

# Sample size considerations for stepped wedge designs with subclusters

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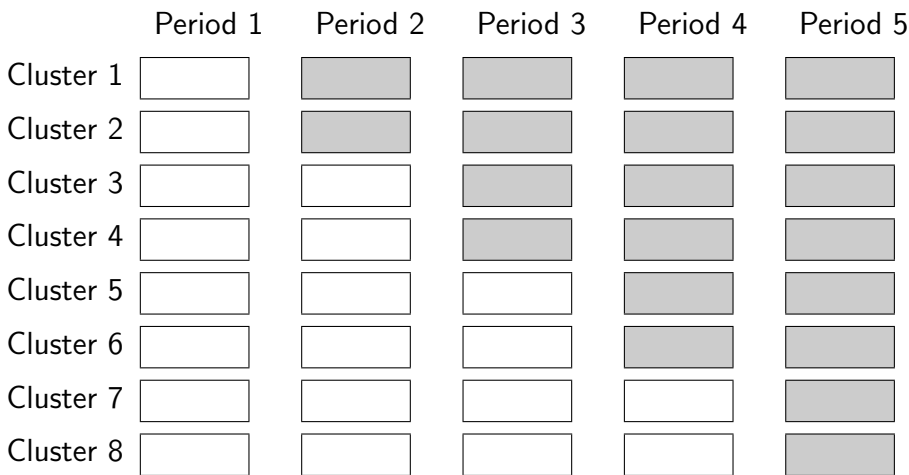
# What is a Cluster Randomized Trial?

In a cluster randomized trial (CRT) the unit of randomization is a *cluster* instead of an *individual* in a randomized controlled trial (RCT).

One might choose a CRT over a RCT if:

- 1 There is a high risk of contamination.
- 2 The goal is evaluate how a practice-wide change affects patient outcomes.

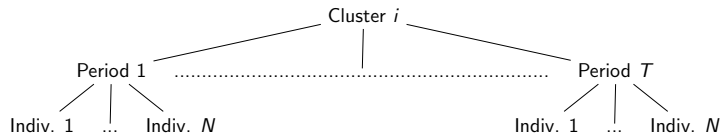
# What is a Stepped Wedge Cluster Randomized Trial?



**Figure:** A schematic illustration of a stepped wedge cluster randomized trial with 8 clusters and 5 periods. Each white cell indicates a cluster-period under the control condition and each gray cell indicates a cluster-period under the intervention condition.

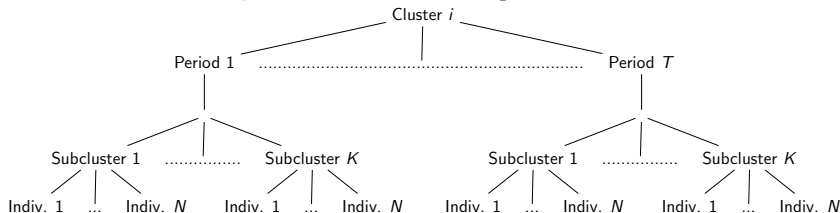
# Example of Multilevel SW-CRT

## SW-CRT without multiple levels of clustering:



Example: Individuals are nested in hospitals (cluster).

## SW-CRT with multiple levels of clustering:



Example: Individuals are nested in primary care providers (subcluster) which are nested in hospitals (cluster).

# Motivating Studies: LIRE & EPT Trials

The Lumbar Imaging with Reporting of Epidemiology (LIRE) trial (Jarvik et al., 2015).

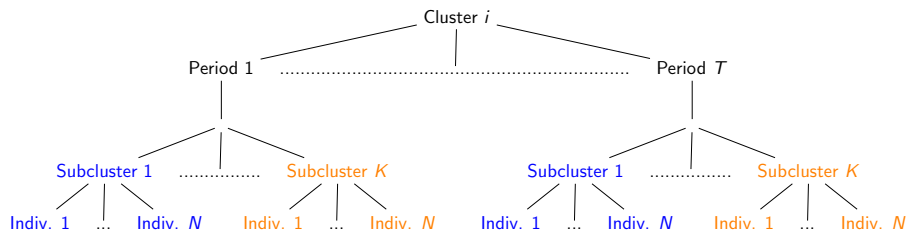
- Randomized clinics consisting of primary care providers.
- Outcome of interest was a composite measure of back pain (Gaussian).

The Washington Expedited Partner Therapy (EPT) trial (Golden et al., 2015).

- Randomized local health jurisdictions containing clinics.
- Outcome of interest was chlamydia reinfection (Binary).

