Using Maslow's Hierarchy of Needs as a Framework to Reduce Hospital Readmissions:
The BASES tool

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Abstract

This Master of Leadership Development thesis project is a proposal for a hospital discharge navigation framework known as the BASES tool. The tool is intended to reduce the incidence of 30-day hospital readmission by viewing each patient’s goals at discharge through the lens of the Maslow Hierarchy. This theory asserts that humans possess needs in a particular and predictable order, starting from basic physiological needs to self-actualization. The BASES tool is simple, low cost, and easy to use. It can guide hospital discharge navigators in addressing basic needs that have been shown to be central to successful transitions of care before addressing needs that are more complex.

This thesis discusses the history of the legislation in the United States that led to a focus on hospital readmissions. This focus has raised an acute awareness of the cost, burden, and harm that results when patients return to the hospital too soon. Statistics show that despite great efforts, hospital readmission rates have not decreased significantly in the past ten years; therefore, this writer proposes that a fresh approach to hospital discharge processes are needed. The research presented illustrates the benefits of following Maslow’s framework during the hospital discharge process. It also covers a variety of best practices already employed by other healthcare organizations, calling on their successes in developing the BASES tool. Financial considerations of the tool are provided, along with an analysis of strengths, weaknesses, opportunities, and threats. Lastly, the challenges and practical applications of the tool are presented.
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**List of Terms**

(ACA) Affordable Care Act

(AHRQ) Agency for Healthcare Research and Quality

(BASES) Basic Needs, Avoiding Harm, Social/Family Connection, Esteem/Ego, Self-Actualization Tool

(CABG) coronary artery bypass graft

(CMS) Centers for Medicare and Medicaid Services

(COPD) chronic obstructive pulmonary disease

(HRRP) The Hospital Readmissions Reduction Program

(HSRs) Hospital-Specific Reports

(IOM) Institute of Medicine

(IRB) Institutional Review Board

(SDoH) Social determinants of health

(SES) Socioeconomic status

(THA/TKA) Elective primary total hip arthroplasty and/or total knee arthroplasty

(SWOT) Strengths, Weaknesses, Opportunities, and Threats Analysis
Introduction

Being admitted to the hospital is necessary, but it is expensive, time-consuming, and often unpleasant. Being readmitted soon after discharge only multiplies a patient’s frustration, worry, and confidence in the healthcare system. Readmission to the hospital has been widely recognized as an indicator of poor health system coordination and the Centers for Medicare and Medicaid Services (CMS) publicly reports 30-day readmission rates for selected conditions—namely, heart attack, heart failure, pneumonia, chronic obstructive pulmonary disease (COPD), elective hip or knee replacement, and coronary artery bypass graft (CABG). Reimbursement is linked to how well hospitals manage and limit readmissions among these patients. In general, a hospital readmission occurs when a patient is returned to a hospital for admission relatively soon after being discharged from an earlier (initial) hospitalization. For Medicare, this period is defined as 30 days and includes hospital readmissions to any hospital, not just the hospital at which the patient was originally hospitalized (Centers for Medicare and Medicaid Services, 2020).

Because CMS and other regulatory bodies not only penalize hospitals for excessive readmissions, but also publicly report these inadequacies to stakeholders, reducing readmissions has become a universal priority for payers, providers, and policymakers who seek to improve healthcare and lower associated costs. In recent years, it has become widely accepted and understood that optimal healthcare requires competent management of patients throughout the healthcare continuum. This is done by managing care across inpatient, outpatient, and community settings to avoid unnecessary and expensive overuse of acute care, including readmissions (Clarke et al., 2017). Based on current trends, patient needs, and
regulatory requirements, work to reduce readmissions should be a universal hospital goal and marker of success in the current value-based payment and public reporting environment.

In recent years, greater emphasis, more research, and grant funding have increasingly focused on social determinants of health in efforts to reduce admissions and readmissions. This includes budgeting resources to transitional care models that address needs persisting after discharge such as housing, access to primary care, and support at home. It is theorized and strongly supported that aligning physical needs and social service resources achieves a cost savings while optimizing patient quality of life (National Institutes of Health, n.d.). Nearly all of these studies, grants, and complex models support a central theme: the delivery of transitional care to address whole-person needs is a cornerstone to improving care and reducing costs. This holistic approach to patient care across the continuum is centered on the patient. According to Boutwell et al. (2016), effective transitional care is patient-centered, data-informed, and evidence-based. Discharge planning should be developed in collaboration with the patient, creating a realistic plan, addressing the whole person needs. The plan should not focus merely on the presenting medical issue, but links to community services and follow-up care as well (Boutwell et al., 2016). Effective discharge navigators must identify outside resources to meet patient post-hospital needs and collaborate with these providers to coordinate care. Current researchers and best practice guidelines implore healthcare providers to avoid waiting until a process is “perfect” to implement a discharge navigation program, rather, start now and make progress as the program moves forward (Boutwell et al., 2016).

One of the most predominant and widely known theoretical frameworks guiding healthcare providers is Maslow’s theory of Motivation (Maslow, 1943). In his 1943 groundbreaking work, Abraham Maslow proposed that all humans possess needs in a particular and predictable order. As each level of need is satisfied, the ability and desire to
achieve the next level is actualized. For example, we must achieve the basic needs of food, water, toileting, and clothing before we can consider our need for safety or security. Next comes our need for support and companionship, followed by respect and social recognition. The final stage has been termed “self-actualization”, which indicates fulfillment or purpose. Figure 1 illustrates Maslow’s Hierarchy.

Figure 1

Maslow’s Hierarchy of Need Pyramid

*Note.* Illustration of needs from basic to self-fulfillment. Needs must be realized from the bottom of the pyramid before more advanced needs can be addressed. Reprinted from Simply Psychology, by S. Mcleod, 2020, [https://www.simplypsychology.org/maslow](https://www.simplypsychology.org/maslow). Copyright 2020 by Simply Psychology.
It is important to break down the hierarchy more clearly by giving specific healthcare-related examples for each level of need. For physiological needs, the provider would consider needs such as adequate food intake and access to food and clean water. The provider would also consider housing needs, sleep, ability to access heat in cold weather, clothing, ability to meet basic living expenses, and ability to make follow-up healthcare appointments. For safety needs, the healthcare assessment is twofold. First, one must ensure that the patient is free from harm such as violence and abuse. Second, the provider must assess safety in the home such as access to wheelchair ramps, avoidance of trip hazards such as cords and rugs, and ability to obtain durable medical equipment such as canes, walkers, or wheelchairs. Next, the provider should assess belonging needs by ensuring that the patient has a support person or “coach” who is willing to assist in daily care activities. Providers should also ensure this level is addressed by determining the patient’s social connections and referring him or her to support groups, senior centers, or other forms of social engagement available in the community. Esteem needs may be addressed in the healthcare setting by assisting the patient in setting personalized health goals, enrolling in post-discharge activities as needed, signing up for a class, or assistance in finally stopping that bad health habit. Additionally, esteem needs should be addressed by being acutely aware of the dignity and egoic needs of the patient. This is accomplished by allowing the patient to participate in goal setting, maintaining privacy, acting with respect, and honoring the patient’s wishes even if they clash with those of the provider. Esteem is also reinforced through education that incorporates decision aids and room for patient feedback. For a few select patients, all of the lower needs will be met and the patient may be in a place to achieve the highest level on the hierarchy, self-actualization. In these circumstances, the provider may encourage the patient to share his or her experiences and insight by volunteering to assist other patients who are suffering from
similar illnesses, share experiences online, or through participation in a patient and family input forum.

When considering Maslow’s hierarchy, one recognizes that it is futile to pursue higher-level discharge needs such as exercise programs or complicated self-care regimens if that patient’s basic needs for housing, food, safety, or support system are not met. Hospitals must implement processes to improve patient health and quality of life by equipping all patients with the tools and information needed to successfully manage their transitions of care, starting with the most basic needs and advancing up the pyramid. Hospital revenue, community health, and patient quality of life are dependent on it. Maslow’s Hierarchy of Needs is a highly respected and well-known framework that can be adapted to produce a successful discharge navigation plan. Based on data presented in this paper and the evidence that shows hospital readmissions are still a burden on US hospitals, this project will review, explore, and present best practices in hospital discharge navigation using Maslow’s theories as a foundational framework and discharge-planning tool. This paper aims to lay a foundation for the need to reduce hospital readmissions, establish the role of the whole person in discharge planning, then apply Maslow’s Hierarchy to a discharge navigation tool called BASES. The goal of this tool is to consider patient needs at discharge through the lens of the Maslow Hierarchy by introducing a simple, low cost, easy to use tool for discharge navigators. This tool can be used universally by most providers who assist in discharge planning. The tool operates on the premise that patients who successfully navigate transitions of care must collaborate with providers to address whole-person needs, starting with the most basic physiological needs such as food and housing, then progressing through safety, belonging, esteem, and self-actualization.
Literature review and personal communication that review challenges and best practices for particular patient populations along with care strategies for long-term health improvement will be discussed. The impact on healthcare processes in the future related to the prevention of readmission will be reviewed and finally, the conclusion will summarize the theory and potential for improvement using the BANCES tool.

