Performance Specifications

Other Outpatient Services

Electro-Convulsive Therapy (ECT)

Psychiatric Consultation on an Inpatient Medical Unit

Performance Specifications

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Electroconvulsive Therapy (ECT)

Providers contracted for this level of care or service are expected to comply with all 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 Therapy (ECT) is a procedure during which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity. The member receiving ECT is placed under general anesthesia, and muscle relaxants are given to prevent body spasms. ECT electrodes can be placed on both sides of the head (bilateral placement) or on one side of the head (unilateral placement). Unilateral placement is usually to the non-dominant side of the brain, with the aim of reducing cognitive side effects. The amount of current to induce a seizure (the seizure threshold) can vary up to 40-fold among individuals. ECT may cause short- or long-term memory impairment of past events (retrograde amnesia) and of current events (anterograde amnesia). The number of sessions undertaken during a course of ECT usually ranges from six to 12. ECT is most commonly performed at a schedule of three times per week. Maintenance ECT is most commonly administered at one- to three-week intervals.

The decision to recommend the use of ECT derives from a risk/benefit analysis for the specific member. This analysis considers the diagnosis of the member and the severity of the presenting illness, the member's treatment history, the anticipated speed of action and efficacy of ECT, the medical risks, and anticipated adverse side effects. These factors should be considered against the likely speed of action, efficacy, and medical risks of alternative treatments in making a determination to use ECT.

Components of Service

1. The provision of a complete clinical workup of the member is required, 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.
    f. Complete psychosocial history.
2. A determination of the number and duration of ECT sessions individually is determined based on clinical work-up and determination of clinical need.
3. There is a written treatment plan that 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 members enrolled in the ECT treatment. These crisis responses are intended to be the first level of crisis intervention whenever needed by the member.
    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 members with a telephone number that allows them to access a clinician either directly or via an answering service. A live person must answer the phone number at all times.
   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 member, if needed, to a Mobile Crisis Intervention (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 MCI program, or to go to a hospital emergency department (ED), does not meet the after-hours emergency on-call requirements.
5. All procedures are in compliance with DMH Regulations 104 CMR 2.04 through 3.10.
6. 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.
7. The member will be informed of the risks and benefits of ECT and of any alternative somatic or non-somatic treatments.
8. The member or the member's legal guardian and the psychiatrist are in agreement 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 electroconvulsive treatment in compliance with the standards set forth by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and with current practice guidelines established by the American Psychiatric Association.

Staffing Requirements

1. The provider complies with the staffing requirements of the applicable licensing body.
2. ECT treatment requires a multi-disciplinary team that includes:
   a. A board-certified psychiatrist trained to administer ECT and privileged by the facility for ECT.
   b. An anesthetist.
      i. For adolescents, anesthesia is administered by qualified personnel experienced in treating adolescents.
   c. A nurse skilled in the care of unconscious members.
   d. A consultant internist, neurologist, ob-gyn, pediatrician (for adolescents), radiologist, and other specialists as appropriate.

Service, Community, and Collateral Linkages

1. Programs will maintain active affiliation agreements with other providers including, but not limited to: mobile crisis intervention providers, acute levels of care, outpatient levels of care, psychiatrists, psychologists, and other services and practitioners necessary to appropriately provide care to members.
2. Facility staff coordinates treatment planning and aftercare with the member's primary care practitioner, 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 member's record. The facility ensures that a written aftercare plan is available to the member at 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, outpatient or community-based provider, PCP, school, and other entities and agencies that are significant to the member's aftercare.
3. When necessary, the program provides or arranges transportation for the member as their needs demonstrate.
4. When necessary, the facility will ensure that the member has appropriate monitoring and support after each treatment, which may necessitate a referral to a day treatment or partial hospital program.
5. The program, with consent of the member, confers with the referral source, MCI team, prior providers, particularly if they have received prior ECT treatment, in order to identify treatment needs, to obtain treatment history, and to develop a treatment plan incorporating this information.

