Insights from HealthHIV's Fifth Annual State of Aging with HIV™ National Survey

Wednesday, May 6, 2026 | 1:00pm Eastern

Agenda

- Aging with HIV in a Policy and Advocacy Context
- Survey Findings and Implications
- Pozitively Aging Program
  and Aligned Offerings
- Q&A

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Learning Objectives

Upon completion of this webinar, participants will be able to:

1. **Describe** the findings and the implications around the state of aging with HIV in the United States derived from the HealthHIV and *Pozitively Aging* State of Aging with HIV National Survey™.

2. **Analyze** approaches to improve health outcomes among people aging with HIV by modifying systemic and psychosocial barriers across five domains: HIV and geriatric care, comorbidities, behavioral health, access and payment, and workforce.

3. **Analyze** how structural factors (transportation, telehealth access, ADAP fragility, Medicaid coverage) and psychosocial exposures (discrimination, isolation, mental health stress) function as drivers of care engagement and quality of life among people aging with HIV, drawing on the report's mediation, latent class, and multilevel findings across 37 states.

4. **Detail** implications of the survey's findings across the domains of HIV and Geriatric Care, Comorbidities, Behavioral Health, Access and Payment, and Workforce.

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***Please note**: CE/CME are not offered for this webinar.*

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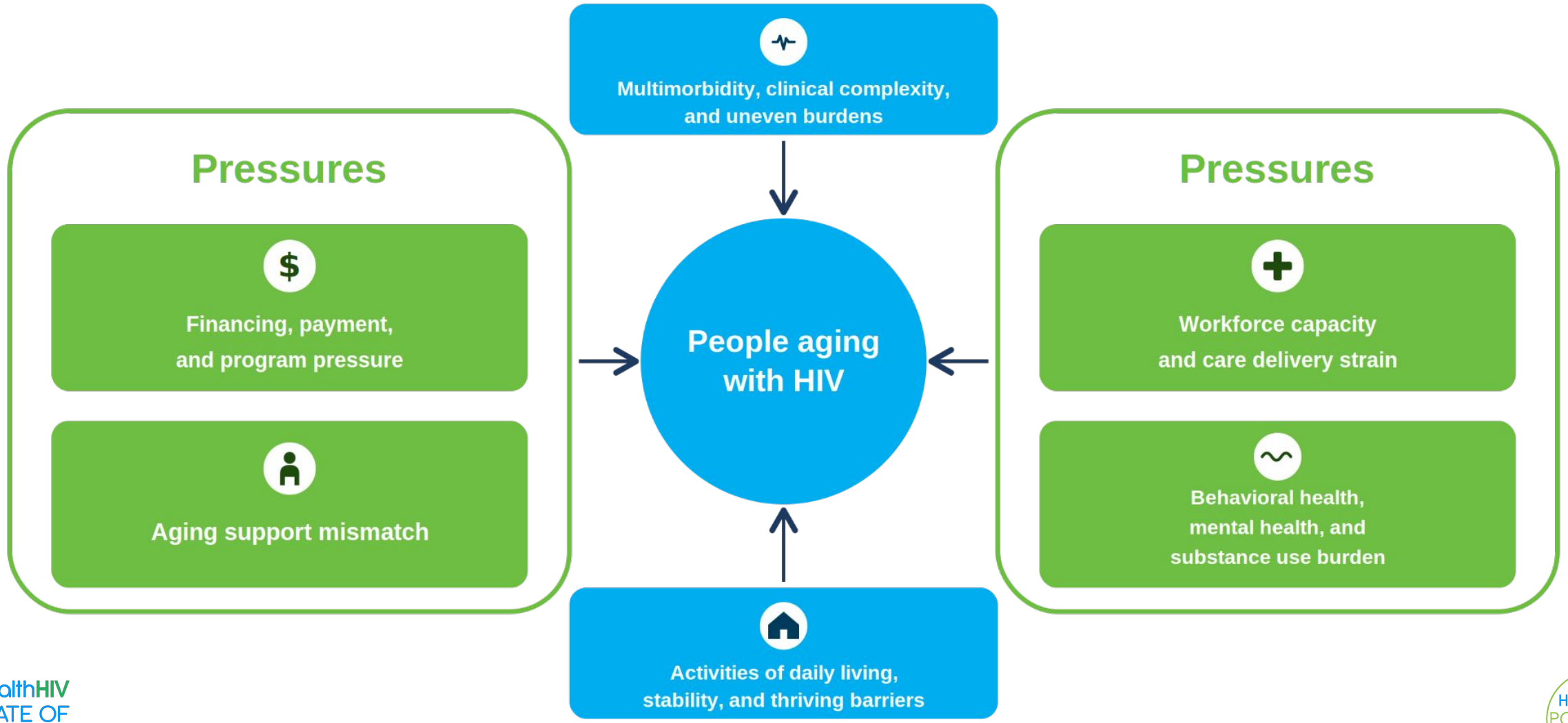
The Moment We Are In: System Collision



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People aging with HIV are carrying more pressure in clinical care and daily life while the systems around them are also under strain.

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The Moment We Are In

- **Financing, Payment, & Program Pressure**
  - Care coordination, continuity and geriatric integration (50+)
  - Medicaid coverage and access instability / eligibility and work requirements
  - Medicare / IRA & Biktarvy / Part D changes
  - Ryan White / State ADAP budgets, eligibility, formulary restrictions, and premium-assistance strain
  - 340B / rebate spreads and budget compression
  - Utilization management, benefit design, and payment pressure
  - ACA subsidy loss / rising premium pressure
  - Section 1557 protections and rollback risk

The Moment We Are In

- **Workforce Capacity and Care Delivery Strain**
  - Retention, loss, implementation strain, time with patients, reimbursement rates
  - Guideline implementation / evidence-to-practice
  - Fragmentation of systems

- **Aging Support Mismatch**
  - Aging support services lag behind actual need
  - Long-term care, transitions of care, and supportive services
  - Older Americans Act in limbo

- **Multimorbidity, Clinical Complexity, and Uneven Burdens**
  - Frailty and functional decline
  - Differences across age groups, diagnosis dates, and treatment histories
  - Aged 65+ urgent needs

The Moment We Are In: System Collision

- **Activities of Daily Living, Stability, and Thriving Barriers**
  - Housing, aging in place / with care, finances, transportation, and access and affordability barriers
  - SDOH, cultural, racial and minority stressors
  - Place-based and geographic access inequities
  - Culturally-relevant access barriers

- **Behavioral Health, Mental Health & Substance Use Burden**
  - High stress, under-recognized need, and delayed follow-through
  - Isolation, coping burdens /self-care, ageism, ableism and exceptionalism, HIV & LGBTQ+ discrimination / stigma, and care scarcity and disruption

A Framework for Our Findings

This report asks what Survival for People Aging with HIV looks like today—and what has shaped, limited, or could improve outcomes over time.

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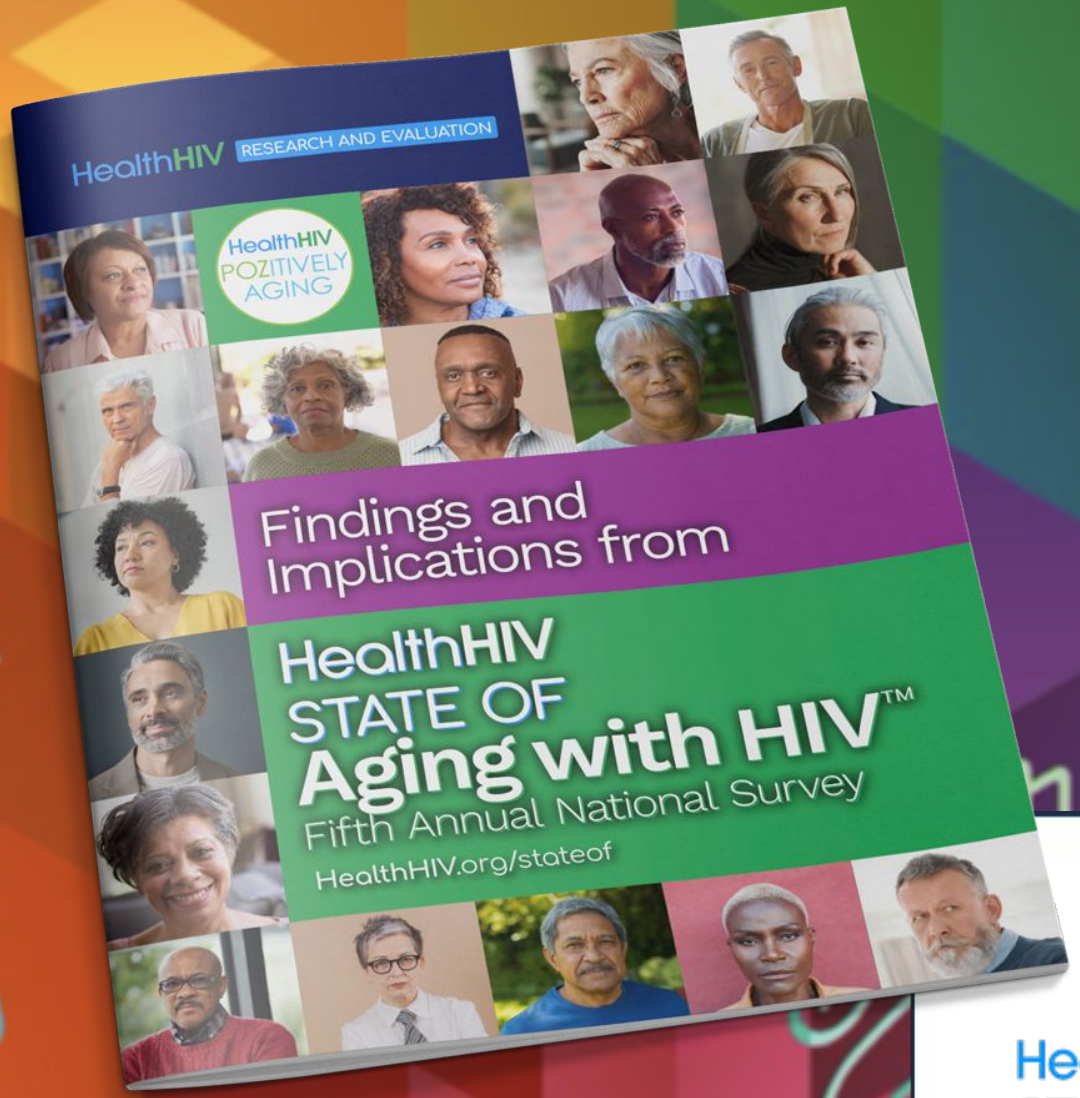

Background: State of Aging with HIV

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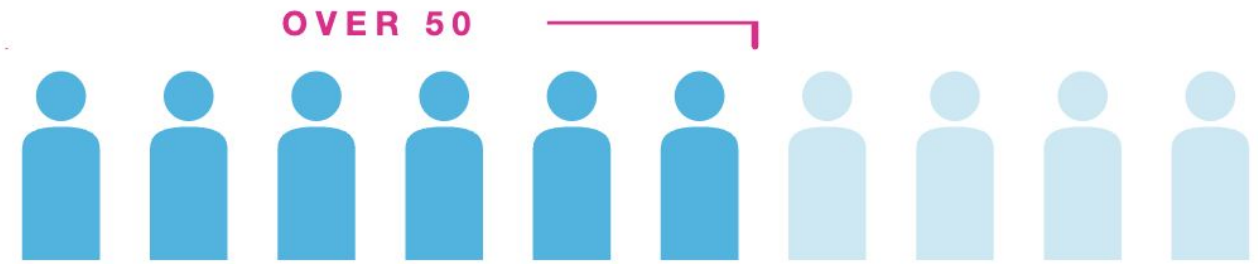
596,044

people aged 50 and older are living with diagnosed HIV in the U.S.



More than half of people living with HIV in the U.S. are over the age of 50.

