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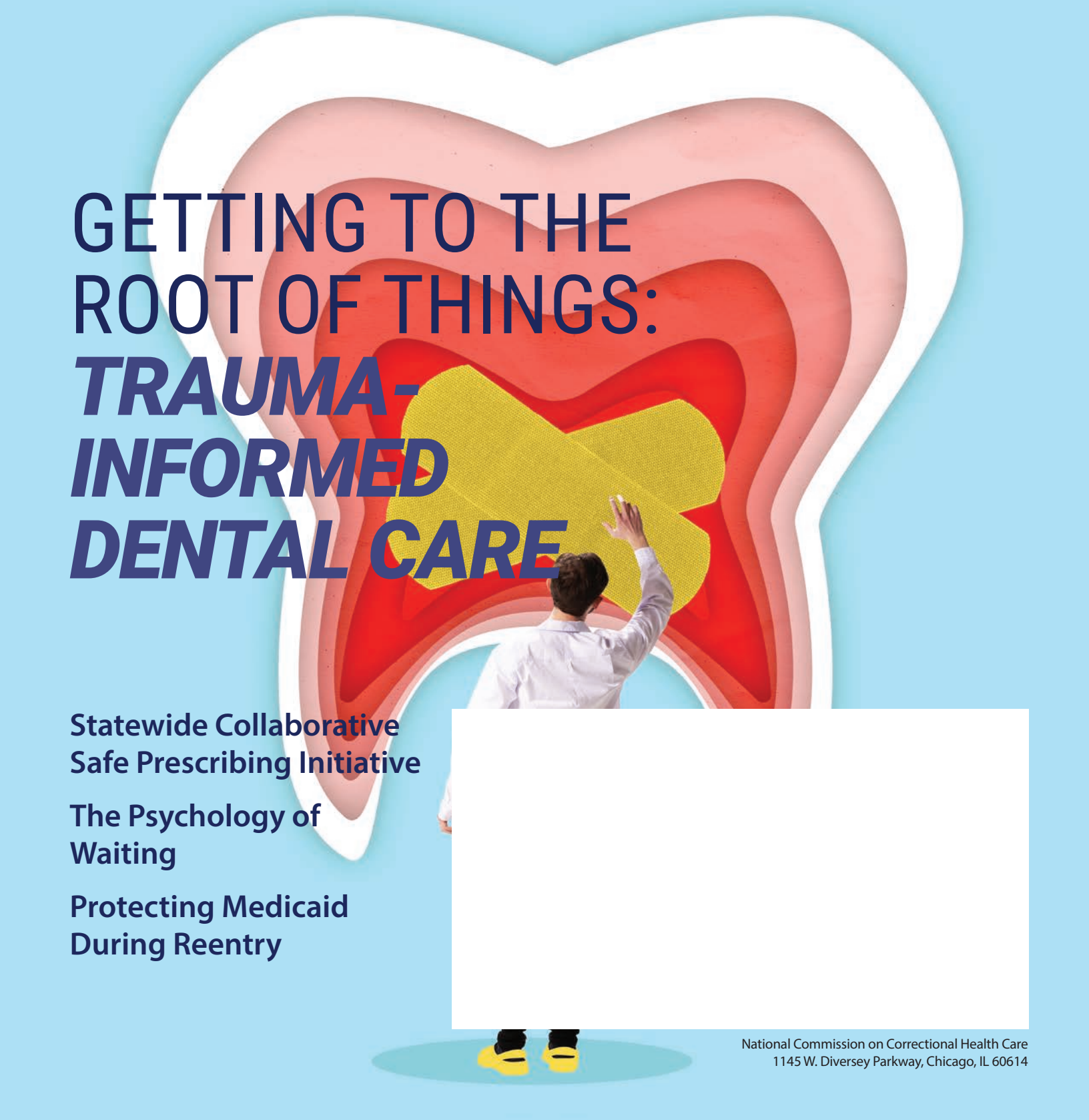
# CorrectCare®

The magazine of the National Commission on Correctional Health Care



# GETTING TO THE ROOT OF THINGS: *TRAUMA-INFORMED DENTAL CARE*

## Statewide Collaborative Safe Prescribing Initiative

## The Psychology of Waiting

## Protecting Medicaid During Reentry

National Commission on Correctional Health Care
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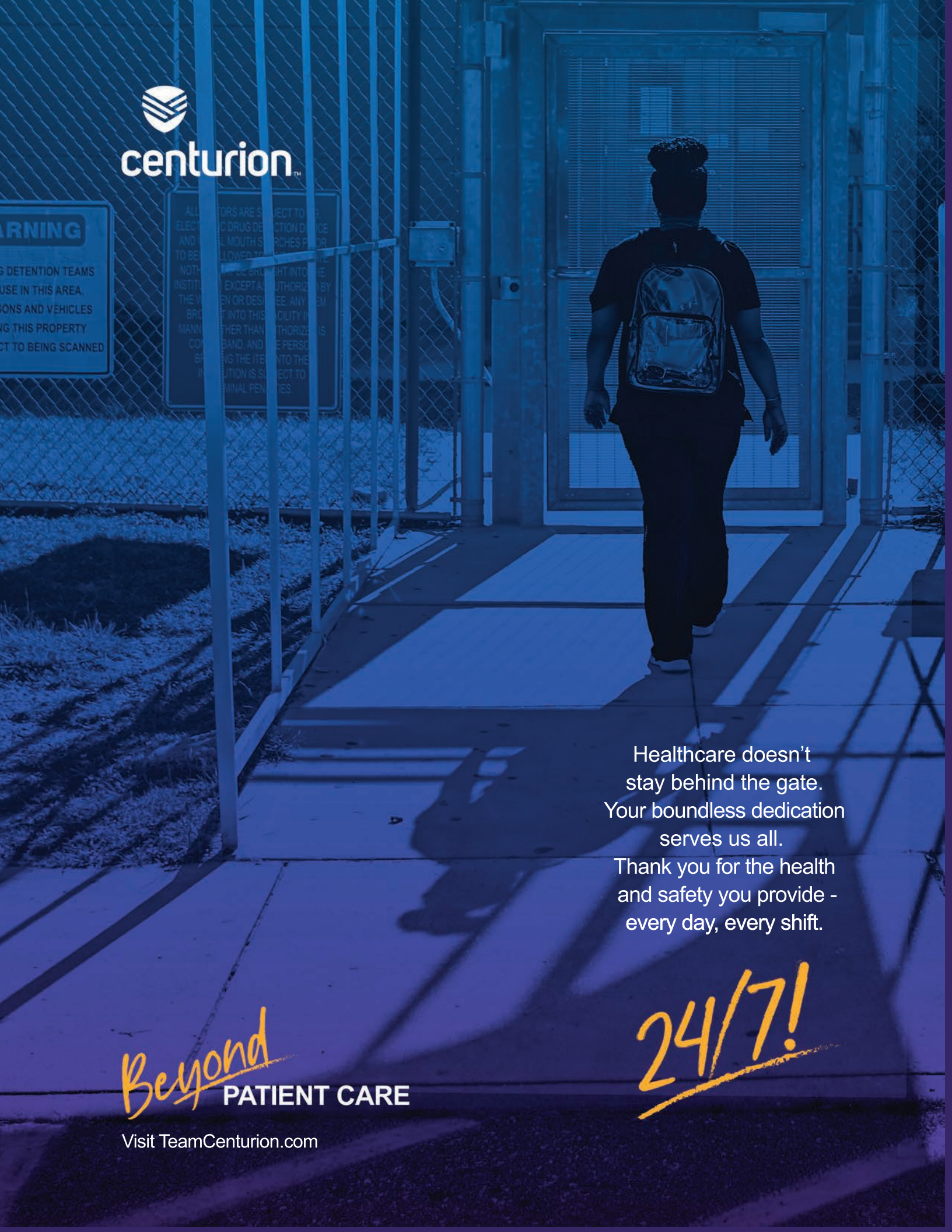
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*CorrectCare*® is published by the National Commission on Correctional Health Care, a nonprofit organization whose mission is to improve the quality of health care in our nation's jails, prisons, and juvenile confinement facilities. NCCHC is supported by the leading national organizations representing the fields of health, mental health, law, and corrections.

