



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

www.coroprevention.eu



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

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 system interface. A blue sidebar on the left contains a menu with options: Home, Subjects, EDC, Documents, Training, Export, Authentication, eCRFLink, and Audit. The main content area is titled 'Subjects / Create' and features a 'New subject' button. Below this, the 'Informed Consent' section is active, showing a form with the following fields: 'Date of written informed consent' (with a date picker set to 01/01/2021) and 'Version informed consent' (with a dropdown menu). A blue circle with the number '2' highlights the 'Version informed consent' field. A 'Show monitoring status' toggle is located at the top right of the form. A 'New Subject' button is visible at the bottom right of the form area.

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

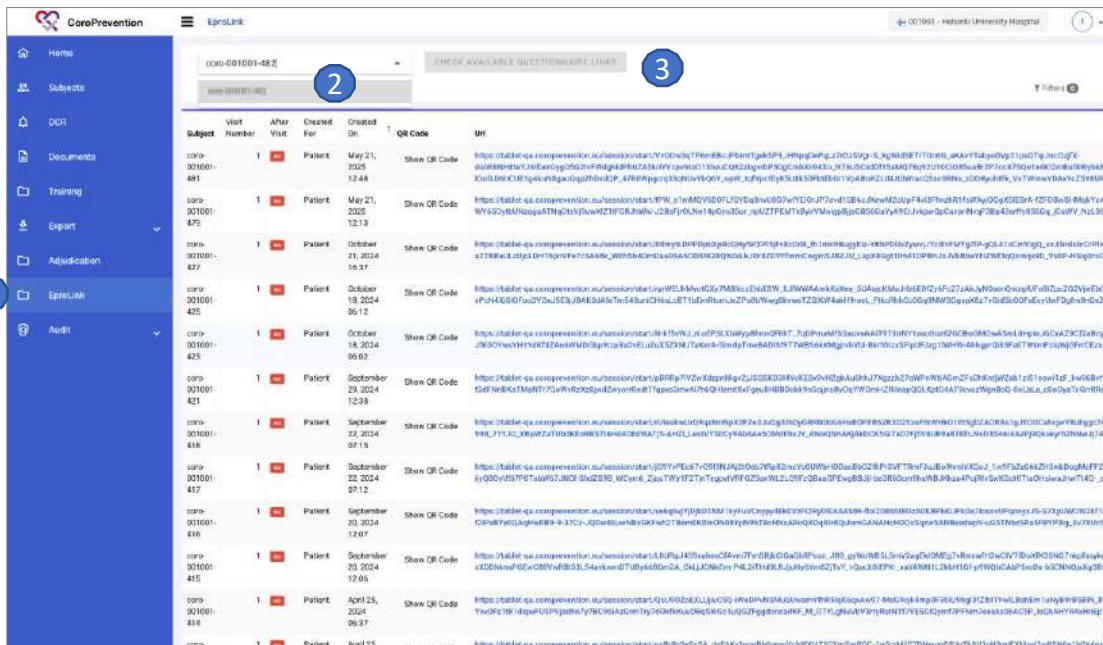
Conduct visit 1 (EDC)

Ask the patient to fill in ePRO questionnaires for visit

11. You can open the ePROs by navigating to “EproLink”.

2 Look up the patient by entering the subject ID.

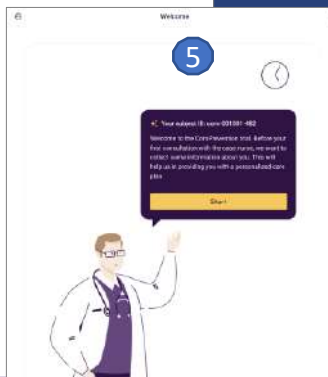
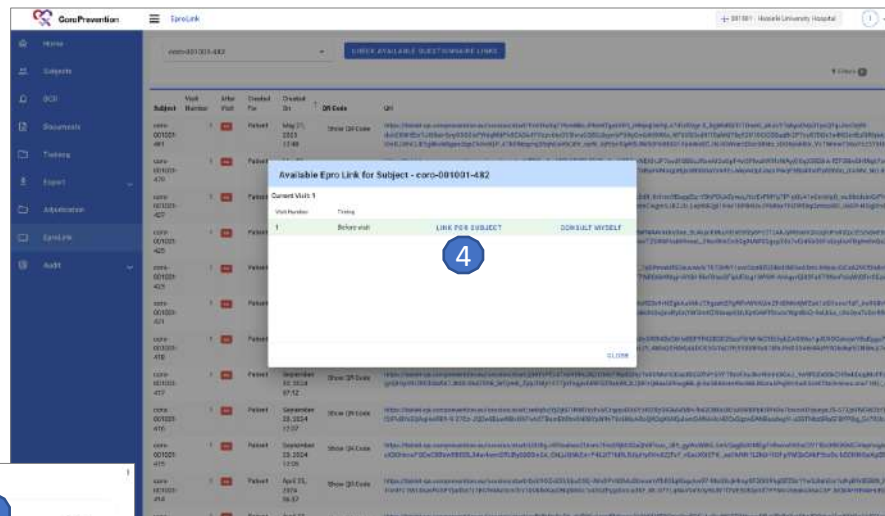
3 Click the button “Check available questionnaire links” to open the links for the ePROs.



Conduct visit 1 (EDC)

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

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



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.

The screenshot shows the CoroPrevention EDC interface. The left sidebar has a blue circle with the number 1 highlighting the 'Medical History' tab. The main content area shows the 'Medical History' section for Visit 1, with a table of medical conditions and their status.

Condition	Status
Ischemic heart disease	No
Myocardial infarction	No
Angina pectoris	No
Coronary artery disease	No
Pericardial disease	No
Cardiomyopathy	No
Heart failure	No
Valvular disease	No
Arrhythmia	No
Stroke	No
Transient ischaemic attack	No
Deep vein thrombosis	No
Pulmonary embolism	No
Other	No

The screenshot shows the CoroPrevention EDC interface. The left sidebar has a blue circle with the number 2 highlighting the 'Randomization' tab. The main content area shows the 'Randomization' section for Visit 1, with a table of randomization results.

Parameter	Value
NT-PROBNP	< 1000
Cystatin C	< 1.0
High-sensitivity troponin	< 1
CERT2	< 1
eGFR	> 30
LDL	< 100
HDL	> 40
Total Cholesterol	< 200
HbA1c	< 6.5

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.

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

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

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

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

The screenshot shows the 'Create patient record' form in the CoroPrevention Alpha interface. The form is titled 'Create patient record' and includes a 'Cancel' button in the top right corner. The form fields are as follows:

- Subject ID:** A text input field containing 'CORV-00000-000'. A blue circle with the number '2' is next to it.
- Retrieve data from EDC:** A checkbox labeled 'Retrieve data from EDC'. A blue circle with the number '3' is next to it.
- Gender:** Radio buttons for 'male' and 'female'.
- Year of birth:** A text input field containing '1985'. A blue circle with the number '4' is next to it.
- Start date:** A text input field containing '01-01-2020'.
- Submit:** A button labeled 'Submit'. A blue circle with the number '5' is next to it.

At the top of the form, there is a header bar with the CoroPrevention Alpha logo, the text '001001 / BE1', a search bar, and a 'Patients' dropdown menu. A blue circle with the number '1' is next to the 'Patients' dropdown menu.

How to create a subject (caregiver dashboard)?

1 Patient record succesfully imported into the Tool Suite.

1

CoroPrevention Alpha 001001 / BE1 [coro-001001-482 \(1685\)](#) Robert Paavels

Patient [Open medication decision support to edit the prescription](#) [View patient record](#) [Start visit 2](#)

[coro-001001-482 \(1685\)](#)

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
<https://tablet-qd.coroprevention.eu/session/start/uf-4sqA/MRQ620y...>

[Print QR code for ePRO application](#) 

[Print a new QR password code for the mobile app](#) [Logout mobile app](#)

[Patient dropped out](#)

Consultations during the study

1 2 3 4 5 6 7

Parameters

[Blood pressure](#) 129/80 mmHg
[Weight](#) 59 kg
[BMI](#) 25.2 kg/m²
[LDL cholesterol](#) 3.04 mmol/L
[HbA1c \(fasting\)](#) 5.2 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 test	Beginner	Inactive

Most recent alerts

Filter: Red 0 Orange 0 Yellow 0 Open 0 Handled 0

Date	Time	Type	Module	Message	Action
------	------	------	--------	---------	--------

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.

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.

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.

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.

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

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.

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

How to view a summary about a patient?

The screenshot displays the CoroPrevention Alpha caregiver dashboard for a patient with ID 001001 / BE1. The interface is organized into several sections:

- General:** Displays patient details such as Subject ID (coro001001-002), Gender (Female), Year of birth (1965), and Start date (01-01-2005). It also includes a QR code and a link to view the app for visit 2.
- Consultations during the study:** A timeline showing consultation status with a green circle indicating a completed visit.
- Parameters:** Lists various medical parameters with their current values and trends, such as Blood pressure (120/80 mmHg), Weight (80 kg), BMI (30.25 kg/m²), LDL cholesterol (2.14 mmol/L), and HbA1c (5.6 mmol/mol).
- Behavioural goals:** Lists goals like Medication adherence, Smoking, Healthy nutrition, Double free living, Stress relief, and Knowledge level, each with a status indicator (e.g., 'Not started', 'Intermediate', 'Achieved').
- Most recent alerts:** A table showing recent alerts with columns for Date, Time, Type, Module, Message, and Action.

Numbered callouts on the image indicate the following features:

1. Patient ID and study name
2. General patient information
3. QR code for mobile app
4. Print QR code button
5. Patient dropped out button
6. Logout mobile app button
7. Consultations during the study timeline

8

9

1

1

1

1

1

1

1

How to view a summary about a patient?



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 top screenshot displays the patient profile for '000008 / 001'. It includes fields for Subject ID, Gender, Year of birth, and Start date. A QR code is visible for the patient's mobile app. A blue circle with the number '1' highlights the 'Open medication decision support' button. The right sidebar shows 'Consultations during the study' and 'Parameters'.

The bottom screenshot shows the 'Medication decision support system' interface. It includes tabs for 'Current medication', 'Add drug', 'Algorithm input', and 'Algorithm output'. A blue circle with the number '2' highlights the 'Add drug' button. The interface also shows a table for 'Current medication' with columns for Drug, Dose, Frequency, and Status.

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 patient ID and a search bar. A red circle with the number 1 highlights the 'View patient record' button in the top right corner. The main content area is divided into several sections:

- Patient:** General information including Subject ID (coro-001001-482), Gender (Female), Year of birth (1995), and Start date (01-01-2025). It also provides a URL and QR code to view the ePro for visit 2.
- Consultations during the study:** A timeline showing consultations 1 through 7.
- Parameters:** A table of vital signs and lab results.
- Behavioral goals:** A table of goals and their status.
- Most recent alerts:** A table of alerts with filters for Red, Orange, Yellow, Open, and Handled.

Parameter	Value
Blood pressure	129/93 mm Hg
Weight	59 kg
BMI	33.2 kg/m²
LDL cholesterol	3.64 mmol/L
HbA1c (Glucose)	51.2 mmol/mol

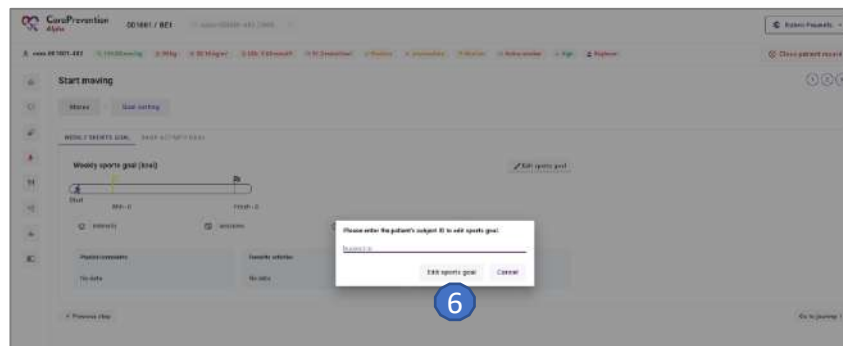
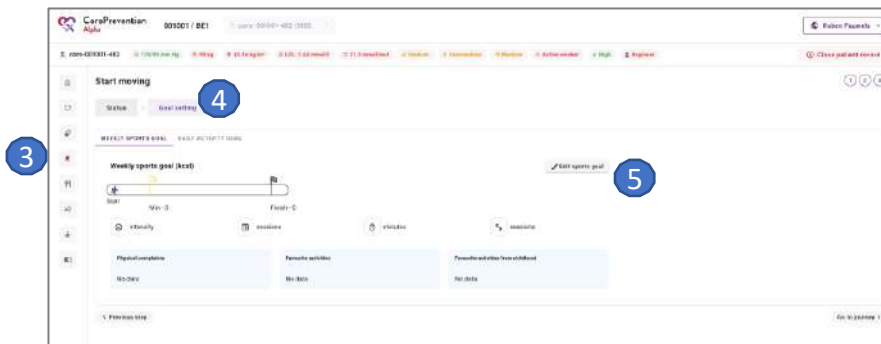
Goal	Status	Action
Medication adherence	Medium	Inactive
Start moving	Strongly bad	Inactive
Healthy nutrition	Medium	Inactive
Smoker-free living	Active smoker	Inactive
Stress relief	High	Inactive
Knowledge test	Beginner	Inactive

Date	Time	Type	Module	Message	Action
------	------	------	--------	---------	--------

Prepare for visit 2 (caregiver dashboard)

EXERCISE PRESCRIPTION

- 3 Navigate to the “Start moving” module by clicking the icon of the running man.
- 4 Click on the “Goal setting” tab.
- 5 In the “Weekly sports goal” tab, click on the “Edit sports goal” button.
- 6 Enter the patient’s subject ID and click the “Edit sports goal” button to open the EXPERT tool.



