



better

**Concerto - User
Manual - Guidelines
for the transfer of
the children's
immune-mediated
diseases database**

Product

Better Portal

Document Version

2.0

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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.

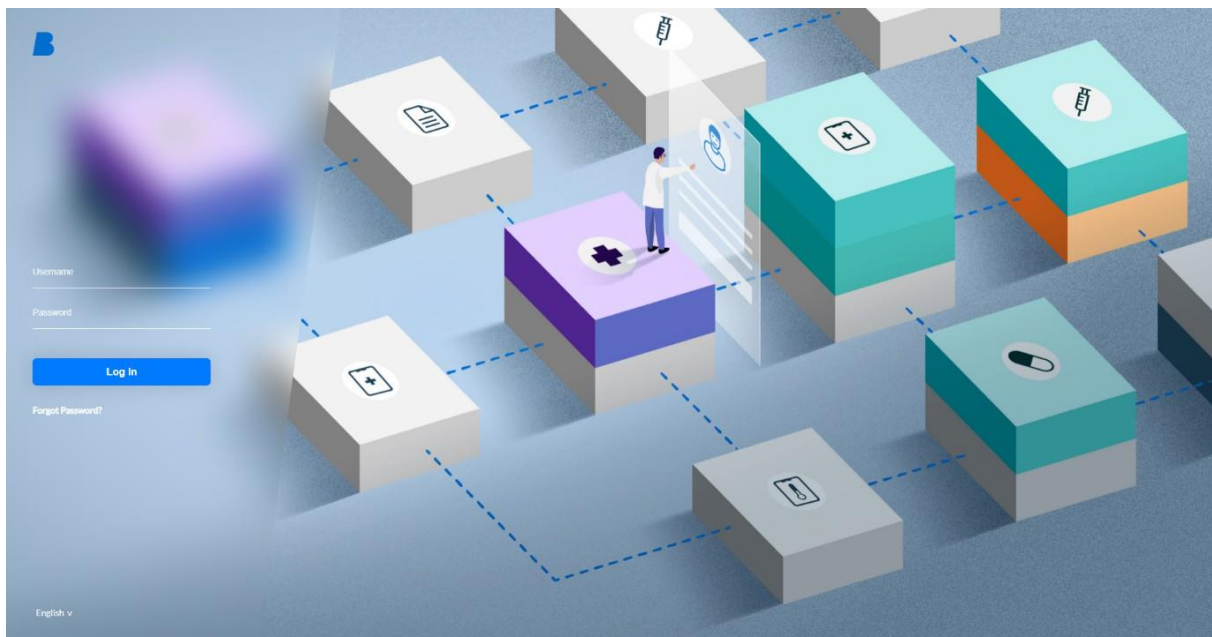


Figure 1. Application login page

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.

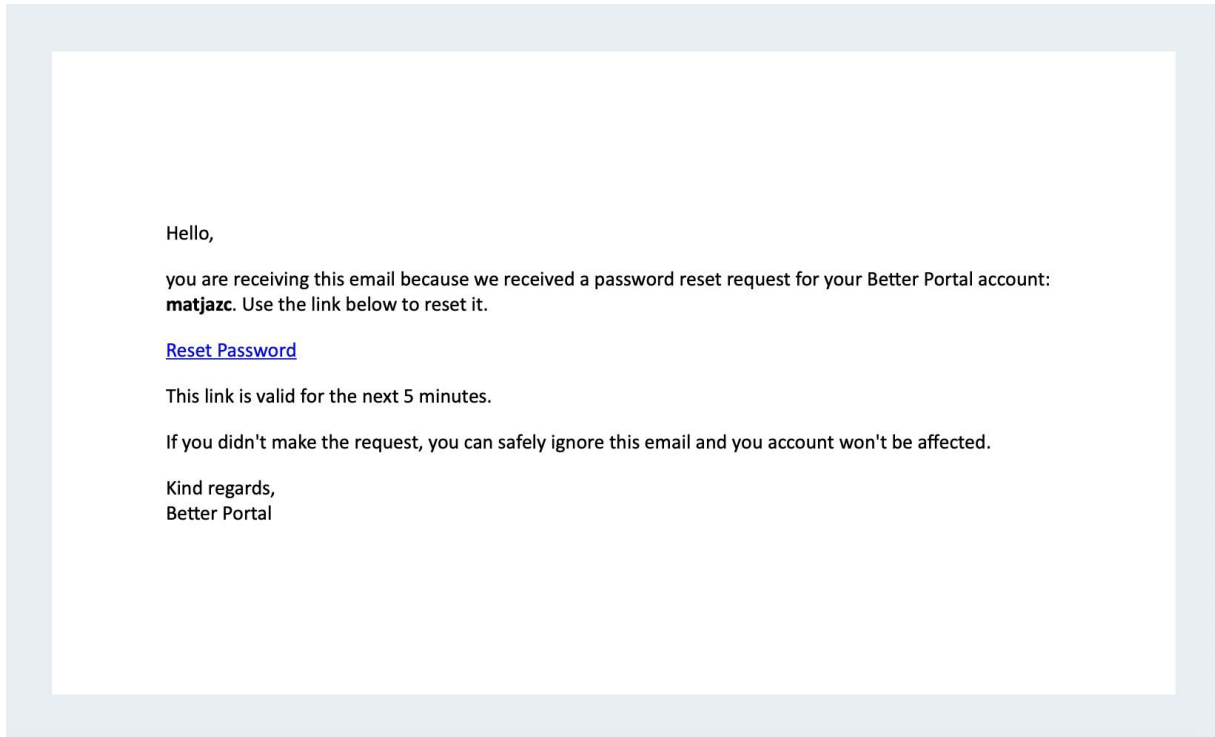
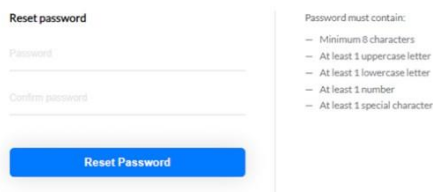


Figure 2. Email for password setup

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.



The image shows a screenshot of the password reset webpage. It features a form with two input fields: "Password" and "Confirm password". Below the fields is a blue button labeled "Reset Password". To the right of the form, there is a list of password requirements:

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

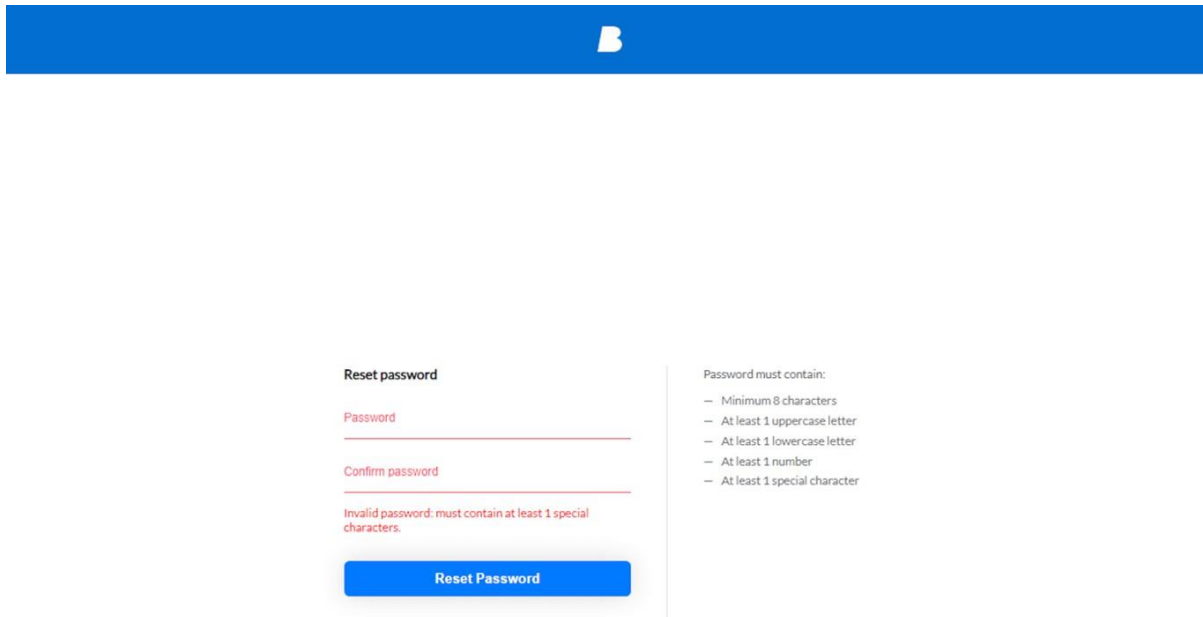


Figure 4. Password reset - password non-compliant to organisational policy

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.

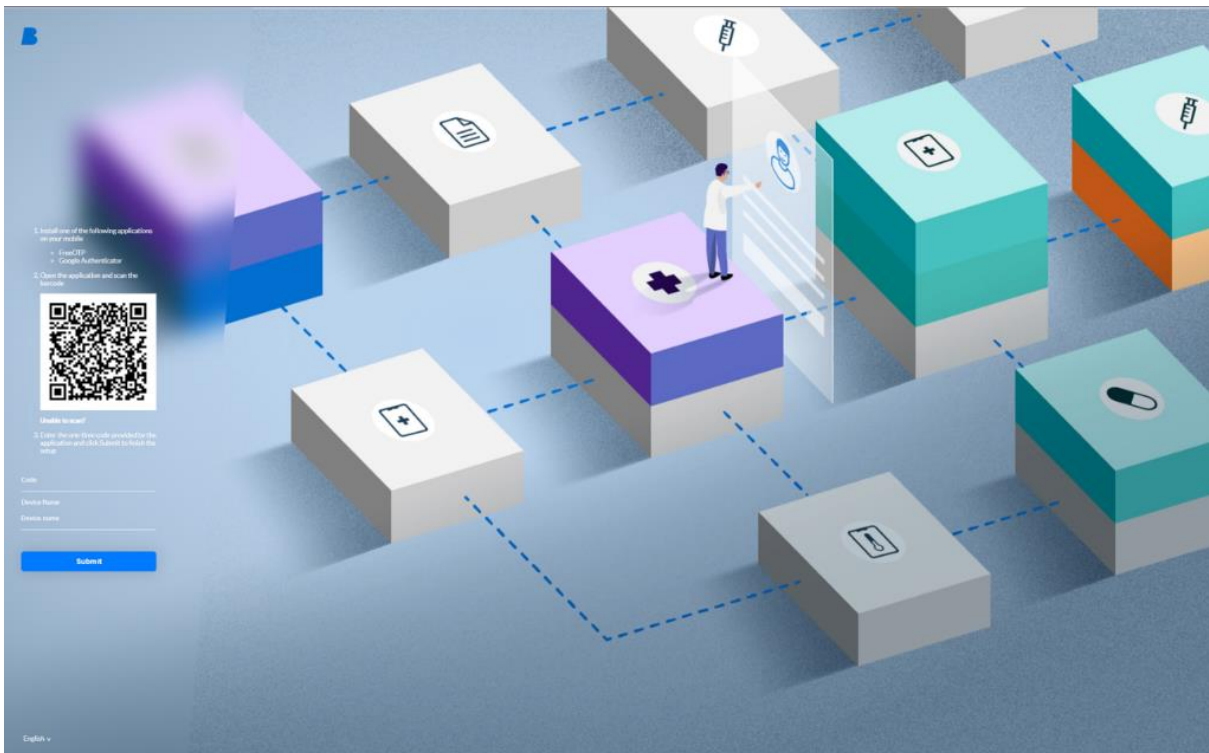


Figure 5. Two-factor authentication set up

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.

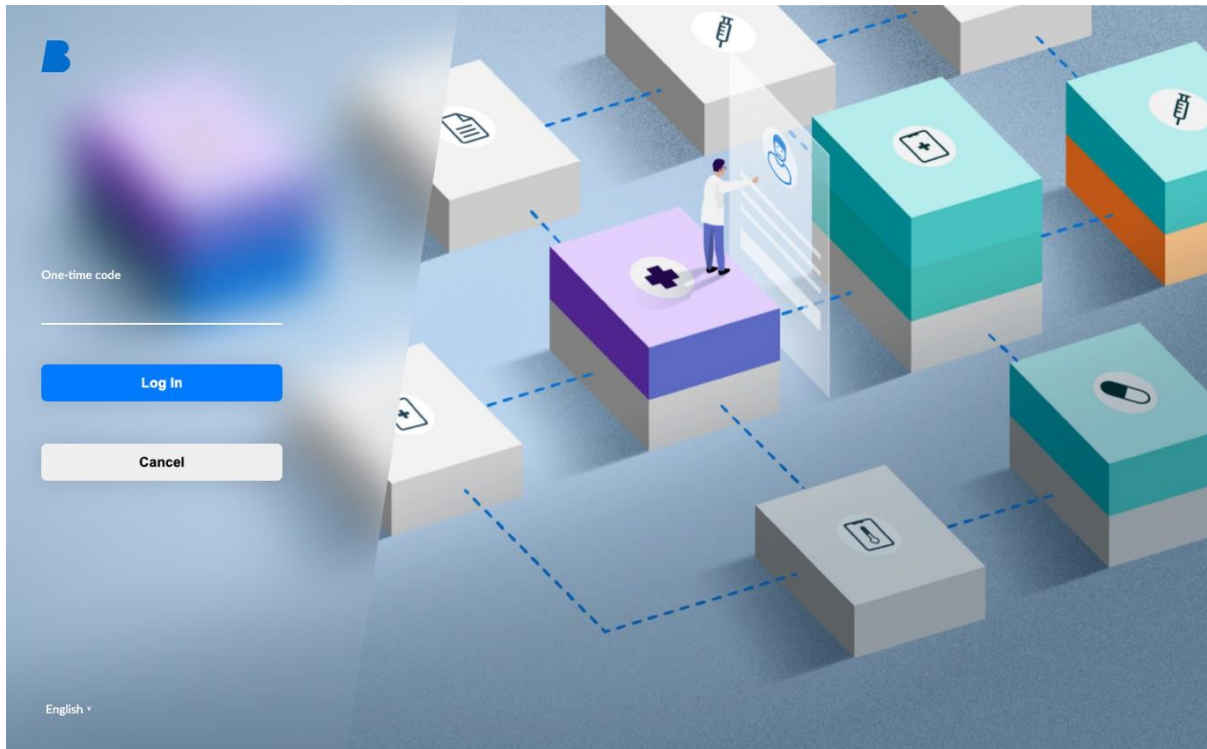


Figure 6. Enter your one-time code generated by authenticator app

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)

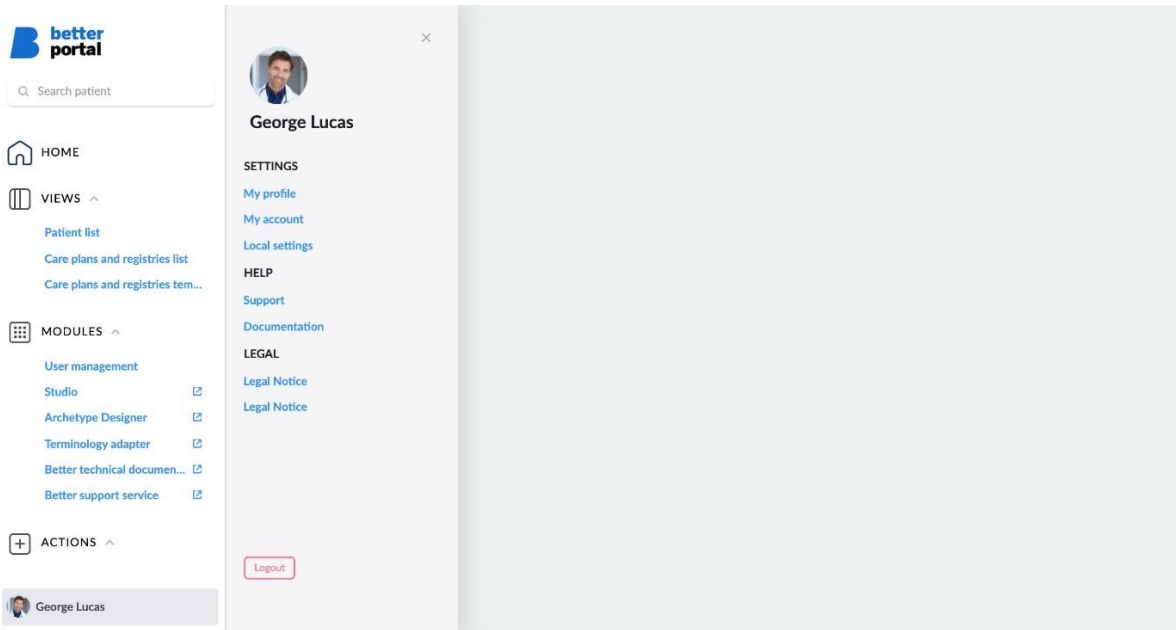


Figure 7. Select Logout from your User Profile dashboard to logout

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.

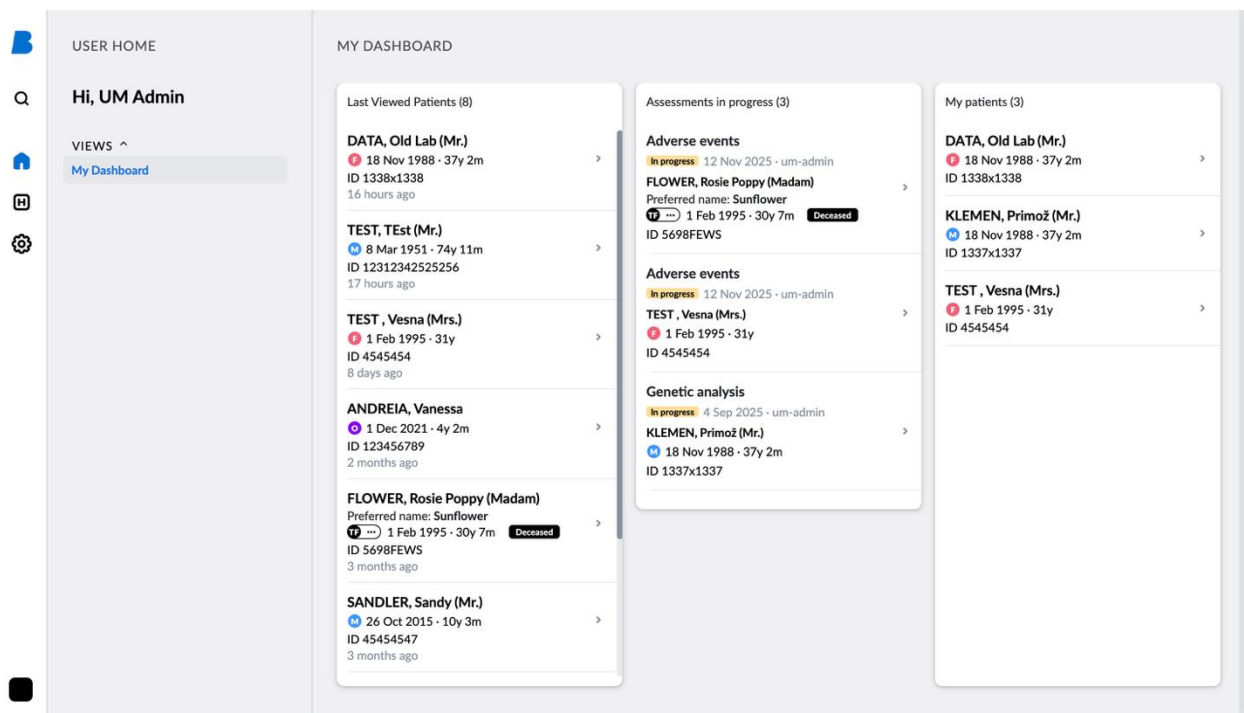


Figure 8. User Dashboard

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.

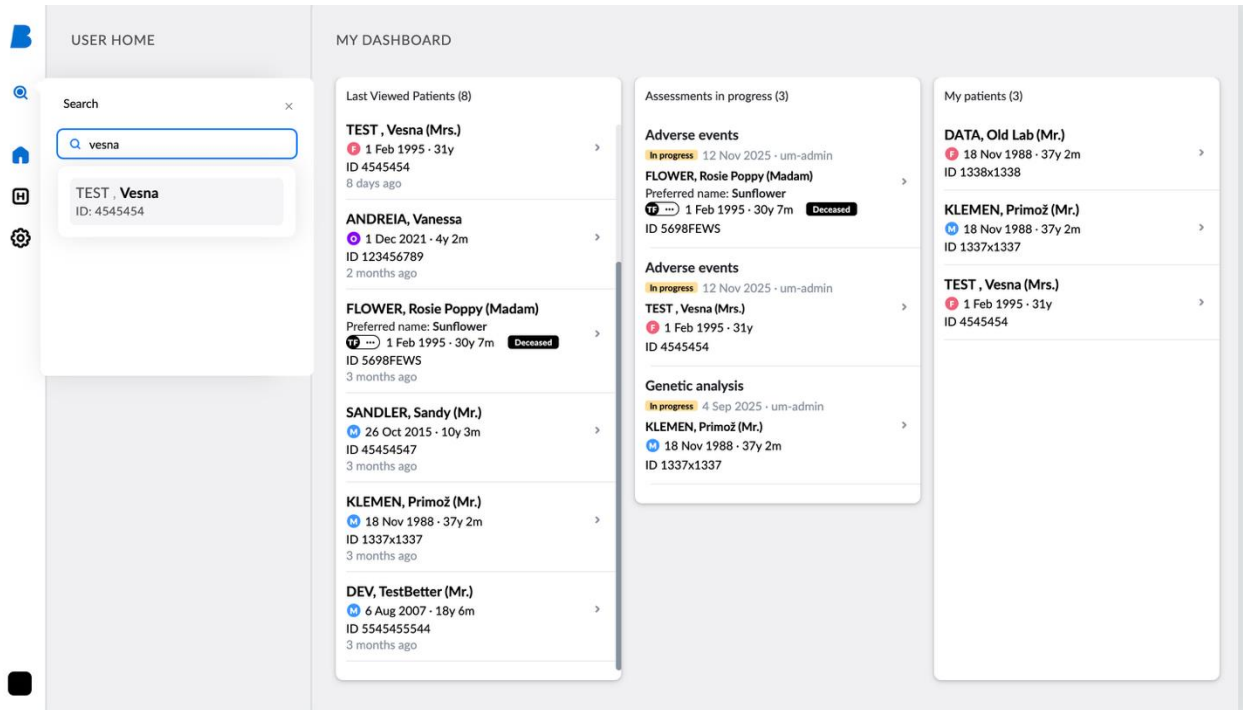


Figure 9. Search is available at the top of your User Dashboard

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.

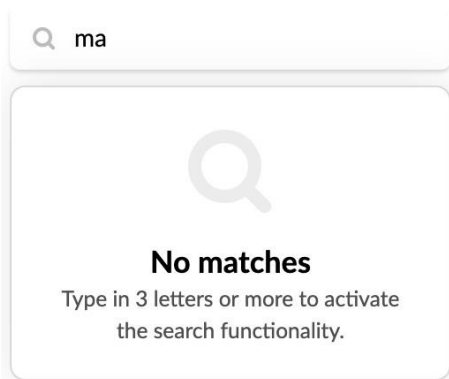


Figure 10. Patient Search is not activated yet

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).

