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Article · January 2014

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Innovative Seniors Housing and Care Models: What We Can Learn from the Netherlands

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Abstract

This brief report highlights some innovative seniors housing and care practices from the Netherlands. The first is the Humanitas Apartments for Life, where if and when residents need assisted living or nursing facility level care, it is brought to them, thereby eliminating stigma and relocation issues. Second is the unique dementia village of *De Hogeweyk*. Both models have specific physical design elements and philosophies that support them and use "small houses" for severe dementia care. Finally, the general approach of community integration that seems to naturally permeate senior living facilities is discussed. This integration takes the form of offering services, such as home care, to the wider community as well as having businesses in the facility that make neighbors feel welcome.

INTRODUCTION

As early as the late 1950s, some northern and western European countries were channeling much of their energy into providing home care, believing that many older people could remain in conventional housing if they received assistance from home care aides (Regnier, 2013). Denmark was a leader in this home care movement, even passing a moratorium on the building of nursing homes in 1988 (Schulz, 2010), and it still provides more home care than other European countries. Much of what older people need is not high-tech. The challenge these countries all faced was that conventional housing did not always lend itself to the provision of services, with small, sometimes substandard, units and few elevators (Regnier, 2013).

In the U.S., only in recent years has there been a significant push toward a more even balance with home and community-based care, as nursing homes were originally chosen as the primary venue for formal long-term care provision. Among nursing facilities, a new trend in the U.S. is the "small house." The Dutch were ahead of the U.S., as this model started in the Netherlands in the 1980s. It has become widespread there to the point that, in 2010, it was estimated that about 25% of all nursing home care for people with dementia was provided in small-scale living facilities, partly with stimulus from the Dutch government (Verbeek, van Rossum, Zwakhalen, Kempin, & Hamers, 2010). In contrast, the first Green Houses, the small house model popularized by Dr. William Thomas, did not open in the U.S. until 2003 (Rabig, Thomas, Kane, Cutler, & McAlilly, 2006). There are now about 150 in existence in the U.S., with another 150 in development (Jaffe, 2013). This number still represents a very small portion—less than 2%—of the 15,700 nursing homes estimated to exist in the U.S. (Harris-Kojetin, Sengupta, Park-Lee, & Valverde, 2013), but this scale also differs from the Netherlands, where 324 nursing homes, 960 residential homes, and 210 combined institutions existed in 2007 (Schäfer et al., 2010).

In the U.S., nursing facilities, along with independent and assisted living, also can be a part of continuing care retirement communities (CCRCs). CCRCs can be a good choice for many people, if they can afford them, and provide opportunities for social interaction, exercise, and shared meals; however, there is always the potential future just down the hall: the care units that independent living residents so desperately want to avoid. Reflecting this fierce sense of denial, people who move into the independent side of a CCRC often will not even visit the attached assisted living and especially the nursing home wing.

Independent CCRC residents often shun the residents of the more dependent levels when they are brought to shared activities and may not even visit longtime friends once they are moved to other units. Shippee (2012) describes how even within the independent side, residents are avoided as they start to display increasing physical or mental problems, as if others cannot stand the reminder of the next stage. Given this fear, a new trend in CCRCs allows people to extend their independent stay somewhat longer by permitting the help of an aide (Fabris, 2013; Hoffman & Hoffman, 2014), thereby postponing the move to assisted living. Additionally, some developers are beginning to build independent living facilities that also meet assisted living regulations. Still, for most older adults, the frightening specter of ultimately moving to a nursing facility looms large.

Apartments for Life

One model that emerged in the Netherlands as a solution to meet the challenges of stigma and relocation is the Apartments for Life concept. Established in 1995 by Humanitas CEO Hans Becker, the concept is still little known in the U.S. The nonprofit Humanitas was founded in 1945 and has continued with a mission of supporting individuals who need assistance. In particular, the organization provides

care and housing services to older adults (van Marrewijk & Becker, n.d.), and it is out of this mission that the Apartments for Life concept evolved. Becker developed it with a disarmingly simple focus on the happiness of the residents. A physical design component and a philosophy undergird it.

