Community Benefit Implementation Strategy

for Goleta Valley Cottage Hospital,
Santa Barbara Cottage Hospital
and Santa Ynez Valley Cottage Hospital

Cottage
Population Health

COTTAGE HEALTH COMMUNITY BENEFIT

Cottage Health (CH) is committed to improving the well-being of Santa Barbara County residents. Good health starts long before someone arrives at a doctor's office or hospital. To better understand the needs and strengths of the entire community, and the many diverse groups within it, Goleta Valley Cottage Hospital (GVCH), Santa Barbara Cottage Hospital (SBCH), and Santa Ynez Valley Cottage Hospital (SYVCH) jointly conducted the Community Health Needs Assessment (CHNA) in partnership with community organizations and agencies from Santa Barbara County. The results of this assessment form a detailed description of residents' health in the County of Santa Barbara that can be used to identify community health needs and prioritize evidence-based, effective strategies to address them.

The 2019 – 2022 Community Benefit Implementation Strategy describes how Cottage Health, representing GVCH, SBCH, and SYVCH, will meet the prioritized community health needs identified in the 2019 CHNA. This report describes Cottage Health's intended actions and strategies, anticipated impact, resources committed, and planned collaborations for addressing these prioritized health needs.

This report complies with federal tax law (Internal Revenue Code section 501[r]) that requires 501(c)(3) hospital facilities to adopt an implementation strategy to meet the community health needs identified through the community health needs assessment.

2019 COMMUNITY HEALTH NEEDS ASSESSMENT

Cottage Health conducted a Community Health Needs Assessment in 2019 to analyze and describe Santa Barbara County's most pressing health needs. The 2019 CHNA describes the well-being of Santa Barbara County's residents and selected social determinants of their health, with comparisons to California's health profile as a whole. It also connects selected health indicators for Santa Barbara County to the goals or targets in *Healthy People 2020 (HP 2020)*, the national planning document created every 10 years by the U.S. Department of Health and Human Services.

The complete 2019 CHNA can be found at https://www.cottagehealth.org/population-health/community-health-needs-assessment/.

Data Collection 2019

To obtain data for this report, Cottage Health conducted a telephone and web survey with approximately 900 community members and a Listening Tour with more than 240 individuals who represent the broad interests of the community, including medically underserved, low-income, and vulnerable populations. Secondary data were also obtained from existing online sources. This approach is consistent with the methodology established in the 2016 Cottage Health CHNA, which also serves as benchmark for the 2019 data.

Health Data

Cottage Health contracted with the Evaluation Institute at the University of Pittsburgh, an academic research unit with extensive experience in survey methodology, analysis, and reporting. The Evaluation Institute used two data sources for the CHNA: a telephone and web survey designed specifically for this effort and existing health and demographic data (such as U.S. Census data) already collected for the county and California. The telephone and web survey, conducted from July through October 2019, obtained data from Santa Barbara County adults ages 18 and older. A group of trained interviewers contacted randomly selected residents and asked a series of questions based on the Behavioral Risk Factor Surveillance System (BRFSS) survey

instrument, created by the Centers for Disease Control and Prevention (CDC). Respondents could complete the survey on the telephone or online. The data were weighted to make sure that survey results were representative of county demographics, such as age, race/ethnicity, and gender, and then compared to the 2016 Santa Barbara County BRFSS, California BRFSS, and Healthy People 2020 Leading Health Indicators.

Community Perspectives: Behavioral Health Listening Tour

The Behavioral Health Listening Tour solicited input from a wide array of community members and leaders, including public health officials, health providers, nonprofit workers, Cottage Health employees, and government leaders. These participants identified significant behavioral health needs in the community. In total, more than 240 individuals participated in the Listening Tour through twenty focus groups conducted from August through September 2019.

Results

Based on results from the 2019 CHNA telephone and web survey, secondary data analysis, Listening Tour and 2016 Cottage Health CHNA, nineteen health indicators were identified for in-depth analysis and prioritization. These indicators were selected using the Leading Health Indicators from Healthy People 2020 and CDC's Community Health Status Indicators (CHSI) as sources.

