Santa Barbara Cottage Hospital

Community Benefit Implementation Strategy

2013-2015

Contents

Executive Summary

Cottage Health—located in Santa Barbara County, California and comprised of Santa Barbara Cottage Hospital, Goleta Valley Cottage Hospital, and Santa Ynez Valley Cottage Hospital—is committed both to serving the South Coast communities' acute care needs and, from a broader perspective, identifying and addressing community health needs.

In order to meet the needs of the service area, Cottage Health conducted a Community Health Needs Assessment, which included information from community members and leaders along with public health data. The results of the assessment include the following areas of opportunity:

- Access to Healthcare Services
- Cancer
- Dementias, Alzheimer's Disease
- Diabetes
- Disability & Activity Limitations
- Heart Disease & Stroke
- Housing & Homelessness
- Immunization & Infectious Diseases
- Infant Health & Family Planning
- Injury
- Mental Health & Mental Disorders
- Nutrition, Physical Activity & Weight
- Oral Health
- Substance Abuse

Cottage Health will provide programs and collaborate with community organizations to address the needs and works towards a healthier community.

Community Health Needs Assessment

In the fall of 2013, Santa Barbara Cottage Hospital and Goleta Valley Cottage Hospital embarked on a comprehensive Community Health Needs Assessment (CHNA) process to identify and address the key health issues for the local community.

Santa Barbara Cottage Hospital

Part of Cottage Health, Santa Barbara Cottage Hospital is a 483-bed acute care teaching hospital and trauma center, the largest of its kind between Los Angeles and the San Francisco Bay Area. The hospital was founded in 1888 by 50 women determined to provide a healthcare facility for the growing community of Santa Barbara.

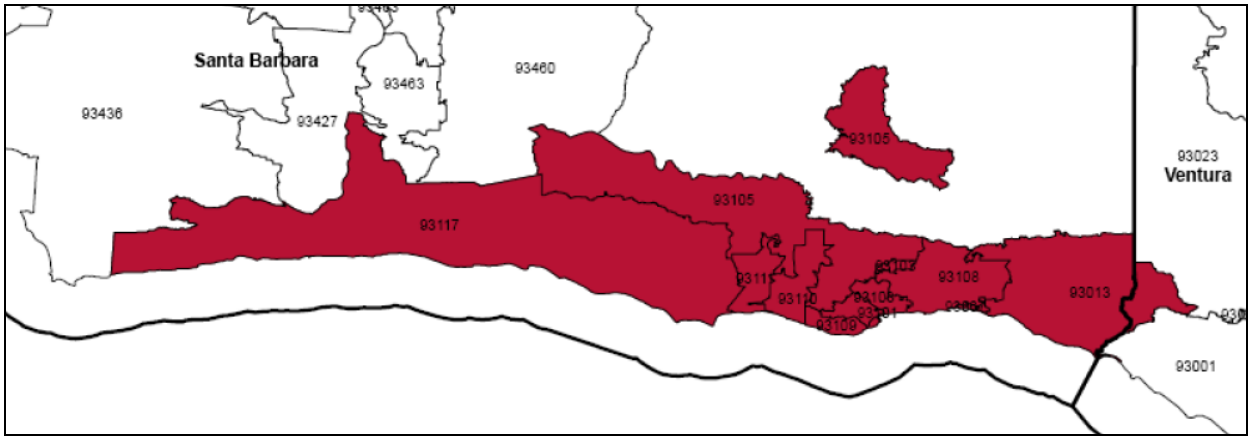
Now with annual admissions of more than 18,000 patients, 44,400 emergency department visits, and 2,300 births, Santa Barbara Cottage Hospital is renowned for the breadth of its services: comprehensive maternal-child services; Cottage Children's Hospital; heart and vascular, neurosurgical, and oncology programs; advanced surgical facilities and minimally-invasive robotic equipment; level II trauma center and emergency services; Cottage Rehabilitation Hospital; psychiatric and chemical dependency programs and Cottage Residential Center; and outpatient services that include the Cottage Center for Advanced Imaging, outpatient surgery, and the MacDougall Eye Center.

Its medical staff of more than 650 physicians includes specialists in all major clinical areas, many of whom are involved in the training and education of new physicians in the hospital's internal medicine, general surgery, and radiology residency programs.

Community Served

Community Definition

Santa Barbara Cottage Hospital's community, as defined for the purposes of the Community Health Needs Assessment in conjunction with Goleta Valley Cottage Hospital, included each of the residential ZIP Codes that comprise the hospital's primary service area, including: 93013, 93067, 93101, 93103, 93105, 93108, 93109, 93110, 93111, and 93117. This community definition, determined based on the ZIP Codes of residence of recent patients, is illustrated in the following map.



