



Meeting Youth Where They Are: Building an Effective Mobile Crisis Response Program

Alecia Cyprian, PhD | Southeast Community Health Systems

Objectives:

Upon completion of this educational activity, you will be able to:

- 1** **Describe** the core components of a 24/7 youth mobile crisis response program delivered in community settings.
- 2** **Identify** key implementation strategies used to establish staffing, referral pathways, and payer coverage for community-based youth crisis care.
- 3** **Apply** lessons learned from one year of program data to expand access to youth behavioral health services within your own health center.

Faculty Disclosure



Alecia Cyprian, PhD

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Has no relevant financial relationships with ineligible companies to disclose.

- Planning committee members and content reviewers for this activity have no relevant financial relationships with ineligible companies to disclose.
- This presentation contains no discussion of off-label or investigational use of pharmaceuticals or devices.
- All program data presented is de-identified and reflects Southeast Community Health Systems operations.
- This session references suicide and youth behavioral health crises. Content is presented without clinical detail or method.

Where We Are Going

Sixty minutes, four questions.



Why

What the need looks like for Louisiana youth, and what happened before the program existed.



What

How the Louisiana youth crisis system is designed and where YMCR sits inside it.



How it is going

Two reporting periods of encounter data, and what the numbers changed about our staffing.



What we would tell you

Barriers, quality improvement cycles, and where to start on Monday.

The Need in Louisiana

Youth behavioral health need is high; the workforce to meet it is not evenly distributed.

74,000

Louisiana adolescents experience a major depressive episode each year

49,000

Louisiana adolescents have serious thoughts of suicide each year

22%

of Louisiana youth ages 0–17 have experienced two or more adverse childhood experiences

#41

Louisiana's rank out of 51 for youth mental health status and access to care

- More than 3 million Louisianans live in communities without enough mental health professionals.
- Suicide-related emergency department visits among Louisiana adolescents cluster during the academic year, not the summer — a pattern our own monthly volume mirrors.

Sources: NAMI Louisiana state fact sheet (data compiled March 2025); Mental Health America, 2025 State of Mental Health in America; peer-reviewed analysis of Louisiana adolescent suicide-related ED visits, 2021–2023.

Before YMCR: The Default Pathway

In our parishes, a young person in crisis had two realistic options.



The emergency department

A long drive to an ED not designed for pediatric behavioral health, often followed by a wait for a bed that never came.



Law enforcement

A crisis handled as a public safety event rather than a health event, with all the consequences that follow.



Or nothing at all

An outpatient appointment three weeks out is not a plan for a child in crisis tonight.



No warm handoff

Stabilized and released without a named clinician, a follow-up date, or a connection back to school.

The program goal we wrote down: reduce unnecessary emergency department utilization and law enforcement involvement for youth in behavioral health crisis, while ensuring timely access to compassionate, community-based care.

Louisiana's Crisis Continuum

Three pillars — and youth services were built after, and differently from, the adult system.



Someone to talk to

988

Free, confidential, 24/7. Louisiana has two in-state certified 988 centers with national backup.



Someone to dispatch

Louisiana Crisis Hub

Operated by Carelton Behavioral Health under contract with LDH, routing callers to local crisis providers.



Someone to respond

MCR and CBCS

Mobile teams deploy to where the young person is. This is where Southeast Community Health Systems sits.

An important distinction for anyone replicating this

The Louisiana Crisis Response System launched in 2022 for Medicaid members age 21 and older. Behavioral Health Crisis Care is 18+ and Crisis Stabilization is 21+. The youth crisis response system — ages 0 through 20 — was built afterward as a separate expansion, and it is mobile-first by design.

Kids Are Not Tiny Grown-Ups

Louisiana's own guidance on why youth crisis response has to be designed differently.



The caller is usually not the youth

It is a parent, a foster parent, a teacher, a school nurse, a probation officer, or a physician. Your access strategy has to reach adults, not teenagers.



