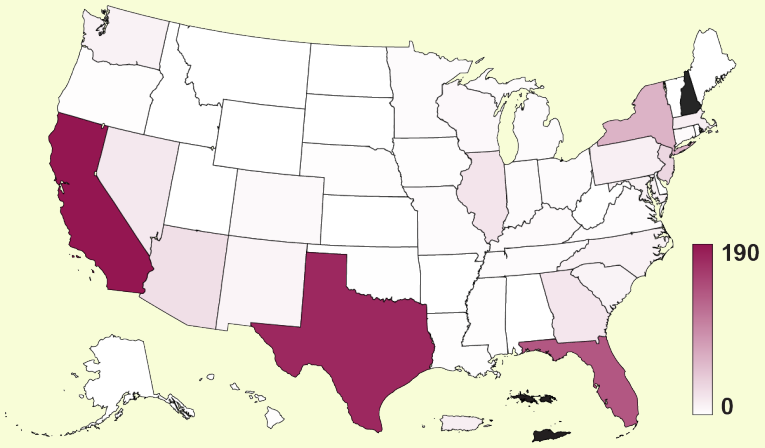
Addressing HIV and aging among U.S. Hispanics: A systems approach

This report provides epidemiologic data, information on structural factors, and tools, strategies, and recommendations to address the needs of Hispanics aging with HIV from a systems approach.

Approximately 65.1 million people, or 19.4% of the U.S. population, identified as Hispanic in 2023. That year, Hispanics made up 21.3% (819) of the 3,838 new HIV diagnoses among people 55 and older and 20.9% (98,582) of the 471,628 PLWH over 55. States with large Hispanic populations, like Texas, California, Florida, and New York, continue to contribute a significant share of HIV diagnoses among Hispanics aged 55 and older. Meanwhile, areas with smaller Hispanic communities, such as Georgia, Illinois, and Arizona, are showing emerging trends of higher HIV rates.

816 new HIV diagnoses among Hispanics, 55+, in the U.S. and Puerto Rico, 2023

(CDC AtlasPlus, 8/1/25, data suppressed for NH and no data for U.S. VA)



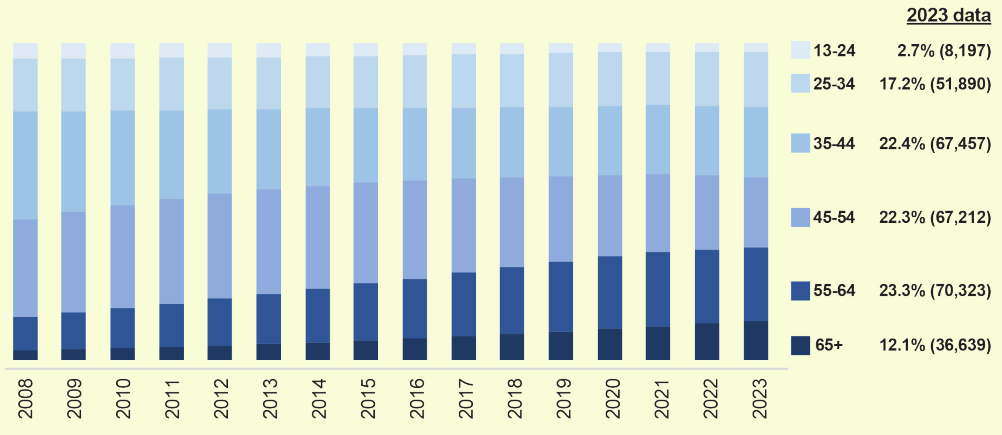
HIV-related mortality has steadily decreased in the USA since the introduction of Highly Active Antiretroviral Therapy (HAART) in 1996. Thanks to the effectiveness of and adherence to HIV medication, PLWH are living longer. While still suboptimal, the number of new diagnoses has decreased over time. Therefore, the proportion of PLWH aged 55 and above has increased and will likely continue to rise.

The intersection of aging and HIV raises questions about the capacity and preparedness of our current health practice, research, and policy to address the emerging health, social, and economic needs of the first large cohort of older adults living with HIV. Furthermore, we must examine the necessary changes to our current HIV and aging health system to ensure quality integrated care.

Hispanic PLWH in the U.S. and Puerto Rico by age, 2008-2023

(CDC AtlasPlus, 7/24/25)

