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Willowglen Academy
Wisconsin, Inc.
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Attachment B

Willowglen Academy
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Statement of Interest - Statewide Long -Term Care Reform Response to Request for Information/Proposals: Wisconsin Department of Health and Family Services

Organization Name (s) (List all public and private entities represented by this statement of interest.):

Willowglen Academy
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Indianapolis 46407
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The organization submitting this Statement of Interest is Phoenix Care Systems, Inc., representative of and parent corporation to Bell Therapy, Inc., Willowglen Academy-Wisconsin, Inc. and Phoenix Pharmacy, Inc.

Contact Person and Contact Person's Organization (List name, address, telephone number, email and fax number.):

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For purposes of streamlined and uninterrupted communication, please direct all inquiries to either:

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Brief Description of Organization (Legal entity status, purpose, scope of enterprise):

Phoenix Care Systems, Inc. (formerly Willowglen Holdings, Inc.) is a private, for-profit social/human services agency incorporated as a Subchapter S Corporation in Wisconsin with a 30+ year history of providing outcome-based quality services to vulnerable populations. We serve adults with developmental disabilities and mental illness in both in-patient and out-patient settings through our Bell Therapy, Inc. subsidiary as well as children and adolescents, also on an in-patient and out-patient basis through our Willowglen Academy-Wisconsin, Inc. subsidiary. We implement, and continue to develop and refine best practice standards, by which we measure treatment outcomes, service quality and consumer satisfaction, and continually strive to improve our services through a proprietary, formal, comprehensive QAI process. Some of our strengths as narrated through out this proposal, include:

1. Strength-based, consumer and goal-oriented services;
2. Professional staff development and ongoing training;
3. Formal outcome-based QAI systems and processes;
4. Formal and informal collaborative relationships with various community partners and agencies.

History/Experience:

Our history begins in 1972, with the opening of Willowglen Academy, Inc. in Plymouth, WI. In the time since we opened our first facility, our agency has been fortunate to have served children, adolescents and adults, with a multitude of developmental disabilities and mental illness in Wisconsin and at other locations throughout the eastern United States. Since 1976, Bell Therapy has provided comprehensive community-based alternatives of care and treatment services for adults living with disabilities.

Historical Timeline:

- In 1973, Willowglen Academy, Inc. began offering comprehensive, community-based residential treatment services for children and adolescents with autism and spectrum and other developmental disabilities in Sheboygan, WI.
- In 1975, Willowglen expanded with the addition of residential services to the adult mentally ill consumer under the corporate name of Belwood Ltd. in Milwaukee, WI.
- In 1976, clinical, day and outpatient services were added under the corporate name of Bell Therapy, Inc., including Community Support Programming (CSP).
- In 1979, Bell Therapy began offering day treatment services to adults with developmental disabilities, helping sustain them in their home and community.
- In 2001, Bell Therapy and Belwood Ltd. merged as Bell Therapy, Inc., offering 24 combined day and residential services to 1,000 individuals with developmental disabilities and mental illness daily, some with co-occurring disabilities (AODA).
- In July of 2005, Belwood/Bell Therapy co-located to a newly renovated facility at 51st and Silver Spring Dr. in Milwaukee, WI, substantially improving the residential quality in terms of environment and community.

Interest in Planning and Implementation of Long-Term Care Reform in Wisconsin:

Phoenix Care Systems, Inc. currently, and through its predecessor company Willowglen Holdings, Inc., is a long standing provider of services to individuals with developmental disabilities, chronic mental illness and co-occurring substance abuse needs. The means by which we continue to accomplish this include community support programs (CSP), residential treatment and less-restrictive, community-based medical day treatment, non-medical day treatment, day programming models and respite services. As we have now been serving our community over thirty (30) years, long enough to have witnessed the development within our various programs of a population of clients who are 60 years of age, or older, we are greatly interested in the future of programming, funding, services, choice and outcomes for this existing and potentially expanding population.

Upon reviewing the recently published RFI for Long-Term Support and Health Care Reform in Wisconsin, we know our organization is well prepared to contribute to and participate in the discussion, planning and implementation of long term support reform (s) intended to serve an elderly and aging population with developmental disabilities in Wisconsin. As mentioned earlier, through our involvement with this client population we have developed the ability to develop programs and deliver services that are relevant and effective in such a way as to preserve a client's choice, independence, control and satisfaction while ensuring the necessary services are made available in the least restrictive setting. We also strive to partner with our clients in terms of setting and attaining treatment goals and subsequent outcome results.

