

Center for Home-Based Care

Supported transitional living, everyday-life training and structured transfer home — for people with care needs, their family caregivers, and people facing broader health-related challenges.

The Centre for Home-Based Care (ZHV) bridges the gap between hospital or rehabilitation, destabilisation at home, and a sustainable care arrangement in the person's own home. The decisive question is not diagnosis alone, but whether the home environment, skills, burden, routines, assistive devices, services and digital support work together in everyday life.



PURPOSE

Stabilise critical transitions so that care at home becomes practically sustainable.

PRINCIPLE

Everyday life before diagnosis; effective support instead of technical or institutional overprovision.

TRANSFER

Test routines, roles, assistive devices, the home environment and digital packages, then transfer them home in an understandable form.

01 • MODEL OF CARE

Introduction

The Center for Home-Based Care (ZHV) is a time-limited, supported transitional living arrangement for people with care needs and their family caregivers, as well as people facing broader health-related challenges. It closes the gap between hospital, rehabilitation, destabilisation at home and a sustainable care arrangement at home.

People with health-related needs and the person who carries primary responsibility for supporting them are considered a care dyad. What matters is not only functional status, but whether the home environment, skills, burden, routines, assistive devices, services and digital support become workable together in everyday life.

A stay typically lasts 3 to 21 days. Everyday routines are observed, stabilised, trained and tested with progressively less guidance. Family caregivers receive practical coaching; the home environment, assistive devices and technology are added only where they solve a concrete barrier.

The outcome is a testable transfer plan with responsibilities, crisis pathways and 30-/90-day follow-up. Research, product testing or co-development are voluntary and must be organisationally separated from care delivery.

The ZHV at a glance

The ZHV is a goal-oriented service for rebuilding capability and readiness to return home. Its core consists of everyday-life assistance, coaching, daily structure, technology onboarding, documentation and coordinated follow-up.

It is not a nursing home, rehabilitation facility, hospital or home care service. Nursing care, therapy, medicine and clinical decisions remain with qualified partners; the ZHV connects their specifications with the realities of everyday life.

How a person moves through the ZHV

The pathway begins with a transition question: What could cause care at home to fail — and which changes need to become visible for returning home, or remaining there, to be responsible and sustainable?

Step	What happens
1. Access & pre-assessment	Referral from hospital/rehabilitation, outpatient care, the municipality or self-referral. Safety, fit, admission limits and a preliminary case hypothesis are clarified.
2. Admission & goal setting	Baseline within the first 24–48 hours, separate consents and three to five concrete everyday-life goals.
3. Stabilise, train, adapt	Daily structure, ADL/IADL, family-caregiver roles, assistive devices, the home environment and selected Habitat packages are tested step by step.
4. Transfer & follow-up	Goal attainment, remaining risks, responsibilities, the support plan and 30-/90-day follow-up are defined.

02 • ADMISSION AND STAY

Admission and goal clarity

Pre-assessment serves safety, fit and goal clarity. Appropriate situations are those in which living at home is fundamentally possible or desired, but routines, assistive devices, family-caregiver roles or services are not yet sustainable or remain unclear. A need for acute hospital care, intensive monitoring, acute risk of self-harm or harm to others, or the absence of an adequate safeguarding and consent framework preclude admission.

After the baseline assessment, a small number of testable goals are agreed — for example a safe bed-to-bathroom transfer, a reliable morning or medication routine, a sustainable division of responsibilities, or functioning orientation at night.

