COMMUNITY HEALTH IMPROVEMENT PLAN
2020 - 2022

Kadlec Regional Medical Center

To provide feedback about this CHIP or obtain
a printed copy free of charge, please email
Karen.Hayes@kadlec.org.

KADLEC

CONTENTS

EXECUTIVE SUMMARY

Kadlec Regional Medical Center, hereafter referred to as Kadlec, is a not-for-profit health care system serving residents in Southeast Washington and Northeast Oregon. Founded in 1944, Kadlec has a rich heritage of offering vital health services to everyone who needs care, regardless of their ability to pay. When Kadlec opened its doors in 1944, the hospital was established to care for the Hanford area workers and their families. Since then Kadlec has grown to a regional medical center providing care for people throughout the Mid-Columbia. Kadlec has grown into a regional referral center providing primary and specialty care services for patients of all ages.

Today more than 3,600 employees work at Kadlec in the hospital, the free-standing Emergency Department, and in primary and specialty care clinics throughout the region. Kadlec is part of the family of mission-driven organizations that make up Providence St. Joseph Health, serving communities across a seven-state footprint. In 2019, Kadlec provided $68,347,223 in community benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in Benton and Franklin Counties and beyond.

Collaborating Organizations

Kadlec collaborates with the public health department known as Benton-Franklin Health District (BFHD) and the Benton-Franklin Community Health Alliance (BFCHA) to conduct the Community Health Needs Assessment (CHNA) and the Community Health Improvement Plan (CHIP) every three years. In 2019, the CHNA steering committee included representatives from Trios Health, Lourdes Health, and Prosser Memorial Health. The CHIP steering committee also includes representatives from Tri-Cities Community Health and Educational Service District (ESD) 123.

---

[1] 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.

Kadlec Community Health Improvement Plan Priorities

As a result of the findings of our 2019 CHNA and through a prioritization process aligned with our Mission, resources, and hospital strategic plan, Kadlec will focus on the following areas for its 2020 - 2022 Community Benefit efforts:

PRIORITY 1: BEHAVIORAL HEALTH CHALLENGES

Behavioral health challenges include mental health, suicide, and substance use disorders. Groups identified as being especially affected are people experiencing homelessness, youth, older adults, veterans, and those who identify as LGBTQ.

PRIORITY 2: ACCESS AND COST OF HEALTH CARE

Access and cost of health care includes access to behavioral health care and medical health care as well as the ability to pay for care. While insurance enrollment rates have increased due to systemic changes at the federal level, the cost of health care remains a financial burden for many in our community.

PRIORITY 3: SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are conditions in the places where people live, work, and play that affect a wide range of health risks and outcomes. Significant health-related areas identified include poverty, housing and homelessness, and food insecurity.

In addition to the three priorities identified through the 2019 collaborative CHNA process, Kadlec identified a fourth priority area.

PRIORITY 4: OBESITY/MAINTAINING HEALTHY WEIGHT

While obesity was not identified as a priority in the 2019 CHNA, obesity rates for children, teens, and adults in Benton and Franklin Counties continue to increase and remain higher than Washington State rates. According to the Center for Disease Control (CDC), "Childhood obesity is a serious problem in the United States putting children and adolescents at risk for poor health. Obesity-related conditions include heart disease, stroke, type 2 diabetes, and certain types of cancer that are some of the leading causes of preventable, premature death." Kadlec is committed to the long-term goal of reducing obesity, and it will continue to be addressed in the 2020 Kadlec CHIP.

Responding to the COVID-19 Pandemic

In addition to the aforementioned priority areas, the 2020 community health improvement process was disrupted 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 2019 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. This CHIP will be updated by March 2021 to better document the impact of and our response to COVID-19 in our community. 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.

MISSION, VISION, AND VALUES

Our Mission	Provide safe, compassionate care.
Our Vision	Health for a better world.
Our Values	Safety—Compassion — Respect — Integrity — Stewardship—Excellence — Collaboration

INTRODUCTION

Who We Are

Kadlec Regional Medical Center is an acute-care hospital founded in 1944 and located in Richland, Washington. There are currently 300 licensed beds. While we have the ability to utilize all 300 beds, we are not staffed for that many at this time. In January of 2021, Kadlec will have 337 licensed beds. Kadlec Regional Medical Center is approximately eleven acres in size. Kadlec has a staff of more than 3600 and professional relationships with more than 450 local physicians. Major programs and services offered to the community include:

- Comprehensive cardiac care
- Neurosurgery and neurology
- Neonatal and pediatrics
- Rural and emergency medicine
- Telehealth services in partnership with clinics and hospitals in Southeast Washington and Northeast Oregon

Our Commitment to Community

Kadlec is a not-for-profit hospital that 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 2019, Kadlec provided $68,347,223 in community benefit[2] in response to unmet needs and to improve the health and well-being of those we serve in Benton and Franklin Counties and beyond. Our region includes two for-profit hospitals: Trios Health and Lourdes Health; two critical access hospitals: Lourdes Health and Prosser Memorial Health; and three Federally Qualified Health Centers (FQHC): Tri-City Community Health, Yakima Farm Workers Clinics, and Columbia Basin Health Association.

