Zoom tips and tricks!

**CHAT:** Please jump in if you have something to share, but we also have this nifty chat function.

**VIDEO:** We want to see you! If your camera isn’t on, start your video by clicking here.

**AUDIO:** You can use your computer speakers or your phone for audio. The phone is generally better quality. If you click “Join Audio,” this “Choose one...” box will pop up. If you dial in, just make sure you include your audio code.

**MUTE/UNMUTE:** *6 or click the mic on the bottom left of your screen.

**ATTENDANCE:** If there are multiple attendees together on the call, please list the names and your location in the chat box.
Agenda

Data Review and Updates
FIT KIT Project
Screening for Depression and Follow-Up
Quality Awards
July QDI Data Report

JANUARY 1, 2020 - JULY 31, 2020
Diabetes Management

Measure

Denominator: Patients 18-75 years of age with diabetes with a visit during the measurement period

Numerator: Patients whose most recent HbA1c level (performed during the measurement period) is >9.0%

UDS, Medicaid PCMH
Colorectal Cancer Screening

Measure

Denominator: Patients 50-75 years of age with a visit during the measurement period

Numerator: Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria:

- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period
- Colonoscopy during the measurement period or the nine years prior to the measurement period
- FIT-DNA during the measurement period or the two years prior to the measurement period
- CT Colonography during the measurement period or the four years prior to the measurement period

UDS, Medicaid PCMH,
Colorectal Cancer Screening (June 2019 vs June 2020)
Cervical Cancer Screening

Measure

Denominator: Women 23-64 years of age with a visit during the measurement period

Numerator: Women with one or more screenings for cervical cancer. Appropriate screenings are defined by any one of the following criteria:

- Cervical cytology performed during the measurement period or the two years prior to the measurement period for women who are at least 21 years old at the time of the test

- Cervical cytology/human papillomavirus (HPV) co-testing performed during the measurement period or the four years prior to the measurement period for women who are at least 30 years old at the time of the test

UDS, Medicaid PCMH
Breast Cancer Screening

Measure:

Denominator: Women 51-74 years of age with a visit during the measurement period

Numerator: Women with one or more mammograms during the measurement period or the 15 months prior to the measurement period

Medicaid PCMH, UDS
<table>
<thead>
<tr>
<th>Measure</th>
<th>2020 QDI Goal</th>
<th>2019 UDS (MT)</th>
<th>2019 UDS (National)</th>
<th>HP 2020</th>
<th>2023 QDI Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1c&gt;9 or untested</td>
<td>15%</td>
<td>25.94%</td>
<td>31.95%</td>
<td>16.2% (not the exact measure - does not include untested)</td>
<td>15%</td>
</tr>
<tr>
<td>Screening for Depression</td>
<td>-</td>
<td>67.64%</td>
<td>71.61%</td>
<td>2.4% (not the exact measure - does not include f/u)</td>
<td>80%</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>45% (PCMH Benchmark)</td>
<td>53.82%</td>
<td>56.53%</td>
<td>93.0%</td>
<td>65%</td>
</tr>
<tr>
<td>CRC Screening</td>
<td>45%</td>
<td>46.06%</td>
<td>45.56%</td>
<td>70.5%</td>
<td>55%</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>55.26% (PCMH Benchmark)</td>
<td>-</td>
<td>-</td>
<td>81.1%</td>
<td>55%</td>
</tr>
</tbody>
</table>
Coming Soon…. Screening for Depression and Follow-Up Plan

Measure Description: Percentage of patients aged 12 years and older screened for depression on the date of the visit or 14 days prior to the visit using an age-appropriate standardized depression screening tool and, if positive, had a follow-up plan documented on the date of the visit.

Denominator: Patients aged 12 years and older with at least one medical visit during the measurement period.

Numerator: Patients who:

- were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool and,

- if screened positive for depression, had a follow-up plan documented on the date of the visit.
Mailed FIT Kit Project
COVID-19 has led to a decrease in primary care visits and therefore, reduced cancer screenings

Surgery centers are backlogged and cannot keep up with the number of patients that are due for procedures, such as colonoscopy

A mailed FIT project aims to prioritize those that are uninsured and underinsured, while also facilitating screening without a primary care visit

FIT allows for prioritization of those patients that truly need a colonoscopy

According to the American Cancer Society, a FIT performed annually has similar reductions in mortality rates as a colonoscopy completed every 10 years
Project Description

MPCA will pay for the cost of the kits and will reimburse the rate that Medicaid would pay minus the FIT kit.

