PRIMARY CARE PREVENTION:

Opportunities & Barriers to Implement Integrated Prevention Services in Primary Care

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JOHNSON & ASSOCIATES

EXECUTIVE SUMMARY

BACKGROUND:

HIV prevention funding has been shifting away from behavioral programs toward medical, *treatment as prevention,* programs over the past decade. The new paradigm asserts that there is a greater opportunity to prevent HIV by reducing viral load in people living with HIV than by teaching people preventive measures to remain HIV negative. This new paradigm coupled with the passage of the Affordable Care Act (ACA), is quickening the elimination of government funding for behavioral prevention programs administered by community based organizations, specifically, those that do not offer primary health care. At present, there are no HIV specific behavioral prevention programs outlined in the ACA or covered by any of the health insurance providers in Los Angeles, other than bio-medical interventions – Pre-Exposure Prophylaxis (PrEP) and Post Exposure Prophylaxis (PEP). The concern is that primary care, as it is currently practiced – either in a preferred provider organization (PPO) or in a managed care setting (HMO) - may not provide adequate support for people living with HIV to stay in care and comply with antiretroviral treatments; and, does little to help people who are HIV negative to remain HIV negative. One proposed solution is to help primary care providers identify patients at risk for acquiring HIV or transmitting HIV, and offer them prevention services. Given the fact that HIV is emerging among lower income and younger men of color, primary care providers serving these men are the targets to provide more comprehensive prevention services;[1] and, the services explored are ones that can most likely be delivered within a managed medical model.

This research explored the possibility of introducing an HIV risk assessment as part of a standard patient encounter at a primary care provider whose patient population is mostly low income, homeless, people of color. The hypothetical risk assessment explored indicated that if a patient showed signs of risk in one of three areas, that s/he would be assessed for all three areas of risk: (1) Unprotected sex or STI exposure, (2) substance use (alcohol or drugs), and (3) mental health status.

RESULTS:

This research demonstrated the potential to implement a coordinated and standardized prevention protocol in managed health care settings.

***Benefits* of this protocol include:**

(1) more informed patient population about risk assessment and prevention activities,
(2) consistent and measurable approach to health service assessment and treatment
(3) improved health outcomes from disease prevention or early treatment, and
(4) potential cost savings if patients take preventive measures, change risk behaviors or, if risk behaviors or infections are identified early by health providers.

[1] These populations are mostly enrolled in managed Medi-Cal (HMO) plans.

***Barriers* of this protocol include:**

(1) Financial – how to pay for prevention services (e.g., charge health plans),

(2) Staff – identify, recruit and train the appropriate staff person in varied clinical settings to conduct the assessment, and

(3) Linkage – link patients to treatment and follow-up when services are not co-located.

***Solutions* to implement this protocol include:**

(1) Documenting encounter – a standard way to track this activity is needed to meet the guidelines of a "medically necessary" billable visit.

(2) Billing – Must be able to charge health plans or other payer sources for this service either on a per encounter basis or embed it into the overall capitation rate[2] based on a profile of higher risk patients being served.

(3) Targeting – aim these activities to prioritize patient populations who are at a greater probability of acquiring HIV.

(4) Organization Buy-In – educate all staff about the goals of the program, provide training and specify how the program will function and be evaluated.

METHODS

Over the course of one month, we conducted a content analysis of a prevention protocol at a Federally Qualified Health Center (FQHC), eight structured individual interviews, and two informal individual interviews with four types of staff – medical assistants (n=4), providers – physician and physician assistants – (n=2), social workers/care managers (n=2) and executives (n=2). Interviews took place at the FQHC's facility and were conducted with two interviewers during each interview. The FQHC was chosen because of the high-risk population it serves. Assessing the difficulty providing services to homeless patients lends greater insight to potential challenges implementing the proposed prevention protocol across varied types of providers and patient populations.

