Analysing patient engagement to improve clinical outcomes

Systematic analysis of engagement rates across a common practice environment can improve patient engagement, which helps to boost psychologists' work satisfaction and improve the personal and financial rewards of private practice, write Dr Brendan Meagher and Dr Sue Lauder.

We know that the therapeutic alliance is inextricably linked to patient outcomes; however, rarely do multi-practitioner practices systematically track, analyse and adapt based upon data relating to psychologists' engagement with patients. Examining engagement rates at a practice-systems level as well as at an individual level allows psychologists working in a common setting to learn from the practices of their colleagues.

Defining patient engagement

Patient engagement in this systems-orientated approach is operationalised as a ratio of the number of consultations completed by the psychologist per financial year divided by the number of new referrals received in that financial year. This ratio can be determined for the practice overall as well as for the individual psychologist.

Formal allocation process

Mind Health Care introduced a systematic allocation process for new referrals in July 2016 as part of a broad and ongoing effort to improve patient outcomes. The allocation process has been shown to improve patient engagement and engagement data has been used to refine the allocation process to further improve patient engagement. It provides a collaborative reflective practice where exploring and sharing engagement and retention rates allows the psychologists to analyse their clinical work at a macro level.

Patient profiles

There is a large body of evidence that psychologists frequently fail to identify failing cases and drop-out rates from psychological treatment often approach 50 per cent (Aubrey, Self & Halstead, 2003). We encourage psychologists to analyse the characteristics of patients who engage in a full episode of care (planned and managed discharge) and patients who discontinue treatment (unplanned closures). This allows the psychologist and the principal to identify areas of strengths and challenges. From here there can be a refinement of the psychologist's new patient preferences with a view to further improving the psychologist's engagement rates over time. This might be achieved by the psychologist building on their strengths and focusing on a particular area of practice, or building their skills through targeted CPD with the aim of providing more effective therapy to the identified patient profile.

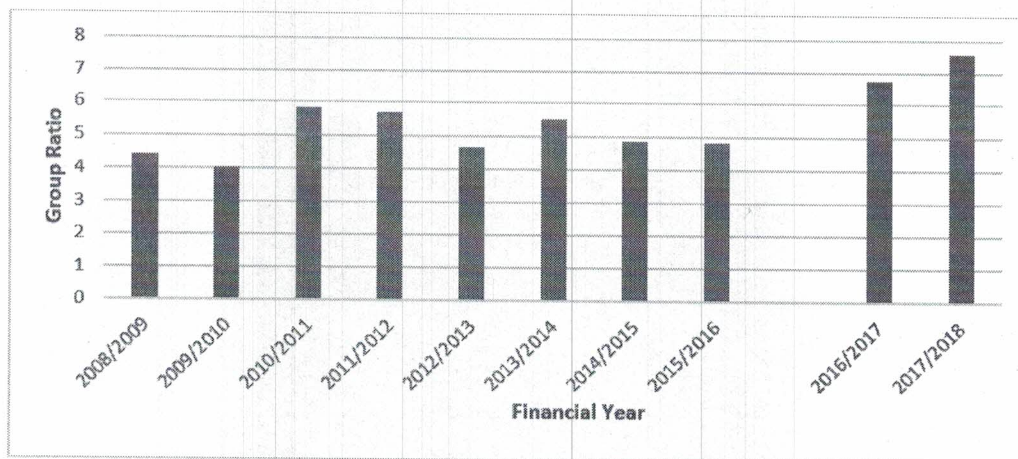
The magical fourth session

Analysis of the number of sessions attended across the practice supported the findings of Aubrey, Self and Halstead (2003), who found a relationship between non-attendance early in therapy and later attrition. Audrey and colleagues found that patients missing any of the first

three therapy sessions either by cancelling or by no showing was highly predictive of later dropping out. In their study, 65 per cent of people who failed to attend one of the first three appointments subsequently dropped out of therapy, while only 21 per cent of those who attended all of the first three sessions subsequently dropped out. Similarly, our analysis found sessions one to three were at the greatest risk for disengagement. Patients who continued to engage by attending session four were more likely to continue with treatment to a planned closure. So sporadic early attendance should serve as a warning of drop-out.

Group ratio

The group ratio is the number of consultations completed by the psychologist in a financial year divided by the number of new referrals in that financial year. The figure below shows a mean of 4.98 consultations provided per new referral over the eight financial years prior to the introduction of the allocation process and an average of 7.15 consultations per new referral following the introduction of the allocation process. Patients attending following the introduction of the allocation process had on average 2.17 more sessions than patients seen prior to the allocation process. This difference was found to be statistically significant as determined by a one-way ANCOVA. There was a significant effect of the allocation process on the number of consultations after controlling for the number of new referrals $F(1,7) = 22.934, p = .002$.



Pre-allocation process

Post-allocation process

Figure 1. Group ratio by financial year

Individual psychologist ratio

The figure below shows the individual psychologist's engagement ratio for the last financial year. This highlights the variability between psychologists. While the group average was 7.57, the average of those psychologists *below* the group average was 5.24, and the average of those psychologists *above* the group average 'high engagement' psychologists was 15.15 consultations per new referral accepted.