7

7

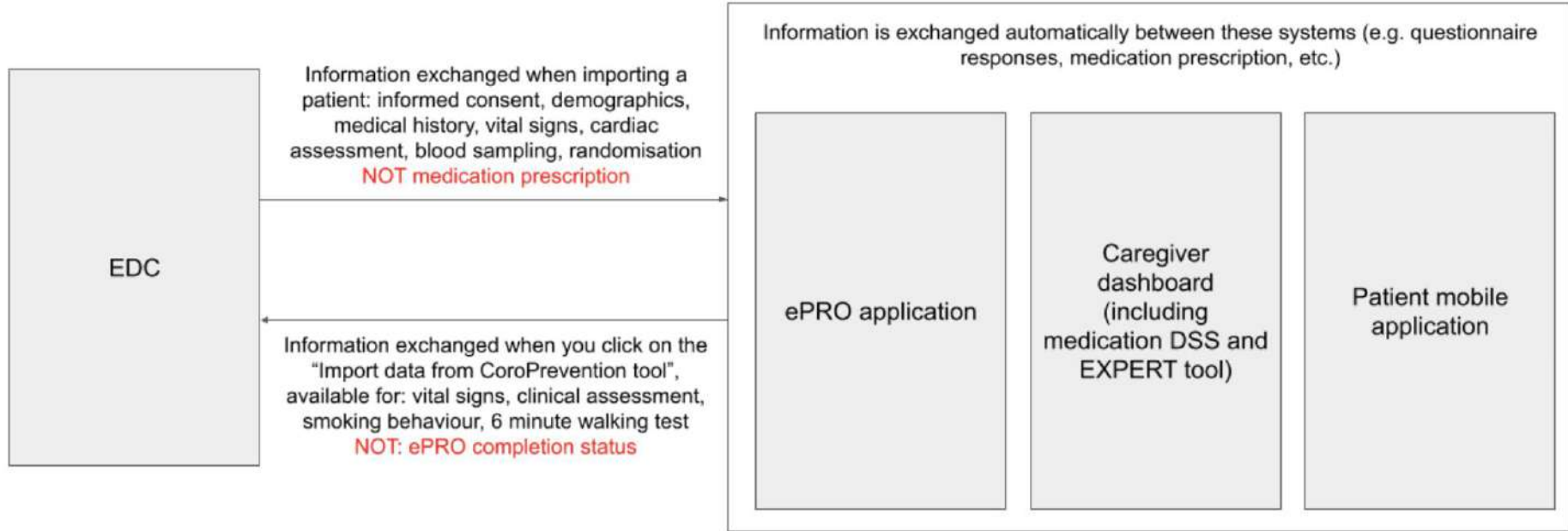
7

7

7

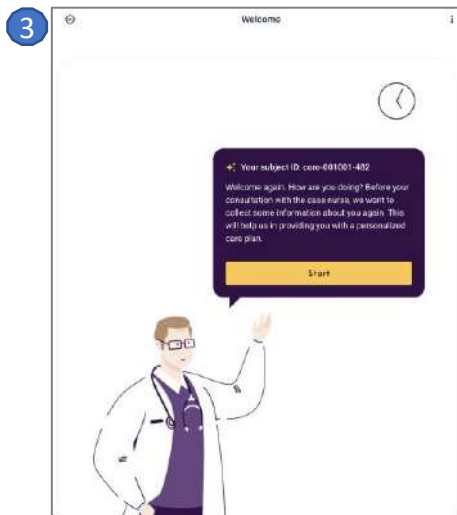
7

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.



The screenshot shows the CoroPrevention caregiver dashboard. At the top, there's a search bar with 'coro-001001-402' entered. The dashboard is divided into several sections:

- General:** Patient ID: coro-001001-402, Gender: Female, Year of birth: 1965, Start date: 01-01-2020.
- URL and code to view the ePRO for visit 2:** A link to the ePRO and a QR code.
- Parameters:** A table showing various parameters and their values.

Parameter	Value
Blood pressure	120/80 mmHg
Weight	70 kg
BMI	25.2 kg/m²
LDL cholesterol	2.56 mmol/L
HbA1c (fasting)	5.7 %
- Behavioural goals:** A table showing goals and their status.

Goal	Status
Medication adherence	On track
Quit smoking	On track
Healthy nutrition	On track
Smoke-free living	On track
Stress relief	On track
Knowledge test	On track

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 displays the CoroPrevention caregiver dashboard for a patient named 'coro-001001-402 (1865)'. The dashboard is divided into several sections:

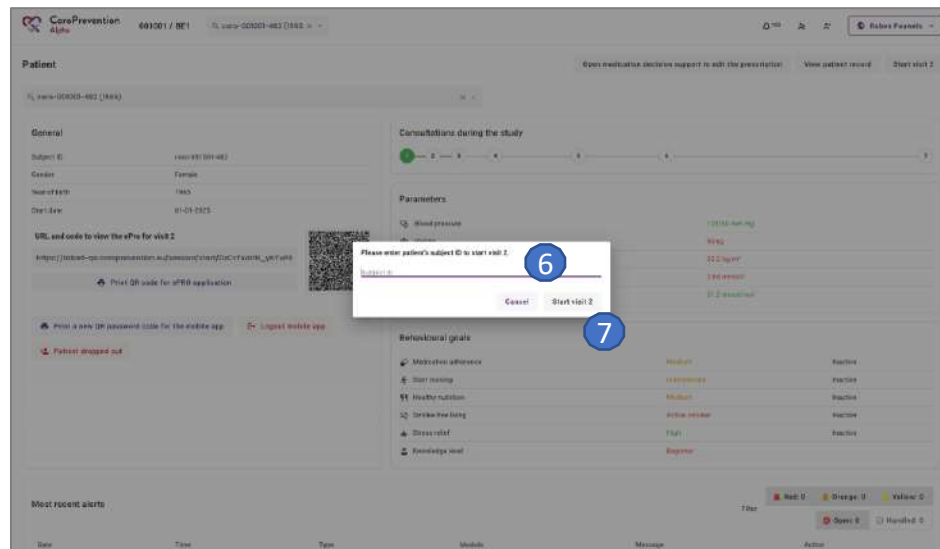
- General:** Displays patient details such as Subject ID (coro-001001-402), Gender (Female), Year of birth (1965), and Start date (01-01-2025). It also provides a QR code and a URL to view the ePro for visit 2.
- Consultations during the study:** A timeline showing visit numbers 1 through 6. Visit 2 is highlighted with a blue circle and the number 4, indicating it is the current visit.
- Parameters:** A section showing various health metrics with their current values and status (e.g., Blood pressure: 129/93 mm Hg, Weight: 60 kg, BMI: 23.2 kg/m², LDL cholesterol: 2.64 mmol/L, HbA1c: 5.12 percentage). A blue circle with the number 5 is placed over this section.
- Behavioural goals:** A table listing goals such as Medication adherence, Start moving, Healthy nutrition, Smoke-free living, Stress relief, and Knowledge level, each with a status (e.g., Medium, Informal, Active, High, Beginner) and an 'Inactive' button.
- Most recent alerts:** A table with columns for Date, Time, Type, Module, Message, and Action.

At the bottom right, there is a legend for alert colors: Red (6), Orange (0), Yellow (0), and a filter for 'Open: 0' and 'Handled: 0'.

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.



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.

- During visit 2, and also 6, the patient has to perform the 6 Minute Walking Test. Record the results in the caregiver dashboard.
9 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.

CoroPrevention Alpha 001001 / BE1

Start an encounter

Vital Signs 6 Minute Walking Test Clinical Assessment Medication ODS Information

Body weight: kg

Blood pressure: systolic diastolic

Pulse rate: bpm

8

CoroPrevention Alpha 001001 / BE1

Start an encounter

Vital Signs 6 Minute Walking Test Clinical Assessment Medication ODS Information

New 6 Minute Walking Test performed? ☐ Yes ☐ No

9

CoroPrevention Alpha 001001 / BE1

Start an encounter

Vital Signs 6 Minute Walking Test Clinical Assessment Medication ODS Information

New following diagnosis since last visit

Diabetes mellitus type 1 ☐ Yes ☐ No

Diabetes mellitus type 2 ☐ Yes ☐ No

Chronic kidney disease ☐ Yes ☐ No

Hypertension ☐ Yes ☐ No

Stroke ☐ Yes ☐ No

FAH ☐ Yes ☐ No

Cardioembolic aetiology ☐ Yes ☐ No

Peripartum aetiology ☐ Yes ☐ No

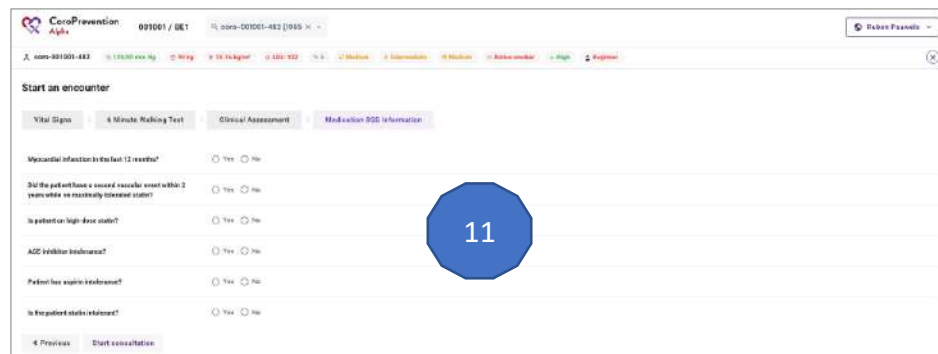
Pharmacological ☐ Yes ☐ No

New diagnosis of IHD? ☐ Yes ☐ No

10

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.



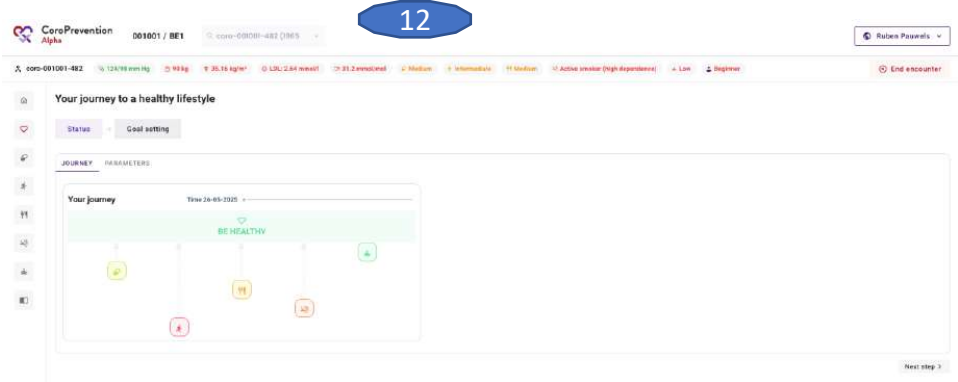
The screenshot shows the CoroPrevention caregiver dashboard. At the top, there's a header with the CoroPrevention logo, patient ID 001001 / DE1, and a search bar. Below the header, there's a navigation bar with tabs: Vital Signs, 6 Minute Walking Test, Clinical Assessment, and Medication DSS information. The 'Medication DSS information' tab is selected. The form contains several questions with radio button options for 'Yes' and 'No':

- Myocardial infarction in the last 12 months? ☐ Yes ☐ No
- Did the patient have a second vascular event within 3 years while on reasonably tolerated statin? ☐ Yes ☐ No
- Is patient on high-dose statin? ☐ Yes ☐ No
- ASD inhibitor introduced? ☐ Yes ☐ No
- Patient has aspirin intolerance? ☐ Yes ☐ No
- Is the patient statin intolerant? ☐ Yes ☐ No

At the bottom of the form, there are two buttons: 'Previous' and 'Start consultation'. A blue circle with the number 11 is overlaid on the form, indicating the step number.

Conduct visit 2 with the patient (caregiver dashboard)

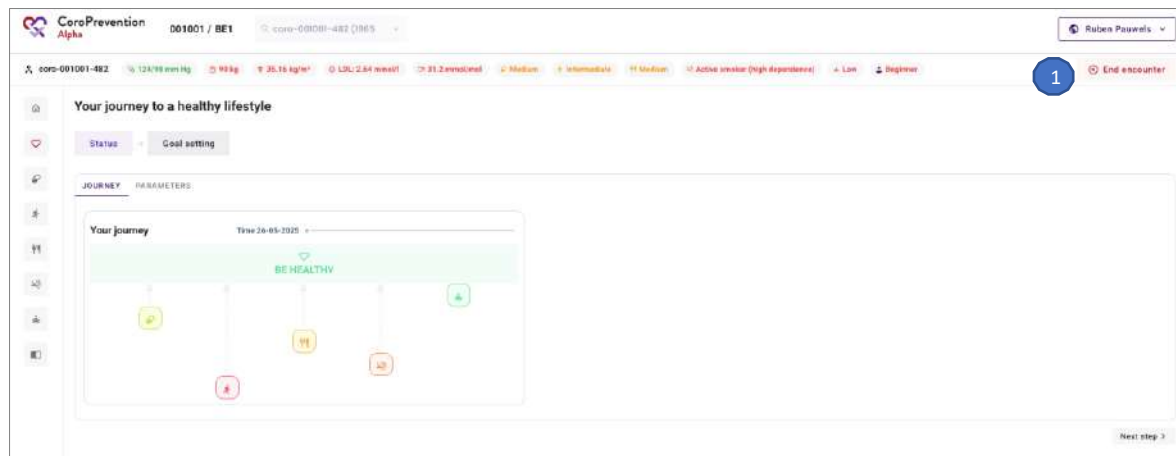
12 Starting with this view, you can have the shared decision-making discussion with the patient about his/her status and goals.



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.



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.

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. On the left is a blue sidebar with navigation icons and labels: Home, Subjects, DCR, Documents, Training, Export, Adjudication, EpiLink, and Audit. The main area shows subject information for 'Subject ID: coro-001001-482' at 'Site: Helsinki University Hospital'. Below this is a list of tasks for 'Visit 2', with 'Vital Signs' selected and highlighted by a red circle with the number 1. The 'Vital Signs' section on the right contains input fields for 'Body weight' (kg), 'Blood pressure' (Systolic, Diastolic, mmHg), and 'Pulse Rate' (bpm). A red circle with the number 2 is placed over the 'Import data from CoroPrevention tool' button in the top right corner of the Vital Signs section. There is also an 'Audit trail' button next to it. At the bottom right of the Vital Signs section is 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 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.

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.

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 dashboard is divided into several sections:

- General:** Displays patient information including Subject ID (001001-482), Gender (Female), Year of birth (1995), and Start date (01-01-2025). It also provides a URL and QR code to view the ePro for visit 2, and buttons to print QR codes for the ePRO application and mobile app.
- Consultations during the study:** A timeline showing the patient's progress through the study, with visit 2 highlighted.
- Parameters:** A table of vital signs and clinical data:

Parameter	Value
Blood pressure	129/90 mm Hg
Weight	90 kg
BMI	25.2 kg/m²
LDL cholesterol	2.64 mmol/L
HbA1c - (planned)	5.2 mmol/mol
- Behavioural goals:** A table of patient goals and their status:

Goal	Status
Medication adherence	Medium
Start moving	Informed
Healthy nutrition	Medium
Smoke-free living	Active smoker
Stress relief	High
Knowledge test	Beginner
- Most recent alerts:** A table of recent alerts with columns for Date, Time, Type, Module, Message, and Action.

Navigation buttons at the top right include "Open medication decision support to edit the prescription", "View patient record" (highlighted with a blue circle and the number 2), and "Start visit 2" (highlighted with a blue circle and the number 1).

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 web application interface, illustrating the steps to start an encounter.

Screenshot 1 (Step 1): The interface shows the 'Start an encounter' section with a navigation bar containing 'Vital Signs', '6 Minute Walking Test', 'Clinical Assessment', and 'Medication DSG Information'. The 'Vital Signs' step is active. Below the navigation bar, there are input fields for 'Body weight' (kg), 'Blood pressure' (systolic/diastolic), and 'Pulse rate' (bpm). A 'Next >' button is visible at the bottom.

Screenshot 2 (Step 3): The interface shows the 'Start an encounter' section with the same navigation bar. The '6 Minute Walking Test' step is active. Below the navigation bar, there is a question 'Has the 6 Minute Walking Test performed?' with radio buttons for 'Yes' and 'No'. A 'Next >' button is visible 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.

