POSITION DESCRIPTION FOR THE ADVANCED PRACTICE NURSE AS A HEALTH CARE PROVIDER FOR INCARCERATED DEVELOPMENTALLY DISABLED MEN

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Dedication

This scholarly project is dedicated to the friend I found during the process of researching and writing about this subject, Lyn O'Connor.

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CHAPTER 1

THE PROBLEM

INTRODUCTION

The developmentally disabled person creates many problems for the criminal justice system (Kindred & Sales, 1986.) While an estimated 3% of the American population is mentally retarded, some authors estimate as much as 5% of the incarcerated population may have significant problems with retardation (Deemer & Canine, 1984.)

Special programs for the developmentally disabled have been created in several criminal justice systems at state and local levels in response to federal mandates. These mandates reflect social, moral and political changes that swept the United States for two decades following their inception in the late 1960s (Brooks, 1993). Development of programs and treatment teams to meet the mandated changes for habilitation, education, and treatment overwhelmed the resources of many communities and eventually the criminal justice system.

In the community setting, nursing has an active role in the care of the developmentally disabled (McMillian & Blackridge, personal communication, April 12, 1995). Within correctional facilities, despite nurses' being primary care providers (Standards of Nursing Practice in Correctional Facilities, 1985), a review of the literature indicated that only one program in the United States established for the developmentally disabled utilized nurses.

STATEMENT OF THE PROBLEM

Federal and state correctional facilities are required by statute and legislation to provide the developmentally disabled with health care and educational opportunities. These should equal opportunities provided for other inmates, which reflect community standards. Modification for their individual disabilities will allow them to be mainstreamed into general population. In the Michigan Department of Corrections (MDOC), an effort to meet these legal and social requirements has been made by the establishment of a Social Skills Development Unit (SSDU) at Handlon Michigan Training Unit (MTU) in Ionia, Michigan.

Founded in 1988 the SSDU, based on a interdisciplinary team concept, does not include a nurse as part of the treatment team. The purpose of this document is to develop a position description for the Advanced Practice Nurse as a health care provider for the developmentally disabled prisoner.

CHAPTER II

CONCEPTUAL FRAMEWORK OVERVIEW

A conceptual framework is presented in which Orem's self-care theory is the structural basis for advanced practice nursing within the Michigan Department of Corrections. Creation of a position description for the Advanced Practice Nurse working with incarcerated developmentally disabled is the focus of this paper. Inclusion of the Advanced Practice Nurse (APN) as a member of the SSDU interdisciplinary team, will enrich the services provided for the developmentally disabled in that setting.

The presentation includes: conceptual definitions, a brief overview of the evolution of Orem's theory of self-care, an explanation of advanced practice nursing and nursing interventions, and an integration of Orem's concept of self-care deficits, dependent-care, theory of nursing systems and advanced practice nursing.

Conceptual Definitions

Self-care: "the practice of activities that maturing and mature persons initiate and perform, within time frames, on their own behalf in the interests of maintaining life, healthful functioning, a continuing personal development, and well-being. It is the personal care that individuals require each day to regulate their own functioning and development" (Orem, 1991, p. 3).

Self-care agent: is the provider of care whether the provider is the individual or another person (Orem, 1985).

Self-care deficit: refers to health related limitations that render a person incapable of continuous self-care or independent care (Orem, 1985).

Dependent-care: "that continuing health-related personal regulatory and developmental care provided by responsible adults for infants and children or persons with disabilities (Orem, 1991, p. 3).

Dependent-care agent: "A maturing adolescent or adult who accepts and fulfills the responsibility to know and meet the therapeutic self-care demand of relevant others who are socially dependent on them or to regulate the development or exercise of these persons' self-care agency" (Orem, 1991, p. 362).

Developmental disabilities: Federal Definition. Public Law 101-496 {Section 102(5)}, The Developmental Disabilities Act.

A severe, chronic disability of a person five years of age or older which:
- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the person attains age twenty-two;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of major life activity: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; and (g) economic self-sufficiency; and
- reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

Mental Retardation: substantial limitations in present functioning. It is characterized by significantly sub average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas; communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests before age 18 (American Association for Mental Retardation 1992, p. 5).

Habilitation: "a personal and social growth developmental frame work" (Palmer, 1991). Habilitation provides a person an opportunity to develop those life skills that will grant them a constructive place in society through various forms of vocational, educational, and therapeutic treatment programs" (O'Connor, 1994). The word *habilitation* is relatively free of certain stereotypes associated with the term *rehabilitations. Rehabilitation* is frequently associated with the concepts of fallen, failed, broken, sick, and unworthy individuals (Palmer, 1991).

Advanced Practice Nurse: is a nurse with an advanced degree, education or experience and is considered to be an expert in a specialized area of nursing. APNs incorporate an interwoven network of roles in their practice; client advocate, clinician, change agent, collaborator, consultant, coordinator, counselor, educator, role model, leader, evaluation and researcher. APNs may be called "clinical nurse specialists," or they may be certified in a specialty area such as family practice or as a nurse midwife. (Peak, 1994). In this paper, the role of the expert nurse will be called the "Advanced Practice Nurse."

Advanced nursing practice: "The deliberative diagnosis and treatment of a full range of human responses to actual or potential health problems. Advanced practitioners can provide rationale for choosing diagnostic and treatment processes. Advanced practice is accompanied by specialized knowledge and skills in dealing with human responses..." (Calking, 1984).

Overview of Orem's Theory

Orem's Theory of nursing, developed in 1959, had self-care as its primary focus. (Easton, 1993; Orem, 1959). Orem's definition of self-care has evolved since that time to include the concept of dependent care. Initially suggesting that self-care was personally initiated by individuals for maintenance of life and a sense of well-being, Orem's concept was revised in 1985 to include the concept that some individuals cannot meet any, or part, of their own maintenance requirements. "Self-care means care that is performed by oneself for oneself when one has reached a state of maturity that is enabling for consistent, controlled, effective and purposeful action. The unborn, the newborn, infants, children, the severely disabled, and the infirmed cannot meet any or some of their own requirements for maintenance and for regulation of their functioning" (Orem, 1985, p. 39). In 1991, Orem introduced the concept of dependent-care, defined as "the continuing health-related personal regulatory and developmental care provided by responsible adults for infants and children or persons with disabling conditions" (p. 3). This concept expanded Orem's self-care theory to include those who cannot provide for themselves. This addition made Orem's theory more applicable to clinical settings.

Orem (1980) maintained that human limitations for self-care, associated with health situations, give rise to a requirement for nursing. The three types of self-care requirements are universal, developmental and health-deviation. Universal self-care

requisites are "common to all human beings during all stages of the life cycle, adjusted to age, developmental state and environmental and other factors" (Orem, 1985, p. 90). These universal needs are identified in Maslow's hierarchy as sufficient amounts of air, water and food. Developmental self-care requisites are related to those living conditions that promote and influence human development (Easton, 1993). Associated with human development processes, and including conditions and events from all stages of the life cycle, the developmental self-care theory includes those events that may adversely affect an individual.

Health-deviation self-care requisites "exist for persons who are ill, injured, have specific forms of pathology including defects and disabilities, and who are under medical treatment" (Orem, 1985, p. 97). These self-care requirements are associated with genetic, structural and functional deviations and their effects upon an individual.

An individual's ability to engage in self-care is affected by age, gender, developmental state, health status, experience, culture and available resources. When limitations are present and these needs are unmet by the individual, that person is in a state of dependency and may need to establish a relationship with a nurse. The goal of nursing actions is to help people meet their own self-care requirements. There are three components of this goal: helping the person accomplish therapeutic self-care; helping the person move toward responsible self-care action, which may take the form of steadily increasing independence in self-care actions or adjustment to interruptions

in self-care capabilities or to steadily declining self-care capacities; and helping members of the person's family or other person who attends the individual become competent in providing and managing the patient's care using appropriate nursing supervision and consultation (Orem, 1985).

