

2026 -
2028

COMMUNITY HEALTH IMPROVEMENT PLAN



Photo courtesy of Benton County

Kadlec Regional Medical Center

Richland, Washington

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Community Health Improvement
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EXECUTIVE SUMMARY

Providence continues its Mission of service in Benton and Franklin Counties and beyond through Kadlec Regional Medical Center (Kadlec). The following Community Health Improvement Plan (CHIP) outlines our strategic response to addressing the prioritized needs from the 2025 Community Health Assessment (CHA). Benton-Franklin Health District identifies the process and document as the Community Health Assessment rather than the Community Health Needs Assessment to reflect their focus on community strengths.

Kadlec dedicates resources to improve the health and quality of life for the communities it serves, with special emphasis on the needs of people experiencing social inequities and health disparities. The Community Health Assessment (CHA) is an opportunity for Kadlec to engage the community every three years with the goal of better understanding community strengths and needs.

For the 2025 Community Health Assessment, Kadlec participated in a collaborative process to evaluate the community's needs in partnership with the Benton-Franklin Health District (health district). In addition to the Community Health Assessment (CHA) collaborative efforts led by the health district and Kadlec, the Core Group included representation from Prosser Memorial Health, Trios Health, Lourdes Health, Greater Health Now, and Kennewick Public Hospital District. The report reflects the hospitals' collaborative efforts to identify the significant health-related needs in the community as well as the community strengths. The hospitals participating in the joint CHA share a service area and community served. The CHA engaged with and sought input from that community. Based on the availability of data, geographic access to the facility, and other hospitals in neighboring counties, Benton and Franklin Counties serve as the boundary for the shared CHA service area.

The results of the CHA 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 CHA process relied on several sources of information: state and national public health data, qualitative data from interviews with community stakeholders and listening sessions with community members, primary data from a community survey, and hospital utilization data.

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.

Kadlec Regional Medical Center Community Health Improvement Plan Priorities

As a result of the findings of our [2025 CHA](#) and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Kadlec will focus on the following areas for its 2026 - 2028 Community Benefit efforts:

PRIORITY 1- BEHAVIORAL HEALTH CHALLENGES INCLUDING SUBSTANCE USE/MISUSE

Both key informants and community members identified behavioral health challenges as a pressing issue in the community, connected to many other needs. They are particularly concerned about substance use/misuse in the community, with key informants speaking to an “overdose crisis.” Key informants emphasized the absence of local detox and recovery facilities, which forces individuals to seek out-of-town services, and noted a particular need for low-barrier treatment options, along with increased public access to naloxone.

PRIORITY 2-HOUSING & HOMELESSNESS

There is a concern about a lack of affordable housing locally and increased homelessness. Community members are particularly concerned about how homelessness affects the perception of safety and comfort using shared spaces, like parks. There is a need for temporary transitional housing, more affordable housing options for low-income individuals, and low-barrier shelters that accommodate diverse needs, including those related to pets, families, religious affiliations, or substance use disorders (SUD).

Specific populations, such as individuals with behavioral health challenges, people whose primary language is not English, mixed-status families, migrant farm workers, and older adults, face unique obstacles in securing housing.

PRIORITY 3- ACCESS TO HEALTHCARE SERVICES

There is a need concerning barriers to accessing primary care and specialty care, with long waiting times for appointments, leading to using the ER for primary care needs. Additional barriers include transportation difficulties and high costs of medical services and prescriptions. The long wait times are exacerbated by provider recruitment and retention challenges.

Specific populations, such as people experiencing homelessness, migrant farm workers, people whose primary language is not English, and Children and Youth with Special Healthcare Needs (CYSHCN) encounter additional barriers. Veterans experience distinct barriers with VA service approvals.

INTRODUCTION

Who We Are

Kadlec is part of the family of Mission-driven organizations that make up Providence, serving communities across a seven-state footprint.

PROVIDENCE

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

KADLEC REGIONAL MEDICAL CENTER

Our Mission Provide safe, compassionate care.

Our Vision Health for a Better World.

Our Promise “Know me, care for me, ease my way.”

Our Values Safety—Compassion—Respect—Integrity—Stewardship—Excellence—Collaboration

When Kadlec opened its doors in 1944, the hospital was established to care for the Hanford area workers and their families. Today, Kadlec is the Tri-Cities’ only not-for-profit health system serving a population of more than 400,000 people in southeastern Washington and northeastern Oregon. Kadlec has a rich heritage of offering vital health services to everyone, regardless of their ability to pay.

