Mono County Public Health

Local Oral Health Program

2025 Oral Health Needs Assessment

Prepared: December 2025

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1. Summary of Key Findings

Overall Oral Health Status

- Oral health needs remain significant across Mono County, particularly for young children, low-income households, Hispanic/Latino families and residents in remote northern and southern regions.
- School Oral Health Reporting (SCOHR) data show fluctuating but consistently meaningful levels of early childhood dental disease, including increases in early decay and persistent rates of untreated caries among kindergarteners.
- Community survey results indicate that 10–18% of respondents experience current dental pain, decay, or swelling with the highest burden in 93514 and 96107 ZIP codes.

Access to Care

- Mono County has about half the statewide dentist-to-population ratio (46.2 vs. 92.9 per 100,000).
- Nearly all dental services are concentrated in Mammoth Lakes; several communities (Bridgeport, Coleville, Benton, Chalfant, June Lake, etc.) have no local dental provider, requiring long-distance travel.
- Mono County has only one full-time public dental clinic accepting Medi-Cal which limits options for low-income families.

Preventive Care & Utilization

- Medi-Cal managed care data show very low reported rates of fluoride varnish application and oral evaluations among children, particularly toddlers (ages 0–3) and adolescents (ages 13–18); however, these data likely underestimate actual service delivery due to reporting and billing limitations.
- Preventive oral health services, including fluoride varnish, are routinely provided by local dental and pediatric medical providers.
- School-linked programs and periodic mobile dental van visits continue to play an important role in delivering preventive services, though reliance on these models contributes to uneven geographic coverage and gaps in routine, continuous care.
- Kindergarten Oral Health Assessment (KOHA) participation is improving; however, Proof of Assessment (PoA) return rates remain lowest in Mammoth Lakes and Bridgeport, indicating ongoing barriers related to access, care coordination, and follow-up.

Disparities & Priority Populations

- Hispanic/Latino and Native American residents report higher levels of current dental problems and lower insurance coverage than White residents.
- Residents in the unincorporated areas of the county (96107, 93514) are less likely to have a recent cleaning and more likely to be uninsured or underinsured.
- Young children, pregnant individuals, seasonal workers, and undocumented residents face overlapping barriers related to language, transportation and insurance acceptance.

Health, Educational, & Economic Impacts

- Untreated dental disease contributes to pain, infection risk, nutritional challenges, chronic disease complications and avoidable emergency visits.
- Educators report that oral health issues impact school
- attendance, concentration and readiness especially among kindergarteners.
- Families bear significant out-of-pocket and indirect costs (travel, lost wages, childcare) to obtain care often requiring several hours of travel for a single appointment.

Program Strengths & Progress

- Expansion of school-linked oral health screenings and education has increased local prevention efforts, particularly in elementary schools.
- Though not locally based and only intermittently available, the dental van has provided essential services including cleanings, X-rays, fluoride and limited restorative care to high-need communities.
- Strong partnerships with WIC, First 5 Mono, Mono County Maternal Child Adolescence Health Program (MCAH), Mammoth Hospital Dental Clinic, Owens Valley Career Development Center (Tribal TANF Program), Mono County Tobacco Education Program and schools have enhanced awareness and oral health outreach.

System Gaps & Opportunities

- Lack of community water fluoridation places additional importance on early preventive services, which remain inconsistently delivered.
- Referral tracking systems are limited; care coordination and follow-up data are inconsistent across programs.
- Significant unmet need exists for expanded dental care access, which could include recruitment of more dental providers, mobile services, increased Medi-Cal participation of existing providers, as well as bilingual outreach and early childhood preventive care.

- There is need for better data on care services. Existing data streams are fragmented and inconsistent.

2. Executive Summary

The 2025 Mono County Oral Health Needs Assessment provides a comprehensive overview of the oral health status, access to care, and preventive service landscape across this rural, frontier county in eastern California. Conducted by Mono County Public Health's Local Oral Health Program (LOHP), this assessment updates and expands upon previous evaluations, incorporating new data from local surveys, managed care plan utilization, school oral health reporting (SCOHR) and key informant interviews.

Mono County's small and geographically dispersed population faces persistent barriers to accessing dental care, particularly in remote northern and southern communities such as Bridgeport, Coleville, Benton, and Chalfant (Mono County CHA, 2024). All current dental providers are located in Mammoth Lakes, with significant numbers of county residents accessing care outside the jurisdiction. Access is particularly limited for low-income and uninsured residents. Medi-Cal participation among local providers is low as the county has only one full-time public health dental clinic that accepts Medi-Cal, creating persistent and significant barriers to care.

Preventive service use is also limited. Medi-Cal data show very low rates of fluoride varnish application and inconsistent annual dental visits among eligible children. In addition, SCOHR data indicate that a significant share of kindergarten oral health assessment forms are not returned, suggesting further gaps in preventive engagement and care coordination (DHCS Medi-Cal Dental Services Division, 2024).

Despite these challenges, meaningful progress has been made since the last assessment. The county has expanded school-linked oral health programs, strengthened partnerships with Mammoth Hospital, First 5 Mono County, and WIC, and initiated mobile and community-based dental services to reach underserved areas. Programs such as the school-linked screening initiative and the partnership with *Smile, California* represent important steps toward bridging geographic and economic gaps in care.

Findings from the 2025 assessment underscore several key themes:

Persistent inequities in access and utilization: Rural geography, transportation barriers, and provider shortages remain primary obstacles, especially for Medi-Cal members and uninsured families.

Low preventive service engagement: Managed care and SCOHR data reveal that many children do not receive early or routine dental care, emphasizing the need for enhanced outreach, education, and care coordination.

Disparities among priority populations: Hispanic/Latino and Native American residents report higher rates of current dental problems, lower insurance coverage, and greater unmet needs than White residents.

Community readiness and partnership strength: Schools, healthcare providers, and public health partners express strong commitment to collaborative oral health promotion and prevention initiatives.

Moving forward, Mono County's oral health strategy will focus on expanding equitable access to preventive services through school-linked programs and mobile care, improving referral systems, and enhancing culturally and linguistically tailored outreach. Strengthening data collection through SCOHR and managed care reporting will also be critical to monitor progress and guide future planning.

With continued investment in preventive services, mobile delivery models and strengthened community partnerships, Mono County can work toward building a more accessible, data-informed and equitable oral health system. While full implementation will take time, these efforts will help expand opportunities for all residents regardless of income, language, or geography to move closer to achieving optimal oral health and overall well-being.

3. Introduction & Background

3.1 Purpose & Scope

The purpose of the Mono County Oral Health Needs Assessment is to evaluate the current status of oral health among county residents, identify key barriers and gaps in access to care and guide strategies to improve oral health outcomes across the community. This assessment examines key factors affecting oral health including provider availability, preventative service use, water fluoridation and geographic access, with a focus on high-risk populations. These high-risk populations include

children, low-income households, older adults and residents in under-resourced areas. Drawing on multiple data sources including Medi-Cal dental utilization data, findings from the 2024 Community Health Assessment, school-linked reporting through SCOHR, and results from a local oral health survey; this report provides a comprehensive overview of oral health needs and disparities in Mono County. The findings are intended to inform evidence-based interventions, strengthen collaboration with community partners, and align with broader goals outlined in the 2025 Community Health Improvement Plan (CHIP).

3.2 Timeline and Context

This assessment represents an update to Mono County's oral health status, building on the previous assessment conducted in 2019 as part of a joint Community Health Assessment (CHA) by Mammoth Hospital and Mono County Public Health. Since that time, the county has faced ongoing provider shortages, geographic barriers to care and the impacts of the COVID-19 pandemic on preventive service utilization. This updated assessment incorporates more recent data, including Medi-Cal dental utilization trends through 2023, findings from the 2024 CHA, and results from a local oral health survey, providing a current and comprehensive understanding of oral health needs in the county.

3.3 County Profile / Demographics

Mono County is a small, rural jurisdiction in east-central California, situated between Yosemite National Park and the Nevada border. It is the fourth-least populous county in the state, with a total population of 13,195 according to the 2020 U.S. Census (U.S. Census Bureau, 2021). The county spans 3,030 square miles—over 94% of which is publicly owned land, primarily federal (California State Association of Counties [CSAC], 2023). The population is distributed across three distinct geographic regions: the northern area, including Bridgeport (the county seat), Coleville, June Lake, Lee Vining, and Topaz; the central area, anchored by Crowley Lake and Mammoth Lakes; and the southern area, encompassing Benton, Chalfant Valley, and Hammil Valley. Mammoth Lakes is the only incorporated town and home to more than half of the population (approximately

7,000 residents), serving as the county's hub for healthcare and public services (Mono County, 2024).

Mono County's demographic profile reflects both diversity and unique rural characteristics. The population is 64.2% White (non-Hispanic), 27.1% Hispanic or Latinx, 4.1% Asian, 1.6% American Indian or Alaska Native, and 0.3% other races (U.S. Census Bureau, 2021). Tribal communities include approximately 100 members of the Miwok, Mono, Paiute, Shoshone, and Washoe tribes in the Bridgeport Indian Colony and 82 members of the Utu Utu Gwaitu Paiute Tribe in the Benton Paiute Reservation (California Department of Public Health [CDPH], 2023). The median age is 40.5 years, and the population is slightly male-majority (55.1% male and 44.9% female) (U.S. Census Bureau, 2021). Linguistic diversity is notable, with 17.2% of residents speaking Spanish at home (U.S. Census Bureau, 2021).

Socioeconomic conditions shape both strengths and challenges for the community. The median household income is $81,650, lower than the California state average of $103,678 (California Department of Finance, 2024). Approximately 11% of children under 18 live in poverty below the statewide average of 15%, but Hispanic children experience disproportionately higher poverty rates at 31% (KidsData, 2023). The economy is heavily dependent on tourism and recreation, which account for about 80% of local jobs, with the largest employment sectors being leisure and hospitality (52.6%) and local government (18.7%) (Mono County Economic Development, 2024). Between 2008 and 2018, visitor volume increased by 14%, reaching approximately 1.7 million annually (Visit Mammoth, 2019). As of December 2024, the unemployment rate was 4.5%, slightly lower than the statewide rate of 5.2% (California Employment Development Department [EDD], 2025).

Several populations face increased vulnerability to oral health inequities due to social, geographic and economic factors. These include children living in poverty, Latino/Latinx residents, Native American communities, older adults (particularly those with chronic conditions), undocumented residents, seasonal workers and those living in geographically isolated areas (CDPH, 2023). Limited provider availability and significant travel distances to dental care with scant public transportation options, particularly in northern and southern Mono County, further exacerbate access challenges. With approximately 46.2 dentists per 100,000 residents, about half the statewide rate of 92.9, or roughly one dentist for every 3,299 county residents, Mono County faces a shortage of dental providers (Health Resources and Services Administration [HRSA], 2024). Medi-Cal dental access is constrained by the single local practice accepting Denti-Cal, limiting affordable care options (CDPH, 2023). These structural challenges underscore the importance of

targeted interventions, such as expanding mobile and school-linked dental programs, enhancing provider recruitment, and strengthening partnerships to address persistent oral health disparities (U.S. Department of Health and Human Services [HHS], 2020).

Populations of Concern

While Mono County is home to just over 13,000 residents, several groups face heightened vulnerability to oral health disparities due to geographic, socioeconomic, and structural barriers. Children living in poverty are among the most impacted, particularly Hispanic and Latinx children, who experience a poverty rate of 31% compared to the county average of 11% (KidsData, 2023). Latino/Latinx and Native American residents face higher rates of uninsurance and lower preventive service use, contributing to delayed or unmet oral health needs (California Department of Public Health [CDPH], 2023). Older adults, especially those with chronic conditions, may experience limited mobility and transportation barriers that hinder access to dental care (National Institute of Dental and Craniofacial Research [NIDCR], 2021).

Geographic isolation further compounds inequities. Residents in the northern and southern regions of the county—such as Walker, Coleville, Bridgeport, Benton, and Chalfant—often live far from available dental services, with limited public transportation options exacerbating access challenges (Mono County, 2024). Seasonal and low-wage service workers, justice-involved individuals, and undocumented residents may also face barriers related to cost, insurance coverage, and trust in the healthcare system (California Pan-Ethnic Health Network [CPEHN], 2022). Additionally, only one of the three dental practices in Mono County accepts Denti-Cal, creating added obstacles for low-income families who rely on Medi-Cal for coverage (CDPH, 2023).

These overlapping barriers contribute to disparities in preventive care utilization, oral health outcomes, and timely treatment, particularly for children and residents in rural or remote areas (Health Resources and Services Administration [HRSA], 2024). Addressing these inequities will require strategies that expand access to care through mobile and school-linked services, increase the number of local providers accepting public insurance, and strengthen culturally and linguistically appropriate outreach efforts (U.S. Department of Health and Human Services [HHS], 2020).

3.4 Oral Health Context

Importance of Oral Health

Oral health is an essential component of overall health and well-being, influencing nutrition, speech, self-esteem and quality of life. Poor oral health can contribute to or worsen chronic conditions such as diabetes, heart disease and adverse pregnancy outcomes. It can also cause pain and infection that limit daily activities, school attendance, and work productivity. In rural communities like Mono County, where access to dental care is limited, unmet oral health needs can have a disproportionate impact on vulnerable populations. Therefore, addressing oral health is critical not only to preventing dental disease, but also to supporting broader public health goals and improving community vitality.

Background on Local Oral Health Program (LOHP)

Mono County's Local Oral Health Program (LOHP) is funded through the California Department of Public Health's Office of Oral Health and was established to improve oral health outcomes and reduce disparities among county residents. The program conducts surveillance activities, including community oral health assessments, and coordinates prevention initiatives such as school-linked dental screenings, fluoride varnish applications, and dental sealant programs. LOHP also works to expand access to care through partnerships with dental providers, community organizations, and schools, and by supporting outreach and education efforts targeting high-risk populations. These activities are guided by data from the county's oral health needs assessments, Medi-Cal utilization reports, and local surveys, ensuring that interventions address the county's unique geographic and demographic challenges.

3.5 Previous Assessments

2019 Joint Mammoth Hospital & Mono County Health Department CHNA

The last oral health assessment conducted in Mono County took place in 2019 as part of a joint Community Health Needs Assessment (CHNA) completed by Mammoth Hospital and Mono County Public Health. This assessment identified oral health (specifically dental care access and preventive care) as one of the county's top four community health priorities, citing significant disparities in access and availability of services.

In 2019, Mono County was designated a Health Professional Shortage Area (HPSA) for dental care, with only one dentist per 2,020 residents, compared to one per 1,200 residents statewide. At that time, the county had just six practicing dentists—five located in Mammoth Lakes and one in Coleville—and only two providers

accepted Medi-Cal Dental coverage, significantly restricting access for low-income residents and Medi-Cal–enrolled children and families. Since that assessment, the dental workforce has further contracted, with the loss of three local providers, exacerbating existing access challenges and deepening the county's dental care shortage.

The Mammoth Hospital Family Dental Clinic served as the county's main safety-net provider, logging more than 8,000 dental visits between 2017 and 2019, of which approximately 85% were Medi-Cal patients. Most visits for children involved routine exams, preventive cleanings, or treatment of caries, while adults were more likely to seek restorative or emergency care. However, wait times often exceeded two to three months, underscoring a persistent capacity issue.

Preventive and early childhood services were supported primarily by First 5 Mono County, which offered fluoride varnish and early dental screenings for children under age five. Despite these efforts, access remained limited, only 17% of young children had seen a dentist annually, and 18% of kindergarten screenings revealed untreated decay, up from 5% the prior year.

Community survey responses reinforced these quantitative findings. About 15% of respondents rated their oral health as poor, 62% reported a dental visit within the past six months, and 23% said they had not received needed dental care. The most common barriers were cost, lack of dental providers, limited Medi-Cal acceptance, and long waits for appointments. Other factors included fear of dental procedures and the inability to take time off work.

The 2019 assessment concluded that improving provider participation in Medi-Cal, expanding preventive and outreach programs, and strengthening early intervention for children and underserved adults were key priorities to improve oral health outcomes across Mono County.

2018–2022 Local Oral Health Program Evaluation

The Mono County Local Oral Health Program (LOHP) Final Evaluation Report (2018–2022) documented the county's initial five years of state-funded oral health planning, implementation, and capacity-building activities under the California Department of Public Health's Oral Health Program. The evaluation highlighted significant progress in establishing local infrastructure, partnerships, and community-level awareness around oral health, while also identifying ongoing barriers to care in this rural, frontier county.

The report noted that Mono County's LOHP successfully created foundational systems for oral health data collection and interagency collaboration. Partnerships

were formalized between Mono County Public Health, First 5 Mono, Mammoth Hospital Dental Clinic, and school-linked programs, laying the groundwork for school-linked screening and fluoride varnish events. The program also developed educational materials, outreach campaigns, and referral pathways connecting children and families to Medi-Cal dental providers.

Despite these accomplishments, the evaluation underscored continued challenges related to limited provider availability, low Medi-Cal participation among dentists, and geographic isolation that restricts access to both preventive and restorative dental services. These factors, combined with a small and dispersed population, resulted in persistently low Medi-Cal dental utilization rates and a shortage of local providers accepting new patients.

The evaluation also emphasized the importance of early prevention, recommending that future LOHP efforts prioritize school-linked and community-based preventive programs, expand mobile or portable dental services, and strengthen cross-sector partnerships. The report concluded that ongoing investment in Mono County's oral health infrastructure (particularly in workforce expansion, preventive care delivery, and data-driven program evaluation) would be essential to sustain progress and reduce oral health disparities across the county.

2024 Mono County Public Health Community Health Assessment

The 2024 Mono County Community Health Assessment (CHA) identified oral health as a significant community concern, particularly within the broader context of access to care and health equity. The CHA highlighted the county's stark shortage of dental providers reporting just 46.2 dentists per 100,000 residents, nearly half the California average of 92.9 as well as community perceptions of the region as a "medical desert," with limited access to dental, medical, and specialty services.

