= 6.29 = 0.2790				
sf36v2mcs   Coef. Std. Err. > rval]	z P> z	[95% Conf. Inte				
case  6185518 2.310124	-0.27 0.789	-5.146311 3.9				
> 09208 sample_time_0   .0904416 .0824841						
> 21074 sample_time_0_case   .0081162 .1136204	0.07 0.943	2145757 .23				
> 08082 age   .0345427 .0599639	0.58 0.565	0829843 .15				
> 20697 sex_recode   -3.824332 2.076321	-1.84 0.065	-7.893848 .24				
> 51829 _cons   47.91201 3.898808	12.29 0.000	40.27049 55.				
> 55354 						
Random-effects Parameters   Estimate S						
patientnum~r: Identity   sd(_cons)   10.17789 .	8205698 8.69	0238 11.92022				
sd(Residual)   9.754879 .	3693489 9.05	7177 10.50633				
LR test vs. linear regression: chibar2(01) =	138.97 Prob >=	chibar2 = 0.0000				
***************** sf36v2pcs ************						
Performing EM optimization:						
Performing gradient-based optimization:						
<pre>Iteration 0: log likelihood = -1792.3313 Iteration 1: log likelihood = -1792.3313</pre>						
Computing standard errors:						
Mixed-effects ML regression Group variable: patientnumber	Number of obs Number of grou					
	Obs per group:	min = 1 avg = 3.8 max = 4				
Log likelihood = -1792.3313	Wald chi2(2) Prob > chi2	= 3.02 = 0.2205				
sf36v2pcs   Coef. Std. Err. z Page 52	P> z  [95	% Conf. Interval]				

	Appendix 8 1_I	CU mixed mod	lel rear	ression TH	IFSTS TECH	
case sample_time_0 _cons	1442684  0764781   37.73532					3 4.142376 3 .0097737 3 40.97531
	ts Parameters					
patientnum~r:	Identity sd(_cons)	İ				
	sd(Residual)	7.5499	3 .28	42922	7.012762	8.128179
LR test vs. li	near regression	: chibar2(01	L) = 2	293.45 Pro	ob >= chib	ar2 = 0.0000
Performing EM	optimization:					
Performing grad	dient-based opt	imization:				
Iteration 0: Iteration 1:	log likelihood log likelihood	= -1774.969 = -1774.969	95 95			
Computing stand	dard errors:					
Mixed-effects I Group variable	ML regression : patientnumber			Number of	f obs f groups	= 479 = 127
				Obs per (	group: min avg max	= 1 = 3.8 = 4
Log likelihood	= -1774.9695			Wald chi2 Prob > ch	2(4) ni 2	= 42.82 = 0.0000
sf36v2pcs		 Std. Err.	z	P>   Z	 [95% Cor	of. Interval]
case sample time O	.5407929  0777901  3488518  1443047   58.58396	1.908518 .0439823	0.28 -1.77	0.777 0.077	-3.199833 1639938	3 4.281419 3 .0084135
	ts Parameters					
patientnum~r:	[dentity	+     9.93615				
	sd(Residual)	+				
LR test vs. linear regression: chibar2(01) = 227.23 Prob >= chibar2 = 0.0000						
Performing EM optimization:						

Performing gradient-based optimization:

log likelihood = -1790.6841
log likelihood = -1790.6841 Iteration 0:
Iteration 1:

Computing standard errors:

Mixed-effects ML regression Group variable: patientnumber Number of obs = Number of groups = 479 127

Appendix 8 1_ICU_mixed_model_	regression_THESIS_ Obs per group:	TECH min = avg = max =	3.84
Log likelihood = -1790.6841	Wald chi2(3) Prob > chi2		
 sf36v2pcs   Coef. Std. Err. > rval]	z P> z	[95% Co	nf. Inte
case   -1.68026 2.341397	-0.72 0.473	-6.26931	5 2.9
> 08794 sample_time_0  1605269 .0636727	-2.52 0.012	285323	203
> 57307 sample_time_0_case   .1596167 .0877711	1.82 0.069	012411	5 .3
> 31645 _cons   38.55505 1.710807 > 90817	22.54 0.000	35.2019	3 41.
		·	
Random-effects Parameters   Estimate	Std. Err. [95%		terval]
patientnum~r: Identity   sd(_cons)   11.60606		.115 1	3.31691
sd(Residual)   7.518586	.2830689 6.98	3756 8	.094373
LR test vs. linear regression: chibar2(01) =	295.43 Prob >=	chibar2 =	0.0000
Performing EM optimization:			
Performing gradient-based optimization:			
<pre>Iteration 0: log likelihood = -1773.237 Iteration 1: log likelihood = -1773.237</pre>			
Computing standard errors:			
Mixed-effects ML regression Group variable: patientnumber	Number of obs Number of grou		
	Obs per group:	min = avg = max =	$\begin{smallmatrix}1\\3.8\\4\end{smallmatrix}$
Log likelihood = -1773.237	wald chi2(5) Prob > chi2		46.48 0.0000
sf36v2pcs   Coef. Std. Err.	z P> z	[95% Cor	
case   -1.036343 2.083814			
> 47858 sample_time_0  1639574 .0636483		2887058	
> 39209 sample_time_0_case   .1635878 .087711			
> 54982	-6.21 0.000	4593358	2

```
Appendix 8 1_ICU_mixed_model_regression_THESIS_TECH
> 38902
       sex_recode | -.1446444
                                1.945027
                                           -0.07
                                                   0.941
                                                            -3.956827
                                                                        3.6
 67538
            _cons |
                     59.44162
                                           16.36
                                                   0.000
                                3.632667
                                                            52.32172
                                                                        66.
> 56151
 Random-effects Parameters | Estimate Std. Err. [95% Conf. Interval]
patientnum~r: Identity
                               9.920035
                                         .7238366
                                                      8.598119
                 sd(_cons) |
                                                                  11.44519
               sd(Residual) |
                               7.519503 .2831105
                                                     6.984596
                                                                  8.095376
LR test vs. linear regression: chibar2(01) = 228.89 Prob >= chibar2 = 0.0000
*******
iesravoidance
*******
Performing EM optimization:
Performing gradient-based optimization:
              log likelihood = -1445.3307
Iteration 0:
              log likelihood = -1445.3306
Iteration 1:
Computing standard errors:
                                             Number of obs
Mixed-effects ML regression
                                                                       503
Group variable: patientnumber
                                             Number of groups
                                             Obs per group: min =
                                                           avg =
                                                           ma\bar{x} =
                                             wald chi2(2)
                                                                     38.11
Log likelihood = -1445.3306
                                             Prob > chi2
                                                                    0.0000
iesravoidance | Coef. Std. Err. z
                                              P>|z| [95% Conf. Interval]
                                      3.90
                                              0.000
                                                       1.019732
        case | 2.05104 .5261872
                                                                  3.082348
                           .0215525
                -.1022694
                                      -4.75
                                              0.000
                                                       -.1445115
                                                                  -.0600272
sample_time_0 |
                           .4302864
      _cons | 1.735924
                                       4.03
                                              0.000
                                                       .8925779
                                                                    2.57927
 Random-effects Parameters | Estimate Std. Err. [95% Conf. Interval]
patientnum~r: Identity
                 sd(_cons)
                               2.283873 .2618185 1.824282
                                                                2.859249
               sd(Residual) | 3.829383 .1418102 3.561287 4.117661
LR test vs. linear regression: chibar2(01) = 37.91 Prob >= chibar2 = 0.0000
Performing EM optimization:
Performing gradient-based optimization:
```

log likelihood = -1426.0634Iteration 0: log likelihood = -1426.0622 log likelihood = -1426.0622 Iteration 1: Iteration 2:

# $\label{lem:computing} \mbox{Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH} \mbox{ Computing standard errors:}$

Obs per group: min = 3.8 avg = 3.8 avg = 3.8 max = 4   Aug = 3.8 max = 4.8	Mixed-effects Group variable	ML regression e: patientnumber			Number o Number o	of obs of group	= os =		499 132
Coef. Std. Err.   Z   P> Z    [95% Conf. Interval]				•	Obs per	group:	avg =		3.8
Case   2.101541	Log likelihood	I = -1426.0622		<b>!</b>	Wald chi Prob > 0	2(4) :hi2	=	0	60.74 .0000
Random-effects Parameters   Estimate Std. Err. [95% Conf. Interval]  patientnum~r: Identity   sd(_cons)   1.994183   .2628381   1.540191   2.581995	iesravoidance	Coef.	Std. Err.	Z	P> z	[95%	6 Conf	. Int	erval]
patientnum~r: Identity	case sample_time_0 age sex_recode _cons	2.101541 1050767 0627491 1.208888 4.990308	.4921218 .0217148 - .014699 - .503658 .962919	4.27 4.84 4.27 2.40 5.18	0.000 0.000 0.000 0.016 0.000	147 091 .221	1.137 76371 15586 17364 03022	3.0 00 01 2 6.8	066082 625164 339396 .19604 877595
1.994183   .2628381   1.540191   2.581995	Random-effec	ts Parameters	Estimate	Std.	Err.	[95%	Conf.	Inte	rval]
Sd(Residual)   3.845094			1.994183	.2628	3381	1.540	)191	2.58	31995
Performing EM optimization:  Performing gradient-based optimization:  Iteration 0: log likelihood = -1440.0743 Iteration 1: log likelihood = -1440.0742  Computing standard errors:  Mixed-effects ML regression Group variable: patientnumber  Number of obs = 503 Number of groups = 133  Obs per group: min = 1 avg = 3.8 max = 4  Log likelihood = -1440.0742  Prob > chi2 = 0.0000		sd(Residual)	3.845094	.142	2807	3.575	5141	4.13	35429
Performing gradient-based optimization:  Iteration 0: log likelihood = -1440.0743 Iteration 1: log likelihood = -1440.0742  Computing standard errors:  Mixed-effects ML regression Group variable: patientnumber    Number of obs	LR test vs. li	near regression	: chibar2(01)	= 2	25.28 Pr	ob >= 0	hibar2	2 = 0	.0000
<pre>Iteration 0: log likelihood = -1440.0743 Iteration 1: log likelihood = -1440.0742  Computing standard errors:  Mixed-effects ML regression</pre>	Performing EM	optimization:							
Computing standard errors:  Mixed-effects ML regression Group variable: patientnumber   Obs per group: min = 1 avg = 3.8 max = 4  Log likelihood = -1440.0742  Prob > chi2 = 0.0000   iesravoidance   Coef. Std. Err. z P> z  [95% Conf. Inte > rval]   case   3.414385 .6708779 5.09 0.000 2.099489 4.7  > 29282 sample_time_0  0330577 .0300284 -1.10 0.2710919123 .02	Performing gra	dient-based opt	imization:						
Mixed-effects ML regression Group variable: patientnumber    Number of obs   = 503   133	Iteration 0: Iteration 1:	log likelihood log likelihood	= -1440.0743 = -1440.0742						
Group variable: patientnumber    Number of groups = 133	Computing stan	dard errors:							
avg = 3.8 max = 4   4	Mixed-effects Group variable	ML regression : patientnumber		N	Number o Number o	f obs f group	= os =		
Log likelihood = -1440.0742				C	Obs per		avg =		3.8
iesravoidance   Coef. Std. Err. z P> z  [95% Conf. Inte > rval] 	Log likelihood			F	Prob > c	2(3) hi2	=	0.	19.45 0000
case   3.414385 .6708779 5.09 0.000 2.099489 4.7 > 29282 sample_time_0  0330577 .0300284 -1.10 0.2710919123 .02		ance   Coe	f. Std. Err		z P>				
sample_time_0  0330577    .0300284    -1.10    0.271   0919123    .02									
> 5./96X	sample_ti	me_0  03305	77 .0300284	-1.	10 0.	271	0919	123	.02
sample_time_0_case  1387897	> 57968 sample_time_0_	case  13878	97 .0425265	-3.	26 0.	001	2221	402	05
> 54392 cons   1.047612	_	cons   1.0476							

-	-	-	-	-

Random-effects Parameters	Estimate	Std. Err.	 [95%	Conf. I	nterval]
patientnum~r: Identity	2.301217				
sd(_cons)  sd(Residual)	+	<del></del>			
LR test vs. linear regression	: chibar2(01)	= 40.35	Prob >= 0	hibar2	= 0.0000
Performing EM optimization:					
Performing gradient-based opt	imization:				
Iteration 0: log likelihood Iteration 1: log likelihood Iteration 2: log likelihood	= -1420.9432 = -1420.9424 = -1420.9424				
Computing standard errors:					
Mixed-effects ML regression Group variable: patientnumber		Numbe Numbe	r of obs r of group	= S =	499 132
		Obs p	er group:	min = avg = max =	3.8 4
Log likelihood = -1420.9424			chi2(5) > chi2		
iesravoidance   Coe	f. Std. Err.	Z	P>   z	[95% C	onf. Inte
case   3.4595					
> 28019 sample_time_0  0356	18 .0303913	-1.17	0.241	09518	39 .0
> 23948 sample_time_0_case  13799	92 .042846	-3.22	0.001	22197	5805
> 40225 age  0626	21 .0146844	-4.26	0.000	09140	1803
> 38401 sex_recode   1.2072 > 93363	86 .5031098	2.40	0.016	. 22120	85 2.1
_cons   4.2924 > 24051	.9855335	4.36	0.000	2.3608	31 6.2
Random-effects Parameters	   Estimate	Std. Err.	[95%	Conf. In	nterval]
patientnum~r: Identity	2.015767				
sd(Residual)	3.793546	.1408326	3.527	323	1.079864
LR test vs. linear regression	: chibar2(01)	= 27.24	Prob >= c	 hibar2 =	= 0.0000
**************************************					

## Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH Performing EM optimization:

Iteration	0:	log	likelihood	=	-1401.8389
Iteration	1:		likelihood		-1401.7193
Iteration	2:	log	likelihood	=	-1401.719
Iteration	3:	log	likelihood	=	-1401.719

### Computing standard errors:

Mixed-effects Group variabl	ML regre e: patie	ession ntnumber		Nur Nur	mber of obs mber of grou	ıps	= =	503 133
				Obs	s per group:	min avg max	=	3.8 4
Log likelihoo	od = -140	01.719			ld chi2(2) bb > chi2		= =	17.47 0.0002
iesrhyperarou > al]	ısal		Std. Err.			_		
 > 749	ase	9228419	.3928168	2.35	0.019	.1529		1.692

>	162 							
>	•	s l	1.213982	.3490778	3.48	0.001	. 5298024	1.898
	sample_time_ 674	0	0/26438	.0211618	-3.43	0.001	1141202	0311

Random-effects Parameters	•	ate Std. Err	<del>-</del>	. Interval]
patientnum~r: Identity sd(_cons)	1.152	255 .2964354	. 695927	1.907802
sd(Residual)	3.77	351 .1384328	3.511712	4.054826

LR test vs. linear regression: chibar2(01) = 4.77 Prob >= chibar2 = 0.0145

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = -1385.4541
Iteration 1: log likelihood = -1385.1451
Iteration 2: log likelihood = -1385.1451

### Computing standard errors:

Mixed-effects ML regression Group variable: patientnumber	Number of obs Number of groups	==	499 132
		n = /g = ix =	3.8 4
Log likelihood = -1385.1451	Wald chi2(4) Prob > chi2	<b>=</b>	33.45 0.0000

Appendix	8	1_ICU_mixed_model_regression_THESIS_TECH
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iesrhyperarousal   Coef.					
case   .9632926 > 395 sample_time_0  0750746 > 062 age  0427285 > 286 sex_recode   .6488599 > 072 _cons   3.508617	.3745488 .0213108 .0111736 .3836091	2.57 -3.52 -3.82 1.69	0.010 0.000 0.000 0.091	.229190 11684 064628 10	1.697 130333 330208 1.40
> 636 Random-effects Parameters	- <b>-</b>				
patientnum~r: Identity sd(_cons) sd(Residual)	.8978469	.34902	8 .	4190899	1.923523
LR test vs. linear regression: Performing EM optimization:					
Performing gradient-based optiliteration 0: log likelihood Iteration 1: log likelihood Iteration 2: log likelihood Iteration 3: log likelihood Computing standard errors:	= -1400.0832 = -1399.9741 = -1399.974				
Mixed-effects ML regression Group variable: patientnumber				obs = groups = oup: min =	503 133 1
				avg = max =	3.8
Log likelihood = -1399.974	<b></b>			() = 	
iesrhyperarousal   Coef					
case   1.70305 > 25212	.0297789	-1.12	0.265	09	159 .0
> 36809cons   .820351 > 18003					

Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH

Random-effects Parameters	Estimate	Std. Err.	[95%		
patientnum~r: Identity sd(_cons)					.906549
sd(Residual)	-+   3.755808	.1377794	3.49	95245 4	1.035796
LR test vs. linear regression	n: chibar2(01)	= 5.07	' Prob >=		0.0121
Performing EM optimization:					
Performing gradient-based op	imization:				
Iteration 0: log likelihood Iteration 1: log likelihood Iteration 2: log likelihood	d = -1383.7649 d = -1383.4794 d = -1383.4794				
Computing standard errors:					
Mixed-effects ML regression Group variable: patientnumbe	•	Numbe Numbe	r of obs r of grou	= ips =	499 132
		Obs p	er group:	min = avg = max =	$\begin{smallmatrix} 1\\3.8\\4\end{smallmatrix}$
Log likelihood = -1383.4794				= =	
iesrhyperarousal   Coe > rval]	ef. Std. Err	. Z	P> z	Г95% Co	nf. Inte
case   1.7318					
sample_time_0  03594 > 23085	.0301193	-1.19	0.233	094980	5 .0
sample_time_0_case  0776				160749	3 .00
> 55352 age  04264 > 07424	.0111772	-3.82	0.000	064556	302
sex_recode   .64829 > 00366				103771	5 1.4
_cons   3.1133 > 31503					
Random-effects Parameters					
<pre>patientnum~r: Identity</pre>	.9178921	. 3409877	.443	1786 1	. 901098
sd(Residual)	3.7693	.1386493	3.50	7117 4	.051083
LR test vs. linear regression	: chibar2(01)	= 2.11	Prob >=	chibar2 =	0.0732
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Performing EM optimization:

Appendix 8 1_ICU_mixed_model_re	egression_THESIS_	TECH
<pre>Iteration 0: log likelihood = -1468.1655 Iteration 1: log likelihood = -1468.1651 Iteration 2: log likelihood = -1468.1651</pre>		
Computing standard errors:		
Mixed-effects ML regression Group variable: patientnumber	Number of obs Number of grou	= 503 ips = 133
	Obs per group:	min = 1 avg = 3.8 max = 4
Log likelihood = -1468.1651		= 29.71 = 0.0000
iesrinterruptions   Coef. Std. Err. > val]	z P> z	[95% Conf. Inter
case   1.735492 .5423174		
> 8415 sample_time_0  0992489 .0226691	-4.38 0.000	1436795054
> 8184		
Random-effects Parameters   Estimate S	td. Err.	Conf. Intervall
patientnum~r: Identity   sd(_cons)   2.317104		
sd(Residual)   4.02875	.150227 3.74	4813 4.334216
LR test vs. linear regression: chibar2(01) =	32.80 Prob >=	chibar2 = 0.0000
Performing EM optimization:		
Performing gradient-based optimization:		
<pre>Iteration 0: log likelihood = -1451.2891 Iteration 1: log likelihood = -1451.2875 Iteration 2: log likelihood = -1451.2875</pre>		
Computing standard errors:		
Mixed-effects ML regression Group variable: patientnumber	Number of obs Number of grou	= 499 ps = 132
	Obs per group:	min = 1 avg = 3.8 max = 4
Log likelihood = -1451.2875	Wald chi2(4) Prob > chi2	= 45.35 = 0.0000
iesrinterruptions   Coef. Std. Err.	z P> z	[95% Conf. Inter

Page 61

Appendix 8 1_ICU > val]		-			
case   1.781996		3.44			7 2.79
> 8005 sample_time_0  1017881	.0228298	-4.46	0.000	146533	8057
> 0425 age  0567757	.0154835	-3.67	0.000	087122	7026
> 4287 sex_recode   1.001513	.5305304	1.89	0.059	038307	8 2.04
> 1333 _cons   4.828345 > 6172					8 6.81
Random-effects Parameters	Estimate		. [95%	% Conf. I	
patientnum~r: Identity   sd(_cons)		<del>-</del>			2.736203
sd(Residual)					
LR test vs. linear regression:	chibar2(01)	= 24.6	9	chibar2 =	= 0.0000
Performing EM optimization:					
Performing gradient-based optim	nization:				
<pre>Iteration 0: log likelihood = Iteration 1: log likelihood = Iteration 2: log likelihood =</pre>	-1463.7908 -1463.7905 -1463.7905				
Computing standard errors:					
Mixed-effects ML regression Group variable: patientnumber		Numb Numb	er of obs er of grou	= ips =	503 133
		Obs	per group:	min = avg = max =	$3.8_{4}^{1}$
Log likelihood = -1463.7905			chi2(3) > chi2		
iesrinterruptions   Coef.	Std. Err.	z	P>   z	[95% Cd	onf. Inte
case   3.04543					
> 13899 sample_time_0  0327648					
> 92612 sample_time_0_case  1333154					
> 54805 _cons   1.177782 > 51646	.4968788	2.37	0.018	. 203917	2 2.1
Random-effects Parameters	 Estimate	Std. Err	 . [95%	Conf. In	itervall
patientnum~r: Identity				~	
	Page 6	2			

,	Appendix 8 1_ICU_ sd(_cons)	_mixed_model 2.338375	_regressio .2780809	n_THESIS_ 1.85	TECH 52204	2.952158
	sd(Residual)	3.981653	.1484446	3.70	1083	4.283493
LR test vs. lin	near regression:	chibar2(01)	= 34.83	Prob >=	chibar2	2 = 0.0000
Performing EM o	ptimization:					
Performing grad	lient-based optim	ization:				
Iteration 1:	<pre>log likelihood = log likelihood = log likelihood =</pre>	-1447.0368				
Computing stand	lard errors:					
Mixed-effects M Group variable:	NL regression patientnumber			r of obs r of grou		
			Obs p	er group:	min = avg = max =	3.8
Log likelihood	= -1447.0368					54.44 0.0000
iesrinterrupti	ons   Coef.	Std. Err.	z	P>   z	[95%	Conf. Inte
	ase   3.083891					
> 21027	ne_0  0351901			0.272		339 .02
> 75538	ase  1323404		-2.93	0.003		9780
> 43883	age  0566799		-3.66	0.000	0870	34202
	ode   1.001844	.5306108	1.89	0.059	0381	339 2.0
	ons   4.160013	1.039292	4.00	0.000	2.123	038 6.1
> 96989						
<b>_</b>						
Random-effect	s Parameters	Estimate	Std. Err.	 [95%	Conf.	Interval]
patientnum~r: I	dentity   sd(_cons)	2.128436	.2781076	1.64	7556	2.749673
	sd(Residual)	3.995895	.1492656	3.71	3792	4.299426
LR test vs. lin	ear regression: o	chibar2(01)	= 26.43	Prob >=	chibar2	= 0.0000
************ ies_total ******						

Performing EM optimization:

Performing gradient-based optimization:

Iteration 0: log likelihood = -1963.3706
Iteration 1: log likelihood = -1963.3696
Page 63

Iteration 2:	Appendix 8 1_Iog likelihood	CU_mixed_mode = -1963.3696	1_regr	ression_TH	ESIS_TECH	
Computing stan	dard errors:					
Mixed-effects Group variable	ML regression : patientnumber			Number of Number of	obs groups	= 503 = 133
				Obs per g		= 1 = 3.8 = 4
Log likelihood	= -1963.3696			Wald chi2 Prob > ch	(2) i2	= 31.54 = 0.0000
ies_total		std. Err.	Z	P>   z	[95% Con	f. Interval]
case sample_time_0 _cons	4.703611  2741289   4.789884	1.400139 .0614108 - 1.165387	3.36 4.46 4.11	0.001 0.000 0.000	1.959389 3944919 2.505767	7.447833 1537659 7.074002
Random-effec	ts Parameters	   Estimate				
patientnum~r:	Identity	j				
	sd(_cons)  sd(Residual)	+				
	near regression			<del></del>		
Performing EM	optimization:					
Performing gra	dient-based opt	imization:				
Iteration 0: Iteration 1: Iteration 2:	log likelihood log likelihood log likelihood	= -1940.8859 = -1940.8797 = -1940.8797	)			
Computing stan	dard errors:					
Mixed-effects Group variable	ML regression : patientnumber				obs groups	
				Obs per g	roup: min : avg : max :	= 3.8
Log likelihood				Prob > ch	12 :	= 51.39 = 0.0000
ies_total	Coef.	 Std. Err.				f. Interval]
case sample_time_0 age sex_recode	4.839384 2817998 1620623 2.853811 13.31922	1.320091 .0618496 - .0394187 -	3.67 4.56 4.11 2.11	0.000 0.000 0.000 0.035	2.252053 4030229 2393216 .2053447	7.426716 1605768 084803 5.502278
_cons	13.31922	2.590258 	5.14 	0.000	8.242404 	18.39603
	ts Parameters	Estimate				
patientnum~r:		Page (	54			

Appendix 8 1_ICU_mixed_model_	regression_THESIS_TECH 7616750 3 711002 6 742217
sd(Residual)   10 96026	.7616759 3.711992 6.742217 .4069526 10.19098 11.78761
LR test vs. linear regression: chibar2(01) =	
Performing EM optimization:	= 17.16 P100 >= CITIDAT2 = 0.0000
Performing gradient-based optimization:	
Iteration 0: log likelihood = -1959.2274 Iteration 1: log likelihood = -1959.2266 Iteration 2: log likelihood = -1959.2266	
Computing standard errors:	
Mixed-effects ML regression Group variable: patientnumber	Number of obs = 503 Number of groups = 133
	Obs per group: $min = 0.05$ avg = 0.00 3.8 max = 0.00 4
Log likelihood = -1959.2266	wald chi2(3) = 40.38 Prob > chi2 = 0.0000
ies_total   Coef. Std. Err. > rval]	z P> z  [95% Conf. Inte
case   8.162645 1.839568 > 76813	
sample_time_0  0987157 .0858133 > 94753	
sample_time_0_case  3515974 .1214973 > 34671	
_cons   3.043/3/ 1.308823 > 08983	2.33 0.020 .4784909 5.6
<del>_</del>	
Random-effects Parameters   Estimate	Std. Err. [95% Conf. Interval]
patientnum~r: Identity   5.788449	.7375448 4.509257 7.430525
sd(Residual)   10.80121	.4000876 10.04484 11.61453
LR test vs. linear regression: chibar2(01) =	27.92 Prob >= chibar2 = 0.0000
Performing EM optimization:	
Performing gradient-based optimization:	
<pre>Iteration 0: log likelihood = -1936.868 Iteration 1: log likelihood = -1936.8634 Iteration 2: log likelihood = -1936.8634</pre>	
Computing standard errors:	
Mixed-effects ML regression Group variable: patientnumber	Number of obs = 499 Number of groups = 132
	Obs per group: min = 1
Page 65	

Appendix 8 1_ICU_mixed_model	_regressior	n_THESIS_	_TECH avg = max =	_				
Log likelihood = -1936.8634	Prob :	> chi2	=					
ies_total   Coef. Std. Err.	. z	P>   z	[95% (	Conf. Inte				
case   8.274726 1.786735 > 77666 sample_time_0  1062585 .0868146	4.63	0.000	4.772					
> 38949 sample_time_0_case  3486396 .1223629 > 88128	-2.85	0.004	58846	66510				
age  1617559 .0394136 > 45067 sex_recode   2.852013 1.350994	-4.10 2.11	0.000		)5108 L31 5.4				
> 99912 _cons   11.55396 2.661677 > 77075	4.34	0.000						
Random-effects Parameters   Estimate	Std. Err.	[95%						
patientnum~r: Identity   sd(_cons)   5.06712	.7496578	3.79	91663	6.771621				
sd(Residual)   10.84247	.4025086	10.0	)8158 	11.66078				
LR test vs. linear regression: chibar2(01) = 18.52 Prob >= chibar2 = 0.0000								
**************************************								
Performing EM optimization:								
Performing gradient-based optimization:								
<pre>Iteration 0: log likelihood = -1821.0635 Iteration 1: log likelihood = -1821.0635</pre>								
Computing standard errors:								
Mixed-effects ML regression Group variable: patientnumber	Number Number	of obs of grou	= ips =	504 133				
	Obs pe	r group:	min = avg = max =	3.8				
Log likelihood = -1821.0635	Wald c Prob >	hi2(2) chi2	=	6.84 0.0328				
hadstotal   Coef. Std. Err.	z P> z	[95	 % Conf.	Interval]				
case  0790379	.61 0.009 .64 0.000	-3.1 18 10.	83089 25432 36742	3.025013 0261242 15.0504				

Random-effec	ts Parameters	Estimate	Std	. Err.	[95% Conf.	Interval]	
patientnum~r:	sd( cons)	8.334093	.62	36234	7.197217	9.650549	
	sd(Residual)	7.057757	.26	00757	6.56599	7.586355	
LR test vs. li	near regression	: chibar2(01	) =	186.64 Pro	b >= chibar2	2 = 0.0000	
Performing EM optimization:							
Performing gradient-based optimization:							
<pre>Iteration 0: log likelihood = -1796.6032 Iteration 1: log likelihood = -1796.6032</pre>							
Computing stand	dard errors:						
Mixed-effects I Group variable	ML regression : patientnumber			Number of Number of	obs = groups =	500 132	
				Obs per g	roup: min = avg = max =		
Log likelihood	= -1796.6032			Wald chi2 Prob > ch	(4) = i2 =	11.76 0.0192	
hadstotal	Coef.	Std. Err.	z	P> z	[95% Conf.	Interval]	
sample_time_0 age sex_recode	0914843   .0330295   3.552879	1.561425 .039261 .0467304 1.595366 3.014082	-0.02 -2.33 0.71 2.23 2.95	0.020 0.480 0.026	1684344 0585605 .4260192	3.02512 0145343 .1246194 6.679739 14.81076	
Random-effects Parameters   Estimate Std. Err. [95% Conf. Interval]						 Interval]	
patientnum~r:	Identity	İ					
		8.181972 +			7.064069		
	sd(Residual) 		- <b></b>			<b></b>	
LR test vs. linear regression: chibar2(01) = 186.49 Prob >= chibar2 = 0.0000							
Performing EM optimization:							
Performing gradient-based optimization:							
Iteration 0: Iteration 1:	log likelihood log likelihood	= -1820.4421 = -1820.4421	l L				
Computing standard errors:							
Mixed-effects M Group variable	ML regression : patientnumber			Number of Number of	obs = groups =	504 133	
				Obs per gi	roup: min = avg = max =	$\begin{smallmatrix} 1\\3.8\\4\end{smallmatrix}$	

### Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH

Log likelihood = -1820.4421		= 8.10 = 0.0440						
hadstotal   Coef. Std. Err.	z P> z	[95% Conf. Inte						
 case   .7834382 1.760458 > 33872		-2.666996 4.2						
sample_time_0  0601402 .0561997 > 00093	-1.07 0.285	1702896 .05						
sample_time_0_case  0889193 .0797144 > 67318	-1.12 0.265	2451566 .0						
_cons   12.27217 1.255647 > 73319								
Random-effects Parameters   Estimate	std. Err. [959	% Conf. Interval]						
patientnum~r: Identity   8.322223								
sd(Residual)   7.049443								
LR test vs. linear regression: chibar2(01) =	186.92 Prob >=	chibar2 = 0.0000						
Performing EM optimization:								
Performing gradient-based optimization:								
<pre>Iteration 0: log likelihood = -1795.5418 Iteration 1: log likelihood = -1795.5418</pre>								
Computing standard errors:								
Mixed-effects ML regression Group variable: patientnumber	Number of obs Number of grou	= 500 ups = 132						
	Obs per group:	min = 1 avg = 3.8 max = 4						
Log likelihood = -1795.5418	Prob > chi2	= 13.94 = 0.0160						
hadstotal   Coef. Std. Err.	z P> z							
	0.62 0.536	-2.325338 4.4						
> 71329 sample_time_0  0342105 .0554633	-0.62 0.537	1429165 .07						
> 44956 sample_time_0_case  1142611 .0783388	-1.46 0.145	2678024 .03						
> 92801 age   .0331613 .0466457	0.71 0.477	0582626 .12						
> 45853 sex_recode   3.54868 1.592471	2.23 0.026	.4274944 6.6						
> 69865 _cons   8.33155 3.034009 Page 68	2.75 0.006	2.385001 14						

Random-effects Parameters | Estimate Std. Err. [95% Conf. Interval] patientnum~r: Identity sd(\_cons) | 8.167778 .6117321 7.052653 9.45922 sd(Residual) | 6.899045 .2550847 6.416774 7.417563 LR test vs. linear regression: chibar2(01) = 187.15 Prob >= chibar2 = 0.0000 \*\*\*\*\*\*\*\* ciq\_total Performing EM optimization: Performing gradient-based optimization:  $\log likelihood = -1516.1372$  $log\ likelihood = -1516.1372$ Iteration 1: Computing standard errors: Mixed-effects ML regression Number of obs 505 Number of groups Group variable: patientnumber 133 Obs per group: min = 3.8 avq =max =Wald chi2(2) 4.92 Log likelihood = -1516.1372Prob > chi2 0.0854 ciq\_total | Coef. Std. Err. z P> | z | [95% Conf. Interval] case | -1.718388 .9876585 -1.74 0.082 -3.654163 . 2173869 .028108 .0206354 1.36 0.173 sample\_time\_0 -.0123367 .0685527 .0206354 14.49926 \_cons 15.93634 21.73 0.000 17.37342 Random-effects Parameters | Estimate Std. Err. [95% Conf. Interval] patientnum~r: Identity 5.358471 .3764615 4.669167 sd(\_cons) | 6.149536 sd(Residual) | 3.645602 .1342049 3.391831 3.918361 LR test vs. linear regression: chibar2(01) = 270.38 Prob >= chibar2 = 0.0000 Performing EM optimization: Performing gradient-based optimization: log likelihood = -1493.5798Iteration 0: Iteration 1:  $log\ likelihood = -1493.5798$ Computing standard errors:

Number of obs

Number of groups =

501

132

Mixed-effects ML regression

Group variable: patientnumber

	Appendix 8 1_I	CU_mixed_mo	del_regr		HESIS_TECH group: min = avg = max =	3.8
Log likelihood	= -1493.5798			Wald chi Prob > cl	2(4) = hi2 =	32.26 0.0000
	Coef.			<b></b>	<b></b>	
case sample_time_0 age sex_recode _cons	-1.524806 .0293874 138995 1.46698 23.60997	.9072668 .0207803 .0271741 .9266094 1.750793	-1.68 1.41 -5.11 1.58 13.49	0.093 0.157 0.000 0.113 0.000	-3.303017 0113413 1922552 3491412 20.17848	.2534041 .0701162 0857347 3.283101 27.04147
	ts Parameters	+	e Sta.	. Err. 		Interval]
patientnum~r:	sd(_cons)	4.83627	4 .352	L0366	4.194954	5.575639
	sd(Residual)	3.65753	2 .135	52534	3.401819	3.932467
LR test vs. lin	near regression	: chibar2(0	1) = 2	224.18 Pro	ob >= chibar	2 = 0.0000
Performing EM o	optimization:					
Performing grad	dient-based opt	imization:				
Iteration 0: Iteration 1:	log likelihood log likelihood	= -1515.93 = -1515.93	51 51			
Computing stand	dard errors:					
Mixed-effects M Group variable:	ML regression : patientnumber			Number of Number of	obs = groups =	505 133
				Obs per g	group: min = avg = max =	3.8
Log likelihood	= -1515.9351				?(3) = ni2 =	
ciq_to	otal   Coe	f. Std. E	r.	z P>	z  [95%	Conf. Inte
	' case   -1.9721					
> 48839	ne_0   .01507					
> 20607 sample_time_0_c						
> 07096	cons   16.064					
> 55501						
Random-effect	s Parameters	   Estimate	 e Std.	Err.	[95% Conf.	Interval]

Appendix 8 1_ICU_mixed_mode patientnum~r: Identity	_			
sd(_cons)   5.356179	.3762535	4.66	725 	6.146801
sd(Residual)   3.644174	.1341463	3.390	513	3.916813
LR test vs. linear regression: chibar2(01)	= 270.58	Prob >= c	hibar2	= 0.0000
Performing EM optimization:				
Performing gradient-based optimization:				
<pre>Iteration 0: log likelihood = -1493.409 Iteration 1: log likelihood = -1493.409</pre>				
Computing standard errors:				
Mixed-effects ML regression Group variable: patientnumber	Number Number	of obs of group	= S =	501 132
	Obs pe	r group: :	min = avg = max =	3.8
Log likelihood = -1493.409				
ciq_total   Coef. Std. Err	. Z	P>   z	[95% C	onf. Inte
case   -1.75986 .9920457				
> 45135 sample_time_0   .0172257 .0294061			04040	
> 48606			05714	
> 57062 age  1390223 .0271614			19225	
> 85787 sex_recode   1.467936 .9261763			34733	
> 83208cons   23.73121 1.762233		0.000	20.27	
> 18512				
Random-effects Parameters   Estimate	 Std. Err.	[95% (	Conf. I	nterval]
patientnum~r: Identity   sd(_cons)   4.833873	.350831	4.1929	924 :	5.572799
sd(Residual)   3.656454	.1352069	3.4008	328	3.931294
LR test vs. linear regression: chibar2(01)	= 224.30	Prob >= ch	nibar2 =	= 0.0000
*************** fim *********				

Performing EM optimization:

Performing gradient-based optimization:

### Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH

### Computing standard errors:

Mixed-effects	Mixed-effects ML regression Group variable: patientnumber							=	505
Group variable	: patientnumber	•				Number	_		
						ons her	group.	avg = max =	3.8 $4$
Log likelihood	= -1718.3012					Wald ch Prob >	i2(2) chi2	= =	5.76 0.0562
		· <u>-</u> -					<del>-</del>		
fim	Coef.	Std.	Err.		Z 	P>   Z	95] 	% Conf	. Interval] 
case sample_time_0 _cons	-2.534272  0564899   121.4672	1.94 .027 1.41	1039 9536 3098	-1 -2 85	.31 .02 .96	0.192 0.043 0.000	-6.3 11 118	38639 12779 1.6976	1.270095 0017019 124.2368
	 ts Parameters 								
patientnum~r:	Identity sd(_cons)		10.87950	 6	.728	31441	9.54	2064	12.40453
	sd(Residual)	+	4.931163	3	.182	7499	4.58	5679	5.302676
LR test vs. li	near regression	: ch	ibar2(0:	1) :	= 3	368.74 P	rob >=	chibar.	2 = 0.0000
Performing EM (	optimization:								
Performing grad	dient-based opt	imiz	ation:						
Iteration 0: Iteration 1:	log likelihood log likelihood	= -;   = -;	1702.805 1702.805	58 58					
Computing stand	dard errors:								
Mixed-effects M Group variable	ML regression : patientnumber	ı				Number o	of obs of grou	= ps =	501 132
						Obs per	group:	min = avg = max =	$3.8\\4$
Log likelihood	= -1702.8058					Wald chi Prob > 0	i2(4) chi2	=	13.41 0.0094
fim	Coef.	 Std.	Err.		 Z	P> z	[95	Conf.	Interval]
case	-2.341415	1.89	9985	-1	. 23	0.218	-6.0	65054	1.382223
case sample_time_0 age sex_recode _cons	1239537	.0569	9293	-2.	. 18	0.029	11 2	20381 35533	0123744
sex_recode _cons	130.0498	3.65	7103	35.	. 56 	0.193	-6.3. 12.	23919 2.882	137.2176
Random-effect	ts Parameters		Estimate	) 	Std.	Err.	[95%	Conf.	Interval]
patientnum~r: ]	<pre>Identity      sd(_cons)</pre>	   : +	10.58131	-	.715	1607	9.26	8491	12.08008
	Page 72								

```
Appendix 8 1_ICU_mixed_model_regression_THESIS_TECH
               sd(Residual) | 4.9513 .1843925 4.602772
                                                                5.32622
LR test vs. linear regression: chibar2(01) = 347.47 Prob >= chibar2 = 0.0000
Performing EM optimization:
Performing gradient-based optimization:
              log likelihood = -1718.241
log likelihood = -1718.241
Iteration 0:
Iteration 1:
Computing standard errors:
Mixed-effects ML regression
                                              Number of obs
                                                                       505
Group variable: patientnumber
                                             Number of groups
                                                                       133
                                             Obs per group: min =
                                                                       3.8
                                                            avg =
                                                            max =
                                             Wald chi2(3)
                                                                      5.88
Log likelihood = -1718.241
                                             Prob > chi2
                                                                    0.1177
                       Coef.
              fim |
                                Std. Err. z p>|z| [95% Conf. Inte
> rval]
                                                   0.177
             case | -2.721194
                                2.013631
                                           -1.35
                                                            -6.667839
                                                                        1.2
> 25451
    sample_time_0 | -.0661129
                                .0393743
                                           -1.68
                                                   0.093
                                                            -.143285
                                                                        .01
 10593
sample_time_0_case |
                    .0194128
                                .0559077
                                           0.35
                                                   0.728
                                                            -.0901643
                                                                        .12
> 89899
            _cons |
                      121.562
                                1.438704
                                           84.49
                                                   0.000
                                                                        124
                                                            118.7422
> .3818
______
 Random-effects Parameters | Estimate Std. Err. [95% Conf. Interval]
patientnum~r: Identity
             sd(_cons) | 10.87503 .7279894 9.537836 12.3997
               sd(Residual) | 4.93106 .1827566 4.585565 5.302587
LR test vs. linear regression: chibar2(01) = 368.43 Prob >= chibar2 = 0.0000
Performing EM optimization:
Performing gradient-based optimization:
              log likelihood = -1702.7396
log likelihood = -1702.7396
Iteration 0:
Iteration 1:
Computing standard errors:
                                             Number of obs
Mixed-effects ML regression
                                                                       501
                                             Number of groups
Group variable: patientnumber
                                             Obs per group: min =
                                                           avg =
                                                           max =
```

#### Appendix 8 1\_ICU\_mixed\_model\_regression\_THESIS\_TECH

Log likelihoo	d = -1702.7	7396				chi2(5) > chi2		_	.3.55 0187
	fim	Coof	c+4	Enn	-	Ds led	FOE0/	conf	Tnto

 fim > rval]			std. Err.		P>   Z	[95% Conf.	Inte
	<b>T</b>						
case	-2.	38982 1	.975112	-1.29	0.199	-6.410131	1.3
> 32167 sample_time_0 > 10565	00	570761 .	0398643	-1.68	0.092	1452086	.01
sample_time_0_case > 09911	.02	205198	.056364	0.36	0.716	0899516	.13
age > 24465	12	239771 .	0569044	-2.18	0.029	2355077	01
sex_recode > 74064	-2.	24597 1	.938128	-1.30	0.193	-6.323258	1.2
_cons	130	).1517 3	.666227	35.50	0.000	122.9661	137

Random-effects Parameters	Estimate	Std. Err.	[95% Conf.	Interval]
patientnum~r: Identity sd(_cons)	10.57642	.7149948	9.263924	12.07486
sd(Residual)	4.951185	. 1844	4.602644	5.32612

LR test vs. linear regression: chibar2(01) = 347.12 Prob >= chibar2 = 0.0000

name: <unnamed>
log: U:\ICU\FINAL ANLAYSES\Marsden\_IC

> U\_mixed\_model\_regression\_31Jan2013.smcl

log type: smcl closed on: 31 Jan 2013, 22:41:26

log close

\_\_\_\_\_

```
Appendix 8.2
```

. keep if sample\_time==0
(858 observations deleted)

\*\*\*\*\*\*\*\*\* Pre-morbid predictors \*\*\*\*\*\*\*\*\*

\*\*\*\*\*\*\*\*\*\*

\* LNS Impairment at 24 months \*

\*\* 1. FIM: pre-morbid \*\*

LnMM3\_lf lns\_impair\_24 fim

#### Log multinomial model

initial:	log likelihood =		(could not	be evaluated)
feasible:	log likelihood = -	-470.00736		
rescale:	log likelihood = -	-127.68049		
rescale eq:	log likelihood = -	-125.99376		
Iteration 0:	log likelihood = -	-125.99376		
Iteration 1:	log likelihood = -	-120.85351		
Iteration 2:	log likelihood = -	-115.59344		
Iteration 3:	log likelihood = -	-114.41805		
Iteration 4:	log likelihood =	-113.8589		
Iteration 5:	log likelihood = -			
Iteration 6:	log likelihood = -	-113.73977		
Iteration 7:	$\log 1$ ikelihood = -	-113.73977		

Log likelihood = -113.73977

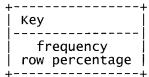
Number of obs	=	128
Wald chi2(1)	=	0.02
Prob > chi2	=	0.8897

		Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1	fim _cons	0011222 -1.539191	.0080951 .9862346	-0.14 -1.56	0.890 0.119	0169884 -3.472175	.0147439
eq2	fim _cons	0125021 2654289	.0038494 .4156213	-3.25 -0.64	0.001 0.523	0200469 -1.080032	0049573 .5491738

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf	. Interval]
eq1	fim	0.998878	0.890	0.983155	1.014853
eq2	fim	0.987576	0.001	0.980153	0.995055

<sup>.</sup> LnMM3\_lf lns\_impair\_24 case fim



Case	LNS impai   Not impai	rmant at 24 Impaired	months Dead	Total
		<del>-</del>		
Control	42 67.74	$10 \\ 16.13$	10 16.13	100.00
Case	39 59.09	14 21.21	13 19.70	66 100.00
Total	81 63.28	24 18.75	23   17.97	128 100.00

log likelihood = -<inf>
log likelihood = -470.00736
log likelihood = -127.68049 (could not be evaluated) initial: feasible: rescale: log likelihood = -125.99376 log likelihood = -125.99376 log likelihood = -121.20495 log likelihood = -116.05528 rescale eq: Iteration 0: Iteration 1: Iteration 2:  $\log likelihood = -114.64468$ Iteration 3: log likelihood = -113.76659
log likelihood = -113.49213 Iteration 4: Iteration 5: Iteration 6: log likelihood = -113.46248Iteration 7:  $\log likelihood = -113.46213$ Iteration 8:  $log\ likelihood = -113.46213$ 

Number of obs = 128 Wald chi2(2) = 0.54 Log likelihood = -113.46213 Prob > chi2 = 0.7651

		Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1	case	.2741659	.3801327	0.72	0.471	4708805	1.019212
	fim	.0000264	.0081673	0.00	0.997	0159813	.0160341
	_cons	-1.827841	1.057656	-1.73	0.084	-3.900809	.2451276
eq2	case	.0055081	.4107422	0.01	0.989	7995318	.8105481
	fim	0124567	.0043163	-2.89	0.004	0209166	0039969
	_cons	2736642	.6102401	-0.45	0.654	-1.469713	.9223844

		RR	P>   z	[95% Conf.	Interval]
eq1	case	1.315433	0.471	0.624452	2.771011
	fim	1.000026	0.997	0.984146	1.016163
eq2	case	1.005523	0.989	0.449539	2.249140
	fim	0.987621	0.004	0.979301	0.996011

## Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX LnMM3\_lf lns\_impair\_24 case fim age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

+	-+
Key	
	- İ
frequency	İ
row percentage	
1	_ 1

Case	LNS impa <sup>.</sup>   Not impai	irmant at 24 Impaired	months Dead	Total
Control	42	10	10	62
	67.74	16.13	16.13	100.00
Case	39	14	13	66
	59.09	21.21	19.70	100.00
Total	81	24	23	128
	63.28	18.75	17.97	100.00

#### Log multinomial model

log likelihood = -<inf>
log likelihood = -470.00736 (could not be evaluated) initial: feasible:  $log\ likelihood = -127.68049$ rescale: log likelihood = -125.99376 log likelihood = -125.99376 log likelihood = -116.47915 log likelihood = -105.18759 rescale eq: Iteration 0: Iteration 1: Iteration 2:  $\log 1$ ikelihood = -97.722564Iteration 3: log likelihood = -96.604919 log likelihood = -96.531052 log likelihood = -96.529801 log likelihood = -96.529799 Iteration 4: Iteration 5: Iteration 6: Iteration 7:

Log likelihood = -96.529799

Number of obs = 128 Wald chi2(4) = 1.08 Prob > chi2 = 0.8976

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case fim age sex_recode _cons	.252107  0035492   .0069096   .1312534   -1.880596	.3793972 .0098823 .0114935 .377753 1.098704	0.66 -0.36 0.60 0.35 -1.71	0.506 0.719 0.548 0.728 0.087	4914978 0229181 0156172 6091289 -4.034016	.9957119 .0158197 .0294365 .8716357 .2728251
eq2 case fim age sex_recode _cons	.0401543 0694317 .1090949 .1940479 -1.300591	.3175517 .0161093 .0256862 .3437142 .6142496	0.13 -4.31 4.25 0.56 -2.12	0.899 0.000 0.000 0.572 0.034	5822356 1010054 .0587509 4796196 -2.504498	.6625441 037858 .1594389 .8677153 0966841

		RR	P>   z	[95% Conf.	Interval]
eq1	case	1.286734	0.506	0.611709	2.706650

Ap	pendix 8 2_ICU_Pre	dict_Impairment i	log_THE:	SIS_TECH_INDEX	
fim	0.996457		0.719	0.977342	1.015945
age	1.006934		0.548	0.984504	1.029874
sex_recode	1.140257		0.728	0.543824	2.390818
eq2					
case	1.040971		0.899	0.558648	1.939721
fim	0.932924		0.000	0.903928	0.962850
age	1.115268		0.000	1.060511	1.172853
sex_recode	1.214154		0.572	0.619019	2.381464

. \*\* 2. Years education: pre-morbid \*\*

LnMM3\_lf lns\_impair\_24 YRSEDN

#### Log multinomial model

```
(could not be evaluated)
initial:
                    log likelihood =
                                                -<inf>
                    log\ likelihood = -430.00672
feasible:
                    \log likelihood = -116.72354
rescale:
                    log likelihood = -115.27517
rescale eq:
                    log likelihood = -115.27517
log likelihood = -104.29838
Iteration 0:
Iteration 1:
                    \log \text{ likelihood} = -99.504029
Iteration 2:
                   log likelihood = -99.407391
log likelihood = -99.407115
log likelihood = -99.407115
Iteration 3:
Iteration 4:
Iteration 5:
```

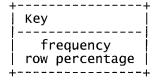
Number of obs = 117 Wald chi2(1) = 1.53 Log likelihood = -99.407115 Prob > chi2 = 0.2167

		Coef.	Std. Err.	Z	P> z	[95% Conf.	. Interval]
eq1	YRSEDN _cons	0984204 6608915	.0796641 .8054982	-1.24 -0.82	0.217 0.412	2545592 -2.239639	.0577184
eq2	YRSEDN _cons	2816578 1.028825	.0931305 .8317281	-3.02 1.24	0.002 0.216	4641902 6013321	0991254 2.658982

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf	. Interval]
eq1	YRSEDN	0.906268	0.217	0.775258	1.059417
eq2	YRSEDN	0.754532	0.002	0.628644	0.905629

LnMM3\_lf lns\_impair\_24 case YRSEDN



	LNS impai	<b>5</b>		
Case	Not impai	Impaired	Dead	Total
Control	42 67.74	10 16.13	10 16.13	100.00
Case	39 59.09	14 21.21	13   19.70	66 100.00
Total	81 63.28	24 18.75	23   17.97	128 100.00

#### Log multinomial model

initial: log likelihood = -<inf> (could not be evaluated) feasible: <math>log likelihood = -430.00672

feasible: log likelihood = -430.00672 rescale: log likelihood = -116.72354 rescale eq: log likelihood = -115.27517 Iteration 0: log likelihood = -115.27517 Iteration 1: log likelihood = -104.25383 Iteration 2: log likelihood = -99.430431 Iteration 3: log likelihood = -99.31392 Iteration 4: log likelihood = -99.313462 Iteration 5: log likelihood = -99.313462

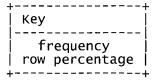
Number of obs = 117 wald chi2(2) = 1.58 Log likelihood = -99.313462 Prob > chi2 = 0.4534

	 	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1	case	.086865	.3909293	0.22	0.824	6793423	.8530724
	YRSEDN	0963246	.080246	-1.20	0.230	2536038	.0609546
	_cons	7321598	.8711743	-0.84	0.401	-2.43963	.9753105
eq2	case	.1077863	.3801151	0.28	0.777	6372257	.8527982
	YRSEDN	2794535	.0937897	-2.98	0.003	4632779	0956291
	_cons	.9437653	.8954123	1.05	0.292	8112106	2.698741

#### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	. Interval]
case	1.090749	0.824	0.506950	2.346846
SEDN	0.908169	0.230	0.775999	1.062851
case	1.113810	0.777	0.528757	2.346203
SEDN	0.756197	0.003	0.629218	0.908801

LnMM3\_lf lns\_impair\_24 case YRSEDN age sex\_recode



Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX

Case	LNS impai   Not impai	irmant at 24 Impaired	months Dead	Total
Control	42	10	10	62
	67.74	16.13	16.13	100.00
Case	39	14	13	66
	59.09	21.21	19.70	100.00
Total	81	24	23	128
	63.28	18.75	17.97	100.00

Log likelihood = -97.372681

Number of obs = 117 Wald chi2(4) = 1.60 Prob > chi2 = 0.8091

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 case YRSEDN age sex_recode _cons	.0952592 0903903 .0017563 .04774 9296625	.3908326 .0867905 .0132383 .3840961 1.460728	0.24 -1.04 0.13 0.12 -0.64	0.807 0.298 0.894 0.901 0.524	6707586 2604965 0241903 7050744 -3.792637	.8612771 .0797159 .0277028 .8005545 1.933312
eq2   case   YRSEDN   age   sex_recode   _cons	.12911 1891493 .0302324 192809 -1.88123	.356238 .0961923 .0178706 .3883245 1.847841	0.36 -1.97 1.69 -0.50 -1.02	0.717 0.049 0.091 0.620 0.309	5691036 3776827 0047934 953911 -5.502931	.8273237 000616 .0652581 .5682929 1.740471

	   RR 	P> z  [95% Conf. Interval]
eq1		
case	1.099944	0.807 0.511321 2.366181
YRSEDN	0.913575	0.298 0.770669 1.082979
age	1.001758	0.894 0.976100 1.028090
sex_recode	1.048898	0.901 0.494072 2.226775
eq2		
case	1.137815	0.717 0.566033 2.287189
YRSEDN	0.827663	0.049 0.685448 0.999384
age	1.030694	0.091 0.995218 1.067434
sex_recode	0.824639	0.620 0.385231 1.765251

\*\* 3. CIQ Total: pre-morbid \*\*

LnMM3\_lf lns\_impair\_24 ciq\_total

#### Log multinomial model

log likelihood = -<inf>
log likelihood = -450.00736 initial: (could not be evaluated)

log likelihood = -450.00/30 log likelihood = -125.18049 feasible: rescale:

log likelihood = -123.18049 log likelihood = -123.49376 log likelihood = -123.49376 log likelihood = -110.86887 log likelihood = -104.11716 log likelihood = -104.11648 log likelihood = -104.11648 rescale eq: Iteration 0: Iteration 1: Iteration 2: Iteration 3: Iteration 4:

Iteration 5:

Log likelihood = -104.11648

Number of obs Wald chi2(1) Prob > chi2 126 1.48 0.2230

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 ciq_total _cons	037208 -1.06782	.0305354 .4894171	-1.22 -2.18	0.223 0.029	0970564 -2.02706	.0226403 1085801
eq2 ciq_total _cons	1223324 0311523	.0321039 .3937384	-3.81 -0.08	0.000 0.937	1852549 8028654	05941 .7405608

#### Exponentiated values of the model coefficients and their 95% confidence limits

	   RR	P>   z	[95% Conf.	Interval]
eq1 ciq_total	0.963476	0.223	0.907505	1.022899
eq2 ciq_total	0.884854	0.000	0.830892	0.942320

#### LnMM3\_lf lns\_impair\_24 case ciq\_total

+	<del> </del>
	Key
	frequency
	row percentage
4	+ <del>-</del>

Case	LNS impai   Not impai	irmant at 24 Impaired	months Dead	Total
Control	42	10	10	62
	67.74	16.13	16.13	100.00
Case	39	14	13	66
	59.09	21.21	19.70	100.00
Total	81   63.28	24 18.75	23 17.97 Page 7	128 100.00

Number of obs = 126 wald chi2(2) = 1.73 Log likelihood = -103.45941 Prob > chi2 = 0.4210

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case ciq_total _cons	.1873925  0362327   -1.187297	.3720311 .0313006 .5661912	0.50 -1.16 -2.10	0.614 0.247 0.036	541775 0975807 -2.297012	.91656 .0251153 077583
eq2 case ciq_total _cons	.2828772  1250076  1586129	.3599538 .0327748 .4725623	0.79 -3.81 -0.34	0.432 0.000 0.737	4226193 1892451 -1.084818	.9883737 0607701 .7675922

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1 case ciq_total	1.206101 0.964416	0.614 0.247	0.581715 0.907029	2.500673 1.025433
eq2 case ciq_total	1.326942 0.882490	0.432 0.000	0.655328 0.827584	2.686861 0.941040

. LnMM3\_lf lns\_impair\_24 case ciq\_total age sex\_recode

+   Key	+ !
   frequency	
row percentag	e

Case	LNS impai   Not impai	irmant at 24 Impaired	months Dead	Total
Control	42	10	10	62
	67.74	16.13	16.13	100.00
Case	39	14	13	66
	59.09	21.21	19.70	100.00
Total	81	24	23   Page 8	128

#### Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX 18.75 17.97 | 63.28 100.00

#### Log multinomial model

log likelihood = -<inf>
log likelihood = -450.00736 (could not be evaluated) initial: feasible:

 $log\ likelihood = -125.18049$ rescale: log likelihood = -123.49376rescale eq: log likelihood = -123.49376 log likelihood = -109.93847 log likelihood = -101.63188 log likelihood = -101.09966 log likelihood = -101.09154 Iteration 0: Iteration 1: Iteration 2: Iteration 3: Iteration 4: Iteration 5:

log likelihood = -101.09153
log likelihood = -101.09153 Iteration 6:

Log like	elihood =	-101.	09153	

Number of obs	=	126
Wald chi2(4)	=	2.16
Prob > chi2	=	0.7060

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode _cons	.235719 0399357 .0006543 .2472514 -1.315392	.3757709 .035477 .0129814 .3797095 1.147026	0.63 -1.13 0.05 0.65 -1.15	0.530 0.260 0.960 0.515 0.251	5007785 1094693 0247889 4969655 -3.563521	.9722164 .0295979 .0260974 .9914682 .9327375
eq2 case ciq_total age sex_recode _cons	.3109257 1085735 .0323968 .0427993 -2.603231	.4105247 .0369638 .0172911 .3932509 1.416624	0.76 -2.94 1.87 0.11 -1.84	0.449 0.003 0.061 0.913 0.066	4936879 1810212 0014931 7279584 -5.379764	1.115539 0361258 .0662867 .8135569 .1733014

### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode	1.265819 0.960851 1.000654 1.280501	0.530 0.260 0.960 0.515	0.606059 0.896310 0.975516 0.608374	2.643798 1.030040 1.026441 2.695189
eq2 case ciq_total age sex_recode	1.364688 0.897113 1.032927 1.043728	0.449 0.003 0.061 0.913	0.610371 0.834418 0.998508 0.482894	3.051213 0.964519 1.068533 2.255918

<sup>\*\* 4.</sup> Charlson age condition: pre-morbid \*\*

Log multinomial model

log likelihood = -<inf>
log likelihood = -470.00736 (could not be evaluated) initial:

feasible:

Page 9

rename charlson\_condition\_age caci

LnMM3\_lf lns\_impair\_24 caci

# Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX log likelihood = -127.68049

```
rescale:
                       log likelihood = -125.99376
log likelihood = -125.99376
log likelihood = -109.53756
rescale eq:
Iteration 0:
Iteration 1:
                       \log likelihood = -101.20706
Iteration 2:
                       log\ likelihood = -100.5038
Iteration 3:
                       log likelihood = -100.49562
log likelihood = -100.49559
log likelihood = -100.49559
Iteration 4:
Iteration 5:
Iteration 6:
```

Number of obs 128 Wald chi2(1) 0.01 Prob > chi2 0.9365

Log likelihood = -100.49559

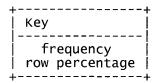
		Coef.	Std. Err.	z	P> z	 [95% Conf.	Interval]
eq1	caci _cons	00415 -1.655021	.0521011	-0.08 -5.53	0.937 0.000	1062664 -2.241541	.0979663 -1.0685
eq2	caci _cons	.2501291 -3.30606	.0405781 .4441829	6.16 -7.44	0.000 0.000	.1705974 -4.176643	.3296608 -2.435478

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	. Interval]
eq1	caci	0.995859	0.937	0.899185	1.102926
eq2	caci	1.284191	0.000	1.186013	1.390496

#### LnMM3\_lf lns\_impair\_24 case caci

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	LNS impai   Not impai	rmant at 24 Impaired	months Dead	Total
Control	42	10	10	62
	67.74	16.13	16.13	100.00
Case	39	14	13	66
	59.09	21.21	19.70	100.00
Total	81	24	23	128
	63.28	18.75	17.97	100.00

#### Log multinomial model

log likelihood = -<inf>
log likelihood = -470.00736 (could not be evaluated) initial:

feasible:  $log\ likelihood = -127.68049$ rescale: log likelihood = -125.99376rescale eq:

Page 10

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX: log likelihood = -125.99376: log likelihood = -107.66909: log likelihood = -96.460562: log likelihood = -04.314878 Iteration 0: Iteration 1: Iteration 2:  $\log likelihood = -94.214878$ Iteration 3:  $\log likelihood = -93.842963$ Iteration 4: Iteration 5: log likelihood = -93.820182 log likelihood = -93.81994 Iteration 6: log likelihood = Iteration 7: -93.81994

Log likelihood = -93.81994

Number of obs	=	128
Wald chi2(2)	=	0.54
proh > chi2	_	0.7640

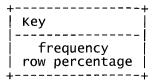
		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	case	.2780245	.3815749	0.73	0.466	4698486	1.025898
	caci	.0031831	.0568778	0.06	0.955	1082954	.1146616
	_cons	-1.841328	.418294	-4.40	0.000	-2.661169	-1.021487
eq2	case	1.55975	.4272405	3.65	0.000	.7223739	2.397126
	caci	.4235119	.0801796	5.28	0.000	.2663628	.580661
	_cons	-5.389956	.9445203	-5.71	0.000	-7.241182	-3.53873

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	case	1.320519	0.466	0.625097	2.789599
	caci	1.003188	0.955	0.897363	1.121494
eq2	case	4.757631	0.000	2.059316	10.991539
	caci	1.527316	0.000	1.305209	1.787219

#### LnMM3\_lf lns\_impair\_24 case caci age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	LNS impa <sup>-</sup>   Not impai	irmant at 24 Impaired	months Dead	Total
Control	42	10	10	62
	67.74	16.13	16.13	100.00
Case	39	14	13	66
	59.09	21.21	19.70	100.00
Total	81	24	23	128
	63.28	18.75	17.97	100.00

Log multinomial model

initial:

log likelihood =

-<inf> (could not be evaluated)

Page 11

```
log likelihood = -470.00736
feasible:
                  log likelihood = -127.68049
log likelihood = -125.99376
rescale:
rescale eq:
Iteration 0:
                  \log likelihood = -125.99376
                  \log likelihood = -112.48564
Iteration 1:
                  log likelihood = -103.11556
log likelihood = -94.887093
Iteration 2:
Iteration 3:
                  log likelihood = -92.962416
Iteration 4:
Iteration 5:
                  log likelihood = -92.872206
                  log\ likelihood = -92.871551
Iteration 6:
Iteration 7:
                  log likelihood = -92.871551
```

Number of obs 128 wald chi2(4) 1.27 Prob > chi2 0.8656

Log likelihood = -92.871551

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case caci age sex_recode _cons	.2058059 0353745 .0105983 .1440565 -2.355877	.4071134 .0820013 .0158467 .3781182 .8015592	0.51 -0.43 0.67 0.38 -2.94	0.613 0.666 0.504 0.703 0.003	5921217 1960941 0204608 5970415 -3.926904	1.003733 .1253451 .0416573 .8851544 78485
eq2 case caci age sex_recode _cons	1.206962 .4265101 .0218249 2517755 -6.608007	.52068 .08183 .0278389 .4003909 2.159446	2.32 5.21 0.78 -0.63 -3.06	0.020 0.000 0.433 0.529 0.002	.1864481 .2661263 0327383 -1.036527 -10.84044	2.227476 .5868939 .0763881 .5329762 -2.37557

#### Exponentiated values of the model coefficients and their 95% confidence limits

RR	P> z	[95% Conf.	Interval]
1.228515	0.613	0.553152	2.728449
1.010655	0.504	0.979747	1.133540 1.042537 2.423359
3.343313 1.531902 1.022065 0.777419	0.020 0.000 0.433 0.529	1.204962 1.304900 0.967792 0.354684	9.276426 1.798394 1.079381 1.703996
	1.228515 0.965244 1.010655 1.154949 3.343313 1.531902 1.022065	1.228515       0.613         0.965244       0.666         1.010655       0.504         1.154949       0.703             3.343313       0.020         1.531902       0.000         1.022065       0.433	1.228515       0.613       0.553152         0.965244       0.666       0.821935         1.010655       0.504       0.979747         1.154949       0.703       0.550438         3.343313       0.020       1.204962         1.531902       0.000       1.304900         1.022065       0.433       0.967792

```
** 5. Apache3 ROD: cases only **
```

LnMM3\_lf lns\_impair\_24 apache3rod

#### Log multinomial model

```
(could not be evaluated)
initial:
                  log likelihood =
                                           -<inf>
                  log likelihood = -270.00354
feasible:
                  log\ likelihood = -66.938756
rescale:
rescale eq:
                  log likelihood = -66.938756
log likelihood = -66.938756
Iteration 0: Iteration 1:
                  \log \text{ likelihood} = -62.852708
Iteration 2:
                  log likelihood = -62.824378
                  \log likelihood = -62.824162
Iteration 3:
Iteration 4:
                  log likelihood = -62.824162
                                            Page 12
```

Number of obs	=	66
<pre>wald chi2(1)</pre>	=	0.32
Prob > chi2	=	0.5708

Log likelihood = -62.824162

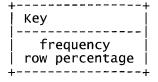
	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 apache3rod _cons	.4468689 -1.657819	.788248 .3182515	0.57 -5.21	0.571 0.000	-1.098069 -2.28158	1.991807 -1.034057
eq2 apache3rod _cons	   .5742907   -1.765546	.8053666 .3371696	0.71 -5.24	0.476 0.000	-1.004199 -2.426386	2.15278 -1.104705

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1 apache3rod	1.563409	0.571	0.333515	7.328762
eq2 apache3rod	1.775870	0.476	0.366338	8.608760

. LnMM3\_lf lns\_impair\_24 case apache3rod

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	LNS impa <sup>.</sup>   Not impai	irmant at 24 Impaired	months Dead	Total
Control	42	10	10	62
	67.74	16.13	16.13	100.00
Case	39	14	13	66
	59.09	21.21	19.70	100.00
Total	81	24	23	128
	63.28	18.75	17.97	100.00

Log multinomial model

note: case omitted because of collinearity note: case omitted because of collinearity

initial: log likelihood = -<inf> (could not be evaluated) feasible: log likelihood = -270.00354 rescale: log likelihood = -66.938756

rescale eq: log likelihood = -66.938756
Iteration 0: log likelihood = -66.938756
Iteration 1: log likelihood = -62.852708
Iteration 2: log likelihood = -62.824378
Iteration 3: log likelihood = -62.824162
Iteration 4: log likelihood = -62.824162

Number of obs = 66

Wald chi2(1)

0.32 Prob > chi20.5708

Log likelihood = -62.824162

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case apache3rod _cons	.4468689 -1.657819	(omitted) .788248 .3182515	0.57 -5.21	0.571 0.000	-1.098069 -2.28158	1.991807 -1.034057
eq2 case apache3rod _cons	.5742907   .1.765546	(omitted) .8053666 .3371696	0.71 -5.24	0.476 0.000	-1.004199 -2.426386	2.15278 -1.104705

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   Z	[95% Conf.	Interval]
eq1 case apache3rod	1.000000 1.563409	0.57i	1.000000 0.333515	1.000000 7.328762
eq2 case apache3rod	1.000000 1.775870	0.476	1.000000 0.366338	1.000000 8.608760

LnMM3\_lf lns\_impair\_24 case apache3rod age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

++
Key
frequency row percentage
++

LNS impairmant at 24 months							
Case	Not impai	Impaired	Dead	Total			
Control	42 67.74	10 16.13	10 16.13	62			
Case	39 59.09	14 21.21	13 19.70	66 100.00			
Total	81 63.28	24 18.75	23 17.97	128 100.00			

Log multinomial model

note: case omitted because of collinearity note: case omitted because of collinearity

(could not be evaluated) initial:

log likelihood = -<inf>
log likelihood = -270.00354
log likelihood = -66.938756 feasible: rescale: rescale eq:

log likelihood = -66.938756 log likelihood = -66.938756 log likelihood = -60.636702 log likelihood = -60.232669 Iteration 0: Iteration 1: Iteration 2: log likelihood = -60.225698 log likelihood = -60.225692 Iteration 3: Iteration 4:

Page 14

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX Iteration 5: log likelihood = -60.225692

Log likelihood	d = -60.22569	2		Wald	er of obs = chi2(3) = > chi2 =	2.28
	Coef.	Std. Err.	Z	P>   z	[95% Conf	. Interval]
eq1 case apache3rod age sex_recode _cons	0 .348378 0002165 .694811 -2.007833	(omitted) .7473653 .0153193 .5080298 1.000788	0.47 -0.01 1.37 -2.01	0.641 0.989 0.171 0.045	-1.116431 0302418 3009091 -3.969341	1.813187 .0298087 1.690531 0463247
eq2 case apache3rod age sex_recode _cons	0 .7340771 .0315384 5177521 -3.657013	(omitted) .8508439 .0212457 .5096518 1.538498	0.86 1.48 -1.02 -2.38	0.388 0.138 0.310 0.017	9335463 0101023 -1.516651 -6.672413	2.401701 .0731792 .481147 6416134

Exponentiated values of the model coefficients and their 95% confidence limits

	   RR	P>   z	[95% Conf. Interval]		
eq1 case apache3rod age sex_recode	1.000000 1.416768 0.999783 2.003330	0.641 0.989 0.171	1.000000 0.327446 0.970211 0.740145	1.000000 6.129954 1.030257 5.422359	
eq2 case apache3rod age sex_recode	1.000000 2.083558 1.032041 0.595858	0.388 0.138 0.310	1.000000 0.393157 0.989949 0.219446	1.000000 11.041939 1.075923 1.617929	

\*\* 1. FIM: pre-morbid \*\*

LnMM3\_lf digit\_impair\_24 fim

Log multinomial model

initial: feasible: rescale: rescale eq: Iteration 0: Iteration 1: Iteration 3: Iteration 4: Iteration 5:	<pre>log likelihood = -<inf> log likelihood = -430.00854 log likelihood = -124.35702 log likelihood = -121.97116 log likelihood = -121.97116 log likelihood = -116.98803 log likelihood = -112.04535 log likelihood = -111.66109 log likelihood = -111.66105 log likelihood = -111.66105</inf></pre>	(could not be evaluated)

```
Number of obs = 137
Wald chi2(1) = 0.27
Prob > chi2 = 0.6023
```

Log likelihood = -111.66105

		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	fim   _cons	.0093636	.0179691 2.219749	0.52 -1.38	0.602 0.167	0258551 -7.416541	.0445823 1.284717
eq2	fim _cons	0148416 0565178	.0035294 .3645897	-4.21 -0.16	0.000 0.877	021759 7711004	0079241 .6580649

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	fim	1.009408	0.602	0.974476	1.045591
eq2	fim	0.985268	0.000	0.978476	0.992107

. LnMM3\_lf digit\_impair\_24 case fim

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

+   Key	+
frequency   row percentag	je

		n impairmant months		
Case	Not impai	Impaired	Dead	Total
Control	50	8	10	68
	73.53	11.76	14.71	100.00
Case	44	12	13	69
	63.77	17.39	18.84	100.00
Total	94	20	23	137
	68.61	14.60	16.79	100.00

#### Log multinomial model

initial: log likelihood = -<inf> (could not be evaluated)

feasible: log likelihood = -430.00854

rescale: log likelihood = -124.35702

rescale eq: log likelihood = -121.97116

Iteration 0: log likelihood = -121.97116

Iteration 1: log likelihood = -116.55903

Iteration 2: log likelihood = -111.59302

Iteration 3: log likelihood = -111.08582

Iteration 5: log likelihood = -111.08582

Number of obs = 137 Wald chi2(2) = 1.33 Log likelihood = -111.08582 Prob > chi2 = 0.5146

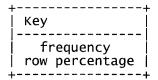
	Ар	pendix 8 2_IC	CU_Predict_I	mpairment	log_TH	ESIS_TECH_INDEX	(
		Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1	·	<b></b>			<del>-</del>		
	case fim	.4290283 .0106746	.4234249 .017475	$\begin{smallmatrix}1.01\\0.61\end{smallmatrix}$	0.311 0.541	4008693 0235757	1.258926 .044925
	_cons	-3.462013	2.191192 	-1.58	0.114 	-7.75667	.832645
eq2							
	case fim _cons	.0518965 0145583 116985	.4112418 .0040336 .5773927	0.13 -3.61 -0.20	0.900 0.000 0.839	7541226 022464 -1.248654	.8579157 0066525 1.014684

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	case	1.535764	0.311	0.669738	3.521637
	fim	1.010732	0.541	0.976700	1.045949
eq2	case	1.053267	0.900	0.470423	2.358240
	fim	0.985547	0.000	0.977786	0.993370

. LnMM3\_lf digit\_impair\_24 case fim age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



	Digit spa	ın impairmant months	at 24	
Case	Not impai	Impaired	Dead	Total
Control	50	8	10	68
	73.53	11.76	14.71	100.00
Case	44	12	13	69
	63.77	17.39	18.84	100.00
Total	94	20	23	137
	68.61	14.60	16.79	100.00

Log multinomial model

```
(could not be evaluated)
initial:
                    log likelihood =
                                                 -<inf>
                    log likelihood = -420.00854
feasible:
                    log likelihood = -121.85702
log likelihood = -119.47116
rescale:
rescale eq:
                    log likelihood = -119.47116
Iteration 0:
Iteration 1:
                    \log likelihood = -111.48529
                    log likelihood = -100.20492
log likelihood = -93.626651
log likelihood = -92.631256
log likelihood = -92.627108
Iteration 2:
Iteration 3:
Iteration 4:
Iteration 5:
Iteration 6:
                    log likelihood = -92.627103
```

Number of obs = 136Wald chi2(4) = 3.72

					<u></u>	
	Coef.	Std. Err.	z	P> z	[95% Conf.	Interval]
eq1 case fim age sex_recode _cons	.4844413 .0063823 .020436 .1531014 -4.423397	.4421704 .0243342 .0150764 .4213858 3.035379	1.10 0.26 1.36 0.36 -1.46	0.273 0.793 0.175 0.716 0.145	3821968 0413118 0091131 6727997 -10.37263	1.351079 .0540764 .0499851 .9790025 1.525836
eq2 case fim age sex_recode _cons	.2488879 0607038 .0891562 .4083883 -1.162975	.3734039 .0128857 .0199252 .4207037 .6519849	0.67 -4.71 4.47 0.97 -1.78	0.505 0.000 0.000 0.332 0.074	4829704 0859593 .0501036 4161758 -2.440841	.9807461 0354483 .1282088 1.232952 .1148923

#### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P> z  [95% Conf. Interval]
eq1 case fim age sex_recode	1.623268 1.006403 1.020646 1.165443	0.273
eq2 case fim age sex_recode	1.282598 0.941102 1.093251 1.504391	0.505

- \*\* 2. Years education: pre-morbid \*\*
- LnMM3\_lf digit\_impair\_24 YRSEDN

#### Log multinomial model

initial: feasible: rescale: rescale eq: Iteration 0: Iteration 2: Iteration 3: Iteration 4: Iteration 5: Iteration 6:	log likelihood = - <inf> log likelihood = -380.00763 log likelihood = -110.06372 log likelihood = -107.37316 log likelihood = -107.37316 log likelihood = -105.9731 log likelihood = -95.228697 log likelihood = -92.727054 log likelihood = -92.390688 log likelihood = -92.390571 log likelihood = -92.390571</inf>	(could not be evaluated)
		Number of obs = Wald chi2(1) =

Log 7	likelihood	I = -92.390572	1		Prob	> chi2 =	0.0369
		Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1	YRSEDN	2168422 1810492	.1039301	-2.09 0.19	0.037	4205414 -1 736522	0131429 2 098621

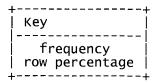
eq2							
•	YRSEDN	2876996	.0956926	-3.01	0.003	4752537	1001456
	_cons	1.044041	.8570262	1.22	0.223	6356993	2.723782

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	YRSEDN	0.805057	0.037	0.656691	0.986943
eq2	YRSEDN	0.749987	0.003	0.621727	0.904706

