

# THE LAZARUS COLLABORATIVE PILOT PROJECT EVALUATION REPORT

Prepared for  
RECOVER ALASKA

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Actionable Data Consulting

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# The Lazarus Collaborative Pilot Project Evaluation Report

## Executive Summary

### Introduction

Recover Alaska is a statewide organization working at the “system level” with a mission to reduce excessive alcohol use and related harms across Alaska. The organization envisions a state where Alaskans live free from the consequences of alcohol misuse and are empowered to achieve their full potential. Recover Alaska employs a cross-sector approach to achieve this mission working alongside partners in healthcare, behavioral health, public health, public safety, housing, education, and other sectors.

One area Recover Alaska has focused on is ensuring access to care for those seeking treatment and recovery support. For an individual to seek treatment it is crucial for them to not be in crisis and feel engaged and empowered. Once the individual is stabilized and out of crisis, they can take advantage of withdrawal management and behavioral health treatment options. It is often that the crisis causes a window of opportunity to open in the mind of the individual to want to change their circumstances and seek support and treatment. The Lazarus Collaborative is focused on assisting individuals to resolve their crisis, take advantage of that window of opportunity, and make a smooth transition into the appropriate treatment services. To resolve the crisis, it is necessary to have integrative care through coordination among different providers and organizations to care for the whole person.

To create a integrative care pilot project, Recover Alaska joined forces with True North Recovery (TNR) to assist with the startup of the Lazarus Collaborative (LC). They provided funding for a facilitator team composed of a public health professional and a psychiatric nurse practitioner to assist with the creation of the collaborative and evaluate the first year of the initiative. The goal of the evaluation is to not only measure the impact of the program, but to gather information that will assist with the replication of this project in communities across the state to further access to care for all Alaskans.

The data collected for this report came from utilization data from TNR, as well as a pre- and post-survey conducted with members of the collaborative. Evaluation reports were created at three, six and nine months and the results were shared Recover Alaska and Collaborative members.

### True North Recovery

The fiscal agent for the Lazarus Collaborative is TNR, a drug and alcohol treatment center located in Wasilla, Alaska. The organization provides client centered, culturally competent behavioral health treatment with same day access to services. TNR services include walk-in integrated assessments, outpatient and intensive outpatient treatment, intensive case management and needs assessments, wrap around care coordination, peer support and recovery support services, residential substance use disorder treatment, and sober living for both men and women. Additionally, the organization is opening a building called the *Day One Center* that will house crisis services including a mobile crisis team, an 8-bed withdrawal management program, and a community crisis center day program based on the “living room model.” The program, called the Launch Pad, will provide peer-support, and is designed to be a place where people experiencing behavioral health crisis can be supported in a calm and safe environment. TNR employs the collaborative care coordinators (CCCs) for the Lazarus Collaborative.

## The Lazarus Collaborative Pilot Project Evaluation Report

### The Lazarus Collaborative

The LC is staffed by a manager and community care coordinators who support individuals in crisis. A Collaborative of providers and organizations that provide services necessary to resolve crises and promote optimal behavioral health agree to accept LC patients within a specific time frame and attend a monthly Multidisciplinary Team Meeting (MDT) to discuss their cases. All providers have their patients/clients sign a shared Release of Information to ensure there can be communication between LC members. The purpose of the Lazarus Collaborative (the Collaborative) Pilot Project is to:

1. Assist individuals in crisis resolution and ensure that their basic needs are met by connecting them with a collaborative network of providers who can address their needs.
2. Help the client access behavioral health treatment services by removing barriers and promoting integrated care through the collaborative.
3. Decrease the amount of time it takes for clients to resolve their crisis and initiate care in order to take advantage of a window of opportunity that exists during a crisis.

The project is open to residents in the core area of Mat-Su through Big Lake and Sutton. Collaborative Care Coordinators (CCCs) from TNR use a case management needs assessment to help individuals identify needed services and find the care and resources they need. The CCC helps the client identify short-term goals, a target completion date, required contacts, and the responsible party for goal achievement. There are at least 24 types of services and resources that the CCCs help their clients to access that fall into three main categories: primary care, behavioral health, and basic needs.

For most clients (81%), CCC contact occurs on the same or the following day. An additional 10% are contacted successfully within 2 to 5 days. CCCs try to contact the client immediately to take advantage of the potential "window of opportunity" that opens to get someone into treatment.



### The founding **Lazarus Collaborative Partners** are:

1. Frontier Family Medicine
2. Jennifer Byers ANP, PMHNP
3. Mat-Su Health Services
4. MyHouse
5. Sunshine Community Health Center
6. Southcentral Foundation Detox Program
7. True North Recovery

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#### What has been helpful about the LC for your patients?

*“Getting clients connected quickly to all the providers in the collaborative. Detox admission was an area that has always been a lengthy wait and through this collaborative we were able to shift that. After gaining a letter of acceptance into treatment, clients were able to admit into a detox program very quickly.” – LC Member*

*“The ability to discuss strategy and to utilize partner staff to connect and disconnect with clients who are struggling, having wrap around support for both staff and clients and a deeper knowledge of service arrays for all those involved.” – LC Member*

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## The Lazarus Collaborative Pilot Project Evaluation Report

### Client Demographics and Referrals

The Lazarus Collaborative has had fifty-two participants since October 2021. Twenty inactive participants have discontinued their involvement with the program after receiving services for varying lengths of time and twenty-four individuals have “graduated.” Graduated is defined as an improvement in the quality of life and circumstances that no longer require the assistance from a CCC to live a stable, sober life. This can include attending an inpatient treatment program.

Referrals for the CCCs mainly come from self-referral from the True North helpline and walk-in referrals (36). Other referral sources were Myhouse (6) and the local hospital (5). AN For most clients (81%), CCC contact occurs on the same or the following day. An additional 10 percent were contacted successfully within 2 to 5 days. CCCs try to contact the client immediately to take advantage of the potential "window of opportunity" that opens to get someone into treatment that exists when a person is in crisis and seeking help.

### Outcomes

Graduated Clients: 24 individuals  
 For graduated clients CCC services totaled 356 hours and cost \$28,722. The hours that graduated clients worked with CCCs ranged from 2.8 to 72 hours, with an average time of 14.2 hours and an average cost of \$1,145 per client. When comparing the different categories of graduated clients, those who were admitted to residential treatment received, on average, over twice the number of CCC hours as compared to those who were stable and/or in outpatient treatment.

Graduates fell into three categories:

1. Stable and in a residential treatment program (13)
2. Stable and not in services (8)
3. Stable and in outpatient treatment (5)

91% were housed.

83% had primary care.

75% were involved in the recovery community.

83% were working on relationships with family and friends.

66% had graduated residential treatment.

**Table 1. Hours and Cost of CCC Support for Graduated Clients**

<i>Status of Graduated Clients</i>	<b>Average CCC hours</b>	<b>Average cost of CCC services</b>	<b>No. of clients in this status category</b>
<i>In Residential Treatment</i>	21.8	\$1,759	13
<i>Outpatient Treatment</i>	8.5	\$686	5
<i>Living with Stability</i>	6.5	\$524	8
<i>Total</i>	14.2	\$1,145	25

Note: Medicaid State Plan reimbursement for crisis intervention services is \$20.17 per 15 min.

## The Lazarus Collaborative Pilot Project Evaluation Report

### Active Clients: 8 individuals

As of June 30, 2022, eight active clients were receiving LC services. These clients each received a needs assessment and integrated behavioral health assessment. Based on the needs assessment, attainable goals were set to move towards receiving the care, treatment, and support they need to improve the quality of their lives.



