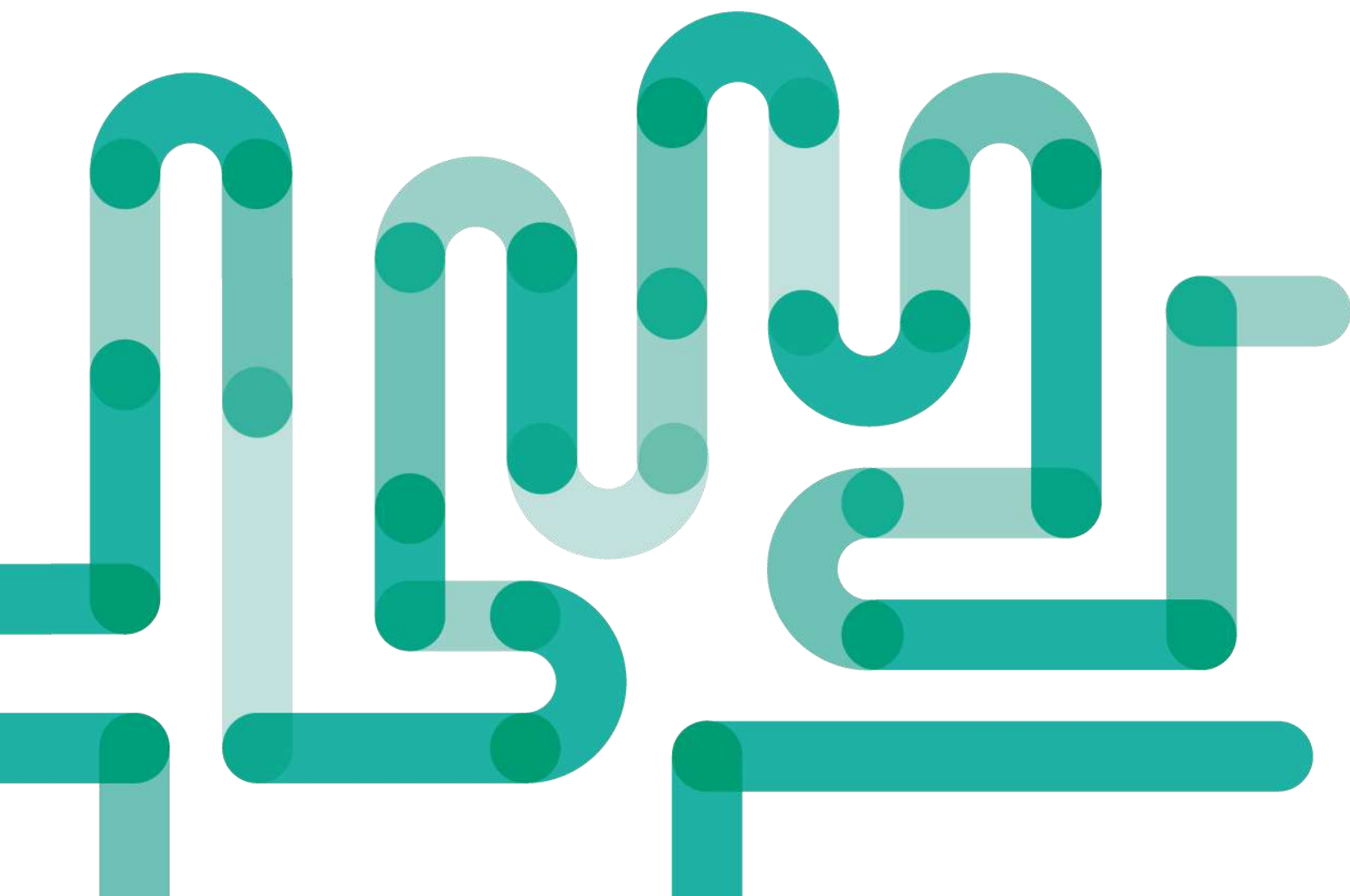


Linee guida sulla trasferibilità della banca dati sulle malattie immuno- mediate dei bambini

FEBBRAIO 2026

Smernice o prenosljivosti baze podatkov o imunsko posredovanih boleznih pri otrocih

FEBRUAR 2026



CONCERTO – Linee guida sulla trasferibilità della banca dati sulle malattie immuno-mediate dei bambini

Descrizione sintetica del documento

Il presente documento descrive gli elementi che rendono la piattaforma **CONCERTO** trasferibile e riutilizzabile in differenti contesti clinici, organizzativi e territoriali nell'ambito della gestione delle malattie immunomediate pediatriche. Più che un semplice sistema informatico, la soluzione rappresenta un ambiente configurabile che integra gestione dei pazienti, raccolta strutturata dei dati clinici, valutazioni standardizzate e configurazione di percorsi assistenziali e registri clinici in un'unica piattaforma.

Uno dei principali fattori di trasferibilità è rappresentato dalla configurabilità del sistema. La piattaforma consente infatti la progettazione e la personalizzazione di Care Plan, Registry, template e strumenti di valutazione senza richiedere modifiche al software di base. Tale approccio permette a differenti organizzazioni sanitarie di adattare la soluzione alle proprie esigenze cliniche e organizzative, favorendone l'adozione in nuovi contesti e per differenti patologie.

CONCERTO – Smernice o prenosljivosti baze podatkov o imunsko posredovanih boleznih pri otrocih

Povzetek dokumenta

*Ta dokument opisuje ključne značilnosti, ki omogočajo prenosljivost in ponovno uporabo platforme **CONCERTO** v različnih kliničnih, organizacijskih in geografskih okoljih na področju obravnave imunsko pogojenih bolezni pri otrocih. Rešitev predstavlja prilagodljivo digitalno okolje, ki združuje upravljanje pacientov, strukturirano zbiranje kliničnih podatkov, standardizirana ocenjevanja ter vzpostavljanje načrtov oskrbe in registrov v enotni platformi.*

Eden glavnih dejavnikov prenosljivosti je možnost konfiguriranja sistema. Platforma namreč omogoča načrtovanje in prilagajanje načrtov oskrbe, registrov, predlog in ocenjevalnih orodij brez spreminjanja osnovne programske opreme. Takšen pristop različnim zdravstvenim organizacijam omogoča, da rešitev prilagodijo svojim kliničnim in organizacijskim potrebam, kar spodbuja njeno uvedbo v novih okoljih in pri različnih boleznih.

Platforma podpira standardizacijo postopkov zbiranja in upravljanja kliničnih podatkov prek strukturiranih predlog, ocenjevanj in nastavljenih registrov. Ta značilnost prispeva k izboljšanju kakovosti, doslednosti in primerljivosti podatkov ter hkrati olajšuje sodelovanje med kliničnimi centri, raziskovalnimi dejavnostmi in večcentričnimi pobudami.

La piattaforma supporta la standardizzazione dei processi di raccolta e gestione dei dati clinici attraverso modelli strutturati, assessment e registri configurabili. Questa caratteristica contribuisce a migliorare la qualità, la coerenza e la confrontabilità dei dati, facilitando al contempo la collaborazione tra centri clinici, attività di ricerca e iniziative multicentriche.

Un ulteriore elemento di trasferibilità è costituito dalla separazione tra attività operative e attività amministrative. Gli utenti clinici possono gestire i pazienti e le valutazioni, mentre gli amministratori possono configurare utenti, gruppi, ruoli, autorizzazioni e percorsi assistenziali in modo indipendente. Tale approccio favorisce l'autonomia delle organizzazioni che adottano la soluzione e ne semplifica la gestione nel lungo periodo.

La piattaforma integra inoltre funzionalità avanzate per la gestione degli accessi, la sicurezza e la governance dei dati, comprese autenticazione a due fattori, gestione granulare dei permessi e controllo degli utenti autorizzati. Questi elementi favoriscono la conformità ai requisiti organizzativi e normativi richiesti in ambito sanitario e costituiscono un prerequisito fondamentale per il trasferimento della soluzione verso nuovi contesti operativi.

La possibilità di interagire con sistemi informativi esistenti e di supportare sia attività assistenziali sia finalità di ricerca rende il Better Portal una soluzione scalabile e sostenibile. Attraverso la combinazione di configurabilità, standardizzazione, sicurezza e riutilizzabilità dei modelli, la piattaforma offre un modello replicabile che può essere adottato da ulteriori organizzazioni sanitarie interessate alla gestione strutturata dei dati clinici e dei percorsi di cura.

Dodaten element prenosljivosti je ločitev med operativnimi in administrativnimi dejavnostmi. Klinični uporabniki lahko upravljajo paciente in ocenjevanja, administratorji pa lahko neodvisno nastavljajo uporabnike, skupine, vloge, dovoljenja in načrte oskrbe. Takšen pristop spodbuja samostojnost organizacij, ki uvedejo rešitev, in poenostavlja njeno dolgoročno upravljanje.

Platforma vključuje tudi napredne mehanizme za upravljanje dostopa, varnost in upravljanje podatkov, vključno z dvofaktorsko avtentikacijo, nadzorom uporabniških pravic ter upravljanjem dovoljenj na različnih ravneh. Te funkcionalnosti podpirajo skladnost z zahtevami zdravstvenih organizacij in predstavljajo pomemben pogoj za uspešen prenos rešitve v nova okolja.

Možnost povezovanja z obstoječimi informacijskimi sistemi ter podpora tako dejavnostim oskrbe kot raziskovalnim namenom omogočata, da je Better Portal razširljiva in dolgoročno vzdržna rešitev. S kombinacijo možnosti konfiguriranja, standardizacije, varnosti in ponovne uporabnosti modelov platforma ponuja ponovljiv model, ki ga lahko uvedejo tudi druge zdravstvene organizacije, zainteresirane za strukturirano upravljanje kliničnih podatkov in poti oskrbe.

Izkušnje, pridobljene v okviru projekta CONCERTO, kažejo, da je rešitev mogoče uvesti tudi v kliničnih okoljih, ki se razlikujejo od prvotno predvidenih. Pristop, ki temelji na konfiguriranju, standardizaciji podatkov in centraliziranem upravljanju dovoljenj, omogoča ponovitev organizacijskega in informacijskega modela v drugih zdravstvenih ustanovah, kliničnih mrežah in registrih bolezni. To prispeva k ovrednotenju rezultatov projekta tudi po njegovem časovnem zaključku ter predstavlja konkretno podlago za prihodnje pobude sodelovanja, raziskovanja in zdravstvene oskrbe na regionalni, nacionalni in čezmejni ravni.

L'esperienza maturata nell'ambito del progetto CONCERTO dimostra che la soluzione può essere adottata anche in contesti clinici differenti rispetto a quelli originariamente previsti. L'approccio basato su configurazione, standardizzazione dei dati e gestione centralizzata dei permessi consente infatti di replicare il modello organizzativo e informativo presso altre strutture sanitarie, reti cliniche e registri di patologia. Ciò contribuisce a valorizzare i risultati del progetto oltre la sua durata temporale e rappresenta una base concreta per future iniziative di cooperazione, ricerca e assistenza sanitaria a livello regionale, nazionale e transfrontaliero.

Il progetto CONCERTO è co-finanziato dall'Unione europea nell'ambito del Programma Interreg VI-A Italia-Slovenia. 4

Projekt CONCERTO sofinancira Evropska unija v okviru Programa Interreg VI-A Italija-Slovenija.

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Introduction

This document combines three user manuals describing Better Portal and two native functionalities available within it: Assessments and Care plan/Registry.

It provides an overview of how to access and navigate the Better Portal (User access and authentication, User Dashboard, and Patient Dashboard) and describes the key workflows supported by the included functionalities. These workflows include starting and viewing assessments, as well as designing, setting up, and managing care plans or registries and patient inclusion within them.

The document is structured to first explain the general Portal functionality and navigation, followed by detailed descriptions of the Assessments and Care plan/Registry features. Each section focuses on practical usage and user actions within the system.

References

Title	Author	Version	Date
User manual - Assessments	Miha Lenić	1.0	14.12.2020
User manual – Better Portal	Miha Lenić	1.0	15.12.2020
User manual – Care plan/Registry	Miha Lenić	1.0	14.12.2020

User Access and Authentication

Application login page URL is subject to your institution's configuration and needs to be provided by your institution's administrator. The default login screen of the Application can be seen in Figure 1.

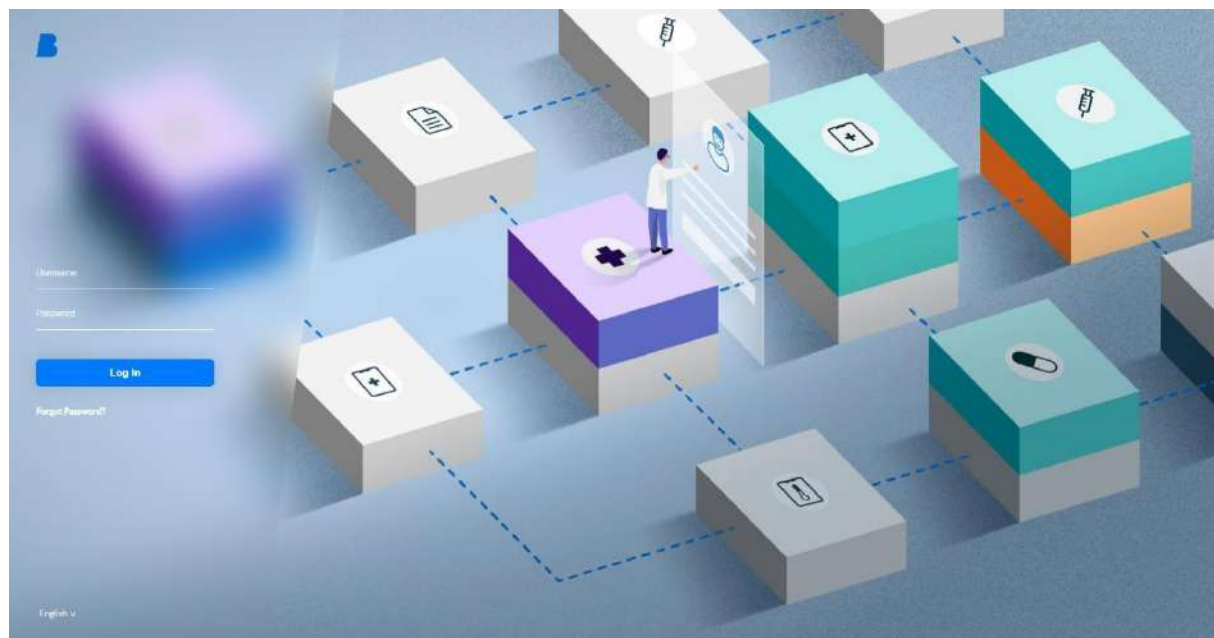


Figure 1. Application login page

Login

You may encounter two scenarios when login into the application:

You will access Better Portal with the username and password provided to you by your institution. You need to enter username and password and click on the “Log in” button.

For all issues related to login, including forgotten password, change password request or other issues related to successful login into the application please turn to your system administrator.

You will set up your account based on an email received after your system administrator has activated your account. Please refer to the subsequent chapters on how to Setup Password, manage forgotten password, log in into application with Two-Factor Authentication (2FA) login.

Password Setup

After the administrator creates an account, you will receive an email that contains a link for setting up your login password as seen in Figure 2.

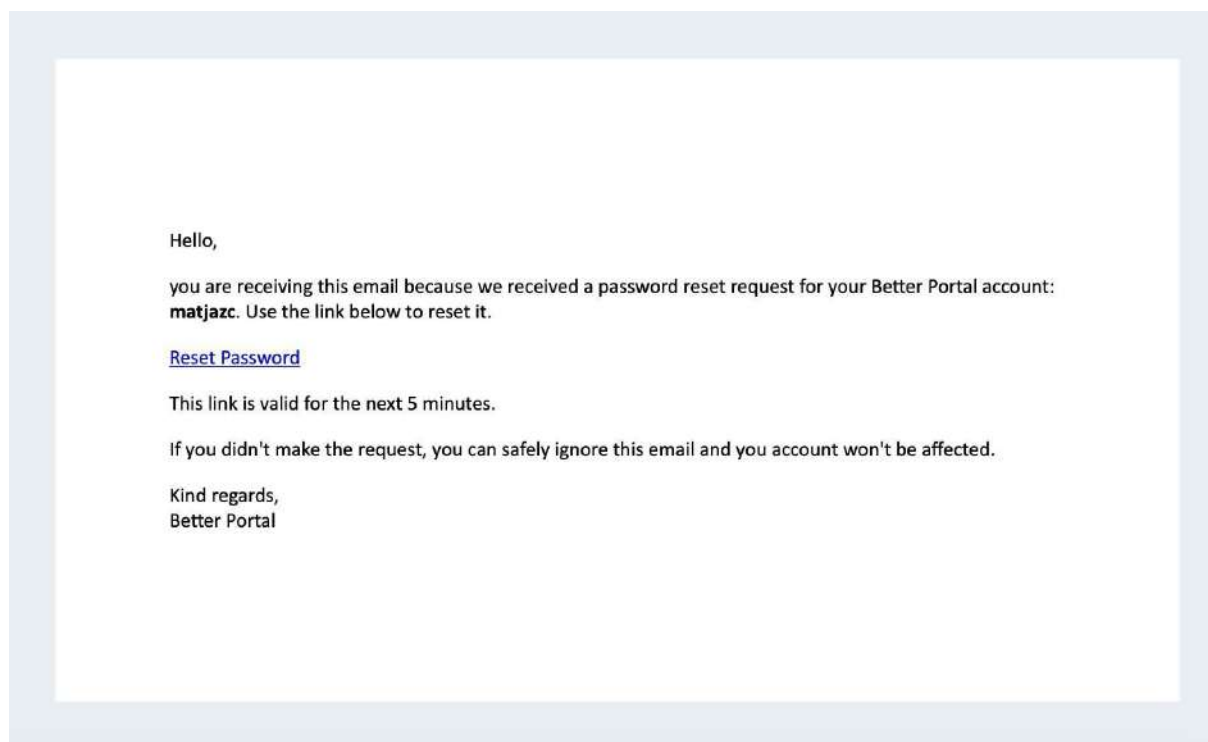


Figure 2. Email for password setup

By clicking on “Reset Password” you will get redirected to Better Portal password setup webpage as seen in Figure 3. Password policy restrictions are defined on the organisational level, usually set upon first application deployment. In such case, you must define a password that matches password policy of your organisation.



Reset password

password

Confirm password

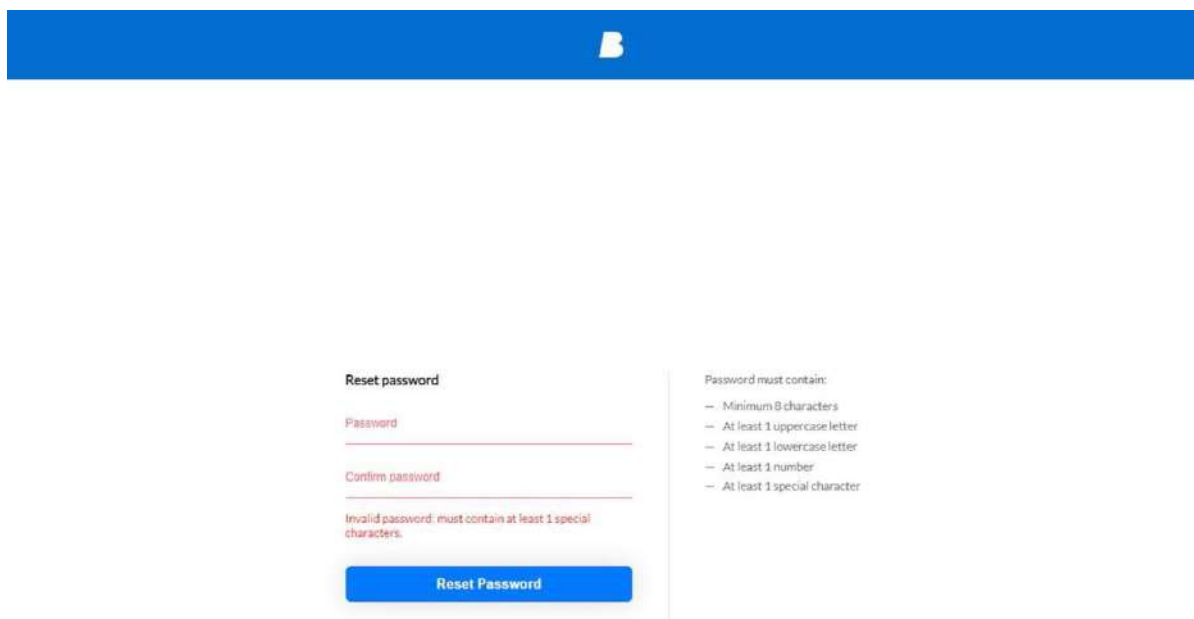
Reset Password

Password must contain:

- Minimum 8 characters
- At least 1 uppercase letter
- At least 1 lowercase letter
- At least 1 number
- At least 1 special character

Figure 3: Password reset

You need to set a password that matches all your organisation's requirements. If one or more requirements are not met, you will get a message to correct the chosen password with missing requirements as seen in Figure 4



The screenshot shows a password reset form with the following elements:

- Reset password** (Section Header)
- Password** (Input field)
- Confirm password** (Input field)
- Invalid password: must contain at least 1 special characters.** (Error message)
- Reset Password** (Button)
- Password must contain:** (List of requirements)
 - Minimum 8 characters
 - At least 1 uppercase letter
 - At least 1 lowercase letter
 - At least 1 number
 - At least 1 special character

Figure 4. Password reset - password non-compliant to organisational policy

To avoid typing mistakes, you need to insert the desired password twice, namely in both "Password" and "Confirm password" input fields, respectively. The password setup action is finalised by clicking on "Reset Password" button.