#### . LnMM3\_lf digit\_impair\_24 case YRSEDN

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



	Digit spa 	an impairmant months	t at 24	
Case	Not impai	Impaired	Dead	Total
Control	50	8	10	68
	73.53	11.76	14.71	100.00
Case	44	12	13	69
	63.77	17.39	18.84	100.00
Total	94	20	23	137
	68.61	14.60	16.79	100.00

#### Log multinomial model

initial: feasible: rescale: rescale eq: Iteration 0: Iteration 1: Iteration 2: Iteration 3: Iteration 4:	<pre>log likelihood =</pre>	(could not be evaluated)
Iteration 4: Iteration 5:	log likelihood = -91.720525 log likelihood = -91.720522	

Number of obs = 122 Wald chi2(2) = 5.51 Prob > chi2 = 0.0637

	 	Coef.	Std. Err.	z	P>   Z	[95% Conf.	Interval]
eq1	case YRSEDN _cons	.5025131 200359 3005975	.4962039 .1042784 1.097964	1.01 -1.92 -0.27	0.311 0.055 0.784	4700287 4047409 -2.452567	1.475055 .0040229 1.851372
eq2	+				<b>-</b>		

#### Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX 0.15 .0576306 .3884774 0.882 -.7037712 .8190323 case .0967916 0.003 -.4755644 -.0961485 YRSEDN

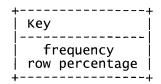
- 2858564 .9921363 0.289 -.8400173 \_cons .9347895 1.06 2.82429

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P> z	[95% Conf.	Interval]
eq1	case	1.652870	0.311	0.624984	4.371276
	YRSEDN	0.818437	0.055	0.667150	1.004031
eq2	case	1.059324	0.882	0.494716	2.268304
	YRSEDN	0.751370	0.003	0.621534	0.908329

LnMM3\_lf digit\_impair\_24 case YRSEDN age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



	Digit spa	an impairmant months	at 24	
Case	Not impai	Impaired	Dead	Total
Control	50	8	10	68
	73.53	11.76	14.71	100.00
Case	44	12	13	69
	63.77	17.39	18.84	100.00
Total	94	20	23	137
	68.61	14.60	16.79	100.00

#### Log multinomial model

initial: log likelihood = (could not be evaluated) -<inf>

feasible: log likelihood = -380.00763

log likelihood = -110.06372 log likelihood = -107.37316 log likelihood = -107.37316 rescale: rescale eq:

Iteration 0: log likelihood = -96.356083Iteration 1: log likelihood = -89.895794Iteration 2:

Iteration 3:

log likelihood = -89.160734 log likelihood = -89.155651 log likelihood = -89.155649 Iteration 4: Iteration 5:

Log likelihood = -89.155649

Number of obs 122 5.80 Wald chi2(4) 0.2144 Prob > chi2

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case   YRSEDN   age	.516024 1732108 .0102246	.4923605 .1079205 .0171228	1.05 -1.60 0.60	0.295 0.108 0.550	4489848 3847311 0233355	1.481033 .0383094 .0437848

Page 20

Ар	pendix 8 2_IC	U_Predict_I	mpairment		ESIS_TECH_INDEX	
sex_recode	.095891	.4320992	0.22	0.824	7510078	.9427898
_cons	-1.282519	1.837935	-0.70	0.485	-4.884805	2.319768
	·		<del>-</del>	- <b></b>		
eq2						
case	.1125891	.3609491	0.31	0.755	5948581	.8200363
YRSEDN	2063816	.0943966	-2.19	0.029	3913956	0213676
age i	.0302578	.017648	1.71	0.086	0043316	.0648472
sex_recode l	2226576	.3888247	-0.57	0.567	98474	.5394248
_cons	-1.738985	1.811656	-0.96	0.337	-5.289766	1.811796

Exponentiated values of the model coefficients and their 95% confidence limits

-	RR	P> z	[95% Conf.	Interval]
eq1 case YRSEDN age sex_recode	1.675353 0.840960 1.010277 1.100639	0.295 0.108 0.550 0.824	0.638276 0.680634 0.976935 0.471891	4.397485 1.039053 1.044757 2.567133
eq2 case YRSEDN age sex_recode	1.119172 0.813523 1.030720 0.800389	0.755 0.029 0.086 0.567	0.551641 0.676113 0.995678 0.373536	2.270582 0.978859 1.066996 1.715020

- . \*\* 3. CIQ Total: pre-morbid \*\*
- . LnMM3\_lf digit\_impair\_24 ciq\_total

#### Log multinomial model

initial: feasible: rescale: rescale eq: Iteration 0: Iteration 2: Iteration 3: Iteration 4: Iteration 5:	<pre>log likelihood = -<inf> log likelihood = -410.00854 log likelihood = -119.35702 log likelihood = -119.35702 log likelihood = -119.35702 log likelihood = -105.74935 log likelihood = -103.18004 log likelihood = -102.94454 log likelihood = -102.94134 log likelihood = -102.94134</inf></pre>	(could not be evaluated)

Number of obs = 139 wald chi2(1) = 0.07 Prob > chi2 = 0.7977

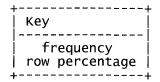
	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 ciq_total _cons	.0092486 -2.066174	.0359933 .6505295	0.26 -3.18	0.797 0.001	0612969 -3.341188	.0797942 7911594
eq2 ciq_total _cons	  1451478   .2421023	.0343306 .4124323	-4.23 0.59	0.000 0.557	2124346 5662501	0778609 1.050455

	   RR 	P>   z	[95% Conf.	Interval]

eq1 ciq_total	1.009292	0.797	0.940544	1.083064
eq2 ciq_total	0.864894	0.000	0.808613	0.925093

#### . LnMM3\_lf digit\_impair\_24 case ciq\_total

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



	Digit spa	n impairmant months	at 24	
Case	Not impai	Impaired	Dead	Total
Control	50 73.53	8 11.76	10 14.71	68 100.00
Case	44 63.77	12 17.39	13 18.84	69 100.00
Total	   94   68.61	20 14.60	23 16.79	137 100.00

#### Log multinomial model

initial:	<pre>log likelihood = -<inf></inf></pre>	(could not be evaluated)
feasible:	$log\ likelihood = -410.00854$	
rescale:	$log\ likelihood = -119.35702$	
rescale eq:	log likelihood = -119.35702	
Iteration 0:	$log\ likelihood = -119.35702$	
Iteration 1:	$log\ likelihood = -104.85322$	
Iteration 2:	$\log likelihood = -101.66202$	
	7 7 1 7 1 1 404 33453	

Iteration 2: log likelihood = -101.66202 Iteration 3: log likelihood = -101.33153 Iteration 4: log likelihood = -101.32626 Iteration 5: log likelihood = -101.32626

	Number of obs		135
	wald chi2(2)	=	0.85
Log likelihood = -101.32626	Prob > chi2	=	0.6539

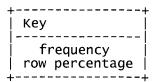
	Coef.	Std. Err.	Z	P>   z	[95% Conf	. Interval]
eq1 case ciq_total _cons	.3773247 .0134426 -2.34701	.4254907 .0378431 .7561702	0.89 0.36 -3.10	0.375 0.722 0.002	4566218 0607284 -3.829076	1.211271 .0876136 8649437
eq2 case ciq_total _cons	.5026241 1619354 .1830782	.3676746 .039155 .4899642	1.37 -4.14 0.37	0.172 0.000 0.709	2180048 2386778 777234	1.223253 085193 1.14339

<del></del>	1		
	RR	P>   z	[95% Conf. Interval]

eq1 case ciq_total	   1.458378   1.013533	0.375 0.722	0.633420 0.941079	3.357751 1.091566
eq2 case ciq_total	1.653053 0.850496	0.172 0.000	0.804122 0.787669	3.398224 0.918335

. LnMM3\_lf digit\_impair\_24 case ciq\_total age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



	Digit span impairmant at 24 months							
Case	Not impai	Impaired	Dead	Total				
Control	50	8	10	68				
	73.53	11.76	14.71	100.00				
Case	44	12	13	69				
	63.77	17.39	18.84	100.00				
Total	94	20	23	137				
	68.61	14.60	16.79	100.00				

#### Log multinomial model

initial:	log likelihood =	- <inf></inf>	(could not b	e evaluated)
feasible:	$\log likelihood = -4$	100 00854	_	_

rescale: log likelihood = -400.00834 rescale eq: log likelihood = -116.85702 Iteration 0: log likelihood = -116.85702

Iteration 0: log likelihood = -116.85702 Iteration 1: log likelihood = -100.05751 Iteration 2: log likelihood = -96.338208

Iteration 2: log likelihood = -96.338208 Iteration 3: log likelihood = -95.959067 Iteration 4: log likelihood = -95.950898 Iteration 5: log likelihood = -95.950892

Number of obs = 134 Wald chi2(4) = 4.34 Log likelihood = -95.950892 Prob > chi2 = 0.3617

	<b></b>					
	Coef.	Std. Err.	Z	P>   z	[95% Conf.	<pre>Interval]</pre>
eq1 case ciq_total age sex_recode cons	. 4224628 . 0250758 . 0282905 . 1563101 4.521656	.439632 .0426822 .0170048 .4366905	0.96 0.59 1.66 0.36	0.337 0.557 0.096 0.720 0.003	4392002 0585798 0050383 6995876 -7.532501	1.284126 .1087315 .0616194 1.012208 -1.510811
			-2.94		-7.332301	-1.310011
eq2 case ciq_total age sex_recode _cons	.390735 132469 .024299 .0229635 -1.805217	.3653855 .0427138 .0180028 .3490182 1.576895	1.07 -3.10 1.35 0.07 -1.14	0.285 0.002 0.177 0.948 0.252	3254076 2161864 0109859 6610996 -4.895874	1.106877 0487516 .0595839 .7070266 1.285441

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX Exponentiated values of the model coefficients and their 95% confidence limits

	···			
	   RR	P>   z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode	1.525714 1.025393 1.028695 1.169189	0.337 0.557 0.096 0.720	0.644552 0.943103 0.994974 0.496790	3.611509 1.114863 1.063557 2.751669
eq2 case ciq_total age sex_recode	1.478067 0.875930 1.024597 1.023229	0.285 0.002 0.177 0.948	0.722233 0.805585 0.989074 0.516283	3.024898 0.952418 1.061395 2.027952

<sup>.</sup> . \*\* 4. Charlson age condition: pre-morbid \*\*

initial: feasible: rescale: rescale eq: Iteration 0:	<pre>log likelihood = -<inf> log likelihood = -420.00854 log likelihood = -121.85702 log likelihood = -119.47116 log likelihood = -119.47116</inf></pre>	(could not be evaluated)
Iteration 1: Iteration 2: Iteration 3: Iteration 4: Iteration 5: Iteration 6: Iteration 7:	log likelihood = -106.7237 log likelihood = -101.34778 log likelihood = -98.550423 log likelihood = -96.716994 log likelihood = -96.649934 log likelihood = -96.64968 log likelihood = -96.649668	(not concave)

	Number of obs		
	Wald chi2(1)	=	
Log likelihood = -96.649668	Prob > chi2	=	(

		Coef.	Std. Err.	z	P> z	[95% Conf.	Interval]
eq1	caci _cons	0039402 -1.950288	.0616279 .3504675	-0.06 -5.56	0.949 0.000	1247287 -2.637192	.1168483
eq2	caci _cons	.2660514 -3.467121	.0423282 .4573916	6.29 -7.58	0.000 0.000	.1830896 -4.363592	.3490131

0.9490

		RR	P>   z	[95% Conf.	. Interval]
eq1	caci	0.996068	0.949	0.882736	1.123949
eq2	caci	1.304802	0.000	1.200922	1.417668

LnMM3\_lf digit\_impair\_24 case caci

LnMM3\_lf digit\_impair\_24 caci

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

Key	-+
frequency	-   
row percentage	_

	Digit span impairmant at 24   months							
Case	Not impai	Impaired	Dead	Total				
Control	50	8	10	68				
	73.53	11.76	14.71	100.00				
Case	44	12	13	69				
	63.77	17.39	18.84	100.00				
Total	94	20	23	137				
	68.61	14.60	16.79	100.00				

Log multinomial model

```
(could not be evaluated)
initial:
                             log likelihood =
                                                                     -<inf>
                             log likelihood = -420.00854
log likelihood = -121.85702
log likelihood = -119.47116
log likelihood = -119.47116
feasible:
rescale:
rescale eq:
Iteration 0:
Iteration 1:
                             \log likelihood = -105.60969
                             log likelihood = -103.60969
log likelihood = -97.754844
log likelihood = -95.017066
log likelihood = -94.876112
log likelihood = -94.871779
log likelihood = -94.871761
log likelihood = -94.871761
Iteration 2:
Iteration 3:
Iteration 4:
Iteration 5:
Iteration 6:
Iteration 7:
```

Number of obs = 136 Wald chi2(2) = 1.32 Log likelihood = -94.871761 Prob > chi2 = 0.5163

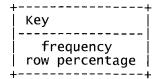
		Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1	case	.5092805	.4436347	1.15	0.251	3602275	1.378789
	caci	0029337	.061759	-0.05	0.962	1239791	.1181116
	_cons	-2.245262	.4563019	-4.92	0.000	-3.139598	-1.350927
eq2	case	.2871884	.2501555	1.15	0.251	2031074	.7774843
	caci	.2831523	.0470329	6.02	0.000	.1909695	.375335
	_cons	-3.738218	.5203929	-7.18	0.000	-4.758169	-2.718267

		RR	P>   Z	[95% Conf.	Interval]
eq1	case caci	1.664093 0.997071	0.251 0.962	0.697518 0.883398	3.970089 1.125370
eq2	case	1.332675	0.251	0.816191	2.175991

1.455479

LnMM3\_lf digit\_impair\_24 case caci age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



	Digit spa	n impairmant months	at 24	
Case	Not impai	Impaired	Dead	Total
Control	50	8	10	68
	73.53	11.76	14.71	100.00
Case	44	12	13	69
	63.77	17.39	18.84	100.00
Total	94	20	23	137
	68.61	14.60	16.79	100.00

#### Log multinomial model

(could not be evaluated) initial: log likelihood = -<inf> feasible: likelihood = -420.00854log rescale: log likelihood = -121.85702rescale eq: log likelihood = -119.47116log likelihood = -119.47116Iteration 0: likelihood = -102.86664Iteration 1: log  $\log 1$  ikelihood = -93.303774Iteration 2: Iteration 3: log likelihood = -91.782776Iteration 4:  $\log$  likelihood = -91.651782 Iteration 5: likelihood = -91.647231log log likelihood = -91.647222 Iteration 6:

 $Log\ likelihood = -91.647222$ 

Number of obs 136 wald chi2(4) 5.93 0.2048 Prob > chi2

		<b></b>				
	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1   case   caci   age   sex_recode   _cons	.39475	.4348441	0.91	0.364	4575288	1.247029
	1413658	.105174	-1.34	0.179	3475031	.0647715
	.0439819	.0212159	2.07	0.038	.0023994	.0855643
	.0949956	.4264712	0.22	0.824	7408725	.9308637
	-4.45048	1.237655	-3.60	0.000	-6.876239	-2.024721
eq2 case caci age sex_recode cons	.2814358	.3803735	0.74	0.459	4640825	1.026954
	.2877937	.0490097	5.87	0.000	.1917364	.3838509
	.0163324	.0237565	0.69	0.492	0302294	.0628942
	.1356278	.3594377	0.38	0.706	5688571	.8401126
	-4.939255	1.677277	-2.94	0.003	-8.226657	-1.651852

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX

eq1				
case	1.484013	0.364	0.632846	3.479988
caci	0.868172	0.179	0.706450	1.066915
age İ	1.044963	0.038	1.002402	1.089332
sex_recode	1.099654	0.824	0.476698	2.536699
eq2				_
case	1.325031	0.459	0.628712	2.792547
caci	1.333482	0.000	1.211351	1.467927
age	1.016467	0.492	0.970223	1.064914
sex_recode	1.145256	0.706	0.566172	2.316628

- . \*\* 5. Apache3 ROD: cases only \*\*
- LnMM3\_lf digit\_impair\_24 apache3rod

initial: feasible: rescale: rescale eq: Iteration 0: Iteration 2: Iteration 3: Iteration 4:	log likelihood = -250 log likelihood = -250 log likelihood = -68.69 log likelihood = -66.40 log likelihood = -66.40 log likelihood = -62.70 log likelihood = -61.89 log likelihood = -61.80 log likelihood = -61.80 log likelihood = -61.80	0.004 93724 48118 48118 02686 95029 88041 80396	be evaluated)
Iteration 5:	log likelihood = -61.88		

	Number of obs	=	69
	wald chi2(1)	=	0.63
Log likelihood = -61.880396	Prob > chi2	=	0.4280

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 apache3rod _cons	.6957673 -1.926774	.8777254 .369149	0.79 -5.22	0.428 0.000	-1.024543 -2.650293	2.416078 -1.203255
eq2 apache3rod _cons	.5364537 -1.802771	.8602937 .3470929	0.62 -5.19	0.533 0.000	-1.149691 -2.483061	2.222598 -1.122482

#### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf	. Interval]
eq1 apache3rod	2.005247	0.428	0.358960	11.201834
eq2 apache3rod	1.709932	0.533	0.316735	9.231285

. LnMM3\_lf digit\_impair\_24 case apache3rod

1	
١	Key
١	
İ	frequency

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX | row percentage |

	Digit span impairmant at 24   months							
Case	Not impai	Impaired	Dead	Total				
Control	50	8	10	68				
	73.53	11.76	14.71	100.00				
Case	44	12	13	69				
	63.77	17.39	18.84	100.00				
Total	94	20	23	137				
	68.61	14.60	16.79	100.00				

note: case omitted because of collinearity note: case omitted because of collinearity

initial: log likelihood = -<inf> (could not be evaluated)
feasible: log likelihood = -250.004
rescale: log likelihood = -68.693724
rescale eq: log likelihood = -66.48118
Iteration 0: log likelihood = -66.48118

Iteration 0: log likelihood = -66.48118 Iteration 1: log likelihood = -62.702686 Iteration 2: log likelihood = -61.895029 Iteration 3: log likelihood = -61.88041

Iteration 4: log likelihood = -61.880396
Iteration 5: log likelihood = -61.880396

Log likelihood = -61.880396

Number of obs = 69 Wald chi2(1) = 0.63 Prob > chi2 = 0.4280

	Coef.	Std. Err.	Z	P> z	[95% Conf	. Interval]
eq1 case apache3rod _cons	0 .6957673 -1.926774	(omitted) .8777254 .369149	0.79 -5.22	0.428 0.000	-1.024543 -2.650293	2.416078 -1.203255
eq2 case apache3rod _cons	0 .5364537 -1.802771	(omitted) .8602937 .3470929	0.62 -5.19	0.533 0.000	-1.149691 -2.483061	2.222598 -1.122482

#### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf	. Interval]
eq1 case apache3rod	1.000000 2.005247	0.428	1.000000 0.358960	1.000000 11.201834
eq2 case apache3rod	1.000000 1.709932	0.533	1.000000 0.316735	1.000000 9.231285

LnMM3\_lf digit\_impair\_24 case apache3rod age sex\_recode

Key
frequency
row percentage

	Digit span impairmant at 24 months							
Case	Not impai	Impaired	Dead	Total				
Control	50	8	10	68				
	73.53	11.76	14.71	100.00				
Case	44	12	13	69				
	63.77	17.39	18.84	100.00				
Total	94	20	23	137				
	68.61	14.60	16.79	100.00				

note: case omitted because of collinearity note: case omitted because of collinearity

(could not be evaluated) initial: log likelihood = -<inf> log likelihood = -250.004 feasible: log likelihood = -68.693724 rescale: log likelihood = -08.093/24 log likelihood = -66.48118 log likelihood = -60.601632 log likelihood = -58.726367 log likelihood = -58.726367 rescale eq: Iteration 0: Iteration 1: Iteration 2: log likelihood = -58.668033 log likelihood = -58.66774 log likelihood = -58.66774 Iteration 3: Iteration 4: Iteration 5:

Log likelihood = -58.66774

Number of obs	=	69
wald chi2(3)	=	2.41
Prob > chi2	=	0.4922

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 case apache3rod age sex_recode _cons	0   .7423878   .0317693   .1185807   -4.092019	(omitted) .8838118 .0231418 .5162949 1.694027	0.84 1.37 0.23 -2.42	0.401 0.170 0.818 0.016	9898515 0135878 8933387 -7.41225	2.474627 .0771263 1.1305 7717873
eq2 case apache3rod age sex_recode _cons	0 .6604939 .0293086 3450346 -3.616038	(omitted) .8987107 .0208386 .5082754 1.528435	0.73 1.41 -0.68 -2.37	0.462 0.160 0.497 0.018	-1.100947 0115342 -1.341236 -6.611717	2.421934 .0701515 .6511668 6203595

	RR	P> z	[95% Conf.	Interval]
eq1 case apache3rod   age   sex_recode	1.000000 2.100946 1.032279 1.125898	0.401 0.170 0.818	1.000000 0.371632 0.986504 0.409287	1.000000 11.877277 1.080179 3.097205

eq2				·····
case	1.000000	•	1.000000	1.000000
apache3rod	1.935748	0.462	0.332556	11.267635
, age	1.029742	0.160	0.988532	1.072671
sex_recode	0.708196	0.497	0.261522	1.917777
i				

\*\*\*\*\*\*\*\*\*\*

\* IES-R Total: Impairment at 24 months \*

\*\* NOTE: no cases "Impaired" after 2 years (all those impaired at time 1 had died)

\*\* so cannot do multinomial regression. Need to recode (0=not impaired,

1=Dead) for log-binomial

tab case iesrtot\_impair\_24

	IES-R total   impairmant at 24   months					
Case		Dead	Total			
Control Case	59   58	10 13	69			
Total		23	140			

\*\*\*\*\*\*\*

\* SF36 PCS: Impairment at 24 months 

\*\* 1. FIM: pre-morbid \*\*
LnMM3\_lf sf36pcs\_impair\_24 fim

#### Log multinomial model

initial: log likelihood = -<inf> (could not be evaluated)  $log\ likelihood = -920.00372$ feasible:

log likelihood = -149.89074rescale: rescale eq:

log likelihood = -140.01063 log likelihood = -140.01063Iteration 0: Iteration 1:  $log\ likelihood = -134.66215$  $\log likelihood = -132.92238$ Iteration 2: Iteration 3:

log likelihood = -131.61798 log likelihood = -131.61663 log likelihood = -131.61663 Iteration 4: Iteration 5:

Number of obs 133 = wald chi2(1) 0.85  $Log\ likelihood = -131.61663$ 0.3555 Prob > chi2

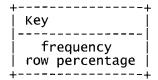
		Coef.	Std. Err.	z	P>   z	[95% Conf	f. Interval]
eq1	fim	.0052834	.0057182	0.92	0.356	0059242	.0164909
	_cons	-1.298419	.7108535	-1.83	0.068	-2.691666	.0948287
eq2	fim	0117049	.0039982	-2.93	0.003	0195412	0038686
	_cons	3967308	.4391522	-0.90	0.366	-1.257453	.4639917

# Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	. Interval]
eq1	fim	1.005297	0.356	0.994093	1.016628
eq2	fim	0.988363	0.003	0.980648	0.996139

#### . LnMM3\_lf sf36pcs\_impair\_24 case fim

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 PCS im   Not impai	npairmant at Impaired	24 months Dead   Total		
Control	17	35	10	62	
	27.42	56.45	16.13	100.00	
Case	24	34	13	71	
	33.80	47.89	18.31	100.00	
Total	41	69	23	133	
	30.83	51.88	17.29	100.00	

#### Log multinomial model

initial:	<pre>log likelihood = -<inf></inf></pre>	(could not be evaluated)
feasible:	log likelihood = -920.00372	
rescale:	$log\ likelihood = -149.89074$	
rescale eq:	log likelihood = -140.01063	
Iteration 0:	$log\ likelihood = -140.01063$	
Iteration 1:	log likelihood = -134.451	
Iteration 2:	log likelihood = -133.10648	
Iteration 3:	$log\ likelihood = -131.17944$	
Iteration 4:	log likelihood = -131.13591	
Iteration 5:	$log\ likelihood = -131.13572$	
Iteration 6:	log likelihood = -131.13572	

	Wara chile(2)	= =	13: 1.4:
$Log\ likelihood = -131.13572$	Prob > chi2	=	0.483

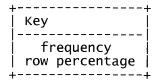
		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	case	1273138	.1682326	-0.76	0.449	4570437	.202416
	fim	.0045935	.0057584	0.80	0.425	0066927	.0158798
	_cons	-1.14925	.7325168	-1.57	0.117	-2.584956	.2864568
eq2	case	0864821	.4160047	-0.21	0.835	9018364	.7288722
	fim	0120795	.0044865	-2.69	0.007	0208729	0032861
	_cons	3061524	.6339879	-0.48	0.629	-1.548746	.9364411

# Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	case	0.880457	0.449	0.633153	1.224357
	fim	1.004604	0.425	0.993330	1.016007
eq2	case	0.917152	0.835	0.405824	2.072742
	fim	0.987993	0.007	0.979343	0.996719

### . LnMM3\_lf sf36pcs\_impair\_24 case fim age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 PCS in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	17	35	10	62
	27.42	56.45	16.13	100.00
Case	24	34	13	71
	33.80	47.89	18.31	100.00
Total	41	69	23	133
	30.83	51.88	17.29	100.00

#### Log multinomial model

log likelihood = -<inf>
log likelihood = -920.00372
log likelihood = -149.89074 (could not be evaluated) initial: feasible: rescale: log likelihood = -140.01063 log likelihood = -140.01063 log likelihood = -120.99405 log likelihood = -113.4224 rescale eq: Iteration 0: Iteration 1: Iteration 2:  $\log \text{likelihood} = -109.26476$ Iteration 3: log likelihood = -106.34672 log likelihood = -106.1363 log likelihood = -106.13376 Iteration 4: Iteration 5: Iteration 6:  $log\ likelihood = -106.13376$ Iteration 7:

Log likelihood = -106.13376

Number of obs	=	133
Wald chi2(4)	=	9.37
Prob > chi2	=	0.0525

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case fim age sex_recode _cons	3380701 0008027 .0113019 .3930768 -1.297622	.1863987 .0078271 .0046109 .1974453 .926164	-1.81 -0.10 2.45 1.99 -1.40	0.070 0.918 0.014 0.047 0.161	7034048 0161435 .0022646 .006091 -3.11287	.0272646 .014538 .0203391 .7800626 .5176261
eq2	 					

Ар	pendix 8 2_IC	U_Predict_I	mpairment	log_THE	SIS_TECH_INDE	X
case	4043285	.6743646	-0.60	0.549	-1.726059	.9174018
fim	054668	.0172387	-3.17	0.002	0884553	0208808
age	.069085	.022877	3.02	0.003	.024247	.113923
sex_recode	.9984989	.7689917	1.30	0.194	5086972	2.505695
_cons	4124227	.8936944	-0.46	0.644	-2.164031	1.339186

	RR	P> z	[95% Conf	. Interval]
eq1 case fim age sex_recode	0.713145 0.999198 1.011366 1.481532	0.070 0.918 0.014 0.047	0.494897 0.983986 1.002267 1.006110	1.027640 1.014644 1.020547 2.181609
eq2 case fim age sex_recode	0.667425 0.946799 1.071527 2.714204	0.549 0.002 0.003 0.194	0.177984 0.915344 1.024543 0.601278	2.502779 0.979336 1.120666 12.252071

- . \*\* 2. Years education: pre-morbid \*\*
- LnMM3\_lf sf36pcs\_impair\_24 YRSEDN

#### Log multinomial model

```
initial:
                    log likelihood =
                                                -<inf>
                                                          (could not be evaluated)
                    log likelihood = -830.00345
feasible:
                    log likelihood = -136.08776
log likelihood = -127.75376
rescale:
rescale eq:
                    log
                    log\ likelihood = -127.75376
Iteration 0:
                    \log likelihood = -113.24866
Iteration 1:
                    log likelihood = -112.20939
log likelihood = -111.26547
Iteration 2:
                   log likelihood = -111.26547
log likelihood = -110.92559
Iteration 3:
Iteration 4:
Iteration 5:
                   log\ likelihood = -110.89853
                   log likelihood = -110.89836
log likelihood = -110.89836
Iteration 6:
Iteration 7:
```

Number of obs = 121 wald chi2(1) = 2.14 Log likelihood = -110.89836 Prob > chi2 = 0.1431

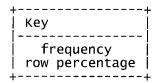
		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	YRSEDN _cons	0512078 1384823	.0349678 .3547701	-1.46 -0.39	0.143 0.696	1197434 8338189	.0173278
eq2	YRSEDN _cons	2601127 .7795363	.0844299 .7473903	-3.08 1.04	0.002 0.297	4255923 6853218	0946332 2.244394

		   RR	P>   z	[95% Conf.	Interval]
eq1	YRSEDN	0.950081	0.143	0.887148	1.017479

eq2				
YRSEDN	0.770965	0.002	0.653383	0.909707

#### . LnMM3\_lf sf36pcs\_impair\_24 case YRSEDN

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 PCS in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	17	35	10	62
	27.42	56.45	16.13	100.00
Case	24	34	13	71
	33.80	47.89	18.31	100.00
Total	41	69	23	133
	30.83	51.88	17.29	100.00

#### Log multinomial model

(could not be evaluated) initial: log likelihood = -<inf> feasible:  $log\ likelihood = -830.00345$ rescale: log likelihood = -136.08776log likelihood = -127.75376log likelihood = -127.75376rescale eq: Iteration 0: likelihood = Iteration 1: log -112.8949 Iteration 2:  $\log likelihood = -110.10461$ Iteration 3:  $log\ likelihood = -108.69999$ log likelihood = -108.63149 log likelihood = -108.63137 log likelihood = -108.63137 Iteration 4: Iteration 5: Iteration 6:

Log likelihood = -108.63137

Number of obs = 121 Wald chi2(2) = 3.45 Prob > chi2 = 0.1780

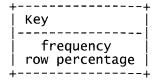
	·	Coef.	Std. Err.	Z	P> z	 [95% Conf.	Interval]
eq1	case	1610462	.1827477	-0.88	0.378	5192251	.1971328
	YRSEDN	0460516	.0366695	-1.26	0.209	1179225	.0258194
	_cons	1042793	.3512038	-0.30	0.767	7926261	.5840674
eq2	case	1.035397	.4990974	2.07	0.038	.0571836	2.01361
	YRSEDN	4514777	.1555225	-2.90	0.004	7562961	1466592
	_cons	1.96436	1.189965	1.65	0.099	3679282	4.296648

		RR	P>   z	[95% Conf.	Interval]
eq1	case	0.851253	0.378	0.594981	1.217906

	Ap YRSEDN	pendix 8 2_ICU_Predict_Impairment 0.954993	log_THES 0.209	SIS_TECH_INDEX 0.888765	1.026156
eq2	case	2.816223	0.038	1.058850	7.490306
	YRSEDN	0.636687	0.004	0.469402	0.863588

. LnMM3\_1f sf36pcs\_impair\_24 case YRSEDN age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 PCS in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	17	35	10	62
	27.42	56.45	16.13	100.00
Case	24	34	13	71
	33.80	47.89	18.31	100.00
Total	41	69	23	133
	30.83	51.88	17.29	100.00

 $\log likelihood = -102.37787$ 

#### Log multinomial model

**Iteration 8:** 

log likelihood = -<inf>
log likelihood = -830.00345 initial: (could not be evaluated) feasible: rescale:  $log\ likelihood = -136.08776$ log likelihood = -127.75376 log likelihood = -127.75376 log likelihood = -113.09483 rescale eq: Iteration 0: Iteration 1: log likelihood = Iteration 2: -107.5785  $log\ likelihood = -104.53315$ Iteration 3: log likelihood = -103.05234 log likelihood = -102.54299 log likelihood = -102.38363 Iteration 4: Iteration 5:
Iteration 6:  $\log likelihood = -102.37787$ Iteration 7:

Log likelihood = -102.37787

Number of obs	=	121
wald chi2(4)	=	11.13
Prob > chi2	=	0.0251

	Coef.	Std. Err.	z	P>   z	[95% Conf.	. Interval]
eq1 case YRSEDN age sex_recode _cons	4238428 .0052746 .0132324 .4669189 -1.56115	.1958194 .0385419 .0061517 .2122004 .7306972	-2.16 0.14 2.15 2.20 -2.14	0.030 0.891 0.031 0.028 0.033	8076417 0702661 .0011753 .0510137 -2.99329	0400439 .0808152 .0252895 .882824 1290096
eq2 case YRSEDN   age   sex_recode   _cons	1.222806 3455811 .0070916 5429069 .5724347	.6418592 .1656938 .0139945 .5090358 2.008679	1.91 -2.09 0.51 -1.07 0.28	0.057 0.037 0.612 0.286 0.776	0352146 6703349 0203371 -1.540599 -3.364504	2.480827 0208273 .0345203 .454785 4.509373

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX

Exponentiated values of the model coefficients and their 95% confidence limits

RR	P> z	[95% Conf.	. Interval]
0.654527 1.005288 1.013320	0.030 0.891 0.031	0.445908 0.932146 1.001176	0.960747 1.084171 1.025612
1.595072	0.028	1.052337	2.417718
3.396707 0.707809 1.007117 0.581057	0.057 0.037 0.612 0.286	0.965398 0.511537 0.979868 0.214253	11.951147 0.979388 1.035123 1.575835
•	1.005288 1.013320 1.595072 3.396707 0.707809 1.007117	1.005288	1.005288       0.891       0.932146         1.013320       0.031       1.001176         1.595072       0.028       1.052337         3.396707       0.057       0.965398         0.707809       0.037       0.511537         1.007117       0.612       0.979868

- . \*\* 3. CIQ Total: pre-morbid \*\*
- LnMM3\_lf sf36pcs\_impair\_24 ciq\_total

initia]: (could not be evaluated) log likelihood = -<inf>  $log\ likelihood = -900.00372$ feasible: log likelihood = -147.39074 log likelihood = -135.01063 log likelihood = -135.01063 rescale: rescale eq: Iteration 0: Iteration 1:  $\log \text{ likelihood} = -117.50472$ Iteration 2:  $\log likelihood = -115.27977$ log likelihood = -115.24862 log likelihood = -115.2485 log likelihood = -115.2485 Iteration 3: Iteration 4: Iteration 5:

Log likelihood = -115.2485

Number of obs	=	131
wald chi2(1)	=	1.06
Prob > chi2	=	0.3031

	Coef.	Std. Err.	Z	P> z	[95% Conf	. Interval]
eq1 ciq_total _cons	0157878 3849134	.0153321 .2511368	-1.03 -1.53	0.303 0.125	0458383 8771324	.0142627 .1073056
eq2 ciq_total _cons	1832286 .7594889	.0482738 .574926	-3.80 1.32	0.000 0.186	2778435 3673454	0886138 1.886323

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1 ciq_total	0.984336	0.303	0.955196	1.014365
eq2 ciq_total	0.832578	0.000	0.757415	0.915199

LnMM3\_lf sf36pcs\_impair\_24 case ciq\_total

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)
Page 36

Key	† 
frequency	l
row percentage	İ

Case	SF36 PCS ir Not impai	npairmant at Impaired	24 months Dead	Total
Control	17	35	10	62
	27.42	56.45	16.13	100.00
Case	24	34	13	71
	33.80	47.89	18.31	100.00
Total	41	69	23	133
	30.83	51.88	17.29	100.00

### Log multinomial model

initial: feasible: rescale: rescale eq: Iteration 0: Iteration 2: Iteration 3: Iteration 4: Iteration 5: Iteration 6:	<pre>log likelihood =</pre>	(could not be evaluated)

Log	likelihood	=	-112.4373

Number of obs	=	131
Wald chi2(2)	=	3.60
Prob > chi2	=	0.1650

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case ciq_total _cons	2590618 0230299 1333733	.1658622 .0164906 .2909885	-1.56 -1.40 -0.46	0.118 0.163 0.647	5841459 0553509 7037003	.0660222 .0092912 .4369537
eq2 case ciq_total _cons	2526694 2267869 1.4999	.3820436 .0637645 .9139857	-0.66 -3.56 1.64	0.508 0.000 0.101	-1.001461 3517631 2914788	.4961224 1018107 3.291279

	   RR	P> z  [95% Conf. Interval]
eq1 case ciq_total	0.771775 0.977233	0.118
eq2 case ciq_total	0.776725 0.797091	0.508 0.367342 1.642341 0.000 0.703447 0.903201

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

++
Key
i
frequency
row percentage
1

Case	SF36 PCS in Not impai	npairmant at Impaired	24 months Dead	Total
Control	17	35	10	62
	27.42	56.45	16.13	100.00
Case	24	34	13	71
	33.80	47.89	18.31	100.00
Total	41	69	23	133
	30.83	51.88	17.29	100.00

#### Log multinomial model

log likelihood = -<inf>
log likelihood = -900.00372
log likelihood = -147.39074 (could not be evaluated) initial: feasible: rescale:  $\log \text{likelihood} = -135.01063$ rescale eq: Iteration 0: log likelihood = -135.01063 log likelihood = -118.36514 log likelihood = -118.36514 log likelihood = -106.62538 Iteration 1: Iteration  $\overline{2}$ : Iteration 3: log likelihood = -100.07776Iteration 4: log likelihood = -95.095901log likelihood = -94.200333 log likelihood = -94.09714 **Iteration 5:** log likelihood = -94.09714 log likelihood = -94.096274 Iteration 6: Iteration 7: Iteration 8: log likelihood = -94.096273

Log likelihood = -94.096273

Number of obs = 131 wald chi2(4) = 16.73 Prob > chi2 = 0.0022

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	<pre>Interval]</pre>
eq1 case ciq_total age sex_recode _cons	6245043	.218746	-2.85	0.004	-1.053239	19577
	0108663	.0205842	-0.53	0.598	0512107	.0294781
	.0207614	.0061993	3.35	0.001	.0086109	.0329119
	.5727519	.2232916	2.57	0.010	.1351084	1.010395
	-1.749352	.6096214	-2.87	0.004	-2.944188	5545164
eq2 case case ciq_total age sex_recode cons	-1.268385	.7723327	-1.64	0.101	-2.78213	.2453588
	7140726	.3508564	-2.04	0.042	-1.401738	0264067
	0317827	.0296007	-1.07	0.283	0897991	.0262337
	1.916397	1.043861	1.84	0.066	1295331	3.962326
	9.784405	6.09858	1.60	0.109	-2.168591	21.7374

	<u> </u>	RR	P>   z	[95% Conf.	Interval]
eq1	case	0.535527	0.004	0.348806	0.822201

Ap	pendix 8 2_ICU_Predict_Impairm	ent log_THES	IS_TECH_INDE	X
ciq_total ˈ	0.989193	0.598	0.950078	1.029917
age	1.020978	0.001	1.008648	1.033459
sex_recode	1.773140	0.010	1.144661	2.746687
			_	<u> </u>
eq2				
case	0.281285	0.101	0.061907	1.278080
ciq_total	0.489646	0.042	0.246169	0.973939
age	0.968717	0.283	0.914115	1.026581
sex_recode	6.796425	0.066	0.878506	52.579506

