2023–2026

Community Benefit Implementation Strategy

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

Cottage
Center for
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), Santa Ynez Valley Cottage Hospital (SYVCH) partnered with Santa Barbara County Public Health Department to conduct the 2022 Community Health Needs Assessment (CHNA) for Santa Barbara County. The results of this assessment form a detailed description of residents' health that can be used to identify health needs and prioritize evidence-based, effective strategies to address those needs.

The 2023 – 2026 Community Benefit Implementation Strategy describes how Cottage Health, representing GVCH, SBCH, and SYVCH, will meet the prioritized community health needs identified in the 2022 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.

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Cottage Health conducted a Community Health Needs Assessment in 2022 to analyze and describe Santa Barbara County's most pressing health needs. The 2022 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 further connects selected health indicators for the county to the goals or targets in *Healthy People 2030 (HP 2030)*, the national planning document created every 10 years by the U.S. Department of Health and Human Services.

The complete 2022 CHNA can be found at https://www.cottagehealth.org/population-health/community-health-needs-assessment/.

Data Collection 2022

To obtain data for this report, Cottage Health conducted a multi-mode survey using mail, email, SMS text, and telephone recruitment with approximately 1,600 community members and a Listening Tour with more than 200 individuals who represent the broad interests of the community, including medically underserved, low-income, and vulnerable populations. To allow for expanded data collection, subpopulation assessments that focused on selected communities within the county were conducted with approximately 350 community members. Additionally, secondary data were obtained from existing online sources. This approach is consistent with the methodology established in the 2016 and 2019 Cottage Health CHNAs, which serve as benchmarks for the 2022 data.

Health Data

Cottage Health contracted with the Population Survey Facility (PSF) at the University of Pittsburgh, an academic research unit with extensive experience in survey methodology, analysis, and reporting. The CHNA used two data sources: 1) a multi-mode survey designed specifically for this effort and 2) existing health and

demographic data (such as U.S. Census data) already collected for the county and California. The multimode survey consisted of mail, email, SMS text, and telephone recruitment and was conducted from August through October 2022 to obtain data from Santa Barbara County adults ages 18 years of age and older. Initial mailings and reminder postcards were sent to residents, which invited them to take a self-administered, web-based survey. Additional recruitment attempts were made via SMS text messages for a sample of households with cell phone numbers. Likewise, non-responders were recruited via email if an email was on file, and if no response was received via mail, text message or email, a group of trained interviewers attempted to contact residents by telephone to either conduct the interview over the telephone or send them an email or text message, based on their preference.

The majority of survey questions were based on the 2022 Behavioral Risk Factor Surveillance System (BRFSS) survey instrument, created by the U.S. Centers for Disease Control and Prevention (CDC). The data collected from the survey were weighted to ensure that survey results were representative of county demographics, such as age, race/ethnicity, and gender. Results were compared to the 2016 and 2019 Santa Barbara County CHNA results, 2021 California BRFSS, and Healthy People 2030 Core Objectives and Leading Health Indicators.

Community Perspectives: Listening Tour

The Listening Tour solicited input from a wide array of community members and leaders, including public health officials, health providers, nonprofit workers, Cottage Health employees, parents, and government leaders. These participants represent the broad interests of the community, including medically underserved, low-income, and vulnerable populations. Secondary data were also obtained and incorporated from the Behavioral Health Asset Mapping project, which consisted of interviews conducted by Santa Barbara Alliance for Community Transformation (SB ACT). In total, more than 200 individuals participated in the Listening Tour through fifty in-person and virtual focus groups and interviews conducted from July through September 2022 with a focus on three topic areas: 1) youth behavioral health, 2) maternal health equity, and 3) COVID-19 pandemic impacts.

Subpopulation Assessments

The CHNA included two Subpopulation Assessments designed to better understand the health and well-being needs of subareas of Santa Barbara County. Designed to provide a more in-depth understanding of specific communities and improve representation of marginalized community members, these Subpopulation Assessments were set-up to be replicated in other areas of the county, allowing for expanded data collection that will be comparable to data at the county level.

