THE ST. PAUL'S CENTER: A COST-EFFECTIVE MODEL OF PSYCHIATRIC CARE

Jeannemarie Baker, MS, RN, PNP
Founding Director, St. Paul's Center of New York, Inc.

Penelope Buschman, MS, RN, PMHCNS-BC, FAAN
Director of Psychiatric Nurse Practitioner Program and Assistant Professor of Clinical Nursing, Columbia University School of Nursing

Joel Gurin
President and Founder, Center for Open Data Enterprise

ABSTRACT

St. Paul's Center (SPC) in New York City operated from 2003 to 2012 as a community-based care center with a unique treatment model. SPC was founded by a group of psychiatric nurse practitioners to serve the socially marginal and chronically mentally ill population who are severely underserved by the larger mental health system. The Center was designed to provide ongoing, comprehensive, and cost-effective psychiatric care to individuals at risk for homelessness, incarceration, and unnecessary hospitalization. Developed, managed, and staffed by psychiatric nurse practitioners, SPC offered assessment of psychiatric disease and treatment including medication management, individual, group, and family therapies, and counseling, education, and crisis intervention.

Because of Medicaid limitations on reimbursement for this type of care, SPC relied primarily on private philanthropic funding for its support. During its years of operation, however, SPC demonstrated the case for public funding of this treatment model. A calculation based on patient records shows that the Center was able to prevent almost all hospitalizations in its patient population in a cost-effective way. In addition, SPC's clinical, academic, and community based partnerships increased its value to the community. There is a good case for a replication of this model, a more thorough outcomes analysis, and changes in Medicaid reimbursement systems to support this model of care.

PROBLEM AND CHALLENGES

St. Paul's Center of New York, Inc. was founded in 2001 to address the needs of individuals suffering with chronic mental illness and at risk for homelessness, incarceration and needless hospitalizations. The Center opened its doors in October 2003 to fulfill its mission of commitment to care for these individuals, especially the poor and homeless, with respect, integrity, compassion, and excellence. As an independent community mental health center managed by psychiatric nurse practitioners, SPC provided an innovative model of care for this population until it ceased operations in 2012.

The Center was intended to address the needs of the homeless mentally ill in a new, cost-effective and compassionate way. Ever since the mass closings of psychiatric hospitals in

the 1960s and 1970s, large numbers of mentally ill individuals have become homeless and destitute. From 1955 to 2010, the number of psychiatric hospital beds in the U.S. plummeted from 300 per 100,000 population to only 14, according to research from the Treatment Advocacy Center GEt. The community care facilities that were supposed to provide care for deinstitutionalized patients have not materialized, at least not at a level sufficient to handle the current population of chronically mentally ill people in America. Many deinstitutionalized people without sufficient supports have become homeless or incarcerated (Torrey 1997, Safran 2009, Glied and Frank 2009).

The problem is reflected in statistics: A recent government report showed that 26 percent of homeless people in the US have a severe psychiatric illness, compared to 5 percent of the general population. (Pearson and Linz 2011). Torrey (1988) has called these homeless and mentally ill persons "the shame of our streets."

The lack of regular care for this population has an economic as well as a human cost. Many people with chronic mental illness are forced to seek intermittent ER and hospital care, care that by its nature is unsuited to the effective treatment of complex and persistent mental illness. Hospitalization in particular is both costly for society and a difficult experience for the patient. Nevertheless, Glied and Frank (2009) have noted rising psychiatric hospitalization rates since 2000 for both children and adults, and posit that this increase reflects a lack of community treatment.

A recent New York Times article summarized the problem (Creswell 2013):

"While there is evidence that other types of health care costs might be declining slightly, the cost of emergency room care for the mentally ill shows no sign of ebbing. Nationally, more than 6.4 million visits to emergency rooms in 2010, or about 5 percent of total visits, involved patients whose primary diagnosis was a mental health condition or substance abuse. That is up 28 percent from just four years earlier, according to the latest figures available from the Agency for Healthcare Research and Quality in Rockville, Md. By one federal estimate, spending by general hospitals to care for these patients is expected to nearly double to $38.5 billion in 2014, from $20.3 billion in 2003. . . .

