Building Healthy Places: How are Community Development Organizations Contributing?

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Building healthy places: How are community development organizations contributing?

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During the past fifty years, community development organizations have worked in low-income communities that face the greatest barriers to good health. While recent changes in the American healthcare system and philanthropic sector provide new opportunities to partner with community development organizations to address health disparities, knowledge of current health-focused strategies and partnerships among local community-based organizations is limited. Through a survey conducted by NeighborWorks America of 242 high-performing community development organizations across the United States, we examine health strategies, partnerships, and services delivered by community development organizations and professionals. In 2015, 218 organizations (88.62 percent) engaged in activities at the nexus of health, housing, and community development; strategies focused on healthy homes and food access were the most common. Among respondents, 205 (83.3 percent) organizations engaged partners to support their work. While our results show significant efforts by community development organizations to explicitly target health, they also highlight opportunities for increased engagement. We elevate calls to address gaps between formal medical care and community health needs through more locally based services and partnerships. As the health care system increasingly addresses social determinants of health, we urge stakeholders to partner with housing and community development organizations already working in communities across the country.

Keywords: community health, community development, social determinants of health; health disparities

Introduction

The places where we live, work, learn, and play critically impact our health and well-being. In many places across the United States, there is significant variation in life expectancy between neighboring geographic areas. In addition, childhood lead poisoning, sexually transmitted infections, and cancer all show strong associations with, and variance by, neighborhood (Krieger et al. 2005, Subramanian et al. 2005). Indeed, studies find that neighborhood-level social and economic characteristics are independently associated with health outcomes, after controlling for individual socioeconomic characteristics (Diez Roux and Mair 2010). Wide variations in structural conditions across the United States contribute to health disparities (Diez Roux and Mair 2010, Casper et al. 2003, Do et al. 2008). Low- income residents and people of color disproportionately live in neighborhoods with greater stressors in the

social, economic, and built environment, as compared to their white (Williams and Jackson 2005) and higher-income counterparts (Ross and Mirowsky 2001).

Housing in particular affects health. It acts as a facilitator for other social predictors of health: employment is difficult without a permanent address (Richards 1979); school performance suffers when children move frequently (Reynolds, Chen, and Herbers 2009); and access to quality education, transportation and social capital is limited by where one lives (Diez Roux and Mair 2010). Substandard housing is a further threat to health (Sharfstein and Sandel 1998) and is associated with increased morbidity, including infectious diseases, chronic illnesses, and mental disorders (Bonnefoy 2007). Lead, mold, indoor air pollutants, and poor heat control directly negatively affect health as well (Shaw 2004).

Beyond the physical conditions of the home, affordability also can impact health. Being rent-burdened (spending more than 30 percent of income on rent) results in less money for other necessities such as medical care and healthy food (Newman and Holupka 2014). Further, eviction, foreclosure and other causes of housing instability are all associated with adverse health outcomes (Arcaya et al. 2013, Burgard, Seefeldt, and Zelner 2012, Cohen 2007).

Despite the importance of high-quality housing for both individuals and communities, unhealthy housing persists in the United States (Ferguson and Yates 2016). This is a particular challenge for low-income families, due to the strong correlation between housing cost and quality. Communities of color disproportionally live in neighborhoods with high concentrations of low-quality housing (JCHS 2016). This pattern is partly due to historical disinvestment from communities of color (Massey and Denton 1993), causing economic and racial segregation and entrenched disparities (Subramanian, Acevedo-Garcia, and Osypuk 2005, Williams and Collins 2001, Shapiro, Meschede, and Osoro 2013).

The community development field emerged over fifty years ago in response to economic deprivation in American communities. Community development professionals and volunteers work in economically disinvested neighborhoods to foster economic and social opportunities and address America's housing challenges (Von Hoffman 2012). Two primary players are community development corporations (CDCs) and community development financial institutions (CDFIs). CDFIs are nonprofit banks that provide capital support for low-income projects and people, and CDCs are nonprofit organizations that promote revitalization through programs and services, usually in under-resourced areas.

Since its inception, the community development field has evolved into a sophisticated developer and manager of housing, an expert coordinator of social services, and an effective catalyst of healthier neighborhoods. By developing housing, economic, social, and educational opportunities, community development contributes

implicitly to health. In this paper, we focus on how community development organizations are explicitly influencing health through specific programs, services, activities, and partnerships.

