



Regular Research Article

Housing Assistance and Health Care Access Among Older Adults with Alzheimer's Disease and Related Dementias: Evidence from Multisource Linked Survey-Administrative Data

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ABSTRACT

Objectives: To examine health care access among older adults, with specific attention to the importance of the US Department of Housing and Urban Development (HUD) housing assistance participation and Alzheimer's disease and related dementias (ADRD) diagnosis. **Design setting and participants:** We used a multisource survey-administrative data linkage, combining the 1999–2016 National Health Interview Survey (NHIS), 1999–2018 HUD administrative housing records, and 1999–2018 Medicare enrollment and claims records. The sample included 46,269 NHIS participants aged 65 and above who were linked to the Medicare enrollment and claims file and who were eligible for linkage to the HUD administrative record, regardless of participation in HUD programs. **Measures:** ADRD status was determined based on a documented diagnosis in Medicare claims. Participation in HUD housing assistance was determined through HUD records. Health care access measures were having no usual source of care, delayed/forgone needed care due to cost, and forgone needed medications due to cost. **Results:** Among adults with ADRD, 10% received HUD housing assistance, compared to 5% in the overall sample. Adults with ADRD receiving housing assistance were 2.3 percentage points less likely

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(95% CI: 1.1–3.7) to report no usual source of care but were more likely to report delayed/forgone care (5.9 percentage points) and forgone medications (4.2 percentage points) compared to those with ADRD but not receiving housing assistance. **Conclusions:** In this nationally representative study of the older adults with ADRD, those receiving housing assistance tended to maintain a usual source of care, but experience cost-related barriers to necessary care. (Am J Geriatr Psychiatry 2026; 34:1068–1078)

Highlights

- **What is the primary question addressed by this study?**

What is the relationship between HUD housing assistance participation and health care access among older adults with and without Alzheimer's disease and related dementias (ADRD)?

- **What is the main finding of this study?**

Adults with ADRD were twice as likely to receive housing assistance as those without ADRD. Among adults with ADRD, those who receive housing assistance were less likely to have no usual source of care but more likely to report cost-related delays of care compared to those who do not receive housing assistance.

- **What is the meaning of the finding?**

Among older adults with ADRD, maintaining a strong connection to a health service provider was not sufficient to avoid barriers to care due to cost.

OBJECTIVE

From 2021 to 2050 the number of Americans 65 years old and older is estimated to increase from 58 million to 88 million, likely increasing the prominence of dementia as a public health concern in the United States.¹ Adults with Alzheimer's disease and related dementias (ADRD) often have complex care needs that require regular medical visits and consistent medication adherence. As a result, adults with ADRD experience an increased risk of emergency department visits and hospitalization, use high levels of postacute care, and have a substantial need for home health care.^{2–4} However, adults with ADRD often face challenges accessing high-quality health care, and thus may use necessary services less than is optimal.^{5,6} Because of the significance of access to care for adults with ADRD, understanding nonhealth factors that may affect the ability to access affordable care is critical. Among these, social determinants of health, such as housing, play an important role.⁷

Access to stable housing is particularly important for health care access among older adults.^{8,9} Although older adults are more likely to own their homes than

younger or middle-aged, they face multidimensional risks to housing affordability and stability,¹⁰ and racial and ethnic minorities are disproportionately affected.¹¹ Unstable housing presents challenges for managing conditions such as ADRD that require complex behaviors, adherence to medications, and regular health care visits.¹² Housing programs that improve housing stability, such as federal housing assistance programs from the US Department of Housing and Urban Development (HUD), may improve health and health care access for older adults, particularly older adults who face challenges accessing quality health care. While access to HUD housing assistance has been shown to improve adult physical and mental health and reduce unmet health care needs,^{13–15} adults with ADRD represent a growing and understudied population in research on the relationship between housing and health.