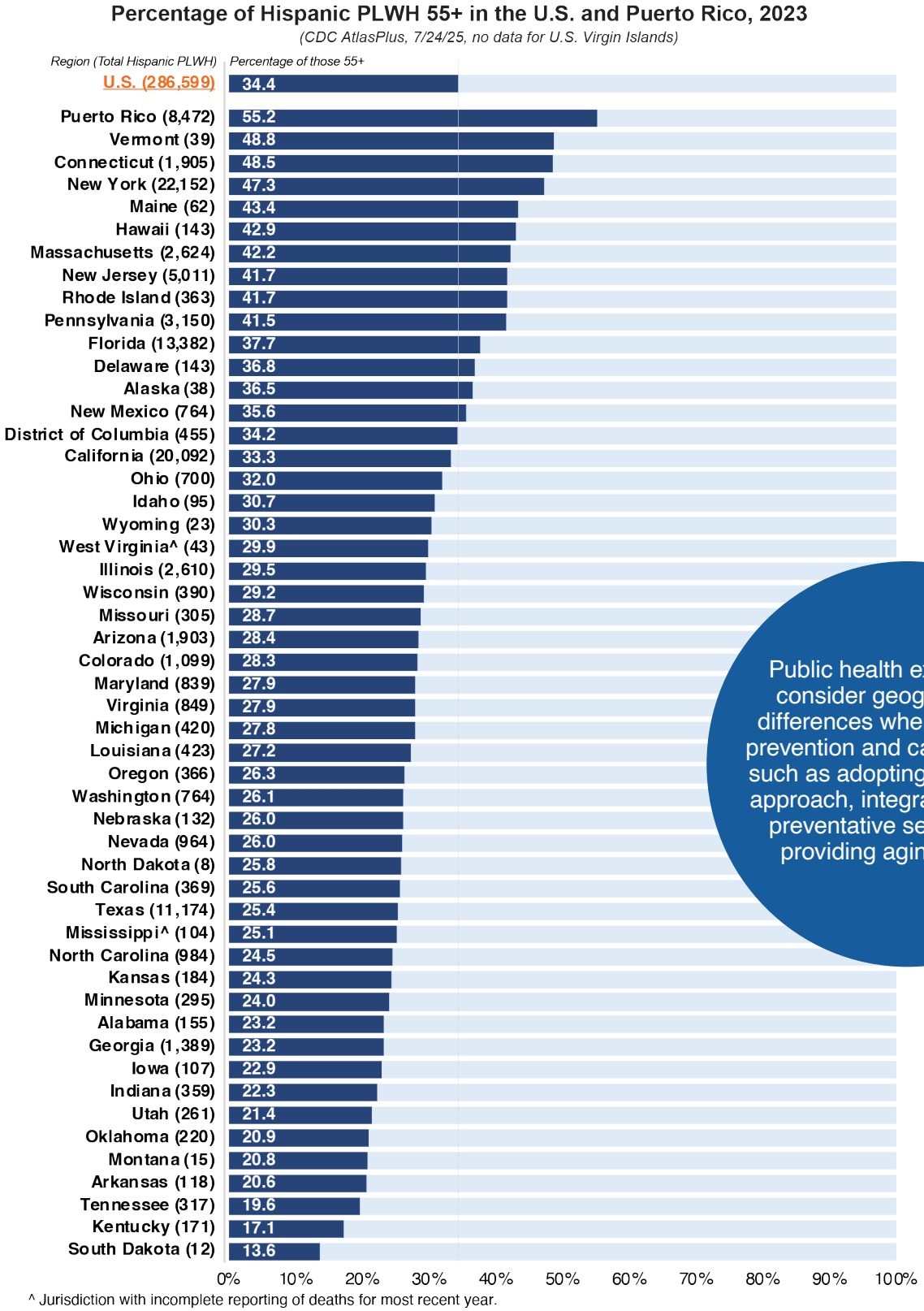
301,718 Hispanics living with HIV in 2023



The ILHE is the research and policy dissemination program of the Latino Commission on AIDS and the Hispanic Health Network. www.ilhe.org | ilhe.info@latinoaids.org

Geographic variations on the percentage and number of Hispanic PLWH 55 +

Over three-quarters (75.3%, 75,385) of older Hispanic PLWH live in New York, California, Florida, Texas, Puerto Rico, and New Jersey, highlighting the urgent need to immediately adapt current HIV care systems to meet the aging needs of PLWH. While the percentage of Hispanic PLWH over 55 is lower in states like Georgia, Texas, and Arizona, these states have a large number of Hispanics aging with HIV. Proactive planning is urgent and necessary to address the growing demand for aging-related services.



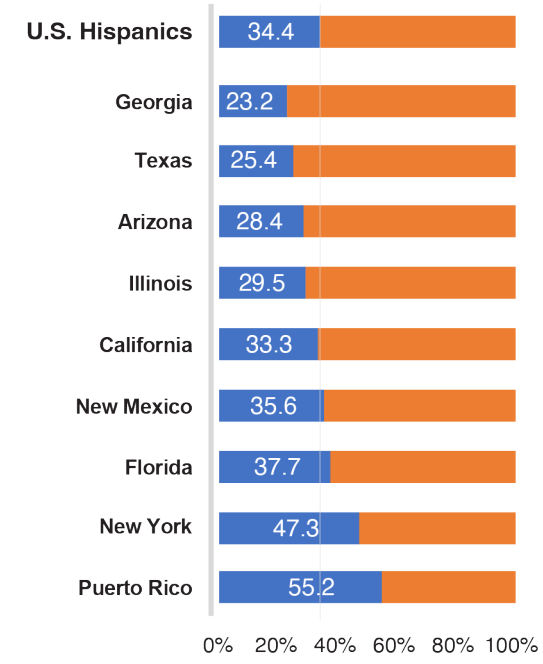
Public health experts must consider geographic age differences when developing prevention and care strategies, such as adopting a life-course approach, integrating HIV and preventative services, and providing aging support.

^ Jurisdiction with incomplete reporting of deaths for most recent year.

Geographic differences in the age makeup of Hispanic PLWH are clear across states, counties, and cities, showing different regional patterns in transmission and care. In places like Georgia, Texas, Arizona, and Illinois, higher diagnosis rates among younger Hispanics aged 25 to 34 lead to a lower average age in the local Hispanic PLWH population. On the other hand, regions with longer HIV epidemic histories and declining new diagnoses, such as Puerto Rico, New York, and New Mexico, tend to have a higher average age.

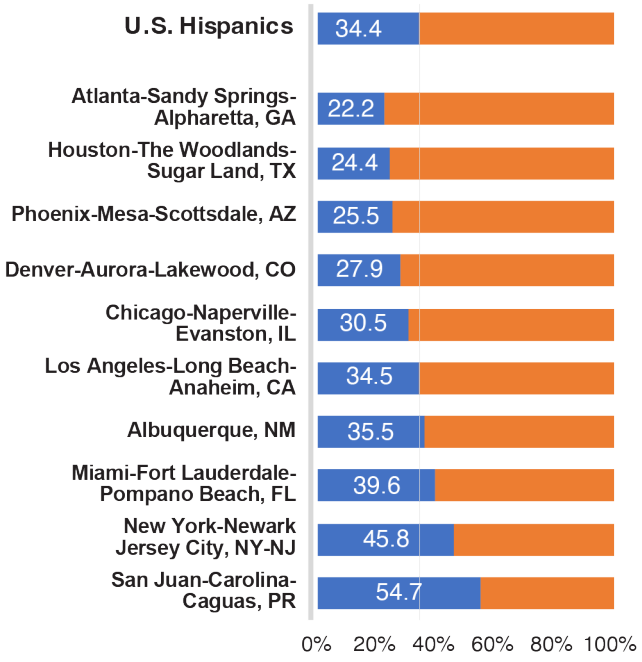
Percentage of Hispanic PLWH 55+ by region, 2023

