Oklahoma's Most in Need List:
Data-Driven Processes for Complex Public Behavioral Health Populations

Mark A. Reynolds, Ed.D.

Oklahoma Department of Mental Health and Substance Abuse Services
Director of Decision Support Services (retired)

CEO of Reynolds Data Analytics, LLC
mark@dataokc.com

Presented at:
National Dialogues on Behavioral Health
October 26-29, 2025
New Orleans, Louisiana

📜 Key Abbreviations

Abbreviation	Definition
MIN	Most in Need – individuals with elevated behavioral health needs
ODMHSAS / DMH / The Department	Oklahoma Department of Mental Health and Substance Abuse Services
PICIS	ODMHSAS online provider portal for data entry and reporting
OHCA	Oklahoma Health Care Authority – state Medicaid agency
ER	Emergency Room
SA Restx	Substance Abuse Residential Treatment
CCBHC	Certified Community Behavioral Health Clinic (formerly CMHCs)

Presentation Outline

- Purpose/Overview
- Initial Stage: Top 100 (started in 2017)
- Current System (started in 2019)
  - Inclusion Criteria
- Demographics/Diagnosis
- Data System Collection & Reporting
- Care Coordination Team
- Provider Perspective
- Incentives
- Results
- Lessons Learned & Challenges

Purpose & Approach

✅ Goal

- Improve service delivery and outcomes for individuals with complex behavioral health needs

🔁 Challenge

- Individuals cycle through higher levels of care (inpatient, crisis, residential), are discharged, and often return
- Many face persistent barriers: homelessness, SMI, lack of continuity in care

📊 Data-Driven Strategy

- Use admission data to identify high-utilizers across ODMHSAS services
- Inform providers of **who**, **where**, and **when** individuals are accessing higher levels of care
- Share timely data to support **follow-up**, **monitoring**, and **re-engagement**

Purpose & Approach (continued)

🤝 Provider Support

- Notify providers when individuals re-enter treatment
- Equip teams with actionable insights for outreach
- Offer financial incentives to encourage sustained engagement with this population

🧱 Foundation

- Began with **Top 100 Cohort** in 2017
- New cohorts **emerge organically** based on utilization trends
- Data and reporting set the stage for scalable, cost-effective interventions
- “Anything we could do was cheaper than what we were doing”

Initial Stage:
Top 100
aka High-End Users

The Top 100
Phase One: Data-Driven Identification & Stratification

🎯 **Target Population Criteria**

- Identify individuals who, within the:
  - Past 1 year or past 3 years, have had admissions to ODMHSAS services (excluding Medicaid psychiatric admissions initially), including:
  - Inpatient psychiatric care, Crisis stabilization units and Substance abuse residential treatment

🗺️ **Demographic & Clinical Profiling**

- For each identified individual:
  - Determine last known city of residence
  - Flag indicators:
    - PACT involvement
    - Homelessness status
    - Severe Mental Illness (SMI) diagnosis

The Top 100
Phase Two: CMHC Collaboration & Case Review

👥 Staffing with Community Mental Health Centers (CMHCs)

- Coordinate staffing meetings with each CMHC
- Review individuals with:
  - Highest number of admissions
  - Longest cumulative stays in higher levels of care

📈 Outreach Efforts

- Providers conducted outreach with varying levels of success
- Documented engagement outcomes and barriers

The Top 100
Phase Three: Foundation for Action

📊 Data & Reporting

- Use compiled data and reports to:
  - Inform next steps in care coordination
  - Prioritize high-risk individuals for intensive intervention
  - Support funding proposals or policy adjustments

Top 100 Overview

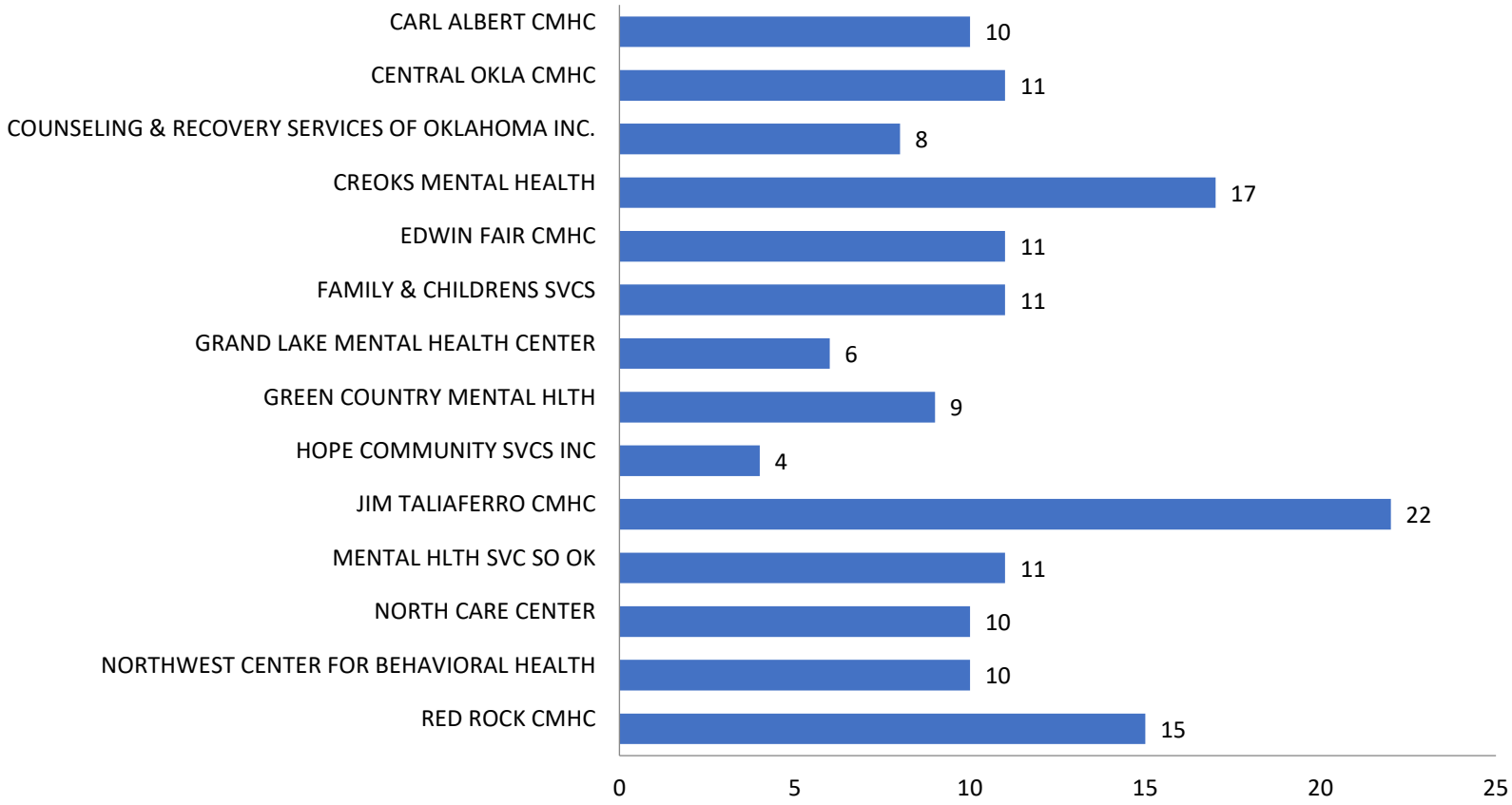
🏥 High-Utilization Snapshot (Past Year)

- **23 individuals** had **10+ admissions**
- **102 individuals** had **5–9 admissions**