Through listening sessions and key informant interviews, residents and stakeholders repeatedly cited challenges related to dental care access, especially for low-income families, rural residents, and Spanish-speaking or Native American communities. Oral health emerged as one of seven key themes prioritized by community stakeholders during the CHA process and was ranked alongside mental health, maternal and infant health, and preventive care as requiring urgent attention. The CHA also noted disparities in preventive care engagement, including well-child and immunization visits, which often overlap with oral health promotion efforts.

These findings directly inform the 2025 Community Health Improvement Plan (CHIP), where oral health will be addressed as part of broader strategies to improve

care access, reduce inequities and integrate services for whole-person health across Mono County.

2025 Mammoth Hospital CHNA

The Mammoth Hospital 2025 Community Health Needs Assessment (CHNA) provides important contextual information relevant to oral health access in Mono County. While oral health was not selected as one of the hospital's three priority focus areas, dental health emerged as a notable concern in community input with "Dental" rated as an important health issue by 75% of survey respondents. The CHNA also identified limited availability of services and specialty care as key barriers to accessing healthcare locally, reflecting structural challenges that similarly affect access to dental services in this rural setting. Additionally, Mono County was reported to have a higher population-to-dentist ratio than the California average, underscoring ongoing workforce and access constraints. Findings from the CHNA reinforce the need for complementary, community-based oral health strategies that address service availability, geographic barriers and access for priority populations, particularly low-income residents, older adults, and individuals requiring additional healthcare support.

4. Methods & Data Sources

This assessment used a mixed-methods approach to gather and analyze information on oral health status, service access, and community needs in Mono County. Both secondary data (from existing state and local sources) and primary data (collected directly from residents, providers, and partners) were used to provide a comprehensive picture of oral health across the county. Combining these sources allowed for a deeper understanding of patterns, barriers, and opportunities to improve oral health outcomes, while also highlighting gaps in data availability.

The table below provides a high-level overview of the data sources used in this assessment, including primary and secondary datasets, collection periods, sample sizes, key strengths and limitations.

Data Source	Type	Dates Collected	Sample Size / Scope	Strengths	Limitations
System for California Oral Health Reporting (SCOHR)	Secondary	2022–23, 2023–24, 2024–25	KOHA data from all Mono County elementary schools	Standardized statewide reporting; provides early childhood oral health indicators	Small denominators; inconsistent PoA return rates; data suppression in small schools
Medi-Cal Managed Care Dental Data (Anthem)	Secondary	2023–2025	County-level utilization for ages 0–18	Highlights preventive care gaps; year-over-year trend visibility	Very low counts lead to suppressed data; limited racial/ethnic breakdowns

Medi-Cal Dental (FFS/MDSD) 2013–2023	Secondary	2013–2023	County-level utilization trends over time	Longitudinal trends; useful for monitoring systemic patterns	Limited timeliness; does not reflect emerging mobile services
Community Oral Health Survey	Primary	June 3 – Aug 1, 2025	N = 320 residents across six ZIP codes	Provides local, community-level insight; captures ZIP-level variation	Convenience sample; overrepresentation of certain ZIP codes and households with children
Oral Health Provider Survey	Primary	Aug 4 – Sept 30, 2025	N = 22 providers from diverse sectors	Captures cross-sector perspectives; identifies practical/systemic barriers	Small sample size; not all regional providers represented
Key Informant Interviews	Primary	Sept – Oct 2025	6 interviews across healthcare, education, WIC, public health, community members	Rich qualitative data; identifies nuanced barriers, cultural factors, and system challenges	Non-generalizable; subjective perspectives
Dental Van Program Data	Primary	Oct 2024 – Sept 2025	94 patient encounters across six service days	Direct insight into service utilization in high-need communities	Limited frequency of visits; inconsistent data completeness
Mammoth Hospital Dental Clinic (Local Utilization Patterns)	Secondary	2022–2025	Clinic-level service and demographic trends	Valuable for understanding safety-net demand	Internal data availability varies; not fully comprehensive countywide

4.1 Secondary Data Sources

SCOHR Data

Data from the System for California Oral Health Reporting (SCOHR) were used to assess participation in school-linked dental assessments and monitor oral health outcomes among kindergarten students. SCOHR is a statewide platform used by schools and local oral health programs to track compliance with California's kindergarten oral health assessment requirement (CDPH, 2023).

For this assessment, data from all participating Mono County schools were compiled for academic years 2022–2023, 2023–2024, and 2024–2025. Schools reported the total number of kindergarten students eligible for dental assessments, the number who submitted proof-of-assessment forms, the number who did not return forms, and the number who submitted waivers. Waivers were further categorized by reason including financial burden, lack of consent, insurance issues and transportation barriers. Outcome measures included the number of students with untreated decay and those with caries experience (CDPH, 2023).

Data was analyzed to identify trends over time, including changes in participation, waiver types, and oral health outcomes. Counts and percentages were calculated for

each category to assess both absolute numbers and proportions relative to the total eligible population. Although small sample sizes and data suppression limit some analyses, SCOHR provides critical local insight into patterns of access, participation, and unmet need (CDPH, 2023).

Managed Care Plan Data

Dental service utilization data were obtained from one of Mono County's two Medi-Cal managed care plans, Anthem, for calendar years 2023 through 2025. Data were requested from both managed care plans serving the county; however, Health Net was unable to provide utilization data within the assessment timeframe. As a result, analyses are based on Anthem data only, which represents the majority of Medi-Cal enrollees in Mono County.

The dataset included aggregate measures of pediatric dental utilization, such as oral evaluation visits, preventive services (including fluoride varnish application), and service use by age group. Where available, data were stratified by race and ethnicity. These data were used to characterize patterns of dental service utilization among Medi-Cal–enrolled children in Mono County (California Department of Health Care Services [DHCS], 2024).

Mammoth Hospital Dental Clinic Administrative Data (2022–2025)

Pediatric dental utilization data were obtained from Mammoth Hospital Dental Clinic administrative encounter records for services provided between January 2022 and November 2025. Analyses were limited to children ages 0–17.99 and included four key indicators: (1) number of children receiving any dental service, (2) dental caries treated (procedure codes D2140–D2954), (3) non-traumatic dental-related emergency department visits (procedure code D9110), and (4) fluoride varnish applications (procedure code D1206). Data was provided in aggregate format and stratified by service year, patient race/ethnicity, payer (Medi-Cal vs. other), and ZIP code of residence. These data were used to assess pediatric dental service utilization patterns, treatment burden, and delivery of preventive services within Mono County's primary safety-net dental clinic.

Other Secondary Data Sources

Additional secondary data sources included Medi-Cal dental utilization data from the California Department of Health Care Services, information on provider availability, water fluoridation status, and population demographics from state and federal public health databases.

4.2 Primary Data Sources

Community Oral Health Survey

A community oral health survey conducted from June 3 to August 1, 2025, provided valuable local data on access to dental care, preventive service use, insurance coverage, oral health status, and unmet needs. A total of 320 responses were collected from residents in six Mono County ZIP codes, with the largest share from Mammoth Lakes (93546, 46%), followed by Walker/Topaz/Coleville (96107, 25%) and Benton/Chalfant (93514, 14%).

Oral Health Provider Survey

An Oral Health Provider Survey conducted between August 4 and September 30, 2025, gathered input from 22 local professionals representing public health, social services, early childhood education, childcare, and K–12 schools, medical and dental providers. Respondents identified major barriers to care, including cost, lack of insurance, limited transportation, and a shortage of dental providers particularly in northern Mono County. Many also noted gaps in preventive care and emphasized the importance of outreach, collaboration, and workforce training to improve service delivery.

Key Informant Interviews

To supplement quantitative data sources and provide community context, Mono County Public Health conducted a series of key informant interviews between September and October 2025 as part of the Oral Health Needs Assessment. The interviews gathered qualitative insights on local oral health needs, barriers to care, service gaps, and opportunities for program improvement from individuals who work closely with populations most affected by oral health disparities.

A total of six key informant interviews were completed with representatives from diverse sectors, including:

- Mammoth Hospital Dental Clinic (clinical care and operations)
- Women, Infants, and Children (WIC) Program staff and leadership
- Early childhood education (Lee Vining Preschool)
- K–12 education (Antelope Elementary School, Coleville Middle and High School)
- Mono County Public Health's Tobacco Education Program
- Local community resident serving families in Chalfant and Benton

Interviews were conducted by Local Oral Health Program staff using a semi-structured interview guide developed by the Local Oral Health Program. The guide

included open-ended questions exploring perceived oral health status, access to care, preventive practices, population-specific needs, existing programs, and recommendations for improvement.

Each interview was conducted via phone or in person and averaged approximately 30–45 minutes. Notes were documented by staff and thematically analyzed to identify common patterns, recurring issues, and illustrative quotes across respondents. The qualitative findings from these interviews complement the quantitative data (e.g., Medi-Cal utilization, school screening results, and community survey responses) to provide a more complete picture of oral health in Mono County.

Dental Van Program Data

Data from Mono County's mobile dental van program provided additional insight into service utilization, unmet needs, and geographic access to care. The van delivers preventive and restorative dental services directly to communities with limited provider availability helping to reduce transportation barriers and improve access for underserved populations.

Service data collected between October 2024 and September 2025 included the number of patients served, age distribution, types of services provided (such as screenings, fluoride varnish applications, sealants, and restorative treatments), and referral outcomes for follow-up care. Analysis of this data helped identify where mobile services were most utilized, where gaps remained, and how service delivery patterns aligned with geographic areas experiencing the greatest barriers to oral health care.

4.3 Limitations & Data Gaps

Interpretation of the findings in this assessment must be approached with caution due to several important data limitations. As a small, rural county with a relatively low population, Mono County frequently encounters challenges with data availability and reporting. Many state and regional data sources either suppress Mono County data entirely or aggregate it with larger jurisdictions to protect confidentiality, limiting the ability to analyze local trends or make meaningful comparisons over time. Small sample sizes also mean that year-to-year fluctuations can appear more dramatic than they are in reality, and individual changes can disproportionately influence reported percentages.

Survey participation was voluntary, which may have introduced selection bias and resulted in underrepresentation from certain geographic areas or demographic groups. Some data sources such as Medi-Cal utilization reports and school screening

records may lag by one or more years, potentially underrepresenting recent changes in service availability or program impact. Differences in data collection methods and reporting standards across sources further limit the ability to make direct comparisons between datasets. Additionally, incomplete reporting such as missing school assessment forms, unreturned documentation, or inconsistencies in waiver submissions can reduce data completeness and reliability.

Despite these challenges, the combination of multiple qualitative and quantitative data sources provides a valuable and well-rounded understanding of oral health in Mono County. The limitations identified in this assessment also underscore the importance of strengthening local data collection and reporting systems. Improving the completeness and timeliness of data, enhancing SCOHR participation, and expanding local data collection efforts beyond school-linked assessments will be essential for monitoring trends, guiding targeted interventions, and evaluating progress toward improved oral health outcomes.

5. Findings

5.1 SCOHR Data

Kindergarten Oral Health Assessment (KOHA) data from the California SCOHR reporting system provide an important snapshot of early childhood oral health needs in Mono County and illustrate shifting patterns in both assessment participation and dental disease burden over the past three school years. Across the county, 139 kindergarten students were eligible for KOHA submission in 2022–23, followed by 104 in 2023–24 and 105 in 2024–25. Proof of Assessment (PoA) submission increased steadily over this period, with approximately two-thirds of eligible kindergarteners completing the assessment in 2022–23 (66.9%), rising to 73.1% in 2023–24 and 74.3% in 2024–25. Although overall enrollment is small and year-to-year variation is expected, this upward trend suggests gradual improvement in families' follow-through with KOHA and schools' capacity to support screening and documentation.

Year	Eligible	PoA	PoA rate
2022–23	139	93	**66.90%**
2023–24	104	76	**73.10%**
2024–25	105	78	**74.30%**

Among children who received an assessment, the burden of dental disease remains meaningful, though annual estimates fluctuate considerably due to small denominators and variation in which children are screened each year. The

proportion of assessed kindergarteners with untreated decay was high in 2022–23 (32.3%), dropped notably in 2023–24 (3.9%), then rose again to 26.9% in 2024–25. Caries experience which includes both current and previously treated decay, followed a similar pattern, decreasing from 12.9% in 2022–23 to 7.9% in 2023–24 before increasing to 30.8% in 2024–25. These fluctuations likely reflect the small size of annual kindergarten cohorts, differences in student participation across years, and the influence of Mammoth Elementary (where most kindergarteners are enrolled) on countywide results. The proportion of children with no dental problems identified was correspondingly variable, reaching its highest level in 2023–24 (60.5%) before decreasing again in 2024–25 (29.5%). Early dental decay (incipient lesions) appears to have increased over time, from 5.4% of assessed students in 2022–23 to 35.5% in 2023–24 and 43.6% in 2024–25. This trend may reflect improved screening practices and documentation, but it also suggests growing detection of early-stage disease among children entering kindergarten. Across all three years, a small but consistent group of children (approximately 1–3% of those assessed) required urgent dental care, highlighting the continued presence of acute or severe oral health needs even in a relatively small population.

School-level data offers further insight into geographic patterns and disparities within the county. In 2024–25, Antelope, Lee Vining, and Edna Beaman Elementary Schools achieved full assessment participation among eligible kindergarteners, while Mammoth Elementary and Bridgeport Elementary had substantially lower PoA rates (65.7% and 57.1%, respectively). Despite higher coverage at the smaller schools, Mammoth Elementary accounted for the majority of dental disease identified countywide simply because it enrolls the largest share of Mono County's kindergarten population. More than one-third of assessed kindergarteners at Mammoth Elementary had untreated decay (39.1%) and caries experience (39.1%), and over half showed signs of early decay (54.3%). Urgent care needs were recorded almost exclusively at Mammoth, affecting roughly 2% of assessed students. In contrast, findings from the smaller rural schools varied widely and should be interpreted cautiously due to very small denominators, though several reported no untreated decay or caries experienced in 2024–25.

Taken together, the KOHA data indicates that although Mono County is making gradual progress in improving assessment participation, substantial oral health needs persist among kindergarten-aged children, particularly in Mammoth Lakes. The fluctuation observed across multiple years underscores the importance of consistent and comprehensive screening, especially in the schools with larger enrollments and more diverse student populations. These findings support continued investment in school-linked prevention efforts, culturally and

linguistically appropriate family outreach, stronger follow-up systems for children with identified dental needs, and targeted strategies to increase KOHA participation in schools where coverage remains low.

5.2 Managed Care Plan Data

Analysis of Anthem data from 2023 through 2025 reveals very low rates of both oral evaluations and preventive fluoride applications among children in Mono County. Oral evaluation rates were near zero in 2023, showed slight improvement in 2024, and remain low in early 2025. Utilization is uneven across ages: toddlers (ages 0–3) rarely had a documented dental visit, school-age children (ages 4–12) showed modest increases with some groups reaching 10–20%, and adolescents (ages 13–18) again demonstrated low and inconsistent utilization.

Topical fluoride application rates are consistently near zero across all three years. With only isolated cases of children receiving varnish, the data suggests a system-wide absence of preventive fluoride delivery rather than a disparity confined to a particular group. This represents a significant gap, as fluoride varnish is most impactful in early childhood, yet virtually no uptake is documented in this critical age range.

Racial and ethnic disparities are difficult to fully assess given small denominators for most groups. White children make up the largest proportion of the population but still have very low utilization rates. American Indian/Alaska Native children are rarely represented, though when they do appear their rates sometimes trend higher; however, these findings are based on very small numbers. Children listed as "Unknown" race/ethnicity are common in early years and in some cases show higher utilization than White children. Black, Asian, and Pacific Islander children appear only sporadically and in very small numbers, limiting the ability to identify clear patterns. The underrepresentation of some groups itself highlights potential inequities in enrollment, access, or reporting.

Overall, the most significant disparity is by age, with toddlers and adolescents consistently underserved despite strong evidence supporting early and ongoing preventive dental care. The absence of topical fluoride application across all ages points to systemic barriers in service delivery. These findings underscore the need for local strategies that expand access to early preventive oral health care, strengthen partnerships with WIC, pediatricians and schools to ensure that preventive services like fluoride varnish are routinely delivered to all children regardless of race, ethnicity, or geographic location.

In summary, between 2023 and 2025, dental service utilization among children in Mono County remain very low. Oral evaluations were rare in toddlers and adolescents, and topical fluoride application was virtually absent across all age groups. While small numbers limit conclusions about racial disparities, the most striking gap is by age, with early childhood and adolescence showing the lowest preventive care. These findings point to systemic barriers in preventive oral health delivery.

5.3 Mammoth Hospital Dental Clinic

Mammoth Hospital Dental Clinic serves as a critical component of Mono County's oral health safety net and is the only dental clinic in the county that accepts Medi-Cal. As a result, the clinic plays a central role in providing access to dental services for low-income children and families who would otherwise face significant barriers to care. In a county with a limited dental workforce and minimal Medi-Cal participation among private providers, Mammoth Hospital Dental Clinic functions as the primary point of access for preventive and restorative dental care for Medi-Cal–enrolled residents, particularly children. Its services are essential to addressing unmet dental needs and mitigating disparities in access across Mono County's geographically dispersed communities.

Number of Children Served

Between 2022 and 2025, Mammoth Hospital Dental Clinic provided dental services to 9,627 pediatric patients, with annual volumes ranging from approximately 2,000–2,800 children per year. Utilization declined notably in 2023, followed by a partial rebound in 2024 and relatively stable service levels in 2025. The majority of pediatric patients were Medi-Cal enrolled (over 80%), and most resided in Mammoth Lakes (93546) and surrounding Mono County ZIP codes, highlighting the clinic's role as a primary safety-net provider for children in the region.

Caries Treated

Across the four-year period, 2,790 visits involved treatment of dental caries among children, representing a substantial proportion of overall pediatric dental encounters. Annual caries treatment volumes remained relatively consistent, ranging from approximately 570 to 760 visits per year, suggesting a persistently high burden of untreated decay among children accessing care. The majority of caries treatment occurred among White and Hispanic/Latino children, reflecting both the underlying population distribution and the clinic's patient mix, with services concentrated in Mammoth Lakes and nearby rural communities.

