

**Boston
Scientific**

CLINICIAN MANUAL

ADVANTICS™ Enhanced Support Program for Heart Failure

Care Coordinator Dashboard

REF 3900

Остаряла версия. Да не се използва.
Zastaralá verze. Nepoužívat.
Forældet version. Må ikke anvendes.
Version überholt. Nicht kasutage.
Aegunud versioon. Ärge kasutage.
Παλιά έκδοση. Μην την χρησιμοποιείτε.
Outdated version. Do not use.
Version obsoleta. Ne pas utilizar.
Version périmée. Nemojte upotrebljavati.
Zastarjela verzija. Neizmantot.
Úrelt útgáfa. Notið ekki.
Versione obsoleta. Non utilizzare.
Pasenusi versija. Nenaudokite.
Elavult verzió. Ne használja!
Dit is een verouderde versie. Niet gebruiken.
Utdatert versjon. Skal ikke brukes.
Wersja przeterminowana. Nie używać.
Versão obsoleta. Não utilize.
Zastaraná verzia. Nepoužívať.
Zastarela različica. Ne uporabite.
Vanhentunut versio. Älä käytä.
Föråldrad version. Använd ej.
Güncel olmayan sürüm. Kullanmayın.

ABOUT THIS MANUAL

This manual contains information about the Care Management Platform for the ADVANTICS Enhanced Support Program for Heart Failure (hereafter referred to as “ESP for HF”). The Care Management Platform is a web application used by health care providers to provide post-discharge support to heart failure patients as part of a support program.

Intended Audience

This literature is intended for use by healthcare providers authorized by their healthcare institution to provide post-discharge support for heart failure patients as part of the ESP for HF. The following are user roles within the application:

- **Care Coordinator** – enrolls heart failure patients in the program and performs tasks related to post-discharge care, including health education and check-ups via telephone calls. They can also view and download reports.
- **Care Coordinator Admin** – manages application settings, user accounts, and assignments for Care Coordinators. They can also view and download reports.

Manual Conventions

The screen illustrations used in this manual are intended to familiarize you with the general screen layout. Information provided on the screens that is imported into the Care Management Platform from the EMR system, as well as settings and some fields displayed, will vary by healthcare institution based on decisions made during system configuration.

Patient names displayed in screen illustrations are fictitious. Any resemblance to a real person, living or dead, is purely coincidental.

Unless serving as a heading, bold words within the text of this manual are intended to represent the actual words appearing in the application.

Abbreviations

The following abbreviations may be used in labeling or within the application.

DIS	discharge date
EMR	electronic medical record
EMR ID	electronic medical record identifier
ESP	enhanced support program
HF	heart failure
KPI	key performance indicator
LC	last contacted date
MRN	medical record number
NHS	National Health Service
SMS	Short Message Service

Trademarks

The following are trademarks of Boston Scientific Corporation or its affiliates: ADVANTICS.

Third-party trademarks referenced within this manual are listed below:

- Android and Chrome are trademarks of Google Inc.
- Internet Explorer is a trademark of Microsoft Corporation.
- Apple, iPad, and Safari are trademarks of Apple Inc.

Остаряла версия. Да не се използва.
Zastaralá verze. Nepoužívat.
Forældet version. Må ikke anvendes.
Version überholt. Nicht kasutage.
Version verhoon. Mην την χρησιμοποιείτε.
Aegunud versioon. Ärge kasutage.
Παλιά έκδοση. Μην την χρησιμοποιείτε.
Outdated version. Do not use.
Version obsolete. Ne utilizar.
Version périmée. Ne pas utiliser.
Zastarjela verzija. Nemojte upotrebljavati.
Úrelt útgáfa. Notið ekki.
Versione obsoleta. Non utilizzare.
Zastarjela verzija. Neizmantot.
Úrelt útgáfa. Notið ekki.
Novecojusi versija. Nenaudokite.
Pasenusi versija. Neizmantot.
Elavult verzió. Ne használja!
Dit is een verouderde versie. Niet gebruiken.
Utdatert versjon. Skal ikke brukes.
Wersja przeterminowana. Nie używać.
Versão obsoleta. Não utilize.
Versiune expirată. A nu se utiliza.
Zastaraná verzia. Nepoužívať.
Zastarela različica. Ne uporabite.
Vanhentunut versio. Älä käytä.
Föråldrad version. Använd ej.
Güncel olmayan sürüm. Kullanmayın.

TABLE OF CONTENTS

THE ADVANTICS ENHANCED SUPPORT PROGRAM FOR HEART FAILURE.....	1
INTRODUCTION	2
Intended Use	2
Contraindications	2
Warnings.....	2
Precautions.....	2
Potential Adverse Events.....	3
Customer Support	3
USING THE CARE MANAGEMENT PLATFORM.....	4
GETTING STARTED.....	5
Requirements	5
Patient, Clinician, and Healthcare Institution Relationships	5
User Privileges	5
Logging In and Out.....	6
Navigating the Site	6
Profile	7
USING THE CARE COORDINATOR DASHBOARD	8
NAVIGATING THE CARE COORDINATOR DASHBOARD.....	9
Banner.....	9
Care Coordinator Dashboard Homepage.....	9
Activity Screens.....	11
Action Menu Button	12
Search	12
Alerts and Notifications.....	12
Care Coordinator Preferences.....	12
Tasks	13
Historical Activities.....	14
Patients.....	14
PATIENT ENROLLMENT.....	15
Enrolling Patients.....	16
Forcing Patient Enrollment.....	19
Post-discharge Enrollments.....	19
Disenrolling Patients.....	20
PATIENT 360	20
Patient Profile	22
Timeline	22
Notes	24
CALL SCRIPTS.....	24
Calling Patients.....	25
REPORTS.....	27
Operational Reports	27
KPI Reports	28
USING THE ADMINISTRATIVE PORTAL	29
NAVIGATING THE ADMINISTRATIVE PORTAL.....	30
Care Coordinator Admin Preferences.....	31
HOSPITAL SETTINGS.....	31
USER ACCOUNT MANAGEMENT.....	32
Creating a User Account.....	32
Modifying a User Account.....	32
Deleting a User Account	32
Viewing User Account Management Reports	33

Password Management.....	3 3
CARE COORDINATOR TEAM MANAGEMENT.....	3 3
PATIENT SUPPORT PROGRAM SETTINGS.....	3 4
TASK MANAGEMENT	3 4
PATIENT MANAGEMENT.....	3 5
REPORTS.....	3 5
USING THE KPI DASHBOARDS	3 6
OVERVIEW.....	3 7
Logging In and Out.....	3 7
Navigating the KPI Dashboards	3 8
SYMBOLS.....	3 9

Остаряла версия. Да не се използва.
 Zastaralá verze. Nepoužívat.
 Forældet version. Må ikke anvendes.
 Version überholt. Nicht verwenden.
 Aegunud versioon. Ärge kasutage.
 Παλιά έκδοση. Μην την χρησιμοποιείτε.
 Outdated version. Do not use.
 Versión obsoleta. No utilizar.
 Version périmée. Ne pas utiliser.
 Zastarjela verzija. Nemojte upotrebljavati.
 Úreлт útгáfa. Notið ekki.
 Versione obsoleta. Non utilizzare.
 Pasenusi versija. Nenaudokite.
 Elavult verzió. Ne használja!
 Dit is een verouderde versie. Niet gebruiken.
 Utdatert versjon. Skal ikke brukes.
 Wersja przeterminowana. Nie używać.
 Versão obsoleta. Não utilize.
 Zastaraná verzia. Nepoužívať.
 Zastarela različica. Ne uporabite.
 Vanhentunut versio. Älä käytä.
 Föråldrad version. Använd ej.
 Güncel olmayan sürüm. Kullanmayın.

THE ADVANTICS ENHANCED SUPPORT PROGRAM FOR HEART FAILURE

CHAPTER 1

This chapter contains the following topics:

- “INTRODUCTION” on page 2

Остаряла версия. Да не се използва.
Zastaralá verze. Nepoužívat.
Forældet version. Må ikke anvendes.
Version überholt. Nicht kasutage.
Aegunud versioon. Ärge kasutage.
Παλιά έκδοση. Μην την χρησιμοποιείτε.
Outdated version. Do not use.
Version obsoleta. Ne utilizar.
Version périmée. Ne pas utiliser.
Zastarjela verzija. Nemojte upotrebljavati.
Úrejt útgáfa. Notið ekki.
Versione obsoleta. Non utilizzare.
Pasenusi versija. Neizmantot.
Elavult verzió. Ne használja!
Dit is een verouderde versie. Niet gebruiken.
Utdatert versjon. Skal ikke brukes.
Wersja przeterminowana. Nie używać.
Versão obsoleta. Não utilize.
Zastaraná verzia. Nepoužívať.
Zastarela različica. Ne uporabite.
Vanhentunut versio. Älä käytä.
Föråldrad version. Använd ej.
Güncel olmayan sürüm. Kullanmayın.

INTRODUCTION

The Care Management Platform is a web application used by healthcare providers to administer the ADVANTICS Enhanced Support Program for Heart Failure, a post-discharge support program.

The application integrates with the healthcare institution's electronic medical record (EMR) system to import patient data. The application assigns an initial patient status of Eligible or Ineligible when data is imported into the Care Management Platform. The status is based on criteria that will be pre-set for the healthcare institution during system configuration.

Healthcare providers assigned to the Care Coordinator role within the application review the patient's health record and communicate with them to conduct a secondary eligibility assessment based on qualitative attributes, such as cognitive and physical function using the application. The Care Coordinator may choose to enroll a patient with either an Eligible or Ineligible status.

Patients are further assessed during enrollment to determine the risk of re-admission and structure of follow-up communication needed. The application uses this information to generate a support plan or "contact strategy" which determines both the order of content and the frequency of contact a patient receives following hospital discharge.