This screenshot shows the 'Start an encounter' form in the CoroPrevention Alpha system, specifically the 'Clinical Assessment' step (Step 4). The form includes a header with patient information and a navigation bar with tabs for 'Vital Signs', '4 Minute Walking Test', 'Clinical Assessment', and 'Medication DSS information'. Below the tabs, there is a section titled 'Have following symptoms since last visit' with a list of medical conditions and 'Yes'/'No' radio buttons. The conditions listed are: 'Diabetes mellitus type 1', 'Diabetes mellitus type 2', 'Chronic kidney disease', 'Hypertension', 'Stroke', 'TIA', 'Coronary artery disease', 'Peripheral artery disease', 'Thromboembolism', and 'New diagnosis of IHD'. A blue circle with the number '4' is placed over the 'Clinical Assessment' tab.

This screenshot shows the 'Start an encounter' form in the CoroPrevention Alpha system, specifically the 'Medication DSS information' step (Step 5). The form includes a header with patient information and a navigation bar with tabs for 'Vital Signs', '4 Minute Walking Test', 'Clinical Assessment', and 'Medication DSS information'. Below the tabs, there is a section titled 'Medication DSS information' with a list of questions and 'Yes'/'No' radio buttons. The questions listed are: 'Myocardial infarction in 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?'. A blue circle with the number '5' is placed over the 'Medication DSS information' tab. At the bottom of the form, there are buttons for '4 Previous' and 'Start consultation', with a blue circle and the number '6' 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 a specific patient. The interface is organized into several sections:

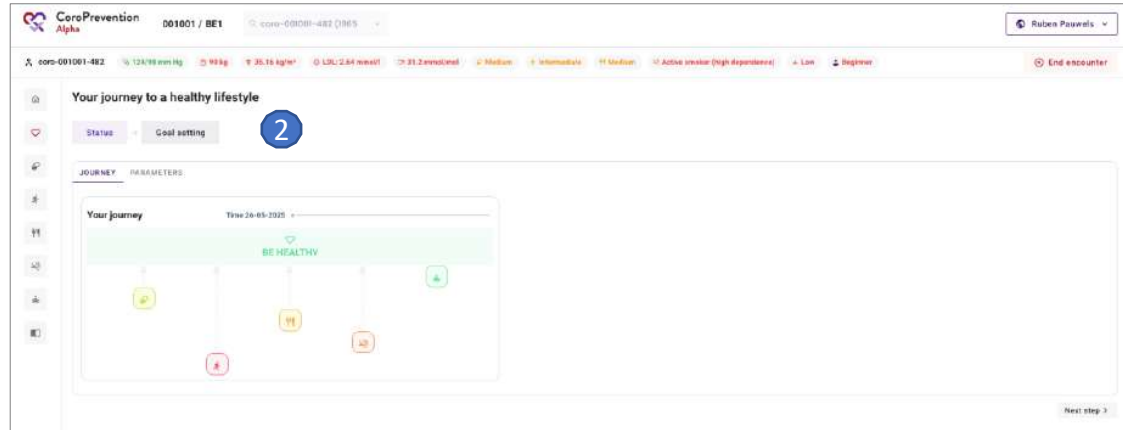
- Header:** Shows the user's name (Robert Parsons) and the patient's ID (001001 / BE1).
- Patient Information:** A sidebar on the left contains general details: Subject ID (001001-482), Gender (Female), Year of birth (1965), and Start date (01-01-2025). It also provides a URL and QR code to view the ePro for visit 2, and buttons for printing a QR code and logging out the mobile app.
- Consultations during the study:** A horizontal timeline at the top right shows a sequence of consultations, with the first one highlighted by a blue circle and the number 1.
- Parameters:** A table on the right lists various physiological parameters with their current values and status indicators (green for normal, red for abnormal):

Parameter	Value	Status
Blood pressure	124/83 mm Hg	Normal
Weight	90 kg	Normal
BMI	35.2 kg/m²	Normal
LDL cholesterol	3.64 mmol/L	Abnormal
Heart rate (b/min)	71.2 bpm	Normal
- Behavioural goals:** A table at the bottom right tracks various goals with their current status and target status:

Goal	Current Status	Target Status
Medication adherence	Medium	Inactive
Start moving	Intermediate	Inactive
Healthy nutrition	Medium	Inactive
Smoker-free living	Active smoker	Inactive
Stress relief	High	Inactive
Knowledge test	Beginner	Inactive
- Most recent alerts:** A table at the bottom left lists recent alerts, with a legend indicating alert levels: Red (4), Orange (0), Yellow (0), Green (0), and Blue (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.

By filtering on “Handled”, you can view all alerts that have been marked as completed/handled.

You can search for alerts for a specific patient by entering their subject ID in the search field.

8 This column indicates the module associated with the alert.

The screenshot shows the 'Pending alerts' section of the caregiver dashboard. It includes a search bar, a table of alerts, and action buttons. Numbered callouts are placed over the interface as follows:

- 1: Filter button (top right)
- 2: Message column header
- 3: Date range selector (top right)
- 4: Action column header
- 5: Undo button (bottom right)
- 6: Open/Handled toggle buttons (top right)
- 7: Search alerts for patient field
- 8: Module column header

Patient	Date	Time	Type	Module	Message	Action
coro-001001-353	2025-05-19	08:15	Orange	Healthy nutrition	The patient's Nutrition-score dropped below 31.	[File lookup] [X]
coro-001001-183	2024-04-02	14:57	Red	Healthy weight	The weight of the patient has increased by 8% since the previous encounter.	[File lookup] [X]
coro-001001-371	2024-04-15	14:09	Red	Healthy weight	The weight of the patient has increased by 8% since the previous encounter.	[File lookup] [X] [Checkmark]
coro-001001-408	2024-05-22	19:49	Red	Lowering cholesterol	LDL-Cholesterol was >70 mg/dL or > 1.8 mmol/L.	[File lookup] [X]
coro-001001-409	2024-05-22	19:55	Red	Healthy weight	The weight of the patient has increased by 8% since the previous encounter.	[File lookup] [X]
coro-001001-337	2024-05-28	10:31	Red	Healthy weight	The weight of the patient has increased by 8% since the previous encounter.	[File lookup] [X]
coro-001001-418	2024-11-05	09:34	Red	Smoke-free living	The patient has relapsed in smoking and is not motivated for a new quit attempt.	[File lookup] [X]
coro-001001-421	2024-11-05	15:42	Red	Smoke-free living	The patient has relapsed in smoking and is not motivated for a new quit attempt.	[File lookup] [X]
coro-001001-423	2024-11-18	11:11	Orange	Healthy weight	The weight of the patient has increased by 6% since the previous encounter.	[File lookup] [X]
coro-001001-419	2024-11-18	13:41	Red	Lowering cholesterol	LDL-Cholesterol was >70 mg/dL or > 1.8 mmol/L.	[File lookup] [X]

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

Patient

Subject ID: coro-001001-482
Gender: Female
Year of birth: 1965
Start date: 05-01-2025

URL and code to view the ePro for visit 2:
<https://mobile-app.coroprevention.eu/sections/start?urlapp=M000204>

Print QR code for ePRO application

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

Alerts:

- Print QR code for ePRO application
- Print a new QR password code for the mobile app
- Logout mobile app
- Patient dropped out

Most recent alerts

Date	Time	Type	Module	Message	Action
25-03-2025	13:28	Yellow	Healthy weight	The weight of the patient has increased by 2% since the previous assessment	A tailored video was sent to the patient.
11-03-2025	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.
11-03-2025	07:28	Yellow	Diabetes management	HbA1c was between 7.0% or between 53.0 mmol/mol in this patient with known diabetes	A tailored infographic was sent to the patient.

Correcting data entry (Dashboard)

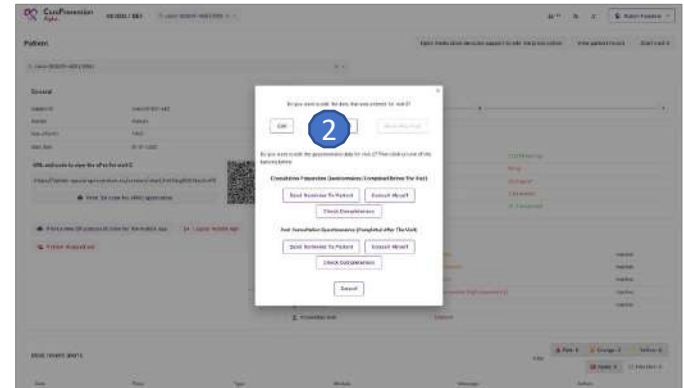
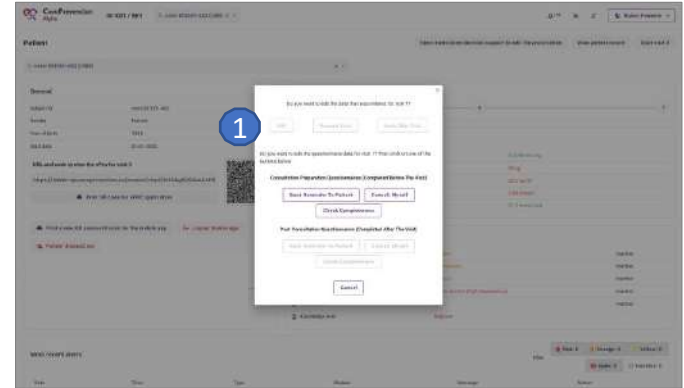
Visit 1 data can be edited (corrected) in the EDC.

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

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

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

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

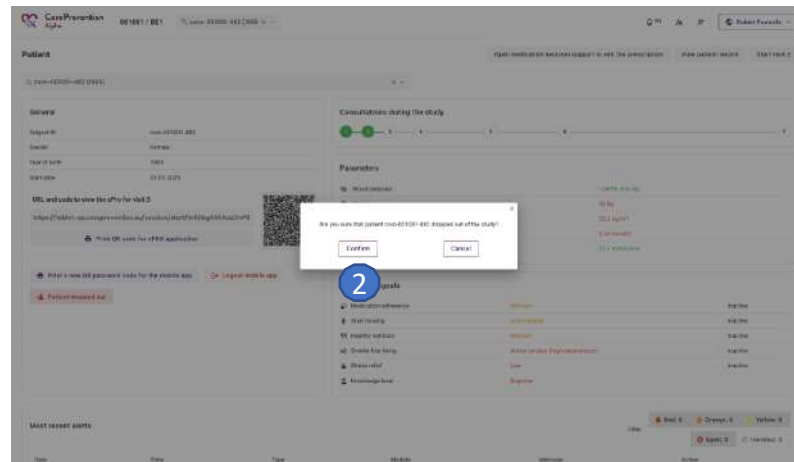
URL and code to view the ePro for visit 3

<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



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

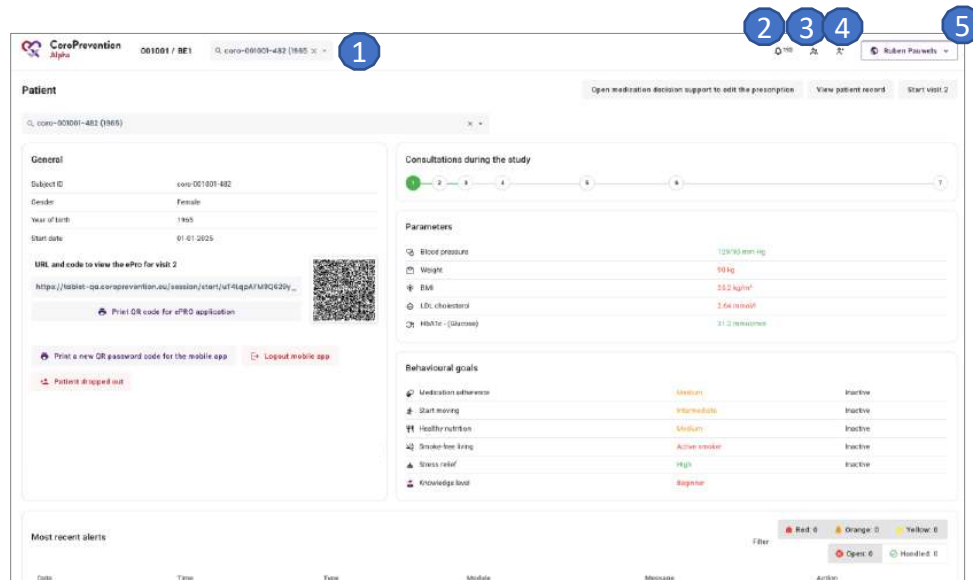


This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 848056

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.



Search all subjects

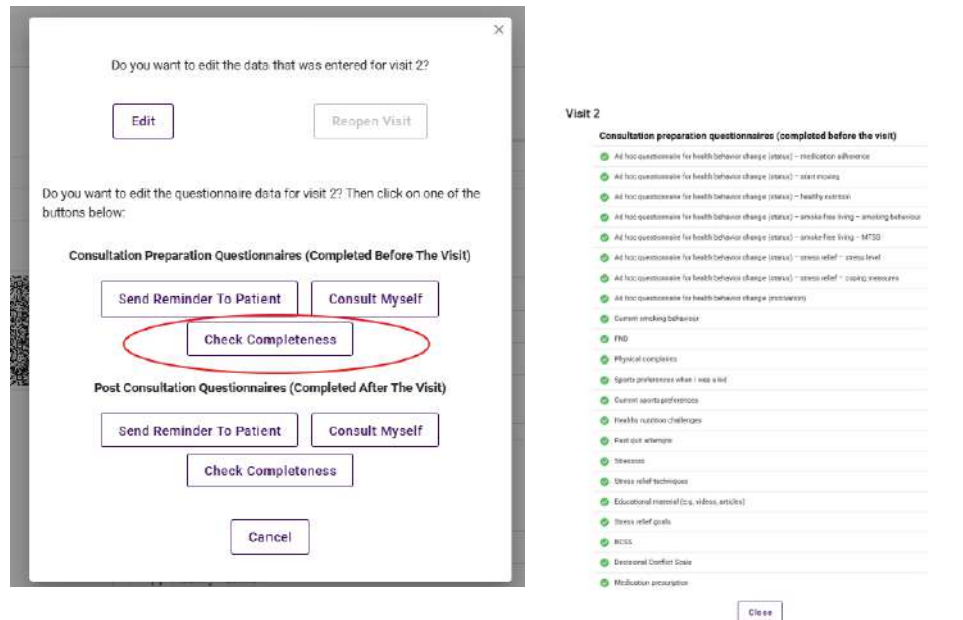
- 1 Click on the “group” icon to view a list of all subjects at your site.
- 2 You can navigate to the next page by clicking Next or by changing the number of rows per page at the bottom of the screen.
- 3 Select the subject by clicking on “Preview icon”.

The screenshot shows the CoroPrevention Alpha dashboard. At the top, there's a header with the logo, site ID (001001 / 001002 / 001003 / 005001), a search bar, and user information (Mia Makinen). Below the header, the section is titled 'All patients'. There's a search bar for patients. A table lists patients with columns: Subject ID, Gender, Year of birth, and Start date. To the right of each row is a 'Preview icon' (a magnifying glass). At the bottom, there's a pagination section showing 'Showing page 1 of 14', 'Rows per page' (a dropdown menu with options 10, 20, 30, 40, 50), and '1-10 of 137'.

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	19-04-2025
coro-001002-508	Male	1973	19-04-2025
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	05-07-2025

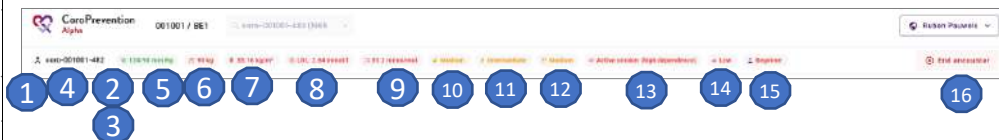
Completeness of ePRO questionnaires

- 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.



