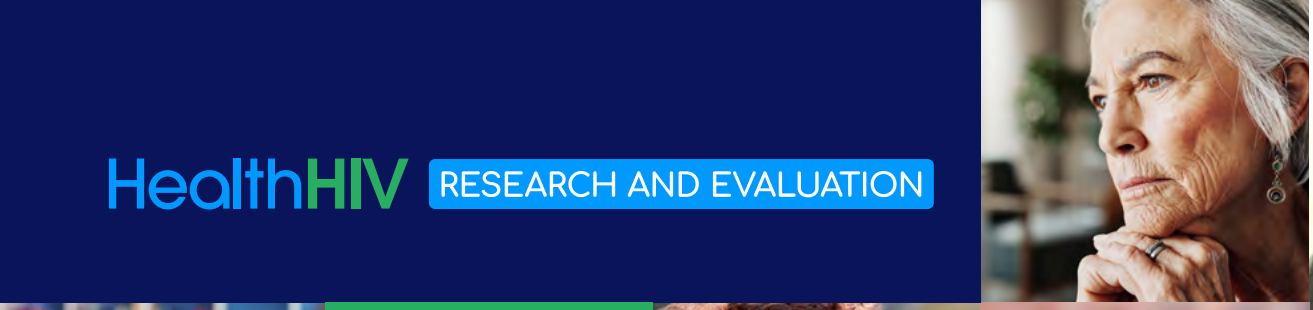
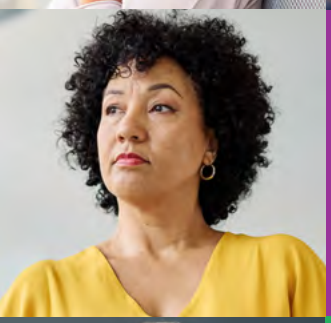
HealthHIV RESEARCH AND EVALUATION



HealthHIV POZITIVELY AGING

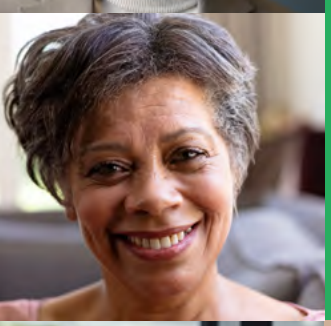


Findings and Implications from

HealthHIV STATE OF Aging with HIV™

Fifth Annual National Survey

HealthHIV.org/stateof



Executive Summary

More than half of people living with HIV in the United States are now age 50 or older.[1, 4]
Many in this age group carry the trauma of surviving while peers did not, alongside limited financial resources tied to early retirement or disability with the expectation of a shorter life, attenuated social support systems, and the physiological cost of decades of stress. Providers, in turn, are managing an increasingly medically complex HIV population that presents with geriatric needs earlier than the general population, against a backdrop of shrinking organizational resources.[2, 3, 15, 16, 75, 79] Understanding what people aging with HIV need, and what the systems and providers who serve them are working with, is essential to improving operations and the health outcomes of people aging with HIV, both for this generation and for those growing older alongside them.

To this end, HealthHIV fielded the fifth wave of the State of Aging with HIV Survey in February 2026. Responses from people aging with HIV (N=365) and HIV-aging service providers (N=341) across 37 U.S. states and the District of Columbia inform most of this report, with additional context provided through trend analyses drawn from five consumer waves (N=2,163; 2020 to 2026) and two provider waves (N=735; 2024 and 2026). The survey revealed an HIV care system that delivers clinical wins. Over 98% of consumers reported being virally suppressed, and nearly 100% are taking antiretrovirals, the highest rates across five waves of the survey. The same data, however, show that the broader clinical reality of aging with HIV, multimorbidity, frailty risk, mental health burden, and the structural conditions of daily life, is not being managed with the same consistency. Frailty screening reaches only 17% of consumers overall and just 11% of consumers under 65. More than 80% report at least one chronic non-HIV medication, 22% have adjusted antiretroviral therapy because of drug-drug interactions, and roughly three-quarters carry moderate or high mental health stress that fewer than 2% name as their most pressing immediate need.

This report details the findings from the survey and their implications across five domains: HIV and Geriatric Care, Comorbidities, Behavioral Health, Access and Payment, and Workforce. (The survey questions and responses are available at **HealthHIV.org/stateof**.)

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Key Findings

The central message of this report is straightforward: people aging with HIV are living longer, but the systems around them are not yet fully built to support aging well.

Viral suppression is high, yet frailty screening remains uncommon. Many respondents report good quality of life, yet mental health stress is widespread and often hidden. Medication coverage is largely intact for now, yet the surrounding payment infrastructure, including the AIDS Drug Assistance Program (ADAP), is increasingly fragile. Providers increasingly recognize these aging-related needs, but many organizations still lack the workflows, staffing, and geriatric expertise to respond consistently. The findings below move from that broad picture into five connected domains, and the implications that follow are intended to respond directly to those findings rather than sit apart from them.

How Would You Describe the State of Aging with HIV in One Word?

When asked to describe aging with HIV in a single word, both consumers and providers most often returned to challenging, difficult, and complicated, the same pattern observed across the prior two waves. The most useful difference between the two groups is loneliness: providers name it more often than consumers do, which suggests that isolation may sometimes be visible to others before people identify it in themselves. This reinforces one of the report's larger themes: strain may be present even when people do not name it directly, which is why proactive screening, conversation, and support matter. *(See Figure 1.)*

FIGURE 1. CONSUMER VS. PROVIDER ONE-WORD DESCRIPTIONS (2026)

HIV and Geriatric Care

Finding: Viral suppression is the highest in five waves of the survey, yet the broader clinical reality of aging with HIV is not being managed at the same level.

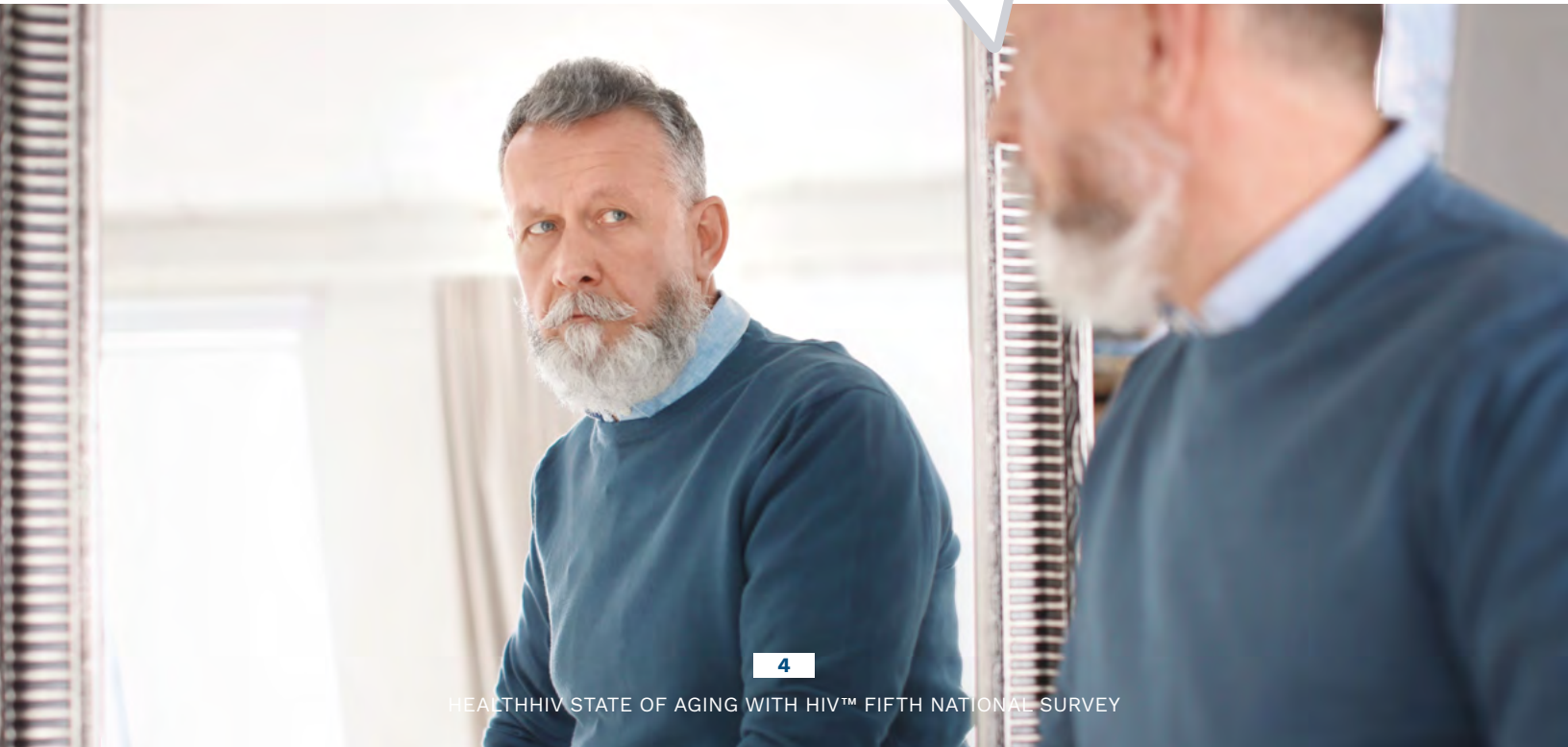
Of the 2026 consumer cohort, 98% are virally suppressed, the highest rate recorded across all five waves. That is a major success and reflects the strength of HIV treatment and re-engagement infrastructure. The same data show that geriatric care has not kept pace: only 17% of consumers were screened for frailty in the past year, and frailty screening among consumers under 65 fell from 25% in 2022 to 11% in 2026, despite a substantial published evidence base on frailty in HIV.[36] Low-income consumers were much less likely to be screened at all. Surviving HIV is not the same as being clinically well-managed as you age. The HIV system is succeeding at viral suppression. The aging-care half of the encounter, frailty screening, multimorbidity management, mental health follow-through, and the structural supports that keep care reachable, remain missing for many patients.

Comorbidities

Finding: Most consumers carry chronic non-HIV medication burden, and a high-needs unmanaged group is invisible to every system except antiretroviral therapy.

People aging with HIV carry a heavy burden of non-HIV comorbidities, and a sizeable high-needs group is only visible to the system through their antiretroviral prescriptions. In the 2026 cohort, more than 80% of consumers report at least one chronic non-HIV medication, and 22% have changed their ART regimen because of drug-drug interactions with those medications. The Geriatric Burden Index averages 52 at a mean age of 61, a score associated with ages 20 years older among people without HIV, underscoring how multimorbidity impacts the life span, even when HIV is well controlled. Latent class analysis shows that more than one in four consumers fall into a very-high-needs, under-served group of people aging with HIV. ART clearly reaches this group; geriatric care, behavioral health, and structured case management largely do not, evidenced by self-reported experiences with polypharmacy, discrimination, high mental health stress, and limited access to frailty screening.

> "HIV does not exist in isolation; it is an inextricable part of living and aging with HIV. HIV specialists need to consider how aging affects health and treatment, and how HIV treatment affects aging with HIV."
>
> – 2026 STATE OF AGING WITH HIV™ NATIONAL SURVEY PARTICIPANT AGING WITH HIV



Behavioral Health

Finding: Stress is widespread, social connection is the strongest protective factor in the data, and outwardly good quality of life can mask serious mental health burden.

Roughly three-quarters of consumers report moderate or high mental health stress, yet fewer than 2% identify mental health as their most pressing immediate need. Stress in HIV has been shown to independently predict physical function, which makes its under-recognition in primary care a meaningful clinical concern.[30] A large share of respondents report good quality of life while also carrying high stress, which means outwardly doing well can mask serious mental health burden. Need that does not present as a clinical complaint will be missed unless providers screen for it directly. At the same time, social connection stands out as a strong protective factor: larger social networks are associated with better quality of life and lower stress across multiple analytic approaches. The findings suggest that stress is a central mechanism through which discrimination and structural strain harm health, while social connection functions as a meaningful buffer.

Access and Payment

Finding: Medication coverage is doing what it was designed to do, but the surrounding payment infrastructure is fragile, with ART access no longer assumed to be stable.

ART access for people aging with HIV has become increasingly fragile. The National Association of State and Territorial AIDS Directors (NASTAD) recently reported that ten ADAP programs reported deficits in the current fiscal year, and forecasted 19 forecast deficits for the next, with new ADAP waiting lists in Iowa and Utah, eligibility limitations in multiple states, premium-assistance cuts, and formulary restrictions. For consumers, transportation remains the strongest single access barrier in the dataset: low-income consumers face nearly six times the odds of missing an HIV appointment because they cannot get there. More than half of Medicare enrollees still rely on RWHAP and ADAP for HIV medications, a safety net parallel to Medicare-Medicaid dual eligibility. Telehealth has improved access where it is reimbursable, but the organizations serving the most marginalized people with HIV are often the least equipped to bill for it or sustain it. The result is a system that can often provide medications, but not support mechanisms to facilitate access to them.[56, 57]

Workforce

Finding: Most providers recognize that aging with HIV is a clinical priority, but few organizations have the staffing, training, or workflows to act on that recognition. Workforce turnover is eroding the practical knowledge needed to deliver aging-informed care.

Providers largely recognize that people aging with HIV need more age-responsive care, but recognition alone is not enough. Only 1.5% of providers in the 2026 sample specialize in gerontology, compared with 21% in HIV medicine. Many organizations say they see the need for aging-focused services, but fewer are actively implementing changes. At the same time, declining ADA awareness and reduced experience in role suggest that workforce turnover is eroding structural knowledge even as advocacy interest grows. The key problem is not motivation; it is operational capacity.

Implications

HIV and Geriatric Care

Implication: Integrate frailty and geriatric screening into Ryan White HIV/AIDS Program-funded clinical visits, and protect the infrastructure that produced the 98% suppression rate.

These findings point to a practical next step: build frailty and geriatric screening into routine HIV care rather than treating it as a separate or future-facing issue. The same coordinated infrastructure that supports a 98% viral suppression rate should also support earlier identification of frailty, falls risk, and broader aging-related needs. The sharp decline in screening among consumers under 65 suggests the system is missing the very window in which intervention may be most effective and least costly. Protecting Ryan White and ADAP infrastructure is therefore not only about medications; it is also about preserving the platform through which more complete aging-informed care can be delivered. Within this population, the subgroup aged 65 and older is increasingly presenting with higher clinical acuity, advanced multimorbidity, frailty, cognitive decline, and immediate care needs around the Medicare transition that require coordinated, geriatric-informed care across multiple systems.[38]

- Build frailty screening, advance care planning, and falls-risk assessment into Ryan White HIV/AIDS Program (RWHAP) service categories for consumers ages 50 and older.
- Protect ADAP and the 340B Drug Pricing Program rebate stream, which now constitutes more than half of total ADAP budgets and is increasingly exposed to IRA-driven rebate compression.
- Continue and expand active re-engagement protocols established during COVID; the 2021 recovery in low-income suppression depended on them.

Comorbidities

Implication: Fund clinical pharmacist consultation as a reimbursable RWHAP service category, and align Older Americans Act eligibility with biological aging.

The implication is that comorbidity care for older people with HIV cannot be handled through medication management alone. Polypharmacy, drug-drug interactions, mental health burden, and structural vulnerability travel together and require integrated, team-based responses. Clinical pharmacist consultation, medication reconciliation, case management, and stronger links to aging services are not optional add-ons for a small subgroup; they are core supports for a population carrying substantial multimorbidity at relatively young ages. Aligning Older Americans Act eligibility and related service supports with the biological realities of aging with HIV would make that response more realistic.

- Establish clinical pharmacist consultation as a standalone reimbursable service in RWHAP service categories for consumers on five or more medications.
- Lower OAA eligibility threshold for people with HIV to age 50 (S.2120). GBI of 52 at mean age 61 demonstrates the case.
- Fund OAA nutrition, transportation, and case management services for people with HIV ages 50 and older.
- Fund supportive housing with HIV-competent property management. Housing is the number one immediate need named by 25% of consumers; 60% report at least one housing concern, and 91% to 98% of consumers say more advocacy on housing is needed.