Emergency Room (ER) Non-Traumatic Dental Visits

Non-traumatic dental-related ER visits among children were low in absolute numbers, totaling 22 visits from 2022 through 2025. Annual counts declined slightly over time, from 7 visits in 2022 and 2023 to just 2 visits in 2025, suggesting either improved access to clinical dental care or barriers that continue to suppress ER utilization for dental conditions. While small in number, these visits are notable as indicators of delayed or unmet dental needs, particularly for pain-related conditions that could often be prevented through earlier intervention.

Fluoride Treatments

Fluoride varnish application was documented in 2,211 visits during the study period, with annual totals ranging from approximately 400 to 600 visits per year. While fluoride delivery remained relatively stable over time, the number of fluoride treatments was substantially lower than the total number of children served, indicating missed opportunities for preventive care. Fluoride treatments were most frequently provided to children residing in Mammoth Lakes and other central Mono County ZIP codes, consistent with access patterns observed across other service types.

Taken together, this data suggest that Mammoth Hospital Dental Clinic plays a critical role in serving Medi-Cal–enrolled children and addressing significant treatment needs, particularly dental caries. However, the gap between the number of children seen and the number receiving fluoride varnish indicates ongoing challenges in delivering comprehensive preventive services—likely influenced by staffing constraints, visit prioritization toward restorative care, and broader workforce shortages. Low ER utilization for dental conditions may reflect both successful diversion to clinic-based care and persistent access barriers that delay care until treatment becomes unavoidable.

5.4 Community Oral Health Survey

The local oral health survey (N = 320), conducted from June 3 to August 1, 2025, collected responses from six Mono County ZIP codes, with the largest share from Mammoth Lakes (93546, 46%), followed by Walker/Topaz/Coleville (96107, 25%) and Benton/Chalfant (93514, 14%). Overall, 88% of respondents reported having a dentist, though access gaps were more pronounced in rural areas such as 96107 and 93514. Preventive care utilization varied: 16% of 96107 residents and 15.8% of 93514 residents had not received a dental cleaning in the past year, compared to only 5.6% in Mammoth Lakes. Dental insurance coverage was reported by 83% overall, but uninsured rates reached 25% in 93514 and 18.3% among Hispanic/Latino respondents. Current dental decay, pain, or swelling was reported by 17.9% of 93514 respondents, 14.8% in 96107, and 12.7% of Native American

respondents, compared to 6.9% of White respondents. Sealant rates were low overall, with the highest numbers in 93546 and 96107, primarily among White and Hispanic/Latino children aged 5–12. These results indicate persistent geographic and racial/ethnic disparities in oral health access, preventive care, and treatment needs across Mono County.

5.5 Medi-Cal Dental Utilization and Sealant Data (2013–2023)

According to data from the California Department of Health Care Services Medi-Cal Dental Services Division (MDSD), dental utilization among Medi-Cal-enrolled children and adults in Mono County has fluctuated modestly over the past decade, reflecting persistent access challenges in a small and rural population.

The proportion of Medi-Cal members with at least one annual dental visit has remained relatively stable since 2013, ranging from approximately 27 to 42 percent. Utilization increased gradually from about 27 percent in 2013 to around 40 percent by 2015, dipped slightly in the mid-2010s, and peaked near 41 percent in 2019 and again in 2022 before declining to roughly 35 percent in 2023. These rates have consistently fallen below statewide averages, indicating that a substantial portion of Medi-Cal-eligible residents do not receive routine preventive or restorative care each year.

Rates for diagnostic exams and oral health evaluations have remained lower than overall visit utilization, typically between 22 and 29 percent across the reporting years. This suggests that even when residents access dental care, visits may be more often driven by urgent or treatment needs rather than routine preventive examinations.

Sealant placement data for children ages 6 to 14 show small-sample variability year to year, with many data points suppressed due to low counts. However, the data that are available indicate that sealant utilization remains limited in Mono County, reflecting both the county's small pediatric Medi-Cal population and the limited availability of providers who can deliver school-linked or preventive sealant services.

Overall, these trends demonstrate that Medi-Cal dental utilization in Mono County remains low and inconsistent, mirroring the barriers identified through local interviews and stakeholder feedback. Geographic isolation, provider shortages, and the absence of specialty and pediatric services contribute to underuse of preventive dental care. Fluctuations in rates from year to year are expected given the small population base, but the data highlight an ongoing need to expand outreach,

provider participation, and school-linked prevention efforts to increase consistent access to dental care for Medi-Cal-enrolled children and adults.

5.6 Provider Survey

Background

Mono County Public Health conducted an Oral Health Provider Survey between August 4 and September 30, 2025 to gather insights from local professionals about the current state of children's oral health, access to services, and community needs. A total of 22 respondents completed the survey, representing a range of sectors including county public health and social services, early childhood education and childcare, and K–12 schools. Respondents reported working in diverse geographic areas across Mono County, including Mammoth Lakes and Crowley Lake (93546), Bridgeport (93517), Lee Vining (93541), Benton and Chalfant (93514), and Walker and Coleville (96107), reflecting perspectives from both central and more rural parts of the county.

Key Findings

Survey results underscore a broad consensus that oral health remains a significant public health issue in Mono County. Nearly all respondents rated oral health as either "very significant" or "extremely significant" for their communities. Despite this recognition, many highlighted persistent barriers that prevent families from accessing care, with the most commonly cited including cost or lack of insurance, limited transportation, a shortage of dental providers (particularly in the northern part of the county), and lack of providers who accept public insurance. As one respondent noted, *"The lack of providers in our county, especially in the north, has made it very difficult to really impact access to oral health care in Mono County."*

Access to pediatric dental services was widely described as limited. Most respondents characterized pediatric dental care as "not very accessible," and many believed that children in their communities typically do not see a dentist until after age three, well beyond the recommended age for a first dental visit. The highest identified unmet oral health need among children included routine dental checkups, treatment of cavities, preventive services such as fluoride and sealants, and caregiver education. Several also pointed to gaps in emergency care and services tailored to children with special needs.

While a majority of respondents reported feeling comfortable discussing oral health with families, many emphasized the need for additional supports and resources to effectively promote oral health. Suggestions ranged from community-based outreach and public awareness campaigns such as "PSAs on local radio stations" and

"meeting with tribal board members" to structural improvements like "increased collaboration with providers" and "more dental providers available in the north of our county." Another respondent recommended exploring innovative models, stating, *"Maybe a combined vaccination/dental clinic"* could help increase engagement and access.

Training gaps were also apparent: most respondents had not received formal training on children's oral health in the past three years, highlighting an opportunity for workforce development and education to strengthen oral health promotion efforts.

The survey findings point to a clear need for expanded access to dental services, particularly for children and families in Mono County's more remote communities. Cost, transportation, and provider shortages remain key structural barriers, while public awareness and engagement efforts may help address behavioral and informational gaps. Providers express readiness to engage in oral health promotion but seek greater support, collaboration, and training to do so effectively. These insights will inform planning and program development efforts as Mono County works to improve oral health outcomes for all residents, particularly children.

5.7 Dental Van Data

Mobile dental services continue to play a critical role in expanding access to preventive and restorative oral health care in Mono County. The dental van program, supported through Smile Dental and partner providers, offers on-site care in communities where no local dental offices exist; including Benton, Chalfant, Bridgeport, Lee Vining, and the Antelope Valley region.

Between October 2024 and September 2025, the dental van conducted six service days in Mono County, delivering a mix of preventive, restorative, and limited surgical procedures. Across all visits, 94 total patient encounters were recorded. Preventive and periodontal treatments represented the majority of services, with several patients also receiving restorative fillings, partial dentures, and referrals for higher-acuity care.

During the first two visits in October 2024, held in Bridgeport and Walker, 36 patients were seen across two days. The majority had Medi-Cal Dental coverage, though several were uninsured. Services included oral hygiene instruction (21 total), full-mouth X-rays (2), periodontal scaling and maintenance (28 total), and a small number of oral surgery and denture fittings.

Subsequent visits in September 2025 expanded to include Lee Vining and the Antelope Valley, with four days of operation. These visits served 58 scheduled patients, of whom 11 did not attend. Among the 47 completed encounters, the most frequent services were dental exams (39), X-rays (37), and cleanings (28). Preventive interventions included 30 fluoride varnish applications and 7 scaling and root planning procedures. Minor restorative treatment was provided to 9 patients, and several cases were referred for follow-up or more advanced treatment.

Insurance coverage varied across visits. Approximately 60 percent of patients were Medi-Cal Dental enrollees, 11 percent had private insurance, and nearly 30 percent reported no dental coverage. The consistent presence of uninsured patients underscores the dental van's essential role as a safety-net provider, particularly in communities with limited provider participation in Medi-Cal.

Overall, the combined data from 2024–2025 demonstrate that mobile dental services are effectively reaching residents who might otherwise go without care. The range of services provided—from preventive cleanings and fluoride treatments to restorative and limited surgical care—illustrates both the depth of community need and the value of maintaining recurring mobile dental clinics throughout Mono County.

5.8 Key Informant Interviews

As part of this Oral Health Needs Assessment, six key informant interviews were conducted with professionals representing a range of sectors, including health care, education, WIC, early childhood programs, and public health. Their perspectives offered valuable insight into community oral health strengths, challenges, and opportunities across Mono County.

Access to Care and Systemic Barriers

Every key informant described limited access to dental care as a central challenge in Mono County. Residents face long travel times, workforce shortages, and insurance limitations that make even basic dental services difficult to obtain. Families must often travel several hours to reach providers who accept Medi-Cal or who can perform specialized services such as pediatric sedation or oral surgery. One clinic supervisor explained, ***"Families have to go down south to Loma Linda since Medi-Cal isn't accepted in Nevada,"*** despite the fact that Nevada is geographically closer for many north-county residents.

Transportation, weather, and work constraints compound these challenges. Many parents work multiple jobs and cannot afford to take time off for dental appointments. As one provider noted:

> *"Often parents work several jobs to survive, so missing work becomes more of a financial burden—not to mention the cost of travel, lodging, gas, and food."*

Informants consistently described Mono County as a ***"health care desert"*** with limited options for both routine and preventive care. Following the loss of facilities such as the Toiyabe Indian Clinic, access gaps widened further. ***"There is far less ease of access to a dental provider,"*** one school administrator shared. ***"Transportation acts as a major barrier, as well as traveling to town and missing work."***

Even among those with insurance, provider availability remains a problem. One WIC staff member in Chalfant observed that ***"my neighbors go to Bishop or to providers in Reno or Carson City,"*** while others simply postpone care until emergencies arise.

Prevention, Education, and Awareness

Across all interviews, participants emphasized the need for stronger oral health education and early prevention efforts. While programs such as WIC's "Happy Teeth" initiative and Children's Dental Health Month presentations provide important outreach, informants agreed these efforts are not sufficient to reach all families or reinforce habits over time.

Many parents are unaware of available benefits or the importance of early dental visits. A WIC director shared,

> ***"Most pregnant moms do not realize they have benefits through Medi-Cal while they are pregnant and post-partum. Most parents are unaware of how to care for infants' gums or to access dental care with the eruption of teeth."***

Several educators also noted a lack of understanding about the connection between oral and overall health. ***"About 35% don't understand the significance or importance of oral health across all school age children and their parents,"*** one principal estimated.

Clinical staff at Mammoth Hospital's Dental Clinic described the consequences of this gap firsthand, seeing children "with severe abscesses" and parents who don't recognize the risks of untreated infections. ***"The dentist must provide education about the infection worsening and spreading to their bloodstream,"*** one provider noted.

Informants emphasized that education should start early and be delivered through multiple settings—schools, preschools, WIC, First 5, and pediatric care—to build lasting understanding and normalize preventive dental visits from infancy onward.

Populations Most at Risk and Opportunities for Collaboration

Interviewees identified Hispanic, low-income, and rural residents as most at risk for poor oral health outcomes due to a combination of financial, linguistic, and geographic barriers. As one WIC nutrition assistant described, ***"The Hispanic culture provides more sugar to their children, especially sugary drinks,"*** and many families ***"face language barriers, financial challenges, and limited provider availability."***

Pregnant women and young children were highlighted as additional priority populations. WIC staff frequently encounter immigrant mothers with longstanding untreated dental issues, limited health literacy, and missed opportunities for covered prenatal care.

> ***"Pregnant women are covered for a shorter time and often have access challenges,"*** one director explained, noting that many ***"phase out of coverage before they can get in to see a provider."***

Despite these barriers, informants pointed to strong community commitment and collaboration as key strengths. Mono County's Local Oral Health Program, WIC, First 5 Mono, School linked programs, Owens River Development Career Development Center/TANF and Mammoth Hospital Dental Clinic were all recognized for working together to improve prevention, education, and screening opportunities. A dental supervisor summarized, ***"Mammoth Hospital Dental Clinic and Mono County Public Health providing countywide education and assessments together"*** would be an ideal next step.

Practical suggestions included expanding mobile dental services to reach remote areas and increasing school-linked programs. One educator proposed, ***"Bring the oral health van every six months and spread across two days—ideally at the school or community center"***

Summary

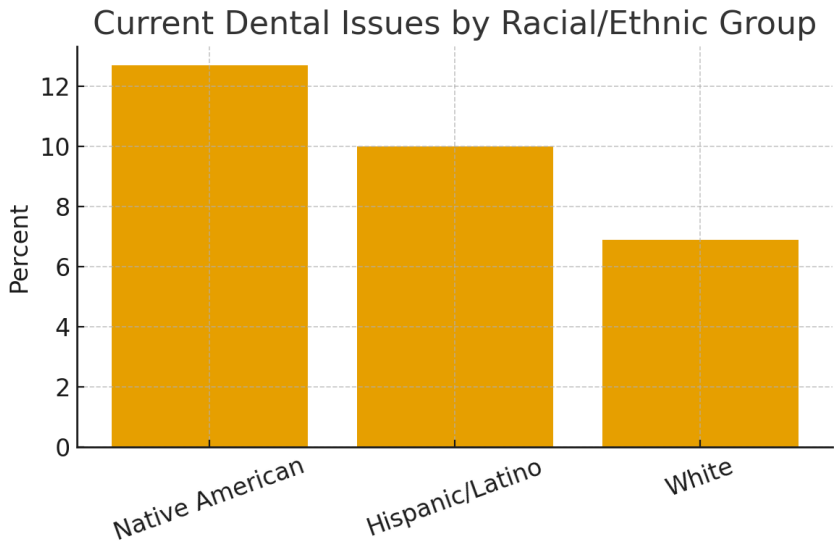
Overall, key informant feedback reinforces that limited access, low oral health literacy, and systemic inequities are driving oral health disparities across Mono County. Yet it also highlights the potential of cross-sector partnerships—uniting dental providers, public health, schools, and family programs—to strengthen prevention, improve access, and close long-standing gaps for children and families.

5.9 Disparities in Oral Health

Survey results and available public data indicate clear disparities in oral health across Mono County by race/ethnicity, geography, age, and socioeconomic status. Geographic differences are notable: residents in rural areas such as Benton/Chalfant (93514) and Walker/Coleville/Topaz (96107) reported the highest rates of current dental problems, with 17.9% and 14.8%, respectively, experiencing decay, pain, or swelling, compared to 8.7% in Mammoth Lakes (93546). Preventive care use also varied by location, with 96107 having the highest proportion of residents without a recent dental cleaning (16%) and consistently lower sealant rates outside Mammoth Lakes.

These disparities are likely compounded by age-related and coverage-related barriers in Walker, which has a substantially older population (median age 66.9 in 2023). Many residents rely on Medicare, which does not include routine dental coverage, limiting access to preventive services and early treatment. For residents dually eligible for Medi-Cal, care options are further constrained by restrictions on receiving services out of state—even when Nevada-based providers are geographically closer—requiring travel to Mammoth Lakes for care. For older adults with chronic conditions or mobility limitations, these distance and transportation barriers may contribute to delayed care, unmet dental needs, and higher reports of pain or infection.

Racial and ethnic disparities were evident in preventive visit rates and current oral health status. Native American respondents were most likely to report no dental visit in the past year (12.7%) and had the highest rate of current dental issues (12.7%), followed by Hispanic/Latino respondents (10% with current issues) and White respondents (6.9%). Insurance coverage gaps were most pronounced among Hispanic/Latino (18.3% uninsured) and White (17.6% uninsured) residents, potentially contributing to reduced access to routine and preventive services. Medi-Cal coverage was generally high among children and low-income households, but rural communities with fewer providers accepting Medi-Cal remain at risk for unmet dental needs.



6. Access to Care

6.1 Availability of Dental Services

Dentists per 100,000 Residents	Mono County	CA State Average
	46.2	92.9

Source: County Health Rankings 2024

Mono County continues to experience significant challenges in accessing dental care due to its extremely limited workforce and rural geography. Although statewide metrics suggest moderate provider capacity—California reports approximately 77 dentists per 100,000 residents—the "dentists per capita" ratio does not accurately reflect the realities in small, rural counties. Mono County's estimated ratio of 46.2 dentists per 100,000 residents appears adequate on paper, but this figure is misleading in a county with a population of just 13,900. In practice, this ratio equates to only a handful of practicing providers, all of whom are located in one community.

Statewide workforce data underscore these disparities. UC Health reports that many of California's Dental Health Professional Shortage Areas (HPSAs) are concentrated in the Northern and Sierra regions, where communities experience persistent shortages of dental providers and limited Medi-Cal participation. Approximately 2.2 million Californians live in designated Dental HPSAs, illustrating a statewide mismatch between reported dental supply and true access to care in rural regions

(UC Health, 2020). Mono County reflects this broader trend, sharing structural workforce shortages common to rural HPSA-designated counties.

