ELECTROCONVULSIVE THERAPY (ECT)

PURPOSE

Performance specifications are intended to enhance MassHealth Enrollee experience and outcomes by promoting transparency and consistency across Plans and providers. Performance specifications are expectations imposed on providers who contract for these specific and related services. Information contained in this document is based on publicly available documents, Plan expectations, your contract, and MassHealth guidance. This information should be and will look materially like any other MassHealth contracted Plan. Performance specifications, your provider manual, and other requirements can be found at providerexpress.com.

Providers contracted for this level of care or service are expected to comply with applicable regulations set forth in the Code of Massachusetts Regulations, and all requirements of these service-specific performance specifications. In addition, providers of all contracted services are held accountable to the General Performance Specifications. Where there are differences between the service-specific and General Performance Specifications, the service-specific specifications take precedence.

OVERVIEW

Electroconvulsive Therapy (ECT) is the initiation of seizure activity with an electric impulse while the Enrollee is under anesthesia. This procedure is administered in a hospital facility or community facility licensed to do so by the Department of Mental Health (DMH). ECT may be administered on either an inpatient or outpatient basis, depending on the Enrollee's mental and medical status. Regulations governing administration of this procedure are contained in Department of Mental Health regulations, *104 CMR 2.04* through *3.10.*

The principal indications for ECT are the following:

1. Major depression with or without psychosis that has not been responsive to adequate trials of medication or when medication is contraindicated;
2. Severe depression with life-threatening behaviors (e.g., refusal to eat or drink, compulsive and impulsive suicide tendencies) when the latency of action of medication places the Enrollee at added risk;
3. Severe depressive illness, a prolonged or severe manic episode, the affective components of schizophrenia and related psychotic disorders, catatonia, or neuro-malignant syndrome (NMS);
4. Previous therapeutic response to ECT.

Providers must complete a workup including medical history, physical examination, and any indicated pre-anesthetic lab work to determine that there are not contra- indications to ECT and that there are no less intrusive alternatives to ECT before scheduling administration of ECT.

SERVICE COMPONENTS

1. The provision of a complete clinical workup of Enrollee including, but not limited to:
    a) Medical history
    b) Physical exam
    c) Pre-anesthetic lab work
    d) Psychiatric treatment history
    e) Psychopharmacology history, including response to current and previously prescribed medications; and,
    f) Complete psychosocial history.
2. A determination of the number and duration of ECT sessions individually determined based on clinical workup and determination of clinical need.
3. A written treatment plan which projects schedule of treatments and identifies available supports during treatment.
4. ECT providers provide initial crisis response 24 hours per day, seven days per week, to all Enrollees enrolled in the ECT treatment. These crisis responses are intended to be the first level of crisis intervention whenever needed by the Enrollee.
    a. During operating hours, these crisis responses are provided by a clinician via telephone and, if clinically indicated, face-to-face through emergent appointments.
    b. After hours, the program provides Enrollees with a telephone number that allows them to access a clinician either directly or via an answering service. A live person must always answer the phone number.
    c. Calls identified as an emergency by the caller are immediately triaged to a clinician.
    d. A clinician must respond to emergency calls within 15 minutes and minimally provide a brief assessment and intervention by phone.
    e. Based upon these initial crisis responses conducted by the ECT provider both during operating hours and after hours, the provider may refer the Enrollee, if needed, to an Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) provider for emergency behavioral health assessment, crisis intervention and stabilization.
    f. An answering machine or answering service directing callers to call 911 or the ESP/MCI program, or to go to a hospital emergency department (ED), does not meet the after-hours emergency on-call requirements.
5. All procedures follow DMH Regulations 104 CMR 2.04 through 3.10.
6. The Enrollee provides a separate written informed consent to ECT on forms provided by DMH, since consent to other forms of psychiatric treatment does not include consent to ECT.
7. The Enrollee will be informed of the risks and benefits of ECT and of any alternative somatic or non-somatic treatments.
8. The Enrollee or the Enrollee's legal guardian and the psychiatrist agree that administration of ECT is desirable, based on a clear understanding of the risks and benefits of ECT, as well as alternative treatments and the likelihood of their success.
9. The facility shall establish a written plan for the administration of ECT in compliance with the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and current practice guidelines established by the American Psychiatric Association.