(CDC, AtlasPlus, 7/14/25)



Percentage of Hispanic PLWH 55+ by MSA, 2023

(CDC, AtlasPlus, 7/3/25)



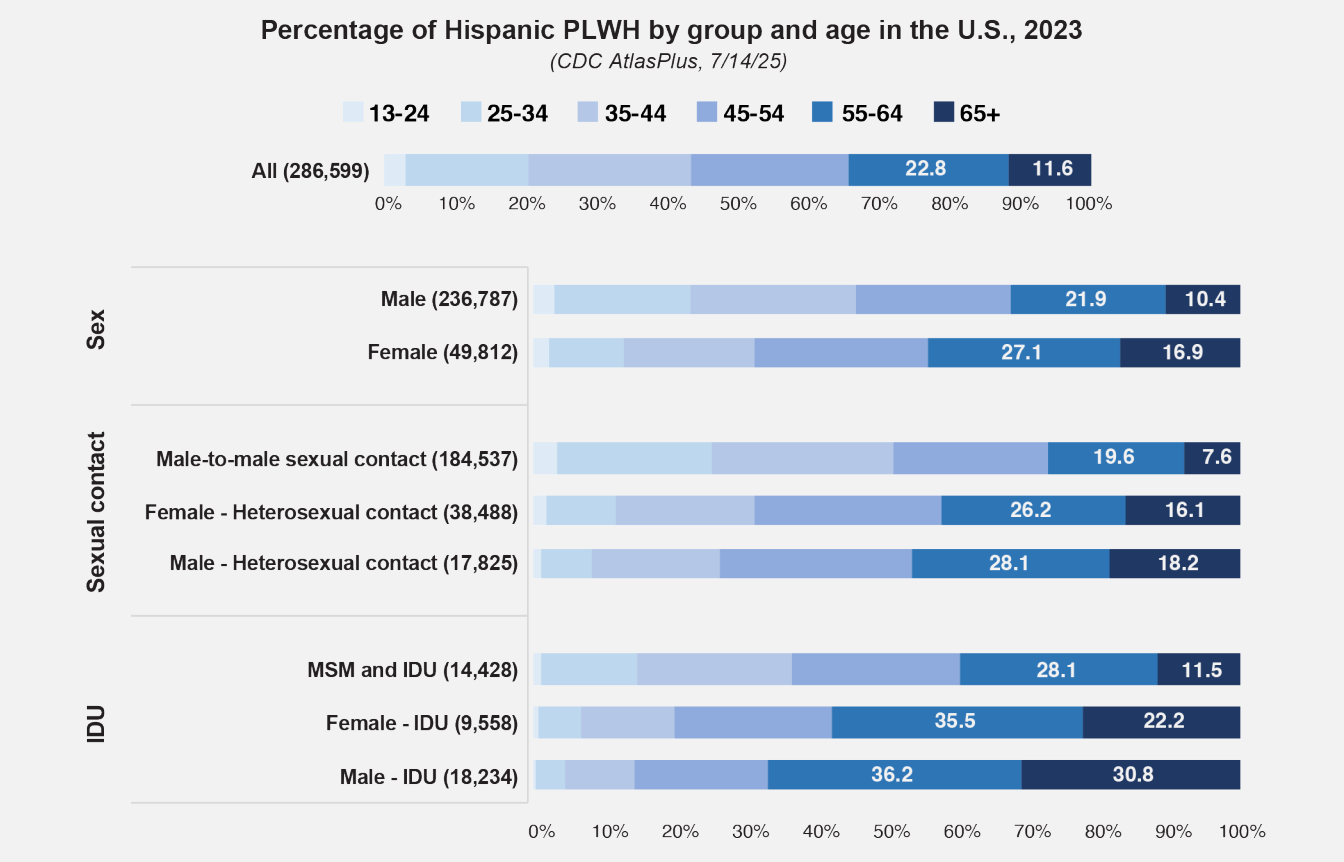
Advances in antiretroviral therapy (ART) have extended life expectancy, though not always resulting in greater quality of life and healthier lives.

Compared to the general population, PLWH face complex multimorbidity, extended polypharmacy, accelerated and accentuated aging, and ongoing health and social stressors. However, most healthcare systems across states and counties are unprepared to integrate aging-related services with HIV care.

Barriers include the complexity of coordinating HIV and preventative care, a shortage of specialized providers, fragmented services, and inadequate geriatric care models—especially for LGBTQI+ older PLWH.

Age variations among Hispanic PLWH and aging needs

Age variations among Hispanic PLWH stem from a complex mix of factors, including demographics, behaviors, historical trends, and disparities in access to antiretroviral therapy (ART). For example, the decrease in HIV transmission among people who inject drugs has resulted in an aging population within this group. Meanwhile, younger men who have sex with men (MSM) continue to face high transmission rates and new diagnoses, leading to an increased proportion of this group.



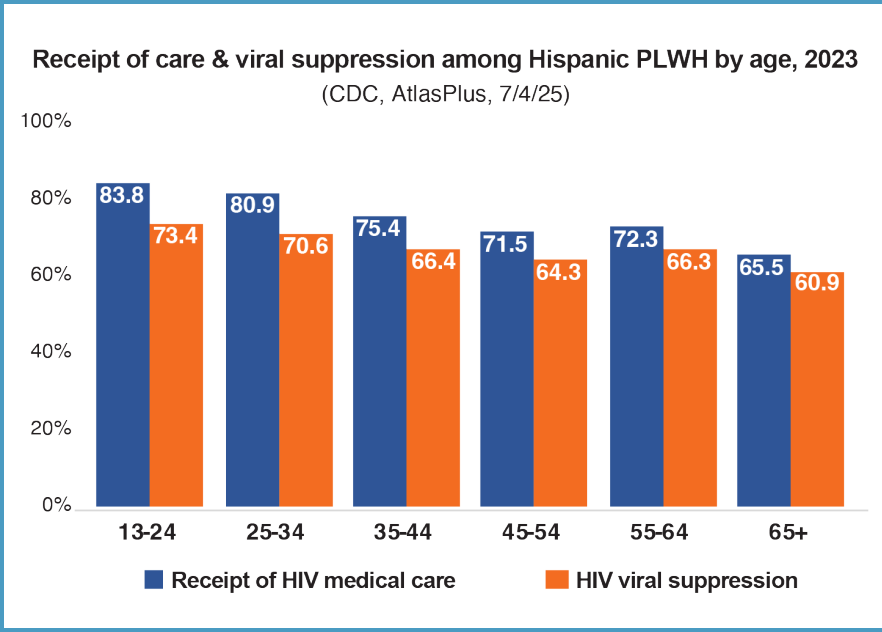
Addressing age-related epidemic trends demands age-appropriate HIV prevention strategies that include education on STIs, mental health, substance use, safe sex practices, and healthy relationships.

