

Better care at home. Time returned to people. A stronger Homecare organization.

Care at home works through relationships: the person receiving support, their chosen circle, visiting staff, coordinators, and referral partners. genus connects those relationships with knowledge, resources, and practical workflows from first inquiry through ongoing support and changing needs. Public resources, the care app, and the partner portal provide connected places to learn, communicate, and follow through. Your service commitments and care practices shape the configuration, with people responsible for the decisions that matter.



Illustration of listening during a home visit; not a customer photograph or Noah's story.

Support that fits a person's life

Keep preferences, purpose, and agreed responsibilities in view. Help clients and chosen supporters understand the next step and whom to contact when an arrangement stops working.

Prepared, supported care staff

Connect approved guidance, role-based learning, and useful visit preparation. Give coordinators a clearer way to explain changes and confirm that the people involved understand them.

Less repeating and chasing

Reuse appropriate resources and pathways, prepare reviewed communications, and clarify handoffs. Measure the full effort across the visit and office team, including corrections and follow-up.

Continuity with sustainable value

Make the first service easier to approach and ongoing support more dependable. Learn why clients and staff stay or leave, while recognizing appropriate transitions and changed needs.

One organizational direction. Personal support at home.

Across configured teams and locations, coordinate approved knowledge, research, branding, care strategies, and governance. Local teams bring service capacity, contacts, and each person's context. Agree access, content distribution, reporting coverage, and common measures. Reviewed local learning can then improve shared preparation without erasing personal choice or local responsibilities.

A changed arrangement, without starting over

In a fictional example, Noah wants support around work and friendships. His cousin can no longer help at the usual time. A coordinator talks with Noah, agrees a realistic next step within the service, and confirms who needs the update. Noah's choices guide the change; he need not retell it to everyone.

One connected care journey

Connect inquiry, preparation, visits, communication, and review. The visit cycle repeats; reassessment and transitions happen when needed. Agree the systems and human responsibilities supporting each stage.



1. Referral, inquiry, and intake

Respond, discuss needs and eligibility, confirm service fit and capacity, and name the next responsible contact.

3. Support at home

Prepare, provide agreed support, and record useful observations and changes through the authorized workflow.

5. Connect and follow through

Share resources and updates, receive questions, and confirm who acts on changes before the next visit.

2. Agree and prepare

Agree goals, sharing, visit arrangements, and responsibilities; orient the client, chosen supporters, and assigned staff.

4. Review before sharing

AI can draft from approved information; staff check accuracy, service boundaries, permissions, and recipients.

6. Review and transition

Review service fit with the person; prepare agreed handoffs, doctor-conversation questions, and changes in support or access.

Supporting work: governance, knowledge, training, scheduling, service records, billing, and accounting. Confirm systems and integrations; this map does not establish EVV, payroll, or claims automation.

Feedback → accountable review → shared learning → better preparation. AI drafts do not reassign staff, change a service commitment, or commit family members to help.



Concept illustration: people, shared tools, and agreed connections support the journey.



Illustration: chosen supporters and staff review an arrangement together.

Personal communication, practical setup at scale

Place contacts and pathways in one or selected communities. Review uploads, validation, and exceptions. Keep client permissions distinct; agree branch coverage, connections, and responsible people before use.

Measure what makes the organization stronger

Use a small scorecard to connect service quality with capacity and financial sustainability. Agree comparable baselines, owners, sources, and review windows. These are proposed local measures, not an automatic dashboard, promised savings, or customer results.

Area	Practical measures and decisions
Referrals and access	Time to human response; eligible referrals reaching first service within the agreed window. Track pending cases and barriers to a suitable start.
Quality and experience	Client-reported usefulness and preserved choice; corrections required before sharing updates. Check follow-through on changed arrangements, not just messages sent.
Time and efficiency	Staff effort per complete visit-to-update or coordination workflow; estimated hours returned. Include preparation, review, correction, sharing, and follow-up across roles.
Training and readiness	Current role requirements and observed readiness, assessed separately. Check whether staff can use the guidance in practice.
Client and staff retention	Client continuity and staff retention as separate starting-cohort measures. Review reasons for leaving; recognize appropriate transitions and planned endings.
Partners and community	Accepted handoffs and person-confirmed useful introductions among cases due. Confirm responsibility and useful support, rather than counting referrals sent.
Learning and captured wins	Reviewed improvements tested; decisions and learning returned to contributors. Carry useful frontline ideas into the next service cycle.
Financial value	Verified expense reduction plus incremental contribution, less applicable costs. Check whether better coordination strengthens the organization after delivery costs.

Time returned is capacity, not automatically cash saved. Incremental contribution is additional earned revenue less variable delivery costs. Deduct implementation and ongoing costs only where not already counted; count each benefit once.

Use consistent cohorts, periods, and branch coverage. Show missing evidence as not yet measured. Pair numbers with client and staff experience; retention without suitable care is not success. Check other changes before attributing an improvement to technology.

Start with one practical improvement

1. Choose one complete workflow. 2. Establish a comparable baseline. 3. Name a responsible owner. 4. Agree a quality check. 5. Review results with the people involved.

Start with one useful change at home, learn with the people involved, and build the next step together.

Discuss your Homecare workflow →