Multiple, simultaneous changes in the public and private sectors -- combined with demographic shifts-- are increasing the potential for collaboration between the health and community development fields (Viveiros 2015). The aging of baby boomers will lead to a larger population of older Americans, with the number of individuals older than 65 projected to double between 2016 and 2060 (Mather, Jacobsen, and Pollard 2015). While building additional senior-friendly housing will help address growing demand (JCHS 2014), supportive services in the home also can play an important role in meeting the needs of this vulnerable population (BPC 2016). Varied policies -- including state waivers and Medicaid and Medicare demonstration projects -- support the development of home- and community-based options for older adults and individuals with disabilities (Wahowiak 2016).

Significant changes in the health system also are driving new investments in non-medical factors that affect health. By increasingly prioritizing health outcomes and social determinants of health, state and federal policy changes have accelerated collaboration between health providers and community development practitioners (Heiman and Artiga 2015). The Affordable Care Act (ACA), as well as subsequent regulations and grant programs, modified delivery and payment models to bring health and social services together to address social and economic conditions that negatively impact health (Heiman and Artiga 2015). New entities, such as Accountable Care Organizations, health homes, and Accountable Health Communities, have begun to coordinate and invest in community-based, non-medical services for low-income patients, including housing. In addition, the ACA and subsequent regulations stipulate that to retain their tax-exempt status, nonprofit hospitals must track their community benefit expenditures, conduct regular Community Health Needs Assessments (CHNAs), and draft implementation and evaluation plans in response to identified needs (Young et al. 2013). CHNAs and community benefit expenditures encourage hospitals to engage housing and community development organizations in their efforts to address health challenges in their catchment area. These policy and regulatory changes have created new revenue streams and partnership opportunities that community development organizations can leverage to improve community health.

Philanthropy also has acted as a significant catalyst for engagement around the social determinants of health. The Robert Wood Johnson Foundation (RWJF) Commission to Build A Healthier America, a national initiative to improve health equity (Mattessich and Rausch 2013), suggests that improving the health of all Americans requires a deeper focus on the non-medical factors underlying health (Arkin et al. 2014). A series of articles, complementing the commission's work, highlights the

promise of greater collaboration between the community development and health sectors and calls for broader social governance and responsibility for health outcomes (Williams and Marks 2011, Arcaya and de Souza Briggs 2011, Williams, McClellan, and Rivlin 2010).

The philanthropic community has heeded this call for action through a series of demonstration projects, data strategies, and technical assistance initiatives. The earliest among these was the County Health Rankings and Roadmaps Program, an initiative to aggregate place-based data on the social determinants of health. This was followed by a series of national demonstration projects that catalyzed cross-sector partnerships to improve community health, including the BuildHealth Challenge and InvestHealth (Network 2016).

These demonstration projects necessitated a deeper understanding of the national landscape; and the first systematic effort to understand the current landscape of community development efforts to improve health equity was a study conducted by Mattesich and Rausch that examined joint initiatives by community development and health organizations (Mattessich and Rausch 2014). Members of twelve associations and networks with known interests in community health and development reported, via an email survey, their health-related, cross-sector activities during the previous twelve months. Between 30 and 40 percent of respondents reported collaborative activity, and 45 percent of these described their initiatives as successful.

Building on this body of work, our study examines the health-related strategies of high-performing community development organizations. It complements the work of the RWJF Commission, and answers additional questions about how community development organizations are building healthy communities. The data are from a survey of organizations affiliated with NeighborWorks America, a congressionally chartered nonprofit with a membership of approximately 250 locally based community development organizations operating in all fifty states, DC, and Puerto Rico. Organizations apply to become a NeighborWorks member and undergo a rigorous assessment. Once a member, NeighborWorks America regularly evaluates organizations' strength using on- and off-site assessments, an annual review of independent compliance and financial health audits, and an examination of activity and performance measures.

This analysis elucidates current health activities and highlights areas with potential to catalyze additional partnerships between community development and health organizations.

METHODS

NeighborWorks America conducted a survey to better understand how member organizations work explicitly to address the health challenges of residents in the

housing and communities they serve. Many of the activities community development organizations typically conduct–such as homeownership counseling and loans, development and management of rental homes, and financial capability coaching–*implicitly* influence health outcomes. However, the survey was designed to document the ways in which these community development organizations provided these and other services to *explicitly* address challenges to health—for example, by implementing smoke-free policies in rental housing or including physical fitness in resident services programming.

