

Early Rehab in ICU: TEAM Trial

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Michelle Kho, PT, PhD

February 10, 2023

12 pm ET

khome@mcmaster.ca



Overview of today's talk



Description of the TEAM
trial and results



You choose: areas for
further discussion



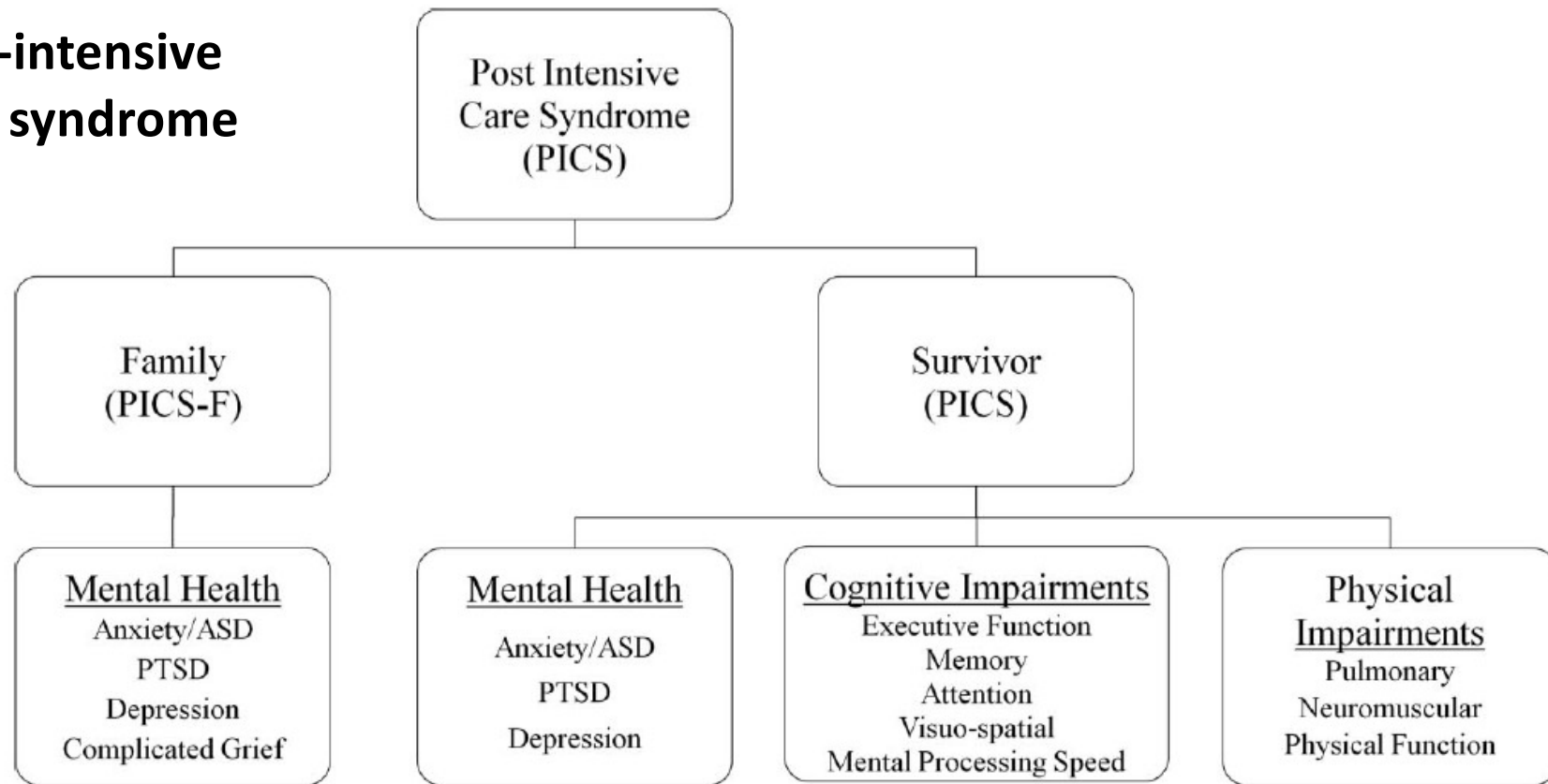
Test your knowledge

Improving long-term outcomes after discharge from intensive care unit: Report from a stakeholders' conference

2012

Needham et al., Crit Care Med 2012; 40.

Post-intensive care syndrome



ORIGINAL ARTICLE

Early Active Mobilization during Mechanical Ventilation in the ICU

The TEAM Study Investigators and the ANZICS Clinical Trials Group*

N Engl J Med 2022; 387:1747-1758

DOI:
10.1056/NEJMoa22
09083

Research Question: In mechanically ventilated adults, does early, goal-directed mobilization compared to usual care improve # days alive and out of hospital by day 180?

PICOS

- **Population:** Mechanically ventilated adults in ICU who were expected to undergo at least 1 additional day of mechanical ventilation
- **Intervention (unblinded):** Minimization of sedation as required, daily physiotherapy (7 days per week), individually tailored to achieve the ***highest possible level of mobilization provided for as long as possible*** before a step-down to lower levels of activity if the patient became fatigued
- **Comparison (unblinded):** Usual Care
- **Outcome:** # days alive and out of hospital by day 180
- **Study design:** Randomized controlled trial in 49 centres and 6 countries

Intervention

Hodgson et al., Crit Care Med. 2016 Jun;44(6):1145-52.

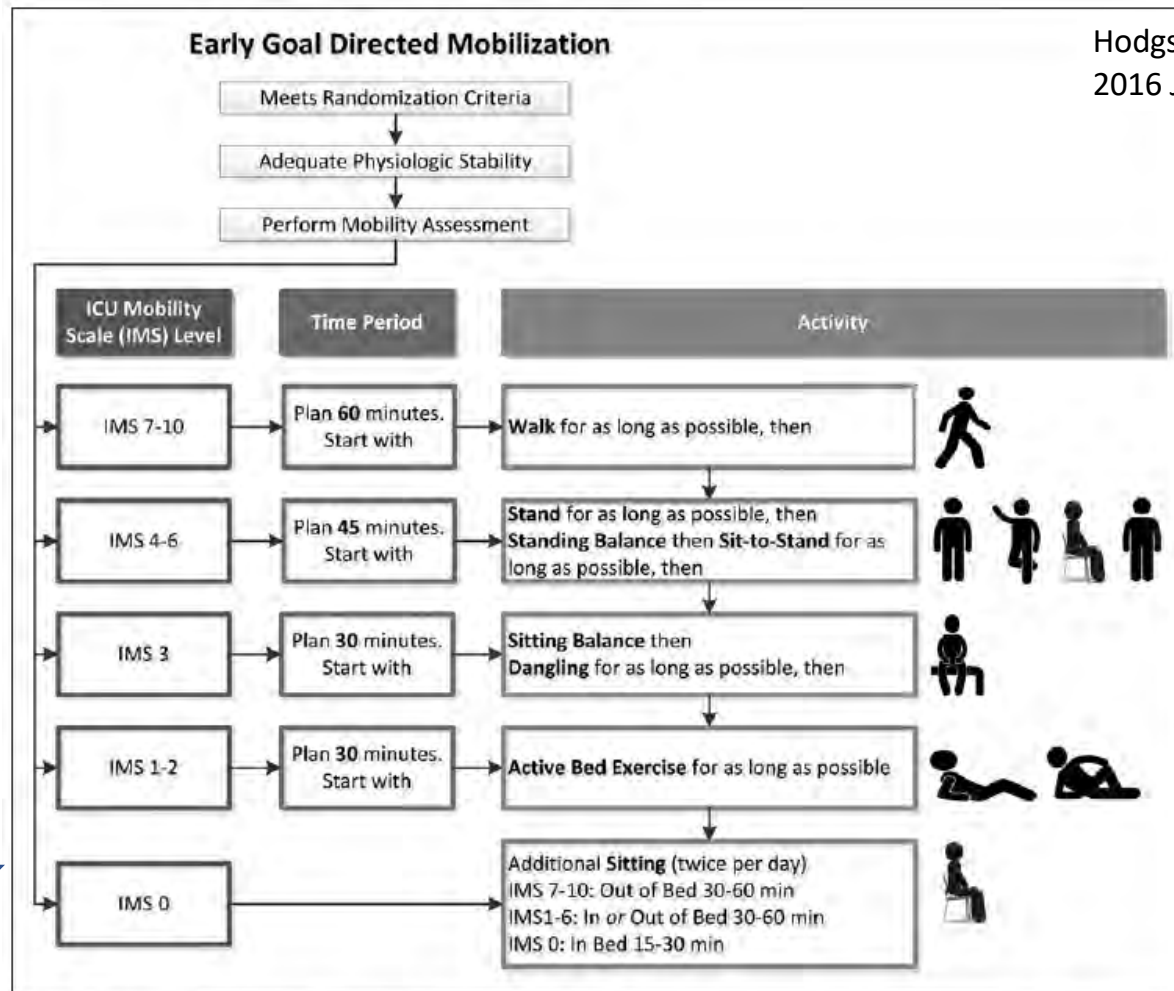
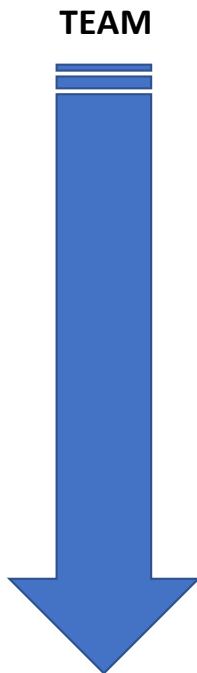


Figure 1. Early goal-directed mobilization algorithm. Once randomized and physiological stability is achieved, the mobility team assessed the ICU mobility scale (IMS) and targeted exercise at the highest possible level of the IMS for as long as possible.