Westside Needs Assessment

The Westside Needs Assessment collected data door-to-door in the primary census tracts on the Westside of Santa Barbara in July through August 2022. The process used a stratified random sample methodology with an option to complete the survey in-person or online. The procedures used in this effort were based on the CDC's Community Assessment for Public Health Emergency Response (CASPER) method. University of California, Santa Barbara (UCSB) supported this assessment in the design, implementation, and analysis phases. Findings will help inform programs and initiatives to support the needs of those living on the Westside and the development of a Westside community resource center.

Santa Maria Needs Assessment

Santa Barbara County Public Health Department collaborated with Cottage Health, Dignity Health, California Department of Public Health (CDPH), and community-based organizations to conduct a rapid needs assessment of Santa Maria in October 2022. Using the CASPER methodology, the Santa Maria Needs

Assessment (SMNA) quickly captured information about the health needs and assets of the community through a random, door-to-door sample of households. This assessment aimed to collect data that can be generalizable and will help inform the future allocation of resources to support the needs of those living in Santa Maria.

Results

Based on results from the 2022, 2019, and 2016 CHNA telephone and web surveys, secondary data analysis, and Listening Tour findings, nineteen health indicators were identified for in-depth analysis and prioritization. These indicators were selected using the Leading Health Indicators and Core Objectives from Healthy People 2030[1].

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 performing slightly better or the same as California and has already met seven Healthy People 2030 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, six areas emerged as priority health areas in Santa Barbara County (alpha order):

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

Cottage Health is committed to taking action based on the findings in the 2022 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.

[1] Office of Disease Prevention and Health Promotion. (n.d.). Healthy People 2030. U.S. Department of Health and Human Services. Retrieved from https://health.gov/healthypeople

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 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 131 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 and community 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:

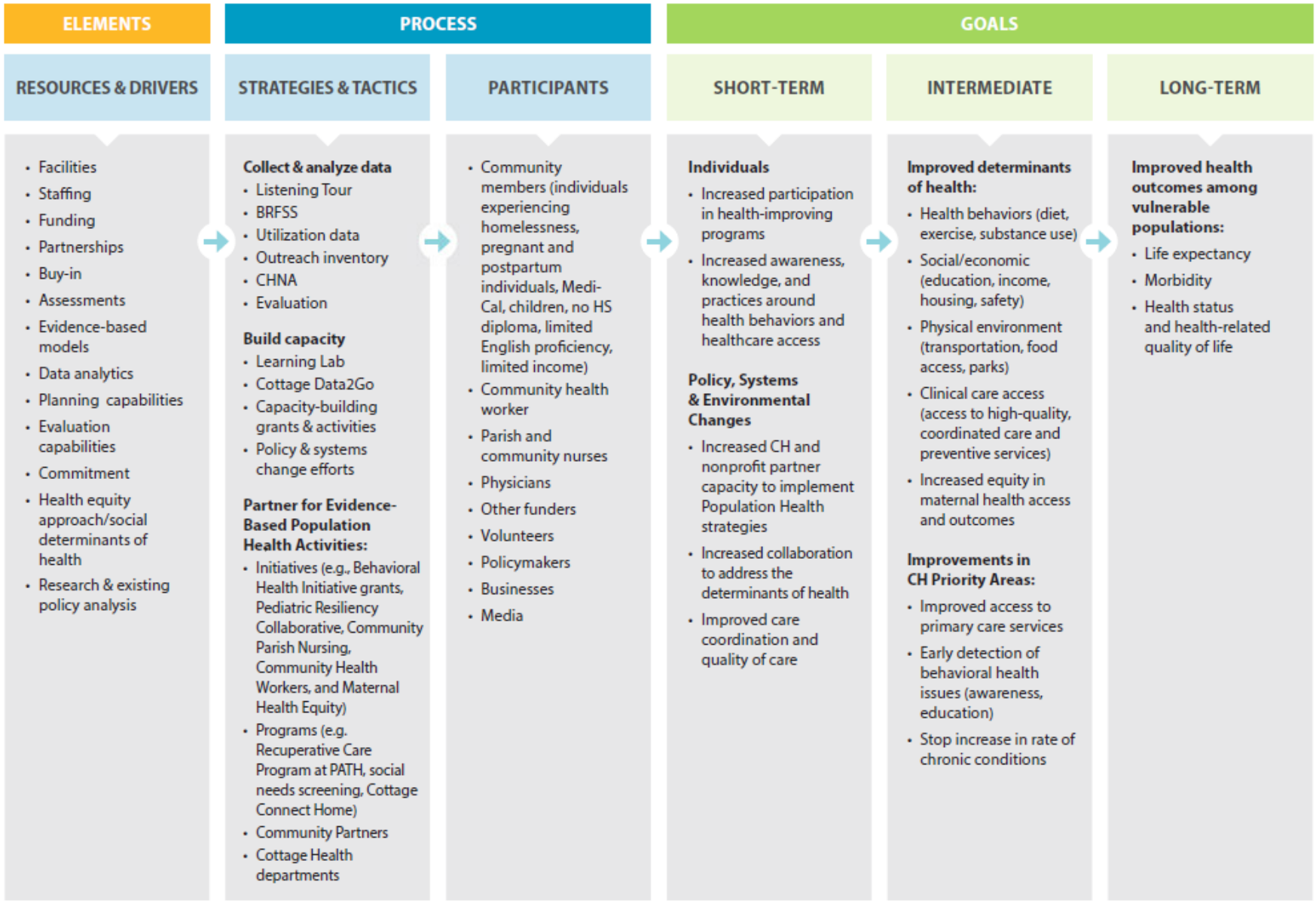
1. What is the problem, and who is impacted? This helps identify the populations that are experiencing health needs, particularly populations experiencing health disparities. While there are many health issues affecting communities at large, it is important to understand which populations are affected the most by these needs.
2. Why this population? 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. 2023-2026 Population Health Intervention Approach