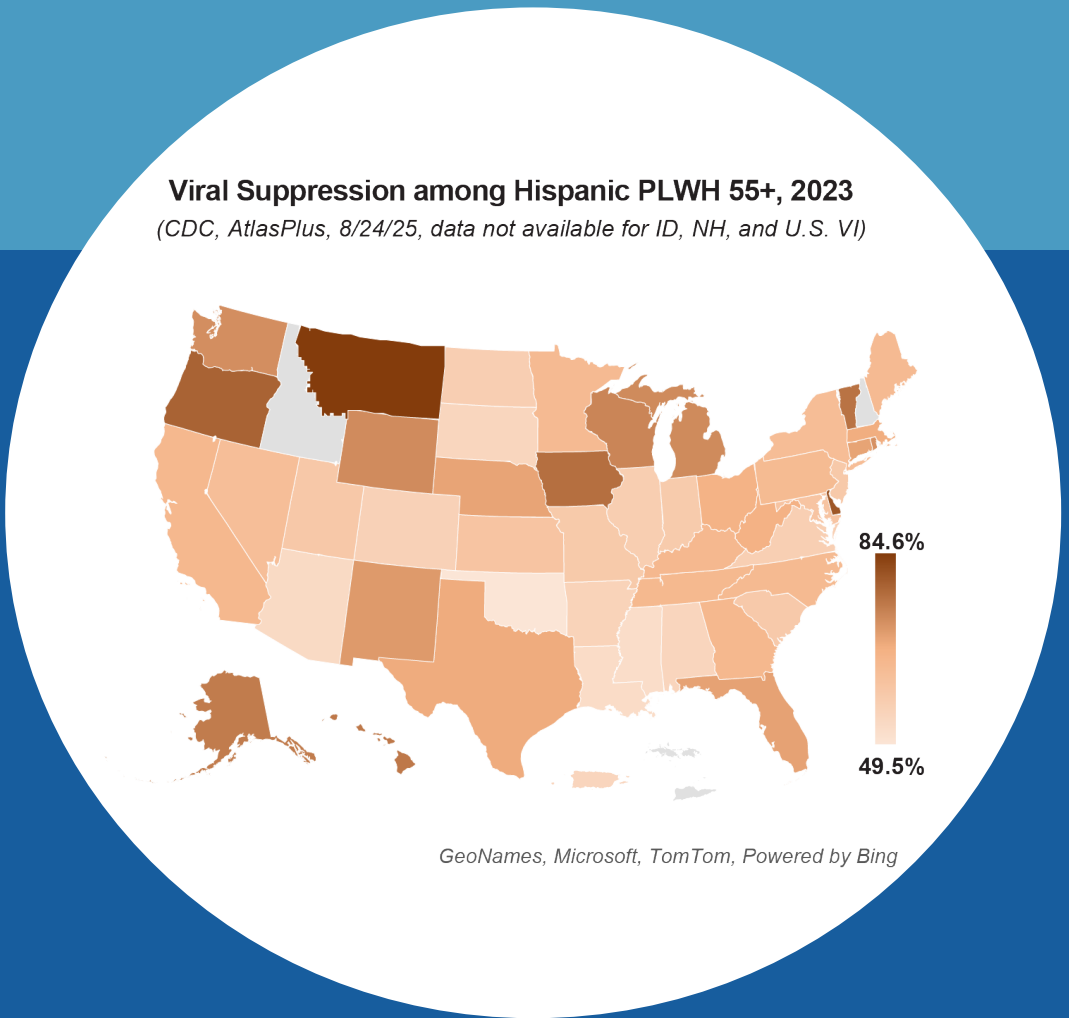
Sexual health education should extend beyond adolescents and must adapt to changing sexual behaviors and relationships throughout adulthood and into old age.

The HIV continuum of care

The HIV care continuum, which includes diagnosis, care linkage, treatment, retention, and viral suppression, is a crucial indicator of health outcomes for PLWH. However, Hispanics aging with HIV face significant infrastructure and geographic barriers to accessing care and reaching viral suppression.

Furthermore, poor health coverage, workforce shortages, and a complicated healthcare system impede timely access to care. Addressing these barriers is crucial for improving health outcomes throughout a person's life course, especially for those age 55 and older.





The map shows the variation in viral suppression among Hispanics aging with HIV across different regions, with some nearing the 90% target while others lag behind.

Ensuring timely care and viral suppression across the U.S. will require closer attention to differences in public health infrastuctures.

