

Additional file 2 Physician questionnaire (English version)

Prescription of opioid analgesics for non-cancer pain in Germany: study protocol for a mixed methods analysis

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Nils Frederik Schrader¹, Anja Niemann¹, Christian Speckemeier¹, Carina Abels¹, Nikola Blase¹, Godwin Giebel¹, Cordula Riederer², Joachim Nadstawek³, Wolfgang Straßmeir³, Jürgen Wasem¹, Silke Neusser¹

¹ University Duisburg-Essen, Institute for Healthcare Management and Research
Correspondence: nils.schrader@medman.uni-due.de

² Department of Healthcare Research and Innovation, DAK-Gesundheit

³ Professional Association of German Doctors and Psychotherapists practicing in Pain Medicine and Palliative Care (BVSD e.V.)

Questionnaire for the study "Opioid Analgesics - Study on development trends in the care of non-cancer pain (Op-US)"

How to complete the questionnaire:

- ➔ If you do not wish to answer a question, simply skip this question without checking an answer box.
- ➔ Please check the applicable answer boxes in each case. Normally, only one answer is possible for each question. Please check only one box.

Example: **Are you familiar with the guideline "Long-term use of opioids for chronic non-cancer pain (LONTS), 2nd update, 2020"?**

- ☒ Yes
☐ No

- ➔ In some questions you are asked to check all the options that apply to your situation. In this case, the question will be followed by "**(multiple answers are possible)**".

Any questions left?

Please feel free to contact us. You can reach us by phone:

- Tuesdays between 9.00 am and 12.00 am and
- Thursdays between 2.00 pm and 5.00 pm

under 0201 / 183 3774 as well as by e-mail: opus@medman.uni-due.de

Please note the following information when completing the questionnaire:

Among other things, the questionnaire is based on the S3 guidelines "Long-term use of opioids for chronic non-tumour-related pain (LONTS)" and "Medication-related disorders" as well as the "WHO Analgesic Ladder".

Consequently, the following applies:

➔ **Long-term therapy** = Therapy duration of more than three months (LONTS, 2020, S.13)

➔ **Classification of analgesics** (WHO Analgesic Ladder):

WHO Analgesic Ladder	
Step 1: Non-opioid analgesics	e.g. acetylsalicylic acid, ibuprofen, diclofenac, paracetamol
Step 2: Weak (low potency) opioid analgesics	e.g. tramadol, tilidine (+naloxone)
Step 3: Strong (high-potency) opioid analgesics	e.g. buprenorphine, fentanyl, hydromorphone, morphine, oxycodone (+naloxone), tapentadol

➔ **Definition of terms** (LONTS, 2020 & Guideline "Medication-Related Disorders" 2020, ICD-10-GM-2021)

- **Misuse**: intentional or unintentional use of the drug that deviates from the prescription.
➔ *Only intentional misuse will be considered in this study.*
- **Abuse**: Excessive use of substances not in accordance with their intended use, resulting in damage to health in a clinically significant manner.
- **Dependence syndrome (ICD-10-GM-2021, F11.2)**: A group of behavioral, cognitive and physical phenomena that develop after repeated substance consumption. Typically, there is a strong desire to consume the substance, difficulty controlling consumption and a persistent substance use despite harmful consequences. Substance consumption is prioritized over other activities and obligations. An increase in tolerance develops and sometimes a physical withdrawal syndrome.

Thank you very much for your participation in this survey!

Please start now with the survey on the next page!

General information

1. Please indicate your age and gender:

a)	21 – 30	31 – 40	41 – 50	51 – 60	Over 60
	☐	☐	☐	☐	☐

b)	Male	Female	Non-binary
	☐	☐	☐

2. Please indicate which Association of Statutory Health Insurance Physicians (KV) you are affiliated with:

☐ KV Baden-Wuerttemberg	☐ KV Hesse	☐ KV Saxonia
☐ KV Bavaria	☐ KV Mecklenburg-Vorpommern	☐ KV Saxonia-Anhalt
☐ KV Berlin	☐ KV Niedersachsen	☐ KV Schleswig-Holstein
☐ KV Brandenburg	☐ KV North Rhine	☐ KV Thüringen
☐ KV Bremen	☐ KV Rheinland-Pfalz	☐ KV Westphalia-Lippe
☐ KV Hamburg	☐ KV Saarland	☐ none

3. How large is the place you are working in?

- ☐ Rural community (< 5,000 inhabitants)
- ☐ Small town (5,000 to < 20,000 inhabitants)
- ☐ Mid-City (20,000 to < 100,000 inhabitants)
- ☐ Large city (100,000 inhabitants or more)

4. Are you working in/as...?

(Multiple answers are possible.)

