



CoroPrevention

PERSONALISED PREVENTION FOR
CORONARY HEART DISEASE

CoroPrevention Tool Suite Caregiver dashboard User guide

For CoroPrevention Tool Suite investigational Medical Device Release 3.3

V7.0, 21 Aug 2025



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www.coroprevention.eu

Table of contents

- [General information](#)
- [Conduct visit 1](#)
- [Prepare for visit 2 \(eDC\)](#)
- [Creating a subject](#)
- [Viewing patient summary](#)
- [Prepare for visit 2 \(Dashboard\)](#)
- [Information exchange between Tool Suite and EDC](#)
- [Conduct visit 2 \(Dashboard\)](#)
- [Closing a visit \(Dashboard\)](#)
- [After visit 2 \(eDC\)](#)
- [Conduct v3-v7](#)
- [Opening a patient record](#)
- [Follow-up in between the visits](#)
- [Handling alerts](#)
- [Correcting data \(dashboard\)](#)
- [Patient discontinuation](#)

Modules

General module

_____ - completeness of ePRO questionnaires

Journey module (follow progress)

Journey module (goal setting)

Education module

Medication adherence module

Physical activity (EXPERT tool) module

Nutrition module

Smoke-free living module

Stress relief module

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.

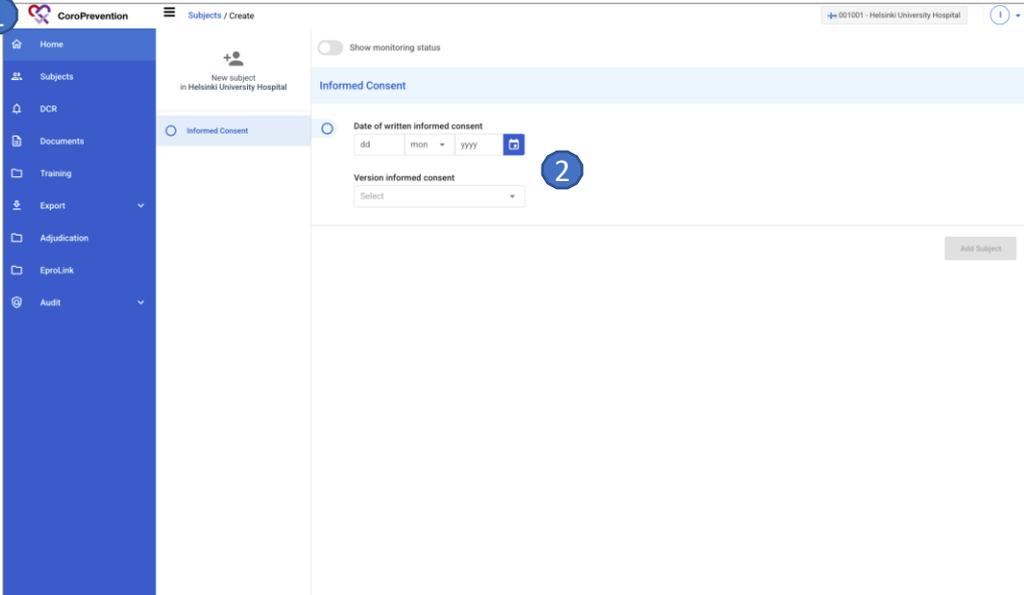
Intended Clinical Benefits

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.



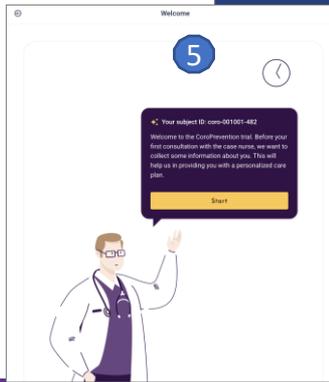
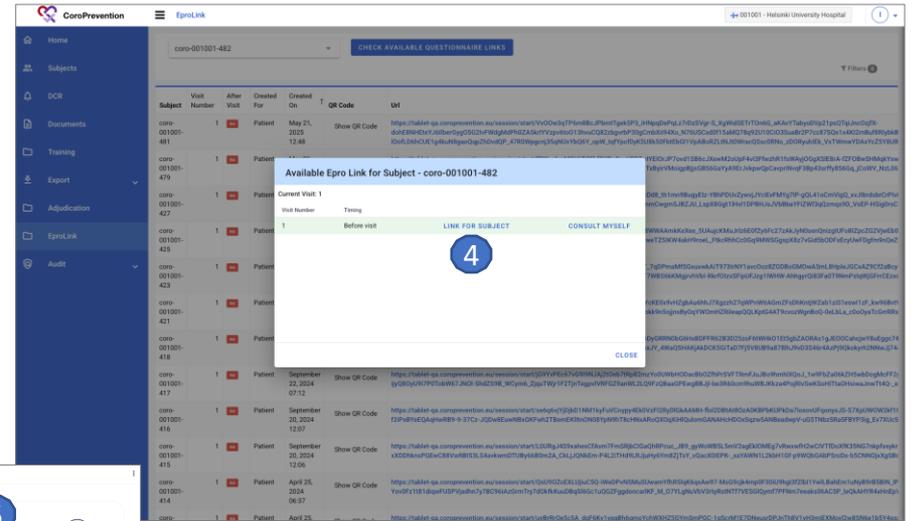
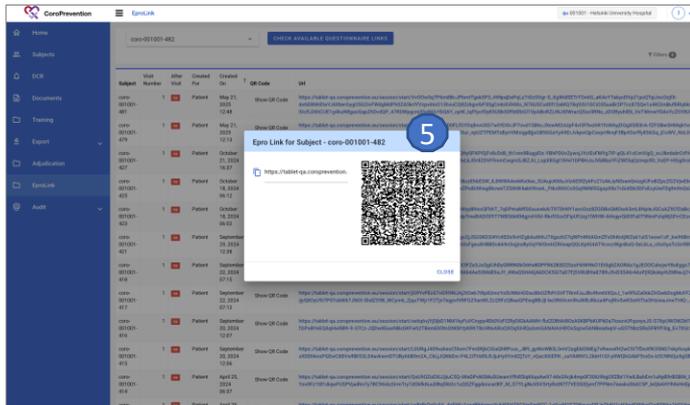
The screenshot displays the CoroPrevention EDC interface. On the left is a blue navigation sidebar with options: Home, Subjects, DCR, Documents, Training, Export, Adjudication, EproLink, and Audit. The main content area is titled 'Subjects / Create' and shows a 'New subject in Helsinki University Hospital' form. A blue circle with the number '1' highlights the top navigation bar. Below the header, there is a 'Show monitoring status' toggle and an 'Informed Consent' section. This section contains a 'Date of written informed consent' field with a calendar icon and a 'Version informed consent' dropdown menu. A blue circle with the number '2' highlights the version dropdown. 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 5 over to the patient, so the patient can complete the ePROs.



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.

Medical History

Id	Condition	Severity	Response
1	Diabetes mellitus type 1		<input checked="" type="radio"/> Yes <input type="radio"/> No
2	Diabetes mellitus type 2		<input type="radio"/> Yes <input checked="" type="radio"/> No
3	Chronic kidney disease		<input type="radio"/> Yes <input checked="" type="radio"/> No
4	Hypertension		<input checked="" type="radio"/> Yes <input type="radio"/> No
5	Cardiovascular disease		<input type="radio"/> Yes <input checked="" type="radio"/> No
6	Respiratory system disease		<input checked="" type="radio"/> Yes <input type="radio"/> No
7	Familial history of cardiovascular disease		<input type="radio"/> Yes <input checked="" type="radio"/> No
8	Transcatheterisation		<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

Randomisation

proBNP
+2

High sensitivity troponin
+1

Cystatin C
+1

Coronary score
+1

Risk Category
High risk

Assigned to ASRM
PPP (Personalised Prevention Program)

Date of treatment assignment
20 May 2025

Subject contacted on
dd mm yy

The subject dropped out before starting intervention
 Yes No

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 ² – 60 kg/m ² 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.

How to create a subject (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 shows the 'Create patient record' form in the CoroPrevention Alpha caregiver dashboard. The form includes the following elements:

- Header:** CoroPrevention Alpha logo, user ID 001001 / BE1, search bar, and user name Ruben Pauwels.
- Title:** Create patient record
- Buttons:** Cancel (top right), Retrieve data from EDC (middle), and Submit (bottom left).
- Fields:** Subject ID (text input with value coro-001001-482), Gender (radio buttons for Male and Female, Female selected), Year of birth (text input with value 1985), and Start date (text input with value 01-01-2025).
- Annotations:** Blue circles with numbers 1 through 5 are overlaid on the interface to indicate the steps: 1. Login, 2. Enter Subject ID, 3. Click 'Retrieve data from EDC', 4. Check data, 5. Click 'Submit'.

How to create a subject (caregiver dashboard)?

1 Patient record successfully imported into the Tool Suite.

The screenshot displays the CoroPrevention Alpha caregiver dashboard for a patient with ID coro-001001-482 (1965). The interface is divided into several sections:

- General:** Subject ID (coro-001001-482), Gender (Female), Year of birth (1965), and Start date (01-01-2025). It includes a QR code and a URL to view the ePro for visit 2, along with buttons for printing QR codes and logging out of the mobile app.
- Consultations during the study:** A progress bar showing 7 consultations, with the first one highlighted in green.
- Parameters:** A list of vital signs and lab results: Blood pressure (129/90 mm Hg), Weight (90 kg), BMI (35.2 kg/m²), LDL cholesterol (2.64 mmol/l), and HbA1c (Glucose) (31.2 mmol/mol).
- Behavioural goals:** A table of goals with their current status and target status.
- Most recent alerts:** A table for alerts, currently empty, with a filter for Red (0), Orange (0), and Yellow (0) alerts, and buttons for Open (0) and Handled (0).

Goal	Current Status	Target Status
Medication adherence	Medium	Inactive
Start moving	Intermediate	Inactive
Healthy nutrition	Medium	Inactive
Smoke-free living	Active smoker	Inactive
Stress relief	High	Inactive
Knowledge level	Beginner	Inactive

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 yet completed, the circle is white.

How to view a summary about a patient?

The screenshot shows the CoroPrevention Alpha caregiver dashboard for a patient. The dashboard is annotated with numbered circles 1 through 7. 1: Patient header area. 2: General patient information section. 3: QR code for mobile app. 4: 'Print a new QR password code for the mobile app' button. 5: 'Patient dropped out' button. 6: 'Logout mobile app' button. 7: 'Consultations during the study' progress indicator.

General

Subject ID: coro-001001-482
Gender: Female
Year of birth: 1965
Start date: 01-01-2023

URL and code to view the ePro for visit 2
<https://hubnet-qps.comprevention.eu/session/start/at4iqpAFM9Q537y>

Parameters

Blood pressure: 129/90 mm Hg
Weight: 90 kg
BMI: 35.2 kg/m²
LDL cholesterol: 2.64 mmol/l
HbA1c - (Glucose): 31.2 mmol/mol

Behavioural goals

Goal	Current Status	Target Status
Medication adherence	Medium	Inactive
Start moving	Intermediate	Inactive
Healthy nutrition	Medium	Inactive
Smoke free living	Active smoker	Inactive
Stress relief	High	Inactive
Knowledge level	Beginner	Inactive

Most recent alerts

Date	Time	Type	Module	Message	Action
25-03-2023	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.
11-02-2023	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.
11-02-2023	07:28	Yellow	Diabetes management	HbA1c is between 7-9% or between 53-75 mmol in this patient with known diabetes.	A tailored infographic was sent to the patient.

8
9
10
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14

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

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.

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.

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.

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

There is a filter for each type of alert and for each status (open/handled).

You can click on a filter to enable or disable it.

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 '001001 / BE1'. The page is divided into several sections:

- General:** Subject ID (csm-001001-482), Gender (Female), Year of birth (1965), Start date (01-01-2025). Includes a QR code and a link to view the ePro for visit 2.
- Parameters:** A table of recent parameter values with color-coded status:

Blood pressure	129/90 mm Hg
Weight	90 kg
BMI	35.2 kg/m ²
LDL cholesterol	2.64 mmol/l
HbA1c (Glucose)	31.2 mmol/mol
- Behavioural goals:** A table showing goal status:

Medication adherence	Medium	Inactive
Start moving	Intermediate	Inactive
Healthy nutrition	Medium	Inactive
Smoke free living	Active smoker	Inactive
Stress relief	High	Inactive
Knowledge level	Beginner	Inactive
- Most recent alerts:** A table of alerts with filters for status (Red, Orange, Yellow, Open, Handled).

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	07:28	Yellow	Diabetes management	HbA1c was between 7-9% or between 50-70 mmol in this patient with known diabetes.	A tailored infographic was sent to the patient.

Numbered callouts (8-14) point to specific UI elements: 8 (visits during study), 9 (visit status), 10 (parameters table), 11 (behavioural goals table), 12 (alerts table), 13 (filter buttons), and 14 (action icons).

Prepare for visit 2 (caregiver dashboard)

MEDICATION PRESCRIPTION

1 NOTE: The medication prescription of the patient is not automatically imported from the EDC to the Tool Suite (caregiver dashboard). Therefore, you have to manually register the patient's medication prescription.

Click the "Open medication decision support" button to open the medication DSS in which you can add / modify the patient's medication prescription.

2 Register the patient's medication prescription. This is the same medication list as the one that was entered in EDC for visit 1.

The screenshot shows the 'Patient' dashboard for subject ID 'covo-00001-482'. It includes a 'General' section with patient details, a 'URL and code to view the ePro for visit 2' with a QR code, and a 'Print QR code for ePRO application' button. A blue circle with the number '1' highlights the 'Open medication decision support to edit the prescription' button at the top right. Other sections include 'Consultations during the study', 'Parameters' (Blood pressure, Weight, BMI, LDL cholesterol, HbA1c), and 'Behavioural goals' (Medication adherence, Start smoking, Healthy nutrition, Smoke free living, Stress relief, Knowledge level).

The screenshot shows the 'Medication decision support system' interface. It features tabs for 'Cardiac medication', 'Other medication', 'Allergies', 'Titration schemes', and 'Algorithm input'. A 'Current prescription' section displays a table for Aspirin and Lovastatin, with columns for 'Daily', 'Morning', 'Even', 'Afternoon', and 'Evening/night'. A blue circle with the number '2' highlights the 'Add drug' button in the top right corner.

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 “View patient record”
Note: alternatively, you can also set the weekly sports goal during the visit with the patient.

