



# CoroPrevention

PERSONALISED PREVENTION FOR  
CORONARY HEART DISEASE

# CoroPrevention Tool Suite Caregiver dashboard User guide

For CoroPrevention Tool Suite investigational Medical Device Release 3.2

V6.0, 16 Oct 2024



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[www.coroprevention.eu](http://www.coroprevention.eu)

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# General information

- The CoroPrevention Tool Suite caregiver dashboard is an investigational medical device.
- Manufacturer
  - Tampere University
  - Medicine and Healthtech
  - Arvo Ylpönkatu 34
  - FIN-33520 TAMPERE
  - FINLAND

# General information

## Intended users

Healthcare professionals adequately trained and delegated for the use in the CoroPrevention trial.

## Precautions

The CoroPrevention Tool Suite is a digital tool which is designed to be used as part of a healthcare professional-led personalised prevention program (PPP) in the CoroPrevention trial.

Healthcare professionals using the Tool Suite should always check that recommendations by the Tool Suite are compatible with the patient's clinical status.

## Intended Clinical Benefits

The intended clinical benefits of the CoroPrevention Tool Suite, including the caregiver dashboard, are:

- Improving the prescription of guideline-based medical therapy and exercise;
- Improving the long-term follow-up of cardiovascular patients.

# Conduct visit 1 (EDC)

- 1 When a subject enrolls in the study, you start in the EDC system.
- 2 To create the patient, you have to fill in the date and version of the informed consent.

The screenshot shows the 'Subjects / Create' page in the EDC system. The page is titled 'Subjects / Create' and 'New subject in Helsinki University Hospital'. The 'Informed Consent' section is highlighted, and the 'Date of written informed consent' field is marked with a blue circle containing the number '2'. The date picker shows 'dd', 'mon', and 'yyyy' fields. Below it is a 'Version informed consent' dropdown menu with 'Select' as the current option. An 'Add Subject' button is located at the bottom right of the form.

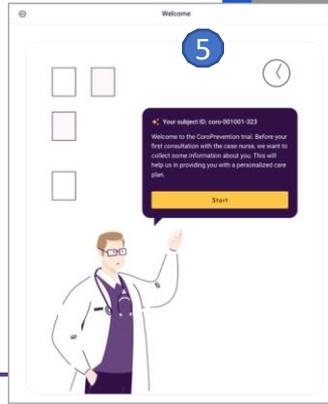
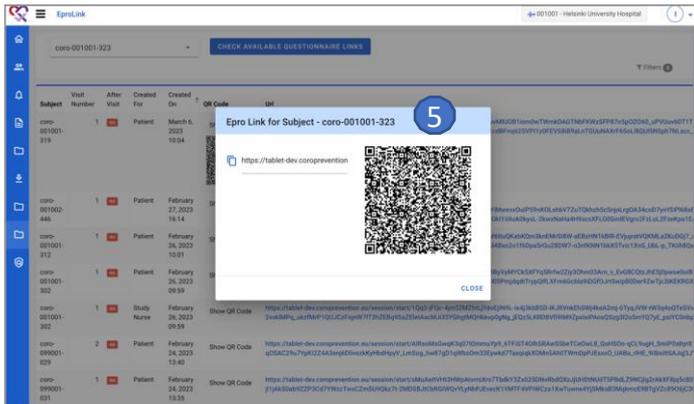
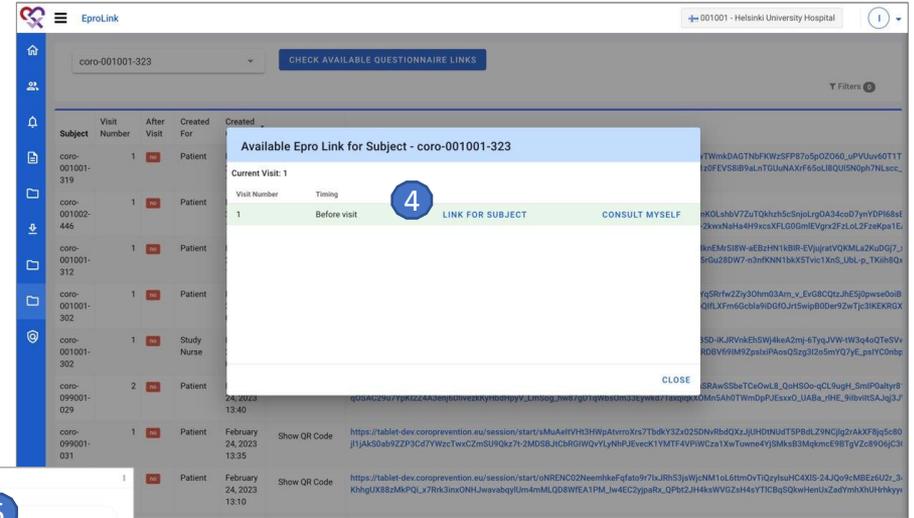
For detailed instructions on how to use the EDC, please see the EDC user manual and eCRF completion guidelines in your investigator site file.



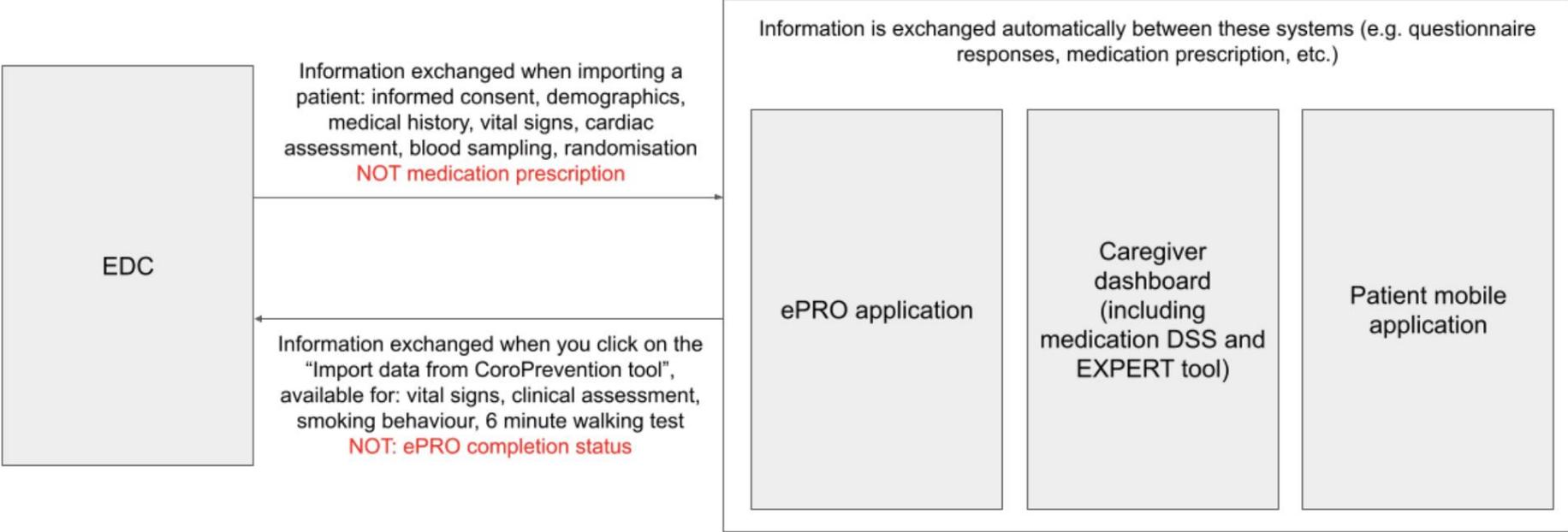
# Conduct visit 1 (EDC)

Click on the “Link for subject” link to generate the QR code for the ePROs for visit 1.

Scan the QR code with the tablet and hand the tablet over to the patient, so the patient can complete the ePROs.



# Which information is exchanged between different systems?



# How to create a patient record?

1 You can navigate to the screen to create a patient record by clicking this button. This button is only available when currently no patient record is opened.

2 You can only create a patient record for a patient who has already been registered in the EDC system and who has been randomized into the PPP intervention group. You have to fill in the subject ID of the patient to import the patient information from the EDC system to the CoroPrevention Tool Suite.

3 When you click this button, the patient information is retrieved from the EDC system, imported to the CoroPrevention Tool Suite, and shown below.

Patient	Date	Time	Type	Module	Message	Action
coro-001002-121	03-10-2022	14:21	Red	Healthy weight	The weight of the patient has increased by 8% since the previous encounter.	It may be necessary to make a telephone call or send a message to assess the patient's barriers to action.
coro-001002-261	30-09-2022	12:18	Red	Lowering cholesterol	LDL-Cholesterol was >100 mg/dL or > 2.6 mmol/L.	It is necessary to make a telephone call or send a message
coro-001002-167	28-09-2022	17:19	Red	Healthy weight	The weight of the patient has increased by 8% since the previous encounter.	It may be necessary to make a telephone call or send a message to assess the patient's barriers to action.
coro-001002-039	16-09-2022	11:31	Red	Healthy weight	The weight of the patient has increased by 8% since the previous encounter.	It may be necessary to make a telephone call or send a message to assess the patient's barriers to action.
coro-001002-030	11-03-2022	09:38	Yellow	Lowering cholesterol	LDL-Cholesterol was between 55-75 mg/dL or 1.4-1.9 mmol/L.	Tailored videos were sent to the patient.
coro-001002-030	11-03-2022	09:33	Red	Healthy weight	The weight of the patient has increased by 8% since the previous encounter.	It may be necessary to make a telephone call or send a message to assess the patient's barriers to action.
coro-001002-141	23-02-2022	19:06	Red	Healthy weight	The weight of the patient has increased by 8% since the previous encounter.	It may be necessary to make a telephone call or send a message to assess the patient's barriers to action.

Subject ID  [Retrieve data from EDC](#)

Gender  Male  Female

Year of birth

Start date

# How to open the patient record?

1 When you want to see more information about the patient then what is shown in the summary, you can open the patient record by clicking this button.

2 Here it is important to choose the correct option. This way, the system keeps track of how far the patient is in his/her timeline in the study.

2 Choose "Start visit" if the patient is sitting in front of you and this is a scheduled study visit. The number of the visit is indicated on the button.

4 Choose "Follow-up on patient" if you are following up on the patient in between visits (e.g. because of alerts or because the patient has called you).

The screenshot shows the 'Patient' record for subject ID 'coro-001002-070'. The 'General' section includes fields for Subject ID, Gender (Male), Year of birth (1960), and Start date (01-10-2021). There are links for QR codes and a 'Patient dropped out' status. The 'Consultations during the study' section shows a timeline with 7 points. The 'Parameters' section lists Blood pressure (100/70 mm Hg), Weight (54 kg), BMI (29 kg/m<sup>2</sup>), LDL cholesterol (95 mg/dL), and HbA1c (10%). The 'Behavioural goals' section lists Medication adherence (High), Start missing (Suboptimal), Healthy nutrition (Low), Smoke-free living (Active smoker (low dependence)), Stress relief (High), and Knowledge level (Beginner). The 'Most recent alerts' table shows an alert for 'Lowering cholesterol' on 19-10-2022 at 16:44.

This screenshot is similar to the one above but includes a modal dialog box. The dialog box asks 'Why do you want to open the patient record?' and provides two options: 'Follow-up on patient' and 'Start visit 2'. The 'Follow-up on patient' button is circled in blue with the number '4', and the 'Start visit 2' button is circled in blue with the number '3'. The 'Why do you want to open the patient record?' text is circled in blue with the number '2'. The 'Open patient record' button in the top right corner is circled in blue with the number '1'.

1 This screen gives you a general overview of the most important information about the patient. The patient record is at this moment not open yet.

2 You can view the general information about the patient, including the patient's subject ID, gender, year of birth and date of enrolment in the CoroPrevention study.

3 You can scan the QR code with the tablet to open the consultation preparation questionnaire for the patient. Alternatively, you can type the URL in the browser of the tablet. You can also print this code to give it to the patient on paper.

4 To login to the patient mobile application, the patient can also use a QR code, instead of his/her login credentials. You can print the QR code by clicking this button. When you print a new QR code for the patient, the patient's login credentials are reset.

5 In the caregiver dashboard, you can indicate that the patient dropped out of the study by clicking this button.

6 If the patient lost his/her smartphone (e.g. the smartphone is stolen), you can remotely log out the patient mobile application on the patient's smartphone. This ensures that the person that finds the patient's smartphone cannot view the personal, medical information about the patient.

7 When the visit was already completed, the circle is green. When the visit was skipped/cancelled, the circle is red. When the visit is not yet completed, the circle is white.

8 You can indicate that a visit was skipped by clicking on the circle of a not yet completed visit.

9 You can view or edit the data that was entered before the encounter, consult the questionnaire results and send the patient a reminder in the mobile app to fill in the questionnaires, by clicking on the circle of an already completed visit.

10 You can view the patient's most recently reported parameter values. The color-coding indicates if the patient's parameters are in the target ranges.

11 For each behavioural goal, you can view how the patient is doing and in which level of guidance the patient is currently. The color-coding indicates how good the patient is doing for the behavioural goal. Furthermore, you can view the patient's current knowledge level. The color-coding indicates the patient's performance on his/her most recent knowledge challenge.

12 You have an overview of all alerts that were triggered for this patient since last visit.

13 There is a filter for each type of alert. You can click on a filter to enable or disable it.

14 You can mark an alert as handled by clicking on the "cross" icon. The cross will then be updated to a checkmark.

# How to view a summary about a patient?

The screenshot shows the patient summary page for 'coro-001002-239 (9956)'. The 'General' section displays patient details: Subject ID (coro-01002-239), Gender (Female), Year of birth (1955), and Start date (13-09-2022). It includes a QR code and buttons for printing QR codes for the ePRD application and mobile app, as well as buttons for logging out the mobile app and marking the patient as 'dropped out'. The 'Consultations during the study' section shows a timeline with colored circles representing visit status. The 'Parameters' section lists values for Blood pressure (160/91 mm Hg), Weight (63 kg), BMI (23.1 kg/m<sup>2</sup>), LDL cholesterol (116 mg/dL), and HbA1c - (Glucose) (5%). The 'Behavioural goals' section shows levels for Medication adherence (High), Start moving (Secondary), Healthy nutrition (Low), Smoke-free living (Active smoker (low dependence)), Stress relief (High), and Knowledge level (Beginner). The 'Most recent alerts' table shows an alert from 19-10-2022 at 16:44 regarding cholesterol, with a message and an action to watch a video. A filter legend at the bottom right shows Red: 0, Orange: 1, and Yellow: 0.

Date	Time	Type	Module	Message	Action
19-10-2022	16:44	Orange	Lowering cholesterol	LDL Cholesterol was between 75-100 mg/dL, or 1.9-2.6 mmol/L.	A tailored video was sent to the patient. It may be necessary to make a telephone call or send a message.

# How to start a visit with the patient?

1 Complete some information about the patient. The system will guide you through these different steps.

2 Vital signs: First, you have to measure the patient's vital signs and record these. You can later import this information into the EDC system.

3 6 Minute Walking Test: In visit 2 and 6, the patient has to perform the Six-Minute Walk Test. You have to record the results in this screen. You can later import this information into the EDC system.

1

2

3

# How to start a visit with the patient?

4

Clinical assessment: Next, you have to complete the clinical assessment. You can later import this information in the EDC system.

5

Medication DSS information: In visit 2 and visit 6, the investigator will use the medication decision support system to review and if needed update the patient's medication prescription. For the medication decision support algorithm to work, you need to enter information on whether patient has any new clinical diagnosis as well as background information about patient's cardiac treatment history.

6

After completing the questions, you can start the visit by clicking this button. The patient record will then be opened for the study visit.

The image displays two screenshots of the CoroPrevention caregiver dashboard. The top screenshot shows the 'Start an encounter' page for patient 'coro-001002-070'. The 'Clinical Assessment' step is active, and a blue circle with the number '4' highlights the 'Previous' button at the bottom left. The bottom screenshot shows the 'Medication DSS Information' step, with a blue circle '5' highlighting the 'Medication DSS Information' button and a blue circle '6' highlighting the 'Start consultation' button at the bottom left. Both screenshots show patient vitals and a list of clinical questions with 'Yes' and 'No' radio button options.

# How to end a visit and close the patient record?

1 Click on "End encounter" if you want to end the patient visit.

The screenshot displays the CoroPrevention Alpha patient record interface. At the top, the patient ID is 001002 and the name is Emmanuel Rivera. Below this, various health metrics are listed: 120/70 mm Hg, 93 kg, 28.7 kg/m2, LDL: 95 mg/dL, 10 %, High, Sedentary, Low, and Active smoker (low dependence). A red button labeled "End encounter" is visible in the top right corner, with a blue circle containing the number "1" overlaid on it. The main content area shows "Your journey to a healthy lifestyle" with tabs for "Status" and "Goal setting". Below this, there are sections for "JOURNEY" and "PARAMETERS". The "Your journey" section includes a timeline for "Time 17-10-2022" and a slider to adjust behavior change goals. The "BE HEALTHY" section features icons for a heart, a person, and a person with a heart, along with a person icon with a heart and a person icon with a heart.

# Prepare for visit 2 (EDC)

In the EDC, complete the information of visit 1. The following information **has to be completed** to be able to import the patient into the Tool Suite:

- Demographics
- Medical History: at minimum Diabetes mellitus type 1, Diabetes mellitus type 2 information
- Vital Signs:
- Cardiac Assessment:
- Blood sampling: At minimum results for NT-PROBNP, Cystatin C, high-sensitive troponin, CERT2, eGFR, CKD, LDL, HDL, Total Cholesterol and HbA1c

2 Randomize the patient.

Subjects / coro-001001-322 / View

Subject ID: coro-001001-322  
Site: Helsinki University Hospital  
Progress: Randomised

Show monitoring status

### Medical History

Please record relevant medical history from the past 5 years by answering yes / no to all questions below or by adding other relevant disorders per investigator judgement. The medical history should be verifiable from source documents.

