GRANT MAKERS IN HEALTH

PHILANTHROPY'S NEWEST MEMBERS

Findings from the 1999 Survey of New Health Foundations

MARCH 2000

Preface

Grantmakers In Health (GIH) has been tracking the emergence and activities of new health foundations for the past several years. In 1999, GIH published *Coming of Age: Findings from the 1998 Survey of Foundations Created by Health Care Conversions* to provide information on the core questions of governance, grantmaking, and community involvement in the development of the foundations' missions and program focus; in addition, the report presented data on foundation structure and assets. We reported that assets from these foundations exceeded $13 billion, and that they resulted from a variety of conversion arrangements, including sales, mergers, joint ventures, and corporate restructuring. We also found that these foundations vary considerably in their board and staff sizes, their relationships to the organizations that spawned them, and the extent of community involvement in the development of their missions and grantmaking agendas. Furthermore, we discovered that by maintaining separate boards and implementing conflict-of-interest policies, many of these foundations strive to remain independent from the organizations involved in the conversion.

In addition to updating data on the development and activities of foundations previously surveyed over the last four years, this report includes data on 15 additional foundations that were formed after the 1998 survey, or that were not in a position to respond to the survey last year. These 15 new foundations reflect some of the same characteristics as their peers surveyed in earlier years — they emerge from a variety of arrangements, they often involve the community in the development of their mission and program focus, and they tend to operate independently of the organizations involved in the conversion. This report concludes by suggesting areas for further exploration.

This report represents a team effort at GIH. Malcolm Williams and Saba Brelvi, program associates, designed the surveys and were responsible for much of the writing and analysis. Anne Schwartz, vice president of GIH, and Lauren LeRoy, president and CEO, were involved in every phase of the project. In addition, this report would not have been possible without the guidance and insights that the many staff and trustees of the new health foundations provided.

Philanthropy's Newest Members is a building block for the work of GIH and its Support Center for Health Foundations in tracking and assisting new health foundations. It is designed to provide information not only for foundation board members and staff, but also for policymakers and others who are interested in the evolution of health philanthropy.

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Background and Overview

The past two decades have witnessed unprecedented growth in the number of transactions involving nonprofit hospitals, health plans, and health systems. Often referred to as *conversions*, many of these transactions involve the transfer of assets from a nonprofit to another health organization through sales, mergers, joint ventures, or corporate restructuring. For struggling nonprofits, converting can offer a way to preserve their historical missions, gain access to capital, and enhance their competitive positions. For thriving nonprofits, converting can allow nonprofit boards to secure the maximum assets for their communities in the face of increasing uncertainty and competition in the health care market. Conversion options such as mergers and joint ventures may offer nonprofit organizations a way to remain viable and stay competitive while retaining partial ownership in the health care organization.

Some conversion transactions have led to the creation of new foundations endowed with assets generated by the conversion and charged with funding health-related activities in their communities.[1] Creating a new health foundation or transferring the assets generated by the conversion to an existing one are common ways to maintain the level of public benefit presumed to have been provided by the nonprofit organization prior to conversion.[2] Although the degree to which nonprofit providers serve the community (and whether their behavior differs from for-profit enterprises) has been much debated, the trend in law and regulation is to require that converted assets be used in a manner consistent with the original nonprofit's mission.[3]

The emergence of these new health foundations has raised questions about their role and impact. They are usually born out of controversy over asset valuation and concern about how those assets will be put to work in the community. Often at issue is whether the foundations are providing public benefits comparable to those of the nonprofit organizations from which their assets came. Perceptions about public benefit are often tied to how foundations' missions are defined and how closely the foundations' missions are linked to those of the converting organizations. These questions have generated great public interest in obtaining information about these new health foundations.

In 1999, Grantmakers In Health (GIH) published *Coming of Age: Findings from the 1998 Survey of Foundations Created by Health Care Conversions* to provide information on the core questions of governance, grantmaking, and community involvement in the development of the foundations' missions and program focus; in addition, the report presented data on foundation structure and assets. We reported that assets from these foundations exceeded $13 billion, and that they resulted from a variety of conversion arrangements, including sales, mergers, joint ventures, and corporate restructuring. We also found that these foundations vary considerably in their board and staff sizes, their relationships to the organizations that spawned them, and the extent of community involvement in the development of their missions and grantmaking agendas. Furthermore, we discovered that by maintaining separate boards and implementing conflict-of-interest policies, many of these foundations strive to remain independent from the organizations involved in the conversion.

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[1] These foundations are often referred to as health care conversion foundations. This is not a legal term nor is it adequately descriptive. The Internal Revenue Service classifies these entities as private foundations or public charities. Some transactions between nonprofits and municipal health care organizations have also led to the creation of foundations.

[2] The reference to a converted organization encompasses both the organizations that were converted from nonprofit to for-profit and those transactions involving nonprofits and municipal health care organizations for which there has been a conversion of mission.

[3] This trend is supported by the *cy pres* doctrine, meaning "as close as possible"; the doctrine supports an application of the assets to a mission as close as possible to that of the original nonprofit.

The foundations included in the 1999 report funded across the spectrum of health issues, with a majority of foundations supporting health promotion, access to care, and maternal and child health. Regardless of which areas they funded in, however, these new health foundations have had the potential to significantly affect funding for health and health care. If they were to pay out 5 percent of their assets in grants (as the Internal Revenue Service requires of private foundations), this would have amounted to approximately $664 million in 1998.[4] This is a substantial amount compared to the estimated $1.9 billion that all foundations gave in health and health-related programs in 1995.[5] The recent devolution of responsibility for health care from the federal government to states and localities also creates tremendous potential for these foundations to effect change. Because these new health foundations give almost exclusively for health-related programs in defined geographic areas, they are often the largest source of nongovernmental health funding in a community or state.

In addition to updating data on the development and activities of foundations surveyed over the last four years, this report includes data on 15 additional foundations that were formed after the 1998 survey, or that were not in a position to respond to prior surveys. While the number of new health foundations continues to grow, the results of the 1999 survey remain similar to those reported previously. These 15 new foundations reflect some of the same characteristics as their peers surveyed in earlier years — they emerge from a variety of arrangements, they often involve the community in the development of their mission and program focus, and they tend to operate independently of the organizations involved in the conversion. The current assets for new health foundations has climbed to more than $15 billion.

Survey Methodology

Grantmakers In Health formally began collecting data on the formation, structure, and behavior of new health foundations in 1996. In 1998, several changes were made to the survey methods to move beyond collecting basic information about the foundations to examine issues of foundation grantmaking, board structure and independence, and community involvement in the development of the foundation.

For this report, GIH was able to identify 15 more foundations that had developed as a result of conversions and in total surveyed 134 foundations regarding their formation, structure, and grantmaking activities.[6] Of these, 97 had responded in 1998 and were asked only to provide updated information on assets, grantmaking areas, staff size, board size, whether there were foundation board members sitting concurrently on the board of the converted organization, and the existence of a conflict-of-interest policy. Newly established foundations and those that did not respond to the earlier survey were asked to respond to a more extensive set of questions concerning the conversion process, community involvement in mission development and grantmaking programs, staff and board composition, and finances.

[4]This calculation is illustrative. Foundations classified by the IRS as public charities and public welfare organizations do not have an annual payout requirement; private foundations are allowed some carryover of distribution requirements. Moreover, some foundations pay out more than 5 percent annually.

[5]The Foundation Center, Health Policy Grantmaking; A Report on Foundation Trends (New York: 1998).

[6]These were identified from several sources including regional associations of grantmakers, the Council on Foundations, the Foundation Center, consumer advocacy organizations, newspapers, conversations with GIH Funding Partners, and the trade press.

Responses were collected via mail, fax, and telephone from 112 of the 134 new health foundations identified. Data on assets, year of formation, location, tax status, and type of organization converted on ten foundations that did not respond to the 1999 survey were drawn from other sources. Findings related to some survey questions thus reflect data from as many as 122 foundations.

Results

The tables and figures presented in this report provide updated information on the development and behavior of new health foundations. Much of the data presented are new. In cases where information is not likely to change from year to year (i.e., year of formation, type of organization converted, and location) the data are drawn from previous surveys. These data are presented in four major sections:

- ***Foundation Structure:*** basic information regarding the year of conversion, assets, type of organization converted, type of conversion arrangement (i.e., sales, mergers, joint ventures, and corporate restructuring), geographic location, tax status, board size, and staff size.
- ***Board Structure and Independence:*** data on the independence of the foundations' boards from the purchasing organizations and the converted health care organizations.
- ***Community Involvement:*** data reflecting the extent to which the foundations have included the community in the development of their missions and grantmaking programs.
- ***Health Funding Priorities:*** data regarding the major funding areas of the foundations.

Foundation Structure

A profile of new health foundations, both individually and collectively, begins with a description of their core attributes. These include assets, type of organization converted, date of foundation formation, location, type of conversion arrangement, tax status, board size, and staff size.

Foundation Size. The total current assets of these new foundations exceed $15 billion (Exhibit 1).[7] The median asset size is $60.5 million; assets range from $2.3 million to $3.5 billion. Conversions of hospitals (accounting for about 75 percent of the new foundations) usually result in smaller foundations with median assets of $41.0 million compared to $106.0 million for those created from health plans and $138.5 million for those created from health systems (Exhibit 2).[8] Although foundations created from health systems have the largest median assets, the largest foundations are the result of health plan conversions; among these 15 foundations, two have assets of more than $1 billion each.[9]

[7]Most foundations reported assets from their last financial audit; others reported assets as of the survey date.