In 2022, HUD provided housing assistance to 9.2 million people in 4.6 million families, including nearly 2 million families headed by an adult 62 years old or older.¹⁶ While these programs provide access to stable and affordable housing, fewer than one in four eligible families receives assistance, while most housing agencies maintain lengthy waiting lists that

average 2 years.¹⁷ Evidence indicates that housing assistance has positive effects on health,¹⁸ while also providing a significant economic boost that may improve access to needed health care and medications.¹⁵

We make three primary contributions to the literature. First, we employ linked survey and administrative data. Past work limited by a lack of comprehensive data. Few surveys contain administrative measures of housing assistance participation¹⁹ and ADRD diagnosis,²⁰ and it is rare for data systems that contain this information to be nationally representative.²¹ Second, our measures of housing assistance and ADRD do not rely on self-reports. To our knowledge, this is the first study to build and apply a multisource linkage of nationally representative survey data, HUD administrative housing data, and Medicare enrollment and claims data. This integrated data system provides concurrent information on health care access, ADRD diagnosis, and housing assistance program participation. Finally, we highlight the significant overlap of individuals with ADRD and those receiving housing assistance, emphasizing the importance of describing health care access for these groups.

METHODS

We created a dataset that links information about the same individuals across three sources: the National Health Interview Survey (NHIS), HUD administrative records, and Medicare enrollment and claims information. NHIS is a nationally-representative household survey of the civilian noninstitutionalized population collected annually in repeated cross-sections by the National Center for Health Statistics (NCHS). The survey collects information on household structure, sociodemographic characteristics, and self-reported measures of health care access and use. We obtained data from IPUMS NHIS at the University of Minnesota-Twin Cities.²² The HUD administrative record contains longitudinal information on HUD housing assistance entry and exit, which is used to assign survey respondents to housing assistance status groups at the time of interview.²³ These data have significant benefits over self-reported housing assistance participation, which is likely to be heavily biased. The Medicare file contains annual information

on Medicare enrollment and health care claims, including disease diagnoses. The file contains an annual flag indicating whether an individual has previously been diagnosed with ADRD or has received a new ADRD diagnosis. Once combined, these three data sources have enormous potential to describe the health care experience of older adults as a function of housing assistance status and ADRD diagnosis.