According to Orem's theory, nursing care is therapeutic self-care and nursing actions are called "the theory of nursing systems". These nursing actions are wholly compensatory, partly compensatory, or supportive-educative. In the wholly compensatory systems, the nurse performs activities the patient cannot, or acts directly for the individual, thus compensating for their inability to perform self-care. In the partly compensatory system, the nurse and the patient collaborate to meet the person's self-care needs. In the supportive-educative system, the individual acts as his or her own self-care agent but requires assistance with decision making, behavior modification, and acquisition of knowledge and skills (Orem 1980, 1985). The level of the system used is dependent upon the individual's physical, cognitive, emotional and social limitations.

Advanced Practice Nurse

Advanced Practice Nurses have the knowledge and expertise to intervene at any or all of these nursing systems levels, thus enabling an individual either to meet their own self-care needs or to assist that person who is providing for an individual to meet those self-care needs. The characteristics of the APN include an interwoven network of roles. These roles include, yet are not limited to, client advocate, clinician, change agent, collaborator, consultant, coordinator, counselor, educator, role model, reader, evaluator, and researcher (Peak, 1993). APNs structuring their practice on Orem's self-care theory, and the within the confines of a correctional setting, will use all of the above roles.

APNs can independently assess, diagnose, and manage primary medical conditions by prescribing medication and treatment, performing invasive health care procedures, identifying behavioral and risk factors, as well as self-care deficits, developing individualized treatment plans in collaboration with other interdisciplinary team members, provide education and support for patients and staff, counsel and educate using any of the major treatment modalities, initiate behavioral programs, and work with individuals or groups for analysis and counseling. According to the Standards of Nursing Practice in Correctional Facilities (1985), the major thrust for nursing care within a correctional setting is to provide primary care services from the time of entry, through transfers within the system to final release. Knowledge of the

usual sequence of physical and psychosocial development is critical for distinguishing the normal development process from pathogenic conditions. (Stevens, 1993). The APN, applying Orem's self-care theory with his or her broad knowledge base, will be able to assess, identify, develop and initiate treatment for these incarcerated individuals.

Integration and Schematic Representation of Conceptual Models

Orem (1985), defines self-care agency as the ability to care for one's self. The individual who provides the self-care (patient or someone else) is the self-care agent. Self-care deficits are those health related limitations that render a person incapable of continuous self- or independent-care. Therapeutic self-care is defined as applied nursing actions. Dependent-care is defined by Orem (1991) as that healthcare or developmental care provided by another for those persons with disabling conditions.

This concept of dependent-care is adaptable to the correctional setting with its unique healthcare issues and to the multiple needs of incarcerated developmentally disabled. Leeke (1986) stated that the developmentally disabled create many special problems for the criminal justice system. They vary widely in their abilities and limitations and are frequently unable to take advantage of the rehabilitation programs. They need special programs to master basic skills that will enable them to be independent and able to function both inside and outside of prison. Personal hygiene, appropriate social and sexual behavior, good work habits, money management,

understanding of rules and anger control are some of the skills the developmentally disabled need to acquire (Kindred & Sales, 1992; Kalmanoff, 1982). According to Orem, nursing is one of the health services that gives aid to people who are in a dependent state and directs them toward obtaining the maximum level of independence possible.

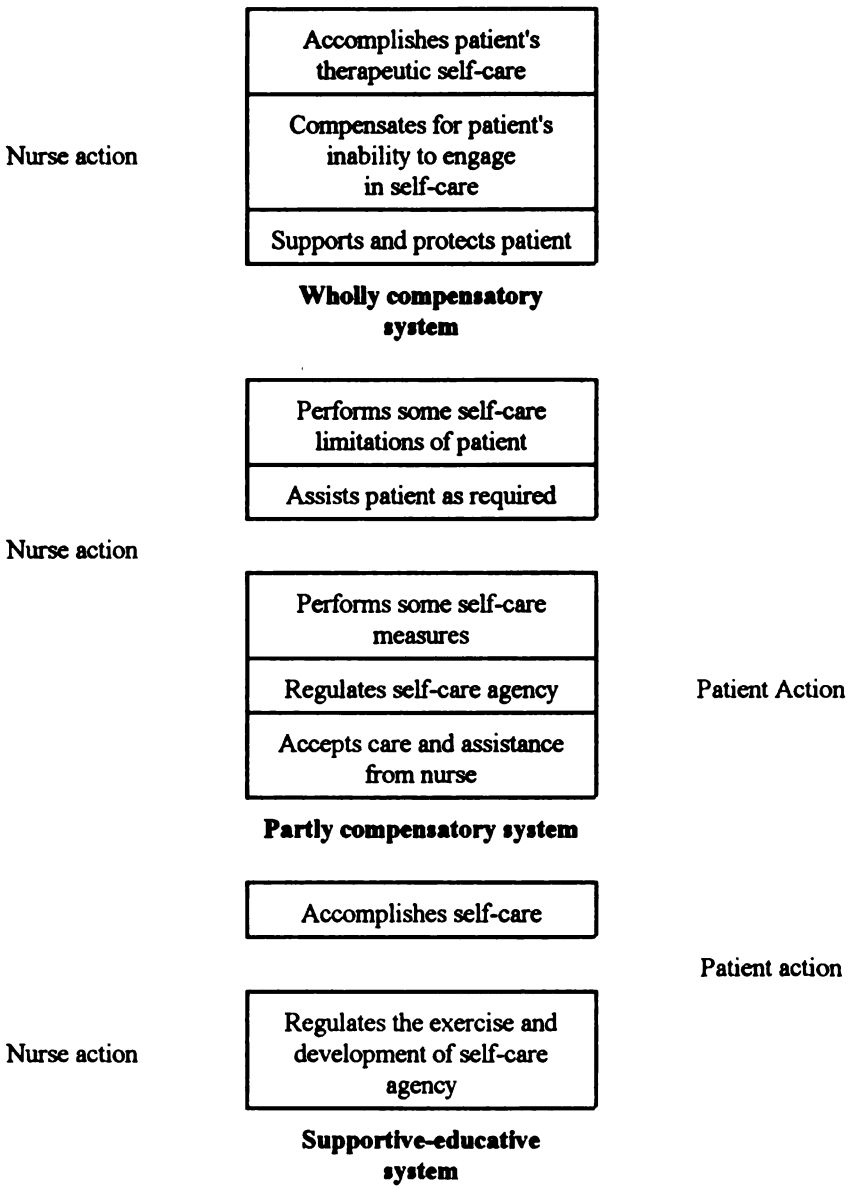

Fig. 1 Basic nursing system. Orem 1991 p. 288.