The average number of goals that were actively worked on before inactive clients left the program was 4.1. The three most addressed goals were:

1. Securing safe housing
2. Having an integrated assessment
3. Admission to residential treatment

### Inactive Clients: 20 individuals

In the program's first nine months, 20 clients stopped receiving Lazarus Collaborative services (inactive clients). Inactive clients received a total of 188.25 hours of CCC services totaling \$15,188. The number of hours CCCs worked with inactive clients ranged from 2 to 32.75, with an average of 9.4 hours and a cost of \$758 per client. The clients were either unreachable, left treatment against medical advice, or moved out of Mat-Su.

### Lazarus Collaborative Partners and Monthly Multi-Disciplinary Team Meeting

After nine months, the LC continues to operate with participation from six of the seven founding members. One member, Sunshine Community Health Center, withdrew due to staffing shortages. LC members were surveyed three months into the pilot project and after nine months. At three months, members were asked which aspects of being part of the LC were important to them, and at nine months, they were asked how valuable the same aspects had been. Early in the project, providers stated they enjoyed being part of the LC and seeing the success of their patients. Their answers focused on how useful it was to learn about other resources for their patients, meet other providers, and see their patients getting the care they needed. In the second survey, providers said timely access, coordinated care, and more resource knowledge has been beneficial.

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#### What successes have you seen with your patients/clients from being in the LC?

*"We were able to get patients started on medications to help in a timely fashion since the CCC was available to facilitate transportation and management."*

*"Clients having same day services is absolutely critical to success and getting them engaged with case management."*

*"We have had more clients enter into treatment as a result of the quick response to requests for assessment and treatment."*

*"I have seen people gain sobriety, learn coping skills, graduate treatment, build a foundation of recovery, comply with probation, gain employment, obtain stable housing, and be able to be a reliable family member to their loved ones. This project has had so many amazing success stories. I am so thankful to be a part of it."*

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## The Lazarus Collaborative Pilot Project Evaluation Report

### Challenges

LC members reported the following major challenges related to working together:

- Some patients/clients receiving medical care from different providers that is not coordinated
- Some partners not understanding their role in the collaborative
- Start-up was slow at the beginning of the Collaborative
- Inconsistent attendance at monthly meetings by Collaborative members
- Providers keeping to the time frames for seeing patients/clients stated in the MOU because of circumstances outside of their control
- Managing participants' paperwork
- Some "no-shows" for appointments

Staff changes have been an issue for TNR. Fully staffed, the program at True North would include a 0.5 FTE manager and two full-time CCCs. The manager has been consistently in place; however, at least six different CCCs have cycled through the program. The manager reports that she learned that the CCC position is not an entry level position, but rather requires an advanced set of skills. These skills include:

- Being able to do "Motivational Interviewing"
- Providing trauma-informed care
- Navigating residential treatment admission across the state
- Creating suicide safety plans with clients
- Providing intensive case management
- Having Peer Support training and a certification
- Being able to recognize small daily wins with the client
- Understanding the ASAM levels of care

CCCs stated that the major challenges they face are:

- Occasional difficulty reaching providers
- Securing scarce housing resources for their clients
- Coordinating with all collateral contacts, such as guardians and probation
- In the hospital, many staff are not familiar with the LC and they don't understand the role of the CCC in helping the in-patient or emergency department patient get the follow-up care they need.
- Patients being discharged from the hospital without a safe place to go that encourages recovery.
- It is very time-consuming and cumbersome to submit a Medicaid application.
- An immediate opening in detox or treatment is often unavailable when the client realizes they want to work towards recovery. A CCC stated that he struggles to keep an individual in that "moment of clarity" when the services they need do not have immediate openings.
- It is difficult to find inpatient and residential treatment for a client with complex needs who is challenging to work with because many programs don't understand how to work with clients with very complex mental illness and/or behavioral struggles.
- Finding a place to keep someone safe while waiting to get into residential treatment.

### Financial Sustainability

In FY 2022, the LC received \$150,846 in grant funds for start-up from the Division of Behavioral Health and funding for facilitation and evaluation of the 9-month pilot project from Recover Alaska. Due to the program's success, LC it will continue beyond this pilot period.

The majority of LC clients qualify for Medicaid, and this is the program's primary means of sustainability. CCCs bill for "crisis intervention services" under the State Medicaid Plan (\$20.17/15 minutes), along with billing for an SBIRT assessment. They use the crisis intervention services code because the CCC can work

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with the client in crisis for 22 hours before a treatment plan is developed. This is crucial to stabilize the client before they agree to enter treatment. During the pandemic, the state suspended the requirement to get state authorization when the work required more than 22 hours. Currently, the CCC can continue to work with the client as needed with Medicaid reimbursement. Once the client is stabilized, the CCC transitions the client to a case manager at TNR or another organization.

**Table 2. The Average and Range of Hours Provided by CCC by Client Status**

<i>Status of Clients</i>	<i>Average CCC hours</i>	<i>Range of hours</i>
<i>Graduated Client</i>	14.2	2.8-72
<i>Inactive Clients</i>	9.4	2 - 32.7

Table 5 shows the average number of hours the CCC reported working with clients with different outcomes. While the average number of hours a CCC works with a client who has graduated or becomes inactive is less than 22 hours, there are clients who require substantially more hours. The executive director of TNR stated that if the State reinstates the requirement to request an authorization to work with a client for more than 22 hours prior to getting an assessment, they will start billing the “peer-based crisis service” (\$20.46/15 minutes) through the 1115 waiver which does not have that requirement. He stated that it is quite time consuming to file for an authorization.

The TNR executive director stated that the CCCs have been under-billing for the time they spend with clients due to factors such as they couldn’t write a note because the client is not yet insured, or they were still being trained on how to do documentation for billing. He stated that they are working to bring their billing up to an appropriate level that represents the services they provide. He stated that it is a requirement for billing the crisis intervention services code that the client be in “acute crisis” and the CCCs are constantly evaluating the acuity of the client’s situation until they are stable.

It is necessary that the CCC have funds that they can use to help stabilize the client. For example, they may need to put them up in a hotel room, buy them a hot meal, etc. These expenses are not billable and must be financed through a grant or other flexible funding source.

The Lazarus Collaborative provides a vital service essential for individuals in crisis to navigate through a complicated group of systems (the physical health system, the behavioral health system, and the social welfare system). The cost of the Lazarus Collaborative is minimal compared to the cost of care in these other systems and the cost to the individual of not getting care. The project amplifies the effectiveness of these other systems in improving individuals' quality of life and health. The model is promising and should be able to be replicated in other areas of Alaska to help individuals in crisis to stabilize to be more likely to receive and benefit from behavioral health treatment.

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## The Lazarus Collaborative Pilot Project Evaluation Report

### Introduction

Recover Alaska is a statewide organization working at the “system level” with a mission to reduce excessive alcohol use and related harms across Alaska. The organization envisions a state where Alaskans live free from the consequences of alcohol misuse and are empowered to achieve their full potential. Recover Alaska employs a cross-sector approach to achieve this mission working alongside partners in healthcare, behavioral health, public health, crisis care, public safety, housing, education, and other sectors.

Recover Alaska works to promote access to care for those seeking treatment and recovery support. For an individual to seek treatment it is crucial for them to not be in crisis and feel engaged and empowered. Once the individual is stabilized and out of crisis, they can take advantage of withdrawal management and behavioral health treatment options. During a crisis, a window of opportunity may be present for the individual to want to change their circumstances and seek support and treatment. The Lazarus Collaborative is focused on assisting individuals to resolve their crisis, take advantage of that window of opportunity, and make a smooth transition into appropriate treatment services. To resolve the crisis, it is necessary to have integrated care through coordination among different providers and organizations who are focused on caring for the whole person.