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?

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.

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.

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

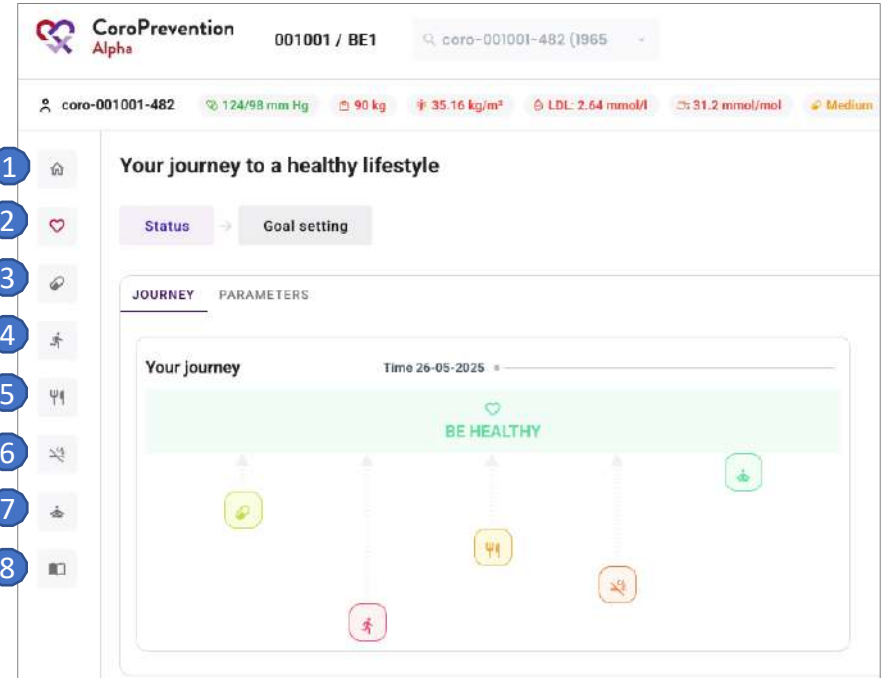
In the “running man” menu item, view the patient's progress and set goals for "Start moving".

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

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

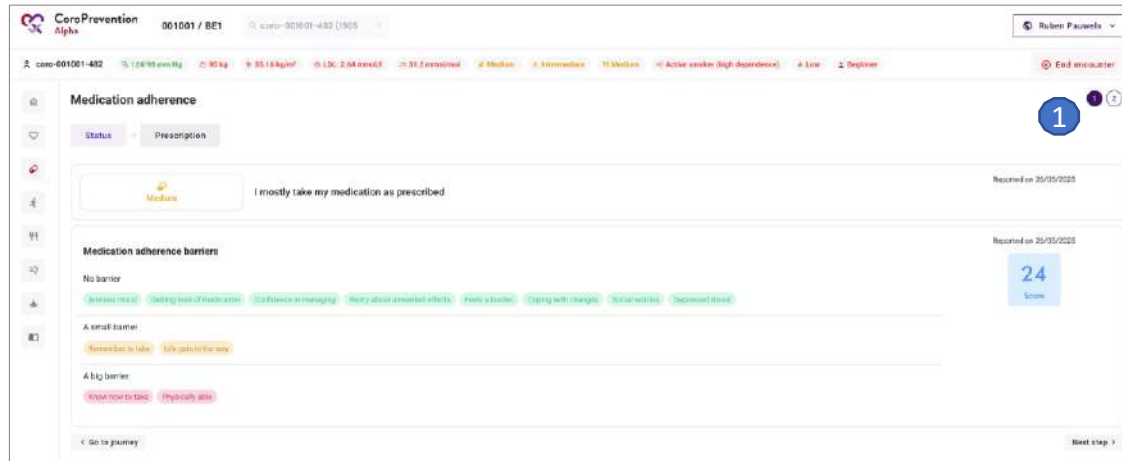
In the “yoga” menu item, view the patient's progress and set goals for "Stress relief".

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.



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.



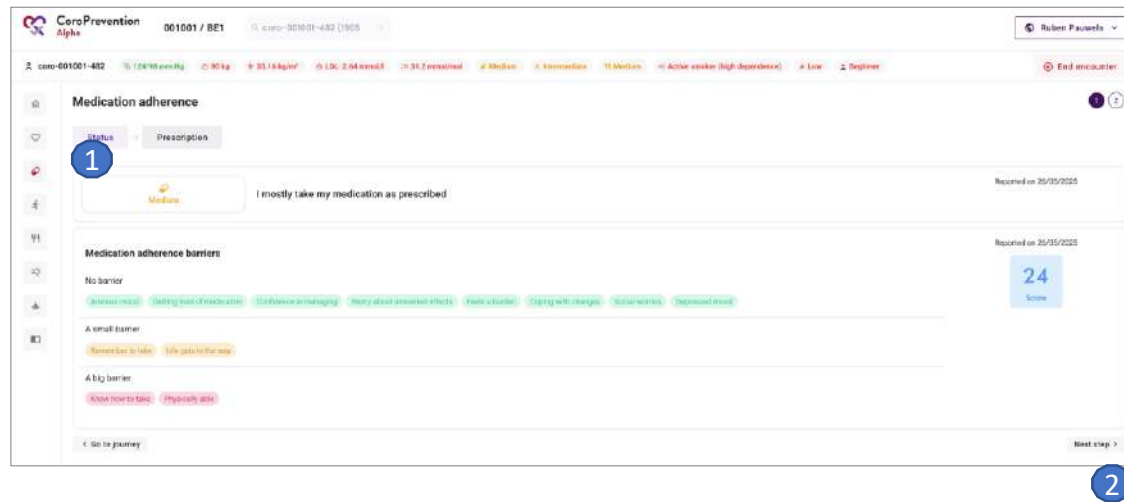
How to structure the conversation about a behavioral goal?

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.

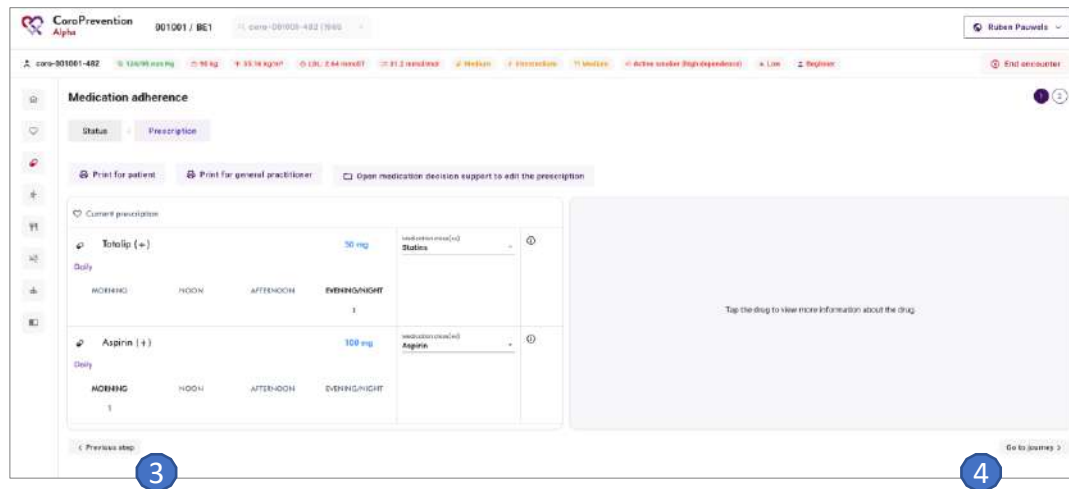


How to structure the conversation about a behavioural goal?

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.





CoroPrevention

PERSONALISED PREVENTION FOR
CORONARY HEART DISEASE

Case nurse manual caregiver dashboard - journey module

V7.0, 21 Aug 2025

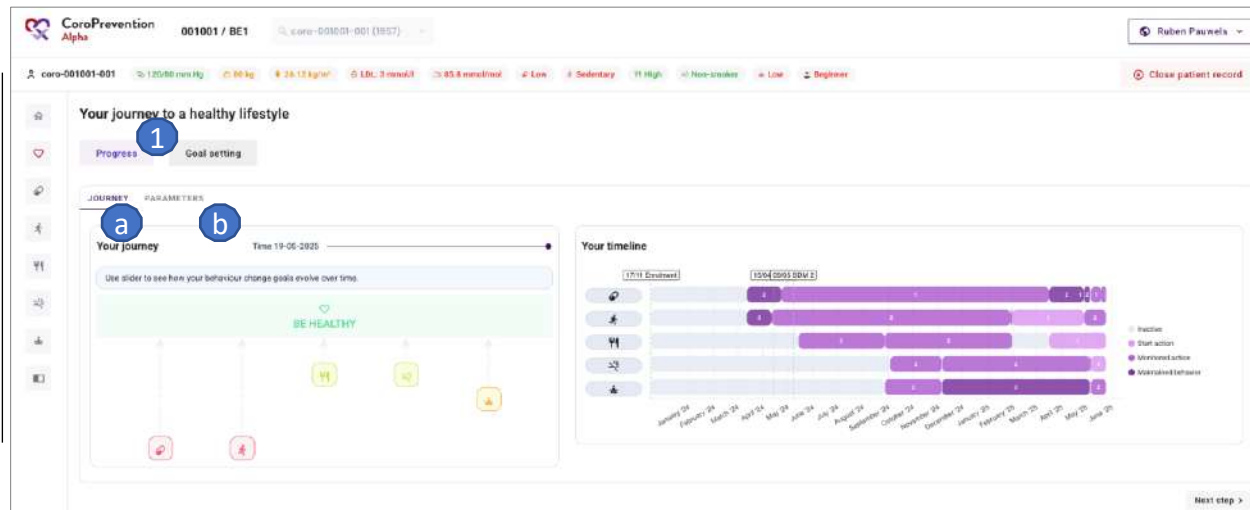


This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 848056

www.coroprevention.eu

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.

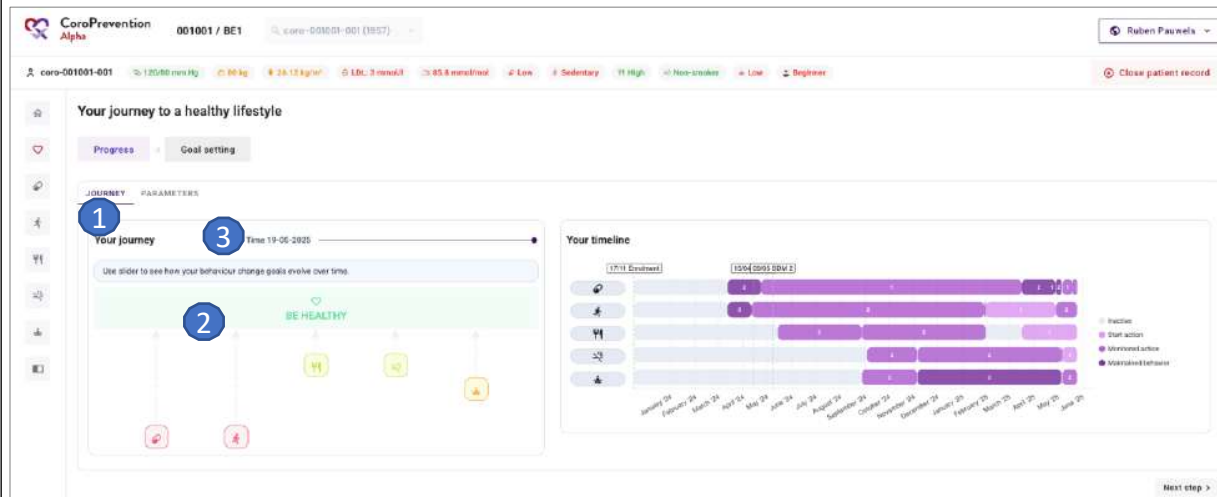


How to follow up on the patient's progress for the behavioral goals?

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.

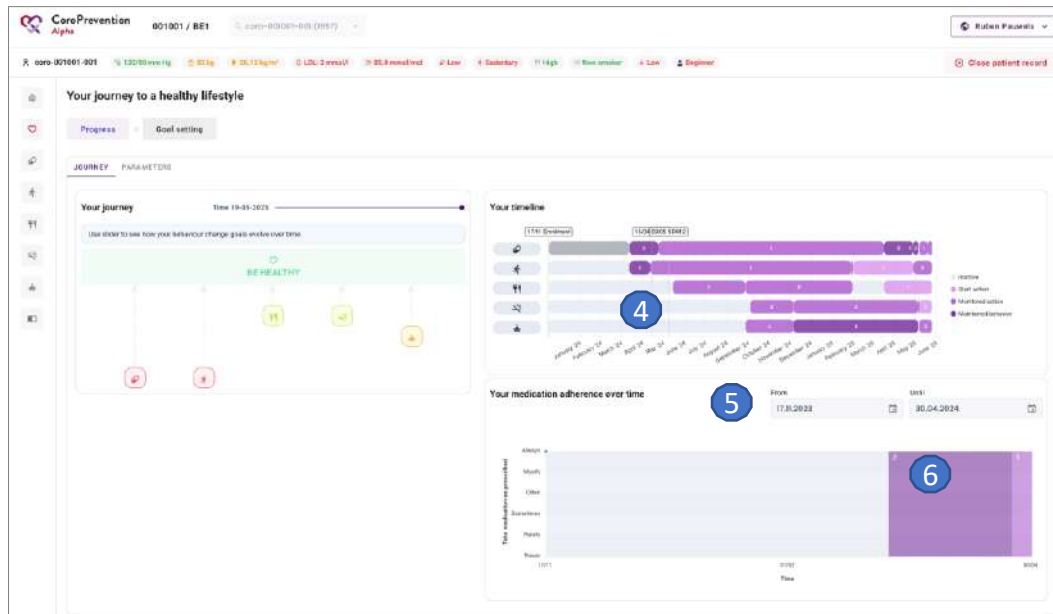


How to follow up on the patient's progress for the behavioural goals?

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.

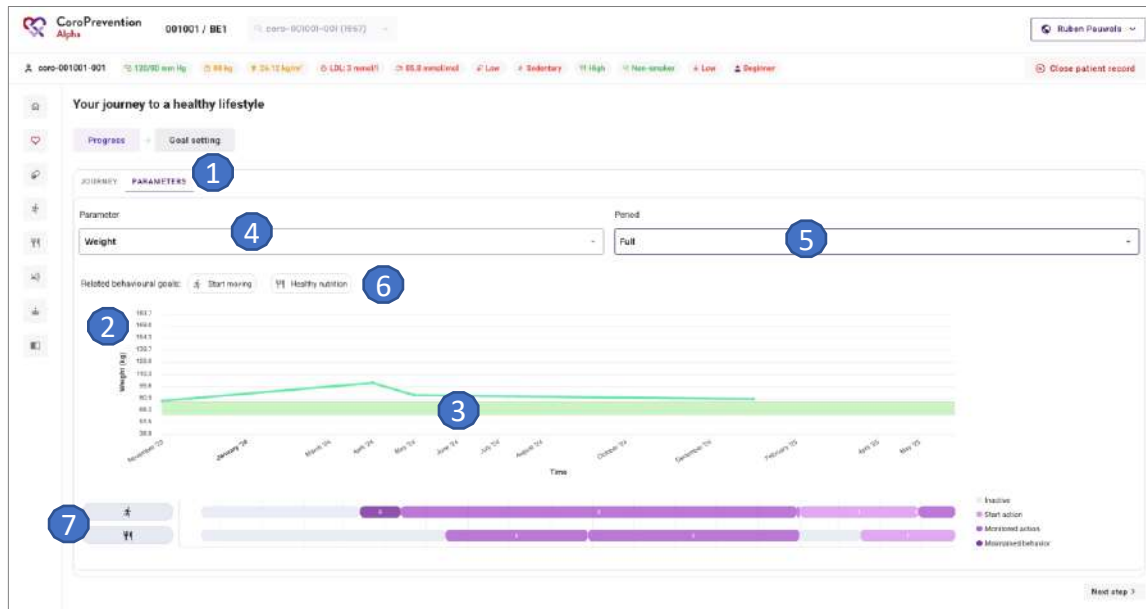
3 The green area is the personalized target zone that the patient should strive to achieve.

