Post-Intensive Care Unit Care

A Qualitative Analysis of Patient Priorities and Implications for Redesign

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Abstract

Rationale: Although survival during critical illness is improving, little evidence exists to guide post-intensive care unit (ICU) care. Understanding patients' needs and priorities is fundamental to improving care quality.

Objectives: To describe the evolution of patients' priorities for recovery across the spectrum of post-ICU care.

Methods: This was a secondary analysis of 39 semistructured interviews conducted from 2005 to 2006 in participants' homes 19 days to 11 years after hospital discharge after critical illness. Adult critical illness survivors ($N=39$) aged 20 years or older from multiple ICUs across the United Kingdom were purposively selected to maximize diversity with respect to time since diagnosis, disease severity, sex, age, ethnicity, socioeconomic group/status, region, age, ICU admitting diagnoses, and length of stay. We used the method of qualitative description to characterize patients' priorities for recovery and their evolution within and between individual patients across three post-ICU periods: ICU transition to wards, early period (approximately the first 2 mo) after discharge to home, and late period (>2 mo) after discharge to home.

Results: The analysis revealed 12 core patient priorities during recovery: feeling safe, being comfortable, engaging in mobility, participating in self-care, asserting personhood, connecting with people, ensuring family well-being, going home, restoring psychological health, restoring physical health, resuming previous roles and routines, and seeking new life experiences. In general, priorities evolved from those pertaining to basic survival during the stay on wards to being broader and more aspirational by the late postdischarge period.

Conclusions: Understanding patients' priorities for post-ICU care is critical for developing stakeholder-driven clinical guidelines. Engaging other stakeholders (e.g., family members, healthcare providers, and institutionalized and frail older adults) to inform the development of clinical guidelines for post-ICU care, together with the barriers and facilitators faced in achieving patient- and family-centered care, is an important next step.

Keywords: critical care outcomes; patient-centered care; health services research; patient-centered outcomes; stakeholder-driven clinical guidelines

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During the past several decades, critical illness survivorship has steadily increased, a success story that has uncovered systemic problems with post-intensive care unit (ICU) care delivery (1–5). Post-ICU healthcare use is high and costly, with 6-month rehospitalization rates exceeding 35% (6, 7), and outcomes are poor, with long-term functional impairments and reduced health-related quality of life in over 50% of survivors (8, 9). In addition, patients' post-ICU experiences are fraught with challenges, for which they and their family caregivers receive little or no preparation or support.

One key barrier to addressing these problems is the lack of evidence-based, patient-centered guidelines that equip interdisciplinary care teams to develop and execute care plans meeting patients' medical, social, and rehabilitation needs after critical illness. Developing such guidelines will require understanding patients' priorities during recovery. Previous studies of critical illness survivors' experiences focused on the impact of long-term physical and psychological impairments on day-to-day life and sense of self (10–13), or they evaluated healthcare delivery on the wards, in ICU recovery clinics, or in usual care (14–19). None have identified patients' priorities through the entire course of post-ICU care. Accordingly, we sought to characterize patients' priorities during post-ICU care and how they evolved over time.

Methods

We conducted a secondary analysis of data from a national archive of qualitative interviews on health and illness held at the University of Oxford (www.healthtalk.org; see the online supplement for methodologic details) (20). The parent study used maximum variation sampling (21) across clinical and demographic variables to achieve a sample of 39 community-dwelling adult patients at least 20 years old who had previously received care in multiple ICUs across the United Kingdom.

A senior qualitative researcher (S.P.) interviewed participants at home between 2005 and 2006. She initially asked participants to describe their experiences in and after the ICU to generate an oral history focused on the participant's priorities and

concerns (22, 23). She then used an interview guide to probe topics identified through prior interviews, literature review, and communication with the HealthTalk advisory panel. The 1–2-hour interviews were video or audio recorded per participant preference and professionally transcribed.

Qualitative Analysis

We used the method of qualitative description (24, 25), which is an ideal analytic tool for comprehensively describing patients' health-related concerns in a clinically relevant way (26, 27). Two coders with training in critical care medicine (L.P.S.) and occupational therapy (J.S.W.) coded transcripts line by line to identify

similar phrases, patterns, themes, and sequences related to patients' priorities, and then they examined similarities and differences among them (26). We checked emerging codes with other clinicians for clinical relevance. We then independently coded all transcripts, meeting after every five transcripts to resolve differences by consensus and discuss new themes and patterns (28). We did not identify any new themes after the 19th transcript (29). We used ATLAS.ti 8.2 for qualitative data management, and after initial coding, we used Crabtree and Miller's template method (30) to add codes for distinct recovery time periods: transition to the wards, early period after discharge to home, and late period after discharge to home.

