Annual Report Swiss Center for Care@home

2025

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Contents

1 Introduction

Following completion of the pilot and build phase: change in SCC leadership and team

Under the leadership of Prof. Sang-Il Kim and Prof. Friederike Thilo, the SCC was successfully transitioned into the operational phase and underwent significant further development last year. Friederike Thilo and Sang-Il Kim succeeded in both advancing the central work packages of the SCC and planning and conducting events and workshops for lead partners and interested parties. Additional milestones were reached with the publication of two work package reports: 'Patients and relatives in Care@home settings' under the direction of Prof. Eva Cignacco and 'Profession development in Care@home settings – interim report' under the direction of Prof. Friederike Thilo. Moreover, in 2025 the number of lead partners was again increased significantly, to approximately 80. I would like to express my sincere gratitude to them for their great commitment to building and consolidating the SCC.

Prof. Sabina Misoch has been heading the SCC since 1 January 2026. Sabina Misoch is a (inter)nationally active ageing researcher at our Institute on Ageing. Prior to her current role, she successfully established the Institute for Ageing Research at the Eastern Switzerland University of Applied Sciences (OST; formerly FHS St. Gallen), having previously worked at the University of Mannheim as a junior professor and the University of Lucerne. She holds a doctorate in sociology and her research focuses on ageing, digitalisation, technology acceptance, ICT, social robotics, identity work, longevity and qualitative research methods. She is an international expert in ICT, ageing and qualitative research methods and is active on several foundation and supervisory boards.

The **team** has been expanded with additional specialists: Silja Leandra Lögler provides support as a research assistant and Monique Sturny is responsible for communications at the SCC Office. In 2026, the management team will add two additional specialists from the School of Health, with Prof. Sabine Hahn taking over as head of the 'Profession development' work package and Gina-Maria Tscherrig as head of the 'Patients and relatives' work package. Sabine Hahn has served as Head of the Nursing Division at Bern University of Applied Sciences since 2012. She earned her doctorate at the University of Maastricht (NL) in health and nursing sciences. Her focus is on the skills that healthcare professionals need to meet current and future challenges in the healthcare sector. In her role as Research Coordinator at BFH, Gina-Maria Tscherrig advises researchers on questions of ethics, finances and contract design. Her background lies in health sciences, clinical research and the further development of a network for leaders in the healthcare sector. Welcome to the SCC – I am very much looking forward to our collaboration!

With fresh momentum, two further reports from the 'Financing models' and 'Digitalisation and technology' work packages, specialist conferences and a renewed focus on previously funded projects in the form of new calls for proposals, we are setting out in 2026 to achieve further milestones for the Care@home vision in Switzerland. Close cooperation with our lead partners, BFH employees and key players in the healthcare sector remains crucial.

I would like to thank everyone involved for their tireless commitment and invite you to learn more about our activities, successes and future plans in the following chapters.