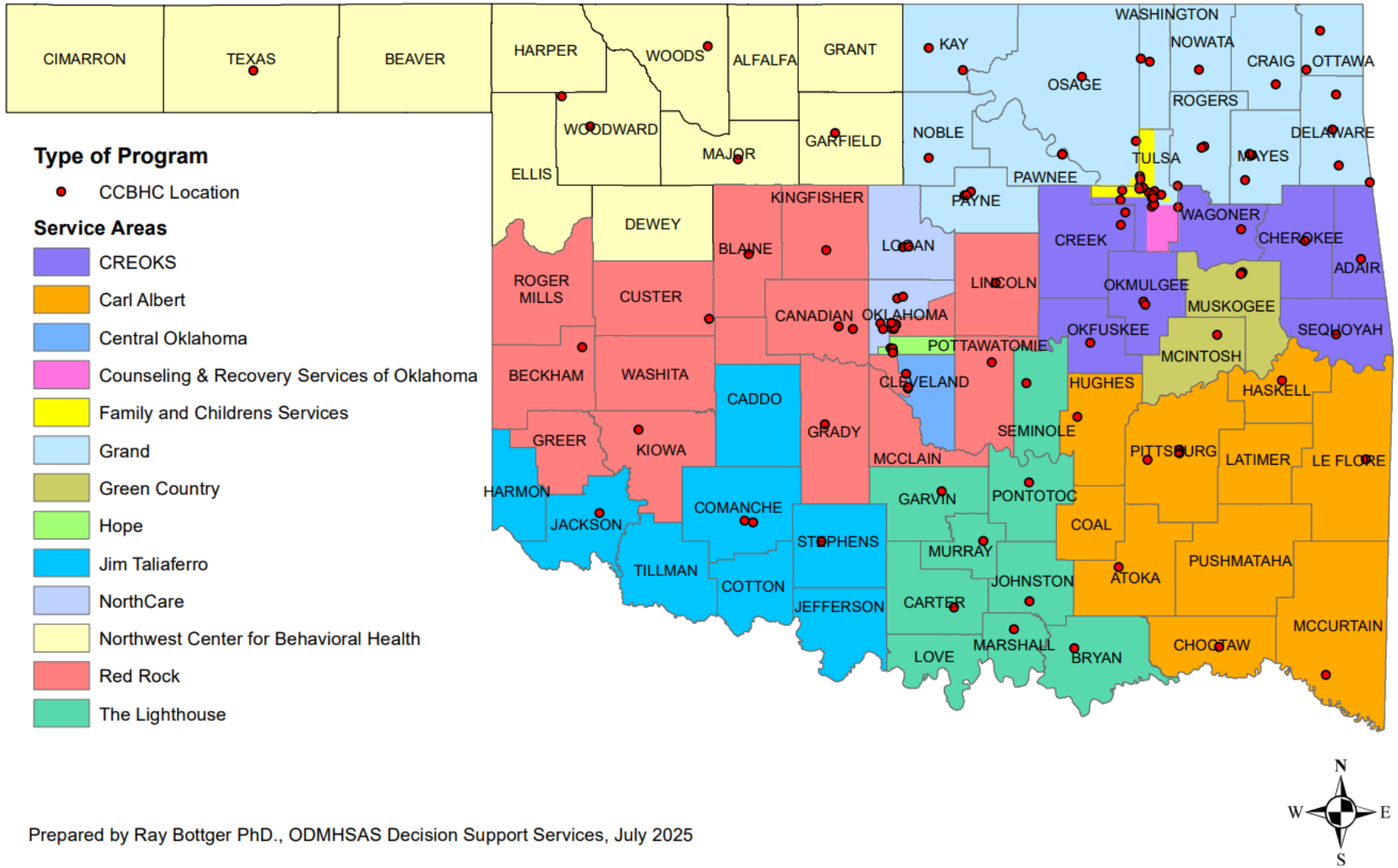
⚠️ Key Characteristics of High-Utilizers

- Among those with **5+ admissions**:
  - **82%** have a history of **homelessness**
  - **Nearly all** are diagnosed with **Serious Mental Illness (SMI)**

Number of Individuals Assigned: 155



CCBHC Services Areas & Locations



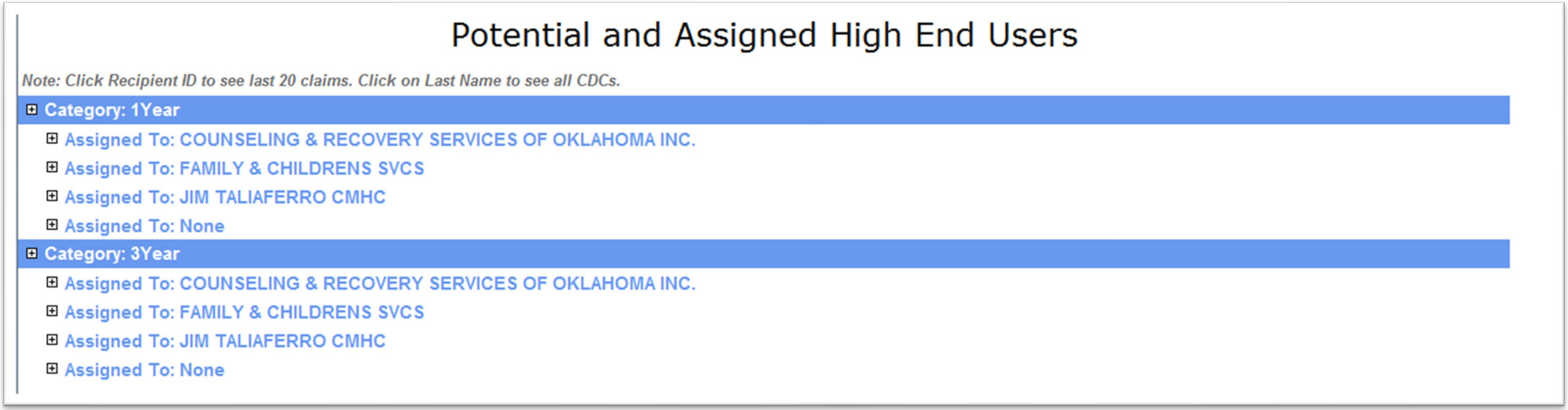
Prepared by Ray Bottger PhD., ODMHSAS Decision Support Services, July 2025

Reports available to CMHCs

- Identification of individuals in the area that are high-end users
- List of individuals assigned to CMHC
- List of individuals assigned which are active at CMHC

- Reports include:
  - Number of admissions, with dates and days of service, by type of care

- Reports available via online, secure web portal



Note: Providers can only see clients assigned to them, not clients assigned to other providers.

Potential and Assigned High End Users

Note: Click Recipient ID to see last 20 claims. Click on Last Name to see all CDCs.

Category: 1Year

Assigned To: COUNSELING & RECOVERY SERVICES OF OKLAHOMA INC.

	Total		Inpatient		Crisis		SA Restx		Homeless		SMI		PACT		Health Home		
Recipient ID	Episodes	Days	Episodes	Days	Episodes	Days	Episodes	Days	If Ever	Last CDC	If Ever	Last CDC	If Ever	Last CDC	If Ever	Last CDC	Last City on CDC
PHI	6	34	1	3	5	31	0	0	Y	N	Y	Y	Y	N	Y	N	TULSA
	4	239	4	239	0	0	0	0	Y	N	Y	Y	N	N	N	N	TULSA
	4	45	3	40	1	5	0	0	Y	N	Y	Y	N	N	N	N	TULSA
	3	45	3	45	0	0	0	0	Y	Y	Y	Y	N	N	N	N	TULSA
	3	21	2	14	1	7	0	0	N	N	Y	Y	N	N	Y	N	TULSA
	3	102	2	11	0	0	1	91	Y	N	Y	Y	N	N	N	N	TULSA
	3	60	2	52	1	8	0	0	Y	N	Y	Y	Y	N	N	N	TULSA
	2	77	0	0	0	0	2	77	Y	N	Y	Y	N	N	N	N	TULSA

Assigned To: FAMILY & CHILDRENS SVCS

	Total		Inpatient		Crisis		SA Restx		Homeless		SMI		PACT		Health Home		
Recipient ID	Episodes	Days	Episodes	Days	Episodes	Days	Episodes	Days	If Ever	Last CDC	If Ever	Last CDC	If Ever	Last CDC	If Ever	Last CDC	Last City on CDC
PHI	23	137	13	76	9	55	1	6	Y	N	Y	N	N	N	N	N	TULSA
	20	122	3	23	17	99	0	0	Y	N	Y	Y	Y	N	N	N	CLAREMORE
	17	69	7	44	10	25	0	0	Y	Y	Y	Y	N	N	Y	N	TULSA
	14	123	4	32	9	60	1	31	Y	N	Y	N	N	N	N	N	TULSA
	13	90	11	74	2	16	0	0	Y	N	Y	Y	N	N	N	N	TULSA
	13	79	9	54	4	25	0	0	Y	N	Y	N	N	N	N	N	TULSA
	12	92	1	8	10	83	1	1	Y	Y	Y	Y	N	N	Y	N	OKLAHOMA CITY
	12	89	5	48	7	41	0	0	Y	Y	Y	Y	N	N	N	N	TULSA

⊟ Assigned To: FAMILY & CHILDRENS SVCS

	Total		Inpatient		Crisis		SA Restx		Homeless		SMI		PACT		Health Home		
Recipient ID	Episodes	Days	Episodes	Days	Episodes	Days	Episodes	Days	If Ever	Last CDC	If Ever	Last CDC	If Ever	Last CDC	If Ever	Last CDC	Last City on CDC
⊟ PHI	23	137	13	76	9	55	1	6	Y	N	Y	N	N	N	N	N	TULSA

