

# Take Control of the Handoff

The new rules of winning  
in skilled nursing

Key findings from the Skilled Nursing Facility  
Transitions of Care Summit

MAY 2026

# An Era of Operational Transformation

Clinical transformation alone is no longer enough

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Eleven senior leaders representing more than 350 skilled nursing facilities came together at the Transitions of Care Summit in May 2026 around a shared reality: SNFs are being held accountable for outcomes they cannot fully see, with information they do not always receive, on timelines they do not control. The leaders in the room were clear that this is not a clinical failing. It is an operational gap — and operational gaps can be closed.

Two questions framed their discussion, and both point to the same problem:

- Why does the transition of care still feel like a gamble?
- Why are so many decisions made without a full picture of the patient's journey, when the SNF carries so much of the accountability for how that journey turns out?

The participants kept returning to a single observation: excellent clinical care is no longer enough. The quality of a transition is decided long before and long after the clinical work happens — in the information that does or doesn't arrive, and in the coordination that does or doesn't happen across organizations.

*“Many SNFs feel like they're absorbing the clinical and operational complexity created upstream.”*

The missing ingredient, they agreed, is not effort or skill. It is connection: the people at every stage of a transition working from the same picture, at the moment decisions actually get made.

## THE STAKES

Census, inbound and outbound referrals, operational performance, long-term survival — every one of them runs through the handoff.

## THE CENTRAL INSIGHT

A SNF's future survival depends on people working together across every transition — connected by shared visibility at each stage of the patient's journey and supported by a deliberate focus on strengthening information flow, training, and operational discipline.

# The Handoff Is the Business

Care coordination is a survival issue



What emerged from the Summit was a clear recognition: transitions of care sit at the core of the SNF business. Census, inbound and outbound referrals, operational performance, long-term survival — every one of them runs through the handoff.

The stakes are asymmetric. Win the handoff, and the facility protects both its patients and its bottom line. Lose it, and avoidable readmissions climb, referral partners look elsewhere, census erodes, and financial pressure compounds — no matter how strong the clinical team is.

The pressures bearing down on SNFs — workforce shortages, rising patient acuity, reputational risk, regulatory scrutiny, and a healthcare system shopping for alternatives to the SNF model — are exactly what make a broken handoff so dangerous. Each one widens the gap between what a facility is accountable for and what it can actually see and control. The facilities that cannot connect across transitions are the ones that will not survive them.

## WHY IT MATTERS

The summit participants converged on a profile of the facilities that will lead the next decade. Beyond delivering excellent care, the winners will be the organizations best able to:

- Respond to referrals with speed and sound judgment
- Coordinate efficiently across handoffs while maintaining real-time operational visibility
- Share measurable outcomes and accountability with their partners
- Manage rising patient complexity while protecting and sustaining their workforce

# The Roadmap to Control

From the referral at the front door  
to the weeks after a patient goes home.

Summit participants described the fix not as working harder with the same tools, but as a continuous loop of control that follows the patient from the referral through the weeks after discharge — aligning everyone who touches a transition, inside the building and across the continuum, around shared visibility and shared accountability. Each area reinforces the others — strengthen one, and the next gets easier.



## See the Whole Journey

Connect information end to end so every decision is made with the full picture in view



## Master the Front Door

Make every referral decision fast and informed, not fast and blind



## Free the Clinicians

Take administrative weight off staff so care gets the attention



## Turn Data Into Decisions

Move information from after-the-fact reports to in-the-moment choices



## Make Coordination the System

Build alignment that doesn't depend on the same heroes showing up



# See the Whole Journey

Connect the journey end to end so every decision is made with the full picture in view.



Summit leaders said it plainly: accountability has expanded faster than visibility. SNFs are measured on the full journey while operating with a view of one piece of it — responsible for outcomes determined well before admission and well after discharge.

Operators are sitting on more data than ever — yet much of it lives in spreadsheets, sits in disconnected platforms, or arrives after the decision is made. Participants pointed to the referral, the coordination call, the discharge plan: too many happen without the full picture in the room, because the information that exists never reaches the person who needs it in time. What's missing isn't more data — it's the connection that lets the same picture follow the patient from one transition to the next, so every decision is made against the whole journey rather than a single slice of it.

*“We did our part. The breakdown is that we were seeing only our piece of the journey, not the whole thing.”*

## KEY INSIGHT

Accountability without visibility is just penalty — you cannot own what you cannot see.

## RECOMMENDED ACTION

Give the facility a single, real-time view of every transition it touches, so admissions, nursing, and downstream planning are working from the same picture instead of piecing it together by hand.



# Master the Front Door

End the admissions gamble through better information, not just faster reflexes.