Behavioral Health

Implication: Make mental health screening a default in HIV primary care, and treat anti-discrimination training as a clinical intervention.

These results support making mental health screening a routine part of HIV primary care rather than waiting for patients to raise concerns on their own. Outwardly good quality of life can mask high distress in this population, which means need will be missed unless providers screen proactively. The data also show that anti-discrimination work and social-connection supports are not peripheral to care quality; they are part of the clinical response. If discrimination increases stress and stress in turn worsens outcomes, then reducing discrimination and strengthening social support are legitimate health interventions. The practical implication is to embed validated screening, strengthen referral pathways, and invest in peer and community-based programs that reduce isolation before it escalates into deeper clinical harm.

- Embed validated mental health screening (e.g., PHQ-9) in HIV primary care visits at the same cadence as viral load monitoring.
- Protect Section 1557 mental health parity protections; rollback would reduce care engagement and quality of life through the documented mediation pathway.
- Fund anti-ageism, anti-discrimination, and HIV-stigma training for clinical and non-clinical staff, with attention to the specific intersectional exposures documented in this report.
- Having a social network is the single most replicated protective factor in this study, elevating the importance of investment in social-connection programs, including peer navigation and intergenerational programming.

Access and Payment

Implication: Support treatment access by treating transportation as essential medical infrastructure, making Medicare telehealth permanent for HIV care, and stabilizing the ADAP rebate base.

These findings argue for treating transportation, telehealth reimbursement, and ADAP stability as core pieces of HIV care infrastructure rather than secondary policy issues. When transportation barriers carry the largest effect size in the dataset, they are not a convenience problem; they are a care-access problem. Likewise, if telehealth works best for people with mobility or distance-related barriers, its sustainability becomes a matter of equity. Affordability pressures now extend beyond supportive care and into treatment access itself: NASTAD's 2026 monitoring indicates that even the medication-coverage layer is starting to fray. The implication is to stabilize the systems around treatment, and to stabilize treatment access itself, not only the prescription.[56, 57, 58]

ADAP fragility evidence as of early 2026: NASTAD's February 2026 ADAP Watch and 2026 Annual ADAP Monitoring Project Report indicate that 10 ADAP programs reported deficits in the current fiscal year and 19 ADAPs forecast deficits for the next fiscal year, driven primarily by rising drug costs per client and the expiration of enhanced Patient Protection and Affordable Care Act premium tax credits. 17 to 23 states have implemented or are considering cost-containment measures including lowered income eligibility, formulary restrictions, and waitlists. Florida's January 2026 ADAP changes, effective March 1, lowered income eligibility from 400% of the Federal Poverty Level to 130% and removed Biktarvy from the formulary; NASTAD estimates more than 16,000 people will lose coverage. Pennsylvania, Kansas, Delaware, and Rhode Island have already lowered income eligibility; Arkansas, Louisiana, and New Jersey are considering waitlists. Connecticut continues to exclude HIV medications from its Medicaid Preferred Drug List, but advocacy organizations report that legislative language affecting antiretroviral access has surfaced in state budget discussions. The 2021 dip in viral suppression among low-income consumers,

which recovered to 97% by 2026 only through active Ryan White HIV/AIDS Program re-engagement work, demonstrates how vulnerable these gains are to structural shocks.[56, 57, 58, 59]

- Fund transportation as essential medical infrastructure (OR=5.86 for missed appointments among low-income consumers; weighted prevalence 18%).
- Make Medicare telehealth flexibility for HIV primary care permanent. Telehealth ICC=0.026 across 37 states; it is the geographic equalizer.
- Protect the ADAP rebate base. The 2026 NASTAD Monitoring Project Report shows ADAP drug rebates are 51% to 52% of total ADAP budgets, exceeding federal earmark funding (28% to 29%); IRA Medicare Part D out-of-pocket caps and Medicare Drug Price Negotiation are reducing partial-pay rebate generation. Targeted federal investment in ADAP administrative infrastructure is needed to manage enrollment surges driven by Medicaid unwinding and ACA tax credit expiration.
- Protect Medicaid (no per-capita caps; no work requirements). Medicaid is the only insurance type significantly associated with integrated PCP-HIV care (OR=2.62, p=0.012).
- Restore and enforce Section 1557 non-discrimination protections.[51, 52, 53] 52% of discrimination's harm to care avoidance and 61% of its harm to QOL travel through the stress pathway; rollback would increase care avoidance through a documented causal chain.

Workforce

Implication: Nonprofits and government agencies need to provide more education and training for the workforce addresses HIV and geriatric care.

- Strengthen the capacity of the aging with HIV workforce by having local, state, and national nonprofits provide and support training and education programs.
- Bolster legislation that provides and sustains funding for education, training, and capacity building related to aging with HIV care.
- Expand workforce funding and support from government agencies, including loan repayment programs.

FIGURE 2. RECOMMENDATIONS ALIGNED TO THE GERIATRICS 6Ms

Each recommendation is mapped to its primary M domain. Modifiable applies universally: every recommendation listed is modifiable through structural and policy change, which is reflected by a dot in the Modifiable column for all 17 items. Adapted from AGS 5Ms (Tinetti, Molnar, Huang, 2017) with the 6th M added by Erlandson and Karris (2019).[2, 19]

POLICY DOMAIN/ RECOMMENDATION	MOBILITY	MIND	MEDICATIONS	MULTI-COMPLEXITY	MATTERS MOST	MODIFIABLE
Ryan White HIV/AIDS Program						
1. Maintain and expand ADAP			●			●
2. Allow RW-funded care to address transport and care coordination	●			●		●
3. Support routine frailty, functional, and geriatric screening	●			●		●
4. Fund clinical pharmacist consultation for polypharmacy			●			●
5. Protect RW Part F (AETCs, SPNS) to build workforce capacity		●		●		●
6. Invest in HIV aging workforce pipeline (HRSA, NIH, NIA)	●	●				●
7. Integrate behavioral health into RW and FQHC settings		●		●		●
8. Require routine validated MH screening (PHQ–9, GAD–7)		●				●
Older Americans Act and S.2120						
9. Lower OAA eligibility to age 50 for PWH (S.2120)	●			●	●	●
10. Extend OAA nutrition and transportation earlier in aging trajectory	●				●	●
11. Integrate HIV-component case management into Aging Network				●	●	●
Medicaid, Medicare, and Civil Rights						
12. Protect Medicaid from cuts, per-capita caps, and work requirements				●	●	●
13. Make Medicare telehealth for HIV primary care permanent	●					●
14. Expand Medicare reimbursement (CPT 99497/99498) for ACP and EOL				●	●	●
15. Enforce Section 1557 and maintain SOGI protections		●				●
16. Expand supportive housing with HIV-competent coordination	●				●	●
17. Align Medicare, Medicaid, and HIV policy as a single access agenda				●	●	●
Recommendations per 6M domain:	**7**	**5**	**2**	**9**	**7**	**17**

Background and Theoretical Frameworks

Three Populations

Individuals aged 50 and older comprise over 54% of those living with HIV in the United States, a demographic shift driven by the success of antiretroviral therapy.[34] For the purposes of this report, this population includes three groups:[1]

- Long-term survivors: people with HIV who have been living with the virus for 15 or more years and carry both the clinical legacy of earlier, more toxic treatment regimens and decades of cumulative stigma exposure.[50, 54, 55]
- Lifetime survivors: sometimes called "dandelions," who have lived with HIV since birth or early childhood and represent a generation of survivors whose existence was once considered improbable.[50, 54]
- Older people with HIV: those who acquired HIV at age 50 or older.

People aging with HIV often experience geriatric comorbidities 10 to 15 years earlier than the general population.[2, 3, 15, 16, 75, 79] Across the lifecourse, many face a higher burden of cardiovascular disease, metabolic complications, COPD, liver and kidney disease, neuropathy, lower bone density, cognitive decline, and cancer risk.[66, 73, 74, 75] HIV and geriatric systems of care remain poorly integrated, even as adults aged 65 and older are presenting with more advanced multimorbidity, frailty, and cognitive needs. In addition to these physical health challenges, many people aging with HIV experience loneliness and social isolation, which can worsen depression, anxiety, and overall quality of life.[6] These patterns make clear the need for an aging framework that reflects both clinical complexity and lived experience.

"Advocacy is key. Whether advocating for yourself in healthcare settings or standing up for others in the community, your voice is powerful. The fight for equity and access to care continues. Every step you take to educate yourself and others, push for progress, and live authentically is a testament to your strength."

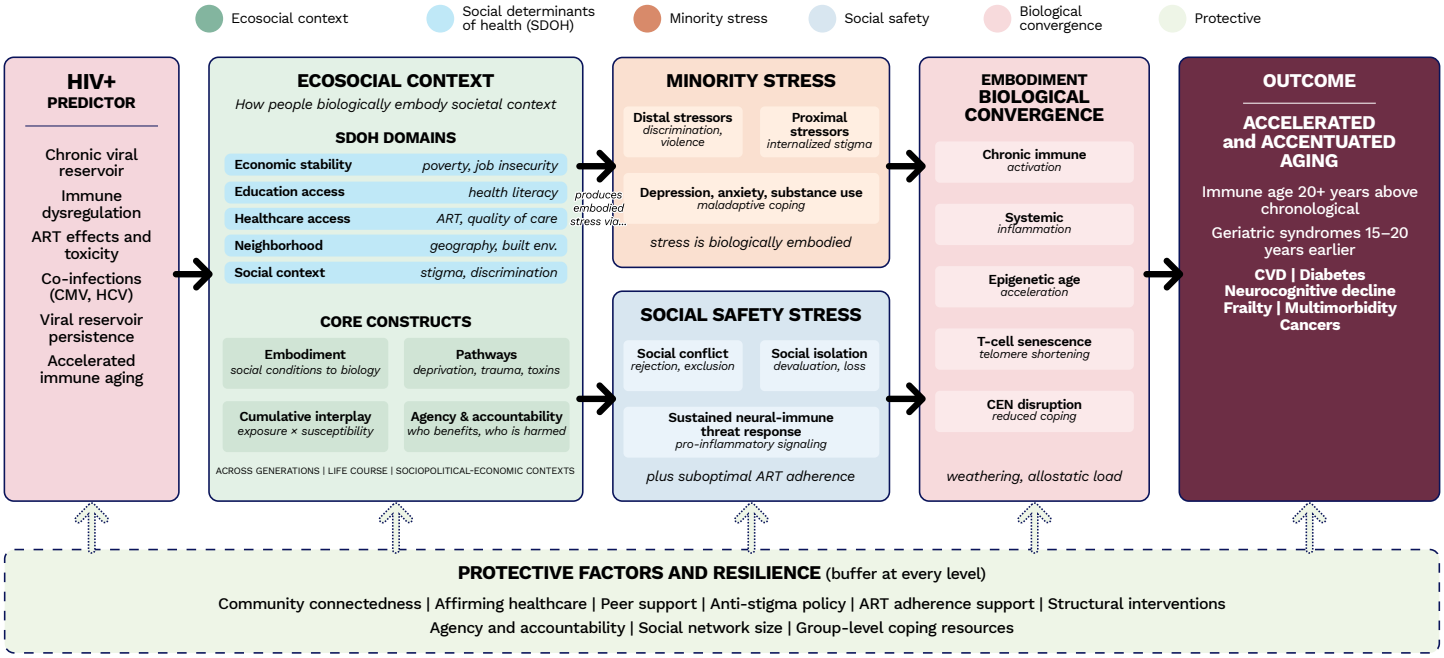
— 2026 STATE OF AGING WITH HIV™ NATIONAL SURVEY PARTICIPANT AGING WITH HIV

HIV-Mediated Accelerated Aging Conceptual Model

This report is grounded in three complementary frameworks. *(See Figure 3.)* Minority stress theory explains how stigma creates chronic stress above and beyond ordinary life stress,[8, 32] while ecosocial theory details how social exposures become biologically embedded across the lifecourse.[9, 35] Williams' detailed how these structural inequities, driven by discrimination and racial disparities, lead to repeated activation of stress-response systems, called allostatic load, resulting in preventable wear and tear on the cardiovascular, metabolic, immune, and neuroendocrine systems.[13, 14] Social safety theory provides a complementary lens on how the absence of trustworthy social ties amplifies physiological stress.[33] Together, these frameworks provide insight into why people aging with HIV may experience multimorbidity, frailty, and cognitive concerns earlier than peers without HIV, even when viral suppression is sustained.[15, 16, 17, 18, 39, 73, 74]

FIGURE 3. HIV-MEDIATED ACCELERATED AGING CONCEPTUAL MODEL

Companion graphic for the executive summary; integrates Krieger's Ecosocial Theory, Frost and Meyer's Minority Stress Framework, and Slavich's Social Safety Theory.

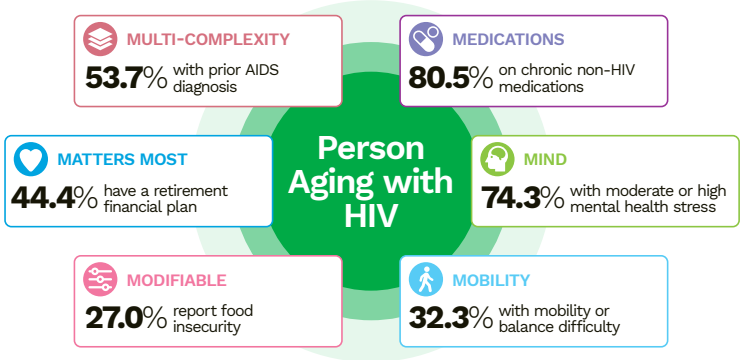


The Geriatrics 6Ms

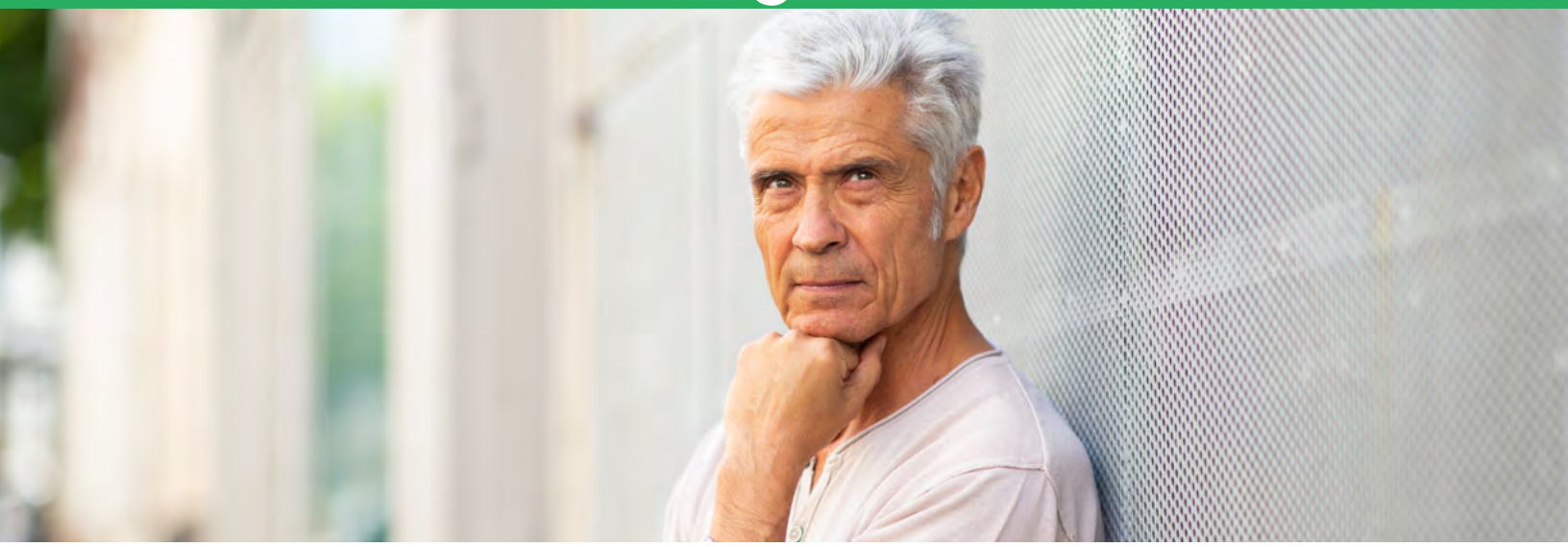
The 6Ms of geriatric care, *Mobility, Mind, Medications, Multi-complexity, Matters Most*, and *Modifiable*, provide an additional lens. *(See Figures 1 and 4.)* Here, Modifiable refers to social and structural factors that can be changed through policy, care design, communication, and practical support. For people aging with HIV, these domains are deeply connected: mobility and cognition affect care access, medication burden shapes daily life, multi-complexity reflects layered clinical burden, Matters Most centers patient goals, and modifiable factors such as stigma, transportation, housing, and care coordination often determine whether care is realistically reachable.[19, 80, 92]

FIGURE 4. THE GERIATRICS 6Ms APPLIED TO PEOPLE AGING WITH HIV

The framework centers the person aging with HIV and maps key findings across six connected domains.



