Linkage and Re-Engagement Demonstration Projects and Programs in Los Angeles County

Speaker Notes

Slide 1
Good morning or afternoon. I would like to thank CDC and GEARS for the opportunity to present to all of you on some of my experiences with Data to Care Programs in Los Angeles County. It is my hope that these experiences will be helpful to you as you develop your Data to Care programs. I am happy to discuss the implications of our results for other health department Data to Care programs at the end of my presentation.

Slide 2
This slide provides an overview of my presentation. I will first provide some context for Data to Care work in Los Angeles County by presenting the HIV cascade and the framework for the Los Angeles County Treatment as Prevention approach. I will next present data on two demonstration projects to highlight an example of a provider-based Data to Care approach and also a community-based Data to Care approach. I will focus on how HIV surveillance data were used for each program; discuss the lessons that were learned from the demonstration projects and describe some health department considerations when making decisions about Data to Care approaches. Finally, I will end with a brief description of a permanent Los Angeles County linkage and re-engagement program that was largely based on best practices from the demonstration projects that I am presenting today.

Slide 3
This slide shows the HIV cascade for Los Angeles County for 2014. As you can see in the bar on the far left, 71% of persons diagnosed with HIV in 2014 were linked to care within one month of their HIV diagnosis.

As shown in the third bar, 71% of the 48,154 persons diagnosed with HIV through the end of 2013 and living with HIV at the end of 2014, were engaged in care defined as 1 or more HIV laboratory tests in 2014.

As shown in the next bar, 59% of persons living with HIV in Los Angeles at the end of 2014 were retained in care defined as 2 or more laboratory tests at least 3 months apart in 2014;

Finally, the last bar shows that an estimated 59% of persons living with HIV at the end of 2014 in Los Angeles County were virally suppressed.

All of these indicators for Los Angeles County are somewhat higher than for the U.S. as a whole although they all still show room for improvement. As with all HIV cascade data, these estimates are subject to the limitations of surveillance data.
Also, in Los Angeles County, we estimate that an additional 12.3% of persons living with HIV are not aware of their HIV infection.

**Slide 4**
Now I am going to present a schematic that shows the framework for the Treatment as Prevention approach in Los Angeles County.

**Slide 5**
The LAC HIV Treatment as Prevention programs are presented in parallel with the federal model of the [HIV Care Continuum](https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum) that can be found at https://www.hiv.gov/federal-response/policies-issues/hiv-aids-care-continuum. We specifically targeted each step along the continuum.

For today’s presentation, I am going to focus on the 3 program components for Link, Re-engage and Retain in Care which are: the Navigation Program, Project Engage, and the Linkage and Re-engagement Program (or LRP).

Our two pilot programs were focused on linking and re-engaging not in care patients.

The Navigation Program applied a clinic-based approach to locating, enrolling and assessing a patient’s needs using one of three interventions. This program started with not in care or NIC lists from providers rather than starting with NIC lists from HIV surveillance data.

The second approach, called Project Engage, was a grassroots, community-based approach that used two recruitment strategies. The first strategy was a social network referral approach to locate hard-to-reach HIV positive persons who were out of care and the second approach used direct recruitment which I will explain in more detail later in my presentation.

We implemented both pilot approaches to target different out of care populations. The Navigation Program focused on HIV positive persons with a relatively recent history of HIV care and Project Engage sought to find the most marginalized out of care HIV positive persons within our community.

Both of the demonstration projects were funded by CDC Category C funding and the California HIV/AIDS Research Program.

The next slides are summaries of each of the demonstration projects, which will be followed by our lessons learned and next steps.

**Slide 6**
- Los Angeles County is a large jurisdiction that is over 4,000 square miles with over 10 million people.
- It is estimated that there are 58,000 people living with HIV in Los Angeles County.
• Los Angeles County’s HIV surveillance not in care list is very large with an estimated 20,000 people not retained in care in 2014.

• With such a large number of people estimated to be out of care, it was important to use limited resources effectively, as it is for all health departments.

**Slide 7**

• We hypothesized that it would be most efficient to start with large clinics with many patients and a large number of people who needed to be located and re-engaged in care. Staff would spend less time driving all over the county by focusing at a few large clinics, develop relationships with clinic staff and eventually become trusted partners with clinic staff and conduct more effective patient location and linkage in coordination with the clinics.

