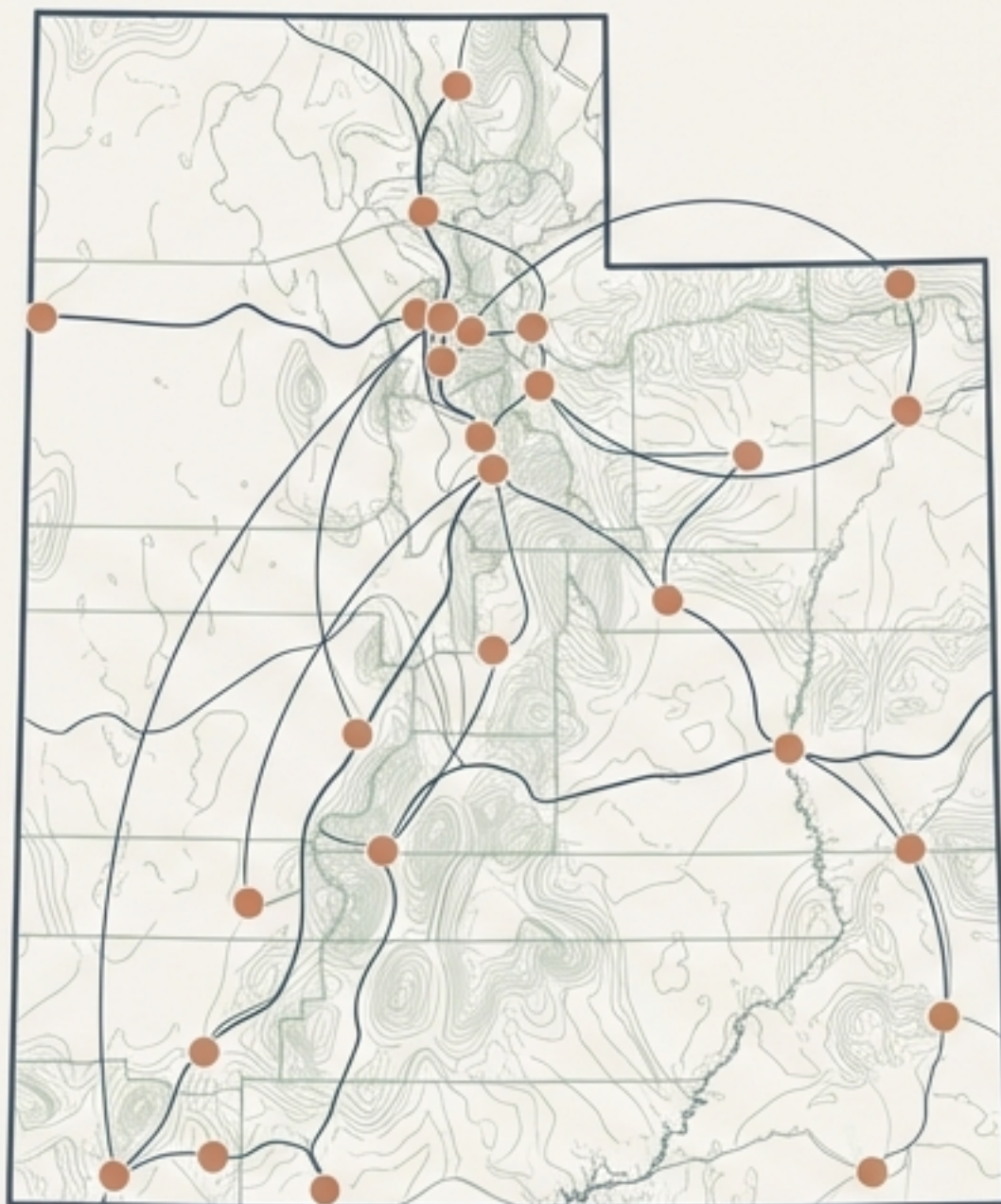


Editorial Consulting

Navigating the Utah OUD Care Landscape

A Practical Reference for Clinicians



A comprehensive, unbiased guide to outpatient MAT, detox and residential programs, methadone OTPs, harm reduction, and care coordination workflows for treating Opioid Use Disorder in Utah.

