

HEALTH LEGACY FOUNDATIONS AND THE PURSUIT  
OF CHARITABLE HEALTHCARE

by

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A dissertation submitted to the faculty of  
The University of North Carolina at Charlotte  
in partial fulfillment of the requirements  
for the degree of Doctor of Philosophy in  
Health Services Research

Charlotte

2014

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## ABSTRACT

SABRINA JONES NIGGEL. Health legacy foundations and the pursuit of charitable healthcare. (Under the direction of DR. WILLIAM P. BRANDON)

Endowed with proceeds from transactions involving nonprofit healthcare assets, health legacy foundations (HLFs) embody tremendous potential to improve health and healthcare in communities across the nation. This dissertation represents the culmination of a systematic search for HLFs, provides community-level analyses of needs where HLFs are established, and describes how HLFs articulate their intent to pursue a charitable health purpose. The first phase of this research entailed the development of a new, comprehensive database of HLFs, which includes 306 foundations in forty-three states; aggregate HLF assets in 2010 totaled more than \$26 billion. The next phase of this study examined health determinants in communities where HLFs have been formed from the sale of local nonprofit hospitals. Compared to non-HLF counties, HLF counties had significantly higher proportions of racial minorities and multiple socioeconomic indicators that render them more vulnerable to health disparities and poor health. The final phase of this research explored the charitable health intent of HLFs formed from hospitals as revealed through their self-defined missions. Although the majority of HLFs adopted an explicit health-related purpose, most depicted health in vague terms. Broadly construed mission statements allow grantmakers the freedom to choose the combination of services and beneficiaries that maximizes utility for their communities. While this flexibility is important for HLFs to address broad health determinants and respond to changing community needs, careful public oversight is critical to ensure that nonprofit healthcare proceeds are strategically redeployed.

## ACKNOWLEDGMENTS

Only with an enduring, supportive network of advisors, professors, colleagues, friends and family has this endeavor been possible. My mentor, Bill Brandon, has dedicated countless hours to reviewing drafts, asking tough questions, and steering and championing my research along the way. From the beginning of my journey as a doctoral student, I have also had the good fortune to learn from Becky Nesbit. Jennifer Troyer and Suzanne Boyd have remained a steadfast source of support and wisdom, both inside and outside the classroom. Among other professors from whom I have had the privilege to learn, I am particularly indebted to Claudia Avellaneda, Martha Kropf, and Sarah Laditka. Professional colleagues David Grogan, Martin Lehfeldt, Kate Treanor, Byron Harrell, and Gene Cochran helped me access the data, resources, and contacts that gave me a platform to pursue this research. Most of all, I am grateful to my wonderful husband and family. Joe, Mom, Dad, Sissel, Darryl, and the whole gang: words cannot express how much your encouragement and support have meant to me.

## INTRODUCTION

Health legacy foundations (HLFs) are philanthropic entities formed with proceeds from nonprofit healthcare conversions and other sales transactions. This dissertation provides new information about HLFs in three separate manuscripts, representing three related but distinct research questions. The specific aims were (1) to undertake a systematic search to identify HLFs throughout the United States and describe emerging new trends pertaining to their endowment; (2) to examine determinants of health, and hence indicators of need, in communities where HLFs have been established; and (3) to explore the charitable health intent of HLFs as revealed through their self-defined missions.

The first manuscript describes the results of a systematic search for HLFs that culminated in a comprehensive database of HLFs that were known to exist as of December 31, 2012; the dataset includes 306 HLFs in 43 states. Information about these foundations reported in the first paper include the location and date of foundation establishment, geographic service areas, asset values and grant awards for 2010, types of transactions and healthcare entities converted, and HLFs' tax-exempt status. Because the lack of a single, consistently applied name has impeded the previous identification of these foundations, the term *health legacy foundation* is recommended to facilitate their future classification and study. This manuscript was published in the January 2014 issue of *Health Affairs*, with co-author William P. Brandon.

Whereas the first paper discusses the scope and nature of all HLFs, the next two papers focus more closely on the largest subpopulation of HLFs, those formed from hospitals and health systems. Based on research showing that the greatest improvements

in population health can be achieved by addressing underlying social factors, the second paper investigates whether HLF communities are characterized by poor social determinants of health, using county-level indicators from 2010 and 2011. Compared to non-HLF counties, HLF counties had significantly higher proportions of racial minorities and multiple socioeconomic indicators that render them more vulnerable to health disparities and poor health. Findings suggest that HLF grantmaking strategies, particularly in the South, must reach beyond medical care in order to improve community health.

The final manuscript examines how HLFs created from hospitals intend to award their grant funding. This study entailed a content analysis of HLF mission statements obtained between 2011 and 2013. Although the vast majority of mission statements reflected an explicit health-related purpose, most HLFs depicted health in broad terms. About one-quarter of mission statements identified target populations, such as the poor or racial minorities, to benefit from grant awards. Larger and perhaps more sophisticated HLFs were more likely to have an overall narrow purpose or to focus on narrowly defined target populations. Because HLFs have adopted flexible parameters for their grantmaking, local oversight is essential for ensuring that grant funds are used wisely. This manuscript concludes with a discussion of the need for new regulation of HLFs that will reflect their unique nature and community origins.

These studies have been undertaken at a critical time. Since the 2010 enactment of the Patient Protection and Affordable Care Act (P.L. 111-148), healthcare mergers and acquisitions have been on the rise. Many new HLFs are expected to be established with transaction proceeds. Recent acquisitions of smaller and stand-alone nonprofit hospitals

may infuse many communities with unprecedented charitable wealth. Given their abundant assets and their unique charitable health legacy, HLFs are well positioned to address communities' disparate health needs. Local accountability and oversight are essential to ensure that charitable health proceeds are strategically redeployed in order to maximize community benefit.

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## CHAPTER 1: HEALTH LEGACY FOUNDATIONS: A NEW CENSUS

### Abstract

Healthcare merger and acquisition activity has increased since enactment of the Affordable Care Act in 2010. Proceeds from transactions involving nonprofit hospitals, health systems, and health plans will endow philanthropic foundations known as *health legacy foundations* (HLFs). Building on work by Grantmakers In Health, we undertook a systematic search for these foundations and generated a newly updated, comprehensive database, which includes 306 HLFs in forty-three states, representing \$26.2 billion in assets in 2010. Concentrated in the South, foundations originating from hospitals and specialty care facilities (86.6%) held mean assets of \$64.7 million per funder and typically restricted grants to local communities. Foundations formed from health plans (13.4%) held higher mean assets (\$222 million), usually served larger areas, and were more likely to engage in healthcare advocacy. Recent transactions involving smaller and stand-alone nonprofit hospitals will infuse many more communities with unprecedented charitable wealth.

## Introduction

Over the past three decades, numerous nonprofit hospitals, health systems, health plans, and specialty care facilities have ventured into agreements—often with for-profit firms—to sell, lease, merge, or otherwise reconfigure their corporate assets. While consumers may see little difference in services attributable to new ownership, changes in the local nonprofit sector are often striking. Nonprofit healthcare conversions and other sale transactions have resulted in billions of dollars in new charitable wealth. Proceeds most often establish brand-new philanthropic foundations but may also enrich existing hospital foundations, community foundations, or municipal health districts (Frost, 2002; Standish, 1998). Collectively known as *health legacy foundations* (HLFs), these grantmaking entities give away millions each year, often for local initiatives. Leveraging these dollars to fulfill strategic healthcare priorities could markedly improve community health status.

Few recent studies have examined HLFs. Although the surge of healthcare mergers and acquisitions in the mid-1990s prompted investigations of conversion processes, only a small number delved into the preservation of charitable assets. *Health Affairs* published a special thematic issue dedicated to hospital and health plan conversions in March 1997, and a *Health System Leader* symposium appeared in October of 1996. Consumers Union and Community Catalyst generated abundant materials to raise awareness about potential pitfalls of conversions (e.g., Consumers Union and Community Catalyst, 2004; Cryan & Gardner, 1999). Several law review articles discussed legal applications of proceeds (e.g., Frost, 2002; Sackett, 1999; Standish, 1998). However, empirical information about these funders has been largely limited to case

studies (e.g., Collins, Gray, & Hadley, 2001; DeLucia, 2001; Filozof et al., 1999; Nelson, Otten, & Sirica, 1999).

Grantmakers In Health, an educational organization assisting grantmakers that fund health-related efforts, has maintained the only database of foundations created from nonprofit healthcare transactions. Grantmakers In Health has produced at least ten reports profiling these foundations. Its most recent report, published in June 2009, listed 155 HLFs and stated that 197 had been identified (Grantmakers In Health, 2009a).

