GRANT MAKERS IN HEALTH

CONNECTING TO COMMUNITY AND BUILDING ACCOUNTABILITY

OCTOBER 2007

FINDINGS FROM THE 2006 SURVEY OF FOUNDATIONS FORMED FROM HEALTH CARE CONVERSIONS

This publication is available on-line at www.gih.org.

PREFACE

Since 1996 Grantmakers In Health (GIH) has been tracking and reporting on the emergence and activities of health foundations formed from transactions involving hospitals, health plans, or health systems. This report is the ninth in this series. It provides an updated profile of health foundations created in the wake of transactions involving the sale, merger, or transfer of assets of nonprofit health organizations and new information on how they relate to communities, their governance policies, and plans for leadership transitions.

One goal of this survey is to provide timely information that allows staff and trustees of similar foundations to benchmark and compare their activities and operations against peers in the field. A second goal is to inform others in philanthropy, public health, health policy, and the nonprofit sector about the status and contributions of health foundations created by health care conversions.

This report was written by Brent Ewig, senior program associate, with substantial guidance and assistance from Lauren LeRoy, president and CEO; Anne Schwartz, vice president; and Delia Reid, program advisor. Kiera Edwards, administrative assistant, was instrumental in collecting supplemental data and preparing the graphics. Gartrell Wright, office technology specialist, assisted with database management and creation of the profile of foundations created by health care conversions that appears in the Appendix of the report. Leila Polintan, communications manager, provided additional editorial support. We extend our thanks to the many staff of the surveyed foundations who provided information and insights. Without them, this report would not be possible.

EXECUTIVE SUMMARY

Beginning in the 1980s a number of new health foundations were created when nonprofit health care organizations converted to for-profit status. Grantmakers In Health (GIH) has identified 185 foundations that were either newly formed with the assets from a health care conversion or received assets generated by a conversion.[1] By 2006 these foundations held a combined total of approximately $21.5 billion in assets. This represents an increase of $3.2 billion over the total reported in the 2005 GIH survey. The conversion phenomenon has slowed since the mid-1990s but still continues. Since 2000 at least 33 new foundations have been created by health care conversions.

Foundations resulting from health care conversions have historically generated significant public interest because of the way they were created, their numbers and sizable assets, and their potential to improve community health. This is the ninth report in a series of GIH publications tracking the field. It examines three critical areas of concern to all foundations: strategies for engaging and assessing communities, institution of governance policies, and leadership succession planning.

The 2006 GIH survey generated three key findings:

- Conversion foundations are actively involved in seeking community input in their work despite few formal requirements for them to do so. The majority (75 percent) of survey respondents report a moderate to high level of systematic community involvement in their foundation's program planning and priority setting.
- A growing number of health foundations are taking steps to strengthen their governance polices to assure ethical and accountable behavior. That number has accelerated since passage of the Sarbanes-Oxley legislation. Nearly two-thirds (62 percent) of responding foundations have a policy specifying appropriate document retention and destruction guidelines, and just over half (52 percent) of responding foundations have a policy for whistleblower protection.
- The survey revealed room for improvement in planning for leadership transitions that are expected with inevitable executive turnover and the impending wake of baby boomer retirements. More than half of all responding foundations expect to have a change in leadership within the next ten years. The GIH survey reveals that only 21 percent of responding foundations currently have a written succession plan that can guide a leadership transition.

Overall, the GIH survey found that a large number of foundations are engaged with and informed by the communities they serve, have moved in recent years to adopt governance policies that improve accountability, and face significant challenges in planning for the expected turnover of executive leadership.

[1] There is no generally accepted definition of foundations formed from health care conversions nor is there commonly accepted terminology for referring to these foundations. GIH defines the term, foundations formed from health care conversions, to include foundations created when nonprofit health care organizations convert to for-profit status; foundations created when nonprofit health care organizations are sold to a for-profit company or another nonprofit organization; those created when assets are transferred through mergers, joint ventures, or corporate restructuring activities; and existing foundations that receive additional assets from the sale or conversion of a nonprofit health care organization.

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INTRODUCTION

The 1980s saw the entry of a new breed of foundations: those created with the proceeds from nonprofit health care organizations converting to for-profit status or transferring assets through sales, mergers, joint ventures, or corporate restructuring activities. This transfer of assets is supported by the legal doctrine of *cy pres*, which stipulates that the assets be used to further a mission as close as possible to that of the original nonprofit organization and to maintain the level of public benefit presumed to have been provided by the nonprofit organization before the conversion took place.

Today GIH has identified 185 foundations that were either newly formed with the assets from health care conversions or received assets generated by a conversion. In 2006 their combined assets amounted to some $21.5 billion. The result of these conversions led to what has been called the greatest redeployment of charitable assets in history (Miller 1997).

Ten years ago conversions drew public interest due to concerns about both the fate of individuals served by the converting nonprofit and how the foundations formed with conversion assets would go about their work. Although many of these foundations are now mature institutions, there continues to be considerable interest in how they operate, how they set their priorities, and how and to whom they are accountable. Interested parties include both regulators and consumer advocates as well as foundation staff, executives, and trustees seeking to benchmark themselves against their peers.

This report focuses on three critical areas of concern to many foundations: strategies utilized for engaging communities, institution of governance policies, and leadership succession planning. The unique circumstances under which the surveyed foundations were created make the question of community engagement particularly salient for them. In light of the recent scandals affecting the corporate sector and the increased scrutiny of the nonprofit sector, the survey sought to determine if foundations created by health care conversions have certain policies in place to deter fraud and promote ethical behavior. Finally, with the well-publicized predictions that many senior executives in the nonprofit sector will be retiring in the near future, this survey sought information on if and how foundations created by health care conversions are preparing for leadership transitions. A final section of the report updates basic information about foundations formed by health care conversions including tax status and year of conversion.

This report focuses on three critical areas of concern to many foundations: strategies utilized for engaging communities, institution of governance policies, and leadership succession planning.

The data described in this report were obtained through a Web-based survey that was open for foundation response in September and October 2006. Instructions for completing the Web-based survey were sent to the 185 conversion foundations identified by GIH.[2] Foundation officials were asked to respond to 67 questions. Of the 185 foundations contacted, 104 completed the survey (56 percent), although not every foundation responded to every question. The Appendix provides general information on all conversion foundations. For nonresponding foundations, GIH obtained information on date of creation and assets from GIH files, publicly available IRS filings, or foundation Web sites.

[2] This number is 13 more than those included in GIH's 2005 survey. One foundation from the list utilized in the last GIH survey had gone out of business by the time of the 2006 survey. New foundations added to the list surveyed for this report were identified by monitoring press reports, Web searches, and a search of the Lexis-Nexis database.

ENGAGING, ASSESSING, AND INFORMING THE COMMUNITY

Because fostering community engagement is one strategy foundations can use to identify and set priorities among community needs, inform program development, build trust and openness, and strengthen accountability, the survey investigated the nature and extent of interactions between foundations and the communities they serve.

The origin of conversion foundation assets has heightened interest in the responsiveness of these foundations to community needs and views. The converting organization received tax-exempt status because of its willingness to provide community benefits. Therefore it can be argued that the community has a stake in how the proceeds of such transactions are used.

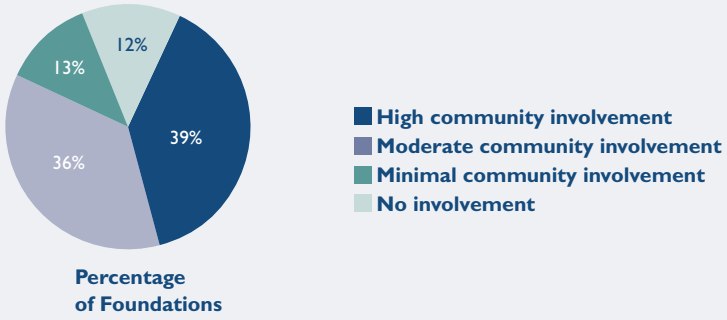
While the first conversions were relatively quiet, over time community stakeholders have been intimately involved in whether a conversion takes place, the valuation of the assets, and both the creation and ongoing operations of foundations formed in the wake of these conversions. Consumers Union and Community Catalyst, consumer advocacy organizations that have played a major role in conversion discussions in many localities, have called for "maintaining an organizational structure that is open and accountable to the public, coupled with practices that offer many opportunities for community input and ongoing, meaningful community involvement" (Consumers Union and Community Catalyst 2004). In practical terms, engaging the community provides a mechanism for the foundation to learn and respond to pressing needs and involve the public in problem solving and decisionmaking. Such work can range from sharing information to including community members in planning and decisionmaking, to building community capacity and leadership (Hashagen 2002).

Strategies for Community Engagement

Foundations created from conversions are, in fact, highly engaged with communities. Most of those surveyed (75 percent) report a moderate to high level of systematic community involvement in program planning and priority setting (Figure 1). Virtually all foundations that engage with their communities use at least several different strategies to do so (Figure 2). The range of foundation activities indicated the respondents can provide a voice for communities, deepen the foundation's understanding of key health issues and community dynamics, and build relationships between foundation staff and current and potential grantees.

Most of those surveyed (75 percent) report a moderate to high level of systematic community involvement in program planning and priority setting.

Figure 1. **Level of Community Involvement in Foundation Program Planning and Priority Setting, 2006**



N=100
Source: Grantmakers In Health, 2006 Survey of Foundations Formed from Health Care Conversions.

Conversion foundations engage with their communities in at least two different ways. They seek input to shape their programs and plans, and they work to be active in the community by sharing information on foundation activities, getting feedback in different forums, and helping support coalitions and nonprofits that are vital to the community. Most (84 percent) survey respondents conduct key informant interviews, a relatively inexpensive technique for tapping into policymakers, community representatives, and opinion leaders. Such interviews can help build trust and rapport. At the same time, those not consulted may raise questions about whether the interviews are fully representative of community concerns or ideas. For that reason, foundations often use other strategies, in addition to key informant interviews, for obtaining community input. For example, about half of respondents have policies to ensure broad community representation on the foundation's board of directors (53 percent) or use focus groups (50 percent). Other strategies include conducting community surveys (45 percent), ad hoc advisory committees (25 percent), and standing community advisory communities (23 percent). Just over half of the respondents (51 percent) encourage their staff to sit on boards of community groups, which could have the dual benefit of the foundation contributing to the community and staff bringing insights about community needs and interests back to the foundation.

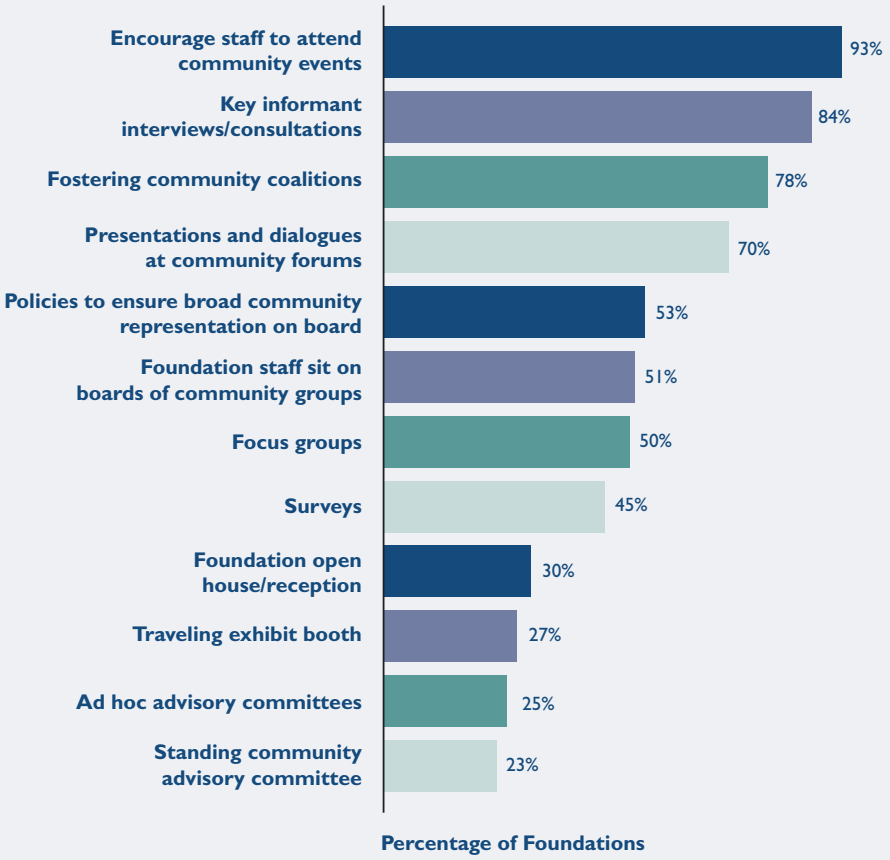
About half of respondents have policies to ensure broad community representation on the foundation's board of directors.

