# Making a Shared Decision:

## A Guide to Patient-Provider Conversations about MOUD

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# Overview

This guide is designed to support health care providers and emergency first responders in having effective, compassionate conversations with individuals who may benefit from medications for opioid use disorder (MOUD). The strategies in this document are drawn from the core principles of **shared decision-making** and **motivational interviewing.** Behavior change in any setting is difficult, and these skills can help you connect with patients and support meaningful change, even with such a tough topic as opioid addiction.

**Shared decision-making (SDM)** is a collaborative approach where providers and patients work together to choose a path forward that aligns with the patient's values, goals, and needs. SDM is supported by a growing body of research showing it **improves patient engagement, trust, satisfaction**, and in many cases, **clinical outcomes** – especially in chronic and stigmatized conditions like opioid use disorder (OUD).

**Motivational interviewing** is a patient-centered communication style designed to strengthen a person's own motivation and commitment to change by exploring and resolving their ambivalence about change. It's a **goal-oriented, collaborative** approach that focuses on the language of change and empowers individuals to make positive behavioral changes.

SDM is increasingly used when deciding on diagnostics and treatments, and can support other aspects of primary, hospital-based, and emergency care. Combining it with motivational interviewing elevates the treatment plan to a strategy for behavior change and increases the likelihood that the plan will stick.

This guide details seven steps that can reinforce positive interactions with your patients who use opioids and can help you help them get closer to their goals.

# Core principles of effective SDM

- Use a trauma-informed approach to foster dignity, respect, and agency.
- Use patient-centered language (e.g., “person with OUD” vs. “addict”).
- Build trust by communicating empathy and support:
  - Address immediate needs, including physical and psychological comfort.
  - Ask about patient experiences, preferences, and goals.
  - Listen without judgement and reflect back to confirm understanding.
  - Provide accurate and unbiased information about the options.
- Navigate the patient’s readiness to change:
  - Ask how motivated on a scale of 1 to 10 your patient is to change and then no matter what the number is, ask why it’s not lower. This helps you to identify why your patient wants to change.
  - Maintain a mindset that you are meeting your patient where they are.
  - Support whatever decision the patient makes, *even if it’s not what you think could be the best one for them.*
  - Identify opportunities for harm reduction.
  - Keep the door open for future conversations. Be explicit. Example: “If you want to try something else, come back to see us.”

## Why SDM matters for MOUD

- MOUD has unique challenges and stigma because of previous regulations and the social impact of drug use. SDM helps reduce stigma for the patient so they are more likely to accept MOUD.
- Helps patients feel heard and respected.

## When to start the conversation about MOUD

- Any time is a good time - even when revisiting the conversation.
- Possible or confirmed OUD.
- Situations where initiating the conversation are especially critical:
  - Post-overdose
  - Withdrawal
  - Patient asks for help
  - Complications of substance use (e.g., infections, legal issues)

# Making shared decisions

In this document, we offer seven concrete steps you can take towards making shared decisions with your patients, including specific tips to help you implement them confidently. It's important to remember that this is not a rigid script – it's a flexible framework that guides a respectful and collaborative conversation.

For patients with OUD, this process can be the turning point toward evidence-based treatment and recovery. The goal is to make each step both practical and relevant to the realities of time-limited, and potentially emotionally charged, environments like doctors' offices, emergency departments, or crisis response. For you to implement this effectively, you will need to practice. Don't be afraid to try out some of these steps in your existing approach with patients with OUD.

## Step 1: Address immediate needs

**Goal:** Ensure the patient can participate in the conversation.

**Key strategies:**

- Identify and immediately treat un- or under-treated pain and/or withdrawal.
- Assess for unmet physical needs including safety, thirst, hunger, etc.
- Directly acknowledge power differentials and previous traumatic interactions within health care settings.
- It's okay to convey fallibility here. Consider emphasizing the patient's expertise with drug use and addiction compared with your own.

### Example language:

> "Is there anything you need right now to feel more comfortable?"

> "Would you like a few minutes to rest before we talk?"

> "You're in control. I'm here to help, not judge."

# Step 2: Ask the patient about their goals

**Goal:** Identify where the patient is on their path to recovery so you can offer options and information that meet them there.

**Key strategies:**

- Use a nonjudgmental tone and body language.
- Affirm the patient's worth and right to safety and autonomy.
- Try to use the same language they do when talking about their goals.

## Example language:

> "What do you do to stay safe when using drugs? What do you do to help your friends or loved ones stay safe?"

> "What's going well for you right now?"

> "Is there anything about your drug use that you'd like to change?"

> "Have you ever tried to cut back or stop using opioids? What was that like for you?"

> "If you want to try cutting back or stopping, what would that look like for you?"