MPCA will ask participating health centers to adhere to guidelines (provided in the manual) and will ask that clinics participate in regular check-ins.

Clinics must be prepared and ready to help those with a positive FIT get into a surgical center for a colonoscopy within 6 months.
Next Steps

MPCA will distribute project manual and ask health centers to fill out application and MOU.

For this project, we have a limited number of FITS and will be distributing them based on health center interest and capacity.

Any questions can be directed towards Laura Gottschalk (lgottschalk@mtpca.org) or Courtney Buys (cbuys@mtpca.org).

Deadline to apply and request number of FIT kits: October 9th.
Depression Screening
Depression Screening

QDI 2020
Table 6B: Line 21
Screening for Depression and Follow-up Plan

**CMS002v9**

Percentage of patients aged 12 years and older screened for depression on the date of the visit or **14 days prior to the visit** using an age-appropriate standardized depression screening tool **AND**, if positive, had a follow-up plan documented **on the date of the visit**

IN 2019, there was no screen 14 days prior to the visit and the follow-up plan was documented on the date of the positive screen.

Documentation of a follow-up plan “on the date of the visit” can refer to ANY reportable visit, not only a medical visit.

Follow-up for a positive depression screening MUST include one or more of the following: Additional evaluation or assessment for depression, Suicide risk assessment, Referral to a practitioner who is qualified to diagnose and treat depression, Pharmacological interventions, Other interventions or follow-up for the diagnosis or treatment of depression.
Measure break down

**DENOMINATOR**

Patients aged 12 years and older with at least one *medical* visit during the measurement period

**NUMERATOR**

Patients who were screened for depression on the date of the visit or up to 14 days prior to the date of the visit using an age-appropriate standardized tool **AND**

if screened positive for depression, had a follow-up plan documented on the date of the visit

**Include patients with a negative screen in the numerator**
Screening Tools

**ADOLESCENT SCREENING TOOLS (12–17 YEARS)**

- Patient Health Questionnaire for Adolescents (PHQ-A)
- Beck Depression Inventory-Primary Care Version (BDI-PC)
- Mood Feeling Questionnaire (MFQ)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Patient Health Questionnaire (PHQ-9)
- Pediatric Symptom Checklist (PSC-17)
- Primary Care Evaluation of Mental Disorders (PRIME MD)-PHQ-2

**ADULT SCREENING TOOLS (18 YEARS AND OLDER)**

- PHQ-9
- Beck Depression Inventory (BDI or BDI-II)
- CES-D
- Depression Scale (DEPS)
- Duke Anxiety-Depression Scale (DADS)
- Geriatric Depression Scale (GDS)
- Cornell Scale for Depression in Dementia (CSDD)
- PRIME MD-PHQ-2
- Hamilton Rating Scale for Depression (HAM-D)
- Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)
- Computerized Adaptive Testing Depression Inventory (CAT-DI)

Examples of Depression Screening Tools can be found on page 149 of the 2020 UDS Manual

Computerized Adaptive Diagnostic
Documenting Follow-up

HRSA Manual

AND if positive, either additional evaluation for depression, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression is documented on the date of the eligible encounter.

CMS002v9

Additional evaluation or assessment for depression such as psychiatric interview, psychiatric evaluation, or assessment for bipolar disorder

* Completion of any Suicide Risk Assessment such as Beck Depression Inventory or Beck Hopelessness Scale

* Referral to a practitioner or program for further evaluation for depression, for example, referral to a psychiatrist, psychologist, social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression

* Other interventions designed to treat depression such as psychotherapy, pharmacological interventions, or additional treatment options
Denominator Exclusions

EXCLUSIONS
Patients with an active diagnosis for depression or a diagnosis of bipolar disorder

EXCEPTIONS
Who refuse to participate
Who are in urgent or emergent situations where time is of the essence and to delay treatment would jeopardize the patient’s health status (Do not exclude patients who are seen for routine care in urgent care centers)
Whose cognitive or functional capacity or motivation to improve may impact the accuracy of results of standardized assessment tools

NOTE: There are no numerator exclusions for this measure
Guidance

HRSA Manual- “in the office of the provider”

Depression screening is required once per measurement period, not at all encounters; this is patient based and not an encounter-based measure.