"Hospitals, which cannot legally turn away any patient seeking care, say the influx of psychiatric patients is straining already busy E.R.'s and creating dangerous conditions. This spring, University Medical Center of Southern Nevada in Las Vegas declared an 'internal disaster,' shutting its doors to arriving ambulances for 12 hours, after mental patients filled up more than half of its emergency room beds."

THE SPC MODEL

At the heart of the SPC model is the work that takes place between the patients and nurse practitioners on a consistent, usually weekly, basis. Treatment includes a full range of psychiatric services: assessment and referral with intensive follow-up for comorbid illnesses related to chronic mental illness; individual, group, and family therapies; medication management; counseling and education; and crisis services. SPC developed a model of care

that is collaborative, continuous and easily accessed, partnering with patients in their treatment. In this model, staff is on call 24 hours a day, 7 days a week.

With a population of homeless mentally ill people who have lost faith in the system, the SPC model is designed to establish trust. It emphasizes access to care, continuity of care, and respect for the patient. The Center won accolades for its treatment model; New York State Senator Thomas K. Duane said that "St. Paul's Center represents an exciting and compassionate alternative for a population which has often been overlooked and underserved."

In its mission statement, the St. Paul's Center was "committed to care for persons suffering from chronic mental illness, especially the poor and homeless, with respect, integrity, compassion and excellence." More specifically, the St. Paul's Center method of care sought to:

- care for people suffering from chronic mental illness who are at risk for homelessness, incarceration, and unnecessary hospitalization
- create partnerships between our patients and caregivers, founded on an evolving and actively fostered mutual trust and respect
- make our care easily accessible to the population we serve
- deliver care that is both comprehensive and continuous
- make unique interventions where we can
- encourage all individuals to reach their maximum potential
- sustain excellence in the programming and delivery of our services
- prepare new psychiatric nurse practitioners
- always seek innovative solutions to the problems of mental illness
- forge and preserve clinical, community, and academic partnerships that make our care stronger
- provide a model for system-wide change in the care of poor and disenfranchised mentally ill people

SPC was the only mental health center in New York, and possibly in the U.S., run and staffed solely by nurse practitioners in psychiatry. It was founded on the belief that community care facilities for the mentally ill run by psychiatric nurse practitioners can offer high-quality care cost-effectively. A recent report by the Urban Institute's Health Policy Center (Bovbjerg et. al. 2009) recommends that policymakers and health care systems could make health care cost less, do more, and be more widely available if they gave a larger role to nurse practitioners. The Executive Director of the Institute for Human Services in Hawaii (Mitchell 2007) strongly advocates for more trained psychiatric nurses to work with the homeless

population, and expresses her concern that most public health systems underutilize nurses by relegating them to hospital work alone, rather than also employing them to lead community-based mental health services.

Lam (1999), Montgomery (1998), Morse (1996), Rosenbeck (1997) and Rowe (1998), in addition to characterizing the mental health system in general as ineffective, report that patients find three things lacking in what care they do receive: respect, continuity of care, and easy access to care. SPC was created to provide these key elements, and founded on the conviction that psychiatric nurse practitioners would be able to fully manage and care for the many needs that the homeless and chronically mentally ill were likely to present.

The SPC staff provided not only a full range of psychiatric services but also primary care services on a regular basis. All patients were encouraged to receive medical screenings. Those with chronic medical illnesses were directed to the appropriate specialists with whom we then maintain regular contact. The unique relationships between the Center's NPs and patients contributed to a positive health outcome.

