Libby Montana's Public Health Emergency, Asbestos Health Screening
Center for Asbestos Related Disease
Grant Number 6 NU61TS000295-02
Year 02
(September 1, 2020 through August 31, 2021)

MAJOR FINDINGS

The goal of the Funding Opportunity Announcement (FOA) is "early detection of certain medical conditions related to environmental health hazards." The CARD screening program has been successful in early detection of asbestos related disease (ARD) and lung cancer resulting from the Libby asbestos exposure public health emergency. Significant outreach and education locally, regionally and nationally are also being conducted to support the screening programs as these activities are an important component for the success of the grant. The clinical data in this report includes the ARD and lung cancer screening programs. Outcomes reported are for years 1 and 2 (Sept. 1, 2019 through Aug. 31, 2021) and the cumulative totals that include all screening activities funded in prior grants (July 1, 2011 through Jun. 30, 2015 and Sept. 1, 2015 through Aug. 31, 2019) or covered by CARD's general fund between grants in July and August of 2015.

Table 1 shows the number of screenings performed and rate of diagnosis for the past 10 years.

TABLE 1: SCREENING OUTCOMES							
Screening Rates	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 total 9/1/20 - 8/31/21	Cumulative Totals
# ARD Screening	599	90	87	102	118	397	7,559
# Diagnosed	143	16	19	20	19	74	2,769
Percent Diagnosed	24%	18%	15%	20%	16%	19%	37%

Table 2 reports screening outcomes including the number of ARD screenings, the number of patients who needed CT evaluations to determine diagnostic status, the number of patients diagnosed with ARD, and the number of individuals who were eligible for ARD Medicare.
It is noteworthy that individuals can be eligible for Medicare through the Environmental Health Hazard designation criteria, but not be clinically diagnosed with ARD by a CARD medical provider. This can occur when: (1) A screening chest x-ray B-read is read positive for asbestos related abnormalities. (2) A screening chest CT is read positive for asbestos related abnormalities by an outside radiologist on the B-reader panel. (3) The screening patient has a documented diagnosis of an asbestos related cancer as designated by Medicare on the Environmental Health Hazard checklist (mesothelioma, lung, colon, rectum, larynx, stomach, esophagus, pharynx or ovarian).
Numbers in this final report for year 02 include the most up to date and accurate information based on results from outside reads, patient follow-up visits, collection of missing paperwork, and making adjustments to the database to correct any past errors. Percent diagnosed with environmental exposure only does not include a cumulative total because it was not collected in prior grants.

TABLE 2: SCREENING OUTCOMES							
Screening Outcomes	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 total 9/1/20 - 8/31/21	Cumulative totals
# ARD screenings	599	90	87	102	118	397	7,559
# CT diagnostic appointments	307	48	51	57	44	200	4,736
# ARD diagnosed	143	16	19	20	19	74	2,769
# ARD Medicare eligible	166	20	22	25	24	91	3,137
% diagnosed w/ environmental exposure only	85%	88%	85%	80%	84%	85%	not collected

GOALS/OBJECTIVES

Goal 1: Provide Medical Screening in the Libby Area and Across the Nation

Asbestos Related Disease Screening in Libby and Across the Nation:
In the screening tables, both in Libby and long distance data are combined and summarized unless specifically stated.
It is noteworthy that the number of screenings has decreased since the beginning of the COVID-19 pandemic. A new metric that is being reported as part of this grant is the number of past screeners diagnosed with ARD seen for follow-up. This number relates to long-term impacts of the grant which leads to ongoing health monitoring and support for those diagnosed with ARD.

TABLE 3: TYPES OF SCREENING APPOINTMENTS							
Appointment Type	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
# screenings	599	90	87	102	118	397	7,559
# new screening patients	252	42	37	41	48	168	5,226
# rescreenings	347	49	49	61	70	229	2,333
residents	310	43	44	58	60	205	3,881
done in clinic	114	24	12	15	38	89	2,882
# of LDS patients	125	16	19	19	14	68	712
(includes both visits)	680	103	96	119	129	447	10,572
both visits)	226	35	42	40	33	150	1,723
Consented for TAR registry	483	73	57	71	89	290	5,788
PCP sent screening results	479	65	63	69	92	289	not collected
with ARD seen for f/u	2550	322	196	259	306	1083	not collected

Table 4 summarizes demographic information for screening program participants.

TABLE 4: DEMOGRAPHICS OF SCREENING PARTICIPANTS							
Demographics	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
# screenings	599	90	87	102	118	397	7,559
# females	355	50	56	58	65	230	4,033
# males	244	40	30	44	53	167	3,526
# under age 35	27	5	6	5	8	24	402
# between 35-49	116	16	17	21	23	77	1,482
# between 50-64	294	44	42	51	53	190	3,763
# age 65+	162	25	22	25	34	106	1,912

In Table 5, clinical findings of ARD screening are summarized. The number of symptomatic participants refers to CARD's medical provider's documentation of patient reported respiratory symptoms that may be asbestos related. This information was used in clinical decision making to determine whether a CT scan should be performed. Many participants did not have spirometry testing due to the COVID-19 pandemic and precautions that were being taken. BMI recording was added in year 01 and not recorded previously.