To create an integrated care pilot project, Recover Alaska joined forces in 2021 with True North Recovery (TNR) to assist with the startup of the Lazarus Collaborative (LC). They provided funding for a facilitator team, from Actionable Data Consulting, composed of a public health professional and a psychiatric nurse practitioner to assist with the creation of the collaborative and evaluate the first year of the initiative. The goal of the evaluation is to not only measure the impact of the program, but to gather information that will assist with the replication of this project in communities across the state to further access to care for all Alaskans. In this report, key points for replication of the project will be highlighted.

The data collected for this report came from utilization data from TNR, as well as a pre- and post-survey conducted with members of the collaborative. Evaluation reports were created at three, six and nine months and the results were shared with Recover Alaska and Collaborative members.

#### Key Point for Project Replication

LC staff take advantage of a window of opportunity that presents itself during a crisis to use integrated care through the Collaborative to help an individual get into behavioral health treatment after the crisis is resolved.

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### True North Recovery

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### The Lazarus Collaborative

The LC is staffed by a manager and community care coordinators who support individuals in crisis. A Collaborative of providers and organizations that provide services necessary to resolve crises and promote optimal behavioral health agree to accept LC patients within a specific time frame and attend a monthly Multidisciplinary Team Meeting (MDT) to discuss their cases. The purpose of the Lazarus Collaborative (the Collaborative) Pilot Project is to:

4. Assist individuals in crisis resolution and ensure that their basic needs are met by connecting them with a collaborative network of providers who can address their needs.
5. Help the client access behavioral health treatment services by removing barriers and promoting integrated care through the collaborative.
6. Decrease the amount of time it takes for clients to resolve their crisis and initiate care to take advantage of a window of opportunity that exists during a crisis.

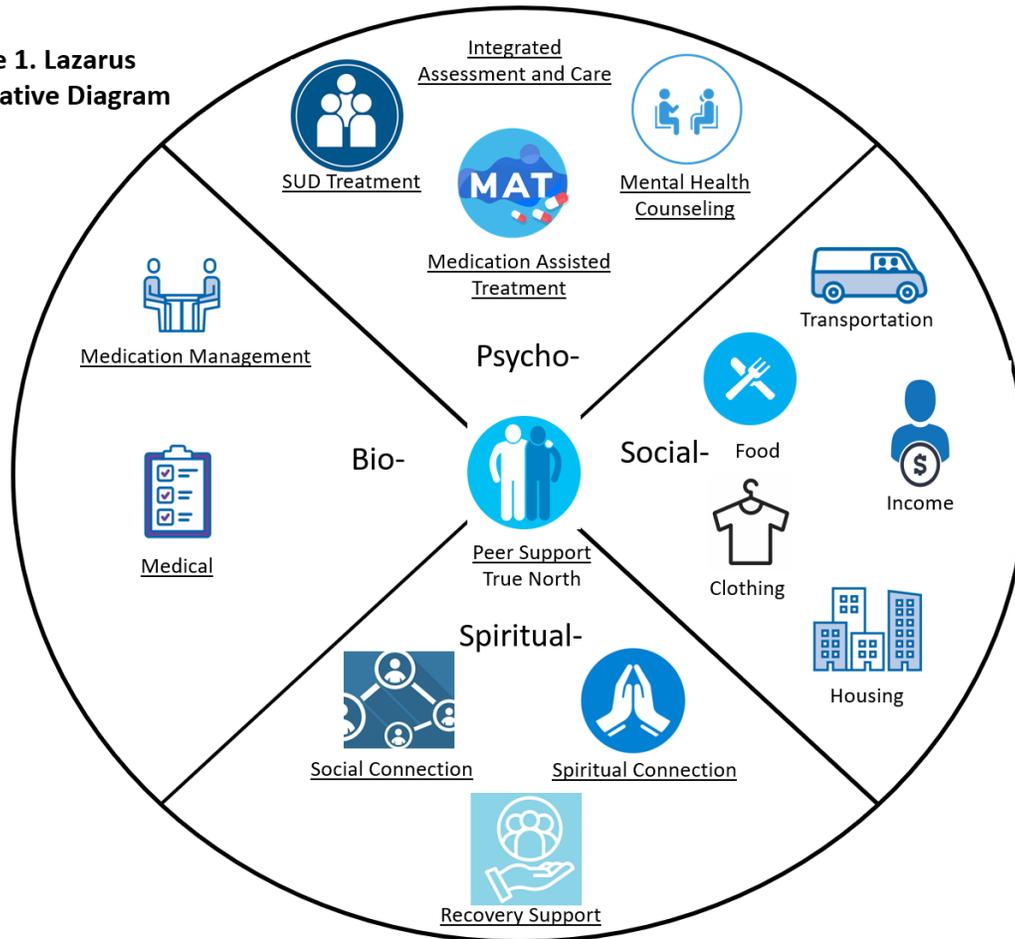
The project is open to residents in the core area of Mat-Su through Big Lake and Sutton. CCCs help individuals identify needed services and find the care and resources they need. There are at least 24 types of services and resources that the CCCs help their clients to access. These fall into four main categories.

1. Basic needs:
  - Medicaid or Public Assistance
  - Housing, food, clothing, employment, and financial assistance
  - Vital statistics documentation
  - Phone
  - Transportation
2. Primary Care:
  - Primary care for chronic and acute conditions
  - Tuberculosis (TB) testing
  - Physical screening for residential admission
  - Hospital care: emergency and inpatient
3. Behavioral Health:
  - Integrated behavioral health assessment
  - Withdrawal management
  - Medicated Assisted Treatment (MAT)
  - Medication management
  - Mental health care
  - Substance Use Disorder (SUD) Treatment
  - Case management
  - Social connection and recovery services
4. Other:
  - Assistance with applications
  - Criminal proceedings and requirements
  - Office of Children's Services compliance

## The Lazarus Collaborative Pilot Project Evaluation Report

The Collaborative recognizes that medical, social, psychological, and emotional/spiritual supports are necessary for long-term recovery. Figure one shows the four dimensions addressed by the Lazarus Collaborative

**Figure 1. Lazarus Collaborative Diagram**



The average client needs assistance with many of these areas and must interact with multiple providers

**Key Point for Project Replication**

The LC is staffed by a manager and community care coordinators who support individuals in crisis. There is a collaborative of providers and organizations that provide services necessary to resolve crises and promote optimal behavioral health. Collaborative members agree to accept LC patients within a specific time frame and attend a monthly Multidisciplinary Team Meeting (MDT) to discuss their cases.

and admission processes. This would be a daunting task for a person not in a crisis, but it can be unsurmountable for someone in crisis. The CCC helps walk a person through the challenge of getting the support they need while in crisis. The CCC refers the person and accompanies them to see the LC partner(s) that can meet their needs. The LC partners agree to have their patients/clients sign a shared Release of Information (ROI) form that will allow the providers to talk with the other LC members about their case. This conversation can happen during regular work hours or at the LC monthly meetings where cases are discussed.