Individuals or couples ages 55-plus are eligible to move into Apartments for Life, and typically they enter while still independent. If individuals eventually require assisted living or nursing home level care, care is brought to them. They do not move. The housing is specifically designed to allow the resident to remain in the same apartment until death—true aging in place. Becker calls this concept *"levesloopbestendige"* or "age-proof dwellings" (Regnier, 2013, p. 4). Universal design is used for the 760-square-foot units. They can accommodate patient lift equipment, oxygen, and wheelchair and stretcher use (Ijeh, 2013), as needed to compensate for aging-related losses. Modifiable aspects include adjustable sink units that can be raised or lowered (Regnier & Denton, 2009). Access to apartments can easily and quickly be gained by elevator as the buildings were designed to be midrise. Apartments have lockable doors, so no one, including care staff, can enter without permission (Aged & Community Services Australia, n.d.).

Becker believes that older people want to remain both independent and involved in society as much as possible (Regnier, 2013). The Humanitas philosophy incorporates four key values: 1) autonomy: be the boss of your own life; 2) the use it or lose it philosophy; 3) the yes culture; and 4) a broad family-centered approach to caregiving (Regnier, 2013). The value placed upon autonomy is underscored by value number three—the "yes culture," which promotes the idea that older adults should be able to make their own decisions and do what they want, even if it means sleeping until noon or drinking at the bar. The idea is to give older residents the freedom to enjoy simple pleasures as well as challenges and stimulation. "Use it or lose it" has been repeated widely in the U.S. in relation to physical and mental activity. Here it reflects the specific Dutch strength-based philosophy that "often views the over-provision of care as more damaging than the under-provision. They believe older people should be challenged to do as much as they can for themselves" (Regnier, 2013, p. 5).

Since the first Apartments for Life, Bergweg, opened in Rotterdam, there are now more than 15 Apartments for Life buildings in the Netherlands, with 1,700 apartments and about 2,500 residents (Tinker, Ginn, & Ribe, 2013). The apartments may be bought or rented (Regnier & Denton, 2009), and municipal support programs may be available for rentals. When health needs are officially recognized, the care provider is compensated by national medical regulations (Algemene Wet Bijzondere Ziektekosten [AWBZ]); residents who want care without meeting medical requirements may pay for that care privately (van Marrewijk & Becker, n.d.). Aide visits can vary from once a day to four to eight times daily (Regnier, 2012).

While the evidence is mostly anecdotal, this non-institutional setting, with heavy volunteering that builds interdependence (Scheidt, 2012) and a strong emphasis on self-actualization, is reportedly as much as 10% to 25% less expensive than comparable institutional care (Ijeh, 2013; Regnier, 2013). Variations of this model have been explored and are now being tested in Australia (Aged & Community Services Australia, n.d.; The Benevolent Society, 2009).

Very few Apartments for Life residents have been forced to move to nursing facilities over the past 15 years (Regnier, 2012). The one exception is those individuals who develop severe dementia. Some residents can continue in their apartments and can access adult day support, but as the dementia progresses, individuals may no longer be safe remaining on their own. Some buildings have now added small group units or clusters in the building for these individuals. Bergweg, for example, has added 29 units in four clusters on the top floor of the building (Regnier, 2013). Otherwise, residents generally remain in their homes surrounded by familiar belongings and

neighbors, even as they need more care. Persons who need assistance and those who do not are mixed together; independent residents could live between neighbors requiring assisted living or nursing home level care. Thus, residents can avoid changing dwelling units and enjoy continuity with the same care staff (Regnier, 2013). This model addresses the whole issue of fear and stigma that often underlies CCRCs, represented by what Becker calls "misery islands," where those with physical and mental disabilities are clustered together (van Marrewijk & Becker, n.d., p. 2). There is a greater acceptance of the aging process inherent in the model. Beyond that, the whole issue of moving is avoided, which is especially beneficial to a married couple; when one spouse needs more care, it can be provided in the same apartment and they can continue their lives together. With a reported 10,000 to 12,000 people on the waiting list, it appears to be a popular model (van Marrewijk & Becker, n.d.). Regnier has long advocated implementing the Apartments for Life model in the U.S. but notes that "ambiguity in regulations has made it difficult to interpret these ideas in a straightforward way" (2013, p. 7), although some low-income seniors housing facilities in the U.S. do bring services to residents (Adler, 2002). There also is the concept known as "CCRC without walls," or "CCRC at home" (Magg, 2012), which embraces the approach of providing services to individuals in their own homes. About 12 currently exist.