The screenshot displays the CoroPrevention Alpha caregiver dashboard for patient coro-001001-482. The interface includes a top navigation bar with the user's name 'Ruben Pauwels' and a search bar. The main content area is divided into several sections:

- General:** Patient details including Subject ID (coro-001001-482), Gender (Female), Year of birth (1965), and Start date (01-01-2025). It also provides a URL and QR code to view the ePro for visit 2, and buttons for printing QR codes and logging out of the mobile app.
- Consultations during the study:** A progress bar showing 7 consultations, with the first one highlighted in green.
- Parameters:** A table of vital signs and lab results:

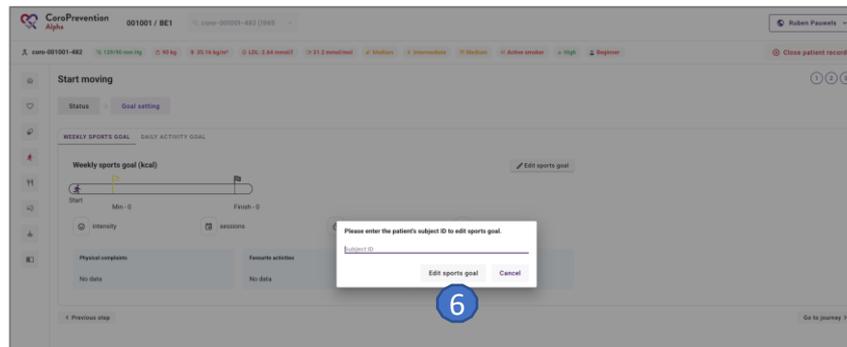
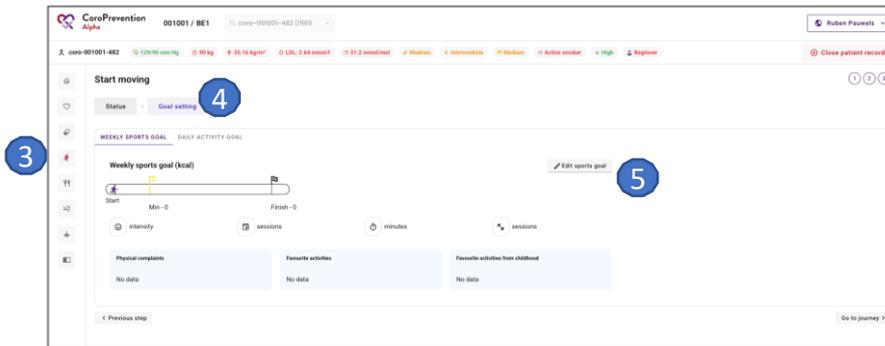
Parameter	Value
Blood pressure	129/90 mm Hg
Weight	90 kg
BMI	35.2 kg/m ²
LDL cholesterol	2.64 mmol/l
HbA1c - (Glucose)	31.2 mmol/mol
- Behavioural goals:** A table of goals and their status:

Goal	Status
Medication adherence	Medium
Start moving	Intermediate
Healthy nutrition	Medium
Smoke-free living	Active smoker
Stress relief	High
Knowledge level	Beginner
- Most recent alerts:** A table with columns for Date, Time, Type, Module, Message, and Action. A filter bar at the top right shows counts for Red (0), Orange (0), Yellow (0), Open (0), and Handled (0).

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

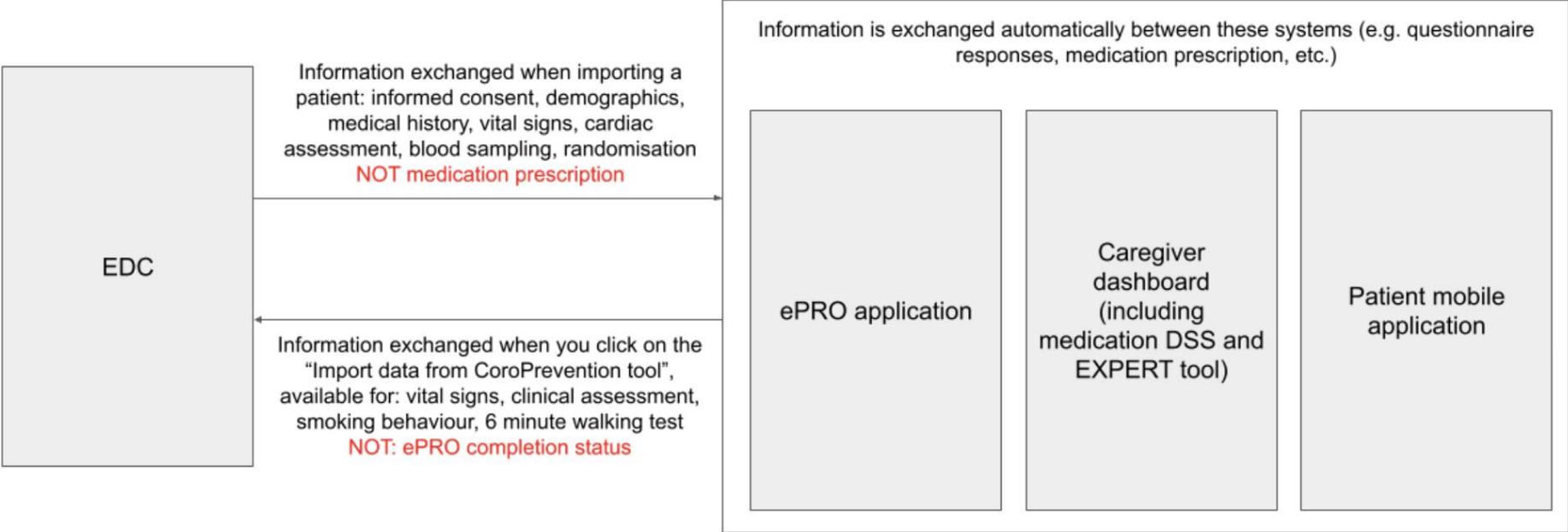
7 Set a weekly sports goal (exercise prescription) for the patient by selecting the relevant primary indications, key risk factors, exercise modifiers, anomalies and medication.

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 interface for a patient named Ruben Pauwels. The patient's profile includes demographic information (Female, 60 years, 90 bpm) and various clinical indicators such as blood pressure (129/90 mmHg), weight (90 kg), cholesterol (35.16 kg/mol), LDL (2.64 mmol/L), and triglycerides (31.2 mmol/mol). The EXPERT tool is active, showing a 'Weekly sports goal' tab. The tool has several sections for selection: 'Primary indication', 'Key risk factor' (with 'Dyslipidemia' and 'Obesity' selected), 'Exercise modifier', 'Anomalies', and 'Medication' (with 'Statins' selected). The 'Recommendation' section shows a goal of 'Moderate' intensity, 3-5 times per week, for 45-60 minutes, every 24 weeks, with a note: 'advise exercise modalities with large caloric expenditure (walking, jogging, stepping, etc) - >900 kcal/week of energy expenditure should be achieved'. A blue circle with the number 8 highlights the 'Save and close' button in the top right corner of the EXPERT tool.

Which information is exchanged between different systems?

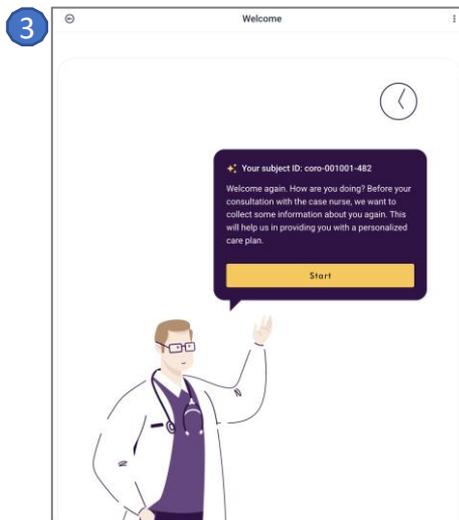


Conduct visit 2 with the patient (caregiver dashboard)

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.



A screenshot of the CoroPrevention caregiver dashboard. The page title is "Patient" and the patient ID is "001001 / BE1". The dashboard is divided into several sections:

- General:** Subject ID: coro-001001-482, Gender: Female, Year of birth: 1965, Start date: 01-01-2025.
- URL and code to view the ePro for visit 2:** A URL and a QR code are displayed.
- Parameters:** A table showing various health metrics: Blood pressure (125/70 mm Hg), Weight (90 kg), BMI (35.2 kg/m²), LDL cholesterol (2.64 mmol/l), and HbA1c (Glucose) (31.2 mmol/mol).
- Behavioural goals:** A table showing goals and their status: Medication adherence (Inactive), Start smoking (Intermediate), Healthy nutrition (Inactive), Smoke-free living (Active smoker), Stress relief (High), and Knowledge level (Beginner).
- Most recent alerts:** A table with columns for Date, Time, Type, Mobile, Message, and Action.

At the top right, there is a search bar and a user profile for "Ruben Pauwels". A blue circle with the number "1" is placed over the search bar. Another blue circle with the number "2" is placed over the QR code. A third blue circle with the number "3" is placed over the "Start" button in the mobile app screenshot to the left.

Conduct visit 2 with the patient (caregiver dashboard)

4 Click the button “Start visit” to open the patient record for a visit.

5 You can also start the visit by clicking the applicable visit number in the timeline.

Note: If you accidentally mark the visit as skipped, you can undo it by clicking the visit number and re-opening the visit.

The screenshot shows the CoroPrevention Alpha caregiver dashboard for patient coro-001001-482. The dashboard is divided into several sections:

- General:** Subject ID: coro-001001-482, Gender: Female, Year of birth: 1965, Start date: 01-01-2025. It includes a QR code and a link to view the ePro for visit 2.
- Consultations during the study:** A timeline showing 6 consultations, with the 4th consultation (Visit 2) highlighted in blue and circled with a '4'.
- Parameters:** A list of vital signs and lab results, with the 5th parameter (Blood pressure) circled with a '5'.

Parameter	Value
Blood pressure	129/90 mm Hg
Weight	90 kg
BMI	35.2 kg/m ²
LDL cholesterol	2.64 mmol/l
HbA1c - (Glucose)	31.2 mmol/mol
- Behavioural goals:** A list of goals with their current status.

Goal	Current Status	Target Status
Medication adherence	Medium	Inactive
Start moving	Intermediate	Inactive
Healthy nutrition	Medium	Inactive
Smoke-free living	Active smoker	Inactive
Stress relief	High	Inactive
Knowledge level	Beginner	Inactive
- Most recent alerts:** A table with columns for Date, Time, Type, Module, Message, and Action. A red alert 'Patient dropped out' is visible.

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 Alpha caregiver dashboard for patient coro-001001-482. The dashboard includes sections for General information, Consultations during the study, Parameters, Behavioral goals, 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 has a 'Cancel' button and a 'Start visit 2' button. A blue circle with the number 6 is placed over the subject ID input field, and another blue circle with the number 7 is placed over the 'Start visit 2' button.

Conduct visit 2 with the patient (caregiver dashboard)

- 8 Measure the vital signs and enter the data.
Note: after the visit, you can import this information in the EDC.

- 9 During visit 2, and also 6, the patient has to perform the 6 Minute Walking Test. Record the results in the caregiver dashboard.
Note: after the visit, you can import this information in the EDC.

- 10 Indicate only NEW diagnosis since last visit.
Note: after the visit, you can import this information in the EDC.

The screenshot shows the 'Start an encounter' form with the '6 Minute Walking Test' tab selected. The question 'Was the 6 Minute Walking Test performed?' has radio buttons for 'Yes' and 'No'. A blue circle with the number 9 is overlaid on the 'No' radio button.

The screenshot shows the 'Start an encounter' form with the 'Clinical Assessment' tab selected. Under the heading 'New following diagnosis since last visit', there are several conditions with radio buttons for 'Yes' and 'No'. A blue circle with the number 10 is overlaid on the 'New diagnosis of AF?' row.

The screenshot shows the 'Start an encounter' form with the 'Vital Signs' tab selected. There are input fields for 'Body weight' (kg) and 'Pulse Rate' (bpm). The 'Blood pressure' section has radio buttons for 'Systolic', 'Diastolic', 'mmHg', and 'mmHg'. A blue circle with the number 8 is overlaid on the 'mmHg' radio button.

Conduct visit 2 with the patient (caregiver dashboard)

11 Fill in the information that is required for the algorithm of the Medication Decision Support System (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.

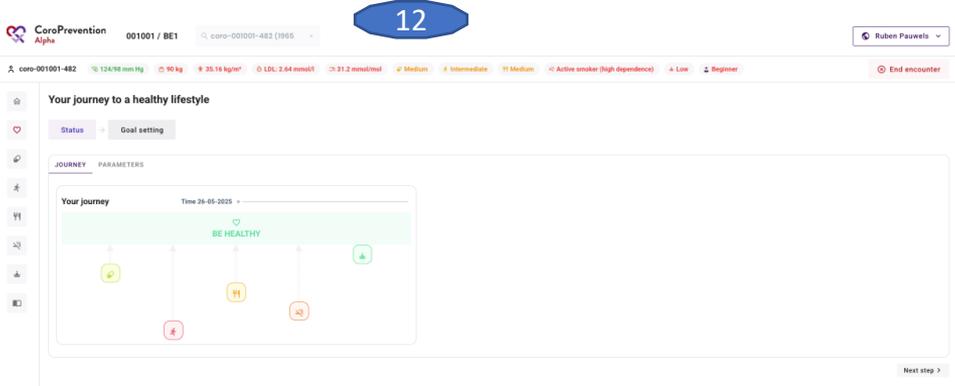
The screenshot shows the CoroPrevention Alpha caregiver dashboard for patient 001001 / BE1. The patient's profile includes vital signs: 120/90 mmHg, 90 kg, 35.16 kg/m², LDL 102, and risk levels for Medium, Intermediate, High, and Beginner. The 'Start an encounter' section is active, with the 'Medication DSS Information' tab selected. The form contains the following questions and 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
- Is the patient statin intolerant? Yes No

Navigation buttons include '4 Previous' and 'Start consultation'. A blue circle with the number 11 is overlaid on the form.

Conduct visit 2 with the patient (caregiver dashboard)

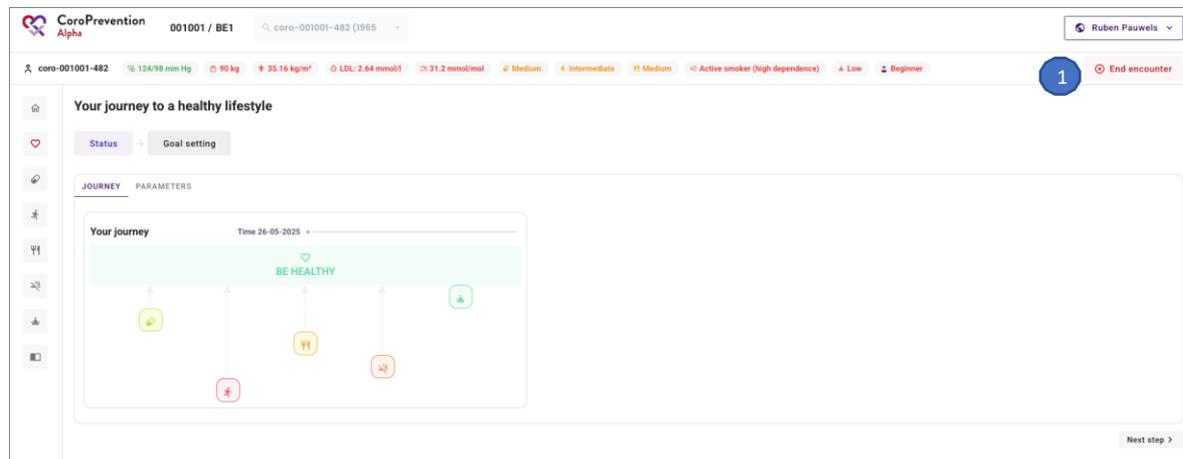
12 Starting with this view, you can have the shared decision-making discussion with the patient about his/her status and goals.



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

How to end a visit and close the patient record?

1 Click on "End encounter" when you have completed the visit and wish to close it in the Dashboard.



The screenshot displays the CoroPrevention Alpha interface for patient ID 001001 / BE1. The top navigation bar includes the patient ID, a search bar with 'coro-001001-482 (1985)', and a user profile for 'Ruben Pauwels'. Below this, a row of patient metrics is shown: 'coro-001001-482', '124/98 mm Hg', '90 kg', '35.14 kg/m²', 'LDL: 2.64 mmol/l', '31.2 mmol/mol', 'Medium', 'Intermediate', 'Y1 Medium', 'Active smoker (high dependence)', 'Low', and 'Beginner'. A red circle with the number '1' highlights the 'End encounter' button in the top right corner. The main content area is titled 'Your journey to a healthy lifestyle' and contains a 'JOURNEY' section with a 'BE HEALTHY' goal and a 'Next step >' button at the bottom right.

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.

Note: After completing the visit in the Dashboard, ensure timely eCRF data entry. This applies to all study visits.

The screenshot displays the CoroPrevention EDC interface for a subject with ID 'coro-001001-482' at the Helsinki University Hospital. The interface is divided into a left navigation menu and a main content area. The main content area shows the 'Vital Signs' section for 'Visit 2', which is highlighted with a red circle and the number '1'. The 'Vital Signs' section includes fields for 'Body weight' (kg), 'Blood pressure' (Systolic and Diastolic in mmHg), and 'Pulse Rate' (bpm). A red circle and the number '2' highlight the 'Import data from CoroPrevention tool' button in the top right corner of the Vital Signs section. The interface also includes a 'Back' button and a 'Next' button.