STAFFING REQUIREMENTS

1. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the Plan service-specific performance specifications and the credentialing criteria outlined in your provider manual that can be found at providerexpress.com.
2. The facility shall have a director who holds an advanced degree from an accredited college/university or discipline appropriate to the care and treatment of the mentally ill.
3. The facility will have a physician fully licensed to practice medicine under Massachusetts law, and who is certified or eligible to be certified by the American Board of Psychiatry and Neurology in Psychiatry to perform ECT.
4. Facility holds a Class VIII License issued by DMH to perform this service and meets all staffing requirements required in CMR 104 under that license class.
5. The facility will have a physician fully licensed to practice and administer anesthesiology under Massachusetts law. For adolescents, anesthesia is administered by qualified personnel experienced in treating adolescents.
6. Nursing staff with a specialty in psychiatric nursing is available to assist and to monitor Enrollees following administration of the ECT, and skilled in the care of unconscious Enrollees.
7. All nursing personnel shall be adequately prepared by education, training, and experience to provide care and treatment to patients with mental illness.
8. A consultant internist, neurologist, ob-gyn, pediatrician (for adolescents), radiologist, and other specialists as appropriate.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. Programs will maintain active affiliation agreements with other providers, including but not limited to, emergency service providers, acute levels of care, outpatient levels of care, psychiatrists, psychologists, and other services and practitioners necessary to appropriately provide care to Enrollees.
2. Facility staff coordinates treatment planning and aftercare with the Enrollee's primary care clinician, outpatient, and other community based providers, involved state agencies, educational system, community supports and family, guardian and/or significant others when applicable. If consent for such coordination is withheld or refused by the parent or guardian of a minor, then this is documented in the Enrollee's record.
3. The facility ensures that a written aftercare plan is available to the Enrollee on the day of discharge. When consent is given, a copy of the written aftercare plan is forwarded at the time of discharge to the referral source, family/guardian/significant other, DMH, (if DMH Enrollee), outpatient or community-based provider, PCP, school, and other entities and agencies that are significant to the Enrollee's aftercare.
4. When necessary, the program provides or arranges transportation for the Enrollee as his/her needs demonstrate.
5. When necessary, the facility will ensure that the Enrollee has appropriate monitoring and support after each treatment. This may necessitate a referral to a day treatment or partial hospital program.

6. The program, with consent of the Enrollee, confers with the referral source, ESP team and prior treaters, particularly if he/she has received prior ECT treatment, to identify treatment needs, to obtain treatment history and to develop a treatment plan incorporating this information.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. The provider ensures there is documentation in the Enrollee's health record that ECT is being used for treating target symptoms in an Enrollee with one of the following conditions: severe depressive illness, a prolonged or severe manic episode, the affective components of schizophrenia and related psychotic disorders, catatonia, or neuro-malignant syndrome (NMS). ECT is used only to achieve rapid and short-term improvement of an Enrollee's severe symptoms after an adequate trial of other treatment options has proven ineffective or when the condition is potentially life threatening.
2. There is documentation in the Enrollee's health record of an assessment of the risks and potential benefits to the Enrollee undergoing ECT.
3. There is documentation that the informed consent process is documented as a dialogue in the health record when the Enrollee can give informed consent. There is documentation of substituted judgment if the Enrollee is not able to give consent. The consent process provides full and appropriate information in a suitable format and in language that allows there to be an informed discussion. There is an explanation of the general risks of ECT, risks specific to the Enrollee, and potential benefits to the Enrollee.

Discharge Planning and Documentation

1. Components of Discharge Planning incorporate Enrollee's identified concerns, including but not limited to housing, finances, healthcare, transportation, familial, occupational, educational, and social supports.
2. The treatment team staff member who is responsible for implementing an Enrollee's Discharge Plan documents in the medical record all discharge-related activities that have occurred while the Enrollee is in the facility, including Enrollee participation in its development.
3. The completed discharge form, including referral to any agency, is available to and given to the Enrollee, and when appropriate, the Enrollee's family or guardian at the time of discharge, which includes, but is not limited to, appointments, medication information and emergency/crises information.
4. Follow up care, appointments, and discharge plan must be in place and documented in Enrollee's chart prior to discharge.
5. For those Enrollees discharged on medications, at least one psychiatric medication-monitoring appointment is scheduled no more than 14 days after discharge.

QUALITY MANAGEMENT

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to Optum, and which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is utilized and may include outcome measures and satisfaction surveys to measure and improve the quality of care and services delivered to Enrollees, including youth and their families.
3. Clinical outcomes data must be made available to Optum upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.