NCCHC CorrectCare®
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### Our Independence Matters

The National Commission on Correctional Health Care has no membership or dues. NCCHC does not require any affiliation to be considered for accreditation, certification, or employment as a consultant or surveyor, or to serve on committees or the Board of Representatives. NCCHC staff and spouses are not allowed to accept gifts or consulting fees from those we accredit or certify. NCCHC is impartial, unbiased, expert, and dedicated only to recognizing and fostering improvements in the field of correctional health care.



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# Taking a Position: New Statements from NCCHC

NCCHC position statements provide in-depth guidance on important topics. New statements are constantly under development; existing statements are continually reviewed and updated to reflect current best practices and the evolving correctional landscape. The newest position statements are:


**Cancer Screening and Diagnosis:** Recommends that correctional facilities follow evidence-based community screening guidelines while accounting for the higher cancer risks of incarcerated populations. It calls for screening for six common cancers (breast, cervical, colorectal, lung, prostate, liver), improved screening rates, timely follow-up and treatment, and continuity of care after release.

**Antimicrobial Stewardship:** Outlines six core elements of an effective antimicrobial stewardship program, aligning with broader national efforts while adapting them to the correctional setting. The statement acknowledges the unique risks within correctional environments while outlining clear, achievable steps to improve care and protect broader community health.

Recently revised position statements include Use of Humanizing and Respectful Language, which calls for person-first, stigma-free language when speaking or writing about people who experience incarceration; Opioid Use Disorder Treatment, which recommends that jails, prisons, and detention centers provide comprehensive, evidence-based treatment for people with OUD, including universal screening and access to FDA-approved medications for opioid use disorder (MOUD); and Transgender and Gender-Diverse Health Care, which reflects significant changes in terminology, clinical guidance, and the scope of recommended care for transgender and gender-diverse people in correctional settings over the previous version published in 2020.

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

## New Members Join NCCHC Board

Byron Kennedy, MD, PhD, Connecticut Department of Correction's director of regulatory and academic affairs, Health Services Unit, is the new American College of Preventive Medicine liaison to the NCCHC Board of Representatives. He brings extensive experience in correctional medicine, public health leadership, and population health strategy to the role.

Jennifer Aldrich, MD, joined the Board as the American College of Physicians liaison. Dr. Aldrich is professor of clinical medicine at the Lewis Katz School of Medicine at Temple University and a nationally respected leader in infectious disease, HIV care, LGBTQ+ medicine, and correctional health care.

NCCHC is supported by the major national organizations representing the fields of health, mental health, law, and corrections. Each supporting organization names a liaison to the NCCHC Board to create a robust, multidisciplinary governing structure that reflects the complexities of correctional health.

# On Purpose and Progress: 50 Years of Raising the Standard

By Deborah Ross, CCHP

This fall, we will gather in Las Vegas for the 50th anniversary of the National Conference on Correctional Health Care. We will celebrate an extraordinary history, but even more, we will celebrate what that history makes possible.

For 50 years, correctional health professionals have come together around a powerful idea: Quality health care matters, no matter where we deliver it.

It's a conviction built into our history. In the 1970s, studies revealed serious deficiencies in health services in jails. Health care leaders did more than document the problems. They acted. They brought people together, developed guidance for improving care, and began building the framework that would become the NCCHC *Standards*.

In 1976, leaders in the field developed the first *Standards for Health Services* in jails along with the first National Conference. From the beginning, prevention and education went hand in hand with health equity. Fifty years later, that connection remains fundamental to who we are.

## Standards as Advocacy

When we talk about advocacy, we often think about speaking up. The standards give us something equally powerful: trusted guidance for what quality correctional health care looks like and how organizations can achieve it.

The standards provide a framework for the systems and practices that support quality care. They give health professionals guidance they can use in their work and organizations a road map for continuous improvement. Most importantly, they meet patient realities.

That is the impact of the *Standards*. They turn our commitment to quality care into guidance we can apply, evaluate, and build upon.

For 50 years, we have turned our belief in quality health care into action—and our collective voice has made the field stronger.

## Our Voice Matters

Today, correctional health care occupies an important place in the larger health care landscape. The care we provide reaches beyond facility walls: to families, communities, health systems, and public health. That gives our work a tremendous, shared purpose.

We need to speak clearly about what supports quality correctional health care. We need to make the case for the resources and systems that help health professionals provide it. We need to bring evidence, experience, and the voices of correctional health professionals into broader conversations.

We also need to support the people who do this demanding work. We need to help talented health professionals see correctional health care as a place where they can build meaningful careers, develop expertise, lead, and make an impact. We need to help corrections staff respond to crises with confidence and safety.

## The Next 50 Years

That is what makes this anniversary so exciting.

When we gather at the National Conference, we will honor the people who established this field and the professionals who have carried their work forward. We will also bring together the people who will shape what comes next.

Our history gives us reason for optimism because it shows what committed people can accomplish together.

Fifty years ago, leaders saw problems that demanded action. They responded by creating standards, building a professional community, and advocating for better correctional health care. Generations of professionals have strengthened that foundation through their expertise, advocacy, and commitment to patients.

As we celebrate 50 years of the National Conference, we can look ahead with clarity. We have trusted *Standards* to guide us and decades of knowledge and experience to draw from. And, as we'll see in October, we have a community of professionals who care deeply about patients and believe in the value of this work.

We still have progress to make, and our history shows that we can make it together. I look forward to celebrating with you and starting our next 50 years together. ●

*Deborah Ross, CCHP, is chief executive officer of the National Commission on Correctional Health Care.*


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# The Heart of Correctional Health Care

By Keith Ivens, MD

As I prepare to step down as chair of the NCCHC Board of Representatives, I find myself thinking less about what we have accomplished and more about the people who made those accomplishments possible.

I have spent much of my career caring for people in correctional settings. It is work that asks a great deal of us. It requires clinical skill, certainly, but also patience, humility, persistence, and the willingness to see people clearly, even when the systems around us make that difficult.

For me, that has always been the heart of correctional health care.

Throughout my career, I have had the privilege of working alongside clinicians, nurses, mental health professionals, administrators, custody partners, educators, and advocates who show up every day because they believe good health care matters. Often, their work happens quietly and without much recognition. But I have seen the difference it makes: one patient treated with dignity, one colleague supported through a difficult day, one facility that decides it can do better and then does.

Those moments accumulate. Over a career, they become much larger than any one of us.

That is one reason serving as chair of NCCHC has meant so much to me. This organization represents a community committed not only to improving correctional health care, but to helping one another do this difficult work well. Through our *Standards*, education, accreditation, certification, and advocacy, we have built a shared expectation that people experiencing incarceration deserve quality health care and that the professionals providing that care deserve the knowledge, resources, and support to succeed.

As I approach retirement, I am increasingly aware of how much this field has given me. Medicine gave me a way to be useful to others. Correctional health care gave that calling a particular purpose. And NCCHC gave me a community of people who understand that our responsibility extends beyond treating illness. We can improve systems. We can raise expectations. We can teach the next generation. And we can leave this work a little better than we found it.