Demographics of Santa Barbara County

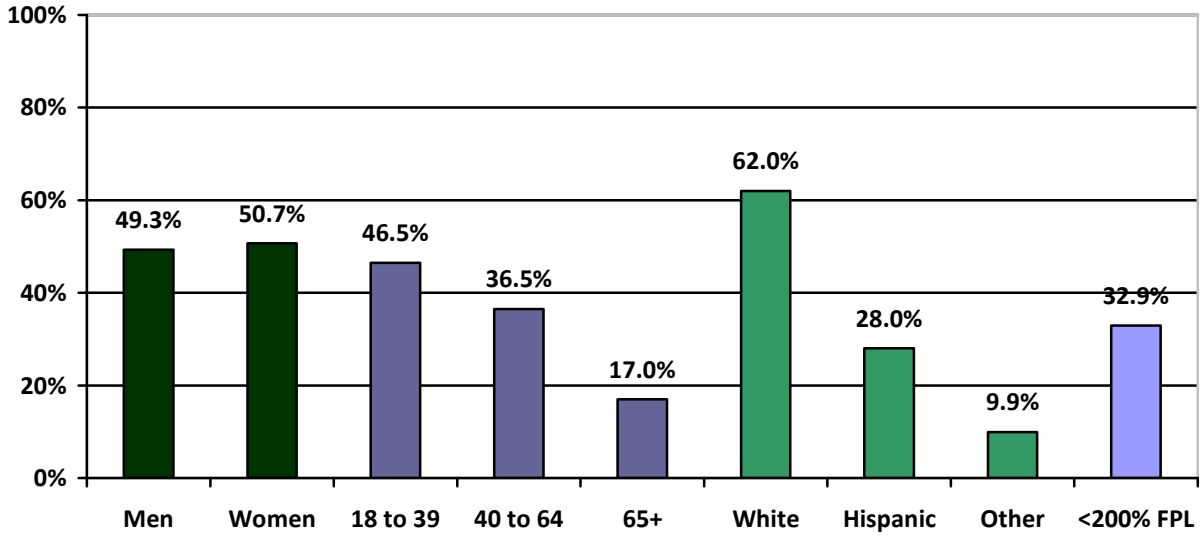
With a population of 435,697, Santa Barbara County encompasses 2,750 square miles of land and inland water area. Much of the county is mountainous. The Santa Ynez, San Rafael and Sierra Madre mountains extend in a predominately east-west direction. Within the county, there are numerous fertile agricultural areas, including the Santa Ynez, Lompoc, Santa Maria, and Cuyama Valleys, and the southeast coastal plain. These areas, which include most of the developed land, also accommodate the majority of the population. Los Padres National Forest, in the eastern part of the county, covers approximately 44% of the total county area. "North County" refers to the area west and north of Gaviota, and includes the Santa Ynez, Lompoc, Santa Maria, and Cuyama valleys. "South County" refers to the Goleta, Santa Barbara, and Carpinteria coastal plain.

- Santa Barbara County's median income is $62,000, which is the same as the State of California's. Within the tri-counties region, Santa Barbara County's median income is below Ventura County's ($77,000), and higher than San Luis Obispo County's ($59,000). Several small census tracts within southern Santa Barbara County are known to have twice the median household compared to the county as a whole.

- Out of a workforce of 197,400 residents, the six top employment sectors account for 71% of this population: Government (38,000); Leisure and Hospitality (22,000); Professional and Business Services (21,700); Educational and Health Services (20,900); Agriculture, Forestry, Fishing and Hunting (18,700); and Retail Trade (17,900).

- The poverty rate for Santa Barbara County is 14.4%, which is the same as the State of California. Within the tri-counties region, Santa Barbara County's poverty rate is slightly higher than San Luis Obispo County's (population 274,000, poverty rate 13.2%), and Ventura County's (population 840,000, poverty rate 9.9%). The 2013 Federal Poverty Level guidelines place the poverty threshold for a family of four at $23,550 annual household income or lower.

The characteristics of those included in the Community Health Needs Assessment for Santa Barbara Cottage Hospital and Goleta Valley Cottage Hospital are shown in the chart below.



Community Resources Available

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified. This list is not exhaustive, but rather outlines those resources identified in the course of conducting the Community Health Needs Assessment.

- Alcohol, Drug, and Mental Health Services (ADMHS)
- Alcoholics Anonymous
- Alzheimer's Association
- American Heart Association
- American Indian Health & Services
- Area Agency on Aging
- Arthritis Foundation
- Bike Paths
- Carpinteria Children's Project
- Casa Esperanza
- Coalition Engaged in A Smoke-free Effort (CEASE)
- City Parks
- Council on Alcoholism and Drug Abuse (CADA)
- Doctors Without Walls
- Eastside Dental Clinic
- Family Resource Centers
- Friendship Center
- Food Bank
- Health Fairs
- Homeless Shelters
- Non-profits
- Orfalea Foundation
- PathPoint
- Planned Parenthood
- Private Practitioners
- Public Officials (City Council/Mayor)
- Red Cross
- Sansum Clinic
- Santa Barbara County Public Health Department
- Santa Barbara Diabetes Research Institute
- Santa Barbara Neighborhood Clinics
- Santa Barbara Rescue Mission
- Schools
- St. Cecilia Society
- Thrive Santa Barbara
- Visiting Nurse and Hospice Care
- YMCA
- Zona Seca, Inc.

How CHNA Data Were Obtained

Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Santa Barbara Cottage Hospital and Goleta Valley Cottage Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- To improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors, which have historically had a negative impact on residents' health.
- To increase accessibility to preventive services for all community residents. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of Cottage Health by Professional Research Consultants, Inc. (PRC). PRC is a nationally recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through a series of key informant focus groups.

Community Health Survey

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) and Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion

and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Santa Barbara Cottage Hospital, Goleta Valley Cottage Hospital, and PRC.

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the Community Health Survey. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency, and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 659 individuals age 18 and older in the Santa Barbara Cottage Hospital and Goleta Valley Cottage Hospital service area. Once the interviews were completed, these were weighted in proportion to the actual population distribution to represent the primary service area appropriately as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Public Health, Vital Statistics, & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Santa Barbara Cottage Hospital and Goleta Valley Cottage Hospital service area were obtained from the following sources:

- California Department of Public Health
- Centers for Disease Control & Prevention
- National Center for Health Statistics
- State of California Department of Justice
- United States Census Bureau
- United States Department of Health and Human Services
- United States Department of Justice, Federal Bureau of Investigation

Note that secondary data reflect county-level data (Santa Barbara County).

Key Informant Focus Groups

As part of this Community Health Needs Assessment, five focus groups were held. The focus group participants included 52 local key informants: representatives from public health, physicians, other health professionals, social service providers, employers, and other community leaders.

A list of recommended participants for the focus groups was provided by Cottage Health. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Through this process, input was gathered from a representative of public health, as well as several individuals whose organizations work with low-income, minority (including Latino/Mixteco, Native

American, Asian, and African American), or other medically underserved populations (specifically, persons who are young adults, elderly, veterans, disabled, lesbian/gay/bisexual/transgender [LGBT], homeless, mentally ill, undocumented, uninsured/underinsured, or receive Medi-Cal/Medicare).