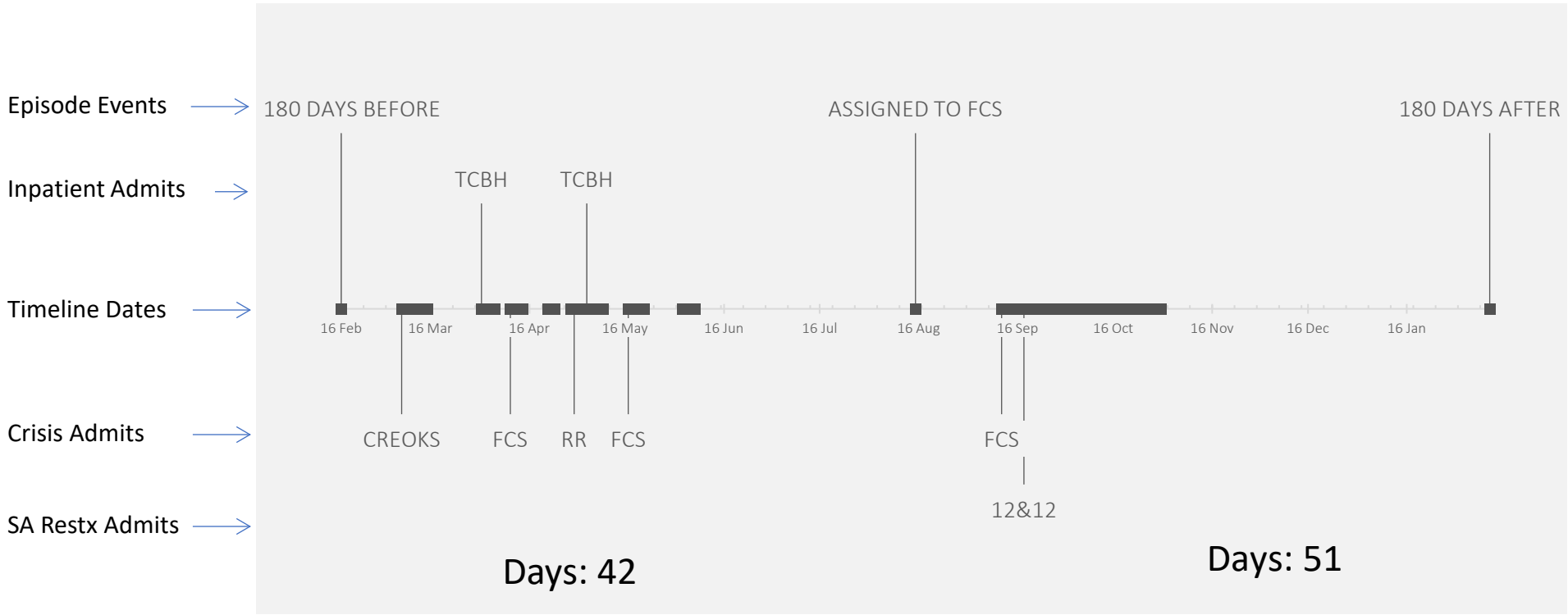
Last Name	First Name	Address	CDC City	Provider Name	Adm Date	Disch Date	Lvl of Care	Svc Focus	Provider City	Legal Status
PHI			TULSA	GREEN COUNTRY MENTAL HLTH	7/27/2017	8/4/2017	Community-Based Structured Crisis	Co-Occurring	MUSKOGEE	Emergency Detention
			Tulsa	TULSA CENTER FOR BEHAVIORAL HEALTH	7/15/2017	7/18/2017	Inpatient	Mental Health	TULSA	Voluntary Admission
			Tulsa	TULSA CENTER FOR BEHAVIORAL HEALTH	7/6/2017	7/10/2017	Inpatient	Mental Health	TULSA	Emergency Detention
			TULSA	CREOKS MENTAL HEALTH	6/28/2017	7/5/2017	Community-Based Structured Crisis	Mental Health	TULSA	Voluntary Admission
			Tulsa	TULSA CENTER FOR BEHAVIORAL HEALTH	6/20/2017	6/26/2017	Inpatient	Mental Health	TULSA	Emergency Detention
			Tulsa	GRIFFIN MEMORIAL HOSPITAL	6/6/2017	6/14/2017	Inpatient	Mental Health	NORMAN	Emergency Detention
			Tulsa	HOUSE OF HOPE	5/11/2017	5/17/2017	Residential Treatment	Substance Abuse	GROVE	Voluntary Admission
			Tulsa	TULSA CENTER FOR BEHAVIORAL HEALTH	5/4/2017	5/11/2017	Inpatient	Mental Health	TULSA	Emergency Detention
			TULSA	FAMILY & CHILDRENS SVCS	5/1/2017	5/4/2017	Community-Based Structured Crisis	Mental Health	TULSA	Emergency Detention
			Tulsa	OKLAHOMA CRISIS RECOVERY UNIT	3/26/2017	3/30/2017	Community-Based Structured Crisis	Mental Health	OKLAHOMA CITY	Emergency Detention
			TULSA	GREEN COUNTRY MENTAL HLTH	3/17/2017	3/24/2017	Community-Based Structured Crisis	Mental Health	MUSKOGEE	Emergency Detention
			Tulsa	TULSA CENTER FOR BEHAVIORAL HEALTH	3/14/2017	3/15/2017	Inpatient	Mental Health	TULSA	Voluntary Admission
			OKLAHOMA CITY	RED ROCK CMHC	2/23/2017	3/1/2017	Community-Based Structured Crisis	Mental Health	NORMAN	Emergency Detention
			Tulsa	TULSA CENTER FOR BEHAVIORAL HEALTH	2/13/2017	2/21/2017	Inpatient	Mental Health	TULSA	Voluntary Admission
			Tulsa	TULSA CENTER FOR BEHAVIORAL HEALTH	2/7/2017	2/10/2017	Inpatient	Mental Health	TULSA	Voluntary Admission
			Tulsa	TULSA CENTER FOR BEHAVIORAL HEALTH	1/24/2017	1/31/2017	Inpatient	Mental Health	TULSA	Emergency Detention
			TULSA	FAMILY & CHILDRENS SVCS	1/17/2017	1/21/2017	Community-Based Structured Crisis	Mental Health	TULSA	Voluntary Admission
			TULSA	CREOKS MENTAL HEALTH	1/11/2017	6/28/2017	Outpatient	Mental Health	TULSA	Voluntary Admission

Episode Example

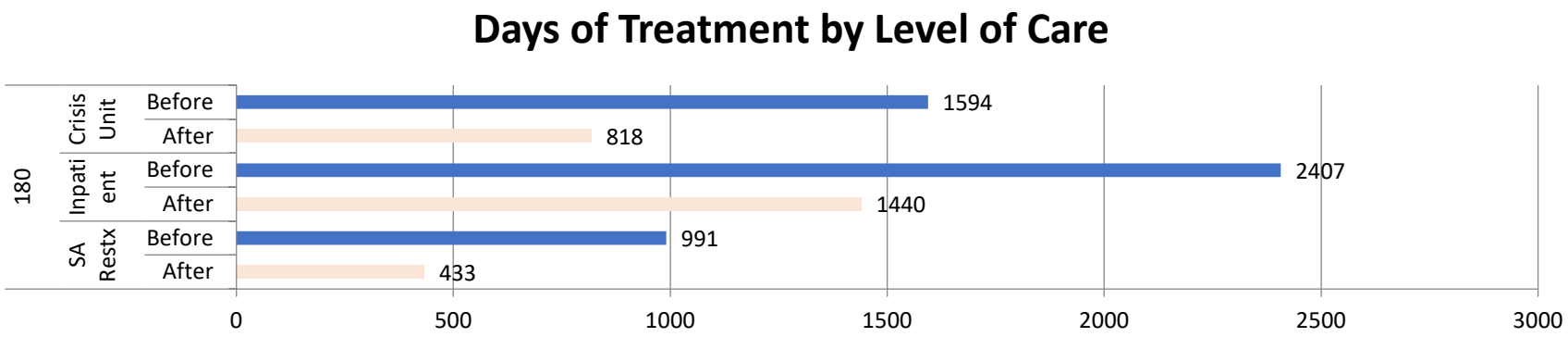
Male, Age 40 years old
Tulsa, OK
Frequently Homeless
Assigned to FCS on August 16, 2017