Conduct visit 3 - 7

Visit 3: ePRO questionnaires + shared decision making conversation with case nurse

Visit 4: ePRO questionnaires + shared decision making conversation with case nurse

Visit 5: ePRO questionnaires + shared decision making conversation with case nurse

Visit 6: ePRO questionnaires + shared decision making conversation with case nurse + **appointment with investigator**

Visit 7: ePRO questionnaires + shared decision making conversation with case nurse + **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.

How to open the patient record?

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

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.

1 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.

2 Choose "View patient record" 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 CoroPrevention Alpha patient record dashboard for patient ID 001001 / BE1. The interface includes a search bar with the patient ID, a user profile for Ruben Pauwels, and several main sections:

- General:** Subject ID (coro-001001-482), Gender (Female), Year of birth (1965), Start date (01-01-2025). It also provides a URL and QR code to view the ePro for visit 2, and options to print QR codes for ePRO application and mobile app, and to log out the mobile app. A "Patient dropped out" status is also visible.
- Consultations during the study:** A timeline showing 7 consultation points, with the current visit (2) highlighted.
- Parameters:** A list of clinical parameters with their values: Blood pressure (129/90 mm Hg), Weight (90 kg), BMI (35.2 kg/m²), LDL cholesterol (2.64 mmol/l), and HbA1c - (Glucose) (31.2 mmol/mol).
- Behavioural goals:** A table of goals and their status:

Goal	Current Status	Target Status
Medication adherence	Medium	Inactive
Start moving	Intermediate	Inactive
Healthy nutrition	Medium	Inactive
Smoke-free living	Active smoker	Inactive
Stress relief	High	Inactive
Knowledge level	Beginner	Inactive
- Most recent alerts:** A table with columns for Date, Time, Type, Module, Message, and Action. A filter bar at the top right shows 0 Red, 0 Orange, 0 Yellow, 0 Open, and 0 Handled alerts.

How to start a visit with the patient?

All visits

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.

The image displays two screenshots of the CoroPrevention Alpha patient dashboard, illustrating the steps for starting an encounter. The top screenshot shows the 'Start an encounter' screen with the 'Vital Signs' step selected. The bottom screenshot shows the 'Start an encounter' screen with the '6 Minute Walking Test' step selected.

Step 1: The top screenshot shows the 'Start an encounter' screen. The 'Vital Signs' step is selected. The patient information bar at the top displays: 001001 / BE1, coro-001001-482 (1865), 128/90 mmHg, 90 kg, 35.14 kg/m², LDL: 102, Medium, Intermediate, T1 Medium, Active smoker, High, Beginner. The 'Start an encounter' section includes a breadcrumb: Vital Signs > 6 Minute Walking Test > Clinical Assessment > Medication DSS Information. Below this are input fields for Body weight (kg), Blood pressure (systolic mmHg and diastolic mmHg), and Pulse Rate (bpm). A 'Next >' button is at the bottom.

Step 2: The bottom screenshot shows the 'Start an encounter' screen. The '6 Minute Walking Test' step is selected. The patient information bar at the top displays: 001001 / BE1, coro-001001-482 (1865), 128/90 mmHg, 90 kg, 35.14 kg/m², LDL: 102, Medium, Intermediate, T1 Medium, Active smoker, High, Beginner. The 'Start an encounter' section includes a breadcrumb: Vital Signs > 6 Minute Walking Test > Clinical Assessment > Medication DSS Information. Below this is a question: 'Was the 6 Minute Walking Test performed?' with radio buttons for Yes and No. A 'Next >' button is at the bottom.

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 screenshot shows the 'Start an encounter' form in the CoroPrevention Alpha system. The 'Clinical Assessment' tab is selected. The form contains several questions with radio button options for 'Yes' and 'No'. A blue circle with the number '4' is placed over the 'No' option for the 'Hypertension' question. The questions listed are: Diabetes mellitus type 1, Diabetes mellitus type 2, Chronic kidney disease, Hypertension, Stroke, TIA, Coronial endarterectomy, Peripheral artery disease, Thromboembolism, and New diagnosis of HF? At the bottom, there are 'Previous' and 'Next' buttons.

The screenshot shows the 'Start an encounter' form in the CoroPrevention Alpha system, with the 'Medication DSS Information' tab selected. The form contains several questions with radio button options for 'Yes' and 'No'. A blue circle with the number '5' is placed over the 'No' option for the question 'Is patient on high-dose statin?'. The questions listed are: Myocardial infarction in the last 12 months?, Did the patient have a second vascular event within 2 years while on maximally tolerated statin?, Is patient on high-dose statin?, ACE-inhibitor intolerance?, Patient has aspirin intolerance?, and Is the patient statin intolerant? At the bottom, there are 'Previous' and 'Start consultation' buttons. A blue circle with the number '6' is placed over the 'Start consultation' button.

Remote follow-up on patient between visits (Dashboard)

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

Note: use “View patient record” 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.

The screenshot displays the CoroPrevention Alpha dashboard for patient 001001 / BE1. The interface includes a search bar with the patient ID, a user profile for Ruben Pauwels, and a navigation bar with buttons for 'Open medication decision support to edit the prescription', 'View patient record', and 'Start visit 2'. A blue circle with the number '1' highlights the 'View patient record' button.

Patient Information:

- Subject ID: coro-001001-482
- Gender: Female
- Year of birth: 1965
- Start date: 01-01-2025

Consultations during the study: A progress bar shows 7 consultations, with the first one highlighted in green.

Parameters:

- Blood pressure: 129/90 mm Hg
- Weight: 90 kg
- BMI: 35.2 kg/m²
- LDL cholesterol: 2.64 mmol/l
- HbA1c - (Glucose): 31.2 mmol/mol

Behavioural goals:

Goal	Level	Status
Medication adherence	Medium	Inactive
Start moving	Intermediate	Inactive
Healthy nutrition	Medium	Inactive
Smoke-free living	Active smoker	Inactive
Stress relief	High	Inactive
Knowledge level	Beginner	Inactive

Most recent alerts:

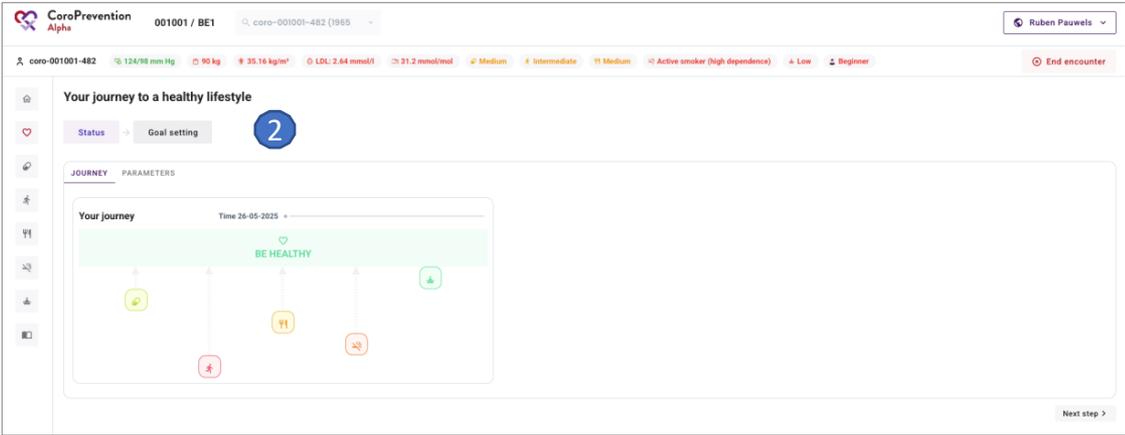
Date	Time	Type	Module	Message	Action

Alert Legend:

- Red: 0
- Orange: 0
- Yellow: 0
- Open: 0
- Handled: 0

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

2 The patient record is open for follow-up.



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 button to mark alert as handled
If you dismiss an alert by mistake, click on the “Undo” button within 30 seconds.
- 5 By filtering on **"Handled"**, you can view all alerts that have been marked as completed/handled.
- 6 You can search for alerts for a specific patient by entering their subject ID in the search field.
- 7 This column indicates the module associated with the alert.

The screenshot shows a 'Pending alerts' dashboard. At the top right, there is a filter section (1) with a 'Filter' button and a status summary: 'Red: 138', 'Orange: 138', 'Green: 138'. Below this are buttons for 'Open' (2) and 'Handled' (3). A search bar (4) contains the text 'Search alerts for patient'. The main area is a table with columns: Patient, Date, Time, Type, Module (8), Message (2), and Action (4). The table lists several alerts with details like patient ID, date, time, severity (Orange, Red), module (Healthy nutrition, Healthy weight, Lowering cholesterol, Smoke-free living), and a message. A tooltip (5) appears over the 'Handled' button in the Action column, showing 'The alert has been handled. UNDO'. At the bottom right, there is a 'Rows per page' dropdown set to 10 and a pagination indicator '1-10 of 22'.

Tip: Click the *Date* column to sort alarms and view the most recent alerts at the top.

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-001001-482. The dashboard is divided into several sections:

- General:** Subject ID (coro-001001-482), Gender (Female), Year of birth (1965), Start date (01-01-2025). Includes a QR code and a link to view the ePro for visit 2.
- Consultations during the study:** A progress bar showing 7 consultations, with the first one completed.
- Parameters:** Blood pressure (129/90 mm Hg), Weight (90 kg), BMI (35.2 kg/m²), LDL cholesterol (2.64 mmol/l), HbA1c - (Glucose) (31.2 mmol/mol).
- Behavioural goals:** Medication adherence (Medium, Inactive), Start moving (Intermediate, Inactive), Healthy nutrition (Medium, Inactive), Smoke free living (Active smoker, Inactive), Stress relief (High, Inactive), Knowledge level (Beginner, Inactive).
- Most recent alerts:** A table showing alerts triggered for the patient since the last visit.

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 in this patient with known diabetes.	A tailored infographic was sent to the patient. ✗

Correcting data entry (Dashboard)

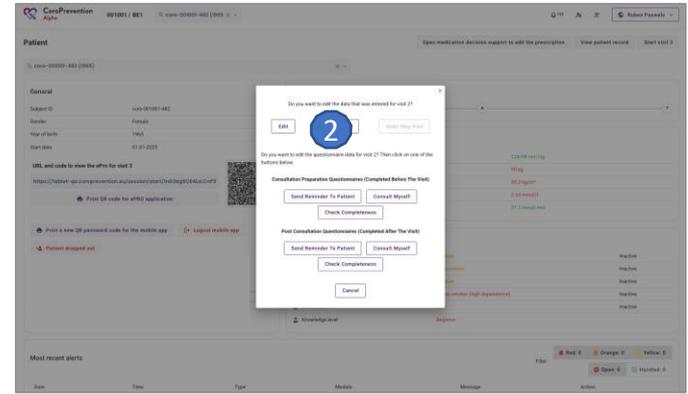
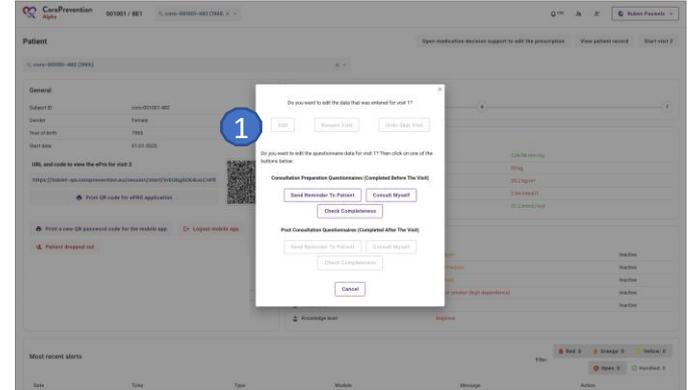
1 Visit 1 data can be edited (corrected) in the EDC.

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

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

2 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.

2 A visit can also be reopened or skipping reverted 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.

Patient

Search: coro-001001-482 (1965)

General

Subject ID	coro-001001-482
Gender	Female
Year of birth	1965
Start date	01-01-2025

URL and code to view the ePro for visit 3

<https://tablet-qa.coroprevention.eu/session/start/In6Obg6OE4LxLnP9>

Print QR code for ePRO application

Print a new QR password code for the mobile app Logout mobile app

1 Patient dropped out

The screenshot shows the patient dashboard for coro-001001-482 (1965). A modal dialog box is open with the text: "Are you sure that patient coro-001001-482 dropped out of the study?". The dialog has "Confirm" and "Cancel" buttons. A blue circle with the number "2" is overlaid on the "Confirm" button. The background dashboard shows patient details, a progress bar for consultations (1/7), and a list of goals such as Medication adherence, Start moving, Healthy nutrition, Smoke-free living, Stress relief, and Knowledge level.

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



CoroPrevention

PERSONALISED PREVENTION FOR
CORONARY HEART DISEASE

Case nurse manual caregiver dashboard - general module

V7.0, 21 Aug 2025



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www.coroprevention.eu

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.

The screenshot shows the CoroPrevention Alpha caregiver dashboard for patient 001001 / BE1. The top navigation bar includes a search bar (1), a button to view alerts (2), a button to search for a patient (3), a button to create a patient record (4), and a user profile dropdown (5). The main content area is divided into several sections: General patient information, Consultations during the study, Parameters, Behavioural goals, and Most recent alerts.

Date	Time	Type	Module	Message	Action

Search all subjects

1 Click on the “group” icon to view a list of all subjects at your site.

2 You can navigate to the next page by clicking Next or by changing the number of rows per page at the bottom of the screen.

3 Select the subject by clicking on “Preview icon”.

The screenshot shows the CoroPrevention Alpha dashboard. At the top, there is a search bar with the text "Search patient" and a dropdown menu. To the right of the search bar, there are icons for notifications, a user profile icon, and a dropdown menu for "Mia Makinen". Below the search bar, the heading "All patients" is displayed. A search bar with the text "Search patient" is located below the heading. The main content is a table with the following columns: "Subject ID", "Gender", "Year of birth", and "Start date". The table contains 10 rows of patient data. At the bottom right of the table, there is a "Rows per page" dropdown menu with options 10, 20, 30, 40, and 50. The current selection is 10. Below the dropdown menu, there is a pagination bar showing "1-10 of 137" and navigation arrows. At the bottom left of the dashboard, there is a text label "Showing page 1 of 14".

Subject ID	Gender	Year of birth	Start date
coro-005001-023	Male	1973	01-07-2023
coro-001003-015	Male	1971	04-09-2024
coro-001003-008	Male	1977	01-12-2023
coro-001002-510	Male	1952	19-04-2025
coro-001002-509	Female	1947	18-04-2025
coro-001002-508	Male	1973	16-04-2025
coro-001002-507	Female	1971	15-04-2025
coro-001002-506	Female	1947	14-04-2025
coro-001002-505	Male	1951	12-04-2025
coro-001002-504	Male	1960	06-07-2025

Completeness of ePRO questionnaires

- By clicking a visit in the timeline (visit number) and clicking the “Check Completeness” button, you can view the overall status of the questionnaires for that visit.
- Completeness of the ePROs is important, as they provide essential information for several sections of the caregiver dashboard and the data analysis.
- Note: ePROs will lock for editing 48h after the visit.

Do you want to edit the data that was entered for visit 2?

