Health Resources & Services Administration
Community-Based Workforce for COVID-19 Vaccine Outreach

Final Report

We are providing our final report using the HRSA-provided recommended template for the Final Report with the following components:

1. Award Recipient and Project Director Contact Information

Recipient Organization Name (As it appears on NOA)	Public Health Institute
Award Number (10-digit number starting with U3S or G32)	U3SHS42187-01-00
Reporting period (award start and end date)	June 1, 2021, to May 31, 2022
Project Name (if any)	Community-Based Workforce for COVID-19 Vaccine Outreach
Project Director Contact Name	Rebecca Silva
Project Director Phone number	(510) 285-5561
Project Director Email address	Rebecca.Silva@phi.org

2. Project Overview

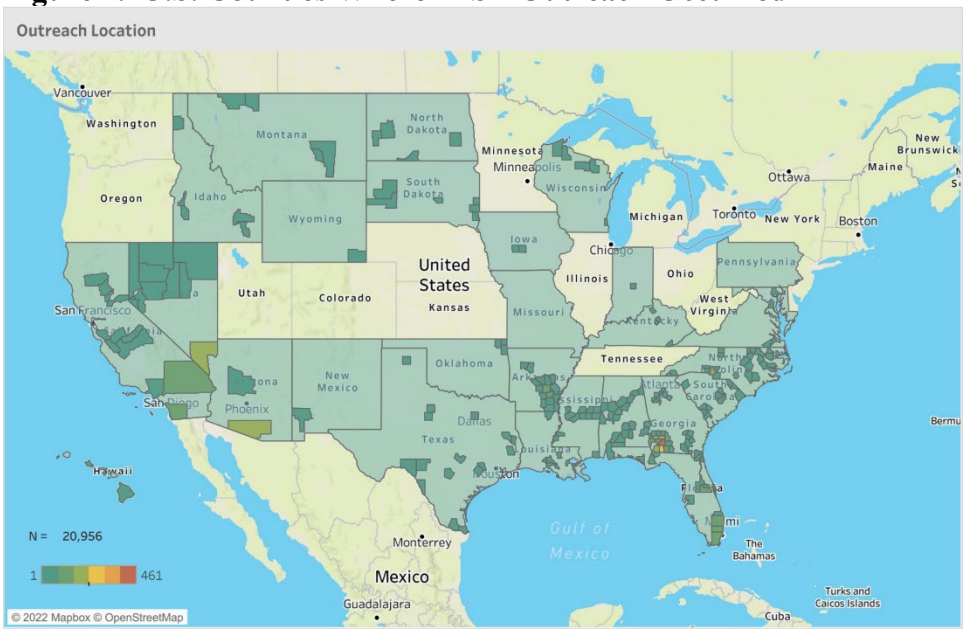
Communities RISE (Reach, Immunizations, System Change for Equity) Together (RISE) is a strategic alliance between the Center for Popular Democracy, Latino Health Access, Migrant Clinicians Network, WE in the World, and the Public Health Institute, along with their partners, CHROMATIC Black, Well Being In the Nation (WIN) Network, Meals on Wheels, National Council on Aging, USAging, National Indian Health Board, Together Towards Health, and the Hawaii Public Health Institute.

Together, these RISE partners, who have "on the ground reach" with over 2,400 community-based organizations, have reached Black, Native-American, Latinx, Asian-American/Pacific-Islander, immigrant/migrant, older adult, and low-income adult populations in over 200 U.S. counties that are hardly reached, hard to reach and hardest to reach.

Our approach to reaching and engaging communities included mapping, supporting, and partnering with trusted networks who are in relationships with hard-to-reach communities. These networks implemented a media marketing and communications strategy paired with direct outreach. RISE:

- scaled up community outreach worker infrastructure by leveraging existing and nontraditional, trusted, natural community members as assets;
- reached over 200 communities using tools, infrastructure, and training to become vaccine ambassadors, known here on out as community health workers (CHWs) and promotoras; and
- used timely data to advance real-time improvement.

Figure 1. U.S. Counties Where RISE Outreach Occurred



RISE program activities included: training infrastructure for the development of CHWs and promotoras and call center operations; vaccine coordination support of community-based vaccine delivery programs through mobile or community points of distribution; mass door-to-door outreach, where trained canvassers utilized face-to-face conversations to understand vaccine hesitancy and recruited people to participate in campaign committees and chapter meetings, where they started taking action together, and began developing leadership skills and digital engagement skills; dissemination of information and learning across communities through the support of a peer-to-peer learning and action collaborative – a cross-network, cross-CBO, cross-community learning collaborative.

Our robust communication and marketing strategies complemented direct outreach by community health workers to reach vaccine-hesitant communities. This empowered trusted messenger networks to combat disinformation and misinformation through storytelling,

programming, and strategic messaging utilizing social listeners to monitor social media channels, correct misinformation, and encourage vaccination. In addition, they amplified the national vaccination campaign and disseminated real-time information, tools, and research to trusted news, media, and communication channels and leveraged the national campaign to onboard and engage trusted messengers, grassroots outreach channels, streaming services, and civic and media partners to disseminate content and messages.

Through the RISE partnership approach, communities effectively utilized the resources to improve vaccine rates and community well-being. Using the community vulnerability and COVID hotspot data, communities targeted high-need counties and engaged trusted local partners. The RISE well-being-oriented vaccine hesitancy assessment provided practical, real-time, locally based data that guided communities to generate solutions to meet local needs. The assessment rates how people are doing overall, attitudes and barriers to vaccination, and underlying social need and equity factors that matter in people's lives holistically. Communities used the data to connect people to their social and well-being needs and drive improvement community well-being in addition to vaccination rates.