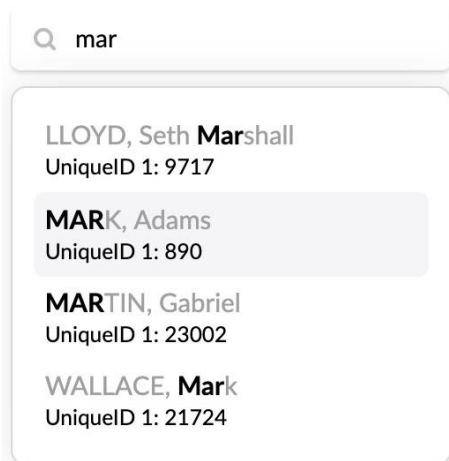


Figure 11. Patient Search results

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.

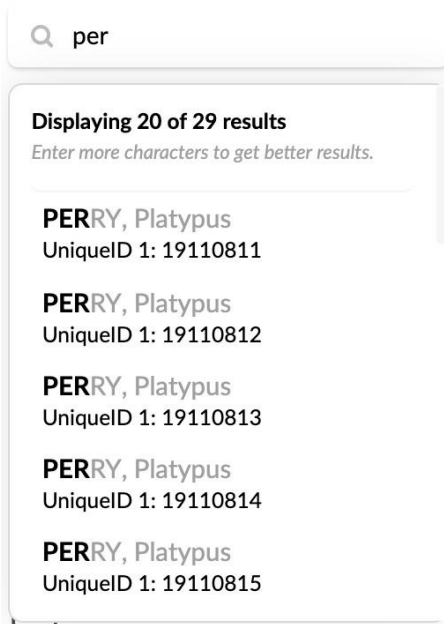


Figure 12. Search results in 29 patients

Searching by unique identifier can be seen on Figure 13.



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.

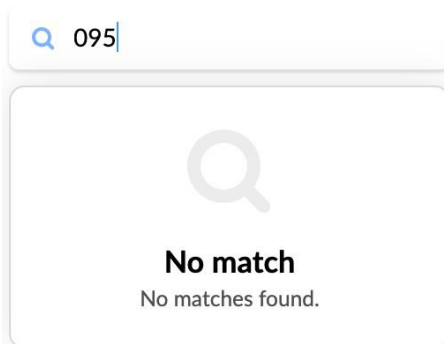


Figure 14. No matches were found

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.

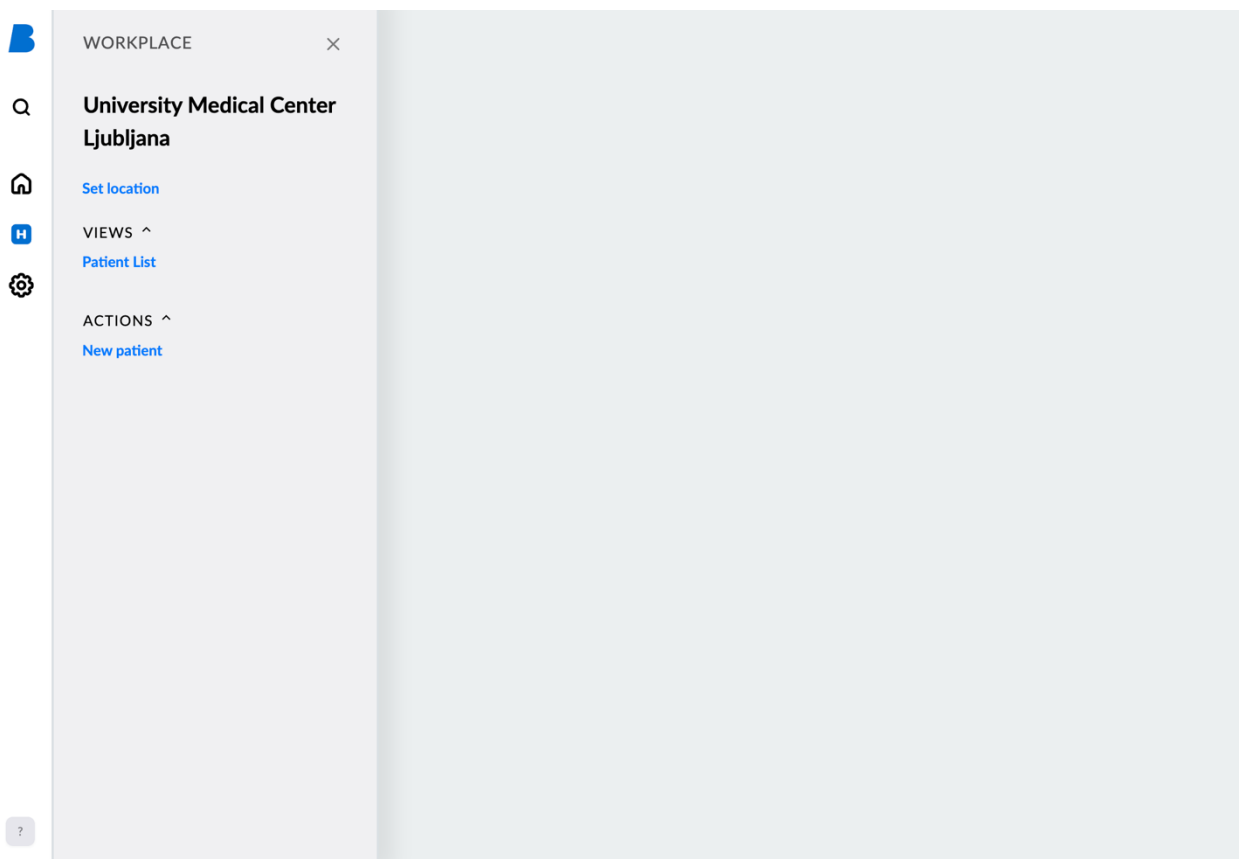


Figure 15. Workplace

New Patient

The New patient button opens a Personal info questionnaire, used for registering a new

patient.

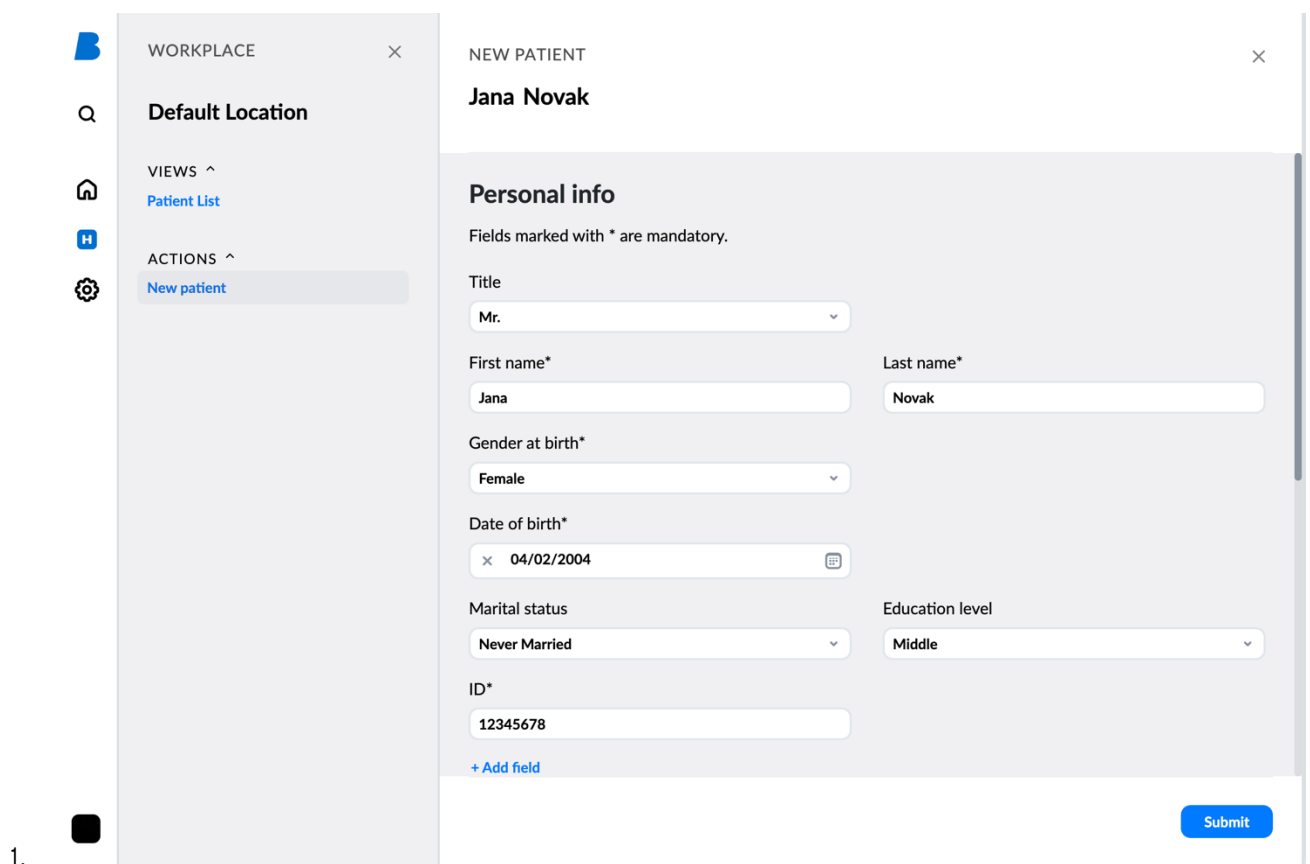
Depending on your organisation's configuration, patients' demographic data can:

- a) Come from an external system – usually from Patient Administration System (PAS).
- b) 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:

1. Select “New patient” from your Workplace under Actions section.
2. New patient form opens to the right
3. 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.

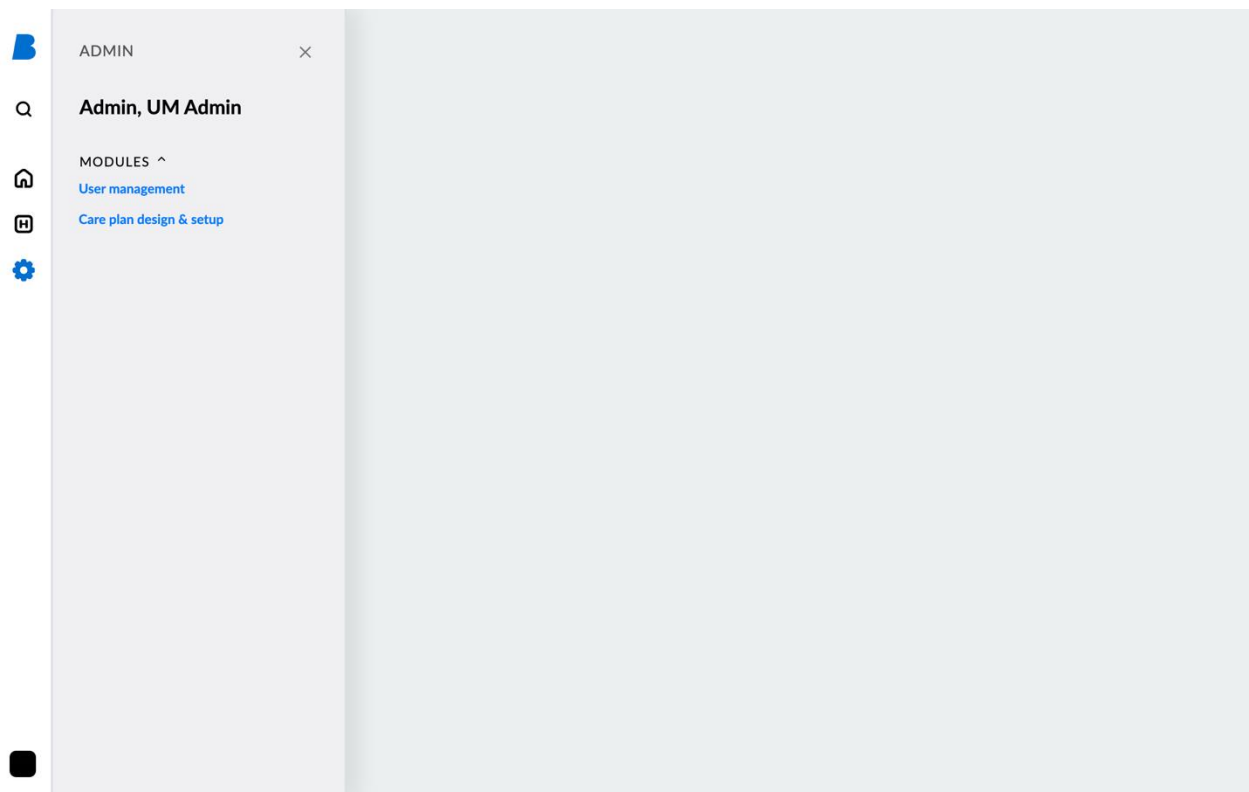


Figure 17. Admin

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

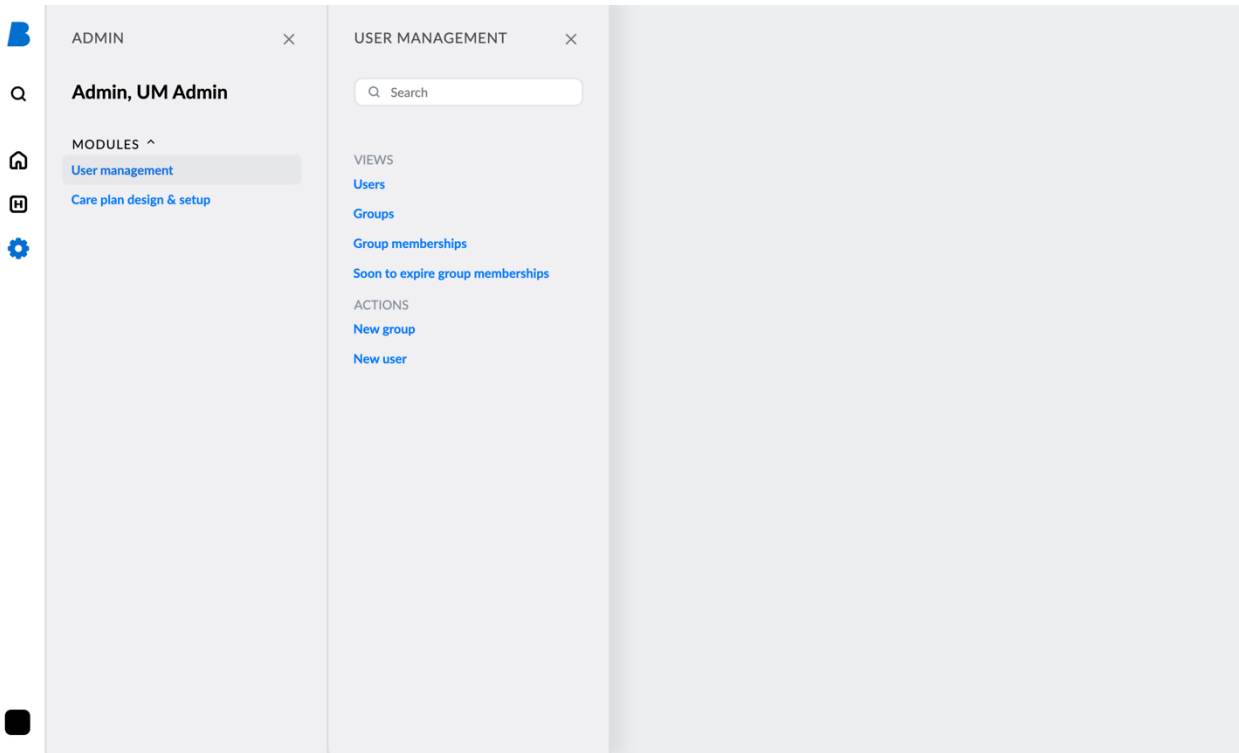


Figure 17. User management

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.

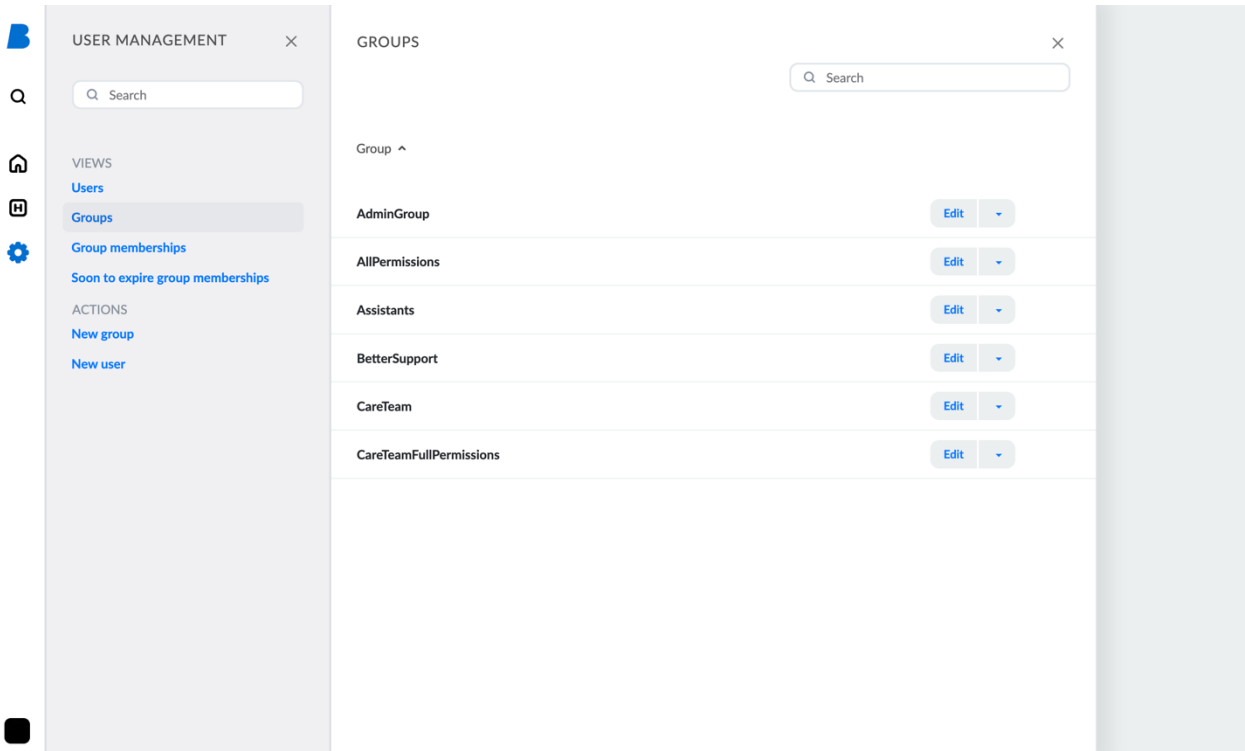


Figure18. Groups

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.

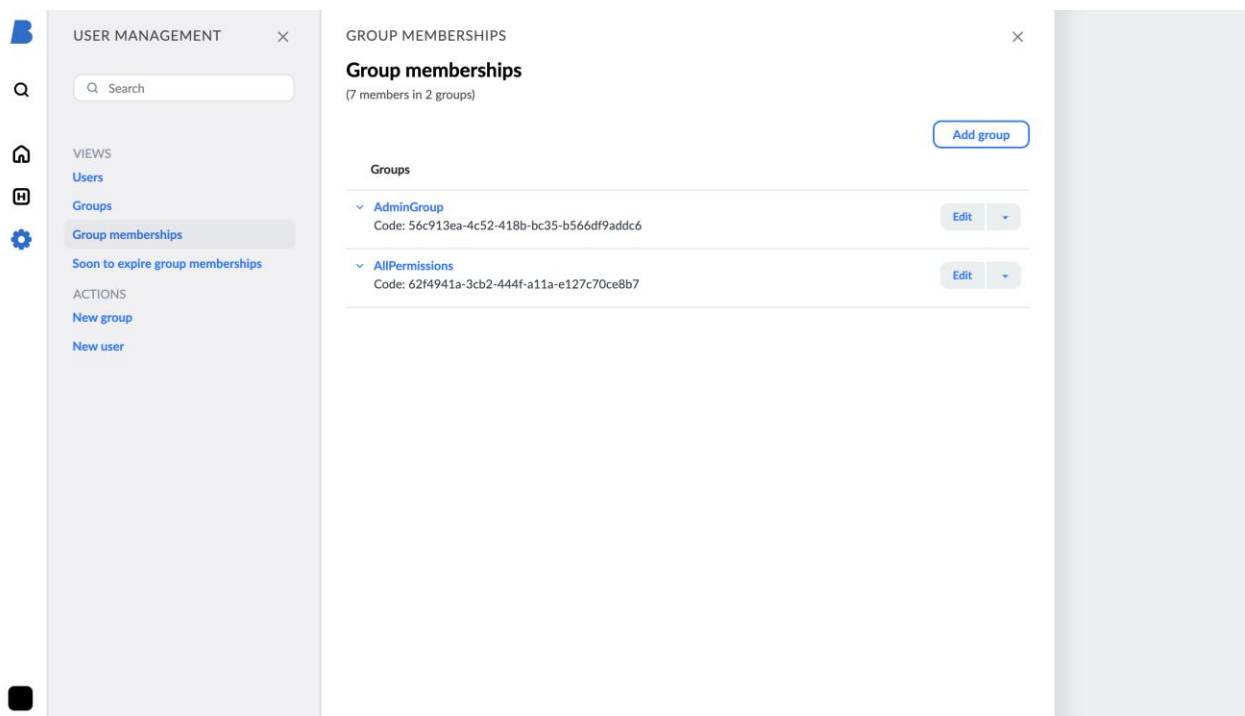


Figure 19. Group membership

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.

