Oklahoma Heart Institute
Advanced Heart Failure Center

BEHAVIORAL CONTRACT FOR VENTRICULAR ASSIST DEVICE CANDIDATES
HMC1053 (04/19)
Review (01/21)

Patient Name: _____ MRN: _____

Oklahoma Heart Institute (OHI) in conjunction with Hillcrest Medical Center currently provides Ventricular Assist Device (VAD) therapy through its VAD program to selected patients with failing hearts. Some of these patients go on to transplant and others keep the VADs permanently. Your physicians have determined that you now require such a device for your heart. The process of making sure patients are good candidates for VAD therapy is often lengthy and having a VAD involves many demands on patients, families and care partners. Most importantly, successful living with VAD therapy depends on establishing a cooperative working relationship between patients, their care partners and the VAD team.

To help determine whether a VAD is the best option for you, there needs to be an understanding about what is required of all parties before and after a VAD is implanted. Before proceeding with further evaluation or treatment we would like to review the following agreement with you and your family and/or care partners. We hope that this document will give you a better understanding of your responsibilities and our responsibilities for your care. If you have questions about this agreement or the process of being considered for a VAD, we encourage you to discuss these questions with team members before signing the agreement and proceeding with VAD evaluation.

First, here are the services OHI in conjunction with Hillcrest Medical Center agrees to provide.

- We will train you and your care partner(s) in the daily operation, maintenance and emergency procedures related to the VAD prior to your discharge home.
- We will provide information regarding the VAD to your community emergency services and local hospital.
- We will be available for any questions regarding your VAD and care 24 hours a day.
- We will review your medications at your clinic visits and answer any questions you have regarding them.
- We will communicate our treatment plan and provide a written list of key components at each visit.
- We will maintain communication with your primary care physician(s).
- We will regularly examine your equipment to assess for any wear and tear and assist in getting malfunctioning equipment replaced.
- We will periodically review emergency procedures as it relates to your VAD.
- We will regularly examine the skin exit site to be sure there are no signs of infection.
- If you plan to travel, we will assist contacting local VAD centers.
- If you plan air travel, we will assist in communication with the airline and airport security.
- We will provide access to dietary counseling and other resources if required.
- We will provide a binder where key information such as emergency numbers and forms can be maintained.

Next, we discuss the responsibilities of VAD patients in the following sections.

After reviewing each section, please initial in the margin if you are in agreement. If you do not agree or have reservations about a section, please note the reason in the space at the end of the section and discuss with a member of the VAD team. Once you have reviewed and understand the entire agreement and had your questions answered to your satisfaction, please sign at the end of this document where indicated.

I _____make a commitment to myself, my care partners and the VAD team to take care of myself before and after implant. The following are additional standards and expectations that I will abide by before and after implantation should I receive a VAD.

_____ I understand that a strong support system is essential for the success of my future with a VAD. In addition, I understand that following implantation I will require assistance upon discharge from the hospital. Therefore, a dedicated care partner must be available for several weeks or longer until I am adequately healed from the surgery. My dedicated care partner must come to appointments with me as much as possible and must agree to participate in device training. This requirement may be adjusted by the physician on a case by case basis. I understand that it is best if I identify more than one care partner for training and support.

_____ I understand that I am financially responsible for the costs of the VAD, which includes hospitalization, physician charges, outpatient testing, laboratory charges, medication expenses and VAD related supplies. I also understand that it is my responsibility to stay updated on my insurance coverage and to inform the VAD team should my insurance coverage change. It is my responsibility to understand what is/is not covered by insurance and know that these uncovered expenses are my financial responsibility.

_____ I understand that I will not be allowed to drive until my doctor's approval.

_____ I will read the device educational materials provided to me by the VAD team and ask questions about any content I do not understand. I understand that I must demonstrate a safe skill level with all aspects of VAD care prior to being discharged from the hospital.