Adaptation of Orem's Nursing Model

A Schematic Representation of

A.P.N. Interventions and Their Effect on Incarcerated Developmentally Disabled

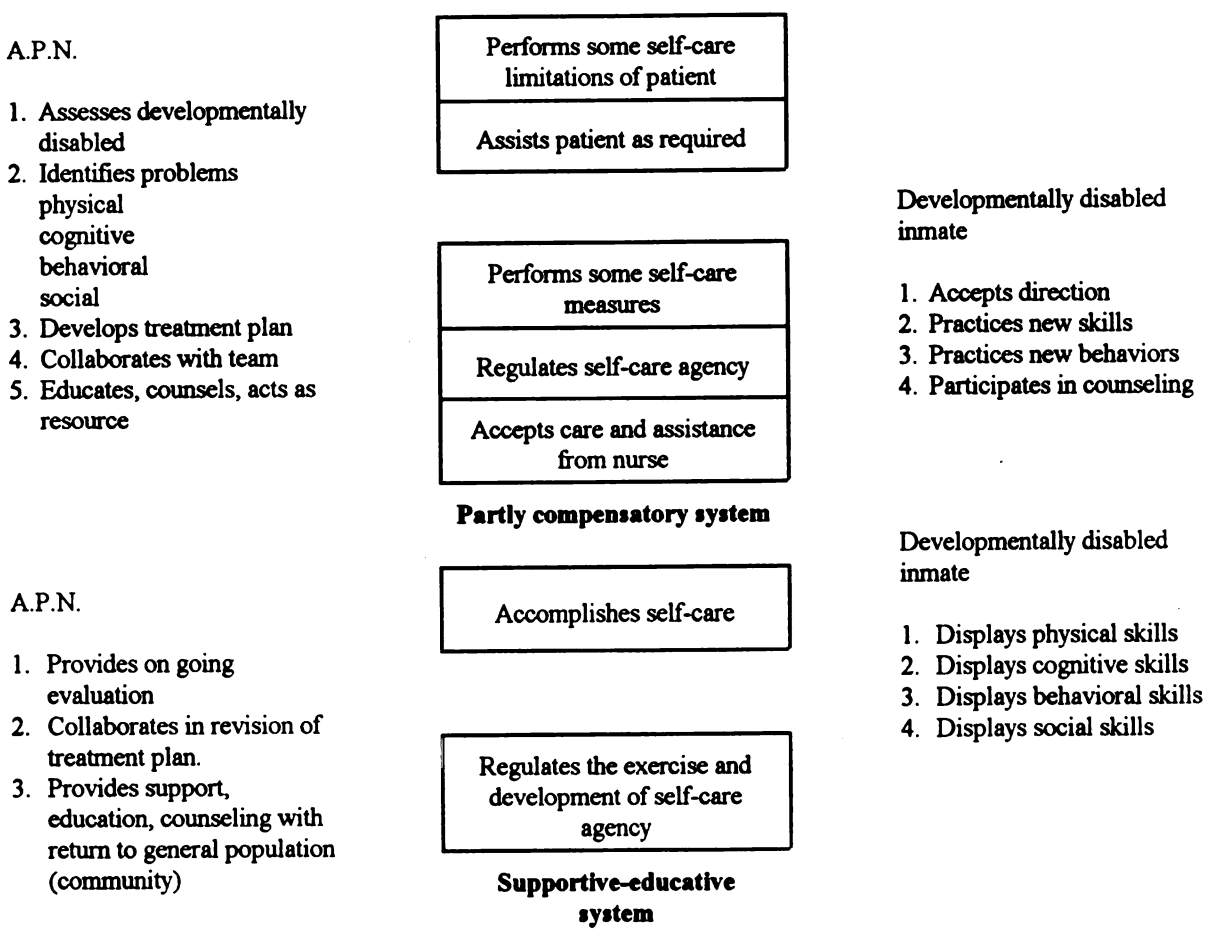

Fig. 2 Adapted from Orem's Basic nursing system.

Some of the developmentally disabled need intervention at the wholly compensatory stage for brief periods of time; most of these incarcerated people need intervention at the partly compensatory and supportive educative levels. Thus the wholly compensatory level is not included in the adaptation of Orem's model. As the cognitive, physical and or behavioral skills increase, the level of intervention will become supervisory and advisory. This corresponds to the partly compensatory system. The next level would be self-care by that individual or self-care under the guidance of another staff as the individual is integrated into the community or general population within the correctional setting, corresponding to the supportive educational system in Figure 2.

Inherent in Orem's theory is the assumption that self-care is a form of conscious, deliberate action and is a behavior that is not inborn but that is learned through culture and habit (Orem 1980; 1985). Education is one of the best ways for the nurse to return control of care to the patient. After identification of the area of deficit, the APN directs the interventions toward helping that patient regain self-care via treatment plans that reflect steps to achieve self-care, whether physical, behavioral, or social in nature. With the developmentally disabled, special attention must be given to the patient's mental age and functional capacity (Robinson, 1983). Most patients with developmental disabilities require some supervision for activities of daily living,

(ADL) decision-making and protection from victimization (Kindred & Sales, 1992; Leeke, 1986; Morrison, 1991).

While intermittent episodic violence, and poor impulse control, can be the most severe behavioral management problem for this population, screening and identifying those developmentally disabled who are at risk is the beginning of habilitation. Nurses can contribute to the goal of habilitation by reconciling and working with the conflicting goals of very different systems, correctional and health care. Security, detention and punishment in the criminal justice setting clash frequently with the goal of improvement, maintenance, education, and treatment within the health care system. This concept will be developed further in the Review of Literature (Chapter III, below).

CHAPTER III

REVIEW OF LITERATURE

INTRODUCTION

The review of literature is divided into four sections. It includes (1) a brief overview of developmental disabilities, (2) the effects of deinstitutionalization of the developmentally disabled who have been main streamed into society and who are incarcerated, (3) a brief description of a special program currently in place for the incarcerated developmentally disabled and, (4) an overview of nursing practice within a correctional setting with an emphasis on the difference between forensic and non-forensic nursing.

DEVELOPMENTAL DISABILITIES CONCEPT

Beginning in 1963, with the passage of the Mental Retardation Facilities and Construction Act, the field of Developmental Disabilities has witnessed a paradigm shift initiated in part by federal legislation. These federal mandates forced the passage of state and local laws. Fundamental changes in the quality of life experienced by these people, their families and society resulted from the passage of these laws (McFadden & Burke, 1991; Schalock, et. al., 1994; Brooks, 1993; Kalmanoff, 1982).

With the emphasis shifting from caretaking and maintenance with hospitals and institutions to habilitation, education and integration into society, federal initiatives

emphasized the individual and their families' involvement in delivery of services (McFadden & Burke, 1991; Schalock, et. al., 1994).

In 1992, the American Association on Mental Retardation (AAMR) published *Mental Retardation: Definition, Classification and System of Support.* This reflected the changes in terminology, IQ cutoff levels and diagnostic role of adaptive behavior that have occurred over the last four decades. An essential component of this conceptual shift views mental retardation as an expression of the functional impact of the interaction between the person with limited intellectual and adaptive skills and that person's environment, not as a trait of an individual (Baumeister, 1987; Bruininks, Thurlow & Gilman, 1987; Edgerton, 1988; Greenspan & Granfield, 1992; Institute of Medicine, 1991; McFadden & Burke, 1991). This shift in conceptualization affects delivery of services, placing the emphasis on the strengths and capabilities of the individual, empowering that individual and leading to integration of services with support systems and to normalized environments (Bradley & Knoll, 1990; Schalock & Kiernan, 1990).

The pattern and intensity of the individual's need for support and services can be assessed and provided for within the framework of Orem's self-care theory. In 1980, Orem stated that a need for nursing care exists when an individual has difficulty engaging in self-care activities adequate for maintaining health. Application of appropriate support services through advance practice nursing intervention can benefit

all individuals who have functional limitations and thus enhance some of the desired outcomes of this paradigm shift. These enhanced adaptive skills maximize the habilitative goals related to health, physical and psychosocial function, and integration into the community (Schalock, et. al.; McFadden & Burke, 1991).

The Institute of Medicine (1991) defines functional limitations as the effect of specific impairment in a social context that reflects the interaction among limitations in intelligence, adaptive skills, and the demands of one's environment. This functional approach to developmental disabilities is consistent with recent federal legislation and the federal definition of developmental disabilities and Orem's theory of self-care deficits.