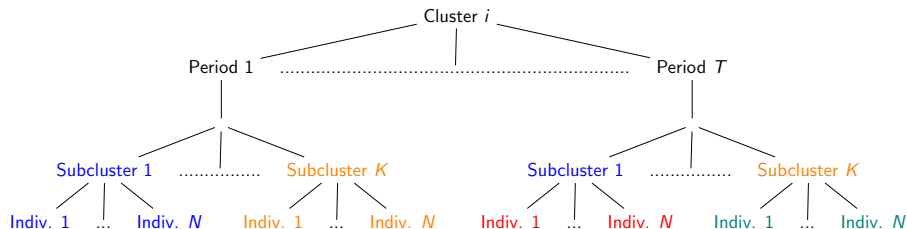
# Design Variants under Multilevel Clustering

(A) Closed-cohort design at both the subcluster and subject level



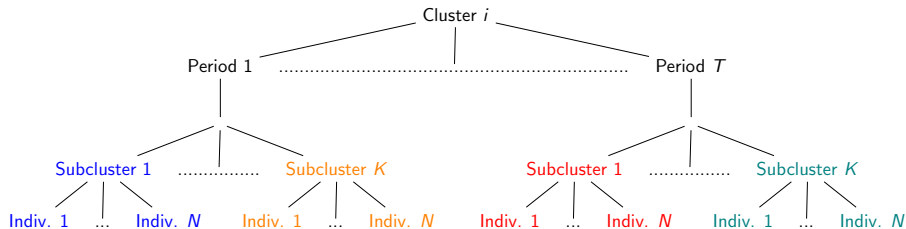
# Design Variants under Multilevel Clustering

(B) Closed-cohort design on the subcluster level but a cross-sectional design at the subject level



# Design Variants under Multilevel Clustering

(C) Cross-sectional design at both the subcluster and subject level





# Current Methods

We want to analyze a trial where participant  $l$  is nested in subcluster  $k$  sampled at time period  $j$  within cluster  $i$ .

- Hussey and Hughes (2007) used a linear mixed model (LMM) to take into account correlations within a cluster using a single random effect.

$$Y_{ijkl} = \beta_j + X_{ij}\delta + b_i + \epsilon_{ijkl}$$

- To differentiate the within- and between-period correlations Hooper et al. (2016) extended the LMM (Hussey and Hughes, 2007).

$$Y_{ijkl} = \beta_j + X_{ij}\delta + b_i + s_{ij} + \epsilon_{ijkl}$$

- To take into account multiple levels of clustering Teerenstra et al. (2019) extended the LMM (Hussey and Hughes, 2007).

$$Y_{ijkl} = \beta_j + X_{ij}\delta + b_i + c_{ik} + \epsilon_{ijkl}$$

## Key problem:

- **Current methods available are too simplistic.** Differentiating the within and between-period correlations are necessary to avoid underpowered trials in SW-CRTs (Taljaard et al., 2016).
- **Extensive simulation studies are required** in order to explore power estimates across various possible correlation parameters.

## Key point of this talk:

- We provide a closed-form variance expression for Gaussian outcomes thus eliminating the need for extensive simulations studies.

# Statistical Model

Given our outcome of interest,  $Y_{ijkl}$ , for individual  $l = 1, \dots, N$  nested in subcluster  $k = 1, \dots, K$  nested in period  $j = 1, \dots, T$  and cluster  $i = 1, \dots, I$ . We are interested in the following model,

$$\text{LMM: } Y_{ijkl} = \beta_j + X_{ij}\delta + \underbrace{b_i + c_{ik}}_{\text{(sub)cluster}} + \underbrace{s_{ij} + \pi_{ijk}}_{\text{period interactions}} + \underbrace{\gamma_{ikl}}_{\text{within-person}} + \epsilon_{ijkl}$$

$\beta_j$  is the effect of period  $j$  (time effect).

$X_{ij}$  is the intervention indicator for cluster  $i$  at period  $j$ .

$\delta$  is the intervention effect.

$b_i \sim \text{Normal}(0, \sigma_b^2)$  is the random cluster effect.

$c_{ik} \sim \text{Normal}(0, \sigma_c^2)$  is the random subcluster effect.

$s_{ij} \sim \text{Normal}(0, \sigma_s^2)$  is the random cluster-by-period effect.

$\pi_{ijk} \sim \text{Normal}(0, \sigma_\pi^2)$  is the random subcluster-by-period effect.

$\gamma_{ikl} \sim \text{Normal}(0, \sigma_\gamma^2)$  is the random participant effect (if closed-cohort).

$\epsilon_{ijkl} \sim \text{Normal}(0, \sigma_\epsilon^2)$  is the error.

