CLINICAL NURSE SPECIALIST TOOLKIT
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CLINICAL NURSE SPECIALIST TOOLKIT
A Guide for the New Clinical Nurse Specialist
Second Edition

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EDITORS

Co-Published With the
National Association of Clinical Nurse Specialists (NACNS)
This book is dedicated to clinical nurse specialists (CNSs) everywhere—those currently practicing in the role, those using CNS knowledge and abilities in other roles, and those no longer in active practice. Once a CNS, always a CNS!
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Preface

This book was initially conceived about 10 years ago by clinical nurse specialists (CNSs) serving on the National Association of Clinical Nurse Specialists (NACNS) Board of Directors. While informally sharing stories of those early years of CNS practice, it became evident that the wisdom embedded in the stories of experienced CNSs should be made available to new CNSs as they begin their professional journey. Regardless of specialty or setting, transitioning to CNS practice brings similar challenges. Experienced CNSs should help ease the way for those following behind. Hence, this book was initially intended as a collection of practical tips and helpful information written by experienced CNSs as advice to new CNSs.

This new edition continues in the tradition of the initial work. It is designed for a new CNS, as well as the more experienced CNS looking for some advice and new ideas. We retained the idea of a toolkit because of the focus on practical guidance for success. Our contributing authors share lessons learned, personal insights, and proven strategies for succeeding in the CNS role from the perspective of experience.

Building on the success of the first edition, this second edition contains updated information and new material addressing current challenges in health care issues faced by CNSs. There is new content addressing evidence-based practice, interprofessional education, and managing a research study or clinical project. And because CNS practice is expanding to new settings with new practice configurations, there is new content on working in outpatient settings and collaborating with physicians in primary care. CNS practice is multifaceted, occurs in the three well-recognized domains of patient/client, nurses/nursing practice and organizations/systems, and serves as a voice of advanced nursing at the bedside and in the boardroom. This toolkit offers advice for success across that broad range of CNS practice.
Preface

As editors, we thank our author contributors for sharing their expertise and personal stories—they made this book the best possible! And we thank our publisher, Margaret Zuccarini at Springer Publishing Company, for her steadfast guidance and patience. And to CNSs everywhere, we wish each of you a long and joyful career as a CNS!

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CHAPTER 19
Facilitating Transitions of Care

PAULA A. O’HEARN ULCH
MARY M. SCHMIDT

If health care settings are islands, the transitions between them are the rolling, foamy waters, waiting to swallow patients up in a sea of uncoordinated care, miscommunication, and service breakdown. Described as vulnerable points of care exchanges with great potential for contributing to unnecessarily high rates of health services use, health care spending, and fragmented care (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011), care transitions are a major focus of health care today. Health care systems are trying to create the ideal boat to ferry the patient safely from one level to the next level of care. Many models of care across the transitions have been created, tested, and proven effective in ensuring safe and successful transitions. In each variation of transitional care, the unifying theme is that transitional care includes: (a) movement of patients within the health care environment and community; (b) a comprehensive care plan; (c) time-limited interventions; (d) patient/family participation; and (e) care coordination.

Transitional care interventions focus on patient need, chronic illness management, and reducing risk for readmission and poor outcomes. Transitional care has been implemented in acute care, focusing on the transitions within hospital environments, the goals of which may include maintaining the patient’s functional status and improving readiness for discharge. Community-based models of transitional care focus on the hand-offs between hospital to home, subacute/rehabilitation facility, or extended care facility. These models may measure readiness for discharge, as well as outcomes such as patient management of chronic illness, partnering with the community providers, information sharing across settings, and readmission reduction. Each model, regardless of setting, is able to be replicated, in pieces or in its entirety, to be implemented to match the needs of the population, location, and organizational goals for transitional care. In 2012, the National Association of Clinical Nurse Specialists (NACNS) created a taskforce to address the clinical nurse specialist (CNS) role in transitional care. The NACNS website (www.nacns.org) provides information on transitional care, including definitions, descriptions of transitional care, and detailed specifics of several models of transitional care.
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ELEMENTS OF TRANSITIONAL CARE