**Background and Context**

As authorized by the Affordable Care Act (ACA), hospitals are at risk of losing up to three percent of total payments annually for failure to manage and reduce readmissions among the identified conditions mentioned (Centers for Medicare and Medicaid Services, 2020). It is also important to note that Medicare uses an “all-cause” definition of readmission. This means that if a patient, for any reason whatsoever returns to the hospital within 30 days of the initial visit, the visit is reported as a “demerit”. This definition is used in calculating the publicly reported rates both nationally and locally. According to Boccuti (2018), 79 percent of all US hospitals were penalized on some level for excessive readmissions in 2017. This penalty is assessed across all admissions—not just those among Medicare beneficiaries (Boccuti, 2018).

Transparency and emphasis on the quality of patient care arose from the firestorm that was created in 1999 when the Institute of Medicine (IOM) report “To Err Is Human” was published. The authors reported that up to 98,000 hospital deaths every year in the United States were due to medical errors and not patient illness. This created panic among providers, spurred hearings in Congress, and a media firestorm (Donaldson, 2015). This initially caused health care organizations to react defensively; however, over time, America’s healthcare
culture was forever altered as public reporting created much needed transparency and accountability. Soon, the IOM report paved the way for the Patient Safety and Quality Improvement Act of 2005 (Upadhyay et al., 2019). This act was established to improve the safety of patients by providing federal legal protections when hospitals voluntarily report medical errors with the purpose of learning from these events. The information reported is protected from civil and criminal actions. The intention at the federal level is to reduce medical errors through information sharing and participation in root cause analysis in order to bring about a widespread reduction in harm. This is accomplished through the establishment of national patient safety databases that provide resources, statistics, trends, and alerts that all healthcare providers share (Office of Civil Rights, 2017).

These two events laid the groundwork for CMS mandatory reporting requirements (CMS, 2020). Eventually, the Patient Protection and Affordable Care Act (ACA) of 2009 was enacted which required reporting of 30-day readmission rates for certain readmissions on the CMS website. From this, the Hospital Readmission Reduction Program (HRRP) was born (Upadhyay et al., 2019). These public programs were born from a theory that publicly reporting quality measures would increase the transparency of the quality of care that hospitals were delivering, thus, encouraging patients to choose hospitals with higher scores. This would create a competitive marketplace that would incentivize hospitals to reduce costs and improve quality, including readmissions.

A large portion of hospital readmissions appears to be avoidable. They create excessive cost as well as significant setbacks for patients. Frequent hospital returns are an indicator of unnecessary care, inadequate care, poverty, poor education, or lack of community and family support (Auerbach et al., 2016). In 2017, hospital readmission penalties in the United States topped out at a half-billion dollars (Upadhyay et al., 2019).
CMS initiated the Hospital Readmissions Reduction Program (HRRP) on October 1, 2012, as a value-based purchasing program was intended to create hospital incentives to reduce avoidable readmissions by improving communication and care coordination. Section 3025 of the Patient Protection and Affordable Care Act requires a reduction in payments to Inpatient Prospective Payment System hospitals for excess readmissions. Moreover, the 21st Century Cures Act requires CMS to “grade” each hospital’s performance in certain quality measures of readmission against other similar hospitals, public reporting this data online beginning in 2019 (Centers for Medicare and Medicaid Services, 2020).

CMS includes the following six condition or procedure-specific 30-day risk-standardized unplanned readmission measures in the program:

- Acute myocardial infarction (AMI)
- Chronic obstructive pulmonary disease (COPD)
- Heart failure (HF)
- Pneumonia
- Coronary artery bypass graft (CABG) surgery
- Elective primary total hip arthroplasty and/or total knee arthroplasty (THA/TKA)

Reduced payment is calculated based on performance over a rolling three-year period. The reductions apply to all Medicare fee-for-service base operating diagnosis-related group (DRG) payments during the fiscal year. The payment reduction is capped at three percent. Each year, CMS sends out Hospital-Specific Reports (HSRs) to hospitals. After a brief review and correction period, this HRRP data is reported in the Hospital Prospective Payment System Final Rule Supplemental Data File on CMS.gov (Centers for Medicare and Medicaid Services, 2020).
It is significant to note that this data is also reported to the public on the hospitalcompare.gov website.

All of this is done for good reason. CMS recognizes the harm, cost, and labor burden created by hospital readmissions and has created robust incentive measures in an effort to reduce them. This includes linking payment to a readmission measure. CMS reduces payments to hospitals based on a 3-year algorithm. The higher the readmission rates, the more payments are reduced (Centers for Medicare and Medicaid Services, 2020).

According to Bailey et al. (2019), readmission rates have remained relatively flat since 2010, decreasing in some demographics while increasing in others. For example, rates for Medicare patients dropped seven percent during this time while readmissions rates for uninsured patients increased 14 percent. Interestingly, the highest readmission rates noted in 2016 were among Medicare and Medicaid patients under the age of 64 despite the improvement in metrics.

According to Klein (2020), some correctable reasons for readmission include omissions of care, medication errors, failure to anticipate needed home equipment, and lack of adequate family planning for care outside the hospital.

CMS and other leaders recognize that hospital readmissions compound the risk, expense, and burden to patients and the healthcare system as a whole. The current model of healthcare is moving away from acute hospitalization and focusing on healthy patient populations. Clinical caregivers, namely, discharge navigators, are key players in helping patients achieve their highest health potential. Discharge navigators play an integral role in care coordination and disease prevention among at-risk patient populations. Discharge navigators may be nurses, social workers, laypeople, leaders, and even pharmacists. Various studies have concluded that socio-economic, cultural, income and educational barriers contribute to
increased risk for hospital readmissions (Johnson, 2016). Many studies culminate in a need to examine social determinants of health when planning for discharge and guiding the patient to success. For example, in a study by Meddings et al. (2016), patients with higher levels of disability, poverty, reduced access to care, and social support were noted to have higher incidences of readmission. This knowledge presents hospitals with a unique opportunity to address each patient’s transition of care holistically; recognizing that some vulnerable patients must have even their most basic needs address before actualization of health can be achieved.

Maslow’s Hierarchy of Needs is a popular and widely studied model from psychology and provides a framework of interpretation in the enhancement of patient care across the continuum. This principle, created in the 1940s, has withstood the test of time and is still appropriate in healthcare today. Maslow’s work has been foundational to many theories of healthcare and nursing over the past 50 years as it provides a holistic framework for addressing patient needs. Unless we address our patient’s basic needs, we cannot possibly expect these same humans to achieve more complex goals that might prevent another hospital admission. Based on this writer’s research on hospital readmissions, patient studies, and Maslow’s paradigm, a simple, usable, and operational framework for discharge navigators should be created to guide any hospital discharge professional when assisting patients through the transitions of care. This framework will be based on a solid theory of holistic patient care and structured to ensure that patients ready for transition out of the hospital have their most basic needs addressed before advancing to more complex needs.

The role of the discharge navigator as a change agent in promoting empowered patients, fewer readmissions, and better health across the transition continuum is not a new concept; however, in the context of this final project, this writer will view readmission reduction from Maslow’s lens, creating a simple, easy to use tool for discharge navigators.
Problem Statement

Readmission to the hospital within 30 days of initial admission has been widely recognized as an indicator of poor health system coordination. Centers for Medicare and Medicaid Services (CMS) publicly report these 30-day readmission rates and penalizes hospitals for poor performance. Being admitted to the hospital, while necessary, is expensive, time-consuming, and often unpleasant. Being readmitted soon after discharge only multiplies a patient’s frustration, worry, and confidence in the healthcare system. Patients who possess higher levels of disability, poverty, reduced access to care, and social support tend to have higher incidences of readmission and, therefore, a lower quality of life. Unless patients receive intervention to meet their most basic needs, such as food, water, clothing, and safety, they will be unable to acquire the skills needed to reach the optimal health and self-fulfillment required for readmission prevention. A simple and easy to follow discharge navigation tool developed using Maslow’s Hierarchy of Needs framework can be used by any discharge navigator as a guide for successful transitions of care for hospitalized patients in order to optimize patient quality of life and reduce the incidence of hospital readmissions.