• The motivation for the design of Project Engage, our community-based approach, was that we wanted to develop a method that would locate and link a different population of HIV positive persons who were off the grid who couldn’t be identified through more traditional methods or through clinics.

**Slide 8**

Now I will present details on the Los Angeles County provider-based demonstration project and the community-based demonstration project.

**Slide 9**

I will start with the provider-based Navigation Program.

The goal of the Navigation program was to re-engage lost HIV clinic patients by combining enhanced DIS or Disease Investigation Services locator techniques with a tailored 3-option linkage intervention strategy.

**Slide 10**

• We had three main objectives for the Navigation Program.

• We designed our protocol to focus on clinics with large number of lost patients. We matched the clinic lists of lost patients to HIV surveillance data to determine who was truly out of care.

• In LAC, HIV surveillance refers to eHARS or enhanced HIV Reporting System plus additional laboratory reporting databases that are also used to obtain contact information and lab data.

• A second objective of the Navigation Program was to evaluate whether enhanced DIS locator techniques that included searches for contact information on Lexis Nexis and other public health databases was an effective approach to locating lost clinic patients.
• Our third objective was to evaluate a tailored three-option intervention strategy for linkage and re-engagement.

**Slide 11**

• This slide provides some additional details on the components of the Navigation program. We used health department-based staff who we called “Navigators” to conduct the locator activities. We had to use health department staff because there are restrictions in California which mandate that HIV surveillance data are only accessible to trained health department staff.

• Our linkage staff were paraprofessionals, most with bachelor degrees, who were supervised by a clinical professional with a Masters in Social Work. The clinical supervisor and project coordinator met with the Navigators daily to discuss client social and medical challenges. The staff also met weekly to review project progress, and review difficult client cases for the benefit of all staff.

• We had previously done another version of this program which we called Navigation 1.0 in which we used ARTAS, which stands for Antiretroviral Treatment Access Services, as the only linkage strategy and found that most people did not need the high-intensive ARTAS services.

• ARTAS was developed by CDC and is a strengths-based case management intervention that includes 5 sessions, is conducted in 4 phases and is time-intensive.

• As a result of our Navigation 1.0 experience, we developed a tiered intervention strategy that allowed us to tailor the intervention to a patient’s readiness to engage in care. The lowest intensity intervention was called “Direct linkage” which consisted of a phone call, the scheduling of a medical appointment and, if the patient was interested, the Navigator would accompany the patient to their medical visit.

• The second least intense intervention called the Motivational Interviewing intervention included the same services offered in the direct linkage intervention plus two 90 minute Motivational Interviewing client-centered counseling sessions. These sessions were designed to help patients explore and address any challenges they had to seeking HIV care.

• The third and most intense intervention was a modified ARTAS approach which included up to 10 in-person strengths-based case management sessions instead of the traditional 5 ARTAS sessions.

• Surveillance data were used to determine program eligibility and monitor care status, linkage to care and retention in care. I will provide more detail on this in the next few slides.

**Slide 12**

• We used HIV surveillance data in numerous ways to increase efficiencies and gather critical information.
• One way that HIV surveillance data were used was to clarify HIV care status for a patient to determine if they were truly an out of care patient and eligible for our program.

• From HIV surveillance data, we could see whether or not there were recent labs for the patient at another clinic indicating that they were in care elsewhere.

• In addition, we could determine from HIV surveillance data if a lost clinic patient had moved out of Los Angeles County. Our HIV surveillance staff participate in the Routine Interstate Duplicate Review activities, RIDR, and, although not perfect, the RIDR process could result in a more current address in eHARS which would tell us if a person was living in another jurisdiction based on lab reports in other areas. This was very useful information to clinics for purposes of updating their records and the Navigation Program staff did not spend any time trying to locate these lost clinic patients, adding to program efficiency.

Slide 13
• HIV surveillance data were also used to provide information to the Navigation staff on a patient’s vital status including whether or not they were deceased based on death certificate matches done by the LAC HIV surveillance staff.

• In addition, there was often information in HIV surveillance on whether the “lost” patient had returned to the clinic on their own based on recent labs. Sometimes the clinic staff wasn’t aware that a patient had returned to the clinic or the patient returned between the time that the clinic not in care or NIC list was matched to the HIV surveillance list.

Slide 14
• HIV surveillance data also often provided additional contact information for the Navigators to use to contact the lost clinic patients to enroll them in the linkage and re-engagement intervention. For instance, sometimes there would be updated contact information on laboratory reports.