Transitional care cannot succeed without care coordination, which is defined by the American Nurses Association (ANA) as (a) ensuring that patients’ needs and preferences are met over time, respective to health services and information sharing across settings, and (b) the purposeful organization of care activities among the patient and involved providers, for appropriate delivery of health care services (Camicia et al., 2013). As a patient moves within the health care setting, coordinated delivery of care and services among providers (focusing on patient need and participation) promotes seamless, cost-effective, and quality care. Nursing, by virtue of education and proximity to the patient, is the role most suited to lead the coordination effort. The Institute of Medicine (IOM) report, The Future of Nursing: Leading Change and Advancing Health, stated that “care coordination is one of the traditional strengths of the nursing profession, whether in the community or the acute care setting” (IOM, 2011, p. 94).

As the patient moves within the health care system and community, a team approach, facilitated by the CNS, is fundamental for care coordination and transitional care. The collaborative team, comprising the engaged patient and interdisciplinary providers, is an identified central concept in transitional care. As the accountable coordinator, the CNS leads the team and facilitates plan development and implementation. The plan, goals, and follow-up recommendations are communicated to all people involved at both the current and future care settings to avoid gaps or duplication of care. Identified and respected as the center of the transitional care effort, the patient and significant others know who is overseeing the plan as the patient moves in and out of the health care system, the extended care setting, or returns home (Snow et al., 2009).

Education of the patient and health care providers is a key component. Patients, family, and providers experience anxiety during care transitions, resulting from a lack of understanding and preparation for self-care, confusion related to conflicting directions, a sense of disregard for their contribution in the care plan, and no identified health care professional to oversee the transition (Snow et al., 2009). CNS involvement and coordination during care transitions present opportunities for patients and providers to learn from one another while developing a better understanding of, and strategies for, a safe transition, thereby reducing anxiety.

Partnerships, built on mutual trust and respect, are essential for team-based transitional care. These partnerships are multidimensional, including the patient, CNS, health care providers, and supportive community personnel. Each partner is aware of his or her role and trusts that the others own their contribution to the safe transition. Given the opportunity to participate, the patient becomes engaged and supportive of the plan and outcome.

As the speed and complexity of health care increase, even the most straightforward situations may require multiple transitions, between home care services, specialty providers, pharmacies, and durable medical equipment (DME) providers. Therefore, transitional care needs should be assessed in all patients seeking care, regardless of reason or location for meeting with a health care
Facilitating Transitions of Care

Each interface with the health care system presents an opportunity to assess and support the patient’s ability to implement the plan of care, be it surgical recovery, medication changes, management of a new diagnosis, or scheduling follow-up appointments. Each assessment and intervention is targeted at avoiding readmissions and preventing negative outcomes.

The expertise of the CNS lends itself to the care of vulnerable, chronically ill populations at risk for poor outcomes. The CNS role in transitional care focuses on a comprehensive plan of care developed by an interdisciplinary team. The plan is aimed at stabilizing physical health status, and improving the health management and functional ability of complex, vulnerable, chronically ill patients, preventing deterioration and readmission. The centrality of the CNS in transitional care is supported by the NACNS, which adopted the position that the “CNS is educated and prepared to be not only a participant in care coordination but also to partner with other providers in the leadership role for coordination of care transitions” (National Association of Clinical Nurse Specialists [NACNS], 2013).

CNS ROLE IN TRANSITIONS OF CARE

The role of the CNS in transitions of care is described, in the following paragraphs, in terms of plan development, implementation, and systems leadership. Exemplar 19.1 describes the role in its entirety.

**Exemplar 19.1**

Bob is a 71-year-old gentleman, retired and divorced, with frequent hospitalizations due to exacerbation of severe chronic obstructive pulmonary disease (COPD). Complicating his situation is obstructive sleep apnea (OSA), hypertension (HTN), diabetes mellitus (DM), anxiety, and history of sudden death.

He was originally discharged with a referral to Margaret, a clinical nurse specialist (CNS) providing transitional care in the community. At that time he was considered “noncompliant” with his medications and continuous positive airway pressure (CPAP) usage. He was instructed to follow up with his primary care physician (PCP) and pulmonologist, but had not been given direction related to diabetic management, despite the fact he was taking steroids to manage his respiratory status.