Table 1. Participant characteristics

Characteristic	Critical Illness Survivors (N = 39)
Age, yr, mean (SD)	52.6 (13.4)
Age groups, n (%)	
20–29 yr old	1 (2.6%)
30–39 yr old	6 (15.4%)
40–49 yr old	10 (25.6%)
50–59 yr old	8 (20.5%)
60–69 yr old	9 (23.1%)
70–79 yr old	5 (12.8%)
Female sex, n (%)	13 (33%)
White race, n (%)	36 (92%)
Marital status, n (%)	
Single	6 (15.4%)
Married or partnered	29 (74.3%)
Divorced or separated	4 (10.3%)
Reason for ICU admission	
Infectious (sepsis, pneumonia)	14 (35.9%)
Hematology-oncology (cancer, sickle cell)	5 (12.8%)
Cardiac (transplant, heart failure)	4 (10.3%)
Pulmonary (ARDS, asthma, COPD)	3 (7.7%)
Neurologic (aneurysms, Guillain-Barré syndrome)	3 (7.7%)
Trauma	3 (7.7%)
Pregnancy related	2 (5.1%)
Other (rheumatologic)	5 (12.8%)
ICU length of stay (range, 2 d–8 wk; one missing)	
≤2 d	4 (10.3%)
2–5 d	3 (7.7%)
5–14 d	11 (28.2%)
>14 d	20 (51.3%)
Ward length of stay (range, 2 d–5 mo; two missing)	
≤2 d	1 (2.6%)
2–5 d	5 (12.8%)
5–14 d	16 (41.0%)
>14 d	15 (38.5%)
Time from discharge to interview (range, 19 d–11 yr)	
≤2 mo (did not contribute to late postdischarge analysis)	3 (7.7%)
2–12 mo (contributed to analysis of all three time periods)	24 (61.5%)
>12 mo (contributed to analysis of all three time periods)	12 (30.8%)

Definition of abbreviations: ARDS = acute respiratory distress syndrome; COPD = chronic obstructive pulmonary disease; ICU = intensive care unit; SD = standard deviation.

Given the structure of the original interviews in which all participants were asked to describe their entire post-ICU course, data analysis was able to explore themes throughout the episode of care. Specifically, all 39 participants reported on both their time on the wards and early after discharge. In addition, 36 participants, whose interviews occurred more than 2 months after hospital discharge, provided insights into the late postdischarge analysis. Thus, we were able to explore patterns of care preference evolution within and across individuals. Owing to the small number ($n = 4$) who were discharged to a rehabilitation facility, we did not explicitly explore the data for this care context.

Strategies of Rigor

Throughout the parent study, an expert advisory panel of patient representatives, researchers, and ICU clinicians advised investigators (31). The study involved prolonged engagement with diverse perspectives to inform data collection and analysis (a form of triangulation) (29). Participants reviewed and corrected interview transcripts to ensure accuracy (known as “member checking”) (29). Interviewing continued until thematic saturation occurred (32, 33). Codes were not mutually exclusive, thereby reducing the chance of losing important ideas (34).

Results

Maximum variation sampling produced a diverse group of participants (Table 1), including 34 emergency and 5 elective admissions. Participants’ ages ranged from 23 to 76 years. Interviews occurred weeks to years after hospital discharge.

Patients’ Priorities and Evolution over Time

We identified 12 priorities that distinctly evolved across the spectrum of post-ICU care (online supplement). Although they are interrelated and frequently co-occur, we present them roughly in the order that patients tend to first experience them after transfer out of the ICU.

Feeling safe. Patients wanted to know they were being cared for, able to communicate their needs, and have their needs addressed:

“I was very scared because I couldn’t do anything to get anybody’s attention. And [the call bell] was no good to me because I, my hands weren’t strong enough to press it.... So I felt really scared. It was like being kind of bound and gagged.” (35-yr-old woman who survived sepsis)

On the wards, prioritizing feeling safe reflected a basic sense of vulnerability and dependence. After discharge, it related to the risk of relapse and how prepared a patient was for discharge. Several found a sense of safety in having a plan for addressing setbacks (e.g., emergency call bells and on-call home care). Others felt unsafe because they were unprepared to manage

new disabilities at home or lacked a plan for condition-specific complications; for example, one had a chaotic emergency department visit because his tracheostomy tube fell out and he did not know what to do.