Conversion foundations also take advantage of opportunities to share information about foundation activities with the community, get to know community organizations and potential grantees, and actively engage with community partners. For example, 70 percent of respondents make presentations or participate in dialogues at community forums or public hearings. They also hold open houses or receptions (30 percent) and sponsor exhibit booths at conferences or community

events (27 percent). More than three out of four respondents (78 percent) also report that they foster community coalitions, taking advantage of the unique role funders can play as neutral conveners. Each of these activities increases a foundation's presence in the community, and they also provide informal learning opportunities that staff and trustees can use in shaping foundation programs.

Relatively few of these foundations are actually bound by law to seek community input. Some do have conditions specified in their governing documents (such as originating legislation, articles of incorporation, or bylaws) that require the funder to seek community input (Figure 3). About one in five (19 percent) are required to seek community input on the nomination of board members, and one in eight (12 percent) must seek input to identify community needs. Only a handful must seek community input on funding priorities or monitoring the foundation's performance.

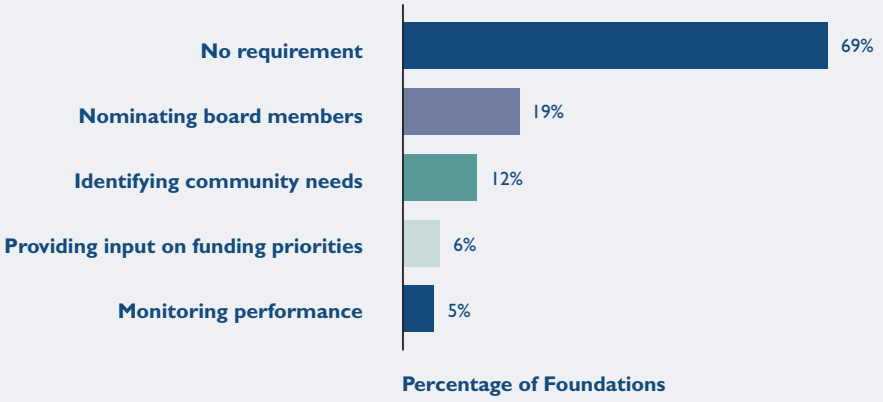
Figure 2. **Strategies Utilized for Community Engagement, 2006**



N=94
Source: Grantmakers In Health, 2006 Survey of Foundations Formed from Health Care Conversions.

More than three out of four respondents (78 percent) also report that they foster community coalitions, taking advantage of the unique role funders can play as neutral conveners.

Figure 3. **Requirements for Community Input into Foundation Operations, 2006**



N=100
Source: Grantmakers In Health, 2006 Survey of Foundations Formed from Health Care Conversions.

CACs are a particular type of committee, recommended by consumer advocacy organizations, that institutionalize community engagement, broaden community participation, and foster more inclusive planning and decision-making by foundations created from conversions.

Community Advisory Committees

The survey looked at some length on the use of community advisory committees (CACs). While about a quarter of conversion foundations create advisory committees to inform the development of a new grant-making venture or to get feedback on past work, CACs are a particular type of committee, recommended by consumer advocacy organizations, that institutionalize community engagement, broaden community participation, and foster more inclusive planning and decisionmaking by foundations created from conversions (Consumers Union and Community Catalyst 2004). CACs are permanent groups that report directly to a foundation's governing board. Consumers Union and Community Catalyst have recommended that regulators institutionalize a CAC structure in the by-laws of a foundation as part of any conversion transaction agreement. They argue that formalizing CACs in these governance documents is important to ensure that their authority does not depend on a particular board or executive (Consumers Union and Community Catalyst 2004).[3]

Twenty-two foundations have standing CACs.[4] Of these, half are required by the foundation's governing documents, while half have instituted a CAC on

[3] For a more textured discussion of how CACs operate, see GIH's publication "Making the Most of Community Advisory Committees." This issue of *Inside Stories* looks at the sometimes bumpy path to effective use of CACs.

[4] For foundations without a standing CAC, close to 25 percent report utilizing ad hoc advisory committees to help inform or oversee the development or implementation of specific grants, initiatives, or grantmaking areas. The most common purpose of such groups is to conduct grant application reviews, provide periodic or ongoing evaluation and feedback on activities, inform program design and development, and carry the foundation's message to community groups. Half of the respondents with CACs indicate that they also utilize ad hoc advisory committees for specific programs.

their own. The majority (65 percent) of foundation CACs meet quarterly, three of the CACs meet biannually, two meet monthly, and the remaining two meet as needed.

In most cases (95 percent), the CAC serves as an ongoing liaison with the community, particularly with respect to identifying community needs and priorities for future foundation efforts (Figure 4). A little over half (55 percent) report that the CAC provides input on foundation funding strategies. Other reported roles and responsibilities of CACs include monitoring and reviewing the foundation's performance (35 percent), serving as a nominating committee to fill vacancies on the foundation board of directors (25 percent), and conducting critical assessments of the foundation's interaction with the community (10 percent). While there may be a potential appearance of overlap between the role of the board and the CAC, only one respondent indicated that its CAC's roles and responsibilities were not clearly distinguished from those of the board of directors.

CACs can also serve as a training ground for future board members, and 85 percent of those with CACs (17 foundations) indicate that some CAC members have subsequently become members of the foundation's board of directors.

Community Health Assessments

Foundations created by health care conversions are actively soliciting information about community health and are shaping their work based on what they find. Nearly half (49 percent) of survey respondents have conducted at least one community health assessment, and most of those (80 percent) report changing their priorities or strategies based

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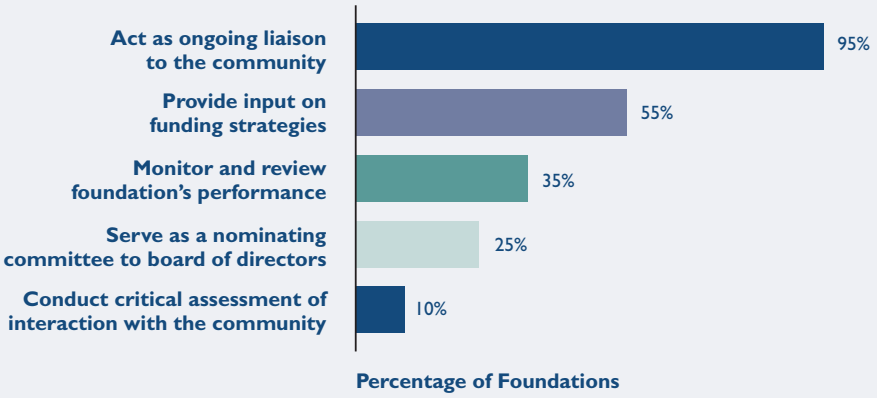
Figure 4. **Roles and Responsibilities of Community Advisory Committees, 2006**



N=20
Source: Grantmakers In Health, 2006 Survey of Foundations Formed from Health Care Conversions.

Seventy percent of respondents indicated that they began a new grant program or initiative based on community assessment results, and about half (51 percent) of those conducting assessments developed partnerships with other funders to address newly identified needs.

on new information uncovered in their assessments, suggesting that they take these seriously. Nearly all (89 percent) of those conducting assessments share the results with other foundations, grantees, and community organizations.

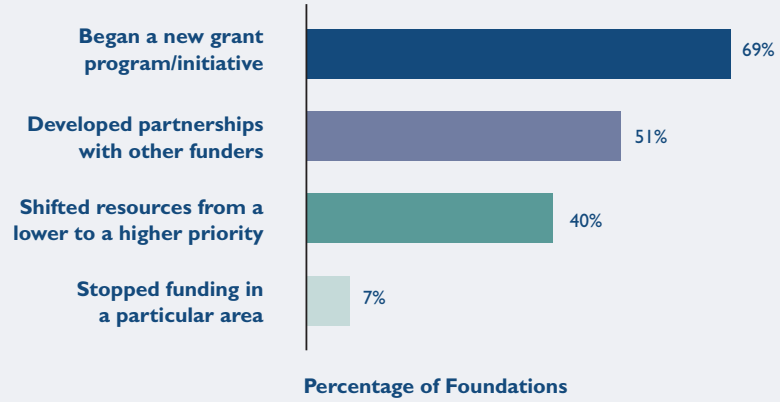
Seventy percent of respondents indicated that they began a new grant program or initiative based on community assessment results, and about half (51 percent) of those conducting assessments developed partnerships with other funders to address newly identified needs. Forty percent of respondents shifted resources to issues identified as higher priorities by the community. A few (7 percent) indicated that they stopped funding in a particular area based on community assessment results (Figure 5).

Only two of the 49 responding foundations that conduct community health assessments are required by their bylaws to do so.

Foundations vary in how often they repeat assessments, most likely reflecting differing planning needs, variable resources, and judgments about how often key indicators change (Figure 6). A number of foundations indicate that they have also conducted more narrowly focused health assessments to collect specific community information on topics such as substance abuse, health disparities, violence prevention, or mental health. In some communities, foundations band together to conduct a joint needs assessment. In other instances, the local public health agency or other nonprofits may already conduct health assessments that obviate the need for foundations to conduct their own.

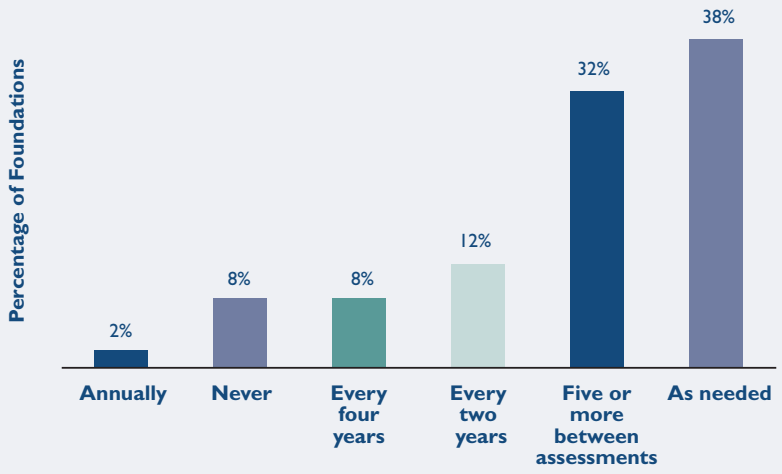
Most foundations conducting community health assessments (67 percent) generate new data on community needs and resources in addition to utilizing data already publicly available.

Figure 5. **Actions Taken Based on a Foundation's Community Assessment, 2006**



N=45
Source: Grantmakers In Health, 2006 Survey of Foundations Formed from Health Care Conversions.

Figure 6. **Frequency of Foundation Community Health Assessments, 2006**



N=50
Source: Grantmakers In Health, 2006 Survey of Foundations Formed from Health Care Conversions.

These new data not only help inform foundation operations, they can extend the benefit of the foundation's investments through their usefulness to other health funders, public officials, and community groups.

Three-quarters of funders (74 percent) include efforts in their assessments to document and track racial and ethnic health disparities in their communities. This information can be particularly helpful in designing programs that are responsive to vulnerable populations and can help fill the well-documented gaps in data on populations suffering from disparities associated with race and ethnicity.

Foundations created by health care conversions obtain the data for health assessments in several different ways, often engaging stakeholders as part of the effort. Most (89 percent) conduct key informant interviews and consult with community leaders. Other commonly used methods are consultations with public health agencies (87 percent) and community health surveys (75 percent). A little more than half (53 percent) use focus groups, and a slightly smaller share (49 percent) incorporate dialogue at community forums or public hearings into their assessment reports.