The program begins once a patient is enrolled and may continue for up to six months. Delivery of the program content does not begin until after the patient has been discharged from the hospital. The Care Coordinator delivers support to the patient directly or through a contact designated by the patient. The program includes health education engaging with the patient via telephone calls, Emails, and text messages.

Patients must consent to participate in the program and may choose to disenroll from the program at any time. The program is designed to reduce hospital re-admissions.

Intended Use

The Care Management Platform is a web application intended for use by healthcare providers to manage delivery of the ADVANTICS Enhanced Support Program for Heart Failure, a support program consisting of follow-up and patient education for heart failure patients after discharge from hospital. The program is designed to reduce hospital re-admissions.

The support program is intended to complement standard of care.

Contraindications

There are no known contraindications.

Warnings

The Care Management Platform is not a replacement of the hospital electronic medical record (EMR) system and is not intended to provide information to change a patient's prescription or therapy.

Precautions

Prior to making a decision regarding changes in medications or other treatment plans, the patient and their medical record should be consulted to verify data found in the Care Management Platform.

The support program is intended to complement standard of care. It does not replace clinical care or decision-making for heart failure patients. Healthcare providers should not rely solely on the platform to create a patient care plan.

The healthcare provider should inform the patient that enrollment in the Enhanced Support Program for Heart Failure is not a replacement for normally scheduled appointments and does not actively monitor the patient's condition.

Potential Adverse Events

There are no known potential adverse events.

Customer Support

Boston Scientific provides technical and general maintenance support to customers using the Care Management Platform. Contact Boston Scientific Customer Support as follows:

- By phone: 01442411690
- By Email: espht.support@bsci.com

USING THE CARE MANAGEMENT PLATFORM

CHAPTER 2

This chapter contains the following topics:

- “GETTING STARTED” on page 5

Остаряла версия. Да не се използва.
Zastaralá verze. Nepoužívat.
Forældet version. Må ikke anvendes.
Version überholt. Nicht kasutage.
Aegunud versioon. Ärge kasutage.
Παλιά έκδοση. Μην την χρησιμοποιείτε.
Outdated version. Do not use.
Version obsoleta. Ne utilizar.
Version périmée. Ne pas utiliser.
Zastarjela verzija. Nemojte upotrebljavati.
Úrejt útgáfa. Notið ekki.
Versione obsoleta. Non utilizzare.
Pasenusi verzija. Neizmantot.
Úrejt útgáfa. Notið ekki.
Novecojusi versija. Nenaudokite.
Elavult verzió. Ne használja!
Dit is een verouderde versie. Niet gebruiken.
Utdatert versjon. Skal ikke brukes.
Wersja przeterminowana. Nie używać.
Versão obsoleta. Não utilize.
Zastaraná verzia. Nepoužívať.
Zastarela različica. Ne uporabite.
Vanhentunut versio. Älä käyttää.
Föråldrad version. Använd ej.
Güncel olmayan sürüm. Kullanmayın.

GETTING STARTED

The Care Management Platform is available to healthcare professionals authorized by their healthcare institution. Each healthcare institution has a unique URL for accessing the application. A Care Coordinator Admin sets up accounts within the application for authorized users.

Requirements

The following Internet browsers are supported for use with the Care Management Platform:

- Chrome™ browser 55.0.2883.87 (Windows 7) or 58.0.3029.110 (Windows 10)
- Internet Explorer™ 11
- Safari™ 5.1.7

For optimal results, use the Care Management Platform on systems with a Windows 7 or Windows 10 operating system.

Users of the Care Management Platform also have the option of using a mobile device for enrollment of patients. The mobile application is accessible on Android™ tablets. Apple™ iPad™ users will be able to access the application but may experience slight delays in performance.

Patient, Clinician, and Healthcare Institution Relationships

Patient follow-up through the Care Management Platform is based on the relationship of patients to healthcare institutions. Each user of the application has a user account that is associated with their specific healthcare institution.

User Privileges

Access to patient data is controlled by role privileges as described below. The functions that each role can perform are shown in Table 1 on page 5. For more information about the user roles, see "Intended Audience" in the front of this manual.

Table 1. Functions Permitted for Users by Privilege

Function	Care Coordinator	Care Coordinator Admin
Receive alerts/notifications	✓	
Edit preferences	✓	✓
Schedule tasks/log activities	✓	
Complete tasks	✓	
Reassign tasks	✓	✓
Enroll/disenroll patients	✓	
View Patient 360	✓	
Edit program and hospital settings		✓
Create/manage user accounts		✓
Reassign Care Coordinators to teams		✓
Reassign patients		✓
View Operational and KPI reports	✓	✓
View User Account Management reports		✓

Function	Care Coordinator	Care Coordinator Admin
View PDF of KPI reports	✓	
Access KPI Dashboards		✓

Logging In and Out

Log in to the Care Management Platform as follows:

1. Launch your web browser and enter the URL assigned to your healthcare institution into the address bar. The login screen appears ("Figure 1. Log In Screen" on page 6).
2. Enter your user name and password and click the **Log In** button.

Incorrect Password — A user's account locks after three failed login attempts using an incorrect password. The account automatically unlocks after 24 hours or can be manually unlocked by a Care Coordinator Admin resetting the user's password. For more information about passwords, see "Password Management" on page 33. For more information on resetting a password, see "Modifying a User Account" on page 32.

Login Session Time Out — An individual session starts each time a user logs in. If a logged-in user is inactive for more than 10 minutes, the session closes automatically, effectively logging the user out. The user is prompted to log in again if they try to access an expired session.

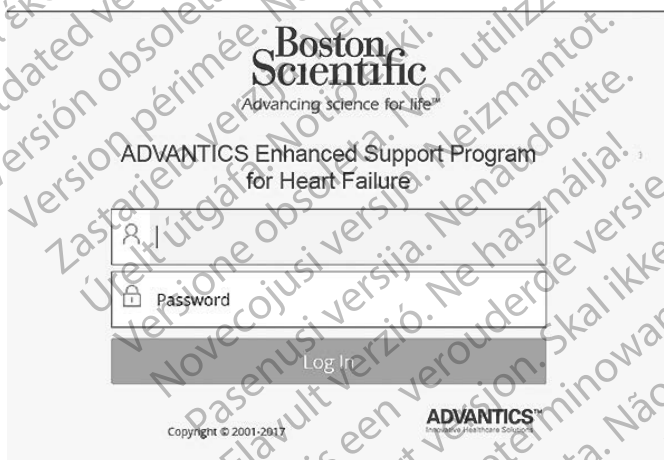


Figure 1. Log In Screen

Log out of the Care Management Platform by clicking the profile icon in the upper right corner of the screen and clicking the **Log Out** button on the profile page.

Navigating the Site

The Care Management Platform contains three portals:

- Care Coordinator Dashboard
- Administrative Portal
- KPI Dashboards

Users assigned to the Care Coordinator role are directed to the Care Coordinator Dashboard after logging in.

Users assigned to the Care Coordinator Admin role are directed to the Administrative Portal after logging in.

Users assigned to both roles will be directed to either the Care Coordinator Dashboard or the Administrative Portal, depending on their primary role allocation. They can navigate to the other portal as follows:

- To access the Administrative Portal or Care Coordinator Dashboard, select the **Switch Role** option on the profile page (Figure 2 on page 7).
- To access the KPI Dashboards, click the hyperlinks on the **KPIS** tab of the Reports page on the Care Coordinator Dashboard.

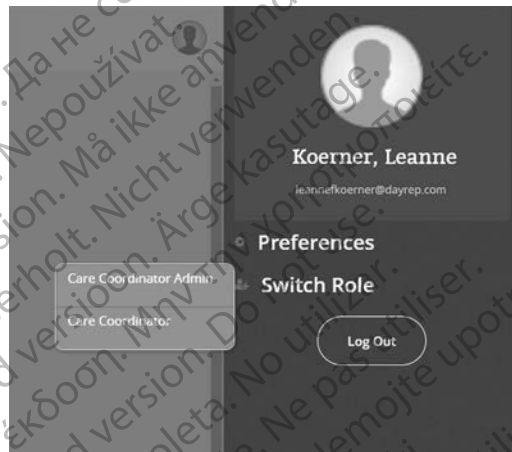


Figure 2. Switch Role

For more information on navigating each portal, see “Using the Care Coordinator Dashboard” on page 8, “Using the Administrative Portal” on page 29, and “Using THE KPI Dashboards” on page 36.

Profile

The profile page, accessed by clicking the profile icon on the banner of the current portal displayed, displays the user's name and Email address along with certain menu options based on the user's assigned roles (Figure 2 on page 7):

- **Preferences** – allows users to view and sometimes edit information related to their account such as password. For more information, see “Care Coordinator Preferences” on page 12 or “Care Coordinator Admin Preferences” on page 31.
- **Switch Role** – allows users with both Care Coordinator and Care Coordinator Admin roles to switch between portals. If the user has only one role, this option will not be displayed.
- **Log Out** – allows users to log out of the application.

USING THE CARE COORDINATOR DASHBOARD

CHAPTER 3

This chapter contains the following topics:

- “NAVIGATING THE CARE COORDINATOR DASHBOARD” on page 9
- “PATIENT ENROLLMENT” on page 15
- “PATIENT 360” on page 20
- “CALL SCRIPTS” on page 24
- “REPORTS” on page 27

NAVIGATING THE CARE COORDINATOR DASHBOARD

Banner

A banner displays at the top of all screens and pages in the Care Coordinator Dashboard. It displays the healthcare institution's logo and is used to navigate the Care Coordinator Dashboard and search for patient information (Figure 3 on page 9). Descriptions are listed in Table 2 on page 9.

