Ensuring Equity in Patient Prioritization on Outpatient Mental Health Waitlists
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Background
Waitlist prioritization continues to be a challenge with clinical, administrative, and ethical implications (Brown et al., 2002). There is little agreement on how to standardize management of outpatient mental healthcare waitlists (Déry et al., 2020). To demand for mental health services has increased while waitlist size has decreased during the COVID19 pandemic (National Council for Behavioral Health, 2021), that has further highlighted the disparities that exist for under-resourced and structurally vulnerable communities.

Structural vulnerability refers to multiple conditions/social determinants (i.e., socioeconomic and cultural factors) that puts individuals or groups at risk for negative health outcomes (Bourgois et al., 2017). While the racial and financial status, and implicit biases have been linked to the access and delivery of competent mental health care, (Alegria et al., 2018; Hasen & Metzel, 2019), there is scarcity of systematic evidence in examining structural vulnerability in relation to patient waitlist prioritization.

Objective
This study seeks to:
1) identify best practices published in ensuring equitable and timely access to outpatient mental health services while optimizing limited resources
2) provide an example of how one outpatient behavioral health unit—MGH Chelsea—prioritizes patients on the referral list.

Methods
An exploratory literature review was conducted using the terms “waitlist prioritization mental health,” “cross cultural psychiatry, mental health care,” “mental health waitlist” in Google Scholar and databases (e.g., MEDLINE, PsycARTICLES). PsychiatryOnline, PsychINFO available through Boston College’s Libraries. Articles were limited to those that addressed outpatient mental health waitlist management; narrow the scope of this study. Insights from the review were aggregated into two overarching themes: (1) waitlist prioritization models and (2) structural vulnerability/social determinants of health.

Results
MGH Chelsea interview Findings: Summary (Table 2)
- Increase in number of referrals since COVID19 pandemic (501-556/week – 9-11/10/2021)
- Patients at MGH Chelsea are from predominantly Hispanic and socially vulnerable communities disproportionately affected by COVID19. The median household income (Racial/Ethnic Breakdown: Hispanic 80% of the population is living below or at or below the poverty line (census.gov).

- Prioritization order:
1) Hospital discharge referrals
2) Safety concerns (e.g., SI)
3) Returning patients
4) Focus on rationale for prioritization of #3 and #4.

- Wait list prioritization is based on accuracy of need conceptualized mainly by clinical judgment
- Since majority of patients belong to low SES background, the question of fair treatment is related to issues of cultural responsiveness and addressing structural vulnerability beyond the appointment.

- Reducing wait time is ideal, and some options are being explored, but addressing environmental, social, and cultural determinants of health still remains a thoughtfully approach with different key decision makers.

- Mission/values drive clinical decisions and policies.

Conclusion
The study provided both an overview of the approaches to managing outpatient mental health waitlists and provided an example of one administrator at MGH Chelsea Behavioral Health Unit reflecting on the process at their institution. The literature review highlights the need for further study on the issue with an intentional focus on questions related to structural vulnerability/social determinants of mental health. Empirical studies identified promising methods for reducing wait time but do not address adequately the issues of fairness and quality of service for marginalized and under-resourced communities. It must, as highlighted by the interviewer, start with examining our own institution’s guiding principles and value system. While reducing wait time to access is ideal, factors such as health disparities and cultural responsiveness warrant a thoughtful approach in systematizing the triage process.

Recommendations
The mission of the department/organization is the driving force behind prioritization and rationalization of the triage protocol.

Does the work group or organization have a mission statement? What are the guiding principles of the organization? Has the group collectively agreed on the triage criteria? Is the methodology reviewed regularly? Do the priorities change with fluctuating demands for service?

Consideration of structural vulnerability/Social determinants of health
With significant increase in referrals for mental health services and economic recession due to the pandemic, these disparities have become more pronounced. How are administrators accounting for these key drivers of demand for behavioral health services in the triage process?

Data driven measures for quality improvement
Reducing wait time does not necessarily increase patients’ satisfaction and improvement, so what comprises “success”? Quality of patient-therapist relationship, for example, is not easily quantifiable. What quantitative and qualitative/subjective approaches could be used to guide decision making? What values (e.g., “We like family here!”) guide the interpretation of data?

References

Table 1: Literature review findings

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sample quotes and points made</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairness and equity</td>
<td>“We like family here!”</td>
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<tr>
<td>Needs-based model</td>
<td>“Many patients come here because they cannot see anyone else.”</td>
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<tr>
<td>Racial and financial issues</td>
<td>“I need to see the patient today.”</td>
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<tr>
<td>Insurance, financial, and immigration issues</td>
<td>“All I need to do is contact the patient and they get an appointment right away.”</td>
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<td>Cultural responsiveness</td>
<td>“We have a robust Community Health team that addresses social determinants.”</td>
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Table 2: Literature review findings

<table>
<thead>
<tr>
<th>Variable</th>
<th>Type of paper</th>
<th>Model/methodology</th>
<th>Structural determinants</th>
<th>Referral outcome (e.g., ADHD)</th>
<th>Training criteria? Is the methodology reviewed regularly?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-led (Opt-in)</td>
<td>Empirical</td>
<td>Triage criteria?</td>
<td>Structural determinants</td>
<td>“All I need to do is contact the patient and they get an appointment right away.”</td>
<td>“We have a robust Community Health team that addresses social determinants.”</td>
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<tr>
<td>Brief intervention</td>
<td>Empirical</td>
<td>Triage criteria?</td>
<td>Structural determinants</td>
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<td>Prognosis/gains-based</td>
<td>Empirical</td>
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Sample quotes and points made: “We like family here!”

Sample quotes and points made: “We have a robust Community Health team that addresses social determinants.”