



Community Health Needs Assessment Report

FOR SANTA BARBARA COUNTY, 2025



TABLE OF CONTENTS

| | |
|---|----|
| Executive Summary..... | 3 |
| Introduction | 6 |
| The Health of Our Community..... | 8 |
| Introduction | 8 |
| Community Defined for the Assessment | 8 |
| Santa Barbara County Demographics | 10 |
| Maternal Health | 19 |
| Children’s Health | 24 |
| Chronic Conditions | 30 |
| Data Sources and Methods..... | 36 |
| Focus Area Identification | 36 |
| Data Collection and Analysis | 37 |
| Prioritization of Health Needs | 38 |
| Data Limitations and Information Gaps | 44 |
| Conducting and Writing the CHNA | 46 |
| IRS Form 990, Schedule H Compliance | 46 |
| Conclusions | 48 |
| Citation | 48 |
| Adoption of Community Health Needs Assessment | 49 |
| References and Resources | 50 |
| Appendix A: Secondary Data Methods, Indicators, and Sources | 54 |
| Appendix B: Listening Tour Methods..... | 56 |
| Appendix C: Local Resources and Assets | 68 |
| Appendix D: Evaluation of Community Benefit Brograms..... | 71 |

EXECUTIVE SUMMARY

The 2025 Community Health Needs Assessment (CHNA) Collaborative partnered to conduct a comprehensive CHNA that highlights the experiences of the county’s communities, laying the foundation for collective action to improve health and well-being across the region. This report describes 2025 CHNA findings through a mixed-methods exploration of the most pressing health needs of Santa Barbara County’s residents, along with community-recommended actionable solutions.

The Health of Our Community

The three areas of focus for the 2025 CHNA—maternal health, children’s health, and chronic conditions—are deeply interconnected across the life course. The life course framework emphasizes how health trajectories are shaped by cumulative experiences and exposures from preconception through adulthood.¹ **Maternal health** before and during pregnancy influences birth outcomes and the long-term health of children, including their risk for developmental delays and chronic diseases later in life. Similarly, early **childhood health** and social conditions—such as nutrition, housing stability, and access to preventive care—lay the foundation for lifelong well-being. **Chronic conditions** that develop in adulthood, such as diabetes or cardiovascular disease, are often linked to these early life factors, as well as to intergenerational patterns. Addressing maternal and child health together, within the broader context of chronic disease prevention, supports healthier outcomes across generations.

Maternal Health

Maternal health is a critical foundation for the health of families and communities. The [2022 CHNA](#) identified persistent disparities in pre- and perinatal care, maternal morbidity, and birth outcomes, with barriers to care being particularly pronounced when culturally- and linguistically- competent care was not affordable. These inequities remain evident in the 2025 CHNA, where both secondary data and community perspectives highlight gaps in care, structural barriers, and opportunities for change.

Secondary data show that early prenatal care in our region remains below statewide levels, with the lowest rates among adolescent mothers and mothers with limited English proficiency. Severe maternal morbidity has doubled over the past 15 years, driven by sepsis, hemorrhage, and hypertensive disorders. Perinatal depression, gestational diabetes, and cesarean deliveries continue to affect families disproportionately, while shortages of infant-toddler childcare and postpartum supports create additional barriers to recovery and follow-up care.

Listening Tour participants described maternal health as a daily struggle shaped by medical risks and social and structural challenges. Families spoke of interpreter shortages, immigration status uncertainty, and financial strain preventing timely access to care. Mothers emphasized isolation, stigma, and unmet needs around perinatal mental health. Some mothers described dismissive or discriminatory treatment, while many North County residents noted long travel distances and workforce shortages. These reflections underscore the need for culturally responsive and linguistically appropriate care, appropriate accountability for unprofessional or discriminatory behavior, stronger navigation and interpretation supports, and greater alignment between clinical services and social supports.

Children’s Health

Children’s health shapes lifelong well-being, influencing resilience, development, and future opportunity. The [2022 CHNA](#) identified key challenges facing children and youth in Santa Barbara County, including disparities in preventive care, obesity, behavioral health, and economic stability. The 2025 CHNA confirms that many of these issues persist, while community voices add context to how teens and families experience and navigate these challenges.

Secondary data highlight elevated rates of youth mental health concerns, including suicidal ideation and chronic sadness, as well as rising substance use. Childhood obesity remains more common among children from families with lower educational attainment and income. Developmental and educational disparities persist, with kindergarten readiness and grade-level achievement lagging among low-income children and children of parents with limited English proficiency. Social drivers—including poverty, food insecurity, and homelessness—continue to create challenging environments for child health and development.

Listening Tour participants underscored that children’s health is shaped as much by structural conditions as by clinical care. Parents described barriers to behavioral health supports, stigma, and long waitlists. Service providers emphasized the impact of poverty, immigration status concerns, and limited access to childcare, transportation, and culturally responsive and linguistically appropriate care. Families also highlighted workforce shortages, especially in pediatric and behavioral health, and the need for school-based resources that integrate wellness and education.

Chronic Conditions

Chronic conditions remain among the most pressing health challenges in Santa Barbara County, driving premature illness and death and shaping daily life for thousands of residents. The [2022 CHNA](#) identified chronic conditions as a leading driver of preventable illness and death in Santa Barbara County. Cardiovascular disease, cancer, and diabetes stood out as persistent contributors to premature mortality, with higher rates experienced by those with less formal education than other populations. Respiratory illnesses, including asthma and Chronic Obstructive Pulmonary Disease (COPD), compounded these disparities, while Alzheimer’s disease emerged as a growing concern due to population aging and limited caregiving infrastructure.²

Secondary data confirm that socioeconomic inequities remain entrenched: cardiovascular, stroke, and diabetes mortality rates differ by demographic characteristics, and obesity and food insecurity are most common among households with lower education and income. Despite progress in areas such as declining COPD and cancer mortality, these rates have not improved since the 2022 CHNA.

Listening Tour participants described what these numbers mean in lived experience. Residents spoke of chronic illness as an “everyday new reality,” requiring constant adjustment and often competing with basic needs like food and housing. Stigma and fear—particularly within immigrant communities—were cited as reasons people delay or avoid care. Housing instability and the high cost of nutritious foods were seen as major obstacles to prevention and management, while many emphasized the importance of long-term trust with providers and frustration with fragmented care systems.

Data Sources and Methods

The 2025 CHNA for Santa Barbara County includes primary data collected through a Listening Tour with more than 200 individuals who represent the broad interests of the community, including medically underserved, low-income, and vulnerable populations. Secondary data were obtained from existing online sources. This approach is consistent with the methodology established in the 2016, 2019, and 2022 CHNAs.

Conclusions

The 2025 CHNA for Santa Barbara County shows a clear throughline: maternal health, children’s health, and chronic conditions are linked across the life course. Early advantages—or disadvantages—shape outcomes from birth to adulthood.

In Santa Barbara County, differences in income, English language proficiency, geography, and immigration status drive housing instability, food insecurity, workforce shortages, and fragmented systems of care. Yet the county’s strengths—community health workers, navigators, school-based services, behavioral health partners, and committed health systems—offer a foundation for progress.

Moving forward, priorities include: strengthened perinatal and pediatric behavioral health; coordinated prenatal–postpartum–primary care; and embedded navigation and social supports at clinics, schools, and community hubs, with intensified focus in high-need areas. The CHNA Collaborative will translate findings into collective actions with measurable, evidence-based goals and transparent reporting.

INTRODUCTION

Background

The 2025 Community Health Needs Assessment (CHNA) Collaborative brings together hospitals, healthcare centers, clinics and public agencies to better understand the health needs and strengths of Santa Barbara County residents. Highlighting the experiences of the county's communities, this CHNA lays the foundation for collective action to improve health and well-being across the region.

CHNA Collaborative

The CHNA Collaborative includes representatives from the following entities:

- CenCal Health
- Cottage Health, representing Goleta Valley Cottage Hospital, Santa Barbara Cottage Hospital, and Santa Ynez Valley Cottage Hospital
- County of Santa Barbara Health Department (County Health)
- Dignity Health / CommonSpirit Health
- Lompoc Valley Medical Center
- Sansum Clinic-Sutter Health
- Santa Barbara County Department of Behavioral Wellness (BWell)

Reporting Requirements

This report presents overall results of the assessment and forms a description of residents' health in Santa Barbara County. In addition, the CHNA complies with federal tax law requirements, including Internal Revenue Code Section 501[r]), which requires 501(c)(3) hospital facilities to conduct community health needs assessments every three years. It is also structured to meet the following:

- State and federal requirements for hospitals, including those outlined in IRS Section 501(r)(3)
- Public Health Accreditation Board Measure 1.1.1
- CenCal Health's DHCS Contract Exhibit A, Attachment III 4.3.A
- Requirements for BWell's QIC Work Plan, Cultural Competency Plan, MHSA/BHSA Plan, and CalAIM
- HRSA compliance requirements for County Health Care Centers

2022 CHNA

Goleta Valley Cottage Hospital, Santa Barbara Cottage Hospital, and Santa Ynez Valley Cottage Hospital published their previous Community Health Needs Assessment and Implementation Strategy in 2022 in partnership with the County of Santa Barbara Health Department. Based on input from the community and hospital leadership, all three hospitals recognized the following as priority health issues:

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

Key community benefit initiatives and programs were identified to address these priority health issues. The tables in Appendix D include an evaluation of the impact of these activities.

Assessment Goals

Building on findings from previous CHNAs, this assessment highlights the scope of population health concerns. The goals of the assessment included the following for Santa Barbara County:

1. Present a detailed description of residents' health needs across and within communities.
2. Increase awareness of health issues and factors contributing to the health of residents.
3. Identify drivers of health affecting health outcomes.
4. Recognize community assets, resources, and strengths available to address health needs and promote well-being.

Development of the Community Health Improvement Plan and a required Implementation Strategy will follow this report.

THE HEALTH OF OUR COMMUNITY

Introduction

The health of a community is shaped by a broad set of social and environmental conditions that influence people’s lives from birth through adulthood. Factors such as economic opportunity, neighborhood conditions, access to care, and supportive systems all play a role in driving health outcomes across populations. In Santa Barbara County, these dynamics are visible in demographic patterns—age, race and ethnicity,* English language proficiency, education, income, poverty, housing affordability, insurance coverage, and disability status—that provide the context for health outcomes and disparities. *See note regarding use of race and ethnicity in this report on page 11.

Building on the priorities identified in the 2022 CHNA, this assessment focuses on three interrelated focus areas: maternal health, children’s health, and chronic conditions. These domains were elevated again through the 2025 prioritization process, reflecting their continued importance to health in Santa Barbara County. Considered together, they illustrate a life course perspective, in which health develops across stages of life and cumulative advantages or disadvantages shape outcomes over time. Maternal health lays the foundation for birth outcomes and early development; children’s health reflects the environments and supports that influence resilience and opportunity; and chronic conditions reveal how risks compound into adult illness and premature death.

For each focus area, the report summarizes key secondary indicators and integrates perspectives from the Listening Tour to capture lived experience, barriers, and context. The topic areas within each focus area were selected through a process that emphasized a review of recent indicators, comparisons to state and national benchmarks, and differences by income, geography, language, age, and insurance status. Priorities were validated through consultation with local healthcare providers, public agencies, and community partners to ensure that findings reflect both the data and the perspectives of those closest to the work.

Community Defined for the Assessment

The 2025 CHNA defines the community for this assessment as all of Santa Barbara County. The map below (Figure 1) shows the community served for the purpose of this report and the Santa Barbara County borders. The map depicts three sub-regions of the county for which data estimates are available, namely North, Mid, and South County regions. Table 1 depicts which ZIP codes are in each sub-region.

Goleta Valley Cottage Hospital, Santa Barbara Cottage Hospital, and Santa Ynez Valley Cottage Hospital define the community served by the geographic area served by the hospital facilities. Grouped by residential ZIP codes, these service areas are the same for all three hospital facilities. This community definition was determined based on the ZIP Codes of residence for recent patients of Cottage Health. Considering patients in the broader context of the communities in which they live, work, and play, the 2025 CHNA extends across the entire county.

Figure 1. Santa Barbara County: ZIP Codes, Regions, and Hospitals

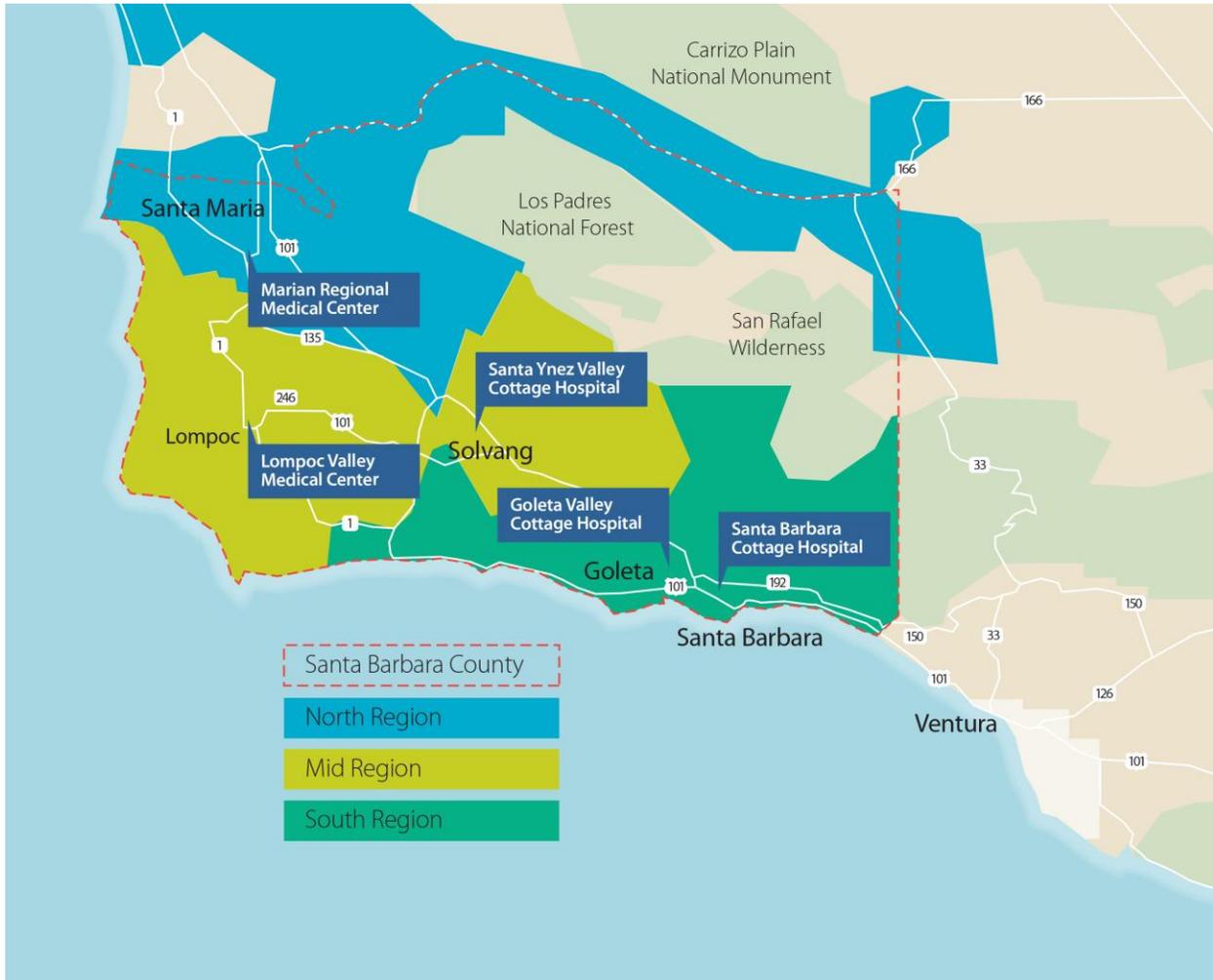


Table 1. Santa Barbara County ZIP Codes by Sub-regions

| |
|--|
| North County |
| 93254, 93429, 93434, 93454, 93455, 93456, 93457, 93458 |
| Mid County |
| 93427, 93436, 93437, 93438, 93440, 93441, 93460, 93463, 93464 |
| South County |
| 93013, 93014, 93067, 93101, 93102, 93103, 93105, 93106, 93107, 93108, 93109, 93110, 93111, 93116, 93117, 93118, 93120, 93121, 93130, 93140, 93150, 93160, 93190, 93199 |

Community Served

Santa Barbara County Demographics

Socioeconomic and demographic conditions shape health across the life course. The World Health Organization notes that those with fewer economic and educational resources face greater barriers to prevention, timely care, and recovery.³ This section provides a current profile of Santa Barbara County's residents to describe population structure, language, educational attainment, income and poverty, health insurance coverage, housing affordability and insecurity, and disability status.

Findings are presented to illuminate differences across populations and places and to inform planning, service delivery, and policy. City-specific context is supported by pre-filtered U.S. Census profiles for each incorporated city in the county, allowing readers to examine local patterns alongside the countywide summary.

Population and Age Distribution

Figure 2. Santa Barbara County Population by Age Group (2019-2023 ACS)

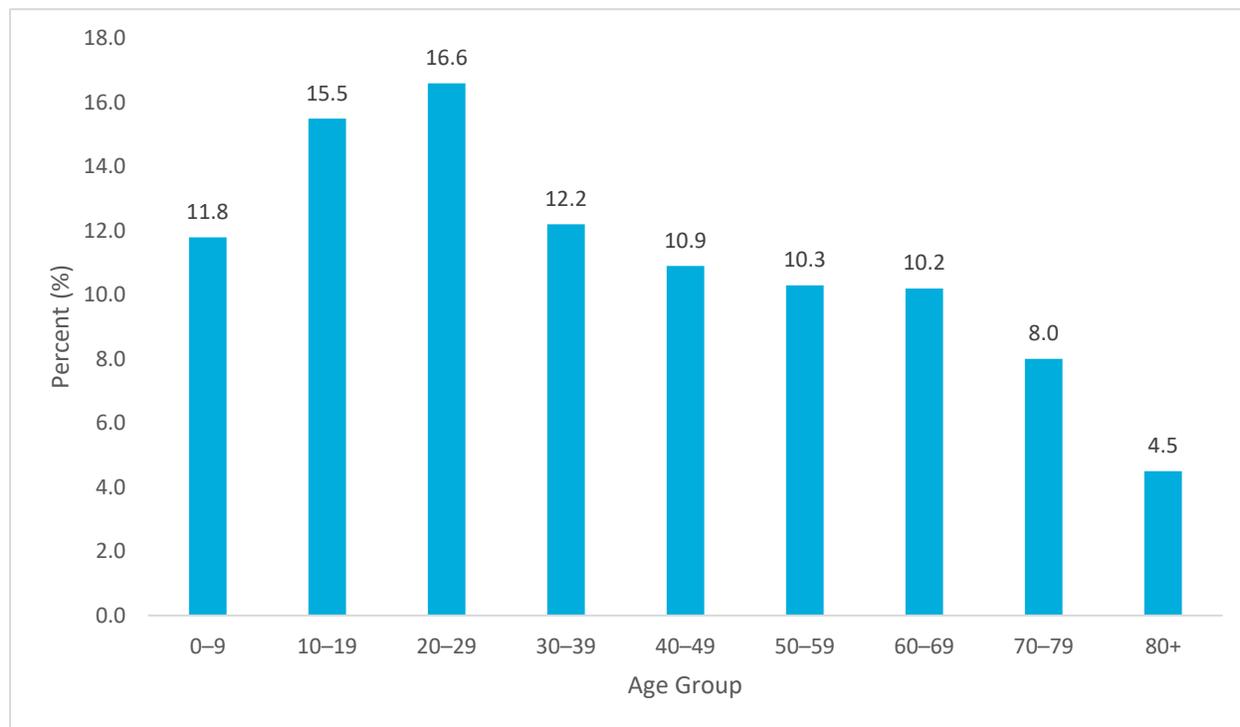


Figure 2 shows Santa Barbara County population distribution by age group (2023 ACS 5-year estimates). The county’s total population is approximately 444,000 (ACS 2019–2023). Santa Barbara County has a young age profile with a median age of about 34.5 years, notably younger than California’s median (~38 years).^{4,5} Over one-quarter (27.1%) of residents are under 20 years old, and only about 16.3% are age 65 or older. Middle-age adults from the ages of 30–59 comprise about one-third (33.4%) of the population, and older adults 70+ account for roughly 12.2% combined.⁵ This age structure indicates a substantial working-age and child population, which has implications for education, employment, and healthcare services.

