

TUTORIAL :

MyPal HCP Web App



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TUTORIAL – CLINICIAN (ADULT STUDY)

The clinician of the Adult-study can login in the platform through a login form. After the clinician logs in the platform will navigate him/her to the notifications page. The clinician through the HCP platform can see information for each of his/her patients, import information, import documents, navigate to the admin panel etc.

1. Login

The clinician inserts his/her credentials to the fields of the login form and presses the “Login” button. After the successful login the user is navigated the notifications page.

1. Add username and password
2. Press “Login” button

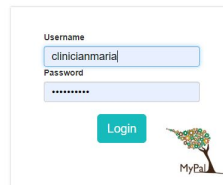
A screenshot of a login form. It features two input fields: 'Username' with the text 'clinicianmaria' and 'Password' with masked characters '*****'. Below the fields is a green 'Login' button. To the right of the button is the MyPal logo, which consists of a stylized tree with colorful leaves and the text 'MyPal' underneath.

Figure 1: Login Page

2. Notifications page

The first page of the clinician platform is the notifications page where any new imported patient's information since clinician's last login are shown. The information are shown in table view and the clinician can see the patient username, week of the study and the scores of BPI, ESAS and Emotional questionnaires.

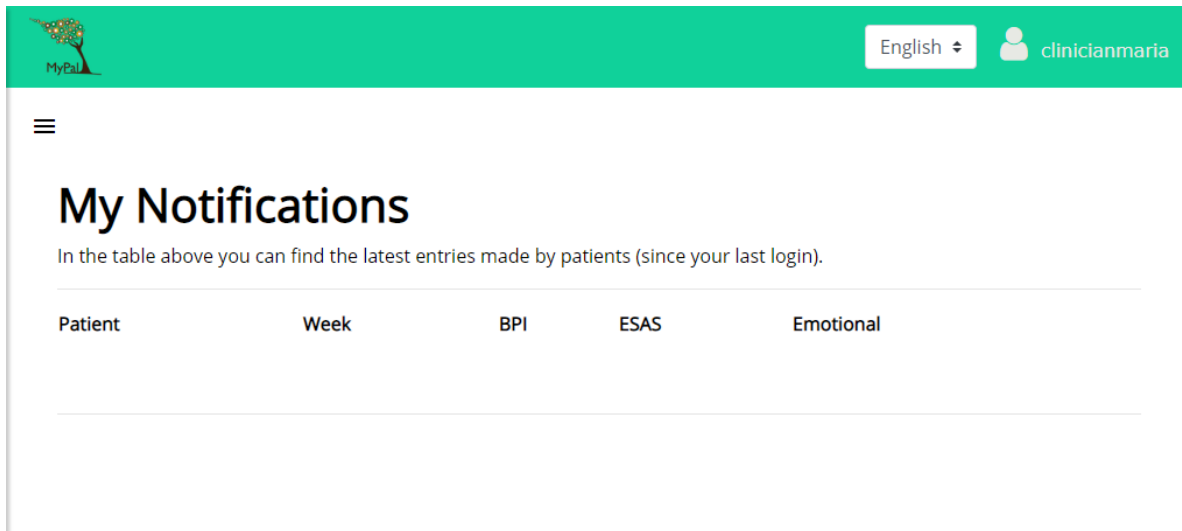


Figure 2: Notifications Page

3. Navigation of the platform

The clinician can select the available tools of the platform by navigating through the menu.

