AGENDA

BOARD OF SUPERVISORS, COUNTY OF MONO
STATE OF CALIFORNIA

Regular Meetings: The First, Second, and Third Tuesday of each month. Location of meeting is specified just below.
MEETING LOCATION Board Chambers, 2nd Fl., County Courthouse, 278 Main St., Bridgeport, CA 93517

Regular Meeting
September 10, 2019

TELECONFERENCE LOCATIONS:

1) First and Second Meetings of Each Month: Mammoth Lakes CAO Conference Room, 3rd Floor Sierra Center Mall, 452 Old Mammoth Road, Mammoth Lakes, California, 93546; 2) Third Meeting of Each Month: Mono County Courthouse, 278 Main, 2nd Floor Board Chambers, Bridgeport, CA 93517.

Board Members may participate from a teleconference location. Note: Members of the public may attend the open-session portion of the meeting from a teleconference location, and may address the board during any one of the opportunities provided on the agenda under Opportunity for the Public to Address the Board.
NOTE: In compliance with the Americans with Disabilities Act if you need special assistance to participate in this meeting, please contact Shannon Kendall, Clerk of the Board, at (760) 932-5533. Notification 48 hours prior to the meeting will enable the County to make reasonable arrangements to ensure accessibility to this meeting (See 42 USCS 12132, 28CFR 35.130).
Full agenda packets are available for the public to review in the Office of the Clerk of the Board (Annex I - 74 North School Street, Bridgeport, CA 93517). Any writing distributed less than 72 hours prior to the meeting will be available for public inspection in the Office of the Clerk of the Board (Annex I - 74 North School Street, Bridgeport, CA 93517). **ON THE WEB**: You can view the upcoming agenda at http://monocounty.ca.gov. If you would like to receive an automatic copy of this agenda by email, please subscribe to the Board of Supervisors Agendas on our website at http://monocounty.ca.gov/bos.
UNLESS OTHERWISE SPECIFIED BY TIME, ITEMS SCHEDULED FOR EITHER THE MORNING OR AFTERNOON SESSIONS WILL BE HEARD ACCORDING TO AVAILABLE TIME AND PRESENCE OF INTERESTED PERSONS. PUBLIC MAY COMMENT ON AGENDA ITEMS AT THE TIME THE ITEM IS HEARD.

9:00 AM Call meeting to Order

Pledge of Allegiance

1. OPPORTUNITY FOR THE PUBLIC TO ADDRESS THE BOARD

on items of public interest that are within the subject matter jurisdiction of the Board. (Speakers may be limited in speaking time dependent upon the press of business

and number of persons wishing to address the Board.)

2. RECOGNITIONS - NONE

3. COUNTY ADMINISTRATIVE OFFICE

CAO Report regarding Board Assignments
Receive brief oral report by County Administrative Officer (CAO) regarding work activities.

4. DEPARTMENT/COMMISSION REPORTS

5. CONSENT AGENDA

(All matters on the consent agenda are to be approved on one motion unless a board member requests separate action on a specific item.)

A. MCAH Agreement Funding Application FY 2019-20

Departments: Public Health

Maternal Child & Adolescent Health (MCAH) Agreement Funding Application (AFA) FY 2019-20

Recommended Action: Approve the Maternal, Child, and Adolescent Health (MCAH) Agreement Funding Application (AFA) for fiscal year 2019-20. Authorize the Chairperson to sign the MCAH AFA Agency Information Form to execute the agreement on behalf of the County. Additionally, provide authorization for the Public Health Director to sign future amendments for the agreement that shift funds between budget categories without changes to the agreement allocation. Provide any desired direction to staff.

Fiscal Impact: There is no impact to the County General Fund. The MCAH program is funded with a mix of federal Title V and Title XIX dollars and Public Health Realignment, totaling $115,103.58 for fiscal year 2019-20. It supports 0.8275 full time equivalent of personnel.

B. 2019-20 Appropriations Limit

Departments: Finance

Proposed resolution establishing the 2019-20 Appropriations Limit.

Recommended Action: Adopt proposed resolution #R19-____, establishing the 2019-20 Appropriations Limit and making other necessary determinations for the County and for those special districts governed by the Board of Supervisors that are required to establish appropriation limits.

Fiscal Impact: None.

C. 2019-20 Property Tax Rates

Departments: Finance

Proposed resolution establishing the 2019-20 tax rates on the secured roll.

Recommended Action: Adopt proposed resolution #R19-____, establishing the 2019-20 tax rates on the secured roll. Provide any desired direction to staff.

Fiscal Impact: None. Allows for the collection of voter approved debt.

D. Notice of Intent to Transfer Surplus Vehicles to Special Districts

Departments: Public Works, Motor Pool

Mono County has a variety of surplus vehicles that have been prepared for auction in October. However, in accordance with Government Code Section 25365, the Board may donate (or sell for less than market value) surplus vehicles to special districts or other public agencies within the County. Several such entities have requested surplus vehicles from the surplus list. Prior to approving that transfer under Section 25365, the Board must publish notice of its intention.

Recommended Action:
(1) Find that Motor Pool Units 0718 (2010 Ford Expedition V.I.N.1FMJU1G52AEB20852 / MILES 160,802), 0738 (2011 Ford Expedition V.I.N.1FMJU1G51BEF33749 / MILES 185,400), 0763 (2013 Ford Expedition V.I.N.1FMJUG59DEF27667 / MILES 176,161), and 0885 (2009 Ford F-350 Ambulance V.I.N.1FDWF37R9EA94193 / MILES 103,287) are in good condition but are excess and/or unneeded property.
(2) Direct staff to publish a notice of intention to transfer Unit 0718 to the White Mountain Fire Protection District (FPD), Unit 0738 to the June Lake FPD, Unit 0763 to the Lee Vining FPD, and Unit 0885 to the Inyo County Special Enforcement Detail (a regional unit that responds to high-risk incidents in both Inyo and Mono Counties) for $50.00 each.

Fiscal Impact: Based on results from previous TNT auctions, the vehicles could yield approximately $6,000 each for the Expeditions, and approximately $3,500 for the ambulance, for an approximate total of $21,500 of unrealized revenue into the Motor Pool.

E. County Medical Services Program (CMSP) Wellness and Prevention Pilot Project Grant Agreement Amendment

Departments: Public Health

FY 2017/20 CMSP County Wellness abd Prevention Pilot Project Funding Grant Agreement, First Amendment.

Recommended Action: Approve County entry into the CMSP County Wellness and Prevention Pilot Project Funding Grant Agreement, First Amendment and authorize the Public Health Director's signature to execute said amendment on behalf of the County. Additionally, provide authorization for the Public Health Director to approve amendments and/or revisions that may occur during the amended contract period of March 1, 2017 - June 30, 2021 with approval as to

form by County Counsel.

Fiscal Impact: There is no fiscal impact to the County General Fund. The agreement amendment will shift budget timelines and does not change the grant allocation.

F. Local Oral Health Program Grant Amendment #17-10707, A01

Departments: Health Department

(Shelby Stockdale) - Proposed contract with California Department of Public Health's Office of Oral Health pertaining to Local Oral Health Program Grant Amendment #17-10707, A01.

Recommended Action: Approve the Local Oral Health Program Grant Amendment #17-10707, A01 and authorize the Public Health Director to sign on behalf of the County. Additionally, provide authorization for the Public Health Director to sign future amendments to the grant that shift funds between budget categories without changes to the grant allocation. Provide any desired direction to staff.

Fiscal Impact: There is zero impact to the Mono County General Fund. This program is funded with Proposition 56 funds totaling $705, 275 over the 5-year grant period.

G. Telepsychiatry Agreement with North American Mental Health Services

Departments: Behavioral Health

Proposed contract with North American Mental Health Services for the provision of Tele-Psychiatry Services at Mono County Behavioral Health and in the Mono County Jail.

Recommended Action: Approve County entry into proposed contract and authorize the Mono County CAO to execute said contract on behalf of the County. Provide any desired direction to staff.

Fiscal Impact: Total payments to the contractor by the county will not exceed $105,000 in any 12 month period. This is covered by Mono County Behavioral Health realignment and Mental Health Services Act.

H. June Lake Citizens Advisory Committee Appointment

Departments: Community Development - Planning

Appointments to the June Lake Citizens Advisory Committee are required to be approved by the Board of Supervisors.

Recommended Action: Appoint Brian McKinney to the June Lake Citizens Advisory Committee, term expiring December 31, 2023.

Fiscal Impact: None.

6. CORRESPONDENCE RECEIVED

All items listed are located in the Office of the Clerk of the Board, and are available for review. Direction may be given to staff regarding, and/or the Board may discuss, any item of correspondence listed on the agenda.

A. Los Angeles Department of Water and Power Temporary Urgency Change Petition to Deviate from Stream Restoration Flow Requirements

LADWP letter to the California State Water Resources Control Board requesting approval of its TUCP, affecting Rush, Lee Vining, Walker, and Parker Creeks.

7. REGULAR AGENDA - MORNING

A. Inyo National Forest Springs Fire Update

Departments: Board of Supervisors

10 minutes

(Gordon Martin, Mammoth - Mono Basin District Ranger) - An update from Inyo National Forest staff regarding the Springs Fire, 13 miles South East of Lee Vining, CA.

Recommended Action: None, informational only.

Fiscal Impact: None.

B. Assessor Compensation Review

Departments: Assessor

5 minutes

(Barry Beck) - Proposed resolution increasing the elected Assessor's salary from $9,180 to $10,000 per month, in order to provide parity and salary structure to the Office of the Assessor.

Recommended Action: Read fiscal impact. Approve proposed resolution R19-_____, amending the rate of pay for the position of the Mono County Assessor, in order to provide parity and salary structure to the Office of the Assessor. Provide any desired direction to staff.

Fiscal Impact: The fiscal impact to the general fund is to increase expenditures by $14,310 annually, of which $9,840 is salary and $4,470 is for benefits. The amount was not included in the fiscal year 2019-2020 adopted budget.

C. 2019 Mono County Community Health Needs Assessment

Departments: Public Health

45 minutes (30 minute presentation, 15 minutes for questions)

(Sandra Pearce) - Presentation by Public Health regarding the 2019 Mono County

Community Health Needs Assessment.

Recommended Action: None (informational only). Provide any desired direction to staff.

Fiscal Impact: None

D. 2018-2019 Grand Jury Report - Board Response

Departments: Public Works

20 minutes

(Tony Dublino, Director of Public Works; Justin Nalder, Solid Waste Superintendent) - Consideration of the 2018-2019 Grand Jury Report (re: the County's Solid Waste program and the January 2023 closing of Benton Crossing Landfill) and the Board Response to the Report.

Recommended Action: Consider response to the 18-19 Grand Jury Report and authorize staff to deliver response, or revise response and bring back to Board at the September 17 meeting.

Fiscal Impact: None.

8. OPPORTUNITY FOR THE PUBLIC TO ADDRESS THE BOARD

on items of public interest that are within the subject matter jurisdiction of the Board. (Speakers may be limited in speaking time dependent upon the press of business and number of persons wishing to address the Board.)

9. CLOSED SESSION

A. Closed Session - Human Resources

CONFERENCE WITH LABOR NEGOTIATORS. Government Code Section 54957.6. Agency designated representative(s): Stacey Simon, Dave Butters, Janet Dutcher, and Anne Larsen. Employee Organization(s): Mono County Sheriff's Officers Association (aka Deputy Sheriff's Association), Local 39 - majority representative of Mono County Public Employees (MCPE) and Deputy Probation Officers Unit (DPOU), Mono County Paramedic Rescue Association (PARA), Mono County Public Safety Officers Association (PSO), and Mono County Sheriff Department’s Management Association (SO Mgmt). Unrepresented employees: All.

B. Closed Session - Real Property Negotiations

CONFERENCE WITH REAL PROPERTY NEGOTIATORS. Government Code section 54956.8. Property: 40 Willow Ave, Unit 5, June Lake, CA (Assessor’s Parcel Number 016-195-005-000). Agency negotiator: Kathy Peterson. Negotiating parties: Larry Emerson for IMACA. Under negotiation: Price and terms of sale.

C. Closed Session - Public Employment

PUBLIC EMPLOYEE PERFORMANCE EVALUATION. Government Code section 54957. Title: County Administrative Officer.

D. Closed Session - Exposure to Litigation

CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION. Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Government Code section 54956.9. Number of potential cases: two.

10. BOARD MEMBER REPORTS

The Board may, if time permits, take Board Reports at any time during the meeting and not at a specific time.

ADJOURN

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

Departments: Public Health

TIME REQUIRED

SUBJECT MCAH Agreement Funding Application FY 2019-20

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Maternal Child & Adolescent Health (MCAH) Agreement Funding Application (AFA) FY 2019-20

RECOMMENDED ACTION:

Approve the Maternal, Child, and Adolescent Health (MCAH) Agreement Funding Application (AFA) for fiscal year 2019-20. Authorize the Chairperson to sign the MCAH AFA Agency Information Form to execute the agreement on behalf of the County. Additionally, provide authorization for the Public Health Director to sign future amendments for the agreement that shift funds between budget categories without changes to the agreement allocation. Provide any desired direction to staff.

FISCAL IMPACT:

There is no impact to the County General Fund. The MCAH program is funded with a mix of federal Title V and Title XIX dollars and Public Health Realignment, totaling $115,103.58 for fiscal year 2019-20. It supports 0.8275 full time equivalent of personnel.

CONTACT NAME: Jacinda Croissant

PHONE/EMAIL: 760.924.1841 / jcroissant@mono.ca.gov

SEND COPIES TO:

Jacinda Croissant

Kim Bunn

Sandra Pearce

MINUTE ORDER REQUESTED:

☑ YES ☐ NO

ATTACHMENTS:

Click to download
BOS Staff Report

MCAH AFA Packet

History

Time	Who	Approval
9/4/2019 7:35 PM	County Administrative Office	Yes
8/28/2019 12:22 PM	County Counsel	Yes
8/30/2019 11:10 AM	Finance	Yes

MONO COUNTY HEALTH DEPARTMENT
Public Health

P.O. BOX 476, BRIDGEPORT, CA 93517 PHONE (760) 932-5580 • FAX (760) 924-1831
P.O. BOX 3329, MAMMOTH LAKES, CA 93546 PHONE (760) 924-1830 • FAX (760) 924-1831

DATE: September 10, 2019
TO: Honorable Board of Supervisors
FROM: Jacinda Croissant, Health Program Manager/PHN

SUBJECT: **Maternal Child & Adolescent Health (MCAH) Agreement Funding Application (AFA) FY 2019-20**

Recommendation:

Approve the Maternal, Child, and Adolescent Health (MCAH) Agreement Funding Application (AFA) for fiscal year 2019-20. Authorize the Chairperson to sign the MCAH AFA Agency Information Form to execute the agreement on behalf of the County. Additionally, provide authorization for the Public Health Director to sign future amendments for the agreement that shift funds between budget categories without changes to the agreement allocation. Provide any desired direction to staff.

Discussion:

For nearly three decades, the Health Department has contracted with the California Department of Public Health for the local Maternal, Child, and Adolescent Health (MCAH) Program in Mono County. The six goals of the MCAH program include the following:

- Improve Outreach and Access to Quality Health and Human Services
- Improve Maternal Health
- Improve Infant Health
- Improve Nutrition and Physical Activity
- Improve Child Health
- Improve Adolescent Health

To achieve these goals, the MCAH program collaborates with local organizations/ agencies and provides a variety of services including but not limited to; prenatal outreach and education, teen pregnancy prevention, comprehensive sex education, SIDS education and prevention, nutrition and physical activity outreach and promotion, health care accessibility, and variety of other endeavors to support the health needs of our local residents.

Fiscal Impact/Budget Projections:

There is no impact to the County General Fund.

The MCAH program is funded with a mix of federal Title V and Title XIX dollars and Public Health Realignment, totaling $115,103.58 for fiscal year 2019-20.

For questions regarding this item, please call Jacinda Croissant at (760) 924-1842.

Submitted by: Jacinda Croissant, Health Program Manager/PHN

Reviewed by: Sandra Pearce, Public Health Director

FY 2019 - 2020 AGREEMENT FUNDING APPLICATION (AFA) CHECKLIST

Agency Name: Mono County Health Department

Agreement #: 2019-26 **Program:** ☒ MCAH ☐ BIH ☐ AFLP ☐ CHVP

(Check one box only)

Please check the box next to all submitted documents. All documents must be submitted by email using the required naming convention on page 2.	
☒	**1. AFA Checklist**
☒	**2. Agency Information Form** with signature (PDF)
☒	**3. Attestation of Compliance with the Sexual Health Education Accountability Act of 2007** (PDF)
☒	**4. Community Profile** submit only one profile including information about your MCAH, AFLP and/or BIH populations and programs as applicable (Word)
☒	**5. Budget Template** submit for the next two upcoming Fiscal Years (19/20 and 20/21) list all staff (by position) and costs (including projected salaries and benefits, operating and ICR). Multiple tabs for completion include Summary Page, Detail Pages, and Justifications. Personnel must be consistent with the Duty Statements and Organizational Charts (Excel)
☒	**6. Indirect Cost Rate (ICR) Certification Form** details methodology and components of the ICR
☒	**7. Duty Statements (DS)** for all staff (numbered according to the Personnel Detail Page and Organization Chart) listed on the budget
☒	**8. Organization Chart(s)** of the applicable programs, identifying all staff positions on the budget including their Line Item # and its relationship to other services for women and children, the local health officer and overall agency
☒	**9. Approval Letters** submit most recent letter on State letterhead with state staff signatures, including waivers for the following positions: ☒ MCAH Director; ☐ BIH Coordinator; ☐ AFLP Director; ☐ Other _____
☒	**10. Scope of Work (SOW)** documents for all applicable programs (PDF/Word)
☒	**11. Annual Inventory –** Form CDPH 1204
☐	**12. Local Health Officer Approval Letter to conduct FIMR** [MCAH only]
☐	**13. Subcontractor (SubK) Agreement Packages** submit Subcontract Agreement Transmittal Form, brief explanation of the award process, subcontractor agreement or waiver letter, and budget with detailed Justifications (required for all SubKs $5,000 or more) (Word)
☐	**14. Certification Statement for the Use of Certified Public Funds (CPE)** [AFLP CBOs and/or SubKs with FFP]
☒	**15. CDPH 9083 Government Agency Taxpayer ID Form**
☒	**16. Attestation of Compliance with the Requirements for Enhanced Title XIX Federal Financial Participation (FFP) Rate Reimbursement for Skilled Professional Medical Personnel (SPMP) and their Direct Clerical Support Staff**

File Naming Convention Example

Please save all electronic documents using the required naming convention below:

Agreement # *(space)* Program Abbreviation *(space)* Document # *(space)* Document Name *(from Checklist Above) (space) (Month/Day/Year)* XXXXXX

Example for MCAH Program:

2019XX MCAH 1 AFA Checklist 03.15.19
2019XX MCAH 2 Agency Information Form 03.15.19
2019XX MCAH 3 Attestation –Sexual Health Educ. Acct. Act 03.15.19
2019XX MCAH 4 Community Profile 03.15.19
2019XX MCAH 5 Budget Template 03.15.19
2019XX MCAH 6 ICR Certification Form 03.15.19
2019XX MCAH 7 Duty Statement 1 03.15.19
2019XX MCAH 7 Duty Statement 2 03.15.19
2019XX MCAH 7 Duty Statement 3 03.15.19
2019XX MCAH 7 Duty Statement 4 03.15.19
2019XX MCAH 8 Org Chart 03.15.19
2019XX MCAH 9 Approval Letter 03.15.19
2019XX MCAH 10 SOW 03.15.19
2019XX MCAH 11 Annual Inventory 03.15.19
2019XX MCAH 12 FIMR Approval Letter 03.15.19
2019XX MCAH 13 SubK Package 03.15.19
2019XX MCAH 14 CPE 03.15.19
2019XX MCAH 15 CDPH9083 03.15.19
2019XX MCAH 16 Attestation – TXIX FFP (SPMP and Direct Support) 03.15.19

Please contact your Contract Manager (CM) if you have any questions.

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
MATERNAL, CHILD AND ADOLESCENT HEALTH (MCAH) DIVISION

FUNDING AGREEMENT PERIOD
FY 2019-2020

AGENCY INFORMATION FORM

Agencies are required to submit an electronic and signed copy (original signatures only) of this form along with their Annual AFA Package.

Agencies are required to submit updated information when updates occur during the fiscal year. Updated submissions do not require certification signatures.

AGENCY IDENTIFICATION INFORMATION

Any program related information being sent from the CDPH MCAH Division will be directed to all Program Directors.

Please enter the agreement or contract number for each of the applicable programs

#2019-26 MCAH	BIH		AFLP	

Update Effective Date: _____ (only required when submitting updates)

Federal Employer ID#:	95-6005661
Complete Official Agency Name:	Mono County Health Department
Business Office Address:	PO Box 3329, Mammoth Lakes, Ca 93546
Agency Phone:	760.924.1830
Agency Fax:	760.924.1831
Agency Website:	www.monohealth.com

AGREEMENT FUNDING APPLICATION
POLICY COMPLIANCE AND CERTIFICATION

Please enter the **agreement or contract** number for each of the applicable programs

#2019-26 MCAH	0	BIH		0	AFLP

The undersigned hereby affirms that the statements contained in the Agreement Funding Application (AFA) are true and complete to the best of the applicant's knowledge.

I certify that these Maternal, Child and Adolescent Health (MCAH) programs will comply with all applicable provisions of Article 1, Chapter 1, Part 2, Division 106 of the Health and Safety code (commencing with section 123225), Chapters 7 and 8 of the Welfare and Institutions Code (commencing with Sections 14000 and 142), and any applicable rules or regulations promulgated by CDPH pursuant to this article and these Chapters. I further certify that all MCAH related programs will comply with the most current MCAH Policies and Procedures Manual, including but not limited to, Administration, Federal Financial Participation (FFP) Section. I further certify that the MCAH related programs will comply with all federal laws and regulations governing and regulating recipients of funds granted to states for medical assistance pursuant to Title XIX of the Social Security Act (42 U.S.C. section 1396 et seq.) and recipients of funds allotted to states for the Maternal and Child Health Service Block Grant pursuant to Title V of the Social Security Act (42 U.S.C. section 701 et seq.). I further agree that the MCAH related programs may be subject to all sanctions, or other remedies applicable, if the MCAH related programs violate any of the above laws, regulations and policies with which it has certified it will comply.

	Chair of the Board of Supervisors
Original signature of official authorized to commit the Agency to an MCAH Agreement	Title
Bob Gardner	
Name (Print)	Date
	MCAH Director
Original signature of MCAH/AFLP Director	Title
Jacinda Croissant	6/6/19
Name (Print)	Date

Exhibit K

Attestation of Compliance with the Sexual Health Education Accountability Act of 2007

Agency Name: Mono County Health Department
Agreement/Grant Number: 2019-26
Compliance Attestation for Fiscal Year: 2019-20

The Sexual Health Education Accountability Act of 2007 (Health and Safety Code, Sections 151000 – 151003) requires sexual health education programs (programs) that are funded or administered, directly or indirectly, by the State, to be comprehensive and not abstinence-only. Specifically, these statutes require programs to provide information that is medically accurate, current, and objective, in a manner that is age, culturally, and linguistically appropriate for targeted audiences. Programs cannot promote or teach religious doctrine, nor promote or reflect bias (as defined in Section 422.56 of the Penal Code), and may be required to explain the effectiveness of one or more drugs and/or devices approved by the federal Food and Drug Administration for preventing pregnancy and sexually transmitted diseases. Programs directed at minors are additionally required to specify that abstinence is the only certain way to prevent pregnancy and sexually transmitted diseases.

In order to comply with the mandate of Health & Safety Code, Section 151002 (d), the California Department of Public Health (CDPH) Maternal, Child and Adolescent Health (MCAH) Program requires each applicable Agency or Community Based Organization (CBO) contracting with MCAH to submit a signed attestation as a condition of funding. The Attestation of Compliance must be submitted to CDPH/MCAH annually as a required component of the Agreement Funding Application (AFA) Package. By signing this letter the MCAH Director or Adolescent Family Life Program (AFLP) Director (CBOs only) is attesting or "is a witness to the fact that the programs comply with the requirements of the statute". The signatory is responsible for ensuring compliance with the statute. Please note that based on program policies that define them, the Sexual Health Education Act inherently applies to the Black Infant Health Program, AFLP, and the California Home Visiting Program, and may apply to Local MCAH based on local activities.

The undersigned hereby attests that all local MCAH agencies and AFLP CBOs will comply with all applicable provisions of Health and Safety Code, Sections 151000 – 151003 (HS 151000–151003). The undersigned further acknowledges that this Agency is subject to monitoring of compliance with the provisions of HS 151000–151003 and may be subject to contract termination or other appropriate action if it violates any condition of funding, including those enumerated in HS 151000–151003.

Signed

Mono County Health Department
Agency Name

2019-26
Agreement/Grant Number

Signature of MCAH Director
Signature of AFLP Director (CBOs only)

4/16/19
Date

Jacinda Croissant
Printed Name of MCAH Director
Printed Name of AFLP Director (CBOs only)

Exhibit K

Attestation of Compliance with the Sexual Health Education Accountability Act of 2007

CALIFORNIA CODES
HEALTH AND SAFETY CODE
SECTION 151000-151003

151000. This division shall be known, and may be cited, as the Sexual Health Education Accountability Act.

151001. For purposes of this division, the following definitions shall apply:

(a) "Age appropriate" means topics, messages, and teaching methods suitable to particular ages or age groups of children and adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

(b) A "sexual health education program" means a program that provides instruction or information to prevent adolescent pregnancy, unintended pregnancy, or sexually transmitted diseases, including HIV, that is conducted, operated, or administered by any state agency, is funded directly or indirectly by the state, or receives any financial assistance from state funds or funds administered by a state agency, but does not include any program offered by a school district, a county superintendent of schools, or a community college district.

(c) "Medically accurate" means verified or supported by research conducted in compliance with scientific methods and published in peer review journals, where appropriate, and recognized as accurate and objective by professional organizations and agencies with expertise in the relevant field, including, but not limited to, the federal Centers for Disease Control and Prevention, the American Public Health Association, the Society for Adolescent Medicine, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists.

151002. (a) Every sexual health education program shall satisfy all of the following requirements:

(1) All information shall be medically accurate, current, and objective.

(2) Individuals providing instruction or information shall know and use the most current scientific data on human sexuality, human development, pregnancy, and sexually transmitted diseases.

(3) The program content shall be age appropriate for its targeted population.

(4) The program shall be culturally and linguistically appropriate for its targeted populations.

(5) The program shall not teach or promote religious doctrine.

(6) The program shall not reflect or promote bias against any person on the basis of disability, gender, nationality, race or ethnicity, religion, or sexual orientation, as defined in Section 422.56 of the Penal Code.

(7) The program shall provide information about the effectiveness and safety of at least one or more drugs and/or devices approved by the federal Food and Drug Administration for preventing pregnancy and for reducing the risk of contracting sexually transmitted diseases.

Attestation of Compliance with the Sexual Health Education Accountability Act of 2007

(b) A sexual health education program that is directed at minors shall comply with all of the criteria in subdivision (a) and shall also comply with both the following requirements:

(1) It shall include information that the only certain way to prevent pregnancy is to abstain from sexual intercourse, and that the only certain way to prevent sexually transmitted diseases is to abstain from activities that have been proven to transmit sexually transmitted diseases.

(2) If the program is directed toward minors under the age of 12 years, it may, but is not required to, include information otherwise required pursuant to paragraph (7) of subdivision (a).

(c) A sexual health education program conducted by an outside agency at a publicly funded school shall comply with the requirements of Section 51934 of the Education Code if the program addresses HIV/AIDS and shall comply with Section 51933 of the Education Code if the program addresses pregnancy prevention and sexually transmitted diseases other than HIV/AIDS.

(d) An applicant for funds to administer a sexual health education program shall attest in writing that its program complies with all conditions of funding, including those enumerated in this section. A publicly funded school receiving only general funds to provide comprehensive sexual health instruction or HIV/AIDS prevention instruction shall not be deemed an applicant for the purposes of this subdivision.

(e) If the program is conducted by an outside agency at a publicly funded school, the applicant shall indicate in writing how the program fits in with the school's plan to comply fully with the requirements of the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act, Chapter 5.6 (commencing with Section 51930) of the Education Code. Notwithstanding Section 47610 of the Education Code, "publicly funded school" includes a charter school for the purposes of this subdivision.

(f) Monitoring of compliance with this division shall be integrated into the grant monitoring and compliance procedures. If the agency knows that a grantee is not in compliance with this section, the agency shall terminate the contract or take other appropriate action.

(g) This section shall not be construed to limit the requirements of the California Comprehensive Sexual Health and HIV/AIDS Prevention Education Act (Chapter 5.6 (commencing with Section 51930) of Part 28 of the Education Code).

(h) This section shall not apply to one-on-one interactions between a health practitioner and his or her patient in a clinical setting.

151003. This division shall apply only to grants that are funded pursuant to contracts entered into or amended on or after January 1, 2008.

Mono County Maternal Child and Adolescent Health Community Profile 2019-2020

FOR FISCAL YEAR 2019-20, PLEASE USE THE LATEST DATA AVAILABLE FROM FHOP TO COMPLETE THE TABLE BELOW AND UPDATE THE NARRATIVE AS NEEDED. (PLEASE SEE THE MCAH LOCAL HEATLH JURISDICTION DATA TABLE CROSSWALK FOR MORE DETAILED INSTRUCTIONS). THERE IS A TWO-PAGE LIMIT.

Section 1 – Demographics

	Local	State
Our Community		
Total Population [1]	**14,168**	**38,896,969**
Total Population, African American	**113**	**2,236,361**
Total Population, American Indian/ Alaskan Natives	**425**	**172,948**
Total Population, Asian/Pacific Islander	**368**	**5,301,831**
Total Population, Hispanic	**3,896**	**15,172,006**
Total Population, White	**9,280**	**14,972,954**
Total Live Births	**147**	**491,789**
Our Mothers and Babies		
% of women delivering a baby who received prenatal care beginning in the first trimester of their pregnancy [2]	**76.9%**	**83.3%**
% of women delivering a baby who had a postpartum visit.[6]	**85.1 %**	**87.5%**
% of births covered by Medi-Cal [2]	**44.9 %**	**44.3%**
% of women ages 18-64 without health insurance [3]	**20.8 %**	**19.7%**
% of women giving birth to a second child within 24 months of a previous pregnancy [2]	**35.1 %**	**26.6%**

	Local	State
Our Mothers and Babies (continued)		
% live births less than 37 weeks gestation [2]	**6.3 %**	**8.4%**
Gestational diabetes per 1,000 females age 15-44	**7.3**	**9.2**
% of female population 18-64 living in poverty (0-200% FPL) [3]	**38.1 %**	**34.7%**
Substance use diagnosis per 1,000 hospitalizations of pregnant women	**5.1**	**19.9**
Unemployment Rate [4]	**8.6**	**7.5**
Our Children and Teens		
Adolescent Birth Rate per 1,000 females aged 15-19[2]	**21.4**	**21.0**
Motor vehicle injury hospitalizations per 100,000 children age 0-14	**13.6**	**14.2**
% of children, ages 0-18 years living in poverty (0-200% FPL) [3]	**50.1 %**	**45.9%**
Mental health hospitalizations per 100,000 age 15-24	**568.2**	**1,499.2**
Children in Foster Care per 1,000 children [5]	**2.1**	**6.3**
Substance abuse hospitalization per 100,000 aged 15-24	**256.6**	**793.4**

Data sources: [1]CA Dept. of Finance population estimates 2014, [2]CA Birth Statistical Master Files 2012-2014, [3]US Census Bureau - Small Area Health Insurance Estimates 2012-2014, [4]CA Employment Development Dept. 2012-2014, [5] Data from CA Child Welfare Indicators Project, UC Berkeley 2012-2014, [6] Data from CA Maternal, Infant Health Assessment (MIHA) 2013-2014.

Section 2 – About Our Community – Health Starts Where We Live, Learn, Work, and Play

Describe the following using brief narratives or bullets: *1) Geography, 2) Major industries and employers (public/private), 3) Walkability, recreational areas*

* Located on the eastside of the Sierra Nevada mountain range; north of Inyo County and south of Nevada State.
* 108 miles long and 38 miles wide; sparsely populated averaging 4.2 persons per square mile, mostly open space managed by the United States Forest Service and the Bureau of Land Management.
* One of the highest counties in the United States; many 13,000-14,000-foot-high peaks, seven highways passes ranging in elevation from 7,000 to 9,945 feet, all towns have elevations above 5,000 feet.
*Winters can last six to seven months and there is usually heavy snowfall between November and April.
* Major industries include recreation, accommodation, food services, arts, entertainment, education, health, social services, construction, retail trade, ranching, agriculture, mining, and a small military presence.
* Large influx of tourists during winters and summers for snow sports, fishing, camping, hiking, biking, and climbing.
* An abundance of open space for walkability, and continued work in towns to create safe routes to school and pedestrian friendly environments.

Section 3 – Health System – Health and Human Services for the MCAH Population

Describe the following using brief narratives or bullets: Strategies/initiatives that address the following: Maternal/Women's Health, Perinatal/Infant Health, Child Health, Adolescent Health, Children with Special Health Care Needs and cross cutting or life course issues (public health issues that impact multiple MCAH population groups).

* Mono County has one birthing hospital, located in Mammoth Lakes. The hospital does not have a Neonatal Intensive Care Unit (NICU), so in general, high risk pregnancies are managed outside of the County. Infants born preterm or with other complications are transported to surrounding major medical centers in Los Angeles, Loma Linda, Reno, and Davis.
* There is one Obstetrics/Gynecology office associated with Mammoth Hospital, and they have chosen not to be a CPSP provider as historically they have been paid higher rates due to their rural health status.
* Sierra Park Dental in Mammoth Lakes and Toiyabe Indian Health Clinic in Coleville both provide services to Denti-Cal clients, but only Sierra Park Dental has Pediatric Dentists on site.
* Local Medi-Cal Managed Care Plans include Anthem Blue Cross and California Health & Wellness.
* Barriers to accessing services include lack of insurance for non-citizens, payment up-front for cash pay, limited public transportation, the culture of poverty, stigma related to accessing some services, beaurocratic/administrative burden, and fear of accessing services for immigrants.

Section 4 – Health Status and Disparities for the MCAH Population

Describe the following using brief narratives or bullets: Key health disparities and how health behaviors, the physical environment and social determinants of health (social/economic factors) contribute to these disparities for specific populations. Highlight areas where progress has been made in improving health outcomes.

Due to the small population in Mono County, local data is often unable to capture health disparities. However, it is evident when looking at anecdotal evidence, that these disparities exist. Examples include the following:

* Health Behaviors: Residents who live in rural parts of Mono County, low-income individuals, and the Hispanic population have higher overweight and obesity rates. Children who come from low-income families and Hispanic children in general have poor oral health habits and more dental decay.
* Physical Environment: The remote location of Mono County and limited resources create an environment where some residents must travel hours for the services they need. This is not realistic for families who have limited means. Even if a family can access free transportation through Medi-Cal Managed Care, they often must travel long distances which are prohibitive when working multiple jobs without paid time off.
* Social Determinants of Health: Low income individuals, people who have limited English proficiency, and individuals with less formal education in general have poorer health.
* Progress Made: While the rates of children living in poverty has significantly declined since 2006, local poverty rates remain statistically higher than for California. Additionally, Mono County has a large population of Spanish-speaking only residents.
*Disparities in health related to income, education and language will continue to be a challenge on a population-wide basis.

☒ **IMPORTANT**: By clicking this box, I agree to allow the state MCAH Program to post my LHJ's Community Profile on the CDPH/MCAH website.

Public Health | Maternal, Child and Adolescent Health Division

BUDGET SUMMARY

FISCAL YEAR	BUDGET	BUDGET STATUS	BUDGET BALANCE
2019-20	ORIGINAL	ACTIVE	0.00

Version 5.0 - 150 Quarterly 04.18.19

Program: Maternal, Child and Adolescent Health (MCAH)
Agency: 201926 Mono
SubK:

		UNMATCHED FUNDING								NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)			
		MCAH-TV		MCAH-SIDS		TBD		AGENCY FUNDS		0		MCAH-Cnty NE		0		MCAH-Cnty E	
	(1)	(2)	(3)	(4)	(5)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
	TOTAL FUNDING	%	TITLE V	%	SIDS	%	TBD	%	Agency Funds*	%		%	Combined Fed/Agency*	%		%	Combined Fed/Agency*
ALLOCATION(S) →			77,008.00		3,000.00		0.00										#VALUE!
EXPENSE CATEGORY																	
(I) PERSONNEL	108,767.94		57,857.34		2,123.19		0.00		0.00		0.00		35,545.16		0.00		13,242.26
(II) OPERATING EXPENSES	5,518.06		2,909.75		626.81		0.00		0.00		0.00		1,981.50		0.00		0.00
(III) CAPITAL EXPENDITURES	0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00
(IV) OTHER COSTS	2,100.00		1,244.53		250.00		0.00		0.00		0.00		605.48		0.00		0.00
(V) INDIRECT COSTS	27,191.99		14,996.38		0.00		0.00		0.00		0.00		12,195.61		0.00		0.00
BUDGET TOTALS*	143,577.99	53.63%	77,008.00	2.09%	3,000.00	0.00%	0.00	0.00%	0.00	0.00%	0.00	35.05%	50,327.75	0.00%	0.00	9.22%	13,242.26
BALANCE(S) →			0.00		0.00		0.00										

TOTAL TITLE V	77,008.00	→	77,008.00		
TOTAL SIDS	3,000.00	→		3,000.00	
TOTAL TITLE XIX	35,095.58	→			[50%] 25,163.88 [75%] 9,931.70
TOTAL AGENCY FUNDS	28,474.43	→		0.00	[50%] 25,163.87 [25%] 3,310.56

$ 115,103.58 — **Maximum Amount Payable from State and Federal resources**

WE CERTIFY THAT THIS BUDGET HAS BEEN CONSTRUCTED IN COMPLIANCE WITH ALL MCAH ADMINISTRATIVE AND PROGRAM POLICIES.

MCAH/PROJECT DIRECTOR'S SIGNATURE — DATE: 7/10/19

AGENCY FISCAL AGENT'S SIGNATURE — DATE: 7/9/19

* These amounts contain local revenue submitted for information and matching purposes. MCAH does not reimburse Agency contributions

STATE USE ONLY - TOTAL STATE AND FEDERAL REIMBURSEMENT		MCAH-TV	MCAH-SIDS	TBD	AGENCY FUNDS	0	MCAH-Cnty NE	0	MCAH-Cnty E
PCA Codes		53107	53112	0		0	53118	0	53117
(I) PERSONNEL		57,857.34	2,123.19	0.00		0.00	17,772.58	0.00	9,931.70
(II) OPERATING EXPENSES		2,909.75	626.81	0.00		0.00	990.75	0.00	0.00
(III) CAPITAL EXPENSES		0.00	0.00	0.00		0.00	0.00	0.00	0.00
(IV) OTHER COSTS		1,244.53	250.00	0.00		0.00	302.74	0.00	0.00
(V) INDIRECT COSTS		14,996.38	0.00	0.00		0.00	6,097.81	0.00	0.00
Totals for PCA Codes	115,103.58	77,008.00	3,000.00	0.00		0.00	25,163.88	0.00	9,931.70

Program:	Maternal, Child and Adolescent Health (MCAH)
Agency:	201926 Mono
SubK:	

(I) PERSONNEL DETAIL

						UNMATCHED FUNDING								NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)					
						MCAH-TV		MCAH-SIDS		TBD		AGENCY FUNDS		0		MCAH-Cnty NE		0		MCAH-Cnty E			
					(1)	(2)	(3)	(4)	(5)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)		
	FULL NAME (First Name Last Name)	TITLE OR CLASSIFICATION (No Acronyms)	% FTE	ANNUAL SALARY	TOTAL FUNDING	%	TITLE V	%	SIDS	%	TBD	%	Agency Funds*	%		%	Combined Fed/Agency*	%		%	Combined Fed/Agency*	J-Pers MCF Per Staff	Staff Traveling (X)
	TOTAL PERSONNEL COSTS				108,767.94		57,857.34		2,123.19		0.00		0.00		0.00		35,545.16		0.00		13,242.26		
	FRINGE BENEFIT RATE		52.91%		37,635.94		20,019.83		734.67		0.00		0.00		0.00		12,299.35		0.00		4,582.09		
	TOTAL WAGES				71,132.00		37,837.51		1,388.52		0.00		0.00		0.00		23,245.80		0.00		8,660.16		
1	Jacinda Croissant	MCAH Director/Public Health Nurse	69.00%	83,965	57,950.00	55.10%	31,930.45		0.00		0.00		0.00		0.00	34.90%	20,224.55		0.00	10.00%	5,795.00	44.9%	X
2	Jacinda Croissant	PSC	3.00%	83,965	2,520.00	55.10%	1,388.52		0.00		0.00		0.00		0.00	10.90%	274.68		0.00	34.00%	856.80	95.0%	X
3	Jacinda Croissant	SIDS Coordinator	3.00%	83,965	2,520.00	0.00%	(0.00)	55.10%	1,388.52		0.00		0.00		0.00	20.90%	526.68		0.00	24.00%	604.80	44.9%	X
4	Shelby Stockdale	MCAH PHN	0.75%	86,084	646.00	60.10%	388.25		0.00		0.00		0.00		0.00	19.90%	128.55		0.00	20.00%	129.20	44.9%	
5	Thomas Boo	Health Officer	3.00%	109,200	3,276.00	55.10%	1,805.08		0.00		0.00		0.00		0.00	6.00%	196.56		0.00	38.90%	1,274.36	44.9%	
6	Sandra Pearce	Public Health Director	2.00%	128,000	2,560.00	55.10%	1,410.56		0.00		0.00		0.00		0.00	44.90%	1,149.44		0.00		0.00	44.9%	
7	Kimberly Bunn	Fiscal & Administrative Officer	2.00%	83,007	1,660.00	55.10%	914.66		0.00		0.00		0.00		0.00	44.90%	745.34		0.00		0.00	44.9%	
8					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
9					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
10					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
11					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
12					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
13					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
14					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
15					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
16					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
17					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
18					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
19					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
20					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
21					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
22					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
23					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
24					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
25					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
26					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
27					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
28					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
29					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
30					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
31					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
32					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
33					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
34					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
35					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
36					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
37					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
38					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
39					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
40					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
41					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
42					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
43					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
44					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
45					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
46					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
47					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
48					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
49					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
50					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
51					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
52					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
53					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
54					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
55					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
56					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
57					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
58					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
59					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
60					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
61					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	

Program:	Maternal, Child and Adolescent Health (MCAH)
Agency:	201926 Mono
SubK:	

						UNMATCHED FUNDING							NON-ENHANCED MATCHING (50/50)				ENHANCED MATCHING (75/25)					
						MCAH-TV		MCAH-SIDS		TBD		AGENCY FUNDS	0		MCAH-Cnty NE		0		MCAH-Cnty E			
					(1)	(2)	(3)	(4)	(5)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)		
					TOTAL FUNDING	%	TITLE V	%	SIDS	%	TBD	%	Agency Funds*	%		%	Combined Fed/Agency*	%		%	Combined Fed/Agency*		
132					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
133					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
134					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
135					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
136					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
137					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
138					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
139					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
140					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
141					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
142					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
143					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
144					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
145					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
146					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
147					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
148					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
149					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	
150					0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00		0.00	0.0%	

CERTIFICATION OF INDIRECT COST RATE METHODOLOGY

4/23/2019

Please list the Indirect Cost Rate (ICR) Percentage and supporting methodology for the contract or allocation with the California Department of Public Health, Maternal Child and Adolescent Health Division (CDPH/MCAH Division).

Date: 4/23/2019

Agency Name: **Mono County**

Contract/Agreement Number: **2019-26** Contract Term/Allocation Fiscal Year: 2019/20

1. NON-PROFIT AGENCIES/ COMMUNITY BASED ORGANIZATIONS (CBO)

Non-profit agencies or CBOs that have an approved ICR from their Federal cognizant agency are allowed to charge their approved ICR or may elect to charge less than the agency's approved ICR percentage rate.

Private non-profits local agencies that do not have an approved ICR from their Federal cognizant agency are allowed a maximum ICR percentage of 15.0 percent of the Total Personnel Costs.

The ICR percentage rate listed below must match the percentage listed on the Contract/Allocation Budget.

____% Fixed Percent of:

☐ Total Personnel Costs:

2. LOCAL HEALTH JURISDICTIONS (LHJ)

LHJs are allowed up to the maximum ICR percentage rate that was approved by the CDPH Financial Management Branch ICR or may elect to charge less than the agency's approved ICR percentage rate. The ICR rate may not exceed 25.0 percent of Total Personnel Costs or 15.0 percent of Total Direct Costs. The ICR application (i.e. Total Personnel Costs or Total Allowable Direct Costs) may not differ from the approved ICR percentage rate.

The ICR percentage rate listed below must match the percentage listed on the Allocation/Contracted Budget.

25% Fixed Percent of:

☒ Total Personnel Costs:

☐ Total Allowable Direct Costs:

3. OTHER GOVERNMENTAL AGENCIES AND PUBLIC UNIVERSITIES

University Agencies are allowed up to the maximum ICR percentage approved by the agency's Federal cognizant agency ICR or may elect to charge less than the agency's approved ICR percentage rate. Total Personnel Costs or Total Direct Costs cannot change.

____% Fixed Percent of:

☐ Total Personnel Costs (Includes Fringe Benefits)

☐ Total Personnel Costs (Excludes Fringe Benefits)

☐ Total Allowable Direct Costs

CERTIFICATION OF INDIRECT COST RATE METHODOLOGY

Please provide you agency's detailed methodology that includes all indirect costs, fees and percentages in the box below.

Please submit this form via email to your assigned Contract Manager.

The undersigned certifies that the costs used to calculate the ICR are based on the most recent, available and independently audited actual financials and are the same costs approved by the CDPH to determine the Department approved ICR.

Signature: 

Printed First & Last Name: Jacinda Croissant

Title/Position: Public Health Director

Date: 4/23/2019

MCAH DIRECTOR
DUTY STATEMENT

Budget Line: #1

Health Jurisdiction: Mono County
Program: Maternal, Child, and Adolescent Health
Program Position: MCAH Director
County Job Specification: Health Program Manager/PHN

The Director of Maternal, Child and Adolescent Health (MCAH) is the lead PHN for this program. This position must meet the definition of a Skilled Professional Medical Personnel (SPMP). Duties and responsibilities of this position include but are not limited to:

Program Development and Implementation

- General responsibility for the implementation of the MCAH contract with evaluation of program goals and objectives
- Plan, organize and coordinate MCAH contract, implementation with evaluation in achievement of objectives
- Gather and analyze data for program planning, management and evaluation
- Develop policies and standards to implement activities designed to improve health outcomes for the MCAH population, including CYSHCN and those eligible for Medi-Cal.
- Maintain appropriate records and reports
- Collaborate with the community in the planning for and development of resources and services for the perinatal population
- Facilitate local, regional, and state partnerships for the improvement of MCAH services

Outreach Activities

- Assure that comprehensive perinatal services are available to all Medi-Cal eligible women.
- Promote services and resources of the perinatal population with community groups and medical resources
- Facilitate client referrals to health and social services
- Promote the use of MCAH services in the community to increase awareness and the use of appropriate services

Health Education/Consultation

- Promote support for MCAH programs within the county government and medical community
- Evaluate progress of community awareness/support for MCAH programs
- Develop community awareness and support for MCAH programs
- Provide training for health professionals and clients to enable the community to meet the needs of the target population

Resource/Provider Development

- Respond to medical professionals and government, providing information and education about the MCAH population
- Facilitate collaboration, coordination, communication, and cooperation among service providers
- Facilitate health promotion for MCAH population
- Attend community and state meetings as indicated

Comprehensive Perinatal Services Program (CPSP)

- The MCAH Director serves as the Perinatal Services Coordinator (PSC)
- Provide pregnancy testing, prenatal vitamins, referral services, and application assistance to all women eligible for MediCal services to promote early prenatal care, improved birth outcomes, and sexual health.

SIDS Program

- The MCAH Director serves as the SIDS Coordinator
- Contact all parents/caregivers who experience a presumed SIDS death to provide grief and bereavement support services
- Attend the State SIDS Annual Conference and/or other SIDS training(s)
- Promote SIDS risk reduction activities by providing risk reduction education and materials to the community
- Upon being notified by the coroner of a presumed SIDS death, consulting with the infant's physician, when possible
- MCAH is also required to keep each county officer advised of the most current knowledge relating to the nature and cause of SIDS.

PSC
DUTY STATEMENT

Budget Line: #2

Health Jurisdiction: Mono County
Program: Maternal, Child, and Adolescent Health
Program Position: PSC
County Job Specification: Health Program Manager/PHN

This position is fulfilled by the MCAH Director and is responsible for managing and coordinating aspects of the Comprehensive Perinatal Services Program (CPSP). This position must meet the definition of a Skilled Professional Medical Personnel (SPMP). Duties and responsibilities of this position include but are not limited to:

- Motivate and assist women eligible for MediCal benefits to receive early and appropriate prenatal care
- Assess ability of women to access OB care and develop implementation strategies to enhance access in coordination with local agencies
- Participate in local or regional information sharing activities to improve access to prenatal care
- Oversee the planning, development and evaluation of all program components, including assisting CPSP providers in their deliverance of services according to the Title 22 California Code of Regulations
- Monitor trends in prenatal care, share findings with local providers and partner agencies, and incorporate assessment findings into the local MCAH plan
- Develop and promote community resources
- Maintain files and records
- Attend the State PSC training workshops as appropriate
- Attend Annual Perinatal Services Coordinator meeting

SIDS Coordinator
DUTY STATEMENT

Budget Line: #3

Health Jurisdiction: Mono County
Program: Maternal, Child, and Adolescent Health
Program Position: SIDS Coordinator
County Job Specification: Health Program Manager/PHN

This position is fulfilled by the MCAH Director and is responsible for managing and coordinating aspects of the SIDS (Sudden Infant Death Syndrome) program. This position must meet the definition of a Skilled Professional Medical Personnel (SPMP). Duties and responsibilities of this position include but are not limited to:

- The MCAH Director serves as the SIDS Coordinator
- Contact all parents/caregivers who experience a presumed SIDS death to provide grief and bereavement support services
- Attend the State SIDS Annual Conference and/or other SIDS training(s)
- Promote SIDS risk reduction activities by providing risk reduction education and materials to the community

MCAH PHN
DUTY STATEMENT

Budget Line: #4

Health Jurisdiction: Mono County
Program: Maternal, Child, and Adolescent Health
Program Position: MCAH PHN
County Job Specification: PHN II/III or Health Program Manager/PHN

Under the supervision of the MCAH Director, this position is responsible for providing MCAH clinical services, educating clients, and linking them to a variety of appropriate agencies and programs. This position must meet the definition of a Skilled Professional Medical Personnel (SPMP). Duties and responsibilities of this position include but are not limited to:

- Provide education to women on reproductive health and contraception.
- Provide referrals to women to improve their safety, well-being, and access to care including insurance programs such as Covered California, Medi-Cal, Presumptive Eligibility and Family PACT.
- Facilitate client referrals to health and social services.
- Provide pregnancy tests, prenatal education, vitamins, and linkage to early and continuous prenatal care including insurance programs such as Covered California, AIM, Medi-Cal, and Presumptive Eligibility.
- Act as liaison between the local program and other local agencies as appropriate.
- Collect data as required by MCAH Branch.
- Maintains files and records.

PUBLIC HEALTH OFFICER
DUTY STATEMENT

Budget Line: #5

Health Jurisdiction: Mono County
Program: Maternal, Child, and Adolescent Health
Program Position: Public Health Officer
County Job Specification: Public Health Officer

The Public Health Officer (PHO) provides medical oversight and consultative direction for Mono County Health Department and MCAH Program. Under administrative direction of the Public Health Director, the PHO serves as the public health subject matter expert, providing medical direction, guidance and clinical consultation to public health staff, including the development of protocols and policies.

The PHO serves as the face of the Public Health, issuing public statements, liaising with federal, state, and local public health agencies, and representing the department to government officials, community organizations and the public. This position provides consultation to the medical community in public health and MCAH as required, assesses local community health indicators and works with health providers and community groups to plan and implement strategies to improve community health.

This position must meet the definition of a Skilled Professional Medical Personnel (SPMP). Duties and responsibilities of this position include but are not limited to:

- Collaborates with the MCAH Director and staff to ensure goals and objectives are achieved, as well as to prioritize needs
- Interagency coordination, including the provider community to ensure MediCal providers are available for all clients
- Oversight of activities designed to improve health outcomes for the MCAH population, including CYSHCN and those eligible for Medi-Cal.
- Training activities
- Program planning
- Community and provider education
- Oversight of standing orders such as pregnancy testing

PUBLIC HEALTH DIRECTOR
DUTY STATEMENT

Budget Line: #6

Health Jurisdiction: Mono County
Program: Maternal, Child, and Adolescent Health
Program Position: Public Health Director
County Job Specification: Public Health Director

This position has its span of responsibility illustrated on the attached organizational chart for the MCAH Program staff and for the Department. The Public Health Director is responsible to the County Administrative Officer for the appropriate programmatic aspects of all Health programs including MCAH. She provides fiscal oversight through the Director of Financial Operations, who directly supervises the Fiscal Agent who produces and manages budgets and expenditures relating to this program. Activities include coordination, training and general administration. This position must meet the definition of a Skilled Professional Medical Personnel (SPMP). Duties and responsibilities of this position include but are not limited to:

- Meets weekly with the MCAH Director and staff to ensure program fits overall department goals and objectives, as well as to prioritize needs
- Supervises MCAH program personnel
- Interagency coordination, including the provider community to ensure MediCal providers are available for all clients
- Oversight of activities designed to improve health outcomes for the MCAH population, including CYSHCN and those eligible for Medi-Cal.
- Training activities
- Program planning and general administration

FISCAL & ADMINISTRATIVE OFFICER
DUTY STATEMENT

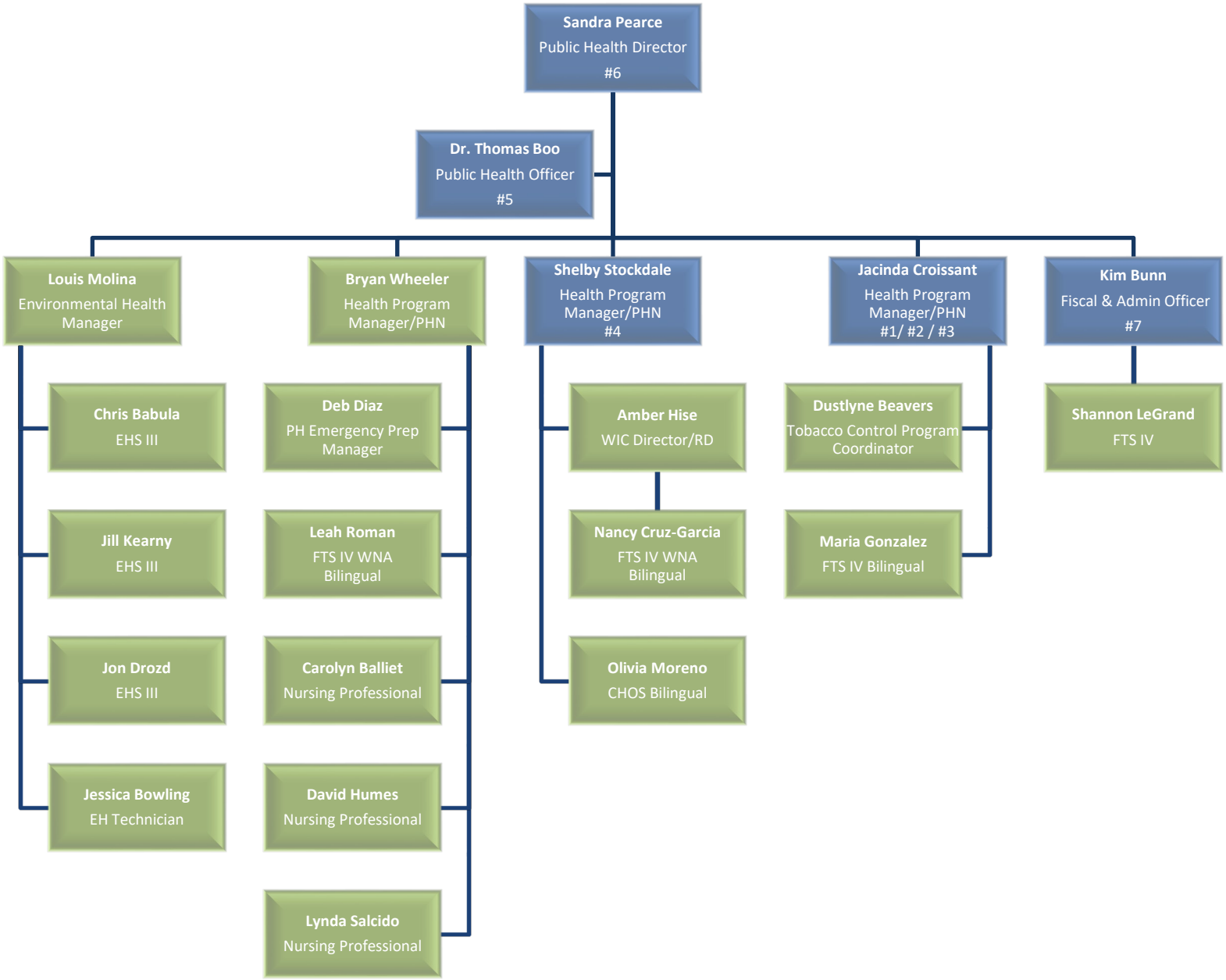
Budget Line: #7

Health Jurisdiction: Mono County
Program: Maternal, Child, and Adolescent Health
Program Position: Fiscal & Administrative Officer
County Job Specification: Public Health Fiscal and Administrative Officer

The Maternal, Child, and Adolescent Health Program fiscal agent performs all fiscal duties in support of the MCAH program. Duties and responsibilities of this position include but are not limited to:

- Preparation of budget and any budget adjustments
- Prepare any materials necessary for submission to Board of Supervisors for approval
- Processes all invoices for payment through the Auditor's office
- Oversees the data entry of time studies
- Prepares invoices
- Deposits all receipts in appropriate accounts
- Maintains inventory of program equipment
- Prepares fiscal information for periodic reports
- Other duties as required

Mono County Health Department Organizational Chart
Fiscal Year 2019/20



Effective 4/1/19

State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Health Officer

EDMUND G. BROWN JR.
Governor

September 13, 2018

Sandra Pearce, RN, PHN, CNS
Director of Public Health
Mono County Health Department
P.O Box 476
Bridgeport, CA 93546

Dear Ms. Pearce:

MCAH ALLOCATION #2018-26
MCAH DIRECTOR APPROVAL FOR MONO COUNTY

Your letter, dated September 7, 2018, to request approval to appoint Jacinda Croissant, RN, PHN, to serve as the Maternal, Child and Adolescent Health (MCAH) Director at 0.45 Full-Time Equivalent (FTE) and you to serve at 0.05 FTE on the MCAH budget, for a total 0.50 FTE MCAH leadership, is approved effective August 13, 2018.

This approval is based on the following:

1. You will have administrative oversight of the MCAH program
2. The MCAH Director position will be budgeted at 0.45 FTE.

This approval is applicable as long as you and Ms. Croissant occupy the positions of Director of Public Health and MCAH Director respectively and Mono County maintains the staffing levels described above.

Mono County is located in a rural resort area of California and we recognize the efforts to hire qualified nursing staff has been difficult. We appreciate all the efforts you have made to fill this position.

Please keep a copy of this letter in your MCAH files for audit purposes.
Please submit a copy with each MCAH Agreement Funding Application submitted while the waiver is in effect.

If there are any questions about this letter, please contact Kathy Sanchez, at 916-322-8981 or kathy.sanchez@cdph.ca.gov or Mary DeSouza, at 916-650-0378 or mary.desouza@cdph.ca.gov.

Sincerely,

Mary DeSouza, Chief
LHJ Program Integrity and Operations Unit
Maternal, Child and Adolescent Health Division

cc: Diana Clements, Contract Analyst
Allocation and Matched Funding Unit
Contract Management and Allocations Section
Maternal, Child and Adolescent Health Division

Kathy Sanchez, Health Program Consultant II
Program Integrity and Operations Unit
Perinatal Programs and LHJ Support Section
Maternal, Child and Adolescent Health Division

MCAH Central File

California Department of Public Health (CDPH)
Maternal, Child and Adolescent Health (MCAH) Program
Scope of Work (SOW)

☒ **IMPORTANT**: By clicking this box, I agree to allow the state MCAH Program to post my Scope of Work on the CDPH/MCAH website.

The Local Health Jurisdiction (LHJ), in collaboration with the State MCAH Program, shall strive to develop systems that protect and improve the health of California's women of reproductive age, infants, children, adolescents and their families. The goals and objectives in this MCAH SOW incorporate local problems identified by LHJs in the 5-Year Needs Assessments and reflect the Title V priorities of the MCAH Division. The local 5-Year Needs Assessment identified problems that LHJs may address in their 5-Year Action Plans. The LHJ 5-Year Action Plans inform the development of the annual MCAH SOW.

All LHJs must perform the activities in the shaded areas in Goals 1-3 and monitor and report on the corresponding evaluation/performance measures. In addition, each LHJ is required to develop at least two local objectives in Goal 1, one to address the health of reproductive age women and one to address the needs of pregnant women and two local objectives for Goal 3, a SIDS/SUID objective and an objective to improve infant health. LHJs that receive FIMR funding will perform the activities in the shaded area in Goal 3.5, including one local objective addressing fetal, neonatal, post-neonatal and infant deaths. In the second shaded column of 3.5a, Intervention Activities to Meet Objectives, insert the number and percent of cases that will be reviewed for the fiscal year. Lastly, if resources allow, LHJs should develop additional objectives, which can be placed under any of the Goals 1-5. All activities in this SOW must take place within the fiscal year. Please see the MCAH Policies and Procedures for further instructions on completing the SOW.

The development of this SOW was guided by several public health frameworks including the ones listed below. Please consider integrating these approaches when conceptualizing and organizing local program, policy, and evaluation efforts.

- The Ten Essential Services of Public Health
- The Spectrum of Prevention
- Life Course Perspective
- The Social-Ecological Model
- Social Determinants of Health
- Strengthening Families

All Title V programs must comply with the MCAH Fiscal Policies and Procedures Manual, which is found on the CDPH/MCAH website

CDPH/MCAH Division expects each LHJ to make progress towards Title V State Performance Measures and Healthy People 2020 goals. These goals involve complex issues and are difficult to achieve, particularly in the short term. As such, in addition to the required activities to address Title V State Priorities and requirements, the MCAH SOW provides LHJs the opportunity to develop locally determined objectives and activities that can be realistically achieved given the scope and resources of local MCAH programs.

