The Village AIDS Day Treatment Program: A Model of Interdisciplinary and Interdependent Care

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This article describes the Village AIDS Day Treatment Program, a program for people living with HIV/AIDS that provides health care by using a full range of interdependent services. Opened in 1988, this program was the first of its kind in the country. It has provided leadership in developing a model of care that addresses the full spectrum of health care—promotion, prevention, maintenance, and treatment. Along with describing the program and its services, this article includes the program's history and its influencing philosophies.


The focus of health care in the United States on diagnosis and treatment, using sophisticated technology and acute care facilities, has left unaddressed important aspects of the health care delivery system. These aspects have to do with wellness and health promotion, illness prevention, and maintenance of quality of life in the face of a chronic illness. The Village AIDS Day Treatment Program (VDTP) in New York City has provided leadership in developing a model of care that addresses the full spectrum of health care delivery.

Opened in 1988, the VDTP provides health care for people living with HIV/AIDS by offering a full range of interdependent services and voices in a milieu of support and caring. The program's organizational features are informed and directed by the following values, which are believed to be necessary for healing and health promotion:

1. Some ideas of equality
2. Some understanding of oppression
3. Some interest in creating community
4. Some respect and value for diversity and difference
5. Some appreciation for process
6. Some ability to be self-reflective and self-directed
7. Some capacity to hear the individual voice, as a separate entity and, simultaneously, as integrated within the community
8. Some creativity and flexibility
9. Some openness to collaboration and sharing power
10. Some hope

The values are stated as “some” to identify the striving nature of the VDTP model and to acknowledge the difficulty of maintaining ethics while coping with life. Program participants who do not fully embrace and demonstrate these values, however, are not excluded. The 10th value, hope, suggests that there is potential for these values to be integrated when people are open to learning from each other.
History

VDTP emerged from the Village Nursing Home (VNH), a not-for-profit nursing home established in the mid-1970s that found itself in the 1980s in the middle of a community confronting the devastating effects of HIV/AIDS. With roots in community activism, the board of directors responded to the AIDS crisis by pioneering an integrated system of care that included neighborhood, home health, and other services to meet physical, social, and psychological needs that were not being met by traditional health care providers.

In discussing the history of the adult day-care model in the United States as it emerged in the 1960s, Mason (1993) indicated that the model, which was borrowed from the English concept of the day hospital, “drew much attention as providers and social planners sought alternatives to long-term institutionalization for the chronically mentally ill and the frail elderly” (p. 2). The passage of the Social Security Act Title XIX (1965), establishing the Medicaid program and allowing reimbursement of adult day programs, stimulated the expansion of the model. Adult day health care programs generally target persons who are chronically ill with the goal of providing care to the whole person. The VNH chose this model because of its flexibility and the depth of services that it could offer (Mason, 1993).

Program Description

The VDTP is Medicaid funded. It serves about 50 clients a day from among 120 clients registered. Eligibility is an AIDS/HIV symptomatic diagnosis and the need for 3 hours of health services a week. The client population reflects the diversity of people living with AIDS in New York City: the majority are people of color; 75% are men, and 25% are women. Comorbidities can include past or active substance use or abuse, mental illness, and homelessness as well as histories of intense physical, sexual, and emotional abuse. Although it is important to identify the client population, Thompson (1996) has raised the issue that identifying groups with labels such as at risk, vulnerable, or underserved runs the risk of further marginalizing people. Rather than using a population label to describe its program, VDTP emphasizes creating community and providing care for individuals and families.

The program is located on the ground floor of a commercial building in Manhattan. The facilities include a large centrally located day room where most of the programming—therapeutic recreation, creative arts, educational forums, workshops, special events, meals, and informal community interactions—takes place. Smaller group work and individual treatments occur in the health services clinic and in private offices. Care is provided on both a walk-in basis and by scheduled appointments.

The majority of VDTP clients have experienced overwhelming loss, which frequently results in isolation, withdrawal, and difficulty in following through with treatment plans. At admission, clients have a comprehensive intake and are assigned a program case manager and a nurse case manager (see Table 1).

Although many impromptu meetings and discussions are common, the formal communication process among staff members is scheduled to keep the care plan an integrated team process. If special issues arise, clients hold client-only meetings without staff members present and elect a client representative to meet with staff members to resolve issues. As required by the state, the client and the various disciplines produce a comprehensive care plan on a quarterly basis that reflects the work they do together. The client determines the goals of the treatment plan in concert with the program clinicians. These goals form the substance of the work the client does at the VDTP, with the support of the clinicians and the community as a whole.

Program Services

Services at VDTP are provided on both a programmatic and a departmental basis and by a diverse group of practitioners because one person cannot be knowledgeable in all areas of care. Table 1 indicates the wide variety of services provided, a necessity for a program whose purpose is to treat the whole client.