Telephone response works less well

Youth are best served face-to-face, in the home or the community. Youth mobile teams operate on a "just go" approach.



Lived experience carries credibility

A Family Peer Support Specialist is a parent or caregiver who has raised a child with complex behavioral health, child welfare, or juvenile justice involvement.



The crisis is defined by the caller

A sudden change in living situation — a removal, a new foster placement — can itself be the crisis. If the family calls it a crisis, it qualifies.



Who We Are

A rural FQHC serving southeast Louisiana since 1992 — and the designated youth crisis response provider for two LDH regions.

4

parishes with clinics

St. Helena, Tangipahoa,
East Baton Rouge,
Livingston

21

service sites

6 community health
centers,
14 school-based sites,
1 mobile medical unit

12,000+

patients per year

Medical, dental,
behavioral
health, pharmacy, WIC

12

**parishes covered by
YMCR**

Regions 2 and 9 —
wider than our clinic
footprint

Joint Commission accredited • NCQA Patient-Centered Medical Home • HRSA Section 330 grantee • First Louisiana health center to earn NACHC Advocacy Center of Excellence Gold status

If a health center this size can stand up a 24/7 mobile crisis program, most health centers in this room can too.



YMCR at a Glance

Southeast Community Health Systems was identified by LDH Office of Behavioral Health as the MCR and CBCS provider for Regions 2 and 9.

24/7/365

Ages 0–20

12 parishes

2 regions

Region 9 — Independence Clinic

Livingston • St. Helena • St. Tammany •
Tangipahoa • Washington

985-247-0816

24 hours a day, every day of the year

Region 2 — Zachary Clinic

Ascension • East Baton Rouge • East
Feliciana • Iberville • Pointe Coupee •
West Baton Rouge • West Feliciana

225-713-3208

24 hours a day, every day of the year

Program launched June 2, 2025.

- YMCR is licensed by the Louisiana Department of Health, Office of Health Standards, and operates as a separate line of business within the organization.
- Our own school-based health centers are referral points as well as clinics — we have responded to a crisis at one of our sites.

Two Services, One Continuum

Both are face-to-face, time-limited, voluntary, and available 24 hours a day.



Mobile Crisis Response (MCR)

- Initial, emergent response during the first phase of a crisis
- Dispatched after a triage screening determines MCR is the right service
- Required on-site response: one hour urban, two hours rural
- Continues until the youth can safely remain in the community or is linked to a higher level of care



Community Brief Crisis Support (CBCS)

- Follow-up within 72 hours by telehealth, then face-to-face community support up to 15 days
- Keeps the youth at home while de-escalating and coordinating with local providers
- Includes the caregiver, not just the youth
- Referred from MCR, the MCO, a crisis center, or an emergency department presentation

Neither service replaces existing behavioral health care. Both exist to keep a young person out of an emergency department and an inpatient bed when the community can safely meet the need.

The Team Behind the Response

The staffing model required by the state — and how our team changed after go-live.



Screener



Family Peer Support
Specialist



Licensed professional



Care coordinator



Nurse



Prescriber

Licensed professionals include LCSW, LPC, LMFT, LMSW, PLPC, or PLMFT. A management team of agency administrator, medical director, and clinical supervisor sits above the response teams.

We launched small, then grew into it

Two behavioral health therapists and four Family Peer Support Specialists covered both regions at go-live. The team is now three clinicians, including the program director, and seven Family Peer Support Specialists. A small team that actually shows up beats a large team that is still hiring.



How We Built It

Four phases — and one we would reorder if we did it again.

01

Assess and design

Mapped where youth in crisis were actually going and designed the service around behavioral health capacity we already had.

02

Recruit and credential

Hired the crisis team, set up supervision and on-call rotation, and stood up the 24/7 answer point.

03

Launch

Went live June 2, 2025, across both regions with two therapists and four Family Peer Support Specialists.

04

Contract and bill

Completed credentialing with managed care organizations, building the billing foundation the program runs on today.