---

[2] 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.

Community Benefit Governance and Management Structure

Kadlec further demonstrates organizational commitment to the community benefit process through the allocation of staff time, financial resources, and participation and collaboration with community partners. The Community Health Investment Manager is responsible for coordinating the implementation of State and Federal 501r requirements as well as providing the opportunity for community leaders and internal hospital Executive Management Team members, physicians and other staff to work together in planning and implementing the CHIP.

Kadlec worked closely with the Benton-Franklin Health District and Benton-Franklin Community Health Alliance and sub-committees throughout the community health improvement planning process to ensure that our goals and strategies are aligned and addressing the priority needs identified in the CHNA. Kadlec's CEO, Executive Team and Board were engaged in the process and approved the 2019 CHNA and Kadlec Executive Summary.

A charter approved in 2019 establishes the Kadlec Community Mission Board. The role of the Kadlec Community Mission Board is to support the Board of Trustees in overseeing community benefit issues. The Community Mission Board acts in accordance with the Board-approved charter. The Community Mission Board is charged with developing policies and programs that address identified needs in the service area particularly for underserved populations, overseeing development and implementation of the CHNA and CHIP reports, and overseeing and directing the Community Benefit activities. The Community Mission Board shall be comprised of 8-15 board members who are not only professionally diverse, but who closely represent the age, gender, race and ethnic profile of the service area. A majority of members have knowledge and experience with the populations most likely to have disproportionate unmet health needs. The Kadlec Community Mission Board generally meets bi-monthly.

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 necessary medical care because they lack health insurance. That is why Kadlec has a Financial Assistance Program (FAP) that provides free or discounted services to eligible patients.

One way Kadlec informs the public of its 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.

Billing statements and letters advise patients of the FAP and direct them to the Kadlec website to obtain an application and/or contact our billing office. The Financial Assistance Program application and policy are available in six languages on the [Kadlec website](#).

For information on our Financial Assistance Program click https://www.kadlec.org/location-directory/k/kadlec-regional-medical-center/patients-and-visitors/billing-assistance.

OUR COMMUNITY

Description of Community Served

Benton and Franklin Counties, located in South Eastern Washington, have a total population of approximately 290,000 people. Each of the three main municipalities that make up the Tri-Cities are located within one of these two counties: Kennewick and Richland within Benton County and Pasco within Franklin County. There are numerous other smaller cities located within this jurisdiction including Prosser, Connell, Eltopia, Benton City, West Richland, Finley, Mesa, Basin City and Kahlotus.

The population estimates for the cities and towns within Benton and Franklin Counties in 2019:

- Benton City: 3,520
- Connell: 5,500
- Kahlotus: 165
- Kennewick: 83,670
- Mesa: 495
- Pasco: 75,290
- Prosser: 6,145
- Richland: 56,850
- West Richland: 15,340

Given these numbers, the estimated population of residents living in unincorporated areas in either county (ex: Finley, Eltopia, Basin City) is 43,000 people.

While the population remains predominantly white, there is a substantial Hispanic/Latinx population that has more than doubled over the past two decades. Approximately 41,000 people living in the bi-county region are foreign born, regardless of citizenship status, and 30% of households report English is not the primary language spoken in the home.

Race	Benton County	Franklin County
White	70%	39%
Hispanic (as a race)	22.5%	55.5%
Black	1.5%	1.5%
American Indian/Alaskan Native	.5%	.5%
Asian	3%	2%
Multi-race	2.5%	1.5%