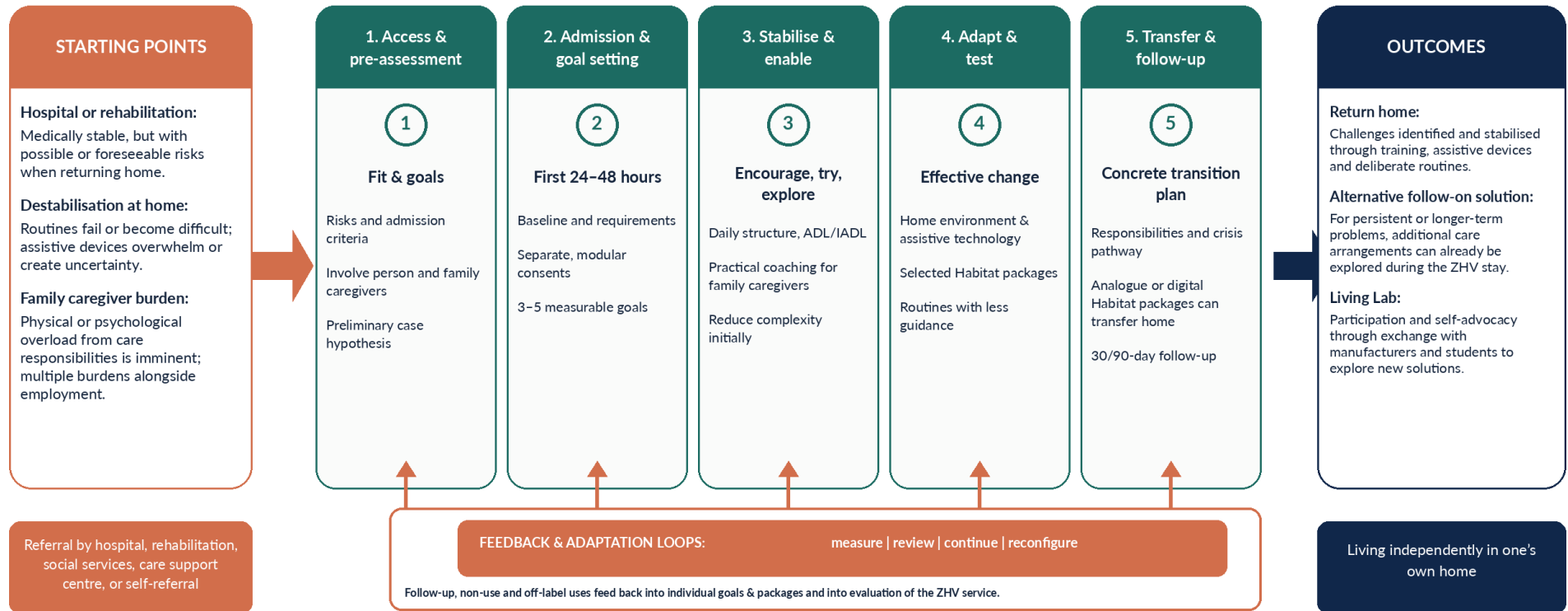
Components of a stay

Component	Function
Everyday-life goals	Concrete, testable target states instead of general promises of safety.
Baseline & reviews	Observation of routines and regular adjustment of the case hypothesis.
Assistance & daily structure	Accompany, remind and practise, while dividing daily life into manageable sequences.
Family-caregiver coaching	Clarify roles, boundaries, respite windows, communication and crisis pathways in practical terms.
Home environment & assistive devices	Test lighting, routes, furniture, bathroom, kitchen, storage and assistive devices in everyday-life conditions.
Habitat packages	Goal-related digital support that reflects consent, local logic and support requirements.
Partner services	Nursing care, therapy and medicine as needed through qualified external partners.
Transfer & follow-up	An understandable handover plan, clear responsibilities and 30-/90-day follow-up.

03 · CARE PATHWAY

THE ZHV CARE PATHWAY

From an uncertain transition to sustainable home-based care



04 • TARGET GROUPS

Target groups and typical transition barriers

Target groups are grouped primarily by the dominant pattern through which care at home is at risk of failing. For a first site, however, a narrow start with common, readily measurable pathways is recommended — especially geriatrics/mobility, daily and medication routines, and orientation at night.

Target group / pathway	Typical everyday-life barrier	ZHV focus
Geriatrics / mobility	Transfers, bathroom/kitchen, night-time routes, fear of falling, unsafe use of assistive devices.	Home-practical training, assistive-device routines, family-caregiver instruction, return-home check.
Orthopaedics / trauma surgery	Load limits, stairs, pain, protective movement patterns and unsafe routes through the home.	Bed-chair-bathroom-kitchen, pacing logic, home-environment and assistive-device plan.
Neurology / neurorehabilitation	Gait, fine motor skills, neglect, language, device operation and fluctuating performance.	ADL sequences, operating aids, fixed storage locations, partner therapy and transfer observation.
Cognition / orientation	Daily anchors, night-time agitation, door/stove routines, sensory overload and caregiver burden.	Calm orientation, simplified routines, status logic and a clear safeguarding framework.
Pulmonology / cardiopulmonary	Dyspnoea, fatigue, load dosing, inhalation, oxygen and indoor air.	Pacing and activity corridor, daily structure, indoor climate and crisis contacts.
Oncology / fatigue	Exhaustion, pain, nausea, cognitive load, visitor pressure and treatment routines.	Energy and rest windows, symptom routines, retreat options, caregiver and appointment logic.
Pain / sleep / mental health	Sleep-wake rhythm, anxiety, overstimulation, avoidance/protective behaviour and loss of daily structure.	Light/rest logic, activation windows and clear professional escalation pathways.
Severe multiple disabilities	Positioning, hoists, accessible bathroom, communication, night-time needs and person-specific knowledge.	Repeatable routines, communication profile, family mode and external specialist partners.
Parent-child dyads	Parental burden, night-time needs, school/daycare, siblings, assistive devices and complex routines.	Parent coaching, role and respite plan, participation mode and strong professional boundaries.
Complex coordination	Medication, appointments, supplies, wounds, incontinence and many organisations involved.	Named-coordinator plan, role overview, navigation pathway, documents and binding follow-up.
Socio-medical transitions	Poverty, language barriers, loneliness, low health literacy and digital exclusion.	Benefits/eligibility check, interpreting and navigation pathways, neighbourhood linkage and low-threshold usability.