Utah's OUD Environment Presents Unique Clinical Challenges



High Fentanyl Exposure:
Widespread counterfeit "M30" pills.



Significant Polysubstance Use:
Frequent co-use of fentanyl and methamphetamine.



Service Gaps in Rural Regions:
Extremely limited access to specialty addiction services outside urban centers.



Few Methadone Clinics:
A limited number of Opioid Treatment Programs (OTPs) statewide places a greater burden on other providers.



Strong Harm Reduction Network: Robust but resource-variable programs, including a national leader in naloxone distribution.

These factors make primary care navigation and referral knowledge especially critical for patient survival and recovery.

Primary Care is the Linchpin of Effective OUD Treatment

According to SAMHSA, NIH, and AHRQ, the primary care setting is crucial for several evidence-based reasons:



First Point of Contact:

Most people with OUD interact with primary care before ever reaching specialty addiction treatment.



Higher Patient Trust:

Patients consistently report higher trust and engagement with PCP-led OUD treatment.



Improved Outcomes:

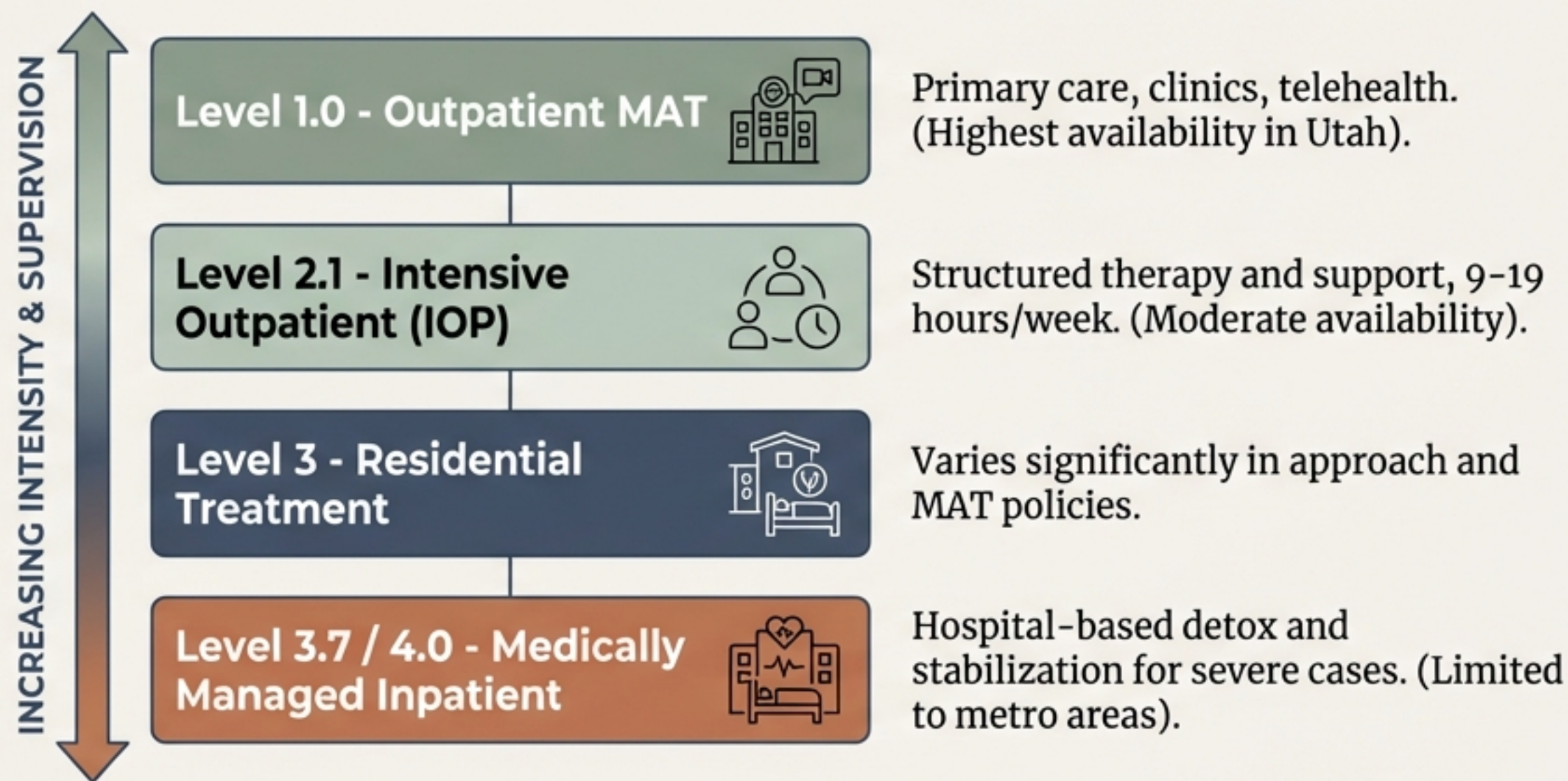
Retention and positive outcomes improve when care is delivered in lower-barrier, familiar settings.