1. Select the menu button ☰ to navigate to the platform
2. Select one of the available tools

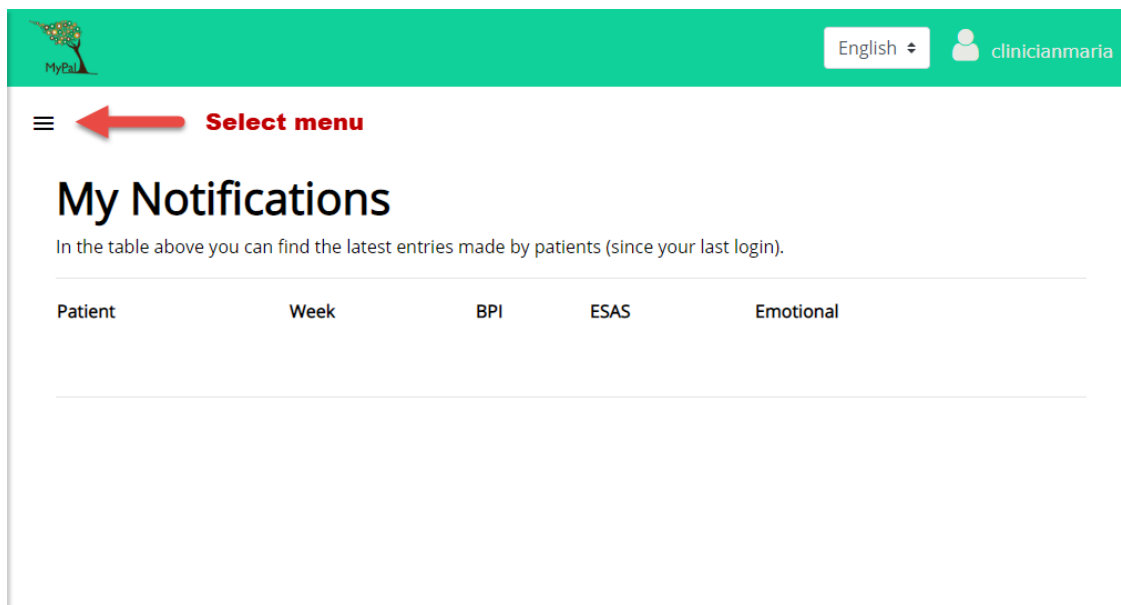


Figure 3: Select menu

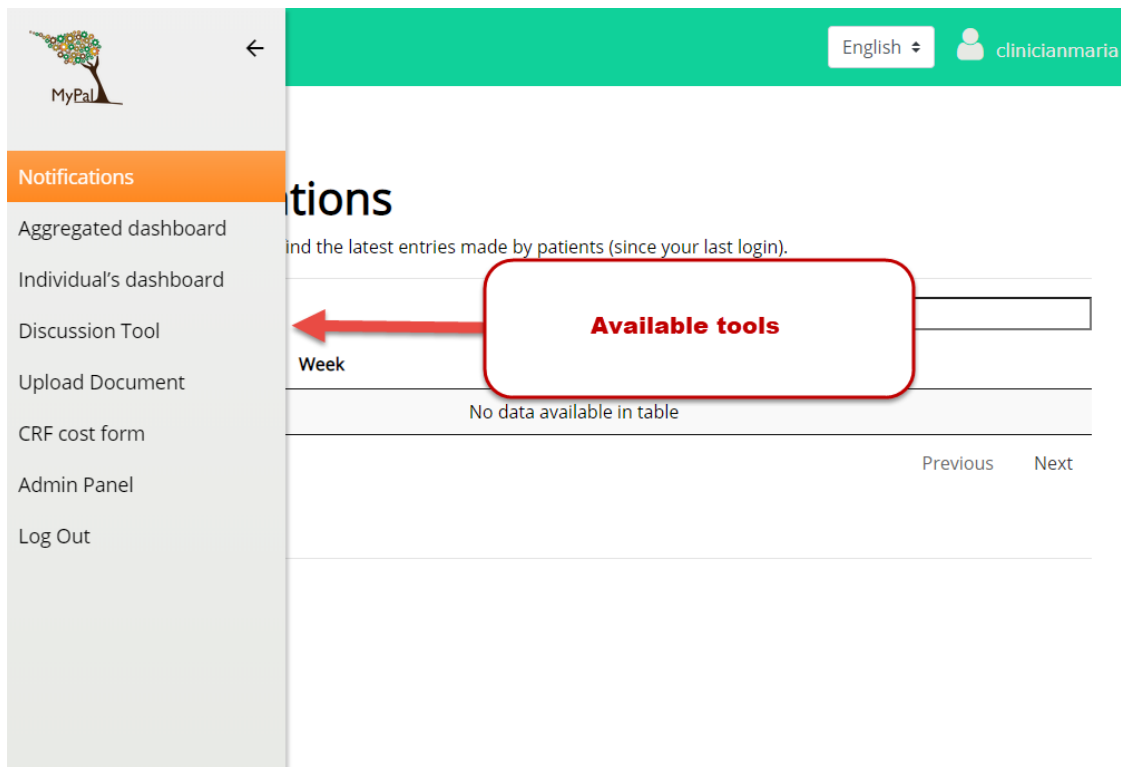


Figure 4: Available tools

4. Aggregated dashboard

The aggregated dashboard shows the statistics of the patients per week starting from the baseline week. The clinician can select week and also can select one of the available tabs which correspond to different information categories.

1. Select week
2. Select one of the available categories
 - a. General Information - The general information tab shows demographics of the available patients as graphs and pies (Figure 5)
 - b. Brief Pain Inventory – The Brief Pain Inventory shows the available scores of the BPI of all patients as graphs
 - c. Edmonton Symptom Assessment System – Similarly this tab shows the information of the Edmonton Symptom Assessment scores of the patients as individual graphs (pain, tiredness, nausea, depression etc.). An example is shown in Figure 6.
 - d. Psychoemotional - This tab shows the scores of emotion thermometers tool of the patients (distress, anxiety, depression, anger etc.)
 - e. Records - The records tab shows a table with all the available patients and their scores in the above questionnaires. The clinician can select one patient by clicking his/hers username and the platform will navigate the clinician to the patient's information in the individual's dashboard tool. An example is shown in Figure 7

