

2026-
|
2028

COMMUNITY HEALTH IMPROVEMENT PLAN



Providence Centralia and St. Peter Hospitals

Centralia, WA

Olympia, WA

Providence  SWEDISH

CONTENTS

Executive Summary.....	3
South Puget Sound Community Health Improvement Plan Priorities.....	3
Introduction	4
Who We Are.....	4
Our Commitment to Community.....	5
Joint CHIP Report.....	5
Financial Assistance Program.....	6
Community Health Needs Assessment Process and Results	7
Our Community and the Community Health Needs Assessment Process and Results	7
Significant Community Health Needs Prioritized.....	7
Needs Beyond the Hospital’s Service Program.....	9
Community Health Improvement Plan	10
Summary of Community Health Improvement Planning Process	10
Addressing the Needs of the Community: 2026-2028 Key Community Benefit Initiatives and Evaluation Plan	10
2026-2028 CHIP Governance Approval.....	19

EXECUTIVE SUMMARY

Providence continues its Mission of service in the South Puget Sound area through Providence Centralia and St. Peter Hospitals. The following Community Health Improvement Plan (CHIP) outlines our strategic response to addressing the prioritized needs from the [2025 Community Health Needs Assessment](#) (CHNA).

The hospitals dedicate resources to improve health and increase equitable access to quality care in Lewis and Thurston Counties. The CHNA is an opportunity for the hospitals to engage the community every three years with the goal of better understanding community strengths and needs.

The results of the CHNA are used to guide and inform efforts to better address the needs of the community. Our commitment to improving the health of our community extends beyond patient care. Through community health improvement and strategic partnerships, health professions education and research, free, discounted and subsidized care, and other means of outreach, we commit to caring for those we serve through high-impact community benefit programs and investments.

South Puget Sound Community Health Improvement Plan Priorities

As a result of the findings in our [2025 CHNA](#) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Providence Centralia and St. Peter Hospitals will focus on the following areas for its 2026-2028 Community Benefit efforts: behavioral health, access to health care, and physical health, with an emphasis on preventive care and chronic conditions.

INTRODUCTION

Who We Are

Our Mission As expressions of God’s healing love, witnessed through the ministry of Jesus, we are steadfast in serving all, especially those who are poor and vulnerable.

Our Vision Health for a Better World.

Our Values Compassion — Dignity — Justice — Excellence — Integrity

[Providence Centralia Hospital](#) is a 128-bed, acute care not-for-profit hospital providing emergency, diagnostic, cancer, birthing, and surgical services to the greater Lewis County region. Located in Centralia, Washington, it was formed in 1988 when Centralia General Hospital merged with St. Helen’s Hospital, Chehalis. It has been recognized as one of the nation’s top performers on key quality measures by the Joint Commission, the primary accrediting body for hospitals. Major programs and services offered to the community include the following:

- Cardiology
- Emergency Care
- Family Birth Center
- General Surgery
- Imaging Center
- Orthopedic Care
- Palliative Care
- Providence Swedish Cancer Institute

[Providence St. Peter Hospital](#) is a [Magnet® recognized](#) 394-bed not-for-profit teaching hospital, founded by the Sisters of Providence in 1887. Located in Olympia, Washington, the state capital, it offers comprehensive medical, surgical, and behavioral health services. As the largest medical center in the five-county area of southwest Washington, it serves as a regional referral center, providing a full array of services to communities in Thurston, Lewis, Mason, Grays Harbor and Pacific counties. Major programs and services offered to the community include the following:

- Anticoagulation Clinic
- Behavioral Health and Recovery
- Diagnostic Imaging
- Emergency Care – Level III Trauma Center
- Family Birth Center and Special Care Nursery
- Orthopedic Care

- Palliative Care
- Providence Swedish Cancer Institute
- Sleep Medicine
- St. Peter Regional Heart Center
- Specialty Surgeries, including Cardiac surgery, da Vinci surgery, ENT procedures, Neurosurgery, Obstetrics and gynecology, Pediatric surgery, Thoracic surgery, Urology, and Vascular surgery

Our Commitment to Community

Providence Swedish South Puget Sound dedicates resources to improve the health and quality of life for the communities and people we serve. For more information, refer to the [Annual Report to our Communities](#) and [Community Health Needs Assessments/Community Health Improvement Plans](#).