Slide 15
HIV surveillance data were also used to track patients following intervention enrollment to confirm that they had linked to care, were retained in care, were virally suppressed or still receiving care in the jurisdiction. These data were used to support the evaluation of the program.

Slide 16
• This slide describes our linkage, re-engagement, retention and viral load suppression definitions.
  
  o We defined linkage to care as a care visit within 90 days of enrollment in the intervention.

  o We defined re-engagement in care as either two medical visits with a physician or one medical visit and one visit with a case manager.
We defined retention in care as a second viral load measure at least 90 days after a first viral load measure following linkage to care and we defined viral load suppression as a measure that was less than 200 copies per ml.

**Slide 17**
This slide shows the data on program enrollment, eligibility and intervention assignment.

As you can see, among the 2,448 lost clinic patients that were screened from the clinic lost patient lists, only a little over a quarter or 691, met the program eligibility criteria for being out of care that included residence in Los Angeles County, age greater than 18 years and able to communicate in English or Spanish.

Among the 691 who were thought to be eligible, 83 or 12% were successfully located and enrolled in the program.

Among the 83 enrolled in the program, following the completion of an assessment by the Navigators, 15 were assigned to the direct linkage intervention, 63 were assigned to the motivational interviewing intervention and 5 were assigned to a modified ARTAS intervention. As you can see, the motivational interviewing intervention was the best fit for most people’s needs.

**Slide 18**
This slide shows the disposition of the 2,448 clients who were screened for the intervention using surveillance and other data sources. As you can see, 25% of the patients that the clinics thought were lost were actually in care at another clinic; 25% had returned to the clinic by the time we finished our matching, 2% of the lost clinic patients were deceased, 10% were no longer residents of Los Angeles County, 7% were ineligible based on the study criteria, 0.2% declined participation, 25% were presumed eligible but we were unable to locate them and 3% or 83 of the lost clinic patients were enrolled in the Navigation Program. The use of surveillance data was extremely helpful to determine client dispositions and greatly improved program efficiencies.

Although not shown on this slide, a high proportion, 62%, of patients identified by the clinics as in need of the Navigation Program were actually ineligible. That is, the patients were either in care elsewhere, returned to the clinic independently, were or they were not a resident of LAC.

This slide highlights the advantages to using HIV surveillance data as a screening tool to save staff time looking for patients who are not out of care or are not in the jurisdiction.

**Slide 19**
This slide includes the demographics of the 83 patients enrolled in the Navigation Program.
The average age of participants was 42; 41% were Latino; 30% were white; 94% were male and 90% were lesbian, gay or bisexual.

Slide 20
This slide highlights some social determinant variables and the patient's care histories.

Among the 83 enrolled persons, 14% reported a history of homelessness and 14% had a lifetime history of injection drug use.

On average, the lost clinic patients had been out of care for 15 months and reported an average of 4 service gaps.

Slide 21
This slide includes the major Navigation Program outcomes.

Starting at the top, 84% were re-engaged in care at the clinic based on the 2 visit definition, 74% linked to care within 90 days of enrollment and 93% were retained in care defined as a second laboratory measure 6 to 12 months following linkage to care.

There was improvement in the percent virally suppressed from 58% at the time of clinic re-engagement to 71% at the time of a second viral load 6 to 12 months following re-engagement in care. These improvements were borderline significant.

There were significant decreases in both the mean and median viral loads between the time of re-engagement and retention in care.

It should be noted that the analyses that compare viral load at time of re-engagement and retention are based on the 65 participants who linked to care who had viral load measures at the time of re-engagement and also 6 to 12 months after they re-engaged in care.

Slide 22
As you think about what type of program to implement at your health department, we have listed some of the advantages to a provider-based approach.

We felt that it was more efficient to have staff work with providers in one location such as a clinic rather than trying to track down NIC patients throughout a jurisdiction.

Also, by focusing on lost clinic patients, the Navigation staff looked for patients who had been in care more recently who they would have a better chance at locating.

In addition, access to clinic contact information is very helpful for locating patients because often a clinic will have more recent contact information than that available in HIV surveillance or other databases.
Slide 23
Other advantages to a provider-based approach are that patient recruitment is often more successful if the patient outreach is conducted on behalf of the clinic who already has a relationship with the patient. There is a level of trust with the patient that isn’t present if a Navigator cold-called the patient on behalf of the health department even following a letter of introduction.