DETAILED RESULTS

We conducted an initial assessment for implementing prevention services in a primary care setting. This assessment took place in a high volume primary care provider setting that serves the needs of patients who are primarily homeless, people of color, and lower income, residing in downtown Los Angeles. This assessment explored:

(1) Current risk protocols used to prompt prevention education, HIV tests, support services, and treatment recommendations;

(2) Accessibility of treatment and support services for patients; and,

(3) Potential to introduce coordinated and standardized prevention services into the current patient assessment.

[2] Capitation rate is the set amount a health maintenance organization (HMO) pays per enrolled patient per month to a health care provider.

I. CURRENT RISK PROTOCOLS FOR RISK ASSESSMENT & SERVICES

HIV testing is part of the universal standard of patient care at JWCH Institute, Inc. (FQHC site of the research). Patients are given an HIV test every three months per clinical protocol. HIV tests are also offered if/when a patient requests a test, provides an indication that s/he may have a sexually transmitted infection (STI) – a patient describes symptoms or an event suggestive of STI exposure.

We explored three primary risk factors for HIV that can most likely be delivered within a managed medical model. We assessed what protocols might prompt prevention education or services: (1) Unprotected sex or STI exposure, (2) substance use (alcohol or drugs), and (3) mental health status. Each risk factor had specific encounter and assessment prompts for education and services. Yet, evidence of risk in one of these three areas did not necessarily trigger an assessment of risk in the other two areas. Therefore, a person with an identified need for substance use education and treatment will not automatically be assessed for mental health or sexual health.

Table 1 outlines the risk areas and the manner in which patient risk is assessed.

Table 1: Risk Assessments at JWCH

RISK CATEGORIES	METHOD OF RISK ASSESSMENT
HIV & STI (Unprotected Sex)	Quarterly Routine Opt-Out HIV Tests & Communicable Test Screening
Substance Use	MA administered intake questionnaire and physician assessment
Mental Illness	MA administered intake questionnaire and physician assessment

II. ACCESSIBLE TREATMENT AND SUPPORT SERVICES

Co-Located Services

Patients of JWCH (Downtown LA – Center for Community Health) have the benefit of accessing services for the three risk areas in the same location. JWCH offers HIV and substance use services within their organization; and, the Los Angeles County Department of Mental Health has co-located staff providing services in the same building, allowing immediate linkage of patients to a mental health provider, when needed. A JWCH provider acknowledges the advantage of co-located services.

> *I like [co-located services] because a lot of my patients see the specialists here. So, I'm able to communicate with the other providers if there's an issue with medication. (Provider)*

A key advantage resulting from co-location of services is the ability to link patients to services that are needed even if the patient does not perceive the need.

> *We have to lead them [patients] in the right direction. They don't always know what they need or how to get it. (Case Coordinator)*

Co-located services are advantageous in providing comprehensive prevention services.

Tracking and Evaluation for Patient Encounters

JWCH uses NextGen, an electronic health record and practice management program to conduct patient intake, manage health records, track patient labs, referrals, case management and performance management data. The system has the capacity to include prompts via query templates for questions related to sexual behaviors, substance use and mental health. Presently, templates and questions that may indicate if a patient were in need of prevention services are limited. A clinic administrator notes:

> *As far as HIV prevention, there's not enough information in [NextGen] at this point. Same thing as mental health. We ask a couple questions and that's as far as it goes. (Operations Administrator)*

A provider confirmed that evaluation questions would be best situated in NextGen.

> *That would be best way to ask…more questions in the PQ [template].(Provider)*

Current questions in JWCH's NextGen templates for risk categories are in Table 2.

Table 2: Risk Categories and Questions at JWCH

RISK CATEGORIES	QUESTIONS ASKED
Sexual behaviors	Not present or not asked
Substance Use	Alcohol consumption and drug use with unclear amount of depth
Mental Illness	Severe mental health needs (e.g., have you been feeling down or hopeless? Or, Do you have thoughts of killing yourself or hurting someone else?).