Start with highest level of activity, then titrate down



Start with lower level of activity, then titrate up



Other ICU Rehab studies

Results

Characteristics of Included Patients (Table 1)

Table 1. Characteristics of the Patients at Baseline.*

Characteristic	Early Mobilization (N = 371)	Usual Care (N = 370)
Age — yr	60.5±14.8	59.5±15.2
Female sex — no. (%)	128 (34.5)	146 (39.5)
Body-mass index†	29.9±7.9	30.4±7.8
Frailty and function		
Median score on Clinical Frailty Scale (IQR)‡	3 (2 to 4)	3 (2 to 4)
Median score on Functional Comorbidity Index (IQR)§	2 (1 to 3)	2 (1 to 3)
Median score on WHODAS 2.0 (IQR)¶	10.4 (2.1 to 25.0)	8.7 (2.1 to 22.7)
Highest score on the ICU Mobility Scale in wk before ICU admission	9.9±0.6	9.8±0.7
Median interval from hospital admission to randomization (IQR) — hr	88.3 (50.5 to 137.0)	81.6 (48.2 to 147.0)
Median interval from ICU admission to randomization (IQR) — hr	60.1 (35 to 92.3)	61.3 (33.8 to 96.1)
ICU admission type — no. (%)		
Planned ICU admission after elective surgery	68 (18.3)	58 (15.7)
Unplanned ICU admission	303 (81.7)	312 (84.3)
Median RASS score at randomization (IQR)**	-3 (-4 to -2)	-3 (-4 to -2)
Measurements and interventions at randomization††		
Positive end-expiratory pressure — cm of water	8.9±3.0	8.8±3.1
Pao ₂ :Fio ₂	226±79.1	230±85.2
Receipt of vasopressors by infusion — no. (%)	228 (61.5)	231 (62.4)
Receipt of renal-replacement therapy — no. (%)	82 (22.1)	79 (21.4)
APACHE II score‡‡	18.2±6.8	18±6.9
Diagnosis subgroup — no. (%)§§		
Sepsis¶¶	246 (66.3)	245 (66.2)
Trauma	15 (4.0)	14 (3.8)
Covid-19	7 (1.9)	10 (2.7)

- 10.5% / 11.9% with Frailty (CFS >4)
- 3.6/ 3.4 days from hospital admission to randomization
- 2.5/ 2.6 days from ICU admission to randomization
- Median RASS @ randomization = -3
- APACHE II = 18.2 / 18.0

Characteristics of included patients (Table S5)

Table S5. Additional characteristics of the patients at baseline: physiology and ICU treatment.

Characteristic	Early Mobilization (n=371)	Usual Care (n=370)
GCS, median [IQR] *	15 [14-15]	15 [14-15]
Serum creatinine, median [IQR]	106 [72-166]	97 [69-160]
PaO ₂ – mmHg †	83.6 ±31.2	84.1± 23.9
Agitation and delirium		
RASS score, median [IQR] ‡	-3 [-4 to -2]	-3 [-4 to -2]
CAM-ICU positive, no. (%)	16 (4.3)	15 (4.1)
ICU supports and therapies, no. (%)		
Sedatives via continuous infusion	363 (97.8)	360 (97.3)
Vasopressors via continuous infusion	228 (61.5)	231 (62.4)
Renal replacement therapy	82 (22.1)	79 (21.4)
Corticosteroids	169 (45.6)	167 (45.1)

Plus-minus values are mean ±SD

* GCS data were available for 736 patients (369 in the early mobilization group and 367 in the usual care group)

† PaO₂ data were available for 737 patients (369 in the early mobilization group and 368 in the usual care group)

‡ RASS data were available for 715 patients (358 in the early mobilization group and 357 in the usual care group)

Abbreviations: CAM-ICU: Confusion Assessment Method for the ICU; GCS: Glasgow Coma Score; ICU: intensive care unit; IQR: interquartile range; no: number; PaO₂: arterial partial pressure of oxygen; RASS: Richmond Agitation Sedation Scale; SD: standard deviation; μmol: A micromole is a unit of measure defined as 10⁻⁶ (one-millionth) of a mole.

Mobilization in ICU (Table 2)

Table 2. Mobilization in the ICU.*

Characteristic	Early Mobilization (N=371)	Usual Care (N=370)	Between-Group Difference (95% CI)†
Patients who were assessed by a physiotherapist on day of randomization — no./total no. (%)	320/370 (86.5)	265/363 (73.0)	13.5 (6.7 to 20.3)
No. of days per patient when physiotherapy assessment occurred	0.94±0.11	0.81±0.24	0.14 (0.12 to 0.16)
No. of minutes of active mobilization per day	20.8±14.6	8.8±9.0	12.0 (10.4 to 13.6)
Mobilization milestones‡			
IMS 3 or higher			
Patients — no. (%)	331 (89.2)	330 (89.2)	0 (-4.3 to 4.3)
Median no. of days since randomization (IQR)	3 (1 to 6)	4 (2 to 7)	-1 (-2.2 to -0.2)
IMS 4 or higher			
Patients — no. (%)	287 (77.4)	286 (77.3)	0.1 (-6.0 to 6.1)
Median no. of days since randomization (IQR)	3 (2 to 7)	5 (3 to 8)	-2 (-3.4 to -0.6)
IMS 7 or higher			
Patients — no. (%)	176 (47.4)	150 (40.5)	6.9 (-0.2 to 14.0)
Median no. of days since randomization (IQR)	5 (3 to 8)	7 (4 to 13)	-2 (-3.4 to -0.7)
Median peak IMS (IQR)	6 (4 to 8)	6 (4 to 8)	0 (-1 to 1)

86.5%/ 73% assessments occurred w/ median RASS = -3

- 5.5/ 6.6 days from ICU admission to sit @ EOB or higher
- 5.5 / 7.6 days from ICU admission to stand or higher
- 7.5 / 9.6 from ICU admission to walk or higher

Outcomes (Table 3, part 1)

Table 3. Primary Outcome, Key Secondary Outcomes, and Adverse Events.*

Outcome	Early Mobilization (N= 371)	Usual Care (N= 370)	Difference or Odds Ratio (95% CI)†	P Value
Primary outcome				
Days alive and out of hospital at day 180‡				
Median no. (IQR)	143 (21 to 161)	145 (51 to 164)	-2.0 (-10 to 6)	0.62
Key secondary outcomes				
Death at day 180				
Patients — no. (%)	83/369 (22.5)	71/364 (19.5)	1.15 (0.81–1.65)§	
Median no. of days since randomization (IQR)	17 (9 to 41)	19 (12 to 50)	-2.0 (-12.0 to 8.0)	
Median no. of ventilator-free days at day 28 (IQR)	21 (8 to 25)	21 (11 to 25)	0.0 (-1.4 to 1.4)	
Median no. of ICU-free days at day 28 (IQR)	16 (0 to 21)	17 (3 to 22)	-1.0 (-3.1 to 1.1)	
Functional outcomes in survivors at day 180¶				
Score on EQ-5D-5L utility score	0.7±0.3	0.7±0.3	0.0 (-0.0 to 0.1)	
Score on EQ Visual Analogue Scale**	70.2±19.7	69.0±20.1	2.0 (-5.7 to 9.7)	
Median score on Barthel Index of ADL (IQR)††	100 (100 to 100)	100 (95 to 100)	0	
Median score on IADL (IQR)‡‡	8.0 (7.0 to 8.0)	8.0 (6.0 to 8.0)	0.2 (-0.9 to 1.3)	
Median score on WHODAS 2.0 (IQR)§§	12.5 (2.1 to 33.3)	14.6 (4.2 to 38.9)	-1.8 (-6.9 to 3.4)	

Secondary Outcomes (Table S13)

Table S13. Additional Secondary Outcome measures.

	Early Mobilization (n=371)	Usual Care (n=370)	Between-Group Difference**	Hazard Ratio**
Day 28 mortality, no. (%)	58 (15.6)	42 (11.4)	4.3 (-0.2 to 8.8)	
Median no. of coma and delirium-free days to day 28	24 (17-26)	24 (18-26)	0 (-1.2 to 1.2)	
Day 180 functional outcomes *				
MoCA Blind Score †	18 (16-20)	18.5 (16-20)	0 (-0.9 to 0.9)	
Median HADS Score [IQR] ‡				
Anxiety symptoms score	4 [2-7]	4 [2-8]	-0.2 (-2.6 to 2.2)	
Depression symptoms score	3 [1-6]	3 [1-7]	-0.6 (-2.4 to 1.2)	
Median IES-R Score [IQR] §	7.0 [1.5-19.5]	7.5 [2.8-20.2]	-0 (-2.6 to 2.6)	
Days in hospital, rehabilitation, or a nursing home to day 180, median [IQR] ¶	25 [13-45]	25 [13-49]	0.0 (-4.4 to 4.4)	
Patients who survived, median [IQR]	28 [16-50]	27 [14-52]	0.9 (-3.7 to 5.6)	
Patients who survived, geometric mean (95% CI)	28.2 (24.5-32.4)	27.7 (24.1-31.9)		
Patients who died, median [IQR]	16 [7-29]	17 [11-47]	-1 (-10.2 to 8.2)	
Patients who died, geometric mean (95% CI)	15.7 (12.3-20)	21 (16.2-27.4)		
Days from randomization to ICU discharge, median [IQR]	7.9 [4.3-15.1]	8.4 [4.9-15.1]		0.91 (0.78-1.06)
Patients who survived, median [IQR]	7.9 [4.3-15.1]	8.2 [4.9-14.3]		
Patients who survived, geometric mean (95% CI)	8.5 (7.4-9.6)	8.5 (7.5-9.6)		
Patients who died, median [IQR]	9.1 [4.1-16.2]	11.9 [7.2-20.7]		
Patients who died, geometric mean (95% CI)	8.4 (6.3-11.1)	12 (8.6-16.7)		
Days from randomization to hospital discharge, median [IQR] ††	17 [9.8-28.9]	17.9 [10.2-32.0]		0.95 (0.81-1.11)
Patients who survived, median [IQR]	19 [10.9-30.9]	19 [10.2-31.9]		
Patients who survived, geometric mean (95% CI)	19 (16.8-21.5)	18.7 (16.6-21.1)		
Patients who died, median [IQR]	10.6 [5.2-18.4]	14.5 [9.5-34.8]		
Patients who died, geometric mean (95% CI)	10.5 (8.1-13.7)	15.6 (11.8-20.6)		