LHJs are required to comply with requirements as stated in the MCAH Program Policies and Procedures Manual, such as attending statewide meetings, conducting a Needs Assessment every five years, submitting Agreement Funding Applications, and completing Annual Progress Reports.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services

The shaded and/or highlighted areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
Objective 1.1 **All women of reproductive age, pregnant women, infants, children, adolescents and children and youth with special health care needs (CYSHCN) will have access to needed and preventive, medical, dental, and social services by:** • Targeting outreach services to identify pregnant women, women of reproductive age, infants, children and adolescents and their families who are eligible for Medi-Cal assistance or other publicly provided health care programs and assist them in applying for these benefits[2] • Decreasing Medi-Cal eligible women, children, post-partum women without insurance[1]	**Assessment** **1.1a** i. Identify and monitor the health status of women of reproductive age, pregnant women, infants, children, adolescents, and CYSHCN, including the social determinants of health and access/barriers to the provision of: • Preventive, medical, dental, and social services ii. Review data books and monitor trends over time, geographic areas and population group disparities	**1.1a** i. This deliverable will be fulfilled by completing and submitting your Community Profile with your Agreement Funding Application each year ii. Briefly describe process for monitoring and interpreting data	**1.1a** Nothing is entered here.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services

The shaded and/or highlighted areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	iii. Annually, share your data with key local health department leadership	iii. Report the date data shared with the key health department leadership. Briefly describe their response, if significant.	
	1.1b Participate in collaboratives, coalitions, community organizations, etc., to review data and develop policies and products to address social determinants of health and disparities.	**1.1b** Report the total number of collaboratives with MCAH staff participation. Submit online Collaborative Surveys that document participation, objectives, activities and accomplishments of MCAH – related collaboratives.	**1.1b** List policies or products developed to improve infrastructure that address MCAH priorities.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services

The shaded and/or highlighted areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	Policy Development **1.1c** i. Review, revise and enact protocols or policies that facilitate access to Medi-Cal, California Children's Services (CCS), Covered CA, and Women, Infants, and Children (WIC)	**1.1c** i. List types of protocols or policies developed or revised to facilitate access to health care services.	**1.1c** i. List formal and informal agreements in place including Memoranda of Understanding with Medi-Cal Managed Care Plans (MCP) or other organizations that address the needs of mothers and infants
	ii. Develop and implement protocols to ensure all clients in MCAH programs are enrolled in a health insurance plan, linked to a provider, and complete an annual visit. Protocols include the following key components: • Assist clients to enroll in health insurance • Link clients to a health care provider for a preventive and/or medical visit • Develop a tracking mechanism to verify that the client enrolled in health insurance, completed a preventive or well medical visit	ii. Briefly describe the key components of the protocols developed to ensure all clients in MCAH programs are enrolled in insurance or a health plan, linked to a provider and complete an annual preventative and/or medical visit.	ii. Describe and summarize the impact of protocols or policy and systems changes that facilitate access to Medi-Cal, CCS, Covered CA, and WIC.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1: Women/Maternal Domain: Improve access to and utilization of comprehensive, quality health and social services

The shaded and/or highlighted areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	Assurance **1.1d** Develop staff knowledge and public health competencies for MCAH related issues	**1.1d** Summarize staff knowledge and competencies gained	**1.1d** Nothing is entered here
	1.1e Conduct activities to facilitate referrals to Medi-Cal, Covered CA, CCS, and other low cost/no-cost health insurance programs for health care coverage[2]	**1.1e** Describe activities to ensure referrals to health insurance, programs and preventive visits	**1.1e** Report the number of referrals to Medi-Cal, Covered CA, CCS, or other low/no-cost health insurance or programs.
	1.1f Provide a toll-free or "no-cost to the calling party" telephone information service and other appropriate methods of communication, e.g., local MCAH Program web page to the local community[2] to facilitate linkage of MCAH population to services	**1.1f** Describe the methods of communication, including the, cultural and linguistic challenges and solutions to linking the MCAH population to services	**1.1f** Report the following: • Number of calls to the toll-free or "no-cost to the calling party" telephone information service • The number of web hits to the appropriate local MCAH Program webpage

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.2: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for reproductive age women.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
REQUIRED LOCAL OBJECTIVE: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ is required to develop at least one specific short and/or intermediate SMART outcome objective(s) to address access to needed preventive services. ***Number each locally developed objective as follows: 1.2, 1.2a, 1.2b, 1.2c, 1.2d, etc.***			
Objective 1.2 By June 30, 2020, partner with community stakeholders to develop one strategy to address opioid and other substance abuse for women of reproductive age.	**1.2** Work with community partners to develop one strategy to reduce adolescent alcohol or drug use. **Assessment** • Conduct key informant interviews to increase understanding of factors contributing to opioid and other substance abuse locally. • Research best practices on reducing use of and access to opioids and other drugs by women of reproductive age. • Assess current capacity and resources. **Policy Development** • Develop one strategy to address opioid and other substance abuse for women of reproductive age. **Assurance** • Build CQI/QA measures in the strategy to ensure plan is implemented as intended.	**1.2** • List partners. Maintain on file the list of meetings, agendas, minutes. • Describe the rationale for the strategy chosen and process for developing the strategy Briefly describe CQI/QA process developed	**1.2** Number of strategies developed/ 1 strategy Briefly describe the following: • The strategy. • The process for implementation and evaluation of the strategy. • Any policies implemented. • The number of individuals served by the strategy. Outcomes of CQI/QA process and the method of measurement, if available.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.3: WOMEN/MATERNAL DOMAIN: <u>All pregnant women</u> will have access to early, adequate, and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
Objective 1.3 **All women will have access to quality maternal and early perinatal care, including CPSP services for Medi-Cal eligible women by:** • Increasing first trimester prenatal care initiation[1] • Increasing postpartum visit[1] • Increasing access to providers that can provide the appropriate services and level of care for reproductive age women[1]	**Assurance** **1.3a** i. Develop MCAH staff knowledge of the system of maternal and perinatal care ii. Develop a comprehensive resource and referral guide of available health and social services iii. Attend the yearly CPSP statewide meeting iv. Conduct local activities to facilitate increased access to early and quality perinatal care	**1.3a** Report the following: i. List of trainings received by staff on perinatal care, such as roundtables, regional meetings, collaborative work ii. Submit resource and referral guide iii. Date and attendance at the CPSP yearly meeting iv. List activities implemented to increase access of women to early and quality perinatal care. Identify barriers and opportunities to improve access to early and quality perinatal care	**1.3a** Provide the number and describe the outcomes of: • Roundtable meetings • Regional meetings • Other maternal and perinatal meetings

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.3: WOMEN/MATERNAL DOMAIN: <u>All pregnant women</u> will have access to early, adequate, and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	1.3b Outreach to perinatal providers, including Medi-Cal Managed Care i. Enroll in CPSP (Fee-for-Service and FQHC/RHC/IHC providers) ii. Identify and work with MCP liaisons to provide CPSP comparable services iii. Assist MCP providers to provide CPSP comparable services	**1.3b** i. Enroll FFS and FQHC/RHC/IHC providers Identify the MCP liaison(s). ii. Work with MCP(s) to provide CPSP comparable services iii. Work with MCP providers to provide CPSP comparable services	**1.3b** Nothing is entered here
	1.3c Coordinate perinatal activities between MCAH and the Regional Perinatal Programs of California (RPPC) to improve maternal and perinatal systems of care, including coordinated post-partum referral systems for high-risk mothers and infants upon hospital discharge	**1.3c** List number of meetings attended to facilitate coordination of activities between RPPC and MCAH and briefly describe outcomes	**1.3c** Nothing is entered here.
	1.3d Conduct technical assistance and face-to-face quality assurance/quality improvement (QA/QI) activities with CPSP providers or managed care providers in collaboration with	**1.3d** Report the number of CPSP provider technical assistance activities conducted by phone or email	**1.3d** Describe the results of technical assistance provided by phone or email

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.3: WOMEN/MATERNAL DOMAIN: <u>All pregnant women</u> will have access to early, adequate, and high quality perinatal care with a special emphasis on low-income and Medi-Cal eligible women.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
	MCP(s) liaison to ensure that CPSP services are implemented and protocols are in place	Report the number of QA/QI face-to-face site visits conducted with: • Enrolled CPSP providers • MCPs providers (with MCP liaison(s)) • Number of chart reviews List common problems or barriers and successful interventions	Describe the results of QA/QI activities that were conducted with: • Enrolled CPSP providers • MCPs providers (with MCP liaison(s)) • Summary of findings from the chart reviews

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 1.4: WOMEN/MATERNAL DOMAIN: Improve access to and utilization of comprehensive, quality health and social services for <u>pregnant women.</u>

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
<u>REQUIRED LOCAL OBJECTIVE</u>: Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ is required to develop at least one specific short and/or intermediate SMART outcome objective(s) to address access to needed preventive services. ***Number each locally developed objective as follows: 1.4, 1.4a, 1.4b, 1.4c, 1.4d, etc.***			
Objective 1.4 By June 30, 2020, develop and begin implementation of at least one strategy to improve oral health or access to oral health care for pregnant women.	**1.4** Collaborate with oral health partners to: **Assessment** • Assess current capacity and resources for Mono County MCAH and participants of the Local Oral Health Coalition to determine the strategy to be implemented. **Policy Development** • Develop one strategy to improve oral health or access to oral health care for pregnant women. • Develop screening form. **Assurance** Build CQI/QA measures in the strategy to ensure plan is implemented as intended.	**1.4** • List partners. Maintain on file the list of meetings, agendas, minutes. • Describe the rationale for the strategy chosen and process for developing the strategy. • Describe screening form. • Briefly describe CQI/QA process developed.	**1.4** Number of strategies developed / 1 strategy • Briefly describe the strategy • Briefly describe any policies implemented. • Briefly describe the process for implementation and evaluation of the strategy. Briefly describe outcomes of CQI/QA process and the method of measurement, if available.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
Objective 2.1 **Provide developmental screening for all children[1] in MCAH programs** • All children, including CYSHCN, receive a yearly preventive medical visit • Increase the rate of developmental screening for children ages 0-5 years according to AAP guidelines – 9 months, 18 months and 30 months	**Child Objective** **2.1a** Promote the American Academy of Pediatrics (AAP) developmental screening guidelines. **The following bolded activities, i, ii, are required:** **i. Promote regular preventive medical visits for all children, including CYSHCN, in MCAH Home Visiting and Case Management programs, per Bright Futures/AAP,** **ii. Adopt protocols/policies, including a QA/QI process, to screen, refer, and link all children in MCAH Home Visiting or Case Management Programs**	**2.1a** **Required** **Describe or report the following for MCAH programs:** **i. Activities to promote the yearly preventive medical visit** **ii. Describe protocols/policies including QA/QI process to screen, refer and link all children in MCAH programs**	**2.1a** **Required** **Describe or report the following for children in MCAH programs** **i. Number of children, including CYSHCN, receiving a yearly preventive medical visit** **ii. Number of children in MCAH programs receiving developmental screening** • **Number of children with positive screens that complete a follow-up visit with their primary care provider** • **Number of children with positive screens linked to services** • **Number of calls received for referrals and linkages to services**

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
	CYSHCN Objective(s) At least one activity is required. Choose from activities 2.1.b-2.1. (highlight your choices in yellow):	***Report the following based on the activities you chose to implement in the second column (highlight your choices in yellow):***	***Describe the following based on the activities you chose to implement in the second column (highlight your choices in yellow):***
	2.1b Promote the use of Birth to 5; Watch Me Thrive, Learn the Signs, Act Early or other screening materials consistent with AAP guidelines	**2.1b** Number of providers or provider systems receiving information about Birth to 5, Learn the Signs, Act Early or other screening materials	**2.1b** Nothing is entered here
	2.1c Participate in Help Me Grow (HMG) or programs that promote the core components of HMG	**2.1c** Describe participation in HMG or HMG like programs	**2.1c** Outcomes of participation in HMG or HMG like programs. Describe results of work to implement HMG core components
	2.1d Increase understanding of the specific barriers to referral and evaluation by early intervention or pediatric specialists (including mental/behavioral health)	**2.1d** Describe barriers to referral and evaluation by early intervention or pediatric specialists	**2.1d** Nothing is entered here
	2.1e Plan and implement a family engagement project to improve local efforts to serve children and youth with special health care needs (e.g., convene a family	**2.1e** Describe project activities, goals, and outcomes such as number of family members engaged, number of community meetings, and other	**2.1e** Nothing is entered here

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
	advisory group to assess how CYSHCN are served in local home visiting or case management programs)	process measures specific to the planned project	
	2.1f Work with health plans (HPs), including MCPs, to identify and address barriers to screening, referral, linkage and to assist the HPs in increasing developmental screenings for their members, per AAP guidelines, through education, provider feedback, incentives, quality improvement, or other methods	**2.1f** Describe barriers and strategies to increase screening, referral and linkage • Number of HPs requiring screenings per AAP guidelines	**2.1f** Nothing is entered here
	2.1g Identify methods to measure and monitor rates of developmental and other types of childhood screening, referrals, and successful linkages to care in your jurisdiction	**2.1g** If applicable, provide data on developmental and other screening rates, referrals, and successful linkages to care for the target population	**2.1g** Nothing is entered here
	2.1h Based on local needs, develop strategies to promote awareness of and address childhood adversity and trauma, including Adverse Childhood Experiences	**2.1h** Provide a description, and data if applicable, on process measures and outcomes relevant to the planned activities	**2.1h** Nothing is entered here

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 2: CHILD/CYSHCN DOMAIN: Improve the cognitive, physical, and emotional development of all children, including children and youth with special health care needs.

The shaded and bolded areas represent required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
	(ACEs), and build family and community resilience		
	2.1i Outreach and education to providers to promote developmental screening, referral and linkages	**2.1i** Describe type of outreach/education performed and results of outreach to providers	**2.1i** Nothing is entered here
	2.1j Provide care coordination for CYSHCN, especially non-CCS eligible children or children enrolled in CCS in need of services not covered by CCS	**2.1j** Describe activities for care coordination provided	**2.1j** List the number of children receiving care coordination

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths

The shaded area represents required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	**Short and/or Intermediate Outcome Measure(s)**
Objective 3.1 **All parents/caregivers experiencing a sudden and unexpected death will be offered grief and bereavement support services**	**Assurance** **3.1a** Establish contact with parents/caregivers of infants with presumed SIDS death to provide grief and bereavement support services[3] Provide grief and support materials to parents	**3.1a** (Insert number) of parents/caregivers who experience a presumed SIDS death and the number who are contacted for grief and bereavement support services.	**3.1a** Nothing is entered here
	3.1b Contact local coroner office to ensure timely reporting and referral of parents of all babies who die suddenly and unexpectedly regardless of circumstances of death	**3.1b** Report the coroner's notifications received Briefly describe barriers and opportunities for success	**3.1b** Nothing is entered here
Objective 3.2. **All professionals, para-professionals, staff, and community members will receive information and education on SIDS risk reduction practices and infant safe sleep**	**3.2a** Disseminate AAP guidelines on infant safe sleep and SIDS risk reduction to providers, pediatricians, CPSP providers, parents, community members and other caregivers of infants	**3.2a** Numbers receiving AAP guidelines on infant safe sleep: • Providers • Pediatricians • CPSP providers • Child care providers • Other – list	**3.2a** Nothing is entered here

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths

The shaded area represents required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
	3.2b Attend the SIDS Annual Conference/SIDS training(s), SIDS Coordinators' meeting and other conferences/trainings related to infant health[3].	**3.2b** Provide staff member name and date of attendance at SIDS Annual Conference/SIDS training(s) and other conference/trainings related to infant health.	**3.2b** Describe results of staff trainings related to infant health.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality by reducing the rate of SIDS/SUID deaths

The shaded area represents required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
REQUIRED LOCAL OBJECTIVE: Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address SIDS/SUID. ***Number each locally developed objective as follows: 3.3, 3.3a, 3.3b, 3.3c., etc.***			
Objective 3.3 By June 30, 2020, 90% of students training to be child care providers will demonstrate increased knowledge and intent to adopt infant safe sleep and SIDS risk reduction practices in child care settings.	**3.3** Coordinate with Community College's Early Childhood Education program to provide SIDS/SUID training to future child care providers. **Assessment** • Assess current policies and protocols. **Policy Development** • Develop training and evaluation tool using resources from the California SIDS center, the SIDS Center, and SIDS Project Impact. **Assurance** • Develop a process to measure knowledge change and intent to use the information in their work. • Follow up with Early Childhood Education teacher to offer TA and to determine changes in practice and awareness as a result of the training.	**3.3** • Brief description of training and process to measure increased knowledge. • Briefly describe the strategy to promote safe sleep environments and SIDS risk reduction practices. • List technical assistance provided. Describe QA/QI process developed.	**3.3** • Number of trainings implemented / 1 training. • Number of child care providers who demonstrate increased knowledge / number of child care providers attending training • Briefly describe the knowledge gained as a result of the trainings. • Describe outcomes of QA/QI process.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 3: PERINATAL/INFANT DOMAIN: Reduce infant morbidity and mortality

The shaded area represents required activities.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<u>REQUIRED LOCAL OBJECTIVE</u>: Insert Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. Each LHJ must provide at least one specific short and/or intermediate SMART outcome objective(s) to address perinatal/infant health. ***Number each locally developed objective as follows: 3.4, 3.4a, 3.4b, 3.4c., etc.***			
Objective 3.4 By June 30, 2020, implement one evidence-based curriculum at Mammoth Middle School related to healthy decision making for adolescents of reproductive age.	**3.4** Collaborate with Mammoth Middle School (MMS) and community partners to: **Assessment:** • Assess current resources and evidence-based curriculum(s) to implement. • Conduct Key informant interviews with teacher and community partners to determine strategy for implementing curriculum. **Policy Development** • Purchase selected evidence-based curriculum(s) • Coordinate with MMS to implement the curriculum. **Assurance** • Review CQI/QA measures with the teacher to ensure the curriculum is implemented as intended.	**3.4** • List partners, brief description of meetings, including the number of meetings and attendees. • Describe curriculum(s) chosen. • Brief descriptions of challenges and opportunities for success.	**3.4** Number of curriculum implemented/ 1 curriculum

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 4: CROSSCUTTING DOMAIN: Increase the proportion of children, adolescents and women of reproductive age who maintain a healthy weight.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<u>OPTIONAL LOCAL OBJECTIVE:</u> Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. ***Number each locally developed objective as follows: 4.1, 4.1a, 4.1b, 4.1c, etc.***			
Objective 4.1 By June 30, 2020, attend at least one community event to improve healthy lifestyle choices related to food and exercise for Mono County residents.	**4.1** Work with the Nutrition and Physical Activity Task Force (NPAT) and community partners to develop one strategy to improve the health of Mono County residents. **Assessment** • Engage community partners and NPAT to discuss current needs. • Review best practices with NPAT and community partners. • Discuss current capacity, resources, and outreach opportunities. **Policy Development** • Develop one strategy to improve the health of Mono County residents. **Assurance** Build CQI/QA measures in the strategy to ensure plan is implemented as intended.	**4.1** • List partners. Maintain on file the list of meetings, agendas, minutes. • Describe the rationale for the strategy chosen and process for developing the strategy. • Briefly describe CQI/QA process developed.	**4.1** Number of strategies developed / 1 strategy Briefly describe the following: • The strategy. • The process for implementation and evaluation of the strategy. • Any policies implemented. Outcomes of CQI/QA process and the method of measurement, if available.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Goal 5: ADOLESCENT DOMAIN: Promote and enhance adolescent strengths, skills, and supports to improve adolescent health.

Short and/or Intermediate Objective(s)	Intervention Activities to Meet Objectives (Describe the steps of the intervention)	Evaluation/Performance Measures Process, Short and/or Intermediate Measures (Report on these measures in the Annual Report)	
		Process Description and Measures	Short and/or Intermediate Outcome Measure(s)
<u>OPTIONAL LOCAL OBJECTIVE:</u> Insert locally developed Short and/or Intermediate Outcome Objective(s), Activities, Evaluation/Performance Measures in the appropriate column below. *Number each locally developed objective as follows: 5.1, 5.1a, 5.1b, 5.1c, etc.*			
Objective 5.1 By June 30, 2020, develop an after-school activity for Mammoth High School students to reduce substance use and improve healthy behaviors for adolescents.	**5.1** Work with community partners to develop one strategy to reduce substance use. **Assessment** • Conduct key informant interviews to increase understanding of factors contributing to substance use by teens. • Research best practices on reducing use of substances by adolescents of reproductive age. • Assess current capacity and resources. • Research pre and post assessment tools **Policy Development** • Develop one strategy to address alcohol and other substance use for adolescents. **Assurance** Build CQI/QA measures in the strategy to ensure plan is implemented as intended.	**5.1** • List partners. Maintain on file the list of meetings, agendas, minutes. • Describe the rationale for the strategy chosen and process for developing the strategy Briefly describe CQI/QA process developed	**5.1** Number of strategies developed/ 1 strategy Briefly describe the following: • The strategy. • The process for implementation and evaluation of the strategy. • Any policies implemented. • The number of individuals served by the strategy. Outcomes of CQI/QA process and the method of measurement, if available.

[1] 2016-2020 Title V State Priorities
[2] MCH Title V Block Grant Requirements
[3] State Requirements

Exhibit _____

INVENTORY/DISPOSITION OF CDPH-FUNDED EQUIPMENT

Current Contract Number: 2019-26

Previous Contract Number (if applicable): 2018-26

Contractor's Name: Mono County Health Department

Contractor's Complete Address: P.O. Box 3329

Mammoth Lakes, CA 93546

Contractor's Contact Person: Jacinda Croissant, Public Health Director

Contact's Telephone Number: 760-924-1842

Date Current Contract Expires: 6/30/19

CDPH Program Name: MCAH

CDPH Program Contract Manager: Diana Clements

CDPH Program Address: 1615 Capital Ave, MS 8305 P.O. Box 997420

Sacramento, CA 95899-7420

CDPH Program Contract Manager's Telephone Number: 916-445-8542

Date of this Report: 4/23/19

(THIS IS NOT A BUDGET FORM)

STATE/ CDPH PROPERTY TAG (If motor vehicle, list license number.)	QUANTITY	ITEM DESCRIPTION 1. Include manufacturer's name, model number, type, size, and/or capacity. 2. If motor vehicle, list year, make, model number, type of vehicle (van, sedan, pick-up, etc.) 3. If van, include passenger capacity.	UNIT COST PER ITEM (Before Tax)	CDPH ASSET MGMT. USE ONLY CDPH Document (DISPOSAL) Number	ORIGINAL PURCHASE DATE	MAJOR/MINOR EQUIPMENT SERIAL NUMBER (If motor vehicle, list VIN number.)	*OPTIONAL— PROGRAM USE ONLY*
		There is no equipment to report	$				
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INSTRUCTIONS FOR CDPH 1204
(Please read carefully.)

The information on this form will be used by the California Department of Public Health (CDPH) Asset Management (AM) to; (a) conduct an inventory of CDPH equipment and/or property (see definitions A, and B) in the possession of the Contractor and/or Subcontractors, and (b) dispose of these same items. Report all items, regardless of the items' ages, per number 1 below, purchased with CDPH funds and used to conduct state business under this contract. (See *Health Administrative Manual (HAM),* Section 2-1060 and Section 9-2310.)

The CDPH Program Contract Manager is responsible for obtaining information from the Contractor for this form. The CDPH Program Contract Manager is responsible for the accuracy and completeness of the information and for submitting it to AM.

Inventory: List all CDPH tagged equipment and/or property on this form and submit it within 30 days prior to the three-year anniversary of the contract's effective date, if applicable. **The inventory should be based on previously submitted CDPH 1203s**, "Contractor Equipment Purchased with CDPH Funds." AM will contact the CDPH Program Contract Manager if there are any discrepancies. (See HAM, Section 2-1040.1.)

Disposal: *(Definition: Trade in, sell, junk, salvage, donate, or transfer; also, items lost, stolen, or destroyed (as by fire).)* The CDPH 1204 should be completed, along with a "Property Survey Report" (STD. 152) or a "Property Transfer Report" (STD. 158), whenever items need to be disposed of; (a) during the term of this contract and (b) 30 calendar days before the termination of this contract. After receipt of this form, the AM will contact the CDPH Program Contract Manager to arrange for the appropriate disposal/transfer of the items. (See HAM, Section 2-1050.4.)

1. List the state/ CDPH property tag, quantity, description, purchase date, base unit cost, and serial number (if applicable) for each item of;

   A. Major Equipment: **(These items were issued green numbered state/ CDPH property tags.)**
   - Tangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more.
   - Intangible item having a base unit cost of $5,000 or more and a life expectancy of one (1) year or more (e.g., software, video.)

   B. Minor Equipment/Property:

   Specific tangible items with a life expectancy of one (1) year or more that have a base unit cost less than $5,000. The minor equipment and/or property items were issued green unnumbered "BLANK" state/ CDPH property tags with the exception of the following, which are issued numbered tags: Personal Digital Assistant (PDA), PDA/cell phone combination (Blackberries), laptops, desktop personal computers, LAN servers, routers and switches.

2. If a vehicle is being reported, provide the Vehicle Identification Number (VIN) and the vehicle license number to CDPH Vehicle Services. (See HAM, Section 2-10050.)

3. If all items being reported do not fit on one page, make copies and write the number of pages being sent in the upper right-hand corner (e.g. "Page 1 of 3.")

4. The CDPH Program Contract Manager should retain one copy and send the original to: California Department of Public Health, Asset Management, MS1801, P.O. Box 997377, 1501 Capitol Avenue, Sacramento, CA 95899-7377.

5. Use the version on the CDPH Intranet forms site. The CDPH 1204 consists of one page for completion and one page with information and instructions.

For more information on completing this form, call AM at (916) 650-0124.

State of California-Health and Human Services Agency

California Department of Public Health
1616 Capitol Ave., Suite 74.262
P.O. Box 997377, MS 1800
Sacramento, CA 95899-7377
www.cdph.ca.gov

GOVERNMENT AGENCY TAXPAYER ID FORM

The principal purpose of the information provided is to establish the unique identification of the government entity.

Instructions: You may submit one form for the principal government agency and all subsidiaries sharing the same TIN. Subsidiaries with a different TIN must submit a separate form. Fields bordered in red are required. Please print the form to sign prior to submittal. You may email the form to: GovSuppliers@cdph.ca.gov or fax it to (916) 650-0100, or mail it to the address above.

Principal Government Agency Name: Mono County

Remit-To Address (Street or PO Box): PO Box 476

City: Bridgeport State: CA Zip Code+4: 93517

Government Type:
- ☐ City
- ☐ Special District
- ☐ Other (Specify)
- ■ County
- ☐ Federal

Federal Employer Identification Number (FEIN): 95-6005661

List other subsidiary Departments, Divisions or Units under your principal agency's jurisdiction who share the same FEIN and receives payment from the State of California.

FI$Cal ID# (if known)	Dept/Division/Unit Name	Complete Address
	Public Health	PO Box 476, Bridgeport, CA 93517

Contact Person: Kimberly Bunn Title: Public Health Fiscal & Administrative Officer

Phone number: 760.932.5587 E-mail address: kbunn@mono.ca.gov

Signature: [signature] Date: 5/8/19

State of California—Health and Human Services Agency
California Department of Public Health

KAREN L. SMITH, MD, MPH
Director and State Public Health Officer

GAVIN NEWSOM
Governor

Attestation of Compliance with the Requirements for Enhanced Title XIX Federal Financial Participation (FFP) Rate Reimbursement for Skilled Professional Medical Personnel (SPMP) and their Direct Clerical Support Staff

In compliance with the Social Security Act (SSA) section 1903(a)(2), Title 42 Code of Federal Regulations (CFR) part 432.2 and 432.50, and the Federal and State guidelines provided, Mono County Health Department has determined that the list of individuals in the attached Exhibit A are eligible for the enhanced SPMP reimbursement rate, for the State Fiscal Year 2019-2020, based on our review of all the criteria below:

☒ Professional Education and Training

☒ Job Classification

☒ Job Duties /Duty Statement

☒ Specific Tasks (if only a portion will be claimed as SPMP enhanced functions)

☒ Organizational Chart

☒ Accurate, complete, and signed SPMP Questionnaire

☒ Active California License/Certification

The undersigned hereby attests that he/she:

- Has personally reviewed the criteria above and its supporting documentation, and determined that the individuals meet the federal requirements for the enhanced SPMP reimbursement rate.
- Will maintain all the aforementioned records and supporting documentation for audit purposes for a minimum of 3 years.
- Certifies that SPMP expenditures are from eligible non-federal sources and are in accordance with 42 CFR Section 433.51
- Understands that if SPMP requirements are not met, the agency will be financially responsible for repaying the costs to the California Department of Public Health (CDPH).
- Understands that CDPH may request additional information to substantiate the SPMP claims and such information must be provided in a timely manner.

Mono County Health Department
Agency Name/ Local Health Jurisdiction

Jacinda Croissant, MCAH Director
Name and Title

5/7/19
Signature *Date*

Exhibit A

	Agency Employee	Classification/Position	Professional Education/Training	Type of Licence	Active CA License No./ Certification No.
1	Sandra Pearce	Public Health Director	BSN, MSN	RN	621295
2	Jacinda Croissant	MCAH Director	BSN	RN	95021915
3	Jacinda Croissant	PSC	BSN	RN	95021915
4	Tom Boo	Public Health Officer	MD	MD	G80249
5	Shelby Stockdale	Public Health Nurse	BSN	RN	95064964
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OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

Departments: Finance

TIME REQUIRED

SUBJECT 2019-20 Appropriations Limit

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Proposed resolution establishing the 2019-20 Appropriations Limit.

RECOMMENDED ACTION:

Adopt proposed resolution #R19-____, establishing the 2019-20 Appropriations Limit and making other necessary determinations for the County and for those special districts governed by the Board of Supervisors that are required to establish appropriation limits.

FISCAL IMPACT:

None.

CONTACT NAME: Stephanie Butters

PHONE/EMAIL: 760-932-5496 / sbutters@mono.ca.gov

SEND COPIES TO:

Finance, sbutters@mono.ca.gov

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

Click to download
2019-20 -Appropriation Staff Report Memo
2019-20 -Appropriation Resolution
2019-20 Approp Limit Reso Exhibit A

History

Time	Who	Approval

9/4/2019 7:29 PM	County Administrative Office	Yes
9/4/2019 2:37 PM	County Counsel	Yes
9/4/2019 3:44 PM	Finance	Yes

DEPARTMENT OF FINANCE
AUDITOR-CONTROLLER
COUNTY OF MONO

Stephanie M. Butters
Assistant Finance Director
Auditor-Controller

Janet Dutcher, CPA, CGFM
Director of Finance

P.O. Box 556
Bridgeport, California 93517
(760) 932-5490
Fax (760) 932-5491

TO: Honorable Board of Supervisors

FROM: Stephanie Butters, Assistant Finance Director

DATE: September 10, 2019

SUBJECT: 2019-20 Appropriation Limit

RECOMMENDATION:

Approve and authorize the Chair's signature on proposed Resolution setting the Appropriation Limit for Fiscal Year 2019-20.

BACKGROUND:

Proposition 4, approved by voters in November 1979, added Article XIIIB to the State Constitution. Article XIIIB places a limit on appropriations of revenue identified as proceeds of taxes. The limit is commonly referred to as the Gann Limit. The Gann Limit as originally approved by voters set the 1978-79 expenditure level as the base spending limit. This limit was adjusted annually for population growth and inflation (using the lower of the percentage growth of the U.S. Consumer Price Index or California's per capita personal income).

Under Article XIIIB and the statutes implementing that Article (Government Code Sections 7900 et. seq.), the governing body of every local jurisdiction in California must establish by resolution its annual appropriation limit for the following fiscal year. The appropriation limit is a limit on the amount of tax dollars that may be appropriated by the governing body during the fiscal year. It is calculated by adjusting the appropriations limit from the previous year to take into account "change in the cost of living and the change in population." (Cal. Const. Art. XIIIB, § 1) If tax proceeds collected in the prior fiscal year exceed the limit, then a reduction in tax rates is required to take place.

The County has several available choices from which to choose the factor for setting the appropriations limit. It can choose the factor that is most advantageous to the County. Of the available choices, using the County-wide population change, the Town population change, or the population change derived from contiguous counties, the County has chosen the "Alternate" rate, derived from the State provided rate for cost of living changes combined with the contiguous counties population change, which gives the County the highest possible appropriations limit.

DISCUSSION:

The Appropriations Limit as calculated is $33,721,634. As County tax proceeds, in conjunction with capital spending, is below this limit by $8,403,064 this year, no change to the tax rate is required.

FINANCIAL IMPACT:

None.

R19-__

A RESOLUTION OF THE MONO COUNTY BOARD OF SUPERVISORS ESTABLISHING THE 2019-20 APPROPRIATIONS LIMIT AND MAKING OTHER NECESSARY DETERMINATIONS FOR THE COUNTY AND FOR THOSE SPECIAL DISTRICTS GOVERNED BY THE BOARD OF SUPERVISORS THAT ARE REQUIRED TO ESTABLISH APPROPRIATION LIMITS

WHEREAS, Article XIII(B) of the California Constitution and the legislation adopted to implement it (California Government Code §7901 et seq.) provide that the State and each local government that receives proceeds of taxes shall establish and be subject to an annual appropriations limit; and

WHEREAS, the County Auditor-Controller has computed the 2019-20 appropriations limit for the County and for those special districts governed by the Board of Supervisors that are required to establish appropriations limits and, for at least fifteen days prior to the meeting at which this resolution is adopted, the documentation used in determining the appropriations limit(s) and other necessary determinations set forth in this resolution has been available for public review in the Auditor-Controller's Office.

NOW, THEREFORE, THE BOARD OF SUPERVISORS OF THE COUNTY OF MONO RESOLVES that:

SECTION ONE: The percentage change in the California per capita personal income computed by the State Department of Finance is hereby selected as the "change in cost of living" for purposes of calculating the appropriation limit(s) established herein for fiscal year 2019-20. The alternative population for contiguous counties is hereby selected as the "change in population" for purposes of calculating the appropriation limit(s) established herein for fiscal year 2019-20.

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SECTION TWO: The 2019-20 appropriations limit for the County of Mono is hereby established as $33,721,634, the calculation of which is set forth in Exhibit "A" attached hereto and incorporated by this reference. The 2019-20 appropriations limit(s) for those special districts governed by the Board of Supervisors that are required to establish appropriations limits are hereby established as also shown on Exhibit "A".

PASSED, APPROVED and **ADOPTED** this 10th day of September, 2019, by the following vote, to wit:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____
John Peters, Chair
Mono County Board of Supervisors

ATTEST:

_____
Clerk of the Board

APPROVED AS TO FORM:

_____
County Counsel

Exhibit A

Statement of Mono County Appropriation (Gann) Limit Calculations
For the Tax Year 2019-20

	2017-18 Limit	Population Change[1]	Per Capita Change	2018-19 Limit	Population Change[1]	Per Capita Change	2019-20 Limit
Mono County	**30,677,019**	**1.0113**	**1.0367**	**32,161,787**	**1.0096**	**1.0385**	**33,721,634**
CSA#1	394,853	1.0098	1.0367	413,356	0.9908	1.0385	425,321
CSA#5	58,761	1.0098	1.0367	61,515	0.9908	1.0385	63,296

[1] The alternate method for population change was used for Mono County per GC 7901.

Appropriation (Gann) Limit Calculation
Based on Projected Revenues
Fiscal Year Ending June 30, 2020

	Projected FY 19-20
Property Taxes	18,944,301
Sales and Use Tax	579,126
Transient Occupancy Tax	3,237,770
Property Tax Transfer Tax	262,407
Cannabis Tax	1,409
Interest	253,182
Franchise Tax Fees	199,833
Motor Vehicle License Fees	1,702,644
Aid of Agriculture (unclaimed gas tax)	94,458
Homeowner's Property Tax Relief	43,440
	25,318,570

2018-19 Limitation	32,161,787
2019-20 Population Factor	1.0096
2019-20 Per Capita Factor	1.0385
2019-20 Appropriation Limit	33,721,634
2019-20 Proceeds of Taxes	(25,318,570)
Amount Under Limitation	8,403,064

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

Departments: Finance

TIME REQUIRED

SUBJECT 2019-20 Property Tax Rates

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Proposed resolution establishing the 2019-20 tax rates on the secured roll.

RECOMMENDED ACTION:

Adopt proposed resolution #R19-____, establishing the 2019-20 tax rates on the secured roll. Provide any desired direction to staff.

FISCAL IMPACT:

None. Allows for the collection of voter approved debt.

CONTACT NAME: Stephanie Butters

PHONE/EMAIL: 760-932-5496 / sbutters@mono.ca.gov

SEND COPIES TO:

Finance, sbutters@mono.ca.gov

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

Click to download
2019-20 Tax Rate Staff Report
2019-20 Tax Rate Resolution.docx
2019-20 Tax Rate Schedule Exhibit A.pdf

History

Time	Who	Approval
9/4/2019 7:30 PM	County Administrative Office	Yes

9/4/2019 2:38 PM	County Counsel	Yes
9/4/2019 3:45 PM	Finance	Yes

DEPARTMENT OF FINANCE
AUDITOR-CONTROLLER
COUNTY OF MONO

Stephanie M. Butters
Assistant Finance Director
Auditor-Controller

Janet Dutcher, CPA, CGFM
Director of Finance

P.O. Box 556
Bridgeport, California 93517
(760) 932-5490
Fax (760) 932-5491

TO: Honorable Board of Supervisors

FROM: Stephanie Butters, Assistant Finance Director

DATE: September 10, 2019

SUBJECT: Tax Rates for Fiscal Year 2019-20

RECOMMENDATION:

Adopt proposed resolution approving the Tax Rates for Fiscal Year 2019-20.

BACKGROUND:

The tax rates are established by law (Proposition 13) and the various bond issues voters have approved for their area throughout the county. These bond issues include the bond series approved by the voters for the Eastern Sierra Unified School District, the Southern Mono Healthcare District, Kern Community College District (Mammoth Campus), and Mammoth Unified School District. The tax rates for the Round Valley School District and Bishop Union High School are prepared by the Auditor-Controller of Inyo County based in part by the values of the affected tax rate areas.

FISCAL IMPACT:

None. Adoption of the proposed Resolution only allows the adopted rate to be placed on the tax rolls to allow the County to collect not only the statutory 1% tax on property, but also to collect for voter approved debt.

R19-__

A RESOLUTION OF THE MONO COUNTY BOARD OF SUPERVISORS ESTABLISHING THE 2019-20 TAX RATES ON THE SECURED ROLL

WHEREAS, Section 29100 of the California Government Code requires the Board of Supervisors to adopt by resolution the rates of taxes on the secured roll; and

WHEREAS, the County Auditor-Controller has duly computed tax rates for the 2019-20 secured roll that will comply with the requirement of state law, including, but not limited to, those imposed by Section 29100 of the Government Code; and

WHEREAS, a copy of said tax rates is attached hereto as Exhibit "A" and incorporated herein by this reference.

NOW, THEREFORE, THE BOARD OF SUPERVISORS OF THE COUNTY OF MONO RESOLVES that: the tax rates set forth in Exhibit "A" hereto are hereby adopted for the 2019-20 secured roll.

PASSED, APPROVED and **ADOPTED** this 10th day of September, 2019, by the following vote, to wit:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____
John Peters, Chair
Mono County Board of Supervisors

ATTEST:

_____
Clerk of the Board

APPROVED AS TO FORM:

_____
County Counsel

Exhibit A

COUNTY OF MONO
TAX RATES
2019-20

TAX AREAS 051-000 THRU 051-013/ 051-019 THRU 051-034		**PERCENTAGE**
PROP 13 (1% Limit)		1.000000
Eastern Sierra Unified School District (ESUSD) Bonds		0.060000
	TOTAL	**1.060000**

TAX AREAS: 051-014 THRU 051-018		
PROP 13 (1% Limit)		1.000000
Eastern Sierra Unified School District (ESUSD) Bonds		0.060000
	TOTAL	**1.060000**

TAX AREAS: 010-000, 010-002, 010-003,010-004, 010-006, 010-008, 010-011, 010-012		
PROP 13 (1% Limit)		1.000000
Mammoth Campus, Kern Community College SFID Bonds		0.033599
Mammoth Unifed School District (MUSD) Bonds		0.061772
Southern Mono Healthcare District Bonds		0.038417
	TOTAL	**1.133787**

TAX AREAS: 010-001,010-005,010-007,010-009,010-010		
PROP 13 (1% Limit)		1.000000
Mammoth Campus, Kern Community College SFID Bonds		0.033599
Mammoth Unifed School District (MUSD) Bonds		0.061772
Southern Mono Healthcare District Bonds		0.038417
	TOTAL	**1.133787**

TAX AREAS: 010-013, 059-000, 059-005, 059-007, 059-012		
PROP 13 (1% Limit)		1.000000
Mammoth Unifed School District (MUSD) Bonds		0.061772
Southern Mono Healthcare District Bonds		0.038417
	TOTAL	**1.100188**

TAX AREAS: 060-000		
PROP 13 (1% Limit)		1.000000
Round Valley Bond (Determined by Inyo County)		0.026063
Bishop HS Bond (Determined by Inyo County)		0.009584
Southern Mono Healthcare District Bonds		0.038417
	TOTAL	**1.074064**

TAX AREAS: 060-001 THRU 060-006		
PROP 13 (1% Limit)		1.000000
Round Valley Bond (Determined by Inyo County)		0.026063
Bishop HS Bond (Determined by Inyo County)		0.009584
	TOTAL	**1.035647**

Unitary Tax Rate		
Unitary 1% Ad Valorem		1.000000
Unitary Debt Service Rate		0.614567
	TOTAL	**1.614567**

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

Departments: Public Works, Motor Pool

TIME REQUIRED

SUBJECT Notice of Intent to Transfer Surplus Vehicles to Special Districts

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Mono County has a variety of surplus vehicles that have been prepared for auction in October. However, in accordance with Government Code Section 25365, the Board may donate (or sell for less than market value) surplus vehicles to special districts or other public agencies within the County. Several such entities have requested surplus vehicles from the surplus list. Prior to approving that transfer under Section 25365, the Board must publish notice of its intention.

RECOMMENDED ACTION:

(1) Find that Motor Pool Units 0718 (2010 Ford Expedition V.I.N.1FMJU1G52AEB20852 / MILES 160,802), 0738 (2011 Ford Expedition V.I.N.1FMJU1G51BEF33749 / MILES 185,400), 0763 (2013 Ford Expedition V.I.N.1FMJUG59DEF27667 / MILES 176,161), and 0885 (2009 Ford F-350 Ambulance V.I.N.1FDWF37R9EA94193 / MILES 103,287) are in good condition but are excess and/or unneeded property.

(2) Direct staff to publish a notice of intention to transfer Unit 0718 to the White Mountain Fire Protection District (FPD), Unit 0738 to the June Lake FPD, Unit 0763 to the Lee Vining FPD, and Unit 0885 to the Inyo County Special Enforcement Detail (a regional unit that responds to high-risk incidents in both Inyo and Mono Counties) for $50.00 each.

FISCAL IMPACT:

Based on results from previous TNT auctions, the vehicles could yield approximately $6,000 each for the Expeditions, and approximately $3,500 for the ambulance, for an approximate total of $21,500 of unrealized revenue into the Motor Pool.

CONTACT NAME: Tony Dublino

PHONE/EMAIL: x5459 / tdublino@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

Click to download

Staff Report
Exhibit A

History

Time	Who	Approval
9/4/2019 7:34 PM	County Administrative Office	Yes
9/5/2019 8:47 AM	County Counsel	Yes
9/5/2019 1:23 PM	Finance	Yes

MONO COUNTY
DEPARTMENT OF PUBLIC WORKS

POST OFFICE BOX 457 • 74 NORTH SCHOOL STREET • BRIDGEPORT, CALIFORNIA 93517
760.932.5440 • Fax 760.932.5441 • monopw@mono.ca.gov • www.monocounty.ca.gov

Date: September 10, 2019

To: Honorable Chair and Members of the Board of Supervisors

From: Tony Dublino, Director of Public Works

Subject: Motor Pool - Transfer of Surplus Vehicles to Special Districts

Recommended Action:

(1) Find that Motor Pool Units 718 (2010 Ford Expedition V.I.N.1FMJU1G52AEB20852 / MILES 160,802), 738 (2011 Ford Expedition V.I.N.1FMJU1G51BEF33749 / MILES 185,400), 763 (2013 Ford Expedition V.I.N.1FMJUG59DEF27667 / MILES 176,161), 885 (2009 Ford F-350 Ambulance V.I.N.1FDWF37R9EA94193 / MILES 103,287) are in good condition but are excess and/or unneeded property.

(2) Direct staff to publish a notice of intention to transfer unit 0718 to the White Mountain Fire Protection District (FPD), unit 0738 to the June Lake FPD, unit 0763 to the Lee Vining FPD, and unit 0885 to the Inyo County Special Enforcement Detail (a regional unit that responds to high-risk incidents in both Inyo and Mono Counties), for $50.00 each.

Fiscal Impact:

The cost of publication for the notices is nominal. The transaction cost of $50 for each vehicle is intended to offset this cost as well as staff time to process the transfer.

Based on results from previous TNT auctions, the vehicles could yield approximately $6,000 each for the Expeditions, and approximately $3,500 for the ambulance, for an approximate total of $21,500 of unrealized revenue into the Motor Pool.

Discussion:

Mono County has several surplus vehicles as well as surplus inventory that has been prepared for auction in October. In accordance with Mono County Code section 3.4, the vehicle list and inventory list has been submitted to the County Administrative Officer for approval.

Offering surplus vehicles to local Special Districts is a longstanding practice in the County that requires additional process. The publication of the attached notice (Attachment A) will fulfill the requirements of Government Code 25365. Following the publication of the notice, the Board will be asked to formally approve the transfers.

If you have any questions regarding this item, please contact me at 932-5459.

Respectfully submitted,

Tony Dublino
Director of Public Works

NOTICE OF INTENTION TO CONVEY PERSONAL PROPERTY (SURPLUS VEHICLES) TO WHITE MOUNTAIN FIRE PROTECTION DISTRICT, JUNE LAKE FIRE DEPARTMENT, LEE VINING FIRE DEPARTMENT, AND THE INYO COUNTY SPECIAL ENFORCEMENT DETAIL

NOTICE IS HEREBY GIVEN that the Board of Supervisors of Mono County intends to convey to White Mountain Fire Protection District, June Lake Fire Department, Lee Vining Fire Department and the Inyo County Special Enforcement Detail the below described personal property:

1. 2010 Ford Expedition V.I.N.1FMJU1G52AEB20852 / MILES 160,802 to White Mountain Fire Protection District.
2. 2011 Ford Expedition V.I.N.1FMJU1G51BEF33749 / MILES 185,400 to the June Lake Fire Protection District.
3. 2013 Ford Expedition V.I.N.1FMJUG59DEF27667 / MILES 176,161 to the Lee Vining Fire Protection District.
4. 2009 Ford F-350 Ambulance V.I.N.1FDWF37R9EA94193 / MILES 103,287 to the Inyo County Special Enforcement Detail.

The terms and conditions of the proposed conveyance are as follows: $50 each.

The Board of Supervisors will meet to conclude the proposed transaction on October 1st, 2019, at 9:00 a.m., at the regular meeting in the Board Chambers of the Mono County Courthouse in Bridgeport, California.

Dated: September 10, 2019

By Order of the Board
of Supervisors of
Mono County

_____

Shannon Kendall
County Clerk
and Clerk of the Board of Supervisors
of Mono County

Authority: Government Code § 25365

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

Departments: Public Health

TIME REQUIRED

SUBJECT County Medical Services Program (CMSP) Wellness and Prevention Pilot Project Grant Agreement Amendment

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

FY 2017/20 CMSP County Wellness abd Prevention Pilot Project Funding Grant Agreement, First Amendment.

RECOMMENDED ACTION:

Approve County entry into the CMSP County Wellness and Prevention Pilot Project Funding Grant Agreement, First Amendment and authorize the Public Health Director's signature to execute said amendment on behalf of the County. Additionally, provide authorization for the Public Health Director to approve amendments and/or revisions that may occur during the amended contract period of March 1, 2017 - June 30, 2021 with approval as to form by County Counsel.

FISCAL IMPACT:

There is no fiscal impact to the County General Fund. The agreement amendment will shift budget timelines and does not change the grant allocation.

CONTACT NAME: Sandra Pearce

PHONE/EMAIL: 760.924.1818 / spearce@mono.ca.gov

SEND COPIES TO:

Sandra Pearce

Kim Bunn

MINUTE ORDER REQUESTED:

☑ YES ☐ NO

ATTACHMENTS:

Click to download
BOS Staff Report
First Amendment

Updated Timeline
Amended Budget
CMSP Grant Contract

History

Time	Who	Approval
9/4/2019 7:32 PM	County Administrative Office	Yes
8/28/2019 2:45 PM	County Counsel	Yes
8/30/2019 11:11 AM	Finance	Yes

MONO COUNTY HEALTH DEPARTMENT
Public Health

P.O. BOX 476, BRIDGEPORT, CA 93517 PHONE (760) 932-5580 • FAX (760) 932-5284
P.O. BOX 3329, MAMMOTH LAKES, CA 93546 PHONE (760) 924-1830 • FAX (760) 924-1831

DATE: September 10, 2019

TO: Honorable Board of Supervisors

FROM: Sandra Pearce, Public Health Director

SUBJECT: **FY 2017/20 CMSP County Wellness & Prevention Pilot Project Funding Grant Agreement, First Amendment**

Recommendation:

Approve County entry into the CMSP County Wellness & Prevention Pilot Project Funding Grant Agreement, First Amendment and authorize the Public Health Director's signature to execute said amendment on behalf of the County. Additionally, provide authorization for the Public Health Director to approve amendments and/or revisions that may occur during the amended contract period of March 1, 2017 - June 30, 2021 with approval as to form by County Counsel.

Discussion:

The Mono County Health Department currently contracts with the County Medical Services Program (CMSP) Governing Board for the County Wellness & Prevention Pilot Project. Community Service Solutions fulfils the following grant goals on behalf of Mono County:

- Educate the target population about available medical services, wellness supports, and public assistance programs.
- Enroll the target population in affordable health insurance, including CMSP.
- Provide indigent members of our target population with better access to nonemergency medical and wellness services through transportation assistance.

This amendment is to extend the grant term to June 30, 2021, to provide more time to complete project goals and utilize available funding.

Fiscal Impact:

There is no fiscal impact to the County General Fund.

The agreement amendment will shift budget timelines and does not change the grant allocation.

For questions about this item, please call Sandra Pearce at (760) 924-1818.

Submitted by:

Sandra Pearce, Public Health Director

FIRST AMENDMENT

COUNTY MEDICAL SERVICES PROGRAM GOVERNING BOARD COUNTY WELLNESS & PREVENTION PILOT PROJECT FUNDING GRANT AGREEMENT

This First Amendment ("Amendment") is by and between the County Medical Services Program Governing Board ("Board") and Mono County Public Health ("Grantee"), and amends the County Medical Services Program Governing Board County Wellness & Prevention Pilot Project Funding Grant Agreement dated effective March 1, 2017 ("Agreement"), by and between Board and Grantee.

Background

A. Board and Grantee previously entered into the Agreement with regard to the County Medical Services Program County Wellness & Prevention Pilot Project ("Pilot Project").

B. Board and Grantee desire to amend the Agreement to extend the term of the Agreement and other matters concerning the Project.

IT IS HEREBY AGREED AS FOLLOWS:

Agreements

1. Section 7 is amended to read as follows:

> 7. Progress and Final Reporting. Grantee shall notify the Board of any proposed substantial changes to the Project's components. The Project's components shall include: (a) the Project plan; (b) the target population; (c) the structure and process for providing services/support; (d) the roles and responsibilities of all participating (partnering) agencies; (e) services provided; (f) key Grantee personnel;(g) the budget; and (h) timelines. The Grantee shall submit seven (7) biannual progress reports to the Board, that: (a) highlights the Project's key accomplishments, to date; (b) identifies challenges and barriers encountered during the prior six (6) months; (c) describes what the Project has learned, to date, about the target population; and (d) provides an update on data collection and evaluation efforts. In addition, the Grantee shall submit a final report to the Board by March 31, 2021, that: (a) highlights the Project's key accomplishments; (b) identifies challenges and barriers encountered during the Project; (c) describes what the Project has learned about the target population; (d) reports the evaluation findings; and (e) thoroughly describes the Project's future activities following the Pilot Project. The Board may, within its sole discretion, terminate this Agreement at any time and suspend and/or discontinue payment of any Grant Funds if Grantee does not satisfactorily meet reporting requirements as set forth herein and in the RFP.

2. Section 8 of the Agreement is amended to read as follows:

8. Term. The term of this Agreement shall be from March 1, 2017, to June 30, 2021, unless otherwise extended in writing by mutual consent of the parties.

3. This Amendment is effective August 1, 2019.

4. Except as expressly amended herein, all other terms and conditions of the Agreement shall remain in full force and effect the same as if this Amendment had not been executed.

Dated effective August 1, 2019.

COUNTY MEDICAL SERVICES PROGRAM GOVERNING BOARD

By_____
Kari Brownstein
Administrative Officer

MONO COUNTY PUBLIC HEALTH

By_____
Name_____
Title_____

CMSP Wellness and Prevention Pilot Project
Updated Project Timeline
August 2019

Program Planning and Startup			
Activity	**Partners/Stakeholders**	**Timeline**	**Responsible Party**
CSS staff will host initial meetings with partners to outline goals and outreach strategy of the project.	Public Health; Social Services; Behavioral Health; Sheriff's Department; Office of Education; Mammoth Unified School District; Eastern Sierra Unified School District; Tribal TANF; Mammoth Hospital; Bridgeport Indian Health Clinic	**Completed in April and May 2017**	CSS Executive Director
CSS staff will contact all partners and stakeholders to: • establish an accurate database of available medical services, wellness supports, and public programs. • obtain informational literature from all partners and stakeholders to distribute during outreach and education events.	Public Health; Social Services; Behavioral Health; Sheriff's Department; Office of Education; Mammoth Unified School District; Eastern Sierra Unified School District; Tribal TANF; Mammoth Hospital; Bridgeport Indian Health Clinic	**Completed April-June 2017; and ongoing throughout the project.**	CSS Executive Director
CSS staff will develop a high-quality brochure and flyer in English and Spanish, explaining health insurance options for the target population, including CMSP.	Social Services	**Completed in May 2017**	CSS Executive Director CSS Outreach Staff

Outreach and Education Activities			
Activity	**Location**	**Timeline**	**Responsible Party**
CSS will host a minimum of four outreach events per month to: • Educate target population about available medical and wellness services, and public assistance programs. • Educate target population about available health insurance options, including CMSP and CMSP PCB. • Assist target population with completion of Covered California applications. • Make referrals for medical, wellness, and support services.	Food banks; WIC clinics; Tribal TANF; Wellness Centers; Public Health community clinics; Mammoth Hospital; Bridgeport Indian Health Clinic; Jail; Mammoth Mountain	**Monthly, May 2017-November 2020**	CSS Executive Director CSS Outreach Staff

CSS will provide outreach, education, and referrals at a minimum of four community events, such as Health Fairs, per year.	Throughout Mono County	**Annually, May 2017-November 2020**	CSS Executive Director CSS Outreach Staff
CSS will widely distribute new health insurance brochures and flyers in highly visible locations reaching target population.	Throughout Mono County	**Monthly, May 2017-November 2020**	CSS Executive Director CSS Outreach Staff
CSS will issue bus vouchers, as needed, to members of the target population needing transportation assistance for non-emergency medical and wellness appointments.	Throughout Mono County	**Ongoing, May 2017-November 2020**	CSS Executive Director CSS Outreach Staff
CSS will provide outreach, education, and referrals at a minimum of six school events, such as Open Houses, per year.	Mono County Schools	**Annually, May 2017-November 2020**	CSS Executive Director CSS Outreach Staff
CSS will distribute health insurance brochures and flyers to families of students in seven schools, reaching over 1,300 families.	Mono County Schools	**Semiannually, May 2017-November 2020**	CSS Executive Director CSS Outreach Staff
CSS will advertise low cost or no cost health insurance options, including CMSP, through a variety of media-based outlets, such as newspapers, community newsletters, and partners' social media sites.	Throughout Mono County	**Monthly, May 2017-November 2020**	CSS Executive Director CSS Outreach Staff
Evaluation and Reporting			
Activity	**Partners/Stakeholders**	**Timeline**	**Responsible Party**
CSS will meet with partners to examine program outcomes and adjust outreach strategy, as necessary.	Public Health; Social Services; Behavioral Health; Sheriff's Department; Office of Education; Mammoth Unified School District; Eastern Sierra Unified School District; Tribal TANF; Mammoth Hospital; Bridgeport Indian Health Clinic	**Semiannually, June 2017-November 2020**	CSS Executive Director

With the input of partners, CSS will create a survey to be completed and collected during outreach events, measuring the knowledge of the target population regarding available services and supports, as well as health insurance coverage and participation in public assistance programs.	Public Health; Social Services; Behavioral Health; Sheriff's Department; Office of Education; Mammoth Unified School District; Eastern Sierra Unified School District; Tribal TANF; Mammoth Hospital; Bridgeport Indian Health Clinic	**Developed in May 2017; Distribution in 2017 Q1 & Q2; 2018 Q1; 2019 Q1 & Q4; 2020 Q1 & Q3**	CSS Executive Director CSS Outreach Staff
CSS will collect data and report on the following indicators: • Percentage of insured residents • Percentage of residents seeking preventative care • Number of emergency room visits for non-emergency care • Percentage of eligible residents utilizing public assistance programs	Social Services; Public Health; Mammoth Hospital; Bridgeport Indian Health Clinic	**Annually, May 2017-December 2020**	CSS Executive Director CSS Outreach Staff
CSS will routinely report on the scope and effectiveness of outreach activities, to include: • challenges and successes of implementation • any modifications to activities or strategy • numbers of persons reached • number and types of outreach events • number and types of referrals • number of Covered California applications completed • number and types of media-based activities • number of bus vouchers issued	Public Health; Social Services; Behavioral Health; Sheriff's Department; Office of Education; Mammoth Unified School District; Eastern Sierra Unified School District; Tribal TANF; Mammoth Hospital; Bridgeport Indian Health Clinic	**Biannually, May 2017-December 2020**	CSS Executive Director CSS Outreach Staff

Amended Budget - Detail Budget

CMSP County Wellness & Prevention Pilot Project

Grantee: Community Service Solutions (Mono County)

Detail Budget – CY 2017 through CY 2020:

Category / Item/Service	Qnty (Year 1)	Cost (Year 1) Actual	Qnty (Year 2)	Cost (Year 2) Actual	Qnty (Year 3)	Cost (Year 3) Anticipated	Qnty (Year 4)	Cost (Year 4) Proposed	Total Cost
Personnel	$34,748.00	**$22,870.04**	$34,748.00	**$31,854.81**	$34,736.00	**$27,017.00**		**$24,270.00**	**$106,011.85**
Executive Director Salary & Benefits	$5,028.00	$4,297.46	$5,028.00	$4,655.54	$21,202.00	$16,395.00		$10,650.00	$35,998.00
Deputy Director Salary & Benefits	$13,760.00	$8,747.75	$13,760.00	$18,565.00					$27,312.75
Two Outreach Staff Salaries & Benefits	$13,460.00	$8,031.96	$13,460.00	$6,826.51	$10,534.00	$9,025.00		$11,020.00	$34,903.47
Evaluation Activities by CSS staff	$2,500.00	$1,792.87	$2,500.00	$1,807.76	$3,000.00	$1,597.00		$2,600.00	$7,797.63
									$0.00
Contractual Services		**$0.00**		**$0.00**		**$0.00**		**$0.00**	**$0.00**
									$0.00
									$0.00
									$0.00
									$0.00
Office Expenses	$2,740.00	**$1,435.73**	$2,740.00	**$2,157.98**	$2,340.00	**$1,627.00**		**$1,090.00**	**$6,310.71**
Rent	$990.00	$660.00	$990.00	$990.00	$990.00	$542.00		$320.00	$2,512.00
Utilities & Telephone	$720.00	$480.00	$720.00	$884.53	$900.00	$590.00		$320.00	$2,274.53
Office Supplies & Postage	$960.00	$227.98	$960.00	$176.07	$250.00	$320.00		$250.00	$974.05
Surveys	$70.00	$67.75	$70.00	$107.38	$200.00	$175.00		$200.00	$550.13
Travel	$4,212.00	**$2,295.86**	$4,212.00	**$4,888.70**	$5,324.00	**$4,824.00**		**$5,500.00**	**$17,508.56**
Mileage within Mono County to provide outreach	$4,212.00	$2,295.86	$4,212.00	$4,888.70	$5,324.00	$4,824.00		$5,500.00	$17,508.56
Mileage based upon Federal Mileage Rate									$0.00
									$0.00
									$0.00
Other	$2,400.00	**$185.58**	$2,400.00	**$287.34**	$1,700.00	**$1,288.48**		**$1,490.00**	**$3,251.40**
Newspaper Advertising	$1,500.00	$185.58	$1,500.00	$221.10	$1,500.00	$1,238.48		$1,440.00	$3,085.16
ESTA Bus Vouchers	$900.00	$0.00	$900.00	$66.24	$200.00	$50.00		$50.00	$166.24
									$0.00
									$0.00
Admin/Overhead (15% Maximum)	$4,900.00	**$3,240.00**	$4,900.00	**$3,966.48**	$4,900.00	**$3,476.00**		**$3,235.00**	**$13,917.48**
Maintenance, Insurance	$4,900.00	$3,240.00	$4,900.00	$3,966.48	$4,900.00	$3,476.00		$3,235.00	$13,917.48
Total Cost	$49,000.00	$30,027.21	$49,000.00	$43,155.31	$49,000.00	$38,232.48		$35,585.00	$147,000.00

This Detail Budget includes CMSP expenses only. In-Kind expenses are listed on the Summary Budget tab.

Totals are set to tally automatically. If a row is added, equations must be adjusted accordingly.

Year 1 Notes
Year 2 Notes
Year 3 Notes
Year 4 Notes

Amended Budget- Summary Budget

CMSP County Wellness & Prevention Pilot Project

Grantee: Community Service Solutions (Mono County)

Summary Budget – CY 2017 through CY 2020:

Category	Total Cost (Year 1)	CMSP Funding (Year 1)	In-Kind/Other Funding (Year 1)
Personnel	$22,870.04	$22,870.04	$0.00
Contractual Services	$0.00	$0.00	$0.00
Office Expenses	$1,660.73	$1,435.73	$225.00
Travel	$2,295.86	$2,295.86	$0.00
Other	$185.58	$185.58	$0.00
Admin/Overhead	$3,240.00	$3,240.00	$0.00
TOTAL YEAR 1	$30,252.21	$30,027.21	$225.00

CMSP totals are set to pull from the Detail Budget automatically.

Total Costs are set to sum CMSP and other funding automatically.

Category	Total Cost (Year 2)	CMSP Funding (Year 2)	In-Kind/Other Funding (Year 2)
Personnel	$31,854.81	$31,854.81	$0.00
Contractual Services	$0.00	$0.00	$0.00
Office Expenses	$2,313.98	$2,157.98	$156.00
Travel	$4,888.70	$4,888.70	$0.00
Other	$287.34	$287.34	$0.00
Admin/Overhead	$3,966.48	$3,966.48	$0.00
TOTAL YEAR 2	$43,311.31	$43,155.31	$156.00

Category	Total Cost (Year 3)	CMSP Funding (Year 3)	In-Kind/Other Funding (Year 3)
Personnel	$27,017.00	$27,017.00	$0.00
Contractual Services	$0.00	$0.00	$0.00
Office Expenses	$1,862.00	$1,627.00	$235.00
Travel	$4,824.00	$4,824.00	$0.00
Other	$1,288.48	$1,288.48	$0.00
Admin/Overhead	$3,476.00	$3,476.00	$0.00
TOTAL YEAR 3	$38,467.48	$38,232.48	$235.00

Category	Total Cost (Year 4)	CMSP Funding (Year 4)	In-Kind/Other Funding (Year 4)
Personnel	$24,270.00	$24,270.00	$0.00
Contractual Services	$0.00	$0.00	$0.00
Office Expenses	$1,325.00	$1,090.00	$235.00
Travel	$5,500.00	$5,500.00	$0.00
Other	$1,490.00	$1,490.00	$0.00
Admin/Overhead	$3,235.00	$3,235.00	$0.00
TOTAL YEAR 4	$35,820.00	$35,585.00	$235.00

Total Grant Award Amount	
Total CMSP Expenses	$147,000.00
Difference	-$147,000.00

AGREEMENT FOR

COUNTY MEDICAL SERVICES PROGRAM GOVERNING BOARD

COUNTY WELLNESS & PREVENTION PILOT PROJECT

between

COUNTY MEDICAL SERVICES PROGRAM GOVERNING BOARD ("Board")

and

MONO COUNTY PUBLIC HEALTH ("Grantee")

Effective as of:
March 1, 2017

AGREEMENT

COUNTY MEDICAL SERVICES PROGRAM
COUNTY WELLNESS & PREVENTION PILOT PROJECT

FUNDING GRANT

This agreement ("Agreement") is by and between the County Medical Services Program Governing Board ("Board") and the lead agency listed on Exhibit A ("Grantee").

A. The Board approved the funding of the County Wellness & Prevention Pilot Project (the "Pilot Project") in participating County Medical Services Program ("CMSP") counties in accordance with the terms of its Request for Proposals for the County Wellness & Prevention Pilot Project in the form attached as Exhibit B ("RFP").

B. Grantee submitted an Application ("Application") for the County Wellness & Prevention Pilot Project in the form attached as Exhibit C (the "Project"). The Project is a grant project ("Grant Project").

C. Subject to the availability of Board funds, the Board desires to award funds to the Grantee for performance of the Project.

The Board and Grantee agree as follows:

1. Project. Grantee shall perform the Project in accordance with the terms of the RFP and the Application. Should there be a conflict between the RFP and the Application, the RFP shall control unless otherwise specified in this Agreement.

2. Grant Funds.

A. Payment. Subject to the availability of Board funds, the Board shall pay Grantee the amounts in the time periods specified in Exhibit A ("Grant Funds") within thirty (30) calendar days of the Board's receipt of an invoice from Grantee for a Grant Project, as described in Exhibit A. Neither the Board nor CMSP shall be responsible for funding additional Project costs, future County Wellness & Prevention Pilot Projects or services provided outside the scope of the Pilot Project.

B. Refund. If Grantee does not spend the entire Grant Funds for performance of the Project within the term of this Agreement, then Grantee shall immediately refund to the Board any unused Grant Funds.

C. Possible Reduction in Amount. The Board may, within its sole discretion, reduce any Grant Funds that have not yet been paid by the Board to Grantee if Grantee does not demonstrate compliance with the use of Grant Funds as set forth in Section 2.D, below. The Board's determination of a reduction, if any, of Grant Funds shall be final.

D. Use of Grant Funds. As a condition of receiving the Grant Funds, Grantee shall use the Grant Funds solely for the purpose of performance of the Project, and shall not use

the Grant Funds to fund Grantee's administrative and/or overhead costs; provided, however, an amount of the Grant Funds equal to or less than fifteen percent (15%) of the total Project expenditures may be used to fund Grantee's administrative and/overhead expenses directly attributed to the Project. Grantee shall provide Board with reasonable proof that Grantee has dedicated the Grant Funds to the Project. Grantee shall refund to the Board any Grant Funds not fully dedicated to the Project. Grantee shall budget for evaluation expenses (such as time spent performing data collection, analyzing data, or preparing reports) in an amount not to exceed ten percent (10%) of total Pilot Project expenditures.

E. Annual Expenditure Reports. The Grantee shall provide the Board with annual expenditure reports documenting the use of Grant Funds in a form as determined by the Board.

F. Matching Funds. The Grantee is not required to provide in kind and/or matching funds but are strongly encouraged to provide such in kind and/or added funds from other sources to maximize the potential scope and reach of the Project. In kind and/or matching funds may be provided solely by the Grantee or through a combination of funding sources.

3. Grantee Data Sheet. Grantee shall complete and execute the Grantee Data Sheet attached as Exhibit D ("Grantee Data Sheet"). Board may, within its sole discretion, demand repayment of any Grant Funds from Grantee should any of the information contained on the Grantee Data Sheet not be true, correct or complete.

4. Board's Ownership of Personal Property. If Grantee's Application anticipates the purchase of personal property such as computer equipment or computer software with Grant Funds, then this personal property shall be purchased in Grantee's name and shall be dedicated exclusively to the Grantee's health care or administrative purposes. If the personal property will no longer be used exclusively for the Grantee's health care or administrative purposes, then Grantee shall, immediately upon the change of use, pay to the Board the fair market value of the personal property at the time of the change of use. After this payment, Grantee may either keep or dispose of the personal property. Grantee shall list all personal property to be purchased with Grant Funds on Exhibit A. This paragraph 4 shall survive the termination or expiration of this Agreement.

5. Authorization. Grantee represents and warrants that this Agreement has been duly authorized by Grantee's governing board, and the person executing this Agreement is duly authorized by Grantee's governing board to execute this Agreement on Grantee's behalf.

6. Data and Project Evaluation. Grantee shall collect Project data and conduct a Project evaluation. Grantee shall report data and evaluation findings to the Board as part of the Progress and Final Reporting set forth in Section 7, below. The Grantee shall not submit any protected health information ("PHI") to the Board. The Board reserves the right to hire an external pilot project evaluator to conduct an evaluation of the Project ("Pilot Project Evaluator"). The Grantee may be required to participate in one or more interviews with Pilot Project Evaluator, have a minimum of one (1) representative participate in quarterly web-based technical assistance meetings, and participate in surveys with the Pilot Project Evaluator as determined by the Board. Grantee shall maintain and provide the Board with reasonable access

to such records for a period of at least four (4) years from the date of expiration of this Agreement. Grantee shall cooperate fully with the Board, its agents and contractors, including but not limited to the Pilot Project Evaluator, and provide information to any such contractor in a timely manner. The Board may, within its sole discretion, terminate this Agreement at any time and suspend and/or discontinue payment of any Grant Funds if Grantee does not satisfactorily meet data collection and reporting requirements as set forth herein and in the RFP.

7. Progress and Final Reporting. Grantee shall notify the Board of any proposed substantial changes to the Project's components. The Project's components shall include: (a) the Project plan; (b) the target population; (c) the structure and process for providing services/support; (d) the roles and responsibilities of all participating (partnering) agencies; (e) services provided; (f) key Grantee personnel;(g) the budget; and (h) timelines. The Grantee shall submit five (5) biannual progress reports to the Board, that: (a) highlights the Project's key accomplishments, to date; (b) identifies challenges and barriers encountered during the prior six (6) months; (c) describes what the Project has learned, to date, about the target population; and (d) provides an update on data collection and evaluation efforts. In addition, the Grantee shall submit a final report to the Board by March 31, 2020, that: (a) highlights the Project's key accomplishments; (b) identifies challenges and barriers encountered during the Project; (c) describes what the Project has learned about the target population; (d) reports the evaluation findings; and (e) thoroughly describes the Project's future activities following the Pilot Project. The Board may, within its sole discretion, terminate this Agreement at any time and suspend and/or discontinue payment of any Grant Funds if Grantee does not satisfactorily meet reporting requirements as set forth herein and in the RFP.

8. Term. The term of this Agreement shall be from March 1, 2017, to June 30, 2020, unless otherwise extended in writing by mutual consent of the parties.

9. Termination. This Agreement may be terminated: (a) by mutual consent of the parties; (b) by either party upon thirty (30) days prior written notice of its intent to terminate; or, (c) by the Board immediately for Grantee's material failure to comply with the terms of this Agreement, including but not limited to the terms specified in paragraphs 6, 7 and 8. Upon termination or expiration of the term, Grantee shall immediately refund any unused Grant Funds to the Board, and shall provide the Board with copies of any records generated by Grantee in performance of the Project and pursuant to the terms of this Agreement.

10. Costs. If any legal action or arbitration or other proceeding is brought to enforce the terms of this Agreement or because of an alleged dispute, breach or default in connection with any provision of this Agreement, the successful or prevailing party shall be entitled to recover reasonable attorneys' fees and other costs incurred in that action, arbitration or proceeding in addition to any other relief to which it may be entitled.

11. Entire Agreement of the Parties. This Agreement constitutes the entire agreement between the parties pertaining to the subject matter contained herein and supersedes all prior and contemporaneous agreements, representations and understandings of the parties.

12. Waiver. To be effective, the waiver of any provision or the waiver of the breach of any provision of this Agreement must be set forth specifically in writing and signed by the

giving party. Any such waiver shall not operate or be deemed to be a waiver of any prior or future breach of such provision or of any other provision.

13. No Third-Party Beneficiaries. The obligations created by this Agreement shall be enforceable only by the parties hereto, and no provision of this Agreement is intended to, nor shall it be construed to, create any rights for the benefit of or be enforceable by any third party, including but not limited to any CMSP client.

14. Notices. Notices or other communications affecting the terms of this Agreement shall be in writing and shall be served personally or transmitted by first–class mail, postage prepaid. Notices shall be deemed received at the earlier of actual receipt or if mailed in accordance herewith, on the third (3rd) business day after mailing. Notice shall be directed to the parties at the addresses listed on Exhibit A, but each party may change its address by written notice given in accordance with this Section.

15. Amendment. All amendments must be agreed to in writing by Board and Grantee.

16. Assignment. This Agreement shall be binding upon and shall inure to the benefit of the parties to it and their respective successors and assigns. Notwithstanding the foregoing, Grantee may not assign any rights or delegate any duties hereunder without receiving the prior written consent of Board.

17. Governing Law. The validity, interpretation and performance of this Agreement shall be governed by and construed by the laws of the State of California.

18. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

Dated effective March 1, 2017.