Soon, others will carry responsibilities I have been fortunate to hold. That is as it should be. No career lasts forever, and no organization depends on one person. The work continues because people continue to care.

I leave the position with enormous gratitude: for my fellow board members, for NCCHC's staff and volunteers, and especially for the correctional health professionals across the country who keep showing up for their patients and for one another.

After a career devoted to caring for others, I can think of no greater privilege than having spent these final years helping support the people who do the same.

Thank you for allowing me to serve alongside you. I will carry this community, and the lessons it has taught me, long after my time as chair has ended. ●

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*Keith Ivens, MD, is the 2026 chair of NCCHC's Board of Representatives and board liaison of the American College of Correctional Physicians.*

Individuals depicted are models used for illustrative purposes only.

## Addressing the opioid epidemic takes a team-based approach. **INDIVIOR WAS BUILT TO DO JUST THAT.**

Opioid use significantly increases a person's chances of involvement with the criminal justice system.[1] Based on a 2025 report, of the estimated **2 million** individuals in jails or prisons in the US between 2019 and 2025, **1 in 5** were incarcerated for drug-related offenses.[2] Certain medications for opioid use disorder (MOUD) are associated with improvements in reducing criminal activity, decreasing drug cravings, and lowering illicit opioid use.[1]


References:

1. Substance Abuse and Mental Health Services Administration (SAMHSA). *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*. SAMHSA; 2019. Accessed March 6, 2025. https://store.samhsa.gov/sites/default/files/medication-assisted-treatment-opioid-use-disorder-criminal-justice-settings-pep19-matusecjs.pdf
2. Sawyer W, Wagner P. *Mass Incarceration: The Whole Pie 2025*. Prison Policy Initiative. Updated March 11, 2025. Accessed March 28, 2025. https://www.prisonpolicy.org/reports/pie2025.html


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# States Must Protect Medicaid for People Returning Home from Incarceration

By Elizabeth Barnert, MD, MPH, and Melissa Goemann, JD

With the passage of H.R. 1, also known as the One Big Beautiful Bill Act, in 2025, Congress enacted a sweeping overhaul of Medicaid, including new work reporting requirements that will begin taking effect in 2027. As states prepare to implement these changes, they face a set of choices that could carry life-or-death consequences for many residents.

Unless officials take deliberate action to preserve access to care, millions of people, including those returning home from incarceration, are likely to fall through the cracks, with damaging ripple effects on public safety and community stability.

## States Still Have Choices

As states contend with H.R. 1's cuts and new administrative burdens, they must understand that they still have a say in how these provisions take shape on the ground in their communities. State policymakers and Medicaid administrators will ultimately determine how aggressively they protect coverage for vulnerable populations, including through exemptions and reporting processes associated with the work requirements. They also will determine whether they continue building out Medicaid reentry waivers, which, once approved by the Centers for Medicare & Medicaid Services, allow states to leverage federal Medicaid dollars to connect people leaving jail or prison to coverage and community-based health care before release.

The stakes are especially high for the reentry population. Compared with the general public, people leaving jail and prison face elevated rates of chronic health conditions such as diabetes, HIV, hypertension, and hepatitis C, alongside significantly higher rates of behavioral health disorders. The risks can be immediate and severe: In the first two weeks postrelease, people's risk of death is 13 times greater than the general mortality rate, and they are 129 times more likely to die from overdose. Access to Medicaid during this fragile period can be the difference between life and death.

Moreover, when people who are recently released lose access to health care, the consequences extend well beyond the individual. People leaving incarceration without care or support are more likely to return to active drug use and experience mental health crises and housing instability, all of which increase their likelihood of recidivism. The ensuing harms undermine public health and safety, increase overall costs to taxpayers, and place communities at greater risk. Ensuring continuity of care for returning citizens is one of the most effective ways to support successful reentry, reduce reincarceration, and bolster collective well-being.

## Bipartisan Support for Medicaid Reentry

There is broad, bipartisan recognition of the value of this approach. Seventy percent of Americans, including majorities across party lines, have expressed support for connecting people in reentry to care. The federal government has approved more than a dozen Medicaid reentry waivers, from California to West Virginia, and continues to invest in continuity-of-care planning. Earlier this year, Wisconsin's legislature, where Republicans hold majorities in both chambers, voted to instruct the state to develop and submit a reentry waiver to CMS, again indicating continued bipartisan support for this commonsense policy. In addition, as of Jan. 1, 2026, states are no longer allowed to terminate Medicaid coverage during incarceration; rather, they are permitted only to suspend coverage, ensuring easier and quicker re-enrollment upon release.

## States Should Build on Reentry Infrastructure

Despite this progress, some states have already begun pausing or scaling back their Medicaid reentry initiatives, citing the strain of preparing for H.R. 1. This is a mistake. Rather than retreating, states should build on the progress they have made and use existing reentry infrastructure to help facilitate processes associated with H.R. 1's new work requirements. Doing so will help prevent massive coverage interruptions and losses, reduce the use of costly emergency services, and save lives.

Past experiences with similar work requirement policies have shown that many people lose coverage and access to care because of bureaucratic red tape, not ineligibility. It is therefore paramount that states implement these requirements thoughtfully. They should simplify and streamline reporting and verification processes by, for example, using automated verification, including data matching with corrections agencies.

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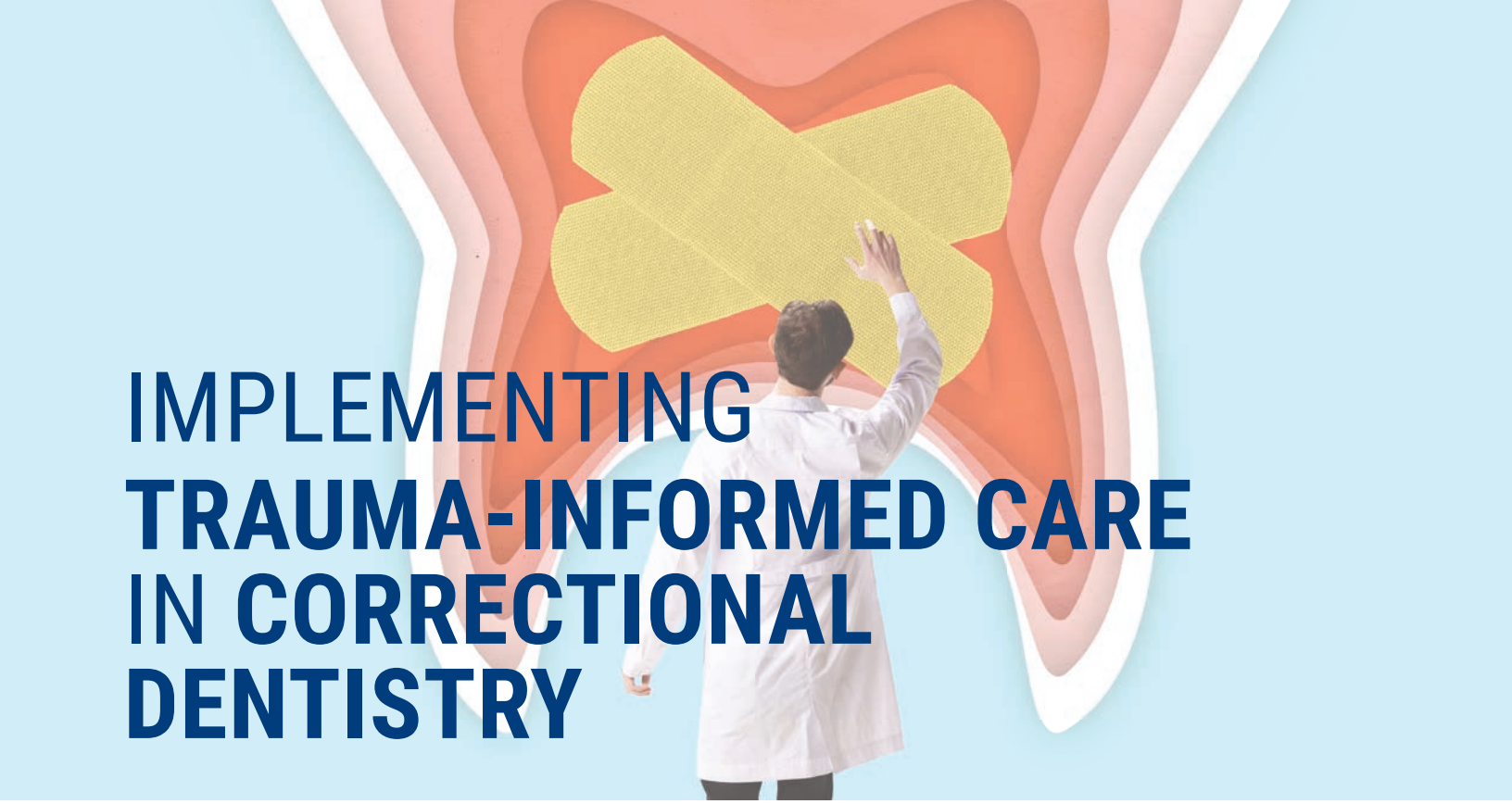