Informing Communities About the Foundation

Foundations also strengthen relationships with the communities they serve by being open and transparent about their mission, strategy, finances, and operations. Foundations created by health care conversions may have additional incentives to share information on their practices because of

Nearly all foundations (89 percent) that conduct community health assessments make that information available to community-based organizations and local policymakers.

the scrutiny and high public interest generated during the transactions that created them. As they try to be open and transparent in their operations, these foundations face the challenges of striking the right balance between providing information the public finds useful, assuring that this information is not used out of context, and presenting the full picture of what the foundation and its grantees are trying to achieve.

Nearly all foundations (89 percent) that conduct community health assessments make that information available to community-based organizations and local policymakers. The most common strategies for sharing assessment results are through presentations at community forums (70 percent) and direct mailing to key stakeholders (70 percent). More than half (53 percent) of foundations also post their assessment results on their Web sites, and more than a quarter (28 percent) make assessment results available upon request. A small number of foundations also release assessment results to local media and target distribution to local and state legislators.

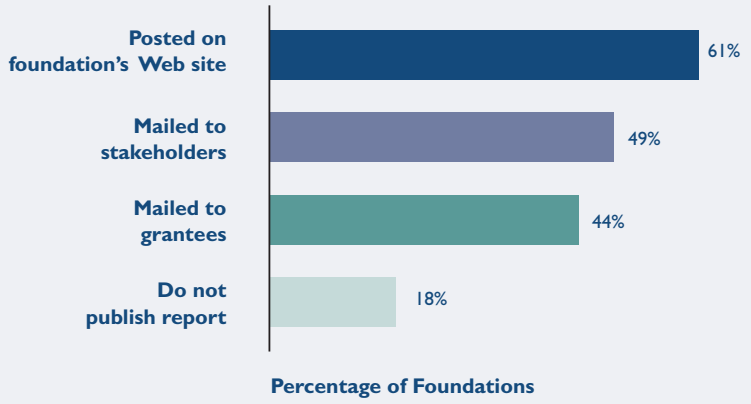
Information on the mission, programs, and finance of conversion foundations is also available in the foundation's annual submission of the Internal Revenue Service (IRS) Form 990. The vast majority of survey respondents (83 percent) rely on the Guidestar Web site to make their organization's Form 990 available and accessible to the public.[5] The Internal Revenue Code also includes a public inspection clause that requires an organization to provide copies of its three most recent Form 990s to anyone who requests them.[6] Additionally, 20 percent of respondents post their Form 990 on their foundation's Web site, and 10 percent include the Form 990 as part of an annual report.

Many foundations also publish an annual report to communicate their priorities and achievements to the community and to share their audited financial statements (Figure 7). Sixty-one percent of responding foundations post an annual report with an audited financial statement on their Web site. Slightly less than half (49 percent) mail a copy of their annual report to key stakeholders, and 44 percent also mail it directly to their grantees. Some foundations convene annual meetings to report to and hear from their communities, and a small number publish reports in local media outlets. Eighteen percent of responding foundations do not publish an annual report.

[5] A small number of foundations included in the survey are exempt from filing 990 forms because they fall within the IRS exception for faith-based organizations.

[6] While Form 990 provides standardized information on foundations, there are limitations in comparing one organization to another unless the organizations are of similar size, age, geography, and field of activity. Further, Form 990s provide little information on the ultimate or relative effectiveness of an organization with respect to meeting its objectives. According to Guidestar, Form 990 data are most useful for examining the evolving health and financial practices of an organization over a period of time (Guidestar 2007).

Figure 7. **How Foundation Annual Reports are Disseminated, 2006**



N=98
Source: Grantmakers In Health, 2006 Survey of Foundations Formed from Health Care Conversions.

Partnering to Strengthen the Capacity of Community-Based Organizations

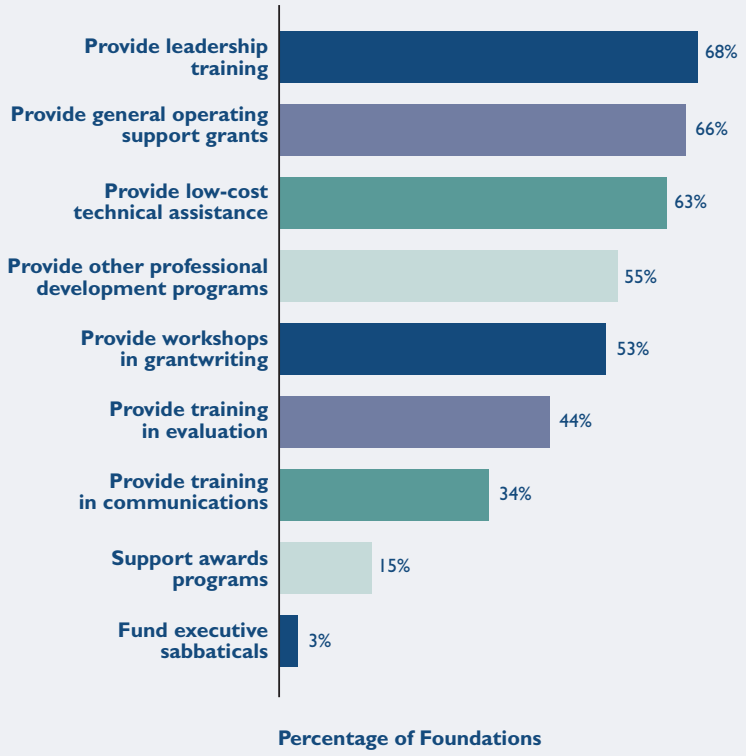
Foundations created by health care conversions are also actively working to strengthen the capacity of community-based organizations (Figure 8). The most common strategy—employed by 68 percent of respondents—is providing or supporting leadership training for staff of local organizations. Sixty-six percent of respondents provide some level of general operating support grants (as opposed to grants tied to a particular health issue, program, or health outcome). Sixty-three percent also provide or support free or low-cost technical assistance, which can enhance the capacity and effectiveness of community partners to address health issues.

There are some standard functions that many community-based nonprofit organizations struggle with, including attracting and retaining effective managers; fundraising; determining and documenting the impact of their programs and services; and effectively communicating their mission, activities, and results. To address these needs, more than half of foundation respondents provide or support general professional development programs (55 percent) and provide or support workshops on grant writing (53 percent). Slightly less than half (44 percent) provide or support training in evaluation, and 34 percent provide or support training in communications. A smaller share (15 percent) support awards programs that recognize local leaders, and a handful (3 percent) funds executive sabbaticals.

Foundations created by health care conversions are also actively working to strengthen the capacity of community-based organizations. The most common strategy—employed by 68 percent of respondents—is providing or supporting leadership training for staff of local organizations.

Nearly all foundations responding to the survey (96 percent) engaged in site visits to their community-based grantees in the past year. Site visits allow foundation representatives to see and learn firsthand about the resources and assets community-based grantees bring to their work. They can help build trust and rapport between foundation and grantee staff and serve as a reality check between how the organization appears on paper and how it actually operates. Site visits are almost always conducted by foundation staff, although 57 percent of responding foundations include board members and close to half (40 percent) of foundations with CACs include committee members as well.

Figure 8. **Strategies Utilized to Help Strengthen the Capacity of Community-Based Organizations, 2006**



N=95

Source: Grantmakers In Health, 2006 Survey of Foundations Formed from Health Care Conversions.

ENSURING STRONG GOVERNANCE POLICIES AND EFFECTIVE BOARDS

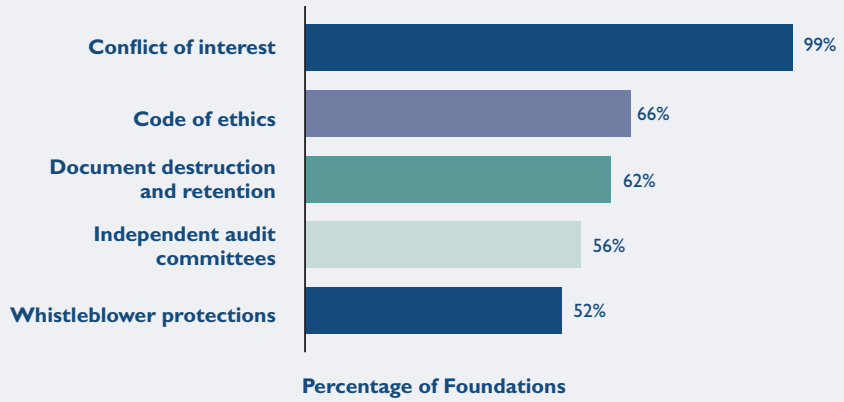
The context for philanthropy has changed in the wake of Enron and other corporate scandals and the increased scrutiny of the nonprofit sector. In response, the survey asked if foundations created by health care conversions have certain policies in place to deter fraud and promote ethical behavior, and, if so, how long they have been in place. The survey also focused on the composition of foundation boards and information about what practices are in place to support and strengthen them.

Because some early conversions occurred without significant involvement by regulators and consumer advocacy groups, concerns about the details of those transactions brought greater scrutiny and public attention to the issue of accountability. Subsequent conversions often involved numerous stakeholders in what were often contentious processes, particularly over valuation of assets and directed use of conversion funds. Communities monitor the structure and growth of grantmaking organizations because of the controversy often surrounding the emergence of these new philanthropic organizations. Today, heightened public interest in the activities and practices of foundations extends well beyond those created by conversions to encompass the entire field of philanthropy.

The corporate accounting and oversight scandals in 2001 and 2002 also focused national attention on the issue of public trust in the corporate sector. Congress responded with *The American Competitiveness and Corporate Accountability Act of 2002*, commonly referred to as Sarbanes-Oxley after its chief sponsors. This law introduced significant new governance standards, requiring the boards of publicly traded companies to more closely oversee financial transactions and auditing procedures.

While primarily intended to deter fraud among publicly traded companies, Sarbanes-Oxley includes two provisions related to protection of whistleblowers and document destruction and retention that apply to all nonprofits and charities (BoardSource and Independent Sector 2003). The legislation, however, and a few highly publicized incidents in which foundations were operating under questionable practices have raised expectations that Sarbanes-Oxley-type restrictions may eventually extend to the nonprofit sector. The Independent Sector and BoardSource recommend that nonprofits "voluntarily incorporate certain provisions of the Act that make good governance sense" through the proactive adoption of policies in additional areas such as conflict of interest, independent audit committees, and disclosure of IRS 990 Forms

Figure 9. **Foundations with Ethics and Accountability Policies, 2006**



N=105
Source: Grantmakers In Health, 2006 Survey of Foundations Formed from Health Care Conversions.

All but one of the foundations surveyed has a policy to address conflicts of interest, and about two-thirds have a code of ethics.

(BoardSource and Independent Sector 2003). Independent Sector's Panel on the Nonprofit Sector, for example, published a report in June 2005 containing numerous recommendations to improve governance, transparency, and accountability of charitable organizations (Panel on the Nonprofit Sector 2005). The panel also formed the Advisory Committee on Self-Regulation to develop *Principles for Effective Practice* that can help guide charities and foundations. Many state governments have also passed or are considering legislation that addresses nonprofits' accounting and auditing procedures.

Governance Policies

The majority of foundations responding to the survey have policies in place to promote ethical and accountable behavior (Figure 9). All but one of the foundations surveyed have a policy to address conflicts of interest, and about two-thirds have a code of ethics. A conflict of interest can arise when a board member or staff person's duty or loyalty to the foundation comes into conflict with a competing financial or personal interest that he or she may have in a proposed transaction. Conflict of interest policies are intended to ensure that all conflicts (even the appearance of a conflict) within an organization are avoided or appropriately addressed through disclosure, recusal, or other means (Panel on the Nonprofit Sector 2007). A code of ethics typically describes the ethical principles that the foundation's staff and board agree to follow and highlights the expectations of how representatives of the organization will conduct the foundation's business. Thirty-five percent (22 foundations) with codes have had

them in place longer than five years, and 65 percent have adopted a code since the passage of Sarbanes-Oxley.

Nearly two-thirds (62 percent) of responding foundations have document retention and destruction policies, and just over half (52 percent) have a policy for whistleblower protection. Some of the foundations responding to the survey have had such policies in effect prior to passage of the Sarbanes-Oxley law, although the survey reveals that a large number of foundations have adopted policies in the last few years. For example, 75 percent of foundations with a document retention policy and 81 percent of foundations with whistleblower protections have adopted these within the past five years.

