Spring 2025 | Volume 39 | Issue 1

CorrectCare®

The magazine of the National Commission on Correctional Health Care

Harvard Study:

Accreditation Saves Lives, Improves Outcomes, Reduces Recidivism

Traumatic Brain Injuries

New Jail Guidelines for Medical Treatment of Substance Use Disorders

Navigating Moral Injury in Correctional Health

National Commission on Correctional Health Care
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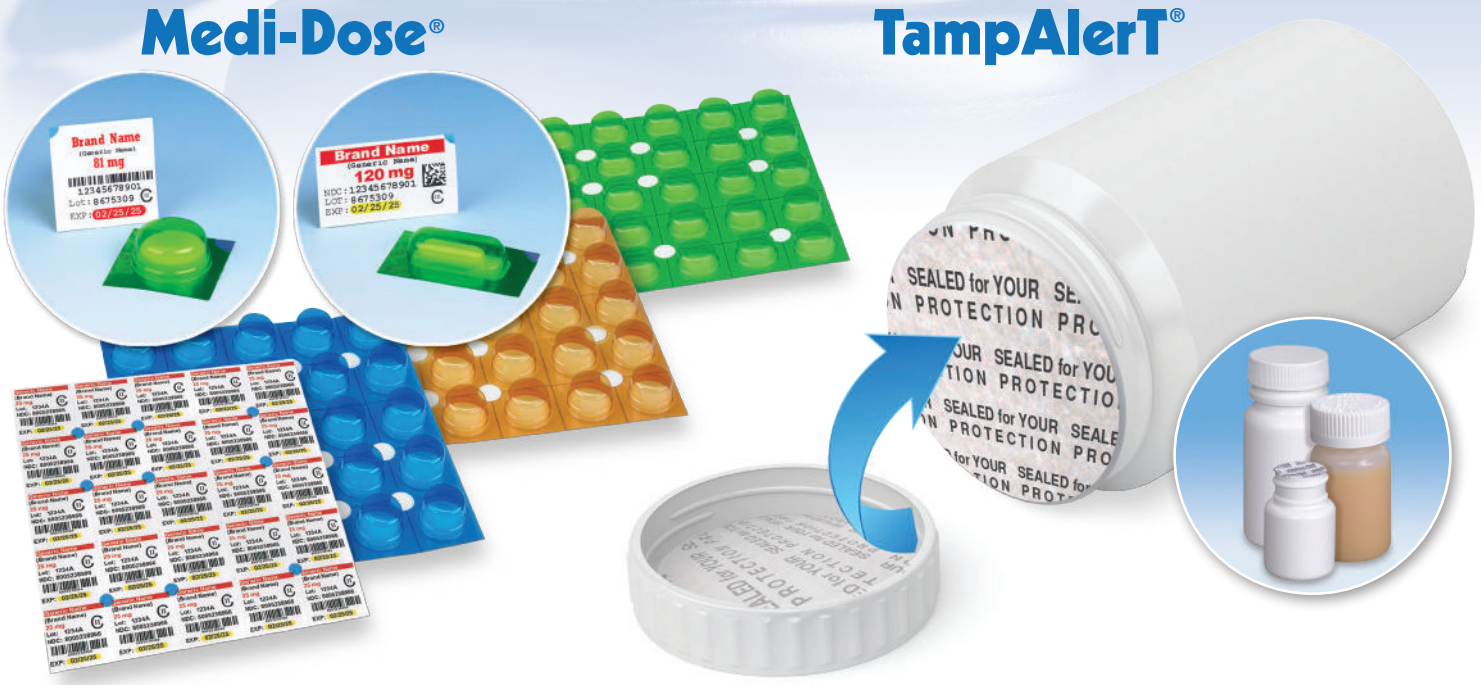

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CorrectCare®
The magazine of the National Commission on Correctional Health Care

6

contents

FEATURES

DEPARTMENTS

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NCCHC Foundation Launches Legacy Society

The NCCHC Foundation proudly announces the launch of the Legacy Society, a new recognition circle honoring individuals who demonstrate their commitment to the future of correctional health care with gifts totaling $5,000 or more.

Total gifts can include cumulative giving through cash donations, bequests, trusts, retirement accounts, or life insurance. Donations made since the Foundation's inception in 2020 count toward Legacy Society membership.

The Legacy Society ensures that critical initiatives, including scholarships, workforce development, education, research, and reentry support, continue to grow and thrive for years to come. Members will be recognized publicly (unless anonymity is preferred) and serve as lasting champions for health equity in corrections.

To learn more or join the Legacy Society, visit **ncchcfoundation.org** or contact the Foundation at info@ncchcfoundation.org.

New Position Statements: Emerging Threats

NCCHC's most recent position statements address emerging threats to both incarcerated populations and the world at large.

Climate Control for Extreme Temperatures in Corrections calls for carceral facilities to implement standards for minimizing extreme temperature exposure indoors and outdoors and to adopt steps for prevention and mitigation.

Diagnosis and Management of Hepatitis C stipulates that opt-out education, testing, and treatment programs for hepatitis C infection be available for all people newly admitted into a correctional facility.

In addition, three position statements aimed at protecting youth who are detained were recently revised: Adolescent Sleep Hygiene, Health Care Funding for Youth in Custody, and Suicide Prevention and Management of Youth in Custody.

Learn more at **ncchc.org/position-statements.**

Press Play: NCCHC Videos

NCCHC and the NCCHC Foundation have released the final two videos in the "Careers in Correctional Health Care" series. One showcases careers in correctional medicine, geared toward physicians and medical students hoping to help an overlooked, underserved patient population. The other features correctional psychologists, therapists, counselors, and social workers discussing the immense rewards of working in correctional mental health.

View and share the videos with students and other health care professionals who may not have considered this unique specialty: **ncchc.org/careers-in-correctional-health-care.**

New Members Join NCCHC Boards

Hon. Mary Ann Borgeson, commissioner with the Douglas County (NE) Board of Commissioners, is the new National Association of Counties liaison to the NCCHC Board of Representatives.

Paula Oldeg, MD, CCHP, medical director at the Buzz Westfall Justice Center - St. Louis County (MO) Jail, was elected as the American College of Emergency Physicians liaison.