High-Stakes Interventions:

Each missed referral opportunity significantly increases the risk of overdose, especially post-detox or post-incarceration.

The ASAM Framework: A Common Language for Matching Patient Need to Care Intensity



Using this framework ensures patients are directed to the appropriate level of care, optimizing outcomes and resource use.

Level 1 & 2.1: The Backbone of Utah's OUD Care System



Section 1: Level 1 - Outpatient MAT

- **Includes:** Primary care clinics (buprenorphine), FQHCs, hospital-affiliated offices, independent MAT programs, telehealth services.
- **Appropriate for:** The majority of people with OUD, including fentanyl users and pregnant individuals (with OB coordination).
- **Utah Context:** This level of care has the greatest availability statewide.



Section 2: Level 2.1 – Intensive Outpatient (IOP)

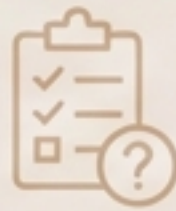
- **Includes:** 9–19 hours/week of therapy, education, group support, case management.
- **Useful for:** Patients needing structured behavioral support or those with recurrent relapse.
- **Utah Context:** Moderately available in urban areas; limited in rural counties.

Higher Levels of Care (3 & 4) Require Careful Vetting and Coordination ⚠️



Section 1: Level 3 - Residential Treatment Programs

The Critical Variation: Programs in Utah vary significantly. Some provide evidence-based treatment and fully support MAT. Others use abstinence-only models or prohibit MAT entirely, which is contraindicated by SAMHSA and ASAM.



Clinician Action: Always verify whether MAT is allowed before referring.



Section 2: Level 3.7 /4.0 - Medically Managed Inpatient Treatment

- **Includes:** Hospital-based detox, inpatient stabilization units, Emergency Departments.
- **Appropriate for:** Severe/complicated withdrawal, acute medical/psychiatric instability, or missed methadone doses >72 hours.
- **Utah Context:** These services are concentrated in Utah's larger metro areas.