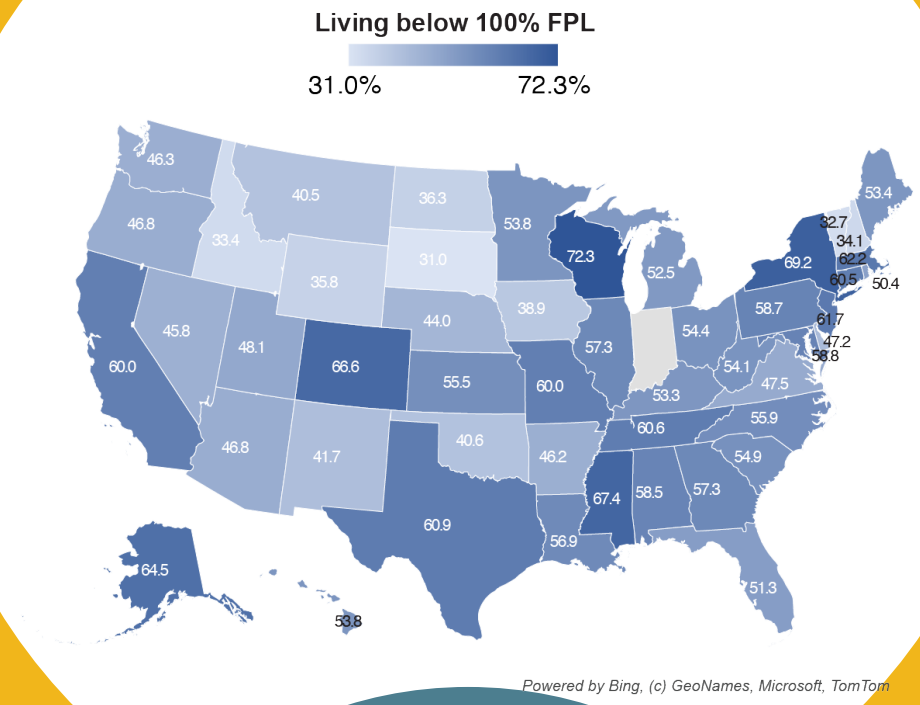
The critical role of the Ryan White HIV/AIDS Program (RW)

Lack of health insurance disproportionately affects Hispanics, with significant differences based on their location. HIV programs often struggle to connect people to care due to limited services, high costs, and poor accessibility. Expanding coverage requires a coordinated, multi-level approach involving local, state, and federal efforts.

Since its enactment 35 years ago, RW has provided essential health coverage and services to the most vulnerable PLWH across the U.S. and territories, including those living in extreme poverty (see map below). Despite its effectiveness, the current funding level for RW is insufficient to meet the growing needs for medical and non-medical case management, specialty and sub-specialty care, and long-term aging services.

Percent of RW clients living in extreme poverty, 2022

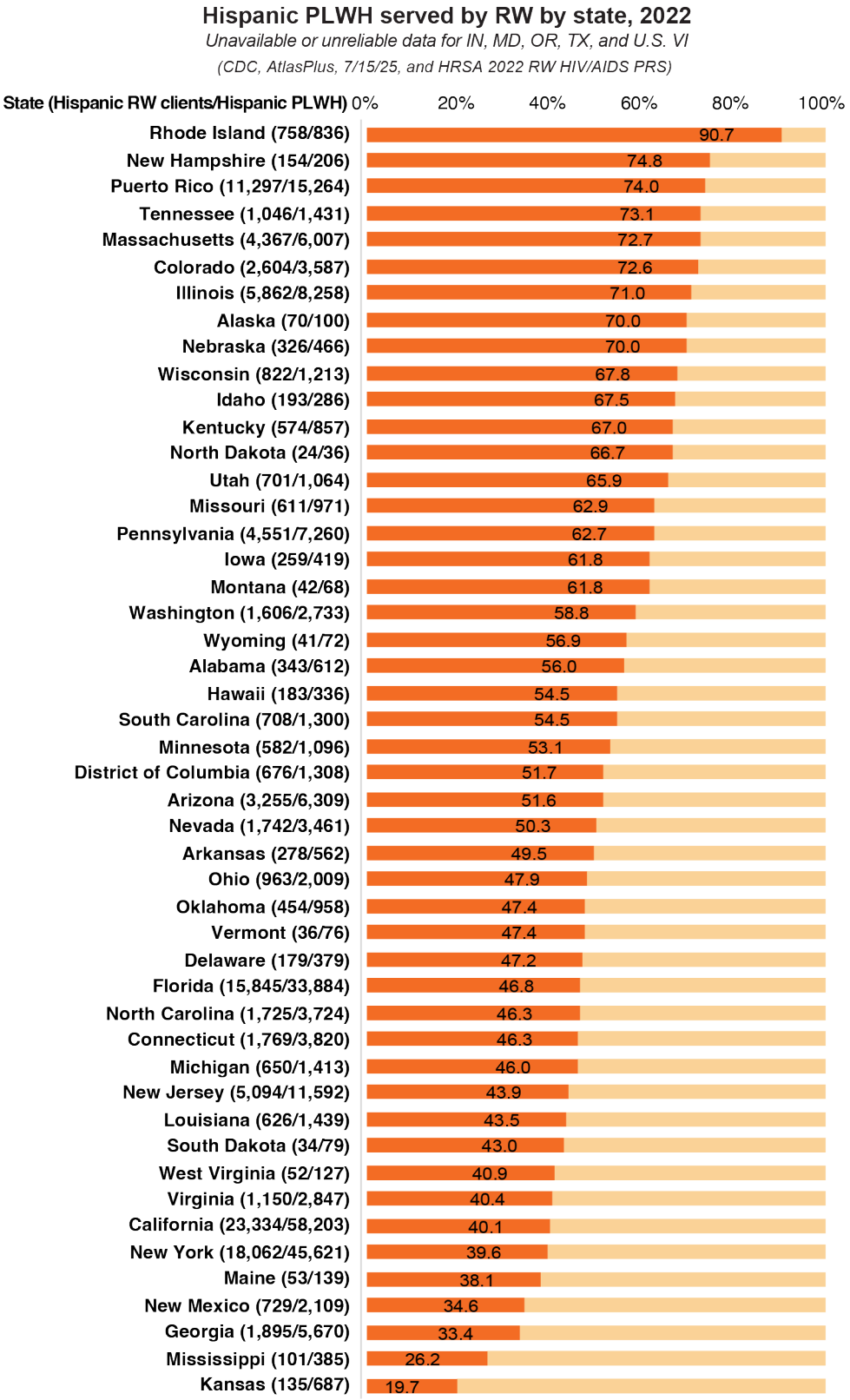
(HRSA, RW HIV/AIDS PRS, data unavailable for IN)



As of May 2025, ten states, including Florida, Georgia, and Texas, which have large Hispanic communities, still have not expanded Medicaid. While Florida has an initiative for a Medicaid expansion ballot measure scheduled for 2026, Texas shows even less momentum. The recent passage of Medicaid expansion in North Carolina underscores the importance of ongoing and comprehensive advocacy efforts in increasing healthcare access.