# ICCs under Statistical Model

Under this model we have the following intraclass correlation coefficients (ICC),

where the total variance is  $\sigma^2 = \sigma_b^2 + \sigma_c^2 + \sigma_s^2 + \sigma_\pi^2 + \sigma_\gamma^2 + \sigma_\epsilon^2$ .

# Calculating Power

The power to detect a treatment effect  $\delta \neq 0$  with nominal type I error rate  $\alpha$  is

$$\text{power} \approx \Phi_t \left( t_{\alpha/2, \text{DoF}}; \text{DoF}, |\delta| / \sqrt{\text{var}(\hat{\delta})} \right),$$

where  $\Phi_t(t; \text{DoF}, \Lambda)$  is the cumulative  $t$ -distribution function with DoF degrees of freedom and noncentrality parameter  $\Lambda$  and  $t_{\alpha/2, \text{DoF}}$  is the upper  $\alpha/2$ th quantile of the central  $t$ -distribution.

We used  $\text{DoF} = I - 2$  which has been found to control type I error rate well (Ford and Westgate, 2020).

We assume an equal number of subclusters and participants across all clusters at all time periods such that  $K_{ij} = K$  and  $N_{ijk} = N$ .

# Variance of Intervention Effect

We can generate the variance of our intervention effect,  $\text{var}(\hat{\delta})$ , using the feasible generalized least squares (FGLS) estimator

$$\sigma^2(\sum_{i=1}^I \mathbf{Z}'_i \mathbf{R}_i^{-1} \mathbf{Z}_i)^{-1},$$

where  $\mathbf{Z}_i$  is the design matrix and  $\mathbf{R}_i$  is the induced correlation matrix for cluster  $i$ .

Given our correlation parameters we can express our extended block exchangeable correlation matrix,  $\mathbf{R}_i$ , as  $\mathbf{R}_i = \mathbf{I}_T \otimes (\mathbf{B} - \mathbf{C}) + \mathbf{J}_T \otimes \mathbf{C}$  where

$$\mathbf{B} = (1 - \alpha_0) \mathbf{I}_{KN} + (\alpha_0 - \rho_0) \mathbf{I}_K \otimes \mathbf{J}_N + \rho_0 \mathbf{J}_{KN}$$

$$\mathbf{C} = (\alpha_2 - \alpha_1) \mathbf{I}_{KN} + (\alpha_1 - \rho_1) \mathbf{I}_K \otimes \mathbf{J}_N + \rho_1 \mathbf{J}_{KN}$$

# Variance of Intervention Effect

$R_i$  has six eigenvalues Graybill (1983),

$$\lambda_1 = 1 - \alpha_0 - \alpha_2 + \alpha_1$$

$$\lambda_2 = 1 - \alpha_0 - \alpha_2 + \alpha_1 + N(\alpha_0 - \alpha_1 - \rho_0 + \rho_1)$$

$$\lambda_3 = 1 - \alpha_0 - \alpha_2 + \alpha_1 + N(\alpha_0 - \alpha_1 + (K - 1)(\rho_0 - \rho_1))$$

$$\lambda_4 = 1 - \alpha_0 + (T - 1)(\alpha_2 - \alpha_1)$$

$$\lambda_5 = 1 - \alpha_0 + (T - 1)(\alpha_2 - \alpha_1) + N(\alpha_0 - \rho_0 + (T - 1)(\alpha_1 - \rho_1))$$

$$\lambda_6 = 1 - \alpha_0 + (T - 1)(\alpha_2 - \alpha_1) + N(\alpha_0 + (T - 1)\alpha_1 + (K - 1)(\rho_0 + (T - 1)\rho_1))$$

Using Leiva (2007) we can generate a closed-form expression of  $R_i^{-1}$

$$\begin{aligned} R_i^{-1} = & \frac{1}{\lambda_1} I_{TKN} - \frac{\lambda_2 - \lambda_1}{N\lambda_1\lambda_2} I_{TK} \otimes J_N + \frac{\lambda_2 - \lambda_3}{KN\lambda_2\lambda_3} I_T \otimes J_{KN} + \frac{1}{T} \left( \frac{1}{\lambda_4} - \frac{1}{\lambda_1} \right) J_T \otimes I_{KN} \\ & + \frac{1}{T} \left( \frac{\lambda_2 - \lambda_1}{N\lambda_1\lambda_2} - \frac{\lambda_5 - \lambda_4}{N\lambda_4\lambda_5} \right) J_T \otimes I_K \otimes J_N + \frac{1}{TK} \left( \frac{\lambda_5 - \lambda_6}{N\lambda_5\lambda_6} - \frac{\lambda_2 - \lambda_3}{N\lambda_2\lambda_3} \right) J_{TKN}. \end{aligned}$$