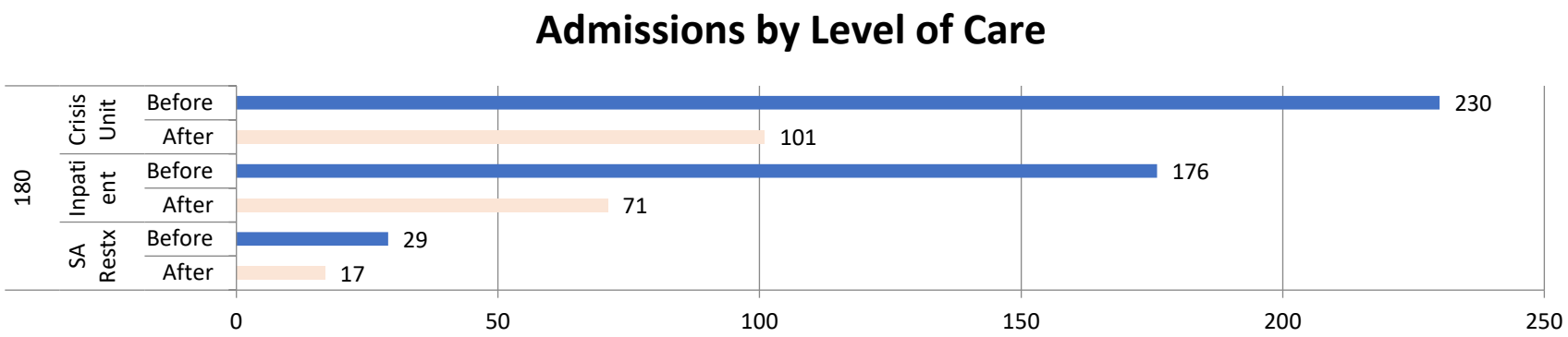
Number of Episodes

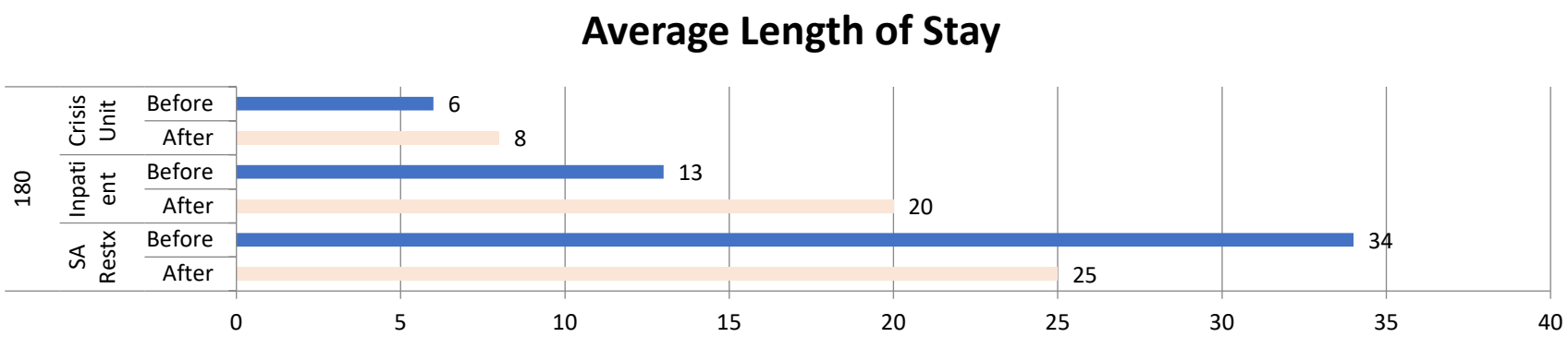
	Before			After
	3 years	1 year	180 days	180 days
Inpatient	11	3	2	0
Crisis Unit	29	17	4	1
SA Restx	1	1	0	1



180 Days Before/After Assignment (Systemwide)







Current System:
Most In Need List

Current System: Most in Need (MIN) List

🔄 Expanded Scope

- Grew from initial **Top 100 cohort** to a comprehensive list of individuals with **elevated behavioral health needs**
- Integrated **Medicaid Psychiatric Inpatient** and **Emergency Room** data for broader visibility

👥 Care Coordination Infrastructure

- Established a **dedicated Care Coordination Team** focused on the MIN List
- Built an **automated system** for:
  - **Weekly updates** to the MIN List
  - **Daily email alerts** to providers

🤝 Provider Engagement & Support

- Actively **engaged providers** across the state
- Delivered **resources**, **training**, and **funding** to support outreach and care continuity

Criteria for Inclusion for Most In Need

Past Twelve Months

Psychiatric Inpatient Discharges
x 2

or

Crisis Unit Visits
x 3

or

Emergency Room Visits*
x 12

or

SA Restx
x 2

Past Month

or

Psychiatric Inpatient
x 1

Past Month

or

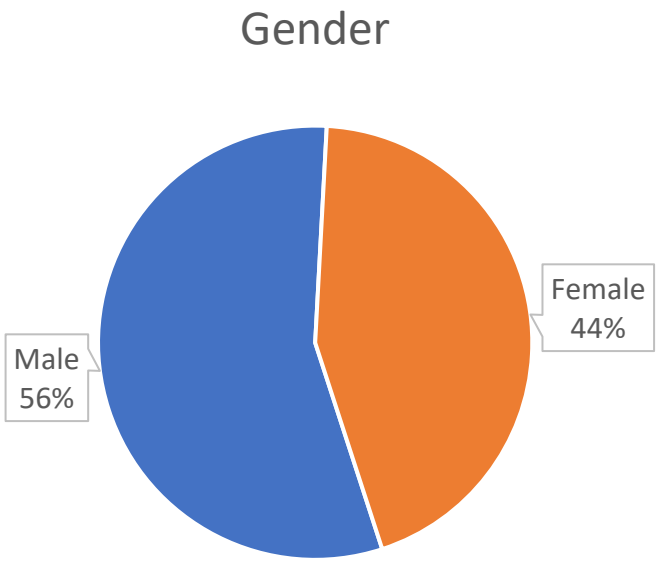
Competency Evaluation
x 1

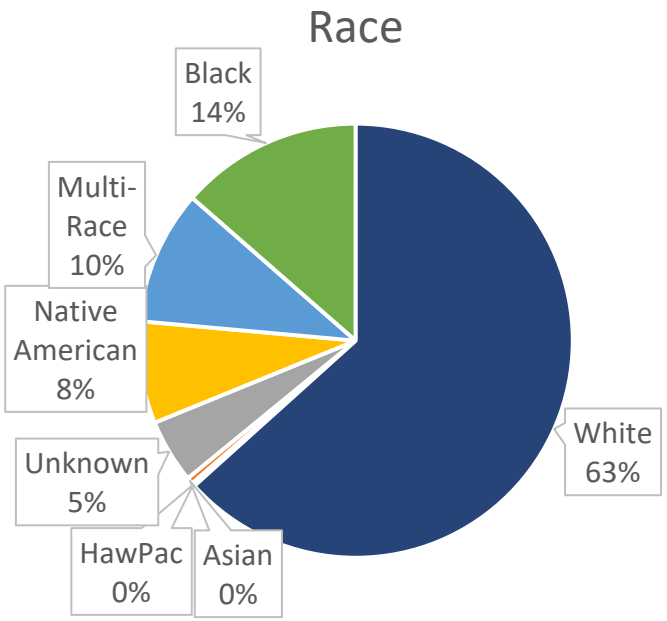
*With MH or SA Diagnosis reported

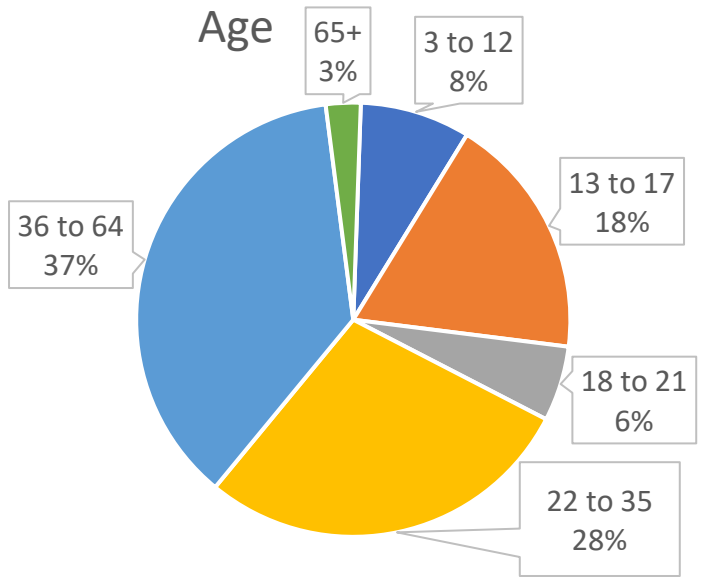
How long will an individual stay on the MIN List?

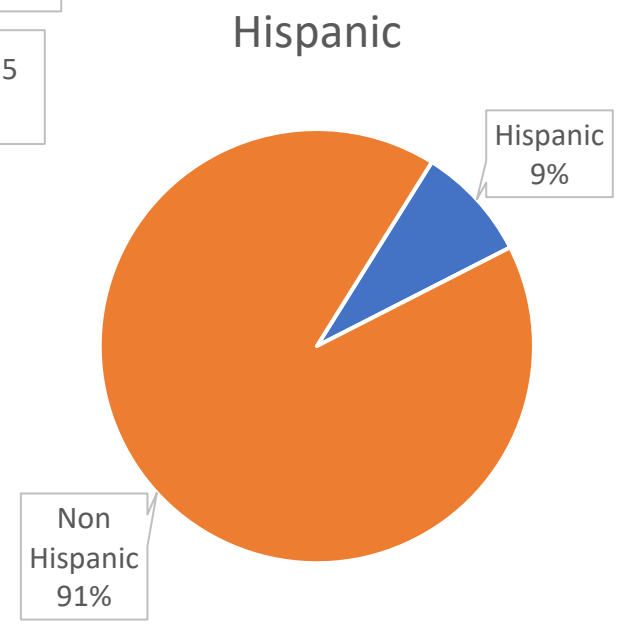
- An individual remains on the list for 12 months, unless additional qualifying events occur during a 12-month period.
  - Exception: Individuals with a single inpatient discharge remain on the list for 3 months.