- ☐ a single practice
- ☐ a group practice
- ☐ a group practice/job sharing practice
- ☐ a medical care center
- ☐ honorary doctor, affiliated doctor
- ☐ the pain ambulance of a hospital
- ☐ other authorized hospital physician (except pain ambulance)
- ☐ in hospital (partial/full inpatient, day clinic)

5. Which (specialist) postgraduate medical education have you completed and/or which are you currently pursuing?

(Multiple answers are possible)

- ☐ Internal medicine
 - ☐ General medicine (incl. general practitioner)
 - ☐ Orthopedics/orthopedics and Trauma Surgery
 - ☐ Neurology
 - ☐ Anaesthesiology
 - ☐ Physical and rehabilitative medicine
 - ☐ Psychosomatic medicine and psychotherapy
 - ☐ Neurosurgery
 - ☐ Other: _____
-

6. Have you completed the additional education "Special Pain Therapy" or are you currently pursuing this education?

- ☐ No
 - ☐ Yes
-

7. Have you completed any other additional education related to pain management?

(Multiple answers are possible)

- ☐ No
- ☐ Yes, the following:
 - ☐ Acupuncture
 - ☐ Geriatric care
 - ☐ Manual medicine/chirotherapy
 - ☐ Palliative care
 - ☐ Physical therapy
 - ☐ Psychoanalysis
 - ☐ Psychotherapy
 - ☐ Primary care in addiction medicine
 - ☐ Other: _____

8. Do you have an authorization from your KV to conduct and submit claims for pain therapy for patients with chronic pain according to the Quality Assurance Agreement on Pain Therapy as defined in §135 Abs. 2 SGB V?

- ☐ No (please continue with question 11)
 - ☐ Yes (please continue with question 9)
-

9. Have you submitted a request to the KV in order to ensure the care of patients with chronic pain, so that you can provide and invoice for more treatments than permitted by the case number restriction (according to EBM)?

- ☐ No, I do not exceed the approved limit set by my KV.
 - ☐ No, I exceed the limit, but this has no consequence with my KV.
 - ☐ No, I exceed the limit and this has consequences with my KV (e.g. lack of reimbursement for excess quantities).
 - ☐ Yes, the request was approved.
 - ☐ Yes, but the request was denied.
 - ☐ Yes, the request is still running.
-

10. If you provide pain therapy, how much of your average working time is dedicated to pain therapy?

- ☐ > 75 % (solely working in the field of pain therapy)
- ☐ 50-75 % (predominantly working in the field of pain therapy)
- ☐ < 50% (partly working in the field of pain therapy)

Preference towards opioids and their use for long-term treatment of chronic non-cancer pain

11. How do you rate the current situation of care for patients with chronic non-cancer pain in Germany who are treated with opioid analgesics?

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Worst possible care					Best possible care					

12. In your opinion, does opioid therapy occur:

a) when indicated

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Too rare				Just right			Too often			

b) in a dose that is

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Too low				Just right			Too high			

c) during the treatment

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Too early				At the right time			Too late			

d) from the duration of treatment

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Too short				Just right			Too long			

13. In your opinion, could the implementation of disease management programs (DMPs) lead to a more appropriate treatment with opioids?

0 1 2 3 4 5 6 7 8 9 10
☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

No, not at all

Yes, absolutely

14. How do you feel about the long-term treatment of patients with chronic non-cancer pain with opioids?

→ Please make a cross in each line.

	I agree...				
	comple- tely	rather	partly	rather not	not at all
The use of opioids in the long-term treatment of chronic non-cancer pain should be avoided.	☐	☐	☐	☐	☐
The use of opioids in the long-term treatment of chronic non-cancer pain should only be done at the explicit request of the patient.	☐	☐	☐	☐	☐
Opioids should be used only as last-line treatment options in the long-term management of chronic non-cancer pain.	☐	☐	☐	☐	☐
I consider the risk of opioid dependence to be a major barrier to opioid use.	☐	☐	☐	☐	☐
Opioids should only be administered by physicians trained to do so.	☐	☐	☐	☐	☐
Possible cost-effectiveness assessments inhibit the provision of opioids.	☐	☐	☐	☐	☐
Treatment of patients with opioids is more time-consuming than with other pain therapies.	☐	☐	☐	☐	☐
Opioids can significantly improve quality of life for selected conditions and patients.	☐	☐	☐	☐	☐

15. Does your preference differ between strong and weak opioids? If so, what is the difference?

- ☐ No
- ☐ I don't know

Yes:

- ☐ I prefer weak opioids to strong opioids.
- ☐ I prefer strong opioids to weak opioids.

