

— 2021 - 2023 —

# COMMUNITY HEALTH IMPROVEMENT PLAN

## Providence Centralia Hospital

Centralia, Washington

*and*

## Providence St. Peter Hospital

Olympia, Washington



To provide feedback on this CHIP or obtain a printed copy free of charge, please email [SWCommunications@providence.org](mailto:SWCommunications@providence.org).

# CONTENTS

- Executive Summary..... 3
  - Providence Southwest Washington Community Health Improvement Plan Priorities ..... 4
- Introduction ..... 5
  - Who We Are..... 5
  - Our Commitment to Community ..... 5
  - Health Equity..... 6
  - Community Benefit Governance..... 6
  - Planning for the Uninsured and Underinsured..... 7
- Our Community..... 8
  - Description of Community Served ..... 8
  - Community Demographics ..... 8
- Community Needs and Assets Assessment Process and Results..... 10
  - Summary of Community Needs Assessment Process and Results ..... 10
  - Significant Community Health Needs Prioritized..... 11
  - Needs Beyond the Hospital’s Service Program..... 11
  - Summary of Community Health Improvement Planning Process ..... 12
  - Addressing the Needs of the Community: 2021- 2023 Key Community Benefit Initiatives and Evaluation Plan..... 13
  - Other Community Benefit Programs ..... 18
- 2021- 2023 CHIP Governance Approval..... 19

# EXECUTIVE SUMMARY

Providence Health & Services continues its Mission of service in Lewis and Thurston through Providence Centralia Hospital and Providence St. Peter Hospital, which together make up the Providence Southwest Washington service area.

Providence Centralia Hospital is an acute-care hospital that was formed in 1988 when St. Helen's Hospital, Chehalis merged with Centralia General Hospital. The hospital has 128 licensed beds. Providence Centralia Hospital has a staff of more than 850 caregivers (employees). Major programs and services offered to the community include emergency, diagnostic, cancer, birthing, and surgical services, specializing in knee and hip replacements.

Providence St. Peter Hospital is an acute-care hospital founded in 1887 and located in Olympia, Washington. The hospital has 390 licensed beds. Providence St. Peter Hospital employs more than 2,900 caregivers. Major programs and services offered to the community include behavioral health, cancer, heart and vascular, neurology, orthopedics, rehabilitation, senior health and women's and children's health.

Providence Medical Group operates 31 primary and specialty care clinics in 38 locations in the region, with more than 270 providers.

Providence Southwest Washington dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. In 2020, Providence Southwest Washington provided \$73.5 million<sup>1</sup> in Community Benefit<sup>2</sup> in response to unmet needs, including \$9 million in free and low-cost care for people who are underinsured or uninsured.

The Community Health Needs Assessment (CHNA) is an opportunity for Providence Southwest Washington 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. Through a mixed-methods approach, using quantitative and qualitative data, the CHNA process relied on several sources of information: state and national public health data, qualitative data from interviews with community stakeholders, publicly-available health data and hospital utilization data.

---

<sup>1</sup> Data is consolidated based on unaudited financial reporting.

<sup>2</sup> A community benefit is an initiative, program or activity that provides treatment or promotes health and healing as a response to identified community needs and meets at least one of the following community benefit objectives: a. Improves access to health services; b. Enhances public health; c. Advances increased general knowledge; and/or d. Relieves government burden to improve health. Note: Community benefit includes both services to the economically poor and broader community. To be reported as a community benefit initiative or program, community need must be demonstrated. Community need can be demonstrated through the following: 1) community health needs assessment developed by the ministry or in partnership with other community organizations; 2) documentation that demonstrates community need and/or a request from a public agency or community group was the basis for initiating or continuing the activity or program; 3) or the involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

## Providence Southwest Washington Community Health Improvement Plan Priorities

As a result of the findings of our [2020 CHNA](#) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Providence Southwest Washington will focus on the following areas for its 2021-2023 Community Benefit efforts:

### PRIORITY 1: HOMELESSNESS/LACK OF SAFE AND AFFORDABLE HOUSING

Homelessness and a lack of safe, affordable housing was prioritized by all stakeholders and consistently ranked as the most important issue that needs to be addressed in the service area. Despite efforts to address housing challenges, there is a lack of housing available in Thurston and Lewis counties, particularly affordable rental units and permanent supportive housing.