Joint CHIP Report

This is a “joint CHIP report,” within the meaning of Treas. Reg. § 1.501(r)-3(b)(6)(v), by and for Providence including Centralia and St. Peter Hospitals. These hospitals completed a joint 2025 CHNA report. A joint approach to addressing the needs identified in the joint CHNA will be most effective given that the hospitals share a CHNA service area and community served, staffing, leadership teams, and resources. The strategies included in this plan are representative of efforts taken by both hospitals to address the identified community needs. The hospitals have a shared governance structure and share one Community Mission Board that adopts the CHIP for both hospitals.

Equity Practices in the CHIP

At Providence, we are committed to addressing the underlying and root causes of health disparities and inequities in the communities we serve. We work to address not only the clinical factors that determine a person’s length and quality of life, but also the social and economic dimensions, physical environment, and other factors that play a role in determining health outcomes. Addressing these factors includes leveraging community strengths and utilizing evidence-based, leading practices.

Through literature and our community partners, we recognize that long-standing systemic inequities exist and that they can lead to health disparities. We routinely evaluate health disparities in the communities we serve and use qualitative and quantitative data to inform how we enhance access to high-quality, evidence-based care. The purpose of the CHIP is to respond to and address the needs identified by our communities. The CHIP strategies are based on the CHNA data to meet the highest level of need, which is in service to all our community members.

Financial Assistance Program

Our mission is to improve the health and well-being of each person we serve, regardless of ability to pay. We believe no one should delay seeking needed medical care because they lack health insurance. Providence has a [Financial Assistance Program \(FAP\)](#) that provides free or discounted services to eligible patients.

COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS AND RESULTS

Our Community and the Community Health Needs Assessment Process and Results

Providence Centralia and St. Peter Hospitals conducted a 2025 Community Health Needs Assessment (CHNA) in partnership with MultiCare Capital Medical Center, Lewis County Public Health and Social Services, and Thurston County Public Health and Social Services. The CHNA service area is the entirety of Lewis and Thurston Counties.

The CHNA is an opportunity for Providence hospitals to engage the community every three years with the goal of better understanding strengths and needs. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relies on several sources of information: state and national public health data, qualitative data from key informant interviews and community listening sessions, hospital utilization data, and more. An oversight committee reviews all the data from the CHNA and identifies priority needs to address in the 2026-2028 Community Health Improvement Plan (CHIP).

More information on the CHNA process and findings can be found in the [2025 CHNA](#) for Providence Swedish South Puget Sound.

Significant Community Health Needs Prioritized

Providence Centralia and St. Peter Hospitals will focus on the following priority areas identified in the 2025 CHNA to best leverage their capacity, expertise, and resources for greatest impact:

PRIORITY 1: BEHAVIORAL HEALTH

Behavioral Health, encompassing both mental health and substance use/misuse, is the most pressing need in our communities. There is a need for more behavioral health services and providers, especially in rural areas. There is limited inpatient behavioral health care, particularly for pediatric psychiatric care, and a lack of substance use/misuse treatment facilities. Workforce shortages exist, especially for culturally specific therapists, and the community noted limited access to psychiatrists and medications. This is further hindered by insurance challenges, the high cost of care, long waitlists, and transportation issues. Systemic barriers include a lack of funding and low reimbursements, as well as difficulty navigating siloed and complex systems.

Community members expressed concerns about substance use/misuse, particularly fentanyl and opioids. Both fatal and nonfatal opioid overdoses have increased in Lewis County, as have suspected overdoses and overdose hospitalizations in Thurston County.

Mental health is also an area of concern. In the South Puget Sound, many mental health indicators top statewide figures, including the prevalence of depression, frequent mental distress, social isolation, suicide mortality, and suicidal ideation in youth.

Increasing behavioral health needs of young people were noted, and the community shared the need to implement more social-emotional health strategies and support for parents as they navigate issues such as the use of cell phones and social media.

Community members desire more education and training from people with lived experience, as well as peer-led recovery models.

Mistrust and past trauma were noted as deterring members of BIPOC and LGBTQIA+ communities from accessing behavioral health services, highlighting the need for culturally responsive and trauma-informed care.

PRIORITY 2: ACCESS TO HEALTH CARE

Access to both primary and specialty care was identified as a top health concern, with long waitlists to see providers. Residents also expressed the desire for more options for urgent care and for mobile and community-based clinics.