Lieutenant Colonel Elsie Judon, MS, BSW, CJM, CCHP, director of operations - department of detention at the Broward (FL) Sheriff's Office, is the new board liaison to the American Jail Association. She is the first woman of color to be elected first vice president of the AJA.

She replaces former AJA liaison Oscar Aviles, CJM, CCE, CCHP, deputy county administrator of Hudson County (NJ), who completed his term on the NCCHC board. He has joined the board of NCCHC Resources, the organization's consulting subsidiary.

Three Pinnacle Awards for Three Accreditations

PINNACLE AWARD

NCCHC's Pinnacle Award is the highest honor in correctional health care, presented to only a handful of facilities that have successfully achieved accreditation in three separate service areas.

Three facilities, each with health services provided by NaphCare, Inc., recently earned this honor: Middlesex County Office of Adult Corrections & Youth Services in New Jersey; Washoe County Detention Facility in Nevada; and Clackamas County Jail in Oregon.

For more information go to **ncchc.org/accreditation.**

Caring for Those In the Shadows

By Patricia Blair, PhD, JD, MSN, CCHP-RN, CCHP-A

Lately I have been reflecting on what led me to become so engaged in correctional health care, a journey that began while I was pursuing my health law degree. It was during this time that I first became aware of the deeply troubling health disparities faced by individuals in the correctional system.

Many of the people coming into our jails and prisons are not only marginalized by society, they also suffer from a range of unmet health needs. These individuals come from some of the most underserved and neglected communities, and their health, already compromised, is often worsened by inadequate care – or, in some cases, no care at all.

It became clear to me that the justice system, tasked with the duty of upholding law and order, was failing to meet the basic human rights of those in its care. The absence of proper health care not only affects the well-being of these individuals but also poses a larger threat to public health overall. And this is why I remain so passionate about correctional health care – it's not just about improving care within our facilities, it's about understanding that the health of justice-involved individuals is a public health issue.

Over the years, there have been moments of progress, but they have not come easily. It has taken relentless advocacy, consent decrees issued by courts of law, decisions by the U.S. Supreme Court, and the tireless efforts of organizations like NCCHC to drive much-needed reforms. These victories have helped elevate quality of care, but the fact remains: we are not where we need to be.

Our work is about much more than just providing health care. It's about recognizing the dignity of every human being, regardless of the circumstances that brought them into the justice system. It's about addressing health inequities, mitigating the effects of social determinants of health, and ultimately creating a healthier, more just society.

I firmly believe that how we treat the most vulnerable among us is a direct reflection of our nation's values.

Hubert H. Humphrey once said, "The moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy, and the handicapped."

These words resonate deeply with me, and I believe they hold up a mirror to our collective responsibilities.

We must rise to the challenge of improving health care for those who are in the "shadows" – those whose voices are often silenced, those who lack access to basic resources, and those who are often forgotten by society. And that includes the incarcerated.

In my role as Board chair, I am committed to working alongside all of you to advocate for national standards, more comprehensive care, and a justice system that acknowledges the humanity of every individual it touches. Together, we have the power to bring about meaningful change – not just in the lives of those behind bars but in the health and well-being of our nation as a whole.

Thank you for your unwavering dedication to correctional health care. I look forward to working with you as we continue to advance this mission and make a lasting impact. ●

Patricia Blair, PhD, JD, MSN, CCHP-RN, CCHP-A, is the 2025 chair of NCCHC's Governance Board and board liaison of the American Bar Association.

At a Glance: Meet Patricia Blair

Career Highlights

- Associate professor, graduate nursing program, University of Texas Medical Branch

NCCHC Positions

- Board of Representatives, 2007-present
- Chair, CCHP-RN subcommittee, 2018-present
- Co-chair, Nursing Education subcommittee, 2022-present

Education

- PhD in Clinical Sciences, University of Texas Medical Branch Graduate School of Biomedical Sciences
- Master of Laws in Health Law, University of Houston, Health, Law & Policy Institute
- Master of Science in Nursing, University of Texas Medical Branch School of Nursing
- Juris Doctor (Law), Texas Southern University, Thurgood Marshall School of Law
- Bachelor of Science in Nursing, University of Texas, San Antonio

Harvard Study:

Accreditation Saves Lives, Improves Outcomes, Reduces Recidivism

A recent Harvard University study reveals that NCCHC accreditation saves lives, improves health care quality, reduces reincarceration rates, and enhances coordination between custody and health staff.

Researchers from the Harvard Kennedy School and Harvard Law School completed a multiyear randomized controlled trial with 44 small to medium-sized U.S. jails not previously accredited by NCCHC. The study employed a variety of survey instruments to evaluate how accreditation affects quality of care and mortality.

The study found that completing NCCHC's accreditation process has "statistically significant and economically meaningful effects on a range of outcomes," including improved collaboration between health and custody staff, staff preparation, and compliance with quality standards – without additional staff or large capital investments.

"Ultimately, our study shows that accreditation can improve health care and save lives in U.S. jails," the researchers, Marcella Alsan, MD, PhD, MPH, from Harvard Kennedy School, and Crystal Yang, PhD, JD, from Harvard Law School, concluded.

What the Study Tells Us About Accreditation

According to the study, the NCCHC accreditation process led to an 86% decrease in mortality as measured by deaths per month, which translates into nearly 20 lives over the course of the study. Researchers surmise this is due to a closer alignment between custody and health staff in terms of processing and screening individuals, particularly in the first few days of incarceration, when mortality tends to be the highest.

Another striking result of NCCHC accreditation: the study found that it facilitates better coordination between custody and health staff, addressing a longstanding challenge. Facilities reported improved communication and collaboration, with custody staff supporting medical decisions more effectively. This level of coordination is pivotal in ensuring timely and appropriate care for incarcerated individuals.

The researchers also found evidence to suggest that accreditation impacts recidivism, showcasing the societal benefits of better health care during incarceration. Individuals released from accredited facilities were 52% less

likely to return to the same jail within six months relative to control facilities. "These health gains are realized alongside suggestive reductions in six-month recidivism, such that accreditation is highly cost effective," the study authors wrote. Cost-effectiveness analysis suggests that accreditation generates $59 million in benefits per jail per year.