After clicking on "Reset Password" button, you will get a notification that your password has been successfully set up. You are redirected to Better Portal login page.

Forgotten Password

In case you have forgotten your password, select “Forgot Password” and follow the instructions you will receive in an email.

Basic Login

Steps to login:

1. Open URL of Portal Application
2. On the login screen (Error! Reference source not found.) insert your username and password you have received by email from your administrator
3. Select “Log In” to enter the Portal

Two-Factor Authentication Login

To improve online security, Better Portal supports login with 2-factor authentication (2FA). Simply put, 2FA adds a second step in the usual log-in process. It is your organization that defines whether 2FA is required at each login.

The 2FA method supported in the Better Portal is the OTP (one-time password) generated by an authenticator application. To set up the OTP, you will need to install an authenticator application on your mobile device. FreeOTP or Google Authenticator application can be used, and you can find them in application stores on your mobile device.

At first login, you set up an account in the authenticator application by scanning the QR code displayed on the Better Portal screen.

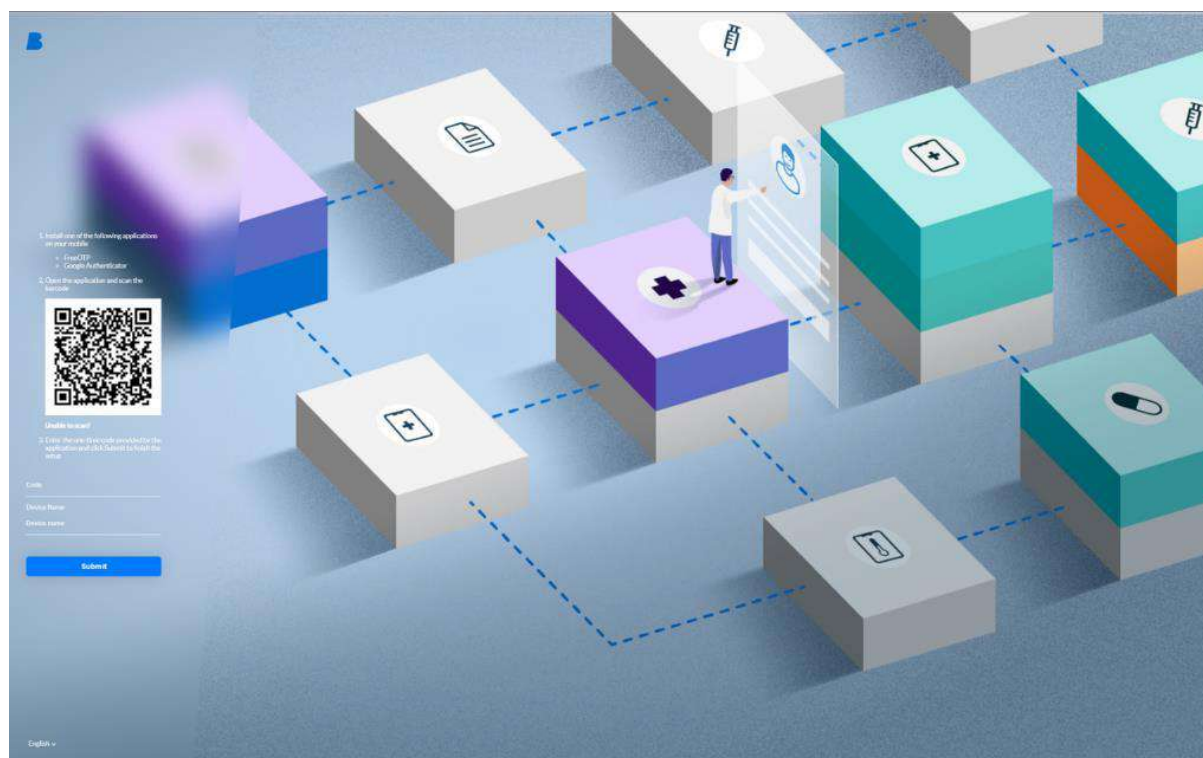


Figure 5. Two-factor authentication set up

After account is successfully added in the authenticator application, you will need to use that application at each login. After you enter the username and password, you will always be prompted to enter also the one-time code.

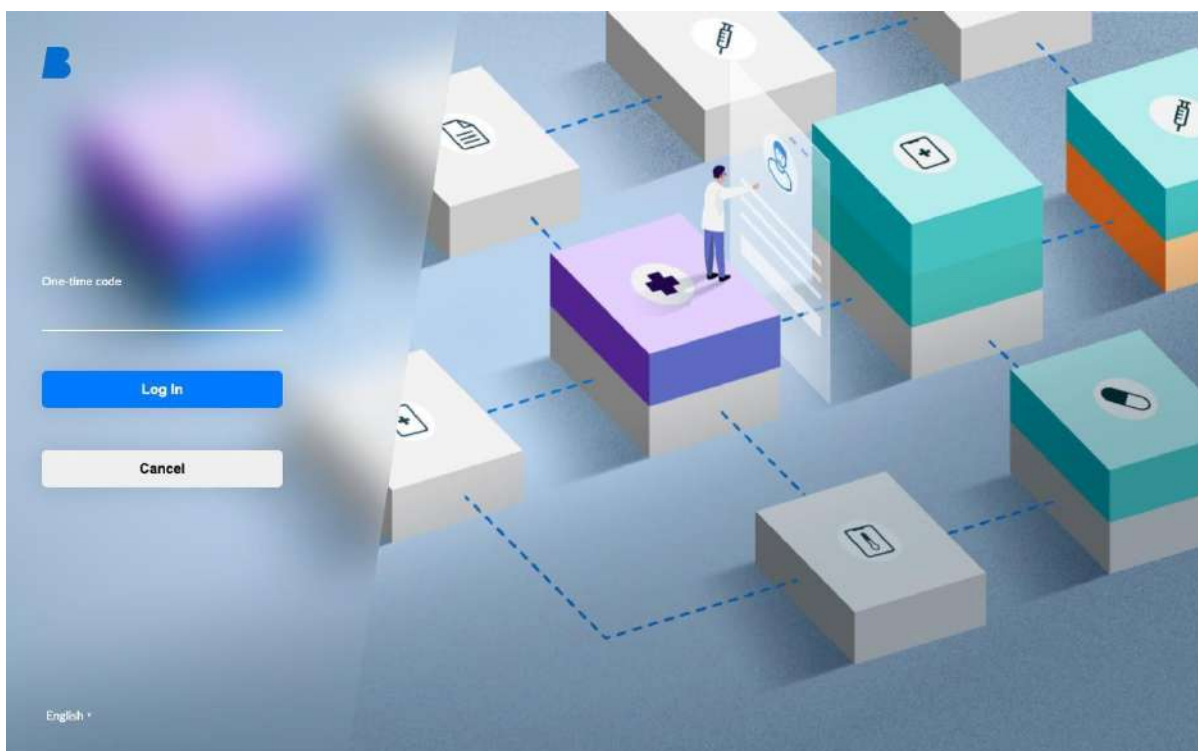


Figure 6. Enter your one-time code generated by authenticator app

That code can be found only in the authenticator application and is refreshed every few seconds. In this way, even if someone obtains your username and password, they still cannot hack into the Better Portal, since they would also need the one-time code, that is only found in your authenticator application.

Logout

Steps to log out from the Portal:

1. Go to your User Profile
2. Select "Logout" from your User Profile (bottom of the dashboard)

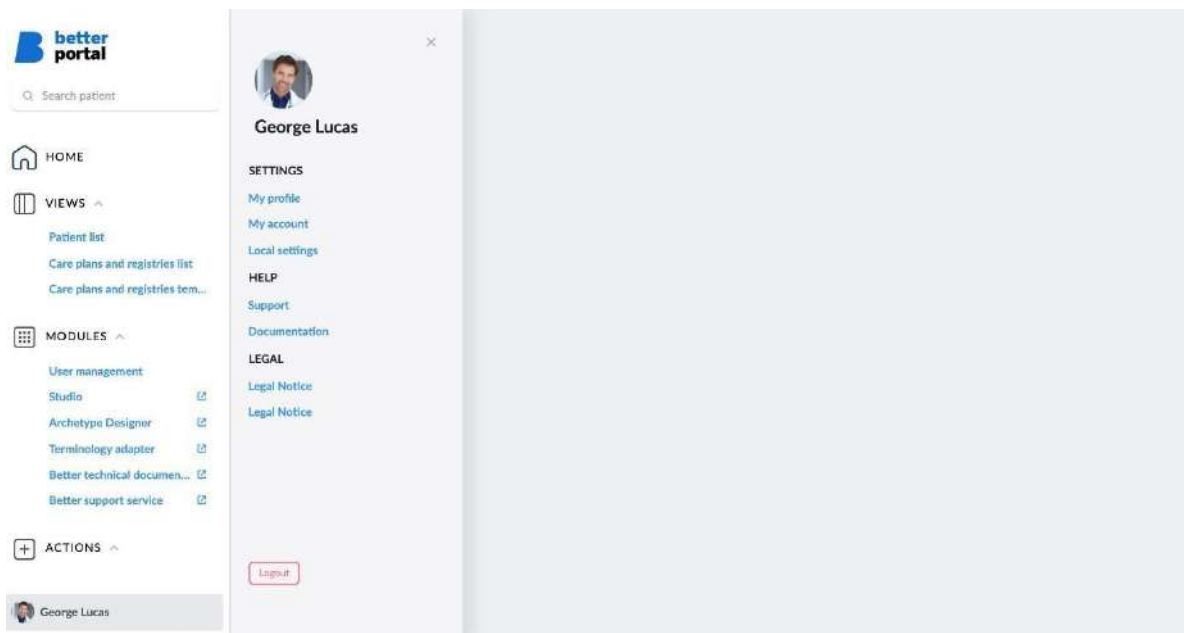


Figure 7. Select Logout from your User Profile dashboard to logout

User Dashboard

User Dashboard is your landing page – home screen – where you login and from where you can initiate all your actions and perform all the work.

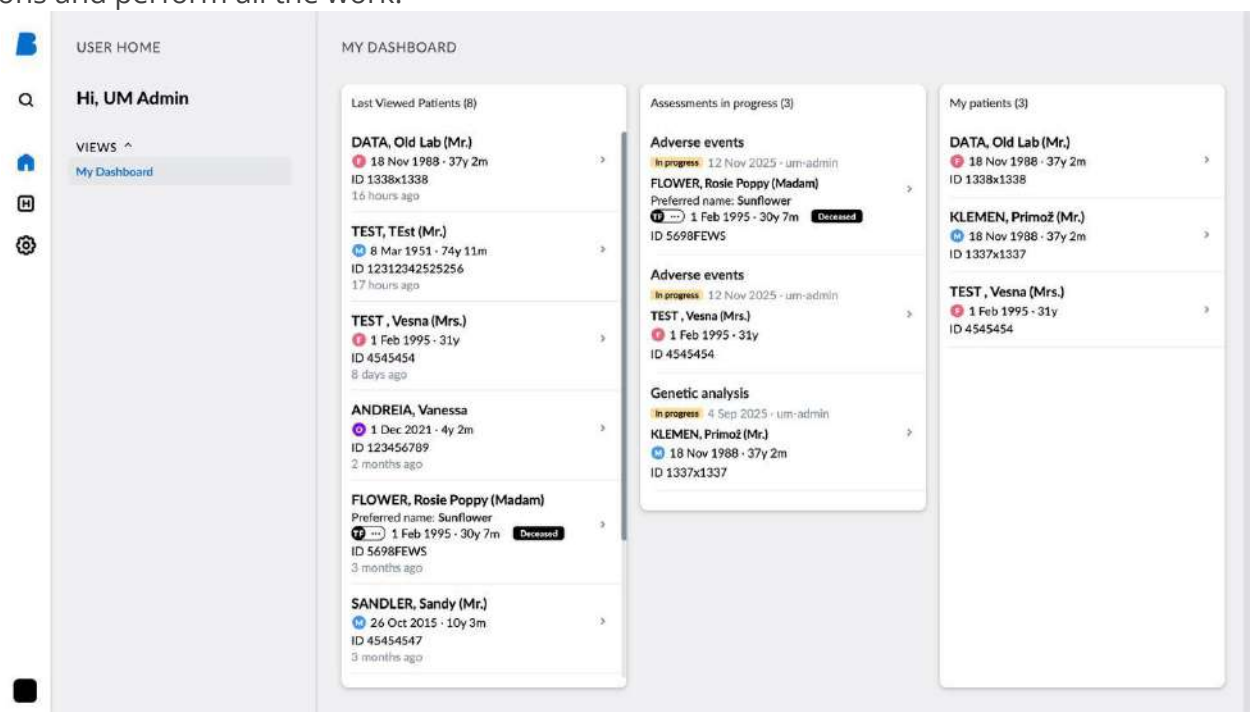


Figure 8. User Dashboard

Your dashboard is a selection of items available and dependent on your user role as well as permissions you have been assigned. These are managed by your IT administrator, who is responsible for Portal user management.

Under My Dashboard, there are structured dashboard cards that provide quick access to patient-related activity and personal workload overview.

The Last Viewed Patients card displays a chronological list of recently accessed patient records, including key demographic information (name, gender indicator, date of birth, age, and identifier) and the time of last access, enabling you to quickly return to patients you have recently worked on.

The Assessments in progress card lists assessment documents that have been started but not yet submitted, clearly marked with their status and date, allowing you to resume incomplete documentation directly from the dashboard.

The My patients card shows patients that you have individually marked as “My patient,” supporting focused monitoring and prioritization of specific individuals. Each item within these cards is interactive and opens the corresponding patient dashboard.

On the left, there is main navigation panel, structured into the following sections

1. Patient Search
2. My Home
3. Workplace
4. Admin
5. User Profile

Patient Search

Patient Search feature enables you to search and access desired patient record directly from your User Dashboard.

Steps to search a particular patient

1. Start searching for a patient by typing in:
 - a. First name or/and Last name or the combination of both.
 - b. Any ID of the patient (IDs defined for patients depend on your organization)
2. Once you have identified the patient choose the patient from the results.
3. Patient Dashboard opens to the right of the User Dashboard.

The search is performed among all patients in the database. Therefore, in the acute setting, you can access also patients that are currently not hospitalised.

The screenshot displays the 'USER HOME' and 'MY DASHBOARD' sections. On the left, a sidebar contains navigation icons. The main area features a search bar at the top with the text 'vesna' entered. Below the search bar, a list of patients is shown, including 'TEST, Vesna (Mrs.)' with ID 4545454. The dashboard also includes sections for 'Last Viewed Patients (8)', 'Assessments in progress (3)', and 'My patients (3)'. Each section lists patient details such as name, date of birth, age, and ID, along with status indicators like 'In progress' or 'Deceased'.

Figure 9. Search is available at the top of your User Dashboard

Note! In order to activate the search functionality, you need to type in at least three characters, otherwise you are presented with the pop-up notification as presented in Figure 10.

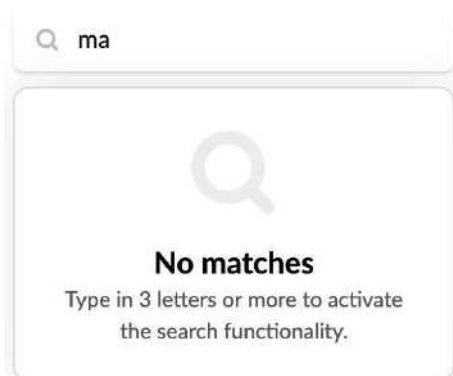


Figure 10. Patient Search is not activated yet

Upon inputting 3 characters, the list of available patients is presented as shown in Figure 11. The matching characters for each patient are shown in bold text. To ensure that you choose the right patient, all patients in the results are shown along with their unique identifier (one being set as primary identifier in your organisation).

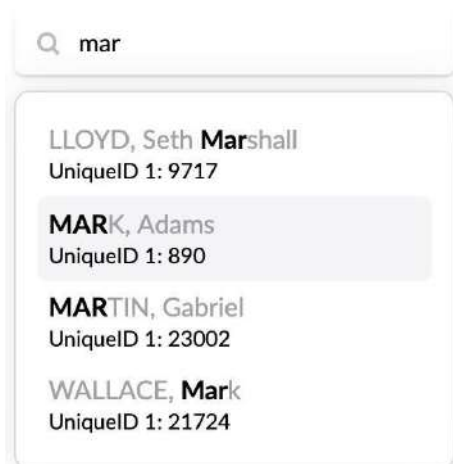


Figure 11. Patient Search results

The search can result in more patients that can be presented in the dropdown menu. In that case, you will be presented with a notification on how much patients are shown out of total number of results as seen in Figure 12.

Q per

Displaying 20 of 29 results
Enter more characters to get better results.

PERRY, Platypus
UniquelD 1: 19110811

PERRY, Platypus
UniquelD 1: 19110812

PERRY, Platypus
UniquelD 1: 19110813

PERRY, Platypus
UniquelD 1: 19110814

PERRY, Platypus
UniquelD 1: 19110815

Figure 12. Search results in 29 patients

Searching by unique identifier can be seen on Figure 13.

Q 2610002

COOPER, Ted
PID: 2610002

Figure 13. Searching by unique identifier

In an event that inputted characters do not correspond to any patient record, you will be alerted that no matches were found as seen in Figure 14.

Q 095

No match
No matches found.

Figure 14. No matches were found

My Home

The My Home button returns you to the main entry area of the Better Portal. Selecting My Home reloads the My Dashboard page, which serves as the default starting point after login. The My Dashboard page provides a user-centric overview of recent and ongoing work (last viewed patients, assessments in progress, my patients). The expected outcome is that you are brought back to the primary landing page for quick access to commonly used dashboard information.

Workplace

The Workplace button opens your active workplace context and displays the workplace name at the top of the panel. Within Workplace, you can access Views, including Patient List, and Actions, including New patient (availability depends on organisational configuration and permissions). The expected outcome is access to workplace-specific views and actions required for daily operational workflows. Patient List is described on the page 22.