Mapping Utah's Medication Providers: Buprenorphine vs. Methadone

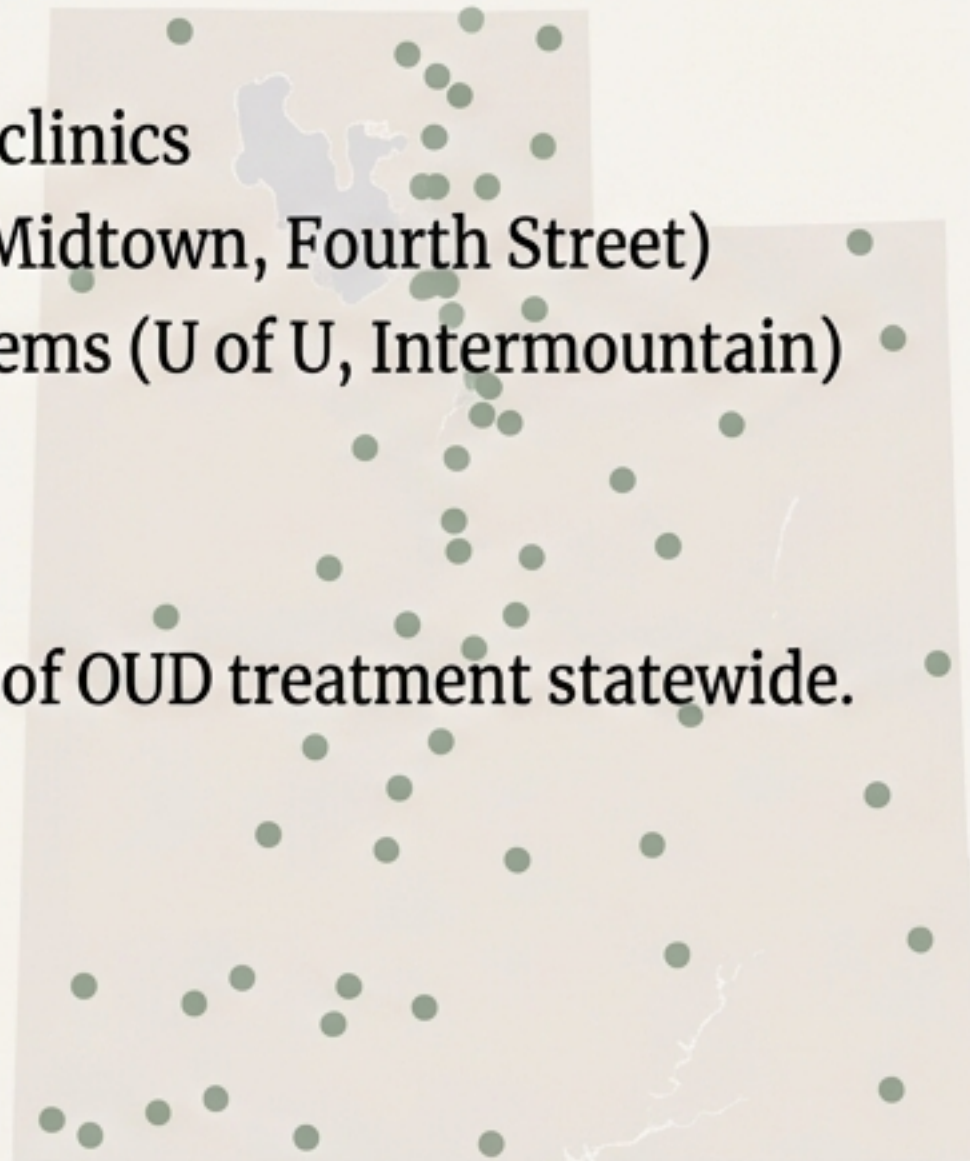
Outpatient MAT Providers (Buprenorphine)

Who

- Primary care clinics
- FQHCs (e.g., Midtown, Fourth Street)
- Hospital systems (U of U, Intermountain)
- Telehealth

Availability

The foundation of OUD treatment statewide.



Methadone Clinics (OTPs)

