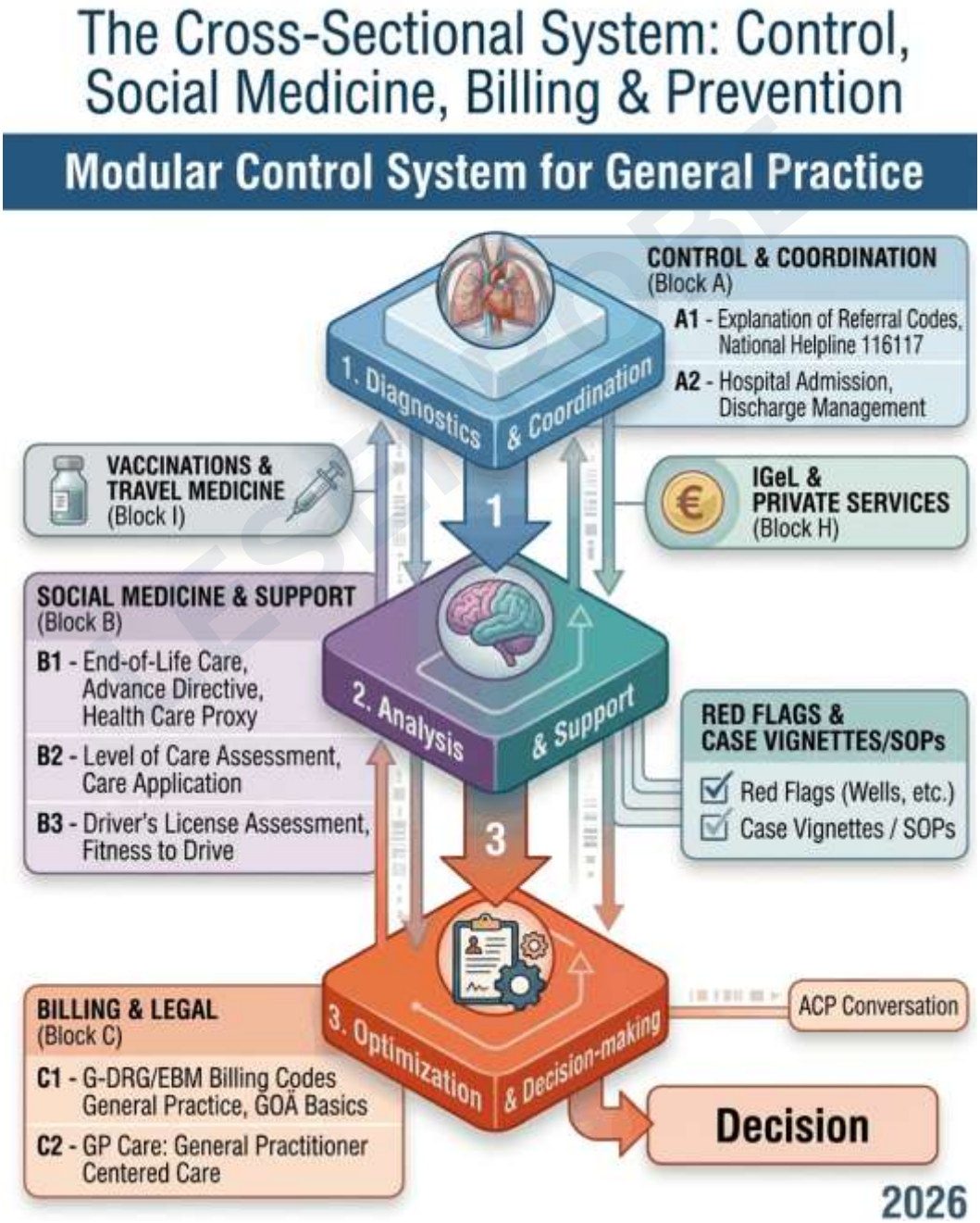
ClinicalOS – Structured decision-making in general practice

Volume 9: GP-specific Cross-Cutting Topics



Social Medicine · Care Coordination · Billing · Organisation · Prevention
Vaccination · Digitalisation · IGEL & Private Services · Psychosomatics

About this sample

Volume 9 · GP-specific Cross-Cutting Topics

This curated sample has 38 pages from a 250-page volume (15% target; minimum 12 pages, including the notice and end page). The chapters listed below are included in full. Original page numbers are retained; gaps are intentional. This overview and the PDF bookmarks cover the included sections. Cross-references may refer to the full volume.

- **J2 – Lifestyle counselling in GP practice**
- **C6 – Chronic complex pain and multimodal pain management (MMST)**

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Note on Translation, Content, Use and Liability

This English edition is a translation of the original work written in German. The concept, structure, and core medical content of ClinicalOS were originally developed for German general practice and the German healthcare system, to provide practising GPs, trainee GPs, healthcare assistants (HCAs) and medical students with a structured, practice-oriented learning and reference resource. The content is based on current medical literature, guideline-based sources and practical experience in general practice.

During the linguistic adaptation, references to guidelines, clinical practices and regulatory frameworks in other English-speaking settings were taken into account and highlighted where relevant and feasible; in some areas, differences from German recommendations are also presented explicitly. However, the translation does not constitute a systematic adaptation of every medical, therapeutic or regulatory aspect to all English-speaking countries. Professional guidelines, marketing authorisations, approved dosages, prescribing procedures, reimbursement rules and regulatory requirements may vary between countries;

the guidelines, official prescribing information and regulatory provisions currently applicable in the respective country or healthcare system always take precedence. Dosage information applies to adults without significant renal impairment; individual adjustments are required for elderly patients, those with polypharmacy and during pregnancy. **Current national/regional guidelines (e.g. NICE, ESC, ADA) must be followed as a priority.**

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The contents of this manual do not replace an individual medical assessment and should not be construed as binding treatment recommendations. Diagnostic and therapeutic decisions must always be made on a case-by-case basis for each individual patient, taking into account the full clinical picture and the currently valid guidelines. **Doctors bear full and ultimate medical responsibility:** any use of content from this manual — whether as a text module, SOP or treatment recommendation — requires independent professional review by the treating doctor. **AI-supported or digitally generated content cannot and must not replace medical judgement.**

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Introduction: What is Manual 9 – and why does it exist?

General practice is not a specialism that is limited to organ systems or specific medical conditions. GPs are generalists who make decisions on a daily basis that go far beyond purely clinical issues: Who is eligible for a care level? How do you safely refer a patient experiencing a psychiatric crisis to the appropriate care? What is actually relevant in the EBM billing system – and what does it cost the practice if you are unaware of it? How do you explain to a 72-year-old patient that the urgency code on her referral speeds up access to a specialist? Which screening tests are evidence-based – and which are IGEL services offering no added value?

Manual 9 answers precisely these questions. It is the manual covering Cross-Cutting Topics in GP practice: those areas that are not given sufficient space in the clinical manuals of the series (Manuals 2–4), but which are relevant in day-to-day practice. It is not a textbook on general practice, but rather an operationalised framework for the topics that lie at the intersection of clinical practice, organisation, communication, documentation and law.

Key point ✔

Manual 9 is the manual for Cross-Cutting Topics. It does not answer 'What is the diagnosis?' or 'Which treatment is in line with guidelines?', but rather: 'How do I manage patients correctly? How do I document in a legally compliant manner? How is a modern GP practice organised – and how do I bill for these services?'

Concept and distinction from the Manual series

The ClinicalOS series is systematically organised according to levels of care. Manual 9 is deliberately structured differently from the clinical-diagnostic and therapeutic volumes. It does not follow the logic of an organ system, but rather the logic of real-world practice.

Manual	Main focus	Relationship to Manual 9
Manual 1	Decision-Making Architecture and clinical reasoning	The basis for all GP decisions – Manual 9 applies this logic to process and organisational issues.
Manual 2	Rational Diagnosis – test decisions and diagnostic stewardship	Clinical diagnostics; Manual 9 supplements this with care management.
Manual 3	Communication and conducting consultations	Manual 9 integrates topic-specific communication modules (e.g. ACP discussions, explaining referral codes).
Manual 4	Patient Management, treatment algorithms, dosages	Clinical therapy. In-depth clinical special topics (UTI, osteoporosis, irritable bowel syndrome) are planned as an annex to Manual 4.
Manual 7	Practice organisation, team processes, SOPs	Overlap in organisational topics; Manual 9 complements the strategic and social medicine aspects.
Manual 9	GP-specific Cross-Cutting Topics (this manual)	Care management, social medicine, billing, prevention, digitalisation, IGEL, vaccination.