28-day mortality: 15.6% / 11.4%

Days from randomization to ICU discharge: 7.9 / 8.4

Days from randomization to hospital discharge: 17 / 17.9

Conclusions (authors)

- No difference in number of days alive and out of hospital @ 180 days between early goal-directed mobilization than usual care
- Intervention associated with increased adverse events

Strengths

- ✓ Largest ICU rehabilitation study in the field – 750 patients!
- ✓ Multi-centre, multi-national
- ✓ High consent rate – 91%
- ✓ 7 days per week physiotherapy (intervention)
- ✓ 6-month follow-up for physical function, cognition, psychological distress
- ✓ Patient-reported outcomes blinded



Interpretation

1. Current state of the field
 - “Unique hypotheses”
2. How is early mobility defined in this [trial](#)?
 - Usual care
3. Is early mobility [safe](#)?
 - Dependent on duration of exposure and types of activities
 - Serious adverse events are very rare
 - Adverse events are rare; Total number of sessions per group unclear
4. How does this study fit in the [literature](#)?

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EDITORIAL



**Early Mobilization of Critical Care Patients
— Still More to Learn**

Marc Moss, M.D.

- Researchers design studies to answer unique hypotheses
- Early mobilization compared to usual level of mobilization in ICU
 - Does usual care reflect current practice in other hospitals?
 - High frequency of early mobilization in usual care group
 - 94% ICU days PT assessment intervention vs. 81% usual care
- # days alive and out of hospital may require larger sample sizes to detect meaningful differences
- Future ICU studies need to ID appropriate comparison group

Interpretation

1. Current state of the field
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4. How does this study fit in the [literature](#)?

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Intervention and Usual Care

Intervention



Counted in mobility time
IMS 3 or more

Not counted in mobility time, but still occurred
IMS 2 or less

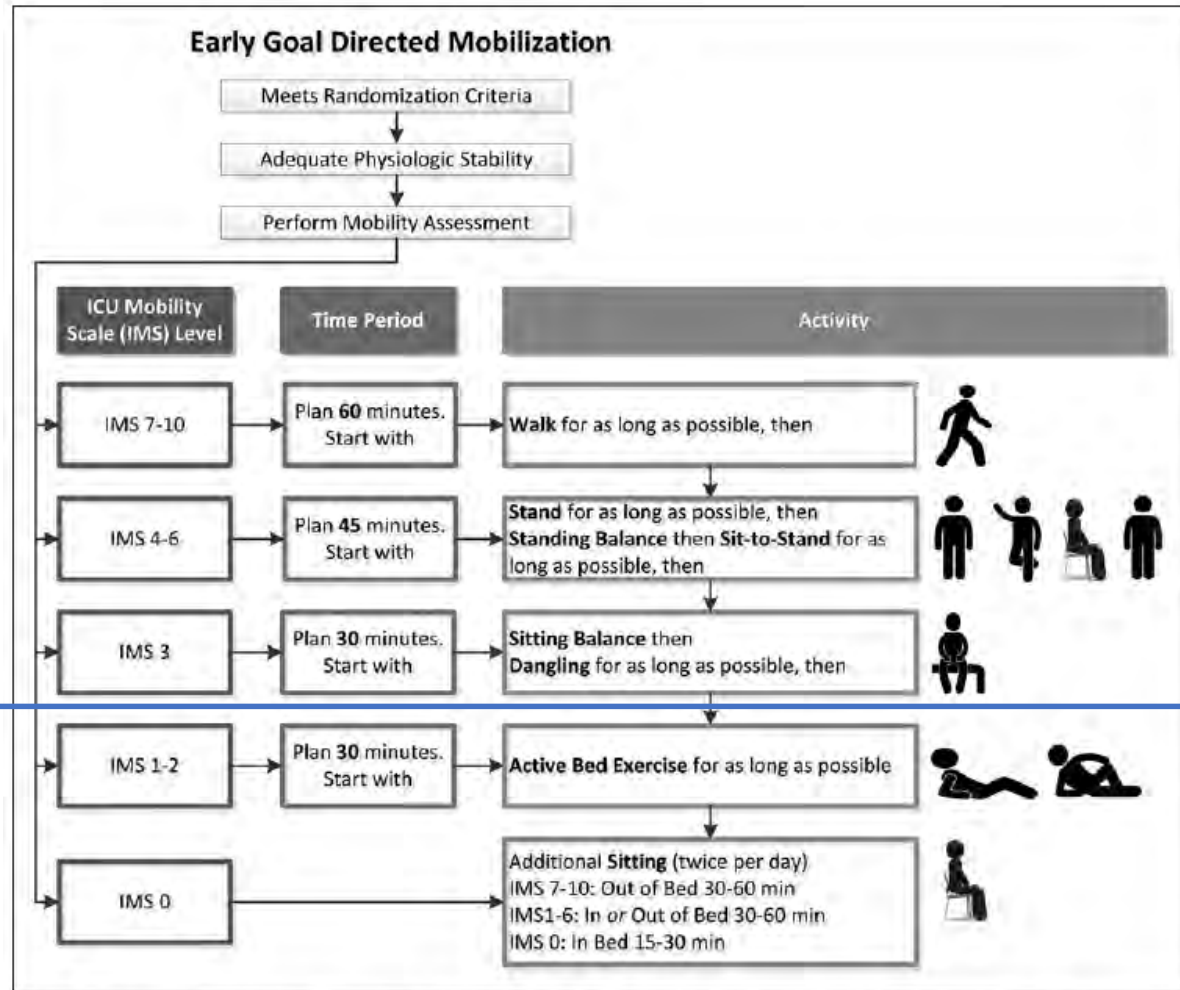



Figure 1. Early goal-directed mobilization algorithm. Once randomized and physiological stability is achieved, the mobility team assessed the ICU mobility scale (IMS) and targeted exercise at the highest possible level of the IMS for as long as possible.

Hodgson et al., Crit Care Med.
2016 Jun;44(6):1145-52.

A large orange shape on the left side of the slide, consisting of a vertical rectangle on the left and a quarter-circle on the right.

Comparison: Usual Care

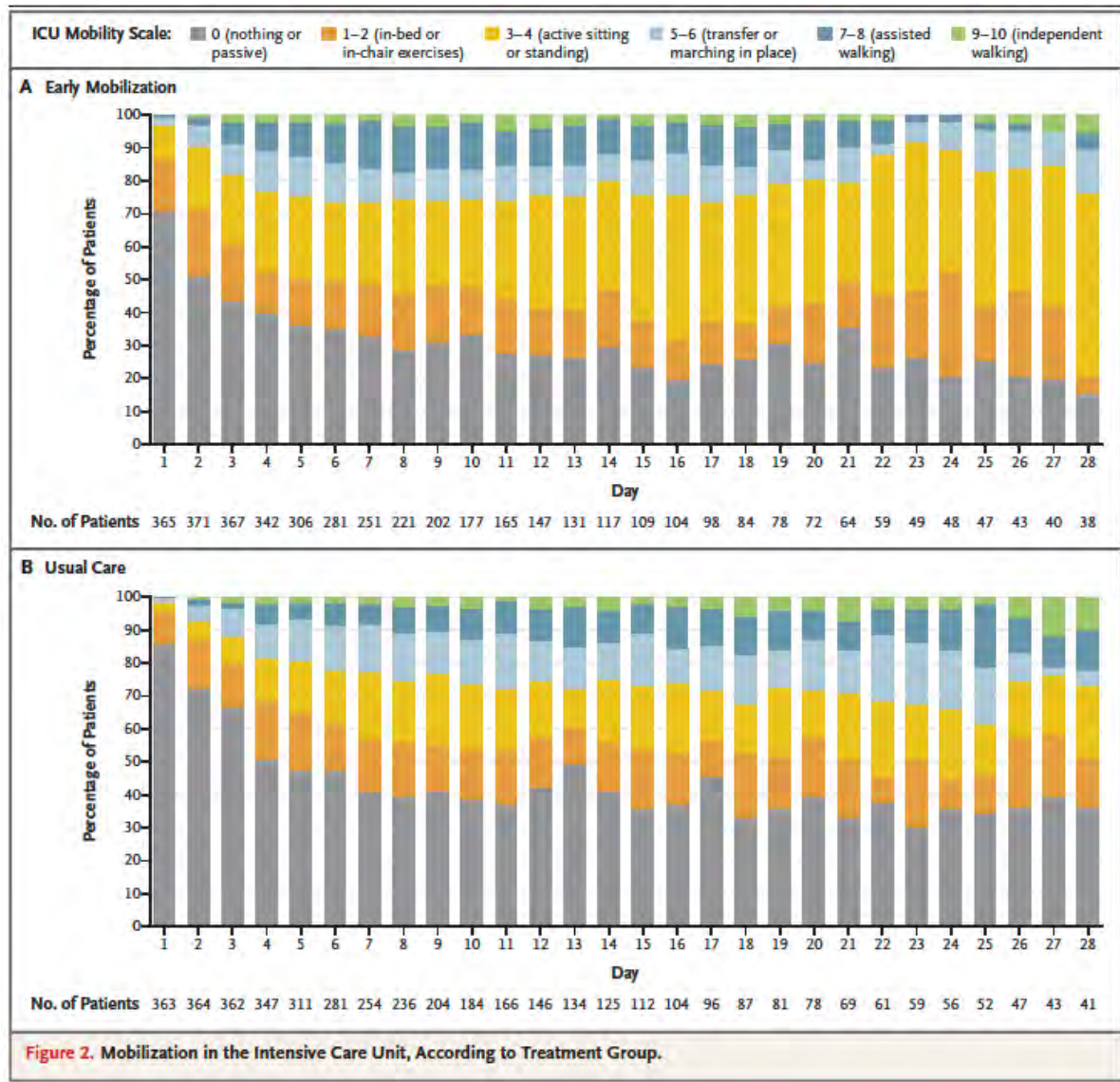
- Usual care from physiotherapy staff not involved in delivering the intervention, whenever feasible
- 
- A yellow dashed line in the bottom right corner, consisting of four curved segments.