III. COORDINATED AND STANDARDIZED PREVENTION SERVICES

Implementation potential is assessed based on feedback about the prevention program's (a) perceived benefits, (b) barriers, and (c) best approach to implementation.

PERCEIVED BENEFIT

Higher level management staff and providers indentified the benefit of a single prevention event triggering other prevention services. From an operations perspective, the long-term cost savings outweigh the immediate non-reimbursable cost.

> *We still find a way of implementing that [prevention conversation with the provider] because in the long run, it's helping us save in other ways. (Operations Administrator)*

A provider noted the benefit, while indicating that it should be dependent on the visit.

> *Yes, I think there's a benefit…It depends on the visit. But when it is the STD screening, mental health? It would be good. (Provider)*

A clearly identified prevention assessment mechanism was consistently valued.

> *If there is someone to keep track of those things [prevention assessment], it would take a load off the doctor because the MA has a lot to track. (Case Coordinator)*

Executives indicated this protocol would benefit anyone at risk, primarily people of color:

> *Younger people of color, Latinos and black men, who are MSM or not gay identified, impoverished men and substance users, would be the primary targeted people we need to get services to. (Executive)*

BARRIERS TO IMPLEMENTATION

The most frequently mentioned barriers to implementing the proposed prevention protocol – where a single prevention event triggers other prevention services – include: (a) funding, (b) time, (c) offending patients, and (d) available facilities.

Funding

Compensation for a patient encounter does not currently include an allocation of time or cost factor associated with conducting a standardized prevention assessment. It also does not provide a cost factor of prevention services, should they be identified as necessary. An executive explains the need to develop codes for prevention encounters, which are validated by plans and other payer sources for billing purposes.

> "*We either need a specific reimbursement for the visit, or better yet, funding to determine what we need to do so that we could appropriately document the visit in the electronic health record and meet the guidelines for a proper billable visit."*

> *"We need to make sure we develop this* [prevention assessment] *so that the service delivery and coding meets the "medically necessary visit" requirements of Medi-Cal so that we can begin making the argument to plans that these services are appropriate and possible to deliver the way we know they need done."*

Time

Time spent conducting the prevention assessment and educating patients about preventing sexually transmitted infections were consistently mentioned as barriers. A case manager and provider each explain the time requirements that are essential to establish rapport for prevention discussions; yet, often inconsistently provided.

> *You have to get to know the patients... You have to dedicate enough time and not be in a hurry. (Case Manager)*

> *Some patients, you know, five minutes, boom, you're done. Other patients, you know, you have to dig a little. If a patient requires a half hour, then I'm going to spend a half hour. I don't cut corners. Period. (Provider)*

A case manager with nearly two decades of HIV experience mentioned the need to properly educate patients in order to prevent the proliferation of STIs.

> *If you don't explain [STI information] to the patient, they're going to continue with the same behavior and we're going to end up with that patient being HIV positive in two years or less. (Case Manager)*

Offending Patients

Medical assistants (MAs) were especially wary of asking sexual behavior questions for fear that patients may think the questions are irrelevant or too personal.

> *– If a person came in for burning urine, of course, we're going to do STD [test]. Then that's the questions you can ask. The questions, in my opinion, of sexual stuff, probably should be at the times when you need to ask them…We have TB patients…'have you had sex - yesterday, a week ago in this or that type of position?' "I'm just here for a TB test!"*

> *– It might be a little personal for them. As for me, it would be like a part of my job.*

> *– Do you wear protection when you have intercourse?' I don't think that's a big deal. But then 'how many times do you have sex a day? Do you also have a partner on the side? Is that your only partner? Okay, wait! Hold up!'*

Patients may fail to disclose rather than display offense at being asked the types of personal questions required for a thorough prevention assessment.