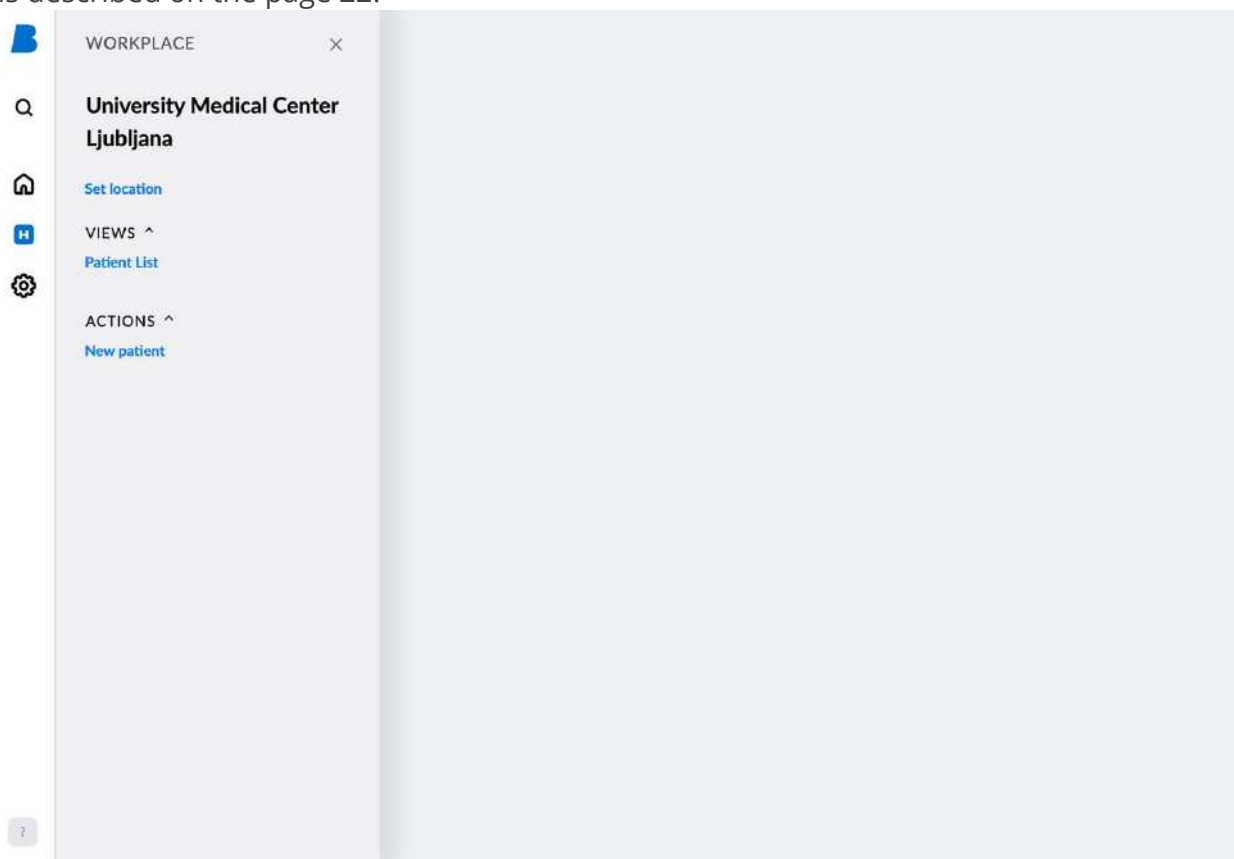


Figure 15. Workplace

New Patient

The New patient button opens a Personal info questionnaire, used for registering a new patient. Depending on your organisation's configuration, patients' demographic data can:

- Come from an external system – usually from Patient Administration System (PAS).
- Can be added manually to the Better Portal via New Patient action.

Note! In case patients are added to the Portal from an external system via integration, you cannot change their demographic and encounter data.

Steps to create a new patient in the system:

- Select “New patient” from your Workplace under Actions section.
- New patient form opens to the right
- Enter patient mandatory data (*) and select “Submit”

1.

Figure 16. Adding new patient

Beside mandatory data, Marital status and Education level, you can add additional personal information via “Add field” button (Patient photo, Middle name, Preferred name, Preferred gender, Religion, Ethnic origin, Spoken languages and Date of death & cause). Other information that could be added is address, phone and email and related contact.

All patient information is accessible in Patient Banner.

Admin

The Admin button provides access to administrative modules intended for configuration and governance tasks. In Admin, users with appropriate permissions can access modules such as User management and additional administrative modules available in the organisation (for example, care plan design and setup). These modules support tasks such as managing users, configuring organisational setup, and maintaining administrative structures required for portal operation. The expected outcome is that authorised users can perform administrative configuration and user management activities in a dedicated administrative area.

The Admin button provides access to administrative modules intended for configuration, governance, and system-level management. The Admin area is designed for users with appropriate permissions and supports organisational setup, access control, and maintenance of administrative structures required for portal operation.

Upon selecting Admin, the user is presented with an administrative landing page displaying available modules: User management and Care plan design & setup.

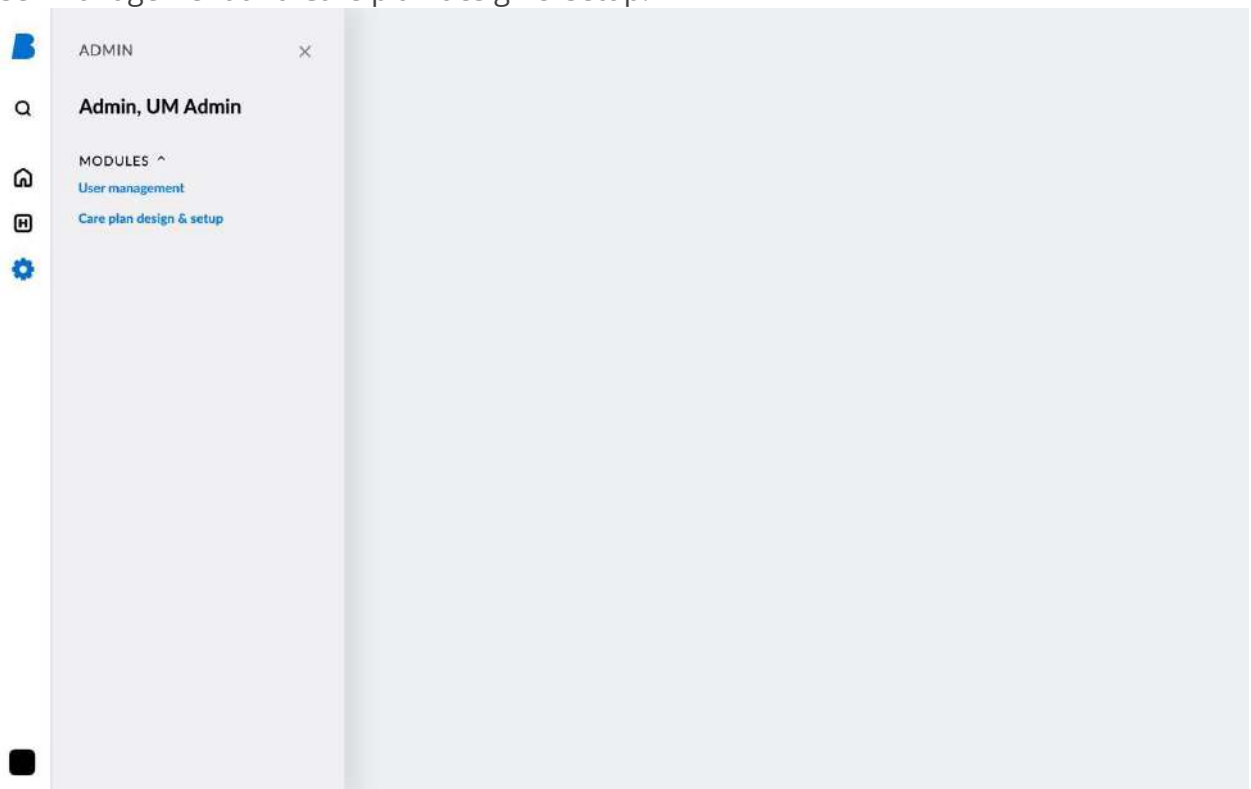


Figure 17. Admin

User management

The User management module enables administrators to manage system users, groups, and their memberships. The module contains a search field at the top of the left panel, allowing administrators to quickly locate users or groups.

Within User management, the following Views are available: Users, Groups, Group memberships, Soon to expire group memberships

In addition, the following Actions are available: New group, New user

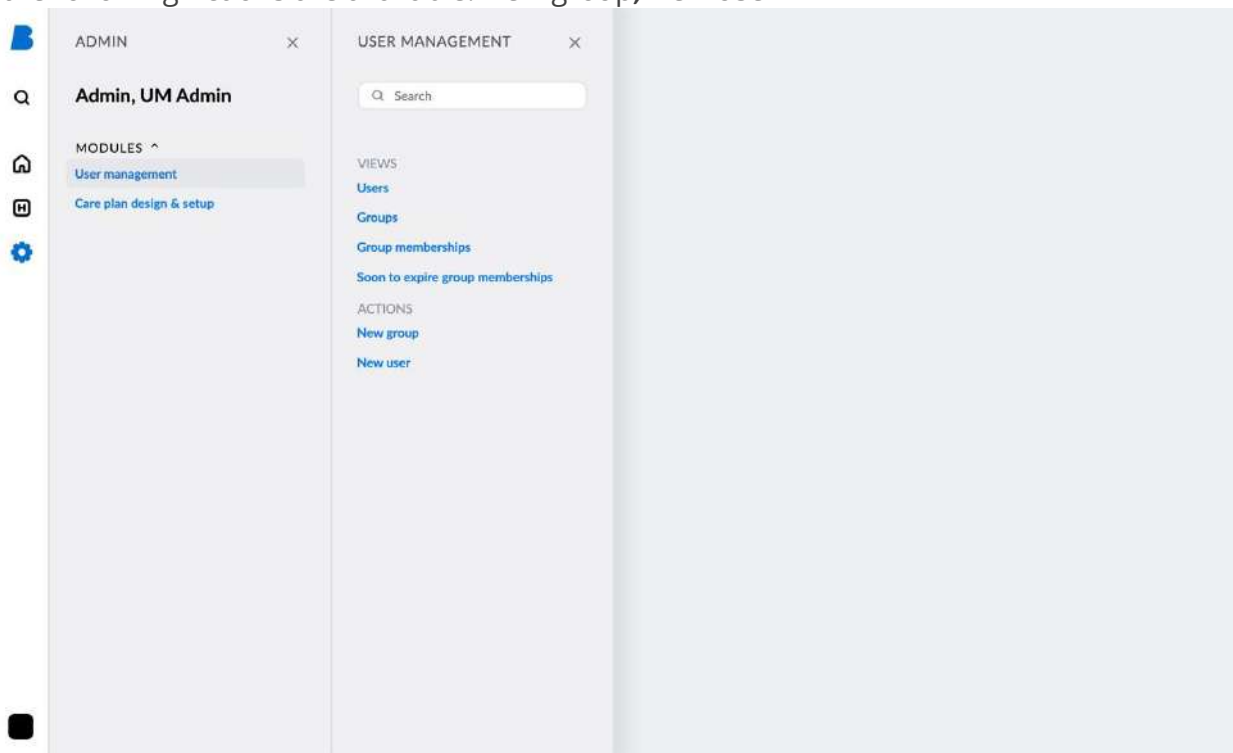


Figure 17. User management

Users

The Users view displays a structured list of system users in a tabular format. The table includes columns such as User, E-mail, Username, and Status. Users can be sorted by column headers where applicable. Each user record displays their current status (for example, Active).

A search field is available at the top of the Users panel, along with a Filter option to further refine search results. Selecting a user from the list allows the administrator to access and modify user details.

When creating a new user via the New user action, a dedicated form panel opens. The form includes fields such as Status (e.g., Active), First name, Last name, Username, and E-mail. After entering the required information, the administrator confirms the creation by selecting Save.

Groups

The Groups view displays all defined user groups within the system. Each group is listed by name, and administrative controls such as Edit and additional options (via dropdown menu) are available per group. This enables administrators to modify group settings or manage associated permissions.

Groups serve as containers for permissions and are used to assign access rights to multiple users simultaneously.

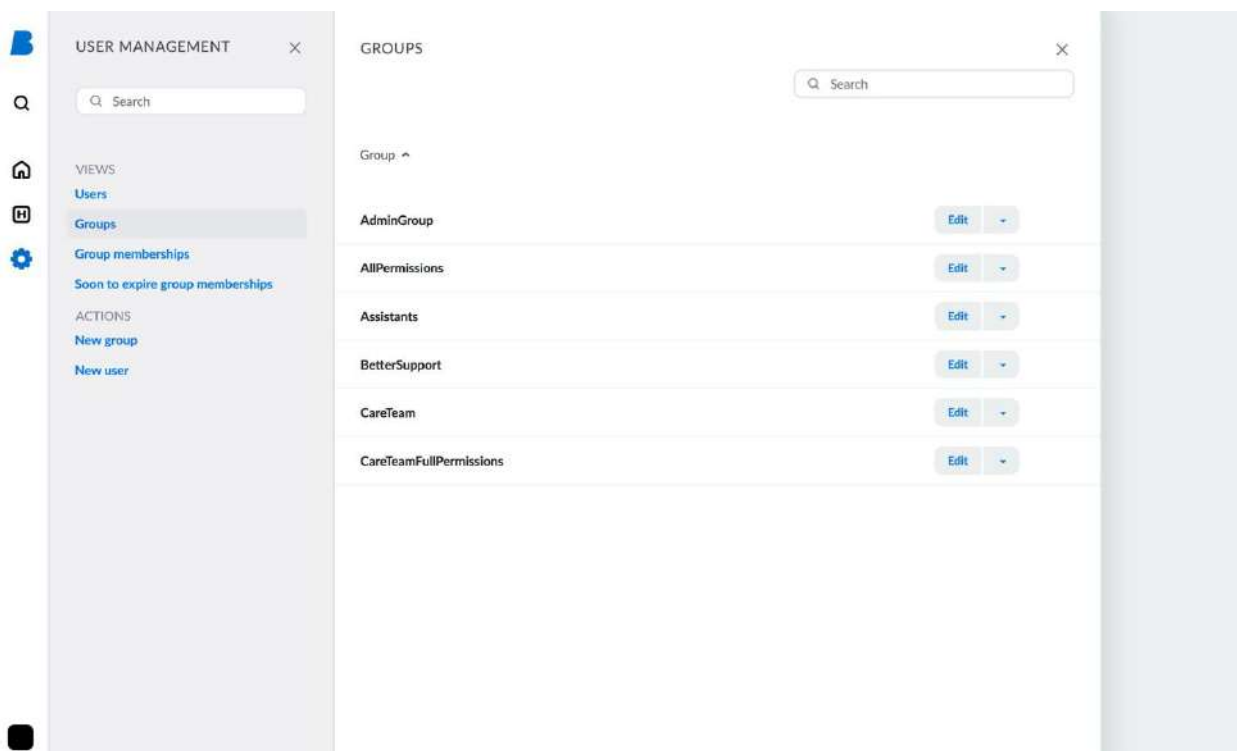


Figure 18. Groups

Group membership

The Group memberships view provides an overview of users assigned to specific groups. The interface displays the number of members and the number of groups. Each group entry can be expanded to show additional information, including a unique group code.

Administrators can manage memberships directly from this view. The Add group button allows assigning additional group memberships. Edit controls are available for maintaining group associations.

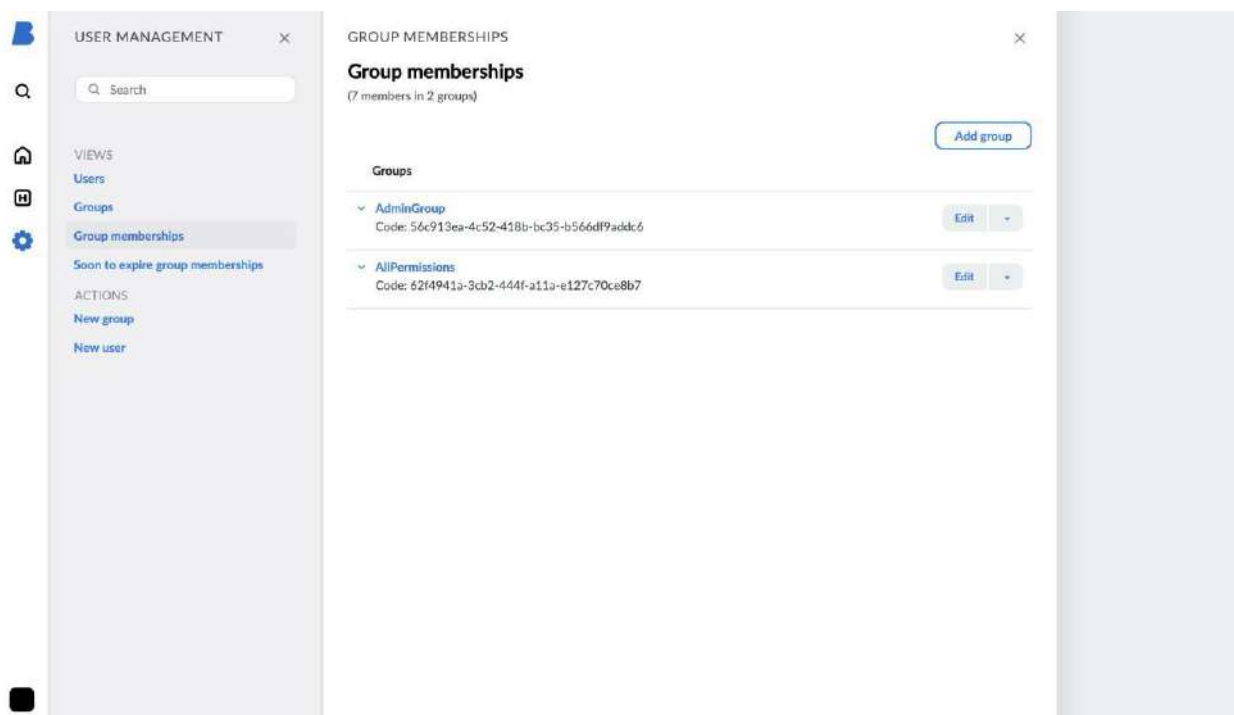


Figure 19. Group membership

Soon to expire group memberships

The Soon to expire group memberships view enables administrators to monitor memberships that are approaching their expiration date. The table layout includes columns such as User, Group, Effectivities, and Location (where applicable). This functionality supports proactive management of temporary access rights and ensures proper governance of user permissions.

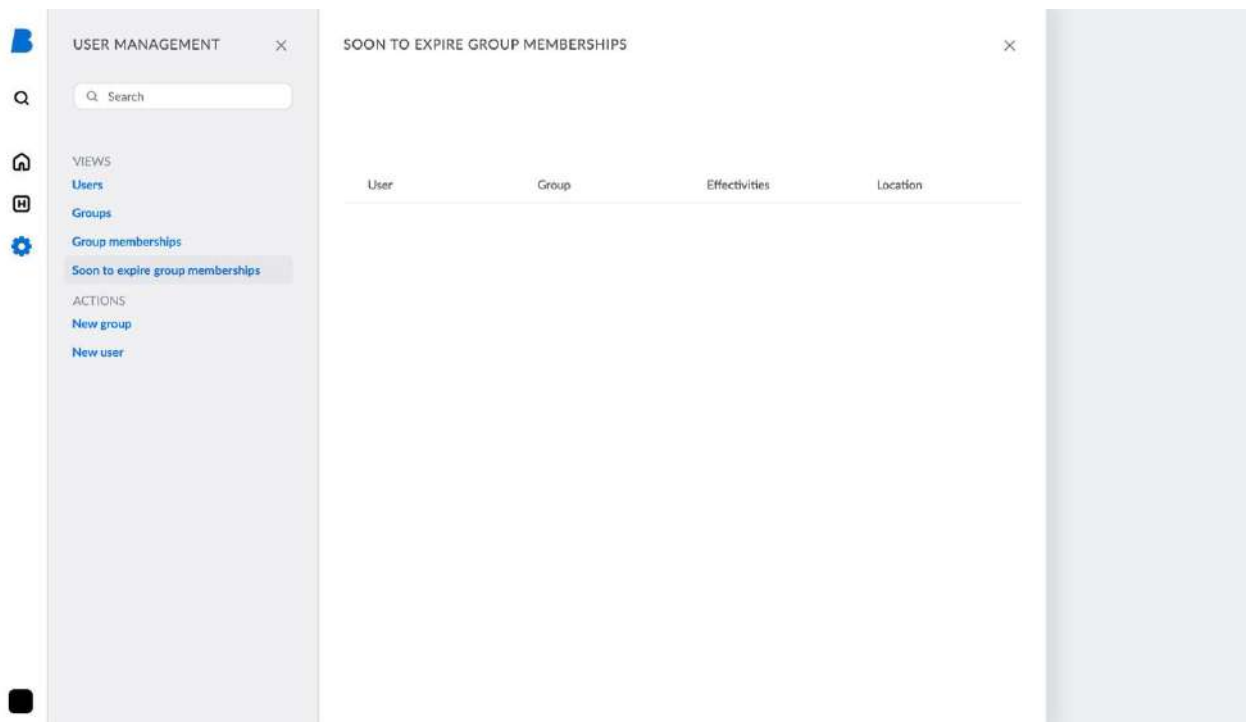


Figure 20. Soon to expire group memberships

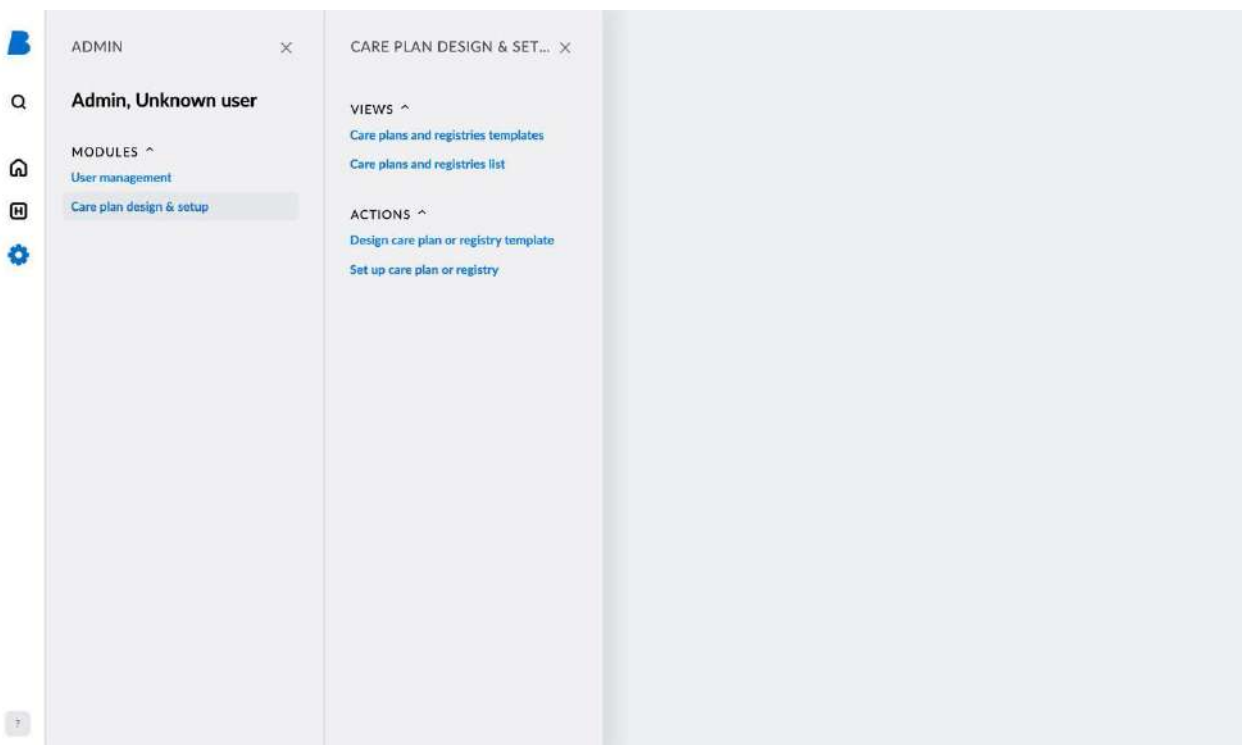


Figure 21. Care plan design & setup

New group

By selecting New group under the Actions section within *User management*, the system opens the New group configuration panel. This functionality enables administrators to create a new permission group that can later be assigned to users.