In-depth clinical topics such as the management of urinary tract infections, the diagnosis and treatment of osteoporosis, abdominal symptoms and irritable bowel syndrome are not included in Manual 9, but are presented as expanding supplementary material (Annex) to Manual 4. This allows Manual 9 to remain concise and consistently focused on its core function – Cross-Cutting Topics relating to practice organisation and social medicine. Should the volume of Manual 9 increase significantly in the future, a separate Volume 11 is planned for expanded Cross-Cutting Topics.

Chapter overview and topic allocation

Manual 9 is divided into thematic blocks. The chapters currently included are marked with a chapter code. Planned chapters will be added in due course.

Block	Topic
A – Care Management & Coordination	GP referral case, 116117, urgency code, TSS
A – Care Management & Coordination	Hospital admission, discharge management, referral to rehabilitation
B – Social Medicine & Support	End-of-life care, living wills, enduring powers of attorney, palliative care, assisted suicide
B – Social Medicine & Support	Care needs assessment, application for care levels, coordination
B – Social Medicine & Support	Driving licence assessments, driving fitness in the case of medical conditions
B – Social Medicine & Support	Occupational and Environmental Medicine: occupational disease notification, fit note (Statement of Fitness for Work), exposure
C – Billing & Legal Matters	EBM billing codes for GP practices, GOÄ principles, checklists
C – Billing & Legal Matters	HZV: GP-centred care, contract logic, distinction from EBM
H – IGEL & Private Services	IGEL: Essential vs. Non-essential, GOÄ, GLP-1 analogues, IGeL information requirements

Style, Structure and Usage Notes

Manual 9 follows the standard ClinicalOS chapter format. All chapters are structured according to the same modular logic that runs throughout the entire manual series.

Module	Function	Identifying Features
Key point ✔	Condensed key message or safety principle	Green box with blue header
Practice Pearl ★	A specific, simple rule with great practical value	Blue box
Red flag ⚠	Dangerous errors, critical escalation situations	Red Box
Practical errors!	Common, avoidable errors in day-to-day practice	Orange box
SOP	Numbered, ready-to-implement procedure description	Blue-light blue box
HCA module	Specific team section for practice organisation and delegation	Blue-light blue box
Case study	Typical GP-related case with a solution	Purple box
Quick comparison / table	An overview of terms, approaches and options at a glance	Blue-grey table

Use in everyday practice

- Each chapter can be used independently – no need to read through linearly.
- SOPs and checklists are designed to be used directly during a consultation or over the phone.
- MFA modules are standalone functional blocks – they can be extracted from the chapter and used as team resources.
- Patient information modules at the end of each chapter can be used directly as leaflets or waiting room notices.
- Text modules for referrals and doctors' letters can be inserted into all standard practice management systems.
- AI prompt modules (in selected chapters) can be stored in the practice wiki or AI assistant.

Target audiences and differentiation

Target audience	Particularly relevant modules	Typical entry points in Manual 9
GP's	All chapters; in particular, decision-making logic, SOPs, red flags and Practice Pearls	Billing (C1), Care Coordination (A1), End-of-life care (B1)
Residents	Quick comparisons, learning objectives, case vignettes, classification systems	A1 (116117 system), B1 (ACP basics), C1 (EBM logic)
Healthcare assistant (HCA) / Practice team	Healthcare assistant (HCA) modules, checklists, telephone screenings, recall protocols, patient information leaflets	A1 HCA checklist, B1 HCA tasks, C1 coding SOPs

Evidence base and principle of timeliness

Manual 9 follows the evidence hierarchy standardised across the entire ClinicalOS series. For socio-medical and organisational topics, guidelines and directives are often less readily available than in clinical medicine – in such cases, the experiential and consensus-based knowledge of qualified primary care experts is used to supplement this, but is always clearly identified as such.

Type of evidence	Use in Manual 9	Marking in the text
Laws, regulations, guidelines (SGB, BGB, EBM, GOÄ, G-BA)	Binding basis; highest priority	Formulated as a binding framework
Guidelines (DEGAM, AWMF, KBV, BÄK, G-BA)	Medical and scientific basis	Including reference to guidelines and level of recommendation
KV/KBV information materials, official sources	Billing logic, healthcare provision structures	With references
Practical recommendations / expert consensus	Where guidelines are lacking or impractical	Marked as a practical recommendation
Empirical knowledge / Care reports	Illustration of the reality of care and practical problems	Explicitly marked as empirical or contextual material

Manual 9 is a living document. All chapters are revised in the event of relevant legislative changes, guideline updates or structural changes to the healthcare system. The version number is indicated in the footer of each chapter.

J2 – Lifestyle counselling in GP practice

Prevention: balancing ideals, time constraints and realistic implementation

Learning objectives

After completing this chapter, you will be able to:

- Understand and organise lifestyle counselling as a repeatable, delegable practice process rather than a one-off action.
- Identify the most common reasons for the failure of lifestyle counselling in everyday GP practice and address them specifically.
- apply the 5-A model, short forms of motivational interviewing, SMART goals and risk visualisation (SCORE2/arriba) within the time constraints of a routine consultation.
- Use at least four counselling formats – 30-second prompt, 3-minute micro-counselling, 10-minute risk counselling, separate prevention appointment – appropriately for the situation.
- Address typical problem cases (ambivalence, shame, a desire for medication rather than lifestyle changes, language barriers, a feeling of being patronised) in a way that is realistic from a GP's perspective rather than a moralising one.
- Structure consultations using healthcare assistant (HCA) preparation, recall logic, patient materials and PMS text modules in such a way that they remain documentable and repeatable even under time pressure.

Opening scene

SCENE

Friday afternoon, 4.40 pm, the last patient before the weekend. Mr K., aged 58, has come in for a prescription for his blood pressure medication. Glancing at his latest lab results, the female GP notices: LDL 168 mg/dl, HbA1c 6.2 per cent, BMI 31, a smoker for 35 years. A textbook case for 'lifestyle advice now'. The doctor takes a deep breath – and realises at that very moment that there are still four patients waiting, that the prescription was actually the sole reason for the appointment, and that Mr K. has recently responded to every suggestion to 'change his diet' with a polite but firm 'I know, Doctor, I know'.

She could now invest five minutes that weren't planned – and which, as experience shows, achieve little if they end up as a lecture. Or she could write the prescription and postpone the topic until 'next time', as has already happened in the last three consultations.

This chapter deals with the third option: a brief, targeted prompt that fits within the time available, creates a point of connection for next time – and is not intended to ease the doctor's guilty conscience, but to actually set something in motion for Mr K.

Basic principle

Lifestyle counselling is not about imparting knowledge. Most patients know that smoking is harmful, being overweight is unhealthy and exercise helps. The problem almost never lies in a lack of knowledge, but rather in ambivalence, habit, social and psychological stress, and a lack of structure for putting advice into practice. A consultation that provides additional knowledge where ambivalence already exists generates resistance rather than change.

This implies a shift in the GP's role: not to persuade, but to explore a willingness to change, agree on small next steps, and revisit these repeatedly over time – the GP's key resource. A single, perfect consultation is less effective than a brief, repeated nudge across several consultations.

Key point / Remember box

Lifestyle counselling is not a one-off consultation, but a documented process within the practice that is repeated over time. The strength of the GP lies not in the duration of the consultation, but in the continuity of care.

Practice Pearl

In most situations, the question 'What would be a first small step for you?' replaces any lengthy explanation – and can be asked in 20 seconds.

1. Why lifestyle counselling is important for GP's

Prevention and lifestyle counselling are rightly regarded as core tasks of general practice: In cases of cardiovascular risk, hypertension, dyslipidaemia, diabetes/metabolic syndrome, obesity, smoking, sleep disorders, stress, physical inactivity, functional complaints, chronic pain and psychological distress, lifestyle intervention is, in accordance with guidelines, the first line of treatment or at least of equal importance to, or alongside, pharmacotherapy [1,3].