The developmental disabilities concept evolved in an effort to eliminate fragmentation, duplication and compartmentalization in departments that provided similar and overlapping services for the developmentally disabled including, yet not limited to, mental retardation, cerebral palsy, epilepsy and autism. The federal definition of developmental disabilities is the accepted standard for identification of those who are eligible for federal funds and provision of services. (Schalock, et. al., 1994; Kindred & Sales, 1986; McFadden & Burke, 1991).

IMPACT OF DEINSTITUTIONALIZATION ON SOCIETY AND THE DEVELOPMENTALLY DISABLED

Widespread adoption of the developmental disabilities concept was enhanced by the availability of federal funding leading to reclassification that excluded a group of individuals, formerly known as the borderline retarded, or those whose standardized abilities scores fell between one and two standard deviations below the mean (Grossman, 1973). In 1990, Zetlin & Murtaugh stated that one out of every seven people are members of this group and have no community support to enable them to become functioning members of society. Most support services are available for the moderately to severely mentally retarded and those individuals who are not behavioral management problems (Brooks, 1973; Zetlin & Murtaugh, 1990; Leeke, 1986). Even available services do not reach all eligible individuals. Frequently they avoid contact with agencies and services that are designated for persons with special needs to avoid society's stigma of retardation (Zetlin & Murbaugh, 1990; Allen, 1988). Poor social skills, limited understanding of societal rules and laws, behavioral acting out and frequent victimization threatens integration into community life (Leeke, 1986).

Although studies have shown that behavioral interventions and social skills training provided on a consistent basis can be an effective treatment for chronic and potentially dangerous behavioral problems, those individuals needing these

interventions are often not receiving them (Huguenen, 1993; Allen, 1988; Corrigan, 1991; Bernstein, 1980).

Frequently victimized, as well as victimizers, the developmentally disabled violate society mores and rules and are incarcerated. Once incarcerated, the process begun in society continues. They are isolated from other "normal" inmates, either for protection, or by an attempt to pass as normal. They are viewed as objects of ridicule and fear, or as incomplete, not fully human (Kalamanoff, 1982). An inability to comprehend rules or the social mores "inside" may lead to victimization and abuse. Screening for this group of inmates on admission is the first step to treatment and relates to assessment and identification of the functional loss or self-care deficit in Orem's theory.

INCARCERATED DEVELOPMENTALLY DISABLED

The development of special programs for these offenders has been supported by legislation. The law states that incarceration does not justify denying normal medical care, which includes treatment for mental illness (Klein, 1979). By suggestion, this also includes the developmentally disabled. Legislation mandating education, treatment and habilitation has been the basis for the establishment of treatment programs for the developmentally disabled, within both correctional and societal settings.

The Michigan Department of Corrections (MDOC) opened a Social Skills Development Unit (SSDU) at Handlon Michigan Training Unit in Ionia in 1988. Based on policy directive PD-DWA 05.01.120, the goal of the SSDU is to provide specialized housing for prisoners with impaired adaptive behaviors. Adaptive behavior is defined as a person's effectiveness in areas such as social skills, communication, daily living skills, and how well that person meets the societal standards of personal independence and social responsibility (MDOC, 1991). The general directions for admission, programming, and release from the unit are also included in the policy.

Development of life skills which include basic ADL, behavioral, and social skills, will provide inmates with problem-solving techniques which may lead to a more productive life during their incarceration and after their release. Some members of this group will not be able to overcome acquired or inborn limitations due to their limited intellect or physical handicaps. Most will require patience on the part of the staff, calm reiteration of rules, and direction and constant tutoring in social skills that most take for granted. Many have difficulty comprehending and remembering rules and cannot read or write. Frequent behavior outbursts express their frustration (Kein, 1990; Farkas, 1992). This group of people, ranging from the emotional and developmental level of toddler to adolescent to adult, is uniquely able to be treated based on Orem's concepts and self-care requisites. Orem (1971) stated that the

human's ability to engage in self-care is affected by age, gender and developmental state, health, experience, culture, and available resources. The universal self-care requisite associated with life processes and maintenance of the structural and functional integrity of a human being is relevant to limited adaptive behavior of the incarcerated developmentally disabled individual. The developmental self-care requisites are associated with the developmental processes and life cycles events and relates to the limited social skills, life management skills and cognitive impairment of this group. Health deviation self-care requisites are concerned with genetic, constitutional, structural, and functional deficits. These effects can be related to the physical care, assessment, treatment, and modification of housing programs for this group. The self-care agent, either line staff or APNs and/or the inmate can use one of the three nursing systems, wholly compensatory, partly compensatory, or supportive-educative, to meet self-care requisites.

In the SSDU at HMTU the clinical staff includes a program director, a psychologist, a recreational therapist, an outreach specialist, the case managers and one secretary. Custody staff includes a resident unit manager (RUM), an assistant resident unit manager (ARUM), and three officers per shift. Nursing is not currently included as part of this interdisciplinary team.

As with other programs created in other states, several hundred prisoners have participated in the program but did not graduate (i.e. meet the release criteria). At

present only 24 inmates have successfully completed all required criteria and have graduated from the SSDU. This compares with similar programs in Texas, New York and Illinois (Newton, personal communication, May 11, 1995; Johnson, personal communication, May 11, 1995; Nunnelar, personal communication, May 11, 1995). In fact, in the state of Illinois, the DOC has stopped concentrating on the developmentally disabled and has integrated them back into general population where their lifestyles continue on a sub-adaptive level and where they are frequently the victims (Nunnelar, D., personal communication, May 25, 1995). One of the major problems for the failure of the program(s) thus far is due to the basic human fear response. When released from a protective environment, this group of people ceased to function at their highest capabilities (Newton & Johnson, personal communication, May 11, 1995).

By acting as an advocate for the developmentally disabled, APNs can facilitate an optimal level of adaptation, self-care, and health maintenance for this group of people. Additionally, APNs could provide outpatient follow-up assessment, evaluation, diagnosis and treatment via conventional support, education of custody staff, and re-education of inmates, thus helping to reduce the recidivism rate of this program.

CORRECTIONAL NURSING

Nurses working with correctional patients (inmates) face the challenge of reconciling conflicting goals of very different systems (Caplan, 1993). The themes of security, detention and punishment conflict with the goals of health maintenance and improvement of functioning levels. Nurses within the correctional setting must first and always enforce the special rules and regulations pertaining to a correctional setting. Goffman (1961) identified nursing staff as the "tradition carriers" trusted more by the inmates, and it is their role to see that rules and regulations are understood and followed. While correctional settings foster isolation, aggression, violence and manipulation, officers and nurses need to maintain security and perform disciplinary procedures while being cursed at, threatened, and assaulted. At the same time, nurses are expected to respect and support prisoners' rights, prevent suicide and homicides, and collaborate with other health care providers in crisis intervention and programs. That so many officers and inmates view nurses with respect, instead of with prejudice and suspicion, is a compliment to the training and education nurses undergo (Galindez, 1990; Caplan, 1993).

Providing health care in a setting antithetic to traditional health care may overwhelm caregivers. Many inmates are non-compliant, demanding and manipulative (Folsom, 1989). Most prisoners, prior to incarceration, had limited access to health care at any level. This population with low incomes, poor diets, and

lack of education often arrive in the system with multiple health related problems. Compliance with treatment and continuity of care is an ever present difficulty related to prior and present lifestyles and the complexities of the criminal justice system (Glasser & Greifinger, 1993).

SUMMARY

The social and legal reforms that swept the United States, beginning in the 1970s, have had far reaching consequences for the people directly affected and on society in general. Designed originally to protect, educate and habilitate the disabled, these laws had the effect of creating a population of incarcerated disenfranchised (Sonner & Hurley, 1989). Stone (1978) stated that, while jails were emptied with the establishment of asylums, the process has been reversed with deinstitutionalization.