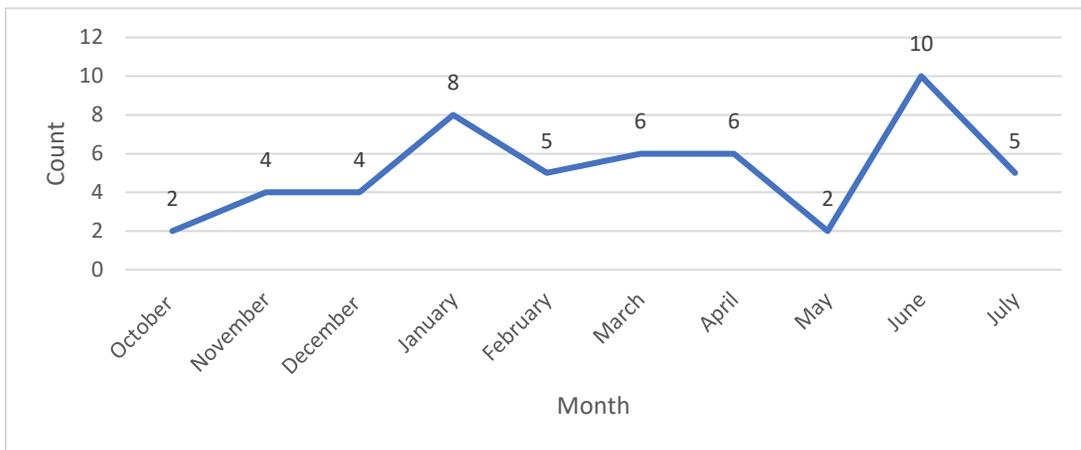
## The Lazarus Collaborative Pilot Project Evaluation Report

When a client enters the program, the CCC administers a case management needs assessment that helps identify the client's needs and pinpoint areas where goals can be developed. This assessment identifies the issues to be worked on and the CCC helps the client identify short-term goals, a target completion date, required contacts, and the responsible party for goal achievement.

### Client Demographics

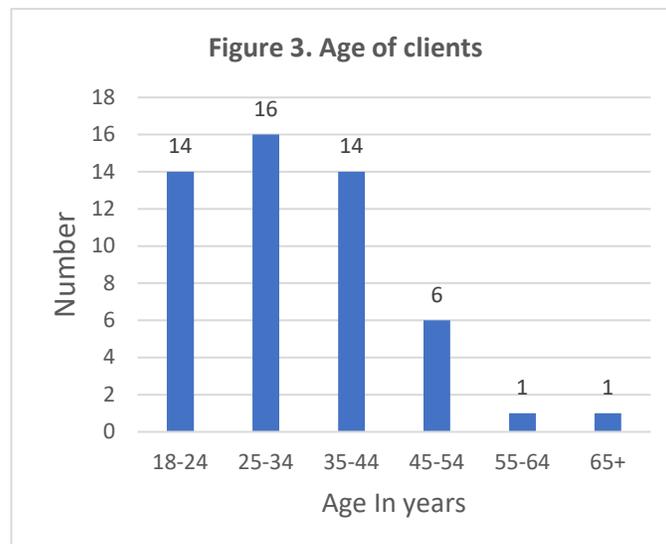
The Lazarus Collaborative has had fifty-two participants since the beginning of service provision in October 2021. As of July 1, 2022, CCCs were serving eight active individuals. Twenty inactive participants have discontinued their involvement with the program after receiving services for varying lengths of time, and 24 individuals have “graduated.”<sup>1</sup> The program started taking clients in October; however, it only accepted three clients in the first two months. More clients were enrolled each subsequent month (see Figure 1).

**Figure 2. Number of Clients Enrolled in the Lazarus Collaborative from October 1, 2021 to June 30, 2022**



**Gender:** There were more male (28) individuals served as compared to females (24).

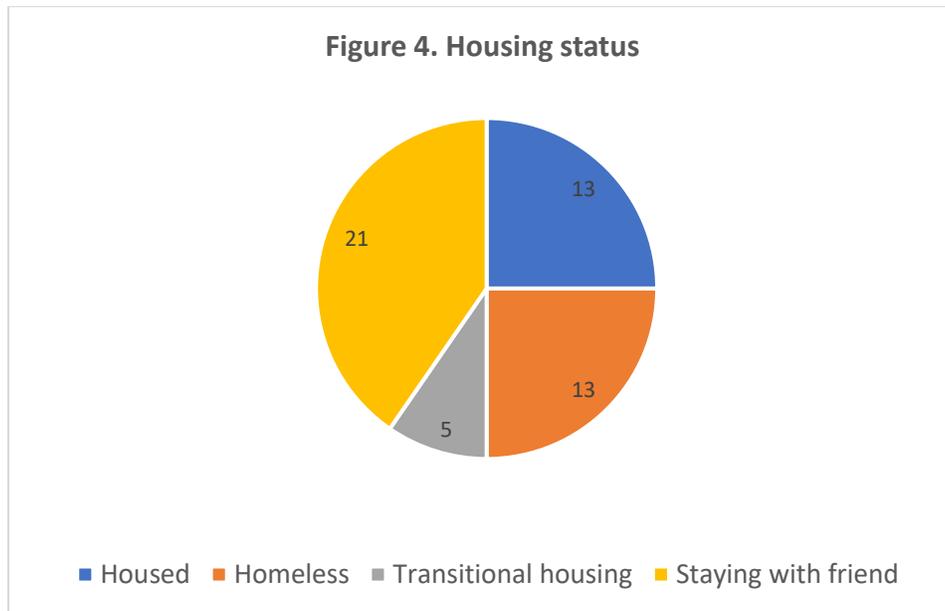
**Age:** Most respondents were under 45 years of age (85%), with only eight clients over 44.



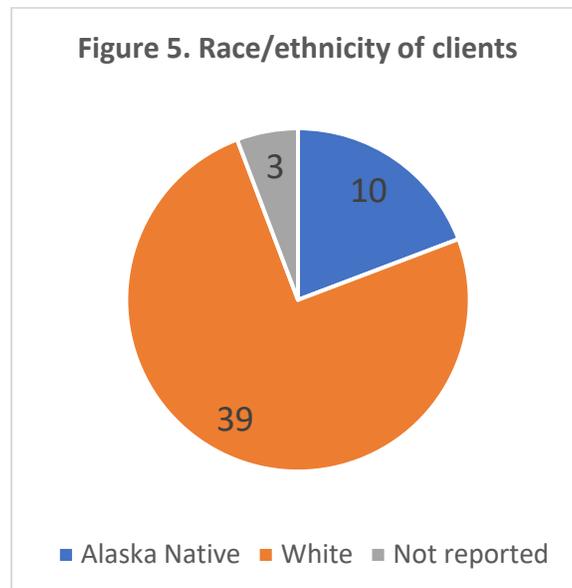
<sup>1</sup> Graduated is defined as an improvement in the quality of life and circumstances that no longer require the assistance from a CCC to live a stable, sober life. This can include attending an inpatient treatment program.

## The Lazarus Collaborative Pilot Project Evaluation Report

**Housing Status at Enrollment:** Thirteen clients were housed at enrollment, thirteen were homeless, twenty-one were staying with friends, and five were in transitional housing.



**Race:** Most clients identified their race/ethnicity as White (39), while 10 identified as Alaska Native, and three did not report race.



**Sexual Orientation:** Most clients identified as heterosexual (46), and six stated they were homosexual, bisexual, or asexual.

## The Lazarus Collaborative Pilot Project Evaluation Report

**Medical Insurance:** Most clients had Medicaid insurance (45), while two had private insurance, four had no insurance, and one had Tricare.

**Veteran/Military Experience:** Two clients were veterans or in the National Guard or military.

**Criminal Justice Involvement:** Ten individuals were involved with the justice system at enrollment.

**Office of Children's Services Involvement:** At the time of enrollment, three individuals were involved with the Office of Children's Services.

**Behavioral Health Needs:** At enrollment, 44 clients had co-occurring behavioral health needs, and 8 had substance use disorders (SUD).