Consumer Findings



Consumer Participant Profile

The consumer sample included adults aged 50 and older and people who had been living with HIV for at least 15 years. Most respondents had lived with HIV for many years, and nearly half had received an AIDS diagnosis. The sample was geographically broad and racially diverse, with responses from a range of urban and non-urban settings and from people across income levels. These characteristics matter because aging with HIV is not one experience; it is shaped by treatment history, structural position, and access to support. *(See Figures 5 and 6.)*

Consumer Clinical Status: HIV Treatment Era Successes

Viral suppression has been above 93% across all five survey waves, reflecting sustained engagement across the HIV care continuum.[20] In 2026, 98% of consumers report viral suppression and 99% are on antiretrovirals. Polypharmacy is near-universal: more than 80% report at least one chronic non-HIV medication, and 22% have adjusted ART because of drug-drug interactions with non-HIV medications. The 2021 dip to 85% viral suppression among low-income consumers, which fully recovered to 97% by 2026, is direct evidence that Ryan White HIV/AIDS Program re-engagement infrastructure works when activated and that disruption produces measurable clinical harm.

FIGURE 5. HEALTH AND STRESS PROFILE AMONG CONSUMER PARTICIPANTS, 2026 (N=365)

Left: physical health. Center: quality of life. Right: mental health stress in the past six months.

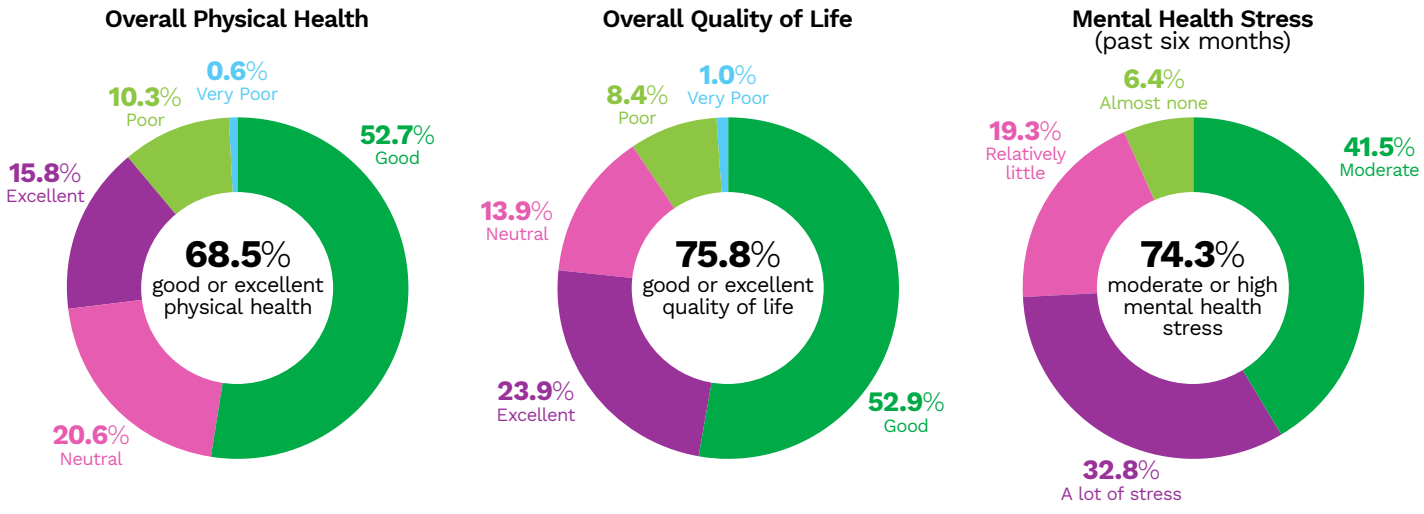
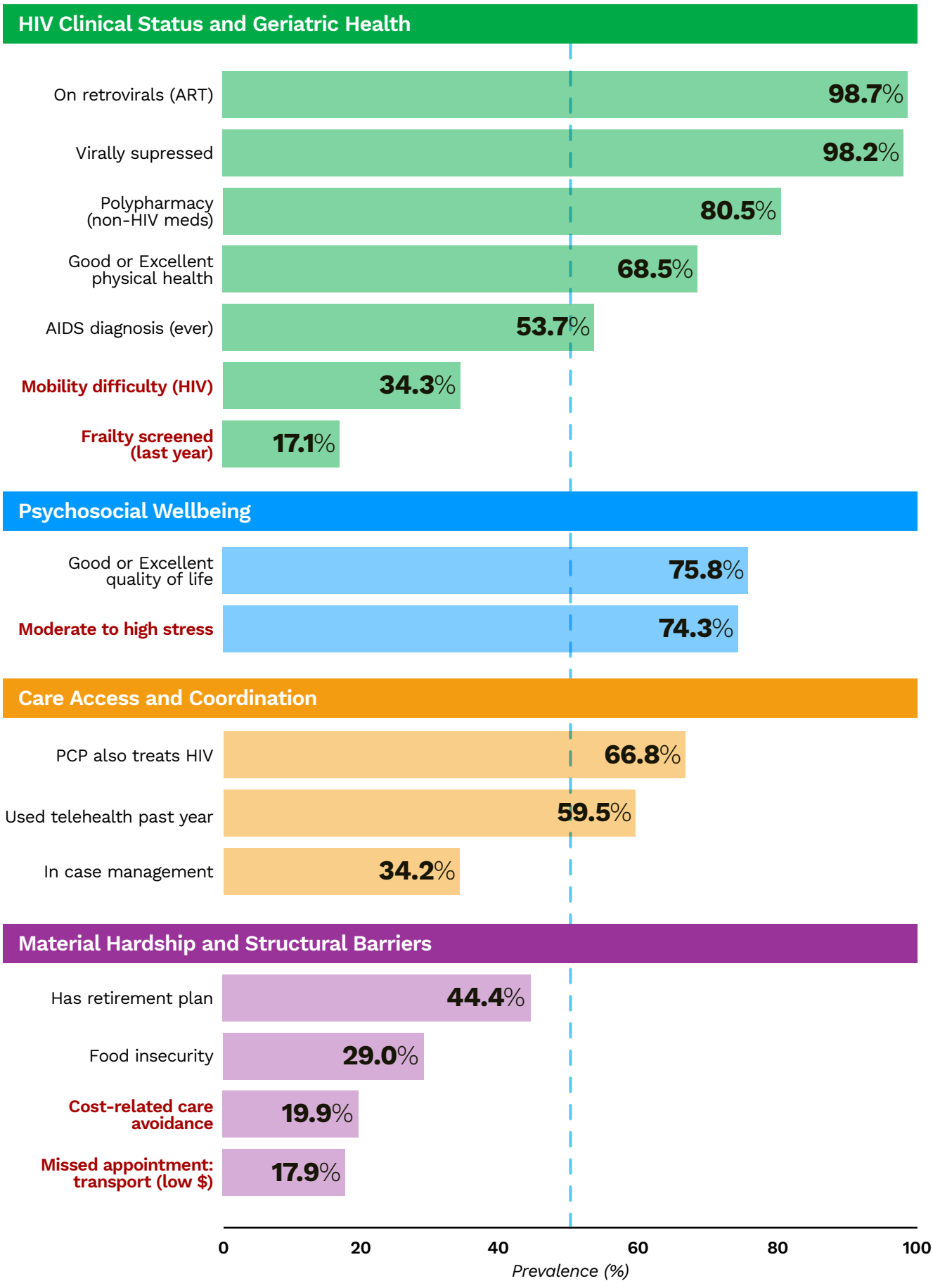


FIGURE 6. KEY CONSUMER OUTCOMES, 2026 (N=311 TO 365)

Red indicates priority concerns. Point position represents prevalence; label shows exact percentage.



Geriatric Burden, Structural, and Psychosocial Indices

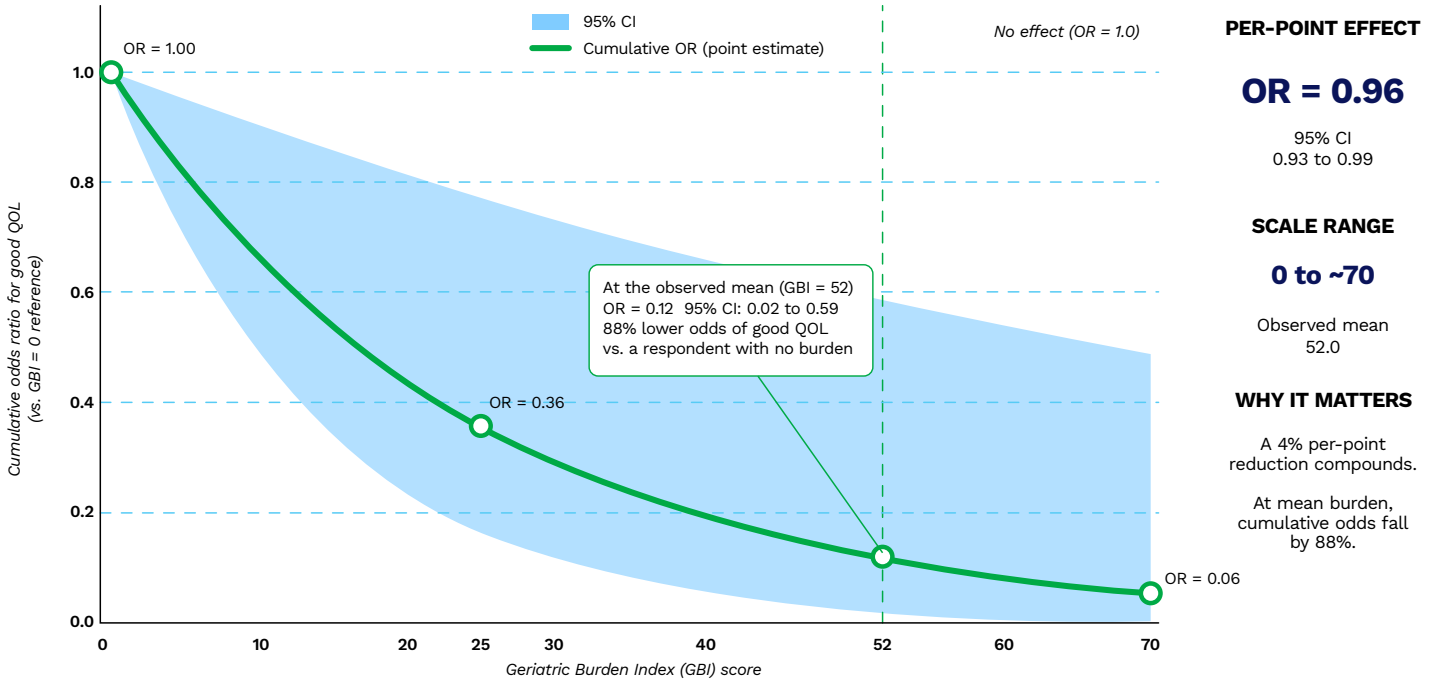
The Geriatric Burden Index (GBI) is a 5-component composite aligned with the Geriatrics 6Ms framework (Mobility, Mind, Medications, Multicomplexity, Matters Most, and Modifiable), adapted for HIV-specific aging by incorporating chronic medication burden, perceived stress, and lifetime AIDS diagnosis history alongside mobility limitation and ADL need. The five components are weighted equally and rescaled to a 0 to 100 metric, with higher scores indicating greater geriatric burden, consistent with the deficit-accumulation logic of established frailty indices.[15, 16, 42, 82, 83]

In this study, LGBTQ+ consumers carried a mean GBI of 54 compared to 44 for straight consumers, reflecting documented physiological consequences of chronic minority stress, while Black/African-American consumers carried a GBI of 42 compared to 56 for White consumers, a 14-point difference.[8, 14, 29, 32, 60, 61] This pattern may reflect cultural differences in self-reported health; however, Black/African Americans often show elevated cortisol and flatter diurnal cortisol slopes even when not reporting perceived stress, a marker of HPA axis dysregulation (weathering) driven by chronic exposure to racial discrimination.[11, 14, 86, 87, 93, 94]

The Structural Vulnerability Index (SVI) operationalizes the structural vulnerability framework[84, 85, 95] as a count of six binary structural disadvantages (low income, food insecurity, housing instability, transportation barrier, cost-related care avoidance, lack of retirement plan; range 0 to 6), capturing cumulative exposure to material and institutional disadvantage. The Minority Stress Burden Score (MSBS), in turn, operationalizes Meyer's minority stress framework,[8, 29] summing four minority stress exposures (any discrimination, ageism in healthcare, homophobia or transphobia, internalized HIV stigma; range 0 to 4) to capture cumulative exposure to identity-based and stigma-related stressors.[88, 89, 90, 91] After controlling for the GBI and each other, both indices significantly predict high mental health stress (SVI: OR=1.04 per 1-point increase, p<0.001; MSBS: OR=1.12 per 1-point increase, p<0.001), confirming that structural exposures and minority stress each feed the stress pathway independently. Once stress is held constant, neither index directly predicts QOL or physical health, indicating that the harm of structural and minority stress exposures travels through stress to reach health outcomes. *(See Figure 7.)*

FIGURE 7. PER-POINT EFFECT OF THE GERIATRIC BURDEN INDEX ON QUALITY OF LIFE

Multivariable logistic regression among consumer participants, 2026 (N=365). Per-point OR=0.96 (95% CI: 0.93 to 0.99); at the observed mean GBI of 52, cumulative OR=0.12 (95% CI: 0.02 to 0.59), an 88% lower odds of good QOL versus a respondent with no burden.



GBI is a composite of functional limitations, fall history, polypharmacy, and frailty indicators (range 0 to 70). Cumulative OR = per-point OR raised to the GBI score. Model adjusted for sociodemographic and clinical covariates.