The crucial difference lies between one-off advice ("You should lose weight") and a supported process of change (agreeing on goals, follow-up contact, adjustment). Simple advice without structure has been shown to rarely change behaviour; structured brief interventions with goal-setting and follow-up, on the other hand, demonstrate replicable, albeit moderate, effects – for example, motivational interviewing on BMI, cholesterol, systolic blood pressure and alcohol consumption [2].

Indications	Significance of lifestyle intervention
Cardiovascular risk / hypertension / dyslipidaemia	Guideline-recommended basic measure prior to or alongside pharmacotherapy [1,3]
Diabetes / metabolic syndrome	Diet and exercise as the first pillar of treatment, even whilst on medication
Smoking	The 5-A model combined with pharmacotherapy significantly increases abstinence rates compared with counselling alone [4,9]
Sleep disorders	Sleep hygiene and elements of cognitive behavioural therapy as the first-line treatment, rather than hypnotics [5]
Stress, functional symptoms, chronic pain	Relaxation techniques and activation are often more effective than purely somatic escalation of diagnostic investigations

Lifestyle counselling is therefore not a 'soft' supplementary topic alongside 'proper' medicine, but rather the actual intervention in many consultations – just one that needs to be structured differently from a prescription.

2. Why lifestyle counselling often fails in everyday practice

The discrepancy between aspiration and practice does not stem from a single cause, but arises from the interplay of several well-documented factors:

Factor	Specific manifestation in practice
Lack of time	A consultation time of 7–10 minutes leaves little scope for a structured counselling session in addition to the actual reason for the visit.
Lack of structure	Without a structured framework for the discussion, the result is a vague appeal (“exercise more, eat less”) rather than a specific next step.
The doctor speaks, the patient remains passive	Simply imparting knowledge encourages listening, but does not foster a sense of personal commitment.
Moralising tone	“You really ought to...” creates defensiveness rather than cooperation, particularly where there is pre-existing shame.
Unrealistic goals	“30 minutes of exercise every day starting tomorrow” is rarely put into practice and ends in a sense of failure.
Lack of follow-up	Without a follow-up appointment, any agreement on goals will come to nothing.
No involvement of healthcare assistants	The consultation remains entirely tied to the doctor’s appointment time, even though preparation and follow-up could be delegated.
No written plan	Verbal agreements are remembered differently by both parties or are simply forgotten.
Social pressures	Shift work, care responsibilities and financial constraints limit the scope for action, regardless of motivation.
Mental health comorbidities	Depression, anxiety disorders or chronic stress significantly reduce one’s capacity for change.
Low health literacy	Abstract risk information (“Your cholesterol is too high”) has no practical implications for action.
Lack of documentation	Without an entry in the patient record system, the next consultation is a fresh start rather than a continuation of the previous one.
Lack of billing prospects	Time-consuming consultations without a clear remuneration structure are systematically sidelined in the organisation of medical practices.
Frustration among doctors	Repeated experiences of ‘non-response’ lead to resignation and avoidance of the issue.

AVOID PRACTICE MISTAKES

- Squeezing in lifestyle advice as a spontaneous ‘side issue’ at the end of a consultation that is already running over time.
- When ambivalence is apparent, continuing with explanations and appeals rather than addressing the ambivalence itself.
- Responding to failure by avoiding the topic rather than adjusting the approach (making it shorter, more specific, and revisiting it later).

RED FLAG – TAKE IMMEDIATE ACTION

When a moralising or persuasive counselling style has the opposite effect:

- The patient reacts to the topic being raised with defensiveness, a change of subject or irritability – further insistence usually only intensifies the resistance.
- Repeated unsuccessful attempts at dieting, issues of shame or a history of eating disorders: in such cases, an appeal-based approach to weight management can be iatrogenically harmful and should be postponed or managed with specialist support.
- Signs of depressive exhaustion or suicidal ideation: set aside lifestyle issues and prioritise mental health care.

3. A realistic approach

The key misconception is the idea that lifestyle counselling must be completed in a single, as comprehensive as possible, consultation. It is precisely this expectation that creates the time pressure which then causes the counselling to fail. A more realistic – and demonstrably more effective – approach is a phased model that spreads the counselling over several short sessions and delegates tasks in a targeted manner.

Format	Duration	Context of use	Content
30-second prompt	~30 sec.	Acute consultation (e.g. infection, prescription)	A sentence that keeps the topic open: “I’ve noticed that X. Shall we address this specifically at our next appointment?”
3-minute micro-consultation	2–3 mins	Routine consultation with a little extra time	5-A short form, one question about willingness to change, one SMART goal
10-minute risk consultation	8–12 mins	Check-up/health assessment	SCORE2/arriba visualisation, more detailed goal-setting, written plan
Separate prevention/chronic condition appointment	15–20 mins	Scheduled additional appointment, DMP contact	In-depth consultation, barrier analysis, integration of course programmes/DiGA
Consultation prepared by a healthcare assistant (HCA)	variable	Before seeing the doctor	The healthcare assistant (HCA) collects key details from the patient’s history-taking, issues materials, prepares risk score
Follow-up/progress check	5–10 mins	By telephone or at a follow-up appointment	Teach-back question, adjustment of goals, recognition of small progress

Written patient materials (mini-plan, QR code linking to patient information or apps) and digital support – exercise and nutrition apps, digital health applications (DiGA) where indicated, structured prevention courses under Section 20 of the German Social Code, Book V (SGB V) – complement each of these formats but do not replace the face-to-face consultation.

Key point / Remember box

Lifestyle counselling does not have to be completed in a single consultation. It must be organised as a repeatable practice process – with clearly defined, short formats rather than a single, overly extensive discussion.

Practice Pearl

A SMART goal set in 90 seconds is more effective than a perfect explanation lasting 10 minutes that nobody puts into practice.

4. Structured counselling methods

The following methods are not additional theory, but tools that flesh out each of the formats mentioned above. They can be used individually or in combination.

5-A Model: Ask, Advise, Assess, Assist, Arrange

Step	Content	Example phrasing
Ask	Actively raise the topic, assess the situation	"Do you still smoke? How many cigarettes a day?"
Advise	Brief, clear, personalised advice	"Given your risk profile, giving up smoking would be the most effective single step you could take."
Assess	Assess willingness to change	"On a scale of 0 to 10 – how important is this to you at the moment?"
Assist	Offer practical support	"There are effective medicines and a helpline – shall I write that down for you?"
Arrange	Arrange a follow-up	"Let's have a quick chat on the phone in four weeks' time to see how things are going."

Motivational Interviewing in a nutshell (OARS)

For the GP's 3-minute version, four basic techniques are sufficient, which explore ambivalence rather than trying to persuade the patient [2]:

- Open-ended questions: "What would change for you if you drank less alcohol?" rather than "Do you drink too much?"
- Affirmation: "The fact that you're still coming for your check-up despite everything shows me that you do care about this issue."
- Reflective listening: "You say exercise is important to you, but you lack the energy in the evenings – am I getting that right?"
- Summarising: a brief recap at the end that acknowledges the ambivalence rather than glossing over it.

SMART goals instead of general advice

Non-specific advice (avoid)	SMART goal (aim for)
“Get more exercise.”	“I’ll go for a 15-minute walk after dinner three days a week – starting on Monday.”
“Eat more healthily.”	“On weekdays, I’ll swap my breakfast pastries for porridge with fruit.”
“You should lose weight.”	“I’ll weigh myself once a week and log it in the app; target range: –0.5 kg per month.”

Risk visualisation, teach-back, written mini-plan

Abstract laboratory results are made tangible through visual risk tools: SCORE2 shows the 10-year risk of a cardiovascular event as a percentage, whilst arriba adds a traffic-light display and the concept of ‘risk age’ – both are suitable for conveying a concrete picture rather than an abstract figure in under two minutes.

Teach-back ensures that the message has actually been understood: “Can you tell me in your own words what we’ve just discussed?” – rather than the ineffective check question “Have you understood that?”, which is almost always answered with “Yes”.

A brief written plan (see patient handout below) sets out the agreed goal and makes it possible to review progress at the next appointment. The closing question “What was easy, and what was difficult?” opens every follow-up appointment more constructively than a blanket assessment of success, because it explicitly frames setbacks as information rather than failure.