These data were further analyzed based on demographic differences. Many differences were found within demographic groups, such as economic status, race/ethnicity, and educational attainment. When viewing population-level data, demographic differences provide a deeper understanding of the health outcomes of various groups.

PRIORITY AREA IDENTIFICATION

The results show that on many health indicators, Santa Barbara County is slightly lower than California and has already met four Healthy People 2020 targets. The benefits of good health and well-being do not extend to all groups in the county, with Hispanic/Latinx residents, people with low incomes, and those with less education suffering the most from health disparities.

Cottage Health conducted an external prioritization survey and an internal prioritization process using a scoresheet that ranked priorities based on community resources available, state and national benchmarks, the extent to which certain populations are disproportionately affected, and community input. Overall, five areas emerged as priority health areas in Santa Barbara County (alpha order):

- Access to Care
- Behavioral Health
- Chronic Conditions
- Resiliency
- Social Needs

Cottage Health is committed to taking action based on the findings in the 2019 Community Health Needs Assessment. Efforts to address these areas could lead to significant population health improvements in the county. In implementing evidence-based population health programs and policies, we will also promote health equity through focused strategies among communities and in neighborhoods that are experiencing poorer health outcomes.

In addition, Cottage Health has identified injury and violence as a priority health area, based on CH Emergency Departments' (ED) trauma registry reporting. The registry indicates that falls, motor vehicle collisions, and bicycle and pedestrian injuries are the top three causes of trauma ED visits across all three hospitals. Interventions that address these activities have the potential to prevent unintentional injuries and violence.

Population Health Approach

Cottage Health's hospitals have sought to improve the health outcomes of patients and community members in Santa Barbara County for more than 125 years. Community outreach programs and strategies have been ongoing in the six priority health areas for many years. With a focus on population health, Cottage Health continues to serve the community through these long-standing community benefit strategies, while seeking opportunities to align these efforts with broader initiatives and priority areas. In addition, key programs and strategies will address these priority areas through a population health approach.

Cottage Health will promote significant population health improvements among patient, community, and insured populations, focusing on vulnerable demographics (e.g., individuals experiencing homelessness, low-income, no high school degree, Medi-Cal, and children) and using evidence-based programs and policies. Key programs addressing health needs of priority populations will focus on these often-overlapping populations through the intervention approach as outlined in Figure 1.

Taking this Population Health approach, we ask the following questions and take the following steps:

1. What's the problem, and who has it? These questions help identify the populations that are experiencing health needs, particularly populations experiencing health disparities. While there are many health issues affecting communities at large, it is important to understand which populations are affected the most by these needs.

2. Why them? Further delving into the population in need, we seek to understand why this population in particular is experiencing this health need.

3. What is the plan for action? Working with the identified population, this population health approach helps determine the best plan of action in the form of programs, strategies, research and/or partnerships to address health needs.

To support this approach both within Cottage Health and across the many organizations and agencies working in the community, Population Health offers online data mapping and evaluation tools, hosts workshops and community convening events, and provides technical assistance. These resources and this expertise sharing aim to build community capacity and promote an evidence-based, data-driven approach to addressing the health needs across the population.

Developed through internal and external stakeholder conversations, the *Population Health Planning Tool – A Roadmap Identifying Resources, Activities and Outcomes* (Figure 2) outlines the anticipated impact and critical elements of all programs and strategies taken in a population health approach.