BOARD:	GRANTEE:
COUNTY MEDICAL SERVICES PROGRAM GOVERNING BOARD	
By: _____	By: Lynda Salcido
Kari Brownstein, Administrative Officer	Title: Public Health Dir.
Date: 3/24/17	Date: 3-14-17

EXHIBIT A

GRANTEE: Mono County Public Health

GRANTEE'S PARTNERS UNDER CONTRACT1

_____
_____
_____

GRANT FUNDS:

Total Amount To Be Paid under Agreement: $147,000
Amount to Be Paid Upon Execution Of This Agreement: $50,000
Amount To Be Paid On January 1, 2018: $50,000
Amount To Be Paid On January 1, 2019: $37,500
Amount To Be Paid On Board's Determination and Acceptance of Grantee's Completion of its Obligations under the Terms of this Agreement: $9,500
If Funds will be Used to Purchase Personal Property, List Personal Property to be Purchased:

_____
_____
_____

NOTICES:

Board:
County Medical Services Program Governing Board
Attn: Alison Kellen, Program Manager
1545 River Park Drive, Suite 435
Sacramento, CA 95815
(916) 649-2631 Ext. 119
(916) 649-2606 (facsimile)

Grantee:
Mono County Public Health
Attn: Lynda Salcido, Director
PO Box 3329
Mammoth Lakes, CA 93546
(760) 924-1842
(760) 924-1831 (facsimile)

_____

1 Attach copy of any contract.

EXHIBIT B

REQUEST FOR PROPOSAL

BOARD'S REQUEST FOR PROPOSAL

REQUEST FOR PROPOSALS
County Wellness & Prevention Pilot Project

COUNTY MEDICAL SERVICES PROGRAM GOVERNING BOARD

I. ABOUT THE COUNTY MEDICAL SERVICES PROGRAM

The County Medical Services Program (CMSP) was established in January 1983, when California law transferred responsibility for providing health care services to indigent adults from the State of California to California counties. This law recognized that many smaller, rural counties were not in the position to assume this new responsibility. As a result, the law also provided counties with a population of 300,000 or fewer with the option of contracting back with the California Department of Health Services (DHS) to provide health care services to indigent adults. DHS utilized the administrative infrastructure of Medi-Cal's fee-for-service program to establish and administer the CMSP program.

In April 1995, California law was amended to establish the County Medical Services Program Governing Board (Governing Board). The CMSP Governing Board, composed of ten county officials and one ex-officio representative of the Secretary of the California Health and Human Services Agency, is authorized to set overall program and fiscal policy for CMSP. This law also authorized the Governing Board to contract with DHS or an alternative contractor to administer the program. Between April 1995 and September 2005, the Governing Board contracted with DHS to administer CMSP. Beginning October 1, 2005, Anthem Blue Cross Life & Health (Anthem) assumed administrative responsibility for CMSP medical, dental, and vision benefits. Advanced Medical Management (AMM) assumed this responsibility on April 1, 2015. MedImpact Healthcare Systems, Inc. (MedImpact) assumed administrative responsibility for CMSP pharmacy benefits beginning April 1, 2003 and continues to serve in this role.

Thirty-five counties throughout California now participate in CMSP: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo and Yuba.

CMSP is funded by State Program Realignment revenue received by the CMSP Governing Board and county general purpose revenue provided in the form of County Participation Fees. CMSP members are medically indigent adults, ages 21 through 64, who meet all of CMSP's eligibility criteria and are not otherwise eligible for Medi-Cal or Covered California. Enrollment in CMSP is handled by county social services departments located in the 35 participating counties. All CMSP members must be residents of a CMSP county and their incomes must be less than or equal to 300% of the Federal Poverty Level (based on net nonexempt income). Depending on individual circumstances, CMSP members may have a share-of-cost. Enrollment terms for CMSP

members are up to 6 months. At the end of the enrollment term, CMSP members must reapply for CMSP to continue eligibility for benefits.

For all CMSP members *except* undocumented members, the CMSP Standard Benefit provides coverage of medically necessary inpatient, outpatient, vision, dental, and prescription drug services based upon a defined benefit package that is determined by the Governing Board. For undocumented CMSP members, the CMSP Standard Benefit provides coverage for medically necessary emergency care services only, including prescription drug services.

Beginning May 1, 2016 and for a two-year pilot project period, all CMSP members with a monthly share-of-cost for their Standard Benefit and all undocumented CMSP members are provided an additional Primary Care Benefit that does not require a monthly share of cost payment. This added benefit provides coverage of the following health care services:

- Up to three (3) medical office visits with a primary care doctor, specialist or for physical therapy (any combination of visits);
- Preventive health screenings, including annual physical, specific lab tests and cancer screenings;
- Specific diagnostic tests and minor office procedures; and,
- Prescription drug coverage with a $5.00 copay for each prescription (maximum benefit limit of $1,500 in prescription costs).

II. ABOUT THE CMSP COUNTY WELLNESS & PREVENTION PILOT PROJECT

The CMSP Governing Board seeks to test the effectiveness of providing local-level wellness and prevention services to CMSP eligible and potentially eligible persons that address any of the following three project areas:

- *Community Wellness:* Community based, collaborative strategies to provide wellness and prevention services for uninsured populations, with a focus on potential CMSP enrollees.
- *Whole Person Care:* Integrated systems development strategies that link local health and human service delivery systems to better serve CMSP enrollees, potential CMSP enrollees, and other publicly funded populations.
- *Addressing the Social Determinants of Health:* Collaborative local efforts to work across five determinants – Economic Stability, Education, Social and Community Context, Health and Health Care, and Neighborhood and Built Environment – to establish policies and strategies that positively influence social and economic conditions and those that support changes in individual behavior for the uninsured, including potential CMSP enrollees.

The target populations for county Pilot Projects must include persons potentially eligible for CMSP or enrolled in CMSP. In addition, the target populations may also include persons potentially eligible for or enrollees of other public programs. The goals of the Pilot Project are to promote timely delivery of necessary medical and support services to the target populations, improve their health outcomes, and link the target populations to other wellness resources and support. County Pilot Projects shall identify and

describe all of its target populations based upon the project area or areas that the Pilot Projects will be giving focus.

III. PILOT PROJECT APPLICANTS

Lead Agency Applicant Requirements

County Pilot Projects may focus within one CMSP county or two or more counties that participate in CMSP. Additionally, they may focus on one geographic region of a county or operate countywide. The Lead Agency Applicant must be a CMSP county that is applying solely for the county or on behalf of a group of CMSP counties working jointly. Lead Agency Applicants may be a County Health and Human Services Agency, County Health Department, or County Public Health Department. The Lead Agency Applicant must describe the community support they have in carrying out the project and provide evidence of that support through Letters of Commitment and/or Support from community based providers or organizations, such as local hospitals, primary care providers, non-profit community service agencies, or the local Medi-Cal managed care plan. In addition, the Lead Agency Applicant must demonstrate their collaboration with other county agencies, as relevant and appropriate for their project focus, as demonstrated by Letters of Commitment and/or Support. Such other county agencies may include Social Services, Mental Health, Drug and Alcohol Services, and the Justice System (including Probation, Sheriff and Courts).

IV. PILOT PROJECT TIMELINE

The following timeline shall guide the County Wellness & Prevention Pilot Project:

7/8/16	Pilot Project Request for Proposals (RFP) Released
8/4/16	RFP Assistance Teleconference
8/8/16	Pilot Project Letters of Intent (LOI) Due
9/2/16	Pilot Project Applications Due
10/27/16	Pilot Project Applications Reviewed and Approved by Governing Board
10/31/16	Pilot Project Awards Announced Via Letter
1/1/17	Pilot Project Agreements Executed and Projects Begin Implementation
12/31/19	Pilot Projects End
3/31/20	Final Pilot Project Reports due from Counties to Governing Board

V. FUNDING AWARDS – ALLOCATION METHODOLOGY

The Governing Board, within its sole discretion, may provide funding to counties participating in CMSP for the County Wellness and Prevention Pilot Project activities described in this RFP. As approved by the Governing Board on May 26, 2016 the maximum amount of funding available to each participating CMSP County is presented in APPENDIX Table 1. The Governing Board, within its sole discretion, may release all or some of the amounts presented in Table 1 based on the overall quality of the Pilot Project proposal submitted by the county or group of counties acting jointly and the manner in it which it addresses the needs of the identified target populations. Total

funding provided by the Governing Board for the County Wellness & Prevention Pilot Project may equal up to $7.65 million over the three-year period.

Following the Governing Board's approval of a County's Wellness and Prevention Pilot Project Application, the County will receive a total 3-year allocation, one-third of which will be allocated each program year, with Year 2 and Year 3 funding allocated on the basis of County compliance with program requirements, including specified Pilot Project reporting on services and outcomes.

Applicants receiving funding under the Pilot Project shall not be required to provide in-kind and/or matching funds to receive the grant, but are strongly encouraged to provide such in-kind and/or added funding from other sources to maximize the potential reach and scope of their Pilot Projects. Administrative and/or overhead expenses shall equal no more than 15% of the total Pilot Project expenditures. No Pilot Projects funds shall be used for administrative and/or overhead costs not directly attributed to the project. In addition, Pilot Projects shall be required to budget for evaluation expenses (such as time spent performing data collection, analyzing data, or preparing reports) in an amount not to exceed10% of total Pilot Project expenditures.

VI. FUNDING AWARDS – METHODOLOGY FOR REVIEW AND SCORING

The Governing Board shall have sole discretion on whether to award funding for a Pilot Project. Pilot Project proposals shall be reviewed and scored to assure that the projects meet minimum standards for receipt of County Wellness and Prevention Pilot Project funding. County Wellness & Prevention Pilot Project Applications will be reviewed and scored based upon the following criteria:

1) Project Narrative (65% in total)
    - Statement of Need (5%)
    - Target Population (5%)
    - Proposed Project/ Approach (15%)
    - Capacity (15%)
    - Organization and Staffing (10%)
    - Project Implementation (15%)
2) Budget (10%)
3) Logic Model (10%)
4) Proposed Evaluation Method (10%)
5) Letters of Commitment/Support (5%)

In order for the Governing Board to consider approving funding for a CMSP county's Pilot Project, the county's proposal must achieve a minimum score of seventy-five percent (75%).

VII. APPLICATION ASSISTANCE

A. RFP Assistance Teleconference

To assist potential applicants, Governing Board staff will conduct an RFP assistance teleconference on August 4, 2016 at 10:00 a.m. *Call-in details (including phone number, pass code, etc.) will be provided at a later time.* Applicants are encouraged to "save the date" for this teleconference, participate on the teleconference, and bring any questions they have regarding Pilot Project requirements and the application process to this teleconference.

B. Frequently Asked Questions (FAQ)

Once the application process gets underway, questions that are received by the Governing Board will be given written answers and these questions and answers will be organized into a Frequently Asked Questions (FAQ) document that will be posted on the Governing Board's website under the Pilot Project tab.

C. Letter of Intent (LOI)

The Governing Board requests that all Pilot Project funding applicants intending to submit an application provide a brief Letter of Intent (LOI) to the Governing Board that is presented on the letterhead of the applicant organization. While the LOI is not required, receipt of an LOI from all likely applicants will assist the Governing Board in planning for application review and related processing. Please submit the LOI no later than August 8, 2016 by 5:00 p.m. PST. The LOI may be submitted by e-mail or fax to the addresses listed below:

Via E-Mail: wellness&preventionpp@cmspcounties.org
SUBJECT: Wellness & Prevention Pilot Project RFP

Via Fax: CMSP Governing Board
ATTN: Wellness & Prevention Pilot Project
916-649-2606

D. Pilot Project Contact Information

Please direct any questions regarding the RFP to: lkemper@cmspcounties.org

VIII. PILOT PROJECT PROPOSAL FORMAT AND REQUIREMENTS

A. Application Cover Sheet

Using the form provided, please include the county name or names (if counties are acting jointly), identified Lead County Applicant and Lead Applicant's contact name(s), address, telephone, and e-mail contact information. The application cover sheet

(Attachment A) is available for download at the Governing Board's website at http://www.cmspcounties.org/about/grant_projects.html.

B. Project Summary (no longer than 2 pages)

Describe the proposed project concisely, including its goals, objectives, overall approach, target population(s), key partnerships, anticipated outcomes, and deliverables.

C. Project Narrative (no longer than 10 pages)

1. Clear Statement of Problem or Need Within Community

All Pilot Projects should be based upon identified needs of the target population(s) within the community. Please describe the target population(s) to be served in your proposed project. Define the characteristics of the target population(s) and discuss how the proposed project will identify members of the target population(s). Provide an estimate of the total number of clients that will be served through each year of the Pilot Project. Include any background information relating to the proposed county or counties to be served, geographical location, unique features of the community, or other pertinent information that helps shape the target population's need within the community.

2. Local Health Care Delivery System Landscape

Describe how medical care is delivered within the proposed county or counties. Identify the main sources of care for the target population(s) as well as strengths and existing challenges in the health care delivery system. Describe the Lead Applicant role and the roles of other counties, if acting jointly, as well as all key planning project partners' roles within the health care delivery system.

3. Description of Proposed Project

Describe and discuss the proposed activities to be performed in the Pilot Project. All activities discussed should correspond with the items listed in the logic model (see Section VIII D below) and be incorporated into the Implementation Work Plan. *As a part of this description, identify how the proposed Pilot Project will educate the public about CMSP and the CMSP Primary Care Benefit and link potential CMSP applicants to the county social services department for CMSP application assistance and processing.*

4. Organization and Staffing

This section should describe and demonstrate the Applicant's organizational capability to implement, operate, and fully participate in the evaluation of the proposed project. In addition, information provided should clearly delineate the roles and responsibilities of the Lead Applicant County, other counties if acting jointly, and key partners and include the following:

- An organizational chart and description of organizational structure, lines of supervision, and management oversight for the proposed project, including oversight and evaluation of consultants and contractors;
- Identification of a project manager with day-to-day responsibility for key tasks such as leadership, monitoring ongoing progress, preparing project reports, and communicating with other partners; and,
- The roles, qualifications, expertise, and auspices of key personnel.

5. *Implementation Work Plan*

This section should include a Project Implementation Work Plan and timetable for completion of implementation activities.

D. Logic Model

All applicants are required to submit a logic model. A logic model is a series of statements linking target population conditions/circumstances with the service strategies that will be used to address the conditions/circumstances, and the anticipated outcomes. Logic models provide a framework through which both program and evaluation staff can view the relationship between conditions, services and outcomes. (A brief guide on designing logic models is found in Attachment C.) All logic models should include a description of the: 1) target population(s); 2) program theory; 3) activities; 4) outcomes, and 5) impacts.

E. Proposed Evaluation Methodology (no longer than 2 pages)

To inform the Governing Board of the Pilot Project's proposed strategy for providing evidence of the effectiveness of the Pilot Project, all applicants shall outline and describe the specific programmatic, clinical and/or financial metrics that will be used to evaluate the effectiveness of their proposed Pilot Project. As a part of this effort, applicants shall identify the data sources to be used and the frequency of data submission, and provide a brief written assessment of the relative availability and reliability of the data sources. Applicants shall also identify any barriers to data collection or the evaluation that could impede a determination of the effectiveness of the Pilot Project. Finally, applicants shall describe how the Pilot Project will comply with federal and state laws requiring confidentiality of protected health information. Please Note: Pilot Projects may additionally be subject to external evaluation by an evaluation contractor hired by the Governing Board, at the sole discretion of the Governing Board.

F. Budget and Budget Narrative (no longer than 2 pages)

Complete the Detail & Summary Budget Templates (See Attachments B1 and B2) and provide a brief budget narrative detailing all expense components that make up total operating expenses and the source(s) of in-kind and/or direct matching funding. These Budget Templates are available as an Excel spreadsheet for download at http://www.cmspcounties.org/about/grant_projects.html.

As part of the budget narrative, describe all administrative costs and efforts to minimize use of Pilot Projects funds for administrative and overhead expenses. Please note: No Pilot Projects funds shall be used for administrative and/or overhead costs not directly attributed to the project. In addition, administrative and/or overhead expenses shall equal no more than 15% of the total Pilot Project expenditures.

All Pilot Projects are required to budget for evaluation related activities in an amount up to 10% of total Pilot Project expenditures. Evaluation related activities shall include tasks such as data collection, data cleaning, and data analysis. Such funding is intended to support the evaluation component of the Pilot Project as set forth in Section VIII E above. Projects may additionally be required to work with an external project-wide evaluation contractor that is contracted with the CMSP Governing Board.

G. Letters of Commitment and/or Support

Letters of Commitment and/or Support from key partners should be included and will be utilized in scoring (5%). Letters should describe the key partner's understanding of the proposed Pilot Project and their organizations' role in supporting or providing services.

Lead Applicants (CMSP county alone or lead CMSP county acting on behalf of a group of counties working jointly) must provide evidence of support from community based providers or other service organizations in the county or counties, if acting jointly, through Letters of Commitment and/or Support. In addition, the Lead Applicants must demonstrate their collaboration with other county agencies, as relevant and appropriate for their Pilot Project focus. Such other county agencies may include Social Services, Mental Health, and Drug and Alcohol Services, and Justice System (including Probation, Sheriff, and Courts)

IX. APPLICATION INSTRUCTIONS

A. All Pilot Project applications must be complete at the time of submission and must follow the required format and use the forms and examples provided:

   1. The type font must be Arial, size 12 point.
   2. Text must appear on a single side of the page only.
   3. Assemble the application in the order and within the page number limits listed with the Proposal Format & Requirements sections.
   4. Clearly paginate each page.

B. Applications transmitted by facsimile (fax) or e-mail will not be accepted.

C. The application shall be signed by a person with the authority to legally obligate the Applicant.

D. Provide one original hard-copy Pilot Project application clearly marked original, and two (2) hard copies.

E. Provide an electronic copy (CD) of the following application documents: 1) Project Summary (Word document), 2) Project Narrative (Word document), and 3) Budget (Excel document), 4) Logic Model, and 5) Proposed Evaluation Methodology.

F. Do not provide any materials that are not requested, as reviewers will not consider the materials.

G. Folders and binders are not necessary or desired; please securely staple or clip the application in the upper left corner.

H. Applications must be received in the office no later than 5:00 p.m. PST on September 2, 2016. Submit all applications to:

CMSP Governing Board
ATT: Wellness & Prevention Pilot Project Applications
1545 River Park Drive, Suite 435
Sacramento, CA 95815

APPENDIX: Table 1 CMSP County Wellness and Prevention Pilot Project Maximum County Allocations			
Population Category	**County**	**County Population**	**3-Year Grant Amount**
> 400,000 population	Sonoma County	500,292	$375,000
	Solano County	431,131	$375,000
> 100,000 population	Marin County	260,750	$300,000
	Butte County	224,241	$300,000
	Yolo County	207,590	$300,000
	El Dorado County	183,087	$300,000
	Shasta County	179,804	$300,000
	Imperial County	179,091	$300,000
	Madera County	154,548	$300,000
	Kings County	150,269	$300,000
	Napa County	141,667	$300,000
	Humboldt County	134,809	$300,000
> 50,000 population	Nevada County	98,893	$225,000
	Sutter County	95,847	$225,000
	Mendocino County	87,869	$225,000
	Yuba County	73,966	$225,000
	Lake County	64,184	$225,000
	Tehama County	63,067	$225,000
	San Benito County	58,267	$225,000
	Tuolumne County	53,831	$225,000
< 50,000 population	Calaveras County	44,624	$150,000
	Siskiyou County	43,628	$150,000
	Amador County	36,742	$150,000
	Lassen County	31,749	$150,000
	Glenn County	27,955	$150,000
	Del Norte County	27,212	$150,000
	Colusa County	21,419	$150,000
	Plumas County	18,606	$150,000
	Inyo County	18,410	$150,000
	Mariposa County	17,682	$150,000
	Mono County	13,997	$150,000
	Trinity County	13,170	$150,000
	Modoc County	9,023	$150,000
< 5,000 population	Sierra County	3,003	$75,000
	Alpine County	1,116	$75,000
	TOTAL	3,671,539	$7,650,000

Attachment A

APPLICATION COVER SHEET
CMSP Wellness & Prevention Pilot Project

1. **CMSP County or Counties Included in the Pilot Project:**

2. **Funding:**
   CMSP Pilot Project Requested Amount: $_____
   In-Kind and/or Other Matching Amount Provided by Applicant (if any): $_____

3. **Applicant:**
   Organization:
   Applicant's Director or Chief Executive:
   Title:
   Applicant's Type of Entity (specific county department):
   Address:
   City: State: CA Zip Code: County:
   Telephone: ( ) Fax: ( )
   E-mail Address:

4. **Primary Contact Person** (*Serves as lead contact person during the application process.)*
   Name:
   Title:
   Organization:
   Address:
   City: State: CA Zip Code: County:
   Telephone: ( ) Fax: ( )
   E-mail Address:

5. **Secondary Contact Person** (*Services as alternate contact during the application process.)*
   Name:
   Title:
   Organization:
   Address:
   City: State: CA Zip Code: County:
   Telephone: ( ) Fax: ( )
   E-mail Address:

6. **Financial Officer** *(Serves as chief Fiscal representative for project.)*
Name:
Title:
Organization:
Address:
City: State: CA Zip Code: County:
Telephone: ( ) Fax: ( )
E-mail Address:

7. By submitting this application for Wellness & Prevention Pilot Project funding, the applicant signifies acceptance of the applicant's responsibility to comply with all requirements stated in this Request for Proposals (RFP) authorized by the County Medical Services Program Governing Board ("Governing Board"). Further, the applicant understands that should the Governing Board award pilot project funding to the applicant, the Governing Board is not obligated to fund the pilot project grant until the applicant submits correct and complete documents as required for the pilot project agreement; the Governing Board is otherwise satisfied that the applicant has fully met all Governing Board requirements for receipt of pilot project funding; and the pilot project agreement between the Governing Board and the applicant has been fully executed. The Governing Board shall have sole discretion on whether or not to award pilot project funding of any amount to the applicant.

I declare that I am an authorized representative of the applicant described herein. I further declare under penalty of perjury under the laws of the State of California that the information set forth in this Cover Sheet and the attached response to the Wellness & Prevention Pilot Project RFP is true and correct.

Official Authorized to Sign for Applicant:

Signature: Date:

Name:
Title:
Organization:
Address:
City: State: CA Zip Code: County:
Telephone: ( ) Fax: ( )
E-mail Address:

Attachment B1

County Wellness & Prevention Pilot Project Budget Guidelines

Applicants should use the budget detail and summary formats provided. Applicants may either use the actual tables or create a spreadsheet with the same categories and format. ***Pilot Projects*** should budget for anticipated expenditures in all three years of the pilot project.

Budget items should be placed into one of 5 categories. Five categories and a brief description of each category are listed below. Any expenses that are categorized within "Other" should be explained the budget summary.

Personnel
Gross salary and fringe benefits related to staff or funded project. Fringe benefits included employer FICA, unemployment and workers compensation taxes, medical insurance, vacation/sick leave and retirement benefits.

Contractual Services
Payments related to subcontractors and consultants who provide services to the project. Includes all expenses reimbursed including salaries, office expenses, travel.

Office Expenses
Directly attributable expenses for photocopies, postage, telephone charges, utilities, facilities, educational materials, general office supplies, computer equipment and software, and medical supplies.

Travel
Actual project-related travel expenses, including airfare, meals, hotels, mileage reimbursement, parking and taxis. If the organization has an established per diem policy, per diem may be charged to the grant in lieu of actual incurred expenses.

Other
Items that do not fall into any of the other categories listed above. Each item listed in other should be discussed in the brief budget summary.

No grant funding should be used for administrative and/or overhead costs not directly attributed to the project.

Budget Narrative
Provide a brief (no more than 2 pages) budget summary detailing all expense components that make up total operating expenses and the source(s) of in-kind and/or direct matching funding, if any. Describe all administrative costs and efforts to minimize use of pilot projects funds for administrative and overhead expenses.

Attachment B2: Budget Template - Summary Budget
CMSP County Wellness & Prevention Pilot Project

Applicant:

Summary Budget – CY 2017 through CY 2019:

Category	Total Cost (Year 1)	CMSP Funding (Year 1)	Other Funding (Year 1)
Personnel			
Contractual Services			
Office Expenses			
Travel			
Other			
TOTAL YEAR 1			

Category	Total Cost (Year 2)	CMSP Funding (Year 2)	Other Funding (Year 2)
Personnel			
Contractual Services			
Office Expenses			
Travel			
Other			
TOTAL YEAR 2			

Category	Total Cost (Year 3)	CMSP Funding (Year 3)	Other Funding (Year 3)
Personnel			
Contractual Services			
Office Expenses			
Travel			
Other			
TOTAL YEAR 3			

Attachment B2: Budget Template - Detail Budget
CMSP County Wellness & Prevention Pilot Project

Applicant:

Detail Budget – CY 2017 through CY 2019:

Category Item/Service	Qnty (Year 1)	Cost (Year 1)	Qnty (Year 2)	Cost (Year 2)	Qnty (Year 3)	Cost (Year 3)	**Total Cost**
Personnel							
Contractual Services							
Office Expenses							
Travel							
Other							

Guidelines for Logic Model

I. Purpose

Applicants for County Wellness & Prevention Pilot Project funding must submit a logic model. Designing a logic model will enable applicants to define their program, pinpoint their approach, identify resources and consider outcomes. The purpose of a logic model is to build a foundation for program development, ensure consensus among stakeholders and provide a framework for program evaluation. Each site is responsible for completing an evaluation of their project. A logic model provides a common "map" to be used by program staff and evaluators to design a useful evaluation. Designing an evaluation, before completing a logic model, may lead to collecting information on irrelevant outcomes. Conversely, programs may fail to collect information regarding individuals or services that may contribute to the success of a program. The creation of thoughtful logic model is the first step in designing an effective County Wellness & Prevention Pilot Project.

Applicants are encouraged to use the guidelines that follow, although other forms of logic models are acceptable.

II. Overview

The development of logic models is a useful tool for establishing dialogue between evaluation and system development efforts. Logic modeling is a method of articulating a program's theory or beliefs about how and why services are expected to produce particular results. In its simplest form, a logic model describes the clients that a system of care intends to serve, the services and supports that will be offered, and the short and long term outcomes that are expected to be achieved.

Kumpfer, et al. (1993) believe that logic models are useful tools for local stakeholders for several reasons. First, logic models can elicit consensus among staff and other system stakeholders regarding the service strategies and outcomes for a particular program. Second, they serve as a model to compare the intended program approach with what actually occurred. Third, they facilitate the articulation of specific beliefs about what services and strategies are related to the achievement of outcomes. Finally, logic models provide a framework for evaluation efforts through the linkage of action to results. Overall, logic models provide a framework through which both program and evaluation staff can view the linkages between conditions, services and outcomes.

The first step for stakeholders in developing a logic model is to clearly articulate their service delivery strategy. This means that stakeholders throughout a service system, including administrators, service providers, and inter-agency collaborators, should be able to describe the target population they intend to serve, the services they expect to provide along with the supporting collaborative infrastructures, and the results they expect to achieve (Usher, 1998; Hernandez,

Hodges, & Cascardi, 1998). When these basic questions are answered, stakeholders will be in a better position to complete their logic model.

Logic models depicting a program's approach can be compared to maps with guideposts that help keep program strategies on course (Alter & Murty, 1997). This approach takes into account the slippage or shifts that often occur in service delivery and uses the logic model as a stabilizer for a program or services during times of change. By knowing what changed in a program and when it changed, outcome information can be better interpreted and utilized. In this regard, the logic model becomes the ongoing documentation of changes in a program and enables stakeholders to track them.

Evaluators have the important role of eliciting the underlying service delivery theory by asking service personnel, managers, interagency stakeholders key questions about the target population served, the service approach employed and the goals that the service approach hopes to accomplish. If there is not agreement among program staff and stakeholders in their answers to these questions, then the evaluator helps the group reach consensus through further discussion. This process makes the results of evaluation more relevant to the service strategy under study, and hence more useful toward improving services.

III. Components of a Logic Model

It seems that there is a different vocabulary used for each type of logic model. Although logic models may vary slightly in their purpose (i.e., program logic model vs. evaluation logic model), most models include the same types of components described in slightly different ways. In general, a logic model can be broken down into five (5) basic components: 1) Target Population; 2) Program Theory; 3) Program Activities; 4) Outcomes; and, 5) Impact/Goals. A logic model template is shown in chart 1.

- ***Target Population***

Consider the target population carefully. Ethnicity, race, age, gender, geographic location, primary language spoken, housing status, and medical conditions contribute to the definition of the target population.

Program Theory
This component should discuss the "theory" or the basis of the program or intervention. The "program theory" refers to the underlying assumptions that guide program planning and service delivery. These assumptions are critical to producing change and improvement in the target population. For example, a program theory regarding disease case management for diabetics may state:

> "Case management services for CMSP diabetics should include local coordination of all health and social service providers to address needs in

a timely and efficient manner that conserves resources and eliminates duplication."

The program theory assumes that local coordination across service providers is important for serving an indigent population. Several theories may be combined to define an overall approach to serving the target population. For example, a program to serve children with severe emotional disturbances and their families had the following program theories:

- Family involvement in program design and implementation
- Incentive-oriented for providers
- Wide array of services to address needs in multiple areas
- Broad network of local providers
- Collaboration with multiple sectors
- Collaboration with existing local systems of care

It is important to note that these are theories and approaches, *not* activities. Activities are the actual services offered or the formation of a collaborative body with family members, or the linking of regional providers through a formal referral system. Program theories shape the creation of activities. The formation of program theories is one of the most difficult components of logic model development, however, clearly developed theories will ensure consensus among stakeholders.

- ***Activities***

Activities are the specific processes and/or events that comprise the program. Some examples of activities are:

- Mental health counseling
- Case management
- Community forums
- Creation of a new health service
- Dental referral mechanism

Activities are the interventions focused on the target population that are intended to impact individual health or community health outcomes. Activities are often measured by process outcomes. For example, 35 individuals received case management services for 6 months…..20 individuals received preventative dental care….. 10 injury prevention classes were held during 6 months….12 men and 23 women attended the diabetes self-management workshop.

- ***Outcomes***

Outcomes are the results of the activities provided by the program. Outcomes may be measured on an individual or group level. Outcomes provide a way to measure change in participants' lives and/or community conditions. Outcomes may be short-term, intermediate or long-term depending on how far in to the

future they are measured. For example, a diabetes case management program may not expect to see differences in kidney disease among diabetics for several years (long-term outcome), however, the program may see decreases in hospitalizations due to hypoglycemia during the first year of the program (short-term).

Identifying short-, intermediate- and long-term outcomes also will enable programs to define indicators. Indicators describe outcomes in specific and measurable terms. For example, a disease case management program may target fewer health complications due to diabetes as an outcome. Several indicators may include, a 10% reduction in hypoglycemic episodes among diabetics whom are case managed. Another example may be a substance abuse program that seeks to reduce drug use by 50% among participants. An indicator variable would be the number of clients who tested negative for drug use over a 6-month period. Defining outcomes and indicators will contribute to the development of useful program evaluations.

- ***Impacts***

Impacts are the long-term changes that the program expects to make. They provide direction and focus to the program and should be consistent with the larger mission and vision of the organization. Impacts are often closely influenced by many other factors in addition to the program such as economic conditions, and cultural values. Some examples of impacts are:

- Improved mental health among program participants
- Better health outcomes for the medically under served in the community

IV. Completing a Logic Model

Use the categories above to create a logic model for your Pilot Project. Begin with the overall impacts of the program and then jump to the target population and move forward. As you fill in the program theory, activities and outcomes for your model always go back to the target population and make sure the activities you plan are effecting the appropriate people. Use a flowchart, like the one provided in chart 1, to help visualize the flow of the program as you are constructing the different components.

The logic model should provide your program with a clear map that can be used as a reference for program design, implementation and evaluation.

References

Alter, C. & Murty, S. (Winter 1997). Logic Modeling: A Tool for Teaching Practice Evaluation. *Journal of Social Work Education, 33* (1), 103-117.

Hernandez, M., Hodges, S., & Cascardi, M. (1998). The Ecology of Outcomes: System Accountability in Children's Mental Health. *The Journal of Behavioral Health Services & Research, 25*(2), 136-150.

Kumpfer, K.L., Shur, G.H., Ross, J.G., Bunnell, K.K., Librett, J.J. & Millward, A.R. (1993). Measurements *in Prevention*. Rockville, MD: U.S. Dept. Of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention.

Usher, C. L. (1998). Managing Care Across Systems to Improve Outcomes for Families and Communities. *The Journal of Behavioral Health Services & Research, 25*(2), 217-229.

Source

Modified from original source. Originally prepared by Dennis Rose & Associates for the
County Medical Services Program's Wellness & Prevention Program (2001)

ATTACHMENT C

Chart 1: Logic Model Template

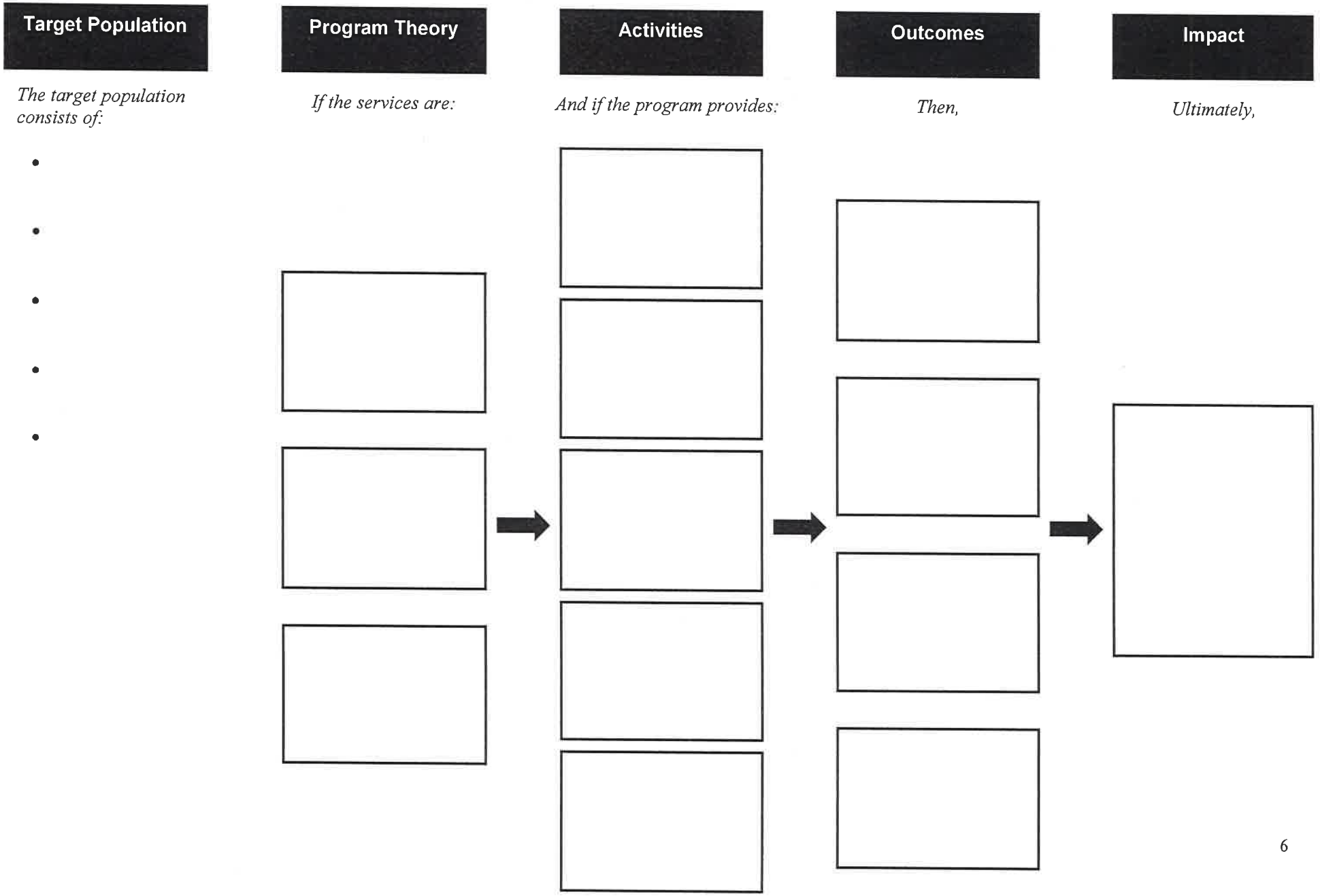

EXHIBIT C

APPLICATION

GRANTEE'S APPLICATION

Attachment A

APPLICATION COVER SHEET
CMSP Wellness & Prevention Pilot Project

1. **CMSP County or Counties Included in the Pilot Project:**
   Mono County

2. **Funding:**
   CMSP Pilot Project Requested Amount: $147,000.00
   In-Kind and/or Other Matching Amount Provided by Applicant (if any): $3,000.00

3. **Applicant:**
   Organization: Mono County Public Health
   Applicant's Director or Chief Executive: Lynda Salcido
   Title: Director
   Applicant's Type of Entity (specific county department): Health Department
   Address: P.O. Box 3329
   City: Mammoth Lakes State: CA Zip Code: 93546 County: Mono
   Telephone: (760) 9241830 Fax: (760) 9241831
   E-mail Address: lsalcido@mono.ca.gov

4. **Primary Contact Person** (*Serves as lead contact person during the application process.*)
   Name: Lynda Salcido
   Title: Public Health Director
   Organization: Mono County
   Address: PO 3329
   City: Mammoth Lakes State: ca Zip Code: 93546 County: Mono
   Telephone: (760) 9241842 Fax: ( )
   E-mail Address: lsalcido@mono.ca.gov

5. **Secondary Contact Person** (*Services as alternate contact during the application process.*)
   Name: Sandra Pearce
   Title: Public Health Nursing Director
   Organization: Mono County Public Health
   Address: PO 3329
   City: mammoth lakes State: CA Zip Code: 92456 County: Mono
   Telephone: (760) 9241818 Fax: ( )
   E-mail Address: spearce@mono.ca.gov

Attachment A

6. **Financial Officer** *(Serves as chief Fiscal representative for project.)*
Name: Kimberly Bunn
Title: Public Health Fiscal and Administrative Officer
Organization: Mono County Public Health
[illegible]
City: Bridgeport State: CA Zip Code: 93517 County: Mono
Telephone: (760) 9325587 Fax: ( )
E-mail Address: kbunn@mono.ca.gov

7. By submitting this application for Wellness & Prevention Pilot Project funding, the applicant signifies acceptance of the applicant's responsibility to comply with all requirements stated in this Request for Proposals (RFP) authorized by the County Medical Services Program Governing Board ("Governing Board"). Further, the applicant understands that should the Governing Board award pilot project funding to the applicant, the Governing Board is not obligated to fund the pilot project grant until the applicant submits correct and complete documents as required for the pilot project agreement, the Governing Board is otherwise satisfied that the applicant has fully met all Governing Board requirements for receipt of pilot project funding, and the pilot project agreement between the Governing Board and the applicant has been fully executed. The Governing Board shall have sole discretion on whether or not to award pilot project funding of any amount to the applicant.

I declare that I am an authorized representative of the applicant described herein. I further declare under penalty of perjury under the laws of the State of California that the information set forth in this Cover Sheet and the attached response to the Wellness & Prevention Pilot Project RFP is true and correct.

Official Authorized to Sign for Applicant:

Signature: [signature] Date: 12/15/2016

Name: Lynda Salcido
Title: Public Health Director
Organization: Mono County
Address: PO Box 3329
City: mammoth lakes State: CA Zip Code: 93546 County: Mono
Telephone: (760) 9241842 Fax: ( )
E-mail Address: lsalcido@mono.ca.gov

Project Summary

Community Service Solutions is pleased to submit this proposal for the CMSP County Wellness and Prevention Pilot Project on behalf of Mono County and Mono County Public Health Department. The goal of this project is to improve the health and wellness of our low-income residents, using a Community Wellness Approach. Our project focuses on three primary objectives:

1. Educate the target population about available medical services, wellness supports, and public assistance programs.
2. Enroll the target population in affordable health insurance, including CMSP.
3. Provide indigent members of our target population with better access to nonemergency medical and wellness services through transportation assistance.

Our overall approach for this project utilizes community-based strategies in reaching our target population. We will educate our target population by hosting monthly educational outreach events at locations such as food banks, wellness centers, and the county jail. We will collaborate with partners to provide education at partner-sponsored events, such as dinners sponsored for American Indians by the Tribal Temporary Assistance for Needy Families (Tribal TANF) Program. We will participate in community-wide and school events, such as Health and Safety fairs, sponsored by our partners, which provide excellent opportunities to reach the target population. Outreach events will also serve as opportunities to enroll our target population in affordable health insurance, including CMSP and Medi-Cal.

Our partners in the health care delivery system will collaborate on this project by promoting low cost and no cost health insurance options to uninsured patients. Our partners will distribute informational brochures that we will create, highlighting and explaining these health insurance options. They will also join us in community and school outreach events. We will directly assist members of our target population with enrollment in health insurance or refer them to Mono County Social Services if necessary.

We will employ media-based strategies to educate the target population about health insurance options. This will include Public Service Announcements in the local newspapers. We will reach Hispanic and undocumented members of our target population through the local Spanish newspaper. Also, our partners for this project have strongly encouraged the use of their social media sites to promote low cost health insurance options for our residents.

Our approach includes improving access to necessary medical services and wellness supports for our target population. Many of our indigent residents live in remote areas of the county and lack the ability to get to the hospital or health clinic. We will address this

by providing transportation assistance, through bus vouchers, for our indigent population to reach necessary medical and wellness appointments.

In keeping with our Community Wellness approach, our target population for this project includes all uninsured residents of Mono County, as well as those receiving or likely eligible for public assistance programs. This population includes those who are between ages of 21 and 64 and potentially eligible for CMSP; low-income individuals and families; homeless residents; American Indians; and the Hispanic community. Through our targeted outreach activities and collaboration with partners, we estimate reaching 3,000 members of our target population per pear.

Our partnerships are essential to the success of this project. Our partners in the healthcare delivery system include Mono County Public Health, Mammoth Hospital, and Bridgeport Indian Health Clinic. Our key community partners include:

- Mono County Social Services
- Mono County Behavioral Health
- Mono County Sheriff's Department
- Mono County schools
- Tribal TANF

As a result of our project, we anticipate improved health and wellness among our target population. We will be evaluating several outcomes as a measure of our progress and impact. By the conclusion of this three-year project, we anticipate:

- an increase in the percentage of insured residents;
- an increase in the percentage of residents utilizing public assistance programs;
- an increase in preventative care visits;
- a decrease in nonemergency Emergency room use; and
- a decrease in preventable hospital stays.

Project Narrative

1. Statement of Need within Mono County

The CMSP County Wellness and Prevention Pilot Project in Mono County will focus on uninsured residents, including those potentially eligible for CMSP health insurance. The target population for this Pilot Project will be expanded to include Mono County residents who are enrolled in, or potentially eligible for, other public assistance programs, including but not limited to, Medi-Cal, CalFresh, and In-Home Supportive Services (IHSS).

Mono County ranks as the fifth smallest county in California based upon population, with approximately 13,909 residents. The majority of the population (68%) is between the ages of 18 and 65 and is Caucasian (65.6%). The Hispanic population has increased in recent years and is currently estimated at nearly 28 percent. Three percent of residents are American Indian and mostly live on the Bridgeport Indian Reservation and the Benton Paiute Indian Reservation.[1]

As of 2016, an estimated 3,254 residents (23.4%) of Mono County are uninsured, higher than the State average of 19 percent.[2] Of the CMSP-eligible age group (21 – 64) in Mono County, 18.2 percent are uninsured. Low-income residents are more likely to be uninsured than those earning higher incomes: among those ages 21 to 64 earning less than 250 percent of the Federal Poverty Level, 29 percent are uninsured in Mono County.[3]

The most recent data indicates that approximately 3,044 residents of Mono County receive public assistance benefits through the CalFresh, Medi-Cal, and IHSS programs.[4] A significant young transient population, drawn to Mono County because of its offering of outdoor activities, applies for food stamps and other social assistance programs. The number of residents eligible for public assistance programs is potentially greater. For example, while only 790 residents were receiving food stamp benefits in the month of June 2015, the estimated number of residents eligible for food stamps was just over 4,000.[5] This large discrepancy can be attributed to lack of knowledge about available programs, misconceptions about eligibility, social stigma, and other reasons.

Members of the target population for the CMSP Wellness and Prevention Pilot Project will be identified primarily through various locations and programs offering public assistance in Mono County. This includes food banks; Social Services offices; Behavioral Health Wellness Centers; Women, Infants, and Children (WIC) sites; Tribal Temporary Assistance for Needy Families (Tribal TANF) program; and the IHSS program.

The Mono County Jail will be particularly useful in helping to identify homeless members of the target population. There are no homeless shelters in Mono County and several of

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[1] http://www.census.gov/quickfacts/table/AGE275210/06051

[2] https://wwwn.cdc.gov/CommunityHealth/profile/currentprofile/CA/Mono/310021

[3] http://www.census.gov/did/www/sahie/data/interactive/sahie.html

[4] Mono DSS Statistical Report Fiscal Year 2014-2015 (Aid Services).

[5] SNAP-Ed County Profiles 2015: Mono. https://www.cdph.ca.gov/programs/NEOPB/Documents/Mono.pdf

the county's homeless residents eventually enter the criminal justice system. CSS staff meets with inmates at the Mono County Jail two to three times per week and has provided services to several homeless inmates. While the homeless population is relatively small, our project will seek to identify these vulnerable residents and connect them with necessary medical and support services.

Additionally, the target population will be identified through schools where 50 percent or more of the students receive a free or reduced price lunch. Mono County has seven schools meeting this criteria, serving over 1,300 students.[6] Our project will target the families of these students, as they are likely eligible for other public assistance programs.

Hispanic members of our target population will be reached through public assistance programs, the county's schools, and Public Service Announcements (PSAs) in the local Spanish newspaper. We will also be consulting with the Mono County Behavioral Health Cultural Outreach Committee and the Mammoth Lakes Police Department Hispanic Advisory Committee. We have witnessed first-hand that many of our Hispanic residents, particularly those who are undocumented, are wary of public assistance programs. It is commonly feared that use of such programs will be detrimental to achieving legal immigration status. Our outreach to Hispanic residents will seek to reach across cultural barriers and correct misconceptions, so that they may receive necessary supports. Mono County's Spanish-speaking personnel will be available to translate as necessary.

Our goal is to provide outreach, education, and referrals to a minimum of 3,000 Mono County residents each year. This will be achieved through outreach events and distribution of literature at locations where residents receive public assistance, as well as other highly visible locations reaching our target population, including libraries, schools, and places of employment. The county's hospital and Rural Health Clinics will also be primary locations for our outreach and education efforts, as these locations frequently serve our target population. Hospital and clinic staff will have acute knowledge of the needs of much of our target population and will be an integral part of the project.

In order to better understand the challenges of our target population, it is essential to understand the environment in which they live. Mono County is a rural, frontier county located on the eastern edge of the Sierra Nevada Mountain Range. The county spans approximately 3,044 miles of high desert, mountainous terrain and averages a sparse 4.6 persons per square mile.[7] Mono County has one main thoroughfare, US Highway 395, which travels the length of the county and usually remains open, except during temporary closures due to snow storms in the winter, or wildfires in the summer. Mono County has three mountain passes which close approximately 6 months of the year, limiting travel options to outlying areas of the county, as well as to neighboring counties.

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[6] 16 http://www.cde.ca.gov/ds/sd/sd/filessp.asp

[7] http://www.census.gov/quickfacts/table/PST045215/06051

More than half (7,946) of Mono County's residents live in Mammoth Lakes, which is a popular tourist destination and the location of most of the county's services.[8] The rest of the county's residents live in small towns and ranching communities separated by many miles. These small towns are likely to have basic services, such as a general store, post office, school, and small restaurants and shops that close during the winter season.

2. Local Health Care Delivery System Landscape

Mono County is served by one full-scope hospital, Mammoth Hospital, located in Mammoth Lakes. Mammoth Hospital offers a full range of services: 24-hour emergency department; family medicine; women's health; pediatrics; behavioral health; physical therapy; general and orthopedic surgery; laboratory and medical imaging services; and family dental services, among others. Specialty services, such as cardiology, dermatology, and podiatry are offered part-time by visiting physicians.

Mammoth Hospital also operates a Rural Health Clinic in Bridgeport, staffed by a nurse practitioner most days of the workweek and one day per week by a physician. The Rural Health Clinic addresses the routine health needs of patients. There are no specialty services offered here.

In the northern part of Mono County, Toiyabe Indian Health Project operates the Bridgeport Indian Health Clinic, located in the town of Walker. The Bridgeport Indian Health Clinic serves all residents, offering a range of outpatient services, including, but not limited to: family medicine; pediatrics; geriatric medicine; orthopedics; behavioral health; routine diagnostic testing; family dentistry; and a pharmacy. Bridgeport Indian Clinic also offers minor outpatient surgery.

Mono County Public Health administers a variety of free and low cost programs and preventative services for Mono County residents. Programs include: California Children's Services; Child Health and Disability Prevention; Family Planning and Prenatal Guidance; STD and HIV/AIDS Programs; Tobacco Education; and WIC, among several others. Mono County Public Health has two offices, one in Mammoth Lakes and one in Bridgeport. They also offer a community clinic for blood pressure screening and immunizations, available once per week in Mammoth Lakes; twice per month in Walker; once per month in Bridgeport; and once per month in Benton.

Members of the target population also travel to nearby counties for medical treatment and services. South Lake Tahoe, in El Dorado County, is home to Barton Memorial Hospital, a 63-bed acute care hospital offering a full range of services. Residents of the northern part of Mono County have been known to use this hospital, as it is nearly the same distance away as Mammoth Hospital. Northern county residents have also been known to use the Carson Valley Medical Center (CVMC), in Gardnerville, Nevada, which is approximately a 30 minute drive. However, because it is located in Nevada, residents with Medi-Cal or CMSP cannot use the facility for routine care without paying out-of-

[8] http://www.census.gov/quickfacts/table/PST045215/0645358

pocket. American Indian residents living on the Benton Paiute Reservation frequently travel to Bishop, in Inyo County, to the main Toiyabe Indian Health Clinic, which is only a 30 minute drive from Benton.

Data from the 2016 Mammoth Hospital Community Health Needs Assessment (CHNA) indicates that a strength of the health care delivery system in Mono County is the ease with which residents can receive preventative and routine care. Approximately 82 percent of respondents to the Mammoth Clinic Patient Survey indicated that they would be able to receive preventative care and immunizations when necessary. Additionally, 72% of respondents indicated that they would be able to see a doctor when needed. [9]

Another strength of the health care delivery system is that insurance for the low-income population is accepted at all of the major health care locations in Mono County. Mammoth Hospital, the Bridgeport Indian Health Clinic, and Mono County Public Health accept Medi-Cal and CMSP health insurance plans.

However, one of the most notable challenges of the health care delivery system in Mono County is access to care for our rural residents. With most of the medical and support services located within the town of Mammoth Lakes, many rural low-income residents have difficulty with travel for necessary medical services, due to lack of transportation, or the expense of such transportation. The 2016 Mammoth Hospital CHNA highlighted the issue of access to care for rural residents, stating, "A lack of preventative care was mentioned as placing the rural residents at higher risk in addition to other factors such as transportation, distance, and availability of services and the length of time it takes to get to an appointment or reach emergency services."[10]

Another notable challenge to the health care delivery system is access to regular specialty services. The number one response of participants in the Mammoth Clinic Patient Survey when asked what could improve the health of the community was, "Make it easier for people to see a specialist."[11] Residents requiring regular specialty care are forced to travel great distances to Loma Linda Medical Center or Stanford Medical Center, for example. Residents requiring ongoing psychiatric care must do so through telemedicine. Residents in need of residential substance abuse treatment must seek care as far away as Southern California, Sacramento, or the San Francisco Bay region. The costs associated with a trip to see a specialist can be too great for many Mono County residents to bear, particularly for indigent and homeless residents, for whom it is nearly impossible.

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[9] 2016 Mammoth Hospital Community Health Needs Assessment, p.13. http://mammothhospital.org/wp-content/uploads/2015/11/Mammonth_CHNA_2016_Final-CHNA.pdf

[10] 2016 Mammoth Hospital Community Health Needs Assessment, p.18. http://mammothhospital.org/wp-content/uploads/2015/11/Mammonth_CHNA_2016_Final-CHNA.pdf

[11] 2016 Mammoth Hospital Community Health Needs Assessment, p.14. http://mammothhospital.org/wp-content/uploads/2015/11/Mammonth_CHNA_2016_Final-CHNA.pdf

Mammoth Hospital, Mono County Public Health, and Bridgeport Indian Health Clinic, three of our partners for the CMSP County Wellness and Prevention Pilot Project, are the primary sources of care for the target population. Our goals and activities are closely aligned with the strategies outlined in the 2016 Mammoth Hospital CHNA, in order to streamline efforts to improve the health outcomes of our target population.

3. Description of Proposed Project

The definitive goal of our CMSP County Wellness and Prevention Pilot Project in Mono County is to improve the health and wellness of our low-income residents, through improved access to medical, wellness, and support services. Our expected outcomes over the course of this three-year project include:

1. An increase in the percentage of insured residents;
2. An increase in the percentage of residents seeking preventative care;
3. A decrease in the number of emergency room visits for non-emergency care;
4. A decrease in the number of preventable hospital stays; and
5. An increase in the percentage of residents utilizing public assistance programs.

Our overall approach to this project was developed based on the Community Health Worker model, an evidence-based public health practice that is supported by the 2011 National Prevention Strategy.[12] The Centers for Disease Control (CDC) defines community health workers as "frontline public health workers who serve as a link between health and social services and the community."[13] The Federal Office of Rural Health Policy finds that the Community Health Worker model is particularly effective in rural communities, due to the intimate knowledge community health workers have of their community and its' residents.[14] In the Community Health Worker model, the community health worker acts as a liaison, helping to create connections between target populations, health care, and social support services; enrolling target populations in health insurance; and advocating for policies that improve the health and wellness of target populations.

Based on this information, we designed our Implementation Work Plan to focus on four primary activities. The first activity is educating the target population about the availability of medical services, public assistance programs, and wellness supports offered in Mono County. CSS staff will conduct outreach and education events at locations serving the target population, such as the county's American Indian reservations, food banks, WIC clinics, wellness centers, schools, jail, Tribal TANF offices, Mammoth Hospital, Public Health Department, and Rural Health Clinics. CSS staff will also provide outreach and education events at places of employment for many of the county's low-income residents, particularly Mammoth Mountain, which employs a large number of low-income seasonal workers. CSS staff will provide outreach at the Annual Community Health Fair, as well as at various community and school events offered in the county throughout the year.

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[12] https://www.surgeongeneral.gov/priorities/prevention/strategy/report.pdf

[13] http://www.cdc.gov/dhdsp/programs/spha/docs/chw_summary.pdf

[14] https://www.ruralhealthinfo.org/community-health/community-health-workers

The second activity is educating the target population about health insurance options, including CMSP and the new CMSP Primary Care Benefit (PCB); and assisting with the completion of required Covered California enrollment applications. CSS will be creating a high quality brochure, in English and Spanish, that will explain the available low cost, or no cost, health insurance options for the target population to include CMSP. CSS will place special emphasis on health insurance options for undocumented persons in its Spanish brochure. The cost associated with printing these brochures will be an in-kind donation by CSS. Education and outreach about health insurance options will be conducted at every outreach event. Members of the target population will receive direct assistance from CSS staff in completing Covered California health insurance applications. In addition, CSS will be implementing an aggressive media-based strategy to educate the target population about health insurance options, with emphasis on reaching the Hispanic population through the local Spanish newspaper as mentioned previously.

Our partners in the healthcare delivery system will be assisting with health insurance outreach. Mammoth Hospital, Bridgeport Indian Health Clinic, and Mono County Public Health will be provided with the health insurance literature that we have created for this project. Members of their staff will provide health insurance brochures to uninsured patients at the point of service. Members of their staff will also join us at community and school outreach events, such as the Annual Community Health Fair, Mammoth Lakes Health and Safety Fair, and Kindergarten Roundups.

The third activity of our project is to assist low-income residents with transportation to necessary medical and wellness appointments, including preventative care, by providing bus vouchers to locations offering necessary medical and wellness supports within Mono County. This includes Mammoth Hospital, the Rural Health Clinics, Public Health community clinics, Behavioral Health Wellness Centers, and other locations providing medical and wellness services. The Eastern Sierra Transit Authority (ESTA) operates the only public transportation system in Mono County. Residents who live in central Mammoth Lakes have access to the free Purple Line service offered by ESTA, which makes stops at Mammoth Hospital, the main Public Health clinic, and the main Behavioral Health Wellness Center. Rural residents must pay varying fees to use the bus service for medical and wellness appointments in Mammoth Lakes. Current bus fares between Mammoth Lakes and outlying towns in Mono County range from a minimum of $13 round trip (June Lake) to a maximum of $30 round trip (Coleville).

Access to local sources of medical and wellness services, such as Rural Health Clinics and community clinics, is more convenient and affordable for our rural residents. ESTA offers alternate services in the northern and eastern parts of Mono County. Residents who live in the Topaz/Coleville/Walker areas can use ESTA's Dial-A-Ride service to take them to the Bridgeport Indian Health Clinic, Walker Wellness Center, and Public Health community clinic for approximately six dollars round trip. Residents of Benton who are seeking care at the Toiyabe Indian Health Clinic in Bishop can use ESTA's community bus service for approximately 12 dollars round trip.

To help provide indigent residents with access to medical and wellness services, CSS will acquire bus vouchers from ESTA for various routes, with funds from the CMSP County Wellness and Prevention Pilot Project. Indigent members of the target population who lack transportation will be able to request a bus voucher from CSS for a non-emergency medical or wellness appointment. To eliminate misuse of funds, CSS would require proof of the appointment, such as an appointment card, before issuing bus vouchers.

The final activity of our project is to collaborate with community partners and stakeholders on a regular basis to examine program outcomes, adjust strategies, and communicate ideas in order to maintain the most effective approach to the project. CSS staff will meet with partners and stakeholders semiannually to examine the progress of the project. It will be pertinent to identify which outreach methods are working well and which outreach methods may need modification. Regular meetings will also allow CSS staff and partners to ensure that the referral process is working smoothly and make any necessary adjustments to internal procedures. Collaboration is also key in ensuring that the target population is reached effectively with the most accurate and up-to-date information. Regular communication with partners and stakeholders, outside of formal meetings, will be integral throughout the course of this project.

The Logic Model served as the primary tool for designing program activities; therefore, all activities in the Implementation Work Plan directly correspond with the Logic Model. This project will directly educate the target population about CMSP and the new CMSP PCB through place-based and media-based outreach, as detailed in the Implementation Work Plan. The target population will receive direct assistance with Covered California applications from CSS staff; those we are unable to assist directly will receive a referral to Mono County Social Services for application assistance.

4. Organization and Staffing

Carolyn Williams, Executive Director of Community Service Solutions (CSS), began her career in the public sector in 1997 as an Administrative Analyst for Yuba County, while earning her Master's Degree in Public Administration. While there, she wrote a $900,000 grant for two family resource centers; a foster care program with counseling for foster children and education for foster parents; a grant which allowed senior citizens to remain in their homes; a therapy and treatment program for the homeless population; and a fluoride program for public school students.

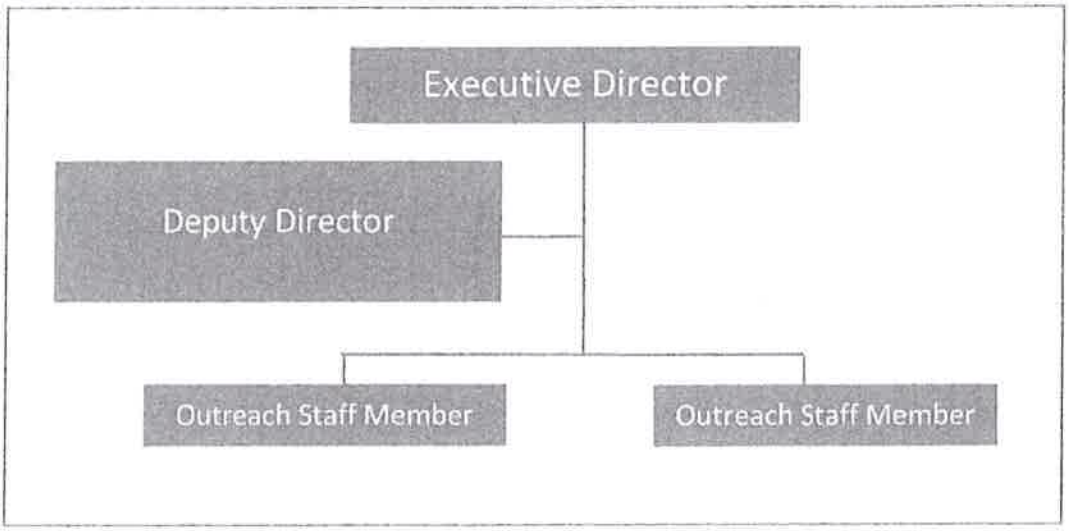
In 2002, Carolyn and two partners co-founded the nonprofit organization, CSS. Over the course of its fourteen year history, CSS has established IHSS Registries in three different California counties; written annual Child Welfare County System Improvement Plans (SIP) and overall County Self Assessments CSA) for two counties; completely restructured a county Child Welfare Department; written a county-wide evacuation plan; created an onsite school beauty salon for at-risk high school students, and wrote a grant to provide professional therapy for those same at-risk students.

Notably, CSS was the administrator of the CMSP Medi-Cal Outreach and Enrollment Pilot Project in Mono County from 2014 through 2016. Activities included outreach and Medi-Cal enrollment at the county's food banks, schools, health fairs, jail, libraries, and community college, among other locations. Over the course of the two-year project, CSS successfully reached nearly 2,500 residents with valuable information about Medi-Cal.

CSS currently administers several programs in Mono and Alpine Counties. Since 2002, CSS has been administering the IHSS Provider Registry in Mono County, as well as performing IHSS Quality Assurance and Program Integrity activities; and overseeing the IHSS Advisory Committee. CSS recently began administering the Reentry Coordinator Program for the Mono County Sheriff's Department, assisting inmates with a variety of supports designed to help them succeed upon release, such as enrollment in health insurance; setting up court-ordered drug/alcohol counseling programs; and assistance finding affordable housing.

CSS has administered the Supplemental Nutrition Assistance Program-Education (SNAP-Ed) Program in Mono County since 2013 and in Alpine County since 2016. Activities include nutrition education and physical activity interventions to low-income residents at food banks, qualifying schools, CalFresh offices, Public Health Departments, American Indian reservations, and Tribal TANF offices, among others. Activities also include collaboration to improve school wellness policies, improve healthy retail options, and promote community health through county programs.

Carolyn, as Executive Director, will oversee the entirety of the CMSP County Wellness and Prevention Pilot Project. Amanda Hoover, Deputy Director, will be the Project Manager, overseeing day to day implementation of the project, evaluating project process and progress, preparing necessary reports, and communicating with partners. Amanda will be supported by two staff members, who will be assisting with outreach activities, reporting, and data collection. Please see the following Organizational Chart:



5. Implementation Work Plan

Program Planning and Startup			
Activity	**Partners/Stakeholders**	**Timeline**	**Responsible Party**
CSS staff will host initial meetings with partners to outline goals and outreach strategy of the project.	Public Health; Social Services; Behavioral Health; Sheriff's Department; Office of Education; Mammoth Unified School District; Eastern Sierra Unified School District; Tribal TANF; Mammoth Hospital; Bridgeport Indian Health Clinic	To be completed in January 2017	CSS Executive Director CSS Deputy Director
CSS staff will contact all partners and stakeholders to: • establish an accurate database of available medical services, wellness supports, and public programs. • obtain informational literature from all partners and stakeholders to distribute during outreach and education events.	Public Health; Social Services; Behavioral Health; Sheriff's Department; Office of Education; Mammoth Unified School District; Eastern Sierra Unified School District; Tribal TANF; Mammoth Hospital; Bridgeport Indian Health Clinic	To be completed in January 2017, and ongoing, as necessary	CSS Deputy Director
CSS staff will develop a high-quality brochure and flyer in English and Spanish, explaining health insurance options for the target population, including CMSP.	Social Services	To be completed in January 2017	CSS Deputy Director CSS Outreach Staff

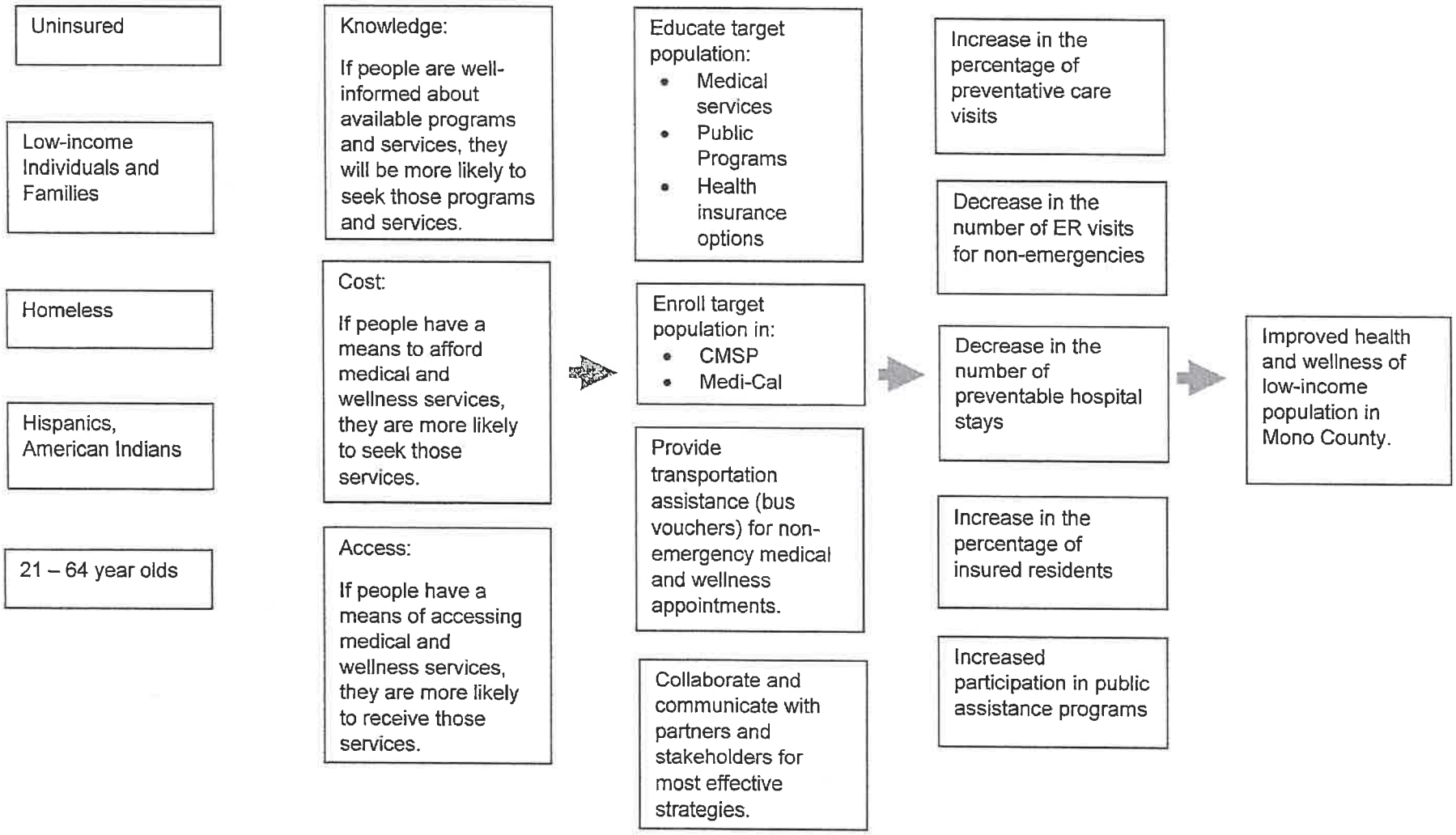
Outreach and Education Activities			
Activity	**Location**	**Timeline**	**Responsible Party**
CSS will host a minimum of four outreach events per month to: • Educate target population about available medical and wellness services, and public assistance programs. • Educate target population about available health insurance options, including CMSP and CMSP PCB. • Assist target population with completion of Covered California applications. • Make referrals for medical, wellness, and support services.	Food banks; WIC clinics; Tribal TANF; Wellness Centers; Public Health community clinics; Mammoth Hospital; Bridgeport Indian Health Clinic; Jail; Mammoth Mountain	Monthly, beginning in January 2017-December 2019	CSS Deputy Director CSS Outreach Staff
CSS will provide outreach, education, and referrals at a minimum of four community events, such as Health Fairs, per year.	Throughout Mono County	Annually, beginning in January 2017-December 2019	CSS Deputy Director CSS Outreach Staff
CSS will widely distribute new health insurance brochures and flyers in highly visible locations reaching target population.	Throughout Mono County	Monthly, beginning in January 2017-December 2019	CSS Deputy Director CSS Outreach Staff
CSS will issue bus vouchers, as needed, to members of the target population needing transportation assistance for non-emergency medical and wellness appointments.	Throughout Mono County	Ongoing, beginning in January 2017-December 2019	CSS Deputy Director CSS Outreach Staff

CSS will provide outreach, education, and referrals at a minimum of six school events, such as Open Houses, per year.	Mono County Schools	Annually, beginning in January 2017-December 2019	CSS Deputy Director CSS Outreach Staff
CSS will distribute health insurance brochures and flyers to families of students in seven schools, reaching over 1,300 families.	Mono County Schools	Semiannually, beginning in January 2017-December 2019	CSS Deputy Director CSS Outreach Staff
CSS will advertise low cost or no cost health insurance options, including CMSP, through a variety of media-based outlets, such as newspapers, community newsletters, and partners' social media sites.	Throughout Mono County	Monthly, beginning in January 2017-December 2019	CSS Deputy Director CSS Outreach Staff

Evaluation and Reporting

Activity	Partners/Stakeholders	Timeline	Responsible Party
CSS will meet with partners to examine program outcomes and adjust outreach strategy, as necessary.	Public Health; Social Services; Behavioral Health; Sheriff's Department; Office of Education; Mammoth Unified School District; Eastern Sierra Unified School District; Tribal TANF; Mammoth Hospital; Bridgeport Indian Health Clinic	Semiannually, Beginning in June 2017-December 2019	CSS Executive Director CSS Deputy Director
With the input of partners, CSS will create a survey to be completed and collected during outreach events, measuring the knowledge of the target population in regards to available services and supports, as well as health insurance coverage and participation in public assistance programs.	Public Health; Social Services; Behavioral Health; Sheriff's Department; Office of Education; Mammoth Unified School District; Eastern Sierra Unified School District; Tribal TANF; Mammoth Hospital; Bridgeport Indian Health Clinic	Development in January 2017; Then distribution in 2017 Q1; 2018 Q1; 2019 Q1 & Q4	CSS Executive Director CSS Deputy Director CSS Outreach Staff
CSS will collect data and report on the following indicators: • Percentage of insured residents • Percentage of residents seeking preventative care • Number of emergency room visits for non-emergency care • Percentage of eligible residents utilizing public assistance programs	Social Services; Public Health; Mammoth Hospital; Bridgeport Indian Health Clinic	Annually, beginning in January 2017-December 2019	CSS Executive Director CSS Deputy Director CSS Outreach Staff
CSS will routinely report on the scope and effectiveness of outreach activities, to include: • challenges and successes of implementation • any modifications to activities or strategy • numbers of persons reached • number and types of outreach events • number and types of referrals • number of Covered California applications completed • number and types of media-based activities • number of bus vouchers issued	Public Health; Social Services; Behavioral Health; Sheriff's Department; Office of Education; Mammoth Unified School District; Eastern Sierra Unified School District; Tribal TANF; Mammoth Hospital; Bridgeport Indian Health Clinic	Quarterly, beginning in January 2017-December 2019	CSS Executive Director CSS Deputy Director CSS Outreach Staff

Logic Model


Uninsured
Low-income Individuals and Families
Homeless
Hispanics, American Indians
21 – 64 year olds
Knowledge:
If people are well-informed about available programs and services, they will be more likely to seek those programs and services.
Cost:
If people have a means to afford medical and wellness services, they are more likely to seek those services.
Access:
If people have a means of accessing medical and wellness services, they are more likely to receive those services.
Educate target population:
• Medical services
• Public Programs
• Health insurance options
Enroll target population in:
• CMSP
• Medi-Cal
Provide transportation assistance (bus vouchers) for non-emergency medical and wellness appointments.
Collaborate and communicate with partners and stakeholders for most effective strategies.
Increase in the percentage of preventative care visits
Decrease in the number of ER visits for non-emergencies
Decrease in the number of preventable hospital stays
Increase in the percentage of insured residents
Increased participation in public assistance programs
Improved health and wellness of low-income population in Mono County.