What we would sequence differently

Community need moved faster than the credentialing timeline, so the program went live while MCO contracting was still in progress. That shaped early billing capacity. Credentialing is now complete with roughly 90% of MCOs, and starting it earlier would smooth the first year for anyone following this path.

Reach Strategy: One Number, Always Answered

Awareness work is not marketing. It is access.



Schools and Head Start

Counselors, principals, and school nurses are the referral source most likely to recognize a crisis first.



Law enforcement

Officers need an alternative they can actually reach at 11 p.m. on a Saturday, or they will default to transport.



Emergency departments

A standing relationship turns a discharge into a referral instead of a repeat visit.



Families directly

Word of mouth between caregivers is the highest-trust referral channel we have.

We must be able to receive phone calls 24 hours a day, 365 days a year — from agencies and from families.

Region 9: 985-247-0816

Region 2: 225-713-3208

The Crisis Coalition We Built

A referral network is something you construct on purpose, partner by partner.



Schools and Head Start

Counselors, principals, and school nurses recognize a crisis first, across school districts in all 12 parishes.



Group homes and child welfare

A placement change can itself be the crisis. Residential staff and DCFS workers are among our most frequent callers.



Law enforcement

Officers need an alternative to transport that actually answers at 11 p.m. on a Saturday, or they default to the ED.



Faith-based organizations

Pastors and youth ministers often know a family is struggling before any clinician does. They needed a number they could call.

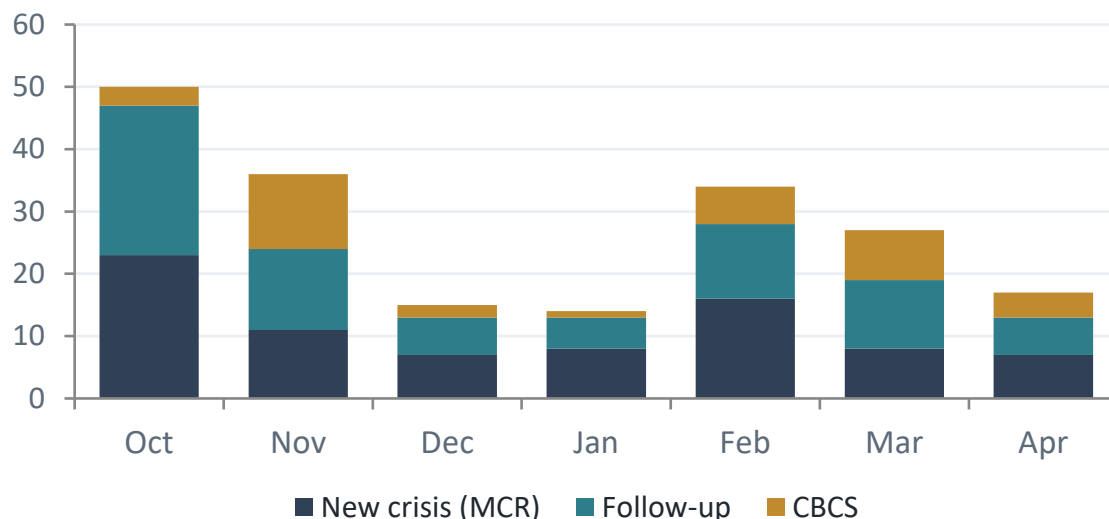
What the coalition produced: a published Youth Mobile Crisis Coalition Resource Guide, updated as new partners join.

shchc.org/youth-mobile-crisis • Partners are added on request.

The First Eleven Months

Two reporting periods since launch, and what the numbers changed about our staffing.