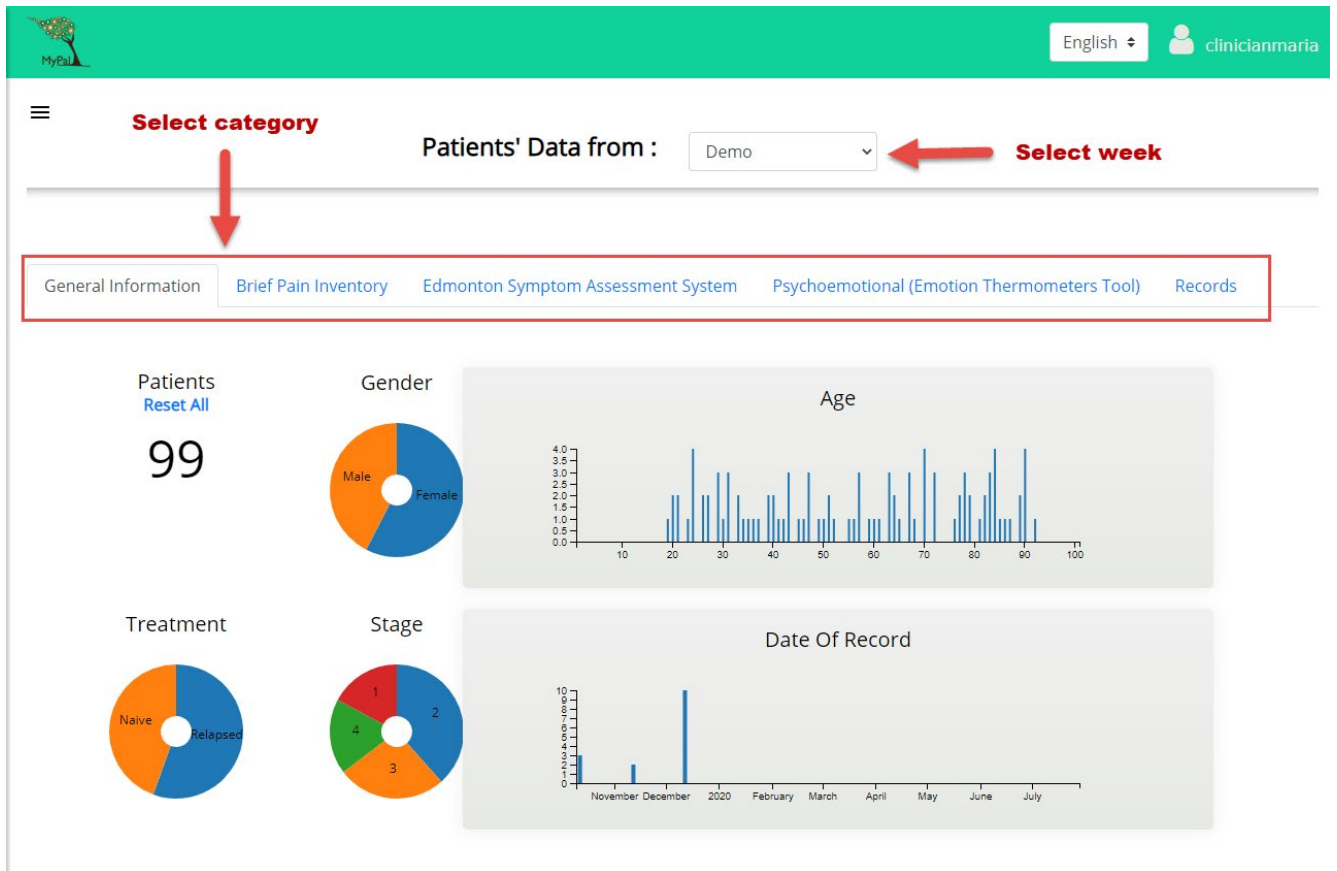


Figure 5: Aggregated dashboard

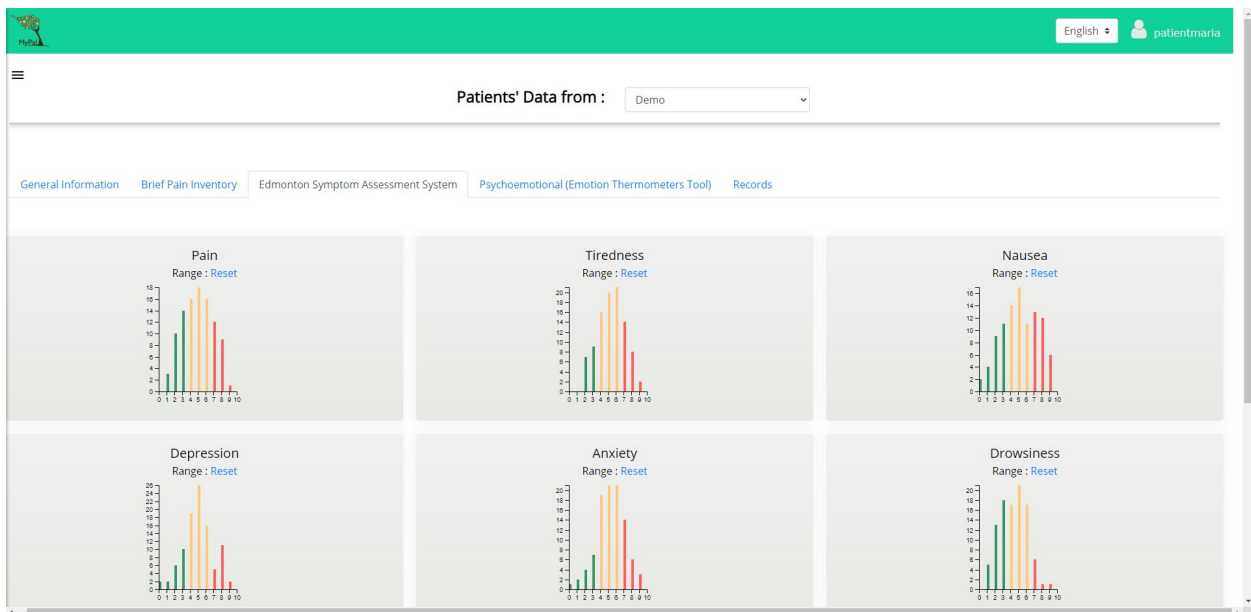


Figure 6: Edmonton Symptom Assessment scores example

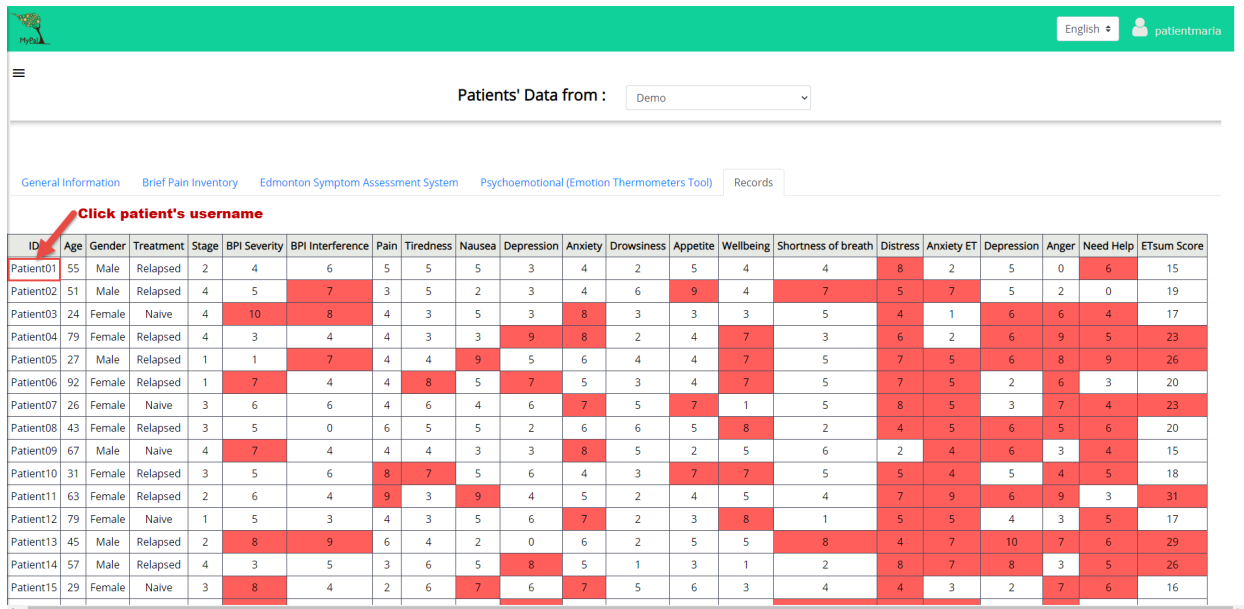


Figure 7: Records tab example

3. Individual's Dashboard

In individual's dashboard the clinician can select a specific patient based on his username by a dropdown menu as shown in Figure 8. Then the clinician can see the statistics of this patient and also add new information such as treatment plans, response logs and appointments. The clinician can navigate to these different categories by pressing the corresponding tabs as shown Figure 10. An example of the statistics of BPI scores is shown in Figure 9. The clinician in each graph can select the score he would like to see, zoom in, zoom out and also can see the medications in combination with the questionnaire scores.