Consumer Mental Health and the Stress-Health Paradox

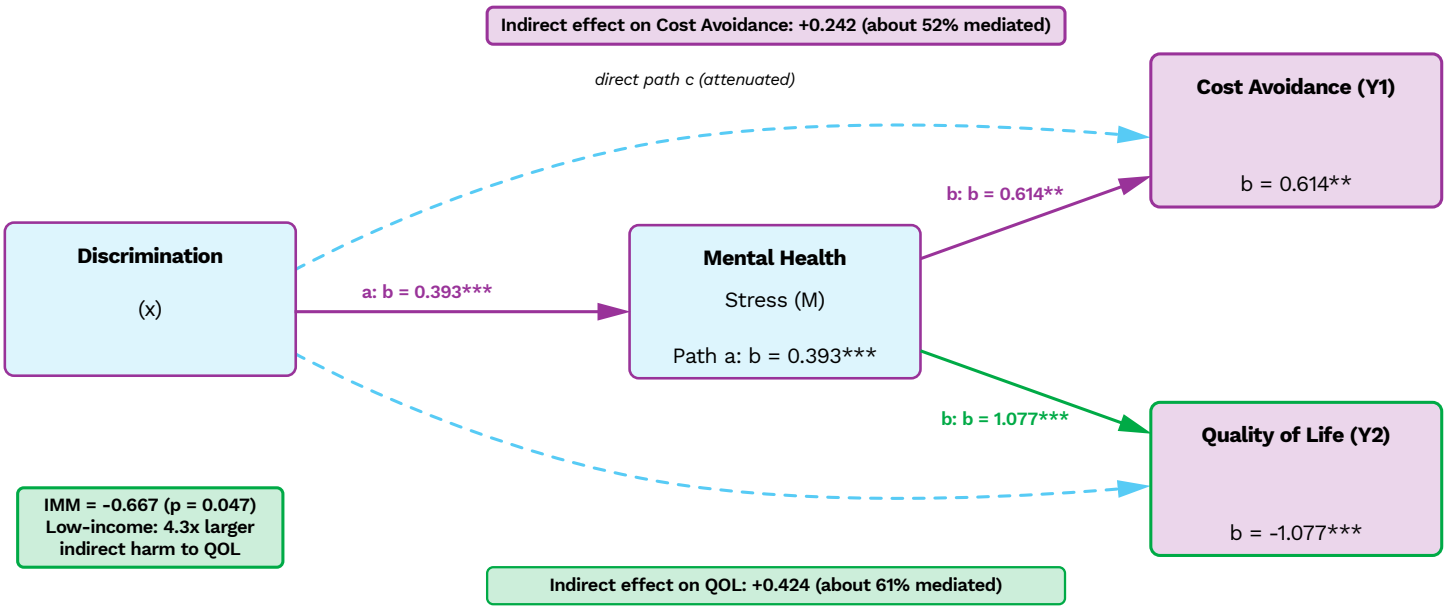
Just under three-fourths of consumers (74%) report moderate or high mental health stress, yet only 2% name mental health as their most immediate need. Mental health in this cohort is experienced as the texture of life with HIV, not as a presenting complaint. It will not surface in clinical encounters unless providers screen for it explicitly. Yet 76% report good or excellent quality of life despite the stress burden. This finding speak to the Stress-Health Paradox, a phenomena that reflects five convergent mechanisms: (1) domain separation between HIV management and psychosocial burden; (2) response shift among long-term survivors who have recalibrated what constitutes good QOL; (3) survival selection, as the most vulnerable members of this cohort did not survive to participate; (4) viral suppression as a clinical floor that prevents the worst functional decline; and (5) the buffering effect of social networks. Understanding the paradox prevents two equally dangerous errors: reading good QOL data as the absence of need, or dismissing the stress burden because QOL appears high.

Consumer Discrimination and Mediation

Discrimination is common, age-inverted, and concentrated. Among survey respondents, one half of those with HIV under age 50 reported experiencing any discrimination, compared with 24% of consumers aged 65 and older. People with a current or prior AIDS diagnosis, those facing transportation barriers, and women, transgender, and gender-nonconforming individuals face greater odds of discrimination exposure. *(See Figure 8.)*

Discrimination harms quality of life through a stress pathway, consistent with stigma operating as a fundamental cause of population health inequalities.[22, 76] The mediation model traces this step by step: discrimination first elevates stress (path a, $p<0.001$). That stress depletes the cognitive and material resources needed to navigate care, maintain appointments, and sustain quality of life (path b, $p<0.001$ for QOL; $p=0.003$ for cost-related care avoidance). The indirect effect on QOL is 0.42, accounting for roughly 61% of discrimination's total harm to QOL, while indirect effect on care avoidance is 0.24, accounting for approximately 52%.[27, 28]

FIGURE 8. MEDIATION MODEL: DISCRIMINATION, STRESS, AND DOWNSTREAM OUTCOMES (BARON-KENNY SEQUENTIAL OLS)
Solid arrows indicate confirmed mediation pathways; dashed arrows indicate attenuated direct effects. The bottom box shows the Index of Moderated Mediation for low-income consumers.



The moderated mediation analysis quantifies how much worse this causal chain becomes when discrimination intersects with poverty. The Index of Moderated Mediation is 0.667 (p=0.047), meaning the indirect effect of discrimination on QOL is significantly larger for low-income consumers. Specifically, the indirect harm is 4.3 times larger in the low-income group. This is not because low-income people respond to discrimination more emotionally. It is because they have no material cushion. They cannot change providers, absorb a lost workday, cover last-minute childcare for a rescheduled appointment, or pay out of pocket through a different channel.[11, 12, 29, 63, 70, 76]

Consumer Social Connection and Buffering

Social network size is the most consistently replicated predictor of QOL in this dataset. Across five independent analytic methods, OR=2.40 (95% CI: 1.63 to 3.52, p<0.001), meaning people aging with HIV with larger social networks have more than twice the odds of reporting good quality of life. Social connection independently reduces stress (OR=0.66, 95% CI: 0.44 to 0.98, p=0.042) and holds after controlling for income, food insecurity, mobility, discrimination, clinical status, and insurance. It is not a proxy for income or education; in block regression it remains significant after controlling for every other variable in the model.[6, 33] *(See Figure 9.)*

Consumer Latent Class Analysis: Five Profiles of Aging with HIV

Latent class analysis reveals that the average consumer does not exist. Five distinct profiles emerge from 11 binary indicators (BIC = −6121.5, N=311). Class membership counts and percentages below sum to N=311 with rounding.

- **Minimal Needs Consumers** (18%). Lowest-burden profile. No high stress or mobility difficulty; minimal food insecurity, discrimination, or ADL needs. Telehealth and social network at sample averages.
- **High Clinical, Connected Consumers** (22%). Highest clinical complexity paired with intact psychosocial scaffolding. Chronic medication, mobility difficulty, ADL assistance, and telehealth all near top of sample; mental health stress, food insecurity, and discrimination all moderate. Highest social network breadth (68% report four or more close people). Half report retirement planning. Clinically heavy, psychosocially buffered, structurally engaged. The outcome the HIV care system is designed to produce; the minority who actually receive it.
- **Low-Moderate Needs Consumers** (23%). Emerging burden without crisis. Stress, discrimination, and mobility difficulty present but contained; chronic non-HIV medication burden signals the early clinical weight of aging. Most likely to benefit from preventive intervention before complexity crosses a threshold that requires intensive case management.
- **High-Needs, Resource-Dependent Care Consumers** (9%). Smallest group, most visible to the safety net. Universal food insecurity, high chronic medication burden, more than half report high stress; highest case management and telehealth use in the sample. Outside those service touchpoints, buffering is thin: retirement planning is nearly absent and only 28% report a social network of four or more. A system-touching group, not a system-failing one.
- **Very High, Unmanaged Care Consumers** (27%). The defining finding of this LCA: more than one in four consumers in the sample. Universal chronic non-HIV medication burden, universal discrimination exposure, universal high mental health stress, and no frailty screening. ART reaches them; geriatric care, behavioral health, and structural support do not. This is a care absence, not a care gap. *(See Figure 10.)*

FIGURE 9. FOREST PLOT OF SIGNIFICANT REGRESSION FINDINGS FROM POOLED CONSUMER ANALYSES, 2020 TO 2026

Log-scale OR on the x-axis. Color: light blue indicates social predictors; medium blue indicates structural predictors; navy indicates clinical predictors; red indicates discrimination.

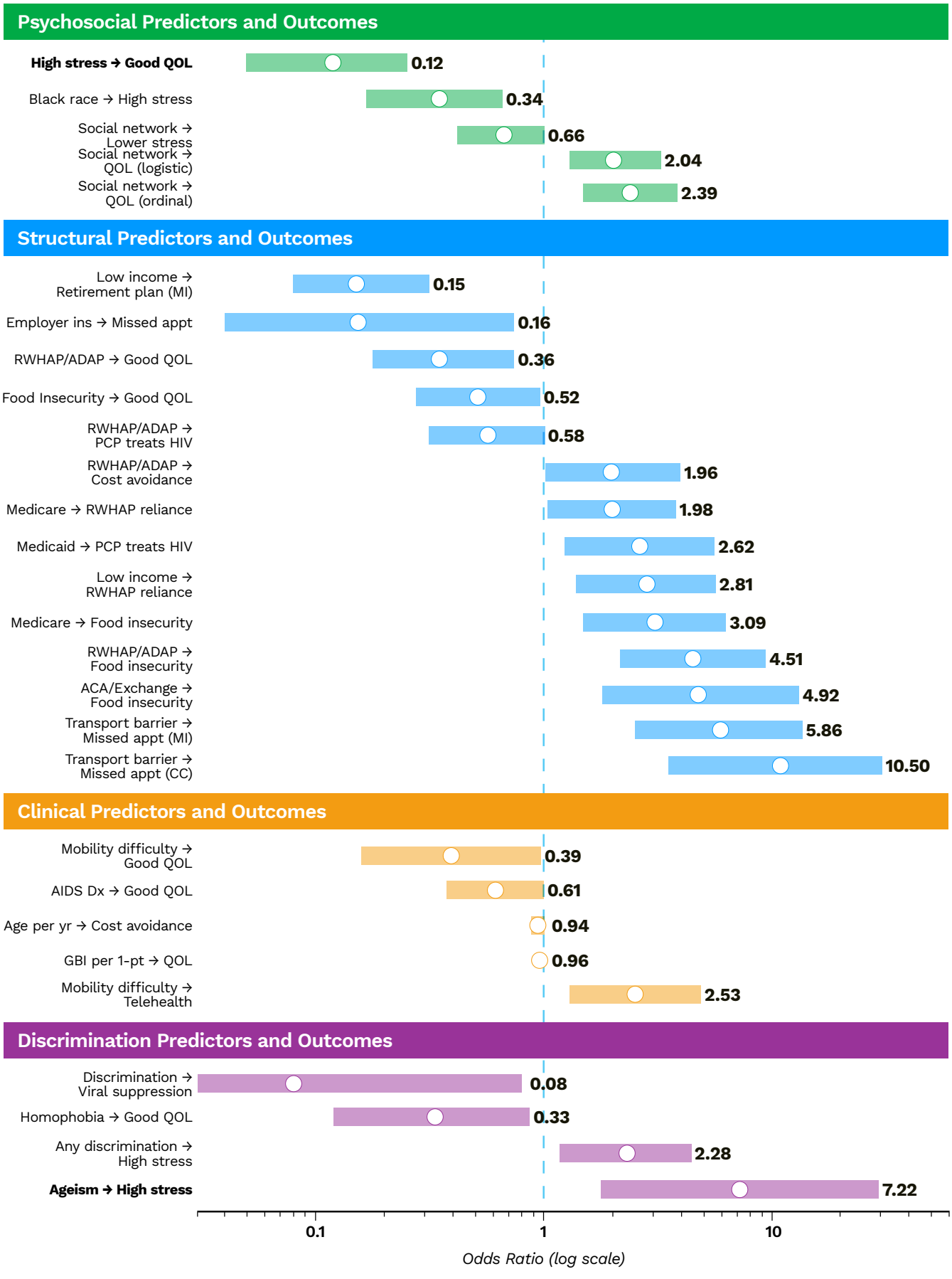
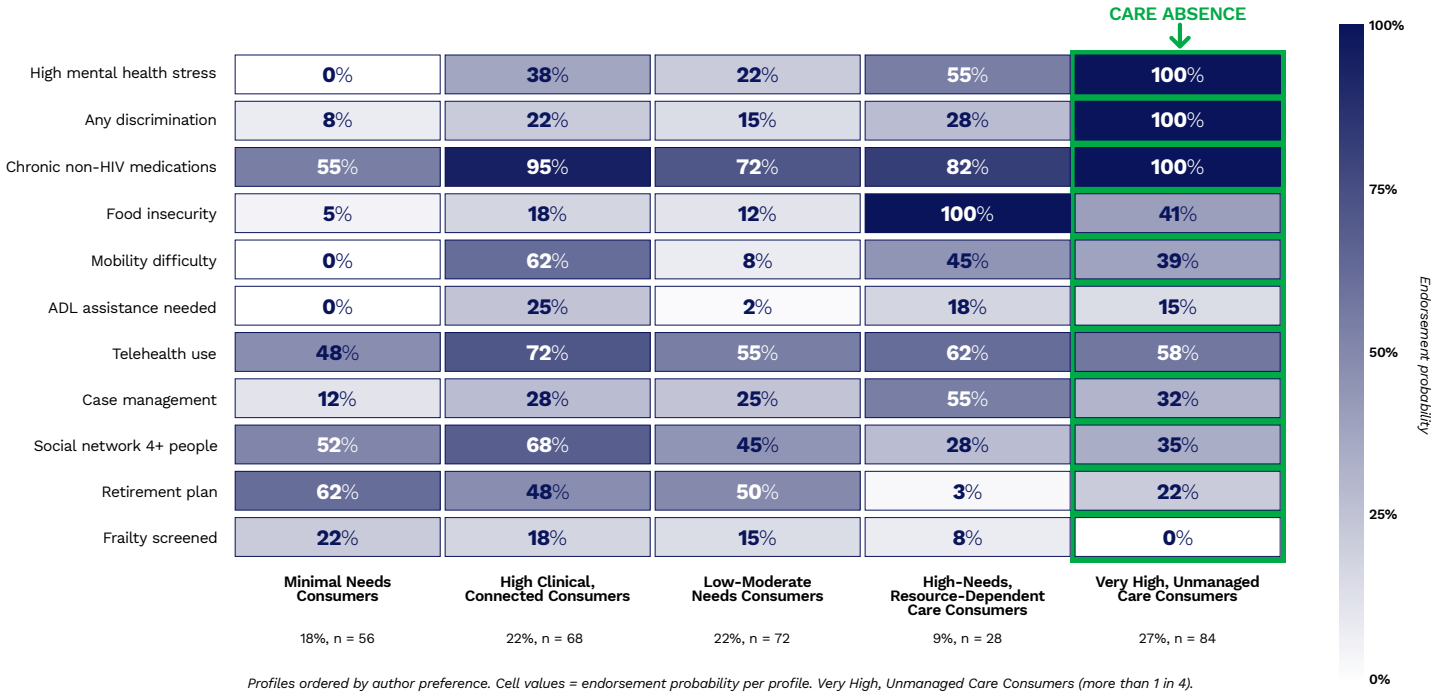


FIGURE 10. CONSUMER LATENT CLASS ANALYSIS HEATMAP, FIVE-CLASS SOLUTION (BIC=−6121.5, N=311)

Blue intensity reflects endorsement probability (white=0%, dark navy=100%).



Profiles ordered by author preference. Cell values = endorsement probability per profile. Very High, Unmanaged Care Consumers (more than 1 in 4).

Consumer Care Access and Coordination

Two-thirds of consumers (67%) have a primary care provider who also treats their HIV, while just over one-third (34%) work with a case manager, and less than one-fifth (18%) with a peer navigator or wellness coach. Telehealth use has remained strong since the pandemic, with nearly 60% reporting telehealth use in the past year. Nearly three-fourths of consumers with mobility limitations reported using telehealth in the past year (compared to 52% of those with mobility issues), highlight its power to connect people to care (OR=2.53, p=0.007). Removing telehealth would close the door for a specific subset of consumers who cannot otherwise reach a clinic. *(See Figure 11.)*

FIGURE 11. HIV MEDICATION INSURANCE COVERAGE AMONG CONSUMER PARTICIPANTS, 2026 (N=367)

Center statistic: 51.7% of Medicare enrollees still rely on the Ryan White HIV/AIDS Program and AIDS Drug Assistance Program.