[8]The type of organization converted is based on foundation self report.

[9]Respondents were asked only about current assets, not about assets at the time of formation.

Exhibit 1. *New Health Foundations by Year of Conversion and Current Assets (millions of dollars)*

YEAR OF CONVERSION	NUMBER	TOTAL ASSETS	MEDIAN ASSETS	MEAN ASSETS
1973	1	$36.1	$36.1	$36.1
1981	1	2.3	2.3	2.3
1983	2	26.7	13.4	13.4
1984	11	429.1	25.6	39.0
1985	7	1,194.7	128.1	170.7
1986	3	127.2	32.3	42.4
1987	2	100.9	50.5	50.5
1988	1	19.7	19.7	19.7
1989	1	40.3	40.3	40.3
1990	1	138.0	138.0	138.0
1991	1	102.7	102.7	102.7
1992	3	1,208.4	72.0	402.8
1993	2	74.9	37.5	37.5
1994	14	4,729.0	104.5	337.8
1995	22	2,455.1	91.0	111.6
1996	24	2,875.4	60.2	119.8
1997	10	459.3	51.3	45.9
1998	12	1,350.2	49.0	112.5
1999	4	177.0	44.5	44.3
Total	122	15,596.2	61.2	127.8

N=122
Note: Data include two foundations reporting expected assets.
Source: Grantmakers in Health, Survey of New Health Foundations, 1998 and 1999.

Date of Foundation Formation. Most new health foundations were established in the mid-1980s or mid-to-late 1990s (Exhibit 1). Over the last five years, the ranks have swelled most rapidly; of foundations responding, 70.5 percent were formed between 1994 and 1999. In 1996 alone, at least 24 new foundations were created.

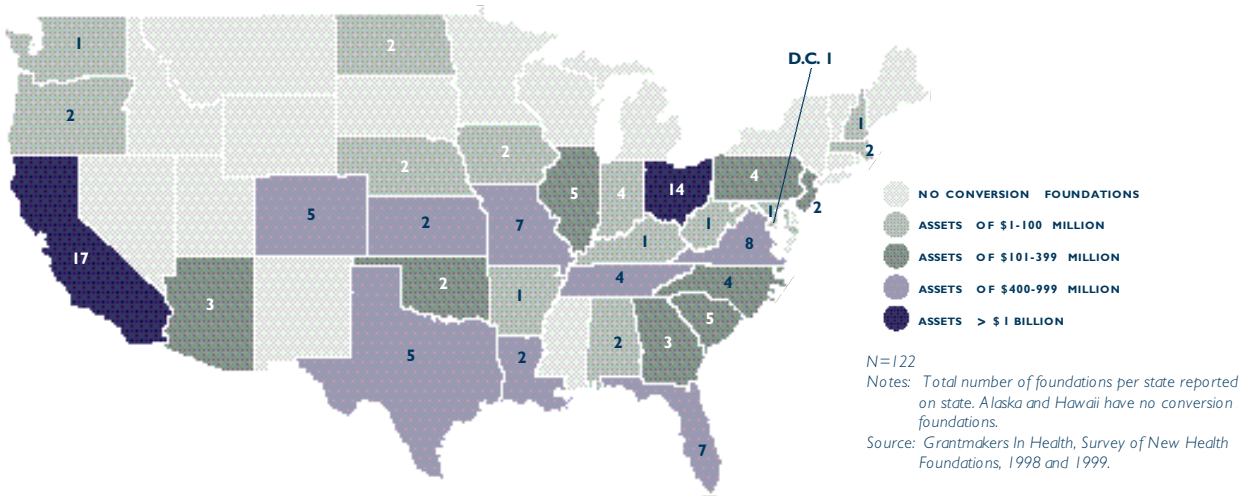
Exhibit 2. *Assets of New Health Foundations (millions of dollars) by Type of Organization Converted, 1999*

TYPE OF ORGANIZATION	NUMBER	TOTAL ASSETS	MEDIAN ASSETS
Hospital	91	$6,816.9	$41.0
Health Plan	15	6,581.1	106.0
Health System	12	2,054.5	138.5
Other	3	55.8	10.5
Total	121	15,508.3	60.5

Notes: Data exclude one foundation that was formed from the conversion of more than one type of organization.
Data include two foundations reporting expected assets.
Source: Grantmakers in Health, Survey of New Health Foundations, 1998 and 1999.

Geographic Distribution of Foundations. New health foundations operate in 31 states and the District of Columbia (Exhibit 3). Sixty percent of these foundations, however, are located in just nine states: California, Colorado, Florida, Illinois, Missouri, Ohio, South Carolina, Texas, and Virginia. The two states with the greatest number of these foundations are California (17) and Ohio (14). Total combined foundation assets in California ($6.9 billion) are more than five times that of Ohio ($1.1 billion), reflecting both the larger number of foundations and the larger average size of the foundations formed in California.[10] Virginia has the third greatest number of new health foundations with eight. Colorado has only five of these new foundations but ranks third in total assets, with $924.4 million.

Exhibit 3. *States with New Health Foundations by Number and Total Assets, 1999*



N=122
Notes: Total number of foundations per state reported on state. Alaska and Hawaii have no conversion foundations.
Source: Grantmakers In Health, Survey of New Health Foundations, 1998 and 1999.

Type of Conversion Arrangement. Most foundations have developed as the result of a sale of a nonprofit hospital, health system, or health plan (Exhibit 4). In a few cases, foundations have come about as a result of mergers, joint ventures, or corporate restructuring. The conversion arrangement has important implications for foundation independence. Unlike sales, mergers and joint ventures result in agreements that maintain relationships between the nonprofit organizations and the purchasing or for-profit converted organizations. Mergers link nonprofits to purchasing organizations and joint ventures link nonprofits to the for-profit converted organizations.

[10]California is also the state where the largest new health foundations have been created.

Exhibit 4. *New Health Foundations by Type of Conversion and Conversion Arrangement, 1999*

TYPE OF CONVERSION	NUMBER	CONVERSION ARRANGEMENT	PERCENT
Nonprofit to For Profit [a]	79.0	All	100.0
	62.5	Sale/Buyout/Acquisition	79.1
	1.5	Merger	1.9
	10.0	Joint Venture	12.7
	5.0	Corporate Restructuring	6.3
Nonprofit to Nonprofit [b]	31.0	All	100.0
	22.0	Sale/Buyout/Acquisition	71.0
	6.0	Merger	19.4
	2.0	Joint Venture	6.5
	1.0	Corporate Restructuring	3.2

N = 110

[a] *Data include 1 foundation that received assets from the sale of several hospitals and the merger of 1 health center. A weighted average was created for this foundation's 2 types of conversion arrangements by assigning (.5) for the sales and (.5) for the merger.*

[b] *Data include 1 foundation formed from the conversion of a municipal hospital to nonprofit status.*

Note: *Responses on the conversion arrangement were missing for 2 foundations.*
Source: *Grantmakers in Health, Survey of New Health Foundations, 1998 and 1999.*

Tax Status. Once a conversion occurs, the foundation must choose a tax status. The tax status of the organization carries with it certain regulatory requirements and operational expectations that have implications for the foundation's structure, including board size and staffing. Any foundation that existed prior to the conversion may maintain the same tax status; those newly created must apply to the Internal Revenue Services (IRS) for one of several tax status categories, including private foundation, public charity, and social welfare organization (see Appendix 2 for a description of these categories). Several important differences exist between these tax statuses. Unlike private foundations, public charities must continue to raise funds from the community to supplement their endowments. In addition, the IRS places fewer demands on the amount of grantmaking required of public charities in a given year relative to private foundations and social welfare organizations. Another impor-

Exhibit 5. *Tax Status of New Health Foundations by Assets (millions of dollars), 1999*

TAX STATUS	NUMBER	TOTAL ASSET SIZE	MEAN ASSET SIZE
Private Foundation	51	$9,032.5	$177.1
Social Welfare Organization 501 (c) (4)	4	1,298.2	324.6
Public Charity	56	4,613.9	82.4
509 (a) (1)	28	2,163.7	77.3
509 (a) (2)	6	584.5	97.4
509 (a) (3)	22	1,865.7	84.8
Total	111	14,944.6	134.6

N = 111

Note: *Data from 1 foundation resulting from the conversion of a municipal hospital is excluded. This endowment does not have a tax status.*
Source: *Grantmakers In Health, Survey of New Health Foundations, 1999.*

tant difference concerns lobbying. Private foundations are generally not permitted to lobby, public charities may lobby with some restrictions, and social welfare organizations may lobby without special restrictions.

Among the 112 foundations responding to the 1999 survey, the most common tax status represented was public charity (50.5 percent), followed by private foundations (45.9 percent) (Exhibit 5).[11] Private foundations, however, hold a disproportionate share of the total assets of new health foundations. The mean assets of private foundations are $177.1 million, compared to $82.4 million for public charities. The mean assets of social welfare organizations are substantially larger ($324.6 million) than those of either public charities or private foundations. This is due in part to the fact that most social welfare organizations were created from the conversion of health plans.

Board Size and Composition. The boards of new health foundations vary in both size and composition. Board size ranges from 5 to 56 members for the responding foundations. The median board size among all new health foundations is 13 members (Exhibit 6). Private foundations tend to have slightly smaller boards, with a median of 11 members compared to 15 for public charities.