1. Select patient



Figure 8: Individual's dashboard

- Clinical Data ▶
- Treatment Plan ▶
- Response Log ▶
- Schedule Appointment ▶

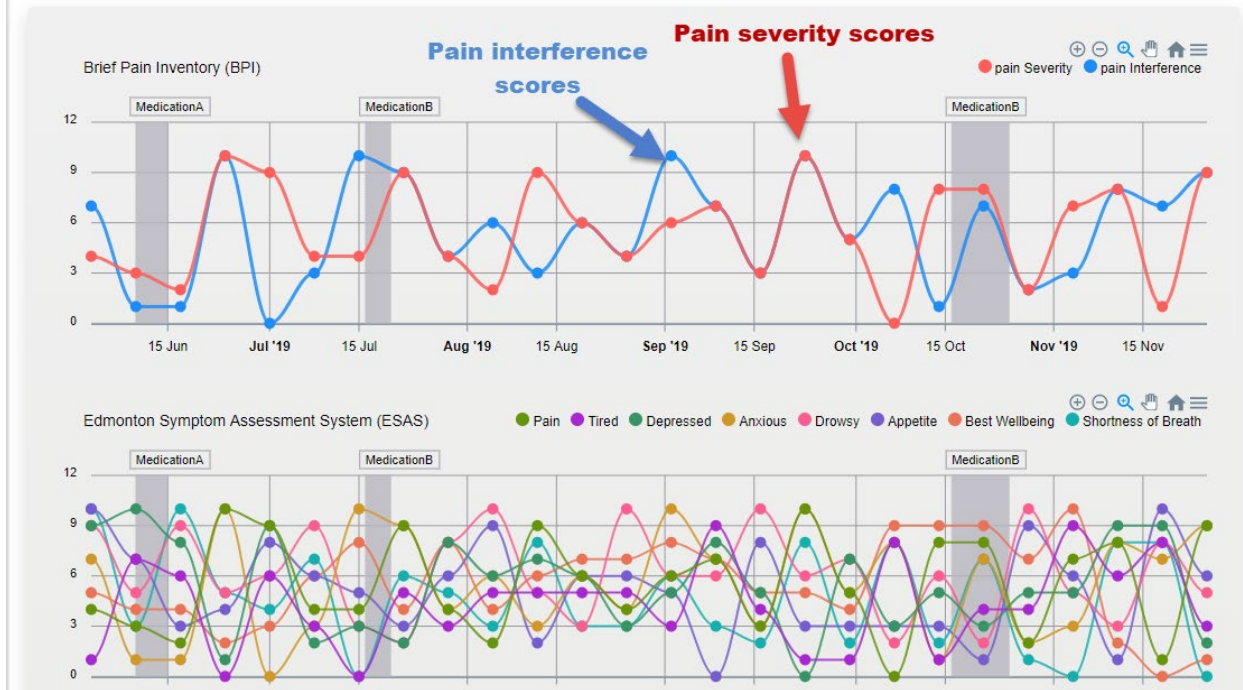


Figure 9: BPI scores graph

1.1.1 Clinical Data

In clinical data tab the clinician can see some basic information of the selected patient such as gender, age, treatment, diagnosis etc.

1. Select clinical data tab for patient's information

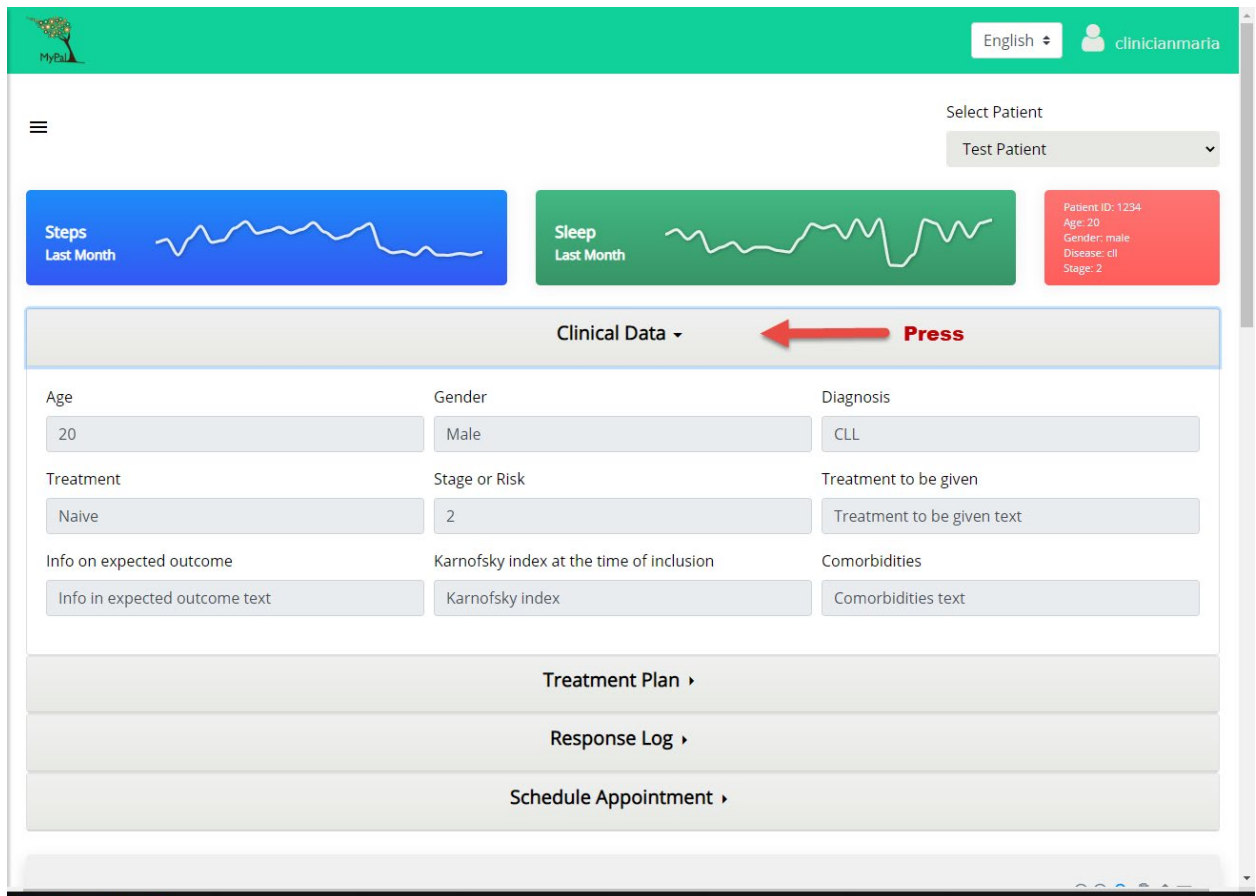
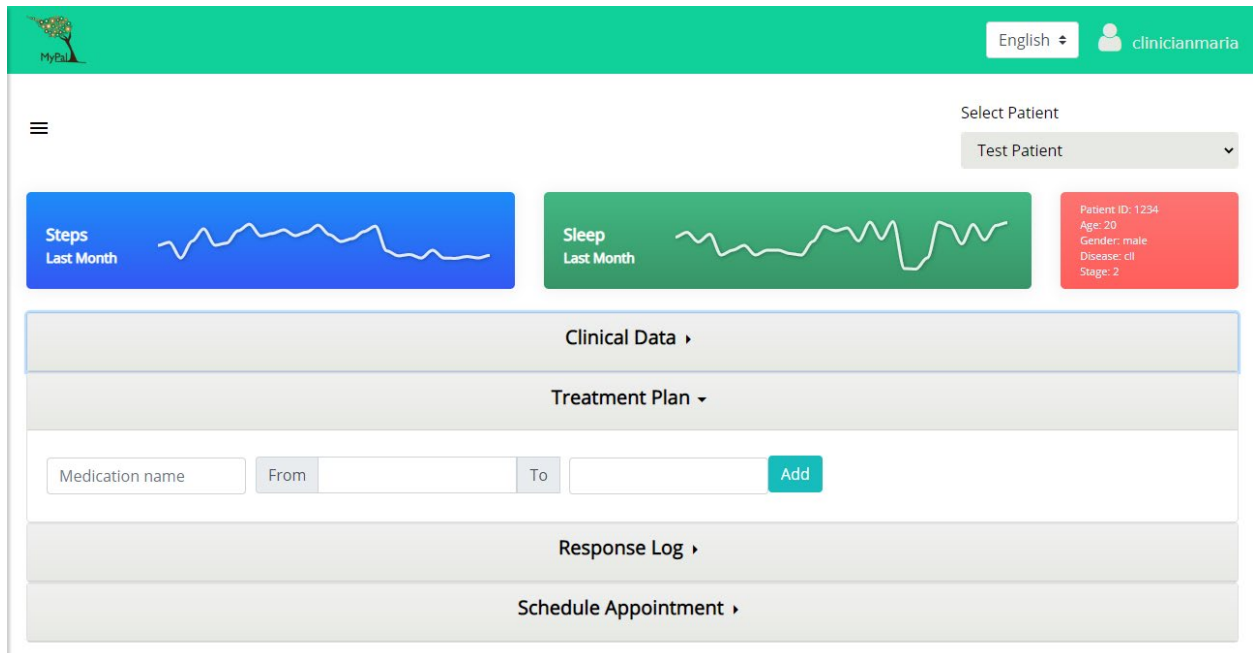


Figure 10: Clinical data

1.1.2 Treatment Plan

In treatment plan tab the clinician can add the medication of the selected patient. This tab is connected with the appointments tab. If the clinician wants to add a treatment's appointment, he has to create the treatment plan first in the treatment plan tab.