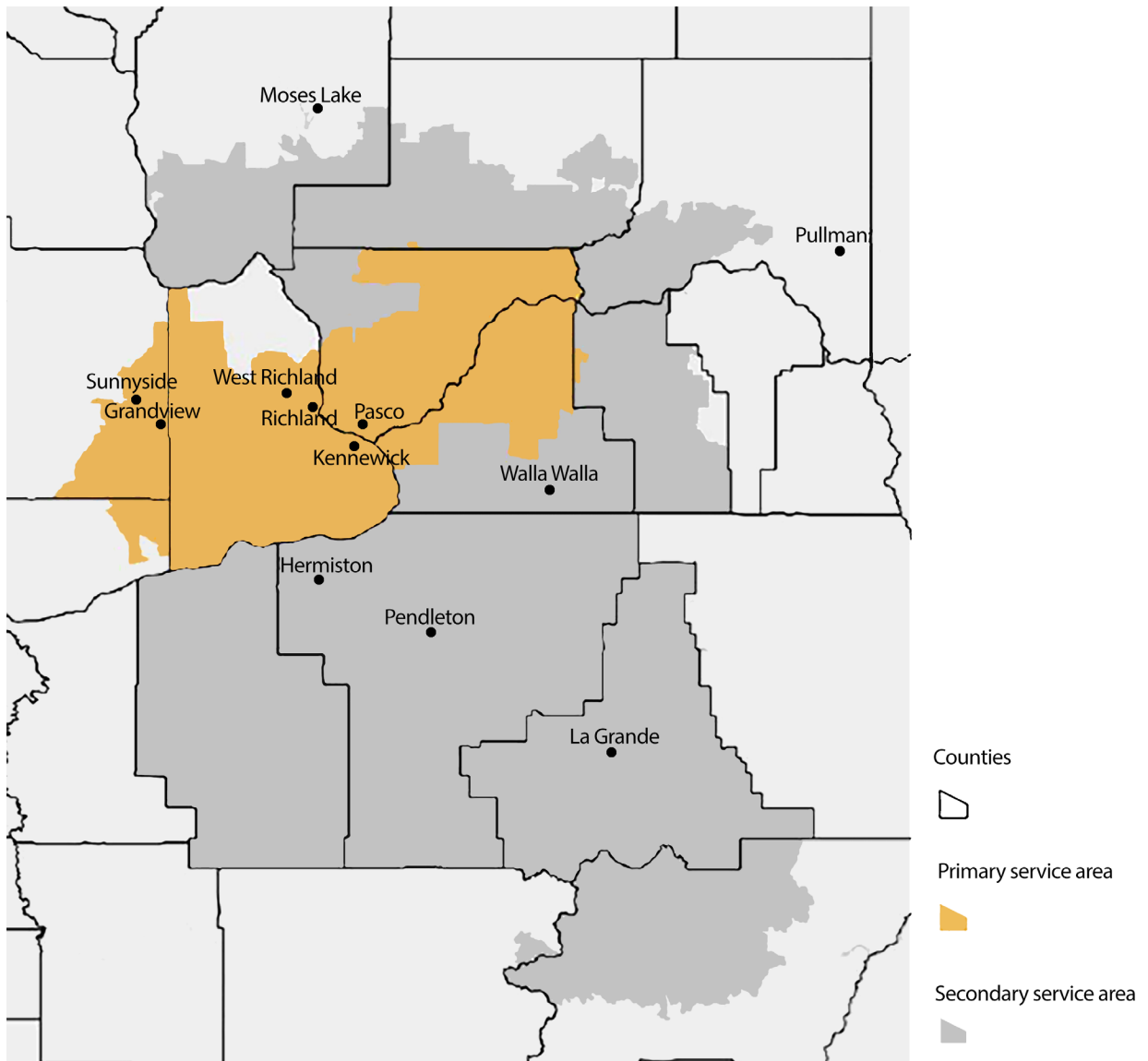The age distribution for Benton and Franklin Counties is approximately:

- 0-17 years: 28%
- 18-34 years: 22 %
- 35-64 years: 37%
- 65+ years: 13%

Sources:
Washington State Office of Financial Management
Benton-Franklin Trends
Community Health Assessment Tool (CHAT)

The map on the next page illustrates the approximate hospital service area of the four local healthcare systems in the region: Kadlec Regional Medical Center (Kadlec), Trios Health (Trios), Lourdes Health (Lourdes), and Prosser Memorial Health (PMH).

The bi-county region is also considered to be a health care provider shortage area for primary care providers, mental health providers, and dental providers, meaning there are not enough providers for the population size, geographic location, or facility type. Franklin County is also considered to be a medically underserved area which the federal government classifies as an area that has too few primary care providers, high infant mortality, high poverty, or a high elderly population. These definitions and more information can be found on the website for the Health Resources & Services Administration (HRSA).

Figure 1. Kadlec Primary and Secondary Service Areas

COMMUNITY NEEDS AND ASSETS ASSESSMENT PROCESS AND RESULTS

Summary of Community Needs Assessment Process and Results

The Community Health Needs Assessment was conducted as a collaboration between Kadlec Regional Medical Center, the Benton-Franklin Health District (BFHD) and the Benton-Franklin Community Health Alliance (BFCHA). The collaboration also included representatives from Trios Health, Lourdes Health, and Prosser Memorial Health.

The steering committee was formed in March 2019 and began meeting weekly shortly thereafter. BFHD's Health Officer participated in the development of the CHNA in 2013 and the update in 2016. A modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) strategic planning model promoted by the National Association of County and City Health Officials (NACCHO) was used.

The steering committee identified a list of quantitative health-related data points based on the 2013 and 2016 CHNA data books, the stakeholder survey, and priority issues highlighted by community members and stakeholders. These data points make up the Local Health Status Indicators. The Performance Management team from the BFHD then compiled the list of desired data points and determined which ones could be supported by a reliable source. Sources used during this process included the Healthy Youth Survey (HYS), Behavioral Risk Factor Surveillance System (BRFSS), Community Health Assessment Tool (CHAT), Office the Superintendent of Public Instruction (OSPI), Department of Education, American Community Survey (ACS), and partner-collected data from the local health care systems and community organizations. Based on these sources, the BFHD epidemiologist compiled the most current data for 120 individual data points into a 2019 Data Workbook for the steering committee's review and consideration.