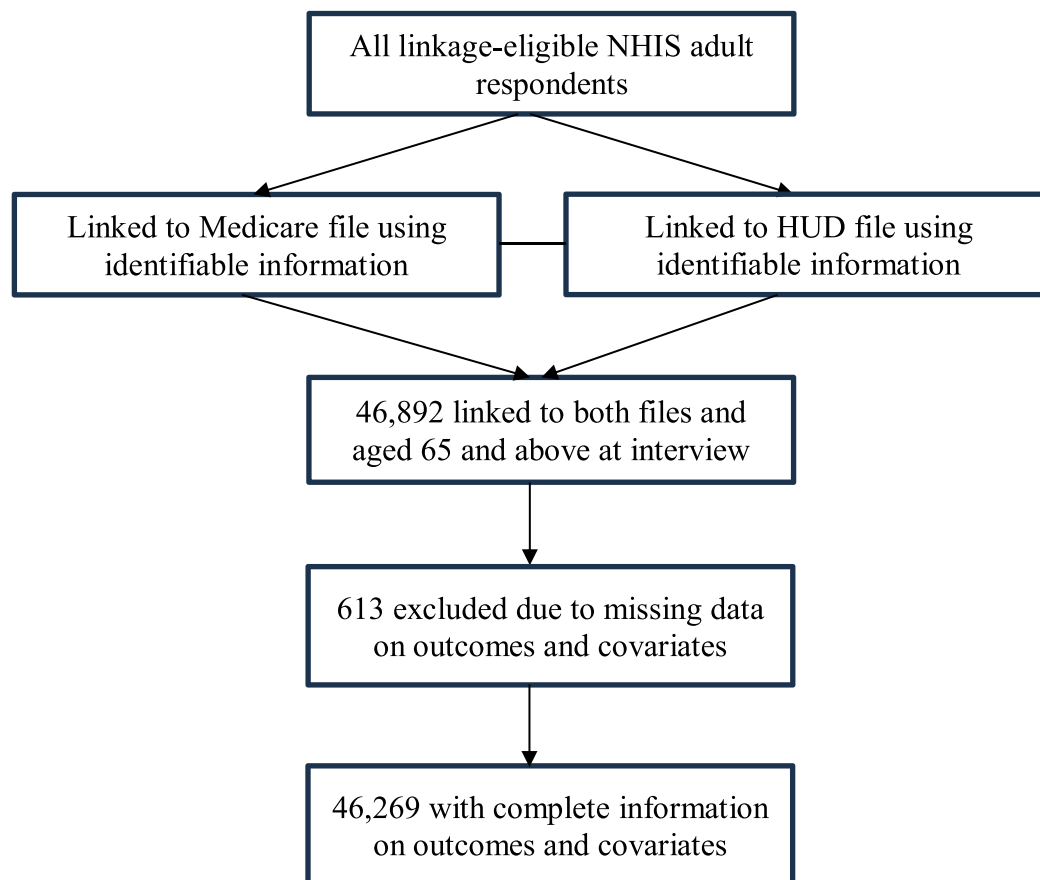
Linkage

The NHIS samples from 1999 to 2016 serve as the base of the analysis, and survey participants were separately matched to each of the HUD and Medicare data files. To be eligible for linkage, individuals must consent to have their data linked and must provide sufficient identifiable information to NHIS. NCHS links individuals using social security number, first and last name, and date of birth.²³ Matches are determined probabilistically based on a likelihood score that the match represents the same individual. Once individuals are linked to the Medicare file, we have an annual record of disease diagnoses. Linkage to the HUD record provides information on HUD housing assistance participation, including no HUD housing assistance during the observation period. NCHS also developed weights that adjust for selectivity in linkage eligibility in order to maintain the representativeness of the linkage-eligible sample. [Figure 1](#) presents the process used to construct the final linked sample from the individual datasets.

Sample

The sample includes adults aged 65 and over who were interviewed by NHIS (1999–2016), linked to the Medicare record, and either linked to the HUD record or linkage-eligible to that record. We used Medicare Chronic Condition Data Warehouse to identify whether a respondent had received a diagnosis of either Alzheimer's disease or other dementias in any year following Medicare enrollment. Individuals diagnosed with either condition by the time of their NHIS interview were considered as having ADRD. We excluded 623 individuals from the sample (1.3%) due to missing data on one or more of the outcomes. The final sample included 46,269 individuals. At the time of their interview, 2,232 adults had received a diagnosis of

FIGURE 1. Sample construction process involving linkage of NHIS, Medicare, and HUD data files.



ADRD, while 44,037 had not. Housing assistance status was measured at the time of the NHIS interview using the entry date and exit date based on the HUD record. At the time of the interview, 2,304 were currently receiving housing assistance, of whom 232 respondents had both a diagnosis of ADRD. Because about 5% of the overall sample received HUD housing assistance, and only 10% of that group had an ADRD diagnosis, we were limited in our ability to create a quasi-experimental comparison group as has been used in other studies of housing assistance.^{13,14} However, the NHIS-HUD-Medicare linked dataset is the only data source capable of studying health care access in a national sample of housing assistance recipients with ADRD. To our knowledge, ours is the first study to use this unique multisource linkage for that purpose.

Health Care Access Measures

We used three binary measures of health care access from the NHIS to assess unmet health care need: 1) no usual source of care, 2) delayed/forgone care due to cost, and 3) forgone prescription medications due to cost. First, we examined whether a respondent reports having no usual source of care (“usual place you go when sick or need medical advice”). Second, we combined two questions from NHIS about delayed or forgone care due to cost in the past year. We coded respondents as having delayed/forgone care if they answered affirmatively that they “delayed medical care because of worry about the cost” or “needed but did not get medical care because they couldn’t afford it.” Finally, we examined whether respondents reported that they “needed prescription medicine but did not get them because they couldn’t afford it” in the past year.

Covariates

We included demographic and socioeconomic characteristics from NHIS: age group (65–84, ≥85), sex, race/ethnicity (non-Hispanic White, non-Hispanic Black, Hispanic, other), level of education (less than high school, high school diploma, some college, Bachelor's degree), marital/partnership status (single vs. married/partnered), and family size (1, 2, ≥3). To account for geographic variation in housing supply and local housing agency priorities, we adjusted for U.S. region of residence. Finally, we adjusted for interview year to account for temporal changes in housing assistance and health care access. We did not include additional characteristics that are likely to change in response to housing assistance or ADRD diagnosis. Including such variables as income, employment, health status, or neighborhood characteristics could reduce observable differences between the HUD and ADRD groups but may also introduce bias by adjusting for factors on the pathway from housing assistance or ADRD to healthcare access. For instance, employment and income may change in response to entry into housing assistance or the timing of an ADRD diagnosis. Similarly, housing assistance may directly affect health status¹³ or the types of neighborhoods that individuals access.²⁴