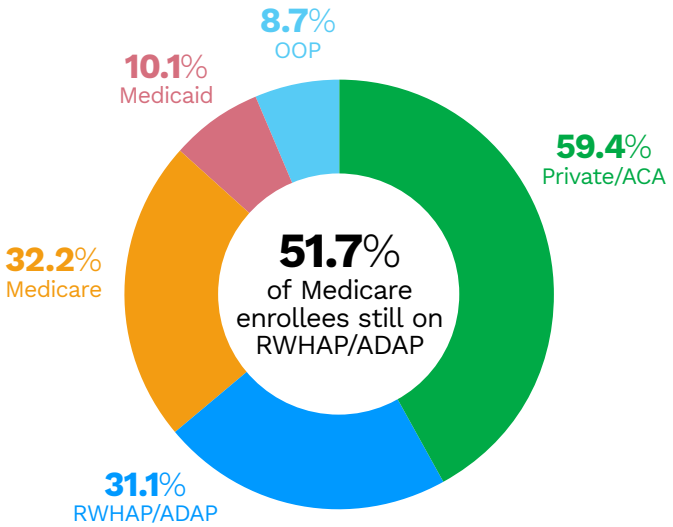
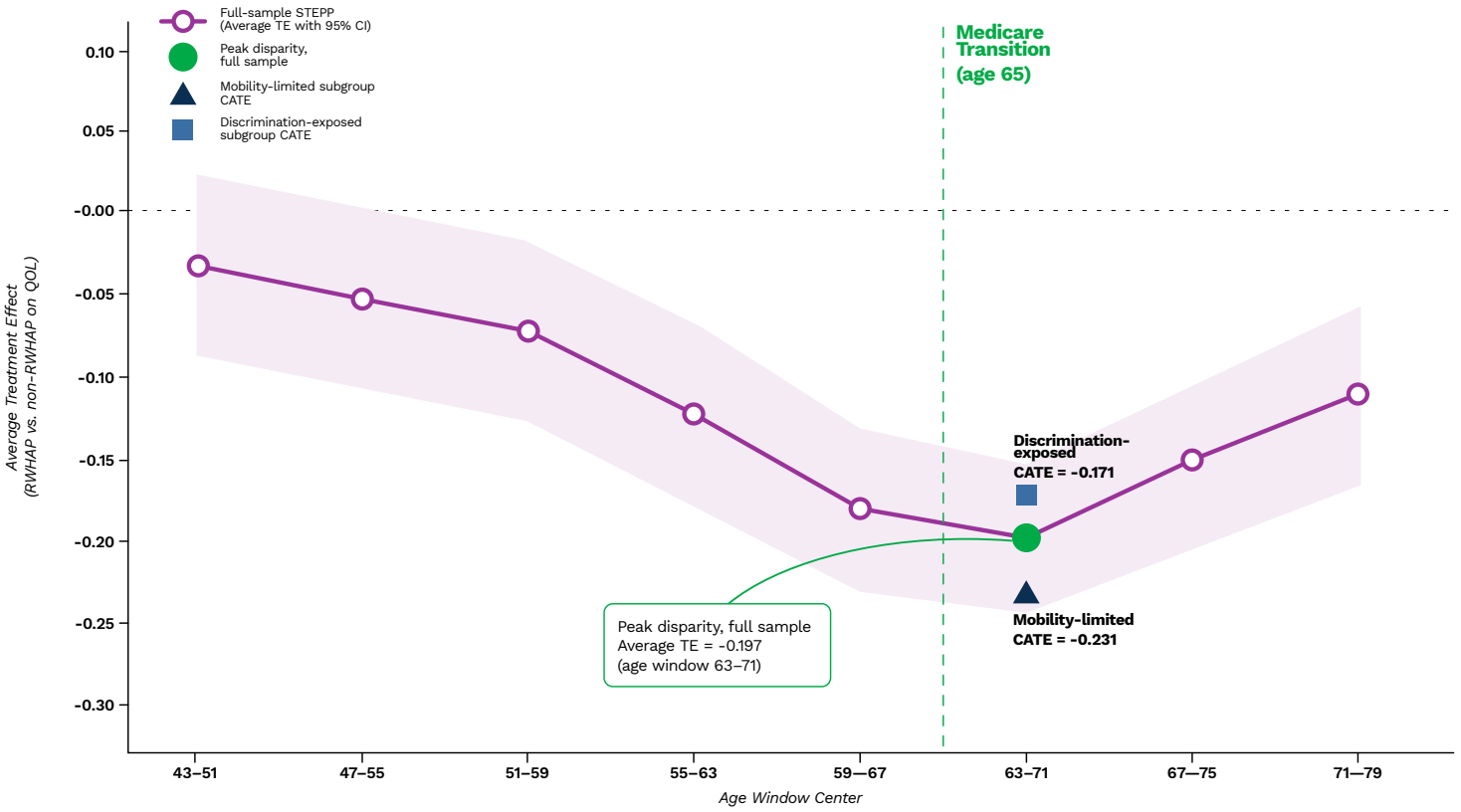


FIGURE 12. STEPP ANALYSIS: RYAN WHITE HIV/AIDS PROGRAM VS NON-RWHAP QUALITY-OF-LIFE DISPARITY BY AGE WINDOW

Confidence band shaded. Red dashed line marks the Medicare transition at age 65; peak disparity occurs around the transition.



Low income is independently associated with 84.5% lower odds of having any retirement plan ($p<0.001$), signaling high financial risk in a cohort whose median age now exceeds 55, a consequence of a generation that, for much of the epidemic's early decades, planned around a shorter life. Food insecurity, reported by just over 30% of participants, is associated with lower QOL ($p=0.016$). Among low-income consumers, 20% reported cost-related care avoidance and 18% missed an HIV-related appointment due to transportation barriers (OR=5.86, $p<0.001$). Substance use increased the odds of health care discrimination, opioid use nearly quadrupled the odds of cost-related care avoidance. (See Figure 13.)

FIGURE 13. SUBSTANCE USE AND SELECTED HEALTH OUTCOMES AMONG PEOPLE AGING WITH HIV

Logistic regression, lifetime substance exposure (any vs never), adjusted for age, low income, male gender, and AIDS diagnosis (N=230 to 260).

ALCOHOL (ANY USE)
→ Healthcare discrimination

2.59

95% CI 1.02 to 6.61

UNFAVORABLE

OPIOID (ANY USE)
→ Cost-related avoidance

3.72

95% CI 1.16 to 11.88

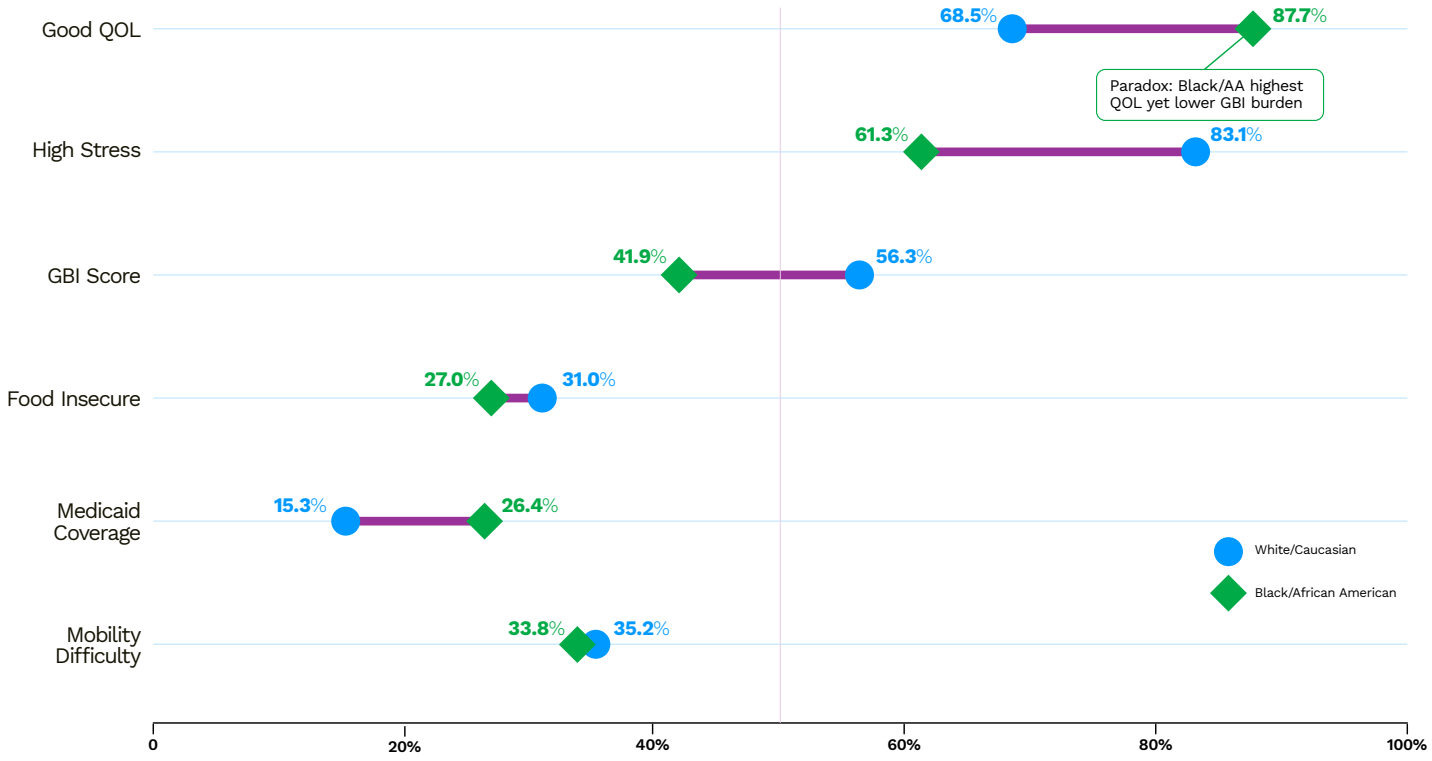
UNFAVORABLE

Consumer Stratified Outcomes

Race-stratified

Black/African-American consumers report higher QOL (88% vs 69%, p<0.01) and lower high stress (61% vs 83%, p<0.001) than White consumers, despite higher Medicaid use, similar food insecurity, and a GBI of 42 compared to 56. This finding speak speaks to the Stress-Health Paradox, with Black/African-American race independently predicting two-thirds lower odds of high stress (OR=0.34, 95% CI: 0.18 to 0.64, p<0.001). *(See Figure 14.)* The pattern reflects documented response shift, survival selection, and distinct frameworks for appraising QOL drawn from community, faith, and the identity of having survived.5,14,21,64,65,67,68,69,76,78 Among consumers 65 and older, Black/African-American consumers have the lowest PCP-HIV integration (47% vs 73% White, p=0.030); the resilience advantage does not translate into care-system equity.

FIGURE 14. RACE-STRATIFIED OUTCOMES, CONSUMER 2026

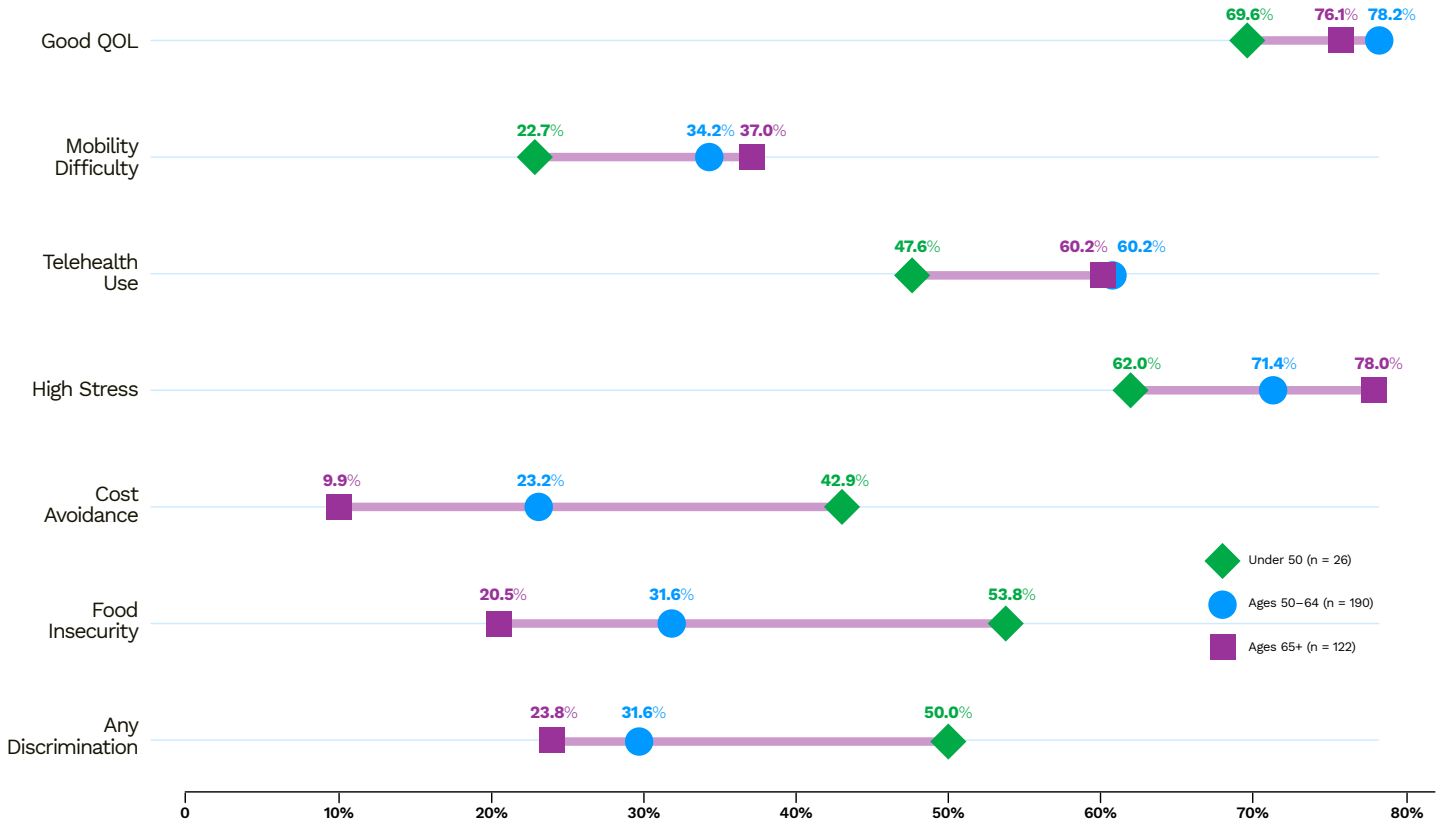


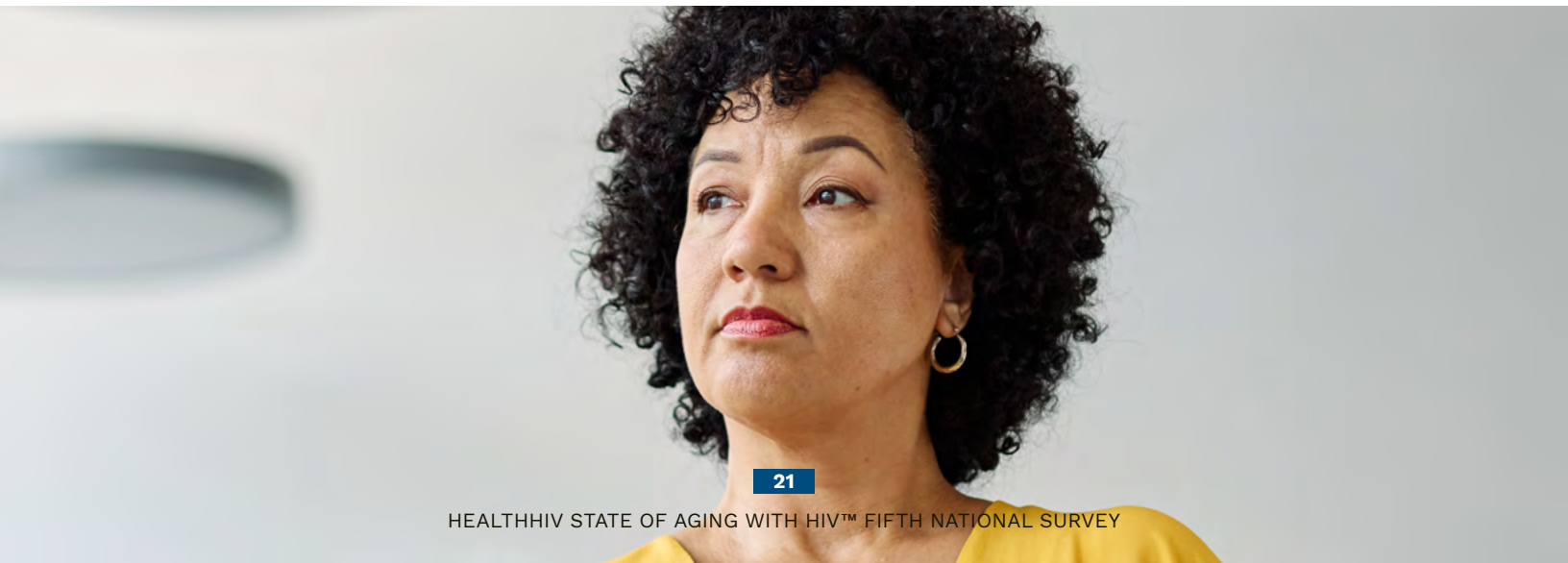
Age-stratified

Among consumers under 50 (n=26), discrimination, food insecurity, and cost avoidance are highest. *(See Figure 15.)* Younger consumers entering care today face more than double the discrimination of long-term survivors. This contradicts the assumption that HIV stigma accumulates only with age and argues against complacency about anti-discrimination protections.

