Establishing a Standardized Discharge Process for Outpatients on Clozapine

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Background

Humber River Health (HRH) is a large community hospital whose Mental Health Department manages over 20,000 outpatient visits annually. The outpatient Clozapine Clinic, serving over 140 patients, is staffed by a Registered Nurse and multiple Psychiatrists. It supports the complex needs of individuals prescribed clozapine, an anti-psychotic for treatment-resistant schizophrenia. As the clinic increasingly accepts acutely ill patients, the lack of a standardized discharge process has led to a backlog of stable patients, limiting access to those with more urgent needs.

Given clozapine's stringent prescribing and monitoring requirements, HRH engaged key stakeholders to design and implement a standardized discharge pathway. This transitions stable patients to community-based Primary Care Providers (PCPs), ensuring continued monitoring while optimizing specialized psychiatric resources. Many patients face socioeconomic barriers and belong to marginalized communities. Transitioning care to the community promotes continuity, reduces stigma, and improves access. Ultimately, the project enhances equity by increasing availability of hospital-based psychiatric services for acutely ill individuals.

Aim

To implement a standardized process that facilitates the safe discharge of stable outpatients on clozapine to community-based Primary Care Providers.

Measures

1. Number of stable patients discharged and 'stepped down'
2. Patient and provider experience upon discharge
3. Adverse outcomes 1 year after discharge (including treatment cessation, readmission, or cessation of bloodwork)

Impact/Results

To date, four patients have been discharged, and nine are progressing through the step-down pathway. Patients and PCPs reported high satisfaction with the information and support provided. No adverse outcomes (e.g., readmissions, missed bloodwork, treatment lapses) were reported.

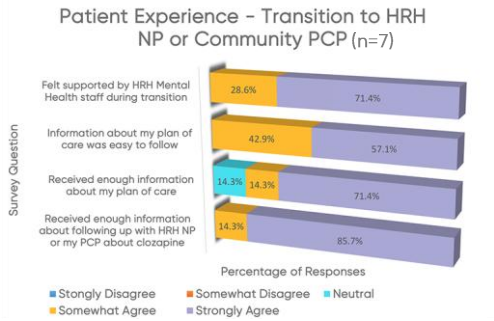

Figure 1. Patient Experience Survey results showed that patients felt supported and informed during their transition to HRH NP or community-based PCPs.

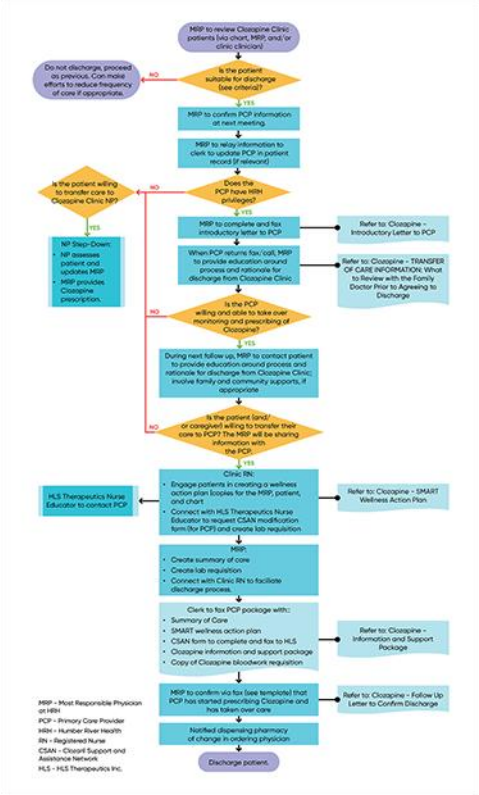

Figure 2. Clozapine discharge transition pathway.

Implementation of Change Concepts

In February 2022, a needs assessment was conducted, and key stakeholders were engaged to co-develop a safe and sustainable outflow process. Consensus criteria were created to identify appropriate stable patients, regulatory restrictions for PCP prescribing were clarified, and minimum handover requirements were defined.

An outflow process map and templates were developed and refined through multiple iterations with input from HRH's Quality and Patient Safety (QPS) team. Select sample of psychiatrists and patients were consulted and assisted with revisions.

For patients ineligible for discharge, a "step-down" pathway was introduced, transitioning care to a departmental Nurse Practitioner.

We engaged Psychiatrists, Nurses, Pharmacists, other hospitals and PCPs in co-developing discharge criteria and workflows, enabling clinical feasibility and buy-in. Patients and their families were engaged through shared decision-making to ensure comfort and safety in transitioning care.

Lessons Learned

Given the significant influence of local clozapine regulatory requirements on our pathway and criteria, expertise from Professional Practice and Pharmacy earlier in the project would have been beneficial. These requirements restrict the number of patients who can be discharged to Primary Care, thus limiting our ability to discharge some stable patients. In response, we concomitantly opened a 'step down' pathway from psychiatric to nurse practitioner led care in our department. In the step down pathway the psychiatrist continues to prescribe clozapine for the patient and the NP provides follow up visits, thus increasing capacity for psychiatry to see newly referred patients.

Information from our experience surveys highlighted additional opportunities for change. Patient feedback showed an opportunity to improve the way information was shared about the change to enhance overall understanding. In the future, we plan to provide more detailed patient information using "plain language" that will be delivered over a longer period of time using the teach back method to confirm understanding. It would also be important to share information about the patient's learning style with the PCP to ensure continuity in the plan of care.

During the evaluation phase, participants reported that referencing bloodwork intervals in weeks (e.g., 26 weeks) rather than months (e.g., 6 months) was often confusing and overwhelming. Simplifying timeframes to months improved clarity and reduced anxiety. Additionally, aligning bloodwork appointments with pharmacy visits for prescription pick-up significantly supported patients' successful transition from hospital to community care. Moreover, we recognized that it would have been valuable to obtain feedback from our NP.

Discussion

Creating and implementing a standardized process facilitated appropriate and streamlined care transitions from acute hospital-based care to community care. Standardization improved comprehensive transfer of information, enhancing patient safety and reducing risk. The process was well received by patients and Primary Care Providers with no associated adverse outcomes. Using 'plain language' and education over time can enhance the transfer process in future.

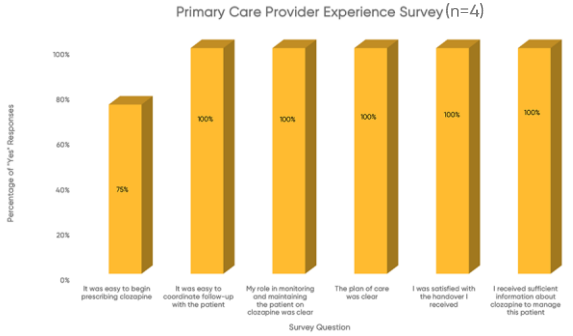

Figure 3. PCP Experience Survey results showed that PCPs had overwhelmingly positive experiences transitioning patients to community care.