The Center was also committed to preparing graduate psychiatric nurse practitioners in community psychiatry. SPC operated in close partnership with the Columbia University School of Nursing and engaged many graduate students from Columbia's clinically-focused program for Psychiatric Mental Health Nursing. To this end, The Jonas Center for Nursing Excellence annually supported a Jonas Scholar over five years to be mentored at St. Paul's Center. Continuing education for the staff was also part of SPC's model: Peer supervision took place on a weekly basis, in addition to regular and *ad hoc* meetings with the Center's dedicated collaborating psychiatrist.

SPC also worked closely with the larger mental health community of New York City. The ,epartment of Homeless Services assisted SPC in identifying and contacting the many shelters and drop-in centers around the City of New York who referred SPC's first patients. In addition, SPC reached out to every agency and community organization that in any way interfaced with its target population. Two such organizations include a nationally recognized neighborhood shelter offering beds and services for troubled, runaway youth and an organization that manages transitional housing programs.

The brief case histories of two SPC patients, representative of the hundreds who were treated at SPC, demonstrate the kind of difference that SPC was able to make in people's lives.

The first patient was a woman in her late twenties who came to SPC with a ten-year psychiatric history of bipolar I disorder and borderline personality disorder. She had moved from her home town to New York City during a manic episode and ended up in a crisis center that referred her to the SPC team. Before coming to SPC, her suicidal ideation and suicide attempts had led to about one psychiatric hospitalization a year over several years. At the outset of her care regimen at SPC, this young woman was in perpetual conflict with her immediate family members and struggled to form and maintain human relationships of any

kind. The symptoms of her chronic mental illness were largely unchecked and she had almost no tools at her command to manage them.

Through weekly individual supportive therapy and instruction in medication management, she learned to manage her condition and was able to live a life far less inhibited by her chronic mental illness. She did not experience any psychiatric decompensation and required no hospitalization during four years of treatment at SPC. She became an active member and volunteer at two organizations dedicated to the treatment of mental illness, did well in college, and reentered the workforce.

The second patient, a middle-aged man, was admitted to SPC suffering from paranoid schizophrenia diagnosed almost three decades prior to admission. At admission, his symptoms were largely uncontrolled and included depression, paranoid delusions, and command auditory hallucinations, at times resulting in violence toward himself and others. The patient had long attempted to self-medicate with drugs and alcohol and was suffering from polysubstance dependence. His history included multiple psychiatric hospitalizations, detox/rehabilitations, and incarcerations. He was unable to manage his medication and had no access to regular therapy or a caregiver well-enough acquainted with his condition to explore and implement effective treatment options.

St. Paul's Center began to work with this individual through weekly therapy sessions and teaching medication management. With this treatment, his psychotic and depressive symptoms went into remission. He was able to achieve sobriety, a change he attributed to SPC and to his enrollment in Alcoholics Anonymous (AA). By working with Community Access, a non-profit that helps people with psychiatric disabilities find housing, SPC helped this man and his long-time girlfriend obtain a supportive housing arrangement for couples (common for those in stable relationships). At the encouragement of the SPC treatment team, the patient also quit smoking, took up a regular exercise regimen, improved his sleep schedule, and improved his diet.

OUTCOMES AND COST EFFECTIVESS

St. Paul's Center was designed to be a pilot of a new treatment modality, not a rigorous research project. Nevertheless, the basic statistics on treatment outcomes from the Center make the case that SPC provided a cost-effective approach that dramatically improved its clients' quality of life. With a relatively small staff, the Center was able to offer regular therapy to hundreds of patients a year and prevent psychiatric hospitalization in a high-risk population.

Over the two-year period from June 2008 through June 2010:

- 212 unduplicated patients were served at SPC, representing 3,341 attended visits (approximately 20% of the scheduled visits were not attended).
- Additionally, 237 psychiatric evaluations were conducted at SPC for separate housing clearances on unique individuals.

- Approximately 2,200 patient visits were conducted at Covenant House through the Center's contract with Covenant House.
- Approximately 1,500 individuals were assisted to obtain or remain in housing through psychiatric evaluation clearances, referrals for supportive housing and HRA application filings.
- There were 7 hospitalizations (rate of 3%).
- There were 0 incarcerations.
- The total number of conducted visits was 5,878.