1. Select treatment plan tab
2. Add treatment plan's information (Figure 11)
 - Medication name
 - Select Starting date (From)
 - Select Ending date (To)
3. Press "Add" button



The screenshot shows the MyPal HCP Web App interface. At the top, there is a green header with the MyPal logo, a language dropdown set to 'English', and a user profile for 'clinicianmaria'. Below the header, a 'Select Patient' dropdown menu is set to 'Test Patient'. The main content area features three summary cards: 'Steps Last Month' (blue), 'Sleep Last Month' (green), and a patient information card (red) displaying 'Patient ID: 1234', 'Age: 20', 'Gender: male', 'Disease: cl', and 'Stage: 2'. Below these cards are five expandable menu items: 'Clinical Data', 'Treatment Plan', 'Response Log', and 'Schedule Appointment'. The 'Treatment Plan' section is currently expanded, showing a form with fields for 'Medication name', 'From', and 'To', followed by an 'Add' button.

Figure 11: Treatment plan tab

1.1.3 Response log

In the response log the clinician can add response logs for the selected patient as shown in Figure 12

1. Select response log
2. Add response log information
3. Select Date from the calendar
4. Press "Add" button

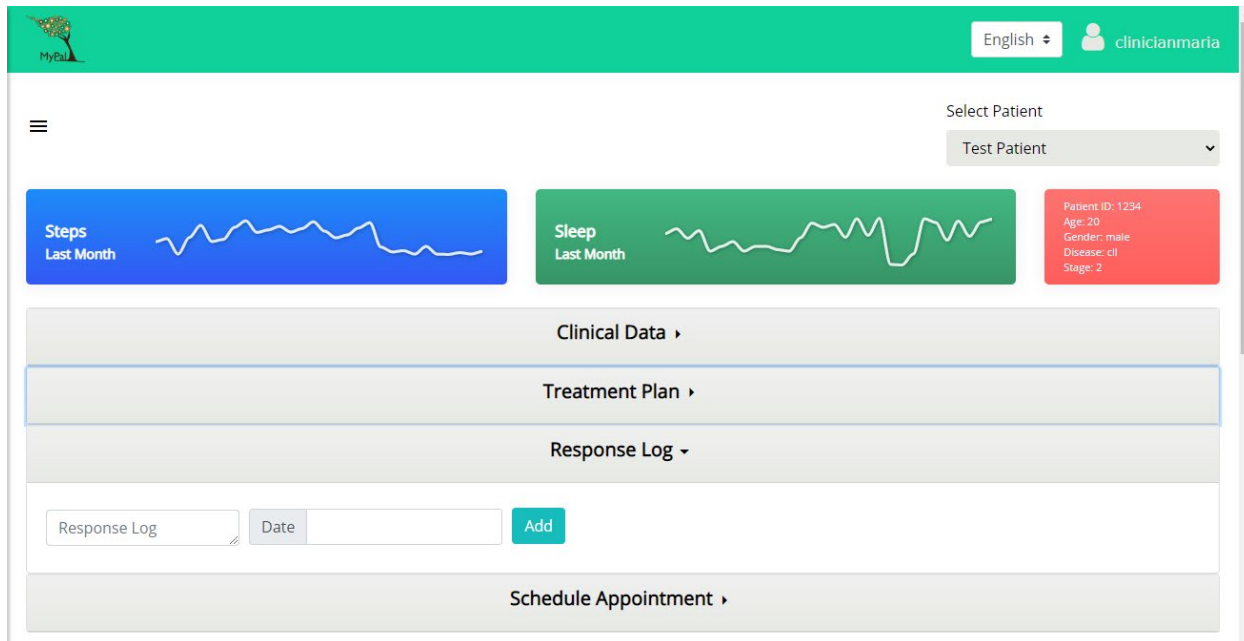


Figure 12: Response log tab

1.1.4 Schedule Appointment

The clinician can add the information of a patient’s appointment. The appointment can be a treatment appointment or a simple appointment. If the clinician wants a treatment appointment, he has to press the checkbox and then a dropdown with the available treatment plans will be shown (the treatment plans that the clinician has added in treatment plan tab)

1. Select appointment
2. Add appointment information
 - If it is a treatment appointment, the treatment plan should have been already saved in the treatment plan tab.
 - Select Date from the calendar
 - Select time
 - Select if it is treatment appointment(optional)
 - If it is a treatment appointment you can select the treatment plan from a dropdown
3. Press “Add” button

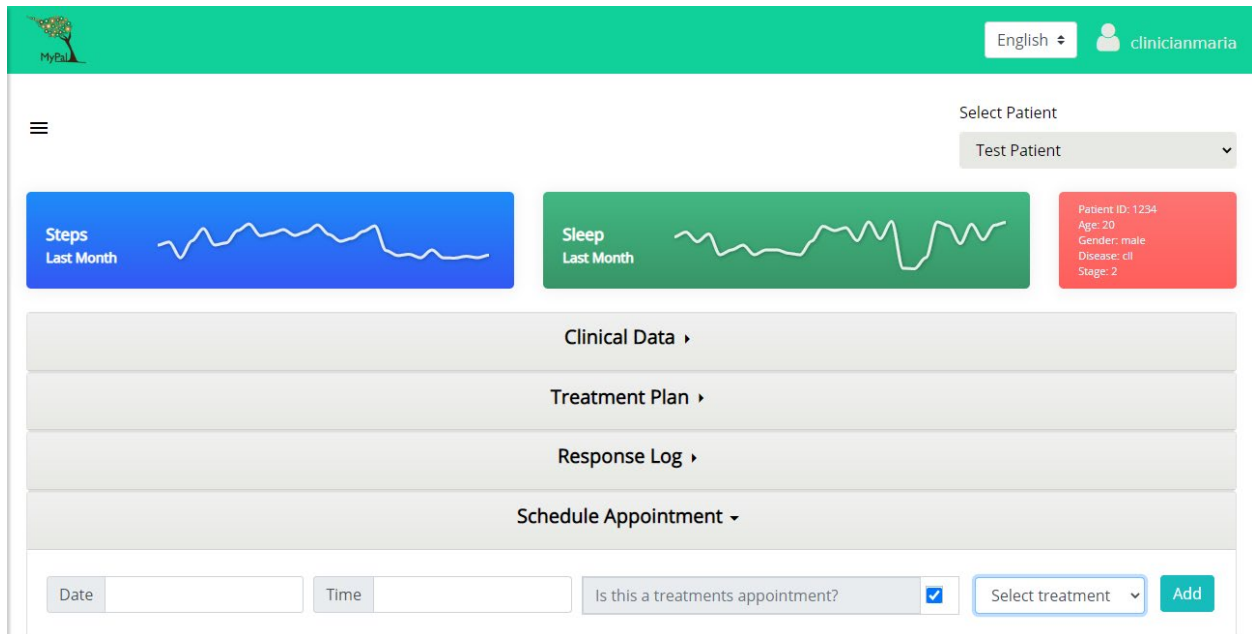


Figure 13: Appointments

4. Discussion Tool

For first use, users can watch a short video at the bottom of the first page – or click ‘Next’ to move to next page.