Use the *most recent* screening results

The name of the *age appropriate standardized* depression screening tool utilized MUST be documented in the medical record

The follow-up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."
Guidance continued

Do not count patients who are *re-screened* as meeting the measurement standard as a follow-up plan to a positive screen.

Do not count a PHQ-9 screening that follows a positive PHQ-2 screening during the measurement period as meeting the measurement standard for a *follow-up plan* to a positive depression screening.
Clinical Measure - % of Patients >= 12 Years with Depression Screening and Follow up

State vs. Selected Health Centers - 2019, Sorted by Value, Descending

**National CHC Grantee (2019) 71.61%**
<table>
<thead>
<tr>
<th>Smart Form</th>
<th>Responses</th>
<th>Result</th>
<th>Follow-Up Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHQ2 (Old)</td>
<td>No to Both Questions</td>
<td>Negative</td>
<td>N/A</td>
</tr>
<tr>
<td>PHQ2: 2015 Edition (New)</td>
<td>Score = 0, 1, or 2</td>
<td>Negative</td>
<td>N/A</td>
</tr>
<tr>
<td>PHQ9 Only</td>
<td>▪ PHQ2 (Not Done)</td>
<td>Negative</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>▪ PHQ9 (Score = 0, 1, 2, 3, 4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQA Only</td>
<td>▪ PHQ2 (Not Done)</td>
<td>Negative</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>▪ PHQA (Score = 0, 1, 2, 3, 4 or No to 12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHQ2 (Old)</td>
<td>Yes to Either Question</td>
<td>Positive</td>
<td>▪ Medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Referral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Structured Data</td>
</tr>
<tr>
<td>PHQ2: 2015 Edition (New)</td>
<td>Score ≥3</td>
<td>Positive</td>
<td>▪ Medication</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Referral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Structured Data</td>
</tr>
<tr>
<td>PHQ9 Only</td>
<td>▪ PHQ2 (Not Done)</td>
<td>Positive</td>
<td>▪ Medication</td>
</tr>
<tr>
<td></td>
<td>▪ PHQ9 (Score ≥5)</td>
<td></td>
<td>▪ Referral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Structured Data</td>
</tr>
<tr>
<td>PHQA Only</td>
<td>▪ PHQ2 (Not Done)</td>
<td>Positive</td>
<td>▪ Medication</td>
</tr>
<tr>
<td></td>
<td>▪ PHQA (Score ≥5 or Yes to Question 12 or 13)</td>
<td></td>
<td>▪ Referral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Structured Data</td>
</tr>
</tbody>
</table>
When documenting a Diagnosis for the Exclusion-Select Onset Date from the Calendar Dropdown
Documenting Follow-up in Structured Data
### Depression Screening

**Symptoms**

<table>
<thead>
<tr>
<th>c/o</th>
<th>Denies</th>
<th>Symptom</th>
<th>Duration</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td></td>
<td>PHQ-2 In last tw...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S</td>
<td></td>
<td>PHQ-9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S</td>
<td></td>
<td>GAD-7 Form</td>
<td></td>
<td></td>
</tr>
<tr>
<td>S</td>
<td></td>
<td>Depression</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Intervention**

- Intervention
Screening Not Performed

Path:  Progress Notes > HPI > Depression Screening > Screening not performed > Reason

Document the reason a depression screening was not performed as structured data in the HPI section of the Progress Notes.

To document the reason screening was not performed:

1. Click Depression Screening from the left pane.
2. Click the Duration column next to Screening not performed on the right pane.
3. Select one of the following options from the Value drop-down list next to Reason:
   - patient refusal to participate
   - urgent/emergent visit
   - patient lacks the functional capacity

The Reason is documented.
To document an Outgoing Referral the **Specialist** must be one of these below. May have to submit a ticket to have them mapped in your system.

Psychiatry, child & adolescent psychiatry, clinic, clinical psychologist, depression management program, emergency clinic, liaison psychiatry service, mental handicap psychiatry service, mental health counseling, mental health counseling service, mental health counselor, mental health team, mental health worker, psychiatric aftercare, psychiatrist for the elderly mentally ill, psychiatry service, psychogeriatric day hospital, psychogeriatric service, psychologist.
Questions?

Leslie Southworth
Director of the MT HCCN
lsouthworth@mtpca.org
(406) 594-3863
Depression Screening - Why Screen?

INTEGRATED BEHAVIORAL HEALTH
Why Screen for Depression

Lacey Alexander-Small, LCSW
Why Screening for Depression Matters?