- \*\* 4. Charlson age condition: pre-morbid \*\*
- LnMM3\_lf sf36pcs\_impair\_24 caci

log likelihood = -<inf>
log likelihood = -920.00372
log likelihood = -149.89074
log likelihood = -140.01063 initial: (could not be evaluated) feasible: rescale: rescale eq:  $\log likelihood = -140.01063$ Iteration 0: log likelihood = -140.01063 log likelihood = -119.85731 log likelihood = -114.25961 log likelihood = -113.02371 log likelihood = -112.55829 log likelihood = -112.55828 Iteration 1: Iteration 2: Iteration 3: Iteration 4: Iteration 5: Iteration 6:

 $Log\ likelihood = -112.55828$ 

Number of obs	=	133
<pre>wald chi2(1)</pre>	=	1.22
Prob > chi2	=	0.2696

		Coef.	Std. Err.	z	P> z	[95% Conf.	Interval]
eq1	caci _cons	.0217776 7600609	.0197266 .1345892	1.10 -5.65	0.270 0.000	0168858 -1.023851	.0604409 496271
eq2	caci _cons	.2375561 -3.30567	.0584701 .5419766	4.06 -6.10	0.000 0.000	.1229569 -4.367925	.3521553

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	caci	1.022016	0.270	0.983256	1.062305
eq2	caci	1.268146	0.000	1.130836	1.422129

- \*LnMM3\_lf sf36pcs\_impair\_24 case caci \*LnMM3\_lf sf36pcs\_impair\_24 case caci age sex\_recode
- \*\* above models wont converge
- \*\* 5. Apache3 ROD: cases only \*\*
- LnMM3\_lf sf36pcs\_impair\_24 apache3rod

Log multinomial model

```
Appendix 8 2_ICU_Predict_Impairment log_THESIS_TECH_INDEX
                   log likelihood = -<inf>
log likelihood = -470.00218
log likelihood = -79.17385
                                                       (could not be evaluated)
initial:
feasible:
rescale:
                   log\ likelihood = -76.805005
rescale eq:
                   log\ likelihood = -76.805005
Iteration 0:
                  log likelihood = -73.762286
log likelihood = -72.729166
log likelihood = -72.532468
Iteration 1:
Iteration 2:
Iteration 3:
                   log likelihood = -72.531858
Iteration 4:
                   \log likelihood = -72.531858
Iteration 5:
                                                              Number of obs
                                                              Wald chi2(1)
                                                                                           0.38
Log likelihood = -72.531858
                                                              Prob > chi2
                                                                                         0.5371
              | Coef. Std. Err. z P>|z| [95% Conf. Interval]
  apache3rod | .2281727 .3696673 0.62 0.537 -.4963619 .9527073
_cons | -.7910405 .1598867 -4.95 0.000 -1.104413 -.4776682
eq2
                  .403969 .7452129
-1.798187 .326015
  apache3rod |
                                                 0.54 0.588
                                                                      -1.056622
                                                                                       1.86456
     _cons |
                                                 -5.52
                                                          0.000
                                                                      -2.437165
                                                                                      -1.15921
Exponentiated values of the model coefficients and their 95% confidence limits
                                                                        [95% Conf. Interval]
                                                           P> | Z |
                         RR
eq1
  apache3rod
                     1.256302
                                                           0.537
                                                                        0.608741
                                                                                      2.592719
eq2
  apache3rod
                     1.497757
                                                           0.588
                                                                        0.347628
                                                                                      6.453093
  LnMM3_lf sf36pcs_impair_24 apache3rod age sex_recode
Log multinomial model
                                                      (could not be evaluated)
initial:
                  log likelihood =
                                        -<inf>
                  log\ likelihood = -470.00218
feasible:
                  log likelihood = -79.17385
rescale:
                  log likelihood = -76.805005
rescale eq:
                  log likelihood = -76.805005
log likelihood = -69.301944
log likelihood = -66.874683
Iteration 0: Iteration 1:
Iteration 2:
                  \log likelihood = -66.229571
Iteration 3:
                  log likelihood = -66.227791
log likelihood = -66.22779
Iteration 4:
Iteration 5:
                                                             Number of obs =
                                                                                             71
                                                             wald chi2(3) =
Prob > chi2 =
                                                                                           4.68
Log likelihood = -66.22779
                                                                                         0.1964
                      Coef. Std. Err.
                                                  z P>|z| [95% Conf. Interval]
eq1
                                3508927
0084429
                                                                      - 515261
.0008479
  apache3rod |
                  .172476
.0173957
.1513236
                                                  0.49
                                                           0.623
                                                                                        .860213
                                                                                    .860213
    age | .0173957 .0084429 2.06 0.039 .0008479 .0339434
ex_recode | .1513236 .2332007 0.65 0.516 -.3057415 .6083886
_cons | -1.978096 .6378344 -3.10 0.002 -3.228228 -.7279633
  sex_recode i
ea2
```

```
Appendix 8 2_ICU_Predict_Impairment log_THESIS_TECH_INDEX | .5306521 .768164 0.69 0.490 -.9749217
   apache3rod
                                                                             2.036226
                                            1.33
-0.71
                                                     0.185
                   .0219943
                               .0165994
                                                                 -.01054
                                                                              .0545286
          age
                               .5191872
                                                     0.480
                  -.3670911
                                                               -1.384679
                                                                              .6504972
   sex_recode
                  -3.115754
                               1.239286
                                            -2.51
                                                     0.012
                                                               -5.544711
                                                                             -.6867975
        _cons
Exponentiated values of the model coefficients and their 95% confidence limits
                      RR
                                                     P> | Z |
                                                                [95% Conf. Interval]
eq1
  apache3rod
                   1.188243
                                                     0.623
                                                                0.597345
                                                                             2.363664
          age
                   1.017548
                                                     0.039
                                                                1.000848
                                                                             1.034526
                                                                             1.837468
   sex_recode
                   1.163373
                                                     0.516
                                                                0.736577
eq2
                   1.700041
                                                     0.490
  apache3rod
                                                                0.377222
                                                                             7.661639
                   1.022238
                                                                0.989515
                                                     0.185
                                                                             1.056043
          age
  sex_recode
                   0.692747
                                                     0.480
                                                                0.250404
                                                                             1.916493
   ***********
   * SF36 MCS: Impairment at 24 months
    ******
   ** 1. FIM: pre-morbid **
   LnMM3_lf sf36mcs_impair_24 fim
Log multinomial model
initial:
                 log likelihood =
                                                 (could not be evaluated)
                                        -<inf>
                    likelihood = -520.00736
feasible:
                 log
                 log\ likelihood = -133.93049
rescale:
                log\ likelihood = -130.99376
rescale eq:
                log likelihood = -130.99376
log likelihood = -127.1069
Iteration 0:
                log likelihood = -127.1069
log likelihood = -123.68251
Iteration 1:
Iteration 2:
Iteration 3:
                log\ likelihood = -121.90374
                \log likelihood = -121.79252
Iteration 4:
                log likelihood = -121.79224
log likelihood = -121.79224
Iteration 5:
Iteration 6:
                                                       Number of obs
                                                                                   133
                                                                                  0.22
                                                       Wald chi2(1)
                                                                         =
Log likelihood = -121.79224
                                                       Prob > chi2
                                                                               0.6363
                                                               [95% Conf. Interval]
                     Coef. Std. Err.
                                                   P> | z |
eq1
                   .0052869
                               .0111794
                                             0.47
                                                     0.636
         fim
                                                               -.0166244
                                                                             .0271982
                 -2.164289
                              1.376924
                                            -1.57
                                                     0.116
                                                               -4.863012
                                                                              .534433
        _cons
eq2
         fim
                 -.0137723
                               .0037226
                                            -3.70
                                                     0.000
                                                               -.0210685
                                                                            -.0064762
                 - . 1548987
                               .3939759
                                                                            .6172799
                                            -0.39
                                                     0.694
                                                               -.9270774
       _cons |
Exponentiated values of the model coefficients and their 95% confidence limits
                                                                [95% Conf. Interval]
                      RR
                                                     P> | z |
```

0.636

0.983513

1.027571

eq1

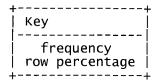
fim |

1.005301

eq2				· · · · · · · · · · · · · · · · · · ·	
f	im	0.986322	0.000	0.979152	0.993545

#### . LnMM3\_lf sf36mcs\_impair\_24 case fim

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 MCS ir   Not impai	mpairmant at Impaired	24 months Dead	Total
Control	36	16	10	62
	58.06	25.81	16.13	100.00
Case	45	13	13	71
	63.38	18.31	18.31	100.00
Total	81	29	23	133
	60.90	21.80	17.29	100.00

#### Log multinomial model

log likelihood = initial: -<inf> (could not be evaluated) feasible:  $log\ likelihood = -520.00736$ rescale: log likelihood = -133.93049rescale eq:  $\log likelihood = -130.99376$ log likelihood = -130.99376 log likelihood = -127.06112 Iteration 0: Iteration 1: Iteration 2: log likelihood = -123.45323Iteration 3:  $log\ likelihood = -121.39281$ log likelihood = -121.24254 log likelihood = -121.24226 Iteration 4: Iteration 5: Iteration 6:  $log\ likelihood = -121.24226$ 

Log likelihood = -121.24226

Number of obs = 133 Wald chi2(2) = 1.18 Prob > chi2 = 0.5532

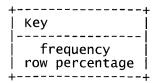
		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	case	3254429	.3316902	-0.98	0.327	9755436	.3246579
	fim	.0043883	.0116646	0.38	0.707	0184738	.0272505
	_cons	-1.895611	1.455576	-1.30	0.193	-4.748487	.9572646
eq2	case	0485747	.4067159	-0.12	0.905	8457234	.7485739
	fim	0140912	.0041618	-3.39	0.001	0222481	0059342
	_cons	0913641	.5872704	-0.16	0.876	-1.242393	1.059665

		RR	P>   z	[95% Conf.	. Interval]
eq1	case	0.722207	0.327	0.376987	1.383557

	Ap fim	pendix 8 2_ICU_Pre 1.004398	dict_Impairment log_THES 0.707	SIS_TECH_INDEX 0.981696	1.027625
eq2	case	0.952586	0.905	0.429247	2.113983
	fim	0.986008	0.001	0.977998	0.994083

. LnMM3\_lf sf36mcs\_impair\_24 case fim age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 MCS ir   Not impai	npairmant at Impaired	24 months Dead	Total
Control	36	16	10	62
	58.06	25.81	16.13	100.00
Case	45	13	13	71
	63.38	18.31	18.31	100.00
Total	81	29	23	133
	60.90	21.80	17.29	100.00

### Log multinomial model

log likelihood = -<inf>
log likelihood = -520.00736
log likelihood = -133.93049 initial: feasible: (could not be evaluated) rescale:  $log\ likelihood = -130.99376$ rescale eq: log likelihood = -130.99376 log likelihood = -120.72593 log likelihood = -114.57985 Iteration 0: Iteration 1: Iteration 2: Iteration 3:  $log\ likelihood = -110.86536$  $\log likelihood = -109.35991$ Iteration 4: log likelihood = -109.24784 log likelihood = -109.24421 log likelihood = -109.24421 Iteration 5: Iteration 6: **Iteration 7:** 

Log likelihood = -109.24421

Number of obs	=	133
wald chi2(4)	=	3.64
Prob > chi2	=	0.4565

	Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
eq1 case fim age sex_recode cons	4041969 .006286 .0061294 .4183405	.3275306 .0170267 .0099328 .3376199 2.21237	-1.23 0.37 0.62 1.24 -1.21	0.217 0.712 0.537 0.215 0.226	-1.046145 0270857 0133386 2433824 -7.01627	.2377513 .0396577 .0255974 1.080063 1.656062
eq2	 					
case fim   age   sex_recode   _cons	.4366435 0441841 .0611006 .4729241 -1.240349	.4194291 .0105868 .016383 .442976 .7579987	1.04 -4.17 3.73 1.07 -1.64	0.298 0.000 0.000 0.286 0.102	3854225 0649338 .0289905 3952928 -2.725999	1.258709 0234344 .0932106 1.341141 .2453006

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1				
cașe	0.667513	0.217	0.351289	1.268394
fim	1.006306	0.712	0.973278	1.040455
age	1.006148	0.537	0.986750	1.025928
sex_recode	1.519438	0.215	0.783972	2.944866
eq2				
case	1.547504	0.298	0.680163	3.520875
fim	0.956778	0.000	0.937129	0.976838
age	1.063006	0.000	1.029415	1.097693
sex_recode	1.604680	0.286	0.673483	3.823404

- . \*\* 2. Years education: pre-morbid \*\*
- LnMM3\_lf sf36mcs\_impair\_24 YRSEDN

log likelihood = -<inf>
log likelihood = -490.00654 (could not be evaluated) initial: feasible: rescale:  $log\ likelihood = -122.52155$  $\log likelihood = -120.60557$ rescale eq: Iteration 0: Iteration 1: log likelihood = -120.60557 log likelihood = -112.17382  $\log likelihood = -110.16891$ Iteration 2:  $log\ likelihood = -109.57624$ Iteration 3: log likelihood = -109.53226 log likelihood = -109.53214 log likelihood = -109.53214 Iteration 4: Iteration 5: Iteration 6:

Log likelihood = -109.53214

Number of obs	=	121
<pre>wald chi2(1)</pre>	=	1.23
Prob > chi2	=	0.2674

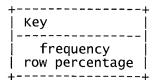
			<del></del>				<del>-</del>
		Coef.	Std. Err.	Z	P>   Z	[95% Conf.	Interval]
eq1							
•	YRSEDN	0661762	.0596619	-1.11	0.267	1831115	.0507591
	_cons	7843869	.6100022	-1.29	0.198	-1.979969	.4111954
eq2							
	YRSEDN	2029536	.0721032	-2.81	0.005	3442732	061634
	_cons	.2284922	. 64785	0.35	0.724	-1.04127	1.498255

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P> z	[95% Conf.	. Interval]
eq1	YRSEDN	0.935966	0.267	0.832675	1.052069
eq2	YRSEDN	0.816316	0.005	0.708735	0.940227

<sup>.</sup> LnMM3\_lf sf36mcs\_impair\_24 case YRSEDN

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)
Page 44



Case	SF36 MCS ir   Not impai	npairmant at Impaired	24 months Dead	Total
Control	36	16	10	62
	58.06	25.81	16.13	100.00
Case	45	13	13	71
	63.38	18.31	18.31	100.00
Total	81	29	23	133
	60.90	21.80	17.29	100.00

#### Log multinomial model

Log likelihood = -108.60925

Number of obs = 121 Wald chi2(2) = 3.36 Prob > chi2 = 0.1861

		<b></b>					
		Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
eq1	case	4434533	.3279603	-1.35	0.176	-1.086244	.1993371
	YRSEDN	0666841	.0552353	-1.21	0.227	1749433	.0415751
	_cons	5492709	.5780118	-0.95	0.342	-1.682153	.5836113
eq2	case	.2104411	.3888829	0.54	0.588	5517555	.9726377
	YRSEDN	2008973	.0754938	-2.66	0.008	3488625	052932
	_cons	.0811007	.6806164	0.12	0.905	-1.252883	1.415084

		RR	P>   z	[95% Conf.	Interval]
eq1	case	0.641816	0.176	0.337482	1.220593
	YRSEDN	0.935491	0.227	0.839505	1.042451
eq2	case	1.234222	0.588	0.575938	2.644912
	YRSEDN	0.817996	0.008	0.705490	0.948444

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

Key	+
   frequency	
row percenta	ge

Case	SF36 MCS in Not impai	npairmant at Impaired	24 months Dead	Total
Control	36	16	10	62
	58.06	25.81	16.13	100.00
Case	45	13	13	71
	63.38	18.31	18.31	100.00
Total	81	29	23	133
	60.90	21.80	17.29	100.00

#### Log multinomial model

(could not be evaluated) initial: log likelihood = -<inf>  $\log likelihood = -490.00654$ feasible:  $\log \text{likelihood} = -122.52155$ rescale: log likelihood = -120.60557 log likelihood = -120.60557 log likelihood = -109.82272 rescale eq: Iteration 0: Iteration 1: Iteration 2:  $\log likelihood = -106.82985$ log likelihood = -105.75265 log likelihood = -105.72985 log likelihood = -105.72983 log likelihood = -105.72983 Iteration 3: Iteration 4: Iteration 5: Iteration 6:

Number of obs = 121 Wald chi2(4) = 5.67 Log likelihood = -105.72983 Prob > chi2 = 0.2256

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 case YRSEDN age sex_recode _cons	5241813 0680406   .0000777   .5263603  7524099	.3259171 .0632395 .0112515 .3253045 1.167654	-1.61 -1.08 0.01 1.62 -0.64	0.108 0.282 0.994 0.106 0.519	-1.162967 1919878 0219748 1112248 -3.04097	.1146046 .0559066 .0221301 1.163945 1.53615
eq2 case YRSEDN age sex_recode _cons	.3229501 1249877 .0283687 1969424 -2.533737	.4097065 .0783857 .0172374 .41161 1.710131	0.79 -1.59 1.65 -0.48 -1.48	0.431 0.111 0.100 0.632 0.138	4800599 2786209 005416 -1.003683 -5.885531	1.12596 .0286455 .0621534 .6097985 .8180577

		RR	P>   z	[95% Conf.	Interval]
eq1	case	0.592040	0.108	0.312557	1.121430
	YRSEDN	0.934223	0.282	0.825317	1.057499
	age	1.000078	0.994	0.978265	1.022377

sex_recode	endix 8 2_ICU_ 1.692760	_Predict_Impairment	0.106	0.894738	3.202544
eq2 Case YRSEDN age sex_recode	1.381196 0.882508 1.028775 0.821238		0.431 0.111 0.100 0.632	0.618746 0.756827 0.994599 0.366527	3.083175 1.029060 1.064126 1.840061

- . \*\* 3. CIQ Total: pre-morbid \*\*
- . LnMM3\_lf sf36mcs\_impair\_24 ciq\_total

log likelihood = -<inf>
log likelihood = -500.00736 (could not be evaluated) initial: feasible: log likelihood = -131.43049 log likelihood = -125.99376 log likelihood = -125.99376 rescale: rescale eq: Iteration 0:  $\log likelihood = -116.38256$ Iteration 1: log likelihood = -113.74775 log likelihood = -113.34764 log likelihood = -113.34152 Iteration 2: Iteration 3: Iteration 4: log likelihood = -113.34152 Iteration 5:

Log likelihood = -113.34152

Number of obs = 131 wald chi2(1) = 0.14 Prob > chi2 = 0.7105

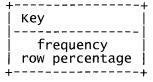
	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 ciq_total _cons	010438 -1.33785	.0281217 .4791626	-0.37 -2.79	0.711 0.005	0655556 -2.276992	.0446796
eq2 ciq_total _cons	1346231 .0954153	.0362658 .4448719	-3.71 0.21	0.000 0.830	2057028 7765176	0635434 .9673482

Exponentiated values of the model coefficients and their 95% confidence limits

	   RR	P>   z	[95% Conf	. Interval]
eq1 ciq_total	0.989616	0.711	0.936547	1.045693
eq2 ciq_total	0.874045	0.000	0.814075	0.938433

LnMM3\_lf sf36mcs\_impair\_24 case ciq\_total

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX

Control	36	16	10	62
	58.06	25.81	16.13	100.00
Case	45	13	13	71
	63.38	18.31	18.31	100.00
Total	81	29	23	133
	60,90	21.80	17.29	100.00

initial: log likelihood = -<inf> (could not be evaluated) log likelihood = -500.00736 log likelihood = -131.43049 log likelihood = -125.99376 log likelihood = -125.99376 feasible: rescale: rescale eq: Iteration 0:  $\log likelihood = -116.14889$ Iteration 1: log likelihood = -110.14809 log likelihood = -113.13957 log likelihood = -112.55157 log likelihood = -112.53984 log likelihood = -112.5398 log likelihood = -112.5398 Iteration 2: Iteration 3: Iteration 4: Iteration 5: Iteration 6:

Log likelihood = -112.5398

Number of obs = 131 Wald chi2(2) = 1.57 Prob > chi2 = 0.4553

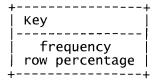
	Coef.	Std. Err.	Z	P>   Z	[95% Conf	. Interval]
eq1 case ciq_total _cons	3917662 0133405 -1.096525	.3300959 .0270138 .4911101	-1.19 -0.49 -2.23	0.235 0.621 0.026	-1.038742 0662865 -2.059083	.2552098 .0396056 1339671
eq2 case ciq_total _cons	.2731147 1340583 0745873	.3688147 .0359609 .5072099	0.74 -3.73 -0.15	0.459 0.000 0.883	4497488 2045402 -1.0687	.9959781 0635763 .9195259

#### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1 case   ciq_total	0.675862 0.986748	0.235 0.621	0.353900 0.935863	1.290732 1.040400
eq2 case   ciq_total	1.314051 0.874539	0.459 0.000	0.637788 0.815022	2.707371 0.938403

LnMM3\_lf sf36mcs\_impair\_24 case ciq\_total age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Appendix 8	3 2_ICU_Predic	t_Impairment	log_THESIS	_TECH_INDEX
------------	----------------	--------------	------------	-------------

Case	SF36 MCS im   Not impai	pairmant at Impaired	24 months Dead	Total
Control	36	16	10	62
	58.06	25.81	16.13	100.00
Case	45	13	13	71
	63.38	18.31	18.31	100.00
Total	81	29	23	133
	60.90	21.80	17.29	100.00

(could not be evaluated) initial: feasible:

rescale: rescale eq: Iteration 0: Iteration 1: Iteration 2: Iteration 3: Iteration 4: Iteration 5: Iteration 6:

Log likelihood = -109.20432

Number of obs Wald chi2(4) Prob > chi2 131 4.43  $0.351\bar{1}$ 

	Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode _cons	4542333 0140904 .0062208 .4850641 -1.683761	.3249389 .0311062 .0119639 .339026 1.072602	-1.40 -0.45 0.52 1.43 -1.57	0.162 0.651 0.603 0.152 0.116	-1.091102 0750575 017228 1794146 -3.786022	.1826351 .0468766 .0296697 1.149543 .4184995
eq2 case ciq_total age sex_recode _cons	.2737376 1152816 .0276619 .1671236 -2.270308	.369926 .0415487 .0181 .3623306 1.579901	0.74 -2.77 1.53 0.46 -1.44	0.459 0.006 0.126 0.645 0.151	4513039 1967156 0078134 5430314 -5.366858	.9987792 0338476 .0631373 .8772785 .8262415

	   RR	P> z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode	0.634935 0.986008 1.006240 1.624279	0.162 0.651 0.603 0.152	0.335846 0.927690 0.982920 0.835759	1.200376 1.047993 1.030114 3.156749
eq2 case ciq_total age sex_recode	1.314870 0.891115 1.028048 1.181900	0.459 0.006 0.126 0.645	0.636797 0.821424 0.992217 0.580984	2.714965 0.966719 1.065173 2.404347

\*\* 4. Charlson age condition: pre-morbid \*\*

LnMM3\_lf sf36mcs\_impair\_24 caci

#### Log multinomial model

Iteration 7:

(could not be evaluated) initial: log likelihood = -<inf>  $log\ likelihood = -520.00736$ feasible:  $\log \text{ likelihood} = -133.93049$ rescale: log likelihood = -130.99376 log likelihood = -130.99376 log likelihood = -116.83726 rescale eq: Iteration 0: Iteration 1: Iteration 2:  $log\ likelihood = -110.38912$  $\log likelihood = -109.70834$ Iteration 3: log likelihood = -109.42966 log likelihood = -109.41898 log likelihood = -109.41897 log likelihood = -109.41897 Iteration 4: Iteration 5: Iteration 6:

Log likelihood = -109.41897

Number of obs Wald chi2(1) 133 0.40 Prob > chi2 0.5292

		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	caci _cons	0299471 -1.391555	.047597 .2551841	-0.63 -5.45	0.529 0.000	1232356 -1.891707	.0633413
eq2	caci _cons	.2547737 -3.376883	.0419857 .4528315	6.07 -7.46	0.000	.1724834 -4.264417	.3370641 -2.48935

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf. Interval]
eq1	caci	0.970497	0.529	0.884055 1.065390
eq2	caci	1.290170	0.000	1.188252 1.400829

LnMM3\_lf sf36mcs\_impair\_24 case caci

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

+	+
Key	
	·
frequency	ĺ
row percentage	ĺ
+	+

Case	SF36 MCS in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	36	16	10	62
	58.06	25.81	16.13	100.00
Case	45	13	13	71
	63.38	18.31	18.31	100.00
Total	81	29	23   Page 50	133

## Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX | 60.90 21.80 17.29 | 100.00

#### Log multinomial model

log likelihood = -<inf>
log likelihood = -520.00736 (could not be evaluated) initial: feasible: log likelihood = -133.93049rescale: log likelihood = -130.99376rescale eq: log likelihood = -130.99376 log likelihood = -116.74885 log likelihood = -109.96864 Iteration 0: Iteration 1: Iteration 2: Iteration 3:  $\log likelihood = -108.66836$  $\log likelihood = -108.31108$ Iteration 4: log likelihood = -108.30764 log likelihood = -108.30762 log likelihood = -108.30762 Iteration 5: Iteration 6: Iteration 7:

Log likelihood = -108.30762

Number of obs = 133 Wald chi2(2) = 1.52 Prob > chi2 = 0.4668

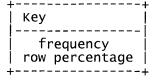
		Coef.	Std. Err.	Z	P> z	[95% Conf	. Interval]
eq1	case	3436785	.3297017	-1.04	0.297	989882	.302525
	caci	0298918	.0466333	-0.64	0.522	1212914	.0615078
	_cons	-1.222958	.2854873	-4.28	0.000	-1.782502	6634129
eq2	case	.351231	.2509119	1.40	0.162	1405473	.8430094
	caci	.2733669	.0468165	5.84	0.000	.1816082	.3651255
	_cons	-3.701141	.5329082	-6.95	0.000	-4.745622	-2.65666

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P> z	[95% Conf.	Interval]
eq1	case	0.709157	0.297	0.371621	1.353271
	caci	0.970551	0.522	0.885776	1.063439
eq2	case	1.420816	0.162	0.868883	2.323348
	caci	1.314382	0.000	1.199144	1.440695

. LnMM3\_1f sf36mcs\_impair\_24 case caci age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 MCS in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	36 58.06	16 25.81	10 16.13	62 100.00
Case	45	13	13   Page 51	71

		2_ICU_Predict 18.31			TECH_INDEX
Total	81 60.90	29 21 - 80	23	133 100,00	

(could not be evaluated) initial: log likelihood = -<inf> feasible:  $\log likelihood = -520.00736$ log likelihood = -133.93049 log likelihood = -130.99376 rescale: rescale eq:  $log\ likelihood = -130.99376$ Iteration 0: Iteration 1: log likelihood = -114.73456 $\log likelihood = -109.35448$ Iteration 2: log likelihood = -106.55326 log likelihood = -105.27259 log likelihood = -105.23686 Iteration 3: Iteration 4: Iteration 5: log likelihood = -105.23677
log likelihood = -105.23677 Iteration 6: Iteration 7:

Log likelihood = -105.23677

Number of obs = 133 Wald chi2(4) = 6.54 Prob > chi2 = 0.1622

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 case caci age	4200824 1065544 .0215016	.3208567 .0697726 .0133459	-1.31 -1.53 1.61	0.190 0.127 0.107	-1.04895 2433061 0046559	.2087852 .0301974 .047659
sex_recode _cons	.3589484 -2.372349	.3242729 .7436321	1.11 -3.19	0.268 0.001	2766147 -3.829842	.9945116 9148573
eq2						
case caci age   sex_recode   _cons	.2103047 .2724824 .0195 .0046394 -4.945477	.3472642 .048941 .021948 .3515514 1.610612	0.61 5.57 0.89 0.01 -3.07	0.545 0.000 0.374 0.989 0.002	4703205 .1765598 0235173 6843887 -8.102219	.89093 .368405 .0625174 .6936675 -1.788735

#### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1 case caci age sex_recode	0.656993 0.898926 1.021734 1.431823	0.190 0.127 0.107 0.268	0.350305 0.784031 0.995355 0.758347	1.232180 1.030658 1.048813 2.703404
eq2 case caci age sex_recode	1.234054 1.313220 1.019691 1.004650	0.545 0.000 0.374 0.989	0.624802 1.193106 0.976757 0.504398	2.437395 1.445427 1.064513 2.001041

<sup>\*\* 5.</sup> Apache3 ROD: cases only \*\*

Log multinomial model

LnMM3\_lf sf36mcs\_impair\_24 apache3rod

```
Appendix 8 2_ICU_Predict_Impairment log_THESIS_TECH_INDEX
                   log likelihood = -<inf> (could not be evaluated)
log likelihood = -260.00409
initial:
feasible:
rescale:
                   log\ likelihood = -70.794718
rescale eq:
                   \log likelihood = -69.440979
                   log likelihood = -69.440979
log likelihood = -65.985552
log likelihood = -64.349138
log likelihood = -63.761103
Iteration 0:
Iteration 1:
Iteration 2:
Iteration 3:
                   log likelihood = -63.660734
log likelihood = -63.660137
log likelihood = -63.660137
Iteration 4:
Iteration 5:
Iteration 6:
                                                               Number of obs =
                                                                                          1.36
                                                               wald chi2(1) =
Prob > chi2 =
Log likelihood = -63.660137
               Coef. Std. Err. z P>|z| [95% Conf. Interval]
  apache3rod | .9363234 .803752 1.16 0.244 -.6390015 2.511648
_cons | -1.943396 .3597264 -5.40 0.000 -2.648447 -1.238345
  apache3rod | .572305 .8736831 0.66 0.512 -1.140082 2.284692
_cons | -1.839984 .3504278 -5.25 0.000 -2.52681 -1.153158
Exponentiated values of the model coefficients and their 95% confidence limits
                                                             P> | z |
                                                                         [95% Conf. Interval]
                         RR
eq1
  apache3rod |
                                                             0.244 0.527819 12.325230
                     2.550587
                                                             0.512
  apache3rod |
                     1.772348
                                                                      0.319793 9.822663
. LnMM3_lf sf36mcs_impair_24 apache3rod age sex_recode
Log multinomial model
                   log likelihood =
                                                        (could not be evaluated)
initial:
                                             -<inf>
                   log likelihood = -260.00409
log likelihood = -70.794718
feasible:
rescale:
                  log likelihood = -70./94/18
log likelihood = -69.440979
log likelihood = -69.440979
log likelihood = -65.353473
log likelihood = -62.394324
rescale eq:
Iteration 0:
Iteration 1:
Iteration 2:
                  log likelihood = -61.628622
log likelihood = -61.62149
log likelihood = -61.621487
Iteration 3:
Iteration 4:
Iteration 5:
                                                               Number of obs = Wald chi2(3) = Prob > chi2 =
                                                                                              1.98
Log likelihood = -61.621487
                                                               Prob > chi2
              | Coef. Std. Err. z P>|z| [95% Conf. Interval]
eq1
```

#### Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX eq2 apache3rod .7946068 .8829943 0.90 0.368 -.9360302 2.525244 age .0375663 .0233467 1.61 0.108 -.0081924 .0833249 -0.73 0.468 -1.362918 -.3685135 .5073586 .6258911 sex\_recode -4.204874 1.723564 -2.44 0.015 -7.582998 - . 8267495 \_cons Exponentiated values of the model coefficients and their 95% confidence limits P> | z | [95% Conf. Interval] RR eq1 apache3rod 2.407982 0.256 0.528912 10.962833 0.994209 0.735 0.961299 1.028244 age 0.522401 sex\_recode 1.427127 0.488 3.898714 eq2 apache3rod 0.392182 2.213571 0.368 12.493941 1.038281 0.991841 0.1081.086895 age 0.691762 0.468 0.255913 1.869912 sex\_recode \*\*\*\*\*\*\*\* \*\* 1. FIM: pre-morbid \*\* LnMM3\_lf social\_impair\_24 fim Log multinomial model (could not be evaluated) initial: log likelihood = -<inf> likelihood = -300.00944feasible: log rescale: log likelihood = -93.650323rescale eq: log likelihood = -93.650323 $\log likelihood = -93.650323$ Iteration 0: log likelihood = -89.247317 log likelihood = -85.868903 Iteration 1: Iteration 2: Iteration 3: $log\ likelihood = -84.045257$ **Iteration 4:** log likelihood = -83.472947Iteration 5: $log\ likelihood = -83.181051$ log likelihood = -83.149926 log likelihood = -83.149711 Iteration 6: Iteration 7: log likelihood = -83.149711Iteration 8: Number of obs Wald chi2(1) 134 0.89 Log likelihood = -83.149711Prob > chi2 0.3468 \_\_\_\_\_\_ Coef. Std. Err. z P>|z| [95% Conf. Interval] eq1 fim | .233365 .248051 0.94 0.347 -.2528059 .719536 -32.07877 31.15549 \_cons | -1.03 0.303 -93.1424 28.98486 eq2 fim | -.0151083 .0034679 -4.36 0.000 -.0219052 -.0083114 - . 698287 \_cons | -.0056376 . 353399 -0.02 0.987 .6870118 Exponentiated values of the model coefficients and their 95% confidence limits

P> | z |

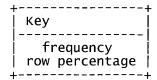
[95% Conf. Interval]

RR

eq1	fim	1.262842	0.347	0.776619	2.053480
eq2	fim	0.985005	0.000	0.978333	0.991723

#### . LnMM3\_lf social\_impair\_24 case fim

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	Social imp   Not impai	pairmant at Impaired	24 months Dead	Total
Control	53 84.13	0.00	10 15.87	63 100.00
Case	51	7	13	71
	71.83	9.86	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

#### Log multinomial model

```
(could not be evaluated)
initial:
                 log likelihood =
                                          -<inf>
                      likelihood = -300.00944
feasible:
                 log
                 log likelihood = -93.650323
rescale:
                 \log likelihood = -93.650323
rescale eq:
                 log likelihood = -93.650323
log likelihood = -88.946636
Iteration 0:
Iteration 1:
Iteration 2:
                 log\ likelihood = -84.667329
                 \log likelihood = -80.776546
Iteration 3:
                 log likelihood = -79.214549
log likelihood = -78.764229
Iteration 4:
Iteration 5:
                 log likelihood = -78.715038
Iteration 6:
                 log\ likelihood = -78.707269
Iteration 7:
Iteration 8:
                 log likelihood = -78.70585
                 log likelihood = -78.705538
log likelihood = -78.705461
Iteration 9:
Iteration 10:
                 log likelihood = -78.705461
Iteration 11:
                 log likelihood = -78.705442
Iteration 12:
```

Log likelihood = -78.705442

Number of obs = 134 Wald chi2(2) = 0.65 Prob > chi2 = 0.7225

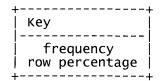
	   	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	case	15.71782	1064.495	0.01	0.988	-2070.654	2102.089
	fim	.1963074	.2435378	0.81	0.420	2810178	.6736327
	_cons	-42.53969	1064.933	-0.04	0.968	-2129.769	2044.69
eq2	case	0237631	.4047149	-0.06	0.953	8169898	.7694635
	fim	0152178	.0039415	-3.86	0.000	022943	0074926
	_cons	.0198726	.5603378	0.04	0.972	-1.078369	1.118114

Page 55

		RR	P> z	[95% Conf.	Interval]
eq1	case fim	6.70e+06 1.216901	0.988 0.420	0.000000 0.755015	1.961349
eq2	case fim	0.976517 0.984897	0.953 0.000	0.441759 0.977318	2.158608 0.992535

. LnMM3\_lf social\_impair\_24 case fim age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	Social imp   Not impai	oairmant at Impaired	24 months Dead	Total
Control	53 84.13	0.00	10 15.87	63 100.00
Case	51	7	13	71
	71.83	9.86	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

#### Log multinomial model

```
(could not be evaluated)
initial:
                   log likelihood =
                                               -<inf>
                   log likelihood = -300.00944
log likelihood = -93.650323
feasible:
rescale:
                   log\ likelihood = -93.650323
rescale eq:
Iteration 0:
Iteration 1:
                   log likelihood = -93.650323
                   log likelihood = -87.244448
log likelihood = -76.730122
log likelihood = -71.483245
Iteration 2:
Iteration 3:
Iteration 4:
                   log\ likelihood = -68.897497
                   \log likelihood = -67.879697
Iteration 5:
Iteration 6:
                   log likelihood =
                                           -67.6907
Iteration 7:
                   log
                        likelihood =
                                          -67.67415
                   \log 1 ikelihood = -67.670332
Iteration 8:
Iteration 9:
                   log likelihood = -67.66952
                   log likelihood = -67.669352
Iteration 10:
                   log likelihood = -67.669314
log likelihood = -67.669304
log likelihood = -67.669303
Iteration 11:
Iteration 12:
Iteration 13:
```

	Number of obs	=	134
	Wald chi2(4)	=	0.90
Log likelihood = -67.669303	Prob > chi2	=	0.9245

Coef. Std. Err. z P>|z| [95% Conf. Interval]

#### Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX eq1 0.992 -3392.539 3425.675 case 16.56819 1739.372 0.01 0.371 .2721999 -.2899659 .7770383 fim .2435362 0.89 0.29 .0069392 .0237816 -.0396719 .0535503 age 0.746 -1.641533sex\_recode -.2330061 .7186492 1.175521 0.977 -3459.416 -49.64128 1739.713 -0.033360.133 \_cons eq2 .4003788 .3988884 1.00 0.316 -.3814281 1.182186 case -.027485 fim -.0476804 .010304 -4.63 0.000 -.0678759 .0355689 .0982742 .0159966 0.000 .0669216 4.18 age .3891553 .4282469 0.91 0.363 .4501931 1.228504 sex\_recode \_cons -1.173212 .7110061 -1.65 0.099 -2.566758 .2203343

Exponentiated values of the model coefficients and their 95% confidence limits

RR	P> z	[95% Conf.	Interval]
1 570+07	0 992	0 000000	
			2.175021
1.006963	0.770	0.961105	1.055010
0.792149	0.746	0.193683	3.239829
1.492390	0.316	0.682886	3.261495
0.953438	0.000	0.934376	0.972889
1.069212	0.000	1.036209	1.103265
1.475734 	0.363	0.637505	3.416115
	1.57e+07 1.275753 1.006963 0.792149 	1.57e+07 0.992 1.275753 0.371 1.006963 0.770 0.792149 0.746 1.492390 0.316 0.953438 0.000 1.069212 0.000	1.57e+07       0.992       0.000000         1.275753       0.371       0.748289         1.006963       0.770       0.961105         0.792149       0.746       0.193683         1.492390       0.316       0.682886         0.953438       0.000       0.934376         1.069212       0.000       1.036209

- . \*\* 2. Years education: pre-morbid \*\*
- . LnMM3\_lf social\_impair\_24 YRSEDN