Primary care shortages contribute to avoidable Emergency Department visits, preventable emergency services calls, and the need to travel outside the area to access services. Additionally, this is a factor in the prevalence of unmanaged chronic conditions.

More than 20,000 South Puget Sound residents lack health insurance, often due to affordability issues, and community members shared difficulty finding providers who accept Medicaid. There are few resources for people who are uninsured, underinsured, or not Medicaid-eligible. The benefits cliff is also a concern—the point at which public benefits drop off sharply with a small increase in income.

Transportation is a significant barrier, as are the cost of prescriptions, hours of appointments during work time, limited health care literacy, distrust in the medical system, and access to or comfort with technology.

Specific populations may experience additional barriers to accessing responsive and affirming care, including people with low incomes, rural residents, older adults, the Spanish-speaking community, LGBTQIA+ individuals, and people with undocumented status. Stigma and discrimination and a lack of providers who are bilingual and bicultural contribute to these challenges.

PRIORITY 3: PHYSICAL HEALTH

The prevalence of chronic conditions is a priority concern for community health. In the South Puget Sound, chronic diseases are among the leading causes of death. The prevalence of asthma, COPD, diabetes, heart disease, and obesity tops statewide figures. Many residents want resources to manage these conditions but have difficulty due to factors like food insecurity and limited access to health care services, which are both causes and effects of high chronic disease rates.

Barriers to physical health include coexisting behavioral health needs and chronic conditions, necessitating integrated care approaches. Older adults particularly need more support as they often have multiple chronic diseases.

There is a strong need for greater focus on preventive care, rather than just managing aftereffects, to address chronic conditions and physical health in general. Lewis and Thurston County residents get routine health checkups at lower percentages than in Washington State overall, and a lower percentage of children in Thurston County are fully vaccinated by age three than in Lewis County or the state. Physical inactivity is an area of concern in Lewis County and, in the South Puget Sound overall, excessive screen time and social media use among youth are more prevalent than statewide.

Limited health literacy presents challenges in managing chronic conditions effectively, including completing recommended treatments or screenings. Health education is needed, such as healthy cooking skills and weight loss strategies for those with diabetes and hypertension.

Needs Beyond the Hospital's Service Program

Providence Swedish is committed to improving the health of the communities we serve and investing in spaces where we can have the greatest impact. By leveraging our expertise and core competencies as health care providers, we can meaningfully contribute to high-impact solutions for expanded access to high-quality, equitable health care.

The following community health needs identified in the 2025 CHNA will not be directly addressed, and an explanation is provided below:

- **Basic Needs and Economic Security:** As health care providers, Providence Centralia and St. Peter Hospitals do not directly address factors such as household income, food security, housing security, and education. Due to a lack of capacity and expertise to effectively address these specific needs, the hospitals will continue to work with partner organizations who specialize in these areas.

All health needs identified as part of Centralia and St. Peter Hospitals' 2025 CHNA touch on core social drivers of health and share commonalities. For areas outside our immediate focus, we will continue to invest in community programs and initiatives that work to address social drivers of health and expand our capacity to reach those in need through referrals, in-kind donations, and grant making.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The 2025 CHNA completed for Providence Centralia and St. Peter Hospitals was the basis for the 2026-2028 CHIP. The assessment identified community needs, assets, resources, and strategies to improve health residents of Lewis and Thurston Counties.

The CHNA Advisory Council evaluated the needs and supporting data identified in the 2025 CHNA and selected areas of focus for the hospitals: behavioral health, access to health care, and physical health. Prioritizing these needs allows the hospitals to focus on leveraging their strengths, expertise, and resources for greatest impact.

A multi-disciplinary team was convened as part of the 2026-2028 CHIP Committee to identify strategies, programs, and initiatives that respond to the prioritized needs. Individuals on the committee bring their deep knowledge of the prioritized needs, clinical and community based best practices, and South Puget Sound communities.

Through a series of dialogue and feedback sessions with members of the committee and other internal subject matter experts, a set of core CHIP strategies were presented to senior leaders, and the Community Mission Board for additional review, feedback, and alignment.

In April 2026, the Community Mission Board adopted the 2026-2028 CHIP, including the following strategies for addressing the priority community needs.

Addressing the Needs of the Community: 2026-2028 Key Community Benefit Initiatives and Evaluation Plan

The following strategies for addressing priority needs consider how communities change over time, as well as their existing strengths and capacity. They were intentionally selected with the understanding that some community health needs may evolve during the duration of the CHIP, and that subsequent implementation strategies may require adjustment based on resources and to best meet the needs of our communities. While our response to community need must remain flexible to changing dynamics, our commitment to improving the health of our communities is unwavering.