> *Sometimes a patient just doesn't always tell the full honest truth about something affecting their care. Sometimes, they don't feel comfortable talking to the doctor or they think the doctor just doesn't have the time. (Case Manager)*

Available Facilities

A provider noted the urgency in connecting a motivated patient to prevention services immediately, especially for substance use programs.

> *We do have programs. I think the only barrier is trying to get them into a detox program. Not only are the hospitals crowded, it's an insurance thing. On our part, that's a barrier because if a patient is ready, you've got to get them then because five minutes from now they may not want it. (Provider)*

Best Approach to Implement

Staff recommended implementing the proposed prevention protocol by identifying:

(a) The best person to provide the assessment and education;

(b) How the assessment should take place; and,

(c) How to provide linkage and follow up.

Best person to conduct the assessment

Among management and health staff, responses varied regarding who would be the most appropriate person to conduct the risk assessment.

Providers thought they were best equipped:

> *Most patients are more comfortable talking to a provider about the education and prevention [of STDs]. I think it's more common that a patient will say something to a medical assistant but a lot of times the stories change if they're not comfortable with the medical assistant until we [providers] get in the room and it's a whole different thing. (Provider)*

> *If there was someone specifically to do that [STD screening/education], I think that would be good as well. I just think a lot of people like talking to the provider. (Provider)*

> *I don't think it's appropriate, you know, for the MA to ask these questions. (Provider)*

An operations administrator also believed providers would be the best equipped to have the prevention conversation. However, the staff member admitted his belief was based on the fact that he prefers having such conversations with a provider:

> *I think that [conversation] should be with the provider, only because I noticed that a lot of the patients are not comfortable enough to speak about some private issues information with a medical assistant or nurse. (Operations Administrator)*

A case manager indicated that the conversation could be conducted by anyone with proper training. Success, according to the case manager, depends on preparation, a willingness to take the time to "read" the screening questions and enjoy the work:

> *It's not that difficult, it just takes somebody who knows what they're doing so they can do it. You have to do a lot of reading. It is knowing, you like your job and being willing to do it. (Case Manager)*

How the assessment should take place

The first step in assessing risk is asking patients to provide honest feedback. This task will require extensive training, rapport and technique. One medical assistant who expressed reluctance asking questions about sexual behaviors thought if questions were more indirect, it might be more successful.

> *Probably if you could sneak to it. 'oh so you do that [use substance] have you also been having unprotected sex...? Did you have unprotected sex while you were high? Something like that you can sneak in. (Medical Assistant)*

Although developing cunning techniques to evaluate HIV risk is not recommended, it does illustrate the need for staff training to be comfortable speaking about health, especially sexual, mental and behavioral health. The assessment will require a health professional who is comfortable speaking about these issues. A case manager reinforced the connection between patient comfort and patient honesty.

> *Especially with this population [homeless], it really has to do with the comfort level. You can ask questions, but they may not answer honestly. (Case Manager)*

Establishing an environment where patients are comfortable being honest is the responsibility of the health provider; and, developing that environment demands a well-trained health provider. As such, any new prevention service implementation in a primary care model should be accompanied with extensive training. A medical assistant echoed the need for training and added the desire for added compensation.

> *Pay-wise, it would be like I'm doing more this and more that, is there a raise that comes in with that?...Maybe there should be some kind of training for MA's so it's 'ok, this is what's going to happen to teach them the ropes.' (Medical Assistant)*

For primary care providers without co-located services, it is recommended that they have a thorough knowledge, and consistently updated list, of contacts at access points where they can link people to care.