# Variance of Intervention Effect

Using  $\mathbf{R}_i^{-1}$  we can derive a closed-form expression for the variance of the intervention effect

$$\text{var}(\hat{\delta}) = \frac{(\sigma^2 / KN) IT \lambda_6 \lambda_3}{(U^2 + ITU - TW - IV) \lambda_6 - (U^2 - IV) \lambda_3},$$

where  $U = \sum_{i=1}^I \sum_{j=1}^T X_{ij}$ ,  $V = \sum_{i=1}^I (\sum_{j=1}^T X_{ij})^2$ , and  $W = \sum_{j=1}^T (\sum_{i=1}^I X_{ij})^2$  are the same design constants used by Hussey and Hughes (2007) and others.

$$\lambda_3 = 1 - \alpha_0 - \alpha_2 + \alpha_1 + N(\alpha_0 - \alpha_1 + (K - 1)(\rho_0 - \rho_1))$$

$$\lambda_6 = 1 - \alpha_0 + (T - 1)(\alpha_2 - \alpha_1) + N(\alpha_0 + (T - 1)\alpha_1 + (K - 1)(\rho_0 + (T - 1)\rho_1))$$

Connection to other design variants:

- 1 Closed-cohort on subcluster level and cross-sectional on participant level ( $\alpha_2 = \alpha_1$ )
- 2 Cross-sectional on subcluster (and participant) level ( $\alpha_2 = \alpha_1 = \rho_1$ )

This expression can be used for each of the three design variants and any type of longitudinal CRT (parallel or crossover designs).



# Design Effect

The variance ratio under a multilevel cluster randomized trial design to individual randomization is

$$\text{design effect} = \frac{I^2 T \lambda_6 \lambda_3}{4(U^2 + ITU - TW - IV)\lambda_6 - 4(U^2 - IV)\lambda_3}.$$

$$\lambda_3 = 1 - \alpha_0 - \alpha_2 + \alpha_1 + N(\alpha_0 - \alpha_1 + (K - 1)(\rho_0 - \rho_1))$$

$$\lambda_6 = 1 - \alpha_0 + (T - 1)(\alpha_2 - \alpha_1) + N(\alpha_0 + (T - 1)\alpha_1 + (K - 1)(\rho_0 + (T - 1)\rho_1))$$

- Design effect increases with increasing within-period ICCs ( $\alpha_0$  and  $\rho_0$ ).
- Design effect *typically* increases with decreasing between-period ICCs ( $\alpha_1$ ,  $\rho_1$ , and  $\alpha_2$ ).

# Simulation Study: Overview

To validate our sample size methodology we conducted a simulation study. We assumed design variant (B), closed-cohort on the subcluster level and cross-sectional at the individual level ( $\alpha_1 = \alpha_2$ ).

- Number of clusters,  $I$ , varied between 8 and 30.
- Number of subclusters,  $K$ , varied between 2 and 6.
- Subcluster sizes,  $N$ , up to 15.
- Number of periods,  $T$ , varied between 4 and 7.
- Standardized effect sizes,  $\delta/\sigma$ , ranged between 0.1 and 0.5 (for Gaussian outcomes).
- Three sets of ICCs representing small and large correlations.

# Simulation Study: Results (n=1000)

$\delta/\sigma$	$\alpha_0$	$\alpha_1$	$\rho_0$	$\rho_1$	$I$	$K$	$N$	$T$	Test Size	Empirical	Predicted
0.1	0.03	0.015	0.0075	0.00375	24	6	15	7	3.6	88.2	85.3
0.1	0.01	0.005	0.0025	0.00125	30	6	15	4	4.3	82.5	82.2
0.2	0.1	0.05	0.025	0.0125	24	6	10	4	4.5	85.4	83.3
0.2	0.03	0.015	0.0075	0.00375	15	3	10	6	4.0	81.1	80.9
0.2	0.01	0.005	0.0025	0.00125	10	4	10	6	2.7	79.4	80.2
0.25	0.1	0.05	0.025	0.0125	21	4	10	4	5.2	83.7	84.6
0.25	0.03	0.015	0.0075	0.00375	12	2	10	7	3.5	81.0	80.3
0.25	0.01	0.005	0.0025	0.00125	24	2	8	4	4.1	83.7	84.3
0.35	0.1	0.05	0.025	0.0125	10	3	8	6	1.9	83.6	83.1
0.35	0.03	0.015	0.0075	0.00375	9	3	12	4	2.4	84.3	83.8
0.35	0.01	0.005	0.0025	0.00125	8	3	7	5	1.7	77.7	80.4
0.4	0.1	0.05	0.025	0.0125	18	2	7	4	3.2	87.9	86.2
0.4	0.03	0.015	0.0075	0.00375	8	3	7	5	1.1	84.3	83.9
0.4	0.01	0.005	0.0025	0.00125	15	2	5	4	3.3	81.2	83.3
0.5	0.1	0.05	0.025	0.0125	12	2	4	5	3.2	84.3	82.6
0.5	0.03	0.015	0.0075	0.00375	9	2	8	4	1.8	87.4	85.8