Anticipating the creation of many new foundations from the current surge in nonprofit healthcare deals, we undertook a systematic search for HLFs, which resulted in a newly updated, comprehensive database containing 306 foundations in forty-three states. The difficulty in identifying these organizations may account for their limited study to date. Not only is there no standard name or definition for these foundations, but the increasingly complex transactions from which they originate also make them difficult to identify. Moreover, the U.S. Internal Revenue Service (IRS) does not distinguish foundations endowed by healthcare transactions from other types of grantmaking institutions.

Updated information about HLFs is important for two key reasons. First, healthcare reform heightens the importance of identifying and maximizing existing community resources. Second, the recent increase in hospital deals likely presages another surge in new HLFs, as did the wave of healthcare mergers and acquisitions in the early 1980s and mid-1990s. In 2010, 77 hospital agreements were announced, the most since 2001 (Irving Levin Associates, 2011). This surge continued in 2011 with 92 hospital deals announced, followed by 94 in 2012 (Irving Levin Associates, 2013).

Industry analysts anticipate continued mergers and acquisitions in 2013, especially those involving smaller and stand-alone nonprofit hospitals (Fitch Ratings, 2013; Irving Levin Associates, 2013; Standard & Poor's Rating Services, 2013).

The purpose of this study is to provide timely information about foundations formed from the sale, merger, lease, or other restructuring of nonprofit healthcare assets. Specifically, we report the location and date of foundation establishment, asset values and grant awards, geographic service areas, types of transactions and healthcare entities converted, and HLF tax-exempt status. We also advocate using the term *health legacy foundation* to facilitate their future identification, classification, and study.

#### Study Data and Methods

Conceptualizing our unit of analysis constituted the first step in our research. Although transaction proceeds most often establish new foundations, proceeds are sometimes invested in existing public charities or government affiliates (Kane, 1997; Standish, 1998). Grantmakers In Health crafted a definition to encompass these different entities, which we adapted for our study by adding *government affiliates* to the last component:

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 *and government affiliates* that receive additional assets from the sale or conversion of a nonprofit health care organization (2007, p. iii)

Foundation professionals and scholars have referred to these entities with little consistency. Common terms include *healthcare conversion foundations*, *hospital conversion foundations*, and *new health foundations*. During a recent assembly of health

foundation leaders in the Southeast, CEOs coined the term *health legacy foundations* to signify the unique lineage of these foundations and to indicate independence from both the *old* and *new* healthcare entities (Southeastern Council of Foundations, 2006). The term also avoids confusion associated with the term *conversion*, given that some foundations are formed from nonprofit acquisitions of other nonprofits (Nelson, Otten, & Sirica, 1999). The name *health legacy foundation* appears to be catching on beyond the Southeast United States and even beyond philanthropic circles (Alexander, 2007; Harrell, 2009).

#### Data Collection

Building on existing profiles of foundations provided by Grantmakers In Health, we searched for HLFs using a variety of online data sources, including the Foundation Center, GuideStar, National Center for Charitable Statistics, and regional associations of grantmakers. Search terms included the following words and word combinations: *acquisition, conversion, foundation, health, health plan, healthcare, hospital, insurance, joint venture, merger, and sale*. Additional information was obtained through correspondence with foundation personnel, IRS Form 990s, press releases, and foundation websites and annual reports.

Total assets and grants paid reported on 2010 Form 990s or financial statements were found for 96% of funders described in this analysis. When 2010 data were unavailable, financial information for the fiscal year closest to 2010 was reported. Employer Identification Numbers were recorded and sorted to eliminate duplications resulting from foundations that changed names. Whenever possible, we recorded the year

of the initial transfer of sale proceeds as the date of establishment. Analyses were conducted using Stata® SE version 11.2.

### Limitations

Several limitations are noted with regard to data collection. Although we used extensive search parameters within multiple data sources to locate HLFs, it is likely that some have yet to be identified. The lag time for start-up and receipt of tax-exempt determination impeded identification of newer foundations. Also, search methods were not as likely to identify conversion proceeds designated for municipal entities or existing charities. Finally, although we cross-referenced data from multiple sources, our analysis depended on the accuracy, availability, and accessibility of secondary data.

### Study Results

The search for HLFs uncovered a total of 306 organizations in 43 states that have been endowed with proceeds from the sale, merger, lease, joint venture or other restructuring of nonprofit healthcare assets. Combined foundation assets totaled \$26.2 billion, with assets of individual funders ranging between \$6,072 and \$3.7 billion in 2010. Mean and median assets were \$85.8 million and \$32.1 million, respectively. Foundations awarded a total of \$1.1 billion in grants in 2010, with an average of \$3.7 million paid per foundation.

### Date of Endowment

As the timeline in Figure 1 shows, HLFs are a relatively new phenomenon. The earliest known sale of nonprofit healthcare assets that resulted in a grantmaking foundation occurred in early 1970, when proceeds from Crippled Children's Hospital endowed Crippled Children's Foundation in Birmingham, Alabama. Prior to 1982, only

three HLFs were in operation. Surges in foundation establishment occurred in the mid-1980s and mid-1990s and peaked in 1995, when 32 HLFs were established.

The surge initiated in the mid-1990s lasted a decade. Between 1994 and 2003 a total of 186 HLFs were endowed, with only one year (2000) producing fewer than ten foundations. Although Figure 1 shows a declining number of foundations established since 2010, this underreport will reverse within several years, as proceeds from the current wave of nonprofit healthcare sales and other transactions endow new foundations, a process that usually takes several years.

#### Location and Assets

HLFs were concentrated in the South (Figure 2). At least 130 foundations (42.5%) held combined assets of \$8.2 billion in the southern region (Table 1). Florida and Virginia led the South in terms of the number of these foundations (each with 20), with Virginia holding the greatest assets, \$1.3 billion. Nearly one quarter of all HLFs in the country were located in the South Atlantic Census division.

In terms of assets, the Pacific division trumped all other divisions. Combined assets in the Pacific states were nearly twice those in the South Atlantic (\$7.56 billion versus \$3.89 billion). The extraordinary asset value in the West was skewed by California, which dominated all states in terms of both number ( $n = 30$ ) and assets (\$7.3 billion). Nearly half of all HLF assets in the West resulted from the conversion of Blue Cross of California.

#### Distributions and Designated Service Areas

Table 1 shows total and mean grant amounts paid in 2010. Total awards ranged from \$26.9 million in New England to \$338 million in the Pacific division. The high

mean payout in Mountain states, \$12.6 million per funder, was primarily due to the Colorado Health Foundation, which awarded nearly \$96 million in grants in 2010. The median of grants per funder awarded for this division was \$2.7 million.

Grant distributions of HLFs were largely restricted to their local communities. More than 80% designated a local community, often a single county, as their primary service area. Funders that specified local service areas awarded \$633 million in grants in 2010 (Table 2). The 43 funders that restricted their payouts to a single state awarded \$442 million, and the 14 funders with a regional or multistate focus paid out \$49 million. Only three funders designated their primary service areas as national or international. Most HLFs appeared to restrict their grantmaking to the service area of the converting nonprofit healthcare entity. Ninety percent of funders specifying a local service area converted from hospitals or health systems.

#### Converting Entities

Among all known HLFs, 82.0% originated from hospitals and health systems, 13.4% from health plans, and 4.6% from specialty care organizations, such as nursing homes and cancer, kidney, or rehabilitation facilities (Table 3). While fewer HLFs resulted from health plans, their mean assets were notably higher (\$222 million) when compared with those formed from other healthcare entities (results not shown).

At least 265 HLFs with mean assets of \$64.7 million stemmed from hospitals, health systems, and specialty care organizations. Acquisitions represented the most common type of transaction: 77.7% came from sales, 11.0% from joint ventures and other asset restructuring, 9.4% from mergers, and 1.9% from lease agreements. In the 1970s and 80s, nearly 90% of hospital deals producing HLFs came from sales

transactions. In subsequent decades transactions have become more complex, with an increase in mergers, joint ventures and other corporate restructuring. Since 2007, 23.8% of hospital transactions resulting in foundations were mergers, more than twice the percentage of foundations formed from mergers in any previous decade.

#### Tax-Exempt Status

Almost all converting hospitals endowed 501(c)(3) tax-exempt organizations, which include public charities and private foundations that pursue a charitable, scientific, educational, or other purpose identified by the IRS Code (U.S. Department of the Treasury, 2011). Slightly more hospital conversions result in public charities (125) than in private foundations (121) (Table 3). Most health plan legacy foundations (82.9%) were also designated as 501(c)(3) organizations. However, among the eight HLFs designated as 501(c)(4) social welfare organizations, all but one converted from health plans. Although they constituted only 2.6% of the total number of HLFs, 501(c)(4) foundations held \$2.46 billion in combined assets—nearly 10% of all HLFs' assets.