Monthly visits by type, Oct 2025 – Apr 2026



397

total visits since launch

201 / 196

first period / second period

74

unique youth, Oct – Apr

0

accidents since inception

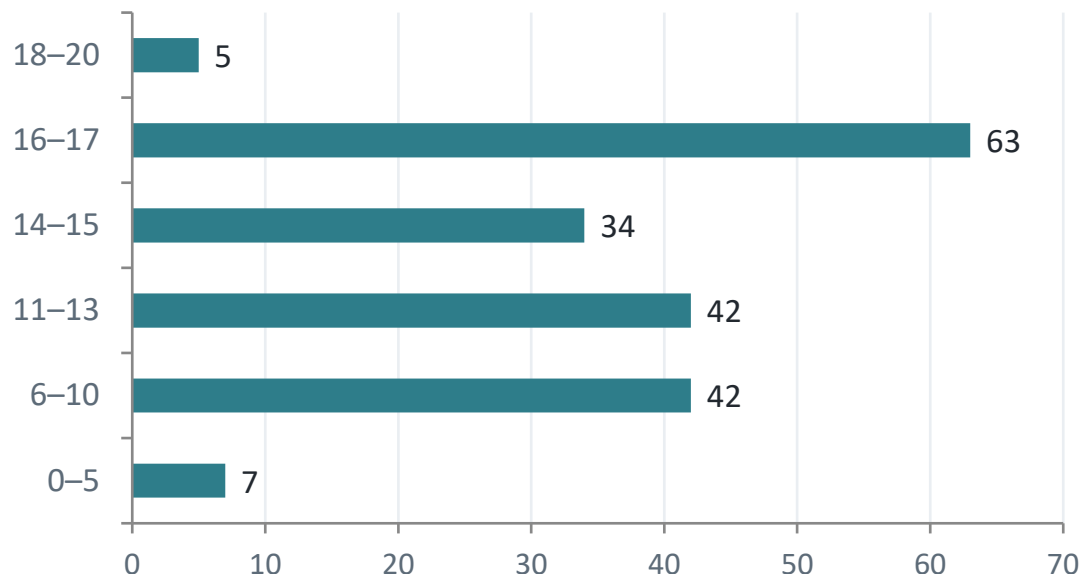
- Volume follows the school calendar: a 50-visit October, a December trough, a February rebound.
- Follow-up and CBCS account for 113 of the 193 classified visits. Most of the work happens after the first response.
- Peak demand runs 9 a.m. to 8 p.m. in Region 2, with an evening peak in Region 9. Families call after work.

97.4% of visits completed

Sources: YMCR Program Board Reports, June 2 – September 30, 2025 and October 1, 2025 – April 30, 2026. Visit-type detail classifies 193 of the 196 most recent visits.

Who We Serve: Age and Gender

Visits by age group



89.3%

of patients served are under 18 — the program is reaching its intended population.

Gender

Female 56.6% (111)
Male 41.8% (82)
Not recorded 1.5% (3)

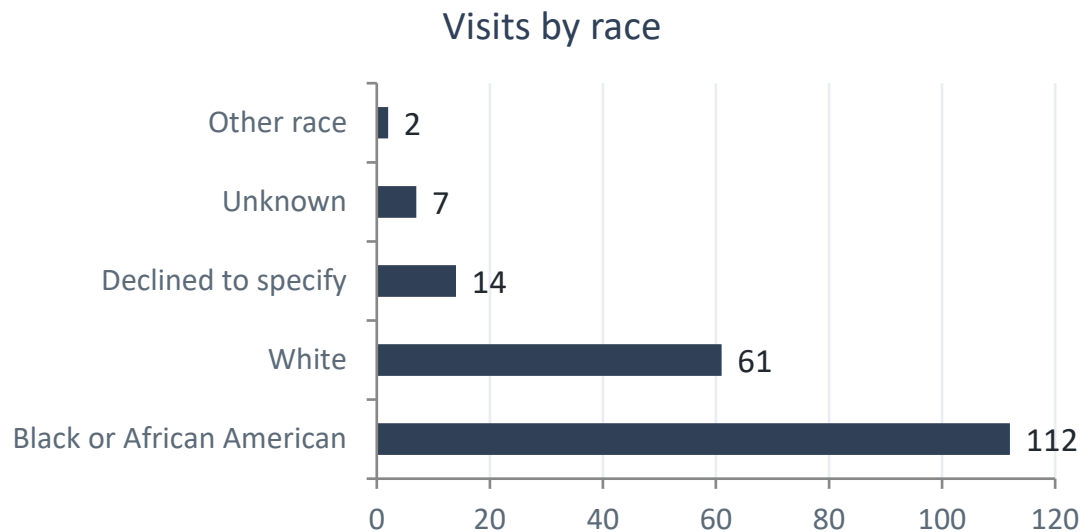
16-17 is now the largest group at 32.6%, ahead of middle-school-age youth.