Early Mobility Scale

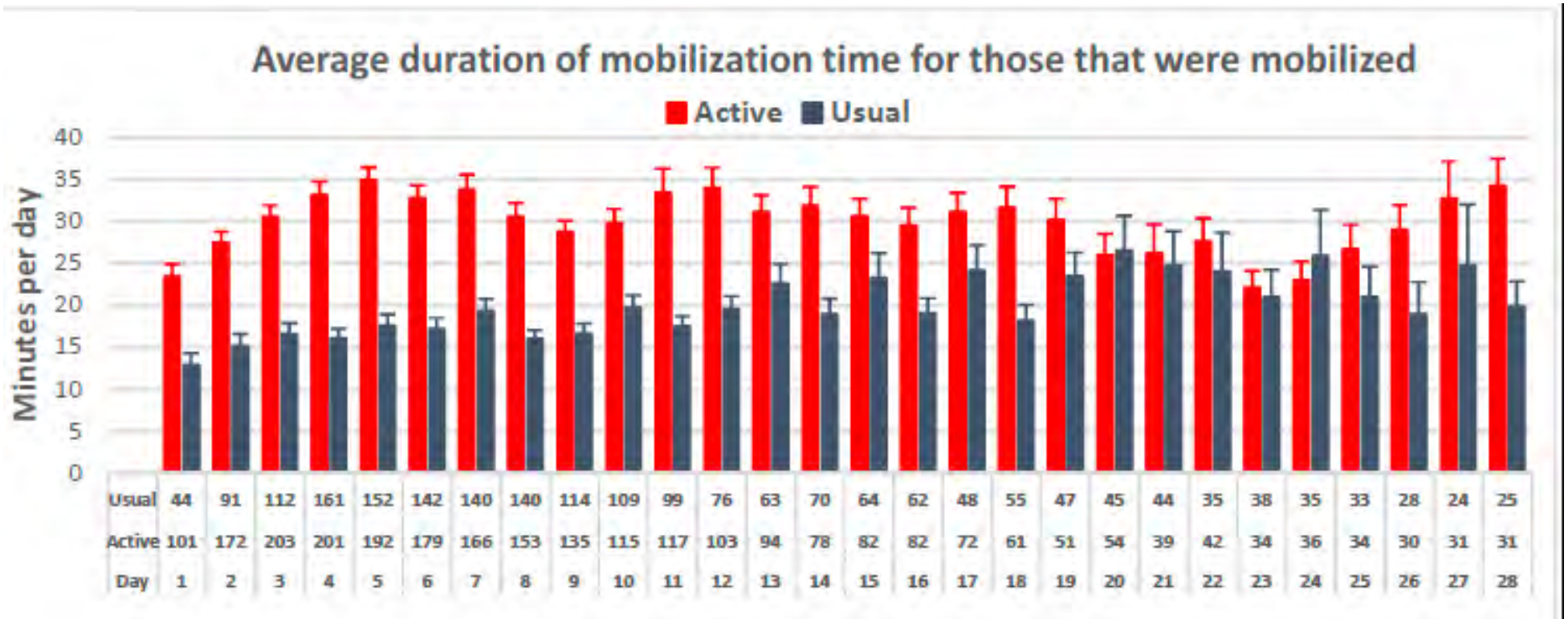
Table 1
ICU Mobility Scale.

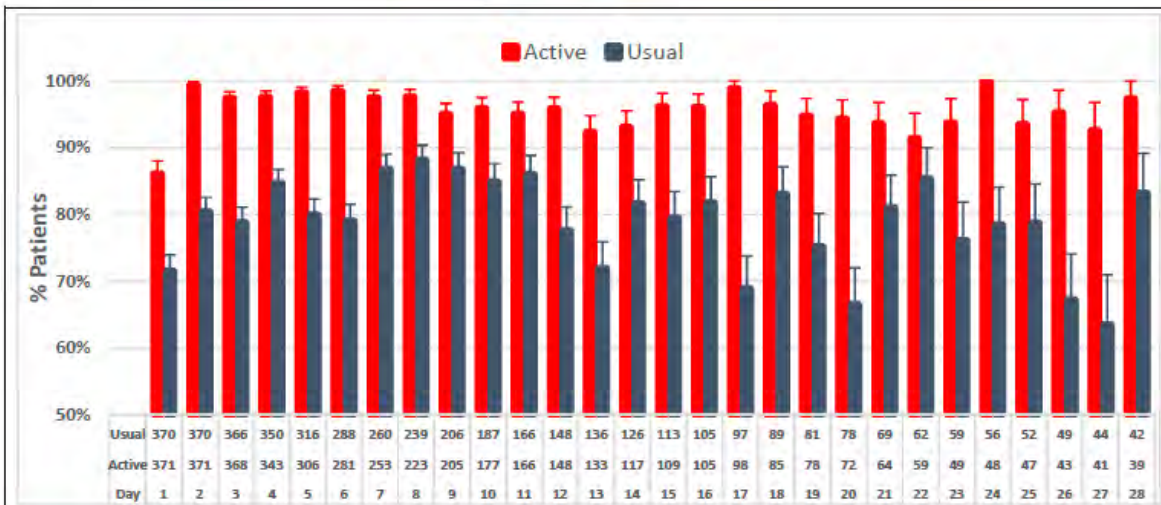
Classification	Definition
0 Nothing (lying in bed)	Passively rolled or passively exercised by staff, but not actively moving
1 Sitting in bed, exercises in bed	Any activity in bed, including rolling, bridging, active exercises, cycle ergometry and active assisted exercises; not moving out of bed or over the edge of the bed
2 Passively moved to chair (no standing)	Hoist, passive lift or slide transfer to the chair, with no standing or sitting on the edge of the bed
3 Sitting over edge of bed	May be assisted by staff, but involves actively sitting over the side of the bed with some trunk control
4 Standing	Weight bearing through the feet in the standing position, with or without assistance. This may include use of a standing lifter device or tilt table
5 Transferring bed to chair	Able to step or shuffle through standing to the chair. This involves actively transferring weight from one leg to another to move to the chair. If the patient has been stood with the assistance of a medical device, they must step to the chair (not included if the patient is wheeled in a standing lifter device)
6 Marching on spot (at bedside)	Able to walk on the spot by lifting alternate feet (must be able to step at least 4 times, twice on each foot), with or without assistance
7 Walking with assistance of 2 or more people	Walking away from the bed/chair by at least 5 m (5 yards) assisted by 2 or more people
8 Walking with assistance of 1 person	Walking away from the bed/chair by at least 5 m (5 yards) assisted by 1 person
9 Walking independently with a gait aid	Walking away from the bed/chair by at least 5 m (5 yards) with a gait aid, but no assistance from another person. In a wheelchair bound person, this activity level includes wheeling the chair independently 5 m (5 yards) away from the bed/chair
10 Walking independently without a gait aid	Walking away from the bed/chair by at least 5 m (5 yards) without a gait aid or assistance from another person

Hodgson et al., Heart & Lung 43 (2014) 19e24



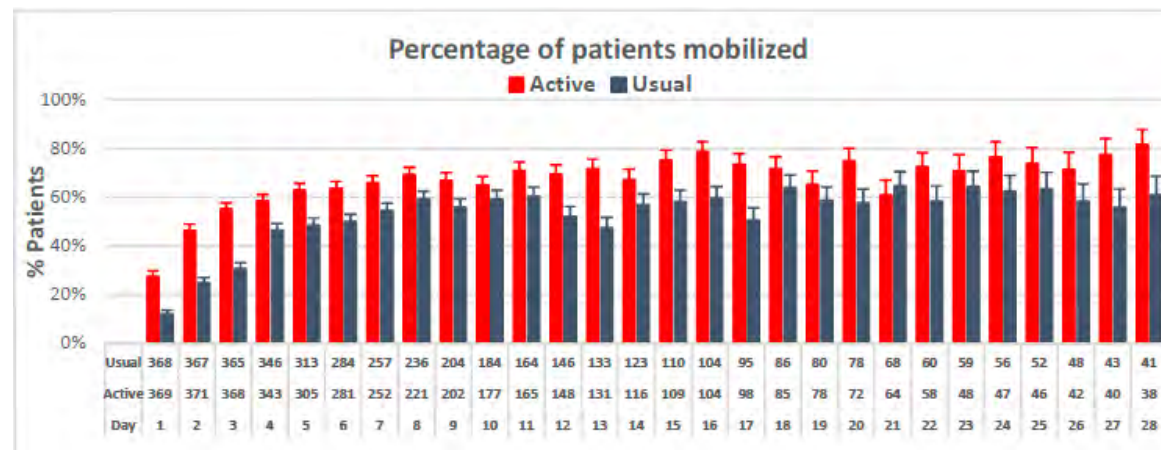
Duration of mobilization time (Fig S1)





Patients assessed (Fig S2)

Figure S2: Daily proportion of patients assessed by a physiotherapist



Patients mobilized (Fig S1)

Barriers to mobilization out of bed (Fig S4)

