commonwealth care alliance®

Outpatient Electroconvulsive Therapy (ECT)
Performance Specifications

Providers contracted for this level of care or service are expected to comply with all the requirements of these service-specific performance specifications. Additionally, providers contracted for this service and all contracted services are held accountable to the General performance specifications. The requirements outlined within these service-specific performance specifications take precedence over those in the general performance specifications.

Electroconvulsive (ECT) Therapy is the initiation of generalized seizure activity with an electric impulse while the Member is placed 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 Member's mental and medical status. Providers should follow DMH regulations that govern administration of this procedure. ECT may cause short or long-term memory impairment of past or current events. The number of sessions undertaken during a course of ECT usually ranges from 6 to 12. ECT is typically performed at a schedule of three (3) times per week. Maintenance ECT is typically administered at one to three-week intervals. The decision to recommend the use of ECT derives from a risk/benefit analysis for Members. This analysis considers the diagnosis of the individual and the severity of the presenting illness, the individual's treatment history, the anticipated speed of action/efficacy of ECT, the medical risks, and anticipated adverse side effects. 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.

COMPONENTS OF SERVICE:

The general criteria for ECT are the following:

- Major depression with or without psychosis that has not been responsive to adequate trials of medication or when medication is contraindicated
- Previous therapeutic response to ECT
- 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 Member at added risk

Pre-ECT Evaluation:

- At a minimum, the provider or facility ensures it has documented a minimal set of procedures to be undertaken for all individuals including:
  - A medical evaluation specifically focused on the safety of ECT including an updated history and physical examination to assess for cardiovascular, pulmonary, neurologic systems risk including any past concerns with risks for anesthesia
  - Physical exam
  - Pre-anesthetic treatment history
  - Psychiatric history and examination to determine the indication for ECT, including previous response to ECT
  - A psychiatric diagnostic assessment that includes a DSM-5 diagnosis, inclusive of psychosocial and disability concerns
  - A full mental status assessment including, at a minimum, a Mini Mental Status Examination and associated score

    - Careful review of all past treatments
  - Documentation of current and previous medications including pharmacotherapy. The medication prescribed, dosage, duration of each trial, compliance, response, side effects, and response to augmentation strategies
  - A dental examination
  - All of the above needs to be documented in the Members record
- A determination of the number and duration of ECT sessions individually is determined based on clinical work-up and determination of clinical need.
- There is a written treatment plan that projects schedule of treatments and identifies available supports during treatment.
- ECT providers provide initial crisis response 24 hours per day, seven days per week, to all Members enrolled in ECT treatment. These crisis responses are intended to be the first level of crisis intervention whenever needed by the Member.
  - During operating hours, these crisis responses are provided by a clinician via telephone, and if clinically indicia ted, face-to-face through emergency appointments.
  - After hours, the program provides Members 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.
  - Calls identified as an emergency by the caller are immediately triaged to a clinician.
  - A clinician must respond to an emergency call(s) within 15 minutes and minimally provide a brief assessment, crisis intervention and stabilization.
  - An answering machine or answering service directing callers to call 988, 911 or Adult Mobile Crisis Intervention (AMCI) program, or go to a hospital emergency department (ED) does not meet the after-hours emergency on-call requirements.
- All procedures are in compliance with DMH regulations 104 CMR 2.04 through 3.10.
- The Member 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.
- The member will be informed of the risks and benefits of ECT and of any alternative somatic or non-somatic treatments.
- The Member or the Member's legal representative/guardian and the psychiatrist agree that administration of ECT is desirable, based on clear understanding of the risks and benefits of ECT, as well as alternative treatments and the likelihood of their success.
- The facility shall establish a written plan for the administration of ECT in compliance with standards set by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and with current practice guidelines established by the American Psychiatric Association.

