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). Demand for mental health services has increased while access 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, (Alegría et al., 2018; Hasen & Metzel, 2019), there is scarcity of systematized guidance in examining structural vulnerability in relation to patient waitlist prioritization.

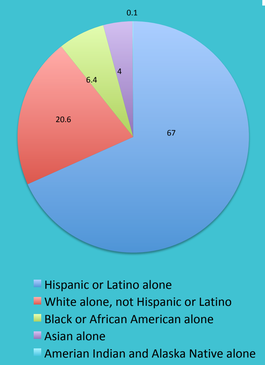
Objectives

This study seeks to
1) identify best published practices 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 waitlist" and "mental health waitlist" in Google Scholar and databases (e.g., MEDLINE, PsycARTICLES, PsychiatryOnline, PschINFO) available through Boston College's Libraries. Articles were limited to those that addressed outpatient mental healthcare waitlists to narrow the scope of this study. Insights from the review were aggregated into two overarching themes: waitlist prioritization models and structural vulnerability/social determinants of health.

Figure 1. Chelsea, MA, demographics 2019 from census.gov. (Note: 32.8% indicated, "Two or More Races.")



Methods

To supplement the findings in the literature review, a semi-structured interview was conducted with an administrator at MGH Chelsea Behavioral Health Unit in charge of managing referrals. Recurring themes that illuminated the unit's patient prioritization model were identified.

Results

Literature Review Summary (see Table 1)

•Models such as triage, patient-led (self opt-in), and multidisciplinary approaches showed promise in reducing patient wait time (e.g., Woodhouse, 2006, showed that an opt-in system significantly increased first-appointment attendance and significantly decreased wait time.)
•No standard way of prioritizing patients across articles.
•Reducing wait time and brief intervention did not necessarily mean improved symptoms and patient satisfaction.
•"Cultural norms" and "cultural expectations" were mentioned as one of the many factors to consider in formulating waitlist procedures.
•"Social factors" used broadly as one among many assessment criteria for prioritization.
•"Fairness" and "equity" were mentioned in relation to possible biases of clinical judgment, but no further discussion on the structural vulnerability/social determinants that contribute to the biases and barriers to access in relation to waitlist management.

MGH Chelsea Interview Findings Summary (Table 2)
- Increase number of referrals since COVID-19 pandemic (12-15/week → 40-55/week)
- Patients at MGH Chelsea are from predominantly Hispanic and structurally vulnerable communities disproportionally affected by COVID19. The median household income (2019) is approximately $56,802. 45.4% of the population is foreign born and 18% is living in poverty (census.gov).

•Prioritization order:
1) Hospital discharge referrals
2) Safety concerns (e.g., SI)
3) Returning patients
4) Everyone else
•Focus on rationale for prioritization of #3 and #4.
•Wait list management based primarily on acuity of needs 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 demands given the demographics require thoughtful approach with different key decision makers.
•Mission/Values drive clinical decisions and policies

Table 1. Literature Review findings

Author(s), date, country	Type of paper	Models mentioned	Structural Vulnerability/ Social Determinants of Health mentioned
Brown et al. (2002); USA	Commentary	Triage (Costs and benefits)	Brief discussion on fairness and providers' ethical responsibility
Lynch & Hedderman (2014); Ireland	Empirical	Triage Referral out to ADHD specialists	Not mentioned
Smith, Hadorn, & the Steering Committee of the Western Canada Waiting List Project (2002); Canada	Empirical	Point-count (needs) measure	"Social factor" used broadly for needs assessment
Stallard & Sayers (1998); U.K.	Empirical	Opt-in system Brief intervention	Fairness mentioned
Thomas et al. (2020); Australia	Systematic Literature Review (20 articles focusing on research design)	Triage Patient led (Opt-in) Walk-in Brief intervention Tiered services Multidisciplinary	Not mentioned
Woodhouse (2006); Scotland	Empirical	Patient initiative through opt-in system Based on predictive positive outcomes rather than needs	Not mentioned

Table 2. Interview findings

THEMES	Sample quotes and points made
Relationship matters	"We' re like family here!" •Former patients who come back after a hiatus have priority •Culturally, patients (and staff) appreciate the familial atmosphere •Mission/values drive decision making
Prioritize people, not waitlist	"Many patients come here because they cannot be seen anywhere else." •Insurance, financial, and immigration issues •Ideal to speed up the wait time but the human issues cannot be easily resolved •Limited number of available therapists and concern for their wellbeing too "
Effect of COVID-19 Public Health Crisis	Telehealth has not changed how we prioritize." •Prior to COVID, 12-15 referrals a week •Since December 2020, 40-55/week •Currently more than 200 adults in the queue
Needs-based	"We look at needs, not color, language, etc." •Tension of focusing on needs and being culturally responsive •Even needs have to be conceived in cultural context •Rely mostly on clinical judgment
Collaborative and multidisciplinary	"We have a robust Community Health team that addresses social determinants." •Often, patients who receive services from community health no longer request therapy •Other collaborators: Social workers, lawyers, PCP' s, neuropsychology, and psychiatry
Next steps	"We do many things well but there' s still a lot of work to do." •Continue effort to hire bilingual and bicultural staff to meet needs of the population •Try to implement a systematic way (e.g., tiered services) to distinguish patients who could benefit from brief interventions and patients who could benefit from long-term relationship •Explore alternatives to needs-based model (e.g., prognosis/gains-based model)

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 warrants a thoughtful approach in systematizing the triage process.

Recommendations

The mission of the department/organization as 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 approaches could be used to guide decision making? What values (e.g., "We're like family here!") guide the interpretation of data?

Selected References:

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