## Outcomes

TNR staff define success as when clients have increased "quality of life." They measure the needs of an individual and monitor status improvement using the TNR Client Needs Assessment which has the following categories.

Housing	Employment readiness	Criminal justice
Education	Mental health status	PAWS management
Employment	Mental health treatment	MAT
Transportation	Detoxification Clean UA	Mental health assessment
Primary Care Provider	Recovery milestones	SUD assessment
Recovery social supports	SUD treatment	Financial resources
Sponsor/mentor	Do you feel supported?	Financial planning
Food	Education readiness	Housing readiness
Clothing	Family relationships	Driver's license
Medicaid/insurance	Relationships with dependents	Vehicle
Physical health	Office of Children Services involvement	Insurance
Medication adherence	Transportation to visitations	Current credit
Level of hope	Relationships with friends	Recreation hobbies
	Motivation for recovery	Obtaining vital records

## Graduated Clients: 24 individuals

Staff define "graduation" as clients who no longer need the services of TNR because they are:

1. Stable and in a residential SUD treatment program (13 participants)
2. Stable and not in services (8 participants)
3. Stable and in outpatient SUD treatment (5 participants)

## The Lazarus Collaborative Pilot Project Evaluation Report

**Table 3. Types of Goals Achieved by Participants Who Have Graduated**

<b>In Out-patient SUD Treatment</b>		<b>Living with Stability</b>
<b>80%</b>	Safely housed	100%
<b>100%</b>	Have primary care	71%
<b>80%</b>	Involved in recovery community	71%
<b>60%</b>	Employed	86%
<b>80%</b>	Graduated residential treatment	57%
<b>80%</b>	Receiving mental health treatment	29%
<b>20%</b>	In MAT	29%
<b>0%</b>	On Probation	29%
<b>80%</b>	Working on relationships with family and friends	86%

A goal of the Lazarus Collaborative is to help clients achieve stability in their lives and participate in the behavioral health treatment they need. Table 3 shows that those who have graduated have success in several areas of their lives. Those receiving outpatient care are more likely than those not in care to have graduated from residential treatment, be receiving mental health treatment, have a primary care provider, and be involved in a recovery community. Those not in outpatient treatment were more likely to be housed, employed, and working on relationships with family and friends. The individuals who have "graduated" and are currently enrolled in residential treatment are working on many of the goals that the other graduated participants have achieved.

CCC services for graduated clients totaled 356 hours and cost \$28,722. The hours that graduated clients worked with CCCs ranged from 2.8 to 72 hours, with an average time of 14.2 hours and an average cost of \$1,145 per client. When comparing the different categories of graduated clients, those in residential treatment received, on average, over twice the number of CCC hours as compared to those who were stable and/or in outpatient treatment.

### Key Point for Project Replication

The LC defines success as when clients have increased "quality of life." They measure the needs of an individual and monitor status improvement using the TNR Client Needs Assessment. The CCC work stops once a client is stable whether they are in treatment or not. Clients are "graduated" if they are stable and in outpatient or residential treatment or living in recovery.

## The Lazarus Collaborative Pilot Project Evaluation Report

**Table 4. Hours and Cost of CCC Support for Graduated Clients**

<i>Status of Graduated Clients</i>	<b>Average CCC hours</b>	<b>Average cost of CCC services</b>	<b>No. of clients in this status category</b>
<i>In Residential Treatment</i>	21.8	\$1,759	13
<i>Outpatient Treatment</i>	8.5	\$686	5
<i>Living with Stability</i>	6.5	\$524	8
<i>Total</i>	14.2	\$1,145	25

Note: Medicaid State Plan reimbursement for crisis intervention services is \$20.17 per 15 min.

### Active Clients: 8 individuals

As of June 30, 2022, eight active clients were receiving Lazarus Collaborative services. These clients each received a needs assessment and integrated behavioral health assessment. Based on the needs assessment, attainable goals were set to move them towards receiving the care, treatment, and support they needed to improve the quality of their lives. As of June 30th, active clients had progressed on an average of 6.1 goals. One active client received many more hours of CCC assistance than other clients (146 hours). This analysis did not include this individual to avoid skewing the results. Active clients received 85 hours of CCC services totaling \$6,858. The number of hours CCCs worked with active clients ranged from 4.25 to 22.3, with an average of 14.2 hours and a cost of \$1,146 per client.

Clients made progress in the following areas:

- Medicaid application: 1
- Being housed: 1 individual
- Being fed: 3 individuals
- Social connection/recovery support: 4 individuals
- Working towards receiving:
  - MAT: 3 individuals
  - Primary care: 6 individuals
  - Mental health care: 5 individuals
  - SUD treatment services: 5 individuals
  - Detox services: 2 individuals

### Inactive Clients: 20 individuals

In the program's first nine months, 20 clients stopped receiving Lazarus Collaborative services (inactive clients). Inactive clients received a total of 188.25 hours of CCC services totaling \$15,188. The number of hours CCCs worked with inactive clients ranged from 2 to 32.75, with an average of 9.4 hours and a cost of \$758 per client.

These clients left the program for a variety of reasons, including:

- Incarceration
- Left residential treatment against medical advice
- Declined services or were unreachable
- Moved out of Mat-Su

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Inactive clients received services, referrals, and other assistance while in the program. The average number of goals actively worked on when the client was in the program was 4.1. The three most addressed goals were getting the clients housing, obtaining an integrated assessment, and being admitted to residential treatment.

### Lazarus Collaborative Partners and Monthly Multi-Disciplinary Team Meeting

The founding Lazarus Collaborative Partners are:

1. Frontier Family Medicine
2. Jennifer Byers ANP, PMHNP
3. Mat-Su Health Services
4. MyHouse
5. Sunshine Community Health Center
6. Southcentral Foundation Detox Program
7. True North Recovery

The Collaborative providers offer the following services:

- Behavioral health and addiction treatment
- Care coordination and case management
- Employment services
- Medication-assisted treatment (MAT)
- Medication management
- Mental health treatment
- Peer support
- Primary care
- Transitional housing

After nine months, the Collaborative continues to operate with participation from six of the seven founding members. One member, Sunshine Community Health Center, withdrew due to staffing shortages and their inability to provide immediate behavioral health services. The other members of the Collaborative attend the monthly multi-disciplinary (MDT) meeting with varying frequency and have different levels of involvement during the meeting. In the MDT meetings, the most active participants are the mental health treatment/MAT/medication management providers, the detox provider, and the CCCs.

Attendance for the monthly MDT meetings has ranged from nine to fourteen attendees (not including ADC staff). At each meeting, a discussion is held to address any internal challenges the Collaborative might have. New clients are presented to the group, and cases discussed in the past, if needed, are revisited.