Qualitative data was gathered in an attempt to gain insightful and equitable community input. This took a significant amount of time and effort in the form of listening sessions with members of priority populations and stakeholder interviews and surveys with those who serve these populations. Based on feedback from the Public Health Officer who participated in the CHNA process in 2016, the steering committee identified community input and involvement as an area of opportunity for improvement. Steering committee members wanted to be more intentional about incorporating health equity into this engagement process. One way in which this was accomplished was by utilizing existing tools, like the *2018 Health Disparities Report* published by BFHD. This report helped to inform the ultimate decisions on which priority population groups would be a primary focus for the listening sessions, specifically highlighting the Hispanic/Latinx and the LGBTQ communities. Another way the committee sought to be more inclusive was to offer multiple listening sessions in Spanish, the other predominant language in Benton and Franklin Counties besides English. A facilitator provided by Providence St. Joseph Health (PSJH) conducted three of the ten listening session completely in Spanish with Spanish-speaking note takers at all of them. Finally, the steering committee worked diligently to ensure a wide variety of sectors and populations were represented in the 16 stakeholder interviews including representation

from the following population and sector categories: behavioral health, homelessness, health care, seniors, Hispanic/Latinx people, domestic and sexual violence, first responders, substance abuse, pre-K-12th grade education, post-secondary education, LGBTQ identifying people, refugees, and persons living with a disability. The sessions were typically recorded with participant permission, and one or two note takers captured participant responses.

In an effort to include input from as many community partners as possible, the steering committee opted to disseminate the stakeholder survey from the stakeholder interview packet. An electronic copy was distributed via email distribution lists from BFHD, hospital partners, and BFCHA. Paper surveys were also completed by members of 20 coalitions, boards, and community partner agencies. Over 200 survey responses were received, analyzed and included in the community input data.

Identification and Selection of Significant Health Needs

The CHNA steering committee recognizes the value in having community members and community stakeholders participate in the CHNA process and share their perspectives. As the people who live and work in the counties, they have first-hand knowledge of the needs and strengths of their community. To gather community input, listening sessions were conducted with community members and community stakeholders were interviewed and surveyed.

Ten listening sessions were completed with a total of 96 community members. Participants shared their vision for a healthy community, the health-related needs of the community, and the assets that currently help the community be healthy.

Surveys were completed by 256 stakeholders. They were asked to identify their top five health-related community needs. Stakeholders prioritized one health-related need substantially above the others: behavioral health challenges, including mental health and substance use disorder. Two additional needs were given high priority and tied for importance: access to behavioral health services and homelessness/housing instability. These top three needs mirror those of the stakeholders who were interviewed.

The steering committee completed 16 community stakeholder interviews, including 40 stakeholders who are people invested in the well-being of the community with first-hand knowledge of community needs and strengths. Stakeholders were asked to rank unmet health-related community needs. For those needs, stakeholders shared which populations are most affected, gaps in community services to address the needs, and barriers to services.

Community Health Needs Prioritized

The collaborative partners identified the following three priority health needs:

PRIORITY 1: BEHAVIORAL HEALTH CHALLENGES

Behavioral health challenges include mental health, suicide, and substance use disorders. Groups identified as being especially affected are people experiencing homelessness, youth, older adults, veterans, and those who identify as LGBTQ.

PRIORITY 2: ACCESS AND COST OF ALL HEALTH CARE

Access and cost of all health care includes access to behavioral health care and medical health care as well as the ability to pay for care. While insurance enrollment rates have increased due to systemic changes at the federal level, the cost of health care remains a financial burden for many in our community.

PRIORITY 3: SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are conditions in the places where people live, work, and play that affect a wide range of health risks and outcomes. Significant health-related areas identified include poverty, housing and homelessness, and food insecurity. Kadlec will focus SDOH efforts on addressing housing instability and homelessness.

In addition to the three priorities identified through the 2019 collaborative CHNA process, Kadlec identified a fourth priority area.

PRIORITY 4: OBESITY/MAINTAINING HEALTHY WEIGHT

While obesity was not identified as a priority in the 2019 collaborative CHNA, obesity rates for children, teens, and adults in Benton and Franklin Counties continue to increase and remain higher than Washington State rates. According to the Center for Disease Control (CDC), "Childhood obesity is a serious problem in the United States putting children and adolescents at risk for poor health. Obesity-related conditions include heart disease, stroke, type 2 diabetes, and certain types of cancer that are some of the leading causes of preventable, premature death." Kadlec is committed to the long-term goal of reducing obesity, and it will continue to be addressed in the 2020 Kadlec CHIP.

Needs Beyond the Hospital's Service Program

No hospital facility can address all of the health needs present in its community, and some needs identified in the CHNA are the mission of other organizations. For example, addressing food insecurity is the mission of Second Harvest, the Community Action Coalition, and local food banks.

While addressing food insecurity is not a direct focus of this CHIP, food insecurity is addressed in several ways. Kadlec organizes an annual food drive to provide food for those in need. Kadlec's Project Homecoming program addresses the nutritional needs of patients when they are discharged through a partnership with Meals on Wheels if they were diagnosed with malnutrition while in our care.

While poverty will not be the direct focus of CHIP strategies outlined for 2020-2022, Kadlec's Financial Aid Program (FAP) provides free or discounted services to eligible patients. Poverty and food insecurity will also be impacted through the housing instability and homelessness initiative.

During the COVID-19 pandemic, Kadlec is working with community organizations such as Communities in Schools to provide meals for students and families in need, and exploring ways to partner with Master Gardeners to help low-income, food-challenged families start growing their own produce.