Kind regards,

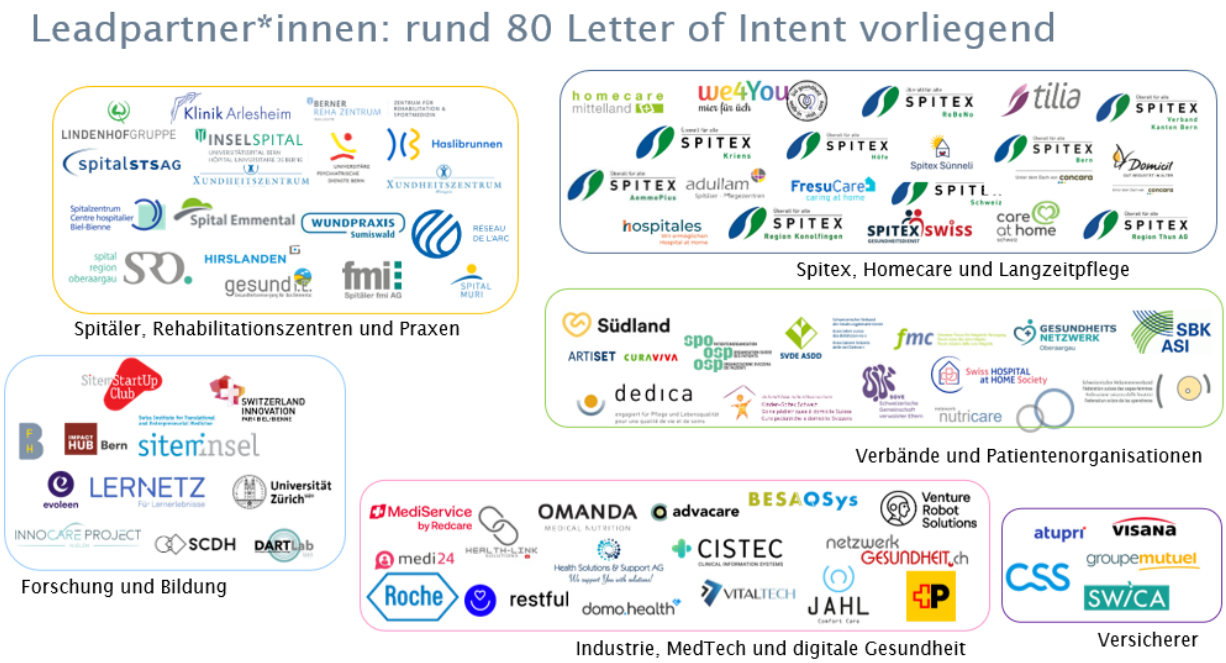
Prof. Sebastian Wörwag
President, Bern University of Applied Sciences

2 Results

2.1 Lead partners

The SCC currently brings together a broad alliance of around 80 lead partners, including hospitals, home care organisations, general practitioners, health insurance companies, retirement and nursing homes, outpatient healthcare providers and other healthcare institutions. These lead partners have confirmed their participation and interest in the collaboration through a 'letter of intent':

Lead partners (by industry)



With links to the partners: [Swiss Center for Care@home: lead partners | BFH]

2.2 Events

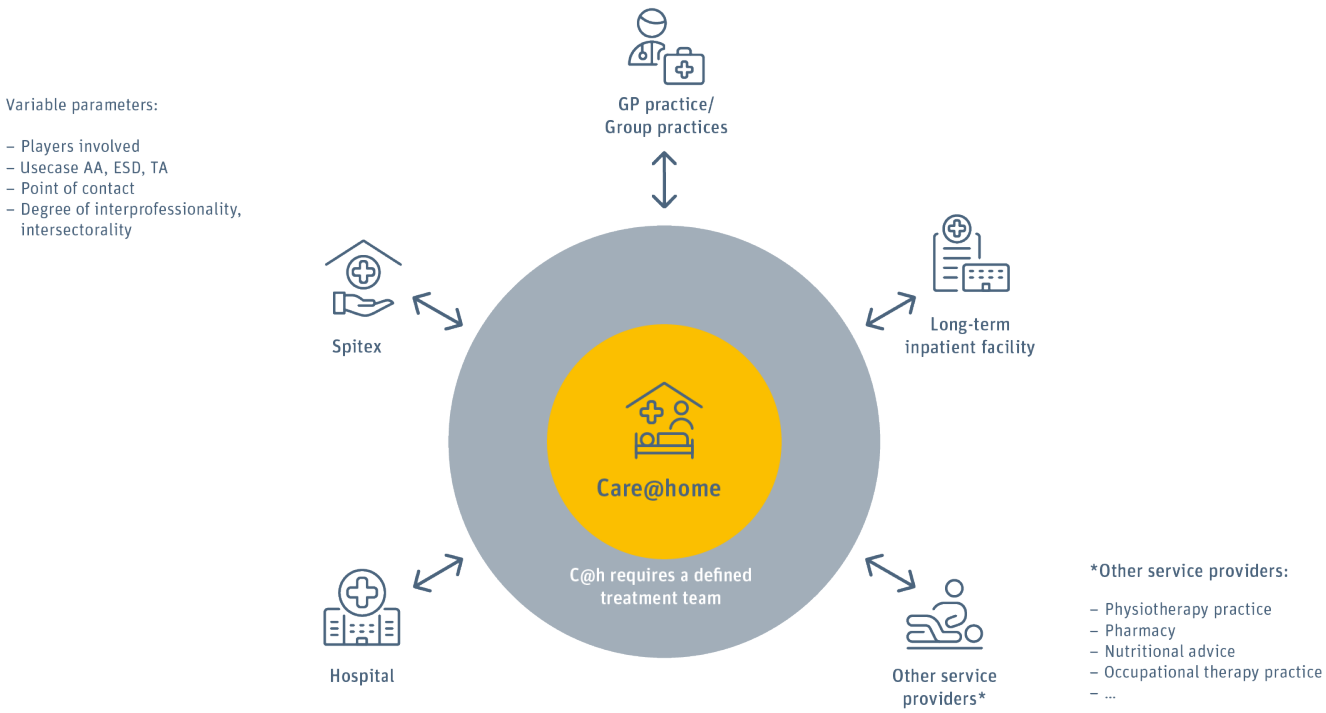
18 June 2025
SCC workshop on Care@home care models
Three keynotes, SCC definition 2.0 of Care@home, workshops on care models, 40 participants.