The age profile shifted between reporting periods — high-school-age youth moved from a middle tier to the largest single group. Worth watching, because it changes where outreach should go.



Closing a Data Gap: Race and Ethnicity

A field we were not capturing a year ago.



10.7%

of visits still lack a recorded race or ethnicity — our current improvement target.

Ethnicity

Not Hispanic or Latino 86.7%
Hispanic or Latino 4.1%
Declined to specify 5.6%
Unknown 3.6%

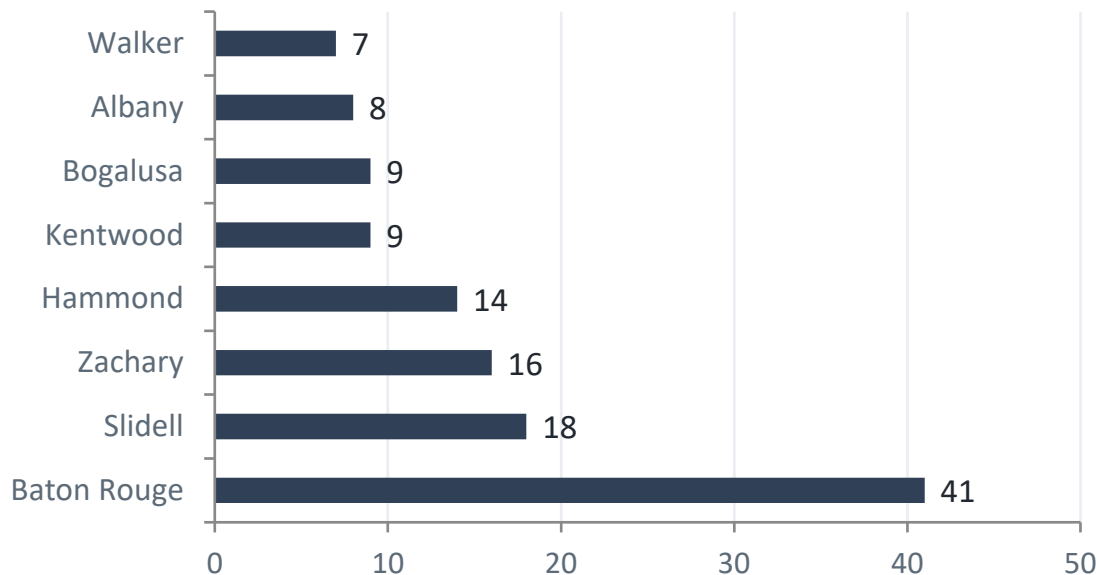
This slide did not exist last year

Our earlier extracts did not capture race or ethnicity at all, so we could not describe who the program reached. Black or African American youth account for 57.1% of visits and White youth for 31.1%. Adding the fields was its own quality improvement cycle.



Where We Serve

Top cities by visit volume, Oct 2025 – Apr 2026



27 cities

and 57 ZIP codes reached across 12 parishes.

The regions have evened out

Jun–Sep 2025: Region 2 carried 139 of 201 visits (69%).

Oct–Apr: Zachary 102 (52.8%), Independence 91 (47.2%).