#### Discussion

This study provides timely information about foundations formed from nonprofit healthcare sales and other transactions and reveals trends in HLF establishment, behavior, and potential for impact. Our research describes many foundations not previously reported in the literature and identifies 264 that have existed for at least a decade.

Although this census does not reflect the recent increase in hospital mergers and acquisitions, we anticipate the establishment of many new HLFs in the near future. The increased pace of healthcare conversions in the mid-to-late 1990s resulted in a decade-long surge of new HLFs. The process of converting assets and establishing a HLF

involves a series of intricate financial transactions and a multitude of stakeholders with possibly competing agendas (Hall & Conover, 2003; U.S. Department of the Treasury, 2011). Because of this lengthy and complicated process, HLFs created in the wake of the Affordable Care Act may not appear in future updates of our dataset for some time. Future studies will reveal how current trends in transactions—such as the increase in more complex forms of hospital transactions and the increase in deals involving smaller and stand-alone hospitals—will affect the number and asset size of new foundations (Fitch Ratings, 2013).

Preserving proceeds for public benefit is critical given HLFs' potential for impact, which varies largely by the type of converting entity. Compared with foundations formed from hospitals, health plan legacy foundations have much higher mean assets and distribute funds across larger geographic areas, typically one or more states. These funders are also more likely to operate as 501(c)(4) organizations. Unlike their 501(c)(3) counterparts, 501(c)(4) organizations are less restricted in their efforts to influence policymaking (Shriber, 1997; U.S. Department of the Treasury, 2011). This greater freedom allows health plan legacy foundations to emphasize advocacy, which enhances their health policy influence and potential as major change agents.

#### Geographic Impact

Two geographic trends emerged from our analysis: the regional concentration of HLFs and the restriction of grant awards to generally small designated giving areas. First, the geographic concentration in the South provides the region with extraordinary potential to address health-related matters, which is particularly important given the region's history of health disparities and poor health indicators. Southerners have higher

rates of obesity, hypertension, end-stage renal disease, coronary heart disease, congestive heart failure, stroke, cognitive impairment, many types of cancer, and all-cause mortality (Cooper et al., 2000; Perry & Roccella, 1998; Wadley et al., 2011). The substantial philanthropic funds available in HLFs can be a vital resource for addressing health disparities.

The second geographic characteristic is the commitment of most HLFs to award grants within the area served by the converting healthcare facility. Foundations formed from hospitals, especially in rural and suburban areas where the converting hospital was the sole facility, often benefit communities with relatively small populations. In South Carolina, for example, the Chester Healthcare Foundation was endowed with nearly \$29 million in 2006 from the lease of Chester County Hospital and Nursing Center to Health Management Associates (Chester Healthcare Foundation, 2011). Grants are limited to Chester County, which had an estimated 2012 population of less than 33,000 (U.S. Census Bureau, 2013).

While such philanthropies are a boon to many communities, operating in geographically restricted areas with small populations raises several concerns. For example, it may be difficult to find employees and board members with desired experience. Another challenge is grantmaking. Some foundations may prefer to meet their payout goals by awarding a lower number of large-scale grants rather than a large number of small-dollar awards. However, funders in smaller or less affluent communities may find few nonprofit organizations with the experience or capacity to manage large-scale grants. In response, many HLFs have dedicated resources to organizational development. Dozens of HLFs also recently awarded capacity-building grants during the

Great Recession, when many charities—particularly grassroots agencies—struggled to stay in business (Grantmakers In Health, 2009b).

In addition to building capacity, many newer HLFs in smaller, less affluent communities have opted to address social determinants of health. Both the Gilmore Foundation in Amory, Mississippi, and the Wythe-Bland Foundation in Wytheville, Virginia, award community college scholarships and provide substantial funding for public education. The Ottumwa Regional Legacy Foundation in Iowa also provides funding for education, as well as economic development and community revitalization. In urban areas, too, funders target social determinants of health. Newer HLFs, such as the Potomac Health Foundation in Woodbridge, Virginia, and the Health Care Foundation for Greater Kansas City, Missouri, have funded social services, cultural competency programs, housing, transportation, mobile and free health clinics, and healthcare reform advocacy. Future investigations of HLFs should entail a closer examination of grantmaking performance and impact.

### Political Economy

Although community need and the prospect of new philanthropic resources might lead communities to readily accept hospital conversions, in reality, sales of nonprofit hospitals commonly elicit opposition. Changes in ownership, especially those generating fear of reduced services or closure, have been controversial since investor-owned hospitals began expanding in the health-planning era of the late 1960s and 1970s. Vulnerable communities, especially, see their identity and solidarity as dependent on the continued existence of local health providers. Moreover, health facilities represent an important source of entry-level and semiskilled jobs that have historically provided career

ladders for unskilled workers (Doeksen, Lowen, & Stawn, 1990; Senate Special Committee on Aging, 1988).

Yet the for-profit acquisition of small independent hospitals may stabilize rather than close them. If facilities remain open, communities may experience a triple win when a HLF is established: the economic capital that generates jobs and provides health services to the population is maintained or even augmented, while new social capital is created in the form of HLFs' philanthropic resources, and growth in human capital is fostered by the demand for more sophisticated skill sets required by foundations and prospective grantees (Coleman, 1988).

Conversions can usefully be understood as allowing disinvestment of nonprofit resources from almost totally illiquid assets—hospital buildings and equipment—and reinvestment in liquid assets devoted to community needs. Philanthropic spending can change in response to changing community needs, whereas small independent hospitals face difficulties even in responding to changing patient needs, particularly if demand for traditional services is falling and revenue decreasing (Senate Special Committee on Aging, 1988). Inefficiency, especially in reallocating resources in rapidly changing environments, is a much greater problem in the nonprofit sector than in for-profits (Hansmann, 1987; Marmor, Schlesinger, & Smithey, 1987). The nonprofit structure generally lacks the strict market discipline that forces firms to adjust or go out of business—what Schumpeter recognized as capitalism's "creative-destruction" (1950). Thus, the creation of HLFs following ownership conversion may constitute an exception, providing a clear and useful exit strategy for communities with struggling nonprofit hospitals and potential purchasers.

## Conclusion

Our census provides baseline data in anticipation of a wave of new HLFs. For years, the lack of a single, consistently applied name for these foundations has impeded their identification and study. Adopting the generic term *health legacy foundation* helped us organize seemingly dissimilar phenomena in meaningful ways. Continued study of these unique philanthropic entities will better discern trends in philanthropy dedicated to health and healthcare.

Table 1: Health legacy foundation assets and grants paid, by U.S. Census division

<b>Geographic Area</b> (number of HLFs)	<b><u>2010 Assets</u></b>		<b><u>2010 Grants Paid</u></b>	
	<b>Total</b>	<b>Mean</b>	<b>Total</b>	<b>Mean</b>
<b>United States</b> ( <i>N</i> = 306)	\$26,248,945,454	\$85,780,867	\$1,129,898,091	\$3,692,477
<b>Northeast</b> ( <i>n</i> = 48)	2,399,338,097	49,986,210	97,942,144	2,040,461
New England ( <i>n</i> = 14)	691,015,912	49,358,279	26,921,133	1,922,938
Middle Atlantic ( <i>n</i> = 34)	1,708,322,185	50,244,770	71,021,011	2,088,853
<b>Midwest</b> ( <i>n</i> = 77)	5,678,303,383	73,744,200	249,033,126	3,234,196
East North Central ( <i>n</i> = 48)	2,554,956,951	53,228,270	127,937,743	2,665,370
West North Central ( <i>n</i> = 29)	3,123,346,432	107,701,601	121,095,383	4,175,703
<b>South</b> ( <i>n</i> = 130)	8,182,498,492	62,942,296	293,752,158	2,259,632
South Atlantic ( <i>n</i> = 74)	3,890,218,530	52,570,521	155,833,820	2,105,862
East South Central ( <i>n</i> = 25)	1,334,277,818	53,371,113	51,215,335	2,048,613
West South Central ( <i>n</i> = 31)	2,958,002,144	95,419,424	86,703,003	2,796,871
<b>West</b> ( <i>n</i> = 51)	9,988,805,482	195,858,931	489,170,663	9,591,582
Mountain ( <i>n</i> = 12)	2,424,225,328	202,018,777	150,926,444	12,577,204
Pacific ( <i>n</i> = 39)	7,564,580,154	193,963,594	338,244,219	8,672,929

**Source:** Author's database of HLFs. **Notes:** Means are reported as per foundation. Financial data were obtained from IRS Form 990s for 2010 or most recent year available. Financial statements accessed through individual foundation websites supplemented the analysis where necessary. A list of states by U.S. Census region and division is provided in Appendix A.