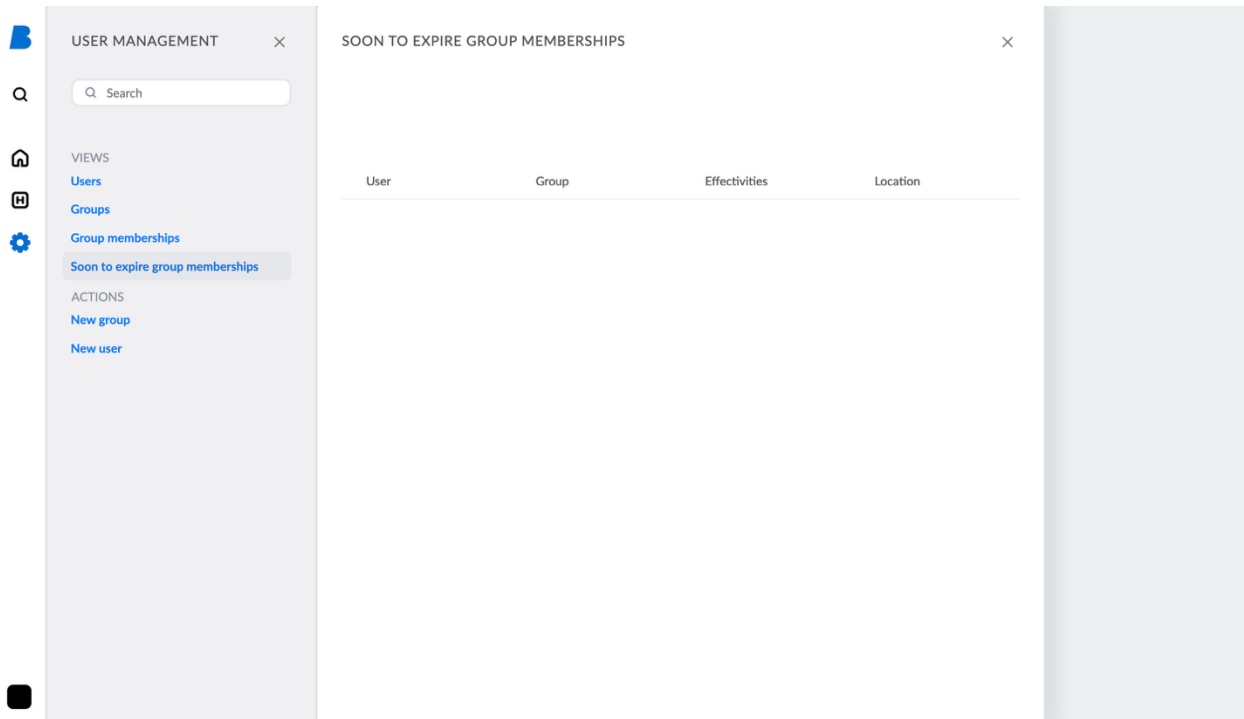


Figure 20. Soon to expire group memberships

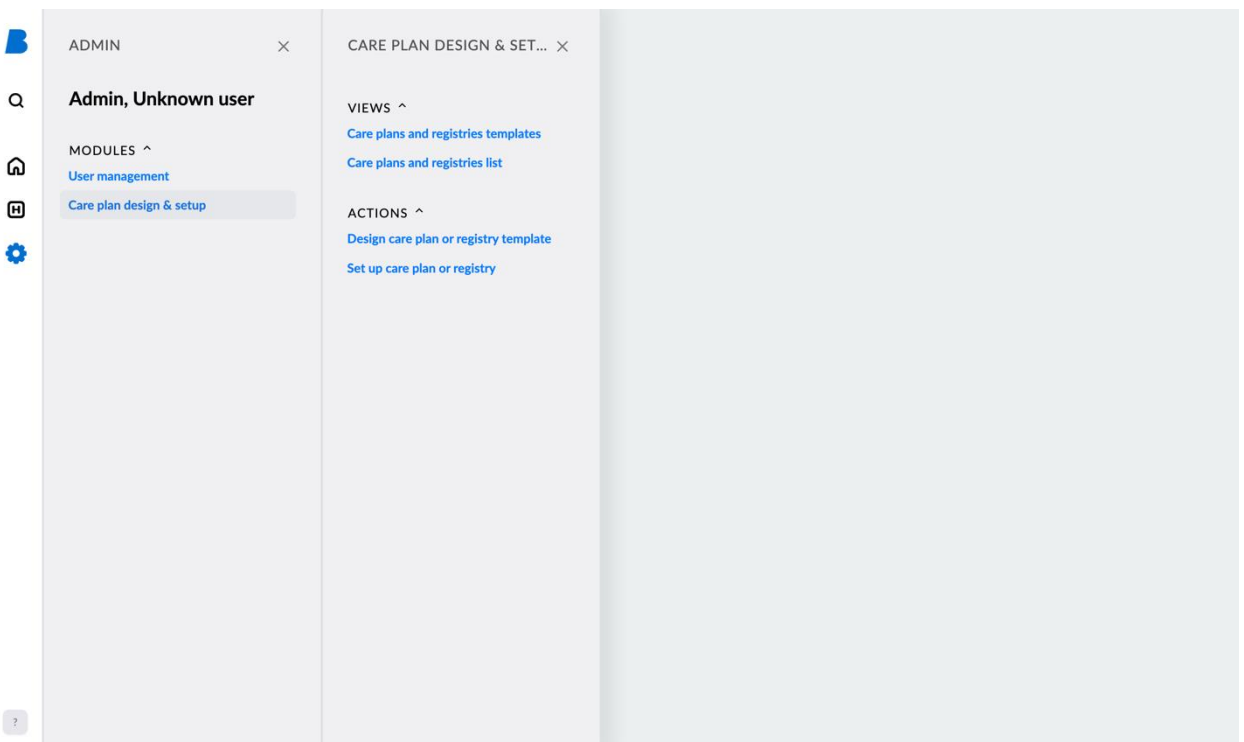


Figure 21. Care plan design & setup

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.

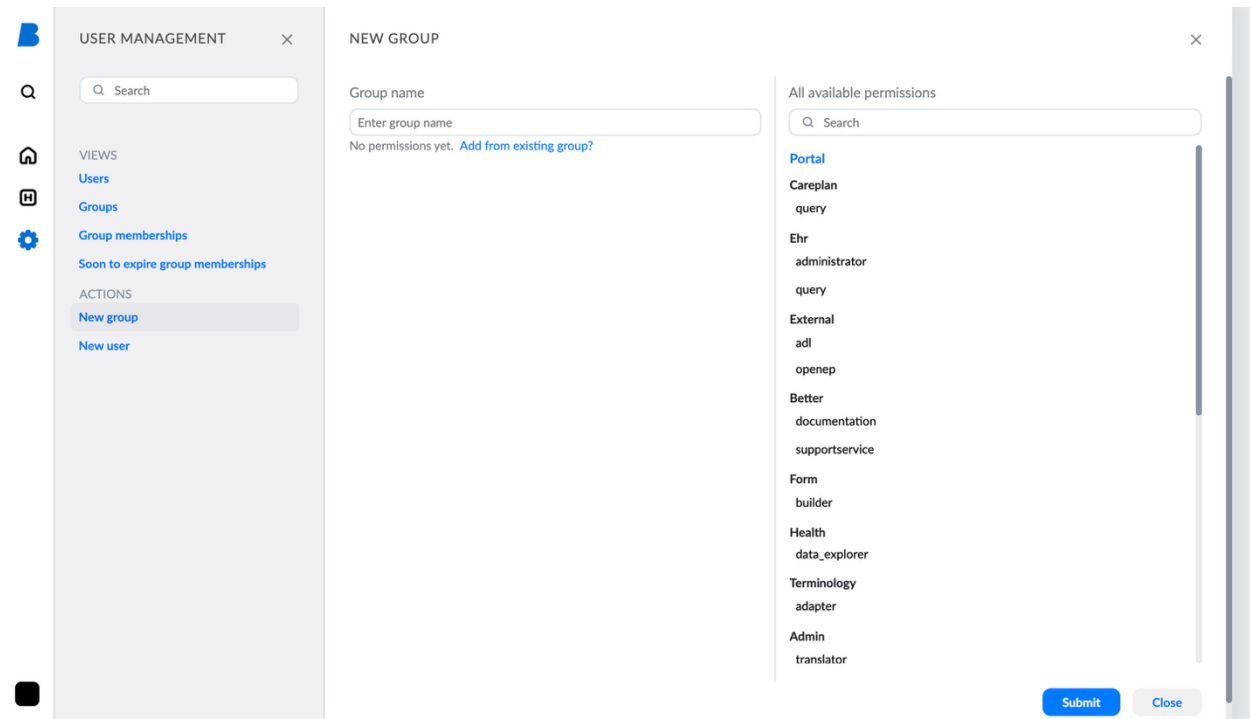


Figure 22. New group

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.

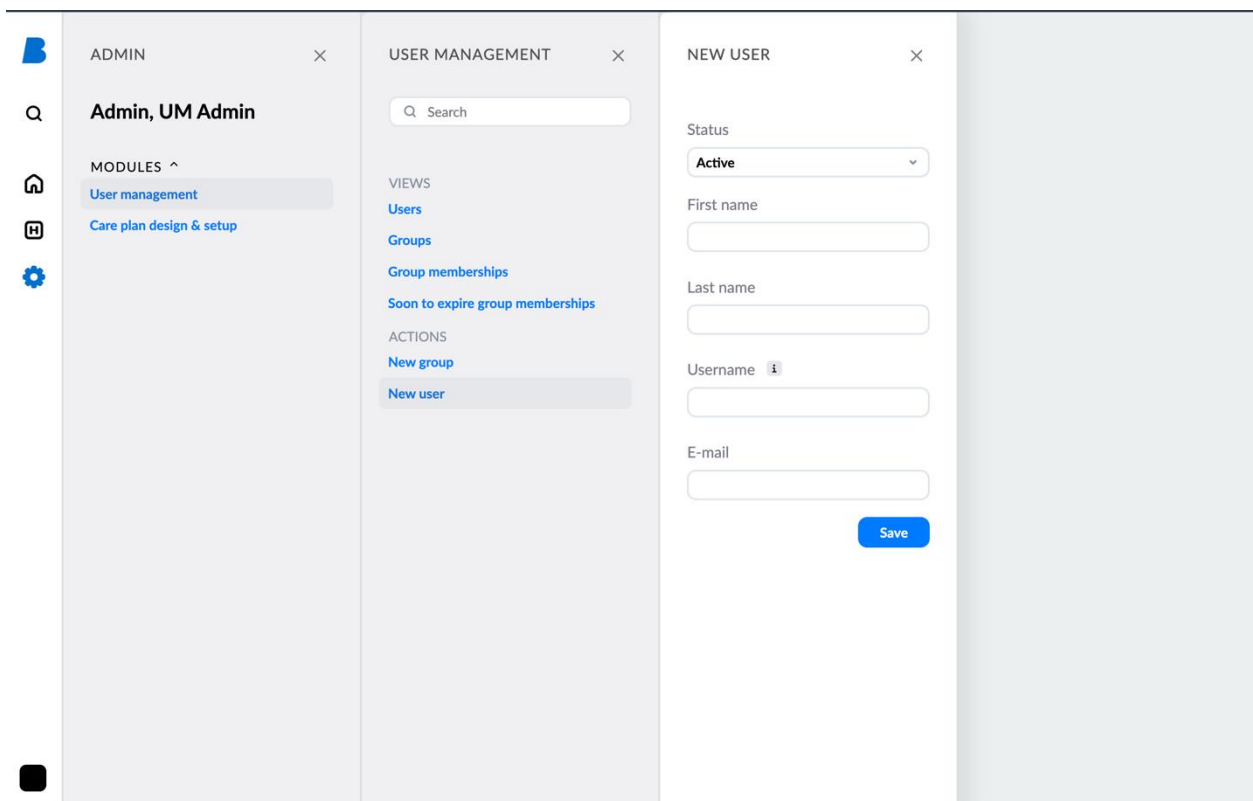


Figure 23. New user

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 you 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:

- a) Simplified user profile (only giving you the possibility to log out via the user profile)
- b) 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.

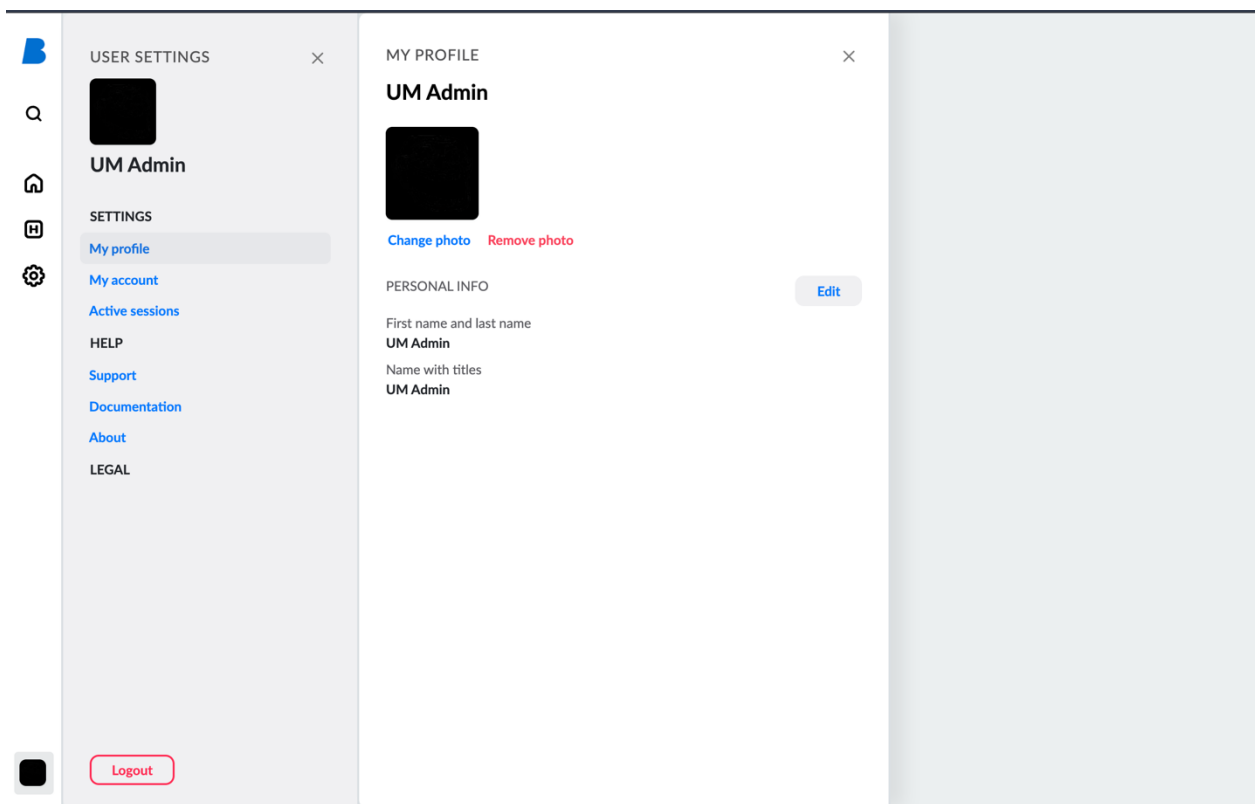


Figure 24. My profile

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.

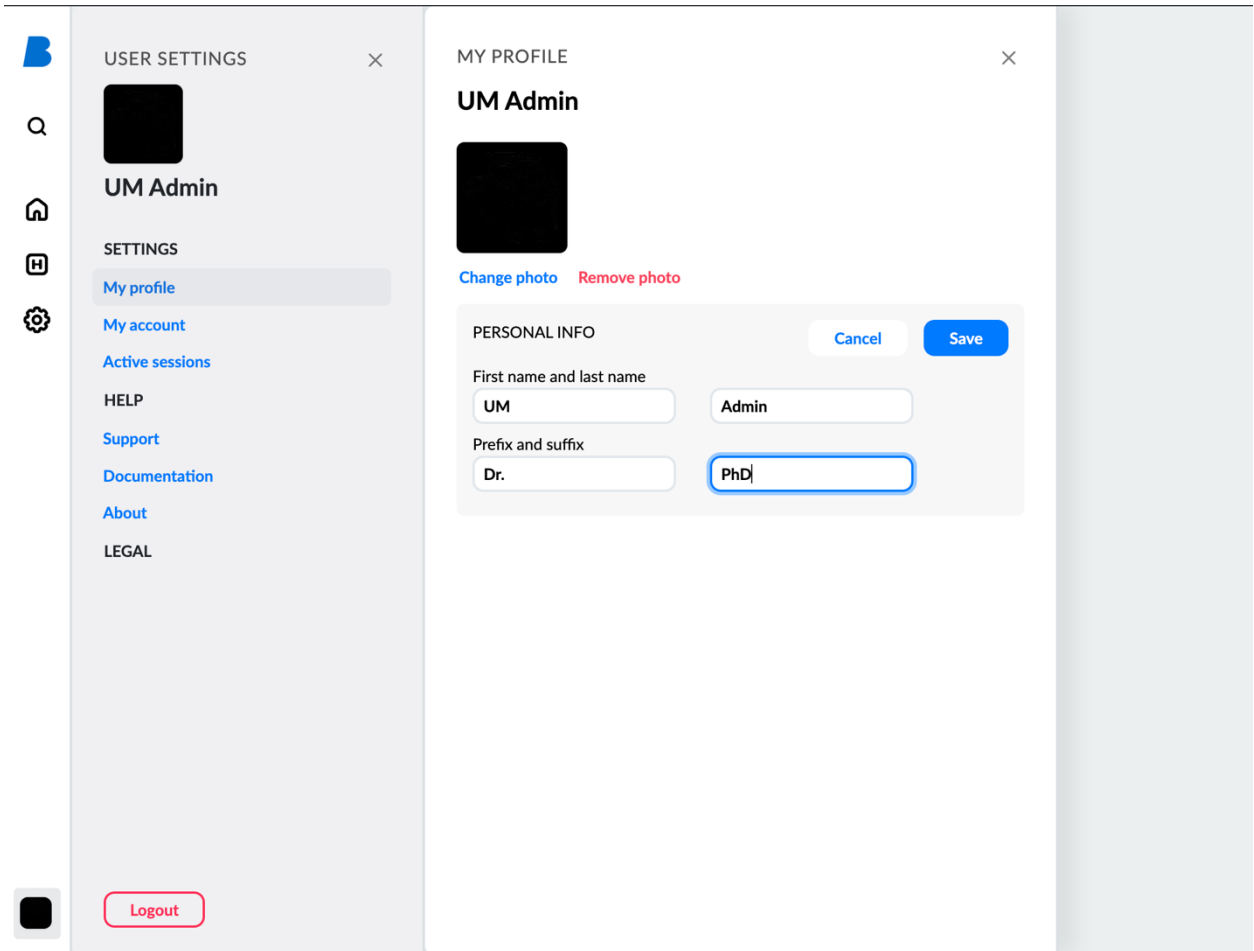


Figure 25. Changing titles

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.

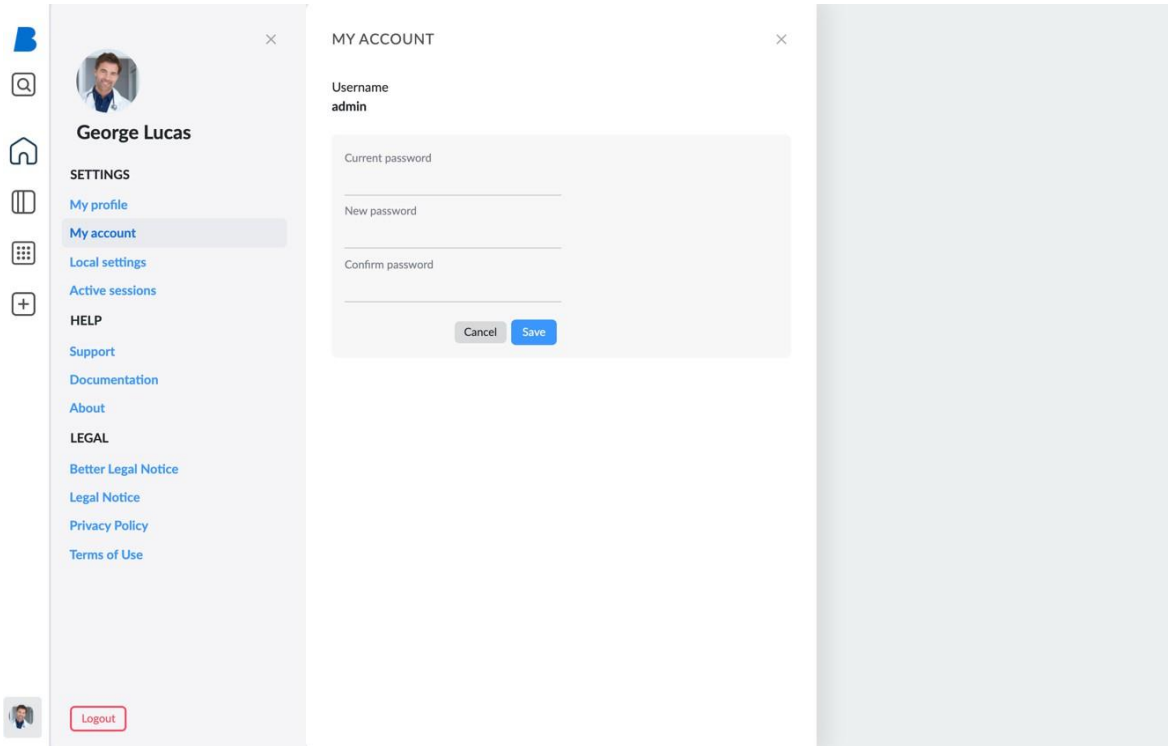


Figure 26 Change your password

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.