Also, the clinic staff can provide guidance on successful patient recruitment such as provide information about how patients like to be contacted (e.g. text versus phone call) or if they have any specific issues that the Navigation staff should be aware of such as substance use, homelessness, mental illness, aggression, etc.

The disadvantages to this type of approach are that recruitment can be slow and the program is resource intensive although this is the case for most Data to Care Programs.

Slide 24
This slide provides a summary of the staffing resources required for the Navigation Program which might be helpful to some health departments as you plan your Data to Care activities and programs.

It should be noted that this was a demonstration project that was evaluated more than a normal program so the staff time is somewhat inflated here.

We used 3 full-time Navigators for 2 years to enroll 83 patients. The work included cleaning the clinic lists, gathering patient locator information, locating and enrolling clients, conducting baseline assessments and completing the linkage intervention.

Slide 25
This slide lists issues that a health department might want to consider when implementing a similar program.

For example, does the health department have staff available to work with the clinics to match clinic and surveillance data to help prioritize patient follow up?

It might be helpful to know that in the case of Los Angeles County, most of the staff time was spent locating the patients and less time was actually spent linking them to care.

Also, is it possible that staff can be re-assigned from other work to do this type of work?

Is it even legally possible for the health department to share HIV surveillance data with clinic staff through a data sharing agreement or other mechanism?

Another question is whether there are health department staff or staff from community-based organizations available to do the linkage to care work?
Slide 26
Now I am going to present on another model for locating and linking not in care (NIC) persons to HIV care. In Los Angeles County we called this second community-based program, Project Engage. In this community-based recruitment model, we wanted to determine if the use of social network referrals or direct recruitment was more effective for identifying and engaging HIV positive persons who are out of care who are hard-to-reach or hidden.

Slide 27
We employed two recruitment approaches, the first of which was a social network recruitment method in which our staff worked with clinic and agency staff to identify “seeds” or persons who were acquainted with HIV positive people who were out care who they could refer to our program for linkage to HIV care. A seed could be HIV+, HIV-, out of care or in care.

The key seed criterion was that the seed was acquainted with HIV+ people who were out of care, who we called “alters”, which is the term used in respondent-driven sampling or RDS which is the technical name for this approach.

An eligible seed had to also be comfortable talking to their out of care friends about HIV and HIV care.

An eligible seed could refer out of care people or “alters” and would receive $40 for each referred alter who completed a baseline assessment and an additional $40 when their referred alter completed their first medical visit.

The out of care alters also received $40 when they completed their baseline assessment and $40 when they completed their first medical visit.

Alters could in turn bring in members of their social networks who were HIV positive and out of care and receive the same reimbursements as the seeds.

Slide 28
The second recruitment method was called direct recruitment in which the Project Engage staff met with staff at clinics, shelters, substance abuse treatment facilities, and other agencies to see if agency staff were aware of any clients who were HIV positive and out of care and in need of support to link to care.

Project Engage staff also directly recruited out of care alters and seeds in public areas such as parks, street corners and freeway underpasses where out of care persons were known to congregate.

As part of the direct recruitment method, we also posted fliers at clinics, agencies and public areas and we left program recruitment pocket cards in clinic exam rooms, and agency lobbies. We also handed out pocket cards directly to potential participants in the field or at agencies that included program contact information.
The incentives for the direct recruitment method were the same as that for the social network method: a seed received $40 when an out of care alter completed their baseline assessment and $40 when the alter completed their first medical visit. An alter also received $40 when they completed their baseline assessment and another $40 when they completed their first medical visit.

**Slide 29**
This slide summarizes the linkage intervention that was used for Project Engage which was similar to the direct linkage intervention in the Navigation Program.

The staff would spend time talking to the out of care alters about their barriers to engaging in HIV care, explain the importance of HIV care and assess their readiness to engage in care.

Sometimes they would have to circle back with the client several times before the client was ready to engage in care.

Once a client was ready to engage in care, Project Engage staff scheduled an HIV medical clinic appointment at a clinic that had robust on-site case management services that could support the co-morbidities common for the Project Engage clients such as substance use, homelessness, etc.

Staff also provided transportation support and visit accompaniment if necessary.

**Slide 30**
- This slide describes how HIV surveillance data were used for Project Engage.

- HIV surveillance data were used to help project staff verify that a potential Project Engage participant was truly out of care and met the eligibility criteria.