Administering ECT:

- The individual should be fasting overnight prior to treatment
- The ECT psychiatrist should determine the choice of electrode placement and be skilled in both unilateral and bilateral ECT. The utilization of either procedure should be based on an ongoing assessment of risk versus benefit to the individual
- Close monitoring is provided during and after treatment until the individual is fully recovered from anesthesia including a focus on assessing Members cognitive functioning
- During treatment, monitoring includes observation of seizure duration, airway obstruction, agitation, vital signs, and adverse effects. Additionally, any onset of new risk factors, or significant worsening of those present at pre-ECT, should be evaluated prior to the next treatment

- After treatment:
    - For ECT administered in an acute setting: individuals are monitored for at least 24 hours to assess cognitive side effects, or prolonged or late seizures (tardive seizures) that may occur after the ECT session.
    - A neurology consultation is obtained if recurrent or prolonged seizures occur.
    - For ECT administered in an outpatient setting: individuals are clinically assessed prior to each ECT session and after each ECT session for any adverse effects that may occur during the recovery period.
    - It is expected that ECT providers will refer to the American Psychiatric Association's (APA) guidelines for ECT.
- ECT treatment is usually done in 6-12 sessions at a frequency of 2-3 times a week. ECT frequency may change when a positive response is obtained as determined by the ECT psychiatrist and the attending psychiatrist working in consultation

STAFFING REQUIREMENTS:

- The facility and program comply with the staffing requirements of the applicable licensing body.
- The facility will have a board-certified 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
- The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the service-specific performance specifications, and the credentialing criteria
- In addition to the above, the ECT treatment requires a multi-disciplinary team that includes:
    - Anesthetist
    - Nursing staff with a specialty in psychiatric nursing
    - Consultant internist, neurologist, radiologist, and other specialists as appropriate, all who have been trained in working with Members diagnosed with mental health and psychiatric diagnosis

Training Expectations:

It is the expectation of CCA that all contracted providers will offer ongoing staff training in order to best serve the diverse identities and experiences of the CCA Member population. Staff training should be inclusive of, but not limited to:

- Social determinants of health (SDOH)
- Trauma-informed behavioral health and medical care (including, but not limited to, ways in which the ACE study informs care delivery for Members, and trauma-specific treatment approaches)
- Best practices in delivering LGBTQIA+ inclusive and affirming— and, specifically, transgender inclusive and affirming— behavioral health and medical care
- Best practices in delivering culturally responsive, inclusive, and anti-racist behavioral health and medical care
- Best practices in health equity and inclusivity for Members of various racial, ethnic, and cultural backgrounds, as well as disabled Members, Members of various religious backgrounds, and Members with multiply marginalized identities
- Organizational strategies and resources for accessing interpreter services for Members who primarily communicate in languages other than English (including ASL)

Transgender Inclusive and Affirming Expectations:

It is the expectation of CCA that all contracted providers will provide inclusive and affirming care to our transgender/non-binary/gender diverse Members. This expectation is inclusive of, but not limited to:

- Consistently using the name and pronouns that the Member uses for themselves, even if this is not the name and/or pronoun set reflected in the Member's legal identification and/or CCA insurance card
- Making admission decisions without regard to the Member's gender identity
- Making determinations about access to any gender-based/gender separated service based on the gender with which the Member identifies, even if this is not the gender reflected in the Member's legal identification and/or CCA insurance card
- Ensuring that staff are regularly trained in best practices in delivering LGBTQIA+ inclusive and affirming— and, specifically, transgender inclusive and affirming— behavioral health and medical care

Trauma-Informed Care Expectations:

It is the expectation of CCA that all contracted providers will provide care to our Members that is fundamentally trauma informed. Trauma-informed care is inclusive of, but not limited to:

- Providing staff with ongoing training in trauma-informed behavioral health and medical care (including, but not limited to, ways in which the ACE study informs care delivery for Members, and trauma-specific treatment approaches)
- Providing comprehensive trauma screening as part of the standard evaluative process, in order to avoid potentially traumatic re-screening
- Integrating knowledge of trauma, and trauma responsiveness, into the creation and implementation of policies and procedures
- Including the Member's voice, involvement, and feedback in treatment planning—including offering harm reduction strategies in all aspects of treatment
- Seeking to avoid re-traumatization for Members receiving care by creating a safe treatment environment
- Offering trauma-specific treatment interventions and approaches