While the Sarbanes-Oxley legislation does not require foundations to have a written policy regarding document destruction, it applies criminal liability to anyone involved in the destruction, alteration, or falsification of records needed for federal investigations and bankruptcy proceedings. Additionally, many state and local regulations generally require all nonprofit organizations to retain certain business records—including applications for employment, payroll records, tax forms, and contracts—for specified lengths of time (Panel on the Nonprofit Sector 2007). Independent Sector therefore recommends that foundations have written document retention policies for their governance and business records to demonstrate legal compliance and protect against allegations of wrongdoing by the foundation's directors and staff. According to their recommendations, a document retention policy should address the length of time specific types of documents must be retained as well as when it is permissible or required to destroy specific types of documents. The policy should provide guidance to staff for handling paper documents as well as electronic files and email messages.

Similar to the provisions on document destruction, the Sarbanes-Oxley Act provides protections for whistleblowers and imposes criminal penalties for actions taken in retaliation against those who take risks to report suspected illegal activities in an organization. A so-called whistleblower protection policy establishes procedures that enable individuals to come forward with credible information on illegal practices or violations of organizational policies without fear of retaliation. It generally allows for direct access to the board or audit committee with appropriate provisions for anonymity. Of the 52 percent of foundations with whistleblower protections, 17 percent have had their policies in place longer than five years, while 83 percent have adopted them post-Sarbanes-Oxley.

More than half (56 percent) of responding foundations have an audit committee separate from a finance or investment committee. BoardSource and Independent Sector recommend that all nonprofit organizations conducting outside audits, particularly

More than half (56 percent) of responding foundations have an audit committee separate from a finance or investment committee.

medium to large organizations, have an audit committee that is separate from the finance committee (BoardSource and Independent Sector 2003).

Congressional interest in both corporate and nonprofit practices has helped spur many foundations to strengthen governance policies over the past five years. While most foundations now have an array of policies in place, the survey reveals that there is room for improvement to more fully ensure and promote ethical and accountable behavior.

Ensuring Effective Boards

To be effective, a foundation needs a strong board of directors that understands its various roles and is empowered to assure that the organization is fulfilling its mission. Foundation boards generally have fiduciary responsibility as well as a charge to review and assess the organization's priorities and program activities, establish and monitor compliance with key organizational policies and procedures, hire and retain a qualified and effective chief executive, and ensure that the foundation is responding to the health needs of its community.

To be effective, a foundation needs a strong board of directors that understands its various roles and is empowered to assure that the organization is fulfilling its mission.

The structure of the board has important implications for its independence, mix of expertise, and ability to represent the diversity of the community the foundation serves. Because of these important roles, there is continuing interest in basic information on the recruitment and composition of foundations' boards of directors. This section explores several components of board composition and membership and provides information on how the boards of foundations created by health care conversions are selected and supported.

Board Composition

Foundation board membership can be affected by both the goals that guide board compositions and the strategies used to recruit new board members. Among responding foundations, 63 percent have a written policy describing goals for the composition of the board of directors, which often specify the mix of skills, backgrounds, expertise, and geographic representation the foundation is seeking. The most common method for boards to seek new members is via a nominating committee led by current board members, which is utilized by 92 percent of survey respondents. These nominating committees sometimes include members of the foundation's CAC (if applicable) and other community representatives. Sixteen percent of survey respondents indicated that they sponsor an open call for nominations, and 14 percent of respondents indicated that they engage in widely publicized opportunities for members of the community to submit candidates for consideration. A small number indicated that they post a call for nominations on their foundation's Web site (7 percent) or advertise their call for board nominations in the local media (6 percent).

Board Diversity

The nation's growing racial and ethnic diversity creates a new imperative for foundation boards, which historically have been dominated by white men. Increasing the racial and ethnic diversity of boards offers the opportunity to bring diverse voices and viewpoints into critical decisions about resources and strategy. Having a diverse board can also improve relationships between a foundation and the communities it serves, ultimately strengthening its ability to achieve its mission.

Board diversity for conversion foundations improved slightly from 2004 to 2006 with the number of foundations with at least two minority board members increasing from 60 percent to 65 percent. The typical conversion foundation board is one-quarter minority but a substantial number (28 percent) have no minority board members. On boards with minority representation, those members were most likely to be African American or Hispanic.

Representation of women on health foundation boards also lags behind their representation in the population as a whole. The typical board of directors consists of 15 individuals, with an average of 10 men and 5 women.

Board Development

Most (75 percent) responding foundations provide prospective board members with written expectations delineating the duties of board service. An even greater number (88 percent) provide a formal orientation or training for new board members to help support them in becoming effective directors.

One of the primary roles of a foundation's board of directors is to provide oversight of the organization's assets and financial transactions to protect the interests of the organization and its charitable purposes. Consequently, most boards place a high premium on recruiting a portion of members with a substantial level of financial literacy to critically assess and advise on the organization's financial position. To supplement this experience, the survey results show that slightly more than half (54 percent) of respondents provide board members with special training to help them understand the foundation's financial statements and systems.

In addition to enhancing financial literacy and expertise, foundations are working to educate board members on specific health issues, many of which are complex. Moreover, not all health foundation board members have health backgrounds. Most (86 percent) respondents provide opportunities for board members to seek ongoing training or attend educational sessions on the specific health issues their foundation is addressing or plans to take on in the future.

Sixty percent (57 respondents) indicated that their foundation board conducted a self-assessment of its

Board diversity for conversion foundations improved slightly from 2004 to 2006 with the number of foundations with at least two minority board members increasing from 60 percent to 65 percent.

76 percent of responding foundations also report that their board has conducted a formal strategic planning process in the past five years.

strengths, weaknesses, and training needs in the past three years. This can help foundations identify where they may need to strengthen their governance functions and better plan for the future. To further enhance planning, 76 percent of responding foundations also report that their board has conducted a formal strategic planning process in the past five years. To allow for the time necessary for board assessment and strategic planning, 45 percent of respondents said they conduct an annual retreat or extended meeting, and 44 percent report they conduct planning retreats as needed.

The results indicate that many foundations are engaged in serious efforts to build and strengthen their boards of directors. The continued focus on accountability and the complexity of many health issues underscore the need for inspired and educated leadership in this sector. Building and maintaining a strong board of directors will therefore likely continue to be a high priority for many conversion foundations.

LEADERSHIP TRANSITION PLANNING

Finally, with the well-publicized predictions that many senior executives in the nonprofit sector will be retiring in the near future, this survey sought information on if and how foundations created by health care conversions are preparing for leadership transitions.

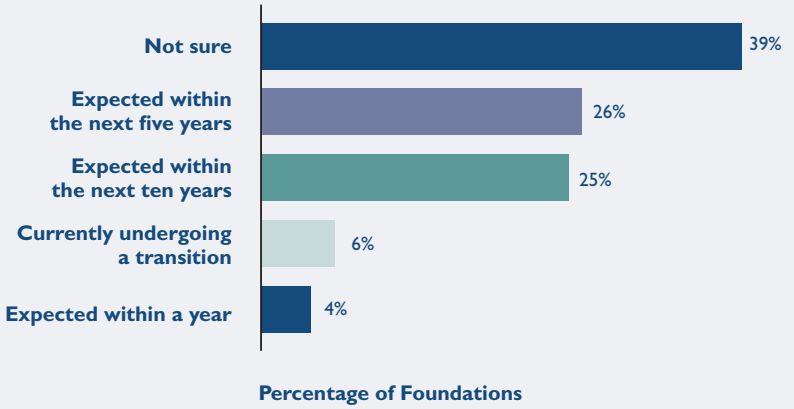
In recent years a growing body of research has raised awareness about the expected turnover of the nation's nonprofit executive workforce, particularly as the baby boomer generation reaches retirement age in increasing numbers. A survey released in 2006, for example, reported that three-quarters of surveyed nonprofit executive directors do not plan to be in their current jobs within five years, and 9 percent were currently in the process of leaving (Compass Point Nonprofit Services and The Meyer Foundation 2006). These findings, along with other similar reports, serve as a wake-up call for the nonprofit field—including health foundations—to focus on retaining the best current executives not slated for retirement, developing a viable generation of new leaders, and preparing for inevitable executive turnover.

The survey's first task was to document whether this relatively new segment of philanthropy had yet experienced substantial turnover in its executive leadership. The results indicate that 31 percent of foundations have gone through an executive transition in the past five years. Almost all of the rest (some 63 percent) are still led by the founding executive.

Most foundations anticipate going through an executive transition in the intermediate future (Figure 10).

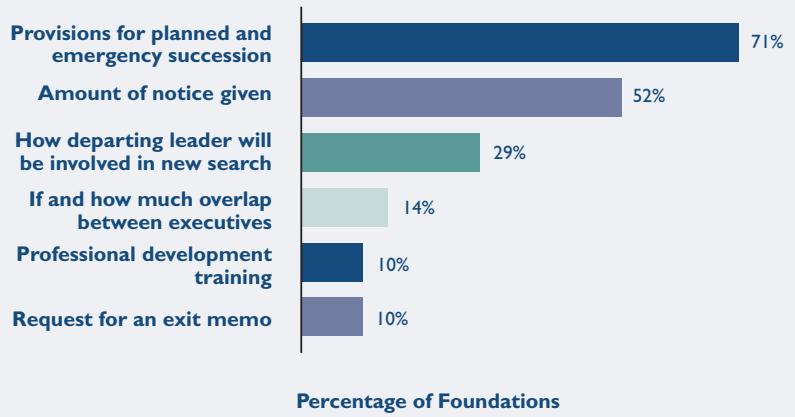
The results indicate that 31 percent of foundations have gone through an executive transition in the past five years.

Figure 10. **Timing of Expected Foundation Executive Transitions, 2006**



N=91
Source: Grantmakers In Health, 2006 Survey of Foundations Formed from Health Care Conversions.

Figure 11. **Elements Included in Foundation Leadership Succession Plans, 2006**



N=21
Source: Grantmakers In Health, 2006 Survey of Foundations Formed from Health Care Conversions.

More than half (55 percent) of all responding foundations expect to have a change in leadership within the next ten years.

More than half (55 percent) of all responding foundations expect to have a change in leadership within the next ten years. Breaking this number down further, 4 percent expect a change in the next year, 26 percent expect a leadership transition in the next five years, and 25 percent expect a change within the next ten years. Of the remaining 45 percent of respondents, 6 percent of respondents are currently experiencing a leadership transition, and 39 percent are not sure on the timing of change in their executive leadership. Foundation leadership transitions raise a number of issues related to succession planning; processes to preserve and pass along institutional knowledge; and strategies to identify, recruit, and retain new leaders.

One method to support the foundation during an executive leadership change is to create and adhere to a written succession plan that guides the transition. The GIH survey reveals that only 21 percent of responding foundations currently have such a plan in place. Of those that have succession plans, 71 percent include provisions for both emergency and planned succession (Figure 11). Fifty-two percent include guidance on how much notice the departing leader should give; 29 percent specify if and how the departing leader will be involved in the search for a successor; 14 percent address if and how much overlap there should be between outgoing and incoming leaders; and 10 percent have provisions to request an exit memo from the departing executive capturing institutional history and learning. Ten percent of written succession plans also include reference to professional development training

for current staff to ensure that they can take on management roles during any transition or to prepare them as potential successors.

Because the challenges of executive turnover and the impending baby boomer retirements are not limited to foundation leadership alone, the survey asked if foundations provide any funding or technical assistance to their grantees for their own succession planning. Twenty-two percent of respondents report making grants for this purpose.

Overall, the survey discovered significant room for improvement in planning for leadership transitions that are expected with inevitable executive turnover and the impending baby boomer retirement.

FOUNDATION STRUCTURE

GIH has identified 185 foundations created by health care conversions. These foundations are located in 37 states and the District of Columbia. This section updates the overall numbers, distribution, and tax status of conversion foundations.

More than half of all foundations resulting from conversions (98) were created between 1996 and 2006. The busiest period for conversions was 1996 and 1997 when 22 new foundations were created in each year. Conversion activity declined since the late-1990s but continues with 33 new foundations created by health care conversions since 2000.