A. Barriers to mobilization out of bed in the early mobilization group by day

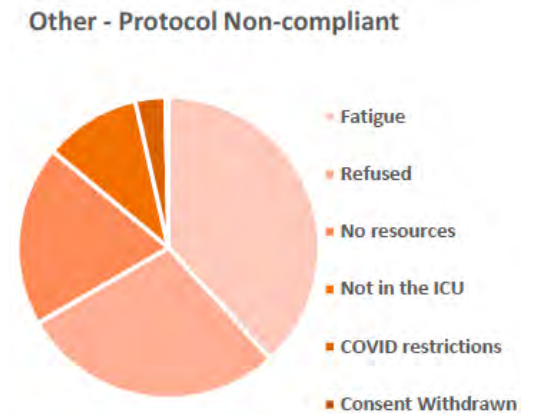
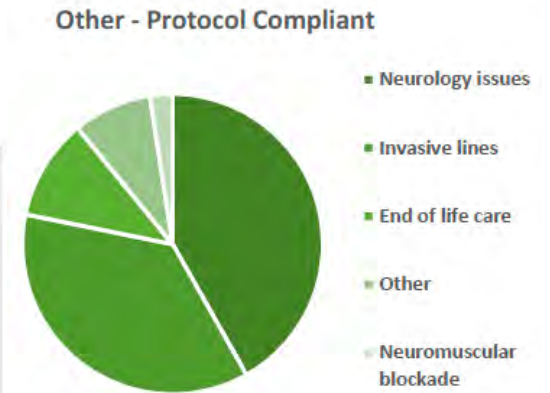
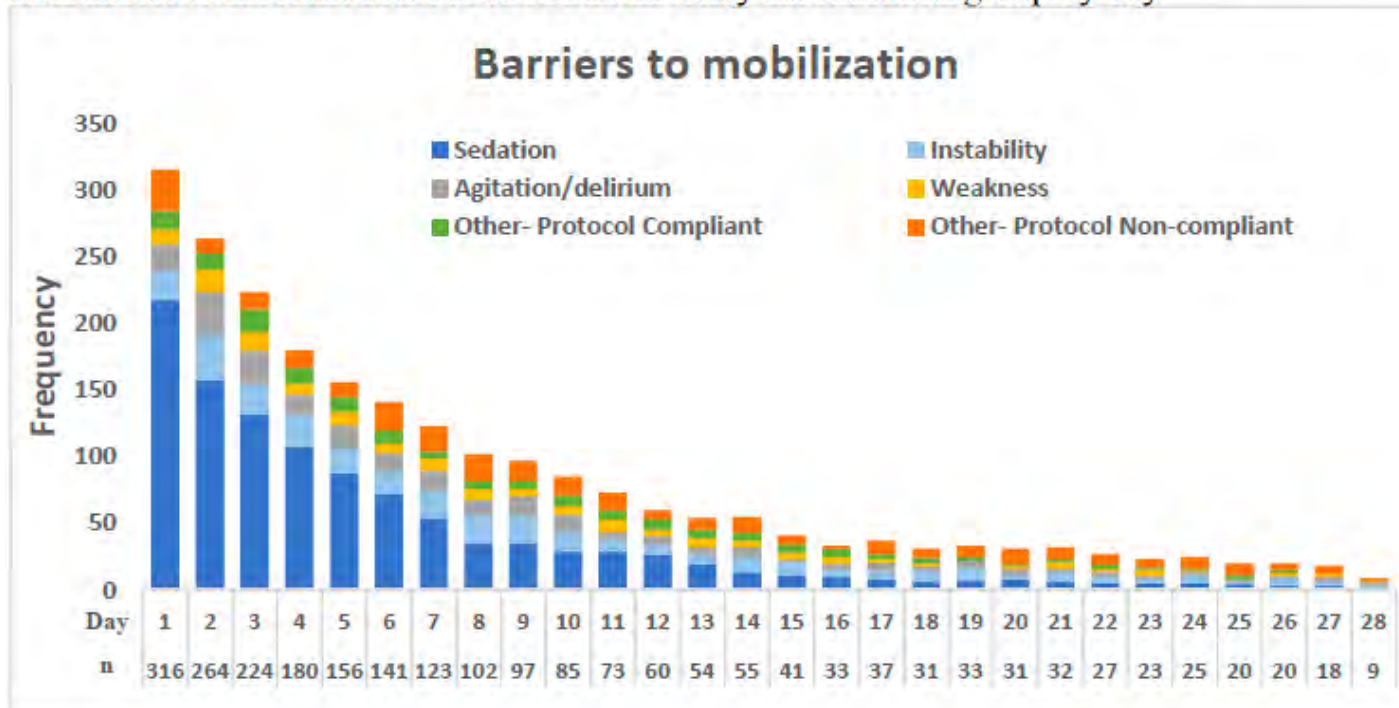


Figure S4: Reasons mobilization out of bed (ICU mobility scale ≥ 3) was not possible in patients assigned to early mobilization.

Safety

More adverse events?



Consider:

- What was the Adverse event?
- A-priori (*Severe* adverse events) or other (adverse events)?
- When did events occur?
- Risks of reporting bias in an open-label trial

Research

Serious adverse events in academic critical care research

Deborah Cook MD, François Lauzier MD, Marcelo G. Rocha MD, Mary Jane Sayles RN, Simon Finfer MD

CMAJ. 2008. 178(9): 1181-1184.

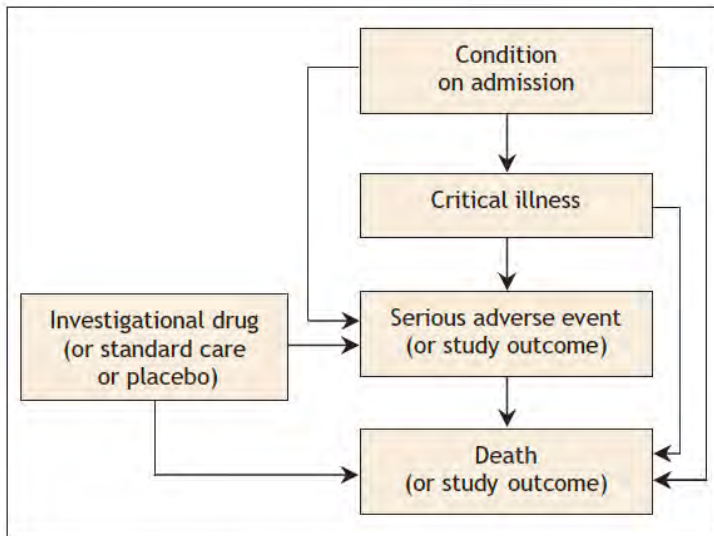


Figure 1: Possible relationships between the condition on admission, a patient's critical illness, the study drug, serious adverse events and death in academic trials of drugs in common use in critical care.

Challenges:

1. Variable definition and reporting of serious adverse events
2. Interpretation of serious adverse events in light of natural history of critical illness
3. Attribution of serious adverse events to the drug being tested
4. Attribution of death to serious adverse events
5. Interpretation of serious adverse events by REBs

Serious Adverse Events (Table S15)

Table S15. Serious Adverse Events*			
	Early Mobilization (n=371)	Usual Care (n=370)	P value
Fall to the floor	0 (0)	0 (0)	1.0
Cardiac arrest	0 (0)	0 (0)	1.0
Arrhythmia, no. (%) †	5 (1.3)	0 (0)	0.06
Desaturation, no. (%) ‡	1 (0.3)	1 (0.3)	1.0
Unplanned extubation	0 (0)	0 (0)	1.0
Line removal requiring urgent replacement, no. (%)	0 (0)	0 (0)	1.0
Other, no. (%)§	1 (0.3)	0 (0)	1.0

*Serious Adverse Events (SAE) include events that, in the investigator's opinion, were reported as probably, possibly or definitely related to the study. The SAE categories were prespecified at the outset of the trial.

† Arrhythmia includes rapid atrial fibrillation (defined as ventricular rate >150bpm), ventricular tachycardia or other dangerous arrhythmia

‡ Desaturation is defined as SpO₂ less than 80% for greater than 3 minutes

§ The event in the "other" category was a cerebrovascular accident resulting in unilateral weakness.

Abbreviations: no.: number; SpO₂: oxygen saturation as measured by pulse oximetry

8 serious adverse events: 7 patients in early mobilization group; 1 patient in usual care

Adverse events (Table 3; not pre-specified)

	N=371	N=370		
Adverse events — no. (%) ¶¶				
Patients with ≥1 adverse event <u>potentially</u> due to mobilization — no. (%)	34 (9.2)	15 (4.1)	2.55 (1.33–4.89)§	0.005
Adverse events per patient — no. (%)				0.02
0	337 (90.8)	355 (95.9)		
1	19 (5.1)	11 (3.0)		
2	4 (1.1)	2 (0.5)		
≥3	11 (3.0)	2 (0.5)		
Type of adverse events — no. (%) 				
Altered blood pressure	13 (3.5)	8 (2.2)		0.27
Cardiac arrhythmia	13 (3.5)	4 (1.1)		0.03
Oxygen desaturation	8 (2.2)	1 (0.3)		0.02
Pain or agitation	4 (1.1)	1 (0.3)		0.37
Removal of invasive line	2 (0.5)	2 (0.5)		1.00
Gastrointestinal	2 (0.5)	1 (0.3)		1.00
Tachypnea	3 (0.8)	0		0.25
Altered neurologic state	1 (0.3)	1 (0.3)		1.00
Other	4 (1.1)	0		0.12