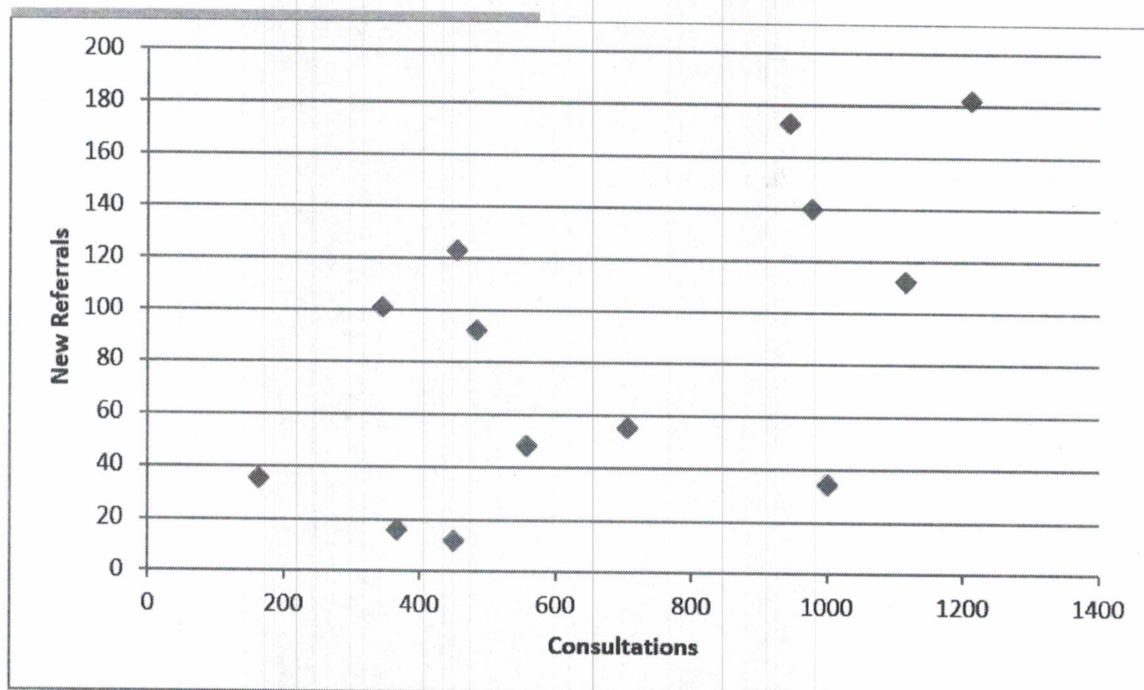


Figure 2. Individual psychologist's ratios for the 2017/2018 financial year.

Analysis of the 'high engagement' psychologists showed:

- 42 per cent less appointments cancelled, rescheduled or non-attended in the last quarter of last financial year
- 21 per cent more email correspondence with the practice principle psychologist
- 38 per cent more email correspondence with reception
- 27.5 per cent longer website profiles
- 82 per cent of all non-Medicare funded work completed within the group
- 100 per cent of appointments provided outside standard consulting hours (80 versus zero) in the last quarter of last financial year.

Flexibility

Collectively these factors may indicate that high engagement psychologists demonstrate a greater level of flexibility to meet the clinical needs of patients and have a stronger emphasis on providing a positive customer experience. The higher engagement rates reflect a stronger therapeutic alliance which resulted in less appointment cancellations, reschedules and non-attendance. Given the less frequent appointment changes it was interesting to observe the 38 per cent higher levels of email interaction with reception. It appears likely that the high engagement psychologists take a more proactive and involved role in scheduling and rescheduling than lower engagement psychologists.

Financial

Higher engagement rates were also shown to translate into financial reward for the psychologist with the lower engagement psychologists having 79 per cent more appointments cancelled or not attended which were *not* replaced, equating to $5,924 less revenue per year in comparison with their high engagement peers.

Supervision

Dedicating a portion of peer supervision time to systematically analysing the supervisees' therapeutic alliance, engagement rate and the nature of their planned and particularly unplanned closures at a macro level may offer an efficient means to identify targeted areas for development. Patients who discontinue treatment often experience problems with the process of therapy (for example, dissatisfaction, lack of fit, feeling therapy is going nowhere) and psychologists often attribute failed therapy to clients (that is, lack of readiness for change or insufficient motivation). Being aware of this tendency and encouraging the supervisee to look for alternative explanations is critical to optimal development.

Conclusion

Systematic analysis of engagement rates across a common practice environment can improve patient engagement. It can also increase the psychologists' work satisfaction by increasing the portion of their work life engaged in meaningful and productive therapeutic work. This can improve both the personal and financial rewards of private practice. Psychologists should be encouraged to systematically analyse their planned and unplanned closures at a macro level.

This systems-oriented approach provides some challenging but illuminating markers where the psychologist can explore their individual practice while benchmarking against their peers. It provides another aspect to reflective practice. This can be confronting, at least initially, in a supportive practice environment; however, it enables a constructive self-reflective opportunity that can result in better clinical outcomes for the patient, and create a better model of practice for the psychologist.

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