Figure 1. 2019-2022 Population Health Approach

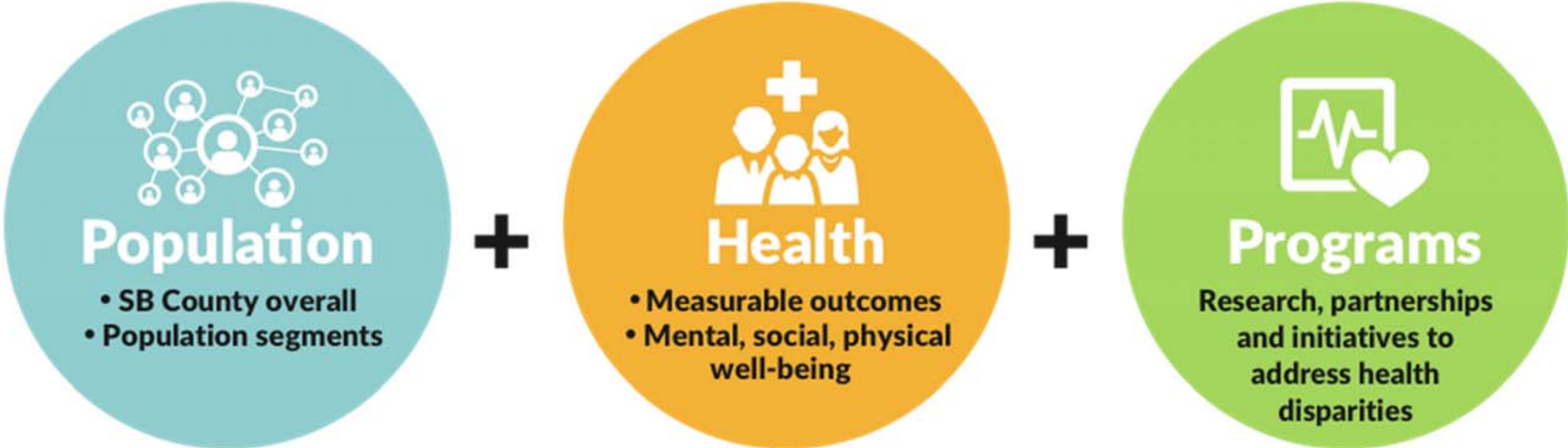


Figure 2. Population Health Planning Tool – A Roadmap Identifying Resources, Activities and Outcome

Population Health Planning Tool

A visual tool to show the relationship between resources, activities, and results you want to achieve.

ELEMENTS	PROCESS		GOALS		
RESOURCES & DRIVERS	**STRATEGIES & TACTICS**	**PARTICIPANTS**	**SHORT-TERM**	**INTERMEDIATE**	**LONG-TERM**
• Facilities • Staffing • Funding • Partnerships • Buy-in • Assessments • Evidence-based models • Data analytics • Planning capabilities • Evaluation capabilities • Urgency • Health equity approach/social determinants of health • Research & existing policy analysis	**Collect & analyze data** • Listening Tour • BRFSS • Utilization data • Outreach inventory • CHNA **Build capacity** • Learning Lab • Cottage Data2Go • Capacity-building grants & activities • Policy & systems change efforts **Partner for Evidence-Based Population Health Activities:** • Initiatives (e.g., Behavioral Health Collaborative, Behavioral Health Initiative grants, Pediatric Resiliency Collaborative) • Programs (e.g., Recuperative Care Program at PATH, social needs screening, SB Connect Home) • Community partners • Cottage Health departments	• Community members (individuals experiencing homelessness, Medi-Cal, children, no HS diploma, limited English proficiency, limited income) • Physicians • Other funders • Volunteers • Policymakers • Businesses • Media	**Individuals** • Increased participation in health-improving programs • Increased knowledge, awareness and attitudes re: health behaviors and health care access **Policy, Systems & Environmental Changes** • Increased CH and nonprofit partner capacity to implement Population Health strategies • Increased collaboration to address the determinants of health • Improved care coordination and quality of care	**Improved determinants of health:** • Health behaviors (diet, exercise, substance use) • Social/economic (education, income, housing, safety) • Physical environment (transportation, food access, parks) • Clinical care (access to high-quality coordinated care and preventive services) **Improvements in CH Priority Areas:** • Improved access to primary care services • Early detection of behavioral health issues (awareness, education) • Stop increase in rate of chronic conditions	**Improved health outcomes for vulnerable populations:** • Life expectancy • Morbidity • Health status and health-related quality of life

Priority Health Area: Access to Care

Cottage Health will improve access to comprehensive, quality care for vulnerable populations. Strategies will focus on patients, community, and insured populations.

Strategies and Programs

The Cottage Recuperative Care Program at PATH and Santa Barbara Connect Home are two key programs for addressing access to care. Additional access to care strategies or programs are shown in Figure 3.