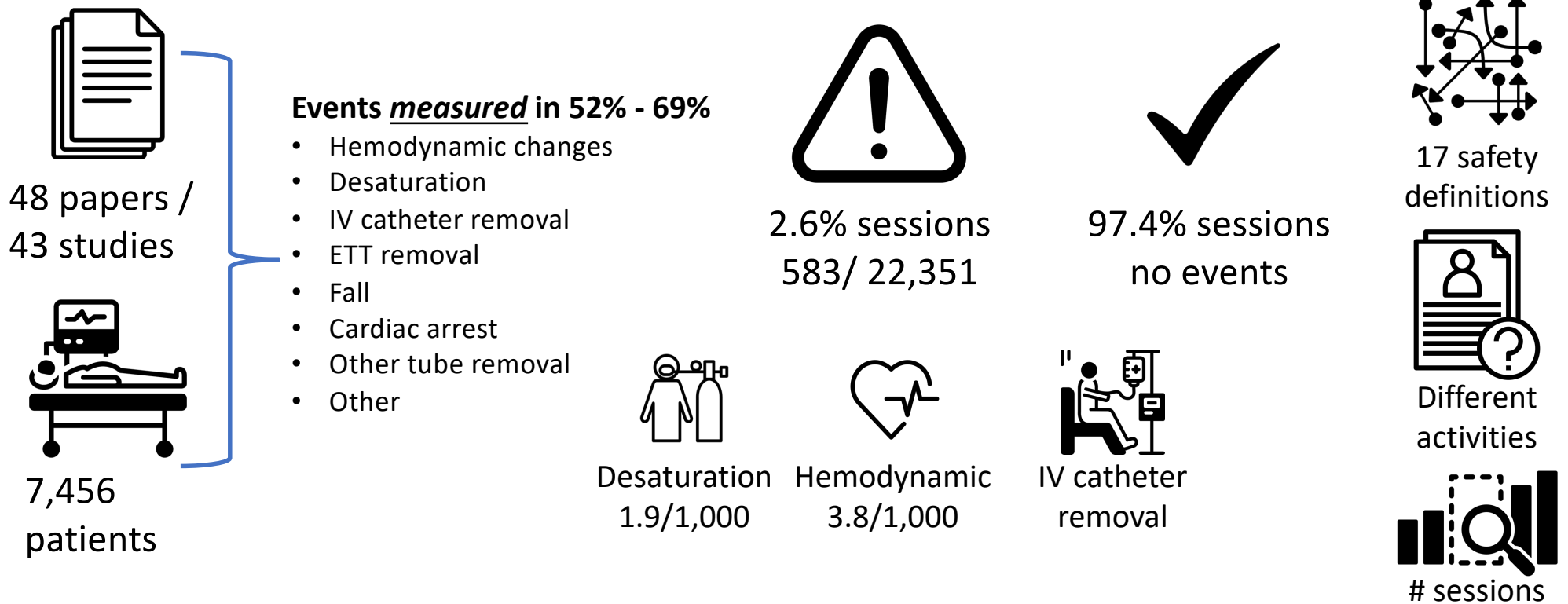
49 adverse events: 34 patients in early mobilization group; 15 in usual care

Safety of Patient Mobilization and Rehabilitation in the Intensive Care Unit

Systematic Review with Meta-Analysis

Peter Nydahl^{1*}, Thiti Sritharoenchai^{2*}, Saurabh Chandra³, Firuzan Sari Kundt⁴, Minxuan Huang⁵, Magdalena Fischill⁶, and Dale M. Needham⁷

Nydahl et al., Ann Am Thorac Soc Vol 14, No 5, pp 766–777, May 2017



Increased mortality?



Consider:

- Totality of evidence
- Baseline mortality rate
- Need for an updated systematic review

Physical Rehabilitation in the ICU: A Systematic Review and Meta-Analysis

Wang et al., Crit Care Med. 2022 Mar 1;50(3):375-388

Time point	Study	N	Intervention n (%)	Control n (%)	
ICU Discharge	Wang et al. 2022	2,752	215/1,379 (15.6)	207/1,373 (15.1)	30 studies
28-day mortality	TEAM	741	58/371 (15.6)	41/370 (11.4)	
Hospital discharge	Wang et al. 2022	3,143	244/1,567 (15.5)	250/1,576 (15.9%)	26 studies
	TEAM	?	?	?	
6 months	Wang et al. 2022	1,373	193/684 (28.2)	187/689 (27.1)	9 studies
180 days	TEAM	741	83/371 (22.5)	71/370 (19.5)	

How does this study fit
in the literature?

When should we measure the primary outcome?



Consider:

- Primary outcome measured at 6-months post-ICU
- Proximity of primary outcome to treatment intervention
- Time to muscle weakness
- Confounding post-ICU

ICU Rehabilitation study heterogeneity



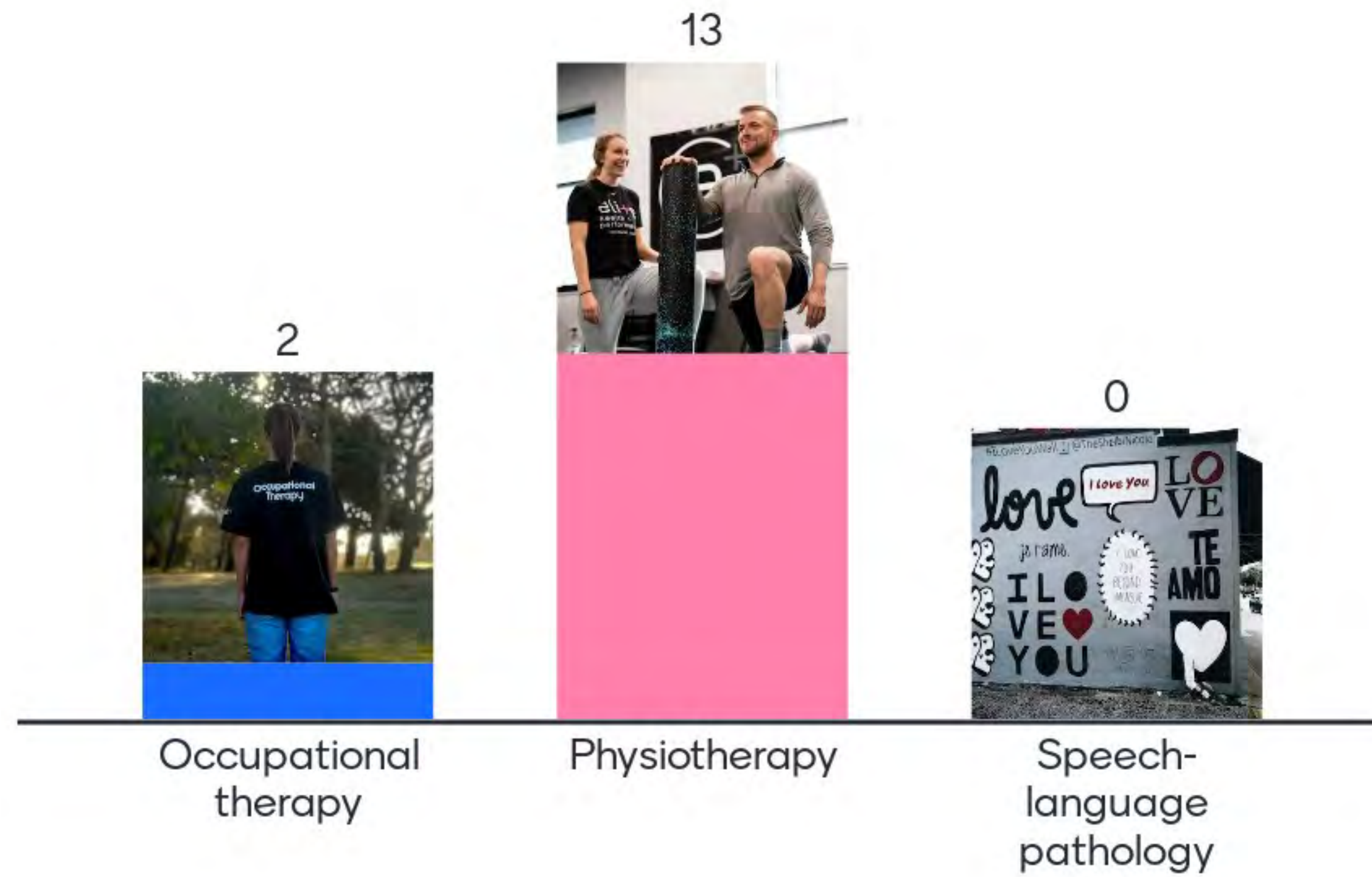
Intervention	Author	Enrolled	Population					
Progressive Mobility	Hodgson et al., 2016	50	Sepsis/not reported	-----				
	Schaller et al., 2016	200	Mixed	-----				
	Dong et al., 2014	60	Medical	-----				
	Dong et al., 2016	106	Cardiovascular	?	-----	?		
	Roberts et al., 2014	71	Not reported	?	-----	?		
			ICU Admit	<7 days	>7 days	ICU d/c	Hospital d/c	
Intervention	Author	Enrolled	Diagnostic					
Multi-component	Morris et al., 2016	300	Medical	-----				
	Brummel et al., 2014	87	Medical/surgical	----- ----->				
	Schweickert et al., 2009	104	Medical	-----				
	Kayambu et al., 2015	50	Medical	-----				
	Nava et al., 1998	80	Medical	-----	?			
	Denehy et al., 2013	150	Medical	----- ----->				
	Moss et al., 2016	120	Medical/surgical	----- ----->				
	Yosef-Brauner et al., 2015	18	Medical/surgical	?	-----			
	Chen et al., 2012	36	Medical	?	-----	10 sessions		
	Dantas et al., 2012	59	Not reported	?	-----			
	Chen et al., 2011	49	Medical/surgical	?	-----	6 weeks		
	Patman et al., 2001	236	Cardiovascular	?	-----	28 days		
				ICU Admit	<7 days	>7 days	ICU d/c	Hospital d/c

