

Final Hallmark Assignment

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Health care within the U.S. correctional system has long been characterized by limited staffing, scarce resources, and rising clinical demands (Rosen et al., 2023). The population behind bars continues to age, and with that comes a growing prevalence of chronic illnesses that require consistent management. In addition, mental health conditions, substance-use disorders, and infectious diseases remain common. Delivering adequate care in these environments is about fairness, as it is a constitutional obligation under the Eighth Amendment. However, many facilities struggle to meet even basic standards. Traditional physician-centric models are proving unsustainable, especially in rural or state-run prisons where recruiting and retaining qualified clinicians is a constant challenge (Mohammadiagham et al., 2020).

Nurse-led care models supported by telehealth are emerging as a feasible way to bridge these systemic gaps. The combination of clinical autonomy for nurses and real-time virtual access to specialists allows correctional facilities to provide quality care without the logistical and financial burden of frequent off-site transfers (Sethuram et al., 2022). The following is a comprehensive approach to implementing a nurse-led telehealth program in a medium-security U.S. correctional facility, demonstrating how nurse-driven telehealth can transform correctional health services into more efficient, equitable, and sustainable systems.

Current State Analysis

The U.S. is high, with an even higher number living with at least one chronic illness. Among the most common are hypertension, diabetes, and hepatitis, along with mental health conditions that often go untreated (Papa et al., 2021). A report from the National Commission on Correctional Health Care [NCCHC] (2022) found that more than one-third of facilities operate with long-term nursing vacancies, and roughly half reported delayed access to off-site specialist

appointments. The outcome is predictable, including prolonged symptoms, higher emergency referrals, and increased mortality rates compared with community populations. As a result, the 5 Whys technique reveals why these gaps persist.

1. Why are medical appointments delayed? Because facilities rely heavily on external hospitals for specialty care.
2. Why is external care so frequent? On-site providers lack specific expertise, and teleconsultations are not integrated.
3. Why is telehealth not integrated? The facility lacks infrastructure and trained personnel to operate it.
4. Why is training insufficient? Budgets prioritize security needs over health care development.
5. Why is funding misaligned? Health care is often viewed as a cost center rather than an investment in safety and rehabilitation.

A Fishbone Diagram (Appendix A) illustrates how staffing, funding, policy, technology, and communication failures converge to limit access to timely care. In particular, the diagram shows how communication breakdowns between custody and clinical departments delay treatment approvals and off-site transports. The correctional environment also creates psychological barriers for patients. Many inmates distrust the health system because of previous neglect or the perception that care decisions are driven by security rather than compassion. Nurses often serve as the first and most consistent point of contact, placing them in a unique position to rebuild trust and coordinate ongoing treatment. Recognizing their central role forms the foundation of the nurse-led model proposed in this plan.

Practice Setting and Stakeholders

The proposed setting is a state-run, medium-security correctional facility housing about 1,200 inmates. The on-site clinic includes eight registered nurses, one nurse practitioner, a part-time physician, and two medical assistants. The facility maintains a basic electronic health record (EHR) but lacks telecommunication tools for real-time consultations. Internet access is secure and firewalled, enabling the addition of telehealth capabilities without compromising security. The following are the key stakeholders in the proposed initiative. Nursing staff lead clinical coordination and manage telehealth sessions. Their buy-in is essential because they understand both patient needs and operational limits. The facility's administration is also responsible for budgeting, scheduling, and compliance with state and federal standards. Another group of stakeholders is the correctional officers. Their cooperation is vital to ensure smooth scheduling and inmate movement during telehealth visits. There are also external specialists and partner hospitals that provide remote consultations and follow-up recommendations.

Another stakeholder is the IT department, tasked with ensuring hardware security, encrypted connections, and software updates. Inmate patients are also another stakeholder whose feedback on satisfaction and perceived quality of care will guide adjustments. Additionally, the state health authority oversees regulatory approvals and monitors outcomes under quality-improvement mandates.