> *The places that I refer my patients, is places that I know…So, I know when I refer a patient there, they're going to receive confidentiality. (Case Manager)*

CONCLUSION

Implementing prevention services in managed care settings will be a significant challenge. Efforts from the AIDS Coordinator's Office to encourage health providers to adopt routine opt-out HIV testing demonstrated the challenges associated with any policy changes in health care settings. Even when the will to change is strong, there must be leadership within the organization to keep the momentum of change alive. The more comprehensive risk assessment and linkage to care program proposed in this research would require collective effort from and negotiation between health organizations and managed care plans. Organizations are unlikely to invest extra time with this proposed assessment if they are not compensated for their efforts, even if it is more cost-effective in the long run. Managed care plans will need to be willing to compensate providers for this enhanced or additional patient encounter, even when there may not be evidence to support the medical necessity, particularly in high risk populations. If there are similar prevention assessments taking place for diabetes or cardiovascular disease, these assessments and reimbursement mechanisms may act

as a point of reference to build the case for the proposed coordinated and standardized HIV prevention assessment. A next step is to identify the elements needed to conduct a coordinated assessment in a primary care setting and evaluate the effectiveness of the protocol based on performance metrics. For example, (1) are patients with high risk behaviors consistently identified through the assessment; (2) after high risk behavior is confirmed, are patients being linked to services, which provide appropriate prevention interventions; (3) are more risk factors identified in the targeted patient population as a result of the assessment; and, (4) are there quantifiable health outcome improvements found as a result of the assessment and linkage to care?

PRINCIPAL INVESTIGATORS:

Aaron Celious, Ph.D., is Director of Research & Strategy for Maroon Society, a Los Angeles based research and strategy firm. His work focuses on how to best introduce organizational change and implement large-scale public policies related to public health and transportation. This includes understanding how end users (health providers, patients, transit users) experience public health and transportation system changes, especially among racially and linguistically diverse communities. Recent studies include: (a) regional planning for ethnic diversity and aging in Southern California, (b) Update to the City of Los Angeles white paper – HIV prevention and support strategy, (c) environmental impact of introducing high-speed rail transit to Burbank Airport, (d) barriers and opportunities that Community Health Centers encounter while implementing Routine Opt-Out HIV test policies (e) measuring efficacy of health promoter programs (promotoras de salud) to mitigate mental illness among monolingual Spanish speaking Latinos, (f) strategies to integrate urban greening strategies adjacent to Los Angeles County Metro rail stations, and (g) mass transit passenger response to shifting from an honors-based payment system to mandated payment system.

Michael J. Johnson, is a health care attorney and consultant at Johnson & Associates located in the Greater Los Angeles area. He assists FQHCs, community clinics, IPAs and other service delivery organizations as they shift their operations into managed care business models. He also assists HMOs, PPOs, and medical groups in contracting and negotiating with commercial business lines and payer sources. He can be reached at LBLawMike@aol.com and (562) 335-6354.

Print Date: 11/2/14

CASH REQUEST

Department on Disability - City of Los Angeles

Contractor:	**Maroon Society, Inc.**	Agreement No.:	
Program:	**Training Assistance Grant: Prevention in Primary Care**	Agreement Period:	**6/10/14 - 7/10/14**
Funding Stream (WIA Only):		Amendment No.:	
	(For WIA: Please prepare a separate request for each funding stream.)	Amendment Period:	
For the Month(s) of:	**June 2014 - July 2014** Request No.: **1**	Agreement Amount:	**$4,950.00**

CASH STATUS SUMMARY

Cost Category Number	Description	Program Budget (1)	Cash Received to Date (2)	Cash Requested for the Period (3)	Budget Available (4) = (1 - 2 - 3)
# 1000 -	Personnel Costs	2,722.50		**2,722.50**	0.00
# 2000 -	Other Costs				0.00
# 2100 -	Participant Related Costs			**0.00**	0.00
# 2200 -	Subcontractor Costs - (**Show breakdown below**.)	0.00		**0.00**	0.00
	Mike Johnson Johnson & Associates	2,227.50		**2,227.50**	0.00
# 4000 -	Indirect Costs	0.00			0.00
# 5000 -	Capital Costs	0.00			0.00
	Total	**4,950.00**			**0.00**
	Request for this period.			**4,950.00**	

