Overnight Program

Program Description

Team Wellness Center offers 24 Hour Community Mental Health (CMH) Services as a part of our model of holistic care. The 24 Hour CMH program uses a clinically-based approach to provide treatment to people with mental illness and substance use disorders while addressing the social determinants that adversely affect their recovery. The goal of the 24-Hour program is to improve the mental, physical, emotional and economic well-being of participants by providing access to treatment services around the clock.

Program Philosophy

Team Wellness Center is dedicated to enhancing the well-being of individuals by providing an array of comprehensive behavioral and physical services in an environment that promotes quality of life, continuous improvement, and social awareness.

Program Goals

- Provide 24-hour overnight services to persons experiencing homelessness coupled with co-occurring disorders which increases the risk of crimes, crisis episodes and vagrancy.
- Initiate integration of services to further stabilize the person's condition and prepare him/her for transfer to an alternative level of care.

Specific Services Offered

Services offered included: Mental Health Treatment; Substance Use Treatment; Individual and Group Therapy; Peer Mentorship; Employment, Skill Building & Pre-Vocational Training; Adult Education / G.E.D. Classes; Dental Care; Primary Care Services; Housing Assistance; and Food & Accommodations (as available).

Components of the disease management program include:

- Population Identification: The above conditions and health behaviors are assessed during the intake process and flagged in the member's chart.
- Evidence-Based Practice Guidelines: The physicians, RN's, and member treatment teams are critical to educating members on an ongoing basis about how to better manage their conditions. TWC staff are educated on practice guidelines and utilize the "Paths to Improved Outcomes" manual to ensure Evidence-Based Care is provided to members with the targeted chronic conditions.
- Collaboration: The Paths to Improved Outcomes employ a collaborative and interdisciplinary approach to care, including care coordination with outside agencies.
- Self-Management Education: TWC recognizes that individuals who are better educated about how to manage and control their condition receive better care.
- Outcomes Measurement: The Chronic Conditions are monitored on a regular basis to ensure disease management interventions and approaches are effective.

Population Served

TWC serves persons at least 18 years of age, homeless with mental health and/or substance abuse issues.

Eligibility/Admissions Criteria

Member must be actively homeless with a mental health, substance abuse and/or developmental disability. Members may be referred from hospital ER departments, independent physicians, TWC clinics/sites, other entities throughout the community and the mental health authority.

All members receiving services from TWC for behavioral health issues will be considered members of the Health Home. TWC receives referrals in a variety of ways, including MCPN referral, hospital referral, or self-referral. Members that decline to participate in the Health Home will be required to sign-off on the declination, and this will be noted in the member's chart. Members can decide to enroll in the Health Home at any time following the declination.

Eligibility and admission to TWC's Outpatient Services is determined by the following:

- Member is identified as eligible to be defaulted into a contracted MCPN by DWMHA's Central Access Department
- Member is identified as being a part of a contracted payer
- Member is covered under a contracted private insurance
- Referred by MPRI
- Referred by other Rehabilitation Facilities
- Member is deemed medically stable or is under the care of a physician
- Member is psychologically stable enough to participate in individual and/or group therapy (not in need of hospitalization to treat illness)
- Member is able to manage behavior in such a way as not to be of harm to themselves or others
- Member is in need of access to a comprehensive array of mental health or developmental disability services to meet their needs
- A member/family may be referred to Outpatient Services by a hospital, School Social Worker, Primary Care Physician, or the DWIHN
- TWC also accepts self-referrals

Modalities of Treatment

Our treatment modalities are based on Evidence-Based Practices and research in the arena of Mental Health

The most commonly utilized treatment modalities are:

- Cognitive Behavior Therapy
- Brief Solution Focused Therapy
- Group Therapy
- Family Therapy
- Crisis Intervention/Stabilization

- Stages of Change/Motivational Interviewing
- Behavior Modification
- Relapse Prevention
- DBT
- Peer Support Specialists/Recovery Coaches

Primary care services that are provided internally follow best practices in medicine, as defined by the U.S. Preventive Services Task Force (USPSTF). Health Indicators are based on recommendations by the USPSTF and the National Council for Behavioral Health.

Adequate Services

A single entrance will be used for accessing all services. Primary care, behavioral health, and SUD services are provided seamlessly in the clinic. Upon admissions into the program, members will be assigned a Health Home Team. The Health Home Team consists of a therapist, a primary care coordinator, a back-up care coordinator, and a peer support specialist (see Program Description section on Staffing). The Health Home Team is responsible for performing intake and annual assessments with the member, assisting the member in articulating goals, developing a person-centered plan of care, and providing the member with necessary support, assistance, and referrals. Members will also be assigned to a psychiatrist and a primary care provider (unless an external PCP has already been assigned). Care Coordinators ensure coordination between the behavioral, primary care, and specialty providers, regardless of whether a member receives primary care services internally or externally.