Quality Management (QM)

1. The facility and/or program will develop and maintain a quality management plan that is consistent and that utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is used and will include outcome measures and satisfaction surveys to measure and improve the quality of care and service delivered to members, including youth and their families.
3. Clinical outcomes data must be made available upon request and must be consistent with performance standards for this service.
4. All Reportable Adverse Incidents will be reported within one business day of their occurrence per Carelon 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.
5. The facility and/or program will adhere to all reporting requirements of DPH and/or DMH regarding serious incidents and all related matters.

Process Specifications

Assessment, Treatment Planning, and Documentation

1. The provider ensures there is documentation in the member's health record that ECT is being used for treating target symptoms in a member 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 a member's severe symptoms after an adequate trial of other treatment options has proven ineffective or when the condition is considered to be potentially life threatening.
2. There is documentation in the member's health record of an assessment of the risks and potential benefits to the member undergoing ECT.
3. There is documentation that the informed consent process is documented as a dialogue in the health record when the member is able to give informed consent. There is documentation of substituted judgment if the member 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 member, and potential benefits to the member.

Discharge Planning and Documentation

1. Components of discharge planning incorporate the member's identified concerns, including but not limited to, housing, finances, healthcare, transportation, and familial, occupational, educational, and social supports.

2. The treatment team staff member who is responsible for implementing a member's discharge plan documents in the medical record all of the discharge-related activities that have occurred while the member is in the facility. This documentation reflects member participation in its development.
3. The completed discharge form, including referral to any agency, is available to and given to the member, and when appropriate, the member's family or guardian at the time of discharge, which includes, but is not limited to, appointments, medication information, and emergency/crises information.
4. At least one initial aftercare appointment is scheduled not more than seven days from the member's discharge from the facility, which is clearly documented in the member's medical record.
5. For those member's discharged on medications, at least one psychiatric medication monitoring appointment is scheduled no more than 14 days after discharge.

Performance Specifications

Other Services
Psychiatric Consultation on an Inpatient Medical Unit

Providers contracted for this level of care or service are expected to comply with all 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.

Psychiatric Consultation on an Inpatient Medical Unit is the subspecialty of psychiatry concerned with the provision of consultation to medically ill members who are hospitalized on inpatient medical units. This service does not apply to members presenting to emergency departments (EDs). The goals of this service are: 1) to ensure the safety and stability of members within the medical environment; 2) to collect sufficient history and medical data from appropriate sources to assess the member and formulate the problem; 3) to conduct a mental status examination; 4) to establish a differential diagnosis; and 5) to initiate a treatment plan.

Whenever possible, the consultant is a liaison psychiatrist working as part of a ward-based multi-disciplinary team who is familiar with the routines of the medical/surgical environment. The use of outside consultants, unknown to hospital physicians and unfamiliar with the particular hospital system, is discouraged.

Components of Service

1. The provider complies with the staffing requirements of the applicable licensing body, the staffing requirements in the Carelon service-specific performance specifications and the credentialing criteria.
2. Psychiatric consultation for members in the general medical setting is available 24 hours per day, seven days per week, and 365 days per year.
3. Psychiatric consultation is provided by any of the following who have appropriate credentials and privileges at the facility:
    a. Psychiatrist or child psychiatrist who is board-certified and/or who meets Carelon's credentialing criteria for a psychiatrist or child psychiatrist;
    b. A clinical psychologist;
    c. A child-trained Psychiatric Nurse Mental Health Clinical Specialist (PNMHCS) who is board-certified; or
    d. A Nurse Practitioner/Board-Certified Registered Nurse Clinical Specialist (RNCS).
4. The consultant has specialized training and/or experience in the evaluation of the mental health of members with serious medical illness, formulation of their problems and diagnosis, and organization and implementation of an effective treatment plan.
5. The consultant is able to evaluate a member with a suspected psychiatric disorder, a psychiatric history, or use of psychotropic medications in order to determine the effect the psychiatric condition has on the medical/surgical condition. The consultant is able to assess the extent that the member's psychiatric condition is caused by the medical/surgical illness.
6. The consultant has experience in the evaluation of the medical and psychiatric reasons for acute agitation. The evaluation carefully reviews the medical and psychiatric reasons for agitation (e.g., psychosis, intoxication, withdrawal, dementia, delirium) and delineates possible etiologies (e.g., toxic metabolic disturbances, cardiopulmonary, endocrine, neurologic disorders).