> "Ultimately, our study shows that accreditation can improve health care and save lives in U.S. jails."
>
> Marcella Alsan, MD, PhD, MPH, Harvard Kennedy School, and Crystal Yang, PhD, JD, Harvard Law School

How the Study Was Conducted

The trial divided the 44 participating jails into two groups: 22 treatment facilities received substantial subsidies to pursue accreditation; 22 control facilities received smaller subsidies to begin the process at the study's end.

The researchers developed and administered comprehensive questionnaires for jail leadership, custody staff, and health care staff. They also conducted independent audits of medical records and death logs; qualitative interviews with jail leadership and incarcerated individuals; and surveys of experts and formerly incarcerated individuals to assess the importance of various standards. Jails were randomized after fulfilling all study qualifications.

"For years, we have had anecdotal evidence about the power of accreditation to improve quality," said NCCHC Chief Executive Officer Deborah Ross, CCHP. "Now, a rigorous scientific study has made those improvements tangible. We are extremely grateful to the researchers, our accreditation staff and surveyors, and the participating jails."

For More Information

To read the study in its entirety, scan the QR code to the right.

To receive a recording of a free webinar about the study, go to **ncchc.org/ncchc-accred-study-webinar.**

For more information on accreditation, go to **ncchc.org/accreditation**.

Key Findings: The Transformative Power of NCCHC Accreditation

The study, conducted by Harvard University researchers, highlights the impact of NCCHC accreditation on jail health care in several critical areas.

Decreased Reincarceration Rates

54% reduction in return to same jail within three months

52% reduction in return to same jail within six months

Reduced Mortality

86% reduction in mortality, which equates to nearly 20 lives during the study period

Improved Compliance with Quality Standards

15% increase in adherence to personnel training standards

11% increase in adherence to patient care and treatment standards

Return on Investment

$59 million

in benefits, including reduced legal liabilities, enhanced operational efficiency, and public health improvements

Source: The Hidden Health Care Crisis Behind Bars: A Randomized Trial to Accredit U.S. Jails, Marcella Alsan and Crystal Yang, NBER Working Paper No. 33357

Are Brain Injuries Going Undetected and Unmanaged in Your Correctional Facility?

By Kelly Sarmiento, MPH

Brain injuries in correctional facilities are more common than you might think. It is estimated that more than 600,000 head and brain injuries occur in U.S. correctional facilities each year. About half of incarcerated adults have had at least one brain injury during their lifetime, and as many as one-third have experienced multiple brain injuries, according to one meta-analysis.

Estimates of brain injuries among this population are markedly higher than in the general public and may happen before or during incarceration, and yet they are likely undercounted. Concerns about reporting a brain injury and seeking medical care, as well as limited screening for brain injuries in correctional facilities, all likely play a role.

Exposure to violence (such as a strike or punch to the head) and car crashes are among the leading causes of brain injury among people incarcerated in correctional facilities. However, brain injuries can also result from a loss of oxygen to the brain due to a drug overdose or by being choked, strangled, or suffocated.

Potential Effects of a Brain Injury

When the brain is injured, it sets off a complex process that may include bleeding, swelling, and/or neuronal damage or death. This process can lead to short- or long-term changes in how the brain functions and how parts of the brain communicate with one another. Changes in cognition are the hallmark symptom of brain injury, but other common symptoms can include physical problems such as headaches and sensitivity to light and noise and problems with sleep, behavior, communication, and emotions.

The potential effects of a brain injury vary in severity and length. In one study, half of people with a mild brain injury no longer experienced symptoms six months postinjury, while the other half had symptoms for six months or longer. People with a history of multiple brain injuries are at higher risk of having a prolonged recovery and displaying psychological, physical, sleep, and cognitive symptoms.

When symptoms persist, they can worsen existing health and behavioral problems, including severe depression and anxiety, substance use disorders, uninhibited or impulsive behavior, and self-harm. Brain injury symptoms may also contribute to situations that increase the chance for disciplinary action within the correctional setting.

Identification

Improving identification of people living with brain injury symptoms is critical – and also challenging. Developing robust and responsive care pathways is important. The first step is screening.

Common Brain Injury Symptoms

Problems with attention or memory. A person living with a brain injury may have trouble focusing or remembering information, or be unable to learn instructions or complete a required task. This may appear as uncooperative or defiant behavior.

Irritability, anger, or impulsive behavior. Poor judgment, impulsive behavior, and trouble controlling emotions are challenges for some people living with a brain injury. This may result in acts of physical violence, aggression, and substance use – putting themselves and others at risk for harm or injury.

Trouble learning, communicating, or processing information. The effects of a brain injury may result in a person responding slowly to questions or becoming confused or distressed when presented with information. This may appear as being uncooperative or indifferent.

Problems with motor skills and speech. A brain injury can lead to problems with balance or walking in a straight line. A person living with a brain injury may also have trouble with speaking, such as slurring words. Together, this may appear as if the person is intoxicated.

Difficulty regulating emotions. A brain injury can affect a person's ability to regulate their emotions. This may include showing emotions that do not match the situation, such as being easily irritated or angry without a specific cause or laughing or smiling when being disciplined. This can lead to miscommunication and an escalation of a situation.

Sensitivity to light or noise. Sensitivity to light or noise is more common soon after a brain injury. A person may cover their eyes or ears, look distracted, or become distressed, irritable, or angry when exposed to loud noises (such as in crowded areas) or bright lights. This may appear as uncooperative or defiant behavior.

Problems with organization or planning. Individuals living with brain injury may have problems organizing tasks, keeping their cells or living areas clean, or planning ahead. They may also become confused when their schedule is changed. This may appear as if they are refusing to follow instructions.

Source: Centers for Disease Control and Prevention

A history of a brain injury does not mean a person will experience long-term effects. However, routine brain injury screening may help identify individuals experiencing persistent symptoms in need of a clinical evaluation and accommodations. Currently, screening for a history of brain injury in correctional facilities is rare.

In their report "Mind Matters: Building a Justice System That Is Inclusive and Responsive to Brain Injury," Megan Davidson and Kate Reed with the Council of State Governments Justice Center outline a basic infrastructure framework for making brain injury screening more commonplace. The report suggests beginning with a focus on brain injury screening in youth detention systems and then expanding to adults.