# IMPLEMENTING **TRAUMA-INFORMED CARE IN CORRECTIONAL DENTISTRY**

By Vaishnavi Bhakar, DDS, CCHP

Incarcerated individuals experience significantly higher rates of oral disease compared with the general population, with studies documenting elevated prevalence of untreated dental caries, periodontal disease, tooth loss, and oral pain.

These oral health disparities stem from both preincarceration barriers—often rooted in poverty, lack of insurance, and limited access to preventive care—and systemic barriers to timely dental treatment within correctional facilities, including long wait times, limited resources, and competing institutional priorities.

Beyond the clinical burden of disease, individuals in correctional settings frequently carry histories of significant trauma, including childhood adversity, interpersonal violence, systemic racism, poverty, and prior negative encounters with health systems. For many incarcerated patients, previous dental experiences have been sources of pain, humiliation, or violation of bodily autonomy, creating anxiety and mistrust that shape their willingness to seek and engage with dental care.

Historically, correctional facilities have functioned primarily as centers of punishment and isolation, and this carceral approach has perpetuated marginalization rather than rehabilitation.

However, advocacy efforts by organizations such as the National Commission on Correctional Health Care are helping catalyze a paradigm shift, positioning correctional facilities as critical sites for rehabilitation and reentry.

Health care providers working in these settings occupy a unique position to address health inequities by reframing incarceration not as the consequence of individual lifestyle choices, but as an outcome shaped by systemic social inequities and trauma histories.

Central to this shift is the adoption of trauma-informed care, a strengths-based framework grounded in an understanding of, and responsiveness to, the impact of trauma. The framework emphasizes physical, psychological, and emotional safety for both providers and survivors and creates opportunities for survivors to build a sense of control and empowerment. By implementing trauma-informed approaches, correctional health care providers can transform clinical encounters into opportunities for dignity, trust-building, and therapeutic alliance—essential foundations for both individual healing and broader public health impact.

Despite growing recognition of trauma's prevalence and impact within correctional populations, few studies have explored the practical application of trauma-informed care principles in correctional dentistry. Although trauma-informed frameworks have been adopted for mental health services, substance use treatment, and primary care, dental care presents unique challenges and opportunities for trauma-informed practice. Dental procedures can trigger traumatic memories or retraumatize patients with histories of physical or sexual abuse, medical maltreatment, or institutional violence. Correctional providers also face distinctive constraints, including security protocols,

limited appointment times, restricted access to advanced treatments, and inherent power imbalances between clinicians and incarcerated patients. These structural barriers, combined with the high prevalence of dental anxiety and trauma histories among incarcerated populations, create a need for effective strategies to implement trauma-informed dental care.

The current evidence base for trauma-informed care in oral health services is limited. Studies emphasize the need for further investigation into trauma-informed dental practices to evaluate their impact and inform the development of evidence-based frameworks responsive to the unique context of oral health care delivery.

This article presents best-practice principles for incorporating trauma-informed care into correctional dentistry. The recommendations are structured according to distinct phases of dental operations, recognizing that trauma-related barriers may emerge at different points along the care continuum. Each phase-specific practice is aligned with the core trauma-informed principles of the Substance Abuse and Mental Health Services Administration (SAMHSA) to translate theory into actionable workflows within correctional dental settings (see box, below).

## Phase 1: Preappointment and Scheduling

During the preappointment phase, patients may face several barriers, including limited knowledge about how to access care, uncertainty about the scope of available services, literacy challenges, extended appointment wait times, and limited support for interim pain management. These challenges may be compounded by perceptions among staff that dental care is nonessential or that patients exaggerate pain, leading to delayed or dismissive communication.

### Trauma-Informed Workflow Modifications

- Prompt Triage: Review dental sick-call referrals as soon as possible.
- Interim Pain Management: Order medications or other pain-relief measures while patients await definitive care.
- Staff Empowerment and Education: Train staff on the scope of dental services, proper assessment of dental complaints, and trauma-informed principles.
- Priority-Based Care System: Implement a clear prioritization framework, such as emergency, urgent, and routine, to guide communication with patients during nursing encounters.
- Trauma-Informed Nursing Assessments: Encourage nurses to incorporate both subjective patient reports and objective clinical findings, acknowledging that patient experiences of pain are valid and deserving of attention.

### SAMHSA Core Principles Applied

- Safety: Prompt triage and interim pain relief reduce physical and psychological stress.
- Trustworthiness and Transparency: Clear communication about wait times, priorities, and pain management builds confidence.
- Empowerment, Voice, and Choice: Educating staff to engage patients collaboratively supports autonomy and shared decision-making.
- Collaboration and Mutuality: Integrating nursing assessments with trauma-informed principles fosters cooperative patient-staff interactions.

## Phase 2: Dental Appointment

Dental anxiety is common among patients in correctional facilities. Many patients also believe correctional dental care is limited to extractions without adequate anesthesia or postoperative pain management. Past stigmatization may lead patients to withhold important medical information because of fear of judgment, discrimination, or breach of confidentiality. Patients receiving medication-assisted treatment may also be placed in a position where they must miss pill call to attend dental appointments.

### Trauma-Informed Workflow Modifications

- Medical History Review and Normalization of Disclosure: Review medical history forms verbally with patients rather than relying on paperwork alone. Use language that reduces stigma, such as, "Many patients here have these conditions, and knowing this helps me provide the safest care." Explain why each piece of medical information is necessary for patient safety and clinical decision-making, and reinforce confidentiality.
- Chairside Manner: Introduce yourself and your role. First impressions set the tone for the encounter. Body language and chairside mannerisms personalize the service and help establish trust.
- Inclusive Documentation: Use forms and language that reflect gender identity, sexual orientation, and chosen names and that reduce stigma.
- Staff Training: Ensure that all dental staff are trained to respond to disclosures with neutrality, respect, and professionalism.
- Medication Continuity Coordination: Communicate with

*Continued on next page*

### SAMHSA's Core Principles of a Trauma-Informed Approach

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, historical, and gender issues

*Source: Substance Abuse and Mental Health Services Administration, Trauma and Justice Strategic Initiative*

nursing staff responsible for medication administration so patients attending dental appointments can receive medication-assisted treatment or other scheduled medications without interruption.