- Primary care clinics are a **gateway** for individuals with behavioral health and primary care needs.
- Primary Care Providers (PCPs) prescribe 80% of antidepressants, 67% of psychoactive agents, and 92% of elderly patients receive their mental health services in primary care.
- High levels of stigma and discrimination against this population create lack of access to services.
- Around **50% of Americans** will experience a diagnosable Substance Use Disorder (SUD) or Mental Health (MH) disorder at some time in their life.
- Montana’s suicide rate is more than **twice the national average**. 45% of completed suicide patients had a PC visit within one month, 20% of those had visited within 24 hours.
- Alcohol was found in the bloodstream at a **2 times higher** rate than national average for completed suicide patients.
Why Screening for Depression Matters Cont.

- Depression is among the leading causes of disability in persons 15 years or older.³

- It accounts for $30–50 billion in lost productivity and direct medical costs annually in the U.S.⁴

- Major depression disproportionately affects women

- Depressed mothers may have infants that display delayed:
  - Psychological
  - Cognitive
  - Neurologic
  - Motor development.
At some point in your lifetime you will have symptoms of Depression
Prevalence of Major Depressive Disorder in Chronic Disease

<table>
<thead>
<tr>
<th>Chronic Disease</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s</td>
<td>11</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>17</td>
</tr>
<tr>
<td>Cerebrovascular</td>
<td>23</td>
</tr>
<tr>
<td>Diabetes</td>
<td>27</td>
</tr>
<tr>
<td>Cancer</td>
<td>42</td>
</tr>
<tr>
<td>Parkinson’s</td>
<td>51</td>
</tr>
</tbody>
</table>

Chronic Illnesses Improvement rates Increase
Is it Depression or Diabetes-Related Distress

<table>
<thead>
<tr>
<th>Clinical Depression</th>
<th>Diabetes-Related Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I have persistent sad, anxious, or empty feelings”</td>
<td>“I have feel that diabetes is taking up too much of my mental and physical energy every day”</td>
</tr>
<tr>
<td>“I have feelings of hopelessness and/or pessimism”</td>
<td>“I feel angry, scared, and/or depressed when I think of living with diabetes”</td>
</tr>
<tr>
<td>“I have feelings of guilt, worthlessness, and/or helplessness”</td>
<td>“I feel like I’m failing my diabetes regimens”</td>
</tr>
<tr>
<td>I have irritability and/or restlessness</td>
<td>“I feel that my family or friends are not supportive enough of my self-care efforts”</td>
</tr>
<tr>
<td>“I have lost interest in activities or hobbies that were once pleasurable”</td>
<td>“I feel that diabetes controls my life”</td>
</tr>
<tr>
<td>“I have fatigue and decreased energy”</td>
<td>“I do not feel confident in my day-to-day ability to manage my diabetes”</td>
</tr>
<tr>
<td>“I have difficulty concentrating, remembering details and making decisions”</td>
<td>“I feel that serious long-term complications will happen regardless of my efforts to prevent them”</td>
</tr>
<tr>
<td>“I have insomnia, early morning wakefulness or excessive sleeping”</td>
<td>“I feel that my family and friends don’t appreciate the difficulty of living with diabetes”</td>
</tr>
<tr>
<td>“I overeat or I have appetite loss”</td>
<td>“I feel overwhelmed by the demands of living with diabetes”</td>
</tr>
<tr>
<td>“I have thoughts of suicide or have attempted suicide”</td>
<td>“I don not feel motivated to keep up with diabetes self-management”</td>
</tr>
<tr>
<td>“I have persistent aches or pains, headaches, cramps or digestive problems that done ease even with treatment”</td>
<td></td>
</tr>
<tr>
<td>PHQ-9 Question</td>
<td>Not at all</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>1. Over the <em>last 2 weeks</em>, how often have you been bothered by any of the following problems?</td>
<td></td>
</tr>
<tr>
<td>a. Little interest or pleasure in doing things</td>
<td></td>
</tr>
<tr>
<td>b. Feeling down, depressed, or hopeless</td>
<td></td>
</tr>
<tr>
<td>c. Trouble falling/staying asleep, sleeping too much</td>
<td></td>
</tr>
<tr>
<td>d. Feeling tired or having little energy</td>
<td></td>
</tr>
<tr>
<td>e. Poor appetite or overeating</td>
<td></td>
</tr>
<tr>
<td>f. Feeling bad about yourself or that you are a failure or have let yourself or your family down</td>
<td></td>
</tr>
<tr>
<td>g. Trouble concentrating on things, such as reading the newspaper or watching television.</td>
<td></td>
</tr>
<tr>
<td>h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.</td>
<td></td>
</tr>
<tr>
<td>i. Thoughts that you would be better off dead or of hurting yourself in some way.</td>
<td></td>
</tr>
</tbody>
</table>
Snap-Shot of Whole Health Of Patient
✓ Misdiagnoses and/or playing whack a mole game