Edit Reopen Visit

Do you want to edit the questionnaire data for visit 2? Then click on one of the buttons below:

Consultation Preparation Questionnaires (Completed Before The Visit)

Send Reminder To Patient Consult Myself

Check Completeness

Post Consultation Questionnaires (Completed After The Visit)

Send Reminder To Patient Consult Myself

Check Completeness

Cancel

Visit 2

Consultation preparation questionnaires (completed before the visit)

- Ad hoc questionnaire for health behavior change (status) – medication adherence
- Ad hoc questionnaire for health behavior change (status) – start moving
- Ad hoc questionnaire for health behavior change (status) – healthy nutrition
- Ad hoc questionnaire for health behavior change (status) – smoke-free living – smoking behaviour
- Ad hoc questionnaire for health behavior change (status) – smoke-free living – MTSS
- Ad hoc questionnaire for health behavior change (status) – stress relief – stress level
- Ad hoc questionnaire for health behavior change (status) – stress relief – coping measures
- Ad hoc questionnaire for health behavior change (motivation)
- Current smoking behaviour
- FND
- Physical complaints
- Sports preferences when I was a kid
- Current sports preferences
- Healthy nutrition challenges
- Past quit attempts
- Stressors
- Stress relief techniques
- Educational material (e.g. videos, articles)
- Stress relief goals
- BCSS
- Decisional Conflict Scale
- Medication prescription

Close

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?



*You can change the units for LDL and HbA1c in **Settings**.

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 interface for patient 001001 / BE1. The top navigation bar includes the patient ID and a search field. Below this, a row of health metrics is shown: 124/98 mm Hg, 90 kg, 35.16 kg/m², LDL: 2.64 mmol/l, and 31.2 mmol/mol, with a 'Medium' risk indicator. The main content area is titled 'Your journey to a healthy lifestyle' and features a 'Status' and 'Goal setting' toggle. A 'JOURNEY' tab is active, showing a timeline for 'Your journey' as of 26-05-2025. The central focus is a green bar labeled 'BE HEALTHY'. Below this bar, several icons represent different goals: a green pill icon, a red running man icon, a yellow cutlery icon, and an orange smoking icon. A green checkmark icon is also visible on the right side of the journey bar.

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 'Medication adherence' section of the CoroPrevention Alpha patient dashboard. At the top, the patient's name 'Ruben Pauwels' is visible. Below the patient's name, various clinical data points are listed: '124/98 mm Hg', '90 kg', '35.16 kg/m²', 'LDL: 2.64 mmol/l', '31.2 mmol/mol', 'Medium', 'Intermediate', 'H Medium', 'Active smoker (high dependence)', 'Low', and 'Beginner'. The 'Medication adherence' section is divided into two tabs: 'Status' and 'Prescription'. The 'Status' tab is active, showing a 'Medium' adherence level with a highlighted circle containing the number '1'. Below this, the text 'I mostly take my medication as prescribed' is displayed, along with the date 'Reported on 26/05/2025'. The 'Medication adherence barriers' section is also visible, showing a 'Score' of '24' with a highlighted circle. The barriers are categorized into 'No barrier', 'A small barrier', and 'A big barrier'. The 'No barrier' section includes 'Anxious mood', 'Getting hold of medication', 'Confidence in managing', 'Worry about unwanted effects', 'Feels a burden', 'Coping with changes', 'Social worries', and 'Depressed mood'. The 'A small barrier' section includes 'Remember to take' and 'Life gets in the way'. The 'A big barrier' section includes 'Know how to take' and 'Physically able'. At the bottom of the section, there are navigation options: '< Go to journey' and 'Next step >'. The overall interface is clean and modern, with a focus on patient data and adherence tracking.

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 CoroPrevention Alpha interface for a patient named Ruben Pauwels. The top navigation bar includes the patient's name and a search bar. Below this, a row of health indicators shows values for blood pressure (124/98 mm Hg), weight (90 kg), cholesterol (35.16 kg/mol), LDL (2.64 mmol/l), and triglycerides (31.2 mmol/mol), along with risk levels for Medium, Intermediate, and High dependence. The main content area is titled 'Medication adherence' and features a 'Status' tab (highlighted with a blue circle '1') and a 'Prescription' tab. The 'Status' section shows a 'Medium' adherence level with the text 'I mostly take my medication as prescribed' and a 'Reported on 26/05/2025' date. Below this, the 'Medication adherence barriers' section lists various barriers such as 'Anxious mood', 'Getting hold of medication', 'Confidence in managing', 'Worry about unwanted effects', 'Feels a burden', 'Coping with changes', 'Social worries', and 'Depressed mood'. A 'Score' of 24 is displayed in a blue box. At the bottom, there are navigation buttons for '< Go to journey' and 'Next step >' (highlighted with a blue circle '2').

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 'Medication adherence' section of the CoroPrevention Alpha interface. At the top, there are patient identifiers and a search bar. Below this, a row of vital signs and clinical indicators is shown. The main area is titled 'Medication adherence' and includes tabs for 'Status' and 'Prescription'. There are three action buttons: 'Print for patient', 'Print for general practitioner', and 'Open medication decision support to edit the prescription'. Under 'Current prescription', two medications are listed: 'Totalip (+)' 50 mg and 'Aspirin (+)' 100 mg. Each medication entry includes a frequency table with columns for MORNING, NOON, AFTERNOON, and EVENING/NIGHT. A large grey box on the right 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. A blue circle with the number '3' is positioned over the 'Previous step' button, and another blue circle with the number '4' is positioned over the 'Go to journey' button.



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Case nurse manual caregiver dashboard - journey module

V7.0, 21 Aug 2025

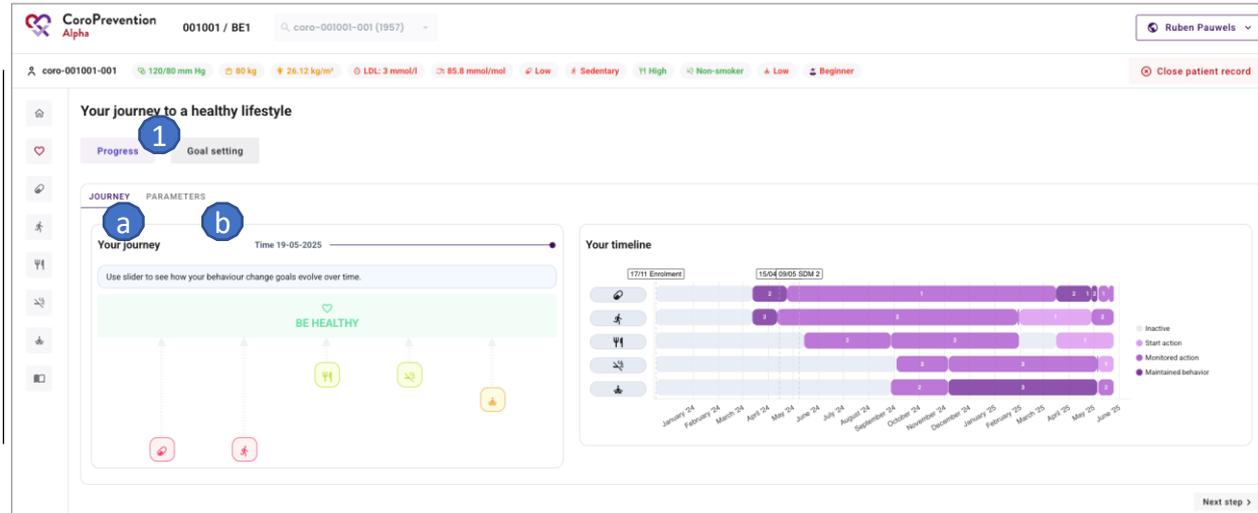


This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 848056

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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.

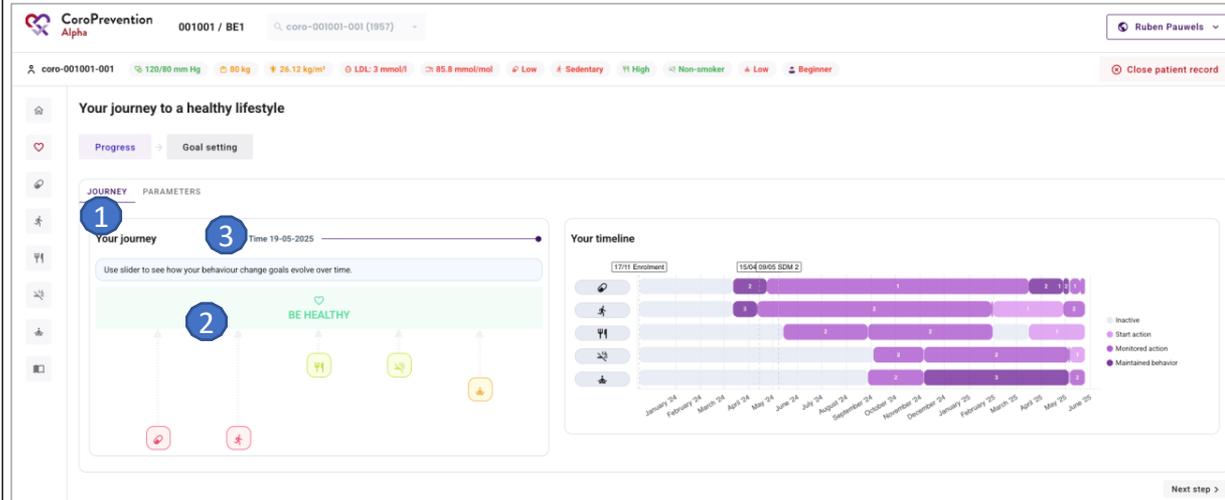


How to follow up on the patient's progress for the behavioral goals?

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 "Medication adherence" and "Start moving" are far from the "Be healthy", so these risk factors need most improvement. "Healthy nutrition" and "Smoke-free living" are near to the "Be healthy", so these risk factors are well under control. "Stress relief" is in the middle, so still quite some room for improvement.

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

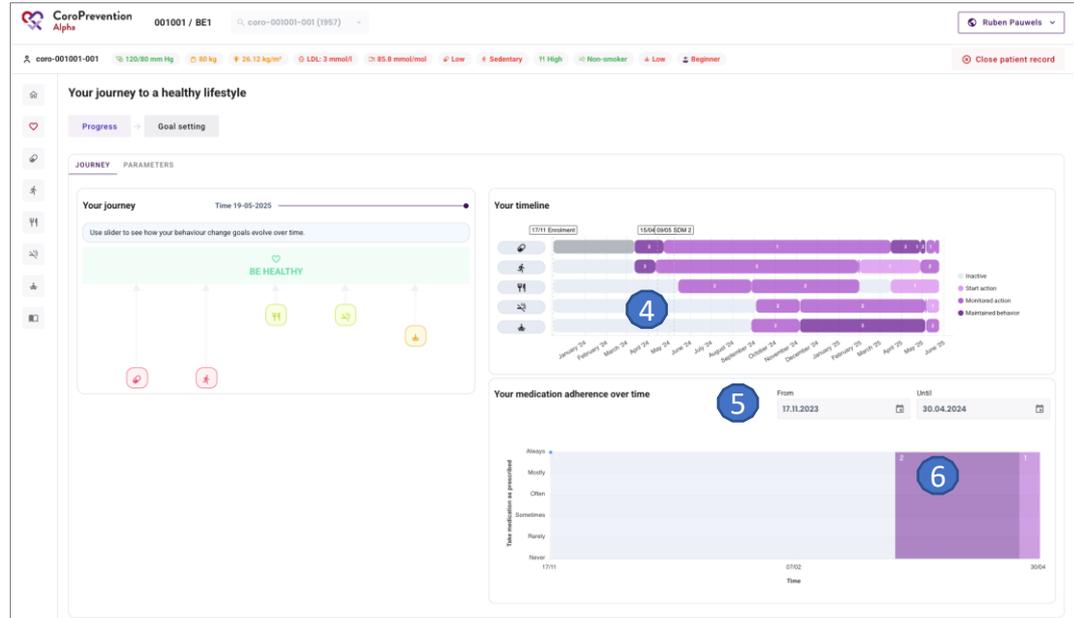


How to follow up on the patient's progress for the behavioural goals?

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.

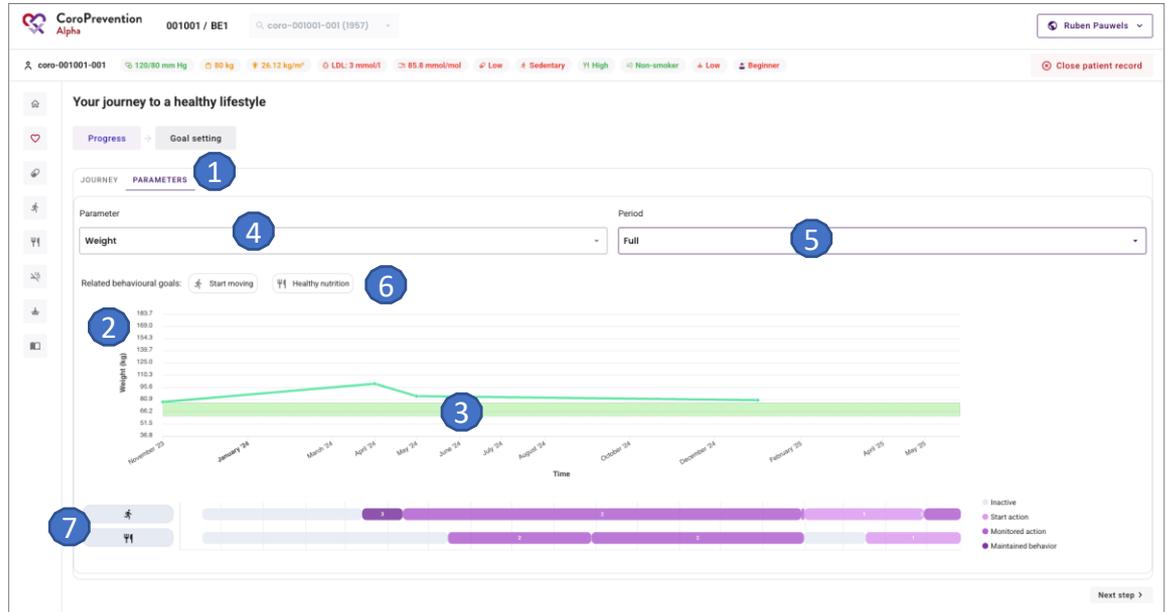
3 The green area is the personalized target zone that the patient should strive to achieve.

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.

The screenshot shows the CoroPrevention Alpha dashboard for patient 001001 / BE1. The patient's current status is "Goal setting" (indicated by a blue circle '1'). The dashboard displays various health metrics and a table of behavioural and outcome goals with their status and motivation levels. A decision matrix is also visible on the right.

Goal	Status	Motivation
Medication adherence	Medium	Moderate
Start moving	Intermediate	High
Healthy nutrition	Medium	Low
Smoke-free living	Active smoker (high dependence)	High
Stress relief	Low	Low

The decision matrix on the right shows the following actions:

Decision	Inactive	Start action	Monitored action	Maintained behavior
Start moving				
Healthy nutrition				
Smoke-free living				
Stress relief				

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.

3 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 'Your journey to a healthy lifestyle' section in the Coroprevention Alpha caregiver dashboard. It features a table of behavioural goals with columns for Status, Motivation, and Decision. The 'Medication adherence' goal is highlighted with a blue circle '1' and has a 'Medium' status and 'Moderate' motivation. The 'Start moving' goal has an 'Intermediate' status and 'High' motivation. The 'Healthy nutrition' goal has a 'Medium' status and 'Low' motivation. The 'Smoke free living' goal has an 'Active smoker (high dependence)' status and 'High' motivation. The 'Stress relief' goal has a 'Low' status and 'Low' motivation. The 'Decision' column shows options like 'Inactive', 'Start action', 'Monitored action', and 'Maintained behavior'. A blue circle '2' is over the 'Status' column, a blue circle '3' is over the 'Motivation' column, and a blue circle '4' is over the 'Decision' column.