Tax Status

Nearly half of all conversion foundations (87 foundations) are classified as 501(c)3 private foundations (defined as grantmaking foundations that have an endowment from a single source such as an individual, family, or corporation and that do not raise funds from the public). Most of the remaining foundations hold 501(c)(3) status but are designated as public charities (defined as tax-exempt religious, educational, or social service organizations that receive regular contributions from several sources such as individuals, corporations, private foundations, government, and sometimes fees for services). Foundations that are public charities may be one of three types:

- A traditional public charity under section 509(a)(1) of the Internal Revenue Code (IRC) receives funds from public donations or government. It generally must meet a public support test requiring that, over the most recent four-year period, its support from donations and grants equaled or exceeded one-third of its total support. Thirty-nine conversion foundations are traditional public charities.

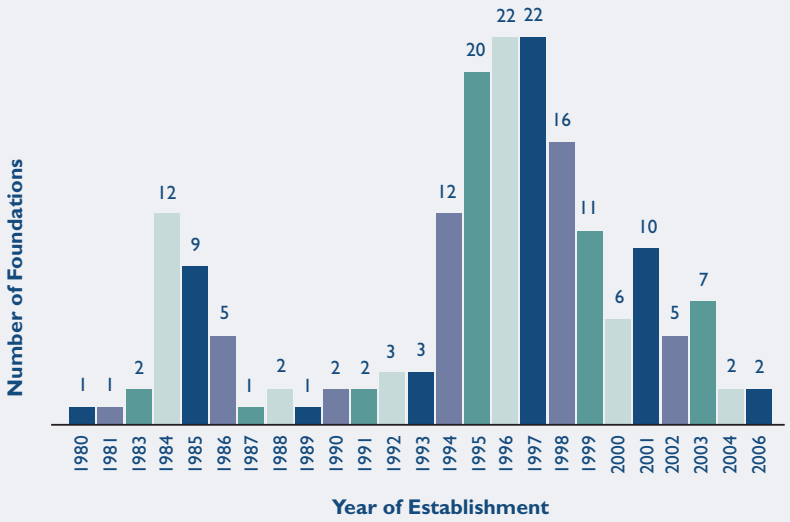
- A 509(a)(2) gross receipts organization is a public charity that must raise more than one-third of its total support from any combination of gifts; grants; contributions; membership fees; and gross receipts from admissions, merchandise sales, or services provided in relation to its tax-exempt function. Only four conversion foundations fall in this category.

- A supporting organization under 509(a)(3) of the IRC is a nonprofit corporation that has an established relationship with 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 organization with which they are affiliated. Thirty-five conversion foundations surveyed belong to this category.

- The final category of foundations formed from health care conversions falls under section 501(c)(4) of the IRC. These tax-exempt organizations are known as social welfare organizations. 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. Six conversion foundations are in this category.

It should be noted that the federal IRC does distinguish between certain types of nonprofits such as public charities and private foundations, but IRS tax status does not distinguish in any way if a foundation was or was not created by a health care conversion transaction.

Figure 12. **Year and Number of Conversion Foundations Established**



Source: Grantmakers In Health, 2006 Survey of Foundations Formed from Health Care Conversions.
Note: Ten foundations that were either created by health care conversions or received assets from a conversion transaction were created prior to 1980.

CONCLUSION

Although the wave of new conversion foundations that peaked in the mid-1990s has subsided, smaller numbers of new conversion foundations continue to emerge. Moreover, many of the foundations formed from health care conversions have been operating now for a decade or more. In sum, the GIH survey found that these foundations are engaged with and informed by the communities they serve, have made strides in recent years to adopt governance policies that improve accountability, and face significant challenges in planning for the expected turnover in executive leadership. Conversion foundations can be expected to continue to be a vital force in health philanthropy and will continue to make important contributions to the health of the people and communities they serve. The issues they face, such as those included in this report, are shared by colleague organizations in health philanthropy regardless of their origins. The practices they have adopted to respond to them can be instructive to others throughout the field.

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APPENDIX: A PROFILE OF FOUNDATIONS FORMED FROM HEALTH CARE CONVERSIONS

Name, Location, and Web Address	Established	Assets	IRS Tax-Exempt Status	Focus of Grantmaking
Allegany Franciscan Ministries *Clearwater, FL* www.afmfl.org	1998	$152,000,000	Public charity, 509(a)(3) supporting organization	Physical, mental, and spiritual health; healthy living promotion and screening; development of neighborhood health advocates; family skill-building for parent/adult engagement with children; health education; and health disparities and cultural competency in health services
The Alleghany Foundation *Covington, VA*	1995	$45,445,859	Private Foundation	Quality of life, nurses, school and dental services, and education
Alliance Healthcare Foundation *San Diego, CA* www.alliancehf.org	1988	$80,000,000	Private Foundation	Access to health care, mental health, and community health
Andalusia Health Services, Inc. *Andalusia, AL*	1981	$2,478,976	Private Foundation	Medical scholarships
Anthem Foundation of Ohio *Cincinnati, OH* http://www.greatercincinnatifdn.org/page494.cfm	1995	$25,987,152	Public charity, 509(a)(3) supporting organization	Preventive oral health care, family violence, prevention programs for indigent populations
Archstone Foundation *Long Beach, CA* www.archstone.org	1985	$117,280,783	Private Foundation	Elder abuse prevention, fall prevention, end-of-life issues, and responsive grantmaking
Asbury Foundation of Hattiesburg, Inc. *Hattiesburg, MS*	1997	$35,371,446	Private Foundation	General health
The Assisi Foundation of Memphis, Inc. *Memphis, TN* www.assisifoundation.org	1994	$220,000,000	Private Foundation	Delivery of preventive, primary, and related health care services; health promotion and education; support and enhancement of health and human services systems; and healthy communities
Austin-Bailey Health and Wellness Foundation *Canton, OH* www.foundationcenter.org/grantmaker/austinbailey	1996	$9,200,000	Private Foundation	Health care affordability concerns of the uninsured and underinsured, the poor, children, single parents, and the aged; programs that speak to the mental health needs of individuals and families
Baptist Community Ministries *New Orleans, LA* www.bcm.org	1924	$265,000,000	Private Foundation	Physical, mental, and spiritual health; reducing health risk factors and promoting protective factors; access to care; care coordination; education; public safety; and governmental oversight

Name, Location, and Web Address	Established	Assets	IRS Tax-Exempt Status	Focus of Grantmaking
Baptist Healing Trust *Nashville, TN* www.healingtrust.org	2001	$130,000,000	Public charity, 509(a)(1) traditional	Access to appropriate and affordable health care and capacity building of nonprofit organizations
Baptist Health Foundation of San Antonio *San Antonio, TX* www.bhfsa.org	2004	$114,000,000	Public charity, 501(c)(3) supporting organization	Health care clinics, indigent care programs, assisted living facilities, mobile health and primary care facilities, substance abuse programs, behavioral health facilities, health education scholarships, and other nonprofit health care providers
Barberton Community Foundation *Barberton, OH* www.bcfcharity.org	1996	$94,391,950	Public charity, 509(a)(3) supporting organization	Public health, human services, education, recreation, and community development
Bedford Community Health Foundation *Bedford, VA* www.bchf.org	1984	$4,496,510	Public charity, 509(a)(1) traditional	Emergency medical services, senior care, nursing scholarships, and charity care
Bernardine Franciscan Sisters Foundation, Inc. *Newport News, VA* www.bfranfound.org	1996	$15,762,442	Public charity, 509(a)(3) supporting organization	Promote, support, conduct or participate in charitable, scientific or educational activities related to the health care and charitable works of the Bernardine Sisters of the Third Order of Saint Francis; services to the sick and injured; human services and education
BHHS Legacy Foundation *Phoenix, AZ* www.bhhslegacy.org	2000	$121,000,000	Public charity, 509(a)(3) supporting organization	Children, families, and seniors
Birmingham Foundation *Pittsburgh, PA* www.birminghamfoundation.org	1996	$21,020,694	Private Foundation	Children's well-being, senior safety, health access and promotion, capacity building, community life, health disparities, and vulnerable populations
Mary Black Foundation *Spartanburg, SC* www.maryblackfoundation.org	1986	$81,000,000	Private Foundation	Early childhood development and active living
The Blowitz-Ridgeway Foundation *Schaumburg, IL* www.blowitzridgeway.org	1984	$26,000,000	Private Foundation	Provide health care and human services for the economically disadvantaged and the disabled; social service programs for challenged youth; biomedical research; and medical, psychological, and residential care for persons who have not yet reached age of majority
Brandywine Health Foundation *Coatesville, PA* www.brandywinefoundation.org	2001	$28,500,000	Public charity, 509(a)(1) traditional	Increasing access to medical, dental, and mental health services; removing insurance and language barriers; improving community health status by reducing health disparities; after-school programs; domestic violence; and drug and alcohol programs

Name, Location, and Web Address	Established	Assets	IRS Tax-Exempt Status	Focus of Grantmaking
The Brentwood Foundation *Seven Hills, OH* www.brentwood-foundation.org	1994	$23,700,000	Private Foundation	Medical education, research, and community health
Drs. Bruce and Lee Foundation *Florence, SC*	1995	$160,000,000	Private Foundation	Health, human services, and youth education
The Byerly Foundation *Hartsville, SC* www.byerlyfoundation.org	1995	$25,500,000	Private Foundation	Education, economic development, and community life
Calhoun County Community Foundation *Anniston, AL* www.cccfoundation.org	1997	$21,500,000	Private Foundation	Substance abuse, child abuse and neglect intervention and prevention
The California Endowment *Los Angeles, CA* www.calendow.org	1996	$3,500,000,000	Private Foundation	Access to affordable, quality health care; workforce diversity; cultural competency; and health disparities.
California HealthCare Foundation *Oakland, CA* www.chcf.org	1996	$850,000,000	Social welfare organization, 501(c)(4)	Chronic disease, hospitals and nursing homes, health insurance, and public financing and policy
The California Wellness Foundation *Woodland Hills, CA* www.tcwf.org	1992	$1,100,000,000	Private Foundation	Increasing diversity in health professions, environmental health, healthy aging, women's health, mental health, teen pregnancy prevention, violence prevention, work and health, support for the health safety net and efforts to increase access to health care for underserved populations
The Cameron Foundation *Petersburg, VA* www.thecameronfoundation.org	2003	$89,883,474	Public charity, 509(a)(1) traditional	Health care, human services, civic affairs, community and economic development, education, conservation and historic preservation, and cultural enrichment
Cape Fear Memorial Foundation *Wilmington, NC*	1996	$63,000,000	Private Foundation	Health, medical, and human services
Caring for Colorado Foundation *Denver, CO* www.caringforcolorado.org	1998	$162,000,000	Social welfare organization, 501(c)(4)	Health infrastructure, addressing emerging community issues, responding to community-specific issues, and enabling informed health decisions
Carlisle Area Health & Wellness Foundation *Carlisle, PA* www.cahwf.org	2001	$85,000,000	Public charity, 509(a)(1) traditional	Behavioral health, including substance abuse and mental health; oral health; chronic disease, including diabetes, cardiovascular disease, asthma and chronic obstructive pulmonary disease, and cancer; efforts focus on prevention and education and target at-risk populations

Name, Location, and Web Address	Established	Assets	IRS Tax-Exempt Status	Focus of Grantmaking
Central Florida Healthcare Development Foundation *Leesburg, FL* www.cfhcdh.org	1997	$126,750,308	Public charity, 509(a)(3) supporting organization	Access to care, education, and direct service
Central Susquehanna Community Foundation *Berwick, PA* www.csgiving.org	1999	$31,000,000	Public charity, 501(c)(3) community	Health and wellness through community-based prevention and collaboration approaches
Chestnut Hill Health Care Foundation *Philadelphia, PA* www.chhcfoundation.org	2005	$26,000,000	Private foundation 501(c)(3)	Frail elderly, reducing premature death caused by cancer and heart disease, children and families, and education about health care and health insurance options
Children's Fund of Connecticut *Farmington, CT* www.childrensfundofct.org	1992	$30,000,000	Public charity, 509(a)(3) supporting organization	Advocacy, leveraging public and private resources, and partnering with other organizations focused on prevention and systemic change related to pediatric and primary health care for children and their families
Christy-Houston Foundation *Murfreesboro, TN*	1986	$71,367,397	Private Foundation	Health care, education, charitable activities, nursing homes, and nursing education
The Colorado Health Foundation *Denver, CO* www.coloradohealth.org	1995	$771,000,000	Public charity, 509(a)(1) traditional	Improving access to quality health care and empowering people to take charge of their health
Colorado Springs Osteopathic Foundation *Colorado Springs, CO* www.csof.org	1984	$11,497,701	Public charity, 509(a)(1) traditional	Medical education and medical care to meet community needs
The Colorado Trust *Denver, CO* www.coloradotrust.org	1985	$459,000,000	Private Foundation	Accessible and affordable health care, health education, and health promotion
Columbus Medical Association Foundation *Columbus, OH* www.goodhealthcolumbus.org	1958	$74,000,000	Public charity, 509(a)(3) supporting organization	The foundation focuses people, ideas, and money to support initiatives that improve health.
Community Health Endowment of Lincoln *Lincoln, NE* www.chelincoln.org	1997	$46,689,099	Other	Improving community health
Community Health Foundation *Massillon, OH* www.chfoundation.org	1999	$5,896,965	Private Foundation	Physical, mental, and emotional health of community residents