While many states have developed special programs for the incarcerated developmentally disabled, nursing has not been an integral part of these programs, and the programs have high recidivism rates (Newton & Johnson, personal communication May 17, 1995; Farkas, 1995). APNs could be a cost effective addition to these programs and by using their unique perspective, skills, and knowledge help to increase the effectiveness of the programs.

A review of literature indicates limited research that describes the impact of nursing within a correctional setting, although it is a field that is wide open for the advanced health care provider who, using their knowledge, expertise, and skills, can

intervene and make a difference in the lives of both staff and inmates. Additionally, a review of literature indicates a lack of statistical data that correlates developmental disabilities victimization, decreased adaptation, and incarceration, although experientially these things happen. Development of a position description, collaborative guidelines for practice, and methods for evaluation of the practitioner will be discussed in Chapter IV below.

CHAPTER IV

In this chapter a brief presentation of the format to follow when creating a new position within Michigan's Department of Corrections is presented. Additionally, a brief outline of the development of the guidelines and methods to evaluate the APN is presented.

Development of a position description.

Michigan's Department of Civil Service has established policies and procedures to follow when a division or department submits a proposal to add or create a new position and classification level. Within the Department of Corrections, a division of Civil Service, final approval to add a health care position must come from the administrator of the Bureau of Health Care (BHC), which oversees all aspects of the correctional health care system.

The procedures used to draft a proposal to add a new classification level and position are as follows:

: Assessment and data collection that demonstrates the need for an additional position.

: Explanation of services to be provided with expected outcomes and benefits to employer.

: Projected cost, probable funding sources, and comparison with other facilities within the MDOC or with comparable outside facilities.

: Description of the focus of duties, with guidelines for performance and evaluation of the employee.

The written proposal rises through ascending levels of managerial staff, finally reaching the BHC administrator, who reviews the feasability of the proposal and approves or disapproves the request. The proposal, if approved, is sent back to the requesting department with recommendations or as is. Once the new position is approved, the personnel department becomes involved and forms CAJ-600 and CS-214 are filled out with the pertinent information (Appendices A and B). Following policy directive 02-06.111 for employment screening and evaluation, the position is then filled by the most qualified applicant.

Documentation that demonstrates a growing need for primary health care providers has been readily available from within the Department of Corrections itself. With the establishment of community standards in prison health services, these services became a costly part of correctional facilities (Weiner & Runo, 1992). Federal mandates, increased public and consumers awareness, increasing health care cost, and the increasing population with substantial health care needs has led to a noticeable lack of available primary health care providers (Swanson, J. et. al., 1993). In a personal communication, C. Brown (1995) stated "I am unable to hire one physician and I need ten to provide the minimum of health care and meet federal and state mandated requirements. Advertising in the paper and primary care providers

magazines has not helped to supply the demand". The southeastern region of the Michigan correctional system includes thirteen facilities, each with an average population of 1500 and only 2.5 primary health care physicians (Khan, personal communication, June 20, 1995). "The class Health Care Practitioner, p-11, 12, 13 is being reviewed in an effort to alleviate hiring and retention difficulties as experienced by Corrections in their Bureau of Health Care" (Drake, D., 1995).

APNs could meet and fill many of the positions needed for primary health care providers, would be less expensive for the state employer, and can provide services for those inmates with chronic health care problems as well as simple acute problems. The APNs' national average annual salary range is $60,000 to $70,000 (NPSS 1994), compared to the $100,000 to $150,000 average physician's wage paid by the MDOC. Employment of APNs as primary care providers would enable the MDOC to meet the needs of inmates in a cost effective manner.

In a federal experiment with physician extenders, it was found that teams of physicians and APNs provide a higher quality of care than do physicians alone. Studies (Appendix C) have shown that APNs have high rates of consumer satisfaction and better communication, counseling, and interviewing skills than physicians (Office of Technology Assessment, 1986). Summarizing the findings of the numerous studies of nurse practitioners' performance in a variety of settings, the study by the OTA (op. cit.) concluded: Nurse practitioners have performed as well as physicians with respect

to patient outcomes, proper diagnosis, management of specified medical conditions, and frequency of patient satisfaction, indicating that APNs are prepared to fill some of the primary health care positions needed by MDOC

Once approval of the position description is sent back to the requesting department the development of the practice guidelines follows. Evaluation of the practitioner is included with the guidelines.

DEVELOPMENT OF GUIDELINES

The guidelines for practice and the focus of duties will be in essence a collaborative agreement between the State of Michigan, the medical director of the Ionia complex, of which HMTU is a part, and the APN. The guidelines for practice will include the following:

: A written description of duties and responsibilities of the APN.

: A mutual agreement upon reference texts to be utilized by the APN to define consultation and or referral criteria.

: Annual review and update of reference texts, as needed.

: A written agreement for the APN and physician colleague to meet monthly to review cases and discuss management plans.

: A statement acknowledging that each professional has separate accountability.

: A written statement delegating prescriptive authority in accordance with state and federal laws and departmental policy.

: Agreement by the collaborating physician(s) to be available physically or by telephone for consultation, as necessary. Documented evidence of consultation will include a progress note entry or referral letter.

: Specification of hours yearly for continuing education (paid).

: Participation in peer case reviews.

: Evaluation of the APN as per MDOC policy, to be clarified in the future.

: Increase in the acquisition of adaptive skills by the developmentally disabled.

: Maintenance of those skills when mainstreamed.

SUMMARY

The development of, and the procedure to gain approval to create, a new position (Advanced Practice Nurse) within the Department of Corrections in Michigan has been presented. Approval depends upon need, availability of funds, and social and legal requirements. Health care expenditure is a large part of MDOC's budget. New positions are added after research proving the need and benefits they would bring to the system.

In Chapter V below, the position description and the guidelines will be presented. Additionally, the implication for nursing education, nursing practice, and nursing research will be discussed.

CHAPTER V

ADVANCED PRACTICE NURSE: POSITION DESCRIPTION

General summary: provides cost effective, comprehensive health care in collaboration with other providers. The focus will be on assessment, identification, diagnosis, and management of common acute and chronic health care problems. Established guidelines will focus on health promotion, education, and illness prevention in a holistic manor, including development of cognitive, behavioral, and adaptive social skills treatment plans.

Focus of Duties and Responsibilities

1. Initial and ongoing comprehensive assessment of the client's health status.
   : Elicits comprehensive health history including development, maturation, coping ability, activities of daily living, physiological function, emotional and social well-being, and adaptive skills.
   : Performs complete physical examinations.
   : Orders and/or performs pertinent diagnostic tests.
   : Analyzes data collected to determine health status of clients.
   : Records in the client's health record all pertinent data about the client including history and physical exam, problems identified, and plans for follow-up or referral.

: Collaborates with other team members and health care providers to develop a comprehensive treatment care plan.

2. Identifies and manages common acute and chronic health problems.

: Analyzes client history, physical exam and diagnostic data to identify health problem(s).

: Develops and implements, with the client and other team members, a plan of care to promote, maintain, and restore health and to enhance the client's ability to participate fully in the health care process.

: Evaluates, with the individual and other team members, response to both the health care provided and the effectiveness of the care.

: Modifies the plans and interventions as needed.

: Records in the client's health record all pertinent data including problem(s) identified, interventions provided, results of care, and updated plan of treatment.

: Recognizes the client's need for referral to other health care professionals and coordinates referrals to assure continuity and appropriate follow-up.

3. Serves as a client educator.

: Assesses individual and group learning needs for specific knowledge and skills required to maintain health, prevent illness, and self-manage acute and chronic illnesses.

: Assesses individual and groups for specific adaptive skills and knowledge required to function within the correction system and within society.