No.	Condition	Specify	Applicable
1	Diabetes mellitus type 1		<input checked="" type="radio"/> Yes <input type="radio"/> No
2	Diabetes mellitus type 2		<input checked="" type="radio"/> Yes <input type="radio"/> No
3	Chronic kidney disease		<input checked="" type="radio"/> Yes <input type="radio"/> No
4	Hypertension		<input type="radio"/> Yes <input checked="" type="radio"/> No
5	Cerebrovascular disease		<input type="radio"/> Yes <input checked="" type="radio"/> No
6	Peripheral artery disease		<input type="radio"/> Yes <input checked="" type="radio"/> No
7	Familiar history of cardiovascular disease		<input type="radio"/> Yes <input checked="" type="radio"/> No
8	Thromboembolism		<input type="radio"/> Yes <input checked="" type="radio"/> No
9	Chronic obstructive pulmonary disease		<input type="radio"/> Yes <input checked="" type="radio"/> No
10	Inflammatory bowel disease		<input type="radio"/> Yes <input checked="" type="radio"/> No
11	Rheumatoid arthritis		<input type="radio"/> Yes <input checked="" type="radio"/> No
12	Depression		<input type="radio"/> Yes <input checked="" type="radio"/> No
13	Sleeping disorder		<input type="radio"/> Yes <input checked="" type="radio"/> No

+ Click here to add a new row

Subjects / coro-001001-344 / View

Subject ID: coro-001001-344  
Site: Helsinki University Hospital  
Progress: Enrolled

Show monitoring status

### Randomisation

gpiHbP  
+1

High sensitivity troponin  
+1

Cystatin C  
+1

Crabtree score  
+1

Crabtree score  
+4

Risk Category  
High risk

Next

# Prepare for visit 2 (EDC)

To be able to import the patient into the Tool Suite the patient's values are to be within these ranges.

Parameter	Allowed ranges
Body weight	BMI: 12 kg/m <sup>2</sup> – 60 kg/m <sup>2</sup> Body weight: using the formula and range for BMI and the patient's height
Blood pressure	Systolic: 40 mmHg – 280 mmHg Diastolic: 30 mmHg – 160 mmHg
Pulse rate	Pulse rate: 35 – 140 bpm
HBA1CH	HbA1c: 2.15% - 20%
CHOLBC	Total cholesterol: 50 mg/dl– 500 mg/dl
LDLBC	LDL: 10 mg/dl – 450 mg/dl
HDLS	HDL: 10 mg/dl – 200 mg/dl.

# Prepare for visit 2 (caregiver dashboard)

1 If the patient is randomised into the PPP group, the patient has to be imported into the Tool Suite. This is done by logging in to the caregiver dashboard and navigating to the [“Create patient record”](#) screen.

Note: patients that are not in the PPP group cannot be imported into the Tool Suite.

2 Fill in the subject ID.

3 Click the button “Retrieve data from EDC” to fetch the data from the EDC.

4 Check if the data shown in the screen is correct for the patient.

If the data is not correct, go to the EDC to correct the data and repeat the steps above.

5 If the data is correct, click the “Submit” button to initiate the actual import of the patient from the EDC.

Note: each patient can only be imported once into the Tool Suite.

The screenshot displays the 'Create patient record' interface in the CoroPrevention Alpha system. At the top, the user is logged in as 'Ruben Pauwels'. The page title is 'Create patient record'. The form contains the following elements:

- Subject ID:** A text input field containing 'coro-001001-038'. A blue callout '2' is positioned over this field.
- Retrieve data from EDC:** A button with a refresh icon. A blue callout '3' is positioned over this button.
- Gender:** Radio buttons for 'Male' and 'Female'. A blue callout '4' is positioned over the 'Male' radio button.
- Year of birth:** An empty text input field.
- Start date:** An empty text input field.
- Submit:** A button at the bottom of the form. A blue callout '5' is positioned over this button.

Additional callouts include '1' in the top right corner (login) and '4' on the left side of the form area.

# Prepare for visit 2 (caregiver dashboard)

1 Patient record successfully imported into the Tool Suite.

1

The screenshot displays the CoroPrevention caregiver dashboard for a patient. The interface includes a search bar at the top with the patient ID 'corp-00001-322 (1965)'. A blue circle with the number '1' highlights the 'General' section. The 'General' section contains the following information:

- Subject ID: corp-001001-322
- Gender: Female
- Year of birth: 1965
- Start date: 23-01-2022

Below the general information, there is a URL for the patient's session, a QR code, and buttons for 'Print QR code for ePRO application', 'Print QR code for mobile app', 'Logout mobile app', and 'Patient dropped out'. A 'Load scenario' dropdown menu is also present.

The 'Consultations during the study' section shows a timeline with 6 consultation points, with the first point highlighted in green.

The 'Parameters' section lists the following values:

- Blood pressure: 80/90 mmHg
- Weight: 68 kg
- BMI: 30.2 kg/m<sup>2</sup>
- LDL cholesterol: 100 mg/dL
- HbA1c - (Glucose): 5%

The 'Behavioural goals' section lists the following goals and their status:

- Medication adherence: Inactive
- Start moving: Inactive
- Healthy nutrition: Inactive
- Smoke-free living: Inactive
- Stress relief: Inactive
- Knowledge level: Beginner

The 'Most recent alerts' section is currently empty, with a filter bar showing 0 Red, 0 Orange, and 0 Yellow alerts.

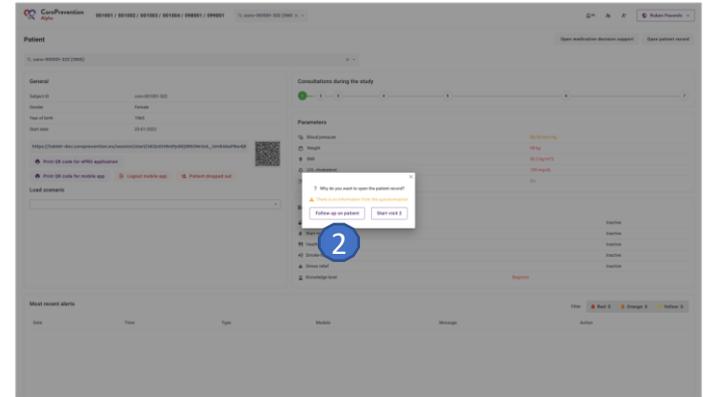
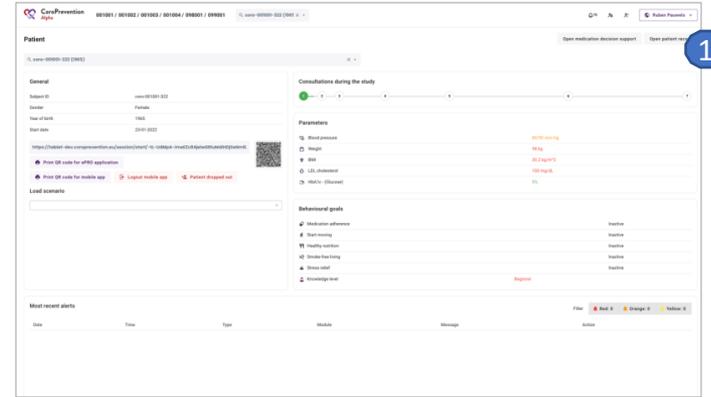


# Prepare for visit 2 (caregiver dashboard)

## EXERCISE PRESCRIPTION

1 During the visit, you will discuss the exercise goals with the patient. To set a weekly sports goal (exercise prescription). Click on the button “Open patient record”  
Note: alternatively, you can also set the weekly sports goal during the visit with the patient.

2 Open the patient record by clicking on the “Follow-up on patient” button.



# Prepare for visit 2 (caregiver dashboard)

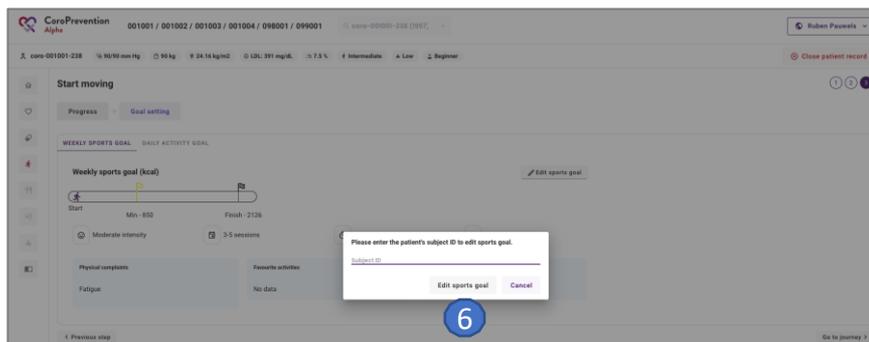
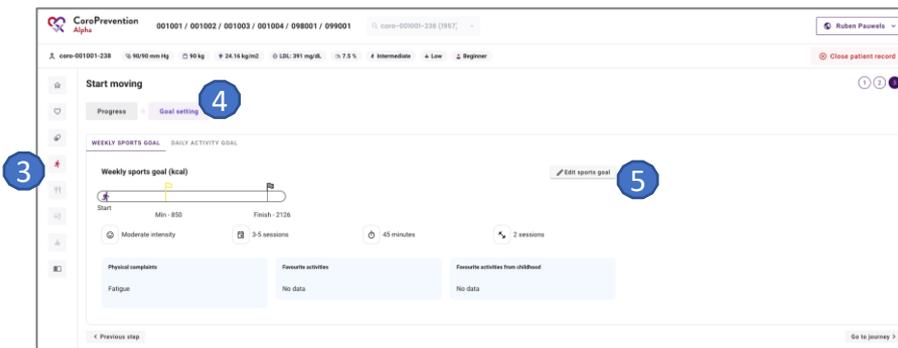
## EXERCISE PRESCRIPTION

3 Navigate to the “Start moving” module by clicking the icon of the running man.

4 Click on the “Goal setting” tab.

5 In the “Weekly sports goal” tab, click on the “Edit sports goal” button.

6 Enter the patient’s subject ID and click the “Edit sports goal” button to open the EXPERT tool.



# Prepare for visit 2 (caregiver dashboard)

## EXERCISE PRESCRIPTION

7 Set a weekly sports goal (exercise prescription) for the patient by selecting the relevant primary indications, key risk factors, exercise modifiers, anomalies and medication.

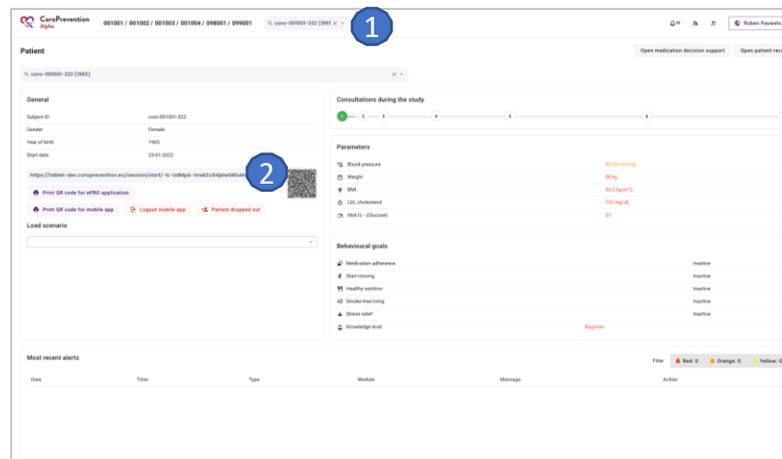
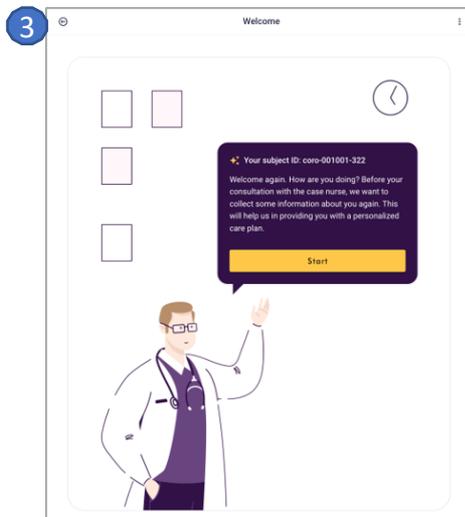
Note: filling in this information might require you to look at the patient's electronic health record.

8 When you have created the weekly sports goal for the patient, you can close the EXPERT tool by clicking the "Save and close" button.

The screenshot displays the CoroPrevention Alpha EXPERT tool interface. At the top, the patient's name is 'Roben Pauwels' and the patient ID is '001001 / 001002 / 001003 / 001004 / 098001 / 099001'. The patient's details are: Male, 66 years, 90 bpm, 160/90 mm Hg, 90 kg, 24.16 kg/m<sup>2</sup>, LDL: 391 mg/dL, 7.5%, Intermediate, Low, Beginner. The EXPERT tool is open, showing a 'Weekly sports goal' and 'Safety precautions' section. The 'Primary indication' is 'CAD, PCL CAD, and minimally invasive CABG'. The 'Key risk factor' is 'Dyslipidemia'. The 'Exercise modifier' is empty. The 'Anomalies' section is empty. The 'Medication' section is empty. The 'Recommendation' section shows a moderate goal with 3-5 sessions per week, 20-45 minutes per session, and a 12-week duration. The 'Save and close' button is highlighted with a blue circle and the number 8.

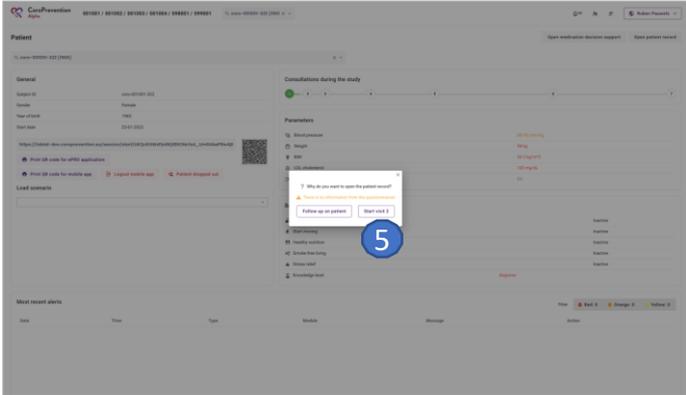
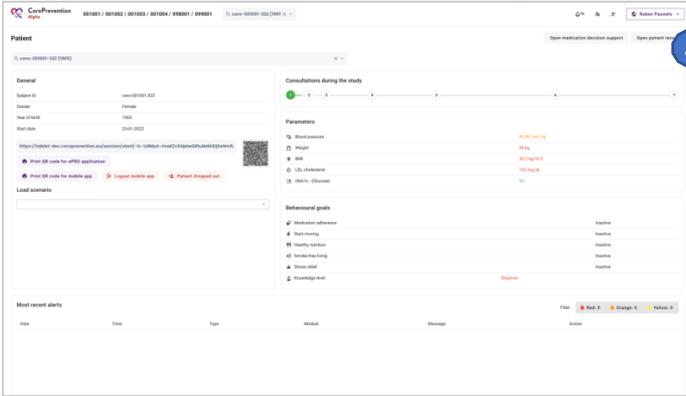
# Conduct visit 2 with the patient (caregiver dashboard)

- 1 Use the search function to find the patient record.
- 2 Take the tablet and scan the QR code (or copy the link) to open the ePRO for the patient.
- 3 Give the tablet to the patient so he/she can complete the questionnaires.



# Conduct visit 2 with the patient (caregiver dashboard)

- 4 Click the button “Open patient record” to open the patient record for a visit.
- 5 In the pop-up, click the button "Start visit 2" to start the visit.  
Note: only use "Start visit X" when patient is sitting with you.



# Conduct visit 2 with the patient (caregiver dashboard)

6 Fill in the subject ID to make sure you are opening the patient record of the correct patient.

7 Click the “Start visit 2” button to start the visit.

The screenshot displays the CoroPrevention caregiver dashboard for a patient with subject ID coro-00001-322. The dashboard includes sections for Patient information, Consultations during the study, Parameters (Blood pressure, Weight, BMI, LDL cholesterol), and Most recent alerts. A modal dialog box is open, prompting the user to enter the patient's subject ID to start visit 2. The dialog box has a 'Start visit 2' button and a 'Cancel' button. A blue circle with the number 6 is overlaid on the input field, and a blue circle with the number 7 is overlaid on the 'Start visit 2' button.

# Conduct visit 2 with the patient (caregiver dashboard)

When you start the visit, you have to measure and fill in the vital signs information in the caregiver dashboard.

Note: after the visit, you can import this information in the EDC.

During visit 2, and also 6, the patient has to perform the 6 Minute Walking Test. You have to record the results in the caregiver dashboard.

Note: after the visit, you can import this information in the EDC.

Fill in the information regarding the clinical assessment (based on information in the medical records or questions asked to the patient). Indicate only NEW diagnosis since last visit.

Note: after the visit, you can import this information in the EDC.

This screenshot shows the '6 Minute Walking Test' form. The 'Vital Signs' tab is selected. The form includes a question 'Was the 6 Minute Walking Test performed?' with 'Yes' selected. Below this are input fields for 'Distance walked' (with a red error message 'This field is required') and a dropdown for 'Borg dyspnea' set to '0 - Very light'. Navigation buttons for 'Previous' and 'Next' are at the bottom.

This screenshot shows the 'Clinical Assessment' form. The 'Clinical Assessment' tab is selected. It lists various conditions with radio buttons for 'Yes' and 'No'. A blue circle highlights the 'New diagnosis of IHD?' option, which is currently selected with 'Yes'. Navigation buttons for 'Previous' and 'Next' are at the bottom.

This screenshot shows the 'Vital Signs' form. The 'Vital Signs' tab is selected. It contains input fields for 'Body weight' (92 kg), 'Blood pressure' (Systolic 120 mmHg, Diastolic 80 mmHg), and 'Pulse Rate' (87 bpm). A blue circle highlights the 'Vital Signs' tab. A 'Next' button is at the bottom.

# Conduct visit 2 with the patient (caregiver dashboard)

11

Fill in the information that is required for the algorithm of the medication DSS to make personalized medication recommendations for the patient. This information can be filled in based on information that you can find in the medical records.

The screenshot shows the CoroPrevention Alpha caregiver dashboard for patient 'coro-001001-322'. The patient's vital signs are listed as 80/90 mm Hg, 98 kg, 30.25 kg/m<sup>2</sup>, LDL: 100 mg/dL, and 5% cholesterol saturation. The user is identified as 'Ruben Pauwels'. The dashboard is titled 'Start an encounter' and has a navigation bar with 'Vital Signs', '6 Minute Walking Test', 'Clinical Assessment', and 'Medication DSS Information'. The 'Medication DSS Information' section contains five questions with radio button options:

- Myocardial infarction in the last 12 months:  Yes  No
- Did the patient have a second vascular event within 2 years while on maximally tolerated statin?:  Yes  No
- Is patient on high-dose statin?:  Yes  No
- ACE-inhibitor intolerance?:  Yes  No
- Patient has aspirin intolerance?:  Yes  No

At the bottom of the form, there are two buttons: 'Previous' and 'Start consultation'.

# Conduct visit 2 with the patient (caregiver dashboard)

12 The patient record is open for visit. From now on, you can have the shared decision making discussion with the patient about his/her status and goals.

During visit 2, you will also help to install the CoroPrevention mobile application on the patient's smartphone.