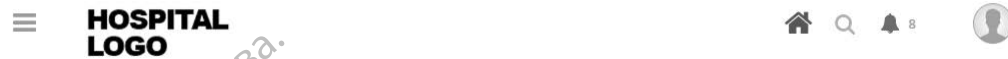








Figure 3. Care Coordinator Dashboard Banner

Table 2. Care Coordinator Dashboard Banner

	<p>Dashboard menu. Opens a page with the following menu options:</p> <ul style="list-style-type: none"> • Dashboard – links to the Care Coordinator Dashboard. This is the same as the homepage. • Patients – links to a list of patients. This is the same information as is displayed on the Patients tab of the Care Coordinator Dashboard. For more information, see “Patients” on page 14. • Reports – links to a page that allows you to filter and view program data in chart format. For more information, see “REPORTS” on page 27. • Help/Contact Us – links to a page that provides information about obtaining a printed copy of this manual along with customer support contact information. <p>The bottom section of the page displays information about the software such as manufacturer, model number, and software version.</p>
	Logo. This content will be replaced with the healthcare institution's logo. For more information, see “HOSPITAL SETTINGS” on page 31.
	Home. Links to the Care Coordinator Dashboard homepage.
	Search. Opens a window that allows Care Coordinators to search for patients. For more information, see “Search” on page 12.
	Alert. A red icon indicates new alerts and/or notifications have been added since the last time the Care Coordinator viewed them. The number of alerts and/or notifications displays to the right of the icon; click the icon or the number to view them. For more information, see “Alerts and Notifications” on page 12.
	Profile. Opens a page that allows Care Coordinators to set their user preferences and log off. Care Coordinators who are also assigned to the Care Coordinator Admin role will also have an option to switch roles and access the Administrative Portal. For more information, see “Profile” on page 7.

Care Coordinator Dashboard Homepage

The Care Coordinator Dashboard homepage is the first page displayed after logging on to the Care Management Platform for those assigned the primary role of Care Coordinator. The page consists of a header and tabs that Care Coordinators use to view information and manage their tasks (Figure 4 on page 10). The header consists of

four square tiles that display information and contain links to allow for navigation. The three tabs below the header allow the Care Coordinator to switch between different types of information they want to view. Descriptions are listed in Table 3 on page 10.

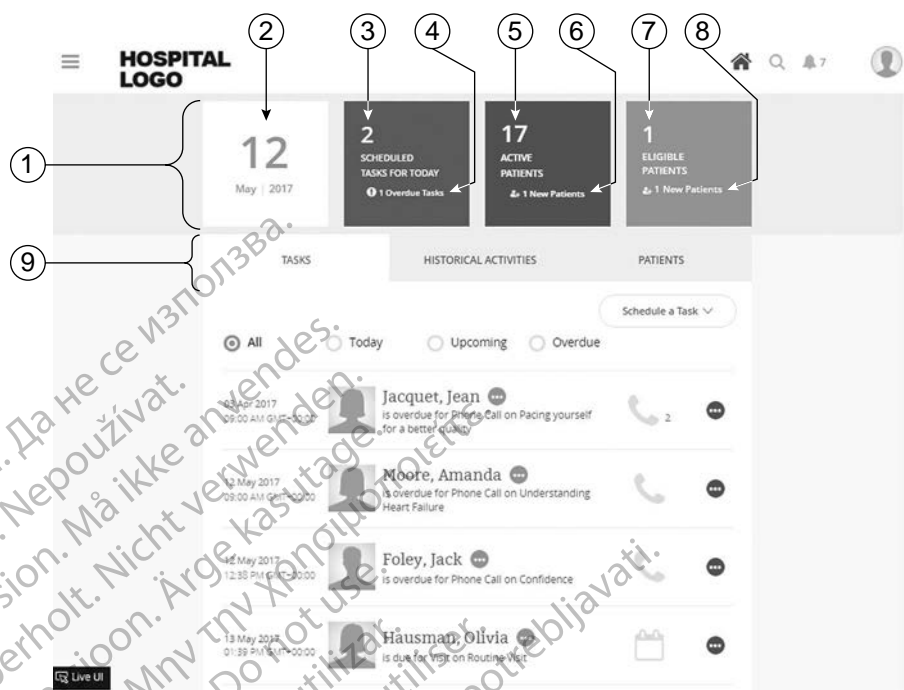


Figure 4. Care Coordinator Dashboard Homepage

Table 3. Care Coordinator Dashboard Homepage

(1)	Header.
(2)	Current date.
(3)	Number of tasks scheduled for the Care Coordinator and/or their team for the day. Click to navigate to a filtered view of these tasks on the Tasks tab.
(4)	Number of overdue tasks scheduled for the Care Coordinator and/or their team. Click to navigate to a filtered view of these tasks on the Tasks tab.
(5)	Number of enrolled patients assigned to the Care Coordinator and or their team. Click to navigate to a filtered view of these patients on the Patients tab.
(6)	Number of enrolled patients assigned to the Care Coordinator and or their team within the past 24 hours. Click to navigate to a filtered view of these patients on the Patients tab.
(7)	Number of all patients in the application with a status Eligible. Click to navigate to a filtered view of these patients on the Patients tab.
(8)	Number of new eligible patients added to the application today, Click to navigate to a filtered view of these patients on the Patients tab.
(9)	<p>Tabs used to select the type of information to display on the lower portion of the page:</p> <ul style="list-style-type: none"> • Tasks • Historical Activities • Patients <p>For more information about each tab, see the following sections later in this chapter: "Tasks" on page 13, "Historical Activities" on page 14, and "Patients" on page 14.</p>

Activity Screens

The Care Coordinator Dashboard contains sets of screens used to perform activities such as enrolling patients or scheduling a patient call. These screens display a standard header with patient information and a standard footer used to navigate through the series of screens (Figure 5 on page 11). Descriptions are listed in Table 4 on page 11.

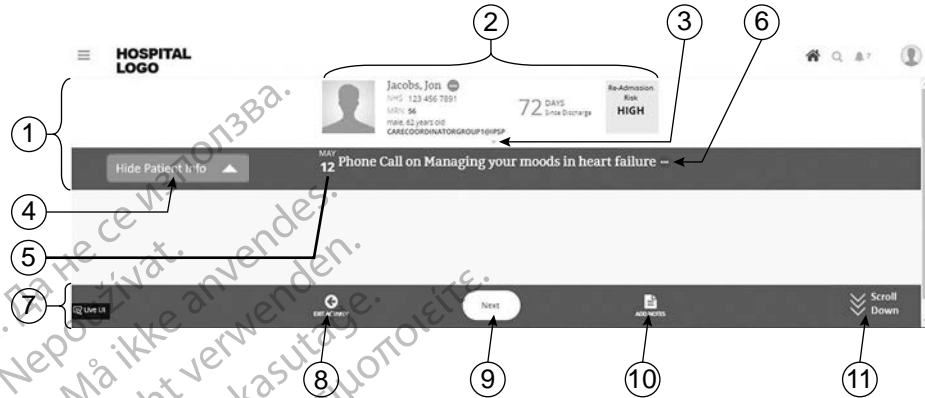





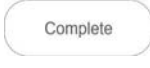




Figure 5. Activity Screen

Table 4. Activity Screen

(1)	Header	Displays information at the top of the page for the Care Coordinator to reference as they complete an activity.
(2)	Patient Information	Displays information about the patient related to the activity including their name, EMR number, sex, age, number of days since discharge, and status.
(3)		Opens a Patient 360 pop-up window. For more information, see "PATIENT 360" on page 20.
(4)	 	Hide Patient Info button. Click to collapse the top portion of the header displaying patient information and the arrow to open a Patient 360 window. If patient info is hidden, the button name is View Patient Info and clicking it expands the top portion of the header.
(5)	Current date	Displays the current date.
(6)	Activity name	Displays the name of the activity.
(7)	Footer	Provides options for the Care Coordinator to navigate and enter notes related to an activity.
(8)		Exit Activity button. Click to leave the activity screen and return to the screen where you entered the activity. When the activity is resumed, it will begin with the screen that was last exited.
(9)	 	Next button. Click to proceed to the next screen in the series. If this is the last button in the series, the button name is Complete . NOTE: You will not be able to return to the previous screen once you click Next or Complete .
(10)		Add Notes button. Click to open the Add Note window and enter a note to be captured in the Patient 360. For more information, see "Notes" on page 24.
(11)		Scroll Down button. Click to scroll down to view all information between the activity screen header and footer before proceeding to the next screen.

Action Menu Button

Action menu buttons appear throughout the Care Coordinator Dashboard (Figure 6 on page 12). These buttons indicate that a drop-down menu is available from which the Care Coordinator can choose available actions. Click the button to open the menu.



Figure 6. Action Menu Button

Search

The search icon on the Care Coordinator Dashboard banner opens a window that allows Care Coordinators to search for patients by name, date of birth, or EMR number. Additional search features may be added by the healthcare institution during system configuration. The search is executed automatically. Results display at the bottom of the search window.

If no results are found, a message displays suggesting the user enter an EMR ID.

NOTE: *Patients available for search include all patients currently admitted to the healthcare institution, patients enrolled in the program, and patients discharged from the healthcare institution or disenrolled from the program during the configurable time period in which their information has not yet been removed from the Care Management Platform.*

Alerts and Notifications

The Care Management Platform generates an alert or notification when certain events occur in the application such as an overdue task, an incomplete task, or re-admission or discharge of an enrolled patient. Alerts prompt the Care Coordinator to take action (e.g., overdue task) whereas notifications are informative notices (e.g., patient re-admission).

When an alert or notification is created, the alert icon on the Care Coordinator Dashboard banner turns red and the number displayed to the right of the icon increases by 1. To view alerts and notifications, the Care Coordinator clicks the icon or the number to the right of the icon and a window opens displaying a list of alerts and notifications. Once the window is opened, the alert icon turns gray. The Care Coordinator clicks the "x" to the left of an alert or notification in the window to remove it from the list and reduce the number of alerts that displays next to the icon on the Care Coordinator Dashboard.

Alerts for overdue tasks that are not completed in a specified number of days are escalated via Email to the individual assigned as team lead during system configuration. The number of days before an alert is escalated is controlled in the **Patient Support Programme Settings**. For more information, see "PATIENT SUPPORT PROGRAM SETTINGS" on page 34.