SPENDING PLAN

	Month 1 June	Month 2 July	Month 3 August	Month 4 September	Month 5 October	Month 6 November	
Plan-YTD		4,950.00					
Plan-Monthly							
Actual for the Month							
Variance-Over (Under)	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Month 8	**Month 9**	**Month 10**	**Month 11**	**Month 12**	**Supplemental**	**TOTAL AMOUNT**
Plan-YTD							
Plan-Monthly							**4,950.00**
Actual for the Month							
Variance-Over (Under)	0.00	0.00	0.00	0.00	0.00	0.00	

CERTIFICATION BY CONTRACTOR

We hereby each certify under penalty of perjury under the laws of the State of California that this Cash Request, and its supporting financial records, are true in all respects and that all funds have been or will be used solely for the purposes set forth in the Statement of Work contained in the agreement entered into by this Contractor and the Department on Disability (DOD). We also understand that allowability of cash requested is subject to final acceptance by DOD and that payroll tax returns have been timely filed and applicable payroll taxes have been timely paid.

Preparer's Name	Signature	Title	Date	Phone No.
Aaron Celious		**Director/Vice President**	**November 3, 2014**	**(310) 309-9003**
Authorized Reviewer's Name	**Signature**	**Title**	**Date**	**Phone No.**

FOR CITY USE ONLY:

Department on Disability Approval:

Accountant's Name & Signature	**Date**		**Date**
Supervisor's Name & Signature	**Date**	**Batch #** _____ **HUD Act** **HUD Activity #**	
		PV # _____	
Insurance, EBO, LWO on File:		**PV #** _____	
Senior Accountant/Mgmt Analyst Name & Signature	**Date**	**TOTAL**	

COMMENTS

PLEASE SHOW BREAKDOWN FOR #2200 - SUBCONTRACTOR(S) COSTS BELOW:

Subcontractor Name	Cash Received to Date	Cash Requested for Period	Total
			0
			0
			0
			0
			0
TOTAL	0	0	0

OTHER COMMENTS: (Use additional paper if necessary)

EXPENDITURE REPORT

Department on Disability - City of Los Angeles

Contractor: **Maroon Society, Inc.**
Program: **Training Assistance Grant: Prevention in Primary Care**
Funding Stream (WIA Only):
(For WIA Contractors: Please prepare a separate report for each funding stream.)
For the Period Ended: **July 30, 2014** Report No.: **1**

Agreement No.:
Agreement Period: **6/10/14 - 7/10/14**
Amendment No.:
Amendment Period:
Agreement Amount: **$4,950.00**

Item Description / Cost Categories	Approved Budget (1)	Prior Expenditures -2	-3	-4	Expenditures This Invoice -5	-6	GRAND TOTAL Cumulative Expenditures (7) = (2 + 5)
A. EXPENDITURES by LINE ITEM:							
# 1000 - Personnel Costs							
SALARIES	2,227.50				2,227.50		2,227.50
FRINGE BENEFITS	495.00				495.00		495.00
Subtotal - #1000: Personnel Costs	**2,722.50**				**2,722.50**		**2,722.50**
# 2000 - Other Costs							
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
Subtotal - #2000: Other Costs	**0.00**	**0.00**			**0.00**		**0.00**
# 2100 - Participant Related Costs							
Mike Johnson Johnson & Associates	2,227.50				2,227.50		2,227.50
							0.00
							0.00
							0.00
							0.00
Subtotal - #2100: Participant Related Costs	**2,227.50**	**0.00**			**2,227.50**		**2,227.50**
# 2200 - Subcontractor(s) Costs							
							0.00
							0.00
							0.00
							0.00
							0.00
Subtotal - #2200: Subcontractor(s) Costs	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**		**0.00**
							0.00
							0.00
							0.00
							0.00
	0.00	**0.00**	**0.00**	**0.00**	**0.00**		**0.00**
# 4000 - Indirect Costs							
% of		**0.00**					**0.00**
		0.00					**0.00**
Total Cumulative Expenditures	**4,950.00**	**0.00**	**0.00**	**0.00**	**4,950.00**		**4,950.00**
B. SUMMARY OF EXPENDITURES:							
1. Prior Period Total Expenditures		**0.00**					0.00
2. Current Period Expenditures		**0.00**					0.00
3. **Total Cumulative Expenditures (B1 + B2)**	**4,950.00**	**0.00**	**0.00**	**0.00**	**0.00**		**0.00**
4. **Total Stand-in Costs**		**0.00**					**0.00**
C. CASH STATUS:							
1. Cash Received to Date							
2. Add: Cash In-Transit							
3. **Total Cash Received to Date Plus In-Transit (C1 + C2)**		**0.00**					**0.00**
4. Less: Cash Disbursements to Date							
5. **Cash Balance (C3 - C4)**		**0.00**					
D. PROGRAM INCOME EARNED:							
1. Total Cumulative Program Income Earned							
2. Total Expenditures Paid from Program Income Received							
3. **Program Income Balance (D1 - D2)**		**0.00**					