The screenshot displays the CoroPrevention Alpha caregiver dashboard for a patient. At the top, the patient's ID is 001001 / 001002 / 001003 / 001004 / 098001 / 099001, and the patient name is coro-001001-319 (1985). The user is identified as Ruben Pauwels. A search bar shows the patient ID. Below this, a row of health metrics is displayed: 134/56 mm Hg, 78 kg, 23.55 kg/m2, LDL: 170 mg/dL, 19.4%, Low, Low, Medium, Non-smoker, Low, and Beginner. An 'End encounter' button is visible in the top right. The main content area is titled 'Your journey to a healthy lifestyle' and features a large blue oval with the number '12'. Below this, there are tabs for 'Status' and 'Goal setting'. The 'JOURNEY' tab is active, showing a 'Your journey' timeline starting on 06-03-2023. The timeline includes a green bar labeled 'BE HEALTHY' and several icons representing different health goals or activities. A 'Next step >' button is located at the bottom right of the journey visualization.

# After visit 2 with the patient (EDC)

1 Short after visit 2, all missing information for visit 2 has to be completed in the EDC.

2 You can also use the “Import data from CoroPrevention tool” to import data that you already registered in the caregiver dashboard.

The screenshot displays the EDC interface for subject **coro-001001-292**. The sidebar on the left contains a navigation menu with the following items: Subject Summary, Informed Consent, Informed Consent: Blood Sampling Sub-study for Future Research, Enrollment v1, Visit 2 (highlighted with a red circle and the number 1), Visit Date, Counselling and Goal-Setting, Vital Signs (selected), Clinical Assessment, Concomitant Medications, Questionnaires, Smoking Behaviour, Subject Reported Clinical Endpoints, 6 Minute Walking Test, Adverse Events, and Device Deficiencies. Below these are Visit 3 and Visit 4. The main content area is titled 'Vital Signs' and includes a 'Show monitoring status' toggle. It contains input fields for 'Body weight' (kg), 'Blood pressure' (Systolic and Diastolic in mmHg), and 'Pulse Rate' (bpm). In the top right corner of the Vital Signs section, there is a button labeled 'Import data from CoroPrevention tool' (highlighted with a red circle and the number 2) and an 'Audit trail' link. A 'Next' button is located at the bottom right of the main content area.

# Conduct visit 3 - 7

Visit 3: ePRO questionnaires + shared decision making conversation with case nurse (see slide 24->)

Visit 4: ePRO questionnaires + shared decision making conversation with case nurse (see slide 24->)

Visit 5: ePRO questionnaires + shared decision making conversation with case nurse (see slide 24->)

Visit 6: ePRO questionnaires + shared decision making conversation with case nurse (see slide 24->)

**+ appointment with investigator**

Visit 7: ePRO questionnaires + shared decision making conversation with case nurse (see slide 24->)

**+ uninstall patient mobile app**

At the end of each visit, view the patient's disease related knowledge and the patient's usage of the educational module.  
Configure relevant educational content for the patient.

At V3-V7 you can open the PPP patient ePRO via eCRF or via Tool Suite.

Note that for high-risk UC patients you can only open the V6 and V7 ePRO via eCRF.

# Remote follow-up on patient between visits (caregiver dashboard)

Note: use “Follow-up on patient” to view the patient record when the patient is not with you e.g. to view the patient’s progress or to prepare for the visit.

1 Click the button “Open patient record” to open the patient record for a follow-up.

2 In the pop-up, click the button “Follow-up on patient” to start the follow-up.

The image displays two screenshots of the CoroPrevention Caregiver dashboard. The top screenshot shows the 'Patient' record page for a patient named 'James 011011-011'. The page includes sections for 'General' (Subject ID, Name, Date of birth, Start date), 'Consultations during the study' (a progress bar), 'Parameters' (Blood pressure, Weight, BMI, UK cholesterol, HDL cholesterol), 'Behavioural goals' (Medication adherence, Diet, Healthy nutrition, Smoke-free living, Stress relief, Knowledge), and 'Most recent alerts'. A blue circle '1' highlights the 'Open patient record' button in the top right corner. The bottom screenshot shows the same page with a pop-up dialog box over the 'Parameters' section. The dialog box contains the text 'Why do you want to open the patient record?' and two buttons: 'Follow-up on patient' and 'Start visit'. A blue circle '2' highlights the 'Follow-up on patient' button.

# Remote follow-up on patient between visits (caregiver dashboard)

3 The patient record is open for follow-up.

The screenshot displays the CoroPrevention caregiver dashboard for a patient. At the top, the patient's ID is 001001 / 001002 / 001003 / 001004 / 098001 / 099001, and the user is identified as Ruben Pauwels. The patient's profile includes vital signs and risk factors: 134/56 mm Hg, 78 kg, 23.55 kg/m2, LDL: 170 mg/dL, 19.4%, Low, Low, Medium, Non-smoker, Low, and Beginner. A red 'End encounter' button is visible in the top right.

The main section is titled 'Your journey to a healthy lifestyle' and features a '3' in a blue circle. Below this, there are tabs for 'Status' and 'Goal setting'. The 'JOURNEY' tab is active, showing a timeline for 'Your journey' starting on 06-03-2023. The central focus is a green box labeled 'BE HEALTHY' with a heart icon. Below this, a series of icons represent different health goals: a red heart, a red person with a plus sign, a yellow person with a plus sign, a green person with a plus sign, and a red person with a plus sign. A 'Next step >' button is located at the bottom right of the journey section.

# Handling alerts (caregiver dashboard)

- 1 Click the “Bell” icon to view the list of pending alerts.  
Alerts get triggered based on the patient’s reported behaviour (from the mobile app).  
Note: alerts are shared between all nurses of a site.
- 2 The required action is described in the alert.
- 3 Click the “File lookup” icon to open the patient record.
- 4 Click the “Cross” icon to mark the alert as handled

CoroPrevention Alpha 001001 / 001002 / 001003 / 001004 / 098001 / 099001 Search patient Ruben Pauwels

Pending alerts Filter Red: 82 Orange: 13

Search patient

Show 10 alerts per page From 11.02.2022 Until 07.03.2023

Patient	Date	Time	Type	Module	Message	Action
coro-001001-117	07-03-2023	03:30	Orange	Medication adherence	The patient's average three-month medication adherence was less than 70%.	A tailored message and a video were sent to the patient.
coro-001001-122	07-03-2023	03:30	Red	Medication adherence	The patient's average six-month medication adherence was less than 70%.	A telephone call is recommended to assess the patient's barriers to action.
coro-001002-062	07-03-2023	03:30	Red	Medication adherence	The patient's average six-month medication adherence was less than 70%.	A telephone call is recommended to assess the patient's barriers to action.
coro-001002-064	07-03-2023	03:30	Red	Medication adherence	The patient's average six-month medication adherence was less than 70%.	A telephone call is recommended to assess the patient's barriers to action.
coro-001001-033	07-03-2023	03:30	Orange	Medication adherence	The patient's average three-month medication adherence was less than 70%.	A tailored message and a video were sent to the patient.
coro-001002-217	07-03-2023	03:30	Red	Medication adherence	The patient's average six-month medication adherence was less than 70%.	A telephone call is recommended to assess the patient's barriers to action.
coro-001002-218	07-03-2023	03:30	Red	Medication adherence	The patient's average six-month medication adherence was less than 70%.	A telephone call is recommended to assess the patient's barriers to action.
coro-001002-220	07-03-2023	03:30	Red	Medication adherence	The patient's average six-month medication adherence was less than 70%.	A telephone call is recommended to assess the patient's barriers to action.
coro-001001-127	07-03-2023	03:30	Red	Medication adherence	The patient's average six-month medication adherence was less than 70%.	A telephone call is recommended to assess the patient's barriers to action.
coro-001002-222	07-03-2023	03:30	Red	Medication adherence	The patient's average six-month medication adherence was less than 70%.	A telephone call is recommended to assess the patient's barriers to action.

Showing page 1 of 11

# Handling alerts (caregiver dashboard)

In the patient overview, there is a section “Most recent alerts”. This section shows all alerts (handled and unhandled) that were triggered for the patient since last visit.

Note: yellow alerts are handled automatically by the system (e.g. tailored education sent to the patient).

Red alert: high priority alert, requiring intervention from the case nurse

Orange alert: medium priority alert, requiring some action from the case nurse

Yellow alert: low priority alert, requiring no action from the case nurse since an automatic action was already performed by the system

The screenshot shows the CoroPrevention Alpha caregiver dashboard for patient coro-001002-094 (1967). The dashboard is divided into several sections:

- General:** Subject ID: coro-001002-094, Gender: Male, Year of birth: 1967, Start date: 07-02-2022. Includes a QR code and links for printing QR codes for the ePRO application and mobile app, and a 'Patient dropped out' button.
- Load scenario:** A dropdown menu.
- Consultations during the study:** A progress bar showing 7 consultations, with the first one completed.
- Parameters:** Blood pressure: 111/111 mm Hg, Weight: 88 kg, BMI: 27.8 kg/m<sup>2</sup>, LDL cholesterol: 77.3 mg/dL, HbA1c - (Glucose): 8.1%.
- Behavioural goals:** Medication adherence (Monitored action), Start moving (Inactive), Healthy nutrition (Inactive), Smoke-free living (Inactive), Stress relief (Inactive), Knowledge level (Beginner).
- Most recent alerts:** A table with 4 alerts, filtered by Red (0), Orange (1), and Yellow (2).

Date	Time	Type	Module	Message	Action
25-03-2022	10:28	Yellow	Healthy weight	The weight of the patient has increased by 2% since the previous encounter.	A tailored video was sent to the patient. ✓
11-02-2022	07:28	Orange	Lowering cholesterol	LDL-Cholesterol was between 75-100 mg/dL or 1.9-2.6 mmol/L.	A tailored video was sent to the patient. It may be necessary to make a telephone call or send a message. ✗
11-02-2022	07:26	Yellow	Diabetes management	HbA1c was between 7-9% or between 53-75 mmol/l in this patient with known diabetes.	A tailored infographic was sent to the patient. ✗

# Correcting data entry (caregiver dashboard)

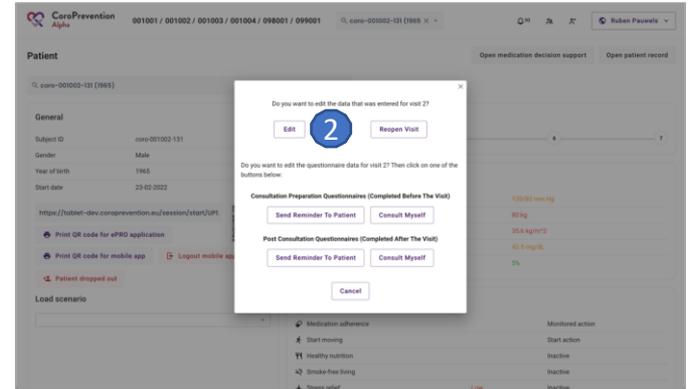
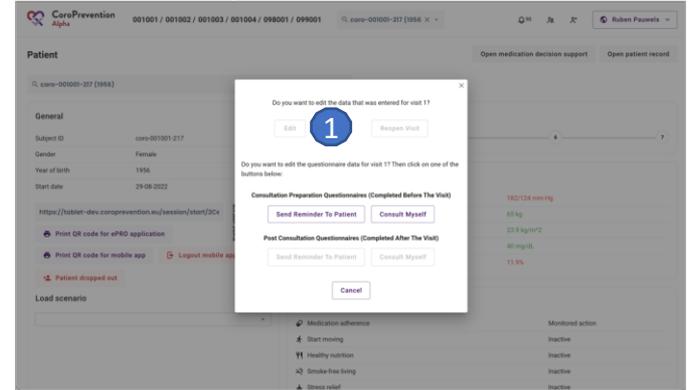
Visit 1 data can be edited (corrected) in the EDC.

Visit 1 data cannot be edited in the Tool Suite after import.

1 Therefore it is important to check the data thoroughly before importing!

Visit 2-7 data of “Start an encounter” screens can be edited (corrected) in the caregiver dashboard. If data is corrected, remember to make corrections also in the EDC.

A visit can also be reopened and links for ePRO questionnaires can be resent to the patient.



# Patient discontinuation (dashboard)

- 1 If a patient discontinues the trial click on the “patient dropped out button”.
- 2 Check and click confirm to proceed with discontinuation.

The screenshot shows the patient dashboard for Subject ID coro-001001-351. The 'Patient dropped out' button is highlighted with a blue circle containing the number 1. Other buttons include 'Print QR code for ePRO application', 'Print QR code for mobile app', 'Unblock patient account', and 'Logout mobile app'. The 'Consultations during the study' section shows a progress bar with 6 visits, and the 'Parameters' section lists blood pressure (156/74 mm Hg), weight (66 kg), BMI (17 kg/m<sup>2</sup>), LDL cholesterol (154 mg/dL), and HbA1c (15.1%). The 'Behavioural goals' section lists medication adherence (Medium), start moving (Low), and healthy nutrition (High).

The screenshot shows the patient dashboard with a confirmation dialog box overlaid. The dialog box asks, "Are you sure that patient coro-001001-351 dropped out of the study?" and has "Confirm" and "Cancel" buttons. The "Confirm" button is highlighted with a blue circle containing the number 2. The background dashboard shows the same patient information as the previous screenshot.

Patients who complete the trial per protocol will automatically lose access to the CoroPrevention mobile app upon completion of the visit 7.



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# Case nurse manual caregiver dashboard - general module

V6.0, 14.10.2024

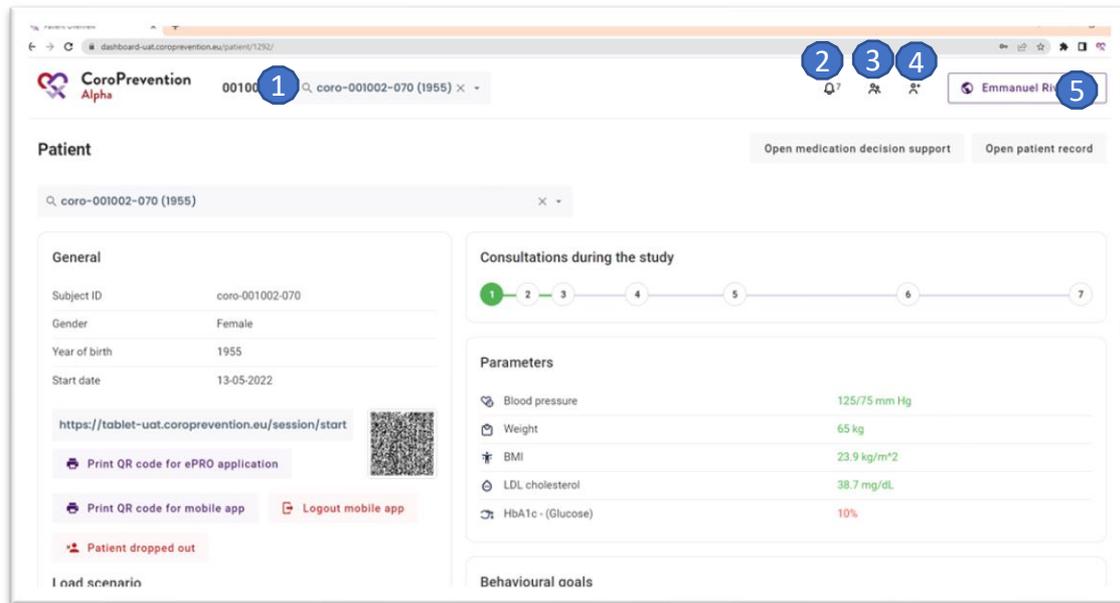


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# What can I find in the top navigation bar?

- 1 In the search bar, you can type the subject ID of a patient. The system gives suggestions for patients that match with your search criteria.
- 2 You can view the alerts by clicking this button. There is an indication of how many pending alerts you have.
- 3 You can open the screen to search a patient in your trial centre by clicking this button.
- 4 You can create a patient record by clicking this button.
- 5 You can view who is logged in in the caregiver dashboard. In the account menu, open the about page, access settings and log out of the caregiver dashboard.



1	Below the top navigation bar, you can find the risk profile bar. In the risk profile bar, you have a quick overview of the patient's risk profile.
2	You can hover over any of the items in the risk profile bar to view the name of the parameter or behavioural goal and the date on which the value was reported.
3	You can click on an item in the risk profile bar to navigate to the screen to view more details.
4	You can view the subject ID of the patient.
5	You can view the patient's blood pressure. Blood pressure can be reported by the patient (in the mobile app) or by a case nurse (in the caregiver dashboard).
6	You can view the patient's weight. Weight can be reported by the patient (in the mobile app) or by a case nurse (in the caregiver dashboard).
7	You can view the patient's Body Mass Index (BMI). The patient's BMI is calculated automatically based on the most recently reported weight. Weight can be reported by the patient (in the mobile app) or by a case nurse (in the caregiver dashboard).
8	You can view the patient's LDL cholesterol. LDL cholesterol can be reported by the patient (in the mobile app) or by a case nurse (in the caregiver dashboard). The LDL cholesterol is always shown in mg/dL.
9	You can view the patient's HbA1c - (Glucose) value displayed in percents. HbA1c - (Glucose) can be reported by the patient (in the mobile app) or by a case nurse (in the caregiver dashboard).
10	You can view the patient's medication adherence. The patient's medication adherence is assessed with a single question that asks the patient if he/she is taking his/her medication as prescribed.
11	You can view the patient's physical activity. The patient's physical activity is assessed with the Rapid Assessment of Physical Activity (RAPA) questionnaire.
12	You can view how healthy the patient's nutrition is. The patient's nutrition is assessed using the Nutrition-score. The Nutrition-score is based on the MedDietScore, which is a measure to assess the patient's adherence to the Mediterranean dietary pattern.
13	You can view the patient's smoking behaviour. The patient's smoking behaviour is assessed using a single question asking if the patient smokes and the Fagerström Test for Nicotine Dependence, which is a standard instrument for assessing the intensity of physical addiction to nicotine.
14	You can view how well the patient's coping with mental health and stress management is. The patient's mental health and stress management is assessed using 3 different measures: the Generalised Anxiety Disorder Assessment (GAD-7), the Patient Health Questionnaire (PHQ-9), and the perceived stress scale. If the patient has suicidal thoughts, or a high depression or anxiety score, there is an exclamation mark to draw your attention to this, so you can discuss it with the patient.
15	You can view how well the patient's disease related knowledge is. The patient's disease related knowledge is assessed with the knowledge challenge, a short multiple-choice quiz that assesses the patient's knowledge about cardiovascular disease.
16	You can close the patient record by clicking this button.