Kadlec, a level II trauma center, has grown to a 337-bed regional referral center with over 400 providers offering primary and specialty care services for patients of all ages including comprehensive cardiac care, neurosurgery and neurology, cancer care, neonatal and pediatrics, and emergency medicine.

More than 4,340 dedicated caregivers and volunteers work and serve at Kadlec delivering on our mission of providing safe, compassionate care.

Our Commitment to Community

Kadlec 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](#).

Equity Practices in the CHIP

We are committed to addressing the underlying and root causes of health disparities and inequities in the community 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 community. The CHIP strategies are based on the CHA data to meet the highest level of need, which is ultimately 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 ASSESSMENT PROCESS AND RESULTS

Our Community and the Community Health Assessment Process and Results

Kadlec conducted a 2025 Community Health Assessment (CHA) in partnership with Benton-Franklin Health District. The Core CHA Group included representation from Prosser Memorial Health, Trios Health, Lourdes Health, Greater Health Now, and Kennewick Public Hospital District. The CHA service area is the entirety of Benton and Franklin counties.

The CHA is an opportunity for hospitals to engage the community every three years with the goal of better understanding strengths and needs through a mixed-methods approach, using state and national public health data, qualitative data from key informant interviews and community listening sessions, hospital utilization data, and more. We collected information from the following sources:

- Behavioral Risk Factor Surveillance System (BRFSS)
- Centers for Disease Prevention and Control, National Syndromic Surveillance Program, Electronic Surveillance System for Early Notification of Community-based Epidemics (CDC, NSSP, ESSENCE)
- Environmental Justice Index
- Healthy Youth Survey
- Hospital-level data
- Local public health data
- Massachusetts Institute of Technology's Living Wage Calculator
- Public Health Information Management System
- U.S. Census Bureau, American Community Survey (ACS)
- U.S. Environmental Protection Agency
- Washington Association of Sheriffs and Police Chiefs
- Washington State Center for Court Research
- Washington State Department of Commerce
- Washington State Department of Natural Resources
- Washington State Office of Financial Management (OFM)
- Washington State Office of Superintendent of Public Instruction (OSPI)

The Benton-Franklin Counties 2025 CHA identified the following priority areas: mental health, housing, poverty and income, access to healthcare, and food security.

Kadlec’s Community and Population Health Committee reviewed the CHA data and identified priority needs to address in the 2026 - 2028 Kadlec Community Health Improvement Plan (CHIP).

The 2025 Benton Franklin Counties CHA findings were presented to Kadlec’s Community and Population Health Committee on August 14, 2025. At the committee meeting on October 9, 2025, the Community and Population Health Committee evaluated the five identified needs alongside relevant primary and secondary data and conducted a vote via EasyPolls.com to establish further prioritization. After evaluating the polling results, Kadlec Regional Medical Center is committed to addressing the following priorities areas: behavioral health challenges including substance use/misuse, housing and homelessness, and access to healthcare services.

More information on the CHA process and findings can be found in the [2025 Kadlec CHA](#).

Significant Community Health Needs Prioritized

Kadlec will focus on the following priority areas identified in the 2025 CHA to best leverage their capacity, expertise, and resources for greatest impact:

BEHAVIORAL HEALTH CHALLENGES INCLUDING SUBSTANCE USE/MISUSE

Both key informants and community members identified behavioral health challenges as a pressing issue in the community, connected to many other needs. They are particularly concerned about substance use/misuse in the community, with key informants speaking to an “overdose crisis.” Key informants emphasized the absence of local detox and recovery facilities, which forces individuals to seek out-of-town services, and noted a particular need for low-barrier treatment options, along with increased public access to naloxone.

HOUSING & HOMELESSNESS

There is a concern about a lack of affordable housing locally and increased homelessness. Community members are particularly concerned about how homelessness affects the perception of safety and comfort using shared spaces, like parks. There is a need for temporary transitional housing, more affordable housing options for low-income individuals, and low-barrier shelters that accommodate diverse needs, including those related to pets, families, religious affiliations, or substance use disorders. Specific populations, such as individuals with behavioral health challenges, people whose primary language is not English, mixed-status families, migrant farm workers, and older adults, face unique obstacles in securing housing.

ACCESS TO HEALTHCARE SERVICES

There is a need concerning barriers to accessing primary care and specialty care, with long waiting times for appointments, leading to using the ER for primary care needs. Additional barriers include transportation difficulties and high costs of medical services and prescriptions. The long wait times are exacerbated by provider recruitment and retention challenges. Specific populations, such as people experiencing homelessness, migrant farm workers, people whose primary language is not English, and Children and Youth with Special Healthcare Needs (CYSHCN) encounter additional barriers. Veterans experience distinct barriers with VA service approvals.