*Racial and Ethnic Composition**

***Note: Use of Race and Ethnicity in This Report**

References to race and ethnicity in this Community Health Needs Assessment should be understood as qualified by both data reliability and nondiscrimination standards.

Cottage Health is committed to providing equal access to its facilities, programs, and services without regard to race, color, national origin, sex, age, disability, or any other status protected by law.

Consistent with this commitment—and in accordance with Section 1557 of the Affordable Care Act (45 C.F.R. Part 92), the Title VI regulations at 45 C.F.R. Part 80, and all other applicable laws—demographic data are included solely for facilitating identification of verifiable barriers to care or differences in health outcomes that may affect residents within Cottage Health’s service area and that the organization can meaningfully address.

Cottage Health recognizes that measurable disparities in health outcomes can arise from multiple, intersecting factors — including socioeconomic status, insurance coverage, language access, geography, transportation, and

health-system navigation — and commits to identifying and addressing those specific, verifiable barriers to care through lawful, evidence-based approaches.

Accordingly, this Community Health Needs Assessment does not prescribe race-specific interventions. Its findings are intended to guide objective analysis and practical improvements that advance quality and access for all members of the community, consistent with federal law.

Figure 3. Santa Barbara County Population by Race/Ethnicity (2019-2023 ACS)

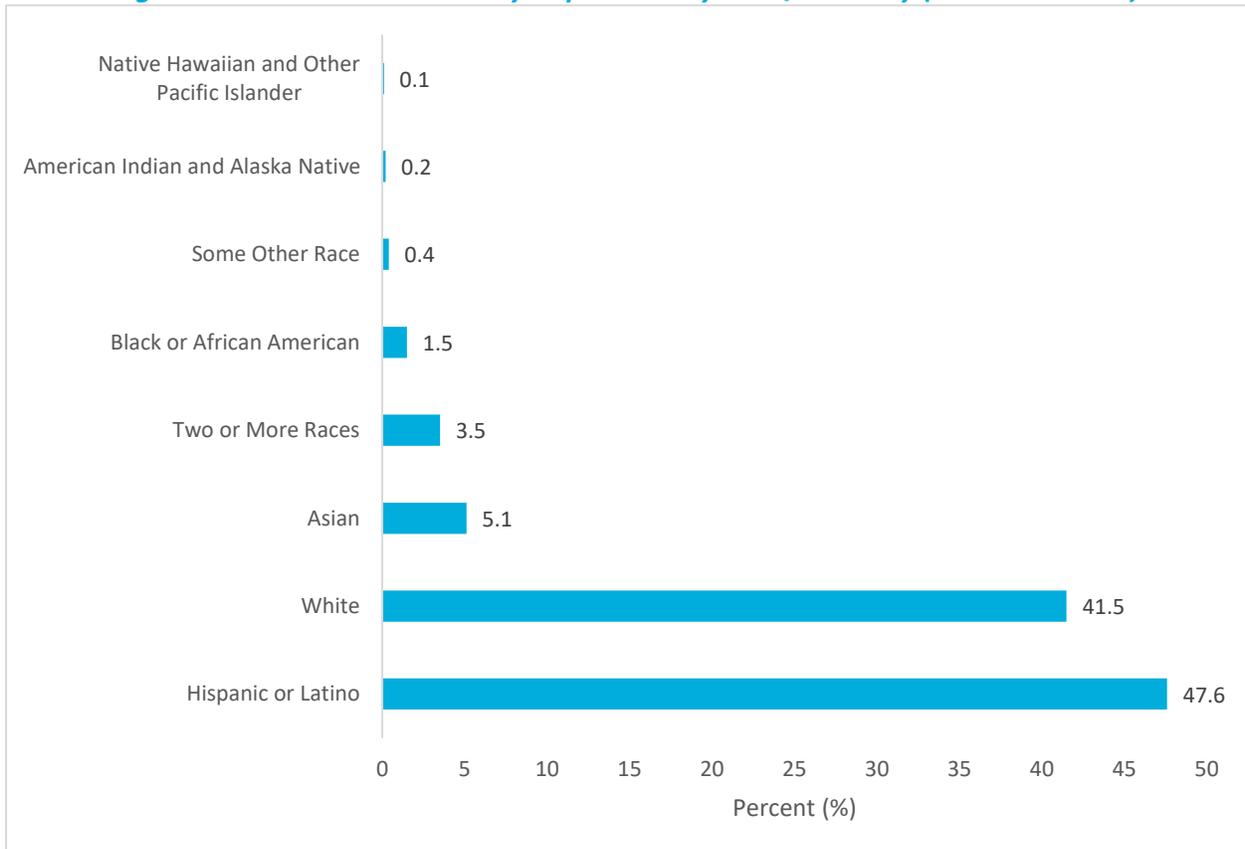


Figure 3 shows Santa Barbara County population by race and ethnicity (ACS 2019-2023). The county is majority Hispanic/Latino and White, with 47.6% of residents identifying as Hispanic/Latino and 41.5% as non-Hispanic/Latino White.⁵ Smaller proportions include about 5.1% Asian, 3.5% multiracial (two or more races), and 1.5% Black or African American.⁵ Other racial groups each constitute under 1% (including Native American or other Pacific Islander, and those classified as “Some Other Race”).⁵ Santa Barbara County’s racial/ethnic makeup differs from California’s overall, with a higher Hispanic/Latino share (47.6% vs 40.8% statewide).⁵

Educational Attainment

Figure 4. Santa Barbara County Population by Educational Attainment, Age 25 and Older (2019-2023 ACS)

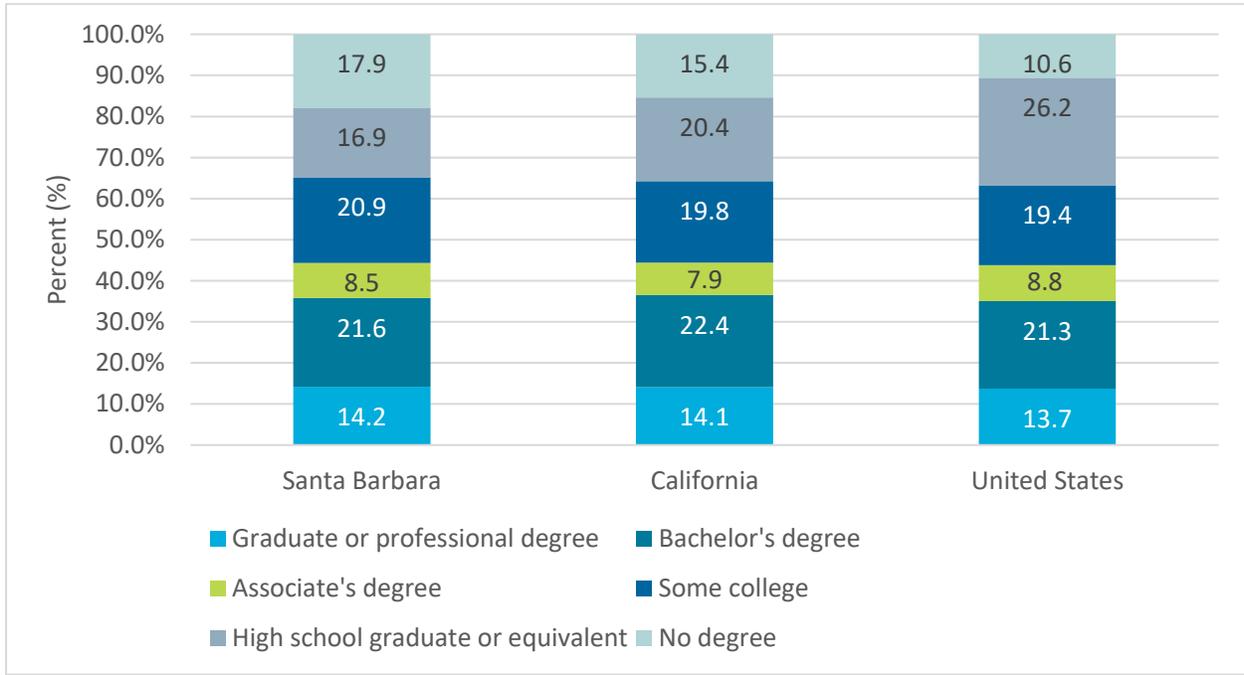
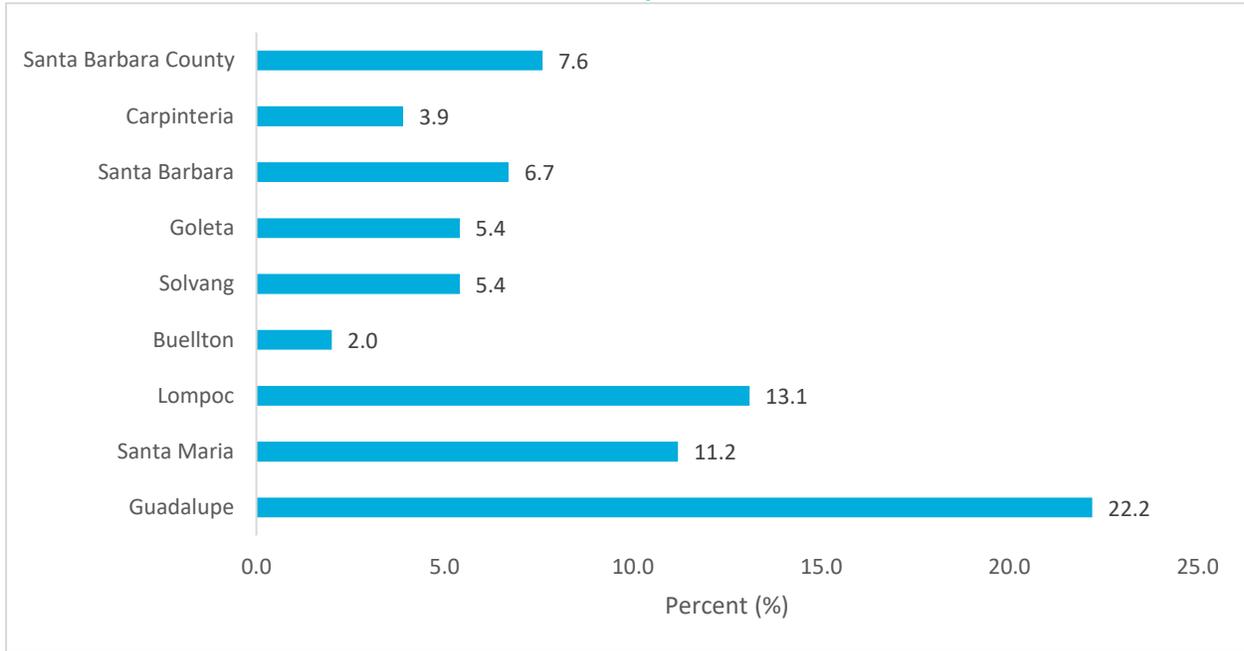


Figure 4 shows mixed educational attainment levels for adults (25+) in Santa Barbara County. 82.1% of adults have at least a high school diploma (ACS 2019-2023).⁴ However, approximately 17.8% of adults have no high school degree, which is higher than the U.S. average (10.6%) and slightly above California’s rate (15.4%).⁵ About 35.9% of county adults hold a bachelor’s degree or higher, roughly on par with national levels (36.8%) and just below the state average (36.5%).⁵ This includes 21.6% with a bachelor’s and 14.2% with a graduate/professional degree.⁵ Santa Barbara County has a sizable population with low educational attainment with nearly one in five adults lacking any diploma.⁵ These differences can impact employment opportunities, health literacy, and income.

Income and Poverty

Figure 5. Santa Barbara County, Families Below Federal Poverty Threshold by City (2019-2023 ACS)



Santa Barbara County has a median household income of \$95,977 (ACS 2019–2023), lower than California’s median (\$96,334).⁵ The average household income in Santa Barbara County is \$137,063; this number is pulled upward by very high earners, highlighting significant income inequality.⁵ Figure 5 shows that an estimated 7.6% of families in Santa Barbara County live below the federal poverty threshold.⁵ This exceeds the statewide poverty rate (12.5%), suggesting many low-income individuals, including single adults and non-family households, face economic hardship.⁴ Poverty is concentrated in certain communities—family poverty rates reach about 11.2% in Santa Maria, 13.1% in Lompoc, and 22.2% in Guadalupe, compared to under 3.9% in Carpinteria.⁵ The overall poverty rate for individuals is higher—13.8% of residents in Santa Barbara County are below the federal poverty threshold.⁵ These data highlight a county of economic contrasts—high average incomes alongside notable poverty in specific populations and areas.

Health Insurance Coverage

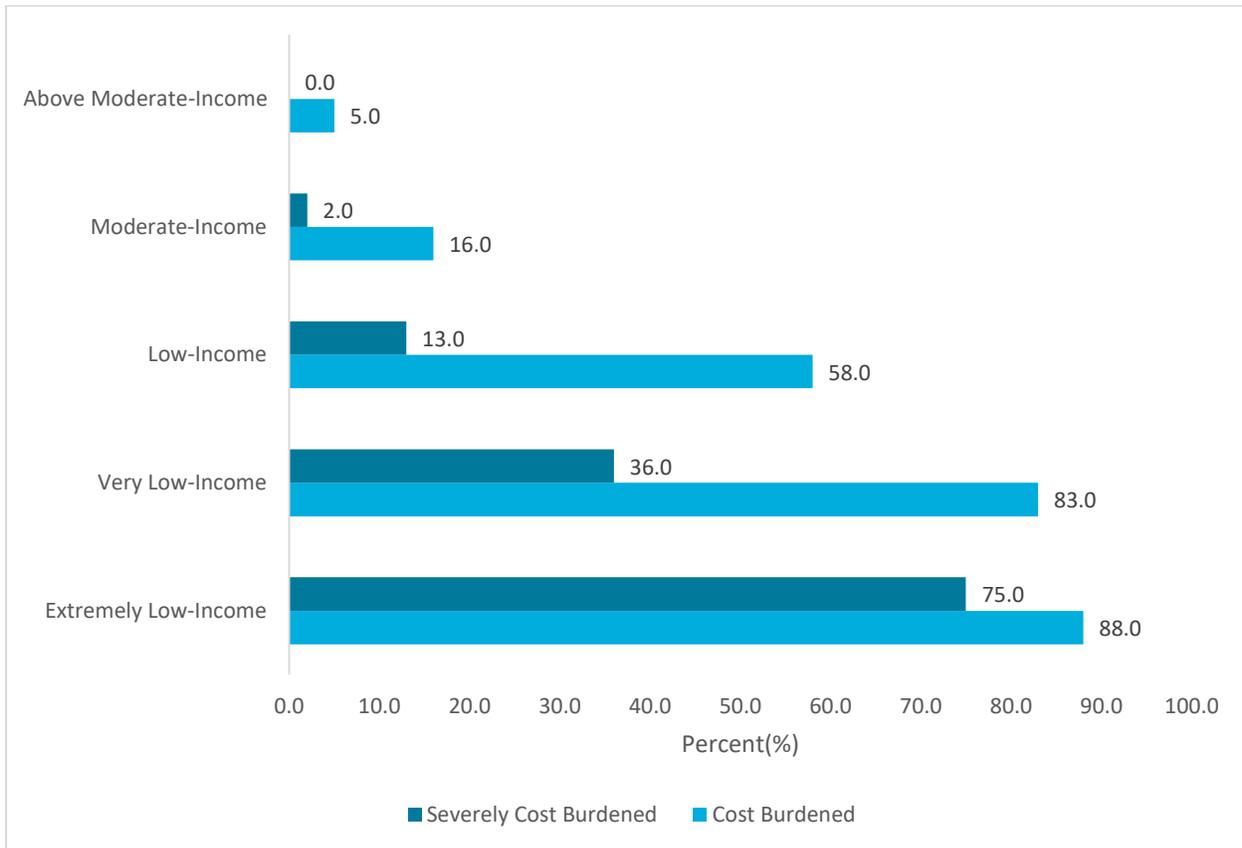
Table 2. Santa Barbara County, Health Insurance Coverage

| Category | Subgroup | 2022 Santa Barbara CHNA % | 2021 California BRFSS % | 2030 Healthy People Target % |
|------------------|---------------------|---------------------------|-------------------------|------------------------------|
| Overall | — | 93.8 | 91.5 | 92.4 |
| Education | < High School | 85.6 | 76.0 | |
| | High School Grad | 85.3 | 89.3 | |
| | Some College | 94.8 | 94.4 | |
| | College Grad | 98.6 | 98.1 | |
| Income | < \$35,000 | 84.2 | 84.3 | |
| | \$35,000–\$74,999 | 93.0 | 91.3 | |
| | \$75,000 or greater | 97.8 | 97.6 | |

Table 2 shows that most adults in Santa Barbara County have health insurance, with 93.8% reporting coverage—slightly higher than California’s 91.5% rate in 2022. 2 Coverage remains uneven across groups, with lower rates among men (91.9%) compared to women (95.3%). Insurance coverage increases with age, from 89.7% among adults aged 18–44 to 98.4% among those 65 and older. 2 Educational attainment and income are also strongly correlated with insurance coverage, as just 85.6% of adults without a high school diploma are insured, compared to over 94.8% among those with at least some college education. Coverage rises from 84.2% among those earning less than \$35,000 annually to 97.8% among those earning \$75,000 or more.2

Housing Insecurity and Cost Burden

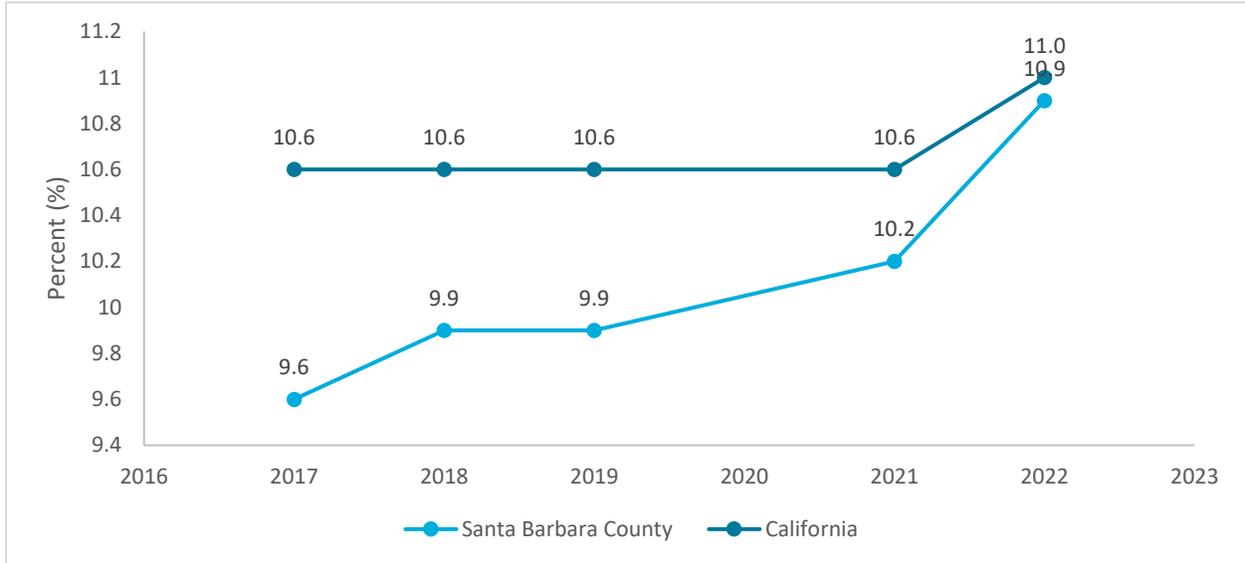
Figure 6. Santa Barbara County, Housing Insecurity and Cost Burden (2023)



Santa Barbara County faces significant housing insecurity and cost burdens, with 17,037 low-income renter households lacking access to affordable homes.⁶ As shown in Figure 6, 75% of extremely low-income renters are severely cost burdened, meaning they spend more than half of their income on housing costs.⁶ By contrast, only 2% of moderate-income households fall into this category.⁶ Households are considered cost burdened when 30% or more of income goes toward housing.⁶ The average monthly asking rent of \$2,554 requires an hourly wage of \$49.11, or 3.1 times the state minimum wage, to afford without being cost-burdened.⁶ Asking rents in the county increased by 3.8% between the fourth quarter of 2022 and the fourth quarter of 2023, further straining affordability for lower-wage workers such as home health aides, farmworkers, and childcare providers.⁶ These conditions highlight the persistent gap between housing costs and local wages, contributing to growing housing instability across Santa Barbara County.⁶

Disability Status

Figure 7. Santa Barbara County, Residents Living with a Disability Prevalence (2019-2023 ACS)



8.6% of Santa Barbara County residents aged 18 to 64 years old live with a disability.⁷ This share rises to 10.9% when including seniors as shown in Figure 7.⁷ The county's disability rate is on par with the California average (11.0%).⁷ Disabilities include a range of physical, cognitive, and sensory impairments that can affect individuals' daily living and healthcare needs.⁷

City-Level Demographic Profiles

To further explore local demographics, below are links to U.S. Census Bureau data profiles for the eight incorporated cities in Santa Barbara County. These profiles provide detailed 2019–2023 data on each city's population characteristics, economic indicators, housing, and social factors:

- Buellton – [ACS Data Profile: Buellton, CA](#)
- Carpinteria – [ACS Data Profile: Carpinteria, CA](#)
- Goleta – [ACS Data Profile: Goleta, CA](#)
- Guadalupe – [ACS Data Profile: Guadalupe, CA](#)
- Lompoc – [ACS Data Profile: Lompoc, CA](#)
- Santa Maria – [ACS Data Profile: Santa Maria, CA](#)
- Santa Barbara – [ACS Data Profile: Santa Barbara, CA](#)
- Solvang – [ACS Data Profile: Solvang, CA](#)

Additional Local Data Resource

In addition to Census data, the [Santa Barbara County Statistical Profile \(2025\)](#) provides a comprehensive overview of local conditions drawn from multiple state and federal data sources. The profile includes recent statistics on population, employment, income, housing, education, public assistance, and agriculture—alongside tri-county comparisons and jurisdiction-level data. Developed by the County Executive Office, it consolidates indicators from the American Community Survey (ACS), Employment Development Department, and County departments into a single, accessible resource for planning and policy. This profile complements the CHNA’s demographic and socioeconomic analysis by offering additional context on economic activity, workforce composition, and community infrastructure across Santa Barbara County.

