



# Characterizing Late Diagnoses: Results from Health Resources and Services Administration-HIV/AIDS Bureau's Updated Approach

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## Presentation Overview

- Follow up to presentation at annual meeting on updated approach to estimate unmet need
- One of three presentations to discuss estimates
  - **Late diagnoses (April 2023)**
  - Unmet need for medical care (May 2023)
  - In care but not virally suppressed (June 2023)
- Define of unmet need measures and populations, present results and discuss how to use in our work



## What is Unmet Need?

- Defined by HRSA HIV/AIDS Bureau as:  
“ the need for HIV-related health services by individuals with HIV who are aware of their status, but are not receiving regular primary [HIV] health care.”
- Estimated Unmet Need has been a reporting requirement for RWHAP recipients since 2005
- Data and methods to estimate unmet need have evolved with improvements in HIV care and data quality
- New and expanded methodology released 2021 and implemented in 2022

1. "HRSA/HAB Definitions Relate to Needs Assessment," prepared for the Division of Service Systems, HIV/AIDS Bureau by Mosaica: The Center for Nonprofit Development and Pluralism, June 10, 2002.

2005

- Focus on people aware of their HIV/AIDS diagnosis but not in regular HIV medical care
- People living with diagnosed HIV and AIDS with no evidence of care (at least one **viral load [VL]** or **CD4 test** or **ART prescription**) in past 12 months

2017

- Care markers updated to align with HIV Care Continuum Definitions
- People living with diagnosed HIV and AIDS with no evidence of care (2 or more **medical visits** or **VL** or **CD4 tests** at least 90 days apart) in past 12 months

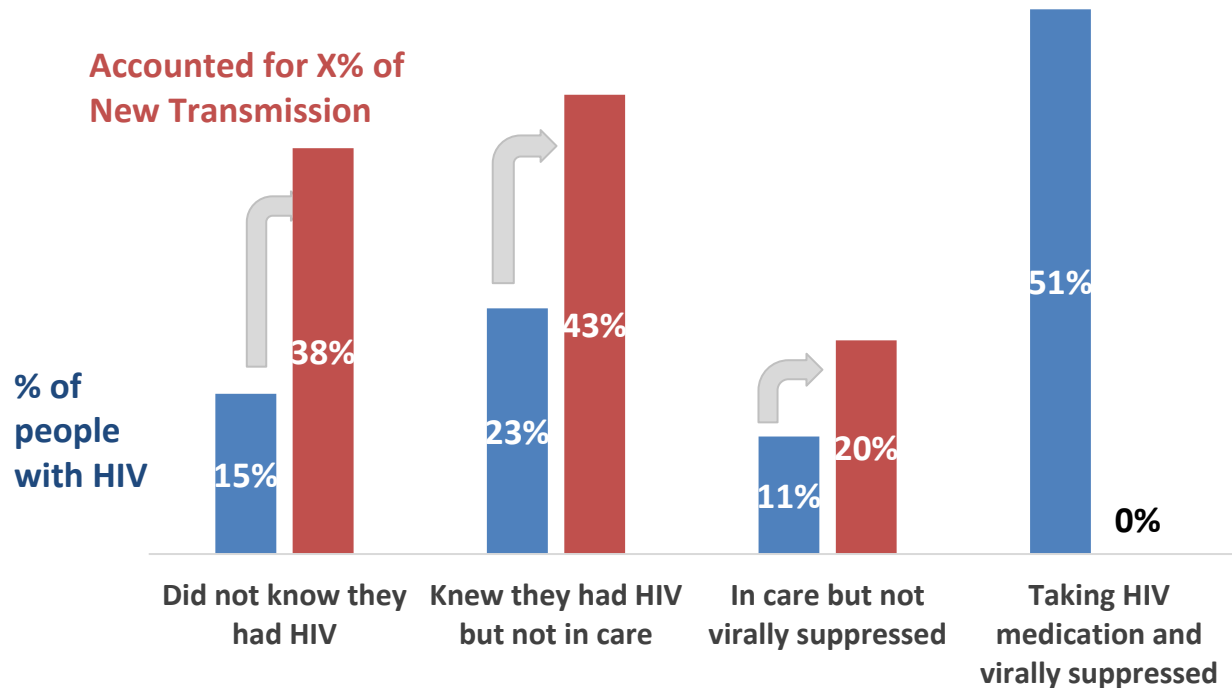
2021

- Revised care markers and expanded populations
- People living with **diagnosed HIV** with no evidence of care (at least one **VL or CD4 test**) in the past 12 months
- Adds two new indicators:
  - Persons diagnosed with HIV in the past 12 months with **LATE DIAGNOSIS (Stage 3 (AIDS))** diagnosis or an **AIDS-defining condition**  $\leq$  3 month after HIV diagnosis)
  - Persons living with diagnosed HIV **IN MEDICAL CARE** (at least one VL or CD4 test) who were **NOT VIRALLY SUPPRESSED** in the past 12 months