De Hogeweyk, the "Dementia Village"

In the town of Weesp can be found the "dementia village" of *De Hogeweyk*, which is unique in the world. The roots of the village originated in a more traditional long-term care facility, when several of the key staff sat down one day in 1993 to discuss the shortcomings of the current model of care (van Amerongen-Heijer, 2013[1]). The critical question they asked was, "Is this a place I would want to bring my parents?" Their answer was no. The ideas that emerged at that time were to strive to make it "life as usual," and they made several changes that improved quality outcomes, such as a decrease in challenging behaviors and the use of incontinence materials, sedatives, and the need for ground food. Residents, families, and staff all had increased satisfaction with the new approach.

The leaders received $22.5 million in funding to build the village of *De Hogeweyk*, which opened in 2008. The 152 residents, all of whom have severe dementia, live in 23 small houses, each with six to seven bedrooms (172 to 215 square feet), two bathrooms, and a kitchen. The organizers found that people feel safer being together in the daytime, so the bedrooms were intentionally made smaller. The buildings are no more than two stories. A unique aspect of *De Hogeweyk* is the goal to house residents with likeminded people in these small houses. The organizers employed a company to help them identify these lifestyle groups, based on a Dutch database that reflected the national population. This approach goes beyond demographics and differentiates between seven lifestyle choices that can be roughly translated as:

- "Homey": simple life, focus on housekeeping and family
- Christian: religion is an important part of life, may affect lifestyle choices
- Craftsman: traditional, hardworking, early to rise/early to bed
- Arts and culture: international travelers, colorful interior design, more adventurous in food choices
- Aristocracy: formal, classic design, accustomed to having servants
- Indonesian/Colonial: interested in nature, spirituality, Indonesian food
- Urban: outgoing, informal

This design is intended to make life as normal as possible. People have choices to be able to live among those with whom they have something in common, and with the kind of décor that seems familiar and is

aligned with their personal tastes.

In addition, *De Hogeweyk* has restaurants, gardens, a grocery store, pub, theater, and hair salon—all the essentials found in a village. Residents see themselves in what appear to be familiar and normal surroundings, thereby reducing their anxiety and fear (Archer, 2012). Because of the thoughtful design, residents can walk freely throughout the community without danger of leaving the premises. The grounds are purposefully orchestrated so that there is something interesting to see around every curve of the path. *De Hogeweyk* organizers believe that social interaction, fresh air, sunlight, and exercise are all beneficial for those with dementia. The 120 volunteers and 240 employees (170 are full-time) dress in street clothes and are specifically trained to work with individuals with dementia. With their help, residents can live their lives as normally as possible and in safety, even the 30% of residents who are mostly bedridden (Hurley, 2012).

Van Amerongen-Heijer (2013[1]), one of the founders, states that *De Hogeweyk* provides this care with the same government reimbursement levels as other Dutch facilities serving those with dementia, but the quality and cost-effectiveness have not been formally studied (Tinker, Ginn, & Ribe, 2013). While the monthly cost of residency is similar to other nursing homes at $6,555/month, the lifestyle is incomparable (Sampson, 2014). Germany and Switzerland are starting to build similar villages (Archer, 2012).

Community Integration and Cooperation with Other Agencies

In the Netherlands, seniors housing facilities are often woven into the surrounding neighborhoods by offering community services, such as adult day programs, home care, and dementia housing, and by having spaces that welcome the community. For example, an Apartments for Life in Rotterdam has a child care center on the first floor of the building to serve the neighborhood. It also has an attractive restaurant/bar/café that is open to both the residents as well as the neighbors. *De Hogeweyk* itself opens up its restaurant to the neighborhood and rents out its theater for performances and conferences (Tagliabue, 2012).