Needs Beyond the Hospital's Service Program

We are committed to improving the health of the community we serve and investing 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 CHA will not be addressed, and an explanation is provided below:

- Poverty and Income
- Food Security

Kadlec will not directly address the needs above due to resource constraints. Other organizations in the community are addressing these needs, and Kadlec will collaborate with them when possible, on programs and projects.

In addition, Kadlec will collaborate with local organizations that address the aforementioned community needs to coordinate care and referrals to address these unmet needs.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The 2025 Community Health Assessment for Benton and Franklin Counties is the basis for the 2026 - 2028 CHIP. The assessment, which was completed in collaboration with the Benton Franklin Health District, identified community needs, assets, resources, and strategies to improve health for Benton and Franklin County residents.

Kadlec's Community and Population Health Committee includes representatives of community organizations and the health district. The Committee evaluated the needs and supporting data identified in the 2025 CHA and selected areas of focus for Kadlec: behavioral health challenges including substance use/misuse, housing and homelessness, and access to healthcare services. Prioritizing these needs allows the hospital to focus on leveraging their strengths, expertise, and resources for greatest impact.

A multi-disciplinary CHIP work group comprised of Kadlec's Community and Population Health Committee members was convened to identify strategies, programs, and initiatives that address the CHA prioritized needs. The work group includes representatives of population health, clinical network, strategy, quality improvement, and mission. Through a series of dialogue and feedback sessions with members of the work group and other internal subject matter experts, a set of core CHIP strategies were developed.

The CHIP was presented to the Kadlec Community and Population Health Committee and the Southeast Washington Service Area Community Mission Board for their review, feedback, and alignment.

In April 2026, the Southeast Washington Service Area 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 community. 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 CHALLENGES INCLUDING SUBSTANCE USE/MISUSE

Population Served

People in need of mental health care, people experiencing behavioral health crisis, people with limited access to behavioral care due to age, disability or lack of culturally responsive care options. In line with

our Mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured.

Long-Term Goal(s)/ Vision

To reduce behavioral health conditions and substance use disorders (SUD) through evidence-based prevention, treatment, and recovery support services.

Table 1. Strategies and Measures for Addressing Behavioral Health Challenges including Substance Use/Misuse (SUM)

Identified need: Behavioral Health Challenges including Substance Use/Misuse				
Strategy	Population Served	Strategy Measure(s)	Baseline	2028 Target
1. Integrate mental health care in primary care setting	People in need of mental health services	# of patients served	5,000 unique patients served in 2025	Increase # of patients served by 5%
2. Utilize psychiatrist to expand behavioral health service line	Individuals with complex behavioral health needs and treatment resistance	# of patients served	Psychiatry services will begin in SEWA in fall 2026	Increase percentage of unique patients served by 5% in 2027 and 10% in 2028. Target will be updated in 2027
3. Trauma Support Program (TSP) Provides support for patients who have experienced physical trauma. Support services include care coordination, drug/alcohol screening, and behavioral health screening. Brief interventions for depression, PTSD, and alcohol misuse are provided	ED patients 18+ who have experienced physical trauma with focus on the Hispanic/Latinx population living in Benton and Franklin Counties	Patient Health Questionnaire (PHQ) and PTSD Checklist 5 (PCL-5) screening utilization # of TSP participants with no primary care provider (PCP) who establish with a PCP	In 2025, 41 out of 75 eligible patients participated in TSP and were screened using the PHQ and PCL-5 tools In 2025, 9 patients with no PCP established with a PCP	Maintain PHQ and PCL-5 screening utilization Increase # of patients established with PCP by 5%

4. Create Mental Health Promotion, Education and Stigma Reduction Messaging Campaign	Hispanic/Latinx, Spanish speaking populations	Social media hits, in-person event numbers, radio listener numbers, qualitative interviews	New program	Campaign will launch by December 2026; campaign evaluation will follow; plan will be developed to continue messaging if needed/wanted
5. Partner with Comprehensive Healthcare to support the needs of Columbia Valley Center for Recovery (CVCR) clients	People experiencing behavioral health and SUD challenges	Measure(s) will be determined as CVCR services are established	Columbia Valley Center for Recovery is scheduled to open in 2026	Partnership and referral process are established and progress is being tracked through defined metrics

Community and Research Informed Resources

[Behavioral health primary care integration](#)

[Naloxone education & distribution programs](#)

[Positive Community Norms](#)

Resource Commitment

Kadlec will dedicate staff time and resources as needed for 2026–2028. Kadlec also collaborates with community partners to address behavioral health needs in Benton and Franklin counties and helps secure funding from various health system sources.