ASSESSMENT, TREATMENT PLANNING, DOCUMENTATION:

- The initial assessment between the physician and the Member includes all of elements of the Pre-ECT Evaluation listed above as well as all the elements of an initial psychiatric evaluation and a medical evaluation with a focus on major areas of risk including history of seizures or other neurological conditions
- The provider ensures there is documentation in the Member's health record with reference to ECT being used for treating target symptoms in an individual 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 individual's severe symptoms after an adequate trial of other treatment options has proven ineffective
- The ECT provider and program will develop a preliminary individualized treatment plan with expected length and number of treatments prior to the initiation of treatment. By the third

treatment, an updated treatment plan will be written, including projected length and number of treatments to be delivered. This information is updated in the Members record

- The provider ensures that the Member and the Member's legal guardian and the psychiatrist agree that administration of ECT is appropriate based on a clear understanding of the risks and benefits of ECT
- The provider documents the Members informed consent. If the Member cannot give consent, this is documented in the Members' record. Informed consent needs to be presented and reviewed in a culturally sensitive manner and in the Members language of choice
- With consent, the Members family and/or other natural supports are included in the initial assessment and informed consent process
- All treatment outcomes, and will be documented in the Member's record
- All data regarding the seizure activity, anesthesia, number of treatments, response to treatments and other Regulations set forth by DMH regulations shall be recorded in the Member's record
- The program makes all reasonable efforts to assure that Members have access to supportive staff during the time immediately following a treatment
- Best practices for care include collaboration with Commonwealth Care Alliance Care Team. With the approval from the Member and appropriate release of information, Providers are expected to contact the CCA Care Team using CCA's Provider Services Line 866-420-9332 to alert the Members Care Team that the Member is receiving services and to discuss any services that might help support the Member for seamless continuity of Care

DISCHARGE AND COLLABORATION WITH COMMUNITY BASED PROVIDERS & SERVICES:

- The ECT treatment team collaborates with the Member's outpatient providers in the development of treatment and discharge plans
- The discharge Planning includes Member's identified psychosocial concerns housing, finances, healthcare, transportation, familial, occupational, educational, and social supports
- The treatment team documents all discharge-related activities that have occurred while the Member is in the facility, including Member participation in its development in the medical record
- Upon discharge, discharge paperwork and agency referrals are given to the Member, and when appropriate, the Member's family or guardian, and includes appointments, medication information and emergency/crises information. The discharge plan is documented in the Members record
- For Members discharged on medications, at least one psychiatric medication monitoring appointment is scheduled no more than 14 days after discharge

QUALITY MANAGEMENT:

- The facility will develop and maintain a quality management plan which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides
- The facility utilizes a continuous quality improvement process and will include outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to members, including their families
- Clinical outcomes data must be made available to Commonwealth Care Alliance (CCA) upon request, and must be consistent with CCA's performance standard for ECT
- Providers are required to collect and measure outcome data and incorporate the data in treatment plans in the medical records and inform clinical programming.

- Clinical outcomes data must be made available to Commonwealth Care Alliance (CCA) upon request and must be consistent with CCA' s performance standards for this level of care for quality management and Network Management purposes.
- Providers will comply with all applicable laws and regulations including but not limited to any and all applicable Medicare and/or Medicaid laws, regulations, and instructions of CMS and/or EOHHS relating to addressing and reporting Serious Reportable Events (SREs). A more complete list of SRE's can be found in Section 11 of CCA's Provider Manual.
- The success of the program and the care and well-being of members rely on a collaborative partnership with Commonwealth Care Alliance and its provider network.
- All reportable adverse incidents will be reported within one business day of their occurrence per policy and DMH licensing requirements. A reportable adverse incident is an occurrence that represents actual or potential harm to the well-being of a Member, or to others by action of a Member, who is receiving services, or has recently been discharged from services.
- The facility and/or program will comply with all requirements contained in their contract with CCA including any corrective actions required by CCA or applicable regulatory agencies.

DOCUMENT UPDATES:

- December 2024: Revised template
- March 2026: Annual review