Care Coordinators can choose to receive an Email when certain types of alerts and notifications are issued by setting alert preferences in their Profile. When such preferences are set, the application generates an Email in addition to the alert or notification that appears on the Care Coordinator Dashboard. For more information on setting alert and notification preferences, see "Care Coordinator Preferences" on page 12.

Care Coordinator Preferences

Care Coordinators can modify some of their user account settings and set preferences as follows:

1. Click the profile icon on the Care Coordinator Dashboard banner. The profile page displays.
2. Click **Preferences**. The preferences window opens ("Figure 7. Preferences window" on page 13).
3. Set your user account preference for language in the **User Locale** drop-down field.
4. To change your password, click **Update password**. Enter your new password into both fields on the **Change Password** window and click **Submit**.
5. In the **Alert Types** box, select the check boxes for each type of alert or notification for which you would like to receive Email in addition to the alert or notification appearing in the Care Coordinator Dashboard. For more information about alerts and notifications, see "Alerts and Notifications" on page 12.
6. On the preferences window, click **Save**. An "Applied Successfully" message displays to the right of the **Save** button, indicating that your changes were applied successfully.
7. Click **Close** to close the window without saving changes and return to the Care Coordinator Dashboard.

The image shows a 'Preferences' window for a user named Leanne Koerner. At the top, the name 'Koerner, Leanne' is displayed. Below it, there is an 'Email' field containing 'leannekoerner@dayrep.com'. To the right of the email field are 'Save' and 'Close' buttons. Below the email field is a 'User Locale' dropdown menu currently set to 'English (United States)'. Below the locale dropdown is an 'Update password' button. At the bottom of the window is the 'Alert Types' section, which lists four categories: 'Overdue Task', 'Admissions / Discharges', 'Medication Changes', and 'Mortality'. Each category has a checkbox labeled 'Receive email for this alert'.

Figure 7. Preferences window

Tasks

The **Tasks** tab on the Care Coordinator Dashboard homepage displays a list of upcoming tasks for the Care Coordinator or their team. The list displays the date the task is or was scheduled to occur, patient information, a description of the task, an icon associated with the type of task, and an action menu button containing a drop-down menu.

Options across the top of the tab allow the Care Coordinator to filter the list by **All**, **Today**, **Upcoming**, or **Overdue** tasks.

Care Coordinators can add a task to the list using the **Schedule a Task** drop-down field in the upper right corner. For more information about adding a task, see Create an Activity in "Timeline" on page 22.

The action menu button displays a drop-down menu that allows the Care Coordinator to modify the task, open the task, or mark the task as missed. For more information, see "CALL SCRIPTS" on page 24.

Reassign a Task

If a Care Coordinator is not going to be available to perform a task (e.g., going on vacation) they can reassign it to another Care Coordinator.

To reschedule a task:

1. Click the **Tasks** tab.
2. Click the activity button for the task you want to reassign and select **Modify Activity**.

NOTE: This option is also available on the Timeline tab of the Patient 360.

3. Select the Care Coordinator to whom you want to reassign the task from the **Care Coordinator** drop-down field on the **Modify an Activity** window.
4. Click **Save Changes**.

Historical Activities

The **Historical Activities** tab on the Care Coordinator Dashboard homepage displays a list of activities that have already been completed for patients assigned to the Care Coordinator or their team. The list displays patient information, a description of the activity, icon(s) associated with the type of activity, and the date the activity occurred.

Care Coordinators can add a historical activity to the list using the **Log an Activity** drop-down field in the upper right corner. For more information about adding an activity, see Create an Activity in "Timeline" on page 22.

Patients

The **Patients** tab on the Care Coordinator Dashboard homepage displays a list of all Eligible and Ineligible patients in the application as well as active or enrolled patients assigned to the Care Coordinator or their team. The list displays patient information, status, discharge date (DIS), last contacted date (LC), and location in the hospital if they have not yet been discharged. Patients filtered from the list (e.g., patients assigned to a different Care Coordinator or group) can be viewed using the search feature. For more information, see "Search" on page 12.

Care Coordinators can filter the list of patients, by selecting an option from the **Showing** drop-down field in the upper right corner:

- **All** – Patients of all statuses
- **Eligible** – Meets initial criteria for enrollment, but is not currently enrolled
- **Started** – The enrollment process has been initiated but not completed by a Care Coordinator
- **Low** – Enrolled in the program and assessed as having a low risk of re-admission

- **High** – Enrolled in the program and assessed as having a high risk of re-admission
- **Ineligible** – Does not meet initial criteria for enrollment and is not currently enrolled
- **Newly Active** – Enrolled in the program since midnight that same day
- **Active** – Currently enrolled in the program
- **Newly Eligible** – Identified by the application since midnight that same day
- **Disenrolled** – Disenrolled from the program, but eligible for re-enrollment

A patient's name serves as a hyperlink everywhere that it appears in the Care Coordinator Dashboard. Click the link to view more information about the patient by navigating to the **Patient Profile** tab in the Patient 360. For more information, see "Patient Profile" on page 22.

Remove an Eligible Patient

Patients with a status of Eligible can be removed from the list by selecting the **Remove from Eligibility List** option from the action button drop-down menu to the right of the patient's name. The Care Coordinator will be prompted to select a reason for removing the patient from the eligibility list. Upon clicking **Submit**, the patient's status changes to Ineligible. Their identifiable data will not be removed from the Care Management Platform until after they are discharged. The timeframe for removing data is set by the healthcare institution during system configuration.

PATIENT ENROLLMENT

Care Coordinators typically enroll patients in the program at the hospital; however, enrollment may occur post-discharge as long as certain conditions are met. For more information, see "Post-discharge Enrollments" on page 19.

Patients must consent to participate in the program and may choose to disenroll from the program at any time. If a Care Coordinator records a missed phone call or visit, the application will automatically re-schedule the call for the same time the next day. Patients who miss the same call three times are automatically disenrolled. After disenrollment, a patient's identifiable data (e.g., name, status, and contact strategy) is removed from the Care Management Platform. For more information, see "Disenrolling Patients" on page 20.

In cases where the Care Coordinator decides not to enroll the patient or the patient decides not to enroll, the Care Coordinator can remove the patient, preventing their identifiable data from showing up in the Care Management Platform. For more information, see "Remove an Eligible Patient" on page 15.

Patients who deny consent will have their status changed to Denied and will be removed from all patient lists. Their identifiable data will not be removed from the Care Management Platform until they are discharged. If the patient changes their mind and wishes to be enrolled during their admission, a Care Coordinator can locate the patient using the Search feature and complete enrollment.

When a patient completes the program, their status changes to Inactive and their identifiable data is removed from the Care Management Platform. If the patient consented to use of their anonymized data when enrolling in the program, their anonymized data that is relevant to application reports will be retained and fed back into those reports.

Enrolling Patients

To enroll a patient, the Care Coordinator completes the following series of activity screens:

- Eligibility
- Patient Consent
- Risk Assessment
- Barrier Assessment
- Contact Preferences
- Program Summary

For more information about using activity screens, see “Activity Screens” on page 11.

Enrollment can be completed over multiple sessions as long as it is completed within the timeframe set by the healthcare institution during system configuration (see “Post-discharge Enrollments” on page 19). When a Care Coordinator exits the enrollment process, the application saves their place. Upon selecting **Resume Enrolment** from the action menu button drop-down menu next to the patient's name, the application resumes enrollment on the page where the Care Coordinator last exited.

Eligibility

Eligibility to participate in the program is initially determined by criteria pre-set in the application for the healthcare institution during system configuration, setting a patient's initial status to Eligible or Ineligible. Care Coordinators further determine a patient's eligibility for enrollment in the program by reviewing their health record and conducting a Patient Eligibility Assessment.

If a patient's initial status is Ineligible, the Care Coordinator must force enrollment of the patient to access the Patient Eligibility Assessment screen. For more information, see “Forcing Patient Enrollment” on page 19.

If the patient's initial status is Eligible, the Care Coordinator completes the Patient Eligibility Assessment as follows:

1. Locate the patient in the Care Coordinator Dashboard, either in the eligible patient list or by using the search functionality.
2. Click the action menu button to the right of the patient's name and select **Start Enrolment** from the drop-down menu. The patient's status changes to **Started**.
3. The Eligibility screen displays the **Patient Eligibility Assessment**.
4. Follow the instructions on the page to determine whether or not to continue with enrollment.
5. To exit without completing the assessment, click **Exit Activity**. Otherwise, when the assessment is complete, click **Next** to continue with the enrollment process.

Patient Consent

The Care Coordinator is responsible for requesting a patient's consent to participate in the program as well as their consent for use of their anonymized data.

Patient consent to participate in the program is mandatory, but consent to allow use of anonymized data is optional and may be denied without preventing participation in the program.

The Care Coordinator is responsible for ensuring the patient understands what the program entails, what the program expectations are, and what they are consenting to

regarding both participation in the program and use of their anonymized data before asking the patient for consent.

NOTE: Care Coordinators are responsible for following the healthcare institution's procedure on paper consent forms.

Complete the following steps to capture a patient's consent within the application:

1. Read the consent statement from the **Patient Consent** screen to the patient.
2. Ask the patient for a "yes" or "no" answer.
3. Record the patient's response to consent for enrollment within the application (Figure 8 on page 17).
4. If the patient denied consent to participate in the program, ask the patient to provide a reason for declining consent and record it in the field below the consent options by selecting the reason that most closely matches the patient's response from the drop-down list

This ends the enrollment process for the patient. Their identifiable data will be removed from the Care Management Platform after they are discharged. The timeframe for removing data is set by the healthcare institution during system configuration. Click **Next** and **Close** to exit the enrollment process and return to the Care Coordinator Dashboard.

5. If the patient consented to participate in the program, ask the patient for consent to use their anonymized data.
6. Record the patient's response to consent for use of their anonymized data within the application.
7. Click **Next** to continue with the enrollment process.