3. Summary of Key Activities

The table below summarizes the key activities accomplished over the full award period. There were four fluid phases of the project approach and key activities within each phase: 1. Set up project team, 2. Mapping and strategy, 3. Communications, implementation and network mobilization, and 4. Building infrastructure and systems to support outreach, training, data and monitoring, for real-time learning, course correction, and spread and scale of best practices.

Key Activity	Geographic Area and/or Target Population	Resources & Partners	Outcomes/Impact
1. Set up project team and subcontracts with each major partner and key network	Black, Native-American, Latinx, Asian-American/Pacific-Islander, immigrant/migrant, and low-income older adult populations that are hardly reached, hard to reach, and hardest to reach	Fiscal agent: Public Health Institute (PHI) Core Partners: WE in the World (WE) (RISE program facilitator), Migrant Clinicians Network (MCN), Latino Health Access (LHA), The Center for Popular Democracy (CPD), Chromatic Black (CB), Meals on Wheels (MOWA), National Council on Aging (NCOA), US Aging, National Indian Health board, (NIHB) Together	**10** = core partners sub-awarded **70** = Sub-recipients contracted

		Towards Health, & Hawaii Public Health Institute (HIPHI)	
2.a. Community mapping and engagement of trusted community health workers	Black, Native-American, Latinx, Asian-American/Pacific-Islander, immigrant/migrant, and low-income older adult populations that are hardly reached, hard to reach, and hardest to reach	Core Partners Resources: CDC's Social Vulnerability Index; May 2021 US Census Bureau's Household Pulse Survey for vaccine hesitancy; KFF COVID -19 May 2021 Report; local, state and national reports on CDC	Prioritization of communities with highest social vulnerability and highest COVID burden **27** = states RISE worked in **166** = Counties RISE worked in **2,066** = CHWs hired
2.b. Identification and categorization of "how hard to reach" each community/sub-population is and the best engagement and communications strategies	Black, Native-American, Latinx, Asian-American/Pacific-Islander, immigrant/migrant, and low-income older adult populations that are hardly reached, hard to reach, and hardest to reach	Core Partners	Determined the nature of outreach strategy and associated depth of resources needed to accomplish, estimated cost to reach per person outreached to, and impact on health and cost outcomes
3.a. Focus groups with subpopulations to understand vaccine hesitation for message development	Vaccine hesitant African–Americans with a hyper focus on rural populations defined as vulnerable	CB	Completed and developed multiple campaigns—highlighted in 3.b.
3.b. Development of culturally appropriate communication strategies, content, and materials by communities and networks from national coordination to hyperlocal implementation	Black, Native-American, Latinx, Asian-American/Pacific-Islander, immigrant/migrant, and low-income older adult populations that are hardly reached, hard to reach, and hardest to reach	CB, MCN, MOWA, NCOA, NHIB, USAging Resources: Acts of Love Campaign; Keep Black Love Alive; SHIP TA videos	**4,188** = communication materials developed and used door-to-door, at community events, for direct mailing, and for social media posts

3.c. Recruit, hire and train a corps of social listeners to monitor and promote content on social media channels	Vaccine hesitant African–Americans with a hyper focus on rural populations defined as vulnerable	CB	
3.d. Train network partners and CBOs on hyperlocal communication strategies and tactics, provide tools and resources for execution	Black, Native-American, Latinx, Asian-American/Pacific-Islander, immigrant/migrant, and low-income older adult populations that are hardly reached, hard to reach, and hardest to reach	Core partners	70 = CBOs trained and provided low tech tools, resources, funding, and equipment to develop hyper localized campaigns 3,108 = Community health workers trained provided low tech tools, resources, funding, and equipment to develop hyper localized campaigns 1,150 = culturally competent and tailored resources to communities
3.e. Development of human, wise, and emotional stories, and content	Black, Native-American, Latinx, Asian-American/Pacific-Islander, immigrant/migrant, and low-income older adult populations that are hardly reached, hard to reach, and hardest to reach	Odd Duck Communications ReThink Health Resource: ReThink Health story series RISE newsletter	Publication will highlight 9 stories, illustrating how RISE builds trust, civic capacity, and transforms systems
3.f. Launch of national campaign with network, content disseminated	Black, Native-American, Latinx, Asian-American/Pacific-Islander,	CB & sub-recipient communities Resources: links to TV, newspaper, and	**110** = Hyper local TV, newspaper, radio outreach coordinated by sub-recipients in 12 states

through multi-channel subscriptions to support hyperlocal campaigns	immigrant/migrant, and low-income older adult populations that are hardly reached, hard to reach, and hardest to reach	web articles: Facebook ads for Keep Black Love Alive; Charlotte Weekly; Arkansas Community Institute; Action Institute; Make the Road Nevada; Sowega Council on Aging;	
3.g. Social media and radio listening and engagement in multi-media to fight misinformation and disinformation and provide vaccination info	Vaccine hesitant – populations with a hyper focus on communities defined as vulnerable by the CDC	CB	**43,530,241**= people reached through multi-media strategies
4.a. Overall well-being, vaccination status and attitudes, underlying social need and equity factors, assessments	Black, Native-American, Latinx, Asian-American/Pacific-Islander, immigrant/migrant, and low-income older adult populations that are hardly reached, hard to reach, and hardest to reach	CHWs, promotoras, and community sub-recipients Resources: HRSA & RISE surveys	See section 6 for presentations of well-being and needs assessments
4.b. CHW and promotora training and support	Black, Native-American, Latinx, Asian-American/Pacific-Islander, immigrant/migrant, and low-income older adult populations that are hardly reached, hard to reach, and hardest to reach	LHA, CPD & WE Training and Learning Resource Library: Overview of Communities RISE; Vaccine Ambassador-Outreach and Hesitancy Modules; Data, Reporting, and Technology Modules; Call Center Module; & Canvassing Outreach Modules	**75** = training sessions throughout the grant period **3,108** = CHWs and promotoras trained RISE core partners provided one-on-one technical assistance throughout the project and housed resources on the Notion website