As of November 2025, Mono County's dental workforce is limited to three clinics, all located in Mammoth Lakes:

Dr. Comfort's Office	Mammoth Dental	Mammoth Hospital Dental Clinic
• 1 dentist • 1 hygienist • 1 per-diem hygienist	• 1 dentist • 1 full-time hygienist • Capacity for up to 4 part-time hygienists	***Only clinic in Mono County accepting Medi-Cal* • 1 full-time adult Dentist • Adult Dentist one week/month • Pediatric Dentist two weeks/month • Pediatric Dentist one week every other month (or less) • 1 full-time hygienist • 1 per-diem hygienist

Despite what the statewide ratio might imply, the county effectively has only three full-time dentists, supplemented by a variable-schedule of traveling dentists at Mammoth Hospital. No providers operate full-time in any of the county's northern or southern regions, leaving communities such as Walker, Coleville, Bridgeport, Lee Vining, Benton, and Chalfant without local access to routine or urgent dental care. Residents in these areas must often travel long distances—frequently over mountainous terrain and in winter weather—to receive even basic dental services.

Survey findings highlight these disparities. While many residents report having dental insurance and having identified a usual source of care, individuals living in rural ZIP codes are significantly less likely to obtain preventive services and more likely to experience gaps in care. Limited Medi-Cal acceptance among the county's few practices further restrict access for low-income families and children.

The absence of full-time public dental services outside Mammoth Lakes has led to increased reliance on episodic and short-term solutions, including mobile dental vans, one-day clinics, and short-term visiting providers. While these services provide valuable stopgap support, they cannot replace a stable, locally available dental workforce—particularly in a region already exhibiting characteristics of a Dental Health Professional Shortage Area.

In summary, the standard "dentists per 100,000 residents" metric substantially overstates Mono County's true provider capacity and does not capture the geographic concentration, limited Medi-Cal participation, and shortage-area conditions that define dental access in the Eastern Sierra. A more accurate picture reveals a county with only two full-time dentists, no permanent dental presence in

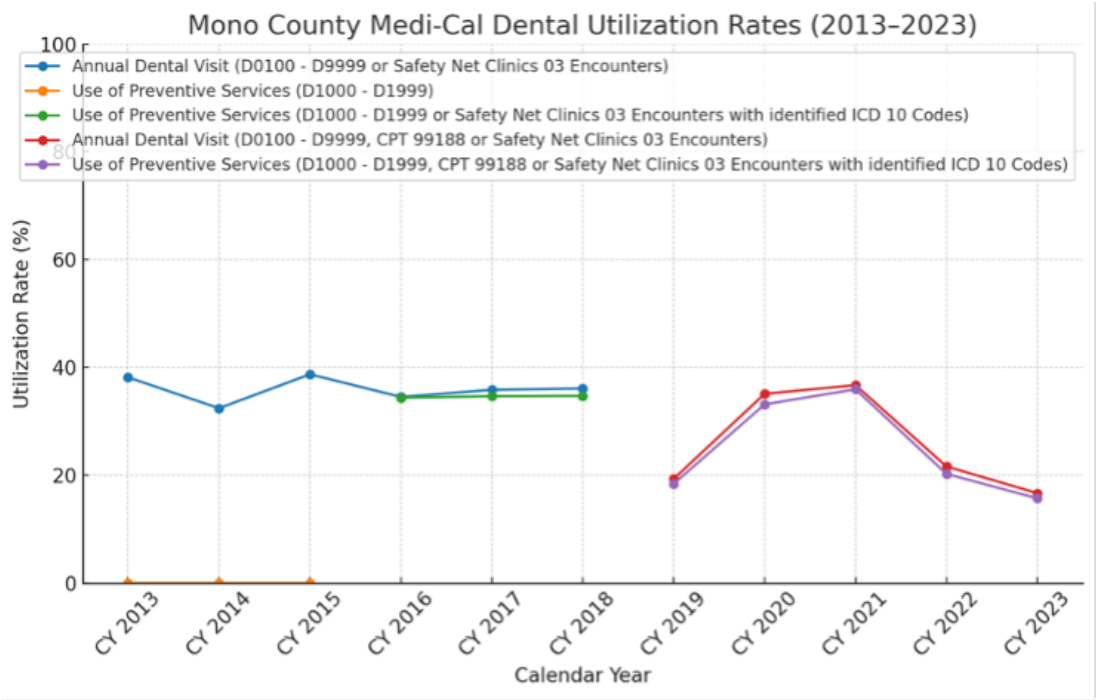
remote communities, and structural barriers consistent with California's rural Dental Health Professional Shortage Areas.

6.2 Dental Hygienist Workforce Shortages and Preventive Care Access

In addition to dentist shortages, limited availability of dental hygienists presents a significant barrier to preventive oral health care in Mono County. Statewide data indicate that shortages of dental hygienists have become widespread since the COVID-19 pandemic, with many practices reporting difficulty recruiting and retaining hygienists and other allied dental staff. National and California workforce analyses show that vacant hygienist positions have reduced overall dental practice capacity by approximately 10%, directly limiting the number of patients who can receive routine cleanings, sealants, fluoride applications, and other preventive services (Healthforce Center at UCSF & California Department of Health Care Access and Information [HCAI], 2023).

These constraints are particularly impactful in rural and HPSA-designated areas such as Mono County, where dental practices already operate with minimal staffing and limited redundancy. When hygienist availability is reduced—due to unfilled positions, reliance on per-diem coverage, or regional workforce shortages—preventive appointments are often delayed or deprioritized in favor of urgent or restorative care. This dynamic disproportionately affects children, older adults, and Medi-Cal–enrolled residents, for whom preventive services are critical to avoiding more serious oral health conditions. As a result, hygienist shortages further compound existing geographic and workforce barriers, contributing to lower utilization of preventive dental care and reinforcing disparities observed across the county.

6.3 Medi-Cal Utilization



Medi-Cal enrollees in Mono County experience some of the most significant barriers to obtaining timely and preventive oral health services. Beyond the county's limited dental workforce, low participation in the Denti-Cal program further restricts options for coverage-based care, especially for families living outside Mammoth Lakes. These challenges are exacerbated in northern and southern communities, where long travel distances and limited transportation make routine dental visits difficult to maintain.

Medi-Cal utilization trends from 2013–2023 show that these barriers translate into consistently low engagement with the dental system. Annual dental visit rates have remained between 32% and 45% over the past decade, with a sharp drop during the COVID-19 pandemic and an incomplete rebound in the years since. Preventive care utilization is even more concerning: many years include suppressed or near-zero preventive service counts due to extremely small numbers, and in years where the data are reportable, preventive visits remain far below treatment or diagnostic encounters. This pattern suggests that most Medi-Cal dental care is problem-driven rather than preventive in nature (DHCS, 2024).

Overall, the data point to a system in which geography, provider availability, and low Denti-Cal participation intersect to limit preventive care and delay treatment. Strengthening mobile and rotating dental services, expanding school-based and school-linked prevention programs, and developing incentives or partnerships to

increase Medi-Cal provider participation will be essential to reducing unmet needs and improving oral health outcomes for children and other vulnerable populations in Mono County (DHCS, 2024).

6.4 Barriers to Care

Mono County residents experience layered challenges to securing consistent oral health care, many of which extend beyond provider shortages or insurance participation alone. With only one full-time public dental clinic operating in Mammoth Lakes, service availability remains limited relative to the size and geographic spread of the county, leaving large regions without nearby routine or preventive care options (CDPH, 2023).

Geographic isolation amplifies these gaps. For residents of northern and southern communities, long travel distances and limited transportation not only complicate routine care but also make it difficult to return for follow-up visits, specialty referrals, or time-sensitive treatment. These constraints particularly affect older adults, low-income residents, and families with young children, for whom missing work or securing childcare may pose additional barriers.

Financial and coverage-related obstacles also influence care-seeking behavior. While prior sections describe low Denti-Cal participation, cost concerns extend beyond insurance acceptance. Families report delaying cleanings, evaluations, or sealant placement due to co-pays, lack of coverage for certain services, or uncertainty about costs. Survey data also indicate that a subset of residents—especially in rural ZIP codes and among Hispanic/Latino households—remain uninsured, which can deter preventive care until dental problems become urgent (CDPH, 2023).

Access barriers further intersect with awareness, navigation, and system-level challenges. High numbers of unreturned Kindergarten Oral Health Assessment forms suggest gaps in communication with families or limited familiarity with school requirements. Language differences, literacy levels, and cultural perceptions of dental care may also contribute to inconsistent engagement with prevention programs. In addition, limited availability of dentists trained in pediatric care, special health care needs, or bilingual service delivery reduces options for families who require more specialized or culturally responsive care.

Finally, preventive service delivery remains inconsistent countywide. Preventive treatments such as fluoride varnish are only sporadically documented in managed care data, and school-linked oral health programs—while growing—lack the

staffing and geographic reach needed to serve all schools equitably. The absence of community water fluoridation places even greater emphasis on in-office and school-based prevention, which are not equally accessible across communities (CDPH, 2023).

Together, these factors underscore the need for a more coordinated and equitable oral health system—one that expands mobile and community-based services, strengthens culturally and linguistically appropriate outreach, bolsters the dental workforce, and supports families in navigating available programs. Without these strategies, many residents—particularly children, rural households, and Medi-Cal–eligible families—will continue to experience preventable oral health challenges

6.5 Oral Health Literacy and Cultural/Linguistic Barriers

Oral health literacy—the ability to obtain, understand, and use oral health information—plays a critical role in shaping preventive behavior, care-seeking, and long-term oral health outcomes. Findings from the community survey, provider survey, and key informant interviews indicate that limited oral health literacy and cultural or linguistic barriers significantly contribute to disparities in oral health across Mono County.

Spanish-Language Gaps and Communication Challenges

A substantial portion of Mono County residents—17.2%—speak Spanish at home, yet key informants consistently emphasized gaps in Spanish-language communication related to dental services, preventive care, and insurance benefits. Families who primarily speak Spanish often rely on informal networks for health information, which can lead to inconsistent messaging or misunderstanding about the importance of early dental visits, fluoride varnish, and sealant placement.

Several school and WIC staff noted that parents may not understand KOHA requirements, preventive recommendations, or when and how to access local dental services. These gaps directly influence participation in school-linked prevention programs and timely follow-up on referrals.

Cultural Perceptions of Dental Care

Interviews revealed cultural beliefs that influence when and how families seek dental care. Some parents, particularly from Hispanic/Latino and immigrant communities, may prioritize dental treatment only when pain or visible problems arise, rather than viewing routine prevention as essential. Providers described instances in which caregivers did not recognize the seriousness of early decay or the risks associated with untreated infections.

These cultural perceptions can delay care-seeking, resulting in children entering school with more advanced dental disease and requiring higher-acuity treatment. They also shape attitudes toward fluoride, sealants, and early dental visits, which are not universally understood as standard preventive practices.

KOHA Form Return and System Navigation Barriers

The kindergarten oral health assessment (KOHA) process highlights broader challenges with system navigation and communication. While PoA submission rates have improved countywide, schools with larger and more linguistically diverse student populations—such as Mammoth Elementary—continue to report lower return rates. Feedback from educators and program partners suggests that unreturned forms often reflect barriers such as:

- Limited understanding of the requirement,
- Confusion about where to obtain a dental assessment,
- Difficulty scheduling appointments due to work or transportation challenges, and
- Language or literacy gaps that make instructions unclear.

These issues underscore the need for more culturally responsive outreach and hands-on navigation support.

Limited Awareness of Medi-Cal Benefits, Especially for Pregnant Individuals

WIC staff and clinic providers consistently reported that many pregnant individuals do not realize they have dental coverage through Medi-Cal during pregnancy and the postpartum period. This lack of awareness leads to missed opportunities for early intervention, prevention of pregnancy-related oral health complications, and connection to dental homes for both parents and infants.

For immigrant families or households with mixed documentation status, uncertainty about eligibility or fears related to public benefits can further deter the use of available dental services.

Implications for Equity and Access

Together, these findings show that disparities in oral health literacy and communication contribute to later-stage disease, lower preventive utilization, and reduced engagement with school-linked and community programs. Strengthening culturally and linguistically appropriate communication—through trusted messengers, bilingual materials, and integrated outreach across WIC, MCAH, schools, and community organizations—will be essential to improving oral health outcomes, particularly for Hispanic/Latino, Native American, and rural families.

Improving oral health literacy is not only a clinical priority but also a key component of health equity, as it empowers families to understand preventive care, access services earlier, and navigate available resources effectively.

7. Preventive Services and Public Health Infrastructure

7.1 Community Water Fluoridation (CWF)

Mono County does not have any community water systems that provide optimally fluoridated water. Most residents rely on small community systems, private wells, or other non-fluoridated sources, leaving the population without the proven cavity-preventing benefits of community water fluoridation (CDPH, 2023). This absence is especially notable given that approximately 64% of Californians and 73% of the U.S. population served by public water systems receive fluoridated water (CDPH, 2023). In a county with rural geography, limited preventive dental access, and low Medi-Cal preventive utilization rates, the lack of fluoridation increases reliance on in-office preventive measures, which are less accessible in underserved areas (CDPH, 2023).

7.2 Topical Fluoride Varnish Application

Preventive oral health services in Mono County are delivered through a combination of clinical and community-based settings, with a growing emphasis on early childhood fluoride varnish application. Pediatric providers at Mammoth Hospital routinely apply fluoride varnish during well-child visits, beginning at tooth eruption and continuing through age five, consistent with evidence-based preventive care recommendations for young children.

The Mono County Local Oral Health Program supplements clinical services by providing fluoride varnish during oral health outreach activities, including school-linked oral health events and community-based assessments. These efforts are designed to reach children who may face barriers to accessing routine dental care, particularly in rural and underserved areas of the county. In addition, fluoride varnish will be offered at newly scheduled oral health events hosted at public libraries throughout the county, further expanding access to preventive services in familiar, non-clinical settings.

Looking ahead, the Mono County Local Oral Health Program has identified fluoride varnish application as a key preventive strategy and a priority area for continued expansion. By integrating varnish application across multiple service settings and age-appropriate touchpoints, the program aims to strengthen early prevention

efforts and reduce the risk of early childhood caries, particularly among populations with limited access to ongoing dental care.

7.3 School-Linked Oral Health Services

Mono County has made meaningful progress in implementing school-linked oral health programs that connect children with preventive and restorative dental care. Since 2022, the Local Oral Health Program (LOHP) has partnered with a community-based dental hygienist to provide on-site school screenings, oral health education, and referrals for students in need of follow-up care. These services have focused primarily on kindergarten and elementary-aged children, with screenings offered at multiple school sites across the county.

Mono County currently operates a hybrid model of school-linked oral health services. While sealant placement is not currently offered directly within schools, the program aims to incorporate this preventive service in the future as part of its ongoing expansion efforts. The current model emphasizes oral health assessments, education, and referrals for students requiring additional care through community dental providers.

The school-linked program model used in Mono County follows a coordinated approach that begins with selecting schools based on need—taking into account student socioeconomic factors, distance from local dental offices, and historical access barriers. Program staff work closely with school administrators and district personnel to obtain approval, schedule visits, and ensure that activities align with the academic calendar. Early engagement of clinicians and school partners has helped to build trust and increase participation among families.

Mono County is unique in its active consent process for school-linked oral health assessments. Unlike many other counties that utilize passive consent forms, Mono County requires signed parental consent prior to participation, as outlined in the Memorandum of Understanding (MOU) with participating schools. While this approach supports family engagement and transparency, it can also contribute to lower participation rates compared to counties using passive consent models.

The county's approach emphasizes education and outreach as key components of improving oral health literacy. Through classroom-based education, parent communication, and distribution of preventive materials, students and families gain awareness of oral hygiene practices, the importance of routine dental visits, and available community resources.

While progress has been made, several areas for improvement have been identified. At present, referral tracking and follow-up largely rely on spreadsheets and manual

communication rather than a formal electronic system. As a result, it can be difficult to monitor whether children referred for dental care successfully receive treatment. The county would benefit from implementing a referral management and care coordination platform, such as an integrated system, to support real-time communication between parents, dental providers, and program staff. This would also enhance the program's ability to track referral outcomes, measure impact, and share data with schools, funders, and stakeholders.

Additionally, program reach remains uneven across the county, with most school-linked activities concentrated in Mammoth Lakes and limited engagement in northern and more remote communities such as Walker, Coleville, and Benton. Limited staffing and logistical challenges—such as travel distances and varying school schedules—contribute to these gaps. Future expansion of the program to unincorporated areas and small rural schools would help ensure that all Mono County children have equitable access to preventive dental services.

The LOHP and its partners continue to strengthen local provider networks by maintaining relationships with regional dental offices, Federally Qualified Health Centers, and Medi-Cal dental providers willing to accept referrals. Establishing standardized referral criteria and performance indicators will further enhance program quality and accountability.

Moving forward, Mono County's school-linked oral health program aims to build on early successes by expanding outreach, adopting data-driven referral management tools, and integrating program metrics into broader community health improvement planning. These efforts align with statewide goals to increase access to preventive services, reduce untreated dental decay, and support the overall health and academic success of children in Mono County.

7.4 Mobile Dental Van Visits

Smile, California is a statewide initiative of the California Department of Health Care Services designed to increase access to Medi-Cal dental care through education, outreach, and mobile service delivery. In Mono County, where geographic isolation and a shortage of dental providers continue to limit preventive and routine care, establishing a recurring partnership with Smile, California could fill a significant service gap. The program's mobile dental clinics are equipped to deliver cleanings, exams, fluoride treatments, and sealants directly in communities where residents would otherwise need to travel long distances—often several hours—to reach a dentist.

Mono County's Local Oral Health Program is actively working to bring Smile, California to the county at least twice each year for multi-day visits. These events would rotate among underserved communities such as Bridgeport, Coleville, and Benton to ensure equitable access across the region. Integrating Smile, California's mobile services with local outreach efforts—including schools and community health fairs—would provide residents with convenient preventive care opportunities while reinforcing the importance of regular dental visits and early intervention. This partnership represents a practical and sustainable strategy for improving preventive oral health services in a frontier county where traditional access models remain limited.

8. Discussion & Interpretation

The findings of the 2025 Mono County Oral Health Needs Assessment highlight both meaningful progress and persistent challenges in achieving equitable oral health outcomes across this rural, geographically dispersed region. While Mono County has strengthened its oral health infrastructure—expanding school-linked screening programs, enhancing partnerships with health and early childhood providers, and increasing access through mobile dental services—systemic barriers continue to limit residents' ability to obtain timely, preventive, and affordable dental care.