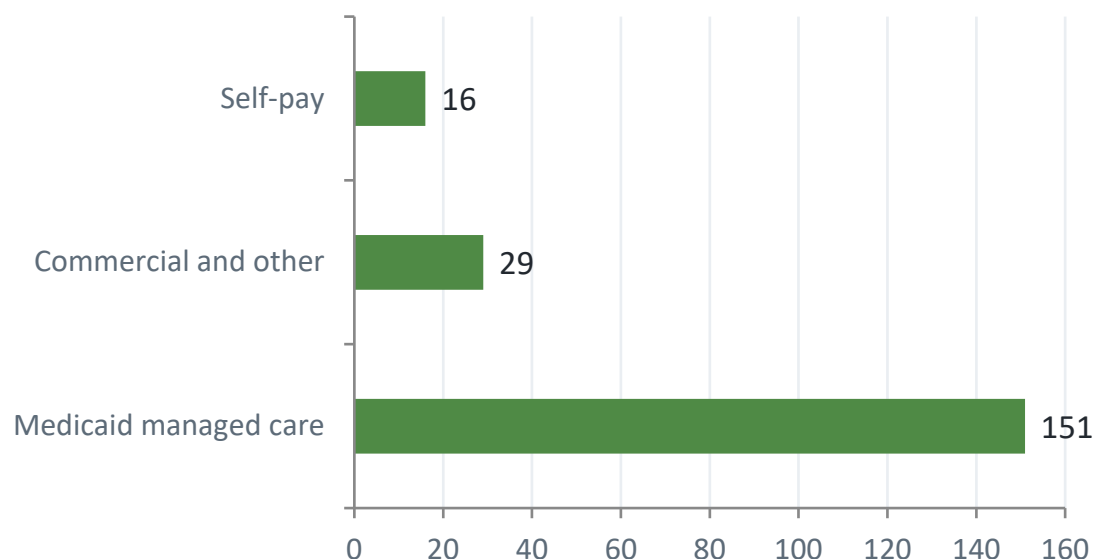
Referral relationships, not population, drive where the calls come from.

Mobile response means the service radius is wider than any clinic waiting room — and drive time is a real cost line, not a rounding error.

Making It Sustainable

A crisis program funded only by grants has an expiration date.

Visits by coverage type, Oct 2025 – Apr 2026



91.8%

of visits are covered; 77% through Louisiana Medicaid managed care. Self-pay is 8.2% and climbing.

What made that possible

- Credentialing with roughly 90% of Louisiana MCOs
- Crisis codes built into the EHR at the point of care
- FQHC sliding fee scale removes cost as a reason a family hesitates to call
- Grant dollars reserved for start-up and expansion, not core operations

Three revenue lines, not one

Medicaid managed care covers the operating base. ARPA crisis dollars, administered through the Louisiana Crisis Hub, fund start-up and expansion only. Health center infrastructure — billing, credentialing, IT — carries the rest.

How the Money Actually Moves

The state selects the provider. A contracted administrator moves the dollars. Both facts matter.



LDH selects, Carelon administers

Carelon Behavioral Health administers the Louisiana Crisis Hub under contract with LDH. LDH selects providers and sets award amounts; Carelon is the pass-through.



Two agreements, not one

A Facility Participation Agreement governs referrals dispatched to us through the Hub. Separate grant agreements, one per region, govern the ARPA dollars.



The dollars are milestone-based

Half on being operational and delivering the expected scope of services by a set date. Half on demonstrating real-time documentation in the state crisis platform.



Supplement, not supplant

Grant funds cannot replace Medicaid, commercial, or other revenue you would have earned anyway. Budget them as start-up and expansion money from day one.

What This Program Unlocked

Crisis capability is the CCBHC requirement most health centers cannot meet.



All three crisis components, or you do not certify

CCBHC criteria require emergency crisis intervention, 24-hour mobile crisis teams, and crisis receiving and stabilization — directly or through a state-sanctioned partner.



We already run two of the three

A licensed 24/7 mobile crisis team and a 24-hour answer point tied to 988 and the Crisis Hub. Our response standard is tighter than the federal expectation.