Step 1: Nonclinical staff may screen for lifetime history of brain injury during intake using a single yes or no question. Example: Have you ever been knocked out or lost consciousness, been dazed or confused, or had a gap in your memory because of a hit, blow, or jolt to the head?

Step 2 *(only needed for individuals who screen positive in step 1)*: Clinical or nonclinical staff may screen for brain injury-related symptoms using a screening form. This step helps identify those who may need further evaluation and support. Examples of screening forms include the TBI Symptom Screener for Corrections (user guide), the Ohio State University TBI Identification Method, and the Online Brain Injury Screening and Support System (OBISSS).

Step 3 *(only needed for individuals who screen positive in step 2):* Clinical staff may conduct a physical exam and symptom-based assessment and create a management plan as needed. Components of the physical exam generally include a cognitive exam, neurological evaluation, and vestibular/ocular-motor screening. Neuroimaging is not routinely used for diagnosis of mild brain injuries and concussion. An example of a symptom-based assessment form is the Acute Concussion Evaluation (ACE) Test.

Management

Several studies point to the benefits of using accommodations, including those available through the Americans with Disabilities Act (ADA), to support recovery following a brain injury – even if it's many years postinjury.

Implementing accommodations for a person with a brain injury in a correctional facility may seem challenging. However, for many people with a brain injury, even small and short-term accommodations are helpful.

Identifying the greatest need of the person is a good place to start. For example, repeating instructions or summarizing information can make a big difference for a person struggling with memory or cognitive problems. When possible, providing quiet locations and rooms with dimmed lights can be a break for people who experience sensitivity to light or noise. Communicating with custody staff about how accommodations may help their jobs become easier can encourage them to implement some of the small easy steps. Clinical guidelines recommend follow-up evaluation and referral to specialized care for individuals whose symptoms do not improve with accommodations after four weeks.

The effects of a brain injury may lead to problems with family and social interactions, as well as the ability to work or be employed, drive, and navigate other day-to-day activities. Adding to this, without support, a person may struggle to access health care and other services. That can make the already-challenging process of postincarceration reintegration into the community even more difficult.

Providing support for people with a brain injury may improve success rates for return to community, lowering recidivism and increasing productivity in the community. Coordinating with probation services and parole supervision, as well as partnerships with brain injury and other organizations, are effective ways to make sure people living with brain injury get linked to services (including case management) and medical care upon their release.

Building a Program

Lack of awareness, misconceptions, and stigma limit the ability to identify and manage brain injuries. Encouraging educational training on brain injury is a good first step to creating more robust systems.

The AHEAD program (Achieving Healing through Education, Accountability, and Determination) provides training for people incarcerated in correctional facilities who screen positive for a brain injury to learn how to better manage their symptoms, including mental health symptoms.

Training is facilitated by facility staff using a guide and teaching tools provided

Illustration © M7Studio/Shutterstock

Continued on page 19

JAIL GUIDELINES FOR MEDICAL TREATMENT OF SUBSTANCE USE DISORDERS 2025

By Claire Wolfe, MPH, MA, CCHP

NCCHC's newest resource, "Jail Guidelines for the Medical Treatment of Substance Use Disorders 2025," encompasses the latest research and best practices for addressing the opioid crisis and ensuring that incarcerated individuals receive effective treatment. This new publication incorporates up-to-date, evidence-based recommendations for implementing and evaluating medication-assisted treatment (MAT) programs.

A Note on Language

Medication-assisted treatment (MAT) and medications for opioid use disorder (MOUD) are terms commonly used to describe buprenorphine, methadone, and naltrexone to treat opioid use disorder. However, the term MOUD excludes medications for the treatment of alcohol use disorder, a highly prevalent condition among jail and prison populations.

For that reason the guidelines use MAT, a term that is commonly used and understood by jail administrators, custody staff, and health staff to refer to addiction treatment for both OUD and AUD.

The new guidelines offer:

- A structured overview of the key stages of MAT program implementation
- An analysis of regulations governing MAT in correctional settings
- References to additional resources for deeper exploration of specialized topics
- Case studies showcasing real-world examples of successful MAT programs

In 2018, NCCHC partnered with the National Sheriffs' Association to develop "Jail-Based MAT: Promising Practices, Guidelines, and Resources." Since then, the landscape of substance use disorder treatment in jails and the broader community has evolved significantly. Despite a growing legal mandate to provide MAT, many agencies still face knowledge gaps that hinder effective program implementation.

The new guidelines equip correctional professionals with the tools they need to navigate these challenges and expand access to lifesaving treatment. The publication is endorsed by both the American Jail Association and the National Sheriffs' Association.

What's New?

Jail-based treatment for substance use disorders has changed since 2018, when "Jail-Based Medication-Assisted Treatment" was originally published. Now, more jails offer access to methadone, buprenorphine, and/or naltrexone, the three medications for the treatment of opioid use disorder (OUD) approved by the Food and Drug Administration. In addition, the legal environment has evolved to elevate the standard of care that jails are required to meet. Meanwhile, increasingly lethal drugs have become common, and the number of overdoses in the United States remains alarmingly high.

With this update, NCCHC seeks to capture these changes by including up-to-date research, new resources, and changes that reflect the current landscape of jail-based MAT treatment.

The guidelines are organized into five program components, which are listed below along with the main organizing principles of each. Please refer to the complete resource guide for details and in-depth understanding of the issues. See the box to the right for information on how to access "Jail Guidelines for the Medical Treatment of Substance Use Disorders 2025."

Program Component 1: Screening

- All individuals entering a jail should be systematically screened for substance use disorders upon intake. Screeners should explain the reason for the questions (e.g., "We ask these questions to ensure you receive appropriate treatment while you are here").
- Protocols to support timely screening for, and evidence-based management of, active withdrawal syndromes should be in place. Substance withdrawal must be addressed early in the intake process (ideally, within four hours of admission) to reduce the risk of medical complications and fatalities. Acute withdrawal symptoms may begin within eight to 48 hours of the last opioid use and last up to four to 10 days for short-acting opioids or 10 to 12 days for long-acting opioids.
- Jails should establish systems to ensure that patients who had been receiving MAT before their arrest, particularly methadone and buprenorphine, have MAT continued in a timely manner. Withdrawal from prescribed MAT after an arrest is predictable and avoidable by continuing the individual on their prescription. Given the frequency of unexpected releases and transfers from jails, a decision to stop clinically appropriate MAT is high risk.
- Individuals should be assessed by a qualified treatment provider to determine whether MAT is clinically indicated. If indicated, medication for addiction treatment, and the specific medication chosen, should be based on a medical recommendation and an individual's decision, not imposed by facility policy.