TABLE 5: CARD CLINICAL FINDINGS ASSOCIATED WITH ASBESTOS RELATED DISEASE							
CARD Clinical Findings	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
# screenings	599	90	87	102	118	397	7,559
# symptomatic	381	51	58	69	72	250	5,039
# abnormal spirometry	171	13	7	25	31	76 (116 not done due to COVID)	1,946
# abnormal BMI (≥30)	248	28	30	39	47	145	not collected
# CXRs completed	592	88	87	102	116	393	7,346
# no CXR done	7	2	0	0	2	4	213
# abnormal CXR (CARD)	17	1	0	2	2	5	416
pleural only	15	1	0	1	2	4	375
interstitial only	1	0	0	0	0	0	20
both	1	0	0	1	0	1	21
# CTs completed	307	48	51	57	44	200	4,736
# abnormal CT (CARD)	143	15	19	20	19	73	2,741
pleural only	122	13	14	18	18	63	2,173
interstitial only	5	0	0	0	1	1	18
both	16	2	5	2	0	9	550

In Table 6: Masses identified are reported instead of confirmed cancers. This is done because CARD refers patients with significant findings to specialists for appropriate follow-up, and it is not known whether a cancer diagnosis was made unless patients choose to share their medical records with CARD. Focal opacities are common in screening studies and their prevalence is well documented in literature. Only a small percentage of them turn out to be cancers, but they are tracked in our database so that we can follow them in future screenings or ongoing care if they were diagnosed with ARD. If the focal opacity is greater than 6 mm, the individual is between 50-84 years of age, and they have a 15 pack year smoking history, then they qualify for lung cancer screening. These criteria have been updated beginning in grant year 3. For all grant periods in this report lung cancer screening program criteria were at least 20 pack years of smoking history and between the ages 55-84. The update was made in year 3 with the approval of ATSDR based on scientific literature. Lung masses reported in this table do not include lung cancers identified through the lung cancer screening program. Also new to this grant are numbers collected on verified cancers, incidental findings, specialist referrals, and depression follow-ups. These are all important follow-up/ outcome activities related to asbestos health screening.

TABLE 6: SIGNIFICANT FINDINGS IDENTIFIED THROUGH ARD SCREENING							
Significant Findings	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
# lung masses	6	0	3	2	0	5	68
# thyroid masses	0	0	0	0	0	0	22
# kidney masses	0	0	0	0	0	0	23
# breast masses	1	0	1	0	0	1	21
# other masses	1	0	2	0	1	3	56
Total # masses identified	8	0	6	2	1	9	190
# focal opacities	159	25	25	28	18	96	1378
# cancers verified possibly asbestos related	14	9	3	0	2	14	not collected
# participants w/ incidental findings	252	40	43	46	54	183	not collected
# specialist referrals	3	0	0	0	0	0	not collected
# depression follow-ups completed	190	49	16	31	53	100	not collected

Fecal Occult Blood Testing:

Fecal occult blood testing (FOBT) was offered to all screening participants between the ages of 50-75. If a patient had regularly scheduled colonoscopies or was not interested in participating they declined the FOBT. 55% of all FOBTs given were returned during year 02.

TABLE 7: FECAL OCCULT BLOOD TESTING FOR EARLY DETECTION OF COLON CANCER							
Fecal Occult Blood Tests	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
# FOBTs given	204	30	27	31	30	118	2,545
# FOBTs returned	102	16	16	17	13	65	1,013
# FOBTs abnormal	0	0	0	0	0	0	4

Outside Radiology Reads:

A group of five B-readers, three of which are radiologists, make up the outside reader panel. One reader from the panel reads every image taken as part of the screening program. Images are distributed to readers in a systematic cyclic process to ensure even workloads. Many images are read outside of the quarter that the images were performed in because they are burned to disk and mailed in groups then read and returned by mail from the outside readers. On average, it takes readers 7 weeks from the time images are mailed to outside readers for them to be returned to CARD. All reads of images done in grant year 02 have now been returned and added to the cumulative totals.

TABLE 8: SINGLE OUTSIDE READ RESULTS BY B-READER (CXR) OR RADIOLOGIST (CT)							
Outside Read Findings	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
# CXRs	592	88	87	102	116	393	7,346
# B reads	592	88	87	102	64	393	7,298
# B reads abnormal	32	6	3	6	1	20	603
Pleural	26	4	2	5	1	16	494
Interstitial	4	2	1	1	0	4	81
Both	2	0	0	0	0	0	28
# CTs	307	48	51	57	44	200	4,736
# Outside CT reads	307	48	51	57	25	200	4,670
# Outside CT reads	56	8	5	7	3	24	1,533
Pleural only	17	3	3	2	2	10	824
Interstitial only	33	4	2	4	1	12	415
Both	6	1	0	1	0	2	294

Quality control panel readings of radiographs and HRCT scans:

There have been 19 peer review session over the past ten years, two were conducted in year 02 of the current grant. In the charts below, the year 02 results are labeled 10A and 10B. Post peer review comparison analysis was completed by Dr. Curtis Noonan, CARD's contracted epidemiologist. For each peer review session, he evaluated reader agreement on the 54 B-reads completed by the five-person panel of B-readers, and on the 24 CT reads performed by the panel of three thoracic radiologists. The comparisons are based on a SAS macro, %MAGREE, which allows for comparison of multiple raters when multiple responses (ratings) are on a nominal scale. This methodology employed by the macro is based on Fleiss (2003) and Fleiss et. al. (1979). The accompanying charts reflect Kappa trends over the past ten years for chest x-rays and CTs. Supporting raw data is available upon request.

