CASE STUDY

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Increasing referrals and enrollment to opioid treatment and addiction services

Background

For years, The University of Kansas Health System, an 890-bed academic medical center in Kansas City, Kan., had no reliable way to ensure patients with opioid use disorder (OUD) stayed connected to treatment after discharge. Many patients left the hospital without outpatient appointments, confirmed insurance coverage for treatment services, or family support — making it difficult to continue medication for opioid use disorder (MOUD) treatment after discharge. Clinicians described seeing some patients return repeatedly with abscesses and other opioid-related medical complications after failing to connect to ongoing treatment.

Providers found patients were more likely to follow through with outpatient care when a licensed addiction counselor helped coordinate next steps before discharge from an inpatient hospital or emergency department (ED) stay; consequently, the health system identified counselors who could serve in a newly defined addiction coordinator role. In early 2026, the health system used the AHA HRET Bridge to Care toolkit to connect hospitalized patients with outpatient addiction treatment before discharge. The team used the toolkit to identify barriers to follow-through, strengthen coordination between inpatient and outpatient teams and develop more consistent referral and communication workflows to ensure as many patients as possible could engage in treatment.

Creating a reliable referral process across care settings by embedding addiction coordinators into inpatient care

In spring 2026, team leaders began developing a coordinator consult workflow. The workflow focused on warm handoffs to outpatient treatment before discharge and expanded the role of addiction coordinators in helping patients transition into ongoing care. By late spring 2026, the health system was training addiction coordinators and building a new consult order in the electronic health record (EHR) that allowed addiction psychiatrists to refer patients directly to coordinators for discharge planning and outpatient treatment coordination. The team also developed clinical documentation templates, referral pathways and communication processes to support the new workflow before launch.

Rather than hiring new staff, leaders adapted existing counselor roles to support the new workflow. Counselors from the health system's outpatient treatment program rotated into the inpatient setting one to two days per week, with backup coverage built into the schedule to maintain continuity when counselors were unavailable.

Implementing the workflow required additional operational changes across inpatient and outpatient settings. In spring 2026, hospitalists and addiction psychiatry leaders created a formal coordinator consult order in the EHR, allowing addiction psychiatrists to specify follow-up services for each patient after the initial consult. Counselors also received hospital-issued phones with access to the secure messaging platform used by inpatient clinicians, allowing them to communicate with care teams in real time during hospitalization.

Leaders also developed standardized documentation templates and trained counselors on inpatient workflows, EHR documentation and hospital communication systems before they began seeing patients independently. Midway through implementation, the physical OTP clinic relocated several miles from the main hospital campus, requiring leaders to coordinate counselor travel, parking and workspace access across sites.

Implementing the workflow required coordination across addiction psychiatry, hospital medicine, behavioral health and ambulatory addiction services. Hospitalist leaders helped develop the referral process and EHR workflow, while behavioral health and addiction leaders trained counselors on inpatient workflows, EHR documentation and communication processes. Working alongside the addiction psychiatry consult service, addiction coordinators met with patients and families at the bedside, helped patients navigate insurance and treatment eligibility issues, arranged outpatient intake appointments, and connected patients with opioid treatment programs (OTPs) and other community treatment resources.

Working with hospitalists to reduce barriers for inpatient teams

Hospitalist leaders played a major role in shaping a referral process that inpatient clinicians could realistically use. Early planning discussions revealed adding another referral step for frontline hospitalists would likely limit adoption. In response, the teams redesigned the workflow so addiction psychiatrists, rather than inpatient hospitalists, placed the coordinator consult orders after evaluating patients. That decision allowed hospitalists to continue using the existing addiction psychiatry consult process rather than adding another referral step. One hospitalist leader with expertise in EHR configuration also helped build the coordinator consult order and made it easier for clinicians to locate.

The collaboration also created a more direct working relationship between addiction psychiatry, hospitalists and addiction counselors, which improved communication around discharge planning and outpatient follow-up for patients with OUD.

Measuring if more patients stay connected to care

The coordinator consult process officially launched on May 1, 2026, and the health system was still in the early stages of implementation and data collection when this case study was developed.

The team set goals of reaching 75% of consult patients before discharge and enrolling an additional two to four patients per week in the OTP. Leaders plan to track how often addiction psychiatry consults generated coordinator referrals, the percentage of patients seen before discharge, enrollment in the outpatient addictions clinic and OTP, and successful warm handoffs to community treatment programs. In the future the team hopes to reduce rehospitalizations related to OUD, improve continuity of treatment after discharge and leverage their two outpatient addiction psychiatry clinics.

Even before formal metrics were available, leaders believe the new workflow has already improved communication and coordination between inpatient teams, outpatient addiction services and community treatment programs across Kansas.

In summation, adding counselors to an inpatient addiction psychiatry team can provide several important benefits and help achieve key treatment goals. These include but are not limited to increased patient contact and support; improved treatment engagement; enhanced psychosocial assessment; better continuity of care; comprehensive treatment focusing on medication management, cognitive behavioral interventions, relapse prevention counseling, psychoeducation, skills training, and recovery coaching; and reduced burden on addiction psychiatric staff. Using this model, counselors serve as a bridge between psychiatric treatment, behavioral interventions and recovery support, helping create a more holistic and effective inpatient addiction treatment program.

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