: Provides health education, counseling, support, and behavioral modification to individuals and or groups in areas identified.

4. Serves as a staff educator.

: Serves as a clinical expert, resource, and consultant to other staff members including health care professionals and non-health care staff.

: Provides teaching to individuals and groups of employees to enhance clinical knowledge base and skill development.

5. Assumes responsibility and is accountable for quality of services provided.

: Evaluates own practice and assures that it meets professional standards.

: Seeks opportunities to participate in peer review.

: Participates in continuing education programs and/or other learning opportunities to assure current knowledge and maintenance of certification.

: Utilizes research findings to modify and improve clinical practice and client outcomes.

Knowledge, Skills and Abilities

It will be necessary for the individual who will attain this position to have the following qualifications:

: Masters Degree in primary care.

: Current Board Certification within six months of employment.

: Current State of Michigan Licensure as a registered nurse and specialty certification as an APN.

: Advanced physical assessment skills and clinical background with the developmentally disabled, primary care, acute care, and emergency care.

: The ability to provide the highest possible standard of nursing care utilizing and/or conducting nursing research, paper review, evaluation of care, and continuing professional education.

: Ability to summarize medical and health information in a manner understandable to non-medically trained persons.

: Maintenance of CEUs and speciality license.

GUIDELINES FOR PRACTICE AND EVALUATION

1. The undersigned APN, medical director, and associated physicians of HMTU of MDOC agree to the following provisions of health care and guidelines for services to patients at Handlon Michigan Training Unit and associated correctional facilities.

: The APN provides independent services in the following areas:

: provides management of acute/episodic illnesses

: provides management of stable chronic illnesses

: provides initial and on going comprehensive assessment

: provides comprehensive history and complete physical exam

: diagnoses and treat single acute/episodic and stable chronic illnesses

: interprets lab results, performs specified diagnostic/therapeutic procedures

: prescribes medication and treatments within the agreed upon guidelines

: provides appropriate counseling, support, and education to the client

: makes referrals to other health care providers as needed

: maintains complete and detailed records

: collaborates with other health care providers to develop comprehensive treatment plans

: participates in on-call rotation

: demonstrates competence in providing direct patient care, negotiating multiple health care systems

: displays excellent interpersonal skills, and leadership/ program development ability

: practices within the regulations of the Public Health Code, Michigan Department of Licensing and Regulation, and abides by the ethical "Code

for Nurses" established by the American Nursing Association and the policies and procedures of Michigan Department of Corrections.

The physicians agree to delegate prescriptive authority in accordance with agreed upon standards for the facility and within the policy directives of the MDOC.

2. We agree to meet at least monthly to review cases and discuss management plans. In addition, the following reference texts will be utilized by the nurse practitioner to define consultation and/or referral criteria:

: Principles of Ambulatory Medicine (Barker, Barton, Ziene, 1991)

: Manual of Medical Therapeutics, 27th ed. (Woodley & Whelan, 1992)

: Clinical Guidelines in Family Practice (Uphold & Graham, 1994)

: Color Atlas & Synopsis of Clinical Dermatology (Fitzpatrick, Johnson, Polano, & Wolff, 1992)

: Color Atlas of ENT Diagnosis, 2nd ed. (Bull, 1990)

: Patient Care Guidelines for Nurse Practitioners (Hoole, Greenberg, & Pickard, 1992)

: Primary Care Medicine (Goroll, 1994)

: Manual of Laboratory Diagnostic Tests (Fishbach, 1992)

: Other manuals/protocols mutually agreed upon.

3. The collaborating Physicians and the Nurse Practitioner/Advanced Practice Nurse (Sharon Craycraft) agree to review these reference texts annually.

4. The collaborating physicians agree to be available physically or by telephone for consultation as necessary. Documented evidence of consultation will include a progress note entry or referral letter.

5. Periodic oral reports reviewing the mutual goals of this collaborative practice will occur.

6. The Physicians and Advanced Practiced Nurse acknowledge that each professional has separate accountability for his/her own scope of practice as defined in the Public Health Code of Michigan.

7. Twenty hours of paid leave shall be available for CEUs.

8. Expected productivity will be at 100% within a year.

Performance and evaluation standard will be initially at three (3) months, at six (6) months and yearly thereafter in accordance with Civil Service and Michigan Department of Corrections policy and procedures.

The following factors will be considered with the above policies and procedures for performance.

Clinical component

1. Assessment of health status, including:
   : obtaining a relevant health and medical history
   : performing a physical examination based on age and history
   : conducting preventive screening procedures based on age and history
   : identifying medical and health risks and needs
   : updating and recording changes in health status
2. Diagnosis, including:
   : formulating appropriate differential diagnosis based on the history, physical examination, and clinical findings
   : identifying needs of the individual, family, or community as a result of the evaluation of the collected data
3. Development of a treatment plan, including:
   : ordering appropriate diagnostic tests
   : identifying appropriate pharmacologic agents
   : identifying non-pharmacologic interventions
   : developing a patient education plan
4. Implementation of the plan, including actions that are:
   : consistent with the appropriate plan of care/protocol
   : based on scientific principles, theoretical knowledge, and clinical expertise

: individual to the specific situation

: consistent with teaching and learning opportunities

: appropriate in the following respects:

a. accurately conducting and interpreting diagnostic tests

b. prescribing pharmacologic agents

c. prescribing non-pharmacologic therapies

d. providing relevant patient education

e. making appropriate referrals to other health professionals and community agencies

5. Systematic follow up and evaluation of patient status, including:

: determining the effectiveness of the plan of care through documentation of patient care outcomes

: reassessing and modifying the plan as necessary to achieve medical and health goals

6. Maintenance of a safe environment:

: following MDOC policies and procedures.

7. Interdisciplinary/collaborative responsibilities:

: Participating as a team member in the provision of medical and health care, interacting with professional colleagues to provide comprehensive care.

8. Accurate documentation of client status and care:

: Maintaining accurate, legible, and confidential records.

9. Productivity expectations:

: working proactively with physicians to analyze and resolve productivity problems

: meeting progressive productivity targets as established in annual contract.

10. Performs clinical procedures relevant to specialty area.

Professional component

1. Specialty certification and continuing education:

: maintains 20 CEUs per year.

: maintains CPR certification, ACLS certification, ATLS certification.

: obtains and maintains specialty certification.

: obtains and maintains prescriptive privileges as per Michigan state law.

2. Maintains privileges at hospitals if required by collaborating physicians.

3. Quality Assurance:

: participates in peer review process

: incorporates research findings into practice.

IMPLICATIONS FOR NURSING EDUCATION

The implications for nursing education that can be inferred from this paper are pertinent for graduate and undergraduate programs and staff development in the work place. The profession of nursing is defined by what is taught in the nursing schools,

and we practice what we are taught. Continuing education and experience can improve and modify that practice which is based on what we were first taught.

The goal of nursing, according to Orem (1990), is to promote self-care for the whole individual by or through evaluation of the total individual and the effects of self-care system on the individual. The complexity of evaluating the total individual's ability to achieve responsible self-care is considerable. This skill in advanced assessment can be taught only through education and practice based on experience and research.

Nurses in undergraduate programs have been taught to use the nursing process. To become an APN one must move from the acute case setting and mind set to the more skilled primary care setting. This conceptual leap is achieved through education and practice of advanced skills, along with the challenging experiences of graduate school.

As the need for primary care providers expands, nursing education will have to become expert at teaching the many specialty areas the needs arise in, such as correctional health care, home health care for the mentally ill and developmentally disabled, hospice, and other areas too numerous to mention. The expanding need for primary care providers will directly impact nursing practice and nursing research in many areas. The direct impact of the need for correctional (forensic) APNs will be discussed next.

