HealthHIV
STATE OF
Aging with HIV™
Fifth Annual National Survey

Organizational Readiness for Aging-Related HIV Care: A Four-Class Latent Class Analysis of Providers

Circe Gray Le Compte, ScD, MS, Senior Director of Research and Evaluation, HealthHIV

Poster 21

Models of Care

Most providers (**90%**) said their organization recognizes the need for age-responsive services, and **78%** said it is implementing changes.

Capacity is the constraint: the largest class (**34.6%**) recognized the need at 72% but was implementing at 42%, a **30-point gap**, against a 2-point gap in the most capable class.

The workforce is thin where it matters: HIV medicine outnumbered gerontology **14 to 1** (20.5% vs. 1.5%), and one in four organizations offered end-of-life or advance care planning.

BACKGROUND AND AIM

More than half of people with HIV in the United States are aged 50 or older, projected to exceed 70% by 2030, and geriatric syndromes appear 15 to 20 years earlier than chronological age would predict. Organizational readiness is usually framed as provider awareness, which implies education is the remedy. We tested whether recognition of aging-related need is already widespread and whether the constraint is the capacity to act.

METHODS

- HealthHIV's State of Aging with HIV National Survey, February to March 2026, REDCap: 341 providers (clinicians, case managers, community health workers, behavioral health professionals, policy advocates) in 37 states, Puerto Rico and the District of Columbia.
- Latent class analysis of 11 binary indicators (recognition, implementation, service offerings, advocacy capacity, workforce experience); Bayesian information criterion (BIC) selection across two- through seven-class models retained a four-class solution.
- For each class, the percentage-point gap between endorsing recognition of aging-related need and endorsing active implementation of change.

HIV AND GERIATRIC CARE DOMAIN

Four classes of organizational readiness: recognition did not separate them, capacity to implement did

	Full HIV and geriatric implementation 17.3%	Clinically focused 31.2%	Community and advocacy focused 16.9%	Minimal capacity 34.6%
Recognizes aging-related need	97%	92%	95%	72%
Actively implementing change	95%	68%	82%	42%
Agency collaboration, past year	94%	82%	91%	65%
Telehealth offered	88%	90%	52%	48%
Advance care planning offered	62%	25%	35%	8%
Advocacy confidence (very confident)	72%	22%	68%	18%
ADA awareness	78%	45%	69%	28%
Injectable ART interest (clinical)	92%	95%	45%	55%
Patients experienced discrimination	72%	68%	65%	58%
Caregivers have adequate support	35%	18%	28%	8%
Five or more years in role	72%	65%	58%	45%

Endorsement probability by class, all eleven indicators (BIC-optimal four-class solution, N=341). Classes ordered by implementation capacity.

What else marks each class

Clinically focused
Injectable ART familiarity 95%; advance care planning knowledge 25%; advocacy confidence 22%.

Community and advocacy focused
Agency collaboration 91%, the highest of any class.

Minimal capacity
Advance directive planning 8%. The largest class, and the one in the safety net serving people with the greatest need.

WORKFORCE DOMAIN

HIV medicine outnumbers gerontology 14 to 1 among the providers serving people aging with HIV

Share of providers by specialty, 2026

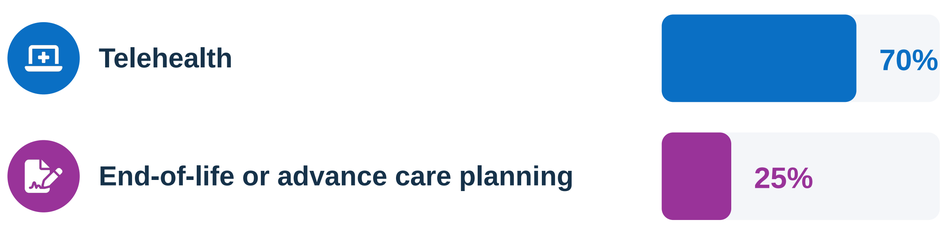


RWHAP clinics made up 32.0% of the organizations, and 71.6% were within the combined safety net.