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



Priority Health Area: Access to Care

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

Strategies and Programs

The Cottage Recuperative Care Program at PATH, Cottage Connect Home and Cottage Virtual Care are three 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, and other funders, Cottage Health provides medical respite care for patients who are experiencing homelessness and have an acute medical need. Patients receive 90 days of support from Cottage Health nurses, a social needs navigator and PATH respite care monitors, who provide around-the-clock support. Future areas for continued expansion will include increased access to behavioral health services, job skill training and employment opportunities, and permanent supportive housing.

Cottage Connect Home

Cottage Connect Home focuses on the needs of the most vulnerable individuals experiencing homelessness. This includes individuals living on the streets and in shelters as well as those who were formerly experiencing homelessness and have recently been housed. Clients are provided with case management, medical care, and navigation to transitional shelter with the long-term aim of obtaining permanent housing. A team consisting of a licensed clinical social worker and a registered nurse builds trust with these vulnerable clients and connects them to local resources to help address their basic needs.

Cottage Virtual Care

Cottage Virtual Care is an online platform offering 24/7 virtual care visits in English and Spanish for all California residents. This telehealth service can address common medical conditions and is provided at a low cost and without the need for insurance. Patients participate in an online interview or video consultation with a bilingual provider. The Virtual Care platform expanded to offer services in Spanish to increase access to care for the community's Spanish-speaking, Latino community members, who often experience challenges with accessing care and poorer health outcomes than their white counterparts. In addition, Spanish-speaking Cottage Community Health Workers help spread the word about the Virtual Care services and can provide assistance to community members seeking to access the platform.

Figure 3. Strategies/Programs to Address Access to Care

Strategies/Programs	Hospitals
Access to Care	
Advance Care Planning	GVCH / SBCH / SYVCH
Cancer Screenings & Prevention Events	GVCH / SBCH / SYVCH
Charity Care	GVCH / SBCH / SYVCH
Childbirth & Parenting Education Classes & Programs	SBCH
Community Capacity Building: Evaluation Toolkit, CH Data2Go	GVCH / SBCH / SYVCH
Community Case Management	SBCH
Community Parish Nursing	SBCH
Community Programs Support (e.g., sponsorships)	GVCH / SBCH / SYVCH
Concussion Clinic & Discussions	SBCH
Cottage Community Health Workers	GVCH / SBCH / SYVCH
Cottage Connect Home	SBCH
Cottage Recuperative & Transitional Care Programs at PATH	GVCH / SBCH / SYVCH
Cottage Virtual Care	GVCH / SBCH / SYVCH
CPR Classes	GVCH / SBCH / SYVCH
Flu Shot Clinics	GVCH / SBCH / SYVCH
Grants Programs	GVCH / SBCH / SYVCH
Homelessness Roundtable	GVCH / SBCH / SYVCH
Insurance Enrollment	GVCH / SBCH / SYVCH
Medical Education	GVCH / SBCH / SYVCH
Medicare and MediCal Shortfalls	GVCH / SBCH / SYVCH
Mental Health Fair	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 Partnerships, 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 (BHI), which focuses on increasing access to behavioral health services for youth and addressing barriers to accessing services. 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, notably in youth. 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.