SCC definition 2.0 of Care@home
Care@home models are integrated, interprofessional, frequently intersectoral and hospital-equivalent healthcare models that enable patients of all ages to receive high-quality acute medical, nursing, therapeutic and social care at home.

The goal of Care@home models is either to avoid a hospital stay (admission avoidance – AA), to shorten the length of the stay in a hospital (early supported discharge/early transfer – ESD) or to ensure timely care in peripheral regions (timely access – TA).

Care@home includes hospital-at-home activities in which hospital-equivalent somatic care and psychiatric care are provided, as well as situations involving tertiary prevention where there is a high risk of deterioration. Care@home also offers healthcare models that utilise telemedicine.

Care@home basic model



26 August 2025
Networking workshop
Pitches for seed-funded projects from the 1st and 2nd calls for proposals, details of the 3rd call for proposals, workshops and presentation of results, 60 participants.

At the **networking workshop** on 26 August, fascinating insights were provided into the ongoing seed-funded projects (2nd call for proposals – CfP), along with results as well as lessons learned from the projects already completed as part of the 1st CfP. Details were also provided regarding the 3rd CfP. In the workshop setting, current challenges and project ideas were discussed and further developed on a collaborative basis. Topics: digitalisation, technology use, profession development, patient pathways, family carers and evaluation.

4 November 2025
SCC workshop on Care@home work packages
Practice keynote, presentation of work package results, workshops, pitches for seed-funded projects from the 1st and 2nd CfPs, 60 participants.

The **results of the work packages** were presented at the SCC event on 4 November. The research desiderata and recommendations for action were then discussed in depth and prioritised in workshops with an engaged group of participants.

2.3 Work packages

To ensure the consistent and focused creation of subject-specific content relevant to Switzerland, four work packages (WPs) were defined as part of the development of the SCC. In these work packages, members of the SCC are working with interested researchers at BFH, as well as representatives of lead partner organisations, on key issues relating to Care@home. We would like to extend our sincere thanks to all lead partners who are actively collaborating on the work packages and significantly contributing to the progress of the substantive work. **Two of the four reports (WP1 and WP4) were completed by the end of 2025. Two further reports on the 'Financing models' and 'Digitalisation and technology' work packages are in progress and will follow in spring/summer 2026. They will be presented in the next Annual Report.**

WP 1: Profession development

Management until 2025: Prof. Friederike J.S. Thilo, School of Health, BFH
Management from 2026: Prof. Sabine Hahn, School of Health, BFH

Brief description

- Demographic change, chronic diseases and the need for cross-sector care mean that treatment at home is becoming increasingly important.
- Care@home models enable hospital-equivalent care in the home environment.
- Main objectives: avoiding hospital admissions, shortening hospital stays, ensuring timely care in peripheral regions.
- International evidence shows comparable or better outcomes than inpatient care and high levels of satisfaction among patients and healthcare professionals.