Literature Review

The Incidence and Cost of Readmissions

According to Bailey et al. (2019), nine of eighteen principal diagnosis types experienced increasing readmission rates from 2010 to 2016. These included blood diseases, which were 81 percent higher in 2016, followed by neoplasms, which were 28 percent higher. More than one-fourth of the total readmissions were for issues concerning the circulatory and digestive
systems. Areas in which readmissions dropped from 2010 to 2016 were pregnancy/childbirth, which dropped by 74 percent, followed by ear/mastoid process diseases which dropped by 52 percent. Finally, readmissions for musculoskeletal system diseases decreased by 51 percent.

The issue of hospital readmissions is widespread and a concern nationally as well as locally. As an example, this writer’s locality, Vigo County, Indiana, has a rate of all-cause, gender, age, payer, and race readmissions that is slightly higher than the state and national average (CMS, 2020). Many localities across America share similar concerns. Figure 2 illustrates all-cause readmissions in this writer’s locality. These statistics can be accessed from cms.gov. for any region.

**Figure 2**

*All-cause readmissions per 100 admissions across all populations, Vigo County, Indiana, and Nation*

Data from CMS (2020) shows that readmissions are a challenge locally, statewide, and nationally as well.

It is important to note that in 2016, the average readmission cost across any type of principal diagnosis at index admission was almost $2000 more than the initial hospital visit. In fact, 12 of the 18 principal diagnosis types had an average readmission cost that was at least ten percent higher than the average cost of the index admission in 2016. Figure 3 illustrates the average index cost of initial admissions versus readmission for 18 diagnosis types.

Figure 3

Average cost of index and 30-day all-cause readmissions by principal diagnosis at index admission
From 2010 to 2016, readmissions among Medicare patients did decrease by seven percent; however, readmissions among uninsured patients increased by 14 percent (Bailey et al., 2019). This data suggests that hospitals may be targeting Medicare patients due to CMS penalties, but overlooking the negative impacts and costs associated with other patients. What is also interesting is that while readmission rates for Medicare patients did decrease, the actual number of these patients who returned to the hospital within 30 days was two times higher than all other payers (Bailey et al., 2019). Among all payers, the highest jump in readmissions was experienced by non-maternal patients aged 1-20 years, followed by younger Medicaid patients under the age of 64 years. This is a group not commonly known to experience chronic health issues; therefore, this data indicates a growing need to address needs outside the obvious medical concern. Figure 4 illustrates the rate of all-cause readmissions by payer source. Note that despite robust nationwide efforts, the readmission rate for all payers remained relatively flat.
Hospital readmissions are expensive. Not only are patients billed for these extra hospitalizations, but readmission penalties assessed on US hospitals exceeded half a billion dollars in 2017 (Byrnes, 2016). In 2015, Medicare alone spent more than 15 billion dollars on readmissions as one in five elderly beneficiaries returned to the hospital within 30 days, creating penalties for 82% of American hospitals (Wilson, 2019). Avoidance of readmission results in better financial positions for hospitals, who already operate on a thin margin. According to Upadhyay et al. (2019), decreasing readmissions by one percentage point is associated with a $50 increase in operating revenues per patient and a ten percent decrease in...
readmission rates resulted in a one percent overall operating margin.

The cost of readmissions cannot be linked only to the simple act of hospital returns. The entire transition of care from acute, long term, home care, and community transitions of care must be considered. According to Clarke et al. (2017), failure to coordinate transitions from the hospital to other care settings costs our system an estimated $12 billion to $44 billion per year because of negative health outcomes related to issues such as injuries, medication errors, infections, falls, and complications.

Readmissions result in emotional costs as well. A study by Smeraglio et al. (2019) showed that the majority of patients who returned to the hospital felt that the stay could have been avoided if follow-up services had been better organized and education better administered. The same study showed that discharge navigators failed to recognize their role in preventing the readmissions, leading to further emotional frustration by patients and their families. Certainly, a hospital environment that adopts a simple, direct, and effective discharge-planning tool will be more apt to improve patient and staff satisfaction, advance the cause of better whole-person care, and ultimately decrease readmissions.

**Why do Patients Keep Coming Back?**

A literature review of studies performed in the past five years reveals some recurrent trends in both causes and characteristics of readmissions. As previously stated, studies reported by Johnson (2016) state that socio-economic factors such as income, race, gender, and age are solid predictors of a higher risk of readmissions. This issue is compounded by the fact that patients with these socioeconomic concerns are at a higher risk of suffering from the very chronic health conditions that predispose these patients to a quick hospital return such as diabetes, heart disease, stroke, cancer, and hypertension.
Felix et al. (2015) performed a large-scale survey of patients who were readmitted to a hospital in the Southern United States and found that low socioeconomic status (SES) was the largest predictor of readmission. Those with low SES were less apt to discuss concerns with their doctor’s office or the hospital, indicating a need for targeted education concerning self-care and helping this population see the benefit of collaborating with their providers, taking charge of their own health. This group with lower SES was also less likely to fill their prescriptions after discharge, indicating limited resources. The second key discovery was that only 31.3 percent of readmitted patients had seen their primary care physician for follow up after the initial discharge. In many cases, a follow-up appointment had been arranged; however, the average appointment date was 14.5 days post-discharge while the average number of days from discharge to readmission was 12.2 days. It seemed that patients were readmitted before their follow-up physician visit even occurred. Findings from this study suggest that follow physician visits should be arranged before discharge and scheduled sooner rather than later.

A systemic review performed by Newell & Jordan (2015) synthesized patient experience data related to patient and nurse engagement. The study showed that institutions with lower patient satisfaction scores and higher rates of readmissions engaged in nursing communication strategies that were more focused on hospital needs rather than patient and family-focused, creating a gap in patient needs at discharge. In other words, engaging patients as full partners in establishing goals that are pertinent to their own experience will improve the patient experience, reduce readmissions, and reduce harm.

Carter et al. (2019) performed a prospective cohort study of 202 readmitted patients at a Boston hospital between 2012 and 2016 to determine patient perceptions of their reason for readmission. Interestingly, few patients reported an inability to access healthcare after discharge; rather, many stated that they needed more general assistance in order to stay well.
For example, nearly 40 percent of patients who were surveyed after readmission stated that they could not afford their medications or needed more help with activities of daily living while 86 percent of this same group denied having a specific medical need or barrier that precipitated the return to the hospital. Homelessness, minority race, and substance abuse disorder were associated with a risk of readmission. Those patients with two or more unmet needs related to Social determinants of health (SDoH), such as housing, food insecurity, or paying for clothing, experienced a preventable readmission at three times the rate of others. Table 1 describes both crude and adjusted odds ratios of readmission for each of the previously described risk factors.

**Table 1**

*Crude and Adjusted Odds Ratios of Preventable Readmissions among identified risk factors.*

<table>
<thead>
<tr>
<th>Covariate</th>
<th>Crude OR (95% CI)</th>
<th>Adjusted OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td>Non-white</td>
<td>1.75 (0.73-4.19)</td>
<td>1.70 (0.68-4.23)</td>
</tr>
<tr>
<td>Homeless in the last year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td>Yes</td>
<td>2.93 (1.03-8.37)</td>
<td>1.76 (0.54-5.70)</td>
</tr>
<tr>
<td>Substance use disorder history</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td>Yes</td>
<td>2.11 (1.06-4.21)</td>
<td>1.38 (0.72-3.49)</td>
</tr>
<tr>
<td>Problem with at least 2 SDoHs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>Ref</td>
<td>Ref</td>
</tr>
<tr>
<td>Yes</td>
<td>2.55 (1.30-5.00)</td>
<td>2.09 (1.03-4.25)</td>
</tr>
</tbody>
</table>

Abbreviation: SDoH, social determinants of health.

\( ^a \) Adjusted logistic regression models included race, Social determinants of health, homelessness, and substance use disorder history as predictors.

\( ^b \) \( P < .05 \)

This study drives home the need to strengthen nonmedical support during the discharge planning process. It is apparent that for patients who do not have more basic needs met, such as housing and food, a focus on improved social assistance would positively influence their rates of readmission.

In an observational study of over 1000 readmitted patients between 2012 and 2013, Auerbach et al. (2016) found that 27 percent of hospital readmissions could have been avoided. Factors leading to preventable readmissions included emergency department decision making regarding the readmission, failure to communicate with the next provider of care, discharge of patients too soon, and lack of patient and family discussions about care goals. Other factors that affected readmission rates included an inability to keep appointments after discharge and patient lack of awareness of whom to contact after discharge. The study concluded that caregivers should place a high priority on improving communication with patients, families, and the next provider of care. Staff should ensure that patients have the knowledge and tools needed for self-care while also ensuring each patient has a robust support system.

