Supplemental Material

Outpatient Care System for Left Ventricular Assist Device Patients during COVID-19 Outbreak: Results from a European Experience

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Routine Questionnaire & Feedback Questionnaire
1. Monitoring of LVAD-Patients during COVID-19: Routine Questionnaire

The routine phone call performed in the context of the outpatient LVAD care system developed at our institution during COVID-19 outbreak was based on the following questions.

1. Have you had close contact with a confirmed case within the last 7 days?
   - Yes, if yes when? ____________________________
   - No
   - I do not know

2. Within the last 7 days, have you had:
   - Fever?
     - Yes - if yes, since when? ____________________________
     - No
   - Shivering?
     - Yes - if yes, since when? ____________________________
     - No
   - Increased fatigue or a significantly lower resistance?
     - Yes - if yes, since when? ____________________________
     - No
   - Limb pain?
     - Yes - if yes, since when? ____________________________
     - No
   - Headache?
     - Yes - if yes, since when? ____________________________
     - No
   - Sore throat?
     - Yes - if yes, since when? ____________________________
     - No
   - Loss of taste and smell?
For the following 2 questions it is important whether you suffer from a chronic disease like chronic bronchitis, allergy, chronic intestinal disease. Compare your current symptoms with your previous problems.

3. Within the last 7 days, have you had:
   - persistent cough?
     □ Yes - if yes, since when?  
     __________________________________________
     □ No
   - persistent running nose?
     □ Yes - if yes, since when?  
     __________________________________________
     □ No
   - Diarrhea?
     □ Yes - if yes, since when?  
     __________________________________________
     □ No

4. Have you been out of breath faster than usual in the last 7 days?
Select yes if you
   - become short of breath or have difficulty breathing during light exercise, such as walking or climbing a few steps
   - have the feeling of shortness of breath when sitting or lying
   - have a feeling of shortness of breath when getting up from bed or stool
     □ Yes, if yes, since when? ________________________________
     □ No

5. Are you currently taking cortisone (in pills)?
   □ Yes – if yes, which medication? ________________________________
   □ No
   □ I do not know
6. Are you currently taking immunosuppressive drugs? Immunosuppressive drugs are taken or received after an organ transplant, during the treatment of an autoimmune disease or as part of chemotherapy.

☐ Yes – if yes, which medication? ________________________________
☐ No
☐ I do not know

8. Have you had a flu vaccination between October 2019 and today?

☐ Yes – if yes, which medication? ________________________________
☐ No
☐ I do not know


At the beginning of the second COVID-19 outbreak, patients were asked to give a feedback on the first outpatient LVAD care system based on the following questions.

1. Did you feel sufficiently informed by the phone conversation? (From 0 to 10)

   0  1  2  3  4  5  6  7  8  9  10

2. Did you understand the advice/information you received throughout the phone call? (From 0 to 10)

   0  1  2  3  4  5  6  7  8  9  10

3. How satisfied you were with the advice and information you received? (From 0 to 10)

   0  1  2  3  4  5  6  7  8  9  10

4. Did you feel that your health issues were treated correctly? (From 0 to 10)

   0  1  2  3  4  5  6  7  8  9  10

5. Did you feel psychologically supported during the phone call? (From 0 to 10)

   0  1  2  3  4  5  6  7  8  9  10
6. Did you feel safer after being included in the LVAD-COVID program? (From 0 to 10)

0 1 2 3 4 5 6 7 8 9 10

7. Do you think that the phone calls and questionnaire were useful? (From 0 to 10)

0 1 2 3 4 5 6 7 8 9 10

8. Do you think that this program was a good alternative to the standard outpatient clinic visits during the COVID-19 pandemic? (From 0 to 10)

0 1 2 3 4 5 6 7 8 9 10

9. Did you undergo medical treatment after one of our calls because of COVID-19?

☐ No
☐ Yes, I went to the hospital   Date:______ /_______/___________
☐ Yes, I went to a general practitioner   Date:______ /_______/___________
☐ Yes, I had a COVID test   Date:______ /_______/___________

10. Did you have a positive COVID-19 test?

☐ Yes   Date:______ /_______/___________
☐ No

11. If you had a positive COVID-19 test, what happened afterwards?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

12. Did you undergo medical treatment after one of our calls because of your LVAD?

☐ No
☐ Yes, I went to the hospital   Date:______ /_______/___________
☐ Yes, I went to a family doctor   Date:______ /_______/___________
☐ Yes, I went to the outpatient clinic   Date:______ /_______/___________
13. If yes, which of the following situations occurred?

☐ Nosebleed                           Datum:______ /_______/___________
☐ Gastrointestinal bleeding          Datum:______ /_______/___________
☐ Problems with INR                  Datum:______ /_______/___________
☐ Driveline infection                Datum:______ /_______/___________
☐ Right heart failure                Datum:______ /_______/___________
☐ New arrhythmia                     Datum:______ /_______/___________
☐ Neurological problems              Datum:______ /_______/___________
☐ Pump thrombosis                    Datum:______ /_______/___________
☐ Driveline repair/replacement       Datum:______ /_______/___________
☐ Other                              Datum:______ /_______/___________

If other, please specify:

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

14. Did you undergo medical treatment after one of our calls because of heart failure?

☐ No
☐ Yes, I went to the hospital         Date:______ /_______/___________
☐ Yes, I went to a family doctor     Date:______ /_______/___________
☐ Yes, I went to the outpatient clinic Date:______ /_______/___________

If yes, please specify what happened:

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

15. Did you undergo medical treatment after one of our calls for other diseases?

☐ No
☐ Yes, I went to the hospital         Date:______ /_______/___________
☐ Yes, I went to a family doctor     Date:______ /_______/___________
☐ Yes, I went to the outpatient clinic Date:______ /_______/___________

If yes, please specify what happened:

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

16. Did you receive all the materials you needed during the COVID-19 pandemic (i.e. masks, wound dressings..)?
17. Do you have any comments to this LVAD-COVID program?

☐ No
☐ I don’t know.
☐ Yes. If yes, please specify:

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________