The Opportunity Alliance (TOA) Behavioral Health Home

About Our Resilience-Based Approach to Wellness

We help people who struggle with mental health to achieve their health and wellness goals. **We use a model of care called a Behavioral Health Home** that supports you in the community in achieving your goals and aspirations for wellbeing.

You are in charge of your care. Your treatment and the services you receive are specific to the goals that you develop and meet your individualized needs. You direct the treatment and the services you receive. Our team is here to support and guide you.

Recovery is ever-changing and looks different for everyone. Recovery is defined by the person seeking it.

Recovery Is Possible!

People can and do move forward in life even when experiencing challenges and struggles. In the BHH, **you are not defined by your illnesses, struggles, or traumas, but are respected as an individual**. We value your resilience, and honor the belief that anyone has the ability to create a fulfilling life by exploring their hopes and dreams and taking the steps to move toward them.

How We Will Help You Achieve Your Goals

- Care coordination: Supports clients through advocacy, connection to community resources, coordination of mental health and physical health appointments, and support during an appointment.
- Peer navigation and support: a team member identifying as having their own lived experience with a mental health struggle works one-on-one with people to make connections in the community, form relationships, set goals, advocate to providers, and teach people how to advocate for themselves.

- Wellness programming
- Health education
- Medication review
- Emotional support
- Connection to other services

You are the most important person on your care team.

How You Lead Your Care Team

You will work with your Care Coordinator to identify your goals and to develop a treatment plan (called an ISP) that help you work towards your health, wellness, and quality of life goals. Your ISP is reviewed at least every 90 days, but you can request to update your plan at any time. The only goal you are required to have in your plan is an Emotional/Mental Health goal.

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Your Care Team:

• **Care Coordinators** support you through advocacy, by connecting you resources in the community, by helping coordinate mental health and physical health appointments, and by providing support during an appointment. The Care Coordinator can meet you at your home, at providers' offices, at TOA locations, and in some community settings. Care Coordination looks different depending on plan of care you create.

• The **BHH Peer Health Navigator** is a member of the BHH Team who outwardly identifies as own lived experience with a mental health struggle. Peer Health Navigators can work with you one-on-one to make connections in the community, identify things that may be helpful for your in your recovery, and have conversations to help identify hopes, dreams and goals. Peer Health Navigators can help you advocate for yourself with your providers. Peer Health Navigators also offer Peer Wellness Programming, which includes monthly groups and workshops.

• The **Nurse Care Manager** supports your team with their physical health expertise. They can provide support and information about any physical health challenges you experience. The Nurse Care Manager can also help advocate with your medical providers, when necessary. The Nurse Care Manager will attend your Case Presentation. The Nurse Care Manager cannot treat you or write prescriptions.

• The **Psychiatric Consultant** supports your team with their psychiatric health expertise. They are available to educate team members on specific treatment options and medications and is available at the Case Presentation. Upon request through your Care Coordinator, they also can review your medication and treatment to make suggestions for improving care.

• The **Primary Care Consultant** supports your team by providing information and suggestions regarding your physical health care needs. The Primary Care Consultant is available at the Case Presentation, and to your Care Coordinator upon request.

Requesting a Care Coordinator

You will be assigned a Care Coordinator based on their current case load. Generally, you cannot request a specific Care Coordinator.

Care Coordination for Families

Each family member who needs care coordination services will receive their own Care Coordinator. This enables you to focus on your goals and needs. Your care coordinator can collaborate with those of your family when necessary and requested.

Services We Can Connect You To Outside of the BHH:

- Counseling & other mental health services
- Housing
- Medical care
- Other community and social services

Learn more:
https://www.opportunityalliance.org

the Opportunity Alliance