Referrals get decided in minutes, and participants were blunt about the trap: a facility either moves fast or someone else takes the patient — but a fast yes isn't always a good yes. Admit a patient whose needs fall outside what the facility can deliver, and it has taken on a commitment it can't honor, at real cost to the patient, the team, and a clinical reputation built over years. Speed without judgment is simply faster mistakes.

Responsiveness, the leaders agreed, is becoming the differentiator. The buildings that respond fast and smart will take share — not by luck, but because they built a system that does both at once. And the infrastructure is arriving. Digital tools are available, and referral sources are beginning to share patient information. The catch is that most SNFs can't use those pipes yet, held back by resource constraints, manual workflows, and limited access to the federal incentives that would speed adoption.

*“If I had a magic wand, I'd want to see the hospital's charting for the last 72 hours on every admission.”*

## KEY INSIGHT

The narrow decision window isn't going away, but the information inside it can change. The fix is connecting that inbound view to visibility across every other transition, so a yes at admission is made knowing who's discharging, when beds will open, and what's happening downstream.

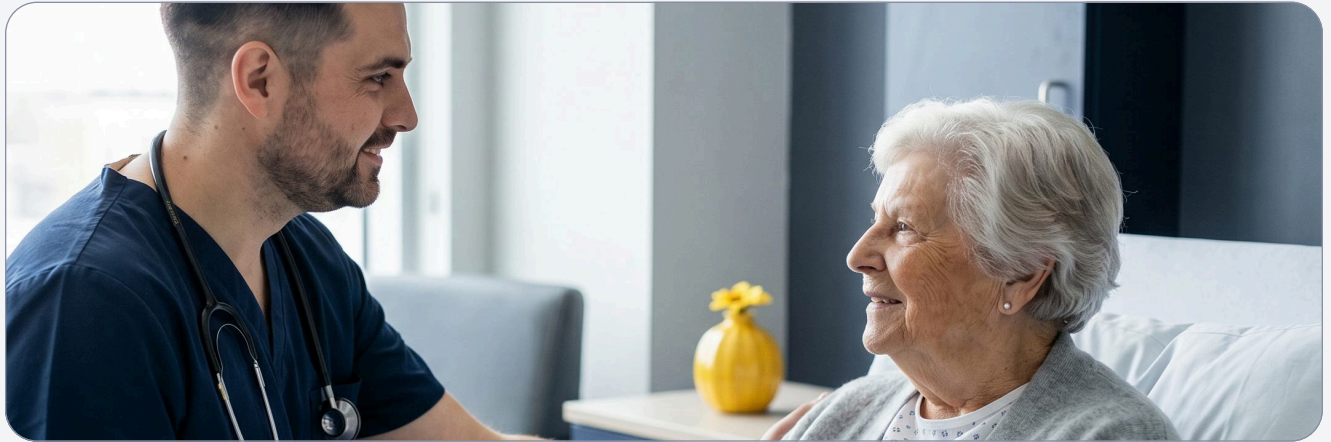
## RECOMMENDED ACTION

Build faster, smarter inbound referral management that connects front-door visibility to discharge timing, bed availability, and downstream flow — so speed never comes at the expense of clinical appropriateness, staffing balance, or census planning.



# Free the Clinicians

Don't reinvent the operating model — optimize it so clinicians can deliver care.



The operating model that built the SNF industry was labor-heavy by design: more hands, more shifts, more bodies. That worked when trained expertise was available to hire, and participants were clear it isn't anymore. So, the question has changed — no longer "how do we find more people?" but "how do we take the administrative load off the people we already have?"

Agentic AI, trained on a facility's own processes, can walk newer staff through a workflow step by step, surface the right information faster, and compress the learning curve from years to months. The operators who face this head-on will pull away from the pack; the ones who wait risk arriving in 2030 with staffing problems they cannot hire, train, or wish away.

*“We're predicted to be short 10,000 nurses by 2035.”*

## KEY INSIGHT

Agentic AI that both takes work off staff and trains them through transition workflows is how SNFs can absorb a workforce shortage they cannot hire their way out of.

## RECOMMENDED ACTION

Use agentic AI to take administrative work off staff and walk less experienced team members through transition workflows step by step — shortening the learning curve and protecting control over census and throughput when staffing is short.



# Turn Data Into Decisions

Drowning in dashboards,  
starving for decisions.



SNFs are graded on everything — outcomes, responsiveness, operational performance — and the grade helps decide whether the next patient comes through the door. Then, the patient discharges, and the facility is responsible for what happens next, even as the view disappears.

The twist participants named: the data that would help isn't so much lost as unshared. Downstream partners hold information the SNF never sees; what does exist sits in disconnected platforms or in a report that lands two weeks too late. This isn't a clinical problem — it's a data problem, and data problems quietly shape every decision that follows.