_____ I will follow the treatment plan as prescribed by the VAD team. I will keep my clinic appointments, complete lab work and tests as ordered and take my medications as directed.

_____ I will know my medications and the reason I am taking them. I will inform the VAD team of any new medications, including those purchased over the counter that I am taking.

_____ I will keep daily records including blood pressures, temperatures, weights and VAD readings and I will bring the information to all clinic visits.

_____ If alcohol or substance abuse has been identified as an issue for me and I understand that I will need to stop drinking and/or abusing illicit/prescription drugs. I will be required to participate in drug screenings and follow the recommendations of the VAD team.

_____ If alcohol abuse or dependence has not been identified as an issue for me, I agree to limit my alcohol intake as it can impair appropriate decision making regarding management of my device that may lead to death if I do not respond to an alarm. Alcohol can cause fluid loss that can impair device output.

_____ If tobacco dependence is identified as an issue for me, I understand that I will need to successfully complete a smoking cessation program and will remain abstinent from tobacco use for the rest of my life, understand that it can contribute to a poor health outcome.

_____ I understand that if any aspect of my mental health is identified for me (including depression, anxiety,panic attacks, suicidal or homicidal ideation), I will follow the recommendations made by the VAD team. I understand that these recommendations may include outpatient services including psychiatry and counseling services.

_____ I will adhere to safe sex guidelines to prevent sexually transmitted diseases which can contribute to the risk for death in VAD patients. I understand that transmission of such diseases can be life threatening or fatal. I will ensure that a safe method of contraception is used as becoming pregnant while implanted with a VAD can be life threatening or fatal.

_____ I will comply with the instructions and recommendations I receive from the VAD team regarding the prevention of infections, including care of my driveline site and understand that infection is the leading cause of death in patients with VADs. I will adhere to good hygiene practices including handwashing, driveline care, good oral care and keeping my body and environment clean. I understand that care of my driveline site will require the assistance of my care partners particularly for the first month after implantation. I understand that damage to the driveline lead may cause the pump to stop and result in death.

_____ I understand that based upon an assessment by physical therapy of my functional status after surgery, the medical team may recommend transition to an inpatient rehabilitation facility prior to discharge to home. I understand that this will improve my ability to function independently at home.

_____ I understand that VADs do not last forever and may wear out. Should my device fail, death may occur. In the event of device malfunction, I may be eligible to receive another device.

_____ When I receive a VAD, I understand that these recommendations continue and are necessary for my VAD management and continued health. I agree to provide an advanced health directive as part of my health care records.

_____ I understand that I must complete an emergency preparedness plan with the VAD coordinator prior to discharge.

_____ I understand that my home must be equipped with at least two grounded (not attached to a light switch), 3 prong outlets that will be dedicated to powering the power module.

Care Partner's Requirements

_____ I commit to being in the immediate vicinity of the VAD patient at all times or will arrange for another trained care partner to be with the VAD patient until the VAD patient can function independently, as determined by the VAD team.

_____ I will provide transportation to and from the hospital for frequent clinic appointments, labs and tests.

_____ I will be trained in the daily operation, maintenance and emergency procedures related to the VAD. This will require committing to several sessions at the hospital after VAD surgery.

_____ I will complete a hands-on training prior to the patient being discharged from the hospital.

_____ I will adhere to good hygiene practices including handwashing, driveline care and will strive to maintain a clean environment for the patient.

I have read the above list of expectations. If my care partner cannot or does not meet the above criteria, then I will be expected to find a care partner that agrees to the above expectations.

_____ _____
Patient Signature Date

The responsibilities of the care partner have been fully explained to me and I agree to abide by the above list of expectations.

_____ _____
Care Partner Signature Date

I have explained fully the expectations of both patient and care partner(s) to participate in the Oklahoma Heart Institute VAD program. I have asked if the participants have any questions and answered those questions to the best of my ability.

_____ _____
VAD Coordinator Date

_____ _____
Physician/Provider Date

_____ _____
Social Worker/Case Manager Date