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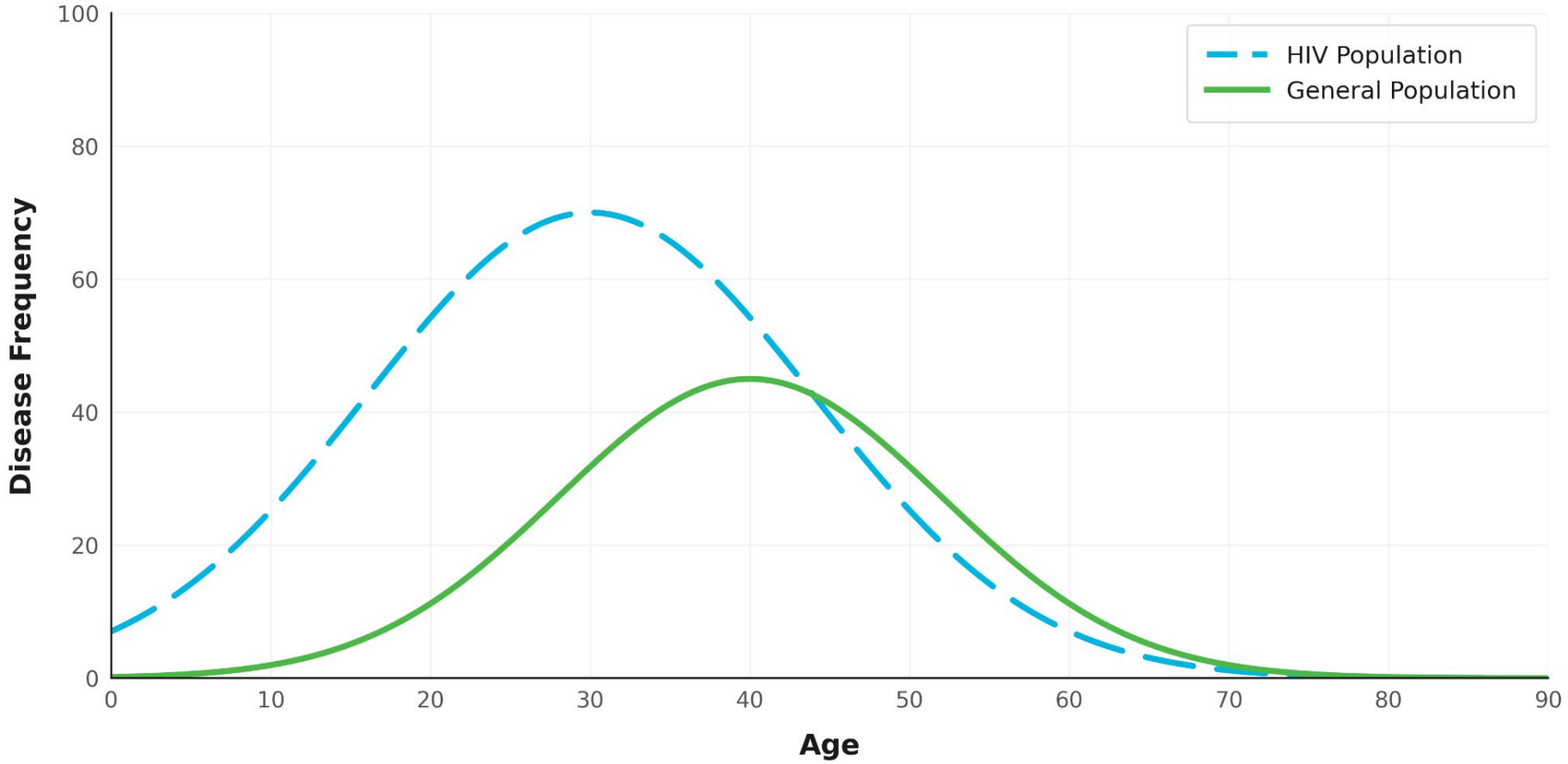
People Aging with HIV Experience Accelerated, Accentuated Aging Compared to the General Population



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Survey Overview & Frameworks

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Survey Participants by Wave, 2020 to 2026

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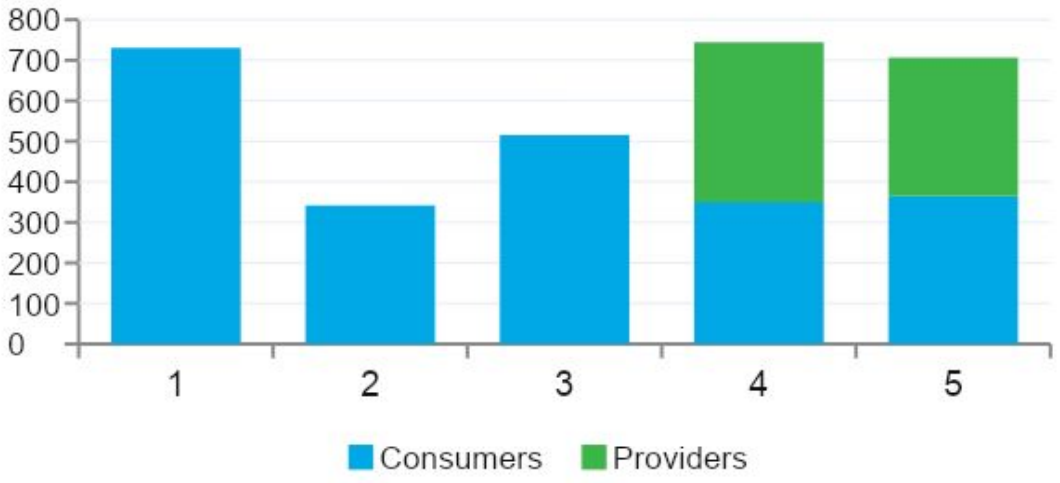
Total N = 2,898 across consumers and providers

2,163
CONSUMERS
5 waves: 2020 to 2026

735
PROVIDERS
2 waves: 2024 and 2026

2,898
POOLED TOTAL
All participants combined

Participants per Wave



Participants by Wave and Cohort

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. Shaded 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.

Consumers: One Word Descriptions of Aging with HIV

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Providers: One Word Descriptions of Delivering Aging with HIV Care

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Consumers & Providers: One Word Descriptions of Aging with HIV

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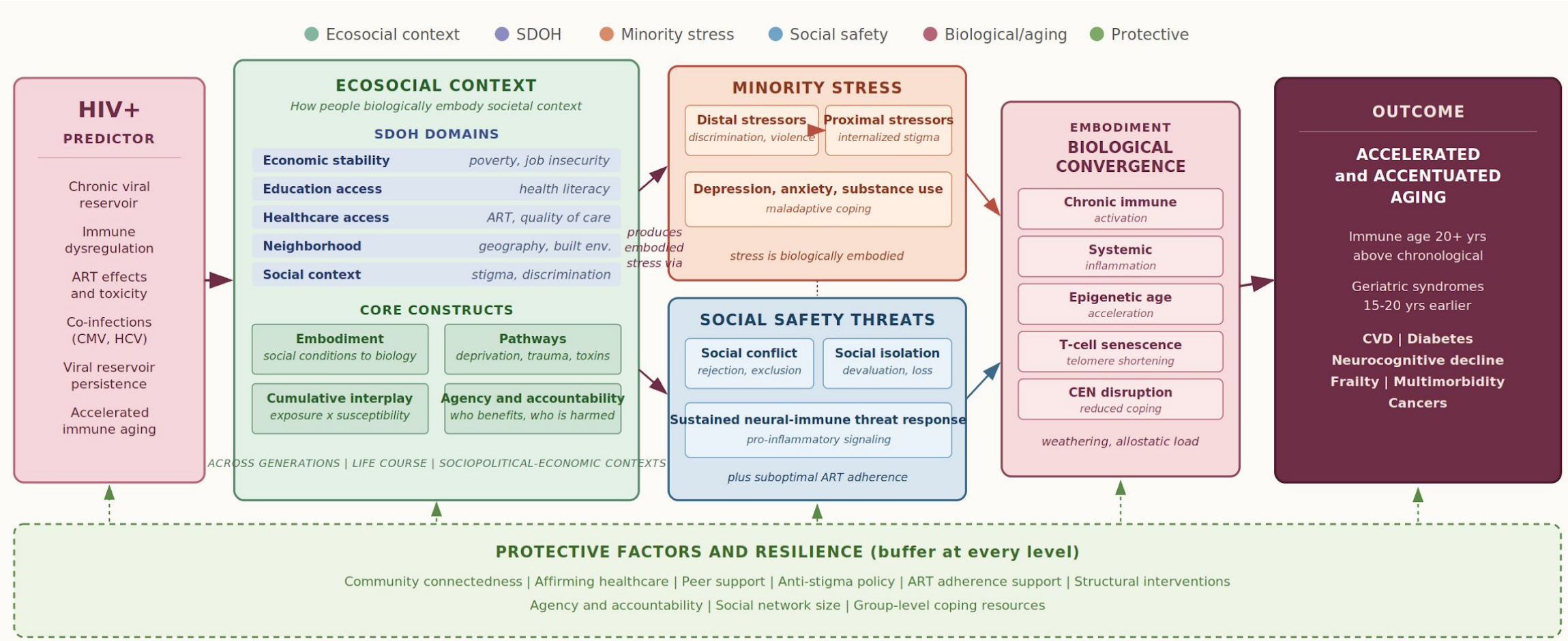
Conceptual Model: Accelerated Aging with HIV



*Integrating **Ecosocial Theory** (Krieger) | **Minority Stress Framework** (Frost and Meyer) | **Social Safety Theory** (Slavich)*

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Provider Approaches to Aging with HIV: Geriatrics 6Ms Framework

*Applied to Aging with HIV | Adapted from **AGS 5Ms** (Tinetti, Molnar, Huang, 2017) with a 6th M added by **Erlandson and Karris** (2019) for PWH.*

Mind — 74.3%

Consumers report moderate/high mental health stress

Large social networks → 2× higher Quality of Life ($p < 0.001$)

High stress reduces high-QoL odds by 86%

Social engagement buffers psychological and cognitive decline.

Mobility — 34.3%

Consumers report mobility or balance difficulty

Mobility → lower QoL: OR = 0.39 ($p = 0.026$)

Mobility → telehealth: OR = 2.53 ($p = 0.007$)

Only 17.1% frailty-screened. Telehealth functions as a mobility accommodation.

Medications — 80.5%

Consumers on chronic non-HIV medications

Current ART side effects: 14.6% (n = 294)

Regimen adjusted for interactions: 22.1%

Viral suppression at 98.2%, but near-universal polypharmacy signals active complexity.

Multi-complexity — 53.7%

Consumers with prior AIDS diagnosis

Very-high-needs class: 27.0%

Geriatric Burden Index ages 75–80: 52.0%

Class 4 carries 100% chronic meds + high stress, zero frailty screening, mean age 61.

Matters Most — 44.4%

Consumers have a retirement financial plan

Low income → retirement: OR = 0.155

Orgs offering advance care planning: 24.6%

Housing is the #1 immediate need (25.4%). Aging with HIV: challenging, uncertain.