05 • ACTORS AND PROCESSES

Participants and improved processes

The ZHV coordinates a time-limited care unit consisting of the care dyad, assistance staff, specialist partners, the home environment and – where desired – digital support. Its added value lies less in creating another institution than in reliably operationalising critical transitions.

Participant	How the ZHV helps	Processes supported
Person with health-related challenges	Tests everyday life, assistive devices and support in a realistic but buffered environment for a safeguarded transfer.	Goal setting, routines, self-efficacy, return-home decision and adaptation.
Family caregivers / close support persons	Receive practical guidance, clearer roles and predictable respite windows, reducing uncertainty and worry.	Coaching, task allocation, crisis pathway, substitution/backup and burden review.
Hospital, rehabilitation and social services	Gain a structured pathway for medically stable cases that remain uncertain in practical home-living terms, and greater decision confidence.	Referral, handover, goal alignment, transfer report and feedback.
Outpatient services and municipality	Can link housing advice, care counselling, community resources and follow-on services in a targeted way and reduce coordination burden.	Coordination, access to benefits/services, neighbourhood linkage, follow-up and escalation.
Assistive-device and technology partners	Receive vendor-neutral documented insights into fit, support needs, non-use and transfer to improve their offer.	Instruction/onboarding, field testing, adaptation, support profile and implementation learning.
Research, universities and startups	Work in an everyday-life setting with voluntary participation and clear boundaries, gaining access to ecologically valid insights.	Co-design, feasibility, mixed methods, evidence generation and safe further development.

Processes the ZHV operationalises

- Admit suitable cases based on safety, fit and goal clarity.
- Translate medical fitness for discharge into practical readiness to return home.
- Test routines, assistive devices, the home environment and family-caregiver roles together.
- Connect specialist services cleanly to qualified partners and make responsibilities visible.
- Identify non-use, overload, technical faults or poor fit at an early stage.
- Produce an understandable transfer report and concrete next steps.
- Track 30-/90-day stability, support needs and transferability.

06 • OPERATING MODEL

Operating model, professional boundaries and partnerships

The current ZHV approach starts with an assistance-based model: a small, broadly qualified pool covers everyday life, housing, technology, coaching, documentation, household tasks and organisational transfer work. Regulated professional services are not folded into the core operation, but are delivered through binding partner arrangements.

For pilot and routine operation, a staged build-up is envisaged: first a return-home check and follow-up without a dedicated residential unit, then a pilot room, followed by “ZHV-light” with one to three and, in the longer term, four to six spatially clustered units.

Assistance-based core operation

Scheduled morning and evening blocks, flexible project time and clear admission limits keep operations manageable. Regular overnight staffing is not part of the base model; where nursing care or monitoring is required at night, a partner or a different setting is needed.

Clear professional boundaries

ZHV assistants may remind, accompany, observe, document and implement approved plans. Nursing-care planning, treatment nursing, diagnostics, medication decisions, therapeutic assessment and clinical triage remain the responsibility of qualified nurses, therapists and physicians.

Habitat as a digital, privacy-compliant companion

Habitat structures goals, roles, consents, support packages, reviews and follow-up. Event data are used only for concrete decisions; raw signals remain local wherever possible, access is role- and purpose-bound, and consent can be withdrawn at any time.

Partnership and revenue logic

The ZHV charges for its own residential, assistance, organisational, technology and transfer services. Some packages may in certain cases be reimbursable through health insurance. External nursing care, therapy and medical services remain the responsibility of the respective partners and are generally billed separately. Manufacturer and research services should be run as separate B2B or project modules.

From transitional living to a learning infrastructure

A ZHV can begin with a small number of clearly bounded pathways and expand step by step. The decisive factors are not the largest possible number of devices or target groups, but repeatable processes, reliable partners, sustainable staffing and measurable readiness to return home.

With explicit consent, the setting can additionally serve as a burden-buffering Living Lab. It observes everyday-life fit, use, non-use, support effort and transferability — not only the technical functioning of a product. Negative results are themselves valuable findings.

Thirty- and ninety-day follow-ups examine whether routines persist, are adapted or discontinued at home, how family-caregiver burden and service use develop, and which packages, assistive devices or home adaptations actually prove sustainable.

The ZHV turns an uncertain transition into a testable pathway: safeguard everyday life, test solutions together, clarify responsibility, and transfer home only what can actually be sustained there.