COMMUNITY HEALTH IMPROVEMENT PLAN

Summary of Community Health Improvement Planning Process

The prioritization process included evaluating Local Health Status Indicators, considering change over time, comparison to target numbers outlined by *Healthy People 2020*, and the severity of the difference between state and local numbers. Approximately 70 data points were categorized into nine topic areas: obesity, physical health, mental health and suicide, substance abuse, homelessness and poverty, aging issues, community violence and safety, access to health care, and sexual and reproductive health.

A community partner compression prioritization session was held with over 50 representatives from community partners and agencies. Participants included representation from health care networks, local clinics, public health, first responders, behavioral health, long-term care facilities, local chambers of commerce, student nursing programs, and other service-oriented community-based organizations. The prioritization process included group discussion and reporting out which resulted in seven priority health issues: obesity, youth sexual and reproductive health, violence and community safety, social determinants of health, behavioral health challenges, access and cost of all health care, and aging and long-term care issues. Participants then selected their top three issues which resulted in three issues being clearly identified as the top three priority issues:

1. Behavioral health challenges
2. Access and cost of all health care
3. Social determinants of health

Kadlec has also independently prioritized a fourth issue: Obesity/Maintaining Healthy Weight.

Kadlec anticipates that improvement plan 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 Kadlec in the enclosed CHIP.

Addressing the Needs of the Community: 2020- 2022 Key Community Benefit Initiatives and Evaluation Plan

PRIORITY #1: BEHAVIORAL HEALTH CHALLENGES

Community Need Addressed

Behavioral health challenges include mental health, suicide and substance use disorder.

Goals (Anticipated Impact)

Reduction in the suicide rate and improved community substance use disorder treatment services.

Scope (Target Population)

Older adults and youth.

Table 1. Outcome Measures for Addressing Behavioral Health Challenges

Outcome Measure	Baseline	FY20 Target	FY22 Target
1. Decrease suicide rates per 100,000	20.11 per 100,000	16 per 100,000	Zero suicide
2. Reduce opioid overdose hospitalization rate and opioid overdose death rate	19.86 per 100,000; and 8.6 per 100,000	18.5 per 100,000; and 8.2 per 100,000	17.87 per 100,000; and 7.8 per 100,000

Table 2. Strategies and Strategy Measures for Addressing Behavioral Health Challenges Note: *Behavioral health and homelessness are connected**

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Complete suicide risk assessment in Kadlec Emergency Department on patients presenting with mental health as chief complaint and those with diagnostic triggers	Percentage of patients screened	ED patients presenting with mental health as chief complaint and diagnostic triggers are screened for suicide risk; gathering data on % screened to establish baseline	Increase baseline percentage of ED patients screened by 10%	Goal % TBD
Train providers and community members in Mental Health First Aid (MHFA) and Positive Approach to Care (PAC)**	Number of people trained	165 trained in MHFA in 2019; and 0 trained in PAC in 2019	180 trained in MHFA; and 100 trained in PAC	250 trained in MHFA; and 150 trained in PAC
Integrate behavioral health in primary care	Number of clinics with integrated BH providers	One clinic	Three clinics	Four clinics
Work with partners to improve access to detox, recovery, and substance use treatment in Benton and Franklin counties	Number of providers and levels of service available	No detox and/or recovery center in Benton and Franklin Counties	Support community efforts to establish a detox and recovery center	Established detox and recovery center in Benton or Franklin County

** Explore partnership opportunities to provide mental health and suicide prevention education to the Hispanic/Latinx community.

Related Activities and Tactics

In addition to the strategies noted here, Kadlec will explore Providence's Community Resource Desk model to link vulnerable patients to social service agencies; implement a positive messaging campaign to reduce stigma related to mental health; continue support groups and educational programs to provide information and connection to those living with chronic illness and for family caregivers; continue Healthy Ages Wellness Programs to educate and reduce social isolation; explore opportunities to implement Nurse-Family Partnership program; and stand up a task force to determine whether to implement Naloxone dispensing program in hospital ED.

Evidence Based Sources and Other Supporting Resources

http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/

https://gcach.org/apps/website_resources/record/d7b7b36a2b2fd3a8ef74aa30641f130f/gcach191019annualreportv2finalweb.pdf

https://wellbeingtrust.org/areas-of-focus/clinical-transformation/

https://zerosuicide.edc.org/

http://suicidepreventionmessaging.org/

https://www.psychiatry.org/patients-families/warning-signs-of-mental-illness

https://teepasnow.com/wp-content/uploads/2019/01/Overview-of-Research-Evidence-for-PAC-vs-Dec-2018.pdf

https://www.dontgiveupsigns.com/

https://qprinstitute.com/

https://www.doh.wa.gov/YouandYourFamily/DrugUserHealth/OverdoseandNaloxone

https://stopoverdose.org/naloxone-law-in-washington/

https://www.doh.wa.gov/Portals/1/Documents/2300/2018/NaloxoneDist-ED.pdf

https://www.nami.org/Find-Support/NAMI-Programs/Compartiendo-Esperanza-Speaking-with-Latinos-abou

http://www.509recovery.org/

*https://mentalillnesspolicy.org/consequences/homeless-mentally-ill.html

*https://nationalhomeless.org/wp-content/uploads/2017/06/Substance-Abuse-and-Homelessness.pdf