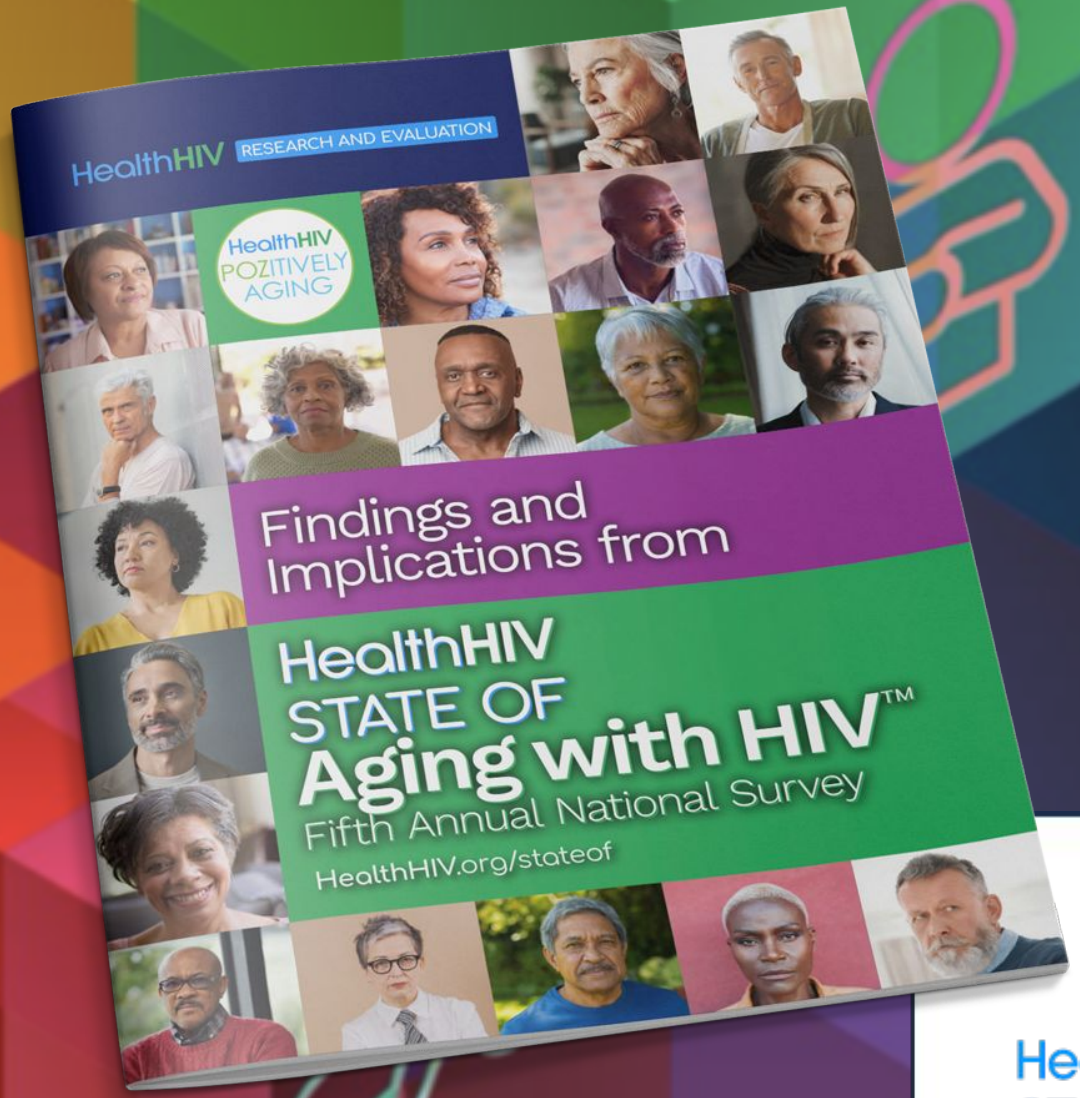
Modifiable — 27.0%

Consumers report food insecurity

Current tobacco use: 28.9%

Mobility difficulty (activity proxy): 34.3%

These three modifiable burdens overlap — most actionable entry points for non-pharmacological intervention.



Findings & Implications

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Survey Findings and Implications Across Five Domains

→ Stretched Thin. Falling Behind: Aging with HIV Workforce Under Pressure

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.

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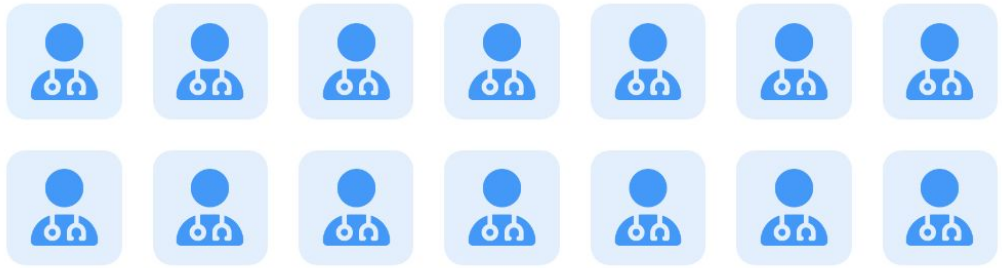
Providers We Heard from in 2026:
Specialty Concentration: The Geriatric Gap

HIV MEDICINE

20.5% *of provider sample*



14

HIV Medicine providers

:

GERONTOLOGY

1.5% *of provider sample*

1

Gerontology provider

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Infectious Diseases
13.2%

Behavioral Health
12.6%

Primary Care
4.7%

For every **14** HIV Medicine providers in this sample, there is just **1** Gerontology provider.

More than 1 in 3 Providers: Minimal Capacity to Deliver Needed Services to People Aging with HIV

Latent class analysis of 11 indicators identified four groups. BIC = –optimal, N = 341

30 pp

RECOGNITION-TO-ACTION GAP

Recognition is widespread. Capacity to act is not.

The 30-percentage-point gap in the largest class is the structural finding: these organizations see the problem clearly but lack the resources, staffing, and infrastructure to address it.

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Provider Organizations by Type: The HIV Safety Net & Beyond

The HIV safety net is carried by non-profits and Ryan White clinics, not by hospital systems.

THE HIV SAFETY NET: 71.6% *combined*

Non-profit 501(c)	RWHAP Clinic	ASO / HIV-STI	Hospital / Health System	FQHC	LGBTQ+ health center
39.6%	32.0%	16.4%	14.4%	12.0%	8.5%

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Categories not mutually exclusive. Many providers work across multiple settings. N = 341 providers.

→ Support Training for the Aging with HIV Workforce

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

Strengthen aging with HIV workforce via local, state, and national nonprofits 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.

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"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

→ Suppression of HIV at 98%, but Frailty Screening Only 17%: Integration of HIV & Geriatric Care Imperative

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.

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.

Consumers We Heard From in 2026

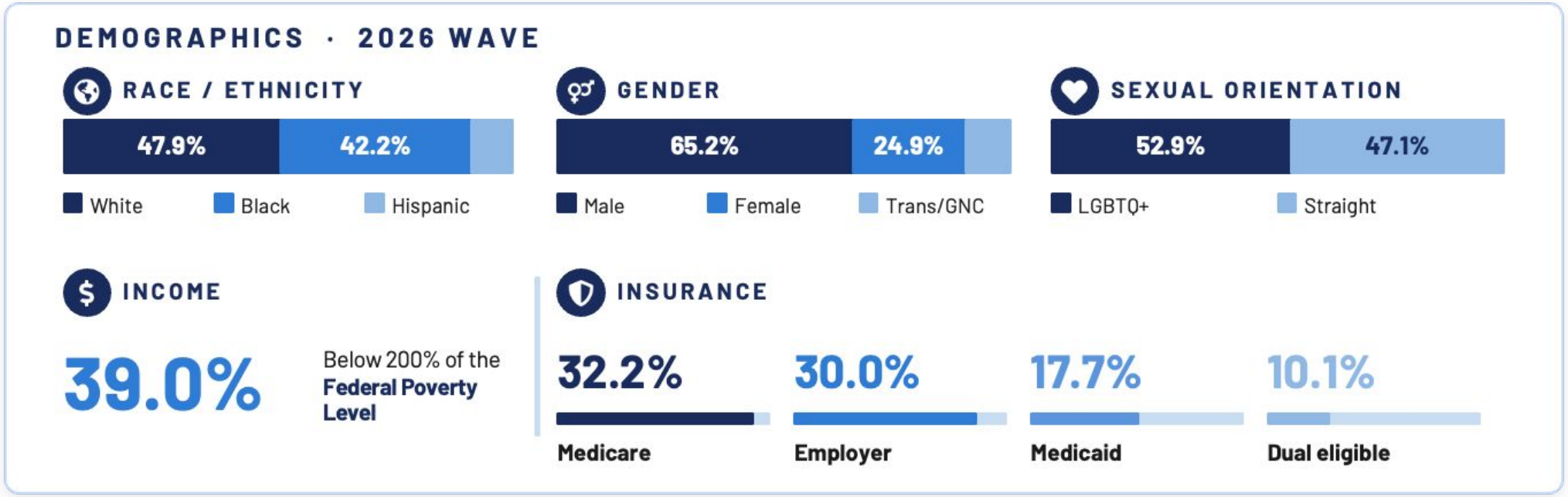
People aged 50 or older living with HIV, or long-term survivors with 15 or more years of HIV.

365
2026 consumers

61.2
Mean age (years)

53.7%
Prior AIDS diagnosis

2,163
Pooled N, 2020 to 2026



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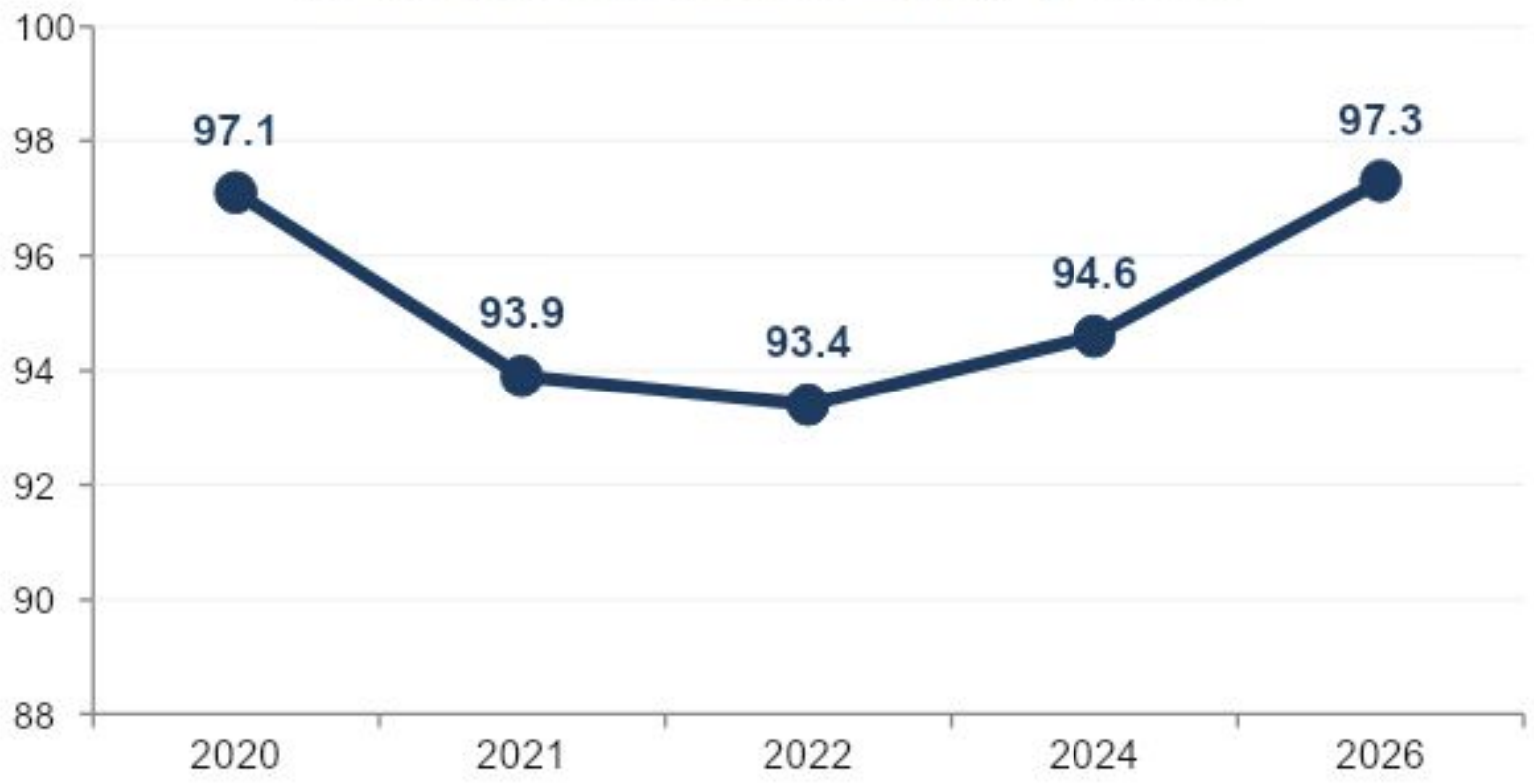
Overall Viral Suppression Among People with HIV: Stable and High, but with Notable Disparities



>93%
every wave
K-W ** p=0.009; CA T=-0.96 n.s.