Cottage Recuperative Care Program at PATH

In partnership with PATH (People Assisting the Homeless) Santa Barbara, Santa Barbara County Public Health Department, CenCal Health, UniHealth Foundation, and other funders, Cottage Health provides recuperative care for patients who are experiencing homelessness, have an acute medical need, and are interested in permanent housing solutions. Patients receive 90 days of support from Cottage Health nurses and a social needs navigator and PATH respite care monitors, who provide around-the-clock support. Future areas for expansion will include increased access to behavioral health services, job skill training and employment opportunities, and permanent supportive housing.

Santa Barbara Connect Home

Santa Barbara Connect Home is supported by the California Homeless Emergency Aid Program (HEAP) and is a partnership of the City of Santa Barbara, City Net, Cottage Health, and Santa Barbara Restorative Police. The program focuses on the needs of the most vulnerable individuals experiencing homelessness and the highest utilizers of crisis services, such as police, fire, AMR and the emergency department. Clients are linked to coordinated case management and a mobile navigation center to ensure connection to housing, medical and support services. A team of outreach workers, including navigators, a registered nurse, and Restorative Police Officers, builds trust with these vulnerable clients to help them find the help they need.

Figure 3. Strategies/Programs to Address Access to Care

ACCESS TO CARE	STRATEGIES/PROGRAMS	HOSPITAL(S)
	Cottage Recuperative & Transitional Care Programs at PATH	GVCH / SBCH / SYVCH
	Santa Barbara Connect Home	SBCH
	Cancer Screenings & Prevention Events	GVCH / SBCH / SYVCH
	Charity Care	GVCH / SBCH / SYVCH
	Childbirth & P arenting Education Classes & Programs	SBCH
	Community Capacity Building: Evaluation Toolkit, CH Data2Go	GVCH / SBCH / SYVCH
	Community Programs Support (e.g., sponsorships)	GVCH / SBCH / SYVCH
	Concussion Clinic & Discussions	SBCH
	CPR Classes	GVCH / SBCH / SYVCH
	Flu Shot Clinics	GVCH / SBCH / SYVCH
	Grants Programs	GVCH / SBCH / SYVCH
	Insurance Enrollment	GVCH / SBCH / SYVCH
	Medical Education	GVCH / SBCH / SYVCH
	Medicare and MediCal Shortfalls	GVCH / SBCH / SYVCH
	Mental Health Fair	SBCH
	Parish Nursing	SBCH
	SAGE Medical Library	SBCH
	Santa Barbara Neighborhood Clinic partnership	GVCH / SBCH / SYVCH
	Santa Ynez Valley Annual Health Fair	SYVCH

Priority Health Area: Behavioral Health

Cottage Health will improve access to care and health outcomes for vulnerable populations with behavioral health needs through focused population level strategies and programs.

Strategies and Programs

The Behavioral Health Initiative, Behavioral Health Collaborative, and Bridge Clinic are key programs for improving behavioral health outcomes in Santa Barbara County. Additional behavioral health strategies or programs are shown in Figure 4.

Behavioral Health Initiative

Cottage Health's Community Partnership Grants program supports the Behavioral Health Initiative, which focuses on behavioral health programs providing direct services and taking a policy, systems, or environmental approach. Behavioral health was selected as the focus area to increase access to behavioral health services and improve mental health status among residents within Santa Barbara County. Taking an initiative-level approach, the grants program provides grantees with technical assistance, workshops, and shared learning opportunities and evaluates impact across the multiple partners. In future years, the Behavioral Health Initiative's specific focus areas will draw on the findings of the 2019 CHNA and learnings from the initiative-level evaluation.

Behavioral Health Collaborative

The Behavioral Health Collaborative is a collective impact effort that emerged from a convening of leading health organizations in Santa Barbara County. Serving as the backbone organization, Cottage Health coordinates the collective impact effort, convening community partners to plan and implement strategies to address policies, systems, and environmental barriers to behavioral health services in Santa Barbara County. The Collaborative seeks to improve health outcomes of patients struggling with mental illness and/or substance use disorders.