However, barriers still exist even in states where Medicaid and other insurance options are available. Not only do many residents distrust the healthcare system, but they also face high premiums, inadequate coverage, limited public transportation, inconvenient service hours, a shortage of bilingual providers, and increased stigma around seeking preventative care.

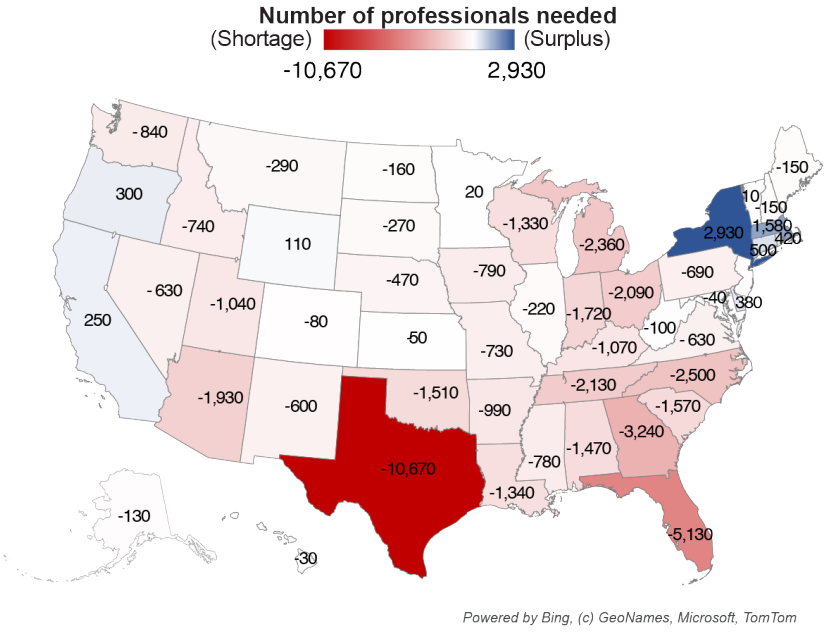
Hispanics living with HIV as clients of RW services



While highly successful in improving outcomes, RW faces ongoing critical challenges: flat funding combined with increased demand, a mismatch between formula-based funding and local needs, reliance on discretionary appropriations instead of mandatory funding, coverage gaps despite Medicaid expansion and the ACA, rising care costs (e.g., aging-related multimorbidities), and service fragmentation. As the table above shows, a large percentage of Hispanic PLWH depend on RW for services. Hispanic health leaders must collaborate with political leaders and public health officials to advocate for expanding and strengthening this vital program.

The shortage of the behavioral health workforce

Projected shortage and surplus of psychologists by 2030
(HRSA, Health Workforce Projections)



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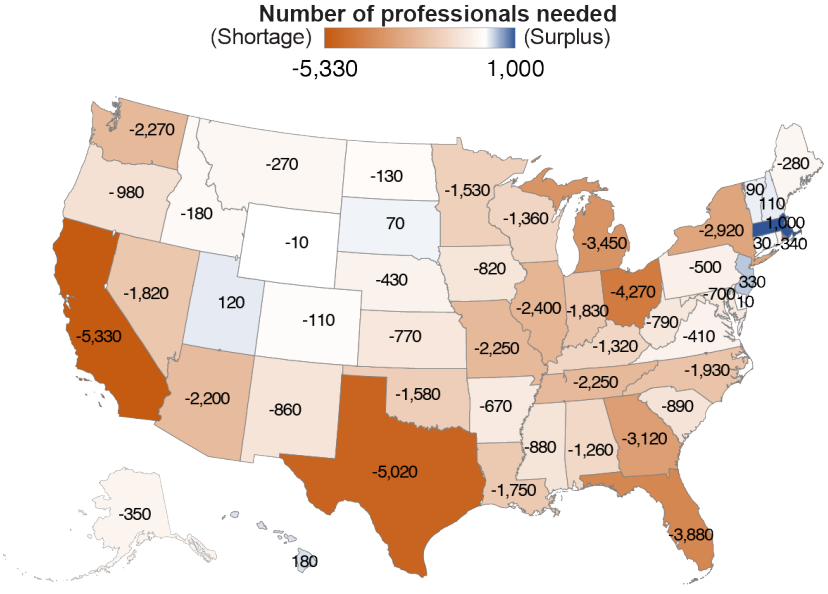
Projected shortage and surplus of addiction counselors by 2030
(HRSA, Health Workforce Projections)



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The goal of addressing the syndemic of HIV, mental illness, and substance use disorders continues unfilled.

Multiple individual and community barriers restrict the availability, accessibility, and use of behavioral health services, including harm reduction programs.

These factors include low behavioral health literacy, pervasive stigma, distrust of providers, and concerns related to immigration.

Structural barriers further restrict access to mental health and substance use services, including a lack of culturally and linguistically responsive care, insufficient health insurance coverage, and limited affordable options.

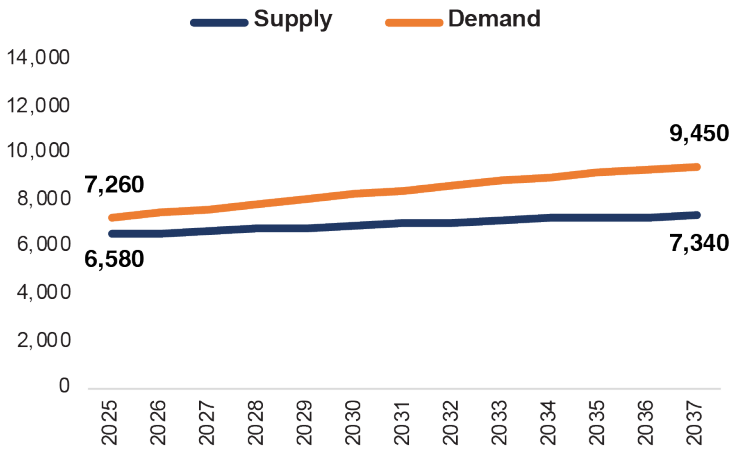
Additionally, in many areas, there is strong cultural and political opposition to certain services like needle exchange programs.