Reid et al. Journal of Intensive Care (2018) 6:80

Author (Year)	Design (n)	Intervention	Primary Outcome	Time point			Result
				ICU D/C	Hospital D/C	Post-hospital	
Schweickert (2009)	RCT (104)	Order for early exercise and mobilization during sedation interruption	Return to independent functional status		✓		✓
Morris (2008)	Quazi-random (n=330)	Automatic order for ICU mobility team	% ICU survivors receiving physical therapy		✓		✓
Burtin (2009)	RCT (n=90)	In-bed cycling, respiratory physiotherapy, upper/lower limb activity	6-minute walk distance		✓		✓
Denehy (2013)	RCT (150)	Intensive exercises in ICU, ward, outpatient	6-minute walk distance			6 months	X
Moss (2015)	RCT (120)	Intensive physiotherapy up to 28 days	Continuous scale physical functional performance test short form			1 month	X
Morris (2016)	RCT (300)	Standard rehab from ICU to hospital d/c 7d/wk	Hospital length of stay		✓		X
Schaller (2016)	RCT (200)	Early goal-directed mobilization w/ closed loop communication (104)	SICU optimal mobilization score	✓			✓



1 What is your rehab profession?



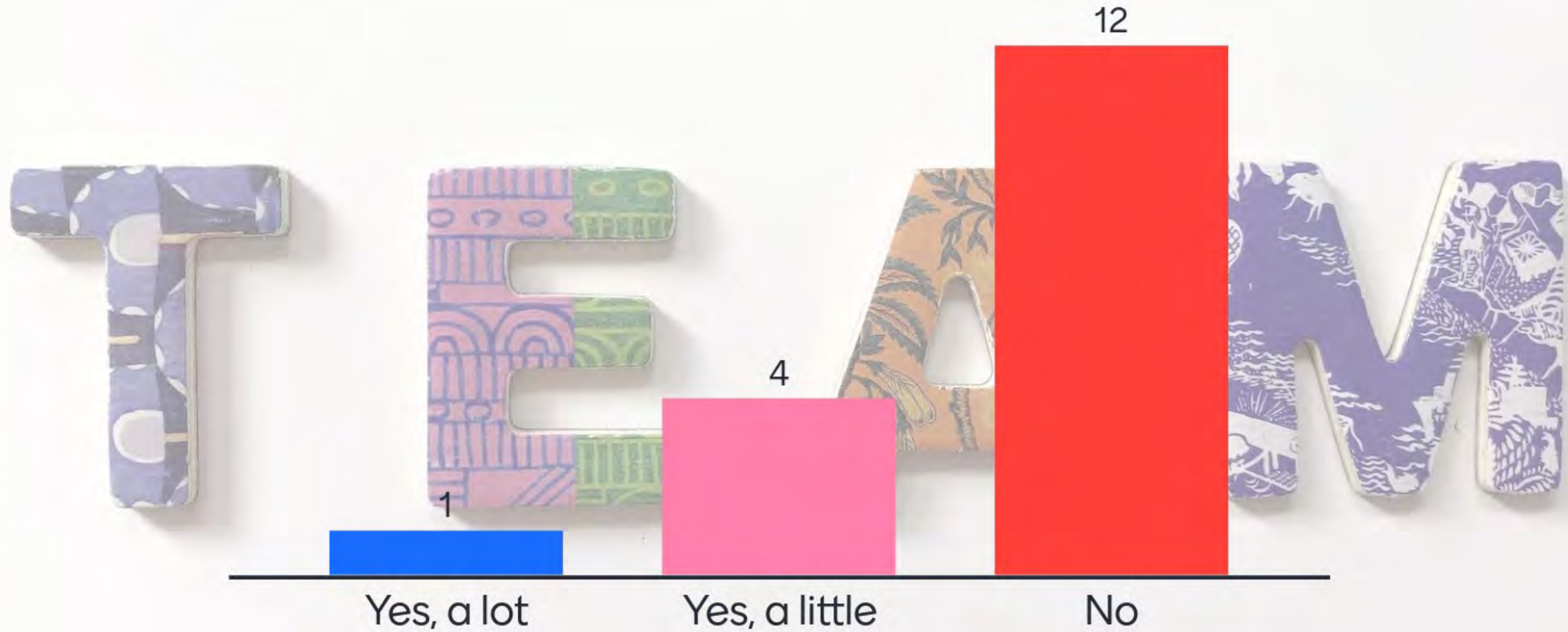


2 Where do you work?

Mentimeter



4 Are you familiar with the TEAM trial?





5 What other topics are of interest to you for future sessions?

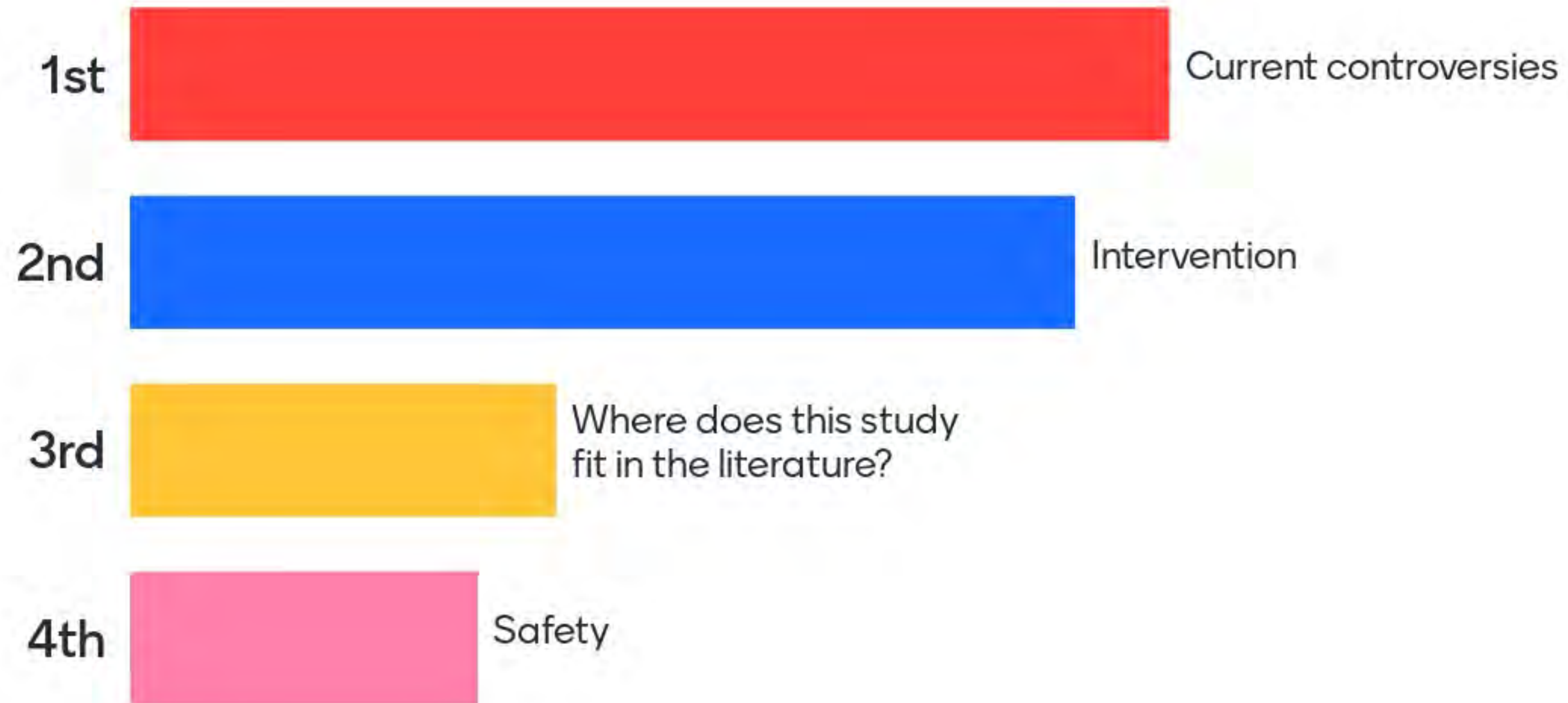
Anything that the audience wants to know about :)