Resource Commitment

Staff time, grant funding, sponsorships, other resources to be determined in the 2020-2022 cycle

Greater Columbia Accountable Communities of Health (GCACH), Educational Service District (ESD) 123, Community Prevention and Wellness Initiative (CPWI) Coalitions, KEY Connection, Benton Franklin Recovery Coalition, Ideal Option, Benton-Franklin Health District, Consistent Care, National Alliance on Mental Illness (NAMI), Lourdes Health, Tri-Cities Community Health

PRIORITY #2: ACCESS AND COST OF HEALTH CARE

Community Need Addressed

Access to health care includes behavioral health and medical care access, provider to population ratios resulting in extended wait times to see a provider, and access to providers with specialization in the unique needs of populations, such as people who identify as LGBTQ or adults living with disabilities.

Goal (Anticipated Impact)

Primary care and mental health provider to population ratios have improved which has resulted in reduced wait times to see providers. Patients are being connected with community services and resources.

Scope (Target Population)

People experiencing homelessness, youth, older adults, veterans, those who identify as LGBTQ, individuals experiencing Substance Use Disorder (SUD), and individuals whose primary language is Spanish.

Table 3. Outcome Measures for Addressing Access and Cost of Health Care

Outcome Measure	Baseline	FY20 Target	FY22 Target
1. Increase access to Primary Care Providers (PCP)	Benton County 1470:1 Franklin County 4100:1 (WA State: 1220:1)	Benton County: 1400:1 Franklin County: 3800:1	Benton County: 1350:1 Franklin County: 3500:1
2. Increase access to mental health providers	Benton County 470:1 Franklin County 780:1 (WA State 310:1)	Benton County: 450:1 Franklin County: 720:1	Benton County: 400:1 Franklin County: 650:1

Table 4. Strategies and Strategy Measures for Addressing Access and Cost of Health Care

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Continue provider recruiting efforts	Number of providers	In flux responding to COVID-19 pandemic needs	TBD due to COVID-19	TBD
Expand telemedicine services, including telepsych	Numbers of services available via telemedicine; number of people served	Responding to needs of COVID-19	TBD due to COVID-19	TBD
Implement Medication Assistance Program (MAP)	Number of patients enrolled in MAP	Program started	50	120
Implement a Diversity, Equity, and Inclusion committee	Committee formed, chartered, and meeting regularly	No committee	Chartered committee to have met at least 3 times	Established committee with work plans and goals re: LGBTQ and Hispanic/Latinx community members
Provide Medicare education to those turning 65 and others for financial planning*	Number of clients assisted	435 clients assisted in 24 Medicare classes	500 clients assisted	650 clients assisted

*While Medicare education impacts access and cost of care, it often reduces stress for seniors making critical decisions impacting their medical and financial health.

Related Activities and Tactics

In addition to the strategies noted here, Kadlec will explore Providence's Community Resource Desk model to link vulnerable patients to social service agencies.

Evidence Based Sources and Other Supporting Resources

https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/access-to-primary

https://www.integration.samhsa.gov/integrated-care-models/behavioral-health-in-primary-care

https://oregon.providence.org/our-services/p/providence-community-health-division/community-resource-desk/

https://www.tandfonline.com/doi/abs/10.1080/01634372.2015.1072759

Resource Commitment

Staff time, grants, and other resources to be determined in the 2020-2022 cycle

Lourdes Health, Trios Health, Tri-Cities Community Health, Yakima Farm Workers Clinic, Tri-City Regional Chamber of Commerce, Tri-Cities Washington Economic Development Council (TRIDEC)

PRIORITY #3: SOCIAL DETERMINANTS OF HEALTH

Community Need Addressed: Housing instability and homelessness

By focusing on housing instability and homelessness we anticipate indirect impacts on poverty and food insecurity as well.

Goal (Anticipated Impact)

The goal is 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.

Scope (Target Population)

People experiencing homelessness, particularly those with unstable housing, youth, older adults, veterans, those who identify as LGBTQ, and individuals experiencing SUD.

Table 5. Outcome Measures for Addressing Housing and Homelessness

Outcome Measure	Baseline	FY20 Target	FY22 Target
Reduce homelessness in Benton and Franklin counties as measured by the Point in Time Count	Per the 2019 Point-In-Time (PIT) Count, at any time at least 222 people in Benton and Franklin County are homeless	TBD	Functional Zero/Built for Zero for chronic and veteran homelessness

Table 6. Strategies and Strategy Measures for Addressing Housing and Homelessness

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Host housing workshop to identify shared community goals	Workshop completed; community-wide goals established	Pending workshop; delayed due to COVID-19 pandemic	TBD by workshop participants	TBD by workshop participants
Explore Built for Zero (BFZ) model	Program implementation	Exploring next steps to implement BFZ	Begin BFZ implementation	Complete BFZ program and achieve Functional Zero for veterans

				and chronic homelessness
Implement SDOH screening	Percentage of patients screened	2 Providence pilot sites planned for early 2020; on hold due to COVID-19 pandemic	TBD	TBD

Related Activities and Tactics

In addition to the strategies noted here, Kadlec will explore Providence's Community Resource Desk model to link vulnerable patients to social service agencies; opportunities to make referrals for housing assistance and promote access to low-barrier housing in the community. These goals will be further refined and updated following the community housing workshop.