Health Outcomes Implications

Across all data sources, a clear pattern emerges: limited access to preventive and routine dental care contributes to higher levels of untreated decay, delayed treatment, and preventable oral health complications. High proportions of kindergarteners with early decay or untreated caries, particularly in Mammoth Lakes, suggest that many children are entering school with disease already present. Managed care data show that children—especially toddlers and adolescents—rarely receive oral evaluations or fluoride varnish, increasing the risk of caries progression and emergency dental needs over time.

Untreated dental disease is not merely a localized issue. It can contribute to systemic health problems such as poor nutrition, sleep disruption, chronic pain, impaired growth, and increased inflammatory burden. Providers interviewed described seeing children with severe abscesses and infections, emphasizing the potential for dental disease to spread and result in medical complications requiring hospital-level intervention. For pregnant individuals—many of whom remain unaware of their Medi-Cal dental benefits—untreated dental disease may elevate risks for adverse pregnancy outcomes, while older adults face challenges that intersect with chronic conditions like diabetes and heart disease. These findings

underscore that oral health remains closely tied to overall health and wellness, particularly in communities with limited access to continuous care.

Educational Implications

The assessment demonstrates clear connections between oral health and school readiness, attendance, and academic engagement. Children experiencing dental pain, untreated decay, or infections are more likely to miss school days, have difficulty concentrating in class, and participate less in learning activities. SCOHR data show substantial early decay among kindergarteners; the population most vulnerable to developmental and educational disruption. Local educators and key informants repeatedly observed that dental problems interfere with students' comfort and participation, noting examples of children unable to focus or needing to leave school due to tooth pain.

School-linked oral health programs have begun to address these gaps, but participation remains uneven across the county, and active consent requirements may limit reach in certain communities. Improved dental access, particularly preventive care for children ages 0–5, would support healthier school entry, improve attendance, and align with broader educational goals outlined in the 2024 Community Health Assessment. Strengthening oral health literacy among families, particularly Spanish-speaking households, can further support early childhood education and readiness.

Economic Burdens

Oral health challenges in Mono County carry significant economic consequences for families, employers, and the healthcare system. Residents in northern and southern regions often travel long distances for dental care—sometimes several hours each way—resulting in lost wages, fuel costs, childcare expenses, and in some cases, overnight lodging. Key informants consistently described how missed work, multiple jobs, and inflexible schedules make it difficult for families to complete dental appointments, follow-up referrals, or emergency care. These indirect costs frequently deter preventive visits, leading to more advanced disease that requires higher-cost interventions.

For uninsured residents and those with limited Medi-Cal provider options, out-of-pocket costs can be prohibitive, causing families to postpone care until pain or infection becomes unbearable. At the system level, low preventive utilization and reliance on emergency or urgent dental services increase overall healthcare expenditures, including hospital-based treatment for severe dental infections. As mobile dental vans, school-linked programs, and local dental clinics absorb demand

for safety-net services, the economic burden of untreated dental disease becomes increasingly visible across multiple sectors.

For economically disadvantaged families, the cost of basic dental hygiene supplies—such as toothbrushes, toothpaste, and floss—can present a meaningful barrier to maintaining oral health, potentially contributing to higher rates of dental decay, cavities, and untreated pain. Mono County's geographic isolation further exacerbates this challenge, as limited retail options and higher transportation costs increase the price and reduce the accessibility of essential dental supplies compared to urban and suburban areas with greater retail availability.

Bringing the Findings Together

Overall, the assessment reveals that oral health in Mono County is shaped by the intersection of geographic isolation, limited dental workforce capacity, socioeconomic disparities, and gaps in preventive care infrastructure. While innovative models—such as school-linked screenings, mobile dental services, and expanding cross-sector partnerships—are reducing geographic barriers, they have not yet closed long-standing inequities that disproportionately affect rural, low-income, Hispanic/Latino, and Native American residents.

Addressing these disparities requires a coordinated approach that integrates health, education, and economic considerations. Improving oral health access is not only a matter of clinical care but also a driver of healthier childhood development, stronger educational outcomes, and reduced financial strain on families and the health system. As Mono County advances its oral health strategies through the Community Health Improvement Plan (CHIP), continued investment in preventive services, workforce expansion, culturally competent outreach, and robust data systems will be essential to building a more equitable and sustainable oral health system for all residents.

9. Areas for Further Research & Recommendations

Several important gaps remain in our understanding of oral health needs in Mono County, highlighting areas for further research and improved data collection. A key priority is strengthening SCOHR reporting to ensure more complete and consistent submission of assessment forms, waivers, and outcome data across all schools and grade levels. Improved reporting would allow for more accurate tracking of oral health status, trends over time, and the impact of preventive programs. In addition, deeper exploration of the barriers families face in accessing care or returning forms—such as cost, transportation, or awareness—would help inform targeted interventions. Expanding local data collection efforts beyond school-linked

assessments, including ongoing surveys of community dental providers and population-level surveillance, would provide a more comprehensive picture of oral health in Mono County. Continued investment in robust, locally relevant data will be essential for guiding effective programming and evaluating progress toward improved oral health outcomes.

10. Action Plan / Next Steps

Addressing oral health disparities in Mono County requires a coordinated, multi-sector approach that focuses on prevention, access, and long-term program sustainability. Building on existing partnerships and identified needs, the County's oral health program intends to prioritize expansion of school-linked prevention activities, improved access to care and dental supplies for residents in remote areas, and the development of sustainable funding and workforce strategies to ensure lasting impact.

One proposed area of focus is the strengthening of school-linked and community-based oral health programs. The County hopes to expand Kindergarten Oral Health Assessment (KOHA) screenings and fluoride application events across all schools, with the support of school administrators, nurses, and teachers, and to explore opportunities to extend preventive oral health activities into preschool, licensed home daycares, and other early learning settings as a strategy to address early childhood dental issues. Outreach would continue to align with early childhood programs such as MCAH and WIC to promote prevention and education among pregnant individuals and children under five. Language accessibility will remain a central consideration to ensure Spanish-speaking families receive clear and culturally appropriate information and services.

Mono County is exploring opportunities to pilot alternative models for delivering preventive dental care. One approach under consideration is the periodic use of Public Health offices and mobile clinic sites in outlying communities to host visiting dental hygienists—potentially on a monthly or quarterly basis—to provide fluoride varnish, dental sealants, and limited preventive services, with clinical oversight supported through teledentistry. This model would offer a locally accessible option for families who face transportation and distance barriers to established dental clinics. If feasible, this pilot could inform the development of a more consistent preventive care schedule in partnership with regional dental providers.

The County is further evaluating how telehealth could enhance local capacity and continuity of care. Under current state regulations (California Business and Professions Code §1910 and §2290.5), registered dental hygienists may perform

certain duties in public health or community settings under the supervision of a dentist via telehealth. This includes determining which radiographs to perform when a supervising dentist is not on site, following established protocols. As part of this exploration, the County may consider collaborating with qualified hygienists to pilot limited procedures supported by telehealth communication with supervising dentists. These efforts remain conceptual but represent an innovative opportunity to expand preventive care access in rural areas.

Improving access to oral health services and hygiene kits in the county's outlying communities remains a long-term priority. Because most dental care is concentrated in Mammoth Lakes, the County continues to explore the potential of managed mobile dental units to deliver preventive and restorative services to Medi-Cal members and uninsured residents. Partnerships with pediatricians and primary care providers will continue to integrate oral health education and fluoride varnish applications during well-child visits. Additional strategies, such as addressing transportation barriers and ensuring dental hygiene supplies are available in remote areas, would further support equitable access.

To ease the economic burden of purchasing dental supplies Mono County has partnered with the schools, local library, Tanf and thrift stores in the outlying areas to provide free dental kits to all school age children and families in need of supplies. Another joint venture includes collaborating with the Managed Care Plans to purchase a vending machine for Mammoth Lakes with readily available no-cost oral health supplies. If financially viable, Mono County has plans to place vending machines throughout the county reducing the financial strain of preventative dental care supplies .

Sustained progress will require strong partnerships across sectors. Mono County Public Health will continue working closely with schools, First 5 Mono County, MCAH, WIC, County Libraries, Managed Care Plans and the Eastern Sierra Oral Health Care Coalition to align outreach, referral pathways, and data tracking.

Support for Registered Dental Hygienists in Alternative Practice (RDHAPs) represents a potential strategy for strengthening local workforce capacity and expanding access to preventive oral health services. While these approaches remain in the exploratory phase, long-term sustainability would depend on the availability of stable funding sources. Potential funding mechanisms may include multi-year state and federal grants, as well as cost-sharing arrangements with Medi-Cal managed care plans and local health systems.

To assess feasibility and inform future planning, Mono County may draw on existing data sources—including Kindergarten Oral Health Assessment (KOHA) results, Statewide Oral Health Outcomes and Reporting (SCOHR) data, and Medi-Cal utilization data—to evaluate need, service gaps, and potential impact. In parallel, the County is exploring options to directly bill Medi-Cal for eligible preventive services provided in partnership with a local non-profit organization, with the goal of expanding access to care while reducing reliance on Mammoth Hospital Dental Clinic as the county's sole Medi-Cal dental provider.

Finally, once implementation begins, progress will be measured and reported through clear performance metrics, including the number of students screened, fluoride and sealant applications provided, and mobile or telehealth services delivered. Data will be disaggregated by geography, language, and insurance status to ensure outreach reaches those with the greatest need. Annual partner meetings will help review outcomes, identify challenges, and refine strategies to maintain a sustainable and equitable oral health system for Mono County residents.

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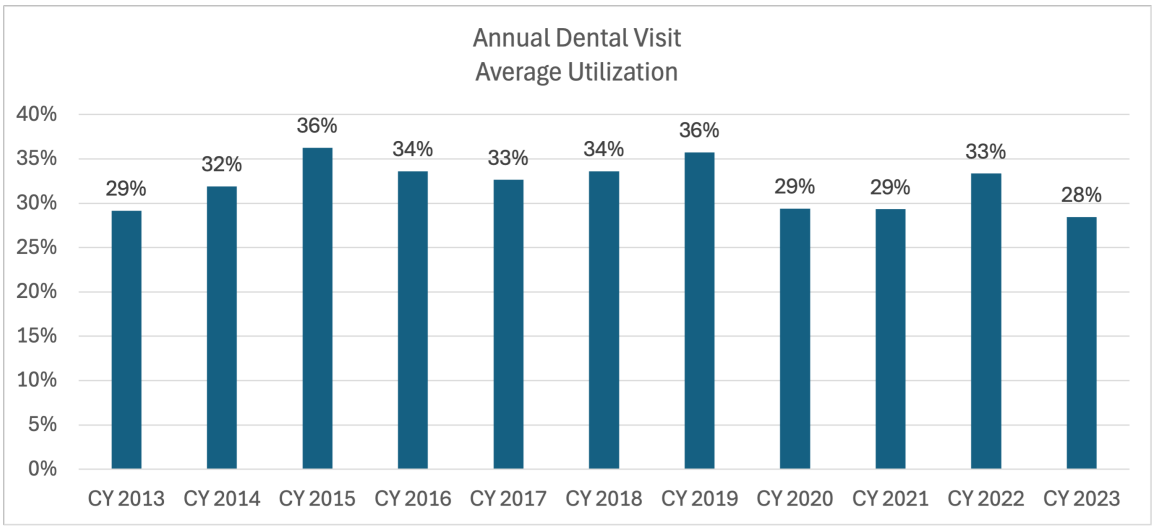
12. Appendices

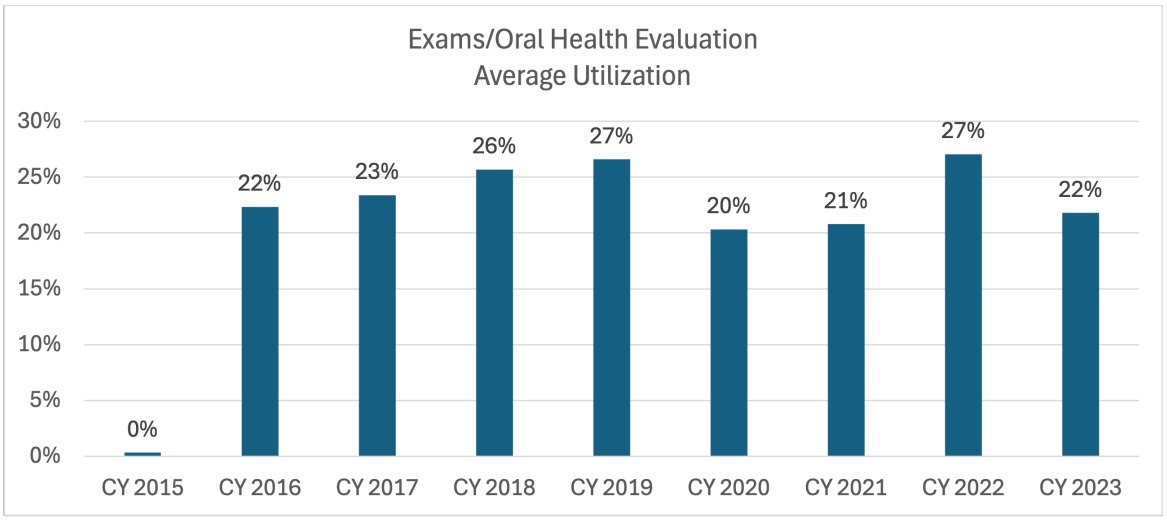
Appendix A: Additional Tables & Graphs

Medi-Cal Dental Utilization and Sealant Data (2013–2023)