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 caregiver dashboard for patient 061001 / BE1. The dashboard includes a header with patient information and a sidebar with navigation icons. The main content area is titled "Your journey to a healthy lifestyle" and features a "Goal setting" tab. Below the tab, there are two columns: "Behavioural goals" and "Outcome goals". The "Behavioural goals" column lists five goals: Medication adherence, Start moving, Healthy nutrition, Smoke-free living, and Stress relief. The "Outcome goals" column lists five goals: Medication adherence, Start moving, Healthy nutrition, Smoke-free living, and Stress relief. Each goal has a "Status" and "Motivation" column. The "Status" column shows the current status (e.g., Medium, Intermediate, Low) and the "Motivation" column shows the motivation level (e.g., Moderate, High, Low). A "Decision" column on the right shows the decision to be made (e.g., Inactive, Start action, Monitored action, Maintained behavior). The dashboard also includes a "Previous step" button at the bottom left.

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

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

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

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

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

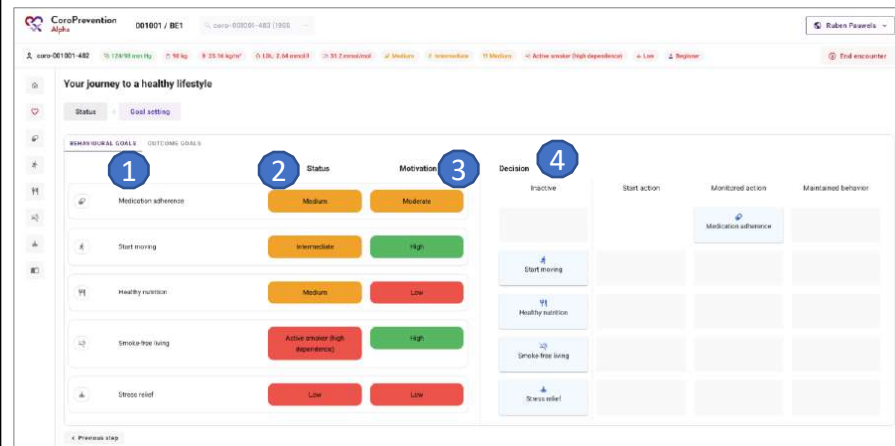
View how motivated the patient is to work on the behavioural goal. You can use this information when determining the patient's level of guidance for a behavioural goal.

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

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

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

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



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

How to set the patient's outcome goals?

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.

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.

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."

CoroPrevention Alpha

001001 / BE1

core-001001-482 (1955)

core-001001-482 135/95 mmHg 95 kg 35.16 kg/m² 130/ 2.64 mmol/L 31.2 mmol/mol Medium Intermediate 91 Median Active smoker (high dependency) Low Beginner End encounter

Your journey to a healthy lifestyle

Status → Goal setting

BEHAVIOURAL GOALS OUTCOME GOALS

	Status	Outcome goal
Lowering blood pressure	Good	☐
Healthy weight	Poor	☒ Add target weight
Lowering cholesterol	Poor	☒
Diabetes management	Good	☐

Previous step

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 shows the CoroPrevention Alpha interface for a patient named Ruben Pauwels. The main section is titled 'Your journey to a healthy lifestyle' and includes a 'Goal setting' tab. Under the 'OUTCOME GOALS' sub-tab, there is a table with the following data:

Goal	Status	Outcome goal
Lowering blood pressure	Good	☐
Healthy weight	Poor	☒ Target weight: 85.5 kg Remove target weight
Lowering cholesterol	Plan	☒
Diabetes management	Good	☐

Blue circles with numbers 4 and 5 are overlaid on the image. Circle 4 points to the 'Target weight' input field, and circle 5 points to 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

www.coroprevention.eu

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.

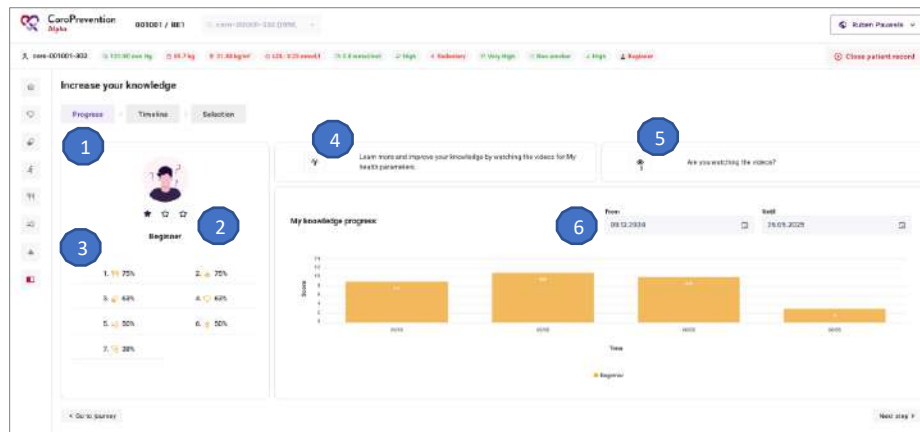
2 You can view the patient's current knowledge level. There are three knowledge levels: beginner, advanced knowledge, and health expert. Within these levels, the patient can attain 1, 2 or 3 stars, depending on the number of correct answers in the last knowledge challenge.

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.

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.

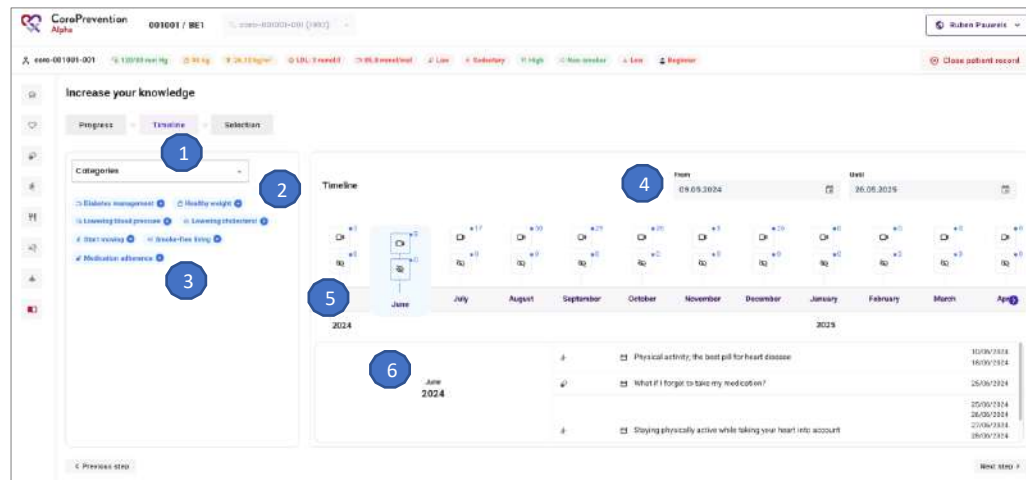
2 You can select the categories (multiple) that you want to include in the timeline.

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.

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.

You can search educational content by using the search function.

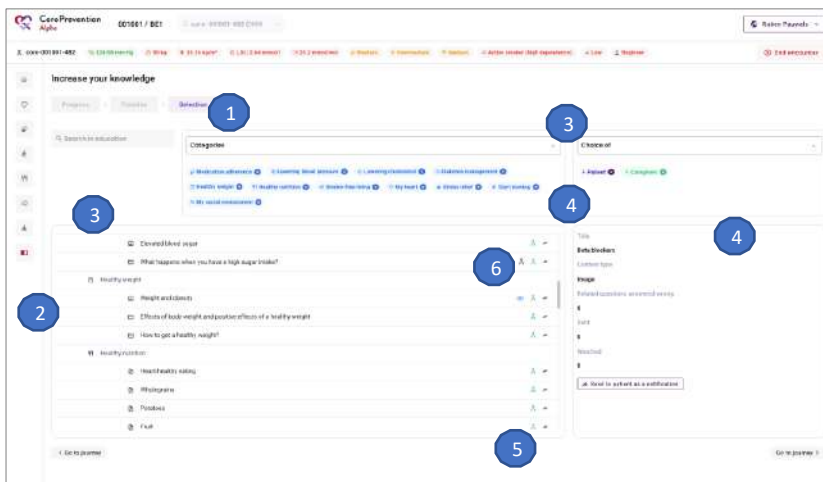
3 You can also apply filters to look for specific educational content based on the category or who selected the educational content.

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.

Based on the patient's current outcome and behavioural goals, a set of recommended educational content is automatically selected for

5 the patient. As a caregiver, you can also update this set of recommended educational content. Educational content that is selected by the algorithm or by you, has a "caregiver" symbol.

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



How to select personalized educational material for the patient?

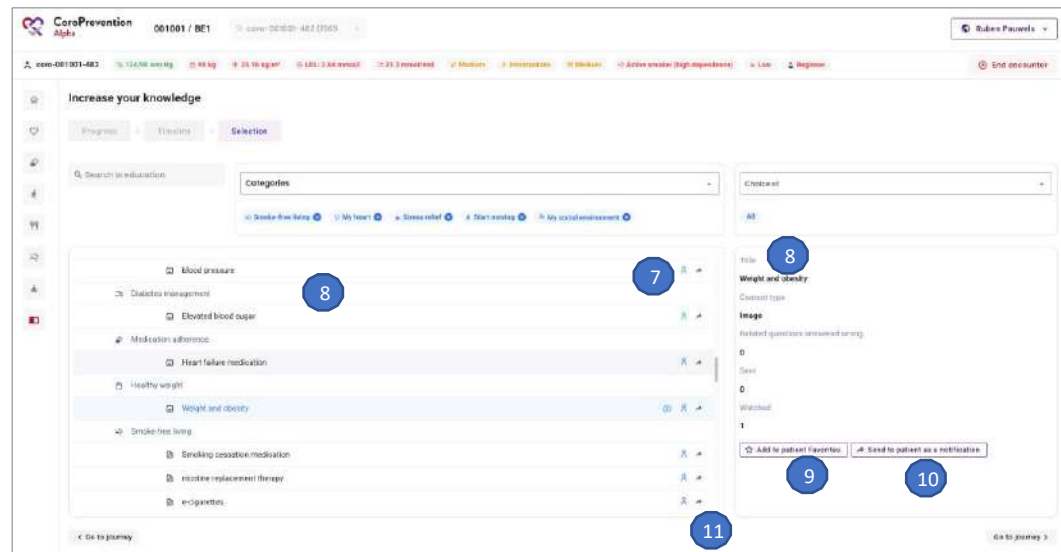
7 You can remove an educational item from the patient's or caregiver's choice by clicking on the "patient" or "caregiver" symbol respectively.

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

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

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

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





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

www.coroprevention.eu

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 'Medication adherence' section of the CoroPrevention Alpha patient dashboard. At the top, the patient's name 'Ruben Pauwels' is visible. Below the header, a navigation bar shows various patient metrics and status indicators. The main content area is divided into two sections: 'Medication adherence' and 'Medication adherence barriers'. The 'Medication adherence' section includes a 'Status' button (1) and a 'Medication' button (2). The 'Medication adherence barriers' section lists various barriers with color-coded indicators: green for no barriers, orange for small barriers, and red for major barriers. A score of 24 is displayed on the right. The dashboard also includes a 'Next step' button at the bottom right.

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

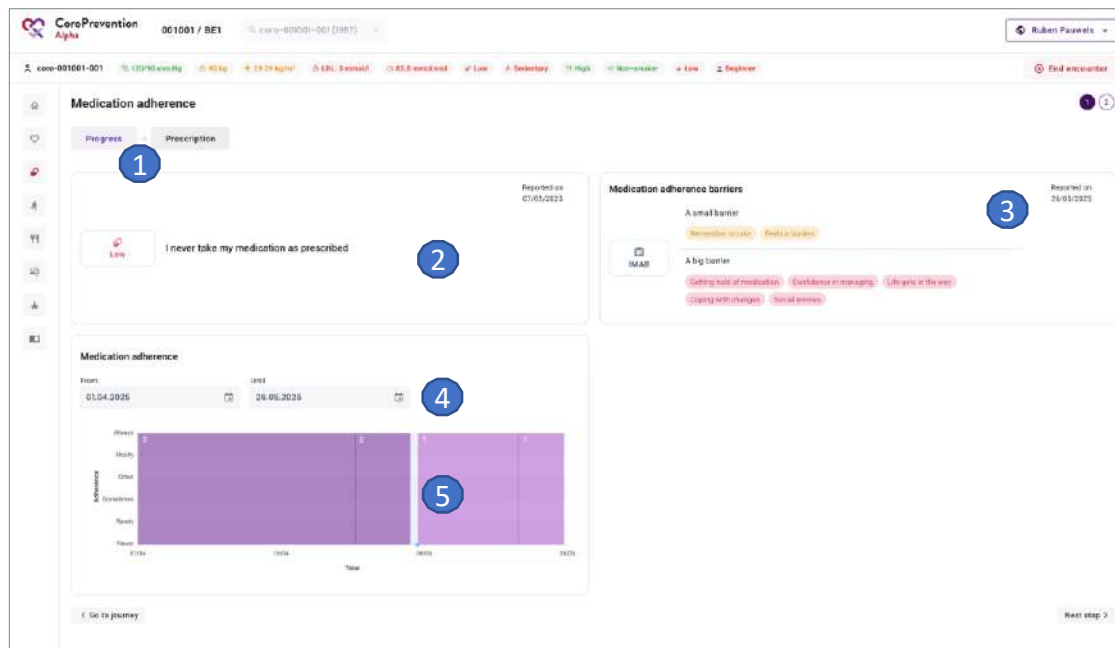
1 In "Progress", you have an overview of the patient's progress for medication adherence.

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.