COMMUNITY NEED ADDRESSED #1: BEHAVIORAL HEALTH

Population Served

In line with our mission, we are focused on underserved populations, including those with low incomes and those who are uninsured and underinsured. Within these populations, we aim to serve individuals experiencing challenges with mental health and/or substance use/misuse.

Long-Term Goal

Expand timely access to high-quality behavioral health care, improve the quality of behavioral health services, and partner with community resources to help individuals lead healthy, fulfilling lives.

Table 1. Strategies and Measures for Addressing Behavioral Health

Identified need: Behavioral Health			
Strategy	Population Served	Strategy Measure(s)	2028 Target
Meet individuals where they are to deliver behavioral health care through the Providence Swedish Mobile Clinic in Thurston County, in collaboration with MultiCare Capital Medical Center and other community partners	People experiencing homelessness or housing instability who are in need of behavioral and/or physical health care services	Percentages of unhoused individuals who receive access to and who utilize mobile clinic services Percentage of follow up visits Patient Health Questionnaire-9 (depression) and General Anxiety Disorder-7 (anxiety) scales	Provide services to 65% of unhoused individuals based on each year’s U.S. Department of Housing and Urban Development Point-in-Time count 30% of individuals receiving care at the mobile clinic engage in follow up services with the program Improved mental health of individuals served, as measured by questionnaires
Provide intensive outpatient treatment for mental health and substance use disorders to help people manage their symptoms and develop skills to live healthier lives	Individuals with mental health and/or substance use disorders	Patient Health Questionnaire-9 (depression)	Improved depression treatment response, as measured by questionnaire
Utilize community partnership grants to improve behavioral health in the communities we serve	Individuals with behavioral health needs in Lewis and Thurston Counties	Number of individuals whose needs are met as determined from semi-annual progress reports from funded partners	Meet the needs of at least 1,000 individuals through collaboration with community based organizations who deliver behavioral health services

Deliver services to individuals with cancer to support their mental and emotional health	Individuals with cancer, their caregivers, and family members	Number of counseling sessions completed Number of individuals with cancer and their family members served Number of support group sessions delivered	Provide: 750 one-on-one counseling sessions at no cost to 225 individuals with cancer and their family members Access to 180 support group sessions at no cost to participants
Treat opioid use disorder by providing medication assisted treatment at the addiction medicine clinic at Providence Chehalis Family Medicine	Individuals with substance use disorder	Number of patients enrolled in program Number of patients identified with Hepatitis C who are treated and demonstrate sustained viral response or cure from Hepatitis C Number patients who graduate from Lewis County Drug Court Number of patients who establish primary care at Providence Chehalis Family Medicine	Establish baseline and demonstrate continued growth in strategy measures

Community and Research Informed Resources

County Health Rankings & Roadmaps. (2023). Medication-assisted treatment access enhancement initiatives. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/medication-assisted-treatment-access-enhancement-initiatives>

County Health Rankings & Roadmaps. (2024). Mobile health for mental health. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/mobile-health-for-mental-health>

County Health Rankings & Roadmaps. (2022). Social service integration. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/social-service-integration>

National Cancer Institute. (n.d.). Evidence-Based Cancer Control Programs (EBCCP), Survivorship Recommendations. Retrieved from <https://ebccp.cancercontrol.cancer.gov/recommendation.do?topicId=102270>

Resource Commitment

Providence Swedish South Puget Sound will commit staff time and funding to support these strategies.

Key Community Partners

To implement these strategies, Providence Swedish will partner with external behavioral health providers, as well as community organizations, agencies, and other entities that provide needed resources and services to individuals with behavioral health needs. Key partners include, but are not limited to, MultiCare Capital Medical Center, Catholic Community Services, Community Youth Services, City of Olympia, Family Support Center of South Sound, Gather Church, Interfaith Works, Olympia Union Gospel Mission, Olympic Health and Recovery, Salvation Army, Thurston County, Cascade Community Healthcare, and Thurston Mason Behavioral Health Administrative Services Organization.

COMMUNITY NEED ADDRESSED #2: ACCESS TO HEALTH CARE

Population Served

In line with our mission, we are focused on underserved populations, including those with low incomes and those who are uninsured and underinsured. Within these populations, we aim to serve individuals who live in underserved areas and those from historically marginalized groups and communities.

