Background

The Lazarus Collaborative is a network of providers focused on assisting clients in moving into recovery, gaining resilience, and successfully integrating into the community. The collaborative provides the individual with primary care, medication management, medication-assisted treatment (MAT), mental health treatment, employment and housing services, behavioral health and addiction treatment, peer support, care coordination, and case management. Collaborative Care Coordinators (CCCs) from True North Recovery will help each individual identify needed services and find the care and resources they need.

CCCs are the "connectors" for a behavioral health system in which many people "fall through the cracks" when they transition between services or seek multiple services at the same time. A key role of the CCC is helping the participant identify what services are available and may be helpful.

Often participants are unsure of what help they may need or what services are available, thus the CCC's help identify available resources and describe processes for clients. CCCs help participants with:

- Finding affordable housing or shelter
- Getting food
- Getting an identification card
- Transportation to attend an appointment or meet basic life needs
- Filling out paperwork to get into behavioral health services
- Getting medical tests (i.e., TB test and Urine Analysis) for eligibility for residential services
- Advocating for the participant to get into treatment
- Attending appointments with the participant

The Lazarus Collaborative providers listed in the box above meet monthly for a multi-disciplinary team (MDT) meeting to discuss how the collaborative is functioning and cases that would benefit from a group discussion. Prior to the meeting, True North Recovery (TNR) sends out a signed Release of Informations (ROIs) to each provider for the participants who will be discussed.

The collaborative is being facilitated by Kathleen Matthews, DNP, APRN and evaluated by Melissa Toffolon, PhD, MPH from Actionable Data Consulting (ADC). This project is funded by Recover Alaska and the State of Alaska, Department of Health and Social Services, Division of Behavioral Health.

Service Data (October 2021 – March 2022)

The Lazarus Collaborative has had 25 participants since beginning service provision in October 2021 and currently are serving 12 individuals and remain on call for seven individuals who have "landed" in a treatment program. There are five inactive participants who have moved out of state or decided not to participate in services and one individual was lost to follow-up. The time from referral to CCC contact is often same or next day (68%) or between 2-4 days (12%). Eight percent of participants saw a CCC between 5-10 days after referral and 12% of participants had an extended period before they met with a CCC (>20 days).

Table 1. Lazarus Collaborative Service Data

DEMOGRAPHICS	NUMBER	PERCENT
STATUS*		
ACTIVE	12	48
ACTIVE-LANDED	7	28
INACTIVE	5	20
UNKNOWN	1	4
TOTAL	25	100
TIME FROM REFERRAL TO CCC CONTACT		
SAME OR NEXT DAY	17	68
2-4 DAYS	3	12
5-10 DAYS	2	8
11-19 DAYS	0	0
20-30 DAYS	2	8
>30 DAYS	1	4
MONTH SERVICE BEGAN		
OCTOBER	1	
NOVEMBER	2	
DECEMBER	7	
JANUARY	8	
FEBRUARY	3	
MARCH	4	

*Active- still receiving services; Active-landed – currently in treatment services and CCCs will continue to support; Inactive – moved out of state or stopped participating; Unknown – lost to follow-up

The participants were almost evenly representative of both genders (male 48%; female 52%). The majority were heterosexual (76%) while the rest were homosexual (4%), bisexual (12%) or asexual (4%). Most were White (64%) while 24% were Alaska Native/American Indian people. Fifty-two percent of participants were between 25-44 years of age while 12% where young adults (18-24 years) and 28% were 45 years or older. There were two participants who were veterans or in the National Guard. Most participants had Medicaid (92%).

Table 2. Lazarus Collaborative Participant Demographic Data

DEMOGRAPHICS	NUMBER	PERCENT
GENDER		
MALE	12	48
FEMALE	13	52
SEXUAL ORIENTATION		
HETEROSEXUAL	20	80
HOMOSEXUAL	1	4
BISEXUAL	3	12
ASEXUAL	1	4
RACE		
ALASKA NATIVE/AMERICAN INDIAN (ANY MENTION)	6	24
WHITE	16	64
UNKNOWN	3	12
AGE		
18-24 YEARS	3	12
25-34 YEARS	7	28
35-44 YEARS	7	28
45-54 YEARS	6	24
55-64 YEARS	1	4
75 YEARS OR OLDER	1	4
VETERAN/NATIONAL GUARD	2	
INSURANCE		
MEDICAID	23	92
UNKNOWN	2	8

MDT meetings have been held monthly from January thru March with attendance ranging from 9-14 attendees (not including ADC staff). At each meeting a discussion is held to address any internal challenges the collaborative is having, new participants are presented to the group and cases that were discussed in the past, if needed, are revisited. Discussion between providers and the CCCs on patient care included the following themes:

- Discussion with providers on how to get patients appointments (the procedures at a clinic).
- Medication management providers sharing about characteristics of medications that participants are taking.
- CCCs informing providers about referrals.
- Medication management provider suggesting a 1x per month injectable for a participant who is having difficulty taking medication consistently and informing CCC that getting a state guardian may be helpful for this person in the future.

- Providers sharing on care they provided for Lazarus Collaborative participants.
- Providers teaching on mental health conditions.
- Providers informing CCCs and other providers about delays in providing services in their organizations.
- The CCC informing the medication management provider when a participant is unreachable. This is relevant because the participant was on medication that shouldn't be stopped suddenly.
- Providers asking about a patient that has been unreachable who is in a True North residential treatment program.
- MAT provider informing CCC about a participant who is participating in ambulatory detox.
- Provider discussing referrals they sent over to the CCC.