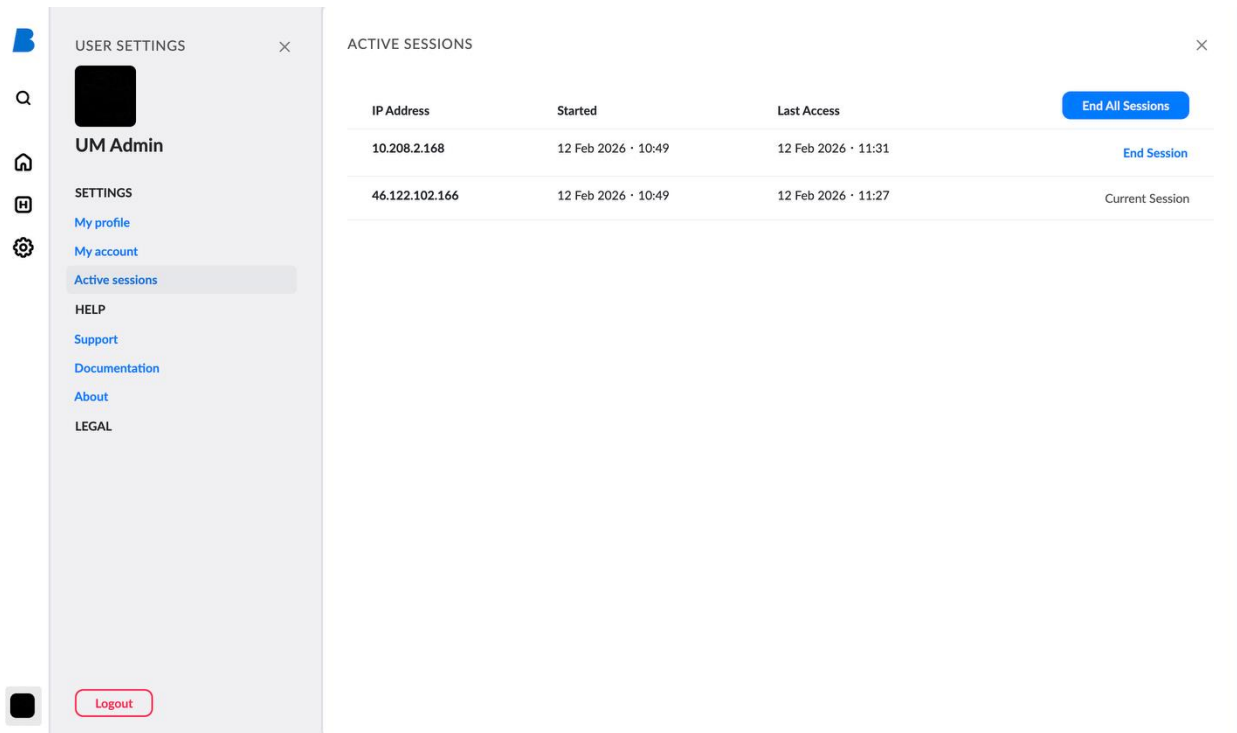


Figure 27. Managing your active sessions

Support

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

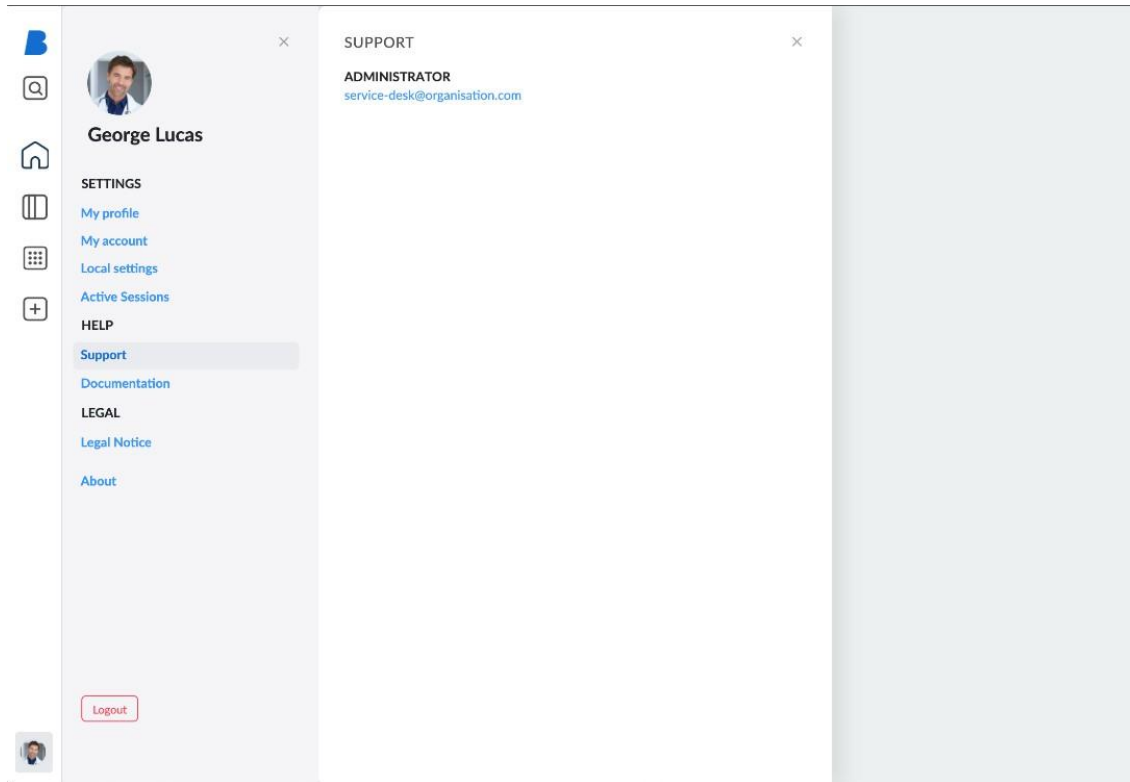


Figure 28. Contact your support desk when troubleshooting

Documentation

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

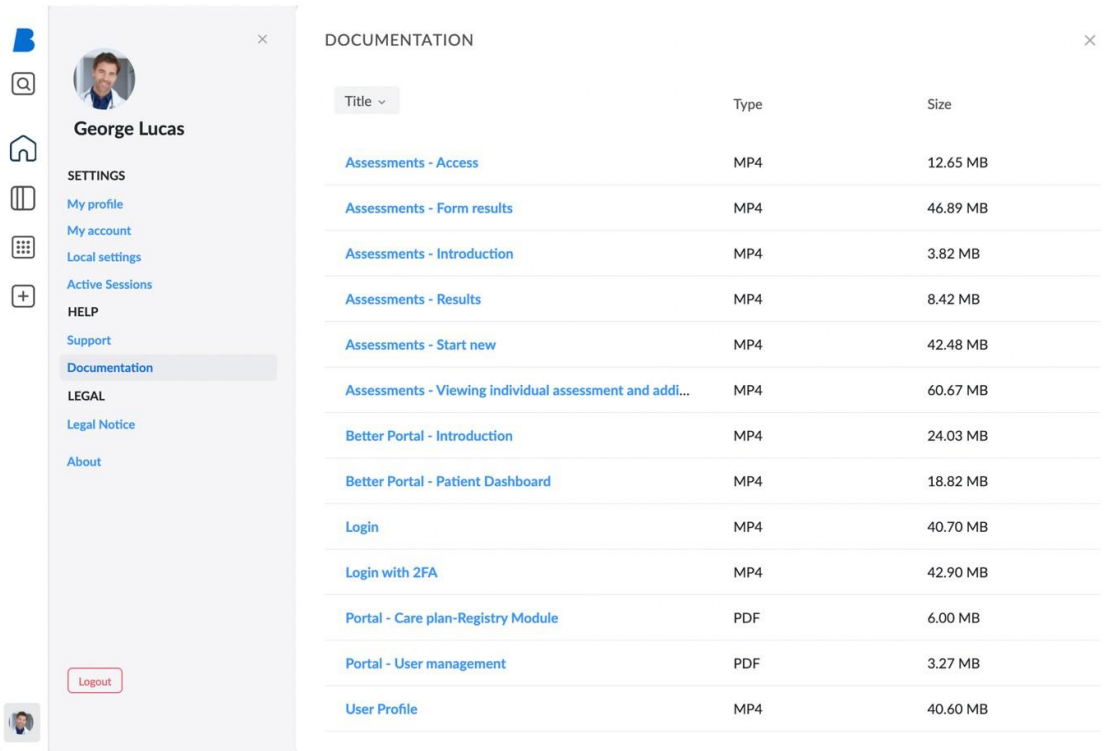


Figure 29. Read user manuals or watch training videos

Better Legal Notice

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

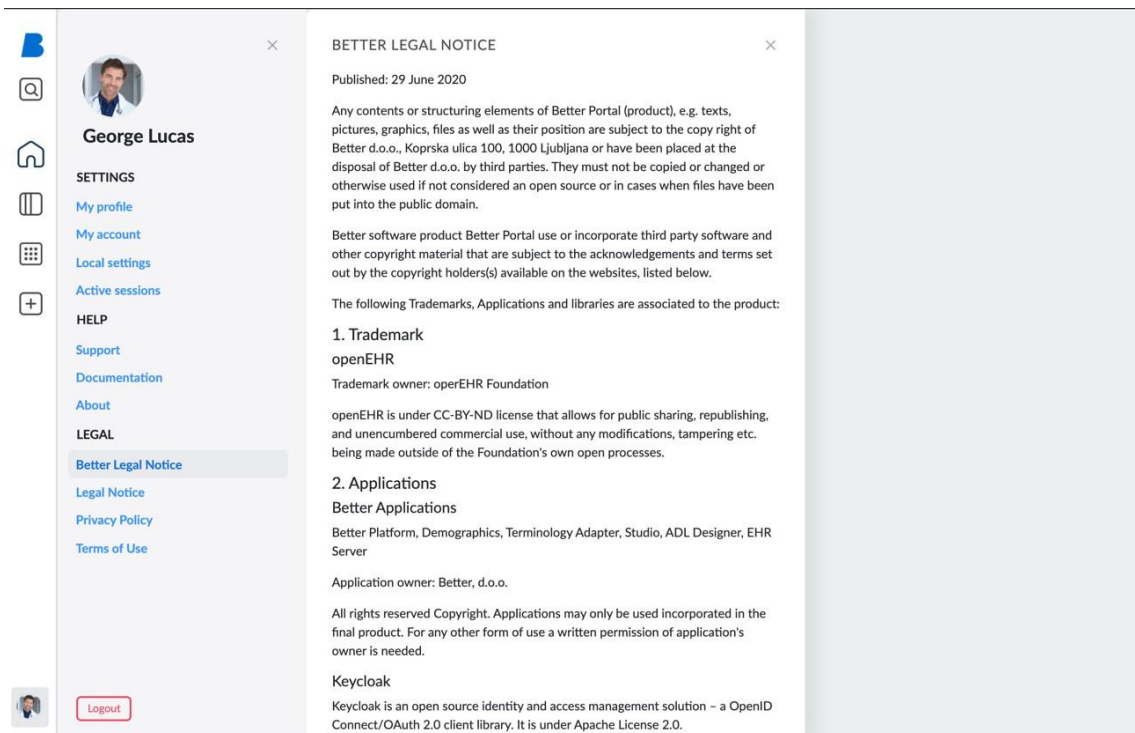


Figure 27. Better Legal Notice

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.

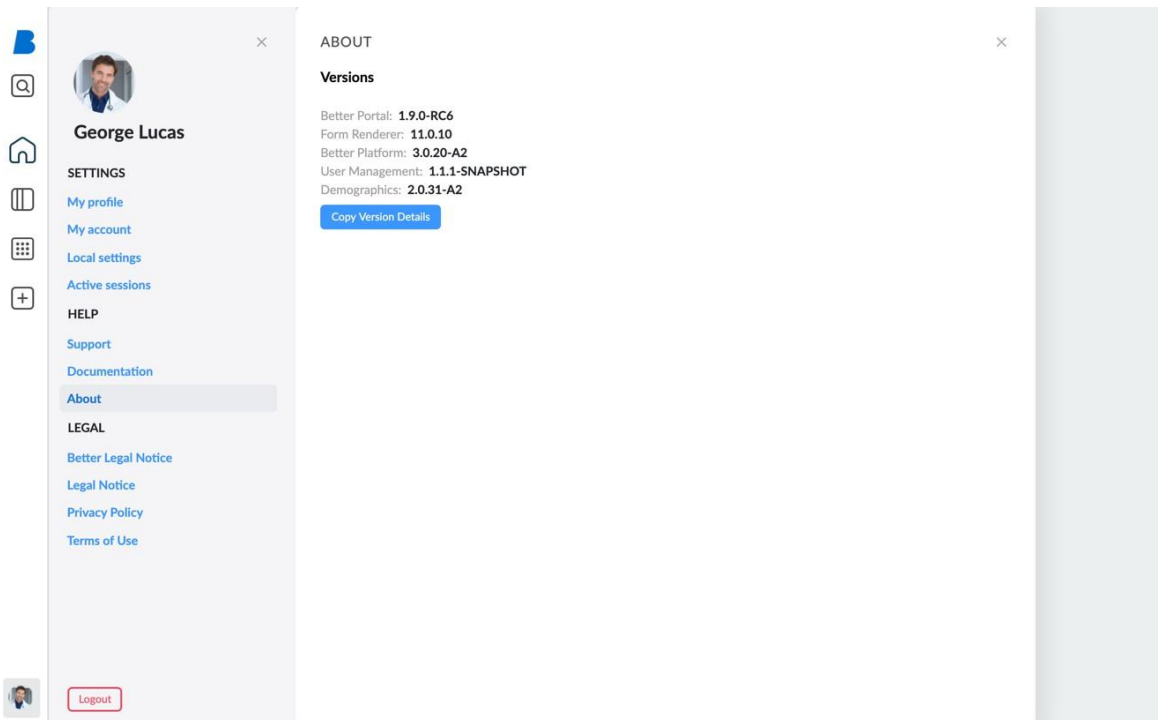


Figure 28. See information about your software

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.

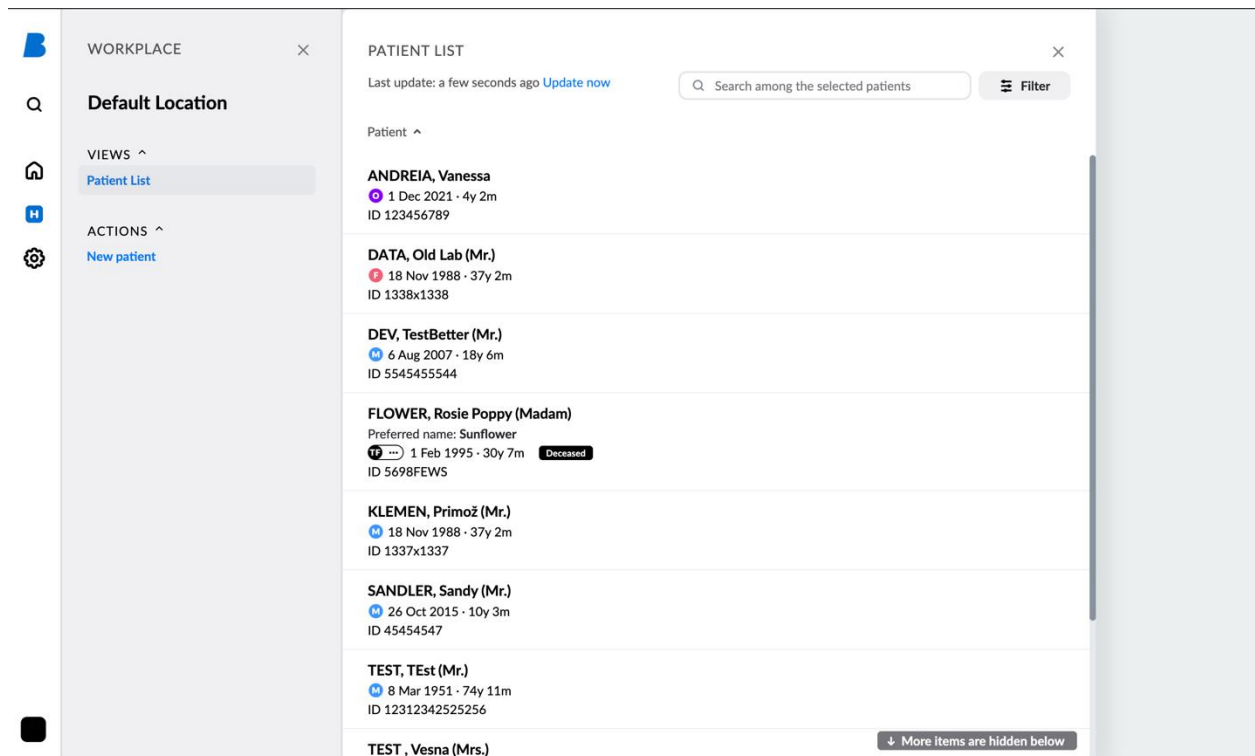



Figure 29. Access Patient list from User Dashboard

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 Careplans
 - 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

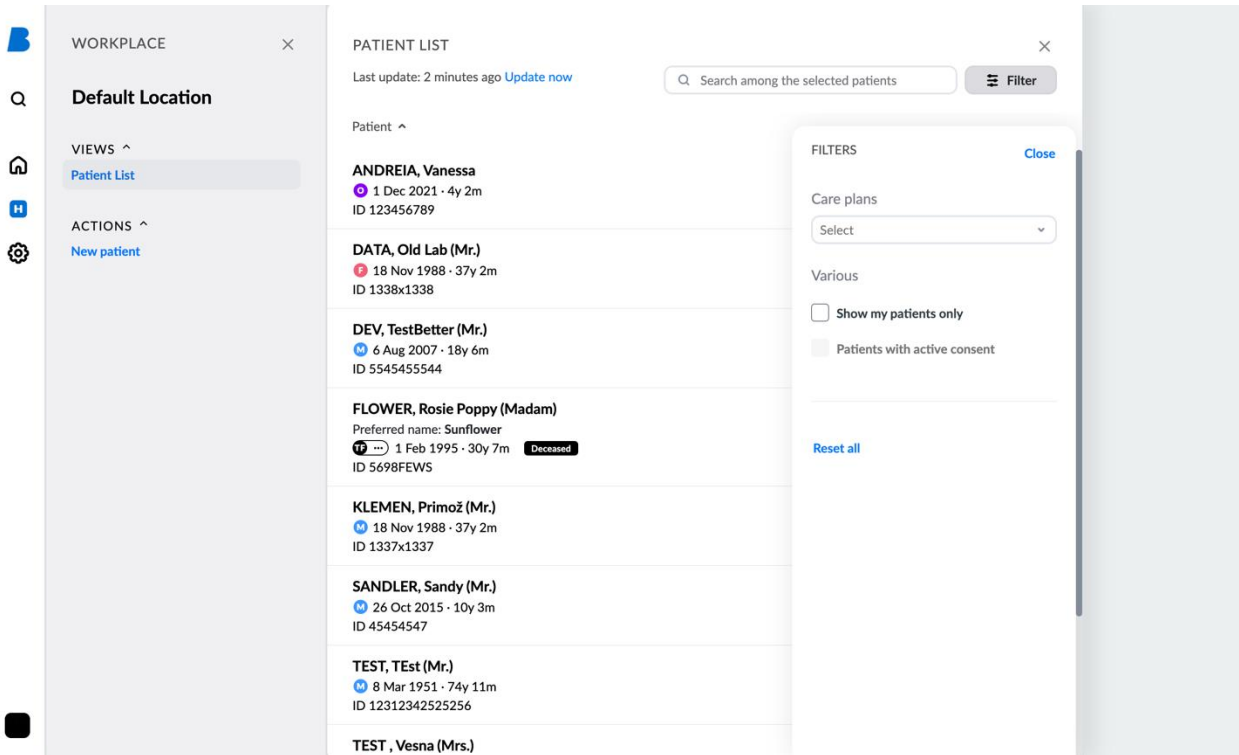


Figure 30. Apply filters to Patient list

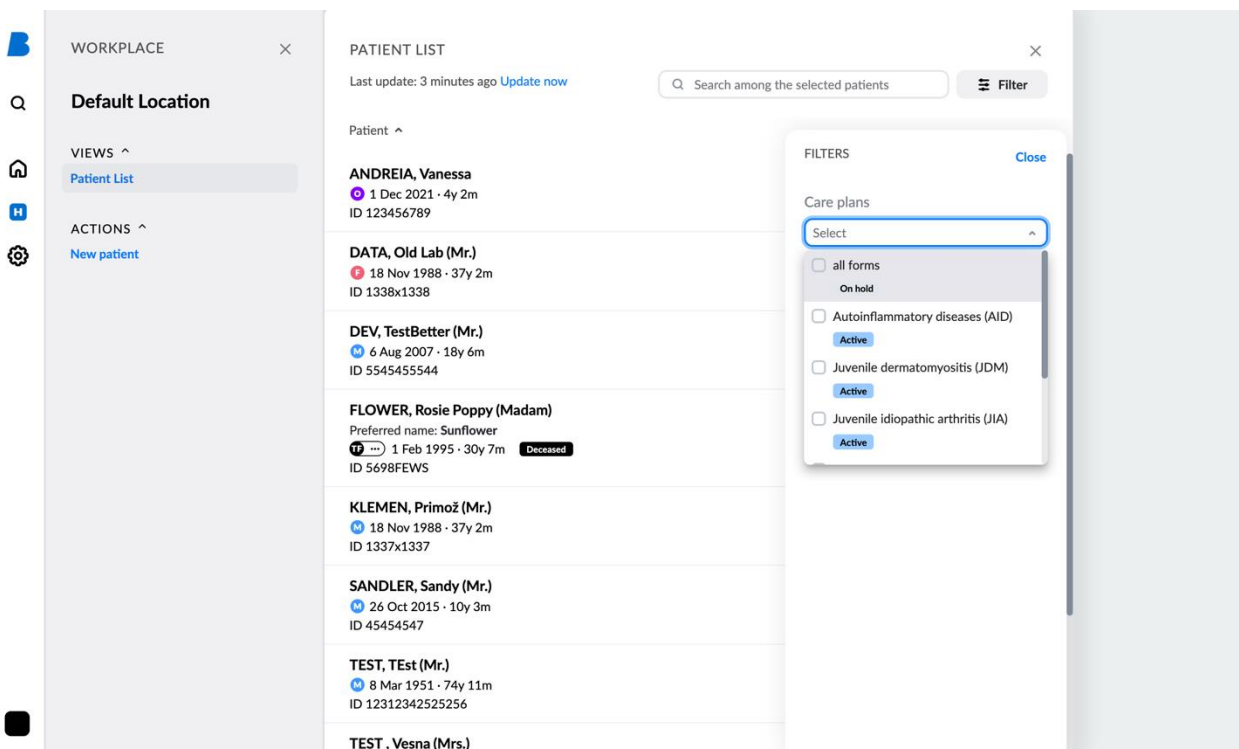


Figure 31. Filter patient list by care plan

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

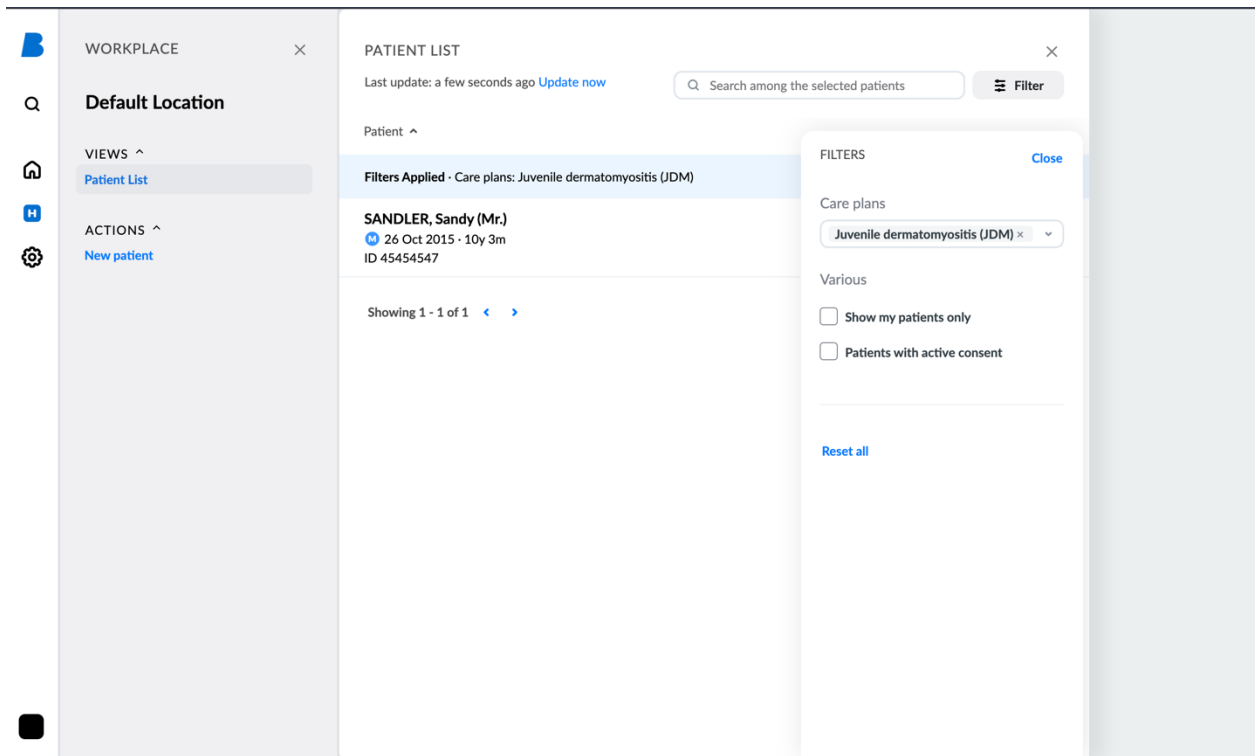


Figure 32. Applied filters are visible in the blue ribbon above patient list

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.