The 2023-2025 BHI aims to ensure that adolescents (12- 18 years old) and their families who are struggling with behavioral health needs have improved behavioral health outcomes and quality of life in south Santa Barbara County. This model aims to address barriers to accessing and utilizing behavioral health services, as well as making services readily available. The model also seeks to increase access and utilization of behavioral health services in two ways: 1) navigation support to streamline access and make finding and using behavioral health services easier for families and 2) local resources for psychiatry/psychology, buffering supports, and community based behavioral health services.

Behavioral Health Partnerships

Cottage Health partners to address behavioral health needs across Santa Barbara County with a focus on youth behavioral health and their families. Behavioral health includes both mental illness and substance use disorders. These partnerships include understanding and compiling local strengths and existing resources through an asset mapping process, convening community stakeholders to plan and implement strategies to address policies, systems, and environmental barriers to behavioral health services, and participating in community and funder collaborations to address behavioral health needs.

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 substance use disorder 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 includes assisting patients with insurance enrollment, benefits, housing and community treatment referrals.

Figure 4. Strategies/Programs to Address Behavioral Health

Strategies/Programs	Hospitals
Behavioral Health	
Behavioral Health Initiative	GVCH / SBCH / SYVCH
Behavioral Health Partnerships	GVCH / SBCH / SYVCH
Coast Caregiver Resource Center	SBCH
Community Capacity Building: Evaluation Toolkit, CH Data2Go	GVCH / SBCH / SYVCH
Community Parish Nursing	SBCH
Community Programs Support (e.g., sponsorships)	GVCH / SBCH / SYVCH
Cottage Outpatient Center of San Luis Obispo	SBCH
Cottage Residential Center	SBCH
Emergency Department Holding Unit (EDHU)	SBCH
Grants Programs	GVCH / SBCH / SYVCH
Inpatient Psychiatry & Addiction Medicine Services	SBCH
Mental Health Intensive Outpatient Program	SBCH
Prescribing Safe	GVCH / SBCH / SYVCH
Psychiatric Grand Rounds	SBCH
Santa Barbara Neighborhood Clinics Bridge Clinic	SBCH
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

The Community Health Worker and Parish Nursing programs focus on this priority health area. Figure 5 outlines the range of programs and strategies for addressing chronic conditions.

Cottage Community Health Workers

Cottage Community Health Workers (CHWs) partner in the community and hospital with nurses, social workers, partners, and others to support Hispanic/Latino patients with accessing medical care, addressing basic needs, and improving health outcomes. CHWs partner to help transition patients with chronic conditions (e.g., congestive heart failure [CHF]) when exiting the hospital and returning to their homes. This program focuses on supporting identified patient populations (e.g., Spanish-speaking CHF patients) with education and information on how to live with and manage their chronic condition and screening and connection to social needs and referrals. Additional partnerships with community organizations extend the reach of CHWs to provide health information and connection resources among marginalized and vulnerable populations. Traditionally called promotores in the Hispanic/Latino community, CHWs are part of the Hispanic/Latino community and offer trusted support, guidance, and understanding in addressing patients' needs.

Community Parish Nursing

Community Parish Nursing supports the prevention and management of chronic conditions to vulnerable community members. Parish nurses provide basic medical care, health education, screenings, medication management, spiritual care, and behavioral health support. Parish Nurses work similarly to holistic nurses—incorporating mind, body, and spirit to assist members of their community to heal and maintain overall health and wellness.

Figure 5. Strategies/Programs to Address Chronic Conditions

Strategies/Programs	Hospitals
Chronic Conditions	
Aphasia Recovery Group	SBCH
Cardiac Rehab Event	SYVCH
Community Capacity Building: Evaluation Toolkit, CH Data2Go	GVCH / SBCH / SYVCH
Community Parish Nursing	
Community Programs Support (e.g., sponsorships)	GVCH / SBCH / SYVCH
Cottage Community Health Workers	GVCH / SBCH / SYVCH
Diabetes Education Programs	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: Maternal Health

Cottage Health will improve maternal health outcomes for vulnerable populations by identifying, describing, and addressing disparities in maternal health access and outcomes.