Exhibit 6. *Median Foundation Board Size by Tax Status and Asset Size (millions of dollars), 1999*

TAX STATUS	NUMBER	ASSET SIZE	MEDIAN FOUNDATION BOARD SIZE
Private Foundation	51	$0-500+	11.0
	5	0-10	12.0
	31	11-100	10.0
	13	101-500	11.0
	2	Greater than 500	13.0
Social Welfare Organization 501 (c) (4)	4	0-500+	12.5
Public Charity	56	0-500+	15.0
509 (a) (1)	28	0-500+	15.0
	6	0-10	15.0
	15	11-100	13.0
	7	101-500	18.0
	0	Greater than 500	N/A
509 (a) (2)	6	0-500+	13.5
509 (a) (3)	22	0-500+	15.0
	2	0-10	20.0
	14	11-100	15.0
	6	101-500	16.0
	0	Greater than 500	N/A
All Foundations	111	0-500+	13.0

N = 111

Notes: *N/A indicates that a median could not be calculated.*
Data from 1 foundation resulting from the conversion of a municipal hospital are excluded. This endowment does not have a tax status.

Source: *Grantmakers In Health, Survey of New Health Foundations, 1999.*

[11] The 1999 survey saw, for the first time, an endowment developed from the conversion of a municipal hospital to nonprofit status. This endowment is not a foundation because it is a separate fund administered by the city. It does however, have a board, a grantmaking agenda, a mission and program focus, and otherwise behaves similarly to the private foundations and public charities responding to the survey.

Staff Size. Like board size, staff size varies among the different foundations. Both tax status and asset size appear to be factors affecting staff size. Public charities require more staff than private foundations in order to run their nongrantmaking activities, such as fund raising and the operation of direct service programs. One public charity surveyed, for example, operates a number of community health programs in addition to grantmaking, thus requiring it to employ roughly 175 additional full and part-time employees in addition to its grantmaking staff.

Foundation staff sizes ranged between 0 and 125 people; most of them have staff sizes of seven or less. The median staff size, depending on tax status, ranges from 1 to 10, and generally increases with the assets of the foundation (Exhibit 7). The median staff size of public charities is twice that of private foundations.

Exhibit 7. *Median Foundation Staff by Tax Status and Asset Size (millions of dollars), 1999*

TAX STATUS	NUMBER	ASSET SIZE	MEDIAN FOUNDATION STAFF SIZE
Private Foundation	51	$0-500+	2.0
	5	0-10	1.0
	31	11-100	2.0
	13	101-500	7.0
Social Welfare Organization 501 (c) (4)	4	0-500+	10.0
Public Charity	56	0-500+	4.0
509 (a) (1)	28	0-500+	3.0
	6	0-10	2.5
	15	11-100	3.0
	7	101-500	5.0
	0	Greater than 500	N/A
509 (a) (2)	6	0-500+	4.5
509 (a) (3)	22	0-500+	4.5
	2	0-10	1.5
	14	11-100	4.0
	6	101-500	5.5
	0	Greater than 500	N/A
All Foundations	111	0-500+	4.0

N = 111
Notes: *The median assets of two private foundations with assets greater than $500 million were not listed separately.*
N/A indicates that a median could not be calculated.
Data from 1 foundation resulting from the conversion of a municipal hospital are excluded. This endowment does not have a tax status.
Source: *Grantmakers In Health, Survey of New Health Foundations, 1999.*

Staffing Solutions of Foundations Without Permanent Staff. Ten of the surveyed foundations do not have staff. They typically rely on board members, consultants, staff from other organizations, or a combination of these to accomplish the foundation's work (Exhibit 8). Lack of staff does not necessarily correlate with foundation age. Only four of the ten foundations without staff were formed during or after 1996, and only one of these foundations was responding to this survey for the first time in 1999. In fact, some foundations with no permanent staff were created as early as 1981.

Board Structure and Foundation Independence

A key issue for new health foundations has been the independence of their boards from the organizations involved in the conversions. Independence is a complex issue. It is not easy to discern how independent a foun-

Exhibit 8. *Staffing Solutions of Foundations Without Permanent Staff, 1999*

STAFFING SOLUTION	NUMBER OF FOUNDATIONS
Board Members	2
Consultant(s)	2
Staff from Other Organizations	4
Combination of Board Members And Consultants	2

N = 10
Note: Data do not include three foundations that use a combination of permanent staff and other staffing options.
Source: Grantmakers In Health, Survey of New Health Foundations, 1998 and 1999.

dation should be from its roots; much depends on the nature of the transaction, the missions of the organizations involved, and the policies used to limit conflicts of interest.

Concerns of community organizations and regulators about independence often stem from the possibility that an ongoing relationship with the converted organization will compromise the foundation's ability to provide a public benefit or to carry out the mission of the original organization. While nonprofit to nonprofit transactions may not raise concerns over the loss of public benefit, issues may remain about similarity and compatibility of mission with that of the original organization. Maintaining ties to any other organizations involved in the conversion (for example, through shared board members) may also create actual or apparent conflicts of interest.

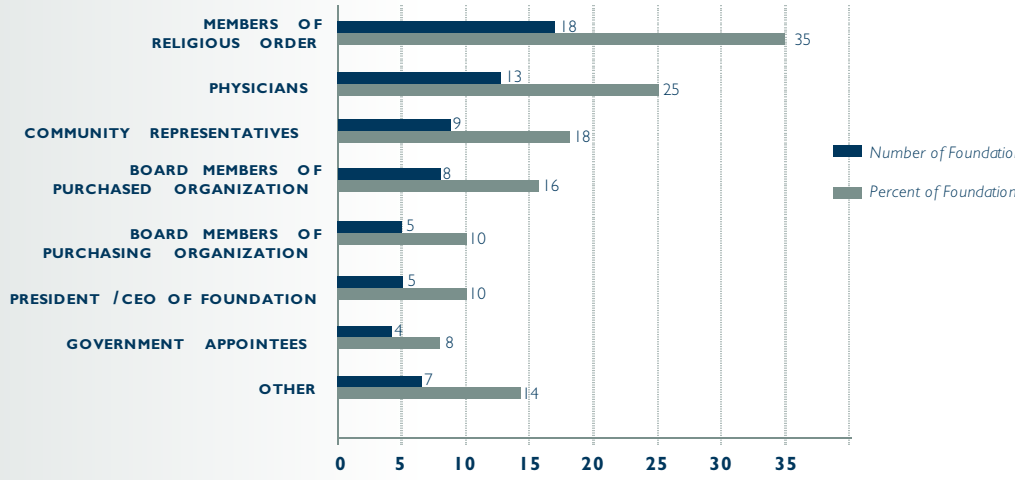
One way for a new health foundation to preserve the assets of the converted organization for the public's benefit is to remain independent from the financial interests of both the purchasing organization and the converted organization. For some foundations, a complete separation from the purchased and purchasing organizations has been the clearest way to avoid the reality or appearance of conflicts of interest. This is not always possible, however, given the complex nature of many transactions. Mergers and joint ventures, for example, require a continued relationship between the foundation and the converted nonprofit or the purchasing organization.[12]

In an effort to gauge the autonomy of new health foundations, the survey focused on three types of policies and practices related to independence: the existence of reserved seats for the purchasing and converted organizations, the presence of foundation board members sitting concurrently on the board of the converted organization — whether or not their seats were reserved — and the existence of conflict-of-interest policies. Foundations were not asked to report on the behavior of board members.

Reserved Foundation Board Seats. Fifty-one new health foundations reported having reserved seats on the board. Of these, 35 percent reserved seats for members of the religious order that had previously owned or been affiliated with the purchased organization; 25 percent reserved seats for physicians; and 18 percent reserved seats for representatives of the community (Exhibit 9). Thirteen foundations (25 percent) reserved seats for board members of the purchasing or purchased organizations. Others for whom seats were sometimes reserved included the CEO or president of the foundation and government appointees.

[12]The IRS has closely watched joint ventures between foundations and for-profit partners to administer a nonprofit organization, ruling in 1998 that some of these partnerships left too much control of the nonprofit health organization to the for-profit partner. Without changes in the structure of these joint ventures, the nonprofit tax status of the foundations involved is in jeopardy

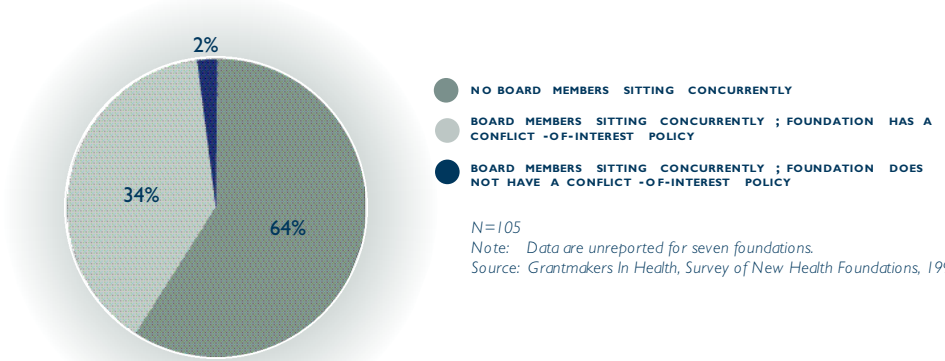
Exhibit 9. *Reserved Board Seats of Foundations by Type of Seat Reserved, 1999 (number and percentage of foundations)*



N=51
Notes: Foundations may have reported more than one type of reserved board seat. Fifty-four foundations reported no reserved board seats. Data for seven foundations are missing.
Source: Grantmakers In Health, Survey of New Health Foundations, 1999.