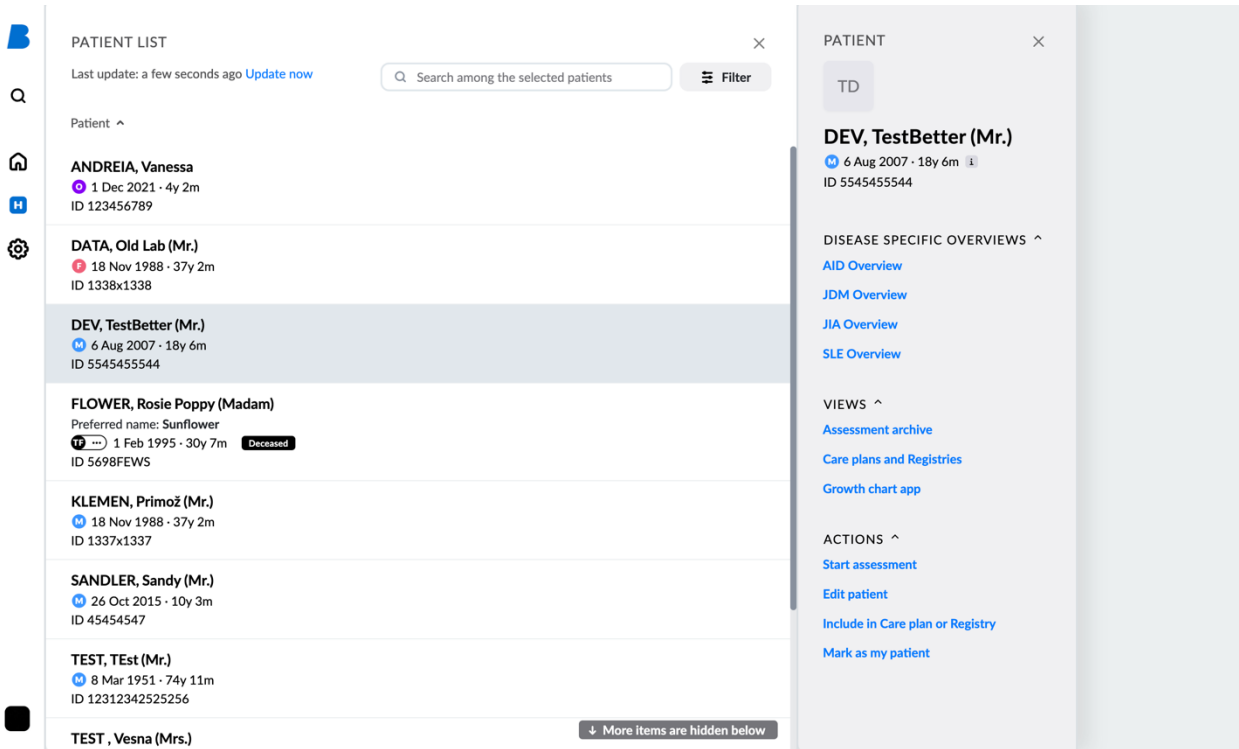


Figure 33. Opening Patient Dashboard through Patient List

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.



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.

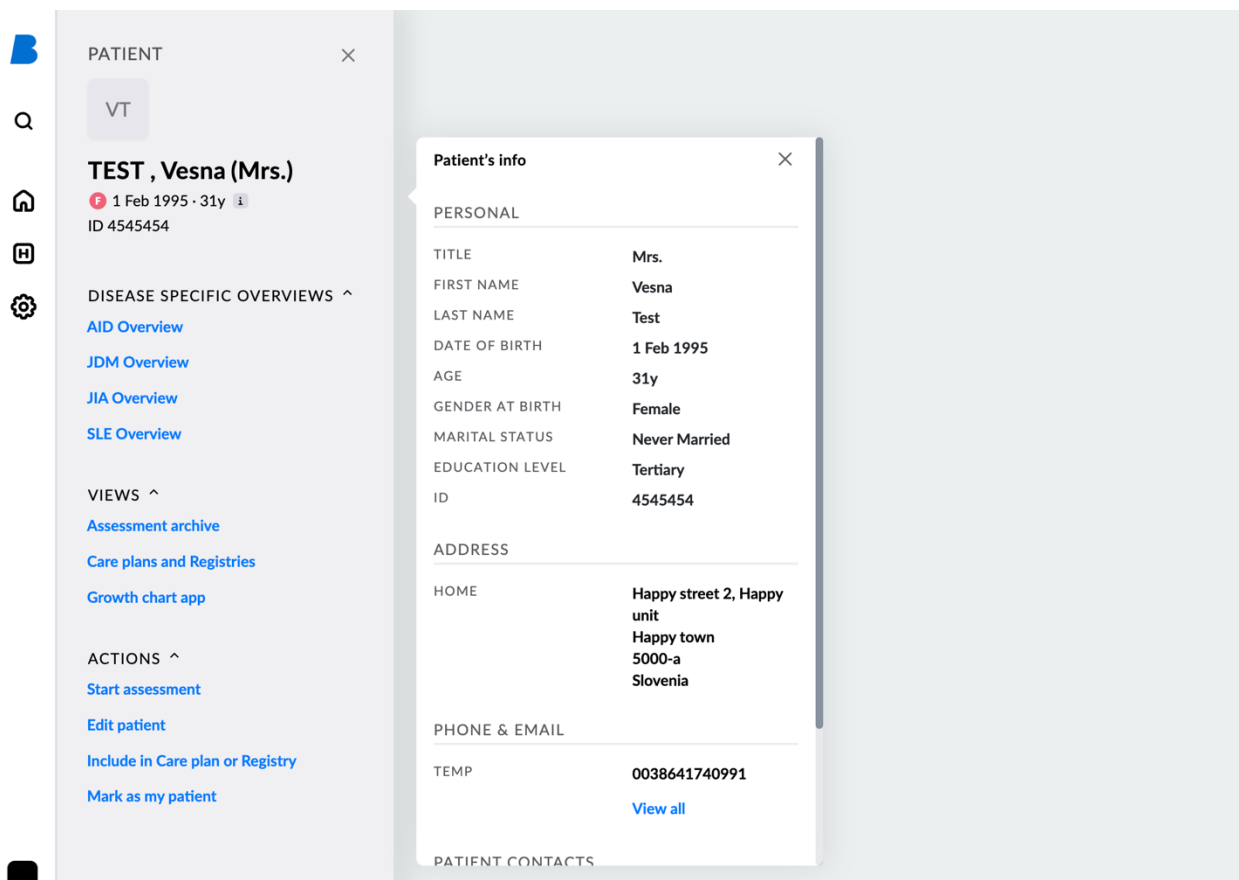


Figure 35. Patient's info

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.

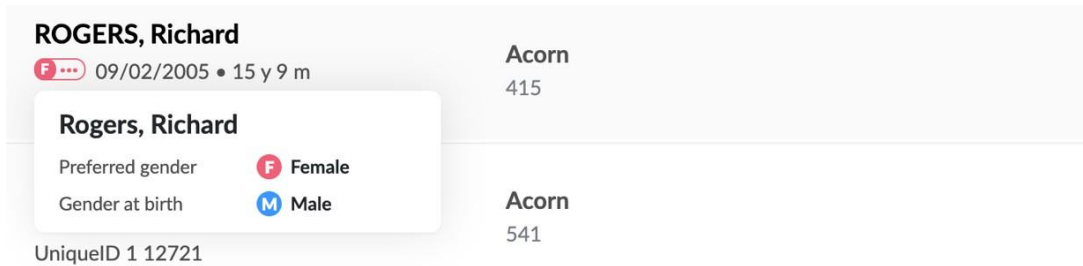


Figure 38. Preferred gender hover over

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.

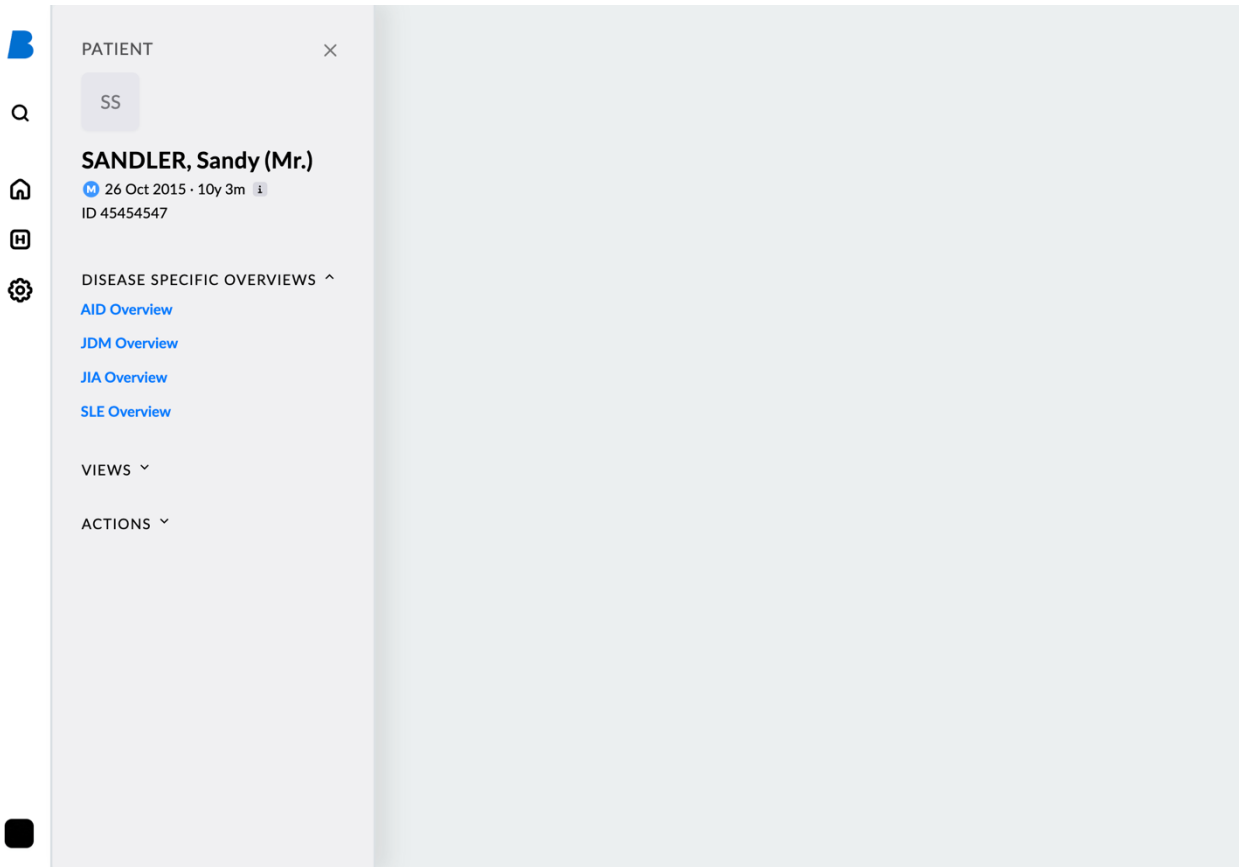


Figure 39. Disease specific overviews

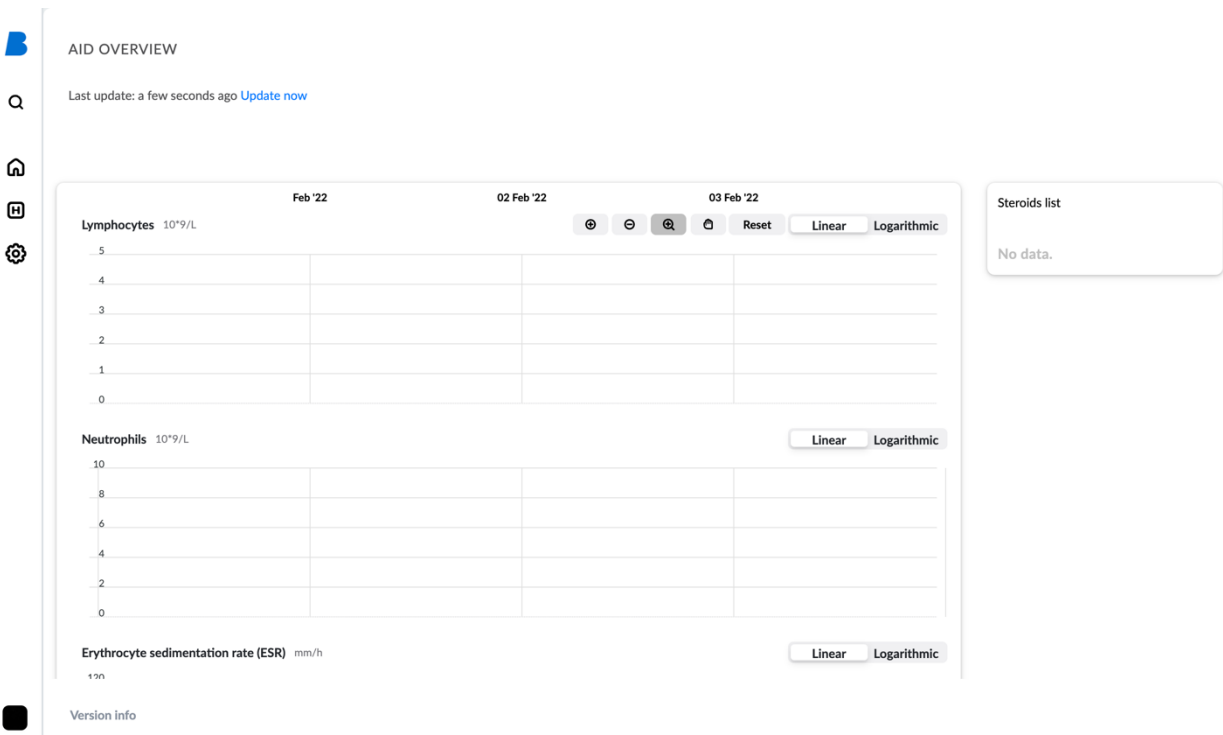
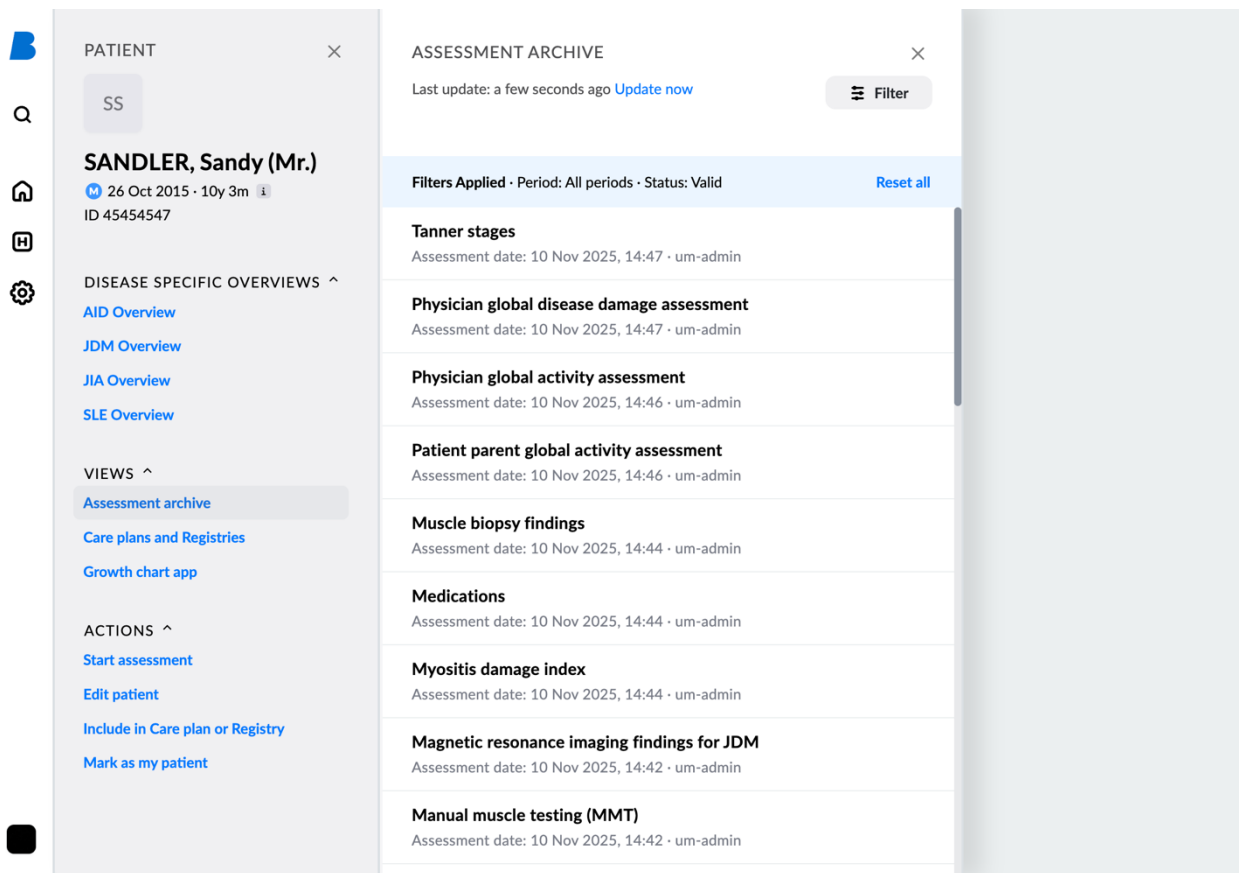


Figure 40. AID Overview

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 ×

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 ×

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

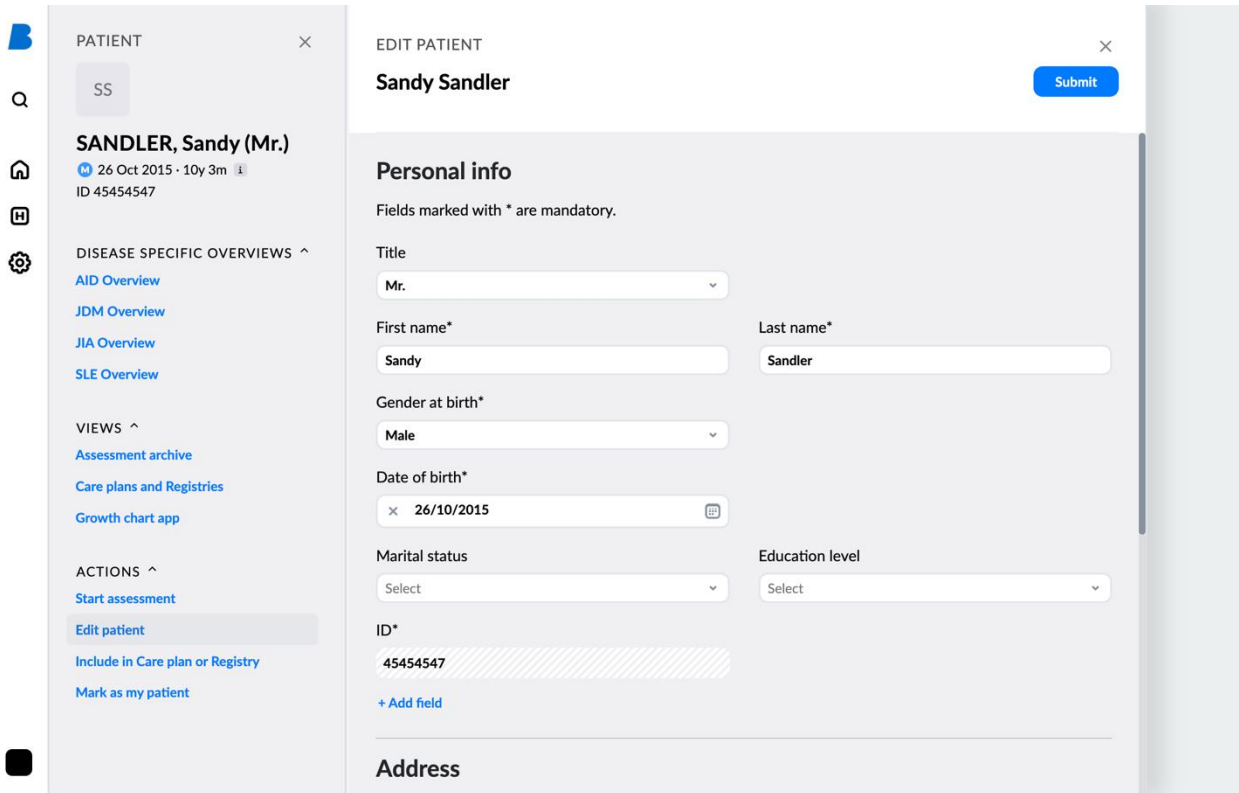
Figure 41. Patient Assessment archive

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”.

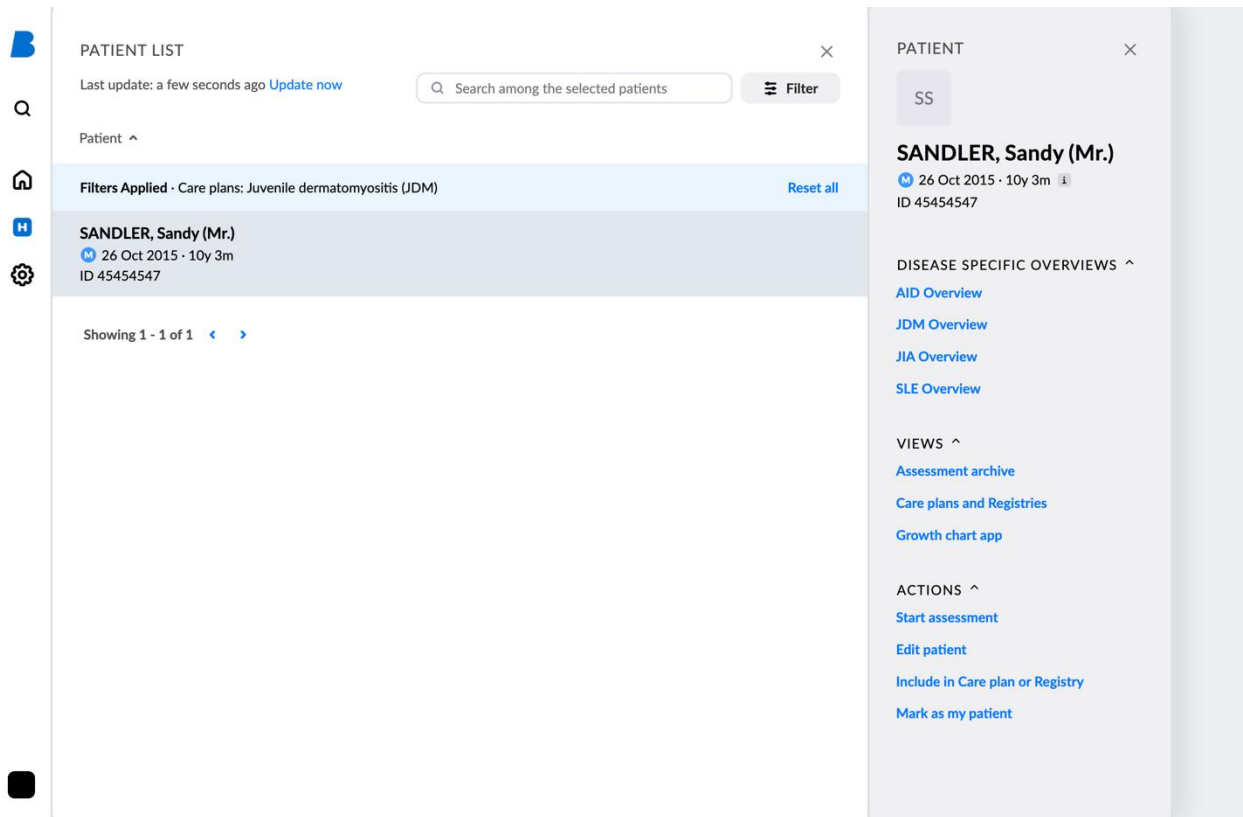


Figure 43. Mark as my patient

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.