In working with Bob, Margaret extended herself in an authentic and caring way to establish a relationship built upon mutual respect and goals. A plan of care was developed, which was reflective not only of his medical needs, but also of Bob’s social and psychosocial needs. Bob’s goal was “symptom management.” He was tired of feeling short of breath and scared all the time. In order to make this happen, (continued)
Margaret needed to address his CPAP usage and respiratory treatment plan. Through expert assessment, it became apparent that Bob thought the mask was uncomfortable. As he didn’t see the purpose for using the CPAP, the discomfort of the mask outweighed using the machine. Margaret worked with the durable medical equipment (DME) provider to have Bob fitted with a different mask and helped Bob to understand the risks/benefits of CPAP use. When that provider did not respond to her requests, Margaret needed to work with Bob’s insurance company to identify an alternate in-network DME provider, and then connected with the new provider, visiting Bob at home to address the issue of the uncomfortable mask and to review CPAP use.

Bob’s anxiety and depression played a significant role in the management of his COPD exacerbation. Through regular inquiry, Margaret explored his openness to scheduled anxiolytics and coached him to advocate for that in the PCP office. As his respiratory status worsened, Bob’s functional status gradually diminished and he became increasingly home bound and isolated. To counter that, Margaret facilitated the pulmonologist’s recognition of this development and a referral to pulmonary rehabilitation. When the order was entered, pulmonary rehab was scheduled at an inconvenient location. Margaret worked the system to have the location changed and Bob was assessed by the pulmonary rehabilitation nurse.

Bob had a positive relationship with his endocrinologist who was a provider in another health system in the city. Margaret was challenged to cross health systems to facilitate communication of Bob’s treatment plan among the PCP, pulmonologist, and endocrinologist in order to establish a collaborative plan of care.

In creating the plan of care with Bob, Margaret discussed end of life planning and treatment wishes. She involved Scott, Bob’s son with whom he lives. Bob has three sons, but Scott helps his dad by assisting with medication management and coordinating appointments.

At one point, Bob’s anxiety and shortness of breath worsened to the point of needing an acute care admission. At this time, Margaret communicated with Sara, the inpatient CNS, to ensure that the plan of care, initiated in the community, would be woven into the inpatient plan. Sara took the hand-off from Margaret and developed an authentic therapeutic relationship with Bob. Sara and Bob reviewed the community-based plan of care to validate continued accuracy specific to his medications, social supports, concerns, goals for self-management, and community barriers/issues. Sara gathered input from the inpatient providers, and revised the plan, tailoring it to the inpatient setting. Bob had not yet had a chance to be enrolled in pulmonary rehabilitation and was vacillating about his decision and willingness to participate. Recognizing the need for quick intervention to foster engagement (before he changed his mind), Sara brought the pulmonary rehabilitation nurse to his bedside to meet Bob and begin incorporating pulmonary rehabilitation services into the plan of care.

In the past, Bob tested positive for methicillin-resistant Staphylococcus aureus (MRSA), which was noted in the medical record along with the need for isolation. This
Exemplar 19.1 (continued)

was problematic for Bob. He was concerned that his strength and functional status was deteriorating while he was isolated in his hospital room for a week. It was up to Sara to question that old lab report—validate the existence of MRSA or request an updated test—and to challenge the “isolation rule” that Bob could not leave his room or to challenge the staff (nursing, therapy) to bring a piece of exercise equipment to his bedside to give Bob a chance to stretch his legs, provide a diversion, ease his mind, and maintain his preadmission level of functioning.

Because Bob’s eating habits in the community were irregular, his diabetes was managed using short-acting insulin. During the hospitalization, he was taking long-acting and short-acting insulin, which controlled his blood sugars. Bob now needed education to prepare for his discharge home. He needed to know how to resume his insulin regimen and how to plan his meals. To better understand Bob’s skill for self-management, Sara inquired about his usual meals, managing his diet and diabetes, and using prednisone. Sara shared this information with the team at daily rounds for planning Bob’s transitional care and to ensure a safe hand-off to the next level of care, in the home.