# Unmet need estimates attempt to measure the gaps between the HIV care continuum

- To reduce HIV transmission

- To improve health outcomes among PLWDH

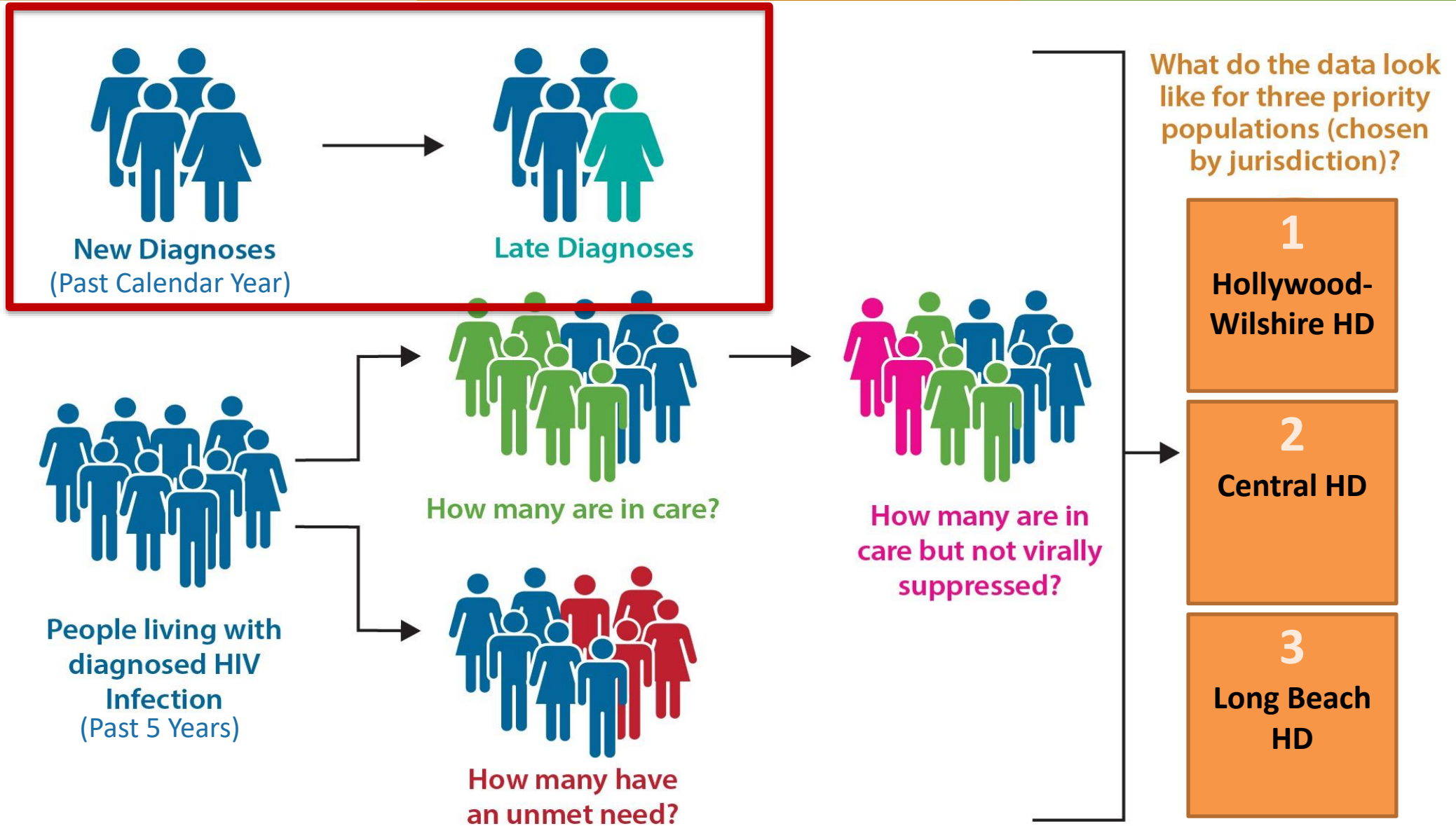


**HIV Transmissions in the United States, 2016<sup>1</sup>**

- Start ART early in infection
- Reduce HIV comorbidities, coinfections and complications
- Slow disease progression
- Extend life expectancy
- Reduce HIV-related mortality

1. Li Z, Purcell DW, Sansom SL, Hayes D, Hall HI. *Vital Signs: HIV Transmission Along the Continuum of Care — United States, 2016*. MMWR Morb Mortal Wkly Rep 2019;68:267–272. DOI: <http://dx.doi.org/10.15585/mmwr.mm6811e1>.  
 2. National HIV/AIDS Strategy for the United States (2022-2025). <https://files.hiv.gov/s3fs-public/NHAS-2022-2025.pdf>

# LAC Populations for Estimates of Unmet Need





# Approaches to Identify Disparities and Gaps - Examples

## Across Group Comparison\*

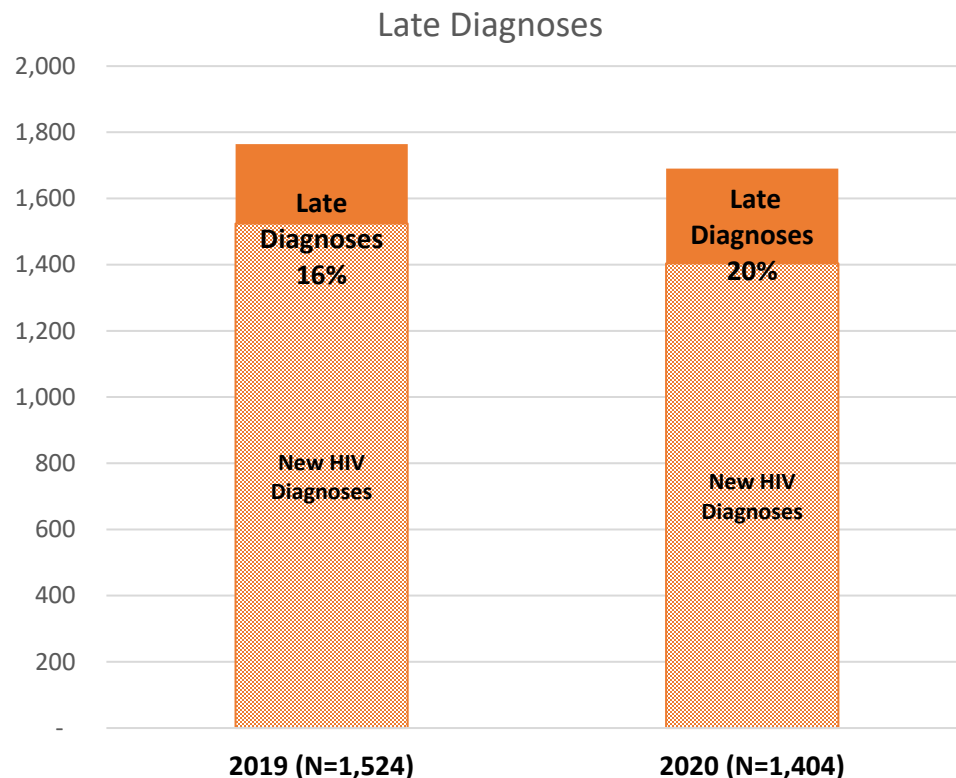
- Helpful for describing a population
  - Latino males made up **24%** of LAC residents in 2020
- Identify disparities across populations
  - Latino males made up **53%** of LAC residents newly diagnosed HIV in 2020
  - Proportional difference between residents who were Latino males (**24%**) to compared to new diagnoses who were Latino males (**53%**)