The administrator must first enter the Group name in the designated input field. The group name should clearly reflect the intended role or permission scope (for example, department-based or function-based access).

On the right-hand side, the panel displays All available permissions, organised by modules (e.g. Portal, Careplan, EHR, External, Better, Form, Health, Terminology, Admin). Each module contains specific permissions (such as *query*, *administrator*, *builder*, *data explorer*, *translator*, etc.). Permissions can be selected individually and added to the group configuration.

If a similar group already exists, the administrator may use the “Add from existing group?” option to copy permissions from another group, which simplifies configuration and ensures consistency across similar roles.

Once all required permissions are selected, clicking Submit creates the group. Selecting Close cancels the action without saving changes.

The newly created group becomes available in the Groups view and can subsequently be assigned to users through the Group memberships functionality.

Figure 22. New group

New user

By selecting New user under the Actions section within *User management*, the system opens the New user creation panel.

The administrator must define the user's Status, which determines whether the account is active. By default, the status is typically set to Active, but it can be adjusted if needed.

The following mandatory information must be entered: First name, Last name, Username, E-mail address.

The Username field includes an informational tooltip that provides guidance on username requirements. The username must be unique within the system.

After entering all required information, clicking Save creates the new user account. The user will then appear in the Users view, where additional configuration can be performed, such as assigning the user to one or more groups via Group memberships.

User access rights are determined by the permission groups assigned to them. Therefore, after creating a new user, the administrator should ensure that appropriate group memberships are configured.

The screenshot shows a web application interface with three main panels. The left panel is the 'ADMIN' sidebar, showing 'Admin, UM Admin' and a list of modules: 'User management' (selected), 'Care plan design & setup', and a settings gear icon. The middle panel is 'USER MANAGEMENT', featuring a search bar and a list of views: 'Users', 'Groups', 'Group memberships', and 'Soon to expire group memberships'. Under the 'ACTIONS' section, 'New group' and 'New user' (selected) are listed. The right panel is the 'NEW USER' form, which includes a 'Status' dropdown menu set to 'Active', and input fields for 'First name', 'Last name', 'Username' (with an information icon), and 'E-mail'. A blue 'Save' button is located at the bottom right of the form.

Figure 23. New user

Care plan design & setup

The Care plan design & setup module is accessible from the Admin section under Modules. This module enables authorised users to design care plan templates and configure care plans or registries at institutional level.

A detailed description of the Care plan design and setup functionality is provided in the Care plan design & setup section of this manual, starting from page 48 onward.

User Profile

User Profile is available at the bottom of User Dashboard. You can see your first and last name along with your photo or your name initials.

By clicking on your name, you access the User Profile that appears in a new panel on the right of User Dashboard.

Based on your institution settings, you have access to:

- Simplified user profile (only giving you the possibility to log out via the user profile)
- Extended user profile giving you access to Settings, Help and Legal section.

My Profile

By clicking on the “My profile”, you can manage your profile photo, your first and last name, and titles.

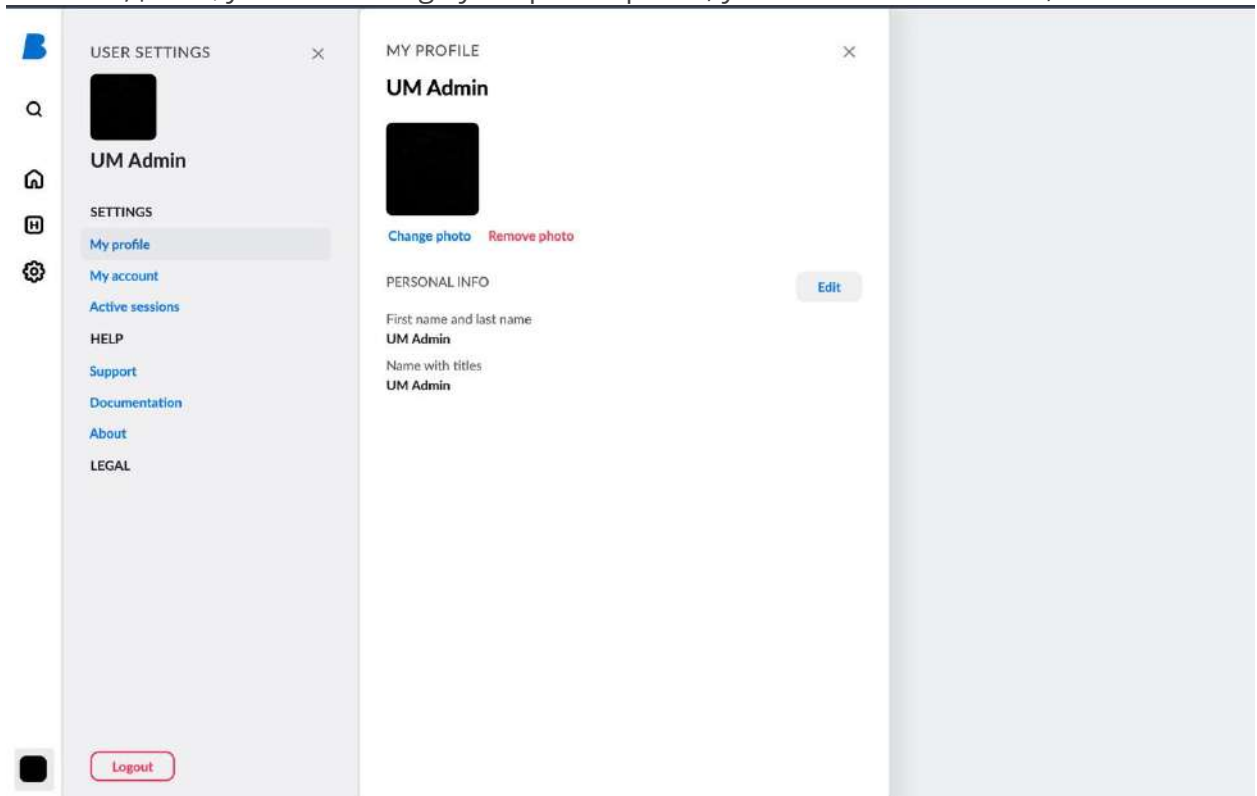


Figure 24. My profile

By clicking on “Change photo” you can add, edit or change the photo. At any time, you can simply remove it by clicking on the “Remove photo” button.

By clicking on the “Edit” button you can change your name or manage your titles. Figure 22 shows how to change prefix and suffix.

The screenshot shows a web application interface with a sidebar on the left and a main content area. The sidebar contains a search icon, a home icon, a 'My profile' link (highlighted), and other settings links. The main content area displays the 'MY PROFILE' modal window for 'UM Admin'. It includes a profile picture placeholder with 'Change photo' and 'Remove photo' buttons. Below is the 'PERSONAL INFO' section with 'First name and last name' (UM Admin) and 'Prefix and suffix' (Dr. PhD) fields, along with 'Cancel' and 'Save' buttons.

Figure 25. Changing titles

My Account

Within My account you can see your username and you have the option to change your account password by clicking on “Change password”.

In order to change your password, you must enter your Current password and your New password twice to avoid typing mistake. You confirm the new password by clicking on “Save”.

Please turn to your system administrator if you have forgotten your current password.

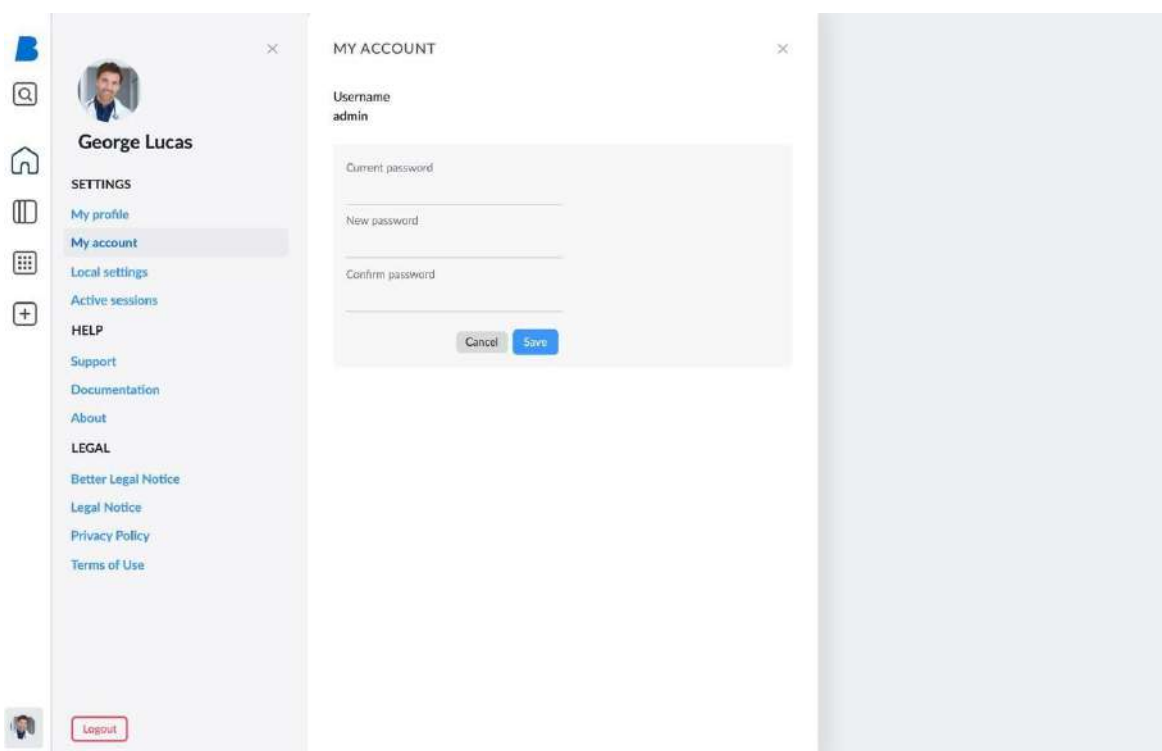


Figure 26 Change your password

Active Sessions

Under Actives Sessions, you have access to all the active session being run under your account. You can end an active session on the device that you are currently using or end a session on any other device in which you are logged in.

Q

USER SETTINGS

UM Admin

SETTINGS

[My profile](#)
[My account](#)
[Active sessions](#)

HELP

[Support](#)
[Documentation](#)
[About](#)

LEGAL

Logout

ACTIVE SESSIONS

IP Address	Started	Last Access	
10.208.2.168	12 Feb 2026 · 10:49	12 Feb 2026 · 11:31	<div>End All Sessions</div> End Session
46.122.102.166	12 Feb 2026 · 10:49	12 Feb 2026 · 11:27	Current Session

Figure 27. Managing your active sessions

Support

Under Support you can access contact information to get help from your support desk.

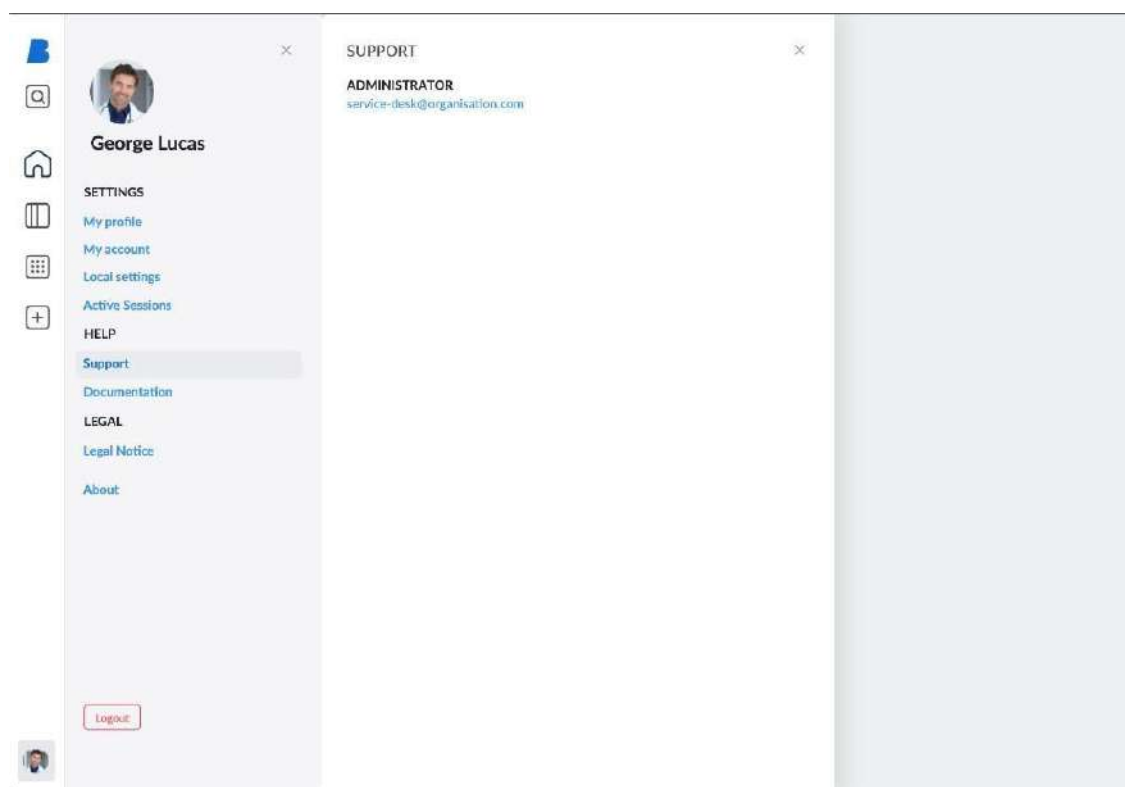


Figure 28. Contact your support desk when troubleshooting

Documentation

Under Documentation you can download and read user manuals and video trainings to learn how to use the Application.

George Lucas

SETTINGS

[My profile](#)

[My account](#)

[Local settings](#)

[Active Sessions](#)

HELP

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LEGAL

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DOCUMENTATION

Title ▾	Type	Size
Assessments - Access	MP4	12.65 MB
Assessments - Form results	MP4	46.89 MB
Assessments - Introduction	MP4	3.82 MB
Assessments - Results	MP4	8.42 MB
Assessments - Start new	MP4	42.48 MB
Assessments - Viewing individual assessment and addi...	MP4	60.67 MB
Better Portal - Introduction	MP4	24.03 MB
Better Portal - Patient Dashboard	MP4	18.82 MB
Login	MP4	40.70 MB
Login with 2FA	MP4	42.90 MB
Portal - Care plan-Registry Module	PDF	6.00 MB
Portal - User management	PDF	3.27 MB
User Profile	MP4	40.60 MB

Figure 29. Read user manuals or watch training videos

Better Legal Notice

Read about Better trademarks, copyrights, and licence rights under Legal Notice.

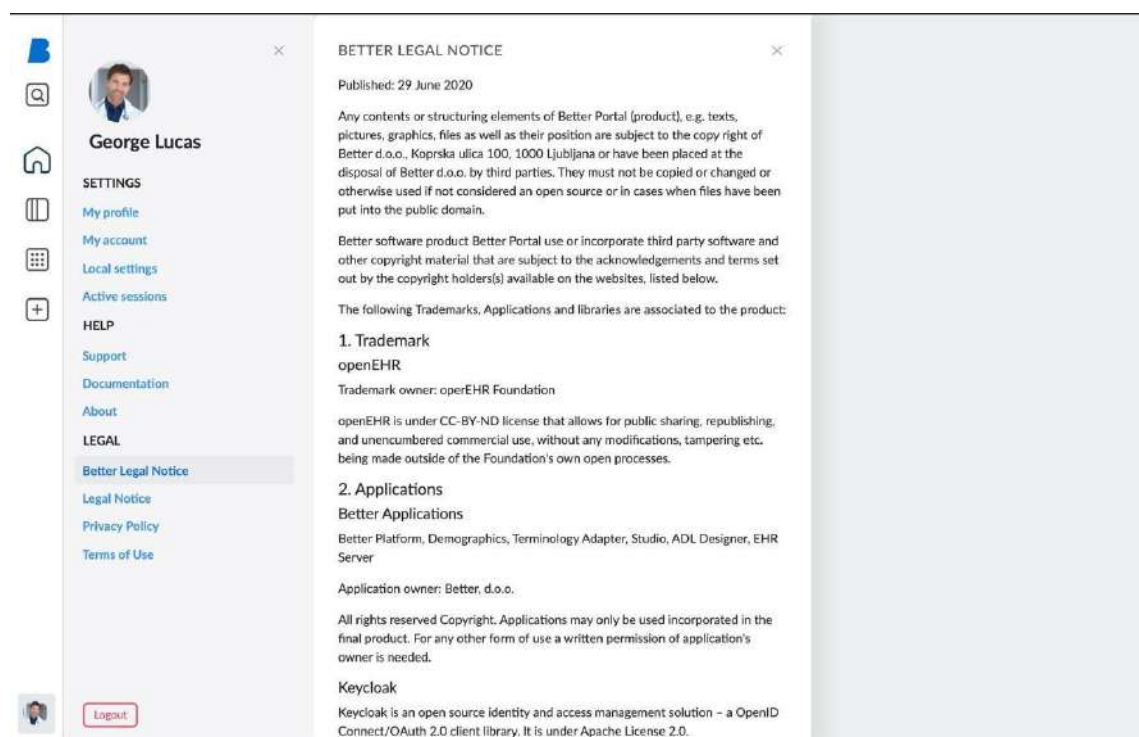


Figure 27. Better Legal Notice

About

Under “About” section, you can access software versions that you are using.

Sometimes your system administrator will ask you to tell him the version of the software that you are using in order assist you easier. Simple click on the “Copy Version Details” and share them with your administrator.