GRAPH 1: KAPPA FOR CT READS

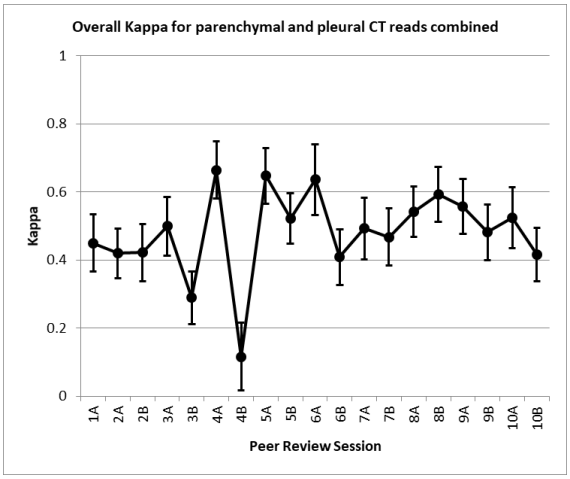
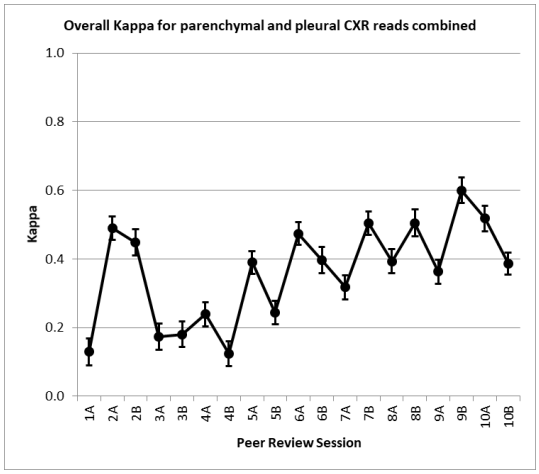


CHART 2: KAPPA FOR CXR READS



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Lung Cancer Screening for High Risk Individuals:

Eligible participants for the Lung Cancer Screening (LCS) program were between the age of 55-84, had at least 20 pack years of smoking history, and were diagnosed with ARD **or** had Libby asbestos exposure and a nodule greater than 6 mm. These criteria were updated at the beginning of year 3 of the grant as stated above. In addition, the eligible nodule size was changed to 6 mm from 4 mm in this grant and we added a pre-engagement mailing that is sent out to each LCS participant prior to their LDCT (low-dose CT scan). This gives participants information on the risks and benefits of lung cancer screening so that an informed decision about participation can be made. A thoracic radiologist experienced in lung cancer detection from the International Early Lung Cancer Action Program (I-ELCAP) over-read all LDCTs done for lung cancer screening. Lung cancers reported in this table do not include lung cancers identified through the asbestos related disease screening program. Of note, 120 (24%) of the 510 lung cancer screeners were current smokers. Participants who are current smokers are offered one-on-one smoking cessation counselling when they are given their results and are also sent the information about smoking cessation with their lung cancer screening results.

TABLE 9: LUNG CANCER SCREENING OUTCOMES SPECIFICALLY FROM LUNG CANCER SCREENING PROGRAM

Lung Cancer Screening	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
# completed LDCTs	524	128	102	111	169	510	4,042
# new LCS participants	65	9	9	18	16	52	not collected
participants	449	119	93	93	153	458	not collected
# less than annual f/u	52	19	13	21	14	67	not collected
# referrals	12	1	3	3	6	13	not collected
# confirmed cancers	3	3	1	0	0	4	36
# other findings	1	0	0	1	0	1	not collected
# current smokers	114	29	29	27	35	120	not collected
# no longer participating	33	5	9	6	17	37	not collected

Lung cancer screening allows for early detection of cancers resulting in better health outcomes. Without screening, many lung cancers would not be identified until late stages of disease leading to increased morbidity and mortality. Of the four lung cancers identified in year 02, three were identified in stage 1 allowing for a high likelihood of curative treatment.

TABLE 10: STAGE CONFIRMED CANCER IDENTIFIED

Stage Identified	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
# confirmed cancers	3	3	1	0	0	4	36
Cancer identified in stage 1	1	2	1	0	0	3	18
Cancer identified in stage 2	0	0	0	0	0	0	5
Cancer identified in stage 3 or 4	0	0	0	0	0	0	5
Cancer identified without stage	2	1	0	0	0	1	8

For early detection of cancer in high risk populations consecutive LCS is recommended so that lung cancers can be treated in the earliest possible stage. 458 of those who participated in lung cancer screening in year 02 had participated in lung cancer screening previously. Participants join the program whenever they become eligible and interested, but some drop out due to being diagnosed with lung cancer, dying, moving out of the area, aging out of the program, or being lost to follow-up for some other reason. For those who remain local and eligible to participate in the program, recall letters are mailed annually and follow-up phone calls are made to those who do not schedule their follow-up lung cancer screenings.

TABLE 11: CONSECUTIVE YEARS LUNG CANCER SCREENING

Consecutive years	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
Established LDCT participants	445	119	93	93	153	458	1381
Participated 2-4 consecutive years	238	56	44	35	61	196	717
Participated 5-8 consecutive years	161	50	28	24	61	163	465
Rescreened but not consecutive	46	13	21	34	31	99	199

ANA Screening:

A new component added to the grant in 2019 was ANA (antinuclear antibodies) screening. The test is offered to all screening participants based on research that has shown a relationship between Libby asbestos exposure and autoimmune disease. Screenings are ordered by CARD and done at Cabinet Peaks Medical Center. Results are received and evaluated by a CARD physician and patients are notified by a nurse of their results. Patient education is given prior to and following ANA screening. If follow-up is recommended an appointment with CARD's physician is offered. Table 12 shows ANA screening results.

TABLE 12: ANA Results	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21
# ANA tests completed	424	71	64	77	96	308
# Abnormal ANA	93	16	20	11	16	63
# Abnormal ANA requiring f/u	23	5	2	8	10	25
% Postive ANA not diagnosed w/ ARD	not collected	67% (6 of 9)	100% (9 of 9)	63% (5 of 8)	29% (2 of 7)	67% (22 of33)

Results are also sent to CARD's contracted Ph.D. consultant, Jean Pfau who reviews results and submits interpretation of them on a quarterly and annual basis.