Key Informant Focus Group	Date
Employers & Business Leaders	October 8, 2013
Social Service Providers (Group A)	October 8, 2013
Social Service Providers (Group B)	October 8, 2013
Physicians & Other Health Providers	October 9, 2013
Other Community Leaders	October 9, 2013

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps in some ways might limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

Vulnerable Populations

The Community Health Needs Assessment analysis and report yielded a wealth of information about the health status, behaviors, and needs for the local population. A distinct advantage of the primary quantitative (community health survey) research is the ability to segment findings by geographic, demographic and health characteristics to identify the primary and chronic disease needs and other health issues of vulnerable populations, such as uninsured persons, low-income persons, and racial/ethnic minority groups.

For additional statistics about uninsured, low-income, and minority health needs please refer to the complete Community Health Needs Assessment report, which can be viewed online at http://santabarbaragoleta.healthforecast.net.

Public Dissemination

This Community Health Needs Assessment is available to the public using the following URL: http://santabarbaragoleta.healthforecast.net. HealthForecast.net™ is an interactive, dynamic tool designed to share Community Health Needs Assessment data with community partners and the public at large.

This site:

- Informs readers that the Community Health Needs Assessment report is available and provides instructions for downloading it;
- Offers the Community Health Needs Assessment report document in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the report;
- Grants access to download, view, and print the document without special computer hardware or software required for that format (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital organization or facility or to another entity maintaining the website.

Links to this dedicated HealthForecast.net™ site are also made available at Cottage Health's website at: www.cottagehealth.org.

Santa Barbara Cottage Hospital will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. Santa Barbara Cottage Hospital will also maintain at its facilities a hardcopy of the Community Health Needs Assessment report that may be viewed by any who request it.

Community Health Summary Tables

The following tables provide an overview of indicators in the Santa Barbara Cottage Hospital and Goleta Valley Cottage Hospital primary service area, grouped to correspond with the focus areas presented in Healthy People 2020.

The columns to the right of the service area column provide comparisons between the service area and any available state and national findings, and Healthy People 2020 targets. Colors indicate whether the primary service area compares favorably (green), unfavorably (red), or comparably (white) to these external data. Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

General Health Status	SBCH/GVCH Service Area	CA	US	HP2020
% "Fair/Poor" Physical Health	**17.8**	18.7	15.3	
% Activity Limitations	**25.4**	21.3	21.5	

Access to Health Services	SBCH/GVCH Service Area	CA	US	HP2020
% [Age 18-64] Lack Health Insurance	**20.4**	21.5	15.1	0.0
% [Insured] Went Without Coverage in Past Year	**5.8**		8.1	
% Difficulty Accessing Healthcare in Past Year (Composite)	**39.0**		39.9	
% Inconvenient Hours Prevented Doctor Visit in Past Year	**12.5**		15.4	
% Cost Prevented Getting Prescription in Past Year	**12.8**		15.8	
% Cost Prevented Physician Visit in Past Year	**16.1**		18.2	
% Difficulty Getting Appointment in Past Year	**18.7**		17.0	
% Difficulty Finding Physician in Past Year	**11.7**		11.0	
% Transportation Hindered Doctor Visit in Past Year	**7.1**		9.4	
% Skipped Prescription Doses to Save Costs	**13.4**		15.3	
% Difficulty Getting Child's Healthcare in Past Year	**7.5**		6.0	
% [Age 18+] Have a Specific Source of Ongoing Care	**69.3**		76.3	95.0
% [Age 18-64] Have a Specific Source of Ongoing Care	**69.1**		75.6	89.4
% [Age 65+] Have a Specific Source of Ongoing Care	**75.2**		80.0	100.0
% Have Had Routine Checkup in Past Year	**61.7**		65.0	
% Child Has Had Checkup in Past Year	**74.5**		84.1	
% Two or More ER Visits in Past Year	**5.7**		8.9	
% Rate Local Healthcare "Fair/Poor"	**14.4**		16.5	

Arthritis, Osteoporosis & Chronic Back Conditions	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
% [50+] Arthritis/Rheumatism	**32.0**		37.3	
% [50+] Osteoporosis	**11.5**		13.5	5.3
% Sciatica/Chronic Back Pain	**21.8**		18.4	

Cancer	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
Cancer (Age-Adjusted Death Rate)	**149.2**	158.2	174.2	160.6
% Skin Cancer	**8.2**	5.8	6.7	
% Cancer (Other Than Skin)	**6.3**	5.8	6.1	
% [Women 40+] Mammogram in Past 2 Years	**78.9**		80.1	
% [Women 50-74] Mammogram in Past 2 Years	**79.9**	81.4	83.6	81.1
% [Women 21-65] Pap Smear in Past 3 Years	**87.7**	80.8	83.9	93.0
% [Age 50+] Sigmoid/Colonoscopy Ever	**79.7**	61.5	75.2	
% [Age 50+] Blood Stool Test in Past 2 Years	**29.6**	27.0	36.9	
% [Age 50-75] Colorectal Cancer Screening	**77.9**		75.1	70.5

Chronic Kidney Disease	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
Kidney Disease (Age-Adjusted Death Rate)	**4.0**	8.6	15.2	
% Kidney Disease	**1.6**		3.0	

Diabetes	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
Diabetes Mellitus (Age-Adjusted Death Rate)	**15.3**	20.3	21.3	20.5
% Diabetes/High Blood Sugar	**7.4**	8.9	11.7	
% Borderline/Pre-Diabetes	**10.7**		5.1	
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	**49.8**		49.2	

Dementias, Including Alzheimer's Disease	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
Alzheimer's Disease (Age-Adjusted Death Rate)	**27.3**	29.2	25.0	

Family Planning	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
% Births to Teenagers	**10.9**	9.0	9.9	

Hearing & Other Sensory or Communication Disorders	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
% Deafness/Trouble Hearing	**6.8**		10.3	