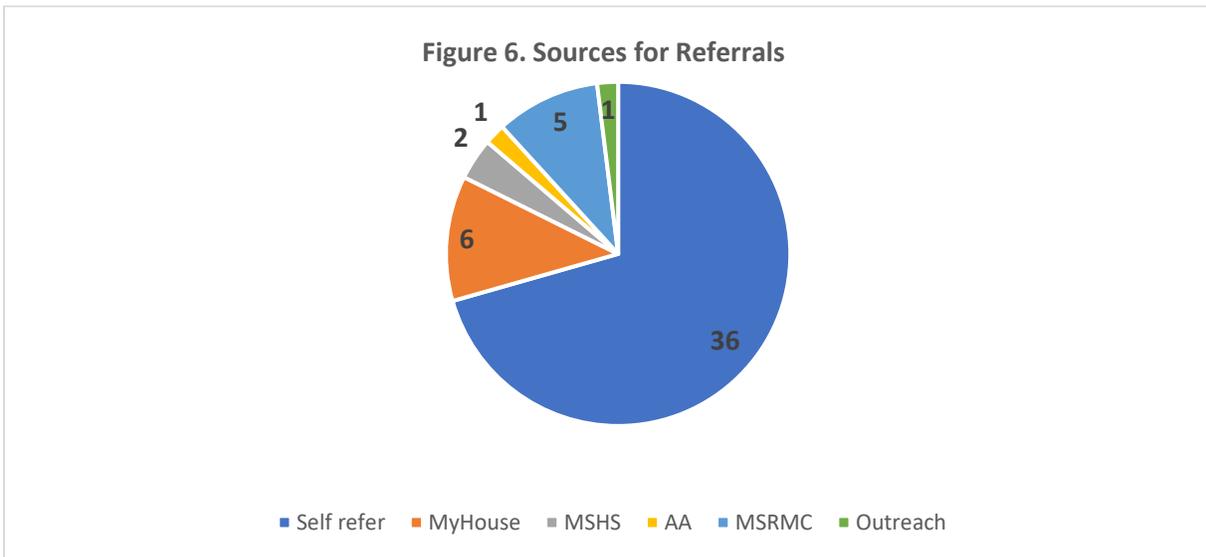
#### Key Point for Project Replication

The LC partners sign a memorandum of agreement (MOA) to work together to provide coordinated care for LC patients/clients and see them for their first appointment within a specified time frame. The patients/clients sign a shared Release of Information (ROI) form that will allow provider/CCCs to talk with the other LC partners about their case. CCCs and members discuss client cases as needed for care provision and at the monthly MDT meeting.

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When the CCCs were asked what benefit the MDT meeting provides, they said that they learned more about the medications their clients are taking and types of detox, and the meetings helped to eliminate triangulation that the client may drive when working with multiple providers. Between two to six cases were presented at each meeting. Discussions between providers and the CCCs on patient care included these themes:

- Scheduling patients/clients
- Medication management
- Coordinating care between providers
- Education on mental health conditions, appropriate detox referrals, and medication
- Organizational updates
- Patient/client compliance



Note: MSHS = Mat-Su Health Services; AA=Alcoholics Anonymous; MSRMC=Mat-Su Regional Medical Center

### Referrals and Intake

Referrals for the CCCs mainly come from self-referral from the True North helpline and walk-ins. For most clients (81%), CCC contact occurs on the same or following day. An additional 10 percent were contacted successfully within 2 to 5 days. Three participants saw a CCC between 5 and 10 days after the referral was made, and three participants had an extended period after the referral before meeting with a CCC (>20 days). CCCs try to contact the client immediately to take advantage of the potential "window of opportunity" that opens to get someone into treatment that exists when a person is in crisis and seeking help.

The TNR executive director suggested that in the future it would be good to have CCCs and providers from other behavioral health organizations be part of the collaborative. This may increase the number of referrals coming from these organizations and provide other treatment referral options for clients. Additionally, he mentioned that the next step to diversify referral sources would be to continue to develop the relationship with the local hospital to connect with patients who could benefit from the LC. He said that currently the CCCs will get a referral for a patient after they have left the hospital and often the individual does not want to pursue services. However, if the CCC could meet them in-person prior to

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discharge and develop a relationship, this could increase the likelihood that the person participates in the LC.

### Staffing

Staff changes have been an issue for TNR. Fully staffed, the program at True North would include a 0.5 FTE manager and two full-time CCCs. The manager has been consistently in place; however, six different CCCs have cycled through the program. The manager reports that she learned that the CCC position is not an entry level position, but rather requires an advanced set of skills. These skills include:

- Being able to do “Motivational Interviewing”
- Providing trauma-informed care
- Navigating residential treatment admission across the state
- Creating suicide safety plans with clients
- Providing intensive case management
- Having Peer Support training and certification
- Being able to recognize small daily wins with the client
- Understanding the ASAM levels of care

The manager reported that it is important to have the CCCs and their supervisor form a cohesive team that has open communication and trust and provide support for one another. Additionally, the CCCs can fill in to provide support to each other’s clients when needed. The work of the CCC is different every day and requires the CCC to have the independence to make spur of the moment decisions to support their client and deescalate crisis. One CCC stated that the job is not for the “tender hearted” because it is difficult to witness the challenging lives of the clients and at times the CCC may invest a large amount of time helping a client only to see the client relapse into crisis and be lost to follow-up.

### Lessons Learned and Challenges Reported by the CCCs

CCCs report that they learned the following lessons during the pilot project period:

- It is necessary to attend all appointments with the client and not just schedule them for the client. Doing so gives the care coordinators an in-depth understanding of the services the client is receiving and the additional referrals that may be needed for improved quality of life.
- LC partners should inform the CCC staff when they will be out of the office and if other providers will be filling in for them.
- It is essential to complete detox pre-screenings with clients to eliminate clients' conflicting information on active use. Doing so limits triangulation and supports the client in feeling safe with being honest.
- Review ROIs with LC partners for accurate completion, which ensures compliance with HIPPA.
- It is crucial to have access to safe drug disposal and policies and procedures to document incidents.
- It is important to inquire about current client engagement with probation and guardians and have strong communication with those agencies to ensure clients can access needed services.

#### Key Point for Project Replication

The role of a CCC is complex and requires the peer support worker to have experience and many skills related to motivating individuals, understanding the treatment system and how to handle crisis intervention and complex behavioral health needs. The manager/CCC team needs to have open communication, trust, and provide support for one another.

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CCCs stated that the major challenges they faced are:

- Securing scarce housing resources for their clients
- Coordinating with all collateral contacts, such as guardians and probation
- In the hospital, many staff are not familiar with the LC and they don't understand the role of the CCC in helping the in-patient or emergency department patient get the follow-up care they need.
- Patients being discharged from the hospital without a safe place to go that encourages recovery.
- It is very time-consuming and cumbersome to submit a Medicaid application.
- An immediate opening in detox or treatment is often unavailable when the client realizes they want to work towards recovery. A CCC stated that he struggles to keep an individual in that "moment of clarity" when the services they need do not have immediate openings.
- It is difficult to find inpatient and residential treatment for a client with complex needs who is challenging to work with because many programs don't understand how to work with clients with complex mental illness and/or behavioral struggles.
- Finding a place to keep someone safe while waiting to get into residential treatment.

### Collaborative Member Perceptions

#### Benefits of being in the collaborative

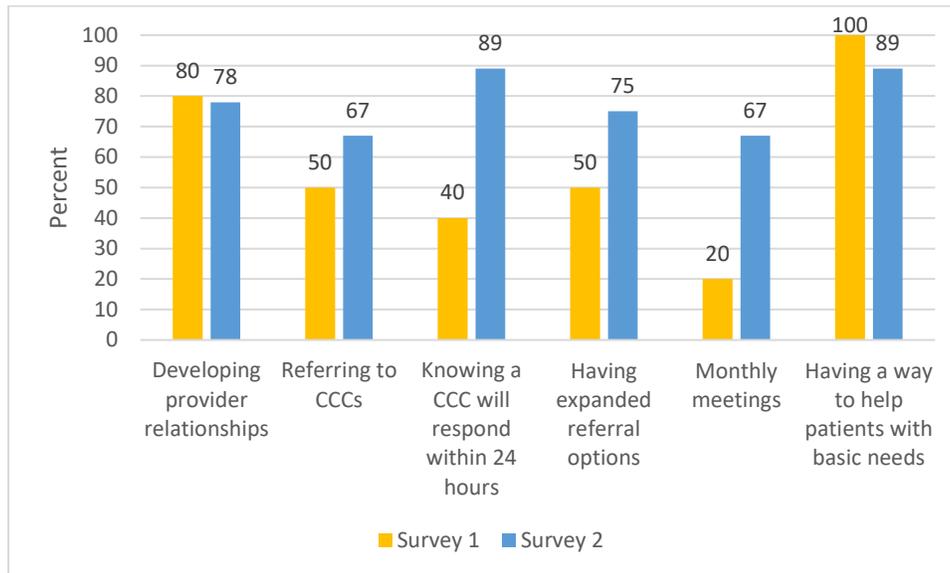
Collaborative members were surveyed three months into the pilot project and after nine months. At three months, members were asked which aspects of being part of the LC were important to them, and at nine months, they were asked how valuable the same aspects had been. The responses were collected on a Likert Scale, ranging from *not important/not useful* to *very important/very useful*. Most responses were *somewhat or very important*. Figure 7 shows the percentage of LC members surveyed at the two different times who chose the answer *very important* to the two questions. The value of being in the collaborative appears to have increased on these factors over time.