### SAMHSA Core Principles Applied

- Safety: Respectful communication and uninterrupted access to medications reduce fear and support patient stability.
- Trustworthiness and Transparency: Explaining information-gathering processes and confidentiality boundaries builds trust.
- Cultural, Historical, and Gender Issues: Inclusive language and recognition of the impact of stigma and discrimination support patient engagement with health care.

## Phase 3: Clinical Examination and Treatment

Dental procedures involve invasion of personal space, physical vulnerability, and anticipation of pain or discomfort, all of which can be trauma triggers. Many patients experience embarrassment or shame related to the condition of their dentition, particularly after prolonged lapses in care caused by limited access to dental services in the community.

### Trauma-Informed Workflow Modifications

- Patient Consent: Ask explicit permission before entering personal space, such as, "May I examine your mouth now?" Frequently assess comfort and pain by asking questions such as, "How are you doing?" and "Does this hurt?" Establish a clear hand signal for "pause" or "stop" and honor it immediately. Allow patients to sit up, take breaks, or adjust positioning as needed.
- Power-Neutral Positioning: Avoid standing over patients. Sit at eye level when discussing findings or treatment options.
- Nonstigmatizing Oral Health Education: Provide hygiene education in neutral language that acknowledges systemic barriers, limited resources, and lack of access to preventive care tools.
- Pain Management: Believe patients' reports of pain. Provide pain management options immediately for acute pain. Explain the pain management plan clearly, including timing and expectations, and follow up on pain control at the next visit.

### SAMHSA Core Principles Applied

- Safety: Clear communication, pause signals, and respectful positioning reduce physical and psychological distress.
- Trustworthiness and Transparency: Clear explanations and follow-through on pain management plans build credibility.
- Empowerment, Voice, and Choice: Patient-controlled pacing, consent, and breaks help restore autonomy.
- Collaboration and Mutuality: Procedures are framed as a shared process rather than something done to the patient. Examination and education are conducted collaboratively rather than unilaterally.
- Cultural, Historical, and Gender Issues: Acknowledging structural inequities and resource limitations reframes oral health disparities without blame.

## Phase 4: Postprocedure Care and Discharge

After dental procedures, patients often experience anxiety about pain, swelling, bleeding, or complications. In correctional settings, this anxiety may be amplified by limited access to clinicians after hours, uncertainty about how to request follow-up care, and prior experiences in which postoperative pain was inadequately addressed.

Health literacy challenges may make verbal instructions difficult to retain, particularly after stressful procedures or when patients are experiencing discomfort.

### Trauma-Informed Workflow Modifications

- Clear Verbal and Written Instructions: Review postprocedure care instructions verbally and provide a written copy using plain language and visual aids when possible.
- Teach-Back Method: Confirm understanding by asking patients to explain instructions in their own words, such as, "Can you tell me what you'll do if you have pain tonight?"
- Set Realistic Expectations: Explain which symptoms are normal and which require urgent attention, including expected timelines for healing.
- Access to Follow-Up Care: Clearly explain how and when patients can seek additional care if pain worsens or complications arise.
- Pain Management Transparency: Review pain management plans, including medication use, expected effectiveness, and limitations.
- Affirmation and Validation: Acknowledge the effort

required to complete dental treatment. For example: "I know that wasn't easy. Thank you for trusting me today."

### SAMHSA Core Principles Applied

- Safety: Clear guidance and access to follow-up reduce fear of unmanaged complications.
- Trustworthiness and Transparency: Honest communication about healing expectations and pain management builds credibility.
- Empowerment, Voice, and Choice: Teach-back and education support informed self-management.

## Phase 5: Follow-Up and Continuity of Care

In correctional settings, follow-up care is often inconsistent because of transfers, housing changes, custody demands, and staffing constraints. Patients may be uncertain about whether their concerns warrant another sick-call request, or they may avoid requesting follow-up care because of previous experiences with delayed responses or dismissed symptoms.

For individuals with histories of trauma, institutional systems characterized by broken promises and fragmented care can reinforce mistrust. When providers fail to follow through on stated plans, or when patients must repeatedly reexplain their histories, confidence in the health care system erodes.

### Trauma-Informed Workflow Modifications

- Proactive Follow-Up: Initiate follow-up for patients undergoing complex procedures, those who experienced significant distress, or those with prolonged delays in care rather than waiting for patients to reinitiate contact.
- Housing Unit Check-Ins: When feasible, conduct postprocedure rounds in housing units to assess healing and pain control.
- Consistency of Providers: Assign patients to the same dental provider whenever possible to foster familiarity and trust.
- Clear Documentation: Record patient preferences, anxieties, effective coping strategies, and successful trauma-informed approaches in the dental record to support continuity across visits and providers.
- Interdisciplinary Coordination: Communicate with primary care, mental health, nursing, and custody staff regarding nondental follow-up needs.
- Reliability in Follow-Through: Honor commitments made to patients, such as "I'll check on you tomorrow," and communicate promptly if plans must change.

### SAMHSA Core Principles Applied

- Safety: Ongoing monitoring reduces anxiety about untreated complications.
- Trustworthiness and Transparency: Following through on commitments builds institutional credibility.
- Collaboration and Mutuality: Coordination across health care teams supports comprehensive care.

## Phase 6: Systems-Level Advocacy and Continuous Quality Improvement

Individual trauma-informed interactions cannot fully compensate for structural barriers embedded within correctional health care systems. Limited staffing, restricted clinic capacity, competing custody priorities, and fragmented coordination across disciplines contribute to delayed care, unmet needs, and patient frustration. Without mechanisms to measure and address these barriers, inequities persist and patient experiences remain unchanged.

### Trauma-Informed Workflow Modifications

- Data-Informed Advocacy: Track and analyze wait times, treatment refusals, deferrals, postprocedure complications, antibiotic prescribing patterns, and patient-reported experience measures.
- Transparent Reporting: Share quality metrics with facility leadership and interdisciplinary partners to advocate for adequate staffing, equipment, and appointment availability.
- Policy Development: Participate in the creation and revision of policies that address access to care, treatment deferral versus refusal, and pain management.
- Interdisciplinary Education: Provide trauma-informed care education to dental staff, nursing, custody staff, and facility leadership to promote shared understanding and consistent practice.
- Staff Support and Debriefing: Implement regular team debriefs to address challenging cases, reduce burnout, and mitigate secondary traumatic stress among staff.
- Replication and Dissemination: Share successful workflows and outcomes through internal reports, conference presentations, and peer-reviewed publications to contribute to the evidence base for trauma-informed correctional dentistry.
- Continuing Professional Development: Complete professional development on trauma-informed care to support consistent application of new protocols and remain current with emerging practices.

### SAMHSA Core Principles Applied

- Trustworthiness and Transparency: Open reporting of performance metrics builds institutional credibility.
- Collaboration and Mutuality: Shared responsibility across disciplines promotes systemwide improvement.
- Peer Support: Team-based learning and staff support strengthen resilience and consistency.
- Cultural, Historical, and Gender Issues: Policies that address inequities and stigma support marginalized populations.

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# Standardizing Prescribing Practices Through Collaboration at the State Level

By Alisson Richards, MD, and Elizabeth Samson, MA, LMHC, CCHP

The Health Services division of the Vermont Department of Corrections (VTDOC), in partnership with Wellpath, launched a statewide quality improvement initiative to standardize prescribing practices for stimulant medications used in the treatment of attention-deficit/hyperactivity disorder (ADHD).

The effort was driven by concern about increasing stimulant use, both within Vermont and nationally, as well as the potential risks associated with misuse, diversion, and adverse outcomes.

Within correctional settings, these challenges are often compounded by variability in documentation at intake, differences in provider practice patterns, and the absence of standardized expectations across sites.