Future State and SMART Goal

The vision for the future state is a correctional clinic where nurses manage chronic and low-acuity conditions on-site through virtual consultations with physicians and specialists. Instead of transporting inmates to outside hospitals for routine follow-ups, telehealth stations will

connect the facility directly with partnering medical centers. Nurses will perform initial assessments, relay findings, and participate in virtual sessions to ensure continuity of care.

The initiative's SMART goal is as follows.

Within 12 months of launch, reduce external medical transfers by 30 percent and increase compliance with scheduled chronic-care follow-ups from 60 percent to 85 percent, as verified through quarterly audits.

Evidence-Based Technological Intervention

The intervention centers on installing a nurse-coordinated telehealth system that allows remote consultations with physicians and specialists. The approach combines evidence from both correctional and community health research showing that nurse-led telemedicine can improve chronic care management, reduce costs, and enhance patient satisfaction (Williams et al., 2024). The core components include having secure video stations located in the clinic, equipped with high-resolution cameras, stethoscopes, and diagnostic peripherals. The second component is integration with the existing EHR, enabling direct documentation and prescription management. There are also remote monitoring tools for high-risk patients, including digital blood pressure cuffs, glucometers, and pulse oximeters that automatically upload readings.

Another component is nurse training modules covering telehealth etiquette, privacy protocols, and troubleshooting. Another component is workflow redesign, which helps schedule teleconsultations during regular clinic hours to minimize staffing conflicts. Available evidence supports this model. Hewson et al. (2024) documented that nurse-led telehealth coordination in state prisons improved blood pressure control among hypertensive inmates and reduced unscheduled emergency visits. Similarly, Capodici et al. (2025) established that nurse-driven teleconsultations reduced appointment wait times by 25.4% compared with traditional physician-

only scheduling. Beyond efficiency, these programs strengthened patient trust by providing more consistent face-to-face interaction. Also, telehealth helps address off-site medical trips that require at least two correctional officers, which pose the risk of escapes or incidents. Reducing those trips means more officers remain on post, improving institutional safety.

Decision Analysis and Implementation Plan

The following three options were considered. The first option is maintaining the current model with off-site referrals as needed. The second option is contracting with an external telemedicine vendor to manage virtual visits. The third option is developing an internal nurse-led telehealth program using existing staff and targeted training. From these options, the third was chosen for its long-term sustainability. Contracted services tend to charge per-visit fees and lack flexibility for on-site coordination. An internal model allows nurses to build competencies and integrate telehealth into daily practice.

Phase 1 – Assessment (Months 1–2):

Conduct a technology audit to confirm network capacity and determine equipment needs. Gather baseline data on current referral rates, chronic-care compliance, and costs.

Phase 2 – Planning (Months 3–4):

Select a HIPAA-compliant telehealth platform and establish data-sharing agreements with partnering hospitals. Form a steering committee that includes nurses, administrators, and IT specialists to finalize protocols.

Phase 3 – Training (Months 5–6):

Provide structured training for nurses on telehealth equipment and virtual communication. Develop checklists for pre-visit preparation and documentation.

Phase 4 – Pilot Implementation (Months 7–9):

Launch the telehealth program for two chronic conditions, including diabetes and hypertension. Evaluate technical performance, patient satisfaction, and workflow efficiency.

Phase 5 – Evaluation and Expansion (Months 10–12):

Compare referral and follow-up data to the baseline. Adjust procedures before expanding to include mental health and infectious disease consultations. As such, evaluation metrics will include referral volume, chronic-care compliance rates, cost savings, and qualitative feedback from both staff and inmates.

