CHIR Success Stories: **Transforming Lives**

Community Health Innovation Regions (CHIR) are dedicated and committed to their communities. The collective efforts of the CHIR is allowing them to transform the lives of residents in ways they could not before. Below are a few of the emerging stories that illustrate how their work is transforming lives.

One individual was struggling with substance use and was initially just hanging out at the Community Living Room. He started volunteering. We helped get him into treatment and he is doing great. He has his whole future ahead of him.

"To see them transform the way they did—just from being able to socialize with positive people—was amazing."
- Community Resource Specialist

"When you wrap supports around people, they feel supported by their community. It can improve their mental health."
- Social Services Partner

A young single parent was referred to the hub by their patient-centered medical home. The hub helped them find child care and sign up for college classes. They were also able to find a job to support their family.

"A person presents to the emergency department for something, and then we find out that the reason why they're at the emergency department is because they've been homeless because they lost their job a month ago. The person has a dog, and their dog has been living in their car in the Meijer parking lot for the past 3 weeks.... All of those things made them end up in the emergency department. From there, we were able to connect that person with the resource they needed, and now that person has a place to stay. I think that they actually got a job."

"They're actually able to turn their life around and become a contributing member of society again. It's amazing."
-Health Sector

"There have been several thank you notes in just the last six months. People have been positively impacted, so I think that's the key."
- Social Services Partner

An individual was undergoing medical treatment for a serious condition and had exhausted all the resources available. Because of the CHIR, they were referred to care coordination by the patient-centered medical home. The hub then successfully connected them to local community resources to cover basic living expenses.

One individual was visiting the emergency department multiple times per week. They were identified by the predictive model and were connected with care coordination services. Now, they have transportation to their appointments, their medications have been corrected, and they haven't visited an emergency department in four months.

"Before the CHIR, his case managers were not able to connect with him. I could because I am able to do home visits."
- Community Health Worker