Concurrent Board Seats. A dimension of board composition that can affect the independence of foundations is the presence of foundation board members who also sit on the board of the converted organization, whether or not their seats were reserved. This occurs in a minority of foundations. Of the 112 respondents, 38 reported having board members sitting concurrently on the boards of the converted organizations (Exhibit 10). Nine of these 38 foundations were created out of joint ventures, and two were created from mergers; it would be expected that these organizations would share board members as a component of the partnership. Twenty-

Exhibit 10. *Foundations with Board Members Sitting Concurrently on Board of Converted Organization, 1999 (percentage of foundations)*



N=105
Note: Data are unreported for seven foundations.
Source: Grantmakers In Health, Survey of New Health Foundations, 1999.

six foundations created as the result of a sale of a nonprofit health organization shared board members with the converted organization, and one resulting from a corporate restructuring has shared board members. Only one foundation — created as a result of a sale — shares board members with the purchasing organization.

Conflict-of-Interest Policies. Another measure of board independence is the existence of a written conflict-of-interest policy. These policies are designed for foundation board members who are affiliated with other organizations. Such policies increase the independence of foundations by establishing rules of conduct for board members with respect to potential conflicts. These conflicts of interest most often arise when a foundation trustee is affiliated with a potential grantee organization. A conflict-of-interest policy usually requires board and staff to disclose all outside affiliations and recuse themselves from voting on grants to these entities. Of the 106 foundations responding to this question, 97 have written conflict-of-interest policies. Only two foundations with board members sitting concurrently on the boards of the converted organizations do not have written conflict-of-interest policies.

Community Involvement

It is often expected (and sometimes required) that new health foundations will involve the public in the development of their structure, purpose, governance, and system of accountability. If done with skill and sensitivity to the many competing concerns, community participation can help a foundation repair damaged relations in the aftermath of a difficult conversion, and it can heighten the foundation's credibility in the long run. Public involvement can also enable a new foundation to chart its course most effectively by ensuring that the use of charitable assets continues to be sensitive to and accountable for addressing the health care needs and concerns of the community.

In addition to having community members sit on the board (a strategy employed by 87 foundations), effective ways of involving community stakeholders range from working directly with the public to consulting experts, or combining several strategies. Different strategies work in different communities depending upon the nature of the conversion and the characteristics of the stakeholders. This year's survey measured three dimensions of community involvement: direct involvement in the development of both the mission and program focus and the use of geographic grantmaking restrictions.

Development of the Foundation's Mission. One dimension of community involvement is the level of participation in the development of the foundation's mission. The mission drives the foundation's work. Each grant proposal that the foundation reviews is evaluated in terms of its responsiveness to the mission. Foundations often use more than one approach to integrating the community's needs and interests in developing the mission.

Forty-two percent of the responding foundations involved the community in the initial development of the mission (Exhibit 11). About 40 percent of these foundations reported that they consulted directly with the community through community forums, almost 40 percent reported using focus groups, and nearly one-third held public hearings. Some foundations relied on the expertise of health professionals to gauge the needs of the community. More than half relied on consultations with public health officials and more than one-third sought

the professional assistance of academic experts. Other foundations relied on professionals from the community. About 11 percent of the foundations with any type of public involvement relied on advisory committees or consultations with local experts to represent the needs of the community, and 9 percent sought the assistance of stakeholders served by the converted nonprofit organization. In addition, more than half of the respondents with some level of community involvement reported using formal or informal needs assessments to better understand the community.

Development of the Foundation's Program Focus. Community participation in the development of the program focus provides another measure of community involvement. The foundation's program focus describes the specific areas of health that will be funded in order to satisfy the mission of the foundation.

In a manner similar to the development of their missions, foundations relied on a number of strategies to involve the community in developing their program focus and often pursued more than one method. Forty-seven percent of foundations relied on community input in developing their program focus, slightly more than the percentage of foundations involving the community in development of the mission (Exhibit 11). Most of these foundations looked to experts who could convey the viewpoints of the community. Almost 60 percent of those with community involvement relied on consultations with public health officials, and 47 percent consulted academics. Some took a more direct approach. Thirty-eight percent of the foundations that sought community input when developing the program focus conducted focus groups and 36 percent held community

Exhibit 11. *New Health Foundations Involving the Community in the Development of the Mission and Program Focus by Type of Community Involvement, 1999*

TYPE OF COMMUNITY INVOLVEMENT	MISSION		PROGRAM FOCUS	
	Number	*Percent*	*Number*	*Percent*
Community Forums	20	42.6	19	35.8
Consultations with Academic Experts	17	36.2	25	47.2
Consultations with Public Health Officials	27	57.4	31	58.5
Focus Groups	18	38.3	20	37.7
Formal Community Needs Assessment	22	46.8	29	54.7
Public Hearings	15	31.9	7	13.2
Advisory Committee and Local Experts	5	10.6	9	17.0
Community Stakeholders in the Converted Organization	4	8.5	2	3.8
Informal Community Needs Assessment	3	6.4	3	5.7
Court Order	1	2.1	0	0.0
Other	5	10.6	4	7.5
	N=47 for mission		*N=53 for program focus*	

Note: *Foundations may have responded with more than one category of community involvement.*
Source: *Grantmakers In Health, Survey of New Health Foundations, 1998 and 1999.*

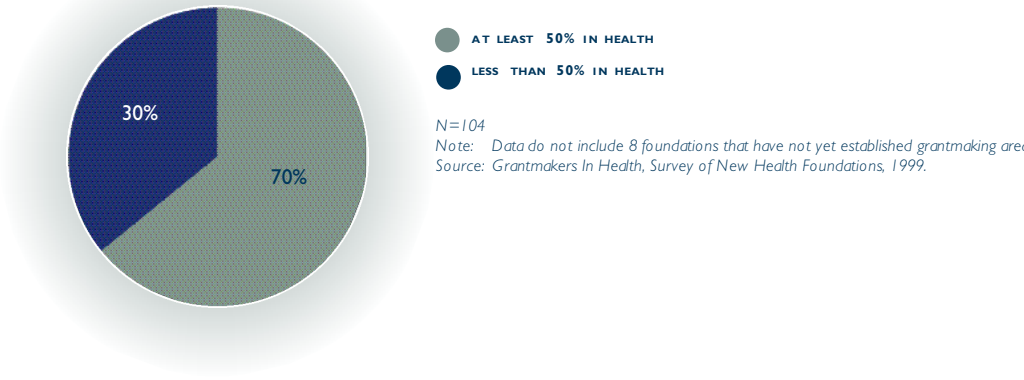
forums. Additionally, a little more than 60 percent of these foundations reported formal or informal needs assessments in determining their program focus.

Geographic Grantmaking Restrictions. A third and final dimension of community involvement measured by the survey is the existence of geographic grant restrictions. Geographic restrictions narrow the focus of the foundations' grantmaking and facilitate foundations' understanding of community needs and interests. In addition, by restricting grants to the local community, foundations developed as the result of hospital conversions are preserving the former nonprofit organization's mission to provide services locally. The 1998 and 1999 surveys asked respondents to report on their grant restrictions. Of those responding, 89 foundations indicated that they had geographic grant restrictions. Several of the remaining foundations have not yet determined their grantmaking areas, and even those without strict guidelines fund mostly in their local communities. In the case of foundations created from larger transactions, generally health plans, the grants were often restricted to the state rather than the community.

Health Funding Priorities

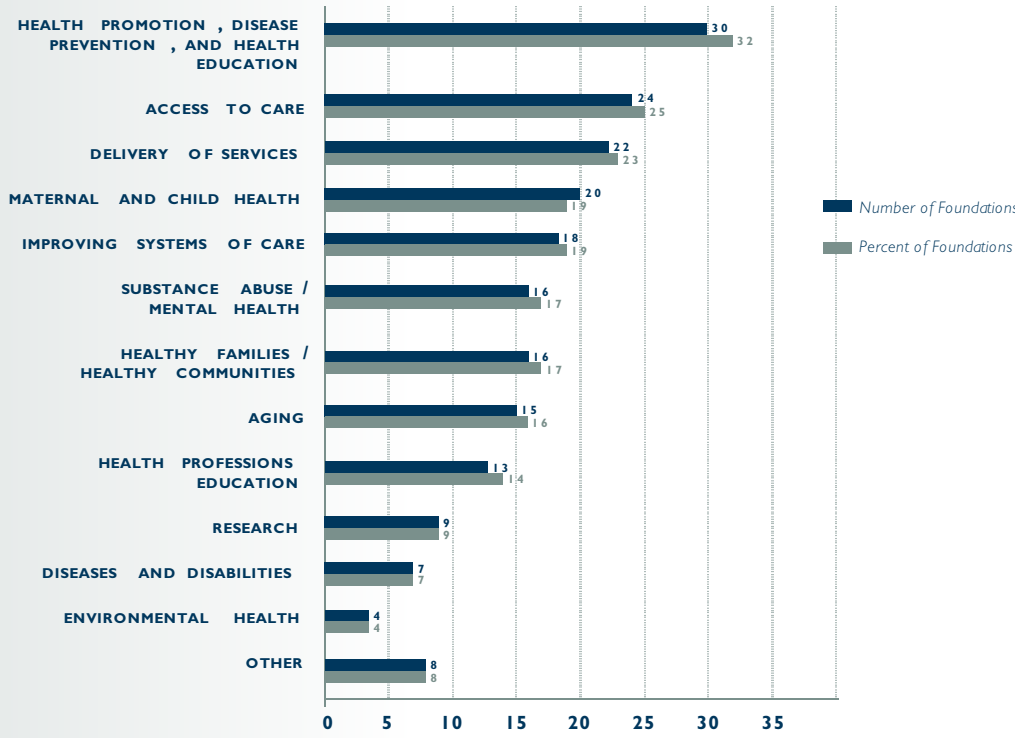
Most new health foundations dedicate some or all of their grantmaking to health, human services, or other health-related areas, such as aging (Exhibit 12). These foundations fund a wide variety of health activities in their communities with many focusing on disease prevention, health promotion, and health education; access to care; and the delivery of services (Exhibit 13). Many also fund projects targeting specific populations in their communities such as adolescent tobacco cessation and prescription drugs for the elderly.