Risks, Ethics, and Safety Considerations

Ethical obligations in correctional health extend beyond clinical care to issues of privacy, equity, and autonomy. Introducing telehealth creates new responsibilities for protecting patient information and maintaining fairness in access (Williams et al., 2024). These aspects are discussed below. The first issue is privacy: all virtual sessions must take place in a private room so that other inmates or officers cannot overhear conversations. Audio and video files should not be stored locally. Instead, documentation should occur within the secure EHR. The second aspect is equity, where every inmate, regardless of custody level or housing assignment, must have equal access to telehealth appointments. Priority scheduling should follow medical urgency, not behavioral status. The third aspect is informed consent, in which nurses must clearly explain the telehealth process, outlining how data are transmitted and who participates in each session. Participation should remain voluntary whenever feasible.

Another aspect is safety. This requires clear triage protocols to differentiate between cases suitable for telehealth and those requiring in-person evaluation (Kobeissi & Ruppert, 2021). Emergency response procedures should be rehearsed so that teleconsultations never delay

urgent interventions. Another aspect is professional boundaries. This is because telehealth can feel less formal; nurses should maintain the same professional demeanor as during in-person care (Williams et al., 2024). Ethical training must address potential role confusion, especially in mental health consultations, where emotional rapport develops over repeated sessions (Keenan et al., 2025). As such, when these risks are addressed upfront, the facility can uphold ethical standards while strengthening trust between providers and patients.

Resources and Return on Investment (ROI)

The first is hardware. This will require two telehealth stations, each costing around \$25,000, with diagnostic attachments. The second is software. The software must be HIPAA-compliant to enable effective licensing and integration, at an average annual cost of \$15,000. The following resource is training. Here, initial sessions for nurses and IT staff can cost around \$10,000. There is also maintenance, including equipment servicing and data security updates, averaging \$5,000 per year. From the above, the initial total cost to start will be approximately \$55,000.

The following are the projected savings and benefits. The average cost of an off-site medical visit is about \$1,200. This will include transportation, officer escort, and overtime pay. If the facility reduces external visits by 120 per year, it can experience a modest 30 percent cut. At the end of the year, significant savings are projected, covering the entire investment in the initial year. Beyond direct cost savings, intangible returns will also be felt significantly. Telehealth reduces inmate anxiety associated with transport, reduces exposure to external pathogens, and decreases the incidence of confrontational incidents during hospital trips (Williams et al., 2024). For staff, fewer transfers mean improved scheduling and morale. Another important outcome is job satisfaction. Knop et al. (2024) show that granting nurses greater

autonomy and involvement in technology-driven initiatives improves professional identity and retention. In an environment where turnover is chronic, that stability itself represents an economic advantage.

Conclusion

Correctional health systems stand at a crossroads between rising demand and limited capacity. Nurse-led care teams that are empowered through telehealth represent a practical way forward. The plan offers a roadmap for a state correctional facility to implement such a model responsibly, emphasizing measurable improvement, ethical diligence, and fiscal accountability. The proposed 12-month implementation sets achievable goals, including a 30% drop in off-site medical transfers and an 85% compliance rate for chronic-care follow-ups. Evidence from national programs shows these targets are not only realistic but likely conservative. A special aspect of this initiative is its reliance on nurses as central coordinators. Their presence in daily patient life, combined with structured telehealth access to specialists, creates a continuous care loop previously missing in many facilities (Williams et al., 2024).

Inmates benefit from timely interventions and consistent follow-up, while institutions save resources and strengthen safety. As a result, telehealth should not be seen as a replacement for in-person medicine but as a vital extension of it (Williams et al., 2024). Therefore, by integrating digital consultation into nursing workflows, correctional systems can modernize without overextending their budgets. Success here could guide similar transformations across state networks, reinforcing the idea that humane, efficient care is achievable even in restrictive environments. To conclude, this proposal is strong because it amplifies the nursing role aided by technology. When nurses are trusted to lead and equipped to connect, they become catalysts for

change, thereby turning a constrained system into one that finally meets its promise of care, dignity, and justice.

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APPENDIX A: Fishbone Diagram