For neighborhood-level views, [Cottage Data2Go](#) provides interactive maps that bring together federal, state, county, and community data on a broad range of issues critical to the well-being of all Santa Barbara County. Data displayed within Cottage Data2Go helps users visualize the link between geographies and the specific needs of varying demographics, allowing users to see and interact with correlations across multiple variables. Nearly 200 indicators from diverse sources are included for the county’s census tracts, cities, and census designated places.

Maternal Health

Maternal health refers to the health of people during pregnancy, childbirth and the postnatal period after they give birth.⁸ The postnatal or postpartum period refers to the two months immediately following childbirth. According to the CDC, “health problems—like diabetes, high blood pressure, and depression—can arise before, during or after pregnancy, putting the mother's or infant's health at risk.”⁹ Social factors like food insecurity and lack of childcare also play a critical role.¹⁰ Ultimately, maternal health is defined by the presence of conditions that ensure respectful, high-quality, and comprehensive care for every pregnancy and birth.¹¹

Overview

Maternal health is a critical foundation for the health of families and communities. The [2022 CHNA](#) identified community needs in access to prenatal care, maternal health concerns, and birth outcomes. The 2025 CHNA helps better understand these needs, highlighting gaps in care, structural barriers, and opportunities for change.

To align with California guidance, this report defines the perinatal period as the period from the establishment of pregnancy to one month following delivery, per California W&I §14134.5(b). This definition is reflected in the California Department of Public Health's Local Maternal Child & Adolescent Health Program's Policies and Procedures.

Secondary Data

Secondary data show that early prenatal care remains below statewide levels, with the lowest rates among adolescents and mothers from Spanish-speaking homes. Severe maternal morbidity has doubled over the past 15 years, driven by sepsis, hemorrhage, and hypertensive disorders, with the highest rates among Hispanic/Latino. Perinatal depression, gestational diabetes, and cesarean deliveries continue to affect families disproportionately, while shortages of infant-toddler childcare and postpartum supports create additional barriers to recovery and follow-up care.

Listening Tour

Listening Tour participants described maternal health as a daily struggle shaped by medical risks and social and structural challenges. Families spoke of interpreter shortages, immigration status concerns, and financial strain preventing timely access to care. Mothers emphasized isolation, stigma, and unmet needs around perinatal mental health. Some mothers described dismissive or discriminatory treatment, and many North County residents noted long travel distances and provider shortages. These reflections underscore inequities shown in the data and point to the need for culturally responsive and linguistically appropriate care, stronger navigation and interpretation, patient education about pathways for reporting discrimination and harassment, and greater alignment between clinical services and social supports.

These findings echo themes from the [MCAH Title V Needs Assessment](#), which highlights the same inequities in prenatal access, perinatal mental health, and birth equity. Together, these sources point toward an urgent need for systemic action.

Improving maternal health will require upstream investments in childcare, transportation, housing, and food security, alongside enhanced models of prenatal, birth, and postpartum care. Listening Tour participants highlighted the need to expand access to mental health services, strengthen interpreter and navigator programs, support home visitation and doulas, and create integrated “one-stop” perinatal models. Progress depends on coordinated strategies to improve clinical outcomes and address the social and structural drivers of maternal health.

Maternal Health Findings

Findings below are summarized by topic area. All data are for Santa Barbara County unless otherwise noted.

Access to Care

Access to healthcare remains a persistent maternal health challenge.

- First-trimester prenatal care was initiated by 77.2% of mothers in Santa Barbara County, compared to 86.5% statewide (2021-2023). Rates were lowest among teens (49.8%).¹²
- Adequate prenatal care was received by 80.5% of mothers in Santa Barbara County (2021–2023). Rates were lowest among teens (57.6%).¹²
- Exclusive breastfeeding in hospitals was 62.9% locally, compared to 68.9% statewide (2021-2023). Rates were lowest among low-birthweight infants.¹³

Listening Tour participants praised social support resources such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), community health workers, and lactation consultants, but described persistent barriers to accessing prenatal and postpartum care, including transportation challenges, limited availability of Spanish and Indigenous language services, and concerns about immigration status.

Interpreters in the patient's preferred language is one of the biggest obstacles.
– Service Provider

Maternal Morbidity

Maternal morbidity is defined as any health condition attributed to and/or complicating pregnancy and childbirth that has a negative impact on the woman's well-being and/or functioning.⁸

- Severe maternal morbidity (SMM) refers to unexpected, potentially life-threatening complications during labor or delivery that can lead to serious short- or long-term health consequences. It includes 20 indicators representing major complications (e.g., sepsis, acute renal failure) or procedures used to manage them (e.g., ventilation, hysterectomy), excluding cases identified solely by blood transfusion codes.¹⁴ Santa Barbara County's SMM rate was 111.5 per 10,000 births in 2021-2023, compared to 110.4 per 10,000 statewide. This has doubled from 52.1 SMM incidents per 10,000 births since 2008-2010.¹⁴
- Gestational diabetes affected 10.1% of births in Santa Barbara County compared to 11.4% statewide (2021–2023).¹⁵
- Prenatal depression affected 14.6% of mothers in Santa Barbara County, and postpartum depression impacted 11.2% of mothers. The burden was higher among mothers living below the federal poverty level, with 17.0% reporting prenatal depression and 12.2% reporting postpartum depression (2020-2022).¹⁶
- Hypertension during pregnancy affected 13.0% of births to adults ages 20 to 44 in 2024.¹⁷

Listening Tour participants emphasized that maternal morbidity is compounded by systemic barriers. Families described gestational diabetes care as confusing, stigmatized, and poorly coordinated, with delays in referrals and limited culturally tailored education. Perinatal depression and anxiety were described as common but under-screened, with few bilingual or perinatal-trained providers.

We see a fair amount of people who are diagnosed with gestational diabetes who are already prediabetic. They're just not getting medical care in any other time besides the perinatal period. So they're not necessarily knowing what their numbers were before. So I think that's a pretty common occurrence for us. – Healthcare Provider

Birth Outcomes

Birth outcomes include indicators of both maternal and newborn health that reflect the quality and accessibility of healthcare before, during, and immediately after pregnancy, labor, and delivery.⁸

- The preterm birth rate was 8.8% in 2021-2023 (vs. 9.1% statewide). Rates were highest among mothers aged 40+ (14.7%).¹⁸
- The low birthweight rate was 7.0% in 2021-2023 (vs. 7.4% statewide).¹⁹
- Cesarean deliveries accounted for 32.2% of all births in Santa Barbara County, slightly above the statewide rate of 31.1% (2021-2023). Vaginal birth after cesarean (VBAC) rates remained low across groups.²⁰
- Cannabis use during pregnancy was reported by 4.0% of mothers in Santa Barbara County (2020–2022), up from 2.3% in 2016–2018, reflecting a rising trend.²¹
- Neonatal Abstinence Syndrome (NAS) occurred at a rate of 5.3 per 1,000 live births, nearly double the statewide rate of 2.8 (2021-2023).²²

Listening Tour participants described gaps in monitoring and follow-up during pregnancy and after delivery, as well as differences in how complications are addressed across populations. Service providers noted that teenagers face higher risks for premature birth, low birthweight, and infant mortality, underscoring the need for expanded supports for young mothers.

Another challenge among the teenagers is premature birth, low birth weight, and a higher infant mortality risk. – Service Provider

Social and Structural Drivers

Social and structural barriers such as intimate partner violence and limited access to affordable childcare continue to shape maternal health, recovery, and the ability to maintain consistent postpartum care.

- Between 2013 and 2022, 12.9–15.2% of mothers living in poverty reported physical, psychological, or sexual intimate partner violence (IPV) during pregnancy, with rates declining to 12.9% in the most recent 3-year period.¹⁶
- Licensed childcare capacity for infant and toddler care is severely impacted with some areas experiencing severe shortages, including New Cuyama (0% could access licensed childcare for ages 0-2), Santa Ynez Valley (2%), Orcutt/Los Alamos (4%), Lompoc (7%), and Guadalupe (8%).²³

Listening Tour participants emphasized that maternal health cannot be separated from broader social conditions. Housing instability, food insecurity, lack of paid leave, and IPV were described as major barriers to healthy pregnancies and recoveries.

Poverty, lack of access to food, inadequate housing and lack of transportation can affect maternal health outcomes. – Service Provider

Emerging Themes

Several forces shape how mothers and families experience maternal health in Santa Barbara County, including:

1. Interpreter shortages and gaps in culturally responsive care that undermine trust and understanding, especially for Mixteco-speaking families.
2. Concerns about immigration status that deter timely use of prenatal and postpartum services or public benefits.
3. Perinatal mental health needs that are widespread, yet under-resourced, with stigma, long waits to access care, and few bilingual or perinatal-trained providers.
4. Trusted supports (e.g., navigators, community health workers, home visiting) that help families access and coordinate services, but remain underfunded and unevenly available.
5. Socioeconomic privilege shaping access to comprehensive supports (e.g., private doulas, lactation consultants) and widening gaps in care quality.
6. Structural constraints—housing instability, childcare shortages, food insecurity, and lack of paid leave—directly affecting pregnancy and recovery.
7. Fragmentation of care across prenatal, delivery, and postpartum settings that disrupts continuity, handoffs, and follow-up.

Actionable Solutions

Community members and providers highlighted solutions that would make maternal health care more accessible, supportive, and culturally responsive. These include:

- Develop coordinated gestational diabetes clinics offering tailored education, interpretation, and integrated follow-up.
- Increase access to lactation services by expanding insurance reimbursement, breastfeeding education, and workplace supports.
- Expand postpartum supports, including home visiting, navigation, and integrated behavioral health care.
- Expand interpreter access, especially for Mixteco dialects, through both in-person and virtual models.
- Invest in community-based models of perinatal care—combining clinical providers and trained support professionals (including community health workers)—to provide linguistically and culturally competent care and support before, during, and after birth.
- Strengthen perinatal mental health services through peer groups, bilingual providers, and warm handoffs to specialized care.
- Address social needs as part of maternal health policy, ensuring housing, food, childcare, and paid leave are treated as core health priorities.
- Create “one-stop” perinatal hubs that integrate medical, mental health, and social supports for comprehensive care.

Additional Listening Tour secondary data analysis will be forthcoming on the Cottage Health website. A complete list of local resources to address these needs is provided in Appendix C. Additional resources can also be found at [ConnectSBC.org](https://connectsbc.org).

Children’s Health

Child health refers to the ability of individual children or groups of children to achieve their full potential, meet their essential needs, and build the skills necessary to interact effectively with their biological, physical, and social environments.²⁴ Shaped by medical, behavioral, and environmental factors, child health is central to understanding how early influences impact well-being and create the groundwork for a lifetime of health.²⁵

Overview

Children’s health shapes lifelong well-being, influencing resilience, development, and future opportunity. The [2022 CHNA](#) identified key behavioral health challenges facing children and youth in Santa Barbara County. The 2025 CHNA seeks to understand these needs more broadly and adds context to how teens and families experience and navigate these challenges.

Secondary Data

Secondary data identified elevated rates of youth mental health concerns—including suicidal ideation and chronic sadness—as well as rising substance use. Childhood obesity remains more common among children from families with lower education and income. Developmental and educational disparities persist, with kindergarten readiness and grade-level achievement lagging among Hispanic/Latino and low-income children. Broader social drivers—poverty, food insecurity, and homelessness—continue to create inequitable environments for child health and development.

Listening Tour Findings

Listening Tour participants underscored that children’s health is shaped as much by structural conditions as by clinical care. Parents described barriers to behavioral health supports, stigma, and long waitlists for care. Service providers emphasized the impact of poverty, immigration status concerns, and limited access to childcare, transportation, and culturally responsive and linguistically appropriate care. Families also highlighted workforce shortages, especially in pediatric and behavioral health, and the need for school-based resources that integrate wellness and education.

These findings reinforce insights from the [2024 Santa Barbara County Children’s Scorecard](#), which documented similar trends in children’s health, well-being, and disparities. Together, the Scorecard, secondary data, and Listening Tour voices point to clear priorities: strengthening behavioral health resources, addressing obesity and food insecurity, ensuring equitable access to education and preventive care, and tackling upstream social drivers, such as housing and poverty.

Children's Health Findings

Mental Health

Mental health concerns among children and adolescents have intensified since the 2022 CHNA, with persistent gaps in early identification, crisis response, and access to appropriate care.

- About one in six students in grades 9 (14.2%) and 11 (15.5%) in 2017-2019 reported suicidal ideation, with higher rates among students in non-traditional school settings (17.4%), which includes continuation, county community day, district community day, juvenile court, opportunity, or special education schools.²⁶
- Emergency department visits for suicide/intentional self-injury were highest among ages 15–24.²⁷
- Depression-related feelings was more common among girls and students who felt disconnected from school. Non-traditional students had the highest overall risk of depression-related feelings.^{28,29}

Listening Tour participants described behavioral health as the most urgent and unmet need for children. Families emphasized the toll of stigma and isolation, while providers noted long wait times and the shortage of bilingual, pediatric-trained specialists. Parents reported frustration with gaps in school-based counseling and limited crisis supports, leaving many children without consistent care during critical periods.

Anxiety and fear have always been prevalent, but I feel like even more so today, particularly now. Many of our youth are living through so much trauma. – Cottage Health Employee

Substance Use and Risk Behavior

Substance use and related risk behaviors continue to affect youth well-being, with earlier initiation and limited access to prevention and treatment resources.

- Alcohol and drug use increased with age, reported by 6.9% of 7th graders, 14.6% of 9th graders, and 24.1% of 11th graders in Santa Barbara County (2017–2019).³⁰
- Alcohol and drug use was most common among students with low school connectedness of 27.8%, compared to 17.8% with medium and 9.8% with high connectedness (2017–2019).³⁰
- Gang involvement was higher among older and non-traditional male students: 6.2% of 11th-grade males and 8.7% of non-traditional males, versus 3.3% of 7th-grade and 5.0% of 9th-grade males (2017–2019).³¹

Listening Tour participants expressed growing concern about substance use beginning earlier and becoming more normalized among youth. They described limited prevention programming, barriers to adolescent treatment, and the added dangers of more potent substances circulating in the community. Families worried that stigma and fear often kept young people from seeking help until use escalated into crisis.

Some of my friends, they've decided to self-medicate with drugs such as marijuana, and I think it's kind of a big issue. I don't know if it's only my friend group, but I feel like a lot of other kids take up substances in order to help with things such as anxiety and depression, rather than trying to get the help they need. – Teen Community Member

Physical Health and Chronic Conditions

Chronic and preventable conditions, such as asthma and obesity, continue to impact children’s health, reflecting environmental, behavioral, and access-related factors.

- Child asthma prevalence declined from 12.7% (2011-2012) to 4.7% (2019–2020), below the state average (12.4% in 2019-2020); meanwhile, asthma hospitalizations among ages 0–17 rose from 1.4% (2020) to 3.7% (2022).^{32,33}
- Childhood obesity remains essentially unchanged over the past decade, affecting 41.4% of 5th graders, 41.7% of 7th graders, and 38.3% of 9th graders in 2019.³⁴

Listening Tour participants linked children’s health to neighborhood realities such as high food costs, limited access to safe recreation, and environmental triggers. Providers noted travel burdens for specialty clinics and limited availability of culturally tailored nutrition guidance, which complicates prevention and disease management.

[There’s] an ironic lack of access to fresh food and how expensive it is—even though so much of it comes from here. I think we see that affecting children’s health through both malnourishment and obesity. – Service Provider

Access to Care and Preventive Services

Access to timely and preventive care remains uneven, particularly for Medi-Cal–enrolled and North County children who face logistical and systemic barriers to services.

- Childhood immunization rates among Medi-Cal–enrolled children in Santa Barbara County improved from 40.6% in 2023 to 42.7% in 2024, on par with the Medicaid ninetieth percentile benchmark of 42.3%.³⁵
- Immunizations for adolescents were 45.1% in 2024, slightly below the Medicaid ninetieth percentile benchmark of 48.7%.³⁵
- Lead screening for children reached 74.0% in 2024, nearing the Medicaid ninetieth percentile benchmark of 79.5%.³⁵
- Well-child exams in the first 15 months of life increased from 64.2% in 2023 to 68.9% in 2024.³⁵

Listening Tour participants described multiple barriers to care—language, concerns about documentation, rigid work schedules, transportation, and complex referral systems. North County families reported long travel distances for specialty care (often to Santa Barbara or Los Angeles) and months-long waits for pediatric psychiatry and autism evaluations.

We look at various data... developmental screenings tend to be a little lower, and trying to identify why that is... also working on increasing well-child visits. – Healthcare Provider

Early Development and Education

Early development and educational readiness vary widely across the county, with persistent inequities linked to income, language, and access to early learning supports.

- Academic disparities persist, with low-income students less likely to meet grade-level standards. In 2023–2024 among all kindergarten students, only 33% of children were “Ready to Go” for kindergarten, 42% met academic readiness, and 34% met social-emotional benchmarks.³⁶
- Among students in special education, 39.0% had learning disabilities, 21.4% had speech or language impairment, and 12.4% had autism spectrum disorder—similar to statewide rates of 37.2%, 20.8%, and 15.6%, respectively (2020).³⁷
- Across grades 3, 4, 5, 6, 7, 8, and 11, 33.7% of public school students met or exceeded grade-level math standards, similar to the statewide rate of 33.8%, while 46.5% met or exceeded English language standards—below the statewide average of 49.0% (2021).^{38, 39}

Listening Tour participants described long waits for evaluations and therapies, uneven resources across districts, and difficulty coordinating care. Providers worried that delays in screening lead to missed opportunities for early intervention, with lasting effects on learning and behavior.

I think we also have struggles for our families, for our kiddos who have intellectual disabilities and ADHD to get evaluations through the school district. They can get IEPs through the school district, but it's a long process and often very delayed because they're pretty backed up. – Healthcare Provider

Social and Structural Drivers

Children’s health and development are shaped by broader social and economic conditions—including housing stability, food security, and family income—that influence opportunity and well-being.

- Child poverty in Santa Barbara County declined from 23% in 2014 to 13% in 2020, before rising again to 17% in 2023.⁴⁰
- Households with children reported a food insecurity rate of 11.7% (2019), while adult food insecurity rose to 25.5% (2022).^{41,48}
- Student homelessness affected 13.2% of students—nearly three times the state average—with most students classified as “doubled up,” meaning they were temporarily sharing another household due to loss of housing, economic hardship, or similar circumstances (2024).⁴²

Listening Tour participants emphasized that families prioritized rent, food, and safety before health and school engagement. Immigration related concerns and transportation barriers reduced service use. Providers described North–South disparities in nonprofit presence and access, with rural towns like Los Alamos particularly isolated.