Heart Disease & Stroke	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
Diseases of the Heart (Age-Adjusted Death Rate)	**153.9**	168.2	184.6	158.9
Stroke (Age-Adjusted Death Rate)	**36.6**	39.2	40.2	33.8
% Heart Disease (Heart Attack, Angina, Coronary Disease)	**4.9**		6.1	
% Stroke	**2.1**	2.2	3.9	
% Blood Pressure Checked in Past 2 Years	**91.4**		91.0	92.6
% Told Have High Blood Pressure (Ever)	**31.9**	27.8	34.1	26.9
% [HBP] Taking Action to Control High Blood Pressure	**90.4**		89.2	
% Cholesterol Checked in Past 5 Years	**90.7**	75.5	86.6	82.1
% Told Have High Cholesterol (Ever)	**29.5**	36.0	29.9	13.5
% [HBC] Taking Action to Control High Blood Cholesterol	**86.0**		81.4	
% 1+ Cardiovascular Risk Factor	**73.6**		82.3	

HIV	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
HIV/AIDS (Age-Adjusted Death Rate)	**1.2**	2.6	3.3	3.3
% [Age 18-44] HIV Test in the Past Year	**27.2**		19.3	18.9

Immunization & Infectious Diseases	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
Pertussis per 100,000	**9.4**	15.4	6.3	
% [Age 65+] Flu Vaccine in Past Year	**51.3**	57.2	57.5	90.0
% [High-Risk 18-64] Flu Vaccine in Past Year	**37.8**		45.9	90.0
% [Age 65+] Pneumonia Vaccine Ever	**67.3**	68.1	68.4	90.0
% [High-Risk 18-64] Pneumonia Vaccine Ever	**35.9**		41.9	60.0
Tuberculosis Incidence per 100,000	**5.8**	6.4	3.6	1.0
% Have Completed Hepatitis B Vaccination Series	**43.9**		44.7	

Injury & Violence Prevention	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
Unintentional Injury (Age-Adjusted Death Rate)	**31.8**	28.9	38.2	36.0
Motor Vehicle Crashes (Age-Adjusted Death Rate)	**8.3**	8.8	11.9	12.4
% "Always" Wear Seat Belt	**93.5**	97.7	84.8	92.0
% Child [Age 5-17] Healthy Weight	**61.1**		56.7	
% Child [Age 0-17] "Always" Uses Seat Belt/Car Seat	**96.0**		92.2	
% Child [Age 5-17] "Always" Wears Bicycle Helmet	**65.4**		48.7	
Firearm-Related Deaths (Age-Adjusted Death Rate)	**5.1**	8.1	10.2	9.2
% Firearm in Home	**17.3**		34.7	
% [Homes With Children] Firearm in Home	**18.7**		37.4	
% [Homes With Firearms] Weapon(s) Unlocked & Loaded	**7.1**		16.8	
Homicide (Age-Adjusted Death Rate)	**2.7**	5.6	5.6	5.5
Violent Crime per 100,000	**401.1**	425.8	392.8	
% Victim of Violent Crime in Past 5 Years	**2.8**		2.8	
Domestic Violence Offenses per 100,000	**374.7**	428.1		
% Victim of Domestic Violence (Ever)	**11.9**		15.0	

Maternal, Infant & Child Health	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
% Late or No Prenatal Care	**1.9**	3.2		
% of Low Birthweight Births	**5.9**	6.8	8.2	7.8
Infant Death Rate	**5.5**	5.1	6.5	6.0

Mental Health & Mental Disorders	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
% "Fair/Poor" Mental Health	**12.9**		11.9	
% Diagnosed Depression	**22.1**		20.4	
% Symptoms of Chronic Depression (2+ Years)	**35.0**		30.4	
Suicide (Age-Adjusted Death Rate)	**11.1**	10.3	11.8	10.2
% [Those With Diagnosed Depression] Seeking Help	**84.0**		76.6	
% Typical Day Is "Extremely/Very" Stressful	**11.9**		11.9	

Nutrition & Weight Status	SBCH/GVCH Service Area	CA	US	HP2020
% Eat 5+ Servings of Fruit or Vegetables per Day	**45.0**		39.5	
% "Very/Somewhat" Difficult to Buy Fresh Produce	**14.5**		24.4	
% Medical Advice on Nutrition in Past Year	**42.7**		39.2	
% Healthy Weight (BMI 18.5-24.9)	**41.9**		34.4	33.9
% Overweight (BMI 25+)	**56.1**	60.2	63.1	
% Obese (BMI 30+)	**18.6**	23.8	29.0	30.5
% [Overweights] Perceive Self "About the Right Weight"	**26.7**		22.1	
% Medical Advice on Weight in Past Year	**25.0**		23.7	
% [Overweights] Counseled About Weight in Past Year	**34.8**		31.8	
% [Obese Adults] Counseled About Weight in Past Year	**41.0**		48.3	
% [Overweights] Trying to Lose Weight Both Diet/Exercise	**36.7**		39.5	
% Children [Age 5-17] Overweight (85th Percentile)	**29.2**		31.5	
% Children [Age 5-17] Obese (95th Percentile)	**18.0**		14.8	14.5

Oral Health	SBCH/GVCH Service Area	CA	US	HP2020
% [Age 18+] Dental Visit in Past Year	**75.0**	69.6	65.9	49.0
% Child [Age 2-17] Dental Visit in Past Year	**87.4**		81.5	49.0
% Have Dental Insurance	**58.4**		65.6	

Physical Activity	SBCH/GVCH Service Area	CA	US	HP2020
% No Leisure-Time Physical Activity	**16.2**	19.1	20.7	32.6
% Meeting Physical Activity Guidelines	**59.7**		50.3	
% Moderate Physical Activity	**40.8**		30.6	
% Vigorous Physical Activity	**41.5**		38.0	
% Medical Advice on Physical Activity in Past Year	**51.7**		44.0	
% Child [Age 2-17] Physically Active 1+ Hours per Day	**55.5**		48.6	