Strategies and Programs

A Maternal Health Needs Assessment will inform the development and launch of new maternal health equity research and interventions for this priority health area. Figure 6 outlines the ongoing work across Cottage Health in the area of maternal health.

Maternal Health Equity Research

Hispanic/Latino women in Santa Barbara County face challenges that increase their risk for poor reproductive health outcomes. This prospective, qualitative study aims to examine the extent to which factors contributing to racial/ethnic disparities are identified in the experiences or perceptions of mothers giving birth at Santa Barbara Cottage Hospital. Additional aims of this study are to identify and characterize: (1) experience(s) of bias or discrimination, (2) experience(s) of gaps in patient-provider communication, (3) experience(s) of lack of culturally congruent or culturally attuned care, (4) perception(s) of barriers to decision-making autonomy, and (5) perceived level of respect by providers and staff. In-depth, semi-structured interviews will be conducted by a trained facilitator with each participant. Results will help inform possible interventions to address maternal health needs across the county.

Maternal Health Partnerships

Based on needs assessment and research findings, Cottage Health seeks to develop and pilot new maternal health programs and partnerships aimed at supporting perinatal health from conception through the post-partum period for all pregnant people. These partnerships may include convening community stakeholders to plan and implement strategies to address policies, systems, and/or environmental barriers to maternal health equity and participating in community and funder collaborations to address maternal health needs.

Figure 6. Strategies/Programs to Address Maternal Health

Strategies/Programs	Hospitals
Maternal Health	
Birth & Parent Education Classes	SBCH
Cottage OBGYN Clinic	SBCH
Donor Milk Drive	SBCH
Implicit Bias Training with Perinatal Providers	GVCH / SBCH / SYVCH
Maternal Health Equity Research Project	GVCH / SBCH / SYVCH
Maternal Health Partnerships	
Mother's Circle	SBCH
Warm Line	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 expansion and implementation of the Pediatric Resiliency Collaborative is a focus area within this priority health area.

Pediatric Resiliency Collaborative (PeRC)

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 County. 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 also supports clinics in accessing a dedicated therapist and 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 to explore the perceived impact of PeRC interventions on past participants.

Santa Barbara County Network of Care

PeRC and Resilient Santa Barbara County partnered to form the Santa Barbara County Network of Care (NoC) in early 2020. ACEs Aware defines a Network of Care as "a group of interdisciplinary health, education, and human service professionals, community members, and organizations that support adults, children, and families by providing access to evidence-based "buffering" resources and supports that help to prevent, treat, and heal the harmful consequences of toxic stress." Over the last two years, NoC has worked together to expand ACEs screening efforts and connection to trauma-informed buffering services in Santa Barbara County. Looking to the future, NoC will continue to promote and implement strategies to further these efforts, including the use of a closed loop referral IT platform, training on ACEs for community organizations, and buffering services.

Connect Santa Barbara County

Through an intensive community-centered process, Santa Barbara County identified and adopted Connect Santa Barbara County (using FindHelp) as a shared electronic platform to offer closed-loop community referrals. Cottage Health and the NoC provide trainings and technical assistance to help organizations implement the platform among their clients, establish workflows, and integrate with existing technology. This platform will be available for supporting PeRC, the NoC, and any community partner interested in adopting the platform.

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 7) work to increase access to resources surrounding these 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, housing, and childcare resources. As part of the program, Cottage employees are offered 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. Employee needs are confidential and only accessed by Family Service Agency representatives. Cottage continues to offer employees who screen positive for food insecurity additional access to food-related resources through a dedicated food program. Expansion areas will include strategies to expand screening, particularly among Spanish-speaking employees, and offering in-person resource navigation on-site at Cottage.

Patient Resource Connect

Patient Resource Connect assists patients with accessing food, transportation, and housing resources. This program began in Goleta Valley Cottage Hospital Emergency Department and has expanded to Santa Ynez Valley Cottage Hospital Emergency Department and vulnerable patient groups at Santa Barbara Cottage Hospital. Patients complete a social needs screener provided by Patient Access or a Cottage Community Health Worker. 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. Patients facing food insecurity also have access to additional resources for a food program. Cottage Health will utilize the learnings from the Patient Resource Connect program to expand social needs screening across the health system.