Table 2: Health legacy foundation distributions, by service area parameters

Primary service area	Number of HLFs (%)	Total grants paid, 2010
International	2 (0.6%)	\$4,572,272
National	1 (0.3%)	\$862,579
Regional / Multiple States	14 (4.6%)	\$48,983,691
State	43 (14.1%)	\$442,029,002
Local	246 (80.4%)	\$633,450,547

**Source:** Author's database of HLFs. **Notes:** This table shows the geographic parameters within which grants were awarded by HLFs. *Local* refers to the community where the HLF is located, with grant awards typically restricted to a single county. Grant payout is reported from IRS Form 990s for 2010 or most recent year available. Financial statements accessed through individual foundation websites supplemented the analysis where necessary. HLF websites, personnel, and publications provided data for primary service areas.

Table 3: Sources of endowment and tax-exempt status of health legacy foundations, by U.S. Census region

Converting entity	501(c)(3)		501(c)(4)	Local Gov't	Total (%)	Total Assets (in millions)
	Private foundation	Public charity				
<b>United States</b>						
Hospital	121	125	1	4	251 (82.0%)	\$16,753
Health plan	24	10	7	0	41 (13.4%)	9,095
Specialty care	9	5	0	0	14 (4.6%)	401
<b>Northeast</b>						
Hospital	12	22	0	0	34 (70.8%)	1,340
Health plan	7	1	1	0	9 (18.8%)	936
Specialty care	2	3	0	0	5 (10.4%)	123
<b>Midwest</b>						
Hospital	33	29	0	1	63 (81.8%)	3,833
Health plan	5	4	3	0	12 (15.6%)	1,793
Specialty care	2	0	0	0	2 (2.6%)	52
<b>South</b>						
Hospital	61	53	1	1	116 (89.2%)	7,742
Health plan	5	2	0	0	7 (5.4%)	215
Specialty care	5	2	0	0	7 (5.4%)	226
<b>West</b>						
Hospital	15	21	0	2	38 (74.5%)	3,838
Health plan	7	3	3	0	13 (25.5%)	6,151
Specialty care	0	0	0	0	0 (0.0%)	n/a
<b>Total assets by tax-exempt status</b> (in millions)	\$14,147	\$9,452	\$2,461	\$189		

**Source:** Author's database of HLFs. **Notes:** This table shows HLFs by the type of entities converting and HLF tax-exempt status. *Hospital* category includes health systems. Data are presented for the U.S. and for each Census region. Assets are reported in millions and reflect total assets reported on Form 990s for 2010 or most recent year available.

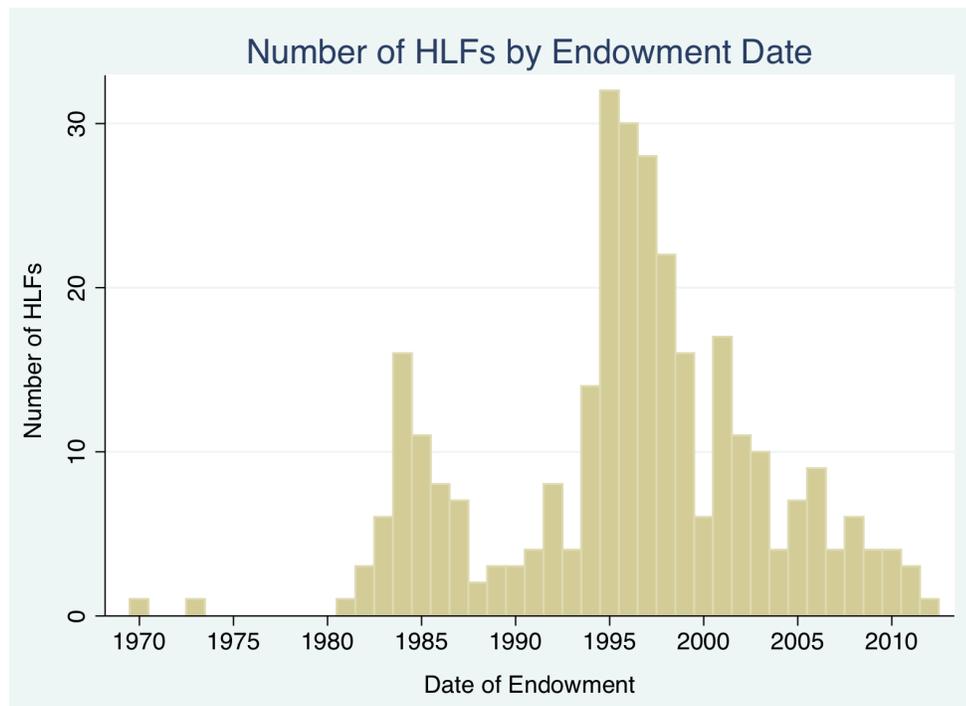


Figure 1: Number of health legacy foundations by endowment date

**Source:** Author's database of health legacy foundations. **Notes:** Whenever possible, we recorded the year of the initial transfer of sale proceeds as the date of establishment. Information pertaining to establishment was obtained through press releases, hospital and foundation websites and publications, and GuideStar, the Foundation Center, and the Urban Institute's National Center for Charitable Statistics.

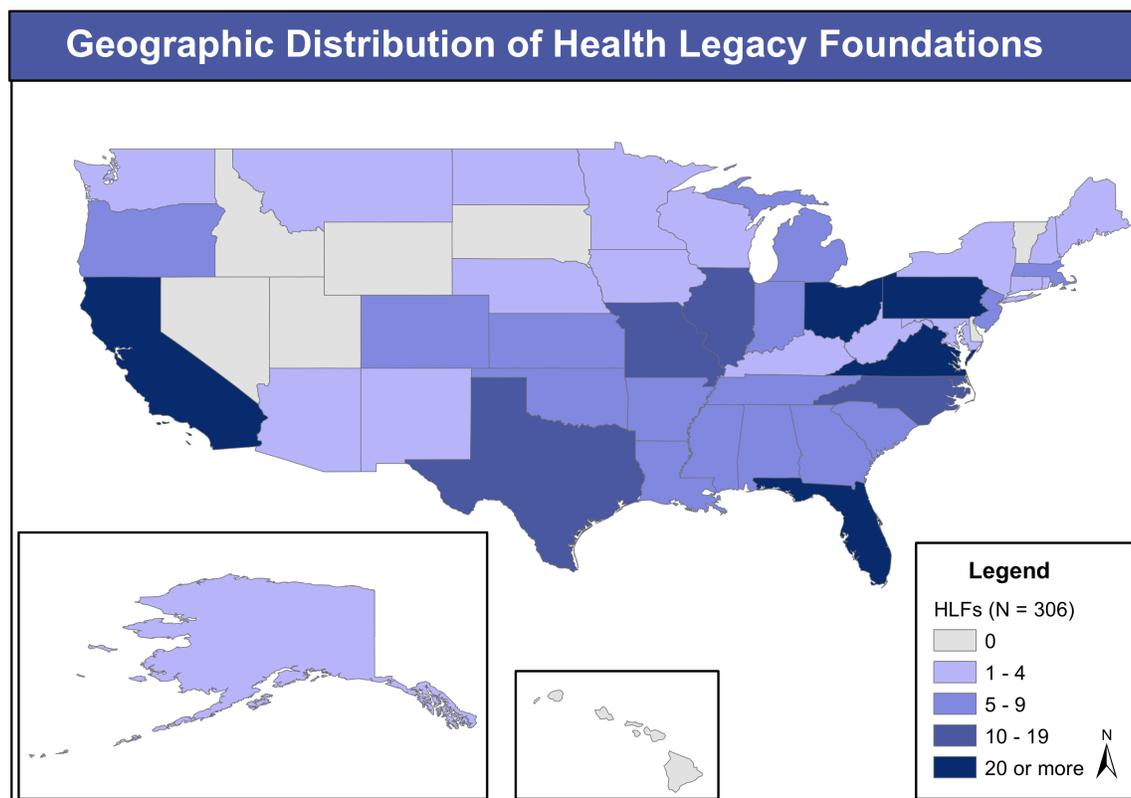


Figure 2: Geographic distribution of health legacy foundations

Source: Author's database of health legacy foundations.

## CHAPTER 2: COUNTY-LEVEL SOCIAL DETERMINANTS OF HEALTH: INFORMING POLICY AND PRACTICE OF HEALTH LEGACY FOUNDATIONS

### Abstract

Nonprofit hospital mergers and acquisitions are on the rise. Proceeds from many transactions will endow new *health legacy foundations* (HLFs). These philanthropic entities represent substantial charitable potential for communities across the nation. Some policymakers and consumer advocates contend that grant funds should be used strictly for indigent medical services. However, research indicates that the greatest improvements in population health can be achieved by addressing underlying social factors. Determining whether HLF communities are characterized by poor social determinants of health would provide new insight into how grant dollars should be expended. This paper compared socioeconomic, demographic, and access-to-care indicators in HLF versus non-HLF counties using two-sample *t*-tests and Mann-Whitney rank sum tests, controlling for geographic influences. Compared to non-HLF counties, HLF counties had significantly higher proportions of racial minorities and multiple socioeconomic indicators that render them more vulnerable to health disparities and poor health. However, HLF counties had better access to care. Findings suggest that HLF grantmaking strategies, particularly in the South, must reach beyond medical care in order to improve community health.

