# Inpatient-to-Ambulatory Handoff Process for High-Risk Oncology Patients

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## Background

Oncology readmission rates range from 11.9%–39%, with higher rates among medically and psychosocially high-risk patients (Leung et al., 2023). These findings highlight the importance of structured inpatient to ambulatory transition processes (Agency for Healthcare Research and Quality, 2025). High-risk oncology patients often face complex medical, psychosocial, and Social Determinants of Health (SDOH)-related barriers that increase risk for fragmented care and readmission (Hodgkinson et al., 2023). Standardized social work handoffs support continuity of care, strengthen interdisciplinary communication, and facilitate timely post-discharge interventions (Tyler et al., 2023; Agency for Healthcare Research and Quality, 2025).

In response, UHealth developed a standardized operating procedure (SOP) to guide social workers in identifying, assessing, and transferring high-risk patients between inpatient and ambulatory settings. This initiative aims to reduce fragmentation, address social determinants of health, and enhance patient experience through proactive, collaborative care planning.

## Intervention

**Assess** → **Identify** → **Handoff**

The Complex Discharge Screening Score (CDSS) is a standardized risk stratification tool used to identify patients at risk for complex discharge and hospital readmission based on medical, functional, psychosocial, and social factors. Additional criteria include frequent admissions, Social Determinants of Health (SDOH), and psychological needs.

| Screening Score Categories | |
|---|---|
| 1-9 | Low |
| 10-20 | Moderate |
| >20 | High Risk - requires handoff |

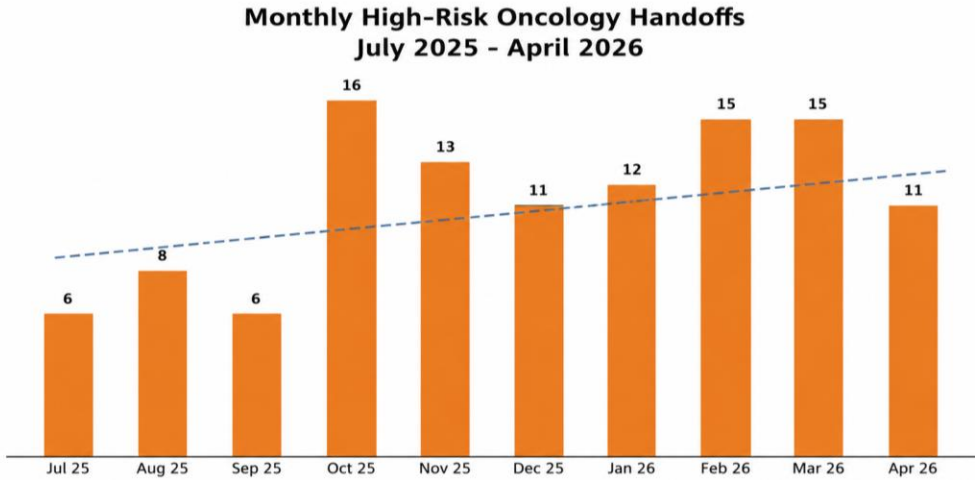
Inpatient social workers initiate ambulatory social work referrals through secure EHR communication. Scheduled phone calls are used to review patient needs, risk factors, and barriers. All handoff interactions are documented in the EHR. Ambulatory social workers complete follow-up within 48 hours of discharge, then assess, intervene, and provide ongoing support. Updates are communicated to care teams, as needed.

**SCAN ME** to view the CDSS tool

## Accomplishments

Accomplishments of this project include:

- Integration of the Complex Discharge Screening Score (CDSS)
- Implementation of a standard operating procedure (SOP) and EHR-driven communications
- 113 high-risk oncology handoffs completed since implementation in July 2025
- Average of 13 handoffs per month in 2026, which is 30% increase from 2025
- 100% compliance of follow up within 48 hours of discharge, from random chart audit




## Conclusion

A standardized inpatient-to-ambulatory oncology social work handoff strengthened continuity of care for high-risk patients. Consistent communication, documentation, and follow-up enabled earlier identification of psychosocial and SDOH needs, demonstrating that a structured handoff can meaningfully improve coordinated, patient-centered oncology care.

Opportunities exist to collect enhanced data on handoff completion, follow-up timeliness, and utilization outcomes.

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