Name, Location, and Web Address	Established	Assets	IRS Tax-Exempt Status	Focus of Grantmaking
Community Health Foundation of Western and Central New York *Buffalo, NY* www.chfwcny.org	2001	$100,000,000	Private Foundation	Health and health care for frail elders and children in low-income communities
Community Health Partnership *Portland, OR* www.communityhealthpartnership.org	1997	$1,359,024	Public charity, 509(a)(1) traditional	Public health, graduate scholarships, public health workforce development, and urgent needs in public health system
Community Memorial Foundation *Hinsdale, IL* www.cmfdn.org	1995	$90,000,000	Private Foundation	Positive youth development, primary health care for uninsured or underinsured residents, strengthening families, encouraging community cohesiveness, and supporting healthy aging
CommunityCare Foundation, Inc. *Springdale, AR* www.ccfound.org	1998	$134,500,000	Public charity, 509(a)(3) supporting organization	Health, human services, and education
Con Alma Health Foundation, Inc. *Santa Fe, NM* www.conalma.org	2001	$28,861,350	Private Foundation	Improve health status and access to health care services
Moses Cone-Wesley Long Community Health Foundation *Greensboro, NC* www.mcwlhealthfdn.org	1997	$120,000,000	Public charity, 509(a)(3) supporting organization	Access, with particular emphasis on eliminating barriers to health services; wellness, with particular attention to physical activity and nutrition, substance abuse, responsible sexual behavior, mental health, and injury prevention
Connecticut Health Foundation *New Britain, CT* www.cthealth.org	1999	$30,000,000	Private Foundation	Oral health, children's mental health, and reducing racial and ethnic health disparities
Consumer Health Foundation *Washington, DC* www.consumerhealthfdn.org	1994	$42,000,000	Private Foundation	Health status; enable people to be more actively involved in their own health; improve access to care; AIDS services; and build capacity for local organizations and providers, most vulnerable communities, and populations where health disparities are the greatest
Dakota Medical Foundation *Fargo, ND* www.dakmed.org	1994	$28,084,000	Public charity, 509(a)(1) traditional	Measurably improving health and access to health care services, with an emphasis on children's health
Danville Regional Foundation *Danville, VA* www.danvilleregionalfoundation.org	2005	$200,000,000	Private 501(c)(3)	Health and wellness, economic transformation, educational attainment, community engagement
Daughters of Charity Healthcare Foundation of St. Louis *St. Louis, MO* www.daughtersofcharityfdn.org	1995	$28,000,000	Public charity, 509(a)(3) supporting organization	Seniors living independently, child abuse and neglect prevention, and dental initiatives

Name, Location, and Web Address	Established	Assets	IRS Tax-Exempt Status	Focus of Grantmaking
Deaconess Community Foundation *Brooklyn, OH* www.fdncenter.org/grantmaker/deaconess	1994	$35,037,975	Public charity, 509(a)(3) supporting organization	Resources that help organizations empower people to become self-sufficient
Deaconess Foundation *St. Louis, MO* www.deaconess.org	1972	$90,000,000	Public charity, 509(a)(3) supporting organization	Public health challenges dealing with capacity building efforts and programs for children in low-income neighborhoods
Desert Healthcare Foundation *Palm Springs, CA* www.dhcd.org/grant-program	1998	$6,027,976	Public charity, 509(a)(1) traditional	Enhancing community health and wellness
Duneland Health Council *Michigan City, IN*	1997	$7,891,348	Private Foundation	Education, family services, health care, health care clinics/centers, human services
Eden Township Healthcare District *Castro Valley, CA* www.ethd.org	1998	$32,663,000	Other	Health care access and affordability, delivery of health-related services to high-risk or special needs populations, and collaboration with other organizations
Endowment for Health *Concord, NH* www.endowmentforhealth.org	1999	$100,000,000	Private Foundation	Oral health and economic, geographic, and social/cultural barriers to accessing health care services
EyeSight Foundation of Alabama *Birmingham, AL* www.eyesightfoundation.org	1997	$58,000,000	Public charity, 509(a)(3) supporting organization	Public education regarding preventive and routine eye care and vision screening; eye care for the medically indigent; low-vision and rehabilitation services; improved geographical access to general and specialty eye care services; education and training of eye care professionals and scientific investigators; research in the prevention and treatment of eye diseases, disability, or impairment prevalent in Alabama; the development of effective methods of treatment, surgery, or rehabilitation; and basic science research on the visual system
FISA Foundation Pittsburgh, PA www.fisafoundation.org	1913	$45,000,000	Private Foundation	Health and well-being of women, girls, and people with disabilities; gender disparities in health care; diseases that affect women or girls; domestic and sexual violence; teen pregnancy; and access to health and dental care for people with disabilities
Foundation for a Healthy Kentucky *Louisville, KY* www.healthyky.org	2001	$56,415,338	Public charity, 509(a)(1) traditional	Access to health and mental health care; health education and prevention programs focused on nutrition and fitness, tobacco, and substance abuse

Name, Location, and Web Address	Established	Assets	IRS Tax-Exempt Status	Focus of Grantmaking
Foundation for Community Health *Sharon, CT* www.fchealth.org	2003	$20,000,000	Public charity, 509(a)(3) supporting organization	Mental health and substance abuse, access to services, and oral health
Foundation for Seacoast Health *Portsmouth, NH* www.ffsh.org	1984	$71,374,313	Private Foundation	Organizational capacity building aimed at improving the health and well-being of residents of the Maine and New Hampshire seacoast, scholarships to local students pursuing health-related fields of study, and programs aimed at providing preventive health services
Four County Community Foundation *Almont, MI* www.4ccf.org	1987	$5,693,254	Public charity, 509(a)(1) traditional	Healthy seniors, healthy youth, and public safety
Franklin Benevolent Corporation *Corte Madera, CA* www.frankben.org	1957	$37,713,521	Private Foundation	General health-related issues
Galesburg Community and Health Foundation *Galesburg, IL*	2004	$7,725,215	Public charity, 509 (a)(1) traditional	Local organizations meeting health and health education needs of the community, health care scholarships for college-bound students, help for the mentally ill, nutrition education, kids' health programs in schools
Georgia Baptist Health Care Ministry Foundation *Duluth, GA* www.gbhcs.org	1993	$214,078,504	Public charity, 501(c)(3) supporting organization	Health care needs that benefit organizations and individuals within Georgia
The Georgia Health Foundation *Atlanta, GA* www.gahealthfdn.org	1985	$9,045,498	Private Foundation	Innovative approaches to personal and community health, including access, delivery, maintenance, public awareness, education, quality evaluation, clinical research, and preventive care
Good Samaritan Foundation, Inc. *Lexington, KY* www.gsfky.org	1995	$1,794,408	Private Foundation	Charitable and educational activities related to health care, health education, and research
Grant Healthcare Foundation *Lake Forest, IL* www.granthealthcare.org	1996	$26,794,307	Private Foundation	Health care services to the people of the Chicago metropolitan area; direct medical services provided by community organizations, including operational and capital support; preventive medical programs and mental health and substance abuse services; programs designed to assist, rehabilitate, and maintain the disabled; medical research; and patient educational programs

Name, Location, and Web Address	Established	Assets	IRS Tax-Exempt Status	Focus of Grantmaking
The Greater Rochester Health Foundation *Rochester, NY* www.thegrhf.org	2006	$205,000,000	Private Foundation	Prevention, improving health delivery and the health status of poverty-ridden neighborhoods
Greater Saint Louis Health Foundation *Saint Louis, MO* www.gstlhf.com	1985	$4,500,000	Private 501(c)(3)	Health promotion and illness prevention
Grotta Fund for Senior Care *Whippany, NJ* www.ujfmetrowest.org/section_display.html?ID=162	1993	$6,394,642	Private Foundation	Aging, mental and physical health of elderly, family caregivers, and nonclinical in-home services
Gulf Coast Community Foundation of Venice *Venice, FL* www.gulfcoastcf.org	1995	$150,000,000	Public charity, 509(a)(1) traditional	Health, human services, education, civic affairs, and arts and culture
Gulf Coast Medical Foundation *Wharton, TX*	1983	$18,000,000	Private Foundation	Medically related services, local emergency medical services, and primary care
The Harvest Foundation *Martinsville, VA* www.theharvestfoundation.org	2002	$193,000,000	Private Foundation	Health, education, and welfare
Health Care Foundation of Greater Kansas City *Kansas City, MO* www.healthcare4kc.org	2003	$526,000,000	Public charity, 509 (a)(1) traditional	Safety net health care, healthy lifestyles, and mental health
The Health Foundation of Central Massachusetts, Inc. *Worcester, MA* www.hcfm.org	1999	$60,000,000	Social welfare organization, 501(c)(4)	Oral health, child abuse, and children's mental health
The Health Foundation of Greater Cincinnati *Cincinnati, OH* www.thehealthfoundation.org	1978	$248,800,000	Social welfare organization, 501(c)(4)	Community primary care, school-aged children's health care, substance use disorders, and severe mental illness
The Health Foundation of Greater Indianapolis, Inc. *Indianapolis, IN* www.thfgi.org	1985	$30,000,000	Private Foundation	HIV/AIDS advocacy and prevention, access to primary care and school-based health, and childhood obesity
Health Foundation of South Florida *Miami, FL* www.hfsf.org	1993	$158,000,000	Public charity, 509(a)(1) traditional	Access to quality health care and health status improvement

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The Health Trust *San Jose, CA* www.healthtrust.org	1996	$123,800,000	Public charity, 509(a)(2) gross receipts	Community-based health; disease prevention; and wellness activities, especially for medically indigent children, frail elderly, and vulnerable adults
The HealthCare Foundation for Orange County *Santa Ana, CA* www.hfoc.org	1996	$14,000,000	Private Foundation	Health promotion; prevention; cultural competency; access; community health; and health needs of children, adolescents, and pregnant women
The Healthcare Foundation of New Jersey *Millburn, NJ* www.hfnj.org	1996	$154,400,000	Private Foundation	Health care needs of vulnerable populations
Healthcare Georgia Foundation, Inc. *Atlanta, GA* www.healthcaregeorgia.org	1999	$129,454,579	Private Foundation	Health disparities, strengthening nonprofit health organizations, and expanding access to primary health care
Helena Health Foundation *Helena, AR*	2002	$9,860,000	Private Foundation	Access to health care for poor and elderly and health education
Hillcrest Foundation, Inc. *Mountain Brook, AL*	1984	$32,310,940	Private Foundation	Mental health, arts, and education
Hilton Head Island Foundation *Hilton Head Island, SC* www.cf-lowcountry.org	1994	$34,552,307	Public charity, 509(a)(1) traditional	Community development, health, and human services
HNHfoundation *Concord, NH* www.hnhfoundation.org	1997	$24,383,833	Private Foundation	Projects and programs that break down barriers to enrolling and retaining children in the State Children's Health Insurance Program, public education about the importance and status of health care insurance, evaluation of access to health insurance, and promotion of healthy lifestyles
The Horizon Foundation *Columbia, MD* www.thehorizonfoundation.org	1998	$83,000,000	Public charity, 509(a)(1) traditional	Health system improvement, community health and wellness, older adult health, adolescent health, and information technology and health
Illini Community Health Care Foundation *Pittsfield, IL* www.ichcf.org	1948	$1,096,258	Public charity	Health support and improvement, education toward the enhancement of quality of life, well-being and state of wellness.
Incarnate Word Foundation *St. Louis, MO* www.incarnatewordfund.com	1997	$33,600,000	Public charity, 509(a)(3) supporting organization	Promotion of community health and well-being; addressing the root causes of problems; and supporting collaboration among various organizations with a special interest in the poor, women, children, and the elderly

