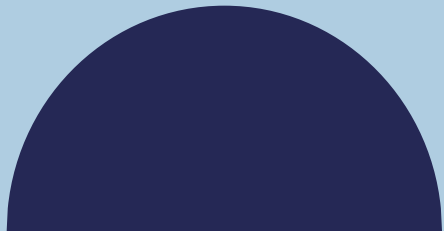




Turning the Tide: Building Bridges to Navigate the Waves of the Opioid Crisis

Twyla Crain, LSW, and Amy Stahley, Lincoln Trail District
Health Department



Site Information

- **County:** Hardin County
- **State:** Kentucky (KY)
- **Year OFR started:** 2021 with case reviews starting in 2022
- **Overdose deaths per year:** First year of case review in 2022 (50), 2023 (38), 2024 (35)
- **Size of jurisdiction:** 112,000 residents
- **Funding sources:** Currently, Hardin County OFR does not have a funding source



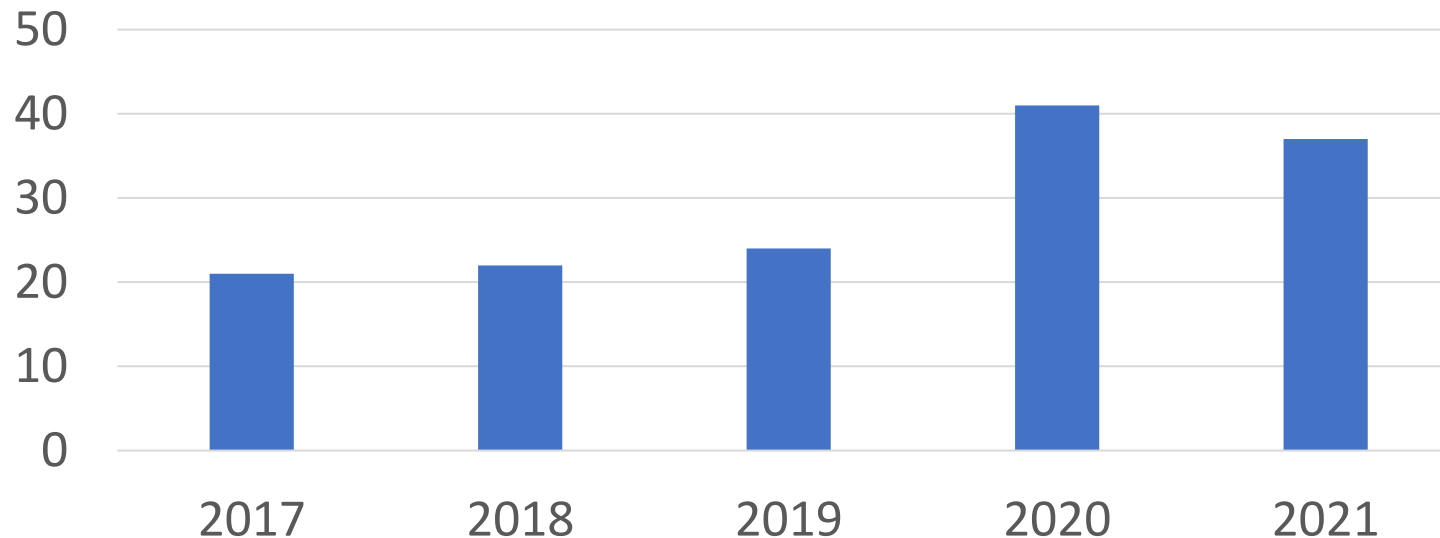
Stakeholders Involved in Hardin County's Overdose Fatality Review



Our Story

- 2017–2021: Hardin County experienced a consistent rise in fatal overdoses
- 2021: Tragic overdose of a local teen
- This event prompted the local hospital’s Chief of Medicine to engage with local officials and community partners, sparking collaborative efforts to tackle the problem.

Fatal Overdose Rates



Key Challenges We Faced

Limited ability to hold in-person meetings due to COVID-19 restrictions

Uncertainty about how and where to begin addressing the issues

Disconnected communication between essential agencies, including law enforcement, hospital staff, and detention centers

Insufficient coordination of medical care for justice-involved individuals

Lack of trust between agencies to share critical information

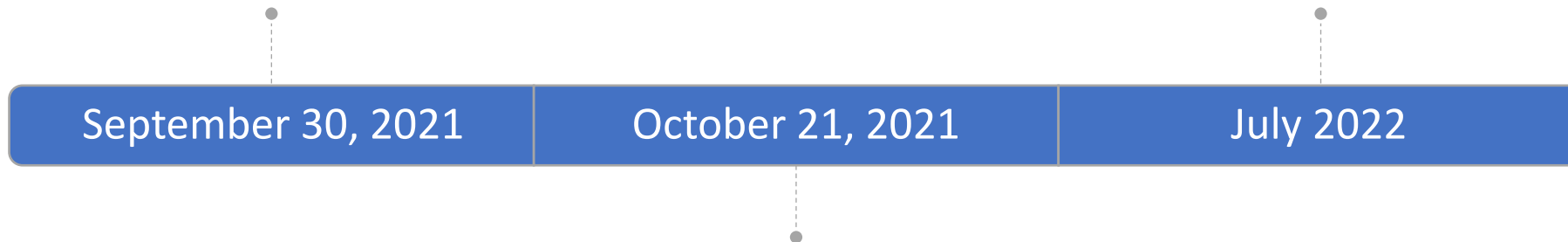
Bringing It All Together

First Meeting (September 30, 2021)