Upon Bob’s return home, Sara handed the plan of care off to Margaret, reviewing the updated plan, documenting interventions, outcomes met, and outstanding issues. Margaret, upon her initial home visit postdischarge, reviewed the latest iteration of the plan for accuracy and reflectiveness of Bob’s wishes. Recognizing Bob’s concern about the increasing length of his hospital stay, Margaret reviewed Bob’s understanding of his current health status, verifying his goals for health and self-management skills. Based on this discussion, Bob and Margaret mutually developed outcomes and revised the plan of care. As he was again tapering prednisone, Margaret worked with Bob to manage his blood sugars with the short-acting insulin. Originally, Bob’s endocrinology appointment was 6 months from his discharge. Margaret coached Bob on the value of earlier follow-up and facilitated Bob to reschedule the follow-up appointment within 2 weeks after discharge. At this and subsequent provider appointments, Margaret ensured that the plan of care was updated, and that Bob and his physician understood the plan of care.

CNS Role in Plan Development

“A CNS is most likely to care directly for a patient whose diagnosis or care is complex, unique or problematic” (Hamric, Hanson, Tracy, & O’Grady, 2014, p. 370). In becoming involved in the care of patients with a history of discharge failure, whether in the acute care setting or the community, the CNS works to identify the primary reasons for readmission and to alleviate the barriers to success in the community. The expert assessment by the CNS often unearths overlooked details, such as chaotic or unstable housing, knowledge deficits, financial limitations, delivery issues, or repeated failures in transportation, which may explain the patient’s behaviors with greater clarity. The assessment may include depression and cognitive screening, health literacy, and quality
Reaching Out

and reliability of social support, any one of which would impact the patient’s ability to engage in and follow the plan of care.

The plan of care begins with the development of the therapeutic partnership between the CNS and the patient. Incorporating a holistic perspective into crafting the plan of care, the CNS acknowledges the patient’s personhood and need for self-determination. The CNS mentors staff in how to consider and include the patient as a partner in the team, central to coordinated transitional care. Role-modeling advanced communication skills and respect for an open dialogue ensure patient participation and shared decision making in the development of the plan of care. Basing the plan on individual characteristics, needs, and desires facilitates patient engagement and ensures creation of a plan balanced between best practice standardization and the patient’s reality. The ability to personalize his or her own plan of care facilitates the patient’s feelings of empowerment and confidence in his or her ability to develop self-management skills necessary for living with chronic illness.

“Collaboration between a CNS and other health care professionals leads to effective and efficient health care” (Hamric et al., 2014, p. 379). Serving as expert consultant, the CNS shares personal experiences and insights into care coordination while collaborating with providers and staff in the acute care, outpatient, and community settings. The medical component of the plan of care is generated by facilitating multidisciplinary collaboration and providing patient-specific consultation to help the health care providers understand the patient’s willingness, abilities, and limitations to engage with the prescribed plan. The CNS can gather and integrate the insights of many individuals with differing perspectives into the plan of care. For the acute care CNS, this can occur during daily rounds. In the community, the CNS accompanies the patient to select provider appointments to communicate the existing plan and incorporate the providers’ perspectives into plan revision. The plan of care may include mobilizing specialty providers or departments, acute care, or community resources. As a clinical expert, the CNS may intervene by identifying and suggesting creative alternatives to create a successful plan, or by facilitating timely referrals to other members of the multidisciplinary team to achieve outcomes (Hamric et al., 2014). The CNS, with the ability to see the broad perspective and anticipate the disease trajectory, recognizes the need to modify the plan as the patient moves along the trajectory. The elements of the plan must also include the patient’s perspective on end-of-life planning.

Success in a plan of care is dependent on outcomes that are realistic and attainable. It may be the CNS’s role to act as the voice of reason in stressing realistic outcomes; for example, for a patient with diabetes mellitus (DM) who never monitors blood sugars, setting a goal for complete reversal and four-times-daily monitoring is not realistic. Instead, the CNS could propose a goal of twice daily monitoring initially, gradually building up to the preferred four times daily. Setting goals that are attainable and tailored to the patient will increase the patient’s motivation to participate.