### PRIORITY 2: BEHAVIORAL HEALTH (INCLUDES MENTAL HEALTH AND SUBSTANCE USE)

There is a lack of mental health and substance use treatment services in the community. Gaps include a lack of behavioral health integration into primary care, school-based mental health services, a local inpatient detox facility, and case management services. People have difficulty accessing mental health services due to long wait times, a lack of providers who take Medicaid and Medicare, and transportation barriers. These populations include school-aged children, older adults, people experiencing homelessness, people living in rural communities, veterans, people who are undocumented, and monolingual Spanish speakers.

### PRIORITY 3: ACCESS TO HEALTH CARE

There are a number of barriers to accessing health care. A common concern was transportation, particularly for older adults, people experiencing homelessness, and people living in rural communities. Language barriers prevent people from receiving appropriate and responsive care and documentation status is a barrier to accessing health insurance.

### *Equity Framework*

Stakeholders chose to prioritize a fourth health-related need, health and racial equity, throughout the improvement plans for all three needs listed above. This means when addressing housing, mental health and substance use, and access to care, Providence Southwest Washington will use an equity framework for approaching planning and implementation.

# INTRODUCTION

## Who We Are

<b>Our Mission</b>	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.
<b>Our Vision</b>	Health for a Better World.
<b>Our Values</b>	Compassion — Dignity — Justice — Excellence — Integrity

The Providence Southwest Washington service area is made up of Providence Centralia Hospital in Centralia and Providence St. Peter Hospital in Olympia, in Lewis and Thurston counties, respectively.

Providence Centralia Hospital is an acute-care hospital that was formed in 1988 when St. Helen’s Hospital, Chehalis merged with Centralia General Hospital. The hospital has 128 licensed beds. Providence Centralia Hospital has a staff of more than 850 caregivers (employees). Major programs and services offered to the community emergency, diagnostic, cancer, birthing, and surgical services, specializing in knee and hip replacements.

Providence St. Peter Hospital is an acute-care hospital founded in 1887 and located in Olympia, Washington. The hospital has 372 licensed beds. Providence St. Peter Hospital employs more than 2,900 caregivers. Major programs and services offered to the community include behavioral health, cancer, heart and vascular, neurology, orthopedics, rehabilitation, senior health and women’s and children’s health.

Providence Medical Group operates 31 primary and specialty care clinics in 38 locations in the region, with more than 270 providers.

## Our Commitment to Community

Providence Southwest Washington dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of the economically poor and vulnerable. During 2020, our hospitals provided \$73.5 million in Community Benefit in response to unmet needs and improved the health and well-being of those we serve in Southwest Washington, including \$9 million in free and low-cost care for people who are underinsured or uninsured. Our region includes five counties served by Providence St. Peter and Providence Centralia hospitals. Within this geographical area, Thurston and Lewis Counties are designated as the primary service area for the two hospitals. The secondary service area includes Grays Harbor, Mason, and Pacific Counties.

Providence Health & Services Southwest Washington further demonstrates organizational commitment to the community health needs assessment (CHNA) through the allocation of staff time, financial resources, participation, and collaboration to address community identified needs. The Southwest Washington Chief Mission Integration Officer is responsible for ensuring compliance with Federal 501(r) requirements, as well as providing the opportunity for community leaders and internal hospital

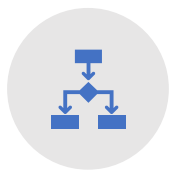
leadership, physicians, and others to work together in planning and implementing the resulting Community Health Improvement Plan (CHIP).

## Health Equity

At Providence St. Joseph Health, we acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. Our Vision is “Health for a Better World,” and to achieve that we believe we must address not only the clinical care factors that determine a person’s length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes.

To ensure that equity is foundational to our CHIP, we have developed an equity framework that outlines the best practices that each of our hospital will implement when completing a CHIP. These practices include, but are not limited to the following:

**Figure 1. Best Practices for Centering Equity in the CHIP**



Address root causes of inequities by utilizing evidence-based and leading practices



Explicitly state goal of reducing health disparities and social inequities



Reflect our values of justice and dignity



Leverage community strengths

## Community Benefit Governance

Providence Southwest Washington further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, participation, and collaboration to address community identified needs. The Southwest Washington Chief Mission Integration Officer is responsible for ensuring compliance with Federal 501(r) requirements.