Demographics

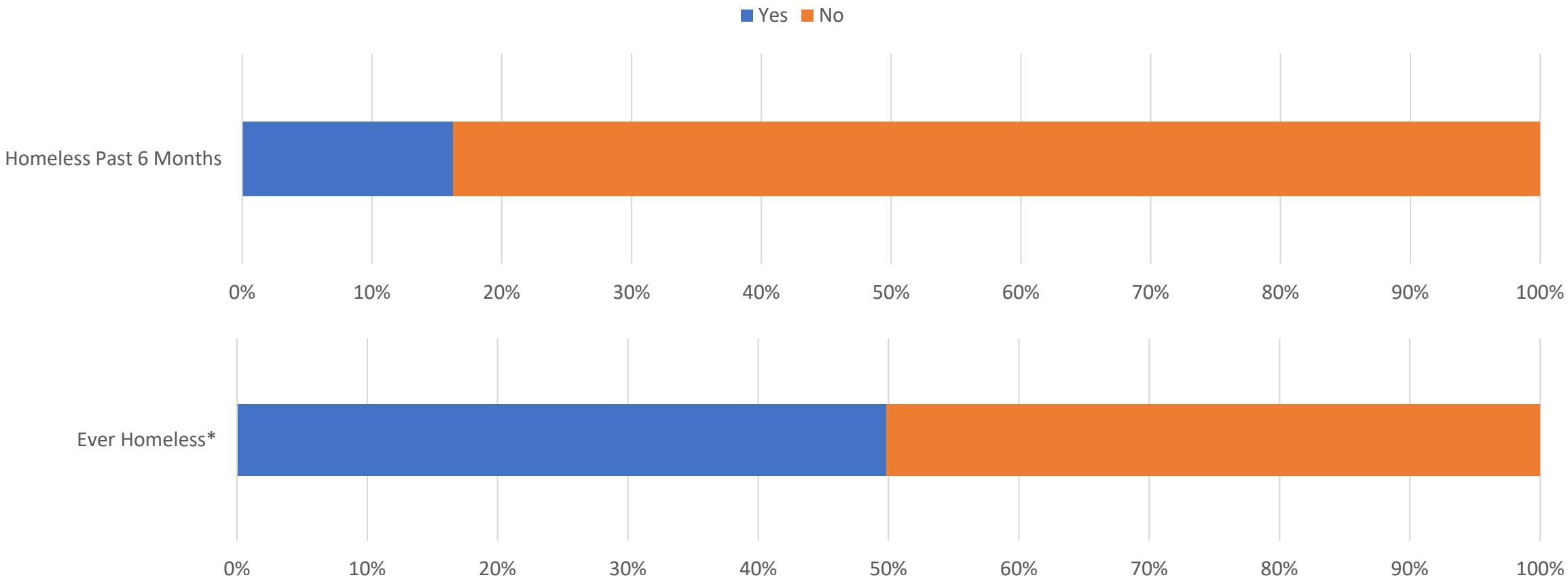






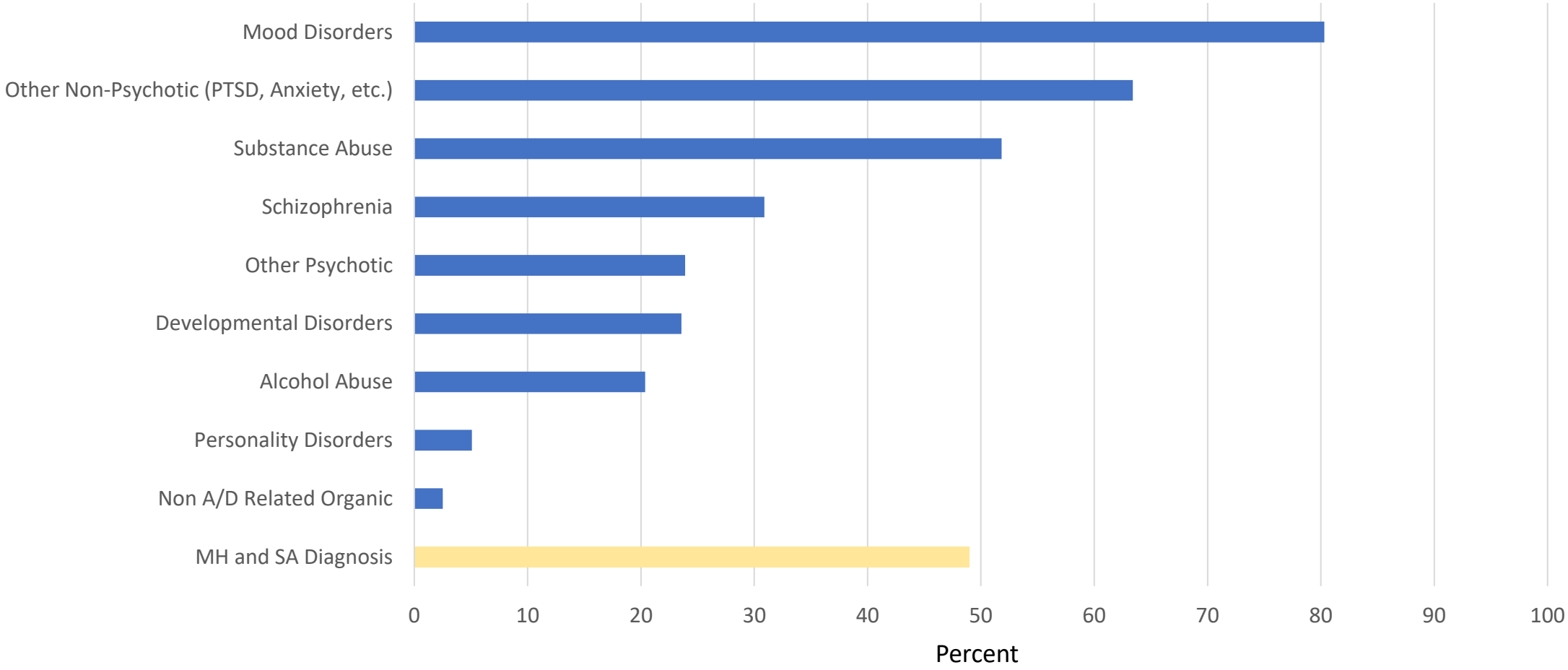


Demographics



*Ever Homeless for individuals reported in system in past 10 years

Diagnosis Groups for MIN List Individuals*



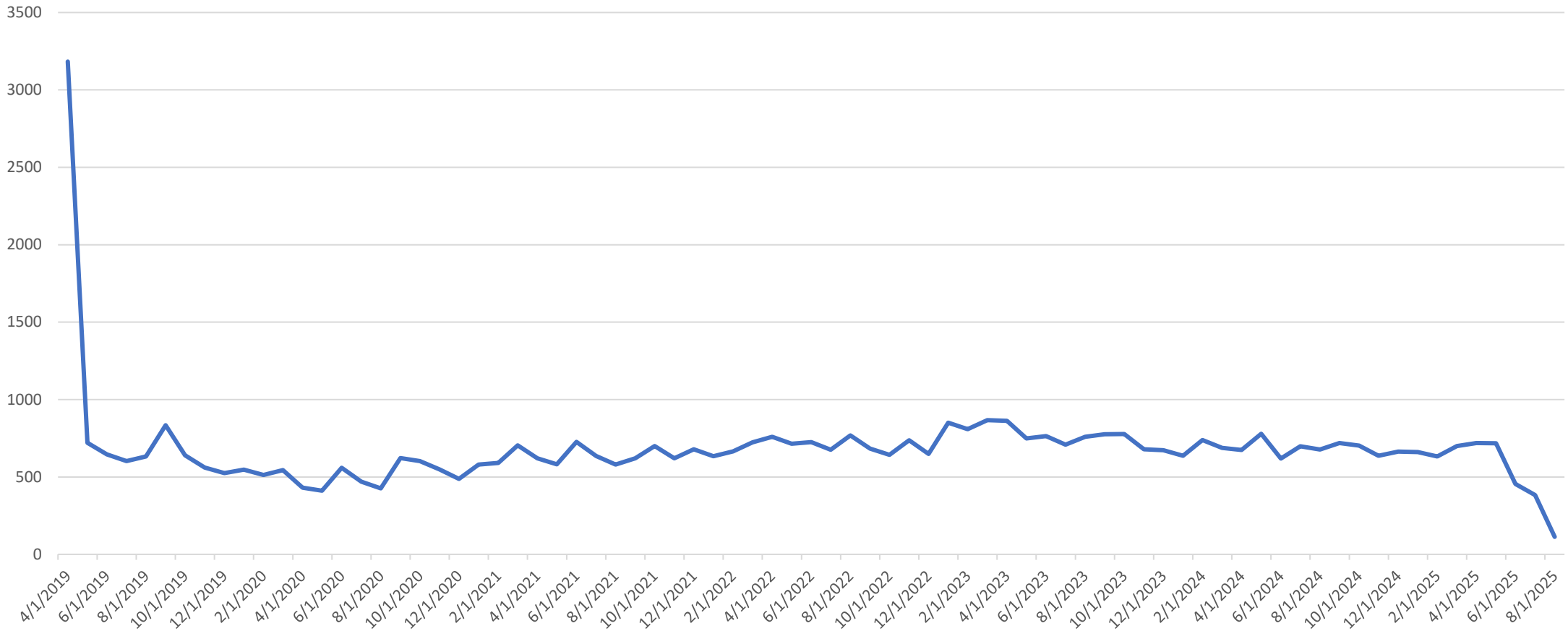
*Individuals will have multiple diagnoses

Most Frequent ICD-10 Diagnosis for MIN List Individuals*

ICD-10	Description	Percent
R45851	Suicidal Ideations	37.02
F332	Major Depressive Disorder, Recurrent Severe w/o Psych Features	32.41
F4310	Post-Traumatic Stress Disorder, Unspecified	27.84
F411	Generalized Anxiety Disorder	26.58
F419	Anxiety Disorder, Unspecified	24.66
F29	Unsp Psychosis Not Due To A Substance Or Known Physio Condition	22.90
F32A	Depression, Unspecified	22.01
F1520	Other Stimulant Dependence, Uncomplicated	21.99
F3481	Disruptive Mood Dysregulation Disorder	17.49
F3481	Major Depressive Disorder, Recurrent, Moderate	17.40