Log multinomial model

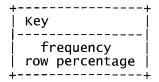
initial: feasible: rescale: rescale eq: Iteration 0: Iteration 1: Iteration 3: Iteration 4: Iteration 5:	<pre>log likelihood =</pre>	(could not be evaluated)
	•	Number of obs

Log likelihood = -72.188919			wald	er of obs chi2(1) > chi2	= = =	122 3.12 0.0773		
	   	Coef.	Std. Err.	Z	P> z	[95% C	onf.	Interval]
eq1	YRSEDN   _cons	2965846 1822314	.167893 1.484045	-1.77 -0.12	0.077 0.902	62564 -3.0909		.0324797 2.726444
eq2	YRSEDN _cons	2269546 .4539745	.0776505 .6968272	-2.92 0.65	0.003 0.515	37914 91178		0747625 1.819731

		RR	P> z	[95% Conf.	Interval]
eq1	YRSEDN	0.743353	0.077	0.534914	1.033013
eq2	YRSEDN	0.796957	0.003	0.684445	0.927964

#### . LnMM3\_lf social\_impair\_24 case YRSEDN

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	Social imp   Not impai	oairmant at Impaired	24 months Dead	Total
Control	53 84.13	0.00	10 15.87	63
Case	51 71.83	7 9.86	13 18.31	71 100.00
Total	104 77.61	7 5.22	23 17.16	134

### Log multinomial model

(could not be evaluated) initial: log likelihood = -<inf> log likelihood = -270.00863 log likelihood = -84.536353 feasible: rescale: log likelihood = -84.536353 rescale eq: Iteration 0:  $log\ likelihood = -84.536353$ log likelihood = -73.074667 log likelihood = -69.021065 log likelihood = -68.430621 Iteration 1: Iteration 2: Iteration 3: Iteration 4:  $log\ likelihood = -68.285938$ Iteration 5: log likelihood = -68.251227log likelihood = -68.244322 log likelihood = -68.242857 log likelihood = -68.24251 Iteration 6: Iteration 7: Iteration 8: Iteration 9: log likelihood = -68.242432log likelihood = -68.242415 log likelihood = -68.242412 Iteration 10: Iteration 11:

Log likelihood = -68.242412

Number of obs = 122 Wald chi2(2) = 2.79 Prob > chi2 = 0.2478

		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	case YRSEDN _cons	16.31287 3464245 -15.49659	1652.231 .2073944 1652.232	0.01 -1.67 -0.01	0.992 0.095 0.993	-3222 75291 -3253.811	3254.626 .060061 3222.818
eq2	case	. 1673293	.3897829	0.43	0.668	5966312	.9312898

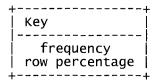
Page 58

App	pendix 8 2_IC	U_Predict_Ir	npairment	log_THE	SIS_TECH_INDE	Χ
YRSEDN	2409655	.0847535	-2.84	0.004	4070794	0748517
_cons	. 4882397	.7892319	0.62	0.536	-1.058626	2.035106

		RR	P>   z	[95% Conf.	Interval]
eq1	case YRSEDN	1.22e+07 0.707212	0.992 0.095	0.000000 0.470994	1.061901
eq2	case YRSEDN	1.182143 0.785869	0.668 0.004	0.550664 0.665591	2.537780 0.927881

LnMM3\_lf social\_impair\_24 case YRSEDN age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	Social imp   Not impai	oairmant at Impaired	24 months Dead	Total
Control	53 84.13	0.00	10 15.87	100.00
Case	51	7	13	71
	71.83	9.86	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

#### Log multinomial model

```
initial:
                                                       (could not be evaluated)
                   log likelihood =
                                             -<inf>
                   log\ likelihood = -270.00863
feasible:
                  log likelihood = -84.536353
log likelihood = -84.536353
log likelihood = -84.536353
rescale:
rescale eq:
Iteration 0:
Iteration 1:
                   log\ likelihood = -72.951775
                   log likelihood = -69.090748
Iteration 2:
                  log likelihood = -66.580983
log likelihood = -65.90035
Iteration 3:
Iteration 4:
                   \log 1 \text{ ikelihood} = -65.779204
Iteration 5:
Iteration 6:
                   log likelihood = -65.74667
Iteration 7:
                   log likelihood = -65.741163
                   log likelihood = -65.739861
log likelihood = -65.739552
Iteration 8:
Iteration 9:
Iteration 10:
                   log\ likelihood = -65.739489
Iteration 11:
                   log\ likelihood = -65.739479
                   log likelihood = -65.739476
Iteration 12:
```

Number of obs Wald chi2(4) 122 3.54 Log likelihood = -65.7394760.4719 Prob > chi2 Coef. Std. Err. z P>|z| [95% Conf. Interval] Page 59

	<b></b>				- <i>-</i>	
eq1						
case	16.21562	1514.654	0.01	0.991	-2952.452	2984.883
YRSEDN	3736829	.2174916	-1.72	0.086	7999587	.0525929
age	0097538	.0251821	-0.39	0.699	0591097	.0396022
sex_recode	4690126	.8012778	-0.59	0.558	-2.039488	1.101463
cons	-14.33908	1514.657	-0.01	0.992	-2983.012	2954.334
_cons	14.33300	1314.037	-0.01	0.992	-2903.012	2334.334
eq2	 	<b></b>			<b></b>	
•	.2529337	.3821651	0.66	0 500	496096	1 001063
case			0.66	0.508		1.001963
YRSEDN	1603643	.0805782	-1.99	0.047	3182947	002434
age	.0318679	.0172958	1.84	0.065	0020311	.065767
sex_recode	1905879	. 3971706	-0.48	0.631	969028	.5878521
_cons	-2.388427	1.685859	-1.42	0.157	-5.692649	.9157956
_cons	2.300427	1.003033	1.76	0.137	3.032043	. 5 ± 51 550

### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P> z	[95% Conf.	. Interval]
eq1 case YRSEDN age sex_recode	1.10e+07 0.688195 0.990294 0.625620	0.991 0.086 0.699 0.558	0.000000 0.449348 0.942603 0.130095	1.054000 1.040397 3.008564
eq2 case YRSEDN age sex_recode	1.287798 0.851833 1.032381 0.826473	0.508 0.047 0.065 0.631	0.608903 0.727388 0.997971 0.379452	2.723624 0.997569 1.067978 1.800118

- .
  . \*\* 3. CIQ Total: pre-morbid \*\*
- LnMM3\_lf social\_impair\_24 ciq\_total

### Log multinomial model

initial: feasible: rescale: rescale eq: Iteration 0: Iteration 2: Iteration 3: Iteration 4: Iteration 5:	log likelihood = - <inf> log likelihood = -280.00944 log likelihood = -88.650323 log likelihood = -88.650323 log likelihood = -88.650323 log likelihood = -79.83291 log likelihood = -78.267057 log likelihood = -78.08987 log likelihood = -78.0884 log likelihood = -78.0884</inf>	(could not be evaluated)
	,	

		Number of obs		132
		Wald chi2(1)	=	0.00
Log likelihood =	-78.0884	Prob > chi2	=	0.9616

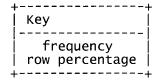
	Coef.	Std. Err.	Z	P> z	[95% Conf.	. Interval]
eq1 ciq_total _cons	.0029017 -2.984924	.0602126 1.065798	0.05 -2.80	0.962 0.005	1151127 -5.073849	.1209162 8959988
eq2 ciq_total _cons	0996833 3941089	.0239389 .2971818	-4.16 -1.33	0.000 0.185	1466027 9765745	052764 .1883567

# Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1 ciq_total	1.002906	0.962	0.891266	1.128530
eq2 ciq_total	0.905124	0.000	0.863637	0.948604

### . LnMM3\_lf social\_impair\_24 case ciq\_total

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	Social imp   Not impai	pairmant at Impaired	24 months Dead	Total
Control	53 84.13	0.00	10 15.87	63 100.00
Case	51 71.83	7 9.86	13 18.31	71
Total	104   77.61	7 5.22	23 17.16	134 100.00

### Log multinomial model

initial: feasible:	]	og likelihood og likelihood	=	-280.00944	(could	not	be	evaluated)
rescale:	7	og likelihood	=	-88.650323				
rescale eq:	: 1	og likelihood	=	-88.650323				
Iteration (	): l	og likelihood	=	-88.650323				
Iteration 1	1: 1	og likelihood	=	-78.381364				
Iteration 2	2: 1	og likelihood	=	-74.867067				
Iteration 3	3: 7	og likelihood	=	-72.828734				
Iteration 4	4: l	og likelihood	=	-72.357692				
Iteration 5	5: 1	og likelihood	=	-72.276652				
Iteration 6	5: 1 <sub>0</sub>	og likelihood	=	-72.2584				
Iteration 7	7: 1	og likelihood	=	-72.254964				
Iteration 8	3: 1	og likelihood	=	-72.254189				
Iteration 9		og likelihood						
Iteration 1		og likelihood						
Iteration 1		og likelihood						
Iteration 1		og likelihood						
		3						

Log likelihood = -72.253958

Number of obs	=	132
<pre>wald chi2(2)</pre>	=	0.00
Prob > chi2	=	0.9992

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case ciq_total _cons	17.28471   .0029055   -19.64965	2330.155 .0729829 2330.155	0.01 0.04 -0.01	0.994 0.968 0.993	-4549.734 1401384 -4586.669	4584.304 .1459494 4547.37

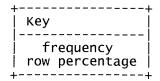
eq2						
case	.536066	.3957242	1.35	0.176	2395393	1.311671
ciq_total	1176323	.0295341	-3.98	0.000	1755181	0597464
_cons	4577988	.3645418	-1.26	0.209	-1.172288	.25669

### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   Z	[95% Conf.	Interval]
eq1 case ciq_total	3.21e+07 1.002910	0.994 0.968	0.000000 0.869238	1.157138
eq2 case ciq_total	1.709269 0.889023	0.176 0.000	0.786990 0.839022	3.712372 0.942003

. LnMM3\_lf social\_impair\_24 case ciq\_total age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	Social imp   Not impai	pairmant at	24 months Dead	Total
Case	NOC IIIPAI	Illipa i i eu	Deau	10tai
Control	53 84.13	0 0.00	10 15.87	63 100.00
Case	51 71.83	7 9.86	13 18.31	71 100.00
Total	104 77.61	7 5.22	23   17.16	134 100.00

#### Log multinomial model

```
(could not be evaluated)
initial:
                log likelihood =
                                      -<inf>
                \log likelihood = -280.00944
feasible:
                log\ likelihood = -88.650323
rescale:
                    likelihood = -88.650323
rescale eq:
                log
Iteration 0:
                log
                    likelihood = -88.650323
Iteration 1:
                log likelihood = -77.468375
                    likelihood = -74.904361
Iteration 2:
                log
Iteration 3:
                1oā
                    likelihood = -70.907894
                    likelihood = -70.003352
Iteration 4:
                log
Iteration 5:
                log\ likelihood = -69.841274
                log\ likelihood = -69.824001
Iteration 6:
                \log \text{ likelihood} = -69.819941
Iteration 7:
Iteration 8:
                log
                    likelihood = -69.818936
Iteration 9:
                    likelihood = -69.818741
                log
Iteration 10:
                log likelihood = -69.818709
Iteration 11:
                log likelihood = -69.818702
Iteration 12:
                log likelihood =
                                    -69.8187
```

Number of obs = 132 Wald chi2(4) = 0.10 Prob > chi2 = 0.9987

Log likelihood = -69.8187

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode _cons	16.4236 .0150036 .0052978 1840035 -19.24026	1508.931 .0786603 .0231621 .7529433 1508.933	0.01 0.19 0.23 -0.24 -0.01	0.991 0.849 0.819 0.807 0.990	-2941.028 1391678 0400991 -1.659745 -2976.694	2973.875 .1691749 .0506948 1.291738 2938.214
eq2 case ciq_total age sex_recode _cons	.4404159 1101763 .0343997 .1636354 -2.890971	.3836995 .0346979 .0175891 .3646813 1.371285	1.15 -3.18 1.96 0.45 -2.11	0.251 0.001 0.050 0.654 0.035	3116214 1781829 0000742 5511268 -5.578641	1.192453 0421697 .0688737 .8783975 2033011

	RR	P> z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode	1.36e+07 1.015117 1.005312 0.831933	0.991 0.849 0.819 0.807	0.000000 0.870082 0.960694 0.190187	1.184327 1.052002 3.639107
eq2 case ciq_total age sex_recode	1.553353 0.895676 1.034998 1.177785	0.251 0.001 0.050 0.654	0.732259 0.836789 0.999926 0.576300	3.295155 0.958707 1.071301 2.407039

- \*\* 4. Charlson age condition: pre-morbid \*\*
- LnMM3\_lf social\_impair\_24 caci

Log multinomial model

initial:	<pre>log likelihood = -<inf></inf></pre>	(could not be evaluated)
feasible:	$log\ likelihood = -300.00944$	
rescale:	$log\ likelihood = -93.650323$	
rescale eq:	$log\ likelihood = -93.650323$	
Iteration 0:	$log\ likelihood = -93.650323$	
Iteration 1:	log likelihood = -79.45085	
Iteration 2:	$log\ likelihood = -72.492005$	
Iteration 3:	log likelihood = -71.52816	
Iteration 4:	log likelihood = -71.381163	
Iteration 5:	log likelihood = -71.38084	
Iteration 6:	log likelihood = -71.38084	
		Number of obs =

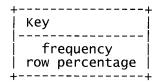
Log likelihood = -71.38084						chi2(1) > chi2	=	0.00 0.9886
		Coef.	Std. Err.	Z	P> z	[95%	Conf.	Interval]
eq1	caci _cons	0015234 -2.944952	.1067586 .6111242	-0.01 -4.82	0.989 0.000	2107 -4.142		.2077196 -1.74717
eq2	caci	.2780387	.0438006	6.35	0.000	.1921	911	.3638863

Page 63

		RR	P> z	[95% Conf	. Interval]
eq1	caci	0.998478	0.989	0.809963	1.230868
eq2	caci	1.320537	0.000	1.211902	1.438911

#### . LnMM3\_lf social\_impair\_24 case caci

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	Social imp   Not impai	pairmant at Impaired	24 months Dead	Total
Control	53 84.13	0.00	10 15.87	63
Case	51	7	13	71
	71.83	9.86	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

#### Log multinomial model

```
initial:
                   log likelihood =
                                                       (could not be evaluated)
                                             -<inf>
                   log\ likelihood = -300.00944
feasible:
                  log likelihood = -93.650323
log likelihood = -93.650323
log likelihood = -93.650323
rescale:
rescale eq:
Iteration 0:
Iteration 1:
                  log\ likelihood = -72.735289
Iteration 2:
                  log likelihood =
                                        -67.71392
                  log likelihood =
                                        -66.28297
Iteration 3:
Iteration 4:
                   log
                       likelihood = -65.831358
                       likelihood = -65.777244
Iteration 5:
                  log
                  log\ likelihood = -65.763492
Iteration 6:
                  \log likelihood = -65.760706
Iteration 7:
                  log likelihood = -65.7601
log likelihood = -65.759963
log likelihood = -65.759929
Iteration 8:
Iteration 9:
Iteration 10:
                  log\ likelihood = -65.759923
Iteration 11:
```

Log likelihood = -65.759923

Number of obs	=	134
<pre>wald chi2(2)</pre>	=	0.01
Prob > chi2	=	0.9958

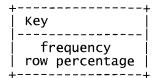
		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	case   caci	15.47897 .0094876	925.9172 .1053366 Pa	0.02 0.09 age 64	0.987 0.928	-1799.285 1969684	1830.243 .2159436

	Ар	pendix 8 2_IC	J_Predict_I	[mpairment	log_THE	SIS_TECH_INDEX	
	_cons	-17.83857	925.9173	-0.02	0.985	-1832.603	1796.926
eq2	case   caci   _cons	.2669831 .2959221 -3.806172	.2674677 .048773 .5402761	1.00 6.07 -7.04	0.318 0.000 0.000	257244 .2003288 -4.865094	.7912102 .3915155 -2.74725

		RR	P>   z	[95% Conf.	Interval]
eq1	case caci	5.28e+06 1.009533	0.987 0.928	0.000000 0.821217	1.241032
eq2	case caci	1.306018 1.344365	0.318 0.000	0.773180 1.221804	2.206065 1.479221

. LnMM3\_lf social\_impair\_24 case caci age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	Social imp   Not impai	oairmant at Impaired	24 months Dead	Total
Control	53 84.13	0.00	10 15.87	63 100.00
Case	51 71.83	7 9.86	13 18.31	71
Total	104 77.61	7 5.22	23   17.16	134 100.00

Log multinomial model

```
(could not be evaluated)
initial:
                   log likelihood =
                                             -<inf>
                   log\ likelihood = -300.00944
feasible:
                   log likelihood = -93.650323
rescale:
                  log likelihood = -93.650323
log likelihood = -93.650323
log likelihood = -76.379061
rescale eq:
Iteration 0:
Iteration 1:
Iteration 2:
                   log likelihood =
                                        -70.82735
                  \log likelihood = -70.716205
                                                       (not concave)
Iteration 3:
                  log likelihood = -69.059623
log likelihood = -67.240061
Iteration 4:
Iteration 5:
                  log likelihood = -66.019742
Iteration 6:
Iteration 7:
                  log likelihood = -65.683133
                  log likelihood =
Iteration 8:
                                        -65.63672
                  log likelihood = -65.634442
log likelihood = -65.633969
Iteration 9: Iteration 10:
                  log likelihood = -65.633866
Iteration 11:
Iteration 12:
                  log likelihood = -65.633844
                  log likelihood = -65.633838
Iteration 13:
```

 $\begin{smallmatrix}0.01\\1.0000\end{smallmatrix}$ 

	Coef.	Std. Err.	z	P>   z	[95% Conf.	<pre>Interval]</pre>
eq1 case caci age sex_recode _cons	15.64997 .001786 .0020389 0107343 -18.09878	1007.366 .1644966 .0333611 .774128 1007.367	0.02 0.01 0.06 -0.01 -0.02	0.988 0.991 0.951 0.989 0.986	-1958.751 3206214 0633477 -1.527997 -1992.502	1990.051 .3241934 .0674256 1.506529 1956.304
eq2 case caci age sex_recode _cons	.2333933 .2885059 .0105251 .0565495 -4.483184	.3820721 .0520863 .0219677 .3659846 1.535224	0.61 5.54 0.48 0.15 -2.92	0.541 0.000 0.632 0.877 0.003	5154542 .1864186 0325307 6607672 -7.492168	.9822408 .3905932 .053581 .7738662 -1.4742

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	. Interval]
eq1	6 36 06	0.000	0.00000	
case	6.26e+06	0.988	0.000000	
cacı	1.001788	0.991	0.725698	1.382915
age	1.002041	0.951	0.938617	1.069751
sex_recode	0.989323	0.989	0.216970	4.511045
eq2				
case	1.262878	0.541	0.597229	2.670433
caci İ	1.334432	0.000	1.204927	1.477857
age	1.010581	0.632	0.967993	1.055042
sex_recode	1.058179	0.877	0.516455	2.168132
JCA_, CCOUC	1.0301.3	0.077	0.510155	2.100132

```
** 5. Apache3 ROD: cases only **
```

### Log multinomial model

initial: feasible: rescale: rescale eq: Iteration 0: Iteration 1: Iteration 2: Iteration 3:	<pre>log likelihood =</pre>	(could not be evaluated)
Iteration 3: Iteration 4:	log likelihood = -53.485745 log likelihood = -53.485745	
iteration 4.	10g 17ke1711000 = -33.463743	

Number of obs = Wald chi2(1) = Prob > chi2 = Log likelihood = -53.485745

	Coef.	Std. Err.	Z	P>   Z	[95% Conf.	. Interval]
eq1 apache3rod _cons	1.813675 -2.861592	1.02555 .5567358	1.77 -5.14	0.077 0.000	1963659 -3.952774	3.823715 -1.770409
eq2					·	

LnMM3\_lf social\_impair\_24 apache3rod

Арр	endix 8 2_IC	U_Predict_Ir	npairment	log_THE	SIS_TECH_INDEX	
			0.65	0.515	$-1.141\overline{134}$	
_cons	-1.838944	.3500555	-5.25	0.000	-2.52504	-1.152848

	RR	P>   z	[95% Conf	. Interval]
eq1 apache3rod	6.132943	0.077	0.821712	45.773965
eq2 apache3rod	1.764931	0.515	0.319456	9.750877

. LnMM3\_lf social\_impair\_24 apache3rod age sex\_recode

Log multinomial model

log likelihood = -<inf>
log likelihood = -200.00463 (could not be evaluated) initial: feasible: log likelihood = -59.145832 log likelihood = -57.199777 log likelihood = -57.199777 rescale: rescale eq: log likelihood = -57.155777 log likelihood = -53.944392 Iteration 0: Iteration 1:  $\log likelihood = -51.820752$ Iteration 2: log likelihood = -51.775992 log likelihood = -51.775811 log likelihood = -51.775811 Iteration 3: **Iteration 4:** Iteration 5:

Log likelihood = -51.775811

Number of obs = 71 Wald chi2(3) = 3.13 Prob > chi2 = 0.3724

	Coef.	Std. Err.	Z	P>   Z	[95% Conf.	Interval]
eq1 apache3rod age sex_recode _cons	1.903646 .0045303 2096741 -3.082884	1.084006 .0249793 .7193987 1.64906	1.76 0.18 -0.29 -1.87	0.079 0.856 0.771 0.062	220966 0444283 -1.61967 -6.314983	4.028259 .0534888 1.200321 .1492155
eq2 apache3rod age sex_recode _cons	.6385154 .030764 3545082 -3.723835	.9209488 .0207733 .5086456 1.517456	0.69 1.48 -0.70 -2.45	0.488 0.139 0.486 0.014	-1.166511 0099509 -1.351435 -6.697994	2.443542 .0714789 .6424189 7496759

	RR	P> z	[95% Conf.	Interval]
eq1 apache3rod age sex_recode	6.710318 1.004541 0.810848	0.079 0.856 0.771	0.801744 0.956544 0.197964	56.163030 1.054945 3.321184
eq2 apache3rod age sex_recode	1.893667 1.031242 0.701518	0.488 0.139 0.486	0.311452 0.990098 0.258868	11.513749 1.074095 1.901074

#### Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX \*\*\*\*\*\*\*\*\*\* \* Mobility: Impairment at 24 months \* \*\* 1. FIM: pre-morbid \*\* LnMM3\_lf mobility\_impair\_24 fim Log multinomial model log likelihood = -<inf> log likelihood = -300.00944 (could not be evaluated) initial: feasible: $log\ likelihood = -93.650323$ rescale: rescale eq: log likelihood = -93.650323log likelihood = -93.650323 log likelihood = -88.957757 log likelihood = -86.018784 Iteration 0: Iteration 1: Iteration 2: $log\ likelihood = -84.409294$ Iteration 3: $\log likelihood = -84.279358$ Iteration 4: log likelihood = -84.279037 log likelihood = -84.279037 Iteration 5: Iteration 6: Number of obs 134 0.03 wald chi2(1) Log likelihood = -84.279037Prob > chi20.8524 z P>|z| [95% Conf. Interval] Coef. Std. Err. eq1 -0.19 0.852 fim -.0030996 -.0357603 .0295611 .0166639 \_cons i -2.580536 2.017605 -6.53497 -1.280.201 1.373897 eq2 fim -.0144258 .0036246 -3.980.000 -.0215298 -.0073218 -.0855772 .3780605 -0.23.6554079 \_cons | 0.821 -.8265622 Exponentiated values of the model coefficients and their 95% confidence limits P>|z| [95% Conf. Interval] RR eq1 fim 0.996905 0.852 0.964872 1.030002 eq2 0.000 0.978700 0.992705 fim 0.985678

. LnMM3\_lf mobility\_impair\_24 case fim

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

Key	+ 
frequency	
row percentag	e
+	+

Case	Mobility in Not impai	npairmant at Impaired	24 months Dead	Total
Control	51 80.95	3.17	10 15.87	63 100.00
Case	53	5	13   Page 68	71

#### 

Log multinomial model

(could not be evaluated) initial: log likelihood = -<inf>  $log\ likelihood = -300.00944$ feasible: log likelihood = -93.650323 log likelihood = -93.650323 rescale: rescale eq: log likelihood = -93.650323Iteration 0: Iteration 1:  $log\ likelihood = -88.901496$ log likelihood = -85.855875 **Iteration 2:** log likelihood = -83.940207 log likelihood = -83.769614 Iteration 3: Iteration 4: Iteration 5:  $log\ likelihood = -83.769353$ Iteration 6: log likelihood = -83.769353

Log likelihood = -83.769353

Number of obs = 134 Wald chi2(2) = 0.95 Prob > chi2 = 0.6217

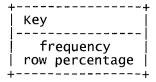
	   	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	case	.7925449	.8231972	0.96	0.336	8208918	2.405982
	fim	0008263	.0161809	-0.05	0.959	0325402	.0308877
	_cons	-3.348375	2.107806	-1.59	0.112	-7.479599	.7828481
eq2	case	0298194	. 4063244	-0.07	0.941	8262006	.7665617
	fim	0145124	. 0040977	-3.54	0.000	0225436	0064811
	_cons	059416	. 5790022	-0.10	0.918	-1.19424	1.075408

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[05% Conf	Interval]
			P> Z  	[93% COIII.	
eq1	case	2.209011	0.336	0.440039	11.089312
	fim	0.999174	0.959	0.967984	1.031370
eq2	case	0.970621	0.941	0.437709	2.152353
	fim	0.985592	0.000	0.977709	0.993540

. LnMM3\_1f mobility\_impair\_24 case fim age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	Mobility in Not impai	mpairmant at Impaired	24 months Dead	Total
Control	51 80.95	2 3.17	10   15.87   Page 69	63 100.00

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX

Case	53	5	13	71
	74.65	7.04	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

#### Log multinomial model

log likelihood = initial: (could not be evaluated) -<inf> log likelihood = -300.00944 log likelihood = -93.650323 log likelihood = -93.650323 feasible: rescale: rescale eq: Iteration 0:  $log\ likelihood = -93.650323$  $log\ likelihood = -86.773024$ Iteration 1: log likelihood = -76.364638 log likelihood = -70.783727 log likelihood = -68.731943 Iteration 2: Iteration 3: Iteration 4: log likelihood = Iteration 5: -68.5911 Iteration 6:  $\log likelihood = -68.590969$ Iteration 7:  $log\ likelihood = -68.590969$ 

Log likelihood = -68.590969

Number of obs = 134 Wald chi2(4) = 3.03 Prob > chi2 = 0.5520

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 case fim age sex_recode _cons	.8337845  0087733   .0270771  8004949   -3.878487	.8110493 .0214796 .0252373 .8207502 2.408133	1.03 -0.41 1.07 -0.98 -1.61	0.304 0.683 0.283 0.329 0.107	755843 0508726 0223872 -2.409136 -8.59834	2.423412 .033326 .0765413 .8081459 .8413671
eq2 case fim age sex_recode _cons	.2552574 0614534 .0913558 .4373361 -1.237385	.3577982 .0135498 .0213446 .4032859 .6610047	0.71 -4.54 4.28 1.08 -1.87	0.476 0.000 0.000 0.278 0.061	4460142 0880104 .049521 3530898 -2.53293	.9565291 0348963 .1331905 1.227762 .0581608

#### Exponentiated values of the model coefficients and their 95% confidence limits

			5050/ - C	
	RR 	P>   Z	L95% Conf	. Interval]
eq1				
case	2.302014	0.304	0.469615	11.284296
fim	0.991265	0.683	0.950400	1.033888
age	1.027447	0.283	0.977862	1.079547
sex_recode	0.449107	0.329	0.089893	2.243744
eq2				
case	1.290794	0.476	0.640175	2.602647
fim	0.940397	0.000	0.915751	0.965706
age	1.095659	0.000	1.050768	1.142468
sex_recode	1.548576	0.278	0.702514	3.413581

<sup>\*\* 2.</sup> Years education: pre-morbid \*\*

LnMM3\_lf mobility\_impair\_24 YRSEDN

## Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX Log multinomial model

(could not be evaluated) log likelihood = initial: -<inf>  $log\ likelihood = -280.00854$ feasible: rescale: log likelihood = -86.857023 $\log likelihood = -86.857023$ rescale eq: log likelihood = -86.857023 log likelihood = -74.683012 Iteration 0: Iteration 1:  $log\ likelihood = -70.931841$ Iteration 2: Iteration 3:  $log\ likelihood = -70.557187$ log likelihood = -70.550151 log likelihood = -70.550142 log likelihood = -70.550142 Iteration 4: Iteration 5: Iteration 6:

Log likelihood = -70.550142

Number of obs = 122 Wald chi2(1) = 6.21 Prob > chi2 = 0.0127

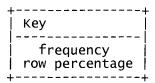
		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	YRSEDN	6203985	.248929	-2.49	0.013	-1.10829	1325067
	_cons	2.737834	1.990342	1.38	0.169	-1.163164	6.638833
eq2	YRSEDN	2735136	.0962607	-2.84	0.004	4621811	0848461
	_cons	.8997652	.8657878	1.04	0.299	7971478	2.596678

### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P> z	[95% Conf.	Interval]
eq1	YRSEDN	0.537730	0.013	0.330123	0.875897
eq2	YRSEDN	0.760702	0.004	0.629908	0.918654

#### . LnMM3\_lf mobility\_impair\_24 case YRSEDN

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	Mobility in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	51 80.95	3.17	10   15.87	63 100.00
Case	53	5	13	71
	74.65	7.04	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

```
Appendix 8 2_ICU_Predict_Impairment log_THESIS_TECH_INDEX
                      log likelihood =
initial:
                                                    -<inf>
                                                                 (could not be evaluated)
                      log likelihood = -280.00854
log likelihood = -86.857023
log likelihood = -86.857023
feasible:
rescale:
rescale eq:
                      log likelihood = -86.857023
Iteration 0:
                      \log \text{likelihood} = -74.547623
Iteration 1:
                      log likelihood = -70.488816
log likelihood = -70.090803
log likelihood = -70.08144
log likelihood = -70.081435
Iteration 2:
Iteration 3:
Iteration 4:
Iteration 5:
```

Number of obs = 122 Wald chi2(2) = 6.77 Log likelihood = -70.081435 Prob > chi2 = 0.0338

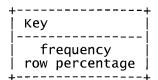
		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	case	.5698431	.7688359	0.74	0.459	9370476	2.076734
	YRSEDN	6300481	.252421	-2.50	0.013	-1.124784	135312
	_cons	2.446307	2.091019	1.17	0.242	-1.652015	6.54463
eq2	case	.1404256	.3899374	0.36	0.719	6238376	.9046888
	YRSEDN	2732886	.096895	-2.82	0.005	4631993	0833779
	_cons	.8137392	.9139707	0.89	0.373	9776104	2.605089

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	case	1.767990	0.459	0.391783	7.978366
	YRSEDN	0.532566	0.013	0.324723	0.873443
eq2	case	1.150763	0.719	0.535884	2.471163
	YRSEDN	0.760873	0.005	0.629267	0.920003

LnMM3\_lf mobility\_impair\_24 case YRSEDN age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	Mobility im   Not impai	npairmant at Impaired	24 months Dead	Total
Control	51 80.95	3.17	10 15.87	63 100.00
Case	53	5	13	71
	74.65	7.04	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

```
(could not be evaluated)
initial:
                          log likelihood =
                                                               -<inf>
                          log\ likelihood = -280.00854
feasible:
                          log likelihood = -86.857023
rescale:
                          log likelihood = -86.857023
log likelihood = -86.857023
log likelihood = -73.817376
log likelihood = -69.311067
log likelihood = -67.18202
rescale eq:
Iteration 0:
Iteration 1:
Iteration 2:
                          log likelihood = -67.18202
log likelihood = -66.825934
log likelihood = -66.823395
log likelihood = -66.823394
Iteration 3:
Iteration 4:
Iteration 5:
Iteration 6:
```

Log likelihood = -66.823394

Number of obs = 122 Wald chi2(4) = 7.95 Prob > chi2 = 0.0934

						<del></del>
	Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
eq1 case YRSEDN age sex_recode _cons	.5689919  6162956  0046067  6365374   2.862295	.7614808 .2711476 .027761 .7742973 3.50573	0.75 -2.27 -0.17 -0.82 0.82	0.455 0.023 0.868 0.411 0.414	923483 -1.147735 0590171 -2.154132 -4.008809	2.061467 0848562 .0498038 .8810573 9.733399
eq2 case YRSEDN age sex_recode _cons	.1633974   .1987823   .0343832   .2482893   -2.112659	.3632011 .0918965 .0175821 .3881666 1.752663	0.45 -2.16 1.96 -0.64 -1.21	0.653 0.031 0.051 0.522 0.228	5484636 3788962 0000772 -1.009082 -5.547815	.8752584 0186684 .0688435 .5125033 1.322497

### Exponentiated values of the model coefficients and their 95% confidence limits

<del></del>	RR	P>   z	[95% Conf.	Interval]
eq1				
case	1.766485	0.455	0.397133	7.857487
YRSEDN	0.539941	0.023	0.317355	0.918644
age	0.995404	0.868	0.942691	1.051065
sex_recode	0.529121	0.411	0.116004	2.413450
eq2		<del></del>		
case	1.177505	0.653	0.577837	2.399495
YRSEDN	0.819728	0.031	0.684617	0.981505
age İ	1.034981	0.051	0.999923	1.071269
sex_recode	0.780134	0.522	0.364554	1.669465
	1			

<sup>. \*\* 3.</sup> CIQ Total: pre-morbid \*\*

initial: feasible: rescale: rescale eq: Iteration 0: Iteration 2: Iteration 3:	<pre>log likelihood = -<inf> log likelihood = -280.00944 log likelihood = -88.650323 log likelihood = -88.650323 log likelihood = -88.650323 log likelihood = -79.664782 log likelihood = -78.169421 log likelihood = -77.995291</inf></pre>	(could not be evaluated)
Iteration 3:	log likelihood = -77.995291 Page 73	3

LnMM3\_lf mobility\_impair\_24 ciq\_total

# Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX: log likelihood = -77.993909: log likelihood = -77.993909

Iteration 4: Iteration 5:

Log likelihood = -77.993909

Number of obs 132 wald chi2(1) 0.01 Prob > chi2 0.9357

	Coef.	Std. Err.	z	P> z	[95% Conf.	. Interval]
eq1 ciq_total _cons	.0049194 -3.018499	.0609798 1.082089	0.08 -2.79	0.936 0.005	1145988 -5.139354	.1244377 8976443
eq2 ciq_total _cons	100478 3816301	.0235976 .2912788	-4.26 -1.31	0.000 0.190	1467284 9525262	0542276 .1892659

#### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf	. Interval]
eq1 ciq_total	1.004932	0.936	0.891724	1.132511
eq2 ciq_total	0.904405	0.000	0.863528	0.947216

#### LnMM3\_lf mobility\_impair\_24 case ciq\_total

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

Key	+
frequency	
row percentage	ĺ

Case	Mobility im   Not impai	npairmant at Impaired	24 months Dead	Total
Control	51	2	10	63
	80.95	3.17	15.87	100.00
Case	53	5	13	71
	74.65	7.04	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

#### Log multinomial model

log likelihood = -<inf>
log likelihood = -280.00944
log likelihood = -88.650323 (could not be evaluated) initial: feasible: rescale: rescale eq:  $\log likelihood = -88.650323$ Iteration 0: log likelihood = -88.650323log likelihood = -79.199259 log likelihood = -76.862672 log likelihood = -76.441804 Iteration 1: Iteration 2: Iteration 3: log likelihood = -76.428821Iteration 4: Iteration 5:  $\log likelihood = -76.428802$ Iteration 6: log likelihood = -76.428802Page 74

	Number of obs	=	132
	Wald chi2(2)	=	0.88
likelihood = -76.428802	Prob > chi2	=	0.6437

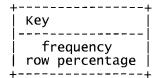
	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 case ciq_total _cons	.7656764 .0065119 -3.52655	.8184125 .0672058 1.330909	0.94 0.10 -2.65	0.349 0.923 0.008	8383826 1252091 -6.135085	2.369735 .1382329 9180156
eq2 case ciq_total _cons	.5439065 1179413 4581808	.3972847 .0293659 .3533847	1.37 -4.02 -1.30	0.171 0.000 0.195	2347572 1754973 -1.150802	1.32257 0603852 .2344404

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P> z	[95% Conf	. Interval]
eq1 case ciq_total	2.150448 1.006533	0.349 0.923	0.432409 0.882312	10.694562 1.148243
eq2 case ciq_total	1.722723 0.888748	0.171 0.000	0.790763 0.839040	3.753055 0.941402

. LnMM3\_lf mobility\_impair\_24 case ciq\_total age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Log

Case	Mobility in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	51 80.95	3.17	10 15.87	63 100.00
Case	53	5	13	71
	74.65	7.04	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

Log multinomial model

initial: log likelihood = -<inf> (could not be evaluated)
feasible: log likelihood = -280.00944
rescale: log likelihood = -88.650323
rescale eq: log likelihood = -88.650323
Iteration 0: log likelihood = -88.650323
Iteration 1: log likelihood = -77.718488
Iteration 2: log likelihood = -76.297469
Iteration 3: log likelihood = -73.24225
Iteration 4: log likelihood = -72.413932

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX: log likelihood = -72.286148: log likelihood = -72.285683: log likelihood = -72.285683 Iteration 5: Iteration 6: Iteration 7:

Number of obs Wald chi2(4) Prob > chi2 132 3.67 0.4519 Log likelihood = -72.285683

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode _cons	.6717303 .0646313 .0326643 -1.005943 -6.164647	.8154965 .0766465 .0260742 .8497674 2.500543	0.82 0.84 1.25 -1.18 -2.47	0.410 0.399 0.210 0.236 0.014	9266135 085593 0184401 -2.671457 -11.06562	2.270074 .2148557 .0837688 .6595703 -1.263674
eq2 case ciq_total age sex_recode _cons	.4212974 1121594 .0366861 .1793147 -3.012885	.3838317 .0344312 .0180776 .3638215 1.387865	1.10 -3.26 2.03 0.49 -2.17	0.272 0.001 0.042 0.622 0.030	3309989 1796434 .0012546 5337624 -5.733049	1.173594 0446754 .0721175 .8923918 2927203

#### Exponentiated values of the model coefficients and their 95% confidence limits

	   RR	P> z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode	1.957622 1.066766 1.033204 0.365700	0.410 0.399 0.210 0.236	0.395892 0.917968 0.981729 0.069151	9.680118 1.239683 1.087377 1.933961
eq2 case ciq_total age sex_recode	1.523937 0.893902 1.037367 1.196397	0.272 0.001 0.042 0.622	0.718206 0.835568 1.001255 0.586395	3.233592 0.956308 1.074782 2.440961

```
** 4. Charlson age condition: pre-morbid **
```