IMPLICATIONS FOR NURSING PRACTICE

More than 5.1 million Americans, or almost 2.7% of the adult population, were under some form of correctional supervision in 1994, according to the U.S. Department of Justice (Signal, 1995).

Glasser & Grenfinger (1993) stated that most inmates prior to incarceration had limited access to health care, thus entering the system with many communicable diseases. The criminal justice system can play an important public health role during incarceration and immediate post release of these inmates. APNs educated in epidemiology, acting as resources for education, counseling, early detections, and treatment can be integral in the system helping both the inmate and society, by helping to control communicable disease.

Nursing in a correctional setting is challenging and demanding. Many inmates are non-compliant, several suffer from chronic or sexually transmitted diseases, and many others are victims of trauma, have addictions, or are mentally ill. Inmates require health and nutritional counseling, education, and information. Inmates are social outcasts, many are self destructive, and all require special interventions (Folson, 1992).

Advanced practice nursing in a non-medical facility requires special training and expertise. The nurse must always maintain the security of the facility, the client, and his/her self and still be concerned with the total health care of the inmate and treat

him/her with dignity and respect. In correctional settings, APNs work more closely with non-professional staff than do nurses in other settings, as security and safety of all staff and inmates is of primary importance.

Correctional nursing is a growing field, with nurses working in jails, state and federal prisons, detention centers, and juvenile training centers. The greatest difficulty in correctional nursing is continuity of long term care due to the frequent movement of prisoners for security reasons. Establishment of a state-wide quality assurance program would correct some of these problems.

Correctional nurses in all settings have the primary goal of providing health care which is equivalent to that available in the community. APNs are uniquely able, by education and training, to aid in reaching that goal.

IMPLICATIONS FOR NURSING RESEARCH

APNs in correctional settings have a unique opportunity to assess and identify physical, developmental, emotional, and social health care problems. Frequently inmates have "grown up" in the system which keeps excellent records. Starting with juvenile convictions, to ultimate incarcerations, there are multiple in-depth interviews and assessments in individual files. Many inmates have family members within the systems, thus providing cross generational and longitudal studies.

The frequency of clusters of problems in inmates is readily noticeable by the structure of placement of inmates. The developmentally disabled and those with

learning disabilities and psychiatric or health problems are housed in special units or grouped units after the initial intake screening. Inmates are universally interested in why "I'm" different and many cooperate with tests and research studies. The correctional facility is uniquely designed for research on health care problems, societal problems (gangs), and longitudal studies of addictions, learning disabilities, and many others. The department of corrections is a micro-organism that reflects society within a contained setting, thus increasing the feasibility of qualitative and quantitative research on many health care issues.

SUMMARY

In this chapter, the position description, guidelines, and implications for nursing education practice and research have been presented. The APN could have a positive impact on the developmentally disabled and other inmates within a correctional setting by filling the need for primary caregivers. APNs fill that unique role of counselor, educator, leader, clinician, and much more to all his/her clients.

Appendices

Appendix A

Appendix A

State of Michigan's Civil Service position description form (CS-214)

CS-214
8-93

1. Position Numbe

State of Michigan
Department of Civil Service
Classification and Selection Operations Bureau
Classification Division

A portion of this information is protected by federal privacy laws and/or state confidentiality requirements.

POSITION DESCRIPTION

AUTHORITY: In accordance with Article XI, Section 5, Michigan Constitution of 1963 and Public Act 431 of 1984.

This form is to be completed by the person that occupies the position being described, and reviewed by the supervisor and appointing authority to ensure its accuracy. It is important that each party sign and date the form. If the position is vacant, the supervisor and appointing authority should complete the form.

This form will serve as the official classification document of record for this position. Please take the time to complete this form as accurately as you can since the information in this form is used to determine the proper classification of the position. **THIS PAGE SHOULD BE FILLED OUT BY SUPERVISOR/APPOINTING AUTHORITY.**

2. Name of Incumbent (Last, First, M.I.) Vacant - New	**8. Department/Agency** Dept. of Corrections
3. Social Security Number N/A	**9. Bureau (Institution, Board, or Commission)** Bureau of Health Care
4. Civil Service Classification of Position Advanced Practice Nurse	**10. Division** Ionia Medical Complex
5. Working Title of Position (What the Agency Titles the Position) Nurse Practioner Advanced Practice Nurse	**11. Section** Handlon Michigan Training Unit
6. Name and Classification of Immediate Supervisor Primary Care Provider (Physician) Vacant	**12. Unit** Medical Services
7. Name and Classification of Next Higher Level Supervisor Medical Director of Ionia Complex	**13. Work Location (City and Address)/Hours of Work** 80 hours per pay period Monday-Friday, 8 a.m. to 4:30 p.m. with scheduled on call hours monthly.

14. General Summary of Function/Purpose of Position

General summary: to provide cost effective, comprehensive health care in collaboration with other providers. The focus will be on assessment, identification, diagnosis and management of common acute and chronic health care problems. Established guide lines will focus on health promotions and education, and illness prevention in a holistic manor, including development of cognitive, behavioral and adaptive social skills treatment plans.

For Civil Service Use Only

15. Please describe your assigned duties, percent of time spent performing the duty, and explain what is done to complete the duty.

List duties in order of importance from most important to least important.

Duty 1
General Summary of Duty 1 **% of Time** 25-30%

Initial and ongoing comprehensive assessment of clients health status

Individual tasks related to the duty.

1. Comprehensive health history
2. Identify self-care deficits
3. Complete physical exam
4. Orders and/or performs pertanent diagnostic tests.

Duty 2
General Summary of Duty 2 **% of Time** 25-30%

Identifies and manages common acute & chronic health problems.

Individual tasks related to the duty.

: Elicits comprehensive health history including development, maturation, coping ability, activities of daily living, physiological function, emotional and social well-being, and adaptive skills.
: Performs complete physical examinations.
: Orders and/or performs pertinent diagnostic tests.
: Analyzes data collected to determine health status of clients.
: Records in the client's health record all pertinent data about the client including history and physical exam, problems identified and plans for follow-up or referral.
: Collaborates with other team member and health care providers to develop a comprehensive treatment care plan.

Duty 3
General Summary of Duty 3 **% of Time** 10%

Collaboration, consultant, evaluator for discharged clients.

Individual tasks related to the duty.

1. Assessment of unit needs
2. Assessment of invididual clients needs
3. Assessment of staff potential
4. Assessment of team members
5. Coordinating
6. Initiating behavioral programs
7. Counseling and analysis

Duty 4
General Summary of Duty 4 **% of Time** 15%

Client educator

Individual tasks related to the duty.

: Assesses individual and group learning needs for specific knowledge and skills required to maintain health, prevent illness, and self-manage acute and chronic illnesses.
: Assess individual and groups for specific adaptive skills and knowledge required to function within the correction system and within society.
: Provide health education, counseling, support and behavioral modification to individuals and or groups in areas identified.

Duty

General Summary of Duty **% of Time** 10-15%

Staff educator - clinical expert, resource consultant to all staff members.

Individual tasks related to the duty.

1. Assess need for individual and group inservice to enhance clinical knowledge base and skill development.
2. Provides needed education/skills or arranges for them to be taught.
3. Monitors and reassess effects of inservice.
4. Maintains records of same.

Duty

General Summary of Duty **% of Time** 5%

Maintenance of certification/speciality licensure.

Individual tasks related to the duty.

1. Seeks out continuing education programs and learning opportunities.
2. Renews certification and licensure at appropriate times.
3. Documents at least 20 C.E.U.'s per year.
4. Evaluates and upgrades own practice to meet professional standards.
5. Particpates in peer review.
6. Utilizes research funding to modify and improve clinical practice and client outcomes.