Time effect used in simulation:  $\beta_1 = 0$  with  $\beta_{j+1} - \beta_j = 0.1 \times (0.5)^{j-1}$  for  $j \geq 1$ .

# Application to LIRE Trial

The LIRE trial (Jarvik et al., 2015) randomized 100 clinics consisting of a total of 1700 primary care providers (PCP) over 6 periods.

- Assuming an equal number of PCPs per clinic we have:  $I = 100$ ,  $K = 17$ , and  $T = 6$ .

The outcome of interest was spine-related RVUs, a composite measure of back pain. Assuming an effect size of -0.1 and total variance of 2.5, we are interested in calculating the required number of patients per PCP,  $N$ , to achieve at least 80% power at the 5% nominal test size.

- Using the ICC estimates from the study design, we assume the following:  
 $\alpha_0 = 0.046$ ,  $\alpha_1 = 0.023$ ,  $\rho_0 = 0.040$ ,  $\rho_1 = 0.020$ .
- Using our closed-form expression for  $\text{var}(\hat{\delta})$  and the power formula we found that having 77 participants per PCP,  $N = 77$ , produced 87.5% power.

## Additional extensions include:

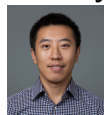
- Non-Gaussian outcomes under a GLMM.
- Unequal cluster sizes.

This work was recently published in *Biometrics Methodology* and is available online: <https://onlinelibrary.wiley.com/doi/10.1111/biom.13596>.

## Future work in this area includes:

- Extending the current methodology to accommodate a decaying correlation structure.
- Open enrollment.

## Thank you to my collaborators:



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Dr. Monica Taljaard, Ottawa Hospital Research Institute

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# References I

- Ford, W. P. and Westgate, P. M. (2020). Maintaining the validity of inference in small-sample stepped wedge cluster randomized trials with binary outcomes when using generalized estimating equations. *Statistics in Medicine*, 39(21):2779–2792.
- Golden, M. R., Kerani, R. P., Stenger, M., Hughes, J. P., Aubin, M., Malinski, C., and Holmes, K. K. (2015). Uptake and population-level impact of expedited partner therapy (ept) on chlamydia trachomatis and neisseria gonorrhoeae: the washington state community-level randomized trial of ept. *PLoS Med*, 12(1):e1001777.
- Graybill, F. A. (1983). Matrices with applications in statistics. *Wadsworth, California, USA*.
- Hooper, R., Teerenstra, S., de Hoop, E., and Eldridge, S. (2016). Sample size calculation for stepped wedge and other longitudinal cluster randomised trials. *Statistics in medicine*, 35(26):4718–4728.
- Hussey, M. A. and Hughes, J. P. (2007). Design and analysis of stepped wedge cluster randomized trials. *Contemporary clinical trials*, 28(2):182–191.
- Jarvik, J. G., Comstock, B. A., James, K. T., Avins, A. L., Bresnahan, B. W., Deyo, R. A., Luetmer, P. H., Friedly, J. L., Meier, E. N., Cherkin, D. C., et al. (2015). Lumbar imaging with reporting of epidemiology (lire)—protocol for a pragmatic cluster randomized trial. *Contemporary clinical trials*, 45:157–163.
- Leiva, R. (2007). Linear discrimination with equicorrelated training vectors. *Journal of multivariate analysis*, 98(2):384–409.

- Taljaard, M., Teerenstra, S., Ivers, N. M., and Fergusson, D. A. (2016). Substantial risks associated with few clusters in cluster randomized and stepped wedge designs. *Clinical Trials*, 13(4):459–463.
- Teerenstra, S., Taljaard, M., Haenen, A., Huis, A., Atsma, F., Rodwell, L., and Hulscher, M. (2019). Sample size calculation for stepped-wedge cluster-randomized trials with more than two levels of clustering. *Clinical Trials*, 16(3):225–236.



**Thank you!**