Evidence Based Sources and Other Supporting Resources

https://endhomelessness.org/

https://www.cbpp.org/research/housing/supportive-housing-helps-vulnerable-people-live-and-thrive-in-the-community

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4130906/

https://community.solutions/our-solutions/built-for-zero/

Resource Commitment

Staff time, other resources to be determined within the 2020-2022 cycle

Key Community Partners

Greater Columbia Accountable Community of Health (GCACH), Benton and Franklin Counties Department of Human Services, City of Kennewick, City of Pasco, City of Richland, Benton & Franklin Counties Domestic Violence Services, Benton Franklin Community Action Council, Blue Mountain Action Council, Communities in Schools, Benton Franklin Community Action Council, Housing Authority of the City of Pasco/Franklin County, Housing Authority of Kennewick, Lourdes Counseling Center, Oxford House, Columbia Basin Veterans Coalition

PRIORITY #4: OBESITY/MAINTAINING HEALTHY WEIGHT

Community Need Addressed

Obesity rates for children, teens and adults in Benton and Franklin Counties continue to increase and remain higher than Washington state rates.

Goal (Anticipated Impact)

The long-term goal is to reduce obesity rates in children and adults in Benton and Franklin Counties.

Scope (Target Population)

Children and families, particularly low-income families.

Table 7. Outcome Measures for Addressing Obesity/Maintaining Healthy Weight

Outcome Measure	Baseline	FY20 Target	FY22 Target
Reduce child and teen obesity rates, per Youth Risk Behavior Surveillance System (YRBSS)	30% (8th, 10th, 12th graders)	TBD	28%

Table 8. Strategies and Strategy Measures for Addressing Obesity/Maintaining Healthy Weight

Strategy(ies)	Strategy Measure	Baseline	FY20 Target	FY22 Target
Implement Coordinated Approach to Child Health (CATCH) program in partnership with schools and programs	Number of schools/programs implementing CATCH; number of students in program	No schools or programs participating	One school or implementing CATCH program	Three schools or programs implementing CATCH program

Evidence Based Sources and Other Supporting Resources

https://catchinfo.org/research/

https://www.healthypeople.gov/2020/topics-objectives/topic/nutrition-and-weight-status

https://www.cdc.gov/prc/resources/tools/catch.html

https://usafacts.org/articles/obesity-rate-nearly-triples-united-states-over-last-50-years/

https://www.cdc.gov/healthyyouth/data/yrbs/index.htm

Resource Commitment

Staff time, grant funding, sponsorships, other resources to be determined within the 2020-2022 cycle

Key Community Partners

Elementary schools in Benton and Franklin Counties, Boys and Girls Club of Benton and Franklin Counties, YMCA of Greater Tri-Cities, Communities in Schools, Educational Service District (ESD) 123/21st Century Extended Day Program

Other Community Benefit Programs

Table 7. Other Community Benefit Programs in Response to Community Needs

Initiative (Community Need Addressed)	Program Name	Description	Target Population (Low Income, Vulnerable or Broader Community)
1. Access	Grace Clinic	Medical care, medications, urgent dental care, mental health counseling, and spiritual care at no cost	Low Income, Uninsured
2. Education	Classroom Makeover	Monetary gift awarded to teacher for classroom resources and tools	Youth, Broader Community
3. Family/Community Support	Financial Contributions	Community organizations and programs consistent with our mission, goals and commitments and that work to improve health and wellness	Broader Community
4. Education	Columbia Basin College	Supporting and investing in health care education	Broader Community
5. Family/Community Support	Coats for Kids	School challenge to collect winter coats	Low Income
6. Economic Development	Community Building	Support activities that address poverty, homelessness and	Broader Community

		environmental issues by offering expertise and resources	
7. Economic Development	Tri-City Regional Chamber of Commerce Board of Directors	Executive Team participation	Broader Community
8. Workforce Development	Benton-Franklin Community Health Alliance Board of Directors	Collaboration that addresses community-wide health issues, and woks to address affordable and accessible health care	Broader Community
9. Workforce Development	Tri-City Cancer Center Board of Directors	Coordinates the highest quality, compassionate cancer care	Broader Community
10. Workforce Development	Experience Healthcare	High school student health care immersion program	Broader Community
11. Community Benefit Operations	Salary and Benefits	System and region	Broader Community
12. Community Health Education	Community Health Journal	Health and wellness community education	Broader Community
13. Community Health Education	Healthplex Workshops	Wide variety of programs and services	Broader Community, Adults and Children
14. Community Health Education/Support Groups/Chronic Disease	Kadlec Neurological Resource Center and Community Health	Support groups, educational programs, library, Medicare education, Mall Walkers program	Broader Community, Older Adults, Caregivers, People of all ages with Chronic Conditions
15. Community Health Education	Two Minute Take	Television segment to introduce physicians, and to communicate services, activities and events surrounding health and wellness	Broader Community