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Institute for Health Care Advancement *La Habra, CA* www.iha4health.org	1993	$27,878,218	Private Foundation	Demonstrating innovative health care practices and educating health care providers and consumers
Irvine Health Foundation *Irvine, CA* www.ihf.org	1985	$23,500,000	Private Foundation	Quality health and dental care research and policy and capacity building of safety net providers and the community
The Jackson Foundation, Inc. *Dickson, TN* www.jacksonfoundation.org	1995	$76,609,673	Public charity, 509(a)(1) traditional	Motivate and educate children and adults through the use of technology in the area of the arts, science, and humanities
The Jenkins Foundation *Richmond, VA* www.tcfrichmond.org	1995	$42,000,000	Public charity, 509(a)(3) supporting organization	Prevention of violence and substance abuse and the expansion of access to health care services for the uninsured and underinsured
The Jewish Foundation of Cincinnati *Cincinnati, OH*	1996	$84,000,000	Private Foundation	Capital improvement projects
Jewish Healthcare Foundation *Pittsburgh, PA* www.jhf.org	1990	$127,386,328	Public charity, 509(a)(1) traditional	Advance work redesign to improve patient outcomes, best clinical practices, health care safety, health education and curriculum development, and health workforce attraction and retention
Kansas Health Foundation *Wichita, KS* www.kansashealth.org	1985	$482,746,243	Private Foundation	Children's health, leadership, public health, and policy
Lancaster Osteopathic Health Foundation *Lancaster, PA* www.lancasterosteopathichealthfoundation.org	1999	$11,000,000	Public charity, 509(a)(1) traditional	Broad-based community health and wellness with an emphasis on children and their families and scholarship support for osteopathic medical school and nursing school students
LMC Community Foundation *Arvada, CO* www.lmccf.org	1975	$48,000,000	Public charity, 509 (a)(1) traditional	Programs, initiatives, and organizations that strengthen lives and improve the well-being of the metropolitan Denver community in all its dimensions
Lower Pearl River Valley Foundation *Picayune, MS*	1998	$16,450,500	Private Foundation	Improving physical, mental, emotional, spiritual, and social health
Lutheran Foundation of St. Louis *St. Louis, MO* www.lutheranfoundation.org	1984	$97,172,745	Public charity, 509(a)(3) supporting organization	Physical and development disabilities, children, elderly, substance abuse, parish nursing, and congregation services in the community

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Dr. John T. Macdonald Foundation, Inc. *Coral Gables, FL* www.jtmacdonaldfdn.org	1992	$34,000,000	Private Foundation	Health education, prevention and early detection of disease; children and the economically disadvantaged; medical rehabilitation; direct medical and dental care
MacNeal Health Foundation *Berwyn, IL* www.macnealhf.org	1999	$88,560,000	Private Foundation	Health care agencies that benefit the residents of the western suburbs of Chicago, medical research, and education
Maine Health Access Foundation *Augusta, ME* www.mehaf.org	2001	$113,000,000	Private Foundation	Affordable and timely access to comprehensive quality health care and strategic solutions to improve access to health care, particularly for the medically uninsured and underserved
The Memorial Foundation *Hendersonville, TN* www.memfoundation.org	1994	$150,000,000	Public charity, 509(a)(1) traditional	Improve the quality of life for people through support of nonprofit organizations
Menorah Legacy Foundation *Kansas City, MO* www.menorahlegacy.org	2003	$30,000,000	Private Foundation	Promote healthy living throughout all stages of life
Methodist Healthcare Ministries of South Texas, Inc. *San Antonio, TX* www.mhm.org	1995	$377,000,000	Public charity, 509(a)(3) supporting organization	Primary care clinics providing medical, dental, and support/counseling services for uninsured clients; parenting programs; church-based nursing programs; community clinics serving uninsured clients; and clinical pastoral education
MetroWest Community Health Care Foundation *Framingham, MA* www.mchcf.org	1999	$109,000,000	Private Foundation	Programs targeting children, elders, and the disabled and community health initiatives
Mid-Iowa Health Foundation *Des Moines, IA* www.midiowahealth.org	1984	$16,034,180	Private Foundation	Preventive health services for vulnerable populations
Missouri Foundation for Health *St. Louis, MO* www.mffh.org	2000	$1,220,000,000	Social welfare organization, 501(c)(4)	Reducing disparities, improving access, strengthening the safety net, health promotion and disease prevention, improving the health of children, community building, and public policy activities
The Mt. Sinai Health Care Foundation *Cleveland, OH* www.mtsinaifoundation.org	1994	$140,000,000	Public charity, 509(a)(3) supporting organization	Health of the Jewish community, health of the urban community, academic medicine and bioscience, and health policy
Mount Zion Health Fund *San Francisco, CA* www.mzhf.org	1990	$48,000,000	Public charity, 509(a)(1) traditional	Meeting the needs of vulnerable populations; filling funding gaps; and providing responsive and creative solutions to health-related needs, mainly in San Francisco

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New York State Health Foundation *New York, NY* www.nyshealthfoundation.org	2002	$270,000,000	Private Foundation	Expand health insurance coverage, increase access to high-quality health care services, and strengthen public and community health
North Penn Community Health Foundation *Lansdale, PA* www.npchf.org	2002	$44,318,000	Public charity, 509(a)(3) supporting organization	Promoting access to health and human services for at-risk populations, including the underinsured and uninsured; helping people with chronic illnesses and disabilities to remain living in their own homes and communities; promoting the use of volunteers; promoting wellness and informed decisionmaking through prevention and education; and strengthening organizational effectiveness and partnerships among community health and human services organizations
Northern Virginia Health Foundation *Alexandria, VA*	2005	$43,000,000	Private Foundation	Improve the health of residents of Northern Virginia with emphasis on supporting efforts to improve the health and health care of low-income, uninsured and underinsured persons; and on supporting the provision of health education, prevention of disease, and wellness programs
Northwest Health Foundation *Portland, OR* www.nwhf.org	1997	$90,000,000	Social welfare organization, 501(c)(4)	Access to quality health care; youth mental health; improving the nursing workforce; arthritis-related research; children's health; rural health; and health care delivery to culturally diverse communities, impoverished families, and persons with chronic conditions
Northwest Osteopathic Medical Foundation *Portland, OR* www.nwosteo.org	1984	$6,989,131	Public charity, 509(a)(1) traditional	Children and families, scholarships to osteopathic medical students, and training clinics for osteopathic residency programs
Obici Healthcare Foundation *Suffolk, VA*	2006	$31,875,720	Private Foundation	Improve health care in Suffolk and surrounding communities by giving attention to the unmet needs of the medically indigent and uninsured; and by supporting programs, which have the primary purpose of preventing illness and disease
Osteopathic Founders Foundation *Tulsa, OK* www.osteopathicfounders.org	1996	$15,350,000	Public charity, 509(a)(1) traditional	Support osteopathic medical education and community health
Osteopathic Heritage Foundations *Columbus, OH* www.osteopathicheritage.org	1961	$266,000,000	Private Foundation	Community health, quality of life, osteopathic health care, medical education, and medical research

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Osteopathic Institute of the South *Grayson, GA* www.oisonline.org	1986	$3,269,291	Public charity, 509(a)(1) traditional	Supports programs in osteopathic education and clinical services
Pajaro Valley Community Health Trust *Watsonville, CA* www.pvhealthrust.org	1998	$14,000,000	Public charity, 509(a)(1) traditional	Oral health prevention and access, diabetes and contributing factors, promoting entry and advancement in the health professions, health insurance coverage, and education on using the health care system
Palm Healthcare Foundation, Inc. *West Palm Beach, FL* www.palmhealthcare.org	2001	$70,000,000	Public charity, 509(a)(1) traditional	Access to care and strengthening health professions education, particularly nursing
Paso del Norte Health Foundation *El Paso, TX* www.pdnhf.org	1995	$200,000,000	Private Foundation	Health improvement through education and prevention, healthy communities, physical fitness, youth alcohol and tobacco use, teen pregnancy prevention, preventive health screening promotion, and health services research
The Patron Saints Foundation *Pasadena, CA* www.patronsaintsfoundation.org	1985	$11,042,565	Private 501(c)(3)	Community health education and services, community health outreach programs, medical and other professional health care education, equipment purchases, renovation of buildings, capital expenditures, medical research
Annie Penn Community Trust *Reidsville, NC* www.anniepenncommunitytrust.org	2001	$34,000,000	Private Foundation	Improve health and quality of life
Phoenixville Community Health Foundation *Phoenixville, PA* www.pchf1.org	1997	$49,500,000	Private Foundation	Wellness and prevention, physical and behavioral health, public health and safety, community-based health support environmental health, community health, and educational opportunities for health-related fields
Portsmouth General Hospital Foundation *Portsmouth, VA* www.pghfoundation.org	1988	$15,150,000	Private Foundation	Supports innovative programs impacting the health of the Portsmouth community, particularly children ages 0 to 5
Pottstown Area Health & Wellness Foundation *Pottstown, PA* www.pottstownfoundation.org	2003	$93,000,000	Private Foundation	Assuring increased access to health and wellness education and services
Presbyterian Health Foundation *Oklahoma, OK* www.phfokc.com	1985	$180,413,301	Private Foundation	Supports medical research to save and enhance human life

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Prime Health Foundation *Kansas City, MO* www.primehealthfoundation.org	1989	$6,191,675	Public charity, 509(a)(3) supporting organization	Managed care, health care education, and disease management
Quad City Osteopathic Foundation *Bertendorf, IA*	1984	$4,200,000	Private Foundation	Scholarships and grants for medical education
Quantum Foundation *West Palm Beach, FL* www.quantumfoundation.org	1995	$165,000,000	Private Foundation	Access to health care for the residents of Palm Beach County, improve the quality of care and provide support for people with chronic health conditions, promote healthy communities and lifestyles through educational programming
QueensCare *Los Angeles, CA* www.queenscare.org	1998	$382,460,000	Public charity, 509(a)(1) traditional	Nonprofit health care agencies
John Randolph Foundation *Hopewell, VA* www.johnrandolphfoundation.org	1995	$34,600,000	Public charity, 509(a)(2) gross receipts	Primary care, access to care, children, and quality of care
The Rapides Foundation *Alexandria, LA* www.rapidesfoundation.org	1994	$210,721,150	Public charity, 509(a)(2) gross receipts	Prevention, wellness and health care, healthy communities, and K-12 education
REACH Community Health Foundation *North Adams, MA* www.nbhealth.org/index.php?nav_id=33	1998	$125,000,000	Public charity, 509(a)(1) traditional	Improving the health of women, children, families, and elders; health promotion and disease prevention; health care and disease management initiatives; access to health care; and health communications
The REACH Healthcare Foundation *Merriam, KS* www.reachhealth.org	2003	$116,000,000	Public charity, 501(a)(2) gross receipts	Oral health, mental health, and safety net programs that serve indigent and uninsured populations
Michael Reese Health Trust *Chicago, IL* www.healthtrust.net	1991	$119,837,020	Private Foundation	Supports the direct delivery of community-based health services to vulnerable populations, including the medically indigent and underserved, immigrants and refugees, the elderly, the mentally and physically disabled, and children and youth
John Rex Endowment *Raleigh, NC* www.rexendowment.org	1999	$80,000,000	Private Foundation	Supports visible and measurable improvements in the health of children by improving access to health services, promoting healthy behaviors, and providing children with opportunities for growth and development