Has the patient given consent for enrollment?

☐ YES, this patient has given consent to enroll in this programme.

☐ NO, this patient has not given consent to enroll in this programme.

Figure 8. Consent for Enrollment

Risk Assessment

The risk assessment determines the patient's potential risk of re-admission based on their recent healthcare interactions. The patient's risk level will determine the frequency of contact they receive over the course of the program.

The assessment consists of a series of questions with **Yes** or **No** answers. A **Don't Know** option is also available. The Care Coordinator records the patient's responses to each question on the **Risk Assessment** screen.

Complete the assessment by reading the questions on the **Risk Assessment** screen to the patient and recording their responses. Click **Next** to continue the enrollment process.

NOTE: The risk assessment is repeated on the fourth scheduled call with the patient.

Barrier Assessment

The barrier assessment identifies psychosocial barriers that may inhibit the patient's ability to comply with their treatment plan or recover as expected. This assessment also determines the topics and content covered with the patient over the course of the program.

The assessment consists of a series of questions with **Yes** or **No** answers. A **Don't Know** option is also available.

Complete the assessment by reading the questions on the **Barrier Assessment** screen to the patient and recording their responses. Click **Next** to continue the enrollment process.

Contact Preferences

Participants in the program are required to provide a primary contact who will receive telephone calls, Emails, and SMS text messages. While the primary contact is usually the patient, in some cases a relative or caregiver may fill this role. There can only be one primary contact, but additional contacts may be added.

NOTE: After enrollment is complete, information for primary and additional contacts can be edited on the **Patient Profile** tab of the Patient 360.

The lower portion of the **Contact Preferences** screen captures the name of and Email address for the patient's general practitioner. This information is automatically populated based on the patient's electronic medical record, but Care Coordinators can update and/or add information here as needed. This information is displayed on the **Patient Profile** tab of the Patient 360.

NOTE: Information imported from the EMR system that can be edited in the Care Management Platform (e.g., General Practitioner) remains in the Care Management Platform and cannot be exported back to the EMR system.

Lastly, the screen allows the Care Coordinator to capture information about the patient's tobacco use, hearing impairments, and sight impairments, as well as the patient's primary language. This information is displayed on the **Patient Profile** tab of the Patient 360.

Complete the following steps to complete the enrollment information on the **Patient Contact Preferences** page for the patient:

1. Ask the patient if they will serve as the primary contact during the program or if they want someone else to be contacted on their behalf.
2. Record the information for the patient's primary contact, including name, relationship to the patient, phone number, preferred time of day and/or day of the week to be contacted, phone number for receiving text messages, and Email address.
3. Ask the patient if they would like to add any additional contacts. If they want to add a contact, click the **Add Another Contact** button and enter information for the additional contact. Repeat until all contacts have been added.
4. Ask the patient to confirm that the name of their general practitioner entered in the **General Practitioner Name** field is correct. If it is not, edit the contact information for the patient's general practitioner.
5. Ask the patient to answer the questions in the **Additional Information** fields. Record the patient's response to each question.
6. Click **Next** to continue the enrollment process.

Program Summary

The Program Summary screen is used to inform the patient of the benefits and expectations of the program.

CAUTION: The healthcare provider should inform the patient that enrollment in the Enhanced Support Program for Heart Failure is not a replacement for normally scheduled appointments and does not actively monitor the patient's condition.

Complete the following steps to complete the program summary:

1. Review the contents of the Program Summary screen with the patient.
2. Click **Next** to complete the enrollment process. A message displays, confirming that the patient is enrolled in the program.
3. Inform the patient that their primary contact will receive an Email with an attachment including more information about the program. If the patient is currently admitted to the hospital, the Email will not be sent until after they are discharged.

4. Click **Close**.

In addition to sending the welcome Email, the patient's status is updated to Low or High re-admission risk based on their risk assessment when enrollment is complete.

Forcing Patient Enrollment

Care Coordinators can force enrollment for patients with a status of Ineligible. For example, if a patient is not yet coded for heart failure but heart failure is suspected, the doctor or nurse may decide to enroll the patient. When forcing enrollment, the Care Coordinator must select a reason for enrollment based on options presented within the application.

Complete the following steps to force enrollment:

1. Click the action menu button to the right of the patient's name and select **Force Enroll** from the drop-down menu. The Patient Eligibility Assessment page for the Ineligible patient will open.
2. Select a reason for enrollment.
3. Follow the instructions on the page to determine whether or not to continue with enrollment.
4. To exit the screen with intention of completing the Eligibility Assessment later, click **Exit Activity**. The patient's status changes to Started.
5. When the Patient Eligibility Assessment is complete, click **Next** to continue with the enrollment process. The patient's status changes to Started.

For additional instructions on enrolling the patient, see "Enrolling Patients" on page 16 beginning with Patient Consent.

Post-discharge Enrollments

There are two scenarios in which enrollment may occur post-discharge:

- Enrollment was started while the patient was in the hospital, but was not completed prior to discharge.
- Patient did not start enrollment in the hospital, has been discharged, and wants to enroll.

In both cases there is a timeframe in which enrollment may be completed post-discharge. This timeframe is set by the healthcare institution during system

configuration. Once the timeframe expires, the patient's identifiable data will be removed from the Care Management Platform.

It is important to complete enrollment as soon after discharge as possible to prevent delays in the contact strategy. For more information, see "Contact Strategy" on page 23.

Complete the enrollment process as described in "Enrolling Patients" on page 16 beginning with the Eligibility screen. If enrollment was not started prior to discharge, use Search to locate the patient in the Care Coordinator Dashboard (see "Search" on page 12).

Disenrolling Patients

A patient can ask to be disenrolled at any point in the program. Patients may also be automatically disenrolled from the program if they miss a call three times.

Whether a patient is disenrolled by choice or automatically disenrolled due to missed calls, there is a timeframe in which the patient can be re-enrolled. This timeframe is set by the healthcare institution during system configuration. Once the timeframe expires, the patient's identifiable data will be removed from the Care Management Platform and the patient cannot re-enroll in the program unless they are re-admitted to the hospital. If the patient consented to use of their anonymized data when enrolling in the program, anonymized data that is relevant to application reports will be retained and fed back into those reports.

Complete the following steps to disenroll a patient:

1. Click the action menu button to the right of the patient's name and select **Disenroll from Programme** from the drop-down menu. The **Disenroll from Programme** window opens.
2. Select a reason for the patient's disenrollment from the **Reason for disenrollment** drop-down list.
3. Click **Disenroll Patient**. This ends the patient's enrollment in the program. Their identifiable data will not be removed from the Care Management Platform until after they are discharged. The timeframe for removing data is set by the healthcare institution during system configuration.

PATIENT 360

The Patient 360 page is automatically populated upon discharge based on information from the patient's EMR with additional information collected during the enrollment process ("Figure 9. Patient 360" on page 21). Care Coordinators navigate to this page by clicking on a patient's name or by selecting **Go To Patient 360** from the action menu button drop-down list.

Figure 9. Patient 360

The page header displays patient information, the name of the Care Coordinator or group to whom the patient is assigned, the number of days since the patient was discharged, and the patient's status.

Below the header are tabs used to select the type of information to display on the lower portion of the page:

- **Patient Profile**
- **Timeline**
- **Notes**

For more information about each tab, see “Patient Profile” on page 22, “Timeline” on page 22, and “Notes” on page 24.

Patient Profile

The **Patient Profile** tab on the Patient 360 page displays patient information imported from the EMR. The information provided will vary by healthcare institution based on decisions made during system configuration.

NOTE: *Information imported from the EMR system that can be edited in the Care Management Platform (e.g., General Practitioner) remains in the Care Management Platform and cannot be exported back to the EMR system.*

Contact information added during the enrollment process can be edited here. Click the **Add Contact** button to add a new contact for the patient. Click the pencil icon to edit contact information. For more information about adding contacts, see “Contact Preferences” on page 18.

Care Coordinators can add goals to a patient's profile for follow-up purposes. For example, if a patient mentions during a phone call that they are working toward improving their health in order to attend an upcoming event, the Care Coordinator can record the goal to be reviewed with the patient on future calls. Click the **New Goal** button to add a new goal for the patient.

Add a New Goal

To add a new goal to a patient's profile:

1. Click the **Patient Profile** tab.
2. Click the **New Goal** button. The **New Goal** window opens.
3. In the **Target** field, enter a date for when the patient expects to complete the goal or click the calendar icon on the right side of the field to select a date from the calendar.
4. In the **Goal Topic/Categories** field, select a topic for the goal from the drop-down list.
5. In the **Goal Description** field, enter a description of the patient's goal.
6. Click the **Submit** button. The goal displays on the Patient Profile with an Edit Goal button to the right.

Edit a Goal

To edit a goal, click the **Edit Goal** button to the right of the goal on the Patient 360 page.

If the goal has been met, select the **Goal Achieved** check box. Once complete, a goal can no longer be edited.










Timeline

The **Timeline** tab on the Patient 360 page displays the patient's personalized contact strategy in chronological order, including upcoming activities as well as past activities. Icons identify the type of activity scheduled (Table 5 on page 23). This information is

automatically populated upon enrollment and is updated as tasks are completed and new activities are scheduled.

Activities generated as part of the contact strategy cannot be edited or deleted, but they can be rescheduled. Care Coordinators can schedule or log additional calls and visits from the **Timeline** tab or from the **Tasks** and **Historical Activities** tabs on the Care Coordinator Dashboard using the **Create an Activity** window.