While this low rate of hospitalization is meaningful in and of itself, we have also reviewed patient records to estimate the decrease from these patients' normal risk of hospitalization. We selected a group of 100 patients who were clear examples of people with serious and persistent mental illness (SPMI) and who used the Center's services for six months or more.

These patients as a group had a history of 334 hospitalizations before they came to St. Paul's. While some had had only one or two hospitalizations, others had as many as 30 over a period of many years. The data are not precise enough to give an annual hospitalization rate for this group before and after their treatment at St. Paul's Center. It seems reasonable, however, to estimate that they may have experienced an average of one hospitalization per patient per year before treatment at the Center.

Recent studies have estimated the average cost of psychiatric hospitalization at $5000 or more. (Stensland 2012). By these estimates, St. Paul's Center may have saved about $500,000 per year in hospitalization costs for a group of 100 patients. That figure is slightly higher than the average annual budget for St. Paul's Center for 2009 through 2011.

This rough approximation suggests that the cost of providing treatment at St. Paul's Center was at least breakeven when considering the costs to public health system. These numbers don't include the amount saved on emergency room visits or on incarceration – less common than hospitalization for these patients, but also potentially expensive for the state. More important, this calculation does not quantify the huge quality of life benefit that the St. Paul Center's model offers, or the fact that many SPC patients were able to return to productive education and work paths that contribute to the economy.

Though they are rough estimates, these financial calculations suggest that the St. Paul's Center model can provide far better care for the homeless mentally ill at no greater financial burden than the cost of their treatment today. The results of SPC's treatment program make the case for a more controlled, rigorous study of this approach. And that research, in turn, could have a major impact on Medicaid programs – the major source of funding for this population's care – and how they pay for preventive versus acute treatment.

CONCLUSION: MAKING THE MODEL SUSTAINABLE

We believe SPC's model can serve as a template for innovation on a national scale. To replicate and grow the model, however, will require more research, new financial models, and the ability to challenge existing Medicaid reimbursement policies.

St. Paul's Center was not economically viable in the end, for one major reason: The Center was unable to secure Medicaid approval for payment. The great majority of St. Paul's Center patients received Medicaid benefits and the Center tried several times to gain approval to receive Medicaid reimbursement, but without success. Although each of the Center's psychiatric nurse practitioners was fully credentialed and certified by the State of New York, the state's Medicaid policy did not recognize SPC as a primary care site. Without access to Medicaid funds, the Center was forced to rely on philanthropic support, which was not sustainable in the long term.

The success of SPC presents a compelling model worth further study and an argument for Medicaid policy change. We hope that the model will be replicated in a way that allows for rigorous study and cost-benefit analysis. If the model proves out, it could make a strong case for Medicaid reform. A reallocation of Medicaid dollars from acute to preventive care could support a cost-effective approach to better, more effective, and more humane treatment for homeless people with mental illness.

Making this model work may require changes in the training of psychiatric nurse practitioners. Few programs now prepare these professionals to both assess psychiatric patients and intervene with medication, individual, group, and family treatment, the combination of skills that the SPC model requires. New models of training could improve psychiatric nurse practitioners' professional capacity and develop a new public health resource for mental health treatment.

The model may also require changes in the support structure for homeless people with mental illness. In New York, the SPC leadership was able to work with the New York State Assembly to change the policy of the Human Resources Administration, and to allow psychiatric nurse practitioners to sign housing referrals for the Center's patients. Basic reforms like this can make a significant difference in helping these patients find critical services as a part of their treatment.

For nine years, the St. Paul's Center provided innovative, cost-effective care for homeless people with mental illness – a population that has been dramatically underserved and undertreated. It demonstrated a model for holistic, humane care that can dramatically improve treatment outcomes and quality of life. We hope the SPC experience can serve as a model for further research, treatment development and innovation to help this population receive the care they need and deserve.

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