A meta-analysis performed by Braet et al. (2016) found that hospital readmissions are reduced among patients who encounter interventions that involve transitions of care from the hospital to home. What’s more, actions that empower the patient by placing him or her at the center of the discharge plan and assisting in goal setting that is realistic and relevant to the
patient’s perception of need were seen as pivotal to success. The study emphasizes the benefit of patient empowerment in the reduction of readmissions.

A meta-analysis performed by Boccuti (2018) shows that readmission rates rise among patients who are poor or receive government assistance for healthcare. The study confirmed that socioeconomic struggles such as lack of transportation, access to food, and lack of assistance in activities of daily living were contributors to readmission among this population. Congress and CMS have recently suggested a revision in readmission penalties based on “peer group” comparison as it has been suggested that the current readmission program is unfair to hospitals that serve a greater proportion of patients with socioeconomic struggles (Boccuti, 2018). While this approach may alleviate some hospital financial penalties in the short term, it does not address the deeply rooted issues that surround the unmet basic needs of some of the most vulnerable populations in hospitals today. This writer proposes that addressing the needs of each patient from simple to advanced, bringing in support systems, understanding the main drivers for the patient, and achievement of realistic and measurable goals are strategies that will create a positive change in this population. Figure 5 summarizes many causes of readmissions based on the presented literature review.
Note. Overlapping factors.

**Best Practices in Preventing Readmissions**

In a qualitative systemic review aimed at determining the most effective methods of patient influence toward health independence, Truglio-Londrigan et al. (2012) consider the shared decision-making model to be most efficacious in eliciting positive patient health results. This model is preferable to the paternalistic style of information sharing where it is implied that the nurse or doctor knows best. The study claims that this shared decision-making model is also superior even to an informed decision-making model because valuable input from the provider is often lost in this process. The study authors define shared decision
making as the process in which patients and their caregivers jointly share responsibility in knowledge exchange and even negotiating treatment decisions. In this model, at least two participants must be actively involved; however, the family may also play a role as coach or advisor. Optimal shared decision making requires the patient and provider to find middle ground in setting realistic goals that are attainable for the patient while the provider also assumes responsibility for ensuring that the patient is given the tools and information he or she needs to make good decisions. The study did reveal some inconsistencies in this decision-making model. First, patient success with shared decision making varied based on age, culture, and socioeconomic status. The authors caution that each case and each patient should be evaluated for their readiness to learn and ability to take in knowledge. Moreover, shared decision-making may not be as effective in vague situations where a clear assessment is difficult to make. Ideally, the provider can clearly deliver information in a manner that is easily understood by a patient who is receptive to learning and participating in the plan of care so that both parties become mutual partners. When these conditions are met, optimal outcomes are derived from the shared decision-making model. Figure 6 is an illustration of the three components of shared decision-making. First, trust and respect are achieved between the patient and caregiver when truthful information is exchanged and the relationship is established. Next, the work toward shared decision-making occurs as accurate assessments are made along with solid teaching and learning. Finally, the trust, information, and mutual decisions achieved then culminate in either action or inaction by the patient, returning to the caregiver for feedback as needed.
Figure 6

Illustration of a shared decision-making model

Note. Three components of the shared decision-making model. Reprinted from The Open Nursing Journal, by Truglio-Londrigan & Slyer, 2018,
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5806202/, Copyright 2018 by Truglio-Londrigan and Slyer, 2018

In a longitudinal experimental study of older adults experiencing transitions in primary healthcare, Dantas et al. (2020) found that subjects who received multidimensional health
interventions such as social assistance, education, and coaching saw statistical improvements in physical functioning, depressive symptoms, and general health perceptions versus the control group. While this study did not measure readmissions specifically, it is still a significant review in that it supports the notion that holistic discharge targeted at the achievement of basic to advanced needs using education, goal setting, and consideration of social issues will result in fewer readmissions.

In a review by Corbett et al. (2020), researchers concluded that taking a structured approach to discharge planning resulted in less confusion among patients and ultimately fewer hospital admissions. The study used a process called “CHAT&PLAN” as the theoretical framework but asserted that the key to success was to use a person-centered approach and set mutually agreed-upon goals, placing the patient’s priorities as the focus by creating a structured conversation that is scripted from the designated framework. Study researchers did express some concerns that using a process such as this would take extra staff time; however, it was concluded that staff education on the topic along with the usefulness of the exercise would result in pleasing patient outcomes, creating a positive return on investment.

To reiterate and support previously cited literature, yet another study by Coronado-Vázquez et al. (2020) found evidence to support the effectiveness of both shared decision making and structured decision aids when providing education or counseling to patients during the discharge process. Another study on decision aids found that it only took an average of 2.6 extra minutes to introduce a pamphlet, chart, video, or other decision tools; however, participants who were given these decision aids rated their knowledge level and comfort with decision making as significantly higher than the control group (Stacey et al., 2017). The study was limited, however, in that the patient sample was not representative of all patient populations.
Motivational Initiatives to Reduce Readmissions

Berenson & Rice (2015) assert in their study that as our society has become increasingly consumer-driven and focused on immediate gratification, patient demands in healthcare have also changed. Direct medical advertising and competition among providers have created a culture that insists on the overuse of services and care that utilizes the latest technology, rather than simple assessment techniques to address customer needs. This culture of healthcare then produces patients who look for someone to blame when outcomes do not meet expectations. This issue, in turn, creates a culture of physicians who practice “defensive medicine,” driven by fear of lawsuits and fear of poor public reporting. The study authors assert that a “more is better” healthcare environment breeds overuse and higher readmission rates. Again, this trend can be tempered with a discharge navigation program that places the patient and family, not in the driver’s seat, but as co-pilots along with the provider. One important intervention that could temper the overuse of healthcare services, improve patient quality of life, and reduce readmissions all at the same time is the implementation of palliative care for those patients who meet criteria. Patients who have been diagnosed with a serious, chronic illness along with a significant decline in overall health can qualify for palliative care (Mittelberger, 2020). These patients are not required to refuse treatment or embrace comfort care only, rather, palliative care focuses on quality of life and limiting unnecessary treatments so that the time left for patients is meaningful. In a study of over 1500 patients performed by Ranganathan et al. (2013), those discharged to home health care had nearly double the readmission rates than those who were discharged to palliative care (9.0=1% versus 17.2%). As humans live longer and with more chronic illness, the need to embrace palliative care has never been greater. Discharge navigation tools would do well to identify those who would benefit from palliative care and encourage its utilization.
In their highly regarded work, the Agency for Healthcare Research and Quality (AHRQ) in collaboration with CMS, Boutwell et al. (2016) outlines some best practices in preventing readmissions. These include implementation of whole person discharge assessments, feasible goal setting, ensuring timely follow-up physician appointments, and engaging in post-discharge phone calls. One particular best practice of note by the authors is the transmission of the patient hospital record to the next level of care at discharge. This action seems simple but sadly, it is not common practice. Patients undergo new treatments, are given a new diagnosis, and are prescribed new medications while in the hospital. If this pivotal information is not passed on to the next provider of care, key information may fall through the cracks. This action can be easily achieved via many electronic information-sharing formats, via fax, or even by allowing the patient to take a copy of their record with them at discharge to share at their appointment.

Meta-analysis performed by Clarke et al. (2017) shows that readmissions are reduced when hospitals employ a transitional care coordinator model such as a discharge coach, coordinator, or navigator. This person leads the plan of care, directs education, and points the patient or family in the direction of needed services in the community. The study also supports other successful strategies previously mentioned in this paper such as communication of patient medical information to the next provider of care, identification of family or social support person, timely follow-up appointments, and follow-up phone calls.

Studies Addressing Basic Need Requirements

In a study conducted by Kreuter et al. (2016), patients who were identified to have multiple unmet basic needs or money needs were more compliant with follow-up health
appointments when discharge navigators intervened in a hands-on manner as opposed to simple verbal instructions or written information by mail.

In general, humans tend to orient their minds and needs toward unmet needs. Research studies have shown that unmet basic needs contribute to poor decision making. For example, hungry test subjects were more likely to focus on food-related words than other subjects who were not hungry. Simulating poverty conditions created test subjects who had a lower ability to manage their behavior (Thompson et al., 2015). Other studies have shown that people who have achieved higher levels of actualization are far more likely to behave in ways that promote health than those who have unmet basic needs (Thompson et al., 2015). Yet another study determined that study participants’ experience of stress and forgetfulness was directly proportionate to their number of unmet basic needs (Cappelletti et al., 2015). In other words, the more basic needs that go unmet, the higher the perception of stress and thus, the more forgetful a person becomes. These studies suggest that assisting patients with their basic needs will create a positive effect, allowing them to increase their mental capacity for learning and goal setting.