Table 5. Activity Icons

	Email. The application will automatically generate and send an Email to the patient.
	Email sent. If Track Email Metrics is set to On, this icon confirms that an Email was successfully sent. For more information, see "HOSPITAL SETTINGS" on page 31..
	Email not sent. If Track Email Metrics is set to On, this icon confirms that an Email failed to send. For more information, see "HOSPITAL SETTINGS" on page 31.
	Text message. The application will automatically generate and send an SMS text message to the patient.
	Phone call. A patient call is scheduled with a Care Coordinator.
	Missed call. The number to the right indicates the number of times a call has been missed. If a patient misses a call three times, they are automatically disenrolled from the program.
	Patient activity. Indicates an update to the patient's record (e.g., admission, discharge, lab test result).
	Visit. The patient has a scheduled visit with a healthcare provider.
	Missed visit. The number to the right indicates the number of times a visit has been missed. If a patient misses a visit three times, they are automatically disenrolled from the program.

Contact Strategy

Upon discharge, the Care Management Platform generates a personalized support plan for enrolled patients which determines both the content and the frequency of contact a patient receives. The contact strategy may include telephone calls, text messages, and Email messages. Telephone calls are scheduled and assigned to a Care Coordinator and/or their team assigned to the patient. Text messages and Email messages are scheduled and sent automatically by the application. Email messages may contain attachments on a variety of educational topics relevant to heart failure patients such as exercise, sleep, and travel.

Create an Activity

To add an activity or task to a patient's timeline:

1. Click the **Timeline** tab.
2. Click the **Schedule a Task** button.

NOTE: On the **Tasks** tab, this button is called **Schedule a Task**. On the **Historical Activities** tab, this button is called **Log an Activity**.

3. Select **Call** or **Visit** from the drop-down list. The **Create an Activity** window opens.
4. The **Patient** field is pre-filled with the name of the patient from the Patient 360. When creating a task or activity from the **Tasks** or **Historical Activities** tabs, type the patient's name into the field.
5. Enter the date that the task or activity occurred or is scheduled to occur in the **Event Date** field or click the calendar icon on the right side of the field to select a date from the calendar.
6. The **Activity Details** field displays **Call** or **Visit** based on the option you selected earlier. Enter a description of the topic in the **Topic** field.
7. Enter any notes about the activity or task in the comments field.
8. Click the **Create** button. The activity or task will display on the **Timeline** tab. Future activities will also display on the **Tasks** tab of the Care Coordinator Dashboard. Past activities will also display on the **Historical Activities** tab of the Care Coordinator Dashboard.

Notes

The **Notes** tab on the Patient 360 page displays all notes regarding the patient added during enrollment and calls.

Use the **Add Note** button to add a new note. The note displays on the **Notes** tab alongside a date and time stamp indicating when the note was added.

CALL SCRIPTS

Call scripts contain guidelines and talking points for Care Coordinators to use in telephone communications with patients. Calls are scheduled as part of the patient's contact strategy.

Call scripts are associated with tasks shown on the **Tasks** tab of the Care Coordinator Dashboard and on the **Timeline** tab of the Patient 360.

When calling a patient using a call script, the Care Coordinator completes a series of activity screens that cover the following:

- Call Preparation
- Introduction
- Barrier Assessment
- Transition Talking Points
- Call Completed Verification

For more information about using activity screens, see "Activity Screens" on page 11.

Calling Patients

Call Preparation

This step of the call script helps the Care Coordinator prepare for the call with the patient.

It is recommended that the Care Coordinator review the patient's previous health status and any previous goals set before entering the call script. This information is located in the **Notes** tab and in the **Goals** section of the **Patient Profile** tab.

Complete the Call Preparation screen of the call script as follows:

1. Open the call script by selecting **Open Task** from the action menu button menu drop-down list on the task record in the **Tasks** tab of the Care Coordinator Dashboard or on the **Timeline** tab of the Patient 360. The call script opens.
2. Review the topics to be discussed and patient's primary contact information within the first screen of the call script.
3. Make a note of the patient's primary contact number.
4. Click **Next**.

Introduction

The Introduction screen content varies depending on the topic. In some cases, there may be no educational content, just guidance for the Care Coordinator on the topic to discuss with the patient.

Begin a call as follows:

1. Review the goals for the call within the Objectives section.
2. Call the patient using the primary contact phone number noted earlier.

NOTE: If the patient does not answer, leave a voicemail saying that you will call back at the same time tomorrow and leave the clinic phone number in case the patient wants to call back. Then record the call as missed by selecting **Mark Activity as Missed** from the action menu button so that the application will automatically reschedule the call. For more information, see "Recording a Missed Call" on page 26. If the patient answers but asks to reschedule, select **Reschedule Activity** to reschedule the call for a more convenient time.

3. Use the call script as a guidance to greet the patient, collect updated health check-in information, introduce the topic of educational content for the call, and ask about the patient's experience.
4. Review the educational content in the call script with the patient. If the script includes questions for the patient, record their answers within the call script.
5. Click **Next**.

Barrier Assessment

The Barrier Assessment conducted as part of a call script is the same as the Barrier Assessment completed during enrollment. The responses may alter the order of the patient's contact strategy.

Complete the barrier assessment by reading the questions on the Barrier Assessment screen to the patient and recording their responses. Click **Next** to continue the enrollment process.

Transition Talking Points

1. Follow the call script to guide the conversation with the patient.
2. Click **Next**. A Call Completed message appears.
3. Click **Complete**. A Call Completed message displays, confirming that the task associated with the call script is complete.

The following occur in the application when a call script is complete:

- The application generates an Email to the patient with educational material attached based on answers to questions recorded in the call script by the Care Coordinator.
- **Patient Profile** tab on the Patient 360 page is populated with information collected during the call. For more information about Patient 360, see "PATIENT 360" on page 20.
- **Timeline** tab on the Patient 360 page is updated to indicate the call is complete.
- **Tasks** tab on the Care Coordinator Dashboard is updated to indicate the call is complete.
- If a risk assessment was conducted as part of the call, the patient's status may be updated to Low or High re-admission risk based on the assessment results.
- The patient's contact strategy may be updated. For example, the order of topics to discuss with the patient may be switched based on the most recent Barrier Assessment and an activity record is logged if an Email was sent to the patient. For more information, see "Timeline" on page 22.

Recording a Missed Call

NOTE: Patients who miss the same call three times are automatically disenrolled from the program. If a patient has already missed two calls and you want to keep them enrolled, reschedule the call instead of marking it as missed. For more information, see "Rescheduling a Call" on page 26.

To record a missed call:

1. Locate the patient in the **Tasks** tab of the homepage or on the Patient 360 Timeline tab.
2. Click the activity menu button to the right of the patient's name and select **Mark Missed** from the drop-down list. The Missed Activity window opens.
3. In the **Reason** drop-down field, select a reason for the missed call.
4. Click **Mark as Missed**. The application will automatically reschedule the call for the same time the next day. A number displays to the right of the Call icon in the **Tasks** tab indicating the number of times the patient has missed this call.

A call can also be marked as missed by selecting **Mark Activity as Missed** from the action menu button in a call script.

Rescheduling a Call

If a patient is not going to be available to take calls (e.g., going on vacation, was admitted to the hospital) calls must be manually rescheduled to ensure that the patient is not inadvertently disenrolled from the program due to missed calls.

To reschedule a call, select the **Modify Activity** option on the activity button for the call record on the **Tasks** tab of the homepage or on the Patient 360 **Timeline** tab. A call can

also be rescheduled by selecting **Reschedule Activity** from the action menu button in a call script.

When rescheduling a call you will be prompted to enter a reason for rescheduling.

REPORTS

Two types of reports are available on the both Care Coordinator Dashboard and Administrative Portal:

- Operational Reports
- KPI Reports

Operational Reports

Operational reports are used to view information such as how many patients are enrolled in the program and the numbers of tasks completed. For example, the Completed Tasks report shows the number of tasks completed by type (Figure 10 on page 27).

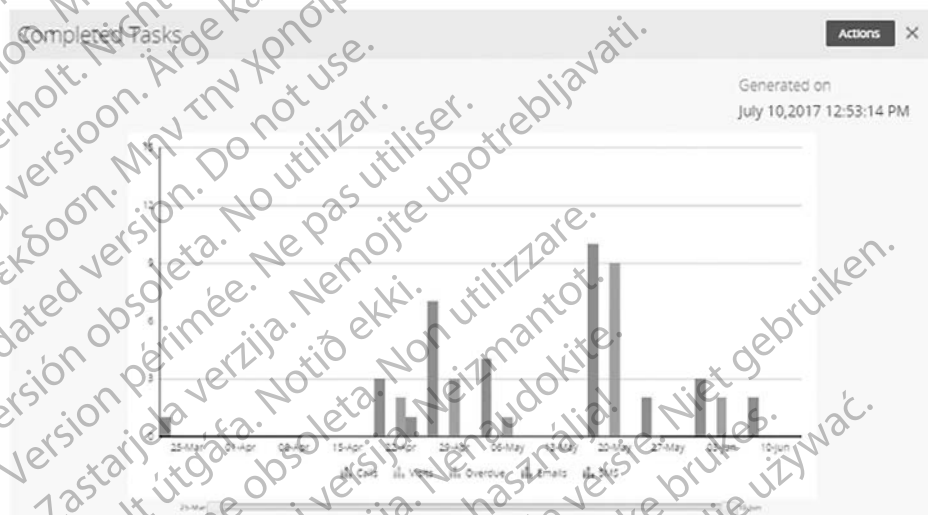


Figure 10. Operational Report Example - Completed Tasks

The following Operational Reports are available:

- **Overview** – shows trend lines for the volume of patients that have been admitted, enrolled, inactive, and disenrolled over time.
- **Programme Enrolments** – shows cumulative volume of patients enrolled over time with status of Low or High re-admission risk.
- **Disenrollment Rate** – shows cumulative volume of disenrolled patients over time.
- **Disenrollment Points** – shows frequency of disenrollment over time, by point in time when event happened in program timeline. For example, the number of patients disenrolled at Day 43 of 180, the number of patients who died and the dates on which the deaths occurred.
- **Scheduled Tasks** – shows the volume of scheduled tasks by type by week, along with overdue tasks.
- **Completed Tasks** – shows the number of tasks completed by type.

