Champions for Inclusive Communities

Star Community

New Berlin, WI

Every community has its unique strengths. For New Berlin, Wisconsin, a suburb of Milwaukee located in the southeast corner of the state with a population of about 38,000, the medical home approach is growing through the efforts of Southwest Pediatrics.

This success in implementing a medical home for every family is due largely to the collaborative efforts of Southwest Pediatrics, the Wisconsin Title V program's Southeast Regional Center for Children and Youth with Special Health Care Needs, and Children's Hospital of WI in Milwaukee. Physicians at Southwest Pediatrics first became alerted to the benefits of medical homes five years ago when some of their staff members attended a medical home learning collaborative. They quickly realized that medical homes were a road map to achieving good quality of care for families, especially families with CYSHCN.

Parents Making an Impact

The most exciting part of implementing the medical home concept has been the opportunity to partner closely with families. One of the first things Southwest Pediatrics did was form a parent advisory board. Doctor Rohloff, Pediatrician at Southwest Pediatrics emphasized, "To really appropriately create a medical home, one had to have a parent advisory board. There needed to be parent input."

Parents on the advisory board have impacted the practice by doing everything from distributing a "special needs newsletter" that informs parents of CYSHCN about useful community resources to assisting in the design of a new office. The parents on the board, in fact, support each other during the meetings by providing strategies to deal with an issue or learn about a new resource. Through the development of parent information nights, this support is reaching out beyond the practice to families throughout the entire community. The best part is that the parents are committed to their work and to growing a strong family-centered medical home philosophy at the practice.

Successful Community Partnering

A key factor in the community's success is the partnership between Southwest Pediatrics and the Southeast Regional Center for Children and Youth with Special Health Care Needs. Over the years, Meg Steimle, Outreach Specialist at the Regional Center (located at Children's Hospital of WI in Milwaukee), has provided endless access to community resources and information that the practice can pass on to families in need. Many families are referred to Meg when they have questions or concerns, and she, in turn, refers them to the needed services. Some of these families are underserved or minority families. The goal of the center is to help *any* family, with special efforts made to meet the needs of families of varying cultures.

Another successful partnership has been with the local school district. A connection was made with the school district to provide a presentation at a parent information night. Lori Karcher volunteers as a district parent liaison in a neighboring school district, acting as a conduit between Southwest Pediatrics and her school district. The message she wants to get across is that it *is* possible for medical homes to successfully partner with schools. The community has found that it's not as difficult as some may think to involve children's medical home providers when drafting out IEPs (Individual Education Plans). Having medical professionals involved in these plans is important because, as Lori says, "As a parent, you don't always have the medical background or the right words to say the correct information." Having a child's pediatrician and other specialty doctors involved solves that problem.

Navigating Insurance and Financing

The Southeast Regional Center is key in helping families navigate the murky waters of health benefits. As families are referred to the center, they are consistently being asked about their financial

What makes a Star Community?

ChampionsInC has created the Star Communities program to recognize exceptional communities.

Star Communities will show excellence in 6 Performance Measures:

- Families are partners
- A "Medical Home" provides coordinated care
- Children receive early and continuous screening
- Families have adequate funding/insurance to pay for services
- Services are organized so families can use them easily and are satisfied
- Youth receive necessary services to make the transition to adult life

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situation and their need of assistance. A variety of resources such as BadgerCare Plus, Medicaid, and Katy's Kloset (a pediatric equipment lending organization) are available to these families.

In many cases, parents network with other parents to discover funding opportunities. For example, one parent applied for and received a grant from United Healthcare. These dollars helped to pay medical bills not covered by insurance. That parent then spread the word about her success so that other parents could become aware of that specific opportunity. In some instances parents need to talk to another parent with similar experiences or diagnoses, so Southwest physicians refer them to Parent to Parent of WI for a parent match.

Screening Training Being Spread Around Community

Southwest Pediatrics is working to ensure that the pediatricians in their area are able to take advantage of as many training opportunities in screening as possible. For example, a state CSHCN program initiative recently provided training to pediatricians across the state. Participants then returned to their community and hosted their own smaller trainings for other providers in the community. In all, New Berlin had 6 physicians and other community providers attend these smaller trainings to learn about the Ages and Stages Questionnaire (ASQ) and its use in fostering coordination with the Part C Early Intervention program and the broader public health sector. Additional trainings were held throughout the Metro Milwaukee area with a total of 20 physicians trained to use the ASQ.

Case Managers: "Bright Stars"

Some of the "bright stars" in the community of New Berlin are the case managers in the Special Needs Program at the Children's Hospital of WI who coordinate services for CYSHCN. These case managers were created by the hospital to serve CYSHCN with a large number of health concerns. They work hard to help the family identify and coordinate services for their child. They coordinate appointment schedules to be more convenient for the family, ensure the appropriate test results go to the right provider, and check to make sure the child's specialists are communicating with the primary care doctor. As Dr. Rohloff says, "The first time one of [the case managers] called me, it sounded like something that was way too good to be true." To have a third party making sure the family's needs are being met is an immense relief for all doctors. Ultimately, the goal of the Special Needs Program case managers is to get parents to a point where they can be a good advocate for their child all on their own without needing a third party.

Because it is such a successful program, the hospital can only accept a limited number of children into the program. Those who do not make it into the program are referred to the Southeast Regional Center, where staff provides many of the same care coordination services between the family and their pediatric practice (which is oftentimes Southwest Pediatrics) so that the child may get the services he or she needs.

Medical Homes Lead to Successful Transition

One of the benefits of having such a strong medical home is that it also positively affects other aspects of the community. Transitioning into adult life is almost intuitive for families of youth with special health care needs because their medical home is there to support them, helping them find the right services.

Medical home providers make sure to start talking about transition early on. When a child is as young as 11 or 12 years old, their pediatrician may begin to discuss things like special needs trusts and guardianship issues. Information is readily available in the medical offices. Additionally, the Southeast Regional Center provides training on transition topics for families and youth such as housing options and guardianship.

Southwest Pediatrics has a considerable hand in encouraging transition awareness throughout the community. Dr. Rohloff recently proposed a transition program to Children's Hospital of WI that would involve many of the community partners. As the result of a state-wide Transition Collaborative, staff from Children's Hospital of WI and metro Milwaukee physicians including CHW case managers, compiled a comprehensive, useful list of adult health care providers who would be willing to accept youth and adults with special health care needs. This information is shared with families as well as pediatricians, encouraging communication among the pediatric and adult health care providers.

Model of Success

Southwest Pediatrics in New Berlin is a good model to all communities of family leadership, service coordination, and comprehensive care for all children and youth with special health care needs. Thanks to the strong community partnerships that exist, especially those between Southwest Pediatrics, the Southeast Regional Center for CYSHCN, and Children's Hospital of WI, and the intense emphasis on a medical home, the community has lifted many of the burdens families with CYSHCN carry.

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