## Where can I see the patient's risk profile?

The screenshot displays the CoroPrevention caregiver dashboard for patient Emmanuel Rivera. The dashboard is organized into several sections. At the top, the patient's name and ID (001002) are visible. Below this, a row of health metrics is shown: blood pressure (125/75 mmHg), weight (65 kg), BMI (23.88 kg/m2), LDL cholesterol (38.7 mg/dL), and HbA1c (10%). A 'Status' section indicates the patient is a 'Beginner' and an 'Active smoker (low dependence)'. The main content area features a 'Your journey to a healthy lifestyle' header, a 'Status' button, and a 'Goal setting' button. Below these, there are tabs for 'JOURNEY' and 'PARAMETERS'. The 'JOURNEY' tab shows a progress bar for 'Your journey' from 03-10-2022, with a slider to adjust goals over time. At the bottom, there is a green button labeled 'RE HEALTHY'. A 'Close patient record' button is located in the top right corner.

# What can I do in the menu on the left?

1 The navigation menu on the left allows you to switch between different modules or behavioral goals. The house icon takes you back to the main page of the patient profile.

2 In the “heart” menu item, view the patient's progress for parameters and his/her journey to a healthy lifestyle. Also, you can select the outcome and behavioural goals for the patient.

3 In the “pill” menu item, view the patient's progress and set goals for "Medication adherence".

4 In the “running man” menu item, view the patient's progress and set goals for "Start moving".

5 In the “cutlery” menu item, view the patient's progress and set goals for "Healthy nutrition".

6 In the “smoking” menu item, view the patient's progress and set goals for "Smoke-free living".

7 In the “yoga” menu item, view the patient's progress and set goals for "Stress relief".

8 In the “book” menu item, view the patient's disease related knowledge and the patient's usage of the educational module or configure relevant educational content for the patient.

The screenshot displays the CoroPrevention Alpha caregiver dashboard for patient 001002. The top navigation bar includes the patient ID and a search bar. Below this, a row of health parameters is shown: 125/75 mm Hg, 65 kg, 23.88 kg/m2, LDL: 38.7 mg/dL, 10 %, High, Sedentary, and Low. The main content area is titled "Your journey to a healthy lifestyle" and features a "Status" section with "Active smoker (low dependence)", "High", and "Beginner" indicators. Below this is a "JOURNEY" section with a slider for "Time 03-10-2022" and a "BE HEALTHY" goal area with icons for medication, walking, and nutrition.

# How to know the patient's level of guidance for a behavioral goal?

1 When you have opened the details about a behavioral goal, you can view the patient's level of guidance for the behavioral goal by looking at the circles. The circle of the patient's current level of guidance for the behavioral goal is highlighted. If there is no circle highlighted, the patient is in inactive mode (level of guidance 0) for the behavioral goal.

The screenshot displays the CoroPrevention Alpha patient record for Emmanuel Rivera (ID: 001002). The patient's current level of guidance for the behavioral goal is highlighted with a blue circle containing the number 1. The interface shows the following details:

- Medication adherence:** Status is "High" (highlighted in green), with the text "I always take my medication as prescribed" and a "Reported on 12/10/2021" timestamp.
- Medication adherence barriers:** Reported on 12/10/2021, with a score of 30 (highlighted in blue).
  - No barrier:** Includes "Anxious mood", "Know how to take", "Physically able", "Remember to take", "Getting hold of medication", "Confidence in managing", and "Depressed mood".
  - A big barrier:** Includes "Worry about unwanted effects", "Feels a burden", "Life gets in the way", "Coping with changes", and "Social worries".

Navigation options include "Go to journey" and "Next step".

# How to structure the conversation about a behavioral goal?

1

For each menu item on the left (i.e. module or behavioral goal), there are several discussion steps. The currently selected discussion step is highlighted. You can click on a discussion step to view the related screen.

2

You can go to the next discussion step by clicking this button.

The screenshot displays the 'Medication adherence' screen in the CoroPrevention Caregiver dashboard. At the top, patient information is shown: 'coro-001002-070' with various vitals (125/75 mm Hg, 65 kg, 23.88 kg/m2, LDL: 38.7 mg/dL, 10 %) and risk factors (High, Sedentary, Low). A 'Close patient record' button is in the top right. The main content area is titled 'Medication adherence' and has a 'Status' tab selected over 'Prescription'. A blue circle with the number '1' highlights the 'Status' tab. Below the tabs, a green pill with 'High' indicates the adherence level, with the statement 'I always take my medication as prescribed' and a 'Reported on 12/10/2021' date. Underneath, 'Medication adherence barriers' are listed, categorized into 'No barrier' (Anxious mood, Know how to take, Physically able, Remember to take, Getting hold of medication, Confidence in managing, Depressed mood) and 'A big barrier' (Worry about unwanted effects, Feels a burden, Life gets in the way, Coping with changes, Social worries). A blue box shows a '30 Score'. At the bottom, a 'Go to journey' button is on the left, and a blue circle with the number '2' highlights the 'Next step >' button on the right.

# How to structure the conversation about a behavioural goal?

3 You can go to the previous discussion step by clicking this button.

4 After going through all discussion steps for a module or behavioral goal, you can return to the patient's journey by clicking this button.

Repeat the same steps for each behavioral goal as applicable.

The screenshot displays the CoroPrevention Alpha interface for a patient named Emmanuel Rivera. The patient's ID is 001002, and their primary care physician is Dr. coro-001002-239 (1955). The patient's profile includes vital signs: 170/80 mm Hg, 64 kg, 23.51 kg/m2, and LDL 116 mg/dL. Risk factors are listed as High, Sedentary, Low, and Active smoker (low dependence). The dashboard is currently on the 'Medication adherence' page, with a 'Prescription' tab selected. Below the navigation bar, there are buttons for 'Print for patient', 'Print for general practitioner', and 'Open medication decision support'. The 'Current prescription' section lists two medications: Bisoprolol (20 mg, Beta blockers) and Totalip (10 mg, Statins). The Bisoprolol entry shows a frequency of 'Daily' and a timing of 'MORNING 1' and 'EVENING/NIGHT 1'. The Totalip entry shows a frequency of 'Daily' and a timing of 'MORNING' and 'EVENING/NIGHT 2'. A large grey box on the right side of the screen contains the text 'Tap the drug to view more information about the drug.' At the bottom left, there is a '< Previous step' button, and at the bottom right, there is a 'Go to journey >' button. Two blue circles with the number '3' are overlaid on the interface: one on the '< Previous step' button and another on the 'Go to journey >' button.



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# Case nurse manual caregiver dashboard - journey module

V6.0, 14.10.2024

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*This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 848056*

# How to follow up on the patient's progress for the journey?

In "Progress", you can view the patient's progress for his/her journey towards a healthy lifestyle. You can view the patient's progress for a) the behavioural goals and b) the parameters.

The screenshot displays the Coroprevention Caregiver dashboard for patient ID 'coro-001002-070'. At the top, various patient metrics are listed: 119/69 mm Hg, 71 kg, 26.08 kg/m2, LDL: 38.7 mg/dL, 10%, High, Sedentary, 11 Low, Active smoker (low dependence), High, and Beginner. A red 'End encounter' button is visible in the top right.

The main section is titled 'Your journey to a healthy lifestyle' and is divided into 'Progress' and 'Goal setting' tabs. The 'Progress' tab is active. Below this, there are two sub-sections: 'JOURNEY' and 'PARAMETERS'. The 'JOURNEY' section shows a progress bar for 'Your journey' ending on 'Time 24-10-2022'. A slider below it allows viewing how behaviour change goals evolve over time. The 'PARAMETERS' section shows a 'BE HEALTHY' goal with icons for diet, exercise, and smoking. A 'Next step >' button is located at the bottom right of the dashboard.

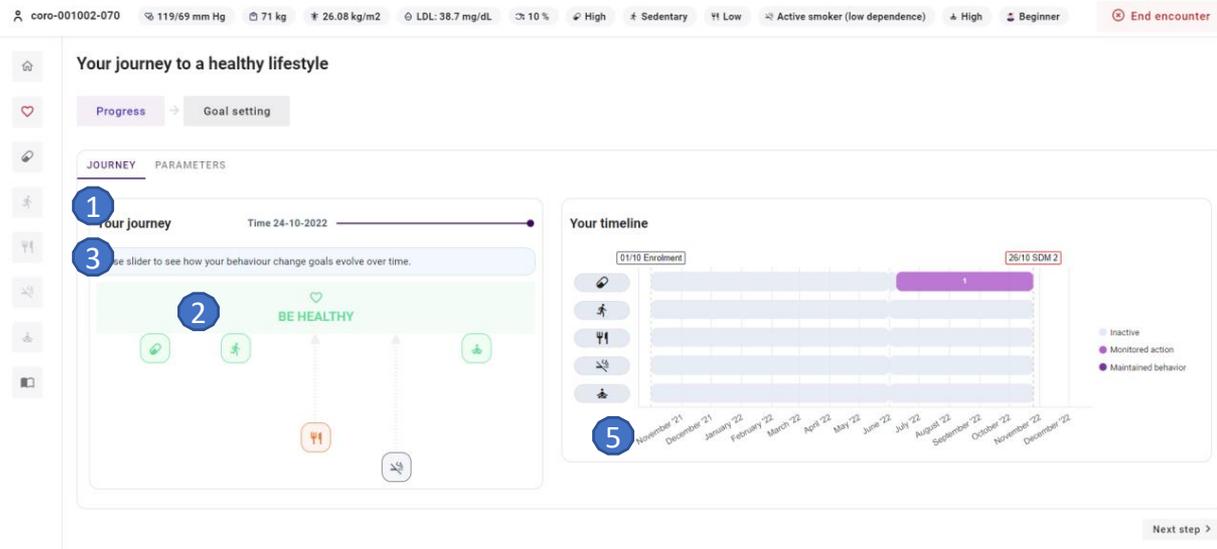
The 'Your timeline' section shows a calendar view from November '21 to December '22. It highlights two events: '01/10 Enrolment' and '26/10 SDM 2'. A legend on the right indicates that blue bars represent 'Inactive', purple bars represent 'Monitored action', and dark purple bars represent 'Maintained behavior'.

# How to follow up on the patient's progress for the behavioural goals?

1 The "Journey" tab in "Progress", shows an overview of the patient's progress for the five behavioural goals.

2 The closer the behavioural goal is to the "Be healthy", the better the related risk factor is under control. In the example, you can see that "Healthy nutrition" and "Smoke-free living" are far from the "Be healthy", so these risk factors need most improvement. "Medication adherence", "Start moving" and "Stress relief" are near to the "Be healthy", so these risk factors are well under control.

3 You can explore the patient's progress towards a healthy lifestyle over time by moving the slider.

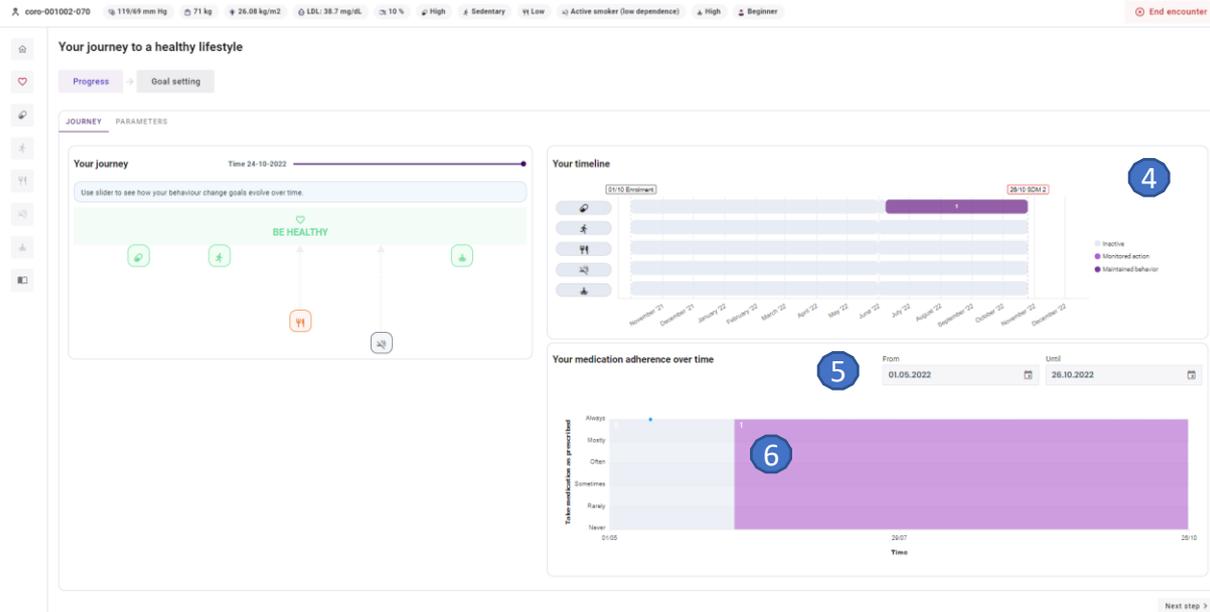


# How to follow up on the patient's progress for the behavioural goals?

4 The number on the timeline indicates which level of guidance the patient was for the behavioral goal in the specified period. If no number is indicated, the patient was in inactive mode for the behavioural goal.

5 Click an icon of one of the behavioural goals or a period in the timeline, to see a detailed overview of the patient's self-reported behavior for that behavioural goal (reported in the ePRO application or in the mobile app). Select the period from the date picker.

6 The numbers in the chart indicate the level of guidance that the patient was in at that moment for the behavioural goal.



# How to follow up on the patient's progress for parameters?

1 The "Parameters" tab in "Progress", shows an overview of the patient's progress for his/her parameters. The available parameters are blood pressure, weight, lipids, and glucose.

2 The chart depicts the evolution of the parameter over time. You can hover over a dot to see the exact value for a certain date or the average for a certain period.

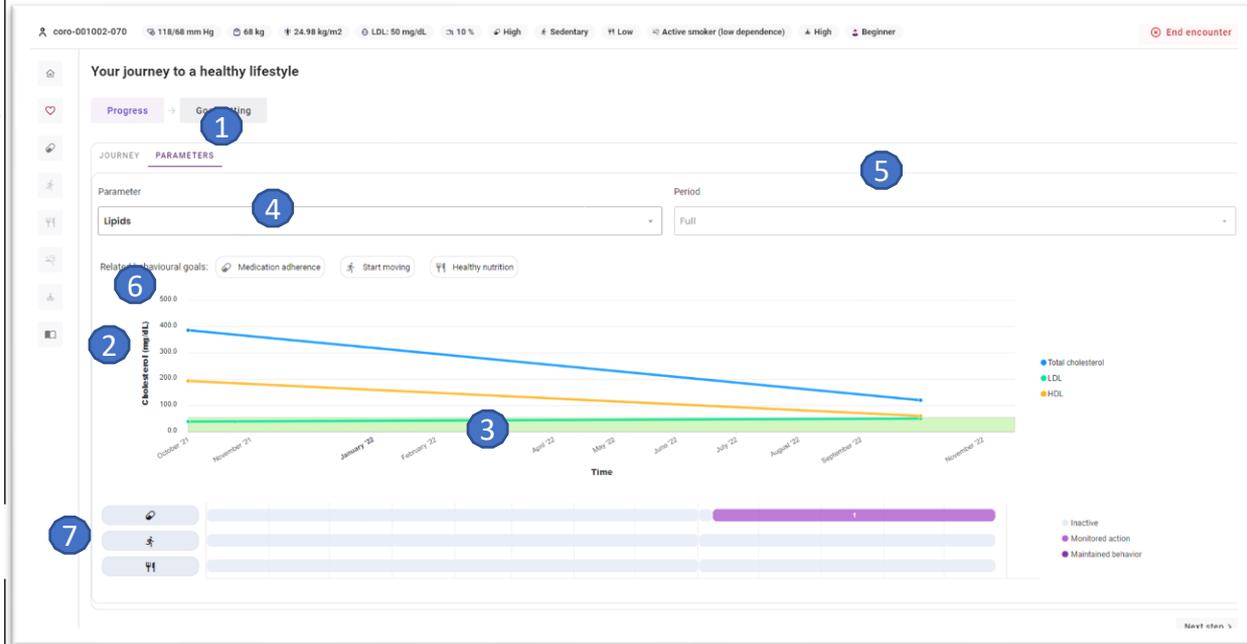
3 The green area is the personalized target zone that the patient should strive to achieve.

4 You can choose which parameter you want to visualise.

5 You can choose the timeframe that you want to visualise.

6 There is an overview of the behavioural goals that are related to the selected parameter.

7 For each related behavioral goal, you can view in which level of guidance the patient was for that behavioral goal over time.



# How to set the patient's behavioural and outcome goals

1. In "Goal setting", you can set the patient's
  - a) behavioural goals and
  - b) outcome goals. The patient should aim to achieve the outcome goals by working on the behavioural goals.

CoroPrevention Alpha 001002 Q coro-001002-070 (1960)

100/50 mm Hg 94 kg 29.01 kg/m2 LDL: 61 mg/dL 10 % High Sedentary Low

Active smoker (low dependence) High Beginner

### Your journey to a healthy lifestyle

Status → Goal setting 1

BEHAVIOURAL GOALS OUTCOME GOAL

	Status	Motivation	Decision
Medication adherence	High	High	Inactive
Start moving	Sedentary	High	Start action
Healthy nutrition	Low	High	Monitc

Medication adherence

Start moving

# How to change the configuration of the levels of guidance for the patient's behavioural goals

1 In the "Behavioural goals" tab in "Goal setting", select together with the patient for each behavioural goal its level of guidance.

View the current status, i.e., how well the patient is doing in terms of outcomes.

2 This is the same as the information depicted in the risk profile bar (at the top in the caregiver dashboard). You can use this information when determining the patient's level of guidance for a behavioural goal.

View how motivated the patient is to work on the behavioural goal. You can use this information when determining the patient's level of guidance for a behavioural goal.

For each behavioural goal, the goal is to discuss and decide together with the patient in which level of guidance the patient will be.

There are three levels of guidance: "start action", "monitored action", and "maintained behavior".

4 Change the level of guidance of a behavioural goal by dragging the behavioural goal to the desired level of guidance. If the patient doesn't want to work on a behavioural goal, leave that goal at inactive.

Changes to level of guidance done in the caregiver dashboard, will be automatically applied in the patient mobile application.

The screenshot shows the CoroPrevention Alpha caregiver dashboard for patient 001002. The patient's profile includes vital signs: 100/50 mm Hg, 94 kg, 29.01 kg/m2, LDL: 61 mg/dL, 10% cholesterol, High blood pressure, Sedentary activity, and Low cholesterol. The 'Your journey to a healthy lifestyle' section is active, showing a table of behavioural goals. The table has columns for Status, Motivation, and Decision. The 'Medication adherence' goal is highlighted with a blue circle 1, and its status is 'High' (green), motivation is 'High' (green), and decision is 'Inactive'. The 'Start moving' goal has status 'Sedentary' (red), motivation 'High' (green), and decision 'Start moving'. The 'Healthy nutrition' goal has status 'Low' (red), motivation 'High' (green), and decision 'Start moving'. A 'Medication adherence' goal is also shown in the decision column.