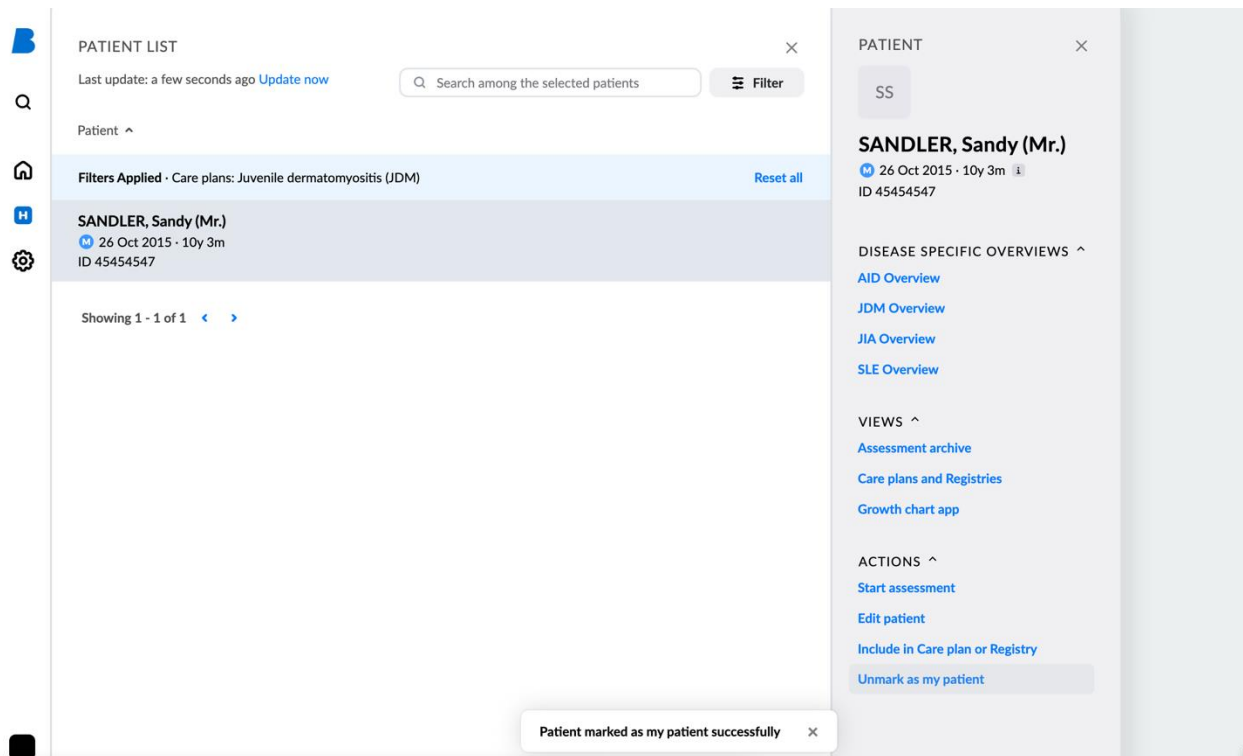


Figure 44. Notification that patient has been marked as my patient successful

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

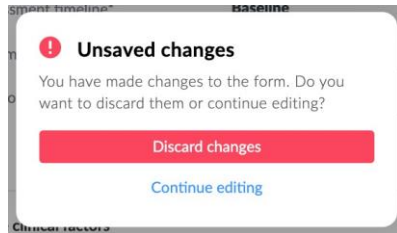
After you have selected a patient the Patient Dashboard is displayed. A patient must be included in a care plan or registry to start entering assessments available for that particular care plan or registry.

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.

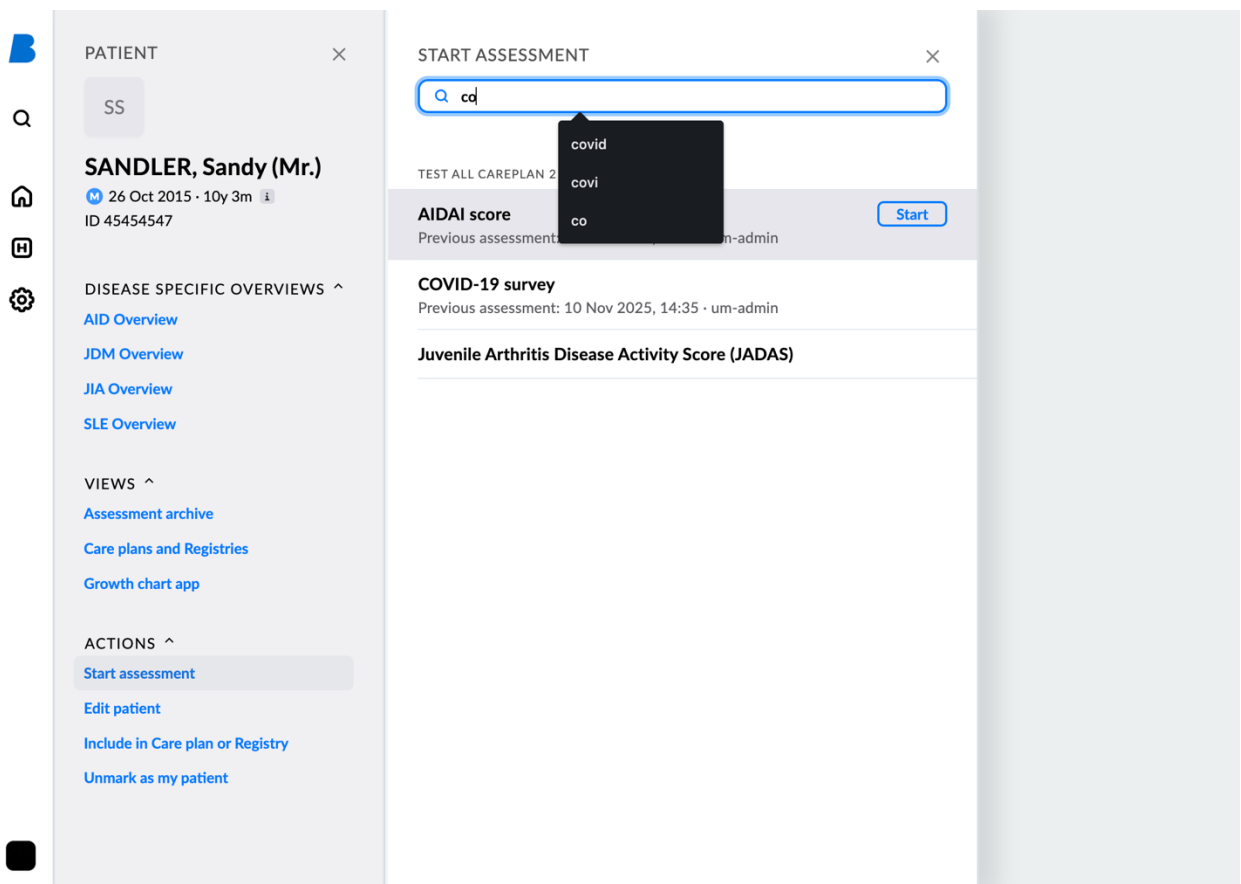


Figure 45. Start patient assessment

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.

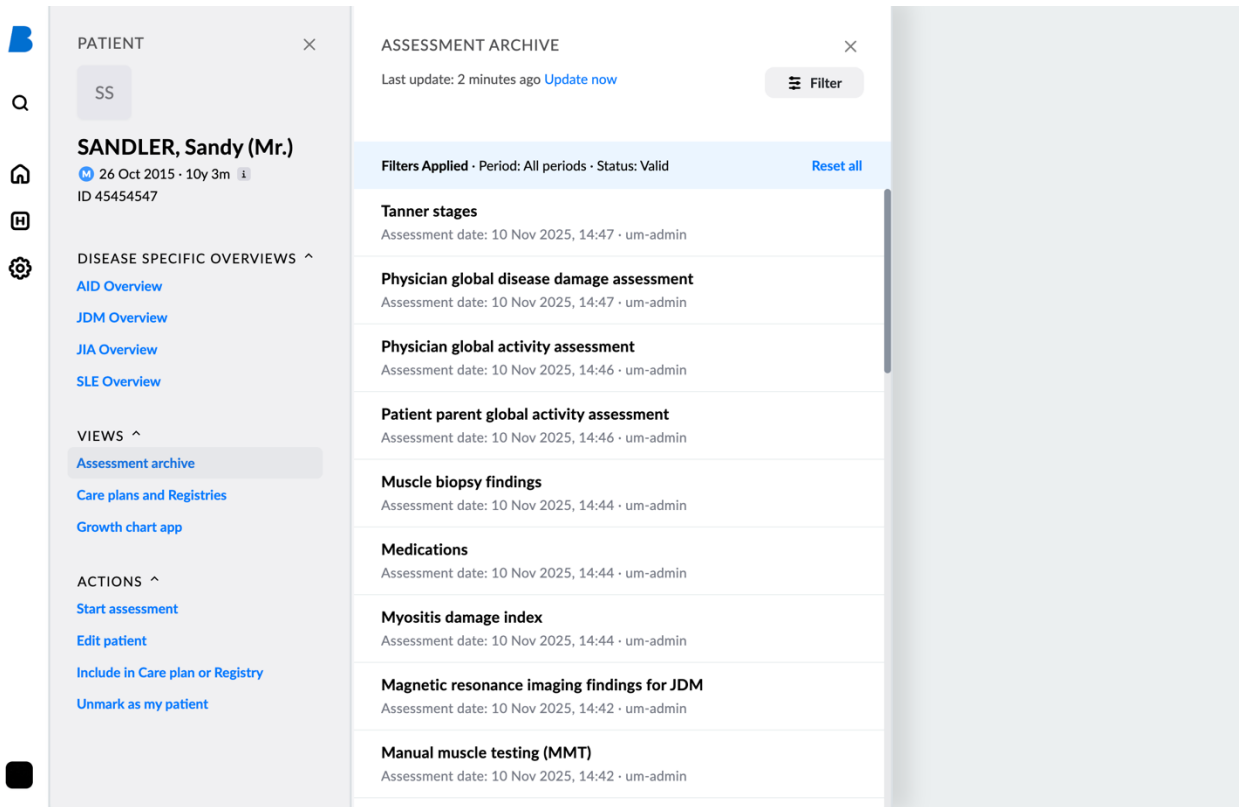


Figure 46. Assessment archive

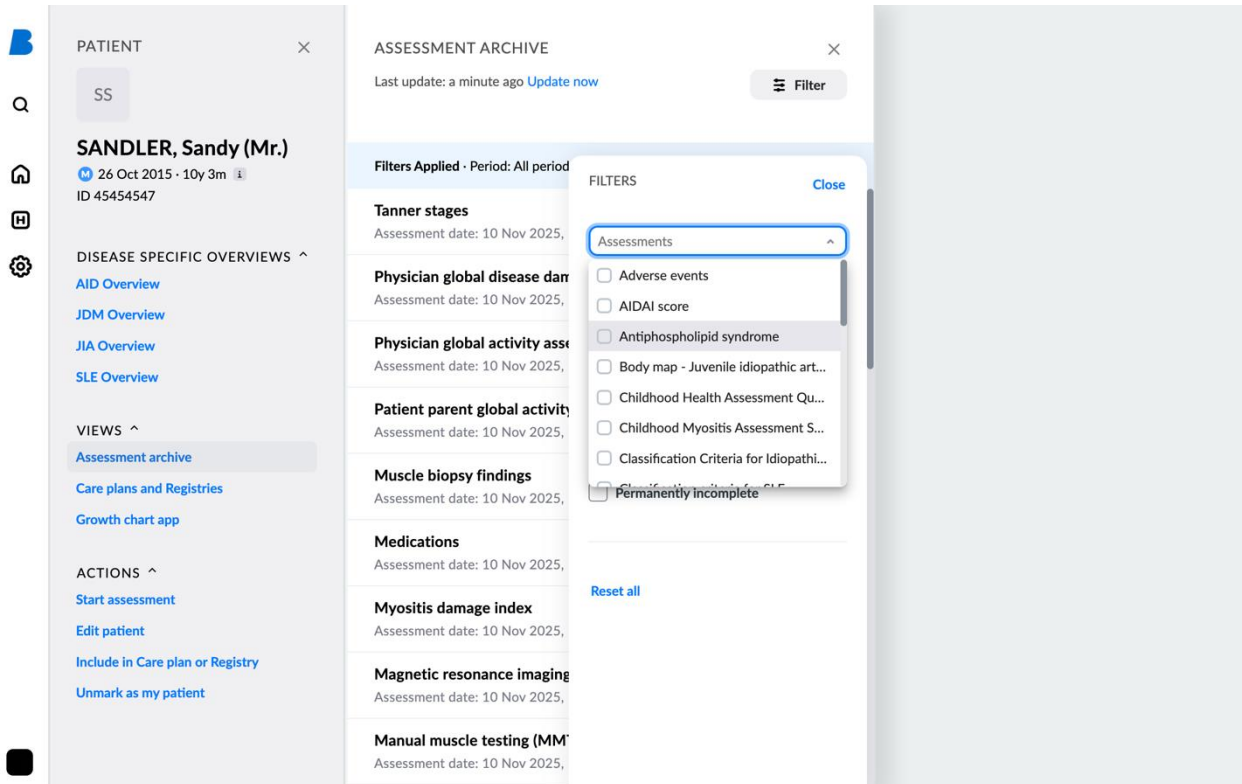


Figure 47. Using filter in Assessment archive

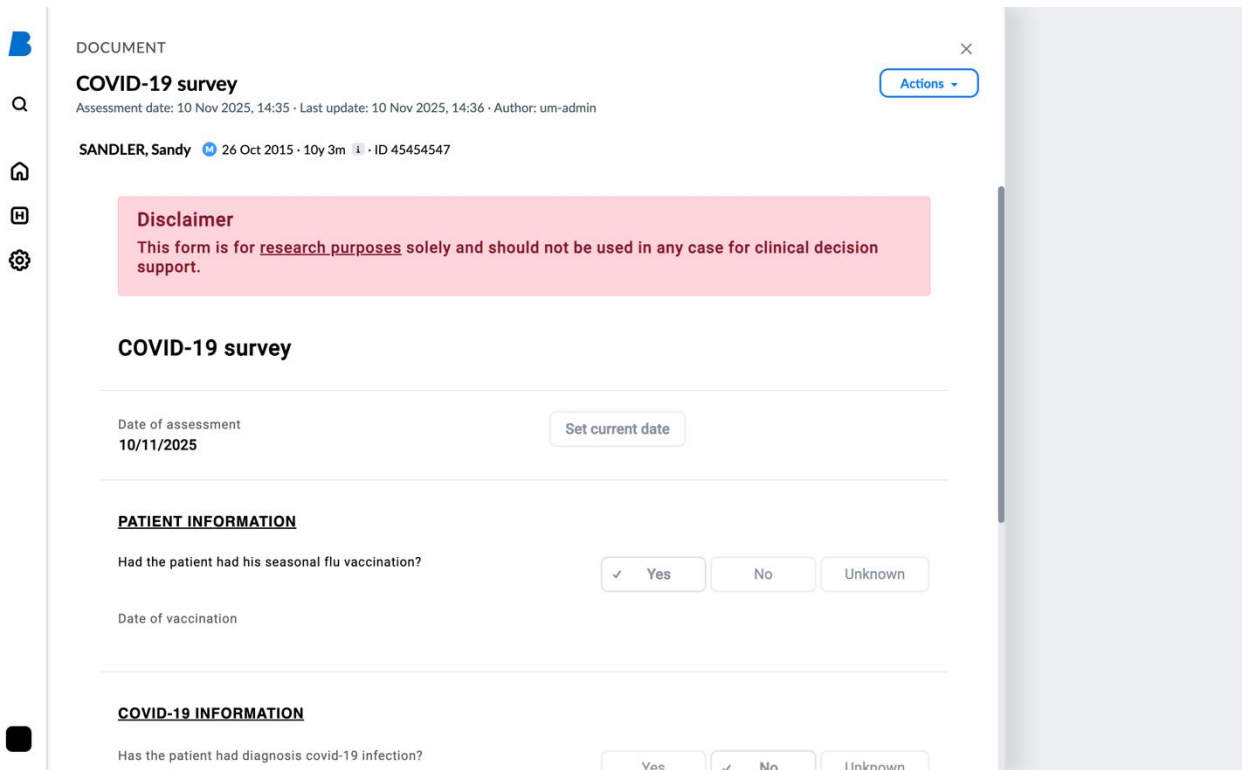


Figure 48. Document opens in structured Presentation view

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

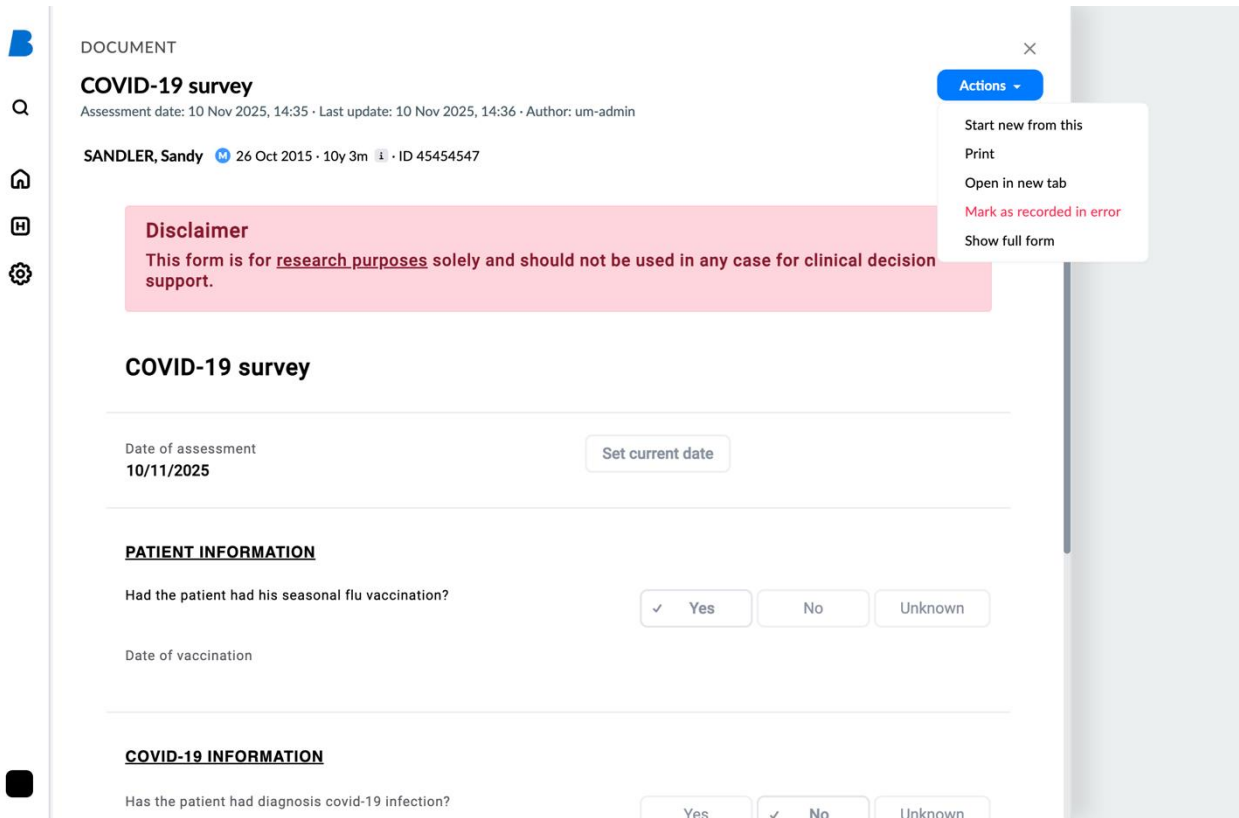


Figure 49. Assessment archive and additional document option

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

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

DOCUMENT

COVID-19 survey Actions

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 Set current date
10/11/2025

PATIENT INFORMATION

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

Date of vaccination

COVID-19 INFORMATION

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.

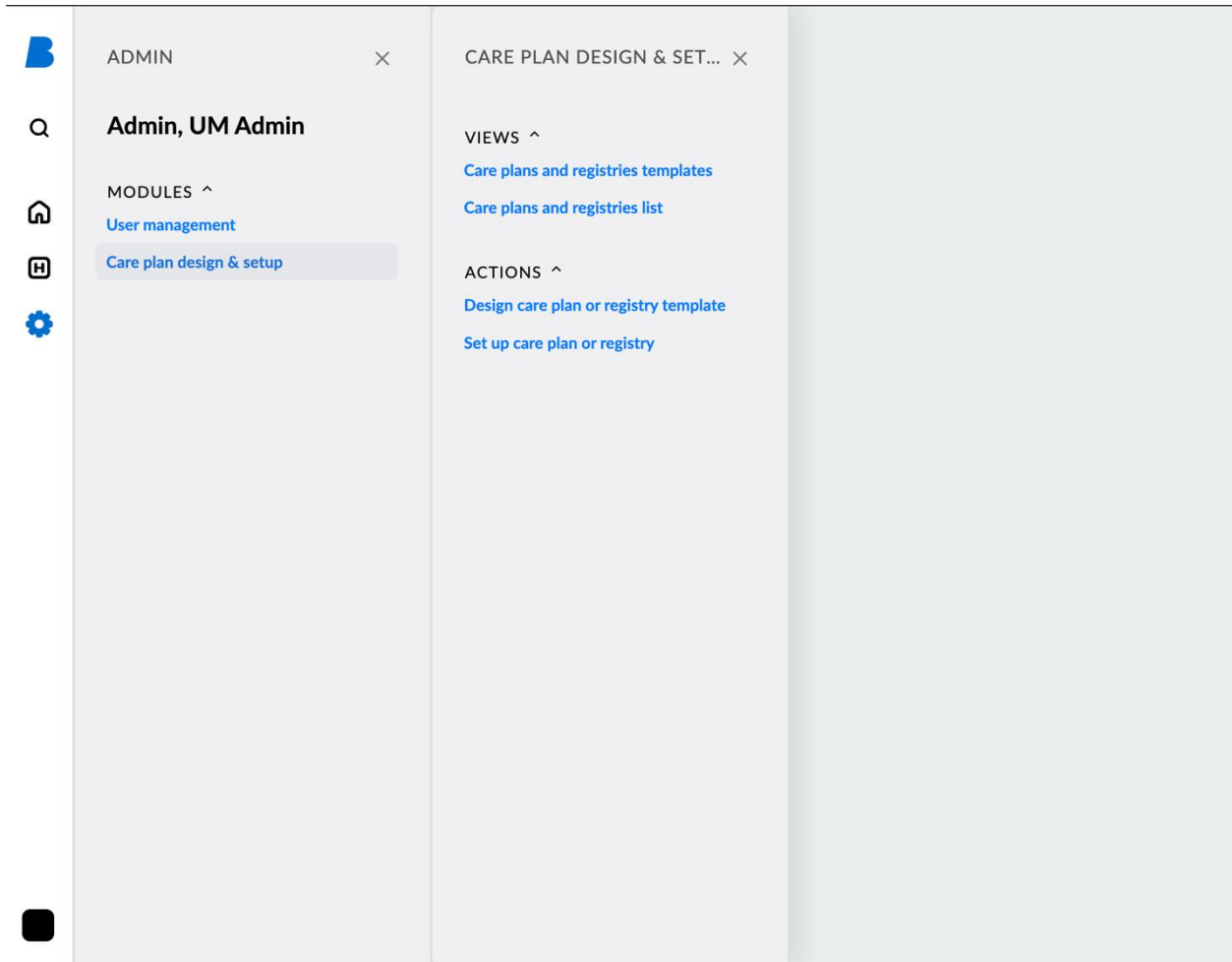


Figure 53. Care plan design & setup

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.