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Riverside Community Health Foundation *Riverside, CA* www.rchf.org	1972	$82,000,000	Public charity, 509(a)(1) traditional	Access, health education and prevention, and health and safety
Roanoke-Chowan Foundation, Inc. *Ahoskie, NC*	1998	$14,187,530	Public charity, 509(a)(1) traditional	Wellness, health, and well-being
Rose Community Foundation *Denver, CO* www.rcfdenver.org	1995	$266,973,000	Public charity, 509(a)(3) supporting organization	Prevention, access, health policy leadership, aging, child and family development, education, and Jewish life
St. David's Community Health Foundation *Austin, TX* www.sdchf.org	1925	$226,476,000	Public charity, 509(a)(1) traditional	Supports programs increasing access to primary health care, mental health and oral health services, and basic needs for the elderly
St. Joseph Community Health Foundation *Fort Wayne, IN* www.stjosephhealthfdn.org	1998	$7,200,000	Public charity, 509(a)(1) traditional	Supports efforts focused on health care, wellness, and access for the poor and underserved
St. Joseph's Community Health Foundation *Minot, ND*	1998	$2,063,539	Public charity, 509(a)(1) traditional	Mental, physical, and spiritual well-being
St. Joseph's Health Ministries Foundation *Lancaster, PA* www.sjhm.org	2000	$6,231,575	Public charity, 509(a)(3) supporting organization	Children's health and faith-based health initiatives, focusing on services to poor, disadvantaged, and underserved populations
St. Luke's Foundation *Bellingham, WA* www.stlukesfoundation.org	1983	$9,040,101	Public charity, 509(a)(2) gross receipts	Health care
Saint Luke's Foundation of Cleveland, Ohio *Cleveland, OH* www.saintlukesfoundation.org	1997	$211,208,000	Private Foundation	Improvement and transformation of the health and well-being of individuals, families, and communities of greater Cleveland; health and health care; human services; and neighborhood employment
St. Luke's Health Initiatives *Phoenix, AZ* www.slhi.org	1995	$105,000,000	Public charity, 509(a)(3) supporting organization	Health care access, quality, and cost; and developing resilient, healthy communities
Salem Health & Wellness Foundation *Salem, NJ* http://fdncenter.org/grantmaker/salem	2002	$48,756,342	Public charity, 509(a)(1) traditional	Access to health care; preventive services; and recruitment, education, and retention of skilled health care professionals

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San Angelo Health Foundation *San Angelo, TX* www.sahfoundation.org	1995	$46,384,574	Private Foundation	Community health and wellness
SHARE Foundation *El Dorado, AR*	1996	$87,936,286	Public charity, 509(a)(1) traditional	Wellness and prevention, hospice care, and indigent care
Sierra Health Foundation *Sacramento, CA* www.sierrahealth.org	1984	$173,864,050	Private Foundation	Support for local and regional health activities affecting underserved populations, including conferencing and convening, capacity building, leadership development, and youth
J. Marion Sims Foundation, Inc. *Lancaster, SC* www.jmsims.org	1994	$67,973,076	Private Foundation	Health, human services, and economic and community development
Sisters of Charity Foundation of Canton *Canton, OH* www.scfcanton.org	1996	$79,147,008	Public charity, 509(a)(3) supporting organization	Supports efforts focused on health care access and affordability for the poor and underserved, disparities in care for racial and ethnic minorities, prescription assistance, and oral health
Sisters of Charity Foundation of Cleveland *Cleveland, OH* www.socfdncleveland.org	1996	$82,038,678	Public charity, 509(a)(3) supporting organization	Improve the lives of those most in need with special attention to families, women, and children living in poverty; sustain the ministries of women; reduce health disparities for those living in poverty
Sisters of Charity Foundation of South Carolina *Columbia, SC* www.sistersofcharitysc.com	1996	$88,800,000	Public charity, 509(a)(3) supporting organization	Economic and community development addressing the root causes of poverty; strengthening families; and promoting educational success
Sisters of Mercy of North Carolina Foundation, Inc. *Charlotte, NC* www.somncfdn.org	1995	$239,106,484	Public charity, 509(a)(3) supporting organization	Programs and services for disadvantaged populations, especially those serving women, children, the elderly, and the economically poor
The Sisters of St. Joseph Charitable Fund *Parkersburg, WV* www.ssjcharitablefund.org	1996	$22,500,000	Public charity, 509(a)(3) supporting organization	Health and wellness issues with a particular focus on healthy communities, access for those who are vulnerable or underserved, health ministries in faith-based congregations, improving physical inactivity and poor nutrition
South Lake County Community Foundation *Clemont, FL* www.cfslc.org	1995	$9,128,910	Public charity, 509(a)(1) traditional	General health and wellness

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Spalding Health Care Trust *Griffin, GA*	1984	$28,271,546	Public charity, 509(a)(3) supporting organization	Funds free health clinics, emergency equipment for fire departments, capital projects, education, and social and human services
Sunflower Foundation: Health Care for Kansans *Topeka, KS* www.sunflowerfoundation.org	2000	$102,051,752	Public charity, 509(a)(3) supporting organization	Expanding access to health care by supporting expansion of primary care and primary prevention services; eliminating disparities in health care and health status; building the organizational capacity of health and human service providers; supporting healthy behaviors and prevention, with a focus on promoting physical activity and healthy eating, and enhancing a built environment to facilitate physical activity by building community-based walking trails; and strengthening tobacco use prevention and control
Taylor Community Foundation *Ridley Park, PA* www.taylorcommfdn.org	1997	$10,939,685	Public charity, 509(a)(1) traditional	Scholarships, community support, and support of Taylor Hospital
Truman Heartland Community Foundation *Independence, MO* www.thcf.org	1994	$26,000,000	Public charity, 509(a)(1) traditional	Strong neighborhoods, education, community spirit, health needs, leadership development, senior services, positive youth development, transportation, and violence prevention
Tucson Osteopathic Medical Foundation *Tucson, AZ* www.tomf.org	1996	$10,639,518	Private Foundation	Osteopathic medical education, public's understanding of osteopathic medicine, community health and well-being, higher education, community service organizations, and public policy
Tuscora Park Health and Wellness Foundation *Barberton, OH* www.bcfcharity.org/bef/tuscorapark_txt.html	1996	$3,246,754	Private Foundation	Health and wellness
Two Rivers Health & Wellness Foundation *Easton, PA*	2001	$13,000,000	Private Foundation	Prevention through education and access
UniHealth Foundation *Los Angeles, CA* www.unihealthfoundation.org	1998	$302,606,349	Private Foundation	Activities that significantly improve the health and well-being of individuals and communities in its service area
Union Labor Health Foundation *Bayside, CA* www.hafoundation.org/grants/other_grants/index.html#ulgeneral	1997	$4,442,000	Public charity, 509(a)(3) supporting organization	Physical, mental, and moral well-being of individuals

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United Methodist Health Ministry Fund *Hutchinson, KS* www.healthfund.org	1986	$66,000,000	Public charity, 509(a)(3) supporting organization	Access to health care, oral health, and healthy lifestyles
Universal Health Care Foundation of Connecticut, Inc. *Meriden, CT* www.universalhealthct.org	2000	$51,000,000	Public charity, 509(a)(3) supporting organization	Health advocacy, legal intervention and action research
Valley Care Association *Sewickley, PA* www.valley-care.org	1999	$7,928,073	Public charity, 509(a)(1) traditional	Aging
The Valley Foundation *Los Gatos, CA* www.valley.org	1984	$55,342,624	Private Foundation	Research, education, and social service agencies dealing with health issues
Washington Square Health Foundation, Inc. *Chicago, IL* www.wshf.org	1985	$25,713,053	Private Foundation	Promoting and maintaining access to adequate health care for residents of its service area; and grants for medical and nursing education, medical research, and direct health care services
Welborn Baptist Foundation, Inc. *Evansville, IN* www.welbornfdn.org	1998	$107,235,261	Private Foundation	School-based health programs as well as programs targeting the promotion of early childhood development and healthy adolescent development; improvements in community health status; and faith-based programs in health ministries, adolescent development, and other areas
Westlake Health Foundation *Oakbrook Terrace, IL* www.westlakehf.com	1980	$4,105,000	Private Foundation	Improving community health
Williamsburg Community Health Foundation *Williamsburg, VA* www.wchf.com	1996	$131,000,000	Private Foundation	Reduce the incidence of preventable illness and disease; increase primary health services for the poor, underinsured, and underserved, especially children and young families; improve the health and well-being of the growing senior population; support other existing and future community health initiatives; and promote healthy communities
Winter Park Health Foundation *Winter Park, FL* www.wphf.org	1994	$130,000,000	Private Foundation	Healthy communities, youth, older adults, access, and community education

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Woodruff Foundation *Cleveland, OH* www.fmscleveland.com/woodruff/	1986	$11,530,000	Private Foundation	Mental health and addiction services
Wyandotte Health Foundation *Kansas City, KS*	1997	$47,095,000	Private Foundation	Primary health care, prevention, intervention, and education
Wythe-Bland Community Foundation *Wytheville, VA* www.wbcfoundation.org	1991	$50,000,000	Public charity, 509 (a)(3) supporting organization	Obesity, health and nutritional issues, substance abuse prevention, environmental health, mental health, healthcare needs of the underprivileged and uninsured, health education, education of future generations, support for first response units (such as rescue and fire), and improving the quality of life in Wythe and Bland counties

ABOUT GIH

With a mission to help grantmakers improve the health of all people, Grantmakers In Health (GIH) seeks to build the knowledge and skills of health funders, strengthen organizational effectiveness, and connect grantmakers with peers and potential partners. We help funders learn about contemporary health issues, the implications of changes in the health sector and health policy, and how grantmakers can make a difference. We generate and disseminate information through meetings, publications, and on-line; provide training and technical assistance; offer strategic advice on programmatic and operational issues; and conduct studies of the field. As the professional home for health grantmakers, GIH looks at health issues through a philanthropic lens and takes on operational issues in ways that are meaningful to those in the health field.

Expertise on Health Issues

GIH's Resource Center on Health Philanthropy maintains descriptive data about foundations and corporate giving programs that fund in health and information on their grants and initiatives. Drawing on their expertise in health and philanthropy, GIH staff advise grantmakers on key health issues and synthesize lessons learned from their work. The Funding Partner Network, which contains information on thousands of grants and initiatives, is available on-line on a password-protected basis to GIH Funding Partners (health grantmaking organizations that provide annual financial support to the organization).

Advice on Foundation Operations

GIH focuses on operational issues confronting both new and established foundations through the work of its Support Center for Health Foundations. The Support Center offers an annual two-day meeting, The Art & Science of Health Grantmaking, with introductory and advanced courses on board development, grantmaking, evaluation, communications, and finance and investments. It also provides sessions focusing on operational issues at the GIH annual meeting, individualized technical assistance, and a frequently asked questions (FAQ) feature on the GIH Web site.

Connecting Health Funders

GIH creates opportunities to connect colleagues, experts, and practitioners to one another through its Annual Meeting on Health Philanthropy, the Fall Forum (which focuses on policy issues), and day-long Issue Dialogues, as well as several audioconference series for grantmakers working on issues such as access to care, obesity, public policy, racial and ethnic health disparities, and health care quality.

Fostering Partnerships

Grantmakers recognize both the value of collaboration and the challenges of working effectively with colleagues. Although successful collaborations cannot be forced, GIH works to facilitate those relationships where we see mutual interest. We bring together national funders with those working at the state and local levels, link with other affinity groups within philanthropy, and connect grantmakers to organizations that can help further their goals.

To bridge the worlds of health philanthropy and health policy, we help grantmakers understand the importance of public policy to their work and the roles they can play in informing and shaping policy. We also work to help policymakers become more aware of the contributions made by health philanthropy. When there is synergy, we work to strengthen collaborative relationships between philanthropy and government.

Educating and Informing the Field

GIH publications inform funders through both in-depth reports and quick reads. Issue Briefs delve into a single health topic, providing the most recent data and sketching out roles funders can and do play. The *GIH Bulletin,* published 22 times each year, keeps funders up to date on new grants, studies, and people. GIH's Web site, www.gih.org, is a one-stop information resource for health grantmakers and those interested in the field. The site includes all of GIH's publications, the Funding Partner Network (available only to GIH Funding Partners), and the Support Center's FAQs. Health issue pages provide grantmakers with quick access to new studies, GIH publications, information on audioconferences, and the work of their peers.

DIVERSITY STATEMENT

GIH is committed to promoting diversity and cultural competency in its programming, personnel and employment practices, and governance. It views diversity as a fundamental element of social justice and integral to its mission of helping grantmakers improve the nation's health. Diverse voices and viewpoints deepen our understanding of differences in health outcomes and health care delivery, and strengthen our ability to fashion just solutions. GIH uses the term, diversity, broadly to encompass differences in the attributes of both individuals (such as race, ethnicity, age, gender, sexual orientation, physical ability, religion, and socioeconomic status) and organizations (foundations and giving programs of differing sizes, missions, geographic locations, and approaches to grantmaking).

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