	Status	Motivation	Decision
Medication adherence	High	High	Inactive
Start moving	Sedentary	High	Start moving
Healthy nutrition	Low	High	Start moving

Note: For the behavioural goal "Medication adherence", only "inactive", "monitored action" and "maintained behaviour" are available.

Note: "Smoke-free living" and "Stress relief" will be made available mid 2024 hence these are currently set on "inactive".

# How to set the patient's outcome goals?

1 In the "Outcome goals" tab in "Goal setting", you can select the outcome goals for the patient. In contrast to the behavioural goals, here direct measured outcomes are given.

2 You can view how well the patient is doing for each outcome goal. This is directly linked to the patient's current parameter values.

The outcome goals are automatically updated by the system based on the patient's reported parameter values. However, if desired, you can adjust this.

3 Note: If a patient reports a not optimal parameter value (e.g. high blood pressure) in the mobile app or the nurse reports a not optimal parameter value in the "Start an encounter" screen in the dashboard, the related outcome goal (e.g. "Lowering blood pressure") is enabled automatically. The same applies for other parameters/outcome goals."

The screenshot shows the 'Your journey to a healthy lifestyle' dashboard. At the top, patient parameters are listed: 100/50 mm Hg, 94 kg, 29.01 kg/m2, LDL: 61 mg/dL, 10 %, High, Sedentary, Low. Below this, the 'Goal setting' tab is active, indicated by a blue circle '1'. The dashboard is divided into 'BEHAVIOURAL GOALS' and 'OUTCOME GOAL'. The 'OUTCOME GOAL' section has a 'Status' column (blue circle '2') and an 'Outcome goal' column (blue circle '3').

	Status	Outcome goal
Lowering blood pressure	Moderate	<input checked="" type="checkbox"/>
Healthy weight	Moderate	<input checked="" type="checkbox"/> <a href="#">Add target weight</a>
Lowering cholesterol	Poor	<input checked="" type="checkbox"/>
Diabetes management	Poor	<input checked="" type="checkbox"/>

# How to set the patient's outcome goals?

4 You can, together with the patient, set a target weight. When you add a target weight and the patient's current BMI is more than 25 kg/m<sup>2</sup>, the recommended target weight is set automatically to a 5 percent weight reduction. If the patient's BMI is already 25 kg/m<sup>2</sup> or lower, it is recommended to maintain the same weight

5 You can, together with the patient, remove the target weight.

The screenshot displays the CoroPrevention Alpha caregiver dashboard for a patient named Emmanuel Rivers. The patient's ID is 001002, and their search ID is coro-001002-070 (1980). The dashboard shows various patient metrics: 100/50 mm Hg blood pressure, 94 kg weight, 29.01 kg/m<sup>2</sup> BMI, 61 mg/dL LDL cholesterol, and 10% HbA1c. The patient is categorized as an active smoker (low dependence), high risk, and sedentary. The main section is titled "Your journey to a healthy lifestyle" and includes a "Goal setting" tab. Under the "OUTCOME GOAL" tab, there is a table of goals:

Goal	Status	Outcome goal
Lowering blood pressure	Moderate	On
Healthy weight	Moderate	On
Lowering cholesterol	Poor	On
Diabetes management	Poor	On

On the right side of the dashboard, the "Target weight" is set to 66 kg. A red button labeled "Remove target weight" is visible next to the target weight field. The number 4 is circled in blue, and the number 5 is circled in blue, indicating the steps described in the text.



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# Case nurse manual caregiver dashboard - education module

V6.0, 14.10.2024



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# How to follow up on the patient's disease-related knowledge?

1 In "Progress", you have an overview of the patient's progress for his/her disease-related knowledge. The patient's disease-related knowledge is assessed in the knowledge challenge. This is a small quiz consisting of 14 multiple-choice questions. The maximal score is 14.

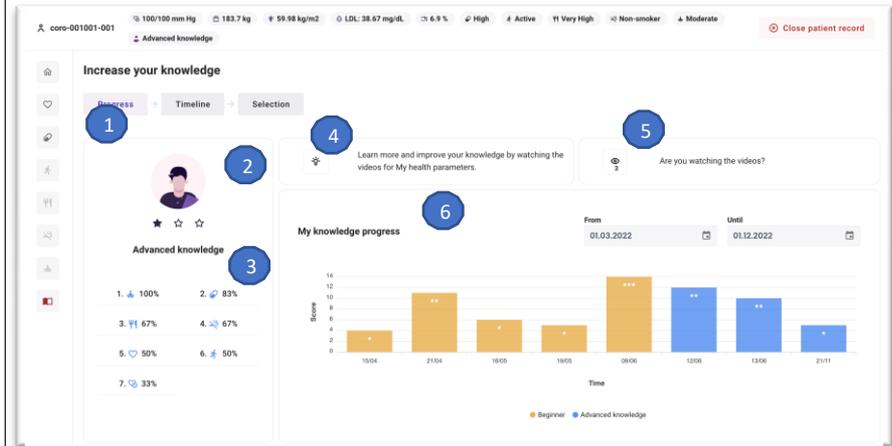
2 You can view the patient's current knowledge level. There are three knowledge levels: beginner, advanced knowledge, and health expert. Within these levels, the patient can attain 1, 2 or 3 stars, depending on the number of correct answers in the last knowledge challenge.

3 There is an overview of how well the patient's knowledge is for different categories. The categories are respectively: stress relief, medication adherence, healthy nutrition, smoke-free living, my heart, start moving, and health parameters. The percentage indicates how well the patient scored on this category in his/her current knowledge level.

4 There is a tip that about which categories the patient needs to improve his/her knowledge. This tip can be used in the shared decision making conversation with the patient.

5 There is an overview of how many educational videos the patient watched since the last visit.

6 The graph depicts the evolution of the patient's score on the knowledge challenge over time. The different colors indicate the patient's knowledge level at that moment. The stars in the bar depict the patient's score on the knowledge challenge. In the upper right corner, you can adjust the time period shown in the chart.



# How to follow up on the personalized educational material sent to the patient?

1 In "Timeline", you can follow up on how many of the personalized educational items (e.g. video, article, image) that you sent to the patient were viewed by the patient.

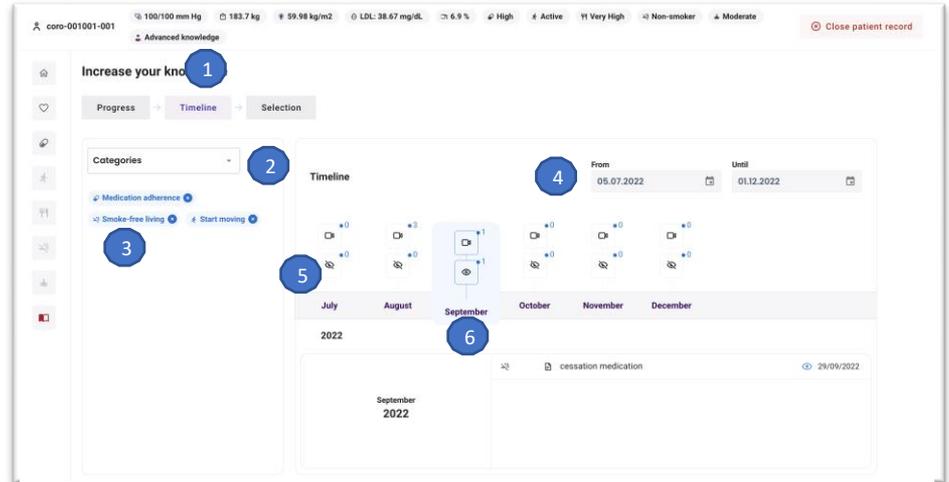
2 You can select the categories (multiple) that you want to include in the timeline.

3 Categories that are currently selected are displayed. These can be removed by clicking on the "cross" icon.

4 You can change the time period that you want to see in the timeline.

5 The timeline shows per month how many educational items were sent to the patient ("camera" symbol) and how many of these items were viewed by the patient ("eye" symbol).

6 You can click on a month to view more detailed information about the educational items that were sent to the patient.



# How to select personalized educational material for the patient?

1 In "Selection", you can select the educational content that is relevant for the patient.

2 Overview of action related educational material that is available in the CoroPrevention Tool Suite. For each educational item, there is an icon representing the type of education (i.e. text, image or video), the category and if the patient already viewed this educational item or not.

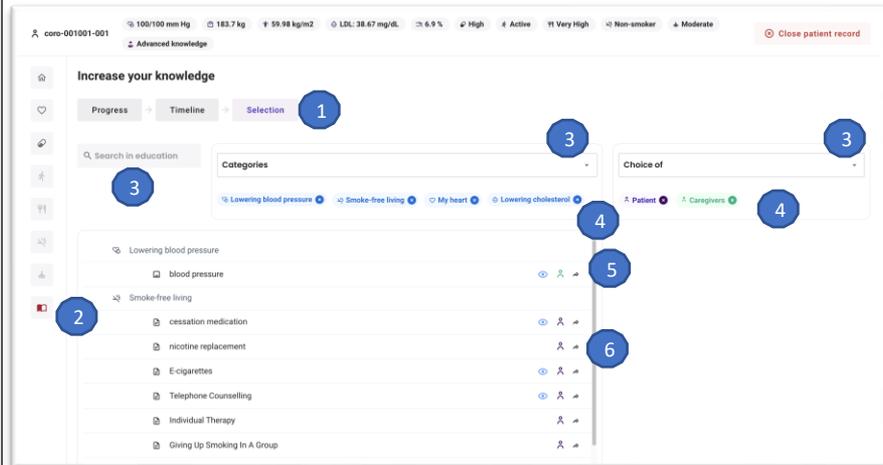
3 You can search educational content by using the search function.

3 You can also apply filters to look for specific educational content based on the category or who selected the educational content.

4 You can view the filters for the category and choice of that are currently applied. You can remove any of these filters by clicking on the "cross" icon.

5 Based on the patient's current outcome and behavioural goals, a set of recommended educational content is automatically selected for the patient. As a caregiver, you can also update this set of recommended educational content. Educational content that is selected by the algorithm or by you, has a "caregiver" symbol.

6 Educational content that is selected by the patient has a "patient" symbol.



# How to select personalized educational material for the patient?

7 You can remove an educational item from the patient's or caregiver's choice by clicking on the "patient" or "caregiver" symbol respectively.

8 You can click on the educational item to view more information (i.e. title, content type, number of related questions of the knowledge challenge that the patient answered wrong, how many times the educational item was sent to the patient, and how many times the educational item was viewed by the patient).

9 You can add the educational item to the patient's favourites by clicking this button.

10 You can send the educational item to the patient as a notification (i.e. in an application reminder) by clicking this button.

11 You can also send the educational item to the patient (i.e. in an application reminder) by clicking on the "share" icon.

The screenshot displays the 'Increase your knowledge' section of the CoroPrevention Caregiver dashboard. At the top, patient information is shown: core-001002-239, 170/80 mm Hg, 64 kg, 23.51 kg/m2, LDL: 116 mg/dL, 5%, High, Sedentary, 91 Low, Active smoker (low dependence), High, Beginner, and a 'Close patient record' button. The main area is titled 'Increase your knowledge' and has tabs for 'Progress', 'Timeline', and 'Selection'. A search bar labeled 'Search in education' is on the left. Below it, a 'Categories' dropdown is set to 'Lowering cholesterol', with other categories like 'Medication adherence', 'Diabetes management', 'Healthy weight', 'My heart', 'Lowering blood pressure', 'Start moving', and 'My social environment'. A list of educational items follows, with 'LDL & HDL Cholesterol' selected. This item has a 'Share' icon (4), a 'Favorite' icon (8), and a 'Send to patient as a notification' icon (7). The right sidebar shows the 'Choice of' section with 'Patient' selected (7) and 'Caregiver' as an alternative. Below this, the 'Title' is 'LDL & HDL Cholesterol' (8), and the 'Content type' is 'Image'. It also shows 'Related questions answered wrong' (0), 'Sent' (0), and 'Watched' (0). At the bottom of the sidebar, there are buttons for 'Add to patient Favorites' (9) and 'Send to patient as a notification' (10).



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# Case nurse manual caregiver dashboard - medication adherence module

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# How to view the patient's status for medication adherence?

- 1 In "Status", you have an overview of the patient's status for medication adherence.  
You can see how the patient describes his/her medication adherence in general.
- 2 Note: The "Status" button is available until the end of visit 2. After that, see "Progress" button on next page of this manual.
- 3 You can see an overview of the patient's barriers for medication adherence (only V2). The barriers are based on the patient's answers on the Identification of Medication Adherence Barriers (IMAB) questionnaire that was completed in the ePRO application at V1. Higher IMAB scores are indicative of the greater barriers for medication adherence.
- 4 The elements indicated in green are no barriers for the patient.
- 5 The elements indicated in orange are small barriers for the patient.
- 6 The elements indicated in red are major barriers for the patient. These are the elements that the patient has limited knowledge about, or that go wrong on a regular basis. These are the patient's main points for improvement and should be the focus of the shared decision making discussion.

The screenshot displays the 'Medication adherence' section of a patient's record. At the top, there are patient vitals and a navigation bar with 'End encounter'. Below this, the 'Medication adherence' section is divided into 'Status' and 'Prescription' tabs. The 'Status' tab is active and shows a 'High' adherence level with the text 'I always take my medication as prescribed', reported on 01/12/2022. Below this, the 'Medication adherence barriers' section shows a score of 33, also reported on 01/12/2022. The barriers are categorized into three levels: 'No barrier' (green), 'A small barrier' (orange), and 'A big barrier' (red). The 'No barrier' category includes 'Know how to take', 'Physically able', and 'Worry about unwanted effects'. The 'A small barrier' category includes 'Remember to take' and 'Feels a burden'. The 'A big barrier' category includes 'Getting hold of medication', 'Confidence in managing', 'Life gets in the way', 'Coping with changes', and 'Social worries'. Navigation buttons for 'Go to journey' and 'Next step' are visible at the bottom.

# How to follow up on the patient's progress for medication adherence?

1 In "Progress", you have an overview of the patient's progress for medication adherence.

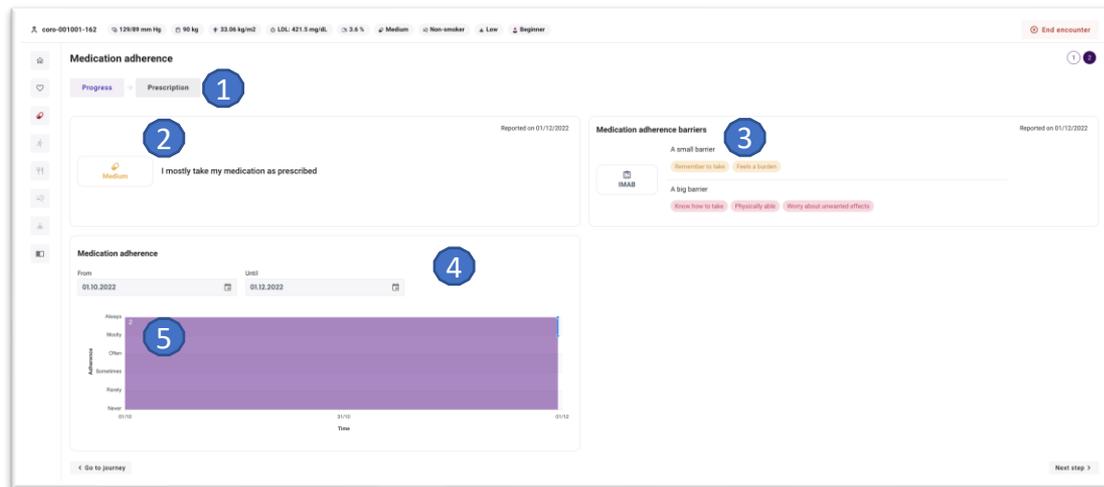
2 You can see how the patient describes his/her medication adherence in general.

The patient's small (orange) and major (red) barriers for medication adherence are depicted. The barriers are based on the patient's answers on the

3 Identification of Medication Adherence Barriers (IMAB) questionnaire that was completed in the ePRO application. The IMAB questionnaire assesses the patient's difficulties with taking medication.

The chart depicts how the patient's medication adherence evolved over time. The medication adherence was reported by the patient in the mobile application or the ePRO application. With date picker you can adjust the time period shown in the chart.

The numbers in the chart indicate the level of guidance 5 for "Medication adherence" that the patient was in at that moment.



# How to follow up on the patient's progress for medication adherence?

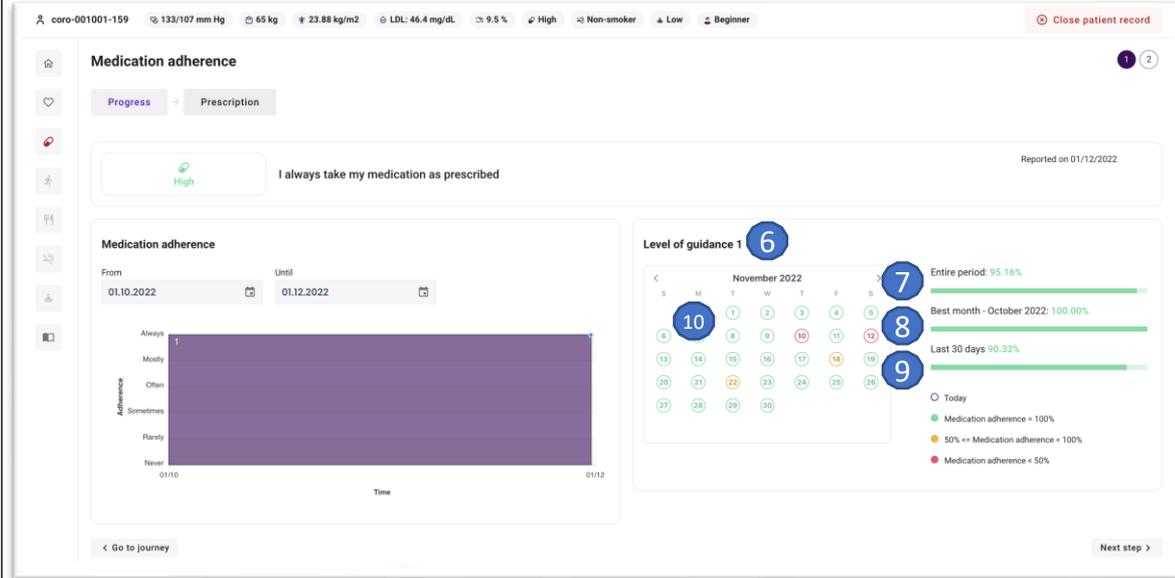
6 You can click on a period in a level of guidance to view more details about this period.

7 You can view the medication adherence percentage over this entire period in level of guidance 1 for "Medication adherence".