HIV AND GERIATRIC CARE DOMAIN

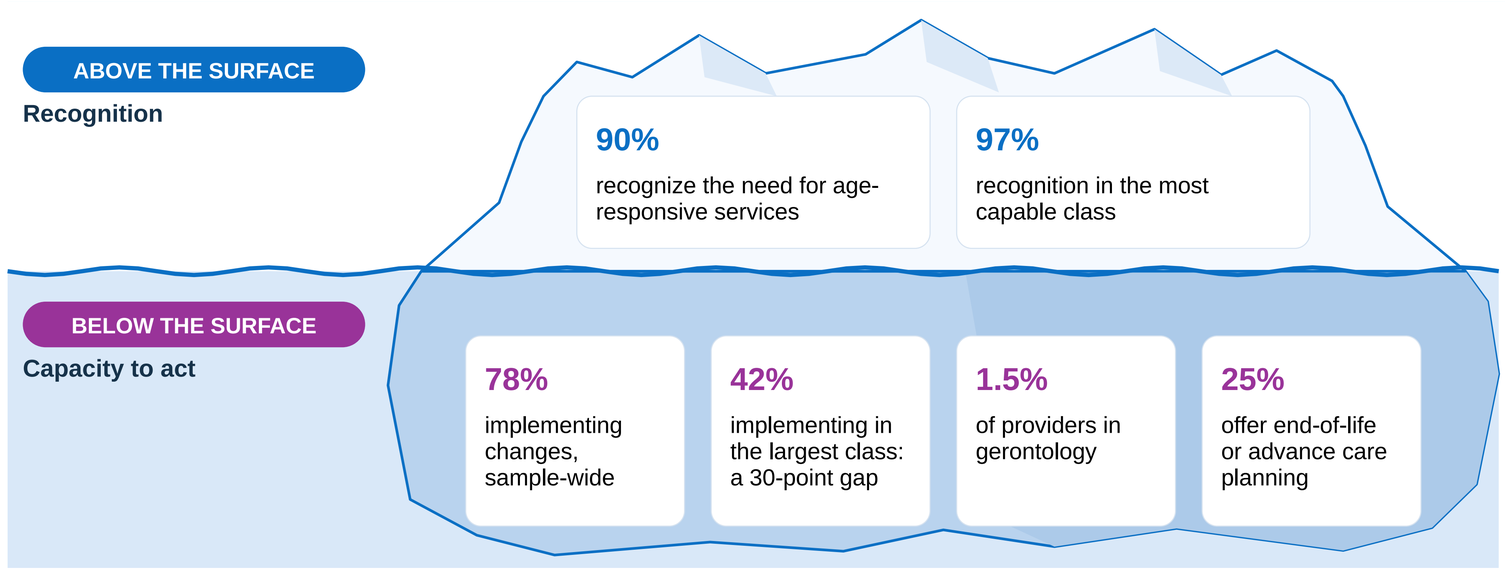
Telehealth is common; end-of-life, advance care planning are not

Share of organizations offering each service, 2026



The services that aging-related care depends on lag well behind the recognition of need.

CONCLUSIONS: ORGANIZATIONAL READINESS DRIVEN BY STRUCTURAL INEQUITIES AND GAPS BENEATH THE SURFACE



Recognition was high in every class
Three of four classes recognized the need at 92% or higher.

Capacity to implement care drove differences across classes
From a 2-point gap in the most capable class to 30 points in the least capable.

Financing drives inequities in service delivery, staffing, and geriatrics training
Awareness campaigns are unlikely to close that shortfall. The least capable class is the largest, and it is the one in the safety net serving people with the greatest need.

Limitations: cross-sectional, self-reported, non-probability data; organizational characteristics not independently verified; class assignment is probabilistic; published class counts total 342 against a stated N=341, so membership is reported as percentages. ADA = Americans with Disabilities Act; RWHAP = Ryan White HIV/AIDS Program.

HealthHIV's State of Aging with HIV™ Fifth Annual National Survey
Full report, data tables and webinar: HealthHIV.org/stateof/agingwithhiv Contact: research@healthhiv.org

Scan for the full report

HealthHIV
HealthHIV.org