Housing is a huge problem here in Santa Maria. Most children grow up very differently than I did. There'll be five family members in a room designed for one or maybe two people... So yeah, there's just not enough room to be a kid and play and have some alone time where you can just be quiet or kick a ball and not worry that it's going to run out into the street. – Service Provider

Emerging Themes

Several forces shape how families and providers experience children’s health in Santa Barbara County:

1. Behavioral health needs are widespread and under-resourced. Families described stigma, long waits, and shortages of pediatric-trained, bilingual providers.
2. Service shortages and long waitlists create delays for developmental evaluations, mental health counseling, and specialty pediatric care.
3. Language access and gaps in culturally responsive care remain barriers, especially for Indigenous and Mixteco-speaking families.
4. Work schedules, transportation, and childcare make it difficult for families to access preventive and specialty services.
5. Schools play a pivotal role in children’s health, but resources vary widely across districts and campuses.
6. Trauma and immigration related concerns influence children’s learning, behavior, and overall health.
7. Navigation challenges and fragmented systems leave families without clear entry points or consistent follow-up.

Actionable Solutions

Community members and providers highlighted solutions that would make children’s health services more accessible, coordinated, and responsive to family needs. These include:

- Reduce wait times for evaluations and therapies by adding local developmental specialists and investing in early screening and referral pathways.
- Strengthen navigation and community health worker models to guide families through healthcare, behavioral health, education, and social services.
- Invest in safe parks, affordable afterschool programs, and culturally tailored nutrition initiatives to address obesity and asthma.
- Increase access to well-child and dental care with mobile clinics, expanded clinic hours, and co-located services at schools and community hubs.
- Expand bilingual and culturally responsive behavioral health capacity through school-based services, telehealth, and community programs.
- Develop one-stop family centers and school wellness hubs integrating medical, counseling, case management, and benefits enrollment services.
- Support trauma-informed practices in schools, clinics, and social services to address the impact of trauma and immigration stress.
- Address upstream drivers—housing, food, childcare, transportation, and income supports—as essential elements of children’s health policy.
- Recruit and retain pediatric and behavioral health professionals by building local training pipelines and offering incentives for service in Medi-Cal populations.

Additional Listening Tour secondary data analysis will be forthcoming on the Cottage Health website. A complete list of resources with links is provided in Appendix C. Additional resources can also be found at [ConnectSBC.org](https://www.connectsbc.org).

Chronic Conditions

Chronic health conditions are long-lasting or recurring diseases that require ongoing medical care, limit daily activities, or both.⁵³ Common examples include heart disease, cancer, and diabetes, and are leading causes of death, disability, and rising healthcare costs in the US.⁵⁴ While many conditions cannot be cured or prevented by vaccines, they are often manageable through early detection, healthy behaviors, and medical treatment. Most are linked to preventable risk factors such as tobacco use, poor nutrition, physical inactivity, excessive alcohol use, and air pollution.⁵⁵

Overview

Chronic conditions remain among the most pressing health challenges in Santa Barbara County, driving premature illness and death and shaping daily life for thousands of residents. The [2022 CHNA](#) identified chronic conditions as a priority health need in Santa Barbara County. In the 2025 CHNA, cardiovascular disease, cancer, and diabetes stood out as persistent contributors to premature mortality. Respiratory illnesses, including asthma and COPD, compounded existing disparities, while Alzheimer’s disease emerged as a growing concern due to population aging and limited caregiving infrastructure.²

Secondary Data

Analysis of recent secondary data confirms that racial and socioeconomic inequities remain entrenched. In addition, obesity and food insecurity are most common among households with lower education and income. Despite progress in areas such as declining COPD and cancer deaths, inequities have not narrowed.

Listening Tour Findings

Listening Tour participants described what these numbers mean in lived experiences. Residents spoke of chronic illness as an “everyday new reality,” requiring constant adjustment and often competing with basic needs like food and housing. Stigma and fear—particularly within immigrant communities—were cited as reasons people delay or avoid care. Housing instability and the high cost of nutritious foods were seen as major obstacles to prevention and management, while many emphasized the importance of long-term trust with providers and frustration with fragmented care systems. These themes reveal the mechanisms behind the disparities seen in the data and underscore how structural conditions drive inequitable outcomes.

Listening Tour participants shared potential solutions for addressing chronic conditions. Overall, they felt that preventing and managing chronic disease will require upstream investments in food and housing security, safe and supportive environments, and culturally responsive and linguistically appropriate care, alongside stronger care coordination and continuity. Progress will depend on aligning clinical and community systems so that residents encounter consistent support across settings, rather than facing fragmented services.

Chronic Conditions Findings

Heart Disease, Diabetes, and Obesity

Santa Barbara County residents struggle to manage many chronic conditions, including cardiovascular conditions like heart disease and stroke and metabolic disorders like diabetes and obesity.

- Heart disease remains the leading cause of death, with a rate of 206.1 per 100,000 residents in Santa Barbara County—slightly below the statewide rate of 208.8 per 100,000 (2021–2023).²⁷
- Stroke death rates were 48.4 per 100,000 residents in Santa Barbara County, higher than the statewide rate of 41.4 per 100,000 (2021–2023).²⁷
- Diabetes-related death rates were higher among men (14.1 per 100,000) than women (6.8 per 100,000) in Santa Barbara County, with an overall rate of 10.0 per 100,000 (2021–2023).²⁷
- Obesity continues to be an upstream driver—in 2022, more than 40% of adults without a high school diploma were classified as obese, compared to much lower rates among college-educated residents (20.1%). In addition, those with diabetes report obesity at 57.6% compared to the county average of 27.6%.⁴³

Listening Tour participants described diabetes as an epidemic in Santa Barbara County, beginning at younger ages and leading to complications such as blindness, amputations, and early death. They noted the strong connection between diabetes, obesity, high blood pressure, and cholesterol—conditions that disproportionately affect those with lower incomes. Residents and providers cited a lack of prevention programs and culturally tailored education. Hypertension was described as a “silent killer,” often undiagnosed until serious damage occurs.

Hypertension is... the silent killer, because no one feels bad until it causes organ damage. – Advanced Practice Provider

Cancer

Cancer remains a leading cause of death in Santa Barbara County, reflecting persistent disparities by cancer type and access to treatment.

- Cancer continues to drive death rates, with prostate (22.5 per 100,000 residents), lung (22.1), and breast (19.1) cancer the leading causes of cancer-related death (2021–2023).²⁷
- The overall cancer death rate in Santa Barbara County was 137.8 per 100,000 residents, comparable to the statewide rate of 135.3 per 100,000 (2021–2023).²⁷
- Men experienced higher cancer death rates (157.4 per 100,000) than women (123.8 per 100,000) in Santa Barbara County (2021–2023), a trend consistent statewide.²⁷

Listening Tour participants described how cancer is increasingly managed as a long-term condition. Patients often live many years with cancer, but experience depression, fatigue, financial hardship, and disruptions to relationships. Families described difficulty traveling for out-of-county treatment and limited access to transportation, lodging, and social work services to support ongoing care.

I see a lot of cancer patients who've been alive for a long time living with cancer. And there's a lot of depression, divorce, financial ruin that comes along with that. – Physician

Respiratory Conditions

Chronic respiratory illnesses, such as asthma and COPD, continue to affect many residents, with higher burdens among men, children, and low-income populations.

- COPD deaths have declined from 34.5 per 100,000 residents in 2000-2002 to 20.4 per 100,000 in 2021-2023, yet remain higher among men (22.0 per 100,000 in 2021-2023).²⁷
- Lifetime asthma prevalence among adults was 17.2% in Santa Barbara County, compared to 15.2% statewide (2021), fluctuating between 10% and 20% between 2015 and 2021.⁴⁴
- Asthma-related emergency department visits occurred at a rate of 21.3 per 10,000 residents in Santa Barbara County, below the statewide rate of 34.9 (2023).⁴⁴

Listening Tour participants described asthma and other chronic respiratory illnesses as persistent concerns, especially for children. Participants emphasized the importance of affordability and medication adherence, noting that economic pressures often prevent consistent management of chronic lung conditions.

[My patient's] asthma might not be as controlled as it could be if they could afford their regular medications just to keep good maintenance of their asthma.
– Healthcare Provider

Alzheimer's and Dementia

Neurological disorders such as Alzheimer's disease and other dementias are increasing in prevalence, particularly among older adults and women.

- Alzheimer's disease and related dementias accounted for a death rate of 60.2 per 100,000 residents in Santa Barbara County (2021–2023), slightly below the state at 66.3 per 100,000 residents.²⁷
- Death associated with Alzheimer's disease and related dementias occurred more frequently among women (66.6 per 100,000) than men (49.8) (2021–2023).²⁷

Listening Tour participants described neurological care as a significant gap in the county. Families often travel far distances—sometimes to Los Angeles—for specialty neurology appointments. Long waits for specialists locally, including endocrinologists and neurologists, delay diagnosis and treatment, increasing the burden on primary care providers.

*Dementia and Alzheimer's associated or cognitive impairment type conditions... that's another chronic condition I'm seeing a lot more of and having a harder time managing, especially the more mild to moderate cases that don't really qualify for services and that are being solely managed by the family are very nuanced. There are not many medications out there for it.—
Advanced Practice Provider*

Substance Use Factors

Substance use including tobacco use, alcohol consumption, and other substance use contribute significantly to the county's chronic disease burden.

- Current cigarette smoking among adults in Santa Barbara County was 4.7% in 2022, compared to 8.8% statewide in 2021.⁴⁵
- Smoking prevalence was higher among men (5.6%) than women (4.0%) and among adults with less than a high school education (12.5%) compared to college graduates (0.8%) (2022).⁴⁵
- Binge drinking among adults in Santa Barbara County was 21.1% in 2022, higher than the statewide rate of 14.9% in 2021.⁴⁶
- Binge drinking rates were higher among men (25.5%) than women (17.7%) (2022).⁴⁶
- Drug overdose mortality nearly tripled, rising from 11.3 deaths per 100,000 residents in 2009–2011 to 32.3 in 2021–2023, with the highest rates among men ages 35–44 (67.9).²⁷

Listening Tour participants described the ways behavioral risk factors intersect with chronic disease. Poor diet, limited exercise, and tobacco and substance use contribute to illness, while depression and anxiety make self-care more difficult. Youth mental health needs continue to grow, and stigma around obesity, HIV, and substance use keeps many from seeking help. Participants also cited the influence of social media on behaviors such as smoking and vaping, both as a source of risk and as a potential tool for outreach.

*Active substance use is a trauma, and so many of our clients are just living in a constant state of survival from day to day, sometimes hour to hour.
— Service Provider*

Social and Structural Drivers

Social and structural drivers such as housing instability, food insecurity, and limited access to transportation and preventive care exacerbate chronic disease risks and outcomes across communities.

- Physical inactivity is more common among residents with low income and limited education in 2022, contributing to obesity and cardiovascular risk.⁴⁷
- In 2022, one in four adults reported food insecurity, with rates surpassing 50% among those without a high school diploma.⁴⁸

Listening Tour participants described how housing instability and homelessness disrupt access to care and medication, compounded by trauma and substance use. Transportation barriers—especially for older adults and North County families—limit attendance at appointments and access to healthy food. Food insecurity and a lack of culturally appropriate education on how to eat nutritiously worsen conditions such as diabetes and obesity. Caregivers described heavy burdens balancing jobs, family needs, and health responsibilities without affordable support.

They don't know where they're eating tonight for dinner, so there's no conscious awareness of, 'Oh, I need to go get my lab work done,' or 'I need to go to my doctor for my annual visit.' They're worried about where they're sleeping tonight and what food they're going to eat next and if they even have access to food, let alone healthy food. – Service Provider

Emerging Themes

Several forces shape how people experience chronic illness:

1. Concerns related to immigration status prevent many from seeking care or using benefits.
2. Stigma and isolation around illness, mental health, and homelessness discourage help-seeking.
3. Culturally and linguistically competent care and trusted networks (such as community health workers, churches, and peer support) are essential, yet services in Spanish and Mixteco remain limited.
4. Social media influences beliefs and behaviors, often spreading misinformation, while also offering opportunities for outreach.

Actionable Solutions

Community members and providers highlighted solutions that make care easier, more supportive, and more culturally responsive. These include:

- Expand whole-person, team-based care models with physicians, nurses, social workers, and health coaches working together.
- Offer practical, multilingual education on nutrition, medication, and self-care through health coaching and community workshops.
- Strengthen navigator and community health worker programs to help families access benefits and local resources.
- Improve data sharing, discharge planning, and follow-up to prevent care gaps.
- Support social needs such as healthy meals, transportation, housing, and caregiver respite.
- Increase specialist capacity through recruitment, telehealth, and expanded nursing roles.
- Invest in prevention and community partnerships to reduce avoidable emergency visits and hospitalizations.

These findings highlight the persistent disparities shaping chronic disease outcomes and reinforce the need for integrated prevention, culturally and linguistically competent care, and structural interventions to address the root causes of illness. Additional Listening Tour secondary data analysis will be forthcoming on the Cottage Health website. A complete list of resources to support with chronic conditions in Santa Barbara County is provided in Appendix C. Additional resources can also be found at [ConnectSBC.org](https://www.connectsbc.org).

DATA SOURCES AND METHODS

The 2025 CHNA followed a mixed-methods approach, incorporating primary data collection with analysis of the most recent available secondary data for Santa Barbara County and the state of California. Topic selection was guided by input from community stakeholders and informed by current trends identified in state and county health indicators. Based on identified needs from previous assessments and stakeholder consensus, the 2025 CHNA sought to understand the broad health and well-being needs in Santa Barbara County and the needs within three focus areas: maternal health, children's health, and chronic conditions.

Focus Area Identification

In 2022, Cottage Health and County of Santa Barbara Health Department conducted a CHNA with a focus on maternal health equity, youth behavioral health, and COVID-19 impacts as well as detailed analysis of eighteen health indicators. Together, these focus areas and indicators provided a portrait of the health and well-being of the county's population and its many subgroups. The 2025 CHNA analysis sought to build on these findings through further investigation of these prioritized health needs.

The 2025 CHNA Collaborative began this assessment by conducting an in-depth review of the 2022 CHNA learnings and facilitating conversations with the Collaborative and community partners to identify emergent local health needs. The CHNA Collaborative recognized gaps in collective understanding of three topic areas:

1. **Maternal health**
2. **Children's health**
3. **Chronic conditions**

The 2025 CHNA Collaborative further defined the following sub-focus areas.

Maternal Health

Within maternal health, the CHNA focused on assets, resources, gaps, and disparities in the community, including for the following:

1. Access to timely care when pregnant, including:
 - a. Pregnancy loss
 - b. Fertility treatments
2. Mental health
3. Breastfeeding
4. Gestational diabetes

Children's Health

Within children's health, the CHNA focused on better understanding previously identified needs, including for the following:

1. Access to care
 - a. Chronic conditions
 - b. Preventive services and developmental screenings
2. Behavioral health
 - a. Trauma
3. Social drivers of health (e.g., poverty, homelessness, education, English language learners)

Chronic Conditions

Within chronic conditions, the CHNA focused on gaining a broad-based understanding of needs and assets, including for the following:

1. Priority chronic conditions
2. Access to care
3. Continuity of care
4. Social drivers of health (e.g., homelessness/housing)
5. Living with chronic conditions

These focus areas and subareas guided the 2025 CHNA's data collection, analysis, and community engagement efforts to better understand the needs of residents and how to improve health outcomes in Santa Barbara County.

Data Collection and Analysis

This assessment integrated secondary data from publicly available federal, state, and local sources to describe key health trends and disparities across the county. These findings were complemented by qualitative insights from a Listening Tour with community health partners, which explored lived experiences and barriers underlying quantitative trends. Together, these data sources provided a comprehensive understanding of community conditions and informed the selection of focus areas for further exploration.

Details on methodology for secondary data analysis and the Listening Tour are included in Appendix A and Appendix B, respectively.

Prioritization of Health Needs

Prioritization Process

Needs and opportunities within maternal health, children’s health, and chronic conditions were prioritized through a process that emphasized rigor, community input, and transparency. A prioritization survey requested input from community representatives and leaders. Using a scoresheet, priority areas were identified within maternal health, children’s health, and chronic conditions.

Key qualitative data findings emerging from the 2025 Listening Tour and secondary data analysis informed prioritization within the priority areas defined from the 2022 CHNA. Final priorities were determined in collaboration between the County of Santa Barbara Health Department and Cottage Health.

The prioritization process included the following elements:

1. Prioritization Survey

Community representatives who attended or were invited to attend the Listening Tour focus groups and interviews were engaged again through an anonymous online prioritization survey, which can be found in Appendix F. Respondents prioritized the sub-focus areas and secondary data indicators in maternal health and children’s health and the most frequently mentioned chronic conditions based on the following criteria:

- Need
- Urgency
- Collaboration efforts among community organizations
- Health disparities

The prioritization survey also asked respondents to identify potentially available resources to address these health indicators and provide written comments on the 2022 CHNA Report and Implementation Strategy. These responses are summarized in Appendix D.

2. Prioritization Scoresheet

Prioritization was conducted using a scoresheet (see Table 3). Indicators were rated against four criteria:

- **Need:** The extent to which the indicator was identified as a priority health need by community stakeholders
- **Urgency:** How strongly the issue is perceived as an immediate or critical concern
- **Collaboration:** The level of existing collaboration among community organizations working to address the issue
- **Disparities:** The extent to which specific populations are disproportionately affected by the health area

Within maternal health, children’s health, and chronic conditions, the sub-focus areas, secondary data indicators, and chronic conditions were ranked as low, medium, or high by respondents. Indicators rated with the highest or worst outcome from survey respondents were assigned a -1, the middle outcome was assigned a score of 0, and the lowest outcome was assigned a score of +1. A total of 27 indicators were assessed for each criterion. The results were as follows by each criterion:

- **Need:**
 - 23 indicators were rated as “significant need exists within our community” and assigned a score of -1.
 - 4 indicators were rated as “some need exists in our community” and assigned a score of 0.
 - No indicators were rated as “no need exists in our community” and assigned a score of +1.

The distribution suggests that nearly all indicators were seen as high priority needs by respondents, with very few rated as moderate, and none seen as low need.

- **Urgency:**
 - 16 indicators were rated as having “significant urgency” and assigned a score of -1.
 - 11 indicators were rated as having “some urgency” and assigned a score of 0.
 - No indicators were rated as having “no urgency” resulting in no indicators receiving a score of +1.

This distribution suggests that while a majority of indicators are seen as urgent, some are considered moderately time-sensitive, and none were seen as low-priority in terms of timeliness.

- **Collaboration:**
 - No indicators were identified as having “no effective collaboration” or “a lot of effective collaboration,” resulting in no indicators receiving a score of -1 or +1.
 - All 27 indicators were rated as having “a little effective collaboration” and received a score of 0.

This distribution suggests that respondents viewed collaboration efforts across indicators as generally moderate, without notable strengths or gaps.

- **Disparities:**
 - All 27 indicators were rated as “greatly impacts certain populations disproportionately” and received a score of -1.
 - No indicators were rated as having a “small impact on certain populations disproportionately” or “does not affect certain populations disproportionately,” resulting in no indicators being assigned a score of 0 or +1.

This result suggests that respondents consistently perceived inequities as relevant across all priority areas.

The score on each criterion was totaled, with a possible maximum score of +4 and a minimum score of -4. A score of -4 meant the sub-area/indicator/chronic condition performed poorly, demonstrating a priority need, whereas a score of +4 meant the indicator performed well.