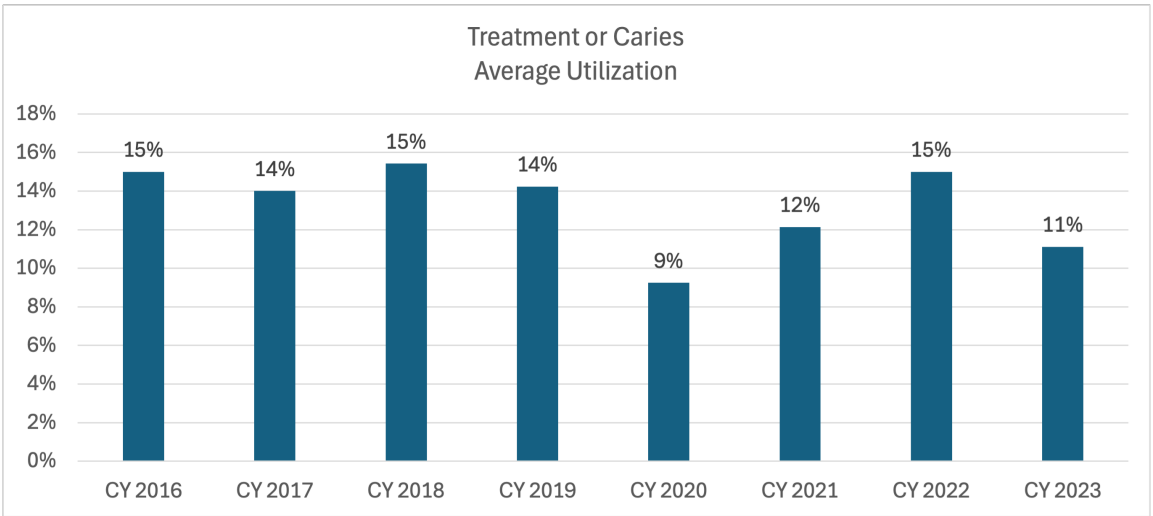
Annual Dental Visit



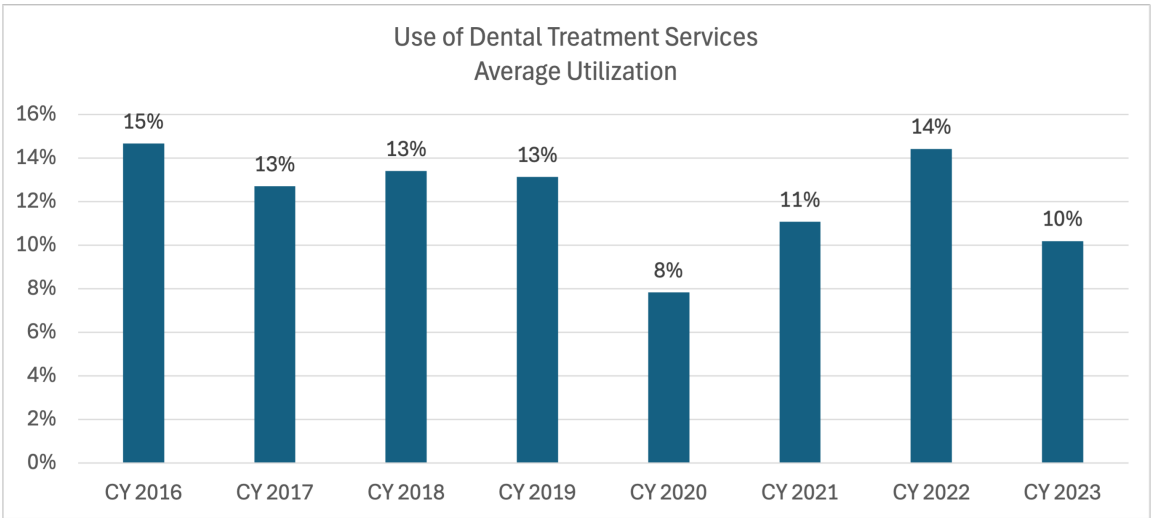
Exams/Oral Health Evaluation



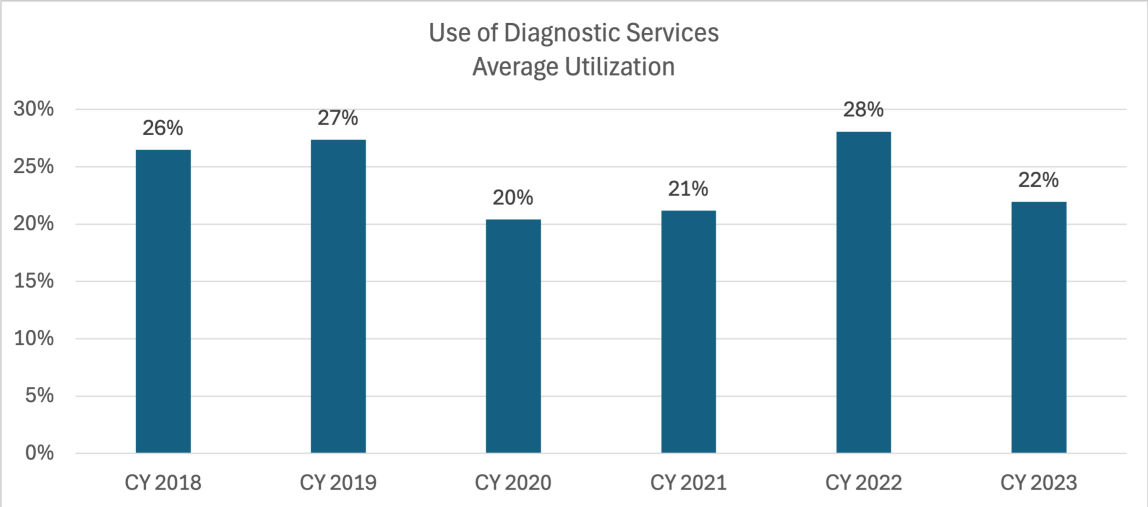
Treatment or Caries



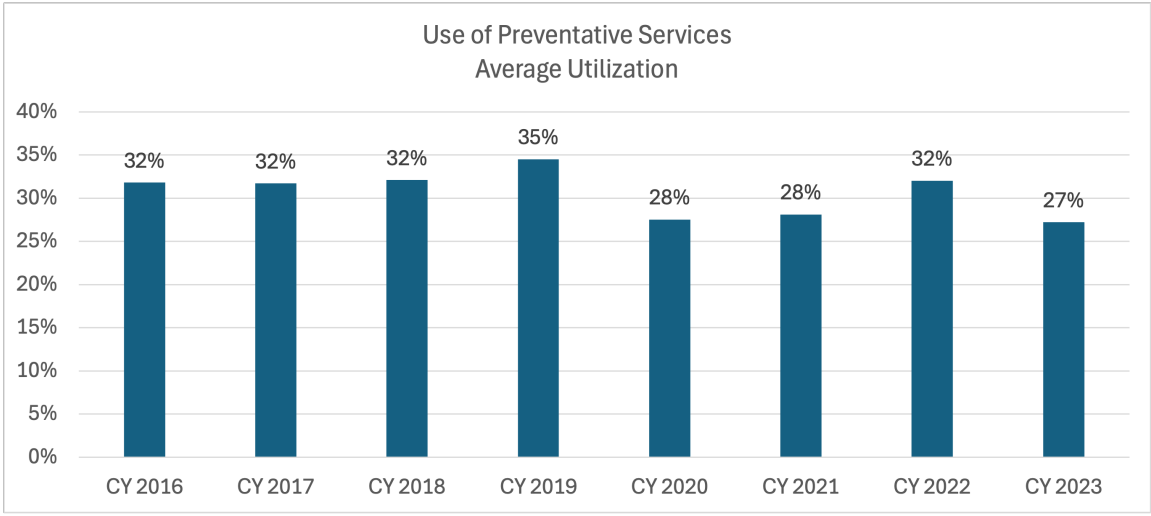
Use of Dental Treatment Services



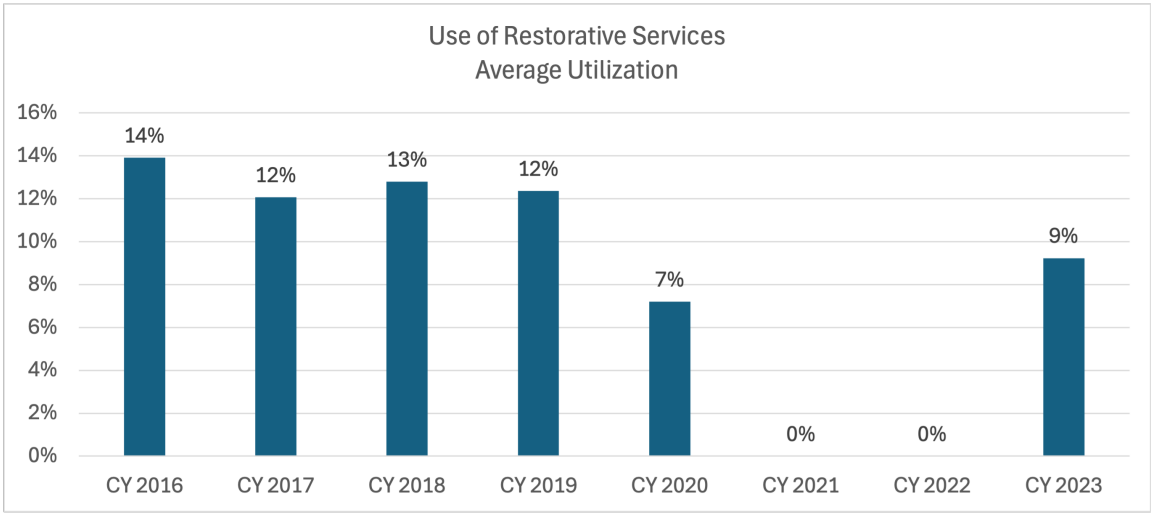
Use of Diagnostic Services



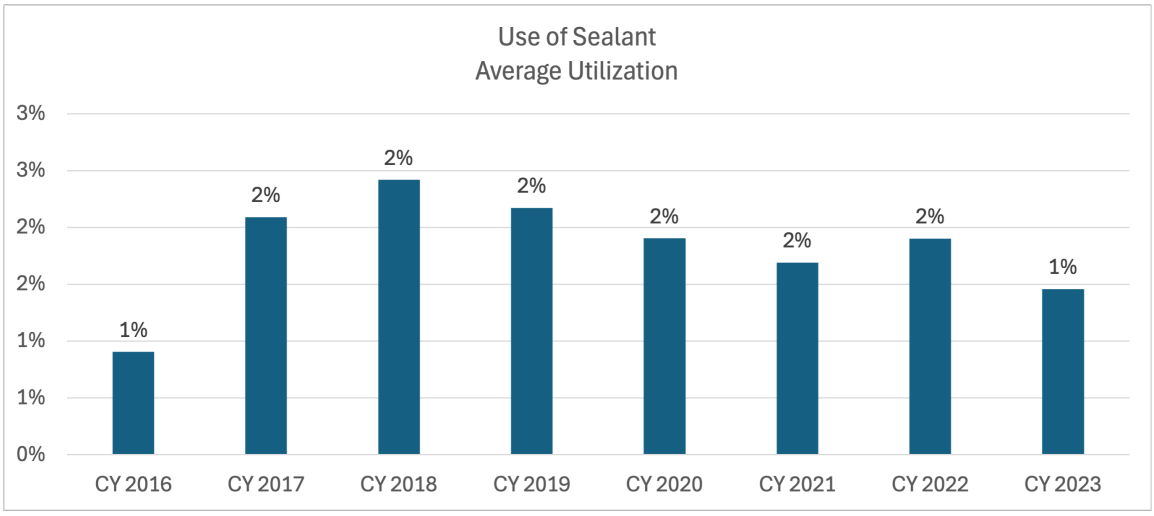
Use of Preventative Services



Use of Restorative Services



Use of Sealant



Mammoth Hospital Dental Clinic Utilization

Number of Children

Mammoth Hospital - Dental Encounters - January 2022-November 2025
1) Number of Children (Ages 0-17.99) who received any Dental Service

Visits By Ethnic Group, Race, & Year

4) Age Group	0-17.99

		Service Year				
Ethnic Group	**Person Race**	**2022**	**2023**	**2024**	**2025**	**Grand Total**
Hispanic or Latino	Black or African American	2	10	6	2	20
	Hispanic	283	191	235	237	946
	Multiple	21	8	10	16	55
	Native American	29	14	16	18	77
	Other	5	7	5	4	21
	Other Pacific Islander		1			1
	Patient Refuses	5	2	5	9	21
	Spanish/Hispanic	43	29	30	12	114
	Unknown/Unreported				2	2
	White	1,757	1,206	1,461	1,414	5,837
Hispanic or Latino Total		**2,145**	**1,468**	**1,768**	**1,714**	**7,094**
Other	American Indian/Alaskan Native	2	4	4		10
	Asian Indian				1	1
	Black or African American	5				5
	Hispanic	3	3	10	1	17
	Multiple	5	4	7	11	27
	Native American	51	58	51	52	212
	Native Hawaiian or Other Pacific Island			5	1	6
	Other	1	1		6	8
	Other Asian	21	14	14	11	60
	Patient Refuses	5				5
	Unknown/Unreported	9	4		4	17
	White	541	428	621	575	2,165
Other Total		**643**	**516**	**712**	**662**	**2,533**
Grand Total		**2,788**	**1,984**	**2,480**	**2,376**	**9,627**

Patients By Ethnic Group, Race, & Year

4) Age Group	0-17.99

		Service Year				
Ethnic Group	**Person Race**	**2022**	**2023**	**2024**	**2025**	**Grand Total**
Hispanic or Latino	Black or African American	2	2	2	2	2
	Hispanic	89	71	75	76	148
	Multiple	9	5	5	9	14
	Native American	10	7	9	7	14
	Other	3	3	2	2	5
	Other Pacific Islander		1			1
	Patient Refuses	3	2	3	1	4
	Spanish/Hispanic	12	9	8	5	17
	Unknown/Unreported				1	1
	White	552	458	479	469	858
Hispanic or Latino Total		**680**	**558**	**583**	**572**	**1,064**
Other	American Indian/Alaskan Native	1	1	1		1
	Asian Indian				1	1
	Black or African American	2				2
	Hispanic	1	1	2	1	2
	Multiple	2	2	5	5	7
	Native American	17	24	18	19	38
	Native Hawaiian or Other Pacific Island			2	1	2
	Other	1	1		1	3
	Other Asian	7	4	7	5	10
	Patient Refuses	2				2
	Unknown/Unreported	4	2		2	8
	White	206	178	238	243	487
Other Total		**243**	**213**	**273**	**278**	**563**
Grand Total		**923**	**771**	**856**	**850**	**1,627**

Visits By Payer & Year

4) Age Group	0-17.99

	Service Year				
Medi-Cal or Other	**2022**	**2023**	**2024**	**2025**	**Grand Total**
Medi-cal	2,413	1,646	2,028	1,907	7,994
Other	375	338	452	469	1,633
Grand Total	**2,788**	**1,984**	**2,480**	**2,376**	**9,627**

Patients By Payer & Year

4) Age Group	0-17.99

	Service Year				
Medi-Cal or Other	**2022**	**2023**	**2024**	**2025**	**Grand Total**
Medi-cal	786	633	695	675	1,336
Other	150	163	180	191	423
Grand Total	**923**	**771**	**856**	**850**	**1,627**

Patients By Zip Code & Year

4) Age Group	0-17.99

Zip Format	Service Year 2022	2023	2024	2025	Grand Total
		1	2	2	2
80634		1			1
89010	2		2	2	2
89128	1	1	1		1
89511				1	1
90808			1		1
91006			1		1
92677	1				1
93103			1		1
93512		3		4	4
93513	13	15	12	15	30
93514	254	188	224	211	430
93515	12	2	4	1	13
93517	16	19	22	14	39
93526	1		1		2
93529	16	21	26	25	45
93541	31	31	26	25	58
93545	9	8	4	7	12
93546	560	473	522	530	953
93573				1	1
93647	1				1
96107	5	4	7	9	20
96133		4			4
96150	1				1
96161				2	2
96744				1	1
Grand Total	**923**	**771**	**856**	**850**	**1,627**

Visits By Zip Code & Year

4) Age Group	0-17.99

Zip Format	Service Year 2022	2023	2024	2025	Grand Total
		5	4	6	15
80634		2			2
89010	4		4	3	11
89128	4	1	1		6
89511				3	3
90808			1		1
91006			1		1
92677	1				1
93103			1		1
93512		5		13	18
93513	29	37	25	26	117
93514	634	478	641	566	2,319
93515	31	6	7	4	48
93517	47	54	48	40	189
93526	3		1		4
93529	63	46	69	72	250
93541	77	66	82	42	266
93545	27	27	8	14	76
93546	1,860	1,245	1,565	1,558	6,228
93573				1	1
93647	1				1
96107	6	4	22	25	57
96133		8			8
96150	1				1
96161				2	2
96744				1	1
Grand Total	**2,788**	**1,984**	**2,480**	**2,376**	**9,627**

Carries Treated

Mammoth Hospital - Dental Encounters - January 2022-November 2025
1) Carries Treated Only (Codes D2140-D2954) - Age Group 0-17.99

Visits By Ethnic Group, Race, & Year

1) Carries - Treated	Yes
4) Age Group	0-17.99

		Service Year				
Ethnic Group	**Person Race**	**2022**	**2023**	**2024**	**2025**	**Grand Total**
Hispanic or Latino	Black or African American		5	1		6
	Hispanic	79	51	83	89	302
	Multiple	4	1		3	8
	Native American	11	4	2	9	26
	Other		1	1		2
	Patient Refuses	2	1		8	11
	Spanish/Hispanic	21	12	17	2	52
	White	469	340	441	429	1679
Hispanic or Latino Total		**586**	**415**	**545**	**540**	**2086**
Other	American Indian/Alaskan Native	1	3	1		5
	Black or African American	3				3
	Hispanic	1		5		6
	Multiple		1	1	3	5
	Native American	19	25	14	16	74
	Native Hawaiian or Other Pacific Island			2		2
	Other				3	3
	Other Asian	5	6		5	16
	Patient Refuses	2				2
	Unknown/Unreported	1	1			2
	White	143	121	169	153	586
Other Total		**175**	**157**	**192**	**180**	**704**
Grand Total		**761**	**572**	**737**	**720**	**2790**

Patients By Ethnic Group, Race, & Year

1) Carries - Treated	Yes
4) Age Group	0-17.99

		Service Year				
Ethnic Group	**Person Race**	**2022**	**2023**	**2024**	**2025**	**Grand Total**
Hispanic or Latino	Black or African American		2	1		2
	Hispanic	38	31	38	38	91
	Multiple	2	1		3	5
	Native American	8	2	2	4	11
	Other		1	1		2
	Patient Refuses	2	1		1	2
	Spanish/Hispanic	7	6	5	2	11
	White	245	189	221	209	521
Hispanic or Latino Total		**302**	**233**	**268**	**257**	**645**
Other	American Indian/Alaskan Native	1	1	1		1
	Black or African American	2				2
	Hispanic	1		1		2
	Multiple		1	1	1	2
	Native American	9	13	8	6	23
	Native Hawaiian or Other Pacific Island			2		2
	Other				1	1
	Other Asian	3	2		2	4
	Patient Refuses	1				1
	Unknown/Unreported	1	1			2
	White	79	64	88	82	219
Other Total		**97**	**82**	**101**	**92**	**259**
Grand Total		**399**	**315**	**369**	**349**	**904**

Visits By Zip Code & Year

1) Carries - Treated	Yes
4) Age Group	0-17.99

	Service Year				
Zip Format	**2022**	**2023**	**2024**	**2025**	**Grand Total**
		3	2	3	8
80634		1			1
89010				1	1
89128	2				2
89511				1	1
93512		1		3	4
93513	9	12	9	7	37
93514	190	155	176	181	702
93515	9	1		2	12
93517	15	20	10	14	59
93529	24	8	27	26	85
93541	22	13	29	7	71
93545	6	14	2	5	27
93546	480	342	473	459	1754
93647	1				1
96107	3		9	11	23
96133		2			2
Grand Total	**761**	**572**	**737**	**720**	**2790**

Patients By Zip Code & Year

1) Carries - Treated	Yes
4) Age Group	0-17.99

	Service Year				
Zip Format	**2022**	**2023**	**2024**	**2025**	**Grand Total**
		1	1	2	2
80634		1			1
89010				1	1
89128	1				1
89511				1	1
93512		1		1	2
93513	5	7	5	6	14
93514	109	90	99	95	251
93515	5	1		1	5
93517	10	12	5	6	23
93529	11	6	12	11	23
93541	12	9	14	5	26
93545	4	5	1	3	9
93546	239	180	228	211	530
93647	1				1
96107	2		4	6	12
96133		2			2
Grand Total	**399**	**315**	**369**	**349**	**904**

ER Non-Traumatic Dental Visits

Mammoth Hospital - Dental Encounters - January 2022-November 2025
2) ER Non-Traumatic Dental Visits (Visits that Use Code D9110- Emergency Palliative) - Age Group 0-17.99

Visits By Ethnic Group, Race, & Year

2) ER Non-Traumatic Dental Visits	Yes
4) Age Group	0-17.99

		Service Year				
Ethnic Group	**Person Race**	**2022**	**2023**	**2024**	**2025**	**Grand Total**
Hispanic or Latino	Hispanic	1	3			4
	White	5	3	6		14
Hispanic or Latino Total		**6**	**6**	**6**		**18**
Other	Native American				1	1
	White	1	1		1	3
Other Total		**1**	**1**		**2**	**4**
Grand Total		**7**	**7**	**6**	**2**	**22**

Patients By Ethnic Group, Race, & Year

2) ER Non-Traumatic Dental Visits	Yes
4) Age Group	0-17.99

		Service Year				
Ethnic Group	**Person Race**	**2022**	**2023**	**2024**	**2025**	**Grand Total**
Hispanic or Latino	Hispanic	1	2			3
	White	5	3	6		13
Hispanic or Latino Total		**6**	**5**	**6**		**16**
Other	Native American				1	1
	White	1	1		1	3
Other Total		**1**	**1**		**2**	**4**
Grand Total		**7**	**6**	**6**	**2**	**20**