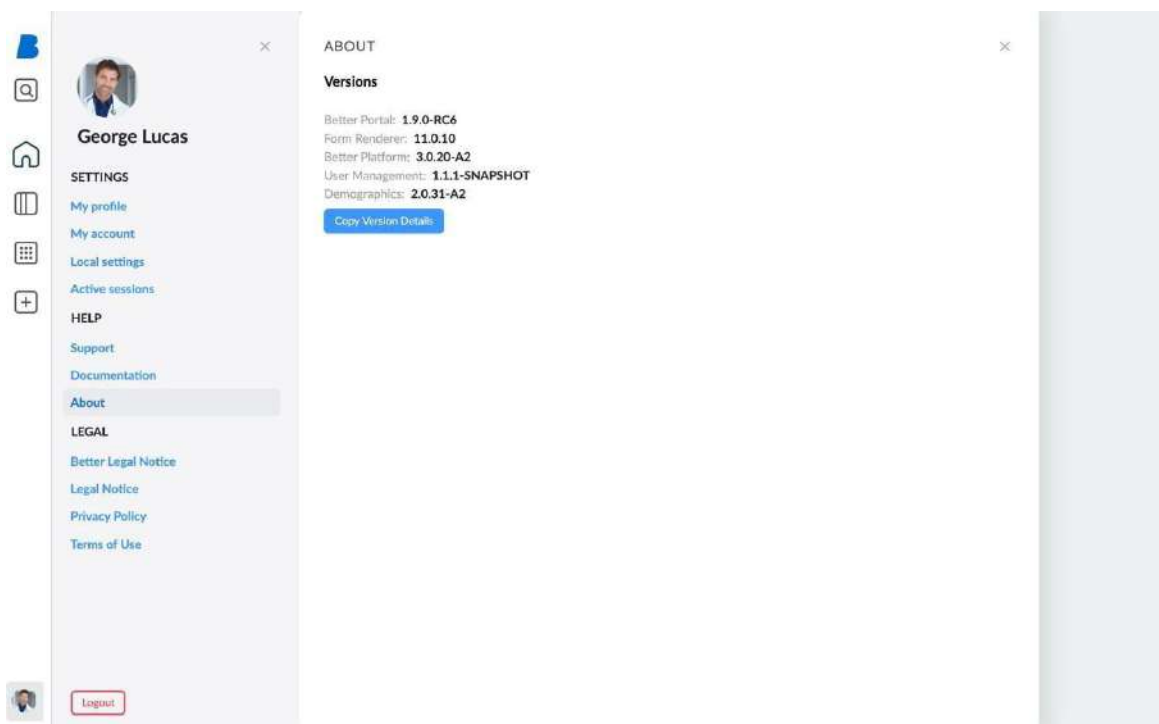


Figure 28. See information about your software

Patient List

Patient list is one of the two access points (the other is Patient Search) to see details of a particular patient.

Access Patient list from Workplace by clicking on Patient list under section Views. Patient list is displayed to the right.

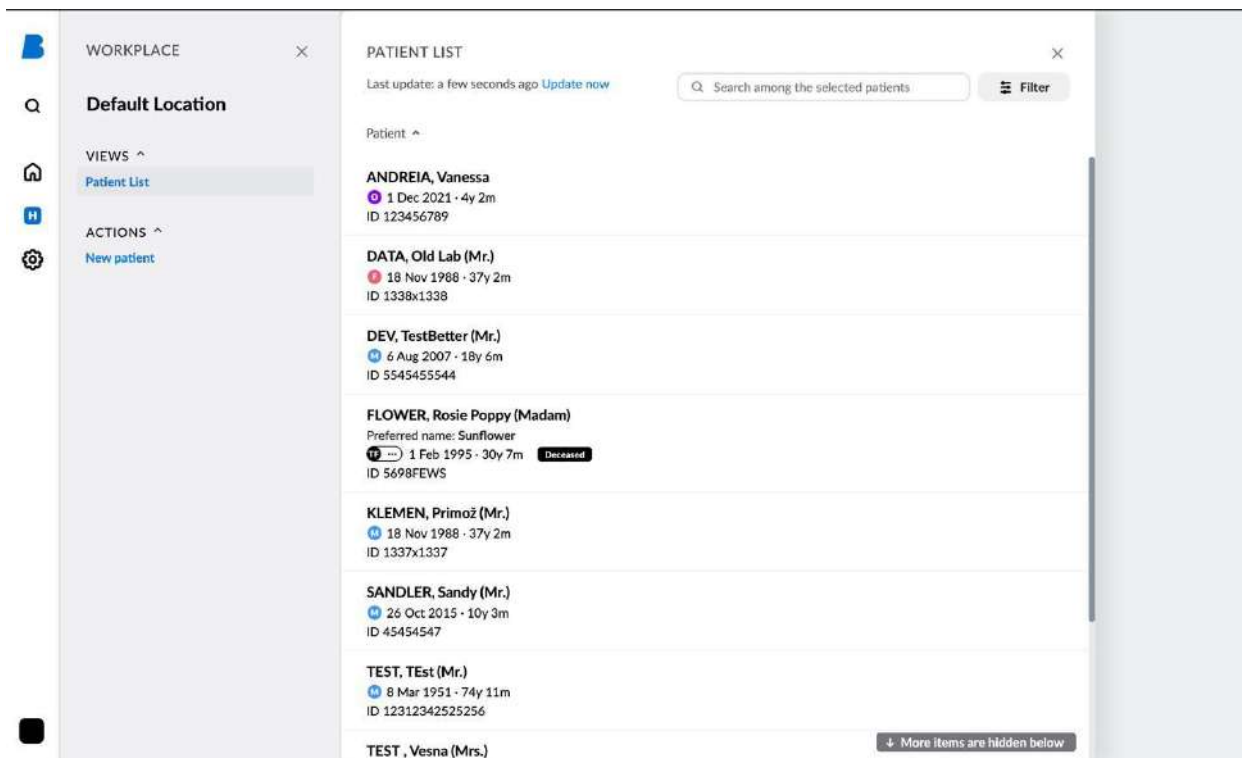


Figure 29. Access Patient list from User Dashboard

Filter patients

Patient list offers filter of patients.

1. Click Filter button to start applying filters
2. Filter opens on right hand side.
3. Filter by Care plans
 - a. Search by typing in and narrow down the list, or
 - b. Scroll to choose a care plan.
 - c. You can choose multiple care plans.
4. You can filter also by your patients – click Show my patients
5. You can filter down, after you have selected the care plan, also those patients that have active consents in those chosen care plans.
 - a. First select care plan(s)
 - b. Mark checkbox Patients with active consent
6. To hide the filter pane, click either  Filter or  Close button

WORKPLACE

Default Location

VIEWS ^

Patient List

ACTIONS ^

New patient

PATIENT LIST

Last update: 2 minutes ago [Update now](#)

Search among the selected patients [Filter](#)

Patient ^

ANDREIA, Vanessa
1 Dec 2021 · 4y 2m
ID 123456789

DATA, Old Lab (Mr.)
18 Nov 1988 · 37y 2m
ID 1338x1338

DEV, TestBetter (Mr.)
6 Aug 2007 · 18y 6m
ID 554545544

FLOWER, Rosie Poppy (Madam)
Preferred name: Sunflower
1 Feb 1995 · 30y 7m **Deceased**
ID 5698FEWS

KLEMEN, Primož (Mr.)
18 Nov 1988 · 37y 2m
ID 1337x1337

SANDLER, Sandy (Mr.)
26 Oct 2015 · 10y 3m
ID 45454547

TEST, TEST (Mr.)
8 Mar 1951 · 74y 11m
ID 12312342525256

TEST, Vesna (Mrs.)

FILTERS [Close](#)

Care plans

Select

Various

☐ Show my patients only

☐ Patients with active consent

[Reset all](#)

Figure 30. Apply filters to Patient list

WORKPLACE

Default Location

VIEWS ^

Patient List

ACTIONS ^

New patient

PATIENT LIST

Last update: 3 minutes ago [Update now](#)

Search among the selected patients [Filter](#)

Patient ^

ANDREIA, Vanessa
1 Dec 2021 · 4y 2m
ID 123456789

DATA, Old Lab (Mr.)
18 Nov 1988 · 37y 2m
ID 1338x1338

DEV, TestBetter (Mr.)
6 Aug 2007 · 18y 6m
ID 554545544

FLOWER, Rosie Poppy (Madam)
Preferred name: Sunflower
1 Feb 1995 · 30y 7m **Deceased**
ID 5698FEWS

KLEMEN, Primož (Mr.)
18 Nov 1988 · 37y 2m
ID 1337x1337

SANDLER, Sandy (Mr.)
26 Oct 2015 · 10y 3m
ID 45454547

TEST, TEST (Mr.)
8 Mar 1951 · 74y 11m
ID 12312342525256

TEST, Vesna (Mrs.)

FILTERS [Close](#)

Care plans

Select

☐ all forms

☒ On hold

☐ Autoinflammatory diseases (AID) **Active**

☐ Juvenile dermatomyositis (JDM) **Active**

☐ Juvenile idiopathic arthritis (JIA) **Active**

Figure 31. Filter patient list by care plan

[Reset all](#)

7. To reset all filters click [Reset all](#) button on filters pane or blue ribbon above the patient list
8. Applied filters are visible in the blue ribbon above patient list

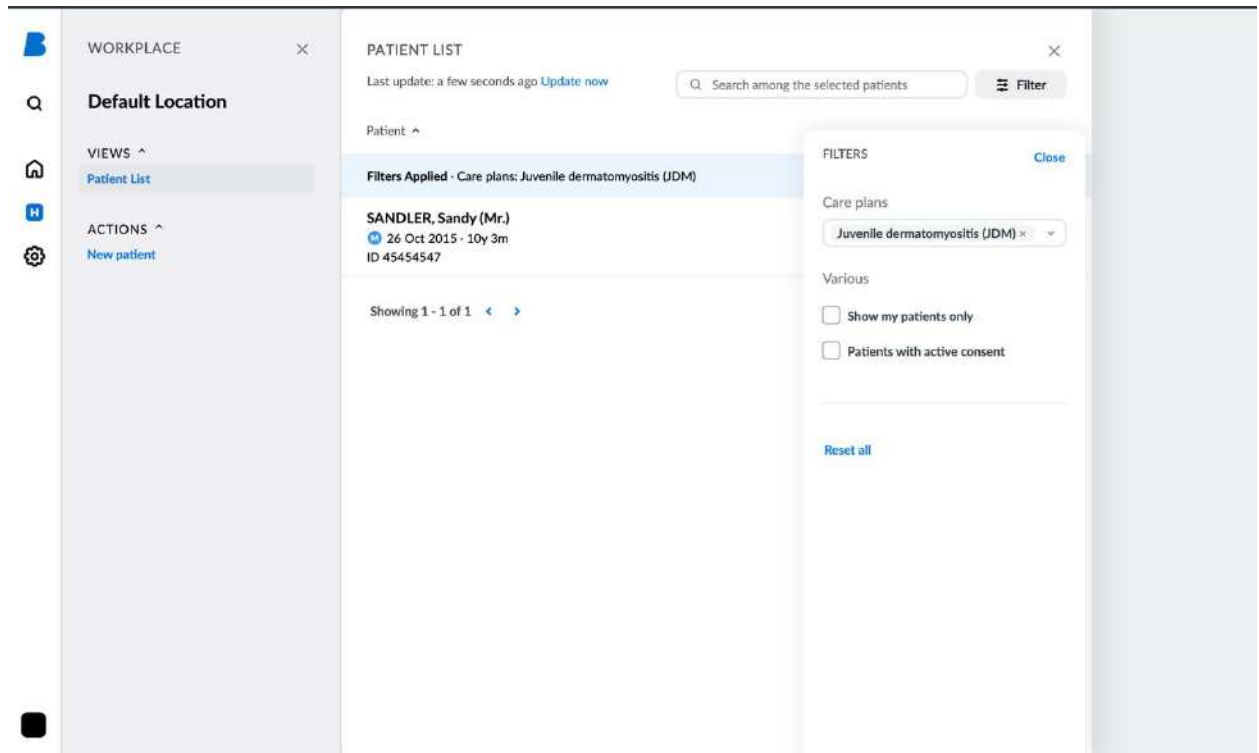


Figure 32. Applied filters are visible in the blue ribbon above patient list

Patient Dashboard

Patient Dashboard gives you access to an individual patient and his patient record. You can reach an individual patient record by clicking on the patient either in Patient Search or Patient List. Patient Dashboard provides a placeholder where you can access all modules and tools relevant for a particular patient and contains the following sections:

1. Patient Banner (Simple and Extended)
2. Views, Modules and Actions section

The availability of features among sections depends on your role and permissions and your organisation's configuration.

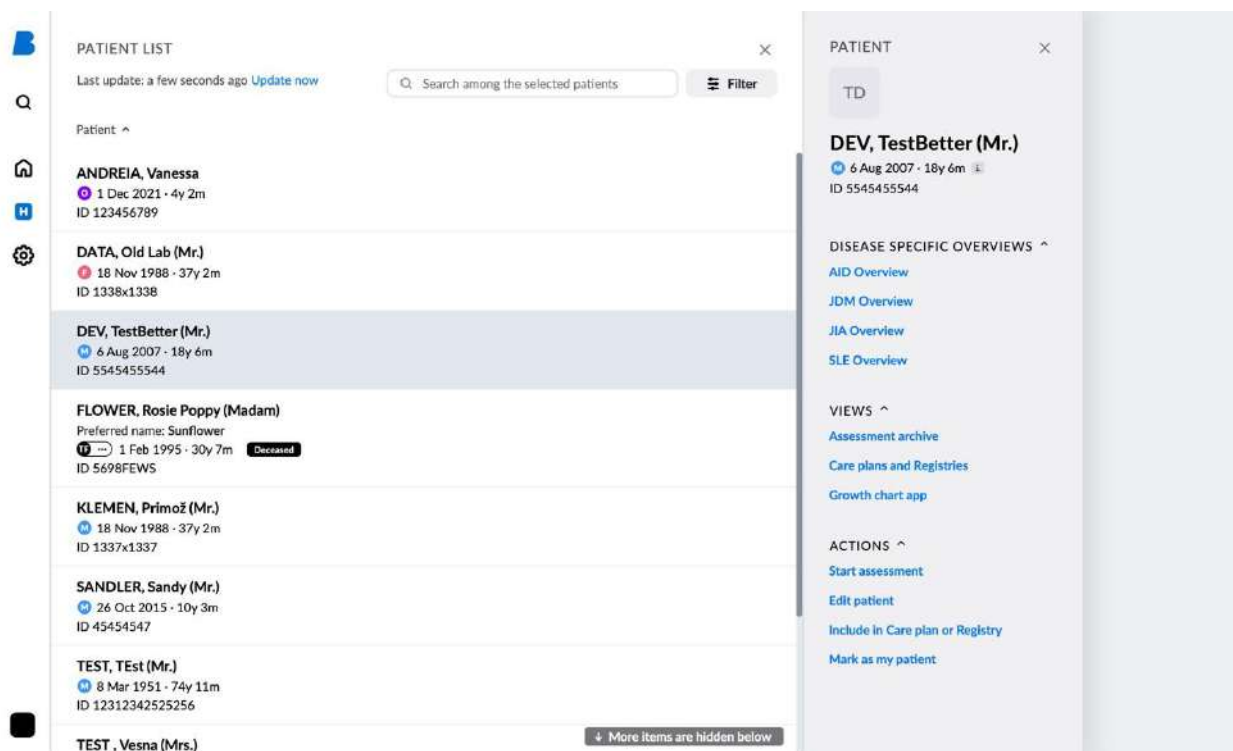


Figure 33. Opening Patient Dashboard through Patient List

Patient Banner

Patient Banner is a feature that identifies the patient throughout the Application. It can be seen within the Patient List, My Dashboard and Patient Dashboard.

In the Patient Dashboard, the Patient Banner displays the following information:

1. Patient initials (avatar)
2. LAST NAME, First name (including title, if applicable)
3. Gender icon
4. Date of birth and age (in years)
5. Unique identifier (ID)

If applicable, a visual indicator (e.g. deceased tag) is displayed next to the patient's name.

SPIELBERG, Patrick

5/17/00 • 20 y 6 m

MRN 21717

Elliot

541

Figure 34. Patient Banner in the Patient List

By clicking on the Patient Banner, a side panel titled “Patient’s info” opens, displaying extended patient demographic information.

By clicking on the Patient Banner, a side panel titled “Patient’s info” opens, providing extended demographic and contact information about the patient. The information is presented in a structured layout divided into clearly separated sections.

The Personal section displays the patient’s core demographic information, including title, first name, last name, date of birth, and automatically calculated age. It also shows gender at birth, marital status, education level, and the patient’s unique identifier (ID). This section reflects the primary identity and demographic data stored in the system.

The Address section displays the patient’s registered home address. The address is presented in a structured multi-line format and includes street name and house number, unit (if applicable), city, postal code, and country.

The Phone & Email section provides access to the patient’s registered contact details, including phone numbers and email addresses. When multiple contact entries are available, a “View all” option is displayed, allowing users to review additional contact information associated with the patient record.

The Patient Contacts section contains information about registered related persons, such as next of kin. This includes the contact’s name, relationship to the patient, phone number, and email address. This information supports identification of responsible or emergency contacts linked to the patient.

The Patient’s info panel can be closed by selecting the “X” button in the upper right corner. Patient data can be modified by selecting the Edit patient action available within the Patient Dashboard under the Actions section.

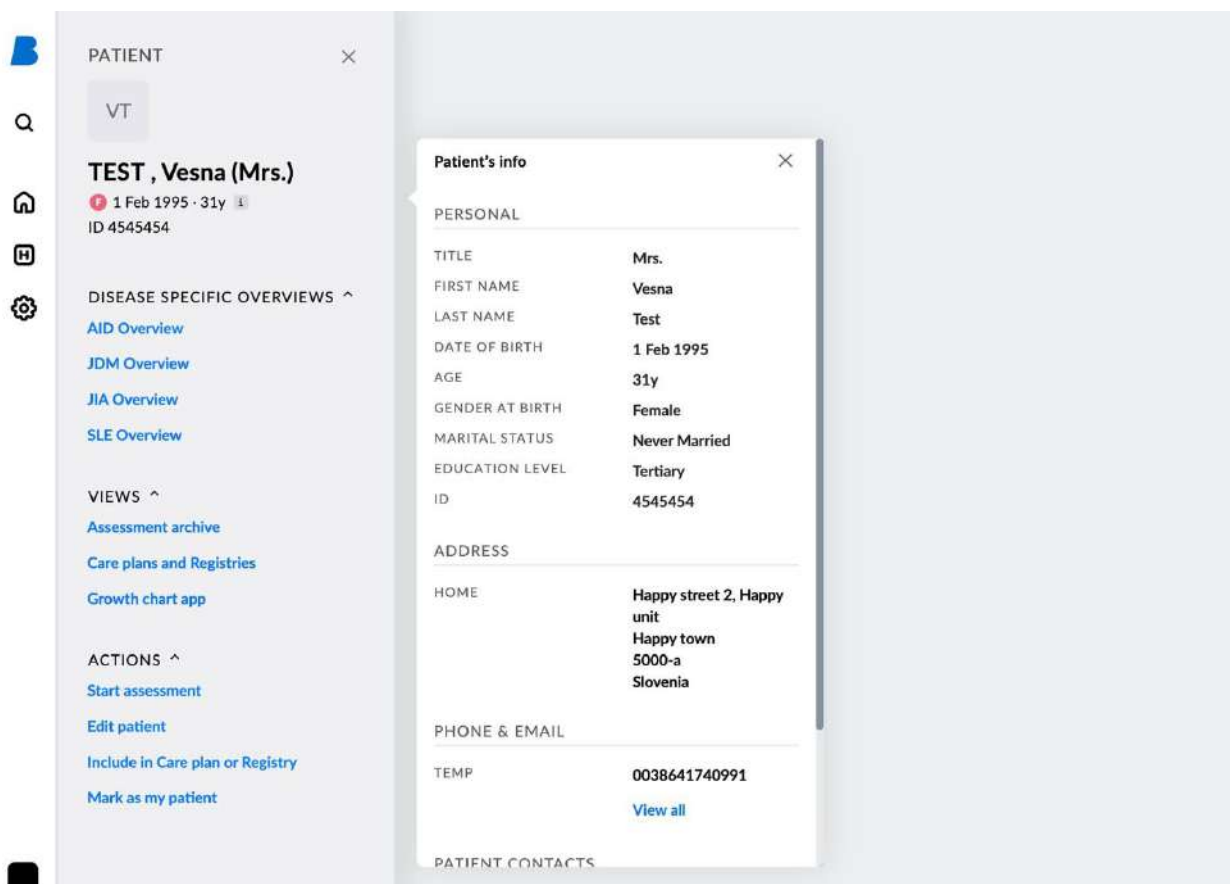


Figure 35. Patient's info

Patient Gender

The Application supports gender at birth and preferred gender.

If gender at birth and preferred gender are the same, the Patient Banner shows gender at birth.

Special icons indicating patient gender are being used. The available options for gender at birth are seen in Figure 36.