Respiratory Diseases	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
CLRD (Age-Adjusted Death Rate)	**30.8**	38.1	43.2	
Pneumonia/Influenza (Age-Adjusted Death Rate)	**12.0**	17.9	16.4	
% COPD (Lung Disease)	**3.3**		8.6	
% [Adult] Currently Has Asthma	**7.1**	8.4	9.4	
% [Child 0-17] Currently Has Asthma	**9.7**		7.1	

Sexually Transmitted Diseases	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
Gonorrhea Incidence per 100,000	**18.1**	69.9	101.0	
Primary & Secondary Syphilis Incidence per 100,000	**1.2**	5.8	4.5	
Chlamydia Incidence per 100,000	**349.3**	417.5	429.6	
Hepatitis B Incidence per 100,000	**0.3**	0.4	1.2	
% [Unmarried 18-64] 3+ Sexual Partners in Past Year	**8.9**		11.7	
% [Unmarried 18-64] Using Condoms	**42.4**		33.6	

Substance Abuse	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)	**12.1**	11.3	9.2	8.2
% Current Drinker	**63.3**	57.1	56.5	
% Chronic Drinker (Average 2+ Drinks/Day)	**5.1**	6.2	5.2	
% Binge Drinker (Single Occasion - 5+ Drinks Men, 4+ Women)	**16.3**	18.6	19.5	24.4
% Drinking & Driving in Past Month	**6.5**		5.0	
Drug-Induced Deaths (Age-Adjusted Death Rate)	**13.2**	11.2	12.7	11.3
% Illicit Drug Use in Past Month	**4.6**		4.0	7.1
% Ever Sought Help for Alcohol or Drug Problem	**7.9**		4.9	

Tobacco Use	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
% Current Smoker	**7.8**	13.6	14.9	12.0
% Someone Smokes at Home	**6.2**		12.7	
% [Non-Smokers] Someone Smokes in the Home	**3.8**		6.3	
% [Household With Children] Someone Smokes in the Home	**3.9**		9.7	
% [Smokers] Received Advice to Quit Smoking	**59.4**		67.8	
% [Smokers] Have Quit Smoking 1+ Days in Past Year	**73.6**		55.9	80.0
% Smoke Cigars	**4.2**		4.1	0.2
% Use Smokeless Tobacco	**1.7**		4.0	0.3

Vision	**SBCH/GVCH Service Area**	**CA**	**US**	**HP2020**
% Blindness/Trouble Seeing	**8.9**		8.5	
% Eye Exam in Past 2 Years	**59.7**		56.8	

Prioritized Health Needs

After reviewing the Community Health Needs Assessment findings, leaders from Santa Barbara Cottage Hospital met on February 27, 2014, to determine the health needs to be prioritized for action. During the detailed presentation of the Community Health Needs Assessment findings, consultants from PRC used audience response system technologies to lead steering committee members through a process of understanding key local data findings (areas of opportunity) and ranking identified health issues against the following established, uniform criteria:

- Scope & Severity - the number of persons affected along with the degree to which the issue affects or exacerbates other quality of life and health-related issues. Also, take into account variance from benchmark data and Healthy People targets.
- Ability to Impact - the ability Santa Barbara Cottage Hospital can reasonably affect the issue, given available resources.

From this exercise, the areas of opportunity were prioritized as follows:

1. Heart Disease & Stroke
2. Access to Healthcare Services
3. Mental Health & Mental Disorders
4. Diabetes
5. Nutrition, Physical Activity, & Weight
6. Substance Abuse
7. Infant Health & Family Planning
8. Cancer
9. Immunization & Infectious Diseases
10. Injury
11. Dementias, Alzheimer's Disease
12. Disability & Activity Limitations
13. Oral Health
14. Housing & Homelessness

Community-Wide Community Benefit Planning

As individual organizations begin to parse out the information from the Community Health Needs Assessment, it is Santa Barbara Cottage Hospital's hope and intention that this will foster greater desire to embark on a community-wide community health improvement planning process. Santa Barbara Cottage Hospital has expressed this intention to partnering organizations and is committed to being a productive member in this process as it evolves.

Implementation Strategy

For 125 years, Santa Barbara Cottage Hospital has demonstrated its commitment to meeting the health needs of the community. This summary outlines Santa Barbara Cottage Hospital's plan (Implementation Strategy) to address community health needs by sustaining efforts operating within a targeted health priority area along with promoting an understanding of these health needs among other community organizations and within the public itself.

Hospital-Level Community Benefit Planning

Priority Health Issues To Be Addressed

In consideration of the top health priorities identified through the Community Health Needs Assessment process — and taking into account hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined that Santa Barbara Cottage Hospital would focus on developing and/or supporting strategies and initiatives to improve:

- Access to Healthcare Services
- Cancer
- Dementias, Alzheimer's Disease
- Diabetes
- Disability & Activity Limitations
- Heart Disease & Stroke
- Housing & Homelessness
- Immunization & Infectious Diseases
- Infant Health & Family Planning
- Injury
- Mental Health & Mental Disorders
- Nutrition, Physical Activity & Weight
- Oral Health
- Substance Abuse

Cottage Health provides programs that address all identified priority needs, including funding for community programs, which includes grants, sponsorships, and health fairs. In addition, Santa Barbara Cottage Hospital has programs that address some of the community needs. Therefore, all community health needs will be addressed.

Integration With Operational Planning

Beginning in 2013 and going forward each year, the Board approved Cottage Health Top Goals document will include an annual community benefit goal.

Implementation Strategies & Action Plans

The following displays outline key community benefit initiatives that Santa Barbara Cottage Hospital plans to address the priority health issues chosen for action from 2013 through 2015. System-wide programs are also listed that will help address the community needs.