- To be eligible for the project, a client had to have had no HIV clinic visits in more than 12 months; no lab tests in 7-12 months and last viral load previous to that time was greater than 200 copies/ml; newly diagnosed and not linked to care; in inconsistent care such as received care at multiple providers over the previous 12 month period or an eligible person could be diagnosed with HIV in another state or country with no current HIV medical home.

- Partially due to the re-imbursements, we had a lot of people who were interested in participating in Project Engage but who turned out to either be in care already, not HIV positive or otherwise ineligible. Thus surveillance data allowed us to confirm that eligible participants were in fact HIV positive and out of care.

**Slide 31**
- This slide lists some of the ways that HIV surveillance data were used for Project Engage to monitor care indicators as the project progressed.
For example, HIV surveillance data was used to confirm that a client had linked to care as demonstrated by an HIV laboratory test result.

HIV surveillance data were also used to monitor viral suppression and retention in care using lab tests following linkage to care for a participant.

Finally, HIV surveillance laboratory data were used to locate and track clients who were lost to care and may have changed providers in Los Angeles County or moved out of the county.

**Slide 32**
This slide shows the screening and enrollment numbers for Project Engage.

120 seeds were screened and among those, 62 or 52% were enrolled in the project. 335 out of care alters were screened and 112 or 33% were enrolled.

Among the out of care alters who were enrolled, 38 or 33% were enrolled using the direct recruitment method and 74 or 67% were enrolled using the social network recruitment method.

75 or 72% of the out of care alters were retained in care 6 to 12 months after linkage to care among the 104 alters with 6 to 12 months of follow-up data.

In addition, at the time of enrollment, 38% of the 112 out of care alters had had no HIV care visits in more than 12 months, 11% had had no HIV care for 7 to 12 months with a most recent viral load greater than 200 copies per ml, and 14% were newly diagnosed and not linked to care within three months of their diagnosis. Also 47% had recently been released from jail and had no HIV provider and 13% met other definitions of inconsistent care.

**Slide 33**
This slide discusses two recruitment techniques. The social network recruitment method recruited 74 people or 67% of the total. Our one “superseed” recruited 59 persons. Other seeds for the social network recruitment arm had more shallow recruitment waves and referred approximately two people on average.

It should be noted that much of the success for this project can be attributed to the large social network of our superseed.

It’s a little hard to hypothesize how successful the social network referral arm would have been without the superseed because without him, we would have likely found other seeds who may have been as productive or we may have worked with more seeds with smaller networks to recruit similar numbers of alters. As it was, our staff spent a lot of time with the superseed because he knew so many out of care persons.

As noted on this slide, 38 people were recruited through the direct recruitment approach.
**Slide 34**
This slide shows a comparison of the directly recruited participants versus the participants recruited through the social network referral arm.

As shown, the participants recruited through the social network arm were more likely to not have insurance and were less likely to be employed.

**Slide 35**
This slide shows more comparisons between the directly recruited and the social network arms with respect to some social determinant measurements.

The social network referral participants were more likely than the directly recruited participants to be homeless and to have engaged in sex work in the previous six months. Overall almost 38% of the social network referral participants had engaged in sex work in the previous 6 months. The SN participants also were more likely to have a history of non injection drug use and injection drug use in their lifetimes and during the past 3 months.

**Slide 36**
This slide shows a comparison of baseline HIV testing and HIV care history and the social network referral participants had significantly more unmet service needs compared to the directly recruited participants.

These data suggest that the HIV positive out of care participants recruited through social network referrals were more marginalized with more sex workers, more homelessness, more drug use and greater service needs than the participants recruited through direct recruitment. These findings suggest that our seeds had access to a hidden and vulnerable population not reachable through health department staff, agencies, clinics and other more traditional recruitment approaches.

**Slide 37**
This slide shows the linkage and retention outcomes for all 112 of the recruited alters and includes clients recruited through both the social network referral and direct recruitment approaches.

As you can see, 69% linked to care within 3 months once they were enrolled in Project Engage. This is less than the 85% goal from the National HIV/AIDS strategy, but a good outcome for this population considering their multiple social challenges.

Seventeen clients were lost to follow up including 10 participants who were incarcerated within the 6 months after they enrolled in the program and one client who passed away.