#### Log multinomial model

initial: feasible: rescale: rescale eq: Iteration 0: Iteration 2: Iteration 3: Iteration 4: Iteration 5: Iteration 6:	log likelihood = - <inf> log likelihood = -300.00944 log likelihood = -93.650323 log likelihood = -93.650323 log likelihood = -93.650323 log likelihood = -79.079465 log likelihood = -72.203714 log likelihood = -71.30712 log likelihood = -71.127367 log likelihood = -71.126849 log likelihood = -71.126849</inf>	(could not be evaluated)

Number of obs Wald chi2(1) 134 0.10 Log likelihood = -71.126849Prob > chi2

LnMM3\_lf mobility\_impair\_24 caci

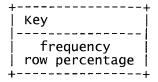
	Ap	pendix 8 2_IC	:U_Predict_I	mpairment	log_THE	SIS_TECH_INDEX	(
		Coef.	Std. Err.	. Z	P> z	[95% Conf.	Interval]
eq1							
•	caci	.0335505	.1036762	0.32	0.746	1696511	.236752
	_cons	-3.112737	.6376574	-4.88	0.000	-4.362522	-1.862951
eq2		<b></b>					
•	caci	.2754887	.0436245	6.31	0.000	.1899862	.3609912
	_cons	-3.51933	. 4678704	-7.52	0.000	-4.436339	-2.602321

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	caci	1.034120	0.746	0.843959	1.267127
eq2	caci	1.317174	0.000	1.209233	1.434751

LnMM3\_lf mobility\_impair\_24 case caci

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	Mobility im   Not impai	npairmant at Impaired	24 months Dead	Total
Control	51 80.95	3.17	10 15.87	63 100.00
Case	53	5	13	71
	74.65	7.04	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

Log multinomial model

```
log likelihood = -<inf>
log likelihood = -300.00944
log likelihood = -93.650323
log likelihood = -93.650323
log likelihood = -78.592603
initial:
                                                                          (could not be evaluated)
feasible:
rescale:
rescale eq:
Iteration 0:
Iteration 1:
Iteration 2:
                         \log likelihood = -71.182092
                         log likelihood = -69.941249
log likelihood = -69.573625
log likelihood = -69.568321
Iteration 3:
Iteration 4:
Iteration 5:
                         log likelihood = -69.568315
Iteration 6:
```

```
Number of obs
Wald chi2(2)
Prob > chi2
                                                                          1.11
Log likelihood = -69.568315
       | Coef. Std. Err. z P>|z| [95% Conf. Interval]
```

134

eq1	case	.8172174	.8195338	1.00	0.319	7890393	2.423474
	caci	.0421278	.1050175	0.40	0.688	1637027	.2479584
	_cons	-3.664712	.8959443	-4.09	0.000	-5.420731	-1.908694
eq2	case	.3221465	.2593739	1.24	0.214	1862169	.8305099
	caci	.2941259	.048426	6.07	0.000	.1992127	.3890392
	_cons	-3.822871	.5368994	-7.12	0.000	-4.875174	-2.770567

Exponentiated values of the model coefficients and their 95% confidence limits

				505% - 6	
		RR	P>   z	L95% Conf.	Interval]
eq1					
	case	2.264191	0.319	0.454281	11.284996
	caci	1.043028	0.688	0.848994	1.281407
eq2		4 20000			2 224422
	case	1.380087	0.214	0.830093	2.294488
		1.341953	0.000	1.220442	1.475562

. LnMM3\_lf mobility\_impair\_24 case caci age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

++	
Key	
frequency	
row percentage	
++	

Case	Mobility in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	51 80.95	3.17	10 15.87	63 100.00
Case	53	5	13	71
	74.65	7.04	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

#### Log multinomial model

```
log likelihood = -<inf>
log likelihood = -300.00944
log likelihood = -93.650323
log likelihood = -93.650323
                                                                         (could not be evaluated)
initial:
feasible:
rescale:
rescale eq:
Iteration 0: Iteration 1:
                         log likelihood = -93.650323
                         \log likelihood = -76.117713
                        log likelihood = -71.235154
log likelihood = -69.829976
log likelihood = -68.844851
Iteration 2:
Iteration 3:
Iteration 4:
                         log likelihood = -68.491823
Iteration 5:
                        log likelihood = -68.42486
log likelihood = -68.423602
log likelihood = -68.4236
Iteration 6:
Iteration 7:
Iteration 8:
```

Number of obs = 134 Wald chi2(4) = 2.93 Prob > chi2 = 0.5698

	Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
eq1 case caci age sex_recode _cons	.6399397 0885028 .0379521 8229706 -5.076771	.8164577 .1622516 .0350058 .826686 2.000726	0.78 -0.55 1.08 -1.00 -2.54	0.433 0.585 0.278 0.319 0.011	960288 4065102 0306581 -2.443246 -8.998122	2.240167 .2295045 .1065622 .7973042 -1.155419
eq2 case caci age sex_recode _cons	.2765389 .2905962 .0105099 .0521235 -4.514749	.3802657 .0518694 .0222205 .3654529 1.5437	0.73 5.60 0.47 0.14 -2.92	0.467 0.000 0.636 0.887 0.003	4687682 .1889341 0330415 664151 -7.540345	1.021846 .3922583 .0540612 .7683981 -1.489152

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P> z  [95% Conf. Interval]
eq1 case caci age sex_recode	1.896367 0.915301 1.038681 0.439125	0.433       0.382783       9.394904         0.585       0.665970       1.257976         0.278       0.969807       1.112447         0.319       0.086878       2.219549
eq2 case caci age sex_recode	1.318558 1.337224 1.010565 1.053506	0.467 0.625773 2.778319 0.000 1.207961 1.480320 0.636 0.967498 1.055549 0.887 0.514710 2.156309

- . . \*\* 5. Apache3 ROD: cases only \*\*
- LnMM3\_lf mobility\_impair\_24 apache3rod

## Log multinomial model

initial: feasible: rescale: rescale eq: Iteration 0: Iteration 1: Iteration 3: Iteration 4: Iteration 5:	log likelihood = - <inf> log likelihood = -180.00481 log likelihood = -54.504492 log likelihood = -53.119376 log likelihood = -53.119376 log likelihood = -49.025653 log likelihood = -46.757035 log likelihood = -46.736524 log likelihood = -46.736459 log likelihood = -46.736459</inf>	(could not be evaluated)
		Number of obs =

Log likelihood = -46.736459			Wald chi2(1) = Prob > chi2 =			8.72 0.0031	
	Coef.	Std. Err.	z	P> z	[95%	Conf.	Interval]
eq1 apache3rod _cons	3.19647 -3.886107	1.082406 .8190584	2.95 -4.74	0.003 0.000	1.074 -5.491		5.317947 -2.280782
eq2	   	.8358611	0.62	0.533	-1.117	325	2.15919

71

Page 79

#### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf	. Interval]
eq1 apache3rod	24.446080	0.003	2.929972	2.04e+02
eq2 apache3rod	1.683597	0.533	0.327154	8.664121

. LnMM3\_lf mobility\_impair\_24 apache3rod age sex\_recode

### Log multinomial model

initial: feasible: rescale: rescale eq: Iteration 0: Iteration 2: Iteration 3: Iteration 4: Iteration 5:	log likelihood = - <inf> log likelihood = -180.00481 log likelihood = -54.504492 log likelihood = -53.119376 log likelihood = -53.119376 log likelihood = -48.125462 log likelihood = -43.695332 log likelihood = -43.370423 log likelihood = -43.348977 log likelihood = -43.34885</inf>	(could not be evaluated)
Iteration 5: Iteration 6:	<pre>log likelihood = -43.348885 log likelihood = -43.348885</pre>	

Loa	likelihood	=	-43.348885

Number of obs	=	71
wald chi2(3)	=	6.62
Prob > chi2	=	0.0852

	Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
eq1 apache3rod age sex_recode _cons	4.418249 .0824868 9671678 -9.665504	1.778789 .0695293 .914771 5.447729	2.48 1.19 -1.06 -1.77	0.013 0.235 0.290 0.076	.9318857 053788 -2.760086 -20.34286	7.904612 .2187617 .8257504 1.011847
eq2 apache3rod age sex_recode cons	.5623209 .030668 3638859 -3.69425	.895459 .0208138 .510548 1.512352	0.63 1.47 -0.71 -2.44	0.530 0.141 0.476 0.015	-1.192746 0101263 -1.364542 -6.658406	2.317388 .0714623 .6367699 7300951

## Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1				
apache3rod	82.950908	0.013	2.539293	2.71e+03
age	1.085984	0.235	0.947633	1.244535
sex_recode	0.380158	0.290	0.063286	2.283594
eq2				
apache3rod	1.754740	0.530	0.303387	10.149133
age	1.031143	0.141	0.989925	1.074078
sex_recode	0.694971	0.476	0.255498	1.890365

## 

use "Marsden\_ICU\_ALL\_data\_CLEAN\_v3\_Impairment\_coded", clear

. keep if sample\_time==1
(858 observations deleted)

\*\* 1. FIM: 1 month \*\*

LnMM3\_lf lns\_impair\_24 fim

#### Log multinomial model

initial:	<pre>log likelihood = -<inf></inf></pre>	(could not be evaluated)
feasible:	$log\ likelihood = -470.00736$	
rescale:	log likelihood = -127.68049	
rescale eq:	log likelihood = -125.99376	
Iteration 0:	$\log likelihood = -125.99376$	
Iteration 1:	log likelihood = -111.56833	
Iteration 2:	log likelihood = -103.32572	
Iteration 3:	$log\ likelihood = -102.1554$	
Iteration 4:	log likelihood = -102.14487	
Iteration 5:	log likelihood = -102.14487	

Log likelihood = -102.14487

Number of obs = 128 Wald chi2(1) = 1.37 Prob > chi2 = 0.2417

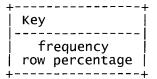
		Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1	fim _cons	0115589 3888446	.0098723 1.085269	-1.17 -0.36	0.242 0.720	0309082 -2.515933	.0077904 1.738244
eq2	fim   _cons	0423528 2.76518	.008061 .7338758	-5.25 3.77	0.000	0581521 1.326809	0265535 4.20355

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	fim	0.988508	0.242	0.969565	1.007821
eq2	fim	0.958532	0.000	0.943506	0.973796

LnMM3\_lf lns\_impair\_24 case fim

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX

	LNS impai	irmant at 24	months	
Case	Not impai	Impaired	Dead	Total
Control	42	10	10	62
	67.74	16.13	16.13	100.00
Case	39	14	13	66
	59.09	21.21	19.70	100.00
Total	81	24	23	128
	63.28	18.75	17.97	100.00

#### Log multinomial model

log likelihood = -<inf>
log likelihood = -470.00736 initial: (could not be evaluated) feasible: rescale:  $log\ likelihood = -127.68049$  $log\ likelihood = -125.99376$ rescale eq:  $\log likelihood = -125.99376$ Iteration 0: log likelihood = -116.05386 log likelihood = -108.22493 Iteration 1: Iteration 2: Iteration 3:  $\log likelihood = -102.41457$  $\log likelihood = -97.314114$ Iteration 4: log likelihood = -96.574265 log likelihood = -96.561952 log likelihood = -96.56194 log likelihood = -96.56194 Iteration 5: Iteration 6: Iteration 7: Iteration 8:

Log likelihood = -96.56194

Number of obs	=	128
Wald chi2(2)	=	1.29
Prob > chi2	=	0.5258

		Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
eq1	case	.0774523	.4655992	0.17	0.868	8351053	.99001
	fim	0095575	.0119454	-0.80	0.424	03297	.013855
	_cons	6539042	1.490405	-0.44	0.661	-3.575045	2.267236
eq2	case	-2.802619	1.121199	-2.50	0.012	-5.000129	6051091
	fim	0919716	.0247061	-3.72	0.000	1403946	0435485
	_cons	9.38217	2.995768	3.13	0.002	3.510572	15.25377

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	case	1.080531	0.868	0.433829	2.691261
	fim	0.990488	0.424	0.967568	1.013951
eq2	case	0.060651	0.012	0.006737	0.546015
	fim	0.912131	0.000	0.869015	0.957386

LnMM3\_lf lns\_impair\_24 case fim age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

<sup>+-----</sup>| Key |

|----| | frequency | | row percentage |

Case	LNS impai   Not impai	rmant at 24 Impaired	months Dead	Total
Control	42	10	10	62
	67.74	16.13	16.13	100.00
Case	39	14	13	66
	59.09	21.21	19.70	100.00
Total	81	24	23	128
	63.28	18.75	17.97	100.00

#### Log multinomial model

log likelihood = -<inf>
log likelihood = -470.00736
log likelihood = -127.68049 (could not be evaluated) initial: feasible: rescale: log likelihood = -125.99376 log likelihood = -125.99376 log likelihood = -115.56034 rescale eq: Iteration 0: Iteration 1:  $log\ likelihood = -106.86033$ Iteration 2:  $log\ likelihood = -95.175282$ Iteration 3: log likelihood = -86.693094 log likelihood = -83.281735 log likelihood = -83.095496 Iteration 4: Iteration 5: Iteration 6: Iteration 7: log likelihood = -83.08978 log likelihood = -83.08976 Iteration 8: log likelihood = -83.08976 Iteration 9:

Log likelihood = -83.08976

Number of obs = 128 Wald chi2(4) = 1.72 Prob > chi2 = 0.7863

	Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
eq1 case fim age sex_recode _cons	.0737487 0100409 .0066728 .0845157 -1.055451	.4700872 .0130016 .0122407 .3702722 1.839609	0.16 -0.77 0.55 0.23 -0.57	0.875 0.440 0.586 0.819 0.566	8476053 0355235 0173186 6412044 -4.661019	.9951028 .0154417 .0306642 .8102359 2.550116
eq2 case fim age sex_recode _cons	-4.594817 1803993 .1181494 1185282 11.19052	1.671874 .0521517 .0320109 .290988 4.601284	-2.75 -3.46 3.69 -0.41 2.43	0.006 0.001 0.000 0.684 0.015	-7.87163 2826147 .0554091 6888541 2.172169	-1.318004 0781839 .1808896 .4517978 20.20887

#### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	. Interval]
eq1 case fim age sex_recode	1.076536 0.990009 1.006695 1.088190	0.875 0.440 0.586 0.819	0.428440 0.965100 0.982830 0.526658	2.705002 1.015562 1.031139 2.248438

eq2	ľ			
case	0.010104	0.006	0.000381	0.267669
fim	0.834937	0.001	0.753810	0.924794
age	1.125412	0.000	1.056973	1.198283
sex_recode	0.888227	0.684	0.502151	1.571134

- . \*\* 2. MMSE: 1 month \*\*
- . LnMM3\_lf lns\_impair\_24 mmse

#### Log multinomial model

	Number of obs	=	104
	Wald chi2(1)	=	4.49
$Log\ likelihood = -87.544646$	Prob > chi2	=	0.0341

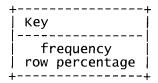
	<del></del>	Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
eq1	mmse	1189416	.0561332	-2.12	0.034	2289606	0089225
	_cons	1.796167	1.537347	1.17	0.243	-1.216977	4.809311
eq2	mmse	0303147	.0989718	-0.31	0.759	2242959	.1636666
	_cons	-1.215998	2.818085	-0.43	0.666	-6.739342	4.307346

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	mmse	0.887860	0.034	0.795360	0.991117
eq2	mmse	0.970140	0.759	0.799079	1.177822

#### LnMM3\_lf lns\_impair\_24 case mmse

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



	LNS impai   Not impai	rmant at 24	months	
Case	Not impai	Impaired	Dead	Total
Control	42	10	10	62
			Page 84	

#### Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX 67.74 16.13 16.13 100.00 39 14 13 Case 66 59.09 19.70 100.00 21.21 128 Total 18.75 17.97 100.00 63.28

Log multinomial model

(could not be evaluated) initial: log likelihood = -<inf> feasible: log likelihood = -350.00627log likelihood = -99.873772rescale: log likelihood = -91.726168
log likelihood = -91.726168 rescale eq: Iteration 0:  $log\ likelihood = -89.150893$ Iteration 1: **Iteration 2:**  $\log likelihood = -87.618019$ log likelihood = -87.111158 log likelihood = -87.058647 log likelihood = -87.058488 Iteration 3: **Iteration 4:** Iteration 5: Iteration 6: log likelihood = -87.058488

Log likelihood = -87.058488

Number of obs = 104 Wald chi2(2) = 5.07 Prob > chi2 = 0.0791

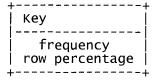
		- <b></b>					
		Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
eq1							
·	case mmse _cons	.2740134 1084307 1.339192	.4026126 .0573698 1.66102	0.68 -1.89 0.81	0.496 0.059 0.420	5150928 2208734 -1.916347	1.06312 .0040121 4.594732
eq2	case   mmse   _cons	.2964739 0185115 -1.723327	.546411 .1014704 2.976962	0.54 -0.18 -0.58	0.587 0.855 0.563	7744721 2173897 -7.558066	1.36742 .1803668 4.111412
	•						

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	. Interval]
eq1	case	1.315232	0.496	0.597445	2.895390
	mmse	0.897241	0.059	0.801818	1.004020
eq2	case	1.345107	0.587	0.460947	3.925210
	mmse	0.981659	0.855	0.804616	1.197657

LnMM3\_lf lns\_impair\_24 case mmse age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



| LNS impairmant at 24 months Case | Not impai Impaired Dead | Total Page 85

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX

Control	42	10	10	62
	67.74	16.13	16.13	100.00
Case	39	14	13	66
	59.09	21.21	19.70	100.00
Total	81	24	23	128
	63.28	18.75	17.97	100.00

#### Log multinomial model

initial: log likelihood = -<inf> (could not be evaluated)

feasible: log likelihood = -350.00627 rescale: log likelihood = -99.873772 rescale eq: log likelihood = -91.726168

rescale eq: log likelihood = -91.726168
Iteration 0: log likelihood = -91.726168
Iteration 1: log likelihood = -85.444562
Iteration 2: log likelihood = -83.3058
Iteration 3: log likelihood = -83.239455
Iteration 4: log likelihood = -83.239282
Iteration 5: log likelihood = -83.239282

Number of obs = 104 Wald chi2(4) = 6.08 Log likelihood = -83.239282 Prob > chi2 = 0.1934

Coef. Std. Err. z P>|z| [95% Conf. Interval] eq1 -.593681 -.2187042 case .2058887 .4079512 0.50 0.614 1.005458 0.083 .0133705 -.1026669 .0592038 mmse -1.730.97 -.0121933 .0120293 .0123587 0.330 .036252 age .0490827 3748707 0.896 -.6856504 sex\_recode 0.13 7838159 \_cons | 1.929667 -3.339243 .4428344 0.818 4.224912 eq2 .5353954 0.12 0.901 -.9826875 case .0666681 1.116024 -.0238389 .1052678 -0.230.821 -.23016 .1824823 mmse .0212877 1.94 .0830547 age .0413315 0.052 -.0003917 .5314239 -1.412393 -.3708215 -0.70 0.485 .6707502 sex\_recode \_cons | -3.995137 3.411438 0.242 -1.17-10.68143 2.691159

#### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	. Interval]
eq1				
case	1.228616	0.614	0.552291	2.733160
mmse	0.902428	0.083	0.803559	1.013460
age	1.012102	0.330	0.987881	1.036917
sex_recode	1.050307	0.896	0.503762	2.189812
eq2				
case	1.068941	0.901	0.374304	3.052692
mmse	0.976443	0.821	0.794406	1.200193
age	1.042198	0.052	0.999608	1.086601
sex_recode	0.690167	0.485	0.243560	1.955704

\*\* 3. CIQ Total: 1 month \*\*

LnMM3\_lf lns\_impair\_24 ciq\_total

#### Log multinomial model

Log likelihood = -106.06518

Number of obs = 128 Wald chi2(1) = 4.48 Prob > chi2 = 0.0342

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 ciq_total _cons	0641012 -1.12335	.0302689 .270882	-2.12 -4.15	0.034 0.000	1234273 -1.654269	0047752 592431
eq2 ciq_total _cons	1071149 8855594	.0347115	-3.09 -3.55	0.002 0.000	1751482 -1.375032	0390816 3960868

#### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	. Interval]
eq1 ciq_total	0.937910	0.034	0.883886	0.995236
eq2 ciq_total	0.898422	0.002	0.839333	0.961672

#### . LnMM3\_lf lns\_impair\_24 case ciq\_total

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

+   K	 ey	+
r	frequency ow percentage	-      -

Case	LNS impa <sup>.</sup>   Not impai	irmant at 24 Impaired	l months Dead	Total
Control	42	10	10	62
	67.74	16.13	16.13	100.00
Case	39	14	13	66
	59.09	21.21	19.70	100.00
Total	81	24	23	128
	63.28	18.75	17.97	100.00

```
Appendix 8 2_ICU_Predict_Impairment log_THESIS_TECH_INDEX
                     log likelihood = -<inf>
log likelihood = -470.00736
log likelihood = -127.68049
                                                                (could not be evaluated)
initial:
feasible:
rescale:
rescale eq:
                      log likelihood = -125.99376
                      \log likelihood = -125.99376
Iteration 0:
                     log likelihood = -112.32303
log likelihood = -105.7036
log likelihood = -105.58667
log likelihood = -105.58494
Iteration 1:
Iteration 2:
Iteration 3:
Iteration 4:
Iteration 5:
                     log likelihood = -105.58494
```

Log likelihood = -105.58494

Number of obs = 128 Wald chi2(2) = 4.50 Prob > chi2 = 0.1056

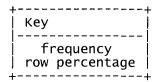
					_	
	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case ciq_total _cons	0457144 0642382 -1.096723	.3825531 .0313875 .39726	-0.12 -2.05 -2.76	0.905 0.041 0.006	7955047 1257566 -1.875338	.704076 0027198 3181076
eq2 case ciq_total _cons	2991582 1122887 6800001	.3432714 .0329551 .3093202	-0.87 -3.41 -2.20	0.383 0.001 0.028	9719579 1768796 -1.286257	.3736414 0476979 0737436

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P> z	[95% Conf.	. Interval]
eq1 case ciq_total	0.955315 0.937782	0.905 0.041	0.451353 0.881829	2.021977 0.997284
eq2 case ciq_total	0.741442 0.893786	0.383 0.001	0.378342 0.837881	1.453016 0.953422

. LnMM3\_lf lns\_impair\_24 case ciq\_total age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	LNS impa <sup>.</sup>   Not impai	irmant at 24 Impaired	months Dead	Total
Control	42	10	10	62
	67.74	16.13	16.13	100.00
Case	39	14	13	66
	59.09	21.21	19.70	100.00
Total	81	24	23	128
	63.28	18.75	17.97	100.00

```
(could not be evaluated)
initial:
                        log likelihood =
                                                          -<inf>
                        log\ likelihood = -470.00736
feasible:
rescale:
                        \log likelihood = -127.68049
                       log likelihood = -125.99376
log likelihood = -125.99376
log likelihood = -111.21394
rescale eq:
Iteration 0:
Iteration 1:
                        \log likelihood = -103.03818
Iteration 2:
                       log likelihood = -103.03818
log likelihood = -102.43404
log likelihood = -102.34518
log likelihood = -102.34325
log likelihood = -102.34325
Iteration 3:
Iteration 4:
Iteration 5:
Iteration 6:
```

Number of obs Wald chi2(4) 128 4.74 0.3153 Log likelihood = -102.34325Prob > chi2

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode _cons	0541388 0684279 0011004 .2749024 -1.121005	.3907871 .0345907 .0117984 .375374 .9163199	-0.14 -1.98 -0.09 0.73 -1.22	0.890 0.048 0.926 0.464 0.221	8200674 1362245 0242248 4608171 -2.916959	.7117898 0006313 .0220239 1.010622 .6749491
eq2 case ciq_total age sex_recode _cons	0980676 0836735 .0360239 0149425 -3.408352	.3535523 .0340071 .0175765 .377506 1.380644	-0.28 -2.46 2.05 -0.04 -2.47	0.781 0.014 0.040 0.968 0.014	7910173 1503262 .0015746 7548406 -6.114365	.5948822 0170207 .0704731 .7249557 7023394

#### Exponentiated values of the model coefficients and their 95% confidence limits

	   RR	P>   z	[95% Conf.	Interval]
eq1				_
case	0.947301	0.890	0.440402	2.037635
ciq_total	0.933861	0.048	0.872647	0.999369
age	0.998900	0.926	0.976066	1.022268
٦,	1.316402	0.464	0.630768	2.747309
sex_recode	1.316402	0.404	0.030/06	2.747309
eq2		-		
case	0.906588	0.781	0.453383	1.812817
ciq_total	0.919732	0.014	0.860427	0.983123
<b>!</b>		0.040	1.001576	1.073016
age	1.036681			
sex_recode	0.985169	0.968	0.470086	2.064640

```
*********
* Digit Span: Impairment at 24 months * *********************
```

LnMM3\_lf digit\_impair\_24 fim

Log multinomial model

```
(could not be evaluated)
initial:
```

log likelihood = -<inf>
log likelihood = -430.00854
log likelihood = -124.35702 feasible: rescale:

<sup>\*\* 1.</sup> FIM: 1 month \*\*

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX log likelihood = -121.97116
: log likelihood = -121.97116
: log likelihood = -112.19342
: log likelihood = -105.25995
: log likelihood = -100.62025
: log likelihood = -100.48791 rescale eq: Iteration 0: Iteration 1: Iteration 2: Iteration 3: log likelihood = -100.48791 log likelihood = -100.48756 log likelihood = -100.48756 Iteration 4: Iteration 5: Iteration 6:

> Number of obs  $\begin{smallmatrix} 137\\0.81\end{smallmatrix}$ wald chi2(1) = Prob > chi2 0.3680

Log likelihood = -100.48756

		Coef.	Std. Err.	z	P>   z	[95% Conf.	. Interval]
eq1	fim   _cons	0107479 7247082	.0119379 1.323696	-0.90 -0.55	0.368 0.584	0341457 -3.319105	.0126499 1.869689
eq2	fim   _cons	046861 3.178721	.0082452 .7438875	-5.68 4.27	0.000	0630212 1.720728	0307008 4.636714

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P> z	[95% Conf.	Interval]
eq1	fim	0.989310	0.368	0.966431	1.012730
eq2	fim	0.954220	0.000	0.938924	0.969766

#### LnMM3\_lf digit\_impair\_24 case fim

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

+	H
Key	
	ĺ
frequency	ĺ
row percentage	
+	Ŀ

Case	Digit spa Not impai	n impairmant months Impaired	at 24 Dead	Total
Control	50	8	10	68
	73.53	11.76	14.71	100.00
Case	44	12	13	69
	63.77	17.39	18.84	100.00
Total	94	20	23	137
	68.61	14.60	16.79	100.00

#### Log multinomial model

log likelihood = -<inf>
log likelihood = -430.00854 (could not be evaluated) initial:

feasible: log likelihood = -124.35702 log likelihood = -121.97116 rescale: rescale eq:

Iteration 0: log likelihood = -121.97116
Iteration 1: log likelihood = -111.32592
Iteration 2: log likelihood = -103.50513
Iteration 3: log likelihood = -97.223998
Iteration 4: log likelihood = -96.856986
Iteration 5: log likelihood = -96.853418
Iteration 6: log likelihood = -96.853414

Number of obs = 137 Wald chi2(2) = 1.10 Log likelihood = -96.853414 Prob > chi2 = 0.5771

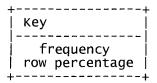
		Coef.	Std. Err.	z	P> z	[95% Conf.	Interval]
eq1	case	.2873411	.4877629	0.59	0.556	6686566	1.243339
	fim	0063267	.0138028	-0.46	0.647	0333797	.0207263
	_cons	-1.376819	1.695079	-0.81	0.417	-4.699114	1.945475
eq2	case	-1.507695	.5306363	-2.84	0.004	-2.547723	467667
	fim	0725985	.013996	-5.19	0.000	1000301	0451669
	_cons	6.665966	1.573884	4.24	0.000	3.581209	9.750722

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P> z	[95% Conf.	Interval]
eq1	case	1.332879	0.556	0.512396	3.467170
	fim	0.993693	0.647	0.967171	1.020943
eq2	case	0.221420	0.004	0.078260	0.626462
	fim	0.929974	0.000	0.904810	0.955838

#### . LnMM3\_lf digit\_impair\_24 case fim age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



	Digit spa 	Digit span impairmant at 24 months							
Case	Not impai	Impaired	Dead	Total					
Control	50	8	10	68					
	73.53	11.76	14.71	100.00					
Case	44	12	13	69					
	63.77	17.39	18.84	100.00					
Total	94	20	23	137					
	68.61	14.60	16.79	100.00					

Log multinomial model

initial: log likelihood = -<inf> (could not be evaluated)
Page 91

#### Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX log likelihood = -420.00854 feasible: log likelihood = -121.85702 rescale: log likelihood = -119.47116 log likelihood = -119.47116 log likelihood = -107.87953 log likelihood = -98.510641 rescale eq: Iteration 0: Iteration 1: Iteration 2: log likelihood = -89.923217 log likelihood = -88.421214 log likelihood = -88.407555 log likelihood = -88.407483 log likelihood = -88.407483 Iteration 3: Iteration 4: Iteration 5: Iteration 6: Iteration 7: Number of obs = Wald chi2(4) = Prob > chi2 = 4.02 $Log\ likelihood = -88.407483$ 0.4035 | Coef. Std. Err. z P>|z| [95% Conf. Interval] \_\_\_\_\_\_ eq1 -.5147168 -.0327851 -.0072044 -.612548 -8.21368 .4488771 .4916386 0.91 -0.20 1.53 0.50 0.910.361 case | 1.412471 0.844 0268077 fim | -.0029887 age | .0260222 sex\_recode | .2121823 .0152025 .0169527 0.125 .0592489 .2121823 0.614 .4207885 1.036913 \_cons | -3.687043 2.309551 -1.60 0.110 .8395945 ea2 case -1.302026 .5289067 -2.46 0.014 -2.338664 -.2653874 fim -.0797543 .0164999 -4.83 0.000 -.1120935 -.0474152 age .0316255 .01609 1.97 0.049 .0000897 .0631612 ecode .2993633 .308036 0.97 0.331 -.3043762 .9031028 \_cons 5.034128 2.310712 2.18 0.029 .5052168 9.56304 sex\_recode | x\_recode | .2993633 .308036 \_cons | 5.034128 2.310712

136

Exponentiated	values	of	the model	coefficients	and	their	95%	confidence	limits
---------------	--------	----	-----------	--------------	-----	-------	-----	------------	--------

	RR	P>   z	[95% Conf.	Interval]
eq1 case fim age sex_recode	1.566552 0.997016 1.026364 1.236373	0.361 0.844 0.125 0.614	0.597670 0.967746 0.992821 0.541968	4.106089 1.027170 1.061039 2.820495
eq2 case fim age sex_recode	0.271980 0.923343 1.032131 1.349000	0.014 0.000 0.049 0.331	0.096456 0.893961 1.000090 0.737583	0.766909 0.953691 1.065199 2.467247

```
** 2. mmse: 1 month **
```

LnMM3\_1f digit\_impair\_24 mmse

```
log likelihood = -<inf>
log likelihood = -290.00717
log likelihood = -86.667073
initial:
                                                                                          (could not be evaluated)
feasible:
rescale:
                               \log likelihood = -86.667073
rescale eq:
                             log likelihood = -86.667073
log likelihood = -77.038119
log likelihood = -75.212518
log likelihood = -74.840502
log likelihood = -74.773039
Iteration 0: Iteration 1: Iteration 2:
Iteration 3:
Iteration 4:
                                                                          Page 92
```

# Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX: log likelihood = -74.772183: log likelihood = -74.772182

Iteration 5: Iteration 6:

Log likelihood = -74.772182

Number of obs 108 wald chi2(1) 23.17 = Prob > chi2 0.0000

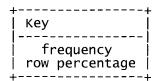
		Coef.	Std. Err.	Z	P>   Z	[95% Conf.	Interval]
eq1		2455754	0510175	4 01	0.000	2455670	1455020
	_cons	2455754 4.785316	.0510175 1.241451	-4.81 3.85	0.000 0.000	3455679 2.352117	1455829 7.218515
eq2	<del>-</del>						
	mmse _cons	0071395 -1.914348	.0967665 2.758279	-0.07 -0.69	0.941 0.488	1967984 -7.320475	.1825194 3.491779

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P> z	[95% Conf.	Interval]
eq1	mmse	0.782254	0.000	0.707818	0.864518
eq2	mmse	0.992886	0.941	0.821356	1.200237

#### LnMM3\_lf digit\_impair\_24 case mmse

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



	Digit spa 	an impairmant months	at 24	
Case	Not impai	Impaired	Dead	Total
Control	50	8	10	68
	73.53	11.76	14.71	100.00
Case	44	12	13	69
	63.77	17.39	18.84	100.00
Total	94	20	23	137
	68.61	14.60	16.79	100.00

#### Log multinomial model

log likelihood = -<inf>
log likelihood = -290.00717
log likelihood = -86.667073 (could not be evaluated) initial: feasible: rescale: log likelihood = -86.667073 log likelihood = -86.667073 log likelihood = -76.5297 log likelihood = -74.658649 rescale eq: Iteration 0: Iteration 1: Iteration 2: log likelihood = -74.34302Iteration 3: log likelihood = -74.016128 log likelihood = -73.994629 Iteration 4: Iteration 5:

# Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX: log likelihood = -73.994469: log likelihood = -73.994469

Iteration 6:

Iteration 7:

	Number of obs	=	108
	Wald chi2(2)	=	25.46
Log likelihood = -73.994469	Prob > chi2	=	0.0000

		Coef.	Std. Err.	z	P> z	[95% Conf	. Interval]
eq1							
	case mmse _cons	.5319769 2194798 3.730713	.5482112 .0531003 1.527571	0.97 -4.13 2.44	0.332 0.000 0.015	5424972 3235544 .7367291	1.606451 1154051 6.724697
eq2	case   mmse   _cons	.2882229 .0036048 -2.387081	.5466464 .0979078 2.875912	0.53 0.04 -0.83	0.598 0.971 0.407	7831843 188291 -8.023764	1.35963 .1955007 3.249603

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P> z	[95% Conf.	Interval]
eq1	case	1.702294 0.802936	0.332 0.000	0.581295 0.723573	4.985088 0.891005
eq2	case	1.334055 1.003611	0.598 0.971	0.456949 0.828374	3.894752 1.215920

#### LnMM3\_lf digit\_impair\_24 case mmse age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

++
Key
frequency row percentage
++

Case	Digit spa     Not impai	n impairmant months Impaired	t at 24 Dead	Total
	i Noc impai	Imparred	Dead	ΙΟυαί
Control	50	8	10	68
	73.53	11.76	14.71	100.00
Case	44	12	13	69
	63.77	17.39	18.84	100.00
Total	94	20	23	137
	68.61	14.60	16.79	100.00

#### Log multinomial model

(could not be evaluated) initial:

log likelihood = -<inf>
log likelihood = -290.00717
log likelihood = -86.667073
log likelihood = -86.667073
log likelihood = -86.667073
log likelihood = -74.559081 feasible: rescale: rescale eq: Iteration 0: Iteration 1:

# Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX: log likelihood = -70.575911: log likelihood = -69.224144

Iteration 2: Iteration 3: Iteration 4: log likelihood = -68.827642Iteration 5: log likelihood = -68.78719 log likelihood =
log likelihood = Iteration 6: -68.78655 Iteration 7: -68.78655

Log likelihood = -68.78655

Number of obs 108 wald chi2(4) 23.68

Prob > chi2 0.0001

	Coef.	Std. Err.	z	P>   Z	[95% Conf.	Interval]
eq1 case mmse age sex_recode _cons	.3671604 2292338 .0378384 1179955 1.674049	.5558047 .0612035 .0232624 .3874693 2.209396	0.66 -3.75 1.63 -0.30 0.76	0.509 0.000 0.104 0.761 0.449	7221968 3491905 0077551 8774214 -2.656288	1.456518 1092772 .0834318 .6414303 6.004386
eq2 case mmse age sex_recode _cons	.1730052 .0016884 .0412711 2026369 -4.894912	.5370272 .1027665 .0217998 .5361788 3.313202	0.32 0.02 1.89 -0.38 -1.48	0.747 0.987 0.058 0.705 0.140	8795487 1997302 0014557 -1.253528 -11.38867	1.225559 .2031071 .083998 .8482543 1.598844

#### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P> z	[95% Conf.	Interval]
eq1 case mmse age sex_recode	1.443629 0.795143 1.038563 0.888700	0.509 0.000 0.104 0.761	0.485684 0.705259 0.992275 0.415854	4.290991 0.896482 1.087011 1.899195
eq2 case mmse age sex_recode	1.188872 1.001690 1.042135 0.816575	0.747 0.987 0.058 0.705	0.414970 0.818952 0.998545 0.285496	3.406070 1.225204 1.087627 2.335566

<sup>\*\* 3.</sup> CIQ Total: 1 month \*\*

#### Log multinomial model

initial: log likelihood = (could not be evaluated) -<inf> feasible: log likelihood = -430.00854log likelihood = -124.35702 log likelihood = -121.97116 rescale: log likelihood = -121.97116
log likelihood = -121.97116 rescale eq: Iteration 0: Iteration 1:  $log\ likelihood = -111.27499$ Iteration 2:  $\log likelihood = -104.17912$ log likelihood = -103.94813 log likelihood = -103.94789 log likelihood = -103.94789 Iteration 3: Iteration 4: Iteration 5:

> Number of obs 137 wald chi2(1) 3.89 0.0484 Prob > chi2

 $Log\ likelihood = -103.94789$ 

LnMM3\_lf digit\_impair\_24 cig\_total

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 ciq_total _cons	0676147 -1.324228	.0342627 .3159388	-1.97 -4.19	0.048 0.000	1347684 -1.943457	000461 7049996
eq2 ciq_total _cons	1201004 8363293	.0356047 .2518069	-3.37 -3.32	0.001 0.001	1898843 -1.329862	0503165 3427968

Exponentiated values of the model coefficients and their 95% confidence limits

	   RR	P> z	[95% Conf.	Interval]
eq1 ciq_total	0.934621	0.048	0.873918	0.999539
eq2 ciq_total	0.886831	0.001	0.827055	0.950928

. LnMM3\_lf digit\_impair\_24 case ciq\_total

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

+	+
Key	l
	ĺ
frequency	İ
row percentage	
+	+

	Digit spa 	n impairmant months	t at 24	
Case	Not impai	Impaired	Dead	Total
Control	50	8	10	68
	73.53	11.76	14.71	100.00
Case	44	12	13	69
	63.77	17.39	18.84	100.00
Total	94	20	23	137
	68.61	14.60	16.79	100.00