# Step 3: Introduce the option of MOUD

**Goal:** Normalize the conversation and frame MOUD as a common, safe, effective, and available option.

**Key strategies:**

- Use a nonjudgmental tone and body language.
- Affirm the patient's worth and right to treatment.
- Keep it simple and stigma-free.
- Emphasize that if not today, it will be available in the future.

## Example language:

> "I'm glad you're here. Some medications can help with cravings and withdrawal. And they can save lives. Would you like to talk about those options today?"

# Step 4: Share evidence and options transparently

**Goal:** Provide accurate, digestible information about MOUD, tailored to the patient's health literacy and experience.

**Key strategies:**

- Break down complex information into plain language.
- Use visuals or handouts when available.
- Frame options as choices, not mandates.
- Present all options accurately to allow the patient to make an informed choice.
  There are a few medications available and each works differently.
  Here's how they compare:

**Buprenorphine (e.g., Suboxone):**

- An opioid that reduces cravings and prevents withdrawal symptoms.
- Has a ceiling effect, so higher doses won't increase overdose risk.
- Some people may have tried it off the street with good or bad outcomes; getting it under medical care ensures the correct dose and support and may change your patient's experience with it.
- Available as a daily film/tablet or weekly or monthly injection.
- Where to get it: prescribed at medical offices, certain community programs, opioid treatment programs (OTPs), and many emergency departments. Visits range from weekly to monthly.

**Methadone:**

- An opioid that reduces cravings and prevents withdrawal symptoms.
- Requires more careful dosing – too much can cause sedation; too little won't be effective.
- It is highly effective when used as directed, despite the stigma.
- Where to get it: only at OTPs. Start with daily visits, then move to weekly as progress occurs. Counseling is often part of treatment. Methadone can be started in hospitals and detox centers if follow-up care is assured.

**Naltrexone (e.g., Vivitrol):**

- Completely blocks opioids and has no opioid effects.
- Requires 7 to 10 days without opioid use before starting.
- Less protective against overdose than methadone or buprenorphine.
- Where to get it: medical offices or OTPs in the form of daily pills or monthly injections.

- Discuss treatment settings and clarify misconceptions. Treatment settings vary:
  - **OTPs:** Structured treatment with daily visits and counseling. Provide all three medications.
  - **Medical offices/primary care:** Less structured with weekly to monthly visits. Provide buprenorphine or naltrexone.
  - **Community programs:** Drop-in and street medicine options, often including harm reduction services such as smoking or injection supplies, wound care, and/or drug checking. Provide buprenorphine or naltrexone.
  - **Emergency departments and inpatient hospital teams:** These settings initiate medications but do not continue prescribing once the person is discharged.

## Example language:

> “Let’s look at some options together. There are three medications for opioid use. Each one is used in different settings. You can stop me anytime if you have questions. Where would you like to start — how the medications work, or where you’d take them?”

# Step 5: Explore the patient's reactions and preferences

**Goal:** Understand the patient's perspective, history, fears, and priorities.

**Key strategies:**

- Use open-ended questions.
- Validate feelings and acknowledge past experiences.
- Avoid assuming readiness or intent.

## Example language:

> "Have you used these medications before? What was that like for you? Can we talk about ways to help them work better this time?"

> "What kind of treatment would work best for you? Is there a place you'd like to get care?"

> "Would you like to cut back on fentanyl or stop using it completely?"

## Sample preferences checklist:

**Setting:** ❑ OTP / ❑ Medical Office / ❑ Community Program / ❑ Hospital / ❑ ED

**Visit Frequency:** ❑ Daily / ❑ Weekly / ❑ Monthly

**OUD Counseling:** ❑ Yes / ❑ No / ❑ Open to it

**Medication Interest:** ❑ Buprenorphine / ❑ Methadone / ❑ Naltrexone / ❑ Unsure

## Step 6: Make a shared decision

**Goal:** Partner with the patient to identify the best next step, even if it's a small one.

**Key strategies:**

- Allow space and time for the patient to reflect, even if it's days.
- Confirm understanding without pressure.
- Acknowledge that any progress is valuable.

### Example language:

> "From what you've told me, buprenorphine might be a good fit for you. Do you feel ready to try it? Is there anything making you unsure that we can talk about?"

## Step 7: Support next steps

**Goal:** Ensure a clear, compassionate transition plan – whether it's initiating treatment, connecting to a provider, or just staying safe.

**Key strategies:**

- Use warm handoffs when possible.
- Offer written instructions or a contact card.
- Normalize that patients may change their mind or revisit the conversation.
- Provide harm reduction education and naloxone.

### Example language:

> "If you want to start medication, we can help today. I can also connect you with someone to check in with later. What would make this feel easier for you?"

We hope you find this SDM guide helpful as you start to implement discussions about MOUD with your patients. For additional support, check out the University of Washington Addictions, Drug & Alcohol Institute's certified MOUD patient decision aid brochure and Guide to Talking to Someone About Medications for Opioid Use Disorder.