Table 3. Prioritization Scoresheet

| Areas and Indicators | Need (-1, 0, +1) | Urgency (-1, 0, +1) | Collaboration (-1, 0, +1) | Disparities (-1, 0, +1) | Total |
|---|---------------------|------------------------|------------------------------|----------------------------|-------|
| Maternal Health | | | | | |
| Access to timely care when pregnant | -1 | -1 | 0 | -1 | -3 |
| Breastfeeding education and support | -1 | 0 | 0 | -1 | -2 |
| Fertility care | -1 | -1 | 0 | -1 | -3 |
| Gestational diabetes | -1 | 0 | 0 | -1 | -2 |
| Perinatal mental health | -1 | -1 | 0 | -1 | -3 |
| Pregnancy and infant loss | 0 | 0 | 0 | -1 | -1 |
| Serious health complications during or after childbirth | 0 | 0 | 0 | -1 | -1 |
| Substance use during pregnancy | 0 | 0 | 0 | -1 | -1 |
| Children's Health | | | | | |
| Access to care | -1 | -1 | 0 | -1 | -3 |
| Chronic conditions (asthma, diabetes, obesity) | -1 | -1 | 0 | -1 | -3 |
| Education readiness (specific to English language learners) | -1 | 0 | 0 | -1 | -2 |
| Food insecurity | -1 | -1 | 0 | -1 | -3 |
| Poverty | -1 | -1 | 0 | -1 | -3 |
| Preventive services and developmental screenings | -1 | -1 | 0 | -1 | -3 |
| Trauma | -1 | 0 | 0 | -1 | -2 |
| Unstable housing | -1 | -1 | 0 | -1 | -3 |
| Youth behavioral health (mental health, substance use) | -1 | -1 | 0 | -1 | -3 |
| Chronic Conditions | | | | | |
| Alzheimer's/Dementia | -1 | -1 | 0 | -1 | -3 |
| Asthma | 0 | 0 | 0 | -1 | -1 |
| Cancer | -1 | 0 | 1 | -1 | -1 |

| Areas and Indicators | Need (-1, 0, +1) | Urgency (-1, 0, +1) | Collaboration (-1, 0, +1) | Disparities (-1, 0, +1) | Total |
|---|---------------------|------------------------|------------------------------|----------------------------|-------|
| Chronic Conditions | | | | | |
| Cardiovascular health | -1 | 0 | 0 | -1 | -2 |
| Diabetes | -1 | -1 | 0 | -1 | -3 |
| Hypertension | -1 | -1 | 0 | -1 | -3 |
| Mental health | -1 | -1 | 0 | -1 | -3 |
| Neurological and developmental conditions | -1 | 0 | 0 | -1 | -2 |
| Obesity | -1 | -1 | 0 | -1 | -3 |
| Substance use disorders | -1 | -1 | 0 | -1 | -3 |

3. Identification of Priorities

The following process was used to identify priority areas.

First, from the twenty-seven sub-areas/indicators/chronic conditions in the scoresheet, twenty-two indicators with an overall total score of -2 or less (i.e., -2, -3, and -4) were prioritized within the topics of maternal health, children's health, and chronic conditions. This includes the following:

- Maternal Health
 - Access to timely care when pregnant
 - Breastfeeding education and support
 - Fertility care
 - Gestational diabetes
 - Perinatal mental health
- Children's Health
 - Access to care
 - Chronic conditions (asthma, diabetes, obesity)
 - Education readiness (specific to English language learners)
 - Food insecurity
 - Poverty
 - Preventive services and developmental screenings
 - Trauma
 - Unstable housing
 - Youth behavioral health (mental health, substance use)
- Chronic Conditions
 - Alzheimer's/Dementia
 - Cardiovascular health
 - Diabetes
 - Hypertension
 - Mental health
 - Neurological and developmental conditions
 - Obesity
 - Substance use disorders

Three indicators were not prioritized in maternal health: (1) Pregnancy and infant loss, (2), serious health complications during or after childbirth, and (3) substance use during pregnancy. Two indicators were not prioritized in children's health: (1) asthma and (2) cancer.

Second, these twenty-two sub-areas/indicators/chronic conditions were grouped into six priority areas that represent overarching areas of health need across the county:

1. Access to Care
2. Behavioral Health
3. Chronic Conditions
4. Maternal Health
5. Resiliency
6. Social Needs

See Table 4 for an overview of this alignment.

Third, Santa Barbara County demographics data, including data from the 2022 CHNA, were reviewed within the context of these six priority areas. This highlighted health and well-being needs among the broader population within the six priority areas, which were also adopted as part of the priority areas.

These priorities and related analyses were shared with CHNA Collaborative leaders, including Cottage Health leaders. The selection of interventions to address priority areas in 2025 and beyond is set forth in the implementation strategy.

Table 4. Sub-areas, Indicators, and Chronic Conditions by Priority Areas

| Sub-area, Indicator, or Chronic Condition | Access to Care | Behavioral Health | Chronic Conditions | Maternal Health | Resiliency | Social Needs |
|---|----------------|-------------------|--------------------|-----------------|------------|--------------|
| Maternal Health | | | | | | |
| Access to timely care when pregnant | ✓ | | ✓ | ✓ | | |
| Breastfeeding education and support | ✓ | | | ✓ | | ✓ |
| Fertility care | ✓ | | ✓ | ✓ | | |
| Gestational diabetes | ✓ | | ✓ | ✓ | | |
| Perinatal mental health | ✓ | ✓ | | ✓ | | |
| Children's Health | | | | | | |
| Access to care | ✓ | | | | | |
| Chronic conditions (asthma, diabetes, obesity) | ✓ | | ✓ | | | |
| Education readiness (specific to English language learners) | | | | | ✓ | ✓ |
| Food insecurity | | | | | | ✓ |
| Poverty | | | | | | ✓ |
| Preventive services and developmental screenings | ✓ | | | | ✓ | ✓ |
| Trauma | ✓ | ✓ | | | ✓ | |
| Unstable housing | | | | | | ✓ |
| Youth behavioral health (mental health, substance use) | ✓ | ✓ | | | ✓ | |
| Chronic Conditions | | | | | | |
| Alzheimer's/Dementia | ✓ | ✓ | ✓ | | | |
| Cardiovascular health | ✓ | | ✓ | | | |
| Diabetes | ✓ | | ✓ | | | |
| Hypertension | ✓ | | ✓ | | | |
| Mental health | ✓ | ✓ | ✓ | | ✓ | |

| Sub-area, Indicator, or Chronic Condition | Access to Care | Behavioral Health | Chronic Conditions | Maternal Health | Resiliency | Social Needs |
|---|----------------|-------------------|--------------------|-----------------|------------|--------------|
| Chronic Conditions | | | | | | |
| Neurological and developmental conditions | ✓ | | ✓ | | | |
| Obesity | ✓ | | ✓ | | | |
| Substance use disorders | ✓ | ✓ | ✓ | | | |

Data Limitations and Information Gaps

The 2025 CHNA relies on two evidence streams: (1) secondary data from publicly available sources and (2) qualitative information gathered through the Listening Tour. As with any assessment, limitations and information gaps remain. The CHNA does not measure every aspect of health nor fully represent all subpopulations. Certain groups—such as people experiencing homelessness, institutionalized persons, rural residents, pregnant people, undocumented residents, LGBTQ+ residents, and smaller racial/ethnic or immigrant communities—may be difficult to identify in secondary datasets or may be represented in numbers insufficient for distinct analyses. The corollary is also true: when a subgroup is small within Santa Barbara County, drawing meaningful conclusions about that population is inherently difficult and must be approached with caution to avoid over-interpreting statistically unstable data or anecdotal observations. Where demographic differences are reported, they are included for transparency and to inform further inquiry—not as the basis for identity-based assumptions or interventions prohibited under federal law.

Specific Limitations: Secondary Data

- Reporting lag and comparability:** Some indicators have a 1–3 year lag between the time data are collected and when they are published. Method changes over time (including pandemic-era adjustments) can affect comparability across years or sources.
- Geographic granularity:** Not all sources publish sub-county (city/ZIP/tract) estimates. Where only countywide data are available, neighborhood-level variation may be obscured.
- Stratification availability:** Stratified results (e.g., by race/ethnicity, language, age, insurance) are only shown when the original source publishes reliable estimates. Small subgroup sizes may preclude reporting or lead to wide confidence intervals.
- Suppression and reliability flags:** To protect privacy and avoid unstable estimates, many sources suppress small counts or label estimates as statistically unreliable. Suppressed or unreliable values limit comparisons and may create apparent gaps in tables or figures.
- Definition and denominator differences:** Indicators from different publishers may use non-identical case definitions, time windows, or denominator populations. Cross-source comparisons are therefore limited to like-for-like measures from the same source.
- Survey-based estimates:** Some indicators originate from sample surveys. Sampling error, nonresponse, and mode effects (phone/web) can introduce uncertainty, especially for small geographies and subgroups.

- **Administrative data constraints:** Indicators derived from administrative systems reflect service use or reporting practices and may under-ascertain conditions among people with limited access to care or outside formal systems.

Specific Limitations: Listening Tour

- **Group dynamics:** In mixed-role discussions, participation may be influenced by power dynamics (e.g., organizational leaders with frontline staff), which can shape what is and is not shared.
- **Duplicate participation:** Some individuals may have contributed in more than one session, potentially amplifying specific perspectives.
- **Geographic balance:** While many participants offered countywide perspectives, some areas may be over- or under-represented relative to population or need.
- **Participant characteristics:** Limited demographic detail and the absence of occupation/work-location fields constrain subgroup analyses (e.g., differentiating viewpoints by professional role or service area).
- **Qualitative scope:** Findings reflect the experiences and perceptions of participants and are not statistically generalizable; they are intended to complement, not replace, quantitative indicators.

Despite these limitations, the 2025 CHNA applies consistent inclusion rules (use of publisher definitions, units, stratifications, and suppression conventions) and documents all sources and data vintages in Appendix A. Together, the secondary indicators and Listening Tour insights provide a coherent, actionable picture of community health needs while acknowledging areas where additional data collection or improved reporting would strengthen future assessments.

Interpretive Note on Subgroup Data

Consistent with Cottage Health's nondiscrimination obligations under Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, and other applicable laws, these data do not imply or authorize conclusions, preferences, or interventions on any basis prohibited by law. All findings are intended to guide further inquiry and improvement in care for all residents.

Conducting and Writing the CHNA

The 2025 Community Health Needs Assessment for Santa Barbara County strategically engaged a consultant and partners to gain a comprehensive understanding of residents’ health and well-being needs.

2025 CHNA Collaborative

The 2025 CHNA Collaborative worked together to plan and execute CHNA activities. Involvement included participation in the planning and implementation meetings, recruitment of Listening Tour participants and engagement of community partners.

Cottage Center for Population Health

Cottage Center for Population Health (CCPH) led the development of the framework for the 2025 CHNA and managed the project. CCPH coordinated community partners and multiple consultants, conducted the prioritization process to enable the selection of priorities, and managed the development of this comprehensive report. Population Health will also lead development of the implementation strategy.

Population Health Innovation Lab

The Population Health Innovation Lab (PHIL), a program of the Public Health Institute, served as Cottage Health’s comprehensive partner for the 2025 CHNA, overseeing project coordination; leading the secondary data component (indicator selection aligned to 2019+ data, county and sub-county extraction where available, equity stratifications, quality assurance, and development of methods and limitations); planning and implementing the Listening Tour (instrument design, recruitment, data collection, and qualitative analysis); integrating secondary and qualitative findings into concise summaries for the maternal health, children’s health, and chronic conditions focus areas; and preparing publication-ready report content and appendices with transparent sources, data vintages, and technical documentation for partner review and final release.

IRS Form 990, Schedule H Compliance

For nonprofit hospitals, a Community Health Needs Assessment also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals’ reporting on IRS Form 990 Schedule H, the following list cross-references related sections.

| | |
|---|---------------------------------------|
| Part V Section B Line 1a | Beginning on Page 8 |
| A definition of the community served by the hospital facility | |
| Part V Section B Line 1b | Beginning on Page 10 |
| Demographics of the community | |
| Part V Section B Line 1c | Beginning on Page 65 |
| Existing health care facilities and resources within the community that are available to respond to the health needs of the community | |
| Part V Section B Line 1d | Beginning on Pages 34, 51, and 53 |
| How data were obtained | |
| Part V Section B Line 1e | Beginning on Pages 10, 18, 23, and 28 |
| The health needs of the community | |

Part V Section B Line 1f Addressed Throughout
Primary and chronic disease needs and other health issues of medically underserved, low-income, and minority populations

Part V Section B Line 1g Beginning on Page 35
The process for identifying and prioritizing community health needs and services to meet the community health needs

Part V Section B Line 1h Beginning on Page 53
The process for consulting with persons representing the community's interests

Part V Section B Line 1i Beginning on Page 41
Information gaps that limit the hospital facility's ability to assess the community's health needs

CONCLUSIONS

The 2025 Community Health Needs Assessment highlights a clear continuum: maternal health, children’s health, and chronic conditions are interconnected across the life course. Early advantages—or disadvantages—accumulate over time, shaping birth outcomes, childhood development, and the onset of chronic illness in adulthood. In Santa Barbara County, structural conditions such as housing instability, food insecurity, limited language access, workforce shortages, and fragmented systems of care continue to drive poor health outcomes.

At the same time, Santa Barbara County has substantial strengths. Trusted community organizations, community health workers and navigators, school-based programs, behavioral health providers, and committed healthcare partners form a strong foundation for coordinated action. Aligning these assets toward shared goals presents a powerful opportunity to close gaps and improve health for all residents.

Moving forward, progress will require an integrated strategy that combines prevention with coordinated care. Priority actions include expanding culturally and linguistically competent care (including Mixteco interpretation); strengthening perinatal and pediatric behavioral health; improving continuity across prenatal, postpartum, and primary care; and embedding navigation, benefits enrollment, and social supports—such as housing, food, transportation, and childcare—within trusted settings like clinics, schools, and community hubs. Data-driven targeting should focus resources in areas of greatest need, particularly North County and high-poverty neighborhoods. Cross-sector collaboration will be essential to advance solutions such as one-stop perinatal and family wellness hubs, coordinated gestational diabetes and obesity prevention efforts, and workforce pipelines for pediatric and behavioral health care.

The CHNA Collaborative will translate these findings into a shared action plan with clear goals, metrics, and regular public reporting. By aligning clinical care, public health, education, and community partners—and centering resident voices in design and decision-making—Santa Barbara County can advance health and well-being across generations.

Citation

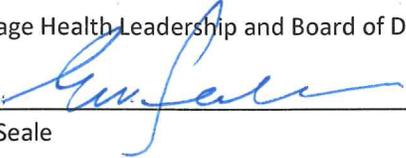
These findings will be useful to future health improvement work and contribute to a healthier community. Please use the following citation:

2025 CHNA Collaborative (2025). *Community Health Needs Assessment Report for Santa Barbara County, 2025*. Santa Barbara, CA.

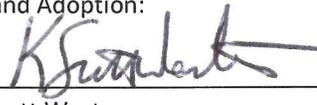
Adoption of Community Health Needs Assessment

On December 5, 2025, the Cottage Health Board of Directors met to discuss this 2025 Community Health Needs Assessment Report for Santa Barbara County. Upon review, the Board of Directors approved this Community Health Needs Assessment Report 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:



Eric Seale
Chair
Cottage Health
Board of Directors



Scott Wester
President & CEO
Cottage Health

12.5.25
Date

12-5-25
Date

References and Resources

1. Halfon, N., & Hochstein, M. (2002). Life course health development: An integrated framework for developing health, policy, and research. *The Milbank Quarterly*, 80(3), 433–479. <https://doi.org/10.1111/1468-0009.00019>
2. Cottage Health. (2022). *Community Health Needs Assessment Report 2022 for Santa Barbara County*. <https://content.civicplus.com/api/assets/05745f31-138d-4bbd-9d81-e56d055b409f>
3. World Health Organization. (2024). *Social determinants of health*. <https://www.who.int/health-topics/social-determinants-of-health>
4. Census Reporter. (2023). *Santa Barbara County, CA profile (05000US06083)*. <http://censusreporter.org/profiles/05000US06083-santa-barbara-county-ca/>
5. U.S. Census Bureau. (2023). *American Community Survey 5-year estimates, 2018–2023*. <https://data.census.gov/>
6. California Housing Partnership. (2024). *Santa Barbara County 2024 affordable housing needs report*. https://chpc.net/wp-content/uploads/2024/05/Santa-Barbara_Housing_Report.pdf
7. U.S. Census Bureau. (2023). *Disability characteristics (Table S1810): American Community Survey 5-year estimates, 2019–2023*. U.S. Department of Commerce. <https://data.census.gov/table/ACSST5Y2023.S1810?q=S1810>
8. Agency for Healthcare Research and Quality. (2022, October). *2022 National healthcare quality and disparities report: Maternal health*. U.S. Department of Health and Human Services. <https://www.ncbi.nlm.nih.gov/books/NBK587184/>
9. Centers for Disease Control and Prevention. (2024, June 3). *Maternal health indicator definitions*. U.S. Department of Health and Human Services. <https://www.cdc.gov/cdi/indicator-definitions/maternal-health.html>
10. Laraia, B. A., Gamba, R., Saraiva, C., Dove, M. S., Marchi, K. S., & Braveman, P. A. (2022). Severe maternal hardships are associated with food insecurity among low-income women during pregnancy: Results from the 2012–2014 California Maternal Infant Health Assessment. *BMC Pregnancy and Childbirth*, 22(1), 138. <https://doi.org/10.1186/s12884-022-04464-x>
11. World Health Organization. (2025). *Maternal health*. https://www.who.int/health-topics/maternal-health#tab=tab_1
12. California Department of Public Health. (2025). *Prenatal care surveillance data*. <https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Prenatal-Care.aspx>
13. California Department of Public Health. (2024). *Breastfeeding initiation statistics*. <https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Breastfeeding-Initiation.aspx>
14. California Department of Public Health. (2025). *Severe maternal morbidity data*. <https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Severe-Maternal-Morbidity.aspx>

15. California Department of Public Health. (2025). *Maternal health conditions at delivery*. <https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Maternal-Health-Conditions-at-Delivery.aspx>
16. California Department of Public Health. (2025). *Maternal and Infant Health Assessment (MIHA) data snapshots dashboard*. <https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/Data-Snapshots-Dashboard.aspx>
17. Santa Barbara County Public Health Department. (2025). *Hypertension charts from birth certificate survey data of Santa Barbara County residents (data extracted March 2025 from the California Vital Records BI System)* [Unpublished data].
18. California Department of Public Health. (2025). *Preterm birth data*. <https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Preterm-Birth.aspx>
19. California Department of Public Health. (2025). *Low birthweight statistics*. <https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Low-Birthweight.aspx>
20. California Department of Public Health. (2025). *Delivery methods data*. <https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Delivery-Methods.aspx>
21. California Department of Public Health. (2025). *Prenatal substance use surveillance data*. <https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Prenatal-Substance-Use.aspx>
22. California Department of Public Health. (2025). *Neonatal abstinence syndrome data*. <https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Neonatal-Abstinence-Syndrome.aspx>
23. United Way Santa Barbara County. (2024). *Childcare needs and assets assessment*. <https://www.unitedwaysb.org/sites/unitedwaysb/files/SBC%20Childcare%20Needs%20%26%20Assets%20Assessment%20-%20May%202024.pdf>
24. National Research Council, & Institute of Medicine. (2004). *Children’s health, the nation’s wealth: Assessing and improving child health* (Chapter 2, “Children’s health: A new conceptual framework”). National Academies Press. <https://www.ncbi.nlm.nih.gov/books/NBK92198/>
25. Stein, R. E. K. (2024). Defining child health in the 21st century. *Pediatric Research*, 96, 1438–1444. <https://doi.org/10.1038/s41390-024-03423-w>
26. WestEd, California Department of Education. (2020). *California Healthy Kids Survey (CHKS) & Biennial State CHKS—Suicidal ideation (student reported), by gender and grade level*. Retrieved from KidsData.org: <https://www.kidsdata.org/topic/1826/suicidal-ideation-gender/trend#fmt=2295&loc=273&tf=81,134&ch=78,305,306,431,1177&>
27. California Department of Public Health. (2025). *Community burden of disease dashboard*. <https://skylab.cdph.ca.gov/communityBurden/>