97%-98%
White respondents
all waves stable; K-W n.s.

93%-97%
Black/AA respondents
all waves stable; K-W n.s.

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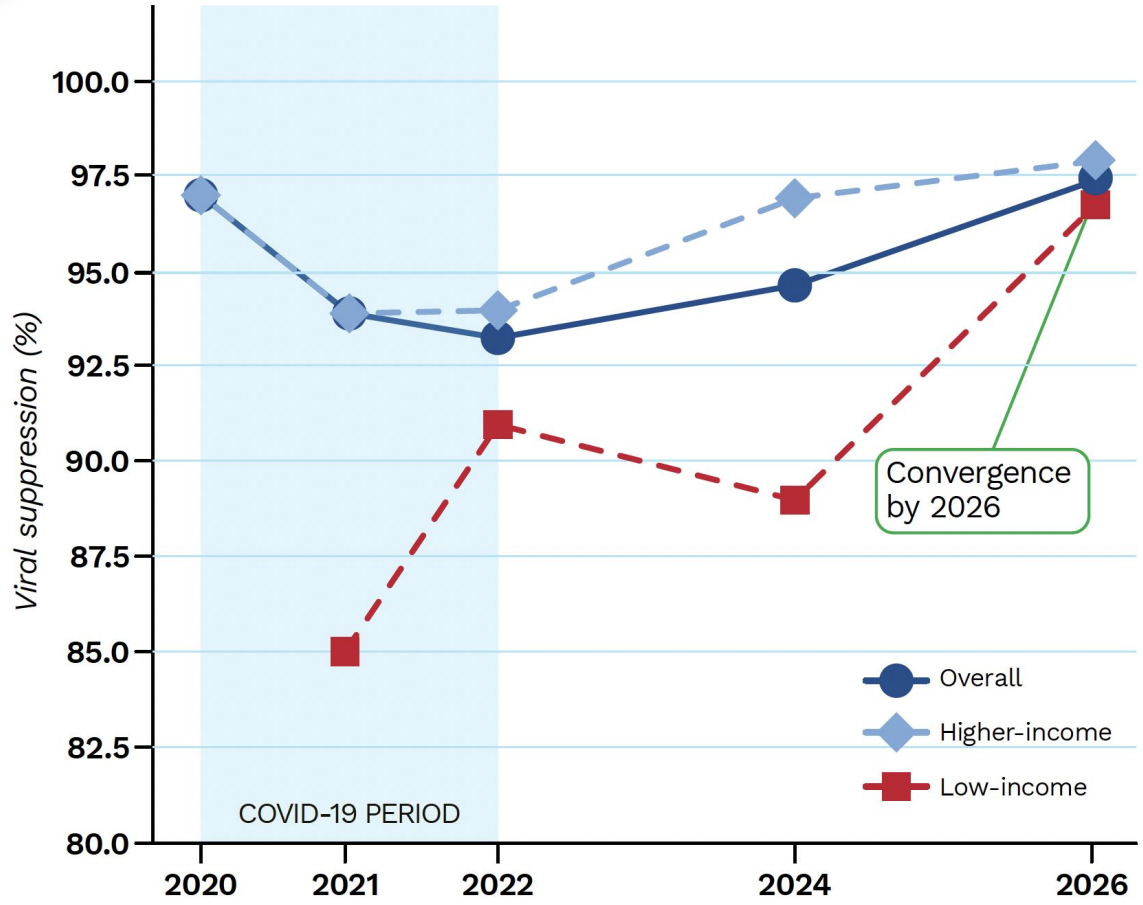
Cross-racial consistency above 93% across five waves and a global pandemic. RWHAP, as currently structured, is working.

Viral Suppression Convergence by Income Tier



Telehealth use (%)

12pp

income gap 2021

Low income 85% vs higher 97%

Recovered

low-income suppression

RWHAP Part B emergency funding flexibility and ADAP expansion during the COVID PHE

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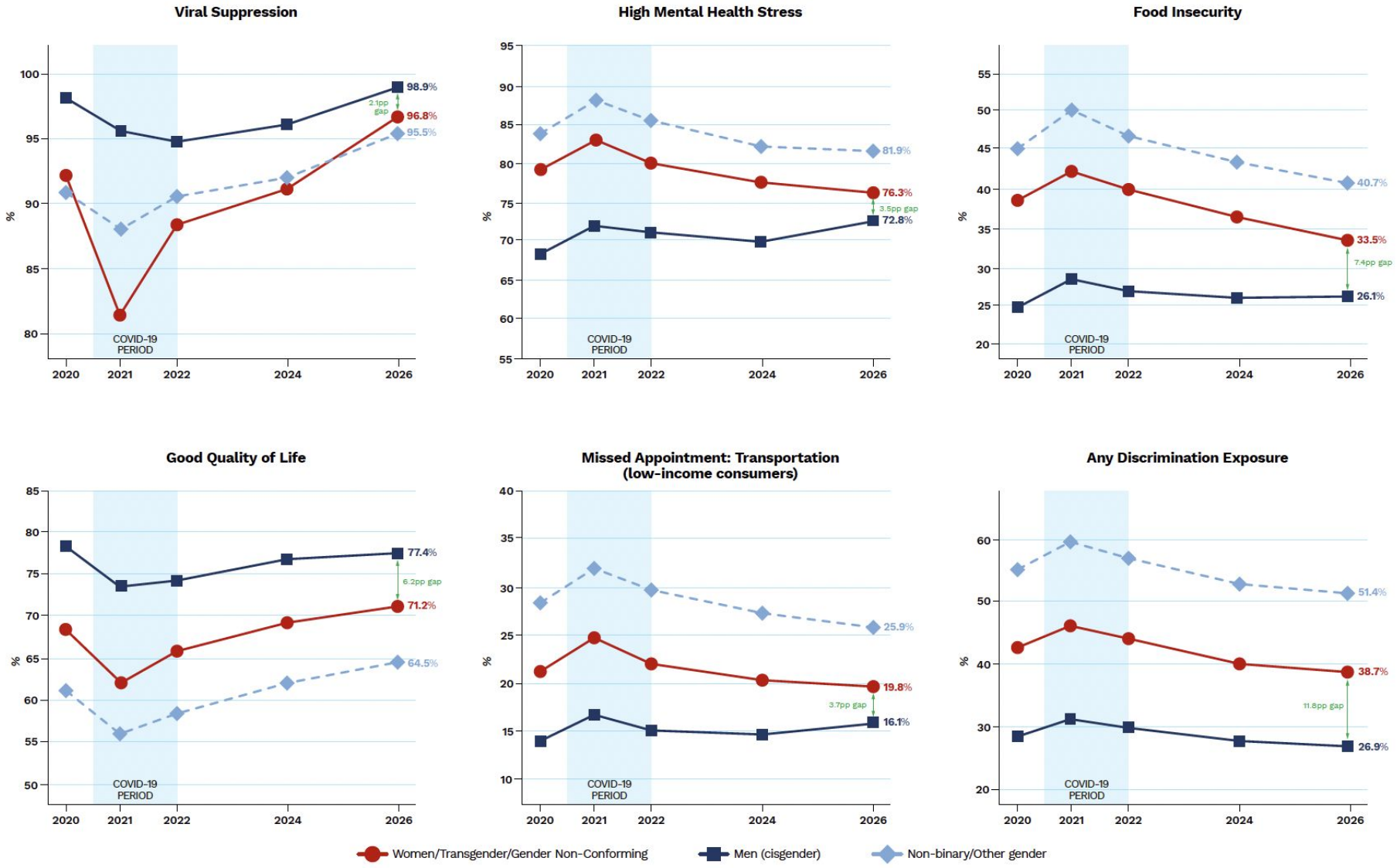
Key Outcome Trends by Gender, 2020 to 2026



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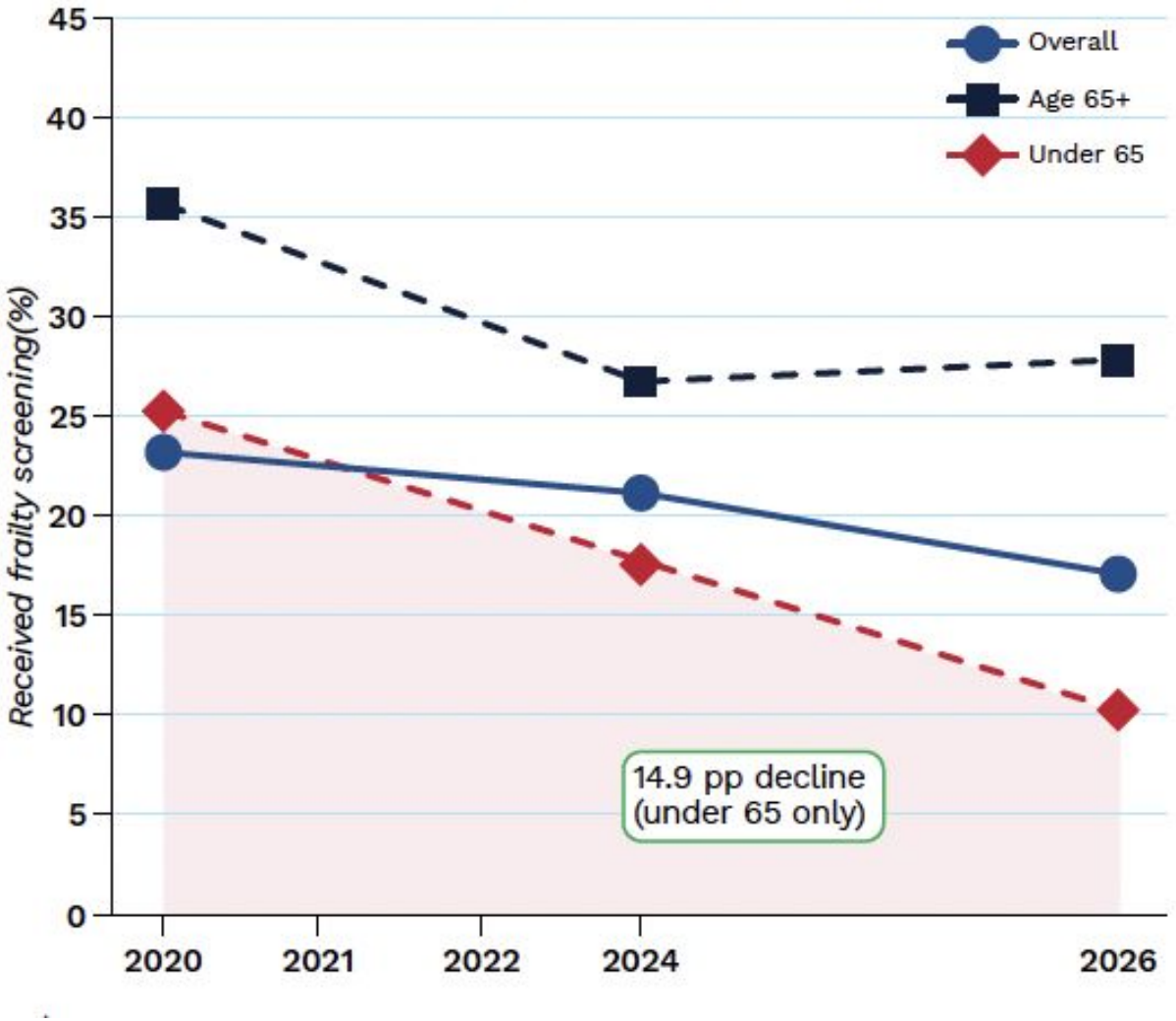
Frailty Screening Rates Low Among All People Aging with HIV, Especially Those Under Age 65



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→ Integrate Geriatric & HIV Care: Follow the 6Ms, Ramp Up Screenings

Integrate frailty and geriatric screening into clinical visits, and protect the infrastructure that produced the 98% suppression rate.

HIV AND GERIATRIC CARE

Build frailty screening, advance care planning, and falls-risk assessment into Aging with HIV care by age 50

Protect funding streams (ADAP & the 340B Drug Pricing Program rebate stream).