## Introduction

Since enactment of the Patient Protection and Affordable Care Act in 2010 (ACA; P.L. 111-148), hospital merger and acquisition activity has been on the rise (Fitch Ratings, 2013; Irving Levin Associates, 2012; Standard & Poor's Rating Services, 2013).

Proceeds from transactions involving nonprofit hospitals often endow new philanthropic foundations called *health legacy foundations* (HLFs). Previous spikes in nonprofit hospital deals that occurred in the early 1980s and mid-1990s resulted in scores of new HLFs, altering the charitable landscape in hundreds of communities across the nation. With their sizable assets and their narrowly defined geographic service areas, these foundations provide new opportunities to address health and healthcare. For some communities, the millions of dollars in new philanthropic assets represent unprecedented charitable potential. How HLFs will use these funds to respond to community needs is a crucial issue.

Some policymakers and consumer advocates contend that HLFs should distribute grant funds strictly for medical services (Consumers Union, 2007; Jaffe & Langley, 1996; Meyer, 1997; U.S. General Accounting Office, 1997). However, a growing body of evidence indicates that the keys to improving population-level health in developed countries are social and economic in nature (Frieden, 2010; Marmot & Wilkinson, 2008; Robert Wood Johnson Foundation, 2008; Tarlov, 1999). Interventions that target unemployment, education, racial discrimination, poverty, and similar health influences are especially needed in communities with minimal capacity for economic growth (Marmot & Wilkinson, 2008). Given that the financial distress that leads nonprofit hospitals to sell their assets may reflect larger socioeconomic vulnerabilities of the

surrounding community, HLF counties may have poorer determinants of health compared to other counties. If so, investing grant funds in strategies that address the underlying causes of poor health will be essential for improving community health. The purpose of this study, therefore, is to examine the social and economic determinants of health in communities where HLFs have been established. Findings from this analysis may help inform HLFs and policymakers about the types of grantmaking interventions that have the greatest potential to improve community health and wellness.

To this end, the first section of this paper will review the literature about HLFs and describe multiple socioeconomic, demographic, and other access-to-care measures that have been consistently associated with poor health status, behavior, and outcomes (hereinafter referred to generally as *health*). Details about how these specific measures were compared in HLF counties versus non-HLF counties will be discussed in the methods section. The analysis will reveal that, compared to other counties, HLF counties as a group have significantly higher proportions of racial minorities and multiple indicators of poor health, even when controlling for rurality and regionalism. On the other hand, HLF counties have better access to care. Practical implications of these findings will be discussed, along with recommendations for HLF operations and grantmaking. After addressing study limitations, the paper will conclude by advocating for flexibility in policies that stipulate how HLF grant dollars should be expended.

## Literature Review

### Health Legacy Foundations

Mergers and acquisitions of nonprofit healthcare organizations have received abundant attention in the literature, with particular attention paid to the for-profit

acquisition of nonprofit hospitals. Such ownership conversions have fueled debate about the differences between nonprofit and for-profit hospitals and prompted investigations into how hospital conversions affect patients and service delivery. However, few studies have examined the philanthropic foundations that are endowed with conversion proceeds. Federal and most state laws require that proceeds from the sale of nonprofit healthcare organizations must go to a private foundation, public charity, or governmental entity (Horwitz, 2007; Miller, 1997; Standish, 1998). The most common result of a hospital conversion is the endowment of a completely new foundation, though funds may benefit an existing nonprofit organization or municipal health district (Kane, 1997; Standish, 1998).

The umbrella term *health legacy foundations* encompass all philanthropic entities endowed with proceeds from the sale of nonprofit hospitals, health systems, health plans, and specialty care facilities. The latest census of HLFs (Niggel & Brandon, 2014) identifies 306 foundations, 251 of which have been formed from transactions involving hospitals and/or health systems. Grantmakers In Health, an organization devoted to assisting foundations and others that award health-related grants, has also published multiple reports about HLFs (e.g., 2002, 2005, 2007, 2009). For the purposes of this paper, the definition of *health legacy foundation* is derived from Grantmakers In Health's definition (2007, p. iii). The amended definition includes only foundations formed from nonprofit hospitals and health systems and adds a reference to government affiliates:

Foundations formed from hospital and health system conversions, to include foundations created when nonprofit hospitals convert to for-profit status; foundations created when nonprofit hospitals 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 *and government affiliates* that receive

additional assets from the sale or conversion of a nonprofit hospital or health system.

Among the limited number of articles that address HLFs, most review the legal underpinnings related to the preservation of charitable assets (e.g., Frost, 2002; Horwitz, 2002; Standish, 1998). At least two legal doctrines provide a framework to guide the philanthropic pursuits of HLFs (Isaacs, Beatrice, & Carr, 1997). First, the *charitable trust* doctrine requires that nonprofit assets must always be dedicated to the charitable purpose for which a nonprofit organization was originally established. Second, if the original purpose cannot be fulfilled, proceeds resulting from the sale of a nonprofit entity should serve a purpose as close as possible to the mission of the original charity, in accordance with the *cy pres* doctrine (Isaacs, Beatrice, & Carr, 1997; Kane, 1997).

Some state officials have opted for a narrow interpretation of these doctrines, requiring that HLFs award grants explicitly for indigent medical services. For example, lawmakers in California—which has 22 HLFs formed from hospitals, the most of any state (Niggel & Brandon, 2014)—argue that funds must be spent on “real healthcare – hospitalization, physician care to the sick, particularly indigents” (Jaffe & Langley, 1996). Nebraska also enacted legislation that requires hospital conversion proceeds to be used for the provision of charitable healthcare (U.S. General Accounting Office, 1997). Some consumer advocates support this stance. Consumers Union developed draft legislation to assist states in adopting their own conversion statutes. This model Nonprofit Conversion Act calls for an HLF’s mission statement to be as close as possible to the converting hospital’s mission (2007).

However, such narrow legal applications do not take into account the underlying social factors that influence health in HLF communities. In fact, no studies have

examined HLF communities as a group to identify shared health factors. At a minimum, federal- and state-level efforts to regulate how HLFs should distribute conversion proceeds should consider whether HLF communities overall are characterized by specific health-related needs. Indeed, the financial dire straits that often spawn hospital conversions may indicate poor socioeconomic status (SES); thus, a closer examination of social determinants of health in HLF communities is warranted. If HLF communities as a group have poor social and economic determinants of health, awarding grant funds solely for indigent medical services will not represent the most effective means of improving health in communities where HLFs have been established.

#### Social Determinants of Health

Evidence increasingly suggests that social and economic variables influence health more so than other factors, including clinical care. Frieden's (2010) Health Impact Pyramid places SES factors at the base of the pyramid, suggesting that poverty reduction, improved education, and similar interventions have the greatest potential impact on population-level health. The County Health Rankings model (University of Wisconsin 2013), which ranks all U.S. counties according to health factors and outcomes, assigns the most weight to social and economic factors. Similarly, Tarlov (1999) describes the relative influence of five major determinant categories of population health, with social/societal characteristics exerting the greatest influence. In another study, 87% of primary care physicians were reported to believe that unmet social needs lead to poor health for all Americans (Fenton, 2011). Pickett and Pearl (2001) reviewed 25 multilevel studies of how community social characteristics affect health, and in 23 of the studies, at least one measure of community-level SES was found to have a statistically significant

effect on mortality, morbidity, and health behaviors. Numerous other studies describe the varied and complex pathways to poor health and conclude that socioeconomic interventions have the best potential for improvements in population-level health (Adler, Boyce, Chesney, Folkman, & Syme, 1993; Centers for Disease Control and Prevention [CDC], 2011; Gornick, 2002; Jia, Moriarty, & Kanarek, 2009; Marmot & Wilkinson, 2008; Muennig, Fiscella, Tancredi, & Franks, 2010; Robert Wood Johnson Foundation, 2008; Starfield, 2007; U.S. Department of Health and Human Services [HHS], Healthy People 2020, 2013).