The interim report from work package 1, 'Profession development', from the SCC, examines **three key issues:**

1. Which role profiles and competencies are required in Care@home models?
2. How does efficient intraprofessional and interprofessional cooperation work across healthcare sectors?
3. What training and continuing education programmes exist and where is there additional need?

The summarised evidence (see Chapter 5) illustrates that Care@home models represent a complex, interprofessional form of healthcare that requires clear role profiles, digital infrastructure, coordinated processes and targeted continuing education to ensure high-quality and safe care in the home environment. On the basis of the evidence presented on profession development in Care@home settings, key research priorities were identified that are crucial for the further development and sustainable implementation of these care models in Switzerland.

The full report: Profession development in Care@home settings – interim report

WP 4: Patients and relatives

Management until 2025: Prof. Eva Cignacco, BFH School of Health
Management from 2026: Gina-Maria Tscherrig, BFH School of Health

Brief description

Care@home models enable patients of all age groups to receive acute, hospital-equivalent medical, nursing, therapeutic and social care in their own homes. The models have **three main objectives:**

1. Avoiding hospital stays (admission avoidance)
2. Supporting early discharge from the hospital (early supported discharge)
3. Ensuring prompt care in peripheral regions (timely access)

In particular, the report highlights the perspective of patients and their families and identifies practical recommendations as well as gaps in the research. The report is based on a comprehensive literature review (2022–2025) and interviews with specialists from the home care, paediatric home care and home treatment fields.

Key findings

- Patients often prefer to receive care at home. They experience better quality of life, autonomy and opportunities to influence their own circumstances – and feel a comparable sense of safety as in the hospital.
- There are challenges when it comes to complex care situations, technical infrastructure and the 24/7 availability of healthcare professionals, among other issues.
- Patient approval strongly depends on trust in the model and the healthcare professionals.

In-depth topics

Six particularly relevant healthcare issues were analysed, including:

- Medication management: particularly prone to errors, especially in cases of polypharmacy and during transitions following discharge from hospital. → Recommendation: involve clinical pharmacists, structured training for relatives.
- Food management: insufficiently integrated at present, despite high prevalence of malnutrition. → Recommendation: involve nutrition professionals, standardised screenings.
- Promotion of physical activity and fall prevention: still little researched, but high potential for functional health and independence.

The full report: Patients and relatives in Care@home settings

3 Seed-funded projects

The Canton of Bern is creating research incentives in the field of Care@home with a time-limited measure in the form of seed funding. The calls for proposals are issued under the leadership of Bern University of Applied Sciences. The project calls were conducted by the BHF Office of the Vice-President Research, which also coordinates the independent evaluation panel.
In 2025, two calls for proposals were launched, through which a total of 13 project applications were funded.

3.1 From the 2nd call for proposals

2nd call 2025
The following eight projects will receive seed funding of up to CHF 50,000 from the second call for proposals.

+ App offering flexible support for relatives of palliative cancer patients
+ Palliative Care@home: trust and telemedicine
+ Nutrition management in Care@home settings: identifying barriers, developing solutions
+ Home success factors for successful Care@home
+ Co-care: coordination of care and support in home-based dementia care
+ Use of digital health interventions in the care of people with long Covid
+ Rehabio: prevention & rehabilitation of fall fractures and injuries in the ageing Swiss population
+ Remuneration and financing of Care@home models throughout the patient journey

➲ App for relatives, offering flexible support for relatives of palliative cancer patients

Abstract
The prevalence of cancer in Switzerland is increasing and relatives often take on central caregiving responsibilities, yet are under considerable strain. This leads to increased stress and mental health problems, particularly among relatives of patients in the palliative stage. Access barriers such as low socio-economic status or residence in rural areas make it more difficult to access support services. The project aims to develop a digital e-health application that provides psychosocial support to family members, reduces stress and enables low-threshold access to support services. Optimised care can prevent unnecessary hospital admissions and ensure comprehensive healthcare provision in both urban and peripheral regions.