Log multinomial model

```
initial: log likelihood = -<inf> (could not be evaluated)
feasible: log likelihood = -430.00854
rescale: log likelihood = -124.35702
rescale eq: log likelihood = -121.97116
Iteration 0: log likelihood = -121.97116
Iteration 1: log likelihood = -111.11107
Iteration 2: log likelihood = -104.20655
Iteration 3: log likelihood = -103.40101
Iteration 4: log likelihood = -103.39439
Iteration 5: log likelihood = -103.39439
```

Log likelihood = -103.39439Number of obs = 137 Wald chi2(2) = 3.88 Prob > chi2 = 0.1441

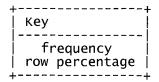
Ap	pendix 8 2_IC	CU_Predict_I	mpairment	log_THI	ESIS_TECH_INDEX	Κ
	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1	+ 					
case ciq_total	.043123  0652164	.4475809 .0365004	0.10 -1.79	0.923 0.074	8341196 1367558	.9203655
_cons	-1.369095	.4862942	-2.82	0.005	-2.322215	4159764
eq2						
case ciq_total _cons	3622259 1282378 5739891	.338403 .0333246 .3008576	-1.07 -3.85 -1.91	0.284 0.000 0.056	-1.025484 1935528 -1.163659	.3010318 0629228 .015681

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P> z  [95%	6 Conf. Interval]
eq1 case ciq_total	1.044066 0.936865		34257 2.510208 72183 1.006343
eq2 case ciq_total	0.696125 0.879644		58623 1.351252 24026 0.939016

. LnMM3\_lf digit\_impair\_24 case ciq\_total age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



	]	an impairman months	t at 24	
Case	Not impai	Impaired	Dead	Total
Control	50	8	10	68
	73.53	11.76	14.71	100.00
Case	44	12	13	69
	63.77	17.39	18.84	100.00
Total	94	20	23	137
	68.61	14.60	16.79	100.00

Log multinomial model

initial: log likelihood = (could not be evaluated) -<inf> feasible: log likelihood = -420.00854log likelihood = -121.85702 log likelihood = -119.47116 log likelihood = -119.47116 rescale: rescale eq: Iteration 0: Iteration 1: log likelihood = -106.70583 $log\ likelihood = -99.014267$ Iteration 2: log likelihood = -96.762273 Iteration 3: Iteration 4: log likelihood = -96.7103 log likelihood = -96.709954 Iteration 5: Iteration 6: log likelihood = -96.709954

> Number of obs = 136Wald chi2(4) = 6.13

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode _cons	.1605797  0593514   .0195569   .2731469   -2.949173	.474047 .0389551 .0169673 .4274079 1.34099	0.34 -1.52 1.15 0.64 -2.20	0.735 0.128 0.249 0.523 0.028	7685353 1357019 0136984 5645572 -5.577465	1.089695 .0169991 .0528121 1.110851 3208822
eq2 case ciq_total age sex_recode _cons	1771103 0979979 .0355142 .0545077 -3.301451	.3633067 .0338925 .0178991 .3847032 1.410916	-0.49 -2.89 1.98 0.14 -2.34	0.626 0.004 0.047 0.887 0.019	8891784 164426 .0004327 6994968 -6.066796	.5349577 0315697 .0705957 .8085122 5361065

### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P> z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode	1.174191 0.942376 1.019749 1.314093	0.735 0.128 0.249 0.523	0.463692 0.873103 0.986395 0.568612	2.973366 1.017144 1.054232 3.036942
eq2 case ciq_total age sex_recode	0.837687 0.906651 1.036152 1.056021	0.626 0.004 0.047 0.887	0.410993 0.848381 1.000433 0.496835	1.707376 0.968923 1.073147 2.244566

\*\*\*\*\*\*\*\*\*\*\* \* IES-R Total: Impairment at 24 months \*

\*\* NOTE: no cases "Impaired" after 2 years (all those impaired at time 1 had

. \*\* so cannot do multinomial regression. Need to recode (0=not impaired, 1=Dead) for log-binomial

tab case iesrtot\_impair\_24

	IES-R total   impairmant at 24   months			
Case		Dead	Total	
Control Case	59   58	10 13	69 71	
Total	   117	23	140	

\*\*\*\*\*\*\*\*\* \* SF36 PCS: Impairment at 24 months \*

\*\* 1. FIM: 1 month \*\*

LnMM3\_1f sf36pcs\_impair\_24 fim

#### Log multinomial model

(could not be evaluated) initial: log likelihood = -<inf> likelihood = -920.00372feasible: log likelihood = -149.89074rescale: log rescale eq: log likelihood = -140.01063log likelihood = -140.01063Iteration 0: Iteration 1:  $\log likelihood = -129.18584$ log likelihood = -127.4483 log likelihood = -127.21385 Iteration 2: Iteration 3: Iteration 4:  $log\ likelihood = -127.1987$ Iteration 5:  $log\ likelihood = -127.19864$ Iteration 6:  $log\ likelihood = -127.19864$ 

Log likelihood = -127.19864

Number of obs = 133 Wald chi2(1) = 1.60 Prob > chi2 = 0.2055

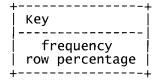
				<b>_</b> _			
		Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
eq1	fim	.0063171	.0049894	1.27	0.205	003462	.0160962
	_cons	-1.370836	.5845155	-2.35	0.019	-2.516465	225207
eq2	fim	0270105	.0062019	-4.36	0.000	039166	014855
	_cons	1.09387	.5734259	1.91	0.056	0300244	2.217764

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	fim	1.006337	0.205	0.996544	1.016226
eq2	fim	0.973351	0.000	0.961591	0.985255

<sup>.</sup> LnMM3\_lf sf36pcs\_impair\_24 case fim

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 PCS in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	17	35	10	62
	27.42	56.45	16.13	100.00
Case	24	34	13	71
	33.80	47.89	18.31	100.00
Total	41	69	23	133
	30.83	51.88	17.29	100.00

133

1.58

0.4543

(could not be evaluated) initial: log likelihood = -<inf>  $log\ likelihood = -920.00372$ feasible:  $log\ likelihood = -149.89074$ rescale: log likelihood = -140.01063 log likelihood = -140.01063 log likelihood = -126.94344 log likelihood = -124.30521 rescale eq: Iteration 0: Iteration 1: Iteration 2: log likelihood = -124.07049 Iteration 3: log likelihood = -124.06628 log likelihood = -124.06627 Iteration 4: Iteration 5:

Number of obs = Wald chi2(2) = Log likelihood = -124.06627 Prob > chi2 =

		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	case	061276	.1927316	-0.32	0.751	439023	.3164709
	fim	.0048672	.0055189	0.88	0.378	0059496	.015684
	_cons	-1.175368	.6938412	-1.69	0.090	-2.535272	.1845356
eq2	case	-1.349055	.690442	-1.95	0.051	-2.702297	.0041863
	fim	0425648	.0113552	-3.75	0.000	0648206	020309
	_cons	3.446012	1.43204	2.41	0.016	.6392654	6.252759

#### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	case	0.940564	0.751	0.644666	1.372276
	fim	1.004879	0.378	0.994068	1.015808
eq2	case	0.259485	0.051	0.067051	1.004195
	fim	0.958328	0.000	0.937236	0.979896

#### . LnMM3\_1f sf36pcs\_impair\_24 case fim age

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

+	+
Key 	
frequen	
row perce	ntage
T	<del></del> +

Case	SF36 PCS in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	17	35	10	62
	27.42	56.45	16.13	100.00
Case	24	34	13	71
	33.80	47.89	18.31	100.00
Total	41	69	23	133
	30.83	51.88	17.29	100.00

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX Log multinomial model

```
(could not be evaluated)
initial:
                     log likelihood =
                                                   -<inf>
                     log likelihood = -920.00372
feasible:
rescale:
                     \log likelihood = -149.89074
                     log likelihood = -140.01063
log likelihood = -140.01063
log likelihood = -117.47317
rescale eq:
Iteration 0:
Iteration 1:
                     log likelihood = -109.43759
Iteration 2:
                     log likelihood = -104.00493
log likelihood = -99.634726
log likelihood = -98.416069
log likelihood = -97.695086
Iteration 3:
Iteration 4:
Iteration 5:
Iteration 6:
Iteration 7:
                     \log likelihood = -97.572186
                     log likelihood = -97.567678
Iteration 8:
                     log likelihood = -97.567665
log likelihood = -97.567665
Iteration 9:
Iteration 10:
```

Log likelihood = -97.567665

Number of obs = 133 Wald chi2(3) = 9.56 Prob > chi2 = 0.0227

	- <b></b>					<b>-</b>	
		Coef.	Std. Err.	Z	P>   Z	[95% Conf.	Interval]
eq1					- <b></b>		
	case fim	.0974467	.1812037	0.54 $1.31$	0.591 0.191	257706 0044484	.4525994
	age _cons	.0121789 -2.494834	.0045137 .9126105	2.70 -2.73	0.007 0.006	.0033322 -4.283518 	.0210255
eq2		2 272270	1 000411	1 07	0.061	6 002110	1552600
	case fim age _cons	-3.373379 3671497 .4166296 7.417072	1.800411 .222695 .2807522 3.483635	-1.87 -1.65 1.48 2.13	0.061 0.099 0.138 0.033	-6.902119 8036238 1336346 .5892721	.1553609 .0693244 .9668938 14.24487

Exponentiated values of the model coefficients and their 95% confidence limits

	1	RR	P>   z	[95% Conf.	Interval]
eq1	case	1.102353	0.591	0.772822	1.572394
	fim	1.008961	0.191	0.995561	1.022540
	age	1.012253	0.007	1.003338	1.021248
eq2	case	0.034274	0.061	0.001006	1.168079
	fim	0.692706	0.099	0.447704	1.071784
	age	1.516841	0.138	0.874910	2.629763

LnMM3\_lf sf36pcs\_impair\_24 case fim sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

Key	+
frequency   row percentage	
+	+

1	SF36 PCS	impairmant at	24 months	
Case	Not impai	İmpaired	Dead	Total
+			+	<del></del>

Control	Appendix 8   17   27.42	2_ICU_Predict_ 35 56.45	_Impairment 10   16.13	log_THESIS_TECH_INDE 62 100.00	(
Case	24 33.80	34 47.89	13   18.31	71 100.00	
Total	41   30.83	69 51.88	23   17.29	133 100.00	

#### Log multinomial model

log likelihood = -<inf>
log likelihood = -920.00372 (could not be evaluated) initial: feasible: rescale:  $log\ likelihood = -149.89074$ log likelihood = -140.01063 log likelihood = -140.01063 log likelihood = -125.59206 rescale eq: Iteration 0: Iteration 1:  $log\ likelihood = -120.41468$ Iteration 2: log likelihood = -119.66091 log likelihood = -119.65427 log likelihood = -119.65426 Iteration 3: Iteration 4: Iteration 5:

Log likelihood = -119.65426

Number of obs 133 Wald chi2(3) 3.39 Prob > chi2 0.3353

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case fim sex_recode _cons	0839797 .0032985 .2189043 -1.09037	.1945423 .0059699 .1698121 .7308391	-0.43 0.55 1.29 -1.49	0.666 0.581 0.197 0.136	4652757 0084022 1139213 -2.522788	.2973162 .0149992 .5517299 .3420483
eq2 case fim sex_recode _cons	-1.690899 0573482 .9036903 4.760438	.7016596 .0145654 .5159859 1.60622	-2.41 -3.94 1.75 2.96	0.016 0.000 0.080 0.003	-3.066126 0858958 1076235 1.612305	3156714 0288005 1.915004 7.908571

### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	. Interval]
eq1 case fim sex_recode	0.919450 1.003304 1.244712	0.666 0.581 0.197	0.627962 0.991633 0.892328	1.346241 1.015112 1.736254
eq2 case fim sex_recode	0.184354 0.944265 2.468697	0.016 0.000 0.080	0.046601 0.917690 0.897966	0.729299 0.971610 6.786967

- \*LnMM3\_lf sf36pcs\_impair\_24 case fim age sex\_recode \*\*NOTE: model won't converge with both age and sex as covariates
- bysort case: tab sf36pcs\_impair\_24 sex, summ(fim)

-> case = Control

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX

SF36 PCS impairmant at 24 months	SE F	X	Total
Not impai	124.5	124	124.11765
	1.9148542	3.0276504	2.7586762
	4	13	17
Impaired	122	113.94118	118.08571
	4.087283	14.964419	11.420754
	18	17	35
Dead	92.6	109	100.8
	37.944697	18.881208	29.547702
	5	5	10
Total	116.92593	116.97143	116.95161
	19.321025	13.541843	16.165565
	27	35	62

\_\_\_\_\_\_

-> case = Case

Means, Standard Deviations and Frequencies of FIM

SF36 PCS impairmant at 24 months	 	X M	Total
Not impai	113.5	108.35714	110.5
	11.530154	21.058918	17.589523
	10	14	24
Impaired	107	113.41176	110.20588
	13.638182	12.334194	13.211059
	17	17	34
Dead	92	97.75	95.538462
	31.168895	27.814436	27.992902
	5	8	13
Total	106.6875 17.600289 32	108.38462 19.834334 39	107.61972 18.747469

```
. ** 2. mmse: 1 month **
```

LnMM3\_lf sf36pcs\_impair\_24 mmse

#### Log multinomial model

```
initial: log likelihood = -<inf> (could not be evaluated)
feasible: log likelihood = -720.00327
rescale: log likelihood = -120.63577
rescale eq: log likelihood = -103.95751
Iteration 0: log likelihood = -103.95751
Iteration 1: log likelihood = -102.95547
Iteration 2: log likelihood = -102.62349
Iteration 3: log likelihood = -102.6173
Iteration 4: log likelihood = -102.61729
```

Number of obs = 108

Wald chi2(1)

0.30

Log likelihood = -102.61729

Prob > chi2

0.5849

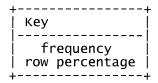
		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	mmse	0100103	.0183234	-0.55	0.585	0459236	.025903
	_cons	3230509	.5157314	-0.63	0.531	-1.333866	.6877641
eq2	mmse	.0108837	.0682107	0.16	0.873	1228068	.1445742
	_cons	-2.425198	1.954907	-1.24	0.215	-6.256744	1.406349

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	mmse	0.990040	0.585	0.955115	1.026241
eq2	mmse	1.010943	0.873	0.884435	1.155547

LnMM3\_lf sf36pcs\_impair\_24 case mmse

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 PCS im   Not impai	npairmant at Impaired	24 months Dead	Total
Control	17	35	10	62
	27.42	56.45	16.13	100.00
Case	24	34	13	71
	33.80	47.89	18.31	100.00
Total	41	69	23	133
	30.83	51.88	17.29	100.00

Log multinomial model

initial: (could not be evaluated)

log likelihood = -<inf>
log likelihood = -720.00327 feasible:

 $log\ likelihood = -120.63577$ rescale:  $\log likelihood = -103.95751$ rescale eq: Iteration 0:

log likelihood = -103.95751 log likelihood = -102.93273 log likelihood = -102.45347 log likelihood = -102.44818 Iteration 1:
Iteration 2:

Iteration 3: Iteration 4:  $log\ likelihood = -102.44818$ 

Number of obs Wald chi2(2) 108 0.50 Log likelihood = -102.44818Prob > chi2 0.7805

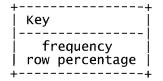
	Ар	<pre>ppendix 8 2_ICU_Predict_Impairment 1</pre>		log_THESIS_TECH_INDEX			
		Coef.	Std. Err.	Z	P>   Z	[95% Conf.	Interval]
eq1	·						
•	case	0818792	.1837471	-0.45	0.656	4420169	.2782586
	mmse	0125463	.0191214	-0.66	0.512	0500237	.024931
	_cons	2067831	.5747139	-0.36	0.719	-1.333202	.9196354
eq2	1						
	case	.2838521	. 5485498	0.52	0.605	7912857	1.35899
	mmse	.0192997	.0700899	0.28	0.783	1180741	.1566734
	_cons	-2.829557	2.106992	-1.34	0.179	-6.959185	1.300072

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	. Interval]
eq1	case	0.921383	0.656	0.642739	1.320828
	mmse	0.987532	0.512	0.951207	1.025244
eq2	case	1.328236	0.605	0.453262	3.892260
	mmse	1.019487	0.783	0.888630	1.169614

LnMM3\_lf sf36pcs\_impair\_24 case mmse age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 PCS ir   Not impai	npairmant at Impaired	24 months Dead	Total
Control	17	35	10	62
	27.42	56.45	16.13	100.00
Case	24	34	13	71
	33.80	47.89	18.31	100.00
Total	41	69	23	133
	30.83	51.88	17.29	100.00

Log multinomial model

```
initial:
                                                     (could not be evaluated)
                  log likelihood =
                                           -<inf>
                  log likelihood = -720.00327
feasible:
rescale:
                  \log likelihood = -120.63577
                  \log likelihood = -103.95751
rescale eq:
                      likelihood = -103.95751
                  log
Iteration 0:
Iteration 1:
                  \log 1 ikelihood = -93.784622
                  log likelihood = -89.648381
Iteration 2:
Iteration 3:
                  \log likelihood = -87.330632
                 log likelihood = -87.22856
log likelihood = -87.227652
log likelihood = -87.227651
Iteration 4:
Iteration 5:
Iteration 6:
```

Number of obs = 108 Wald chi2(4) = 13.66 Prob > chi2 = 0.0085

Log likelihood = -87.227651

					_	
	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 case mmse age sex_recode _cons	3283209	.1969021	-1.67	0.095	7142419	.0576001
	0327422	.0203858	-1.61	0.108	0726977	.0072133
	.0182341	.0052594	3.47	0.001	.0079259	.0285423
	.3915378	.1882104	2.08	0.037	.0226522	.7604233
	8469782	.6290895	-1.35	0.178	-2.079971	.3860145
eq2 case mmse age sex_recode _cons	.3607191	.5718798	0.63	0.528	7601448	1.481583
	.008168	.0787732	0.10	0.917	1462245	.1625606
	.0250334	.0154557	1.62	0.105	0052592	.0553259
	2870879	.556674	-0.52	0.606	-1.378149	.8039731
	-4.080273	2.398762	-1.70	0.089	-8.78176	.6212128

### Exponentiated values of the model coefficients and their 95% confidence limits

   RR	P>   z	[95% Conf.	Interval]
0 720122	0.005	0.480563	1 050201
			1.059291 1.007239
,		•	1.028953
1.479254	0.037	1.022911	2.139182
1.434360	0.528	0.467599	4.399905
1.008201	0.917	0.863964	1.176520
1.025349		0.994755	1.056885
0.750446	0.606	0.252045	2.234401
	0.720132 0.967788 1.018401 1.479254 1.434360 1.008201	0.720132       0.095         0.967788       0.108         1.018401       0.001         1.479254       0.037             1.434360       0.528         1.008201       0.917         1.025349       0.105	0.720132       0.095       0.489563         0.967788       0.108       0.929882         1.018401       0.001       1.007957         1.479254       0.037       1.022911         1.434360       0.528       0.467599         1.008201       0.917       0.863964         1.025349       0.105       0.994755

```
. ** 3. CIQ Total: 1 month **
```

### Log multinomial model

initial: feasible:	<pre>log likelihood = -<inf> log likelihood = -920.00372</inf></pre>	(could not be evaluated)
rescale:	$\log likelihood = -149.89074$	
rescale eq:	log likelihood = -140.01063	
Iteration 0:	$log\ likelihood = -140.01063$	
Iteration 1:	log likelihood = -128.98067	
Iteration 2:	$log\ likelihood = -127.55894$	
Iteration 3:	$log\ likelihood = -127.49722$	
Iteration 4:	$\log \text{ likelihood} = -127.49619$	
Iteration 5:	$\log \text{ likelihood} = -127.49619$	
		Number of obs =
		Wald chi2(1) =
Log likelihood	= -127.49619	Prob > chi2 =

Log likelihood = -127.49619					> chi2 =	0.8200
	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 ciq_total _cons	.0024668 6812557	.010838 .1400054	0.23 -4.87	0.820 0.000	0187753 9556612	.0237089
eq2   ciq_total	0973331	.0306283 Pa	-3.18 ge 106	0.001	1573635	0373026

<sup>.</sup> LnMM3\_lf sf36pcs\_impair\_24 ciq\_total

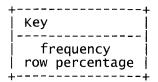
Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX \_cons | -1.001416 .2266504 -4.42 0.000 -1.445642 -.5571893

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1 ciq_total	1.002470	0.820	0.981400	1.023992
eq2 ciq_total	0.907254	0.001	0.854393	0.963385

. LnMM3\_lf sf36pcs\_impair\_24 case ciq\_total

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 PCS in   Not impai	mpairmant at Impaired	24 months Dead	Total
Control	17	35	10	62
	27.42	56.45	16.13	100.00
Case	24	34	13	71
	33.80	47.89	18.31	100.00
Total	41	69	23	133
	30.83	51.88	17.29	100.00

Log multinomial model

log likelihood = (could not be evaluated) initial: -<inf> log likelihood = -920.00372 log likelihood = -149.89074 log likelihood = -140.01063 feasible: rescale: rescale eq:  $\log likelihood = -140.01063$ Iteration 0:  $\log likelihood = -126.77097$ Iteration 1: log likelihood = -126.07365 log likelihood = -124.53106 log likelihood = -124.34063 Iteration 2: Iteration 3: Iteration 4: Iteration 5:  $\log likelihood = -124.33354$ log likelihood = -124.33352
log likelihood = -124.33352 Iteration 6: Iteration 7:

Log likelihood = -124.33352

Number of obs = 133 Wald chi2(2) = 1.02 Prob > chi2 = 0.6009

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 case ciq_total _cons	1801476 0025202 5382166	.1833321 .0125232 .1983672	-0.98 -0.20 -2.71	0.326 0.841 0.007	5394719 0270652 9270092	.1791767 .0220248 149424
eq2 case	7275359	. 43344 Pa	-1.68 ge 107	0.093	-1.577063	.1219909

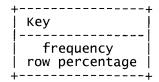
Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX  $-.144750\overline{4}$ -3.23 -0.54 0.001 -.232548 .0447955 -.0569527 ciq\_total \_cons -.2536637 .4675263 0.587 -1.169998.662671

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P> z	[95% Conf.	. Interval]
eq1 case ciq_total	0.835147 0.997483	0.326 0.841	0.583056 0.973298	1.196232 1.022269
eq2 case ciq_total	0.483098 0.865238	0.093 0.001	0.206581 0.792512	1.129744 0.944639

LnMM3\_lf sf36pcs\_impair\_24 case ciq\_total sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 PCS in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	17	35	10	62
	27.42	56.45	16.13	100.00
Case	24	34	13	71
	33.80	47.89	18.31	100.00
Total	41	69	23	133
	30.83	51.88	17.29	100.00

Log multinomial model

(could not be evaluated) initial: log likelihood = -<inf> likelihood = -920.00372log feasible:  $log\ likelihood = -149.89074$ rescale:

 $\log likelihood = -140.01063$ rescale eq: log likelihood = -140.01063 log likelihood = -125.74285 Iteration 0: Iteration 1: Iteration  $\overline{2}$ : log likelihood = -123.30443Iteration 3: log likelihood = -122.80448log likelihood = -122.78911 log likelihood = -122.78909 log likelihood = -122.78909 Iteration 4: Iteration 5:

Iteration 6:

Number of obs 133 3.53 wald chi2(3)  $Log\ likelihood = -122.78909$ Prob > chi2 0.3163

	Coef.	Std. Err.	z	P> z	[95% Conf.	[Interval]
eq1 case ciq_total sex_recode _cons	1591472 .0006105 .254984 7019576	.1707483 .0125747 .1660238 .2228353	-0.93 0.05 1.54 -3.15	0.351 0.961 0.125 0.002	4938077 0240354 0704167 -1.138707	.1755133 .0252565 .5803847 2652085

Page 108

<del>-</del>						
eq2						
case	6217611	.4292705	-1.45	0.148	-1.463116	.2195937
ciq_total	1471944	.0448489	-3.28	0.001	2350967	0592922
sex_recode	0337122	.3630795	-0.09	0.926	745335	.6779106
_cons	2785411	. 4864639	-0.57	0.567	-1.231993	.6749106
•						

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf	. Interval]
eq1 case ciq_total sex_recode	0.852871 1.000611 1.290441	0.351 0.961 0.125	0.610298 0.976251 0.932005	1.191858 1.025578 1.786726
eq2 case ciq_total sex_recode	0.536998 0.863126 0.966850	0.148 0.001 0.926	0.231514 0.790494 0.474575	1.245571 0.942431 1.969758

```
. *LnMM3_lf sf36pcs_impair_24 case ciq_total age
. **NOTE: model won't converge with both age and sex as covariates
```

\*\* 1. FIM: 1 month \*\*

LnMM3\_lf sf36mcs\_impair\_24 fim

### Log multinomial model

initial:	<pre>log likelihood = -<inf></inf></pre>	
feasible:	$log\ likelihood = -520.00736$	
rescale:	$\log likelihood = -133.93049$	
rescale eq:	$\log likelihood = -130.99376$	
Iteration 0:	$log\ likelihood = -130.99376$	
Iteration 1:	log likelihood = -119.85718	
Iteration 2:	log likelihood = -117.06463	
Iteration 3:	log likelihood = -116.25206	
Iteration 4:	log likelihood = -116.01364	
Iteration 5:	$\log likelihood = -116.00491$	
Iteration 6:	$log\ likelihood = -116.00491$	

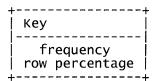
	Number of obs	=	133
	Wald chi2(1)	=	0.21
Log likelihood = -116.00491	Prob > chi2	=	0.6488

	 	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1	fim _cons	.0046707 -2.049143	.0102571 1.176623	0.46 -1.74	0.649 0.082	0154327 -4.355281	.0247742
eq2	fim   _cons	0334033 1.771952	.0062246 .5509365	-5.37 3.22	0.000 0.001	0456032 .6921368	0212033 2.851768

		RR	P>   z	[95% Conf.	Interval]
eq1	fim	1.004682	0.649	0.984686	1.025084
eq2	fim	0.967148	0.000	0.955421	0.979020

### . LnMM3\_lf sf36mcs\_impair\_24 case fim

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 MCS in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	36	16	10	62
	58.06	25.81	16.13	100.00
Case	45	13	13	71
	63.38	18.31	18.31	100.00
Total	81	29	23	133
	60.90	21.80	17.29	100.00

### Log multinomial model

(could not be evaluated) initial: log likelihood = -<inf> log likelihood = -520.00736feasible:  $log\ likelihood = -133.93049$ rescale: log likelihood = -130.99376 log likelihood = -130.99376 rescale eq: Iteration 0: Iteration 1:  $log\ likelihood = -117.61384$  $\log likelihood = -114.62617$ Iteration 2:  $log\ likelihood = -113.12857$ Iteration 3: log likelihood = -112.8873 log likelihood = -112.87535 log likelihood = -112.87531 log likelihood = -112.87531 Iteration 4: Iteration 5: Iteration 6: Iteration 7:

Number of obs = 133 Wald chi2(2) = 1.08 Log likelihood = -112.87531 Prob > chi2 = 0.5817

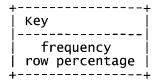
		Coef.	Std. Err.	Z	P> z	[95% Conf	. Interval]
eq1	case	3593452	.3887774	-0.92	0.355	-1.121335	.4026445
	fim	000915	.0114518	-0.08	0.936	0233602	.0215301
	_cons	-1.243562	1.405079	-0.89	0.376	-3.997466	1.510342
eq2	case	-1.099805	.5386602	-2.04	0.041	-2.15556	0440504
	fim	0459359	.0097555	-4.71	0.000	0650563	0268155
	_cons	3.68151	1.169547	3.15	0.002	1.389239	5.973781

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX

		RR	P>   z	[95% Conf.	Interval]
eq1	case	0.698133	0.355	0.325845	1.495775
	fim	0.999085	0.936	0.976911	1.021764
eq2	case	0.332936	0.041	0.115838	0.956906
	fim	0.955103	0.000	0.937015	0.973541

. LnMM3\_lf sf36mcs\_impair\_24 case fim age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 MCS in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	36	16	10	62
	58.06	25.81	16.13	100.00
Case	45	13	13	71
	63.38	18.31	18.31	100.00
Total	81	29	23	133
	60.90	21.80	17.29	100.00

### Log multinomial model

(could not be evaluated) initial: log likelihood = -<inf> log likelihood = -520.00736feasible: rescale:  $log\ likelihood = -133.93049$ log likelihood = -130.99376 log likelihood = -130.99376 log likelihood = -116.47878 log likelihood = -109.58245 rescale eq: Iteration 0: Iteration 1: Iteration 2:  $\log likelihood = -105.61743$ Iteration 3: log likelihood = -103.72586 log likelihood = -103.62549 log likelihood = -103.62529 log likelihood = -103.62529 Iteration 4: Iteration 5: Iteration 6: Iteration 7:

Log likelihood = -103.62529

Number of obs = 133 Wald chi2(4) = 3.74 Prob > chi2 = 0.4424

	Coef.	Std. Err.	Z	P>   z	[95% Conf	. Interval]
eq1 case fim age sex_recode   _cons	399523 .0005516 .0068078 .460787 -2.04458	.3866327 .0144811 .0105387 .337685 2.008336	-1.03 0.04 0.65 1.36 -1.02	0.301 0.970 0.518 0.172 0.309	-1.157309 0278308 0138477 2010635 -5.980846	.3582631 .028934 .0274634 1.122637 1.891686
eq2   case	-1.105548	.5612364 Pa	-1.97 ge 111	0.049	-2.205551	0055451

Ар	pendix 8 2_IC	:U_Predict_I	mpairment	log_THE	SIS_TECH_INDEX	
fimˈl					1200809	042643
age	.0439446	.0156132	2.81	0.005	.0133433	.0745459
sex_recode	.9122636	.5037978	1.81	0.070	0751619	1.899689
_cons	3.931922	1.827511	2.15	0.031	. 3500654	7.513778

## Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1 case fim age sex_recode	0.670640 1.000552 1.006831 1.585321	0.301 0.970 0.518 0.172	0.314331 0.972553 0.986248 0.817861	1.430842 1.029357 1.027844 3.072948
eq2 case fim age sex_recode	0.331029 0.921860 1.044924 2.489952	0.049 0.000 0.005 0.070	0.110190 0.886849 1.013433 0.927593	0.994470 0.958253 1.077395 6.683817

- . \*\* 2. mmse: 1 month \*\*
- LnMM3\_lf sf36mcs\_impair\_24 mmse

### Log multinomial model

initial:	<pre>log likelihood = -<inf></inf></pre>	(could not be evaluated)
feasible:	$log\ likelihood = -390.00627$	
rescale:	$log\ likelihood = -107.46857$	
rescale eq:	log likelihood = -96.726168	
Iteration 0:	$\log likelihood = -96.726168$	
Iteration 1:	log likelihood = -95.289368	
Iteration 2:	$log\ likelihood = -95.158701$	
Iteration 3:	$log\ likelihood = -95.158145$	
Iteration 4:	log likelihood = -95.158145	

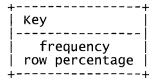
	Number of obs	=	TO
	Wald chi2(1)	=	0.43
Log likelihood = -95.158145	Prob > chi2	=	0.5240

		Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1	mmse	.0359199	.0563664	0.64	0.524	0745562	. 146396
	_cons	-2.4468	1.631016	-1.50	0.134	-5.643533	. 749933
eq2	mmse	.0108133	.0686566	0.16	0.875	1237512	.1453778
	_cons	-2.42321	1.967412	-1.23	0.218	-6.279266	1.432845

		RR	P>   z	[95% Conf.	Interval]
eq1	mmse	1.036573	0.524	0.928155	1.157655
eq2	mmse	1.010872	0.875	0.883600	1.156476

### . LnMM3\_lf sf36mcs\_impair\_24 case mmse

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



_	SF36 MCS in	npairmant at		
Case	Not impai 	Impaired	Dead	Total
Control	36	16	10	62
	58.06	25.81	16.13	100.00
Case	45	13	13	71
	63.38	18.31	18.31	100.00
Total	81	29	23	133
	60.90	21.80	17.29	100.00

### Log multinomial model

initial: | log likelihood = -<inf> (could not be evaluated)

feasible: log likelihood = -390.00627 rescale: log likelihood = -107.46857 rescale eq: log likelihood = -96.726168 Iteration 0: log likelihood = -96.726168 Iteration 1: log likelihood = -95.105029 Iteration 2: log likelihood = -94.932297 Iteration 3: log likelihood = -94.931978 Iteration 4: log likelihood = -94.931978

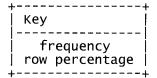
Number of obs = 108 Wald chi2(2) = 0.74 Log likelihood = -94.931978 Prob > chi2 = 0.6895

		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	case	1904152	.3448664	-0.55	0.581	8663409	.4855104
	mmse	.0312494	.0553753	0.56	0.573	0772842	.1397831
	_cons	-2.213191	1.63814	-1.35	0.177	-5.423886	.9975037
eq2	case	.2633349	.5411379	0.49	0.627	7972759	1.323946
	mmse	.015519	.0714788	0.22	0.828	1245768	.1556149
	_cons	-2.710644	2.119057	-1.28	0.201	-6.863919	1.442632

		RR	P>   z	[95% Conf.	Interval]
eq1	case mmse	0.826616 1.031743	0.581 0.573	0.420487 0.925627	1.625004 1.150024
eq2	case	1.301262 1.015640	0.627 0.828	0.450555 0.882870	3.758221 1.168376

. LnMM3\_lf sf36mcs\_impair\_24 case mmse age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)



Case	SF36 MCS ir   Not impai	npairmant at Impaired	24 months Dead	Total
Control	36	16	10	62
	58.06	25.81	16.13	100.00
Case	45	13	13	71
	63.38	18.31	18.31	100.00
Total	81	29	23	133
	60.90	21.80	17.29	100.00

### Log multinomial model

initial: log likelihood = (could not be evaluated) -<inf>  $log\ likelihood = -390.00627$ feasible:  $\log likelihood = -107.46857$ rescale: log likelihood = -96.726168 log likelihood = -96.726168 rescale eq: Iteration 0:  $log\ likelihood = -94.903101$ Iteration 1: Iteration 2: log likelihood = -90.614388 $\log likelihood = -90.166361$ Iteration 3: log likelihood = -90.147035 log likelihood = -90.146968 Iteration 4: Iteration 5: Iteration 6: log likelihood = -90.146968

Log likelihood = -90.146968

Number of obs = 108 Wald chi2(4) = 3.91 Prob > chi2 = 0.4183

	Coef.	Std. Err.	z	P>   z	[95% Conf.	Interval]
eq1 case mmse age sex_recode	3096479 .0311641 .0129415 .4423206	.341126 .0531155 .0111483 .3380315	-0.91 0.59 1.16 1.31	0.364 0.557 0.246 0.191	9782426 0729405 0089087 220209	.3589468 .1352686 .0347917 1.10485
_cons	-3.164769 +	1.742371 	-1.82 	0.069 	-6.579752 	.2502145
eq2 case   mmse   age   sex_recode   _cons	.1382746 .0251221 .0398669 1741637 -5.45477	.5219344 .0656512 .0207404 .535657 2.498669	0.26 0.38 1.92 -0.33 -2.18	0.791 0.702 0.055 0.745 0.029	8846981 1035519 0007836 -1.224032 -10.35207	1.161247 .1537961 .0805175 .8757048 5574682

		RR	P>   z	[95% Conf.	Interval]
eq1	case	0.733705	0.364	0.375971	1.431821

Ар	pendix 8 2_ICU_Pre	edict_Impairment	log_THES	SIS_TECH_INDEX	
mmse	1.031655	•	0.557	0.929656	1.144844
age	1.013026		0.246	0.991131	1.035404
sex_recode	1.556315		0.191	0.802351	3.018772
eq2			<del></del> .		
case	1.148291		0.791	0.412839	3.193914
mmse	1.025440		0.702	0.901629	1.166253
age	1.040672		0.055	0.999217	1.083848
sex_recode	0.840159		0.745	0.294042	2.400567

. \*\* 3. CIQ Total: 1 month \*\*

LnMM3\_lf sf36mcs\_impair\_24 ciq\_total

Log multinomial model

```
log likelihood =
initial:
                        likelihood = -<inf>
likelihood = -520.00736
                                                         (could not be evaluated)
feasible:
                   log
                   log likelihood = -133.93049
rescale:
rescale eq:
                   log\ likelihood = -130.99376
                   \log likelihood = -130.99376
Iteration 0:
                   log likelihood = -119.7715
log likelihood = -118.59598
log likelihood = -118.58421
Iteration 1:
Iteration 2:
Iteration 3:
                   log likelihood =
Iteration 4:
                                         -118.5842
```

Log likelihood = -118.5842

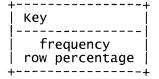
Number of obs = 133 Wald chi2(1) = 0.82 Prob > chi2 = 0.3653

	Coef.	Std. Err.	Z	P> z	[95% Conf.	. Interval]
eq1 ciq_total _cons	.0197923 -1.732352	.0218602 .2986182	0.91 -5.80	0.365 0.000	0230529 -2.317633	.0626374 -1.147071
eq2 ciq_total _cons	115942 8599764	.0370707 .2600674	-3.13 -3.31	0.002 0.001	1885992 -1.369699	0432848 3502537

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	. Interval]
eq1 ciq_total	1.019989	0.365	0.977211	1.064641
eq2 ciq_total	0.890527	0.002	0.828118	0.957639

LnMM3\_lf sf36mcs\_impair\_24 case ciq\_total



Case	Appendix 8 :	2_ICU_Predict <sub>-</sub> Impaired	_Impairment Dead	log_THESIS_T Total	ECH_INDEX
Control	36 58.06	16 25.81	10   16.13	62 100.00	
Case	45 63.38	13 18.31	13   18.31	71 100.00	
Total	81 60.90	29 21.80	23   17.29	133 100.00	

Log multinomial model

(could not be evaluated) initial: log likelihood = -<inf> feasible:  $\log 1$  ikelihood = -520.00736likelihood = -133.93049rescale: log  $log\ likelihood = -130.99376$ rescale eq: Iteration 0:  $log\ likelihood = -130.99376$ Iteration 1:  $\log likelihood = -117.16812$ log likelihood = -114.5278 log likelihood = -114.49853 log likelihood = -114.49847 Iteration 2: Iteration 3: Iteration 4: Iteration 5: log likelihood = -114.49847

Log likelihood = -114.49847

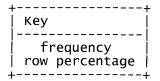
Number of obs = 133 Wald chi2(2) = 1.26 Prob > chi2 = 0.5329

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 case ciq_total _cons	2609955 .0110456 -1.511762	.386301 .0266179 .4441948	-0.68 0.41 -3.40	0.499 0.678 0.001	-1.018132 0411245 -2.382367	.4961405 .0632158 6411557
eq2 case ciq_total _cons	-1.396481 2180034 .6477719	.5178306 .0609379 .5988494	-2.70 -3.58 1.08	0.007 0.000 0.279	-2.41141 3374396 5259513	3815514 0985673 1.821495

