Michigan MATCH Program – Asthma In-home Case Management
(Managing Asthma Through Case-management in Homes)

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

- Visits/care conferences are reimbursed by some health plans, which contract with individual MATCH programs. Contracting between the health plans and MATCH programs/lead organizations is done privately. MDHHS staff use partnerships and health plan champions to help promote contracting and reimbursement.

- Referral to the program can be from almost any source (providers, health plans, nursing staff, allied health professionals, self). The PCP and/or specialist is sent a letter regarding MATCH at enrollment and discharge from the program.

- Participants (N=173) from three established MATCH programs who completed at least one visit after intake showed the impact of the program at real-world completions levels:
  - 70% decrease in inpatient hospitalizations
  - 51% decrease in emergency department visits
  - 40% decrease in missed school days
  - 57% decrease in missed work days

For a comprehensive look at MATCH, including detailed information on contracting, outcomes and sustainability, download the 2018 MATCH whitepaper.

Visit the MATCH page on the GetAsthmaHelp.org website for program contact information.

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