Practice Pearl

‘What was easy, what was difficult?’ provides more information in two sentences for the next goal adjustment than ten minutes of general questioning.

5. Typical cases and problem cases

The following ten case vignettes cover the most common scenarios encountered in practice. They have deliberately been written not as ideal cases, but as realistic situations featuring typical missteps and an alternative strategy that can be implemented within the time available.

CASE STUDY Case 1 – Check-up patient with elevated SCORE2 risk, little awareness of their condition

Initial situation: Mr B., aged 54, at a check-up: non-smoker, but LDL 175 mg/dl, BP 148/92 mmHg, SCORE2 risk 9 per cent – "but I feel in great shape".

Typical misstep: A lengthy explanation of the pathophysiology of atherosclerosis, which the patient perceives as an abstract threat but which fails to prompt any action.

Better strategy: Visually demonstrate the SCORE2 score (traffic light system/arriba), state the 'risk age' rather than just a percentage, and agree on a SMART goal rather than a complete lifestyle overhaul.

Example wording: "Your cardiovascular system currently carries a risk equivalent to that of a man who is, on average, 9 years older. Even a single measure – such as cutting down on salt – can measurably reduce this. What would be feasible for you?"

PMS module: "SCORE2 9%, risk age +9 years discussed, SMART target of reducing salt intake agreed, BP check in 4 weeks."

Healthcare assistant's task: Hand over the BP self-monitoring log; schedule a follow-up appointment in 4 weeks.

Follow-up: At the follow-up appointment, discuss the BP log, ask a teach-back question, and, if necessary, add the next SMART target (exercise).

CASE STUDY Case 2 – Smoker at risk of COPD, "doesn't really want to give up"

Initial situation: Mr T., 61, 40-year smoking history, mild cough, borderline spirometry results. When asked about giving up smoking: "I've tried too many times already, it's no use."

Typical misstep: Appealing to reason or instilling fear ("You'll get COPD!") despite a clear lack of current willingness.

Better strategy: Apply the 5-A model; explore ambivalence rather than resistance (MI); keep the door open for a later time rather than shelving the issue.

Example phrasing: "On a scale of 0 to 10, how important is this issue to you right now? […] What helped most during your previous attempts, and what helped least?"

PMS module: "Smoking status: 40 pack-years; Ask/Advise/Assess carried out; currently low willingness to change (scale 3/10); revisit the topic in 3 months."

Healthcare assistant (HCA) task: Provide information material on smoking cessation counselling/telephone helpline; set a reminder for the next contact.

Follow-up: At the next contact, bring it up again in a non-intrusive manner: "Last time you were at 3 out of 10 – where are you today?"

CASE STUDY Case 3 – Female patient with obesity, feelings of shame and a history of repeated dieting

Initial situation: Ms S., aged 47, BMI 34, reports resignedly, when asked, that she has been on "ten diets, none of which worked".

Typical misstep: Repeating general dietary advice or referring to calorie balance, which reinforces the shame she has already experienced.

Better strategy: Decouple the issue from weight as a number; focus on a single, shame-free behavioural goal; actively ask about diet-related frustration and, where relevant, signs of an eating disorder before continuing with counselling.

Example phrasing: "I don't want to talk about a number on the scales, but rather: is there one thing that you've found easier or harder to do in recent weeks?"

PMS module: "Class I obesity, history of multiple unsuccessful attempts at dieting; agreed to focus on a behavioural goal rather than a weight goal."

Healthcare assistant (HCA) task: If necessary, provide information on local nutritional counselling or self-help groups; do not schedule weight checks unless the patient explicitly requests them.

Follow-up: Next contact: Follow up on the agreed behavioural goal, not primarily on weight.

CASE STUDY Case 4 – Diabetic with high HbA1c, prefers medication to a dietary consultation

Initial situation: Mr A., aged 58, HbA1c 8.9%, says straight away: "Just give me a stronger tablet; I don't have time for a diet."

Typical mistake: Either completely ignoring the patient's dietary request and simply increasing the medication, or insisting on a dietary consultation against the patient's explicit wishes.

Better strategy: Combine both approaches rather than pitting them against each other: adjust the medication and, during the same consultation, offer a single, very specific dietary SMART goal – as a supplement, not as a condition.

Example wording: "We'll adjust your medication now. In addition, without any major dietary changes: how about replacing your breakfast pastries with something higher in protein? That would help lower your levels even further."

PMS module: "HbA1c 8.9%, medication escalated, one nutritional SMART goal (breakfast) agreed, HbA1c check in 3 months."

Healthcare assistant (HCA) task: Hand over blood glucose diary/app recommendation; arrange an appointment for an HbA1c check in 3 months.

Follow-up: Combine the HbA1c check-up with a teach-back session on the dietary target; add a second target if necessary.

CASE STUDY Case 5 – Hypertension patient refuses medication, wants to try "natural methods first"

Initial situation: Ms M., aged 52, has repeatedly recorded a BP of 158/96 mmHg; she explicitly does not want to take tablets: "I want to get this under control naturally first."

A common pitfall: ignoring the patient's wishes and enforcing the prescription anyway, or, conversely, agreeing to it without comment, without setting a time limit or monitoring criteria.

Better strategy: Respect the patient's wishes, but frame this as a time-limited, verifiable trial: specific lifestyle measures, a fixed BP target, and a fixed date for re-evaluation.

Example wording: "Agreed, let's try reducing salt intake, exercising and self-monitoring for 8 weeks. If the reading isn't below X by then, we'll discuss medication again – is that a fair deal?"

PMS module: "BP 158/96 mmHg, patient requests lifestyle trial before pharmacotherapy, limited to 8 weeks, target BP and follow-up appointment agreed."

Healthcare assistant's task: Hand over the instructions for the home BP monitor and the log sheet; enter a follow-up appointment in 8 weeks' time.

Follow-up: If the target is achieved, continue the lifestyle programme and extend the interval; if not achieved, make a renewed, non-confrontational offer of pharmacotherapy based on the jointly agreed rule.

CASE STUDY Case 6 – Stressed working patient with sleep disturbance, "no time for exercise"

Initial situation: Ms L., 39, full-time worker with two children, has had difficulty falling asleep for months; in response to the exercise recommendation: "When am I supposed to do that? I don't have a minute to spare."

Typical misstep: Standard recommendation of '30 minutes' exercise, three times a week' despite obvious time constraints – highly unlikely to be followed and likely to generate additional feelings of guilt.

Better strategy: Prioritise sleep hygiene over an exercise programme; incorporate measures into existing routines rather than demanding extra time.

Example wording: "Let's start with sleep first; that won't take any extra time: a fixed wake-up time, and screens off 30 minutes before bedtime. We can add exercise later, once your sleep is more stable."

PMS module: "Insomnia due to work/family stress; sleep hygiene measures discussed (wake-up time, screen time); exercise topic postponed; follow-up in 4 weeks."

Healthcare assistant (HCA) task: Hand out the sleep hygiene patient information leaflet; provide a sleep diary if necessary.

Follow-up: After 4 weeks, enquire about sleep quality; only then address the topic of exercise in the smallest feasible dose (e.g. 10 minutes).

CASE STUDY Case 7 – Elderly patient at risk of falling and using sleeping pills

Initial situation: Mr W., aged 78, has been taking a benzodiazepine to help him fall asleep for years; he has recently suffered a fall and lives alone.

Typical misstep: Continuing to prescribe the sleeping pill without comment, because attempting to wean the patient off it seems time-consuming and likely to cause conflict; failing to link the risk of falling to the medication.

Better strategy: Explicitly link the risk of falling to the sleeping pill; use sleep hygiene as a bridge before or alongside gradual deprescribing; reduce the dose gradually in small steps rather than stopping abruptly.

Example wording: "The sleeping pill increases your risk of falling. Let's reduce the dose in small steps and, at the same time, stabilise your sleep through fixed routines – very slowly, not overnight."

PMS module: "History of a fall, long-term use of benzodiazepines, link discussed, gradual deprescribing initiated, sleep hygiene added."

HCA task: Provide a fall risk checklist (tripping hazards, home emergency call system, check of visual aids), and monitor the reduction plan according to the schedule.