Literature Support for Maslow’s Hierarchy of Needs

Maslow (1943) describes human beings as a perpetually wanting animal, meaning that the most prominent goal will take over a man or woman’s consciousness until the need is filled. Less prominent desires tend to become minimized until the most urgent need is filled. It is then that the next higher need re-emerges and in turn, dominates the person by taking center stage. Maslow asserted that human needs could be likened to a chronically hungry man:

“It is quite true that man lives by bread alone—when there is no bread. But what happens to man’s desires when there is plenty of bread and when his belly is chronically filled? At once
other (and “higher”) needs emerge and these, rather than physiological hungers, dominate the organism. And when these needs in turn are satisfied, again new, (and still “higher”) needs emerge and so on” (Maslow, 1943, p.375)

It is interesting to note Maslow’s assertion that satisfied needs are not a motivator among humans. It is those same unmet needs that will push a person toward the next level of achievement. This concept should be utilized when formulating a discharge-planning tool because patients are more apt to be motivated to succeed when they focus on goals that they have personally identified as being prominent unmet needs in their life.

The principal concepts of Maslow’s Hierarchy of Needs have applications in a variety of fields, particularly healthcare. The hierarchy has been proven in several historical and recent studies to demonstrate usefulness in improving patient care. For example, one group of researchers was able to apply Maslow’s framework to treat pain and shortness of breath among hospice patients (Zalenski & Raspa, 2014). Another study showed that nurses who applied the Maslow scheme when assessing patients at high risk for falls saw in decline in patient harm (Abraham, 2011). The framework also allowed researchers studying the special needs of older people in emergency rooms to see that the primary focus of these patients during an emergency room visit was safety and basic needs, not higher needs (Nydén et al., 2003). In a study performed by Bayoumi (2011), it was ascertained that among hemodialysis patients, the Maslow framework was useful in determining that overall, this group values self-esteem and dignity over love and belonging. Finally, a riveting study by Jackson et al. (2016) recognized the usefulness of Maslow’s hierarchy when caring for critically ill intensive care patients. The study concluded that basic needs during the acute phase of illness were most important, but as patients recovered, the issues common to survivorship, cognitive delay, and the prospect of long-term complications created other concerns and Maslow’s
framework was pivotal in providing insight. Figure 7 summarizes the researcher’s conclusion on how Maslow’s Hierarchy applies to intensive care patients.

**Figure 7**

*Summation of Maslow’s Hierarchy applied to critical care*

![Diagram of Maslow's Hierarchy in Critical Care](image)


An evidence-based article by Silton et al. (2015) demonstrates how Maslow’s theory can be integrated with attachment theory and evolutionary threat assessment systems theory to create a theoretical framework related to human motivation. The integration of these theories along with evidence allowed the researchers to conclude that at times, patients might make higher-order needs a priority over lower needs. The researchers remind us that healthcare providers must ask the patient about his or her perceived needs as many times the provider’s
viewpoint of needs may be completely different from the patient’s primary goals. As previously discussed, the study performed by Nydén et al. (2003) is an excellent example. One would expect that the emergency room patients in the study would perceive their primary need to be related to the illness that brought them to the emergency room to start with; however, most expressed a need for safety instead.

Burton (2020) reminds us that Maslow considered the four lower needs such as food, shelter, safety, intimacy, ego, and connection as “deficiency” needs because if left unmet, humans will become anxious and obsessed with meeting the need. Conversely, the fifth and final level in the hierarchy is considered a “growth” need because self-actualization inspires one to fulfill a life purpose or achieve true potential. A person who has met deficiency needs will then have the life energy to refocus his or her anxiety to self-actualization, shifting from survival mode to an expanded awareness. The authors also assert that only a minority of humans ever reach true self-actualization. This process requires uncommon human qualities such as courage, creativity, and independence. Furthermore, in his 1970 publication, Maslow himself claimed that only about two percent of humans would ever reach actualization (Maslow, 1970).

Mcleod (2020) reports that Maslow revised his initial statements in 1987 and clarified that completing a hierarchical level of need is not necessarily an “all or nothing” construct. Instead, a need can be “more or less” satisfied and the anxiety will dissipate so that habits and needs will become focused on the next or higher levels of need. This information contributes to this project as it helps to understand that in many cases, lower-level needs might be salient and the hierarchy is not as ‘black and white” as previously assumed. In his 1970 book, Maslow studied several people that he considered to be self-actualized, which included
Abraham Lincoln and Albert Einstein. Table 2 illustrates the characteristics of self-actualized people as well as behaviors that lead to self-actualization according to Maslow.

Table 2

*Characteristics of self-actualized people and behaviors that lead to self-actualization*

<table>
<thead>
<tr>
<th>Behavior that leads to self-actualization</th>
<th>Traits of Self-Actualized People</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willing to have a child-like fascination with life with full concentration</td>
<td>Tolerance for uncertainty</td>
</tr>
<tr>
<td>Trying new things instead of sticking to safe paths</td>
<td>Self-acceptance</td>
</tr>
<tr>
<td>Listening to true feelings in evaluating experiences instead of tradition, authority, or majority</td>
<td>Spontaneous thoughts and actions, unusual sense of humor</td>
</tr>
<tr>
<td>Avoiding pretense by living honestly</td>
<td>Problem centered as opposed to self-centered</td>
</tr>
<tr>
<td>Being comfortable with being unpopular if views conflict with the majority</td>
<td>Able to see life objectively</td>
</tr>
<tr>
<td>Being responsible and hard-working</td>
<td>Creative; resistant to enculturation</td>
</tr>
<tr>
<td>Identifying defenses and having the courage to release them.</td>
<td>Democratic in attitude; strong moral and ethical standards</td>
</tr>
<tr>
<td></td>
<td>Need for privacy</td>
</tr>
<tr>
<td></td>
<td>Possess a deep appreciation of basic life-experiences as well as peak experiences</td>
</tr>
<tr>
<td></td>
<td>Establish deep satisfying interpersonal relationships with a few people</td>
</tr>
<tr>
<td></td>
<td>Deep concern for the welfare of others and humanity</td>
</tr>
</tbody>
</table>
Looking at Maslow’s Theory with a Critical Eye

One group of researchers analyzed survey responses of 60,000 participants over five years on questions related to Maslow’s six needs; basic, safety, love and support, achievement, and autonomy. The same subjects also performed a self-assessment of positive feelings, negative feelings, and life as a whole. The results confirmed the notion that these basic human needs exist universally regardless of cultural differences; however, the order of needs differed among various cultural viewpoints (Mcleod, 2020).

One must question Maslow’s sampling methodology of Maslow’s analysis of 18 people whom he identified as self-actualized (Maslow, 1970). Most of these subjects (such as Thomas Jefferson, Beethoven, Aldous Huxley, and Albert Einstein) were white, male, and well educated. Only two women were included in his sample, Eleanor Roosevelt and Mother Theresa. It is challenging to generalize the characteristics of self-actualized people across all genders, ethnicities, and cultures. When viewing Maslow’s assertion that lower needs must be satisfied before a person can address higher needs, one must consider third world cultures where poverty and famine are commonplace, but higher needs such as love, belonging, and esteem must surely exist among some people. Furthermore, some of the most famous self-actualized humans such as Van Goh and Mother Theresa lived in relative poverty but achieved great actualization. This information will assist this writer in understanding that there is no “one size fits all” definition of need; therefore, individualized holistic assessment of each patient is essential to positive patient outcomes.
Geller (1982) argued that people in western cultures experience relatively little hunger or homelessness, yet divorce rates, cynicism, boredom, and despair run rampant and suicide rates are highest among those with higher social status and wages than those with lower incomes. Furthermore, Twenge et al. (2017) report that the suicide rate among Caucasians in the United States is twice the rate of minorities and there is evidence that narcissism is growing in America, not self-actualization. One might expect people who are well fed, well dressed, living in sturdy homes, employed, and money in their pockets to be striving for transcendence, altruism, and service. This writer proposes that the experience of injustice, suffering, resentments, and relational struggles might stifle the progress of those who may otherwise achieve actualization; however, it is not the experience of suffering that has the greatest effect, but the person’s reaction and response to the suffering. In other words, one’s perception of need is more powerful than the presence or absence of need itself in some instances. In understanding this concept, healthcare providers must be acutely aware of the patient’s perceptions of their need might be equally or even more important than the actual need itself.