Being comfortable. A few patients expressed a desire to avoid ongoing or disabling pain on the wards:

“So, this chest drain.... [E]very time I breathed in was, you know, rubbing on my, between the two ribs and ... I was a bit too stoic and I put up with it for about two days and then ... a doctor came and I burst into tears, which I’d never ever done before.” (43-yr-old woman who survived nephrectomy)

None described comfort as a priority after discharge.

Engaging in mobility. Patients prioritized being able to transfer, sit, stand, walk, take the stairs, and build strength and stamina:

“And [the physiotherapists] were absolutely amazed because I had a [walker], and I said, ‘Right I will have this Zimmer frame on one condition: I am not taking this [walker] out of this hospital. I am going to get walking properly or else I shall be here forever, and I am determined that I shall walk.’” (66-yr-old man who survived acute respiratory distress syndrome)

Focusing on basic mobility was typical on the wards. Early after discharge, patients mostly discussed enhancing mobility as a means of facilitating other priorities (e.g., acquiring the strength and stamina to resume normal roles and routines).

Figure 1. Patient priorities on the wards, early home, and late home organized using Maslow's hierarchy. The pyramid on the left depicts Maslow's hierarchy. The expansion on the right demonstrates the related codes at each time point (wards, early home, and late home).

Participating in self-care. Performing self-care activities such as toileting, eating, dressing, bathing, grooming, cooking, cleaning, using transportation, and sleeping was important to patients:

“[W]hat I needed to achieve to be able to come out was to be able to stand up and walk to the toilet by myself. That became the kind of, the benchmark.” (35-yr-old woman who survived sepsis)

On the wards, participating in self-care was of primary importance and revolved around activities of daily living. Early after discharge, focus shifted to instrumental activities of daily living. Late after discharge, it became aspirational, seeking to build capacity for other goals, such as travel and going back to work.

Resuming normal roles and routines.

Patients aimed to manage a daily routine, engage in leisure activities, fulfill their normal roles in their relationships with friends and family, and go back to work:

“I started beginning to roam around a bit. I mean obviously I couldn’t do what I would say normally do, as far as do-it-yourself jobs and house husbandry and stuff like that....”

Wife: *“And then you suddenly made up your mind you were going to start playing bowls again.... He said, ‘Right I’ll go but I won’t play.’ So then he came but he couldn’t resist it.”* (72-yr-old man who survived heart failure)

On the wards, resuming normal roles and routines focused on leisure activities such as watching television and reading. Early after discharge, patients began to focus on reestablishing daily routines and functioning within their families, and by late after discharge, they wanted a broader sense of being “back to normal.”

Connecting with people. Patients consistently wanted human connections. Some expressed this need by socializing with anyone available (e.g., other patients and clinical staff), whereas others carefully managed time with family and friends:

“I wanted very, very close friends. I would almost say friend and family, that was it. Not many [because I got too tired].” (63-yr-old man who survived immune thrombocytopenic purpura)

On the wards, patients described connecting with people in terms of the need for human contact. They rarely discussed it early after discharge. However, late after discharge, they prioritized

strengthening the relationships that had grown during the experience of critical illness.

Asserting personhood. Patients expressed a need for agency and dignity, feeling respected, setting boundaries, and being empowered to play a role in their recovery:

“[On the wards] I felt myself going downhill—the depression started. Because I wasn’t getting that, well they can’t get individual with everybody.... But I think there’s a lot of things that they can keep a watch on, if someone’s distressed, you know? And then you didn’t get your night drink, which upset me.... I’m lying there waiting for

Table 2. Hypothetical structures, processes, and outcomes of care to incorporate into patient-centered design of post-intensive care unit care to address priorities on wards

