

Michigan MATCH Program – Asthma In-home Case Management

The Michigan MATCH (Managing Asthma Through Case-management in Homes) program is based on the asthma case management model developed for the Grand Rapids area by the Asthma Network of West Michigan (ANWM) in 1996. The model is also implemented by the Genesee County Asthma Network (Flint area), the Ingham County Health Department and the Wayne Childhood Healthcare Access Program (Detroit).

Standard program elements of the intervention:

- ≥ 3 Home visits (includes environmental assessment)
- ≥ 1 Social Worker home visit/consultation for psychosocial intervention
- ≥ 1 Physician care conferences (joint consultation with patient, primary care provider, and case manager) to make or update the asthma action plan
- Case manager providing service is a certified asthma educator (AE-C)
- All patients receive, or have updated, an asthma action plan
- ≥ 1 case-manager visit to school/daycare as appropriate, work visit if requested by client

Visits/care conferences are reimbursed by some health plans, which contract with MATCH programs. Referral to the program can be from almost any source, including: providers, health plans, nursing staff, allied health professionals, and the families themselves. The PCP and/or specialist is sent a letter informing about the client's involvement and at discharge from the program.

MATCH evaluation has shown that when the model is used in areas with the capacity and burden to sustain it, participants benefit from greater control over asthma exacerbations. Costly urgent and extended care visits are avoided, and there were fewer interruptions to daily activities for participants and their families. Participants from three of the established MATCH programs who completed at least 5 months and 6 visits of case management experienced:

- 83% decrease in inpatient hospitalizations
- 60% decrease Emergency Department visits
- 58% decrease in missed school days
- 45% decrease in missed work days

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