In other examples of reaching out to the larger community, some of the elder care facilities extend the provision of home care to people living in surrounding neighborhoods. Some facilities have managed to claim a few rooms within their buildings to tuck in a small adult day program. This idea has many advantages. It makes adult day services less costly to provide, compared to building a free-standing center; the smaller number of clients—perhaps eight to 10—make it less stressful for persons with dementia; and the number of adult day programs can be increased, making them more accessible and convenient to family caregivers. Apartments for Life residents also can use adult day programs.

One final, almost radical, aspect of housing options in the Netherlands is that boundaries between companies and agencies appear to be more permeable. For example, an assisted living facility had a large and attractive dining room for residents to have their main meal in the middle of the day. Another living facility for older adults was next door. What was surprising was that those residents could also have meals in the dining room of the assisted living facility, even though the building was owned and operated by a different company. Similarly, in a little Dutch town, there were four small group homes built near each other. To a passerby, they would have looked no different from the houses around them. In addition to being structured according to the small house model described previously, two of the homes were run by a company that served older adults, and two were run by an agency serving people with mental health needs. They sometimes shared staff. This kind of interagency collaboration seemed to generate greater efficiency in the operation of the units.

Conclusion

In the U.S., when individuals need long-term care, they often end up in nursing facilities with a roommate. We place the individual in whatever room has a bed available, regardless of whether the new roommates have anything in common. Schedules are regimented and staff members are often overextended. Residents may seldom be able to spend time outside.

This report highlights some of the innovative practices that have been implemented in the Netherlands. Implementation in the U.S. would require overcoming some obstacles. The small house with private rooms for six to nine residents, opening to a living room/kitchen, and managed by one aide for the six to nine residents is certainly appealing. So far, this idea has begun to emerge on a small scale in the U.S. The idea of families filling out questionnaires to point their loved ones toward compatible "lifestyle" groups, which is done at *De Hogeweyk*, has an admirable intent but could be challenging to implement in the U.S., with its highly diverse population. Furthermore, major policy and reimbursement changes would be required to enable widespread implementation of the Apartments for Life.

Providers are beginning to look at the Apartments for Life and *De Hogeweyk* models. They could be piloted as a first step. Likewise, the idea of offering a small adult day program within an existing retirement community, or having businesses on the first floor that attract the wider neighborhood, or interagency collaboration—these ideas are all feasible and advantageous. Some seniors housing facilities are already moving to adopt these approaches. We would do well to learn from the Dutch as we help our older adults be all they can be in an environment that provides a sense of community and better celebrates the differences between individuals.

Endnotes

[1]The description of *De Hogeweyk* is based on a presentation prepared and given by Y.E. van Amerongen-Heijer at the Presidential Symposium on Housing Development for Seniors, 20th International Association of Gerontology and Geriatrics World Congress of Gerontology and Geriatrics, Seoul, South Korea, in June 2013. For additional information about *De Hogeweyk* (in English), the interested reader is directed to:

- CNN, *Untold Stories: Dementia Village* (July 2013). Accessible at http://www.youtube.com/watch?v=LwiOBlyWpko.
- BBC News, *Dementia patients in Dutch village given alternative reality (n.d.)*. Accessible at http://www.utne.com/community/holland-dementia-village-revolutionizes-alzehimer-caregiving.aspx#axzz32IRevJK9 (scroll to bottom).
- *Dementia Village Wiedlisbach, Switzerland* (August 2013). Accessible at http://www.youtube.com/watch?v=72zrqv74R0w.
- Dementia village 'De Hogeweyk' in Weesp. *Detail: Das Architekturportal* (September 2012). Accessible at http://www.detail-online.com/architecture/topics/dementia-village-de-hogeweyk-in-weesp-019624.html (includes photos and site plans).

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ACKNOWLEDGEMENT

Ms. Glass appreciates the assistance of the Marga Klompé Foundation, which partially supported her travel in the Netherlands in 2013.

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