7. The consultant has experience in the evaluation of a member who wishes to die, including one who requests hastened-death, physician-assisted suicide, or euthanasia.
8. The consultant has experience in the evaluation of competency to consent to medical or surgical treatment.
9. If the consultation is requested to assess the adequacy of pain management, the consultant is familiar with:
    a. Types of pain (acute, chronic, recurrent, and cancer-related).
    b. The distinction between pain, nociception, suffering, and pain behaviors.
    c. The multidimensional nature of pain.
    d. Pain measurement and assessment.
    e. Pain management (therapeutic goals, pharmacological and non-pharmacological strategies, multidisciplinary and multimodal management, monitoring of strategies and side effects).
    f. The impact of pain and unrelieved pain (on recovery from illness or surgery, on the individual, on the family).
10. If the consultation is requested to assess the extent that the psychiatric disturbance is related to a substance use disorder, the consultant has clinical skills in addiction medicine or addiction psychiatry.
11. If the consultation is requested for a child or adolescent, the consultant is trained in child and adolescent psychiatry and is familiar with the developmental and family issues as they apply to diagnosis and intervention. In addition, the consultant has an in-depth understanding of medical illness as well as a general knowledge of procedures, medications, hospital routines, and outcomes for children and adolescent members.

Service, Community, and Collateral Linkages

1. Consultations are usually requested by physicians who are directly responsible for the care of the member. The so-called “routine consultation” may have life-and-death implications for the member because the overt cause of the referral may reflect a more serious problem. For example, the member who appears withdrawn may be suicidal, or an uncooperative member with mild agitation may be delirious. The consultant ensures direct contact with the individual who initiated the request in order to obtain accurate information about the member’s behavior, which may not appear in the member’s health record.
2. The consultant is familiar with how to access other professionals when additional expertise is required. Such expertise includes, but is not limited to, neurology, pain, substance use, neuropsychology, and physical medicine and rehabilitation. This expertise may be provided by practitioners from a variety of disciplines (e.g., psychology, social work, occupational therapy, physical therapy, speech and language, special education, vocational rehabilitation, pastoral counseling, etc.).
3. The consultant is familiar with medical necessity criteria for admission to inpatient psychiatric levels of care and is able to determine that a member is medically stable for admission.
4. The consultant is familiar with Carelon policies and procedures to secure outpatient follow-up care for all members.

Quality Management (QM)

1. The facility and/or program will develop and maintain a quality management plan that is consistent and that utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is used, and will include outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to members, including youth and their families.

3. Clinical outcomes data must be made available upon request, and must be consistent with performance standards of this service.
4. 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.
5. The facility and/or program will adhere to all reporting requirements of DPH and/or DMH regarding Serious Incidents and all related matters.

Process Specifications

Assessment, Treatment Planning, and Documentation

1. All psychiatric consultations on a medical/surgical unit are provided and documented in a progress note in the member's health record as soon as possible and no later than within 24 hours of the consultation. Although the comprehensive consultation requires attention to all domains, the consultation note is best if brief and focused on the referring physician's concerns. The consultant avoids the use of acronyms, psychiatric jargon, or other wording likely to be unfamiliar or confusing to other medical/surgical specialists. The structured consultation note provides a framework for providing information back to the referring physician. The note is titled with mention of "Psychiatry" and "Consultation" or equivalent terms.