16. Do you use opioids for long-term pain therapy in principle?

- ☐ No → please continue with question 17
- ☐ Only weak opioids → please continue with question 18
- ☐ Strong opioids (and weak opioids) → please continue with question 19

17. If no, why?

(Multiple answers are possible)

- ☐ For the conditions I treat, a sufficient therapeutic success can already be achieved without the use of opioid analgesics.
- ☐ I do not want to prescribe medications to my patients that potentially result in opioid dependence.
- ☐ The adverse effects of opioids are too strong in my opinion.
- ☐ I am not trained in prescribing opioids and prefer to refer to a pain doctor or qualified physician.
- ☐ The treatment of patients with opioids is too complex due to the need for frequent, time-consuming care.
- ☐ Prescribing opioids is too expensive with regard to cost-effectiveness assessment.

→ Please continue with question 20

18. If only weak opioids, why?

(Multiple answers are possible)

- ☐ Weak opioids have fewer adverse effects. In my opinion, strong opioids have too many adverse effects.
- ☐ Weak opioids have a lower opioid dependence potential.
- ☐ Weak opioids can be prescribed on a "normal" prescription. The acquisition of and handling with a narcotic prescription form (BTM) is in my opinion too time-consuming.
- ☐ Weak opioids are less expensive and less of a burden on the budget.
- ☐ Weak opioids are sufficient for the medical conditions I care for.
- ☐ Due to the higher risks of strong opioids, I recommend a pain specialist or qualified doctor for it.

→ Please continue now with question 19

19. If you use opioids for long-term therapy, over what period of time, on average, do the patients you manage take opioid analgesics?

- ☐ Between three and six months
- ☐ Between six months and one year
- ☐ Between one year and two years
- ☐ Between two and five years
- ☐ More than five years

20. Does the fulfillment of the drug quotas / drug guideline values of your KV influence your prescribing behavior of opioids?

	0	1	2	3	4	5	6	7	8	9	10	
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
No, this does not affect my prescribing behavior at all					partly							Yes, I strongly base my prescribing be- havior on the quotas / guideline values

Guideline-based care

21. Are you familiar with the guideline on the long-term use of opioids for chronic non-cancer pain (LONTS)?

- ☐ No
- ☐ Yes, but I do not know the contents.
- ☐ Yes, and I am aware of the principles covered in the guideline.
- ☐ Yes, and I am familiar with parts of the guideline recommendations.
- ☐ Yes, and I am mostly to fully aware of the recommendations of the guideline.

22. What is your position on the guideline on the long-term use of opioids for chronic non-tumor related pain (LONTS)?

- ☐ The guideline is very helpful.
- ☐ The guideline serves well as an orientation.
- ☐ The guideline does not provide any significant benefit.
- ☐ The guideline restricts me too much in my actions.

23. What is your position on adherence to the guideline on long-term use of opioids for chronic non-cancer pain (LONTS)?

- ☐ The guideline should always be followed.
- ☐ Deviations from the guideline should only be made in justified exceptional cases.
- ☐ Deviations from the guideline may be made on a regular basis if justified.
- ☐ The guideline should not play a fundamental role in treatment.

24. Which of the following conditions do you treat with opioids on a long-term basis? If the condition is not relevant to your area of specialization, please tick "No answer".

➔ Please make one cross in each line.

	Yes	No	In exceptional cases	No answer
Inflammatory bowel disease	☐	☐	☐	☐
Chronic pancreatitis	☐	☐	☐	☐
Chronic arthritis pain	☐	☐	☐	☐
Chronic back pain	☐	☐	☐	☐
Diabetic polyneuropathy	☐	☐	☐	☐

The question will be continued at the next page!

	Yes	No	In exceptional cases	No answer
Parkinson syndrome	☐	☐	☐	☐
Phantom Pain	☐	☐	☐	☐
Polyneuropathy of etiology other than diabetes	☐	☐	☐	☐
Postzosterneuralgia	☐	☐	☐	☐
Primary headaches (e.g. migraine, tension and cluster headaches)	☐	☐	☐	☐
Restless Legs Syndrom	☐	☐	☐	☐
Rheumatoid arthritis with persistent pain	☐	☐	☐	☐
Pain after spinal cord injury	☐	☐	☐	☐
Painful radiculopathy	☐	☐	☐	☐
Tumor pain	☐	☐	☐	☐

Information on the LONTS recommendations relevant here.