Dr. Pfau's annual report:
The screening group for this year (2020-2021) continues with trends reported previously for Libby, by presenting with a high frequency of positive ANA tests and of autoimmune diagnoses. The prevalence of SLE and RA cases continue to be above expected prevalence values for these diseases in the U.S., which were two of the diseases with significant increases in prevalence in Libby compared to expected (Diegel, R., 2018). However, there were no cases of scleroderma or sarcoidosis in this year's screening. The Libby population is also experiencing autoimmune diseases that are not characterized by having positive ANA tests, so ANA testing would not assist with screening for those diseases. However, most of those were not above expected prevalence rates (Chart 1). This screening group has a very high frequency of autoimmune symptoms (59%), suggesting a continuing concern about undiagnosed autoimmune conditions that do not meet diagnostic criteria, but that fit the diffuse characteristics of the autoimmune conditions seen in populations exposed to Libby Asbestiform Amphiboles (LAA) (Diegel R., 2018).

The CT data indicate that nearly 50% of SP's in the CARD screening program test positive for lung abnormality, consistent with last year's report and previous publication (Szeinuk, et al., 2017). Sensitivity and specificity values for ANA testing associated with CT scan data were very low, suggesting that ANA testing is not helpful in screening for pleural or parenchymal abnormalities as seen by CT scan. This is consistent with our previous studies for two reasons. One is that previous work showed that ANA was only associated with progressive LPT, not stable disease (Pfau, et al., 2019). The current CT scan data do not provide any information about progression of the disease. Second, subjects can be ARD negative simply due to negative chest xray and lack of ARD symptoms, not requiring a CT scan. When the analysis was performed using all of the ARD diagnosis data, the specificity was higher, suggesting that a subject with a negative ANA test is more likely to be free of ARD, although false positives occur.

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Chart 1: Reported Autoimmune Diagnoses, 2020 - 2021

	Number of subjects (n= 308)	**CARD Prevalence**	**US Prevalence**
Rheumatoid Arthritis	17	5.5%	1.0% [a]
Psoriasis, Psoriatic arthritis	13	4.2%	2.4% [b]
CFS/Fibromyalgia	11	3.8%	2.0% [c]
Multiple Sclerosis	6	1.9%	0.001% [f]
Hashimoto's thyroiditis	4	1.3%	1.3% [d]
Systemic Lupus Erythematosus	4	1.3%	0.1% [a]
Ulcerative colitis, Celiac	4	1.3%	(with Crohn's)
Grave's Disease	3	1.0%	0.5% [e]
Crohn's Disease	3	1.0%	1.3% [c]
Vitiligo	3	1.0%	0.5% [e]
Raynaud's Phenomenon	3	1.0%	11% [d]
Eczema (atopic, adult)	3	1.0%	7% [c]
Type I Diabetes	2	0.6%	0.6% [c]
Sjogren's	2	0.6%	2% [e]
Lichen Planus	1	0.3%	2.0% [d]
Ankylosing Spondylitis	1	0.3%	0.5% [g]
Bullous Pemphigoid	1	0.3%	0.005% [h]
Wegener's Granulomatosis	1	0.3%	0.003% [d]
Dermatomyositis	1	0.3%	< 0.001% [d]
Narcolepsy, Autoimmune	1	0.3%	< 0.001% [a]
Polymyalgia rheumatica	1	0.3%	0.5% [d]
Uveitis, autoimmune	1	0.3%	0.001% [h]
Reiter's Syndrome	1	0.3%	< 0.001% [d]
Serpiginous Chorditis	1	0.3%	Very rare

a = From www.uptodate.com
b = From www.psoriasis.org
c = www.CDC.gov
d = www.medscape.com
e = www.medlineplus.gov
f = www.healthline.com
g = NHANES
h = Jamanetwork.com

Smoking Cessation:
In table 13 the number of screening individuals who smoke and cessation activities are reported. The percentage of screening individuals who smoke (16.9%) is slightly more than the Montana state average of 16.4% according to americashealthrankings.org. Smoking cessation continues to be extremely important for patient health maintenance. Smoking cessation is included as part of CARD's asbestos health screening and lung cancer screening programs. Respiratory therapists and spirometry techs provide brief counseling to all identified smokers upon review of their tobacco use history questionnaires. Past quit attempts and current interest is explored. If interested, referral is made to our Case Manager for free one-on-one cessation counselling. Medical providers also educate about the importance of smoking cessation and refer to the Case Manager when patients appeared genuinely interested. CARD's Case Manager was trained as a tobacco treatment specialist during year 01 through the University of Massachusetts: Center for Tobacco Treatment Research and Training's program. The Case Manager also provides resources such as CARD's smoking cessation workbook and Montana Quit Line resources (counseling, follow up calls and cessation medications at low or no cost).