4.c. Trusted messengers engage communities through a combination of canvassing, door to door outreach, telephone outreach and communication activities	Black, Native-American, Latinx, Asian-American/Pacific-Islander, immigrant/migrant, and low-income older adult populations that are hardly reached, hard to reach, and hardest to reach	CPD, LHA & sub-recipient communities	**2,066** = CHWs and promotoras engaged **2,185** = staff engaged **834,790** = people outreached to directly (canvassing, door to door outreach, telephone outreach) **43,655,241** = people outreached to (indirect – social media, radio, newspaper, etc.) **507** = events organized or participated in **227** = hyper-local community partnerships activated
4.d. Trusted messengers connect people, once engaged, to vaccination and social needs (food, housing, etc.)	Black, Native-American, Latinx, Asian-American/Pacific-Islander, immigrant/migrant, and low-income older adult populations that are hardly reached, hard to reach, and hardest to reach	CHWs, promotoras, and sub-recipient communities	**214,462** = people connected to social needs **184,203** = people vaccinated
4.e. Trusted messengers use data and their experience in communities to adapt the program to improve the community in real time	Black, Native-American, Latinx, Asian-American/Pacific-Islander, immigrant/migrant, and low-income older adult populations that are hardly reached, hard to reach, and hardest to reach	Core Partners Resources: Partner dashboards All RISE Peer-to-Peer and Core Partners workstream meetings convene communities to share, review data, & adapt	Developed partner dashboards in Tableau **22** Biweekly RISE Partner and Community Measurement calls held throughout the grant period to review data and use it to drive insight

4.f. Engagement with public health systems, operations, and clinical leadership	Public health systems in the communities of focus	WE and PHI	**226 =** County health departments outreached to **49** = Engaged health departments in **15** states
4.g. Adapt existing technology platform for program evaluation and reporting		WE Resource: Partner data dashboards	Live Stories/Tableau
4.h. Peer-to-Peer Learning and Action Collaborative	Black, Native-American, Latinx, Asian-American/Pacific-Islander, immigrant/migrant, and low-income older adult populations that are hardly reached, hard to reach, and hardest to reach	Core Partners, sub-recipient communities, CHWs, and promotoras	**3** RISE Communities Peer Exchanges held throughout the grant period

4. Successes

The alliance of RISE partners achieved many milestones under this project award, such as connecting vulnerable communities to vaccines and well-being resources and rebuilding trust in the public health system. The data submissions and monthly reports capture the results of this effort. Beyond those milestones, we will highlight three specific examples of successes, drawing from the final reports submitted by RISE partners.

a. Fostered deeper connections and trust among partners and community residents and established groundwork for future projects.

RISE partners were selected due to their trusted networks and relationships with hard-to-reach communities. As a result of the work on the RISE project, the 70 sub-recipient community partners reported reaching and engaging community members in new ways and plan to continue the efforts post-award. An example of this includes NIHB's ability to create conversations with Native youth, increase attendance at their youth summit, and use the momentum of this project to inform future projects around vaccines and health equity among Tribal communities.

The phone canvassing strategy afforded local affiliates of Meals on Wheels opportunities to get to know their homebound community members better and discover topics of concern to them. Meals and Wheels reports that partnerships and coalitions that were created to work on this project have continued and are addressing additional ways to impact the community. Nearly all partners doing door-to-door canvassing work in hard-to-reach areas reported this

as a major success of the project. These partners were able to build connections among residents and establish relationships, name recognition, and systems that their organizations can implement for future programming. Additionally, all RISE communities are connected through peer-to-peer exchanges where they learn from one another's challenges and successes. This collaborative continues to support communities to set shared population-level outcome goals for vaccine equity, to address social needs, and to create policy and systems change.

b. Delivered culturally competent and tailored resources to communities.

RISE partners and their subrecipients developed over 1,150 culturally competent and tailored resources to communities. For example, NCOA created 130 pieces of tailored and customized content that were distributed to their sub-recipient older adult communities. These included custom-designed mailouts, billboards, flyers, brochures, websites, public service announcements, and other collateral.

Tribes often are community-focused, which was important to understand as the messaging for the Act of Love Campaign was developed by NIHB. The Campaign focused on what Tribes and Tribal citizens could do to protect their communities, including the most vulnerable (e.g., elders, youth, and immunocompromised). By focusing on how to protect others, Tribal interest in the Act of Love Campaign increased and NIHB saw more requests come in for the Act of Love kits, which included a 3-ply cotton face mask, hand sanitizer, antimicrobial wipes, stickers, a magnet, an enamel pin, and 3 postcards with positive vaccine messaging for friends and family. The RISE project helped fund the redesign of the Act of Love Campaign graphics, including regional-specific logos using historical and cultural symbols and images.

USAging contracted the State Health Insurance Program Technical Assistance Center to develop a new consumer handout explaining Medicare coverage of the COVID vaccine. The handout, available in seven languages, comes with a companion guide for professionals in English and Spanish titled Talking about Medicare Coverage of the COVID-19 Vaccine. The guide includes de-escalation tips applicable to difficult conversations on any topic, not just COVID-19. In addition, CPD developed a comprehensive 100-page outreach team training manual for CHWs and promotoras conducting door-to-door canvassing and one-on-one phone conservations.

c. Implemented bi-directional use of survey data to support decision making for community well-being.

