

Models of Post-ICU Clinics



Advances in critical care have shifted the focus from survival alone to enhancing long-term recovery and quality of life for patients and their families. Post-Intensive Care Syndrome (PICS) encompasses persistent physical, cognitive, and psychological problems that emerge after critical illness. To address these issues, several supportive strategies have been developed, including nurse navigators, pulmonary rehabilitation, ICU diaries, peer support groups, and post-ICU (recovery) clinics.

Post-ICU clinics play a central role in identifying and managing PICS symptoms, reviewing ICU experiences, and coordinating multidisciplinary care involving psychiatry, cognitive and physical rehabilitation, and occupational therapy. The first such clinic was established in Reading, UK, in 1993, and similar models now exist in several countries, though their effectiveness remains debated. Evidence ranges from reduced mortality and physical improvement to minimal or even negative impacts on quality of life. Despite this uncertainty, post-ICU clinics are expanding globally, supported by recent position statements from both Dutch and Indian critical care societies.

Building on previous work on post-ICU outcomes, a recent review seeks to inform the creation of a post-ICU clinic in a publicly funded teaching hospital in a low- and middle-income country. While past studies highlight the importance of PICS follow-up, few provide detailed insights into clinic design and operations, particularly in resource-limited settings. Most research has focused on isolated interventions rather than integrated care models. This systematic review examines different post-ICU clinic models, explores barriers and facilitators to implementation, and assesses innovative approaches, such as telemedicine, to support comprehensive, sustainable post-ICU care.

The review included studies published after 2000 that described adult post-ICU clinic models addressing PICS. A comprehensive search identified 19 eligible studies.

Three main post-ICU clinic models were identified: (1) hospital-based in-person visits, (2) hybrid models combining in-person and telehealth consultations, and (3) fully remote models using telehealth or home visits. Attendance was highest in remote models (88.7%), followed by hybrid (59%) and in-person models (51.9%). Key barriers included limited resources, transportation challenges, lack of awareness, inadequate insurance, and weak interdisciplinary coordination. Facilitators included flexible scheduling, early stakeholder engagement, multidisciplinary collaboration, and telehealth use. Hybrid models show promise for low- and middle-income countries by balancing accessibility and comprehensive care, though evidence of clinical benefit, cost-effectiveness, and long-term sustainability remains limited.

The review found that most post-ICU recovery programmes were developed in high-income countries over the past decade, primarily targeting patients at high risk of PICS. Evidence on the effectiveness of these clinics remains mixed: while some studies report short-term improvements in depression and mental health, others show no benefit or even worsened quality of life, as seen in a recent French RCT. Inadequate multidisciplinary input, unrealistic expectations, and the burden of repeated appointments may contribute to these negative findings. Reports from the UK also highlight persistent gaps in psychological and rehabilitation services, emphasising the need for structured, patient-centred recovery models.

Health education for patients and families improves engagement, though timing of follow-up remains critical. Too early can be overwhelming, while too late may delay care. Regular telephonic or hybrid follow-ups enhance participation and confidence, particularly when led by multidisciplinary teams in tertiary or academic hospitals. Attendance remains a universal challenge, but hybrid and telehealth models consistently show better engagement than purely in-person ones. In-person models are often hindered by patient frailty, transportation issues, absence of caregivers, and lack of insurance coverage.

Funding and reimbursement gaps remain major barriers worldwide, limiting the establishment and sustainability of post-ICU services. Even where recovery clinics have expanded, inequities in access to psychological and physical rehabilitation persist. In resource-limited settings, low-

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cost innovations, such as digital “distress thermometers,” web-based follow-up platforms, and telemedicine, offer promising, scalable alternatives, improving accessibility while reducing infrastructure needs. However, telehealth-only approaches can fall short for patients with cognitive impairments and require further validation to ensure comprehensive, multidimensional care.

Common facilitators across studies include strong clinical leadership, multidisciplinary collaboration, administrative support, stakeholder engagement, and advocacy from patient–family groups. Key barriers include limited funding, access inequities, and workforce shortages.

Drawing on insights from this review and local stakeholder feedback, the authors developed a contextually adapted post-ICU care model for a public teaching hospital in a low- and middle-income country. The feasibility and acceptability of this model are being prospectively evaluated.

The review concludes that hybrid post-ICU clinic models provide a balanced, flexible approach to follow-up care, especially effective in low-resource settings. They promote continuity, improve accessibility, and accommodate diverse patient recovery needs. Successful implementation depends on institutional support, multidisciplinary collaboration, and context-specific design. By overcoming structural and logistical barriers and integrating technology-driven solutions, healthcare systems can strengthen survivorship care and reduce the long-term impact of critical illness.

Source: [Critical Care](#)

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