Project manager
Prof. Alexander Wünsch, Head of Psycho-oncology, Inselspital, University Hospital Bern

Project participants
Dr Monica Fliedner (Inselspital), Georgette Jenelten (Spitex Bern), Ursula Dolder (Spitex Bern), Luca Willi (AvanzaTec)

➲ Palliative Care@home: Trust and telemedicine

Abstract
Demographic trends pose major challenges for GPs: the growing need for decentralised support can often barely be met. Remaining in one's own home plays an important role in palliative care – however, this often depends on family carers. Acute deterioration in the state of health often leads to uncertainty and unnecessary hospital admissions. These could be avoided through rapid contact with healthcare professionals and proactive emergency planning. Trust and safety are key factors for successful palliative care in the home environment. Our project therefore relies on the use of video consultations in outpatient specialised palliative care (SPC). Video consultations not only reduce travel times but also offer targeted support to patients with reduced mobility. Relatives and patients are trained in the clinical setting in the use of a digital communication tool, which can then be used at home.

Project manager
Maud Maessen, postdoc, University Centre for Palliative Care, Inselspital, University Hospital Bern & Institute of Social and Preventive Medicine (ISPM), University of Bern

Project participants
Prof. Steffen Eychmüller (Inselspital), Dr Monica Fliedner (Inselspital), Dr Julia Rehsmann (BFH), Sabrina Gröble (BFH)

➲ Nutrition management in Care@home settings: identifying barriers, developing solutions

Abstract
One of the biggest challenges in the Care@home setting is nutrition management. Inadequate nutrition management can promote malnutrition, which leads to serious health consequences such as increased complication rates, longer hospital stays and more frequent readmissions. At the same time, it places a burden on patients and family carers and reduces quality of life. Barriers such as lack of time, lack of guidelines, inadequate communication and insufficient awareness make interprofessional nutrition management in the outpatient setting more difficult. The aim of this project is to identify such barriers and develop innovative, practical solutions. Needs are identified, the current status of the nutrition management analysed and digital and interprofessional support options discussed in a workshop.

Project manager
Dr Andine Lehmann, Head of Degree Programme MSc Nutrition and Dietetics, lecturer, senior scientist, Nutrition and Dietetics division, School of Health, Bern University of Applied Sciences

Project participants
Katja Uhlmann (BFH), Sara Maria Hägi (FresuCare AG), Daniel Reichenpfader (BFH), Raphael Banz (Omanda)

➲ Home success factors for successful Care@home

Abstract
There is a lack of evidence-based knowledge regarding the social and spatial factors that influence successful Care@home provision, as well as a lack of tools for assessing home environments. Interprofessional cooperation between inpatient and outpatient care is often uncoordinated, causing gaps in care and duplication. Patients and relatives generally bear the burden of complex coordination, often without sufficient knowledge of available options. Early hospital discharges frequently give rise to follow-up care problems that favour readmissions and may be exacerbated in the Care@home setting. The aim of the project is the participatory development of a tool that allows Care@home to be set up at an early stage and in a person-centred manner, taking into account social, spatial and professional requirements and avoiding care gaps as much as possible.