Providence Southwest Washington has dedicated staff focused on community benefit throughout the year, as well as during the three-year CHNA and CHIP cycle. Community benefit staff worked with the Population Health Council to review the CHNA, prioritize needs to address in the CHIP, and to identify strategies to address those needs. The Community Mission Board reviewed and approved the final CHIP document and is committed to regular review of the progress and challenges to the priorities and strategies.

## Planning for the Uninsured and Underinsured

Our Mission is to provide quality care to all our patients, regardless of ability to pay. We believe that no one should delay seeking needed medical care because they lack health insurance. That is why Providence Southwest Washington has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

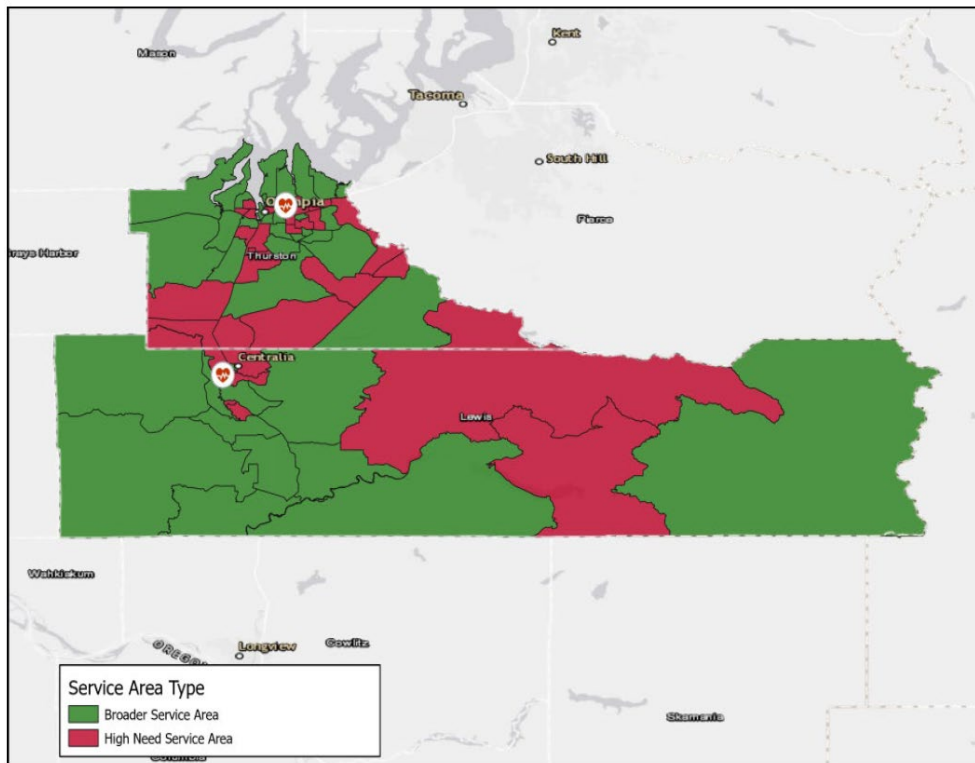
One way Providence Southwest Washington informs the public of FAP is by posting notices. Notices are posted in high volume inpatient and outpatient service areas. Notices are also posted at locations where a patient may pay their bill. Notices include contact information on how a patient can obtain more information on financial assistance as well as where to apply for assistance. These notices are posted in English and Spanish and any other languages that are representative of 5% or greater of patients in the hospital's service area. All patients who demonstrate lack of financial coverage by third party insurers are offered an opportunity to complete the Patient Financial Assistance Application and are offered information, assistance, and referral as appropriate to government sponsored programs for which they may be eligible. For information on our Financial Assistance Program click [here](#).

# OUR COMMUNITY

## Description of Community Served

Providence Centralia and Providence St. Peter Hospitals provide Lewis County and Thurston County communities in southwestern Washington with access to advanced care and advanced caring. This includes a population of approximately 368,367 people, an increase of 6.3% from the prior assessment.