The VDTP’s purpose was motivated by the lack of responsiveness of the health care system to the concerns of clients with AIDS. By bringing clients and providers together on a level playing field, the VDTP seeks to address the imbalance of power between clients and health care providers projected by the medical model.

A level playing field is achieved through interdependence, which means that no member of the community (i.e., client or staff, supervisor or supervisee, nurse or physician, man or woman, gay or straight, infected or affected) is considered more important than another. At different times, one member of the community will need to be supported by another. An interdependent community affirms the humanity of all members (their strengths and their weaknesses); encourages the inclusion of all voices; and accepts that roles in the community, such as teacher, leader, healer, receiver, or giver, are flexible. As put forth by Lorde (1984),

Difference must be not merely tolerated, but seen as a fund of necessary polarities between which our creativity can spark like a dialectic. Only then does the necessity for interdependency become unthreatening. Only within that interdependency of different strengths, acknowledged and equal, can the power to seek new ways of being in the world generate, as well as the courage and sustenance to act where there are no charters. (p. 111)

Influencing Philosophies

The philosophies that have influenced the VDTP model were not expressly identified in its inception but, rather, have emerged as self-evident during the program’s operation. The philosophy of self-empowerment was influenced by the People With AIDS (PWA) movement, which was born from the “obvious concept that PWA ought to par-
Another philosophy influencing the VDTP model of care is harm reduction, a way of working with people who use substances. Harm reduction was developed in the mid-1980s specifically to prevent the spread of HIV. Springer (1991) wrote: “Underlying the Harm Reduction Model is a philosophy which affords the same rights to life, liberty, economic stability, and health care to drug users as non–drug users believe to be theirs.”

Table 1  Program Overview

<table>
<thead>
<tr>
<th>Department</th>
<th>Staff</th>
<th>Services</th>
<th>Focus of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Services and Substance Use/ Abuse Counseling</td>
<td>Director: Certified Social Worker (3 FTE): 1 Certified Social Worker 1 BA in Psychology 1 Certified Substance Abuse Counselor</td>
<td>Program case management Individual, couple, and family counseling (including permanency planning) Substance use and abuse counseling Intake/admission coordination (Mason, 1993)</td>
<td>Support client in dealing with emotional aspects of illness Support couple and family relationships Stabilize lives and establish a foundation on which to provide health care Ensure basic entitlements—income, housing, health insurance, etc. Support sobriety and decrease incidence of relapse</td>
</tr>
<tr>
<td>Health Services and Psychiatry</td>
<td>Director: Registered Nurse Staff (3.4 FTE): 1 Registered Nurse 1 Psychiatrist .4 Internist 1 Nurse Practitioner</td>
<td>Nurse case management General medical care Health education Medication management Primary psychiatric care Psychiatric liaison services (Markowitz &amp; Perry, 1990; Nokes, 1991)</td>
<td>Coordinate health care and assist client with follow-through of treatment plan Assess and treat a wide range of chronic and acute conditions Ensure access to health care Treatment of psychiatric illness, management of psychotropics, and psychotherapy</td>
</tr>
<tr>
<td>Rehabilitation and Wholistic Health Services</td>
<td>Director: Occupational Therapist Staff (.8 FTE): .2 x 2 Acupuncturists .2 Massage Therapist .2 Chiropractor</td>
<td>Occupational therapy and wholistic modalities Chinese and Western herbs, biofeedback, meditation, guided visualization, acupuncture, chiropractic, and massage therapy (Gutterman, 1990)</td>
<td>Independence through self-care Stress management Coping with or managing pain Management of disability or deterioration Healing through spirituality Ensure access to wholistic modalities</td>
</tr>
<tr>
<td>Therapeutic Recreation and Creative Arts Therapy</td>
<td>Director: BA in Fine Arts Staff (3.2 FTE): .4 Creative Writing Specialist 1 Recreation Therapist 1 Music Therapist</td>
<td>Recreational activities Community programming Creative arts programming Individual—Art therapy, music therapy, creative writing (Gardner, 1994, Grossman &amp; Caroleo, 1996)</td>
<td>Provide respite, comfort and healing from illness Maintain individuality Decrease isolation Foster a sense of community Provide opportunities for emotional expression Discover and nurture new skills Ensure access to recreation and creative arts opportunities</td>
</tr>
<tr>
<td>Nutrition and Food Services</td>
<td>Director: Registered Dietitian, MS Staff (1.8 FTE): 1 Kitchen Manager/Chef .8 Kitchen Assistant</td>
<td>Daily therapeutic meal program Nutrition education Wellness and symptom-based dietary counseling Nutrition supplements Emergency food resources (ADA &amp; CDA, 1994)</td>
<td>Maintain optimal body weight Prevent loss of muscle mass Stabilize digestion function Ensure access to food</td>
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<tr>
<td>Facilities and Operations</td>
<td>Director of Nutrition directs Facilities Staff (2.2 FTE): 1 Facilities Manager 1 Facilities Supervisor and .2 Assistant</td>
<td>Environmental safety Facility maintenance Transportation management Program administration Program billing</td>
<td>Create accessible, functional, community environment Coordinate reliable transport to facilitate program attendance Provide administrative needs of clients and staff members Facilitate payment for program services</td>
</tr>
</tbody>
</table>

Note: FTE = full-time employees; BA = bachelor of arts; ADA & CDC = American Dietetic Association and Canadian Dietetic Association; MS = master of science. Other services that are provided on a more programmatic basis include HIV education and risk reduction, pastoral counseling and spirituality work, referral for home care, disclosure counseling, immigration issues, and advanced directives. All department directors and the program director provide direct client services.