Telehealth use is similar across age groups (48% to 61%), refuting the digital divide narrative for this population. Note: under-50 cell n=26; subgroup confidence intervals are wide and findings should be interpreted with appropriate caution.

FIGURE 15. AGE-STRATIFIED CONSUMER OUTCOMES, 2026

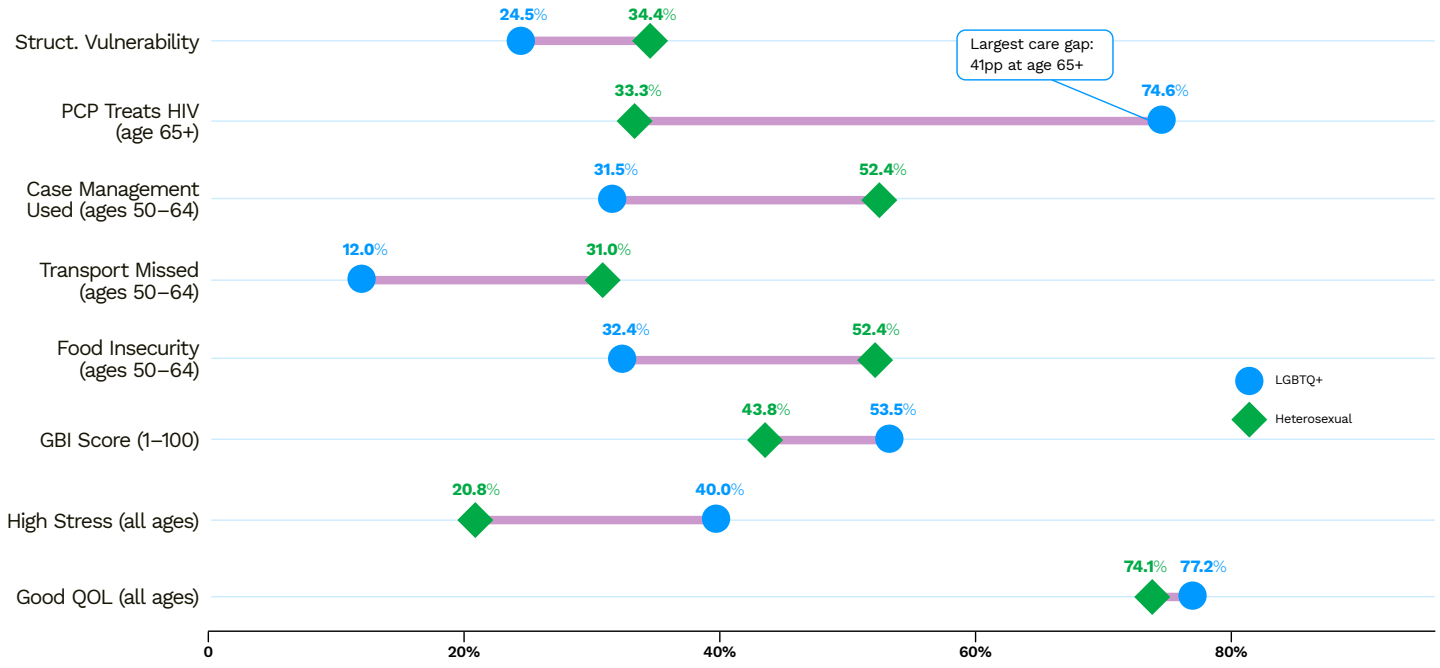




Gender identity

LGBTQ+ consumers carry more stress and more geriatric burden; straight consumers carry more structural vulnerability and worse care integration at older ages. *(See Figure 16.)* LGBTQ+ high stress is 40% versus 21% for straight consumers. Straight consumers aged 50 to 64 face significantly more food insecurity (52% vs 32%, p=0.024) and missed transportation appointments (31% vs 12%, p=0.007). The infrastructure explanation: LGBTQ+-centered HIV care settings produce measurably better PCP-HIV integration at age 65 and older (75% vs 33%, p=0.003), the largest single care-access gap in the dataset.[7, 23]

FIGURE 16. LGBTQ+ VS STRAIGHT STRATIFIED OUTCOMES

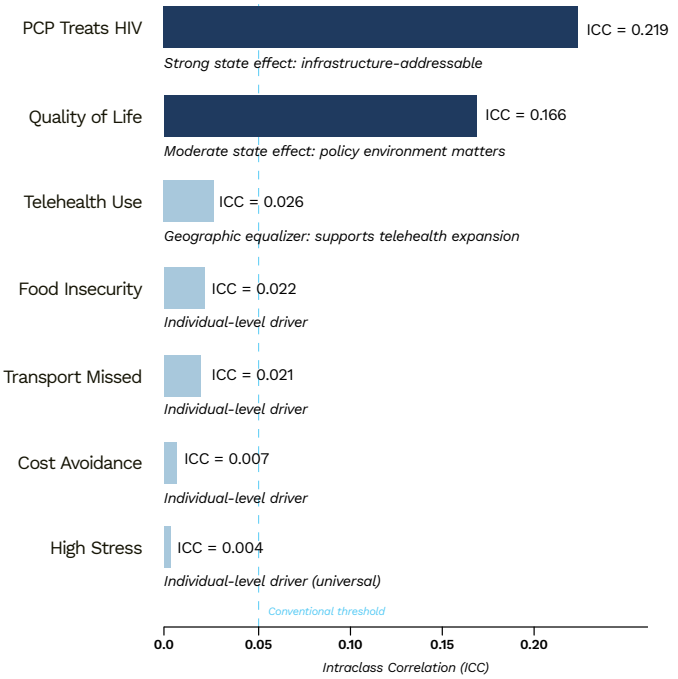


Consumer Multilevel Analysis (State-Level)

Not all outcomes are equally shaped by where you live. Whether your primary care doctor also treats your HIV (ICC=0.219) is substantially determined by state-level factors. Whether you are food insecure (ICC=0.022) or experience high stress (ICC=0.004) is driven almost entirely by individual-level factors. Telehealth has an ICC of 0.026, near zero, the geographic equalizer. The proportion of providers in a state reporting that their patients experienced discrimination negatively predicts PCP-HIV integration at the consumer level (MLM coefficient=−0.75, 95% CI: −1.36 to −0.13, p=0.018). Discrimination is a healthcare system problem that operates across levels. *(See Figure 17.)*

FIGURE 17. INTRACLASS CORRELATIONS (ICC) FOR SEVEN OUTCOMES ACROSS 37 STATES

Darker blue indicates stronger state clustering (policy-addressable); light blue indicates near-zero (individual-level driver). Threshold line at ICC=0.05.



Provider Findings

Provider Participant Profile

N=341 providers from 37 states, Puerto Rico, and the District of Columbia answered questions about their patients' psychosocial needs, barriers to care, training needs, and strategies for HIV treatment and prevention in aging populations. Eligible participants included healthcare providers, case managers, community health workers, behavioral health professionals, and policy advocates. The majority (72%) worked in non-profit or Ryan White HIV/AIDS Program clinical settings.

The 1-to-14 Geriatric Workforce Gap

Only 5 of 341 providers in the 2026 sample (1.5%) specialize in gerontology, compared to 70 (21%) in HIV medicine. The 1-to-14 ratio is itself the finding: a cohort with a Geriatric Burden Index of 52 at mean age 61, functionally equivalent to HIV-negative adults aged 75 to 80, is being served by a workforce trained to manage the virus rather than the aging that now defines the clinical encounter.[15, 16, 38, 75]

"Many clients diagnosed in the 1980s to 1990s era have expressed that they didn't plan on living so long. Many don't have financial savings because they were not expecting to be here, they have no retirement plans or future ideas."

CASE MANAGER, PENNSYLVANIA 340B DRUG PRICING PROGRAMS / HRSA RYAN WHITE HIV/AIDS PROGRAM COVERED ENTITY

Organizational Payor Mix

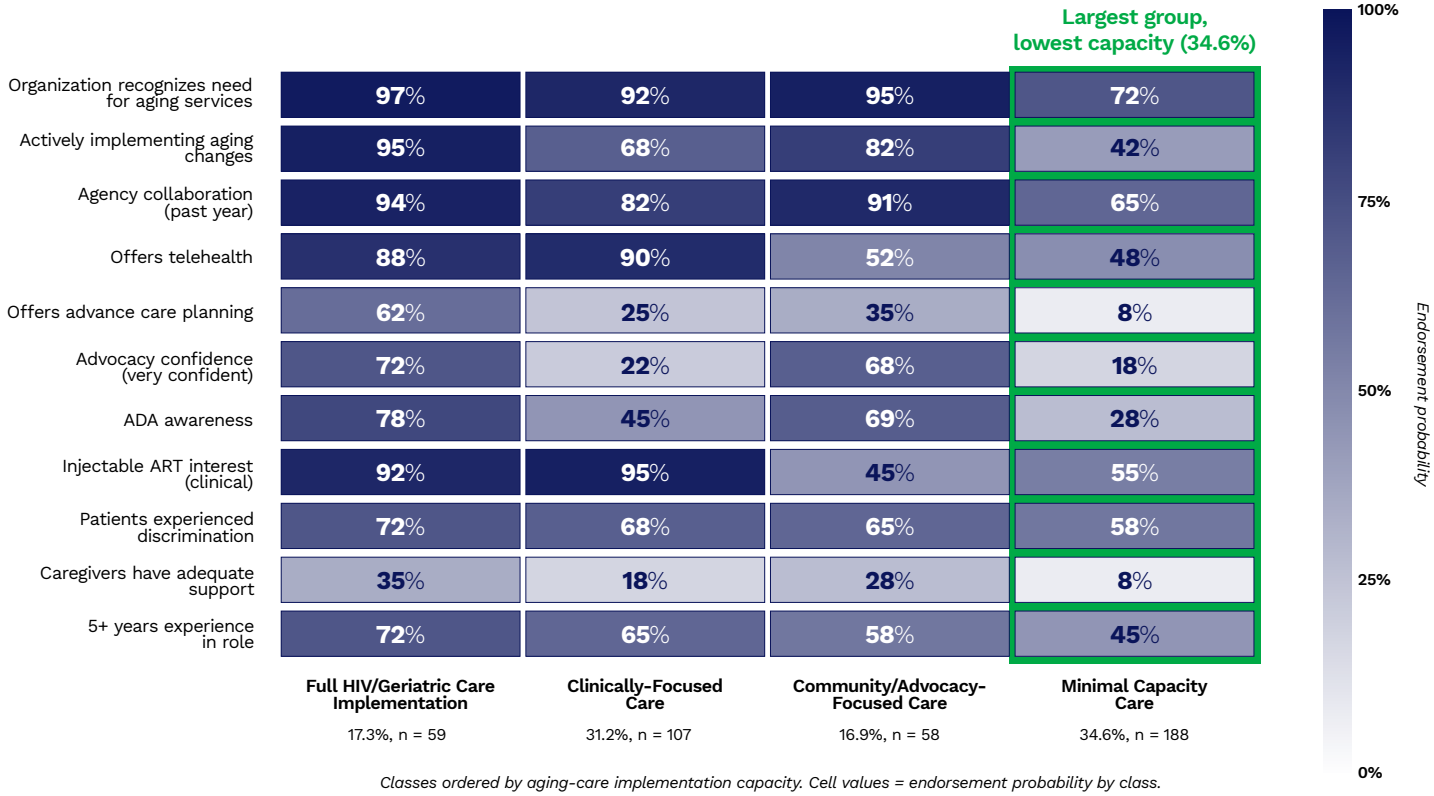
Nearly 72% of providers in this sample work in non-profit or Ryan White HIV/AIDS Program clinical settings, making these organizations the structural backbone of HIV care for people aging with HIV. Their capacity to serve is shaped by payor mixes. FQHCs accept an average of 3.3 payor types (Medicaid, Medicare, RWHAP/ADAP, private), while RWHAP/340B clinics accept 2.9, hospitals 2.8, and Non-profit community-based organizations just 1.0. The organizations closest to the most marginalized clients are therefore the ones least equipped to sustain services through reimbursable billing. Organizational infrastructure is the dominant driver of Medicare acceptance, which is consistent with payor type mix, after controlling provider role. FQHCs are 4.6 times more likely than other organizations to accept Medicare ($p<0.001$), and RWHAP/340B clinics 2.4 times as likely ($p<0.001$). Clinical provider role contributes modest independent odds ($p=0.040$). Overall, clinics with stronger infrastructures have the mechanisms in place to handle Medicare; smaller community organizations often cannot. Across all organization types, aging-care readiness lags, with only 25% offering advance care planning.

Provider Latent Class Analysis

LCA of the 2026 provider sample identified four distinct provider profiles based on eleven indicators spanning organizational recognition, program implementation, clinical service offerings, advocacy capacity, and workforce experience. Four groups (classes) of providers emerged (classes): *(See Figure 18.)*

- **Full HIV/Geriatric Care Implementation Providers** (17%). Benchmark group. Score high across every indicator: 97% recognize organizational need, 95% are actively implementing changes, 88% offer telehealth, 92% have injectable ART familiarity, 78% have ADA awareness, 72% report high advocacy confidence.
- **Clinically-Focused Care** (31%). Nearly one-third of providers have a strong clinical infrastructure, but narrow scope. They possess high injectable ART familiarity (95%), well-established telehealth (90%), nearly universal recognition (92%), but have less developed advance care planning knowledge 25% and advocacy confidence at 22%.
- **Community- and Advocacy-Focused Care** (17%). This group strong on collaboration and advocacy but limited clinical infrastructure. High agency

FIGURE 18. PROVIDER LATENT CLASS ANALYSIS HEATMAP, FOUR-CLASS SOLUTION (BIC-OPTIMAL, N=341).



Classes ordered by aging-care implementation capacity. Cell values = endorsement probability by class.

collaboration (91%), meaningful ADA awareness (69%), solid advocacy confidence (68%); but telehealth at 52%, injectable ART interest 45%, advance care planning 35%.

- **Minimal Capacity Care Providers** (35%). Among the largest group of providers, few provide advance directive planning (8%) and caregiver support (8%). Over one-fourth are aware of the ADA (28%) and 72% recognized to address the needs of people aging with HIV, but only 42% are actively implementing changes in their practice, which reflects a 30 pp recognition-to-action gap. These organizations see the problem clearly but lack the resources, staffing, and structural support to address it.