**Figure 2. Providence Southwest Washington Total Service Area**



Of the over 368,000 permanent residents of Thurston and Lewis Counties, roughly 47% live in the “high need” area, defined by lower life expectancy at birth, lower high school graduation rates, and more households at or below 200% FPL compared to census tracts across the county. For reference, in 2020, 200% FPL represents an annual household income of \$52,400 or less for a family of four. These households are more likely to regularly make spending tradeoffs regarding utilities, rent, groceries, medicine, and other basic expenses.

## Community Demographics

### POPULATION AND AGE DEMOGRAPHICS

The high need service area consists of a disproportionate amount of residents ages 18 to 34, while older adults, ages 65 to 84 are less likely to live in the high need service area. Lewis and Thurston Counties have higher percentages of people over age 65 than the state. The male-to-female distribution is roughly equal across Southwest Washington geographies.



## POPULATION BY RACE AND ETHNICITY

In the service area, the majority population (80.3%) are white. 5.9% of service area residents identify as two or more races, 5.9% are Asian/Pacific Islander, 3.4% are another race, 2.9% are Black, and 1.6% are American Indian. In the hospitals' service area, 9.77% of the population is of Hispanic ethnicity. Within the high need portion of the service area, 11.07% of the population is of Hispanic ethnicity.

Individuals who identify as Hispanic or "other" race are more likely to live in high needs census tracts than their peers of other races. People who identify as white are slightly less likely to live in high need census tracts, highlighting inequities by race.

## SOCIOECONOMIC INDICATORS

**Table 1. Income Indicators for Providence Southwest Washington Service Area**

Indicator	Broader Service Area	High Need Service Area	Thurston and Lewis Counties
<b>Median Income</b> Data Source: American Community Survey Year: 2019	\$76,890	\$56,707	\$66,242
<b>Percent of Renter Households with Severe Housing Cost Burden</b> Data Source: American Community Survey Year: Estimates based on 2013 – 2017 data	19.04%	25.23%	25.60%

The hospitals' service area has a lower economic status when compared to the state. The median household income in the service area is \$66,242. Over one quarter (29.4%) of the area is considered low-income, living at 200% of less of the federal poverty level (FPL). 6.7% of area adults are unemployed and 16.1% access SNAP (food stamp) benefits. Among area renters, 25.6% experience a severe housing cost burden, as they spend 50% or more of their income on rent.

**Full demographic and socioeconomic information for the service area can be found in the [2020 CHNA for Providence Southwest Washington](#).**

# COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

## Summary of Community Needs Assessment Process and Results

The Community Health Needs Assessment (CHNA) process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by the hospitals, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members to provide additional context to the quantitative data through qualitative data in the form of interviews. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often have biases based on collection methodology.

In addition, we recognize that there are often geographic areas where the conditions for supporting health are substantially poorer than nearby areas. Whenever possible and reliable, data are reported at the ZIP Code or census block group level. These smaller geographic areas allow us to better understand the neighborhood level needs of our communities and better address disparities within and across communities.

We reviewed data from the American Community Survey, County Health Rankings, and local public health authorities. In addition, we included hospital utilization data to identify disparities in utilization by income and insurance, geography, and race/ethnicity when reliably collected.

### QUANTITATIVE DATA

#### *Public Health Data*

Quantitative data used to identify community needs included community data from County Health Rankings and Esri data and mapping.

#### *Hospital Utilization Data*

Hospital utilization data used to identify community needs included avoidable emergency department visits and avoidable hospitalizations. Hospital utilization data for July 2019 – June 2020 was used for the 2020 CHNA.

A summary of quantitative data can be found starting on page 25 of the [2020 CHNA](#) for Providence Southwest Washington.

### QUALITATIVE DATA

#### *Stakeholder Interviews*

Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who have low incomes, have chronic conditions, and/or are medically underserved. Providence St. Patrick Hospital aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives.

A summary of qualitative data can be found starting on page 33 of the [2020 CHNA](#) for Providence Southwest Washington.