Recognizing these risks, VTDOC took a proactive approach—focusing on consistency, safety, and clinical appropriateness.

## Identifying the Opportunity

A review of prescribing patterns across facilities revealed variation in how stimulant medications were initiated, documented, and continued. In many cases, providers were making thoughtful clinical decisions, but without a shared framework, practices differed from site to site.

This variability created an opportunity to strengthen alignment around several things:

- Diagnostic expectations
- Documentation standards
- Prescribing practices
- Ongoing monitoring

The goal was not to limit access to care, but to ensure that prescribing decisions were consistent, evidence-informed, and well-documented across the system.

## Building a Standardized Approach

The initiative was led by the statewide psychiatric director in close collaboration with quality, medical, and operational leadership. Together, the team developed clear, standardized expectations for stimulant prescribing.

Key components included:

- Defined diagnostic criteria to support appropriate initiation and continuation of medications
- Standardized documentation expectations
- Provider education and training
- Data monitoring and reporting

A pharmacy partner supported data collection and analysis, allowing the team to evaluate prescribing patterns across the system and identify areas for improvement. Throughout implementation, the message remained consistent: this was a quality and patient safety initiative—not a restriction effort. Patients meeting appropriate clinical criteria continued to receive needed treatment.

## Implementation and Results

Education and communication were central to success. Psychiatry and mental health staff received targeted training, and leadership reinforced expectations through ongoing engagement and support.

Prescribing trends were monitored using a standardized rate to allow for meaningful comparison over time. Within one year of implementation, the system saw a 56% reduction in stimulant prescribing rates.

Importantly, this change reflected improved alignment with diagnostic and prescribing standards—not decreased access to care. Patients with clear clinical indications continued to receive appropriate treatment, while unnecessary or inconsistent prescribing decreased.

## Sustaining the Improvement

To ensure long-term success, the initiative was embedded into existing Continuous Quality Improvement (CQI) processes. Ongoing strategies include:

- Routine monitoring of prescribing trends
- Periodic review of high-risk or outlier cases
- Continued provider education
- Oversight at both the site and system levels

By integrating these practices into CQI, VTDOC created a sustainable framework that supports continuous evaluation and adaptation as new risks or trends emerge.

## Lessons Learned

**Standardization reduces variability**. Clear expectations help align providers while still allowing for clinical judgment.

**Education is critical**. Providers are more likely to adopt changes when they understand the "why" behind them.

**Data drives improvement.** Ongoing monitoring allows organizations to identify trends, measure impact, and respond proactively.

**Framing matters.** Positioning the initiative as a patient safety and quality effort—not a restriction—was essential to gaining buy-in.

## Implications for Other Systems

Correctional systems across the country face similar challenges related to prescribing variability and evolving public health risks.

This initiative demonstrates that a structured, collaborative approach can:

- Improve consistency in clinical practice
- Enhance patient safety
- Support providers with clear expectations
- Create sustainable, systemwide change

Organizations looking to implement similar efforts can start by assessing current prescribing patterns, engaging clinical leadership, and building standardized expectations supported by education and data.

## Conclusion

The VTDOC statewide collaborative initiative highlights the power of aligning clinical leadership, quality improvement, and data-driven decision-making to address complex health care challenges.

By focusing on consistency, education, and continuous monitoring, the system strengthened prescribing practices while maintaining access to appropriate care. ●

*Alisson Richards, MD, is statewide psychiatric director of Wellpath – Vermont Department of Corrections. Elizabeth Samson, MA, LMHC, CCHP, is vice president of quality at Wellpath.*

# The Psychology of Waiting: Why Time Feels Different in Correctional Health Care

By Emily Scordellis, PsyD, CCHP, and Tommy Williams, BSN, RN, CCHP

Waiting is a universal experience. In the correctional health care environment, patients wait to be seen, receive results, and access treatment—often while also waiting for custody staff to escort them. At the same time, clinical staff wait for information, security clearance, patient transport, and access to spaces where care can safely take place.

Even routine care depends on coordinated movement between custody and health care operations. Yet waiting is not simply the passage of time. It is a psychological experience shaped less by minutes on a clock than by uncertainty, control, and meaning.

## Time Is Felt, Not Measured

Research in behavioral science has consistently shown that unstructured waiting—time without clear expectations—feels significantly longer and more stressful than time that is defined and predictable. When people do not know how long they will be waiting or what comes next, the brain fills in the gaps, often with anxiety, frustration, and worst-case scenarios.

In health care settings, this effect is especially pronounced because waiting is often tied to outcomes that matter deeply. A patient waiting for lab results is not simply passing time. They may be imagining diagnoses, anticipating bad news, or replaying symptoms in their mind. Even relatively short waits can feel prolonged when the stakes are high.

In corrections, the psychological impact of waiting is often intensified. Patients already experience reduced personal control over their daily lives. Schedules, movement, and access are externally structured. When health care access involves delays or unclear timelines, feelings of helplessness can increase. What may appear outwardly as irritability, resistance, or noncompliance may be better understood as a response to prolonged uncertainty.

This distinction is critical. When behavior is interpreted only as noncompliance, the response may become punitive or dismissive. When it is understood as a reaction to uncertainty and loss of control, it creates an opportunity for de-escalation and therapeutic engagement.

For staff, the experience of waiting is different but no less important. Waiting for critical information, test results, decisions, or patient movement can interrupt work flow and contribute to frustration. Over time, repeated exposure to these "micro-delays" can accumulate, leading to fatigue and decreased job satisfaction. In high-stakes environments, even small delays can feel magnified. Repeated interruptions can also contribute to cognitive fatigue and moral distress, particularly when staff feel unable to deliver timely care because of factors outside their control.

## Understanding Perceived Time

One useful way to understand this phenomenon is through the concept of perceived time. Time is not experienced objectively. It expands and contracts based on context. Uncertain, unoccupied, or unexplained time feels longer. Time that is structured, explained, or purposeful feels shorter, even when the actual duration is the same.

For example, a 20-minute wait with clear expectations—such as knowing a patient will be called after count clears—often feels shorter than a 10-minute wait with no explanation. The difference is not duration; it is predictability.

Several factors consistently influence how waiting is perceived.

## Uncertainty Increases Stress

Uncertainty is one of the most powerful drivers of distress while waiting. When individuals do not know how long they will be waiting or what the outcome will be, the mind naturally begins to fill in the gaps.

In correctional health care, patients may imagine worsening diagnoses, delays in treatment, or being forgotten altogether. Staff may be unsure when results will return or when custody will be available to facilitate movement. This lack of clarity keeps the brain in a heightened state of vigilance as it scans for information that is not yet available.

As a result, even relatively short waits can feel prolonged and emotionally taxing. Providing structure through timelines or updates can reduce stress by replacing ambiguity with expectation.

## Lack of Control Amplifies Frustration

A perceived lack of control intensifies the emotional burden of waiting, particularly in correctional environments where autonomy is already limited. Patients have little influence

*Photo © amgun/Shutterstock*

over when they are seen, how they are moved, or how quickly care progresses. When delays occur, this lack of agency can lead to helplessness.

Restoring even a small degree of perceived control—such as offering choices when possible or explaining next steps—can help reduce frustration and improve cooperation.

## High-Stakes Outcomes Intensify Perception

The more important the result, the longer the wait feels. The significance of what is being waited for plays a critical role in how time is experienced. When outcomes carry emotional or physical importance, such as diagnostic results, treatment decisions, or changes in health status, waiting becomes more than a passive experience. It becomes an active psychological process filled with anticipation, concern, and often fear.

In correctional health care, where patients may already feel vulnerable, this effect is magnified. A short delay can feel disproportionately long because of the weight attached to the outcome. Similarly, staff may feel increased pressure and urgency when waiting for critical information needed to guide care.