Socioeconomic determinants. Although there is debate about the specific mechanisms by which social factors influence health, several social determinants have been consistently identified as strongly related to poor health. Among the well-documented SES measures are unemployment, poverty, low social support, and low education (CDC, 2011; University of Wisconsin, 2013; HHS, Healthy People 2020, 2013; Janlert & Hammerstram, 2009; Lantz & Pritchard, 2010; Mansfield, Wilson, Kobrinski, & Mitchell, 1999; Marmot & Wilkinson, 2008; Muennig et al., 2010; Parrish, 2010; Robert Wood Johnson Foundation, 2008; Shavers, 2007; Winkleby, Jatulis, Frank, & Fortmann, 1992). At both the community and individual level, these indicators are highly interrelated and have multiple pathways to poor health (Ahern, Galea, Hubbard, & Karpati, 2008; Marmot & Wilkinson, 2008). For example, communities with higher unemployment are associated with fewer educational opportunities and a less qualified workforce. Communities with chronic economic distress have lower rates of social cohesion and higher rates of poverty, violence, and many health risk behaviors, such as smoking and excessive drinking (Marmot & Wilkinson, 2008). At the individual level,

causal pathways between unemployment and poor health include stress, material deprivation, loss of control, low self-esteem, loss of identity and purpose, and lack of social support, to name a few (Janlert & Hammarstrom, 2009; Marmot & Wilkinson, 2008). Social isolation and decreased purchasing power for adequate housing, nutritious meals, and good hygiene exacerbate social marginalization. The loss of social support is associated with depression, anxiety, and hostility and can be especially detrimental to single parents, who already lack the practical and emotional support spouses can provide (Marmot & Wilkinson, 2008).

Sociodemographic determinants. Not only can demographics amplify these social effects on health, but they can also act as independent correlates of poor health (Marmot & Wilkinson, 2008; Robert Wood Johnson Foundation, 2008). Among the demographic groups consistently identified as vulnerable to poor health are racial and ethnic minorities, older adults, and individuals living in rural areas (CDC, 2011, 2013; HHS, Healthy People 2020, 2013; Marmot & Wilkinson, 2008; Muennig et al., 2010; Robert Wood Johnson Foundation, 2008). First, at the population level, a higher proportion of racial and ethnic minorities in a community is associated with higher rates of poverty and underuse of healthcare services (Marmot & Wilkinson, 2008; Robert Wood Johnson Foundation, 2008). Poor health status and premature mortality are most common among non-Hispanic Blacks (CDC, 2013; Mansfield et al., 1999; Muennig et al., 2010). With a long history of oppression and exclusion from education, employment, and property ownership in the U.S., Blacks also have the highest rates of social inequality, inadequate housing, and female-headed households (CDC, 2013; Marmot & Wilkinson, 2008; Robert Wood Johnson Foundation, 2008). Aging also has independent and joint effects

on health. The link between advanced age and declining health is a given among all populations, and older minorities are a particularly disadvantaged population (HHS, Healthy People 2020, 2013). Pathways between aging and poor health not only include decreases in physical and cognitive function but also SES inequalities. The psychosocial effects associated with declines in mobility, loss of control, and perceived lower social status can be especially detrimental to the health, function, and quality of life of older adults (HHS, Healthy People 2020, 2013; Marmot & Wilkinson, 2008). Finally, rurality has been well documented as a powerful demographic determinant of health. Pathways between rurality and poor health include real and perceived isolation, income inequality, and increased risk-taking behaviors (Blakely, Lochner, & Kawachi, 2002; Eberhardt et al., 2001; Hartley, 2004). By far the most notable barrier to care among rural communities is their limited access to healthcare services (Gornick, 2002; Hartley, 2004).

Access to care determinants. Access to care is closely related to social, economic, and demographic variables. Three community-level indicators of access that have been consistently associated with poor health are uninsurance, physician supply, and ambulatory care sensitive conditions (ACSC). A major health risk, the lack of health insurance is associated with a significant reduction in quality-adjusted life years (Muennig et al., 2010), unmet medical needs (Ayanian et al., 2000; HHS, Healthy People 2020, 2013), delays in receiving care (HHS, Healthy People 2020, 2013), and medical injuries resulting from substandard medical care (Burstin, Lipsitz & Brennan, 1992). At the population level, lower revenues generated by communities with high uninsured rates result in less access to primary care, specialty services, and hospital care (Institute of Medicine, 2003). Communities with fewer service providers experience negative effects

on physical and mental health status, prevention of disease and disability, quality of life, and premature death (Gornick, 2002; HHS, Healthy People 2020, 2013). A poor provision of ambulatory care is also associated with increased preventable hospitalizations, captured by the ACSC rate (Brown et al., 2001). Furthermore, high ACSC rates are associated with poor patient compliance, patient delay in seeking care, unobserved disease progression, and delay in treatment (Brown et al., 2001).

In light of abundant evidence that social factors influence health and healthcare, findings about community-level determinants of health should be used to prioritize and develop strategies aimed at improving health. This study will examine whether HLF communities as a group are characterized by social determinants that render them more vulnerable to poor health compared to non-HLF counties. If HLF counties are more disadvantaged, then focusing HLF resources on underlying health determinants would potentially yield the greatest improvements in community health.

## Methods

### Data Sources

Two data sources were used for this study. First, Niggel & Brandon's (2014) recently developed database of HLFs was queried to obtain a subset of foundations that were developed from hospitals and health systems. The database includes information on 251 HLFs developed from the sale, merger, lease, or other corporate restructuring of nonprofit hospital or health system assets. The second source of data used was County Health Rankings & Roadmaps (CHR; University of Wisconsin, 2013). Although CHR employs a model of population health to rank the overall health of every county, this data source was used only to obtain county-level data for the nation's 3,140 counties and

similar jurisdictions. Original sources pertaining to each variable selected for this analysis are provided in Appendix A, along with additional methodological details.

### Variables

As described in the literature review, a number of indicators are consistently revealed as significantly associated with health vulnerability. The strongest indicators of poor population health include unemployment, poverty, minimal social support, low educational attainment, percent age 65 and older, percent Black, percent rural, and limited access to healthcare. Based on these findings, twelve health determinant variables were selected for this analysis. SES measures included unemployment, child poverty, single-parent homes, and high school graduation. Demographic variables included in this analysis are the percent of the population age 65 and over, percent Black, percent not proficient in English, and rurality. Limited access to healthcare was measured using four variables: percent uninsured, ACSC rate, and the rate of primary care physicians and dentists per population in a county.

### Analysis

The units of analysis were counties and similar jurisdictions, referred to simply as *counties* for the purposes of this paper. These geographic units also include parishes, boroughs, and cities in the Commonwealth of Virginia that have been incorporated independently of counties. These counties and geographic equivalents represent approximations of the converting nonprofit hospital service areas. Dummy variables were used to designate HLF counties (1/0) in the dataset. Codes were also assigned to each state to designate corresponding Census divisions. A list of states by the nine U.S. Census divisions is provided in Appendix A.

Measures for each of the social, economic, demographic, and access-to-care indicators were used to compare health determinants in counties where HLFs have been established or are headquartered (HLF counties) versus counties where no HLFs have been established (non-HLF counties). The 251 HLFs are located in 180 different counties and similar jurisdictions within 38 states across the U.S. Only counties located within these 38 states were used for comparisons. Eliminating states where no HLFs have been established creates a more homogenous comparison group for HLFs. Moreover, it also avoids bias that may be introduced by including locations that may uniquely differ from those in which HLFs have been established. For example, some state laws or regulations may render the sale of nonprofit hospitals to private investors prohibitively difficult. After excluding the states in which no HLFs have been established, the total number of counties retained in this analysis was 2,731, representing 87.0% of all US counties and similar jurisdictions. This number includes 180 HLF counties and 2,551 non-HLF counties.

Health determinant measures are provided as overall rates (unadjusted) and stratified by rurality (adjusted). Data were stratified by rurality for two reasons. First, rurality is associated with many other determinants of health, such as access to care, and could potentially confound comparisons between HLF and non-HLF counties. Second, HLF and non-HLF counties differ notably in terms of the percentage of the population that is rural. Thus, controlling for rurality is important to ensure that differences in health factors are not attributable to rurality.

The conceptualization for *rurality* was based on the U.S. Census Bureau's population estimates, which employ measures of rurality by calculating the percentage of

each county's population that lives in a rural area. According to the Census definition, *rural* encompasses populations, housing, and territories that are not included in *urban* areas, which either (1) have 50,000 or more people, or (2) have an urban cluster of between 2,500 and 50,000 people (U.S. Census Bureau, 2010). For the purposes of this study, the percentage of each county's population that lives in a rural area was divided into thirds to create three strata: *urban* counties that are less than or equal to 33.3% rural, *suburban* counties that are between 33.4% and 66.6% rural, and *rural* counties that are at least 66.7% rural. To control for regionalism, county-level measures were also compared to other counties within their respective Census divisions and within their respective states.

Median, mean, and standard deviation are reported for each indicator. For variables with normal distributions, two-sample *t*-tests were used to test for statistically significant differences between HLF and non-HLF counties. For variables with skewed distributions, the Mann-Whitney two-sample rank sum test was used. Also known as the Wilcoxon ranks sum test, this non-parametric test compares entire distributions rather than a single parameter, such as the median (Acock, 2010). All analyses were conducted using Stata® SE version 11.2.