The initial meeting was held virtually via Zoom and served as an informational session.

Case Reviews Began (July 2022)

After months of planning and coordination, the team began conducting case reviews in July 2022.



Second Meeting (October 21, 2021)

This meeting focused on identifying key stakeholders who needed to be involved in the conversation.

Case Example:
Key Issues in
Justice-involved
Patient Care

Scenario: Multiple individuals ingested baggies of assumed controlled substances before arrest

Communication Breakdown: Police officers transporting patients without medical training

Unclear Expectations: Ambiguity around the term “medical clearance”

Why It Mattered: Life-threatening gaps in care for justice-involved patients

Outcome: Resulted in overdoses, emphasizing critical safety concerns

Response: Implementing a New Protocol

**Medical Report
Form**

**Complete Visit
Record**

**Direct
Communication
Line**

Denial of Admission

DENIAL OF ADMISSION

In accordance with KRS 441.045 & 501 KAR 3:120(2): Prior to accepting a person for admittance to Hardin County Detention Center (HCDC), medical & HCDC staff shall carefully observe the person's behavior & physical conditions to determine if the person needs emergency medical attention. A person in need of emergency medical attention shall not be accepted for admittance. A Denial of Admission Form shall be completed by HCDC or medical staff & signed by an HCDC Supervisor on any person not accepted for admittance. No person shall be accepted for admittance to HCDC:

- Until the intake questioning & medical clearance is complete and HCDC supervisor or booking staff signs Admittance Form accepting person into HCDC custody.
- In an unconscious state or with evidence of serious illness or injury. This decision is based upon judgement of the HCDC Supervisor on duty &/or contracted Physician, nurse or paramedic.
- With a BA = or > .28. Any person with a BA of .28 may be retested after 20 minutes. If retest is = or > .28, they will not be accepted.
- Without clear and documented legal authority.
- Unless the escorting officer is positively identified and a duly authorized officer.

Arrestee Name:	Date of Birth:	SSN:
Arrest Date:	Arrest Time:	Arrest Location:
Intake Date:	Intake Time:	Agency:
Transporting Officer:	Unit/Badge:	

Medical Concern for Send Out:

This person will not be accepted for admittance to Hardin County Detention Center due to: (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Extreme/Severe Intoxication of unknown substance | <input type="checkbox"/> Incoherent or unable to stand or walk w/out assistance. |
| <input type="checkbox"/> BA .28 or > <u>RETEST</u> : Y N RESULTS: _____ | <input type="checkbox"/> Serious injury or wound. |
| <input type="checkbox"/> Exhibiting symptoms of alcohol or drug withdrawal | <input type="checkbox"/> Serious illness |
| <input type="checkbox"/> Actively Suicidal | <input type="checkbox"/> Injury sustained during or relating to arrest. |
| <input type="checkbox"/> Vermin/ Infestation | <input type="checkbox"/> Displaying signs/symptoms of being mentally unstable |
| <input type="checkbox"/> Narcan Administration < 24 hours | <input type="checkbox"/> Possible foreign object identified in body cavity upon body scan |
| <input type="checkbox"/> Unconscious, semiconscious or unable to stay awake. | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Head injury < 24 hrs. | |
| <input type="checkbox"/> Officer w/out ID or Improper ID | |
| <input type="checkbox"/> Improper/incomplete commitment documents | |
| <input type="checkbox"/> Unstable Vitals, extremely high/low BP or Heart Rate | |
| <input type="checkbox"/> Pregnant & having contractions or in Labor. | |
| <input type="checkbox"/> Pregnant & Intoxicated/ Admits recent illegal drug use. | |
| <input type="checkbox"/> Seizures or seizure like activity | |
| <input type="checkbox"/> Infectious or Communicable illness | |

HCDC Supervisor:	Badge:	Date of Denial:	Time of Denial:
Medical Staff Conducting Screening:	BA Results:	Heart Rate:	BP:

Name of Medical Staff: _____ Signature of Medical Staff: _____ Date: _____

Name of HCDC Supervisor: _____ Signature of HCDC Supervisor: _____ Date: _____



Denial of Admission

Extreme/severe intoxication of
unknown substance

Exhibiting symptoms of alcohol
or drug withdrawal

BA 0.28 or >

Actively suicidal

Narcan administration < 24
hours

Possible foreign object identified
in body cavity upon body scan

Results

Significant improvements in patient safety and care coordination

Strengthened collaboration between law enforcement, hospitals, and detention centers

Reduction in critical information gaps, enabling better-informed decision making

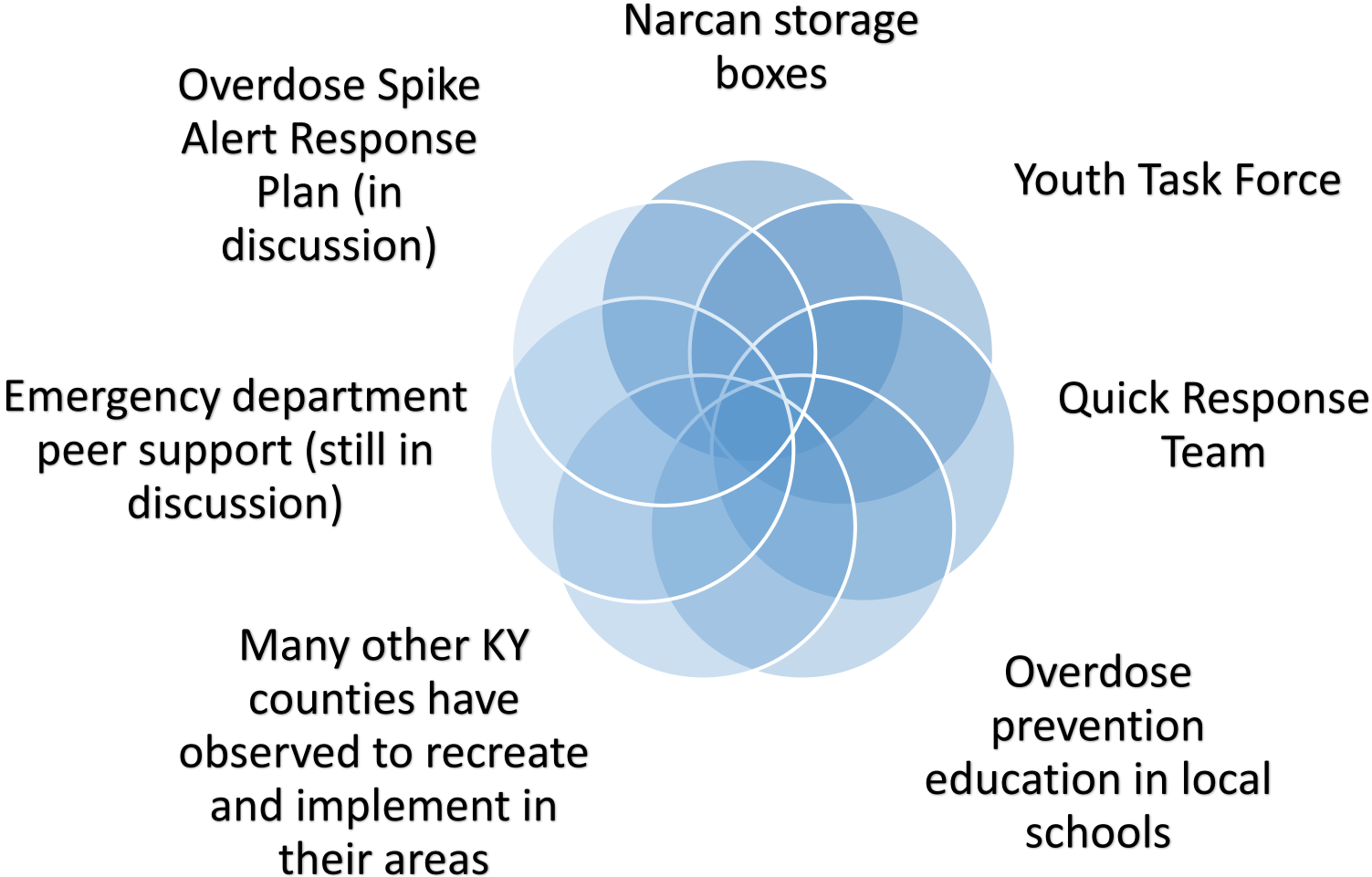
Increased efficiency and fewer avoidable errors

Lessons Learned



- Collaboration Is Key
- Transparent Communication
- Flexibility and Trust
- Small Steps, Big Impact

Other Activities to Come From Our OFR



The Future of Hardin County's OFR



*Institute for Intergovernmental Research
OFR Training and Technical Assistance Team

Twyla Crain, LSW
Harm Reduction Specialist
twyla.crain@ltdhd.org

Amy Stahley
Safe Community Specialist
amy.stahley@ltdhd.org



Website: www.ltdhd.org