✓ Better outcomes – patients get better faster

✓ Education patient of symptoms

✓ Decrease on High utilizers

✓ Addresses Motivation or Lack of Motivation

✓ Screening provides snapshot of Whole health for better tx

✓ Provides opportunities to identify further social determents of health and resources needed

✓ Decrease in medical cost and increase of other screening

✓ Decrease Stigma
  ✓ normalizing mental health connection to physical Health
Questions/Comments

Thank You for Screening!
Breakout Session

Is your clinic currently screening for depression via telehealth? If so how? (portal, visit, etc)

Is a social needs screening being done in conjunction with a depression screening?
Quality Awards
<table>
<thead>
<tr>
<th>Health Center Grantee</th>
<th>State</th>
<th>Clinical Quality Improvers</th>
<th>Health Center Quality Leaders</th>
<th>National Quality Leaders</th>
<th>Access Enhancers</th>
<th>Value Enhancers</th>
<th>Health Disparities Reducers</th>
<th>Advancing Health Information Technology (HIT) for Quality</th>
<th>Patient Centered Medical Home (PCMH) Recognition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellowstone City-County Health Department MT</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$10,750</td>
<td>$45,000</td>
</tr>
<tr>
<td>Missoula, County Of MT</td>
<td>$22,068</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$10,750</td>
<td>$30,000</td>
</tr>
<tr>
<td>Montana Migrant &amp; Seasonal Farm Workers Council Inc. MT</td>
<td>$5,982</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$10,750</td>
<td>$45,000</td>
</tr>
<tr>
<td>Community Health Partners, Inc. MT</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$10,750</td>
<td>$45,000</td>
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<tr>
<td>Butte-silver Bow Primary Health Care Clinic, Inc. MT</td>
<td>$22,521</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$10,750</td>
<td>$35,000</td>
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<tr>
<td>LINCOLN COUNTY COMMUNITY HEALTH CENTER MT</td>
<td>$14,448</td>
<td>$25,373</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$10,750</td>
<td>$35,000</td>
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<tr>
<td>GLACIER COMMUNITY HEALTH CENTER, INC. MT</td>
<td>$6,246</td>
<td>$20,333</td>
<td>$0</td>
<td>$0</td>
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<td>$0</td>
<td>$0</td>
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<td>$30,000</td>
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<tr>
<td>Bullhook Community Health Center, Inc. MT</td>
<td>$7,694</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$8,250</td>
<td>$30,000</td>
</tr>
<tr>
<td>FLATHEAD, COUNTY OF MT</td>
<td>$11,321</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$8,250</td>
<td>$30,000</td>
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<tr>
<td>Bighorn Valley Health Center, Inc. MT</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$10,750</td>
<td>$50,000</td>
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<tr>
<td>Sapphire Community Health, Inc. MT</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$7,100</td>
<td>$30,000</td>
</tr>
<tr>
<td>Marias Healthcare Services Inc MT</td>
<td>$0</td>
<td>$23,231</td>
<td>$34,731</td>
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<td>$8,625</td>
<td>$8,250</td>
<td>$30,000</td>
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<tr>
<td>Community Health Care Center, Incorporated MT</td>
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<td>$0</td>
<td>$0</td>
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Upcoming Events

- **August 26 12:00pm Advancing Health Center Excellence** The Advancing Health Center Excellence Framework aims to help HRSA and health centers advance health center maturity and innovation in key domain areas that align with HRSA’s mission and the mission of the Health Center Program. The framework will also help HRSA make decisions about deploying resources, including providing technical assistance (TA) and funding, with more intention and transparency.

- **September 15 11:00 am** Telehealth Tuesdays: Emerging Trends in Telehealth

- **September 22-24** The Azara 2020 Virtual User Conference

- **September 30th** QDI Peer Learning Call

- **October 5-8** The VIRTUAL 2020 Montana Healthcare Conference