The comprehensive plan of care serves as a prescription for the health care team and the patient, and includes information about who is accountable for what aspect of the plan; for example, does the cardiologist or the primary...
care provider (PCP) manage the warfarin? Is the endocrinologist or the PCP managing the DM? The plan also includes discharge elements including next steps in terms of patient/family education, provision of DME, medication changes, and medical follow-up. The CNS ensures that the accountable individual—patient, pharmacy, provider, and so forth—accepts responsibly and follows through accordingly, and that interventions are necessary and effective in achieving outcomes.

A plan of care is effective only if all participating members know the plan. To that end, the CNS puts much effort and time into communicating and ensuring understanding of the transitional plan. Communication must occur among acute care departments, the acute care setting, and all facets of the community with which the patient will interface—provider clinics, the setting to which the patient is being discharged (if not home), home care, and DME agencies. It is common for the CNS to align with the patient in facilitating communication among providers—a confident, informed patient is able to participate in communicating the plan of care. The communication process is much easier with an electronic health record that ties the settings together. The plan that flows between the acute care setting and the community must be made as visible as possible.

**CNS Role in Plan Implementation**

The CNS in transitional care provides ongoing surveillance of the patient, monitoring clinical response to treatment, promoting clinical stability, and ensuring early intervention with developing symptoms. Communicating the clinical response to providers is necessary to update and to revise the patient's plan of care. The CNS coaches nursing staff to include evidence-based interventions in the plan of care and make revisions based on an individual patient situation.

The CNS is actively involved in educating and coaching the patient in how to carry out the plan. By understanding the patient’s motivation for adhering to the plan, the CNS is able to leverage this knowledge to facilitate behavior change and outcomes achievement. The CNS either provides education or facilitates experts (e.g., certified DM educators or pulmonary rehabilitation nurses) to educate the patient.

The CNS uses the partnership with the patient to increase the patient’s confidence and ability in health management, self-advocacy, resource mobilization, and navigation within the health care system. The patient who is confident in heart failure management will contact a provider when there is unanticipated weight gain rather than waiting until additional symptoms develop, resulting in an emergency department visit or avoidable hospitalization. The patient can then incorporate provider instructions into the plan of care (e.g., increase the diuretics for a day or two) and avoid undesirable outcomes (e.g., worsening symptoms and hospitalization).

The holistic assessment, conducted by the CNS, may reveal logistics or system barriers to the plan, such as transportation or parking issues with follow-up appointments, pharmacy prior authorization, or delivery concerns. By identifying the barriers, the CNS is able to work with the patient, provider, and
system to reduce or eliminate barriers. Appreciating the challenge a provider has between schedule constraints and time spent with the patient, the CNS coaches the patient in better understanding of the provider’s role and consults with the provider to prepare for a focused visit, thereby resolving the time issue and resulting in an efficient and effective patient/provider visit.

The building of relationships and partnerships across settings is instrumental for successful transitional care. The CNS uses advanced skills in forming authentic partnerships and is positioned within the health care system and in the community to foster a team approach and connect the points of transition. The CNS uses leadership skills in building a team based on mutual respect, team learning, and professional accountability, as the CNS facilitates understanding of multiple disciplines’ disparate priorities and negotiates alignment of the differing perspectives. “This mediation benefits patients, promotes communication and creates an environment that fosters collaboration” (Hamric et al., 2014, p. 379). Time spent in resource mobilization and community collaboration allows the CNS to assist the patient in identifying supports, informal or formal, that are available to help him or her implement the plan.

The challenge in transitional care is the dynamic nature of the plan of care. Each provider with whom the patient interfaces may revise or update components of the plan. As health conditions change, specific services or necessary follow-up may become less or more frequent; medication regimens are altered. It is essential that all contributors to the plan, including the patient, feel ownership in communicating changes. Equally important is the need for providers to assume responsibility for asking about any recent changes. Written documentation is an effective means to communicate plan changes, allowing the patient to retain and carry this information from provider to provider. When the patient is admitted to the hospital, the plan of care should be reviewed and carried forward from the community, and, upon discharge, the plan is again updated and carried forward from the acute care setting.

CNS Role in Systems Thinking and Leadership

As a leader, the CNS champions opportunities to improve patient care, advance nursing practice, and challenge the health care system to modify current delivery of services. Building on education and clinical expertise, the CNS creates a leadership toolbox, consisting of, for example, diplomatic communication skills, expert consultation, mentorship, role modeling, acting as a change agent, and global awareness. The CNS uses these tools to link disciplines forming collaborative interdisciplinary teams for transitional care.