28. WestEd, California Department of Education. (2020). *California Healthy Kids Survey (CHKS) & Biennial State CHKS—Depression-related feelings, by gender and grade level*. Retrieved from KidsData.org: <https://www.kidsdata.org/table/2129/santa-barbara-unified/387/depressive-feelings-gender>
29. WestEd, California Department of Education. (2020). *California Healthy Kids Survey (CHKS) & Biennial State CHKS—Depression-related feelings, by level of school connectedness*. Retrieved from KidsData.org: <https://www.kidsdata.org/topic/389/depressive-feelings-connectedness/bar>
30. WestEd, California Department of Education. (2020). *California Healthy Kids Survey (CHKS) & Biennial State CHKS—Alcohol/drug use in past month, by level of school connectedness*. Retrieved from KidsData.org: <https://www.kidsdata.org/topic/614/alcohol-drug-connectedness/bar>
31. WestEd, California Department of Education. (2020). *California Healthy Kids Survey (CHKS) & Biennial State CHKS—Gang membership, by grade level*. Retrieved from KidsData.org: <https://www.kidsdata.org/topic/668/gang-grade/trend>
32. UCLA Center for Health Policy Research. (2022, February). *California Health Interview Survey (CHIS)—Children ever diagnosed with asthma*. Retrieved from KidsData.org: <https://www.kidsdata.org/topic/238/asthma-diagnoses/table>
33. California Department of Public Health. (2024, August). *California Breathing: Tabulation of data from the California Department of Health Care Access and Information—Asthma hospitalization rate, by age group*. Retrieved from KidsData.org: <https://www.kidsdata.org/topic/239/asthma-hospitalization-rate/trend>
34. California Department of Education. (2020). *Physical Fitness Testing Research Files: Statewide data files for the Physical Fitness Test (PFT) program—Overweight and obesity (students who are overweight or obese, by grade level)*. Retrieved from KidsData.org: <https://www.kidsdata.org/topic/725/overweight/trend>
35. CenCal Health. (2025). *CenCal Health population needs assessment 2025*. https://www.cencalhealth.org/wp-content/uploads/2025/09/2025-CenCal-Health-Population-Needs-Assessment_Final.pdf
36. First 5 Santa Barbara County. (2024). *Child development: Fiscal year 2023–2024*. <https://content.civicplus.com/api/assets/ebae38fc-fa5a-42ee-9298-e6eb34624830>
37. California Department of Education. (2021). *Special Education Division—Special education enrollment, by disability*. Retrieved from KidsData.org: <https://www.kidsdata.org/topic/96/special-education-disability/table>
38. California Department of Education. (2022, February). *Test results for California’s assessments—Students meeting or exceeding grade-level standard in English language arts (CAASPP), by grade level*. Retrieved from KidsData.org: <https://www.kidsdata.org/topic/127/reading-caaspp-grade/table>
39. California Department of Education. (2022, February). *Test results for California’s assessments—Math CAASPP scores by grade (table)*. Retrieved from KidsData.org: <https://www.kidsdata.org/topic/107/math-caaspp-grade/table>

40. Population Reference Bureau. (2020, October). *Analysis of U.S. Census Bureau American Community Survey summary files and public use microdata—Poverty by race (trend)*. Retrieved from KidsData.org: <https://www.kidsdata.org/topic/234/poverty-race/trend>
41. Feeding America. (2021, July). *Map the Meal Gap— Children living in food insecure households*. Retrieved from KidsData.org: <https://www.kidsdata.org/topic/764/food-insecurity/table>
42. California Department of Education. (2024). *Homeless enrollment by district type (2023–24 school year)*.
<https://dq.cde.ca.gov/dataquest/DQCensus/HmlsEnrByDT.aspx?agglevel=County&cds=42&year=2023-24>
43. Cottage Health. (2022). *Health indicator profile: Adult obesity*.
https://stmlcottagehealthncus001.blob.core.windows.net/public/2023_Health_Indicator_Profile_Adult_Obesity_103023.pdf
44. Tracking California. (2023). *Asthma emergency department visit rates data portal*.
https://data.trackingcalifornia.org/?area=nadm_asthma&event=ASED&type=AR10K&sex=TOTL&age=TOTL&race=TOTL&year=2023&co=
45. Cottage Health. (2022). *Health indicator profile: Smoking (cigarettes and vaping)*.
https://stmlcottagehealthncus001.blob.core.windows.net/public/2023_Health_Indicator_Profile_Smoking_103023.pdf
46. Cottage Health. (2022). *Health indicator profile: Binge drinking*.
https://stmlcottagehealthncus001.blob.core.windows.net/public/2023_Health_Indicator_Profile_Binge_Drinking_103023.pdf
47. Cottage Health. (2022). *Health indicator profile: Physical inactivity*.
https://stmlcottagehealthncus001.blob.core.windows.net/public/2023_Health_Indicator_Profile_Physical_Inactivity_103023.pdf
48. Cottage Health. (2022). *Health indicator profile: Food insecurity*.
https://stmlcottagehealthncus001.blob.core.windows.net/public/2023_Health_Indicator_Profile_Food_Insecurity_103023.pdf
49. CenCal Health. (2024). *Internal HEDIS performance data for Santa Barbara County, measurement years 2022–2023* [Unpublished dataset].
50. WestEd, California Department of Education. (2020). *California Healthy Kids Survey (CHKS) & Biennial State CHKS—Depression-related feelings, by race/ethnicity*. Retrieved from KidsData.org: <https://www.kidsdata.org/topic/388/depressive-feelings-race/bar>

APPENDIX A: SECONDARY DATA METHODS, INDICATORS, AND SOURCES

Methods

The secondary data component summarizes recent, publicly available indicators to describe Santa Barbara County's population and the three focus areas—maternal health, children's health, and chronic conditions. This assessment utilizes secondary indicators obtained from official public sources. No independent estimation, modeling, or reweighting was performed. All values are reported exactly as published by the source, including units, stratifications, and geographies. The methodology that follows describes the procedures for indicator selection, data retrieval, documentation, quality assurance, and presentation to ensure transparency and reproducibility.

Scope and Selection

Indicators were limited to data years 2019 or later and to measures published for Santa Barbara County by authoritative public agencies (e.g., CDPH/DMCAH, HCAI, CDC programs, CHIS/CHKS, CDE, U.S. Census/ACS). Within each domain, indicators were included when (1) the publisher provided a clear definition and unit of measurement; (2) Santa Barbara County estimates were available, including sub-county geographies when published; and (3) the indicator could reveal population differences based on reliable stratifications (e.g., age, sex, language, insurance status). Results are presented using the original values, definitions, units, and any suppression or reliability notations as reported by the source. Data are shown at the county level and, where available, at sub-county levels (e.g., city, ZIP/ZCTA, census tract), with disaggregation by relevant sociodemographic characteristics when provided by the source.

Retrieval and Documentation

Indicators were downloaded from the publisher's portal or dashboard or, when offered, retrieved through a public API using the publisher's parameters. For each indicator, the following metadata were recorded: official source name, dataset/dashboard title, data years/vintage, geography and stratification availability, canonical URL, date accessed, and any publisher caveats (e.g., suppression thresholds, reliability flags, series breaks). No transformations were applied beyond standardizing table formats and labels for readability.

Handling of Measures

Values are shown as published (percent, count, median, rate per 1,000 or 100,000). Age-adjusted rates or rolling multi-year rates are used only when provided by the publisher and are identified as such in figure notes. Denominators and population bases remain those used by the publisher; no substitutions were made. If a publisher suppresses small counts or flags estimates as statistically unreliable, those indicators are either shown with the publisher's symbol and footnote or omitted from comparisons, consistent with the source's guidance.

Geographies and Stratifications

County results are presented for all indicators. Sub-county (city, ZIP/ZCTA, census tract) and subgroup (e.g., age, sex, race/ethnicity, language, insurance) breakdowns are included only when the same indicator is published by the source for those units and flagged as reliable by the source.

Quality Assurance

Basic consistency checks were performed against the same publisher's totals or marginals (e.g., subgroup shares summing to 100%, county values matching dashboard tiles) and against the publisher's metadata (years/vintage, units, definitions). Any discrepancies were resolved by re-downloading the published table or by aligning to the most recent vintage documented on the publisher's page. No cross-source reconciliation was attempted when definitions differed.

Presentation Conventions

The report preserves the publisher's precision (e.g., one decimal for percentages unless the source uses whole numbers). Comparisons across geographies (e.g., county vs. state) are shown only when they originate from the same source and indicator series. Healthy People 2030 targets are referenced only when stated by the source for that indicator.

Limitations

The secondary data are subject to the reporting lags, sampling variability, suppression rules, and series changes described by their publishers. These limitations are summarized in the report's Data Limitations section and should be considered when interpreting trends or subgroup differences.

APPENDIX B:

LISTENING TOUR METHODS

The 2025 CHNA Listening Tour for Santa Barbara County aimed to uncover the stories behind statistics and identify barriers, gaps, and assets through the sharing of diverse community perspectives on priority health needs. This process expanded on secondary data analysis findings and focused on maternal health, children’s health, and chronic conditions by engaging with community leaders, families, healthcare providers, and other key stakeholders. Connecting quantitative and qualitative data while employing a variety of participatory engagement methods facilitated a deeper understanding of health priorities and ensured meaningful community engagement throughout the assessment.

Objectives

The primary purpose of the Listening Tour was to gather diverse community perspectives on priority health needs. By engaging directly with residents and stakeholders, the 2025 CHNA Listening Tour aimed to:

- Uncover the lived experiences and narratives behind statistical trends in chronic conditions, children’s health, and maternal health.
- Identify barriers, service gaps, and existing community assets that influence health outcomes among residents.
- Inform future work in advancing community health and addressing needs.

Participants

Stakeholders were organized into interviews and focus groups by the three focus areas of chronic conditions, children’s health, and maternal health. Each focus area included representation from community leaders, health care and social service providers, and community members. Based on participants’ preference, focus groups were conducted in English and Spanish, and interviews were conducted in English and Mixteco.

1. Community Leaders and Health and Social Service Providers

Santa Barbara County is home to more than 2,000 nonprofits, in addition to schools, health clinics, and other frontline organizations, all of which contribute significantly to the health and well-being of local communities. Collectively, these organizations serve as critical access points, addressing a wide spectrum of needs, including chronic disease management, children’s health, and maternal health. To effectively identify priorities and implement responsive strategies, it is essential to integrate the perspectives of both frontline practitioners, who maintain direct and consistent interactions with community members, and institutional leaders, whose decisions shape health outcomes at a structural level.

Through the CHNA Collaborative, community leaders and health and social service providers were invited to participate in the Listening Tour. Invitees included those who advocate for and represent the interests of the broader community, including medically underserved, low-income, and vulnerable populations. This approach ensured that the perspectives of those most affected by chronic conditions, children’s health, and maternal health were central to discussions.

To inform each focus area, seventeen virtual focus groups (four for chronic conditions, six for children’s health, and seven for maternal health), and five virtual interviews (one for children’s health and four for maternal health) were held with community leaders and services providers between July 14 - August 13, 2025. A full list of organizations and populations represented is provided in Table 5.

Participants represented a wide array of sectors and roles, including:

- Countywide healthcare leaders
- Counseling and therapy providers
- Healthcare providers delivering direct patient care
- School district representatives
- Other service providers, such as community clinics and nonprofit organizations addressing social drivers of health

Through this process, participants included representatives from public health and organizations serving low-income, disproportionately affected, or medically underserved populations experiencing health disparities or barriers to care—such as lack of insurance, underinsurance, geographic, language, or financial related challenges. Populations represented included Hispanic/Latino/Mixteco, Middle Eastern or North African, American Indian or Alaskan Native, Asian, White, and African American communities, as well as young adults, older adults, veterans, individuals with disabilities, LGBTQIA+ individuals, people experiencing homelessness, those with mental health conditions, undocumented individuals, and Medi-Cal or Medicare recipients.

Internal stakeholders from Cottage Health were also included to offer valuable insights from both their professional and personal experiences. This included Cottage Health physicians, leadership, and staff with professional and personal insights on chronic health, children’s health, and maternal health. A total of four virtual and in-person focus groups with Cottage Health participants were conducted in English and Spanish. Participants represented a range of roles, including:

- Administration
- Clinical staff providing relevant services
- Clinical staff working at the patient’s bedside (e.g., case managers, patient educators)
- Nurses
- Physicians
- Staff working in the community (e.g., social workers)
- Support services (e.g., Environmental Services)

Table 5. Community Groups Represented by Leaders and Service Providers in the Listening Tour

| Organization | Medically Underserved | Low-Income Residents | Disproportionately Impacted Populations |
|---|-----------------------|----------------------|---|
| Children's Health | | | |
| American Indian Health & Services | X | X | X |
| CALM | X | X | X |
| Carpinteria Children's Project | | X | X |
| CenCal Health | X | X | X |
| Children & Family Resource Services (CFRS / Health Linkages (SBCEO) | X | X | X |
| Cottage Health | X | X | X |
| Council on Alcoholism & Drug Abuse (CADA) | X | X | X |
| County of Santa Barbara Health Department | X | X | X |
| Family Service Agency | | X | X |
| Fighting Back Santa Maria Valley | | X | X |

| Organization | Medically Underserved | Low-Income Residents | Disproportionately Impacted Populations |
|---|-----------------------|----------------------|---|
| Children's Health | | | |
| First 5 Santa Barbara County | | X | X |
| Flux Coaching and Consulting | | X | |
| Girls Inc. of Greater Santa Barbara | | X | X |
| KIDS Network | X | X | X |
| LEAP (Isla Vista Youth Project) | | X | X |
| Lompoc Valley Pediatrics | X | X | X |
| Community Systems Consulting | X | X | X |
| Marian Regional Medical Center | X | X | X |
| Mariposas Project | X | X | X |
| Maternal Child Adolescent Health (MCAH) | X | X | X |
| Mental Wellness Center | X | X | X |
| Orcutt Union School District | | X | X |
| Resilient Santa Barbara County | | | X |
| Sanctuary Centers | X | X | X |
| Sansum Clinic - Sutter Health | X | X | X |
| Santa Barbara County Department of Behavioral Wellness | X | X | X |
| Santa Barbara Unified School District | | X | X |
| Santa Ynez Valley People Helping People | | X | X |
| Teddy Bear Cancer Foundation | | X | |
| Together for Children Network | X | X | X |
| YouthWell | | X | X |
| Maternal Health | | | |
| CALM | X | X | X |
| Carpinteria Children's Project | | X | X |
| CenCal Health | X | X | X |
| CommUnify | X | X | X |
| Community Health Centers of the Central Coast | X | X | X |
| Cottage Health | X | X | X |
| County of Santa Barbara Health Department | X | X | X |
| Dar a Luz: Legal Rights for Farmworkers in Pregnancy and Postpartum | X | X | X |
| Domestic Violence Solutions | | X | X |
| Family Service Agency | | X | X |
| KIDS Network | X | X | X |
| Lompoc Valley Medical Center | X | X | X |
| Mamatoto Santa Barbara | | X | |
| Marian Regional Medical Center | X | X | X |
| Maternal Child Adolescent Health (MCAH) | X | X | X |
| Mothers' Helpers | | X | X |

| Organization | Medically Underserved | Low-Income Residents | Disproportionately Impacted Populations |
|---|-----------------------|----------------------|---|
| Maternal Health | | | |
| Planned Parenthood California Central Coast | X | X | X |
| Postpartum Education for Parents (PEP) | X | X | X |
| Sansum Clinic - Sutter Health | X | X | X |
| Sansum Diabetes Research Institute | X | X | X |
| Santa Barbara Birth Center | | X | |
| Santa Barbara County Breastfeeding Coalition | X | X | X |
| Santa Barbara County Public Health Department | X | X | X |
| Santa Barbara Endocrinology | X | X | |
| Santa Barbara Lactation | X | X | |
| Transition House | X | X | X |
| UCSB Human Resources Lactation Support Group | | | X |
| WIC/SBCPHD | X | X | X |
| Women, Infants and Children (WIC) Program | X | X | X |
| Chronic Conditions | | | |
| Alpha Resource Center | X | X | X |
| American Cancer Society | X | X | X |
| American Indian Health & Services | X | X | X |
| CenCal Health | X | X | X |
| Cottage Health | X | X | X |
| Good Samaritan Shelter | X | X | X |
| Pacific Pride Foundation | X | X | X |
| Rescue Mission | X | X | X |
| Sansum Diabetes Research Institute | X | X | X |
| Santa Barbara County Promotores Network | X | X | X |
| Santa Ynez Tribal Health Clinic | X | X | X |
| WomenHeart | X | X | X |

2. Community Members

Community members play an essential role in identifying information gaps and providing lived experiences that deepen understanding of community needs. Their perspectives—whether drawn from personal experience or connections through friends, family, or neighbors—are critical to addressing chronic health, children’s health, and maternal health.

Following the same approach used with community leaders and service provider representatives, organizations were identified in each of the three topic areas for their care of low-income, less educated, disproportionately impacted populations, and/or other medically underserved populations. These trusted community organizations helped recruit representatives from their communities to participate in focus groups and interviews. These sessions were held either onsite at service locations or virtually, depending on participants’ preferences. A full list of participants is provided in Table 6.

Between July 14 - September 10, 2025, a total of four community focus groups (one on chronic conditions, two on children’s health, and one on maternal health) and five individual interviews (two on children’s health and three on maternal health) were completed. To honor participants’ language preferences, sessions were offered in English, Spanish, and Mixteco. Community participants included:

- Parents and caretakers
- Teens
- Patients
- Mixteco-speaking community members

Table 6. Community Groups Represented by or Recruiting Participants for Community Member Groups in the Listening Tour

| Organization | Medically Underserved | Low-Income Residents | Disproportionately Impacted Populations |
|---|-----------------------|----------------------|---|
| Children's Health | | | |
| CenCal Health | X | X | X |
| Future Leaders of America | | X | X |
| Youthwell | | X | X |
| Maternal Health | | | |
| Dar a Luz: Legal Rights for Farmworkers in Pregnancy and Postpartum | | X | X |
| Centerline | | | X |
| Chronic Conditions | | | |
| Immigrant Hope | X | X | X |
| Catholic Charities in Santa Barbara County | X | X | X |

Process

The 2025 CHNA Collaborative partnered with the Public Health Institute’s (PHI) Population Health Innovation Lab (PHIL) to develop data collection instruments, collect data, and conduct analysis for the Listening Tour. Community leaders from the CHNA Collaborative provided consultation to refine methods and ensure alignment with community needs.

The data collection team conducted focus groups and semi-structured interviews. A total of thirty-seven sessions were held virtually and in-person, including twenty-six focus groups (nine maternal health, ten children’s health, and seven chronic conditions) and eleven interviews (eight maternal health and three children’s health), with 227 participants. See Table 7 for an overview of Listening Tour engagements by focus area.

Table 7. Listening Tour Participants by Focus Area

| Focus Area | Interviews | Focus Groups | Participants |
|--------------------|------------|--------------|--------------|
| Chronic Conditions | 0 | 7 | 46 |
| Children's Health | 3 | 10 | 100 |
| Maternal Health | 8 | 9 | 81 |
| Totals | 11 | 26 | 227 |

Focus groups and interviews were conducted in the participant's preferred language, including English, Spanish, or Mixteco. Interviews in Mixteco were conducted with the support of an external interpreter. Materials were provided at a sixth-grade reading level, and a \$15 grocery gift card was offered to participating community members.

The sessions centered on three topic areas: 1) maternal health, 2) children's health, and 3) chronic conditions. Each of the three topic areas had tailored guides addressing sub-focus areas. Maternal health discussions explored access to timely care when pregnant, disparities in care, outcomes and conditions, mental health, breastfeeding, gestational diabetes (GDM), pregnancy loss, and fertility treatments. Children's health sessions examined access to care, preventive services and developmental screenings, mental health, social drivers of health, English language learners, chronic conditions, and trauma. Finally, conversations on chronic conditions emphasized priority chronic conditions, access to care, continuity of care, social drivers of health, and living with chronic conditions. See Appendix F for the full focus group and interview guides.

Interviews and focus groups were recorded and transcribed using Otter.ai software, and additional observations and notes were captured by the data collection team. After each session, a brief demographic survey was distributed with questions on zip code, neighborhood, age, gender, number of children in the household, educational attainment, income, language(s) spoken at home, and insurance status. The survey took less than five minutes to complete and was self-administered virtually on Qualtrics or in paper format for in-person focus groups and was later entered into Qualtrics by the data collection team.

