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

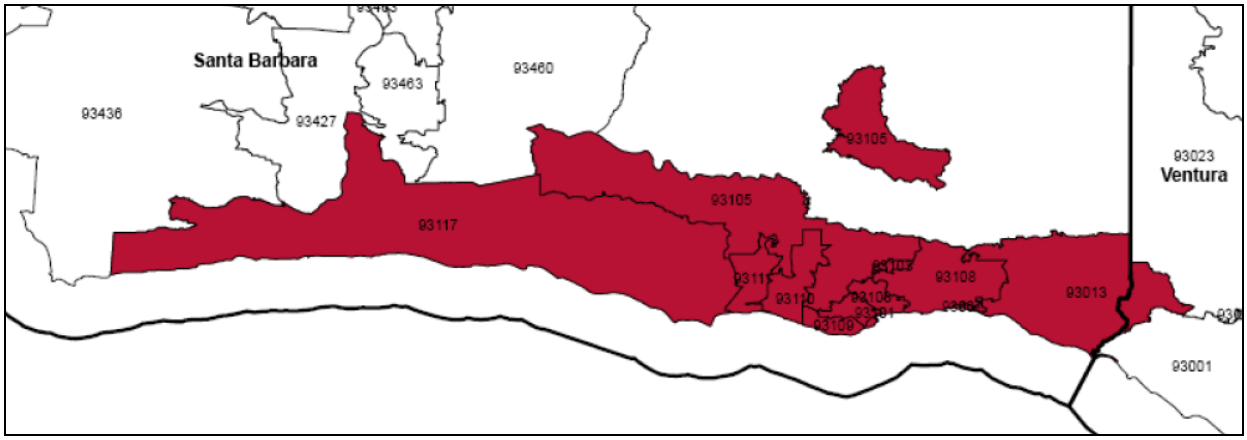
Goleta Valley Cottage Hospital

Part of Cottage Health , Goleta Valley Cottage Hospital is an 122-bed acute care hospital that was founded in 1966 to serve the growing community. Today, Goleta Valley Cottage Hospital admits more than 1,500 patients a year and sees more than 18,000 emergency visits. The hospital is also recognized for the award-winning Center for Wound Management and comprehensive Breast Care Center, which offers digital mammography and bone density scanning. The staff takes great pride in fulfilling its goal of providing each patient with comfortable, personalized care.

Community Served

Community Definition

Goleta Valley Cottage Hospital's community, as defined for the purposes of the Community Health Needs Assessment in conjunction with Santa Barbara 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

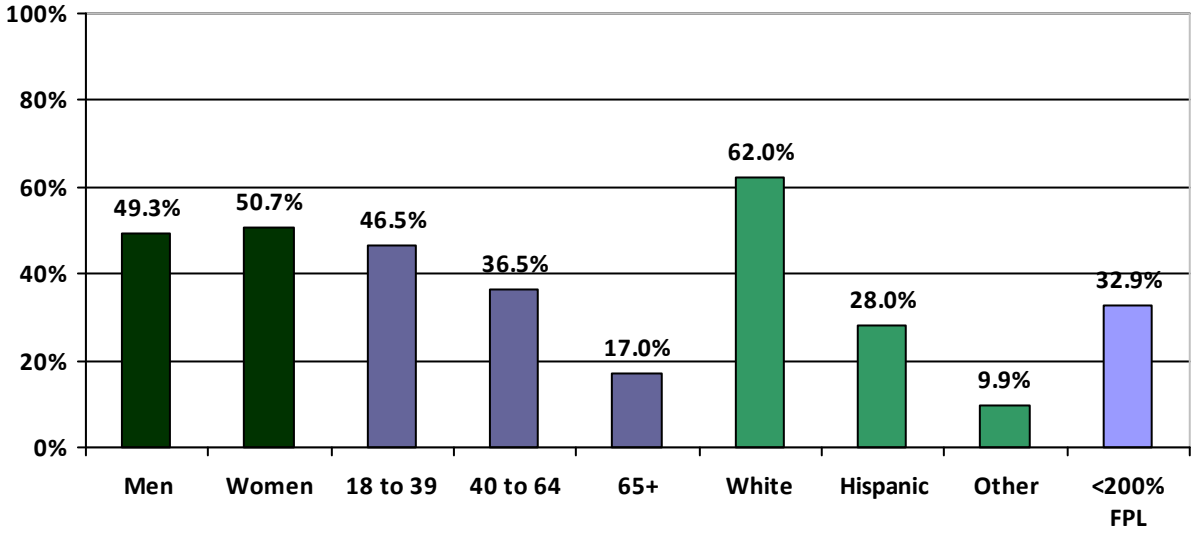
With a population of 435,697, Santa Barbara County encompasses 2,750 square miles of land and inland water area. Much of the county is mountainous. The Santa Ynez, San Rafael and Sierra Madre mountains extend in a predominately east-west direction. Within the county, there are numerous fertile agricultural 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 Goleta Valley Cottage Hospital and Santa Barbara 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 Goleta Valley Cottage Hospital and Santa Barbara 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 Goleta Valley Cottage Hospital, Santa Barbara 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 Goleta Valley Cottage Hospital and Santa Barbara 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 Goleta Valley Cottage Hospital and Santa Barbara 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.