Visits By Zip Code & Year

2) ER Non-Traumatic Dental Visits	Yes
4) Age Group	0-17.99

	Service Year				
Zip Format	**2022**	**2023**	**2024**	**2025**	**Grand Total**
93513	1				1
93514	1	3	1	2	7
93529			1		1
93546	5	4	4		13
Grand Total	**7**	**7**	**6**	**2**	**22**

Patients By Zip Code & Year

2) ER Non-Traumatic Dental Visits	Yes
4) Age Group	0-17.99

	Service Year				
Zip Format	**2022**	**2023**	**2024**	**2025**	**Grand Total**
93513	1				1
93514	1	2	1	2	6
93529			1		1
93546	5	4	4		12
Grand Total	**7**	**6**	**6**	**2**	**20**

Fluoride Treatments

Mammoth Hospital - Dental Encounters - January 2022-November 2025
1) Fluoride Treatments (Code D1206 - FLUORIDE VARNISH TOPICAL) - Age Group 0-17.99

Visits By Ethnic Group, Race, & Year

3) Flouride Treatments	Yes
4) Age Group	0-17.99

		Service Year				
Ethnic Group	**Person Race**	**2022**	**2023**	**2024**	**2025**	**Grand Total**
Hispanic or Latino	Black or African American		4	2		6
	Hispanic	59	31	54	61	205
	Multiple	2	3	5	6	16
	Native American	6	1	6	5	18
	Other	2	1	1	2	6
	Patient Refuses			1		1
	Spanish/Hispanic	8	4	5	1	18
	Unknown/Unreported				1	1
	White	378	245	335	363	1,321
Hispanic or Latino Total		**455**	**289**	**409**	**439**	**1,592**
Other	American Indian/Alaskan Native		1	1		2
	Hispanic	2	1	2		5
	Multiple	2		2	2	6
	Native American	8	10	17	8	43
	Native Hawaiian or Other Pacific Island			1		1
	Other				1	1
	Other Asian	5	1	6	3	15
	Patient Refuses	1				1
	Unknown/Unreported	2	2		1	5
	White	133	103	159	145	540
Other Total		**153**	**118**	**188**	**160**	**619**
Grand Total		**608**	**407**	**597**	**599**	**2,211**

Patients By Ethnic Group, Race, & Year

3) Flouride Treatments	Yes
4) Age Group	0-17.99

		Service Year				
Ethnic Group	**Person Race**	**2022**	**2023**	**2024**	**2025**	**Grand Total**
Hispanic or Latino	Black or African American		2	2		2
	Hispanic	52	28	47	50	105
	Multiple	2	2	5	5	9
	Native American	5	1	5	4	9
	Other	2	1	1	2	4
	Patient Refuses			1		1
	Spanish/Hispanic	6	4	4	1	10
	Unknown/Unreported				1	1
	White	314	219	300	324	624
Hispanic or Latino Total		**381**	**257**	**365**	**387**	**765**
Other	American Indian/Alaskan Native		1	1		1
	Hispanic	1	1	2		2
	Multiple	1		2	2	2
	Native American	7	10	15	7	25
	Native Hawaiian or Other Pacific Island			1		1
	Other				1	1
	Other Asian	5	1	6	3	9
	Patient Refuses	1				1
	Unknown/Unreported	2	2		1	5
	White	116	94	139	136	311
Other Total		**133**	**109**	**166**	**150**	**358**
Grand Total		**514**	**366**	**531**	**537**	**1,123**

Visits By Zip Code & Year

3) Flouride Treatments	Yes
4) Age Group	0-17.99

	Service Year				
Zip Format	2022	2023	2024	2025	Grand Total
		1	1	1	3
80634		1			1
89010	1			2	3
89128			1		1
89511				1	1
93512		1		1	2
93513	3	8	6	4	21
93514	147	93	161	118	519
93515	5		1		6
93517	11	5	11	12	39
93526	1				1
93529	16	15	20	18	69
93541	20	8	15	16	59
93545	4		1	3	8
93546	400	271	376	416	1,463
96107		2	4	5	11
96133		2			2
96161				2	2
Grand Total	**608**	**407**	**597**	**599**	**2,211**

Patients By Zip Code & Year

3) Flouride Treatments	Yes
4) Age Group	0-17.99

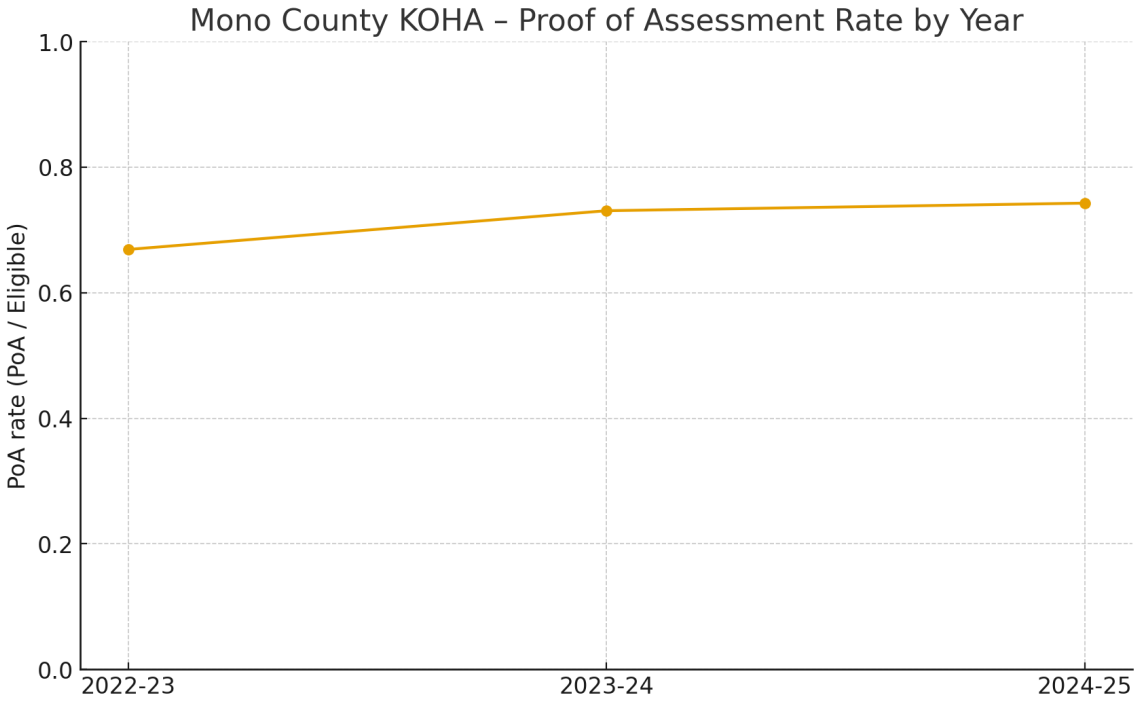
	Service Year				
Zip Format	2022	2023	2024	2025	Grand Total
		1	1	1	2
80634		1			1
89010	1			2	2
89128			1		1
89511				1	1
93512		1		1	1
93513	3	7	6	4	11
93514	132	86	144	109	283
93515	5		1		6
93517	11	5	10	12	25
93526	1				1
93529	11	13	18	18	33
93541	20	8	14	14	40
93545	3		1	3	5
93546	327	240	331	365	696
96107		2	4	5	11
96133		2			2
96161				2	2
Grand Total	**514**	**366**	**531**	**537**	**1,123**

SCOHR Data

Coverage (Proof of Assessment)

Mono County totals (all schools combined, adult ed excluded, duplicates merged):

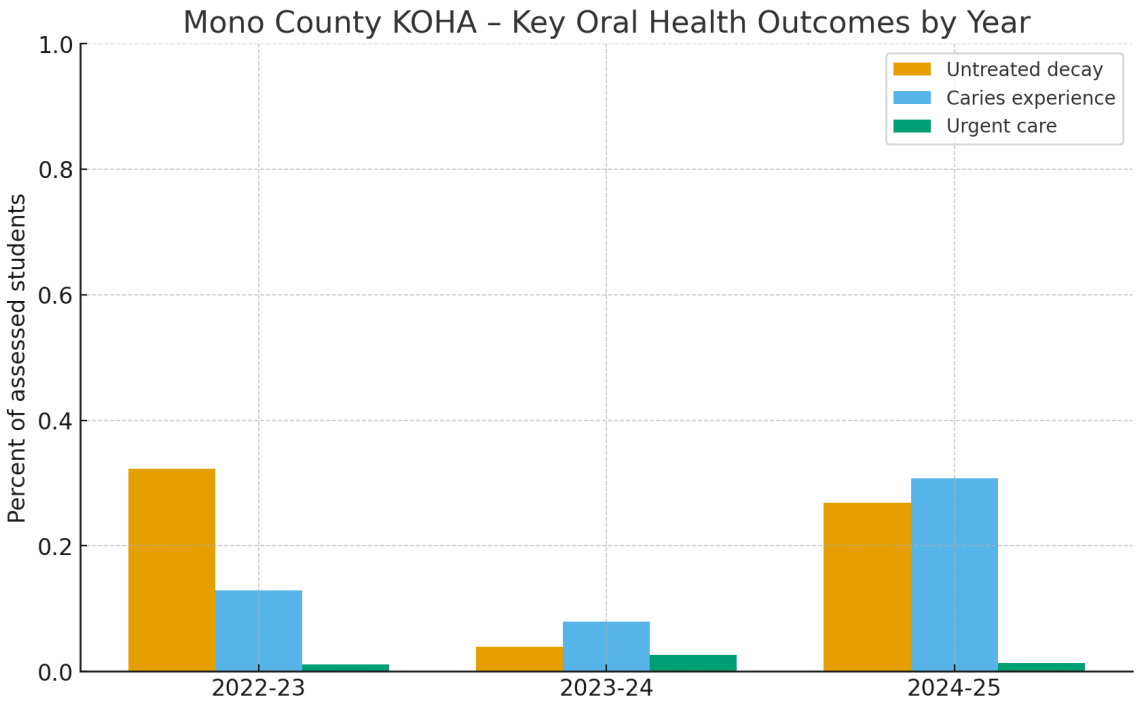
Year	Eligible	PoA	PoA rate
2022–23	139	93	**66.90%**
2023–24	104	76	**73.10%**
2024–25	105	78	**74.30%**



Key Oral Health Outcomes

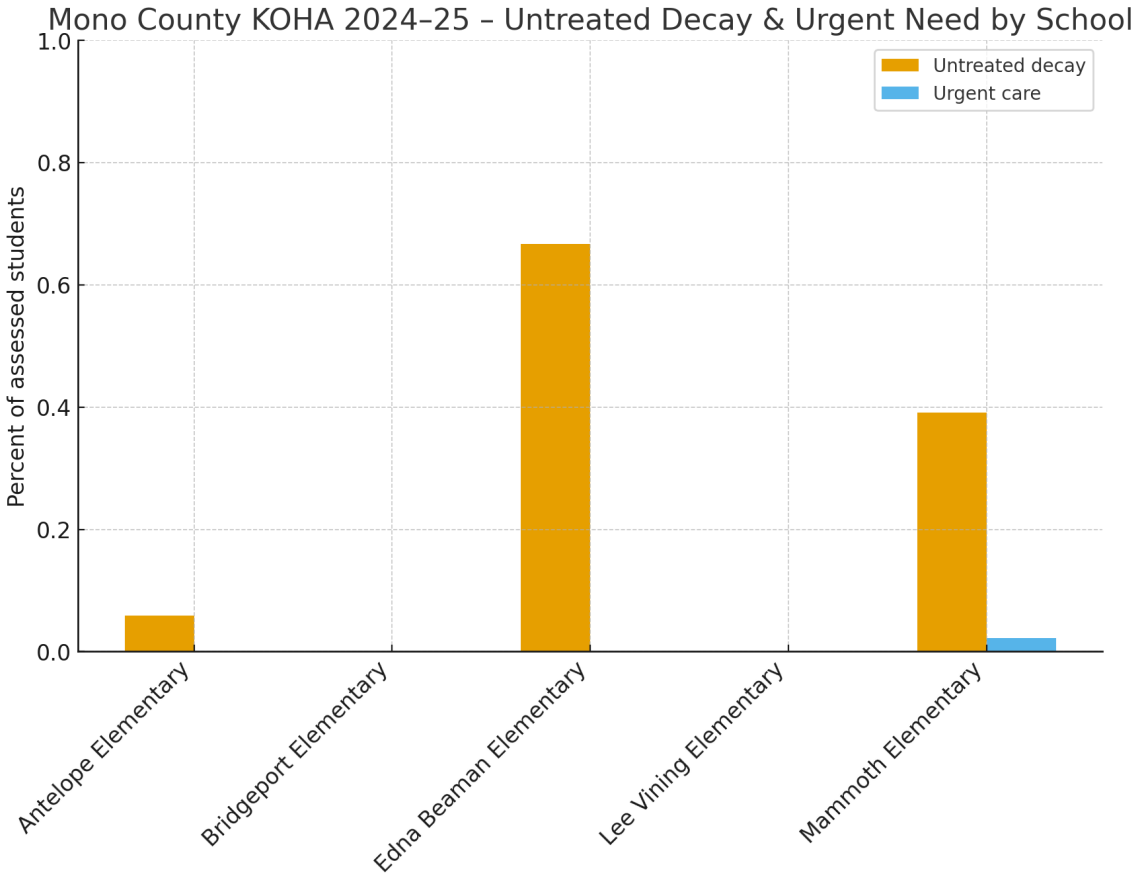
Countywide, among students with PoA.

Outcome	2022–23	2023–24	2024–25
Untreated decay	32.3%	3.9%	26.9%
Caries experience (CE)	12.9%	7.9%	30.8%
No problem found (Nop)	11.8%	60.5%	29.5%
Early decay (Edrc)	5.4%	35.5%	43.6%
Urgent care needed (Ucn)	~1.1%	2.6%	~1.3%



School-Level Breakdown

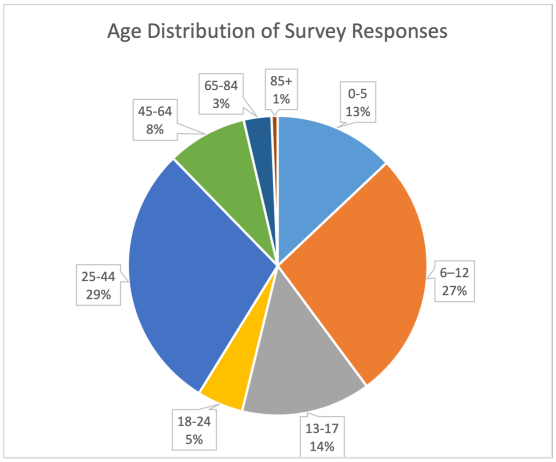
School	Eligible	PoA	PoA rate	% Untrtd	% CE	% Nop	% Edrc	% Ucn
Antelope Elementary	17	17	100%	5.9%	17.6%	58.8%	35.3%	0%
Bridgeport Elementary	7	4	57.1%	0%	25.0%	75.0%	25.0%	0%
Edna Beaman Elementary	3	3	100%	66.7%	66.7%	33.3%	66.7%	0%
Lee Vining Elementary	8	8	100%	0%	0%	100%	0%	0%
Mammoth Elementary	70	46	65.7%	39.1%	39.1%	2.2%	54.3%	2.2%



Community Oral Health Survey

1. Age

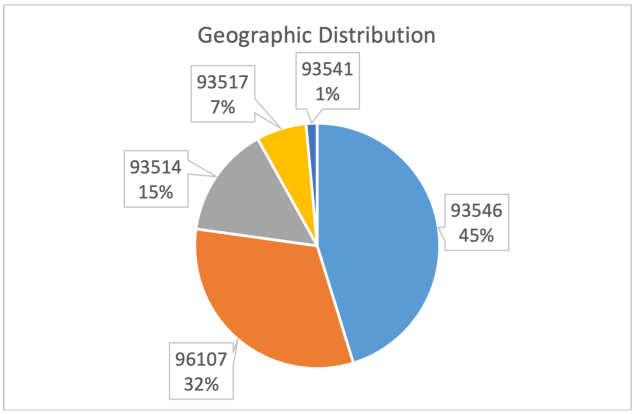
A total of 301 survey respondents provided their age. The average age was 23 years, with a median of 16 years and a range from 1 to 88 years. The most frequently reported ages were 5 and 10 years. The standard deviation was 17.6, reflecting a broad age distribution among participants. In terms of age groups, 162 respondents (54%) were under 18, 131 (44%) were between 18 and 64, and 8 (3%) were age 65 or older. These data indicate that the survey sample was weighted toward children and adolescents, aligning with the oral health program's focus on youth populations but still capturing responses from adults and older residents.



2. Zip Code

The majority of survey respondents were concentrated in ZIP code 93546 (Mammoth Lakes), which accounted for approximately 44 percent of all responses. This was followed by 96107 (Bridgeport and surrounding northern Mono County communities), representing about 31 percent of respondents. Smaller proportions were reported from 93514 (Bishop area, primarily residents on the county border) at 14 percent, and from 93517 (Coleville/Walker area) at 6 percent. Only a small number of respondents, around 1 percent, were from 93541 (Lee Vining).

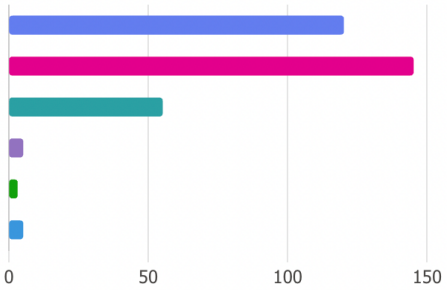
Overall, the data show that most survey participants were located in the more populated southern and northern ends of Mono County—particularly Mammoth Lakes and Bridgeport—reflecting both the county's population distribution and likely accessibility of outreach and survey collection activities.