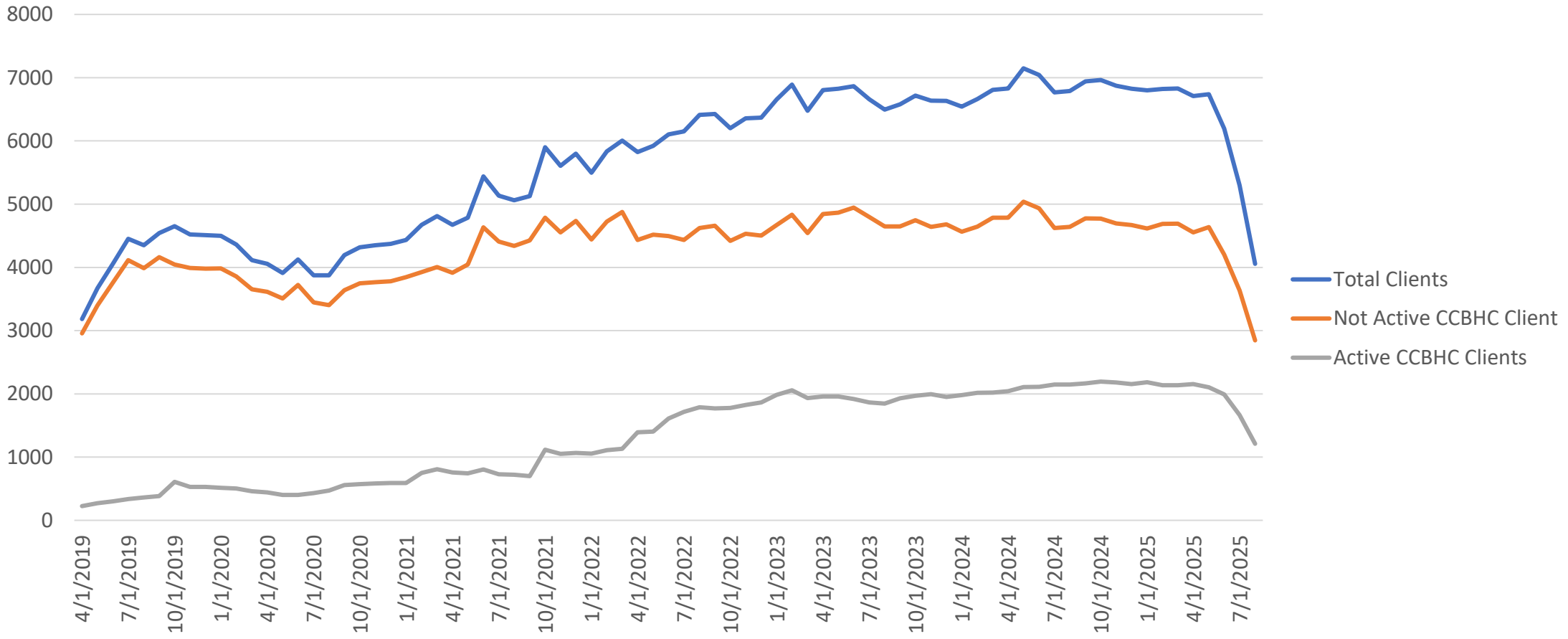
*Individuals will have multiple diagnoses

Count of First Month Added to MIN List



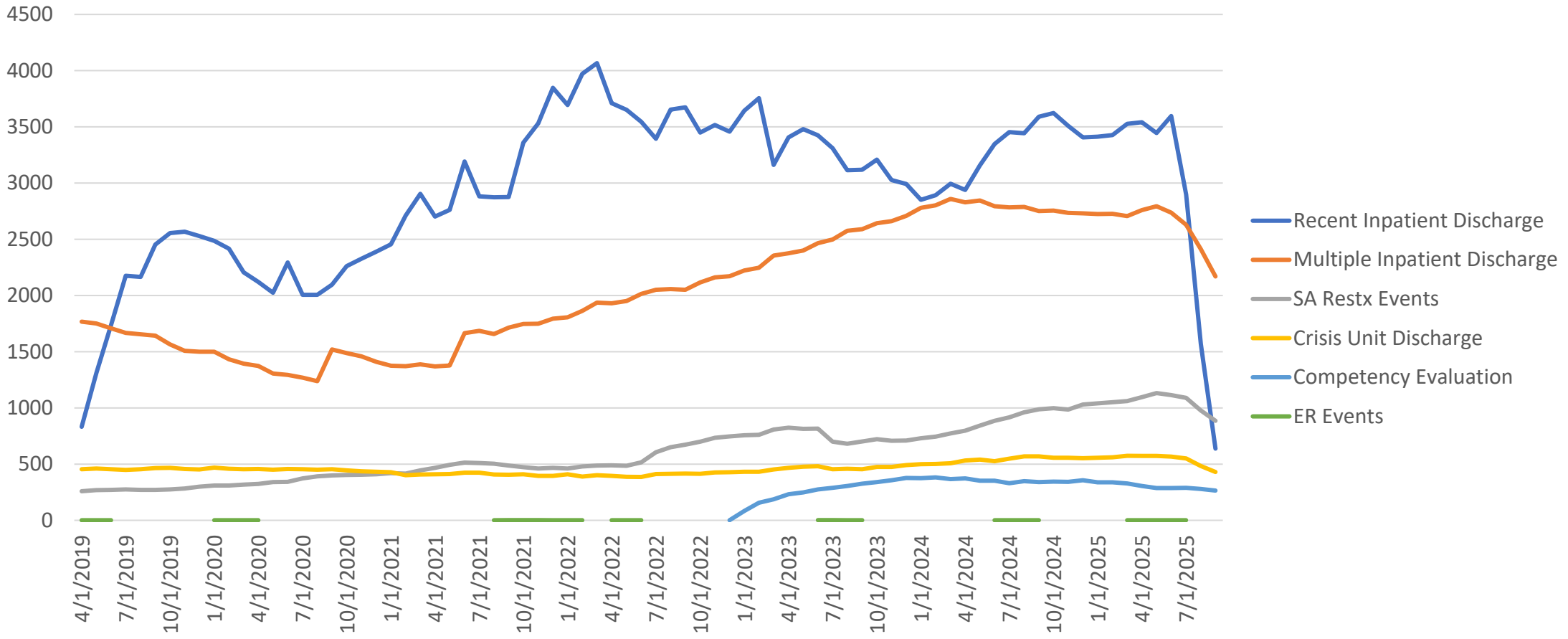
Note: Due to 12-month look-back and data lag, later months will naturally have fewer individuals.

Oklahoma's MIN List Count by Month



Note: Due to 12-month look-back and data lag, later months will naturally have fewer individuals.

Which criteria adds person to MIN List?



Note: Due to 12-month look-back and data lag, later months will naturally have fewer individuals.

Average Cost of Services for Previous Year

- Top 1 Percent: $139,938.70
- Top 10 Percent: $65,278.71
- Top 25 Percent: $40,921.11
- Top 50 Percent: $26,167.84
- Top 90 Percent: $16,197.11
- All MIN List: $14,620.65

Top 10 on MIN List Cost

Client 1: $227,417.76
Client 2: $226,451.61
Client 3: $221,382.06
Client 4: $204,175.35
Client 5: $194,458.46
Client 6: $191,369.93
Client 7: $186,170.60
Client 8: $182,395.78
Client 9: $175,833.31
Client 10: $173,494.42

Medicaid Psychiatric Inpatient & ER Visit Data Flow

📥 Data Sources

- **OHCA/Medicaid Authority MMIS**
  - *Weekly retrieval of psychiatric inpatient & ER visit data*
- **ODMHSAS Authorization System (PICIS)**
  - Inpatient admissions/discharges
  - Crisis Unit activity
  - Substance Abuse Residential Treatment (SA Restx)

🔄 Data Distribution & Usage

- **Daily Emails** → Sent to **Care Coordination Team** for individuals on the **MIN List**
- **Weekly Reports** → Used to **update the MIN List**
- **Provider Systems** → Most providers **automatically download** updated MIN List weekly
- **Reports Include**:
  - Individual **addresses**
  - **Previous treatment history**

Active Client - Daily Email Example

Care Coordination - Message (HTML) (Read-Only)

File Message Help Tell me what you want to do

Share to Teams | Mark Unread | Find | Zoom | Phish Alert Report

Care Coordination

Ralstin, Austin
To McEntire, Malissa; Cao, Christine; Fonte, Shirley; Lovett, Jeanetta; Lyde, Leonard; Green, Christina

Reply | Reply All | Forward

Mon 7/14/2025 8:00 AM

Good morning Malissa and team,

Please note: Due to the presences of PHI, this list should remain internal.

This list contains individuals that were enrolled as a CCBHC recipient as of last Friday (07/11/2025), present on the Most In Need (MIN) list as of 07/14/2025, and received an admission at an elevated level of care since last Friday.

Care Coordination alerts

CCBHC Provider	Elevated Provider	Treatment Level	Admit Date	Recipient ID	Name
FAMILY & CHILDRENS SVCS	GRAND LAKE MENTAL HEALTH CENTE	Residential Treatment	2025-07-11	PHI	
GRAND LAKE MENTAL HEALTH CENTE	GRAND LAKE MENTAL HEALTH CENTE	Residential Treatment	2025-07-11		

Austin D. Ralstin, PsyD
Oklahoma Dept. of Mental Health and
Substance Abuse Services

procedure located at tableau.dbo.Email_Care_Coordination

NOT Active Client - Daily Email Example

Care Coordination Non-CCBHC Recipients - Message (HTML) (Read-Only)

File Message Help Tell me what you want to do

Share to Teams | Mark Unread | Find | Zoom | Phish Alert Report

Care Coordination Non-CCBHC Recipients

Ralstin, Austin
To McEntire, Malissa; Cao, Christine; Fonte, Shirley; Lovett, Jeanetta; Lyde, Leonard; Green, Christina

Reply | Reply All | Forward

Mon 7/14/2025 8:00 AM

Good morning Malissa and team,

Please note: Due to the presences of PHI, this list should remain internal.