8 You can view the best month of this period in level of guidance 1 for "Medication adherence".

9 You can view the medication adherence percentage of the last 30 days in this period in level of guidance 1 for "Medication adherence".

10 In the calendar overview, you can view on which days the patient's medication adherence was good (green), moderate (orange), or bad (red).



# How to view the patient's medication prescription?

1 In "Prescription", you have an overview of the patient's medication prescription.

2 The patient's current medication prescription is shown. There is also an indication of the changes that were made since last encounter. These changes are especially relevant to discuss with the patient.

3 Drugs that were added since last visit are indicated by a "plus" icon.

4 Drugs that were edited since last visit are indicated by a "pencil" icon.

5 Drugs that were deleted since last visit are scratched through.

6 Pills are indicated by a "pill" icon, while injections are indicated by a "syringe" icon.

7 You can click on a row in the medication prescription to view more information about the drug.

8 You can view the parameters that the medication is related to, the reason why the patient has to take the medication, the date that it was prescribed and by whom it was prescribed, and which changes were made to this drug over time. There is also an infographic that you can use in the discussion with the patient to explain the mechanisms that the drug works on and the reason why the patient has to take the drug.

9 To be able to view the additional information about a drug, the medication class of the drug should be selected.

10 You can record additional notes for the drug.

11 If you have an investigator role in the study / in dashboard, you can open the medication decision support system by clicking this button.

12 You can print the medication prescription for the patient and the recommendations for the patient's general practitioner by clicking these buttons.

The screenshot displays the 'Medication adherence' section of a patient's record. At the top, there are patient vitals and a 'Close patient record' button. The main area is titled 'Medication adherence' and has a 'Prescription' tab selected. Below this, there are buttons for 'Print for patient', 'Print for general practitioner', and 'Open medication decision support'. The 'Current prescription' section lists three medications: Aspirin (+), Tadalafil, and Bisoprolol (L). Each medication row includes a plus icon (3), a pencil icon (4), a pill icon (5), the medication name (6), dosage (7), and medication class (9). A right-hand panel shows details for 'Aspirin', including 'Related parameters' (8), 'Reason' (To prevent thrombus formation), and 'Change history' (When: 01/12/2022, Who: Investigator, What: Added the drug to the prescription). An infographic titled 'P21616 inhibitors' is also visible. At the bottom, there is a 'Notes' section (10) and a 'Print for general practitioner' button (11).



**CoroPrevention**

PERSONALISED PREVENTION FOR  
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# Case nurse manual caregiver dashboard - medication DSS

V6.0, 14.10.2024

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*This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 848056*

# How to open the medication decision support system (medication DSS)?

There are three ways to open the medication DSS.

1 In the patient summary, you can open the medication DSS by clicking this button.

2 Open the patient record, click the "House" menu item to open the medication DSS by clicking the "Open medication decision support" button.

3 In the "Medication adherence" module, you can go to "Prescription" and click on this button to open the medication DSS.

Note: The nurse role can open and add/edit the medication DSS until the visit 2 is closed in the dashboard. Nurse cannot run the medication DSS algorithm.

CoroPrevention Alpha 001002 coro-001002-070 (1960) Emmanuel Rivera

Patient

1 Open medication decision support Open patient record

General

Subject ID coro-001002-070

Gender Male

Year of birth 1960

Start date 01-10-2021

https://tablet-uat.coroprevention.eu/session/start

Print QR code for ePRO application

Print QR code for mobile app Logout mobile app

Patient dropped out

Consultations during the study

Parameters

Blood pressure 100/50 mm Hg

Weight 93 kg

BMI 28.7 kg/m<sup>2</sup>

LDL cholesterol 61 mg/dL

HbA1c - (Glucose) 10%

CoroPrevention Alpha 001002 coro-001002-070 (1960) Emmanuel Rivera

100/50 mm Hg 93 kg 28.7 kg/m<sup>2</sup> LDL: 61 mg/dL 10% High Sedentary Low

Active smoker (low dependence) High Beginner

2 Open medication decision support

3 Open medication decision support

Medication adherence

Progress Prescription

Print for patient Print for general practitioner Open medication decision support

Current prescription

Bisoprolol 2.5 mg Medication class(es) Beta Blockers

Daily

MORNING NOON AFTERNOON EVENING/NIGHT

Xarelto 2.5 mg Medication class(es) Direct oral anti...

Daily

MORNING NOON AFTERNOON EVENING/NIGHT

Tap the drug to view more information about the drug.

# How to navigate in the medication DSS?

1 There are four tabs in the medication DSS: a) cardiac medication, b) other medication, c) allergies, and d) titration schemes.

2 You can save the medication prescription by clicking this button. After saving the medication prescription, the changes are automatically made to the patient's medication prescription on his/her smartphone.

3 You can print the medication prescription by clicking any of these buttons.

4 If the patient has a low renal function, there is a warning indicating this.

5 You can close the medication DSS by clicking this button. You cannot leave the medication DSS when the medication prescription is incomplete.

coro-001002-070 158/139 mm Hg 79 kg 29.02 kg/m<sup>2</sup> LDL: 54 mg/dL 10% High Sedentary Low Active smoker (low dependence) High

Beginner

1 Medication decision support system 2 Save and close 3 Print for general practitioner Print for patient Refresh Algorithm

a Cardiac medication b Other medication c Allergies d Titration schemes

4 ⚠️ Low renal function (eGFR 4 ml/min/1.73m<sup>2</sup>). The patient age for the algorithm can be up to year older than the EDC reported value.

Current prescription

Bisoprolol 20 mg Beta blockers

	Morning	Noon	Afternoon	Evening/night
Daily	1	0	0	1

No notes added

More info

Change history

# How to prescribe cardiac medication following the guidelines using the medication DSS?

12 If the drug was added to the medication prescription by the patient since last encounter, there is an icon indicating this.

The screenshot displays a medication entry for Aspirin 20 mg. The interface includes a header with the drug name, dosage, and unit, and a table for frequency. A small icon in the top right corner of the entry indicates it was added by the patient. Below the table, there are sections for notes and change history.

	Morning	Noon	Afternoon	Evening/night
Daily	1	0	0	0

No notes added

Change history

# How to prescribe cardiac medication following the guidelines using the medication DSS?

1 In the "Cardiac medication" tab, you find an overview of all cardiac medication entered into the prescription.

If the drug has a **green** background color, it means that the drug is already correctly prescribed, as recommended by the ESC guidelines.

If the drug has a **yellow** background color, it means that the drug was added by the algorithm of the medication DSS because it is recommended according to the guidelines.

You have to check if you want to follow this recommendation and if that is the case, complete the missing information for the drug. After completing the missing information, the background color for the drug changes from yellow to green.

If the drug has a **white** background color, it means that the drug is not recommended according to the guidelines. It is also possible that a drug is a combination drug of which some components are recommended by the guidelines and some others are not. This is indicated by a white row with a recommendation icon for the recommended medication classes.

Note: The color-codes and recommendation algorithm are visible for investigators only.

3 View the route of administration (i.e. oral/pill or injection medication), the name and the dosage (dose and unit) of the drug.

4 View the medication class(es) of the drug. If it is a combination drug, multiple medication classes are indicated.

The screenshot displays the medication DSS interface. At the top, patient information is shown: 001002-070, 156/139 mm Hg, 79 kg, 29.02 kg/m<sup>2</sup>, LDL: 54 mg/dL, 10%, High, Sedentary, 11 Low, Active smoker (low dependence), High, Beginner. Below this, there are tabs for Cardiac medication, Other medication, Allergies, Titration schemes, and Algorithm input. The 'Current prescriptions' section shows a prescription for Bisoprolol 20 mg, classified as a Beta blocker. The prescription is shown in a green box, indicating it is correctly prescribed. The dosage is 20 mg, and the frequency is Daily. The route of administration is not explicitly stated, but the dosage and frequency suggest oral administration. The medication class is Beta blocker. The recommendation section shows a recommendation for Direct oral anticoagulants, which is not currently prescribed. The recommendation is shown in a white box, indicating it is not recommended. The interface also includes a 'More info' dropdown and a 'Change history' dropdown for the current prescription.

# How to prescribe cardiac medication following the guidelines using the medication DSS?

5 View the frequency and at what time(s) the that the patient is prescribed to take the drug.

6 View the notes about the drug.

7 Edit the drug by clicking this button.

You can delete the drug from the medication prescription by clicking this button. If you delete a drug that is recommended according to the guidelines, you will be asked to state the reason why you rejected the recommendation. Immediately after deleting one of the drugs the action can be undone by clicking the "Undo" button in the confirmation message. If you delete a recommended drug, it is only deleted from the prescription but still shown in the recommendations.

8 You can view more information about the drug by clicking this button. The detailed information includes: the class of recommendation, the level of evidence, the guideline information, the guideline source, and the changes that were made to this drug in the past.

9 You can add a drug to the patient's medication prescription by clicking this button. When prescribing the same medication class twice, a warning will be displayed.

10 You can view the change history for the drug.

The screenshot displays the medication DSS interface for a patient with ID 'coro-001002-070'. The patient's profile includes vital signs and clinical data: 158/139 mm Hg, 79 kg, 29.02 kg/m<sup>2</sup>, LDL 54 mg/dL, 10%, High, Sedentary, Low, Active smoker (low dependence), High, Beginner. The interface is divided into 'Current prescription' and 'Recommendation' sections.

**Current prescription:** Shows a prescription for Bisoprolol 20 mg, classified as Beta blockers. The frequency is Daily, with doses at Morning (1), Noon (0), Afternoon (0), and Evening/night (1). Callouts 5 and 6 point to the frequency and time columns. Callout 7 points to the edit button, and callout 8 points to the delete button. Callout 9 points to the 'More info' button, and callout 11 points to the 'Change history' button.

**Recommendation:** Shows a recommendation for Direct oral anticoagulants. The frequency is Daily, with doses at Morning (0), Noon (0), Afternoon (0), and Evening/night (0). Callout 10 points to the 'Add drug' button. A message states: 'This medication has been recommended by the algorithm.'

# How to make changes to the patient's medication prescription?

1 Save the changes to the patient's medication prescription by clicking this button.

2 After you clicked the "Save and close" button, you have an overview of the patient's medication prescription (cardiac and other medication) and the titration schemes.

3 Return to the medication DSS to edit the patient's prescription by clicking this button.

Note: You cannot exit the medication DSS if there are "open recommendations" (i.e., recommendations that were not accepted or rejected by the caregiver).

The screenshot shows the top of the Medication decision support system (DSS) interface for patient coro-001002-070. The patient's status is 'Beginner'. A blue circle with the number '1' highlights the 'Save and close' button. The interface includes navigation tabs for 'Cardiac medication', 'Other medication', 'Allergies', 'Titration schemes', and 'Algorithm input'. A warning message is visible: 'Low renal function (eGFR 10 ml/min/1.73m2). The patient age for the algorithm can be up to 1 year older than the EDC reported value'. The 'Current prescription' section shows 'Bisoprolol' 2.5 mg, Beta blockers, with a dosing table for Morning, Noon, Afternoon, and Evening/night.

The screenshot shows the Medication decision support system (DSS) interface for patient coro-001002-070. The patient's status is 'Beginner'. A blue circle with the number '3' highlights the 'Edit prescription' button. The interface shows the 'Cardiac medication' section with 'Bisoprolol' 2.5 mg, Beta blockers, and a dosing table. Below it, the 'Other medication' section shows 'Totalip' 20 mg, Statins, with a dosing table. A blue circle with the number '2' highlights the 'Cardiac medication' tab.

# How to make changes to the patient's medication prescription?

4 You can return to the CoroPrevention caregiver dashboard by clicking this button.

The screenshot displays the patient's profile and medication management interface. At the top, patient information includes ID (coro-001002-070), age (100/50 mm Hg), weight (93 kg), BMI (28.7 kg/m2), cholesterol (LDL: 61 mg/dL), and other clinical data. A 'Beginner' alert is visible. The medication management section shows a table for 'Daily' dosing with columns for Morning, Noon, Afternoon, and Evening/night. Below this, the medication 'Ozempic' is listed with a dosage of 0.5 mL. A table for 'Being repeated for every 1 Week(s) on Tuesday' shows dosing frequency for Morning, Noon, Afternoon, and Evening/night. A 'Titration schemes' section provides details for a beta blocker, including start and target dosages and a description. A 'Go to patient overview' button is located at the bottom right.

	Morning	Noon	Afternoon	Evening/night
Daily	1	0	0	0

	Morning	Noon	Afternoon	Evening/night
Being repeated for every 1 Week(s) on Tuesday	0	0	0	1

Titration scheme for beta blocker	
Start dosage	25 mg
Target dosage	75 mg
Description	Increase after 3 weeks when there are no contraindications

# How to view the patient's other (non-cardiac) drugs in the medication DSS?

Note: It is not mandatory to enter other medication to the Tool Suite. No medication decision support system algorithm is applied on the other medication.

1 In the "Other medication" tab, view the non-cardiac medication entered.

2 You can view the way of administration (i.e. oral/pill or injection medication) of the drug.

3 You can view the name of the drug.

4 You can view the dosage of the drug (dose and unit).

5 You can view the frequency that the patient has to take the drug.

6 You can view at what time(s) the patient has to take the drug.

The screenshot shows the 'Medication decision support system' interface for patient 'coro-001002-070'. The patient's profile includes vital signs (100/50 mm Hg, 93 kg, 28.7 kg/m<sup>2</sup>, LDL: 61 mg/dL, 10%), risk factors (High, Sedentary, Low), and smoking status (Active smoker). The navigation bar shows 'Other medication' as the active tab. The 'Current prescription' section lists two medications: Fulfium D3 800 (80 ug) and Ozempic (0.5 mL). The Fulfium D3 800 prescription is detailed with a frequency of 'Daily' and a dosage of '1' in the 'Morning' column. The Ozempic prescription is detailed with a frequency of 'Being repeated for every 1 Week(s) on Tuesday' and a dosage of '1' in the 'Evening/night' column. Two warning messages are visible: 'Low renal function (eGFR 10 ml/min/1.73m<sup>2</sup>)' and 'The patient age for the algorithm can be up to year older than the EDC reported value'.

# How to view the patient's allergies in the medication DSS?

1 In the "Allergies" tab, the medication allergies entered for the patient are shown. This includes notes about aspirin and ACE inhibitor intolerance.

The screenshot displays the CoroPrevention Alpha Medication Decision Support System (DSS) interface. At the top, the patient's name is Emmanuel Rivera. The patient ID is 001002, and the search query is coro-001002-070 (1960). The patient's demographic and clinical information is shown below, including blood pressure (100/50 mm Hg), weight (93 kg), BMI (28.7 kg/m2), LDL (61 mg/dL), and other factors like sedentary status and active smoker status. The 'Allergies' tab is selected and highlighted with a blue circle containing the number 1. The 'Allergies' section shows 'No aspirin intolerance' and 'No ACE inhibitor intolerance'. There are also two warning messages: 'Low renal function (eGFR 10 ml/min/1.73m2)' and 'The patient age for the algorithm can be up to 1 year older than the EDC reported value.'

# How to view and edit the patient's titration schemes in the medication DSS?

In the tab "Titration schemes", define the titration schemes for medication that should be up-titrated.

- 1 You can create two types of titration schemes: dosage titration schemes and drug addition titration schemes.  
Create a new dosage titration scheme by clicking this button. A dosage titration scheme defines for a certain drug the start and target dosage.
- 2 Create a new drug addition titration scheme by clicking this button. A drug addition titration scheme defines a start medication class and medication classes that should be added based on the patient's parameter values.
- 3 Edit the titration scheme by clicking this button.
- 4 Delete the titration scheme by clicking this button.

The screenshot displays the 'Titration schemes' tab in the medication DSS interface. The patient's profile is visible at the top, including parameters like '100/50 mm Hg', '93 kg', '28.7 kg/m2', 'LDL: 61 mg/dL', '10%', 'High', 'Sedentary', '1 Low', 'Active smoker (low dependence)', 'High', and 'Beginner'. The 'Titration schemes' tab is selected, and a blue circle '1' highlights the 'Titration schemes' breadcrumb. Below the breadcrumb, there are two sections for titration schemes. The first section is titled 'Titration scheme for beta blocker' and shows 'Start dosage: 25 mg', 'Target dosage: 75 mg', and 'Description: Increase after 3 weeks when there are no contraindications'. To the right of this section are two blue circular buttons labeled '4' and '5'. The second section is titled 'Titration scheme for angina pectoris' and shows 'Start medication: Beta blockers', 'Add medication: Calcium channel blockers', and 'Description: If the angor is not controlled with the beta blocker, consider adding the extra drug'. At the bottom of the interface, there are two buttons: 'Add dosage titration scheme' and 'Add drug addition titration scheme'. A blue circle '2' is positioned below the 'Add dosage titration scheme' button, and a blue circle '3' is positioned below the 'Add drug addition titration scheme' button.



**CoroPrevention**

PERSONALISED PREVENTION FOR  
CORONARY HEART DISEASE

# Case nurse manual caregiver dashboard – Physical activity module (including EXPERT tool)

V6.0, 14.10.2024



[www.coroprevention.eu](http://www.coroprevention.eu)



*This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 848056*

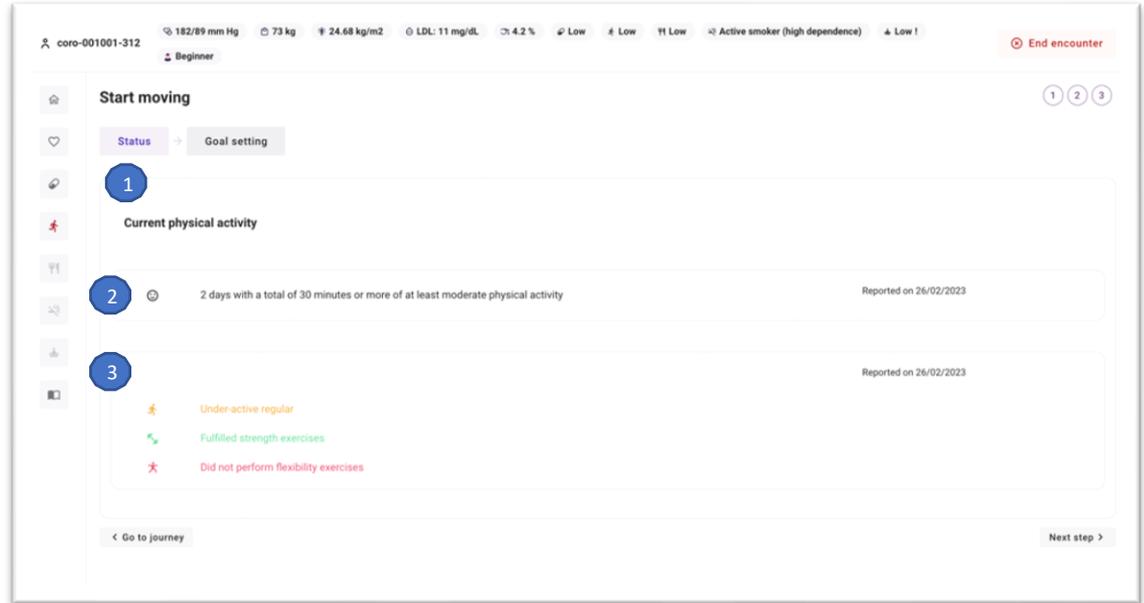
# How to view the patient's current status for physical activity?