We developed partner reports and community dashboards to get real-time data back to communities to tell their stories and to use the data to drive improvement. This data infrastructure also led to far greater motivation to report because they could visualize and interact with the information to meet their data needs. These reports and dashboards are available on the RISE website (www.rise4ALL.org) under Resources.

5. Challenges

RISE partners across the board experienced similar challenges during implementation but took steps to mitigate setbacks by maintaining focus and patience and finding creative ways to

overcome obstacles. We've included three specific examples of challenges, drawing from the final reports submitted by RISE partners.

a. Hiring and retaining a diverse CHW and promotora workforce.

Hiring CHWs and promotoras who were representative of the communities served proved difficult, especially during the Delta and Omicron surges and given the short duration of the award period. Some partners had difficulties recruiting for part-time positions. Partners addressed the CHW and promotora shortage by reassigning existing staff or recruiting volunteers to work on RISE, while some partners collaborated with local agencies who had an existing public health workforce. For example, HIPHI overcame this obstacle by collaborating with Bay Clinic and West Hawaii Community Health Center to coordinate and promote weekly testing and vaccination events at a local community center. They also partnered with Project Vision Hawaii and the Hawaii State Department of Health Public Health Nursing to strengthen their CHW door-to-door campaign. Finally, RISE activated a nontraditional public health workforce and trained them to be community health workers—from faith leaders to community organizers to school leaders and meal drop off volunteers.

b. Reconciling the politicized landscape around COVID and the distrust in government officials and outsiders.

Because COVID become politicized, some partners could not ensure collaboration from local health departments, media sources, or other partnering agencies because COVID had become too polarizing. For example, much of the vaccine hesitancy in Hawaii stems from long standing distrust in the government and a history of military occupation. Another example included a community in New Mexico that could not secure a radio spot because the radio station did not want to alienate its listeners with what they saw as a politically divisive issue.

RISE communities met this challenge by 1) Hiring CHWs and promotoras directly from communities being served; 2) Being persistent and finding other willing and cooperative partners; and 3) Remaining steadfast in their commitment to meet well-being needs of communities, often focusing the conversations on well-being resources first, to open the door to addressing vaccines.

c. Retaining CHWs and promotoras who experienced COVID fatigue, burnout, or even felt unsafe during door-to-door canvassing work.

Partners reported that continued training and investment in the well-being of CHWs and promotoras contributed to keeping them onboard for the project duration. Steps taken to resolve challenges included preparing CHWs and promotoras to have difficult conversations and defining what a successful interaction with residents looked like (e.g., does not have to always end in vaccination). In some cases, shifting to outdoor community events gave canvassers time to rest and recover from door-to-door activity. By supporting CHWs and promotoras through peer exchanges, coaching, mentoring, and training in active listening and motivational interviewing, they were able to combat misinformation and connect with vaccine-hesitant individuals while having support to deal with COVID fatigue.

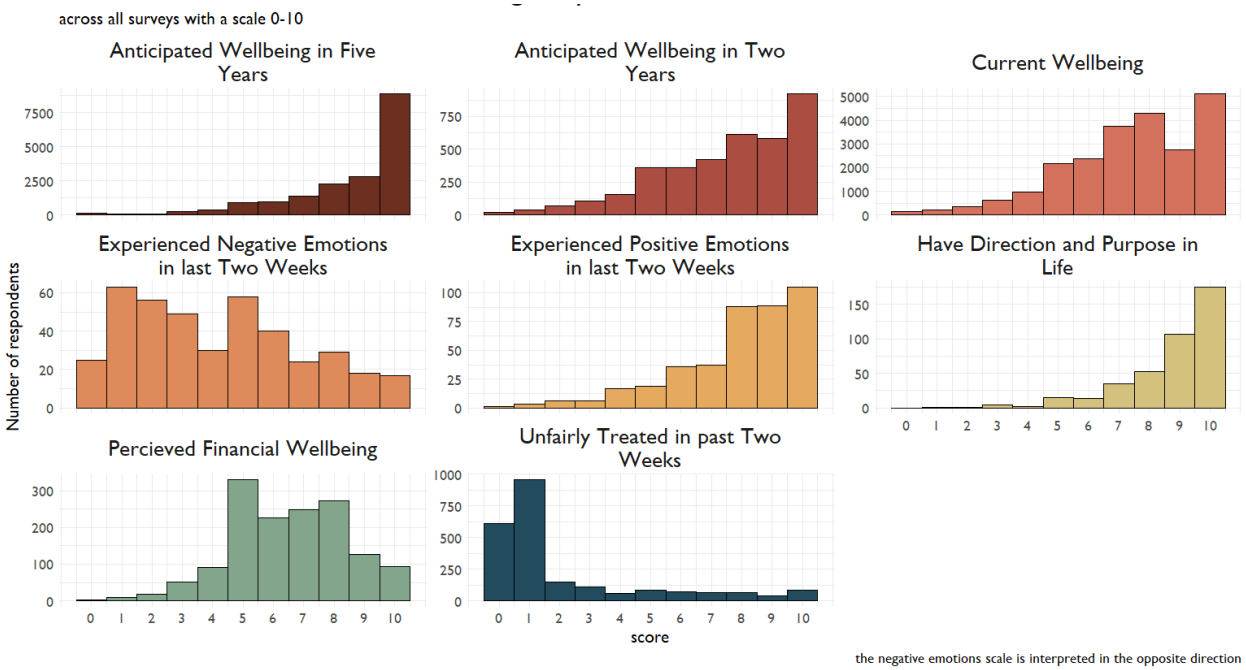
6. Data Analysis

We gathered a large amount of additional data during the award period. Our additional data (beyond what was submitted weekly to HRSA) falls into two categories: data on *well-being* (for both community members and CHWs/promotoras) and data on *needs*.

a. Well-being (community members): We looked at multiple metrics of well-being. We asked people to rate their current well-being on a scale of 0-10, using a modified version of Cantril's ladder. We then asked them to rate their future well-being (in either five- or two-year intervals) on the same scale. We also asked people about their perceived direction and purpose in life, their perceived financial well-being, the experience of either positive or negative emotions, and whether they believed they had been unfairly treated because of their race or other identity-related factors. Depending on the form and the partner, not all respondents got the same questions.

