

CASE STUDY

UNIVERSITY MEDICAL CENTER NEW ORLEANS

Developing systemwide approaches to inpatient OUD treatment and care transitions

Background

University Medical Center New Orleans (UMCNO), a 446-bed Level 1 trauma center within the LCMC Health system, in 2026 expanded ongoing efforts to improve how emergency department clinicians, inpatient teams and outpatient providers identify, treat and follow patients with opioid use disorder (OUD). Hospital leaders participated in the AHA HRET [Bridge to Care](#) initiative while continuing broader system efforts related to medication for opioid use disorder (MOUD), care transitions and follow-up addiction treatment. Teams focused particularly on patients hospitalized with injection-related infections, trauma-related injuries and other serious medical conditions associated with OUD.

Before developing the 2026 action plan, clinicians conducted an internal review of inpatient care patterns and found that only about 25% of eligible patients with OUD received MOUD during hospitalization. Teams also found that relatively few patients returned for addiction medicine follow-up after discharge.

Clinicians identified several factors contributing to those outcomes, including inconsistent OUD identification and coding practices, limited inpatient addiction medicine resources, clinician unfamiliarity with MOUD initiation, limited methadone access and fragmented workflows for connecting patients to outpatient care.

In February 2026, UMCNO submitted an action plan focused on improving inpatient MOUD initiation, strengthening OUD screening and building infrastructure to better track treatment and follow-up care over time. Teams also outlined goals extending through late 2026 and into 2027.

Building infrastructure to measure and improve care

During spring 2026, clinicians, operational leaders and information technology (IT) teams prioritized the development of a quality dashboard within the electronic health record (EHR) to track MOUD initiation, addiction medicine referrals, naloxone distribution and follow-up addiction care after discharge.

Teams chose to focus first on measurement and infrastructure before implementing broader workflow changes across the health system. Clinicians wanted a more consistent way to evaluate whether future interventions improved treatment rates, follow-up care and retention over time.

As teams developed the dashboard, clinicians and IT staff encountered challenges related to diagnosis and coding variation. Patients hospitalized with OUD often receive diagnosis codes related to overdose, infection or polysubstance use rather than a specific OUD diagnosis, making it difficult for teams to identify the appropriate patient population and measure outcomes consistently across the system.

Clinicians also noted that many hospitalized patients with OUD enter the hospital for trauma, infection, chest pain or other acute medical conditions, and coding practices do not always capture OUD consistently within the medical record.

In response, teams began refining screening and identification workflows during spring 2026. Emergency department and inpatient teams explored the use of nursing triage questionnaires, fentanyl screening, prospective ICD-10 coding approaches and EHR alerts to identify patients who may benefit from MOUD and follow-up addiction care. Teams also began developing standardized order sets, documentation tools, referral workflows and follow-up processes within the EHR to support more consistent inpatient treatment and care transitions after discharge.

Expanding methadone access during hospitalization

During spring 2026, hospital leaders revised policies to allow clinicians to initiate methadone treatment for eligible hospitalized patients. Previously, clinicians could continue methadone treatment for patients already receiving it but could not initiate methadone during hospitalization.

Clinicians view the hospital policy change as an important step toward expanding treatment options for patients who either preferred methadone or had not responded well to buprenorphine in the past. Teams considered the addition of methadone as an important option for patients with complex trauma and pain management needs.

Within several weeks of the policy revision, clinicians had already initiated methadone treatment for hospitalized patients who previously would not have qualified under the prior policy.

Coordinating system-wide efforts

Clinicians, hospital leaders, trauma teams, pharmacy staff, population health leaders and IT teams all participated in the initiative. Teams plan to continue engaging nursing staff, outpatient addiction medicine providers and substance use navigators as implementation expands.

The work aligns with broader Louisiana Medicaid incentive programs focused on improving naloxone distribution, MOUD initiation and follow-up care coordination for patients with OUD and stimulant use disorder.

Teams worked to strengthen referral relationships with outpatient addiction medicine clinics, opioid treatment programs, skilled nursing facilities and long-term acute care hospitals to improve care transitions after discharge.

Teams plan to continue developing an inpatient addiction medicine consult service and integrating substance use navigators into emergency department, inpatient and outpatient workflows.

Challenges and next steps

At the time this case study was developed in spring 2026, staffing shortages and competing operational demands slowed broader implementation efforts across the health system. Teams were also managing ICU workflow changes and faculty turnover while simultaneously building new addiction care infrastructure. Despite these challenges, clinicians and operational leaders continued laying the foundation for long-term change by developing updated MOUD protocols, expanding EHR tools, standardizing OUD screening workflows, and creating additional referral pathways for outpatient addiction treatment.

Although teams had not yet collected long-term outcome data, clinicians and operational leaders view the initiative as an opportunity to create more consistent systems for identifying, treating and following hospitalized patients with OUD across care settings and across the broader health system.

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