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

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 displays the 'Your journey to a healthy lifestyle' dashboard in the CoroPrevention Alpha system. At the top, patient information includes '001001 / BE1' and 'coro-001001-482 (1865)'. A navigation bar shows various health metrics: 124/98 mm Hg, 90 kg, 35.16 kg/m², LDL: 2.84 mmol/l, 31.2 mmol/mol, Medium, Intermediate, 11 Medium, Active smoker (high dependence), Low, and Beginner. The main content area is titled 'Your journey to a healthy lifestyle' and has two tabs: 'BEHAVIOURAL GOALS' and 'OUTCOME GOALS' (the latter is selected and marked with a blue circle '1'). Under 'OUTCOME GOALS', there are four items: 'Lowering blood pressure' (Status: Good, marked with a blue circle '2'), 'Healthy weight' (Status: Poor, marked with a blue circle '2'), 'Lowering cholesterol' (Status: Poor, marked with a blue circle '2'), and 'Diabetes management' (Status: Good, marked with a blue circle '2'). To the right of these items, there are three toggle switches for 'Outcome goal' (marked with a blue circle '2'). The first toggle is off, the second is on (with an 'Add target weight' button next to it, marked with a blue circle '3'), and the third is off. A '< Previous step' button is at the bottom left.

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/m², the recommended target weight is set automatically to a 5 percent weight reduction. If the patient's BMI is already 25 kg/m² 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 interface for a patient named Ruben Pauwels. The patient's profile includes ID 001001 / BE1 and various health metrics such as blood pressure (124/98 mm Hg), weight (90 kg), BMI (35.16 kg/m²), LDL (2.64 mmol/L), and HbA1c (31.2 mmol/mol). The 'Your journey to a healthy lifestyle' section is active, showing a 'Goal setting' tab. Under 'OUTCOME GOALS', the 'Healthy weight' goal is currently set to 'Poor' status. The 'Outcome goal' section shows a target weight of 85.5 kg. A blue circle with the number 4 is placed over the target weight input field, and a blue circle with the number 5 is placed over the 'Remove target weight' button.



CoroPrevention

PERSONALISED PREVENTION FOR
CORONARY HEART DISEASE

Case nurse manual caregiver dashboard - education module

V7.0, 21 Aug 2025



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

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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.

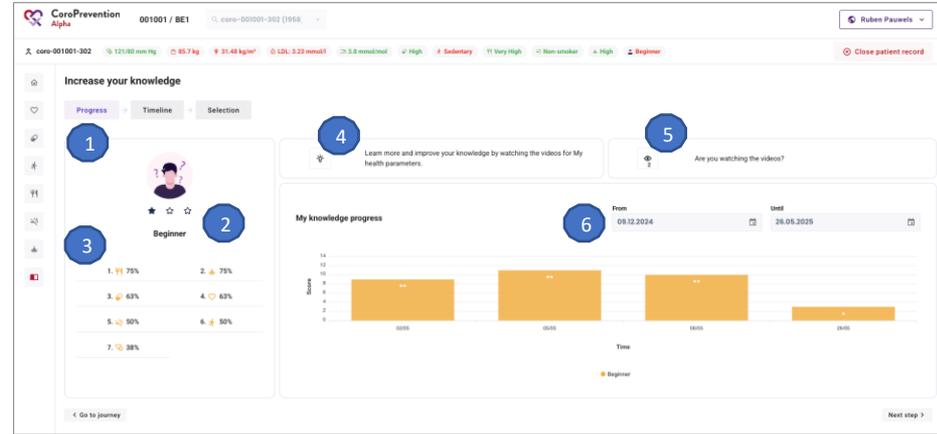
2 You can view the patient's current knowledge level. There are three knowledge levels: beginner, advanced knowledge, and health expert. Within these levels, the patient can attain 1, 2 or 3 stars, depending on the number of correct answers in the last knowledge challenge.

3 There is an overview of how well the patient's knowledge is for different categories. The categories are respectively: healthy nutrition, stress relief, medication adherence, my heart, smoke-free living, 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.

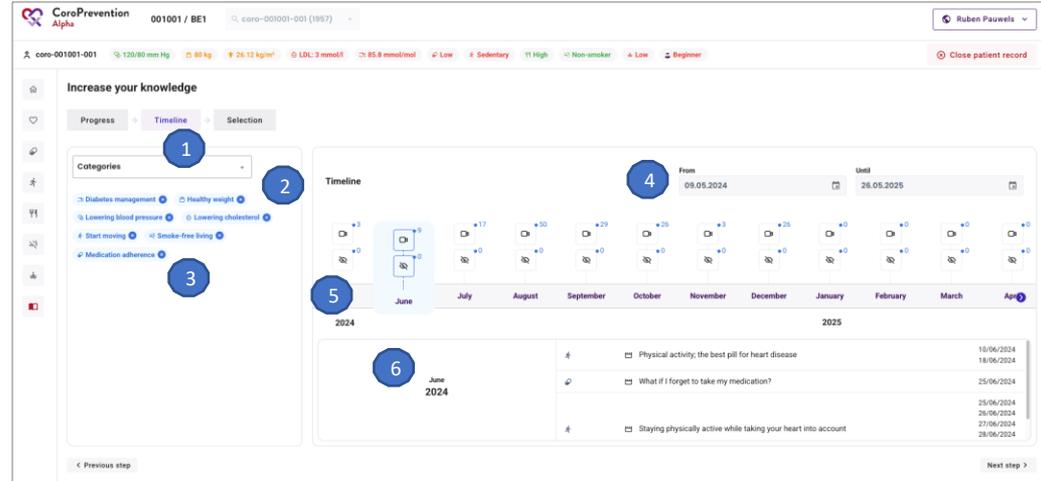
2 You can select the categories (multiple) that you want to include in the timeline.

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.

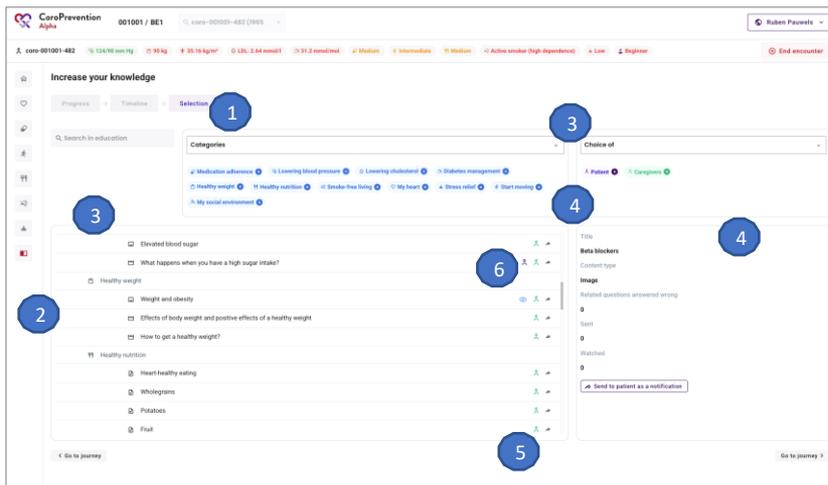
3 You can also apply filters to look for specific educational content based on the category or who selected the educational content.

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.

5 Educational content that is selected by the patient has a "patient" 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 CoroPrevention Alpha interface for patient management. At the top, the patient's profile is shown with various health metrics such as blood pressure, cholesterol, and weight. Below this, the 'Increase your knowledge' section is active, showing a list of educational items. The 'Weight and obesity' item is selected and highlighted in blue. To the right of the list, a detailed view of the selected item is shown, including its title, content type, and related questions. At the bottom of this view, there are two buttons: 'Add to patient Favorites' and 'Send to patient as a notification'. Numbered callouts (7-11) point to specific UI elements: 7 points to the 'share' icon, 8 to the title, 9 to the 'Add to patient Favorites' button, 10 to the 'Send to patient as a notification' button, and 11 to the 'share' icon at the bottom of the item list.



CoroPrevention

PERSONALISED PREVENTION FOR
CORONARY HEART DISEASE

Case nurse manual caregiver dashboard - medication adherence module

V7.0, 21 Aug 2025



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

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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 specific questionnaires i.e., IMAB (medication barriers), GAD-7 (symptoms of anxiety) and PHQ-9 (signs of depression) that were completed in the ePRO application at V1.

4 The elements indicated in green are no barriers for the patient.

5 The elements indicated in orange are small barriers for the patient.

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 CoroPrevention Alpha dashboard for patient 001001 / BE1. The top navigation bar includes the patient's name, ID, and a search bar. Below the navigation bar, a summary of patient data is shown, including blood pressure (124/98 mmHg), weight (90 kg), BMI (35.16 kg/m²), LDL cholesterol (2.64 mmol/L), and HbA1c (31.2 mmol/mol). The patient's medication status is listed as Medium, Intermediate, and Medium, with a note for Active smoker (high dependence). The main content area is titled "Medication adherence" and features a "Status" button (1) and a "Prescription" button. The status is "Medium" (2) with the text "I mostly take my medication as prescribed" and a report date of 26/05/2025. Below this, the "Medication adherence barriers" section shows a score of 24 (3) and a list of barriers: "No barrier" (4), "Sad mood" (5), "Confidence in managing" (6), "Worry about unwanted effects", "Feels a burden", "Coping with changes", "Social norms", and "Depressed mood". The barriers are color-coded: green for no barrier, orange for small barrier, and red for major barrier. The "Sad mood" barrier is orange, while the others are green. The "Go to journey" button is at the bottom right.

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

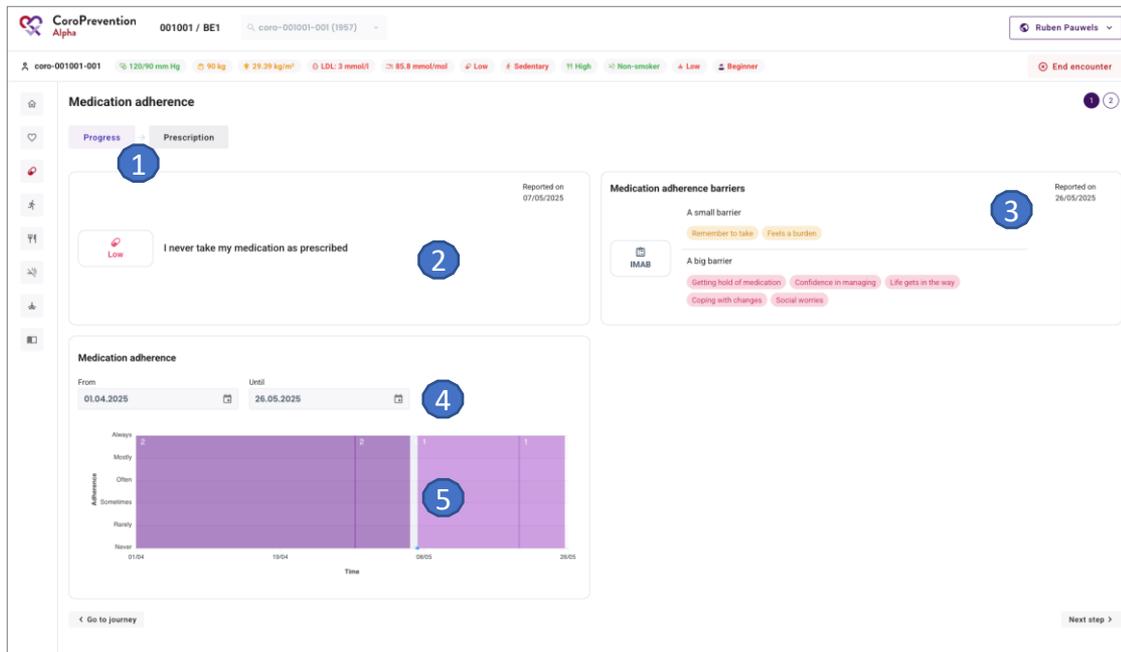
1 In "Progress", you have an overview of the patient's progress for medication adherence.

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 specific questionnaires i.e. IMAB, GAD-7 and PHQ-9 that were completed in the ePRO application at V1.

4 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?

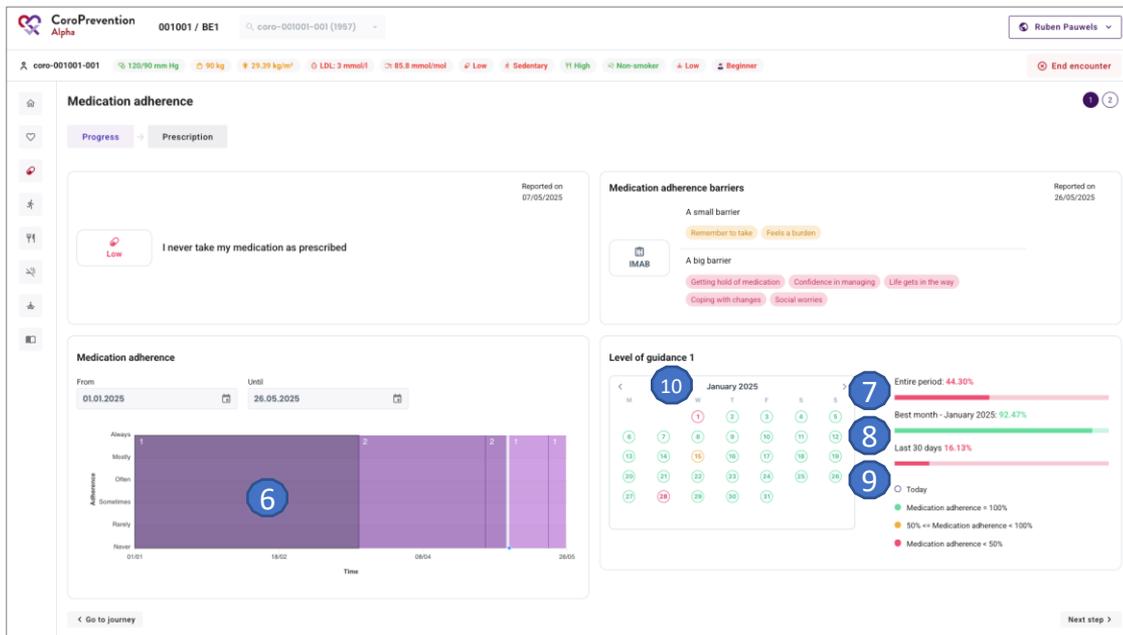
6 You can click on a period in a level of guidance to view more details about this period.

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.

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.

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.

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

The screenshot shows the 'Medication adherence' section of the CoroPrevention Alpha dashboard. The interface includes a patient header with ID '001001 / BE1', vital signs (124.98 mmHg, 90 kg, 35.16 kg/m²), and lab results (LDL: 2.64 mmol/L, 31.2 mmol/mol). The 'Medication adherence' section lists three medications: Totalip (50 mg), Clopidogrel (75 mg), and Aspirin (+) (100 mg). Each medication row has a 'Medication class(es)' dropdown menu. On the right, there is a 'Totalip' section with 'Related parameters' (HDL, LDL, Total cholesterol), a 'Reason' for the medication, and a 'Change history' table. The 'Change history' table shows three entries: a decrease in evening/night pills from 2 to 1, an increase from 1 to 2, and the addition of the drug to the prescription. A 'Notes' section is at the bottom right. Numbered callouts (1-12) point to various UI elements: 1 (Prescription tab), 2 (Current prescription dropdown), 3 (Aspirin (+) pill icon), 4 (Totalip pill icon), 5 (Clopidogrel pill icon), 6 (Print for patient button), 7 (Medication class dropdown), 8 (Totalip section), 9 (Medication class dropdown), 10 (Notes section), 11 (Open medication decision support button), and 12 (Print for general practitioner button).



CoroPrevention

PERSONALISED PREVENTION FOR
CORONARY HEART DISEASE

Case nurse manual caregiver dashboard - medication DSS

V7.0, 21 Aug 2025



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

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

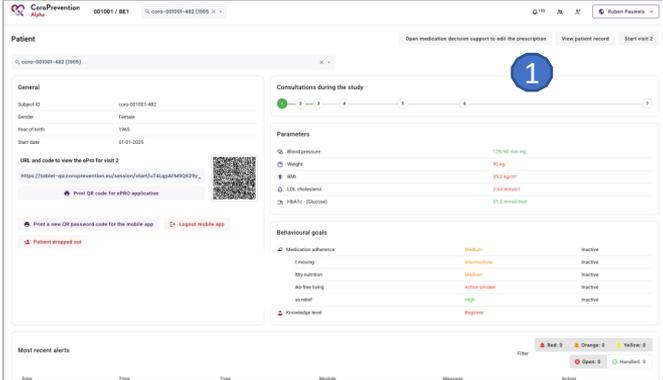
There are three ways to open the medication DSS.

