



Potentially Preventable ICU Admissions



As our population continues to age, and as medical conditions become more complex, the need for intensive care unit beds continues to increase. One possible way to ensure adequate capacity is by reducing potentially preventable ICU stays.

Increased demand for critical care services could be managed through improved ICU triage and increased interprofessional ICU staffing. Also, recognising that some patients may not even need, want or benefit from ICU admission is another way of dealing with this growing demand. To date, very little work has been done to explore preventable ICU hospitalisations.

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An analysis was conducted to determine the proportions of ICU admissions that would be considered potentially preventable. Potentially preventable hospitalisations were identified using existing definitions for ambulatory care sensitive conditions (ACSCs) and life-limiting malignancies (LLMs). In the first case, ICU admission could be avoided with timely and appropriate outpatient care and in the second instance, advance care planning and/or earlier palliative care services could help avoid admission to the ICU. Hospitalisations were thus defined as potentially preventable if they included codes for an ACSC (e.g., hypertension, UTI, uncontrolled diabetes etc.), or LLM.

The purpose of elaborating on the types of ICU admissions that could be preventable is important mainly because the gold standard definition of "preventability" of hospital or ICU admission still remains elusive. By understanding preventable mechanisms, it may be possible to set clear targets for policy and care management interventions, and can also more clearly describe the burden of potentially preventable hospitalisations associated with ICUs.

The analysis suggests that ICU-associated hospitalisations with an ACSC has declined over time, but those with an LLM have increased. Overall, the proportion of ICU admissions that may be potentially preventable could range between 16 to 20%. However, this figure may be an underestimation since it does not include potentially preventable admissions for opioid overdose, firearm-related injuries and motor vehicle collisions due to distracted driving or intoxication.

One of the best ways to reduce this preventable burden on ICUs may be through improved triage and care delivery, as well as increased investment in outpatient services that would ensure prevention of such hospitalisations in the first place. Also, data suggests that patients dying with cancer who are admitted to the ICU near the end of life and other seriously ill patients may be offered early palliative care which could in turn reduce ICU admissions and costs, as well as improve patient-and family-centred outcomes. Greater investment in early, outpatient palliative care could thus be an important measure to reduce hospitalisation burden in ICUs.

Source: [Annals of the American Thoracic Society](#)
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