3. Race/Ethnicity

3. Race/Ethnicity | *Raza/Etnicidad*

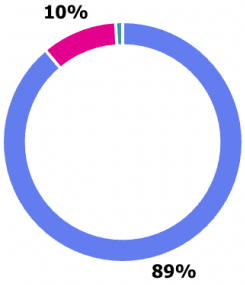
Hispanic/Latino | *Hispano/Latino*	120
White | *Blanco*	145
Native American | *Indio Americano*	55
Black | *Afroamericano*	5
Asian | *Asiático*	3
Other	5



4. Do you or your child have a dentist?

4. Do you or your child have a dentist? | *¿Usted o su hijo/a tienen dentista?*

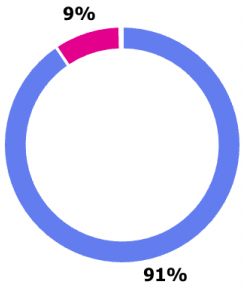
Yes | *Si*	279
No | *No*	32
I don't know | *No sabe*	3



5. Have you or your child been to the dentist for a cleaning or check-up in the last year?

5. Have you or your child been to the dentist for a cleaning or check-up in the last year? | *¿Usted o su hijo/a han ido al dentista para una limpieza o revisión en el último año?*

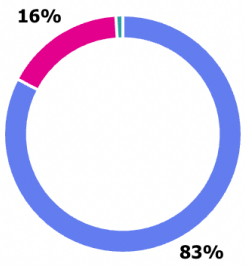
Yes | *Si*	287
No | *No*	29
I don't know | *No sabe*	1



6. Do you or your child have insurance that covers dental care?

6. Do you or your child have insurance that covers dental care? | *¿Tiene usted o su hijo/a un seguro que cubra la atención dental?*

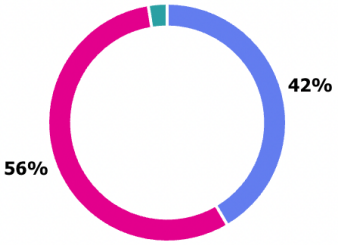
Yes | *Si*	262
No | *No*	52
I don't know | *No sabe*	3



7. Do you or your child have MediCal?

7. Do you or your child have MediCal? | *¿Usted o su hijo/a tienen MediCal?*

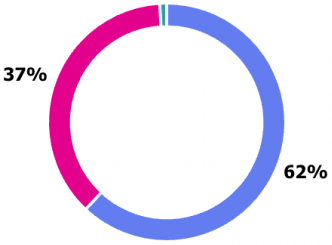
Yes | *Si*	130
No | *No*	175
I don't know | *No sabe*	8



8. Have you or your child ever had dental fillings?

8. Have you or your child ever had dental fillings? | *¿Usted o su hijo/a han tenido alguna vez empastes dentales?*

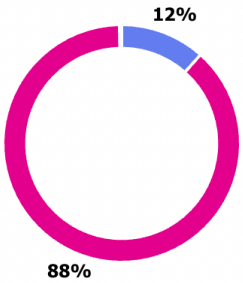
Yes | *Si*	197
No | *No*	118
I don't know | *No sabe*	3



9. Do you or your child currently have dental decay, pain, or swelling in your mouth?

9. Do you or your child currently have dental decay, pain, or swelling in your mouth? | *¿Tiene usted o su hijo/a actualmente caries dental, dolor o hinchazón en la boca?*

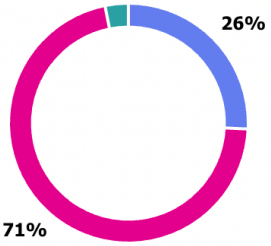
Yes | *Si*	37
No | *No*	282
I don't know | *No sabe*	1



10. Has your child had dental sealants?

10. Has your child had dental sealants? | *¿Su hijo/a ha tenido selladores dentales?*

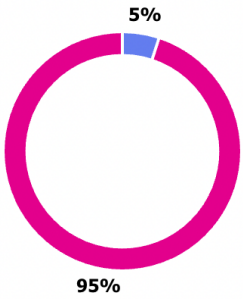
Yes | *Si*	82
No | *No*	226
I don't know | *No sabe*	10



11. Do you smoke or use tobacco products? Is your child exposed to smoke?

11. Do you smoke or use tobacco products? Is your child exposed to smoke? | *¿Fuma o usa productos de tabaco? ¿Está su hijo expuesto al humo?*

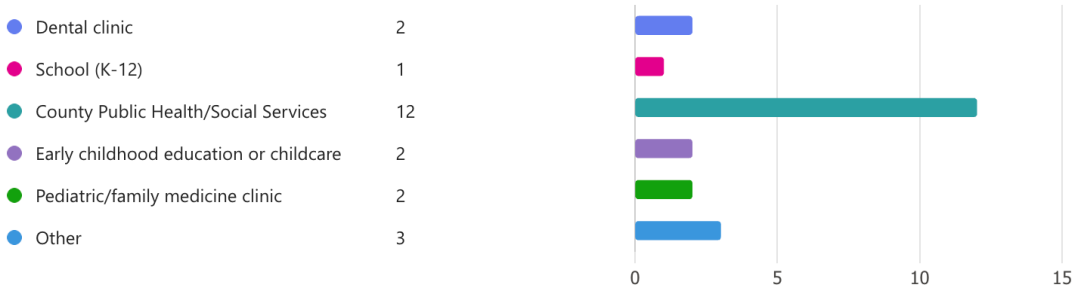
Yes | *Si*	16
No | *No*	304
I don't know | *No sabe*	0



Provider Survey

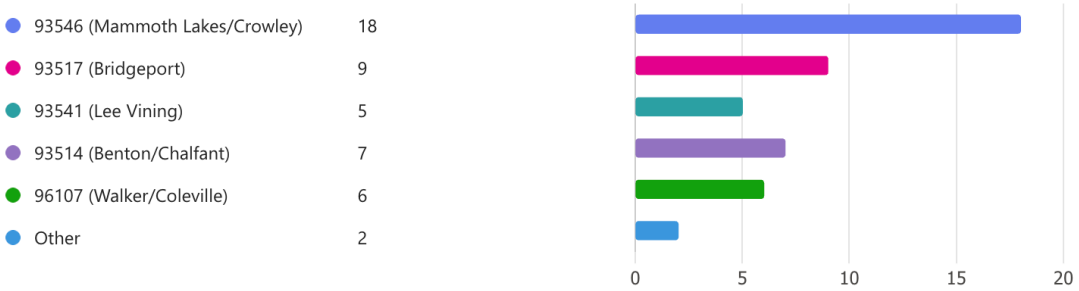
1. What type of setting do you primarily work in?

1. What type of setting do you primarily work in?



2. What Mono County ZIP code do you primarily interact with in your work? (Select all that apply)

2. What Mono County ZIP code do you primarily interact with in your work? (Select all that apply)

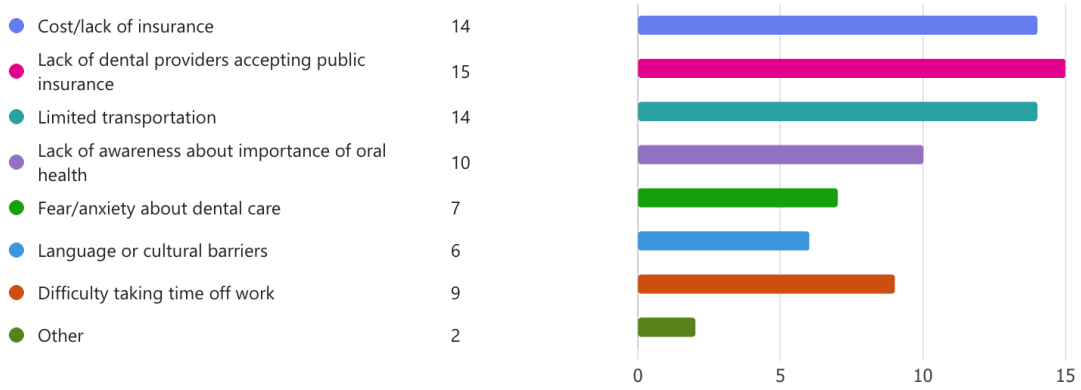


3. In your opinion, how significant is oral health as a public health issue in your community?

3. In your opinion, how significant is oral health as a public health issue in your community?

4. What are the top barriers you believe families face in accessing oral health care? (Select up to 3)

4. What are the top barriers you believe families face in accessing oral health care? (Select up to 3)



5. How accessible are pediatric dental services in your area?

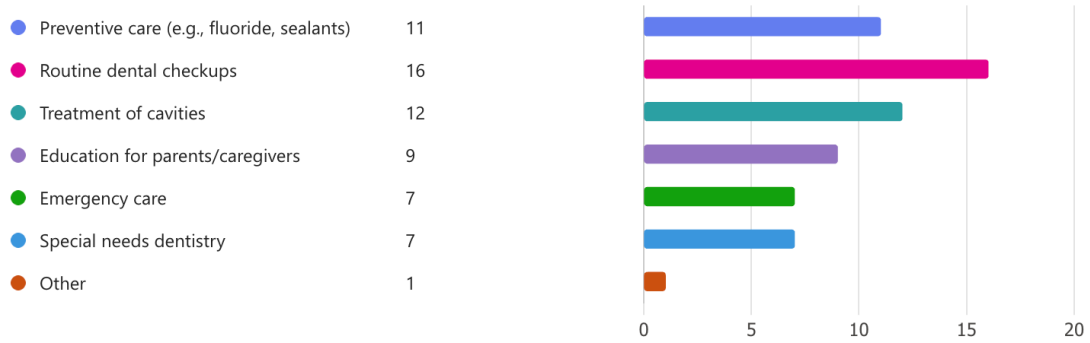
5. How accessible are pediatric dental services in your area?

6. At what age do you think most children in your community first see a dentist?

6. At what age do you think most children in your community first see a dentist?

7. What oral health needs are most unmet among children in your community? (Select all that apply)

7. What oral health needs are most unmet among children in your community? (Select all that apply)



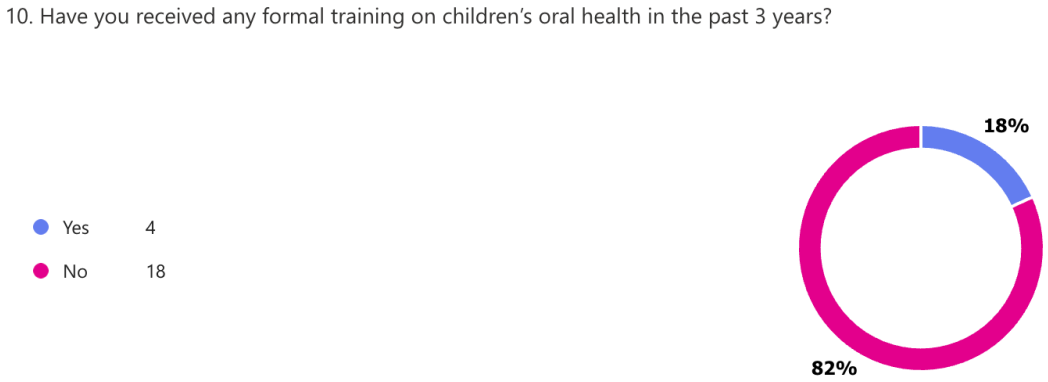
8. How comfortable do you feel discussing oral health with families?

8. How comfortable do you feel discussing oral health with families?

9. What supports or resources would help you better promote oral health?

Increased access to children in the schools, increased collaboration with providers and dental providers available in the north of our county
Community-based outreach to teach parents and children the importance of children's oral health
More providers to refer to that are willing to take new patients
Something that is an attention grabber. I no longer use social media but perhaps trying that, have PSA's on local radio stations, possibly meeting tribal board members.
A list of all oral health providers in the area, hours of ops, services provided and insurance.
Multiple dental van visits every 6 months? then funds to help families who need specialty care
A dentist in the area that accepts adult clients with Medi-Cal
More dentists that accept MediCal
More dentists, specialty dentists
Transportation and education to parents. Parents not being able to take time off work. Week days (particularly mid day) interrupts work schedules and school schedules.

10. Have you received any formal training on children's oral health in the past 3 years?



11. Please provide any additional thoughts or comments related to oral health in your community:

The lack of providers in our county, especially in the north has made it very difficult to really impact the access to oral health care in Mono County. The assessments we've been able to provide in the schools have been helpful but not super impactful. We look forward to some new collaborations in the next year to set up more sustainable services.
It's a travesty. I don't know how to encourage people to take care of their teeth. Plus, I am the daughter and niece of dentists so I hold the issue close to my heart. Maybe, a combined vaccination/dental clinic.
I think we need more dentists in Bishop area but especially need more dentists in practices that accept Medi-Cal
Access is #1. More dentists/clinics in Mono County.
I can primarily speak to adult population, ped's clinic manager will have more info on ped's population. Our major issue is with private insurance, we feel relatively confident in ped's access on Medi-Cal based on my understanding.

Appendix B: Survey Instruments

Community Oral Health Survey Questions

*Survey was offered in both English & Spanish

1. Age
2. Zip Code
3. Race/Ethnicity
4. Do you or your child have a dentist?
5. Have you or your child been to the dentist for a cleaning or check-up in the last year?
6. Do you or your child have insurance that covers dental care?
7. Do you or your child have MediCal?
8. Have you or your child ever had dental fillings?

9. Do you or your child currently have dental decay, pain, or swelling in your mouth?
10. Has your child had dental sealants?
11. Do you smoke or use tobacco products? Is your child exposed to smoke?

Provider Survey Questions

1. What type of setting do you primarily work in?
2. What Mono County ZIP code do you primarily interact with in your work? (Select all that apply)
3. In your opinion, how significant is oral health as a public health issue in your community?
4. What are the top barriers you believe families face in accessing oral health care? (Select up to 3)
5. How accessible are pediatric dental services in your area?
6. At what age do you think most children in your community first see a dentist?
7. What oral health needs are most unmet among children in your community? (Select all that apply)
8. How comfortable do you feel discussing oral health with families?
9. What supports or resources would help you better promote oral health?
10. Have you received any formal training on children's oral health in the past 3 years?
11. Please provide any additional thoughts or comments related to oral health in your community.

Key Informant Interview Questions

1. Background & Role

- Can you tell me about your role and how it relates to oral health in the community?

- How long have you been working in this capacity in our county?

- What populations do you primarily serve or interact with?

2. Perceptions of Oral Health Status

- How would you describe the overall oral health of the population you serve?

- Are there specific groups in the community with better or worse oral health outcomes? If so, who?

- Have you noticed any changes or trends in oral health needs over the past few years?

3. Access to Care

- What are the main ways people in this community access dental care?

- Are there enough dental providers to meet the community's needs?

- What gaps do you see in services (e.g., pediatric, specialty, emergency, preventive)?

- How far do patients typically need to travel for routine and specialty dental care?

4. Barriers to Care

- What are the biggest barriers preventing people from getting dental care? (Examples: cost, transportation, language, insurance coverage, provider availability, clinic hours, trust, cultural considerations)

- How do these barriers differ among children, adults, and older adults?

- Are there any seasonal or situational factors that affect access (e.g., tourism, weather, migrant work patterns)?

5. Prevention & Education

- What oral health education or prevention programs currently exist in the community?

- How well do community members understand the link between oral health and overall health?

- Are there school-linked oral health programs (e.g., sealants, screenings, fluoride rinse)? How effective are they?

6. High-Need Populations

- Which populations do you think are most at risk for poor oral health in our county? Why?

- What unique challenges do these groups face in accessing and maintaining good oral health?

7. Integration & Partnerships

- How well are oral health services integrated with other health and social services?

- Are there partnerships that could be strengthened or created to improve oral health outcomes?

- Are primary care providers in the area engaged in promoting oral health?

8. Opportunities for Improvement

- If you could change one thing to improve oral health in the community, what would it be?

- What resources, policies, or programs would make the biggest impact?

- Are there successful approaches from other communities that you think could work here?

9. Final Reflections

- Is there anything we haven't discussed that you think is important for us to know?

- Who else should we talk to as part of this needs assessment?

Appendix C: Glossary

Caries
Tooth decay caused by bacteria that break down the tooth surface. Often referred to as "cavities."

Caries Experience (CE)
A measure that includes both current decay and past treated decay (fillings). Used in SCOHR/KOHA reporting.

Denti-Cal / Medi-Cal Dental
The dental benefit program for Medi-Cal enrollees. Provides preventive, diagnostic, and restorative dental services.

Early Decay (Edrc)
Initial signs of tooth decay that have not yet progressed to cavities. Identified during screenings as "incipient lesions."

Fluoride Varnish
A protective coating applied to teeth to help prevent cavities, especially in young children.

Kindergarten Oral Health Assessment (KOHA)
A California requirement that kindergarteners or first-time first graders receive a dental check-up and submit proof of assessment. Reported through SCOHR.

Managed Care Plan (MCP)
A health plan contracted with Medi-Cal (e.g., Anthem Blue Cross, Health Net) to provide covered services to enrollees, including dental utilization data.

Mobile Dental Van
A dental clinic on wheels that provides preventive and limited restorative services in remote communities, reducing travel barriers.

Oral Health Literacy
The ability to find, understand, and use oral health information to make decisions about dental care and preventive practices.

Preventive Dental Services
Services that help stop dental problems before they develop (e.g., fluoride varnish, dental sealants, routine exams and cleanings).

Proof of Assessment (PoA)
Documentation returned by families confirming their child received the KOHA-required dental check-up.

Registered Dental Hygienist in Alternative Practice (RDHAP)
A specially licensed dental hygienist who can provide preventive services independently in community settings such as schools, preschools, and rural communities.

School-Linked Oral Health Program
A prevention-based program that provides screenings, education, and referrals in schools and connects children to dental care in the community.

Sealants
Thin, protective coatings applied to the chewing surfaces of molars to prevent cavities in children.

SCOHR (System for California Oral Health Reporting)
The statewide platform used to track KOHA results, including assessments, waivers, and oral health outcomes for kindergarteners.

Untreated Decay (Untrtd)
Active dental caries that have not been treated and may lead to pain, infection, or further deterioration.

Urgent Care Need (Ucn)
Dental conditions identified during screenings that require immediate attention, such as abscesses or severe pain.

Appendix D: Partner Resources & Contacts

Eastern Sierra Oral Health Coalition

Name	Title / Organization	Email

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