Exhibit 12. *Foundation Funding in Health by Level of Funding, 1999 (percentage of foundations)*



N=104
Note: Data do not include 8 foundations that have not yet established grantmaking areas
Source: Grantmakers In Health, Survey of New Health Foundations, 1999.

Exhibit 13. *Health Grantmaking Areas, 1999 (number and percentage of foundations)*



N=95

Notes: Foundations may have reported more than one health grantmaking area. Six foundations have not yet identified health grantmaking areas. Data for eleven foundations are missing.

Source: Grantmakers In Health, Survey of New Health Foundations, 1999.

Conclusions

Foundations with origins in health care conversions have been in existence for almost three decades. Those formed in the 1980s are reaching—or have reached—maturity in their organizational lifecycles. Many of these older foundations are now virtually indistinguishable from their counterparts that were formed in more traditional ways. Their boards and staffs are experienced in foundation operations, and their grantmaking reflects a carefully constructed focus and strategy. Distinguishing these more mature organizations by their origins may no longer be a relevant or useful way to characterize them.

Nevertheless, these new organizations have enormous potential to affect the health of the communities they serve as well as the field of health philanthropy. Beyond the basic information gathered in this survey remain a number of interesting questions. For example, how does the maturing of these foundations change their grantmaking? Are there trends toward greater emphasis on strategic initiatives or increased attention to strategic planning and program evaluation? Moreover, it would be interesting to compare the grantmaking priorities and styles of these new foundations with those of the broader field of health philanthropy. Noting these similarities and differences would help illuminate whether these foundations approach their work differently from other grantmakers and whether their practices have influenced the broader field.

GIH is also interested in learning more about the use of conversion funds by organizations not considered new health foundations. This year's survey yielded information on alternative organizational arrangements for grantmaking with conversion-related funds. For the first time, GIH reports on an endowment set up after the conversion of a municipal hospital to nonprofit status. That endowment makes grants for health and human services but is not a foundation in the traditional sense, as its assets are controlled by the city government. In addition, a number of other conversion funds are being administered by community foundations and have not resulted in the development of new foundation. Future work will attempt to track the grantmaking generated by these conversion arrangements as well.

APPENDIX I

A Profile of New Health Foundations

NAME AND LOCATION	YEAR OF CONVERSION	1999 ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Alleghany Foundation *Covington, VA*	1995	$52,000,000	Hospital	Quality of life, nurses, school and dental services, education
Alliance Healthcare Foundation *San Diego, CA*	1994	$106,000,000	Health Plan	Care for medically underserved, substance abuse, communicable diseases, violence, mental health, environmental and community health, public education
Andalusia Health Services, Inc *Andalusia, AL*	1981	$2,300,393	Hospital	Medical scholarships
Archstone Foundation *Long Beach, CA*	1985	$128,082,121	Health Plan	Aging, end-of-life care, and care givers of elderly
Arlington Health Foundation *Arlington, VA*	1996	$408,069,000	Hospital	Access to health services, substance abuse prevention and treatment, teen pregnancy, support for frail elders
The Assisi Foundation of Memphis, Inc. *Memphis, TN*	1994	$188,000,000	Hospital	Medical research, preventive and primary care, health promotion and education, support and enhancement of health and human services systems, healthy communities.
Austin Bailey Health & Wellness Foundation *Canton, OH*	1996	$11,000,000	Hospital	Community clinics for indigent care, mental health, senior health, childhood health care, domestic violence, parenting health and wellness education
Baptist Community Ministries *New Orleans, LA*	1995	$225,000,000	Health System	Health, education, public safety, governmental oversight, church nursing, chaplaincy training
Barberton Community Foundation *Barberton, OH*	1996	$95,900,000	Hospital	Health, education, human services, economic and community development
Bedford Community Health Foundation, Inc. *Bedford, VA*	1984	$4,526,795	Hospital	Medical and health-related services, nursing education, preventive medicine, wellness, public health
Bernardine Franciscan Sisters Foundation *Newport News, VA*	1996	$11,287,636	Hospital	General health improvements, care for the sick and injured, educational activities related to health care
Birmingham Foundation *Pittsburgh, PA*	1996	$21,815,924	Hospital	Health-related needs of children, teens, the elderly and the working poor; health prevention; health outreach and access programs
Mary Black Foundation, Inc. *Spartansburg, SC*	1996	$87,000,000	Hospital	Health and wellness, prevention, children, housing, literacy, safety, healthy families, healthy communities, teenage pregnancy, substance abuse, nutrition
The Blowitz-Ridgeway Foundation *Northfield, IL*	1984	$26,000,000	Hospital	Mental health, health care, social services, research
Brentwood Foundation *Maple Heights, OH*	1994	$23,401,349	Hospital	Medical education, research, patient care, and public education in the area of osteopathic medicine

NAME AND LOCATION	YEAR OF CONVERSION	1999 ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Drs. Bruce and Lee Foundation *Florence, SC*	1995	$105,000,000	Hospital	Health; human services; education; arts; religion; civic affairs; historical, cultural, and environmental preservation.
Byerly Foundation *Hartsville, SC*	1995	$28,401,257	Hospital	Education, human services, economic and community development
The California Endowment *Woodland Hills, CA*	1994	$3,500,000,000	Health Plan	Medically under- and uninsured, public health, community health, strengthening health care
California HealthCare Foundation *Oakland, CA*	1996	$813,666,049	Health Plan	Access to health care, under- and uninsured, health policy, public health, quality of care
The California Wellness Foundation *Woodland Hills, CA*	1992	$1,108,027,501	Health Plan	Violence prevention, population health, work and health, community health, teenage pregnancy prevention
Cape Fear Memorial Foundation *Wilmington, NC*	1996	$60,000,000	Hospital	Elderly, physical and mental disability, under- and uninsured, domestic violence, substance abuse, STDs, maternal and infant health, chronic diseases
Caring for Colorado Foundation *CO*	1998	$140,000,000	Health Plan	Guidelines not available
Christy-Houston Foundation *Murfreesboro, TN*	1986	$89,918,429	Hospital	Health care, education, charitable activities, nursing homes, nursing education
Colorado Springs Osteopathic Foundation *Colorado Springs, CO*	1984	$18,699,851	Hospital	Family practice residency training program, clinic for underserved populations, public education on osteopathic medicine and good health
The Colorado Trust *Denver, CO*	1985	$365,243,528	Hospital	Community-based planning and problem solving, disease prevention, and health promotion
Columbus Medical Association Foundation *Columbus, OH*	1992	$72,000,000	Health Plan	Health care delivery, education, innovative health care projects, research.
Community Care Foundation, Inc. *Springdale, AR*	1998	$140,000,000	Health System	Guidelines not available
Community Health Corporation *Riverside, CA*	1997	$43,180,602	Hospital	Children and families, inpatient and outpatient health care
Community Health Endowment of Lincoln *Lincoln, NE*	1997	$41,000,000	Hospital	Guidelines not available
Community Health Foundation *Massillon, OH*	1999	$8,000,000	Hospital and Health System	Emotional, physical, and mental health and wellness
Community Memorial Foundation *Hinsdale, IL*	1995	$98,000,000	Hospital	Youth, older adults, strengthening family, creating community cohesiveness, access to health care
Moses Cone—Wesley Long Community Health Foundation *Greensboro, NC*	1997	$120,000,000	Hospital	Wellness, health care access for underinsured populations, community capacity building
Consumer Health Foundation *Washington, DC*	1994	$31,500,000	Health Plan	Public health, improving access to care, consumer education and empowerment
Dakota Medical Foundation *Fargo, ND*	1994	$103,000,000	Hospital	Community health, clinical research, community and patient education, medical education