Domain	Potential Interventions
Structures of care	
Personnel	<ul style="list-style-type: none"> • Rehabilitation specialists • Family support personnel • Peer navigators (43) • Spiritual care providers
Equipment and facilities	<ul style="list-style-type: none"> • Mobility and self-care equipment • Quiet spaces for rest/decompression • Community spaces for socialization • Recreational equipment (e.g., crafts and puzzles)
Processes of care	
Screening	Change from baseline/ICU admission related to <ul style="list-style-type: none"> • Nutrition and hydration • Pain and discomfort • Physical function • Psychosocial function • Caregiver well-being
Communication	Anticipatory guidance <ul style="list-style-type: none"> • Transition to the wards • Transition to home • Advance care planningValues elicitation and short- and long-term goal setting • Focus up the hierarchy (e.g., love and belonging, self-esteem, and self-actualization) • Unpack what is meaningful about “going home” • Introduce the idea of setting goals around seeking new experiences (38, 44)
Culture change, care planning and treatment	Culture change and care planning <ul style="list-style-type: none"> • Staff training to recognize and respond to unmet priorities • Enhanced opportunities for choice, autonomy, and self-efficacy • Identify and prescribe services, equipment, and medications required for a successful community discharge • Identify personnel responsible for follow-upTreatment • Rehabilitation • Patient and family education and training in rehabilitation and care (45, 46) • Psychiatric medication and peer support
Patient-centered outcomes	
Physical function	Strength, endurance, and self-care
Psychosocial function	Symptoms related to mood and sleep
Caregiver well-being	Frequency and types of social contact
Global health and function	Mood and stress
	Preparation for home caregiving
	Successful community discharge (36)
	Quality of life

Definition of abbreviation: ICU = intensive care unit.

Some of the included elements anticipate priorities that patients describe as occurring later (e.g., screen for psychological function on the wards) because early identification and treatment may support more rapid recovery in multiple domains (e.g., poor motivation resulting from unrecognized depression may reduce participation in rehabilitation). Items in boldface type are novel for the post-ICU context.

my night drink.... I felt that I'd been deprived of everything." (76-yr-old woman who survived pancreatitis)

Asserting personhood was mostly a priority on the wards and late after discharge. On the wards, it involved pushing back against depersonalizing systems issues (e.g., hospital gowns, poorly coordinated care, unresponsiveness to their needs, and exclusion from medical decision making) and policies or attitudes that limited mobility or self-care. Late after discharge, this priority involved the healthcare system and personal relationships. Many called out providers who were late to appointments, canceled follow-up appointments if they did not perceive clear benefits, and advocated for patient-centered care. Some set new boundaries with people who did not support them in the ways they needed (e.g., those who had not visited while they were in the hospital).

Ensuring family well-being. Many patients recognized how critical illness impacted their families and wanted to ensure that family members were okay:

"[I]t's only me and my son and I couldn't afford to ... so we're here [at my brother's]. He was looked after by my mum and my dad and my brother, and my sisters and everybody sort of looked after him." (38-yr-old woman who survived a Crohn's disease exacerbation)

The concern related to the emotional and physical toll of caregiving, as well as the ways families suffered when patients could not fulfill their normal roles. This priority was not common enough to describe temporal trends.

Going home. This desire to go home was nearly universal on the wards:

"My main concern was just to get better and to get out." (45-yr-old man who survived sepsis)

Early after discharge, a small number were living with relatives or had brief stays in rehabilitation facilities and still maintained the goal of going home. All were home by the late discharge period.

Restoring physical health. Patients prioritized achieving and maintaining physical health. They protected themselves from sick contacts, monitored how they felt, took medications, followed medical advice, and advocated for themselves:

"[A]ll the time I was in there really, I had to have aims. I aimed to get off the ventilator by [my wife's] birthday ... and I did it a couple days beforehand. I then aimed

to be off, have the tracheostomy out by then, end of January, which I did, by a couple of days again." (60-yr-old man who survived Guillain-Barré syndrome)

On the wards, patients tracked their progress by their liberation from medical supports such as suctioning, medical devices such as tracheostomies, and proximity to discharge. Early after discharge, they tracked it by how frequently they accessed home health and other postdischarge services and the extent to which ongoing healthcare needs interfered with resuming their normal roles and routines. Late after discharge, several noted backsliding on attempted lifestyle modifications.