This list contains individuals **NOT** enrolled in a CCBHC recipient as of last Friday (07/11/2025), yet present on the Most In Need (MIN) list as of 07/14/2025, and received an admission at an elevated level of care since last Friday.

Care Coordination alerts

CCBHC AREA	Elevated Provider	Treatment Level	Admit Date	Recipient ID	Recipient City	Name
RR/NC/Hope	GRAND LAKE MENTAL HEALTH CENTE	Residential Treatment	2025-07-12	PHI		
None	GRAND LAKE MENTAL HEALTH CENTE	Residential Treatment	2025-07-12			
CRS/FCS/CREOKS/Grand	GRAND LAKE MENTAL HEALTH CENTE	Residential Treatment	2025-07-12			
NCBH	RED ROCK CMHC	Community-Based Structured Crisis	2025-07-11			

Austin D. Ralstin, PsyD
Oklahoma Dept. of Mental Health and
Substance Abuse Services

procedure located at tableau.dbo.Email Care Coordination 2

Care Coordination Team

👥 Who We Are

- A **dedicated team of 4 professionals**
- Focused on supporting high-need individuals through coordinated care

🔗 Key Responsibilities

- **Collaborate with CCBHCs** and psychiatric facilities statewide
- **Monitor and follow up** with individuals on the **MIN List**
- Ensure timely communication and continuity of care across systems

📈 Impact

- Strengthens care transitions
- Reduces unnecessary hospitalizations
- Improves engagement with treatment plans

- Video from:
- Christine Cao
- Care Coordinator
- ODMHSAS

Mic

RE: follow up

2025-08-22 15:21 UTC

Recorded by
Reynolds, Mark A

Organized by
Reynolds, Mark A

Care Coordination Team - Video Transcript

Hi, I'm Christine Cao, one of the Care Coordinators at the Oklahoma Department of Mental Health and Substance Abuse Services in Oklahoma. What we do is we work with the Most In Need individuals in the state. These are the individuals who are frequent in our crisis units, inpatient facilities, and emergency room. There's a total of four of us on a team and we are each side to assigned to different agencies.

What we do is we want to make sure that we partner with our outpatient facilities in the community to ensure that when these individuals are discharged that they have a place to go and that they don't fall through the cracks. Our primary goal is to make sure that they're served and then they don't go back into the system numerous times. Essentially what we do is we work as liaisons with different agencies in our community to make sure that they get the services that they need.

Whenever our community partners are struggling with one of these individuals and they can reach out to us to see what we can do to assist to offer additional assistance. What that typically looks like is we'll have staffings for them and then that's where we get together bring in any additional resources that partners and the community that may be helpful. Then we staff the case to see what we can do to help get these individuals the resource and help that they need.

Through the partnership with our outpatient providers, the state hospitals and any other partners that may be helpful, we've had quite a few successes. A couple of examples that come to mind are we had a jail liaison that we worked with. Then he started noticing that there is an individual who started having mental and physical health decline. The individual didn't know why he was there anymore. He reached out - the jail liaison - to the care coordination and we staffed the case. With staffing we brought in our supervisor to help as well. What ended up happening was we reached out to the judge and the DA to help petition to move this individual to a healthcare facility that would better help and serve his needs. It took after four months; he was approved and was able to be moved to a proper facility for his needs. So that was a success story.

We have another one that comes to mind is there is this individual that we work with and she was numerous times she's been in and out of the hospitals quite sometimes. We'll think that we helped her and it went OK and then like she'll be back again. So numerous staffing and this individual had dementia neurocognitive decline, a victim of domestic violence, her mom just passed, she's had multiple failed placements, abandonment, just like a slew of things. We never gave up on her and neither did the state hospitals that we worked with. After many trials we were able to get her Social Security benefits and she received funds or money from her mom's estate to help her. Then also we were able to find nursing home with memory care that we were able to get her set up with. Then APS (Adult Protective Services) also got involved and offered support as well. So that is another one of our success stories as examples.

Yeah I guess that's it and if you have any questions again my name is Christine Cao and you can reach out to Mark and he can give you my contact information. I'll be happy to answer any other questions that you may have. That's it, thank you.

Provider Perspective Video – John Gavino, Family & Children's Services in Tulsa, OK

Provider Perspective - Video Transcript

Hello, my name is John Gavino, LCSW, Director of CBHC Fidelity and Compliance at Family and Children Services in Tulsa. OK, I'm honored to join you today to share how we use the most in need list or MIN list in partnership with Oklahoma Department of Mental Health and Substance Abuse Services.

For over 120 years, Family and Children Service's has been Tulsa's mental health safety net. We serve over 50,000 individuals each year with a full spectrum of behavioral health services and integrated care. As a CBHC since 2021, we provide inclusive whole person services across the lifespan, regardless of income, insurance, replace residence with 10 clinic sites and over 170 embedded community-based locations and partnerships. We truly meet people where they are.

One of the most powerful tools in identifying and responding to some of our most vulnerable and high-risk clients in our community is the MIN list. The list flags individuals at elevated risk of crisis and often disengagement from care. Often these individuals have multiple psychiatric inpatient hospitalizations, ER visits and crisis episodes. We receive MIN's elevated alert emails almost daily. We review the updated MIN list monthly to identify new clients on the list, and we track a specifically targeted men cohort annually.

When someone appears on the list, especially during or following inpatient stays, we immediately notify the treatment team and partnering providers time is essential. Embedded staff begin engagement with the client. They start care coordination and discharge planning. Sometimes we complete the outpatient intake before the client discharges from the inpatient facility. We provide transportation to ensure clients can begin services without delay. Removing barriers can mean the difference between recovery or another crisis. Once the list is reviewed for clients not admitted to services or specialized men's outreach teams take action, they conduct intensive searches using every available data source, such as our electronic health record care fragmentation alerts from the health information exchange, jail bookings, shelter, check-ins, etc.

If the client has a history with us, we reactivate our touch points, contacting their emergency contact or treatment. Advocates send HIPAA compliant text messages, letters and we conduct in person field-based outreach to shelters, encampments or known addresses. But outreach is only one element of our service delivery. We use MIN data in our population health management dashboards, and it's weighted in our risk stratification reports. This helps inform clinical decision making and ensures that we align each client's level of risk to the appropriate level of care and treatment team.

For example, with the clients and housed, we refer to our homeless outreach team. If psychosis is present, we do refer to our pact factor navigate teams. If substance use is identified, we refer to our substance use specialized programs and for traditional clients without a defined eligible criteria, we assign them to one of our bridge teams. We maintain close partnerships with inpatient crisis facilities, hospitals, detox centers and substance use residential facilities to coordinate discharge planning and continuity of care. Equally critical is prevention through mobile crisis response crisis hotlines, field outreach and proactive discharge planning, we aim to intervene before someone escalates to the point of landing on the mid list.

Let me share a quick success story. The youth client on the men list is now successfully engaged in problematic sexual behavior treatment. Trauma focused CBT, service coordination and child psychiatry. He attends weekly therapy, monthly medication management, and family support. Questions, sense, engagement. He and his family have seen significant improvements in home stability and safety, trauma, symptom management, school attendance and overall stability. This is a power of an all-hands-on deck, tailored approach to care.

Of course there are challenges. Clients can be extremely difficult to engage or even to locate. Needs are very complex, and resources don't always match the intensity required. But the MIN list provides us with a shared framework and real time data to ask what are we doing right now for this client. This is how do we ensure that they get the right care at the right time and the right dosage to support engagement and recovery.

I want to thank Mark Reynolds and the rest of the ODMHSAS staff for championing this initiative and thank you for the opportunity to share how Family and Children Service's uses the MIN list to improve lives and now comes every day in Tulsa. If you would like to learn more, please contact Mark so he can facilitate an introduction. Thank you.