NAME AND LOCATION	YEAR OF CONVERSION	1999 ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Daughters of Charity Healthcare Foundation of St. Louis *St. Louis, MO*	1995	$26,700,000	Hospital	Primary and preventive medical service, health and wellness education, social service, spiritual health care
Daughters of Charity West Central Region Foundation *Clayton, MO*	1996	$245,288,564	Hospital	Health and wellness education, primary and preventive medical service, spiritual health care, social service
Deaconess Community Foundation *Cleveland, OH*	1994	$45,000,000	Hospital	Aging, mental health, child immunization, housing, education
Deaconess Foundation *St. Louis, MO*	1997	$71,400,000	Health System	Public health, children at risk, faith and health
Desert HealthCare Foundation *Palm Springs, CA*	1997	$6,400,000	Hospital	Improving community access to health and wellness services
The Federation of Independent School Alumnae (FISA) Foundation *Pittsburgh, PA*	1996	$42,567,369	Rehabilitation Center	Health and human service needs of women and girls; quality of life issues of men, women, and children with disabilities
Foundation for Seacoast Health *Portsmouth, NH*	1985	$75,858,203	Hospital	Health promotion and disease prevention for children and youth, women, underinsured and indigent
Franklin Benevolent Corporation *San Francisco, CA*	1998	$36,000,000	Hospital	Health education and research
Georgia Osteopathic Institute *Tucker, GA*	1986	$5,000,000	Hospital	Statewide training program for third- and fourth-year medical students working in underserved areas
Good Samaritan Foundation, Inc. *Lexington, KY*	1995	$24,000,000	Hospital	Access for low-income and underinsured, health education in underserved areas, training of health care professionals
Grotta Foundation for Senior Care *South Orange, NJ*	1993	$10,500,000	Nursing Home	Aging, mental and physical health of elderly, family caregivers of the elderly
Group Health Foundation *St. Louis, MO*	1985	$4,900,000	Health Plan	Grants to health care providers, health promotion and illness prevention, seed money for new projects.
Gulf Coast Medical Foundation *Wharton, TX*	1983	$18,000,000	Hospital	Local emergency medical services, primary care
The Health Foundation of Central Massachusetts, Inc. *Worcester, MA*	1995	$57,000,000	Health Plan	Guidelines not available
The Health Foundation of Greater Cincinnati *Cincinnati, OH*	1996	$285,238,017	Health Plan	Primary care to the poor, school-based child health, substance abuse, severe mental illness
The Health Foundation of Greater Indianapolis, Inc. *Indianapolis, IN*	1989	$40,278,917	Health Plan	Adolescent programs, HIV/AIDS, general community health
Health Foundation of South Florida *Miami, FL*	1993	$64,379,591	Hospital	Indigent care, research, social services, nursing scholarships, homeless health care, and school-based health clinics
Health Future Foundation *Omaha, NE*	1984	$70,000,000	Hospital	Indigent care, research, health-related projects at Creighton University
The Health Trust *Campbell, CA*	1996	$115,000,000	Health System	Children, frail elderly, vulnerable adults, medically indigent, health services research and education

NAME AND LOCATION	YEAR OF CONVERSION	1999 ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
The Healthcare Foundation of New Jersey *Roseland, NJ*	1996	$180,541,000	Hospital	Health care for the vulnerable in Newark and in the Jewish community, promoting humanism in medicine
The HealthCare Foundation for Orange County *Santa Ana, CA*	1996	$20,885,185	Hospital	Support for community-based organizations and nonprofit hospitals working with community-based organizations
Healthcare Georgia, Inc. *Atlanta, GA*	1999	$80,000,000	Health Plan	Guidelines not available
HealthONE Alliance *Denver, CO*	1995	$150,457,000	Health System	Guidelines not available
Hill Crest Foundation *Bessemer, AL*	1984	$28,000,000	Hospital	Mental health, arts, education
Hilton Head Island Foundation, Inc. *Hilton Head, SC*	1994	$34,000,000	Hospital	Arts and culture, community development, education, environment, health, human services.
The Horizon Foundation of Howard County *Columbia, MD*	1998	$62,000,000	Hospital	Guidelines not available
Incarnate Word Foundation *St. Louis, MO*	1997	$33,000,000	Hospital	Community health; wellness; social, spiritual, and mental health
Irvine Health Foundation *Irvine, CA*	1985	$27,000,000	Hospital	Health services, research, education, prevention
The Jackson Foundation, Inc. *Dickson, TN*	1995	$80,000,000	Hospital	Education, arts, technology training
Annabella R. Jenkins Foundation *Richmond, VA*	1995	$41,099,419	Hospital	Access to care for medically underserved, teen pregnancy prevention, violence prevention, substance abuse prevention
The Jewish Foundation of Cincinnati *Cincinnati, OH*	1996	$96,283,000	Hospital	Capital improvement and health projects that enhance the functioning of the Jewish community
Jewish Healthcare Foundation *Pittsburgh, PA*	1990	$138,000,000	Hospital	Advancing health: information technology and biomedical research; financing health: insuring quality; integrating health: physical, behavioral, environmental, and public health
Kansas Health Foundation *Wichita, KS*	1985	$451,689,000	Hospital	Public health, children's health, leadership
Lutheran Charities Foundation of St. Louis *St. Louis, MO*	1987	$88,000,000	Hospital	Physical and developmental disabilities, children, elderly, substance abuse, parish nursing, specific diseases, education, employment, and church outreach programs
Dr. John T. Macdonald Foundation, Inc., *Coral Gables, FL*	1992	$28,375,124	Hospital	Health education, prevention and early detection of diseases, children and the economically disadvantaged, medical rehabilitation, direct medical and dental care, education
The Memorial Foundation, Inc. *Goodlettsville, TN*	1994	$150,990,974	Hospital	Youth and children, human services, substance abuse, senior citizens, health and rehabilitation, education, social agencies
Methodist Healthcare Ministries of South Texas, Inc. *San Antonio, TX*	1995	$84,000,000	Hospital	Operation of three clinics providing medical, dental, and support services, grants to four community health clinics to provide medical and dental services to uninsured indigent clients

NAME AND LOCATION	YEAR OF CONVERSION	1999 ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
MetroWest Community Health Foundation *Framingham, MA*	1996	$44,000,000	Health System	Poor, elderly, and children
Mid-Iowa Health Foundation *Des Moines, IA*	1984	$17,960,117	Hospital	Adolescent health, parent/early childhood health, access to health services, prevention health practices
The Mt. Sinai Health Care Foundation *Cleveland, OH*	1994	$137,000,000	Health System	Child development, elderly, organizational capacity building, community programs, scholars program at Case Western Reserve University School of Medicine
North Dade Medical Foundation, Inc. *North Miami, FL*	1997	$37,500,000	Hospital	Health, education, and general welfare
Northwest Health Foundation *Portland, OR*	1997	$59,320,000	Health Plan	Health promotion and disease prevention; health protection especially for children; improving the delivery, accessibility, and quality of health care
Northwest Osteopathic Medical Foundation *Portland, OR*	1984	$10,073,000	Hospital	Families and children, scholarships to osteopathic medical students, training clinics for osteopathic residency programs
Osteopathic Founders Foundation *Tulsa, OK*	1996	$5,100,000	Hospital	Osteopathic medical education, community health
Pajaro Valley Community Health Trust *Watsonville, CA*	1998	$7,000,000	Hospital	Direct medical care, prevention, wellness education
Paso Del Norte Health Foundation *El Paso, TX*	1995	$210,000,000	Hospital	Health education and disease prevention
Phoenixville Community Health Foundation *Phoenixville, PA*	1996	$37,000,000	Hospital	Community health, emphasizing access to medical, dental, and mental health care; projects dealing with public safety and environmental health and those affecting the economic, social, and civic health of the community
Portsmouth General Hospital Foundation *Portsmouth, VA*	1988	$19,743,284	Hospital	Pregnancy prevention, health and the family, indigent care, substance abuse prevention, and health education and preventive health programs
Presbyterian Health Foundation *Oklahoma City, OK*	1985	$142,000,000	Hospital	Medical research, scholarships, clinical pastoral education, community health-related programs primarily through the University of Oklahoma
Quad City Osteopathic Foundation *Davenport, IA*	1984	$6,007,869	Hospital	Grants, loans and scholarships to advance quality and availability of osteopathic health care professionals
Quantum Foundation, Inc. *West Palm Beach, FL*	1995	$155,132,466	Hospital	Health and education, children's health, children's behavioral health, independent living, school nurses, and various school reform initiatives
QueensCare *Los Angeles, CA*	1998	$325,000,000	Hospital	Direct health care, education and outreach, preventive care, research, policy, ethics, and law
John Randolph Foundation *Hopewell, VA*	1995	$34,465,000	Hospital	Teen pregnancy, violence prevention, mental health, substance abuse, access to care, prevention and health promotion, quality of life

NAME AND LOCATION	YEAR OF CONVERSION	1999 ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
The Rapides Foundation *Alexandria, LA*	1994	$202,955,000	Hospital	Adolescent risk and pregnancy reduction, early childhood development, functional status of older adults, health care access, community development, education, arts and humanities
Michael Reese Health Trust *Chicago, IL*	1991	$102,737,199	Hospital	Health care, health education, health research, strengthening community-based efforts to provide health services to the vulnerable and underserved in metropolitan Chicago
Roanoke-Chowan Foundation, Inc. *Ahoskie, NC*	1998	$17,500,000	Hospital	Health and wellness
Rose Community Foundation *Denver, CO*	1995	$250,000,000	Hospital	Aging, child and family development, education, health, Jewish life
Saint Ann Foundation *Cleveland, OH*	1973	$36,100,000	Hospital	Quality of life for women, children, and youth; religious communities' ministries
St. David's Foundation *Austin, TX*	1996	$118,000,000	Hospital	Access and prevention programs, behavioral health, parenting, life skills, violence, teen pregnancy, medical education, research.
St. Joseph's Community Health Foundation *Minot, ND*	1998	$2,000,000	Hospital	Improvement, availability, and provision of charitable health care
The St. Joseph Community Health Foundation *Fort Wayne, IN*	1998	$28,000,000	Hospital	Physical, mental, and spiritual health of the poor and underserved
St. Luke's Charitable Health Trust *Phoenix, AZ*	1995	$112,176,959	Health System	Health prevention programs for children, youth and families; access and delivery of health services to underserved; behavioral health.
St. Luke's Foundation *Bellingham, WA*	1983	$8,700,000	Hospital	Health education and capital improvements
Saint Luke's Foundation of Cleveland *Cleveland, OH*	1997	$80,000,000	Hospital	Enhance community involvement and ownership in promotion of healthy behaviors, increase and improve health care, educate health care professionals serving the needs of inner-city residents
San Angelo Health Foundation *San Angelo, TX*	1995	$67,282,678	Hospital	Education, health, humanities, human services
San Luis Obispo Community Health Foundation *San Luis Obispo, CA*	1998	$2,700,000	Blood Bank	Blood-related program, services, and research
SHARE Foundation *El Dorado, AR*	1996	$60,466,740	Hospital	Health education, humanities, and disease prevention; hospice, medical clinic, drug prevention, chaplaincy, and scholarships
Sierra Health Foundation *Sacramento, CA*	1984	$155,063,838	Health Plan	Children's health, various health-related projects
J. Marion Sims Foundation *Lancaster, SC*	1994	$80,000,000	Hospital	Health, human services, economic and community development
Sisters of Charity Foundations of Canton, Cleveland, and South Carolina *Cleveland, OH*	1995	$239,500,000	Health System	Health, human services, and education focused on addressing the needs of the underserved; specific areas include health care access and coverage, indigent and low-income care for ages 0-18, child care, affordable housing, father absence, substance abuse, behavioral disorders, job training