Program Component 2: Medication Choice

- People receiving prescribed MAT should be allowed to continue their medication when that is the patient's wish and is clinically appropriate. That means that jails need to provide access to all three FDA-approved medications: methadone, buprenorphine, and naltrexone.
- The selected medication must be matched to the needs of the individual. The guide provides a comprehensive overview of the three medications.
- Expert consensus supports long-term or even lifelong prescription of MAT. OUD is a chronic condition with alterations in brain function. Relapse rates are high and relapse is often fatal. Long-term MAT is often required in the same way that long-term medications are needed for other chronic conditions.
- The FDA has also approved three drugs to treat alcohol use disorder: naltrexone, disulfiram, and acamprosate.

Program Component 3: Partnerships, Communication, and Collaboration

- Collaborative relationships, both within the facility and with outside community-based organizations, benefit patients and staff. The ways in which jails provide access to MAT will vary depending on the facility's resources, location, community resources, health services vendor, and leadership, among other factors.
- Jail MAT programs should include ongoing monitoring through drug screening and other risk mitigation strategies. Prior research has found that diversion is often cited as a barrier to providing MAT. Although fears of medication diversion are not unfounded, research has demonstrated that a MAT program can disrupt illegal buprenorphine markets in jail and lead to a more favorable environment.

Program Component 4: Discharge Planning and Postrelease Assistance

Facilities should strive to employ a designated discharge planner who is responsible for ensuring continuity of care postrelease and can assist with other practical needs.

Time of release from jail can be difficult to predict. Thus, discharge planning must begin at intake and continue throughout incarceration. At the very least, the facility should ensure that a newly released individual has an appointment with, or a warm handoff to, a community provider to continue MAT.

Continued on page 21

Access the New MAT Guidelines

To download a free copy of the new guidelines, go to **ncchc.org/jail-based-MAT.**

Navigating Moral Injury in Correctional Health

By Stephanie Gangemi, PhD, LCSW, CCHP

The concept of moral injury, originally studied among military personnel, is gaining recognition as a critical issue in health care – especially in settings as complex as correctional facilities. In an environment where the line between care and punishment is sometimes blurred, correctional health professionals face situations where their duties as caregivers conflict with institutional policies focused on safety and security. That conflict can leave them vulnerable to moral injury: profound psychological distress resulting from actions or inactions that go against deeply held moral beliefs.

Illustration © Ken Tackett/Shutterstock

A Soul Wound

Moral injury refers to the emotional and psychological suffering that occurs when individuals feel they have betrayed their moral values, particularly when working in high-stakes environments. That could be due to following orders that violate their professional ethical codes or failing to prevent harm due to institutional restrictions. Unlike burnout, which is characterized by exhaustion, and post-traumatic stress disorder, often related to physical danger, moral injury is more closely associated with guilt, shame, and a feeling of having compromised one's ethical principles.

When health professionals find themselves unable to provide the patient care they know is right or must participate in actions they find morally unacceptable, they experience a "soul wound" that can significantly impact their mental health and their ability to continue practicing effectively.

For the past two years, I served as the principal investigator on an exploratory study on moral injury among correctional health professionals. This phenomenological, qualitative study included in-depth interviews with 25 correctional health professionals across the U.S. Participants included nurses, physicians, mental health professionals, dietitians, recreational therapists, and more. The findings, recently published in the "Journal of Correctional Health Care," highlight how moral injury manifests in their work.

The interviews reveal that moral injury is not only present in this field but is nearly unavoidable. Participants described working in correctional health care as emotionally taxing, requiring them to constantly navigate ethical dilemmas while recognizing the limitations on their ability to care for their patients. My research assistant, Camille Dysart, and I identified five major themes, which I outline here.

Moral Injury as Occupational Hazard

Moral injury is a part of the job for correctional health professionals. All 25 interviewees reported experiencing some form of moral injury, often describing their work as being emotionally overwhelming and morally complex. They expressed feelings of anger, frustration, regret, shame, and helplessness in response to situations in which their professional roles conflicted with their moral beliefs.

Many participants initially did not have a name for the feelings they were experiencing. Learning the term "moral injury" provided them with validation and clarity, helping them better understand their emotional and psychological responses to their work. Most of those interviewed reported that the concept of moral injury was enlightening. One described wishing their colleagues and leadership knew that moral injury is "truly a wound" and said, "The more it builds up, the bigger the wound gets…and it's hard to stop the bleeding once it starts." Another shared that it felt like a "silent injury," emphasizing that the harm experience is not always visible, even to those around them, which makes it difficult to address or seek help.

Types of Moral Injury: Incidental vs. Cumulative

The study found that moral injuries can be incidental or cumulative. Both types were common among the individuals to whom we spoke.

Incidental injuries occur from one-time, intensely distressing events, for instance, a specific case where a health professional was unable to provide necessary care due to security policies or administrative restrictions. One participant recounted an event in which health staff were forced to administer AED shocks while a patient was kept in metal handcuffs during resuscitation efforts. Medical personnel had requested the handcuffs be removed due to safety concerns about electrical conductivity, but custody staff declined the request, despite the patient's clear incapacitation. This event left the health professionals feeling distressed and powerless, and it deeply affected their sense of duty as care providers.

Cumulative moral injuries build gradually as health professionals are repeatedly exposed to morally compromising situations. One person described cumulative injuries from repeated exposure to excessive use of force on incarcerated individuals while feeling helpless to intervene. These incidents accumulate, leading to a sense of helplessness, disengagement, and emotional fatigue.