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

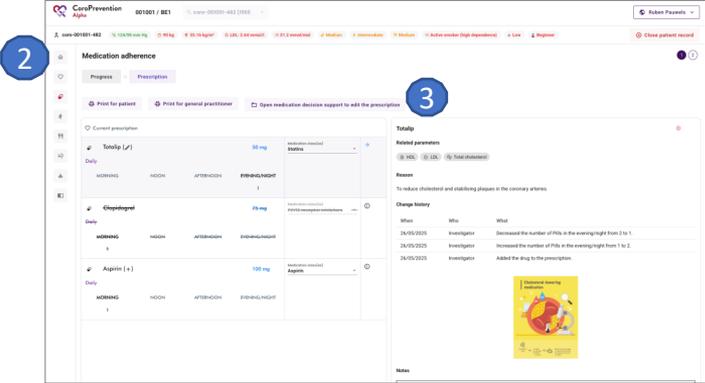
2 Open the patient record, click the "House" menu item to open the medication DSS by clicking the "Open medication decision support" button.

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 visit 2 is closed in the dashboard. The nurse cannot run the medication DSS algorithm.



The screenshot shows the 'Patient' summary page for a patient with ID 001001 / BE1. The page is divided into several sections: 'General' (Subject ID, Gender, Year of birth, Start date), 'URL and code to view the ePDR for visit 2', 'Consultations during the study' (with a timeline and a blue circle '1' highlighting the 'Open medication decision support to edit the prescription' button), 'Parameters' (Blood pressure, Weight, Sex, Uric acidemia, HbA1c), and 'Behavioural goals' (Medication adherence, Smoking, Weight, Age, Knowledge level). At the bottom, there is a 'Most recent alerts' section.



The screenshot shows the 'Medication adherence' module. The 'Prescription' tab is selected, highlighted with a blue circle '2'. Below the tab, there is a table of prescriptions with columns for drug name, dose, frequency, and time. A blue circle '3' highlights the 'Open medication decision support to edit the prescription' button at the top of the prescription list. To the right, there is a 'Totally' section with 'Related parameters' and a 'Change history' table showing changes to the number of pills in the evening.

How to navigate in the medication DSS?

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

You can close the medication DSS by clicking this button. The changes are automatically made to the patient's medication prescription on his/her smartphone.

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

All warnings from the medication DSS for this patient are grouped in this section.

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

The screenshot shows the Coroprevention medication decision support system interface. At the top, there is a patient information bar with the patient ID '001001 / BE1' and a search bar containing 'coro-001001-482'. Below this, a status bar displays various patient metrics: '124/98 mm Hg', '90 kg', '35.76 kg/m²', 'LDL: 2.64 mmol/L', '31.2 mmol/mol', 'Medium', 'Intermediate', '11 Medium', 'Active smoker (high dependence)', 'Low', and 'Beginner'. The main section is titled 'Medication decision support system' and features four tabs: 'Cardiac medication' (a), 'Other medication' (b), 'Allergies' (c), and 'Titration schemes' (d). A 'Close' button is located to the right of the tabs. Below the tabs, there is a 'Current prescription' section showing a table for 'Aspirin 100 mg' with columns for 'Morning', 'Noon', 'Afternoon', and 'Evening/night'. The table shows a 'Daily' prescription with a value of '1' in the 'Morning' column and '0' in the others. Below the table, there is a message: 'This medication has been recommended by the algorithm.' and a 'More info' dropdown menu. To the right of the main content, there is a 'Warnings' section with several warning messages, each preceded by a yellow triangle icon. At the bottom right, there is an 'Add drug' button. The interface is annotated with numbered callouts: 1 points to the 'Cardiac medication' tab, 2 points to the 'Close' button, 3 points to the 'Print for general practitioner' and 'Print for patient' buttons, 4 points to the 'Warnings' section, and 5 points to the 'Close' button in the top right corner.

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 for a patient with ID 001001-482. The patient's vital signs are shown at the top: 124/98 mmHg, 90 kg, 35.14 kg/m², LEC: 2.64 mmol/L, 31.2 mmol/mol, Medium, Intermediate, 11 Medium, Active smoker (high dependence), and Low. The interface has tabs for Cardiac medication, Other medication, Allergies, Titration schemes, and Algorithm input. The Cardiac medication tab is active, showing a list of current prescriptions. The first entry is Aspirin 100 mg, which is highlighted in green, indicating it is recommended. The second entry is Clopidogrel 75 mg, which is highlighted in white, indicating it is not recommended. The interface also shows a recommendation section for Clopidogrel and P2Y12 receptor inhibitors. The interface includes a warning section on the right side, which contains several warnings related to the patient's age, systolic BP targets, OAC recommendations, and beta-blockers.

1

2

3

4

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.

9 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, and the guideline source.

10 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.

11 You can view the change history for the drug.

The screenshot displays the medication DSS interface for a patient with ID 001001-482. The patient's vital signs are shown at the top: 124/98 mmHg, 90 kg, 35.14 kg/m², 101.24 mmHg, and 31.2 mmol/mol. The interface is divided into several sections:

- Cardiac medication:** Shows a prescription for Aspirin 100 mg, taken daily. The frequency and time are indicated by a circled 5. There are buttons for editing (7), deleting (8), and adding (10) the drug.
- Recommendation:** Shows a recommendation for Clopidogrel 75 mg, taken daily. There are buttons for editing (7) and deleting (8) the recommendation.
- Warnings:** Several warnings are displayed on the right side, including: "The patient age for the algorithm can be up to 1 year older than the EDC reported value.", "Warning: Systolic BP targets (e.g. 140 mmHg) should be considered among patients meeting the following criteria: * pre-treatment, symptomatic, orthostatic hypotension * and/or age >85 years * clinically significant, moderate to severe frailty at any age * and/or limited predicted lifespan (<math><3\text{ years}</math>).", "Warning: OAC are recommended in those with a CHA2DS2-VASc score of 2 or more and should be considered in those with a CHA2DS2-VASc score of 1.", "Warning: It is recommended that beta blockers are combined with any of the other major BP-lowering drug classes when there are other competing indications for their use, e.g. angina, post-myocardial infarction, heart failure with reduced ejection fraction, or for heart rate control.", and "Warning: It is recommended to take medications at the most convenient time of day for the patient to establish a habitual pattern of medication taking to improve adherence."
- Buttons:** A circled 6 is next to the "More info" button, and a circled 11 is next to the "Change history" button.

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 prescription interface for Aspirin 20 mg. The interface includes a header with the drug name, dosage, and unit, and a table for daily dosing. A small icon in the top right corner of the header indicates that the drug was added by the patient since the last encounter. The table shows a daily dose of 1 unit in the morning and 0 units in the afternoon and evening/night. There are also sections for notes and change history.

	Morning	Noon	Afternoon	Evening/night
Daily	1	0	0	0

No notes added

Change history

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

1 Close the medication prescription by clicking this button.

2 After you clicked the "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 'Medication decision support system' interface for patient 001001 / BE1. The 'Close' button is highlighted with a blue circle containing the number 1. The interface displays a list of medications, including Aspirin, and a table showing the prescription details. The table has columns for Morning, Noon, Afternoon, and Evening/night, with a 'Daily' row showing a value of 1 in the Morning column. The interface also includes a 'Print for patient' button and a list of warnings on the right side.

The screenshot shows the 'Medication decision support system' interface for patient 001001 / BE1. The 'Edit prescription' button is highlighted with a blue circle containing the number 3. The interface displays a list of medications, including Aspirin and Clopidogrel, and a table showing the prescription details. The table has columns for Morning, Noon, Afternoon, and Evening/night, with a 'Daily' row showing a value of 1 in the Morning column. The interface also includes a 'Print for general practitioner' button and a 'Print for patient' button.

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 medication management interface. At the top, a patient summary bar includes the ID 'coro-001001-482' and various clinical metrics: 124/96 mm Hg, 90 kg, 35.16 kg/m², LDL 2.64 mmol/L, 31.2 mmol/mol, Medium, 4 Intermediate, 11 Medium, Active smoker (high dependence), Low, and Beginner. Below this, there are two medication cards. The first card shows 'Daily' dosing with a table: Morning (1), Noon (0), Afternoon (0), Evening/night (0). A note states 'This medication has been recommended by the algorithm.' The second card is for 'Clopidogrel' 75 mg, P2Y12 receptor inhibitors, with the same dosing table and algorithm recommendation note. Below these is a section for 'Other medication' which is currently empty, with the text 'The medication prescription is empty.' At the bottom, there is a 'Titration schemes' section for a 'beta blocker' with a table: Start dosage (25 mg), Target dosage (75 mg), and Description (Increase after 3 weeks when there are no contra-indications). A 'Go to patient overview' button is located in the bottom right corner of the interface.

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.

CoroPrevention Alpha 001001 / BE1

coro-001001-482 124/98 mm Hg 90 kg 35.16 kg/m² LDL: 2.64 mmol/l 31.2 mmol/mol Medium Intermediate Medium Active smoker (high dependence) Low Beginner

Medication decision support system

Cardiac medication → **Other medication** → Allergies → Titration schemes

Close Print for general practitioner Print for patient

⚠ The patient age for the algorithm can be up to 1 year older than the EDC reported value.

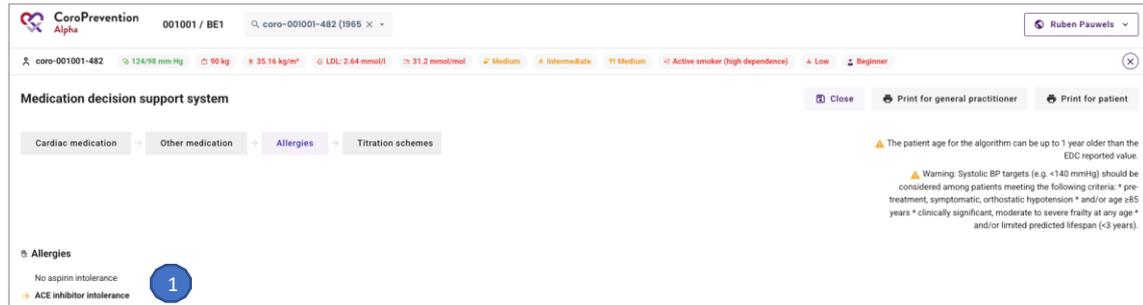
⚠ Warning: Systolic BP targets (e.g. <140 mmHg) should be considered among patients meeting the following criteria: * pre-treatment, symptomatic, orthostatic hypotension * and/or age ≥85 years * clinically significant, moderate to severe frailty at any age * and/or limited predicted lifespan (<3 years).

Current prescription

	Morning	Noon	Afternoon	Evening/night
Fulium D3 800 80 ug	1	0	0	0
Ozempic 0.5 mL	0	0	0	1

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.



CoroPrevention Alpha 001001 / BE1

coro-001001-482 124/98 mmHg 90 kg 35.16 kg/m² LDL: 2.64 mmol/l 31.2 mmol/mol Medium Intermediate High Medium Active smoker (high dependence) Low Beginner

Medication decision support system

Close Print for general practitioner Print for patient

Cardiac medication Other medication Allergies Titration schemes

Allergies

- No aspirin intolerance
- ACE inhibitor intolerance

Warning: Systolic BP targets (e.g. <140 mmHg) should be considered among patients meeting the following criteria: * pre-treatment, symptomatic, orthostatic hypotension * and/or age ≥85 years * clinically significant, moderate to severe frailty at any age * and/or limited predicted lifespan (<3 years).

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 CoroPrevention medication decision support system (DSS) interface for a patient named Ruben Pauwels. The patient's ID is 001001 / BE1, and the system is displaying data for patient coro-001001-482. Key patient parameters include a blood pressure of 126/99 mmHg, a heart rate of 90 bpm, and cholesterol levels (LDL: 2.64 mmol/l, HDL: 31.2 mmol/mol). The patient is classified as Medium risk, with intermediate and high dependence on active smoking, and is a beginner.

The interface shows a navigation menu with tabs for Cardiac medication, Other medication, Allergies, and Titration schemes. The Titration schemes tab is active, and a blue circle '1' highlights the 'Titration schemes' button in the navigation menu.

Under the 'Titration schemes' section, there are two entries:

- Titration scheme for beta blocker:** Start dosage 25 mg, Target dosage 75 mg. Description: Increase after 3 weeks when there are no contra-indications. A blue circle '4' highlights the edit button (pencil icon) and a red circle '5' highlights the delete button (trash icon).
- Titration scheme for angina pectoris:** Start medication: Beta blockers. Additional medication classes: Calcium channel blockers. Description: If the nagor is not controlled with the beta blocker, consider adding the CCB. A blue circle '2' highlights the 'Add dosage titration scheme' button, and a red circle '3' highlights the 'Add drug addition titration scheme' button.

Warning messages are visible: 'The patient age for the algorithm can be up to 1 year older than the EDC reported value.' and 'Warning: Systolic BP targets (e.g. <140 mmHg) should be considered among patients meeting the following criteria: * pre-treatment, asymptomatic, orthostatic hypotension * and/or age >85 years * clinically significant, moderate to severe frailty at any age * and/or limited predicted lifespan (<3 years).'



CoroPrevention

PERSONALISED PREVENTION FOR
CORONARY HEART DISEASE

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

V7.0, 21 Aug 2025



www.coroprevention.eu



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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.

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

- 2 You can view how much the patient is moving globally.

- 3 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.

The screenshot displays the CoroPrevention Alpha patient dashboard for patient ID 001001 / BE1. The top navigation bar includes the patient's name, ID, and a search bar. Below the navigation bar, a row of vital signs and risk factors is shown: 124/98 mm Hg, 90 kg, 35.16 kg/m², LDL 2.64 mmol/L, 31.2 mmol/mol, Medium, Intermediate, Medium, Active smoker (high dependence), Low, and Beginner. The main content area is titled "Start moving" and contains two tabs: "Status" (selected) and "Goal setting". The "Status" tab shows a "Current physical activity" section with a summary bar indicating "1 day(s) with a total of 30 minutes or more of at least moderate physical activity" reported on 26/05/2025. Below this, a RAPA questionnaire result is shown with three items: "Under active regular" (yellow), "Fulfilled strength exercises" (green), and "Did not perform flexibility exercises" (red). The interface includes a sidebar with navigation icons, a "Go to journey" button at the bottom left, and a "Next step" button at the bottom right. Three blue circles with numbers 1, 2, and 3 are overlaid on the image to highlight the "Status" button, the physical activity summary bar, and the RAPA questionnaire results, respectively.

How to view the patient's progress for physical activity?

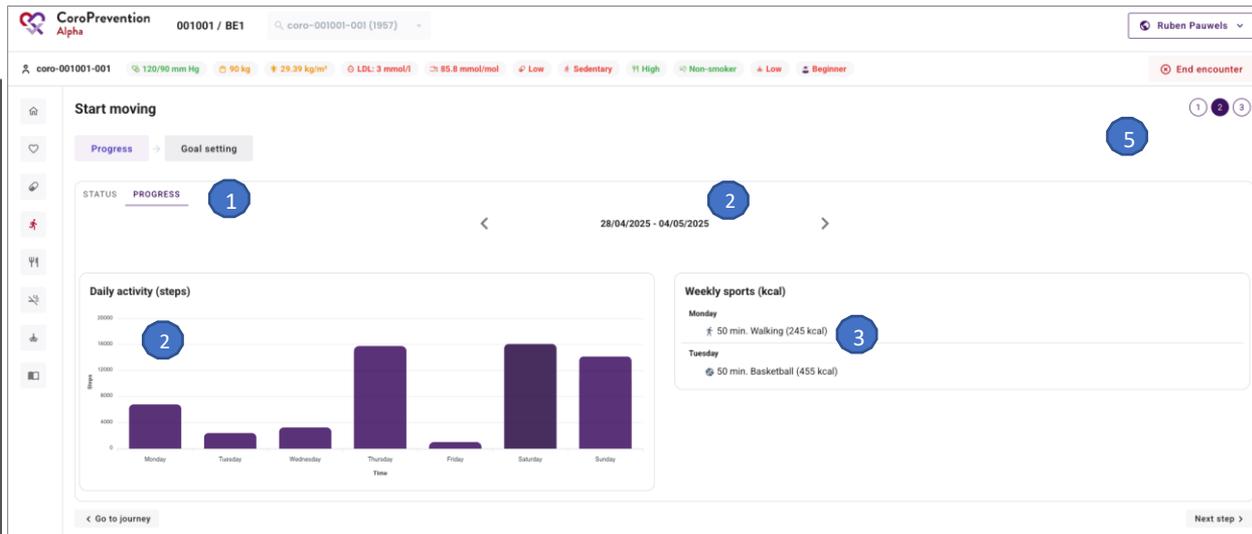
1 Navigate to the progress tab in the **Start moving** module.