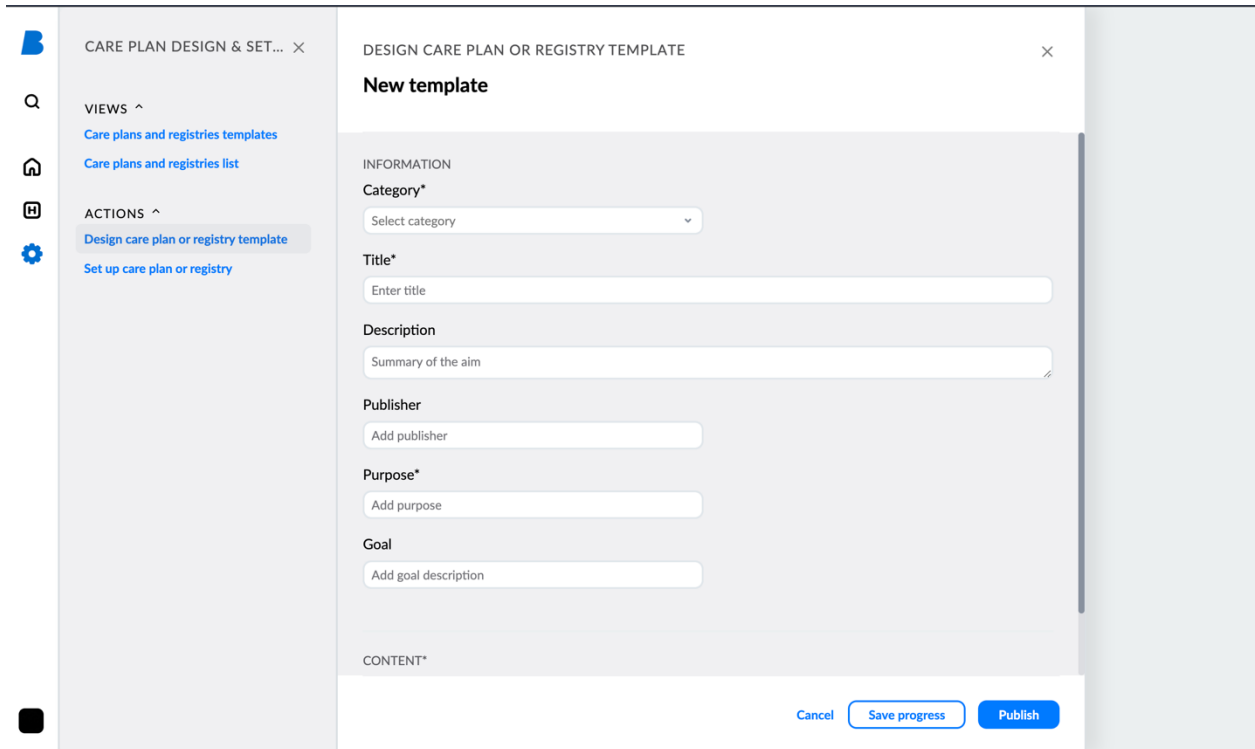


Figure 54. Design Care plan or registry template initial screen

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

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

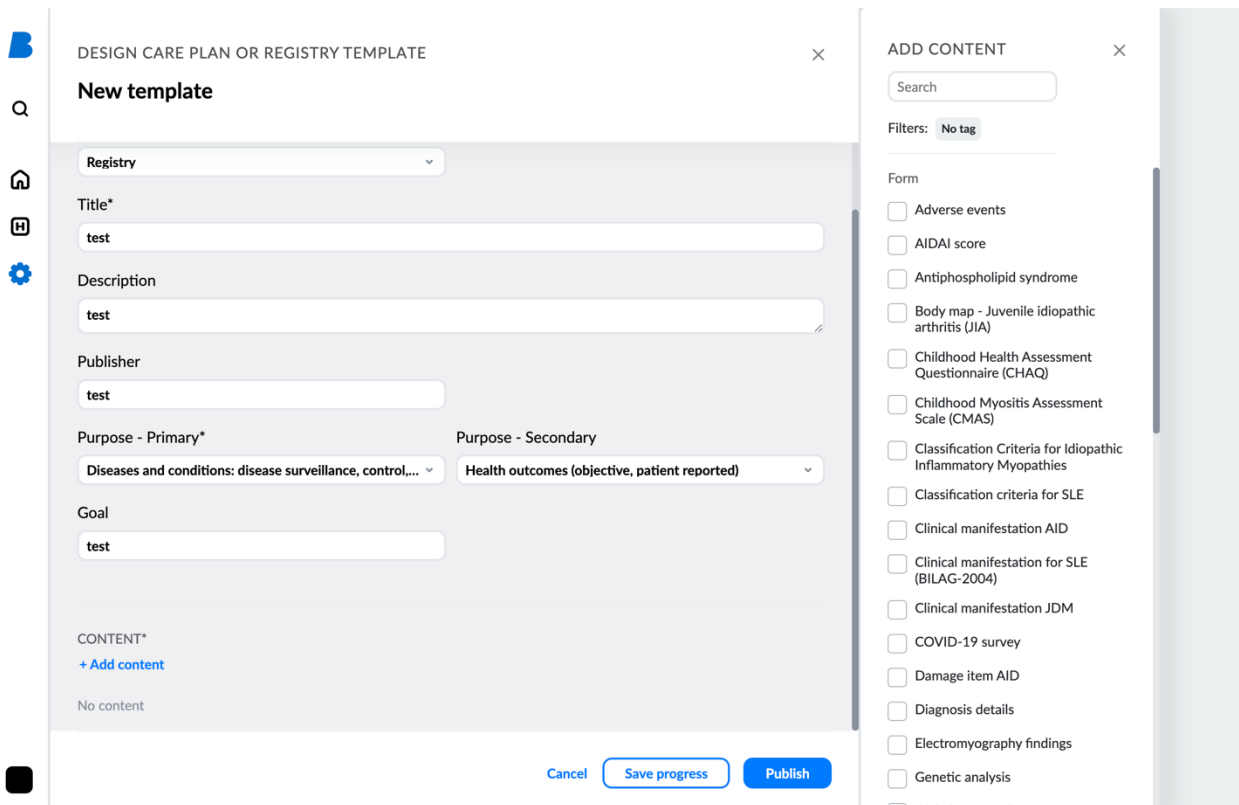


Figure 55. Adding content – assessment to care plan or registry template

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.

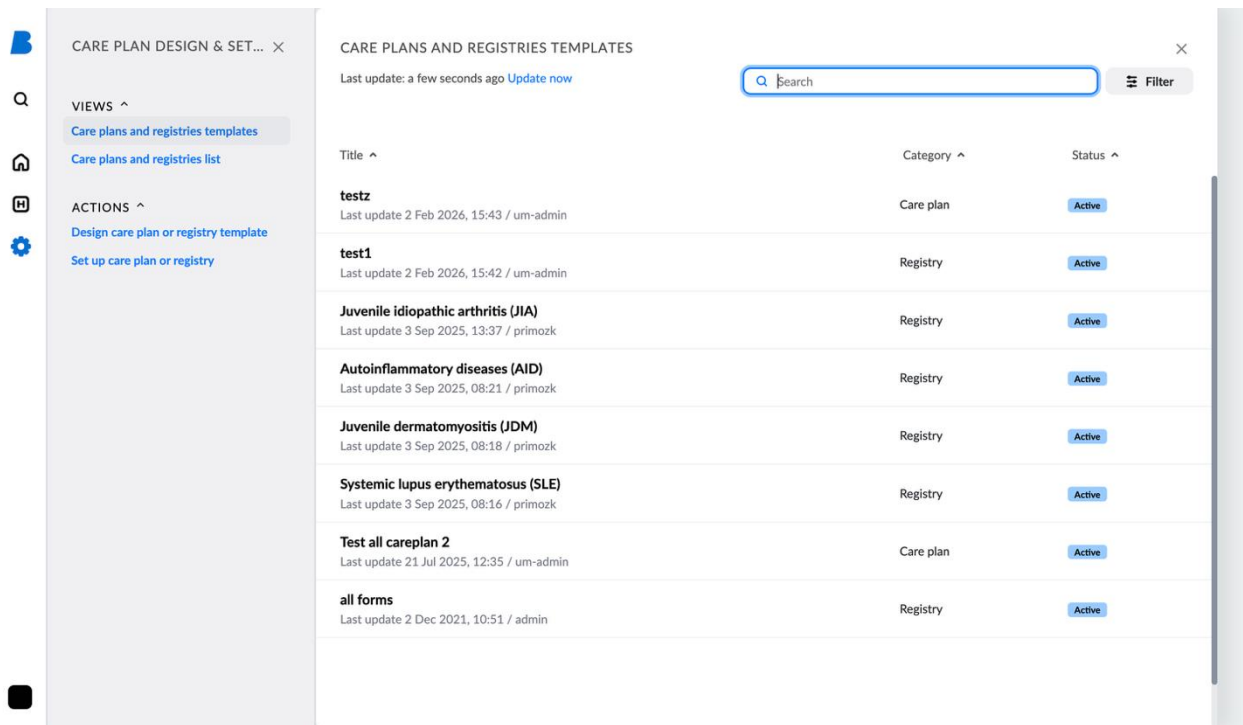


Figure 56. Access to the Care plans and registries templates

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)

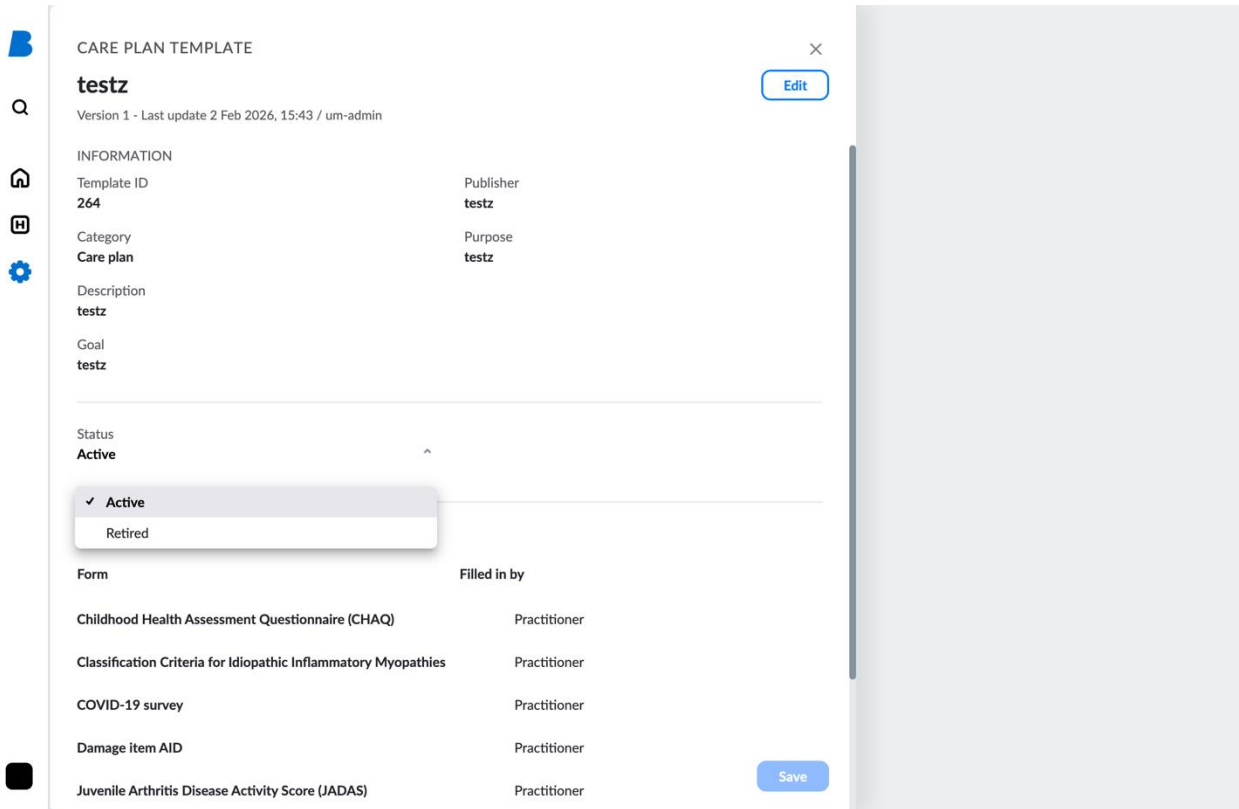


Figure 57. Ability to change the template status within the care plan/registry details page

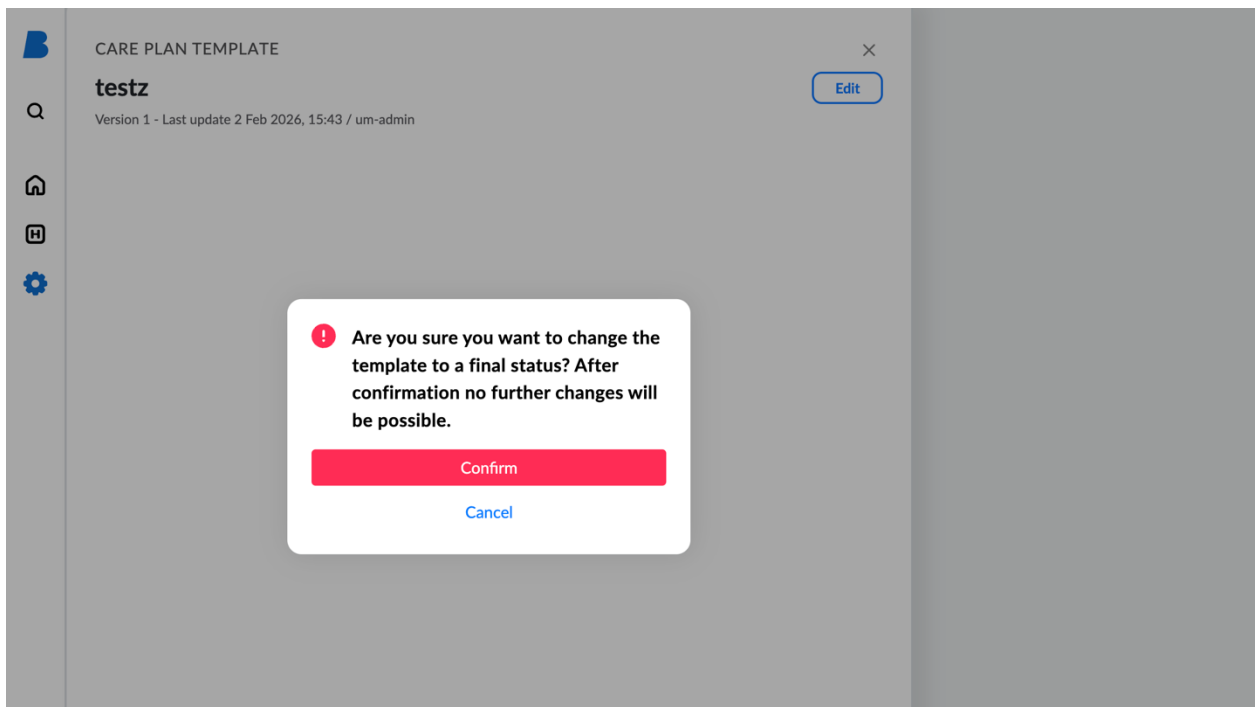


Figure 58. Additional warning for the user in case when choosing the »Retired« status

- 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.

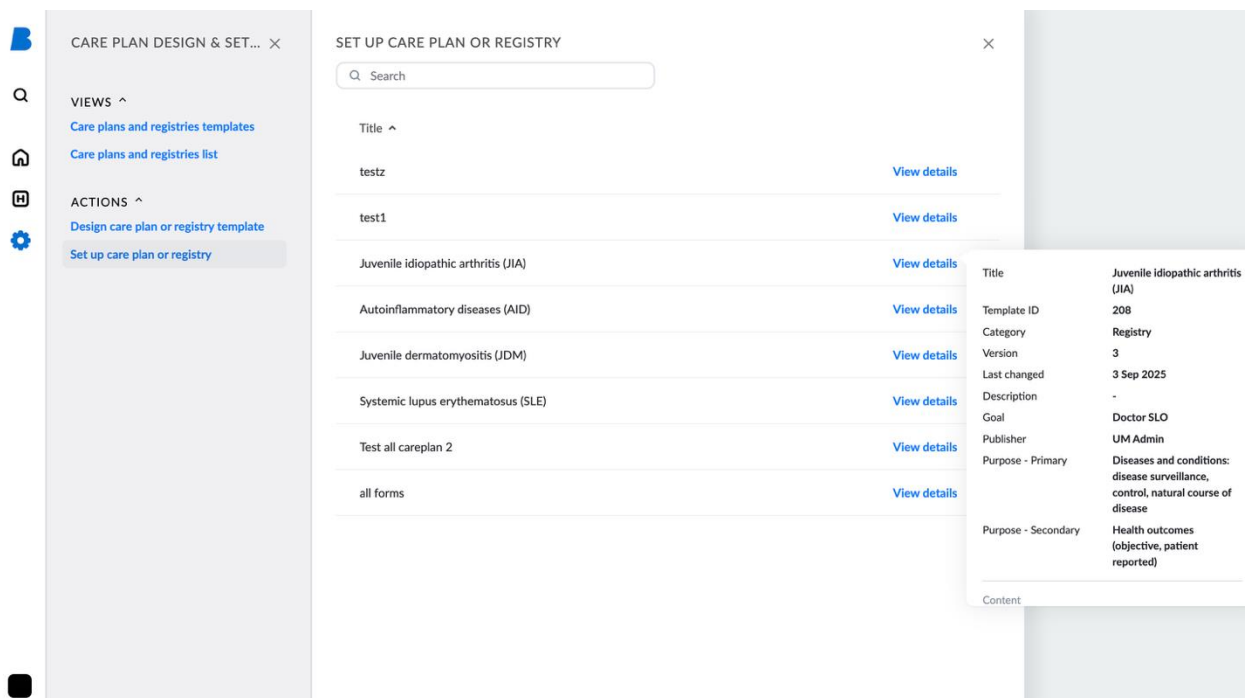
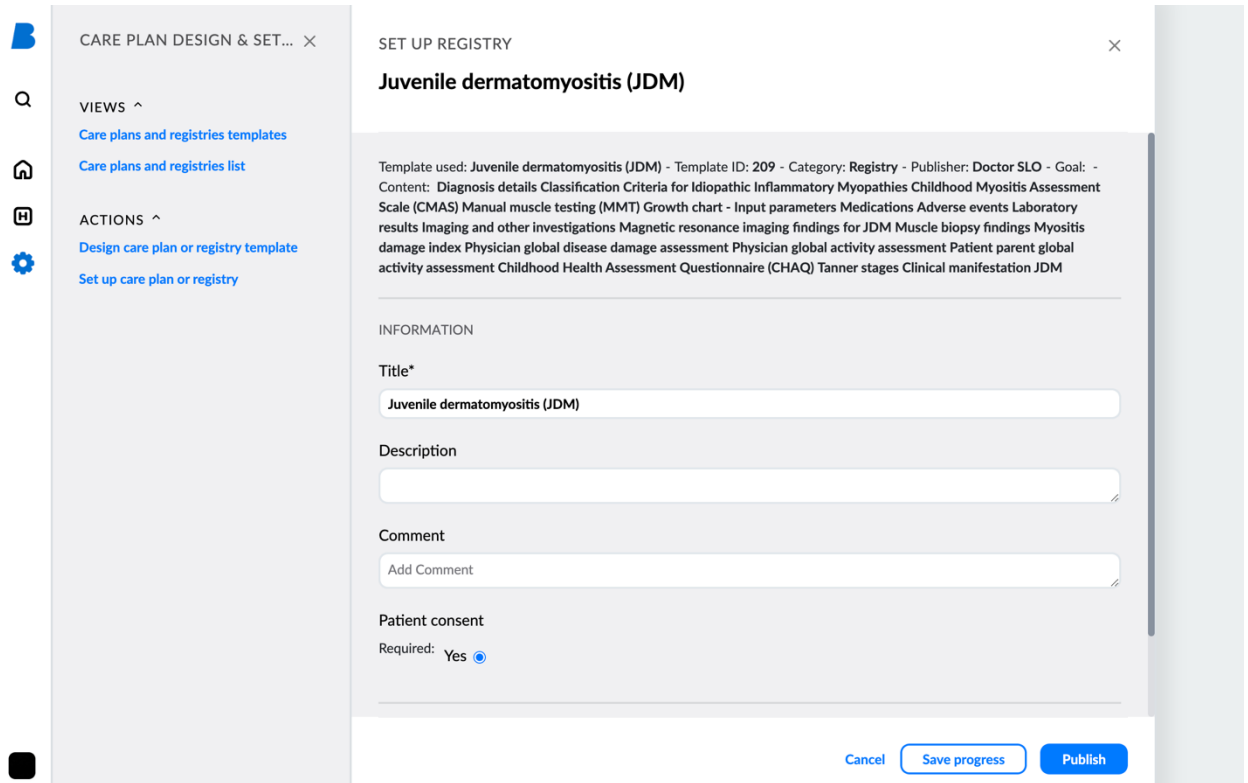


Figure 60. Set up care plan or registry template and detailed template view

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

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. 3
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 statutes 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.

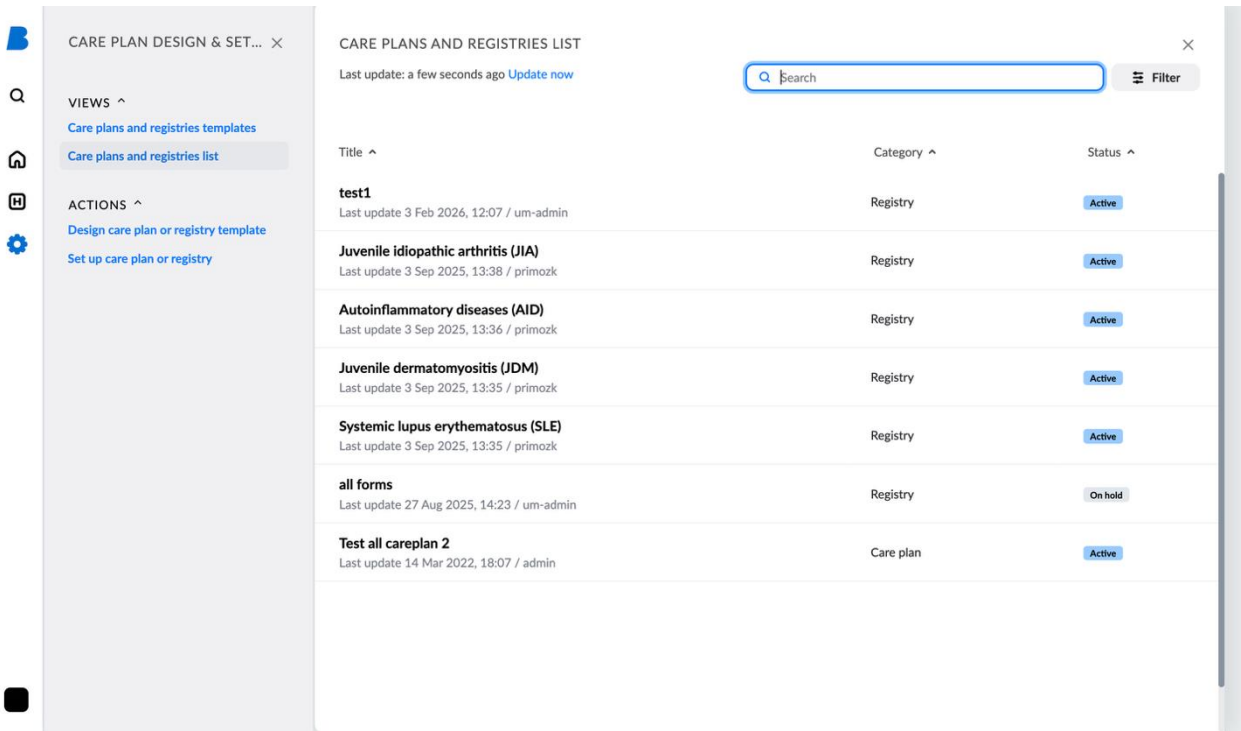


Figure 62. Access to the Care plans and registries list.