The survey categories and questions were derived from multiple sources, including the Centers for Disease Control and Prevention, the National Center for Healthy Housing, and other NeighborWorks America surveys. Questions were reviewed by both internal and external subject-matter experts. In addition, the survey was piloted by NeighborWorks organizations and revised to improve the validity of responses.

The questions were fielded as part of an online annual survey conducted in 2014 and 2015, with participation required of all NeighborWorks America network organizations. All 246 member organizations responded. In addition to questions with an explicit health focus, the survey included questions about the demographics of individuals served, housing production, staffing, organizational characteristics and other programs and services offered. This paper focuses on the 2015 data, but incorporates findings from 2014 to allow an examination of changes in partnerships and activities.

Table 1 displays the major health categories, referred to in the survey findings as "strategies". For each strategy, organizations were asked about the number of specific programs or activities they provided or conducted. For example, within the healthy homes strategy, activities included but were not limited to: mold removal; smoke free housing; and lead and other chemical hazard remediation. The survey asked about a total of 38 activities across seven strategies.

Respondents were asked to identify the types of partners that supported their work at the intersection of health, housing and community development. Participating organizations also were asked if they provided or partnered with others to offer any of the services on an accompanying list. The prevalence of each partnership and service type was assessed. Basic descriptive analysis was conducted to understand the characteristics of the organizations. Finally, the Wilcoxon rank-sum (Mann-Whitney) was used to evaluate differences in the mean number of health activities employed by the groups. Spearman's rank correlation coefficient was used to evaluate correlations between continuous organizational characteristics and the number of health-related activities performed.

For all analyses, a CDFI was defined as any organization that currently or was formerly certified as such. Size was defined by the number of full-time employees (FTE). Organizations with at least one collaboration supporting their health work were defined as having a partnership, and the partnership count is a simple total of the number of such arrangements reported. Health board membership was defined by having at least one person from the health sector on an organization's board of directors; and the number of health board members is a count of those health sector board members. Medical partnership was defined as having one or more partnerships with hospitals, physicians, nurses, providers, provider associations, health clinics, health centers, or pharmacies. Rental provider was defined as an organization owning 100 or more units in the previous fiscal year. Place-based organizations were those that engage in strategic, intentional efforts to coordinate multiple, often diverse activities in the same place to leverage impact and create lasting change.

All analysis was conducted using Stata/SE 12.0.

Results

Organizational characteristics for the 246 NeighborWorks network organizations in 2015 are summarized in Table 2. The distribution of health activities was right-skewed, due to 28 organizations reporting no explicit health activities. Organizations reporting the most activities, defined as those in the upper quartile, provided a mean of 18.46 activities, and had a mean of 6.86 partnerships and a median of 43 FTEs. Organizations reporting no explicit health activities were smaller, with a median of 10 FTEs.

In 2015 218 (88.62%) organizations engaged in at least one activity at the nexus of health and community development. Thirty-two organizations engaged in all seven health strategy categories. Healthy homes was the most common strategy employed by NeighborWorks organizations and community design was the least common.

A total of 205 (83.3%) organizations reported partnering with others to support their work at the intersection of health, housing, and community development. Although the overall rate of partnerships decreased by 4.8% between 2014 and 2015, the total number of organizations with at least one such arrangement increased from 203 in 2014 to 204 in 2015.

To assist in understanding which activities were partnership-driven, Table 5 shows the analysis of partnership engagement for activities traditionally associated with the health and social service system. Among the activities reported, referral services were the most common and operation of a nursing home, assisted-living facility, hospice, or Alzheimer's care center was least common.

Nonparametric statistics (Wilcoxson rank sum and Spearman rank order correlation coefficient) were used because of the skewed distribution of the number of activities in which organizations engaged. We report the mean for each group for binary

characteristics, along with the Z stat and P value. For continuous outcomes, we report the Pearson rho and P value.