## Within Group Comparisons\*

- Helpful to understand how specific groups are impacted compared to each other
  - Linkage to care among 170 newly diagnosed Hollywood-Wilshire HD residents (**85%**) compared to among 126 newly diagnosed among Central HD residents (**67%**) compared to 92 newly diagnosed Long Beach HD residents (**80%**)



# Considerations when thinking about this data



- These data represent the characteristics of LAC residents with confirmed new HIV diagnoses in 2020 reported to DHSP
- These data do not reflect
  - How, where and to whom HIV testing services are available or accessed
  - Testing behaviors or frequency among LAC residents
- For example, changes in new diagnoses and late diagnoses from 2019 to 2020 may be due to
  - Decreased testing access or availability due to COVID-19
  - Fewer people seeking testing services



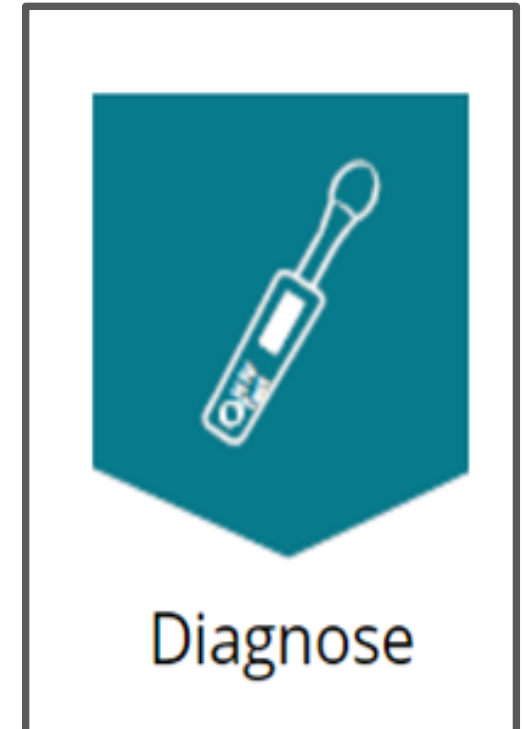


## Unmet Need Estimate: Late Diagnoses in LAC, 2020



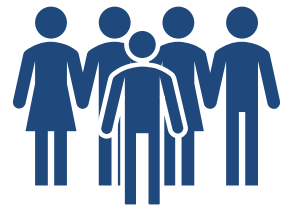
## Context for Late Diagnoses

- National goal: reduce late diagnoses by 25%
  - In LAC that means decreasing the percent of late diagnoses from 24% to 18% by 2025<sup>1</sup>
- On average, it takes 8 years to progress to late stage disease from time of infection to diagnosis<sup>2</sup>
- Identification of late diagnoses is not done at point of care – providers are not likely to know degree of disease progression at time of testing
  - Helpful to track how well our care system is identifying infection early and across populations but cannot guide services



# Late Diagnosis Estimate in LAC, 2020

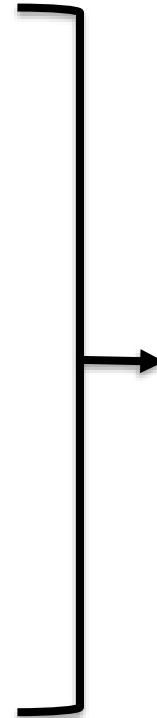
## PART A Geographic Priority Populations



**1,404 New  
Diagnoses**



**20% Late  
Diagnoses  
(N=286)**



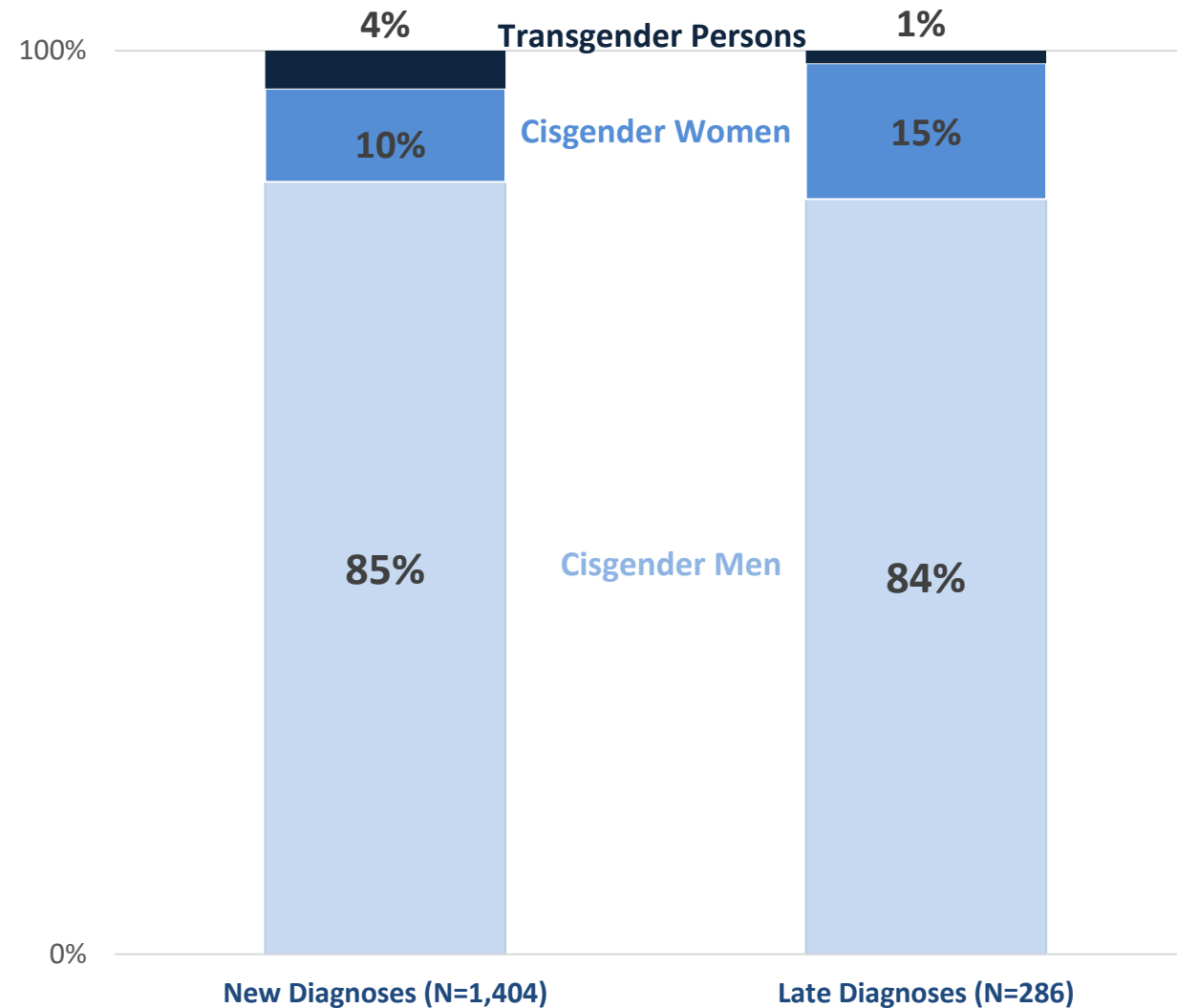
**15%**  
**Hollywood-  
Wilshire HD**  
**(N=171)**