E. Proposed Evaluation Methodology

As part of our CMSP County Wellness and Prevention Pilot Project, we will be evaluating program processes and outcomes to determine the effectiveness of our project. We will be evaluating program processes on a quarterly basis, particularly examining reach and effectiveness of strategies. With input from partners and stakeholders, we will be assessing the following programmatic measures:

- Are we reaching our target population?
- Are the locations of outreach most effective in reaching our target population?
- What activities have been most successful and why?
- What barriers have we experienced in reaching our target population?
- How can we overcome any barriers to reaching our target population?
- Have any new issues been identified through outreach events?
- Have we identified any new strategies, resources, or partners that would be valuable in serving the target population?

We will be using aggregated clinical data, acquired from our partners in the healthcare delivery system, and surveys to measure the outcomes and impact of our project on an annual basis. Using surveys distributed to the target population, we will be assessing the target population's knowledge of available medical and preventative services; public assistance programs; and health insurance options. Surveying will occur during the first quarters of 2017, 2018, and 2019, as well as the fourth quarter of 2019. Survey results will be included in quarterly reports. We will be using aggregated clinical data and statistical data to measure the following specific outcomes:

- Percentage of those with health insurance coverage
- Percentage of those utilizing public assistance programs
- Percentage of those seeking preventative care
- Number of non-emergency Emergency Room visits
- Number of preventable hospital stays

Statistical data pertaining to health insurance coverage will be obtained through the U.S. Census Bureau. Statistical data pertaining to utilization of public assistance programs will be collected from Mono County Social Services. To maintain compliance with HIPAA privacy laws protecting confidential health information, only aggregated clinical data pertaining to medical care will be requested from Mammoth Hospital, Mono County Public Health, and the Bridgeport Indian Health Clinic. Aggregated clinical data will also be utilized from national public health databases.

Statistical and aggregated clinical data will be collected on an annual basis, as available, and included as part of our quarterly reports. Statistical and aggregated clinical data will be considered the most reliable forms of data to measure impact of the project. Surveys will be anonymous and will not contain any personally identifiable information. If the survey sample size is determined to be very small by CSS and its' partners, the survey results will not be reported. Very small sample size not only raises privacy and confidentiality concerns, it also limits the usefulness and accuracy of the data.

F. Budget and Budget Narrative

CSS is requesting $49,000 per year to implement the CMSP County Wellness and Prevention Pilot Project in Mono County. The single greatest expense in implementing the project will be personnel costs. The Executive Director of CSS will oversee the entirety of the project and will only require .10 FTE. The Deputy Director of CSS will serve as the Project Manager (.25 FTE), directing and providing outreach and education activities, as well as evaluation and reporting activities. The Executive Director and Deputy Director are both full-time staff members. Two part-time staff members will assist with outreach, education, evaluation, and reporting activities; one staff member will be working half-time on the project (.5 FTE) and the other staff member will be quarter-time (.25 FTE). Total staff time required to implement the project is estimated at 34 hours per week. Translation services from our partners will be considered in-kind support.

Office expenses for this project will be less than six percent of the overall budget. Office expenses include office rent, utilities, and telephone costs of $1,710 per year. Postage and office supplies, such as paper, printer ink, and notepads are estimated at $960 per year. The cost to print 2,000 high-quality, color brochures and flyers for distribution, as described in the Project Narrative, is estimated at $1,000 per year and will be considered in-kind support from CSS.

The cost of travel is a significant expense in implementing the project. As described in the Project Narrative, Mono County is a large county, with isolated towns separated by many miles. Travel from the CSS office in Walker to Mammoth Lakes is approximately 168 miles round trip. Travel to Benton is over 200 miles round trip in good weather and over 250 miles round trip in winter months, due to closed roads. In order to implement monthly outreach and education activities, CSS staff will travel an estimated 150 miles per week, or 650 miles per month. The budget for travel was calculated at 54 cents per mile, the current Federal Mileage Reimbursement Rate. Total travel expenses per year are estimated at $4,212.

Other costs include the expense of media-based outreach in the local English and Spanish newspapers. As discussed in the Project Narrative, CSS will employ an aggressive media campaign, with monthly Public Service Announcements in a variety of newspapers reaching the target population. CSS has found this to be a particularly useful strategy in past projects, especially in reaching the Hispanic population. Other costs also included bus vouchers, for which CSS made a conservative estimate of $900 per year. The outcomes of the first year of the project will determine if this budget item requires modification in Years 2 or 3.

Indirect and overhead costs were kept to a minimum, at only $4,900 per year. This represents ten percent of the entire annual budget for this project. Mono County Public Health factored in only those indirect and overhead costs which can be directly attributed to the oversight of this project.

Total evaluation costs for the project are approximately five percent. This includes staff time to distribute, collect, and analyze surveys; and collect and analyze statistical and clinical data. Total personnel costs directly attributed to evaluation activities is estimated at only $2,500 per year. In addition, CSS factored in $70 per year for the cost of having surveys printed. This line item is listed separately under Office Expenses.

Attachment B2: Budget Template - Detail Budget
CMSP County Wellness & Prevention Pilot Project

Applicant: Community Service Solutions (Mono County)

Detail Budget – CY 2017 through CY 2019:

Category Item/Service	Qnty (Year 1)	Cost (Year 1)	Qnty (Year 2)	Cost (Year 2)	Qnty (Year 3)	Cost (Year 3)	**Total Cost**
Personnel	34,748	34,748	34,748	34,748	34,748	34,748	104,244
Executive Director Salary & Benefits	5,028	5,028	5,028	5,028	5,028	5,028	15,084
Deputy Director Salary & Benefits	13,760	13,760	13,760	13,760	13,760	13,760	41,280
Two Outreach Staff Salaries & Benefits	13,460	13,460	13,460	13,460	13,460	13,460	40,380
Evaluation activities by CSS staff	2,500	2,500	2,500	2,500	2,500	2,500	7,500
Contractual Services	0	0	0	0	0	0	0
n/a	0	0	0	0	0	0	0
Office Expenses	2,740	2,740	2,740	2,740	2,740	2,740	8,220
Rent	990	990	990	990	990	990	2,970
Utilities & Telephone	720	720	720	720	720	720	2,160
Office Supplies and Postage	960	960	960	960	960	960	2,880
Surveys	70	70	70	70	70	70	210
Travel	4,212	4,212	4,212	4,212	4,212	4,212	12,636
avg. 150 miles per week @.54	4,212	4,212	4,212	4,212	4,212	4,212	12,636
Other	7,300	7,300	7,300	7,300	7,300	7,300	21,900
Newspaper Advertising	1,500	1,500	1,500	1,500	1,500	1,500	4,500
ESTA bus vouchers	900	900	900	900	900	900	2,700
Maintenance, Insurance	4,900	4,900	4,900	4,900	4,900	4,900	14,700
	49,000	49,000	49,000	49,000	49,000	49,000	147,000

Attachment B2: Budget Template - Summary Budget
CMSP County Wellness & Prevention Pilot Project

Applicant: Community Service Solutions (Mono County)

Summary Budget – CY 2017 through CY 2019:

Category	Total Cost (Year 1)	CMSP Funding (Year 1)	Other Funding (Year 1)
Personnel	34,748	34,748	0
Contractual Services	0	0	0
Office Expenses	3,740	2,740	1,000
Travel	4,212	4,212	0
Other	7,300	7,300	0
TOTAL YEAR 1	50,000	49,000	1,000

Category	Total Cost (Year 2)	CMSP Funding (Year 2)	Other Funding (Year 2)
Personnel	34,748	34,748	0
Contractual Services	0	0	0
Office Expenses	3,740	2,740	1,000
Travel	4,212	4,212	0
Other	7,300	7,300	0
TOTAL YEAR 2	50,000	49,000	1,000

Category	Total Cost (Year 3)	CMSP Funding (Year 3)	Other Funding (Year 3)
Personnel	34,748	34,748	0
Contractual Services	0	0	0
Office Expenses	3,740	2,740	1,000
Travel	4,212	4,212	0
Other	7,300	7,300	0
TOTAL YEAR 3	50,000	49,000	1,000

MAMMOTH HOSPITAL
Elevate Your Health

2015 Press Ganey Pinnacle of Excellence Award Winner

November 29, 2016

CMSP Governing Board
1545 River Park Drive, Suite 435
Sacramento, CA 95815

Dear Members of the CMSP Governing Board:

I would like to express our support of Community Service Solutions as the lead agency for the CMSP Wellness and Prevention Pilot Project in Mono County. Since 2002, Community Service Solutions has been successfully implementing various programs for Mono County Social Services, Mono County Public Health, and the Mono County Sheriff's Department. Southern Mono Healthcare District will gladly support outreach, education, and wellness efforts as Community Service Solutions implements the CMSP Wellness and Prevention Pilot Project.

Sincerely,

Gary Myers
Chief Executive Officer

Office of the ... DEPARTMENT OF SOCIAL SERVICES

COUNTY OF MONO

P. O. Box 2969 • Mammoth Lakes • California 93546

KATHRYN PETERSON, MPH
Director

BRIDGEPORT OFFICE
(760) 932-5600
FAX (760) 932-5287

MAMMOTH LAKES OFFICE
(760) 924-1770
FAX (760) 924-5431

November 28, 2016

CMSP Governing Board
1545 River Park Drive, Suite 435
Sacramento, CA 95815

RE: Community Service Solutions

Dear Members of the CMSP Governing Board,

I would like to express my full support of Community Service Solutions as the lead agency for the CMSP Wellness and Prevention Pilot Project in Mono County. Since 2002, our department has had the pleasure of contracting with Community Service Solutions for various programs. Our department will gladly support outreach, education, and coordination of care efforts as Community Service Solutions implements the CMSP Wellness and Prevention Pilot Project.

Carolyn Williams, Executive Director of Community Service Solutions, has several decades of experience successfully working in the public sector in various California counties. Her expertise and professionalism continue to be an asset to her nonprofit organization, as well as to Mono County. We look forward to working with Community Service Solutions on this new endeavor.

Sincerely,

Kathryn Peterson, Director
Mono County Department of Social Services

MONO COUNTY SHERIFF 911

P.O. BOX 616 • 49 BRYANT STREET • BRIDGEPORT, CA 93517 • (760) 932-7549 • WWW.MONOSHERIFF.ORG

Ingrid Braun
Sheriff/Coroner

MONO COUNTY SHERIFF'S OFFICE

Michael Moriarty
Undersheriff

November 28, 2016

CMSP Governing Board
1545 River Park Drive, Suite 435
Sacramento, CA 95815

Dear Members of the CMSP Governing Board,

On behalf of the Mono County Sheriff's Office, I would like to express my full support of Community Service Solutions as the lead agency for the CMSP Wellness and Prevention Pilot Project in Mono County. Our office has had the pleasure of contracting with Community Service Solutions this year for the Reentry Coordination Program at the Mono County Jail.

Our office will gladly support Community Service Solutions as they implement the CMSP Wellness and Prevention Pilot Project, through education and coordination of care efforts among our inmate population. The professionalism and work ethic of Community Service Solutions' staff will ensure their success in this new endeavor.

Sincerely,

Ingrid Braun
Sheriff-Coroner

Eastern Sierra Unified School District

P.O. Box 575 – 231 Kingsley Street
Bridgeport, CA 93517
Telephone (760) 932-7443 – Fax (760) 932-7140

Don Clark, Ed.D.
Superintendent

CMSP Governing Board
1545 River Park Drive, Suite 435
Sacramento, CA 95815

Dear Members of the CMSP Governing Board,

On behalf of the Eastern Sierra Unified School District, I would like to express my support of Community Service Solutions as the lead agency for the CMSP Wellness and Prevention Pilot Project in Mono County. Community Service Solutions has been working in our schools since 2013, teaching nutrition education to our students through their Supplemental Nutrition Assistance Program-Education (SNAP-Ed) grant.

We will gladly support Community Service Solutions as they seek to improve the health and wellness of Mono County's vulnerable residents, through outreach and education efforts to the families of our students.

Sincerely,

Dr. Don Clark, Superintendent
Eastern Sierra Unified School District

EXHIBIT D

COUNTY MEDICAL SERVICES PROGRAM GOVERNING BOARD
GRANTEE DATA SHEET

Grantee's Full Name:	Mono County Public Health
Grantee's Address:	PO Box 3329 Mammoth Lakes, CA 93546
Grantee's Executive Director/CEO: (Name and Title)	Lynda Salcido, Director
Grantee's Phone Number:	(760) 924-1842
Grantee's Fax Number:	(760) 924-1831
Grantee's Email Address:	lsalcido@mono.ca.gov
Grantee's Type of Entity: (List Nonprofit or Public)	Public
Grantee's Tax Id# [EIN]:	95-6005661

I declare that I am an authorized representative of the Grantee described in this Form. I further declare under penalty of perjury under the laws of the State of California that the information set forth in this Form is true and correct.

GRANTEE:

By: Lynda Salcido
Title: Public Health Director
Date: 3-14-17

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

Departments: Health Department

TIME REQUIRED

SUBJECT Local Oral Health Program Grant Amendment #17-10707, A01

PERSONS APPEARING BEFORE THE BOARD Shelby Stockdale

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Proposed contract with California Department of Public Health's Office of Oral Health pertaining to Local Oral Health Program Grant Amendment #17-10707, A01.

RECOMMENDED ACTION:

Approve the Local Oral Health Program Grant Amendment #17-10707, A01 and authorize the Public Health Director to sign on behalf of the County. Additionally, provide authorization for the Public Health Director to sign future amendments to the grant that shift funds between budget categories without changes to the grant allocation. Provide any desired direction to staff.

FISCAL IMPACT:

There is zero impact to the Mono County General Fund. This program is funded with Proposition 56 funds totaling $705, 275 over the 5-year grant period.

CONTACT NAME: Shelby Stockdale

PHONE/EMAIL: 760-924-1841 / sstockdale@mono.ca.gov

SEND COPIES TO:

Shelby Stockdale

Sandra Pearce

Kim Bunn

MINUTE ORDER REQUESTED:

☑ YES ☐ NO

ATTACHMENTS:

Click to download
LOHP Grant Amendment #17-10707, A01 Staff Report

- Grant Amendment Agreement #17-10707, A01
- Exhibit B - Budget Detail and Payment Provisions
- Document D - Scope of Work

History

Time	Who	Approval
9/4/2019 7:34 PM	County Administrative Office	Yes
8/28/2019 12:18 PM	County Counsel	Yes
9/4/2019 3:47 PM	Finance	Yes

MONO COUNTY HEALTH DEPARTMENT
Public Health

P.O. BOX 476, BRIDGEPORT, CA 93517 PHONE (760) 932-5580 • FAX (760) 924-1831
P.O. BOX 3329, MAMMOTH LAKES, CA 93546 PHONE (760) 924-1830 • FAX (760) 924-1831

DATE: August 21, 2019
TO: Honorable Board of Supervisors
FROM: Shelby Stockdale, Health Program Manager/PHN

SUBJECT: Local Oral Health Grant Amendment #17-10707, A01

RECOMMENDED ACTION: Approve the Local Oral Health Program Grant Amendment #17-10707, A01 and authorize the Public Health Director to sign on behalf of the County. Additionally, provide authorization for the Public Health Director to sign future amendments to the grant that shift funds between budget categories without changes to the grant allocation. Provide any desired direction to staff.

DISCUSSION: On December 19, 2017, the Board approved County entry into the Local Oral Health Program Grant Agreement #17-10707 and the grant contract has been fully executed. The California Department of Public Health's Office of Oral Health is requesting that the CDPH-1229A – Grant Agreement Amendment Form be signed to amend the contract, contact personnel, budget and scope of work. This amendment is for technical purposes that allow flexibility to move funds from one budget year to the next without changing the grant allocation and amends the scope of work based on Mono County Oral Health priorities and needs.

The goal of the Local Oral Health Program is to create and expand capacity at the local level to educate, prevent and provide linkages to treatment programs, including dental disease caused by the use of cigarettes and other tobacco products. Mono County Health Department has and will continue to establish its Local Oral Health Program by including the following program activities related to oral health: education, disease prevention, linkages to treatment, case management and surveillance. These activities will improve the oral health of Mono County residents. This goal will be achieved by undertaking activities that support demonstrated oral health needs and prioritize underserved areas and populations. This contract authorizes the Mono County Health Department to receive funding to fulfill the program goals and requirements.

FISCAL IMPACT: There is zero impact to the Mono County General Fund. This program is funded with Proposition 56 funds totaling $705, 275 over the 5-year grant period.

If there are any questions regarding this item, please contact Shelby Stockdale at 760.924.1841.

Submitted by: Shelby Stockdale, Health Program Manager/PHN

Reviewed by: Sandra Pearce, Public Health Director

CALIFORNIA ORAL HEALTH PROGRAM

Local Oral Health Plan

Awarded By

THE CALIFORNIA DEPARTMENT OF PUBLIC HEALTH, hereinafter "Department"

TO

County of Mono ~~County Public Health Department~~, hereinafter "Grantee"

Implementing the project, Mono County Local Oral Health Program," hereinafter "Project"

AMENDED GRANT AGREEMENT NUMBER 17-10707, A01

The Department amends this Grant and the Grantee accepts and agrees to use the Grant funds as follows:

AUTHORITY: The Department has authority to grant funds for the Project under Health and Safety Code, Section 104750 and 131085(a).

PURPOSE FOR AMENDMENT: This amendment is: 1) To revise Exhibit B, 4, A. Amounts Payable, to include a lump sum total and Exhibit B is hereby replaced in its entirety with Exhibit B, A01; 2) To replace the Document D (Scope of Work and Deliverables) FY 2017-2022 in its entirety; and 3) To change the name of the grantee from " Mono County Public Health Department" to "County of Mono" to align and standardize grantee's name with the new FI$Cal accounting system.

Amendments are shown as: Text additions are displayed in **bold and underline**. Text deletions are displayed as strike through text (i.e., ~~Strike~~).

Exhibit A Document D – Scope of Work and Deliverables is hereby replaced in its entirety.

Exhibit B BUDGET DETAIL AND PAYMENT PROVISIONS is hereby replaced with Exhibit B, A01 in its entirety.

PROJECT REPRESENTATIVES. The Project Representatives during the term of this Grant will be:

California Department of Public Health	Grantee: **County of Mono ~~County Public Health Department~~**
Name: ~~Angela Wright~~ **Kimberly Steele**, Grant Manager	Name: ~~Sandra Pearce, Public Health Director~~ **Shelby Stockdale, Health Program Manager**
Address: MS 7218, 1616 Capitol Avenue, Suite 74.420	Address: 437 Old Mammoth Road, Suite Q
City, ZIP: Sacramento, CA 95814	City, Zip: Mammoth Lakes, CA 93546
Phone: (916) ~~552-9898~~ **445-8012**	Phone: 760-924-~~1818~~ **1841**
Fax: (916) ~~552-9729~~ **636-6678**	Fax: 760-924-1831
E-mail: ~~Angela.Wright~~**Kimberly.Steele**@cdph.ca.gov	E-mail: ~~spearce@mono.ca.gov~~ **sstockdale@mono.ca.gov**

Direct all inquiries to:

California Department of Public Health, Oral Health Program	Grantee: **County of Mono ~~County Public Health Department~~**
Attention: ~~Angela, Wright~~ **Kimberly Steele**	Name: ~~Sandra Pearce, Public Health Director~~ **Shelby Stockdale, Health Program Manager**
Address: MS 7218, 1616 Capitol Avenue, Suite 74.420	Address: 437 Old Mammoth Road, Suite Q
City, Zip: Sacramento, CA 95814	City, Zip: Mammoth Lakes, CA 93546
Phone: (916) ~~552-9898~~ **445-8012**	Phone: 760-924-~~1818~~ **1841**
Fax: (916) ~~552-9729~~ **636-6678**	Fax: 760-924-1831
E-mail: ~~Angela.Wright~~**Kimberly.Steele**@cdph.ca.gov	E-mail: ~~spearce@mono.ca.gov~~ **sstockdale@mono.ca.gov**

All payments from CDPH to the Grantee; shall be sent to the following address:

Grantee: County of Mono
Attention: "Cashier"
Address: P.O. Box 476
City, Zip: Bridgeport, CA 93517
Phone: (760) 924-1841
Fax: Not Applicable
E-mail: sstockdale@mono.ca.gov

Either party may make changes to the information above by giving a written notice to the other party. Said changes shall not require an amendment to the agreement, but the Grantee will be required to submit a completed CDPH 9083 Governmental Entity Taxpayer ID Form or STD 204 Payee Data Record Form which can be requested through the CDPH Project Representatives for processing.

All other terms and conditions of this Grant shall remain the same.

IN WITNESS THEREOF, the parties have executed this Grant on the dates set forth below.

Executed By:

Date: _____

~~Stacy Corless, Chairperson~~
~~Mono County Board of Supervisors~~
~~P.O. Box 715~~
~~Bridgeport, CA 93517~~
Sandra Pearce, Public Health Director
Mono County Public Health Department
437 Old Mammoth Road, Suite Q
Mammoth Lakes, CA 93546

Date:

~~Marshay Gregory~~ **Joseph Torrez**, Chief
Contract Management Unit
California Department of Public Health
1616 Capitol Avenue, Suite 74.317
P.O. Box 997377, MS 1800- 1804
Sacramento, CA 95899-7377

Exhibit B
Budget Detail and Payment Provisions

1. Invoicing and Payment

A. Upon completion of project activies as provided in Exhibit A Grant Application, and upon receipt and approval of the invoices, the State agrees to reimburse the Grantee for activities performed and expenditures incurred in accordance with the costs specified herein.

B. Invoices shall include the Grant Number and shall be submitted not more frequently than monthly in arrears to:

~~Angela Wright~~ **Kimberly Steele**
California Department of Public Health
Office of Oral Health ~~Program~~
MS ~~7208~~ **7218**
1616 Capitol Avenue, Suite 74.420
P.O. Box 997377, Sacramento, CA 95899-7377

C. Invoices shall:

1) Be prepared on Grantee letterhead. If invoices are not on produced letterhead invoices must be signed by an authorized official, employee or agent certifying that the expenditures claimed represent activities performed and are in accordance with Exhibit A Grant Application under this Grant.
2) Bear the Grantee's name as shown on the Grant.
3) Identify the billing and/or performance period covered by the invoice.
4) Itemize costs for the billing period in the same or greater level of detail as indicated in this Grant. Subject to the terms of this Grant, reimbursement may only be sought for those costs and/or cost categories expressly identified as allowable and approved by CDPH.

2. Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, the State shall have no liability to pay any funds whatsoever to Grantee or to furnish any other considerations under this Agreement and Grantee shall not be obligated to fulfill any provisions of this Agreement.

B. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to either cancel this Agreement with no liability occurring to the State, or offer an agreement amendment to Grantee to reflect the reduced amount.

3. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Government Code Chapter 4.5, commencing with Section 927.

Exhibit B
Budget Detail and Payment Provisions

4. **Amounts Payable**

A. The amounts payable under this Grant shall not exceed: **$705,275**

~~1) $141,055 for the budget period of 01/01/2018 through 06/30/2018.~~
~~2) $141,055 for the budget period of 07/01/2018 through 06/30/2019.~~
~~3) $141,055 for the budget period of 07/01/2019 through 06/30/2020.~~
~~4) $141,055 for the budget period of 07/01/2020 through 06/30/2021.~~
~~5) $141,055 for the budget period of 07/01/2021 through 06/30/2022.~~

B. Payment allocations shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are fulfilled and/or goods are received.

5. Timely Submission of Final Invoice

A. A final undisputed invoice shall be submitted for payment no more than ninety (90) calendar days following the expiration or termination date of this Grant, unless a later or alternate deadline is agreed to in writing by the program grant manager. Said invoice should be clearly marked “Final Invoice”, indicating that all payment obligations of the State under this Grant have ceased and that no further payments are due or outstanding.

B. The State may, at its discretion, choose not to honor any delinquent final invoice if the Grantee fails to obtain prior written State approval of an alternate final invoice submission deadline.

6. Travel and Per Diem Reimbursement

Any reimbursement for necessary travel and per diem shall be at the rates currently in effect as established by the California Department of Human Resources (CalHR).

Scope of Work and Deliverables
FY 2017-2022

GOAL: The California Department of Public Health, Oral Health Program (CDPH/OHP) shall grant funds to Local Health Jurisdictions (LHJ) from Proposition 56, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Prop 56) for the purpose and goal of educating about oral health, dental disease prevention, and linkage to treatment of dental disease including dental disease caused by the use of cigarettes and other tobacco products. LHJs are encouraged to implement the strategies recommended in the California Oral Health Plan and shall establish or expand upon existing Local Oral Health Programs (LOHP) to include the following program activities related to oral health in their communities: education, dental disease prevention, linkage to treatment, surveillance, and case management. These activities will improve the oral health of Californians.

Objectives 1-5 below represent public health best practices for planning and establishing new LOHPs. LHJs are required to complete these preliminary Objectives before implementing Objectives 6-11 outlined below. LHJs that have completed these planning activities may submit documentation in support of their accomplishments. Please review the LOHP Guidelines for information regarding the required documentation that must be submitted to CDPH OHP for approval.

Objective 1: Build capacity and engage community stakeholders to provide qualified professional expertise in dental public health for program direction, coordination, and collaboration.

Create a staffing pattern and engage community stakeholders to increase the capacity to achieve large-scale improvements in strategies that support evidence-based interventions, health system interventions, community-clinical linkages, and disease surveillance and evaluation. At a minimum an Oral Health Program Coordinator position should be developed to coordinate the LOHP efforts. Recruit and engage key stakeholders to form an Advisory Committee or task force. Convene and schedule meetings, identify goals and objectives, and establish communication methods. This group can leverage individual members' expertise and connections to achieve measurable improvements in oral health.

Objective 2: Assess and monitor social and other determinants of health, health status, health needs, and health care services available to California communities, with a special focus on underserved areas and vulnerable population groups.

Identify partners and form a workgroup to conduct an environmental scan to gather data, create an inventory of resources, and plan a needs assessment. Conduct a needs assessment to determine the need for primary data, identify resources and methods, and develop a work plan to collect missing data. Collect, organize, and analyze data. Prioritize needs assessment issues and findings, and use for program planning, advocacy, and education. Prepare a report and publish.

Scope of Work and Deliverables
FY 2017-2022

Objective 3: Identify assets and resources that will help to address the oral health needs of the community with an emphasis on underserved areas and vulnerable population groups within the jurisdiction.

Take an inventory of the jurisdiction's communities to identify associations, organizations, institutions and non-traditional partners to provide a comprehensive picture of the LHJ. Conduct key informant interviews, focus groups, and/or surveys, create a map, and publish the assets identified on your website or newsletter.

Objective 4: Develop a Community Health Improvement Plan (CHIP) and an action plan to address oral health needs of underserved areas and vulnerable population groups for the implementation phase to achieve local and state oral health objectives.

Identify a key staff person or consultant to guide the community oral health improvement plan process, including a timeline, objectives, and strategies to achieve the California Oral Health Plan. Recruit stakeholders, community gatekeepers, and non-traditional partners identified in the asset mapping process and members of the AC to participate in a workgroup to develop the CHIP and the Action Plan. The Action Plan will a timeline to address and implement priority objectives and strategies identified in the CHIP. The workgroup will identify the "who, what, where, when, how long, resources, and communication" aspects of the Action Plan.

Objective 5: Develop an Evaluation Plan that will be used to monitor and assess the progress and success of the Local Oral Health Program.

Participate with the CDPH OHP to engage stakeholders in the Evaluation Plan process, including those involved, those affected, and the primary intended users. Describe the program using a Logic Model, and document the purpose, intended users, evaluation questions and methodology, and timeline for the evaluation. Gather and analyze credible evidence to document the indicators, sources, quality, quantity, and logistics. Justify the conclusions by documenting the standards, analyses, interpretation, and recommendations. Ensure that the Evaluation Plan is used and shared.

Objective 6: Implement evidence-based programs to achieve California Oral Health Plan objectives.

To accomplish this Objective, LHJs can choose evidence-based or best practice strategies such as, but not limited to increase the number of low-income schools with a school-based or school-linked dental program; increase the number of children in grades K-6 receiving fluoride supplements, such as fluoride rinse, fluoride varnish, or fluoride tablets; increase the number of children in grades K-6 receiving dental sealants and increase or maintain the percent of the population receiving community fluoridated water.

Scope of Work and Deliverables
FY 2017-2022

Objective 7: Work with partners to promote oral health by developing and implementing prevention and healthcare policies and guidelines for programs, health care providers, and institutional settings (e.g., schools) including integration of oral health care and overall health care.

To accomplish this Objective, LHJs can choose evidence-based or best practice strategies such as, but not limited to: convene partners (e.g., First 5, Early Head Start/Head Start, Maternal Child and Adolescent Health (MCAH), Child Health and Disability Prevention (CHDP), Black Infant Health (BIH), Denti-Cal, Women, Infant and Children (WIC), Home Visiting, schools, community-based organizations, etc.) to improve the oral health of 0-6 year old children by identifying facilitators for care, barriers to care, and gaps to be addressed; and/or increase the number of schools implementing the kindergarten oral health assessment by assessing the number of schools currently not reporting the assessments to the System for California Oral Health Reporting (SCOHR), identifying target schools for intervention, providing guidance to schools, and assessing progress.

Objective 8: Address common risk factors for preventable oral and chronic diseases, including tobacco and sugar consumption, and promote protective factors that will reduce disease burden.

To accomplish this Objective, LHJs can choose evidence-based or best practice strategies such as, but not limited to: increase the number of dental offices providing tobacco cessation counseling; and/or increase the number of dental office utilizing Rethink Your Drink materials and resources to guide clients toward drinking water, especially tap water, instead of sugar-sweetened beverages.

Objective 9: Coordinate outreach programs, implement education and health literacy campaigns, and promote integration of oral health and primary care.

To accomplish this Objective, LHJs can choose evidence-based or best practice strategies such as, but not limited to: increase the number of dental offices, primary care offices, and community-based organizations (CBO) (e.g., Early Head Start/Head Start, WIC, Home Visiting, BIH, CHDP, Community Health Worker/Promotora programs, etc.) using the American Academy of Pediatrics' Brush, Book, Bed (BBB) implementation guide; and/or increase the number of dental offices, primary care clinics, and CBOs using the Oral Health Literacy implementation guide to enhance communication in dental/medical offices; and/or increase the number CBOs that incorporate oral health education and referrals into routine business activities.

Scope of Work and Deliverables
FY 2017-2022

Objective 10: Assess, support, and assure establishment and improvement of effective oral healthcare delivery and care coordination systems and resources, including workforce development and collaborations to serve vulnerable and underserved populations by integrating oral health care and overall health care.

To accomplish this Objective, LHJs can choose evidence-based or best practice strategies such as, but not limited to: regularly convene and lead a jurisdiction-wide Community of Practice comprised of Managed Care Plans, Federally Qualified Health Centers, CBOs, and/or Dental Offices focused on implementing the Agency for Health Care Research and Quality's Design Guide for Implementing Warm Handoffs in Primary Care Settings or the ; and/or identifying a staff person or consultant to facilitate quality improvement coaching to jurisdiction-wide Community of Practice members focused on increasing the number of at-risk persons who are seen in both a medical and dental office; and/or improve the operationalization of an existing policy or guideline, such as the increasing the number of infants who are seen by a dentist by age 1; and/or promote effectiveness of best practices at statewide and national quality improvement conferences.

Objective 11: Create or expand existing local oral health networks to achieve oral health improvements through policy, financing, education, dental care, and community engagement strategies.

To accomplish this Objective, LHJs can choose evidence-based or best practice strategies such as, but not limited to: create a new (or expand an existing) Oral Health Network, Coalition, or Partnership by identifying key groups and organizations; planning and holding meetings; defining issues and problems; creating a common vision and shared values; and developing and implementing an Action Plan that will result in oral health improvements. LHJs are also encouraged, where possible, to collaborate with local Dental Transformation Initiative (DTI) Local Dental Pilot Projects to convene stakeholders and partners in innovative ways to leverage and expand upon the existing momentum towards improving oral health. LHJs that are currently implementing local DTI projects should develop complementary, supportive, but not duplicative activities.

Scope of Work and Deliverables
FY 2017-2022

DELIVERABLES/OUTCOME MEASURES: LHJs are encouraged to implement the strategies recommended in the California Oral Health Plan. Funds are made available through Prop 56 to achieve these deliverables. The activities may include convening, coordination, and collaboration to support planning, disease prevention, education, surveillance, and linkage to treatment programs. To ensure that CDPH fulfills the Prop 56 requirements, LHJs are responsible for meeting the assurances and the following checked deliverables. Deliverables not met will result in a corrective action plan and/or denial or reduction in future Prop 56 funding.

Local Health Jurisdiction Deliverables

Deliverable	Activities	Selected deliverable
Deliverable 1 *Objective 1*	Develop Advisory Committee/Coalition/Partnership/Task Force (AC) and recruit key organizations/members representing diverse stakeholders and non-traditional partners. A. List of diverse stakeholders engaged to develop and mentor the Community Health Improvement/Action Plan. B. List number of meetings/conference calls held to develop a consensus of AC to determine best practice to address priorities and identify evidence-based programs to implement. C. Develop communication plan/methods to share consistent messaging to increase collaboration. D. Develop a consensus on how to improve access to evidence based programs and clinical services.	☒
Deliverable 2 *Objective 1*	Document staff participation in required training webinars, workshops and meetings.	☒
Deliverable 3 *Objective 2 & 3*	Conduct needs assessment of available data to determine LHJs health status, oral health status, needs, and available dental and health care services to resources to support underserved communities and vulnerable population groups.	☒
Deliverable 4 *Objective 4*	Five-year oral health improvement plan (the "Plan") and an action plan (also called the "work plan"), updated annually, describing disease prevention, surveillance, education, linkage to treatment programs, and evaluation strategies to improve the oral health of the target population based on an assessment of needs, assets and resources.	☒
Deliverable 5 *Objective 5*	Create a program logic model describing the local oral health program and update annually	☒
Deliverable 6 *Objective 5*	Coordinate with CDPH to develop a surveillance report to determine the status of children's oral health and develop an evaluation work plan for Implementation objectives.	☒

Scope of Work and Deliverables
FY 2017-2022

Deliverable	Activities	Selected deliverable
Deliverable 7 *Objective 6* School- Based/ School Linked	Compile data for and report annually on educational activities, completing all relevant components on the Data Form: A. Schools meeting criteria of low-income and high-need for dental program (>50% participation in Free or Reduced Price Meals (FRPM) participating in a fluoride program. B. Schools, teachers, parents and students receiving educational materials and/or educational sessions. C. Children provided preventive services.	☒
Deliverable 8 *Objective 6* School-Based/ School-Linked	Compile data for and report annually on School-based/linked program activities, completing all relevant components on the Data Form: A. Schools meeting criteria of low-income and high-need for dental program (>50% participation in Free or Reduced Price Meals (FRPM) participating in a School-based/linked program. B. Schools, teachers, parents and students receiving dental sealant educational materials and/or educational sessions. C. Children screened, linked or provided preventive services including dental sealants.	☒
Deliverable 9 *Objective 6* Fluoridation	Compile data for and report annually on Community Water Fluoridation program activities, completing all relevant components on the Data Form: A. Regional Water District engineer/operator training on the benefits of fluoridation. B. Training for community members who desire to educate others on the benefits of fluoridation at Board of Supervisor, City Council, or Water Board meetings. C. Community-specific fluoridation Education Materials D. Community public awareness campaign such as PSAs, Radio Advertisements	☒
Deliverable 10 *Objective 7* Kinder-Assessment	Compile data for and report annually on kindergarten oral health assessment activities, completing all relevant components on the Data Form: A. Schools currently not reporting the assessments to SCHOR B. Champions trained to promote kindergarten oral health assessment activities	☒

Scope of Work and Deliverables
FY 2017-2022

Deliverable	Activities	Selected deliverable
	C. Community public relations events and community messages promoting oral health. D. New schools participating in the kindergarten oral health assessment activities. E. Screening linked to essential services. F. Coordination efforts of programs such as kindergarten oral health assessment, WIC/Head Start, pre-school/school based/linked programs, Denti-Cal, Children's Health and Disability Prevention Program, Home Visiting and other programs. G. Identify prevention and healthcare policies and guidelines implemented.	
Deliverable 11 *Objective 8*	Compile data for and report annually on tobacco cessation activities, completing all relevant components on the Data Form: A. Assessment of readiness of dental offices to provide tobacco cessation counseling. B. Training to dental offices for providing tobacco cessation counseling. C. Dental offices connected to resources	☒
Deliverable 12 *Objective 8*	Compile data for and report annually on Rethink Your Drink activities, completing all relevant components on the Data Form: A. Assessment of readiness of dental offices to implement Rethink Your Drink materials and resources for guiding patients toward drinking water. B. Training to dental offices for implementing Rethink Your Drink materials. C. Dental offices connected to resources	☒
Deliverable 13 *Objective 9*	Compile data for and report annually on health literacy and communication activities, completing all relevant components on the Data Form: A. Partners and champions recruited to launch health literacy campaigns B. Assessments conducted to assess opportunities for implementation C. Training and guidance provided D. Sites/organizations implementing health literacy activities	☐
Deliverable 14 Objective 10	Compile data for and report annually on health care delivery and care coordination systems and resources, completing all relevant components on the Data Form:	☐

Scope of Work and Deliverables
FY 2017-2022

Deliverable	Activities	Selected deliverable
	A. Assessments conducted to assess opportunities for implementation of community-clinical linkages and care coordination B. Resources such as outreach, Community of Practice, and training developed C. Providers and systems engaged	
Deliverable 15 *Objective 11*	Compile data for and report annually on community engagement activities, completing all relevant components on the Data Form: A. Develop a core workgroup to identify strategies to achieve local oral health improvement. B. Provide a list of community engagement strategies to address policy, financing, education, and dental care.	☐
Deliverable 16 *Objective 1-11*	**Progress reporting:** submit bi-annual progress reports describing in detail progress of program and evaluation activities and progress towards completing deliverables. Provide documentation in sufficient detail to support the reported activities on planning and intervention activities for required and selected objectives.	☒
Deliverable 17 *Objective 1-11*	**Expense documenting:** submit all expenses incurred during each state fiscal year with the ability to provide back-up documentation for expenses in sufficient detail to allow CDPH-OHP to ascertain compliance with Proposition 56, the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 Likewise, provide biannual Progress Reports describing in detail the program activities conducted, and the ability to provide source documentation in sufficient detail to support the reported activities.	☒

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

Departments: Behavioral Health

TIME REQUIRED

SUBJECT Telepsychiatry Agreement with North American Mental Health Services

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Proposed contract with North American Mental Health Services for the provision of Tele-Psychiatry Services at Mono County Behavioral Health and in the Mono County Jail.

RECOMMENDED ACTION:

Approve County entry into proposed contract and authorize the Mono County CAO to execute said contract on behalf of the County. Provide any desired direction to staff.

FISCAL IMPACT:

Total payments to the contractor by the county will not exceed $105,000 in any 12 month period. This is covered by Mono County Behavioral Health realignment and Mental Health Services Act.

CONTACT NAME: Robin Roberts

PHONE/EMAIL: 760-924-1740 / rroberts@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☑ YES ☐ NO

ATTACHMENTS:

Click to download
Staff Report
Agreement between County of Mono and North American Mental Health Services
Tele-Psychatry HIPAA Business Associate Agreement

History

Time	Who	Approval

9/4/2019 7:34 PM	County Administrative Office	Yes
9/5/2019 2:30 PM	County Counsel	Yes
9/4/2019 3:50 PM	Finance	Yes

Behavioral Health Department
COUNTY OF MONO

PO BOX 2619 | 342 OLD MAMMOTH ROAD, STE. 228 MAMMOTH LAKES, CA 93546
(760) 924-1740 • FAX (760) 924-1741 • rroberts@mono.ca.gov

Robin K. Roberts, MFT
Director, Behavioral Health

August 23, 2019

To Honorable Board of Supervisors
From Robin K. Roberts, Behavioral Health Director

Subject **Approve Agreement between County of Mono and North American Mental Health Services to provide tele-psychiatry at Mono County Behavioral Health and in the Mono County Jail.**

Recommendation

Approve County entry into proposed contract and authorize CAO to execute said contract on behalf of the County. Provide any desired direction to staff.

Discussion

Mono County Behavioral Health has provided tele-psychiatry for children and adults since 2014. These services have proven to be extremely valuable to Mono County residents; however, enhanced services (evaluations for LPS conservatees, Medically Assisted Therapies, etc.) are needed and this new service provider, North American Mental Health Services will provide these as needed. Additionally, this contract will allow Mono County to provide tele-psychiatry services in the Mono County Jail each week, including evaluations for vulnerable inmates, as well as Medically Assisted Therapies for those identified as wanting treatment for drug and/or alcohol use.

Fiscal Impact

This program will be funded, primarily, with Mental Health Realignment and Mental Health Services Act funding. Funding for jail services will be covered by the Community Corrections Partnership.

AGREEMENT BETWEEN COUNTY OF MONO AND NATIVE AMERICAN MENTAL HEALTH SERVICES DBA NORTH AMERICAN MENTAL HEALTH SERVICES FOR THE PROVISION OF TELE-PSYCHIATRY SERVICES

INTRODUCTION

WHEREAS, the County of Mono (hereinafter referred to as "County") may have the need for the Tele-Psychiatry services of NATIVE AMERICAN MENTAL HEALTH SERVICES DBA NORTH AMERICAN MENTAL HEALTH SERVICES (NAMHS), of Redding, California (hereinafter referred to as "Contractor"), and in consideration of the mutual promises, covenants, terms and conditions hereinafter contained, the parties hereby agree as follows:

TERMS AND CONDITIONS

1. SCOPE OF WORK

Contractor shall furnish to County, upon its request, those services and work set forth in Attachment A, attached hereto and by reference incorporated herein. Requests by County to Contractor to perform under this Agreement will be made by the Director of Behavioral Health, or an authorized representative thereof. Requests to Contractor for work or services to be performed under this Agreement will be based upon County 's need for such services. County makes no guarantee or warranty, of any nature, that any minimum level or amount of services or work will be requested of Contractor by County under this Agreement. By this Agreement, County incurs no obligation or requirement to request from Contractor the performance of any services or work at all, even if County should have some need for such services or work during the term of this Agreement.

Services and work provided by Contractor at County's request under this Agreement will be performed in a manner consistent with the requirements and standards established by applicable federal, state, and county laws, ordinances, and resolutions. Such laws, ordinances, regulations, and resolutions include, but are not limited to, those that are referred to in this Agreement.

This Agreement is subject to the following Exhibits (as noted) which are attached hereto, following all referenced Attachments, and incorporated by this reference. In the event of a conflict between the terms of an attached Exhibit and this Agreement, the terms of the Exhibit shall govern:

- ☐ **Exhibit 1**: General Conditions (Construction)
- ☐ **Exhibit 2**: Prevailing Wages
- ☐ **Exhibit 3**: Bond Requirements
- ☐ **Exhibit 4**: Invoicing, Payment, and Retention
- ☐ **Exhibit 5**: Trenching Requirements
- ☐ **Exhibit 6**: FHWA Requirements
- ☐ **Exhibit 7**: CDBG Requirements
- ☒ **Exhibit 8**: HIPAA Business Associate Agreement
- ☐ **Exhibit 9**: Other _____

2. TERM

The term of this Agreement shall be from October 1, 2019 to September 30, 2022, unless sooner terminated as provided below.

3. CONSIDERATION

A. Compensation. County shall pay Contractor in accordance with the Schedule of Fees (set forth as Attachment B) for the services and work described in Attachment A that are performed by Contractor at County's request.

B. Travel and Per Diem. Contractor will not be paid or reimbursed for travel expenses or per diem that Contractor incurs in providing services and work requested by County under this Agreement, unless otherwise provided for in Attachment B.

C. No Additional Consideration. Except as expressly provided in this Agreement, Contractor shall not be entitled to, nor receive, from County, any additional consideration, compensation, salary, wages, or other type of remuneration for services rendered under this Agreement. Specifically, Contractor shall not be entitled, by virtue of this Agreement, to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays, or other paid leaves of absence of any type or kind whatsoever.

D. Limit upon amount payable under Agreement. **The total sum of all payments made by County to Contractor for services and work performed under this Agreement shall not exceed one hundred and five thousand dollars ($105,000), in any twelve-month period (hereinafter referred to as "Contract Limit").** Please refer to Attachment B, Schedule of Fees, for hourly rates. County expressly reserves the right to deny any payment or reimbursement requested by Contractor for services or work performed that is in excess of the Contract Limit.

E. Billing and Payment. Contractor shall submit to County, on a monthly basis, an itemized statement of all services and work described in Attachment A, which were done at County's request. The statement to be submitted will cover the period from the first (1st) day of the preceding month through and including the last day of the preceding month. Alternatively, Contractor may submit a single request for payment corresponding to a single incident of service or work performed at County's request. All statements submitted in request for payment shall identify the date on which the services and work were performed and describe the nature of the services and work which were performed on each day. Invoicing shall be informative but concise regarding services and work performed during that billing period. Upon finding that Contractor has satisfactorily completed the work and performed the services as requested, County shall make payment to Contractor within 30 days of its receipt of the itemized statement. Should County determine the services or work have not been completed or performed as requested and/or should Contractor produce an incorrect statement, County shall withhold payment until the services and work are satisfactorily completed or performed and/or the statement is corrected and resubmitted.

F. Federal and State Taxes.

(1) Except as provided in subparagraph (2) below, County will not withhold any federal or state income taxes or social security from any payments made by County to Contractor under the terms and conditions of this Agreement.

(2) County shall withhold California state income taxes from payments made under this Agreement to non-California resident independent contractors when it is anticipated that total annual payments to Contractor under this Agreement will exceed One Thousand Four Hundred Ninety-Nine dollars ($1,499.00).

(3) Except as set forth above, County has no obligation to withhold any taxes or payments from sums paid by County to Contractor under this Agreement. Payment of all taxes and other assessments on such sums is the sole responsibility of Contractor. County has no responsibility or liability for payment of Contractor's taxes or assessments.

(4) The total amounts paid by County to Contractor, and taxes withheld from payments to non-California residents, if any, will be reported annually to the Internal Revenue Service and the California State Franchise Tax Board.

4. WORK SCHEDULE

Contractor's obligation is to perform, in a timely manner, those services and work identified in Attachment A that are requested by County. It is understood by Contractor that the performance of these services and work will require a varied schedule. Contractor, in arranging his/her schedule, will coordinate with County to ensure that all services and work requested by County under this Agreement will be performed within the time frame set forth by County.

5. REQUIRED LICENSES, CERTIFICATES, AND PERMITS

Any licenses, certificates, or permits required by the federal, state, county, or municipal governments, for Contractor to provide the services and work described in Attachment A must be procured by Contractor and be valid at the time Contractor enters into this Agreement. Further, during the term of this Agreement, Contractor must maintain such licenses, certificates, and permits in full force and effect. Licenses, certificates, and permits may include, but are not limited to, driver's licenses, professional licenses or certificates, and business licenses. Such licenses, certificates, and permits will be procured and maintained in force by Contractor at no expense to County. Contractor will provide County, upon execution of this Agreement, with evidence of current and valid licenses, certificates and permits that are required to perform the services identified in Attachment A. Where there is a dispute between Contractor and County as to what licenses, certificates, and permits are required to perform the services identified in Attachment A, County reserves the right to make such determinations for purposes of this Agreement.

6. OFFICE SPACE, SUPPLIES, EQUIPMENT, ETC

Contractor shall provide such office space, supplies, equipment, vehicles, reference materials, support services and telephone service as is necessary for Contractor to provide the services identified in Attachment A to this Agreement. County is not obligated to reimburse or pay Contractor for any expense or cost incurred by Contractor in procuring or maintaining such items. Responsibility for the costs and expenses incurred by Contractor in providing and maintaining such items is the sole responsibility and obligation of Contractor.

7. COUNTY PROPERTY

A. Personal Property of County. Any personal property such as, but not limited to, protective or safety devices, badges, identification cards, keys, uniforms, vehicles, reference materials, furniture, appliances, etc. provided to Contractor by County pursuant to this Agreement is, and at the termination of this Agreement remains, the sole and exclusive property of County. Contractor will use reasonable care to protect, safeguard and maintain such items while they are in Contractor's possession. Contractor will be financially responsible for any loss or damage to such items, partial or total, that is the result of Contractor's negligence.

B. Products of Contractor's Work and Services. Any and all compositions, publications, plans, designs, specifications, blueprints, maps, formulas, processes, photographs, slides, videotapes, computer programs, computer disks, computer tapes, memory chips, soundtracks, audio recordings, films, audio-visual

presentations, exhibits, reports, studies, works of art, inventions, patents, trademarks, copyrights, or intellectual properties of any kind that are created, produced, assembled, compiled by, or are the result, product, or manifestation of, Contractor's services or work under this Agreement are, and at the termination of this Agreement shall remain, the sole and exclusive property of County. At the termination of the Agreement, Contractor will convey possession and title to all such properties to County.

8. WORKERS' COMPENSATION

Contractor shall provide Statutory Workers' Compensation insurance coverage and Employer's Liability coverage for not less than One Million dollars ($1,000,000.00) per occurrence for all employees engaged in services or operations under this Agreement. Any insurance policy limits in excess of the specified minimum limits and coverage shall be made available to County as an additional insured. The Workers' Compensation policy shall be endorsed with a waiver of subrogation in favor of County for all work performed by Contractor, its employees, agents, and subcontractors.

9. INSURANCE

A. Contractor shall procure and maintain, during the entire term of this Agreement or, if work or services do not begin as of the effective date of this Agreement, commencing at such other time as may be authorized in writing by County's Risk Manager, the following insurance (as noted) against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work and/or services hereunder and the results of that work and/or services by Contractor, its agents, representatives, employees, or subcontractors:

☒ General Liability. A policy of Comprehensive General Liability Insurance which covers all the work and services to be performed by Contractor under this Agreement, including operations, products and completed operations, property damage, bodily injury (including death) and personal and advertising injury. Such policy shall provide limits of not less than One Million dollars ($1,000,000.00) per claim or occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project or the general aggregate limit shall be twice the required occurrence limit.

☐ Automobile/Aircraft/Watercraft Liability Insurance. A policy of Comprehensive Automobile/Aircraft/Watercraft Liability Insurance for bodily injury (including death) and property damage which provides total limits of not less than One Million dollars ($1,000,000.00) per claim or occurrence applicable to all owned, non-owned and hired vehicles/aircraft/watercraft. If the services provided under this Agreement include the transportation of hazardous materials/wastes, then the Automobile Liability policy shall be endorsed to include Transportation Pollution Liability insurance covering materials/wastes to be transported by Contractor pursuant to this Agreement. Alternatively, such coverage may be provided in Contractor's Pollution Liability policy.

☒ Professional Errors and Omissions Liability Insurance. A policy of Professional Errors and Omissions Liability Insurance appropriate to Contractor's profession in an amount of not less than One Million dollars ($1,000,000.00) per claim or occurrence or Two Million dollars ($2,000,000.00) general aggregate. If coverage is written on a claims-made form then: (1) the "retro date" must be shown, and must be before the beginning of contract work; (2) insurance must be maintained and evidence of insurance must be provided for at least five years after completion of the contract work; and (3) if coverage if cancelled or non-renewed, and not replaced with another claims-made policy form with a "retro date" prior to the contract effective

date, then Contractor must purchase "extended reporting" coverage for a minimum of five years after completion of contract work.

☐ Pollution Liability Insurance. A policy of Comprehensive Contractors Pollution Liability coverage applicable to the work being performed and covering Contractor's liability for bodily injury (including death), property damage, and environmental damage resulting from "sudden accidental" or "gradual" pollution and related cleanup costs arising out of the work or services to be performed under this Agreement. Coverage shall provide a limit no less than One Million dollars ($1,000,000.00) per claim or occurrence or Two Million dollars ($2,000,000.00) general aggregate. If the services provided involve lead-based paint or asbestos identification/remediation, the Pollution Liability policy shall not contain lead-based paint or asbestos exclusions.

B. Coverage and Provider Requirements. Insurance policies shall not exclude or except from coverage any of the services and work required to be performed by Contractor under this Agreement. The required polic(ies) of insurance shall be issued by an insurer authorized to sell such insurance by the State of California, and have at least a "Best's" policyholder's rating of "A" or "A+". Prior to commencing any work under this agreement, Contractor shall provide County: (1) a certificate of insurance evidencing the coverage required; (2) an additional insured endorsement for general liability applying to County, its agents, officers and employees made on ISO form CG 20 10 11 85, or providing equivalent coverage; and (3) a notice of cancellation or change of coverage endorsement indicating that the policy will not be modified, terminated, or canceled without thirty (30) days written notice to County.

C. Primary Coverage. For any claim made related to this Agreement or work and/or services performed or provided pursuant to this Agreement, Contractor's insurance coverage shall be primary insurance coverage at least as broad as ISO CG 20 01 04 13 as with respect to County, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by County, its officers, officials, employees, or volunteers shall be excess of Contractor's insurance and shall not contribute with it.

D. Deductible, Self-Insured Retentions, and Excess Coverage. Any deductibles or self-insured retentions must be declared and approved by County. If possible, Contractor's insurer shall reduce or eliminate such deductibles or self-insured retentions with respect to County, its officials, officers, employees, and volunteers; or Contractor shall provide evidence satisfactory to County guaranteeing payment of losses and related investigations, claim administration, and defense expenses. Any insurance policy limits in excess of the specified minimum limits and coverage shall be made available to County as an additional insured.

E. Subcontractors. Contractor shall require and verify that all subcontractors maintain insurance (including Workers' Compensation) meeting all the requirements stated herein and that County is an additional insured on insurance required of subcontractors.

10. STATUS OF CONTRACTOR

All acts of Contractor, its agents, officers, and employees, relating to the performance of this Agreement, shall be performed as an independent contractor, and not as an agent, officer, or employee of County. Contractor, by virtue of this Agreement, has no authority to bind or incur any obligation on behalf of, or exercise any right or power vested in, County, except as expressly provided by law or set forth in Attachment A. No agent, officer, or employee of County is to be considered an employee of Contractor. It is understood by both Contractor and County that this Agreement shall not, under any circumstances, be construed to create an employer-employee relationship or a joint venture. As an independent contractor:

A. Contractor shall determine the method, details, and means of performing the work and services to be provided by Contractor under this Agreement.

B. Contractor shall be responsible to County only for the requirements and results specified in this Agreement, and except as expressly provided in this Agreement, shall not be subjected to County's control with respect to the physical action or activities of Contractor in fulfillment of this Agreement.

C. Contractor, its agents, officers and employees are, and at all times during the term of this Agreement shall represent and conduct themselves as, independent contractors, and not employees of County.

11. DEFENSE AND INDEMNIFICATION

Contractor shall defend with counsel acceptable to County, indemnify, and hold harmless County, its agents, officers, and employees from and against all claims, damages, losses, judgments, liabilities, expenses, and other costs, including litigation costs and attorney's fees, arising out of, resulting from or in connection with, the performance of this Agreement by Contractor, or Contractor's agents, officers, or employees. Contractor's obligation to defend, indemnify, and hold County, its agents, officers, and employees harmless applies to any actual or alleged personal injury, death, damage or destruction to tangible or intangible property, including the loss of use. Contractor's obligation under this Paragraph 11 extends to any claim, damage, loss, liability, expense, or other costs that are caused in whole or in part by any act or omission of Contractor, its agents, employees, supplier, or anyone directly or indirectly employed by any of them, or anyone for whose acts or omissions any of them may be liable.

Contractor's obligation to defend, indemnify, and hold County, its agents, officers, and employees harmless under the provisions of this Paragraph 11 is not limited to, or restricted by, any requirement in this Agreement for Contractor to procure and maintain a policy of insurance and shall survive any termination or expiration of this Agreement.

12. RECORDS AND AUDIT

A. Records. Contractor shall prepare and maintain all records required by the various provisions of this Agreement, federal, state, county, municipal, ordinances, regulations, and directions. Contractor shall maintain these records for a minimum of four (4) years from the termination or completion of this Agreement. Contractor may fulfill its obligation to maintain records as required by this Paragraph 12 by substitute photographs, micrographs, or other authentic reproduction of such records.

B. Inspections and Audits. Any authorized representative of County shall have access to any books, documents, papers, records, including, but not limited to, financial records of Contractor, that County determines to be pertinent to this Agreement, for the purposes of making audit, evaluation, examination, excerpts, and transcripts during the period such records are to be maintained by Contractor. Further, County has the right, at all reasonable times, to audit, inspect, or otherwise evaluate the work performed or being performed under this Agreement.

13. NONDISCRIMINATION

During the performance of this Agreement, Contractor, its agents, officers, and employees shall not unlawfully discriminate in violation of any federal, state, or local law, against any employee, or applicant for employment, or person receiving services under this Agreement, because of race, religious creed, color, ancestry, national origin, physical disability, mental disability, medical condition, marital status, sex, age, or sexual orientation. Contractor and its agents, officers, and employees shall comply with the provisions of the

Fair Employment and Housing Act (Government Code section 12900, et seq.), and the applicable regulations promulgated thereunder in the California Code of Regulations. Contractor shall also abide by the Federal Civil Rights Act of 1964 (P.L. 88-352) and all amendments thereto, and all administrative rules and regulations issued pursuant to said Act.

14. TERMINATION

This Agreement may be terminated by County without cause, and at will, for any reason by giving to Contractor sixty (60) calendar days written notice of such intent to terminate. Contractor may terminate this Agreement without cause, and at will, for any reason whatsoever by giving to County sixty (60) calendar days written notice of such intent to terminate.

15. ASSIGNMENT

This is an agreement for the personal services of Contractor. County has relied upon the skills, knowledge, experience, and training of Contractor as an inducement to enter into this Agreement. Contractor shall not assign or subcontract this Agreement, or any part of it, without the express written consent of County. Further, Contractor shall not assign any moneys due or to become due under this Agreement without the prior written consent of County.

16. DEFAULT

If Contractor abandons the work, fails to proceed with the work or services requested by County in a timely manner, or fails in any way as required to conduct the work and services as required by County, then County may declare Contractor in default and terminate this Agreement upon five (5) days written notice to Contractor. Upon such termination by default, County will pay to Contractor all amounts owing to Contractor for services and work satisfactorily performed to the date of termination.

17. WAIVER OF DEFAULT

Waiver of any default by either party to this Agreement shall not be deemed to be a waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach, and shall not be construed to be a modification of the terms of this Agreement unless this Agreement is modified as provided in Paragraph 23.

18. CONFIDENTIALITY

Contractor agrees to comply with various provisions of the federal, state, and county laws, regulations, and ordinances providing that information and records kept, maintained, or accessible by Contractor in the course of providing services and work under this Agreement, shall be privileged, restricted, or confidential. Contractor agrees to keep confidential, all such privileged, restricted or confidential information and records obtained in the course of providing the work and services under this Agreement. Disclosure of such information or records shall be made by Contractor only with the express written consent of County.

19. CONFLICTS

Contractor agrees that he/she has no interest, and shall not acquire any interest, direct or indirect, that would conflict in any manner or degree with the performance of the work and services under this Agreement. Contractor agrees to complete and file a conflict-of-interest statement.

20. POST-AGREEMENT COVENANT

Contractor agrees not to use any confidential, protected, or privileged information that is gained from County in the course of providing services and work under this Agreement, for any personal benefit, gain, or enhancement. Further, Contractor agrees for a period of two (2) years after the termination of this Agreement, not to seek or accept any employment with any entity, association, corporation, or person who, during the term of this Agreement, has had an adverse or conflicting interest with County, or who has been an adverse party in litigation with County, and concerning such, Contractor by virtue of this Agreement has gained access to County's confidential, privileged, protected, or proprietary information.

21. SEVERABILITY

If any portion of this Agreement or application thereof to any person or circumstance shall be declared invalid by a court of competent jurisdiction, or if it is found in contravention of any federal, state, or county statute, ordinance, or regulation, then the remaining provisions of this Agreement, or the application thereof, shall not be invalidated thereby, and shall remain in full force and effect to the extent that the provisions of this Agreement are severable.

22. FUNDING LIMITATION

The ability of County to enter into this Agreement is based upon available funding from various sources. In the event that such funding fails, is reduced, or is modified, from one or more sources, County has the option to terminate, reduce, or modify this Agreement, or any of its terms within ten (10) days of notifying Contractor of the termination, reduction, or modification of available funding. Any reduction or modification of this Agreement effective pursuant to this provision must comply with the requirements of Paragraph 23.

23. AMENDMENT

This Agreement may be modified, amended, changed, added to, or subtracted from, by the mutual consent of the parties hereto, if such amendment or change order is in written form, and executed with the same formalities as this Agreement or in accordance with delegated authority therefor, and attached to the original Agreement to maintain continuity.

24. NOTICE

Any notice, communication, amendments, additions or deletions to this Agreement, including change of address of any party during the term of this Agreement, which Contractor or County shall be required, or may desire to make, shall be in writing and may be personally served, or sent by prepaid first-class mail or email (if included below) to the respective parties as follows:

County of Mono:
Robin K. Roberts, Director
Mono County Behavioral Health
P.O. Box 2619
Mammoth Lakes, CA 93546

Contractor:
Native American Mental Health Services DBA North American Mental Health Services
1742 Oregon Street
Redding, CA 96001

25. COUNTERPARTS

This Agreement may be executed in two (2) or more counterparts (including by electronic transmission), each of which shall constitute an original, and all of which taken together shall constitute one and the same instrument.

26. ENTIRE AGREEMENT

This Agreement contains the entire agreement of the parties, and no representations, inducements, promises, or agreements otherwise between the parties not embodied herein or incorporated herein by reference, shall be of any force or effect. Further, no term or provision hereof may be changed, waived, discharged, or terminated, unless executed in writing by the parties hereto.

IN WITNESS THEREOF, THE PARTIES HERETO HAVE SET THEIR HANDS AND SEALS ON THE DATE FIRST ABOVE MENTIONED.

COUNTY OF MONO	**CONTRACTOR**
By: _____	By: _____
Title: _____	Title: _____
Dated: _____	Dated: _____
	By: _____
APPROVED AS TO FORM:	Title: _____
_____	
County Counsel	Dated: _____

APPROVED BY RISK MANAGEMENT:

_____

Risk Manager

ATTACHMENT A

AGREEMENT BETWEEN COUNTY OF MONO AND NATIVE AMERICAN MENTAL HEALTH SERVICES DBA NORTH AMERICAN MENTAL HEALTH SERVICES FOR THE PROVISION OF TELE-PSYCHIATRY SERVICES

TERM:

FROM: October 1, 2019 TO: September 30, 2022

SCOPE OF WORK:

1. Services. Pursuant to the terms of this Agreement, Contractor shall employ, or otherwise arrange for, services of provider(s), to conduct Tele-psychiatry and on-site visits for the purpose of delivering direct patient care services, as agreed upon by both parties.

1.1 Professional Medical Services. The County hereby grants the right to Contractor to employ, or otherwise arrange for the services of, provider(s), and hereby grants the right to provide professional medical services. Services shall include:

1.1.1 Psychiatry services of Tele-psychiatry, consisting of psychiatric/medication evaluations, prescribing and monitoring medications for clients with mental health and substance abuse disorders.

1.1.2 Services may include psychological evaluation and testing through Tele-psychiatry on an as-needed basis.

1.2 Contractor Services. Contractor to render the following services:

1.2.1 Psychiatric evaluation and follow up, including laboratory evaluation

1.2.2 Pharmaceutical Management including medication pre-authorizations

1.2.3 Drug and alcohol treatment when necessary

1.2.4 Child and adolescent treatment along with the follow up and management

1.2.5 Refills of medication with the assistance of the County, the Mono County Jail and/or Mono County Behavioral Health, if needed. Provide consultation for "call backs", which are screened by the County. Phone consultation will be provided on an as needed basis for emergency or urgent evaluations.