Long-Term Goal

Improve access to health care for people who have low incomes, are uninsured or underinsured, or are from underserved communities by deploying programs that aim to grow the health care workforce and assist with care navigation.

Table 2. Strategies and Measures for Addressing Access to Health Care

Identified need: Access to Health Care			
Strategy	Population Served	Strategy Measure(s)	2028 Target
Utilize the hospitals' Medication Assistance Program to ensure individuals have access to medications needed to manage their health conditions	Individuals who have been diagnosed with cancer	Number of persons served	Remove barriers to care for 2,400 people by facilitating access to free or low-cost medications

Deliver programs that assist individuals with navigating their diagnosis and treatment, facilitate access to resources, and provide support, including financial assistance	Individuals with cancer, their caregivers, and family members	Number of persons served	Provide: Nurse navigation services to 5,250 individuals Social worker assistance for 2,250 individuals
Utilize Community Health Workers (CHWs) to facilitate access to services, improve the quality and cultural sensitivity of service delivery, and increase health knowledge and self-sufficiency	Individuals transitioning from acute care settings who are at risk for readmission due to barriers related to the social drivers of health Adults 18-85 years of age with uncontrolled hypertension Members of Black, Indigenous, and People of Color communities	Number of persons served	3,000 individuals receive CHW services through a range of activities such as outreach, community education, informal counseling, social support, and advocacy
Improve access to health care for underserved populations by building community capacity to meet the region's growing health care needs	Individuals who live in rural areas and/or are members of otherwise underserved or marginalized communities	Number of family medicine and pharmacy residents who receive training in rural health care Number of residents who provide care to members of underserved or marginalized communities	Annually, 9 physician residents and 1 pharmacy resident receive training through the Rural Training Program at Providence Chehalis Family Medicine 30 physician residents and 2 pharmacy residents provide care to underserved individuals at Providence Olympia Family Medicine
Provide career opportunities and pathways in nursing fields to build	Individuals seeking living-wage, fulfilling careers	Percentage of individuals transitioning through nursing career pathways	Percentage of Student Nursing Assistants transitioning into

community capacity to meet the region’s growing health care needs			Certified Nursing Assistant roles Percentage of Nurse Technicians transitioning into nurse residency or nursing roles
Partner with MultiCare Capital Medical Center to build community capacity and deepen impact through strategic grantmaking	Individuals who are uninsured or underinsured	Number of individuals served determined with progress reports from grantee(s) Number of community-based organization partnerships	Meet the health care needs of 250 vulnerable individuals through collaboration with MultiCare and at least one community-based organization

Community and Research Informed Resources

County Health Rankings & Roadmaps. (2022). Career pathways programs. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/career-pathways-programs>

County Health Rankings & Roadmaps. (2023). Community health workers. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/community-health-workers>

County Health Rankings & Roadmaps. (2022). Nurse residency programs. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/nurse-residency-programs>

County Health Rankings & Roadmaps. (2016). Patient navigators. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/patient-navigators>

County Health Rankings & Roadmaps. (2023). Rural training in medical education. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/rural-training-in-medical-education>

National Academies of Sciences, Engineering, and Medicine. (2018). Establishing Effective Patient Navigation Programs in Oncology: Proceedings of a Workshop. Retrieved from <https://www.nationalacademies.org/read/25073/chapter/1>

National Cancer Institute. (n.d.). Evidence-Based Cancer Control Programs (EBCCP), Survivorship Recommendations. Retrieved from <https://ebccp.cancercontrol.cancer.gov/recommendation.do?topicId=102270>

Resource Commitment

Providence Swedish South Puget Sound will commit staff time and funding to support these strategies.

Key Community Partners

To implement these strategies, key community partners include, but are not limited to, MultiCare Capital Medical Center, Interfaith Works’ REST program, the PEACE center, Medline, Centralia College, St. Martin’s University, South Puget Sound Community College, and local high schools in Lewis and Thurston Counties.

COMMUNITY NEED ADDRESSED #3: PHYSICAL HEALTH

Population Served

In line with our mission, we are focused on underserved populations, including those with low incomes and those who are uninsured and underinsured. Within these populations, we aim to serve individuals with chronic conditions, complex health needs, and preventive care needs.