Institutional Betrayal: When Systems Fail

Another major theme was institutional betrayal, which refers to the harm caused when organizations that individuals depend on not only fail to prevent harm but also become complicit in perpetuating it. That betrayal can take many forms, such as enforcing cost-cutting measures that compromise care or creating a culture where health professionals must turn a blind eye to unethical practices to maintain employment. Correctional health professionals often feel let down by the institutions they work for, which fail to protect them or adequately support their need to uphold ethical standards.

One individual described the harms of being forced to work with a patient who had repeatedly sexually harassed her, despite requests for reassignment. Another mentioned how management often ignored his concerns about patient neglect or inadequate care, further deepening the sense of betrayal. Combined with at times being mocked and insulted for showing their patients compassion, these experiences underscore how failure to protect correctional health professionals from harm – and sometimes forcing them to engage in morally compromising behaviors – can erode trust and exacerbate moral injury.

Interplay of Moral Injury, Burnout, and PTSD

Moral injury, burnout, and PTSD are distinct but interconnected experiences. Burnout often results from prolonged stress, while PTSD is a response to traumatic events that threaten physical safety. Moral injury, by contrast, is more about ethical conflict and feeling forced to act against one's moral beliefs.

The degrees of overlap vary greatly depending on each person's experience. Some interviewees reported that while burnout left them exhausted, moral injury felt like a deeper wound that shook their very sense of self. Some viewed it as a precursor to PTSD, arising from repeated violations of their ethical standards. "When you have repeated attacks on your values and are being asked (or told) to do things that conflict with your values directly…that's gonna break a person," said one.

The Road to REPAIR

Despite grappling with the harms of moral injury, correctional health professionals had valuable insights on how to best improve their working conditions. This road to moral repair involves both personal resilience and institutional change.

The people we interviewed (and the literature on moral injury) stress that moral repair must go beyond individual responsibility and should include a systemic approach that addresses root causes. Many recommended integrating discussions of moral injury into training, increasing support from leadership, and fostering a workplace culture that values "moral courage" – the strength to uphold one's ethical beliefs in difficult situations. This was frequently mentioned as crucial for correctional health professionals.

Based on these insights, we suggest a framework, using the acronym REPAIR, for addressing moral injury in correctional health care. The REPAIR framework, emphasizing the need for recognition, education, moral courage, accountability, and institutional reform, offers a promising path forward,

Recognition of moral injury: Integrate the concept of moral injury into the lexicon of possible harms, along with burnout, vicarious trauma, and compassion fatigue.

Education about moral injury: Develop and offer structured training to define moral injury and bring it to awareness. Build a "moral injury-informed" culture.

Promote moral courage: Model moral courage from the top down and bottom up. Acknowledge and uphold morally courageous actions.

Acknowledgement and accountability: Commit to developing a culture based on taking responsibility for ethical and moral behaviors. Hire and support leaders who will address root causes and symptoms of moral injury.

Institutional-level interventions: Resist the urge to make moral injury about individual pathology. Leadership accountability is essential.

Reparations: Consult with health professionals about what they need to move toward repair. Do the things requested.

Our study reveals the importance of addressing moral injury in correctional health care, both to support health professionals and to improve the quality of care for incarcerated individuals. For health professionals, understanding moral injury is the first step toward addressing its impacts and working together to create a healthier, more ethically sound environment. Institutions, in turn, have a duty to provide a supportive work environment in which ethical dilemmas are mitigated rather than exacerbated. Building a moral injury-informed culture could lead to improved staff well-being while also creating a more humane environment for all involved. ●

Stephanie Gangemi, PhD, LCSW, CCHP, is assistant professor in the Department of Social Work at the University of Colorado - Colorado Springs College of Public Service.

FOR MORE INFORMATION

Gangemi, S. & Dysart, C. (2024). Moral injury in correctional health care. Journal of Correctional Health Care. https://doi.org/10.1089/jchc.24.04.0036

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"Shorter Is Better": The Movement to Decrease Unnecessary Antibiotic Use

By Samuel Wilk and Alysse Wurcel, MD, MS

Antimicrobial resistance – born from widespread overprescribing of antibiotics – is a global threat, becoming an increasingly common cause of hospitalization and death. People who are incarcerated have higher rates of several bacterial infections, including cellulitis, pneumonia, and dental infections, and those infections lead to high rates of antibiotic usage in jails and prisons.

Antibiotic stewardship is an approach aimed at decreasing the use of unnecessary antibiotics. Until recently, most clinical providers believed prescribing antibiotics to be the safest and most effective way to treat many common infections. However, antibiotics are not without risks: each has various side effects ranging from nausea and vomiting to bone marrow suppression, as well as risks for secondary infections.

Decreasing antibiotic use has several benefits besides slowing antimicrobial resistance; the most direct is lowering the risk of side effects. Shorter antibiotic courses have lower risks for nausea, fever, diarrhea, and more serious complications.

Shorter courses are also less expensive, saving money without compromising outcomes. By staying up to date on prescription practices and guidelines, carceral health care systems could save millions of dollars. And from a staffing point of view, decreasing antibiotics cuts down on the amount of time staff members are on the cellblocks passing the medications.

The "Shorter Is Better" movement – a term coined and pioneered by Brad Spellberg, MD, Los Angeles General Medical Center's chief medical officer – advises providers to prescribe short-course antibiotics when clinically appropriate. There are more than 100 trials showing that shorter courses of antibiotics are just as good as long courses in treating certain infections. For those studied infections, the research shows that fewer days of treatment provide equal rates of cure, with lower likelihoods of adverse effects, secondary infections, and bacterial resistance – the key outcomes that the global antimicrobial stewardship movement hopes to achieve.

It is important to note that not everything can be treated with less antibiotics. Prosthetic joint infections, for example, need the full 12-week course – six weeks just won't cut it. And antibiotics aren't inherently bad; they save lives every day. We are certainly not suggesting that we need to cut down on all antibiotic use. But health care systems – of any type – should be using the best, most up-to-date evidence possible to determine protocols for antimicrobial prescriptions. Antibiotic use has significant costs, both financially and to our health, and overuse must be taken seriously.

Antimicrobial stewardship teams are a key step in this direction. Becoming more and more established in community and academic medicine, these teams guide prescribing practices that prevent the development of drug-resistant pathogens.