**15%**  
**Central HD**  
**(N=19)**

**15%**  
**Long Beach  
HD**  
**(N=14)**

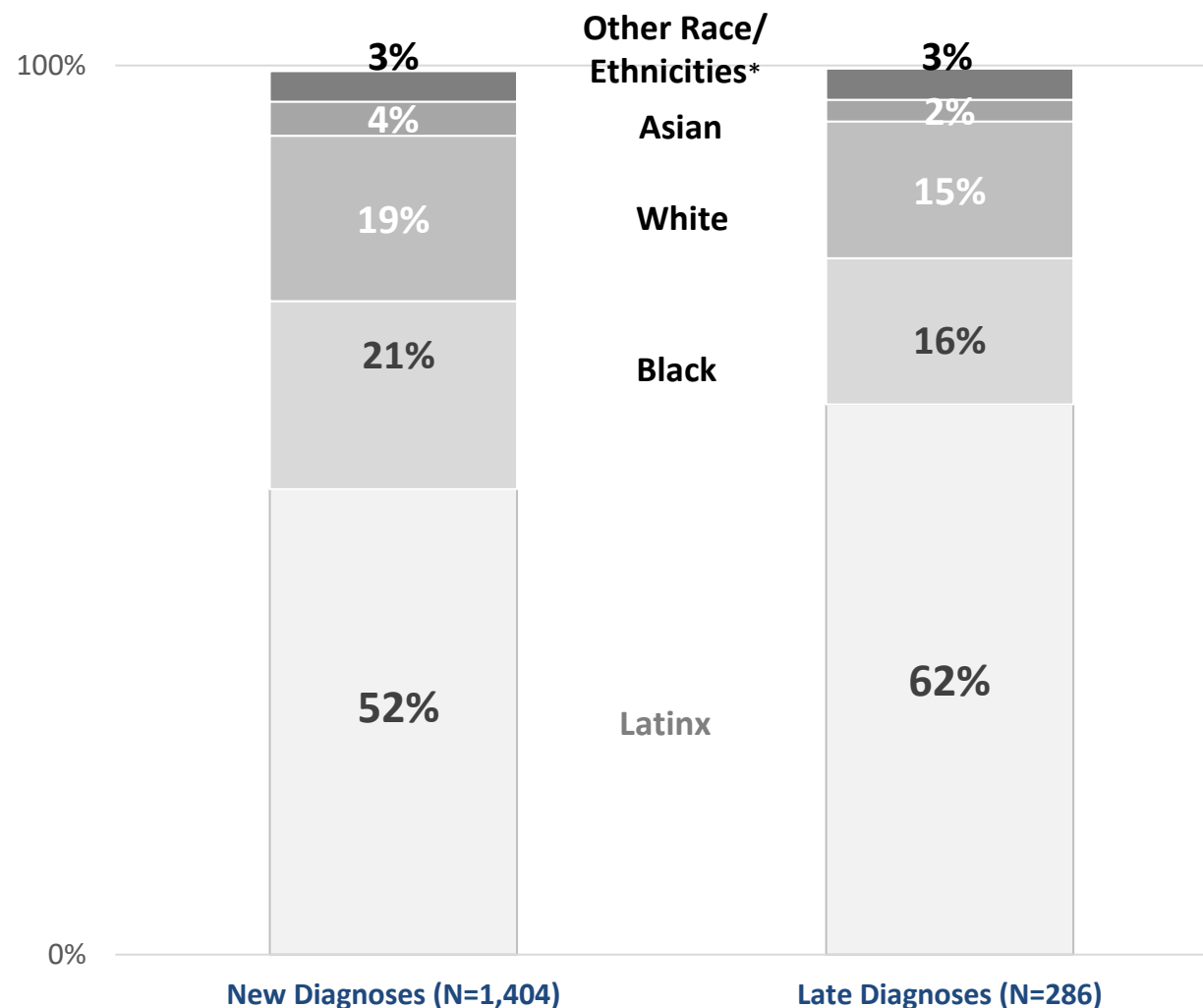
## New and Late HIV Diagnoses by Gender Identity, 2020

- The largest percent of new diagnoses and late diagnoses were among cisgender men
- While 10% of new diagnoses were among cisgender women, they represented 15% of late diagnoses