1.3 Duties of Contractor. During the term of this agreement, Contractor shall have the obligation to:

1.3.1 The above services will be performed at the Mono County Jail onsite or through Telemedicine on an as needed basis, as deemed appropriate by the parties.

1.3.2 Use of Mono County Jail Electronic Health Record (EHR). Contractor shall document services provided under this Agreement in Mono County/Jail EHR no more than 30 days from date of service.

1.3.4 Notwithstanding the Insurance provisions in Paragraph 9 above, Contractor shall provide malpractice coverage of $1,000,000,000 and $3,000,000,000 respectively, for each psychiatric provider employed by contractor.

ATTACHMENT B

AGREEMENT BETWEEN COUNTY OF MONO AND NATIVE AMERICAN MENTAL HEALTH SERVICES DBA NORTH AMERICAN MENTAL HEALTH SERVICES FOR THE PROVISION OF TELE-PSYCHIATRY SERVICES

TERM:

FROM: October 1, 2019 TO: September 30, 2022

SCHEDULE OF FEES:

- Contractor shall provide County with all necessary information regarding the delivery of medical services to assist the County in charging the clients' professional fees for the Telepsychiatric Services, which shall be consistent with and shall not exceed the usual, customary and reasonable community standards for medical services.

- The County agrees to provide compensation to Contractor and Contractor agrees to accept compensation at the following rates:

    - $220 per hour of Telepsychiatric Services provided to clients of Mono County by Pas/NP providers in accordance with this Agreement.
    - $260 per hour of Telepsychiatric Services provided to clients of Mono County by MD providers in accordance with this Agreement.
    - One additional hour will be billed for each date of service, at the rate of the provider type.

- The County guarantees payment for any Scheduled Service Hours. Contractor shall provide an invoice to the County on a monthly basis, which invoice the County shall pay within thirty (30) days of receipt. In no event shall total payments to Contractor by County pursuant to this Agreement exceed $105,000 in any twelve-month period.

AGREEMENT BETWEEN COUNTY OF MONO
AND NORTH AMERICAN MENTAL HEALTH SERVICES
FOR THE PROVISION OF TELE-PSYCHIATRY SERVICES

HIPAA BUSINESS ASSOCIATE AGREEMENT

This Attachment shall constitute the Business Associate Agreement (the "Agreement") between NORTH AMERICAN MENTAL HEALTH SERVICES (NAMHS), (the "Business Associate") and the County of Mono (the "Covered Entity"), and applies to the functions Business Associate will perform on behalf of Covered Entity (collectively, "Services"), that are identified in the Master Agreement (as defined below).

1. **Purpose.** This Agreement is intended to ensure that the Business Associate will establish and implement appropriate privacy and security safeguards with respect to "Protected Health Information" (as defined below) that the Business Associate may create, receive, use, or disclose in connection with the Services to be provided by the Business Associate to the Covered Entity, and that such safeguards will be consistent with the standards set forth in regulations promulgated under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") as amended by the Health Information Technology for Economic and Clinical Health Act as set forth in Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 ("HITECH Act").

2. **Regulatory References.** All references to regulatory Sections, Parts and Subparts in this Agreement are to Title 45 of the Code of Federal Regulations as in effect or as amended, and for which compliance is required, unless otherwise specified.

3. **Definitions.** Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms defined in Sections 160.103, 164.304 and 164.501.

(a) Business Associate. "Business Associate" shall mean the party identified above as the "Business Associate".

(b) Breach. "Breach" shall have the same meaning as the term "breach" in Section 164.402.

(c) Covered Entity. "Covered Entity" shall mean the County of Mono, a hybrid entity, and its designated covered components, which are subject to the Standards for Privacy and Security of Individually Identifiable Health Information set forth in Parts 160 and 164.

(d) Designated Record Set. "Designated Record Set" shall have the same meaning as the term "designated record set" in Section 164.501.

(e) Electronic Protected Health Information. "Electronic Protected Health Information" ("EPHI") is a subset of Protected Health Information and means individually identifiable health information that is transmitted or maintained in electronic media, limited to the information created, received, maintained or transmitted by Business Associate from or on behalf of Covered Entity.

(f) Individual. "Individual" shall have the same meaning as the term ''Individual'' in Section 160.103 and shall include a person who qualifies as a personal representative in accordance with Section 164.502(g).

(g) Master Agreement. "Master Agreement" shall mean the contract or other agreement

to which this Attachment is attached and made a part of.

(h) Minimum Necessary. "Minimum Necessary" shall mean the minimum amount of Protected Health Information necessary for the intended purpose, as set forth at Section 164.514(d)(1): *Standard: Minimum Necessary Requirements.*

(i) Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at Part 160 and Part 164, Subparts A and E.

(j) Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in Section 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

(k) Required By Law. "Required by law" shall have the same meaning as the term "required by law" in Section 164.103.

(l) Secretary. "Secretary" shall mean the Secretary of the United States Department of Health and Human Services ("DHHS") or his/her designee.

(m) Security Incident. "Security Incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system, but does not include minor incidents that occur on a daily basis, such as scans, "pings", or unsuccessful random attempts to penetrate computer networks or servers maintained by Business Associate.

(n) Security Rule. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subparts A and C.

(o) Unsecured Protected Health Information. "Unsecured Protected Health Information" shall have the same meaning as the term "unsecured protected health information" in Section 164.402, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

4. **Compliance with the HIPAA Privacy and Security Rules.**

(a) Business Associate acknowledges that it is required by Sections 13401 and 13404 of the HITECH Act to comply with the HIPAA Security Rule, Sections 164.308 through 164.316, and the use and disclosure provisions of the HIPAA Privacy Rule, Sections 164.502 and 164.504.

(b) Business Associate agrees not to use or further disclose Protected Health Information other than as permitted or required by this Agreement, or as required by law.

5. **Permitted Uses and Disclosures.**

(a) Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity for the purposes specified in Attachment A to this Exhibit, which if completed and attached hereto is incorporated by reference, or as otherwise specified in the Scope of Work (Attachment A) of the Master Agreement, subject to limiting use and disclosure to applicable minimum necessary rules, regulations and statutes and provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity.

(b) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

(c) Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business

Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(d) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by Section 164.504(e)(2)(i)(B).

(e) Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities consistent with Section 164.502(j).

6. **Appropriate Safeguards.**

(a) Business Associate agrees to use appropriate safeguards to prevent the use or disclosure of Protected Health Information other than as provided for by this Agreement. Appropriate safeguards shall include implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Protected Health Information that is created, received, maintained or transmitted on behalf of the Covered Entity and limiting use and disclosure to applicable minimum necessary rules, regulations and statutes.

(b) To the extent practicable, Business Associate will secure all Protected Health Information by technological means that render such information unusable, unreadable, or indecipherable to unauthorized individuals and in accordance with any applicable standards or guidance issued by the Department of Health and Human Services under Section 13402 of the HITECH Act.

7. **Reporting Unauthorized Uses and Disclosures.**

(a) Business Associate agrees to notify Covered Entity of any breach, or security incident involving Unsecured Protected Health Information of which it becomes aware, including any access to, or use or disclosure of Protected Health Information not permitted by this Agreement. Such notification will be made within five (5) business days after discovery and will include, to the extent possible, the identification of each Individual whose Unsecured Protected Health Information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, used or disclosed, a description of the Protected Health Information involved, the nature of the unauthorized access, use or disclosure, the date of occurrence, and a description of any remedial action taken or proposed to be taken by Business Associate. Business Associate will also provide to Covered Entity any other available information that the Covered Entity is required to include in its notification to the Individual under Section 164.404(c) at the time of the initial report or promptly thereafter as the information becomes available.

(b) In the event of a request by law enforcement under Section 164.412, Business Associate may delay notifying Covered Entity for the applicable timeframe.

(c) A breach or unauthorized access, use, or disclosure shall be treated as discovered by the Business Associate on the first day on which such unauthorized access, use, or disclosure is known, or should reasonably have been known, to the Business Associate or to any person, other than the individual committing the unauthorized disclosure, that is an employee, officer, subcontractor, agent or other representative of the Business Associate.

(d) In meeting its obligations under this section, it is understood that Business Associate

is not acting as the Covered Entity's agent. In performance of the work, duties, and obligations and in the exercise of the rights granted under this Agreement, it is understood and agreed that Business Associate is at all times acting as an independent contractor in providing services pursuant to this Agreement and the Master Agreement.

8. **Mitigating the Effect of a Breach, Security Incident, or Unauthorized Access, Use or Disclosure of Unsecured Protected Health Information.**

(a) Business Associate agrees to mitigate, to the greatest extent possible, any harm that results from the breach, security incident, or unauthorized access, use or disclosure of Unsecured Protected Health Information by Business Associate or its employees, officers, subcontractors, agents, or other representatives.

(b) Following a breach, security incident, or any unauthorized access, use or disclosure of Unsecured Protected Health Information, Business Associate agrees to take any and all corrective action necessary to prevent recurrence, to document any such action, and to make said documentation available to Covered Entity.

(c) Except as required by law, Business Associate agrees that it will not inform any third party of a breach or unauthorized access, use or disclosure of Unsecured Protected Health Information without obtaining the Covered Entity's prior written consent. Covered Entity hereby reserves the sole right to determine whether and how such notice is to be provided to any Individuals, regulatory agencies, or others as may be required by law, regulation or contract terms, as well as the contents of such notice.

9. **Indemnification.**

(a) Business Associate agrees to hold harmless, defend at its own expense, and indemnify Covered Entity for the costs of any mitigation undertaken by Business Associate pursuant to Section 8, above.

(b) Business Associate agrees to assume responsibility for any and all costs associated with the Covered Entity's notification of Individuals affected by a breach or unauthorized access, use or disclosure by Business Associate or its employees, officers, subcontractors, agents or other representatives when such notification is required by any state or federal law or regulation, or under any applicable contract to which Covered Entity is a party.

(c) Business Associate agrees to hold harmless, defend at its own expense and indemnify Covered Entity and its respective employees, directors, officers, subcontractors, agents or other members of its workforce (each of the foregoing hereinafter referred to as "Indemnified Party") against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with any breach of this Agreement or from any acts or omissions related to this Agreement by Business Associate or its employees, directors, officers, subcontractors, agents or other members of its workforce. Accordingly, on demand, Business Associate shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results from the Business Associate's acts or omissions hereunder. Business Associate's obligation to indemnify any Indemnified Party shall survive the expiration or termination of this Agreement.

10. **Individuals' Rights.**

(a) Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner designated by the Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual, or a person or entity designated by the Individual in order to meet the requirements under Section 164.524 and HITECH Act Section 13405(e)(1).

(b) Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to make pursuant to Section 164.526, at the request of Covered Entity or an Individual, and in the time and manner designated by the Covered Entity.

(c) Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.

(d) Business Associate agrees to provide to Covered Entity or an Individual, in the time and manner designated by Covered Entity, information collected in accordance with Section 10(c) of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with Section 164.528.

(e) Business Associate agrees to comply with any restriction to the use or disclosure of Protected Health Information that Covered Entity agrees to in accordance with Section 164.522.

11. **Obligations of Covered Entity.**

(a) Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with Section 164.520, as well as any changes to such notice.

(b) Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, if such changes affect Business Associate's permitted or required uses and disclosures.

(c) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with Section 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

12. **Agents and Subcontractors of Business Associate.**

(a) Business Associate agrees to ensure that any agent, subcontractor, or other representative to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees in writing to the same restrictions, conditions and requirements that apply through this Agreement to Business Associate with respect to such information, including the requirement to promptly notify the Business Associate of any instances of unauthorized access to or use or disclosure of Protected Health Information of which it becomes aware. Upon request, Business Associate shall provide copies of such agreements to Covered Entity.

(b) Business Associate shall implement and maintain sanctions against any agent, subcontractor or other representative that violates such restrictions, conditions or requirements and shall mitigate the effects of any such violation.

13. **Audit, Inspection, and Enforcement.**

(a) Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity, available to any state or federal agency, including the Secretary, for the purposes of determining compliance with HIPAA and any related regulations or official guidance.

(b) With reasonable notice, Covered Entity and its authorized agents or contractors may audit and/or examine Business Associate's facilities, systems, policies, procedures, and documentation relating to the security and privacy of Protected Health Information to determine compliance with the terms of this Agreement. Business Associate shall promptly correct any violation of this Agreement found by Covered Entity and shall certify in writing that the correction has been made. Covered Entity's failure to detect any unsatisfactory practice does not constitute acceptance of the practice or a waiver of Covered Entity's enforcement rights under this Agreement.

14. **Permissible Requests by Covered Entity**. Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

15. **Term and Termination.**

(a) The terms of this Agreement shall remain in effect for the duration of all services provided by Business Associate under the Master Agreement and for so long as Business Associate remains in possession of any Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity unless Covered Entity has agreed in accordance with this section that it is not feasible to return or destroy all Protected Health Information.

(b) Upon termination of the Master Agreement, Business Associate shall recover any Protected Health Information relating to the Master Agreement and this Agreement in its possession and in the possession of its subcontractors, agents or representatives. Business Associate shall return to Covered Entity, or destroy with the consent of Covered Entity, all such Protected Health Information, in any form, in its possession and shall retain no copies. If Business Associate believes it is not feasible to return or destroy the Protected Health Information, Business Associate shall so notify Covered Entity in writing. The notification shall include: (1) a statement that the Business Associate has determined that it is not feasible to return or destroy the Protected Health Information in its possession, and (2) the specific reasons for such determination. If Covered Entity agrees in its sole discretion that Business Associate cannot feasibly return or destroy the Protected Health Information, Business Associate shall ensure that any and all protections, requirements and restrictions contained in the Master Agreement and this Agreement shall be extended to any Protected Health Information for so long as Business Associate maintains such Protected Health Information, and that any further uses and/or disclosures will be limited to the purposes that make the return or destruction of the Protected Health Information infeasible.

(c) Covered entity may immediately terminate the Master Agreement if it determines that Business Associate has violated a material term of this Agreement.

16. **Amendment.** The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity and Business Associate to

comply with the requirements of the HIPAA Privacy and Security Rules and the HITECH Act.

17. **Entire Agreement.** This Attachment constitutes the entire HIPAA Business Associate Agreement between the parties, and supersedes any and all prior HIPAA Business Associate Agreements between them.

18. **Notices.**

(a) All notices required or authorized by this Agreement shall be in writing and shall be delivered in person or by deposit in the United States mail, by certified mail, postage prepaid, return receipt requested. Any notice sent by mail in the manner prescribed by this paragraph shall be deemed to have been received on the date noted on the return receipt or five days following the date of deposit, whichever is earlier.

(b) Any mailed notice, demand, request, consent, approval or communication that Covered Entity desires to give to Business Associate shall be addressed to Business Associate at the mailing address set forth in the Master Agreement.

(c) Any mailed notice, demand, request, consent, approval or communication that Business Associate desires to give to Covered Entity shall be addressed to Covered Entity at the following address:

Mono County Privacy Officer
Office of County Counsel
P.O. Box 2415
Mammoth Lakes, CA 93546

(d) For purposes of subparagraphs (b) and (c) above, either party may change its address by notifying the other party of the change of address.

19. **Lost Revenues; Penalties/Fines.**

(a) Lost Revenues. Business Associate shall make Covered Entity whole for any revenues lost arising from an act or omission in billing practices by Business Associate.

(b) Penalties/Fines for Failure to Comply with HIPAA. Business Associate shall pay any penalty or fine assessed against Covered Entity arising from Business Associate's failure to comply with the obligations imposed by HIPAA.

(c) Penalties/Fines (other). Business Associate shall pay any penalty or fine assessed against Covered Entity arising from Business Associate's failure to comply with all applicable Federal or State Health Care Program Requirements, including, but not limited to any penalties or fines which may be assessed under a Federal or State False Claims Act provision.

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

Departments: Community Development - Planning

TIME REQUIRED

SUBJECT June Lake Citizens Advisory Committee Appointment

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Appointments to the June Lake Citizens Advisory Committee are required to be approved by the Board of Supervisors.

RECOMMENDED ACTION:

Appoint Brian McKinney to the June Lake Citizens Advisory Committee, term expiring December 31, 2023.

FISCAL IMPACT:

None.

CONTACT NAME: Michael Draper

PHONE/EMAIL: 7609241805 / mdraper@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

Click to download
Staff report
Application

History

Time	Who	Approval
9/4/2019 7:33 PM	County Administrative Office	Yes
9/4/2019 2:48 PM	County Counsel	Yes
8/29/2019 10:38 AM	Finance	Yes

Mono County
Community Development Department

PO Box 347
Mammoth Lakes, CA 93546
760.924.1800, fax 924.1801
commdev@mono.ca.gov

Planning Division

PO Box 8
Bridgeport, CA 93517
760.932.5420, fax 932.5431
www.monocounty.ca.gov

August 11, 2019

TO: Honorable Mono County Board of Supervisors

FROM: Michael Draper, Planning Analyst, for Bob Gardner, District 3 Supervisor

RE: June Lake Citizens Advisory Committee Appointments

RECOMENDATION
Appoint Brian McKinney to a four-year term on the June Lake Citizens Advisory Committee, expiring Dec. 31, 2023, as recommended by Supervisor Gardner.

FISCAL IMPACT
No fiscal impacts are expected.

DISCUSSION
The June Lake Citizens Advisory Committee (JLCAC) may consist of up to 10 members and two seats are currently vacant. Supervisor Gardner recommends appointing Brain McKinney to his first four-year term to fill one of the currently vacant seats. The application for the proposed member is attached and includes a statement of community interests. With the seat filled, the June Lake Citizens Advisory Committee will consist of 9 members. Terms last for four years and are be staggered to facilitate smooth transitions. The following summarizes the status of appointments and CAC membership:

Proposed appointment for term expiring Dec. 31, 2023:

1. Brian McKinney

Existing Members	**Term Expires**
2. David Rosky	12-31-20
3. Lindsay Chargin	12-31-20
4. John DeCoster	12-31-20
5. Julie Brown	12-31-22
6. Jora Fogg	12-31-22
7. Janet Hunt	12-31-22
8. Sarah Holston	12-31-22
9. Joseph Bogorad	12-31-23

If you have questions regarding this matter, please contact Michael Draper at 760.924.1805 or Supervisor Gardner.

ATTACHMENTS:

- Application for Brian McKinney

Regional Planning Advisory Committees

P.O. Box 347
Mammoth Lakes, CA 93546
760- 924-1800 phone, 924-1801 fax
commdev@mono.ca.gov

P.O. Box 8
Bridgeport, CA 93517
760-932-5420 phone, 932-5431 fax
www.monocounty.ca.gov

MEMBERSHIP APPLICATION

This application is for membership in the following RPAC (choose one):

- ☐ Antelope Valley
- ☐ Benton/Hammil
- ☐ Bridgeport Valley
- ☐ Chalfant Valley
- ☑ June Lake CAC (Citizens Advisory Committee)
- ☐ Long Valley
- ☐ Mono Basin
- ☐ Swall Meadows

Name Brian McKinney

Address [redacted]

City/State/Zip June Lake CA 93529

Phone (day) [redacted] Phone (eve.) [redacted]

Email [redacted]

Occupation/Business Physician

Special interests or concerns about the community:

I have been coming to June Lake since I was a child and recently have been fortunate enough to buy a condo in this area. I very much desire to help develop economic development and opportunities in a way that preserves its small-town charm, the integrity of the pristine outdoor recreation and prioritizes the needs of residents.

Signature B- McKinney Date 6/27/19

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

TIME REQUIRED

SUBJECT Los Angeles Department of Water and Power Temporary Urgency Change Petition to Deviate from Stream Restoration Flow Requirements

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

LADWP letter to the California State Water Resources Control Board requesting approval of its TUCP, affecting Rush, Lee Vining, Walker, and Parker Creeks.

RECOMMENDED ACTION:

FISCAL IMPACT:

CONTACT NAME:

PHONE/EMAIL: /

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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Letter

History

Time	Who	Approval
9/4/2019 7:35 PM	County Administrative Office	Yes
9/4/2019 2:51 PM	County Counsel	Yes
9/4/2019 3:51 PM	Finance	Yes

Board of Supervisors
Mono County

LA DWP Los Angeles Department of Water & Power

CUSTOMERS FIRST

August 27, 2019

Mr. Erik Ekdahl
Deputy Director
Division of Water Rights
State Water Resources Control Board
1001 I Street, 14th Floor
Sacramento, California 95814

Dear Mr. Ekdahl:

Subject: Temporary Urgency Change Petition to Deviate From the Stream Restoration Flow Requirements

The Los Angeles Department of Water and Power (LADWP) requests that the State Water Resources Control Board (SWRCB) approve this Temporary Urgency Change Petition (TUCP), pursuant to Water Code Section 1435, to temporarily deviate from the Stream Restoration Flow requirements as outlined in the SWRCB Order 98-05.

Upon approval of the TUCP, flows will be scheduled in Rush, Lee Vining, Walker, and Parker Creeks in accordance with the enclosed "MONO BASIN OPERATIONS PLAN UNDER THE 2019 TUCP" (OP). The OP was sent to representatives from the California Department of Fish and Wildlife, Mono Lake Committee, CalTROUT, and stream scientists Dr. Bill Trush and Mr. Ross Taylor for comments. There is consensus to support the OP as enclosed.

The above flows are the Stream Ecosystem Flows (SEFs) recommended by the SWRCB-appointed stream scientist in the 2010 Synthesis of Instream Flow Recommendations to the State Water Resources Control Board and the Los Angeles Department of Water and Power. With the approval of this TUCP, almost a full year (360 days) of testing the implementation of the SEFs will conclude on March 28, 2020. The above requested action is exempt from the California Environmental Quality Act pursuant to Public Resources Code Section 15301(i).

Mono Basin Distribution List

Mr. Erik Ekdahl Division of Water Rights State Water Resources Control Board 1001 I Street, 14th Floor Sacramento, CA 95814	Ms. Lisa Cutting Mono Lake Committee P.O. Box 29 Lee Vining, CA 93541
Ms. Amanda Montgomery Division of Water Rights State Water Resources Control Board 1001 I Street, 14th Floor Sacramento, CA 95814	Board of Supervisors Mono County P.O. Box 715 Bridgeport, CA 93517
Mr. Scott McFarland Division of Water Rights State Water Resources Control Board 1001 I Street, 14th Floor Sacramento, CA 95814	Ms. Janet Hatfield California Trout Inc. P.O. Box 3442 Mammoth Lakes, CA 93546
Dr. William Trush Humboldt State University River Institute c/o Dept of Environmental Science & Mgmt 1 Harpst Street Arcata, CA 95521-8299	Mr. Richard Roos-Collins Water and Power Law Group 2140 Shattuck Avenue, Suite 801 Berkeley, CA 94704-1229
Mr. Ross Taylor 1254 Quail Run Court McKinleyville, CA 95519	Mr. Marshall S. Rudolph Mono County Counsel P.O. Box 2415 Mammoth Lakes, CA 93546
Mr. Jon C. Regelbrugge USDA Forest Service P.O. Box 148 Mammoth Lakes, CA 93546	Mr. Steve Parmenter Department of Fish and Wildlife 787 North Main Street, Suite 220 Bishop, CA 93514
Ms. Tamara Sasaki California Department of Parks and Recreation P.O. Box 266 Tahoma, CA 96142	Mr. Doug Smith Grant Lake Reservoir Marina P.O. Box 21 June Lake, CA 93529
Mr. Matthew Green California Department of Parks and Recreation P.O. Box 266 Tahoma, CA 96142	

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

Departments: Board of Supervisors

TIME REQUIRED 10 minutes

SUBJECT Inyo National Forest Springs Fire Update

PERSONS APPEARING BEFORE THE BOARD Gordon Martin, Mammoth - Mono Basin District Ranger

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

An update from Inyo National Forest staff regarding the Springs Fire, 13 miles South East of Lee Vining, CA.

RECOMMENDED ACTION:

None, informational only.

FISCAL IMPACT:

None.

CONTACT NAME: Scheereen Dedman

PHONE/EMAIL: x5538 / sdedman@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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No Attachments Available

History

Time	Who	Approval
9/4/2019 7:33 PM	County Administrative Office	Yes
9/4/2019 2:46 PM	County Counsel	Yes
9/4/2019 3:51 PM	Finance	Yes

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

Departments: Assessor

TIME REQUIRED 5 minutes

SUBJECT Assessor Compensation Review

PERSONS APPEARING BEFORE THE BOARD Barry Beck

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Proposed resolution increasing the elected Assessor's salary from $9,180 to $10,000 per month, in order to provide parity and salary structure to the Office of the Assessor.

RECOMMENDED ACTION:

Read fiscal impact. Approve proposed resolution R19-_____, amending the rate of pay for the position of the Mono County Assessor, in order to provide parity and salary structure to the Office of the Assessor. Provide any desired direction to staff.

FISCAL IMPACT:

The fiscal impact to the general fund is to increase expenditures by $14,310 annually, of which $9,840 is salary and $4,470 is for benefits. The amount was not included in the fiscal year 2019-2020 adopted budget.

CONTACT NAME: Barry Beck

PHONE/EMAIL: 760-932-5510 / bbeck@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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Staff Report
Resolution
Comparison Chart

History

Time	Who	Approval

9/4/2019 7:31 PM	County Administrative Office	Yes
9/5/2019 8:46 AM	County Counsel	Yes
9/5/2019 1:22 PM	Finance	Yes

OFFICE OF THE ASSESSOR
COUNTY OF MONO
P.O. BOX 456, BRIDGEPORT, CALIFORNIA 93517

BARRY BECK, ASSESSOR
(760) 932-5510 FAX (760) 932-5511

To: Honorable Board of Supervisors
From: Barry Beck, Mono County Assessor
Date: September 10, 2019
Subject: Salary Adjustment for the County Assessor Position

Recommendation

Approve proposed resolution increasing the salary for the Assessor position.

Discussion and Justification

Internal Equity - An analysis of salaries for the Assessor, District Attorney, and Sheriff was performed for the period of 2012 through 2019. During the period of 2012 through 2019 the salary of the District Attorney and Sheriff have increased while the Assessor salary has decreased.

	2012	2019
Assessor	$9,564	$9,180
District Attorney	$11,968	$12,447
Sheriff	$11,968	$12,207

Although there was an economic downturn during this period, the cost of living increased, and it would be reasonable to consider this when evaluating salaries, especially as the downturn has been followed by a strong economic recovery.

Salary Compaction – Currently, the Assessor is paid 8.5% more than the Assistant Assessor. The California State Board of Equalization, the oversite organization of County Assessor functions, conducts annual salary surveys for assessor's offices throughout California. In the most recent survey, the average salary spread between the Assessor and the Assistant Assessor is 26.5%. The requested salary for the Mono County Assessor would create a differential between the Assessor and Assistant Assessor of 15.4%, considerably less than the California average, which is an indication of the conservative approach taken in making this request.

The County Administrative Officer and Human Resources Director have reviewed the historical data and salary proposal and they support this request.

I appreciate the opportunity to present to the Mono County Board of Supervisors and request approval to increase the Assessor salary from $9,180 to $10,000 per month.

Fiscal Impact

Approximate annual impact to the general fund is $14,310 of which $9,840 is for salary and $4,470 is for benefits.

R19-__

A RESOLUTION OF THE MONO COUNTY BOARD OF SUPERVISORS AMENDING THE RATE OF PAY FOR THE POSITION OF THE MONO COUNTY ASSESSOR, IN ORDER TO PROVIDE PARITY AND SALARY STRUCTURE TO THE OFFICE OF THE ASSESSOR

WHEREAS, the Mono County Board of Supervisors has the authority under Section 25300 of the Government Code and Article 11, section 4(c) of the California Constitution to prescribe the compensation, appointment, and conditions of employment of County employees and elected officials; and

WHEREAS, the Board of Supervisors wishes to increase the rate of pay to the position of the Assessor to address the fact that the Assessor's compensation has decreased though other county-wide elected officials have not decreased, and to address organizational compaction within the Office of the Assessor; and

NOW, THEREFORE, THE BOARD OF SUPERVISORS OF THE COUNTY OF MONO RESOLVES that: The compensation of the Assessor is hereby increased to $10,000 per month.

PASSED, APPROVED and **ADOPTED** this 10th day of September 2019, by the following vote, to wit:

AYES:

NOES:

ABSENT:

ABSTAIN:

_____
John Peters, Chair
Mono County Board of Supervisors

ATTEST:

APPROVED AS TO FORM:

Clerk of the Board	County Counsel

Surveyed Agencey	Classification Title	2012 Monthly Max	2013	2014	2015	2016	2017	2018 Monthly Max	Percentage Differential	Assistant Assessor	Assistant % of	Staff Count	Roll Value	Parcel Count	15 Most Similar Cost of Living	Classification Title	2018 Monthly Max
Mono	Assessor	$9,564	$9,000	$9,000	$9,000	$9,000	$9,000	$9,180	-4.02%	$8,458	8.54%	10	$6,007,297,744	17,320	Mono	Assessor	$9,180
Amador	Assessor	$8,258	$8,258	$8,258	$8,258	$8,258	$8,678	$8,764	6.13%	$7,136	22.81%	11	$5,270,314,705	23,780	Santa Cruz	Assessor	$18,699
Calaveras	Assessor	$8,203	$8,618	$8,618	$8,963	$8,963	$8,963	$8,963	9.26%	No Info	No Info	e 13	$7,197,591,252	45,148	Orange	Assessor	$16,113
Colusa	Assessor	$6,738	$7,400	$7,400	$7,400	$7,635	$9,974	$10,177	51.04%	$6,740	50.99%	11	$3,236,950,477	15,838	Ventura	Assessor	$16,514
Glenn	Assessor-Recorder-Clerk	$7,860	$8,179	$8,179	$8,179	$8,343	$8,343	$8,343	6.15%	$6,665	25.18%	7	$3,144,768,883	14,442	San Diego	Assessor	$16,594
Inyo	Assessor	$7,654	$8,587	$8,587	$8,759	$8,934	$8,934	$9,113	19.06%	$6,574	38.62%	9	$4,479,290,670	16,647	Sonoma	Assessor	$15,288
Lake	Assessor Recorder	$7,334	$7,334	$7,334	$7,334	$8,067	-	$8,067	9.99%	N/A	N/A	e 15.6	$6,973,813,864	62,523	Napa	Assessor	$15,860
Lassen	Assessor	$7,340	$7,831	$7,831	-	$8,027	$8,433	$8,433	14.89%	N/A	N/A	10.5	$2,173,252,927	29,276	Los Angeles	Assessor	$17,776
Mariposa	Assessor Recorder		$6,926	$6,926	$6,927	$8,243	$8,655	$8,243		$6,994	17.86%	12	$2,337,177,541	13,715	San Benito	Assessor	$13,588
Nevada	Assessor	$9,957	$10,156	$10,156	$10,889	$11,218	$11,786	$12,139	21.91%	$10,953	10.83%	26	$19,723,032,156	64,777	Nevada	Assessor	$12,139
Plumas	Assessor	$6,232	$6,232	$6,232	$6,232	$6,232	$6,232	$6,232	0.00%	$5,145	21.13%	8	$3,769,470,953	25,777	Santa Barbara	Assessor	$17,332
Siskiyou	Assessor/Recorder	$7,464	$7,465	$7,465	$7,465	$7,465	$7,465	$8,179	9.58%	N/A	N/A	15	$4,720,874,347	44,500	Solano	Assessor	$15,344
Sutter	Assessor		$9,724	$9,724	$9,762	$9,957	$9,919	$10,117		$8,200	23.38%	18	$8,551,502,205	34,701	Monterey	Assessor	$17,434
Tehama	Assessor	$8,115	$8,115	$8,115	$8,115	$8,115	$9,171	$9,541	17.57%	N/A	N/A	16	$5,625,782,464	46,202	San Luis Obispo	Assessor	$14,465
Trinity	Clerk/Recorder/Assessor		$6,647	$6,647	$6,330	$6,647	-	$8,302		No Info	No Info	e 4	$1,636,769,047	12,515	Yolo	Assessor	$12,889
Tuolumne	Assessor-Recorder	$8,824	$8,824	$8,824	$9,442	$9,442	$10,520	$11,058	25.32%	$8,618	28.31%	11	$7,370,556,333	38,227	El Dorado	Assessor	$11,999
							Average	$9,053	15.91%	Average	26.57%					Average	$15,076
							Median	$8,864	12.44%	Median	23.10%					Median	$15,602

Inflation adjustment from 2012 to 2019 - 10.5%

U.S. Department of Labor Bureau of Labor Statistics states that $9,564 in 2012 is equivalent to $10,726 in March 2019.

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

Departments: Public Health

TIME REQUIRED 45 minutes (30 minute presentation, 15 minutes for questions)

SUBJECT 2019 Mono County Community Health Needs Assessment

PERSONS APPEARING BEFORE THE BOARD Sandra Pearce

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Presentation by Public Health regarding the 2019 Mono County Community Health Needs Assessment.

RECOMMENDED ACTION:

None (informational only). Provide any desired direction to staff.

FISCAL IMPACT:

None

CONTACT NAME: Sandra Pearce

PHONE/EMAIL: 760.924.1818 / spearce@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

Click to download
BOS Staff Report
2019 Community Health Needs Assessment

History

Time	Who	Approval
9/4/2019 7:29 PM	County Administrative Office	Yes
8/28/2019 12:03 PM	County Counsel	Yes
8/30/2019 11:05 AM	Finance	Yes

MONO COUNTY HEALTH DEPARTMENT
Public Health

P.O. BOX 476, BRIDGEPORT, CA 93517 PHONE (760) 932-5580 • FAX (760) 924-1831
P.O. BOX 3329, MAMMOTH LAKES, CA 93546 PHONE (760) 924-1830 • FAX (760) 924-1831

DATE: September 10, 2019

TO: Honorable Board of Supervisors

FROM: Sandra Pearce, Public Health Director

SUBJECT: 2019 Mono County Community Health Needs Assessment

Recommendation:

None (informational only). Provide any desired direction to staff.

Discussion:

Mammoth Hospital and Mono County Health Department worked collaboratively with the consultant HealthTechS3 to develop the 2019 Mono County Community Health Needs Assessment (CHNA). Mammoth Hospital is required to complete a CHNA every 3 years under regulations from the Patient Protection and Affordable Care Act (ACA), and the timing aligned with the needs assessments that the Health Department was required to complete for the Maternal, Child & Adolescent Health (MCAH) Program and Local Oral Health Program (LOHP) in FY 2018-19. The CHNA defines priorities for health improvement, with an emphasis on the needs of populations that are at risk for poor health outcomes due to geographic, language, financial, or other barriers; commonly referred to as social determinants of health. The CHNA process creates a platform to engage community stakeholders and to understand the needs of the community.

Through data analysis, a focus group, stakeholder interviews, and surveys, four health priorities were identified, and will be addressed over the next three years as part of the Community Health Improvement Plan (CHIP). These priorities include the following:

1. **Substance Abuse Prevention and Treatment**
    - Provide additional treatment options
    - Develop networks and sources for follow-up care
    - Implement provider training
    - Provide community education
    - Enforcement
2. **Behavioral Health Access, Prevention, and Treatment**
    - Increase access to behavioral health care

- Provide services for youth and children with a focus on depression, suicidal ideation. and Adverse Childhood Events (ACEs)
- Provide preventative care and treatment options for adults with a focus on anxiety and depression including Seasonal Affective Disorder
- Consider the impact of Social Determinants of Health on behavioral health such as isolation, housing, and poverty
- Research and implement Trauma-Informed Care

3. **Clinical Care Access and Preventative Care**
    - Provide education and services focused on prevention and promotion of a healthy lifestyle
    - Increase access to primary care and preventative services
4. **Dental Care Access and Preventative Care**
    - Increase access to dental care for children
    - Increase access to dental care for adults
    - Integrate dental care screening as part of primary care practices
    - Provide community education regarding the importance of dental care

Four community and stakeholder workshops will be held in September 2019 to address each of these priorities, and develop interventions for health improvement for the Community Health Improvement Plan. The public workshops will be held at Mammoth Hospital Conference Rooms A/B at the following dates and times:

1. Substance Abuse: Monday, September 16 from 1-4pm
2. Dental Care/Oral Health: Tuesday, September 17 from 1-4pm
3. Behavioral Health: Wednesday, September 18 from 8am-12pm
4. Clinical Care Access/Prevention: Wednesday, September 18 from 1-4pm

Fiscal Impact:

There is no fiscal impact to the County General Fund.

For questions about this item, please call Sandra Pearce at (760) 924-1818.

Submitted by:

Sandra Pearce, Public Health Director

2019

COMMUNITY HEALTH NEEDS ASSESSMENT

Paper copies of this document may be obtained In-person at the following locations:

Mammoth Hospital Administration
Address: 85 Sierra Park Road, PO Box 660, Mammoth Lakes, CA 93546
Phone: (760)-934-3311
Web site: www.http://mammothhospital.org

Mono County Health Department
Address: 437 Old Mammoth Road, Suite Q, Mammoth Lakes, CA 93546
Phone: (760) 924-1830
Web site: https://monohealth.com

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OVERVIEW AND INTRODUCTION

REGULATORY REQUIREMENTS

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, added a requirement that hospitals covered under section §501(r) of the Internal Revenue Code conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy to meet the community health needs identified through the CHNA at least once every three years.

While Mammoth Hospital is required to complete a CHNA every 3 years, the timing aligned with the needs assessments that the Health Department was required to complete for the Maternal, Child & Adolescent Health (MCAH) Program and Local Oral Health Program (LOHP).

In 1992, the Federal Maternal Child Health Bureau required that all Title V funded State agencies perform a 5-year needs assessment using a set of specifically stated indicators and to identify priorities of action. In 1998, the California MCAH Program required local health jurisdictions to monitor these indicators and incorporate them into their 5-year needs assessment and action plans.

The California Oral Health Program (OHP) was established in 2014, and with the passage of Proposition 56 (The California Healthcare, Research and Prevention Tobacco Tax Act of 2016), was given legislative authority to build capacity and infrastructure for the development, implementation, and evaluation of best practices and evidence-based programs in oral disease prevention. Local health jurisdictions were allocated 5-year grants for years 2017-2022 and required to complete a needs assessment and improvement plan, followed by program implementation.

The CHNA defines priorities for health improvement, with an emphasis on the needs of populations that are at risk for poor health outcomes due to geographic, language, financial, or other barriers; commonly referred to as social determinants of health. The CHNA process creates a platform to engage community stakeholders and to understand the needs of the community.

COMMUNITY HEALTH NEEDS ASSESSMENT AND COLLABORATION

Mammoth Hospital and Mono County Health Department worked collaboratively to develop the 2019 Mono County Community Health Needs Assessment. Both organizations define their service area as Mono County.

MAMMOTH HOSPITAL

Mammoth Hospital is a 17-bed federally designated Critical Access Hospital (CAH) that is owned and operated by the Southern Mono Healthcare District, a public entity. The hospital operates a provider-based rural health clinic and is the sole provider of hospital, clinic, and safety net services in the remote, rural mountain region of southern Mono County, California.

The hospital is located in the town of Mammoth Lakes, home of one of the largest ski areas in the nation. This Eastern Sierra region plays host to over 3 to 4 million visitors annually.

OUR VISION

Meticulous Care - Memorable People - Majestic Location

OUR MISSION

To promote the well-being and improve the health of our residents and guests

OUR VALUES

- **Excellence** - We will provide an experience that surpasses all expectations.
- **Leadership** - We believe that effective leadership begins with a commitment to serve others.
- **Empathy** - We will look through the lens of others without judgment.
- **Value** - We will provide worth that pleases and surprises.
- **Accountability** - We will honor and fulfill our agreements and promises.
- **Trust** - We will cherish and respect the privilege and responsibility of our calling to serve others.
- **Encouragement** - We will inspire courage and confidence to overcome adversity and enable healing.

In addition to family medicine, women's health (including labor and delivery), pediatric, and dental services through the rural health clinic, the hospital offers general surgery, orthopedic surgery, and 24-hour emergency care. There is a full-service laboratory onsite and advanced medical imaging services, including computed tomography (C.T.), magnetic resonance imaging (MRI), interventional procedures, ultrasound, mammography, and bone densitometry (DEXA-scan). Specialty services of dermatology; cardiology; podiatry, ear, nose & throat; and urology are available on a part-time basis through visiting specialists. Orthopedic sub-specialty services are offered for spine, foot and ankle, and hand. The District operates orthopedic and physical therapy services in neighboring Inyo County. There are currently a total of nine (9) outpatient clinics.

MONO COUNTY HEALTH DEPARTMENT

The Mono County Health Department provides environmental and public health services that support the health and safety of Mono County residents and visitors.[1] Environmental Health programs include the Certified Unified Program Agency (CUPA), Food Safety, Land Use, Private Wells, Radon, Recreational Health, Small Water Systems, Solid Waste, Vector Control, and Wastewater. Public Health programs include Children's Medical Services (CMS); Communicable Disease; Emergency Preparedness; Immunizations; Local Oral Health; Maternal, Child & Adolescent Health; STD & HIV/AIDS; Tobacco Education; Women, Infants and Children (WIC); and Public Health Community Clinics. Collaboratives facilitated by Public Health include the Breastfeeding Taskforce, Local Oral Health Coalition, Nutrition & Physical Activity Taskforce (NPAT), Prevention Coalition, and Worksite Wellness Committee.

OUR MISSION AND VISION

To promote and protect a Mono County culture of health and safety in the community and environment through outreach, education, and prevention.

OUR CORE VALUES

- Wellness
- Integrity
- Respect
- Caring
- Excellence in Quality and Service
- Personal and Professional Growth
- Collaboration
- Flexibility

Each day, the Mono County Health Department works to protect, prevent, and promote. We protect communities from health threats such as contaminated water, foodborne illness, toxic exposures, preventable injury and illness, and the effects of natural and man-made disasters. We prevent disease through immunizations, surveillance, investigation, screening, treatment, linkage to care and services, and case management. We promote wellness through outreach, education, policy and program development, and collaboration with community partners. As opportunities and challenges continue to shift in the public health landscape, our department must maintain flexibility and change to meet the needs of the County.

2019 CHNA

Copies of the 2019 CHNA may be obtained from the following locations:

Mammoth Hospital Administration

Address: 85 Sierra Park Road, PO Box 660, Mammoth Lakes, CA 93546
Phone: (760)-934-3311
Web site: www.http://mammothhospital.org

Mono County Health Department

Address: 37 Old Mammoth Road, Suite Q, Mammoth Lakes, CA 93546
Phone: (760) 924-1830
Web site: https://monohealth.com

CONSULTANTS

Mammoth Hospital and Mono County Health Department contracted with HealthTechS3 (HTS3) to assist in conducting the 2019 Community Health Needs Assessment. HealthTechS3 is a healthcare consulting and hospital management company based in Brentwood, Tennessee. Carolyn St.Charles, Regional Chief Clinical Officer and Cheri Benander, HealthTechS3 Consultant were the principal consultants for the project.

EXECUTIVE SUMMARY

GEOGRAPHIC ASSESSMENT AREA

Mono County is a rural community located between the Sierra Nevada Mountains and the California/Nevada border. The county is 3,030 square miles in size and in some areas the elevation reaches over 13,000 feet. The county seat is Bridgeport, and the only incorporated town is Mammoth Lakes, which has a population of approximately 7,500 people but can swell to as many as 35,000 with winter visitors.[2]

Mammoth Hospital and the Mono County Health Department's service area is Mono County.

Mono County was utilized as the CHNA geographic area and the source of county data. Mono County includes medically underserved, low-income, and minority populations. The zip codes for both incorporated and unincorporated communities in Mono County are included in the table.

All residents of Mono County were used to determine the CHNA geographic area.

MONO COUNTY	
93512	Benton
93514	Chalfant / Hammil Valley / Swall Meadows / Paradise
93517	Bridgeport
93529	June Lake
93541	Lee Vining / Mono City / Mono Lake
93546	Mammoth Lakes / Crowley Lake / Sunny Slopes / Lake Mary / Tom's Place
96107	Coleville / Walker
96133	Topaz

[2] *Mono County Website. https://www.monocounty.ca.gov/business/mono-county*

STEERING COMMITTEE

The steering committee established the framework and methodology for conducting the CHNA and provided guidance and direction throughout the process. The steering committee members included:

Gary Myers	Chief Executive Officer, Mammoth Hospital Through December 3
Tom Parker	Chief Executive Office, Mammoth Hospital As of December, 3
Craig Burrows, MD	Chief Medical Officer, Mammoth Hospital
Kathleen Alo, RN, CPHQ	Chief Nursing Officer, Mammoth Hospital
Lenna Monte	Director of Quality, Mammoth Hospital
Sarah Rea	Administrative Assistant, Mammoth Hospital
Sandra Pearce, RN, PHN, CNS	Public Health Director, Mono County
Tom Boo, MD	Public Health Officer, Mono County
Jacinda Croissant, RN, PHN	Health Program Manager / Public Health Nurse, Mono County Maternal Child Adolescent Health Director
Shelby Stockdale, RN, PHN	Health Program Manager / Public Health Nurse, Mono County Local Oral Health Program Coordinator

RESEARCH METHODOLOGY

The CHNA was conducted between October 2018 and June 2019. Both quantitative and qualitative methods were utilized to gather data about Mono County.

QUANTITATIVE DATA

A variety of sources were used to identify community health trends and health disparities including but not limited to: iVantage Health Analytics, County Health Rankings, Community Commons, Centers for Disease Control (CDC) BRFSS, California Department of Public Health, California Department of Health Care Services, DataQuest, American Lung Association, U.S. Census Bureau, National Center for Education, and the Bureau of Labor Statistics.

Every effort was made to obtain the most current data. Data were analyzed for comparison purposes with the United States, the state, counties within the state, and Healthy People 2020

when comparative data was available. Unless otherwise sourced in the report, data were abstracted from iVantage Health Analytics.

QUALITATIVE DATA

Qualitative data collection included key stakeholder interviews, a key stakeholder survey, a community survey, and a community focus group.

Key Stakeholder Interviews

Stakeholder interviews were conducted with individuals representing the broad interests of the community including public health, tribal health, and individuals with knowledge of the medically underserved, low–income, minority populations, and populations with chronic disease. Individuals to be interviewed were recommended by the steering committee, Mammoth Hospital leadership, and Mono Public Health leadership.

Twenty-seven (27) interviews were completed by phone between January and March 2019. A list of key stakeholders that were interviewed is in *Appendix 2*. A summary of those interviews is included in *Appendix 3*.

Key Stakeholder Survey

A survey was distributed to key stakeholders, including those that were interviewed, between January and February 2019, with a total of thirty-six (36) respondents.

The stakeholders responding to the survey included individuals that represented organizations that provide services to women, teens, children, residents over the age of 65, ethnic minorities, Native Americans, the homeless, individuals with limited English proficiency, individuals with chronic diseases, survivors of domestic abuse, individuals with mental illness and addiction, and those that provide recreational and emergency services to the community. A summary of the key stakeholder survey is included in *Appendix 4*.

Community Survey

A community survey was conducted from February 1, 2019, to March 7, 2019. The survey, in both English and Spanish, was distributed in various public locations including community clinics, health and human services agencies, and libraries, and was also made available electronically.

There were 355 respondents representing the communities of Benton, Hammil Valley, Chalfant, Bishop, Bridgeport, Crowley Lake, Sunny Slopes, June Lake, Mammoth Lakes, Mono City, Lee Vining, McGee Creek, Swall Meadows, Paradise, Topaz, Coleville, and Walker. One survey was completed by a resident of Fish Lake Valley in Nevada. Most survey respondents were from Mammoth Lakes. A summary of the community survey is included in *Appendix 5*.

Community Focus Group

A focus group was held on October 26, 2018, to gather information regarding the current health status of Mono County and to elicit suggestions for improvements. Sixty-two (62) people were in attendance, representing various service organizations throughout the county. A summary of the focus group meeting is included in *Appendix 6*.

GAP ANALYSIS

Data were obtained from all sources required by the Internal Revenue Code §501(r) in the completion of the 2019 CHNA.

The 2019 CHNA includes:

- Community demographics and populations served
- Methods for obtaining, analyzing and synthesizing data about the health needs of the community
- Process for consulting with persons representing the broad interest of the community, including those with special knowledge of or expertise in public health and/or tribal health
- Process and criteria used to identify the health needs of the community as significant and to prioritize those needs
- Resources to address priority community health needs

Mammoth Hospital and Mono County Health Department are not aware of any information gaps affecting the assessment or prioritization of community health needs.

RESOURCES

A list of resources currently available to meet the health needs of Mono County residents are included in Appendix 1. The list of resources is current as of June 2019.

PRIORITY COMMUNITY HEALTH NEEDS

Prioritization Committee

The CHNA Steering Committee, with the addition of individuals from both Mammoth Hospital and Mono County Health Department, met on May 8, 2019, to review the primary and secondary data and identify community health priorities. Attendees included:

Tom Parker	Chief Executive Office, Mammoth Hospital
Kathleen Alo, RN, CPHQ	Chief Nursing Officer, Mammoth Hospital
Lenna Monte	Director of Quality, Mammoth Hospital
Kate Britton	Population Health Manager, Mammoth Hospital
Lori Ciccarelli	Patient Experience Manager, Mammoth Hospital
Caitlin Crunk, RN	Med Surg Nurse Manager, Mammoth Hospital
Sarah Rea	Administrative Assistant, Mammoth Hospital
Sandra Pearce, RN, PHN, CNS	Public Health Director, Mono County
Tom Boo, MD	Public Health Officer, Mono County
Jacinda Croissant, RN, PHN	Health Program Manager / Public Health Nurse, Mono County Maternal Child Adolescent Health Director
Shelby Stockdale, RN, PHN	Health Program Manager / Public Health Nurse, Mono County Local Oral Health Program Coordinator
Bryan Wheeler, RN, PHN	Health Program Manager / Public Health Nurse, Mono County

Quantitative and Qualitative Data

The quantitative and qualitative data that had been collected as part of the CHNA process was reviewed, including the most important health concerns identified by the community and key stakeholders, as outlined below.

ADULTS	
KEY STAKEHOLDERS	**COMMUNITY**
1. Alcohol Use 2. Mental Health 3. Illegal Drug Use 4. Stress 5. Overweight / Obesity	1. Mental Health 2. Alcohol Use 3. Cancer 4. Illegal Drug Use 5. Diabetes

CHILDREN	
KEY STAKEHOLDERS	**COMMUNITY**
1. Overweight / Obesity 2. Vaping 3. Alcohol Use 4. Dental Health 5. Stress	1. Mental Health 2. Vaping 3. Dental Health 4. Overweight / Obesity 5. Alcohol Use

Prioritization Criteria

The committee elected to utilize five criteria to prioritize community health needs.

Magnitude / Scale of the Problem: The health need affects a large number of people within our community.

Severity of the Problem: The health need has serious consequences (morbidity, mortality, and economic burden) for those affected. There are significant consequences to the community if the problem is not addressed.

Health Disparities: The health needs disproportionately impact the health status of one or more vulnerable populations or groups.

Importance to the Community: The health need is of significant importance to the community.

Ability to Leverage: The opportunity to collaborate with existing community partnerships to address the health need or to build on current programs.

Prioritized Community Health Needs

Each attendee was asked to identify the three most important community health issues using the prioritization criteria as a guide. Although initially, the committee had determined they would select three priorities, the consensus was to expand to four based on the voting process and group discussion. The 2019 community health priorities were:

1. **Substance Abuse Prevention and Treatment**
    - Provide additional treatment options
    - Develop networks and sources for follow-up care
    - Implement provider training
    - Provide community education
    - Enforcement

2. **Behavioral Health Access, Prevention, and Treatment**
    - Increase access to behavioral health care
    - Provide services for youth and children with a focus on depression, suicidal ideation. and Adverse Childhood Events (ACEs)
    - Provide preventative care and treatment options for adults with a focus on anxiety and depression including Seasonal Affective Disorder
    - Consider the impact of Social Determinants of Health on behavioral health such as isolation, housing, and poverty
    - Research and implement Trauma-Informed Care

3. **Clinical Care Access and Preventative Care**
    - Provide education and services focused on prevention and promotion of a healthy lifestyle
    - Increase access to primary care and preventative services

4. **Dental Care Access and Preventative Care**
    - Increase access to dental care for children
    - Increase access to dental care for adults
    - Integrate dental care screening as part of primary care practices
    - Provide community education regarding the importance of dental care

The four priorities are in alignment with the community health needs identified by key stakeholders and the community.

Each of the priorities, including a summary of data relative to each priority, are included in the following sections. Additional detail is included in the main report and the appendixes.

A health improvement plan based on the four (4) priorities will be developed by mid-October 2019 in collaboration with community partners.

COMMUNITY HEALTH PRIORITY 1: SUBSTANCE ABUSE PREVENTION AND TREATMENT

SUMMARY INFORMATION REGARDING THE PRIORITY

Tobacco

A study published by the Journal of the American Medical Association (JAMA), in 2018, identified risk-factors that contributed to disability-adjusted life-years. In California, the second highest risk factor was alcohol and drug use, and the fourth highest risk factor was tobacco use.[3]

The American Lung Association evaluates local efforts towards tobacco control. According to the report, an overall Tobacco Control Grade is a letter grade awarded to the municipality based on its points received in each of the following areas; smoke-free outdoor air, smoke-free housing, and reducing sales of tobacco products. Points from these categories were added together with any emerging issue bonus points received. The points correlate to a letter grade A-F. For 2019, Mammoth Lakes received an overall tobacco control grade of C while the unincorporated areas of Mono County received a grade of D.

For years 2014 – 2016, the smoking prevalence among adults in the Sierra Region including Alpine, Amador, Calaveras, Inyo and Mono (Eastern Sierra) counties was 12.6% which is slightly higher than the rate in California of 11%, but is not statistically different from the Healthy People 2020 target of 12%.[4] California's adult cigarette smoking rate varies by population density, with higher rates predominantly in rural counties.

The California Healthy Kids Survey (CHKS) was developed by the California Department of Education and is administered annually in school districts throughout the state. Student participation is voluntary and confidential.

The 2017-2018 CHKS includes multiple indicators related to the use of tobacco by youth, which are included in Appendix 7. Indicators include:

- 4.3% of 11th graders in the state report current cigarette smoking compared to 0% at Eastern Sierra Unified School District (ESUSD) and 5% at Mammoth Unified School District (MUSD).
- 31.2% of 11th graders in the state report that it is very difficult to obtain cigarettes compared to 17% at ESUSD and 11% at MUSD.
- 1.7% of 11th graders in the state report current smokeless tobacco use compared to 0% at ESUSD and 1% at MUSD.

[3] *The US Burden of Disease Collaborators. The State of US Health, 1990 – 2016 Burden of Disease, injuries, and Risk Factors among US States. JAMA. 2018;319(14):1444-1472. doi:10.1001/jama.2018.0158*

[4] *California Department of Public Health, California Tobacco Control Program, California Tobacco Facts & Figures 2018*

- 42% of 11th graders in the state report great harm of occasional cigarette smoking compared to 29% at ESUSD and 44% at MUSD.
- 4% of 11th graders in Eastern Sierra Unified School District (ESUSD) report both current use of electronic cigarettes and using electronic cigarettes at school. 27% of Mammoth Unified School District (MUSD) 11th grade students report current use of electronic cigarettes, and 15% report using electronic cigarettes at school. In the state, 27% of 11th grade students report use of electronic cigarettes and 15% report use of electronic cigarettes at school.

Opioids

The age-adjusted rate of opioid prescriptions per 1,000 residents in Mono County was 458.73 in the first quarter of 2015 and 239.14 for the 3rd quarter of 2018, a significant decrease. Mono County is statistically lower than the state rate of 583.09 and 450.17 for the same period.[5]

Drug Overdose and Deaths

The California Department of Public Health published rates of drug-induced deaths from 2015-2017 for the state and by county.

- The age-adjusted death rate from deaths due to drug-induced causes for California was 12.7 deaths per 100,000 population, an increase from the 2012-2014 rate of 11.4 per 100,000 population.
- The rate of drug-induced deaths from 2015-2017 for Mono County was 5.9, with 95% confidence limits of 0.3-27.2. The Healthy People 2020 goal for the rate of drug-induced deaths is 11.3 per 100,000 population.[6]

While overdose deaths have become the leading cause of accidental death in the United States, Mono County experienced one overdose death in 2018. Mono County Emergency Medical Services reported 11 responses for overdoses of various substances in 2017, 20 in 2018, and 4 in 2019.

Alcohol

The percent of adults who reported binge or heavy drinking in 2016 in Mono County was 22%, which is statistically higher than the rate in California of 18%. The data is from the Behavioral Risk Factor Surveillance System (BRFSS) and reported by County Health Rankings.

The percent of alcohol-impaired driving deaths in Mono County was 67% from 2013 – 2017 compared to 30% for the state. The rate in Mono County is statistically higher than the state.

[5] *California Department of Justice - Controlled Substance Utilization Review and Evaluation System Data.*
[6] *California Department of Public Health*

The data is from the Fatality Analysis Reporting System and reported on County Health Rankings.

Youth Alcohol and Other Drug Use

The 2017-2018 CHKS includes multiple indicators related to use of alcohol and drugs by youth, which are included in Appendix 8. Indicators include:

- 29.4% of 11th graders in the state report current use of alcohol or drugs compared to 41% at MUSD and 17% at ESUSD.
- 11.6% of 11th graders in the state report current heavy alcohol use (binge drinking), compared to 13% at ESUSD and 19% at MUSD.
- 6% of 11th graders in the state report that it is very difficult to obtain alcohol compared to 17% at ESUSD and 10% at MUSD.
- 16.7% of 11th graders in the state report current marijuana use compared to 31% at ESUSD and 44% at MUSD.
- 5.6% of 11th graders in the state report that it is very difficult to obtain marijuana compared to 21% at ESUSD and 10% at MUSD.

COMMUNITY HEALTH PRIORITY 2: BEHAVIORAL HEALTH PREVENTION AND TREATMENT

SUMMARY INFORMATION REGARDING THE PRIORITY

Mono County is a Health Professional Shortage Area for Mental Health. Based on data from 2018, there was one (1) behavioral health professional for every 520 residents in Mono County The state has one (1) mental health professional for every 310 residents.[7]

The number of self-reported poor mental health days in Mono County was 3.7 per 30-day period compared to the California rate of 3.5. Mono County is not statistically different than the state. The data is from the Behavioral Risk Factor Surveillance System (BRFSS) and reported on County Health Rankings.

The following information is abstracted from the 2018 California Children's Report Card.[8]

- 35% of children in California who reported needing help for emotional or mental health problems receive counseling
- 13% of total hospital discharges in California of children are due to mental illness
- 42% of California children experience one or more Adverse Childhood Experience (ACEs)
- 17% is the approximate percentage of California children receiving therapy or counseling as part of their Individualized Education Plan (IEP), although 70,000 have a serious mental or behavioral health need

The California Healthy Kids Survey for 2017-2018 includes indicators related to depression and thoughts of suicide.

24% of 9th graders and 57% of 11th graders at ESUSD, and 35% of 9th graders and 42% of 11th graders at MUSD report chronic sad or hopeless feelings in the last 12 months. The rate in the state for 9th and 11th graders is 29.6% and 32.3%.

3% of 9th graders and 42% of 11th graders at ESUSD, and 20% of 9th graders and 17% of 11th graders at MUSD report they seriously considered attempting suicide in the last 12 months. The rate in the state for 9th and 11th graders is 16.0% and 15.5%.

The California Healthy Kids Survey included the following related to state results:

> *"Results for two indicators of depression risk in the past 12 months showed slight improvement as compared to 2013-15 but remain at disturbingly high levels. Feelings of incapacitating chronic sadness or hopelessness were reported by 24% of 7th, 30% of 9th, and 32% of 11th graders, representing a 2 point decrease across grade levels. Seriously contemplating suicide decreased from 19% to 16% for both 9th and 11th grade respondents.*

[7] *County Health Rankings, 2019*
[8] *2018 California Children's Report Card*

Females reported a substantially higher prevalence of chronic sadness than males. In 7th grade, females were 1.6 times more likely than males to report chronic sadness (30% vs. 18%); in 9th grade, twice as likely (39% vs. 19%); and in 11th grade 1.8 times (42% vs. 23%)."

The community and key stakeholders both identified mental health as one of the greatest issues affecting the health of Mono County residents. Lack of access to behavioral health services was viewed as problematic overall, but especially in rural parts of the county.

COMMUNITY HEALTH PRIORITY 3: CLINICAL CARE ACCESS AND PREVENTATIVE CARE

SUMMARY INFORMATION REGARDING THE PRIORITY

Mono County is a Health Professional Shortage Area for primary care. Based on data from County Health Rankings, there was one (1) primary care physician for every 1,550 residents in Mono County in 2016. There was one (1) other primary care provider for every 1,880 residents in Mono County based on data from 2018. The state had one primary care physician for every 1,270 residents and one other primary care provider for every 1,770 residents for the same period.

According to the Department of Healthcare Services (DHCS) Management Information System for the fiscal year 2017-2018, preventive care utilization rates for children with Medi-Cal are 42.7% for Mono County and 45.2% statewide.[9] However, the report states, "*Fiscal year 2017-2018 data may be incomplete due to a delay in DHCS receiving the data".*

Limited English proficiency impacts many aspects of an individual's life, including access to care. The percentage of limited English households in Mono County is 6.5%, and 9.5% of the population has limited English proficiency.[10] 25.1% of Mono County residents speak a language other than English at home compared to 44.0% in the state.[11]

Transportation and distance to travel for services, including healthcare, are major challenges. Multiple comments were received about the lack of access to care in rural parts of the county, and the difficulty of travel to Mammoth Lakes, especially in the winter.

Approximately 12% of adults and 5% of children were uninsured in Mono County in 2016, which is not statistically different than the state.[12] A report published in May of 2018 by the California Healthcare Foundation identified that 22% of the population in Imperial, Inyo, and Mono counties were eligible for MediCal but not enrolled.[13]

A study published in 2018, by the Journal of the American Medical Association (JAMA), identified life expectancy and healthy life expectancy. In California, the healthy life expectancy is approximately 10 years shorter for both males and females.[14] Healthy Life Expectancy is defined as the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.

[9] *Analysis of DHCS's Management Information System/Decision Support System Data*
[10] *US Census Bureau, American Community Survey 2012-2016*
[11] *US Census Bureau, QuickFacts Mono County, 2013 - 2017*
[12] *County Health Rankings, 2019*
[13] *California Health Interview Survey, UCLA Center for Health Policy Research*
[14] *The US Burden of Disease Collaborators. The State of US Health, 1990 – 2016 Burden of Disease, injuries, and Risk Factors Among US States. JAMA. 2018;319(14):1444-1472. doi:10.1001/jama.2018.0158*

CALIFORNIA	LIFE EXPECTANCY	HEALTHY LIFE EXPECTANCY
Both Male and Female	80.9 (79.9 – 81.9)	69.9 (66.6 – 72.8)
Female	83.1 (81.6 – 84.3)	71.1 (67.7 – 74.3)
Male	78.6 (77.2 – 80.1)	68.6 (65.5 – 71.6)

The study also identified disability-adjusted life-years related to risk factors. The top ten risk factors in California in rank order are.:

1. High body mass index
2. Alcohol and drug use
3. Dietary risks
4. Tobacco use
5. High fasting plasma glucose
6. High systolic blood pressure
7. High total cholesterol
8. Impaired kidney function
9. Occupational risks
10. Air pollution

Additional data are included in the main report related to many of the identified risk factors including obesity, nutrition and access to healthy food, and physical exercise.

The highest age-adjusted cause of death in Mono County is for coronary artery disease followed by all cancers, and accidents (unintentional injuries).[15] Cause of death in Mono County is not statistically different from the state.

[15] *Source: California Department of Public Health Mono County Health Status Profiles*

COMMUNITY HEALTH PRIORITY 4: DENTAL CARE ACCESS AND PREVENTATIVE CARE

SUMMARY INFORMATION REGARDING THE PRIORITY

Mono County is a Health Professional Shortage Area for dental care. Based on data from County Health Rankings for 2017, there was one (1) dentist for every 2,020 residents in Mono County. The state had one dentist for every 1,200 residents for the same period.

There are a total of six (6) dentists in Mono County. Five (5) are located in Mammoth Lakes, and one is located in Coleville. Of the five (5) located in Mammoth Lakes, only one accepts Medi-Cal Dental insurance. The remainder of dentists only accept private insurance. The dentist in Coleville accepts both Medi-Cal Dental and private insurance.

The Mammoth Hospital Family Dental Clinic had a total of 8,005 visits between November 2017 and April 2019. Of the patients seen:

- 19.7% of patients were ages 5 or younger.
- 36.4% of patients aged 6 – 12
- 20.3% of patients aged 13 – 18
- 23.5% of patients were ages 19 or older

The most frequent dental care visits for children are related to regular checkups and preventative care, normal decay needing Amalgam or composite restoration, ortho extractions/over retained extractions. The most frequent dental care for adults is for restorations, extractions, root canals, crowns, bridges, removable prosthetics, Prophy's, Periodontal root planning.

85% of patients seen in the Dental Clinic have Medi-Cal as their primary payor.

The Dental Clinic reported the following statistics and information for 2018/2019:

- 2 to 3 months to schedule an exam or treatment for an adult
- 1 to 2 weeks to schedule an exam of treatment for a child
- Appointments for toothache or other urgent need range from immediate to one week
- 1 – 2 months average treatment time for an adult
- 2 weeks average treatment time for a child

Measure C, an ordinance prohibiting the Mammoth Community Water District from adding fluoride to the District water supply, was submitted for a public vote in 2005. The ordinance passed with 940 votes in favor of not adding fluoride to the water, and 363 votes against the ordinance.

First 5 Mono County, with funding support from the California Small Population County Funding Augmentation, provides oral health education, oral health checks, and fluoride varnish applications to children under the age of 5. According to First 5 Mono County annual report for 2016/2017,

"*The oral needs of young children in Mono County continue to be high with few children accessing regular preventative care and annual screenings*."

The First 5 Mono County report includes the following information:

- 20% of patients 0-5 had more than one visit to the dentist in the year, down from 24% the previous year
- 17% of children 0-5 visit the dentist annually, but more than half (56%) are seen at least annually
- 18% of the oral health checks completed at kindergarten roundup indicated the child had untreated caries (cavities), up from 5% last year.

Seven questions were included in the community survey regarding dental health.

- Forty-eight percent (48%) of respondents rated the health of their teeth, mouth, and gums as good and indicated that any issues they had were treated. Thirty-six (36%) responded that their dental health was excellent while fifteen (15%) said it was poor.
- The majority of respondents, 72%, brush their teeth two (2) times a day, 19% brush their teeth once a day, 8% brush their teeth three (3) times a day or more and 1% indicated that they brushed their teeth a few times a week or less.
- Questions related to fluoride indicated that 73% buy toothpaste with fluoride, 20% indicated that they and/or their children get fluoride treatments at the dentist while less than one percent (1%) responded that they or their child use fluoride tablets or drops. Nine percent (9%) stated that they and/or their children drink water with fluoride, and 17% stated that they avoid fluoride. One percent (1%) of those responding indicated that they did not know what fluoride was.
- Respondents were asked when the last time was that they went to the dentist. Most of the respondents, 62%, indicated that they had visited the dentist in the last six (6) months or less. 15% had seen a dentist within the last year, 14% within the last two (2) years, 9% within the last five (5) years, and less than 1% stated that they never gone or could not remember when they went to a dentist last.
- Fifty-six (56%) percent indicated that they were receiving the care they needed, while 23% indicated they were not.
- The majority of those responding 196 out of 277 or 70% indicated that they had insurance through an employer, family members/ employer, Medi-Cal, VA, or an alternate source.
- The last question posed in the community survey asked respondents to identify the top three things influencing dental health within the community. The cost of dental care received the most responses; lack of dentists and dental insurance were the second and third most frequent responses.

Community and key stakeholders identified barriers to dental care, including:

- High cost, including high co-pays and up-front costs
- Long wait times to get an appointment
- Lack of emergency dental care
- Lack of pediatric dental care
- Lack of dentists who take Medi-Cal
- Lack of dental insurance
- Fear of going to the dentist including dental pain
- Ability to take time off from work

The factor identified by key stakeholders as having the most influence on dental health was sugar content in food.

2016 CHNA COMMUNITY HEALTH NEEDS

As part of the 2019 Community Health Needs Assessment Mammoth Hospital is required to evaluate the impact of any actions that were taken to address the significant health needs identified in the immediately preceding CHNA.