Social Determinant of Health Screening and Referrals

Cottage Health is conducting a health system-wide review and strategic planning process to expand social determinants of health (SDOH) screening across all hospitals. Cottage aims to provide universal screening for a key set of social determinants. Key to the success to SDOH screening expansion is ensuring referral mechanisms are in place for all patients who screen positive for one or more social needs to be connected with resources to support them.

Supportive Housing for Recuperative Care Graduates

Through a partnership with the Housing Authority of 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 7. Strategies/Programs to Address Social Needs

Strategies/Programs	Hospitals
Social Needs	
Bella Riviera	GVCH / SBCH / SYVCH
Case Management	GVCH / SBCH / SYVCH
Community Capacity Building: Evaluation Toolkit, CH Data2Go	GVCH / SBCH / SYVCH
Community Case Management	GVCH / SBCH / SYVCH
Employee Resource Connect	GVCH / SBCH / SYVCH
Employee Resource Connect – Food Program	GVCH / SBCH / SYVCH
Grants programs	GVCH / SBCH / SYVCH
Homelessness Roundtable	SBCH
Mortgage Assistance Program	GVCH / SBCH / SYVCH
Patient Assistance at Discharge	GVCH / SBCH / SYVCH
Patient Resource Connect	GVCH / SBCH / SYVCH
Social Determinant of Health Screening and Referrals	GVCH / SBCH / SYVCH
Social Workers	GVCH / SBCH / SYVCH
Supportive Housing for Recuperative Care Graduates	GVCH / SBCH / SYVCH

Priority Health Area: Injury and Violence Prevention

Cottage Health will work to prevent injury and violence through strategies and programs (Figure 8) 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. More than 1,300 trauma patients were admitted to CH hospitals in 2022. Interventions that address falls, motor vehicle collisions, and bicycle and pedestrian injuries have the potential to prevent unintentional injuries and violence.

Figure 8. Strategies/Programs to Address Injury and Violence Prevention

Strategies/Programs	Hospitals
Injury and Violence Prevention	
Arrive Alive SBCH	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 Cottage Health CHNAs, as well as a review of California BRFSS data and other leading health indicators from national assessments, including the Leading Health Indicators (LHI) and Core Objectives from Healthy People 2030.[2]. In 2019, Cottage Health and its partners selected eighteen health indicators that would serve as the focus for analysis. These eighteen health indicators were combined into the following twelve health indicator profiles.

1. Access to Care (insurance status, cost as barrier to care, and primary care provider)
2. Adverse Childhood Experiences (ACEs) and Resilience
3. Alcohol Use (binge drinking)
4. Depression, Anxiety, and Other Mental Health Disorders
5. Diabetes
6. Food Insecurity
7. Housing Insecurity
8. Mental Health (poor mental health days and serious mental illness)
9. Obesity
10. Overall Good Health
11. Physical Inactivity
12. Smoking (cigarettes and vaping)

Based on 2019 Cottage Health CHNA results and conversations with community partners, the 2022 CHNA sought deeper insight to emerging needs and their impacts on vulnerable populations. The following indicators were added to the 2022 CHNA:

1. Youth Behavioral Health (mental health and substance use)
2. Maternal Health Equity
3. COVID-19 Impacts
4. Access to Dental Care

The COVID-19 impacts indicator was not grouped in any single category, as this indicator was seen as impacting all six priority areas and identified as a factor to prioritize within each area. Four indicators NOT prioritized were: (1) binge drinking, (2) smoking cigarettes, (3) physical inactivity, and (4) obesity. 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, maternal health, resiliency, and social needs. In addition, there are currently leading community partners/stakeholders who are addressing binge drinking, smoking cigarettes, physical inactivity, and obesity. 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.

[2] Office of Disease Prevention and Health Promotion. (n.d.). Healthy People 2030. U.S. Department of Health and Human Services. Retrieved from https://health.gov/healthypeople

ADOPTION OF IMPLEMENTATION STRATEGY

On May 15, 2023, the Cottage Health 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

May 12, 2023
Date

Steven C. Zola
Chair
Cottage Health
Board of Directors

May 12, 2023
Date