We look forward to contributing to the development, planning and implementation of long-term care support for elderly and aging adults with disabilities in Wisconsin and would like the opportunity to bring our resources, experiences and expertise to the discussion as this planning process gets underway. We share a common interest not only in terms of programming for current clientele, but for the state-wide population of aging and elderly adults with developmental and/or other disabilities, many of whom are known and the many more that may not be known or have not yet attained this level of need. We recognize the importance of managed care in terms of these systems, services, efficiencies and cost containment, and through our own experiences interacting with these types of systems have come to value the efficiencies it can bring to treatment planning, service diversity and delivery, consumer choice and satisfaction, quality and outcomes in the interests of consumers, families and taxpayers.

Geographic Area of Interest (List counties within the potential planning and service area of the entity or consortium.):

We are an organization that currently serves individuals with disabilities in the southeastern portion of the state of Wisconsin. We would be interested in potentially providing services to individuals living in the following counties:

- Brown
- Door
- Outagamie
- Kewaunee
- Winnebago
- Washington
- Manitowoc
- Calumet
- Sheboygan
- Fond Du Lac
- Ozaukee
- Dodge
- Jefferson
- Waukesha
- Milwaukee
- Walworth
- Racine
- Kenosha

Proposed Scope and Nature of the Program (including target groups to be served, benefit package to be offered, and rationale for this proposal in terms of fiscal soundness and program effectiveness)

Our passion is to empower the dreams of those we serve through the creation and delivery of effective, coordinated, individualized and compassionate services that offer our clients the opportunity to maximize their potential. We are a regional provider of services to individuals with developmental disabilities, mental illness and co-occurring disorders, experienced in the process, benefits, flexibility and coordinated care management of the Family Care Program.

As time has passed and through our varied experiences (successes and failures) we have developed a vision of what an ideal system for managing community-based services for aging adults may look like. With respect to coordinating and managing individualized services, ensuring consumer choice, participation and control; delivering high quality, effective, relevant and efficient services by minimizing duplication and overlap, and consistently monitoring a consumers' status to ensure delivery of the least restrictive, most appropriate services, we would advocate for the consideration of a modified model of care management.

We propose the consideration of a CSP-based model of care management targeted to the population of aging and elderly adults with developmental disabilities as well as those with mental illness and co-occurring disorders (AODA). Our experience in the development and implementation of this type of care model has time and again led us to the conclusion that it would be effective and efficient in serving the elderly/aging with developmental disabilities population. A cornerstone of the CSP model is to continually monitor for functional ability in the least restrictive environment, which results in the natural inclusion of informal supports and the orientation of maintaining consumers in the community.

This model would be effective in serving both those clients who require residential placement as well as those who can be maintained in the community with support. A part of this CSP model would include the identification and integration of medically-based services when warranted, a service performed by CSP care managers, that would be included in the overall reform model as part of the continuum of services available to consumers to be developed as part of the creation of Aging and Disability Resource Centers (ADRC's).

The efficiencies gained include a single point of contact and support for consumers, a fully integrated care plan and the monitoring of overall service utilization.

The model we propose would look and feel very much like traditional CSP services as currently offered to consumers with chronically mental illness (CMI). In this model, consumers are identified and eligibility determined by a public agent, a determination is made as to the breadth and scope of services initially required and a referral made to a community CSP provider. The CSP provider then assesses and delivers services geared to the consumer's identified needs/deficits, although a strength-based model seems to be evolving, and continues to serve the consumer as they progress along a continuum of care, from the most intensive services toward the least intensive services that will sustain the consumer in the community, ultimately with the least restrictive, most informal services.

Our vision for reform is similar to this model with the most obvious distinction being the disability category. Access to services and eligibility determination would be made through the regional ADRC who would then make referrals based on the results of the initial evaluation to a/the DD CSP provider associated with that ADRC region. The services package made available to each consumer would be comprehensive and each provider would need to cultivate or secure the expertise to serve the potential range of disabilities identified through the reform process. The care manager in this model would manage all aspects of a consumer's care, from intake to treatment planning and delivery, ongoing monitoring, support, and would not necessarily be limited to non-physical needs.

CSP care managers are capable of monitoring a consumer's physical health needs and would additionally have access to RN's, as part of the CSP program staff, for referral, observation/intervention and feedback. Additionally, for those consumers who remain at home, or in another independent/semi-independent living arrangement, the inclusion of respite services will help sustain and perhaps increase the likelihood that a given consumer can remain in the community. We have found that offering respite services often allows a care-giver, parent or guardian to get needed, brief reprieves from the responsibility of care-giving, which ultimately benefits the consumer.

There are unfortunately, consumers who will need to be maintained in residential settings for various reasons and in these cases, the CSP services would be included in their overall care plan and service array. With the inclusion of the Family Care Program model and funding stream, redundancies could be reduced and services organized around the capitated funding available for each consumer, with the CSP care manager responsible for services, utilization, fiscal monitoring and continued eligibility.

Other comments or information:

There are far too many ideas, concepts, etc to include in only five (5) pages of an RFI. We have attempted to put our best concept on the table for discussion and look forward to participating in the reform planning process beginning in 2006, and beyond.