#### Key Point for Project Replication

A CCC should attend all appointments with the client, complete detox screenings with clients, have procedures for safe disposal of drugs given to them by clients, and check to see if the client is involved with the justice system, the Office of Children's Services, or an appointed guardian and, if so, involve these third parties with the client's crisis resolution.

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**Figure 7. The Percentage of Survey Respondents Who Felt it was *Very Important* (Survey 1) or *Very Useful* (Survey 2) to be in the Collaborative.**



Early in the project, providers listed what they thought was satisfying about being part of the LC and any successes they had seen with their patients. Their answers focused on how hopeful it had been to learn about other resources for their patients, meet other providers, and see their patients getting the care they need. Their quoted responses are in italics below.

### What is satisfying about being part of the Collaborative?

#### Knowing about resources

- *Learning more about what organizations offer for services, the work to streamline the processes for customers seeking care. I really appreciate the focus on the customers' experience and how to support them.*
- *Learning about other organizations and their protocols has been educational for me.*
- *Making connections with other providers.*
- *It's been wonderful knowing that there are other resources within the collaborative that provide services so the ever-increasing need can be spread between numerous entities.*
- *Seeing the community resources available and how the different organizations are coming together to expedite services.*

#### Meeting other providers

- *Joining the team with like-minded people is refreshing*
- *New partnerships*

#### Patient progress

- *Seeing the progress, understanding the tweaks and concerns of the different partners and then seeing the flow for clients!*
- *Seeing clients in crisis successfully getting what they need!*
- *Seeing patient success!*

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The second survey asked respondents to elaborate on what had been useful for them and their patients in being part of the Collaborative. The themes mentioned were timely access, coordinated care, and knowing about more resources.

### What has been useful about the LC for you and your patients?

#### Coordination of care

- *Getting clients connected quickly to all the providers in the collaborative. Detox admission was an area that has always been a lengthy wait and through this Collaborative we were able to shift that. After gaining a letter of acceptance into treatment, clients were able to admit into a detox program very quickly.*
- *Providers have different areas of expertise that positively impacted our clients [and it was helpful to learn from their expertise at the MDT meetings].*
- *Having the MOAs in place to be able to speak freely with other providers.*
- *The ability to discuss strategy and to utilize partner staff to connect with clients who are struggling, having wrap-around support for both staff and clients and a deeper knowledge of service arrays for all those involved.*
- *The energy between team members.*

#### Knowing about resources

- *Knowing there are several different options for clients.*

#### Key Point for Project Replication

Collaborative provider members like participating in the LC because they learned about resources, met other like-minded providers, were able to deliver more coordinated care and saw their patients have more success.

### Challenges

When the Collaborative began, LC members reported that the major challenges were related to several issues about working together and their role in the Collaborative. The challenges that were mentioned were:

- Patients/clients receiving medical care from different providers that was not coordinated
- Partners not understanding their role in the Collaborative
- Start-up was slow at the beginning of the Collaborative
- Inconsistent member attendance at monthly MDT meetings
- Long wait times for providers
- Keeping to the time frames stated in the MOU because of circumstances outside of their control
- Managing participants' paperwork
- Some "no-shows" for appointments

Nine months into the initiative, members reported some of the same challenges of fragmented care with some providers and inconsistent attendance at monthly meetings. The new challenges that emerged were frequent "turnover" of CCCs, keeping and that it is sometimes hard to reach providers.

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### Provider success stories

Nine months into the project, providers were asked to report successes they have seen with their clients/patients due to their participation in the Collaborative. The primary themes in their responses were related to clients getting a timely assessment and appropriate SUD care when needed and individuals being in recovery.

#### Appropriate SUD care

- *Having a higher level of care for SUD clients has been helpful.<sup>2</sup>*
- *MAT referral access in general.*

#### Timely Care

- *We were able to get patients started on medications to help in a timely fashion since the CCC was available to facilitate transportation and management.*
- *Clients having same-day services is absolutely critical to success and getting them engaged with case management.*
- *We have had more clients enter into treatment as a result of the quick response to requests for assessment and treatment.*

#### Achieving recovery

- *I have seen people gain sobriety, learn coping skills, graduate treatment, build a foundation of recovery, comply with probation, gain employment, obtain stable housing, and be able to be a reliable family member to their loved ones. This project has had so many amazing success stories. I am so thankful to be a part of it.*
- *Seeing clients in recovery*
- *Patient success and being able to be a direct line of support especially during the pre-admission, admission, and post-discharge planning.*

#### Members were also asked if participating in the Collaborative changed their organization or practice.

They responded as follows.

- *No, other than having a referral source for a service we do not have.*
- *I think this Collaborative really highlighted the need for walk-in assessment capacity. We have since hired additional assessors to ensure we are able to meet the needs of the clients we serve.*
- *We call the CCCs when we have someone in need of immediate attention for treatment. Like if it is someone we are worried about losing.*
- *Yes, we act more quickly and expect more prompt services from partners. We are able to tell clients that they can receive same-day assessment and it is so hopeful for them.*
- *Yes, collaboration is a huge improvement and I feel we are able to do more with the limited providers we have. We are learning to be a well-oiled machine.*
- *No, other than expanding our referral network.*

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<sup>2</sup> Text in italics is a quote.

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### Individual success stories

CCCs told the following success stories about clients:

- *There was a former client who left the program and the state due to a domestic violence situation. They were then involved in a house fire out-of-state and severely burned. When they returned to Alaska, they immediately called their former CCC to get help with their substance use disorder. The CCC helped them get primary care, medication management, and treatment appointments. Although they are still using substances while they wait for admission to treatment, they are willing to participate and always show up for their appointments.*
- *A client was all set to be admitted to residential treatment. However, when the CCC picked her up and brought her to the True North offices, she failed her urine analysis and couldn't be admitted. The CCC advised her to "hold tight" for one day, and the CCC would return to get her to do another urine analysis test the next day. The next day, the test was negative, and the client was admitted to residential treatment. She was middle-aged and had a severe SUD; this was her first time in treatment ever. This "hiccup" in the admission process had the potential to thwart this person's recovery, but, assisted by the CCC, this did not happen.*
- *One client did an intake with the Lazarus Collaborative program and then disappeared. The CCC reached her 2-3 months later. She is now doing outpatient treatment. The CCCs are there for clients when they are ready to make a change – this doesn't always happen the first time they are in contact with the program.*
- *The CCC continues to work with a young man who has a mental health condition. The CCC stood by him when his medical provider suggested he move to another provider. She helped him with his probation sentencing and meeting his basic life needs. He is doing well with her support and is not currently in crisis, even though he is not always consistent in taking his mental health medication.*
- *A client came in for outpatient treatment, then went to residential treatment, and was released from residential treatment due to a medical condition. They went to live in Anchorage and were in an unsafe living situation. The CCC helped them get back to Mat-Su. The client is currently working, seeing their children, and in a sober living house with treatment.*
- *A client had an active warrant out for their arrest, and the CCC accompanied them to see their Probation Officer (PO). The PO didn't believe that the CCC was with them and went to the waiting room to see if that was true. The CCC helped the client prepare for a bail hearing and do the medical testing necessary for admission to detox. The CCC is currently helping them call the detox provider daily until a slot opens up, and they will go to detox and then do a bed-to-bed transfer to residential treatment after detox.*

### Financial Sustainability

In FY 2022, the LC received \$150,846 in grant funds for start-up from the The State of Alaska, Division of Behavioral Health and funding for facilitation and evaluation of the 9-month pilot project from Recover Alaska. Due to the program's success, LC will continue beyond this pilot period.