Key Terms & Definitions

Program Name	
Community Health Need	Areas of opportunity identified in the Community Health Needs Assessment that will be addressed by the program.
Description	Overview of the community benefit program.
Vision	Program's purpose and aspiration.
Long-Term Community Goals	Factors identified in the 2013 Community Health Needs Assessment, which will be measured every three years continually into the future.
Annual Goals	Cottage Health's activity metrics to address the community needs. Benchmarks are based on activity reported in 2012 and 2013 in the Community Benefit Report for OSPHD.
Strategies & Objectives	Program activities to reach the goals and ultimately vision.

Santa Barbara Cottage Hospital Programs

Community Case Management	
Community Health Need	☒ Access to Healthcare Services ☐ Dementias, Alzheimer's Disease ☒ Disability & Activity Limitations ☒ Housing & Homelessness ☐ Infant Health & Family Planning ☒ Mental Health & Mental Disorders ☐ Oral Health ☐ Cancer ☒ Diabetes ☒ Heart Disease & Stroke ☐ Immunization & Infectious Diseases ☐ Injury ☒ Nutrition, Physical Activity & Weight ☒ Substance Abuse
Description	Community Case Management provides services for people with chronic illness who may require additional support to manage their health needs effectively as they transition from the inpatient to the outpatient setting.
Vision	• Improve population health outcomes and reduce the risk of adverse events. • Enhance care coordination across the health delivery system. • Advance connections with appropriate community services and resources to support health and well-being.
Long-Term Community Goals	• Number of people who report using a hospital emergency room more than once in the past year decreases. • Improvement in medication adherence.
Annual Goals	(New program with benchmarks established in 2014.) • Assist with insurance enrollment when appropriate. • Secure linkage to care with primary care providers. • Assess need for support services and initiate referrals to relevant community organizations. • Ensure successful medication management.

Strategies & Objectives	**Strategy #1: Create a care plan addressing clinical and nonclinical needs.** • Work with the patient and caregivers to create individualized goals. • Promote self-management of health care needs. **Strategy #2: Serve as liaison for patient.** • Foster communication between health care team members. • Act as a health care advocate on behalf of the patient. **Strategy #3: Referrals to community resources and services.** • Provide information on services available. • Coordinate follow-up with community organizations. • Develop and strengthen support networks.

Parish Nursing	
Community Health Need	☒ Access to Healthcare Services ☐ Dementias, Alzheimer's Disease ☒ Disability & Activity Limitations ☒ Housing & Homelessness ☐ Infant Health & Family Planning ☒ Mental Health & Mental Disorders ☒ Oral Health ☐ Cancer ☒ Diabetes ☒ Heart Disease & Stroke ☒ Immunization & Infectious Diseases ☐ Injury ☒ Nutrition, Physical Activity & Weight ☒ Substance Abuse
Description	Parish Nursing's mission is to aid people by expanding their knowledge about whole person wellness, assisting in identifying methods of disease prevention, and increasing access to health and community resources.
Vision	• Age-adjusted death rates due to influenza decrease. • Age-adjusted death rates due to diabetes decrease. • Number of people who report they experienced difficulties or delays in receiving needed healthcare decreases.
Long-Term Community Goals	• Number of people who report having their blood pressure checked in the past two years increases. • Number of people who report having their blood sugar tested in the past three years increases.
Annual Goals	• Serve more than 10,000 community members. • Provide more than 50 hours of service per week in congregations. • Provide more than 30 hours of service per week to the homeless population. • Provide more than five hours of service per week to organizations that prevent homelessness and advance self-sufficiency. • Provide more than 70 hours of service per week to people with disabilities. • Provide more than four hours of service per week in low-income residential facilities.
Strategies & Objectives	**Strategy #1: Provide health assessments and screenings.** • Provide flu vaccinations, medication management, blood pressure checks, glucose and cholesterol checks, and diabetes management support. • Provide education and referrals. **Strategy #2: Partner with organizations and committees.** • Work with organizations that provide end of life planning and care, homeless and transitional housing, low-income housing, mental wellness, substance abuse and recovery, and basic needs, such as food. • Work with committees that convene regarding the homeless population, dental care, and other general health care.

	Strategy #3: Participate in community health events. • Participate in events helping the underserved. • Provide assistance with advance directives, first aid, flu vaccinations, and blood pressures.

Coast Caregiver Resource Center	
Community Health Need	☐ Access to Healthcare Services ☐ Cancer ☒ Dementias, Alzheimer's Disease ☐ Diabetes ☐ Disability & Activity Limitations ☒ Heart Disease & Stroke ☐ Housing & Homelessness ☐ Immunization & Infectious Diseases ☐ Infant Health & Family Planning ☐ Injury ☒ Mental Health & Mental Disorders ☐ Nutrition, Physical Activity & Weight ☐ Oral Health ☐ Substance Abuse
Description	Coast Caregiver Resource Center (CCRC) supports family and other informal (unpaid) caregivers of adults with cognitive disorders and other disabling conditions in Santa Barbara, San Luis Obispo and Ventura counties. Provides respite and counseling to caregivers of older adults in Santa Barbara and San Luis Obispo counties.
Vision	• Health and well-being of unpaid caregivers increases with support from CCRC.
Long-Term Community Goal	• Provide services to increasing number of unpaid caregivers.
Annual Goals	• Provide referrals to more than 500 callers. • Provide more than 100 assessments of caregiver strength and need for supportive services. • Provide more than 600 hours of family consultation, problem solving, coaching, and care planning. • Provide more than 3,000 hours of respite (substitute care) to 90 caregivers. • Provide support groups to more than 1,000 caregivers. • Provide co-sponsored education and training to more than 300 caregivers.
Strategies & Objectives	**Strategy #1: Assess caregiver need and eligibility for resources.** • Provide educational information and referrals to callers. • Provide intake and assessment of new clients eligible for CCRC services. **Strategy #2: Provide support services to caregivers.** • Provide family consultation (coaching, care planning, problem solving). • Provide respite care to family caregivers (Santa Barbara and San Luis Obispo counties only). • Co-sponsor events to inform and educate family caregivers. • Attend other organizations' events to inform about available CCRC services. **Strategy #3: Provide caregiver support groups.** • Organize support groups for caregivers in the tri-county area.

