The Asthma Network of West Michigan is the local asthma coalition serving West Michigan. We collaborate with the Children’s Healthcare Access Program (CHAP) and local healthcare institutions to provide intensive home-based asthma case management services to children and adults with uncontrolled asthma in 3 West Michigan counties (Kent, Ottawa and Muskegon).

Services include:

- Home visits conducted by either nurses (RNs) or respiratory therapists (RRTs) - all of whom are certified asthma educators (we also use Voices for Health for interpreting services).
- Care conferences conducted with primary care providers for the purpose of developing a written asthma action plan and managing complex cases.
- School/daycare visits to assist with managing asthma in those settings.
- Full-time licensed medical social worker (LMSW) on staff who conducts home visits to help families deal with psychosocial issues impacting asthma control.

Referral criteria:

- Referrals can come from: providers, nursing staff, allied health professionals, health plans, or the families themselves
- Children or adults (low-income families are priority) - especially those who have had an emergency department visit(s) or hospital admission(s) due to asthma, unscheduled office visit(s), over-use of albuterol, missed school days, etc.
- Diagnosis of asthma (those with uncontrolled asthma are priority but we can educate patients who are newly diagnosed with asthma as well)
- Reimbursement from: Priority Health (Medicaid, Medicare or Commercial), Meridian Health Plan, and Molina Healthcare.
- Case management services are also available for patients without insurance (or who are not covered by above plans): those costs are then covered by grant dollars.

Improving the health and quality of life of individuals with asthma.
Recognizing the success of the Asthma Network of West Michigan’s (ANWM) home-based asthma case management program, the Michigan Department of Community Health (MDCH) Asthma Prevention and Control Program evaluated the feasibility and impact of replicating the program in other areas of the state through the Managing Asthma Through Case Management in Homes study (MATCH).

**METHODS:** The MATCH model included at least 6 home visits by a certified asthma educator. These visits involve assessment of asthma triggers, consultation about how to reduce asthma triggers, and evaluation of the participant’s asthma exacerbations. Data collected at the intake, discharge and post-discharge visits consists of health care utilization, medication, symptom management, and impact on daily activities.

**PURPOSE:** The purpose of the study was to determine if ANWM’s model of case management is replicable in 2 other counties: Genesee County and Washtenaw County. Just under 200 patients were enrolled – adults and children – through the 3 case management programs, including the Asthma Network of West Michigan.

**MATCH Results (left):** Among participants who completed at least 5 months and 6 visits of case management, the percent of people with at least one asthma related inpatient hospitalization in the last 6 months decreased 83% between intake and discharge assessment.

The percent of participants with at least one Emergency Department visit for asthma in the last 6 months dropped 60%. The percent of children who missed one or more days of school in the last 6 months due to asthma dropped 58%. The percentage of respondents missing at least one day of work dropped 45% at 6 months post discharge.

**CHAP Results (above):** CHAP clients who received 3 or more asthma home visits demonstrated a 23% decrease in ED visits after one year of program involvement compared to the year prior to their program involvement.

**CHAP Results (above):** The percentage of CHAP clients with an asthma action plan more than doubled from intake to discharge, from 32% to 65%.