CERTIFICATION:

We hereby each certify under penalty of perjury under the laws of the State of California that this expenditure report, and its supporting financial records, are true in all respects and that all expenditures have been made solely for the purposes set forth in the Statement of Work contained in the contract entered into by this Contractor and the Department on Disability (DOD). We also understand that allowability of costs reported is subject to final acceptance by DOD. Reported costs based on allocations have an underlying cost allocation plan prepared in accordance with the applicable Office of Management and Budget Regulations. Additionally, payroll tax returns have been timely filed and applicable payroll taxes paid.

Preparer's Name	Signature	Phone No.	Date
Aaron Celious		**(310)309-9003**	**11/03/14**
Reviewer's Name	Signature	Phone No.	Date

SCHEDULE OF PERSONNEL COSTS

Department on Disability, City of Los Angeles

Contractor:	**Maroon Society, Inc.**		
Program:	**Training Assistance Grant: Prevention in Primary Care**	Contract No.:	
Funding Stream (WIA Only):		Contract Period:	**6/10/14 - 7/10/14**
	(For WIA contractors, please prepare a separate report for each funding stream.)	Amendment No.:	
		Contract Amount:	**$4,950.00**
For the Period Ended:	**July 30, 2014**	Report No.:	**1**

POSITION TITLE / FRINGE BENEFIT	EMPLOYEE NAME	A Approved Budget	B Prior Expenditures	C Expenditures This Invoice		B + C GRAND TOTAL CUMULATIVE EXPENDITURES	D - H Available Budget
A. SALARIES:							
Principal Investigator	Aaron Celious	2,227.50		2,227.50		2,227.50	**0.00**
Co-Principal Investigator	Mike Johnson	Independent Contractor				0.00	
						0.00	**0.00**
						0.00	**0.00**
						0.00	**0.00**
						0.00	**0.00**
						0.00	**0.00**
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						0.00	**0.00**
						0.00	**0.00**
						0.00	**0.00**
						0.00	**0.00**
						0.00	**0.00**
						0.00	**0.00**
SUBTOTAL: SALARIES		**2,227.50**	**0.00**	**2,227.50**	**0.00**	2,227.50	**0.00**
B. FRINGE BENEFITS:							
FICA		124.74		124.74		124.74	**0.00**
HEALTH		278.93		278.93		278.93	**0.00**
SUI		62.37		62.37		62.37	**0.00**
WORKERS' COMPENSATION		28.96		28.96		28.96	**0.00**
RETIREMENT		0.00		0.00		0.00	**0.00**
OTHERS				0.00		0.00	**0.00**
						0.00	**0.00**
SUBTOTAL: FRINGE BENEFITS		**495.00**	**0.00**	**495.00**	**0.00**	495.00	**0.00**
TOTAL PERSONNEL COSTS		**2,722.50**	**0.00**	**2,722.50**	**0.00**	2,722.50	**0.00**