The next step in this movement is to encourage jails and prisons to review their antibiotics usage and identify opportunities to safely decrease antibiotic prescriptions. The ultimate goal is to treat infections with the shortest and safest course of antibiotics possible. ●

Samuel Wilk is a medical student at Tufts University School of Medicine. Alysse Wurcel, MD, MS, is an infectious disease specialist at Boston Medical Center.

FOR MORE INFORMATION
bradspellberg.com/shorter-is-better

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New Study Highlights Value of Certification

A recent study published in the journal "Corrections: Policy, Practice, and Research" explores the immense personal and professional value that certification as a Certified Correctional Health Professional offers to those who pursue the credential.

Based on interviews with 33 CCHPs, researchers led by Spencer Headworth, PhD, of Indiana University's Department of Sociology, identified two main benefits: external legitimacy and workplace credibility. Those benefits directly address two of the biggest challenges faced by correctional health professionals.

External legitimacy refers to certification's value in counteracting the stigma associated with corrections and providing validation of correctional health professionals as legitimate members of the health care field. Despite the rigors of working in correctional health, the researchers reported that many correctional health professionals "continue to feel marginalized within the broader medical community and less popularly respected than their peers who work in free-world settings." Certification helps them claim professional validity and social esteem within the broader health care field, signaling their professional legitimacy to colleagues and others.

Workplace credibility – that is, professional authority and influence – helps people assert their expertise, especially in terms of navigating interactions with custody staff and advocating for best practices, according to the CCHPs interviewed. "People feel you really know what you're talking about because you're certified," said one. Correctional health professionals often "experience difficulties in striking a balance between caring for their patients and maintaining good working relationships with custody staff," the authors observed.

"Our interviewees consistently depicted certification as strengthening their credibility in the eyes of others in their workplaces, including security staff and corrections administrators. In turn, they found that this enhanced credibility better positions them to advocate for patients and assert professional authority in interactions with the custody side."

Interviewees also see certification as beneficial to their career trajectories. "Multiple respondents mentioned how their certifications gave them more credibility in the eyes of organizational leaders, which translated into advantages in obtaining jobs and promotions," the authors wrote.

Respondents say CCHP also provides this positive outcome: simply being good at their jobs. "Multiple interviewees noted that certification and following the NCCHC standards helped them build a specialized and up-to-date knowledge base that allowed them to do their best work for patients," according to the study.

Those interviewed recognize the value that certification can offer correctional organizations facing elevated legal threats and understand that certification can help curtail similar legal exposure in the future. But that was not nearly as important to them as the significant personal and professional value being a CCHP offers them.

Collectively, the interviewees' comments make it clear that certification not only validates expertise but also bolsters confidence, credibility, and advocacy in the uniquely challenging environment of correctional health care. ●

FOR MORE INFORMATION

Headworth, S., Chen, R., Zaborenko, C., & Rochford, E. (2024). "A Little More Gravitas": Why Correctional Health Care Workers Value Third-Party Certifications. Corrections, 1–16. https://doi.org/10.1080/23774657.2024.2426106

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through the AHEAD program. Materials can be downloaded and used at no cost from the MINDSOURCE Brain Injury Network website.

The Brain Injury Association of North Carolina and the Raleigh Police Department have created a training video for law enforcement officers. The video includes information on simple engagement or de-escalation strategies for officers who encounter a person with a possible brain injury while on duty. Find Crisis De-escalation and Management for Individuals with Traumatic Brain Injury on YouTube.

Some states have created programs and templates for others looking to improve identification and management of brain injury among people in correctional facilities.

The Washington State Department of Corrections, in partnership with experts from the University of Washington, created a program to improve screening for TBI and build support networks for individuals with brain injury incarcerated in the state. Individuals are identified using a specialized screening form and sometimes housed in brain injury units. You can view the Washington State Department of Corrections Individuals with Disabilities Policy to get an example of accommodations.

In Colorado, the MINDSOURCE Brain Injury Network, in partnership with experts from the Denver County Jail and the University of Denver, developed a protocol that can be adapted by other organizations. The protocol outlines processes for education, training, and care facilitation for people living with a brain injury in correctional facilities and those returning to the community.

A Brain Injury Association of Pennsylvania program includes screening people in correctional facilities for a history of brain injury and building self-efficacy through education and support.

What Can You Do?

You can make a difference and help ensure brain injuries don't go unidentified and unmanaged in your facility.

- Stay up to date on the potential effects of brain injury.
- Learn strategies to improve brain injury identification and management.
- Build upon efforts from others to create your own brain injury program.
- Search for brain injury programs in your state using the TBI Justice Database or the Brain Injury Association of America or National Association of State Head Injury Administrators databases.
- Learn more about brain injury in correctional facilities on the CDC's TBI and Corrections Facilities webpage.
- Find general information on brain injury, including clinical guidelines on brain injury diagnosis and management, on the CDC website. ●

Kelly Sarmiento, MPH, is a public health advisor at the Centers for Disease Control and Prevention's Division of Injury Prevention. The findings and conclusions in this article are those of the author and do not necessarily represent the official position of the CDC.

FOR MORE INFORMATION

Brain Injury Association of America: biausa.org/find-bia

The Centers for Disease Control and Prevention: cdc.gov/traumatic-brain-injury; cdc.gov/traumatic-brain-injury/health-equity/correctional-facilities.html

MINDSOURCE Brain Injury Network: mindsourcecolorado.org/ahead/

National Association of State Head Injury Administrators: nashia.org/state-program-directory

TBI Justice Database: disabilityrightsnc.org/tbi-justice-database/

Washington State Department of Corrections: tbicorrections.washington.edu

As of 2019, drug overdoses are a leading cause of injury-related deaths in the US.[1]

In 2022, **81.8%** of drug overdose deaths involved at least one opioid. Illegally made fentanyls were the most commonly involved drug class and were found in **74.6%** of overdose deaths.[2]

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Reference:

1. National Center for Health Statistics. *Drug Overdose Deaths*. Centers for Disease Control and Prevention (CDC); 2023. Accessed January 2024. https://www.cdc.gov/nchs/hus/topics/drug-overdose-deaths.htm
2. CDC. State Unintentional Drug Overdose Reporting System Dashboard: Fatal Overdose Data. Updated December 26, 2023. Accessed February 2024. https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html#

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Program Component 5: CQI

A continuous quality improvement program enables staff to identify health care aspects to be monitored, to implement corrective action plans when necessary, and to study the effectiveness of corrective action plans. A CQI program is an important aspect of health services in jails and, when applied to a MAT program, will offer insights that may otherwise go unnoticed. This allows for improvements to be made to processes and outcomes.