A distribution of all responses can be found in Figure 2 below. Negative emotions are scored in the reverse direction, meaning that lower scores are "better." The majority of scores are positively skewed, though both financial well-being and experience of negative emotions appears to be normally distributed.

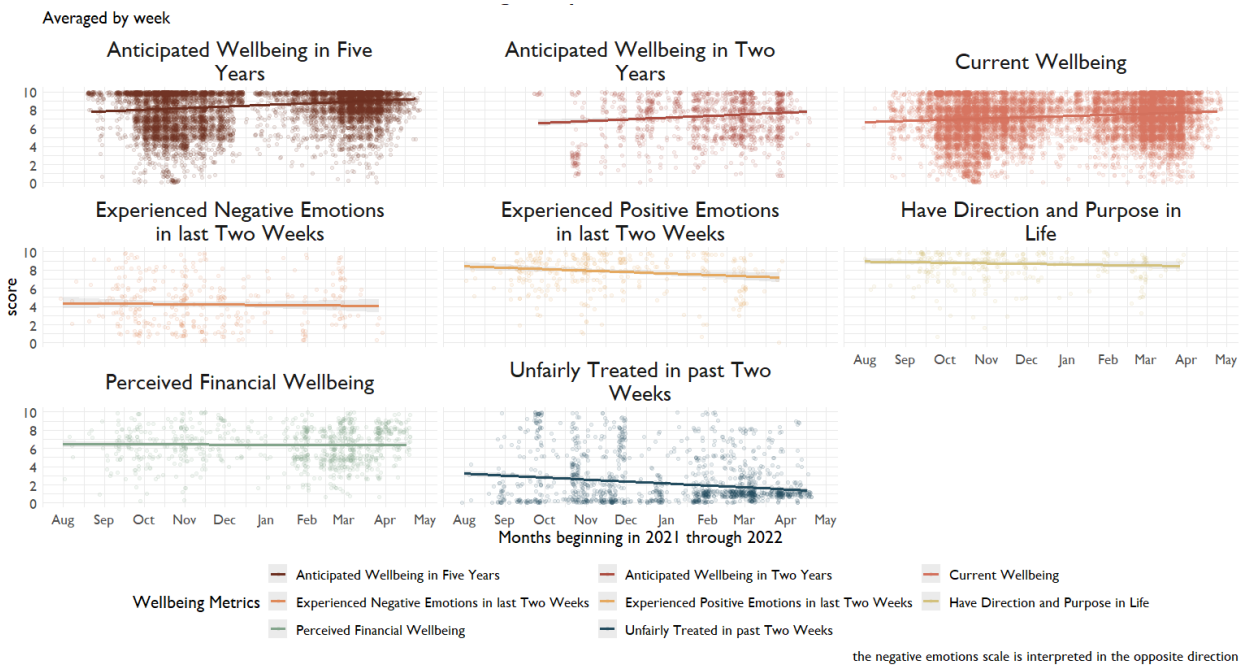
Figure 2. What is the Distribution of Well-being Responses Over the Course of U3S Data Collection?



We then plotted the same well-being trends over the period, looking at the average of the scores by week. We plotted all scores below, with the darker color indicative of more responses. We also plotted a trend line on top of the points to see whether any major trajectories could be seen.

We did not see significant seasonal changes or cycles. Financial well-being appeared to tick up in the Spring of 2022, while positive emotions appeared to decline over the same time period.

Figure 3. What Were the Trends in Well-being Responses Over the Course of U3S Data Collection Period?



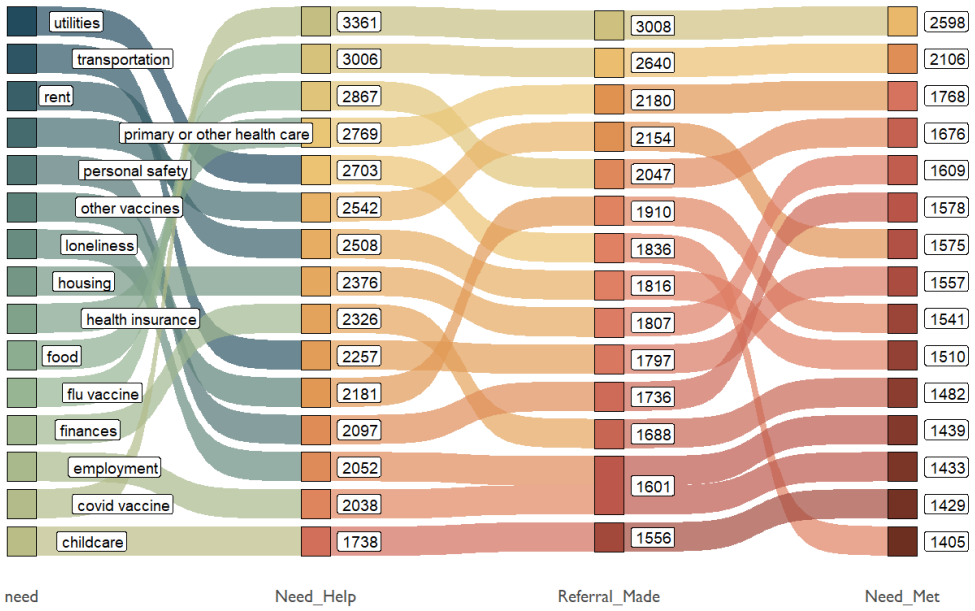
We also looked to see whether certain demographic variables were more associated with any of the well-being metrics; that is, if being a member of a certain category had an outsized influence, positive or negative, on one of the well-being metrics.