2 The subject's daily step count is displayed as a bar chart under "Daily Activity".

3 Any reported sports activities are shown in the "Weekly sports" section.

4 You can browse different weeks by clicking the week indicator (forward and back arrows).

5 The subject's level of guidance is displayed in the top corner.



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 weekly sports is 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 weekly sports goal 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). The daily activity goal is always updated immediately as this is a daily goal.

The screenshot displays the CoroPrevention Alpha interface for a patient named Ruben Pauwels. The top navigation bar shows the patient's ID (001001 / BE1) and various health metrics: 124/98 mmHg, 90 kg, 35.16 kg/m², LDL: 2.64 mmol/l, and 31.2 mmol/mol. The main content area is titled "Start moving" and includes a "Goal setting" section. This section has two tabs: "WEEKLY SPORTS GOAL" and "DAILY ACTIVITY GOAL". The "WEEKLY SPORTS GOAL" tab is active, showing a timeline from "Start - 378" to "Finish - 2834". A blue circle 'a' is placed over the "Weekly sports goal" text, and another blue circle 'b' is placed over the "Daily activity goal" text. Below the timeline, there are settings for "Moderate intensity", "3-5 sessions", "20-60 minutes", and "2 sessions". At the bottom, there are three sections: "Physical complaints" (Balance problems, Shortness of breath), "Favourite activities" (Walking, Cycling), and "Favourite activities from childhood" (Cycling, Soccer). A "Go to journey" button is at the bottom right.

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)) by clicking the "Edit sports goal" button.

The screenshot displays the 'Goal setting' interface for a patient named Ruben Pauwels. The patient's profile information at the top includes: 001001 / BE1, coro-001001-482 (1865), 124/98 mm Hg, 90 kg, 35.14 kg/m², LDL: 2.64 mmol/L, 31.2 mmol/mol, Medium, Intermediate, Medium, Active smoker (high dependence), Low, Beginner. The 'Start moving' section shows the 'Goal setting' tab selected. The 'WEEKLY SPORTS GOAL' section features a progress bar with a yellow flag (1) at the start (378 kcal) and a finish flag (2) at 2834 kcal. An 'Edit sports goal' button (7) is visible. Below the goal, the exercise prescription is shown: Moderate intensity (3), 3-5 sessions (4), 20-60 minutes (5), and 2 sessions (6). The 'Physical complaints' section (4) lists 'Balance problems' and 'Shortness of breath'. The 'Favourite activities' section (5) lists 'Walking' and 'Cycling'. The 'Favourite activities from childhood' section (6) lists 'Cycling' and 'Soccer'. 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 patient receives a credit for the registered activity.

The screenshot displays the 'Daily activity goal' configuration page in the CoroPrevention Alpha system. At the top, patient information for '001001 / BE1' is shown, along with various clinical indicators like blood pressure (124/98 mmHg), weight (90 kg), and cholesterol levels. The main content area is titled 'Start moving' and contains two tabs: 'Status' and 'Goal setting'. The 'Goal setting' tab is active, showing a 'WEEKLY SPORTS GOAL' and a 'DAILY ACTIVITY GOAL'. The 'DAILY ACTIVITY GOAL' section includes a 'Level' dropdown menu currently set to 'Inactive (<2500 steps)', a 'Proposed' goal of 2500 steps, and a 'Save' button. A note below the goal states, 'If you report sports, your daily activity goal will be automatically lowered'. Numbered callouts (1-6) are overlaid on the interface to guide the user through the steps of setting the goal.

*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.

2 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 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 download the weekly sports goal or safety precautions by clicking this button.

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 and safety precautions contain medical terms which might not be understood by the patient hence the printout is not intended to be given to the patients. The date of creation / revision of the exercise prescription is indicated in the printout.

The screenshot displays the CoroPrevention EXPERT tool interface. At the top, patient information is shown: '001001 / BE1', 'coro-001001-482 (1965)', and 'Ruben Pauwels'. Below this, patient vitals and risk factors are listed: '124/98 mm Hg', '90 kg', '35.16 kg/m²', 'LDL: 2.64 mmol/l', '31.2 mmol/mol', 'Medium', 'Intermediate', 'Medium', 'Active smoker (high dependence)', 'Low', and 'Beginner'. The interface has two main tabs: 'Weekly sports goal' (labeled 'a') and 'Safety precautions' (labeled 'b'). The 'Safety precautions' tab is active, showing a 'Primary indication' of 'Heart failure (with lowered LVEF) and CMP' and 'Key risk factors' of 'Dyslipidemia' and 'Obesity'. Below this, there are sections for 'Exercise modifier', 'Anomalies', 'Medication', and 'Recommendation'. The 'Recommendation' section contains a list of exercise prescriptions, including 'Moderate' intensity, '2-5' duration, '30-60' frequency, and 'x24 weeks' duration. The 'Saved prescription' section also shows a similar prescription. A 'Print' button is visible in the top right corner.

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.

The screenshot displays the CoroPrevention Alpha EXPERT tool interface. At the top, patient information is shown: 001001 / BE1, coro-001001-482 (1865), and user Ruben Pauwels. Below this, patient vitals and demographics are listed: Female, 60 years, 78 bpm, 523 m. The main section is the EXPERT tool, with tabs for 'Weekly sports goal' (selected) and 'Safety precautions'. There are five expandable boxes on the left, each with a dropdown arrow on the right. A blue circle with the number '2' is placed next to each dropdown arrow. The 'Recommendation' box is expanded, showing the following text: '• IMT (from 30 up to 60% of P_{max}, 20-30 min/day, 3-5 days/week), and electro muscle stimulation can be added in case of very deconditioned patients', '• advice exercise modalities with large caloric expenditure (walking, jogging, stepping, etc)', '• >900 kcal/week of energy expenditure should be achieved', '• Strength training exercises: 2 days/week, 40-60% of 1RM, 8-15 reps/set', '• HIT Intensity: [Heart failure (with lowered LVEF) and CMP] → above VT2 for 4 min/cycle', '• HIT Sessions: [Heart failure (with lowered LVEF) and CMP] → up to 6 cycles of 4 * 4 min, preceded by 10 min warm-up', '• HIT Frequency: [Heart failure (with lowered LVEF) and CMP] → 2 to 3'. The 'Saved prescription' box is also expanded, showing: '• IMT after CABG surgery (from 30 up to 60 of P_{max}, 20-30 min/session, 3-5 days/week)', '• advice exercise modalities with large caloric expenditure (walking, jogging, stepping, etc)', '• >900 kcal/week of energy expenditure should be achieved', '• Strength training exercises: 2 days/week, 40-80% of 1RM, 12-15 reps/set'.

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 displays the 'EXPERT tool' interface for a patient named '001001 / BE1'. The patient's profile includes: Female, 60 years, 78 bpm, 523 m. Key clinical data shown are: 124/98 mmHg, 90 kg, 35.16 kg/m², LDL: 2.64 mmol/l, 31.2 mmol/mol, Medium, Intermediate, Medium, Active smoker (high dependence), Low, Beginner.

The 'EXPERT tool' is divided into several sections:

- Weekly sports goal** (selected):
 - Primary indication:** Heart failure (with lowered LVEF) and CMAP
 - Key risk factor:** Dislipidemia, Obesity. A table lists selected risk factors with checkboxes, severity, and associated values:

Risk Factor	Severity	Value 1	Value 2	Value 3	Value 4
<input checked="" type="checkbox"/> Obesity	Moderate	3-5	>60	>24 weeks	No
<input type="checkbox"/> Type 1 Diabetes	Moderate	3	>30	>12 weeks	Yes
<input type="checkbox"/> Type 2 Diabetes	Moderate	5	>30	>12 weeks	Yes
<input type="checkbox"/> Hypertension	Moderate-High	Daily	30-60	>6 weeks	Yes
<input checked="" type="checkbox"/> Dislipidemia	Moderate	3-5	>45	>12 weeks	Yes
 - Exercise modifier:** Select exercise modifiers: (empty)
 - Anomalies:** Select anomalies occurred during exercise testing: (empty)
 - Medication:** Select medication that affects exercise prescription: Statin
- Recommendation:** A text box containing:
 - IMT (from 30 up to 60% of Pimax, 20-30 min/day, 3-5 days/week), and electro muscle stimulation can be added in case of very deconditioned patients
 - advice exercise modalities with large caloric expenditure (walking, jogging, stepping, etc)
 - >900 kcal/week of energy expenditure should be achieved
 - Strength training exercises:
 - 2 days/week, 40-60% of 1RM, 8-15 reps/set
 - HIT Intensity:
 - Heart failure (with lowered LVEF) and CMAP: > above VT2 for 4 min/cycle

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, 5 you can accept the recommendation and save it to the patient record by clicking this button.

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

Note: The recommendation by EXPERT tool updates only when changes are made to the guidelines, patient profile, or selections.

The screenshot displays the CoroPrevention Alpha EXPERT tool interface for a patient named Ruben Pauwels. The patient's profile includes: Female, 60 years, 78 bpm, 523 m. Key clinical data shown are: 124/98 mm Hg, 90 kg, 35.16 kg/m², LDL: 2.64 mmol/l, 31.2 mmol/mol, Medium, Intermediate, 1 Medium, Active smoker (high dependence), Low, and Beginner. The EXPERT tool is currently set to 'Weekly sports goal' and shows the following configuration: Primary indication: Heart failure (with lowered LVEF) and CMP; Key risk factor: Dyslipidemia, Obesity; Exercise modifier: (empty); Anomalies: (empty); Medication: Statin. The 'Recommendation' section (highlighted with a blue circle '4') provides a moderate prescription: 2.5 sessions per week, 30-40 minutes per session, for more than 24 weeks, with a 'Yes' frequency. The recommendation text includes: 'IMT (from 30 up to 60% of Pimax, 20-30 min/day, 3-5 days/week), and electro muscle stimulation can be added in case of very deconditioned patients', 'advise exercise modalities with large caloric expenditure (walking, jogging, stepping, etc)', '>900 kcal/week of energy expenditure should be achieved', 'Strength training exercises: 2 days/week, 40-60% of 1RM, 8-15 reps/set', 'HIT Intensity: [Heart failure (with lowered LVEF) and CMP] -> above VT2 for 4 min/cycle', 'HIT Sessions: [Heart failure (with lowered LVEF) and CMP] -> up to 6 cycles of 4 * 4 min, preceded by 10 min warm-up', 'HIT Frequency: [Heart failure (with lowered LVEF) and CMP] -> 2 to 3'. The 'Saved prescription' section (highlighted with a blue circle '5') shows a similar moderate prescription: 3.5 sessions per week, 20-40 minutes per session, for more than 24 weeks, with a 'Yes' frequency. The saved prescription text includes: 'IMT after CABG surgery (from 30 up to 60 of Pimax, 20-30 min/session, 3-5 days/week)', 'advise exercise modalities with large caloric expenditure (walking, jogging, stepping, etc)', '>900 kcal/week of energy expenditure should be achieved', 'Strength training exercises: 2 days/week, 40-80% of 1RM, 12-15 reps/set'. A blue circle '6' is positioned over the 'Save and close' button in the top right corner of the tool interface.

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 creating a new training program or a continuation of the existing one 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 'Recommendation' form for a patient with the following characteristics: Female, 60 years, 78 bpm, 523 m. The patient's health status includes: coro-001001-482, 124/88 mm Hg, 90 kg, 35.16 kg/m³, LDL: 2.64 mmol/l, 31.2 mmol/mol, Medium, Intermediate, Medium, Active smoker (high dependence), Low, Beginner.

The recommendation is currently set to: Moderate intensity, 2-5 times per week, 30-60 minutes per session, for more than 24 weeks. The recommendation is marked as 'Yes'.

The form includes several sections for customization:

- Intensity:** Set to 'Moderate'. Includes a 'Heart rate' field.
- Frequency:** Set to a range of 2 to 5 times per week.
- Session duration:** Set to a range of 30 to 60 minutes.
- Programme duration:** Set to a range of 24 weeks.
- Strength training:** Set to 'Yes'.
- Additional training strategies:** Includes a text box with the following text: '- IMT (from 30 up to 60% of Pimax, 20-30 min/day, 3-5 days/week), and electro muscle stimulation can be added in case of very deconditioned patients' and '- advice exercise modalities with large caloric expenditure (walking, jogging, stepping, etc)'. A 'Reason' field is also present.

Numbered callouts 6, 7, 8, and 9 are overlaid on the interface to indicate the location of the 'Reason' field, the 'Undo' button, the 'Save' button, and the 'Collapse' button, respectively.

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

10 When starting the trial for the patient, you only see the "Recommendation" box as there is no "Saved prescription" yet.
After you click the "Save" button for the first time, you get a "Saved prescription" and a "Recommendation" (i.e., two boxes).

11 Close the EXPERT tool by clicking on the "Close" button.

Note: This closes the EXPERT tool without saving changes.

The screenshot displays the CoroPrevention Alpha EXPERT tool interface. At the top, the patient's profile is shown: 001001 / BE1, female, 60 years, 78 bpm, 523 m. Key clinical data includes: 124/98 mm Hg, 90 kg, 35.16 kg/m², LDL: 2.64 mmol/l, 31.2 mmol/mol, Medium risk, Intermediate, 11 Medium, Active smoker (high dependence), Low, and Beginner. The interface is divided into several sections: Weekly sports goal, Safety precautions, Primary indication (Heart failure (with lowered LVEF) and CMP), Key risk factor (Dyslipidemia, Obesity), Exercise modifier, Anomalies, Medication (Statin), Recommendation, and Saved prescription. The Recommendation section is highlighted with a blue circle containing the number 10. The Saved prescription section is also highlighted with a blue circle containing the number 10. The Recommendation section contains the following text: "• BMT (from 30 up to 60% of Pimax, 20-30 min/day, 3-5 days/week), and electro muscle stimulation can be added in case of very deconditioned patients", "• advice exercise modalities with large caloric expenditure (walking, jogging, stepping, etc)", "• >900 kcal/week of energy expenditure should be achieved", "• Strength training exercises: 2 days/week, 40-60% of 1RM, 8-15 reps/set", "• HIT intensity: [Heart failure (with lowered LVEF) and CMP] -> above VT2 for 4 min/cycle", "• HIT Sessions: [Heart failure (with lowered LVEF) and CMP] -> up to 6 cycles of 4 * 4 min, preceded by 10 min warm-up", "• HIT Frequency: [Heart failure (with lowered LVEF) and CMP] -> 2 to 3". The Saved prescription section contains the following text: "• BMT after CABG surgery (from 30 up to 60 of Pimax, 20-30 min/session, 3-5 days/week)", "• advice exercise modalities with large caloric expenditure (walking, jogging, stepping, etc)", "• Strength training exercises: 2 days/week, 40-80% of 1RM, 12-15 reps/set". A blue circle containing the number 11 is located in the top right corner of the interface.

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.