Recognizing the heightened emotional stakes in these situations allows for more intentional communication and support, helping reduce the perceived burden of time.

## Unacknowledged Waiting Feels Longer

When waiting goes unrecognized, it can create a sense of invisibility and disregard, which can amplify frustration. Individuals who feel that their time and experience are not acknowledged are more likely to perceive the wait as long and more distressing.

In correctional settings, where patients may already feel overlooked or marginalized, this effect can be particularly pronounced. A simple acknowledgment—such as recognizing that someone has been waiting or expressing appreciation for their patience—can validate the experience and reduce emotional tension.

For staff, acknowledgment from colleagues or leadership regarding delays and challenges can also improve morale. These small, low-effort interactions help restore a sense of connection and respect, transforming waiting from an isolating experience into one in which the individual feels seen and understood.

## From Insight to Practice

Understanding these dynamics offers practical opportunities to improve both patient experience and staff workflow, even when actual wait times cannot be reduced.

One of the most effective interventions is clear communication. Providing even approximate timelines can significantly reduce anxiety. Statements such as "This may take about an hour" or "We're still waiting on results, but I'll update you as soon as we have them" help create structure around uncertainty. People generally tolerate waiting better when they know what to expect.

Equally important is transparency in the process. Explaining why something is taking time—whether it involves lab processing, security procedures, or coordination between departments—helps transform waiting from a passive experience into one with context and meaning. When individuals understand that a delay is part of a process rather than oversight, frustration often decreases.

Another key factor is acknowledgment. Simply recognizing that someone has been waiting can have a meaningful impact. A brief statement such as "I know you've been waiting, and I appreciate your patience" validates the experience. This is particularly important in environments where individuals may already feel overlooked or powerless.

For staff, small operational adjustments can also help mitigate the psychological impact of waiting. Clearer work flows, stronger communication between team members, and reduced uncertainty in daily processes can improve both efficiency and morale. Even when delays cannot be eliminated, making them more predictable can reduce their impact.

## Waiting, Behavior, and Safety

Waiting affects not only emotions but behavior. Research suggests that prolonged or uncertain waiting is associated with increased irritability, decreased cooperation, and a higher likelihood of conflict. In correctional settings, where safety and de-escalation are critical, this connection is especially important.

What appears as defiance or agitation may, in part, be a response to the stress of waiting. Reducing that stress is therefore not only a matter of patient experience; it is also a component of safety. Clear communication and acknowledgment can function as low-effort, high-impact de-escalation tools.

While waiting cannot be eliminated from health care, we can change how it is experienced. By reducing uncertainty, increasing communication, and acknowledging the human side of time, we can transform waiting from a source of stress into a more manageable part of care. These changes do not require major resources, but they do require awareness.

Ultimately, the experience of waiting is not defined solely by how long it lasts, but by how it is understood, communicated, and felt. In correctional health care, where time is inherently constrained, managing the experience of waiting is an essential part of care itself. ●

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# You Went Into Correctional Health Care to Change the World. Start With CCHP!

By Matissa Sammons, MA, CCHP

Imagine you're a nurse a few months into a new job at a correctional facility. You know nursing. What you're still learning is how health care works in an environment where clinical needs, security procedures, operations, and patient access intersect in unique ways every day.

Then you face a question about a patient's access to care. You know what you would do clinically, but you realize there's a bigger question: What should the system be doing to make sure this patient receives appropriate care?

A colleague points you to the NCCHC *Standards*. Suddenly, you have more than an answer to one question. You have a framework for understanding what quality correctional health care looks like and how your role fits within it.

That connection between professional expertise and the NCCHC *Standards* is at the heart of the Certified Correctional Health Professional (CCHP) credential. Earning the CCHP demonstrates your knowledge of the NCCHC standards and your ability to apply them to support quality patient care.

## Build Your Expertise

Correctional health care takes a team. Nurses, physicians, mental health professionals, dentists, administrators, custody professionals, and others all contribute to the systems that support patient care. A shared understanding of the *Standards* gives that team a common foundation. It also helps you understand how your decisions connect to the larger health care delivery system. Certification as a CCHP provides tangible evidence of that knowledge and signals your commitment to correctional health care as a career.

## Put Knowledge Into Practice

CCHP means more than passing an examination or adding four letters after your name. Preparing for certification strengthens your knowledge of the *Standards* and your ability to use them in everyday practice.

What that looks like: You can identify opportunities for improvement, ask better questions, reduce organizational risk, share knowledge with colleagues, and contribute more effectively to your team.

CCHP can also strengthen your ability to lead. You don't need a leadership title to recognize a gap, bring an informed perspective to a discussion, or help your organization improve its practices. Making an impact means making better decisions, improving practices, supporting colleagues, and providing quality care to each patient.

## Make an Impact

Most of us did not enter health care because we wanted a credential. We want to help people and do work that matters.

Here's the reality: Good intentions matter, but knowledge turns them into action. In correctional health care, you might identify a problem in a process, advocate for appropriate patient care, help a colleague interpret a *Standard*, or bring a better-informed perspective to a team discussion. Each action can seem small. Together, they improve patient care and strengthen health systems.

## Turn Purpose Into Professional Commitment

As you learn the *Standards* and gain experience, you stop simply bringing your professional expertise into a correctional facility. You begin building expertise in correctional health care itself.

**The bottom line: Earning your CCHP demonstrates your knowledge, strengthens your credibility, and shows your commitment to quality patient care and the field.**

You went into health care because you wanted your work to matter. Start with CCHP and put that purpose to work. I feel honored to have joined the group of professionals who possess certification with NCCHC, and I invite you to join us too. ●

*Matissa Sammons, MA, CCHP, is vice president of certification at the National Commission on Correctional Health Care.*

For formerly incarcerated individuals, it is critically important to note that, despite strong evidence that people in reentry want to work, persistent stigma and administrative hurdles make them particularly vulnerable to burdensome employment-related requirements. For this reason, other compliant activities, such as volunteering and participating in educational programs, are particularly important.

## Exemptions Are Critical for Reentry

H.R. 1 also provides exemptions from the requirements for certain high-need populations, including people recently released from incarceration. This postrelease exemption, however, lasts only three months. It will therefore be essential for states to instruct their carceral systems and reentry provider networks to work with individuals to identify other longer-lasting exemptions, such as the "medically frail" exemption. This exemption may assist people leaving incarceration, given the disproportionately high rate of complex medical needs among this population. States and providers also should help individuals obtain the necessary documentation, so they do not experience lapses in coverage or care while working to stabilize their health, secure housing and employment, and successfully reintegrate.

According to CMS' interim final rule on implementing the new Medicaid work requirements, released June 1, 2026, states must develop a list of diseases, diagnoses, disorders, or other health conditions that meet the medically frail criteria. States should develop these lists as robustly as possible and should explicitly include substance use disorders, which data show affect more than half of all incarcerated individuals.

Individuals whose qualifying physical, mental, or behavioral health conditions significantly impair their ability to comply with the work requirement should qualify for the exemption. However, because CMS is limiting the use of self-attestation, states also must accept verification of this exemption from a wide range of credentialed providers, including physicians, nurse practitioners, physician assistants, psychologists, counselors, therapists, and community social workers.

## States Must Act to Protect Coverage

Just as crucial will be states' public education campaigns around such exemptions. Equipping people recently released from incarceration with information will be especially critical because most will not have claims data already in the Medicaid system that administrators can use to verify an exemption. These individuals will therefore need to take proactive steps to protect their coverage.

The choice before states is clear. They can implement the new Medicaid rules in ways that cushion the blow while simultaneously working to advance their reentry waivers. Or they can double down on red tape, retreat from Medicaid reentry, and watch disparities deepen, costs rise, and communities suffer.