Project manager
Franziska Scheidegger-Balmer, research associate, Institute on Ageing and Applied Research and Development Nutrition & Dietetics, School of Health, Bern University of Applied Sciences

Project participants
Regula Blaser (BFH), Eva Soom Ammann (BFH), Tanny Helfer (BFH), Simon Schrämli (Spitex ReBoNo), Georgette Jenelten (Spitex Bern), Marion Burgener (Spitex Region Thun AG), Sabine Molls (Inselspital)

➲ Co-care: coordination of care and support in home-based dementia care

Abstract
Switzerland is facing the challenge of an ageing population and increasing demand for home care, especially for people with dementia. With around 30,400 new cases annually, of which 5,000 are in the canton of Bern, the need for innovative care models is growing. The aim of the project is to improve care by analysing coordination problems and communication gaps and by developing a prototype for integrated dementia care. This lightens the burden on relatives and supports healthcare professionals. Improved cross-professional service coordination closes knowledge gaps and enables Care@home Bern to take a pioneering role in cross-sectoral care and to optimise support.

Project manager
Dr Minou Afzali, Head of Research, Swiss Center for Design and Health GmbH

Project participants
Dr Heinz Locher (Care at Home Schweiz GmbH), Dr Kosta Shatrov (Spitex Switzerland), Esther Bättig (Spitex Switzerland), Prof. Sang-Il Kim (BFH)

➲ Use of digital health interventions in the care of people with long Covid

Abstract
Roughly four per cent of the population are affected by long Covid. To date, the healthcare system has not been sufficiently prepared or coordinated to provide the best possible support for those affected and their families. Studies show that additional structures and services are needed to ensure adequate, person-centred care. Digital health interventions such as apps, telemedicine and therapy platforms could improve access and networking as well as relieve healthcare professionals. However, there is a lack of data on the use of these services by those affected and by professionals. This project examines the accessibility, acceptance, safety, effectiveness and usability of digital interventions as well as enabling factors and barriers. The goal is to formulate recommendations for future developments and to optimise the provision of care.

Project manager
Prof. Mirjam Körner, Head of the Competence Centre for Interprofessionalism, Co-Head of Degree Programme MSc Healthcare Leadership, School of Health, Bern University of Applied Sciences

Project participants
Prof. Maya Zumstein-Shaha (BFH), Kerstin Denecke (BFH), Chantal Britt (BFH), Karin Van Holten (BFH), Kimet Rashiti (Spitex Thun), Dominic Gorecky (SIPBB), Wolfgang Rieder (SIPBB)

➲ Rehabio: prevention & rehabilitation of fall fractures and injuries in the ageing Swiss population

Abstract
The Rehabio project aims to improve older people's quality of life and mobility through a digital companion application. It combines telemedicine and telephysiotherapy to enable personalised care and monitoring as well as to promote communication between patients, healthcare professionals and nursing facilities. In view of rising fall-related injuries (+38% by 2034) and inadequate prevention methods, Rehabio addresses the consequences of recurring falls and the strain on medical staff. The

project strengthens prevention after rehabilitation by empowering older people to participate actively in their own healthcare.

Project manager
Prof. Johannes D. Bastian, Chief Physician, Head of Orthogeriatrics, Co-Head of the Hip and Pelvis Unit, University Clinic for Orthopaedic Surgery and Traumatology, Inselspital

Project participants
Silviya Ivanova (Inselspital), Prof. Heiner Baur (BFH), Prof. Slavko Rogan (BFH), Chris Gugl (Evoleen AG), Marcel Wüthrich (Evoleen AG), Sophia Mardin (Evoleen AG)

➲ Remuneration and financing of Care@home models throughout the patient journey

Abstract
This project examines the financing and remuneration of Care@home models in Switzerland to develop sustainable structures for high-quality and cost-efficient health services. Currently, C@h models that combine inpatient and outpatient care during acute periods of illness are mostly funded only through pilot projects. There is a lack of a uniform definition of C@h services, clear remuneration models and integration into the healthcare system. The project analyses existing models, cost structures and international approaches. The goal is to develop recommendations for the long-term financing and integration of C@h in Bern in order to improve patient care and make the healthcare system more efficient.