The BASES Project: Approaches Based on Research

The problem statement, expressed earlier in this paper, identified that hospital readmission is an indicator of poor health, is costly, and unpleasant for patients. It also identified that patients, because they progress through a series of progressive achievements based on need, cannot adequately manage complex health treatments, absorb detailed education, or make significant lifestyle modifications if their more basic needs are not met for the most part. Previously cited research has established that patients who experience need or deficiency at the lower end of the hierarchy are statistically more likely to be readmitted to the hospital (Meddings et al., 2016). Furthermore, the research shows that many of these readmissions are
triggered by socioeconomic factors, poor communication, lack of follow-up, and absence of support rather than the illness itself (Klein, 2020). Because national hospital readmission rates have not declined significantly in the last ten years despite aggressive efforts (Bailey et al., 2019), it is apparent that a new approach to discharge navigation should be considered.

The creation of a simple and low-cost discharge navigation tool that is evidence-based, using Maslow’s Hierarchy as an operational framework, will focus on the most pressing needs of the patient first. This tool will guide a discharge navigator systematically, directing the patient’s needs from basic to more complex, identifying the most pressing need that should be met before moving forward. A simple and easy to follow discharge navigation tool developed using Maslow’s Hierarchy of Needs framework can be used by any discharge navigator as a guide for successful transitions of care for hospitalized patients in order to optimize patient quality of life and reduce the incidence of hospital readmissions. Figure 8 below contains a BASES tool infographic, providing a high-level outline of the tool and its methodology. Appendix A contains the BASES tool itself. It should be clarified that the tool presented in this paper will direct the navigator to make referrals for appropriate services based on identified need; however, each program must create its own process for specific referrals since every community is unique in its availability of resources. The BASES tool is a starting point to assist a provider in identifying the most pressing needs, not a list of specific methods of assistance. For illustrative purposes, some best practices in resource solutions will be presented later in the paper. From the evidence collected, the BASES tool will address ten key action items as a part of the discharge navigation program. These key items are incorporated into the BASES tool under the appropriate hierarchy level.
Figure 8

BASES Tool Infographic

Basic Needs are a Priority

As stated many times in this paper, providers must make basic needs an identified priority. Patients who do not have enough food or a warm place to sleep will not absorb education regarding their illness. Patients who cannot pay their electric bills will not fill their costly prescriptions. Those who have no access to transportation will likely not make it to their follow-up physician appointment. In the business of working in a busy healthcare environment, providers may overlook this incredibly simple but profound point. Patients who are identified with a basic need should be referred to appropriate resources in the community. For example, providers at Rush University believe that food and housing are as important as medicine and actually “prescribe” these resources in the electronic medical record (Rush University, 2018). When a patient need is observed through assessment, staff use the electronic medical record to communicate with social service providers, who then match the patient with appropriate assistance in their neighborhood. This hospital is a pioneer in blending technology with good patient communication to address the holistic needs of its patients. While many organizations are not yet sophisticated enough to implement such a program, all hospitals have the ability to reach out to community service organizations when a need is identified. Physiologic needs should be assessed during the basic portion of the BASES tool.

Schedule Post- Discharge Follow-up Appointments within Twelve Days

Evidence shows that follow up appointments made too far from discharge increase the risk of readmission. Patients need to see their provider within 12 days (Felix et al.2015). Another study conducted by Tong et al. (2018) concluded that follow-up visits conducted as early as two days after discharge and up to 22 days after discharge reduced the risk of readmission.
Hospital staff should arrange the appointment before discharge from the hospital to ensure planning is done timely. Follow-up appointment scheduling should be addressed during the social and family support portion of the BASES tool, remembering to consider the patient’s preferences for schedule dates and times.

**Patients and Their Support Persons as Part of the Care Team**

Patients and their families must be treated as a member of the care team, including them in shared decision-making. This is a three-fold process. First, both the provider and patient must agree that a decision about his or her health must be made. Next, the provider must explain the risks, benefits, and alternatives to available treatments. This is accomplished with the assistance of decision aids such as videos, pamphlets, interactive discussion, or reference materials. Finally, the decision must incorporate not only the provider’s point of view but the patient’s as well. This creates a final decision that is informed and mutually agreeable. Note, however, that with this model, providers must recognize that patients might make choices based on values or cultures that differ from the opinion of the provider. These providers must respect the patients’ wishes as long as there is no active wish for harm to self or others. Shared decision-making could occur at any time in the assessment but should be front of mind when providing education in the ego/esteem portion of the tool.

**Consider the Patient’s Perception of Need**

Priority must be placed on the patient’s perception of need, ensuring that their personally identified requirements and goals are addressed, even if the provider does not share the same opinion. This focus allows the patient and provider to find a middle ground. In order to participate in this process, patients or their families must first be unencumbered by control and possess the capacity for action. The medical community often refers to this process as
informed consent (Sedig, 2016). Ask the patient to identify his or her primary need or goal during the ego/esteem portion of the BASES tool.

**Communication to the Next Provider of Care**

Information about the patient’s treatment in the hospital must be communicated to the next provider of care in order to avoid communication gaps. Without essential medical record information, primary care providers or specialists may have no idea about treatments or medications that were implemented in the hospital, increasing the risk of redundancy or gaps in care. Historically, this has been a challenge since each provider uses a multitude of various platforms of communication. One company is changing this dynamic. Epic Systems Corporation has created a product that allows patients to give their providers access to their records through an encrypted internet browser. With this program, patients simply direct their medical records to their providers’ offices and the information can be shared back and forth, creating a dynamic process of knowledge sharing (Arndt, 2017). The program is patient-driven and private practices do not have to have an electronic medical record system to participate since it is web and cloud-based. For hospitals without this luxury, simply faxing the patient’s medical record to the primary physician or sending the patient home with paper copies of their record can be immensely helpful. Ensure this process in place during the social and family portion of the BASES tool.

**Identify a “Coach”**

Before discharge, patients should identify a “coach”. The coach is a friend or family member who will agree to assist and encourage the patient at home and who will participate in hospital teaching or education. Evidence shows that this intervention reduces patient anxiety and risk of readmission (Dantas et al., 2020). It would be disheartening to recover
from a serious illness or surgery, only to have a difficult recovery at home due to a lack of support, reminders, or encouragement. A support coach should participate in the patient’s education and be prepared to assist with activities of daily living as needed. The Joint Replacement Program at Memorial Care, located in Southern California, requires all patients preparing for total knee or hip replacement to choose a coach before surgery (Memorial Care, 2021). Coaches attend pre-operative classes as well as in-hospital education with the patient. The program founders agree that this intervention has created a smoother transition for both coach and patient. Navigators should make a referral for any patient who lacks adequate support as these patients are vulnerable to readmission. Identify the patient’s support network during the social and family portion of the BASES tool.

**Provide a Post-Discharge Contact Number**

Patients should be provided the contact information of someone to call after hospital release for questions or concerns. This can be as complex as a 24-hour call center or as simple as providing the number for the nurse on staff in the medical ward. The primary goal is to provide a contact for the patient so that questions can be addressed or anxieties allayed before the patient makes an unnecessary trip into the Emergency Room. Share this information during the ego/esteem portion of the tool.

**Place a Follow-up Phone Call**

Navigators should follow up with all patients via telephone after discharge to allow time for questions and to ensure the plan of care continues to be implemented. In a study conducted by Harrison et al., (2011), patients who received a discharge follow up phone call within 14 days of discharge were 23.1% less likely to be readmitted than the control group. Hospitals can choose to have their staff perform these phone calls or even hire an outside
company to handle the task. For example, a group of physicians founded a company called TriageLogic in 2007 out of an identified need for this service (TriageLogic, 2020). Customers can employ the company to conduct phone calls or simply purchase software to implement a process in house. Regardless of the method employed, follow up phone calls conducted within 14 days of discharge reduces the risk of readmission. Let the patient and family know during the ego/esteem portion of the tool to expect a follow-up phone call in few days.

Consider Palliative Care for Some Patients

Palliative care should be considered for patients who have been diagnosed with a serious, chronic illness accompanied by a significant decline in overall health. Palliative care is a treatment program in which providers manage symptoms holistically, psychosocial support is a focus, and goals are mutually managed in order to improve the quality of life for those who are suffering from a life-threatening illness. As previously stated, patients discharged to a palliative care program have lower rates of readmission than those who go home to self-care and even lower than those who participate in traditional home health care (Ranganathan et al., 2013). Recent studies indicate that palliative care can reduce hospital admission by forty-eight percent, reducing overall health care costs to society by over 100 billion dollars over the next twenty years (Vossel, 2020). Furthermore, another study shows that patients receiving palliative care reported higher mood and better quality of life than those discharged without the program. These same patients scored higher on an assessment of coping skills than the control group (NCI Staff, 2016). Palliative care reduces uncertainty for patients. The program allows patients to remain comfortable at home, surrounded with familiar objects and cherished loved ones. It maximizes each person’s potential. Palliative Care should be assessed during the self-actualization portion of the BASES tool, as the care will certainly
allow patients to achieve their highest potential in conjunction with their current disease process.