## Significant Community Health Needs Prioritized

### PRIORITY 1: HOMELESSNESS/LACK OF SAFE AND AFFORDABLE HOUSING

Homelessness and a lack of safe, affordable housing was prioritized by all stakeholders and consistently ranked as the most important issue that needs to be addressed in the service area. Despite efforts to address housing challenges, there is a lack of housing available in Thurston and Lewis counties, particularly affordable rental units and permanent supportive housing.

### PRIORITY 2: BEHAVIORAL HEALTH (INCLUDES MENTAL HEALTH AND SUBSTANCE USE)

There is a lack of mental health and substance use treatment services in the community. Gaps include a lack of behavioral health integration into primary care, school-based mental health services, a local inpatient detox facility, and case management services. People have difficulty accessing mental health services due to long wait times, a lack of providers who take Medicaid and Medicare, and transportation barriers. These populations include school-aged children, older adults, people experiencing homelessness, people living in rural communities, veterans, people who are undocumented, and monolingual Spanish speakers.

### PRIORITY 3: ACCESS TO HEALTH CARE

There are a number of barriers to accessing health care. A common concern was transportation, particularly for older adults, people experiencing homelessness, and people living in rural communities. Language barriers prevent people from receiving appropriate and responsive care and documentation status is a barrier to accessing health insurance.

### *Equity Framework*

Stakeholders chose to prioritize a fourth health-related need, health and racial equity, throughout the improvement plans for all three needs listed above. This means when addressing housing, mental health and substance use, and access to care, Providence Southwest Washington will use an equity framework for approaching planning and implementation.

## Needs Beyond the Hospital's Service Program

No hospital facility can address all the health needs present in its community. In addition to the prioritized needs, Providence Southwest identified in the course of the CHNA the following needs: Unemployment and Lack of Living Wage Jobs; Food Insecurity; Access to Oral Health Care. While these needs have not been prioritized for the 2021-2023 CHIP, Providence Southwest recognizes these needs as important to the overall health of our communities.

We are committed to collaborating with partner organizations in the community to address the needs prioritized in this CHIP, with full acknowledgment that these needs are among the most challenging to address in any community, and require long-term focus and investment from all levels of community stakeholders.

## Summary of Community Health Improvement Planning Process

The Population Health Council for Providence St. Peter and Providence Centralia hospitals met in February 2021 to review the final CHNA document and to prioritize needs to address in the CHIP. Following prioritization, the Population Health Council discussed current strategies to address ongoing community needs and how those strategies can be carried forward in the 2021-2023 CHIP.

In March 2021, the Population Health Council reviewed the draft of the CHIP that incorporated recommendations as discussed in the planning meeting. In April 2021, the Community Mission Board met to review and approve the final CHIP.

The 2021-2023 Community Health Improvement Plan (CHIP) process was impacted by the SARS-CoV-2 virus and COVID-19, which has impacted all of our communities. While we have focused on crisis response, it has required a significant re-direction of resources and reduced community engagement in the CHIP process.

This CHIP is currently designed to address the needs identified and prioritized through the 2020 CHNA, though COVID-19 will have substantial impacts on our community needs. These impacts are likely to exacerbate some of the needs identified, and cause others to rise in level of priority. While this is a dynamic situation, we recognize the greatest needs of our community will change in the coming months, and it is important that we adapt our efforts to respond accordingly. We are committed to supporting, strengthening, and serving our community in ways that align with our Mission, engage our expertise, and leverage our Community Benefit dollars in the most impactful ways.

Providence Southwest Washington anticipates that implementation strategies may change and therefore, a flexible approach is best suited for the development of its response to the CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by Providence Southwest Washington in the enclosed CHIP.

# Addressing the Needs of the Community: 2021- 2023 Key Community Benefit Initiatives and Evaluation Plan

## COMMUNITY NEED ADDRESSED #1: HOMELESSNESS/LACK OF SAFE AND AFFORDABLE HOUSING

### Population Served

People experiencing housing instability and at risk of homelessness; people with low incomes experiencing housing instability.

### Long-Term Goal

To end homelessness by reaching functional zero, which means that the system will not have more individuals enter than exit from the homelessness system at any given time.