Participate in those processes where decisions are made which directly affect our lives” (Callan, 1988, p. 288). The PWA movement attributes the notion of self-empowerment to the lessons learned from the feminist and civil rights struggles. PWA’s recommendations and rights, as articulated in what are known as “The Denver Principles” (see Appendix), are woven into the VDTP’s model of care.
Caught the attention of other small and large not-for-profit community-based organizations in New York. Currently, there are 15 operational programs influenced by the VDTP model and 2 in development. These programs have organized under an incorporated trade association, The AIDS Day Services Association, that provides technical assistance, training, and support to its member programs.

Ultimately, financing influences all health care services. Whether the VDTP model and its focus on interdisciplinary and interdependent care will continue to be accepted and reimbursed in an environment of managed care has yet to be determined. The following questions asked by Starfield (1995) seem applicable to the VDTP model: “To what extent does a person-focused relationship between practitioners and patients (longitudinally) enhance the effectiveness of care?” “Does an enhanced benefit package that covers a broader range of services with primary care produce better health outcomes?” (p. 1351). An early evaluation of the VDTP found that the overall rate of acute hospitalizations was significantly lower for its clients than that of a similarly constituted control group of persons with AIDS (Smith, Knickman, & Kuhlman, 1989). These preliminary evaluations need to be followed with both qualitative and quantitative studies to better understand the effect of the VDTP model and to obtain outcome information.

The AIDS epidemic has powerfully demanded that the health care system broaden its view to accommodate both a multiple-causation understanding of disease (Brody & Sobel, 1990) and an interdisciplinary and interdependent concept of care. The clinicians at VDTP are therapeutic partners with clients (Ferguson, 1980). The clinicians offer their knowledge and experience of health care, and the clients offer their knowledge and experience of themselves. Through this partnership, the hope of realizing the full spectrum of health care—promotion, prevention, maintenance, and treatment—can be made manifest. ▲

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Appendix
The Denver Principles (Callan, 1988)

We condemn attempts to label us as victims, a term which implies defeat, and we are occasionally patients, a term which implies passivity, helplessness, and dependence upon the care of others. “We are People With AIDS.”

Recommendations for Health Care Professionals
1. Come out, especially to patients who have AIDS.
2. Always clearly identify and discuss the theory that they favor as to the cause of AIDS because this bias affects the treatments and advice they give.
3. Get in touch with their feelings (e.g., fears, anxieties, hopes, etc.) about AIDS and not simply deal with AIDS intellectually.
4. Take a thorough personal inventory and identify and examine their own agendas around AIDS.
5. Treat people with AIDS as whole people, and address psychosocial issues as well as biophysical ones.
6. Address the question of sexuality in people with AIDS specifically, sensitively, and with information about gay male sexuality in general, and the sexuality of people with AIDS in particular.

Recommendations for All People
1. Support us in our struggle against those who fire us from our jobs, evict us from our homes, refuse to touch us, or separate us from our loved ones, our community, or our peers because available evidence does not support the view that AIDS can be spread by casual, social contact.
2. Do not scapegoat people with AIDS, blame us for the epidemic, or generalize about our lifestyles.

Recommendations for People With AIDS
1. Form caucuses to choose their representatives, to deal with the media, to choose their own agenda, and to plan their own strategies.
2. Be involved at every level of decision-making and specifically serve on the boards of directors of provider organizations.
3. Be included in all AIDS forums with equal credibility as other participants, to share their own experiences and knowledge.
4. Substitute low-risk sexual behaviors for those that could endanger themselves or their partners. We feel that people with AIDS have an ethical responsibility to inform their potential sexual partners of their health status.

Rights of All People With AIDS
1. To live as full and satisfying sexual and emotional lives as anyone else.
2. To obtain quality medical treatment and quality social service provision without discrimination of any form including sexual orientation, gender, diagnoses, economic status, or race.
3. To receive full explanations of all medical procedures and risks, to choose or refuse their treatment, and to make informed deci-

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4. To have the rights of privacy, confidentiality of medical records, human respect and, the choice of who their significant others are.
5. To die—and to live—in dignity.

References


Social Security Act, Title XIX. (1965).