There were four community health priorities identified in the 2016 CHNA:

1. Access to Healthcare Services
2. Substance Abuse
3. Behavioral Health
4. Chronic Care Management

Mammoth Hospital did not receive any feedback on the 2016 CHNA from the community. There were four (4) questions included in the 2019 key stakeholder survey related to the 2016 priorities.

1. *Did the hospital increase the number of physicians/providers?*

YES	NO	NOT SURE
41%	11%	48%

2. *Did the hospital develop a visiting specialist program?*

YES	NO	NOT SURE
59%	0%	41%

3. *Did the hospital improve the information/education provided to the community?*

YES	NO	NOT SURE
23%	8%	69%

4. *Did the hospital improve mental health services?*

YES	NO	NOT SURE
30%	19%	52%

Community Health Priority: Access to Healthcare Services

Goal 1: Enhance collaboration among Mono County agencies, providing community education regarding our health care services and availability of financial assistance
Goal 2: Evaluate additional services and their potential impact on access to care.

Strategies
1. Develop a media campaign highlighting available services to the community.
2. Increase the number of visiting specialists.

Measure of Success
1. Increase the number of clinic visits.

Results
1. Five brochures were developed and circulated in the community. Brochure topics included:
    - Financial Counseling
    - Behavioral Health Services
    - Diabetes
    - Surgical Services
    - Cancer Care Services

2. A media campaign was developed and distributed thru newspaper, radio, and social media channels.

3. Additional providers have been added to the medical staff including family medicine; pediatrics; obstetrics; urology; ear, nose and throat; general surgery; and dental.

4. Same-day clinic appointments were implemented to increase access.

The total number of clinic visits increased by 12.3% from 2016 to 2019.

	2016	2017	2018	2019
Clinic Visits	44,243	45,225	47,816	49,658 (Annualized)

Community Health Priority: Substance Abuse

Goal 1: Provide education and raise awareness related to the prevention and treatment of substance abuse, including drug, alcohol, and tobacco.

Strategy
1. Establish regular screening for drug, alcohol, and tobacco use at clinic visits.

Measure of Success
Increase the number of individuals seeking prevention education and treatment for drug, alcohol, or tobacco use.

Results
The number of clinic visits related to the prevention or treatment of substance abuse increased by 55% from 2018 to 2019.

	2017	2018	2019
Clinic Visits related to alcohol, drug, tobacco use prevention or treatment	474	1,403	2,174 Annualized

Goal 2: Develop a pain management program to serve the community's chronic pain population,

Strategy
Establish a protocol for all physicians to use in determining prescriptions opioids for chronic pain.

Measure of Success
Decrease the number of community members receiving opioid prescriptions for chronic pain.

Results
There has been a 285% increase in the number of chronic pain patients from 2017 to 2018, and a decrease in the number of patients receiving opioids.

	2016	2017	2018	2019
Number of chronic pain patients	25	55	70	270 Annualized
Number of chronic pain patients receiving opioids	24	38	52	106 Annualized
Percent of chronic pain patients receiving opioids	96%	69%	74%	39%

Community Health Priority: Behavioral Health

Goal 1: Increase the awareness of behavioral health resources through education.

Goal 2: Develop additional behavioral health resources to serve the community.

Strategies

1. Design and distribute brochures in the community regarding behavioral health services available in the Eastern Sierra area.

2. Develop a media campaign highlighting available behavioral health services to the community.

3. Increase the number of behavioral health providers

Measure of Success

Increase the number of community members accessing behavioral health services.

Results

1. A media campaign was designed and distributed thru newspaper, radio, and social media channels.

2. Two additional behavioral health providers were added and an option for telemedicine consultation implemented.

The total number of Behavioral Health clinic visits increased by 41.6% from 2017 to 2019. The increase from 2016 is more than 200%.

	2016	2017	2018	2019
Number of behavioral health visits	797	1,731	1,631	2,451 Annualized

Community Health Priority: Chronic Disease

Goal 1: Improve community awareness of the long-term detrimental effects of obesity on health.

Strategies

1. Implement a chronic care case management program.

2. Hire a population health care coordination.

3. Implement dietary consults for chronic disease patients, including those who are overweight or obese.

Measure of Success

Increase the number of individuals with obesity who participate in educational programs and care coordination.

Results

1. A population health care coordinator was hired.

2. Dietary consults are offered to all chronic disease patients.

3. A chronic care management program was established.
   Two chronic care managers have left the organization since 2016. Much of 2018 was spent establishing a structure for the chronic care management program (CCM), including developing standardized processes for enrolling patients, tracking patients, and ensuring Medicare CCM requirements were met consistently.

   The focus of the program in 2019 is building the caseload of patients participating in CCM.

	2017	2018	2019
Number of patients actively enrolled in the Chronic Care Management program	56	33	47

MAIN REPORT

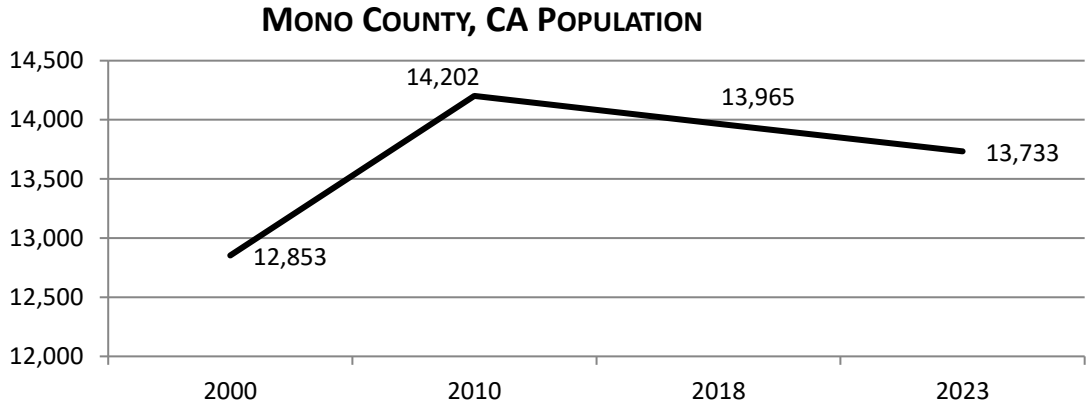
DEMOGRAPHICS

POPULATION

Mono County is a rural community located between the Sierra Nevada Mountains and the California/Nevada border. The County is 3,030 square miles in size and in some areas the elevation reaches over 13,000 feet.

The county seat is Bridgeport, and the only incorporated town in the county is Mammoth Lakes. Mammoth Lakes is the most densely populated area in Mono County with a population of approximately 7,500 people, but this number can increase to as many as 35,000 with winter visitors.[16]

The population in Mono County in 2010 was 14,202. In 2018, the population is estimated to be 13,965. The population is projected to continue to decline by an annual rate of 0.33% with an estimated 2023 population of 13,733 residents.



Source: iVantage Health Analytics, ESRI 2018

AGE

The current median age in Mono County is 38.4, which is expected to increase to 38.9 by 2023, a very slight increase.[17] The median age is lowest in Topaz (28) and highest in Coleville, Walker, Bridgeport, and Benton (49 – 51).[18]

[16] *Mono County Website*
[17] *iVantage Health Analytics, ESRI 2018*
[18] *iVantage Health Analytics, ESRI 2018*

COMMUNITY	CURRENT MEDIAN AGE	PROJECTED MEDIAN AGE 2023
93512 Benton	50	52
93514 Bishop*	46	47
93517 Bridgeport	49	52
93529 June Lake	46	47
93541 Lee Vining, Mono City, Mono Lake	39	41
93546 Mammoth Lakes	35	36
96107 Coleville, Walker	51	53
96133 Topaz	28	29

Source: iVantage Health Analytics, ESRI 2018
**Please note that the 93514 zip code includes Bishop in Inyo County, but also Chalfant, Hammil Valley, Swall Meadows and Paradise in Mono County*

The population aged 5 and under makes up 6.8% of the population and is not expected to change significantly. The population under 18 years old is expected to decrease slightly, by approximately 150 residents. The population over 65 is expected to increase by 420 residents.

	CURRENT POPULATION	PERCENT	PROJECTED POPULATION	PERCENT
0 – 5 years	958	6.8%	945	6.8%
Less than 18	2,671	19.1%	2,521	18.4%
Over 65	1,893	13.5%	2,313	16.8%

Source: US Census Bureau: American FactFinder ACS; Demographic and Housing Estimates 2013-2017

RACE AND ETHNICITY

In Mono County, the white, non-Hispanic population make up approximately 65% of the population and the population with Hispanic origin make-up 28%.[19]

By 2023, the Hispanic population is projected to increase by 5.8% and the White Non-Hispanic population to decrease by 2.0%.

[19] *Data USA; Mono County CA*

RACE AND ETHNICITY	PERCENT
White, alone	91.1%
Black or African American, alone	0.8%
American Indian and Alaska Native, alone	3.0%
Asian, alone	2.2%
Native Hawaiian and Other Pacific Islander, alone	0.4%
Hispanic or Latino Origin (any race)	27.5%
White alone, not Hispanic or Latino	65.5%
Two or more races	2.7%

Source: US Census Bureau: American FactFinder ACS; Demographic and Housing Estimates 2013-2017

CURRENT POPULATION BY RACE AND ETHNICITY						
ZIP-CITY	AMERICAN INDIAN (NON-HISPANIC)	ASIAN (NON-HISPANIC)	BLACK (NON-HISPANIC)	OTHER (NON-HISPANIC)	WHITE (NON-HISPANIC)	HISPANIC
93512 Benton	18	2	0	8	216	39
93514 Bishop*	1,287	249	122	369	8,997	2,963
93517 Bridgeport	44	1	3	19	409	167
93529 June Lake	7	3	0	10	434	147
93541 Lee Vining, Mono City, Mono Lake	29	5	0	7	242	139
93546 Mammoth Lakes	45	200	81	191	5,729	3,061
96107 Coleville, Walker	64	10	16	23	673	131
96133 Topaz	10	8	8	16	320	140

Source: iVantage Health Analytics, ESRI 2018
**Please note that the 93514 zip code includes Bishop in Inyo County, but also Chalfant, Hammil Valley, Swall Meadows and Paradise in Mono County*

PROJECTED CHANGE BY COMMUNITY				
ZIP-CITY	HISPANIC CURRENT	HISPANIC PROJECTED 2023	WHITE (NON-HISPANIC) CURRENT	WHITE (NON- HISPANIC) PROJECTED 2023
93512 Benton	39	44	216	208
93514 Bishop*	2,963	3,274	8,997	8,440
93517 Bridgeport	167	178	409	376
93529 June Lake	147	156	434	403
93541 Lee Vining, Mono City, Mono Lake	139	147	242	221
93546 Mammoth Lakes	3,061	3,212	5,729	5,313
96107 Coleville, Walker	131	145	673	647
96133 Topaz	140	149	320	296

Source: iVantage Health Analytics, ESRI 2018
**Please note that the 93514 zip code includes Bishop in Inyo County, but also Chalfant, Hammil Valley, Swall Meadows, and Paradise in Mono County.*

CITIZENSHIP

In 2016, 86% Of Mono County residents were US citizens, which is lower than the national average of 93%. In 2015, the percentage of US citizens in Mono County was 85.7%, showing that the rate of citizenship is increasing.[20]

[20] *DATA USA: Mono County CA*

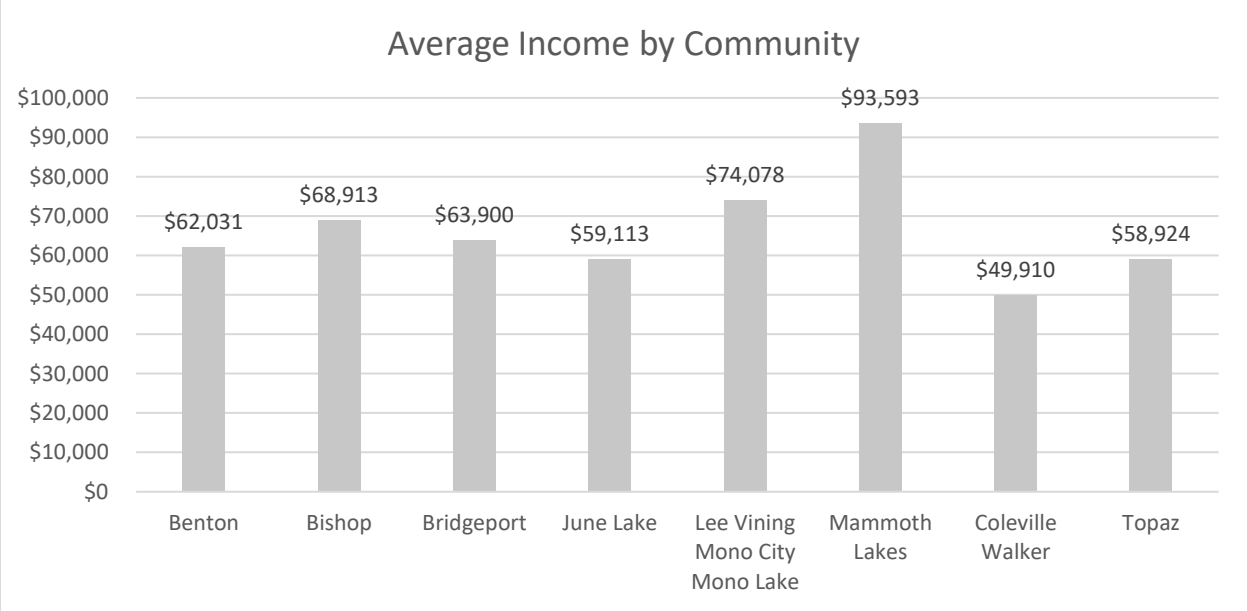
SOCIAL AND ECONOMIC FACTORS

INCOME

The 2017 median household income was $67,169 in California and $60,520 in Mono County.

The 2017 per capita income was $33,128 in California and $30,888 in Mono County.[21]

In Mono County, Mammoth Lakes has the highest average income per household, with Coleville and Walker having the lowest based on data from iVantage.



Source: iVantage Health Analytics, ESRI 2018
Please note that Bishop is in Inyo County, but zip code also includes Chalfant, Hammil Valley, Swall Meadows and Paradise in Mono County

INCOME INEQUALITY

Mono County performs well relative to income inequality, which measures the ratio of household income at the 80th percentile to income at the 20th percentile. A high ratio indicates a greater division between the top and bottom of the income spectrum. Mono County's income ratio is 3.3, compared to the California income ratio of 5.2.[22]

POVERTY

The U.S. Census Bureau estimated that in 2017, approximately 1,097 of people employed in Mono County had an income below the poverty level, and of that number, 32% were women.[23]

[21] *United State Census Quick Facts Mono County California*
[22] *County Health Rankings 2019*
[23] *U.S. Census Bureau, 2013-2017 American Community Survey 5-yr Estimates*

9.9% of the population in Mono County live below the federal poverty level. The highest percent are children under five years of age, 15.8%. Mono County is statistically better than the state for the total population living below the poverty level.[24]

PERCENT OF POPULATION IN POVERTY			
	Mono County	**Margin of Error**	**California**
Total Population	9.9%	+/- 3.8	15.1%
Under 18 years	12.0%	+/- 10.1	20.8%
Under 5 years	15.8%	+/- 10.1	21.5%
5 – 17 years	11.1%	+/- 8.4	20.0%
18 – 64 years	10.1%	+/-4.1	14.0%
65 and over	5.7%	+/-4.4	10.2%

Source: Poverty Status in the Past 12 Months, 2013-2017 American Community Survey 5-Year Estimates

The 2018-2019 California County Scorecard of Children's Well-Being identified 2,836 children living in Mono County, 53% are living at or below two times the poverty level.[25]

7.8% of white residents and 13.3% of Hispanic or Latino residents live in poverty in Mono County.[26]

COMMUNITY FEEDBACK

36% of community members identified financial hardship as the number one reason why people do not get the medical services that they need.

KEY STAKEHOLDER FEEDBACK

84% indicated they felt that children and families living in poverty experienced the greatest challenges in achieving and maintaining good health.

81% rated poverty and stressful conditions accompanying poverty as significant barriers contributing to the health challenges of at-risk populations.

EMPLOYMENT

The unemployment rate from January of 2018 to February of 2019, not seasonally adjusted, in Mono County ranged from a low of 3.4% in April of 2018 to a high of 4.5% in October of 2018.[27] Depending on what season the data is recorded, results may be dramatically different due to tourism and seasonal work.

[24] *US Census Bureau, Fact Finder 2017*
[25] *2018/2019 California County Scorecard of Children's Well-Being*
[26] *US Census Bureau, Fact Finder 2017*
[27] *State of California Employment Development Department*

Mono County Unemployment		
2019	February	3.6%
2019	January	3.7%
2018	December	3.4%
2018	November	4.2%
2018	October	4.5%
2018	September	3.7%
2018	August	3.8%
2018	July	3.8%
2018	June	4.0%
2018	May	3.8%
2018	April	3.4%
2018	March	3.8%
2018	February	3.9%
2018	January	3.9%

EDUCATION

The percent of ninth graders that graduate in four (4) years is higher (better) than the state.[28]

4-Year Graduation Rate				
School Year	**Mono County**	**Mammoth Unified School District**	**Eastern Sierra Unified School District**	**California**
2017 / 2018	95.3%	96.3%	90.0%	87.3%
2016 / 2017	92.7%	96.1%	84.6%	86.7%

Source: Data Quest California Department of Education

The percent of the population in Mono County with some college education is 61%, which is not statistically different than the rate in the state of 64%.[29]

[28] *Mono County School District*
[29] *County Health Rankings, 2019*

LANGUAGE

In Mono County, 25.1% of the population speak a language other than English, of which 21.7% speak Spanish.[30]

The percentage of the population that is not proficient in English, based on data from County Health Rankings from 2013 – 2017, was 6%. This is statistically lower than the rate in the state of 10%.

The 2018-2019 California County Scorecard of Children's Well-Being identified a total of 46% English language learners who gained proficiency in English in Mono County, compared to 47% in the state.

KEY STAKEHOLDER FEEDBACK

66% identified individuals with poor health literacy or limited English proficiency as having the greatest challenges in achieving and maintaining good health. Additionally, 69% identified health literacy and limited English proficiency as contributing to the health challenges of at-risk populations.

Several key stakeholders commented that there is a need for more language translators.

Key stakeholders who were interviewed voiced a concern that the Hispanic population is underserved and under-represented in the community.

HOUSING

The average cost in Mono County of an owner-occupied housing unit is $311,700, and the median gross rent is $1,103.[31]

Based on data from County Health Rankings for 2013 – 2017, 12% of households in Mono County have housing costs above 50% of total household income which is statistically lower than the state rate of 21%.[32]

Based on data from County Health Rankings for 2011 – 2015, 19% of households have severe housing problems defined as at least one of the following: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. The rate is statistically lower than the state rate of 27%.[33]

The Mono County Housing Element published a draft plan for 2019 – 2027, with the following stated goals and information.

[30] *U.S. Census Bureau, 2013 – 2017 American Community Survey 5-year estimates*
[31] *US Census Bureau, QuickFacts Mono County, 2013 - 2017*
[32] *County Health Rankings*
[33] *County Health Rankings 2019*

Goal 1: *Increase overall housing supply, consistent with county's rural character*

Goal 2: *Increase the supply of community housing*

Goal 3: *Retain existing community housing*

Goal 4: *Ensure all other needs related to housing are met*

The County of Mono has a shortage of housing that is affordable to many citizens who work and reside in Mono County. The cost of housing has risen sharply over the past several years due to the cost of housing in the county's resort communities, the increase in second-home residences throughout the county, the scarce and limited amount of private land within the county available for residential development, and the overall increase in the cost of housing throughout the State of California. Wages for workers residing in Mono County have not kept pace with the increase in housing costs. As a result, employees in the lower, moderate, and even upper-moderate income ranges cannot afford to reside in proximity to work centers, have been forced to move greater distances from their places of employment, or have moved from the area entirely. This has decreased the pool of workers necessary to meet the needs of businesses and communities within Mono County. It has also increased commuting time to places of employment and contributes to substandard living conditions for workers and their families that earn low and moderate income levels.

Despite the availability of state and county incentives, there has been little or no market development of residential housing affordable to households earning very low, low, moderate, and even upper-moderate income levels and no other reasonable means to meet this need for workforce and affordable housing are available.[34]

KEY STAKEHOLDER FEEDBACK

Key stakeholders voiced a variety of concerns regarding housing, including a lack of housing in general as well as a lack of affordable housing.

Several comments were made regarding the number of persons that are living in their cars, multiple families living together in single-family homes, and the number of people living in the woods due to lack of affordable housing.

HOMELESS POPULATION

Eastern Sierra Continuum of Care published preliminary data for the 2019 Homeless Point-In-Time count. Based on the data, Mono County had 72 unsheltered homeless individuals and 1 homeless sheltered individual for a total of 73. This is an increase from 2018 of 47 homeless individuals.

[34] *Mono County Housing Element*

The 2018-2019 California County Scorecard of Children's Well-Being indicates that eleven (11) students were experiencing homelessness in the county.

KEY STAKEHOLDER FEEDBACK

Key stakeholders commented that they see homelessness rising in the summer due to the amount of seasonal work available.

TRANSPORTATION

45% of residents drive alone to work, compared to 74% in the state based on data from County Health Rankings for 2013 – 2017.

COMMUNITY FEEDBACK

Multiple respondents commented that residents living outside of Mammoth Lakes experience long travel distances and difficulty in accessing services.

KEY STAKEHOLDER FEEDBACK

Several key stakeholders noted that people sometimes must travel up to an hour one-way, and in the winter, travel may not be possible. For those that must take public transportation, a trip to Mammoth Lakes can take a full-day, and in some instances require an overnight stay.

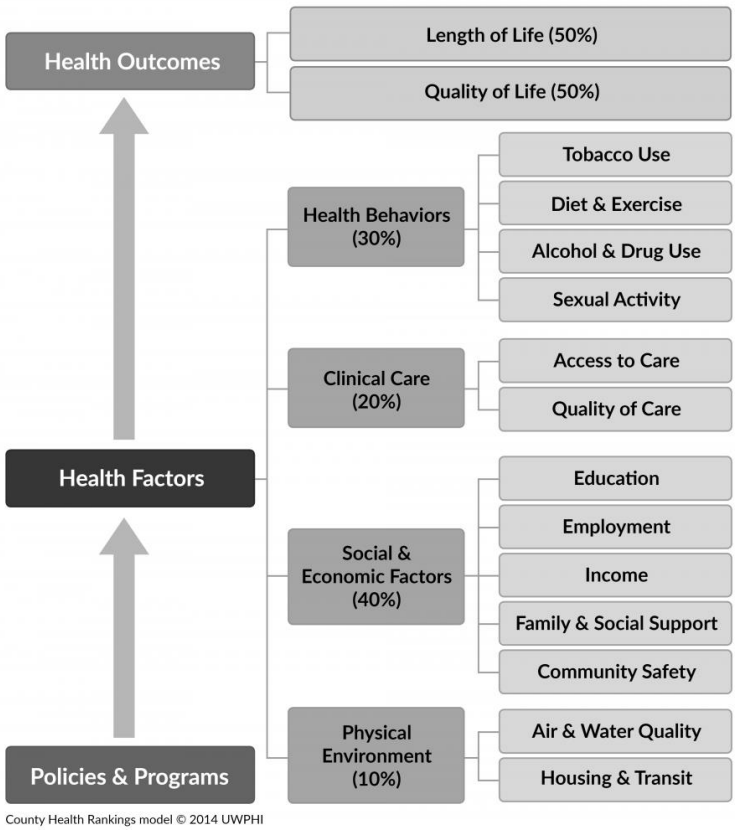
HEALTH OF THE COMMUNITY

COUNTY HEALTH RANKINGS

County Health Rankings & Roadmaps is a collaboration between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work, and play. The rankings are determined by both *Health Outcomes* and *Health Factors,* which are weighted to determine an overall ranking for each county.

Health Outcomes: The overall rankings in health outcomes represent how healthy counties are within California State. The healthiest county in California State is ranked first. The ranks are based on two types of measures: how long people live and how healthy people feel while alive.

Health Factors: The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic factors, and physical environment.



County Health Rankings model © 2014 UWPHI

RANKINGS

The County Health Rankings are included in the table below. Additional detail, including definitions, and years of data collected are included in Appendix 10. A blank cell indicates that information is not included in County Health Rankings data.

The data is provided since it represents the actual data utilized by County Health Rankings to rank Mono County. However, please note that in some instances, more current data is utilized elsewhere in the report if it is available.

Please note that County Health Rankings report the high school graduation rate as 36%. Information from the California Department of Education shows the 4-year graduation rate in Mono County for 2016/2017 was 92.7% and for 2017/2018, it was 95.3%

HEALTH OUTCOMES: Ranked 18th compared to 58 other California counties Length of Life: Ranked 4th Quality of Life: Ranked 38th					
Indicator and Weight	**Mono County**	**Error Margin**	**Top U.S. Performers**	**California**	***Statistical Difference**
Length of life (50%)					
Premature Death (50%)	3,900	2,800- 5,000	5,400	5,300	Better
Quality of Life (50%)					
Poor or fair health (10%)	14%	14 – 15%	12%	18%	Better
Poor physical health days (10%)	3.5	3.3 – 3.6	3.0	3.5	No Diff.
Poor mental health days (10%)	3.7	3.5 – 3.8	3.1	3.5	No Diff.
Low birthweight (20%)	8%	6 – 9%	6%	7%	No Diff.

**Statistical difference between the county and the state.*

HEALTH FACTORS: Ranked 21st compared to 58 other California counties Health Behaviors: Ranked 34th Clinical Care: Ranked 30th Social and Economic Factors: Ranked 14th Physical Environment: Ranked 2nd					
Indicator and Weight	**Mono County**	**Error Margin**	**Top U.S. Performers**	**California**	***Statistical Difference**
Health Behaviors (30%)					
Tobacco Use					
Adult smoking (10%)	13%	12 – 13%	14%	11%	Worse
Adult obesity (5%)	23%	17 – 31%	26%	23%	No Diff.
Diet & Exercise					
Food environment index (2%)	7.4		8.7	8.9	Better
Physical activity (2%)	15%	10 – 22%	19%	17%	No Diff.
Access to exercise opportunities (1%)	92%		91%	93%	No Diff.
Alcohol & Drug Use					
Excessive drinking (2.5%)	22%	21 – 23%	13%	18%	Worse
Alcohol-impaired driving deaths (2.5%)	67%	58 – 74%	13%	30%	Worse
Sexual Activity					
Sexually transmitted infections (2.5%)	237.3		152.8	506.2	Better
Teen births (2.5%)	23	17 - 30	14	22	No Diff.
Indicator and Weight	**Mono County**	**Error Margin**	**Top U.S. Performers**	**California**	***Statistical Difference**
Clinical Care (20%)					
Access to Care					
Uninsured (5%)	10%	9 – 12%	6%	8%	Worse
Primary care physicians (3%)	1,550:1		1,050:1	1,270:1	Worse
Dentists (1%)	2,020:1		1,260:1	1,200:1	Worse
Mental health providers (1%)	520:1		310:1	310:1	Worse
Quality of Care					
Preventable hospital stays (5%)	2,276		2,765	3,507	Better
Mammography (2.5%)	41%		49%	36%	Better
Flu vaccination (2.5%)	35%		52%	40%	Worse

Indicator and Weight	Mono County	Error Margin	Top U.S. Performers	California	*Statistical Difference
Social & Economic (40%)					
Education					
High school graduation (5%)	36%		96%	83%	Better
Some college (5%)	61%	47 – 76%	73%	64%	No Diff.
Employment					
Unemployment (10%)	4.4%		2.9%	4.8%	Better
Income					
Children in poverty (7.5%)	13%	9 – 16%	11%	18%	Better
Income inequality (2.5%)	3.0	2.4 – 3.6	3.7	5.3	Better
Family & Social Support					
Children in single-parent households (2.5%)	17%	6 – 28%	20%	31%	Better
Social associations (2.5%)	8.6		21.9	5.8	Better
Community Safety					
Violent crime (2.5%)	262		63	421	Better
Injury deaths (2.5%)	51	36 - 71	57	49	No Diff.
Indicator and Weight	**Mono County**	**Error Margin**	**Top U.S. Performers**	**California**	***Statistical Difference**
Physical Environment (10%)					
	Mono County	**Error Margin**	**Top U.S. Performers**	**California**	***Statistical Difference**
Air & Water Quality					
Air pollution – particulate matter (2.5%)	6.1		6.1	9.5	Better
Drinking water violations (2.5%)	Yes		NA	NA	NA
Housing & Transit					
Severe housing problems (2%)	19%	13 – 25%	9%	27%	Better
Driving alone to work (2%)	45%	38 – 52%	72%	74%	Better
Long commute-driving alone (1%)	17%	10 – 23%	15%	40%	Better

**Statistical difference between the county and the state.*

LIFE EXPECTANCY

The life expectancy for females in Mono County is 84.6 years compared to 83 years in California and 81.5 nationally, an increase of 6.5% from 1980-2014.[35] For males in Mono County, the life expectancy is 81.6 years compared to 78.6 years in California and 76.7 years nationally, an increase of 11.1% from 1980-2014.[36]

[35] *Institute for Health Metrics and Evaluation (IHME), US County Profile: Mono County, California. Seattle, WA IHME 2016*
[36] *Institute for Health Metrics and Evaluation (IHME), US County Profile: Mono County, California. Seattle, WA IHME 2016*

LIFE EXPECTANCY	MONO COUNTY	CALIFORNIA	UNITED STATES
Female	84.6	83.1	81.5
Male	81.6	78.6	76.7

HEALTHY LIFE EXPECTANCY

A study published in 2018, by the Journal of the American Medical Association (JAMA), identified life expectancy and healthy life expectancy by state. In California, the healthy life expectancy is approximately 10 years shorter for males and females.[37]

Healthy Life Expectancy is defined as the average number of years that a person can expect to live in "full health" by taking into account years lived in less than full health due to disease and/or injury.

CALIFORNIA	LIFE EXPECTANCY	HEALTHY LIFE EXPECTANCY
Both Male and Female	80.9 (79.9 – 81.9)	69.9 (66.6 – 72.8)
Female	83.1 (81.6 – 84.3)	71.1 (67.7 – 74.3)
Male	78.6 (77.2 – 80.1)	68.6 (65.5 – 71.6)

The study also identified disability-adjusted life-years related to risk factors. The top ten risk factors in California and the United States, in rank order, are included in the table below. Although similar, California is better (lower) than the United States for tobacco use. California is ranked higher (worse) than the United States for high body mass index and alcohol & drug use.

[37] *The US Burden of Disease Collaborators. The State of US Health, 1990 – 2016 Burden of Disease, injuries, and Risk Factors Among US States. JAMA. 2018;319(14):1444-1472. doi:10.1001/jama.2018.0158*

California	United States
1. High body mass index	1. Tobacco use
2. Alcohol and drug use	2. High body mass index
3. Dietary risks	3. Dietary risks
4. Tobacco use	4. Alcohol and drug use
5. High fasting plasma glucose	5. High fasting plasma glucose
6. High systolic blood pressure	6. High systolic blood pressure
7. High total cholesterol	7. High total cholesterol
8. Impaired kidney function	8. Impaired kidney function
9. Occupational risks	9. Occupational risks
10. Air pollution	10. Air pollution

HEALTH STATUS BY INCOME

The 2017 California Health Interview Survey reported that 28% of Californians with low incomes reported their health status as fair or poor, compared to 10% of Californians with higher incomes.

SELF-REPORTED HEALTH STATUS BY INCOME					
	Excellent	Very Good	Good	Fair	Poor
≤ 200% Federal Poverty Level	19%	22%	31%	22%	6%
≥200% Federal Poverty Level	28%	35%	26%	8%	2%

Source: Supplemental Nutrition Assistance Program 2017 County Profiles

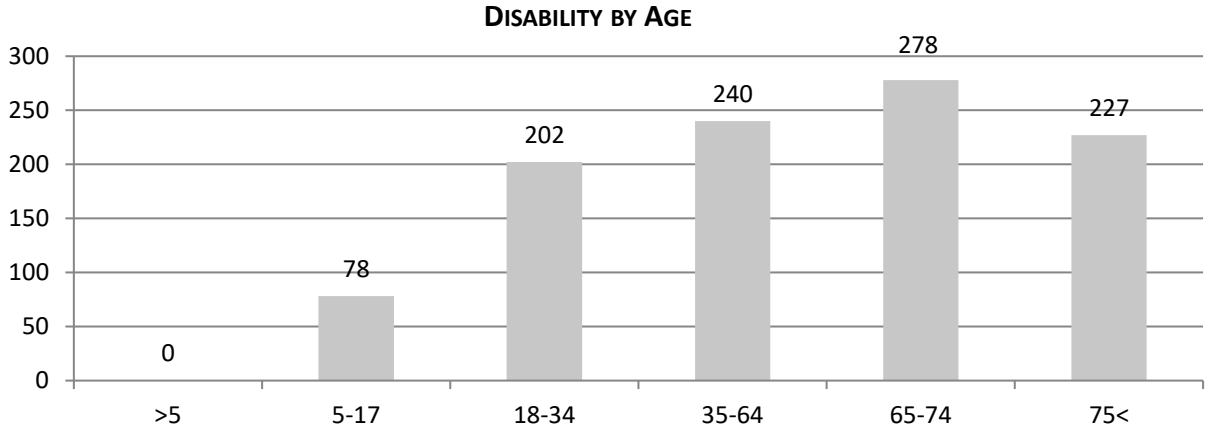
DISABILITY

In Mono County, 7% of the population has a disability compared to 13% nationally.[38] Disabilities include hearing, vision, cognitive, ambulatory, self-care, and independent living disability.[39]

The table illustrates the disabled population by age group. Approximately 12% of households in the county include at least one person who is disabled while 14% report poor or fair health.[40]

[38] *US Census Bureau, American Community Survey 2012-2016*
[39] *US Census Bureau, American Community Survey 2012-2016*
[40] *University of Wisconsin: Population Health Institute*

The number of poor health days was 3.5, and the number of poor mental health days was 3.7 per 30-day period compared to the California rate of 3.5 for both.



Source: US Census Bureau, American Community Survey 2012-2016.

LEADING CAUSE OF DEATH

County Health Rankings indicate that Mono County performs better than most counties, ranking 4th compared to 58 counties in California for premature death based on data from 2015 – 2017.

In Mono County, the three-year average (2014–2016) crude death rate was 335.3, and the age-adjusted death rate was 795.4.

The causes of death are listed in the table in the order of rank with other California counties. A rank of one (1) is better.

The highest age-adjusted rate of death is for all cancers, followed by coronary artery disease and accidents (unintentional injuries). However, due to fewer than 20 data elements, the rates are considered to be unreliable, except for deaths from all causes and all cancer deaths. The age-adjusted death rate for all causes and all cancers in Mono County is not statistically different than the state.

CAUSE OF DEATH	RANKING (58 COUNTIES)	AGE-ADJUSTED DEATH RATE	95% CONFIDENCE LIMITS	CALIFORNIA	STATISTICAL DIFFERENCE
ALL CAUSES	32	685.8	517.1 – 892.0	610.3	No Difference
ALL cancers	11	127.1	67.0 - 218.9	137.4	No Difference
Colorectal cancer	8	*10.1	0.6 – 46.4	12.5	Unreliable
Lung cancer	4	*21.6	3.3 – 71.7	27.5	Unreliable
Female breast cancer	2	*2.6	<0.1 – 34.4	18.9	Unreliable

Prostate cancer	58	*36.8	2.0 – 169.6	19.4	Unreliable
Diabetes	2	*3.9	20.1 – 29.1	21.2	Unreliable
Alzheimer's Disease	14	*25.0	1.4 – 115.3	35.7	Unreliable
Coronary Heart Disease	35	*97.4	40.2 – 197.6	87.4	Unreliable
Cerebrovascular disease (stroke)	46	*43.8	5.3 – 158.3	36.3	Unreliable
Influenza / Pneumonia	5	*9.1	0.5 – 41.8	14.2	Unreliable
Chronic lower reparatory disease	15	*29.5	4.5 – 98.0	32.0	Unreliable
Chronic liver disease and cirrhosis	2	*5.7	0.1 – 31.6	12.2	Unreliable
Accidents (Unintentional injuries)	29	*45.2	15.4 – 102.9	32.2	Unreliable
Motor vehicle traffic crashes	31	*14.8	0.4 – 82.5	9.5	Unreliable
Suicide	16	*10.9	0.6 – 50.3	10.4	Unreliable
Homicide	43	*7.5	<0.1 – 56.4	5.2	Unreliable
Firearm related deaths	41	*13.4	0.7 – 61.8	7.9	Unreliable
Drug induced deaths	3	*5.9	0.3 – 27.2	12.7	Unreliable

Counties were rank ordered first by increasing age-adjusted death rate (calculated to 15 decimal places, second by decreasing size of the population.
**Rate is unreliable due to less than 20 data elements*
Source: California Department of Public Health Mono County Health Status Profiles

HEALTH BEHAVIORS

TOBACCO – ALCOHOL – DRUGS

DISABILITY-ADJUSTED LIFE YEARS

A study published by the Journal of the American Medical Association (JAMA), in 2018, identified risk-factors that contributed to disability-adjusted life-years. In California, the second highest risk factor was alcohol and drug use, and the fourth highest risk factor was tobacco use.[41]

Tobacco

The American Lung Association evaluates local efforts towards tobacco control. According to the report, an overall Tobacco Control Grade is a letter grade awarded to the municipality based on its points received in each of the following areas; smoke-free outdoor air, smoke-free housing, and reducing sales of tobacco products. Points from these categories were added together with any emerging issue bonus points received. The points correlate to a letter grade A-F.

For 2019, Mammoth Lakes received an overall tobacco control grade of a C while the unincorporated areas of Mono County received a grade of D.

The grades are not necessarily reflective of the current initiatives underway in Mono County.

[41] *The US Burden of Disease Collaborators. The State of US Health, 1990 – 2016 Burden of Disease, injuries, and Risk Factors among US States. JAMA. 2018;319(14):1444-1472. doi:10.1001/jama.2018.0158*

2019	MAMMOTH LAKES	MONO COUNTY UNINCORPORATED
Overall Tobacco Control Grade	**C**	**D**
Smoke-free Outdoor Air	**Overall Grade = A** • Dining: 4/4 • Public Events: 4/4 • Recreation Areas: 4/4 • Service Areas: 4/4 • Sidewalks: 0/1 • Worksites: 1/1	**Overall Grade = A** • Dining: 4/4 • Public Events: 4/4 • Recreation Areas: 3/4 • Service Areas: 4/4 • Sidewalks: 0/1 • Worksites: 1/1
Smoke-free Housing	**Overall Grade = C** • Nonsmoking Apartments: 0/4 • Nonsmoking Condominiums: 0/4 • Nonsmoking Common Areas: 4/4	**Overall Grade = F** • Nonsmoking Apartments: 0/4 • Nonsmoking Condominiums: 0/4 • Nonsmoking Common Areas: 0/4
Reducing Sales of Tobacco Products	**Overall Grade = F** • Tobacco Retailer Licensing: 0/4	**Overall Grade = F** Tobacco Retailer Licensing: 0/4
Emerging Issues Bonus Points	**Bonus Points = 1** • Secondhand Smoke: 1/1 • Licensing: 0/1 • Retailer Location Restrictions: 0/1 • Sale of Tobacco Products in Pharmacies: 0/1 • Flavored Tobacco Products: 0/1 • Minimum Pack Size of Cigars: 0/1	**Bonus Points = 2** • Secondhand Smoke: 1/1 • Licensing: 0/1 • Retailer Location Restrictions: 0/1 • Sale of Tobacco Products in Pharmacies: 0/1 • Flavored Tobacco Products: 1/1 • Minimum Pack Size of Cigars: 0/1

Source: State of Tobacco Control 2019- California Local Grades

Adult Tobacco Use

For years 2014 – 2016, the smoking prevalence among adults in the Sierra Region including Alpine, Amador, Calaveras, Inyo, and Mono counties was 12.6% which is slightly higher than the rate in California of 12.2%, but not statistically different from the Healthy People 2020 target. California's adult cigarette smoking rate varies by population density, with higher rates predominantly in rural counties.

	MONO COUNTY	CALIFORNIA	HEALTHY PEOPLE 2020 TARGET
Adults who are current smokers (2014 - 2016)	12.6%	12.2%	12.0

Source: California Department of Public Health, California Tobacco Control Program, California Tobacco Facts & Figures 2018

Youth Tobacco Use

The California Healthy Kids Survey (CHKS) was developed by the California Department of Education and is administered every other year in Mono County. Student participation is voluntary and confidential.

The following is an overview of indicators. Additional information is included in Appendix 7, including information for 7th and 9th grade students.

- 4.3% of 11th graders in the state report current cigarette smoking compared to 0% at Eastern Sierra Unified School District (ESUSD) and 5% at Mammoth Unified School District (MUSD).
- 31.2% of 11th graders in the state report that it is very difficult to obtain cigarettes compared to 17% at ESUSD and 11% at MUSD.
- 1.7% of 11th graders in the state report current smokeless tobacco use compared to 0% at ESUSD and 1% at MUSD.
- 42% of 11th graders in the state report great harm of occasional cigarette smoking compared to 29% at ESUSD and 44% at MUSD.
- 4% of 11th graders in Eastern Sierra Unified School District (ESUSD) report both current use of electronic cigarettes and using electronic cigarettes at school. 27% of Mammoth Unified School District (MUSD) 11th grade students report current use of electronic cigarettes, and 15% report using electronic cigarettes at school. In the state, 27% of 11th grade students report use of electronic cigarettes and 15% report use of electronic cigarettes at school.

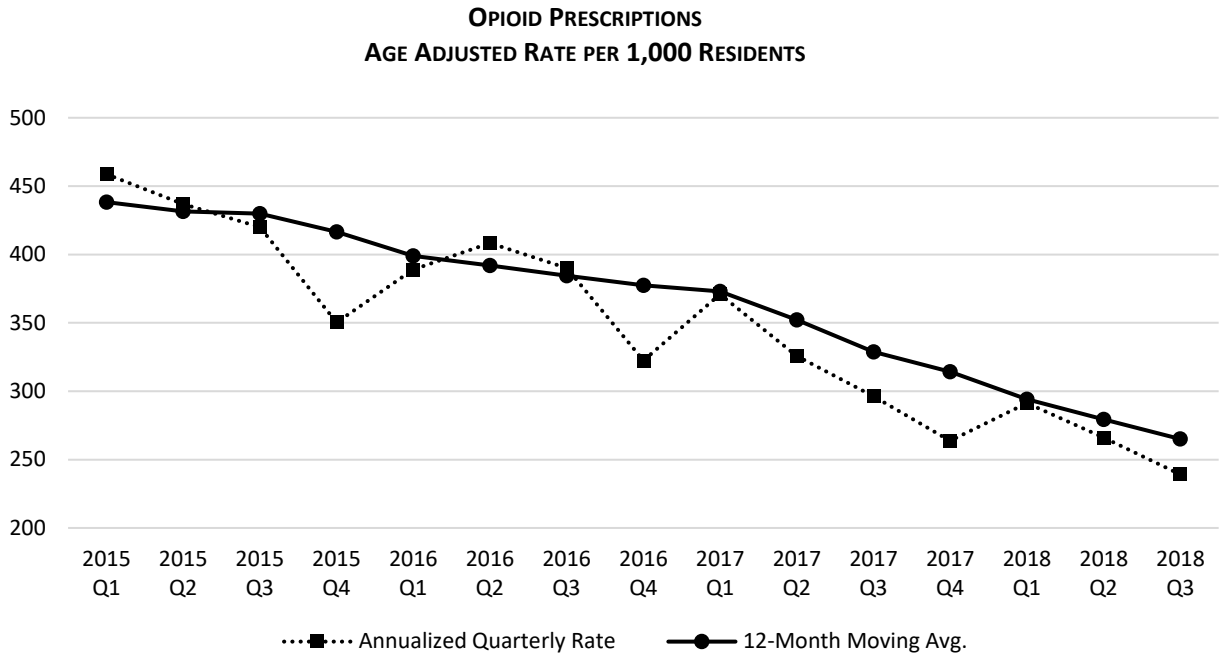
Opioid Prescriptions

The age-adjusted rate of opioid prescriptions per 1,000 residents in Mono County was 458.73 in the first quarter of 2015 and 239.14 for the 3rd quarter of 2018, a significant decrease.[42] Mono County is statistically lower than the state rate of 583.09 and 450.17 for the same period.

Opioid Prescriptions **AGE-ADJUSTED RATE PER 1,000 RESIDENTS**				
QUARTER	**MONO COUNTY ANNUALIZED QUARTERLY RATE**	**CALIFORNIA ANNUALIZED QUARTERLY RATE**	**CONFIDENCE INTERVALS**	**STATISTICAL DIFFERENCE**
2015 Q1	458.73	583.09	582.85 – 583.22	Lower
2015 Q2	437.01	595.41	595.17 – 595.65	Lower
2015 Q3	420.13	581.93	581.7 – 582.17	Lower
2015 Q4	350.23	587.77	595.17 – 595.65	Lower
2016 Q1	388.87	576.84	576.61 – 577.08	Lower
2016 Q2	408.3	563.78	563.78 – 564.24	Lower
2016 Q3	390.09	563.49	563.49 – 563.94	Lower
2016 Q4	322.39	544.55	544.55 – 545.01	Lower
2017 Q1	370.93	530.27	530.05 – 530.49	Lower
2017 Q2	325.66	535.01	534.79 – 535.23	Lower
2017 Q3	296.27	502.43	502.22 – 502.65	Lower
2017 Q4	263.75	466.88	466.67 - 467.08	Lower
2018 Q1	291.29	468.29	468.09 - 468.50	Lower
2018 Q2	266	460.21	460.21 – 460.01	Lower
2018 Q3	239.14	450.17	450.17 – 449.97	Lower

Source: California Department of Justice - Controlled Substance Utilization Review and Evaluation System Data

[42] *California Department of Justice - Controlled Substance Utilization Review and Evaluation System Data*



Source: California Department of Justice - Controlled Substance Utilization Review and Evaluation System Data

Drug Overdose Deaths

All the changes in the following data, published by the CDC for the state of California, are statistically significant.

- The annual age-adjusted rate of drug overdose deaths from all opioids was 4.9 in 2016 and 5.3 in 2017, an 8.2% increase.
- The annual age-adjusted rate of drug overdose deaths due to prescription opioids was 2.8 in 2016 and 2017, showing no change.
- The drug overdose deaths from heroin were 1.4 in 2016 and 1.7 in 2017, a 21.4% increase.
- The annual age-adjusted rate of drug overdose deaths from synthetic opioids was 0.9 in 2016 and 1.3 in 2017, a 44.4% increase.

The California Department of Public Health published rates of drug-induced deaths from 2015-2017 for the state and by county.

- The age-adjusted death rate from deaths due to drug-induced causes for California was 12.7 deaths per 100,000 population, an increase from the 2012-2014 rate of 11.4 per 100,000 population.
- The rate of drug-induced deaths from 2015-2017 for Mono County was 5.9, with 95% confidence limits of 0.3-27.2. The Healthy People 2020 goal for the rate of drug-

induced deaths is 11.3 per 100,000 population.[43] While overdose deaths have become the leading cause of accidental death in the United States, Mono County experienced one overdose death in 2018. Mono County Emergency Medical Services reported 11 responses for overdoses of various substances in 2017, 20 in 2018, and 4 in 2019.

Adult Alcohol Use

The percent of adults who report binge or heavy drinking is higher (worse) than the state. The percent of alcohol-impaired driving deaths is almost double the rate in the state.[44]

	MONO COUNTY	CALIFORNIA	HEALTHY PEOPLE 2020 TARGET
Adults who reported binge drinking or heavy drinking (2016	22% (21% - 23%)	18%	24.2%
Alcohol-Impaired Driving Deaths (2013-2017)	67% (58% to 74%)	30%	No Target

Source: County Health Rankings, 2019

Youth Alcohol and Other Drug Use

The 2017-2018 CHKS includes multiple indicators related to use of alcohol and drugs by youth, which are included in Appendix 8. Indicators include:

- 29.4% of 11th graders in the state report current use of alcohol or drugs compared to 41% at MUSD and 17% at ESUSD.
- 11.6% of 11th graders in the state report current heavy alcohol use (binge drinking), compared to 13% at ESUSD and 19% at MUSD.
- 6% of 11th graders in the state report that it is very difficult to obtain alcohol compared to 17% at ESUSD and 10% at MUSD.
- 16.7% of 11th graders in the state report current marijuana use compared to 31% at ESUSD and 44% at MUSD.
- 5.6% of 11th graders in the state report that it is very difficult to obtain marijuana compared to 21% at ESUSD and 10% at MUSD.

COMMUNITY FEEDBACK - ADULTS

The community identified alcohol use as the second highest health concern for adults in Mono County and the illegal use of drugs as the fourth highest health concern.

[43] *California Department of Public Health*
[44] *County Health Rankings, 2019*

KEY STAKEHOLDER FEEDBACK - ADULTS

Key stakeholders identified alcohol use as the number one health concern for adults in Mono County and the use of illegal drugs as the third highest health concern.

COMMUNITY FEEDBACK - YOUTH

The community identified vaping as the second highest health concern for youth in Mono County and alcohol use as the fourth highest concern.

Tobacco use, along with teen drug, alcohol, or tobacco use, was identified as the number one influence on child wellness and safety. Parental abuse of alcohol and drugs was also identified.

KEY STAKEHOLDER FEEDBACK - YOUTH

Key stakeholders identified vaping as the second highest health concern for children in Mono County, and alcohol as the third most important.

Parents abuse of alcohol and drugs; and teen drug, alcohol or tobacco use, were identified as number one and two for the things that influence child wellness and safety.

NUTRITION, OBESITY AND PHYSICAL ACTIVITY

A study published by the Journal of the American Medical Association (JAMA), in 2018, identified risk-factors that contributed to disability-adjusted life-years. In California, the number one risk factor was high body mass index (BMI).

OBESITY

The percent of students in grades 5, 7, and 9 who are overweight or obese in Mono County is lower than the state.

Additional data related to obesity is reflective of the Sierra County Region, including Tuolumne, Calaveras, Amador, Inyo, Mariposa, Mono, and Alpine counties. This regional data shows the prevalence of obesity is higher than the state for teens aged 12 – 17.

STUDENTS WHO ARE OVERWEIGHT OR OBESE BY GRADE LEVEL - 2017		
GRADE	MONO COUNTY	CALIFORNIA
Grade 5	19.0%	40.7%
Grade 7	31.2%	38.7%
Grade 9	21.2%	37.2%

Source: KidsData

64.0% of adults in the Sierra County Region have a BMI of 25 or higher, and 26.0% have a BMI of 30 or higher, which is considered obese.

OBESITY		
INDICATOR	SIERRA COUNTY REGION	CALIFORNIA
Child (age 2-11) Overweight for Age (>= 95th percentile) (2011 – 2016)		14.0%
Teen (age 12-17) Overweight (>= 85th percentile) (2011 – 2016)	37.0%	34.0%
Adult BMI 25 or higher (Overweight/Obese) (2014 – 2016)	64.0%	63.0%
Adult BMI 30 or higher (Obese) (2014 – 2016)	26.0%	28.0%
Adult (SNAP-Ed eligible) BMI 25 or higher (Overweight / Obese) (2014 – 2016)	57.0%	67.0%
Adult (SNAP-Ed eligible) BMI 30 or higher (Obese) (2014 – 2016)	26.0%	33.0%

Source: California Department of Public Health: Nutrition, Education and Prevention Branch, Mono County Profile 2018

ACCESS AND CONSUMPTION OF HEALTHY FOOD

Supplemental Nutrition Assistance Program–Education or SNAP-Ed eligible adults have access to fresh fruits and vegetables at a rate higher in the Sierra County region than the state (69.0% and 65.0% respectively). The affordability of fresh fruits and vegetables, however, is lower than the state.

Inyo Mono Advocates for Community Action, Inc. offer three options for food assistance in various communities in Mono County; USDA Commodities, Mobile Harvest Food Truck, and Emergency Food Pantry. Food banks are also available through the Food Bank of Northern Nevada and the Salvation Army Food Pantry.

ACCESS TO FRESH FRUIT AND VEGETABLES		
INDICATOR	**SIERRA COUNTY REGION**	**CALIFORNIA**
Adults (SNAP-Ed eligible): Always find fresh fruit/vegetables in neighborhood (2014 – 2016)	69.0%	65.0%
Adults (SNAP-Ed eligible): Fresh fruit/vegetables are always affordable in neighborhood (2014 – 2016)	34.0%	37.0%

Source: California Department of Public Health: Nutrition, Education and Prevention Branch, Mono County Profile 2018

FAST FOOD – SODA – FRUIT AND VEGETABLE CONSUMPTION		
INDICATOR	**SIERRA COUNTY REGION**	**CALIFORNIA**
Percent of children/teens (age 2-17) consuming fast food 1+ times per week (2011 – 2016)	63.0%	73.0%
Percent of adults consuming fast food 1+ times per week (2014 – 2016)	52.0%	64.0%
Percent of adults (SNAP-Ed eligible) consuming fast food 1+ times per week (2014 – 2016)	51.0%	68.0%
Percent of children/teens (age 2-17) consuming 1+ soda yesterday (2013 – 2016)	NA	22.0%
Percent of children/teens (age 2-17) consuming 1+ sugary drinks (non-soda) yesterday (2013 – 2016)	NA	26.0%
Percent of adults consuming soda 7+ times/week on average (2014 – 2016)	7.0%	11.0%
Percent of adults (SNAP-Ed eligible) consuming soda 7+ times/week on average (2014 – 2016)	NA	15.0%
Percent of children (age 2-11) consuming 5+ servings of fruits and vegetables yesterday (2011 – 2016)	42.0%	31.0%
Percent of teens (age 12-17) consuming 5+ servings of fruits and vegetables yesterday (2011 – 2016)	44.0%	24.0%

Source: California Department of Public Health: Nutrition, Education and Prevention Branch, Mono County Profile 2018

FOOD SECURITY

The Food Environment Index is a measure of factors that contribute to a healthy food environment rated on a scale of 0-10, with 10 being the best. Mono County's food environment index is 7.5 compared to 8.8 statewide and 8.6 nationally.[45]

According to the California SNAP-ED 2018 Profile for the Sierra County Region, the food insecurity rate among children under 18 years of age is 17%. The rate of food insecurity for all ages is 11% in the Sierra County Region, 31% of residents are eligible for SNAP-Ed benefits, and 6% are CalFresh participants.[46]

FOOD SECURITY		
INDICATOR	**SIERRA COUNTY REGION**	**CALIFORNIA**
Rate of food insecurity among children < 18 years of age (2016)	1 7% 470	19%
Rate of food insecurity among individuals of all ages (2016)	11% 1,520	12%
Number of CalFresh participants	649	3,907,960

Source: California Department of Public Health: Nutrition, Education and Prevention Branch, Mono County Profile 2018

SNAP-ED ELIGIBLE DEMOGRAPHICS LESS THAN 185% FEDERAL POVERTY LEVEL		
	SIERRA COUNTY REGION	**CALIFORNIA**
Total	31% 4,348	33%
Children < 6 years old	42% 378	44%
Children 6 – 17 years old	51% 982	42%
Adults 18 – 64 years old	29% 2,753	31%
Seniors 65 years and old	13% 235	28%

Source: 2018 NEOP County Profile Dashboard

[45] *County Heath Rankings 2019*
[46] *2017 County Profiles Supplemental Nutrition Assistance Program. Mono County*

OTHER FEDERAL NUTRITION ASSISTANCE PROGRAMS		
	SIERRA COUNTY REGION	CALIFORNIA
CalFresh Participants	6% 784	11%
Students eligible for (FRPM)Free/Reduce Price Meals	64% 1,338	59%

Source: 2018 NEOP County Profile Dashboard

PHYSICAL ACTIVITY

The percentage of children ages 5-11 that are physically active for 1+ hour daily in the Sierra County region is higher than the state,

60% of children/teens are sedentary 2+ hours of the day compared to 55% in the state.

Adults regularly walking for transportation, fun, or exercise in the Sierra County region is 37%.

PHYSICAL ACTIVITY		
INDICATOR	SIERRA COUNTY REGION	CALIFORNIA
Percent of children (age 5-11) physically active 1+ hour every day (2011 – 2016)	48%	29%
Percent of teens (age 12-17) physically active 1+ hour every day (2011 – 2016)	NA	14%
Percent of children/teens (age 1-17) who visited a park or playground or open space in the last month (2011 – 2016)	81%	84%
Percent of children/teens (age 5-17) who walked/biked/skated from school in the past week (2011 – 2016)	34%	41%
Percent of children/ teens (2-17) sedentary 2+ hours on a typical weekday (2013 – 2016)	60%	55%
Adults regularly walking for transportation or fun or exercise (2015 – 2016)	37%	39%
Adults (SNAP-Ed eligible) regularly walking for transportation or fun or exercise (2015 – 2016)	30%	38%

Source: California Department of Public Health: Nutrition, Education and Prevention Branch, Mono County Profile 2018

COMMUNITY FEEDBACK

15% identified the prevalence of overweight/obesity as a health concern for adults. Additionally, 23% identified the prevalence of overweight/obesity as a health concern for children.

Limited access to affordable, nutritious food was identified as one of the top three things that influence child wellness and safety.

Several respondents noted that lack of participation in physical activities, including sports contribute to obesity and the lack of physical exercise. Several commented that the availability of activities for kids is especially limited in unincorporated areas. Another voiced a need for activities for kids who can't afford to ski or snowboard.

Cell phone and screen time were also identified as contributing to a lack of physical activity.

KEY STAKEHOLDER FEEDBACK

Key stakeholders identified being overweight or obese as one of the most important health concerns for children < 18.

Of key stakeholders, 48% identified availability and access to affordable, nutritious food as significant influences on child wellness.

Education regarding how to access healthy foods, cutting out bad habits (mainly sugar), a sugar tax, and nutrition as a prescription were identified as potential strategies.

Key stakeholders commented that a greater awareness of affordable recreation programs throughout the community and engagement/participation in understanding the recreation needs of the community was needed.

Funds for scholarships enabling participation in pay-to-play recreation programs, free indoor space in the winter, more activities, and reducing the amount of time kids spend gaming were all identified as ways to increase physical activity.

Key stakeholders also commented on the need for more social activities for adults.

SEXUALLY TRANSMITTED DISEASES

The data for sexually transmitted diseases in Mono County is suppressed due to small sample sizes, except for chlamydia.

There was an average of 30.3 chlamydia cases per year between 2015 and 2017. The crude case rate per 100,000 was 219.8, which is lower (better) than the rate in the state of 514.6.[47]

[47] *Mono County Health Status Profile for 2019*

ACCESS TO CARE

UNINSURED POPULATION

County Health Rankings reports 12% of adults and 5% of children were uninsured in Mono County in 2016. However, the differences are not statistically significant from rates in California.[48]

	MONO COUNTY	CALIFORNIA
Uninsured Adults (2016)	1,086 - 12% (10 – 14%)	10%
Uninsured Children (2016)	149 - 5% (3 – 7%	3%

Source: County Health Rankings, 2019

The 2017 California Health Interview Survey found that 11% of the population in California at less than 200% of the Federal Poverty Level (FPL) were uninsured compared to 5% of individuals over 200% of the FPL.[49]

	≤ 200% FPL	> 200% FPL
Total Californians (in millions)	13.6	25.1
Income spent on health care	11%	5%
Out of pocket expenses	$2,247	$5,458
Public Programs	70%	26%
Employment-Based	15%	60%
Privately purchased	4%	8%
Uninsured	11%	5%

Source: 2017 California Health Interview Survey, UCLA Center for Health Policy Research

A report published in May 2018 by the California Healthcare Foundation reviewed uninsured individuals by eligibility. Data for the eastern counties, which include Imperial, Inyo, and Mono Counties found that 22% of the population were eligible for Medi-Cal but not enrolled. The report cited multiple factors for people to not enroll, including, "*people not knowing they are eligible, fear of enrolling in a government program, or difficulty with enrollment processes and procedures."*[50]

[48] *County Health Rankings, 2019*
[49] *2017 California Health Interview Survey, UCLA Center for Health Policy Research*
[50] *2017 California Health Interview Survey, UCLA Center for Health Policy Research*

NUMBER OF UNINSURED BY ELIGIBILITY	NOT ELIGIBLE DUE TO IMMIGRATION STATUS	ELIGIBLE FOR MEDI-CAL	ELIGIBLE FOR COVERED CA WITH SUBSIDIES	ELIGIBLE FOR COVERED CA WITH NO SUBSIDIES
California	1,787,000	322,000	1401,000	550,000
Sierra County Region	12,000	5,000	<5,000	<5,000

Source: 2017 California Health Interview Survey, UCLA Center for Health Policy Research

DISTRIBUTION OF UNINSURED BY ELIGIBILITY	NOT ELIGIBLE DUE TO IMMIGRATION STATUS	ELIGIBLE FOR MED-CAL	ELIGIBLE FOR COVERED CA WITH SUBSIDIES	ELIGIBLE FOR COVERED CA WITH NO SUBSIDIES
California	59%	11%	13%	18%
Sierra County Region	52%	22%	NA	NA

Source: 2017 California Health Interview Survey, UCLA Center for Health Policy Research

PRIMARY CARE PROVIDERS

Based on data from County Health Rankings, there was one (1) primary care physician for every 1,550 residents in Mono County, and one other primary care provider for every 1,880 residents.[51] Other primary care professionals include nurse practitioners, physician assistants, and clinical nurse specialists.

The state has more primary care providers and more other primary care providers for each resident than Mono County.

PROVIDERS	MONO COUNTY	CALIFORNIA
Primary Care Providers (2016)	1,550:1	1,270:1
Other Primary Care Providers (2018)	1,880:1	1,770:1

Source: County Health Rankings, 2019

REASONS FOR HEALTH CARE VISITS

The 2017 California Health Interview Survey reported that in California, most health care visits are for a routine checkup.

Individuals ≤200% of the federal poverty level may use the emergency room at a higher rate and have more visits related to emotional/mental and/or alcohol/drug issues than those ≥200% of the federal poverty level.

[51] *County Health Rankings 2019*

CALIFORNIA	≤ 200% FEDERAL POVERTY LEVEL	≥ 200% FEDERAL POVERTY LEVEL
Routine Checkup	72%%	75%
Emergency Room	24%	19%
Emotional/Mental and/or Alcohol/Drug Issues	17%	14%

Source: 2017 California Health Interview Survey, UCLA Center for Health Policy Research

ACCESS TO PRIMARY AND SPECIALTY CARE

The 2017 California Health Interview Survey reported that in California there was not much difference in finding primary care between individuals ≤200% of the FPL and individuals ≥200% of the FPL.

However, the percentage of Californians with low incomes that reported difficulty finding specialty care was 18% compared to 9% of those with higher incomes.

CALIFORNIA	≤ 200% FEDERAL POVERTY LEVEL	≥ 200% FEDERAL POVERTY LEVEL
Difficulty finding primary care	7%	5%
Difficulty finding specialty care	18%	9%

Source: 2017 California Health Interview Survey, UCLA Center for Health Policy Research

DELAYED CARE

The 2017 California Health Interview Survey reported that in California that 12% of individuals in California ≤ 200% of the federal poverty level had more problems paying medical medicals and delayed care due to cost or lack of insurance than those ≥ 200% of the federal poverty level.

CALIFORNIA	≤ 200% FEDERAL POVERTY LEVEL	≥ 200% FEDERAL POVERTY LEVEL
Problems paying medical bills	12%	8%
Delayed needed care due to cost or lack of insurance	6%	4%

Source: 2017 California Health Interview Survey, UCLA Center for Health Policy Research

COMMUNITY FEEDBACK

Lack of insurance, lack of access to healthcare providers, and limited services to rural parts of the county were all identified as barriers to accessing care.

A lack of transportation options and difficulty of travel in the winter were noted as problematic. Several individuals commented that they go to Nevada for healthcare services because it's about the same distance to Mammoth Lakes and there are more services available in Nevada.

Of respondents, 37% identified financial hardship as the number one reason why people do not get the medical services they need. Other reasons included seeking care only when in pain or very sick (35%), the high cost of medical services (31%), and high insurance premiums (29%).

KEY STAKEHOLDER FEEDBACK

Key stakeholders voiced concern regarding the distances people travel to receive care. The county is 3,030 square miles and receiving care in Mammoth Lakes can require traveling long distances, especially in winter when some roads may be closed due to inclement weather. They also expressed concern that the lack of access to transportation is a major barrier, and for those without a car, going to Mammoth Lakes can take an entire day by bus, possibly even requiring an overnight stay.

The top three reasons key stakeholders felt that people do not get the medical services they need were: access medical care only when they are in pain or are very sick (47%), financial hardship (46%), and high cost of medical services (39%).

MENTAL HEALTH PROVIDERS

Based on data from 2018, there was one (1) mental health professional for every 520 residents. California has more mental health providers for each resident than Mono County.

	MONO COUNTY	CALIFORNIA
Mental Health Professionals (2018)	520:1	310:1

Source: County Health Rankings, 2019

COMMUNITY FEEDBACK

Mental Health was identified as the top health concern for adults and children in Mono County by 41% and 38% of respondents respectively.

The top three reasons for people not getting the mental health services they need were identified as: not enough mental health providers, stigma or prejudice, and not understanding mental health disorders.

KEY STAKEHOLDER FEEDBACK

54% felt that stigma and prejudices regarding mental health were the most frequent reasons that individuals do not seek mental health services.

When interviewed, key stakeholders voiced concern related to the lack of inpatient options not only locally but also regionally due to the lack of available mental health beds.

ORAL AND DENTAL HEALTH

ACCESS TO DENTISTS

Based on data from 2017, there was one (1) dentist for every 2,020 residents in Mono County. The state has twice as many dentists for each resident than Mono County.

Mono County is a Dental Health Professional Shortage Area as designated by the California Office of Statewide Health Planning and Development.

In Mono County, there are a total of six (6) dentists. Five (5) are located in Mammoth Lakes, and one is located in Coleville. Of the five (5) located in Mammoth Lakes, only one accepts Medi-Cal Dental insurance. The remainder of dentists only accept private insurance. The dentist in Coleville accepts both Medi-Cal Dental and private insurance.

	MONO COUNTY	CALIFORNIA
Dentists	2,020:1	1,200:1

Source: County Health Rankings, 2019

MAMMOTH HOSPITAL FAMILY DENTAL CLINIC

The Mammoth Family Dental Clinic had a total of 8,005 visits between November 2017 and April 2019. Of the patients seen:

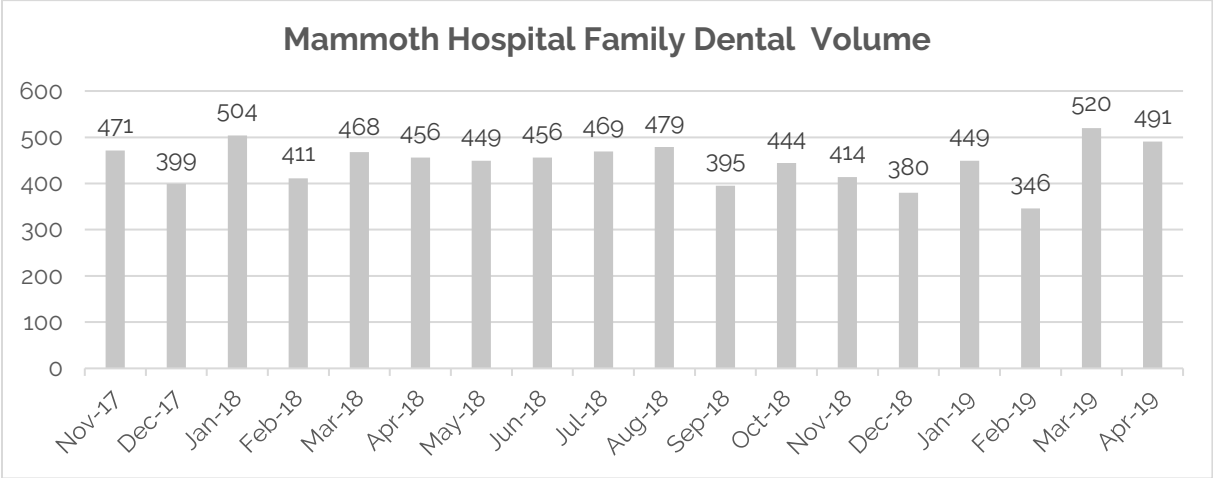
- 19.7% of patients were ages 5 or younger.
- 36.4% of patients aged 6 – 12
- 20.3% of patients aged 13 – 18
- 23.5% of patients were ages 19 or older

The most frequent dental care visits for children are related to regular checkups and preventative care, normal decay needing Amalgam or composite restoration, ortho extractions/over retained extractions. The most frequent dental care for adults is for restorations, extractions, root canals, crowns, bridges, removable prosthetics, Prophy's, Periodontal root planning.