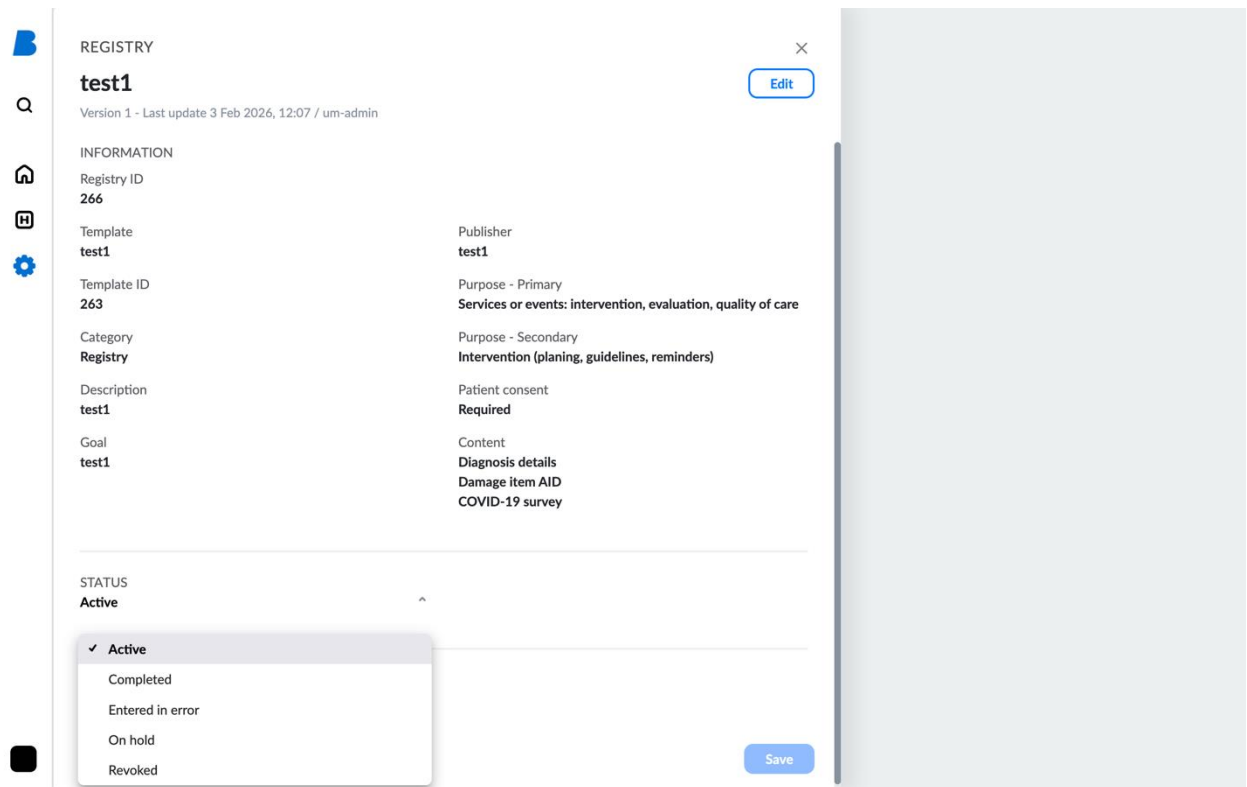


Figure 63. Changing status of care plan/registry

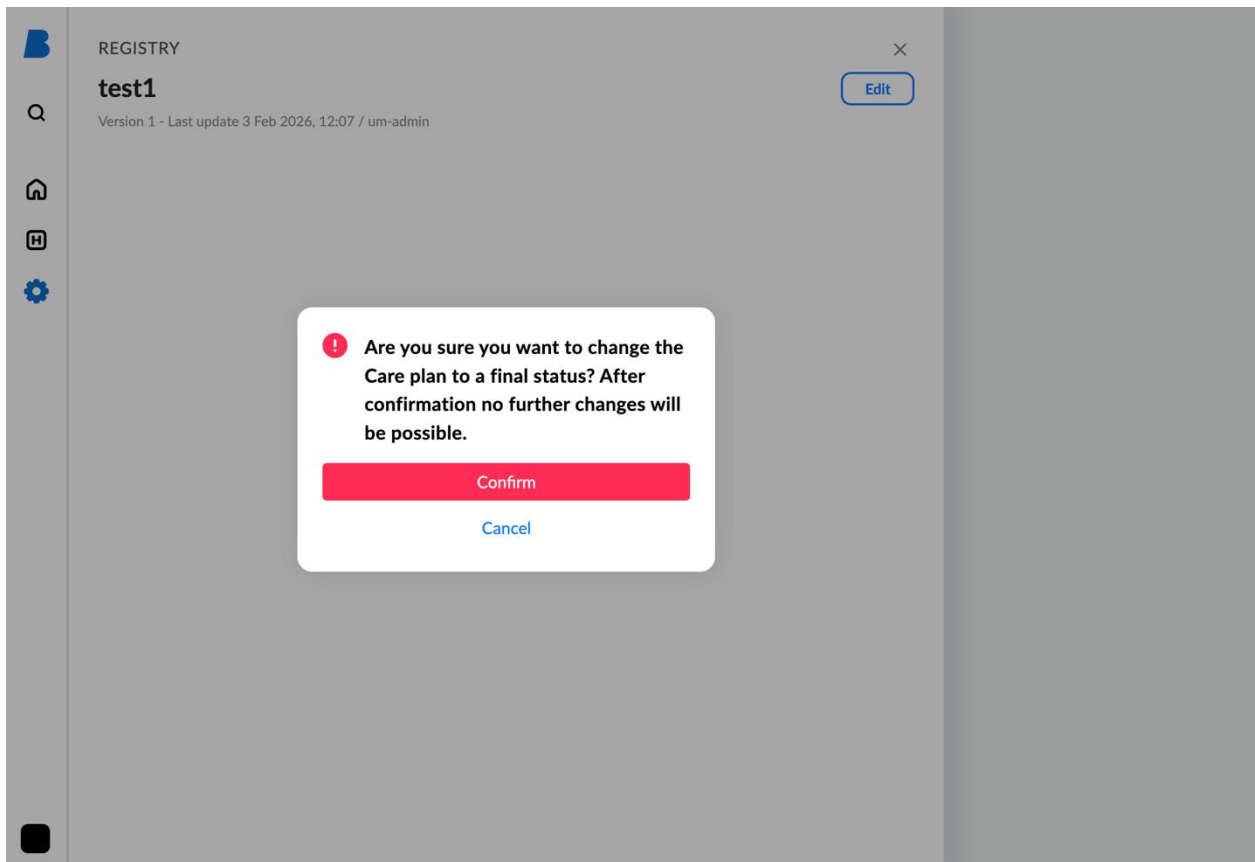


Figure 64. Warning displayed before registry status change

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.

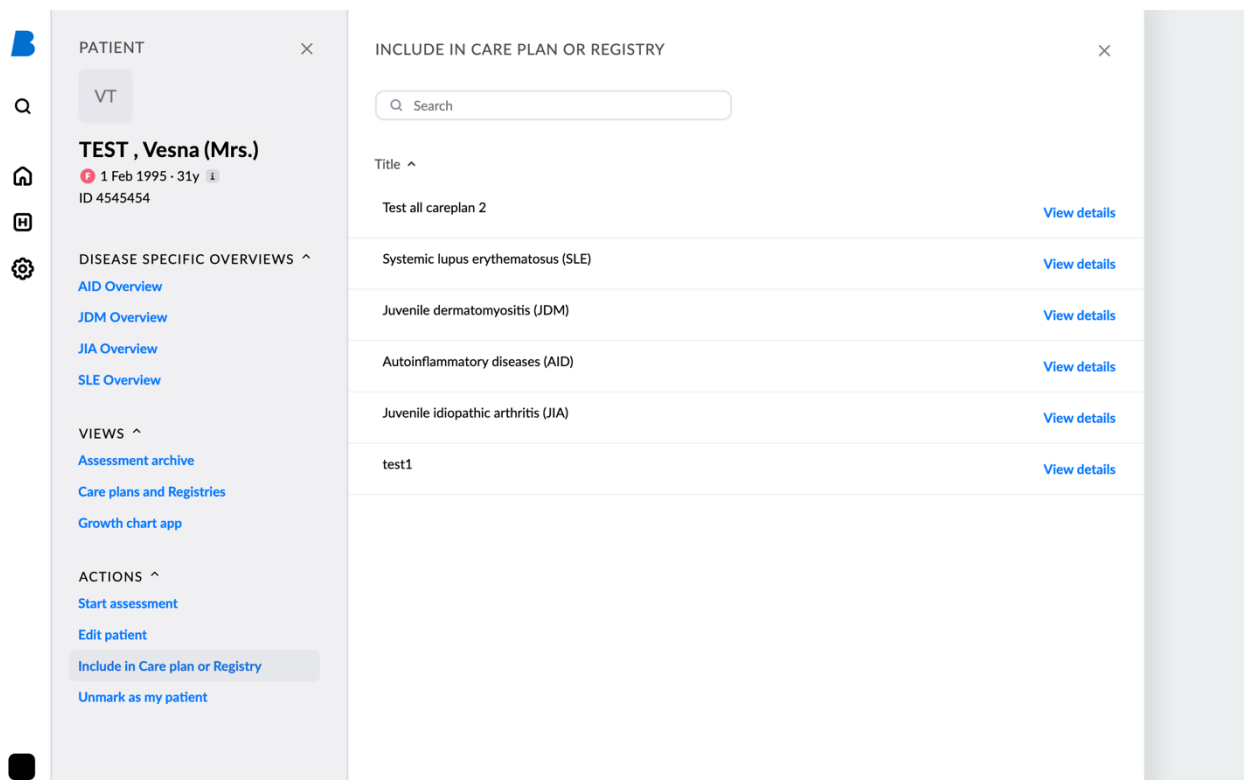
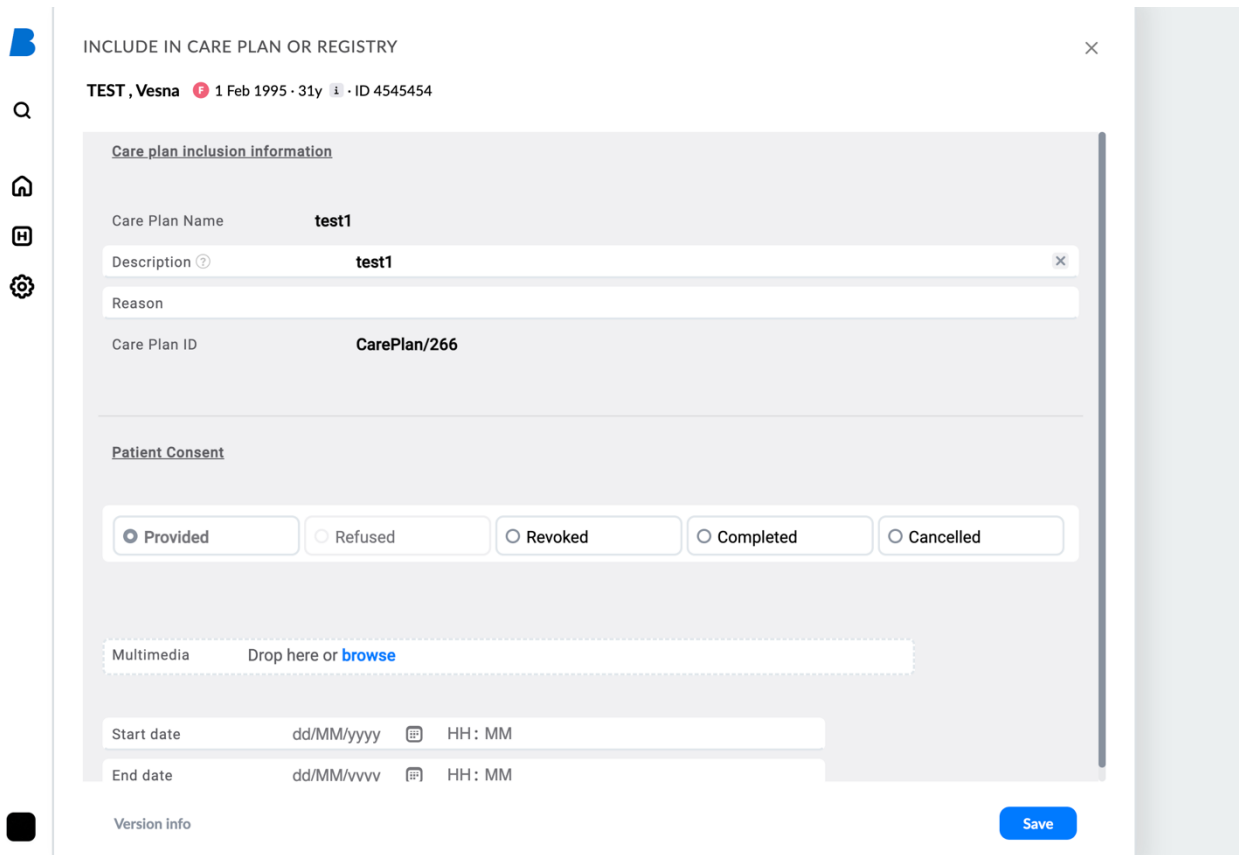


Figure 65. Search patient in the search dialog or open Patient list and Include in care plan



INCLUDE IN CARE PLAN OR REGISTRY ×

TEST, Vesna ● 1 Feb 1995 · 31y i · 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**

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.

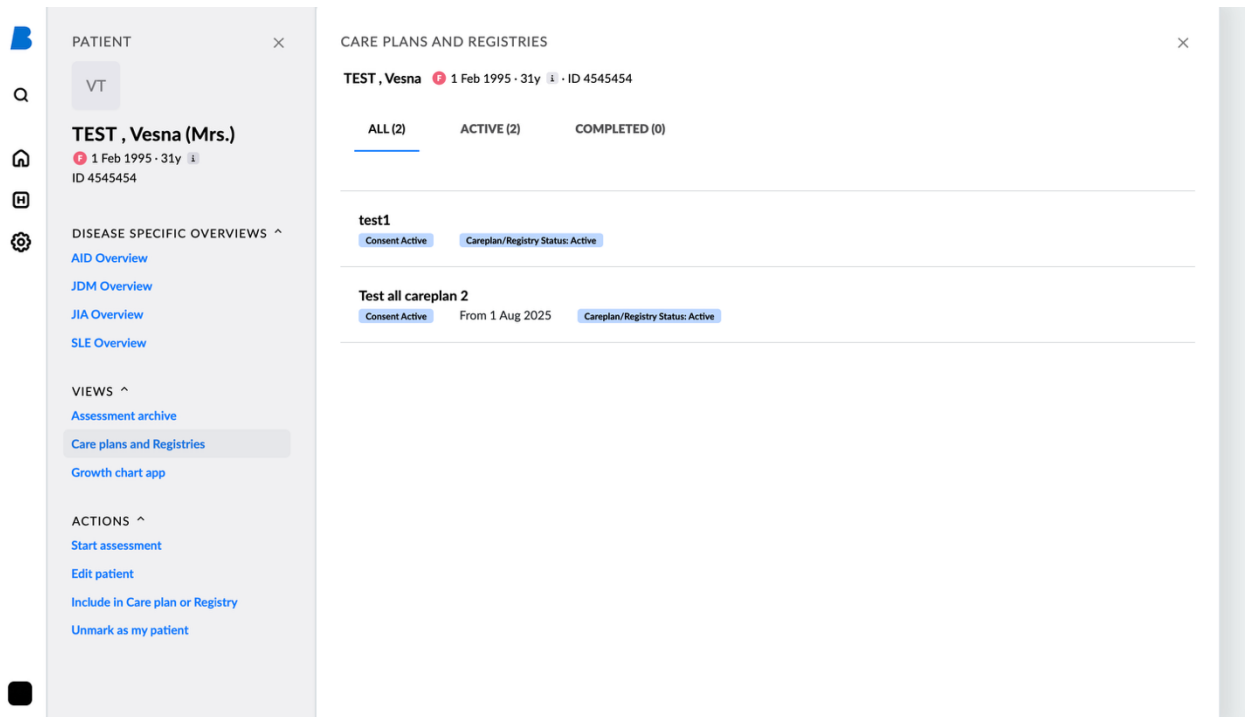


Figure 67. List of care plans/registries in which patient is included

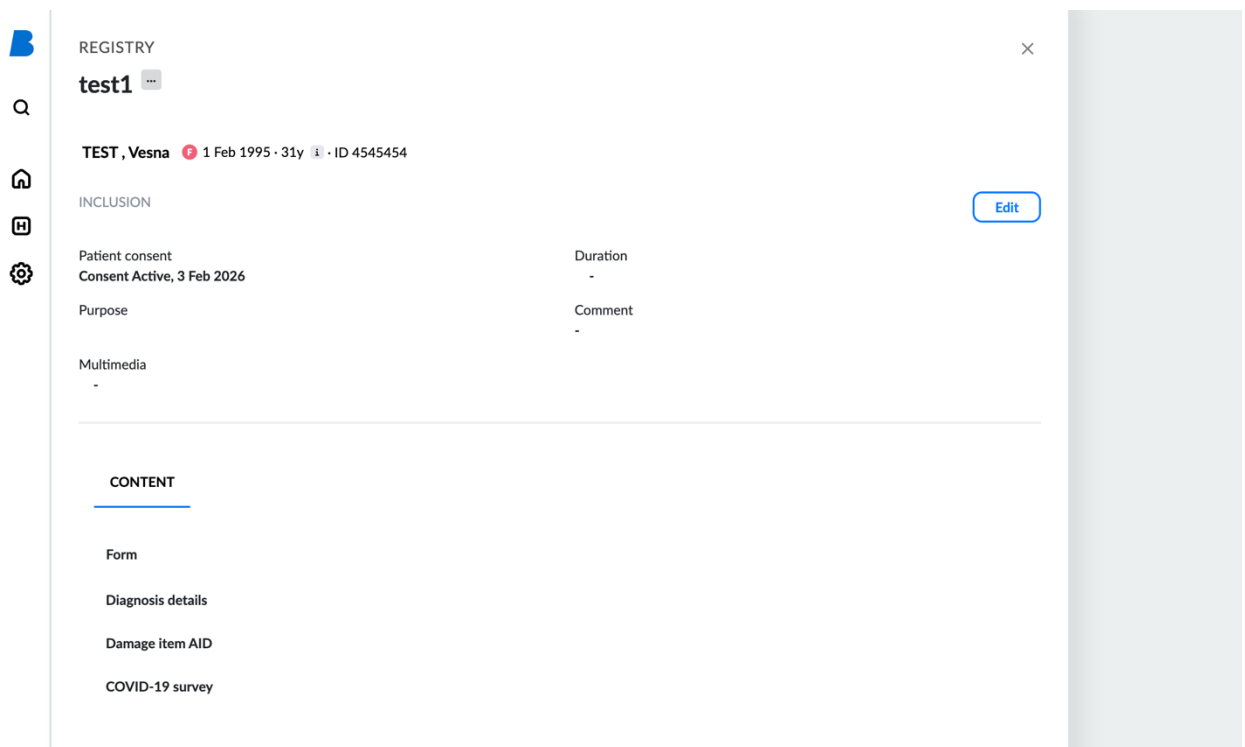
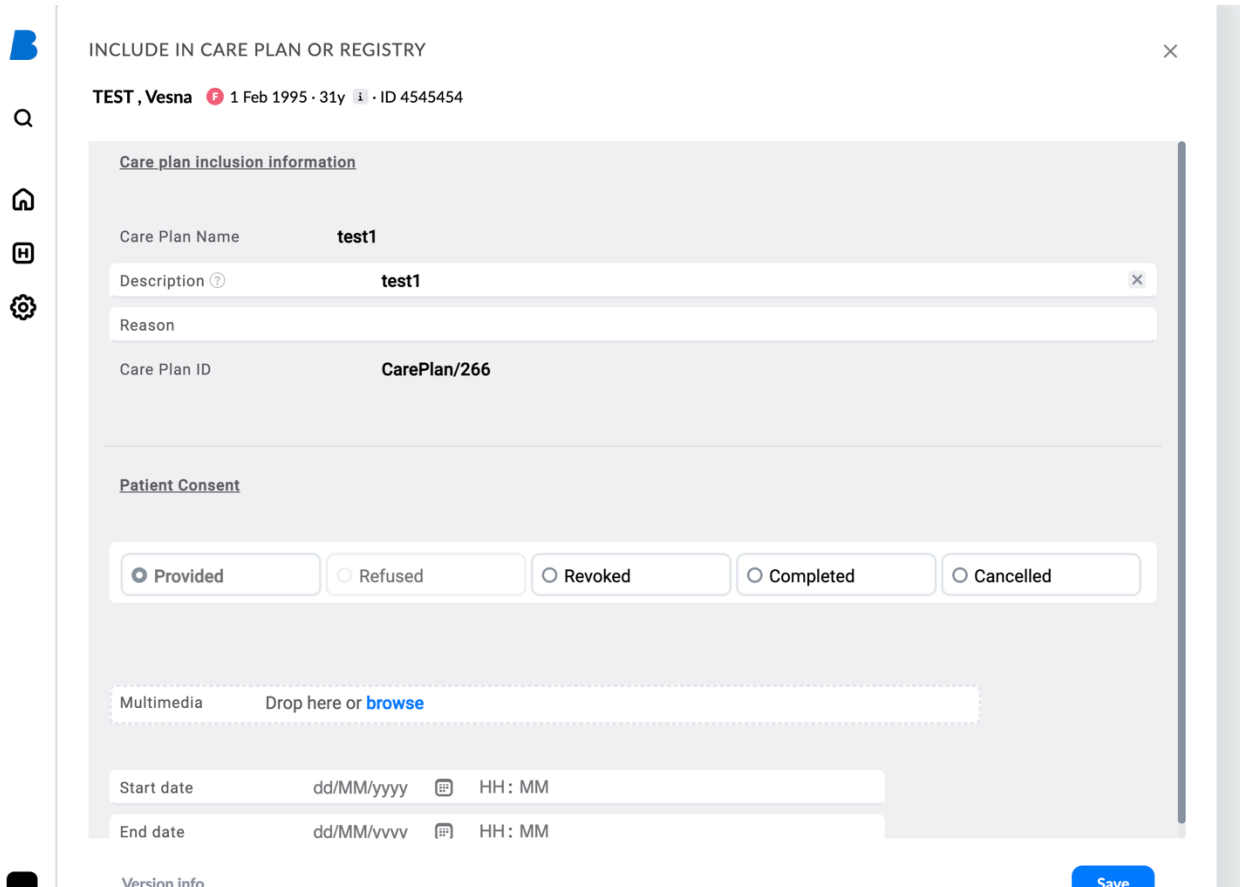


Figure 68. Consent details for a care plan of a patient



B 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/vvvv 📅 HH: MM

Version info Save

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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