	Normal	Inactive	Deceased
Female			
Male			
Other			
Unknown			
Non-disclose			

Figure 36. Gender at birth

In an occurrence, in which a patient has different gender at birth and preferred gender, several visual distinctions are put in place:

First, special icons indicating the difference in gender preference are being used. The possible options for preferred gender type are the following:

	Normal	Inactive	Deceased
Preferred Female			
Preferred Male			
Preferred Other			
Preferred Unknown			
Preferred Non-disclose			

Figure 37. Preferred gender

Second, when you hover over the gender icon, the mouseover event triggers a pop-up box showing patient's name, surname and both gender identifiers as shown in Figure 29.



Figure 38. Preferred gender hover over

Deceased Patient Tag

Patients that have passed away (and this data is either recorded in the Patient Administration System (PAS) or natively within the Better Portal) have a Deceased tag attached to their Patient Banner. Additionally, the gender icon gets black colour in line with specifications in chapter Patient Gender. The information on patient's death date is available in the Extended Patient Banner accessible from Patient Dashboard.



Figure 39. Patient with Deceased and Similar patient tags

Disease specific overviews, Views and Actions Sections

In line with the User Dashboard, Patient Dashboard gives you access to different patient related applications, modules and features native to Better Portal (example would be the Assessment archive), other Better Applications, or 3rd party Applications addressing a particular patient.

To initiate any of the functionalities, click on the relevant button on the Patient Dashboard.

Disease specific overviews

The Disease-Specific Overviews section provides a structured, longitudinal view of a patient's condition. It is organized into four dedicated subsections, each corresponding to a major rheumatologic disease: AID, JDM, JIA, and SLE.

Each subsection presents a comprehensive overview of the selected disease, displaying key clinical data over time in a clear graphical format. This allows clinicians to quickly assess disease progression, trends, and relevant clinical parameters in a visually intuitive way.

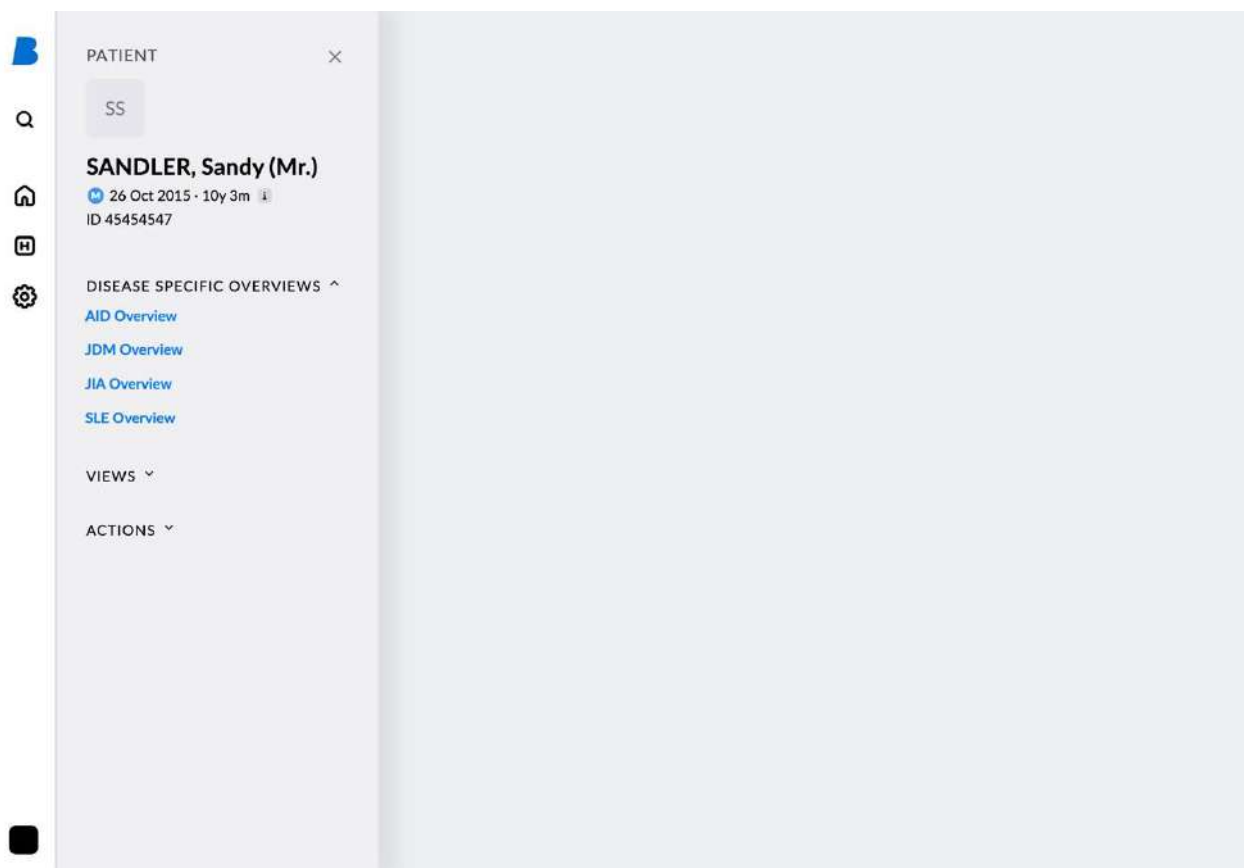


Figure 39. Disease specific overviews

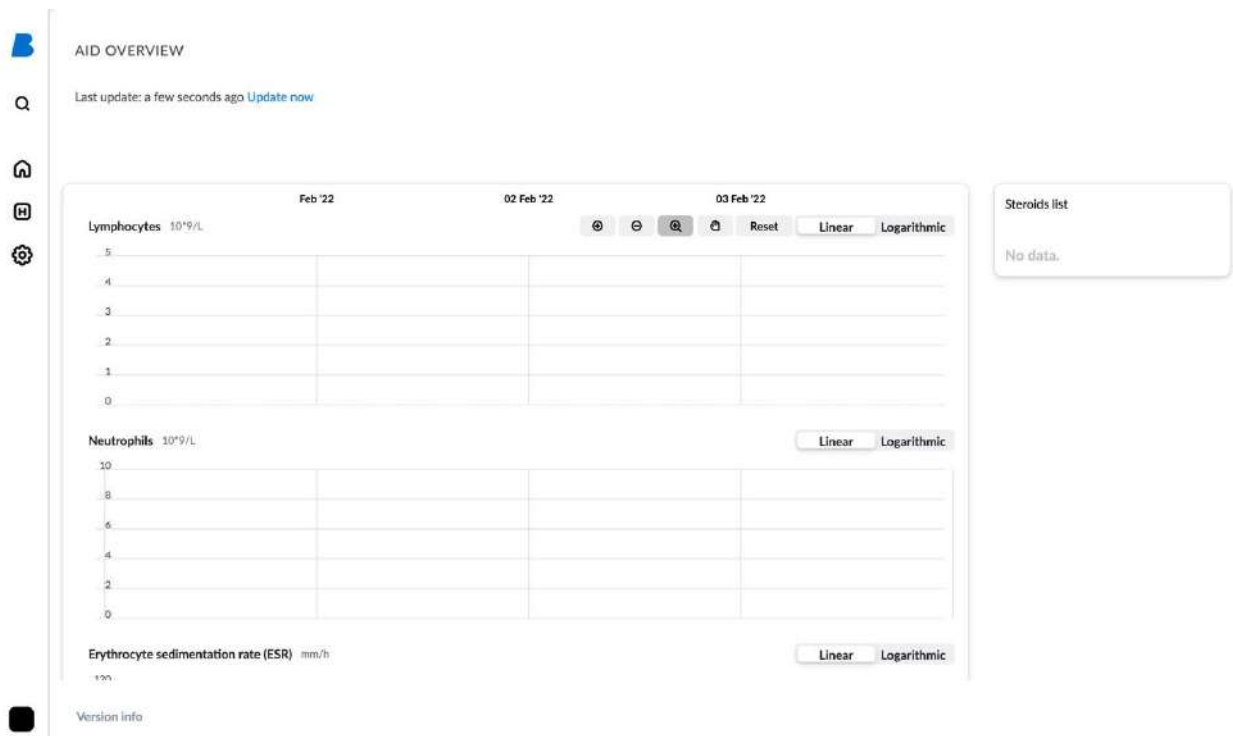


Figure 40. AID Overview

Assessment archive

Assessment archive provides a list of all assessments entered for a particular patient. Assessment can be filtered and searched. Default sort is latest entered on top of the list. For more details see user manual Better Assessments.

PATIENT X

SS

SANDLER, Sandy (Mr.)
26 Oct 2015 · 10y 3m ⓘ
ID 45454547

DISEASE SPECIFIC OVERVIEWS ^

- AID Overview
- JDM Overview
- JIA Overview
- SLE Overview

VIEWS ^

- Assessment archive
- Care plans and Registries
- Growth chart app

ACTIONS ^

- Start assessment
- Edit patient
- Include in Care plan or Registry
- Mark as my patient

ASSESSMENT ARCHIVE X

Last update: a few seconds ago [Update now](#) [Filter](#)

Filters Applied · Period: All periods · Status: Valid [Reset all](#)

Tanner stages Assessment date: 10 Nov 2025, 14:47 · um-admin
Physician global disease damage assessment Assessment date: 10 Nov 2025, 14:47 · um-admin
Physician global activity assessment Assessment date: 10 Nov 2025, 14:46 · um-admin
Patient parent global activity assessment Assessment date: 10 Nov 2025, 14:46 · um-admin
Muscle biopsy findings Assessment date: 10 Nov 2025, 14:44 · um-admin
Medications Assessment date: 10 Nov 2025, 14:44 · um-admin
Myositis damage index Assessment date: 10 Nov 2025, 14:44 · um-admin
Magnetic resonance imaging findings for JDM Assessment date: 10 Nov 2025, 14:42 · um-admin
Manual muscle testing (MMT) Assessment date: 10 Nov 2025, 14:42 · um-admin

Figure 41. Patient Assessment archive

Edit Patient

At any time, you can edit patient information via Patient Dashboard/Edit patient.
Steps:

1. Select "Edit patient" action under Actions section.
2. Change patient data and select Submit at the bottom of the form.
3. Patient data has been updated.

PATIENT

SS

SANDLER, Sandy (Mr.)

26 Oct 2015 · 10y 3m

ID 45454547

DISEASE SPECIFIC OVERVIEWS

AID Overview

JDM Overview

JIA Overview

SLE Overview

VIEWS

Assessment archive

Care plans and Registries

Growth chart app

ACTIONS

Start assessment

Edit patient

Include in Care plan or Registry

Mark as my patient

EDIT PATIENT

Sandy Sandler

Submit

Personal info

Fields marked with * are mandatory.

Title

Mr.

First name*

Sandy

Last name*

Sandler

Gender at birth*

Male

Date of birth*

26/10/2015

Marital status

Select

Education level

Select

ID*

45454547

+ Add field

Address

Figure 42. Edit patient

Mark As My Patient

Sometimes you want to pay special attention to a specific patient. By clicking “Mark as my patient” on the Patient Dashboard you tag a certain patient, which allows you filtering these patients on the patient list. On selecting this action, a pop-up notice appears at the bottom of the screen with confirmation that patient has been marked as yours.

The action on the patient dashboard changes to “Unmark as my patient”.

The screenshot displays the 'B better' patient management interface. On the left, a vertical sidebar contains navigation icons. The main area is titled 'PATIENT LIST' and includes a search bar, a filter button, and a list of patients. One patient, 'SANDLER, Sandy (Mr.)', is highlighted. To the right, a 'PATIENT' sidebar is open, showing details for the selected patient and a list of actions, including 'Mark as my patient'.

PATIENT LIST

Last update: a few seconds ago [Update now](#)

Search among the selected patients

Filter

Patient ^

Filters Applied · Care plans: Juvenile dermatomyositis (JDM) [Reset all](#)

SANDLER, Sandy (Mr.)

26 Oct 2015 · 10y 3m

ID 45454547

Showing 1 - 1 of 1

PATIENT

SS

SANDLER, Sandy (Mr.)

26 Oct 2015 · 10y 3m

ID 45454547

DISEASE SPECIFIC OVERVIEWS ^

- [AID Overview](#)
- [JDM Overview](#)
- [JIA Overview](#)
- [SLE Overview](#)

VIEWS ^

- [Assessment archive](#)
- [Care plans and Registries](#)
- [Growth chart app](#)

ACTIONS ^

- [Start assessment](#)
- [Edit patient](#)
- [Include in Care plan or Registry](#)
- [Mark as my patient](#)

Figure 43. Mark as my patient

At any time, you can unselect patient as yours by simple clicking on “Unmark as my patient”. This is an individual action, so users’ personal tags are only reflected in your own application.

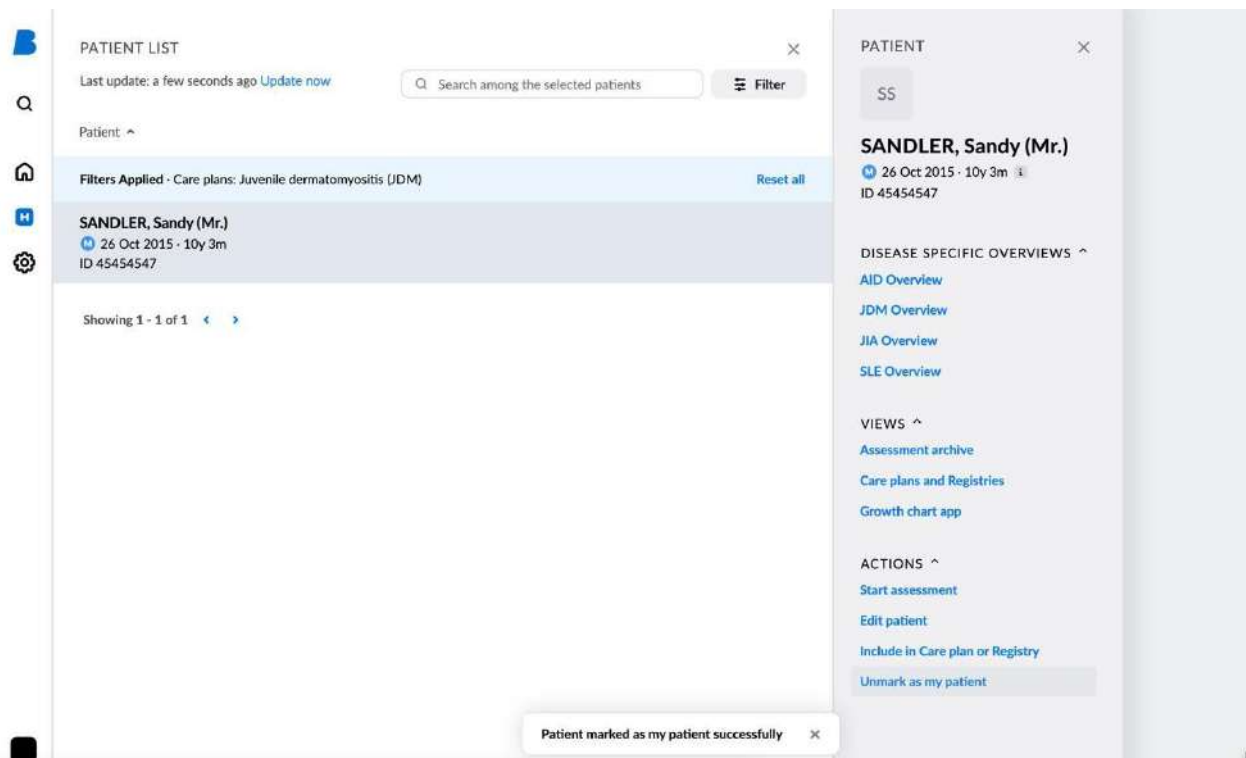


Figure 44. Notification that patient has been marked as my patient successful

Assessments

Assessments functionality within the Portal enables structured entry and review of patient-related clinical data through the options Start assessment and Assessment archive. As this represents a core clinical workflow for documenting and accessing standardized patient information, it is described in a separate section.

Start Assessment

Starting (creating) an assessment requires 2 steps:

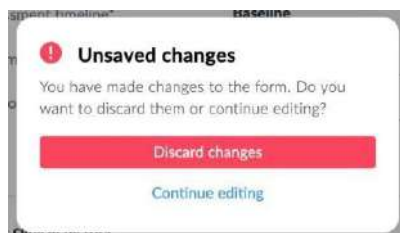
- Find a patient (either using Patient Search or Patient List)
- Start Assessment

After you have selected a patient the Patient Dashboard is displayed. A patient must be included in a care plan or registry to start entering assessments available for that particular care plan or registry.

Steps to Start assessment:

- Open Patient Dashboard
- Select Start Assessment under Actions section
- Search for available assessment or scroll through the list.

- Make sure to choose the correct assessment under a care plan or registry you wish to record data.
- Assessment drafts that have been started are marked with label In progress.
- Select a suitable assessment by clicking on it. Upon selecting an assessment form opens.
- Begin completing the form
- For assessments In progress you have an option to discard the entered data and start from scratch by clicking Start new in the banner above the form
- You can save partial data entry by selecting Save progress. Assessment will be labeled In progress.
- You close the form by clicking on X button. System will display a Warning message asking you to confirm either discarding changes or continue editing



- You can Submit the form once you have finished entering the assessment.
- Submitted assessment are visible in Assessment archive under Views section. See chapter View Assessment.

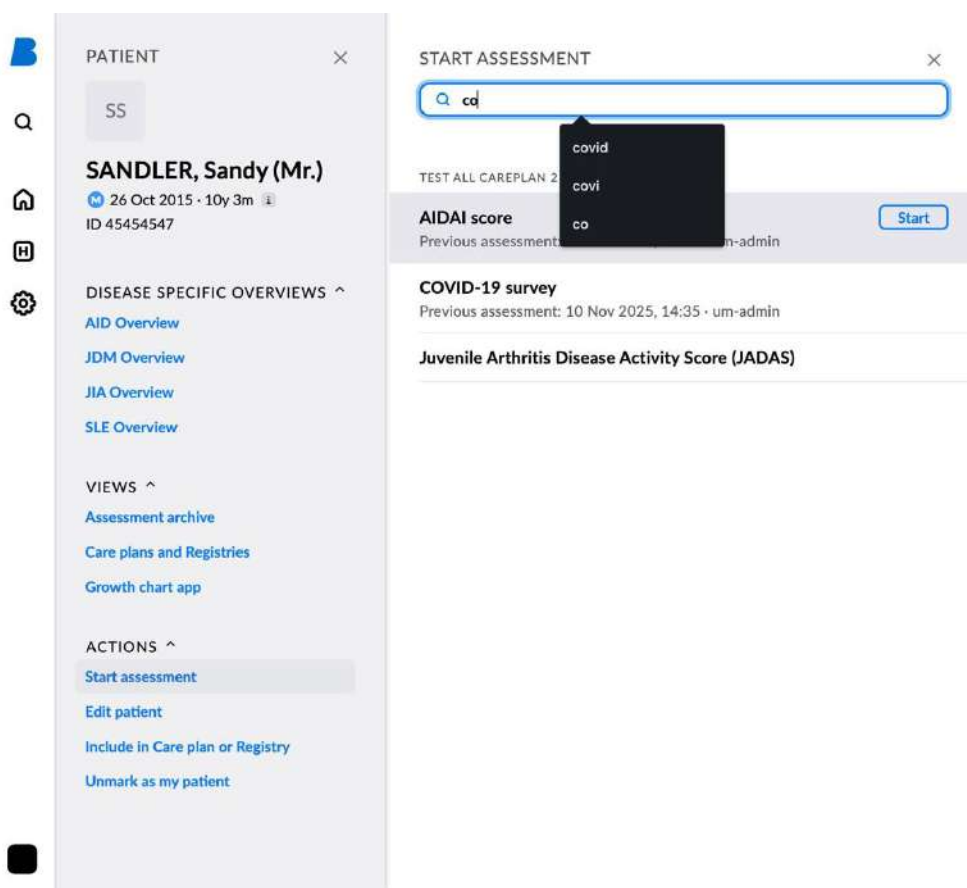


Figure 45. Start patient assessment

View Assessment

Patient's Assessment archive represents all clinical data recorded through assessments.

Steps to view assessment:

4. Open Patient Dashboard (see chapter Patient Search).
5. Click Assessment archive, panel opens to the left.
6. Select an assessment document from the archive
7. Use Filter to narrow down your search results in case of many documents.
8. Document opens in panel to the right in reading mode in a structured presentation.