Key Community Partners

Kadlec works with many community partners across Benton and Franklin counties to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing behavioral health challenges including substance use/misuse (SUD/SUM) include:

[Benton Franklin Health District: Suicide Prevention](#)

[Benton Franklin Health District: What Is Naloxone?](#)

[Charlie Health](#)

[Comprehensive Healthcare](#)

[Educational School District 123](#)

[Grace Clinic](#)

[Key Connection Coalition](#)

[Pasco Prevention Network](#)

[Thriveworks](#)

[Tri Cities Community Health](#)

[Yakima Valley Farmworkers Clinic](#)

COMMUNITY NEED ADDRESSED #2: HOUSING AND HOMELESSNESS

Population Served

In line with our Mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured. Within these populations, we aim to serve individuals experiencing homelessness or housing instability.

Long-Term Goal(s)/ Vision

A seamless connection between health care and homeless services, ensuring that people experiencing homelessness receive timely and appropriate linkage to community-based homeless services.

Table 2. Strategies and Measures for Addressing Housing and Homelessness

Identified need: Housing and Homelessness				
Strategy	Population Served	Strategy Measure(s)	Baseline	2028 Target
1. Community Health Workers Coordinate Homeroom Connect with various community partners	People experiencing homelessness	# of people served	663 people served in 2025	Maintain level of service
2. Increase awareness of community resources for people experiencing housing instability	People experiencing homelessness	Dedicated in-kind time participating in meetings	Participation in monthly Benton-Franklin Housing Continuum of Care (CoC) meetings	Continued participation

<p>3. Screen admitted patients for Social Determinants of Health (SDOH)</p>	<p>Patients admitted to Kadlec Regional Medical Center</p>	<p>Percentage of admitted patients screened for SDOH needs</p> <p># of patients accessing community-based resources via Findhelp.org</p>	<p>95% SDOH screening rate in 2025 for patients admitted at KRMC</p> <p>In 2025, 4.4% of patients screened for SDOH needs, housing was the greatest need reported. Between 5/20/25-12/31/25 there were 57 patient-initiated connections and 3 caregiver-initiated connections</p>	<p>Maintain 95% screening rate</p> <p>Increased number of patients accessing housing resources via findhelp.org</p>
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Community and Research Informed Resources

[Community Health Workers](#)

[Housing First](#)

[Social Determinants of Health Screening](#)

Resource Commitment

Kadlec recognizes the vital intersection between health care and housing and believes both are basic human rights. Kadlec is committed to increasing access to resources and support for individuals who are experiencing homelessness by committing staff time and other resources to be determined in the 2026 - 2028 cycle. Kadlec is committed to collaborating with community partners working in support of safe and affordable housing and to decrease homelessness.

Key Community Partners

Kadlec works with many community partners across Benton and Franklin counties to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing Housing and Homelessness include:

[Benton Franklin Community Action Coalition \(BFCAC\)](#)

[Benton-Franklin Health District](#)

[Greater Health Now: Community Hub](#)

[Housing Resource Center \(HRC\)](#)

[Kennewick Police Department](#)

[Mid-Columbia Libraries](#)

[St. Vincent DePaul Food Bank](#)

[Tri-Cities Union Gospel Mission](#)

COMMUNITY NEED ADDRESSED #3: ACCESS TO HEALTHCARE SERVICES

Population Served

People in need of timely care, including primary and specialty care; people with limited access to care due to age, disability, or lack of culturally responsive care options. In line with our Mission, we are focused on underserved populations, including those with low incomes, uninsured, and underinsured.

Long-Term Goal(s)/ Vision

To ease the way for people to access the appropriate level of care at the right time.

Table 3. Strategies and Measures for Addressing Access to Healthcare Services

Identified need: Access to Healthcare Services				
Strategy	Population Served	Strategy Measure(s)	Baseline	2028 Target
1. Engage and educate community members through bilingual/bicultural outreach, engagement, and education events by Community Health Workers (CHW) Connect people to Primary Care Provider	Underserved or under resourced populations	# of people served by CHWs # of people with no primary care provider (PCP) who are connected to PCP	In 2025, Community Health Workers provided services to 1,722 individuals 83 with no primary care provider who were connected to a PCP	Maintain level of service Increase # of people with no primary care provider (PCP) who are connected to PCP