NAME AND LOCATION	YEAR OF CONVERSION	1999 ASSETS	TYPE OF ENTITY CONVERTED	GRANTMAKING AREAS
Sisters of Mercy of North Carolina Foundation, Inc. *Charlotte, NC*	1995	$230,000,000	Health System	Disadvantaged populations, women's and children's services, health care, education, social services
The Sisters of St. Joseph Charitable Fund *Parkersburg, WV*	1996	$21,510,355	Hospital	Health of the community, senior citizens, and families
South Lake County Foundation *Clermont, FL*	1995	$10,000,000	Hospital	Youth and family services, health and wellness, arts and culture, education, community economic development
Spalding Health Care Trust *Griffin, GA*	1984	$25,561,283	Hospital	Free health care clinics, emergency equipment for fire departments, capital projects, education, social and human services
Truman Heartland Community Foundation *Independence, MO*	1994	$9,273,800	Hospital	Nutrition, public health programs, dental, economic and community development, education, humanities
Tucson Osteopathic Medical Foundation *Tucson, AZ*	1996	$12,819,756	Hospital	Osteopathic medical student scholarships and loans, education, arts and humanities, community service, health care, substance abuse
Tuscora Park Health and Wellness Foundation *Barberton, OH*	1996	$4,485,916	Hospital	Primary care for the underinsured and underserved, health education, safety
UniHealth Foundation *Woodland Hills, CA*	1998	$500,000,000	Hospital and ancillary businesses	Guidelines not available
Union Labor Health Foundation *Bayside, CA*	1997	$5,000,000	Hospital	Enhancing the physical, mental, and moral well-being of people within Humboldt County
United Methodist Health Ministry Fund *Hutchinson, KS*	1984	$67,250,000	Hospital	Capacity building clinics, oral health, health insurance purchasing cooperatives, children and youth, health ethics, health ministries in religious settings
The Venice Foundation *Venice, FL*	1995	$109,000,000	Hospital	Health, human services, education, art and culture, civic affairs
Washington Square Health Foundation, Inc. *Chicago, IL*	1986	$32,329,495	Hospital	Direct health care services, medical equipment, medical and nursing scholarships, clinical research
Welborn Baptist Foundation *Evansville, IN*	1999	$10,000,000	Hospital	Guidelines not available
Welborn Foundation *Evansville, IN*	1999	$79,000,000	Hospital	Guidelines not available
Westlake Health Foundation *Oakbrook Terrace, IL*	1998	$90,000,000	Health System	Guidelines not available
Williamsburg Community Health Foundation *Williamsburg, VA*	1996	$77,500,000	Hospital	Disease prevention, increasing primary health services for poor and uninsured children and families, improvement of health of elderly people, support of community health initiatives
Winter Park Health Foundation *Winter Park, FL*	1994	$117,840,000	Hospital	Older adults, children and families, wellness and prevention
Woodruff Foundation *Cleveland, OH*	1987	$12,867,197	Hospital	Mental health, mental illness, chemical dependency

APPENDIX 2

Tax Status of New Health Foundations

Foundations that receive assets from the conversion of a nonprofit health care organization can operate under several different tax status categories. Which type of tax status they choose will affect their operations, both directly and indirectly. Choice of tax status is revocable, and foundations do find reasons for changing their tax status after they have gained some experience in philanthropy. Below are definitions of the types of tax status new health foundations may obtain from the Internal Revenue Service (IRS).

501(c)(3)

The section of the Internal Revenue Code (IRC) that entitles entities organized exclusively for charitable, educational, or scientific purposes to be exempt from most federal taxes. Many states honor the 501(c)(3) designation and confer similar exemptions for state and local taxes. Several different types of foundations fall under the 501(c)(3) tax category.

Private Foundation. A grantmaking foundation with an endowment from a single source such as an individual, family, or corporation. Private foundations generally do not engage in direct charitable activities but instead make grants to other nonprofit organizations. They do not raise funds from the public and must make grants each year equaling about 5 percent of their endowments. The funds available for the grants and administrative expenses generally come from their endowment income. Private foundations also pay a 1 percent or 2 percent excise tax to the federal government as determined by an IRS formula. Subsets of private foundations include independent foundations, in which the board is selected independently of the donor(s); family foundations, in which the donor or the donor's family controls the board; and corporate foundations, in which the donor corporation has selected the board.

Public Charity. A tax-exempt religious, educational, or social service organization that receives regular contributions from several sources such as individuals, corporations, private foundations, government, and sometimes fees for services. These organizations may operate programs and make grants.

Public charities are classified as 501(c)(3) organizations. Within the 501(c)(3) category, there are subdivisions for further classifying different types of public charities including:

- ***509(a)(1) traditional:*** A public charity that receives funds from public donations and/or government. It generally must meet an IRS public support test requiring that, over the most recent four-year period, its support from public sources equaled or exceeded one-third of its total support.
- ***509(a)(2) gross receipts:*** A public charity that must raise more than one-third of its total support from any combination of gifts, grants, contributions, or membership fees *and* gross receipts from admissions, merchandise sales, or services provided in relation to its tax-exempt function.
- ***509(a)(3) supporting organization:*** A nonprofit corporation with an established relationship to an existing public charity, often a community foundation or a religious order. Supporting organizations do not have to meet a public support test, and they generally receive grantmaking, investment, and administrative assistance from the nonprofit with which they are affiliated.

Community Foundation. These foundations are public charities but, because of their importance in many communities, are described separately here. They develop, receive, and administer endowment funds from private sources and manage them under community control for charitable purposes. Their grants are normally limited to charitable organizations within a specifically identified region or community. A board of directors representing the diversity of community interests oversees their charitable giving. They are classified under the IRC with the designation 509(a)(1), a subset of 501(c)(3).

501(c)(4)

A tax-exempt organization, known as a social welfare organization, that is allowed to lobby. These organizations include political or lobbying groups such as Common Cause or the American Association of Retired Persons. They are not obliged to spend any portion of their income or endowment on charitable activities and are not required to report the same detailed information as private foundations. A few new health foundations have obtained this status if they resulted from the sale of a 501(c)(4) medical association or other type of organization that had the 501(c)(4) status.

About half of the foundations responding to the Grantmakers In Health 1999 survey of new health foundations—mostly those formed in the 1990s—have the classification of public charity. Most of the rest are private foundations. It is likely that many of the public charities will eventually become private foundations because their large endowments make it difficult for them to raise the funds required by the IRS. The IRS allows these new organizations a few transition years before it determines their permanent tax status.

About 20 percent of the public charities surveyed are supporting organizations. They legally affiliate with an existing public charity, such as a community foundation, but operate largely like a private foundation. Most of the supporting organizations formed from health conversions are attached to religious orders and have resulted from the sale of a religious hospital. While the parent organization technically governs the supporting organization, the supporting organization operates independently. It usually has its own board of directors and has the added benefit of not having to meet the public support test or the pay-out requirement of a private foundation.

APPENDIX 3

Resource List

The Conversion Process

Bell J., H. Snyder, and C. Tien, *The Public Interest in Conversions of Nonprofit Health Charities* (New York, NY: Milbank Memorial Fund and Consumers Union, 1997). This report explores why and how health conversions are occurring and how the resulting assets are valued. It also contains a useful overview of nonprofit law and foundation tax status. It concludes with several case studies of conversions including most of the major Blue Cross/Blue Shield conversions and several Columbia/HCA purchases.

Bloche, G., "Should Government Intervene to Protect Nonprofits?" *Health Affairs* (September/October 1998): 7-25. The emergence of investor-owned firms as major actors in U.S. health care financing and delivery has led to calls for federal and state intervention to protect nonprofits and to stem the for-profit sector's growth. High profile scandals involving some of these firms have lent urgency to such proposals. This paper considers the case for government intervention to protect the nonprofit health sector. The controversy over the comparative merits of nonprofits and for-profits is reformed as a debate over the potential and limits of government action, and the case for a general presumption favoring protection for nonprofits is found to be unpersuasive.

Grantmakers In Health, *Coming of Age: Findings from the 1998 Survey of Foundations Created by Health Care Conversions* (Washington, DC: February 1999). This report is based on the findings from Grantmakers In Health's 1998 survey of new health foundations. It provides a brief overview of these foundations in the changing health care market; basic statistics on the foundations such as the year of formation, asset size, tax status, and grantmaking focus; new information on the independence of these foundations from the organizations involved in the conversion; information on how the foundations involve the community in the development of the mission and program focus; and a reference table summarizing information on each new health foundation.