Care Coordinators maintain contact with members at least monthly (more if determined by the IPOS). Therapists and peer support specialists maintain contact with the member as determined by the IPOS, typically 1-4 times per month. Members receiving psychiatric medications will receive an initial psychiatric evaluation (as well as annually) and will be scheduled for follow-up with the psychiatrist on a monthly basis for a medication review. Some members may be scheduled more frequently with the psychiatrist if it is determined to be clinically necessary. Primary Care Providers will examine members at least annually (if receiving PCP services internally). Members with chronic health conditions will be monitored by a PCP at least quarterly, or more often if deemed clinically appropriate.

Members are typically discharged from the behavioral health home when they have met all of the goals outlined in their IPOS, or at their own discretion. TWC care coordinators will ensure a smooth transition into subsequent programming, primary care services, or follow-up care upon discharge.

Comprehensive Care Management

I. Communicating with other primary and specialty care providers: TWC asks all members to complete provide authorization/ROI to communicate with other providers. The care coordinators are responsible for ensuring that all communication between providers occurs and is documented. Types of

information shared will include physical health assessments, medication updates and change, lab results, hospitalization status, and data related to current HEDIS measures. This information will be shared for both members who have a TWC PCP and members who do not.

II. Integrated IPOS: Following a psycho-social assessment, case management assessment, health assessment (and H&P if receiving primary care at TWC), and psychiatric evaluation, the care coordinator will assist members with constructing an IPOS, which outlines interdisciplinary member needs and goals. Interdisciplinary interventions will be included, which will assist member in meeting their goals.

III. Composition of Health Home Team:
   a. Member
   b. Therapist (LMSW, LLMSW, LLPC, or LPC)
   c. 2 care coordinators (LLBSW or LBSW) – 1 will be assigned as "primary"
   d. Peer Support Staff
   e. RN
   f. Psychiatric Provider (psychiatrist or NP)
   g. Primary Care Provider (optional)

Referral Source

Persons are referred to the Overnight program by TWC Case Holders, Therapist, Psychiatrist, Primary Care Physicians, Hospitals, Law Enforcement, self-referral and/or other CMH agencies,

Setting

TWC overnight program is provided in space that is dedicated for overnight accommodations with separation between genders. Participants with have access to clean bedding, laundry facilities, food and leisure activity; in close proximity to linkage with outpatient/health home services.

Staffing

Only a credentialed, qualified Mental Health Professional will provide treatment to children/families. Staff will be employed based on the following minimum criteria:

- Case Managers: Bachelor's Degree in Human Services related field (Licensure must be obtained LLBSW, LBSW, SST)
- Clinical Therapist: Licensed or Limited Licensed Master's Degree in Social Work, LLP, LLPC, MFT
- Nurse: Associate's Degree in Nursing (RN)
- Psychiatrist: MD, DO, or FNP and licensed to provide psychiatric services in the state of Michigan
- Peer Support: Certified Peer Support Specialists
- Primary Care Provider: MD, DO, PA, or FNP licensed to practice in the state of Michigan.

Documentation

The following documents are general in nature and are in no way inclusive of all documents which may be located/required in an individual's Medical Record:

- Intake Paperwork

- Psychiatric Evaluation, Psychosocial Assessment, Nursing, and Case Management Assessments
- History and Physical
- Lethality Assessment
- IPOS
- Individual Progress Notes from each discipline
- Authorization to Release/Request Information
- Crisis Plan
- Medication consent
- Notice of Hearing Rights

Hours of Operation/Frequency

TWC's Overnight program provides Clinical Therapy, Case Management, Primary Care, Peer Support and other supportive services 7-days per-week, 8 p.m. - 8 a.m. Toll free number for all locations: (888) 813-8326

Location

Team East
3646 Mt. Elliott
Detroit, Michigan
(313) 331-3435

Transition/Discharge Criteria

A member may be discharged from Outpatient Services for the following reasons:

- The member/guardian requests to be discharged
- Member has met all goals as written in the IPOS and new functional goals cannot be established. Member is able to function on his/her own, is community integrated and has established independence
- Member is not making additional functional gains or there has been a persistent regression in performance, which has a negative impact on the member's ability to meet goals established. Discharge will be administered due to lack of progress and inability to successfully complete individual member goals. A referral to a more appropriate TWC program or a program within the community will be made.
- Member has behavioral challenges that make treatment in their current level of care unsafe or ineffective. A referral to a more appropriate TWC program or a program within the community will be made.
- Member fails to comply with rules of the program
- Member fails to respond to contact attempts (see discharge policy)

Payer/Funding Source

Funding is provided by Detroit Wayne Mental Health Authority (DWMHA), Michigan Department of Health and Human Services (MDHHS), and private insurances.

Fees

Fee For Service

Additional Information

All services provided by TWC abide by Person Centered Planning guidelines (see Person Centered Planning Policy)
All services provided by TWC abide by rules and regulations established for member rights (see Recipient Rights policy)
All members age 21 or under with Medicaid insurance shall be notified of the availability of EPSDT services and shall link the member and his or her family members to these services, when appropriate
TWC will maintain an up to date Resource Manual that can be conveniently accessed and used by TWC staff
All eligible members shall be offered case management, as well as an informed choice of case managers

Outpatient services are provided to individuals enrolled in contracted payers or are private pay.