16. **Describe the types of decisions you make independently in your position and tell who and/or what is affected by those decisions. Use the attached additional sheets, if necessary.**

See duties 1-6

17. **Describe the types of decisions that require your supervisor's review.**

As in practice agreement

18. **What kind of physical effort do you use to perform your job? What environmental conditions are you physically exposed to on your job? Indicate the amount of time and intensity of each condition. Refer to instructions on page 2.**

19. **List the names and class titles of classified employees whom you immediately supervise or oversee on a full-time, on-going basis (if more than 10, list only class titles and number of employees in each class).**

NAME	CLASS TITLE	NAME	CLASS TITLE
N/A	To be determined probably A.P.N./N.P.	N/A	

20. **My responsibility for the above-listed employees includes the following (check as many as apply):**

- ☐ **Complete and sign service ratings**
- ☐ **Provide formal written counseling**
- ☐ **Approve sick and annual leave requests**
- ☐ **Sign time card**
- ☐ **Orally reprimand**
- ☐ **Assign work**
- ☐ **Approve work**
- ☐ **Review work**
- ☐ **Provide guidance on work methods**
- ☐ **Train employees in the work**

21. **I CERTIFY THAT THE ABOVE ANSWERS ARE MY OWN AND ARE ACCURATE AND COMPLETE.**

Signature	Date

NOTE: Make a copy of this form for your records.

TO BE FILLED OUT BY IMMEDIATE SUPERVISOR

22. Do you agree with the responses from the employee for items 1 through 18? If not, which items do you disagree w and why.

23. WHAT ARE THE ESSENTIAL DUTIES OF THIS POSITION?

24. Indicate specifically how the job's duties and responsibilities have changed since the position was last reviewed.

25. What is the function of the work area and how does this position fit into that function?

26. In your opinion, what are the minimum education and experience qualifications needed to perform the essentia functions of this position.

EDUCATION: Masters prepared in nursing with speciality certification in Family Practice and/or Psychiatric Practice.

EXPERIENCE: Two years experience in acute care, and/or emergency care and supervision. One year related experience in primary care (may include internship). One year experience with developmentally disabled.

KNOWLEDGE, SKILLS, AND ABILITIES: Masters Degree from a Family Clinical Nurse Specialist program.
National Certification a CFNP - current.

Ability to provide expert nursing in an autonomouse, collaborative environment.

Ability to assess the physical and psychosocial health/illness, relate and interpret medical data, identify normal and abnormal findings, and initiate appropriate follow-up.

Ability to provide consultative services and technical assistance, and to remain flexible, positive, relatist, and supportive under adverse conditions.

CERTIFICATES, LICENSES, REGISTRATIONS: Current State of Michigan Licensure as a Registered Nurse and current State of Michigan Specialty License as a Nurse Practitioner.

NOTE: Civil Service approval of this position does not constitute agreement with or acceptance of the desirable qualifications for this position.

27. I certify that the information presented in this position description provides a complete and accurate depiction of the duties and responsibilities assigned to this position.

Supervisor's Signature	Date

TO BE FILLED OUT BY APPOINTING AUTHORITY

28. Indicate any exceptions or additions to the statements of the employee(s) or supervisor.

29. *I certify that the entries on these pages are accurate and complete.*

Appointing Authority's Signature	Date

Appendix B

Appendix B

State of Michigan Department of Corrections (MDOC) new position/ replacement authorization.

MICHIGAN DEPARTMENT OF CORRECTIONS

NEW POSITION/REPLACEMENT AUTHORIZATION

1835 0600 12/89
CAJ-600

Request for New Position X Replacement for a Vacancy _____

(Submit a Position Description when appropriate)

I. Agency Department of Corrections ✓ Permanent _____

Bureau Bureau of Health Care Limited Term _____

Division Ionia Medical Complex Perm. Inter. _____

Section Handlon Michigan Training Unit (S.S.D.U.) Non Career _____

Position No. To be determined TKU _____

Class Title To be determined Mail Code _____

Previous Incumbent Vacant Date Vacated _____

Hourly Rate of Pay 32.-50 Standard Hours _____

II. Account Number _____ Cost Center _____

Source of Financing (State or Other) _____

Early Retirement Covered Position: ✓ "T" Rate Position _____

III. Is an Employment List Requested? Yes. ✓ No ____ Date Ordered 5-12-95

If No, Explain _____

Date Interviews Scheduled ASAP

Anticipated Appointment Date 10-15-95

FOR PERSONNEL USE ONLY

Appointment Type: _____

Appointee: _____

Effective Date: _____

Class Code: _____

Employment List No: _____

Section Authorization Date

Division Authorization Date

Bureau Authorization Date

Finance Authorization Date

Personnel Authorization Date

DISTRIBUTION: White - Requestor; Canary - Finance; Pink - Personnel; Goldenrod - Bureau

Appendix C

Appendix C

American Academy of Nurse Practitioners: Summary of studies of nurse practitioners' performance.

Administration: Capitol Station, LBJ Building • P.O. Box 12846 • Austin, TX 78711 • (512) 442-4262 • Fax (512) 442-6465
Governmental Affairs: P.O. Box 40013 • Washington, DC 20016

Summarizing the findings of the numerous studies of nurse practitioner's performance in a variety of settings, the Congressional Budget Office concluded: Nurse practitioners have performed as well as physicians with respect to patient outcomes, proper diagnosis, management of specified medical conditions, and frequency of patient satisfaction.[1]

Studies have shown that nurse practitioners rate high in consumer satisfaction.[2]

Review of studies comparing nurse practitioners and physicians led the Congressional Office of Technology Assessment to conclude: "NPs appear to have better communication, counseling, and interviewing skills than physicians have."[3]

The OTA study also states: "Malpractice insurance premiums and the incidence of malpractice claims indicate that patients are satisfied with NP care. Although insurance premiums for nurse practitioners are increasing, successful malpractice suits against them remain extremely rare."[4]

In a review of 26 studies comparing nurse practitioner performance to that of physicians, Prescott and Driscoll reported that nurse practitioners received higher scores than physicians on several variables. These included such areas as amount/depth of discussion regarding child health care, preventative health, & wellness; amount of advice, therapeutic listening, and support offered to patients; completeness of history and followup on history findings; completeness of physical examination and interviewing skills; and patient knowledge about the management plan given to them by the provider.[5]

In a review of 15 studies, Record concluded that between 75% and 80% of adult primary care services and up to 90% of pediatric primary care services could be performed by nurse practitioners.[6]

Productivity studies show that if a nurse practitioner is utilized efficiently, s/he could increase the productivity of a solo practice physician by approximately 70%.[7]

A review of several studies shows that the quality of care provided by NPs is as high as the care rendered by physicians for that range of skills which the NPs are trained to use. The quality of care comparison was measured by diagnosis, treatment, and patient outcomes.[8]

Robyn and Hadley report, ". . . it appears that patients respond favorably to the quality of treatment itself, as well as the tendency of nurse practitioners . . . to spend more time with them, to create a more relaxed atmosphere in which they (the patient) feel more comfortable asking questions which they might regard as too trivial for a physician.[9]

The Burlington Randomized Trial Study found that nurse practitioners made appropriate referrals when medical intervention was necessary.[10]

Estimates of increases in the productivity of physician practices that include nurse practitioners range from 20 to 90 percent. The greatest increase in productivity results when the nurse practitioner has primary responsibilities for a subset of patients and refers complicated cases "up" to the physician rather than having the physician delegate routine problems "down" to the nurse practitioner.[11]

In the Burlington Randomized Trial Study, it was found that nurse practitioners were able to provide primary care services as safely and effectively as physicians.[12]

In a federal physician extender reimbursement experiment, it was found that physician/nurse practitioner teams provided a higher quality of care than physicians alone.[13]

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