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

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 displays the CoroPrevention Alpha patient dashboard for patient 001001 / BE1. The patient's profile includes vital signs: 124/98 mm Hg, 90 kg, 35.16 kg/m², 124.64 mmol/L, 31.2 mmol/mol, and risk factors: Medium, Intermediate, High Medium, Active smoker (high dependence), Low, and Beginner. The patient is a 60-year-old female, 78 bpm, and 523 m tall. The 'EXPERT tool' section is active, with the 'Safety precautions' tab selected (marked with a blue circle '1'). Below this, several categories are listed with expandable arrows (marked with blue circles '2'):

- Statin
- CAD, PCI, CABG, and minimally invasive CABG
 - Training intensity has to be below the ischemic threshold (in case of stable ischemic heart disease) as defined by a stress test before starting the training.
 - In patients after acute coronary syndrome or CABG participating a centre-based, structured and multimodal cardiac rehabilitation program is strongly advised in order to implement an individually adjusted training program, to optimize all other aspects of secondary prevention (information and motivation for life style changes, medication and self-control), and to early recognize and prevent potential complications (e.g., recurrent ischemia, arrhythmia, heart failure, post-operative infections, wound healing problems, Dressler syndrome).
 - In patients after CABG surgery:
 - exercise training has to be adjusted on the time course of wound healing and all other potential complications.
 - Thoracic shear and pressure stress has to be strictly avoided during the first 6-8 weeks after thoracotomy; this can be caused by unilateral strength/resistance training of the upper extremities.
 - In patients after elective PCI, exercise training may be started immediately after healing of the punctured vessel. This may be as early as one day after the intervention.
 - In case of CABG surgery, strength training for the arm muscles are only allowed when the sternum is stabilized.
- Dyslipidemia
- Obesity

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 ₂ peak	peak oxygen uptake
VT	ventilatory threshold
IMT	Maximal inspiratory muscle training with P _I 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

V7.0, 21 Aug 2025

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 "Status / 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 displays the 'Healthy nutrition' section of the CoroPrevention Alpha caregiver dashboard. At the top, there is a patient header with the name '001001 / BE1' and a search bar containing 'coro-001001-482 (1955)'. Below this, a row of vital signs and risk factors is shown: '124/98 mmHg', '90 kg', '95.16 kg/m²', 'LDL: 2.64 mmol/l', '31.2 mmol/mol', 'Medium', 'Intermediate', 'Medium', 'Active smoker (high dependence)', 'Low', and 'Beginner'. The main content area is titled 'Healthy nutrition' and has two tabs: 'Status' (selected) and 'Goal setting'. Under the 'Status' tab, there are two sub-sections: 'GENERAL' and 'WEEKLY GOALS'. The 'GENERAL' section contains three rows of data, each with a blue circle callout: 1. A status indicator (sad face) and the text 'My overall diet is poor.' with callout 1. 2. 'Nutrition-score: 51%' with callout 2. 3. 'Healthy nutrition challenges' with a list: 'Limited options at restaurant' and 'Lack of self-restraint' with callout 3. All three rows have a 'Reported on 26/05/2025' timestamp. At the bottom of the dashboard, there are navigation buttons: '< Go to journey' and 'Next step >'. The user's name 'Ruben Pauwels' is visible in the top right corner.

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

1 In the "Progress" → "Weekly goals" tab, you can review the patient's reported nutrition intake for the past week.

For each food group, the following is shown:

- Amount reported by the patient (in servings per week),
- Recommended amount based on the Nutrition-score guidelines
- Whether the patient selected as an active goal (in Level of Guidance 2).

2 This overview shows where the patient meets, exceeds, or falls below dietary recommendations, helping you provide tailored feedback. Use the date arrows to navigate between weeks.

CoroPrevention Alpha 001001 / BE1 coro-001001-001 (1857) Ruben Pauwels

coro-001001-001 120/90 mm Hg 90 kg 29.39 kg/m² LDL: 3 mmol/l 85.8 mmol/mol Low Sedentary High Non-smoker Low Beginner End encounter

Healthy nutrition

Progress → Goal setting

1 WEEKLY GOALS PROGRESS OVER TIME

19/05/2025 - 25/05/2025 3

Goal	Reported amount	Recommended amount	Selected as goal
☑ Eat wholegrain food items	19-31 (servings per week)	≥32 (servings per week)	Not in level of guidance 2
○ Eat a healthy amount of potatoes	3 (servings per week)	4 (servings per week)	Not in level of guidance 2
○ Eat more fruit	1-4 (servings per week)	≥22 (servings per week)	Not in level of guidance 2
☑ Eat more vegetables	21-32 (servings per week)	≥33 (servings per week)	Not in level of guidance 2
☑ Eat more legumes	3-4 (servings per week)	≥7 (servings per week)	Not in level of guidance 2
➔ Eat more fish and healthy protein	<1 (servings per week)	≥7 (servings per week)	Not in level of guidance 2
☑ Eat less meat and change to heart-healthy protein	8-10 (servings per week)	≤1 (servings per week)	Not in level of guidance 2
☑ Eat a healthy amount of poultry	>10 (servings per week)	≤3 (servings per week)	Not in level of guidance 2
☑ Eat healthy dairy	29-30 (servings per week)	≤10 (servings per week)	Not in level of guidance 2
○ Use healthy fats	1-3 (times used)	≥6 (times used)	Not in level of guidance 2
☑ Create a healthy alcohol-drinking habit	400 (mL / consumptions per day)	<300 (mL / consumptions per day)	Not in level of guidance 2
☑ Eat tasty food without added salt	9-10 (grams per week)	<5 (grams per week)	Not in level of guidance 2
☑ Eat tasty food while limiting sugar	72-88 (grams per week)	<24 (grams per week)	Not in level of guidance 2

< Go to journey Next step >

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

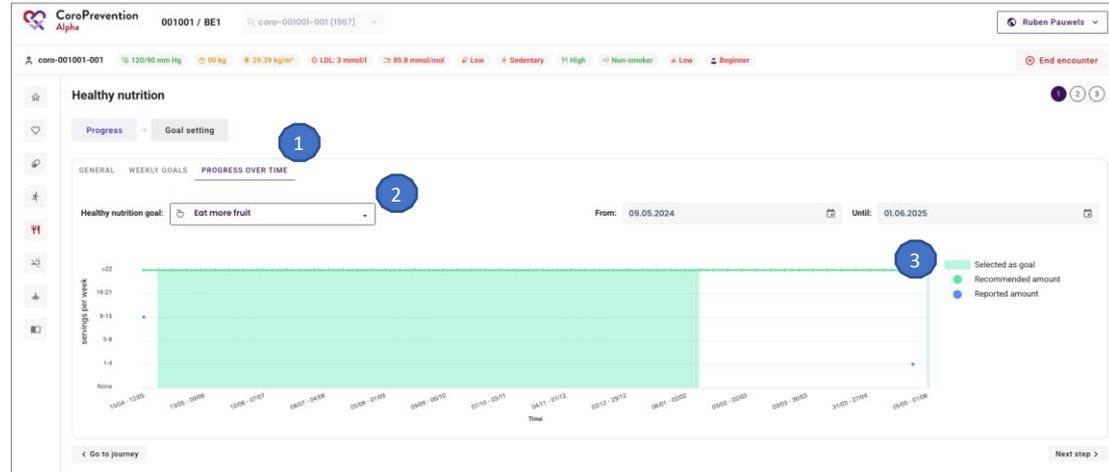
This visual timeline helps to monitor trends, spot recurring difficulties, and provide meaningful feedback or motivation based on progress.

In the **"Progress over time"** tab, you can track how the patient's nutrition behaviour evolves week by week for each selected goal.

Switch between goals by clicking on the drop-down list

The graph displays:

- Reported servings per week (blue)
- Selected goal (green shaded area)
- Recommended intake (horizontal line)



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

- 1 In "Goal setting", 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.

The screenshot shows the 'Healthy nutrition' section in the CoroPrevention Alpha dashboard. A blue circle with the number '1' highlights the 'Goal setting' button. Below it, a text box explains the goal: '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".' A second blue circle with the number '2' highlights the table of nutrition goals.

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 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.
Eat less meat and change to heart-healthy protein	Try to eat red meat as little as possible, ideally this is once every week at a maximum.
Eat a healthy amount of poultry	Poultry is lower in fat (when prepared correctly) and can be consumed two to three times per week.
Eat healthy dairy	Try to limit your full-fat dairy consumption to maximum 2 serving per day.
Use healthy fats	Healthy fats are found in olive oil, in fatty fish and also nuts and seeds. Canola oil, vegetable and nut oil (except coconut oil) can also be used. Try using olive oil in the kitchen instead of butter as a first step! Daily usage of olive oil or other healthy fats for cooking is recommended.
Create a healthy alcohol-drinking habit	Try to limit your alcohol intake to, at a maximum, 2 glasses per day for men and 1 glass per day for women. In alcohol consumption, lower is always better. Aim for at least two alcohol-free days in the week.
Eat tasty food without added salt	Try to replace salt with healthier alternatives such as fresh and dried herbs, spices, black pepper, chilli and lemon. Remove the salt cellar from the table. Choose fresh food items instead of processed and canned food items.
Eat tasty food while limiting sugar	Try reducing your sugar intake to near zero.

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

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

The screenshot shows the CoroPrevention Alpha patient dashboard for patient 001001 / BE1. The patient's profile includes various health metrics such as blood pressure (124/98 mmHg), weight (90 kg), cholesterol (LDL: 2.64 mmol/l), and smoking status (Active smoker). The 'Healthy nutrition' section is active, displaying a table of dietary goals. A blue circle with the number '3' highlights the table header.

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 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.
Eat less meat and change to heart-healthy protein	Try to eat red meat as little as possible, ideally this is once every week at a maximum.
Eat a healthy amount of poultry	Poultry is lower in fat (when prepared correctly) and can be consumed two to three times per week.
Eat healthy dairy	Try to limit your full-fat dairy consumption to maximum 2 serving per day.
Use healthy fats	Healthy fats are found in olive oil, in fatty fish and also nuts and seeds. Canola oil, vegetable and nut oil (except coconut oil) can also be used. Try using olive oil in the kitchen instead of butter as a first step! Daily usage of olive oil or other healthy fats for cooking is recommended.
Create a healthy alcohol-drinking habit	Try to limit your alcohol intake to, at a maximum, 2 glasses per day for men and 1 glass per day for women. In alcohol consumption, lower is always better. Aim for at least two alcohol-free days in the week.
Eat tasty food without added salt	Try to replace salt with healthier alternatives such as fresh and dried herbs, spices, black pepper, chilli and lemon. Remove the salt cellar from the table. Choose fresh food items instead of processed and canned food items.
Eat tasty food while limiting sugar	Try reducing your sugar intake to near zero.



CoroPrevention

PERSONALISED PREVENTION FOR
CORONARY HEART DISEASE

Case nurse manual caregiver dashboard – Smoke-free living module

V7.0, 21 Aug 2025

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", shows 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 nicotine dependence is shown with color coding.

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

4 "Quit attempts before the study", gives 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.

CoroPrevention Alpha 001001 / BE1

124/98 mmHg 90 kg 35.14 kg/m³ LDL: 2.64 mmol/l 31.2 mmol/mol Medium Intermediate Medium Active smoker (high dependence) Low Beginner End encounter

Smoke-free living

1 Status Goal setting

2 Smoking behaviour Reported on 26/05/2025
Number of cigarettes: 20 cigarettes daily
Fagerstrom score: 7 Moderate dependence

3 Motivation to stop smoking Reported on 26/05/2025
I REALLY want to stop smoking but I don't know when I will

4 Quit attempts before the study Reported on 26/05/2025
Number of quit attempts: 1
Most recent quit attempt: 1 January 2025
Options used to quit smoking: Nicotine replacement therapy, E-cigarettes

5 Most recent quit attempt during the study
No data

< Go to journey Next step >

5 Most recent quit attempt during the study Reported on 29/09/2024

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: 124/98 mm Hg, 90 kg, 35.16 kg/m², LDL: 2.64 mmol/L, and 31.2 mmol/mol. The patient is categorized as 'Active smoker (high dependence)' and 'Beginner'. The main content area is titled 'Smoke-free living' and features a 'Goal setting' step highlighted with a blue circle and the number '1'. Below this, a list of nine steps for giving up smoking is provided:

- 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

V7.0, 21 Aug 2025



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

www.coroprevention.eu

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

1 In “Status / 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;

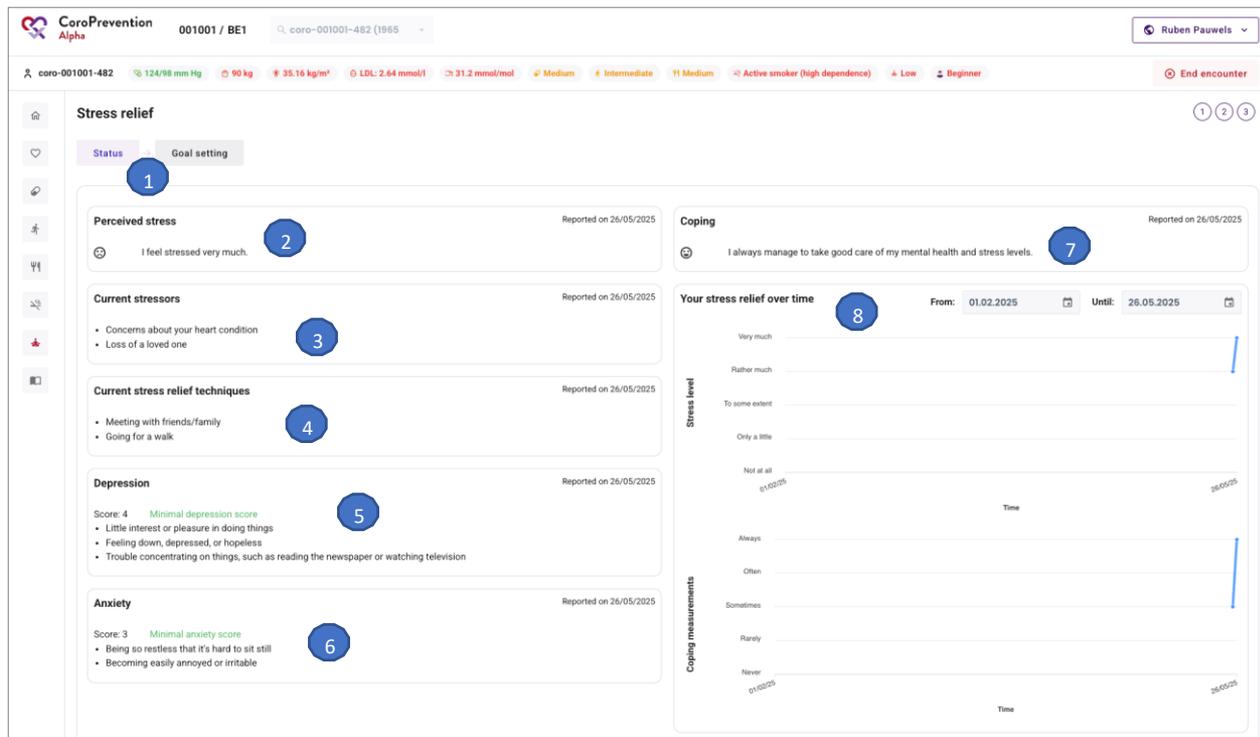
4 The patient’s current stress relief techniques;

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 allow 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 dashboard for patient 001001 / BE1. The patient's ID is coro-001001-482 (1965). The dashboard displays various vital signs and risk factors, including blood pressure (124/98 mm Hg), weight (90 kg), BMI (35.16 kg/m²), LDL (2.64 mmol/l), and cholesterol (31.2 mmol/mol). The patient is classified as a 'Beginner' and an 'Active smoker (high dependence)'. The 'Stress relief' section is active, showing a 'Goal setting' step (1) and a table of goals with motivation levels.

Stress relief goals	Motivation	Reported on
Reduce stress	Neutral	26/05/2025
Improve mental wellbeing	Motivated	
Sleep better	Very motivated	
Sleep better	Very motivated	
Feel less lonely	Not at all	



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PERSONALISED PREVENTION FOR
CORONARY HEART DISEASE