**The Self-Actualized Patient**

Patients who are identified as having reached the level of self-actualization should be encouraged to give back to others by sharing their knowledge, sitting on patient advisory councils, or volunteering to assist others who have experienced similar illnesses or conditions. Refer to Table 2 for traits common in self-actualized people.

**Analysis of the BASES Tool**

**Comparison to other Discharge Navigation Tools**

It has been repeatedly established in this paper that a robust discharge-planning program reduces readmission; however, one must consider other discharge planning tools that might compare to the BASES tool. How are they alike or similar? Has any research been performed to determine their effectiveness? How might the BASES tool achieve superior results or add relevance to current healthcare knowledge?

One tool promoted by the Institute for Healthcare Improvement is the SMART tool (Anne Arundel Medical Center, 2021). The SMART acronym stands for Signs, Medications, Appointments, Results, and Talk with me. The tool focuses on health symptoms, appointments, medication management, and opportunities to discuss concerns. While these topics are all relevant and evidence-based, the tool does not address basic socioeconomic and safety needs as well as other important issues such as palliative care, family and social support, or shared decision making. A literature review did not produce a scientific study confirming the effectiveness of this tool; however, one hospital in Maryland did report an
overall improvement in patient satisfaction and readmissions, stating that the results were modest. The hospital was unable to cite specific statistics to support the claim (Butterfield, 2013).

The most widely known discharge planning guideline is Project RED, produced by researchers at Boston University. Project Red’s current clinical practice guideline is comprised of twelve components that have been shown to improve hospital readmission rates and increase patient satisfaction (Agency for Healthcare Research and Quality, 2020). The 12 components contain many similarities to the BASES design such as education, communication to the next provider, and follow-up phone calls. Its design places an emphasis on identifying the patient’s primary language and ensuring adequate interpretation is obtained. This writer asserts that language identification should be implemented immediately upon entry to the hospital, not waiting until the discharge plan is initiated. It is also important to note that this plan, like the SMART plan, does not first address the basic physiologic and safety needs of the patient. The Texas Health Quality Institute conducted a study of the project’s effectiveness at Valley Baptist Medical Center and found that by employing the strategies in the toolkit, overall hospital readmission rates were reduced by over 30% (Markley et al., 2013). Table 3 illustrates the study hospital’s results compared to other hospitals in the region along with the national benchmark at that time.
Table 3

*Comparison of 30-Day Hospital Readmission Rates for subject hospital against regional rates and national benchmarks*

![Graph showing readmission rates over time](image)


The two presented toolkits provide many similarities to the BASES tool, which confirms adherence to evidence-based guidelines. The BASES tool, however, considers needs that are unique to available discharge planning toolkits today. One focus not addressed in the BASES tool is patient language, which this writer asserts would be addressed upon admission. The BASES tool provides distinctive competencies in that it addresses basic human needs, which are components that are foundational to patient success while still incorporating other important metrics. This distinctive competency provides a competitive advantage over other reviewed discharge navigation tools.
Key Customers and Stakeholders

More than ninety-five percent of hospitals in the United States participate in the Medicare and Medicaid program since nearly sixty percent of all patients are covered by these plans (Dunn & Becker, 2015). Even more, CMS oversees rules and regulations for government payers and requires all participating hospitals to create a discharge planning process for all patients according to its Conditions of Participation (CMS, 2020). Less than a year ago, the CMS rules for discharge planning were revised and hospitals are now required to include access to medical records, a focus on patient goals, post-discharge follow-up care, and inclusion of support persons in the discharge plan (Centers for Medicare and Medicaid Services, 2019). Since the vast majority of hospitals must implement discharge planning and the new CMS requirements have created a need for newer, more progressive plans, the BASES tool is more relevant than ever. The tool incorporates all of the elements of the new requirements while also using solid evidence to address critical patient needs. Key customers and stakeholders would include all hospitals that participate in the Medicare and Medicaid program, specifically, executives and leaders in charge of the discharge planning process.

SWOT Analysis

Some of the identified strengths of the BASES tool includes its focus on holistic patient needs. It does this while still addressing other CMS required components, even meeting recent revision rules.

There are a few identified weaknesses of the tool. First, the tool has not yet been tested in a live patient population. In order to confirm its efficacy, a scientific study is required. The tool provides a foundation for patient assessment, education, and planning; however, it does not provide specific direction for resource referrals. Hospitals with limited resources may
find it difficult to provide adequate resources once needs are identified. Moreover, the tool may be more time consuming than the hurried processes currently employed in many hospitals today. A study of efficacy would require funding and interest from researchers willing to test the tool. Without support from researchers, the tool might not take flight. Additionally, once tested, the tool would require marketing promotion to providers and health systems.

Opportunities for the tool are vast. The tool can change the lens through which healthcare providers see transitions of care, incorporating the whole human into the realm of medicinal care. It has the potential to reduce expenses and improve patient quality of life. Even more, the tool could empower healthcare providers to see more than a disability or illness when addressing patients but understand how social and mental components shape the entire medical picture.

There are a few threats to the tool. Competition among other tools or familiar programs already in use would require assertive persistence on the part of the tool’s sponsor. Furthermore, the tool might lose its competitive edge if not digitized for use in an electronic medical record. Figure 9 illustrates the SWOT analysis for the BASES tool.
Based on this comparison and SWOT analysis, along with an evaluation of key stakeholders, it is clear that the BASES tool has a wide customer base, is relevant to current evidence of prevention of readmission, and it is easy to use. It introduces another layer of consideration when planning care for the patient, using Maslow’s hierarchy to address basic needs before expecting compliance with complex issues. This layer is so simple that it has been often overlooked in medicine. Based on recent changes to CMS rules and the need to reduce costs in medicine, there has never been a better time to introduce this basic but profound concept.
Implementation and Practical Considerations of the BASES Tool

In order to operationalize the BASES tool on an organizational or wider scale, it must be tested. Based on scientific theory, this writer has observed that hospital readmissions are a problem in hospitals today, begging the question, “how can we reduce readmissions?” Next, the hypothesis claims that a discharge navigation tool should incorporate a more holistic approach, using Maslow’s Hierarchy of Need as a framework to address needs that are more basic. Next, the writer predicts that the BASES tool will result in a decrease in overall hospital readmissions. Finally, the tool must be tested to either prove or disprove the prediction, making adjustments and re-testing as needed. The scope of this paper is limited to the presentation and methodology of the BASES tool along with a prediction that the tool will indeed reduce readmission in an acute care setting. A strategy for operationalization is to find an audience through various hospital industry forums, organizations, and gatherings in order to tell the story of the tool, its rationale, and why its implementation will create a positive change in healthcare. The story should include passion and a human element so that the audience makes an emotional connection as well. Many health-related trade organizations have opportunities to create posters, even for virtual events, where products, studies, or other best practices can be shared. This is a perfect way to share the story of the BASES tool to garner support as well. Another step in the operational process is to seek honest feedback on the tool. Having other sets of professional and expert eyes critically evaluating the tool can provide enormous feedback for change or even validation of its potential for success. Feedback can be found among colleagues, industry leaders, and academic experts. Prior to the implementation of a wide-scale study, some smaller organizations may be willing to test the tool using a small test of change. If the results of these smaller studies are encouraging, the chance that funding or sponsorship on a larger scale is greater. These studies would be
operationalized by comparing all-cause readmission rates month over month to confirm stability reliability. Face and content validity would be ensured by submission of the study proposal to the applicable Institutional Review Board (IRB). Predictive validity would be tested as the study progressed, expecting incremental decreases in readmission rates over time. Construct validity would be tested by auditing discharge processes to ensure the tool was being used consistently and appropriately. Once the tool is scientifically tested and proved efficacious, product sponsorship and marketing of the tool to organizations can begin.

Associated Costs of the BASES Tool

The initial physical cost of the BASES tool is simply the cost of the paper on which it is printed. Smaller organizations could simply implement the tool on paper with little to no material cost. Certainly, over time, the tool might be adapted to computer software or electronic medical records and costs would increase to rival other well-adapted tools on the market. The greatest cost consideration should be given to the price of human capital needed to implement the tool. In many organizations, the discharge planning process is hurried. Focus is placed on signing paperwork, making needed arrangements, and giving abbreviated education. Proper implementation of this tool would require staff education prior to the go-live date and allowance for more time with the patient, along with time for follow-up phone calls. The cost savings incurred as readmissions are reduced would theoretically offset the cost of human resources.