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The majority of LC clients qualify for Medicaid and this is the program's primary means of sustainability. CCCs bill for “crisis intervention services” under the State Medicaid Plan (\$20.17/15 minutes), along with billing for an SBIRT assessment. They use the crisis intervention services code because the CCC can work with the client in crisis for 22 hours before a treatment plan is developed. This is crucial to stabilize the client before they agree to do an assessment. During the pandemic, the state suspended the requirement to get state authorization when the work required more than 22 hours. Currently, the CCC can continue to work with the client as needed with Medicaid reimbursement. Once the client is stabilized, the CCC transitions the client to a case manager at TNR or another organization.

**Table 5. The Average and Range of Hours Provided by CCC by Client Status**

<b><i>Status of Clients</i></b>	<b>Average CCC hours</b>	<b>Range of hours</b>
<i>Graduated Client</i>	14.2	2.8-72
<i>Inactive Clients</i>	9.4	2 - 32.7

Table 5 shows the average number of hours the CCC reported working with clients with different outcomes. While the average number of hours a CCC works with a client who has graduated or becomes inactive is less than 22 hours, there are clients who require substantially more hours. The executive director of TNR stated that if the State reinstates the requirement to request an authorization to work with a client for more than 22 hours prior to getting an assessment, they will start billing the “peer-based crisis service” (\$20.46/15 minutes) through the 1115 waiver which does not have that requirement. He stated that applying for an authorization can be very time consuming. The TNR executive director stated that the CCCs have been under-billing for the time they spend with clients due to factors such as they couldn’t write a note because the client is not yet insured, or they were still being trained on how to do documentation for billing. He stated that they are working to bring their billing up to an appropriate level that represents the services they provide. He stated that it is a requirement for billing the crisis intervention services code that the client be in “acute crisis” and the CCCs are constantly evaluating the acuity of the client’s situation until they are stable.

It is necessary that the CCC have funds that they can use to help stabilize the client. For example, they may need to put them up in a hotel room, buy them a hot meal, etc. These expenses are not billable and must be financed through a grant or other flexible funding source.

### Key Point for Project Replication

Start-up funding is key to create a LC initiative. There is a learning curve for CCCs to have effective billing practices and billing cannot begin until the client is covered by Medicaid. The two ways to bill for CCC services are with the “crisis intervention services” billing code through the State Medicaid Plan and with the “Peer-based Crisis Service” code from the 1115 Medicaid Waiver. Funding must also be secured to cover the cost of emergency lodging, food, and other necessities for the individual in crisis.

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### Summary

The needs of many LC clients are complex, and progress in the behavioral health system requires jumping through many "hoops." For example, when a client applies for a residential detox program, there is usually a waiting list, and they must call the program daily to see if a spot has opened. Many clients are starting with very few resources and need assistance for things such as to get an ID to apply for public assistance and Medicaid. Additionally, many clients need assistance basic living needs such as housing, food, and clothing. The LC was created to help these individuals.

The trajectory of recovery differs for each person. It is commonly known that individuals struggling with SUD and other addictions often require multiple treatment attempts before achieving a life of recovery. A 2019 article by Kelly et al. presented an analysis of a cross-sectional nationally representative survey of U.S. adults who had resolved a significant alcohol or another drug problem (n=2002). Kelly et al. reported an average of 5.35 recovery attempts and a median (value at the midpoint of all the attempts listed in order) of 1.5 attempts before long-lasting recovery was achieved.<sup>3</sup> The fact that these two measures are so far apart indicates some subgroups vary significantly from the rest of the sample. This was the case for respondents who were non-Hispanic Black, not married or living with a partner, or those with a higher frequency of involvement with treatment/recovery support services, particularly mental health organizations. These groups experienced more recovery attempts than other groups (whites, married, or those living with a partner, etc.). In this study, an evaluation of the relationship between recovery attempts and quality-of-life and well-being indices suggested that individuals with complicated and long-lasting stress levels needed more recovery attempts before successfully resolving alcohol or drug problems. It is important to understand this common progression when evaluating the results of a program such as the Lazarus Collaborative. When a participant leaves the program, there may be a tendency to see this as a failure. However, most participants who have left the program have received treatment and support and achieved at least a few days of sobriety or MAT. Their Lazarus Collaborative experience may contribute to a journey towards recovery in the long run.

When TNR staff were asked what "success" looks like, they replied that success is an improvement in a client's quality of life. The long-term goal is for a person to successfully engage in their healing journey and/or complete treatment. Their journey may include attending recovery meetings, taking medication as prescribed, and continuing to seek support and connection in the community.

All clients in this pilot program received a service or achieved a goal because of their involvement. For many, there were numerous goals and results achieved. Forty-eight percent of the participants graduated from the program, were living in sobriety, and had an improved quality of life compared to when they first started the program. Thirty-eight percent of clients dropped out of the program. On average, these clients received fewer hours of CCC assistance compared to the currently active or graduated clients.

The responses from LC partners reveal that being part of the Collaborative has been a positive experience for them and their patients/clients. The program start-up had some hiccups in getting the CCCs and the partners working together in a coordinated way. The monthly meetings have helped promote better care coordination for patients/clients.

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<sup>3</sup> Kelly, J. F., Greene, M. C., Bergman, B. G., White, W. L., & Hoepfner, B. B. (2019). How Many Recovery Attempts Does It Take to Successfully Resolve an Alcohol or Drug Problem? Estimates and Correlates from a National Study of Recovering U.S. Adults. *Alcoholism, clinical and experimental research*, 43(7), 1533–1544. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6602820/>

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Many of the challenges mentioned by the CCCs and the LC partners reflect difficulties in the behavioral health care system in general, such as finding participants housing, fragmented medical care, and workforce turnover and shortages. CCCs and LC partners reported that the program's successes included that they were happy to be part of the project and felt that their patients/clients were benefiting from more timely and supportive care through the CCCs.

Due to the program's success, it will continue beyond this pilot period. The project received grant funding from the State of Alaska Division of Behavioral Health which was crucial for the start-up period. The grant funding is only for the first year. The program's primary means of sustainability is Medicaid reimbursement for the CCC's billing for the time they spend with clients.

The Lazarus Collaborative provides a vital service essential for individuals in crisis to navigate through a complicated group of systems (the physical health system, the behavioral health system, and the social welfare system). The cost of the Lazarus Collaborative is minimal compared to the cost of care in these other systems and the cost to the individual of not getting care. The project amplifies the effectiveness of these other systems in improving individuals' quality of life and health. The model is promising and should be able to be replicated in other areas of Alaska to help individuals in crisis to stabilize to be more likely to receive and benefit from behavioral health treatment.