Continue and expand active re-engagement protocols established during COVID.

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"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

→ Burdened by Comorbidities

Most consumers carry chronic, high non-HIV medication burden.

Survey respondents included a high-needs group whose health concerns were essentially unaddressed except for antiretroviral therapy.

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Five Groups of People Aging with HIV

Latent class analysis of 11 indicators identified five distinct groups. Five-group solution: BIC = −6121.5, N = 311.

Minimal Needs

n = 56 • 18% of consumers

Lowest-burden profile. Resilient subgroup.

0% high stress

0% mobility difficulty

5% food insecurity

8% any discrimination

High Clinical, Connected

n = 68 • 22% of consumers

Highest clinical complexity, intact psychosocial scaffolding.

38% high stress

62% mobility difficulty

95% chronic non-HIV meds

68% social network 4+

Low-Moderate Needs

n = 72 • 23% of consumers

Emerging burden without crisis.

22% high stress

8% mobility difficulty

12% food insecurity

72% chronic non-HIV meds

High-Needs, Resource-Dependent Care Consumers

n = 28 • 9% of consumers

Smallest group, most visible to safety net.

55% high stress

100% food insecurity

55% case management

3% retirement plan

Very High, Unmanaged Care

CARE ABSENCE

n = 84 • 27% of consumers

More than 1 in 4. ART reaches them; aging-care does not.

100% high stress

100% any discrimination

100% chronic non-HIV meds

0% frailty screened

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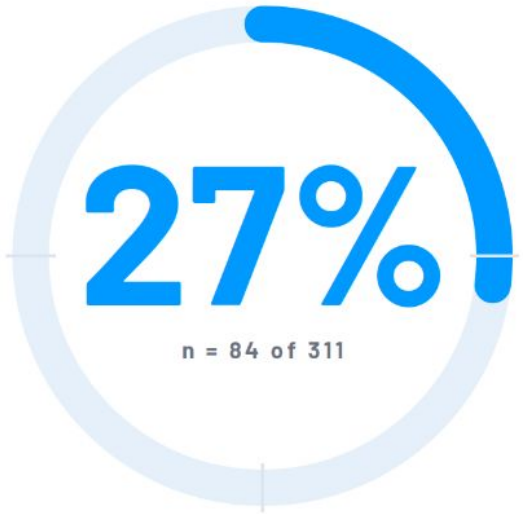
More Than 1 in 4 People Aging with HIV in the Study: Unaddressed Needs, Unmanaged Care

Latent class analysis of 11 indicators identified five distinct groups. Five-group solution: BIC = –6121.5, N = 311.

VERY HIGH, UNMANAGED CARE

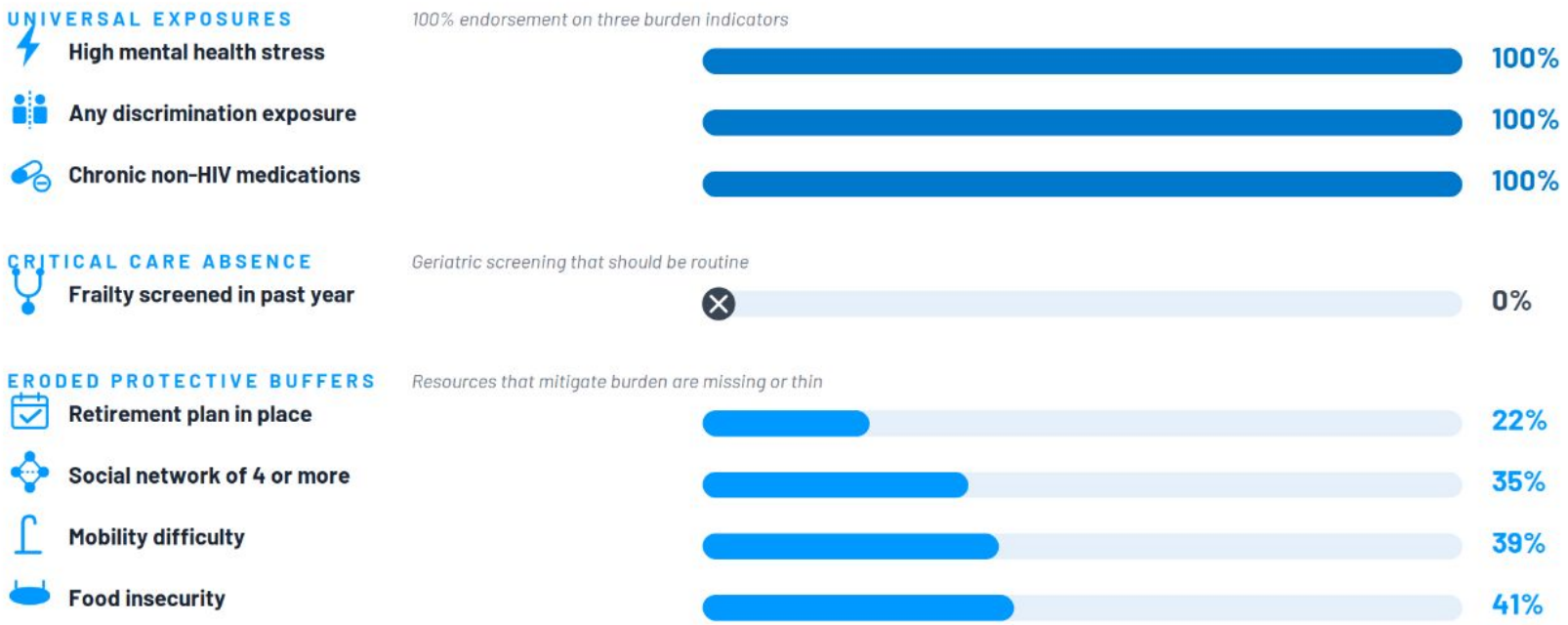


More than one in four people aging with HIV are in this class.

"ART reaches them; geriatric care, behavioral health, and structural support do not. This is a care absence, not a care gap."

CLASS PROFILE · ENDORSEMENT PROBABILITIES

Eight of eleven indicators define the typology



How to read. Solid darker bars mark indicators every member of this class endorses. The empty bar marks a service almost no one received. Light blue bars are the buffers most members lack.

Polypharmacy and ART Burden

Most consumers carry chronic non-HIV medication burden. The Geriatric Burden Index averages 52 at mean age 61.

98.7%

On Antiretrovirals

The clinical floor: ART is reaching essentially everyone in the cohort.

98.2%

Virally Suppressed

Highest rate across all five waves of the survey.

80.5%

≥1 Chronic Non-HIV Med

Polypharmacy is near-universal among consumers.

22.1%

Adjusted ART for DDIs

Drug-drug interactions are forcing regimen changes.

Comorbidities Contribute to Accelerated Aging

PREDICTOR INDEX × OUTCOME

Mutually adjusted odds ratios

	QOL (Good) — Quality of life	Physical Health — Self-rated good	High Stress — PSS top quartile
Structural Vulnerability — SVI	OR 0.995 n.s.	OR 0.991 n.s.	OR 0.964 ***
Geriatric Burden — GBI	OR 0.963 ***	OR 0.964 ***	OR 1.096 ***
Minority Stress Burden — MSBS	OR 0.987 p=.051	OR 0.994 n.s.	OR 1.117 ***

*** p < 0.001 · Borderline (p ≈ 0.05) · n.s. · ▼ OR < 1 protective · ▲ OR > 1 elevates

GERIATRIC BURDEN INDEX

Cohort mean burden score

26.7	61.2	2,163
SD	MEAN AGE	N

Equals burden expected at ages 75 to 80 in the general HIV-negative population.

WHAT THE INDEXES SHOW

Three takeaways from mutual adjustment

GBI is the strongest predictor.
Per 1-point GBI: 3.7% lower odds of good QOL, 3.6% lower odds of good physical health, and 9.6% higher odds of high stress.

−3.7% / +9.6%
QOL · STRESS

SVI acts on stress, not QOL.
Structural vulnerability shifts stress odds (OR 0.964, p < 0.001) without a measurable effect on overall quality of life or physical health.

OR 0.964
ON HIGH STRESS

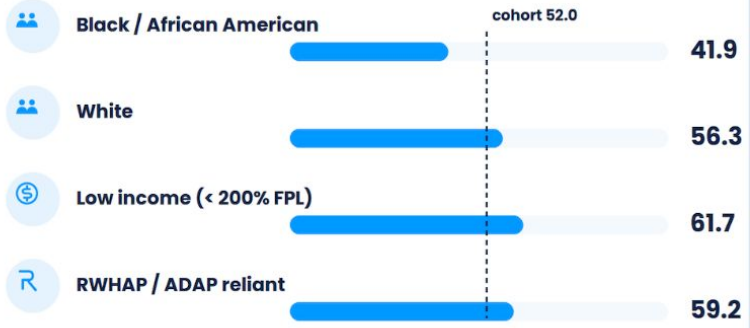
MSBS operates independently.
Even after adjusting for structural and geriatric burden, minority stress predicts an 11.7% higher odds of high stress.

+11.7%
STRESS ODDS

GBI BY SUBGROUP

Burden concentrates with disadvantage

Mean GBI score (0 to 100). Cohort overall = 52.0



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→ Diversify the Clinical and Behavioral Care Team Supporting People Aging with HIV.

Fund treatment, care, and wraparound services to address social determinants driving comorbidities to improve HIV and geriatric outcomes among people aging with HIV.

Lower Older Americans Act (OAA) eligibility threshold for people with HIV to age 50 (S.2120)

Fund OAA nutrition, transportation, and case management services for people with HIV ages 50 and older.

Establish clinical pharmacist consultation as a standalone reimbursable service in RWHAP service categories for consumers on 5+ meds.

Fund supportive housing with HIV-competent property management.

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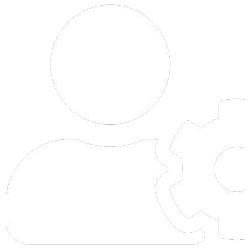

"Isolation and cognitive decline is HUGE for our patients and more information on how to address this would be helpful to receive as a provider."

– LCSW AT A MICHIGAN MEDICAL CENTER

→ Screen for Behavioral Health Issues Every Visit: Addressing Discrimination as Part of Care

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

- Embed validated mental health screening in HIV primary care visits
- Protect Section 1557 mental health parity protections
- Fund anti-ageism, anti-discrimination, and HIV-stigma training for clinical and non-clinical staff
- Support social network building among consumers

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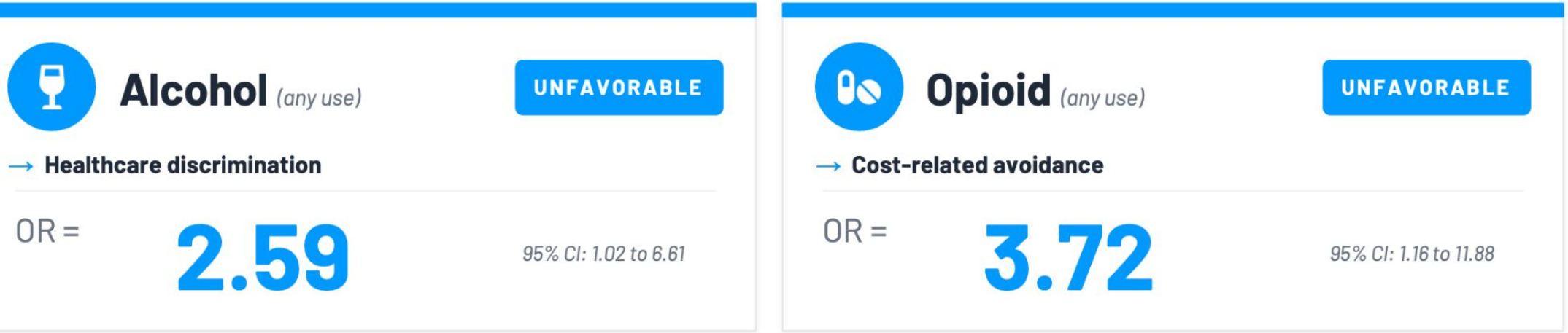
Substance Use & Health Among People Aging with HIV