This analysis proved to be a challenge because of the intersectional nature of the data. If an individual identified as "black," and "white," we treated that as a discrete category. This happened for other variables as well, (e.g., "male," and "transgender"). In some cases, we would have over 70 categories for one variable (such as race). Our preliminary analysis does indicate that some categories had an influence, like sexuality on current well-being, though further analysis is necessary to utilize the data more precisely.

Needs (community members): We also looked at needs across the partnership (Figure 4). We were surprised to see fundamental needs like rent, housing, and food score so highly. This suggests that while people report being well, there are still many social determinants of health in their immediate environment that must be addressed.

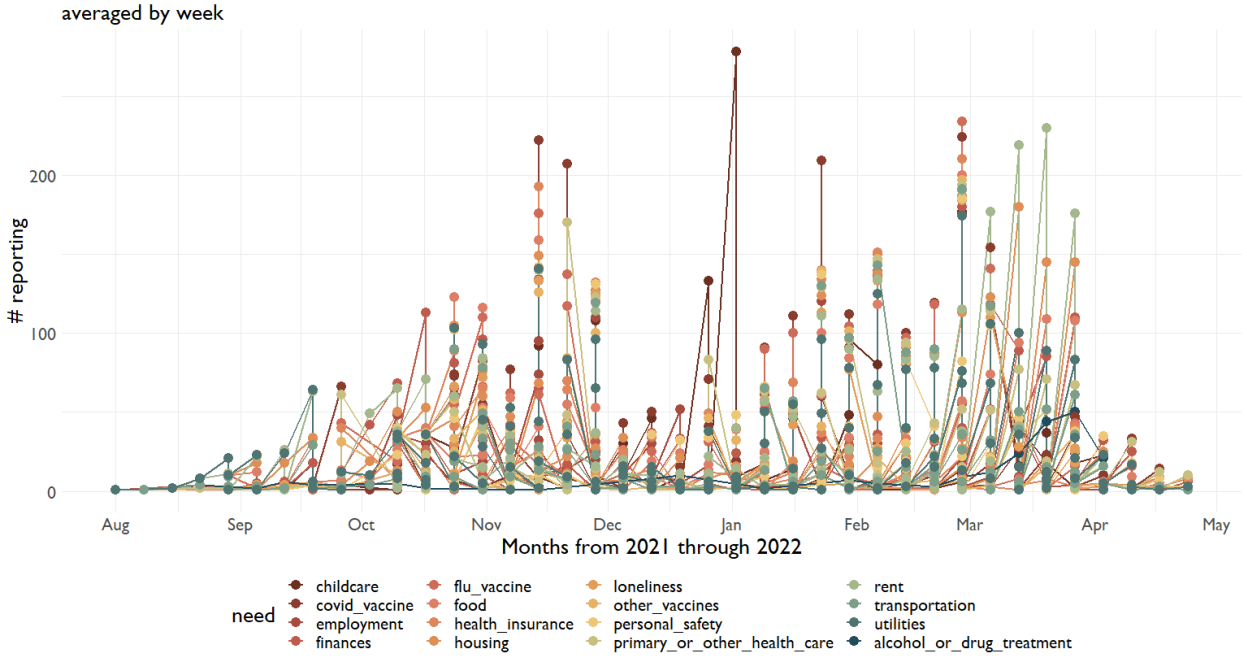
Figure 4. What Needs have Been Identified, Referred, and Met?

This flow diagram shows how many people reported a need, then whether there was a referral, then whether it was met



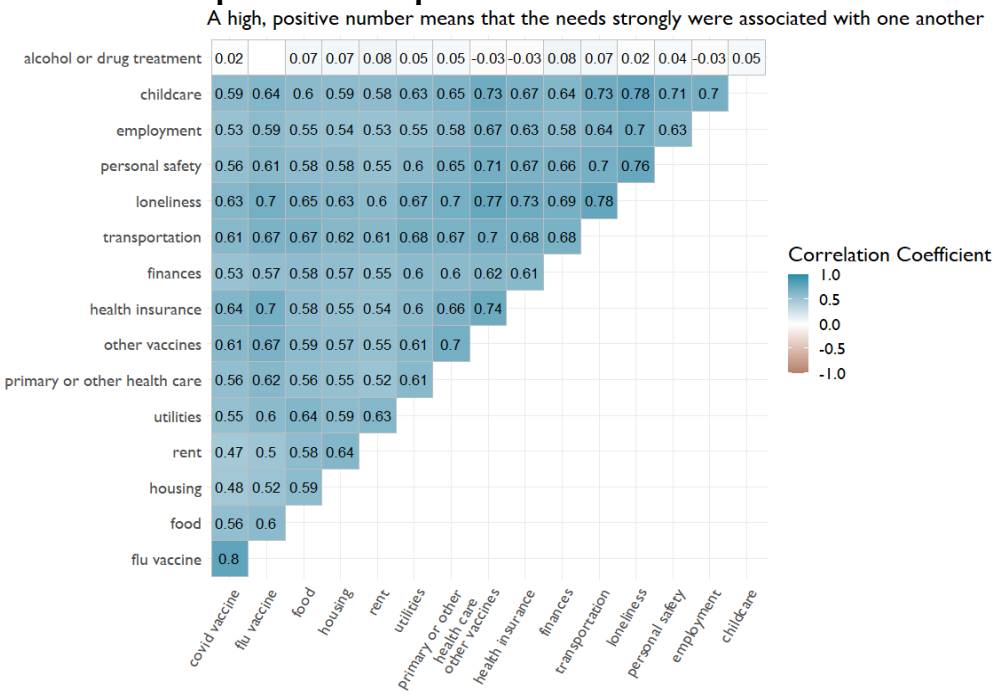
Like our time series plot, we tracked reported needs over time (Figure 5). We saw a huge increase in childcare needs around January, with spikes in primary health care in the early spring. Collecting these data helped CHWs and partners design vaccine events and partnerships aligned with community needs to improve individual and community well-being.