Project manager
Dr Katharina Blankart, Head of the Institute of Health Economics and Health Policy, School of Health, Bern University of Applied Sciences

Project participants
Dr Kosta Shatrov (Spitex Switzerland), Esther Bättig (Spitex Switzerland), Severin Pöchtrager (Swiss Hospital at Home Society), Eva Blozik (SWICA)

3.2 From the 3rd call for proposals (2025 > financing from 2026)

3rd call 2026
The following five projects will receive seed funding of up to CHF 55,000 from the third call for proposals.

+ Value@home: economic evaluation of specialised palliative care in different care settings

+ COALA (Coordination & Assistance for Living at Home)

+ Blended nutrition Care@home: pilot project for a novel nutritional therapy for patients with malnutrition in the home setting

+ Care@home: enabling the living environment as well as the home

+ Digital peer networking for those affected and relatives in psychiatric home care (CoPEER)

➲ Value@home: Economic evaluation of specialised palliative care in different care settings

Abstract
The Value@home project aims to create an integrated cost overview as a basis for coordinated and sustainable palliative care. As a pilot study accompanying the 'Palliativverbund Bern', or Bern palliative care network, it links cost data from acute wards, long-term care, hospice and Spitex/home care and identifies gaps in the data. The backdrop here is the growing need for care: the percentage of those over 65 is set to rise from 19% to over 26% by 2050. Many of those affected wish to stay at home until the end, but specialised palliative care is often provided late and predominantly in hospital, which contributes to gaps in care, hospitalisations and high costs. The EFAS proposal adopted in 2024 is also intended to reduce misaligned incentives.

Project manager
Dr Monika Hagemann, Scientific Researcher in End of Life Care, Center for Palliative Care, University Hospital, Insel Gruppe AG and University of Bern

Project participants
Steffen Eychmüller (Inselspital), Maud Maessen (Inselspital), Georgette Jenelten (Spitex Bern), Ursula Hafed (Wohn and Pflegeheim St. Niklaus Koppigen), Sibylle Jean-Petit-Matile (Stiftung Hospiz Zentralschweiz), Matthias Schwenkglenks (University of Basel), Manuela Weichelt (Palliative.ch)

➲ COALA (Coordination & Assistance for Living at Home)

Abstract
COALA studies how digital orchestration can close gaps in care and make regional services more visible. Demographic change, shortage of healthcare professionals and rising healthcare costs are straining the healthcare system, while the fragmented system of medical, nursing and social services remains difficult to navigate for those affected. Research data on the effectiveness of digital information platforms is lacking and existing solutions tend to focus primarily on medical care or isolated tools. COALA is therefore developing a platform concept and testing it with two regional health networks to examine acceptance, user-friendliness and efficiency potential. Building on the Caro1 Care Organizer, COALA is creating a cross-sector platform for the further development of Care@home.

Project manager
Wolfgang Rieder, Project Manager / Development Engineer Switzerland Innovation Park Biel-Bienne

Project participants
Emma Nadol (SCDH), Michaël Laurac (BFH), Peter Bodziak (Gesundheitsnetzwerk Oberaargau), Martin Jörg-Gygax (Healthinal AG), Stefan Steiner (Verein Smarthöfe), Claudia Monstein (Healthinal AG)

➲ Blended nutrition Care@home: pilot project for a novel nutritional therapy for patients with malnutrition in the home setting

Abstract
This project lays the groundwork for a new blended nutrition therapy that combines personal and digital nutritional advice for malnourished patients after being discharged from the hospital and thus closes a gap in care in an innovative way. Malnutrition affects around 40% of hospitalised individuals and leads to weight loss, muscle reduction, vulnerability, a risk of falling and increased hospitalisation. Although nutritional therapy reduces readmissions and improves quality of life, targeted nutritional follow-up care in the home environment is rarely provided in Switzerland. The pilot project optimises care through practical implementation as well as interviews and workshops with participating institutions and identifies technological, logistical and economic hurdles. A follow-up project is intended to implement the dual therapy and roll it out nationally.