Santa Barbara Neighborhood Clinics Bridge Clinic

Supporting individuals battling drug addiction, Santa Barbara Neighborhood Clinics and Cottage Health operate the Bridge Clinic near Santa Barbara Cottage Hospital to provide treatment and other services. The Bridge Clinic offers walk-in and appointment services, including counseling, medication-assisted treatment, psychiatric evaluation and treatment, non-opioid pain management, and psychosocial resources. Patients enter the program voluntarily through screening and brief intervention at Santa Barbara Cottage Hospital or Santa Barbara Neighborhood Clinics. A key element of the Bridge Clinic is also helping patients with insurance enrollment, benefits, housing and community treatment referrals.

Figure 4. Strategies/Programs to Address Behavioral Health

	STRATEGIES/PROGRAMS	HOSPITAL(S)
BEHAVIORAL HEALTH	Behavioral Health Collaborative	GVCH / SBCH / SYVCH
	Behavioral Health Initiative	GVCH / SBCH / SYVCH
	Santa Barbara Neighborhood Clinics Bridge Clinic	SBCH
	Coast Caregiver Resource Center	SBCH
	Community Capacity Building: Evaluation Toolkit, CH Data2Go	GVCH / SBCH / SYVCH
	Cottage Outpatient Center of San Luis Obispo	SBCH
	Cottage Residential Center	SBCH
	Emergency Department Holding Unit (EDHU)	SBCH
	Employee Assistance Program	GVCH / SBCH / SYVCH
	Inpatient Psychiatry & Addiction Medicine Services	SBCH
	Mental Health Intensive Outpatient Program	SBCH
	Parish Nursing	SBCH
	Prescribing Safe	GVCH / SBCH / SYVCH
	Support Groups	SBCH

Priority Health Area: Chronic Conditions

Cottage Health will improve health outcomes for vulnerable populations with chronic conditions by building on existing programs and strategies.

Strategies and Programs

A new place-based initiative will be a focus for this priority health area. Figure 5 outlines the range of programs and strategies for addressing chronic conditions.

Place-based Initiative

Cottage Health will partner with community organizations, agencies, and funders to develop a place-based model to improve the health and well-being of a defined Santa Barbara community. This initiative will draw on established evidence-based models and existing and new data on community needs. Through engaging community leader and member consultants to leverage expertise, the place-based initiative will connect existing resources and build-on momentum voiced from those who will receive services.

Figure 5. Strategies/Programs to Address Chronic Conditions

	STRATEGIES/PROGRAMS	HOSPITAL(S)
CHRONIC CONDITIONS	Place-based Initiative	GVCH / SBCH / SYVCH
	Aphasia Recovery Group	SBCH
	Cardiac Rehab Event	SYVCH
	Community Capacity Building: Evaluation Toolkit, CH Data2Go	GVCH / SBCH / SYVCH
	Diabetes Education Program (in-patient)	GVCH / SBCH / SYVCH
	Farmers Market	SBCH
	Grants Programs	GVCH / SBCH / SYVCH
	Heart Smart Lecture Series	SBCH
	Nutrition Education: Classes & Presentations	GVCH / SBCH / SYVCH
	Outlook Group	SBCH
	Project Re-entry	SBCH
	Spinal Cord Injury Life Series	SBCH
	Stroke Education Series	SBCH
	Therapeutic Recreation Programs	SBCH
	Weight-loss Surgery and Support Groups	SBCH
	Wheelchair Sports Camp and Clinics	SBCH

Priority Health Area: Resiliency

Cottage Health will address resiliency among vulnerable populations through a focus on Adverse Childhood Experiences (ACEs) and trauma-informed care.

Strategies and Programs

The launch and implementation of the Pediatric Resiliency Collaborative is a focus area within this priority health area.

Pediatric Resiliency Collaborative

PeRC is a community partnership that has the goal of implementing ACEs screening and response in all pediatric clinics in Santa Barbara County. Key partners include, Cottage Health, Child Abuse Listening Mediation (CALM), Santa Barbara Neighborhood Clinics, CenCal Health, Family Service Agency, Carpinteria Children's Project, Santa Barbara County Public Health Department, and Resilient Santa Barbara.

PeRC supports clinics with technical assistance and training related to implementation of ACEs screening and provides critical staffing and supports to ensure that patients and families that screen positive are connected to high quality resources. PeRC supports clinics in accessing a dedicated CALM therapist and FSA navigator to assist families screening positive for ACEs. Expansion of this initiative will include services provided to additional clinics and the development of a research project in partnership with the Cottage Birth Center.