Follow-up: Closely monitor the reduction steps, actively enquire about falls, and adjust the pace of reduction if necessary.

CASE STUDY Case 8 – Patient with back pain expects rest, but needs to be encouraged to be active

Initial situation: Mr D., aged 44, with acute non-specific back pain, asks for sick leave and bed rest "until it gets better".

Typical misstep: Uncritically fulfilling the expectation of rest (sick leave + recommendation for bed rest), even though this promotes chronicity.

Better strategy: Actively explain the benefits of movement rather than rest; recommend specific, low-impact activities rather than a sports programme; keep the sick note short if necessary.

Example wording: "The good news is that bed rest tends to delay recovery. Move around as normally as possible – even if you feel a twinge now and then, that's not dangerous."

PMS module: "Non-specific back pain, activity recommended instead of rest, red-flag symptoms ruled out, fit note (Statement of Fitness for Work) for a short period."

Healthcare assistant (HCA) task: Hand over the patient information leaflet 'Staying Active with Back Pain', arrange a follow-up appointment if symptoms worsen or persist.

Follow-up: If symptoms persist for more than two weeks, reassess; if necessary, recommend physiotherapy instead of further rest.

CASE STUDY Case 9 – Language barrier/low health literacy

Initial situation: Mrs O., aged 61, limited knowledge of German, accompanied by her daughter acting as an interpreter, newly diagnosed with diabetes.

Typical mistake: Handing out complex written dietary advice or communicating exclusively via the daughter, without checking whether the patient herself has understood the key message.

Better strategy: A few, very specific, visual messages rather than comprehensive information; use the 'teach-back' method directly with the patient, not just via the interpreter; use an interpreting service or multilingual materials where necessary.

Example wording: "One thing for this week: less sugar in your tea. Can you show me how much sugar you normally use and how much you're using now?"

PMS module: "Communication with language support (relatives/interpreting service), a simple dietary goal agreed, teach-back carried out with the patient."

Healthcare assistant (HCA) task: Provide multilingual or picture-based patient information; organise an interpreting service for the follow-up appointment if necessary.

Follow-up: At the next contact, carry out a teach-back with the patient herself again (not just via a third party).

CASE STUDY Case 10 – A highly sceptical patient who perceives prevention as patronising

Initial situation: Mr R., aged 49, reacts irritably to any mention of prevention: "I'm old enough to decide for myself how I want to live."

Typical missteps: Responding to his defensiveness with an even stronger appeal or by withdrawing in a huff – both approaches will, in the long term, end the relationship on this issue.

Better strategy: Explicitly acknowledge the patient's autonomy, offer information rather than impose it, and ensure the decision clearly rests with the patient.

Example phrasing: "You're absolutely right, it's your decision. I'll just give you the figures briefly, and you can decide what to do with them – is that all right?"

PMS module: "Patient refuses lifestyle advice, autonomy respected, risk information briefly offered, topic postponed at the patient's request."

HCA task: No active follow-up unless there is a new reason; hand out material only if explicitly requested.

Follow-up: Only raise the topic again if there is a new medical reason (e.g. abnormal lab results), and do so without applying pressure.

6. Typical practice errors

Beyond case-specific missteps, it is possible to identify patterns common across practices that recur in the vast majority of failed counselling sessions:

- Saying “You need to lose weight” without setting out a specific plan or next step.
- Recommending “get more exercise” without specifying the intensity, frequency or starting point.
- Framing smoking cessation advice in moralising rather than supportive terms.
- Failing to ask about the patient’s willingness to change before providing advice.
- Agreeing on too many goals at once during a consultation.
- Failing to arrange a follow-up – the counselling fizzles out without any results.
- Failing to carry out a barrier analysis (time, money, social environment, psychological stress).
- Failing to visualise risks and only citing abstract laboratory results.
- Failing to document the consultation – meaning the next contact is effectively a fresh start.
- Failing to incorporate healthcare assistants (HCA), course programmes or digital tools, even though these tasks can be delegated.
- Pitting medication against lifestyle measures instead of combining them.
- Treat lifestyle counselling as a non-binding ‘free additional service’ rather than as an established practice process with appointments, documentation and follow-ups.

AVOID PRACTICE ERRORS

- Repeating the same general advice at every consultation without relating it to the patient’s current situation.
- Starting a consultation without first knowing how much time is realistically available – this leads to interrupted, incomplete discussions.

7. What is optimal – what is realistic?

An honest comparison between the guideline-compliant ideal and what is feasible for GP-related activities helps to calibrate one’s own expectations – and thereby also relieves the pressure to have to conduct every consultation ‘in full’.

Level	Optimal	Realistic in GP practice
Duration of consultation	Detailed consultation	Micro-intervention + follow-up appointment
Motivation	High willingness to change	Accepting ambivalence
Implementation	Comprehensive plan	A small SMART goal
Progress	Close-knit coaching	Recap or quarterly check-in
Team	Interprofessional	Healthcare assistant (HCA) + patient records + course list
Impact	Major lifestyle change	Small, cumulative steps

Key point / Remember box

The measure of successful lifestyle counselling is not the comprehensiveness of the consultation, but whether it results in a small, specific, documented next step.

8. SOPs and practical tools

The following standard operating procedures make lifestyle counselling repeatable and independent of how you're feeling on the day – they shouldn't have to be reinvented every time.

SOP 1: Lifestyle counselling in a 3-minute format

1. Address the topic in a single sentence (Ask).

2. Gauge willingness to change using a 0–10 scale (Assess).

3. Jointly formulate a single SMART goal (Assist).

4. Summarise the goal verbally or briefly dictate it into the patient records system.

5. Schedule a follow-up appointment or make a note (Arrange).

SOP 2: Lifestyle counselling during check-ups/GU

1. Before the appointment: The healthcare assistant (HCA) prepares the basic data (BP, BMI, laboratory results, smoking status, exercise history).

2. Visually display the SCORE2/arriba result and state the risk age.

3. Work through the 5-A model in full.

4. Agree on at least one SMART goal and hand over a written mini-plan.

5. Arrange and document a follow-up appointment in 4–12 weeks, depending on the topic.

SOP 3: Smoking cessation counselling using the 5-A approach

1. Ask: Actively enquire about smoking status and the amount smoked.

2. Advise: Provide brief, personalised advice on giving up smoking.

3. Assess: Assess readiness to change using a scale-based question.

4. Assist: Offer specific medication-based support and counselling services (e.g. the Smoke-Free Helpline).

5. Arrange: Arrange a follow-up appointment or telephone contact in 2–4 weeks.

SOP 4: Preparation for prevention by healthcare assistants (HCA)

1. Collect basic data before the consultation: smoking status, exercise and sleep history, weight/BMI.

2. Prepare relevant risk questionnaires or score entries.

3. Have suitable patient materials (handout, mini-plan) ready.

4. Maintain the recall list and actively invite patients due for a follow-up appointment.

PMS MODULE: Brief lifestyle counselling

5-A brief counselling session conducted. Topic: [_____]. Willingness to change (0–10): [_]. SMART goal: [_____]. Follow-up: [date/interval].

PMS MODULE: Detailed risk assessment

SCORE2 risk: [_]%, risk age: +[_] years. Visualisation discussed with patient. 5-A model completed in full. Agreed SMART goal: [_____]. Written mini-plan handed out. Teach-back successful. Recall: [Date/Interval].

PATIENT HANDOUT: My next small step

My goal for the coming weeks: _____

When will I start: _____

What might help me with this: _____

What might be difficult, and how will I deal with it: _____

When shall we next discuss how it's gone: _____

Recall logic for prevention and progress

Topic	Recommended recall interval
Smoking cessation counselling	2–4 weeks after the initial consultation, then on an individual basis
Hypertension/lifestyle intervention prior to pharmacotherapy	4–8 weeks
Diabetes/dietary goals	3 months (linked to HbA1c monitoring)
Weight/dietary behaviour	Individual, not primarily weight-based
Sleep hygiene	4 weeks
General preventive health advice during the check-up	linked to the next check-up cycle, with follow-up contact after 3 months if necessary

Practice Pearl

A well-maintained recall list is the most important 'lifestyle intervention' that never takes place in the consultation room – it ensures that good advice does not go unheeded.