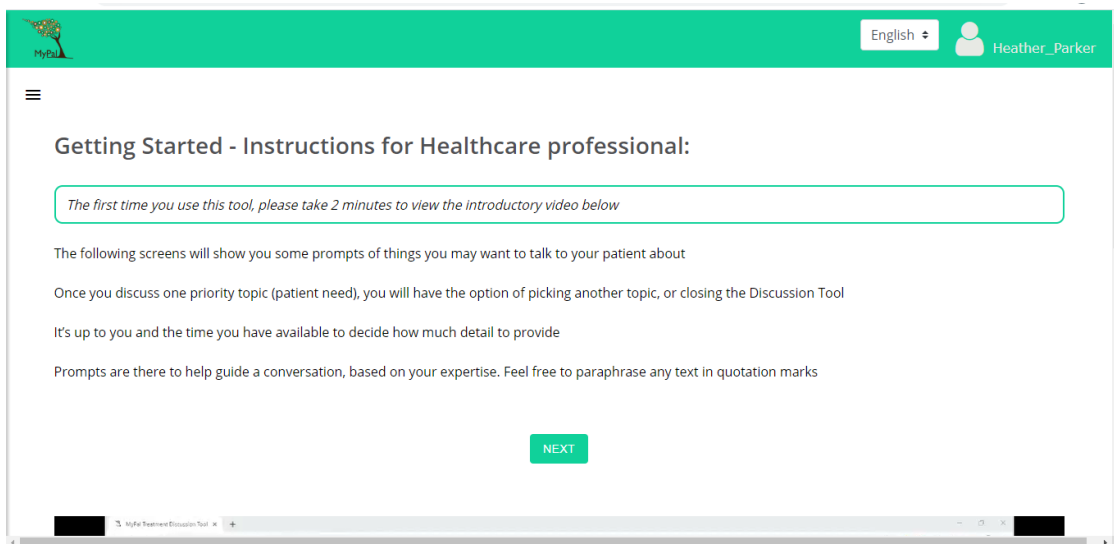


Figure 14: Discussion tool – Introduction Page

1. Enter a patient id for a study participant who has been prescribed medication for CLL or MDS) in order to retrieve their screener survey responses

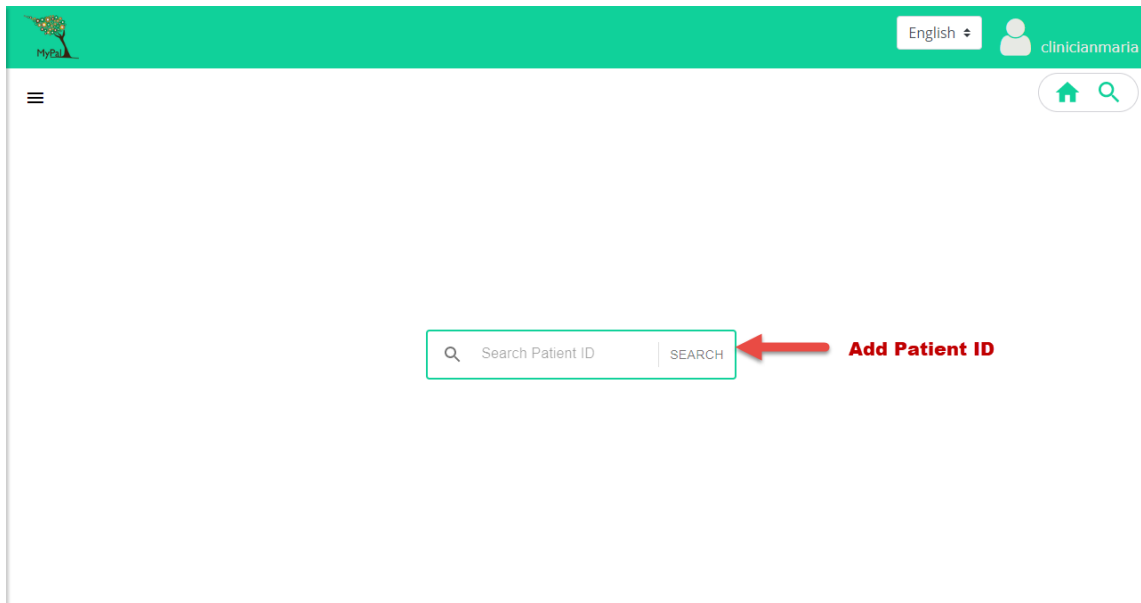


Figure 15: Discussion tool – search screen

- Their Treatment Support (non-adherence risk screener) survey responses will be displayed showing the relative priority for each of the six topics.
- Enter the patient’s ‘Yes’ or ‘No’ response to the medication question ‘Over the past [weeks/months], did you miss any doses?’ The time frame in the question can be tailored according to their specific medication routine.
- Press ‘Save’ to record the answer.