**Table 2. Strategies and Strategy Measures for Addressing Homelessness/Lack of Safe and Affordable Housing**

Strategy	Population Served	Strategy Measure	Baseline	2023 Target
1. Support community-based respite care services	People experiencing homelessness and in need of safe place for medical recovery	Number of respite beds available to people who are homeless	2020: 0 medical respite beds	Providence Southwest supports 4 respite beds in community
2. Implement CRU (Crisis Response Unit) model with community partners	People who are vulnerable and in need of service delivery outside of usual care settings	Care transitions support to be completed at Providence Community Care Center	2020: 1,813 crisis contacts/year	2,417 crisis contacts/year
3. Collaborate with Providence regional efforts to implement Community Solutions’ Built for Zero model	People experiencing homelessness	Point-in-Time Count  Define “By Name List” (BNL) with technical assistance through Community Solutions Built for Zero	2020 Thurston County: 995 individuals Lewis County: 142 individuals BNL to be defined	BNL population moves toward Functional Zero for homelessness

*Evidence Based Sources*

[Housing First](#)

[Service-enriched housing](#)

[County Health Rankings](#)

*Resource Commitment*

Providence recognizes the vital intersection between health care and housing and believe both are basic human rights. Providence Montana is committed to collaborating with community partners working in support of safe and affordable housing. Providence has committed funding for the service area to purchase a mobile medical van to address the inequities of accessing services by underserved populations.

*Key Community Partners*

[Catholic Community Services Catholic Housing Services](#)

[City of Olympia Crisis Response Unit](#)

[Community Solutions Built for Zero](#)

[Interfaith Works](#)

[Lewis County Homeless and Housing Program](#)

[Thurston County Office of Housing & Homeless Prevention](#)

**COMMUNITY NEED ADDRESSED #2: BEHAVIORAL HEALTH (INCLUDES MENTAL HEALTH AND SUBSTANCE USE)**

*Population Served*

People in need of mental health therapy or counseling; people experiencing mental health crisis; people whose mental wellness has been impacted by COVID-19 pandemic.

Patients with a substance use disorder; people seeking substance use disorder treatment.

*Long-Term Goals*

To reduce substance use disorders and related health conditions through evidence-based prevention, treatment, and recovery support services.

To ensure equitable access to high-quality, culturally responsive, and linguistically appropriate mental health services, especially for populations with low incomes.

**Table 3. Strategies and Strategy Measures for Addressing Behavioral Health (Includes Mental Health and Substance Use)**

<b>Strategy</b>	<b>Population Served</b>	<b>Strategy Measure</b>	<b>Baseline</b>	<b>2023 Target</b>
1. Integrated health services	People in need of	# PMG MT patients with	2020: 921 patients	1,200 patients

<p>in primary care and behavioral health care</p>	<p>mental health and substance use disorder services</p>	<p>depression treatment response in 12 months</p> <p># patients receiving integrated primary care in PMG specialty behavioral health clinics</p> <p>% of PMG patients receiving care from an integrated behavioral health provider</p>	<p>2020: 0</p> <p>2020: 1,706 patients</p>	<p>1,000 individuals per year receiving integrated primary care in PMG specialty behavioral health clinics</p> <p>2,200 patients</p>
<p>2. Integrated medication-assisted treatment for opioid use disorder</p>	<p>People seeking treatment for opioid use disorder</p>	<p>IMAT training available</p> <p>Establish best practice clinic workflows for providing MAT</p>	<p>IMAT training for 12 providers per year</p> <p>Establish best practice clinic workflows for providing MAT</p>	<p>Establish standardized workflow in all primary care clinics for provision of MAT</p> <p>Continued support of IMAT training for a minimum of 12 providers per year</p>
<p>3. Mental health crisis response for people experiencing homelessness</p>	<p>People who are homeless and in need of mental health crisis response</p>	<p>Crisis response at Providence Community Care Center</p> <p>Crisis response to vulnerable population</p> <p>Mobile van to provide services to vulnerable population</p>	<p>1,813 crisis contacts/year</p>	<p>2,417 crisis contacts/year</p>

*Evidence Based Sources*

[Behavioral health primary care integration](#)

[Culturally adapted health care](#)

[Substance Abuse and Mental Health Services Administration](#)

*Resource Commitment*

Providence Southwest is committed to providing for the treatment needs of patients through supporting staff to obtain IMAT training and waivers and to collaborating with community partners to support the mental health needs of residents of the service area.