Figure 5. Reported Needs Over Time



Finally, we looked at the interrelationships between needs (Figure 6). We used a correlation matrix to visualize the co-occurrence of needs. While all those statistics below are statistically significant, we noted a large variation between stats hovering around 0.5 (still a VERY strong relationship) and 0.8. and the minimal relationships with alcohol and/or drug treatment.

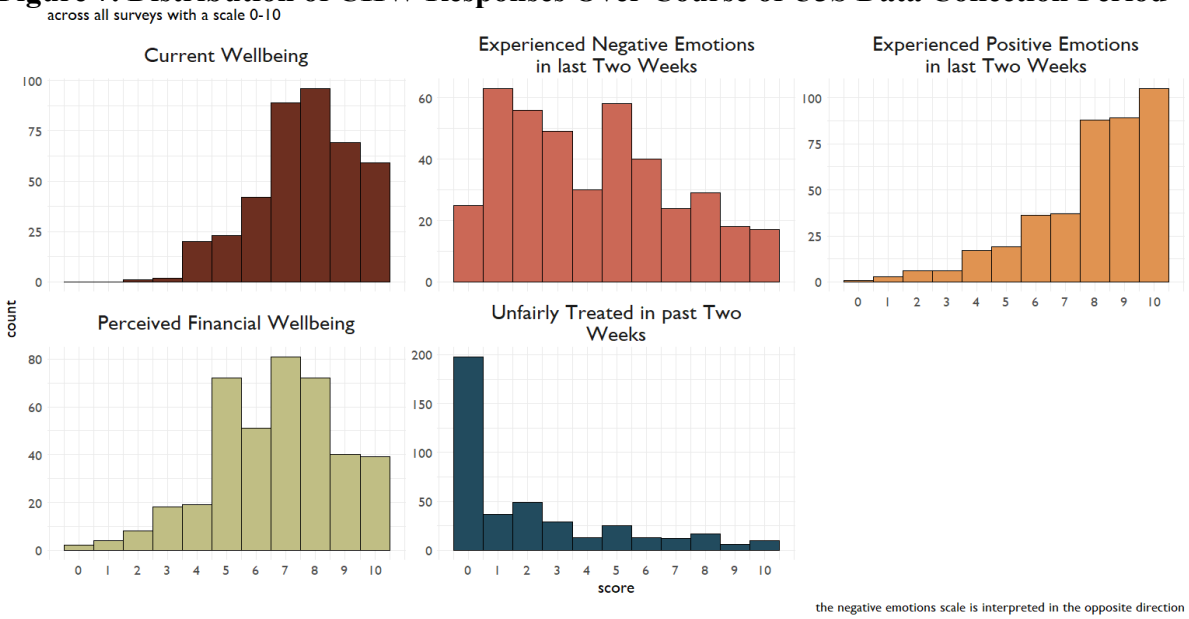
Figure 6. Relationships Between Reported Needs



Taken together, this data analysis shows us patterns across populations over time. A more narrow analysis will give us the specific needs of the population (broken down by partner and subpopulation), and then connect them with specific predicted needs.

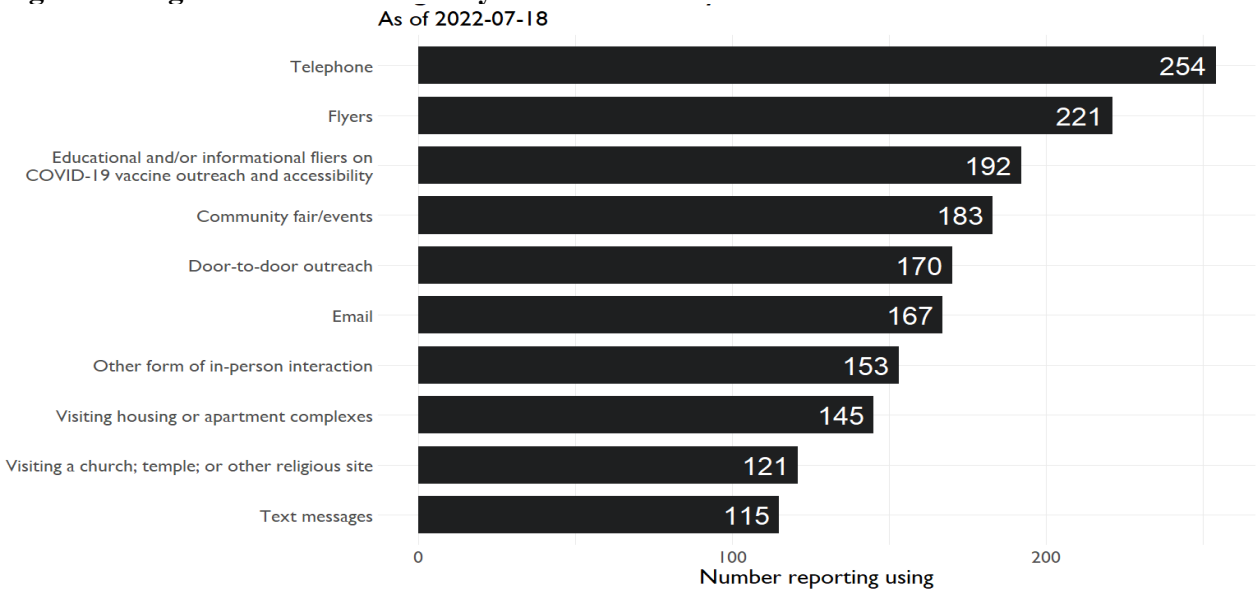
b. Well-being (CHWs and Promotoras): We found the outreach worker well-being data parallel to the larger population (Figure 7).