- **Multimodal treatment** should be provided before and during opioid therapy. In this context, opioid therapy should be supplemented with physiotherapy, psychotherapy, occupational therapy and/or self-help services.
- Multimodal pain therapy treatment requires **interdisciplinary diagnosis by at least two specialist disciplines**. One of these disciplines must be a psychiatric or psychological-psychotherapeutic discipline.
- Prior to the initiation of opioid therapy, a psychosocial **anamnesis** should be taken in addition to a general, addiction- and pain-related anamnesis and, if a mental disorder is suspected, a psychological consultation with a psychiatry and psychotherapy specialist or a medical/psychological psychotherapist should take place.
- Individual and realistic **therapy goals** should be worked out with the patient.
- The **patient** should be **informed** about traffic and workplace aspects and the risks of the therapy.
- **Medications** with a long duration of action or with retarded galenics should be preferred. The use of (ultra-)short-acting preparations, even for on-demand medication, is not recommended.
- **A therapy response** or optimal dose is achieved when the defined therapy goals are reached with simultaneous low or tolerable side effects. Without therapy response, opioid therapy should be gradually discontinued.
- **Regular therapy monitoring and documentation** to check therapy goals and indications for side effects or misuse.
- After six months, a drug pause or dose reduction should be discussed with therapy responders to re-evaluate the indication.

25. Do you see capacity problems for physicians qualified in pain therapy in the current care situation? In your opinion, to what extent are these problems present?

➔ *If you are unable to make an estimation, please skip this question.*

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

No capacity problems

Partly capacity problems

Widespread capacity problems

26. In your experience, how long does it take for the patient to start therapy after a consultation with a pain specialist?

- ☐ Less than a month
- ☐ Between 1 and less than 3 months
- ☐ Between 3 and less than 7 months
- ☐ Between 7 and less than 12 months
- ☐ 12 months or more

27. In principle, do you consider the multimodal treatment recommended in the guideline for outpatient standard care to be ...

➔ Please make one cross in each line.

	I agree...				
	com- pletely	rather	partly	rather not	not at all
... necessary?	☐	☐	☐	☐	☐
... mostly implemented in practice in the stand- ard outpatient care setting?	☐	☐	☐	☐	☐
... completely implementable in practice?	☐	☐	☐	☐	☐

28. For the referral of my pain patients I have a network of:

(Multiple answers are possible)

- ☐ Psychotherapists / Psychiatrists
- ☐ Physiotherapists
- ☐ Pain physicians
- ☐ Facilities for the implementation of (partially) inpatient multimodal pain therapy
- ☐ Facilities for the treatment of dependency diseases (addiction)
- ☐ Exercise therapists
- ☐ Occupational therapists
- ☐ Pain managers or pain nurses
- ☐ Other relevant physicians and facilities
- ☐ No network

29. Communication with other health care providers: Please tick with which health care providers you have patient-related communication about opioid therapy.

➔ Please make a cross in each line, except for your own profession

	no	rarely	some- times	often	always
With the attending general practitioner	☐	☐	☐	☐	☐
With the treating pain physician	☐	☐	☐	☐	☐
With the treating orthopedist / orthopedic pediatrician and trauma surgeon	☐	☐	☐	☐	☐
With the treating neurologist	☐	☐	☐	☐	☐
With the treating psychotherapist / psychiatrist	☐	☐	☐	☐	☐
With the treating physiotherapist	☐	☐	☐	☐	☐
With an attending specialist from another discipline	☐	☐	☐	☐	☐

30. Which therapy goals do you regularly work out with your patients in the context of pain therapy treatment?

(Multiple answers are possible)

- ☐ None
- ☐ Avoidance of a worsening of the status quo
- ☐ Improved quality of life
- ☐ Higher degree of pain relief / lower pain intensity
- ☐ Healing / reduction of the risk of relapse
- ☐ High safety with few adverse effects
- ☐ Best possible prevention of opioid addiction
- ☐ Return to work
- ☐ "Being able to take care of yourself"
- ☐ Improved quality of sleep
- ☐ Ensuring social participation / social reintegration
- ☐ Other: _____

31. Do you use standardized and evaluated questionnaires (e.g. German Pain Questionnaire) as part of the anamnesis and during the course of treatment?