1 In "Status" / "Progress", you have an overview of the patient's current physical activity, as reported in the ePRO application.

2 Note: The "Status" button is available until the end of visit 2. After that you will see "Progress" button.

3 You can view how much the patient is moving globally.

You have an overview of the results of the Rapid Assessment of Physical Activity (RAPA) questionnaire. This includes how active the patient is, if the patient performs strength exercises, and if the patient performs flexibility exercises.



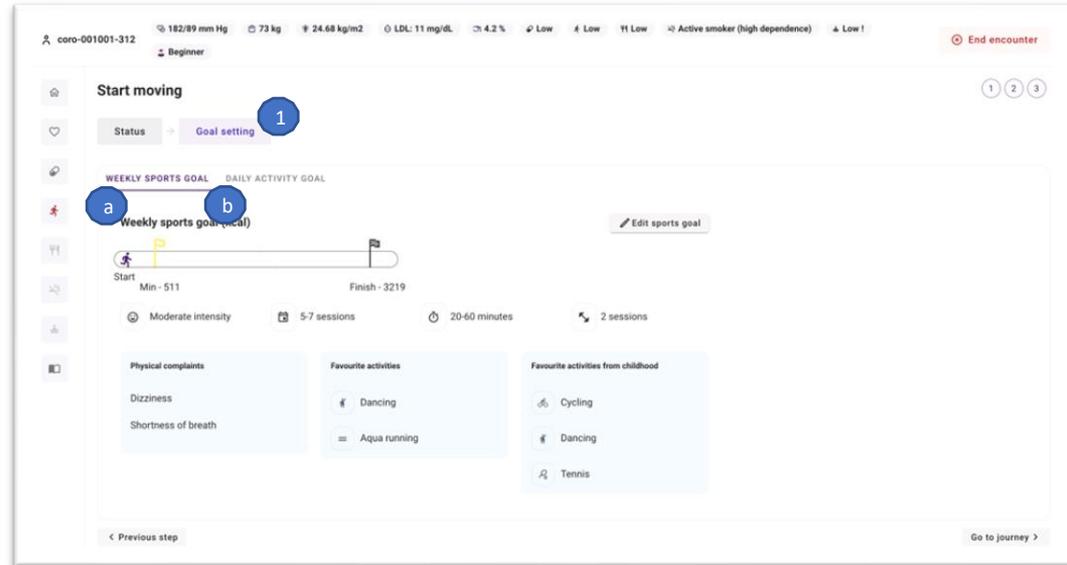
# Which types of physical activity goals can be set for the patient?

- 1 In "Goal setting", you can set the patient's goals for physical activity. Two types of physical activity goals can be set: a) a weekly sports goal and b) a daily activity goal.

Note:

- If no existing goals are yet set for the "monitored action" (level of guidance 2) for "Start moving", the goal becomes applicable from the moment that you save the goal.

- When you edit the physical activity goals for the patient and the patient already has a goal for the ongoing week, the updated goal becomes applicable as of Monday (i.e., start of the new week).



# How to set and edit the patient's weekly sports goal?

1 In the "Weekly sports goal" tab in "Goal setting", view the patient's weekly sports goal for next week.

An overview of the patient's weekly sports goal is shown, expressed in kcal. The flags denote the minimal and optimal goal for the weekly sports goal.  
2 The patient should strive to achieve at least the yellow flag but aim for the finish flag.

3 There is an overview of the exercise prescription, consisting of: the recommended exercise intensity, the recommended number of exercise sessions, the recommended session duration, and the recommended number of strength training sessions.

4 The physical complaints that the patient indicated (in the ePRO application) that he/she suffers from are depicted. This information can be taken into account when setting the weekly sports goal.

5 The patient's current favourite activities are depicted. This information can be taken into account when discussing how to achieve the weekly sports goal.

6 The patient's favourite activities from childhood are depicted. These can be used to motivate the patient to possibly restart this activity.

7 You can edit the patient's weekly sports goal (i.e., exercise prescription) in the EXPERT tool. You can open the EXPERT tool by clicking this button.

The screenshot displays the 'Start moving' section of the CoroPrevention Caregiver dashboard. At the top, patient information is shown: 'coro-001001-312', 'Beginner', and various health metrics (182/89 mm Hg, 73 kg, 24.68 kg/m2, LDL: 11 mg/dL, 4.2%, Low, Low, Low, Active smoker (high dependence), Low). A red 'End encounter' button is in the top right. The main content area is titled 'Start moving' and includes a 'Status' dropdown set to 'Goal setting'. Below this, there are two tabs: 'WEEKLY SPORTS GOAL' (selected) and 'DAILY ACTIVITY GOAL'. The 'WEEKLY SPORTS GOAL' section features a horizontal bar chart for 'Weekly sports goal (kcal)' with a yellow flag at the 'Start' (Min - 511) and a black flag at the 'Finish' (3219). Below the chart, the exercise prescription is shown: 'Moderate intensity', '5-7 sessions', '20-60 minutes', and '2 sessions'. There are three sections for activities: 'Physical complaints' (Dizziness, Shortness of breath), 'Favourite activities' (Dancing, Aqua running), and 'Favourite activities from childhood' (Cycling, Dancing, Tennis). A red 'Edit sports goal' button is located to the right of the goal bar. Navigation buttons for 'Previous step' and 'Go to journey' are at the bottom.

# How to set the patient's daily activity goal?

1 In the "Daily activity goal" tab in "Goal setting", you can set the patient's personalized daily activity goal for next week. The daily activity goal is expressed in steps.

2 You can view the patient's current level for the daily activity goal. There are four levels of step goals: inactive (< 2500 steps), beginner (2500-4999 steps), intermediate (5000-7500 steps) and advanced (> 7500 steps).

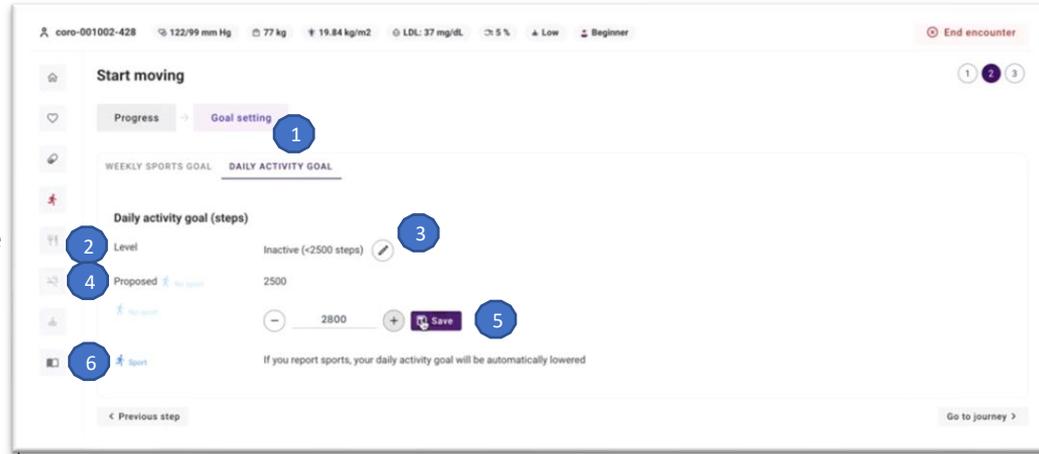
3 You can edit the patient's level for the daily activity goal by clicking this button.

4 Based on the patient's achievement of the daily activity goal last week, there is a proposed daily activity goal no sport\* for next week. If the patient achieved the daily activity goal for that day on at least 5 out of the 7 days and the daily activity goal is not yet at least 7500 steps, the system proposes to increase the daily activity goal no sport by 10 percent. Otherwise, the system recommends that you keep the daily activity goal no sport the same as last week. You can discuss this proposal with the patient.

5 You can edit the patient's daily activity goal no sport for next week.

6 The patient's daily activity goal is different depending on whether the patient performs sports or not. When the patient performs a sports activity, the patient needs to do fewer steps during the day. Therefore, the patient's daily activity goal is lowered automatically on days that he/she reports sports.

Note: if patient reports a sports activity (e.g. between 10h and 11h) the steps taken during that time are not taken into for the daily activity goal. The patients receives a credit for the registered activity.



\*No sport goal is the step goal that the patient should aim to achieve on days that he/she does not perform structured sports activities.

# How to navigate in the EXPERT tool?

The EAPC EXPERT tool is an interactive training and decision support system for exercise prescription in patients with cardiovascular disease. The EXPERT tool is implemented in the CoroPrevention Tool Suite.

1 There are two tabs in the EXPERT tool: a) weekly sports goal and b) safety precautions.

You can save the weekly sports goal and close the EXPERT tool by clicking this button. After saving the weekly sports goal, the changes are automatically made to the patient's weekly sports goal on

2 his/her smartphone.

Note: You cannot leave the EXPERT tool when the weekly sports goal is incomplete or when you did not save the exercise prescription (i.e., accept/reject/change the recommendation).

You can print the weekly sports goal or safety precautions by clicking this button. Depending on the tab where you click this button, the weekly sports goal (i.e., exercise prescription) or safety precautions are printed.

3 Note: The Printout is intended for professionals e.g., an exercise physiologist or physiotherapist if used for creating a detailed exercise program for the patient. The recommendation contains medical terms which might not be understood by the patient hence the printout is not intended to be given to the patients.

The screenshot displays the EXPERT tool interface for a patient. At the top, patient information is shown: coro-001001-312, 182/89 mm Hg, 73 kg, 24.68 kg/m<sup>2</sup>, LDL: 11 mg/dL, 4.2%, Low, Low, Low, Active smoker (high dependence), Low, Beginner. Below this, patient demographics are listed: Female, 44 years, 87 bpm, 723 m. The main area is titled 'EXPERT tool' and has two tabs: 'Weekly sports goal' (labeled 'a') and 'Safety precautions' (labeled 'b'). The 'Safety precautions' tab is active, showing a list of categories: Primary indication (CAD, PCI, CABG, and minimally invasive CABG), Key risk factor (Type 1 Diabetes, Hypertension), Exercise modifier, Anomalies, Medication, and Recommendation. The Recommendation section is highlighted with a blue border and contains the following text: 'IMT after CABG surgery (from 30 up to 60 of Pimax, 20-30 min/session, 3-5 days/week)', 'end exercise session with high-intense or strength exercise to prevent hypoglycemia', 'isometric handgrip exercise training', and 'Strength training exercises: 2 days/week, 40-80% of 1RM, 12-15 reps/set; 2 days/week, 70-85% of 1RM, 8-10 reps/set, at least 21 sets'. At the top right of the interface, there are buttons for 'Save and close' (labeled '2') and 'Print' (labeled '3').

# How to define the patient's weekly sports goal (or exercise prescription)?

1 In the "Weekly sports goal" tab, view and edit the patient's weekly sports goal. The patient's weekly sports goal is represented as the exercise prescription.

2 View the boxes with all the parameters related to cardiovascular diseases. There are five boxes, one for each of the categories included in the EXPERT tool algorithm: primary indications, key risk factors, exercise modifier, anomalies, and medication. You can open each box by clicking on the box.

coro-001001-312 182/89 mm Hg 73 kg 24.68 kg/m<sup>2</sup> LDL: 11 mg/dL 4.2 % Low Low Low Active smoker (high dependence) Low Beginner

Female, 44 years 87 bpm 723 m

EXPERT tool Save and close Print

1 Weekly sports goal Safety precautions

Primary indication Select primary indication: CAD, PCI, CABG, and minimally invasive CABG 2

Key risk factor Select risk factors: Type 1 Diabetes Hypertension 2

Exercise modifier Select exercise modifiers: 2

Anomalies Select anomalies occurred during exercise testing: 2

Medication Select medication that affects exercise prescription: 2

Recommendation

- IMT after CABG surgery (from 30 up to 60 of Pimax, 20-30 min/session, 3-5 days/week)
- end exercise session with high-intensity or strength exercise to prevent hypoglycemia
- isometric handgrip exercise training
- Strength training exercises:
  - 2 days/week, 40-80% of 1RM, 12-15 reps/set
  - 2 days/week, 70-85% of 1RM, 8-10 reps/set, at least 21 sets

Moderate Daily 20-60 >12 weeks Yes

# How to define the patient's weekly sports goal (or exercise prescription)?

3 Within each category, you should select all the conditions that are applicable for the patient by clicking on the corresponding checkmark. The EXPERT tool also automatically selects some risk factors based on the patient's information, e.g., when the patient's BMI is too high, the system will select obesity. Anomalies and medication do not have an individual exercise recommendation, but choices made in these two lists are considered in the final exercise recommendation. For some cases in the "Anomalies" category, you have to define the heart rate at which the patient experienced the anomaly.

The screenshot shows the EXPERT tool interface for a patient. At the top, patient information is displayed: coro-001001-312, 182/89 mm Hg, 73 kg, 24.68 kg/m<sup>2</sup>, LDL: 11 mg/dL, 4.2%, Low, Low, 11 Low, Active smoker (high dependence), Low, Beginner. Below this, patient demographics are shown: Female, 44 years, 87 bpm, 723 m. The main section is titled "EXPERT tool" and has "Save and close" and "Print" buttons. There are two tabs: "Weekly sports goal" (selected) and "Safety precautions". The "Weekly sports goal" section is divided into four categories: "Primary indication", "Key risk factor", "Exercise modifier", and "Anomalies". The "Key risk factor" section is currently expanded, showing a table of risk factors with checkboxes, severity levels, heart rate ranges, and duration options. A blue circle with the number "3" highlights the "Type 1 Diabetes" row, which is checked. The "Exercise modifier" and "Anomalies" sections are currently empty.

Risk Factor	Severity	Heart Rate Range	Duration	Selected
<input type="checkbox"/> Obesity	Moderate	< 3-5	>24 weeks	No
<input checked="" type="checkbox"/> Type 1 Diabetes	Moderate	< 3	>12 weeks	Yes
<input type="checkbox"/> Type 2 Diabetes	Moderate	< 5	>12 weeks	Yes
<input checked="" type="checkbox"/> Hypertension	Moderate-High	< Daily	>6 weeks	Yes
<input type="checkbox"/> Dislipidemia	Moderate	< 3-5	>12 weeks	Yes

# How to define the patient's weekly sports goal (or exercise prescription)?

When you open the EXPERT tool, it automatically suggests a recommendation (indicated by a thick border around the box).

4 Every time you change the disease-related selections, the recommendation is updated automatically. Make sure you check that this recommendation is suited for the patient.

If you agree with the automatically generated recommendation, you can accept the recommendation and save it to the patient record by clicking this button.

6 If you wish to modify the generated recommendation, you can click this button.

The screenshot displays the EXPERT tool interface for a patient with the following characteristics: Female, 44 years, 87 bpm, 723 m, 182/89 mm Hg, 73 kg, 24.68 kg/m<sup>2</sup>, LDL: 11 mg/dL, 4.2%, Low, Low, Low, Active smoker (high dependence), Low, Beginner. The interface is divided into two tabs: "Weekly sports goal" (selected) and "Safety precautions".

The "Weekly sports goal" section includes the following fields:

- Primary indication:** Select primary indication: CAD, PCI, CABG, and minimally invasive CABG
- Key risk factor:** Select risk factors: Type 1 Diabetes, Hypertension
- Exercise modifier:** Select exercise modifiers:
- Anomalies:** Select anomalies occurred during exercise testing:
- Medication:** Select medication that affects exercise prescription:

The **Recommendation** section (highlighted with a thick blue border) shows the following details:

- Intensity:** Moderate
- Frequency:** Daily
- Duration:** 20-60
- Frequency:** >12 weeks
- Goal:** Yes
- Additional instructions:**
  - IMT after CABG surgery (from 30 up to 60 of Pimax, 20-30 min/session, 3-5 days/week)
  - end exercise session with high-intense or strength exercise to prevent hypoglycemia
  - Isometric handgrip exercise training
  - Strength training exercises:
    - 2 days/week, 40-80% of 1RM, 12-15 reps/set
    - 2 days/week, 70-85% of 1RM, 8-10 reps/set, at least 21 sets

Numbered callouts 4, 5, and 6 are present on the interface. Callout 4 points to the recommendation box, callout 5 points to the "Save and close" button, and callout 6 points to the "Print" button.

# How to define the patient's weekly sports goal (or exercise prescription)?

6 You may choose to modify either some or all the fields in the generated recommendation. We advise you to formulate the reason why you have changed the recommendation. This extra information can serve as a future reference when analysing the data of the patient or for other members of the team when accessing the patient's record.

7 You can click the undo button if you want to undo your changes in the recommendation.

8 You can save the modified recommendation by clicking this button. From the second time onwards, when you save a recommendation for a certain patient, you will have to choose between starting a new training program or a follow up recommendation that is considered part of the last (ongoing) training program.

This decision will not have any influence on the exercise training recommendation as such. Considering a recommendation as the beginning of a training program or not has only informative purposes.

9 You can go back to the initial recommendation and collapse the recommendation box by clicking this button.

The screenshot displays the CoroPrevention Caregiver dashboard for a patient named 'coro-001001-312'. The patient's profile includes: 182/89 mm Hg, 73 kg, 24.68 kg/m<sup>2</sup>, LDL: 11 mg/dL, 4.2%, Low, Low, Low, Active smoker (high dependence), Low, and Beginner. The patient is a 44-year-old female with a heart rate of 87 bpm and a distance of 723 m.

The 'Recommendation' section is active, showing a 'Moderate' intensity, 'Daily' frequency, and a duration of '20-60' minutes for '>12 weeks'. The recommendation is set to 'Yes' and has a dependency on 'Heart rate'. The 'Include High Intensity Interval' checkbox is unchecked.

The 'Frequency' section shows a value of '7' with a dependency on 'Heart rate'.

The 'Session duration' section shows a range from '20' to '60' minutes with a dependency on 'Heart rate'.

The 'Programme duration' section shows a range from '12' to 'Max' with a dependency on 'Heart rate'.

The 'Strength training' section shows 'Yes' with a dependency on 'Heart rate'.