PATIENT ×

SS

SANDLER, Sandy (Mr.)
26 Oct 2015 · 10y 3m
ID 45454547

DISEASE SPECIFIC OVERVIEWS ^

- [AID Overview](#)
- [JDM Overview](#)
- [JIA Overview](#)
- [SLE Overview](#)

VIEWS ^

- Assessment archive**
- [Care plans and Registries](#)
- [Growth chart app](#)

ACTIONS ^

- [Start assessment](#)
- [Edit patient](#)
- [Include in Care plan or Registry](#)
- [Unmark as my patient](#)

ASSESSMENT ARCHIVE ×

Last update: 2 minutes ago [Update now](#) Filter

Filters Applied · Period: All periods · Status: Valid Reset all

- Tanner stages**
Assessment date: 10 Nov 2025, 14:47 · um-admin
- Physician global disease damage assessment**
Assessment date: 10 Nov 2025, 14:47 · um-admin
- Physician global activity assessment**
Assessment date: 10 Nov 2025, 14:46 · um-admin
- Patient parent global activity assessment**
Assessment date: 10 Nov 2025, 14:46 · um-admin
- Muscle biopsy findings**
Assessment date: 10 Nov 2025, 14:44 · um-admin
- Medications**
Assessment date: 10 Nov 2025, 14:44 · um-admin
- Myositis damage index**
Assessment date: 10 Nov 2025, 14:44 · um-admin
- Magnetic resonance imaging findings for JDM**
Assessment date: 10 Nov 2025, 14:42 · um-admin
- Manual muscle testing (MMT)**
Assessment date: 10 Nov 2025, 14:42 · um-admin

Figure 46. Assessment archive

PATIENT ×

SS

SANDLER, Sandy (Mr.)
26 Oct 2015 · 10y 3m
ID 45454547

DISEASE SPECIFIC OVERVIEWS ^

- [AID Overview](#)
- [JDM Overview](#)
- [JIA Overview](#)
- [SLE Overview](#)

VIEWS ^

- Assessment archive**
- [Care plans and Registries](#)
- [Growth chart app](#)

ACTIONS ^

- [Start assessment](#)
- [Edit patient](#)
- [Include in Care plan or Registry](#)
- [Unmark as my patient](#)

ASSESSMENT ARCHIVE ×

Last update: a minute ago [Update now](#) Filter

Filters Applied · Period: All period

Tanner stages
Assessment date: 10 Nov 2025,

Physician global disease dan
Assessment date: 10 Nov 2025,

Physician global activity asse
Assessment date: 10 Nov 2025,

Patient parent global activity
Assessment date: 10 Nov 2025,

Muscle biopsy findings
Assessment date: 10 Nov 2025,

Medications
Assessment date: 10 Nov 2025,

Myositis damage index
Assessment date: 10 Nov 2025,

Magnetic resonance imaging
Assessment date: 10 Nov 2025,

Manual muscle testing (MM
Assessment date: 10 Nov 2025,

FILTERS Close

Assessments

- ☐ Adverse events
- ☐ AIDAI score
- ☐ Antiphospholipid syndrome
- ☐ Body map - Juvenile idiopathic art...
- ☐ Childhood Health Assessment Qu...
- ☐ Childhood Myositis Assessment S...
- ☐ Classification Criteria for Idiopathi...
- ☐ Permanently incomplete

[Reset all](#)

Figure 47. Using filter in Assessment archive

DOCUMENT

COVID-19 survey Actions

Assessment date: 10 Nov 2025, 14:35 - Last update: 10 Nov 2025, 14:36 - Author: um-admin

SANDLER, Sandy 26 Oct 2015 · 10y 3m · ID 45454547

Disclaimer
This form is for research purposes solely and should not be used in any case for clinical decision support.

COVID-19 survey

Date of assessment: 10/11/2025 Set current date

PATIENT INFORMATION

Had the patient had his seasonal flu vaccination? ✓ Yes No Unknown

Date of vaccination

COVID-19 INFORMATION

Has the patient had diagnosis covid-19 infection? Yes ✓ No Unknown

Figure 48. Document opens in structured Presentation view

Document Actions

Additional options are available under button Actions:

- Start new from this - start new assessment from the existing document
- Print – print this document to paper or PDF
- Open new tab – opens this document in a new browser tab and in read-only view
- Mark as recorded in error
- Show full form – opens the document in a form view read-only mode

DOCUMENT

COVID-19 survey

Assessment date: 10 Nov 2025, 14:35 · Last update: 10 Nov 2025, 14:36 · Author: um-admin

SANDLER, Sandy · 26 Oct 2015 · 10y 3m · ID 45454547

Disclaimer
This form is for research purposes solely and should not be used in any case for clinical decision support.

COVID-19 survey

Date of assessment: 10/11/2025 [Set current date]

PATIENT INFORMATION

Had the patient had his seasonal flu vaccination? [✓ Yes] [No] [Unknown]

Date of vaccination

COVID-19 INFORMATION

Has the patient had diagnosis covid-19 infection? [Yes] [✓ No] [Unknown]

Actions

- Start new from this
- Print
- Open in new tab
- Mark as recorded in error
- Show full form

Figure 49. Assessment archive and additional document option

Mark as recorded in error

The procedure of marking a document as recorded in error has the following steps:

- Select action Mark as recorded in error
- Provide a reason for marking document as such
- Choosing Incorrect patient will result in not seeing this document in the archive of this patient.
- Choosing Incorrect data will result in still being able to see (filter) this document in the archive.
- Select Confirm to complete.

DOCUMENT

This form was marked as recorded in error. Please provide a reason.

✓ Incorrect patient

Incorrect data

Other

COVID-19 survey

Assessment date: 10 Nov 2025, 14:35 · Last update: 10 Nov 2025, 14:36 · Author: um-admin

SANDLER, Sandy 26 Oct 2015 · 10y 3m ID 45454547

Disclaimer

This form is for research purposes solely and should not be used in any case for clinical decision support.

COVID-19 survey

Date of assessment

10/11/2025

Set current date

PATIENT INFORMATION

Had the patient had his seasonal flu vaccination?

✓ Yes

No

Unknown

Figure 50. Mark document as recorded in error

Q

PATIENT

SS

SANDLER, Sandy (Mr.)

26 Oct 2015 · 10y 3m

ID 45454547

DISEASE SPECIFIC OVERVIEWS

AID Overview

JDM Overview

JIA Overview

SLE Overview

VIEWS

Assessment archive

Care plans and Registries

Growth chart app

ACTIONS

Start assessment

Edit patient

Include in Care plan or Registry

Unmark as my patient

ASSESSMENT ARCHIVE

Last update: a few seconds ago [Update now](#)

Filter

Filters Applied · Period: All periods · Status: Valid · Status: Recorded ... [Reset all](#)

Damage item AID

Assessment date: 10 Nov 2025, 14:36 · um-admin

Electromyography findings

Assessment date: 10 Nov 2025, 14:36 · um-admin

Clinical manifestation JDM

Assessment date: 10 Nov 2025, 14:35 · um-admin

Clinical manifestation JDM

Assessment date: 10 Nov 2025, 14:35 · um-admin

COVID-19 survey

Recorded in error

Assessment date: 10 Nov 2025, 14:35 · um-admin

Clinical manifestation AID

Assessment date: 10 Nov 2025, 14:32 · um-admin

Clinical manifestation for SLE (BILAG-2004)

Assessment date: 10 Nov 2025, 14:32 · um-admin

Classification Criteria for Idiopathic Inflammatory Myopathies

Assessment date: 10 Nov 2025, 13:28 · um-admin

Childhood Myositis Assessment Scale (CMAS)

Assessment date: 10 Nov 2025, 13:26 · um-admin

Figure 51. Document recorded in error in Assessment Archive

Q

U

M

G

DOCUMENT

COVID-19 survey

Assessment date: 10 Nov 2025, 14:35 · Last update: 12 Feb 2026, 12:37 · Author: um-admin

Recorded in error Incorrect data

SANDLER, Sandy 26 Oct 2015 · 10y 3m ID 45454547

Disclaimer

This form is for research purposes solely and should not be used in any case for clinical decision support.

COVID-19 survey

Date of assessment

10/11/2025

Set current date

PATIENT INFORMATION

Had the patient had his seasonal flu vaccination?

☒ Yes
 ☐ No
 ☐ Unknown

Date of vaccination

COVID-19 INFORMATION

×

Actions

Figure 52. Example of document recorded in error

Care plan design & setup

Care plan design & setup is an administrative module within the Portal that enables authorized users to design care plan or registry templates and configure care plans for institutional use. The module supports the definition of structured care frameworks that guide clinical workflows, patient inclusion, and monitoring activities.

The module is organized into two main sections: Views and Actions. Through Views, users can access existing care plan and registry templates as well as configured care plans. Through Actions, users can design new templates or set up care plans and registries based on available templates. Because this functionality includes both configuration-level administration and operational setup of care structures, it is described in a dedicated section.

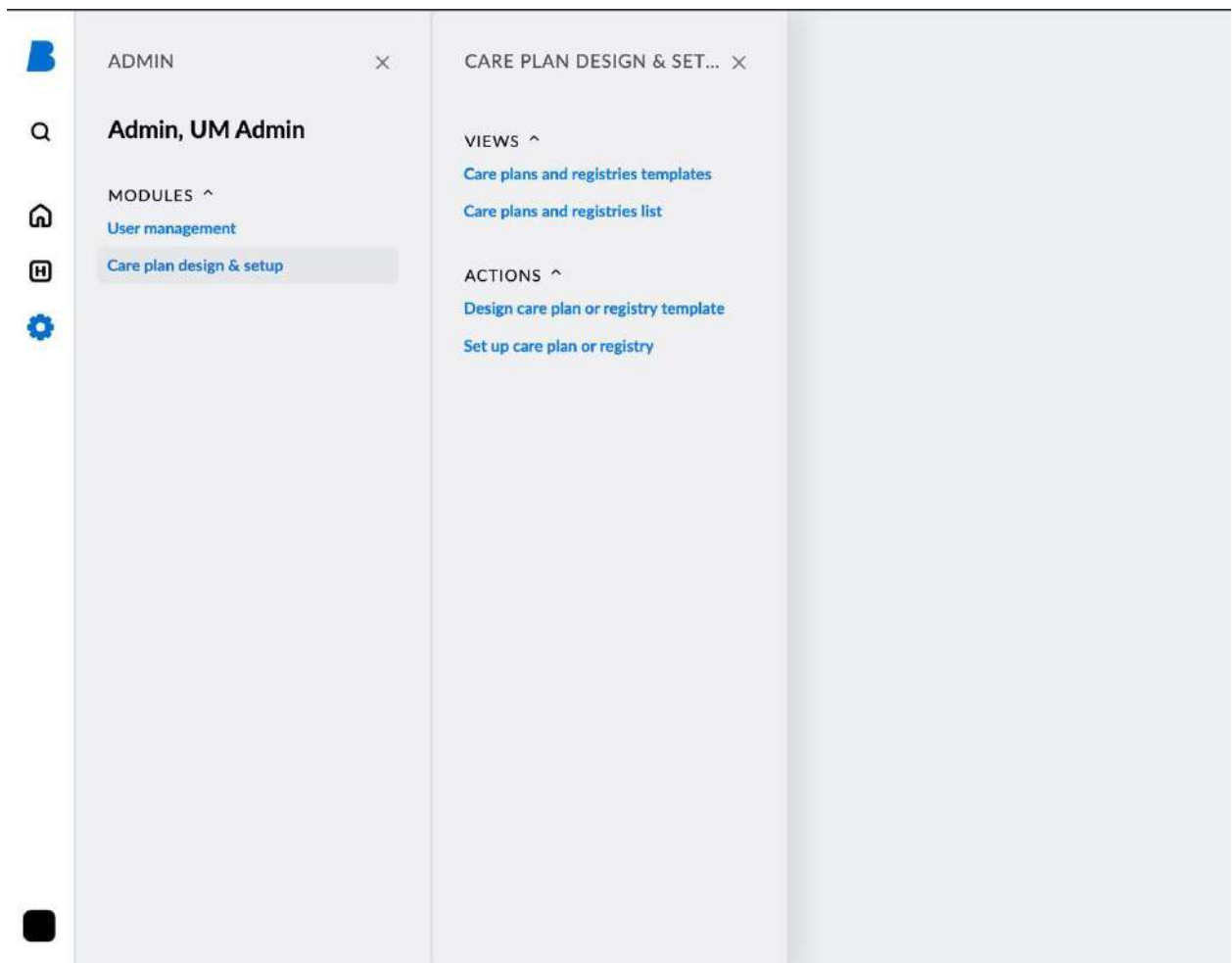


Figure 53. Care plan design & setup

Application Usage Permissions

To be able to work with care plans, the administrator must assign to a user the correct permissions.

The first level of administration must be done within the User Management by assigning the user to a group with permission Careplan-study: careplan_patient_management.

With this permission the user will be able to perform actions within specific care plans and have the option to filter the patient list by a selected care plan.

Next level of administration is done directly within the care plan itself.

When setting up the care plan, the creator of a care plan has to add users to a care plan. Once users are added to the care team of that care plan, they have permission to add, view, and manage patients that are included in the care plan.

Please note: A user has to have the permission “careplan_patient_management” assigned to be able to work with the care plan. Including the user only in the care team of a care plan is not sufficient.

To fill out assessments and questionnaires for a patient included in a specific care plan, user requires to have Ehrform permissions assigned.

The permission Ehrform: read allows a user to access the Assessment archive and read documents but does not allow him to fill out a new form (assessment).

The permission Ehrform: write allows a user to access the list of Assessment forms available for a patient and fill out those forms.

To see how to assign correct permissions see user manual User Management.

Design Care plan or Registry template

Create template

The first step of using the Application is to design a template of a care plan or registry. The template is a generic definition of a care plan or registry. Only individuals with the appropriate permission can create, edit or view a template.

Steps to design a new template:

- Login to Better Portal
- On User Dashboard click on the action "Design care plan or registry template".
- Fill in required information and
- Click Publish to save the template to be later used for "Setting up care plan or registry".
- Or select Save progress if you will continue to work on the template later.

Template content

The template has two distinct sections:

Section Information covers the basic description of the care plan/registry template.

Mandatory fields are marked with an asterix (*).

Steps to complete Information:

- c) Select a Category - Registry or Care plan.
 - The main distinction between the two is that the primary purpose of a care plan is the monitoring and treatment of the individual patient health, while the registries are usually set up to collect patients clinical and social status data for their secondary data usage purpose – for example support post-market surveillance of a product or a drug.
- d) Define template Title in a user friendly format.
- e) Define Care plan/registry description - natural language description of the plan definition.
- f) Define Publisher - an institution or an individual who published the template.
 - This information is especially important in cases when a care plan/registry is following a national, regional or international standard and guidelines and acknowledgment is required by the publisher.

- g) Select the Primary and Secondary purpose of the care plan or registry.
- In the case of a care plan the purpose is free text field, for the registries the purpose is split in two sections: Primary and Secondary purpose. The field has defined values based on international recommendations.
- h) Define Goal – what the plan is trying to establish.

The screenshot displays the 'DESIGN CARE PLAN OR REGISTRY TEMPLATE' window. On the left sidebar, under 'ACTIONS', the 'Design care plan or registry template' option is highlighted. The main panel is titled 'New template' and contains the following sections:

- INFORMATION**
 - Category***: A dropdown menu with 'Select category' as the placeholder.
 - Title***: A text input field with 'Enter title' as the placeholder.
 - Description**: A text input field with 'Summary of the aim' as the placeholder.
 - Publisher**: A text input field with 'Add publisher' as the placeholder.
 - Purpose***: A text input field with 'Add purpose' as the placeholder.
 - Goal**: A text input field with 'Add goal description' as the placeholder.
- CONTENT***: A section at the bottom of the form.

At the bottom right of the form, there are three buttons: 'Cancel', 'Save progress', and 'Publish'.

Figure 54. Design Care plan or registry template initial screen

Section Content allows you to attach the assessments forms for the care plan/registry Steps to complete Content:

- Click Add content to select multiple assessment forms from the list.
 - Use Search and Filter to find relevant items fast.
- Click outside of Content popup dialog to close it.
- For each form, define who should complete the form.
 - The default selection is set to a Practitioner.

DESIGN CARE PLAN OR REGISTRY TEMPLATE

New template

Registry:

Title*:

Description:

Publisher:

Purpose - Primary*: Purpose - Secondary:

Goal:

CONTENT*

[+ Add content](#)

No content

[Cancel](#) [Save progress](#) [Publish](#)

ADD CONTENT

Search:

Filters: No tag

Form

- ☐ Adverse events
- ☐ AIDAI score
- ☐ Antiphospholipid syndrome
- ☐ Body map - Juvenile idiopathic arthritis (JIA)
- ☐ Childhood Health Assessment Questionnaire (CHAQ)
- ☐ Childhood Myositis Assessment Scale (CMAS)
- ☐ Classification Criteria for Idiopathic Inflammatory Myopathies
- ☐ Classification criteria for SLE
- ☐ Clinical manifestation AID
- ☐ Clinical manifestation for SLE (BILAG-2004)
- ☐ Clinical manifestation JDM
- ☐ COVID-19 survey
- ☐ Damage item AID
- ☐ Diagnosis details
- ☐ Electromyography findings
- ☐ Genetic analysis

Figure 55. Adding content – assessment to care plan or registry template

Steps to save, publish, or cancel design of a template:

1. Click Publish to make the template Active.
 - a. Successful save is confirmed by a popup display.
 - b. The user is navigated to the list of all templates created within the institution.
2. Click Save progress if the template cannot be completed immediately.
 - a. The template will be saved as “Draft”.
 - b. User can come at any time to activate the template.
3. Click Cancel or X button in upper right corner (“Close”).
 - a. A warning is displayed “All changes will be lost. Do you want to continue?”
 - b. Clicking “Ok” will close the panel and discard changes.
 - c. “Cancel” will allow you to continue designing the template.

View or edit template

Steps to access, view and edit templates:

1. Click Care plans and registries templates under Views section.
 - The list displays all the templates by title, category and status.

2. Click on the particular template to display details of the care plan or registry template and edit template details.
3. You can use Search to narrow down your search.
4. Click close X button to close the list.
5. Click on columns to sort by individual column.
- The list can be sorted by all three columns.

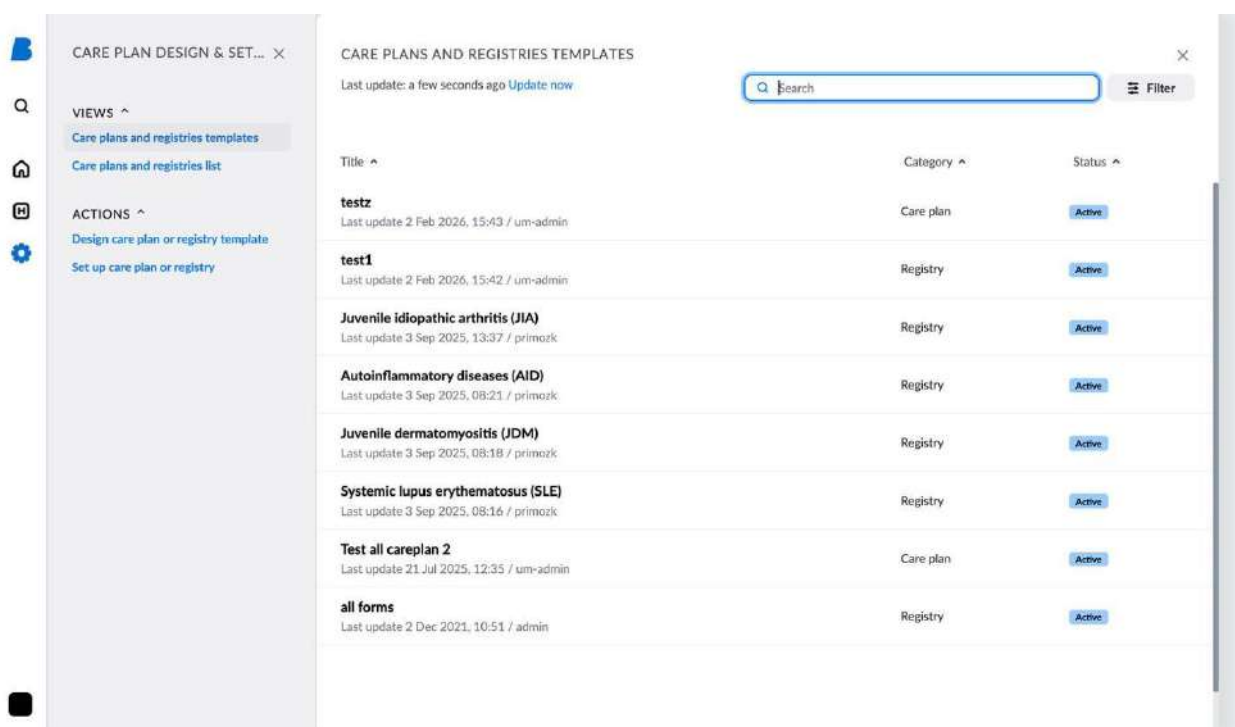


Figure 56. Access to the Care plans and registries templates

Steps to Edit template:

- Select a template from the list of templates.
- Template status can be edited already on the template details view.
 - i. Draft templates can be changed to “Active” (can be used at a later stage to Set up a care plan or registry) or “Retired” (Final status, no changes or usage of this template is possible after the status has been saved.) A special warning is displayed in case of choosing status Retired as the action is irreversible.
 - ii. “Active” templates can only be changed to status “Retired”.
 - iii. Click Save button to save the changes,
 - iv. Click X button to cancel the changes (a warning is displayed)

CARE PLAN TEMPLATE

testz

Version 1 - Last update 2 Feb 2026, 15:43 / um-admin

INFORMATION

Template ID

264

Publisher

testz

Category

Care plan

Purpose

testz

Description

testz

Goal

testz

Status

Active

✓ Active

Retired

Form

Childhood Health Assessment Questionnaire (CHAQ)

Classification Criteria for Idiopathic Inflammatory Myopathies

COVID-19 survey

Damage item AID

Juvenile Arthritis Disease Activity Score (JADAS)

Filled in by

Practitioner

Practitioner

Practitioner

Practitioner

Practitioner

Edit

Save

Figure 57. Ability to change the template status within the care plan/registry details page

CARE PLAN TEMPLATE

testz

Version 1 - Last update 2 Feb 2026, 15:43 / um-admin

INFORMATION

Template ID

264

Publisher

testz

Category

Care plan

Purpose

testz

Description

testz

Goal

testz

Status

Active

✓ Active

Retired

Form

Childhood Health Assessment Questionnaire (CHAQ)

Classification Criteria for Idiopathic Inflammatory Myopathies

COVID-19 survey

Damage item AID

Juvenile Arthritis Disease Activity Score (JADAS)

Filled in by

Practitioner

Practitioner

Practitioner

Practitioner

Practitioner

Edit

Save

Are you sure you want to change the template to a final status? After confirmation no further changes will be possible.