- ☐ No
- ☐ Yes, always
- ☐ Yes, sometimes / for selected patients

32. According to the LONTS guideline, regular patient contact is recommended. How would you define the optimal time between face-to-face patient contacts following the adjustment phase in the context of opioid therapy?

- ☐ More often than once a month
- ☐ Once a month
- ☐ Once a quarter
- ☐ Semiannual
- ☐ Rarely

33. Psychotherapy:

→ Please make a cross in each line.

	I agree...				
	com- pletely	rather	partly	rather not	not at all
I consider it useful to obtain an initial psychotherapeutic assessment by a trained psychotherapist/psychiatrist.	☐	☐	☐	☐	☐
The qualification "Special Pain Psychotherapy" enables psychotherapists/psychiatrists to respond to the needs of pain patients in a more differentiated way.	☐	☐	☐	☐	☐
Obtaining an initial psychotherapeutic/psychiatric assessment is met with incomprehension and rejection by the patients.	☐	☐	☐	☐	☐
I consider obtaining an initial psychotherapeutic/psychiatric assessment to be achievable within a reasonable time.	☐	☐	☐	☐	☐

The question continues on the next page!

	I agree...				
	com- pletely	rather	partly	rather not	not at all
The time to obtain an initial assessment has shortened since the psychotherapy consultation was introduced.	☐	☐	☐	☐	☐
If an underlying mental illness is identified during the initial assessment, guideline therapy or other appropriate interventions can/could be started sufficiently quickly.	☐	☐	☐	☐	☐
I am sufficiently trained to independently perform the initial psychotherapeutic assessment to rule out a contraindication.	☐	☐	☐	☐	☐

Physical therapy

34. Do you think the prescribing of physical therapy is appropriate in the majority of the conditions you treat?

- ☐ Yes
- ☐ No
- ☐ No indication

35. In your opinion, can you adequately prescribe physical therapy as part of the care of opioid patients?

(Multiple answers are possible.)

- ☐ Yes
- ☐ No, because the therapeutic products guideline has a limiting effect / cost-effectiveness assessment
- ☐ No, because there are not enough physiotherapists in my region in general.
- ☐ No, because there are not enough physiotherapists in my region specialized in the special needs of pain patients.
- ☐ No, because: _____

Risk and identification of intentional misuse, abuse, dependence

Definition of terms

- ➔ According to the guidelines, the diagnoses of abuse and dependence should not be made if the patients are receiving the opioids for medical reasons, if no further characteristics of abuse and dependence can be determined in addition to the development of tolerance and withdrawal symptoms, and if this has been confirmed in the context of a benefit-harm assessment of effects and adverse effects carried out with the treating physician.
- ➔ In the context of the following questions, only intentional misuse and not unintentional misuse will be considered.

36. Which of the following factors do you think increase the risk for abuse, intentional misuse, and dependence?

➔ Please make a cross in each line.

	I agree...				
	com- pletely	rather	partly	rather not	not at all
Rapid dose increases	☐	☐	☐	☐	☐
Non-retarding (Demand) Medication	☐	☐	☐	☐	☐
Irregular patient contacts	☐	☐	☐	☐	☐
No reaction to missing therapy response	☐	☐	☐	☐	☐
No relationship of trust between doctor and patient	☐	☐	☐	☐	☐
Different practitioners, the "doctor shopping"	☐	☐	☐	☐	☐
Lack of adequate anamnesis at the start of therapy	☐	☐	☐	☐	☐
Lack of information at the start of therapy	☐	☐	☐	☐	☐
Lack of ability of the patient to take the medication correctly	☐	☐	☐	☐	☐
Lack of reflection of opioid dose after operations	☐	☐	☐	☐	☐

The question continues on the next page!

	I agree...				
	com- pletely	rather	partly	rather not	not at all
Opioid therapy started in hospital	☐	☐	☐	☐	☐
Treatment by healthcare providers not trained and qualified in pain management	☐	☐	☐	☐	☐
Non-application of the guideline	☐	☐	☐	☐	☐
The general capacity shortage of pain physicians and qualified physicians	☐	☐	☐	☐	☐
Existing comorbidities (e.g. sleep disorders) or circumstances (e.g. social isolation) on which opioids have a positive effect	☐	☐	☐	☐	☐

37. How would you rate the risk for abuse, intentional misuse, or dependence for the following patient populations?

→ Please make a cross in each line.