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	. Interval]
eq1 case ciq_total	0.770284 1.011107	0.499 0.678	0.361269 0.959710	1.642370 1.065257
eq2 case ciq_total	0.247466 0.804123	0.007 0.000	0.089689 0.713595	0.682801 0.906135

LnMM3\_lf sf36mcs\_impair\_24 case ciq\_total age sex\_recode



Appendix 8	2_ICU_Predict_Impa	airment log_THESI	S_TECH_INDEX
	impairmant at 24 m		

Case		pairmant at a	24 months Dead	Total
Control	36	16	10	62
	58.06	25.81	16.13	100.00
Case	45	13	13	71
	63.38	18.31	18.31	100.00
Total	81	29	23	133
	60.90	21.80	17.29	100.00

### Log multinomial model

initial: log likelihood = -<inf> (could not be evaluated) feasible: log likelihood = -520.00736 rescale: log likelihood = -133.93049

rescale eq: log likelihood = -130.99376
Iteration 0: log likelihood = -130.99376
Iteration 1: log likelihood = -117.55318
Iteration 2: log likelihood = -110.7147
Iteration 3: log likelihood = -107.86724
Iteration 4: log likelihood = -107.63192
Iteration 5: log likelihood = -107.63165
Iteration 6: log likelihood = -107.63165

Number of obs = 133 Wald chi2(4) = 4.17 Log likelihood = -107.63165 Prob > chi2 = 0.3831

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode _cons	2138843	.3863667	-0.55	0.580	9711491	.5433804
	.0236834	.0295536	0.80	0.423	0342406	.0816075
	.0094059	.0107252	0.88	0.380	0116152	.0304269
	.4279147	.3273555	1.31	0.191	2136902	1.06952
	-2.470526	.9484511	-2.60	0.009	-4.329456	6115964
eq2 case ciq_total age sex_recode _cons	-1.825444	.6658069	-2.74	0.006	-3.130401	5204864
	2872646	.0882022	-3.26	0.001	4601378	1143914
	.0386471	.0142774	2.71	0.007	.0106639	.0666303
	1628985	.3202168	-0.51	0.611	7905119	.464715
	-1.195945	1.231512	-0.97	0.331	-3.609664	1.217773

	RR	P> z	[95% Conf.	. Interval]
eq1 case ciq_total age sex_recode	0.807442 1.023966 1.009450 1.534055	0.580 0.423 0.380 0.191	0.378648 0.966339 0.988452 0.807599	1.721818 1.085030 1.030894 2.913980
eq2 case ciq_total age sex_recode	0.161146 0.750313 1.039404 0.849677	0.006 0.001 0.007 0.611	0.043700 0.631197 1.010721 0.453613	0.594231 0.891909 1.068900 1.591561
	<u> </u>			

```
Appendix 8 2_ICU_Predict_Impairment log_THESIS_TECH_INDEX
   * Social: Impairment at 24 months *
   ** 1. FIM: 1 month **
   LnMM3_lf social_impair_24 fim
Log multinomial model
                 log likelihood =
                                                 (could not be evaluated)
initial:
                                        -<inf>
                log likelihood = -300.00944
log likelihood = -93.650323
log likelihood = -93.650323
feasible:
rescale:
rescale eq:
Iteration 0:
                 log likelihood = -93.650323
                 \log 1 = -79.811095
Iteration 1:
                log likelihood = -76.993689
log likelihood = -75.860061
log likelihood = -75.249271
Iteration 2:
Iteration 3:
Iteration 4:
Iteration 5:
                 log likelihood = -75.11387
                 \log likelihood = -75.105789
Iteration 6:
Iteration 7:
                 log
                     likelihood = -75.105757
                 log likelihood = -75.105757
Iteration 8:
                                                       Number of obs
                                                                                   134
                                                                                  5.88
                                                       Wald chi2(1)
Log likelihood = -75.105757
                                                       Prob > chi2
                                                                                0.0154
                                           z P>|z| [95% Conf. Interval]
                    Coef. Std. Err.
             eq1
                                            -2.42
          fim I
                  -.0355627
                               .0146715
                                                     0.015
                                                               -.0643183
                                                                            -.0068071
                  .7728943
                               1.416849
                                            0.55
                                                     0.585
                                                               -2.004079
                                                                             3.549868
        _cons |
eq2
                                                     0.000
          fim
                                            -4.88
                                                               -.0449124
                                                                            -.0191715
                   -.032042
                               .0065667
                   1.621519
                                                                 .447139
                                                                             2.795898
                               .5991843
                                             2.71
                                                     0.007
        _cons
Exponentiated values of the model coefficients and their 95% confidence limits
                                                     P> | z |
                                                                [95% Conf. Interval]
                      RR
eq1
          fim
                  0.965062
                                                     0.015
                                                                0.937706
                                                                             0.993216
eq2
          fim
                  0.968466
                                                     0.000
                                                                0.956081
                                                                             0.981011
   LnMM3_lf social_impair_24 case fim
Cross-tabulation of the outcome (columns) with the first-named covariate (rows)
 Key
    frequency
 row percentage |
               Social impairmant at 24 months
      Case | Not impai
                          Impaired
                                            Dead |
                                                        Total
   Control
                      53
                                   0
                                              10
                                                           63
```

0.00

15.87 Page 118 100.00

84.13

Case	51 71.83	7 9.86	13   18.31	71 100.00
Total	104 77.61	7 5.22	23   17.16	134 100.00

### Log multinomial model

```
log likelihood = -<inf>
log likelihood = -300.00944
                                                              (could not be evaluated)
initial:
feasible:
rescale:
                     \log 1 ikelihood = -93.650323
                     log likelihood = -93.650323
rescale eq:
                     log likelihood = -93.650323
log likelihood = -79.122
log likelihood = -78.528128
Iteration 0:
Iteration 1:
Iteration 2:
                                                              (not concave)
Iteration 3:
                     log likelihood = -74.336264
                     \log likelihood = -72.34244
Iteration 4:
                     log likelihood = -71.653612
log likelihood = -71.536576
Iteration 5:
Iteration 6:
                     log likelihood = -71.507348
Iteration 7:
Iteration 8:
                     log likelihood =
                                               -71.5013
                     log likelihood = -71.499762
log likelihood = -71.499467
log likelihood = -71.499415
log likelihood = -71.49941
Iteration 9:
Iteration 10:
Iteration 11:
Iteration 12:
```

Log likelihood = -71.49941

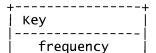
Number of obs = 134 Wald chi2(2) = 2.38 Prob > chi2 = 0.3039

		Coef.	Std. Err.	Z	P> z	[95% Conf.	. Interval]
eq1	case	15.31614	1005.553	0.02	0.988	-1955.531	1986.164
	fim	0229076	.0148424	-1.54	0.123	0519982	.006183
	_cons	-15.31032	1005.554	-0.02	0.988	-1986.16	1955.54
eq2	case	4685537	.3766247	-1.24	0.213	-1.206725	.2696172
	fim	0366005	.0076015	-4.81	0.000	0514991	0217018
	_cons	2.356568	.8250593	2.86	0.004	.7394813	3.973654

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	case fim	4.48e+06 0.977353	0.988 0.123	0.000000 0.949331	1.006202
eq2	case fim	0.625907 0.964061	0.213 0.000	0.299176 0.949805	1.309463 0.978532

. LnMM3\_lf social\_impair\_24 case fim age sex\_recode



 $\label{local_predict_impairment_log_THESIS_TECH_INDEX} Appendix 8 2_ICU_Predict_Impairment log\_THESIS\_TECH\_INDEX | row percentage |$ 

Case	Social imp   Not impai	oairmant at Impaired	24 months Dead	Total
Control	53 84.13	0.00	10 15.87	63 100.00
Case	51	7	13	71
	71.83	9.86	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

### Log multinomial model

```
-<inf>
                                                         (could not be evaluated)
initial:
                   log likelihood =
                   log likelihood = -300.00944
feasible:
                   log likelihood = -93.650323
log likelihood = -93.650323
rescale:
rescale eq:
                   log\ likelihood = -93.650323
Iteration 0:
Iteration 1:
                   log likelihood = -77.362994
                   log likelihood = -66.86504
log likelihood = -62.633359
log likelihood = -62.103949
Iteration 2:
Iteration 3:
Iteration 4:
Iteration 5:
                   \log likelihood = -61.968642
                   log\ likelihood = -61.940024
Iteration 6:
Iteration 7:
                   \log likelihood = -61.933532
                   log likelihood = -61.932447
log likelihood = -61.93219
Iteration 8:
Iteration 9:
Iteration 10:
                   log likelihood = -61.932132
                   log likelihood = -61.932119
log likelihood = -61.932117
Iteration 11:
Iteration 12:
```

Log likelihood = -61.932117

Number of obs	=	134
Wald chi2(4)	=	3.08
Prob > chi2	=	0.5438

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case fim age sex_recode _cons	16.54466 0317813 .0106069 1629925 -16.2315	1935.288 .0190425 .0249425 .7191015 1935.289	0.01 -1.67 0.43 -0.23 -0.01	0.993 0.095 0.671 0.821 0.993	-3776.55 0691039 0382795 -1.572406 -3809.328	3809.639 .0055413 .0594932 1.246421 3776.865
eq2 case fim age sex_recode _cons	7674332 0655782 .0528517 .4336202 1.753401	.4256005 .0139787 .0146479 .3481622 1.53538	-1.80 -4.69 3.61 1.25 1.14	0.071 0.000 0.000 0.213 0.253	-1.601595 092976 .0241424 2487652 -1.255888	.0667283 0381804 .081561 1.116006 4.762691

	RR	P> z	[95% Conf.	Interval]
eq1				
case	1.53e+07	0.993	0.000000	
fim	0.968718	0.095	0.933230	1.005557
age	1.010663	0.671	0.962444	1.061299
sex_recode	0.849598	0.821	0.207545	3.477872

eq2				<del>-</del>
. case	0.464203	0.071	0.201575	1.069005
fim	0.936526	0.000	0.911215	0.962539
age	1.054273	0.000	1.024436	1.084979
sex_recode	1.542833	0.213	0.779763	3.052636

- . \*\* 2. MMSE: 1 month \*\*
- . LnMM3\_lf social\_impair\_24 mmse

### Log multinomial model

initial: feasible: rescale: rescale eq: Iteration 0: Iteration 2: Iteration 3: Iteration 4:	log likelihood = -190.0081 log likelihood = -63.63970 log likelihood = -63.63970 log likelihood = -63.63970 log likelihood = -62.07757 log likelihood = -61.90602 log likelihood = -61.90338 log likelihood = -61.90338	13 13 13 16 15 12 12
Iteration 4: Iteration 5:	log likelihood = -61.90338	

Log likelihood = -61.903385

Number of obs = 109 Wald chi2(1) = 1.11 Prob > chi2 = 0.2927

		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	mmse _cons	062878 -1.165992	.0597617 1.623995	-1.05 -0.72	0.293 0.473	1800089 -4.348964	.0542528 2.01698
eq2	mmse _cons	.01131	.0739044 2.115122	0.15 -1.16	0.878 0.247	13354 -6.592137	.15616 1.69899

### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P> z	[95% Conf.	Interval]
eq1	mmse	0.939058	0.293	0.835263	1.055751
eq2	mmse	1.011374	0.878	0.874992	1.169013

. LnMM3\_lf social\_impair\_24 case mmse

+	Key	-
	frequency   row percentage	
+	+	

I	Social im	pairmant at	24 months	
Case	Not impai	Impaired	Dead	Total
+			<del></del>	+

Control	Appendix 8   53   84.13	2_ICU_Predict 0 0.00	_Impairment 10   15.87	log_THESIS_TECH_INDEX 63 100.00	
Case	51 71.83	7 9.86	13   18.31	71 100.00	
Total	104	7 5.22	23   17.16	134 100.00	

Log multinomial model

```
log likelihood = -<inf>
log likelihood = -190.00817
                                                              (could not be evaluated)
initial:
feasible:
rescale:
                     log\ likelihood = -63.639703
                     \log likelihood = -63.639703
rescale eq:
                     log likelihood = -63.639703
log likelihood = -59.922734
Iteration 0:
Iteration 1:
Iteration 2:
                     log likelihood = -58.33404
                     \log likelihood = -58.061062
Iteration 3:
                     log likelihood = -57.986962
log likelihood = -57.971174
log likelihood = -57.967489
log likelihood = -57.966693
Iteration 4:
Iteration 5:
Iteration 6:
Iteration 7:
                     log likelihood = -57.96658
Iteration 8:
                     log likelihood = -57.966566
log likelihood = -57.966563
Iteration 9:
Iteration 10:
```

Log likelihood = -57.966563

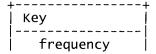
Number of obs = 109 Wald chi2(2) = 0.96 Prob > chi2 = 0.6174

		Coef.	Std. Err.	Z	P>   Z	[95% Conf.	Interval]
eq1	case	15.82221	1251.969	0.01	0.990	-2437.992	2469.636
	mmse	065886	.0670969	-0.98	0.326	1973936	.0656216
	_cons	-16.32101	1251.97	-0.01	0.990	-2470.137	2437.495
eq2	case	.2780767	.5391572	0.52	0.606	7786521	1.334805
	mmse	.015908	.0786893	0.20	0.840	1383202	.1701362
	_cons	-2.739019	2.307422	-1.19	0.235	-7.261483	1.783444

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P> z	[95% Conf.	Interval]
eq1	case	7.44e+06 0.936238	0.990 0.326	0.000000 0.820868	1.067823
eq2	case mmse	1.320587 1.016035	0.606 0.840	0.459024 0.870820	3.799257 1.185466

LnMM3\_lf social\_impair\_24 case mmse age sex\_recode



# Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX | row percentage |

Case	Social imp   Not impai	oairmant at Impaired	24 months Dead	Total
Control	53 84.13	0.00	10 15.87	63 100.00
Case	51	7	13	71
	71.83	9.86	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

### Log multinomial model

```
log likelihood = -<inf>
log likelihood = -190.00817
log likelihood = -63.639703
log likelihood = -63.639703
log likelihood = -63.639703
initial:
                                                                                     (could not be evaluated)
feasible:
rescale:
rescale eq:
                             log likelihood = -63.639703
log likelihood = -61.87336
log likelihood = -55.973698
log likelihood = -55.107447
Iteration 0:
Iteration 1:
Iteration 2:
Iteration 3:
                             \log likelihood = -54.988283
Iteration 4:
                             log likelihood = -54.963888
log likelihood = -54.9581
log likelihood = -54.956862
Iteration 5:
Iteration 6: Iteration 7:
                             log likelihood = -54.956689
log likelihood = -54.956667
Iteration 8:
Iteration 9:
                             log\ likelihood = -54.956663
Iteration 10:
```

Log likelihood = -54.956663

Number of obs = 109 Wald chi2(4) = 1.40 Prob > chi2 = 0.8449

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case mmse age sex_recode _cons	15.41707 0690732 .0091211 4575711 -16.21853	1001.336 .0732993 .0233112 .8366626 1001.338	0.02 -0.94 0.39 -0.55 -0.02	0.988 0.346 0.696 0.584 0.987	-1947.166 2127372 0365679 -2.0974 -1978.805	1978 .0745909 .0548102 1.182258 1946.368
eq2 case   mmse   age   sex_recode   _cons	.1739991 .0337922 .0412836 2193578 -5.804014	.5254026 .0787969 .0213518 .5302262 2.862807	0.33 0.43 1.93 -0.41 -2.03	0.741 0.668 0.053 0.679 0.043	855771 1206468 0005652 -1.258582 -11.41501	1.203769 .1882313 .0831324 .8198665 1930163

	RR	P>   z	[95% Conf.	Interval]
eq1 case mmse age sex_recode	4.96e+06 0.933258 1.009163 0.632819	0.988 0.346 0.696 0.584	0.000000 0.808369 0.964093 0.122775	1.077443 1.056340 3.261729
eq2				

### Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX e | 1.190055 0.424955 3.332655 1.207113 case mmse 1.034370 0.668 0.886347 1.042148 0.053 0.999435 1.086686 age sex\_recode 0.803034 0.679 0.284057 2.270197

. \*\* 3. CIQ Total: 1 month \*\*

LnMM3\_lf social\_impair\_24 ciq\_total

### Log multinomial model

initial: log likelihood = -<inf> (could not be evaluated) log likelihood = -300.00944feasible: log likelihood = -93.650323 log likelihood = -93.650323 rescale: rescale eq: Iteration 0:  $log\ likelihood = -93.650323$ Iteration 1: log likelihood = -81.764524log likelihood = -79.20682 Iteration 2: log likelihood = -79.171139 log likelihood = -79.170959 Iteration 3: Iteration 4: Iteration 5:  $\log likelihood = -79.170959$ 

Log likelihood = -79.170959

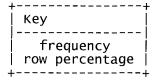
Number of obs = 134 Wald chi2(1) = 2.02 Prob > chi2 = 0.1551

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 ciq_total _cons	0974031 -2.158581	.0685057 .5648904	-1.42 -3.82	0.155 0.000	2316719 -3.265746	.0368656 -1.051416
eq2 ciq_total _cons	1202717 828371	.0371448 .2603485	-3.24 -3.18	0.001 0.001	1930742 -1.338645	0474691 3180974

### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1 ciq_total	0.907190	0.155	0.793206	1.037554
eq2 ciq_total	0.886680	0.001	0.824421	0.953640

LnMM3\_lf social\_impair\_24 case ciq\_total



Case	Social imp   Not impai	Dairmant at Impaired	24 months Dead	Total
Control	53 84.13	0.00	10 15.87	100.00
			Page 124	

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX

Case	51	7	13	71
	71.83	9.86	18.31	100.00
Total	104	7	23	134
	77, 61	5.22	17.16	100.00

Log multinomial model

```
(could not be evaluated)
initial:
                  log likelihood =
                                            -<inf>
feasible:
                  log likelihood = -300.00944
rescale:
                  \log likelihood = -93.650323
                  log likelihood = -93.650323
log likelihood = -93.650323
rescale eq:
Iteration 0:
                  log likelihood = -80.572648
Iteration 1:
Iteration 2:
                  log likelihood = -76.140123
                  log likelihood =
Iteration 3:
                  log likelihood = -75.292751
log likelihood = -75.260189
Iteration 4:
Iteration 5:
                  log likelihood = -75.252494
Iteration 6:
Iteration 7:
                  log\ likelihood = -75.250583
                  \log likelihood = -75.250214
Iteration 8:
Iteration 9:
                       likelihood = -75.250153
                  log
                  \log 11 \text{ ke} 111000 = -75.250133
\log 11 \text{ ke} 111000 = -75.250138
Iteration 10:
Iteration 11:
                  log\ likelihood = -75.250135
```

Log likelihood = -75.250135

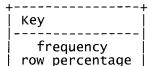
Number of obs = 134 Wald chi2(2) = 0.37 Prob > chi2 = 0.8293

	Coef.	Std. Err.	Z	P>   z	[95% Conf.	Interval]
eq1 case ciq_total _cons	15.63458 0409899 -17.66002	1097.644 .067014 1097.644	0.01 -0.61 -0.02	0.989 0.541 0.987	-2135.709 172335 -2169.003	2166.978 .0903552 2133.683
eq2 case ciq_total _cons	4048187 1326503 5094686	.3606841 .0374202 .3458858	-1.12 -3.54 -1.47	0.262 0.000 0.141	-1.111747 2059925 -1.187392	.3021093 059308 .1684551

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf. Interval]
eq1 case ciq_total	6.17e+06 0.959839	0.989 0.541	0.000000 0.841697 1.094563
eq2 case ciq_total	0.667098 0.875771	0.262 0.000	0.328984 1.352709 0.813839 0.942416

. LnMM3\_lf social\_impair\_24 case ciq\_total age sex\_recode



+----+

Case	Social imp   Not impai	pairmant at Impaired	24 months Dead	Total
Control	53 84.13	0.00	10 15.87	63 100.00
Case	51	7	13	71
	71.83	9.86	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

### Log multinomial model

-<inf> (could not be evaluated) initial: log likelihood = log likelihood = -300.00944feasible:  $\log likelihood = -93.650323$ rescale: log likelihood = -93.650323 log likelihood = -93.650323 rescale eq: Iteration 0: Iteration 1:  $log\ likelihood = -79.88043$  $\log$  likelihood = -74.591407 **Iteration 2:** Iteration 3:  $log\ likelihood = -72.175442$ log likelihood = -71.564872Iteration 4:  $log\ likelihood = -71.461192$ Iteration 5: Iteration 6:  $log\ likelihood = -71.442105$ log likelihood = -71.437784Iteration 7: log likelihood = -71.436757
log likelihood = -71.436535 Iteration 8: Iteration 9: Iteration 10:  $log\ likelihood = -71.436489$ Iteration 11:  $\log likelihood = -71.436478$ Iteration 12:  $log\ likelihood = -71.436476$ 

Log likelihood = -71.436476

Number of obs = 134 Wald chi2(4) = 0.52 Prob > chi2 = 0.9712

	Coef.	Std. Err.	Z	P> z	[95% Conf.	. Interval]
eq1 case ciq_total age sex_recode _cons	16.26323  0439687   .003008  2034906   -18.36311	1495.372 .0688295 .0234461 .7236865 1495.373	0.01 -0.64 0.13 -0.28 -0.01	0.991 0.523 0.898 0.779 0.990	-2914.612 1788721 0429456 -1.62189 -2949.24	2947.138 .0909346 .0489615 1.214909 2912.513
eq2 case ciq_total age sex_recode _cons	2564884 113969 .0395918 .0652419 -3.41075	.3439149 .0345732 .0168698 .3683291 1.321001	-0.75 -3.30 2.35 0.18 -2.58	0.456 0.001 0.019 0.859 0.010	9305492 1817312 .0065276 6566699 -5.999865	.4175724 0462069 .072656 .7871537 8216348

	RR	P>   z	[95% Conf.	Interval]
eq1 case   ciq_total   age   sex_recode	1.16e+07 0.956984 1.003012 0.815878	0.991 0.523 0.898 0.779	0.000000 0.836213 0.957963 0.197525	1.095197 1.050180 3.369987

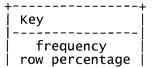
### Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX eq2 0.773764 0.456 0.394337 case 1.518271 0.892286 0.001 0.833825 0.954844 ciq\_total 1.006549 1.040386 0.019 1.075361 age 2.197134 sex\_recode 1.067417 0.859 0.518575 \*\*\*\*\*\*\*\*\*\*\*\*\*\* \*\* 1. FIM: 1 month \*\* LnMM3\_lf mobility\_impair\_24 fim Log multinomial model log likelihood = log likelihood = initial: -<inf> (could not be evaluated) feasible: likelihood = -300.00944log likelihood = -93.650323rescale: rescale eq: log likelihood = -93.650323 $\log 1$ ikelihood = -93.650323Iteration 0: likelihood = -81.279726Iteration 1: log Iteration 2: log likelihood = -78.281949Iteration 3: log likelihood = -77.40601 $\log 1$ ikelihood = -76.987588 Iteration 4: Iteration 5: likelihood = -76.93415 log -76.933169 Iteration 6: log likelihood = Iteration 7: $\log likelihood = -76.933168$ Number of obs 134 2.12 Wald chi2(1) Log likelihood = -76.9331680.1455 Prob > chi2

		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	fim	0239293	.0164381	-1.46	0.145	0561474	.0082889
	_cons	3722645	1.713435	-0.22	0.828	-3.730535	2.986006
eq2	fim	0340244	.0064714	-5.26	0.000	0467081	0213407
	_cons	1.830709	.5794128	3.16	0.002	.695081	2.966337

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	fim	0.976355	0.145	0.945400	1.008323
eq2	fim	0.966548	0.000	0.954366	0.978885

LnMM3\_lf mobility\_impair\_24 case fim



+----+

Case	Mobility im   Not impai	npairmant at Impaired	24 months Dead	Total
Control	51 80.95	3.17	10 15.87	63 100.00
Case	53 74.65	7.04	13 18.31	71 100.00
Total	104 77.61	7 5.22	23   17.16	134 100.00

### Log multinomial model

```
(could not be evaluated)
initial:
                    log likelihood =
                                                -<inf>
                    log likelihood = -300.00944
feasible:
                    log likelihood = -93.650323
log likelihood = -93.650323
log likelihood = -93.650323
rescale:
rescale eq:
Iteration 0:
                    log\ likelihood = -79.886379
Iteration 1:
                    log likelihood = -76.834185
log likelihood = -75.691325
log likelihood = -75.331894
Iteration 2:
Iteration 3:
Iteration 4:
                    log\ likelihood = -75.304044
Iteration 5:
                    log\ likelihood = -75.303818
Iteration 6:
                    log\ likelihood = -75.303818
Iteration 7:
```

Log likelihood = -75.303818

=	134
=	2.20
=	0.3334
	=

		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	case	.4498848	.9154873	0.49	0.623	-1.344437	2.244207
	fim	019041	.0186392	-1.02	0.307	0555732	.0174911
	_cons	-1.180745	2.30908	-0.51	0.609	-5.706457	3.344968
eq2	case	8343903	.4444066	-1.88	0.060	-1.705411	.0366305
	fim	0437467	.0087099	-5.02	0.000	0608178	0266757
	_cons	3.304109	.994504	3.32	0.001	1.354917	5.253301

Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P> z	[95% Conf.	. Interval]
eq1	case	1.568132	0.623	0.260686	9.432932
	fim	0.981139	0.307	0.945943	1.017645
eq2	case	0.434139	0.060	0.181698	1.037310
	fim	0.957196	0.000	0.940995	0.973677

LnMM3\_lf mobility\_impair\_24 case fim age sex\_recode



| frequency | row percentage

Case	Mobility in   Not impai	mpairmant at Impaired	24 months Dead	Total
Control	51	2	10	63
	80.95	3.17	15.87	100.00
Case	53	5	13	71
	74.65	7.04	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

### Log multinomial model

initial: log likelihood = -<inf> (could not be evaluated)
feasible: log likelihood = -300.00944
rescale: log likelihood = -93.650323
rescale eq: log likelihood = -93.650323
Iteration 0: log likelihood = -93.650323
Iteration 1: log likelihood = -77.887766
Iteration 2: log likelihood = -68.928123
Iteration 3: log likelihood = -63.913878
Iteration 4: log likelihood = -63.573115
Iteration 5: log likelihood = -63.565048
Iteration 6: log likelihood = -63.565044

Log likelihood = -63.565044

Number of obs = 134 Wald chi2(4) = 4.04 Prob > chi2 = 0.4013

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case fim age sex_recode _cons	.5587843 0232674 .0269263 6784566 -2.294381	.8726561 .0229991 .0263269 .8359707 3.076451	0.64 -1.01 1.02 -0.81 -0.75	0.522 0.312 0.306 0.417 0.456	-1.15159 0683449 0246734 -2.316929 -8.324115	2.269159 .02181 .078526 .9600159 3.735353
eq2 case   fim   age   sex_recode   _cons	-1.137011 0903501 .0644171 1.015734 3.411318	.4397637 .0216631 .0176845 .5081976 1.75837	-2.59 -4.17 3.64 2.00 1.94	0.010 0.000 0.000 0.046 0.052	-1.998932 132809 .029756 .019685 0350248	2750902 0478913 .0990781 2.011783 6.85766

	RR	P>   z	[95% Conf.	Interval]
eq1	1 740545	0 522	0.216124	0 671361
case	1.748545	0.522	0.316134	9.671261
fim	0.977001	0.312	0.933938	1.022050
age	1.027292	0.306	0.975629	1.081691
sex_recode	0.507400	0.417	0.098576	2.611738
eq2				
case	0.320776	0.010	0.135480	0.759504
fim	0.913611	0.000	0.875632	0.953237

### 

. \*\* 2. MMSE: 1 month \*\*

LnMM3\_lf mobility\_impair\_24 mmse

### Log multinomial model

initial: log likelihood = -<inf> (could not be evaluated) feasible: log likelihood = -190.00817

rescale: log likelihood = -63.639703 rescale eq: log likelihood = -63.639703 lteration 0: log likelihood = -63.639703 lteration 1: log likelihood = -61.493628 lteration 2: log likelihood = -60.949336 lteration 3: log likelihood = -60.939752 lteration 4: log likelihood = -60.939748

Number of obs = 109 Wald chi2(1) = 4.50 Log likelihood = -60.939748 Prob > chi2 = 0.0339

		Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	mmse	1080787	.0509565	-2.12	0.034	2079516	0082057
	_cons	.0193209	1.293193	0.01	0.988	-2.515291	2.553933
eq2	mmse	.0119419	.0754814	0.16	0.874	135999	.1598827
	_cons	-2.464459	2.159607	-1.14	0.254	-6.697211	1.768294

### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	mmse	0.897557	0.034	0.812246	0.991828
eq2	mmse	1.012013	0.874	0.872843	1.173373

. LnMM3\_lf mobility\_impair\_24 case mmse

Key	+
frequency   row percentage	

Case	Mobility in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	51   80.95	3.17	10 15.87	63 100.00
Case	53 74.65	5 7.04	13   18.31   Page 130	71 100.00

+-			+- <b>-</b>	<b>-</b>
Total	104	7	23	134
į	77.61	5.22	17.16 i	100.00

### Log multinomial model

initia]:	<pre>log likelihood = -<inf></inf></pre>	(could not be evaluated)
feasible:	log likelihood = -190.00817	
rescale:	log likelihood = -63.639703	
rescale eq:	$\log likelihood = -63.639703$	
Iteration 0:	log likelihood = -63.639703	
Iteration 1:	log likelihood = -61.027858	
Iteration 2:	$log\ likelihood = -60.095748$	
Iteration 3:	log likelihood = -60.038828	
Iteration 4:	log likelihood = -60.038599	
Iteration 5:	log likelihood = -60.038599	

Log likelihood = -60.038599

Number of obs = 109 Wald chi2(2) = 4.96 Prob > chi2 = 0.0839

	   	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1	case	1.176807	1.1071	1.06	0.288	9930687	3.346682
	mmse	086207	.0527862	-1.63	0.102	189666	.017252
	_cons	-1.400643	1.808292	-0.77	0.439	-4.944829	2.143544
eq2	case	.2957297	.5449614	0.54	0.587	7723751	1.363834
	mmse	.0199796	.0775153	0.26	0.797	1319477	.1719068
	_cons	-2.864409	2.30099	-1.24	0.213	-7.374267	1.64545

### Exponentiated values of the model coefficients and their 95% confidence limits

		RR	P>   z	[95% Conf.	Interval]
eq1	case	3.243998	0.288	0.370438	28.408316
	mmse	0.917404	0.102	0.827235	1.017402
eq2	case	1.344107	0.587	0.461915	3.911162
	mmse	1.020180	0.797	0.876387	1.187567

LnMM3\_lf mobility\_impair\_24 case mmse age sex\_recode

frequency	İ
	-
row percentage	  -

Case	Mobility ir Not impai	npairmant at Impaired	24 months Dead	Total
Control	51 80.95	2 3.17	10 15.87	63 100.00
Case	53	5	13   Page 131	71

### Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX 7.04 18.31 | 100.00 74.65 23 | 104 134 Total 5.22 77.61 17.16 İ 100.00

### Log multinomial model

initial: (could not be evaluated) log likelihood = -<inf>

feasible: rescale:

log likelihood = -190.00817 log likelihood = -63.639703 log likelihood = -63.639703 rescale eq: Iteration 0:  $\log likelihood = -63.639703$ Iteration 1:  $log\ likelihood = -57.539885$ log likelihood = -54.871422 log likelihood = -54.487984 log likelihood = -54.482219 Iteration 2: Iteration 3: Iteration 4: Iteration 5: log likelihood = -54.482207log likelihood = -54.482207Iteration 6:

Number of obs wald chi2(4) 109 6.80 Prob > chi2 0.1467

Log likelihood = -54.482207

Coef. Std. Err. z P>|z| [95% Conf. Interval] eq1 .9033727 1.097647 0.411 -1.247976 0.82 3.054722 case -.2841051 mmse -.1436028 .0716862 -2.00 0.045 -.0031004 .0711845 .0434246 -.0139262 0.101 1.64 .1562953 age sex\_recode -.7682669 .8773728 -0.88 0.381 -2.487886 .9513522 3.169392 -4.248277 -1.340.180 -10.46017 \_cons 1.963617 eq2 .5361986 0.747 .1733078 0.32 -.8776221 1.224238 case -.1539358 .0233896 0.26 0.796 mmse .0904738 .200715 -.0008185 .0407166 .0211918 1.92 0.055 .0822518 age -0.39 -1.78 .2066016 .5323197 0.698 -1.249929 .8367258 sex\_recode

Exponentiated values of the model coefficients and their 95% confidence limits

-11.50315

.550572

0.075

3.074985

	RR	P>   z	[95% Conf.	. Interval]
eq1				
case	2.467913	0.411	0.287085	21.215283
mmse	0.866232	0.045	0.752688	0.996904
age	1.073779	0.101	0.986170	1.169171
sex_recode	0.463816	0.381	0.083085	2.589209
eq2	1			
case	1.189232	0.747	0.415770	3.401572
mmse	1.023665	0.796	0.857327	1.222276
age	1.041557	0.055	0.999182	1.085729
sex_recode	0.813344	0.698	0.286525	2.308795

<sup>\*\* 3.</sup> CIQ Total: 1 month \*\*

-5.476289

Log multinomial model

\_cons

initial: log likelihood = -<inf> (could not be evaluated) Page 132

LnMM3\_lf mobility\_impair\_24 ciq\_total

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX log likelihood = -300.00944 log likelihood = -93.650323 feasible: rescale:  $\log likelihood = -93.650323$ rescale eq: Iteration 0: Iteration 1: Iteration 2: log likelihood = -93.650323 log likelihood = -82.259514 log likelihood = -80.51263 log likelihood = -80.503795 Iteration 3: log likelihood = -80.503789Iteration 4:

Number of obs Wald chi2(1) 134 0.29 Log likelihood = -80.503789Prob > chi2 0.5927

	Coef.	Std. Err.	z	P>   z	[95% Conf	. Interval]
eq1 ciq_total _cons	0311917 -2.657532	.0583087 .6273449	-0.53 -4.24	0.593 0.000	1454747 -3.887106	.0830913 -1.427959
eq2 ciq_total _cons	122892 8076719	.0373679	-3.29 -3.10	0.001 0.002	1961317 -1.318122	0496523 2972221

### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1 ciq_total	0.969290	0.593	0.864612	1.086641
eq2 ciq_total	0.884359	0.001	0.821904	0.951560

### LnMM3\_lf mobility\_impair\_24 case ciq\_total

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

+	+
Key	
	ĺ
frequency	
row percentage	
<b></b>	1

Case	Mobility in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	51 80.95	3.17	10 15.87	63 100.00
Case	53	5	13	71
	74.65	7.04	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

### Log multinomial model

(could not be evaluated) initial: log likelihood = -<inf>

 $log\ likelihood = -300.00944$ feasible: log likelihood = -93.650323 log likelihood = -93.650323 log likelihood = -93.650323 rescale: rescale eq: Iteration 0:

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX
: log likelihood = -83.375062
: log likelihood = -80.681576
: log likelihood = -79.680681
: log likelihood = -79.568663
: log likelihood = -79.567686
: log likelihood = -79.567686 Iteration 1: Iteration 2: Iteration 3: Iteration 4: Iteration 5: Iteration 6:

Number of obs Wald chi2(2) Prob > chi2 134 0.97 Log likelihood = -79.5676860.6146

	. <b></b>					
	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case ciq_total _cons	.7437255 0102326 -3.320351	.8779357 .0619677 1.037726	0.85 -0.17 -3.20	0.397 0.869 0.001	9769969 1316871 -5.354257	2.464448 .1112218 -1.286445
eq2 case ciq_total _cons	4232984 1343973 4830644	.3519565 .0364581 .328836	-1.20 -3.69 -1.47	0.229 0.000 0.142	-1.113121 2058538 -1.127571	.2665237 0629409 .1614424

Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P>   z	[95% Conf.	Interval]
eq1 case ciq_total	2.103759 0.989820	0.397 0.869	0.376440 0.876615	11.756989 1.117643
eq2 case ciq_total	0.654883 0.874243	0.229 0.000	0.328532 0.813952	1.305419 0.938999

LnMM3\_lf mobility\_impair\_24 case cig\_total age sex\_recode

Cross-tabulation of the outcome (columns) with the first-named covariate (rows)

+
Key
frequency
row percentage
+

Case	Mobility in   Not impai	npairmant at Impaired	24 months Dead	Total
Control	51 80.95	3.17	10   15.87	63 100.00
Case	53	5	13	71
	74.65	7.04	18.31	100.00
Total	104	7	23	134
	77.61	5.22	17.16	100.00

Log multinomial model

(could not be evaluated) initial:

log likelihood = -<inf>
log likelihood = -300.00944
log likelihood = -93.650323 feasible: rescale:

Appendix 8 2\_ICU\_Predict\_Impairment log\_THESIS\_TECH\_INDEX log likelihood = -93.650323 
: log likelihood = -93.650323 
: log likelihood = -80.364091 
: log likelihood = -76.042416 rescale eq: Iteration 0: Iteration 1: log likelihood = -80.364091 log likelihood = -76.042416 log likelihood = -74.890047 log likelihood = -74.846206 log likelihood = -74.846081 log likelihood = -74.846081 Iteration 2: Iteration 3: Iteration 4: Iteration 5: Iteration 6:

Log likelihood = -74.846081

Number of obs = 134 Wald chi2(4) = 3.01 Prob > chi2 = 0.5568

	Coef.	Std. Err.	Z	P> z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode _cons	.818693	.8507089	0.96	0.336	8486657	2.486052
	.0080277	.062034	0.13	0.897	1135568	.1296121
	.0264986	.0260318	1.02	0.309	0245227	.0775199
	8239171	.8151256	-1.01	0.312	-2.421534	.7736997
	-4.946358	2.112261	-2.34	0.019	-9.086313	8064029
eq2 case ciq_total age sex_recodecons	2486048	.3384104	-0.73	0.463	9118769	.4146674
	1107621	.0348243	-3.18	0.001	1790164	0425077
	.0399194	.0177694	2.25	0.025	.0050921	.0747467
	.0982308	.370598	0.27	0.791	6281279	.8245896
	-3.476241	1.389614	-2.50	0.012	-6.199835	7526479

### Exponentiated values of the model coefficients and their 95% confidence limits

	RR	P> z	[95% Conf.	Interval]
eq1 case ciq_total age sex_recode	2.267534 1.008060 1.026853 0.438710	0.336 0.897 0.309 0.312	0.427986 0.892654 0.975776 0.088785	12.013749 1.138387 1.080604 2.167772
eq2 case ciq_total age sex_recode	0.779888 0.895152 1.040727 1.103217	0.463 0.001 0.025 0.791	0.401769 0.836092 1.005105 0.533590	1.513867 0.958383 1.077611 2.280944

log close

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ANLAYSES\Marsden\_ICU\_Predict\_Impairment.

> smcl

log type: smcl closed on: 8 Feb 2013, 14:07:10

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