## New and Late HIV Diagnoses by Racial/Ethnic Group, 2020

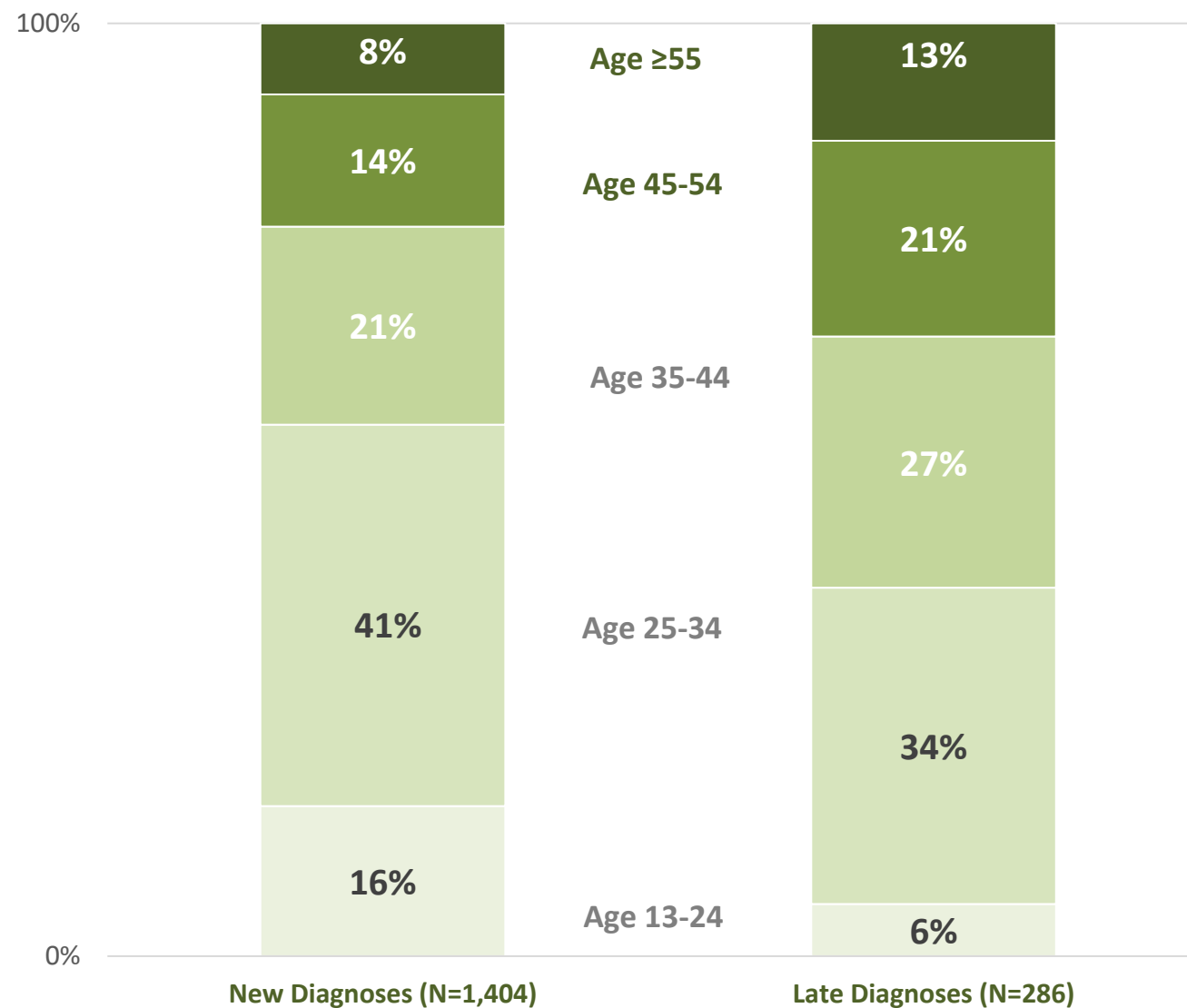
- The largest percent of new diagnoses and late diagnoses were among Latinx residents
- While 52% of new diagnoses were among Latinx residents, they represented 62% of late diagnoses



\*Among new diagnoses, persons of other racial/ethnic groups include: Multiple race (n=42), American Indian/Alaska Native (n=5), and Native Hawaiian/Pacific Islander (<5). Race/ethnicity was not reported for 9 cases.

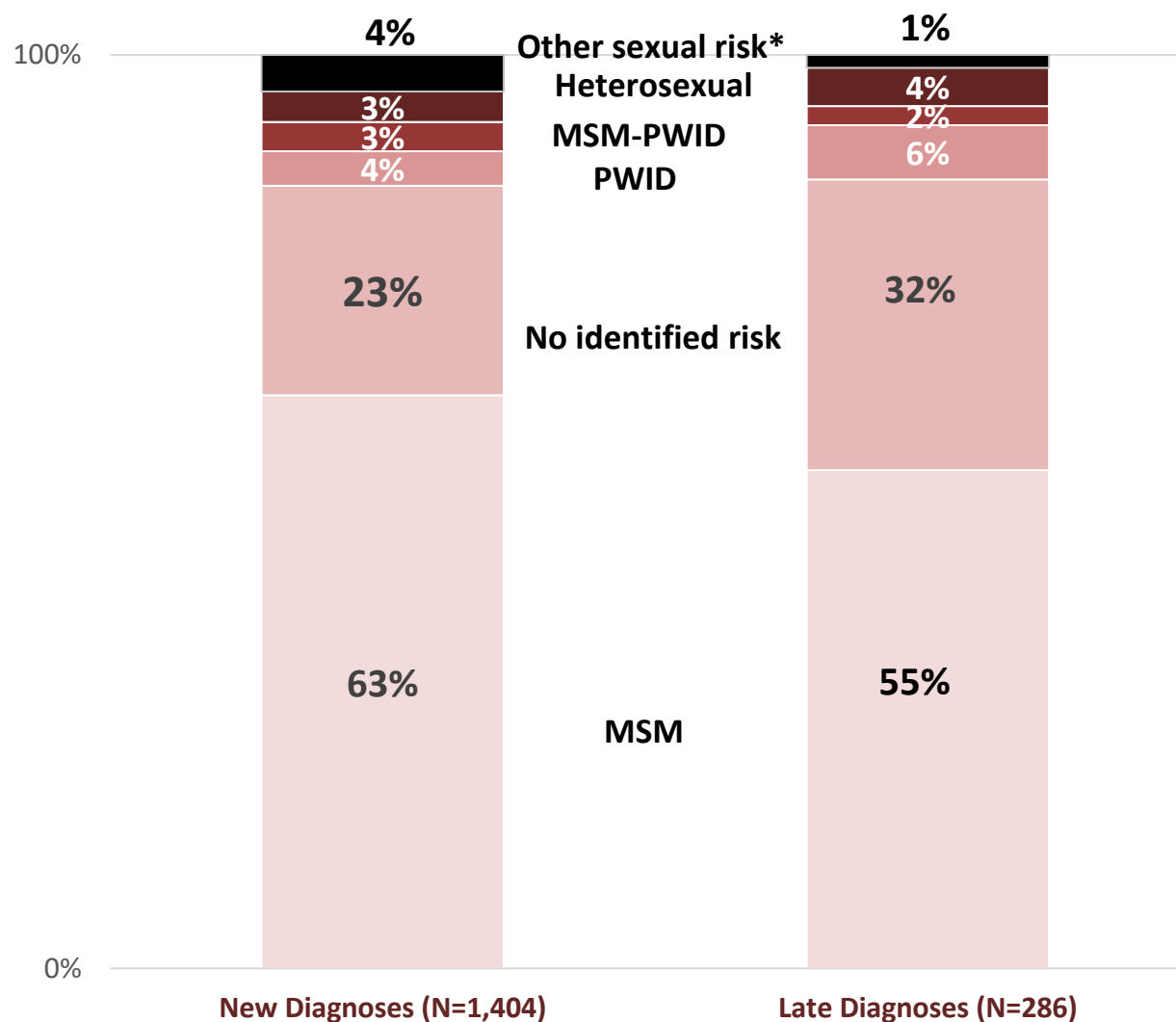
## New and Late HIV Diagnoses by Age Group, 2020