	low	rather low	mode- rate	rather high	high
Patients with mental comorbidities	☐	☐	☐	☐	☐
Patients with existing addictive disorders	☐	☐	☐	☐	☐
Patients with comorbidities that would not allow the prescription of other medications such as NSAIDs	☐	☐	☐	☐	☐
Patients with high opioid doses who were already medicated before the guideline was published	☐	☐	☐	☐	☐
Elderly patients (over 70 years)	☐	☐	☐	☐	☐
Younger patients (under 30 years)	☐	☐	☐	☐	☐
Patients with migration background	☐	☐	☐	☐	☐
Socially disadvantaged patients	☐	☐	☐	☐	☐
Patients incapable of work	☐	☐	☐	☐	☐

Other: _____

38. Where do you see problems in identifying abuse, intentional misuse, and dependence?

	I agree...				
	com- ple- tely	rather	partly	rather not	not at all
Patients for whom one has carried out the primary treatment oneself	☐	☐	☐	☐	☐
Treatment by multiple service providers	☐	☐	☐	☐	☐
Intentional concealment of patients to prevent/delay identification	☐	☐	☐	☐	☐
Lack of communication between service providers	☐	☐	☐	☐	☐
Lack of communication between care providers and pharmacies	☐	☐	☐	☐	☐
Lack of feedback from the KV in the event of anomalies	☐	☐	☐	☐	☐
Lack of feedback from the Federal Opium Agency in the event of anomalies	☐	☐	☐	☐	☐
Lack of feedback from the Federal Opium Agency in the event of irregularities	☐	☐	☐	☐	☐
Currently too limited capacity (too little time to provide patients with sufficient time at appropriate regular intervals).	☐	☐	☐	☐	☐

39. In your opinion, where are current/prospective opportunities to identify abuse, intentional misuse, and dependence?

	I agree...				
	com- pletely	rather	partly	rather not	not at all
Regular patient contacts with a sufficient time frame	☐	☐	☐	☐	☐
Monitoring of the prescription frequencies at each prescription	☐	☐	☐	☐	☐

The question continues on the next page!

	com- plety	rather	partly	rather not	not at all
Information from answered (pain) questionnaires	☐	☐	☐	☐	☐
Electronic patient file (reliable access to relevant comorbidities)	☐	☐	☐	☐	☐
Electronic health card (esp. medication plan)	☐	☐	☐	☐	☐
More intensive communication between the service providers involved	☐	☐	☐	☐	☐
More regular feedback from the monitoring institutions	☐	☐	☐	☐	☐
At the interface between outpatient and inpatient care	☐	☐	☐	☐	☐

Closing questions

40. What factors do you think can contribute to improved opioid care for patients with chronic non cancer pain who are treated long-term with opioids?

	I agree...				
	com- ple- tey	rather	partly	rather not	not at all
Reduction of existing capacity problems	☐	☐	☐	☐	☐
More qualified use of opioids, through...					
... a stronger integration of opioid therapy in medical studies	☐	☐	☐	☐	☐
... the implementation of a "specialist for pain medicine"	☐	☐	☐	☐	☐
... the promotion of the additional training "special pain therapy".	☐	☐	☐	☐	☐
Reduction of cost-effectiveness assessment of drugs, especially opioids	☐	☐	☐	☐	☐
More regular feedback from the supervising institutions (e.g. KV, Health Insurance Fund, Federal Opium Agency)	☐	☐	☐	☐	☐

41. In your opinion, which factors are relevant for the long-term assurance and improvement of pain therapy care?

	very rele- vant	rather relevant	partly	rather not rele- vant	not at all relevant
Promoting the attractiveness of practicing in pain therapy	☐	☐	☐	☐	☐
Establishment of supply networks in health care	☐	☐	☐	☐	☐
Greater focus on outpatient multi-modal care	☐	☐	☐	☐	☐
Greater focus on (partially) inpatient multimodal pain therapy	☐	☐	☐	☐	☐
Implementation of outpatient multi-modal pain care into the EBM architecture	☐	☐	☐	☐	☐
Implementation of "Special outpatient pain medicine care in a team" (SASV) into standard care	☐	☐	☐	☐	☐
Promotion of the next generation of pain therapists	☐	☐	☐	☐	☐
Promotion of the new generation of pain therapists or strengthening of the service providers involved in pain therapy (e.g. psychiatrist / psychotherapist)	☐	☐	☐	☐	☐
Higher reimbursement for pain therapy services	☐	☐	☐	☐	☐
Reduction of cost-effectiveness assessment (drugs / remedies)	☐	☐	☐	☐	☐
Implementation of pain therapy demand planning	☐	☐	☐	☐	☐

Thank you very much for your participation in this survey!