Who

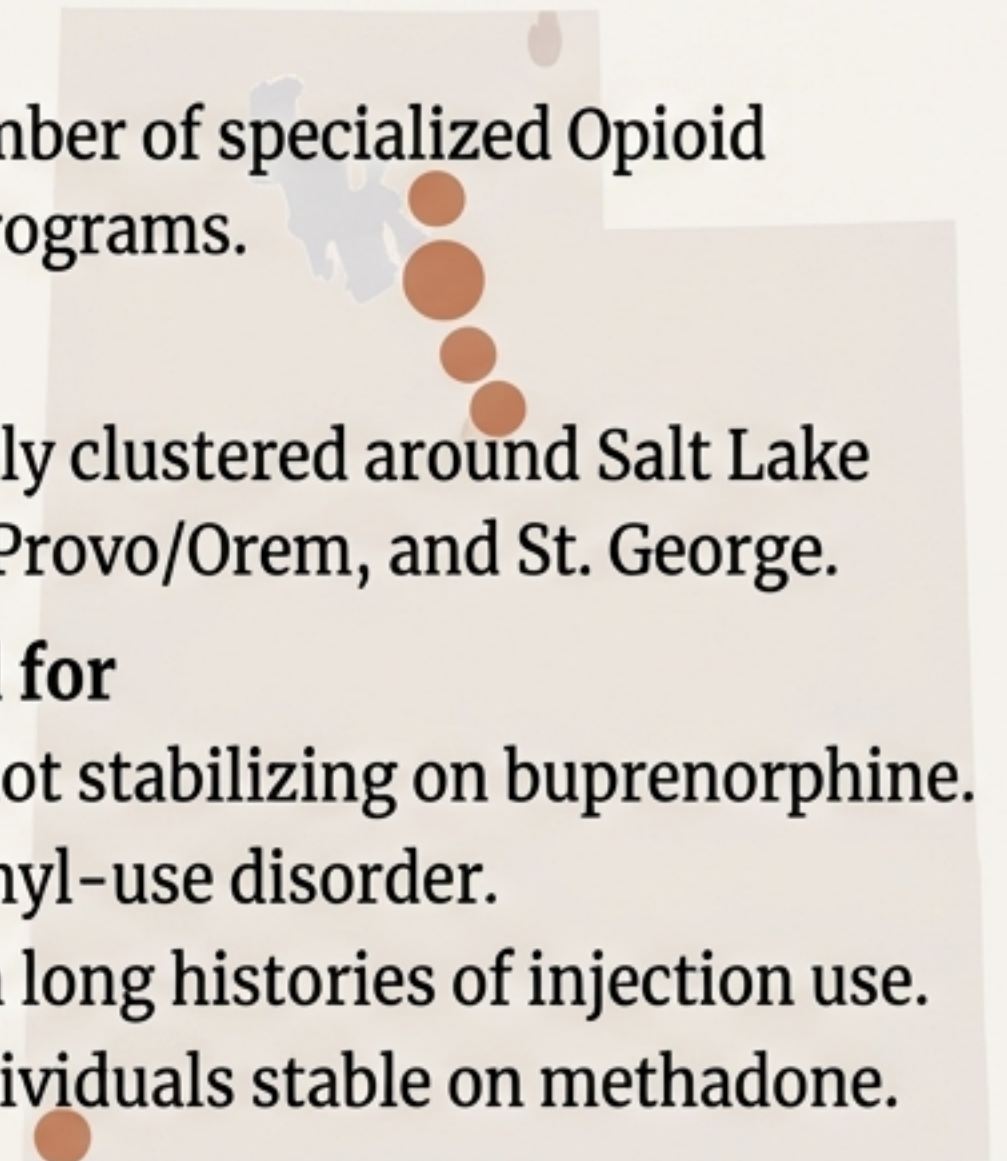
- A limited number of specialized Opioid Treatment Programs.

Availability

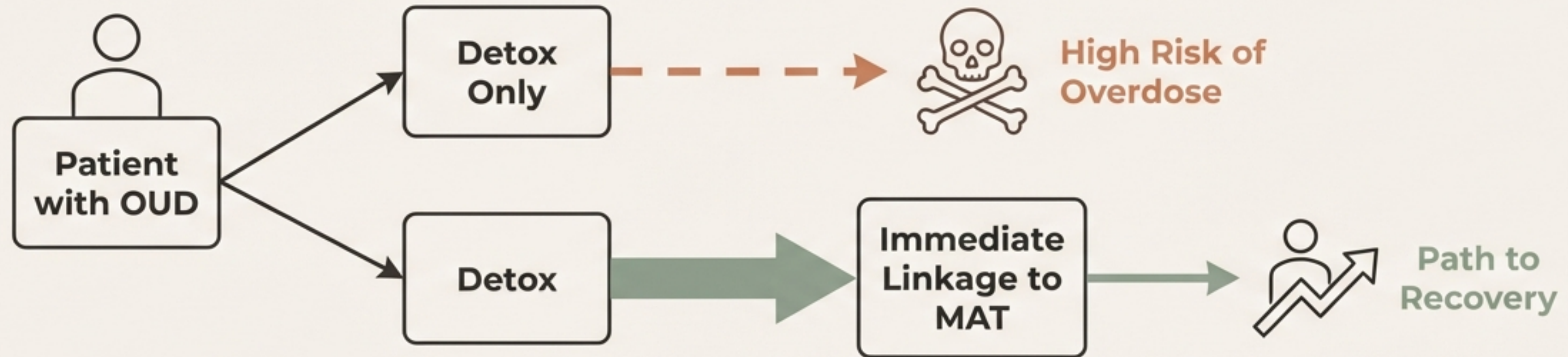
- Geographically clustered around Salt Lake City, Ogden, Provo/Orem, and St. George.

Recommended for

- Individuals not stabilizing on buprenorphine.
- Severe fentanyl-use disorder.
- Patients with long histories of injection use.
- Pregnant individuals stable on methadone.