As the number of partnerships increased, so did the number of health activities (rho=0.638, p=0.0000). Organizations with any type of partnership engaged in more health activities than those without (9.96 vs 2.43 z=-7.257 p=0.000). Likewise, as the number of partnerships increased, so did the number of health activities in which organizations engaged (rho=0.624, p<0.001). However, the number of health board members and size of the organization did not appear to be significantly associated (p>.05); nor was whether an organization was place-based (mean 9.16 vs 8.52 z=-0.462, p=0.644). Organizations with medical partnerships engaged in a significantly greater number of health-related activities (11.67 vs 4.5 z=-8.094 p<.0.001), as did those that were rental providers (11.82 vs 4.93 z=-8.022 p<.001).

Case Studies: Focusing on outcomes

While the survey provides an overview of strategies employed by high-performing community development organizations, the results do not allow us to assess associated health outcomes. Thus, we provide three brief case studies from NeighborWorks organizations that evaluate health outcomes of varied strategies in disparate environments.

Codman Square Neighborhood Development Corporation

Codman Square Neighborhood Development Corporation (CNDC) is a CDC located in Boston, Massachusetts. The organization has worked in and with the Codman Square community for over twenty-five years, and in recent years, has incorporated health into its work in real estate development, economic development and community building, with initiatives focused on food access, the health of black men, and health equity.

CNDC is acting as one of several community partners for a research collaboration led by the Conservation Law Foundation (CLF) and sponsored by the RWJF. The study will help participants and others understand the health impact of investments made through CLF's Healthy Neighborhood Equity Fund (HNEF), along with other co-occurring investments. The HNEF is a $30 million private equity fund that invests in mixed-income, mixed-use, transportation-oriented development projects in historically disinvested communities. The funding model considers health outcomes as well as typical triple-bottom-line metrics, and the projects are intended to create quality housing, job opportunities, and better health in targeted communities. The study explores the relationship between the investments and residents' health, as well as how the latter is impacted by living in communities undergoing gentrification and new

development. Using a community-based participatory research framework, Codman Square residents and CNDC employees act as members of the research team--helping determine research questions, developing and fielding a survey, analyzing results, and disseminating findings. The study also will use administrative data to measure differences in health and neighborhood conditions between the communities with and without investments.

Participation in the study is intended to further understanding of the social and health needs of residents, build capacity to resist development that negatively affects health, and expand positive community changes. While too early to provide health-related results, this research effort is worth watching as an effort to combine multiple, divergent data sources under the guidance of resident leaders to better understand the health implications of comprehensive community development.

Foundation Communities

Foundation Communities, a nonprofit affordable housing provider based in north Texas since 1990, recognized that many of its supportive-housing residents, formerly homeless men and women, were regularly using emergency department services. In addition, low-income families at its other sites were struggling with chronic diseases. In response, Foundation Communities embarked on a systemic effort to improve the well-being of its residents.

To address the health and social needs of residents, the organization installed walking paths and community gardens, organized health and wellness classes, implemented smoke-free policies in rental residences, strengthened resident-engagement, and integrated physical activity into after-school programs. Foundation Communities assessed results in multiple ways. For example, the organization collaborated with the University of Texas to evaluate its physical activity programming, determining that after the programming most after-school participants met or surpassed recommended step goals (Jeansonne and Johnson 2014).

Meanwhile, in its supportive-housing sites, the organization connected residents to a range of health services; hired on-site nurses and social workers; and connected residents to legal support and job training. An independent evaluation found that after the interventions:

- 80 percent of discharged clients reported receiving mental health treatment that met their needs.
- 100 percent of substance abuse treatment recipients said their needs were met.
- 91 percent of program participants maintained stable housing after discharge.
- The number of 911 calls, transports for emergency medical services and criminal justice involvements declined.

Compared to baseline, program participants also reported improvements in multiple measures of quality of life and overall well-being (Kelly 2014).

REACH Community Development

REACH CDC -- an affordable housing developer and property management company serving Portland, Oregon – was a founding member of a Limited Liability Corporation (LLC) designed to integrate housing with health and social services. Cedar Sinai Park, a skilled nursing and independent living facility, launched the Housing with Services (HWS) LLC to provide enhanced health and social service coordination for 1,400 residents at 11 federally subsidized, independent-living, affordable housing properties in Portland. Project elements include an on-site Federally Qualified Health Center (FQHC); culturally specific services for non-English-speaking residents; food distribution for homebound residents and other residents experiencing food insecurity; health navigators; and free mental health consultations.