Priority Health Area: Social Needs

Cottage Health will improve health outcomes for vulnerable populations experiencing social needs, with a focus on food and housing insecurity.

Expanded Strategy and Program

In partnership with community organizations, Cottage Health will address basic social needs through a continued focus on social needs screening and referral programs as well as supportive housing for Recuperative Care Program graduates. Additionally, patient assistance programs, homelessness support, and employee housing assistance (Figure 6) work to increase access to social determinants of health.

Employee Resource Connect

With a strong desire to "start at home" in addressing social needs in Santa Barbara, Cottage Health developed Employee Resource Connect, an intervention connecting employees to food, transportation, behavioral health and housing resources. As part of the program, Cottage Employee Health nurses offer employees a social needs screener. Employees indicate if needs are urgent and can request a list of resources or support navigating resources. Navigators from Family Service Agency, a local resource and referral community organization, receive screening results and respond to requests within 72 hours (24 hours for urgent needs) by email or phone. Employee needs are confidential and only accessed by Family Service Agency representatives. Expansion areas will include strategies to address behavioral health needs, as reported behavioral health needs continue to increase and surpass housing and transportation needs.

Employee Resource Connect – Food Program

The initial implementation of Employee Resource Connect revealed food insecurity as the most common need. In response, Cottage Health developed a food program. Employees who screen positive for food insecurity are eligible to receive $50 loaded onto their employee badge to be used at Cottage Cafeterias, Cottage Café, Park Place Deli, and onsite weekly farmer's markets. They also receive support from a Family Service Agency navigator to assist with identifying long-term solutions, which may include additional financial support.

Patient Resource Connect

Patient Resource Connect assists patients with accessing food, transportation, and housing resources. Beginning in the Goleta Valley Cottage Hospital Emergency Department, patients complete a social needs screener provided by Patient Access. Those who screen positive for one or more social needs are connected with a Resource Navigator, who follows up with patients to access resources and ensure the resource has adequately addressed their need. Expansion of the program will include the development of a volunteer workforce and screening and referrals provided at new locations across the health system, including the Santa Ynez Valley Cottage Hospital Emergency Department.

Supportive Housing for Recuperative Care Graduates

Through a partnership with PATH Santa Barbara and local funders, Cottage Health will develop a supportive housing model for graduates of the Cottage Recuperative Care Program at PATH. Using the Housing First approach, patients will receive transitional housing for up to two years and wrap-around services to help address their medical, behavioral, and social needs. This program will draw on established evidence-based models and existing and new data on community needs. Community leaders and members of the focus demographic will serve as consultants in developing the model.

Figure 6. Strategies/Programs to Address Social Needs

	STRATEGIES/PROGRAMS	HOSPITAL(S)
SOCIAL NEEDS	Patient Resource Connect	GVCH / SBCH / SYVCH
	Employee Resource Connect	GVCH / SBCH / SYVCH
	Employee Resource Connect – Food Program	GVCH / SBCH / SYVCH
	Supportive Housing for Recuperative Care Graduates	GVCH / SBCH / SYVCH
	Bella Riviera	GVCH / SBCH / SYVCH
	Case Management	GVCH / SBCH / SYVCH
	Community Case Management	GVCH / SBCH / SYVCH
	Community Capacity Building: Evaluation Toolkit, CH Data2Go	GVCH / SBCH / SYVCH
	Grants Programs	GVCH / SBCH / SYVCH
	Homelessness Roundtable	SBCH
	Mortgage Assistance Program	GVCH / SBCH / SYVCH
	Patient Assistance at Discharge	GVCH / SBCH / SYVCH
	Social Workers	GVCH / SBCH / SYVCH
	Villa Riviera	SBCH

Priority Health Area: Injury and Violence

Cottage Health will prevent injury and violence through strategies and programs (Figure 7) that reach patient and community populations. CH Emergency Departments' trauma registry reports that falls, motor vehicle collisions, and bicycle and pedestrian injuries are the top three causes of trauma ED visits across all three hospitals. In all 1,398 trauma patients were admitted to CH hospitals in 2019. Interventions that address falls, motor vehicle collisions, and bicycle and pedestrian injuries have the potential to prevent unintentional injuries and violence.