Complete the following steps to view an Operational Report:

1. Select **Reports** from the Care Coordinator Dashboard menu in the upper left corner of the banner.
2. Click the **Operational Reports** tab.
3. Select the report you want to view from the **Showing** drop-down menu.
4. The report appears on the current page.
5. Click the report to open a new window that displays a slider bar beneath the report and an **Actions** button in the upper right corner.
6. Click and slide the handles on the slider bar to set a start and end date for the date range represented in the report.
7. Click the **Actions** button in the upper right corner of the window to select from a list of options (e.g., Export to PDF, Print).
8. To exit the report window and return to the previous portal, click the X to the right of the **Actions** button.

KPI Reports

KPI reports are used to see how key performance indicators such as re-admission, mortality rate, and cost of care have changed over the course of the program. This will help healthcare institutions understand the overall impact that the program is having on their patient health outcomes. Reports listed in the **KPIS** tab are hyperlinks that users click to open the report.

Complete the following steps to view KPI reports:

1. Select **Reports** from the Care Coordinator Dashboard menu in the upper left corner of the banner.
2. Click the **KPIS** tab.
3. Click the hyperlink for the report you want to view.
 - For Care Coordinators, a PDF of the report opens.
 - For Care Coordinator Admins, the KPI Dashboard for the report opens. For more information about KPI Dashboards, see "Using THE KPI Dashboards" on page 36.

USING THE ADMINISTRATIVE PORTAL

CHAPTER 4

This chapter contains the following topics:

- “NAVIGATING THE ADMINISTRATIVE PORTAL” on page 30
- “HOSPITAL SETTINGS” on page 31
- “USER ACCOUNT MANAGEMENT” on page 32
- “CARE COORDINATOR TEAM MANAGEMENT” on page 33
- “PATIENT SUPPORT PROGRAM SETTINGS” on page 34
- “TASK MANAGEMENT” on page 34
- “PATIENT MANAGEMENT” on page 35
- “REPORTS” on page 35

NAVIGATING THE ADMINISTRATIVE PORTAL




The Administrative Portal allows Care Coordinator Admins to manage Care Coordinator user accounts and team assignments, task allocation, and certain settings. It also provides access to reports related to administrative functions.

A banner at the top of the portal displays the healthcare institution's name. Menus accessed from the banner are used to navigate between pages within the portal. (Figure 11 on page 30). Descriptions are listed in Table 6 on page 30.



Figure 11. Administrative Portal Banner

Table 6. Administrative Portal Banner

	<p>Portal menu. Opens a page with the following menu options:</p> <ul style="list-style-type: none"> • Hospital Settings – links to the Hospital Settings page. For more information, see “HOSPITAL SETTINGS” on page 31. • User Account Management – links to the User Account Management. For more information, see “USER ACCOUNT MANAGEMENT” on page 32. • Care Coordinator Team Management – links to the Care Coordinator Team Management page. • Patient Support Programme Settings – links to the Patient Support Program Settings. For more information, see “PATIENT SUPPORT PROGRAM SETTINGS” on page 34. • Task Management – links to the Task Management page. For more information, see “TASK MANAGEMENT” on page 34. • Patient Management – links to the Patient Management page. For more information, see “PATIENT MANAGEMENT” on page 35. • Reports – links to a page that allows you to filter and view program data in chart format. For more information, see “REPORTS” on page 35. • Help/Contact Us – links to this a page that provides information about obtaining a printed copy of this manual along with customer support contact information. <p>The bottom section of the page displays information about the software such as manufacturer, model number, and software version.</p>
	<p>Logo. Displays the healthcare institution's logo. For more information, see “HOSPITAL SETTINGS” on page 31..</p>
	<p>Profile. Opens a page that allows Care Coordinator Admins to access their profile and log off. Care Coordinator Admins who are also assigned to the Care Coordinator role will also have an option to switch role and access the Care Coordinator Dashboard. For more information, see “Care Coordinator Admin Preferences” on page 31.</p>

Care Coordinator Admin Preferences

Care Coordinator Admins can modify settings using the profile page as follows:

1. Click the profile icon on the Administrative Portal banner. The profile page displays.
2. Click **Preferences**.
3. Change the Care Coordinator Admin preference settings for name, Email, and phone number as needed. To update your password, click **Update password**.
4. Click **Save**. An "Applied Successfully" message displays to the right of the Save button, indicating that your changes were applied successfully.
5. Click **Close** to close the window and return to the Administrative Portal.

HOSPITAL SETTINGS

Hospital settings are pre-set for the healthcare institution during system configuration. The **Hospital Settings** page can be used to change the following settings:

- **Logo** – displayed on the banners of both the Care Coordinator Dashboard and Administrative Portal pages.
- **Hospital Name** – displayed in Emails to patients.
- **Language** – determines language in which content is displayed throughout the application.
- **Time Zone** – used to select the time zone for the healthcare institution. Impacts time and date stamps.
- **Track Email Metrics** – used to confirm that Emails were sent successfully. Click Yes to track. Click No to turn off tracking. For more information, see "Timeline" on page 22.
- **Task Distribution Method** – determines the method for allocating asks to Care Coordinators:
 - **Workbasket** – used to distribute tasks to a team of Care Coordinators. Workbaskets are defined by the healthcare institution during system configuration.
 - **Care Coordinator** – tasks are assigned to Care Coordinators based on patients assigned.
 - **Least Loaded Care Coordinator** – tasks are assigned to Care Coordinators based on who has least number of tasks already assigned to them.
- **Maximum Operator Password Age (in days)** – used to control the number of days after which a user's password will expire and have to be reset. There is no minimum. If the value is set to 0 or left undefined, passwords not expire. When passwords do expire, users will be prompted to reset their password the next time they log in; criteria for creating the new password will display on the screen prompt.

After changing settings, click **Submit**. A message displays to the right of the **Submit** button confirming that the changes were saved.

USER ACCOUNT MANAGEMENT

The User Account Management screen allows Care Coordinator Admins to create and manage Care Coordinator or Care Coordinator Admin user accounts (Figure 12 on page 32). Reports on this page also allow Care Coordinator Admins to track user security and patient privacy.

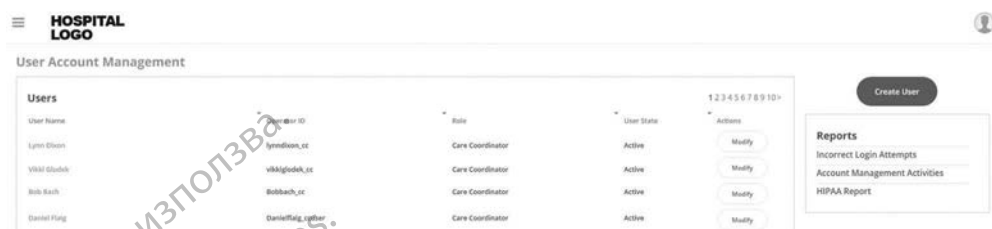


Figure 12. User Account Management Screen

Information on the User Account Management screen can be filtered by clicking the triangle icon in the upper right of column headings (e.g., User Name, User State). In the window that opens, click from the list of values or use the **Search Text** field to enter criteria to filter on, then click **Apply**. Click **Clear Filter** to remove filter criteria and display all results.

Creating a User Account

Click the **Create User** button to create a user account. Use the **Primary Role** field to assign user permissions. If the user will have more than one role, use the **Additional Role** field to assign additional permissions.

If the healthcare institution is using the workbasket method of task distribution, use the **Team** field to assign the user to a workbasket. Teams (or workbaskets) are assigned by healthcare institutions during system configuration.

Modifying a User Account

Once a user account has been created, a Care Coordinator Admin can change the user's role(s), password, team, and other information except for User ID.

- A user's account may also be set to Inactive, which means that no additional tasks will be assigned to them. If the user is a Care Coordinator and tasks are set up to be allocated to them using the settings **Care Coordinator** or **Least Loaded Care Coordinator**, then no one can complete the tasks assigned to them unless a Care Coordinator Admin reassigns them. If the tasks are allocated using the **Workbasket** setting, no action is needed. For more information, see **Task Distribution Method** in "HOSPITAL SETTINGS" on page 31.

To modify a user account, click the **Modify** button in the Actions column of the User Account Management page.

Deleting a User Account

When a Care Coordinator user account is deleted, notes and tasks they previously completed will remain as records in the application. Tasks they were scheduled to complete in the future must be reassigned to another Care Coordinator unless the method for task distribution in the hospital settings is set to **Workbasket**.

Complete the following steps to delete a user account:

1. Locate the user's account on the User Account Management screen.
2. Click the **Modify** button in the Actions column. The Manage User window opens.
3. Scroll to the bottom of the window and click **Delete**.

Viewing User Account Management Reports

The following reports are available on the User Account Management page via a **Reports** menu on the right side of the screen:

- **Incorrect Login Attempts** – Displays the number of user incorrect login attempts by user since last successful login.
- **Account Management Activities** – Displays a list of activities related to user creation and modification.
- **HIPAA Report** – Tracks Care Coordinator user activity such as viewing Patient 360 and opening tasks.

View reports by clicking the report name in the menu. Information on reports can be filtered by clicking the triangle icon in the upper right of column headings.

Exit a report by clicking the X icon in the upper right corner of the screen.

Click the **Actions** button to select from a list of options, (e.g., Refresh, Export to PDF).

Password Management

Passwords are set by the Care Coordinator Admin when setting up a user account. Users can change their password at any time by editing their Preferences. For more information about changing a Care Coordinator password, see "Care Coordinator Preferences" on page 12. For more information about changing a Care Coordinator Admin password, see "Care Coordinator Admin Preferences" on page 31.

A Care Coordinator Admin can reset a user's password (for example, if the user forgets their password) by changing the password value in the user's account. For more information, see "Modifying a User Account" on page 32.