85% of patients seen in the Dental Clinic have Medi-Cal as their primary payor.

The Dental Clinic reported the following statistics and information for 2018/2019:

- 2 to 3 months to schedule an exam or treatment for an adult
- 1 to 2 weeks to schedule an exam of treatment for a child
- Appointments for toothache or other urgent need range from immediate to one week
- 1 – 2 months average treatment time for an adult
- 2 weeks average treatment time for a child


Mammoth Hospital Family Dental Volume
600
500
400
300
200
100
0
471
399
504
411
468
456
449
456
469
479
395
444
414
380
449
346
520
491
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
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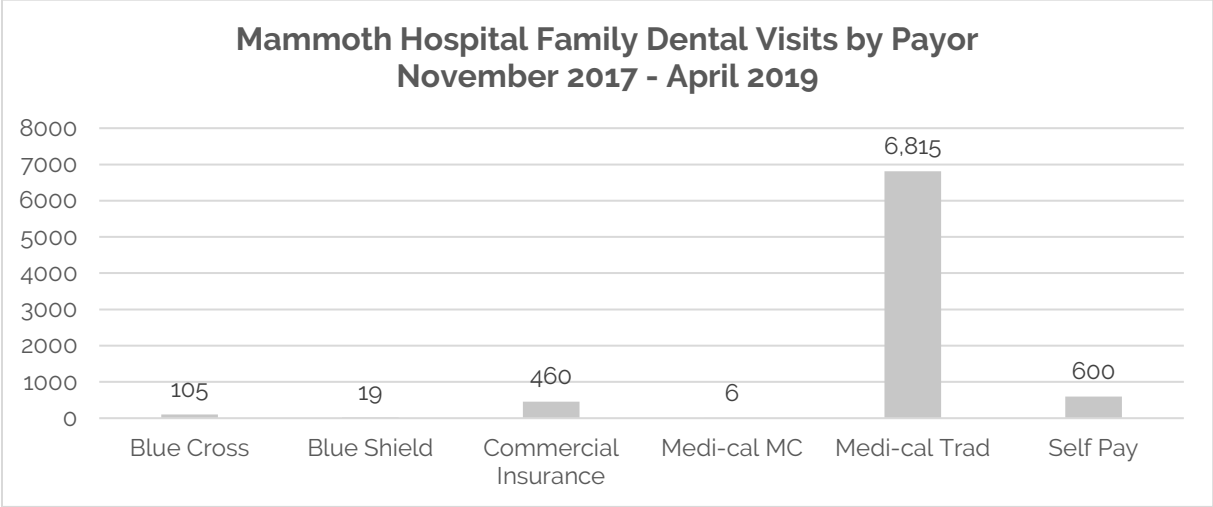
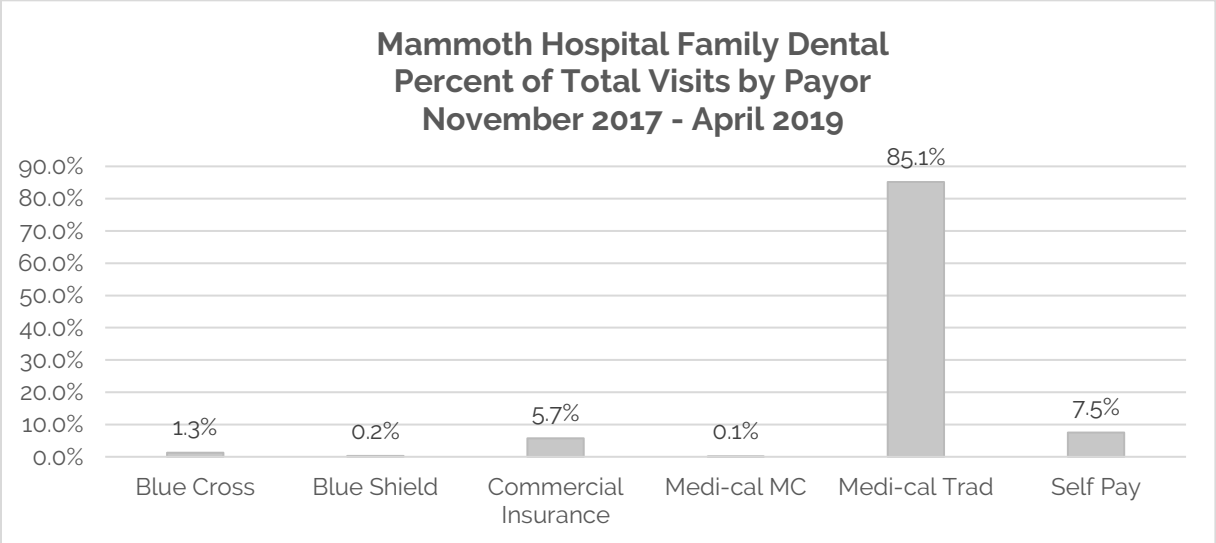
Jan-19
Feb-19
Mar-19
Apr-19


Mammoth Hospital Family Dental Visits by Payor
November 2017 - April 2019
8000
7000
6000
5000
4000
3000
2000
1000
0
105
19
460
6
6,815
600
Blue Cross
Blue Shield
Commercial Insurance
Medi-cal MC
Medi-cal Trad
Self Pay


Mammoth Hospital Family Dental
Percent of Total Visits by Payor
November 2017 - April 2019
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
1.3%
0.2%
5.7%
0.1%
85.1%
7.5%
Blue Cross
Blue Shield
Commercial Insurance
Medi-cal MC
Medi-cal Trad
Self Pay

DENTAL EMERGENCIES

The Status of Oral Health in California reports that in 2012, emergency departments in California had approximately 113,000 visits for preventable dental conditions.

In 2012, Mono County age-adjusted rates of preventable dental emergency department visits per 100,000 were approximately 298, which is statistically the same rate as the state.[52]

FLUORIDE

Drinking water in Mono County is not fluoridated.

Measure C, an ordinance prohibiting the Mammoth Community Water District from adding fluoride to the District water supply, was submitted for a public vote in 2005. The ordinance passed with 940 votes in favor of not adding fluoride to the water, and 363 votes against the ordinance.

In California, based on 2012 data, 63.7% of the population has fluoridated drinking water compared to 74.6% in the United States.

	CALIFORNIA	UNITED STATES
Population served by community water systems that receive optimally fluoridated drinking water (2012)	63.7%	74.6%

Source: California Department of Public Health. Status of Oral Health in California: Oral Disease Burden and Prevention 2017

ADULT ORAL HEALTH AND DENTAL CARE

The age-adjusted prevalence for dental visits by adults is essentially the same in California as the United States. Visits to the dentist by adults diagnosed with diabetes are higher (better).

Loss of all teeth and loss of six or more teeth for adults over 65 is lower (better) than the United States. No loss of teeth occurs at the same rate as the United States.

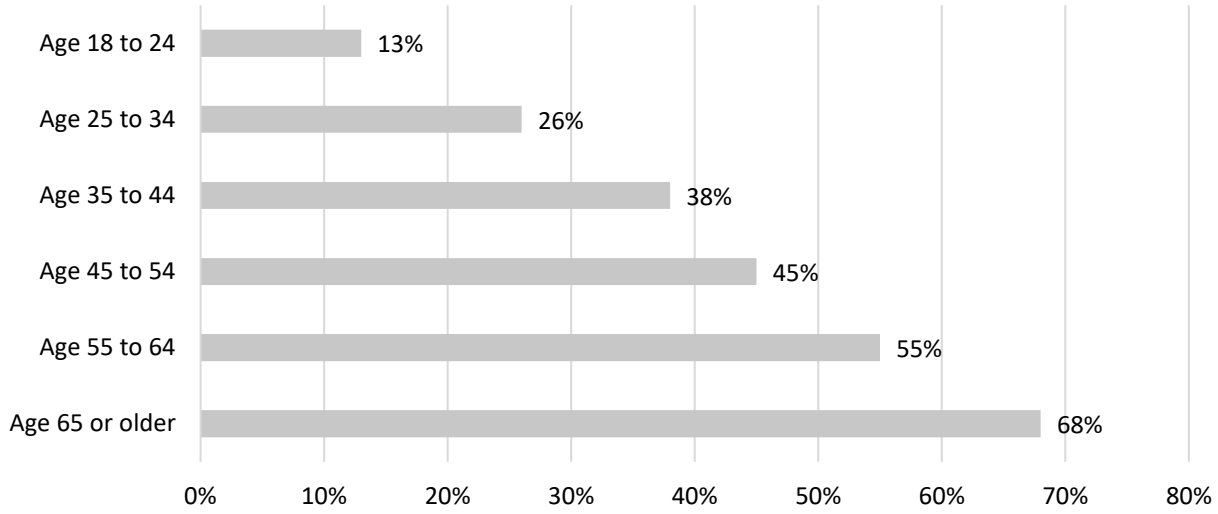
Of adults over the age of 65 in California, 68% have had tooth extraction due to tooth decay or gum disease. The percentage of tooth extraction due to tooth decay or gum disease increases with age.

[52] *Status of Oral Health in California: Oral Disease Burden and Prevention 2017*

ADULT ORAL HEALTH	CALIFORNIA	UNITED STATES
Visits to dentist or dental clinic among adults aged ≥ 18 years (2012)	66.8*	66.8*
All teeth lost among adults aged > 65 (2012)	8.8*	16.5*
Six or more teeth lost aged > 65 (2012)	29.3*	39.5*
No tooth loss among adults aged 18 – 64 (2012)	64.3	64.3
Visits to dentist or dental clinic among adults aged ≥18 years diagnosed with diabetes (2012)	59.2*	50.2*

Age-adjusted prevalence
Source: California Department of Public Health. Status of Oral Health in California: Oral Disease Burden and Prevention 2017

PREVALENCE OF PERMANENT TOOTH EXTRACTION DUE TO TOOTH DECAY OR GUM DISEASE AMONG ADULTS IN CALIFORNIA BY AGE, 2012



Source: California Department of Public Health. Status of Oral Health in California: Oral Disease Burden and Prevention 2017

ORAL HEALTH AND DENTAL CARE FOR CHILDREN

First 5 Mono County, with funding support from the California Small Population County Funding Augmentation, provides oral health education, oral health checks, and fluoride varnish applications.

According to First 5 Mono County annual report for 2016/2017,

> "*The oral needs of young children in Mono County continue to be high with few children accessing regular preventative care and annual screenings.*"

The First 5 Mono County report includes the following information.[53]

Research Question: *"Is the percent of children who regularly access preventive dental care high or increasing"?*

Data Source: Sierra Park Dental Data, 2014 – 2016

Finding: 20% of patients 0-5 had more than one visit to the dentist in the year, down from 24% the previous year.

Conclusion: Using the data of how many children went to the dentist more than one time in the year; we get a picture of how many are able to have work done in addition to annual cleaning and check-ups. Using this as a metric, we know 20% of children needed additional preventative care, but do not know how many of the children who needed additional care this includes. Thanks to a new collaboration with the fiscal department at Mammoth Hospital, this year's data is stronger than it was in the past. With continued support from Mammoth Hospital, we will be better able to track access to oral health care over time.

Research Question: *"Is the percentage of children age 1 or older who receive annual dental screenings high or increasing"?*

Data Source: Sierra Park Dental Data, 2014-16

Finding: 17% of patients had an annual exam and cleaning, 49% had an exam and cleaning in 2 of three years, and 34% had one exam and cleaning in 3 years.

Conclusion: Only 17% of children 0-5 visit the dentist annually, but more than half (56%) are seen at least annually. First 5 Mono County will continue to work through our oral health education efforts to support higher percentages of children having at least one visit to the dentist a year.

[53] *First Five Mono County FY 2016-2017 Evaluation Report*

Research Question: *"Is there a low percentage of children at kindergarten entry with untreated dental problems?"*

Data Source: Kindergarten Round-Up Oral Health Checks

Finding: 18% of the oral health checks completed at kindergarten roundup indicated the child had untreated caries (cavities), up from 5% last year.

Conclusion: While the percentage of untreated caries at kindergarten entry increased, it is hard to draw conclusions based on the low reporting rate of 35%. First 5 Mono County is working with the Mono County Office of Education to ensure school district compliance with their reporting requirements for these forms to support more complete data.

MONO COUNTY DENTAL CARE CHILDREN 0 – 5			
	2014-2015	2015-2016	2016-2017
Number and percent of children 0–5 who regularly access preventive dental care	13%	24%	145 20%
Number and percent of children ages 1 or older who receive annual dental screenings	17%	17%	129 17%
Number and percent of children at kindergarten entry with untreated dental problems	11%	5%	7 18%
Number and percent of prenatal women who receive dental hygiene education	24%	10%	25 19%

Source: First 5 Mono County, Mono County: FY 2016-2017 Evaluation Report- Slide 78

MONO COUNTY ORAL HEALTH VISITS PRESCHOOL AGE CHILDREN				
	Oral Health Checks	Oral Health Education	Fluoride Varnish	Total Services
Preschools/Family Child Care Home	-	125	92	217
Mammoth Elementary Kindergarten Round-up	14	-	15	29
Eastern Sierra Unified School District Birth-to-5 health and safety fairs	28	-	23	51
FY 2016-2017 Totals	42	125	130	297
FY 2015-2016 Totals	39	188	162	389

Source: First 5, Mono County: FY 2016-2017 Evaluation Report- Slide 55

The following oral health assessment data is from Eastern Sierra Unified School District, Mammoth Unified School District, and the Mono Office of Education. There was a total of 17 instances of untreated decay out of a total of 95 students who returned the assessment for the fiscal year 2017-2018 and 26 instances of untreated decay out of 79 students for the fiscal year 2018-2019.

SCOHR SUMMARY REPORT SCHOOL YEAR 2017-2018								
	DIST STAT	(1)TOTAL ELIGIBLE	(2)TOTAL POA	(3)WAIVED FB	(4)WAIVED LA	(5)WAIVED NC	(6)UNTREATED DECAY	(7)NOT RETURNED
Eastern Sierra Unified	Non-Participating	27	24	0	0	0	0	3
Mammoth Unified	Non-Participating	86	59	1	7	19	17	0
Mono County Office of Education	Non-Participating	15	12	0	0	0	0	3

Source: SCOHR Summary Report

SCOHR SUMMARY REPORT SCHOOL YEAR 2018-2019								
	DIST STAT	(1)TOTAL ELIGIBLE	(2)TOTAL POA	(3)WAIVED FB	(4)WAIVED LA	(5)WAIVED NC	(6)UNTREATED DECAY	(7)NOT RETURNED
Eastern Sierra Unified	Non-Participating	9	9	0	0	0	2	0
Mammoth Unified	Non-Participating	90	70	0	4	16	24	0

Mono County Office of Education	Non-Participating	0	0	0	0	0	0	0

Source: SCOHR Summary Report

1. *The total number of pupils in the district, by school, who are subject to the oral health assessment requirement (i.e., the number of kindergarten students plus the number of first-grade students who did not attend public school kindergarten.*
2. *The total number of pupils who present proof of an assessment.*
3. *The total number of pupils who could not complete an assessment due to financial burden.*
4. *The total number of pupils who could not complete an assessment due to lack of access to a licensed dentist or other licensed or registered dental health professional.*
5. *The total number of pupils who could not complete an assessment because their parents or legal guardians did not consent to their child receiving the assessment.*
6. *The total number of pupils who are assessed and found to have untreated decay.*
7. *The total number of pupils who did not return either the assessment form or the waiver request to the school.*

COMMUNITY SURVEY

Seven questions were included in the community survey regarding dental health. Each question and the responses are included in the following paragraphs.

HOW WOULD YOU RATE THE HEALTH OF YOUR TEETH, MOUTH, AND GUMS?

Forty-eight percent (48%) of respondents rated the health of their teeth, mouth, and gums as good and indicated that any issues they had were treated. Thirty-six (36%) responded that their dental health was excellent while fifteen (15%) said it was poor.

HEALTH OF TEETH, MOUTH AND GUMS	NUMBER OF RESPONSES	PERCENT OF RESPONSES
Good, any issues I had were treated	135	48.39%
Excellent, I rarely have issues	101	36.20%
Poor, I have many issues	43	15.41%

HOW OFTEN DO YOU BRUSH YOUR TEETH?

The majority of respondents, 72%, brush their teeth two (2) times a day, 19% brush their teeth once a day, 8% brush their teeth three (3) times a day or more and 1% indicated that they brushed their teeth a few times a week or less.

FREQUENCY OF BRUSHING TEETH	NUMBER OF RESPONSES	PERCENT OF RESPONSES
Twice a day	201	71.79%
Once day	54	19.29%
Three times a day or more	22	7.86%
A few times a week or less	3	1.07%
Never	0	0.00%

HOW DO YOU FEEL ABOUT FLUORIDE?

Questions related to fluoride indicated that 73% buy toothpaste with fluoride, 20% indicated that they and/or their children get fluoride treatments at the dentist while less than one

percent (1%) responded that they or their child use fluoride tablets or drops. Nine percent (9%) stated that they and/or their children drink water with fluoride, and 17% stated that they avoid fluoride. One percent (1%) of those responding indicated that they did not know what fluoride was.

FLUORIDE	NUMBER OF RESPONSES	PERCENT OF RESPONSES
I buy toothpaste with fluoride	200	71.79%
I get (and/or my children get) fluoride treatments at the dentist	55	20.0%
I avoid fluoride	47	17.09%
I drink (and/or my children drink) water with fluoride	25	9.09%
I do not know what fluoride is	3	1.09%
I use (and/or my children use) fluoride tablets or drops	2	0.73%

WHEN WAS THE LAST TIME YOU WENT TO THE DENTIST?

Respondents were asked when the last time was that they went to the dentist. Most of the respondents, 62%, indicated that they had visited the dentist in the last six (6) months or less. 15% had seen a dentist within the last year, 14% within the last two (2) years, 9% within the last five (5) years, and less than 1% stated that they never gone or could not remember when they went to a dentist last.

DENTAL EXAMS	NUMBER OF RESPONSES	PERCENT OF RESPONSES
Six months or less	174	62.14%
Within the last year	42	15.00%
Within the last two years	38	13.57%
Within the last five years or more	24	8.57%
Never	1	0.36%
I do not remember	1	0.36%

DURING THE LAST YEAR, HAS THERE BEEN A TIME WHEN YOU NEEDED DENTAL CARE BUT COULD NOT?

Fifty-six (56%) percent indicated that they were receiving the care they needed, while 23% indicated they were not.

DENTAL CARE	NUMBER OF RESPONSES	PERCENT OF RESPONSES
I received the care I needed	151	54.71%
I did not receive the care I needed	65	23.55%
I did not need dental care	61	22.10%

DO YOU HAVE DENTAL INSURANCE?

The majority of those responding 196 out of 277 or 70% indicated that they had insurance through an employer, family members/ employer, Medi-Cal, VA, or an alternate source.

However, 29% of respondents indicated that they could not afford or did not want dental insurance.

DENTAL INSURANCE	NUMBER OF RESPONSES	PERCENT OF RESPONSES
Yes, through employer or family member employer	161	58.12%
No, cannot afford	60	21.66%
Yes, through Medi-Cal	21	7.58%
No, I do not want it	20	7.22%
Yes, through a source not listed	14	5.05%
I do not know	2	0.72%
Yes, through VA	1	0.36%

WHAT ARE THE TOP THREE THINGS YOU THINK INFLUENCE DENTAL HEALTH IN OUR COMMUNITY?

The last question posed in the community survey asked respondents to identify the top three things influencing dental health within the community.

The cost of dental care received the most responses; lack of dentists and dental insurance were the second and third most frequent responses.

DENTAL HEALTH	NUMBER OF RESPONSES	PERCENT OF RESPONSES
Cost of dental care	158	59.18%
Lack of dentists	105	39.33%
Lack of dental insurance	100	37.45%
Lack of dentists who accept Medi-Cal or Denti-Cal insurance	96	35.96%
Use of sugar including soft drinks and food with high sugar content	72	26.97%
Lack of appointment at a time I can go to the dentist	46	16.85%
Lack of pediatric dentists	44	16.48%
Lack of education about dental health	29	10.86%
Tobacco use	20	7.49%
Lack of dental hygienists	18	6.74%
Lack of oral health screenings to identify problems	18	6.74%
Drug use	16	5.24%
Lack of fluoride in the water	10	3.75%

COMMUNITY FEEDBACK

Access to dental health was identified by 19% of respondents as a health concern for adults in Mono County. Twenty-four percent identified dental health as a health concern for children.

Access to dental care due to the high cost, including high co-pays and up-front costs, were common themes in the written feedback

Other barriers that were noted included: long wait times to get an appointment, lack of emergency dental care, and lack of pediatric dental care.

KEY STAKEHOLDER SURVEY

The key stakeholder survey included a question regarding factors influencing dental health, "*What are the top three (3) things you think influence dental health in our community?*"

The highest response, 63%, was sugar content in food. The second and third choices were both related to access to dental care, including lack of dental insurance (59%) and lack of dentists who accept Medi-Cal or Denti-Cal (41%).

Key stakeholder comments included other factors that influence dental health, including:

- No free dental clinic for people without insurance
- Fear of going to the dentist and dental treatments
- Fear of having dental pain as a result of treatment
- Not making appointments for children due to lack of time-off from parents' employer

Access to dental health was identified by 17% of key stakeholders as a health concern for adults in Mono County. Dental health was identified by 29% as a health concern for children.

MENTAL HEALTH

MENTAL HEALTH PROVIDERS

Based on data from 2018, there was one (1) mental health professional for every 520 residents. California has more mental health providers for each resident than Mono County.

	MONO COUNTY	CALIFORNIA
Mental Health Professionals (2018)	520:1	310:1

Source: County Health Rankings, 2019

HOSPITALIZATIONS

Data from the Family Health Outcomes Project, UCSF shows a significantly lower rate of mood disorder hospitalizations for females 15 to 24, mental health hospitalizations for ages 15 to 24, and substance abuse hospitalizations for ages 15 – 24 than the state. KidsData indicates that rates of mental health hospitalizations for children ages 5 – 19 are similar in Mono County and California. A statistical difference cannot be determined with the data provided.

	Mono County	California
*Mood disorder hospitalizations per 100,000 female population age 15 to 44 (2013 – 2015)	525 (386 – 714)	1,106 (1,102 – 1,111)
*Mental health hospitalizations per 100,000 population age 15 to 24 (2013 – 2015)	605 (424 – 863)	1,499 (1,493 – 1,505)
*Substance abuse hospitalizations per 100,000 population age 15 to 24 (2013 – 2015)	262 (153 – 448)	793 (789 – 798)
**Hospitalization for Mental Health Issues per 1,000 Ages 5 - 14 (2016)	2.6 per 1,000	2.5 per 1,000
**Hospitalization for Mental Health Issues per 1,000 Ages 15 - 19 (2016)	9.5 per 1,000	9.8 per 1,000
**Hospitalization for Mental Health Issues per 1,000 Total ages 5 – 19 (2016)	5.2 per 1,000	5.0 per 1,000

Source: Family Health Outcomes Project, UCSF, June 2018
Source: KidsData Mono County

SUICIDE

The age-adjusted death rate in Mono County from 2015-2017 was 10.9 compared to a rate in the state of 10.4. However, the rate in Mono County may be unreliable due to fewer than 20 data elements.[54]

CHILDREN

The following information is abstracted from the 2018 California Children's Report Card.[55]

- 35% of children in California who reported needing help for emotional or mental health problems receive counseling
- 13% of total hospital discharges in California of children are due to mental illness
- 42% of California children experience one or more Adverse Childhood Experience (ACEs)
- 17% is the approximate percentage of California children receiving therapy or counseling as part of their Individualized Education Plan (IEP), although 70,000 have a serious mental or behavioral health need

The California Healthy Kids Survey for 2017-2018 includes indicators related to depression and thoughts of suicide.

24% of 9th graders and 57% of 11th graders at ESUSD, and 35% of 9th graders and 42% of 11th graders at MUSD report chronic sad or hopeless feelings in the last 12 months. The rate in the state for 9th and 11th graders is 29.6% and 32.3%.

3% of 9th graders and 42% of 11th graders at ESUSD, and 20% of 9th graders and 17% of 11th graders at MUSD report they seriously considered attempting suicide in the last 12 months. The rate in the state for 9th and 11th graders is 16.0% and 15.5%.

Chronic Sad or Hopeless Feelings, Past 12 Months						
	ESUSD Grade 9	MUSD Grade 9	California Grade 9	ESUSD Grade 11	MUSD Grade 11	California Grade 11
No	76%	65%	70.4%	43%	58%	67.7%
Yes	24%	35%	29.6%	57%	42%	32.3%

Source: Eastern Sierra Unified School District (ESUSD) California Healthy Kids Survey 2017-2018
Source: Mammoth Unified School District (MUSD) California Healthy Kids Survey 2017-2018
Source: California Kids Survey 2018

54 California Department of Public Health 2019 County Health Status Profiles
55 2018 California Children's Report Card

Seriously Considered Attempting Suicide, Past 12 months						
	ESUSD Grade 9	MUSD Grade 9	California Grade 9	ESUSD Grade 11	MUSD Grade 11	California Grade 11
No	97%	80%	84.0%	58%	83%	84.5%
Yes	3%	20%	16.0%	42%	17%	15.5%

Source: Eastern Sierra Unified School District (ESUSD) California Healthy Kids Survey 2017-2018
Source: Mammoth Unified School District (MUSD) California Healthy Kids Survey 2017-2018
Source: California Kids Survey 2018

COMMUNITY FEEDBACK

The community survey asked what the three most important health concerns for adults and children were. The highest health concern for both adults and children was mental health.

The community survey asked why people do not obtain mental health services. The top three responses were lack of mental health providers, stigma or prejudice, and not understanding mental health disorders.

Written comments:

- Lack of access to mental health services in rural parts of the county, including Bridgeport, which is the county seat, was a major deterrent to care.
- Several respondents commented on the need to provide more access to private counselors, especially for a short-term situational crisis.

The lack of support services and activities for seniors was identified as contributing to social isolation and depression.

KEY STAKEHOLDER FEEDBACK

Key stakeholders were asked both about the health concerns of adults and the health concerns of children. Of those surveyed, 51.7% identified mental health as the second most important health concern for adults. Mental health was rated as the sixth most important health concern for children (25.9%).

The majority of respondents, 54%, identified stigma or prejudice as the number one reason people do not get the mental health care they need. Lack of mental health providers was number two, 43%, and not understanding mental health disorders was number three, 38%.

Written comments:

- Lack of psychiatrists
- Mental Health services need to be in all parts of Mono County and not just Mammoth Lakes
- Mental Healthcare is not treated as a right; therefore, access is restricted

MATERNAL AND INFANT HEALTH

PRENATAL INDICATORS

Based on data from the Family Health Outcomes Project, Mono County had a significantly lower rate of prenatal care in the first trimester than the state. However, the rate of women who received adequate or better prenatal care was significantly higher than the state.

The concerns of late entry into prenatal care include pre-term birth and low gestational weight, and Mono County shows statistically equivalent rates to the state in both of these measures.

There are other indicators that show Mono County having a statistically different rate from the state, whether better or worse. However, these data points are regional data from the Maternal and Infant Health Assessment (MIHA) Survey and California Health Interview Survey (CHIS) and do not specifically reflect Mono County. Mono County data is combined into the North/Mountain Region for the MIHA survey which includes Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne Counties. Mono County is part of the Sierra County Region for the CHIS survey, which includes Tuolumne, Calaveras, Amador, Inyo, Mariposa, Mono, and Alpine Counties.

RISK FACTORS FOR PRE-TERM AND PREMATURE BIRTH

Numerous publications identify risk factors for pre-term labor and premature birth. A list from the Mayo Clinic is included below:

- Having a previous premature birth
- Pregnancy with twins, triplets, or other multiples
- An interval of less than six months between pregnancies
- Conceiving through in-vitro fertilization
- Problems with the uterus, cervix, or placenta
- Smoking cigarettes or using illicit drugs
- Some infections, particularly of the amniotic fluid and lower genital tract
- Some chronic conditions, such as high blood pressure and diabetes
- Being underweight or overweight before pregnancy
- Stressful life events, such as the death of a loved one or domestic violence
- Multiple miscarriages or abortions
- Physical injury or trauma

INFANT HEALTH

Mono County performs better than the state for breastfeeding in the hospital. Additional data is included in Appendix 9.

MATERNAL MORTALITY

More women die in the US from pregnancy-related complications than in any other developed country. The US is the only industrialized nation with a rising maternal mortality rate and between 2000 and 2014 there was a 26% increase in the maternal mortality rate.

To address this problem, ACOG supports the establishment of maternal mortality review committees (MMRCs). These multidisciplinary committees, comprised of local health experts, study cases of maternal deaths and recommend improvements to prevent future adverse outcomes. Nearly thirty states have an active a Maternal Mortality Review Committee in place or in development. ACOG supports federal legislation that assists state creation or expansion of MMRCs.

Source: The American College of Obstetricians and Gynecologists. https://www.acog.org/About-ACOG/ACOG-Departments/Government-Relations-and-Outreach/Federal-Legislative-Activities/Maternal-Mortalty

Based on information from the California Maternal Quality Care Collaborative (CMQCC) website, the rate of maternal mortality in the state has decreased from 16.9 deaths per 100,000 live births in 2006 to 7.3 deaths per 100,000 live births in 2013. CMQCC noted that African American women are roughly four times more likely to die from pregnancy-related causes than women in all other racial/ethnic groups.

In response to this concerning trend, the California Department of Public Health: Maternal, Child, and Adolescent Health Division launched the *California Pregnancy-Associated Mortality Review* (CA-PAMR) project to identify pregnancy-related deaths, causation, and contributing factors, and then make recommendations on quality improvements to maternity care.

PREVENTIVE CARE FOR CHILDREN

According to the Department of Healthcare Services (DHCS) Management Information System for fiscal year 2017-2018, preventive care utilization rates for children with Medi-Cal are 42.7% for Mono County and 45.2% statewide.[56] The report states, "*Fiscal year 2017-2018 data may be incomplete due to a delay in DHCS receiving the data".*

[56] *Analysis of DHCS's Management Information System/Decision Support System Data*

An audit regarding DHCS' oversight of the delivery of preventive services to children in Med-Cal included the following information:

- An annual average of 2.4 million children enrolled in Medi-Cal do not receive all required preventive services
- Many of the State's children do not have adequate access to Medi-Cal providers who can deliver the required pediatric preventive services.
- Limited provider access is due in part to low Medi-Cal reimbursement rates.
- States with higher utilization rates offer financial incentive programs that California could implement, but it would likely require additional funding.
- DHCS delegates responsibilities to ensure access and use of children's preventive services to managed care plans, but it does not provide effective guidance and oversight.
    - It does not provide adequate information to plans, providers, and beneficiaries about the services it expects children to receive.
    - It does not ensure that plans regularly identify and address underutilization of children's preventive services.
    - It has not followed up on plans' efforts to mitigate cultural disparities in the usage of preventive services.[57]

[57] *Analysis of DHCS's Management Information System/Decision Support System Data*

COMMUNITY FEEDBACK

The community survey asked the top three things that influence prenatal and women's health. The number one (1) response, 57%, was that there are not enough medical providers or doctors.

The second (2nd) most frequent response, 36%, was the inability to take pregnancy or postpartum leave from work.

Two (2) answers tied as the third influence at 28% including lack of access to family planning and/or contraceptives, and substance use during pregnancy.

Written comments:

- Lack of access to women's health services in rural and unincorporated parts of the county and the distance to travel to Mammoth Lakes was mentioned by multiple respondents.
- The need for female OB physicians as well as high-risk specialists, were identified. The need for consistency in providers (less turn-over) was also identified.

The need for prenatal education and breastfeeding education and support was also identified.

In an attempt to ascertain what the sleeping environment is like for infants, respondents were asked to select all the descriptive statements that applied. The overwhelming majority of the respondents (82%) indicated that they did not care for an infant. For those that did provide care for an infant, the responses are included in the Community Survey Appendix 5.,

KEY STAKEHOLDER FEEDBACK

Key stakeholders were asked what three things influence prenatal and women's health.

The top two choices were unable to take time off from work, 33%, and not enough providers, 29%.
Delayed prenatal care and substance abuse during pregnancy, were each rated at 30%.

Written comments:

- Lack of healthcare access
- Cost regarding insurance, time off work, and perceived cost of services
- With parents helping, the "old ways" of care and attitude are continuing
- Medical costs
- Lack of services for high-risk pregnancies
- No psychologist/psychiatrists specializing in postpartum issues

COMMUNITY SAFETY

CRIME

Violent crime in Mono County is lower than the state. The number of offenses shows a higher number of property crime and larceny-thefts in Mammoth Lakes than the county.

VIOLENT CRIME RATE PER 100,000 POPULATION		
	MONO COUNTY	CALIFORNIA
Violent Crime Rate (2014 & 2016)	262	421

Source: County Health Rankings, 2019

OFFENSES KNOWN TO LAW ENFORCEMENT 2017		
	MAMMOTH LAKES	MONO COUNTY
Violent Crime	27	16
Murder / Non-negligent Manslaughter	0	0
Rape	5	1
Robbery	5	0
Aggravated Assault	17	15
Property Crime	147	58
Burglary	21	15
Larceny-Theft	115	38
Motor Vehicle Theft	11	5
Arson	0	0

Source: FBI Uniform Crime Reporting (UCR) Program: Offenses by City and Offenses by Metropolitan and Nonmetropolitan Counties, 2017

DOMESTIC VIOLENCE	MONO COUNTY	CALIFORNIA
Calls to police for violent or aggressive behavior within the home per 100,000 population (2015)	585.2	417.3

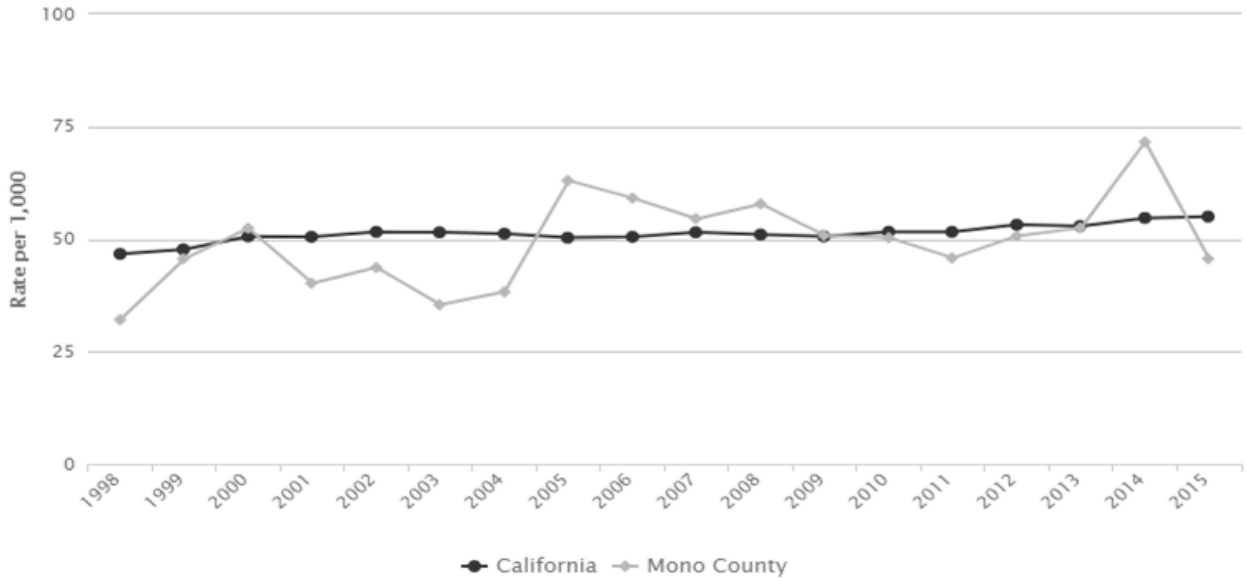
Source: Family Health Outcomes Project, UCSF

CHILD ABUSE AND NEGLECT

In 2015, Mono County had a rate of child abuse and neglect of 45.6 per 1,000 children, compared to a rate of 55 per 1,000 children in California.[58]

[58] *Lucile Packard Foundation for Children's Health: Kidsdata*

REPORTS OF CHILD ABUSE AND NEGLECT: 1998 TO 2015



Source: kidsdata.org

SCHOOL SAFETY

The California Healthy Kids Survey (CHKS) was developed by the California Department of Education and is administered every other year in Mono County. Student participation is voluntary and confidential.

3% of 9th graders and 14% of 11th graders at Eastern Sierra Unified School District (ESUSD), and 3% of 9th graders and 13% of 11th graders at Mammoth Unified School District (MUSD) report feeling unsafe or very unsafe at school. The state rate is 15.6% for 9th grades and 18.2% for 11th graders.

	ESUSD GRADE 9	MUSD GRADE 9	CALIF Grade 9	ESUSD GRADE 11	MUSD GRADE 11	CALIF GRADE 11
Perceived Unsafe or Very Unsafe at School	3%	3%	15.6%	14%	13%	18.2%

Source: California Healthy Kids Survey: Eastern Sierra Unified School District (ESUSD) Elementary 2017-2018 Main Report
Source: California Healthy Kids Survey: Mammoth Unified School District (MUSD) Secondary 2017-2018 Main Report
Source: California Healthy Kids Survey 2017-2018 b Appendix 9: Maternal and Infant Health Indicators

COMMUNITY AND KEY STAKEHOLDER FEEDBACK

Community members ranked bullying as the second highest influence on child wellness and safety, and key stakeholders ranked bullying as fourth.

APPENDIX 1: RESOURCES TO MEET COMMUNITY HEALTH NEEDS

EMERGENCY SERVICES/SERVICIOS DE EMERGENCIA

Fire, Ambulance, Sheriff's. California Highway Patrol	911
Mammoth Hospital–Emergency Department	760-934-3311
Mono County Sheriff's Dispatch	760-932-7549

LAW ENFORCEMENT/ORDEN PÚBLICO

California Highway Patrol	760-932-7995
Mammoth Lake Police Department	760-965-3700
Mono County Animal Control	760-932-5630
Mono County Probation, Bridgeport	760-92-5570
Mono County Probation, Mammoth Lakes	760-932-1730
Mono County Sheriff's Department	760-932-7549

FIRE DEPARTMENTS/DEPARTAMENTO DE BOMBEROS

Antelope Valley	530-495-2900
Benton	760-933-2252
Bridgeport	760-932-7353
June Lake	760-648-7390
Lee Vining	760-647-6400
Long Valley	760-935-4545
Mammoth Lakes	760-934-2300

24-HOUR HOTLINES/TELÉFONOS DE EMERGENCIAS

California Youth Crisis Line	800-843-5200
Child Abuse Hotline	800-422-4453
Child Abuse – To Report Local	800-340-5411/760-932-7755
Mono County Behavioral Health Access Line	800-687-1101
National Domestic Violence Hotline	800-799-7233
National Drug & Alcohol Treatment	800-622-2255
National Parent Support Line	855-427-2736
National Sexual Assault Hotline	800-656-4673
Suicide Prevention Lifeline	800-273-8255
Wild Iris Crisis Line	877-873-7384

DENTAL SERVICES

Mono County First 5	760-;924-7626
Mono County Health Department	760-924-1830
Dr. Christopher J. Comfort, Mammoth Lakes	760-934-3730
Mammoth Dental, Mammoth Lakes	760-934-8571
Sierra Park Family Dental Clinic, Mammoth Lakes	760-924-4007
Tehrani Smiles, Mammoth Lakes	760-914-4442
Toiyabe Indian Health Project Dental Clinic, Coleville	530-495-2100
Toiyabe Indian Health Project Dental Clinic, Bishop	760-873-8464

HOSPITALS/HEALTH CLINICS HOSPITALES/CLINICAS DE SALUD

Mammoth Hospital & Clinics	760-934-3311
Mono County Public Health, Bridgeport	760-932-5580
Mono County Public Health, Mammoth Lakes	760-924-1830
Toiyabe Indian Health Project, Coleville	530-495-2100
Toiyabe Indian Health Project, Lone Pine	760-876-4795

HEALTH INSURANCE ASSISTANCE ASISTENCIA CON SEGURO DE SALUD

Covered California Enroll Online	http://www.coveredca.com
Mono County Department of Social Services	760-924-1770

SUBSTANCE ABUSE PREVENTION & TREATMENT PREVENCION Y TRATAMIENTO PARA ABUSO DE SUBSTANCIAS

Alcoholics Anonymous, Alanon & Alateen	800-851-1304 / 760-934-3434
Alpine Counseling Center (Bishop)	760-873-4357
American Comprehensive Counseling Services (Nevada)	775-883-4325
California Smokers Helpline	800-662-8887
Drug Rehab Gardnerville Rancheros (Nevada)	775-453-4919
Mammoth Hospital Behavioral Health Clinic	760-934-2551
Mono County Behavioral Health – Drug & Alcohol Svcs	760-924-1740
Moo County Health Dept. Tobacco Cessation Assistance	760-924-1830
Toiyabe Indian Health Project	760-873-8464

COUNSELING/SERVICIOS DE TERAPÍA Y ORIENTACIÓN

Mammoth Hospital Behavioral Health Clinic	760-934-2551
Mono County Health Dept. Behavioral Health	760-924-1740
North Star Counseling Center	760-924-7926
Toiyabe Indian Health Project	760-873-8464
Wild Iris	760-934-2491

FINANCIAL, FOOD &/or CLOTHING FINANCIAMIENTO, ALIMENTACION y/o ROPA

Antelope Valley Senior Center, Walker	530-495-2323
IMACA	760-934-3343
Mammoth Lakes Lutheran Church Food Pantry	760-873-8557
Mono County Department of Social Services	760-924-1770
Mono County WIC Program	760-924-4610
Salvation Army Food Pantry, 220 Sierra Manor	760-872-2124
Salvation Army, Bridgeport	760-934-4740
Wild Iris	760-934-2491

HOUSING &/or ENERGY ASSISTANCE ASISTENCIA de VIVIENDA y/o ENERGIA

IMACA	760-934-3343
Mammoth Lakes Housing	760-934-4740
Mono County Department of Social Services	760-924-1770
Wild Iris	760-934-249

NEW PARENT SUPPORTS APOYO PARA PADRES PRIMERIZOS

First 5 Mono	760-924-7626
Mono County Child Care Council	760-934-3343
Mono County Public Health, Bridgeport	760-932-5580
Mono County Public Health, Mammoth	760-924-1830
Mono County Resource & Referral	760-934-3343
Sierra Park Pediatric Clinic	760-924-4000
Women, Infant and Children (WIC)	760-924-4610

PARENT EDUCATIÓN/EDUCACION PARA PADRES

Car Seat Checks	
CHP, Bridgeport	760-932-7995
Mammoth Lakes Fire Department	760-934-2300
Mammoth Lakes Police Department	760-965-3700
Community Service Solutions/SNAP-Ed	530-495-2700
First 5 Mono	760-924-7626
MCOE/Adult Education	760-934-0031
Wild Iris	760-934-2491

EARLY CHILDHOOD RESOURCES RECURSOS PARA LA NIÑEZ TEMPRANA

First 5 Mono	760-924-7626
Mono County Child Care Council	760-934-3343
Mono County Libraries & Raising-a-Reader	760-934-8670
Mono County Public Health, Bridgeport	760-932-5580
Mono County Public Health, Mammoth	760-924-1830
Mono County Resource & Referral	760-934-3343
Sierra Park Pediatric Clinic	760-924-4000
Women, Infant and Children (WIC)	760-924-4610

CHILD CARE CENTERS/PRESCHOOLS CENTROS PREESCOLARES Y DE CUIDADO DEL NIÑO

Benton & Bridgeport Preschools	760-932-7443
IMACA Head Start & CA State Preschools (Mammoth Lakes, Lee Vining & Coleville)	760-934-3343
IMACA for a list of Family Childcare Providers	760-934-3343
Kids Corner	760-934-4700
Mammoth Lutheran Preschool	760-934-4051
Mono County Office of Education	760-934-0031

SCHOOL DISTRICTS & SCHOOLS/DISTRITOS (K-12) ESCOLARES Y ESCUELAS (K-12)

Eastern Sierra Unified School District Office	760-932-7443
Antelope Valley Elementary School	530-495-2541
Bridgeport Elementary School	760-932-7441
Coleville High School	530-495-2231
Edna Beaman Elementary School	760-933-2397
Lee Vining Elementary School	760-647-6460
Lee Vining High School	760-647-6366
Mammoth Unified School District Office	760-934-6802

Mammoth Elementary School	760-934-7545
Mammoth High School	760-934-8541
Mammoth Middle School	760-934-7072
Mono County Office of Education (MCOE)	760-934-0031

LIBRARIES/BIBLIOTECAS Mono County Library Administration 760-934-8670

Benton	760-933-2542
Bridgeport	760-932-7482
Coleville	530-495-2295
Crowley Lake	760-935-4505
June Lake	760-648-7284
Lee Vining	760-647-6123
Mammoth Lakes	760-934-4777

HIGHER EDUCATION/EDUCACIÓN SUPERIOR

Cerro Coso Community College	760-934-2875
MCOE/Adult Education	760-934-0031

JOB SERVICES/SERVICIOS DE TRABAJO

Mono County Department of Social Services	760-924-1770

DEVELOPMENTAL SCREENINGS (AGES 0-3 years)/ REVISIÓN DE DESARROLLO (Edades 0-3 años)

First 5 Mono	760-924-7626
Great Steps Ahead	760-872-2270
Kern Regional Center	760-873-7411
MCOE/Early Start	760-934-0031
Sierra Park Pediatric Clinic	760-924-4000

SPECIAL EDUCATION (AGES 3-21 years)/ EDUCACIÓN ESPECIAL (Edades 3-21 años)

MCOE/Pre-K (Ages 3-5)	760-934-0031
Contact School of Attendance (Ages 5-21) – Schools/Escuelas	

DISABILITY ASSISTANCE/ASISTENCIA POR DISCAPACIDAD

Community Services Solutions	530-495-2700
Disabled Sports of the Eastern Sierra	760-934-0791
Disability Rights – Advocacy	800-776-5746
Mono County Department of Social Services	760-924-1770

ELDERLY ASSISTANCE &/or SENIOR PROGRAMS/ ASISTENCIA A LA TERCERA EDAD Y/o PROGRAMAS PARA ANCIANOS A

Antelope Valley Senior Center	530-495-2323
Community Services Solutions	530-495-2700
Eastern Sierra Area Agency on Aging	877-462-2298
Mono County Department of Social Services	760-924-1770

NATIVE AMERICAN TRIBES/TRIBUS NATIVO AMERICANAS

Bridgeport Indian Colony	760-932-7083
Mono Lake Kutzadika	760-605-6263
Utu Gwaitu Paiute Tribe Benton	760-933-2321

ADDITIONAL NATIVE AMERICAN RESOURCES/ RECURSOS NATIVO AMERICANOS ADICIONALES

Bishop Paiute Tribe	760-873-4477
Owens Valley Career Development Center	
Benton Tribal TANF	760-933-2426
Coleville Tribal TANF	530-495-1000
Toiyabe Indian Health Project	760-873-8461

LEGAL SERVICES/SERVICIOS LEGALES

Mono County Child Support Services	866-901-3212
Mono County District Attorney	760-932-5550
Mono County Probation, Bridgeport	760-932- 5570
Mono County Probation, Mammoth Lakes	760-932-1730
Mono County Recorder	760-932-5530
Mono County Superior Court	760-924-5444
Self-help & Family Law Assistance	760-258-7372

TRANSPORTATION/TRANSPORTE

California Road Conditions	800-427-7623
Dial-a-Ride (Mammoth Lakes Only)	760-924-3184
Eastern Sierra Transit	760-872-1901

RECREATION/RECREACIÓN

Mammoth Lakes Welcome Center	760-924-5500
June Mountain Ski Area	760-648-7733
Mammoth Mountain Ski Area	760-934-2571
Town of Mammoth Lakes, Recreation	760-965-3690

VETERAN SERVICES/SERVICIOS PARA VETERANOS

County of Inyo-Mono Veteran Services	760-873-7850

WELLNESS PROGRAMS/PROGRAMAS DE SALUD

Mammoth Hospital	760-934-3311
Mono County Behavioral Health	760-924-1740
Toiyabe Indian Health Community Wellness	760-873-8851

COUNTY & TOWN OF MAMMOTH LAKES GOVERNMENT/ GOBIERNO DEL CONDADO Y PUEBLO DE MAMMOTH LAKES

Mammoth Lakes Town Council/Clerk	760-965-3600
Mono County Board of Supervisors/Clerk	760-932-5530

ADDITIONAL COUNTY & TOWN OF MAMMOTH LAKES BOARDS & COUNCILS/JUNTAS Y CONSEJOS ADICIONALES DEL CONDADO Y PUEBLO DE MAMMOTH LAKES

http://www.ci.mammoth-lakes.ca.us
http://www.mono.ca.gov/boards

APPENDIX 2: KEY STAKEHOLDERS INTERVIEWED

Tom Parker, Mammoth Hospital, CEO
Tom Cage, Kittredge Sports, P3, Mammoth Chevron and Hertz, Business Owner
Molly DesBaillets, First 5, Executive Director
Kathy Peterson, Mono County, Social Services Director
Anita Reeve, Owens Valley Career Development Center
Tina Murphy, Owens Valley Career Development Center, Case Counselor
Amanda Hoover, Community Services Solutions-Walker, Executive Director
Stu Brown, Mammoth Lakes Parks and Recreation, Director
Chris Mokracek, Mono County, Paramedic Chief
Jacob Eide, Mammoth Hospital Behavioral Health Clinic, Supervisor
Laurey Carlson, Mammoth Resorts/Mammoth Hospital, Director/Board Vice Chair
Alex Tomaier, Mammoth Lakes Fire Department, Division Chief Administration and Training
Edyth Irvine, Patient Family Advisory Committee, Friends of the Library
Marjoree Neer, Toiyabe Indian Health Project, Director of Public Health
Lois Klein, Mammoth Unified School District, Superintendent
Ingrid Braun, Mono County Sherriff / Coroner
Lenna Monte, Mammoth Hospital, Director of Quality
Matthew O'Connor, Wild Iris Family Counseling and Crisis Center, Executive Director
John Peters, Mono County, District 4 Supervisor
Carolyn Korfiatis, Mammoth Hospital Family Medicine Clinic, Nurse Practitioner
Patricia Espinosa, Mono County Social Services, Senior Services Manager
Lori Baitx, Mammoth Hospital, Emergency Department Manager
Robin Roberts, Behavioral Health-Mono County, Director
Al Davis, Mammoth Police Department, Police Chief
Bob Gardner, Mono County, Supervisor
Sandra Pearce, MS, RN, PHN, CNS, Mono County Health Department, Public Health, Director
Kathleen Alo, RN, BSH, CPHQ, Mammoth Hospital, Chief Nursing Officer

APPENDIX 3: KEY STAKEHOLDER INTERVIEW SUMMARY

There were twenty-seven phone interviews conducted with key stakeholders in February and March of 2019. The names of the individual interviewed, and the organizations that they represented are listed in *Appendix 2*.

The interviews were in addition to a key stakeholder survey.

The following is a summary of key themes.

HOUSING

The lack of housing or the lack of affordable housing was the topic most frequently cited by the interviewees as an important need. Most comments focused on the lack of housing in general. Comments mentioned that people are living in their cars, multiple families are living together in single-family homes, or in some cases, they are living in the woods. One commenter referred to a housing survey performed a few years ago that identified a gap of 120-150 housing units in unincorporated Mono County and 500-600 in Mammoth Lakes.

It was noted that there are several single night housing options, but no long-term housing options. Clients who are eligible for emergency housing are often unsuccessful in finding a place to live. It was also noted that homelessness increases in the summer due to seasonal work.

Mammoth Resort is the largest employer, but there is not enough housing for its employees. They are currently providing housing in motels in other communities and providing bus service to and from the resort.

Affordability was another topic discussed related to housing with multiple commenters stating that the available housing is unaffordable. One person felt that vacation homes were driving up property costs. Another stated that wages in the area are low, and the cost of living is high, leaving many residents unable to afford housing.

The lack of housing is perceived to be creating financial hardships for residents and contributing negatively to their mental health.

BEHAVIORAL HEALTH/MENTAL HEALTH

Interviewees identified behavioral health services as the second most important community need.

The perception is that there is a lack of care options within the community leading to the need to transport very ill patients out of the area. However, the concern does not end there, as there is a lack of available beds for treatment across the state.

Comments included the perception that there are a significant number of under-diagnosed or undiagnosed individuals with significant mental health needs.

Also identified in the interviews were other contributing factors such as a lack of understanding of available services, costs of services, and medication; as well as the stigma associated with accessing care. One interviewee commented on the general lack of understanding that exists as it relates to the impact social determinants have on individuals seeking treatment.

Other concerns expressed were the availability of translation services for non-English speaking individuals seeking treatment and the lack of communication between agencies/organizations within Mono County as it relates to behavioral/mental health services.

SUBSTANCE ABUSE

Alcohol abuse was the third most frequently identified community need. While some commenters indicated alcoholism was a higher need, in many cases alcohol abuse was included in the same category as other addictions to include tobacco, marijuana, opioids, methamphetamine, and other "street drugs."

In many cases, the comments regarding addiction were tied to behavioral and mental health concerns.

One commenter indicated that there is an initiative currently underway to develop a prescription treatment program for alcohol addiction in the community.

Another commenter indicated that there is a lack of inpatient substance abuse treatment facilities within the county, and according to one interviewee, inmates who are sentenced to inpatient treatment have nowhere to go to receive treatment.

ACCESS TO SERVICES

Access to services was identified as a significant concern especially in rural and unincorporated parts of the county. Commenters noted that people might have to travel up to an hour one way, and in the winter, travel may not be possible. For those that must take public transportation, the trip can take a full-day, and in some instances require an overnight stay.

Transportation and financial hardships, coupled with distance, are noted to create even more of an impact on access to care. Many commenters felt strongly that there is a need for clinics and services in outlying communities. The need for more services and access for specific populations, including Hispanics, Native Americans, and seniors, were identified.

DENTAL HEALTH

The lack of dental health providers, especially for children, was noted as a concern. Children were noted not to see a dentist as often as they should and are not learning good oral health practices. One individual commented that this is a very visible concern. There are many children who have a full set of silver caps, and there are many adults with poor dental health and/or missing teeth.

HISPANIC POPULATION

Several commenters stated that they believe the Hispanic population is underserved in Mono County.

One commenter felt that as a community, we need to make sure that we understand and address the needs of the Hispanic population, including barriers to healthcare.

Another individual stated that they felt that the Hispanic population stays in the shadows, are very hard workers, stay in the community, and the majority are legal citizens.

Comments indicated that some felt that many Hispanics don't trust the system and are not comfortable with seeking care. A need for more translators was also identified.

COLLABORATION

Several commenters indicated that there should be a more concentrated effort to increase collaboration. There was a feeling that care and resources across the community are not well coordinated, and collaborative relationships need to be strengthened.

OTHER

Other areas of need identified less frequently were childcare, food insecurity, transportation, obesity, vision services, family support, chronic disease, ER use, and poverty.

RECOMMENDED FOCUS

In most cases, the top three needs that were identified in the previous paragraphs were also those that the interviewees felt should be the focus moving forward. The exception was housing, which although a significant community need, it should be addressed as a social determinant to health rather than a focus area.

The recommended focus areas were identified as:

1. Increase access to behavioral health services
2. Increase treatment options for alcohol and substance abuse
3. Increase access to services, especially in rural and unincorporated parts of the county

APPENDIX 4: KEY STAKEHOLDER SURVEY

OVERVIEW OF RESPONDENTS

Mammoth Hospital and Mono County Health Department performed a survey of key stakeholders. The key stakeholder survey was in addition to key stakeholder interviews.

There were 35 respondents. The survey was available from January 9, 2019, to February 22, 2019. The respondents represented varying service types and organizations.

- Twenty-seven provided services to ethnic minorities
- Twenty-six provided services to women and children
- Twenty-four served individuals over 65

Other stakeholders represented included those providing services to the homeless; teens; individuals with limited English proficiency; Native Americans; individuals with chronic disease, mental illness, and addiction; recreational services; emergency services; and survivors of domestic abuse.

Each question and responses are included in the following paragraphs.

Question 3: In Mono County, which populations or groups do you believe have the greatest challenges in achieving and maintaining good health?

The majority, (84%), indicated that children and families who live in poverty experienced the greatest challenges.

The second highest population identified (66%) were individuals with poor health literacy or limited English proficiency.

Four populations, homeless individuals, people with a chronic mental illness, individuals who use illegal drugs, and minorities, were all greater than 50%.

CHALLENGES	NUMBER OF RESPONSES	PERCENTAGE
Children and Families who live in poverty	27	84.38%
Individuals with poor health literacy or limited English proficiency	15	65.63%
Homeless	18	56.25%
Individuals with a Chronic Mental Illness	18	56.25%
Individuals who use illegal drugs	18	56.25%
Minorities	16	50.00%
Individuals with a chronic disease	14	43.75%
Adults who are obese or overweight	12	37.50%
Children who are obese or overweight	12	37.50%
Individuals who smoke or vape	11	34.38%
Immigrants	9	28.13%
Individuals with dental caries	8	25.00%
Individuals over the age of 65	7	21.88%
Migrant workers	4	12.50%

COMMENTS / ADDITIONAL POPULATIONS

- Teens who vape
- Individuals who do not have transportation to medication treatment/follow-up
- Domestic Violence
- Victims of domestic violence and sexual assault
- Native Americans
- Eleven (11) of the categories above, except individuals over 65, will have greater challenges than others without these problems
- Individuals without medical insurance and a lack of understanding of the medical system
- Individuals who abuse alcohol
- Alcoholics

Question 4: What factors or barriers do you believe contribute to the health challenges of at-risk populations (commonly referred to as social determinants of health)?

A large percentage (87%) of respondents identified affordable housing as the most significant factor contributing to health challenges.

Closely behind at 81%, poverty and the stressful conditions that accompany poverty were identified as contributing to the health challenges of at-risk populations.

Limited health literacy or limited English proficiency was also identified as factors (69%). Access to economic opportunities and access to healthcare services, each received a 50% response rate from the key stakeholders.

HEALTH CHALLENGES	NUMBER OF RESPONSES	PERCENTAGE
Access to affordable housing	28	87.50%
Poverty and the stressful conditions that accompany poverty	26	81.25%

Limited Health Literacy or limited English Proficiency	22	68.75%
Access to economic opportunities	16	50.00%
Access to healthcare services	16	50.00%
Access to transportation	14	43.75%
Access to jobs	13	40.63%
Access to job training opportunities	13	40.63%
Access to housing that is maintained and is in good repair	13	40.63%
Distrust of government	13	40.63%
Cultural norms	11	34.38%
Access to educational opportunities	10	31.25%
Discrimination or racism, including residential segregation	7	21.88%
Social support from community, family or friends	6	18.75%
Access to leisure and recreational opportunities	5	15.63%
Access to mass media and emerging technologies (e.g., cell phones, internet, social media)	5	15.63%
Crime and violence	4	12.50%
Public Safety	3	9.38%

COMMENTS / ADDITIONAL FACTORS OR BARRIERS

- Bi-lingual services by persons who are bi-lingual / bi-cultural
- Domestic violence
- Economic disparities between rich whites and the rest
- Some individuals are working several jobs just to survive
- Access to rehabilitation and recovery services
- Food insecurity

Question 5: What strategies or programs have been successful in addressing the health challenges of at-risk populations?

Comments are included below grouped by topic area. This was an open-ended question. Most comments were related to collaboration between agencies.

BEHAVIORAL HEALTH

- Behavioral Health Clinic
- Primary Care Behavioral Health Program at Mammoth Hospital

COLLABORATION AND OUTREACH

- Family wrap-around services; multiple agencies working together
- Owens Valley Community Development Center (OVCDC) and Toiyabe Indian Health Project - in addressing various health concerns such as diabetes, suicide, depression, heart disease, and oral hygiene
- Strategies and programs [should] include people we are trying to serve in the actual planning
- Indian Health Clinics, Health Department outreach

- Multi-department collaboration
- Outreach and making services known
- Collaborations between the county and hospital/clinic programs and providers
- Making sure services are connected (such as making sure first responders know who to contact for long term solutions)

DENTAL HEALTH

- Dental Health Clinic

MINORITIES AND AT-RISK POPULATIONS

- Simple-language public health PSAs targeting minorities and those with limited English proficiency and low health literacy
- Interpreter services
- Bilingual healthcare education

PROGRAMS AND SERVICES

- Early childhood education like Head Start which includes health screening Community-based home visiting and support
- School-based services,
- The many programs under Public Health
- Direct assistance with health insurance enrollment
- First 5
- Food Banks
- Employee Assistance Program (EAP) program
- Tobacco education programs

RECREATION

- Providing high-quality and affordable summer camps, and programs for youth, the construction of new recreation amenities such as the inclusive playground at Mammoth Creek Park, the Volcom Brothers Skate park and the opportunity to enjoy, connect, socialize and participate in athletic activities at our many parks and facilities throughout town

OTHER

- Medicare is in place; however, not all the population understands it. There is a lack of female doctors.
- Workforce housing

Question 6: What is the one action or strategy that if undertaken, could jumpstart other actions to positively impact the health challenges of at-risk populations?

ACCESS

- Free health clinic in Mammoth Lakes
- Increase marketing to services available
- More outreach and education to the help that is available

- Universal healthcare, including a safety net for undocumented immigrants
- Universal healthcare
- Access to care
- Accessing State and Federal funds for increased Home Visiting

BEHAVIORAL HEALTH

- Additional psychiatrists
- Mammoth really needs a psychiatrist
- De-Stigmatization of behavioral health services
- Depression outreach

COLLABORATION

- Interagency collaboration to bring awareness to at-risk communities
- Inclusion of those who are "at risk" in all planning
- Being willing to collaborate
- Partnership between Mammoth Hospital and Toiyabe Indian Health Clinic in Coleville to provide services to the Northern county populations

EDUCATION

- Educational services

FOOD AND NUTRITION

- Educate how to provide healthy food to families, cutting out bad habits mainly sugar
- Sugar tax
- Nutrition as a prescription

HOUSING

- There isn't just one action or strategy, but housing is top on the list
- Affordable housing

RECREATION

- Greater awareness of our many affordable recreation programs throughout the entire community and engagement/participation in understanding the recreation needs.

OTHER

- Use new terminology; remove "at risk" and use strength-based language when describing a person/patient target population
- Immigration reform

Question 7: In your opinion, what are the three (3) most important health concerns for adults in Mono County?

Most respondents (59%) agreed that the most important health concern for adults in the community was alcohol use, followed by mental health (52%).

Stress and being overweight/obesity followed at 31% and 21% respectively.

If all the chronic diseases were combined, including cancer and Alzheimer's, they would account for approximately 13% of the responses.

HEALTH CONCERNS ADULTS	NUMBER OF RESPONSES	PERCENTAGE
Alcohol Use	17	58.62%
Mental Health	15	51.72%
Illegal drug use like opioids or methamphetamines	12	41.38%
Stress	9	31.03%
Overweight / Obesity	6	20.69%
Dental Health	5	17.24%
Cancer	4	13.79%
Domestic Violence	4	13.79%
Stress	4	13.79%
Domestic Violence	3	10.34%
Homelessness	3	6.90%
Diabetes	2	6.90%
Heart Disease	2	6.90%
Marijuana Use	2	6.90%
Tobacco Use	2	6.90%
Vaping	2	3.45%
Asthma / COPD	1	3.45%
Stroke	1	3.45%
Alzheimer's Disease / Dementia	1	3.45%

COMMENTS / OTHER HEALTH CONCERNS

- Alcohol and substance abuse
- Chronic disease
- Stress in lower income families, as a result of overwork, lack of work, high cost of living in Mammoth, lack of affordable childcare – all affect the overall health of individuals

Question 8: In your opinion, what are the three (3) most important health concerns for children under 18 in Mono County?

Overweight / Obesity and Vaping were the most frequently identified health concerns. Alcohol use was number three (3).

Dental health and stress were identified at a rate of 30%, followed by mental health at 26%.

Tobacco use and use of illegal drugs were identified were both 22%.

HEALTH CONCERNS CHILDREN	NUMBER OF RESPONSES	PERCENTAGE
Overweight / Obesity	13	48.15%
Vaping	13	48.15%
Alcohol Use	9	33.33%
Dental Health	8	29.63%
Stress	8	29.63%
Mental Health	7	25.93%

Tobacco Use	6	22.22%
Illegal drug use like opioids or methamphetamines	6	22.22%
Marijuana Use	5	18.52%
Other accidents or injuries (bicycles, dirt bikes, sports, swimming/diving)	5	18.52%
Child Abuse	3	11.11%
Diabetes	2	7.41%
Sexually Transmitted Diseases	2	7.41%
Asthma	1	3.70%
Suicide	1	3.70%

COMMENTS / OTHER HEALTH CONCERNS

- Vaping is a serious teen issue
- Lack of adult supervision

Question 9: What are the top three things you think influence child wellness and safety in our community?

The overwhelming choice for influence on child wellness and safety was identified as parental abuse of alcohol and drugs, 70.37%. Teen drug alcohol or tobacco use was over 50%.

The third choice, 48%, was access to affordable, nutritious food.

CHILD WELLNESS AND SAFETY	NUMBER OF RESPONSES	PERCENTAGE
Parental abuse of alcohol and drugs	19	70.37%
Teen drug, alcohol, or tobacco use/abuse	14	51.85%
Limited access to affordable, nutritious food	13	48.15%
Bullying or harassment	10	37.04%
Limited physical activity	8	29.63%
Violence in home or community	7	25.93%
Not enough adult supervision	5	18.52%
Not enough parenting classes	4	14.81%
No safe place to play	3	11.11%
Lack of support services for children with special health care needs	3	11.11%
Parents not knowing child safety recommendations	2	7.41%
Medicines, drugs, or cleaning supplies are accessible to children in the home	2	7.41%
Child unable to swim, not using a life jacket, or needs water safety education	1	3.70%
Cigarette smoke exposure	1	3.70%
Child Abuse	1	3.70%

COMMENTS / OTHER INFLUENCES RELATED TO CHILD WELLNESS AND SAFETY

- Lack of affordable housing
- Anti-vaccine beliefs and practices

- Somehow helping young parents to understand the importance of being caring, loving, role models to their children even though they themselves growing up did not have a stable family experience
- Lack of access to Optometrists and difficulty accessing dental services due to parents not scheduling visits

Question 10: What are the top three reasons you think people do not get the medical services they need?

Only seeking medical care when in pain or very sick, financial hardship, and the high cost of medical services were the top three choices, 46.43%, 46.43%, and 39.29% respectively.

Not understanding the importance of care and not understanding services available were in the top five reasons. Cultural and language barriers were sixth.

MEDICAL SERVICES	NUMBER OF RESPONSES	PERCENTAGE
Only seeking medical care when in pain or very sick	13	46.43%
Financial hardship	13	46.43%
High cost of medical services	11	39.29%
Not understanding the importance of regular check-ups	10	35.71%
Not understanding what services are available or how to access them	9	32.14%
Cultural or language barriers	6	21.43%
High insurance premiums and copayments	5	17.86%
Difficulty finding an eye doctor when needed	4	14.29%
High costs of medications	4	14.29%
Fear of deportation	4	14.29%
Poverty	4	14.29%
Difficulty finding a dentist when needed	3	10.71%
Families with complicated lives	3	10.71%
Limited transportation	3	10.71%
Untreated mental health issues	3	10.71%
I think people generally get the medical services they need	2	7.14%
Difficulty getting an appointment when needed	2	7.14%
Difficulty finding a specialist when needed	2	7.14%
Lack of trust in the system	2	7.14%
Complicated enrollment process for health insurance	1	3.57%
Discrimination	1	3.57%

COMMENTS / OTHER REASONS

- No local pharmacy

Question 11: What are the top three reasons you think people do not get the mental health services they need?