Figure 7. Strategies/Programs to Address Injury and Violence

INJURY & VIOLENCE	STRATEGIES/PROGRAMS	HOSPITAL(S)
	Arrive Alive	SBCH
	Car Seat Trainings, Classes, & Fittings	GVCH / SBCH
	Community Capacity Building: Evaluation Toolkit, CH Data2Go	GVCH / SBCH / SYVCH
	Concussion Clinic & Discussions	SBCH
	Cribs for Kids Safe Sleep Program	SBCH
	Emergency Preparedness Events	GVCH / SBCH
	Every 15 Minutes Filming/Moulage	GVCH / SBCH
	Grants Programs	GVCH / SBCH / SYVCH
	Matter of Balance Fall Prevention Workshop	GVCH / SBCH
	Pedestrian Safety	GVCH / SBCH
	Safe Kids Santa Barbara County Coalition	SBCH
	Safety Helmet Events & Demonstrations (e.g., Brain Care Bike Fair)	GVCH / SBCH / SYVCH
	Safety Presentations	GVCH / SBCH / SYVCH
	Safety Town	SBCH
	Spinal Cord Injury Life Series	SBCH
	Start Smart Location Sponsor	GVCH / SBCH
	Stop the Bleed	SBCH
	Think First Santa Barbara	SBCH

ADDITIONAL LEADING HEALTH INDICATORS

Cottage Health selected leading health indicators based on assessing emergent local health trends in data from the 2016 and 2019 Santa Barbara County BRFSS, Behavioral Health Listening Tour, California BRFSS and national assessments. Additionally, data from the 2016 Cottage Health CHNA results and conversations with community partners identified a need for deeper insights in the area of behavioral health. Based on this analysis, the following health indicators served as focus for prioritization in the 2019 CHNA:

1. Overall good health
2. Alcohol use (binge drinking, past 30 days)
3. Physical inactivity
4. Oral health (dentist in past year)
5. Smoking (cigarettes)
6. Obesity
7. Insurance status (insured)
8. Primary care provider (have usual PCP)
9. Diabetes
10. Cost as a barrier to care
11. Food insecurity
12. Mental health: depression
13. Poor mental health days
14. Housing insecurity
15. Severe mental illness
16. Mental health: anxiety and other mental health disorders
17. Adverse Childhood Experiences (ACEs) Score
18. Mental health stigma
19. Resilience

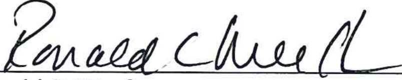
Sixteen of the nineteen leading health indicators were part of the five priority health areas identified from the 2019 CHNA (access to care, behavioral health, chronic conditions, resiliency, and social needs).

The three indicators not prioritized and addressed are: (1) binge drinking, (2) smoking cigarettes, and (3) access to dental care. These health indicators were not ranked as highly (in terms of need, urgency, collaboration among community organizations, health disparities, and community resources available) as were access to care, behavioral health, chronic conditions, resiliency, and social needs. In addition, there are currently leading community partners/stakeholders who are addressing binge drinking, smoking cigarettes, and access to dental care. Though not selected as a priority area, some of the non-prioritized needs will be indirectly addressed through enhancing access to health care and by partnering with lead organizations addressing these areas.

ADOPTION OF IMPLEMENTATION STRATEGY

On April 24, 2020, the Cottage Health Board of Directors met to discuss this Implementation Strategy for Goleta Valley Cottage Hospital, Santa Barbara Cottage Hospital, and Santa Ynez Valley Cottage Hospital. Upon review, the Board of Directors approved this Implementation Strategy for Goleta Valley Cottage Hospital, Santa Barbara Cottage Hospital, and Santa Ynez Valley Cottage Hospital.

Cottage Health Leadership and Board of Directors Approval and Adoption:



Ronald C. Werft
President & CEO
Cottage Health

Gregory F. Faulkner
Chair
Cottage Health
Board of Directors

April 24, 2020
Date

April 24, 2020
Date