These challenges are worsened by a nationwide shortage of mental health and substance use professionals, especially in low-income neighborhoods, rural areas, and immigrant communities.

This shortage is predicted to worsen over the next ten years, decreasing the availability of services for an aging population living with HIV.

The shortage of the geriatric care

Demand & supply of geriatric physicians, 2022-2037
(HRSA, Health Workforce Projections)



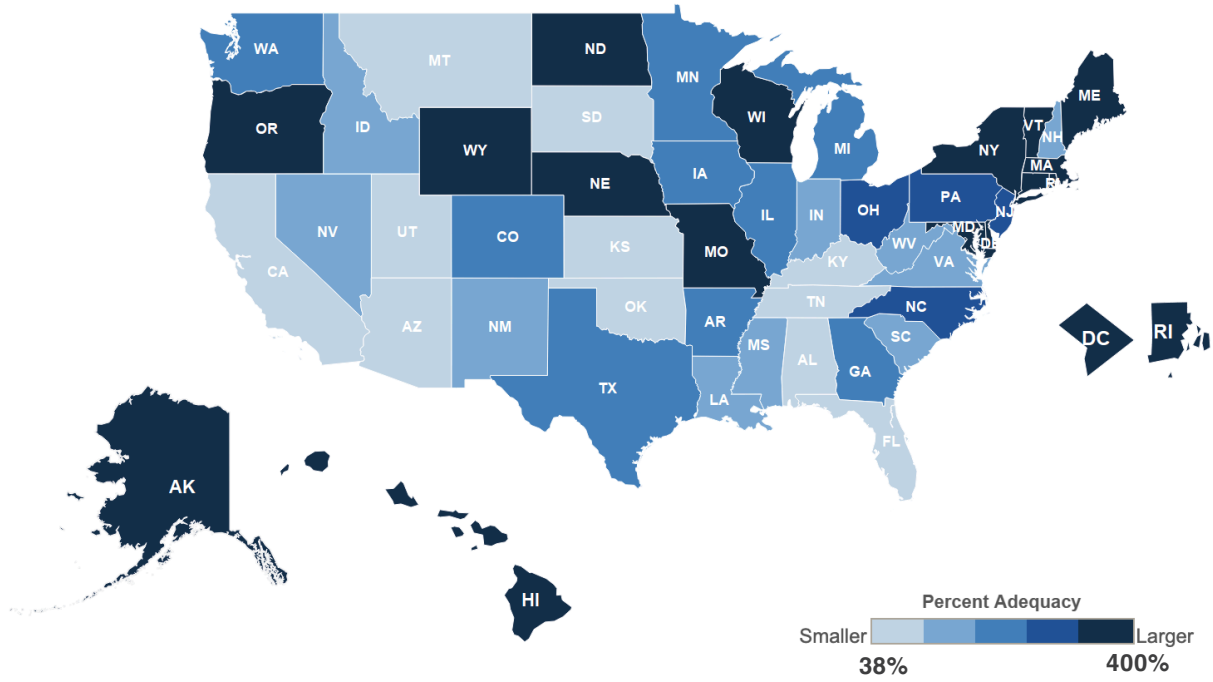
The U.S. also faces a critical shortage of geriatric care providers, a challenge that has significant implications for the growing population of people aging with HIV.

Older adults with HIV often face earlier onset of chronic conditions, complex medication schedules, and higher risks of cognitive decline compared to their peers. Yet, few clinicians are trained to address both HIV and geriatric needs.

The absence of cross-trained providers increases care fragmentation care, unmanaged comorbidities, and poor health outcomes.

Without intentional investment in geriatric workforce development and integration of geriatric principles into HIV care, the health system will have difficulty meeting the needs of this vulnerable and growing population.

Percent adequacy of geriatrics physicians supply and demand by state, 2030
Adequacy is the quotient of supply divided by demand. A larger percentage indicates a higher supply of geriatric physicians.
(HRSA, Health Workforce Projections, 8/20/25)