**Slide 38**
This slide summarizes the data on viral suppression for the Project Engage participants recruited through both social network referrals and direct recruitment for whom follow up lab data was available.
As shown in the first row of data, 26.8% were virally suppressed at the time that they linked to HIV care and 40.8% were virally suppressed at the time of their second viral load test 6 to 12 months following linkage to care. This improvement in the percent virally suppressed is statistically significant.

As shown, there were also significant improvements in median but not mean viral load between time of linkage and the retention timepoint which is impressive given the social challenges of this group of previously out of care persons.

These decreases in viral load suggest reductions in forward transmission and improvements in health status for the Project Engage out of care alters.

Slide 39
- This slide summarizes data from a client acceptability survey that we administered to 75 of the 112 out of care alters after they completed Project Engage.
- As shown in the first bullet, 100% said that they would recommend the program to others
- 81% said that they would not have entered HIV care without the efforts of Project Engage staff and
- 100% said that they were satisfied with the services that they received from Project Engage staff.

Slide 40
This slide summarizes the lessons learned from Project Engage.

We feel that the 2-pronged community-based approach was very effective at identifying hidden or marginalized HIV positive persons who were out of care although much of the success of the project was tied to the one superseed so that should be kept in mind when considering the implementation of a similar program.

The use of surveillance data was critical to the success of the program and allowed us to confirm patient eligibility when there were a lot of people who wanted to participate who turned out to already be in care or were not eligible for other reasons.

A project like this hinges on the success of your staff and it is very important to hire culturally competent staff who have or can build relationships with key community gatekeepers such as our superseed or agency staff.

Also, staff are needed who are comfortable working outside in areas that are not particularly safe such as in parks, under freeways, etc.

Also, HIV clinics with robust social support services are necessary in a community to provide the needed coordinated medical and non medical care for this population.
Finally, the work is very time-consuming so health departments need to be willing to be patient as recruitment will be slow.

**Slide 41**
This slide summarizes the staffing that was needed to enroll the 112 out of care alters.

1.5 full time staff and one part-time Project Coordinator worked for over 2 years to recruit seeds and alters from community-based organizations, public areas and clinics; confirmed that they were HIV positive and out of care using HIV surveillance data; worked with clients to get them ready to link to care and enrolled clients, conducted assessments and linked them to an HIV clinic with an Medical Care Coordination or MCC team. In LAC, the MCC teams are located at Ryan White clinics and included a social worker, case manager and case worker who focused on patient retention and the delivery of needed non-medical social services.

**Slide 42**
This slide lists the issues that might be considered when thinking about starting a program such as Project Engage.

First off, you will want to think about what you know about your jurisdiction in terms of homeless populations, etc. and whether or not there is suggestive data that there are people with HIV who are out of care and hidden.

You will also need to think about whether there are health department staff available who have experience working with the target population.

Other questions are whether or not you have staff who have good relationships with the community gatekeepers such as staff at homeless shelters or drug treatment facilities.

Does your jurisdiction have experience with community-based recruitment of people living with HIV either through the CDC National HIV Behavioral Surveillance project, NHBS, or some other similar project.

Depending on your population and available resources, you could use either the social network or direct recruitment approach.

The advantages to a social network referral approach is that you might have a better chance at reaching hidden HIV positive populations and people who are most likely to transmit HIV such as sex workers or people with high viral loads.

**Slide 43**
Before ending, I will just touch briefly on a permanent Linkage and Re-engagement Program that was established in Los Angeles County primarily based on the best practices and lessons learned from the Navigation Programs and Project Engage.
Slide 44
There are several components to the Los Angeles County Linkage and Re-Engagement Program including a clinic piece similar to the Navigation Program, a jail piece which works to transition HIV positive incarcerated persons to care as they are released from jail and an outreach component similar to Project Engage.

Basically, out of care persons are identified through all of these different techniques and administered one type of intervention which is most similar to the Motivational Interviewing intervention that I described in the Navigation Program. HIV surveillance data are used by health department staff and provide the data that is key to the successful implementation of the program.

Slide 45
I would like to thank my former co-workers in the Los Angeles County Department of Public Health Division of HIV and STD Programs, Sophia Rumanes, Wendy Garland, Mario Perez, Sonali Kulkarni, Alla Victoroff and Jesse Bendetson.

Slide 46
Here is my contact information if you have any follow up questions or would like further information. Thank you for your time and interest. I would be happy to take questions or comments at this time.