A Critical Warning: Detox Alone is Not Treatment and Increases Overdose Risk



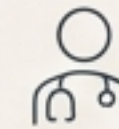
The Utah Reality

Most detox programs in Utah provide only short-term withdrawal management, are abstinence-focused, and do not initiate or continue MAT.



The Evidence-Based Standard (SAMHSA & ASAM)

- Detoxification by itself is not a standalone treatment for Opioid Use Disorder.
- Patients have an extremely high risk of overdose upon discharge from detox due to loss of tolerance.



Clinical Imperative

Patients must be connected to an MAT provider for initiation or continuation of medication *immediately* upon discharge. A referral plan should be in place before detox begins.

Utah's Harm Reduction Ecosystem is an Essential Medical Resource

Key Organizations

- **Utah Naloxone:** Statewide leader in free naloxone distribution.
- **Utah Syringe Exchange Network & Salt Lake County Harm Reduction Project:** Mobile and fixed-site services.
- **Peer Outreach Teams:** Connecting with people directly.

Core Services Provided



Naloxone kits
(free)



Fentanyl test
strips



Safer
injection/inhalation
supplies



Wound care



Peer support &
overdose prevention
education

The Bottom Line (CDC & NIH): Harm reduction is identified as essential, evidence-based medical care that saves lives.

Integrating Support Systems for Crisis, Mental Health, and Housing

Crisis & Mental Health



- **Utah Crisis Line (988):** Immediate, 24/7 support.
- **Mobile Crisis Outreach Teams (MCOT):** In-person response.
- **Behavioral Health Urgent Care:** Walk-in stabilization.
- **County Mental Health Authorities:** Localized services.

Use For: Suicidality, psychosis, or acute psychiatric symptoms needing stabilization before resuming MAT care.