Lutz, Sandy and Preston E. Gee, *The For-Profit Healthcare Revolution: The Growing Impact of Investor-Owned Health Systems in America* (Burr Ridge, IL: Irwin Professional Publishing, 1995). This book chronicles the rise of investor-owned health systems. It pays special attention to Columbia/HCA and Humana, discussing how they became aggressive purchasers of nonprofit hospitals. It also places these activities into the historical context of health care in the United States.

Miller, Linda B., *When Your Community Hospital Goes Up for Sale* (Washington, DC: Volunteer Trustees Foundation for Research and Education, 1996). This booklet is written to help community advocates understand why a nonprofit hospital might be selling and what they can do to protect the community's interests. It contains advice on working with state government officials and the media. It includes a helpful glossary of terms used in the conversion process.

Needlemen, J., Lamphere, J., and Chollet, D., "Uncompensated Care and Hospital Conversions In Florida: What Does it Mean for Communities When Hospitals Convert?" *Health Affairs* (July/August 1999): 125-133. Hospital conversions to for-profit ownership have prompted concern about continuing access to care for the poor or uninsured. This article presents an analysis of the level of uncompensated care provided by Florida hospitals before and after converting to for-profit ownership. Uncompensated care declined greatly in the converting public hospitals, which had a significant commitment to uncompensated care before conversion. Among converting nonprofit hospitals, uncompensated care levels were low before conversion and did not change following conversion. The study suggests that policymakers should assess the risk entailed in a conversion by considering the hospital's historic mission and its current role in the community.

Pomeranz, John, *Communities & Health Care Conversions* (Washington, DC: Center for Policy Alternatives, 1997). This report provides a good legal overview of the health conversion phenomenon. It discusses issues facing policymakers as a result of the consolidation of the health care market and recommends actions they can take to ensure that communities secure the maximum assets from conversion sales.

Shactman, David and Stuart H. Altman, *The Conversion of Hospitals From Not-For-Profit to For-Profit Status* (Boston, MA: The Heller School, Brandeis University, Council on the Economic Impact of Health System Change, 1996). This paper provides an economic analysis of the differences in levels of community benefits provided by for-profit and not-for-profit hospitals. The authors conclude that for-profit hospitals generally have higher prices than their nonprofit counterparts and that competition is causing nonprofit hospitals to behave more like for-profits. The authors also propose a legal and regulatory framework for hospital conversions.

"Special Issue: Hospital & Health Plan Conversions," *Health Affairs* 16(2), March/April, 1997. This is one of the most comprehensive resources on the public policy implications of health care conversions. It is a compendium of articles by different authors that together present a review of national public policy issues, state regulations, the differences between health plan and hospital conversions, and the financial aspects of health conversions, including assignment of a monetary value to the nonprofit entity and management of the assets resulting from the sale.

Young, G. J., and Desai, K. R., "Nonprofit Hospital Conversions and Community Benefits: New Evidence from Three States" *Health Affairs* (September/October 1999): 146-155. This paper reports findings from a systematic investigation of both the short- and long-term community impacts of nonprofit hospital conversions. The authors find that conversions do not, on average, have an appreciable impact on community benefits.

New Health Foundations

The Aspen Institute, *Health Care Conversions and Philanthropy: Important Issues for Practice and Research* (Washington, DC: November 1999). This is a conference report presenting the highlights of the California Forum on Health Care Conversions and Philanthropy, a one-day meeting co-sponsored by the California Nonprofit Research Program of The Aspen Institute and GIH. The conference brought together a diverse group of foundation leaders, community representatives, government officials, and others to explore important, and sometimes controversial, issues relating to health care conversions and philanthropy.

Bader, Barry S., "The Conversion Foundations: A Pot of Gold or Pandora's Box for Communities?" *Health System Leader 3(8) 4-18, October 1996*. This article provides a concise, critical look at the challenges and potential pitfalls inherent in the creation of health care conversion foundations. It also offers examples of some health care conversion foundations' grantmaking and raises questions about their accountability to the public.

Community Catalyst, "The New Health Philanthropy: Ensuring the Effective Use of Conversion Foundation Assets," *States of Health 8(6): 1-7,* November 1998. This article discusses how some health care conversion foundations are being open and accountable to the public and offers suggestions for other ways they can accomplish this.

Council of Michigan Foundations, *The Sale of Nonprofit Hospital Assets to For-Profit Corporations: Philanthropic Options for Community Decision Makers* (Grand Haven, MI: June 1996). This is a concise, easy-to read synopsis of the legal mechanisms for setting up a conversion foundation. It includes the pros and cons of electing to become a public charity, private foundation, or supporting organization to a community foundation. It also contains a useful list of questions for hospital decisionmakers.

Grantmakers In Health, *Some Tools-of-the-Trade in Grantmaking*: *Techniques and Lessons For Health Foundations—Highlights of Workshop Proceedings* (Washington, DC: February 1997). This report shares grantmaking strategies and offers advice on developing a grantmaking agenda. It includes insights on strategies foundations can undertake besides grantmaking, advice on conducting and using community needs assessments, and suggestions for evaluating foundation programs and grantee activities.

Grantmakers In Health, *Telling a Foundation's Story: Nuts & Bolts For New Health Foundations—Highlights of Workshop Proceedings* (Washington, DC: October 1997). This report addresses how health care conversion foundations can use communications strategies and tools to advance their grantmaking mission, community involvement, and public accountability. Suggested strategies include media relations, publications, and Web site management.

Milbank Memorial Fund, *New Foundations in Health: Six Stories* (New York, NY: 1999). This report describes how six foundations that were created as a result of the conversion of nonprofit health care organizations are carrying out their missions. The trustees and staff of each foundation made many difficult choices. The stories that comprise this report describe the creation of these foundations as well as the distinctive social, economic, and political characteristics of the six communities.

Legislation and Regulation

Bovjberg R., J. Marsteller, and L. Nichols, "Nonprofit Conversion: Theory, Evidence, and State Policy Options," *Health Services Research 33(5): 1495-1535,* December 1998. This is an economic analysis of the contributions of nonprofit hospitals and health plans to health care markets. The authors conclude that nonprofit hospitals provide more uncompensated care than for-profit hospitals; however, nonprofit hospitals seem to set norms for providing services that for-profit hospitals follow. The authors conclude by recommending various options to state policymakers for conversion oversight.

Bureau of National Affairs, *Special Report on Nonprofit Conversions: States Slow Pace in Adopting Merger Oversight Laws, Volume 6, No. 35* (Washington, DC: August 1, 1998). This is a summary of the legislative activity of the 16 states that have enacted statutes to oversee and regulate the purchase of nonprofit hospitals by for-profit companies. It includes a discussion of legislative trends regarding health conversions.

Nilles, Kathleen M., *The New IRS Joint Venture Ruling: No Way Out*? Client Memorandum, Gardner, Carton, Douglas (Washington, DC: April 1998). This memorandum discusses the Internal Revenue Service's (IRS) Revenue Ruling 98-15, which provides guidance on how a joint venture between a nonprofit, tax-exempt hospital and a for-profit entity should be structured in order for the nonprofit partner to retain its tax-exempt status. It includes an analysis of the IRS's two hypothetical joint venture scenarios and advises joint ventures to work proactively with the IRS on clarifying their arrangements.

Silas, Julie, *Creating Supporting Organizations: An Option for Conversion Foundations* (San Francisco, CA: Consumers Union, 1998). This document explains in clear and concise language the legal mechanism of a supporting organization and how it can be applied to health conversion assets.

Volunteer Trustees Foundation for Research and Education, *The Sale and Conversion of Not-For-Profit Hospitals: A State-By-State Analysis of New Legislation* (Washington, DC: 1998). This publication identifies and summarizes common elements of legislation governing health care conversions and provides guidelines for oversight by attorneys general. It offers a comparison of hospital conversion legislation across 14 states and a summary of each state's legislation.

Foundations and Philanthropy

Council on Foundations (John A. Edie), *First Steps in Starting a Foundation, Fourth Edition* (Washington, DC: 1997). This is the definitive legal guide to starting a foundation. Written in language that is easily understood by those who are not lawyers, it describes the various tax statuses available for philanthropic foundations including the different types of public charities and the private foundation option. It also includes sample bylaws and IRS forms.

Council on Foundations, *Foundation Management Series, Ninth Edition, Volumes I, II, and III* (Washington, DC: 1998). Based on a survey of 673 foundations, this is the most comprehensive source in the foundation field for comparative data on foundations' management, governance, and grantmaking. Volume I covers finances, portfolio composition, investment management, and administrative expenses. Volume II is devoted to governance, and Volume III focuses on staffing resources and program issues.

Council on Foundations, *Grantmakers Salary Report* (Washington, DC: 1999). Based on a survey of 745 foundations, this report contains salary information for 5,257 full-time employees. It includes a discussion of staffing issues, chief executive compensation, and salary administration. It also includes salary information for 39 foundation positions.

The Foundation Center, *Foundation Giving: Yearbook of Facts and Figures on Private, Corporate, and Community Foundations* (New York: July 1999). This is a comprehensive statistical report on foundation assets, grants, and giving trends. It looks at trends in foundation growth, creation, and giving. It explores funding in areas such as health, human services, international programs, environment, and the arts.

The Foundation Center, *Health Policy Grantmaking* (New York: 1998). This report describes trends in foundation funding for health policy-related activities during the first half of the 1990s. The first chapter discusses why foundations support policy-related activities and strategies for effective grantmaking. The second chapter presents an analysis of foundation grantmaking in 1990 and 1995—based on a sample of larger U.S. foundations. It includes an examination of health policy's share of all giving for health, areas of growth in health policy funding, and emerging topics in the field.