Figure 7. Distribution of CHW Responses Over Course of U3S Data Collection Period



We also looked at some of the methods of outreach that CHWs and promotoras were using (Figure 8). Although this was a normal part of data collection, it was critical in understanding how teams were doing their work. We then used the data to guide how to train and design peer exchanges to support these approaches.

Figure 8. Regular Activities Used by CHWs



7. Lessons Learned

Below are lessons learned from our project activities, working with specific subpopulations, or partnerships with health care delivery locations (health centers, schools, pop-up locations, etc.) using the questions below.

a. What did you do to ensure project activities were reaching vulnerable populations in your service area?

Our partnership mapped communities and populations within each state based on whether they are hardly reached, hard to reach, or hardest to reach. We identified the counties in these states that fall into these categories and prioritized them based on social vulnerability and the prevalence of a specific subgroup (minority populations, older adult populations) who might be at higher risk of harm or who had low vaccination rates. RISE partners worked together to identify where there may be the greatest opportunity for impact and to avoid duplication of effort.

b. In retrospect, is there anything that you would have done differently in regard to your project activities?

Partners expressed a few strategies they would have done differently. For example, HIPHI, covering Hawaii County, was much more challenged than anticipated. They found difficulties hiring CHWs to provide boots on the ground support in some places. In the future, HIPHI would explore opportunities to partner with local community health centers or organizations employing CHWs, especially on a neighboring island. For USAging and MOWA, they would strategize their sub-awarding differently. They both would connect with communities on the ground earlier to confirm their participation and work more closely with potential sub-recipients to match the fund amounts to community needs and abilities to expend the funding.

c. What did you do to pivot or change your strategy during implementation?

As stated above in the work plan, a part of the implementation plan was to train network partners on hyperlocal communication strategies and provide tools and resources for execution and connection to vaccination and social services to meet well-being needs. MOWA had to pivot its communications strategy with their sub-recipients while maintaining the hyperlocal approach. Their original plan was to empower each member program to develop and create communication collateral in their service community. They noticed that some programs had difficulty crafting communications due to capacity and capability. MOWA pivoted to creating all the materials centrally and tailoring them with the local program logo and contact information. This approach created collateral that met the needs of the local programs while maintaining uniformity and appropriate focus on vaccines.

d. Do you have any particularly successful strategies to share about special population groups (i.e., what strategies seemed to be the most effective for specific subpopulations of people you served)?

NCOA stressed the need to be very particular about the language, presentation, and flow of the survey questions that older adult community members are asked to complete. For example, CHWs and promotoras had to break down the questions in the Brief Outreach form into a more straightforward script so that community members could participate and understand the questions. Additionally, CPD stressed the need for multiple touchpoints with special populations; door knocking, community events, and follow-up phone calls.

e. Do you have any specific guidance or feedback to share from this experience to inform other potential funding opportunities specifically for community-based organizations?

It is difficult to hire temporary workers for a six-month grant period. Both in the first and second grant periods, we have not been able to communicate that a no-cost extension was confirmed until toward the end of the period. This led to hesitancy in some partners about whether they would be able to get the work done within a more limited time period.

Communities of color who had experienced harm from past governmental policies (e.g., migrant workers, Black Americans, and indigenous communities) found it very difficult to report data to the government. Terms like "unique identifier" made them feel that they might be getting identified, even though their purpose was the opposite. A lot of time was spent mitigating this fear and setting up systems to collect and give the data back to communities in addition to HRSA.

f. Do you have any other lessons learned to share with HRSA?

Communities used this data to meet common needs for their well-being and attract people to vaccinations and rebuild trust within communities.

8. **Expenditure Analysis** Report on the total amount of funding expended by Budget Category (personnel, fringe benefits, etc.) through your project end date using both Table 1 and Table 2 below.

Table 1 – How much of total award was spent/obligated

***** Obligated includes active staff salary, office rent, obligated program activities spent by end of your project period (for example - November 30th, 2021; May 31, 2022, etc.).

Total Award Amount (on NoA)	Total Spent/Obligated*at Closeout
$11,160,894.00	$11,083,095.60

Table 2 – How did award expenditures (e.g. funds spent/obligated) match the award allocations as listed in your latest Notice of Award (NoA)?

Budget Category	**Allocation Amount** (as listed in latest NoA)	**Expenditure Amount** (funds spent/obligated)
Personnel	$81,029.00	$202,070.87
Fringe	$28,360.00	$51,916.63
Travel	$3,814.00	$0.00
Equipment	$0.00	$0.00
Supplies	$5,000.00	$2,926.24
Contractual	$10,328,103.00	$10,290,579.97
Other	$198,515.00	$26,597.04
Total Direct Charges	$10,644,821.00	$10,574,090.75
Indirect Charges	$516,073.00	$509,004.85
Total	$11,160,894.00	$11,083,095.60