Suctioning in the ICU

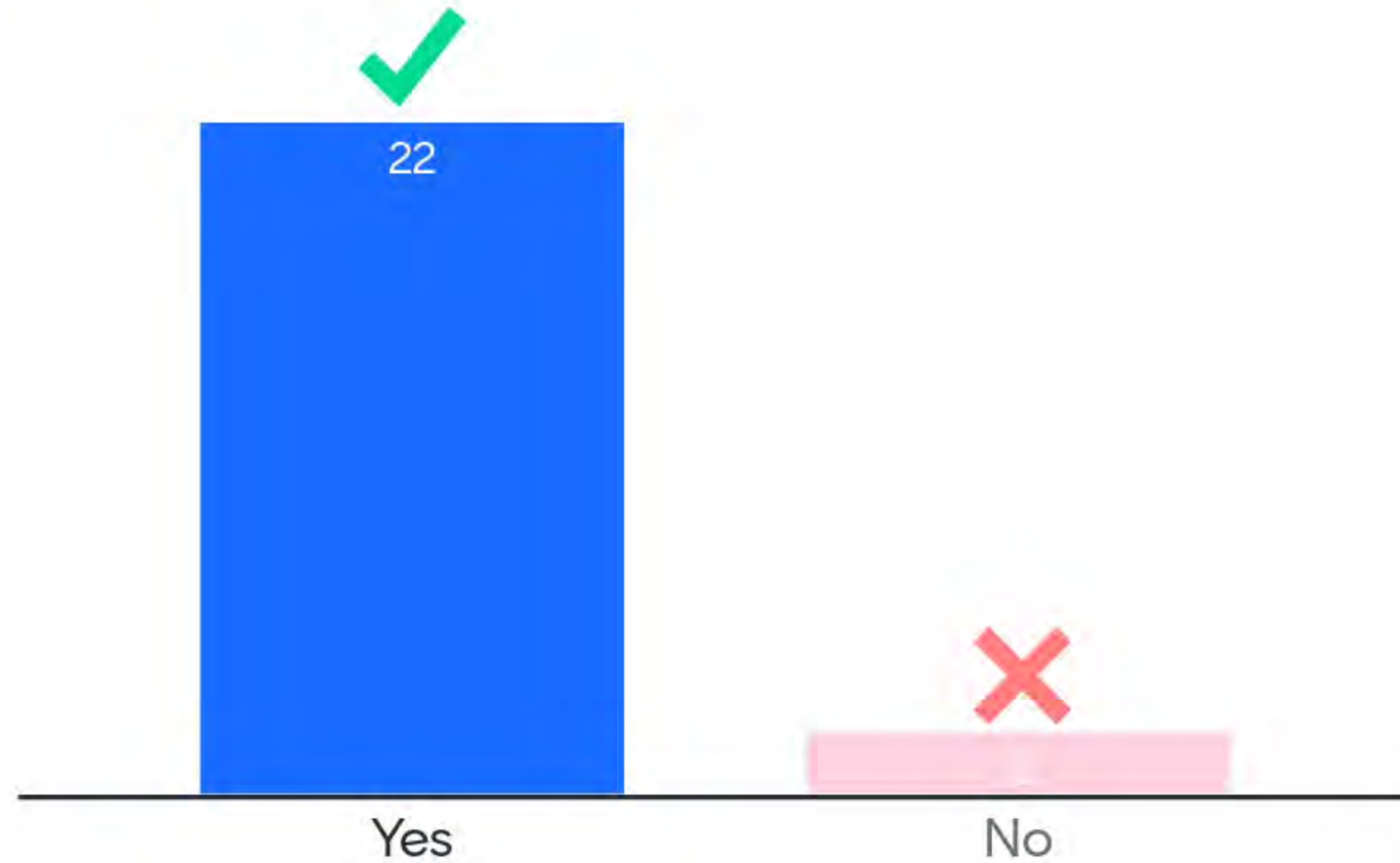
Suctioning

Suctioning

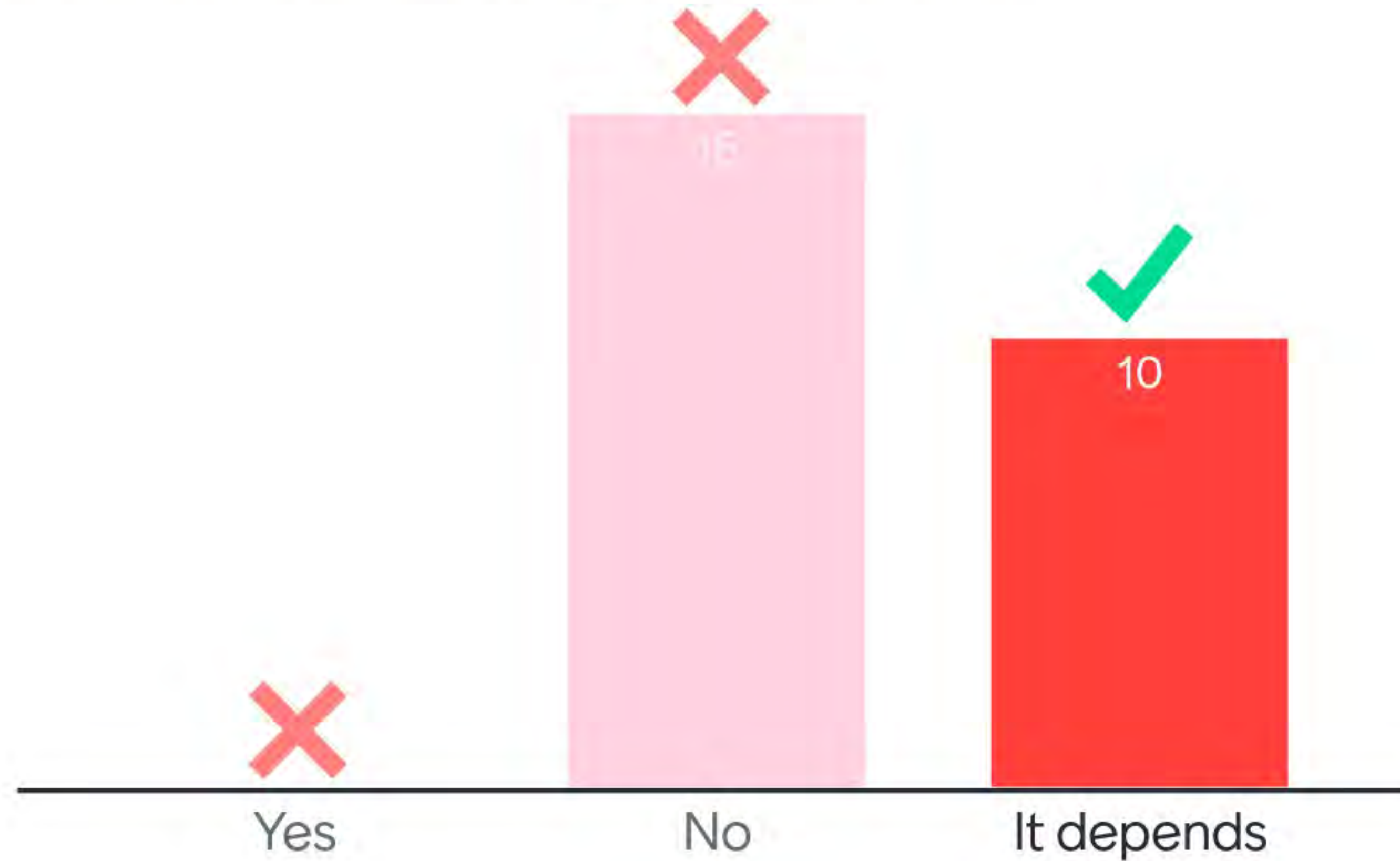
What would you like to discuss more? Please rank your choice.



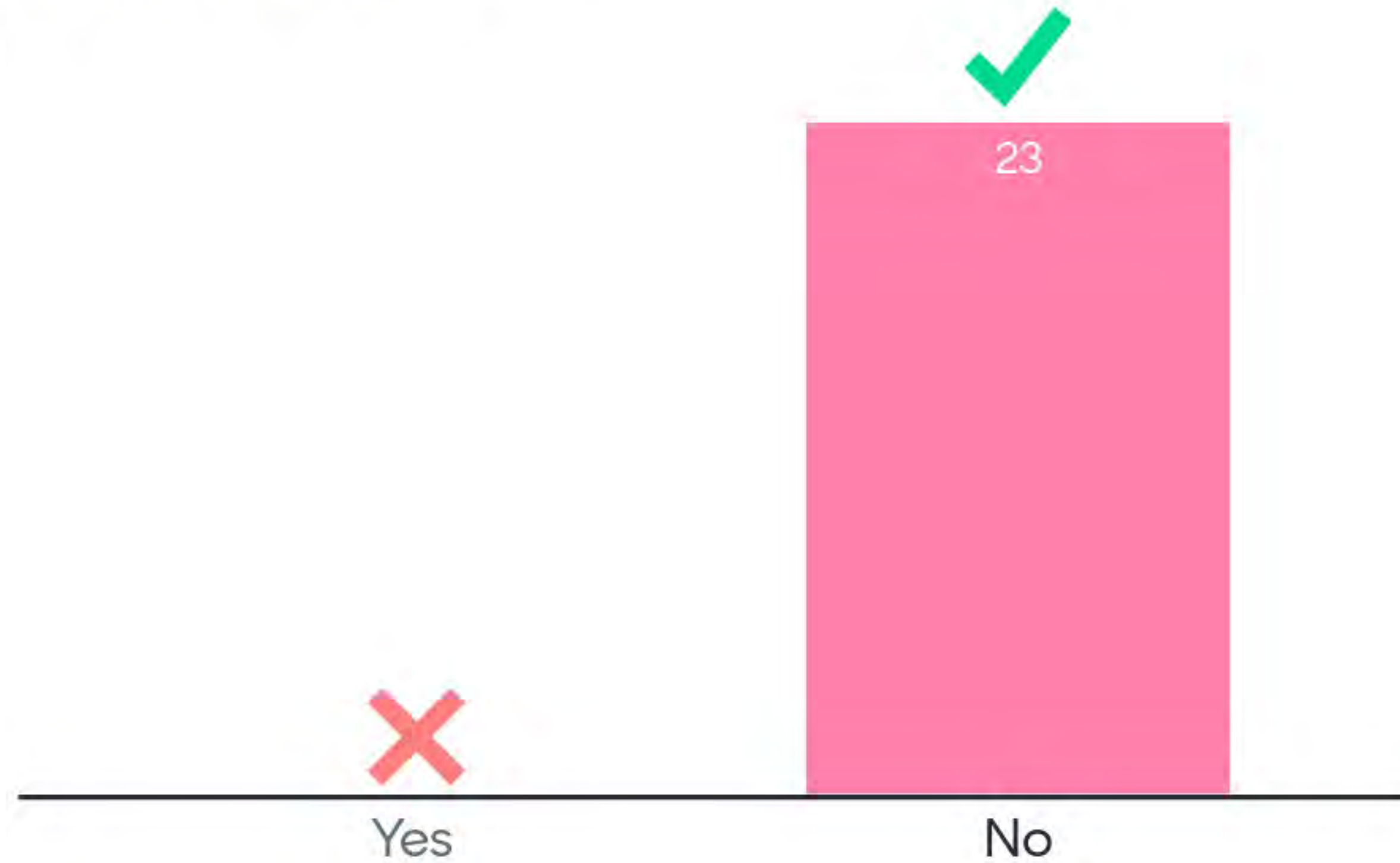
In the TEAM study, the primary outcome was measured at 180 days



Early mobilization is unsafe



Based on the TEAM study, we should stop rehabilitation in the ICU



Post-lecture feedback