To illustrate this point, Terre Haute Regional Hospital in Vigo County, Indiana will be used. According to the 2015 Medicare Cost Report, the last report published by the Hospital, net revenue for Medicare and Medicaid in 2015 was $43,106,000 (Terre Haute Regional Hospital & Indiana State Department of Health, 2015). During this same year, 1.06% of this income was “taken back” from CMS due to readmission penalties, equating to $456,923 (Rau,
2020). The same audited financial report states that the average hospital salary in 2015 was $27.67 and there were 3,879 Medicare and Medicaid admissions during the same time. This writer interviewed the director of Case Management at Terre Haute Regional Hospital who estimated that the current discharge assessment process lasts about 30 minutes. She reviewed the BASES tool and estimated that proper implementation of this plan would require about 20 more minutes at discharge along with approximately 15 more minutes required for each follow-up phone call, for a total of 25 additional minutes of discharge navigation time per patient (K. Hoopingarner, personal communication, January 22, 2021). The data presented indicate that the human resource cost of the BASES tool implementation in 2015 would be $16.14 per patient. At 3,879 patients, the total annual cost would be $62,610. This cost is compared to the annual penalty of $456,923. If the tool implementation were to reduce readmissions by 30%, (the same reduction noted in the Project RED study), the penalty savings would be in excess of $137,000. This savings is more than double the cost of additional human resources and a wise return on investment. A more in-depth cost-benefit analysis might find that implementation of the BASES tool would improve patient satisfaction scores, reduce medical errors, and even improve employee satisfaction. These added benefits would result in other cost savings related to decreased staff turnover and fewer reportable hospital incidents. Investing in good patient care can have a ripple effect even out into the community as patients speak highly of an institution via word of mouth, increasing referrals to the hospital as well. Figure 10 illustrates the comparison of the cost of hospital penalties versus the cost of investing in human capital to implement the BASES tool.
Figure 10

Cost comparison of readmission penalties versus the cost of human capital

Note. Implementation of the tool costs only a fraction of the imposed penalty. Adapted from Terre Haute Regional Hospital, & Indiana State Department of Health, by Indiana.gov, 2015, https://www.in.gov/isdh/files/2015_Terre_Haute_Regional_Hospital_150046_MCR.pdf.

Practical Considerations

As with any human process, the results are only as good as the people who implant the plan. Certainly, those who meet with patients to implement the BASES tool must understand its methodology and have a willingness to implement it with respect for the patient and a belief in the tool’s ultimate purpose. If patients sense insincerity or staff incompetence, the plan will not
be effective. To mitigate these issues, initial staff training must be developed. The education must not only outline details of how to use the tool but relay a sense of humanity so that staff learns to see each patient as they might see their own loved one. When staff connects with each patient on this level, a true sense of connection and shared learning can begin.

Another possible obstacle that might be encountered is that some communities may lack social resources to assist patients when needs are identified. For example, rural communities may not have taxis or other public modes of transportation to assist patients who need help in getting to appointments. When this occurs, staff must learn to brainstorm some creative ideas with the patient, coming up with some solutions that might not have been considered otherwise. In addition, the recognition of these missing community resources is often the first step in creating momentum toward positive community change, involving local political and civic leaders in raising funds or recruiting volunteers for the betterment of the area.

Obstacles are impossible to avoid when starting a new process. No project is perfect, particularly at the outset. The ability to recognize and overcome these obstacles acts to strengthen the resolve of the group and even the process itself as revisions are made that improve outcomes.

**Conclusion: Implications and contributions to knowledge**

Abraham Maslow's theory on the hierarchy of needs asserts that humans are motivated through a hierarchical structure in which the satisfaction of basic needs will propel humans forward toward more complex needs (Maslow, 1943). The presented research, best practices, and creation of the BASES tool illustrate an alternative approach to discharge planning that could reduce the rate of hospital readmissions. More importantly, implementation of the BASES tool can improve the lives of patients by addressing basic human needs as well as
address more complex needs such as esteem, social support, and higher learning. When healthcare providers assist patients in experiencing an improvement in their quality of life and transitions of care, it is only natural to expect an improvement in health that leads to a reduction in hospital returns. This is the essence of healthcare, improving the lives of others. Human health improvement cannot rest solely on physical well-being; rather, one must also address the social, emotional, and spiritual determinants of health in order to achieve sustainable improvement.

The issue of hospital readmission continues to challenge hospitals. These rates have not declined in the past ten years. The BASES tool takes a holistic human approach by adapting Maslow's Hierarchy of Need to create a framework for discharge navigation that addresses basic human needs in sequential steps. The BASES tool ensures that an individualized assessment is performed for each patient, taking into consideration the patient's perceptions, level of need, and social support when creating a discharge plan.

**Practical and Theoretical Implications**

Research shows that poor health status and hospital readmissions are spurred by issues such as poverty, homelessness, lack of social support, and reduced access to physician follow-up (Thompson et al., 2015). This thesis, along with the BASES tool, makes a case for concrete change in the way hospitals approach the patient discharge plan. Using this approach, hospitals might begin to view the patient from more than the physical dimension. On a practical level, the BASES tool can certainly be used in a paper format. As most hospitals have moved to an electronic medical record, the tool can easily be adapted to an electronic format as well. The adaptation could be achieved by creating an interactive document that reflexes a consultation trigger for any “yes” response on the tool. The trigger
would alert the provider to the need to investigate further while also reflexing a notification to social services, case management, or the physician. Implementation of the BASES tool will improve the hospital discharge planning process by guiding caregivers through a holistic assessment of the patient prior to discharge. It will ensure that providers and patients work together in a shared decision-making process to determine the most important needs of the patient, taking action on issues that matter rather than applying “lip service” to goals that are unattainable or unrealistic. The tool recognizes that food, housing, social support, and esteem are as important to health maintenance as physical markers. The work of this thesis strengthens the notion that all humans need to feel safe, cared for, and connected in order to achieve an optimal level of physical health and avoid hospitalization. As the landscape of healthcare continues to evolve, providers must adapt accordingly by implementing processes that empower the patient, reduce costs, and incorporate the entire human phenomenon into the plan of care.
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Appendix A – BASES Discharge Toolkit
## BASES Discharge Navigation Toolkit

**Patient Name:** __________________________________________  **Unit/Room Number:** ____________________

**Date:** __________________________________________  **Navigator:** _______________________________________

<table>
<thead>
<tr>
<th>Skill / Action / Need</th>
<th>Y/N/NA</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sanitized hands for patient safety when interacting with patient care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have adequate access to food and clean water?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have adequate access to shoes and clothing appropriate for the season?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have a satisfactory living or housing situation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the patient able to maintain basic utilities (water, electric, gas)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have access to reliable transportation for follow-up physician appointments?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have the ability to afford prescriptions after discharge?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the patient free from abuse, neglect, or human trafficking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient reside in a safe living situation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient practice safe lifestyle habits by avoiding tobacco, illicit drugs, or excessive alcohol intake?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the patient’s home free of safety hazards? (Ramps to doors as needed, smoke detectors, trip hazards removed).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient have access to needed durable medical equipment to assist with safe activities of daily living, such as a wheelchair, walker, braces, special bed, etc.?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the patient identified a support “coach” who is willing to assist and encourage the patient after discharge?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the coach present for discharge education?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ego, Esteem, and Dignity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the patient able to identify social, family, or community groups in which positive connections are acknowledged?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has a follow up physician appointment been scheduled within 12 days at a date/ time agreed upon by the patient?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Name______________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date and Time______________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Self-Actualization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the patient and coach actively participate in education, including Medications?</td>
</tr>
<tr>
<td>Describe education given</td>
</tr>
<tr>
<td>Was the patient asked to express his or her perceived needs and goals?</td>
</tr>
<tr>
<td>Patient Response______________________________</td>
</tr>
<tr>
<td>Were actions taken in response to the patient’s identified needs and goals?</td>
</tr>
<tr>
<td>Describe______________________________</td>
</tr>
<tr>
<td>Was the patient given a number to call after discharge with questions or concerns?</td>
</tr>
<tr>
<td>Was the patient’s medical record sent to the next provider of care?</td>
</tr>
<tr>
<td>Was the patient informed that someone would be calling within 14 days to follow up?</td>
</tr>
<tr>
<td>Was the patient assessed for palliative care and offered if appropriate?</td>
</tr>
<tr>
<td>Was the patient assessed to determine if he or she is a candidate for volunteer work or appointment to patient and family advisory council?</td>
</tr>
<tr>
<td>Was the patient given information on how to provide a review or feedback on his or her hospital experience?</td>
</tr>
</tbody>
</table>

All “NO” answers must be addressed

- Remember to respect the dignity and viewpoints of the patient regardless of conflicting opinions
- Use decision aides such as videos, pamphlets, research, or smart phone applications when educating and goal setting
- Ensure that the satisfaction of basic needs are a priority prior to discharge

REFERRALS/OBSERVATIONS/COMMENTS