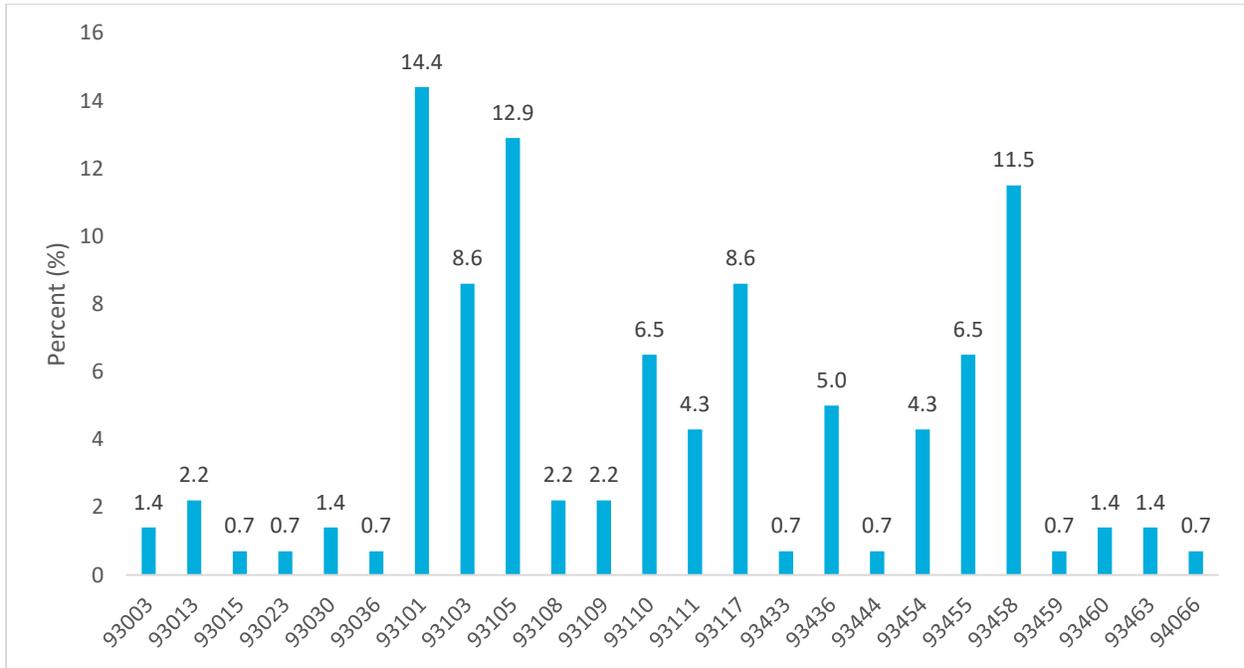
The transcripts were coded in ATLAS.ti using 76 deductive and inductive codes to identify key findings. Initial codes were drawn from the interview and focus group guides, with additional codes added from secondary data indicators and emerging themes.

Codes were reviewed to develop themes related to each focus area and sub-focus area. In addition to sub-focus area themes, qualitative data were analyzed to identify emerging themes, potential solutions, and the community's vision for the future for each sub-focus area.

Listening Tour Demographics

The following charts (Figures 8 – 14) display the demographic profile of the 155 Listening Tour participants who completed a demographics survey after the focus group or interview. Percentages below are presented unweighted.

Figure 8. Percentage of Santa Barbara County Listening Tour Participants, by Zip Code (n=139)

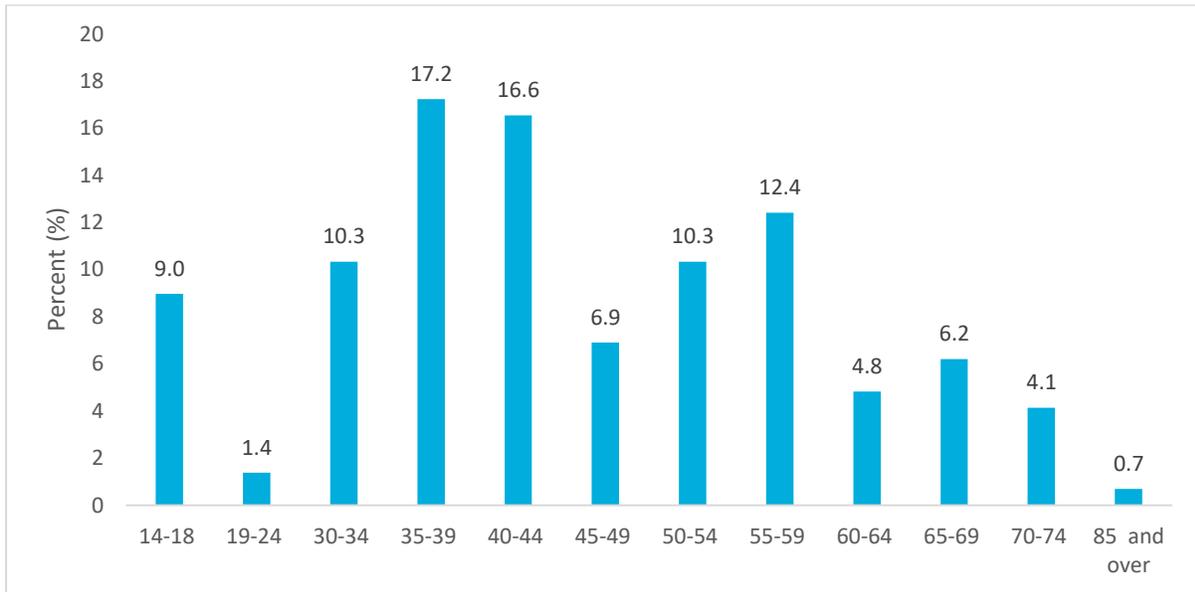


Participation was concentrated in central Santa Barbara and North County: 93101 (14.4%), 93105 (12.9%), and 93458 (11.5%), followed by 93103 (8.6%) and 93117 (8.6%). Mid-range ZIPs included 93110 (6.5%), 93455 (6.5%), and 93436 (5.0%); all others were $\leq 4.3\%$, indicating broad geographic reach with clusters around major population centers.

Table 8. Percentage of Santa Barbara County Listening Tour Participants, by Neighborhood (n=134)

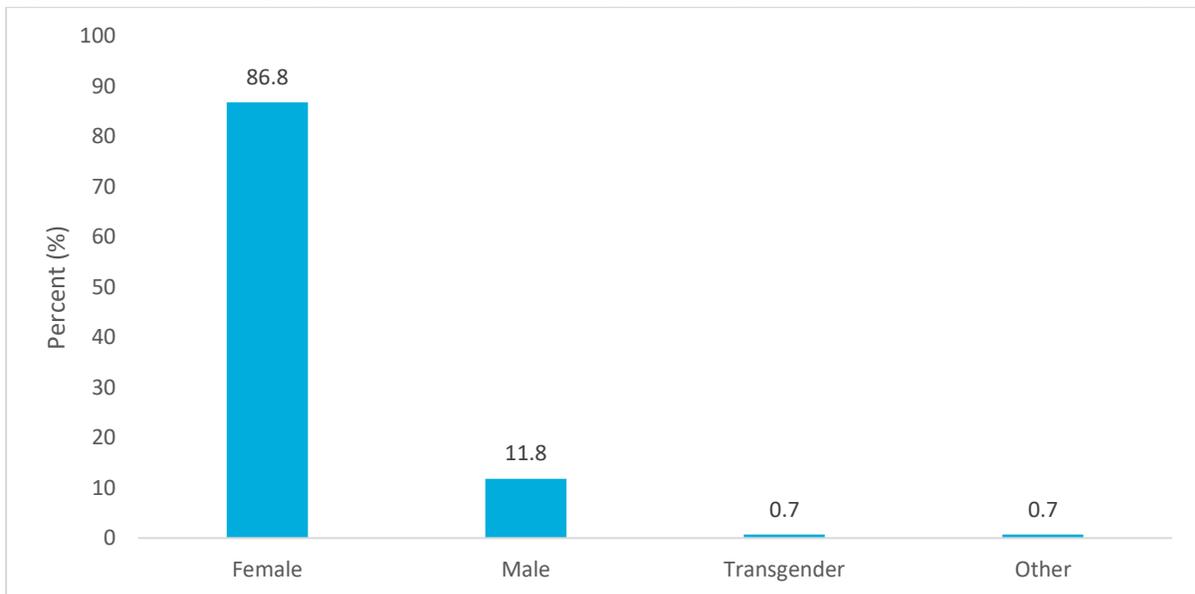
| Neighborhood | Percentage | Count |
|------------------------|------------|-------|
| Buellton | 0.8% | 1 |
| Carpinteria | 3.0% | 4 |
| Downtown Santa Barbara | 3.7% | 5 |
| Eastern Goleta Valley | 0.8% | 1 |
| El Encanto | 1.5% | 2 |
| Ellwood | 0.8% | 1 |
| Foxenwood | 0.8% | 1 |
| Goleta | 6.7% | 9 |
| Grover Beach | 0.8% | 1 |
| Hidden Valley | 1.5% | 2 |
| Hope Ranch | 1.5% | 2 |
| Isla Vista | 0.8% | 1 |
| La Colonia | 0.8% | 1 |
| Lompoc | 0.8% | 1 |
| Lower Riviera | 0.8% | 1 |
| Mesa | 2.2% | 3 |
| Montecito | 2.2% | 3 |
| Noleta | 2.2% | 3 |
| North Santa Maria | 2.2% | 3 |
| Ojai | 0.8% | 1 |
| Orcutt | 4.5% | 6 |
| Oxnard | 0.8% | 1 |
| Painted Cave | 0.8% | 1 |
| Rancho San Antonio | 0.8% | 1 |
| Riviera | 0.8% | 1 |
| Rollingwood | 0.8% | 1 |
| Samarkand | 2.2% | 3 |
| San Marcos | 0.8% | 1 |
| San Marcos Trout Club | 0.8% | 1 |
| San Roque | 5.2% | 7 |
| Santa Barbara | 6.7% | 9 |
| Santa Barbara County | 0.8% | 1 |
| Santa Barbara Eastside | 10.5% | 14 |
| Santa Barbara Westside | 8.2% | 11 |
| Santa Maria | 14.2% | 19 |
| Santa Maria Valley | 0.8% | 1 |
| Santa Ynez | 3.0% | 4 |
| Solvang | 0.8% | 1 |
| Upper State | 1.5% | 2 |
| Vandenberg Village | 1.5% | 2 |
| Ventura County | 0.8% | 1 |

Figure 9. Percentage of Santa Barbara County Listening Tour Participants, by Age (n=145)



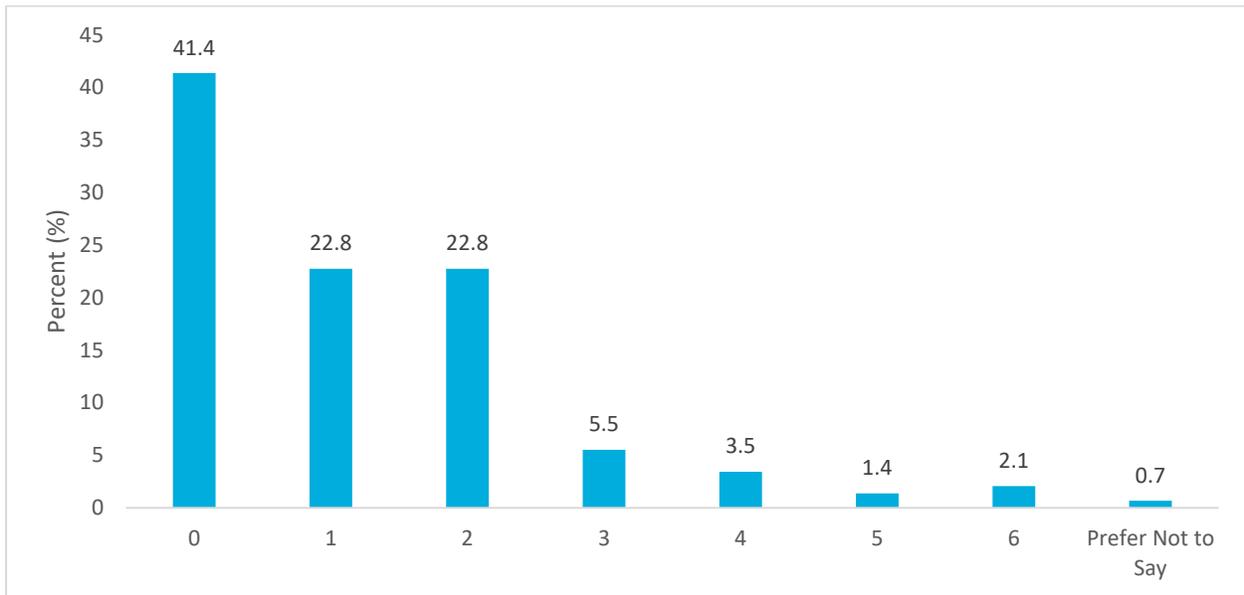
The largest age groups were 35–39 years (17.2%) and 40–44 years (16.6%), followed by 55–59 years (12.4%) and 30–34 years (10.3%) / 50–54 years (10.3%). Younger participants included 14–18 years (9.0%) and 19–24 years (1.4%); older adults included 60–64 (4.8%), 65–69 (6.2%), 70–74 (4.1%), and 85+ (0.7%). Overall, the sample skews working-age.

Figure 10. Percentage of Santa Barbara County Listening Tour Participants, by Gender (n=144)



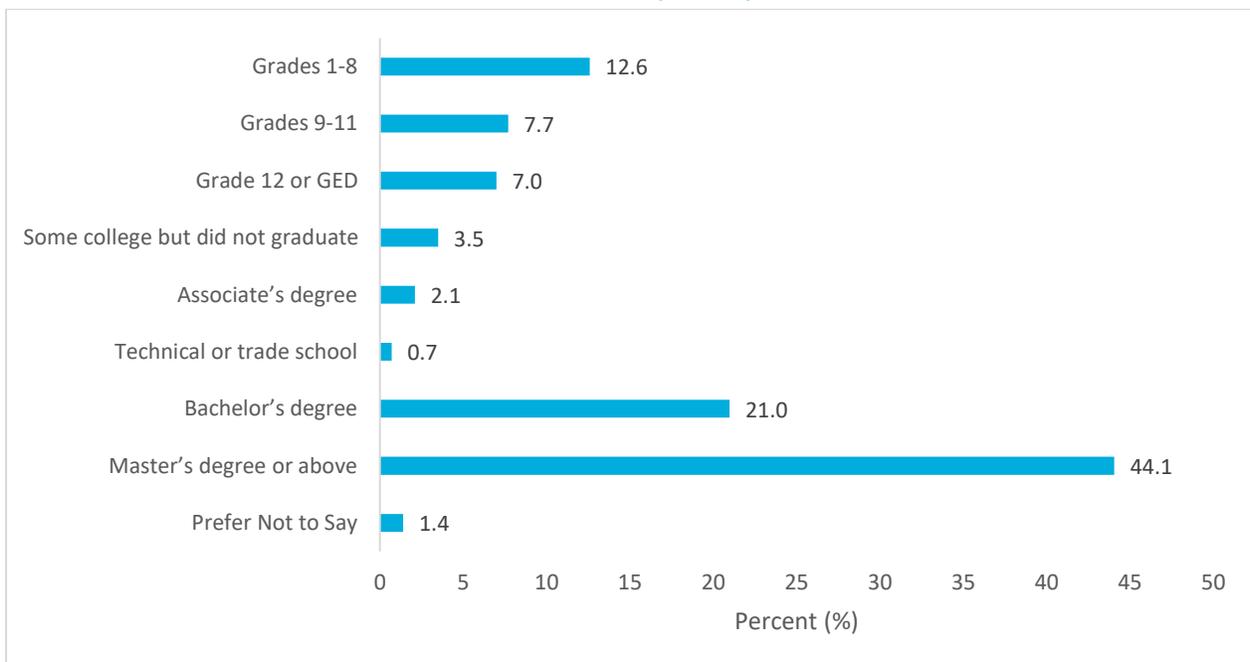
Most respondents identified as female (86.8%) or male (11.8%); 0.7% identified as transgender and 0.7% selected “other,” including a write-in of gender fluid.

Figure 11. Percentage of Santa Barbara County Listening Tour Participants, by Number of Children in the Household (n=145)



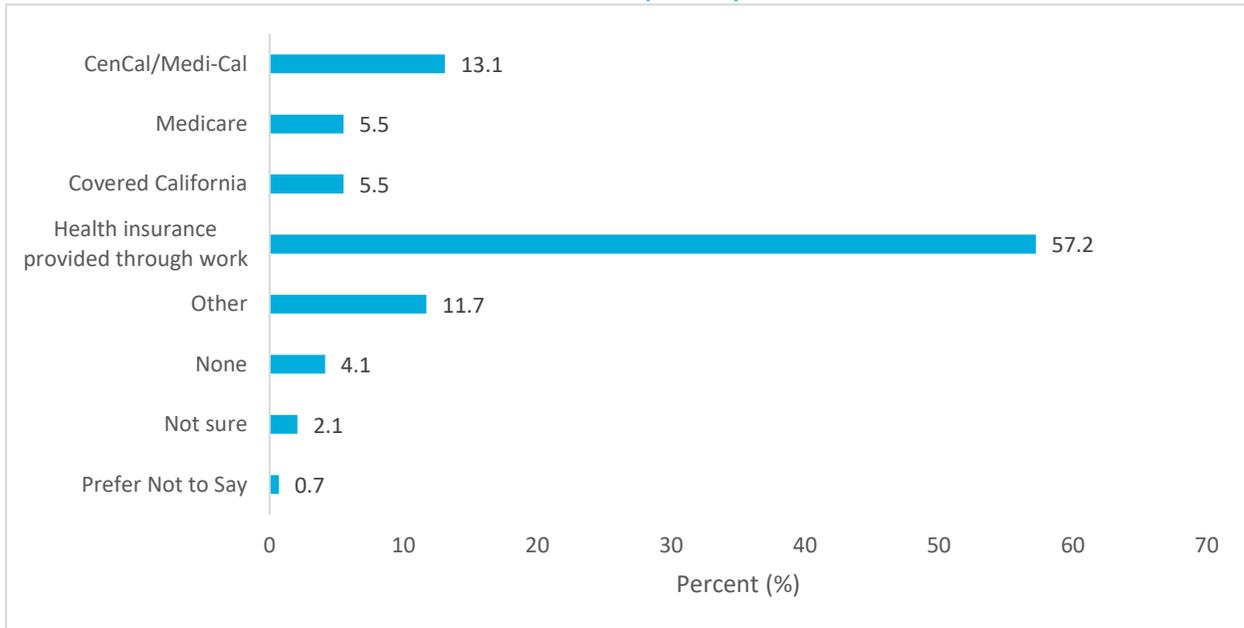
About two in five reported no children at home (41.4%); 22.8% had one child and 22.8% had two. Larger households were less common: three (5.5%), four (3.5%), five (1.4%), or six children (2.1%); 0.7% preferred not to say. In total, roughly three in five had at least one child in the household.

Figure 12. Percentage of Santa Barbara County Listening Tour Participants, by Educational Attainment (n=143)



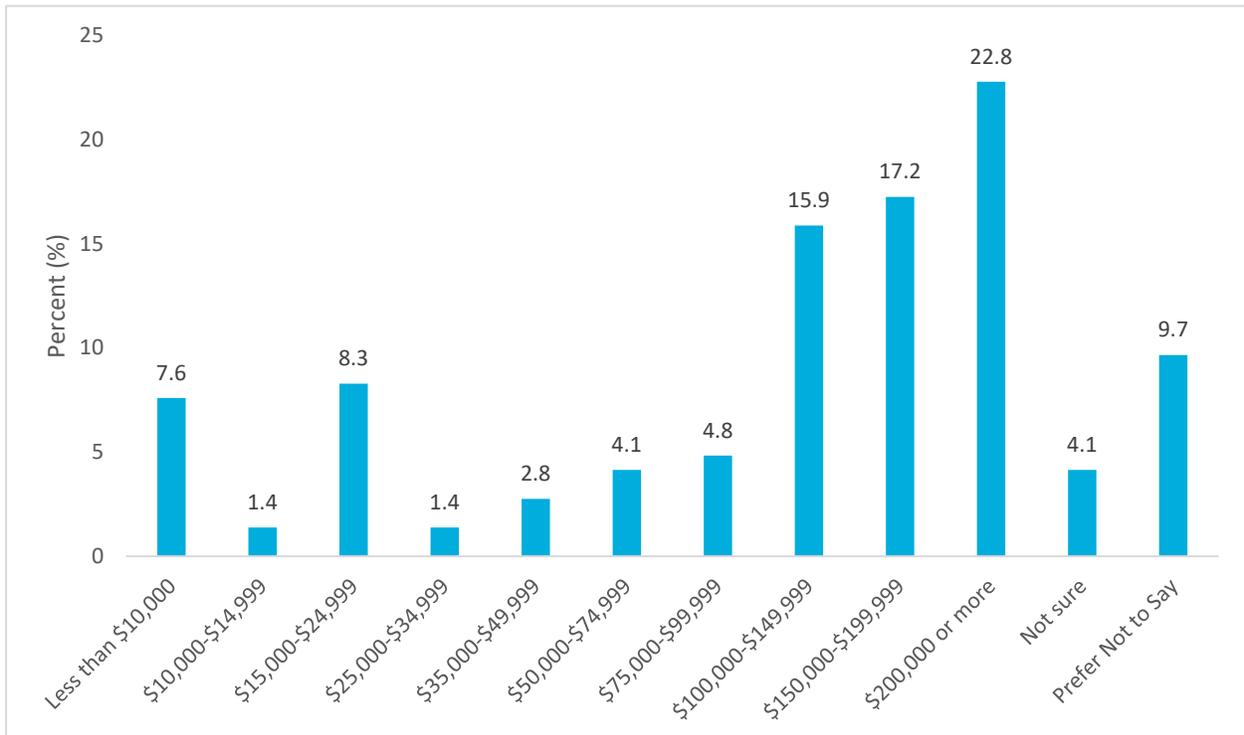
Educational attainment skewed high: 44.1% reported a master's degree or above and 21.0% a bachelor's degree. Earlier educational levels included grades 1–8 (12.6%), grades 9–11 (7.7%), and high school/GED (7.0%); some college without a degree (3.5%), associate's (2.1%), and technical/trade school (0.7%); 1.4% preferred not to say.