TABLE 13: SMOKING CESSATION OUTCOMES AND OURTREACH ACTIVITIES

Smoking Cessation	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
# of screeners who smoked	98	19	13	19	16	67	871
# who quite since last screening appointment	8	1	1	1	3	6	64
# brief cessation ed by medical staff	77	9	12	3	16	40	512
# booklets mailed regionally/nationally	32	11	7	0	1	19	not collected
# booklets given in clinc/local	154	46	25	14	20	105	not collected
# individual follow up smoking cessation sessions	64	9	10	13	6	38	not collected
# engaged in ongoing counseling	17	4	1	0	0	5	69
community members educated re: smoking cessation/prevention	523	175	25	54	657	911	not collected

Goal 2: Conduct Nationwide Outreach to Raise Awareness (of screening and certain Medicare benefits) **and Goal 3: Provide Nationwide Health Education (**to detect, prevent, and treat environmental health conditions)

Outreach and education often go hand in hand. The goal of providing outreach and education about asbestos health and lung cancer screening, risk factors, asbestos related disease, health management, and certain Medicare benefits was often done in a combined fashion. Event tables will indicate if each item is primarily outreach or education. Quality control processes are in place as outreach personnel work very closely with the screening Project Director, and all other appropriate CARD staff in developing and conducting all screening outreach and education activities. All final printed materials and community engagement activities are approved by the

Project Director. CARD physicians review and approve all technical and medical educational materials for professional audiences.

Why Are Individuals Being Screened?

Beginning with this new grant in 2015, CARD began tracking why individuals were being screened for ARD. Collecting this information helps CARD to tailor outreach and educational materials to the concerns of our screening population so that their screening experiences meet their individual needs. Respondents may choose more than one answer to this question.

TABLE 14: WHY ARE YOU BEING SCREENED?

	Yr. 1 total 9/1/19-8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
# answered the question	409	77	74	105	87	343	3,902
# LDS	97	23	24	22	16	85	825
# in clinic	369	54	50	84	70	258	3,134
Medical concerns	98	11	12	20	12	55	1,535
Family member diagnosed	91	9	5	10	8	32	862
Access to Benefits	19	2	0	0	2	4	291
Support research	20	2	0	3	0	5	341
Legal reasons	7	0	0	0	0	0	61
Screening purposes/multiple	170	51	57	72	59	239	689
Employer Requested Screening	1	2	0	1	6	9	121

Outreach Effectiveness Measure

When an individual engages in a screening appointment (in-clinic or long distance) they are asked one multiple choice question to measure the effectiveness of outreach activities. "How did you hear about the CARD screening program?" The answers are provided in the table below.

TABLE 15: HOW DID YOU HEAR ABOUT THE CARD SCREENING PROGRAM?

How did you hear about screening? (IC= in clinic, LD= long distance)	Yr. 1 total 9/1/19-8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
IC- # who answered	315	54	50	84	72	260	3,788
IC- traditional advertising (radio, TV, newspaper)	149	14	18	36	25	242	1,939
IC- website/social media	36	16	10	34	27	123	159
IC- Community networking (parades, local events)	123	24	22	14	20	203	1,655
LD- # who answered	97	23	24	22	16	182	879
LD- traditional advertising (radio, TV, newspaper)	27	2	1	18	5	53	324
LD- website/social media	29	4	0	1	0	34	107
LD- Community networking (events, word of mouth)	41	17	22	3	11	94	447

Screening Satisfaction Measure

Satisfaction surveys are sent to patients following their appointments at CARD. This was started during year 2 of the grant to ensure that every effort is made to meet expectations and improve as needed. Table 16 summarized survey results from year 2.

TABLE 16: SCREENING SATISFACTION SURVEY RESULTS

	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21
# surveys sent	90	86	102	120	398
# surveys returned	20	21	24	36	101
overall: excellent	15	15	16	13	59
overall: good or very good	4	6	4	5	19
overall: fair or poor	1	0	0	0	1
staff: excellent	14	14	3	13	44
staff: good or very good	6	7	1	5	19
staff: fair or poor	0	0	0	0	0

Outreach Efficacy for Enrollment in Certain Medicare Benefits for ARD:

One of the detailed goals in the grant FOA was to increase awareness about certain Medicare benefits available for individuals diagnosed with ARD resulting from Libby asbestos exposure. Traditional Medicare is available for individuals diagnosed with ARD as a result of Libby asbestos exposure regardless of age or disability status. This is facilitated by placing an EHH (Environmental Health Hazard) designation on an individual's Medicare status if they are diagnosed with Libby ARD. The Medicare Pilot program is also available for EHH Medicare patients who live in the designated geographic area (The counties of Lincoln, Flathead, Glacier, Lake, Sanders, Mineral, and Missoula in Montana; Benewah, Bonner, Boundary, Clearwater, Kootenai, Latah, and Shoshone in Idaho; and Ferry, Lincoln, Ponderay, Spokane, Stevens and Whitman in Washington.)

The numbers of individuals reported below in Table 17 are not all screening participants as some had a diagnosis of ARD resulting from the Libby asbestos exposure prior to implementation of the current screening grants. All data in table 17 is based on verification of diagnoses for completion of EHH. We cannot confirm that all of these individuals completed all of the enrollment steps for these benefits however because that is not done through CARD.

Table 17 also includes the number of individuals who have improved access to medical care for chronic conditions. This means they are under age 65, have signed up for Medicare via EHH and they have a chronic condition that needs ongoing medical monitoring. The chronic conditions include: rheumatoid arthritis, lupus, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), pacemaker, intraventricular cardiac defibrillator (CD), hypertension, or diabetes. 34 of 71 (48%) people under the age of 65 have improved access to care for ongoing management of their chronic conditions because of enrollment in Medicare via an EHH status.

TABLE 17: ENVIRONMENTAL HEALTH HAZARD (EHH) DESIGNATION AND ELIGIBILITY FOR BENEFITS

Certain Medicare Benefits	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
# of EHHs completed	118	18	15	27	22	82	3,463
# of EHHs for people over 65	39	7	3	13	3	26	1,166
# of EHHs for people under 65	71	11	4	14	19	48	2,281
# who have improved access to medical care for chronic conditions	34	5	2	5	11	23	773

Table 18, reports the number of people who are enrolled in the Medicare Pilot Program for Asbestos Related Disease (MPPARD). The categories reported in the table were updated during the prior grant to reflect the most accurate numbers available to CARD. After an individual is diagnosed with ARD through screening, the process to get on the Pilot program takes two

months. For example, if an individual was diagnosed on November 12, 2021, their EHH would be effective December 1, 2021 and their Medicare Pilot benefits will be effective January 1, 2022.