Therapeutic Recreation Community Program	
Community Health Need	☒ Access to Healthcare Services ☐ Dementias, Alzheimer's Disease ☒ Disability & Activity Limitations ☐ Housing & Homelessness ☐ Infant Health & Family Planning ☐ Mental Health & Mental Disorders ☐ Oral Health ☐ Cancer ☐ Diabetes ☒ Heart Disease & Stroke ☐ Immunization & Infectious Diseases ☒ Injury ☒ Nutrition, Physical Activity & Weight ☐ Substance Abuse
Description	Part of Cottage Rehabilitation Hospital, the Therapeutic Recreation Community Program addresses health, sport, recreation and support for people with disabilities. Clients are helped to adapt or modify previous leisure activities and find new ones to enjoy.
Vision	• Number of people who report they are limited in activities in some way due to a physical, mental, or emotional problem decreases.
Long-Term Community Goals	• Increase confidence of participants. • Increase socialization of participants.
Annual Goals	• More than 10 individuals participate in adapted golf. • More than 15 individuals participate in adapted cycling. • More than 12 pre-driving evaluations and more than 30 behind the wheel evaluations. • More than 10 individuals participate in youth adapted swim (lessons and open swim). • More than 45 individuals participate in the Junior Wheelchair Sports Camp.
Strategies & Objectives	**Strategy #1: Monthly adapted golf program.** • Partner with venue that has appropriate facilities. • Provide adaptive equipment as needed. **Strategy #2: Monthly adapted cycling program.** • Partner with venue that has appropriate facilities. • Provide adaptive equipment as needed. **Strategy #3: Adapted driving program as requested.** • Partner with venue to provide program. • Provide adaptive equipment as needed. **Strategy #4: Weekly youth adapted swim program.** • Provide adaptive equipment as needed. **Strategy #5: Annual Junior Wheelchair Sports Camp.** • Partner with venue that has appropriate facilities. • Provide adaptive equipment as needed. • Recruit camp counselors.

Injury Prevention	
Community Health Need	☐ Access to Healthcare Services ☐ Dementias, Alzheimer's Disease ☒ Disability & Activity Limitations ☐ Housing & Homelessness ☐ Infant Health & Family Planning ☐ Mental Health & Mental Disorders ☐ Oral Health ☐ Cancer ☐ Diabetes ☐ Heart Disease & Stroke ☐ Immunization & Infectious Diseases ☒ Injury ☐ Nutrition, Physical Activity & Weight ☐ Substance Abuse

Description	Injury prevention services focus on identifying the primary causes of injury both on an individual and community levels, with a programmatic approach to minimizing further risk.
Vision	• Age-adjusted death rates from unintentional injuries decrease. • Age-adjusted death rates from accidental falls decrease.
Long-Term Community Goal	• Child always wears a helmet when riding a bicycle increases.
Annual Goals	• Provide more than 50 no-cost or low-cost helmets. • Provide car seat installation instruction to more than 50 families. • Provide Fall Stop assessment to more than 100 older adults.
Strategies & Objectives	**Strategy #1: Provide no-cost or low-cost safety helmets.** • Research affordable helmet purchasing options. • Provide through emergency departments. • Provide helmets at local health events. • Provide helmet safety education. • Provide helmet fit education. **Strategy #2: Monthly car seat safety class.** • Use NHTSA certified car seat technician. • Technician is knowledgeable of current legislation. • Have parent(s) install car seat at the end of the class. **Strategy #3: Fall Stop assessment program.** • Provide program at events and venues frequented by older adults. • Partner with community organizations to provide program.

Cottage Health Programs

Cancer Screenings		
Community Health Need	☒ Access to Healthcare Services ☐ Dementias, Alzheimer's Disease ☐ Disability & Activity Limitations ☐ Housing & Homelessness ☐ Infant Health & Family Planning ☐ Mental Health & Mental Disorders ☐ Oral Health	☒ Cancer ☐ Diabetes ☐ Heart Disease & Stroke ☐ Immunization & Infectious Diseases ☐ Injury ☒ Nutrition, Physical Activity & Weight ☐ Substance Abuse
Description	Provide site-specific cancer screenings by trained health professionals.	
Vision	• Age-adjusted death rates from cancer decrease. • Prevalence of skin cancer decreases.	
Long-Term Community Goals	• Number of adults age 50-75, have had an appropriate colorectal cancer screening (fecal occult blood testing within the past year and/or sigmoidoscopy/ colonoscopy [lower endoscopy] within the past 10 years) increases. • Number of adults who self-report being diagnosed with skin cancer decreases.	
Annual Goals	• More than 80% of those who received a take-home colon cancer kit will be in 50-75 year old age range. • More than 80% of those who receive a skin cancer screening will be 20 years of age or older. • Awareness of correlation between cancer and nutrition, physical activity, and weight increases.	

Strategies & Objectives	**Strategy #1: Provide free colon cancer screenings at multiple venues throughout the year.** • Provide take-home kits in locations easily accessible for older adults. • Educate attendees on the types of colon screenings available. • Connect those who have a positive take-home kit result with a local clinic for a colonoscopy. **Strategy #2: Provide free skin cancer screenings annually.** • Provide screenings in locations easily accessible for the underserved populations. **Strategy #3: Provide cancer prevention education.** • Utilize promotoras who are bilingual and bicultural. • Educate on the connection between cancer and nutrition, physical activity, and weight.