16. Family/Community Support/Safety	Safe Kids Saturday	Free safety event where attendees learn about electrical, water, fire and railroad safety; how to call 911; and more. Includes bike rodeo, free bike helmets and free car seat checks	Broader Community, Families
17. Community Health Education	Community Education Programs	Life Safety instructor training and courses, Hands On Only CPR, Health Fairs, Home Alone Caring training, and free Prepared Childbirth instruction for those in need	Broader Community, Low Income
18. Community Health Education	Kadlec On Call Radio Program	Radio program that provides education on health and wellness featuring clinicians, caregivers, community partners that shares programs, services, activities and events to improve health	Broader Community
19. Community Health Education/Obesity	Kadlec Academy/Coordinated Approach to Child Health (CATCH)	Education on health and wellness emphasizing the importance of active and healthy lifestyles and nutrition	Children
20. Graduate Medical Education	Kadlec Family Residency Program	Specialty care for the whole family from newborns to seniors	Broader Community; People whose primary language is Spanish, LGBTQ
21. Family Community Support	Tri-Cities Water Follies	Partnership with Lourdes Health Network to provide first aid services	Broader Community
22. Mental Health/Disability	Buddy Club Prom	Provide dinner for Arc of Tri-Cities event that connects teens	Broader Community, Youth

		with disabilities to form friendships with teens without disabilities in their school	
23. Palliative Care	Palliative Care Program	Prevent and ease suffering and improve quality of life by symptom management, end-of-life conversations and comfort care	Broader Community
24. Chronic Disease	Diabetes Learning Center	Diabetes education to help clients gain a better understanding of diabetes and self-management	Broader Community

2020- 2022 CHIP GOVERNANCE APPROVAL

This Community Health Improvement Plan was approved by the Kadlec Community Mission Board of the hospital on April 15, 2020. The final report was made widely available[3] by May 15, 2020.
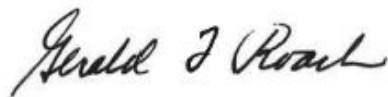
_____ 4/15/2020
Reza Kaleel   Date
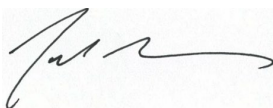Chief Executive
Kadlec Regional Medical Center

_____ 4/15/2020
Jerry Roach   Date
Chair
Kadlec Regional Medical Center

_____ 5/1/2020___
Joel Gilbertson   Date
Senior Vice President, Community Partnerships
Providence St. Joseph Health

CHNA/CHIP Contact:
Karen Hayes
Manager Community Health Investment
888 Swift Blvd, Richland, WA 99352
Karen.Hayes@kadlec.org

To request a copy free of charge, provide comments, or view electronic copies of current and previous Community Health Improvement Plans please email CommunityBenefit@providence.org.

---

[3] Per § 1.501(r)-3 IRS Requirements, posted on hospital website

APPENDICES

Appendix 1: Definition of Terms

Community Benefit: 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.

Community benefit includes services to persons living in poverty, persons who are vulnerable, and the 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:

    a. Community health needs assessment developed by the ministry or in partnership with other community organizations;
    b. 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; or
    c. The involvement of unrelated, collaborative tax-exempt or government organizations as partners in the community benefit initiative or program.

Health Equity: Healthy People 2020 defines *health equity* as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Social Determinants of Health: Powerful, complex relationships exist between health and biology, genetics, and individual behavior, and between health and health services, socioeconomic status, the physical environment, discrimination, racism, literacy levels, and legislative policies. These factors, which influence an individual's or population's health, are known as *determinants of health*. *Social determinants of health* are conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Initiative: An initiative is an umbrella category under which a ministry organizes its key priority efforts. Each effort should be entered as a program in CBISA Online (Lyon Software). Please be sure to report on all your Key Community Benefit initiatives. If a ministry reports at the initiative level, the goal (anticipated impact), outcome measure, strategy and strategy measure are reported at the initiative level. Be sure to list all the programs that are under the initiative. Note: All Community Benefit initiatives must submit financial and programmatic data in CBISA Online.

Program: A program is defined as a program or service provided to benefit the community (in alignment with guidelines) and entered in CBISA Online (Lyon Software). Please be sure to report on all community benefit programs. Note: All community benefit programs, defined as "programs", are required to include financial and programmatic data into CBISA Online.

Goal (Anticipated Impact): The goal is the desired ultimate result for the initiative's or program's efforts. This result may take years to achieve and may require other interventions as well as this program. (E.g. increase immunization rates; reduce obesity prevalence.).

Scope (Target Population): Definition of group being addressed in this initiative: specific description of group or population included (or not included, if relevant) for whom outcomes will be measured and work is focused. Identify if this initiative is primarily for persons living in poverty or primarily for the broader community.

Outcome measure: An outcome measure is a quantitative statement of the goal and should answer the following question: "How will you know if you're making progress on goal?" It should be quantitative, objective, meaningful, and not yet a "target" level.