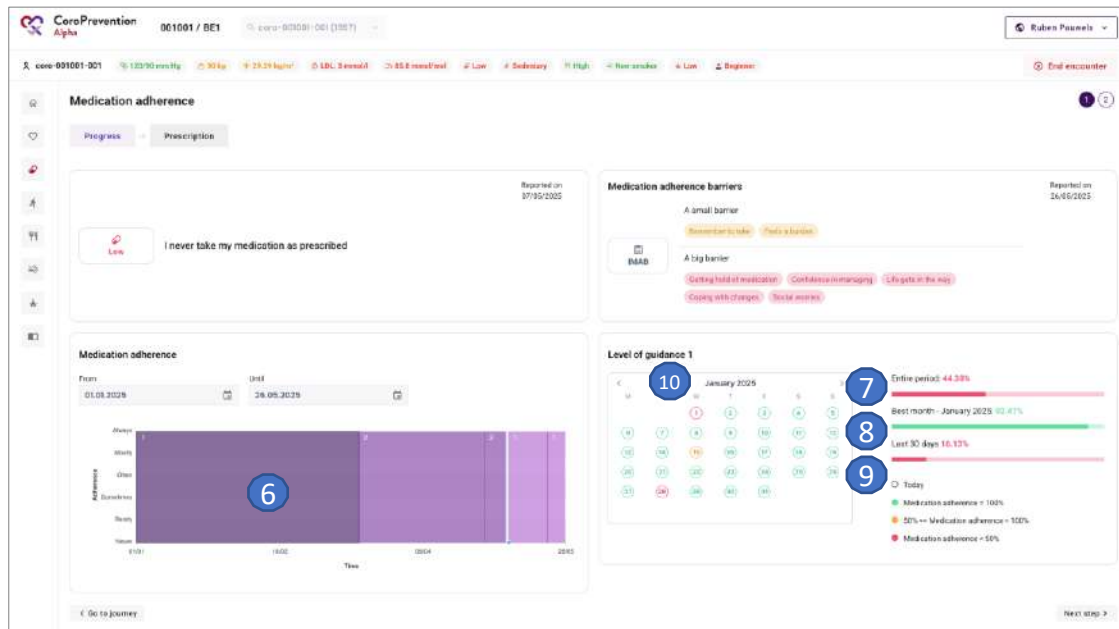
The chart depicts how the patient's medication adherence evolved over time. The medication adherence was reported by the patient in the mobile application or the ePRO application. With date picker you can adjust the time period shown in the chart.

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



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

- 6 You can click on a period in a level of guidance to view more details about this period.
- 7 You can view the medication adherence percentage over this entire period in level of guidance 1 for "Medication adherence".
- 8 You can view the best month of this period in level of guidance 1 for "Medication adherence".
- 9 You can view the medication adherence percentage of the last 30 days in this period in level of guidance 1 for "Medication adherence".
- 10 In the calendar overview, you can view on which days the patient's medication adherence was good (green), moderate (orange), or bad (red).



How to view the patient's medication prescription?

- 1 In "Prescription", you have an overview of the patient's medication prescription.
- 2 The patient's current medication prescription is shown. There is also an indication of the changes that were made since last encounter. These changes are especially relevant to discuss with the patient.
- 3 Drugs that were added since last visit are indicated by a "plus" icon.
- 4 Drugs that were edited since last visit are indicated by a "pencil" icon.
- 5 Drugs that were deleted since last visit are scratched through.
- 6 Pills are indicated by a "pill" icon, while injections are indicated by a "syringe" icon.
- 7 You can click on a row in the medication prescription to view more information about the drug.
- 8 You can view the parameters that the medication is related to, the reason why the patient has to take the medication, the date that it was prescribed and by whom it was prescribed, and which changes were made to this drug over time. There is also an infographic that you can use in the discussion with the patient to explain the mechanisms that the drug works on and the reason why the patient has to take the drug.
- 9 To be able to view the additional information about a drug, the medication class of the drug should be selected.
- 10 You can record additional notes for the drug.
- 11 If you have an investigator role in the study / in dashboard, you can open the medication decision support system by clicking this button.
- 12 You can print the medication prescription for the patient and the recommendations for the patient's general practitioner by clicking these buttons.

The screenshot displays the 'Medication adherence' section of the CoroPrevention Alpha dashboard. The interface includes a top navigation bar with patient information (001001 / BE1) and a sidebar with various icons. The main content area is divided into several sections:

- Medication adherence:** This section contains a table of medications. The first row is for 'Totalip (L)', which is a daily pill. The second row is for 'Glipizide', which is a daily pill. The third row is for 'Aspirin (+)', which is a daily pill. Each row has a 'Medication class' column and a 'Medication icon' column. The 'Medication icon' column contains icons for pills and syringes. The 'Medication class' column contains the medication name and its dosage.
- Buttons:** There are three buttons at the top of the medication list: 'Print for patient', 'Print for general practitioner', and 'Open medication decision support to edit the prescription'.
- Right Panel:** This panel contains a 'Totalip' section with a 'Related parameters' table. The table has columns for 'When', 'Who', and 'What'. It shows three rows of data: '26/05/2023', 'Investigator', 'Decreased the number of pills in the evening/night from 2 to 1'; '26/05/2023', 'Investigator', 'Increased the number of pills in the evening/night from 1 to 2'; and '26/05/2023', 'Investigator', 'Added the drug to the prescription'. Below the table is a 'Change history' section with a table that has the same columns and data. At the bottom of the right panel is a 'Notes' section with a text area.
- Infographic:** There is a small infographic at the bottom right of the right panel, titled 'Cholesterol-lowering medication', showing a circular diagram with a red arrow pointing to a yellow box.

Numbered callouts (1-12) are placed over the interface to highlight specific features:

- 1: 'Prescription' tab in the top navigation bar.
- 2: 'Current prescription' section header.
- 3: 'Aspirin (+)' medication row.
- 4: 'Totalip (L)' medication row.
- 5: 'Glipizide' medication row.
- 6: 'Print for patient' button.
- 7: 'Open medication decision support to edit the prescription' button.
- 8: 'Related parameters' table.
- 9: 'Medication icon' column header.
- 10: 'Notes' text area.
- 11: 'Print for general practitioner' button.
- 12: 'Print for patient' 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

www.coroprevention.eu

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

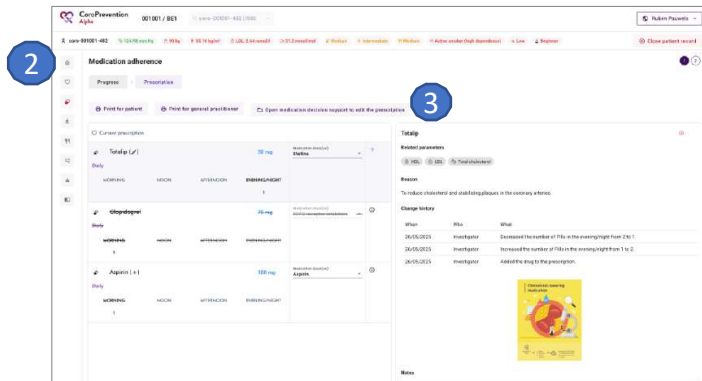
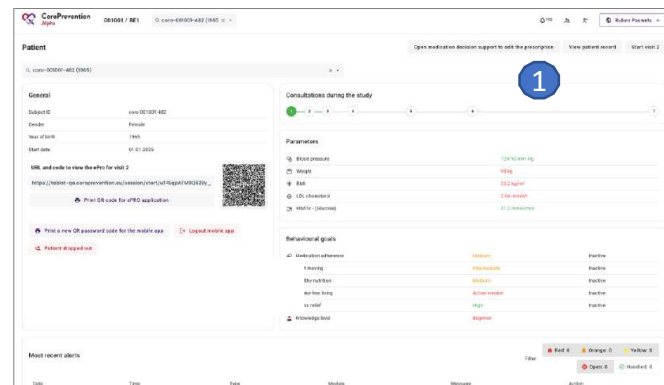
There are three ways to open the medication DSS.

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.



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 displays the Coroprevention medication decision support system (DSS) interface. At the top, the patient's name '001001 / BE1' and a search bar are visible. Below the search bar, the 'Medication decision support system' title is shown. The interface features four tabs: 'Cardiac medication' (a), 'Other medication' (b), 'Allergies' (c), and 'Titration schemes' (d). A 'Close' button (2) is located near the top right. Below the tabs, the 'Current prescription' section shows a table with columns for 'Morning', 'Noon', 'Afternoon', and 'Evening/night'. The table contains a single row for 'Aspirin' with a dosage of '100mg'. A message states: 'This medication has been recommended by the algorithm.' Below this, there are links for 'More info' and 'Change history'. On the right side, a 'Warnings' section (4) lists several warnings, including 'The patient age for the algorithm can be up to 1 year older than the LDC reported value.' and 'Warning: GAT 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.' At the bottom right, there is an 'Add drug' button. A 'Print for patient' button (5) is also visible 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.

1. **Navigation Bar:** Includes links for Case ID (001001-482), Patient Information (124/88 mmHg, 74 kg, 35.14 kg/m², 126.3 J/min, 100 beats/min, 100% SpO2, 100% SaO2), and Action buttons (Add, Edit, Delete, Print, Share, Logout).

2. **Medication Selection:** A dropdown menu with options: Cardio medications, Other medication, Allergies, Titration schemes, and Algorithm input.

3. **Current Prescription:** A table showing the current medication regimen.

Medication	Dose	Frequency	Timing
Aspirin	100 mg	Daily	Morning

4. **Recommendation:** A section showing the recommended medication regimen.

Medication	Dose	Frequency	Timing
Aspirin	100 mg	Daily	Morning

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

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

6 View the notes about the drug.

7 Edit the drug by clicking this button.

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

8 You can view more information about the drug by clicking this button. The detailed information includes: the class of recommendation, the level of evidence, the guideline information, and the guideline source.

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

11 You can view the change history for the drug.

The screenshot displays the CoroPrevention medication DSS interface. At the top, patient information is shown: ID 001482, 54 years old, 70 kg, 163 cm, 163 kg/m², 163 cm, 163 kg/m², 163 cm, 163 kg/m². The interface is divided into several tabs: Cardiac medication, Other medication, Allergies, Titration schemes, and Algorithm input. The Cardiac medication tab is active, showing a list of medications. The 'Current prescription' section displays a table with columns for medication, frequency, and time. The first row shows Aspirin 100 mg, taken daily. The second row shows a warning: 'This medication has been recommended by the algorithm.' The 'Recommendation' section shows a table with columns for medication, frequency, and time. The first row shows Clopidogrel 75 mg, taken daily. The interface includes various buttons and icons for editing, deleting, and adding medications. A warning message is displayed at the top right, stating: 'The patient age for the algorithm can be up to 1 year older than the EDC reported value.' The interface also includes a 'More info' button and a 'Change history' button for each medication.

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 management interface. At the top, a search bar contains 'Asprin' and '20 mg'. Below this, a table shows the medication schedule. The 'Daily' row has a '1' in the 'Morning' column. The 'Evening/Night' column has a '0'. A blue circular icon with the number '12' is visible on the right side of the interface, indicating a patient-added medication.

	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 image displays two screenshots of the CoroPrevention Alpha Medication decision support system (DSS) interface. The top screenshot shows the 'Close' button circled in blue with a '1'. The bottom screenshot shows the 'Edit prescription' button circled in blue with a '3'.

Top Screenshot (1): The interface shows the 'Medication decision support system' for patient 001001 / BE1. The 'Close' button is circled in blue with a '1'. The 'Add drug' button is visible on the right. The 'Current prescription' section shows a table for Aspirin with columns for Morning, Noon, Afternoon, and Evening/Night, and a row for Daily with values 1, 0, 0, and 0. Below the table, it states 'This medication has been recommended by the algorithm.' and provides links for 'More info' and 'Change history'.

Bottom Screenshot (3): The interface shows the 'Medication decision support system' for patient 001001 / BE1. The 'Edit prescription' button is circled in blue with a '3'. The 'Cardiac medication' section shows a table for Aspirin with columns for Morning, Noon, Afternoon, and Evening/Night, and a row for Daily with values 1, 0, 0, and 0. Below the table, it states 'This medication has been recommended by the algorithm.' and provides links for 'More info' and 'Change history'. The 'Other medication' section is also visible.

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

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

000-001001-482

124/68 mm Hg

90 kg

25.14 kg/m²

LDL 2.64 mmol/L

31.2 mmol/mol

Moderate

Intermediate

Mild

Active smoker (high dependence)

Low

Diagnoses

Daily

Morning

Noon

Afternoon

Evening/night

1

0

0

0

This medication has been recommended by the algorithm

Clopidogrel

75

mg

P2Y12 receptor inhibitors

Daily

Morning

Noon

Afternoon

Evening/night

1

0

0

0

This medication has been recommended by the algorithm

Other medication

The medication prescription is empty.

Titration schemes

Titration scheme for beta blocker

Start dosage

25 mg

Target dosage

75 mg

Description

Increase after 3 weeks when there are no contra-indications

Go to patient overview

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

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

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

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

3 You can view the name of the drug.

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

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

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

The screenshot displays the 'Medication decision support system' interface for a patient named 'Ruben Pauwels'. The 'Other medication' tab is selected, showing a list of current prescriptions. The first prescription is 'Fulium D3 800' with a dosage of '80' and unit 'mg'. The frequency is set to 'Daily' with a value of '1'. The time of administration is set to 'Morning' with a value of '0'. The second prescription is 'Overspill' with a dosage of '0.5' and unit 'ml'. The frequency is set to 'Biting repeated for every 1 Week(s) on Monday' with a value of '0'. The time of administration is set to 'Evening/night' with a value of '1'. The interface includes a search bar, patient details, and various tabs for medication management.

Cardiac medication	Other medication	Allergies	Titration schemes
	1		

Current prescription

Drug	Dose	Unit	Frequency	Time
2 Fulium D3 800	80	mg	5 Daily	4 Morning
				0 Noon
				0 Afternoon
				1 Evening/night
Overspill	0.5	ml		

Biting repeated for every 1 Week(s) on Monday

Frequency	Time
0	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

001001-682 | C459 (new Hg) | 90 kg | 26.74 bpm | 130 / 2.44 mmHg | 33.2 mmHg | HbA1c | Intermittent | Insulin | Active smoker (high dependence) | List | Register

Medication decision support system

Cardiac medication > Other medication > Allergies > Titration schemes

Allergies

- No aspirin intolerance
- ACE inhibitor intolerance

1

Warning: Systolic BP targets (e.g. <140 mmHg) should be considered among patients meeting the following criteria: * pre-treatment, symptomatic, orthostatic hypertension * 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

- 2 this button. A dosage titration scheme defines for a certain drug the start and target dosage.

Create a new drug addition titration scheme by clicking this button. A drug addition titration

- 3 scheme defines a start medication class and medication classes that should be added based on the patient's parameter values.

- 4 Edit the titration scheme by clicking this button.

- 5 Delete the titration scheme by clicking this button.



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



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

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

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

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 shows the 'Start moving' screen in the CorePrevention Alpha app. The interface includes a top navigation bar with the app name, user ID, and various status indicators. The main content area is divided into sections: 'Status' and 'Goal setting' tabs, a 'STATUS' section, and a 'Current physical activity' section. The 'Current physical activity' section displays a goal: '1 day(s) with a total of 30 minutes or more of at least moderate physical activity', reported on 26/06/2021. Below this, a list of activities is shown: 'Under active regular' (yellow), 'Fulfilled strength exercises' (green), and 'Did not perform flexibility exercises' (red). The screen is annotated with three blue circles and numbers: 1 points to the 'Status' tab, 2 points to the activity goal text, and 3 points to the list of activities. The bottom navigation bar has 'Go to journey' and 'Next step' buttons.