- The largest percent of new diagnoses and late diagnoses were among residents age 25-34 represent the largest percent of new diagnoses (62%) and late diagnoses (61%)
- Older age groups represent larger percentages of late diagnoses compared to residents in younger age groups



## New and Late HIV Diagnoses by Exposure Category, 2020

- The largest percent of new diagnoses and late diagnoses were among men who have sex with men (MSM)
- While 23% of new diagnoses were among persons with no identified risk exposure reported, they represented 32% of late diagnoses



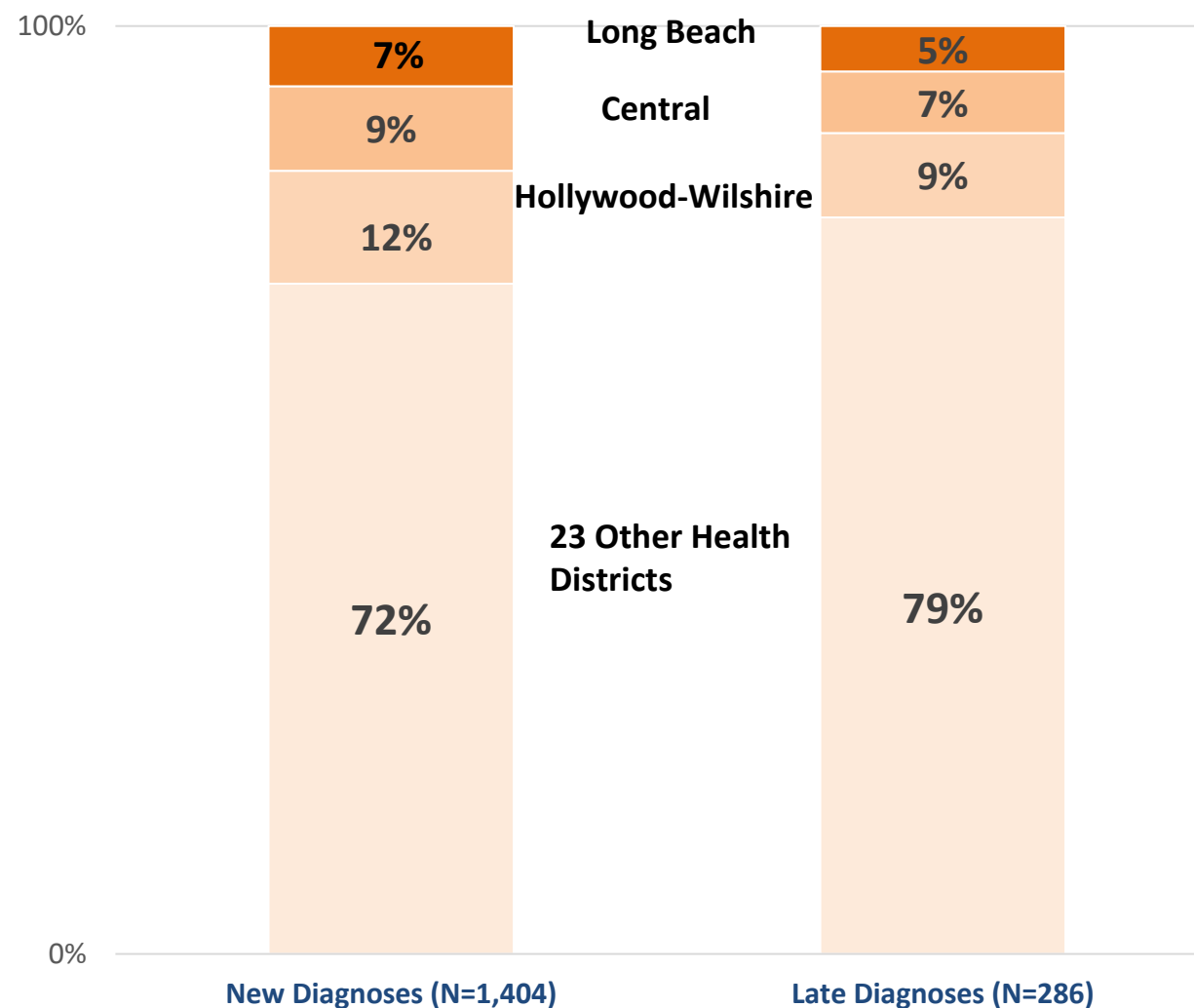
Definitions: MSM: Men who have sex with men; PWID: People who inject drugs

\*Among new diagnoses, other sexual risk includes: sexual contact among transgender individuals(n=48), sexual contact and PWID among trans individuals (n=8).