## Results

### Health Legacy Foundations

Number and location. A total of 251 HLFs endowed with proceeds from hospitals and health systems were located in 180 different counties across the nation. Twenty-two (22) counties had two HLFs, and sixteen counties had three or more HLFs. As the map in Figure 3 reveals, HLFs were concentrated in the South ( $n = 116$ ; 46.2%). More than one

quarter of all HLFs were located in a single Census division, the South Atlantic ( $n = 66$ ; 26.3%). In fact, two Southern states, Florida and Virginia, each had 20 HLFs. The division with the second greatest concentration was the East North Central, with 41 HLFs (16.3%). Except for California, which was home to the greatest number of HLFs formed from hospitals ( $n = 22$ ), the West was largely devoid of these foundations.

**Assets.** Combined assets of all HLFs formed from hospitals totaled \$16.8 billion in 2010, with median assets of \$31.4 million and mean assets of \$66.7 million per HLF. Among HLFs reporting total assets in 2010, asset size ranged from \$6,072 at the St. Joseph's Community Health Foundation in Ward, North Dakota, to \$1.3 billion at the Colorado Health Foundation in Denver, Colorado. As shown in Figure 4, asset size varied notably by location. Not only did the South Atlantic division have the greatest number of HLFs, but it also held the highest combined assets, \$3.72 billion. With only ten HLFs, the Mountain division held \$2.26 billion in assets in 2010. The division with highest mean and median assets in 2010 was the Mountain division ( $M = \$226$  million; median = \$78.2 million), followed by West South Central ( $M = \$101$  million; median = \$46.7 million). At the state level, Colorado had the highest total assets (\$2.0 billion), followed by Texas and Virginia, with \$1.69 billion and \$1.30 billion, respectively.

**Grantmaking.** Across the nation HLFs formed from hospitals awarded a combined total of \$789 million in grants and other distributions in 2010, with an average payout of \$3.14 million per foundation and a median payout of \$1.18 million. As shown in Figure 5, grant dollar amounts varied notably by geographic area. South Atlantic states awarded the most grant funding in 2010, a total of \$147.8 million. At the state level, Colorado paid the highest total amount in grants, \$139 million, followed by California and Texas, which

awarded \$116 million and \$63.0 million, respectively. Colorado's mean payout of \$23.2 million was substantially higher than that of HLFs in other states, primarily due to The Colorado Health Foundation, which awarded \$95.9 million in 2010 to nonprofit organizations throughout the state.

#### Health Determinants in HLF Counties

Socioeconomic and demographic indicators. As shown in Table 4, seven SES and demographic variables known to influence health were compared in HLF counties versus non-HLF counties, with results stratified into rural thirds. Of 180 total HLF counties, 137 (76%) were mostly urban, 30 (16.7%) suburban, and thirteen (7.2%) rural. In contrast, non-HLF counties ( $n = 2,551$ ) were significantly more rural. The mean percent rural in a non-HLF county was 60.9% (median = 61.8%), compared to 20.6% rural (median = 11.4%) in an HLF county.

Overall, HLF counties were significantly more vulnerable to poor health as indicated by percent of children living in single-parent homes ( $p < 0.001$ ), average freshman graduation rate ( $p = 0.003$ ), proportion of the population that is Black ( $p < 0.001$ ), and proportion of the population that is not proficient in English ( $p < 0.001$ ). The most striking differences between HLF and non-HLF counties were seen in the proportion of minorities and the percentage of single-parent homes. Across the nation, the median proportion of Blacks in HLF counties was 10.9%, compared to 2.6% in non-HLF communities. After adjusting for rurality, highly significant differences remained in the proportion of Blacks in urban ( $p < 0.001$ ), suburban ( $p < 0.001$ ), and rural ( $p = 0.003$ ) communities. HLF counties also had significantly higher proportions of the population that were not proficient in English, with a median of 1.9% in HLF counties versus 0.8%

in non-HLF counties; adjusted rates remained significantly higher in both urban ( $p = 0.067$ ) and suburban communities ( $p = 0.051$ ). In addition, unadjusted rates of single-parent homes in HLF counties were significantly higher than non-HLF counties ( $p < 0.001$ ), as were rates within all strata of rurality [urban ( $p = 0.039$ ), suburban ( $p < 0.001$ ), and rural ( $p = 0.010$ )].

Overall, HLF counties also had significantly lower rates of high school graduation ( $p = 0.003$ ); adjusted rates were lower across all strata but not statistically significant. Unemployment was higher in HLF counties compared to non-HLF counties and significantly higher among suburban ( $p = 0.073$ ) and rural HLF counties ( $p = 0.079$ ). Although HLF counties also had significantly lower percentages of children living in poverty ( $p = 0.004$ ), differences between HLF and non-HLF counties were largely a function of living in an urban area, where child poverty rates are lowest. In fact, adjusted values revealed that HLF counties had higher rates of child poverty in urban, suburban, and areas, though these differences were not statistically significant.

In contrast to these findings, the age variable indicated that HLF counties were protected against poorer health, given that they had a significantly smaller proportion of the population age 65 and older ( $p < 0.001$ ). Adjusted rates also showed significantly younger populations in suburban ( $p = 0.017$ ) and rural HLF communities ( $p = 0.098$ ).

Division-level analysis. To examine whether differences in SES and demographic measures might be attributable to regional or state-level factors, the analysis was also stratified by Census division and by state (results not shown). In every division except New England, the median percent Black and the median percent not English proficient were significantly higher among HLF counties compared to non-HLF counties within the

same division. HLF counties were also significantly more urban. However, among suburban and rural HLF counties, 72.1% were located in the South. Moreover, nearly all rural HLF counties (84.6%) were located in one of two southern Census divisions, South Atlantic or East South Central.

State-level analysis. State-level analyses were limited by the small number of HLFs within most states. Nonetheless, several notable differences emerged when comparing HLF to non-HLF counties within the same state. First, the percent Black was higher for HLF counties in all states except two, Alabama and Mississippi; in eighteen states, differences were statistically significant. Second, the median percent not proficient in English was significantly higher among HLFs in most states. Third, the state whose HLF counties had the greatest vulnerability to poor health compared to non-HLF counties was Virginia. HLF counties in Virginia had significantly higher rates of unemployment, higher rates of single parent homes, higher proportions of Blacks, and lower educational attainment compared to non-HLF counties. Furthermore, Virginia was the only state in which HLF counties had significantly higher child poverty rates compared to non-HLF counties.

Indicators of access to care. In contrast to the poorer SES and demographic determinants of health seen in HLF counties, healthcare access measures were significantly better in HLF counties compared to non-HLF counties across all four indicators (Table 5). HLF counties had a lower proportion of uninsured individuals ( $p < 0.001$ ), a lower rate of preventable hospitalizations ( $p < 0.001$ ), and higher rates of primary care physicians ( $p < 0.001$ ) and dentists ( $p < 0.001$ ) per population.

After adjusting for rurality, most of these differences remained statistically significant. The uninsured rate was lower in urban HLF counties and significantly lower in rural HLF counties ( $p = 0.095$ ). A measure of preventable hospitalization, the ACSC rate in urban HLF counties (median = 61.2 per 1,000 Medicare enrollees) was significantly lower compared to the ACSC rate in urban non-HLF counties (median = 66.1,  $p = 0.003$ ). The rate of primary care physicians per population was significantly higher in both urban ( $p < 0.001$ ) and rural ( $p = 0.034$ ) HLF counties compared to their urban and rural non-HLF counterparts. Urban ( $p < 0.001$ ) and suburban ( $p = 0.057$ ) HLF counties also had significantly more dentists per population. Only one adjusted value indicated significantly poorer access to healthcare among HLF counties as compared to non-HLF counties: the rural ACSC rate. The median ACSC rate was 94.4 per 1,000 Medicare enrollees in rural HLF counties, compared to 81.0 in rural non-HLF counties ( $p = 0.064$ ).

Division-level analysis. HLF counties had better access to healthcare compared to non-HLF counties within the same Census division (results not shown). HLF counties had a lower average rate of uninsured in eight out of nine Census divisions and a lower median ACSC rate in every division except New England. The sharpest contrast in access to care between HLF versus non-HLF counties at the division level was seen in the rate of healthcare providers per population. Except for the New England and Mountain divisions, all Census divisions showed significantly higher median primary care physician rates among HLF counties compared to non-HLF counties. In every division except New England, HLF counties had significantly higher median rates of dentists per population.