Analytical Strategy

We examined the relationship between housing status, ADRD, and health care access measures using linear probability models. Although results were consistent using logistic regression models, we preferred linear probability models given concerns with comparing the magnitude of odds ratios across groups within models.²⁵ Linear probability models present more intuitive coefficients reflecting differences in the prevalence of each outcome. We considered differences between four housing assistance/ADRD groups: 1) No ADRD, no housing assistance, 2) ADRD, no housing assistance (reference category), 3) No ADRD, housing assistance, 4) ADRD and housing assistance. We calculated 95% confidence intervals using Taylor series linearized variance estimation. We used NCHS-created weights that adjusted for linkage eligibility and accounted for the complex multistage design of the NHIS.²⁶ All analyses were conducted within a Federal Statistical Research Data Center due

to the use of restricted data. We used Stata 17 for all analyses.

RESULTS

Descriptive characteristics of the sample are shown in [Table 1](#), stratified by ADRD and housing assistance status. In total, 5.0% of the sample received HUD housing assistance at the time of interview (2,304 out of 46,269). Individuals with ADRD were more likely than those without ADRD to receive HUD housing assistance. 10.4% of adults with ADRD were receiving housing assistance (232 out of 2,232) compared to 4.7% of adults without an ADRD diagnosis (2,072 out of 44,037). Given the age groups considered, women constituted the majority of all groups, especially those receiving housing assistance, where approximately 70% are women, consistent with existing research.²¹ Adults receiving housing assistance were more likely to be racial and ethnic minorities, although the difference was smaller among those with an ADRD diagnosis. Individuals with an ADRD diagnosis and/or receiving housing assistance tended to have lower levels of education than those without ADRD or assistance.

[Table 2](#) presents the results of three regression models, each examining one of three health care access outcomes as a function of housing assistance and ADRD status. In all models, adults with ADRD but no housing assistance served as the reference category. The first column examined the probability of having no usual source of care. Controlling for demographic and economic characteristics, those with neither ADRD nor HUD assistance were more likely to have no usual source of care (coef. = 0.007, 95% CI: –0.000, 0.015) although this should be interpreted cautiously ($p = 0.053$). Those with both ADRD and HUD housing assistance were 2.3 percentage points less likely to have no usual source of care (95% CI: 1.1–3.7 percentage points). These findings suggested that, among individuals with ADRD, receiving HUD housing assistance was associated with better connection to a usual source of care.

The second column presented a model predicting whether the respondent reported delayed/forgone care due to cost. Adults receiving HUD housing assistance were significantly more likely to report unmet needs than those not receiving assistance, regardless

TABLE 1. Descriptive Characteristics of NHIS-HUD-M Sample By ADRD and Housing Assistance Status 1999–2016 (N = 46,269)

	No ADRD No Assistance	ADRD Diagnosis No Assistance	No ADRD HUD Assistance	ADRD Diagnosis HUD Assistance
N	41,965 (90.7%)	2,000 (4.3%)	2,072 (4.5%)	232 (0.5%)
Female	0.553	0.624	0.718	0.689
Age Groups				
65–84	0.928	0.720	0.890	0.803
≥85	0.072	0.280	0.110	0.197
Race/Ethnicity				
Non-Hispanic White	0.819	0.796	0.557	0.553
Non-Hispanic Black	0.088	0.108	0.253	0.214
Non-Hispanic Other	0.031	0.028	0.048	0.076
Hispanic	0.063	0.068	0.142	0.156
Education				
Less than high school	0.158	0.255	0.410	0.389
High school	0.292	0.326	0.292	0.307
Some college	0.278	0.230	0.211	0.228
Bachelor's degree	0.272	0.188	0.087	0.077
Marital status				
Single	0.449	0.652	0.907	0.923
Married/Partnered	0.551	0.348	0.093	0.077
Family size				
1	0.368	0.552	0.674	0.822
2	0.476	0.356	0.242	0.131
≥3 ^a	0.156	0.092	0.084	0.047
Region				
Northeast	0.176	0.288	0.290	0.182
Midwest	0.258	0.245	0.263	0.235
South	0.370	0.414	0.268	0.271
West	0.194	0.165	0.181	0.204

Notes: Values shown are proportions unless otherwise noted. Sample is limited to adults ages 65 and above who are linked across the NHIS-HUD-Medicare data system. Percent of total sample shown in parentheses. ADRD: Alzheimer's disease and related dementias.