Project manager
Dr Raphael Banz, Co-Founder, Chief Scientific Officer, Omanda AG

Project participants
Dr Andine Lehmann (BFH), Dr Marvin Grossmann (Inselspital), Dr Mathias Schlögl (Klinik Barmelweid), Dr Katharina Blankert (BFH), Eveline Zbären (Omanda AG)

➲ Care@home: enabling the living environment as well as the home

Abstract
The first part of the project establishes what needs to be taken into account in the living environment in order to effectively support C@h patients – thereby closing a central gap in current discharge planning, which usually only considers the immediate living situation. However, the broader living environment is also crucial for identifying support needs early and avoiding readmissions. Another fundamental problem concerns nutrition: protein-energy malnutrition is widespread among people over 65 and particularly increases the risk of hospital readmissions in chronically ill patients or after visceral surgery. The second part therefore examines how nutrition problems can be better identified and addressed by healthcare professionals.

Project manager
Tannys Helfer, Research Associate, Applied Research and Development in Nursing (Innovation Field Psychosocial Health), BFH

Project participants
Heiner Baur (BFH), Áron Korózs (BFH), William Fuhrer (BFH), Jerylee Wilkes-Allemann (BFH), Christine Wenger (SVDE ASDD), Ruth Hagen (Spitex Switzerland), Nadine Habegger (Spitex AemmePlus AG), Emma Nadol (SCDH)

➲ Digital peer networking for those affected and relatives in psychiatric home care (CoPEER)

Abstract
The CoPEER project complements the existing Care@home provision of psychiatric home care with low-threshold peer-to-peer support for clients and their relatives. Mental health issues are among the most common chronic conditions, and many sufferers experience loneliness, reduced social activities and everyday strains despite professional care. Relatives also often report exhaustion and psychological stress. Studies show that peer support can strengthen hope and self-efficacy and reduce loneliness as well as symptoms of illness. CoPEER connects clients and relatives with other affected parties through a digital platform, thereby creating a bridge between professional care and self-management as well as timely access to support.

Project manager
Dr Anna Hegedüs, Co-Head of the Innovation field ‘Mental Health and Psychiatric Care’, BFH

Project participants
Nora Ambord (BFH), Chantal Kuske (Restful), Raphael Reber (Restful), Sonja Forster (Spitex Kriens)

4 Outlook

2025 brought important progress with 13 newly seed-funded projects, three specialist conferences, two reports from the ‘Profession development’ and ‘Patients and relatives’ work packages and around 80 lead partners. The SCC will build on this progress in 2026 and continue to move things forward.

There was a change of leadership on 1 January 2026, and I am very much looking forward to continuing to shape the SCC as its new head together with a dedicated team. The mission of the SCC remains unchanged: to strengthen intersectoral and interprofessional healthcare through effective and efficient measures in the Care@home field, to connect stakeholders and to bring together the network of lead partners, cantonal representatives and researchers. Seed funding for important pilot projects in the Care@home context will continue to be supported in the future, as these are the cornerstones of our commitment to a socially accepted, needs-based and economically viable healthcare system of the future.

We have a lot planned at the SCC in 2026. Two further reports are expected from the ‘Financing models’ and the ‘Digitalisation and technology’ work packages. We also have plans for two SCC events in June and September as well as a stronger thematic focus in the area of project funding. The goal is to expand the impact of the SCC, further sharpen the vision of Care@home in Switzerland, intensify our efforts to bring together relevant stakeholders in the area of Care@home within the SCC and provide a networking platform. We will also be accelerating concrete steps towards the implementation of Care@home in Switzerland in the spirit of the principle that focus creates the future.

Thus, our collaboration with all stakeholders remains key to the further development of the SCC. We sincerely thank all those involved for their commitment and look forward to tackling the next steps and the further development of the SCC together!

Kind regards,

Prof. Sabina Misoch
Head of the Swiss Center for Care@home