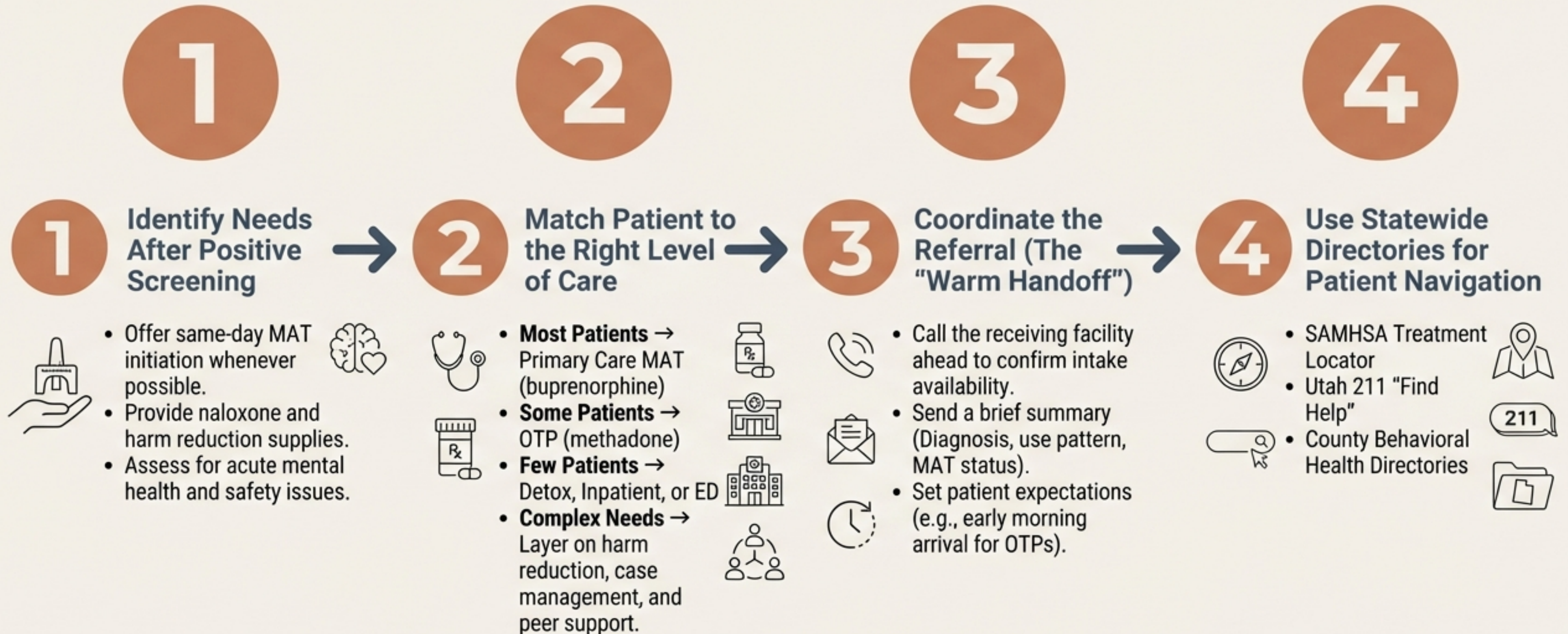
Housing & Social Support



- **The Road Home:** Shelter and case management.
- **VOA & Catholic Community Services:** Programmatic support.
- **Peer Recovery Coaches (DHHS):** Lived experience guidance.
- **Supportive Housing Initiatives:** Salt Lake County focus.

Key Evidence (NIDA): Addressing housing and social needs significantly improves MAT retention rates.

Your Clinic's OUD Referral Pathway: A 4-Step Workflow



Referral Checklists for Safe Transitions of Care

Coordinating with Residential Programs



- ☐ **Confirm MAT continuation policy in writing.**
- ☐ Verify if a medical provider is onsite.
- ☐ Provide written continuation orders for buprenorphine/methadone.
- ☐ Fax patient's current dose and induction plan.
- ☐ **Schedule a discharge follow-up appointment *before* the patient is admitted.**

Coordinating with Methadone OTPs



- ☐ Call ahead to confirm intake spot and timing.
- ☐ Send a brief summary of the patient's OUD diagnosis, current use, and any prior MAT history.
- ☐ Prepare the patient for the common requirement of early-morning arrival for dosing.

Common Clinical Scenarios and Recommended Pathways



Scenario 1: Daily Fentanyl Use, Stable Housing

Primary Care MAT (buprenorphine) via low-dose induction + Naloxone + Harm Reduction supplies.



Scenario 2: Pregnant Patient with OUD

Initiate or continue buprenorphine (per ACOG/ASAM) + Coordinate closely with OB provider + **Do NOT taper or refer to detox.**



Scenario 3: Patient Destabilizing on Buprenorphine

Consider transition to methadone (referral to OTP) + Discuss adding IOP for behavioral support + Continue all harm reduction measures.



Scenario 4: Patient with OUD + Severe Mental Illness

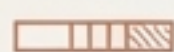
Initiate/continue MAT + Coordinate with mental health services + Use crisis stabilization if needed (MCOT, urgent care) + Engage peer support and case management.

Make Harm Reduction a Standard of Care in Every Encounter

Every Patient with OUD in Utah Should Receive:



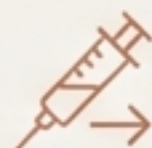
- A naloxone kit and training.



- Fentanyl test strips.



- Education on safer use (e.g., avoiding solitary use).



- Information on syringe exchange services.



- Wound care guidance.

Scripts for Difficult Conversations



When a patient fears withdrawal

“We can use a low-dose method that lets us start buprenorphine while you continue using temporarily, making it much more comfortable.”



When a patient returns to use

“This is a chronic condition. A return to use tells us we need to adjust your support plan, not stop treatment.”



When discussing methadone

“For many people using fentanyl daily, methadone is the most effective treatment for achieving stability. This specialized clinic can help you get there.”

Key Principles for Effective OUD Care Navigation in Utah



1. Use the ASAM Framework to navigate Utah's complex system.



2. Treat Most Patients in Outpatient MAT. It is the most accessible and appropriate level of care.



3. Know Your Local OTPs. Methadone is an essential but limited resource.



4. Detox is Not Treatment. Always link immediately to MAT.



5. Verify Residential MAT Policies. Never refer a patient on MAT without confirming continuation.



6. Leverage Utah's Strong Harm Reduction Network. These services are evidence-based and life-saving.



7. Plan for Co-Occurring Disorders. Integrate crisis and mental health services.



8. Address Social Needs. Housing and case management dramatically improve retention.