Transitional care is a critical point in health delivery. With the ability to cross boundaries and see the broad picture, the CNS is positioned to evaluate transitional care, identifying barriers or gaps within the plan or implementation process and challenging the system to solve these issues. The CNS leads the interdisciplinary team in reviewing lessons learned and implementing performance improvement initiatives. Throughout this process, the CNS mentors and empowers team members to own their discipline/specialty’s responsibilities for practice changes to address breakdowns in service and transitional care delivery.
Facilitating Transitions of Care

An essential component of facilitating transitional care is the communication of the plan among patient, provider(s), and community agency personnel. The electronic health record continues to evolve for enhanced communication across a health care system. The development of a platform to communicate the plan and to coordinate care within the health system and community is instrumental for an efficient transitional care process. As the CNS evaluates transitional care and reviews lessons learned, he or she discovers additional information that, in the role of change agent, is useful for the CNS in collaborating with the interdisciplinary team, informatics specialists, and system leaders to solve issues, close gaps, and create a format to communicate a coordinated and realistic plan of care along the care continuum.

The CNS mentors nursing staff to develop and implement a patient-centered plan for transitional care. The CNS role-models behaviors acknowledging the patient as a whole person, rather than simply identifying the reason for admission. The CNS fosters growth of nursing practice as he or she coaches the staff to develop a therapeutic patient partnership and collaborative approach with caregivers for a coordinated plan incorporating the patient’s unique circumstance.

The CNS provides expert consultation to health care and community personnel to bridge the two environments for transitional care. The CNS uses diplomacy when the need for practice change is communicated and team members are challenged to elevate the individual discipline’s participation and accountability for transitional care (Table 19.1).

Health care transitions pose a significant challenge for patients, providers, and health systems. Simply moving from one level of care to another places the patient at risk for fragmentation of care and service. The CNS is an expert in clinical practice, collaboration, consultation, coaching, global thinking, and systems leadership. As a health care leader, the CNS should be in the center of a system’s effort to address care transitions, leading and partnering in the development and implementation of a transitional plan of care.

**TABLE 19.1 Summary of the CNS Role in Facilitating Transitions of Care**

<table>
<thead>
<tr>
<th>Development of the Plan of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish therapeutic partnership with the patient</td>
</tr>
<tr>
<td>Explore patient’s goals and perceptions of health state</td>
</tr>
<tr>
<td>Collaborate with health care team members to incorporate input into the plan</td>
</tr>
<tr>
<td>Explore end of life goals, as appropriate</td>
</tr>
<tr>
<td>Develop realistic and attainable goals</td>
</tr>
<tr>
<td>Identify and communicate individual accountabilities</td>
</tr>
<tr>
<td>Identify next steps for patient/family—follow-up care, medication management, and so on</td>
</tr>
</tbody>
</table>

(continued)
### TABLE 19.1 Summary of the CNS Role in Facilitating Transitions of Care (continued)

**Communication of the Plan of Care**
- Written plan, computerized
- Provide the patient with a copy of the plan
- All health care team members have a copy of the plan
- Attending rounds, office visits, community visits

**Implementation of the Plan of Care**
- Surveillance of patient: Clinical stability, response to treatment, self-health management
- Communication of patient response, assuring early intervention
- Education and coaching in carrying out the plan of care
- Explore patient’s motivation in order to facilitate behavior change
- Role model and coach advocacy behaviors, building patient confidence and skill
- Identify system, logistical, or patient barriers to plan success
- Intervene to reduce barriers
- Mobilize necessary resources to implement plan
- Mentor patient/provider/staff in updating and communicating plan

**Systems Thinking and Leadership**
- Champion innovative projects or programs
- Change agent—challenge health care system and caregivers to resolve barriers and gaps in care
- Communication skills with diplomacy
- Expert consultation
- Global perspective
- Initiate performance improvement
- Interdisciplinary collaboration—linking disciplines and providers across environments
- Mentor staff to elevate nursing practice, individually and as a whole
- Systems thinking

CNS, clinical nurse specialist.

### REFERENCES