^a Value for family size ≥4 suppressed due to small cell size according to NCHS disclosure guidelines. The small cells occur within individual subgroups. Source: NHIS-HUD-Medicare linked data file 1999–2016.

of ADRD status. Compared to adults with ADRD and without HUD assistance, adults with ADRD receiving HUD housing assistance were 5.9 percentage points more likely to report delayed or forgone care (95% CI: 1.1–10.6). HUD adults without ADRD were 4.2 percentage points more likely to delay or forgo care due to cost (95% CI: 2.2–6.3).

The third model examined whether the respondent reported forgone needed medications due to cost. Adults with ADRD receiving HUD housing assistance were 4.2 percentage points more likely to report forgone medications (95% CI: 1.8–8.3) than those with ADRD not receiving HUD assistance. Those receiving HUD housing assistance but without ADRD were 3.5 percentage points more likely to forgo medications (95% CI: 1.6–5.3). Thus, older adults receiving HUD housing assistance may face economic challenges that have the potential to disrupt access to care and needed prescriptions. While Black adults were no more or less likely than White adults to have a usual source of care, they were more likely

to experience cost-related barriers to accessing care and needed medications. Hispanic/Latino adults were more likely than White adults to have no usual source of care, but also more likely to delay or forgo needed medications due to cost.

DISCUSSION

In this study we used an innovative multisource data linkage to examine the relationship between HUD housing assistance and health care access for adults aged 65 and above with and without ADRD. We provided a nationally representative portrait of health care access concerns among older adults receiving HUD housing assistance, and found mixed results. Adults receiving housing assistance maintained connections to the health care system, and were more likely to have a usual source of care than those without housing assistance. This was especially true among those with an ADRD diagnosis. However, we found that connection to a

TABLE 2. Linear Probability Models Predicting Health Care Access Measures as a Function of ADRD Diagnosis

	No Usual Source of Care	Delayed or Forgone Care Due to Cost	Delayed or Forgone Medications Due to Cost
ADRD/Housing assistance			
ADRD, No HUD (ref.)			
No ADRD, No HUD	0.007 (−0.000,0.015) ^b	0.005 (−0.006,0.015)	0.002 (−0.008,0.012)
No ADRD, HUD	−0.002 (−0.015,0.012)	0.042 (0.022,0.063) ^d	0.035 (0.016,0.053) ^d
ADRD, HUD	−0.023 (−0.037, −0.011) ^d	0.059 (0.011,0.106) ^d	0.042 (0.018,0.083) ^b
Female	−0.020 (−0.024, −0.016) ^d	0.007 (0.002,0.011) ^c	0.010 (0.006,0.014) ^d
Age groups			
65–84 (ref.)			
≥85	−0.009 (−0.115, −0.003) ^d	−0.044 (−0.051, −0.038) ^d	−0.028 (−0.034, −0.022) ^d
Race/Ethnicity			
Non-Hispanic White (ref.)			
Non-Hispanic Black	−0.005 (−0.011,0.001)	0.020 (0.011,0.029) ^d	0.033 (0.023,0.042) ^d
Non-Hispanic other	0.015 (0.001,0.029) ^c	−0.003 (−0.016,0.010)	0.014 (0.002,0.025) ^c
Hispanic/Latino	0.013 (0.004,0.022) ^c	0.008 (−0.002,0.019)	0.021 (0.010,0.031) ^{a,d}
Education			
Less than high school (ref.)			
High School	−0.005 (−0.011,0.001)	−0.024 (−0.031, −0.017) ^d	−0.024 (−0.031, −0.017) ^d
Some college	−0.009 (−0.015, −0.003) ^c	−0.011 (−0.019, −0.003) ^c	−0.011 (−0.019, −0.003) ^c
Bachelor's degree	−0.016 (−0.022, −0.010) ^d	−0.027 (−0.034, −0.019) ^c	−0.027 (−0.034, −0.019) ^d
Married/Partnered	−0.017 (−0.024, −0.011) ^d	−0.017 (−0.025, −0.010) ^d	−0.013 (−0.022, −0.004) ^c
Family size			
1 (ref.)			
2	−0.007 (−0.014, −0.001) ^b	−0.026 (−0.034, −0.017) ^d	−0.001 (−0.010, 0.007)
3	−0.000 (−0.011, 0.011)	−0.019 (−0.030, −0.008) ^c	0.014 (0.001,0.027) ^b
≥4 ^a	−0.005 (−0.018, 0.008)	−0.014 (−0.029, 0.000) ^b	0.015 (−0.001, 0.031) ^b
Region			
Northeast (ref.)			
Midwest	0.009 (0.002, 0.015) ^c	0.008 (0.001, 0.015) ^b	0.006 (0.000, 0.013) ^b
South	0.008 (0.002, 0.014) ^c	0.016 (0.009, 0.022) ^d	0.014 (0.008, 0.020) ^d
West	0.011 (0.005, 0.018) ^c	0.019 (0.011, 0.027) ^d	0.010 (0.004, 0.017) ^c
Year fixed effects			
Yes		Yes	Yes
N	46,269	46,269	46,269