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

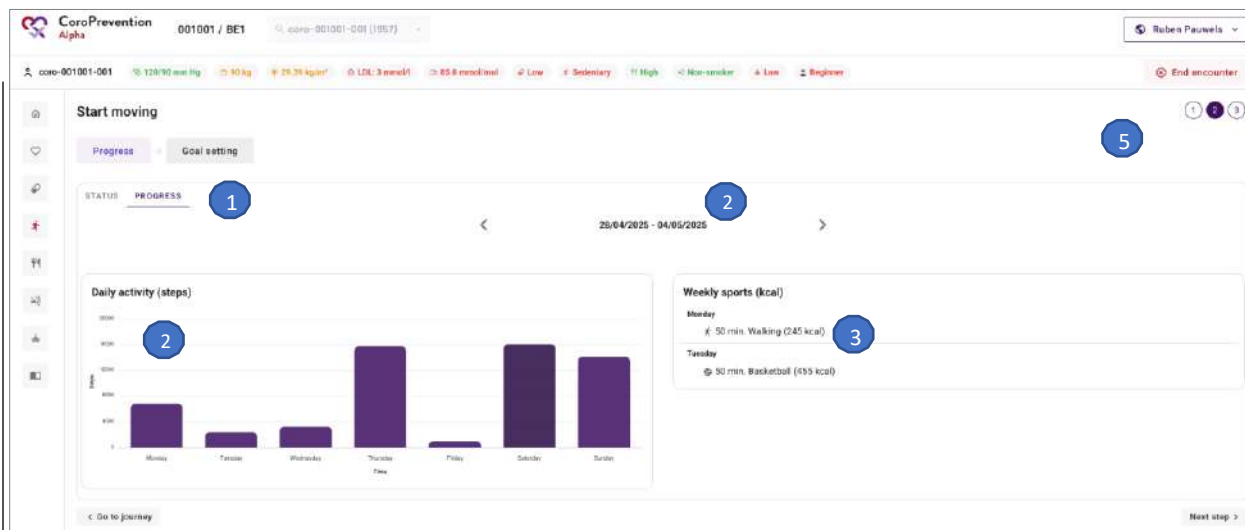
1 Navigate to the progress tab in the **Start moving** module.

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.

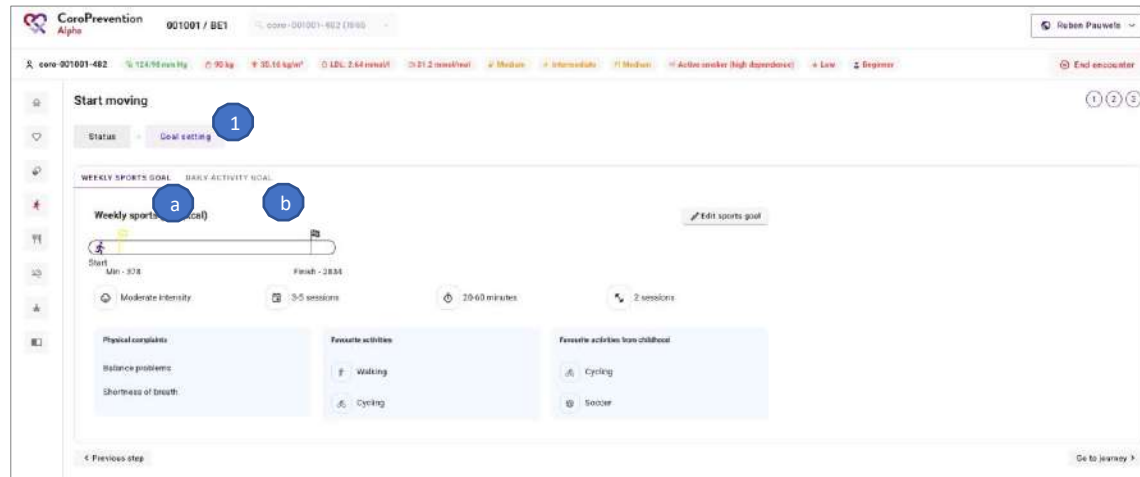


Which types of physical activity goals can be set for the patient?

- 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.



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.

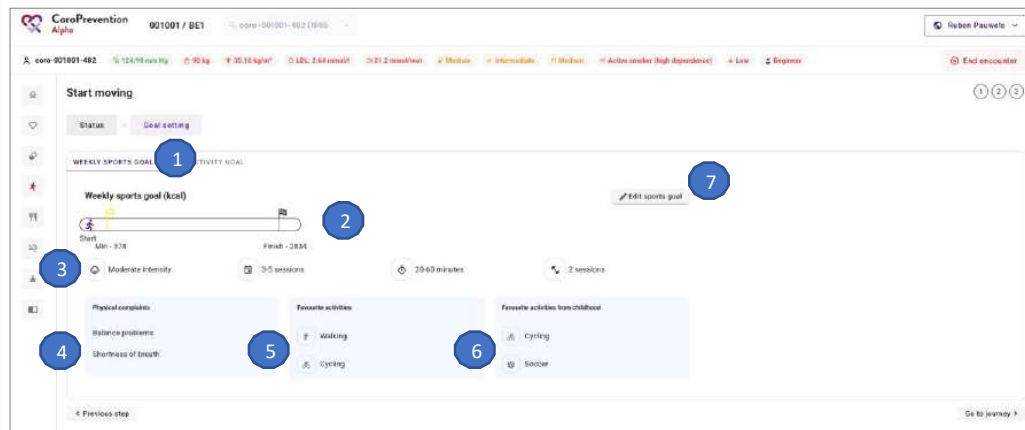
3 There is an overview of the exercise prescription, consisting of: the recommended exercise intensity, the recommended number of exercise sessions, the recommended session duration, and the recommended number of strength training sessions.

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.

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.



How to set the patient's daily activity goal?

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

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

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

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

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

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

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

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

How to navigate in the EXPERT tool?

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

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

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.

2 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.

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.

CoroPrevention Alpha 001001 / BE1

Female, 66 years 78 bpm 523 m

EXPERT tool

Weekly sports goal Safety precautions

1 Select primary indication: Heart failure (with/without LVEF) and CAD

2 Select risk factors: Dyslipidemia Obesity

2 Select exercise modifiers:

2 Select anomalies occurred during exercise testing

2 Select medication that affects exercise prescription: Statins

Recommendation

Moderate 3-5 30-40 >4 weeks Yes

- RMT (from 30 up to 60% of Pmax, 20-30 min/session, 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)
- >450 kcal/week of energy expenditure should be achieved
- Strength training exercises: 2 days/week, 40-60% of 1RM, 8-15 reps/set
- RMT intensity: [heart failure (with lowered LVEF) and CAD] → about VT2 for 4 min/cycle
- RMT Structure: [heart failure (with lowered LVEF) and CAD] → up to 6 cycles of 4 * 4 min, preceded by 10 min warm-up
- RMT Frequency: [heart failure (with lowered LVEF) and CAD] → 2 to 3

Saved prescription

Moderate 3-5 30-40 >4 weeks Yes

- RMT after CABG surgery (from 30 up to 60 of Pmax, 20-30 min/session, 3-5 days/week)
- advice exercise modalities with large caloric expenditure (walking, jogging, stepping, etc)
- >450 kcal/week of energy expenditure should be achieved
- Strength training exercises: 2 days/week, 40-60% 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 details include: Female, 60 years, 70 kg, 163 cm. The interface is divided into several sections:

- Primary indication:** Select primary indication: Heart failure (with licensed LVEF) and CAD.
- Key risk factor:** Select risk factors: Dyslipidemia, Obesity. A table lists selected conditions with their severity, frequency, duration, and status.
- Exercise modifier:** Select exercise modifiers.
- Anomalies:** Select anomalies occurred during exercise testing.
- Medication:** Select medication that affects exercise prescription: Daily.
- Recommendation:** A table showing the final exercise recommendation.

Condition	Severity	Frequency	Duration	Status
Obesity	Moderate	3-5	>4 weeks	No
Type 1 Diabetes	Moderate	3	>12 weeks	Yes
Type 2 Diabetes	Moderate	5	>12 weeks	Yes
Hypertension	Moderate-high	Daily	>6 weeks	Yes
Dyslipidemia	Moderate	3-5	>12 weeks	Yes

Recommendation	Frequency	Duration	Status
Moderate	3-5	>4 weeks	Yes

Additional notes at the bottom of the recommendation section:

- RMT (from 30 up to 40% of Pmax, 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, shopping, etc)
- >300 kcal/week of energy expenditure should be achieved
- Strength training: exercises: 2 days/week, 40-60% of 1RM, 8-15 reps/set.
- RMT intensity: Heart failure (with licensed LVEF) and CAD: > 100% for 4 min/week

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.

- 6 If you wish to modify the generated recommendation, you can 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. At the top, patient information is shown: 001001 / BE1, age 66 years, weight 78 kg, and height 1.73 m. The patient's medical history includes Coronary Artery Disease (CAD), Diabetes, and Hypertension. The EXPERT tool is currently set to 'Weekly sports goal' and 'Safety precautions'. The 'Recommendation' section shows a thick-bordered box with the following text: 'Moderate intensity (30-40% of HRmax, 30-40 min/session, 3-5 days/week), and electro muscle stimulation can be added in case of very deconditioned patients'. The 'Saved prescription' section shows a similar recommendation. The interface includes buttons for 'Save and close', 'Close', and 'Print'.

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.

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.

8 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 shows the CoroPrevention Caregiver dashboard for a patient named 'Pamela, 60 years'. The 'Recommendation' box is expanded, showing various fields for intensity, frequency, session duration, program duration, strength training, and additional training strategies. The recommendation text is visible on the right side of the box.

Recommendation:

- IMT (from 30 up to 60% of Pmax, 30-50 min/day, 3-5 days/week) and electro muscle stimulation can be added in case of very deconditioned patients
- active exercise modalities with large caloric expenditure (walking, jogging, stepping, etc)
- >400 kcal/week of energy expenditure should be achieved
- Strength training exercises
- 2 days/week, 40-60% of 1RM, 8-15 repetition
- HRT intensity
- Heart failure (with lowered LVEF) and CMP: > above VT2 for 4 min/cycle
- HRT Sessions
- Heart failure (with lowered LVEF) and CMP: > up to 6 cycles of 4 * 4 min, preceded by 10 min warm up
- HRT Frequency
- Heart failure (with lowered LVEF) and CMP: > 2 to 3

Intensity:

Format: Value Moderate Dependence: Heart rate

Frequency:

Format: Range 2 5 Dependence:

Session duration:

Format: Range 30 60 Dependence:

Program duration:

Format: Range 36 60K Dependence:

Strength training:

Weight training: Yes Dependence:

Additional training strategies:

- IMT (from 30 up to 60% of Pmax, 30-50 min/day, 3-5 days/week) and electro muscle stimulation can be added in case of very deconditioned patients
- active exercise modalities with large caloric expenditure (walking, jogging, stepping, etc)

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

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

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

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

Note: This closes the EXPERT tool without saving changes.

CoroPrevention Alpha

901001 / BE1

core-001001-482 (1005)

core-001001-482

134/98 mmHg

98 kg

35.14 kg/m²

LDL-C: 2.04 mmol/L

31.2 mmol/mol

Moderate

Intermediate

Moderate

Active disorder (high dependence)

Low

Beginner

Female, 60 years

78 bpm

523 m

EXPERT tool

Save and close

Close

Print

Weekly sports goal

Safety precautions

Primary indication

Select primary indication: Heart failure (with/without LVEF) and CAD

Key risk factor

Select risk factors: Dislipidaemia, Obesity

Exercise modifier

Select exercise modifiers:

Anomalies

Select anomalies occurred during exercise testing:

Medication

Select medication that affects exercise prescription: Statins

Recommendation

Moderate

3-5

30-60

>14 weeks

Yes

10

11

Save prescription

Moderate

3-5

30-60

>14 weeks

Yes

10

• PMT (from 30 up to 60% of P_{max}, 20-30 minutes, 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 exercise:

2 days/week, 40-60% of 1RM, 8-15 reps/set

• HIT intensity

• Heart failure (with lowered LVEF) and CAD → above VT2 for 4 min/cycle

• HIT Sessions

• Heart failure (with lowered LVEF) and CAD → up to 6 cycles of 4 × 4 min, preceded by 10 min warm-up

• HIT frequency:

• Heart failure (with lowered LVEF) and CAD → 2 to 3

• PMT after CABG surgery (from 30 up to 60 of P_{max}, 20-30 min/week, 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 exercise:

2 days/week, 40-60% of 1RM, 10-15 reps/set

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.

CoroPrevention Alpha **001001 / BE1**

🔍 001001-001100 | 📊 100%

👤 coro-001001-402 | 🕒 12d 08 min 14s | 💾 20 kb | ⚙️ 20.36 kg/m³ | 📈 LDL 2.64 mmol/l | 📉 HDL 0.92 mmol/l | 🏃 39.2 min/mile | 🎯 47 Males | 🔗 Intermediate | 🏠 10 Hobbies | 🛡️ Active weaker (High-Dependence) | 📊 Low | 🔄 Progress

♀ Female, 60 years | 🕒 79 hrs | 📅 523 m

EXPERT tool

⌵ Save and close | ✖ Close | 🖨 Print

Weekly sports goal > Safety precautions **1**

Status **2**

CAB, PCI CABG, and minimally-invasive CABG **2**

- 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 multi-modal 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), aimed at early recognition and prevent potential complications (e.g., recurrent ischemia, arrhythmia, heart failure, post-operative infections, wound healing problems, thrombotic syndrome).
- In patients after CABG surgery:
 - exercise training has to be adapted 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.

Dislipidemia **2**

Obesity **2**

Abbreviations (EXPERT tool)

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

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

VO2peak	peak oxygen uptake
VT	ventilatory threshold
IMT	Maximal inspiratory muscle training with PImax (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



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

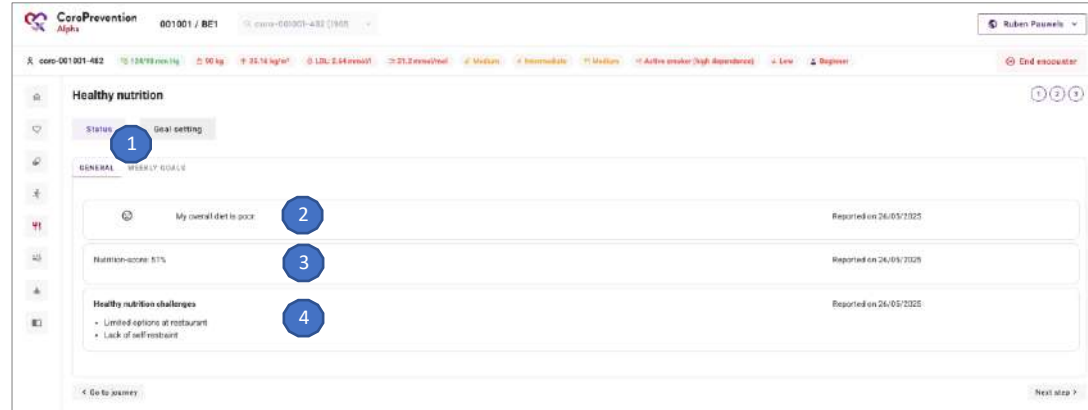
www.coroprevention.eu

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.