Healthcare institutions determine the time period after which passwords expire or whether they expire at all. If an expiration period is defined, users are prompted to reset their passwords upon login when they reach the expiration date. For more information about password expiration settings, see "HOSPITAL SETTINGS" on page 31.

CARE COORDINATOR TEAM MANAGEMENT

The Care Coordinator Team Management screen allows Care Coordinator Admins to reassign Care Coordinators to teams. Click column headings to sort by ascending or descending.

Complete the following steps to reassign a Care Coordinator to a team:

1. From the Administrative Portal menu, select **Care Coordinator Team Management**.
2. Select the Care Coordinator(s) you want to reassign by clicking the check box at the beginning of the row(s).
3. Click **Reassign Selected**. The **Reassign Care Coordinator** window opens.
4. Click on the team to whom you want to reassign the Care Coordinators.
5. Click **Submit**.

PATIENT SUPPORT PROGRAM SETTINGS

Patient Support Program Settings enable Care Coordinator Admins to control the following:

- Phone number for patient to contact the healthcare institution's heart failure department
- Maximum number of days between patient interactions
- Escalation time intervals for overdue tasks

Default settings are determined by the healthcare institution during system configuration.

Complete the following steps to set patient support settings:

1. From the Administrative Portal menu, select **Patient Support Programme Settings**.

2. In the **Hospital Contact Info** field, enter the phone number for the patient to use in contacting the healthcare institution's heart failure department. This will be included in Emails to the patient.

3. In the **Max Number of Days Allowed Between Appointments** field, enter the maximum number of days allowed between calls and visits for patients.

NOTE: This is only applicable when rescheduling calls and will not affect the original contact strategy that is determined for each patient upon enrollment.

4. In the **Low Risk Patients – Days Before Alerted** field, enter the number of days allowed to pass between the time a task is scheduled to occur and the time the Care Coordinator assigned to the patient receives an alert for an overdue task if the patient's status is set to Low re-admission risk.

5. In the **High Risk Patients – Days Before Alerted** field, enter the number of days allowed to pass between the time a task is scheduled to occur and the time the Care Coordinator assigned to the patient receives an alert for an overdue task if the patient's status is set to High re-admission risk.

6. In the **Low Risk Patients – Days Before Escalation** field, enter the number of days after a CC receives an alert about their overdue task before the individual assigned as team lead during system configuration receives an Email notifying them about an incomplete/overdue task if the patient's status is set to Low re-admission risk..

7. In the **High Risk Patients – Days Before Escalation** field, enter the number of days after a CC receives an alert about their overdue task before the individual assigned as team lead during system configuration receives an Email notifying them about an incomplete/overdue task if the patient's status is set to High re-admission risk.

8. Click **Submit**.

TASK MANAGEMENT

The Task Management screen allows Care Coordinator Admins to reassign tasks between the Care Coordinators or teams. Click column headings to sort by ascending or descending.

Complete the following steps to reassign a task:

1. From the Administrative Portal menu, select **Task Management**.

2. Select the task(s) you want to reassign by clicking the check box at the beginning of the row(s).
3. Click **Reassign Selected**. The Reassign Task window opens.
4. Click on the Care Coordinator or team to whom you want to reassign the task.
5. Click **Submit**.

PATIENT MANAGEMENT

Patients are automatically assigned either to the Care Coordinator who enrolled them or within the team of the Care Coordinator who enrolled them.

The Patient Management screen allows Care Coordinator Admins to reassign patients between the Care Coordinators or teams. Click column headings to sort by ascending or descending.

Complete the following steps to reassign a patient:

1. From the Administrative Portal menu, select **Patient Management**.
2. Select the patient you want to reassign by clicking the check box at the beginning of the row.
3. Click **Reassign Selected**. The Reassign Patient window opens.
4. Click on the Care Coordinator or team to whom you want to reassign the patient.
5. Click **Submit**.

REPORTS

The same Operational and KPI reports available on the Care Coordinator Dashboard are available on the Administrative Portal. For more information, see "REPORTS" on page 27 in the chapter "Using the Care Coordinator Dashboard" on page 8.

USING THE KPI DASHBOARDS

CHAPTER 5

This chapter contains the following topics:

- “OVERVIEW” on page 37

Остаряла версия. Да не се използва.
Zastaralá verze. Nepoužívat.
Forældet version. Må ikke anvendes.
Version überholt. Nicht kasutage.
Aegunud versioon. Ärge kasutage.
Παλιά έκδοση. Μην την χρησιμοποιείτε.
Outdated version. Do not use.
Version obsolete. Ne utilizar.
Version périmée. Ne pas utiliser.
Zastarjela verzija. Nemojte upotrebljavati.
Úrejt útgáfa. Notið ekki.
Versione obsoleta. Non utilizzare.
Zastarjela verzija. Neizmantot.
Úrejt útgáfa. Notið ekki.
Novcojusi versija. Nenaudokite.
Pasenusi versija. Neizmantot.
Elavult verzió. Ne használja!
Utdatert versjon. Skal ikke brukes.
Wersja przeterminowana. Nie używać.
Versão obsoleta. Não utilize.
Versiune expirată. A nu se utiliza.
Zastaraná verzia. Nepoužívať.
Zastarela različica. Ne uporabite.
Vanhentunut versio. Älä käytä.
Föråldrad version. Använd ej.
Güncel olmayan sürüm. Kullanmayın.

OVERVIEW

KPI Dashboards are only available to Care Coordinator Admins.

The KPI dashboards display reports that measure key performance indicators such as re-admission rate, mortality rate, and cost of care (Figure 13 on page 37). Each dashboard shows a graph. For example:

- the Readmission Dashboard shows the healthcare institution's re-admission rate of heart failure patients compared to the national average;
- the Mortality Rate Dashboard shows the healthcare institution's mortality rate of heart failure patients compared to the national average; and
- the Benchmarking Dashboard shows the healthcare institution's cost of care at hospital for heart failure patients compared to the national average.

The list of KPI dashboard reports available depends on the reports selected by the healthcare institution during system configuration.



Figure 13. KPI Report displayed in KPI Dashboard

Logging In and Out

To log on to a KPI dashboard:

1. Click the link for the KPI dashboard you want to open on the **KPIS** tab of the Reports page of the Care Coordinator Dashboard. A login screen appears.
2. Enter your user name and password. This will be the same user name and password you use to log on to the Care Coordinator Dashboard. The dashboard window opens.

Log out of the KPI dashboard by selecting **File > Exit** from the menu at the top of the screen.

Navigating the KPI Dashboards

The KPI dashboard landing page contains the following features that allow users to navigate between the available pages:

- Tabs across the top of the landing page
- Buttons at the bottom of each individual page

Filters are used to limit the data displayed on a page. Filter options display on the left side of each page and vary by page. Options selected on one page will have no impact on data displayed on another page.






Users can download data from any dashboard page by clicking the **Download** button at the bottom right-hand corner of the screen and selecting from the list of options. For example, you can download the data as a PDF or image.

SYMBOLS

APPENDIX A

The following symbols may be used on labeling.

Table 7. Packaging Symbols

Symbol	Meaning
	Manufacturer
	Authorized representative in the European Community
	CE mark of conformity
	Consult instructions for use on this website: www.bostonscientific-elabeling.com
	Reference number

Остаряла версия. Да не се използва.
Zastaralá verze. Nepoužívát.
Forældet version. Må ikke anvendes.
Version überholt. Nicht kasutage.
Aegunud versioon. Ärge kasutage.
Παλιά έκδοση. Μην την χρησιμοποιείτε.
Outdated version. Do not use.
Versión obsoleta. Ne pas utilizar.
Version périmée. Nemojte upotrebljavati.
Zastarjela verzija. Neizmantot.
Úrelt útgáfa. Notið ekki.
Versione obsoleta. Non utilizzare.
Zastarjela verzija. Neizmantot.
Úrelt útgáfa. Notið ekki.
Novecojusi versija. Nenaudokite.
Pasenusi versija. Neizmantot.
Elavult verzió. Ne használja!
Utdatert versjon. Skal ikke brukes.
Wersja przeterminowana. Nie używać.
Versão obsoleta. Não utilize.
Versiune expirată. A nu se utiliza.
Zastaraná verzia. Nepoužívát.
Zastarela različica. Ne uporabite.
Vanhentunut versio. Älä käytä.
Föråldrad version. Använd ej.
Güncel olmayan sürüm. Kullanmayın.

Остаряла версия. Да не се използва.
Zastaralá verze. Nepoužívát.
Forældet version. Må ikke anvendes.
Version überholt. Nicht kasutage.
Aegunud versioon. Ärge kasutage.
Παλιά έκδοση. Μην την χρησιμοποιείτε.
Outdated version. Do not use.
Versión obsoleta. Ne pas utilizar.
Version périmée. Nemojte upotrebljavati.
Zastarjela verzija. Neizmantot.
Úrelt útgáfa. Notið ekki.
Versione obsoleta. Non utilizzare.
Zastarjela verzija. Neizmantot.
Úrelt útgáfa. Notið ekki.
Novecojusi versija. Nenaudokite.
Pasenusi versija. Neizmantot.
Elavult verzió. Ne használja!
Utdatert versjon. Skal ikke brukes.
Wersja przeterminowana. Nie używać.
Versão obsoleta. Não utilize.
Versiune expirată. A nu se utiliza.
Zastaraná verzia. Nepoužívát.
Zastarela različica. Ne uporabite.
Vanhentunut versio. Älä käytä.
Föråldrad version. Använd ej.
Güncel olmayan sürüm. Kullanmayın.

Boston Scientific



Boston Scientific Corporation
4100 Hamline Avenue North
St. Paul, MN 55112-5798 USA



Guidant Europe NV/SA
Boston Scientific
Green Square,
Lambroekstraat 5D
1831 Diegem, Belgium

1.800.CARDIAC (227.3422)
+1.651.582.4000

www.bostonscientific.com

© 2017 Boston Scientific Corporation or its affiliates.
All rights reserved.

92107256-001 en Europe 2017-07