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



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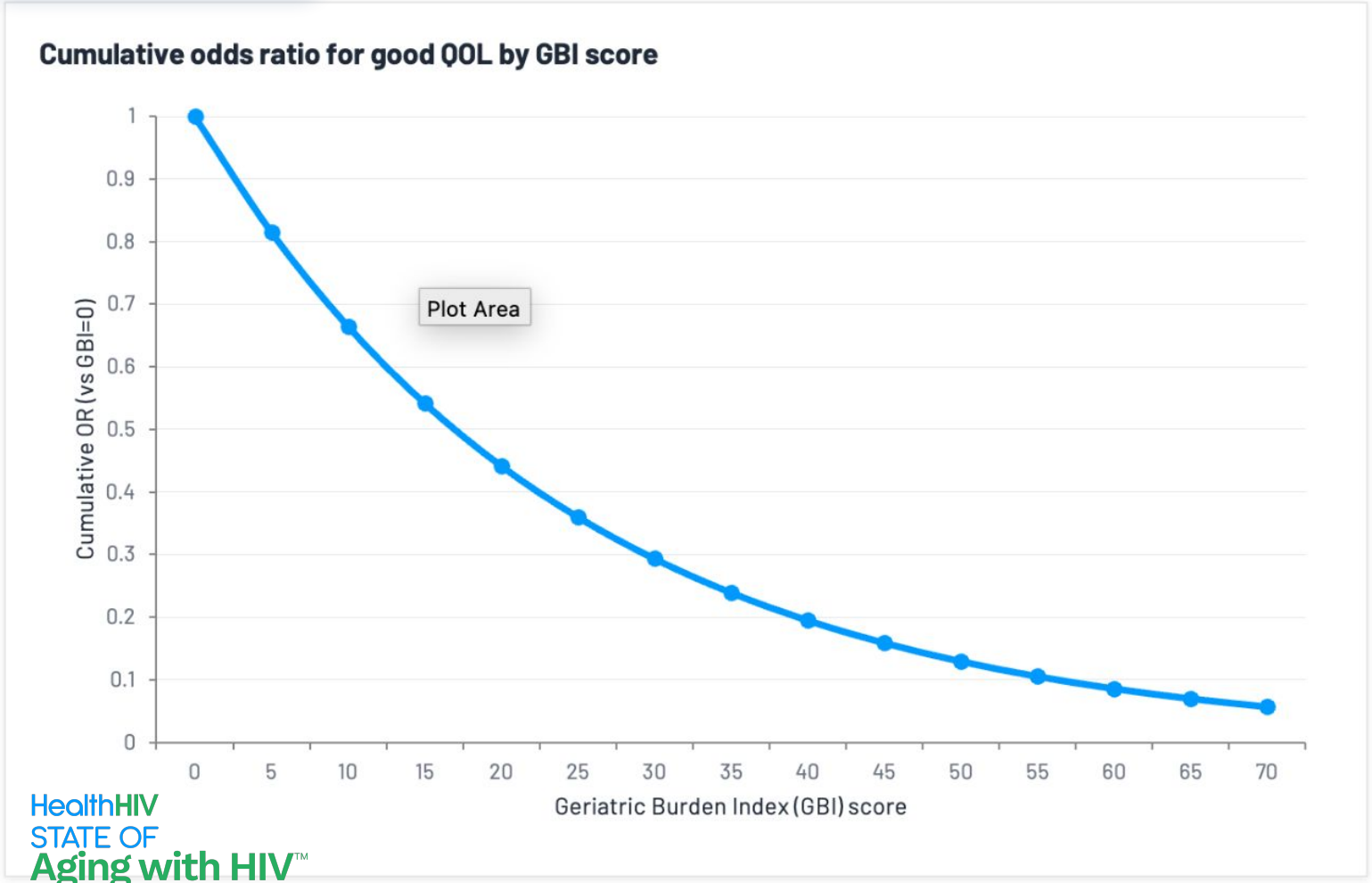
Geriatric Burden Compounds: 88% Lower Odds of Good QOL at Mean Burden



PER-POINT EFFECT

OR = 0.96

95% CI: 0.93 to 0.99 · p<0.05

A 4% per-point reduction compounds across the burden score.

AT MEAN BURDEN (GBI = 52)

88%

lower odds of good QOL versus a respondent with no burden.

WHY IT MATTERS

Each point of geriatric burden reduces good-QOL odds. **Frailty screening, polypharmacy review, and falls-risk assessment intercept this curve early. Currently only 17.1% of consumers are frailty-screened.**

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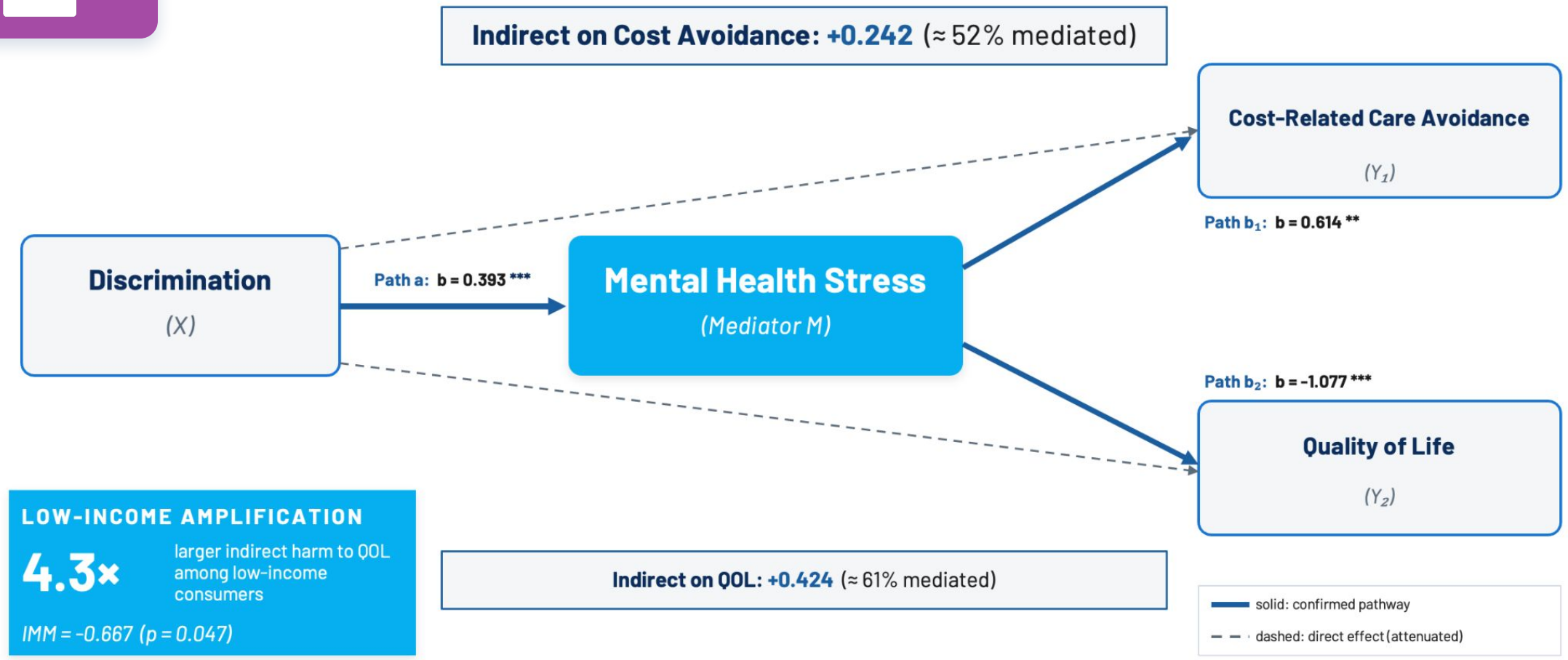
Discrimination Harms QOL Through Stress Pathway

Sequential mediation: discrimination → mental health stress → quality of life and care avoidance.



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*Baron-Kenny sequential OLS mediation with moderated mediation (Hayes' Index). Adapted from Report Figure 8. *** p<0.001 ** p<0.01*

The Stress-Health Paradox: High Stress, Good QOL, and Hidden Need

74% report moderate or high stress, yet fewer than 2% name mental health as their most pressing need.

74.3%

Moderate or High Mental Health Stress

Past six months. The lived texture of aging with HIV.

75.8%

Good or Excellent Quality of Life

Despite the stress burden, most report doing well.

<2%

Name Mental Health as Top Need

It will not surface unless providers screen for it directly.

FIVE MECHANISMS BEHIND THE PARADOX

1. **Domain separation**
   HIV management and psychosocial burden are processed as separate experiences.
2. **Response shift**
   Long-term survivors have recalibrated what "good QOL" means after surviving.
3. **Survival selection**
   The most vulnerable members of the cohort did not survive to participate.
4. **Viral suppression floor**
   ART prevents the worst clinical decline and preserves baseline function.
5. **Social network buffer**
   Larger social networks more than double the odds of good QOL (OR=2.40).

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*Baron-Kenny sequential OLS mediation with moderated mediation (Hayes' Index). Adapted from Report Figure 8. *** p<0.001 ** p<0.01*

Two Paradoxes That Resist Deficit Framing

Two findings invert common assumptions and should inform intervention design rather than be explained away.

PARADOX 1

Stress, Health, and Race

Black/African American consumers report better QOL and lower stress than White consumers in every age stratum, despite higher structural burden.

87.7%
Black/AA, good QOL

68.5%
White, good QOL

- High stress: 61.3% Black/AA vs 83.1% White (p<0.001)
- Adjusted OR for high stress, Black race: 0.34 (p<0.01)
- Geriatric Burden Index: 41.9 vs 56.3 (Black/AA vs White)
- Pattern holds across all three age strata

Read as resilience and physiological response to unaddressed stress related to social marginalization over time. Not a reflection of lower need.

PARADOX 2

LGBTQ+ Care Integration

LGBTQ+ consumers report higher stress but substantially better PCP-HIV care integration, especially at age 65 and above.

74.2%
LGBTQ+ 65+
PCP treats HIV

33.3%
Straight 65+
PCP treats HIV

- Age 65+ gap: 74.2% vs 33.3% (p=0.002), the largest gap in the dataset
- PCP treats HIV overall: 73.6% vs 53.5%
- Stress: 40.0% LGBTQ+ vs 20.8% straight
- Straight 50 to 64 face more food and transport barriers

Reflects historical concentration of HIV infrastructure around LGBTQ+ communities.

IMPLICATIONS

BEHAVIORAL HEALTH

→ Stop Waiting for Patients to Ask. Screen Every Visit.

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

PHQ-9 at viral-load cadence

•Embed validated mental health screening (e.g., PHQ-9) in HIV primary care visits at the same cadence as viral load monitoring.

Defend Section 1557 parity

Protect Section 1557 mental health parity protections. Rollback would reduce care engagement through the documented stress pathway.

Anti-stigma as intervention

Fund anti-ageism, anti-discrimination, and HIV-stigma training for clinical and non-clinical staff,

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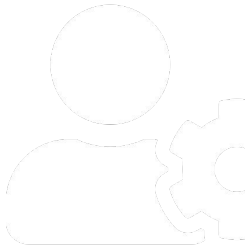

"I'm aging faster than my peers: hearing problems, vision problems, joint pain, foot pain, belly fat, loss of motivation, loss of sex drive, memory issues..."

- **2026 SURVEY PARTICIPANT AGING WITH HIV**

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→ The Safety Net Is Tearing. Patients Are Falling Through.

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.