Table 18: UTILIZATION OF PILOT BENEFITS

Pilot Benefit Utilization	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
# enrolled in Medicare Pilot	50	10	3	5	7	25	1,803
# **screening** participants enrolled in Pilot after diagnosis	5	0	0	2	0	2	679
# of paid Pilot claims	7,658	2,005	1,427	1,518	1,639	6,589	not collected
# Pilot related encounters (face to face, email, phone call, education)	1,007	137	344	273	316	1,070	not collected
# Pilot approved service authorizations processed	750	158	160	159	202	679	not collected
# community Pilot education	95	175	2,190	8,100	702	11,167	not collected

Targeted outreach and education- local and regional/national:

Below, Table 19 describes local outreach and education, and Table 20 describes regional/national outreach and education done during year 02. Many resident of the local area have still not participated in screening, and others have only been screened once a number of years ago. For this reason, recruitment continues locally, and education as well as community outreach are extremely important. Ongoing education to locals helps remind them about the free screening program, reinforces the importance of rescreening, and corrects any misinformation that takes hold through social media or community conversations. Maintaining and improving relationships with local businesses and tourism efforts are also very important to counter deep-rooted community concern that Libby's asbestos legacy hurts the local economy ad deters tourism. CARD works to be a positive force in the community supporting local causes and participating in community events as much as possible. Local activities are described more specifically in each individual report. These activities help keep CARD visible in a positive light in the community and also offer opportunities to educate about CARD services.
Regional and national outreach are both very important for recruitment to long distance screening and for educating a larger population who could encounter exposures to LA in attic insulation or at processing sites around the country.

TABLE 19: TARGETED OUTREACH AND EDUCATION- LOCAL (Lincoln County)

Method	Yr. 1 total 9/1/19- 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 2/28/21	Cumulative totals
Local newspaper ads	157	50	21	16	29	116	871
Education article in newspapers	12	3	3	3	3	12	71
Health Link and Health Resource Guide	2	0	0	0	0	0	12
Radio ads	4,661	262	256	250	1,398	2,166	16,327
TV ads	422	0	0	0	11,137	11,137	19,795
Educational brochures given (screening, LCS, CARD)	298	146	685	216	206	1,253	1,994
Patient Education booklets	310	43	44	58	60	205	3,967
Parades	2	0	0	0	3	3	41
Community events sponsored	45	4	1	11	9	25	210
Commmunity meetings	77	22	17	19	20	78	373
Google AdWords Impressions	10,951	4,385	4,406	2,945	2,503	14,239	not collected
Google AdWords Clicks	771	588	726	244	213	1,771	not collected
Website visits	1,705	716	1,267	1,099	204	3,286	not collected
Website visits to patient education pages	624	142	118	86	45	391	not collected
community presentations/ events attended	17	7	8	12	17	44	137
website visits to provider education pages	207	87	27	38	23	175	not collected
newsletters sent locally	8,143	4,630	0	3,110	3,639	11,379	not collected

TABLE 20: TARGETED OUTREACH AND EDUCATION- REGIONAL & NATIONAL							
Method	Yr. 1 Total 9/1/19 - 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 2/28/21	Cumulative totals
Newspaper -outreach	68	22	17	12	6	57	201
Radio ads -outreach	755	0	0	0	0	0	10,997
TV ads -outreach	21,888	8,748	8,897	9,937	81,632	109,214	139,338
Website -outreach	17,299	5,533	8,037	12,132	11,038	36,740	not collected
Website -patient education	2,411	584	691	785	371	2,431	not collected
Website -provider education	744	243	178	221	183	825	not collected
Google AdWords Impressions- outreach	53,850	9,156	9,815	111,044	98,412	228,427	not collected
Google AdWords Clicks- outreach	3,165	1,662	2,092	6,591	10,307	20,652	not collected
Educational brochures given (screening, tobacco, LDS)	119	0	0	122	40	162	not collected
YouTube Channel	2,822	855	748	870	864	3,337	20,259
Patient Education booklets - education	277	47	31	34	58	170	3,745
Lung cancer screening brochures - education	64	32	9	29	63	133	377
Health promotion events sponsored - outreach	5	0	0	10	1	11	52
Newsletters sent	7,434	3,401	0	3,677	3,953	11,031	not collected

Targeted Ourteach/Education to medical professionals:

Table 21 details efforts directed towards medical professionals. Raising awarness about Libby asbestos within the medical community is important to help facilitate referrals and coordinte care.

TABLE 21: TARGETED OUTREACH TO- HEALTHCARE PROFESSIONALS							
Method	Yr. 1 Total 9/1/19 - 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 2/28/21	Cumulative totals
Website -provider education	744	330	0	0	0	330	not collected
Mailings	121	20	10	19	23	72	not collected
CARD newsletter -education	1,056	839	0	575	571	1,985	29,575
provider education book mailed	271	30	26	28	68	152	1,690
Professional Conferences - education/outreach	3	4	0	5	1	10	49
Medical professionals -education	46	38	0	226	41	305	275
Press release pick ups	228	72	107	141	104	424	not collected
other targeted outreach efforts	301	1	8	13	13	35	not collected

Website Use:

CARD's website is an important tool for outreach, education, and communication with target populations. During grant year 1 a feed to our Facebook page was added to the website's homepage so that users can be informed about the most up to date information. This has been an important communication tool during the COIVD-19 pandemic when the clinic has had reduced staffing, reduced appointment capacity, and we have been closed down temporarily due to pandemic concerns. The number of sessions are the number of times users visited CARD's website and the number of pages viewed includes all of the different pages within CARD's overall website. Page depth is how many pages a single user looks at in one session.