Restoring psychological health. Many patients worked hard at restoring their

psychological health, including managing ongoing depression, anxiety, and panic attacks. They sought information and professional help to process what had happened to them, studied their ICU diaries, started personal diaries, and talked things through with family and friends:

"[Y]ou noticed all these other things then, like the lack of concentration and the nightmares and, you know, not being able to be in a room that's full of people.... And once I'd told [the counselor] about things like that, she'd say, 'From talking to other patients, this is what they've experienced.' ... And that kind of reassures you a bit." (41-yr-old woman who survived postpartum sepsis)

On the wards, patients' desire to restore psychological health was often nascent amid

Table 3. Hypothetical structures, processes, and outcomes of care to incorporate into patient-centered design of post-intensive care unit care to address priorities during early postdischarge period

Domain	Potential Interventions
Structures of care	
Personnel	<ul style="list-style-type: none"> ● Rehabilitation specialists ● Home health personnel ● Mental health professionals ● Healthcare providers trained in ICU recovery ● Peer navigators (43) ● Spiritual care providers
Equipment and facilities	<ul style="list-style-type: none"> ● Mobility and self-care equipment ● Exercise equipment and facilities ● Meal support services
Processes of care	
Screening	Trajectory of and resource use related to <ul style="list-style-type: none"> ● Physical function ● Psychosocial function ● Caregiver well-being
Communication	Check in about progress and new issues Follow-up about values and goals: <ul style="list-style-type: none"> ● Determine which goals have been achieved ● Facilitate new goal setting (47, 48) ● Assess need for additional resources to achieve goals
Culture change, care planning and treatment	Culture change and care planning <ul style="list-style-type: none"> ● Continuity/communication between hospital, ICU follow-up, and primary care teams ● Follow-up on care plan items ● Add newly identified priorities to the care plan ● Rehabilitation ● Family engagement and support (45, 46, 49) ● Psychiatric medication, peer support, and/or counseling
Patient-centered outcomes	
Physical function	Improved strength, endurance Independence in self-care
Psychosocial function	Improved mood and sleep Motivation to participate in rehabilitation and other activities (44)
Caregiver well-being	Mood and stress Role function as a caregiver
Global health and function	Reduced healthcare use Quality of life

Definition of abbreviation: ICU = intensive care unit.

Items in boldface type are novel for the post-ICU context.

their emotional distress related to critical illness, hallucinations, and the experiences of hospital life. A few discussed the catharsis of crying or talking with their families early after discharge. However, the greatest urgency to restore psychological health came late after discharge, when some experienced panic in public settings (e.g., pubs and shopping centers) and many took a more active approach to seeking help.

Seeking new experiences. Patients sought a variety of new experiences during recovery from critical illness. Some found meaning by working to transform ICU care or to develop support programs for survivors. Others did something symbolic of moving on: redecorating the house, traveling, or even having a child. Many committed to making every second count by refocusing on family, training in a new career, or living more intentionally or spontaneously:

"I've just applied for a job, actually I've got an interview tomorrow, for going into home care, albeit only part-time at the moment. But I, that's what I want to do, I want to put something back into the community." (45-yr-old man who survived sepsis)

Only one patient, a mental health professional, discussed seeking new experiences while still on the wards; he was already reforming systems of post-ICU care. The patients who sought new experiences early after discharge were in transitions (e.g., retirement or trying to have a baby) or had preexisting plans before they became critically ill. For the remainder, seeking new experiences seemed to be a marker of advanced recovery.

Discussion

In this qualitative analysis, we identified 12 core patient priorities during critical illness recovery and described their evolution over time, from basic survival priorities on the wards (e.g., feeling safe and being comfortable) to active physical recovery early after discharge (e.g., enhancing mobility and self-care) to more holistic and aspirational priorities late after discharge (e.g., resuming normal roles and routines). These results should inform patient-centered guidelines and post-ICU healthcare delivery systems.

Many of the patient priorities address previously reported sources of suffering, providing new insight into what patients perceive to be important during recovery,

such as prioritizing mobility, self-care, and normal roles and routines; feeling safe; going home; and asserting personhood (10–14, 17, 35–37). However, two patient priorities, connecting with people and seeking new experiences, appear to be novel. This may reflect both the diversity of the sample and the timing of the interviews, many of which were conducted several years after critical illness, enabling patients to report on the full trajectory of recovery and to address goals rather than deficits only.

One unique aspect of this study was the ability to examine how patients' priorities evolved over time, up to several years after critical illness (from basic survival priorities on the wards to aspirational priorities in the late postdischarge period), an evolution that recalls Maslow's hierarchy of needs

(Figure 1) (38). Although Maslow's hierarchy has previously been suggested as a theoretical framework to inform holistic patient care within ICUs (39, 40), this study represents its first application to framing post-ICU care continuity, assessment, and interventions.

