Program Overview

The Asthma Network of West Michigan (ANWM) was established in 1994 in response to a dramatic increase in the prevalence of pediatric asthma in West Michigan. The organization was founded by a team of health professionals from local health care institutions and asthma support groups seeking to create a centralized resource for asthma education and management. Most important, this team included individuals in community leadership roles and a physician champion who were able to combine their strengths to advocate for the program and garner initial grant funding from local hospitals and foundations.

The Asthma Network has been providing its home-based case management services in West Michigan since 1996, and developed the model known as MATCH — Managing Asthma Through Case Management in Homes. Recognizing the success of MATCH and the ANWM asthma case management program, the Michigan Department of Health and Human Services (MDHHS) Asthma Prevention and Control Program pursued replicating the model in other areas of the state. ANWM continues to work with the MDHHS and other MATCH programs on sustainability efforts: supporting a payer summit to help the Genesee County program establish health plan contracts, helping the Washtenaw County program transform from a school-based to a home-based case management program, and sharing MATCH fundamentals with health systems and community partners in additional asthma high-burden communities. Four programs in six communities in Michigan now use the MATCH model.

ANWM’s MATCH model takes a multifaceted case management approach to addressing uncontrolled pediatric asthma by focusing on the medical, environmental, and social conditions affecting asthma. ANWM primarily targets children from low-income families with uncontrolled asthma resulting in missed school days, emergency department visits, or hospitalizations. Children are referred to the program from a variety of sources, including hospital-based and primary care providers, health plans, school nurses, and families. Though the program serves children regardless of insurance status, there is

ANWM Fast Facts

Established: 1994

Location:
- Based in Grand Rapids, Michigan
- Services provided in urban areas, specifically Kent, Ottawa, and Muskegon counties

Populations Served:
- Targets children and adolescents with uncontrolled asthma from low-income families
- Over 80 percent of children served are ethnic minorities
- 78 percent Medicaid patients, 20 percent uninsured/underinsured
- 300 families served to date, 75 to 80 percent pediatric patients

Medicaid Reimbursement:
- Asthma educator and social worker visits are billed to health plans as skilled nursing visits for $80 to $85

Intervention Type:
- Clinic-based and community-based
a waiting list for uninsured and underinsured children due to financial constraints. However, these children will be served by the program eventually, as it does not turn away anyone who has been referred for asthma case management in its service area.

To achieve its goal of improving the overall health and quality of life of asthma patients, ANWM employs a combination of the following community-based and clinic-based interventions.

**Community-Based Interventions**

- The central component of the ANWM program is its home-based case management services, in which certified asthma educators (either a registered nurse or registered respiratory therapist) visit the home of a patient to educate the patient and family on asthma, assess environmental triggers of asthma, and provide case management support. Asthma educators teach self-management techniques, instruct families on proper use of medications and medical equipment, and review a written asthma action plan — an evidence-based practice for reducing the burden of the disease. Asthma educator home visits are usually biweekly for 3 months and then monthly for up to 6-12 months.

- Asthma educators can visit with a child’s school, childcare providers, and extended family to identify asthma triggers and educate caregivers on how to handle attacks and use medication.

- For high-need families, a licensed master social worker (LMSW) performs assessments, provides psychosocial interventions, and coordinates social services such as housing and transportation. The LMSW also makes referrals to financial resources or mental health agencies.

**Clinic-Based Interventions**

- The ANWM case managers work closely with a patient’s medical home to coordinate care; many referrals to ANWM come from a medical home. ANWM also works to connect referred children to a medical home if they do not have a primary care physician.

- ANWM case managers meet with a child’s primary care physician to coordinate an asthma action plan.

Recognizing that significant disparities in asthma outcomes exist among racially and ethnically diverse populations, ANWM strives to provide culturally appropriate services. ANWM has interpreters available for non-English-speaking families through a local medical interpretation service. The program also provides asthma action plans in the family’s native language. Through a medical home pilot, ANWM was able to incorporate community health workers into the ANWM team to provide interpretation and translation and ensure that asthma education is culturally appropriate.
Financing and Measurement

Though ANWM was originally funded entirely through local hospital grants, in 1999 ANWM entered into an agreement with a Medicaid managed care organization, Priority Health, and became the first nonprofit asthma coalition to contract with a health plan in the nation. Since then, ANWM has contracted with three additional Medicaid managed care plans and one private health plan. ANWM bills health plans for skilled nursing visits, revenue code 551, which covers asthma educator and social worker visits with the family, primary care physician care conferences, school visits, and visits with extended family members and child care providers. Reimbursement for skilled nursing visits covers about one-third of the ANWM budget, and the remaining costs (for uninsured patients and other nonreimbursable services such as mileage) are covered through grants from local hospitals, foundations, and the United Way. The other programs implementing the MATCH model also contract with health plans on an individual basis.

ANWM collaborates with the local Children’s Healthcare Access Program, part of Health Net of West Michigan in Grand Rapids, to measure outcomes through a web-based database. The Health Net database allows ANWM to track data on asthma action plans, asthma control test scores, follow-up visits, flu shots, spirometry, medication refills, primary care visits, missed school days, and quality of life. The case manager is able to collect some data through parental reports, and ANWM has also been able to acquire certain usage data from hospitals.

Lessons Learned and Next Steps

Looking forward, ANWM is focusing on building its measurement capacity by working with Health Net to allow nurses to track home-visit data in real time through electronic medical records. ANWM also plans to explore additional reimbursement strategies such as contracting with additional payers or adopting new bundled or risk-based payment models to support sustainability.

Despite the success ANWM has experienced in addressing uncontrolled pediatric asthma, the model has not yet been adopted across the entire state. Key barriers to widespread adoption of models such as ANWM include a lack of awareness, a lack of understanding of how to start, and a need for asthma champions. Other interested states and communities can leverage existing models and partner with existing organizations. For initiatives starting at the community level, local health plans and hospitals are valuable partners for exploring and sustaining funding. State-level agencies, such as Medicaid and state health departments, can play an important role in supporting locally driven asthma initiatives by convening health plans and supporting evaluation to secure additional plan involvement and facilitate long-term sustainability.

Author’s note: This case study is an excerpt from The Effectiveness of Interventions to Address Childhood Asthma, published in August 2016. The information in this case study reflects data verified as of July 2015.
An evaluation of the model across three MATCH programs (including ANWM) suggested that participants needed fewer urgent and extended care visits and experienced greater ability to manage their asthma, and indicated that the model can be successfully replicated in areas with high need and the capacity to support such a program.