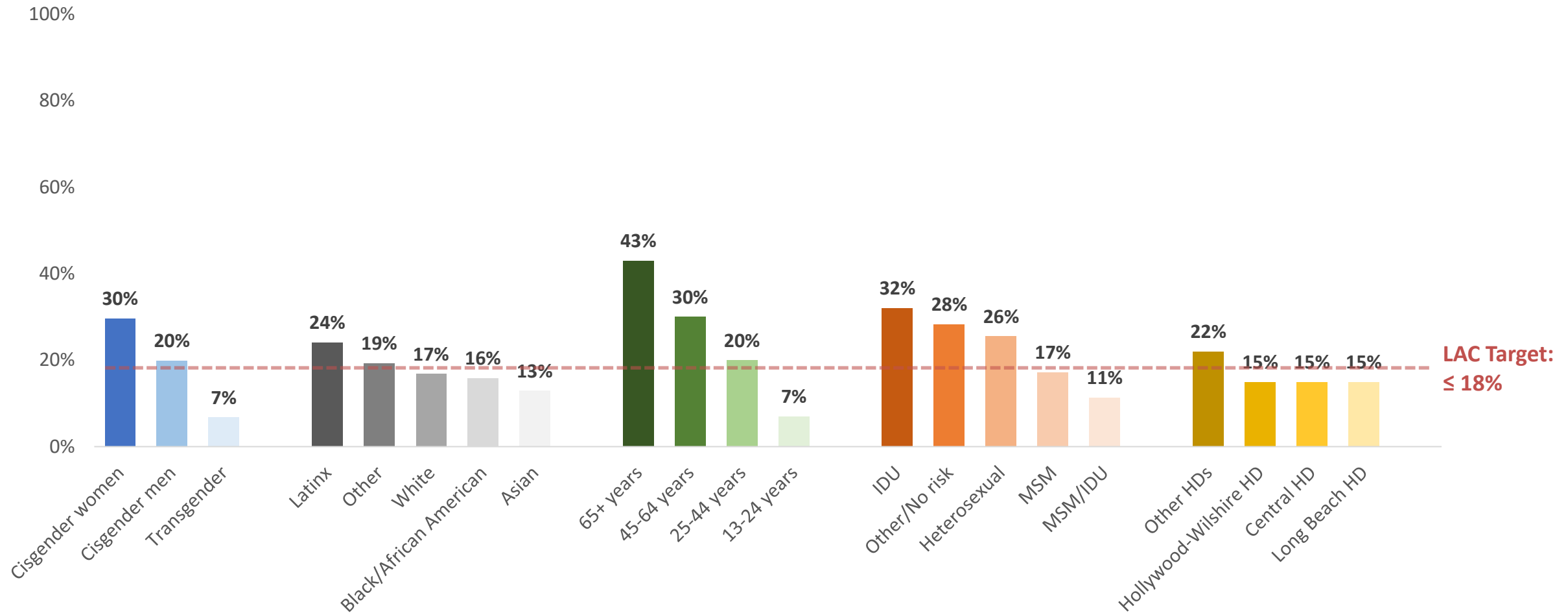


## New and Late HIV Diagnoses by Health District, 2020

- The largest percent of new diagnoses and late diagnoses were reported for residents in other health districts
- Nearly 30% -- or 1 out of every 3 new diagnoses was among residents of Hollywood-Wilshire, Central and Long Beach HD



**Late diagnoses** within each category were highest among cisgender women, Latinx, PLWDH aged 65+ and injection drug users (IDU)



# Key Takeaways

The majority of new diagnoses were timely - 80% identified soon after infection

- How can we build on what is working?

Identified disparities in late diagnoses

- How and where can we improve for impacted populations?

Largest burden of late diagnoses

- Cisgender men
- Latinx
- Age 25-34
- MSM

Unequal % of late vs all diagnoses

- Cisgender women
- Latinx
- Age  $\geq$  35
- No identified HIV risk

Highest % of late diagnoses within population

- Cisgender women
- Latinx
- Age  $\geq$  45
- PWID



# Questions



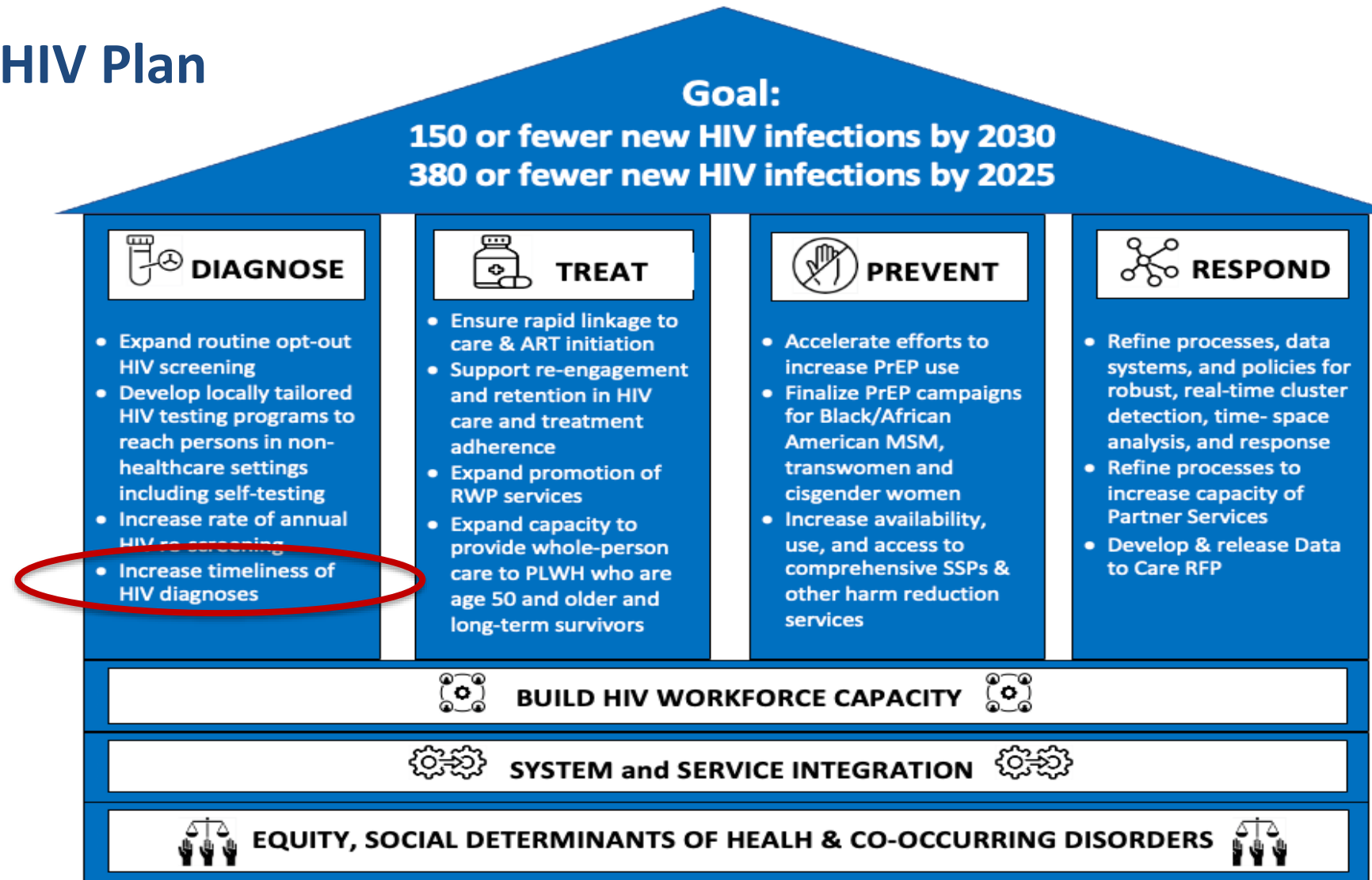
## Discussion – using the late diagnosis estimate for planning