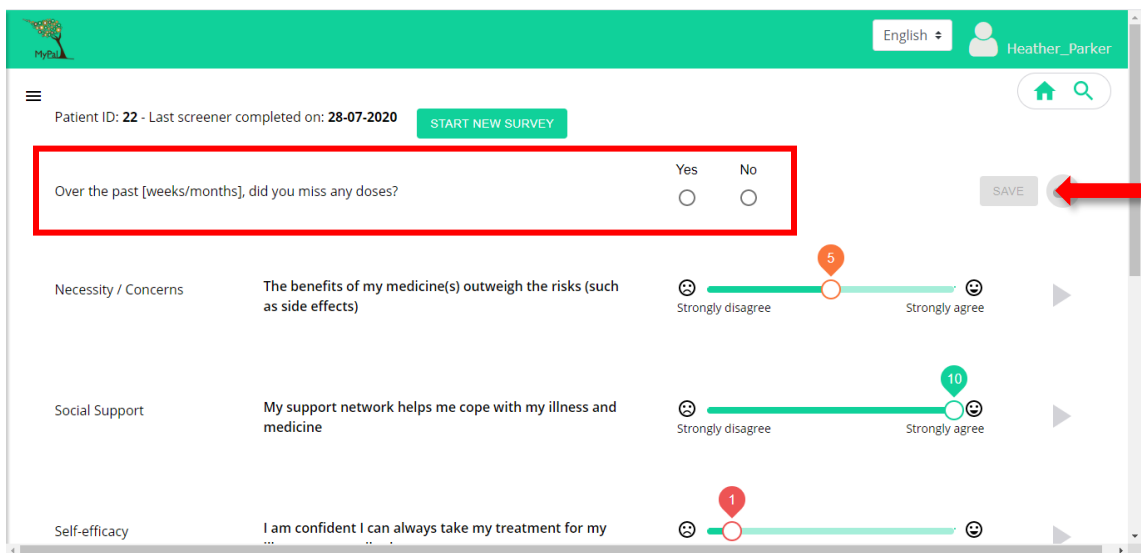


Figure 13: Discussion tool – survey results screen

- Agree with the patient the most important of the topics they would like to discuss further in your consultation.
- Click the Arrow symbol to move to the Discussion pages for your chosen topic



Figure 14: Discussion tool – survey results screen with activated buttons

- Follow the suggested questions to prompt your discussion, and select the options with arrows based on how the patient responds to move forward in the guide pages.

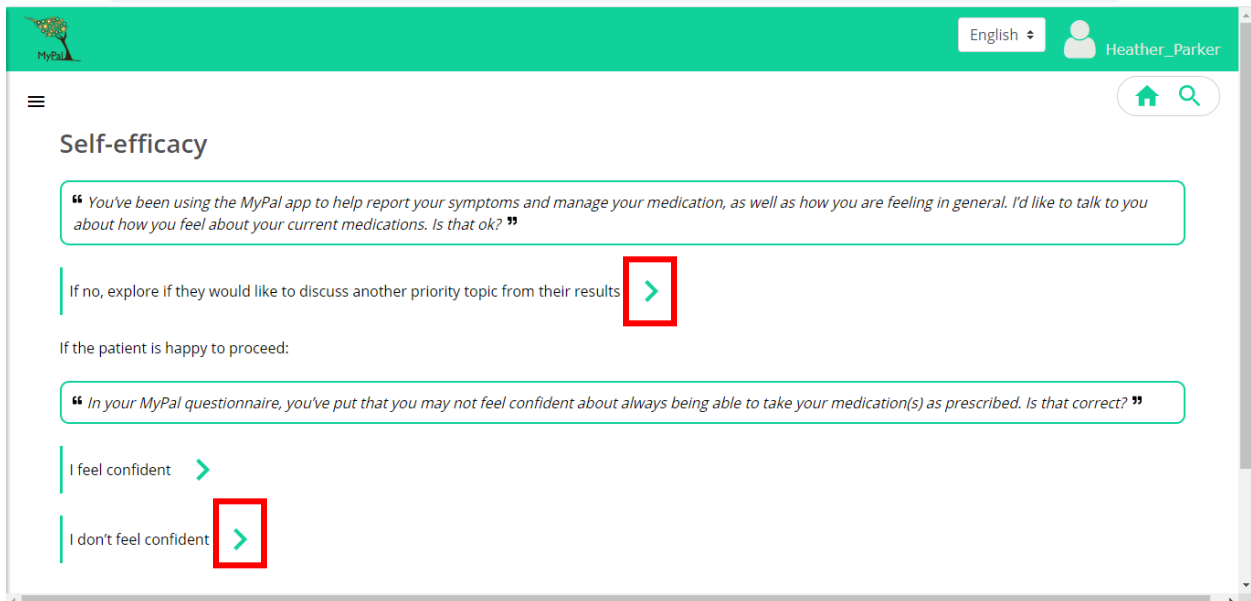


Figure 15: Discussion tool – topic-specific prompts and options to guide the discussion with a patient

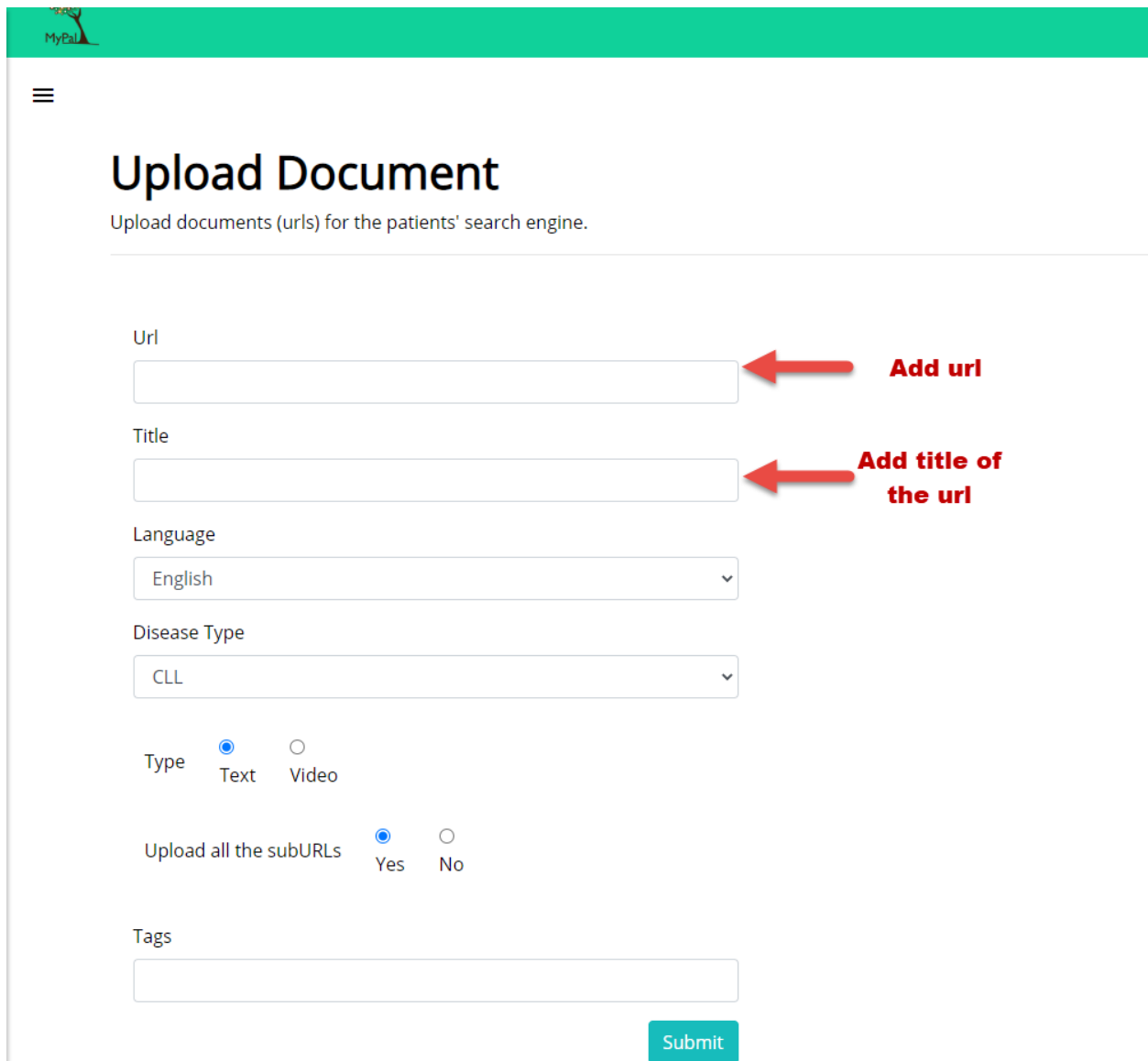
5. Upload Document

In the upload document the clinician adds medical documents that believes should be read from the patients. The documents shown to the patients are only the documents saved in this page from the clinicians.