*“You get into this loop  
that you can't close.”*

## KEY INSIGHT

Leaders saw the next era of coordinated care belonging to buildings that share data freely with their partners — both the hospitals sending patients in and the providers caring for them after discharge. When that data reaches the right person at the moment of decision, the information that once arrived too late, or not at all, becomes the tool that prevents readmissions.

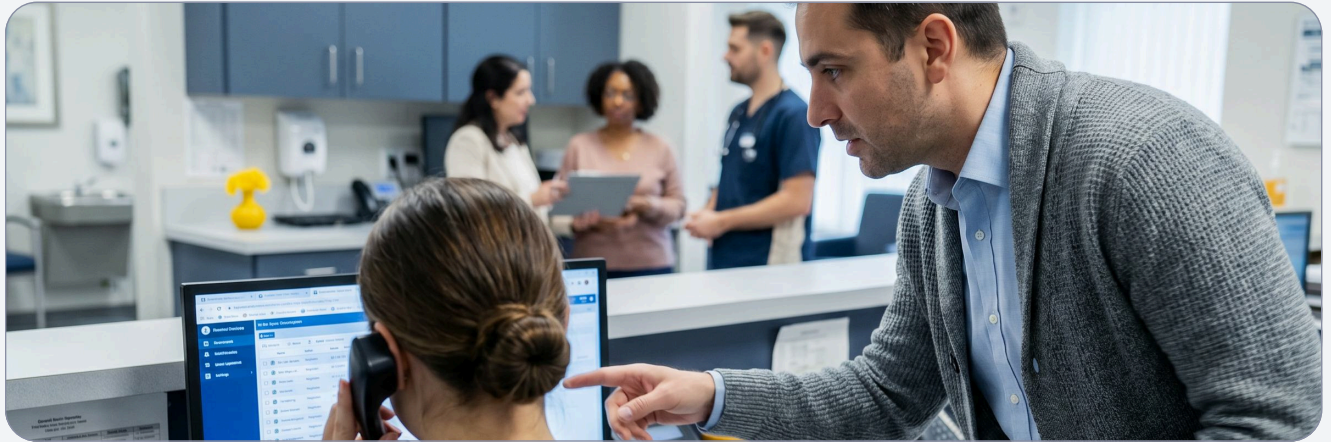
## RECOMMENDED ACTION

Establish data-sharing with partners on both ends of the journey — the hospitals referring patients in and the providers caring for them after discharge — through real interoperability and shared measurement, so the full picture follows the patient across organizational lines.



# Make Coordination the System

Make coordinated, high-quality care a system — not a daily act of heroics.



Clinical quality is the price of entry — necessary, but no longer enough on its own to set a facility apart. In the participants' view, two things set the winners apart: shared visibility, and how well teams along the continuum coordinate on transitions. Those facilities align their departments and push decisions to local leaders, so the right person makes the right call when it matters.

The difference shows up in how the handoff itself is run. When social services, nursing, admissions, physicians, and leadership each own their part of a transition and work from the same realtime picture, the handoff stops being a gamble and becomes something the team executes well, every time. Departments coordinate by default rather than scrambling in a crisis, accountability lives in the workflow rather than in another meeting, and the information that has to move with the patient actually does. Leaders kept returning to culture as the multiplier.

*“What sets the best facilities apart is culture — facility-driven culture and ownership.”*

## KEY INSIGHT

Embed the coordination behaviors — handoff quality, loop closure, and cross-team communication strengthened by data — so excellence becomes repeatable, transferable, and resilient.

## RECOMMENDED ACTION

Shift from reactive coordination to proactive systems. Anticipate operational bottlenecks, manage transitions ahead of time, and create smoother patient movement and clearer accountability across the continuum.

# The Will Is There. The Structure Is Missing.

From solo serves to a rally that never drops.

Not one SNF leader in the room could say they fully own their transitions of care today. At its worst, the work can feel like serving a ball with no one on the other side of the net to return it — every handoff sent out into uncertainty. Yet the conversation was not one of resignation. It was one of resolve: a shared conviction that coordinated care can become a rally, a synchronized exchange that keeps the ball in play and never lets it drop.

These leaders have seen excellence at work, and they have delivered it. What is missing is the structural alignment to turn that knowledge into action — and the means to put SNFs back in real control of their transitions of care already exist.

*“The leaders who act now will be the ones who define the next era of skilled nursing.”*

## Why better transitions are within reach

- SNFs see excellence every day. The model exists — it just isn't yet the standard.
- AI and automation are ready to make a meaningful impact.
- Operators can accelerate and maximize the use of the data they already hold.
- Getting transitions of care right is within reach — it takes greater alignment across the people involved, not reinvention.

# Thank You

Olio wishes to thank the participants of its Transitions of Care Summit for their generous contributions of time, expertise, and perspective. Their candor and insight made this work possible.

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# About Us

Olio connects the people across every transition of care — giving skilled nursing leaders real control over their admissions, census, and referrals.