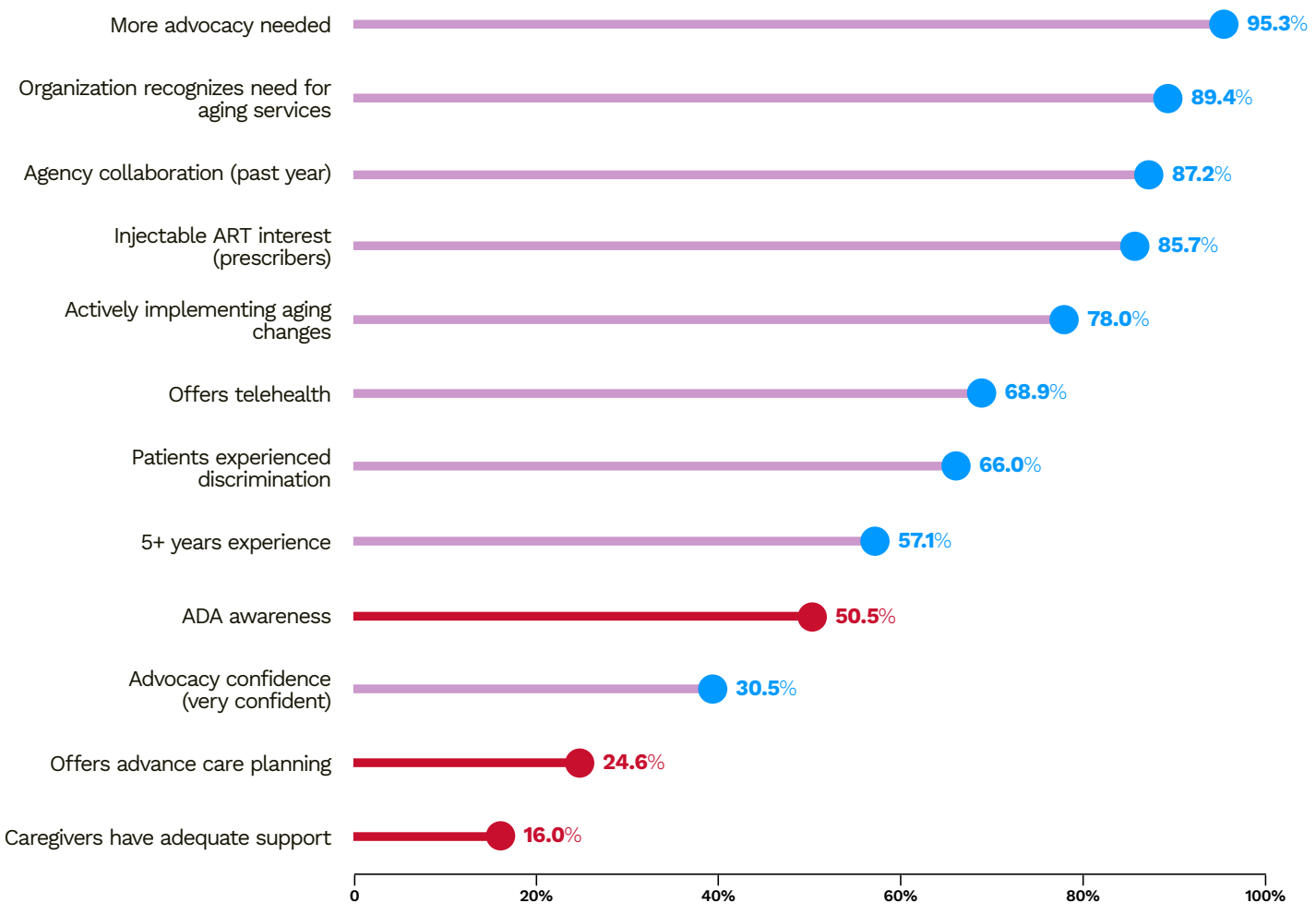
The pattern across all four groups confirms a structural finding: recognition of aging need is widespread, but the capacity to act on it is not. The group with the least capacity to act is the largest, and it is serving the patients who need the most.

Provider Outcomes and Aging-Care Readiness

Most respondents (90%) respondents believe their organization recognizes the need for services geared toward an aging population, but only 78% say their organization is actively implementing changes. Among providers, 87% reported collaborating with another agency to support people aging with HIV in the past year, while 86% of prescribers are interested in newer long-acting injectable HIV treatments. Nearly 70% offer telehealth, yet only one-fourth of provider organizations offer end-of-life or advance care planning services, despite serving a population that survived what was supposed to be a terminal illness. *(See Figure 19.)*

Studies repeatedly indicate that end-of-life planning is often overlooked and inaccessible in traditional care settings, particularly for people of color. Training and confidence gaps compound the problem: only 51% of providers are familiar with Americans with Disabilities

FIGURE 19. KEY PROVIDER OUTCOMES, 2026 (N=341)
Red items represent significant areas of concern or decline from 2024.



Act (ADA) protections that apply to their patients, and less than 40% feel confident advocating for aging patients, even though 95% agree that more advocacy is needed.[24] Nearly two-thirds of providers say their patients have experienced stigma or discrimination from healthcare providers due to their HIV status or age. Approximately one-half of providers reported that informal caregivers of older people with HIV require greater access to support, resources, and training, and that their older patients often feel lonely or isolated, though consumers themselves do not self-report at anything near this rate.

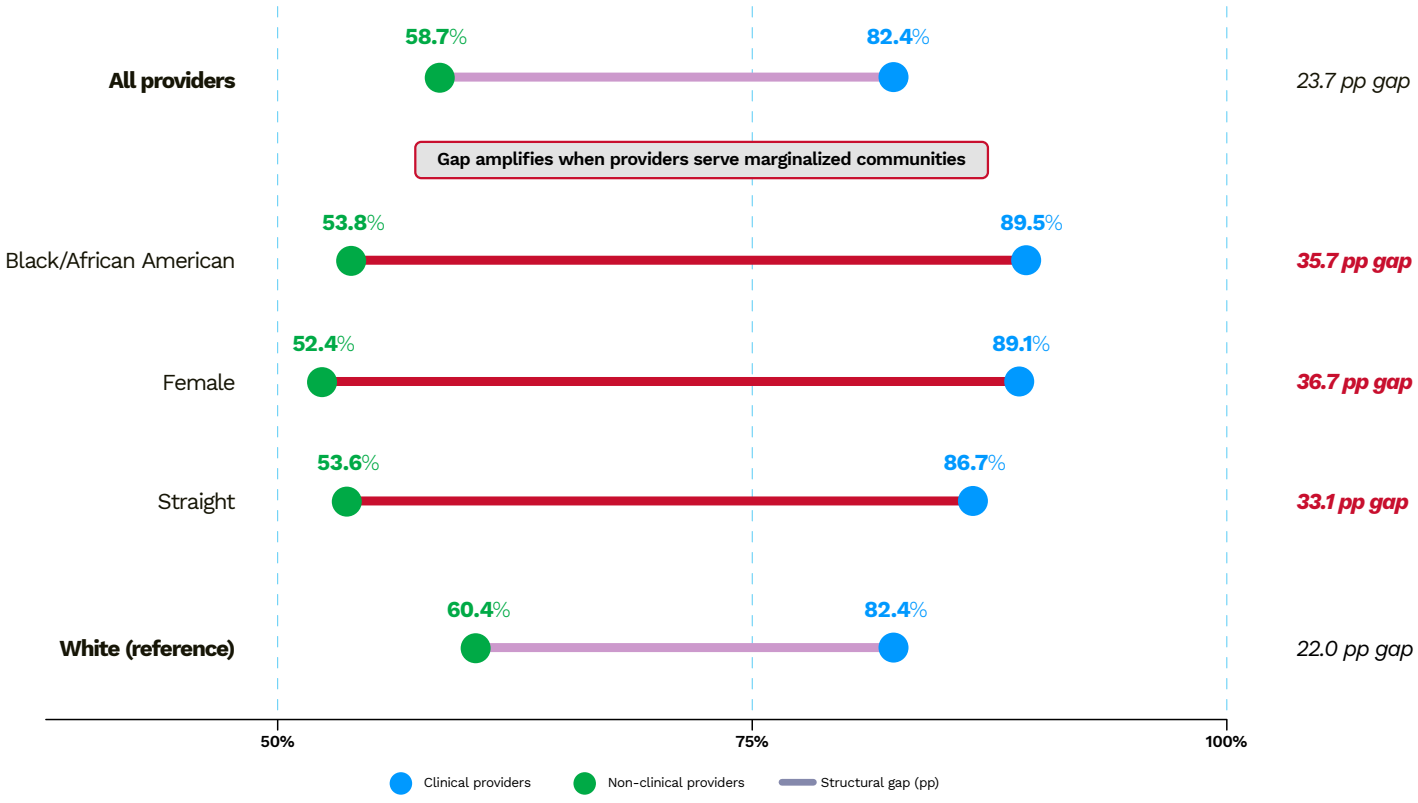
> "Isolation and cognitive decline is HUGE for our patients and more information on how to address this would be helpful to receive as a provider."
>
> – LCSW AT A MICHIGAN MEDICAL CENTER

Provider Telehealth Gap by Patient Population

The telehealth gap hits the most marginalized consumers hardest. The overall gap between clinical and non-clinical providers is 24 pp (82% vs 59%). This widens when providers serve marginalized communities: 36 pp for providers serving Black/African-American patients, 37 pp for providers serving women, and 33 pp for providers serving straight patients. The pattern is consistent: the more marginalized the patient population, the larger the provider telehealth gap, because the organizations serving those populations are the ones most likely to lack the infrastructure to bill for telehealth services. *(See Figure 20.)*

FIGURE 20. THE TELEHEALTH GAP HITS THE MOST MARGINALIZED HARDEST

Clinical vs non-clinical provider telehealth gap by patient population served. Red lines indicate the structural gap in percentage points. Data: Provider Survey 2026 (N=341).



Trends: Consumers

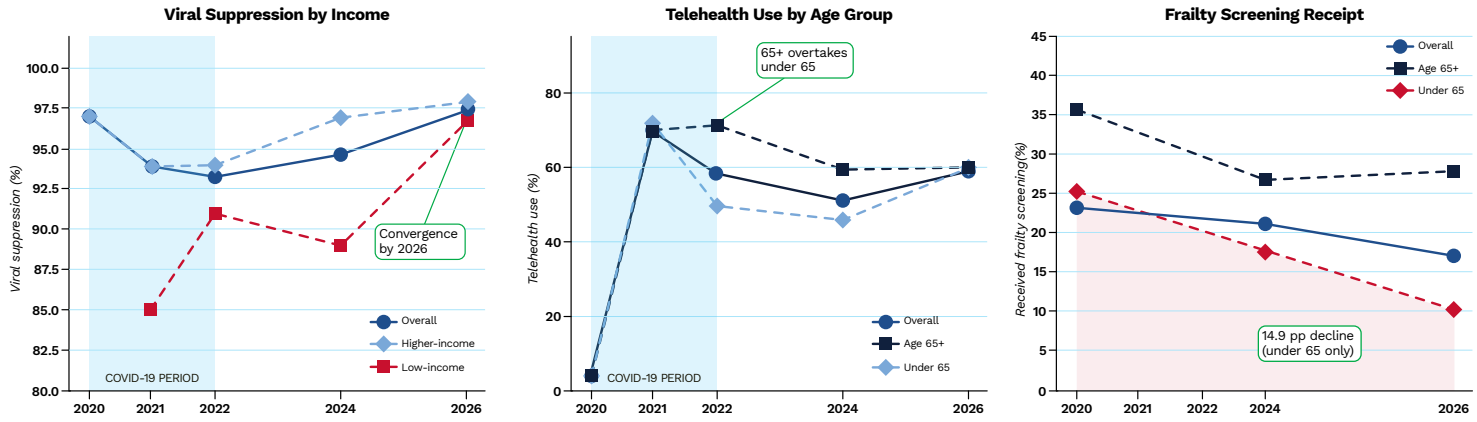
Analysis of the pooled five-wave pooled dataset (N=2,163) revealed some unexpected trends in clinical and behavioral health among people aging with HIV over the past six years. *(See Figure 21.)*

Overall trend lines show recovery, though income-stratified lines show that for the lowest-income consumers, structural recovery remains incomplete.

- Viral suppression is the most stable finding across five years. Held above 93% through COVID-19. The 2021 dip to 85% suppression among low-income consumers, with full recovery to 97% by 2026, is direct evidence that Ryan White HIV/AIDS Program re-engagement infrastructure works when activated and that disruption produces measurable clinical harm.
- Telehealth underwent the most dramatic transformation. From 5% in 2020 to 71% in 2021 and stabilization between 51% and 60% thereafter. Among consumers 65 and older, telehealth use is now higher than among those under 65, a complete inversion of the pre-pandemic pattern.
- Frailty screening among consumers under 65 is the most alarming trend. A 14.9-percentage-point collapse from 25% (2022) to 11% (2026). Among 65 and older consumers, rates held stable (36% in 2022, 28% in 2026). The under-65 group is being lost: young enough for clinicians to defer geriatric assessment, old enough in HIV-biological years to need it. Frailty is most reversible when caught early. The window is closing.

FIGURE 21. CONSUMER TRENDS, FIVE-WAVE COMPARISON, 2020 TO 2026

Lines: viral suppression by income, telehealth use by age group, frailty screening receipt.



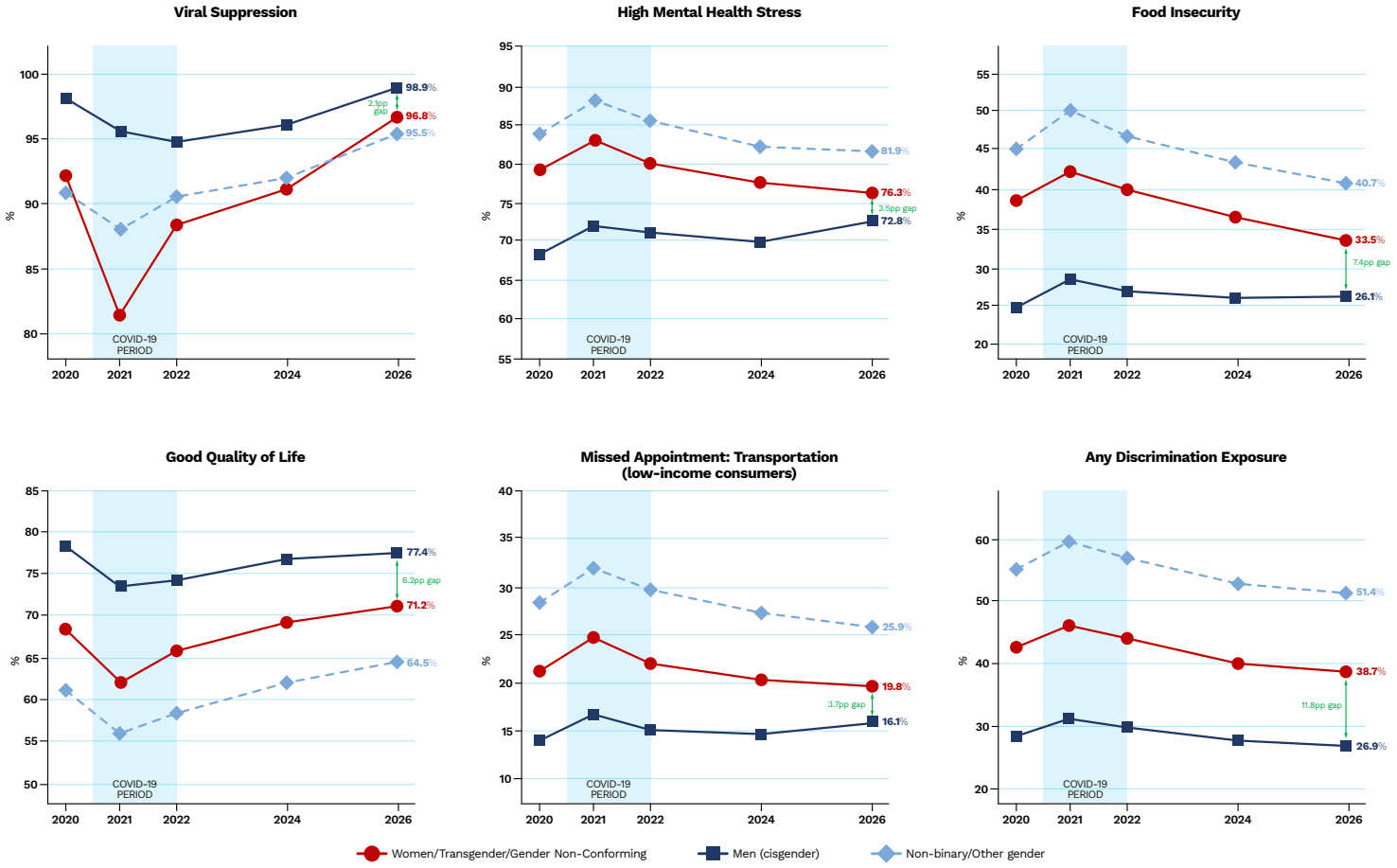
Solid lines = overall sample. Dashed lines = subgroup estimates. Shaded region = COVID-19 period (2020 to 2022).