Yes, this requires coordination, foresight, and a commitment to treating health care access as a core component of successful reentry. But don't we all ultimately want less recidivism, better health outcomes, and stronger, safer communities?

H.R. 1 should not be a reason to abandon this sound approach. If anything, it raises the stakes for getting it right. ●

*Elizabeth Barnert, MD, MPH, is associate professor of pediatrics at the David Geffen School of Medicine at UCLA and chair of NCCHC's Juvenile Health Committee. Melissa Goemann, JD, is a social justice advocacy consultant with Next Generation Justice Consulting.*


*Photo © Drozd Irina/Shutterstock*

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As leaders in oral health, correctional dental professionals can advance trauma-informed care by doing more than revising clinical protocols. This work requires intentional attention to how clinicians communicate with patients, staff, and institutional stakeholders. When leaders consistently model patient-centered, nonstigmatizing language, acknowledge structural barriers to care, validate lived experiences, and avoid blame, they set expectations for how oral health concerns are understood across the system.

This leadership approach fosters a culture in which patients are viewed as partners in care rather than problems to be managed, and in which fear, mistrust, and hesitation are recognized as predictable responses to trauma rather than noncompliance. Ultimately, the way leaders speak about oral health and the people they serve influences how responsibility, risk, and opportunities for healing are perceived throughout the correctional health care environment. ●

*Vaishnavi Bhakar, DDS, CCHP, is staff dentist at the Alameda County Sheriff's Office.*

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## ABOUT CORRECTCARE®

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# Expert Advice on the NCCHC Standards

By Wendy Habert, MBA, CCHP-A

## Pre-Pouring vs. Point of Administration

**Q** We have a couple of units that are locked down during medication pass/medication administration. Can you provide guidance on how these medications should be administered? We are confused on pre-pouring versus point of administration practices for these patients.

**A** While NCCHC does not support pre-pouring of medications for the general population, limited circumstances may require modifications to the medication administration process. For example, patients housed in upper-tier units, restrictive housing, or lock-down behavioral health units may be unable to come to the medication cart or medication window. In these situations, medications may be prepared at the point of administration to accommodate safe delivery.

NCCHC distinguishes point of administration preparation from pre-pouring practices.

The practice of pre-pouring medications refers to removing medications from their original labeled containers and placing them into another appropriately labeled package for an individual patient before the scheduled medication pass, and well in advance of administration.

- Example: Nursing staff prepare medications in the medication room, or other designated area, before the scheduled medication pass by placing them into individually labeled medication cups or envelopes for later administration.

When used for the general population, this method is not supported by NCCHC and may conflict with state nurse practice acts and board of pharmacy regulations.

Facilities that pre-pour medications on a limited basis must follow Standard D-02 Medication Administration Services, compliance indicators #7 - #10.

Point of administration preparation refers to situations where medications are removed from their original labeled containers and placed into a temporary container (for example, small plastic cup or envelope) immediately before administration in the housing unit where medications are being administered.

- Example: When doing medication pass for upper-tier patients housed in a lockdown unit, a nurse brings the medication cart to the housing unit and prepares medications at the base of the stairs and immediately delivers them to each patient's cell for administration.

This is the preferred practice for situations involving individuals that cannot freely come to the medication cart/window (for example, lockdown units when carts cannot access upper tiers) and is recognized and supported by NCCHC.

## Menu Reviews and Heart-Healthy Diets

**Q** Could you provide the specific NCCHC requirements regarding menu reviews and providing a heart-healthy diet? I need this information to ensure our food service vendor understands them and helps us remain compliant with an upcoming survey.

**A** NCCHC Standard D-05 Nutrition Services, compliance indicator #1, requires facilities to provide a heart-healthy diet to incarcerated individuals. A heart-healthy diet includes foods from all food groups and emphasizes a wide variety of fruits and vegetables, whole grains, high-fiber foods, healthy protein sources, minimally processed foods, and foods low in saturated fat, trans fat, and sodium, while limiting red meat and added sugars. Excess sodium is a common concern; when possible, diets should not exceed the average American sodium intake of approximately 3,400 mg per day.

The standard also requires a registered dietitian nutritionist (RDN), or other licensed qualified dietitian professional, as permitted by state scope of practice laws, to conduct and document an annual review of all regular and medical diets for nutritional adequacy. This review should include the dietitian's name, credentials, signature, and date on each menu reviewed.

During an NCCHC accreditation survey, surveyors review documentation of the annual menu review and the dietitian's assessment that the regular menu meets the intent of a heart-healthy diet. ●

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*Wendy Habert, MBA, CCHP-A, is NCCHC's director of accreditation. Send your standards-related questions to accreditation@ncchc.org.*

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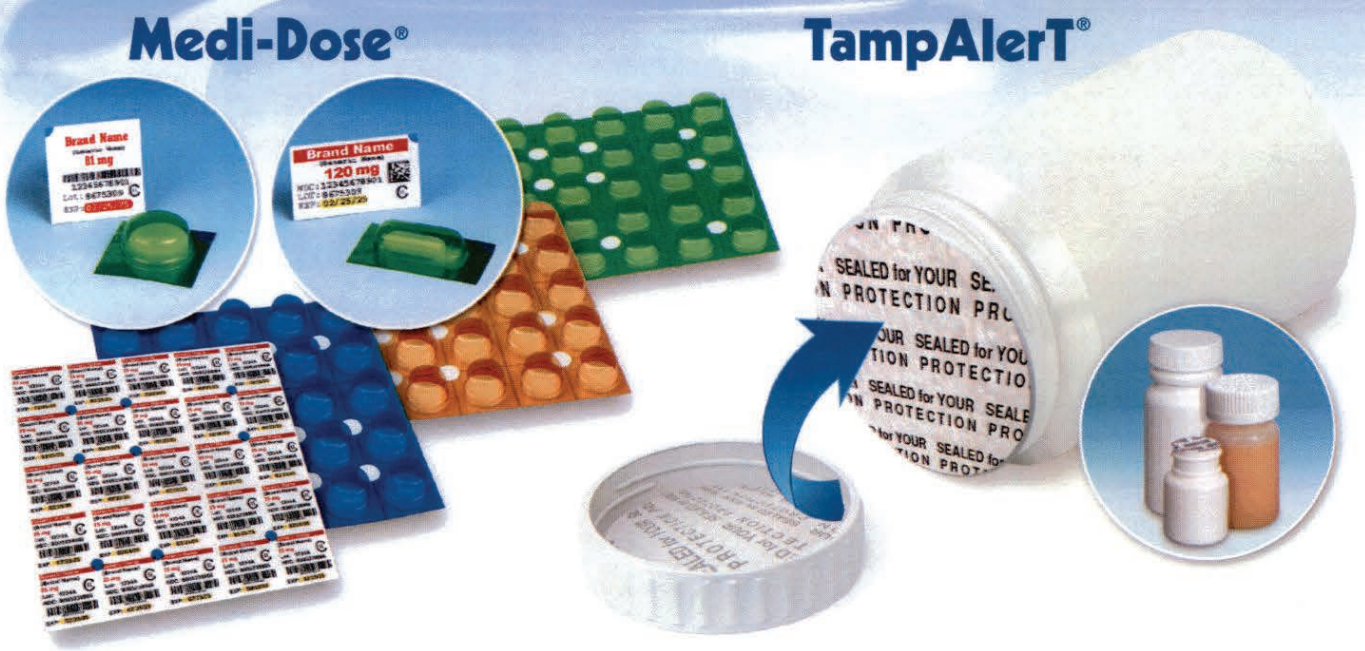


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