Figure 13. Percentage of Santa Barbara County Listening Tour Participants, by Type of Insurance (n=145)



Most respondents had employer-sponsored coverage (57.2%). Public coverage included CenCal/Medi-Cal (13.1%), Medicare (5.5%), and Covered California (5.5%); 11.7% selected “other,” 4.1% reported no coverage, 2.1% were not sure, and 0.7% preferred not to say. “Other” write-ins included California Children's Services (CCS), Medi-Medi, specific private plans, and TRICARE.

Figure 14. Percentage of Santa Barbara County Listening Tour Participants, by Total Annual Household Income (n=145)



Income skewed higher: \$200,000+ (22.8%), \$150,000–\$199,999 (17.2%), and \$100,000–\$149,999 (15.9%). Middle bands included \$75,000–\$99,999 (4.8%), \$50,000–\$74,999 (4.1%), and \$35,000–\$49,999 (2.8%). Lower-income bands included <\$10,000 (7.6%), \$10,000–\$14,999 (1.4%), and \$15,000–\$24,999 (8.3%); \$25,000–\$34,999 (1.4%). 4.1% were not sure and 9.7% preferred not to say.

APPENDIX C:

LOCAL RESOURCES AND ASSETS

This appendix catalogs community organizations and programs that align with the assessment’s focus areas. Entries are included based on (1) direct participation in the CHNA engagement activities (e.g., interviews and focus groups) and (2) a scan of publicly available information demonstrating relevance to the topic. Listings are not exhaustive; rather, they are intended to facilitate referral, partnership development, and future planning. Programs are organized by focus area, and brief descriptions summarize publicly available information from each organization’s website or recognized directories. Where applicable, sources are cited. Additional resources can be found at [ConnectSBC.org](https://www.connectsbc.org).

- A Nursing Corporation
- Abel Maldonado Community Youth Center
- Adira Occupational Therapy
- AHA!
- Alcohol and Drug Program at UCSB
- Allan Hancock College
- Alpha Resource Center of Santa Barbara
- American Indian Health & Services
- Alpha Resource Center
- Apples to Zucchini Cooking School
- Baby Center
- Boys & Girls Club of Santa Barbara County
- California Children’s Services (CCS)
- California Department of Education
- California Department of Social Services (CDSS)
- CALM
- Care Net Pregnancy and Resource Center
- Carpinteria Children’s Project
- Carpinteria Health Care Center
- Casa Pacifica Centers for Children & Families
- Casa Serena
- Catholic Charities of Santa Barbara County
- CenCal Health
- Centerline Community
- Central Coast Childbirth Network
- Child Abuse Prevention Council (CAPC) of Santa Barbara County
- Children & Family Resource Services (CFRS) / Health Linkages
- Children’s Resource & Referral of Santa Barbara County (CRR)
- Coast Valley Substance Abuse Treatment Center
- CommUnify
- Community Health Centers of the Central Coast
- Cottage Children’s Medical Center
- Cottage Health
- Cottage Health — Obstetrics & Gynecology Clinic
- Cottage Rehabilitation Hospital
- Cottage Urgent Care
- Council on Alcoholism and Drug Abuse (CADA)
- County of Santa Barbara Department of Behavioral Wellness
- County of Santa Barbara—Library Services
- County of Santa Barbara Public Health Department
- Cuyama Valley Family Resource Center (CVFRC)
- Dar a Luz at The Center for WorkLife Law
- Daybreak Health
- Doctors Without Walls — Santa Barbara Street Medicine
- Domestic Violence Solutions
- Dos Pueblos Mental Wellness Center
- Dignity Health
- Earth Milk Moon
- Family Care Network, Inc.
- Family Service Agency (FSA)
- Fighting Back Santa Maria Valley
- Findhelp.org
- First 5 Santa Barbara County
- Foodbank of Santa Barbara County
- Franklin Health Care Center
- Future Leaders of America
- Girls Inc. of Greater Santa Barbara
- Good Samaritan Shelter
- Greater Goleta Santa Barbara Lions Club

- Health Care Program for Children in Foster Care (HCPCFC)
- Healthy Families America
- Hearts Aligned
- Help Me Grow Santa Barbara County
- Hosford Counseling & Psychological Services Clinic at UCSB
- Hospice of Santa Barbara
- Koegel Autism Center at UCSB
- Lactation Network
- La Leche League of Santa Barbara
- LEAP: Learn, Engage, Advocate, Partner
- Lifespan Development Center (Doc Rotz)
- Lompoc Health Care Center
- Lompoc Teen Center
- Lompoc Valley Community Healthcare Organization
- Lompoc Valley Medical Center
- Lumos Transforms
- Mamatoto
- Marian Regional Medical Center
- Mariposas Project
- Maternal Child Adolescent Health (MCAH)
- Maternal-Fetal Medicine Specialists of Southern California
- Mental Wellness Center
- MindThrive
- Migrant Education Program – Region 18
- Mindpath College Health (Acacia Wellness)
- Mixteco/Indigena Community Organizing Project (MICOP)
- Mothers of Preschoolers (MOPS) Goleta
- New Beginnings Counseling Center
- NAMI Santa Barbara County
- Noah’s Anchorage Youth Shelter (YMCA)
- North County Rape Crisis & Child Protection Center
- Orfalea Family Children’s Center (UCSB)
- Pacific Pride Foundation
- Pediatric Resiliency Collaborative (PeRC)
- Planned Parenthood California Central Coast
- Postpartum Education for Parents (PEP)
- Pregnancy and Parenting Support Center
- Program for Infant/Toddler Care (PITC)
- PATH- Santa Barbara
- PathPoint
- Resilient Santa Barbara County (RSBC)
- RiteCare Childhood Language Center Santa Barbara
- Rooted Santa Barbara County
- Saint Barbara Parish
- Sanctuary Centers
- Sansum Clinic — Sutter Health
- Sansum Diabetes Research Institute
- Santa Barbara Birth Center
- Santa Barbara City College—The Well
- Santa Barbara County 2-1-1
- Santa Barbara County Breastfeeding Coalition
- Santa Barbara County District Attorney
- Santa Barbara County Education Office (SBCEO)
- Santa Barbara County Promotores Network
- Santa Barbara County Public Defender
- Santa Barbara County SELPA (SBCSELPA)
- Santa Barbara Education Foundation—What Is Love
- Santa Barbara Family YMCA
- Santa Barbara Health Care Center
- Santa Barbara Lactation
- Santa Barbara MomCo
- Santa Barbara Neighborhood Clinics
- Santa Barbara Postpartum Education for Parents (PEP)
- Santa Barbara Public Library
- Santa Barbara Rescue Mission
- Santa Barbara VA Clinic
- Santa Maria Health Care Center
- Santa Maria VA Clinic
- Santa Ynez Tribal Health Clinic
- Santa Ynez Valley People Helping People
- SBNC – Cottage Health Bridge Clinic
- SLO Doula Connection
- SLO Noor — Women’s Mobile Health Unit
- St. Vincent’s
- Standing Together to End Sexual Assault (STESA)
- Storyteller Children’s Center
- Teddy Bear Cancer Foundation
- Transition House
- Transitions-Mental Health Association
- Tri-Counties Regional Center
- UCLA Health
- UCSB Human Resources — Lactation Support Program
- United Way Santa Barbara County

- Vandenberg Space Force Base
- Vandenberg Space Force Base — New Parent Support Program
- Villa Majella Maternity Home
- Westmont College—Health & Wellness
- Wilderness Youth Project
- Women, Infants and Children (WIC) Program
- Stuart C. Gildred Family YMCA
- YOR Place — Youth Opioid Response
- YouthWell Coalition
- Zona Seca

APPENDIX D: EVALUATION OF COMMUNITY BENEFIT PROGRAMS

Cottage Health evaluated community benefit programs outlined in the 2023-2026 Community Benefit Implementation Strategy. Findings below highlight community feedback, key accomplishments, and ongoing efforts to address the identified priority health areas of access to care, behavioral health, chronic conditions, maternal health, resiliency, and social needs.

Community Feedback from Previous Assessment

Cottage Health conducted the last CHNA in 2022 and has received few written comments since then. To better understand the impact of the report, Cottage Health gathered community feedback on the last CHNA. To do this, two questions were added to the prioritization survey that was sent to the broad range of community members invited to the Listening Tour. The following table summarizes these questions and answers.

Table 9. Community Feedback From the 2022 CHNA

| Questions | Responses |
|--|--|
| Have this report and implementation strategy been helpful to you in the past three years? ¹ | 57% of respondents answered yes 43% of respondents answered no |
| What would make the CHNA information more useful to you and your organization in the future? | <p>The majority of respondents shared that the report and data are appreciated as valuable community resources and expressed support for continuing and expanding the reach of the CHNA. Several emphasized the importance of presenting information in accessible formats, including simplified language and interactive tools. Others highlighted opportunities for deeper dives into specific topics, broader community engagement, and more frequent updates. Overall, the responses reflect strong support and a desire to increase its visibility, relevance, and impact.</p> <p>Example responses include:</p> <ul style="list-style-type: none"> • “More and wider notice when new reports issued.” • “Post on various sites, social media; do a ‘road show.’” • “Community discussion with schools and providers around the results to expand further on what was learned.” • “Interactive dashboard to create maps, tables, graphs, etc.” • “More detailed questions regarding access to care for chronic conditions and personal obstacles to success.” • “For us, a deeper dive into exactly what nuances of maternal needs. “ • “The executive summary is very important.” |

¹ 37% of respondents skipped this question

Evaluation of Community Benefit Programs

Cottage Health reviewed and evaluated strategies set forth in the 2023-2026 Community Benefit Implementation Strategy. Within each priority area, corresponding programs implemented by each hospital and key accomplishments are highlighted to share the scope of activities implemented to address each need.

| Priority Health Area Terms and Definitions | |
|---|---|
| Description | Overview of the community benefit priority health area |
| Strategies & Programs | Approaches and activities identified in the 2023-2026 Implementation Strategy to address the priority health area |
| Key Accomplishments | Description of the impact of key actions taken to address the priority health area |

| Priority Health Area: Access to Care | |
|---|--|
| Description | Improve access to comprehensive, quality care through a focus on patients, community, and insured populations. |
| Strategies/Programs | Hospitals |
| Access to Care | |
| Advance Care Planning | GVCH / SBCH / SYVCH |
| Cancer Screening & 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) | |
| 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 |
| Strategies/Programs | Hospitals |
| Access to Care | |
| 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: Access to Care

| | |
|----------------------------------|---|
| <p>Key Accomplishment</p> | <p>#1: Enhanced access to recuperative care and supportive services for individuals experiencing homelessness.</p> <ul style="list-style-type: none">• Provided up to 90 days of recuperative care to more than 200 patients experiencing homelessness through the Cottage Recuperative Care Program.• Connected Cottage Recuperative Care Program graduates with permanent supportive housing and continued wrap-around support through the Cottage Recuperative Care Graduates program.• Partnered with Good Samaritan Shelter to establish 10 new recuperative care beds at DignityMoves Downtown Santa Barbara. <p>#2. Launched a Spanish-language virtual care platform in addition to the existing English-language virtual care.</p> <ul style="list-style-type: none">• Implemented a 24/7/365 Spanish-language virtual care platform, providing continuous access to clinical services for Spanish-speaking patients.• Trained more than 10 community health workers to support patients in navigating the platform.• Hired a certified bilingual provider who conducted more than 40 personal follow-up calls with Spanish-speaking patients post-visit, strengthening care continuity. <p>#3. Supported community members with programs and activities to facilitate accessing care.</p> <ul style="list-style-type: none">• Administered more than 1,000 flu shots to community members in parks, shelters, low-income housing, and congregation settings.• Distributed Charity Care and Community Service Programs in financial assistance to patients who meet income-eligibility requirements for clinical care. |
|----------------------------------|---|

Priority Health Area: Behavioral Health

| | |
|--------------------|--|
| Description | Improve access to care and health outcomes for behavioral health needs through focused population level strategies and programs. |
|--------------------|--|

| 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 |

| | |
|----------------------------|--|
| Key Accomplishments | <p>#1: Established Mind Thrive to support youth ages 12-18 in navigating and accessing behavioral health services.</p> <ul style="list-style-type: none"> • Developed an innovative model integrating behavioral health navigation with ease of access to services for adolescents and their families. • Partnered with six organizations to expand psychiatry, therapy, buffering supports and other community-based behavioral health services. • Served 58 youth and families in the first year with 82% of parents/caregivers reporting Mind Thrive made it "much easier" to access mental health services and reduced wait times for youth. <p>#2. Increased access to substance use disorder treatment and care coordination through the Santa Barbara Neighborhood Bridge Clinic.</p> <ul style="list-style-type: none"> • Offered walk-in, low-barrier access to medical and behavioral health care for individuals with substance use disorders, helping to divert non-emergency patients from the emergency department. • Supported comprehensive discharge planning for patients with substance use needs, improving continuity of care. • Connected an average of 18 patients per month to the Bridge Clinic for follow-up care. |
|----------------------------|--|

Priority Health Area: Behavioral Health

#3: Supported community members with programs and activities to facilitate accessing behavioral health services.

- Annually helped nearly 1,300 family and other informal (unpaid) caregivers of adults with cognitive disorders and other disabling conditions in Santa Barbara, San Luis Obispo, and Ventura counties.
- Provided patients in need of an involuntary hold with support in the Emergency Department Holding Unit.

Priority Health Area: Chronic Conditions

| | | |
|---|---|------------------|
| Description | Improve health outcomes for chronic conditions by building on existing programs and strategies. | |
| | 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 | SBCH | |
| 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 | |
| Key Accomplishments | <p>#1: Launched Cottage Community Health Workers for patients with high medical needs.</p> <ul style="list-style-type: none"> Strengthened the care model by pairing community health workers (CHWs) with Community Case Manager Registered Nurses to enhance treatment adherence and address social and medical needs. Provided over 2,280 CHW encounters focused on congestive heart failure management. <p>#2: Implemented the Center for Disease Control and Prevention PreventT2 curriculum for prediabetic individuals.</p> <ul style="list-style-type: none"> Enrolled 40 community members in the year-long program focused on diabetes prevention. Delivered culturally and linguistically appropriate education on prediabetes, physical activity, behavior modification, and healthy eating. Provided 1:1 case management support to participants needing additional guidance and resources to meet their health goals. | |

Priority Health Area: Chronic Conditions

#3. Supported the prevention and management of chronic conditions through Parish Nursing.

- Offered care for community members at fifteen partner sites, including faith communities and congregations, homeless temporary and transitional housing, and recovery facilities.
- Provided Parish Nursing services to more than 3,000 community members annually.

| Priority Health Area: Maternal Health | |
|---|--|
| Description | Improve maternal health outcomes by identifying, describing, and addressing disparities in maternal health access and outcomes. |
| Strategies/Programs | Hospitals |
| Maternal Health | |
| Birth and Parent Education Classes | SBCH |
| Cottage OBGYN Clinic | SBCH |
| Donor Milk Drive | SBCH |
| Implicit Bias Training with Perinatal Providers | GVCH / SBCH / SYVCH |
| Maternal Health Research Project | GVCH / SBCH / SYVCH |
| Maternal Health Partnerships | GVCH / SBCH / SYVCH |
| Mother's Circle | SBCH |
| Warm Line | SBCH |
| Key Accomplishments | <p>#1: Established a Community Health Worker program to support pregnant community members during the prenatal and postpartum phases.</p> <ul style="list-style-type: none"> Assessed gaps in care among medically underserved pregnant individuals seeking prenatal support. Expanded the Community Health Worker (CHW) program to support pregnant community members at risk for poor maternal health outcomes. Partnered with national experts in CHWs to develop educational materials for high-risk pregnant mothers. <p>#2: Developed the Maternal Health Research Project to better understand how care impacts health outcomes for mothers and babies.</p> <ul style="list-style-type: none"> Completed the Maternal Health Needs Assessment to inform the approach and areas of focus for this research project. Prepared data collection for patients giving birth at Santa Barbara Cottage Hospital. |

| Priority Health Areas: Resiliency | |
|--|--|
| Description | Address resiliency through a focus on Adverse Childhood Experiences (ACEs) and trauma-informed care. |
| Strategies & Programs | <ul style="list-style-type: none"> • Pediatric Resiliency Collaborative • Santa Barbara County Network of Care • Connect Santa Barabara County |
| Key Accomplishments | <p>#1: Expanded Pediatric Resiliency Collaborative screening and referrals within pediatric clinics.</p> <ul style="list-style-type: none"> • Partnered with seven pediatric clinics and 32 providers to implement screening and referrals for children ages 0-3 and their parents/guardians. • Screened 6,088 children and connected 1,102 families to more than twenty-five community organizations addressing the effects of toxic stress and providing therapeutic services. <p>#2: Expanded the Santa Barbara County Network of Care and support for children and their families experiencing ACEs.</p> <ul style="list-style-type: none"> • Adapted PeRC’s ACEs Aware Certified Core Training for community-based organizations and trained more than 300 individuals from more than 60 organizations. • Conducted training on ACEs and trauma informed care to service providers supporting perinatal patients. • Led collaborative meetings with social service providers, community members, and government agencies to facilitate shared learning and technical assistance opportunities in supporting children and families who have experienced trauma. <p>#3: Implemented ConnectSBC.org to support referrals and service navigation in Santa Barbara County.</p> <ul style="list-style-type: none"> • Engaged with more than 30 community-based organizations on ConnectSBC.org, a platform powered by Findhelp. • Enabled over 180,000 searches for programs and services by community members seeking assistance. • Facilitated more than 16,800 connections and submitted more than 4,400 referrals, creating formal connections between individuals or providers and community organizations, with the ability to track outcomes and support closed-loop communication. |

Priority Health Area: Social Needs

| | | |
|---|---|------------------|
| Description | Improved health outcomes for community members experiencing social needs, with a focus on food and housing insecurity. | |
| | 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 | |
| Key Accomplishments | <p>#1: Supported community members with basic needs through the Patient Resource Connect program.</p> <ul style="list-style-type: none"> • Screened 3,210 patients in the GVCH and SYVCH Emergency Departments and found 35% of patients screening positive for one or more social needs. • Connected patients with basic needs to support based on their preferences. <p>#2: Assisted Cottage Health employees with basic needs through the Employee Resource Connect program.</p> <ul style="list-style-type: none"> • Screened over 1,500 employees and found 20% of Cottage Health employees having one or more social needs. • Provided a food program to address food insecurity among employees and offer short-term financial support while finding long-term strategies for food needs. <p>#3: Expanded social drivers of health screening to include inpatient populations.</p> <ul style="list-style-type: none"> • Nearly 72% of inpatient visits were screened for social drivers of health, and more than 10% of patients screened positive for one or more social needs, such as housing, food, or transportation. • Patients with identified social needs received assistance through a social work or resource navigation intervention, strengthening connections between inpatient care and community resources. | |

| Priority Health Area: Injury and Violence Prevention | |
|--|--|
| Description | Prevent injury and violence, including falls, motor vehicle collisions, and bicycle and pedestrian injuries, through strategies and programs that reach patient and community populations. |
| 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 |
| Key Accomplishments | <p>#1: Hosted bicycle safety and helmet distribution events.</p> <ul style="list-style-type: none"> Hosted community-based bicycle safety and helmet distribution events to promote safe riding habits. Educated over 7,000 children and adults annually on the importance of helmet use through the evidence-based Think First injury prevention model. Distributed more than 75 safety-certified bicycle helmets each year to children and families in need. <p>#2: Supported vulnerable community members with programs and activities to prevent injury and violence.</p> <ul style="list-style-type: none"> Promoted trauma response readiness by distributing tourniquets and delivering Stop the Bleed training, reaching more than 300 community members annually. Provided Cribs for Kids safe sleep education to at-risk parents, supporting infant injury prevention through awareness and behavior change. Facilitated car seat safety through hands-on instruction, inspection, and donation of car seats—serving over 100 caregivers annually and distributing more than 15 car seats to families in need. |