Long-Term Goal

Provide the support and resources necessary for people to reach and maintain their highest levels of health and well-being.

Table 3. Strategies and Measures for Addressing Physical Health

Identified need: Physical Health			
Strategy	Population Served	Strategy Measure(s)	2028 Target
Increase community capacity to provide primary and preventive care	Individuals in need of primary and preventive care services	Number of primary care providers added Number of individuals served	Add 12 primary care providers at two new family medicine clinics in Thurston County with the capacity to serve approximately 18,000 individuals Expand primary care capacity to serve approximately 3,000 individuals in Lewis County

<p>Help individuals effectively manage their chronic conditions and improve health outcomes by delivering the fully accredited Diabetes Self-Management Education (DSME) program</p> <p>Monitor reach and access across populations disproportionately impacted by chronic disease</p>	<p>Older adults with high prevalence of diabetes requiring education and self-management support</p>	<p>Number of unique individuals reached annually</p>	<p>Expand access to DSME, reaching ≥5,000 unique individuals annually</p> <p>Use findings for continuous quality improvement</p>
<p>Help reduce the risk of chronic disease by providing the National Diabetes Prevention Program (NDPP)</p> <p>Monitor program reach across populations facing barriers to access</p>	<p>Adults with high prevalence of prediabetes and risk for type 2 diabetes</p>	<p>Number of enrolled participants</p>	<p>Enroll >100 participants annually to support diabetes prevention</p> <p>Adjust strategies as needed to improve access across populations</p>
<p>Integrate complementary health programming and services within primary care to reduce the risk of adverse outcomes from chronic medical conditions</p> <p>Monitor access and integration of Medical Nutrition Therapy services to promote equitable delivery and long-term impact</p>	<p>Individuals with one or more chronic medical conditions</p>	<p>Improved access to and integration of services within primary care</p> <p>Number of individuals receiving Integrated Clinical Pharmacy Services</p> <p>Number of people provided Medical Nutrition Therapy</p>	<p>4,800 individuals receive Integrated Clinical Pharmacy Services such as chronic disease medication management, risk reduction therapies, medication and disease education, lifestyle education, screenings, and referrals</p> <p>Provide individualized Medical Nutrition Therapy delivered by state licensed Registered Dietitians to >1,500 people annually</p>

Utilize partnerships among oncology, pulmonology, primary care, diagnostic imaging, and CT surgery to increase lung cancer screenings in high-risk populations	Adults 50-80 years of age who are at high risk for lung cancer	Number of screenings provided	Provide first-time low-dose lung cancer screening CTs to 7,500 high-risk individuals
--	--	-------------------------------	--

Community and Research Informed Resources

County Health Rankings & Roadmaps. (2024). Chronic disease management programs. Retrieved from <https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/chronic-disease-management-programs>

Guide to Community Preventive Services. (2016). Diabetes management: team-based care for patients with type 2 diabetes. Retrieved from <https://www.thecommunityguide.org/findings/diabetes-management-team-based-care-patients-type-2-diabetes>

National Academies of Sciences, Engineering, and Medicine. (2017). Implementation of Lung Cancer Screening: Proceedings of a Workshop. Retrieved from <https://nap.nationalacademies.org/catalog/23680/implementation-of-lung-cancer-screening-proceedings-of-a-workshop>

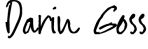
Schottenfeld, L., Petersen, D., Peikes, D., Ricciardi, R., Burak, H., McNellis, R., Genevro, J. (2016). Creating patient-centered team-based primary care. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from <https://ctc-ri.org/sites/default/files/uploads/creating-patient-centered-team-based-primary-care-white-paper.pdf>

Resource Commitment

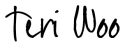
Providence Swedish South Puget Sound will commit staff time and funding to support these strategies.

2026-2028 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Community Mission Board of the hospitals on April 23, 2026. The final report was made widely available by May 15, 2026.

DocuSigned by:

6BC2A0529CE342C 4/27/2026

Darin Goss Date
Chief Executive
Providence Swedish South Puget Sound

DocuSigned by:

476835D2BED64C7 4/23/2026

Teri Woo, PhD Date
Chair, Community Mission Board
Providence Swedish South Puget Sound

CHNA/CHIP Contact:

Liz Selsor
Community Health Investment Manager
Liz.Selsor@providence.org

Contact CHI@providence.org to provide feedback/comments about this CHIP or to request a free printed copy.