The majority of respondents, 54%, identified stigma or prejudice as the number one reason people do not get mental health care. Lack of mental health providers was number two, 43%, and not understanding mental health disorders was number three, 38%.

MENTAL HEALTH SERVICES	NUMBER OF RESPONSES	PERCENTAGE
Stigma or prejudice	15	53.57%
Not enough mental health providers	12	42.86%
Not understanding Mental Health Disorders	11	38.29%
Language or cultural barriers	8	28.57%
Not enough family, individual, or group therapy services	6	21.43%
Lack of coping skills or problem-solving strategies	6	21.43%
Drug or alcohol abuse	6	21.43%
Financial concerns	6	21.43%
Not enough screenings and referrals for Mental Health	4	14.29%
Social acceptance or alcohol and/or drug use	4	14.29%
Chronic Stress	3	10.71%
Multi-general Mental Health issues	2	7.14%
Not enough substance abuse screening or treatment	2	7.14%
Not aware of negative effects of substance use	2	7.14%
Lack of support (community, family, friends)	2	7.14%
Untreated substance use problems	1	3.57%

COMMENTS / OTHER REASONS

- Lack of psychiatrists
- Mental Health services need to be in all parts of Mono County and not just Mammoth Lakes
- Healthcare not treated as a right, therefore access is restricted

Question 12: What are the top three things you think influence prenatal and women's health in our community?

The top two choices were unable to take time off from work, 33%, and not enough providers, 29%.

Delayed prenatal care and substance abuse during pregnancy, were each rated third at 30%.

PRENATAL AND WOMEN'S HEALTH	NUMBER OF RESPONSES	PERCENTAGE
Unable to take pregnancy or postpartum leave from work	9	33.33%
Not enough women's medical providers or doctors	8	29.63%
Delayed prenatal care	8	29.63%

Substance use during pregnancy (alcohol, marijuana, tobacco, opioids, etc.)	8	29.63%
Not enough prenatal or postpartum mental health screenings	5	18.52%
Lack of access to family planning and/or contraceptives	4	14.81%
Domestic Violence	4	14.81%
Not enough prenatal education	3	11.11%
Not enough midwives	2	7.41%
Not enough serves for prenatal mood or anxiety disorders	2	7.41%
Hypertension, pre-eclampsia, and/or eclampsia	1	3.70%
Current or previous cesarean delivery	1	3.70%

COMMENTS / OTHER REASONS

- Lack of healthcare access
- Cost regarding insurance, time off work, and perceived cost of services
- With parents helping, the old ways of care and attitude are continuing
- Medical costs
- Lack of services for high-risk pregnancies
- No psychologist/psychiatrists specializing in postpartum issues

Question 13: What are the top three (3) things you think influence dental health in our community?

The number one response, 63%, was sugar content in food. The second and third choices were both related to access to dental care, including lack of dental insurance (59%) and lack of dentists who accept Medi-Cal or Denti-Cal (41%).

DENTAL HEALTH	NUMBER OF RESPONSES	PERCENTAGE
Use of sugar including soft drinks and other foods with high sugar content	17	62.96%
Lack of dental insurance	16	59.26%
Lack of dentists who accept Medi-Cal or Denti-Cal insurance	11	40.74%
Lack of pediatric dentists	7	25.93%
Lack of education about dental health	7	25.93%
Lack of dentists	6	22.22%
Lack of appointments at a time the community can go to the dentist	3	11.11%
Lack of fluoride in the water	3	11.11%
Lack of oral health screenings to identify problems	3	11.11%
Drugs use	2	7.41%
Lack of dental hygienists	1	3.70%
Tobacco use	1	3.70%

COMMENTS / OTHER REASONS

- No free dental clinic for people without insurance
- Fear of going to the dentist and having dental pain as a result of treatment
- Fear of dental treatments
- Lack of making appointments for children due to lack of sick time from parents' employer

Question 14: If the Hospital and the Health Department, in collaboration with community partners, were to choose five (5) initiatives to work on over the next three (3) years, what would you recommend that they work on?

Each respondent could choose up to five initiatives. The question was open-ended and did not include a forced choice.

Substance Abuse Prevention and Treatment received the highest number of responses, followed by Mental Health Care. Nutrition and Access to Healthy Food and Collaboration with Community partners, each received a total of ten responses.

Each response is listed in the following paragraphs by topic area.

INITIATIVES	NUMBER OF RESPONSES
Substance Abuse Prevention and Treatment	24
Mental Health Care	15
Medical Care	10
Nutrition and Access to Healthy Food	10
Access to recreation and Physical Activity	8
Collaboration	7
Services for Children	7
Cultural Sensitivity	7
Access to Dental Care	6
Access to Vision Services	4

Housing and Homelessness	3
Education	2

SUBSTANCE ABUSE – 24 RESPONSES INCLUDING TOBACCO

TREATMENT

- Alcohol and drug abuse
- Alcohol and drug abuse
- Alcohol and addiction treatment
- Substance abuse programs
- Substance abuse
- Addiction
- Increased access to outpatient substance abuse treatment
- Inpatient substance abuse treatment
- In-county mental health providers specializing in postpartum issues and young children
- Substance Abuse in our youth - alcohol, and drugs

PREVENTION AND EDUCATION

- More robust substance abuse programs
- Substance abuse programs
- Suboxone programs that do not reside in the family medicine clinic
- Addiction treatment (Vivitrol, buprenorphine, etc.)
- Alcohol abuse and drug abuse prevention
- Educating parent and our community on the dangers of teen binge drinking
- Alcohol and drug abuse prevention
- Comprehensive prevention strategy
- Mitigation of young adult alcohol/drug partying culture
- Comprehensive prevention strategy that is different than what is used now to address the use of alcohol by adults and how parental use of alcohol affects kids. Not a "just say no, alcohol is harmful" strategy
- Healthy coping strategies for people who turn towards drugs

TOBACCO

- Tobacco reduction, including vaping
- Substance Abuse in our youth – vaping
- Tobacco cessation

ACCESS TO MENTAL HEALTH CARE – 15 RESPONSES

- Mental Health
- Mental Health
- Mental health access countywide
- Mental health support
- Recruit more psychiatrists
- Find and fund a psychiatrist
- Mental health providers

- Increase providers
- Expand psychologist services
- Increase access to mental health providers, including a local psychiatrist
- Increase access
- Behavioral health integration into medical systems
- Use ACE scores to create strength-based, positive programs for young kids
- Mental Health/confidence in teens
- Mental health care

ACCESS TO HEALTHCARE SERVICES – 10 RESPONSES

- More provider outreach to all areas of Mono County on a regular basis
- Access to services in rural parts of County (mobile clinics)
- Access to appointments
- Free healthcare clinic
- Appointment length
- More female doctors across all departments especially GYN
- Access to care
- More pediatric services
- Medical services for pregnant women
- Prenatal care

NUTRITION – 10 RESPONSES

- Nutrition
- Food insecurity
- Access to affordable healthy nutrition to prevent obesity and diabetes
- Sugar tax
- Nutrition education in a manner that encourages participation
- Nutrition education in schools
- Disallowing purchase of sugary drinks, certain desserts w SNAP benefits
- Access to farmer's market/food cooperatives
- Nutritional needs
- Public school educational programs regarding healthy eating and exercise habits

RECREATION – 8 RESPONSES

- Greater engagement and participation by all community members in the development of quality, affordable recreation programs
- Greater education and awareness of the recreation services and amenities provided by all organizations/agencies in the community
- Fund for scholarships enabling participation in pay-to-play recreation programs and activities
- Free indoor space for young children to play in the winter
- Activities
- Get kids to cut back on gaming
- Offering more for people to do socially that doesn't involve going to the bar
- Multi-use facility

COLLABORATION – 7 RESPONSES

- Improve collaboration with Northern Inyo Hospital
- Partner with the town for community facilities and amenities - multi-use facility
- Development of information and data sharing
- Community engagement throughout the community
- Getting the people you are serving to the table to create strategies and initiatives that they help to create
- Improve collaboration with Northern Inyo Hospital
- Partner with the town on construction and/or programming of needed community facilities and amenities (aquatic facility, community center)

CHILDREN SERVICES – 7 RESPONSES

- Health screenings for young children
- Services for young children and families
- Focus on 0-5 low-income children
- Low-cost immunizations
- Childcare programs
- Childcare centers in Mono's smaller communities
- Developmental screening coordination – Help Me Grow

ACCESS TO DENTAL CARE - 6 RESPONSES

- Dental Health
- Dental Health
- Dental Care
- Oral health services and outreach for children and parents
- Funding for dental care
- Increased access to dental services

CULTURAL SENSITIVITY – 6 RESPONSES

- Development of staff that is bi-lingual, bi-cultural who can move up the ladder into leadership positions
- Teach compassion in schools
- Health education in Spanish
- Cultural acceptance education
- Help minorities access services
- Targeted public health classes for community members with Limited English Proficiency

VISION – 4 RESPONSES

- In-county optometry
- Access to vision care services
- Access to vision services
- Funding for vision care

HOUSING – 3 RESPONSES

- Housing

- Housing / Homelessness
- Homeless shelters

EDUCATION – 2 RESPONSES

- Healthcare education and availability
- Overall health care information/education

OTHER RESPONSES

- Regional approach to SART examinations
- Connecting emergency services with long term care
- Chronic disease
- Regular and affordable transportation throughout Mono County
- Senior care
- Interventions in domestic abuse

Question 15: The hospital developed health priorities in previous strategic planning meetings. Do you believe there have been improvements?

The hospital was interested in knowing if key stakeholders felt there were improvements based on strategic priorities.

5. *Did the hospital increase the number of physicians/providers?*

YES	NO	NOT SURE
41%	11%	48%

6. *Did the hospital develop a visiting specialist program?*

YES	NO	NOT SURE
59%	0%	41%

7. *Did the hospital improve the information/education provided to the community?*

YES	NO	NOT SURE
23%	8%	69%

8. *Did the hospital improve mental health services?*

YES	NO	NOT SURE
30%	19%	52%

APPENDIX 5: COMMUNITY SURVEY

MAMMOTH AND MONO COUNTY

2019 COMMUNITY HEALTH NEEDS ASSESSMENT

COMMUNITY SURVEY SUMMARY

Distribution

A community survey was distributed from February 1, 2019, to March 7, 2019. The survey, in both English and Spanish, was distributed in various public locations including community clinics, health and human services agencies, and libraries, and was also made available electronically.

Questions 1, 2, and 3

Respondents

There were 355* surveys completed, with twenty-five surveys completed in Spanish. The majority of surveys were from residents of Mammoth Lakes, followed by Bridgeport, then Crowley Lake / Sunny Slopes.

LOCATION	NUMBER OF RESPONSES
Benton / Hammil Valley / Chalfant	19
Bishop	6
Bridgeport	59
Crowley Lake / Sunny Slopes	30
Fish Lake Valley, Dyer, Nevada	1
June Lake	9
Mammoth Lakes	183
Mono City / Lee Vining	14
McGee Creek	2
Swall Meadows/Paradise	15
Topaz / Coleville / Walker	26

**Some respondents reported more than one location*

Most respondents, 82.2%, were white or Caucasian, 13.8% were Hispanic or Latino, and 2.8% were American Indian or Alaska Native.

RACE AND ETHNICITY	NUMBER OF RESPONSES	PERCENTAGE
American Indian or Alaska Native	10	2.82%
Asian or Asian American	3	0.85%
Black or African American	0	0.0%
Hispanic or Latino	49	13.84%
Multiple Ethnicity	6	1.69%
Other	5	1.41%
White or Caucasian	291	82.2%

The highest percentage of respondents, 24%, were ages 35-44, and ages 55-64, 22%.

AGE	NUMBER OF RESPONSES	PERCENTAGE
Under 18	1	0.28%
18 – 24	15	4.25%
25 – 34	72	20.40%
35 – 44	86	24.36%
45 – 54	59	16.71%
55 – 64	77	21.81%
65 - 74	36	10.20%
Over 75	7	1.98%

Questions 4 and 5

Three Most Important Health Concerns

Respondents were asked what they felt were the three most important health concerns for adults and children.

The highest health concern, for both adults and children, was mental health.

The remaining top three responses differed between adults and children. While alcohol use was the second (2nd) highest concern for adults, it was ranked fifth (5th) for children.

Dental health was ranked third (3rd) for children and seventh (7th) for adults.

HEALTH CONCERNS ADULTS	RESPONSES	HEALTH CONCERNS CHILDREN	RESPONSES
Mental Health	132	Mental Health	113
Alcohol Use	110	Vaping	98
Cancer	94	Dental Health	71

Question 4: What are the three (3) most important health concerns for adults in Mono County?

Health concerns with at least twenty-five responses are included in the table below. Mental Health, Alcohol Use, and Cancer were ranked as the top three.

HEALTH CONCERNS ADULTS	NUMBER OF RESPONSES	PERCENTAGE
Mental Health	132	40.74%

Alcohol Use	110	33.95%
Cancer	94	29.01%
Illegal drugs use like opioids or methamphetamines	90	27.78%
Diabetes	74	22.84%
Heart Disease	66	20.37%
Dental Health	62	19.14%
Overweight / obesity	49	15.12%
Stress	43	13.27%

Written comments:

Respondents identified physical injuries such as ski and snowboard activities as a concern.

Access to healthcare services was identified as a concern including lack of insurance, lack of access to healthcare providers, and lack of services to rural parts of the county.

Several people commented on the poor air quality in the winter, which contributes to respiratory problems.

Question 5: What are the three (3) most important health concerns for children in Mono County?

Health concerns with at least twenty-five responses are included in the table below. Mental Health and Vaping were ranked as the top two concerns. Dental health, Overweight/Obesity, and Alcohol Use were ranked the third highest concerns.

HEALTH CONCERNS CHILDREN	NUMBER OF RESPONSES	PERCENTAGE
Mental Health	113	37.79%
Vaping	98	32.78%
Dental Health	71	23.75%
Overweight / Obesity	69	23.08%
Alcohol Use	69	23.08%
Illegal drugs use like opioids or methamphetamines	69	23.08%
Other accidents or injuries (bicycles, dirt bikes, sports, swimming diving	64	21.40%
Marijuana Use	58	19.40%
Child Abuse	50	16.72%
Stress	31	10.37%
Sexually Transmitted Diseases	30	10.03%
Tobacco Use	25	8.36%

Written comments:

Several respondents mentioned the lack of up-to-date Vaccinations as a health concern.

Several respondents also identified access to healthcare services in unincorporated areas.

Question 6: What are the top three things you think influence child wellness and safety in our community?

When asked what the top three (3) things that influenced child wellness and safety, the answer that received the most responses (122) was teen drug, alcohol, or tobacco use/abuse.

Bullying and harassment received the second highest number of responses, while limited access to affordable, nutritious food was third. It is important to note that the fourth highest number of responses was parents' abuse of alcohol and drugs.

Factors that influence child wellness and safety with at least twenty-five responses are included in the table below.

CHILD WELLNESS AND SAFETY	NUMBER OF RESPONSES	PERCENTAGE
Teen drug, alcohol, or tobacco use/abuse	122	41.64%
Bullying or harassment	116	39.59%
Limited access to affordable, nutritious food	114	38.91%
Parents abuse of alcohol and drugs	97	33.11%
Limited physical activity	63	21.50%
Not enough adult supervision	56	19.11%
Lack of support services for children with special health care needs	55	18.77%
Violence in home or community	45	15.36%
Cigarette smoke exposure	28	9.56%
Child unable to swim, not using a life jacket, or needs water safety education	25	8.53%

Written comments:

Several respondents commented on the lack of access to pediatric dentists.

Lack of access to physical activities, including sports, was identified. Several individuals commented that the lack of activities is especially problematic in unincorporated areas. Another commented that activities are needed for kids who can't afford to ski or snowboard. Cell phones and screen time were also identified as contributing to a lack of physical activity.

Several respondents noted that it is very difficult for parents to provide adequate support and supervision when both parents must work. Another respondent noted that older children are frequently responsible for caring for younger children.

Question 7: What are the top three reasons you think people do not get the medical services they need?

ACCESS TO MEDICAL SERVICES	NUMBER OF RESPONSES	PERCENTAGE
Financial hardship	109	36.82%
Only seeking medical care when in pain or very sick	104	35.14%
High cost of medical services	92	31.08%
High insurance premiums and co-payments	87	29.39%
Not understanding what services are available or how to access them	70	23.65%
Difficulty finding a specialist when needed	59	19.93%

Difficulty finding a doctor or medical providers special health care needs	56	18.92%
Difficulty getting an appointment when you need it	51	17.23%
Not understanding the importance of regular check-ups	48	16.22%
Difficulty finding a dentist when needed	33	11.15%
High cost of medications	30	10.14%
Limited transportation	26	8.78%

Written comments:

Multiple respondents commented on the limited services and access outside of Mammoth Lakes. The long distances required to travel, especially in winter were noted as very difficult and sometimes impossible.

Several individuals commented that they go to Nevada for healthcare services because it is about the same distance, and there are more services available.

Question 8: What are the top three reasons you think people do not get the mental health services they need?

ACCESS TO MENTAL HEALTH SERVICES	NUMBER OF RESPONSES	PERCENTAGE
Not enough mental health providers	127	44.41%
Stigma or prejudice	108	37.76%
Not understanding mental health disorders	106	37.06%
Financial concerns	89	31.12%
Not enough screenings and referrals for Mental Health	77	26.92%
Not enough family, individual, or group therapy services	56	19.58%
Lack of support (community, family, friends)	45	15.73%
Drug or alcohol abuse	44	15.38%
Language or cultural barriers	29	10.14%
Social acceptance of alcohol and/or drug use	26	9.09%

Written comments:

Lack of access to mental health services in rural parts of the county, including Bridgeport, which is the county seat, was a major deterrent to care.

Question 9: What are the top three things you think influence prenatal and women's health in our community?

When asked what three (3) things influence prenatal and women's health in the community the number one (1) answer by far (57%), was that there are not enough women's medical providers or doctors.

The second (2nd) most frequent response at 36% was the inability to take pregnancy or postpartum leave from work.

Two (2) answers came in as the third (3rd) factor which was the lack of access to family planning and/or contraceptives (28%) and substance use during pregnancy (28%).

PRENATAL AND WOMEN'S HEALTH	NUMBER OF RESPONSES	PERCENTAGE
Not enough women's medical providers or doctors	141	56.63%
Unable to take pregnancy or postpartum leave from work	89	35.74%%
Lack of access to family planning and/or contraceptives	69	27.71%%
Substance use during pregnancy (alcohol, marijuana, tobacco, opioids, etc.)	69	27.71%%
Not enough prenatal education	56	22.49%
Not enough prenatal or postpartum mental health screenings	48	19.28%%
Not enough midwives	42	16.87%
Delayed prenatal care	41	16.47%
Not enough services for prenatal mood or anxiety disorders	40	16.06%

Written comments:

Multiple respondents mentioned lack of access to women's health services in rural and unincorporated parts of the county and the distance to travel to Mammoth Lakes.

The need for female OB physicians was identified as well as the need for consistency in providers (less turn-over) and high-risk specialists.

The need for prenatal education and breastfeeding education and support was also identified.

Question 10: If you care for an infant, what is their sleeping environment like?

To ascertain what the sleeping environment is like for infants, respondents were asked to select all the descriptive statements that applied.

The overwhelming majority of the respondents (82%) indicated that they did not care for an infant. For those that did, the table below lists the descriptive statement and the # of responses for each.

DESCRIPTOR	# RESPONSES	PERCENTAGE
Infant has separate sleeping space	31	12.81%
Infant sleeps on back	25	10.33%
Infant is breastfed	22	9.09%
Infant uses a one-piece sleeper	18	7.44%
Infant shares a bed with an adult or another child	11	4.55%
Infant uses a pacifier	10	4.13%
Infant sleeps on stomach	6	2.48%
Infant is exposed to cigarette or marijuana smoke	4	1.65%
Infant falls asleep in a swing or car seat	3	1.24%
Crib bumpers or cushions inside the crib	3	1.24%
Soft bedding such as pillows, blankets or stuffed animals is used.	3	1.24%
Infant falls asleep on couch	2	0.83%

Question 11 – 17: Seven questions were asked related to dental care.

Question 11: How would you rate the health of your teeth, mouth, and gums?

Question 12: How often do you brush your teeth?

Question 13: How do you feel about fluoride?

Question 14: When was the last time you went to the dentist?

Question 15: During the last year, has there been a time when you needed dental care but could not get it?

Question 16: Do you have dental insurance?

Question 17: What are the top three things you think influence dental health in our community?

Question 11: How would you rate the health of your teeth, mouth, and gums?

Forty-eight percent (48%) of respondents rated the health of their teeth, mouth, and gums as good and indicated that any issues they had were treated. Thirty-six (36%) responded that their dental health was excellent, while 15% said it was fair.

HEALTH OF TEETH, MOUTH AND GUMS	NUMBER OF RESPONSES	PERCENT OF RESPONSES
Good, any issues I had were treated	135	48.39%
Excellent, I rarely have issues	101	36.20%
Poor, I have many issues	43	15.41%

Question 12: How often do you brush your teeth?

The majority of respondents, 72%, brushes their teeth two (2) times a day, 19% once a day, 8% three (3) times a day or more and 1% indicated that they brushed their teeth a few times a week or less.

FREQUENCY OF BRUSHING TEETH	NUMBER OF RESPONSES	PERCENT OF RESPONSES
Twice a day	201	71.79%
Once day	54	19.29%
Three times a day or more	22	7.86%
A few times a week or less	3	1.07%
Never	0	0.00%

Question 13; How do you feel about fluoride?

Questions related to fluoride indicated that 73% buy toothpaste with fluoride, 20% indicated that they and/or their children get fluoride treatments at the dentist while less than one percent (1%) responded that they or their child use fluoride tablets or drops. Nine percent (9%) stated that they and/or their children drink water with fluoride, and 17% stated that they avoid fluoride. One percent (1%) of those responding indicated that they did not know what fluoride was.

FLUORIDE	NUMBER OF RESPONSES	PERCENT OF RESPONSES
I buy toothpaste with fluoride	200	71.79%
I get (and/or my children get) fluoride treatments at the dentist	55	20.0%
I avoid fluoride	47	17.09%
I drink (and/or my children drink) water with fluoride	25	9.09%
I do not know what fluoride is	3	1.09%
I use (and/or my children use) fluoride tablets or drops	2	0.73%

Question 14: When was the last time you went to the dentist?

Respondents were asked when the last time was that they went to the dentist. Most of the respondents, 62%, indicated that they had visited the dentist in the last six (6) months or less. 15% had seen a dentist within the last year, 14% within the last two (2) years, 9% within the last

five (5) years, and less than 1% stated that they never gone or could not remember when they went to a dentist last.

DENTAL EXAMS	NUMBER OF RESPONSES	PERCENT OF RESPONSES
Six months or less	174	62.14%
Within the last year	42	15.00%
Within the last two years	38	13.57%
Within the last five years or more	24	8.57%
Never	1	0.36%
I do not remember	1	0.36%

Question 15: During the last year, has there been a time when you needed dental care but could not?

Fifty-six (56%) percent indicated that they were receiving the care they needed, while 23% indicated they were not.

DENTAL CARE	NUMBER OF RESPONSES	PERCENT OF RESPONSES
I received the care I needed	151	54.71%
I did not receive the care I needed	65	23.55%
I did not need dental care	61	22.10%

Question 16: Do you have dental insurance?

The majority of those responding 196 out of 277 or 70%, indicated that they had insurance through an employer, family members/ employer, Medi-Cal, VA, or an alternate source.

DENTAL INSURANCE	NUMBER OF RESPONSES	PERCENT OF RESPONSES
Yes, through employer or family member employer	161	58.12%
No, cannot afford	60	21.66%
Yes, through Medi-Cal	21	7.58%
No, I do not want it	20	7.22%
Yes, through a source not listed	14	5.05%
I do not know	2	0.72%
Yes, through VA	1	0.36%

Question 17: What are the top three things you think influence dental health in our community?

The last question posed in the Community Survey asked respondents to identify the top three things that influenced dental health in the community.

The cost of dental care received the most responses; the lack of dentists and the lack of dental insurance were the second and third most frequent responses.

DENTAL HEALTH	NUMBER OF RESPONSES	PERCENT OF RESPONSES
Cost of dental care	158	59.18%
Lack of dentists	105	39.33%
Lack of dental insurance	100	37.45%
Lack of dentists who accept Medi-Cal or Denti-Cal insurance	96	35.96%
Use of sugar including soft drinks and other food with high sugar content	72	26.97%
Lack of appointment at a time I can go to the dentist	46	16.85%
Lack of pediatric dentists	44	16.48%
Lack of education about dental health	29	10.86%
Tobacco use	20	7.49%
Lack of dental hygienists	18	6.74%
Lack of oral health screenings to identify problems	18	6.74%
Drug use	16	5.24%
Lack of fluoride in the water	10	3.75%

Question 18: Please feel free to share any comments.

A general comment question was included in the survey. A summary of responses is included in the following paragraph by topic area.

ACCESS TO MEDICAL SERVICES

Multiple comments were related to access. Limited services in Bridgeport and other unincorporated areas was a common theme with a significant disparity noted in services provided outside of Mammoth Lakes. Respondents commented on the extensive travel time to Mammoth Lakes. One respondent noted that due to travel time parents might have to miss a whole day of work, which has a significant financial impact, as well as children missing a day of school.

Several respondents commented that the clinic in Bridgeport should be re-opened, even on a part-time basis. There were also comments regarding the need for pharmacy services.

Specific specialties or services that were identified included: full-time pediatrician, pediatric dental services, OB / GYN providers, specialists to care for high-risk pregnancies, vision services. Most of the comments related to increasing access to OB/GYN physicians, and specifically female OB/GYN physicians.

ACCESS TO DENTAL CARE

Dental care was also a common theme. The high cost of dental care was identified as a significant barrier to dental care, including high co-pays and up-front costs. Other barriers

included long wait times to get an appointment, lack of emergency dental care, and lack of pediatric dental care.

TOBACCO – DRUGS - ALCOHOL

Several respondents commented on the use of tobacco, marijuana, and other drugs from an e-cigarette, vape pen or JUUL by teens. A teacher at Mammoth High School commented that it occurs almost daily either in-school or outside of school.

The need for pediatric mental health screening, especially for children prenatally exposed to opioids and other drugs were identified.

The need for opioid abuse and alcohol abuse/addiction services was identified.

MENTAL HEALTH

Several respondents commented on the need to provide more access to private counselors, especially for a short-term situational crisis.

The lack of support services and activities for seniors was identified as contributing to social isolation and depression.

OTHER

The lack of affordable housing was noted as impacting the health of Mono County residents.

One surveyor commented, *"I think there is a lack of emphasis on whole person wellness in our community."*

APPENDIX 6: FOCUS GROUP MEETING

OCTOBER 26, 2018
MAMMOTH HOSPITAL AND MONO COUNTY PUBLIC HEALTH
COMMUNITY HEALTH NEEDS ASSESSMENT

A focus group was convened to gather information regarding the current health status of Mono County and suggestions for additional improvements. 62 people attended the focus group meeting. A list of attendees follows this summary.

The meeting began with a few opening comments from Gary Myers, Mammoth Hospital and Sandra Pearce, Mono County Public Health. Cheri Benander introduced both herself and Julie Haynes from HTS3 and the steering committee members. Ms. Benander and Ms. Haynes then facilitated an icebreaker that focused on participants introducing themselves to others in their subgroups.

Ms. Benander defined the services group and shared the vision, mission, and values of Mammoth Hospital and Mono County Public Health. She reviewed the IRS guidelines, the accreditation requirements for Public Health, and the community health assessment requirements for the Local Oral Health Program and Maternal, Child, and Adolescent Health Program. She explained the process that Mammoth Hospital and Mono County Steering Committee had chosen to gather data, which included using information obtained using data from state and national surveys, focus groups, interviews, and community surveys.

The first activity the group performed was to reflect upon the changes they had seen in the last five years that they believe have made the community healthier. Below is a summary of the responses,

- School athletic safety
- Healthy organized activities
- A focus on nutrition
- Pain management programs
- Smoking/vaping reduction
- Increased behavioral health initiatives
- Expansion of specialty care
- Childhood vision screening
- Community collaboration
- Increased access to medical healthcare
- Disaster preparedness
- Added specialists
- Reopening of Toiyabe Clinic in Coleville (medical/dental)
- Drug court
- Increased connectivity trails
- Increased restaurants and food choices
- Increase in school nurse Services
- Increase work related to healthier meals and exercise

- Healthy Youth Act
- Increase in quality childcare
- Increase in preventive health options
- Increased insurance coverage
- Improved safety (free car seats, helmets, and defibrillators)
- For seniors – increase meal access and depression screening
- Increase in foster care providers
- Spiritual care
- Hospice
- Increase in park and recreation activities
- Increased state and federal funds for health care – ACA (Affordable Care Act)
- Increased tourism
- Decrease in tent living
- Installation of more sidewalks
- Mandatory influenza vaccines at the hospital
- Community hosting healthier events

The group was then asked why they believe it is important to gain buy-in with the community and what can be done to facilitate change. The responses included:

- Promote shared goals
- Funding
- Availability
- Provide multi-agency events
- Understand diversity
- Provide a voice to all
- Provide consistent and cohesive communication
- Explain the "why"
- Making changes fun - offer rewards
- Provide a feedback process
- Provide clear goals
- Gain information on what is working and what is not
- Demonstrate a willingness to collaborate
- Demonstrate value to all
- Provide broad, informed, positive leadership
- Develop a shared vision
- Provide outreach events
- Gain an understanding of the social determinants of health
- Develop a trusting relationship

Kathleen Alo provided a summary of the 2016 Mammoth Hospital (CHNA), and Sandra Pearce provided a summary of the Maternal, Child, and Adolescent Health (MCAH) Needs Assessment. Ms. Benander then asked the group what they believed made up a healthy community. Responses included good schools, access to specialized programs, collaboration between community organizations and community members, basic needs are met, healthy life style, psychosocial support, tolerance of diversity, community membership represents the population of the community, decreased substance use, access to a variety of health care services, drug-free activities, healthy food, clean air and water, healthy social norms, affordable housing and child care, affordable cost of living, affordable outdoor recreation, continuity of care (consistent providers), social equity, cultural competence and appreciation.

This led to a discussion regarding what words the group would use to describe the community of Mono County. Participants indicated that the community was beautiful, resilient, expensive, physically active, rural, isolated, inspirational, majestic, fun, family-oriented, at-risk, transient, remote, evolving, unchanged, second-home owners, inviting, welcoming, accepting, touristy, invisible, and natural.

The group was also asked to use one word to describe what they believed was important to the community. Responses included; tourism, children, access, safety, economic success, water (shortage concerns), outdoors, recreation, people, public lands, snow, childcare, affordable/available housing, community shelter (for homeless), quality of life, mental health, self-care, diversity, medical care, and spiritual needs.

In their groups, some of the participants were asked to discuss how they felt the quality of life is perceived in the community. Others were asked how perceptions could be changed. They were asked to make a list, select a reporter, and share their thoughts with the larger group. The following perceptions were discussed:

- Tourism as both a blessing and a curse
- Wealthy/Perfect
- No crime
- Ski community
- Paradise
- Outdoors
- Freedom to enjoy but the reality is opposite
- Everyone skis or snowboards
- That the community members are lucky
- Country
- Remote

- That all is good
- The "haves" perceive that everything is good, the "have nots" perceive life as a struggle, feel isolated, don't understand care, and have no support
- Laid back mentality
- The slower pace of life
- No traffic
- People are happy to be here
- Access to nature
- Safe streets
- The county is "Mammoth Centered"
- The community is not diverse
- People are tolerant by necessity
- It's fun all the time
- People are "so lucky" to live here
- There are a privileged few
- The community is not diverse
- Cliquish
- Perception of wealth
- High quality of life

Suggestions on how to change perceptions included:

- Regulate Airbnb®
- Build affordable housing
- Provide childcare
- Provide dog daycare
- Decrease the cost of food and increase the selection
- Renovate
- Increase the lighting on the streets
- Improve trash collection
- Put in more sidewalks
- Provide police coverage from 3:00 a.m. to 7:00 a.m.
- Tear down condemned buildings
- Create a task force to clean up the "diaper forest"
- Be more mindful of cultural separation
- Be more mindful of economic separation
- Provide transportation from the outlying areas
- Provide homeless shelters

- Provide subsidies to condominium owners who provide low-income housing
- Provide more "actual results" as opposed to just talking
- Increase revenues
- Make it S.M.A.R.T.
- Innovations such as "tiny homes"
- Increase awareness and education regarding the issues
- Provide discounts to the locals
- Provide a reality tour of "typical residential areas of the service workers"
- Seek input from those whose lives you're trying to improve
- Shift perceptions from "rose-colored glasses"
- Address food insecurity
- Improve transportation
- Increase activities and safe space for children and youth
- Increase addiction treatment services
- Develop leaders who represent the diversity of the community
- Develop a community center for indoor winter activities
- Increase cultural events outdoors in the summer such as music and theater

Following the discussion, the group was presented the final question of the day; what resources does the community have that can be used to improve the community's quality of life? The following list was created from the individual group discussions;

- Public health
- Urgent care
- Hospital and clinics
- WIC Programs
- Peapods
- Airport
- Inyo Mono Advocates for Community Action (IMACA)
- Community preventive health programs
- Cerro Coso
- All access parks
- Bear Whisperer
- Recycling
- Thrift stores
- EPO
- IMM
- CCS
- MCAH

- Environmental health
- TOG
- Oral health
- Public educational programs
- Wild Iris
- Angel Flight
- MMCF
- Schools
- Behavioral health support groups
- Primary care
- Women's health
- Pediatric providers
- Dermatology
- Orthopedics
- Urology
- Labor and delivery
- Emergency care
- Cardiology
- Rheumatology
- Urology
- Physical/occupational therapy
- General surgery
- Nutrition
- Spiritual care
- Imaging
- Laboratory
- Parks and Recreation
- Safe Kids
- MCOE
- MUSD
- FBO Food Banks
- Rotary Club
- Lions Club
- MACA
- Mammoth Mountain Disabled Sports
- Mammoth student discounts
- Mammoth Mountain School

- Mammoth employee housing
- Bowling alley
- Insurance/TANF/CalFresh
- Indigent Workforce Development
- Child Protective Services, Adult Protective Services, and Foster Care
- Alcoholics Anonymous, ALANON, Narcotics Anonymous
- Low-income housing
- County behavioral health
- First responders
- Tribal services
- CERT
- Head Start
- Mountain Ski Program
- Digital
- Public Library
- ESTA
- Mammoth transport
- Emergency preparedness
- Disease surveillance
- Case management for medically fragile children
- First-time homeowner program
- Housing collaborative
- Regional Planning Advisory Committee
- Development waivers
- Toiyabe Indian Health
- First 5 Mono County
- Husky Club
- Victim/Witness advocates
- Pre-trial and Veterans diversion programs
- Restitution collection/court for victims
- www.monokids.org
- Mono County Community Resource Guide

The day ended with Ms. Benander summarizing what had been accomplished. The group defined what was believed to be a healthy community, described the Mono County community, and identified what was important to the community. The group then acknowledged perceptions that existed of the community and identified ways to improve those perceptions. Finally, the group identified the current assets and resources existing currently within the community. Ms. Benander indicated that the success of any community

needs assessment correlates to the amount of community input and feedback received from all stakeholders and felt that today's focus group yielded a large amount of information. Ms. Benander discussed how the information would be used and informed the group that once the assessment is completed, the information would be made available to the public, and a multi-year implementation developed. She thanked everyone and adjourned the meeting.

REGISTERED ATTENDEES

Kathleen Alo Mammoth Hospital	Jennifer Esparza Mono County Social Services
Dave Anderson Mono County District Attorney's Office	Pat Espinosa Mono County Social Services
Lori Baitx Mammoth Hospital	Bob Gardner Mono County Board of Supervisors
Dustlyne Beavers Mono County Health Department	Maria Gonzalez Mono County Health Department
Tom Boo, MD Mono County Health Department	Nancie Hamilton Mammoth Hospital
Charles Broten IMACA	Amber Hise Mono County Health Department
Stuart Brown Town of Mammoth Lakes	Olivia Hollenhorst Mono County/TOML Information Tech
Craig Burrows, MD Mammoth Hospital	Dan Holler Town of Mammoth Lakes
Alexandra Castor Community Service Solutions	Tim Kendall Mono County District Attorney's Office
Eryn Coffey Mammoth Hospital	Lois Klein MUSD
Caitlin Crank Mammoth Hospital	Lorraine Koenig Mammoth Hospital
Cara Crosby Mammoth Hospital	Diana Lincicum Anthem Blue Cross
Jacinda Croissant Mono County Health Department	Laurel Martin Disabled Sports Eastern Sierra
Nancy Cruz Mono County Health Department	Casey Michel Mammoth Hospital
Cindy Dady Mammoth Resorts	Rochelle Miller IMACA
Melissa Davis Mammoth Resorts	TR Miller Mammoth Hospital
Molly DesBaillets First 5 Mono County	Lenna Monte Mammoth Hospital
Deb Diaz Mono County Health Department	Colleen Moxley Mono County Office of Education
Jacob Eide Mammoth Hospital	Gary Myers Mammoth Hospital
Margee Neer Toiyabe Indian Health Project	Lynette Siverling Anthem Blue Cross
Matthew O'Connor Wild Iris	Canny Staker Mammoth Hospital
Griselda Ortiz IMACA	Shelby Stockdale Mono County Health Department
Sandra Pearce Mono County Health Department	Michelle Stuetelberg Mammoth Hospital
Kathy Peterson Mono County Social Services	Stephen Swisher Mammoth Hospital / Mono County
John Peters Mono County Board of Supervisors	Valerie Taylor Anthem Blue Cross

Michelle Raust Mono County Social Services	Ales Tomaier Mammoth Lakes Fire Department
Sarah Rea Mammoth Hospital	Carly Trainor Mammoth Hospital
Bentley Regehr Mono County Community Development	Bryan Wheeler Mono County Health Department
Robin Roberts Mono County Behavioral Health	Kaysie Willams Mono County Office of Education
Leah Roman Mono County Health Department	Julie Winslow Mammoth Resorts

APPENDIX 7: TOBACCO USE YOUTH

KEY TOBACCO INDICATORS	ESUSD 7th	MUSD 7th	CALIF 7th	ESUSD 9th	MUSD 9th	CALIF 9th	ESUSD 11th	MUSD 11th	CALIF 11th
Ever smoked a whole cigarette	0%	0%	1.6%	3%	5%	7.0%	4%	16%	12.0%
Current cigarette smoking	0%	0%	1.0%	0%	1%	2.6%	0%	5%	4.3%
Current cigarette smoking at school (past 30 days)	0%	0%	0.6%	0%	1%	1.3%	0%	1%	1.3%
Ever tried smokeless tobacco	2%	0%	1.5%	0%	2%	3.6%	0%	13%	5.4%
Current smokeless tobacco use	2%	0%	0.7%	0%	0%	1.5%	0%	1%	1.7%
Current smokeless tobacco use at school	0%	0%	0.5%	0%	1%	1.1%	0%	3%	1.1%
Ever used electronic cigarettes	2%	10%	8.1%	0%	44%	23.2%	13%	44%	31.7%
Current use of electronic cigarettes	0%	5%	3.4%	0%	30%	7.6%	4%	27%	9.8%
Current use of electronic cigarettes at school (past 30 days)	0%	2%	2.0%	0%	11%	3.6%	4%	15%	3.3%
Harmfulness of occasional cigarette smoking (great harm)	31%	43%	34.5%	41%	38%	38.6%	29%	44%	42.`1%
Harmfulness of smoking 1 or more packs/day (great harm)	52%	73%	59.9%	76%	67%	67.7%	58%	71%	73.5%
Difficulty of obtaining cigarettes (very difficult)	44%	28%	8.6%	24%	8%	21.2%	17%	11%	31.2%

Source: California Healthy Kids Survey: Eastern Sierra Unified School District (ESUSD) Elementary 2017-2018 Main Report
Source: California Healthy Kids Survey: Mammoth Unified School District (MUSD) Secondary 2017-2018 Main Report
SOURCE: CALIFORNIA HEALTHY KIDS SURVEY

APPENDIX 8: ALCOHOL & DRUG USE YOUTH

SUMMARY MEASURES LEVEL OF ALCOHOL AND OTHER DRUG USE	ESUSD 7th	MUSD 7th	CALIF 7th	ESUSD 9th	MUSD 9th	CALIF 9th	ESUSD 11th	MUSD 11th	CALIF 11th
Lifetime alcohol or drug use (any use)	5%	11%	12.8%	3%	50%	32.3%	42%	58%	48.2%
Lifetime very drunk or high (7 or more times)	0%	0%	0.9%	0%	5%	6.3%	0%	30%	15.4%
Current alcohol or drug use	0%	6%	7.2%	0%	33%	19.7%	17%	41%	29.4%
Current heavy drug use	0%	1%	1.8%	0%	12%	6.8%	0%	22%	11.3%
Current heavy alcohol use (binge drinking)	0%	2%	1.2%	0%	4%	6.0%	13%	19%	11.6%
Current alcohol or drug use on school property	2%	1%	2.8%	0%	18%	7.1%	4%	15%	7.0%
Harmfulness of occasional alcohol use (great harm)	21%	26%	29.3%	55%	32%	30.9%	29%	31%	30.6%
Difficulty in obtaining alcohol (very difficult)	37%	24%	16.5%	24%	5%	7.7%	17%	10%	6.0%
Harmfulness of occasional marijuana use (great harm)	46%	54%	42.5%	55%	39%	36.4%	21%	29%	30.0%
Difficulty in obtaining marijuana (very difficult)	54%	34%	28%	25%	7%	8.8%	21%	10%	5.6%

Source: California Healthy Kids Survey: Eastern Sierra Unified School District (ESUSD) Elementary 2017-2018 Main Report
Source: California Healthy Kids Survey: Mammoth Unified School District (MUSD) Secondary 2017-2018 Main Report
Source: California Healthy Kids Survey 2017-2018 b *Appendix 9: Maternal and Infant Health Indicators*

APPENDIX 9: MATERNAL AND INFANT HEALTH INDICATORS

DOMAIN AND INDICATOR	PERIOD	LOCAL			STATE			LOCAL COMPARED TO STATE
		RATE	95% CONF. INT		RATE	95% CONF. INT		
			LOWER	UPPER		LOWER	UPPER	
Births less than 37 weeks gestation per 100 live births	2015 - 2016	6.0	3.8	9.4	8.5	8.5	8.6	**No Diff.**
Births weighing less than 2,500 grams per 100 live births	2015 - 2016	6.0	3.8	9.4	6.8	6.8	6.9	**No Diff.**
Births weighing less than 1,500 grams per 100 live births	2013 - 2015	0.4	0.1	1.6	1.1	1.1	1.1	**No Diff.**

Source: Family Health Outcomes Project, UCSF

PRENATAL CARE	PERIOD	LOCAL			STATE			LOCAL COMPARED TO STATE
		RATE	95% CONF. INT		RATE	95% CONF. INT		
			LOWER	UPPER		LOWER	UPPER	
Prenatal care in the first trimester per 100 females delivering a live birth	2013-2015 (2015)	74.5 (75.3)	70.3 (67.9)	78.4 (81.5)	83.3 (83.)	83.3 (83.1)	83.4 (83.3)	**Worse**
Percent of females who received adequate or better prenatal care	2015	58.7	50.7	66.2	34.4	34.3	34.6	**Better**

Source: Family Health Outcomes Project, UCSF

INSURANCE AND POVERTY	PERIOD	LOCAL			STATE			LOCAL COMPARED TO STATE
		RATE	95% CONF. INT		RATE	95% CONF. INT		
			LOWER	UPPER		LOWER	UPPER	
Medi-Cal insured deliveries per 100 live births	2016	48.9	40.5	57.3	43.4	43.3	43.6	**No Diff.**
Uninsured pre-pregnancy per 100 females delivering a live birth	2013-2015	20.6+	17.8	23.4	21.6	20.5	22.7	**No Diff.**
Single mothers living in poverty per 100 single mothers	2016	No Data			34.9			

Source: Family Health Outcomes Project, UCSF

TIMING OF BIRTH	PERIOD	LOCAL			STATE			LOCAL COMPARED TO STATE
		RATE	95% CONF. INT		RATE	95% CONF. INT		
			LOWER	UPPER		LOWER	UPPER	
Births per 1,000 females age 15 to 19	2013-2015	20.2	13.6	29.9	21.0	20.8	21.1	**No Diff.**
Births conceived within 18 months of a previous live birth per 100 females age 15 to 44 delivering a live birth	2013-2015 (2015)	22.0 (24.7)	17.1 (16.4)	27.9 (35.4)	26.6 (26.6)	26. (26.5)	26.7 (26.8)	**No Diff.**
Mis-timed or unwanted pregnancy per 100 females delivering a live birth	2013-2015	31.8+	28.4	35.1	30.5	29.3	31.8	**No Diff.**

Source: Family Health Outcomes Project, UCSF

GESTATIONAL DIABETES	PERIOD	LOCAL			STATE			LOCAL COMPARED TO STATE
		RATE	95% CONF. INT		RATE	95% CONF. INT		
			LOWER	UPPER		LOWER	UPPER	
Gestational diabetes per 100 females age 15 to 44 delivering a live or still-born infant in-hospital	2013-2015	6.8	4.6	9.9	9.2	9.2	9.3	**No Diff.**

Source: Family Health Outcomes Project, UCSF

CESAREAN BIRTH	PERIOD	LOCAL			STATE			LOCAL COMPARED TO STATE
		RATE	95% CONF. INT		RATE	95% CONF. INT		
			LOWER	UPPER		LOWER	UPPER	
Percent of Cesarean births per 100 low-risk nulliparous females	2015 - 2016	22.0	14.7	31.5	25.1	24.9	25.2	**No Diff.**
Cesarean births per 100 live birth	2016	31.0	23.3	39.9	31.9	31.8	32.0	**No Diff.**

Source: Family Health Outcomes Project, UCSF

FOOD INSECURITY AND OBESITY	PERIOD	LOCAL			STATE			LOCAL COMPARED TO STATE
		RATE	95% CONF. INT		RATE	95% CONF. INT		
			LOWER	UPPER		LOWER	UPPER	
Food insecurity during pregnancy per 100 females delivering a live birth	2013-2015	21.4+	18.4	24.3	15.6	14.6	16.5	**Worse**
Pre-pregnancy overweight or obesity per 100 females delivering a live birth	2016	49.6	41.1	58.1	50.0	49.8	50.1	**No Diff.**

Source: Family Health Outcomes Project, UCSF

SUBSTANCE ABUSE	PERIOD	LOCAL			STATE			LOCAL COMPARED TO STATE
		RATE	95% CONF. INT		RATE	95% CONF. INT		
			LOWER	UPPER		LOWER	UPPER	
Substance use diagnoses per 1,000 hospitalizations of pregnant females age 15 to 44	2013-2015				19.9	19.7	20.1	**No Diff.**
Any smoking during the 1st or 3rd trimester per 100 females with live births	2013-2015	12.4+	10.0	14.8	2.7	2.3	3.1	**Worse**
Current smoker per 100 females 18 and older	2012-2016	15.4+	9.6	21.3	9.3	8.7	9.8	**No Diff.**

Source: Family Health Outcomes Project, UCSF

MENTAL HEALTH	PERIOD	LOCAL			STATE			LOCAL COMPARED TO STATE
		RATE	95% CONF. INT		RATE	95% CONF. INT		
			LOWER	UPPER		LOWER	UPPER	
Prenatal depressive symptoms per 100 females delivering a live birth	2013-2015	17.2+	14.6	19.8	14.1	13.1	15.0	**Worse**
Postpartum depressive symptoms	2013-2015	17.1+	14.4	19.8	13.5	12.6	14.4	**Worse**

Source: Family Health Outcomes Project, UCSF

DOMESTIC VIOLENCE	PERIOD	LOCAL			STATE			LOCAL COMPARED TO STATE
		RATE	95% CONF. INT		RATE	95% CONF. INT		
			LOWER	UPPER		LOWER	UPPER	
Domestic violence calls per 100,000 population	2013-2015 (2015)	510 (585.2)	447 (473.6)	581 (723.0)	406 (417.3)	405 (415.2)	407 (419.3)	**Worse**

Source: Family Health Outcomes Project, UCSF

INDICATOR	PERIOD	LOCAL			STATE			LOCAL COMPARED TO STATE
		Rate	95% Conf. Int		Rate	95% Conf. Int		
			Lower	Upper		Lower	Upper	
Tdap immunizations during pregnancy per 100 females delivering a live birth	2015-2016	45.2+	40.6	49.8	50.4	49.0	51.7	**No Diff.**
Exclusive breastfeeding 3 months after delivery per 100 live births	2013-2015	47.3+	43.3	51.3	29.1	27.7	30.5	**Better**
Exclusive in-hospital breastfeeding per 100 females delivering a live birth	2016	82.0	73.3	88.3	69.6	69.5	69.8	**Better**
Deaths at age less than 1 year per 1,000 live births	2013-2015	2.2	0.4	12.5	4.5	4.4	4.6	**No Diff.**

Source: Family Health Outcomes Project, UCSF

APPENDIX 10: COUNTY HEALTH RANKINGS

HEALTH OUTCOMES						
Length of life (50%)	**Year(s)**	**Weight**	**Mono County**	**Error Margin**	**Top U.S. Performers**	**California**
Premature Death Years of potential life lost before age 75 per 100,000 population	2015 – 2017	50%	3,900	2,800-5,000	5,400	5,300
Quality of Life (50%)	**Year(s)**	**Weight**	**Mono County**	**Error Margin**	**Top U.S. Performers**	**California**
Poor or Fair Health % of adults reporting fair or poor health	2016	10%	14%	14 – 15%	12%	18%
Poor physical health days Average number of physically unhealthy days reported in the past 30 days	2016	10%	3.5	3.3 – 3.6	3.0	3.5
Poor mental health days Average number of mentally unhealthy days reported in the past 30 days	2016	10%	3.7	3.5 – 3.8	3.1	3.5
Low birthweight % of live births with low birthweight (<2500 grams)	2011-2017	20%	8%	6 – 9%	6%	7%

HEALTH FACTORS						
Health Behaviors	**Year(s)**	**Weight**	**Mono County**	**Error Margin**	**Top U.S. Performers**	**California**
Adult smoking % of adults who are current smokers	2016	10%	13%	12 – 13%	14%	11%
Adult obesity % of adults that report a BMI ≥ 30	2015	5%	23%	17 – 31%	26%	23%
Food environment index Index of factors that contribute to a healthy food environment (0 – 10)	2015 & 2016	2%	7.4		8.7	8.9
Physical activity % of adults aged 20 and over reporting no leisure-time physical activity	2015	2%	15%	10 – 22%	19%	17%
Access to exercise opportunities % of population with adequate access to locations for physical activity	2010 & 2018	1%	92%		91%	93%
Excessive drinking % of adults reporting binge or heavy drinking	2016	2.5%	22%	21 – 23%	13%	18%
Alcohol-impaired driving deaths % of driving deaths with alcohol involvement	2013 – 2017	2.5%	67%	58 – 74%	13%	30%
Sexually transmitted infections # of newly diagnosed chlamydia cases per 100,000 population	2016	2.5%	237.3		152.8	506.2
Teen births # of births per1,000 female population ages 15 – 19	2011 – 2017	2.5%	23	17 – 30	14	22

Clinical Care	Year(s)	Weight	Mono County	Error Margin	Top U.S. Performers	California
Uninsured % of population under age 65 without health insurance	2016	5%	10%	9 – 112%	6%	8%
Primary care physicians Ratio of population to primary care physicians	2016	3%	1,550:1		1.050:1	1,270:1
Dentists Ratio of populations to dentists	2017	1%	2,020:1		1,260:1	1,200:1
Mental health providers Ratio of population to mental health providers	2018	1%	520:1		310:1	310:1
Preventable hospital stays # of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	2016	5%	2,276		2,765	3,507
Mammography % of female Medicare enrollees ages 65 – 74 that receive mammography screening	2016	2.5%	41%		49%	36%
Flu vaccination Flu Vaccinations is the percentage of fee-for-service Medicare enrollees that had a reimbursed flu vaccination during the year.	2016	2.5%	35%		52%	40%

Social & Economic Factors	Year(s)	Weight	Mono County	Error Margin	Top U.S. Performers	California
High school graduation % of ninth-grade cohort that graduates in four years	Varies	5%	36%		96%	83%
Some college % of adults ages 25 – 44 with some post-secondary education	2013 – 2017	5%	61%	47 – 76%	73%	64%
Unemployment % of populating aged 16 and older unemployed but seeking work	2017	10%	4.4%		2.9%	4.8%
Children in poverty % of children under age 18 in poverty	2017	7.5%	13%	9 – 16%	11%	18%
Income inequality Ratio of household income at the 80th percentile to income at the 20th percentile quality	2013 – 2017	2.5%	3.0	2.4 – 3.6	3.7	5.3
Children in single-parent households % of children that live in a household headed by a single parent	2013 – 2017	2.5%	17%	6 – 28%	20%	31%
Social Associations Number of membership associations per 10,000 population	2016	2.5%	8.6		21.9	5.8
Violent crime Number of violent crimes reported per 100,000 population	2014 & 2016	2.5%	262		63	421
Injury deaths Number of deaths from planned (e.g., homicide or suicide) and unplanned (e.g., motor vehicle deaths) injuries per 100,000 population	2013 - 2017	2.5%	51	36 - 71	57	49

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

Departments: Public Works

TIME REQUIRED 20 minutes

SUBJECT 2018-2019 Grand Jury Report - Board Response

PERSONS APPEARING BEFORE THE BOARD Tony Dublino, Director of Public Works; Justin Nalder, Solid Waste Superintendent

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

Consideration of the 2018-2019 Grand Jury Report (re: the County's Solid Waste program and the January 2023 closing of Benton Crossing Landfill) and the Board Response to the Report.

RECOMMENDED ACTION:

Consider response to the 18-19 Grand Jury Report and authorize staff to deliver response, or revise response and bring back to Board at the September 17 meeting.

FISCAL IMPACT:

None.

CONTACT NAME: Tony Dublino

PHONE/EMAIL: 760.932.5459 / tdublino@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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Staff Report
Draft Board Response Letter

History

Time	Who	Approval
9/4/2019 7:28 PM	County Administrative Office	Yes
9/4/2019 2:35 PM	County Counsel	Yes

8/30/2019 11:03 AM	Finance	Yes

MONO COUNTY
DEPARTMENT OF PUBLIC WORKS

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TO: Board of Supervisors

FROM: Tony Dublino, Director of Public Works

DATE: September 10, 2018

RE: Board of Supervisor's Response to 2018-19 Mono County Grand Jury Report

Recommendation:
Approve proposed Board of Supervisors response or provide additional comments and clarifications.

Fiscal Impact:
None.

Discussion:
State law requires elected officials as well as the Board of Supervisors to respond to the findings and recommendations of Grand Jury reports. The Board must respond within 90 days of the issuance of the report (Penal Code section 933(c).

State law prescribes the specific manner and language to be used by an agency head or governing body in responding to findings and recommendations of a grand jury report. The prescribed response with respect to a finding is to "agree" or "disagree" with an explanation. The prescribed response with respect to a recommendation is generally to indicate whether the recommendation will or will not be "implemented" with an explanation. (Penal Code section 933.05).

The 2018-2019 Grand Jury Report included an investigation into the County's Solid Waste Program, with associated findings and recommendations. The Board is requested to discuss the draft response and provide any comments or clarifications that might be necessary, and/or approve submittal of the response letter. The 90-day response requirement dictates that the Board approve a response no later than the next Board meeting, September 17.

If you have any questions regarding this item, please contact me at (760) 932-5415.

Respectfully submitted,

Tony Dublino
Director of Public Works

Jennifer Kreitz ~ District One Fred Stump ~ District Two Bob Gardner ~ District Three
John Peters ~ District Four Stacy Corless ~ District Five

BOARD OF SUPERVISORS
COUNTY OF MONO

P.O. BOX 715, BRIDGEPORT, CALIFORNIA 93517
(760) 932-5533 • FAX (760) 932-5531
Shannon Kendall, Clerk of the Board

September 10, 2019

Honorable Judge Mark Magit
Presiding Judge of the Superior Court
100 Thompsons Way
P.O. Box 1037
Mammoth Lakes, California 93546

Re: Response to the Mono County Grand Jury 2018-2019 Final Report

Dear Judge Magit:

Please consider this letter as the official response to the Mono County Grand Jury 2018-2019 Final Report and place this document on file as the Mono County Board of Supervisors' response.

As your honor is aware, last year's 2017-2018 Grand Jury Report contained no recommendations within the County's jurisdiction, so there are no continuing reports to provide from last year's report.

The two investigations and reports within the County's jurisdiction are the Final Report of the Solid Waste Committee and the Jail Inspection Report. Because the Mono County Jail is within the purview of the Mono County Sheriff, she will respond separately.

The Board of Supervisors has reviewed the findings and recommendations contained in the Final Report of the Solid Waste Committee and provides the following response:

Findings:
Whatever the process looks like after the Benton Crossing Landfill closure, it will involve long hauling solid waste out of Mono County, presumably to Nevada. The impact this will have on costs to Mono County, TOML, and their citizens is unclear at this time.

The Board agrees with this finding.

F1. The Grand Jury finds that TOML and its exclusive franchisee Mammoth Disposal consider an upgraded transfer station, at the current Mammoth Disposal owned site in Mammoth, will be adequate to meet the needs of the TOML once Benton Crossing Landfill closes.

This finding pertains to matters under the jurisdiction of the Town of Mammoth Lakes, and as such the Board defers response to the Town. .

F2. Through our investigation the Grand Jury concurs with interviewees that the County-owned Pumice Valley site near Mono Lake is the most likely site for a biomass reactor and associated waste programs.

The Board agrees in part and disagrees in part with this finding.

The Board agrees that the Pumice Valley Landfill is *one* likely site for increased waste management programs in the future.

The Board disagrees that Pumice Valley "is the most likely site for a biomass reactor and associated waste programs," because this statement must be based on consideration of economic, environmental, and political issues that has not yet been fully resolved by this Board.

F3. The Grand Jury finds that State of California rural county exemptions for recycling and the amount of organic waste going to landfills are subject to change.

The Board agrees with the finding.

F4. Rural jurisdictions in California face unique challenges in dealing with solid waste mandates coming from the State. For instance, Mono County and TOML could increase their state diversion goal compliance numbers if transformation of recyclables such as paper, cardboard, or organic waste into beneficial product such as biochar could be accepted in State mandates.

The Board agrees with the finding.

F5. Comments made by certain members of the Mono County Board of Supervisors and Council members at public meetings demonstrate a lack of urgency and in some cases, a lack of knowledge surrounding the issue of Solid Waste. Decisions, or lack thereof, made in the next few months may affect solid waste policy for many years to come.

The Board agrees in part and disagrees in part with the finding.

The Board agrees that "decisions, or lack thereof, made in the next few months may affect solid waste policy for many years to come."

The Board does not agree that there is a lack of urgency or lack of knowledge surrounding the issue of solid waste. Although the Grand Jury may interpret comments made by the Board as lacking urgency or knowledge, the Board has been engaged in a frequent, public, and deliberate process to gather input and to plan for the closure of Benton Crossing Landfill and the system that will follow.

F6. There is little information regarding the issue of the closing of the Benton Crossing Landfill and what that will mean to the citizens and visitors of Mono County.

The Board disagrees with this finding.

The subject of Benton Crossing Landfill closure has been in local papers on several occasions over the last ten years, many Board of Supervisors' Agendas, and consistently on the agenda of the Solid Waste Task Force.

The subject of the Benton Crossing Landfill closure is among the most frequently agendized and consistently reported issues involving Mono County government over the last ten years.

F7. There is little or no information about recycling programs within Mono County and the TOML, what is or is not recyclable, ways to control solid waste, etc.

The Board disagrees with this finding.

The County (in addition to any outreach and education performed by the Town and Mammoth Disposal) has consistently expanded recycling outreach and education programs for over 10 years. The County has maintained a web site for the solid waste program that includes information on recycling and available recycling services and programs. There has been an ongoing effort at the County's transfer stations and landfills to distribute recycling information. There have been rate-based incentives in place to promote recycling. There have been ads placed in local news outlets. There has been outreach and education to local schools.

F8. Task Force meetings are posted to the Mono County website. However, when members of the Grand Jury signed up to subscribe to email updates through the link, nothing was ever received. Grand Jury members were also unable to find minutes of previous meetings and supporting documents listed as being posted on the site

The Board agrees with the finding and has since corrected the issue.

Recommendations:

R1. We recommend that the TOML view the Mammoth Disposal transfer station as Phase One of their plan with Phase Two being a larger site which can accommodate the processing of industrial waste, green waste, and other programs which can be used to reduce landfill usage and reduce costs. Timeline: By January 1, 2023.

This recommendation pertains to matters under the jurisdiction of the Town of Mammoth Lakes, and as such the Board defers to the Town for response.

R2. The Grand Jury recommends that TOML and Mono County partner to make necessary improvements to the Pumice Valley site for it to be a viable location for a biomass reactor, associated waste programs, and recycling operations. Timeline: Completed no later than January 1, 2023.

This recommendation requires further analysis.

The Board agrees with the timeline stated in the report related to making improvements to a future waste management site by January 1, 2023, and County staff has been working diligently toward that timeframe.

The Grand Jury's recommendations to 1. Partner with the Town; 2. Use the Pumice Valley Landfill site; and 3. Improve the site to locate a biomass reactor, each require additional analysis.

1. **The scope and parameters of the analysis of a long-term partnership with the Town relating to Solid Waste must include (at least) the analysis of the logistics and economic impacts of transporting waste from the Town to Pumice Valley by both franchise haulers as well as self-haulers, and whether such a proposal meets the interest of the Town government, its citizens, and its waste hauler.**
2. **The scope and parameters of the analysis of using the Pumice Valley site for such programs must include (at least) the potential environmental impacts of increasing volume and other programs, and the political and economic considerations of utilizing the site for these purposes against other available options.**

3. **The scope and analysis of improving the site to locate a 'biomass reactor' must include (at least) the consideration of the environmental impacts of such infrastructure, whether the 'transformation' of material will actually count as diversion in future years, the cost and availability of delivering the output of a biomass reactor to market, and the economic considerations as compared to other available options.**

Solid Waste staff intends to prepare the above items for discussion before the Board by December 2, 2019.

R3. The Grand Jury recommends that TOML and Mono County develop a plan for complying with the amounts of recycling and organic waste going to landfills in the likely event that State of California rural exemptions are changed by July 1, 2020. Timeline: No later than July 1, 2020.

Board Response: this recommendation will not be implemented at this time.

This recommendation is not warranted at this time because it is not yet known what will change with the rural exemptions, and what opportunities for compliance may be available to the County at the time of those changes (i.e, other developments and infrastructure outside the County's jurisdiction). Once those changes are known, the County will take steps to comply with the regulations but until that time, any planning efforts would be premature.

R4. The Grand Jury recommends that Mono County and TOML continue to work with other rural jurisdictions to expand the State's understanding of the challenges that rural areas face in achieving current mandated diversion and recycling goals. Timeline: Ongoing.

This recommendation is already being implemented. County is currently engaged in this effort through membership and attendance in the Environmental Service Joint Powers Authority, a subgroup of the Regional County Representatives of California, that is focused on legislative matters relating to rural solid waste issues.

R5. The Grand Jury recommends that both the Mono County Board of Supervisors and the Council meet with appropriate Mono County and TOML staff on the issues pertaining to solid waste in order to educate themselves about the situation imposed by the closing of the Benton Crossing Landfill, in order to make informed decisions for their constituents. Timeline: By October 31, 2019.

This recommendation has been implemented, with this response letter forming the first in a series of monthly public Board items devoted to Solid Waste issues.

R6. The Grand Jury recommends that both the Mono County Board of Supervisors and the Council and their staff develop a plan for mass communication to their constituents and visitors about the upcoming closure of the Benton Crossing Landfill and what steps they (Mono County Board of Supervisors and Council) are taking to manage that situation. Timeline: October 31, 2019.

This recommendation has been implemented. The Board will provide this mass communication through the traditional means of Board meeting agendas and related staff reports that will occur as a result of the series of Board items described above.

R7. The Grand Jury recommends that the TOML and Mono County work together with local Departments of Public Works, the Task Force, lodging and like associations, Chambers of Commerce and Non-governmental Organizations throughout Mono County to develop programs to educate the public,

especially visitors, about what we can all do to increase recycling and minimize solid waste. Timeline: January 1, 2020.

The recommendation will be implemented in the future and will direct staff to pursue additional outreach efforts with a report back to the Grand Jury in next year's report.

R8. The Grand Jury recommends that Mono County staff support the Task Force website so that Mono County residents can be better informed about Task Force meetings and be able to engage in the process of creating solid waste policies. Timeline: October 1, 2019.

This recommendation has been implemented.

The Board of Supervisors and County staff recognize the critical role the Grand Jury provides to the community and the County by ensuring the legal and financial adequacy of government services. The Grand Jury provides a sense of openness, transparency and accountability that are crucial to our democracy, and the County appreciates the work performed and the guidance offered. The County thanks the members of the Grand Jury for their public service and encourages the Court to continue to ensure broad representation from all communities of Mono County.

Sincerely,

John Peters, Chair
Mono County Board of Supervisors

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

TIME REQUIRED

SUBJECT Closed Session - Human Resources

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

CONFERENCE WITH LABOR NEGOTIATORS. Government Code Section 54957.6. Agency designated representative(s): Stacey Simon, Dave Butters, Janet Dutcher, and Anne Larsen. Employee Organization(s): Mono County Sheriff's Officers Association (aka Deputy Sheriff's Association), Local 39 - majority representative of Mono County Public Employees (MCPE) and Deputy Probation Officers Unit (DPOU), Mono County Paramedic Rescue Association (PARA), Mono County Public Safety Officers Association (PSO), and Mono County Sheriff Department's Management Association (SO Mgmt). Unrepresented employees: All.

RECOMMENDED ACTION:

FISCAL IMPACT:

CONTACT NAME:
PHONE/EMAIL: /

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

Click to download
No Attachments Available

History

Time	Who	Approval

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

TIME REQUIRED

SUBJECT Closed Session - Real Property Negotiations

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

CONFERENCE WITH REAL PROPERTY NEGOTIATORS. Government Code section 54956.8. Property: 40 Willow Ave, Unit 5, June Lake, CA (Assessor's Parcel Number 016-195-005-000). Agency negotiator: Kathy Peterson. Negotiating parties: Larry Emerson for IMACA. Under negotiation: Price and terms of sale.

RECOMMENDED ACTION:

FISCAL IMPACT:

CONTACT NAME: Kathy Peterson

PHONE/EMAIL: / kpeterson@mono.ca.gov; alarsen@mono.ca.gov

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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No Attachments Available

History

Time	Who	Approval
9/4/2019 7:32 PM	County Administrative Office	Yes
9/4/2019 3:40 PM	County Counsel	Yes
8/29/2019 10:38 AM	Finance	Yes

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

TIME REQUIRED

SUBJECT Closed Session - Public Employment

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

PUBLIC EMPLOYEE PERFORMANCE EVALUATION. Government Code section 54957. Title: County Administrative Officer.

RECOMMENDED ACTION:

FISCAL IMPACT:

CONTACT NAME:

PHONE/EMAIL: /

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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No Attachments Available

History

Time	Who	Approval

OFFICE OF THE CLERK
OF THE BOARD OF SUPERVISORS

REGULAR AGENDA REQUEST

Print

MEETING DATE September 10, 2019

TIME REQUIRED

SUBJECT Closed Session - Exposure to Litigation

PERSONS APPEARING BEFORE THE BOARD

AGENDA DESCRIPTION:

(A brief general description of what the Board will hear, discuss, consider, or act upon)

CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION. Significant exposure to litigation pursuant to paragraph (2) of subdivision (d) of Government Code section 54956.9. Number of potential cases: two.

RECOMMENDED ACTION:

FISCAL IMPACT:

CONTACT NAME:

PHONE/EMAIL: /

SEND COPIES TO:

MINUTE ORDER REQUESTED:

☐ YES ☑ NO

ATTACHMENTS:

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No Attachments Available

History

Time	Who	Approval
9/4/2019 7:32 PM	County Administrative Office	Yes
9/4/2019 2:41 PM	County Counsel	Yes
9/4/2019 3:52 PM	Finance	Yes