CCBHC Incentives for MIN List Engagement

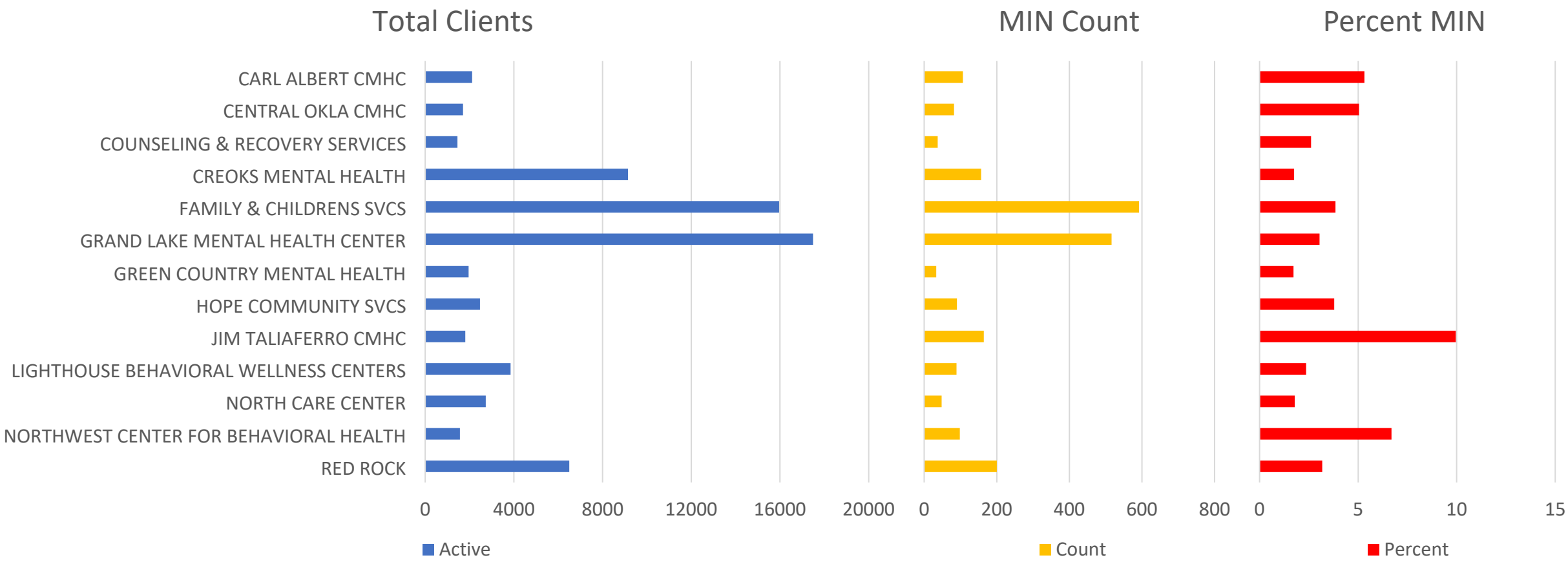
✅ Eligibility Criteria

- To qualify for the incentive, individuals must:
  - Be listed on the **Most in Need (MIN) List** during the month
  - Be **actively engaged** in services at a **Certified Community Behavioral Health Clinic (CCBHC)**

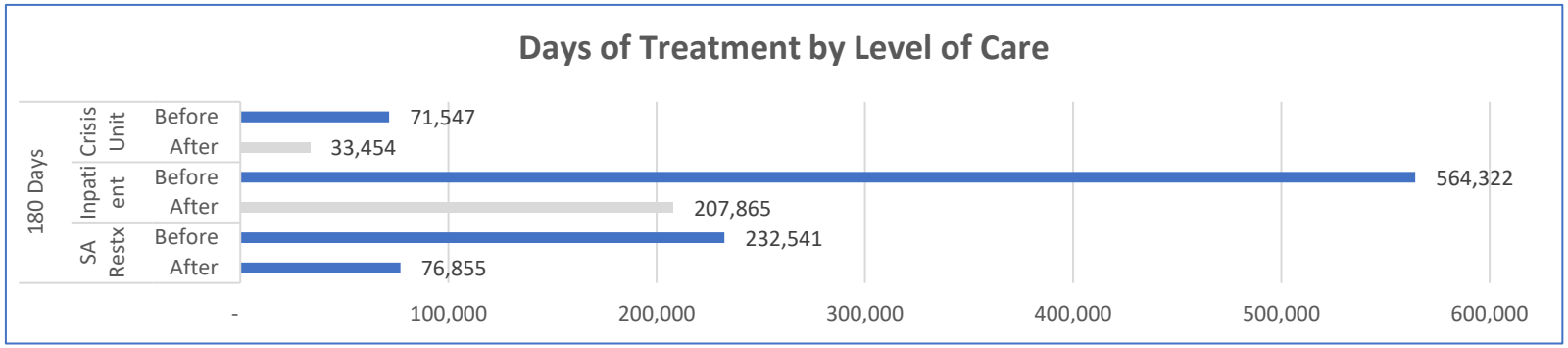
📈 Billing Enhancement

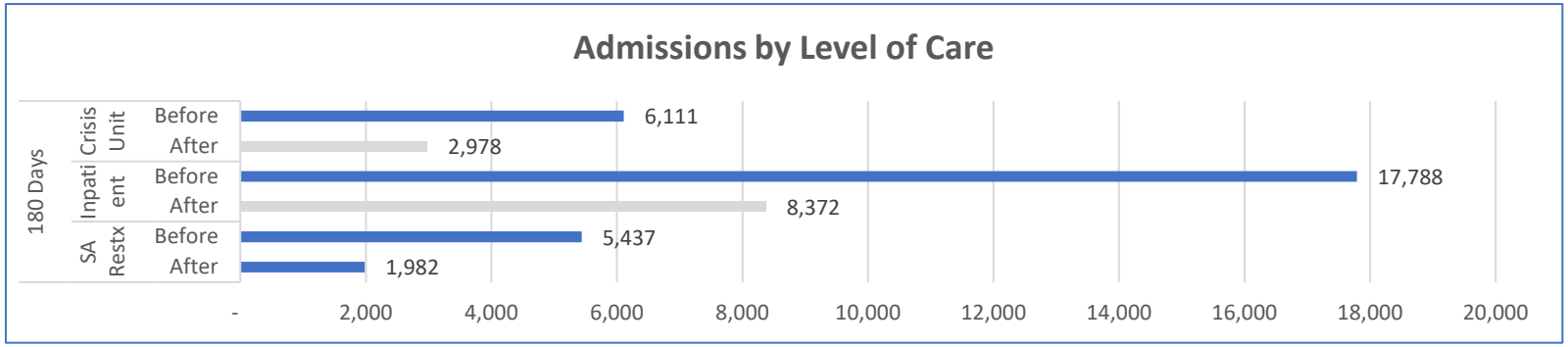
- Providers may **bill an additional monthly rate** on top of their standard CCBHC rate
- **Incentive range: $311.19 – $970.81**, depending on the CCBHC's structure and service model

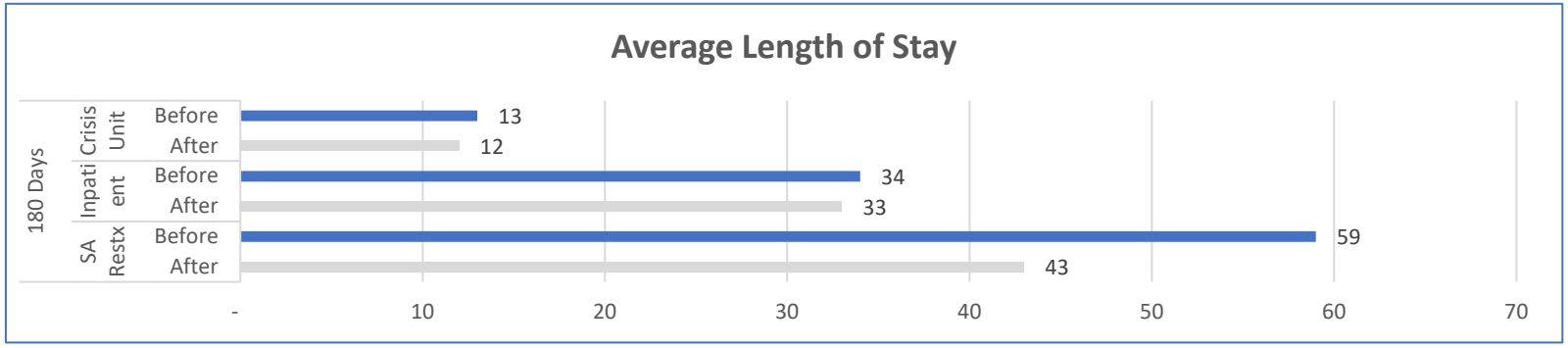
Number of Active MIN by CCBHC



Results







Disclaimer: No direct correlation is implied.

Lessons Learned & Key Challenges

🔄 Sustained Engagement Cycle

- **Engage providers**, deliver **targeted training**, secure **funding** → Repeat consistently to maintain momentum and impact

📊 Data Limitations

- **Insufficient access to Criminal Justice data** → Limits ability to track outcomes and coordinate care effectively

⏳ Reporting Delays

- **Lag in data reporting** affects timely decision-making and performance evaluation

Criteria for Inclusion Detail

Clients are added to the MIN list based on one of the following criteria:

- 2 or more psychiatric inpatient discharges in the past 12 months.
    - This includes ODMHSAS and non-ODMHSAS psychiatric inpatient providers who report to Medicaid.
- 3 or more crisis unit discharges in the past 12 months.
    - This only includes ODMHSAS crisis unit providers.
- 12 or more ER visits in the past 12 months with a mental health or substance abuse diagnosis associated with the visit.
    - This only includes individuals reported to Medicaid.
- 2 or more ODMHSAS Substance Abuse Residential Treatment discharges in the past 12 months.
    - This only includes ODMHSAS Substance Abuse Residential Treatment providers.
- 1 psychiatric inpatient discharge in the past 3 months. This includes non-ODMHSAS psychiatric inpatient providers.
    - Note: This could have overlap with the first criteria but allows individuals with only 1 inpatient discharge in past 3 months. This includes ODMHSAS and non-ODMHSAS psychiatric inpatient providers who report to Medicaid.