TABLE 22: Website use							
Website Use	Yr. 1 Total 9/1/19 - 8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 2/28/21	Cumulative totals
Screening applications submitted via website	105	20	20	13	17	70	377
Contact CARD emails via website	106	24	41	48	29	142	681
# of website sessions	9,441	3,564	5,627	9,005	12,065	30,261	143,573
# pages viewed	17,299	5,533	8,037	12,132	14,591	40,293	309,615
session length 30+ minutes	47	7	16	9	9	41	1,486
session length 10-30 minutes	363	58	71	104	90	323	14,328
session length 3-10 minutes	490	111	99	198	184	592	30,619
session length 1-3 minutes	567	168	164	299	295	926	23,157
session length 31-60 seconds	367	105	111	219	208	643	10,423
session length 11-30 seconds	370	137	174	302	272	885	13,703
session less than 10 seconds	7,237	2,978	4,992	7,874	11,007	26,851	34,088
Page depth: 1-9 Pages viewed in sessio	10,200	3,522	5,580	8,958	14,205	32,265	67,964
10-14 Pages viewed in session	348	29	29	33	23	114	2,171
15-19 Pages viewed in session	175	9	5	8	4	26	815
20+ Pages viewed in session	253	4	13	6	2	25	1,012
# of users	8,782	3,257	4,274	8,163	11,415	27,109	74,965
new users	not cumulative, reported as a percentage	99%	83%	99%	94%	not cumulative, reported as a percentage	not cumulative, reported as a percentage
returning users		1%	17%	1%	6%		
Male users		45%	47%	46%	48%		
Female users		55%	53%	54%	52%		
Age between 18-24		8%	12%	11%	11%		
Age between 25-34		22%	22%	21%	22%		
Age between 35-44		18%	19%	19%	19%		
Age between 45-54		18%	16%	19%	18%		
Age between 55-64		17%	18%	17%	19%		
Age 65+		16%	13%	13%	11%		

Social Media and COVID-19 outreach efforts:

During the COVID-19 pandemic, outreach and educational activities have been significantly limited, so CARD has been focusing on expanding our reach via the internet. We have been working to increase our presence and followers on Facebook and Instagram by posting more often and inviting others to follow us. During the grant year, a new video was posted on YouTube each week as well, and CARD's staff participated in unique outreach efforts such as attending the local Farmer's Market weekly, partnering with other local organizations to reach more diverse audiences, and even hiding painted rocks for community members to find and return. These outreach efforts helped to keep CARD relevant during difficult times when many were limiting social interactions and practicing caution in leaving their homes to avoid COVID-19 exposure and subsequent infection. CARD also opened a COVID-19 testing site for the community and registered to be a Montana COVID-19 vaccine provider. The clinic actively participated in free vaccination clinics during which screening information and take away items were also given away. The vaccination clinics were an excellent way to provide positive outreach while improving the health of our community.

CARD Annual Rally:

CARD's annual Rally was not held in the fall as usual due to COVID precautions. The event is usually held in coordination with the public school, but schools have been taking significant precautions including the cancellation of all extracurricular activities, offering and sometimes mandating at-home learning, and when in person, having smaller groups that stay together.
For these reasons, the annual Rally was held outdoors on June 5 and it was planned in conjunction with our Kiwanis club's Family Day in the Park event. The annual Rally event is an excellent way to engage local youth and their families in education about asbestos related disease and other important health topics. Upon completion of all booths, prizes or other useful items such as mini first aid kits with CARD Screening information will be offered. Table 23 details year 2's Rally attendance.

TABLE 23: CARD RALLY							
	Yr. 1 total 9/1/19-8/31/20	Yr. 2 Q. 1 9/1/20 - 11/3020	Yr. 2 Q. 2 12/1/20 - 2/28/21	Yr. 2 Q. 3 3/1/21 - 5/31/21	Yr. 2 Q. 4 6/1/21 - 8/31/21	Yr. 2 cumulative 9/1/20 - 8/31/21	Cumulative totals
# students present	268	0	0	0	120	120	1,228
# adults present	104	0	0	0	53	53	497

CHALLENGES:
REASON FOR DELAY AND ANTICIPATED CORRECTIVE ACTION OR DELETION

The COIVD-19 Pandemic:

A vast and all-encompassing concern, COVID-19 has impacted the screening program significantly during year 02 of the grant. During quarter 1, the screening programs continued to be impacted by COVID-19 with a decrease in the number of patient that could be seen. This decrease was related to both restrictions such as social distancing, and to patient cancellations due to concern over the virus. In addition, a surge of COVID-19 cases began in Lincoln County, MT in September of 2020 and continued throughout the quarter. This surge forced the closure of CARD's pulmonary function labs beginning on October 19, 2020 in order to protect our patients and staff. Our decision to close the labs was made based on the surge in local cases and taking into consideration recommendations of the American Thoracic Society and other leaders in the field of respiratory medicine. Spirometry in particular can be dangerous for spreading the virus because the maneuver requires patients to blow air out hard and fast, and this of course, cannot be done wearing a mask. The maneuver, by its nature, increases the likelihood of disease transmission and it takes 20 minutes or more for all of the potentially exhaled particles to settle so others in the area could be exposed afterwards. CARD ordered and subsequently installed equipment to convert our labs into negative pressure rooms so that spirometry testing could be safely continued. These rooms, use lower air pressure to suck outside air in and trap potentially harmful particles in the room by preventing air from leaving the space. This protects people outside of the rooms from any potential exposure. Twelve air-flow changes per hour along with built in HEPA filtration protect our spirometry techs and respiratory therapists working in the labs. Air flows directly outdoors, and room pressure is monitored by a system outside of the sealed doors.