A recent evaluation assessed residents' self-reported health, food access, social integration, use of health services and quality of life using surveys of 272 residents before and after the program. In comparison to controls, those with program contact had statistically significantly higher rates of access to a primary care clinic (91% vs 80.7%), flu vaccination (80% vs 67.4%), and preventive screening (89% vs 79%) (IOA 2016).

In addition, Housing with Services and eight other housing providers participated in a study that explored changes in health care costs and utilization after low-income individuals moved into affordable homes and received integrated care services. The study found that in the year after the move to affordable housing, total participant Medicaid expenditures decreased 12%, emergency department visits dropped 18% and primary-care visits increased 20% (CORE 2016).

The three case studies highlight diverse strategies employed by community development organizations to positively influence health outcomes and costs. While strategies varied, all relied on long-term, sustained relationships with a specific, place-based community, combined with new partnerships with health stakeholders.

Discussion

Among high-performing community development organizations across the United States, the vast majority are actively working to improve neighborhood health. These organizations use a variety of strategies designed to improve health, from implementing healthy homes standards to initiating programs to increase physical activity. Some organizations engaged in every category of health strategy explored in the survey, while others reported no involvement in activities explicitly designed to promote health. However, even those organizations that reported no activities, partnerships or services are inherently promoting health by working to address

determinants such as employment, housing and neighborhood revitalization. Given the recent calls for stronger collaboration between community development organizations and the health sector (Williams and Marks 2011, Komro et al. 2013, Schuchter and Jutte 2014, Goldman 2014), these results are a useful guide to such activities already underway.

Our results show that diverse organizations partner with community development organizations to support health-related work, from government agencies to disease-specific nonprofits. The number of partnerships declined slightly from 2014 to 2015, including a nearly 7 percent decrease in collaborations with state and local agencies, and a slight decrease in government alliances at the federal level. Conversely, partnerships with hospitals, insurance companies, faith-based organizations and disease-specific organizations increased during the same time period. This may be the result of shifts in the health landscape—including new payment and delivery models and community-benefit requirements—that favor outcomes-based strategies targeting social determinants of health.

Our examination also shows that organizations commonly provide health and social services in collaboration with a partner, rather than offer them on their own. This suggests some services may be difficult for community development organizations to provide without partner support. When encouraging community development organizations to become more involved in health service provision, some types of services may require external support.

We also noted that certain characteristics correlate with higher levels of health-related activity. Organizations that have at least one partnership, engage in more partnerships, participate in medical collaborations and/or are rental providers appear to be more active in the health arena. These characteristics may reflect the type of organization best positioned to engage in health-related work. On the other hand, organizations interested in engaging in health-promotion activities may simply have sought partnerships to facilitate their work.

Our findings can be extended to other high-performing community development organizations across the United States. These organizations may have greater capacity for health work in comparison to others in the field. NeighborWorks systematically works to ensure that its network includes diverse members in terms of geography, size, expertise, and focus, with the requirement that all organizations include housing in their offerings. Given the heterogeneity of the NeighborWorks network, it is unlikely that members' activities and partnerships differ substantially from other community development organizations.

Although our results demonstrate the current state of activity among NeighborWorks network organizations, the survey did not capture changes to health associated with the organizations' work. Various strategies are underway to better

document outcomes associated with comprehensive community development, including a multi-year demonstration project led by NeighborWorks America and Enterprise Community Partners to provide technical assistance, grant funding and outcomes evaluation to twenty nonprofit organizations working to improve community health (NeighborWorks America 2016). However, more evaluations of outcomes from health-related strategies and tactics would contribute to increased impact and support long-term, sustained investment.

Further, recent national and state-level policy changes call for greater engagement by the formal health sector in social determinants of health. As this occurs, it is important to engage with existing players in housing and community development, rather than funding the health sector to embark upon housing development independently. While some health organizations have done the latter, most successful ventures linking health, housing and community development have forged partnerships with already existing entities.

Because of their deep relationships within their neighborhoods, community development organizations can act as conduits for hospitals and other health care providers wanting to expand their relationships and programs in the localities they serve (Wong, LaVeist, and Sharfstein 2015). Continuous collaboration with community development organizations can help ensure residents are represented, heard and respected. In turn, health providers can become more deeply engaged in community well-being, by co-creating equitable community benefits (Viveiros and Sturtevant 2016).