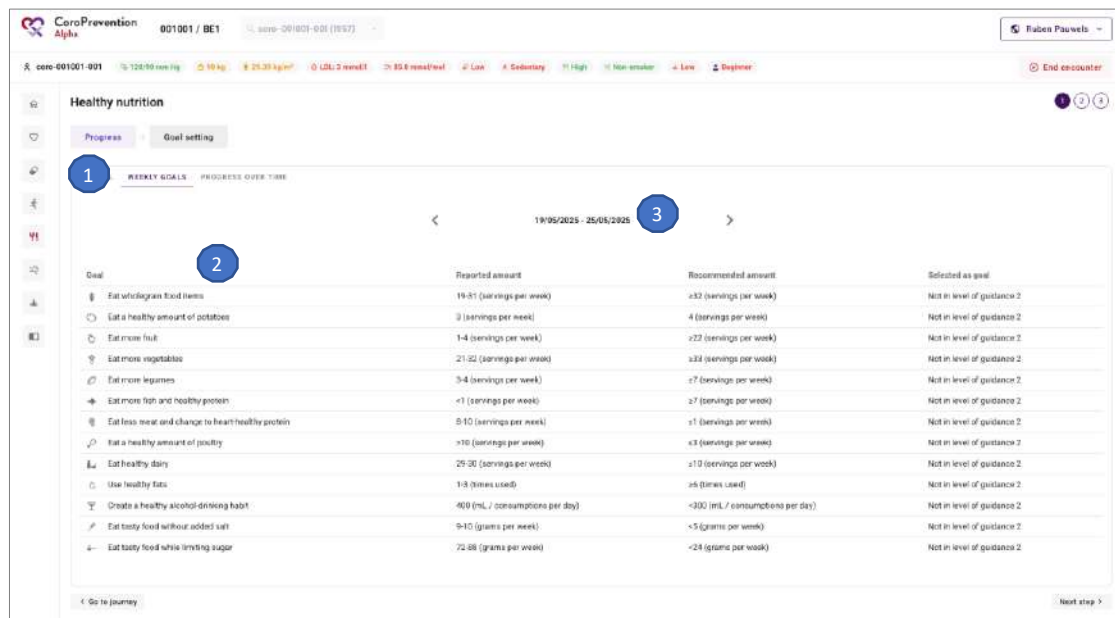
How to follow up on the patient's progress for healthy nutrition?

- 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:

- 2
- 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).

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.



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

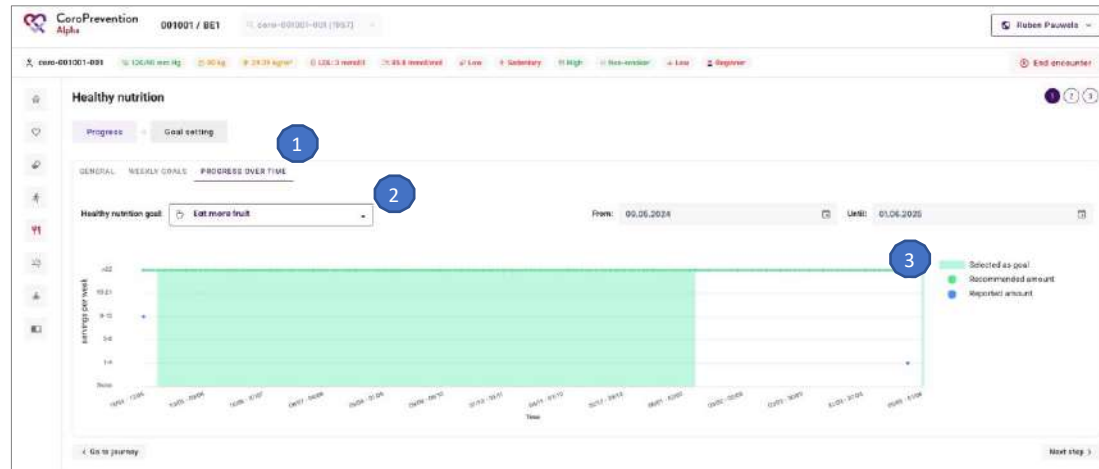
This visual timeline helps to monitor trends, spot recurring difficulties, and provide meaningful feedback or motivation based on progress.

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

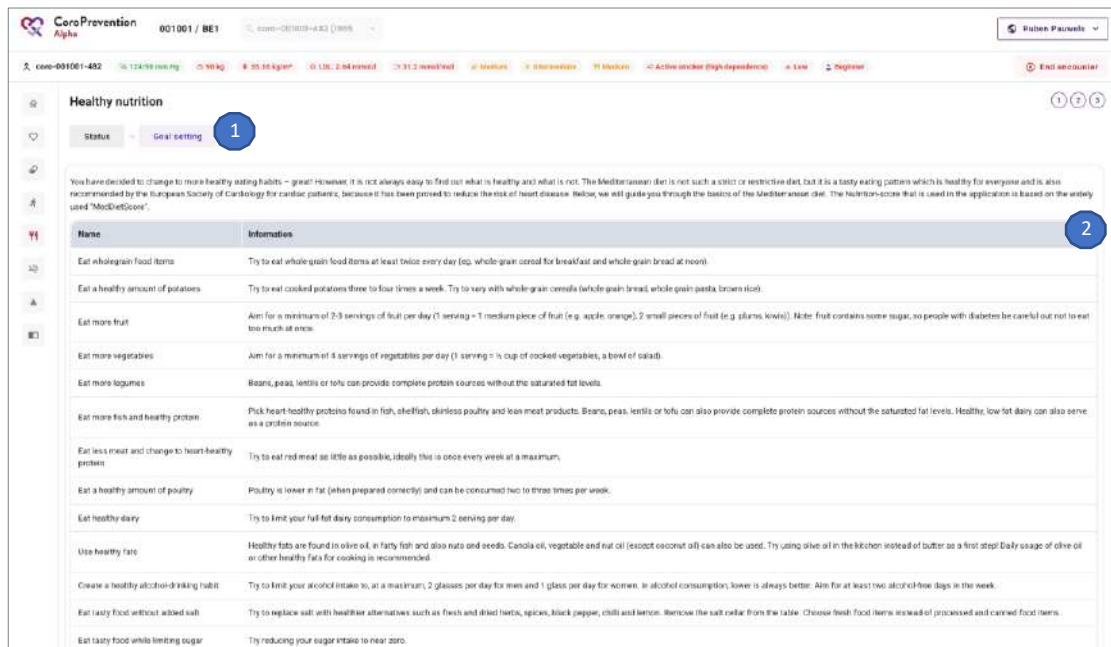
The graph displays:

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



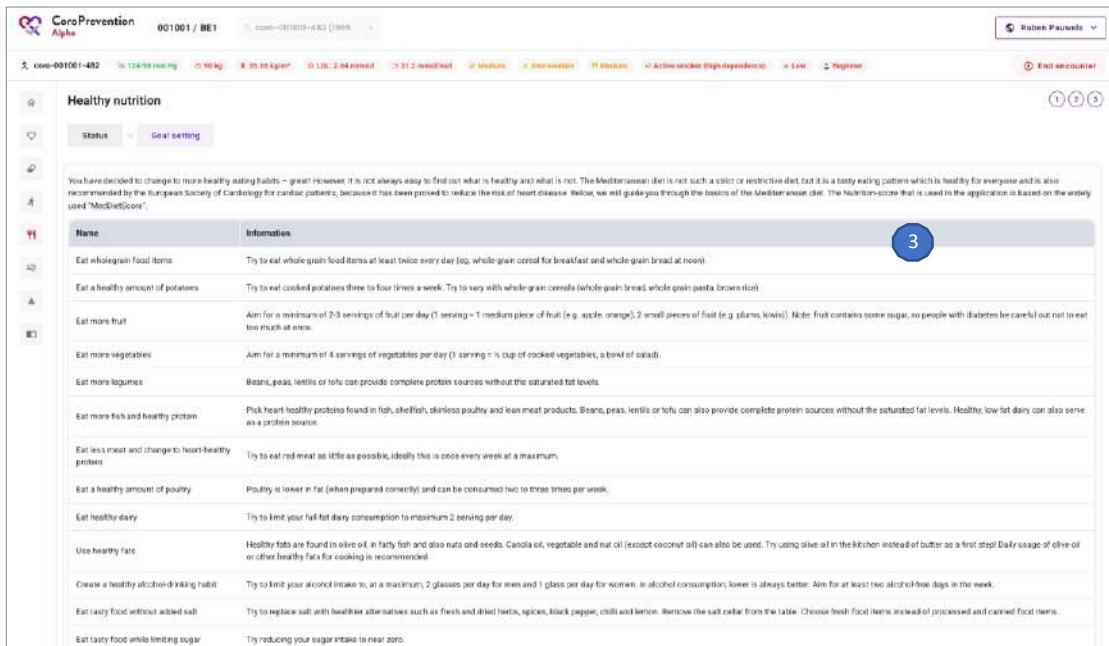
Which types of healthy nutrition goals can be set for the patient?

- 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.



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.



CoroPrevention Alpha 001001 / BE1

core-001001-452 124/98 mmHg 50 kg 80.55 kg/m² 130.2/84 mmHg 31.2 mmHg 100/100 11/10/2024 Active smoker (high dependence) 1 Low Register End assessment

Healthy nutrition

Status Goal setting

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

Name	Information
Eat wholegrain food items	Try to eat wholegrain food items at least twice every day (e.g. wholegrain cereal for breakfast and wholegrain bread at noon).
Eat a healthy amount of potatoes	Try to eat cooked potatoes three to four times a week. Try to vary with wholegrain cereals (wholegrain bread, wholegrain 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 = 1 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 servings 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, chili and lemon. Remove the salt shaker 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 coro-000001-0001 (1805) End encounter

coro-001001-0002 120/80 mmHg 90 kg 35.14 kg/m² LDL 2.44 mmol/L 31.2 mmol/mol Moderate Intermediate Mild Active smoker (high dependence) Low Regular

Smoke-free living

Status (1) Real setting

Smoking behaviour (2) Reported on 26/05/2023

Number of cigarettes: 20 cigarettes daily
Fagerstrom score: 7 Moderate dependence

Motivation to stop smoking (3) Reported on 26/05/2023

I REALLY want to stop smoking but I don't know when I will

Quit attempts before the study (4) Reported on 26/05/2023

Number of quit attempts: 1
Most recent quit attempt: 1 January 2023
Options used to quit smoking:

- Nicotine replacement therapy
- E-cigarettes

Most recent quit attempt during the study (5) 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 at the top includes vital signs: 124/88 mm Hg, 60 kg, 35.16 kg/m², LDL 2.64 mmol/L, and ST 3.2 mmol/mol. The patient is categorized as a 'Medium' risk, 'Intermediate' smoker, and 'Active smoker (high dependence)'. The dashboard shows a 'Smoke-free living' section with a 'Goal setting' tab highlighted by a blue circle with the number 1. The 'Goal setting' tab contains a list of steps for quitting smoking:

- 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 craving, 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 buttons at the bottom 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;

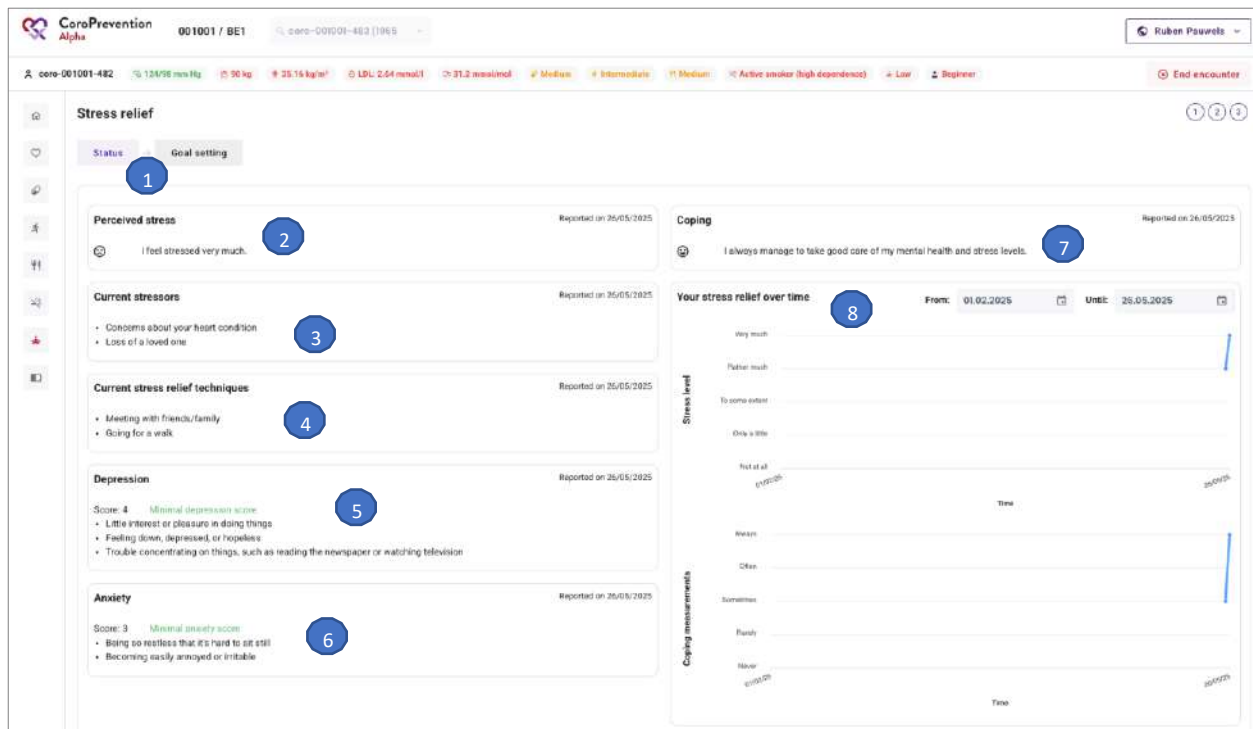
4 The patient’s current stress relief techniques;

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 displays the CoroPrevention Alpha patient dashboard. At the top, the patient's name '001001 / BE1' and ID 'coro-001001-482 (1965)' are shown. Below this, a row of vital signs and risk factors is visible: '124/98 mmHg', '90 kg', '25.16 kg/m²', 'LDL 2.64 mmol/L', '21.2 mmol/mol', 'Medium', 'Intermediate', 'Medium', 'Active smoker (high dependence)', 'Low', and 'Beginner'. The main section is titled 'Stress relief' and includes a 'Status' tab and a 'Goal setting' tab, with a blue circle containing the number '1' next to the 'Goal setting' tab. The 'Goal setting' tab contains a table with two columns: 'Stress relief goals' and 'Motivation'. The table lists five goals: 'Reduce stress' (Neutral), 'Improve mental wellbeing' (Motivated), 'Sleep better' (Very motivated), 'Sleep better' (Very motivated), and 'Feel less lonely' (Not at all). The 'Motivation' column uses colored buttons to represent the patient's motivation level: orange for 'Neutral', green for 'Motivated' and 'Very motivated', and red for 'Not at all'. The table is reported on 26/05/2025. At the bottom, there are buttons for 'Previous step' and 'Go to journey'.

Stress relief goals	Motivation
Reduce stress	Neutral
Improve mental wellbeing	Motivated
Sleep better	Very motivated
Sleep better	Very motivated
Feel less lonely	Not at all



CoroPrevention

PERSONALISED PREVENTION FOR
CORONARY HEART DISEASE