Goleta Valley 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. Goleta Valley 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 Goleta Valley Cottage Hospital and Santa Barbara 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	GVCH/SBCH 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	GVCH/SBCH 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	**GVCH/SBCH 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	**GVCH/SBCH 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	**GVCH/SBCH Service Area**	**CA**	**US**	**HP2020**
Kidney Disease (Age-Adjusted Death Rate)	**4.0**	8.6	15.2	
% Kidney Disease	**1.6**		3.0	

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

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

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

Heart Disease & Stroke	GVCH/SBCH 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	GVCH/SBCH 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	GVCH/SBCH 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	GVCH/SBCH 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	GVCH/SBCH 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	GVCH/SBCH 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	GVCH/SBCH 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	GVCH/SBCH 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	GVCH/SBCH 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	**GVCH/SBCH 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	**GVCH/SBCH 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	**GVCH/SBCH 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	**GVCH/SBCH 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	**GVCH/SBCH 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 Goleta Valley Cottage Hospital met on February 26, 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 Goleta Valley Cottage Hospital can reasonably affect the issue, given available resources.

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

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

Community-Wide Community Benefit Planning

As individual organizations begin to parse out the information from the Community Health Needs Assessment, it is Goleta Valley Cottage Hospital's hope and intention that this will foster greater desire to embark on a community-wide community health improvement planning process. Goleta Valley 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 more than 25 years, Goleta Valley Cottage Hospital has demonstrated its commitment to meeting the health needs of the community. This summary outlines Goleta Valley 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 Goleta Valley 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, Goleta Valley 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 Goleta Valley 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.

Goleta Valley Cottage Hospital Programs

Living Well with Diabetes	
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	Nutrition classes offered twice each month to discuss topics related to living with diabetes.
Vision	• Age- adjusted death rates from diabetes decrease.
Long-Term Community Goal	• Number of people who report having their blood sugar tested in the past three years increases.
Annual Goals	• More than five attendees per month. • Awareness of correlation between diabetes and nutrition, physical activity, and weight increases.
Strategies & Objectives	**Strategy #1: Provide diabetes education on topics related to nutrition, physical activity, and weight.** • Include classes on nutrition and exercise. **Strategy #2: Provide education on other topics related to diabetes.** • Include classes on stress, travel, and complications due to diabetes.

Ostomy & Diabetic Wound Care Education	
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	Provides preoperative and postoperative ostomy services. Specially trained and certified wound, ostomy and continence nurses, provide education on daily maintenance of temporary and permanent stomas, ensuring both patients and their families are comfortable and secure with every aspect of ostomy care. In addition, they assist people in dealing with the emotional issues surrounding life with an ostomy.
Vision	• Decrease number of limb amputations in diabetics due to wounds.
Long-Term Community Goals	• Enable people with stomas to live healthy active lives. • Increase awareness of ostomy options. • Increase awareness of diabetic wound prevention. • Increase awareness of diabetic wound treatment.
Annual Goals	• Educate more than 20 people with the ostomy outreach program. • Increase awareness of wound care for diabetics.
Strategies & Objectives	**Strategy #1: Provide ostomy outreach.** • Attend community events to provide education. • Provide ostomy education classes on site. **Strategy #2: Provide diabetic wound care education.** • Provide education on the potential outcomes of wounds in people who have diabetes. • Attend community events that reach the underserved. • Create educational materials regarding diabetic wound care.

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 ☐ 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	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 ☒ 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 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 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.