Notes: Values shown are linear probability model coefficients. Sample is limited to adults ages 65 and above who are linked across the NHIS-HUD-Medicare data system. ADRD: Alzheimer's disease and related dementias; HUD: Has HUD housing assistance.

^a Value for family size ≥4 is available in the regression analyses because coefficients are not presented separately by subgroup. Source: NHIS-HUD-Medicare linked data file 1999–2016.

^b p < 0.1.

^c p < 0.05.

^d p < 0.01.

^e p < 0.001.

provider was not always sufficient to obtain needed care for this population; adults receiving housing assistance reported being more likely than those not receiving housing assistance to forgo needed care and medications, regardless of ADRD status. Our results suggest that adults receiving rental assistance, both with and without ADRD, experience substantial barriers obtaining needed medical care, which likely compound economic and housing-related challenges that they experience throughout older age.

An important finding is that adults with ADRD rely on housing assistance more than the general older adult population in our sample (10% vs. 5%). Low-income

adults are more likely to experience dementia in older age, and thus are more likely to be eligible for HUD programs.²⁷ But this may also reflect the downstream effects of the financial burden of complex health needs and the high demand for home health care.²⁸ Additionally, older adults with ADRD may be offered housing assistance more quickly after applying than those without ADRD, as public housing agencies may prioritize older adults with complex care needs when allocating housing assistance.^{29,30} However, the extent to which ADRD status specifically influences housing prioritization likely varies across agencies. As a person's dementia progresses, the level of home care use and costs

increase for community-based individuals.³¹ For low-income older adults, even small increases in out-of-pocket expenditures can increase housing affordability concerns and demand for subsidized housing.^{32,33}

Results of fully-adjusted models suggest that HUD housing assistance is associated with a greater connection to a health care provider in older age, but continues to be characterized by unmet health care needs. Among adults with ADRD, those receiving HUD assistance were less likely to report no usual source of care, but significantly more likely to report having delayed or forgone care and forgone medications due to cost compared to those without HUD assistance. Adults receiving housing assistance may have greater care needs, and thus have greater incentive to maintain a usual care provider.³⁴ This finding may also reflect policies that assist older adults with dementia with maintaining a connection to the health care system, and the stability provided by HUD housing assistance that strengthens this relationship.^{35,36} With respect to delayed and forgone care and forgone medication, we speculate that adults receiving housing assistance may have relatively high health care needs and a high prevalence of chronic conditions,¹⁸ which could drive high out-of-pocket costs, both for care and medication.³⁴ Overall, this suggests that access to care and connection with a health care provider may not alone be sufficient to obtain needed care.³⁷

Black and Latino older adults are more likely to experience ADRD than older white individuals. After a dementia diagnosis, both groups have a lower likelihood of receiving a prescription for their condition, and are at a greater risk of suspending the use of their anti-dementia medication.³⁸ Additionally, Black and Latino older adults are more likely than non-Hispanic white older adults to receive HUD housing assistance.¹⁰ With increased use of community-based care and a move away from institutionalization, greater attention should be directed to health care costs of providing services in the community. Persons with dementia frequently depend on family caregivers to help with their care and activities of daily living. Policies that improve access to home-based care services may further help to reduce racial disparities in the ability to age in community.³⁹