Heart Health Fair	
Community Health Need	☒ Access to Healthcare Services ☐ Dementias, Alzheimer's Disease ☐ Disability & Activity Limitations ☐ Housing & Homelessness ☐ Infant Health & Family Planning ☐ Mental Health & Mental Disorders ☐ Oral Health ☐ Cancer ☒ Diabetes ☒ Heart Disease & Stroke ☐ Immunization & Infectious Diseases ☐ Injury ☒ Nutrition, Physical Activity & Weight ☐ Substance Abuse
Description	The annual Heart Health Fair provides low-cost lab work, along with free information, consultations, and services related to maintaining cardiac health and preventing stroke, and diabetes.
Vision	• Age-adjusted death rates from heart disease decrease. • Age-adjusted death rates from stroke decrease. • Age-adjusted death rates from diabetes decrease.
Long-Term Community Goals	• Number of people who report having their blood pressure checked in the past two years increases. • Number of people who report having pre-diabetes or borderline diabetes decreases. • Number of people who report having their blood sugar tested in the past three years increases. • Number of people who report having one or more cardiovascular risks or behaviors decreases.
Annual Goals	• More than 80% of attendees have blood drawn for lab work. • More than 50% of attendees have their body mass index calculated. • More than 50% of attendees are uninsured or underinsured.
Strategies & Objectives	**Strategy #1: Provide low-cost cardiac risk profile and blood chemistry panel.** • Include both glucose and A1C results. • Provide event(s) in locations easily accessible for the underserved populations. **Strategy #2: Provide education on nutrition, physical activity, and weight.** • Engage Cottage Health dietary and therapy services departments. • Utilize community organizations' expertise. • Provide height and weight screenings by promotoras who are bilingual and bicultural. **Strategy #3: Provide medical home information.** • Provide free booth space to local medical clinics that support the underserved.

	• Include FQHC locations in the community with the lab test results that are mailed to attendees.

Mental Health Fair	
Community Health Need	☒ Access to Healthcare Services ☐ Dementias, Alzheimer's Disease ☐ Disability & Activity Limitations ☐ Housing & Homelessness ☐ Infant Health & Family Planning ☒ Mental Health & Mental Disorders ☐ Oral Health ☐ Cancer ☐ Diabetes ☐ Heart Disease & Stroke ☐ Immunization & Infectious Diseases ☐ Injury ☐ Nutrition, Physical Activity & Weight ☒ Substance Abuse
Description	The annual Mental Health Fair provides resources on mental wellness and includes a speaker series featuring local psychologists and psychiatrists.
Vision	• Age-adjusted death rates from suicide decrease. • Age-adjusted death rates from cirrhosis/liver disease decrease. • Age-adjusted death rates from drug-induced deaths decrease.
Long-Term Community Goals	• Self-reported mental health status of good, very good, or excellent increases. • Self-reported perceived level of stress on a typical day of not very stressful or not at all stressful increases.
Annual Goals	• Annual attendance will be at least 200 community members. • There will be more than 25 community organizations represented. • Increase awareness of mental health and substance abuse issues. • Increase awareness of mental health resources available.
Strategies & Objectives	**Strategy #1: Provide information on resources available.** • Have community organizations to participate in the event. • Encourage networking of organizations' staff. **Strategy #2: Provide education regarding mental wellness.** • Psychiatric Services brings information and knowledgeable staff to the event. • Community organizations bring information and knowledgeable staff to the event. • Speakers provide education on various mental health topics.

Flu Shot Clinics	
Community Health Need	☒ Access to Healthcare Services ☐ Dementias, Alzheimer's Disease ☐ Disability & Activity Limitations ☐ Housing & Homelessness ☐ Infant Health & Family Planning ☐ Mental Health & Mental Disorders ☐ Oral Health ☐ Cancer ☐ Diabetes ☐ Heart Disease & Stroke ☒ Immunization & Infectious Diseases ☐ Injury ☐ Nutrition, Physical Activity & Weight ☐ Substance Abuse
Description	Provide low-cost influenza vaccinations to the community during the fall months.
Vision	• Age-adjusted death rates from due to influenza decrease.
Long-Term Community Goals	• Number of adults age 65 and older who report having a flu vaccination in the past year increases. • Number of high-risk adults 18 to 64 who report having a flu vaccination in the past year increases.
Annual Goals	• More than 50% of vaccinations will be given to adults 65 years and older.

	• More than 33% of vaccinations will be given to high-risk adults 18 to 64 years old.
Strategies & Objectives	**Strategy #1: Hold clinics at easily accessible locations.** • Provide vaccinations at venues frequented by community members such as festivals and farmers markets. **Strategy #2: Participate in the Santa Barbara Senior Expo.** • Partner with the Senior Expo to bring influenza vaccine to the Expo on alternating years as Sansum Clinic. **Strategy #3: Provide education regarding vaccinations.** • Provide resources on influenza and other vaccinations, such as pneumococcal and shingles. • Provide education on how to prevent the flu.

Community Programs Support	
Community Health Need	☒Access to Healthcare Services ☒Cancer ☒Dementias, Alzheimer's Disease ☒Diabetes ☒Disability & Activity Limitations ☒Heart Disease & Stroke ☒Housing & Homelessness ☒Immunization & Infectious Diseases ☒Infant Health & Family Planning ☒Injury ☒Mental Health & Mental Disorders ☒Nutrition, Physical Activity & Weight ☒Oral Health ☒Substance Abuse
Description	Provide support to community organizations that make an impact on the community health needs identified in the assessment.
Vision	• Santa Barbara County age-adjusted death rates are below the rates for California. • Santa Barbara County age-adjusted death rates are below the rates for the United States. • Santa Barbara County age-adjusted death rates are below the Healthy People 2020 objectives.
Long-Term Community Goals	• Underlying risk factors (actual causes of death) decrease. o Alcohol use o Tobacco use o Improper diet o Obesity o Sedentary lifestyle o Occupational/environmental exposures o Reckless driving o Safety belt noncompliance o Stress/fatigue o Diabetes o Elevated serum cholesterol o High blood pressure
Annual Goal	• Partner with organizations that are working to improve the health needs of the community.
Strategies & Objectives	**Strategy #1: Community grants** • Provide grants to organizations that impact community health needs. • Focus on programs that increase access to healthcare services. **Strategy #2: Community sponsorships** • Sponsor community events for organizations that impact community health needs.

	Strategy #3: Community health fairs and education • Provide funding to events that provide health screenings and education. • Participate in events that provide health screenings and education.