# LAC Comprehensive HIV Plan Snapshot

## Priority Populations

- Latinx MSM
- Black/African American MSM
- Transgender persons
- Cisgender women of color
- PWID
- Persons < age of 30
- PLWH ≥age 50



# What are strategies to improve diagnosis timeliness?<sup>1</sup>

- Focus on those populations that account for a large portion of residents who are unaware of their HIV infection
  - LAC: persons age 13-34 and Latinx<sup>2</sup>
- Focus on targeting and routine testing for younger age groups to reach people earlier in infection
- Identify barriers to HIV testing and stigma among older populations
- Work with providers to promote routine testing in health care settings
  - DPH Sexual Health Clinics (formerly STD Clinics)
  - Vaccine programs (COVID, Mpx)

## HIV TESTING

### RECOMMENDATIONS

#### US Preventative Services Task Force (2019)

- Persons age 15-65
- <15 and >65 based on risk
- All pregnant women

#### CDC (2006)

- General population:  $\geq 1$  ever
- Persons with risk factors:  $\geq 1$  annually

1. Krueger A, et al. 2019. HIV Testing, Access to HIV-Related Services, and Late-Stage HIV Diagnoses Across US States, 2013-2016. doi: [10.2105/AJPH.2019.305273](https://doi.org/10.2105/AJPH.2019.305273). PMID: [PMC6775941](https://pubmed.ncbi.nlm.nih.gov/3175941/)

2. Division of HIV and STD Programs, Department of Public Health, County of Los Angeles. HIV Surveillance Annual Report, 2021. <http://publichealth.lacounty.gov/dhsp/Reports/HIV/2021AnnualHIVSurveillanceReport.pdf>.

3. Traynor SM, Rosen-Metsch L, Feaster DJ. 2018. Missed opportunities for HIV testing among STD clinic patients. doi: <https://link.springer.com/article/10.1007/s10900-018-0531-z>





## How can our services improve timely diagnoses and HIV awareness?

- More testing programs?
  - Routine vs. targeted
  - Clinical vs. non-clinical
- Rescreening
- Expand existing access points
  - Storefront and social and sexual network programs
  - Mobile or street-based
  - HIV self testing
  - Public health clinics
  - Emergency rooms
- New access points
  - Pharmacies?
  - Other non-clinical settings?
- Linguistically and culturally appropriate services
- Service promotion



## Next Steps for Unmet Need Estimates

- Continue measure-focused presentations to COH
  - Unmet Need (Out of Care)– May
  - In Care but Not Virally Suppressed – June
  - Will include separate analyses for Ryan White Clients
- Further analyses are needed to
  - Identify predictors of late diagnoses among LAC residents
  - Describe care continuum outcomes for late compared to timely diagnoses
- Summary report completed mid-2023

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**THANK  
YOU!**

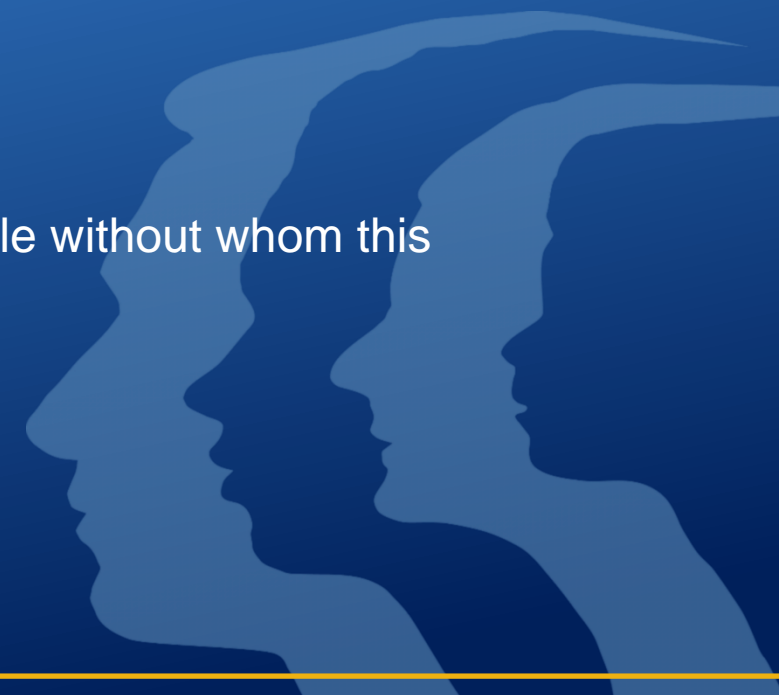
Special thanks to the following people without whom this presentation would not be possible:

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## References and Resources

- Webinar video and slides: Enhanced Unmet Need Estimates and Analyses: Using Data for Local Planning <https://targethiv.org/library/enhanced-unmet-need-estimates-and-analyses-using-data-local-planning>
- Webinar video and slides: <https://targethiv.org/library/updated-framework-estimating-unmet-need-hiv-primary-medical-care>
- Methodology for Estimating Unmet Need: Instruction Manual <https://targethiv.org/library/methodology-estimating-unmet-need-instruction-manual>