Policy Implications

The results highlight that older adults in HUD housing face cost-related barriers to care, even as they

tend to report having a usual source of care. Although a usual source of care does not necessarily imply a strong connection to a provider, it may help to reduce barriers to seeking medical care when the need arises. Thus, while there may also be noncost barriers, policymakers' focus should be reducing out-of-pocket costs, particularly for older adults with ADRD who require consistent care and access to medications. There are potential initiatives that can assist with this goal of targeting services to adults in HUD housing. For example, public housing developments could be the site of community health clinics that can assist with screening and access to basic medications.^{40,41} Alternatively, public housing authorities could improve payment standards for housing vouchers to encourage their use in neighborhoods with better and more affordable health services. Housing authorities could also deduct health care costs from expected rental payments to avoid the possibility that high rents lead individuals to delay or forgo necessary care or prescriptions.

The GUIDE Model offers a promising framework to transform dementia care by leveraging payment reform to incentivize coordination across healthcare and social service sectors.⁴² Stable, affordable housing is a critical, yet often overlooked, component of comprehensive dementia care, especially for low-income older adults and their families. The GUIDE Model has the potential to enhance meaningful partnerships between healthcare providers, community-based organizations, and housing agencies, including potential collaboration with HUD, to address housing insecurity as part of a broader, integrated dementia care strategy.

Limitations

Our study has several limitations that are important to acknowledge. First, our sample consists only of individuals in noninstitutionalized settings, which may exclude a substantial number of individuals with ADRD. However, our focus on the role of HUD housing assistance requires a focus on individuals living in the community, for whom housing policy changes to improve access to assisted housing are most relevant. Second, sample sizes limit our ability to develop a quasi-experimental comparison group, as has been used in other studies using NHIS-HUD linked data.¹³ Relatedly, we have limited power to

consider differences between HUD housing programs that may differ in their effects. Third, we are unable to consider other potential mediators of the relationship between ADRD, housing assistance, and health care access, including housing quality, neighborhood characteristics, and health care resource availability. Examining state or local characteristics and their role in moderating the relationship between housing assistance and health care access should be a goal of future research. Finally, we were only able to focus on diagnosed ADRD and could not consider early stage dementia or mild cognitive impairment. Future work could draw on self-reported cognitive impairment measures to supplement diagnosed ADRD in order to consider the relationship between HUD housing assistance and health care access for individuals at these earlier stages. Future research should also develop a quasi-experimental comparison group to strengthen causal inference.

CONCLUSION

Despite recent declines in the prevalence of ADRD in the United States, the aging of the Baby Boom cohort means that the number of older adults with ADRD will continue to increase for the foreseeable future. Cost of health care services and caregiving for individuals with Alzheimer's disease was estimated to be more than \$500 billion in 2020 in the United States, and will likely rise in the coming decades.⁴² Rising housing insecurity will also add to older adults' existing economic challenges, and may increasingly manifest in difficulty obtaining needed medical care and prescription medications. Inadequate resources for affordable housing programs—eligible families currently wait an average of 2 years to obtain housing assistance—may decrease the ability of low-income adults with ADRD to remain in the community, and may increase demand for long-term care services. The links between housing and health care suggest the need to improve access to affordable

care for older adults who may increasingly rely on nonfamily care support. Consistent with the SUNSHINE model,²⁹ which emphasizes systems-level resilience and integration across health, housing, and community supports, these findings highlight the importance of multi-sector strategies that promote stable housing among older adults with ADRD. Future research should focus on housing interventions most likely to support stable access to health care among older adults with ADRD.

DATA STATEMENT

The data has not been previously presented orally or by poster at scientific meetings.

AUTHOR CONTRIBUTIONS

Andrew Fenelon developed the analytical approach, wrote a proposal for access to the restricted data, was responsible for cleaning and managing the data, completed the statistical analysis, and wrote the first draft of the manuscript. Jie Chen conceptualized the study, provided feedback on the statistical analysis and analytical approach, reviewed and contributed to drafts of the manuscript, and obtained funding.

DISCLOSURES

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