Confirm

Cancel

Figure 58. Additional warning for the user in case when choosing the »Retired« status

- Click Edit button in the right left corner to open the template in edit.
- Click Publish button to save the changes.
- Click Cancel or X button to discard and cancel all changes made (a warning is displayed)

Set up Care plan or Registry

In order for an institution to follow patients within a specific Care plan/Registry, it needs to “Set up care plan or registry”. Setting up a care plan allows institutions to customize pre-existing templates to own institution needs and add users that can manage patients within the care plan or registry. Currently you can only set up care plans or registries that require patient consent.

Steps to Set up care plan or a registry:

1. Select Set up care plan or registry from the list of actions within User dashboard.
2. Select one of the available templates from the list.
 - i. Only templates in Active status can be used to set up a care plan or registry.
 - ii. You can query for a specific template by using Search and Select it from the list.
 - iii. Hover over an individual template to highlight the selected template.
 - iv. Click on the View details to display template information.
 - v. Select a template, by clicking on it.
3. A panel to Set up chosen care plan/registry is displayed.

SET UP CARE PLAN OR REGISTRY

Search

Title	View details
test2	View details
test1	View details
Juvenile idiopathic arthritis (JIA)	View details
Autoinflammatory diseases (AID)	View details
Juvenile dermatomyositis (JDM)	View details
Systemic lupus erythematosus (SLE)	View details
Test all careplan 2	View details
all forms	View details

Details for Juvenile idiopathic arthritis (JIA):

- Title: Juvenile idiopathic arthritis (JIA)
- Template ID: 208
- Category: Registry
- Version: 3
- Last changed: 3 Sep 2025
- Description: -
- Goal: Doctor SLO
- Publisher: UM Admin
- Purpose - Primary: Diseases and conditions: disease surveillance, control, natural course of disease
- Purpose - Secondary: Health outcomes (objective, patient reported)

Figure 60. Set up care plan or registry template and detailed template view

4. You can change the care plan Title and Description for the care plan or registry to accommodate the institutions specifics and add additional Comment.
5. Under section USERS, you add one or more users by clicking +Add users.
 - a. These users will have permission to manage patients in this particular care plan or registry.
6. When you finished you can decide to save the Draft by clicking on Save progress or click Publish to make the care plan available for usage.
 - a. A published care plan or registry is ready to include patients.
7. You can dismiss your work by selecting Cancel or X button in upper right corner ("Close").
 - a. Both actions will take you to the Care plans and registries list.
8. A successfully published care plan will display a popup at the bottom of the screen.
9. The application opens view Care plans and registries list.

CARE PLAN DESIGN & SET... X

VIEWS ^

Care plans and registries templates

Care plans and registries list

ACTIONS ^

Design care plan or registry template

Set up care plan or registry

SET UP REGISTRY X

Juvenile dermatomyositis (JDM)

Template used: Juvenile dermatomyositis (JDM) - Template ID: 209 - Category: Registry - Publisher: Doctor SLO - Goal: - Content: Diagnosis details Classification Criteria for Idiopathic Inflammatory Myopathies Childhood Myositis Assessment Scale (CMAS) Manual muscle testing (MMT) Growth chart - Input parameters Medications Adverse events Laboratory results Imaging and other investigations Magnetic resonance imaging findings for JDM Muscle biopsy findings Myositis damage index Physician global disease damage assessment Physician global activity assessment Patient parent global activity assessment Childhood Health Assessment Questionnaire (CHAQ) Tanner stages Clinical manifestation JDM

INFORMATION

Title*

Juvenile dermatomyositis (JDM)

Description

Comment

Add Comment

Patient consent

Required: Yes

Cancel

Save progress

Publish

Figure 61. Pre-populated care plan or registry based on the chosen template

Care plans and registries list

Steps to access Care plan/Registry:

- c) Click Care plans and registries list under section Views on User Dashboard.
- d) The list displays all care plans and registries by Title, Category and Status. The list can be sorted by all three columns.
- e) Click on the particular Care plan/Registry to View details of the care plan or registry and access to editing functionality.

Steps to Edit Care plan/registry:

1. Click on selected Care plan/registry to open care plan details.
2. Change the status of an item by selecting a dropdown list under section Status.
 - i. Statuses Completed, Entered in error, and Revoked are FINAL STATUSES. Any changes to this item upon saving any of the above status will not be possible anymore. These statuses are irreversible.
 - ii. Before saving item with a final status a warning is displayed.
3. Click Edit button in the right left corner to open the Care plan in edit mode.
4. Once all changes have been made, click Save to save the changes.
5. Click Cancel or Close to discard all changes made.
 - i. A warning will be displayed to confirm discarding any changes made.

CARE PLAN DESIGN & SET... X

VIEWS ^

- Care plans and registries templates
- Care plans and registries list

ACTIONS ^

- Design care plan or registry template
- Set up care plan or registry

CARE PLANS AND REGISTRIES LIST

Last update: a few seconds ago [Update now](#)

Search Filter

Title ^	Category ^	Status ^
test1 Last update 3 Feb 2026, 12:07 / um-admin	Registry	Active
Juvenile idiopathic arthritis (JIA) Last update 3 Sep 2025, 13:38 / primozk	Registry	Active
Autoinflammatory diseases (AID) Last update 3 Sep 2025, 13:36 / primozk	Registry	Active
Juvenile dermatomyositis (JDM) Last update 3 Sep 2025, 13:35 / primozk	Registry	Active
Systemic lupus erythematosus (SLE) Last update 3 Sep 2025, 13:35 / primozk	Registry	Active
all forms Last update 27 Aug 2025, 14:23 / um-admin	Registry	On hold
Test all careplan 2 Last update 14 Mar 2022, 18:07 / admin	Care plan	Active

Figure 62. Access to the Care plans and registries list.

REGISTRY

test1

Version 1 - Last update: 3 Feb 2026, 12:07 / um-admin

INFORMATION

Registry ID
266

Template
test1

Template ID
263

Category
Registry

Description
test1

Goal
test1

Publisher
test1

Purpose - Primary
Services or events: intervention, evaluation, quality of care

Purpose - Secondary
Intervention (planing, guidelines, reminders)

Patient consent
Required

Content
**Diagnosis details
Damage item AID
COVID-19 survey**

STATUS

Active

✓ **Active**

Completed

Entered in error

On hold

Revoked

Edit

Save

Figure 63. Changing status of care plan/registry

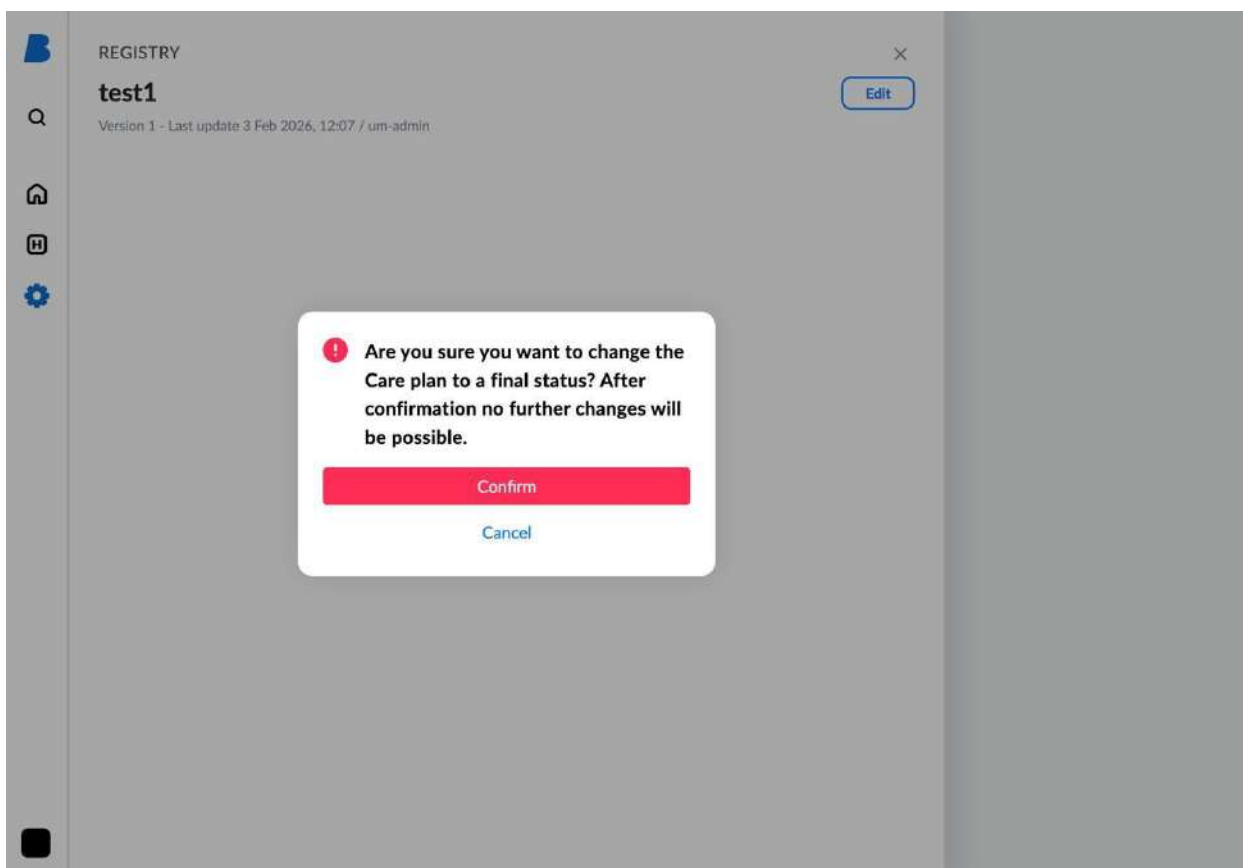


Figure 64. Warning displayed before registry status change

Include patient into Care plan/Registry

The final step before being able to use the care plan or registry is to include patients into the Care plan/Registry. Patient is included in a Care plan/Registry via a consent form. By including a patient into a care plan/registry user will have the assessment forms (content) available directly from the individual patient dashboard.

Steps to include patient into a care plan or registry:

1. Open a specific patient (either from a Patient list or using Patient Search).
2. On Patient dashboard under actions select option Include in Care plan or Registry.
3. List of active care plans and registries in which user is included is displayed.
4. You can search for a specific care plan/registry by name.
5. Before a Care plan/Registry is selected, you can View details of the care plan/registry to make sure it is the correct one.
6. Select Care plan/Registry by clicking on selected line.
7. After selecting a Care plan/Registry, consent form is opened and must be filled out.
 - a. Only mandatory data is the status of the consent, which can be Provided or Refused at the moment of including the patient in a care plan/registry for the first time.

- b. Other data that can be filled out:
 - i. Description: free text that describes activity performed against the plan
 - ii. Reason: free text that describes reason of patient inclusion in a care plan/registry
 - iii. Multimedia: this provides an option to upload e.g. a scanned document of a signed consent.
 - iv. Start/end date: duration of consent validity
8. After you save the consent, patient is included in selected care plan/registry.
9. All care plan/registry inclusions for a patient are seen under Care plans or Registries on Patient Dashboard.
10. After patient is included in the Care plan/Registry, go to Patient Dashboard
11. Select Start assessment under section Actions and only forms for the included care plans and registries are displayed for that patient.

If patient is already included in a care plan/registry and you want to include a patient in the same care plan/registry again, a warning is shown that the patient is already part of the care plan/registry and a screen with existing consent details is opened. You can then make changes on existing consent.

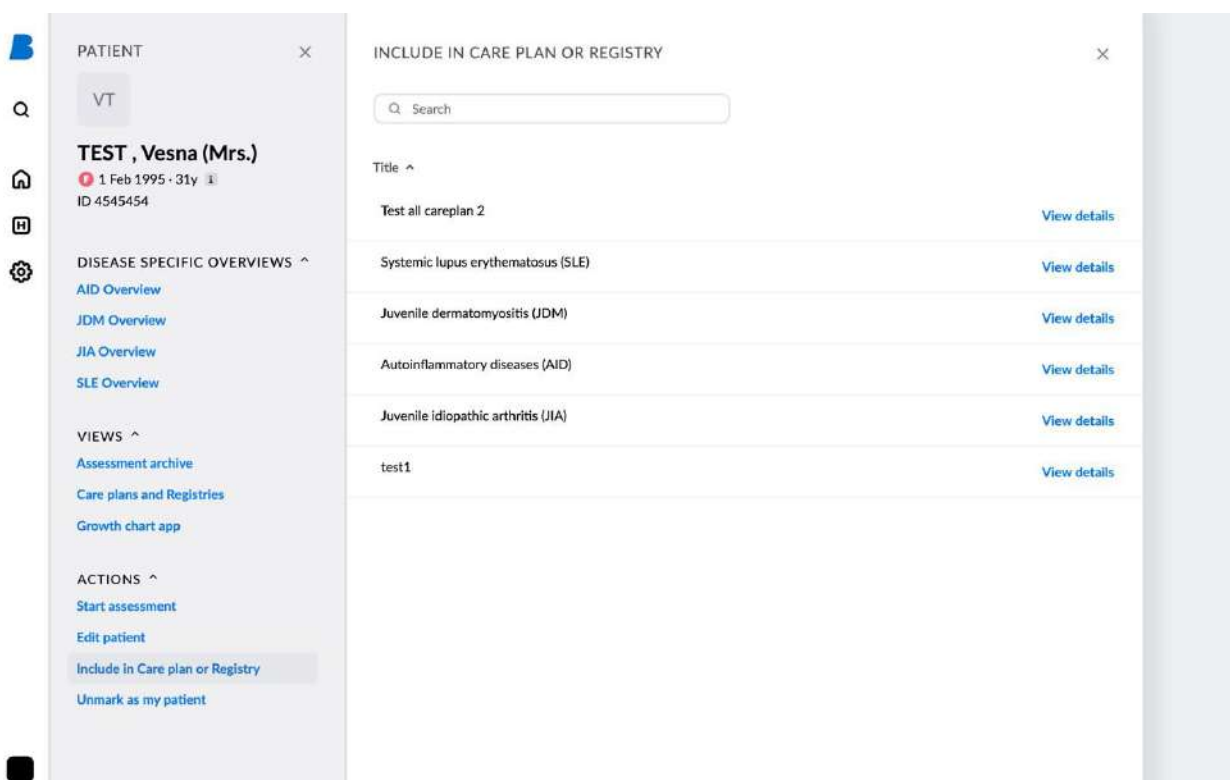


Figure 65. Search patient in the search dialog or open Patient list and Include in care plan

INCLUDE IN CARE PLAN OR REGISTRY [Close]

TEST, Vesna [Red dot] 1 Feb 1995 · 31y [ID icon] ID 4545454

Care plan inclusion information

Care Plan Name: **test1**

Description [?] **test1** [Close]

Reason: [Empty field]

Care Plan ID: **CarePlan/266**

Patient Consent

☒ Provided
 ☐ Refused
 ☐ Revoked
 ☐ Completed
 ☐ Cancelled

Multimedia: Drop here or [browse](#)

Start date: dd/MM/yyyy [Calendar icon] HH: MM

End date: dd/MM/yyyy [Calendar icon] HH: MM

Version info [Empty field]

Save

Figure 66. Complete the missing and mandatory information to include the patient

View or edit patient inclusion in a Care plan/Registry

List of care plans/registries in which a patient is included can be found under Care plans and Registries on Patient Dashboard. There are three tabs providing lists filtered by status of consents - All, Active and Completed.

For easier overview 2 statuses are presented on each item on the list - status of patient consent and status of the Care plan/Registry. Steps to View patient inclusion:

1. Click on the item from the list,
2. Details of the inclusion of patient in the Care plan/Registry are displayed,
3. Under section CONTENT a list of forms that belong to the Care plan/Registry is displayed
4. Select a form to fill it out.

If a care plan/registry is in any other status than Active, then user is warned that he is filling out a form for a care plan/registry that is not Active. Steps to Edit patient inclusion:

1. Click Edit button on consent details screen,
2. A screen for consent editing is displayed,
3. Consent status can be changed at any time.

Patient can be included in a Care plan/Registry only once, afterwards only the status of existing consent can be changed.

Possible status values are: Provided, Refused, Revoked, Completed, Cancelled.

PATIENT X

VT

TEST , Vesna (Mrs.)
1 Feb 1995 - 31y ID 4545454

DISEASE SPECIFIC OVERVIEWS ^

- AID Overview
- JDM Overview
- JIA Overview
- SLE Overview

VIEWS ^

- Assessment archive
- Care plans and Registries
- Growth chart app

ACTIONS ^

- Start assessment
- Edit patient
- Include in Care plan or Registry
- Unmark as my patient

CARE PLANS AND REGISTRIES X

TEST , Vesna 1 Feb 1995 - 31y ID 4545454

ALL (2) ACTIVE (2) COMPLETED (0)

test1

Consent Active Careplan/Registry Status: Active

Test all careplan 2

Consent Active From 1 Aug 2025 Careplan/Registry Status: Active

Figure 67. List of care plans/registries in which patient is included

Q

REGISTRY

test1

TEST, Vesna

1 Feb 1995 - 31y

ID 4545454

INCLUSION

Patient consent

Consent Active, 3 Feb 2026

Duration

-

Purpose

Comment

-

Multimedia

-

Edit

CONTENT

Form

Diagnosis details

Damage Item AID

COVID-19 survey

Figure 68. Consent details for a care plan of a patient

Q

INCLUDE IN CARE PLAN OR REGISTRY

TEST, Vesna

1 Feb 1995 - 31y

ID 4545454

Care plan inclusion information

Care Plan Name

test1

Description

test1

Reason

Care Plan ID

CarePlan/266

Patient Consent

☒ Provided
 ☐ Refused
 ☐ Revoked
 ☐ Completed
 ☐ Cancelled

Multimedia

Drop here or [browse](#)

Start date

dd/MM/yyyy

HH: MM

End date

dd/MM/yyyy

HH: MM

Version info

Save

6

Figure 69. Edit existing consent for a patient

Closing remarks

The Better Portal brings together patient management, structured Assessments, and Care plan/Registry configuration into a unified environment that supports both clinical and administrative workflows. By clearly separating operational activities from configuration and permission management, the system enables institutions to maintain structured governance while ensuring efficient day-to-day clinical work. Through standardized documentation, role-based access control, and configurable care frameworks, the Portal supports consistent data entry, improved traceability, and coordinated patient management. This structured approach contributes to greater efficiency, clearer clinical oversight, and more reliable healthcare documentation across the organization.

Better data, better care.

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