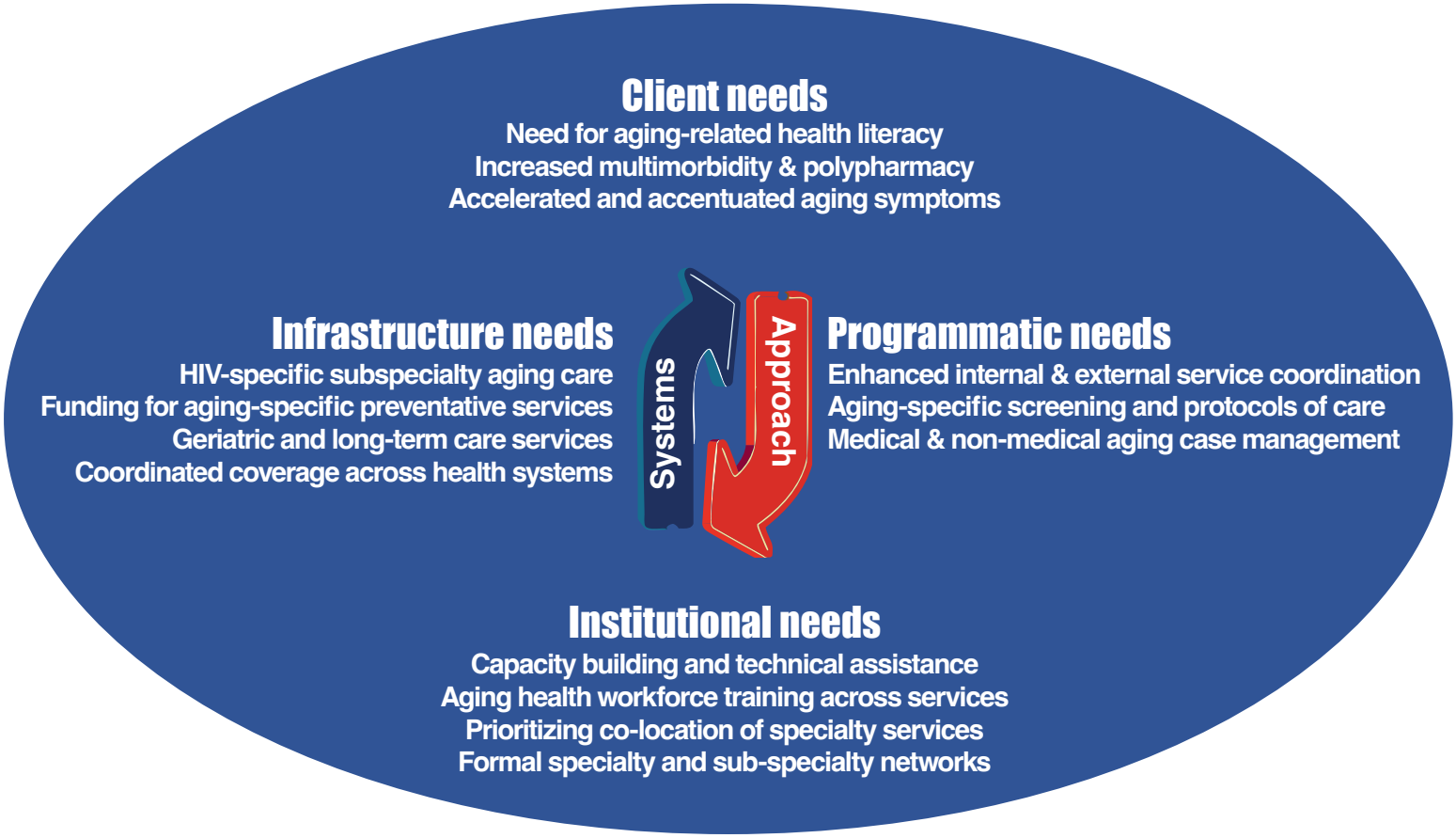
A systems approach to meeting the needs of aging adults living with HIV: Rapid responses and preparedness plans.

While HIV providers may successfully identify their patients' aging needs, multiple barriers prevent the proper delivery of aging-related services to older PLWH. For example, there is widespread fragmentation between aging services and HIV services, a lack of coordination among providers, and limited insurance coverage for subspecialty services.

A key question is how to integrate aging and behavioral care for OPLWH within the existing HIV care model. Various service models aim to address the aging needs of people living with HIV throughout the HIV care continuum. These models include in-house screenings or assessments, referrals to off-site geriatric care, greater integration of HIV care into primary and geriatric care within a clinic, and referrals to off-site geriatric services for evaluations and treatment.

However, the intersection of aging and HIV raises questions about whether our current health practices, research, and policies are prepared to meet the emerging health, social, and economic needs of the first large group of older adults living with HIV.

There is an urgent need to develop rapid response and preparedness plans to address the needs of PLWH at the national, state, and local levels. These responses require a systems approach that considers the local and regional needs of clients, programs, institutions, and public health infrastructure. The diagram below shows a potential approach with key needs at each level.



What strategies has your organization implemented or could implement to integrate HIV care, preventative services, and aging care?

- ☐ Assessing the organization's HIV care and preventative system (e.g., aging trends, workforce, onsite and offsite services, funding sources)

- ☐ Establishing age-specific clinical care protocols tailored to the patient population.
- ☐ Prioritizing major multi-morbidities presented in the patient population
- ☐ Deciding who, what, when, and how to screen (e.g., internal vs. referral)

- ☐ Prioritizing the co-location of critical specialty services based on patient data
- ☐ Establishing formal networks with specialty and sub-specialty providers

- ☐ Streamlining HIV and aging care coordination both internally and externally
- ☐ Establishing medical and non-medical aging case management services
- ☐ Training staff on accelerated and accentuated aging and aging-related services

There are many resources available to help you integrate HIV and aging care. Contact your local health department, the nearest AETC, or reach out to us.
www.ilhe.org ILHE.info@latinoaids.org

The following strategies propose a collaborative approach between communities, providers, academia, and federal, state, and local governments to strengthen our response to HIV while addressing broader health disparities and inequities.

- **Ensure Adequate HIV Funding:** Ensure consistent, multi-year funding for the Ending the HIV Epidemic (EHE) initiative and the Ryan White HIV/AIDS programs, with regular public reporting on expenditures and progress.
- **Enhance Service Coordination and Integration:** Strengthen coordination and integration between HIV, primary, aging, behavioral health, and preventive services to provide seamless, patient-centered care.
- **Strengthen the HIV Response in Puerto Rico, the U.S. Virgin Islands, and Territories:** Assess HIV service gaps and healthcare infrastructure and develop strategies for improving service availability, surveillance, and access to care.
- **Strengthen Local Health Infrastructure:** Allocate resources to bolster county-level health systems, particularly in underserved areas, improving service delivery and capacity.
- **Improve Healthcare Access and Affordability:** Expand coverage options, remove financial barriers, and ensure culturally responsive and non-discriminatory care for all.
- **Expand Rural and Community Health Systems:** Increase funding for Rural Health Centers, Community Health Centers, and Federally Qualified Health Centers (FQHCs) to improve access in underserved areas.
- **Address Workforce Shortages:** Prioritize recruitment, training, and retention strategies to expand a sustainable clinical, behavioral, preventive, and long-term health workforce.

Technical notes

For simplicity, we use the overarching term Hispanic to refer to diverse self-identifications within our communities, including those related to race/ethnicity, family origin, and gender expression (e.g., Hispanic, Latino, Cuban-American, or Latinx).

Data sets were retrieved between July and August 2025.

1. CDC. NCHHSTP AtlasPlus. https://www.cdc.gov/nchhstp/about/atlasplus.html.
2. HHS. HRSA, Health Workforce Projections. https://bhw.hrsa.gov/data-research/review-health-workforce-research
3. HHS. HRSA, 2022 RW Annual Data Report. https://ryanwhite.hrsa.gov/data/reports

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