On the right side of the recommendation box, there are three numbered buttons (7, 8, 9) and a list of notes:

- IMT after CABG surgery (from 30 up to 60 of Pimax, 20-30 min/session, 3-5 days/week)
- end exercise session with high-intense or strength exercise to prevent hypoglycemia
- isometric handgrip exercise training
- Strength training exercises:
  - 2 days/week, 40-80% of 1RM, 12-15 reps/set
  - 2 days/week, 70-85% of 1RM, 8-10 reps/set, at least 21 sets

# How to define the patient's weekly sports goal (or exercise prescription)?

When starting the trial for the patient, you only see the "Recommendation" box as there is no "Saved prescription" yet.

10 After you click the "Save" button for the first time, you get a "Saved prescription" and a "Recommendation" (i.e., two boxes).

The screenshot displays the patient's profile and exercise prescription configuration. The patient's details include: ID: coro-001001-312, BP: 182/89 mm Hg, Weight: 73 kg, BMI: 24.68 kg/m<sup>2</sup>, Cholesterol: LDL: 11 mg/dL, Glucose: 4.2%, Risk Level: Low, Smoking Status: Active smoker (high dependence), and Activity Level: Beginner. The patient is a 44-year-old female with a heart rate of 87 bpm and a height of 1723 m.

The configuration interface includes the following sections:

- Primary indication:** CAD, PCI, CABG, and minimally invasive CABG
- Key risk factor:** Hypertension, Type 1 Diabetes
- Exercise modifier:** (Empty)
- Anomalies:** (Empty)
- Medication:** (Empty)
- Recommendation:** (Contains a blue circle with the number 10)
  - IMT after CABG surgery (from 30 up to 60 of Pimax, 20-30 min/session, 3-5 days/week)
  - end exercise session with high-intense or strength exercise to prevent hypoglycemia
  - isometric handgrip exercise training
  - Strength training exercises:
    - 2 days/week, 40-80% of 1RM, 12-15 reps/set
    - 2 days/week, 70-85% of 1RM, 8-10 reps/set, at least 21 sets

- Saved prescription:** (Contains a blue circle with the number 10)
- IMT after CABG surgery (from 30 up to 60 of Pimax, 20-30 min/session, 3-5 days/week)
- end exercise session with high-intense or strength exercise to prevent hypoglycemia
- isometric handgrip exercise training
- Strength training exercises:
  - 2 days/week, 40-80% of 1RM, 12-15 reps/set
  - 2 days/week, 70-85% of 1RM, 8-10 reps/set, at least 21 sets

# How to view the safety precautions for the patient?

1 In the "Safety precautions" tab, you can consult the list of safety precautions according to the patient's most recently saved exercise recommendation.

You can click on each of the boxes to read more information on each one of the categories.

2 Note: The Printout is intended for professionals e.g., an exercise physiologist or physiotherapist if used for creating a detailed exercise program for the patient. The recommendation contains medical terms which might not be understood by the patient hence the printout is not intended to be given to the patients. Inform the patient verbally about the safety precautions as applicable.

The screenshot shows the CoroPrevention Caregiver dashboard for a patient named 'coro-001001-312'. The patient's profile includes: Female, 44 years, 87 bpm, 723 m. The dashboard features an 'EXPERT tool' section with a 'Weekly sports goal' and a 'Safety precautions' tab (highlighted with a red circle '1'). Below this, there are three expandable categories: 'CAD, PCI, CABG, and minimally invasive CABG', 'Hypertension', and 'Type 1 Diabetes'. The 'Hypertension' category is expanded (highlighted with a red circle '2'), showing a list of safety precautions: 'Stopping exercise suddenly should be avoided as it may result in a precipitous drop in SBP. Alpha blockers and vasodilators may exacerbate this effect. In these cases, extending the cool-down is generally recommended. Educate patients about the symptoms and give advice to ensure appropriate hydration in specific circumstances such as hot weather.', 'If hypertension is poorly controlled, high-intensity physical exercise as well as maximal exercise testing should be discouraged or postponed until appropriate drug treatment has been instituted and BP is lowered.', 'If SBP rises > 250 mmHg and/or DBP > 115 mmHg during exercise, the training session should be terminated and the person should be advised to wait their doctor as this may indicate the need to adjust medical therapy.', and 'Additional isometric handgrip exercise training is advised: 40% of one maximal volitional contraction, performed as several intermittent bouts of handgrip contractions lasting 2 min each for a total of 12-15 min per session.' The 'Type 1 Diabetes' category is also expanded (highlighted with a red circle '2').

# Abbreviations (EXPERT tool)

CAD	Coronary artery disease
PCI	Percutaneous coronary intervention
CABG	Coronary artery bypass graft
LVEF	Left ventricular ejection fraction
CMP	Cardiomyopathy
CRT	Cardiac resynchronization therapy
ICD	implantable cardioverter-defibrillator
TIA	Transient ischemic attack

CRT	Cardiac resynchronization therapy
ICD	implantable cardioverter-defibrillator
COPD	Chronic obstructive pulmonary disease

VO <sub>2</sub> peak	peak oxygen uptake
VT	ventilatory threshold
IMT	Maximal inspiratory muscle training with P <sub>I</sub> max (maximal inspiratory pressure)
HRR	heart rate reserve
1RM	1 repetition maximum (maximal muscle strength)



**CoroPrevention**

PERSONALISED PREVENTION FOR  
CORONARY HEART DISEASE

# Case nurse manual caregiver dashboard – Nutrition module

V6.0, 14.10.2024

[www.coroprevention.eu](http://www.coroprevention.eu)



*This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 848056*

# What is the Nutrition-score?

- The MedDietScore assesses how adherent a person is to the Mediterranean dietary pattern. It assesses the person's nutrition intake for 11 food groups: non-refined cereals, fruit, vegetables, legumes, potatoes, fish, meat and meat products, poultry, full fat dairy products, olive oil and alcohol intake.
- For CoroPrevention, we developed the Nutrition-score (based on the MedDietScore). The Nutrition-score indicates how heart-healthy a person is eating. The key updates made to the MedDietScore to arrive at the Nutrition-score are the following:
  - Update of the scoring protocol for alcohol intake. In the MedDietScore, drinking 0 alcohol is regarded as bad, but in the Nutrition-score this is regarded as good.
  - Update of the food groups to also cover alternatives that are more available in Nordic countries (ref. Nordic diet).
  - Addition of salt and sugar as two extra food groups.
- The Nutrition-score is calculated by looking at how much the person consumes of each of the food groups.
- A Nutrition-score of 100% is the best a person can achieve. However, it is not feasible for everyone to get to this 100%. The patient should aim to get as close as possible to 100%.
- Note that at the visits with the case nurse, the patient completes the MedDietScore questionnaire and two extra questions for sugar and salt in the ePRO application. The scoring protocol from the MedDietScore is used there. Whereas, in the mobile app, the patient completes the Nutrition-score questionnaire, which is a similar questionnaire in the ePRO but the phrasing is adapted so it is easier for the patient to fill in the questions and the scoring protocol is updated.

# How to follow up on the patient's progress for healthy nutrition?

- 1 In "Progress", there is an overview of the patient's current nutrition, as reported in the ePRO application and in the patient mobile app.
- 2 The overall rating of the patient's diet (self-reported by the patient) is depicted.
- 3 The Nutrition-score is shown, expressed as a percentage.
- 4 You can see which challenges the patient reported as hindering him/her in eating healthy.

The screenshot shows a patient's profile with various health metrics: 145/72 mm Hg, 78 kg, 20.1 kg/m², LDL: 154 mg/dL, and 15.1%. The patient's diet is categorized as Medium, Low, High, Occasional Smoker, and Beginner. A 'Close patient record' button is visible in the top right.

The main content area is titled 'Healthy nutrition' and features a progress indicator with three steps: 1 (selected), 2, and 3. The 'Progress' tab is active, showing a smiley face icon and the text 'My overall diet is fair.' (2), reported on 24/11/2023. Below this, the 'Nutrition-score: 62%' (3) is shown, reported on 08/12/2023. The 'Healthy nutrition challenges' section (4) lists 'Price' and 'Lack of self-restraint', reported on 24/11/2023. A 'Go to journey' button is at the bottom left, and a 'Next step >' button is at the bottom right.

# Which types of healthy nutrition goals can be set for the patient?

- 1 In "Goal setting", you can discuss the patient's goals for a healthy nutrition. Instruct the patient to update the goals in the mobile app on a weekly basis when actively working on healthy nutrition (in level of guidance 2).
- 2 The text gives a brief explanation of the Mediterranean and Nordic diet.

coro-001001-351

145/72 mm Hg 78 kg 20.1 kg/m<sup>2</sup> LDL: 154 mg/dL 15.1 % Medium Low

High Occasional Smoker Beginner

Close patient record

## Healthy nutrition

Progress → Goal setting

2

You have decided to change to more healthy eating habits – great! However, it is not always easy to find out what is healthy and what is not. The Mediterranean diet is not such a strict or restrictive diet, but it is a tasty eating pattern which is healthy for everyone and is also recommended by the European Society of Cardiology for cardiac patients, because it has been proved to reduce the risk of heart disease. Below, we will guide you through the basics of the Mediterranean diet. The Nutrition-score that is used in the application is based on the widely used "MedDietScore".

Name	Information
Eat wholegrain food items	Try to eat whole-grain food items at least twice every day (eg. whole-grain cereal for breakfast and whole-grain bread at noon).
Eat a healthy amount of potatoes	Try to eat cooked potatoes three to four times a week. Try to vary with whole-grain cereals (whole grain bread, whole grain pasta, brown rice).
Eat more fruit	Aim for a minimum of 2-3 servings of fruit per day (1 serving = 1 medium piece of fruit (e.g. apple, orange), 2 small pieces of fruit (e.g. plums, kiwis)). Note: fruit contains some sugar, so people with diabetes be careful out not to eat too much at once.



# Which types of healthy nutrition goals can be set for the patient?

- 3 The table on the left provides detailed information about the goals to adhere to the Mediterranean or Nordic diet, where the focus is on having a heart-healthy lifestyle.

coro-001001-351

145/72 mm Hg 78 kg 20.1 kg/m<sup>2</sup> LDL: 154 mg/dL 15.1 % Medium Low

High Occasional Smoker Beginner

Name	Information
Eat wholegrain food items	Try to eat whole-grain food items at least twice every day (eg. whole-grain cereal for breakfast and whole-grain bread at noon).
Eat a healthy amount of potatoes	Try to eat cooked potatoes three to four times a week. Try to vary with whole-grain cereals (whole grain bread, whole grain pasta, brown rice).
Eat more fruit	Aim for a minimum of 2-3 servings of fruit per day (1 serving = 1 medium piece of fruit (e.g. apple, orange), 2 small pieces of fruit (e.g. plums, kiwis)). Note: fruit contains some sugar, so people with diabetes be careful out not to eat too much at once.
Eat more vegetables	Aim for a minimum of 4 servings of vegetables per day (1 serving = ½ cup of cooked vegetables, a bowl of salad).
Eat more legumes	Beans, peas, lentils or tofu can provide complete protein sources without the saturated fat levels.
Eat more fish and healthy protein	Pick heart-healthy proteins found in fish, shellfish, skinless poultry and lean meat products. Beans, peas, lentils or tofu can also provide complete protein sources without the saturated fat levels. Healthy, low-fat dairy can also serve as a protein source.





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# Case nurse manual caregiver dashboard – Smoke-free living module

V6.0, 16.10.2024

[www.coroprevention.eu](http://www.coroprevention.eu)



*This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 848056*

# How to follow up on the patient's progress for smoke-free living?

1 In "Status", there is an overview of the patient's current status for smoke-free living, as reported in the ePRO application and in the patient mobile app.

2 In "Smoking behaviour", you have an overview of how many cigarettes the patient smokes on a daily or monthly basis. The Fagerström score is shown (indicating whether the patient is dependent on nicotine). Degree of dependency is shown with color coding.

3 In "Motivation to stop smoking", you have an overview of the patient's motivation to stop smoking.

4 In "Quit attempts before the study", you have an overview of the quit attempts that the patient undertook before the study.

5 "Most recent quit attempt during the study" will only contain information after the patient performed a first quit attempt with the mobile app. This section details more information about the patient's most recent quit attempt.

The screenshot displays the CoroPrevention Alpha caregiver dashboard for patient 001001 / BE1. The dashboard shows various vital signs and patient status. The main section is titled "Smoke-free living" and contains five numbered callouts (1-5) pointing to specific data points:

- 1 Status:** Overview of the patient's current status for smoke-free living.
- 2 Smoking behaviour:** Number of cigarettes: 18 cigarettes daily; Fagerstrom score: 7 Moderate dependence.
- 3 Motivation to stop smoking:** I want to stop smoking but haven't thought about when.
- 4 Quit attempts before the study:** Number of quit attempts: 2; Most recent quit attempt: 1 January 2024; Options used to quit smoking: Cessation medication.
- 5 Most recent quit attempt during the study:** Quit date: 30 September 2024; 0 day(s); Options used to quit smoking: No data.

# How to discuss the patient's quit plan?

1 In "Goal setting", you have static information on the recommended steps of a quit plan.

You can use this screen as a guideline during the visit, to steer the conversation and to support the patient.

Note that there is no interaction between the caregiver dashboard and the mobile app for this part.

The screenshot displays the CoroPrevention Alpha caregiver dashboard for patient 001001 / BE1. The patient's profile includes vital signs: 145/98 mm Hg, 93 kg, 24.21 kg/m<sup>3</sup>, LDL: 10.86 mmol/l, and 163.4 mmol/mol. The patient is categorized as Sedentary, Occasional Smoker, Low, and Beginner. The main content area is titled "Smoke-free living" and shows a progress bar with "Goal setting" as the current step, indicated by a blue circle with the number 1. Below this, a section titled "How to give up smoking" lists eight steps:

- 1. Decide to quit**  
Recognize and commit to the decision to stop smoking for health and personal reasons.
- 2. Set a quit date**  
Choose a specific day to start your smoke-free journey, providing a clear target to prepare for.
- 3. Ways to quit smoking**  
Explore various methods to quit, such as nicotine replacement therapy, medications, or behavioral strategies.
- 4. Involve others**  
Seek support from friends, family, or support groups to stay motivated and accountable.
- 5. Set the stage**  
Prepare your environment by removing smoking triggers and creating a smoke-free space.
- 6. Challenges**  
Anticipate and plan for potential difficulties like cravings, withdrawal symptoms, and social pressures.
- 7. Benefits and rewards**  
Focus on the health benefits and personal achievements as motivation to stay smoke-free.
- 8. Coping plans**  
Develop strategies to manage stress and cravings, such as exercise, hobbies, or relaxation techniques.
- 9. Keep a diary**  
Maintain a record of your quitting journey to track progress, identify triggers, and reflect on successes.

Navigation options include "Previous step" and "Go to journey".



**CoroPrevention**

PERSONALISED PREVENTION FOR  
CORONARY HEART DISEASE

# Case nurse manual caregiver dashboard – Stress relief

V6.0, 16.10.2024

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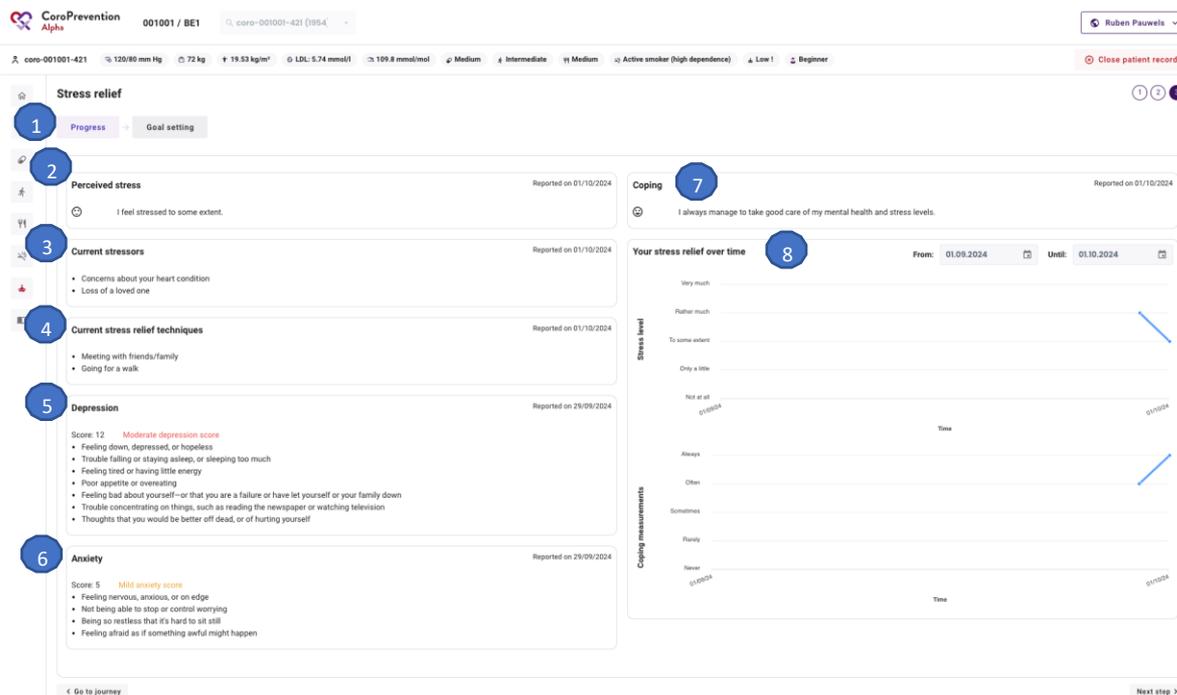
*This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 848056*

# How to follow up on the patient's progress for stress relief?

1 In “Progress”, you have an overview of the patient’s current status for stress relief, as reported in the ePRO application and in the patient mobile app.

You have an overview of:

- 2 The patient’s self-perceived stress level;
- 3 The patient’s current stressors;
- 4 The patient’s current stress relief techniques;
- 5 The results of the depression questionnaire (PHQ-9);
- 6 The results of the anxiety questionnaire (GAD-7);
- 7 The self-administered measurement of how well the patient copes with stress;
- 8 Charts that allows you to view the evolution of the patient’s stress and coping measurements over time.



# How to discuss the patient's goals for stress relief?

1 In "Goal setting", you can view the patient's motivation to work on the different stress relief goals.

Take time to discuss these goals and possible ways to reach the goals with the patient.

Always consider if professional help is needed for the patient's mental health.

The screenshot shows the CoroPrevention Alpha caregiver dashboard for patient 001001 / BE1. The patient's name is Ruben Pauwels. The dashboard displays various vital signs and lifestyle factors. The 'Stress relief' section is highlighted with a blue circle and the number 1, indicating the current step in the goal setting process. The 'Stress relief goals' table shows the following data:

Stress relief goals	Motivation	Reported on
Reduce stress	Motivated	01/10/2024
Improve mental wellbeing	Neutral	
Sleep better	Very motivated	
Feel less lonely	Not very motivated	



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