9. Healthcare Assistant Module

The burden of lifestyle counselling can be substantially reduced if practice teams take on defined, delegable tasks. The doctor's time can then be focused on the actual consultation and setting goals.

Task	Responsible
Collect basic medical history (smoking, exercise, sleep, diet) prior to the appointment	healthcare assistant (HCA)
Measure BP, weight and BMI; prepare to enter the score	healthcare assistant (HCA)
Prepare patient materials/mini-plan and hand them over after the consultation	healthcare assistant (HCA)
Maintain the recall list; invite patients due for a follow-up	healthcare assistant (HCA)
Risk assessment, setting treatment goals, medical decision-making	Doctor
Decision on drug therapy (e.g. pharmacotherapy for smoking cessation)	Doctor

Healthcare assistant (HCA) TRIAGE – IMMEDIATE CONTACT WITH A DOCTOR

- During the preparatory phase, the patient expresses acute suicidal thoughts, severe depressive symptoms or indications of acute risk.
- Newly emerging warning signs (e.g. chest pain, acute neurological symptoms) during the preparatory assessment.
- The patient reports a fall resulting in injury or an acute deterioration in their general condition.

10. A critical perspective for sceptical GP's

The legitimate question asked by many experienced GPs is: Why should I take lifestyle counselling seriously when I have hardly any time and many patients won't change anything anyway? An honest answer avoids appeals to emotion and instead offers a practical argument:

- Not every counselling session needs to be long – a 30-second prompt or a 3-minute micro-counselling session can be fitted into the time allocated for any consultation.
- Short, repeated interventions can increase a patient's willingness to change even if no immediate behavioural change follows – the effect often only becomes apparent over the course of several contacts.
- Repetition over many years is a genuine strength of GP-related practice that no other specialism can offer with this level of continuity.
- Lifestyle counselling helps prevent over-medication by delaying or avoiding escalations in pharmacotherapy where medically justifiable.
- It improves adherence to existing medication because patients perceive their condition as something they can influence, rather than something controlled purely by medication.
- It strengthens the doctor–patient relationship when conducted in an appreciative rather than moralising manner – which also pays dividends in other areas.
- It can be delegated and systematised: preparation by healthcare assistants (HCA), recall lists and patient information materials spread the workload across the whole team.
- It is, in any case, part of the logic underpinning GP-related remuneration and care provision – DMPs, check-ups/general health assessments and preventive services already incorporate these elements; structured implementation makes them documentable and billable rather than an implicit additional service.

Key point / Remember box

The benchmark is not whether every patient changes their behaviour, but whether the practice has a repeatable, documented process that enables change where it is possible – without overburdening the limited time available.

11. Online resources and reference sites

The following links lead to guidelines, practice tools and patient information, organised by country and topic.

Guidelines and professional bodies

- DEGAM: S3 guideline ‘GP-led risk assessment for cardiovascular prevention’ (AWMF Reg. No. 053-024) (https://www.degam.de/leitlinie-s3-053-024)
- AWMF Guidelines Register: S3 guideline on smoking cessation (Reg. No. 076-006) and other lifestyle guidelines (https://register.awmf.org)
- DGSM: S3 guideline on non-restorative sleep/sleep disorders (https://www.dgsm.de)
- Austrian Society for General and Family Medicine (ÖGAM) (https://www.oegam.at)
- Swiss Society for General Internal Medicine / Swiss GPs (mfe) (https://www.hausaerzteschweiz.ch)

Tools and risk calculators

- arriba – GP-related counselling strategy for cardiovascular prevention (risk calculator, patient information) (https://arriba-hausarzt.de)
- gesundheitsinformation.de (IQWiG): evidence-based patient information on lifestyle topics (https://www.gesundheitsinformation.de)
- Austrian Health Portal: risk and prevention information (https://www.gesundheit.gv.at)

Smoking cessation and prevention services

- BZgA’s Smoke-Free Helpline (Germany) (https://www.rauchfrei-info.de)
- Smoke-Free Helpline Austria (https://www.rauchfrei.at)
- AT Switzerland – Working Group on Tobacco Prevention (https://www.at-schweiz.ch)

Links were checked on 18 June 2026. If accessed at a later date, content or URLs may have changed.

12. References and sources

References are formatted according to the Vancouver style. In the main text, [N] is used to refer to the respective source, in the order of its first appearance.

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Vancouver citation style: Numbers in the text [N] – order of first appearance.

C6 – Chronic complex pain and multimodal pain management (MMST)

Assessment of indications, pre-treatment, referral and readmission (Chapter C of the Pain Medicine Module)

⇨ **See also Chapters C5 and C6 in the Clinical Annex (C) of Volume 4: Patient Management**

C5 - A. Pain management in GP practice: Selection, dosing, titration and safety	30-second pain triage, five principles of treatment, non-opioids and neuropathic pain, initiation and titration of opioids, opioid rotation (six-step algorithm), management of adverse effects, geriatrics and renal insufficiency, tapering and misuse
C6 - B. Cancer pain and palliative pain management Basic analgesia, breakthrough pain, special situations and cannabinoids	Cancer pain by mechanism, breakthrough pain and rapid-onset opioids, bone metastases, neuropathic and visceral cancer pain, alternative routes of administration (s.c.), malignant bowel obstruction, cannabinoids, geriatric cancer pain, General outpatient palliative care

Overview

Chapter C addresses the question of when a chronic complex pain syndrome requires interdisciplinary multimodal pain management (MMST), which care setting is appropriate, what a robust referral process looks like, and how a successful handover back to the GP can be achieved. It builds on Chapters A and B.

⚑ Changes compared with the previous version of the chapter

The previous ‘at least 4 out of 7 core criteria’ checklist was an in-house heuristic, not an official OPS criterion, and is being completely replaced: the indication for MMST is determined by an overall clinical assessment, not by a points-based score.

The previous requirement for mandatory outpatient pre-treatment lasting 4–6 months was too rigid and has been replaced: what matters is the quality, scope and documented failure of the pre-treatment – not a rigid minimum duration.

C1. When is outpatient treatment sufficient?

Not every patient with chronic pain requires MMST. Further outpatient treatment is usually appropriate in cases of stable or only moderate functional impairment, demonstrable treatment success, good self-management skills, manageable psychological comorbidity, a clear, specific treatment issue, or outpatient options that have not yet been utilised effectively.

C2. Pain clinic, rehabilitation, day care or inpatient care?

Setting	More suitable if
Pain clinic	Clear medication or diagnostic issue, interventional issue, preserved function, manageable psychosocial complexity, feasibility of outpatient care. Often acts as an interface between outpatient and inpatient care (Pain Society).
Medical Rehabilitation	Focus on work capacity, physical rehabilitation, social participation, workplace adaptation, and long-term increase in physical capacity (German Pension Insurance).
Semi-inpatient IMST (OPS 8-91c)	Daily return home possible, stable home environment, no need for overnight monitoring, intensive interdisciplinary programme required.
Full inpatient MMST (OPS 8-918)	Severe loss of function, complex somatic/psychological comorbidity, significant medication-related issues, high need for structured support, lack of feasibility for outpatient or semi-inpatient care.
Interdisciplinary short-term pain management treatment (OPS 8-91b)	A shorter, intensive, interdisciplinary programme as an alternative to full inpatient MMST, depending on the clinic's services.

What the OPS actually describes

OPS 8-918 (full inpatient), 8-91b (short-term treatment) and 8-91c (semi-inpatient) describe hospital procedure codes with defined structural, process and service characteristics (classifications). The OPS is primarily a hospital code – the GP practice does not itself determine whether all structural characteristics are met, but rather justifies the medical necessity of interdisciplinary multimodal treatment. The receiving hospital decides on the setting and coding.

Draft wording for the referral letter: 'From the GP's perspective, there is an indication to consider fully inpatient, interdisciplinary, multimodal pain therapy.' – not: a binding OPS coding by the GP practice.

MMST is not simply 'more physiotherapy plus psychotherapy': Interdisciplinary multimodal pain therapy means treatment that is coordinated in terms of content, duration and therapeutic approach, with a shared goal of functional and self-management within the team – not merely the sum of several individual therapies (German Pain Society).