Five-Wave Trends by Gender

Across six key outcomes tracked over the five waves, a consistent pattern emerges: women, transgender, and gender non-conforming consumers carry a disproportionate burden on every structural and psychosocial indicator, while cisgender men hold a persistent advantage on clinical and quality-of-life measures. Non-binary and other-gender consumers face the most acute disadvantages across nearly every domain. *(See Figure 22.)*

- Viral suppression: women, transgender, and gender non-conforming consumers dropped to 81% suppression in 2021, a nearly 11-percentage-point collapse, compared to a 2.6-point dip among cisgender men. Both groups recovered by 2026 (women to 97%, men to 99%), but the depth and speed of the COVID-era decline for women reflects how structural disruptions in care access land hardest on those with the fewest buffers.
- Mental health stress: stable across five years, with women and gender non-conforming consumers reporting high stress at rates 3 to 5 pp above cisgender men throughout the period. Non-binary and other-gender consumers consistently reported the highest stress rates (88% in 2021, above 80% through 2026).
- Food insecurity, transportation barriers, and discrimination: gender-related disparities are stable, in some cases widening, and concentrate across precisely the structural domains that the minority stress model identifies as drivers of chronic allostatic load.[32, 46, 62, 63]

FIGURE 22. FIVE-WAVE CONSUMER TRENDS BY GENDER, 2020 TO 2026.

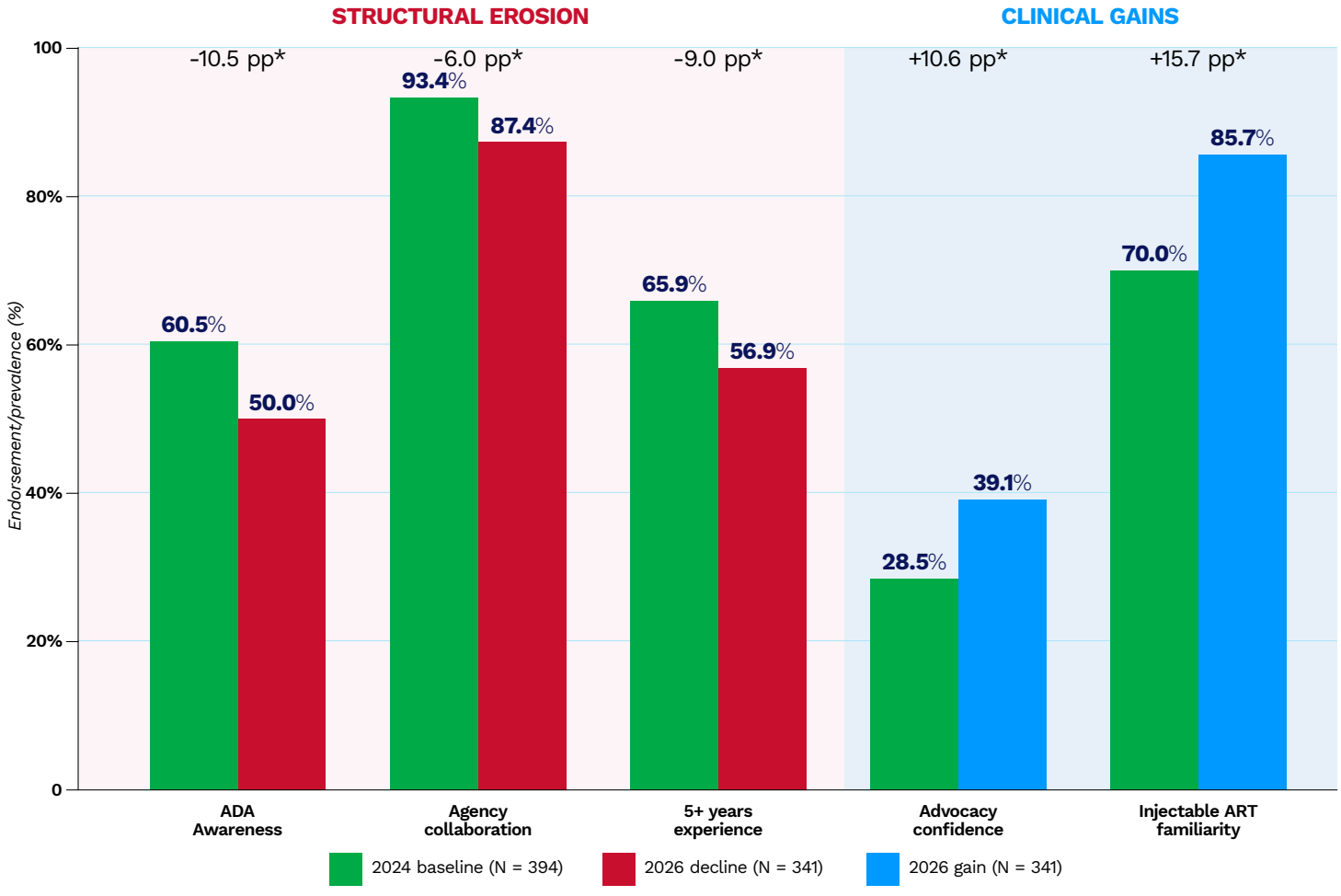


Trends: Providers

A workforce paradox emerges from the two-wave comparison: advocacy confidence is increasing while structural knowledge is declining. ADA awareness fell from 61% to 51% (Δ = −11 pp, p=0.033) and years of experience in role fell from 66% to 57% (Δ = −9 pp, p=0.027), consistent with workforce turnover. At the same time, advocacy confidence increased from 29% to 40% (p=0.023) and clinical interest in injectable ART among prescribers jumped from 70% to 86% (p<0.001). Providers feel more empowered to advocate but know less about the specific legal protections they should be advocating for. The ADA ensures people with HIV have equal access in employment, housing, and healthcare settings, however, declining familiarity with the law among providers is among the most urgent findings in this report. AIDS Education and Training Centers, the primary training vehicle for providers delivering HIV care, may help close this gap, particularly as workforce turnover among HIV providers accelerates.[31] *(See Figure 23.)*

FIGURE 23. TWO-WAVE PROVIDER CAPACITY COMPARISON, 2024 VS 2026

Bars compare 2024 and 2026 values.



*Values = percentage of providers endorsing indicator. pp = percentage point change, 2024 to 2026. *p < .05.*

About the HealthHIV State of Aging with HIV™ Survey

About the Survey and Fielding

This year marks the fifth wave of the HealthHIV State of Aging with HIV™ Survey. The 2026 cohort encompassed 706 respondents representing 37 U.S. states and the District of Columbia: 365 consumers (people with HIV aged 50 and older and/or living with HIV 15 or more years) and 341 behavioral and clinical providers who deliver services to people aging with HIV. Data were collected between February and March 2026 via REDCap nationwide.

In addition to the 2026 cross-sectional data, this report incorporates pooled consumer data (N=2,163) across all five waves (2020, 2021, 2022, 2024, and 2026) and pooled provider data (N=735) across the two waves that included them (2024 and 2026). The 2026 instrument carried items from prior waves to enable longitudinal trend analysis, with new items addressing Geriatric Burden Index components, Structural Vulnerability Index components, and Minority Stress Burden Score components.[49] *(See Table 1.)*

Note among the Consumer trends, the sample shifted from 62% White in 2020 to 48% White and 42% Black/African-Americans in 2026; race-controlled sensitivity analyses were conducted for outcomes with known racial disparities. Second, low-income consumers drove both the COVID-era dip in viral suppression and the slower, shallower recovery in structural outcomes including food insecurity, transportation barriers, and cost-related care avoidance.

Sampling and Eligibility

Consumer eligibility: people with HIV aged 50 and older OR living with HIV 15 or more years. Provider eligibility: professional HIV-aging service delivery. Total: N=706 respondents (367 consumers, of whom 365 were eligible after duplicate and ineligible-response screening; 341 providers). Geographic coverage: 37 U.S. states and the District of Columbia.

TABLE 1. SURVEY PARTICIPANTS BY WAVE, 2020 TO 2026 (TOTAL N=2,898)

Wave Year	2020	2021	2022	2024	2026	Pooled N
Consumers	731	342	516	350	365	2,163
Providers				394	341	735
Total	**731**	**342**	**516**	**744**	**706**	**2,898**

Note. Blank cells indicate providers were not surveyed in those waves. Pooled totals reflect cross-wave participants for whom analyzable responses were available. The 2026 consumer eligibility criterion (people with HIV aged 50 and older and/or living with HIV 15 or more years) was applied retrospectively to prior-wave data when feasible to support trend analyses.

Data Management: Multiple Imputation, Weighting, NaN-Safe Corrections

NaN-Safe Corrected Estimates

Prior waves coded unanswered binary questions as No=0. Six estimates were substantially corrected using NaN-safe coding (denominators = respondents who answered each question). *(See Table 2.)*

TABLE 2: NaN SAFE CODING ESTIMATES

Variable	Prior Estimate	Corrected Estimate	Δ (pp)
Telehealth use	49%	60%	+11
PCP treats HIV	58%	67%	+8
Retirement plan	35%	44%	+10
Mobility difficulty	27%	34%	+7
Cost avoidance	17%	20%	+3
ART adherence	86%	99%	+13

Multiple Imputation

MICE (multiple imputation by chained equations) was implemented in Python using scikit-learn's IterativeImputer with BayesianRidge as the per-feature estimator and sample_posterior=True for proper multiple imputation. 20 imputed datasets were generated; estimates and standard errors were pooled using Rubin's rules. Imputation targets included variables with 10% to 50% missingness (cost avoidance, transportation barrier, telehealth, PCP-HIV integration, current case management, retirement plan, mobility difficulty, ADL assistance, social network size, low income, male gender). Auxiliary predictors (age, AIDS diagnosis, viral suppression, any discrimination, food trouble, high stress, good QOL, ordinal stress) were included to improve imputation fidelity. Binary variables were clipped to [0,1] and rounded after imputation; min/max bounds were enforced at 0.0 and 1.0 for non-continuous variables.[26]

Key fractions of missing information (FMI): transportation barrier 0.35, with MI-pooled OR=5.86 (95% CI: 2.51 to 13.67, p<0.001) preferred over the complete-case estimate; retirement plan 0.22, with MI-pooled OR=0.155 (95% CI: 0.09 to 0.27, p<0.001) preferred. All other variables had FMI<0.15, with complete-case and MI estimates converging.

Sampling Weights

Post-stratification raking weights were calibrated to HRSA Ryan White HIV/AIDS Program 50 and older benchmarks on race, income, and age, using iterative proportional fitting (IPF). Three weight sets were produced: race-only (effective N=269, design effect 1.27); race+income (effective N=256; preferred for policy advocacy); race+income+age (supplemental). Trim bounds: 0.3 to 3.0. Respondents missing demographic data receive weight=1.0.

Analytic Methods: Python Pipeline

All analyses were conducted in Python 3.11. Core libraries: pandas and NumPy for data management; statsmodels for logistic, ordinal, and OLS regression including Baron-Kenny sequential mediation and moderated mediation models; scikit-learn for IterativeImputer multiple imputation; stepmix for latent class analysis (BIC selection across K=2 to K=7 solutions); statsmodels MixedLM for two-level random-intercept multilevel models with 37 states as grouping factor; EconML for heterogeneous treatment effects (T-Learner with gradient-boosted regression trees, Bayesian hierarchical shrinkage applied to subgroup CATE estimates). STEPP (Subpopulation Treatment Effect Pattern Plots) was implemented via sliding age windows with 40% overlap. Trend tests across waves used Cochran-Armitage (primary), Kruskal-Wallis (non-parametric supplemental), and logistic regression with wave year as continuous predictor. All figures were produced in matplotlib (version 3.8) with DejaVu Sans as the typeface.

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Appendix

The following tables provide complete 2026 sample characteristics for consumers (Table A1) and providers (Table A2), along with five-wave consumer trend sample sizes (Table A3) and two-wave provider comparison sample sizes (Table A4).

TABLE A1. CONSUMER SAMPLE CHARACTERISTICS, 2026 (N=365)

Characteristic	n	%
Age		
Mean age (SD)	61.2 (8.9)	-
Under 50	26	7.1%
Ages 50 to 64	190	52.1%
Ages 65 and older	122	33.4%
Gender		
Male (cisgender)	238	65.2%
Female (cisgender)	91	24.9%
Transgender / GNC / Other	36	9.9%
Sexual Orientation		
LGBTQ+	193	52.9%
Straight / Heterosexual	172	47.1%
Race and Ethnicity		
White	175	47.9%
Black/African American	154	42.2%
Hispanic / Latino/a/x	33	9.0%
Other / Multiracial	10	2.7%
Annual Household Income		
Below $32,000	127	34.8%
$32,000 to $64,999	112	30.7%
$65,000 and above	126	34.5%
Geography		
Urban	213	58.4%
Suburban	98	26.8%
Rural	54	14.8%
HIV History		
Living with HIV 15+ years	334	91.5%
Prior AIDS diagnosis	196	53.7%
Currently on ART	360	98.7%
Virally suppressed	358	98.2%
States represented	**37 + DC**	**-**

TABLE A2. PROVIDER SAMPLE CHARACTERISTICS, 2026 (N=341)

Characteristic	n	%
Gender		
Women	249	72.9%
Men	76	22.3%
Non-binary / Other	16	4.7%
Race and Ethnicity		
White	158	46.3%
Black/African American	108	31.7%
Hispanic / Latino/a/x	48	14.1%
Other / Multiracial	27	7.9%
Primary Role		
Case Manager / Medical Case Manager	71	20.8%
Nurse / NP	48	14.1%
Physician / PA	41	12.0%
CHW / Outreach	52	15.2%
Social Worker / Behavioral Health	38	11.1%
Administrator / Program Director	55	16.1%
Other	36	10.6%
Provider Type		
Clinical	157	46.0%
Non-clinical	184	53.4%
Years in Role		
Under 5 years	146	42.9%
5 or more years	195	57.1%
Specialization		
HIV Medicine	70	20.5%
Gerontology	5	1.5%
Other	266	78.0%
Organization Type		
Non-profit / ASO	122	35.8%
RWHAP / 340B	122	35.8%
FQHC	48	14.1%
Hospital	30	8.8%
Other	19	5.6%
States represented	**37 + DC + PR**	**-**

TABLE A3. FIVE-WAVE CONSUMER SAMPLE SIZES, 2020 TO 2026 (POOLED N=2,163)

	2020	2021	2022	2024	2026	Pooled N
Consumers (N)	731	342	516	350	365	2,163

TABLE A4. TWO-WAVE PROVIDER SAMPLE SIZES, 2024 AND 2026 (POOLED N=735)

	2024	2026	Pooled N
Providers (N)	394	341	735

HealthHIV RESEARCH AND EVALUATION

HealthHIV STATE OF Aging with HIV™ National Survey

HealthHIV STATE OF ASOs/CBOs™ National Survey

HealthHIV STATE OF Drug User Health™ National Survey

HealthHCV STATE OF HCV Care™ National Survey

HealthHIV STATE OF HIV Care™ National Survey

National Coalition for LGBTQ Health STATE OF LGBTQ Health™ National Survey

HealthHIV Research and Evaluation conducts regular national surveys to better inform ongoing advocacy, education, research, and training activities. These “State Of” surveys provide unique insight into patient and provider issues in order to optimize primary and support services for diverse communities. The regular reports offer the ability to study multi-year trend analyses illustrating changes, challenges, and opportunities to address the needs of providers and patients. HealthHIV, HealthHCV and the National Coalition for LGBTQ Health conduct State of surveys addressing HIV care, HCV care, drug user health, ASOs/CBOs, LGBTQ healthcare, and aging with HIV.

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The Pozitively Aging program offers resources and tools supporting aging with HIV. These include the Healthy Aging Hub, the Healthy Aging with HIV Series Certificate Program, the Annual State of Aging with HIV™ National Survey, and a range of advocacy activities.

The Healthy Aging Hub serves as a practical hub for a wide range of materials including policy and advocacy, provider education and curricula, research and practice insights, and community-facing resources.

The Healthy Aging with HIV Series Certificate Program explores what it means to age with HIV, connecting science with lived experience and everyday practice. It is a tool for providers, case managers, peer navigators, and advocates to learn about the intersection of medical knowledge with workforce readiness, social determinants of health, and supportive care systems.

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