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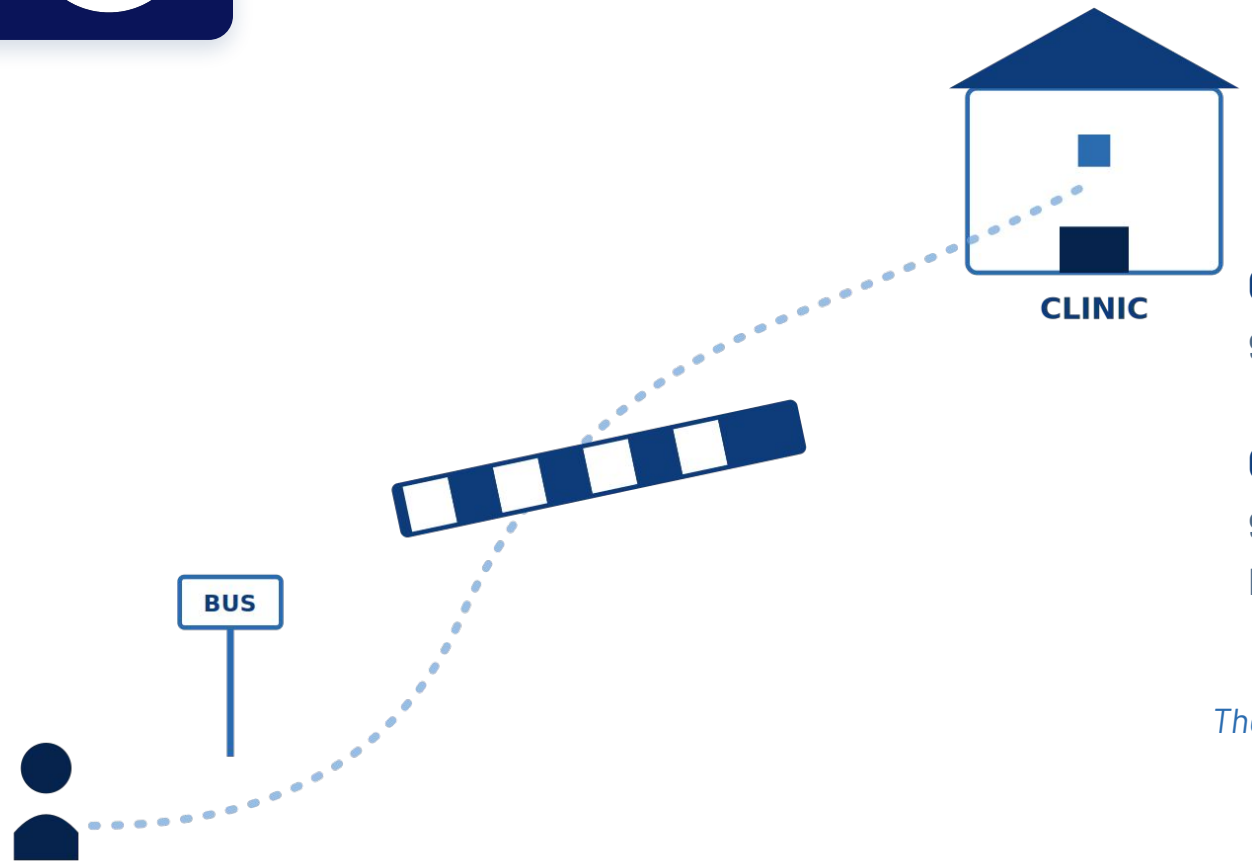
Low-Income PWH Face Six Times the Odds of Missing Appointments Due to Transportation



the appointment that never happens

OR = 5.86 MI-pooled (preferred) *p < 0.001*
95% CI: 2.51 to 13.67 · FMI = 0.35

OR = 10.59 complete-case (overstates effect) *p < 0.001*
95% CI: 4.21 to 26.67
Prevalence: 15.5% unweighted · 17.9% weighted

The most catastrophically predicted outcome in the dataset.

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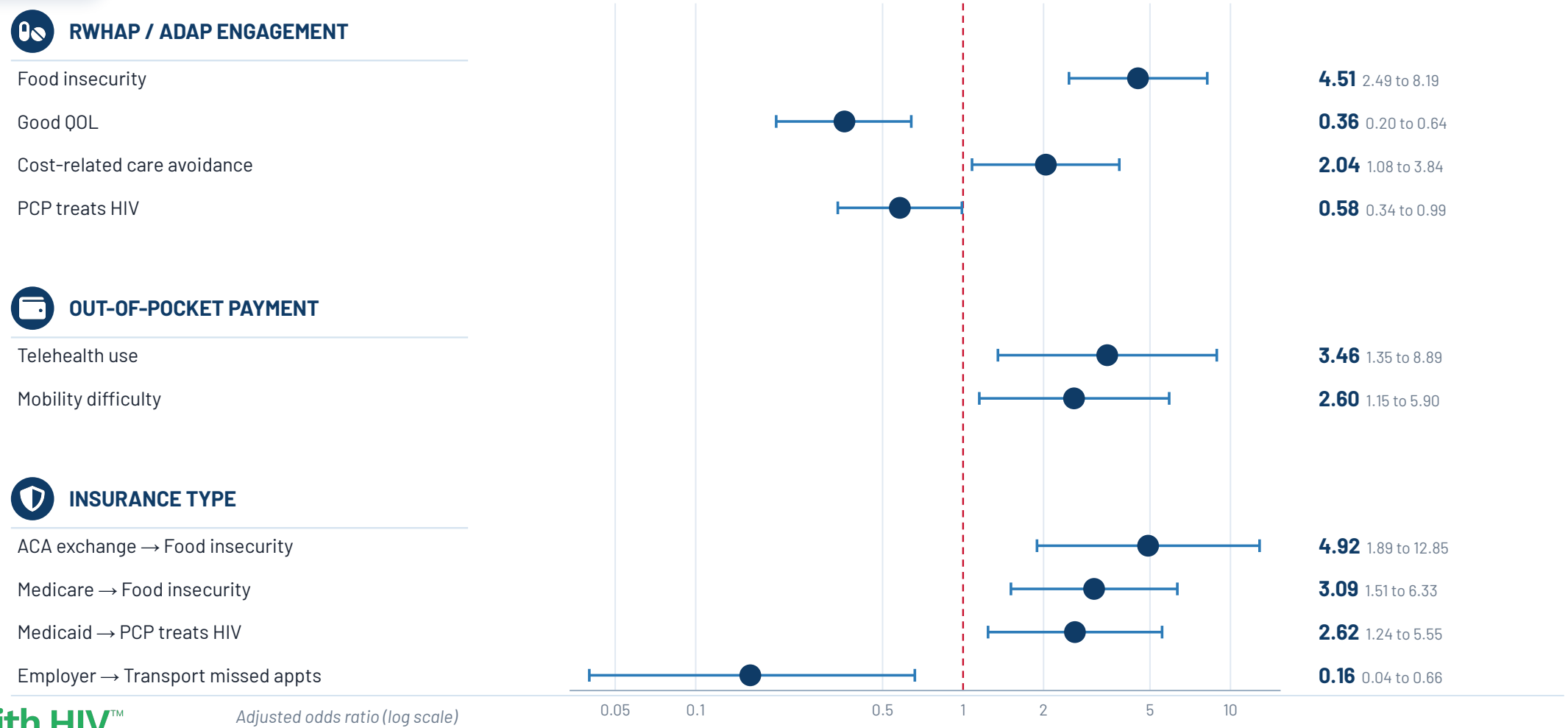
Correlates of Consumer Payers

Adjusted for age, low income, male gender, AIDS diagnosis. Sorted by effect magnitude.

4.92
LARGEST OR MAGNITUDE
ACA exchange → Food insecurity

0.16
LARGEST PROTECTIVE
Employer ins. → Transport appts



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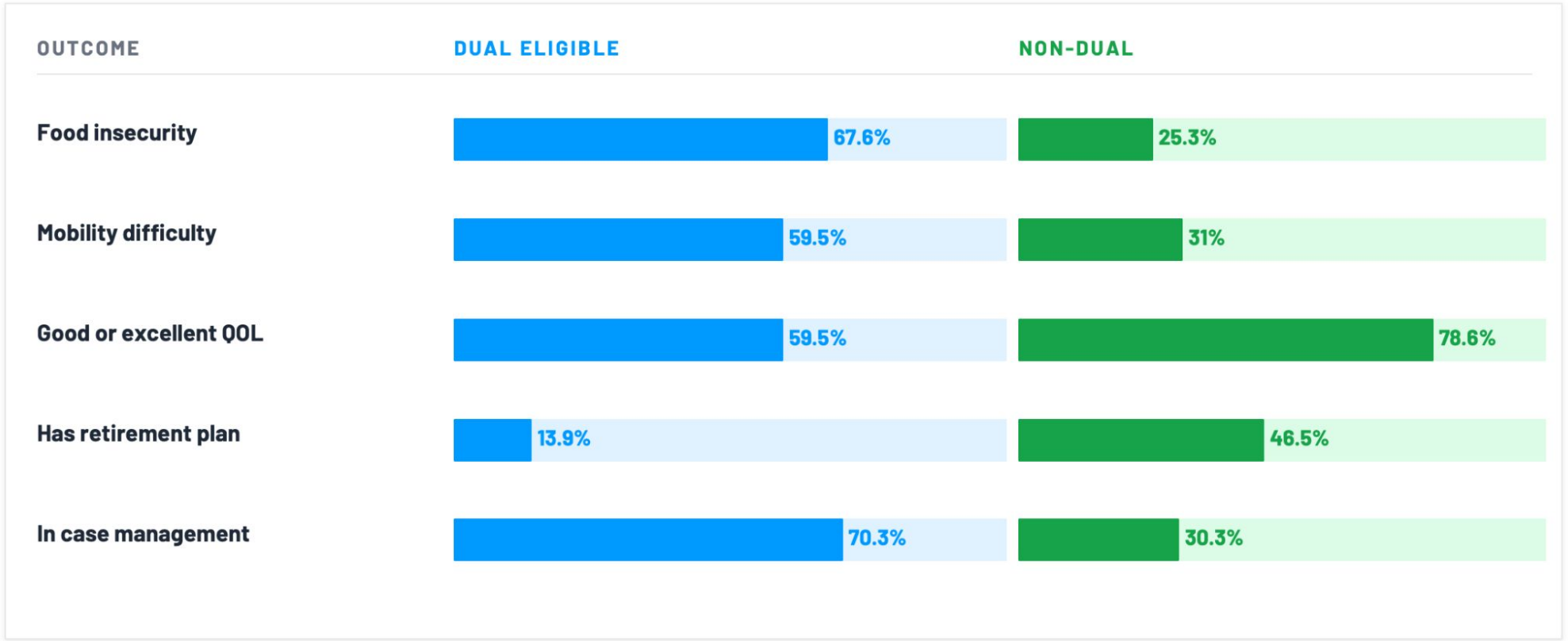
Dual Eligibles Carry the Heaviest Burden

Medicare + Medicaid dual eligible (n=37, 10.9% of consumer sample) compared with non-dual (n=304).



Dual eligibles are correctly identified by service systems but remain the most economically and functionally vulnerable insurance subgroup. 70% are in case management, yet 68% report food insecurity.