C3. MMST indication without a points score

The four core decisions for GP's:

Decision	Key question
1. Is there a chronic complex pain problem?	Assess duration of pain, mechanism, limitations on activity/participation, psychological/social factors, previous treatments, medication use and red flags
2. Is outpatient care sufficient?	Stable/moderate functional impairment, demonstrable success, good self-management skills, manageable comorbidity → usually continue with outpatient care
3. Is a pain clinic or a semi-inpatient programme sufficient?	Clearly defined clinical issue vs. intensive programme where the patient is stable at home
4. Is full inpatient MMST necessary?	Severe functional impairment, complex comorbidities, significant medication-related issues, high need for structured support, lack of feasibility for outpatient management

Exclusion or prior assessment before MMST

Acute neurological red flags, unstable medical condition, acute fracture/infection

Active, untreated substance use disorder requiring detoxification, severe acute psychiatric crisis

Acute situation with purely diagnostic uncertainty

Lack of willingness to undergo active treatment; expectation of exclusively passive measures or complete freedom from pain

ClinicalOS rule: A high level of distress alone is not sufficient – there must also be a need for interdisciplinary treatment and a realistic ability to participate in the programme. No cumulative scoring: a 'no' for suitability may be more relevant than several positive distress criteria. The final decision on admission is made by the treating pain centre following an interdisciplinary assessment.

C4. Document prior treatment

A 'treatment attempt' must be verifiable. 'Gabapentin had no effect' is not sufficient – the following are required: indication/mechanism, starting dose and maximum dose achieved, duration of treatment, adherence to treatment, effect on pain and function, side effects, reason for discontinuation.

Insufficient	Meaningful
"Pregabalin had no effect."	"Pregabalin initiated due to a burning, electric-shock-like radicular pain component; dose increased from 25 mg in the evening to 75 mg twice daily over three weeks, eGFR 68 ml/min. No significant improvement in sleep, walking distance or pain peaks; pronounced dizziness and unsteadiness when walking. Treatment tapered off."

Document the functional profile in detail

Unsuitable	Suitable
“Pain 9/10.” · “Patient severely impaired.” · “Can no longer do anything.” · “MRI shows severe degeneration.”	“Can only stand for about 10 minutes due to pain.” · “Only leaves the flat for doctor’s appointments.” · “Needs help putting on socks.” · “Wakes up 4–5 times per night.” · “Has been continuously unfit for work for 8 months.”

“Outpatient multimodality exhausted” does not mean that every conceivable form of treatment must have been carried out, but rather a documented selection of appropriate components (medical, activity-based, educational, psychosocial, socio-medical) in sufficient form, intensity and duration. There is no rigid minimum duration of ‘4–6 months’ – in cases of rapid, severe functional loss or where outpatient treatment is not feasible, the MMST assessment may be carried out earlier.

‘Unsuccessful physiotherapy’ is no longer accepted as a sufficient description – passive measures alone are not regarded as a sufficient attempt at multimodal activation. Psychosocial factors are documented in concrete terms, rather than being generalised as ‘psychosomatic overlay’.

C5. Patient suitability

Motivation, active participation, ability to work in a group, acceptance of treatment goals, and medical and psychiatric stability are just as crucial as the burden of the illness.

When mental illness must be treated first

Prior to admission to MMST

Acute suicidal ideation, acute psychosis, severe manic episode, acute alcohol/benzodiazepine/opioid withdrawal, uncontrolled severe eating disorder, acute trauma crisis with an inability to cope with group settings or stress.

Stable depression, an anxiety disorder or a somatic stress disorder, on the other hand, is not a reason for exclusion, but is often part of the need for multimodal treatment.

Clarify the patient’s expectations prior to admission

Information leaflet: “The aim of multimodal pain management is usually not to eliminate all pain. The focus is on greater resilience, better pain management, safer medication and a return to as much of everyday life and social participation as possible. This requires active cooperation.”

Unsuitable goals	Appropriate goals
“Freedom from pain.” · “Resolve the MRI findings.” · “Finally find the right, strong medication.” · “Confirm permanent incapacity for work.” · “Avoid all physical exertion.”	Walking distance from X to Y metres · independent ADLs · reduction in opioid dose by X per cent · gradual reintegration · return to a specific everyday activity

C6. Referral letter

New complete version – minimum data set:

Clinical question:

Assessment of an interdisciplinary, multimodal pain management programme and determination of the appropriate outpatient, day-care or inpatient setting.

Pain diagnosis and history: Chronic pain syndrome present since ____, with a focus on ____. Probable dominant mechanism: ____. Relevant red flags have been ruled out by ____.

Functional impairment: Walking distance ____, duration of sitting/standing ____, limitation in ADL ____, incapacity for work since ____, social participation ____.

Biopsychosocial factors and mental stability: ____.

Treatment to date: Activity-based therapy/physiotherapy ____ · Education/self-directed exercises ____ · Psychosomatic/psychotherapeutic treatment ____ · Medication, including dose/duration/outcome ____ · Specialist treatment/rehabilitation to date ____.

Medication issues: currently ____ mg oral morphine equivalent per day; side effects/signs of misuse ____.

Reason for increased treatment intensity: Despite sufficiently structured outpatient treatment, no significant improvement in function has been achieved. The necessary coordination and intensity cannot be adequately achieved on an outpatient basis because ____.

Treatment objectives: Improvement in walking distance to ____, independent ____, reduction of ____, preparation for ____. The patient has been informed that active participation and functional improvement are the primary focus and that complete freedom from pain is usually not a realistic primary objective.

C7. Readmission and aftercare

The GP's responsibility does not end with admission. To be clarified prior to admission: Who will prescribe long-term medication during treatment? Who will handle fit note (Statement of Fitness for Work) matters? Who will coordinate specialist reports? Which medications should not be resumed after discharge? Who will oversee opioid tapering? When will the first GP appointment after discharge take place?

No fixed deadline is specified – in practice, where a significant change in medication is involved, an appointment should be scheduled within a few days.

⚑ The greatest risk in aftercare: a return to the previous treatment

Typical course of events: Opioid dosage is reduced during hospitalisation → pain flare-up after discharge → the on-call service reinstates the old dose → activation is paused due to anxiety → the inpatient treatment plan breaks down within a few weeks.

ClinicalOS rule: Changes made as part of the MMST must not be reversed without a fresh overall assessment. Before increasing the opioid dose again, check: is it a normal flare-up reaction? Withdrawal symptoms? New red flags? Overwhelm due to too rapid a build-up of exercise? Psychosocial crisis? Lack of follow-up care?

Flare-up plan according to the MMST (patient plan)

- Check for red flags · Do not cease activity completely · Adjust activity levels for 24–72 hours; do not pause for weeks on end · Apply learnt relaxation and movement strategies · Use agreed non-opioid on-demand medication · Do not return to the previous opioid dose independently

Contact the practice if: new neurological symptoms, trauma, fever, persistent significant deterioration in function, withdrawal symptoms, severe mental health crisis.

Medication reduction according to MMST

The discharge plan should include: starting dose, current dose, next reduction stage, interval, management of withdrawal symptoms, rules for stopping or pausing treatment, and the prescribing practitioner.

⚑ GP guidelines

Do not carry out any further reduction if the inpatient plan is unclear, without prior consultation with the treating facility. Do not automatically reduce the dose in the event of a temporarily higher pain score, restlessness without a clear cause, sleep disturbance or anxiety about the next reduction stage.

Work capacity and reintegration

Do not simply ask “Are you pain-free again?”, but rather: Which activities are possible? Which physical demands are still restricted? Is a gradual return to work realistic? Are workplace adjustments required? Is medically and vocationally oriented rehabilitation advisable?

C8. Case vignettes

Case 1 – clear indication for MMST

49-year-old warehouse worker: chronic back pain for 2 years, no indication for surgery, on fit note (Statement of Fitness for Work) for 7 months, walking distance 300 m, pronounced fear of movement, depressive symptoms, tilidine/naloxone 400 mg/day with no improvement in function, physiotherapy undertaken on several occasions, predominantly passive, psychotherapeutic co-treatment initiated.