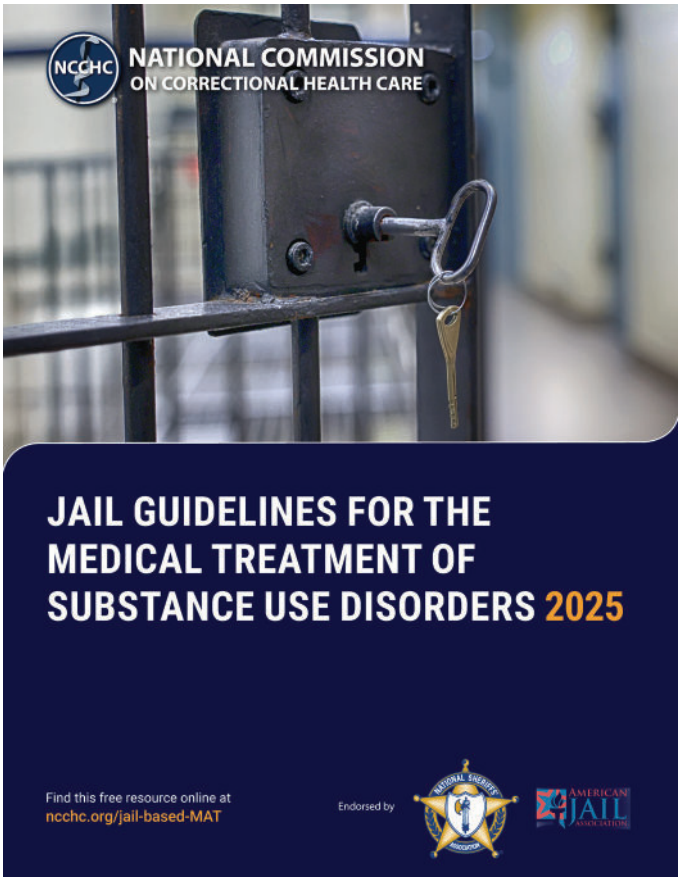
The basic steps to conducting a structured CQI study are outlined and an example is provided.

Also Included...

"Jail Guidelines for the Medical Treatment of Substance Use Disorders 2025" also includes sections on MAT for pregnant women, MAT for youth, and several case studies that show effective MAT programs in action.

Jails are on the front lines of the ongoing opioid epidemic. MAT provides the best opportunity for individuals who are struggling with substance use disorders to recover and go on to lead healthy, meaningful lives. The new guidelines offer clear, evidence-based guidance on how to help them. ●

Claire Wolfe, MPH, MA, CCHP, is program manager with NCCHC Resources, Inc., NCCHC's consulting arm.



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Change of Address: Update your account at ncchc.org or email info@ncchc.org.

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For guidelines, email editor@ncchc.org. We invite letters to the editor, which will be printed as space allows.

Expert Advice on the NCCHC Standards

By Amy Panagopoulos, MBA, BSN, RN, and Wendy Habert, MBA, CCHP-A

Coming Soon! New Jail, Prison, and Mental Health Standards

Q I heard that NCCHC is revising the standards for jails, prisons, and mental health programs. What is the timeline for implementation of the new standards? How will they be different?

A It's true! Revised jail, prison, and mental health standards will be available for purchase this summer. Facilities seeking initial accreditation or reaccreditation in 2026 will be surveyed under the new standards as of January 1, 2026.

NCCHC will begin educating facilities on the new standards during the 2025 mental health conference in July and national conference in November. The CCHP exam will be based on the new standards beginning six months after release of the new manuals.

The process for updating the standards is thorough and comprehensive. The standards are developed with input from correctional thought leaders, clinical and administrative correctional professionals, professional associations, academic organizations, leading correctional organizations, and NCCHC surveyors. The standards are informed by expert consensus, professional guidelines, and law and regulation. New standards added to the manual support patient safety, quality of care, and efficiency.

The basic structure of the standards manuals will remain the same – each standard is described in an intent statement followed by a list of compliance indicators. NCCHC is excited to share that the new manuals provide substantially more support to facilities with enhanced interpretive guidance that puts each standard in context and helps users understand the intent of the standard.

There is also a new section for each standard called Supporting Survey Documentation, which provides recommendations as to what the accreditation surveyors will expect to see during a survey to confirm compliance with the standard.

The new manuals will be the same size, shape, and color as the existing manuals for ease in identification.

Anticipated publication dates are August 15 for jail and prison standards and September 1 for mental health standards. NCCHC will alert the field when the new manuals are available to order through the NCCHC website.

CPR Certification Requirements

Q According to the NCCHC jail and prison standards, who is required to have CPR certification?

A For purposes of this standard, medical, dental, and mental health staff who have direct contact with the patient population are required to have documented CPR certification. Volunteers who are permitted by law to evaluate and care for patients as part of their internship or externship and have direct contact with patients are included.

Emergency Response Roles

Q What is the role of mental health and opioid treatment program staff in emergency response plans such as man-down and mass disaster drills?

A Roles for mental health professionals are coordinated within the health services emergency plan, incorporated into the health services emergency response plan, and made known to all facility personnel.

All staff are to be involved, wherever possible, with assignments appropriate to their skills and training. In addition, mental health staff may provide postcrisis intervention services to the incarcerated population and staff consistent with facility protocols (for example, debriefing, supportive counseling, or grief counseling).

The role of opioid treatment staff varies depending upon who employs the staff:

OTP staff directly employed by the facility or health services vendor are included in the emergency response plan and participate in drills.

OTP staff who are employed by an outside vendor and provide OTP services only are typically not included in the emergency response plan and are not required to participate in drills.

Amy Panagopoulos, MBA, BSN, RN, is NCCHC's vice president of accreditation. Wendy Habert, MBA, CCHP-A, is the organization's director of accreditation.

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