Some facilities conducting spirometry for screening participants at a distance started requiring a COVID test prior to performing the breathing tests during year 2. Paying for the required COVID tests was added to the grant's services with the approval of ATSDR during year 2 and this was also implemented for in-clinic spirometry testing.

Other pandemic-related precautions put in place for COVID-19 during year 2 of the grant have included:

- requiring everyone in the building to wear a mask or face shield
- monitoring symptoms and temperatures of staff and patients coming into the clinic
- sending information about COIVD-19 precautions to patients prior to their visits including a request that patients do not bring extra people to their appointments
- use of a specific sick room for anyone who is symptomatic but needs to be seen
- regular cleaning of surfaces in public areas and in between every patient in offices/patient rooms
- limiting the number of people allowed in our waiting rooms and separating seating for social distancing

- encouraging long distance participation in screening for anyone not from the local area
- continuing to encourage hand washing, flu shots, and COVID-19 vaccinations for those who are eligible
- pre-screening of patients planning to come into the clinic as part of our appointment reminder phone calls. Those with COVID-19 symptoms are asked to reschedule or are sent to a nurse to determine if they need to come in.

During quarter 4, Lincoln County Montana experienced another surge in COVID-19 cases with the delta variant. Cases were higher than at any other point in the pandemic during the final quarter of the grant. In an effort to increase screening numbers safely, CARD began to recall screening participants this quarter and also sent out post cards to area residents about screening. In a satisfaction survey received on July 13, one patient wrote, "I was happy that a rapid COVID test was done and all the improvements to the pulmonary testing

Transition of roles and structure of CARD:
During quarter 3 of year 2, Dr. Brad Black, CARD's CEO and Medical Director chose to move towards partial retirement. He stepped down as CEO and Medical Director and transitioned into a new part-time role as Senior Medical and Research Advisor. He also stopped seeing patients during quarter 4. His prior role of Medical Director transitioned to Dr. Karen Lee Morrissette, and Tracy McNew transitioned into the Executive Director role as of May 2021. To date the transition has been seamless.

Loss of Information Technology employee:
During year 2, CARD's Information Technology (IT) Specialist left the organization to take a new position. Recruitment was attempted but no one with the necessary knowledge and experience applied. CARD made the decision to outsource IT so that our needs would be met in a timely manner. We are working with a company called Montana Technical Solutions or MTS, and to date, the transition has worked well and there has been no interruption in our ability to carry out grant activities.

STATUS OF PROGRAM, SCREENING, INFRASTRUCTURE, AND STAFF

The grant goals and objectives were implemented successfully during year 2 with quality assurances in place for delivery of ARD and LCS screening activities, data management, and screening-related outreach and educational activities. The CARD's infrastructure is solid with well-developed processes that have proven effective over the last ten years of grant implementation. Processes have improved over time with ongoing refinement in areas such as screening data management allowing for more efficient data collection and reporting. Completeness and accuracy of the database is evident by consistency of data reported across multiple tables. All data is quality controlled and scrubbed for accuracy before reports and table outcomes are generated. All screening CT scans are read by a qualified physician, so a CARD physician over-reads all CT images ordered by the Physician Assistant.

MEASURES OF EFFECTIVENESS

Measures of effectiveness were reported under each specific goal above. Some overall grant successes include the following feedback received from patients:

Quarter 1:

- "This appointment with Dr. Lee was great. She was very nice and seemed concernedwith my health. I will come back now."
- "Everyone was very helpful. I thank you all!"
- "The scheduling was excellent. I had little to no wait time between appointments. The staff at all three spots were professional. I especially appreciated the time the staff and
- doctor spent explaining the process and results. An excellent experience."
- "I was so impressed with the extensiveness of the screening and the explanations from the people."

Quarter 2:

- "They explained what was happening to me. Found an infection and got me stated on meds right away."

Quarter 3:

- "I was very pleased. I inquired on how to access the Pilot Program for services and was immediately seen by Stephanie Shaw. She was most helpful and answered the questions on how to proceed."

Quarter 4:

- "The hospital was running late on the x-ray because of an emergency. The clinic and staff made me feel very comfortable and not rushed despite the delay."
- "Everyone was very professional, thorough and explained all test and procedures to my ability and knowledge to understand."
- "Prompt, friendly, informative explanation of procedures for clarity."
- "I felt everything went very smoothly. Staff was friendly and efficient. Great communication and friendly, knowledgeable staff."
- "Everyone was so kind and helpful. They made me feel comfortable and they were very knowledgeable."

FINANCIAL RECAP OF GRANT EXPENDITURES

As of this report, for grant year 2 (September 2020 through August 2021), $2,108,269.46 (84%) had been spent of the $2,499,973.81 grant award. Actual expenses were less than budgeted due to the COVID-19 pandemic as described above, but a carryover of funds was approved to implement a data management project to improve grant reporting abilities in year three so with that, 96% of grant funds were expended.

Photos from year 2:

Left: a community member who found a painted rock on April 23, 2021. Right: Learning about proper hand washing techniques at CARD's annual Rally event held on June 5, 2021 outdoors due to the COVID-19 pandemic.