2. Assist eligible uninsured patients with Medicaid enrollment*	Low income, underserved populations	% of uninsured patients enrolled in Medicaid	In 2025, 11.45% of uninsured patients converted to Medicaid enrollment	Increase the percentage of uninsured patients to Medicaid enrollment by at least 15%
3. Provide in-kind and grant support to Grace Clinic, the only free clinic in the Tri-Cities	Uninsured and underinsured population	# of people served	4,303 people served in 2025 7815 patient visits in 2025	5% increase in patient visits over baseline
4. Post-discharge care provided by Kadlec Clinic Bridge Care (KCBC) KCBC assists with establishment of primary care	People without a PCP in need of primary care	# of patients without primary care provider (PCP) seen % of patients identified as not having a PCP scheduled to establish with a PCP	Bridge Care Clinic started 7/14/25; 394 unique patients served In 2025, 271 (69%) patients scheduled to establish with a PCP (235 internal Kadlec PCP, 36 external clinic)	80% of patients identified as not having a PCP are scheduled to establish with a long-term PCP

* In partnership with Benton-Franklin Health District and healthcare-related partners, we will convene and share best practices and tools to support enrollment and recertification of patients into Medicaid to ensure access to healthcare starting January 2027 or sooner.

[Community and Research Informed Resources](#)

[Chronic Disease Management Programs](#)

[Community Health Workers](#)

[Federally Qualified Health Centers](#)

[Health Insurance Enrollment Outreach & Support](#)

[Kadlec Clinic Bridge Care](#)

[Washington Healthcare Access Alliance](#)

Resource Commitment

Kadlec commits staff time and other resources to be determined in the 2026 - 2028 cycle.

Kadlec is dedicated to enhancing and broadening healthcare access in Benton and Franklin Counties. Their efforts include both expanding Kadlec's own services and partnering with community organizations, as well as providing financial assistance. Kadlec's financial counseling team helps patients secure coverage, such as Medicaid and ACA plans available through Washington Healthplanfinder. The organization remains committed to working with community partners to further improve health access throughout Benton and Franklin counties.

Key Community Partners

Kadlec works with many community partners across Benton and Franklin counties to help address needs for those who are underserved. Examples of the partners we work with as part of our commitment to addressing Access to Healthcare Services:

[Food Access and Security Coalition](#)

[Grace Clinic](#)

[Health Equity and Access Team \(HEAT\)](#)

[Safe and Healthy Aging Coalition](#)

[St. Vincent DePaul](#)

[Tri Cities Community Health](#)

[Tri-Cities Diversity and Inclusion Council](#)

[Yakima Valley Farmworkers Clinic](#)

Other Community Benefit Programs

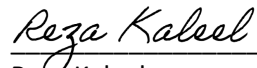
Table 4. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Population Served (Low Income, Vulnerable or Broader Community)
1. Access to Healthcare Services	Kadlec Support Groups	Monthly support groups are available for individuals facing complex health challenges	Broader Community

2. Access to Healthcare Services	Blood Drives	In partnership with the Red Cross, Kadlec staff help coordinate and offer space for monthly blood drives	Broader Community
3. Access to Healthcare Services	Kadlec Family Residency Program	Kadlec offers a comprehensive three-year Family Medicine residency program	Broader Community
4. Access to Healthcare Services	Community Wellness con S.A.B.O.R	This initiative, conducted in partnership with the Tri-Cities Diversity and Inclusion Council and Planned Parenthood, seeks to advance community health and education through organized fitness	Broader Community
5. Access to Healthcare Services	Kadlec Inpatient Dialysis	The dialysis program provides in-patient dialysis services to hospitalized patients at KRMHC to include patients with chronic or newly diagnosed kidney failure, and urgent, or emergency needs for dialysis for other diagnosis	Broader Community
6. Access to Healthcare Services	Kadlec Diabetes Learning Center	Kadlec's Diabetes Learning Center helps clients understand diabetes and develop self-management skills for a healthier, happier life	Broader Community
7. Access to Healthcare Services	Provider Job Fair	Event aims to retain more medical residents in the area; Federally Qualified Health Centers (FQHCs) invited	Broader Community

2026 - 2028 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was adopted by the Southeast Washington Service Area Community Mission Board of the hospital on April 17, 2026. The final report was made widely available by May 15, 2026.

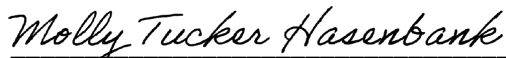


04/17/2026

Reza Kaleel

Date

Chief Executive, Providence Southeast Washington Service Area



04/17/2026

Molly Tucker Hasenbank

Date

Chair, Southeast Washington Service Area Community Mission Board



04/21/2026

Scott O'Brien

Date

Chief Executive, Eastern Washington/Montana

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