Assessment: significant loss of function, biopsychosocial complexity, medication-related issues, loss of work and social participation, and the need for a coordinated, activation-based and psychotherapeutic approach all support an MMST assessment. To be added prior to admission: specific opioid dose/intake pattern, documented functional goals, previous active self-exercises, suicidal ideation/psychiatric stability, willingness to reduce dosage.

Case 2 – no indication for MMST as yet

45-year-old female patient: back pain for 4 months, MRI showing mild degenerative changes, no red flags, continues to work, walking distance not restricted, to date only passive massage and irregular use of NSAIDs, no structured activation programme, no patient education, no psychosocial assessment.

Assessment: Chronicity alone is not sufficient. First, explain the pain model; implement an active self-exercise programme; set movement and functional goals; prescribe rational short-term medication; carry out psychosocial screening; monitor progress.

Key learning point

Four months of pain plus MRI findings do not automatically constitute an indication for MMST.

Case 3 – Pain clinic instead of inpatient MMST

66-year-old patient: postherpetic neuralgia, localised neuropathic pain, otherwise independent, no significant depression, poor tolerance to gabapentin due to CKD. Assessment: clearly defined specialist issue, no need for comprehensive inpatient interdisciplinary care. Appropriate pathway: outpatient pain management/neurology, local therapy, optimisation of medication – no full inpatient MMST.

Case 4 – Rehabilitation rather than MMST

57-year-old patient following disc surgery: pain largely stable, significant deconditioning, long period of sick leave, highly motivated, no severe mental health comorbidity, main goal being physical rehabilitation and return to work. Assessment: focus on training/gradual increase in physical activity/return to work – medical rehabilitation is likely more appropriate than full inpatient MMST.

Case 5 – Psychiatry/addiction medicine first

52-year-old female patient: chronic pain, high-dose oxycodone, additional daily use of benzodiazepines, repeated overdoses, current suicidal thoughts, requesting inpatient pain management. Assessment: MMST is not the first step. Priority: acute psychiatric safety assessment, addiction medicine assessment, structured treatment of sedative/opioid issues. Only after stabilisation should it be assessed whether multimodal pain management is appropriate.

Case 6 – MMST with opioid tapering and readmission (longitudinal)

Time	Course
Outcome	54-year-old patient, chronic non-specific back pain: tilidine/naloxone 600 mg/day, pregabalin 300 mg/day, zopiclone 7.5 mg, on fit note (Statement of Fitness for Work) for 10 months, walking distance 250 m, marked fear of movement.
In-hospital course	Tilidine reduced to 300 mg/day; pregabalin tapered off due to absence of neuropathic symptoms; zopiclone discontinued; daily endurance and strength training; pain management programme. On discharge: walking distance 900 m; pain score only slightly changed.
Week 1 (GP-related follow-up)	Medication review; no repeat prescription for pregabalin or zopiclone; check for withdrawal symptoms; continue training.
Week 4	Walking distance 1,200 m, tilidine 250 mg/day, planning for gradual reintegration.
Week 10	Tilidine 150 mg/day, part-time return to work, pain still 5–6/10, daily life and functioning significantly improved.

⚑ Incorrect vs. correct interpretation

Incorrect: “Pain still 6/10, treatment has had no effect.” Correct: significant improvement in function, reduced use of sedatives, lower opioid dose, better self-management – pain not eliminated, but less debilitating.

Case 7 – Relapse following lack of aftercare (longitudinal)

The patient is discharged following a semi-inpatient IMST programme with duloxetine 60 mg, a reduced dose of oxycodone, a daily exercise plan and ongoing psychotherapy. Week 2: Psychotherapy place not yet arranged; physiotherapy does not start for another 6 weeks; when pain peaks, the on-call service reinstates the previous oxycodone dose. Week 6: renewed rest, increasing fatigue, no exercise, functional level back to pre-treatment levels.

⚠ Systemic failure rather than individual therapeutic failure

No prompt handover back to the GP, no coordinated aftercare, previous medication plan not deactivated, no communication with the on-call service/pharmacy, no flare-up plan. Aftercare is part of the MMST’s effectiveness and must not be treated as an optional extra.

C9. Pocket checklist: MMST in 30 seconds

Step	Checkpoint
1. Acute danger?	Red flags → Acute diagnosis, no MMST
2. Chronically complex?	Loss of function + biopsychosocial complexity + need for an interdisciplinary approach
3. Has sufficient outpatient treatment been attempted?	Document the quality and extent of interventions; no rigid monthly limit
4. Which setting is appropriate?	Specific specialist issue → pain clinic · functional rehabilitation → rehabilitation · intensive programme where the patient is stable at home → day care · high instability/need for monitoring → inpatient care
5. Is the patient suitable?	Motivation, active participation, ability to work in a group, acceptance of goals, medical/psychiatric stability
6. Is the referral letter complete?	Function, clinical history, treatment, medication, psychosocial factors, goals, rationale for the setting

Healthcare assistant (HCA) module for pre- and post-care

Phase	Task	Cannot be delegated
Before admission	Record walking distance, sleep, fit note (Statement of Fitness for Work), medication list, actual consumption, previous therapy sessions, questionnaires, appointments and findings in a structured manner	—
After discharge	Ensure appointment within the specified timeframe, update medication plan, flag old prescriptions/repeat prescriptions, document functional test results, track physiotherapy/psychotherapy/rehabilitation appointments, report warning signs	Decision on increasing opioid dosage, interpretation of delirium, modification of the tapering plan, assessment of an acute red flag

Quality indicators for the practice

Before MMST	After MMST
Proportion of admissions with a documented functional profile · complete medication matrix · specific treatment goal · documented psychosocial assessment · justification for the care setting	Timely medication review · implementation of the discharge plan · no uncritical reinstatement of discontinued medication · documented functional progress · organised aftercare · work/participation planning

Key messages

Key point / Remember box

- The MMST indication is determined by an overall clinical assessment, not by a points score.
- The OPS is a hospital code – the GP practice establishes the medical necessity, whilst the target hospital decides on the setting and coding.
- No fixed duration of prior treatment – what matters is the quality, dosage and documented failure of outpatient measures.
- Loss of function and participation carry greater weight than pain intensity – even when it comes to MMST success.
- Reintegration and aftercare are integral to the effectiveness of MMST, not an optional extra.
- Acute psychiatric and substance abuse crises are treated prior to MMST.

Online resources and reference sources

Guidelines, classifications, professional societies

DEGAM S1 guideline ‘Chronic pain’ (053-036, valid until November 2028)

BfArM/DIMDI – OPS Version 2026, codes 8-918, 8-91b, 8-91c

Medical Review Service – Assessment guide for OPS complex code 8-918

German Pain Society – Interdisciplinary multimodal pain management

German Pension Insurance – Medical rehabilitation

Outpatient clinics, pain centres, referral centres

German Pain Society – Therapist search

Austrian Pain Society – Directory of pain treatment centres

Patient organisations

German Pain League e.V.

References and sources (Vancouver style)

1. German Society for General Practice and Family Medicine (DEGAM). Chronic pain. S1 clinical practice guideline, AWMF registration number 053-036, version 2.1, valid until November 2028.

2. Federal Institute for Medicines and Medical Devices (BfArM). OPS Version 2026: Codes 8-918 (inpatient interdisciplinary multimodal pain therapy), 8-91b (short-term treatment), 8-91c (semi-inpatient IMST).

3. Medical Review Service. Assessment of OPS complex code 8-918 Multimodal pain management – Assessment guide. Essen: Medical Review Service; as at 2019, supplemented in 2025.

4. German Pain Society e.V. Interdisciplinary multimodal pain therapy – Position paper by the ad hoc commission.

5. German Pension Insurance. Medical rehabilitation: objectives and pathways to access.

6. Häuser W, Bock F, Engeser P, Tölle T, Willweber-Strumpf A, Petzke F. Long-term use of opioids for chronic non-cancer-related pain: S3 guideline LONTS. AWMF registration number 145-003. Berlin: AWMF; 2020 (formally expired since March 2025, update pending).

Note on the sources for this chapter

Editorial note

The specific admission decision and the required preliminary documentation vary between pain centres – check the requirements of the specific target hospital before referral. The LONTS guideline has formally expired; its basic principles serve as a professional reference, not as a currently valid guideline.

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