Serengeti CARE

2026 WHCA / IHCA FALL CONFERENCE

FROM DISCHARGE TO HOME:

Creating better outcomes through seamless care transitions.

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THE TRANSITION HOME IS WHERE RECOVERY CONTINUES — OR READMISSION BEGINS.

The discharge plan gets them home. The care plan helps keep them there. Together, they close the loop.

HOME MAY BE:

- Private residence
- Family home
- Apartment
- Retirement Community

5:30 PM

Margaret is discharged.

THE PATIENT PROFILE

- Age 82
- Hospital → SNP → Home
- Rehab successful
- Medication changes
- Walker
- Daughter involved

Who owns Margaret's discharge?

The rehab was successful. But her old medications are still in the cupboard. Her daughter and home health aren't aligned. The discharge paperwork sits on the counter.

Every organization did its job.
And Margaret still fell into the gap between them.

A successful discharge is measured by what happens after the patient leaves.

15.4%

Medicare reported 30-day readmission rate.

SOURCE — MEDPAC, MARCH 2026 REPORT TO CONGRESS

62%

of reported Washington falls occurred at home.

SOURCE — WASHINGTON DEPARTMENT OF HEALTH FALLS DATA

We are good at onboarding new cases.

We need to get better at receiving people.

Referral sent	≠	**Service started**
Paperwork sent	≠	**Information understood**
Family notified	≠	**Family prepared**
Discharged home	≠	**Successfully transitioned**

THE ONLY FRAMEWORK YOU NEED

Connect. Receive. Close.

01

Connect

Before discharge.

02

Receive

At home.

03

Close

After arrival.

THREE ACTIONS. ONE TRANSITION.

1. Connect — before Margaret leaves.

IDENTIFY THE PEOPLE

01 **Discharge / SNF contact**

02 **Home care**

03 **Retirement community**

04 **Home health**

05 **Family / POA**

06 **Clinical contact**

Who needs to know what?

If something changes Saturday morning, who calls whom?

Create clear, purposeful pathways — not broad emails.

Don’t send a novel. Send what matters.

01

RISK

What worries us most?

02

FUNCTION

What can Margaret actually do?

03

SUPPORT

Who will actually be there?

04

NEXT

What is supposed to happen next?

05

CONTACT

Who gets called if it doesn’t?

FAX ≠ HANDOFF

The next provider doesn’t need more information. They need the right information.

SOURCE — AHRQ, COMMUNICATION DURING TRANSITIONS OF CARE

2. A successful discharge requires a successful handoff.

DAY ZERO CHECKLIST

01 Meet Margaret

02 Confirm support arrived

03 Check the real environment

04 Confirm essential needs

05 Identify obvious gaps

06 Know the escalation pathway

Did reality match the plan?

Don’t let the first check be the next crisis.

The plan said:	*Reality: did it happen?*
Walker delivered	—
Daughter available	—
Medication understood	—
Food available	—
Home health scheduled	—
Home care starting	—

A transition fails in the gap between “planned” and “actually happened.”

What I saw. What changed. What I did. What happens next.

EXAMPLE — A CLEAR, OBJECTIVE REPORT

> *“Margaret required significantly more assistance transferring this morning than yesterday. I notified my supervisor according to protocol. Her daughter was updated, and the appropriate clinical contact is being engaged.”*

SHORT. OBJECTIVE. ACTIONABLE.

Train frontline staff to communicate in this structured way — every shift.

3. Close — did it actually happen?

24 – 72 HOUR CHECKLIST

01 Did care start?

02 Did equipment arrive?

03 Are medications available?

04 Is Margaret eating and drinking?

05 Any falls or near-falls?

06 Is mobility working in the real environment?

07 Did follow-up happen?

08 Did anything unexpected occur?

Close the loop.

Measure the actual service start — not the referral.

HOME CARE

Don’t just take the referral. Report back.

24-HOUR TRANSITION UPDATE

- Care started
- Resident received
- Family connected
- Immediate needs addressed
- No concerns — or concern identified & escalated

Become part of their quality strategy.

SOURCE — CMS SNF QUALITY REPORTING PROGRAM

RETIREMENT COMMUNITY

You know Margaret’s normal.

RECOGNIZE THE CHANGE

She always comes to breakfast. Today she didn’t.

She walks to activities. Today she didn’t.

She is usually sharp. Today she’s confused.

She is usually social. Today she’s withdrawn.

You don’t have to diagnose change to recognize change.

REWIND MARGARET

Connect

SNF, family, home care and community partners know the plan.

Receive

Someone compares reality to plan at arrival.

Close

The loop is closed within 24 hours.

NO NEW TECHNOLOGY. NO NEW BUILDING. BETTER CONNECTION.

Did we discharge Margaret? Or did we complete her transition?

The goal isn't just getting Margaret home. It's helping her stay home. Safely. Successfully.

Q & A

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