The resource constraints of today's public health environment further reinforce the importance of collaboration to address community health challenges. Collective responses to inequity and disparities in communities show promise, particularly in low-income neighborhoods where health often is poor (RWJF 2015). Community development organizations can play an integral role in these collective-impact approaches, given their expertise and long-term commitment on the ground.

Together, diverse stakeholders can create cross-sector alliances that are better equipped to address social challenges to health and make every place in America a place of opportunity and health equity. This shift away from treating health as the exclusive domain of the health care sector implies shared governance and responsibility for outcomes. While the extent of health-focused strategies revealed by our survey is significant and generally higher than previously documented, our results suggest that with greater collaboration and sustained partnerships, community development organizations can deepen their work to address the social determinants of health inequities and increase their impact.

Thus, as the health care system increasingly focuses on non-medical determinants of health, we urge these stakeholders to partner with housing and

community development organizations already working in neighborhoods across the country.

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Table 1. Health Strategies

Healthy Homes	Applied healthy homes principles or standards when performing construction, rehab, or maintenance activities
Food	Engaged in activities to provide greater access to healthy foods and increase food security
Community Engagement	Supported health-related projects that engaged or were led by community residents, including participating in a Health Impact Assessment or Community Health Needs Assessment
Environmental Health	Engaged in activities that improved the environmental health of communities, such as brownfield remediation or water quality efforts
Financial Capability	Addressed health-related expenditures in financial capability programming
Physical Activity	Undertook initiatives that promote exercise and physical activity
Community Design	Participated in community design initiatives intended to increase the health and safety of their communities, such as transit-oriented design or Complete Streets pedestrian/bicycle safety efforts

Table 2: Organizational Characteristics

Health Category	**Mean (SD) or Percentage N=246**
	Mean
All Activities	8.43 (6.97)
Number of Partnerships	4.29(3.18)
Size (number of employees)	20.75 (median)
Number of Partnerships	4.29 (3.18)
Number of Health Board Members	.52 (.85)
	Percent
Partnership	83.3%
Medical Partnership	54.88%
Health Board Membership	34.15%
Rental Provider	50.81%
Place-Based	73.42%
CDFI	37.8%

Table 3: Health Strategy Categories: Percent and Number of Organizations

	Organizations Engaged in Health Strategy % (N)
All Strategies	88.62% (218)
Healthy Homes	66.36% (163)
Food	57.32% (141)
Community Engagement	55.28% (136)
Environmental Health	51.63% (127)
Financial Capability	49.59% (122)
Physical Activity	46.34% (132)
Community Design	42.28% (104)

Table 4: Partnerships: Percent in 2014, 2015 and Percent Change

Partnership Type	2014 n=232	2015 n=246	Percent Change
Any Partnership	87.5%	83.3%	-4.80%
State and Local Government Agency	65.5%	60.98%	-6.90%
Food-Related Organization*	47.0%	47.15%	0.32%
Foundation	44.4%	46.75%	5.29%
Financial Institution	37.5%	42.68%	13.81%
Health Clinic, Center or Pharmacy	34.5%	38.21%	10.75%
University or College	30.6%	35.55%	16.18%
Hospital	25.9%	35.52%	37.14%
Faith-Based Organization	26.7%	35.53%	33.07%
Physicians, Nurses, Providers, Provider Association	25.40%	30.08%	18.43%
Federal Agency	28.9%	28.86%	-0.14%
Insurance Companies	18.10%	19.51%	7.79%
Disease-Specific Organizations	7.3%	9.76%	33.70%
Other Supporting Organizations	12.5%	5.69%	-54.48%

Table 5: Partnership engagement in health services: Independent, partnership only, or both independent and partnership

Activity	Total reporting a specific activity	Independent	Partnership	Both (independent and partnership)
Referral services for health and human services	**122**	21	28	73
Supportive housing	**89**	10	28	51
Health education and outreach services	**89**	5	35	49
Health fairs	**85**	6	54	25
Health insurance enrollment assistance	**84**	10	50	24
Violence prevention and response	**70**	7	37	26
Medical and behavioral health services	**65**	2	44	19
Smoking cessation services and/or chronic disease self-management group sessions	**50**	1	37	12
Comprehensive healthy homes asthma services targeting community members with asthma	**28**	1	19	8
Other health & medical services	**24**	4	8	12
Nursing home, assisted-living facility, hospice care and/or Alzheimer's care center	**23**	4	12	7