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Financial Precarity/Retirement Insecurity Among People Aging with HIV

Impacts of low-income compounds across the life course

ECONOMIC PRESSURE PATHWAY

Low income
56% report household income below $50,000 — **56%**

Cost barriers to care
17.3% avoided or delayed care due to cost — **17%**

Delayed care, worse health
Stress (OR=10.66) and mobility (OR=4.61) drive deferred care — **↑risk**

Retirement insecurity
49.7% pooled have no financial retirement plan — **50%**

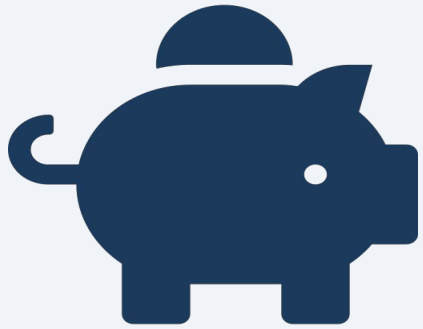
Long-term care vulnerable
78.4% say retirement won't cover home/LTC needs — **78%**

OR = 0.155 (vs. higher-income PWH), *95% CI: 0.088–0.273* $p < 0.001$

LOW-INCOME PWH

85%

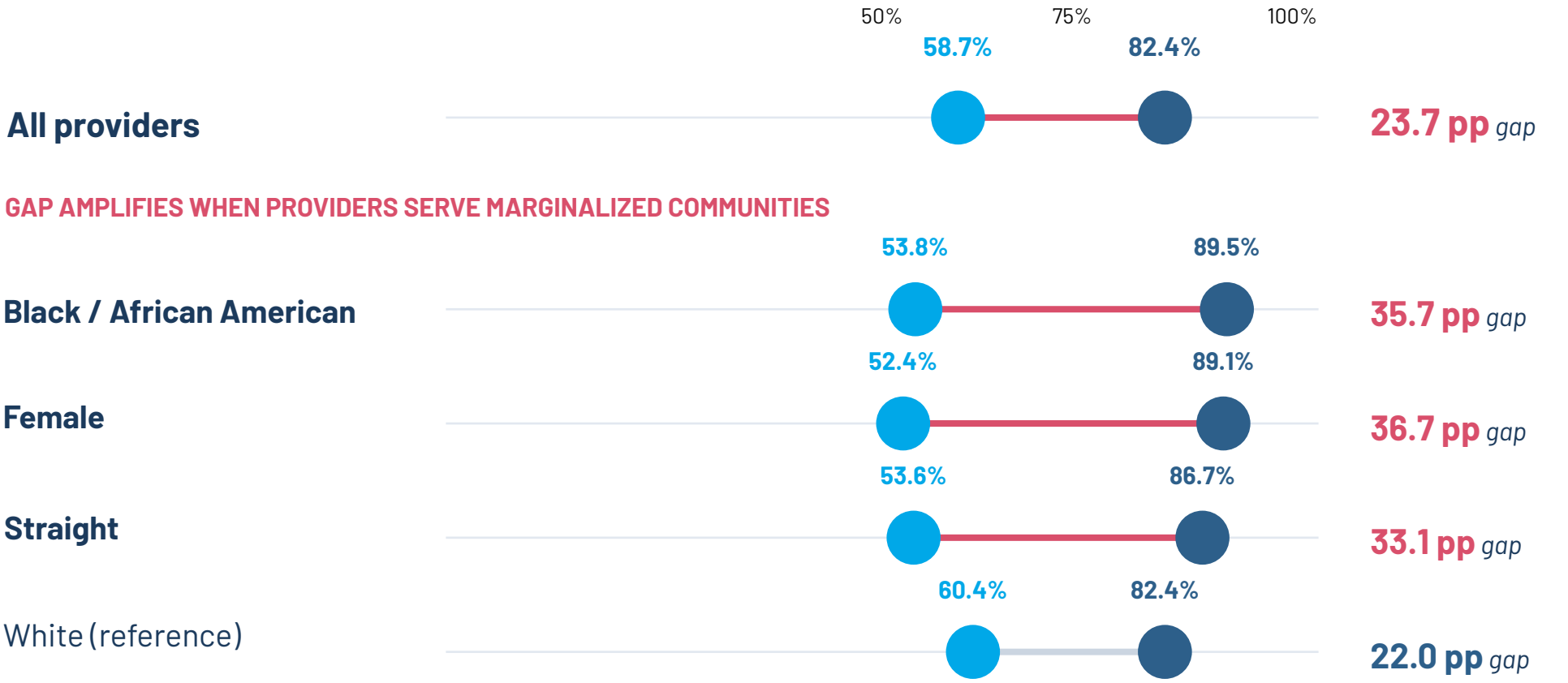
have **no retirement plan** in place



Pooled survey waves 2020–2026. MI-pooled estimate

The Telehealth Gap Hits the Most Marginalized Hardest

CBOs and ASOs serving the most financially marginalized patients lack billing infrastructure. Policy must target organizational infrastructure, not individual training.



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IMPLICATIONS

→ Stabilize Aging with HIV Care or Lose the Progress.

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

ACCESS AND PAYMENT

- **Fund transportation as essential medical infrastructure**
- **Make Medicare telehealth flexibility for HIV primary care permanent.**
- **Protect the ADAP rebate base.**
- **Protect Medicaid (no per-capita caps; no work requirements).**
- **Restore and enforce Section 1557 non-discrimination protections.**

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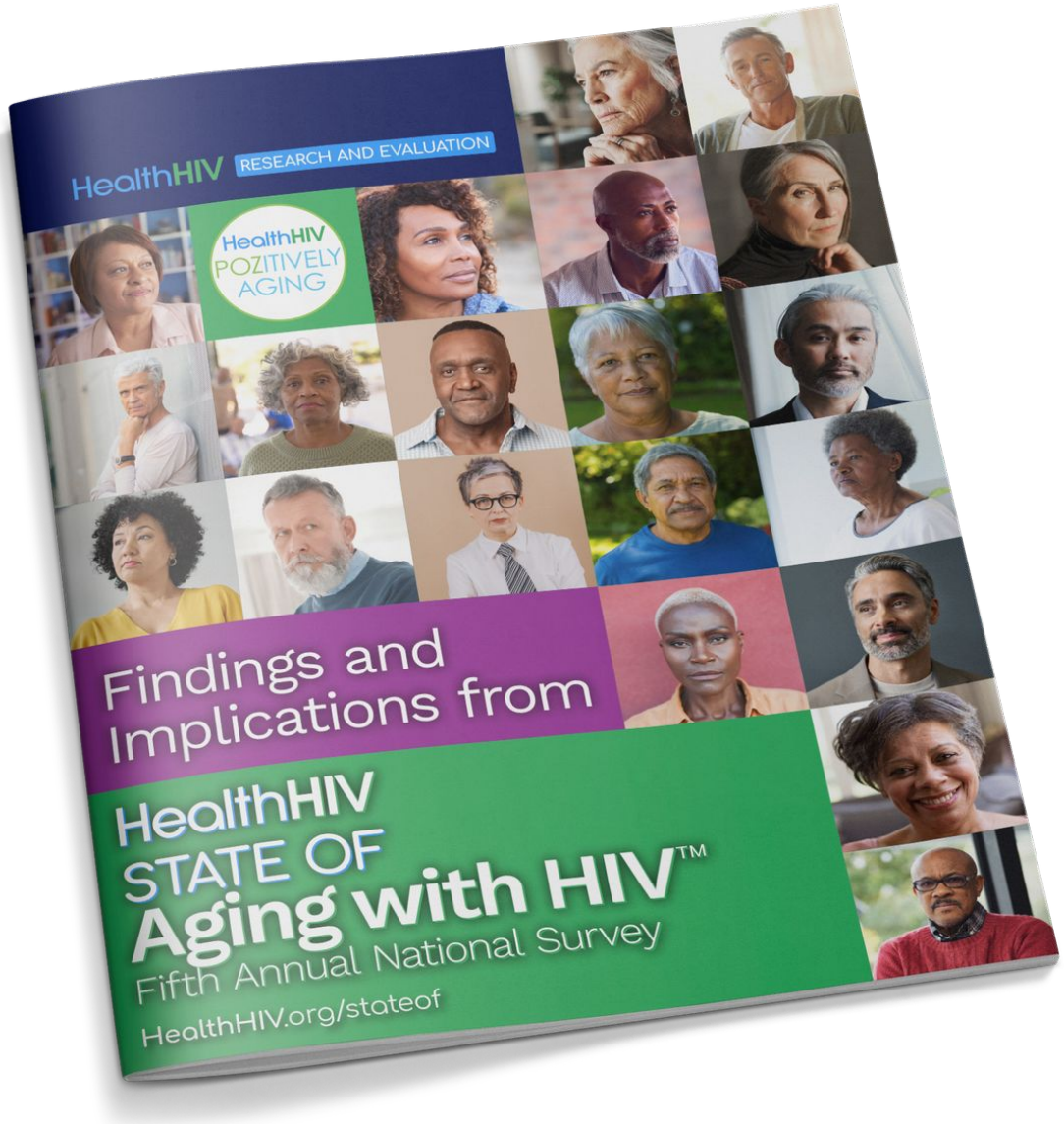

Download the Report

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Contact to Request Data

If interested, email circe@healthhiv.org.

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STATE OF HIV Care™

Seventh Annual National Survey

Survey Release
May 2026

Visit HealthHIV.org/StateOfs
Contact circe@healthhiv.org.

HealthHIV's Pozitively Aging Program

- **Helps strengthen the capacity of providers and the supporting workforce** to better coordinate care for People Living and Aging with HIV across lifespans and healthspans.
- **Works to improve provider and patient understanding** of the experiences of People with HIV over 50—with particular focus on those with higher needs and those over 65.
- **Supports better care coordination and co-management of conditions** associated with Aging with HIV through survey data, medical education, and advocacy.
- **Shares practical tools** on Aging with HIV and care coordination—training resources, State of Aging Survey reports, advocacy materials, and a searchable resource database.

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Healthy Aging Hub

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Healthy Aging with HIV Series

Certificate Program

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Healthy Aging with HIV Series

Certificate Program

A framework for understanding the health, social, and emotional realities of people aging with HIV

HealthHIV POZITIVELY AGING

Accredited Learning Series

- This series is jointly accredited, meaning clinicians across professions—physicians, pharmacists, nurses, physician associates, social workers, and others—can receive continuing education credit from the same activity.

- Each of the (5) modules is accredited individually, offering continuing-education credits [**AAPA, ABIM MOC, ANCC, CME, CPE**], and participants who complete the full series will receive a certificate of completion.

- Explores what it means to Age with HIV, connecting science, lived experience, and practice.

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Accessing the Series

https://healthhiv.org/healthy-aging-series/

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For more information

healthhiv.org

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Aligned Medical Education Offerings

HealthHIV offers live, virtual, on-demand certified medical education education on:

- HIV prevention/ PrEP
- HIV treatment
- Viral hepatitis
- Mpox
- LGBTQ health
- Harm reduction
- Health equity
- Healthcare access

To audiences of:

- Clinicians/ providers
- Allied health workers
- Public health workforce
- Patients
- Advocates

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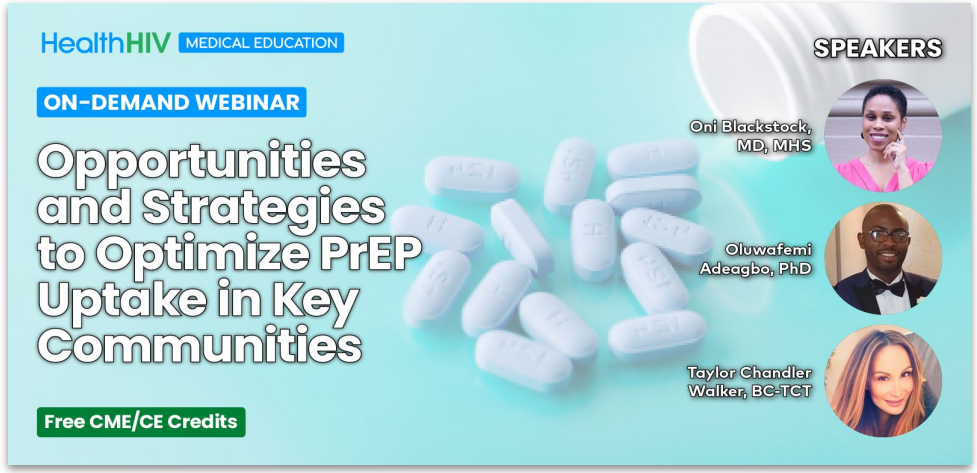

The LGBTQ Equity in HIV Prevention and Treatment Series

1. Individualizing HIV Prevention and Treatment
2. Accessing HIV Prevention & Care Services
3. Providing Optimal HIV Care to Transgender and Nonbinary Patients
4. Engaging Same-Gender-Loving Black and Latino Men in HIV Care
5. Coordinating Care for Older LGBTQ Adults

Enhance your clinical knowledge with expert-driven education

Gain actionable strategies for delivering culturally competent LGBTQ care

Earn up to 5.0 CE/CME/NCPD/AAPA/CPE credits, and a certificate of completion

Join a national community of providers advancing LGBTQ health equity

HealthHIV MEDICAL EDUCATION

healthlgbtq.org

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https://tinyurl.com/AgingWebinar26Eval

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Q&A