1. Add the link of the document you want to upload
2. Add the title of the document

The clinician can:

- Select language
- Add disease Type
- Select text or video
- Select if subURLs will be uploaded or not
- Add tags of the document



Upload Document
Upload documents (urls) for the patients' search engine.

Url **Add url**

Title **Add title of the url**

Language

Disease Type

Type Text Video

Upload all the subURLs Yes No

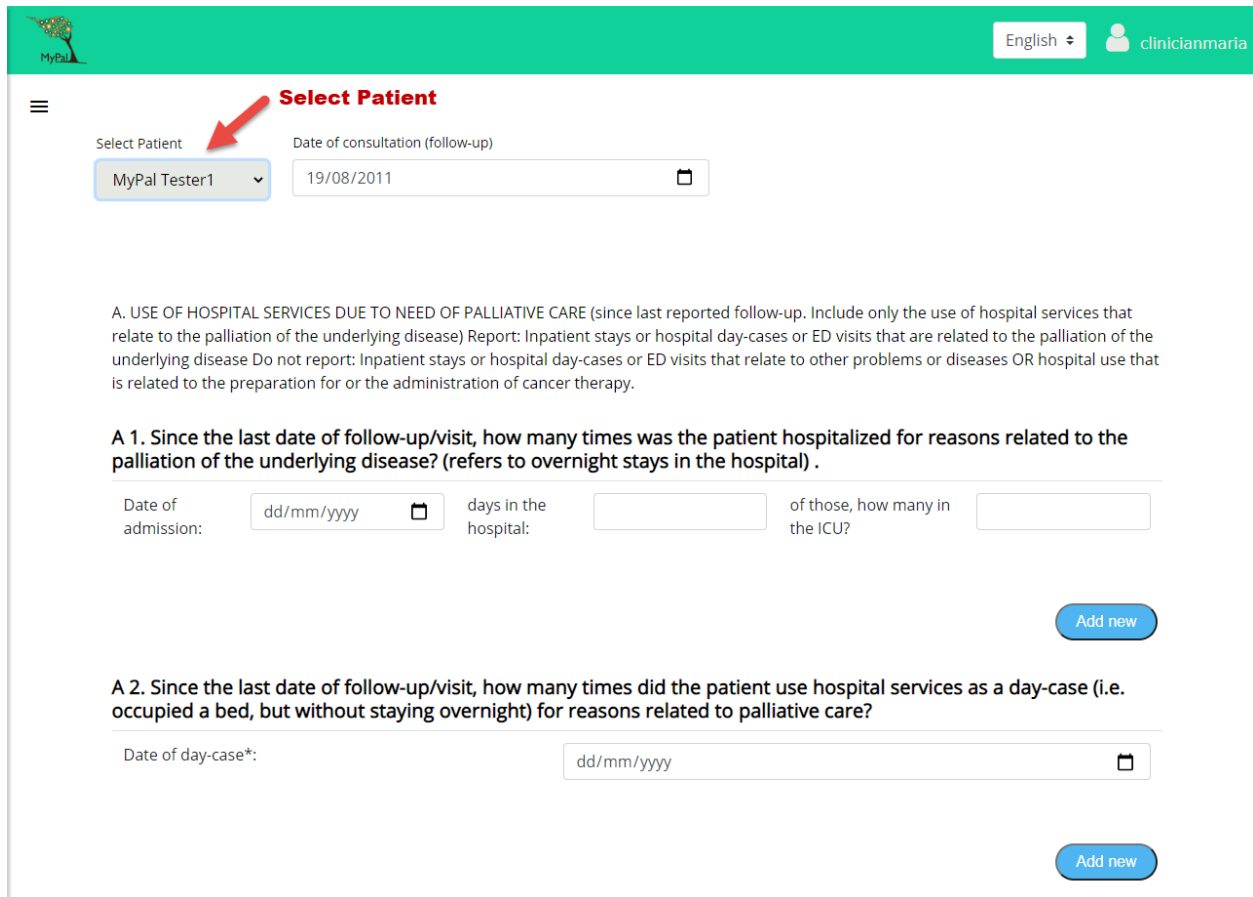
Tags

Figure 16: Upload document

6. CRF cost form

The CRF cost form is a questionnaire which is completed by the clinician about a specific patient. The clinician selects the patients based on his/hers username from a dropdown menu as shown in Figure 17 and also selects the date of consultation.

1. Select patient by pressing the dropdown (Figure 17)
2. Complete the CRF cost form



The screenshot shows the MyPal HCP Web App interface. At the top, there is a green header bar with the MyPal logo on the left, a language dropdown set to 'English', and a user profile icon labeled 'clinicianmaria'. Below the header, a red arrow points to the 'Select Patient' dropdown menu, which is currently set to 'MyPal Tester1'. To the right of this dropdown is a date field for 'Date of consultation (follow-up)' with the value '19/08/2011' and a calendar icon. Below these fields is a section titled 'A. USE OF HOSPITAL SERVICES DUE TO NEED OF PALLIATIVE CARE (since last reported follow-up. Include only the use of hospital services that relate to the palliation of the underlying disease) Report: Inpatient stays or hospital day-cases or ED visits that are related to the palliation of the underlying disease Do not report: Inpatient stays or hospital day-cases or ED visits that relate to other problems or diseases OR hospital use that is related to the preparation for or the administration of cancer therapy.' This section contains two questions: 'A 1. Since the last date of follow-up/visit, how many times was the patient hospitalized for reasons related to the palliation of the underlying disease? (refers to overnight stays in the hospital) .' and 'A 2. Since the last date of follow-up/visit, how many times did the patient use hospital services as a day-case (i.e. occupied a bed, but without staying overnight) for reasons related to palliative care?'. For question A 1, there are input fields for 'Date of admission:' (with a date format 'dd/mm/yyyy' and a calendar icon), 'days in the hospital:', and 'of those, how many in the ICU?'. For question A 2, there is an input field for 'Date of day-case*:' (with a date format 'dd/mm/yyyy' and a calendar icon). Both question sections have a blue 'Add new' button.

Figure 17: CRF cost form