Patients' priorities may inform post-ICU healthcare delivery 1) by their relevance to patient-centered clinical guidelines and outcome measures (35, 41, 42) and 2) by the types and timing of healthcare services offered to patients recovering from critical illness (Tables 2–4; see online supplement for expanded versions of these tables detailing the relationships of proposed healthcare services to the priorities). Thus, patients need services to address mobility and self-care on the wards and early after

Table 4. Hypothetical structures, processes, and outcomes of care to incorporate into patient-centered design of post-intensive care unit care to address priorities during late postdischarge period

Domain	Potential Interventions
Structures of care	
Personnel	<ul style="list-style-type: none"> • Mental health professionals • Healthcare providers trained in ICU recovery • Primary care providers • Peer navigators and/or support groups (43) • Spiritual care providers
Equipment and facilities	<ul style="list-style-type: none"> • Vocational rehabilitation • Exercise equipment and facilities
Processes of care	
Screening	Outstanding recovery goals and resource needs related to <ul style="list-style-type: none"> • Physical function • Psychosocial function • Caregiver well-being
Communication	Check in about progress and new issues Set maintenance goals for health and function Set aspirational goals for wellness/whole health Culture change and care planning
Culture change, care planning and treatment	<ul style="list-style-type: none"> • Formal discharge/handoff process from post-ICU team to primary care team, including all active elements of the care plan Treatment <ul style="list-style-type: none"> • Rehabilitation • Family engagement and support (45, 46, 49) • Psychiatric medication, peer support, and/or counseling
Patient-centered outcomes	
Physical function	Maintenance of strength, endurance, and self-care Achievement of patient's goals related to physical function (47, 48)
Psychosocial function	Return to baseline mood and sleep Resumption of family roles (50) Participation in broader social life (50)
Caregiver well-being	Mood and stress Resumption of normal family and professional roles
Global health and function	Reduced healthcare use Quality of life Success in seeking new experiences (44)

Definition of abbreviation: ICU = intensive care unit.

Items in boldface type are novel for the post-ICU context.

discharge (12, 15, 17, 18, 41), and they need services to address psychological health later (probably >3 mo after discharge) (12, 15, 18, 19). In general, care processes should be redesigned to foster human connections while balancing safety and autonomy/personhood (3, 14); one promising means of doing so is to engage patients and families as partners in care (46, 51–53). Finally, eliciting patients' priorities may also be useful in assessing where they are in the trajectory of functional recovery and anticipating their needs. Thus, resuming normal roles and routines is characteristic of the active recovery phase, indicating screening for physical, occupational, or psychological therapy needs; alternatively, seeking new experiences may signal the transition to an advanced stage of recovery and functional independence.

This study has several potential limitations. First, secondary analyses of qualitative data typically raise concerns about whether the data can adequately address the study question, the secondary analyst is missing key insights into the data, or the data are out of date (20). In our case, the parent study's purpose aligned closely

with ours; the original researcher is a coauthor of this article; and no new post-ICU interventions have been widely adopted in the past decade to significantly change survivors' experiences (54–57). Second, recall bias is more likely the later the interviews occurred, which would particularly reduce the accuracy of patients' descriptions of how their priorities evolved over time. Although their accounts are detailed and often corroborated in multiple interviews, future studies should consider serial interviews to mitigate this concern. Furthermore, interviewing patients in the late postdischarge period provided novel insights about how patients' priorities evolve over time. Third, study participants did not articulate specific priorities for cognitive recovery or end-of-life care, perhaps because they did not recognize the high risk of these outcomes (58–60). Both deserve further study and integration into the framework. Fourth, different healthcare systems have vastly different organization of post-ICU care delivery. The priorities identified by these post-ICU survivors fit with Maslow's hierarchy supporting the generalizability of

the results across the course of ICU recovery, but they will require confirmation outside the United Kingdom, as well as specification for sites of care not included in the study, such as nursing facilities.

Conclusions

The 12 core priorities of critical illness survivors identified in this study should inform stakeholder-driven clinical guidelines and quality measures for post-ICU care (now in their infancy [41]). Future research should extend these findings among other stakeholders (e.g., family members, healthcare providers, and institutionalized and frail older adults) and determine barriers and facilitators to patient-centered post-ICU care. ■

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