There are also often "housekeeping tasks" for the collaborative, such as discussing a new brochure, educating a new representative from an organization, making sure everyone received the ROIs, and the CCCs understanding how to refer a patient to a participating organization.

Challenges

- CCCs stated that accessing primary care has been difficult and at one of the larger organizations all staff were not fully aware of the project and the process to get a participant seen was complicated. CCCs reached out to these providers to discuss these difficulties. It was noted by the team that in the "real world" without the collaborative they would just avoid using these providers rather than try to figure out a way to work with them to benefit the patients.
- Early on there was difficulty getting the signed ROIs for the cases to be discussed to the providers who would be attending the MDT meetings. This procedure was reviewed and resolved by the CCC supervisor.
- CCC's identified the following major challenges they have when trying to help participants:
    - Finding affordable housing and shelter.
    - Getting permission from probation to get a participant a bed in residential treatment.
    - Participants not adhering to their mental health medication and not being stable enough to engage successfully in a treatment program.

Success Stories

1) A CCC stated, "*So I mean, there's a lot of wins, right? Like many [of our participants] they've actively landed in treatment. All of those are wins. We had a client who was a part of the Lazarus Collaborative and got her assessment……She had started MAT through the Lazarus Collaborative and got into residential and then decided, "Hey, I don't want to continue MAT." Through the collaborative we were able to connect her back to Mat-Su Health Services to get a Bridge device. And we were all able to discuss whether* she could *stay in residential treatment with a Bridge on…… And so, she gets her Bridge off tomorrow and she is successfully engaging in residential [treatment]."*

2) A young adult participant was heading on a plane to residential treatment and when they got off the plane, they had a mental health crisis episode and the residential program declined to accept them and took them to the emergency room. The hospital would not allow them to wait in the waiting room due to COVID-19 precautions and the young adult was walking out on the street in minus 30-degree weather. They called their CCC in Mat-Su who called a True North Recovery staff in the area, and the staff member searched for 40 minutes to find the participant and take them to a warm hotel and work with them to secure a mental health acute care inpatient bed for the next day. This intervention may have saved this person's life. The CCC support continued to follow this person when they were discharged from the acute care setting, help them secure transportation to return to Mat-Su, and maintain stability with medication management as they await another residential placement.
3) A CCC stated that she had been working with a participant who had legal requirements holding them back, but they wanted to get treatment. The participant had no phone, no place to stay, and no transportation. The CCC and the participant met with the participant's provider and applied for residential treatment and figured out how to get a phone. The participant was determined and kept showing up for appointments and they are going to get into treatment shortly if the legal situation will allow it. The CCC stated *"And I think the rapport [between the CCC and the participant] helped with that tremendously. Not having that rapport with them - they wouldn't have shown up. They wouldn't have wanted to be a part of this, they wouldn't have felt supported. They wouldn't have felt like they had someone walking next to them through this. So, I think that that's huge*."

Lazarus Collaborative Member Reflections

1) A CCC stated that what is working well is helping participants in the beginning of their journey: "*I think that when someone is experiencing co-occurring or substance use issues, it can often feel very overwhelming. Like where do I start? How do I get those services? I'm ashamed. I don't feel like anyone's going to help me. I feel like being able to sit down and talk to somebody and [for them to understand]- Hey, this is step one. And then this is step two. And what are your needs? And just for someone to come in and ask for help, and then someone to be there to say "Absolutely, I can help you with this." And to hear their overall concerns and be able to break things down into a step by step [process]. Like, "This is what we do. We start with assessment." or "We start with referral" or, "I'm going to help you attend your appointments." I think that's really beneficial. And I think that it really takes away that overwhelming feeling for that person."*

2) *True North staff stated that, "I would say at least half of them [participants] if it weren't for Lazarus would still be out there. We have had some that were released from DOC who had nowhere to go, they had nothing - not even an ID. They knew enough that there was a 982-HOPE number - they called that number and were able to learn about Lazarus and all the services that are provided. We have same day services and there's someone there for them that day. I think half of them wouldn't have engaged in community services or worked towards addressing their co-occurring or SUD concerns if it weren't for the Lazarus Collaborative.Some of them would've been just fine, you know, they needed an assessment, they could have done it on their own. Maybe not as quickly, but they could have done it. I think it's been really impactful for a majority of them*." Another CCC added "*I agree. I think that some of these individuals may have found those services eventually.*

But the less support these people have in crisis, the less likely they're to follow through with any of the things. And so having someone help you with that and navigate through that makes a huge difference."

3) Lazarus collaborative staff were invited to a Mat-Su Public Assistance staff meeting to help understand how the two programs could work together. Staff stated, *"It was a really encouraging meeting. They're very interested in collaborating on folks that they work with and vice versa. It was really cool. There was a lot of encouragement." The staff member went on to say that they anticipate receiving referrals from Public Assistance staff."*

4) A provider in the Collaborative stated at the March MDT meeting, "*You have individually in this group changed the way I'm able to do my job. I can sit in a room, and I can tell people what to do all day long, but if I cannot connect them to every single person in this room, I'm selling them a short bill of sales…… So, the truth is that what we're doing is changing lives on a much greater level than I think we even give ourselves credit for because at the end of the day, every single person that we're talking about- we give them hope. And sometimes at the end of the day, that's the only thing you're holding on to. So, I'm going to say that I can't do my job without you. I'm grateful for everyone sitting in this room. And you're the reason why we get up and come to work every day."*