The gap is beds, and it is honest

Crisis receiving and stabilization is a physical footprint holding someone 24 to 72 hours. In Louisiana that service is currently 21 and older. We cannot build it alone.



The window is open now

Louisiana joined the CCBHC Medicaid demonstration in May 2026. Cost-based prospective payment changes the arithmetic of behavioral health inside a health center.

Barriers We Are Still Working

The honest version.



Financial sustainability

After-hours staff must be compensated at minimum wage plus overtime under legal guidance. Sustaining multiple FPSS positions for continuous coverage strains the operating budget.



Credentialing and billing

Going live while MCO contracting was still under way shaped early billing capacity. Credentialing now covers roughly 90% of MCOs and reimbursement continues to strengthen.



Supervision capacity

Each FPSS requires four supervision hours per month, including one individual in-person hour. A single credentialed supervisor across two regions is a compliance risk.



Recruitment and onboarding

Hiring and onboarding new FPSS candidates takes longer than the schedule allows, and orientation hours are expensive.

Every one of these became a quality improvement cycle rather than a complaint.

Quality Improvement in Practice

Three Plan-Do-Study-Act cycles running right now.



Follow-up calls

Aim: two follow-up calls per crisis within 72 hours and four encounters per CBCS referral.

Standardized script and EHR fields; FPSS owns the call. Expand if completion reaches 70% with positive family feedback.



Cohort onboarding

Aim: cut orientation cost per FPSS without cutting orientation quality.

Nine required daytime training shifts plus evening shadowing, delivered to a cohort rather than one hire at a time.



Dual supervision

Aim: meet the four-hour monthly supervision standard for every FPSS in both regions.

A second supervisor certifying for Region 9 while the original supervisor retains Region 2, with a written coverage matrix.

What we measure every period: visit completion rate, volume by service type and region, follow-up rate after an initial crisis response, supervision compliance, geographic reach, race and ethnicity, and unique youth served.

What It Looks Like on the Ground

Two de-identified examples from our first year.



A school after a student death

After the death of a high school senior in Pointe Coupee Parish, the team deployed to the campus and stayed on site for three days — providing emotional stabilization for students and staff and working alongside faculty, counselors, and the local FQHC on grief processing and crisis management.

Postvention is crisis response. Build for it.



An 18-year-old with nowhere to go

A foster youth who had left her group home and was sleeping outdoors. The team provided safety, emotional grounding, and connection to ongoing counseling. She re-enrolled in school, began part-time work, and remained stable.

Consistent, trauma-informed care beats one good visit.

Seventy-four young people in seven months is a small number. It is also seventy-four families who did not spend a night in an emergency department waiting room.

Lessons Learned



Response time is the whole product

Families judge the program by how fast someone arrives. The one-hour urban and two-hour rural standard drives everything else.



Start credentialing early

MCO contracting takes longer than any project plan assumes. Begin it well before you set a launch date.



Cross-coverage is worth the effort

In the first period one clinician delivered 107 of a region's 139 visits. In the most recent period the top two carried 48% and 46% — a deliberate rebalancing.



Follow-up is where outcomes live

Crisis response without stabilization and linkage just resets the clock. Follow-up and CBCS now account for 113 of 193 classified visits.



Add the field, then report it

Race and ethnicity were missing from our early extracts. We added them, and now we can speak to who the program actually reaches.



Partnerships beat marketing

Schools, Head Start programs, and parish school systems send referrals no advertisement would have reached.



Where to Start Monday Morning

- 01** Map where youth in your service area actually go during a behavioral health crisis today.
- 02** Inventory the doors you already have — schools, Head Start, WIC, school-based health sites.
- 03** Start credentialing with your Medicaid plans early — it takes longer than you expect.
- 04** Design for the caller, not the patient. For youth, the caller is almost always an adult.
- 05** Pick three measures you will report every single period and start reporting them now.

Questions?

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