*Key Community Partners*

[Behavioral Health Resources](#)

[Cascade Mental Health](#)

[Lewis County Public Health and Social Services](#)

[SeaMar Community Health Center](#)

[The Olympia Free Clinic](#)

[Thurston-Mason Behavioral Health Organization](#)

[Valley View Health Center](#)

**COMMUNITY NEED ADDRESSED #3: ACCESS TO HEALTH CARE**

*Population Served*

Uninsured and underinsured individuals and families; BBIPOC communities and those experiencing health disparities.

*Long-Term Goal*

To improve access to health care and preventive resources for people with low incomes and those uninsured by deploying programs to assist with navigating the health care system.

**Table 4. Strategies and Strategy Measures for Addressing Access to Care**

<b>Strategy</b>	<b>Population Served</b>	<b>Strategy Measure</b>	<b>Baseline</b>	<b>2023 Target</b>
1. Implement CRU mobile outreach clinics with community partners	Low-income population with barriers to housing, accessing appropriate care for serious mental illness,	# people served by mobile outreach clinics	2020: 0	3,915 contacts/year (261 work days x 15 contacts per day)



	substance abuse and physical comorbid conditions			
2. Support of patients in need of resources to safely discharge or in need of access to care	Patients with barriers to safe discharge and who are under-resourced or homeless; patients who seek care in ED for ambulatory-sensitive conditions	Explore possibility of community-based medicine with local EMS services  Avoidable ED encounters	No community-based medicine  2019 Providence St. Peter: 31.3% AED Providence Centralia: 31.5%	Community-based medicine offered by EMS  1% decrease in AED

*Evidence Based Sources*

[Medical homes](#)

[Patient navigators](#)

*Resource Commitment*

Providence Southwest commits to collaborating with community organizations in support of people in need of access to health care, with particular regard for those who experience health disparities related to race, lack of health insurance coverage, or housing status.

*Key Community Partners*

[Behavioral Health Resources](#)

[City of Olympia Crisis Response Unit](#)

[The Olympia Free Clinic](#)

[Thurston County Public Health & Social Services](#)

[Valley View Health Center](#)

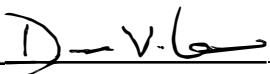
## Other Community Benefit Programs

**Table 5. Other Community Benefit Programs in Response to Community Needs**

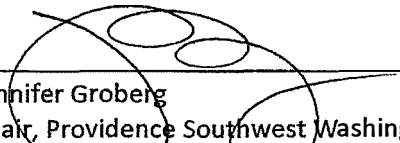
<b>Initiative (Community Need Addressed)</b>	<b>Program Name</b>	<b>Description</b>	<b>Population Served (Low Income, Vulnerable or Broader Community)</b>
1. Substance Abuse Disorder	Providence St. Peter Chemical Dependency Center	Addiction treatment	Vulnerable
2. Mental Health	Providence St. Peter Psychiatry	Outpatient and inpatient care for a variety of mental health conditions	Vulnerable
3. Mental Health	Providence St. Peter Crisis Mental Health Services	Evaluation, information and referral to inpatient and outpatient mental health services in emergency department	Vulnerable
4. Abuse and Assault	Providence Sexual Assault Clinic & Child Maltreatment Center	Medical evaluations for children, adolescents and adults. Social workers provide crisis counseling for the victims and families of sexual assault, physical abuse or chronic neglect	Vulnerable

# 2021- 2023 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Community Mission Board for Providence St. Peter and Providence Centralia hospitals on April 22, 2021. The final report was made widely available by May 15, 2021.

  
\_\_\_\_\_  
Darin Goss  
Chief Executive, Providence Southwest Washington

4/22/2021  
Date

  
\_\_\_\_\_  
Jennifer Groberg  
Chair, Providence Southwest Washington Community Mission Board

4/22/2021  
Date

  
\_\_\_\_\_  
Justin Crowe  
Senior Vice President, Community Partnerships, Providence

May 1, 2021  
Date

## CHNA/CHIP Contact:

Angela Wolle  
Chief Mission Integration Officer, Providence Southwest Washington  
Angela.Wolle@providence.org

To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email [CHI@providence.org](mailto:CHI@providence.org).