State-level analysis. Overall, HLF counties also had better access to care compared to non-HLF counties within the same state. In 32 of the 38 states analyzed, HLF counties had lower rates of uninsured. Only in one state, Illinois, was the rate of uninsured significantly higher in HLF counties compared to their non-HLF counterparts ( $p = 0.07$ ). State-level ACSC rates were also better for HLF versus non-HLF counties in 26 states. Rates of primary care physicians and dentists per population were higher in every state except Alaska and Rhode Island, both of which have only one HLF. Provider rates were significantly higher for HLF counties in most states.

### Discussion

This study is one of the few that discusses HLFs and the only quantitative study to date that matches HLFs with socioeconomic indicators of relative community need. Uncovering determinants of health that characterize HLF counties helps to identify grantmaking opportunities to improve health and well-being and underscores the great potential of HLFs as local sources of philanthropic funding to reduce health disparities. Compared to other counties, HLF counties have significantly higher proportions of racial minorities and multiple SES indicators of poor health, even when controlling for rurality and regionalism. On the other hand, HLF counties have better access to care. The following discussion will explore practical implications of these findings and offer examples of promising HLF strategies that address social determinants of health.

#### Pathways to Poor Health and Health Disparities in HLF Communities

The high proportion of minority populations in HLF counties indicates an opportunity for HLFs to address issues related to race and ethnicity that may lead to health disparities. Although this study did not examine health conditions or the provision

of medical services within HLF communities, racial health disparities are well established in the literature. Black Americans have a disproportionately higher prevalence of the following health conditions or outcomes compared to other racial or ethnic populations: infant mortality, teenage pregnancy, asthma, hypertension, smoking and tobacco use, overweight and obesity, high cholesterol, poor nutrition, physical inactivity, influenza, HIV/AIDS, and tuberculosis (CDC, 2013). In many instances, disparities between Black and White Americans are startling. For example, in 2006, the rate of infant mortality for infants of Black mothers was twice the rate of infants born to White mothers (CDC, 2013). Furthermore, racial disparities are evident in nearly every facet of health and healthcare, including SES factors, health risk behaviors, the physical environment, and measures of access, morbidity, and mortality. Even in HLF communities with high physician-to-population ratios, disparities may exist in healthcare services because Blacks are less likely to trust healthcare providers (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003) and are more likely to live in communities that have low-quality providers and hospitals (Baicker, Chandra, & Skinner, 2005). People with limited English proficiency are also less likely to seek healthcare and are more likely to receive poorer quality of care (Youdelman, 2008).

Findings from this study suggest that HLFs targeting the causal pathways between race and poor health may be most effective in improving population-level health. Not only do HLF counties have higher proportions of Blacks and people with limited English proficiency, but they are also characterized by indicators of poor SES, including high rates of single-parent homes, school dropout, and unemployment. Such SES factors play a critical role in determining health among racial and ethnic groups. In their seminal text

about social determinants of health, Marmot and Wilkinson (2008) discuss complex patterns of racial inequalities, which are influenced by socioeconomic, environmental, behavioral, cultural, psychological, genetic, and various combinations of these factors. Strategies that target underlying barriers to health for disadvantaged populations have potential to improve overall community health and minority health, in particular.

HLFs are well positioned to implement such strategies. As locally governed nonprofit organizations, HLFs are less restricted than governmental entities in their ability to respond to changing community needs. While the redistributive nature of public policies addressing social determinants of health can be controversial, a community-based, philanthropic organization is well suited to distribute charitable assets in a manner that most efficiently and effectively responds to local health needs. Furthermore, most HLFs are located in the South, a region with historically poor SES and racial health disparities. The new infusion of charitable wealth provided by HLFs may offer new hope to many chronically distressed communities in the region, which is home to the greatest concentration of Blacks (CDC, 2013) and the highest concentration of poverty (Holt, 2007). Rural HLF communities, which are also concentrated in southern states, may stand to benefit the most from strategies targeting social determinants of health. The amount of grant awards and the geographic restrictions for HLF payout boost communities' potential to address underlying causes of poor health.

#### Recommendations for HLF Practice

In light of their potential for impact and in light of evidence that socioeconomic interventions have the greatest potential to impact population health (e.g., Frieden, 2010; Mansfield et al., 1999; Muennig et al., 2010), this study's findings have direct

implications for HLF leadership, planning, and grantmaking strategies. This analysis also provides new insight into the role of healthcare access in HLF communities.

**Leadership.** An HLF's responsiveness to community health needs begins with its leadership. As the National Committee for Responsive Philanthropy succinctly states, "Change can only happen when everyone who is affected has a seat at the table and has an opportunity to speak" (<http://www.ncrp.org/about-us>). To engage disadvantaged populations and devise effective strategies for achieving health equity, the governing board of directors and executive staff of HLFs must be representative of the communities they serve. Minority representation is especially critical. Compared to other counties, HLF counties have higher proportions of Blacks and people with limited English proficiency. In spite of these demographic characteristics, the composition of HLF boards is predominantly White. In fact, in a 2006 survey, Grantmakers In Health found that 28% of HLFs had no minority board members. Furthermore, while some foundations use community advisory committees to help connect with and identify needs of the local community, only about one quarter of HLFs surveyed used such a committee (Grantmakers In Health, 2007). Greater minority representation among HLF leadership and other decision-makers would demonstrate the foundation's commitment to empowering historically underrepresented populations, a crucial step toward eliminating racial and ethnic disparities in health.

**Planning.** This study's findings also underscore the need for HLFs to conduct community health needs assessments that go beyond measures of health behavior, status, and outcomes to incorporate measures of socioeconomic influences on health. Because health needs assessments can play a pivotal role in improving health and healthcare, the

ACA now requires that nonprofit hospitals conduct these assessments at least every three years (U.S. Department of the Treasury, 2013). However, the ACA does not require that information about social determinants of health be collected (Rosenbaum & Margulies, 2011). HLFs can ensure that health needs assessments address a broad array of socioeconomic and other factors that influence health, regardless of whether a nonprofit hospital remains in an HLF community after conversion. For communities in which the sole nonprofit hospital converts, an HLF can assume responsibility for conducting a broad health needs assessment. If there is a remaining nonprofit hospital in the community, then the HLF could collaborate in conducting the needs assessment, ensuring that data are collected on a wide range of health determinants. Careful assessment of health indicators among racial minorities and other populations that are vulnerable to poor health would be especially important for identifying and monitoring health disparities.

It should not be taken for granted that HLFs already develop grantmaking plans based on community needs. On the contrary, Grantmakers In Health (2007) found that less than half of HLFs surveyed used a community needs assessment in their planning, and only two of those foundations had adopted bylaws that required them to perform needs assessments. Furthermore, only 37.5% of HLFs conducted community forums or focus groups when developing their program focus (Grantmakers In Health, 1999). Just as nonprofit hospitals are now required to assess community needs and respond accordingly, so should HLFs be required to develop grantmaking strategies based on documented health-related needs.

Obtaining input about health-related challenges and opportunities within the service area is particularly crucial for the design and implementation of grantmaking strategies. HLFs that incorporate findings about community-level SES indicators into their strategic plans would bolster their efforts to achieve better health. Baptist Community Ministries in New Orleans, Louisiana, which dispensed more than \$6 million in 2010 to the greater New Orleans region, is one such HLF that infuses assessment information about economic and community development into its grantmaking plans. Foundation trustees serve on different research teams, such as the public education and workforce literacy teams, that assess needs and identify solutions pertaining to social and economic determinants of health (Baptist Community Ministries, 2005).

Strategic grantmaking. Many HLFs have awarded funding to improve socioeconomic factors in communities where they are established. These foundations offer examples of promising strategies for HLFs and other grantmakers to consider in their pursuit of better community health. One such example is a statewide Fatherhood Engagement Initiative funded by the Sisters of Charity Foundation of South Carolina (n.d.). Targeting single-parent homes, this program strives to reduce negative social and economic consequences associated with father absence. Another example is Oliver's Kitchen, an innovative workforce development program supported by the Advocate Bethany Community Health Fund in Chicago, Illinois (2010). In its first ten years of operation, this program provided nearly 700 individuals in Chicago's West Side with education and training to foster careers in the food services industry. The J. Marion Sims Foundation (2008) in Lancaster, South Carolina, offers another model for HLFs to potentially replicate. Its Adult Literacy and Basic Skills Initiative seeks improved

performance in the workplace, better interaction between healthcare providers and patients, increased language skills among individuals with limited English proficiency, and a stronger educational environment in the home. In addition, both the Assisi Foundation of Memphis, Tennessee (n.d.), and the Sisters of Charity Foundation of Canton, Ohio (n.d.), adopted social justice as a core grantmaking focus area and followed through by funding myriad programs to address root causes of poverty.

Other HLFs have addressed SES factors in their pursuit of healthcare objectives. As part of its long-term strategic initiative to reduce health disparities, the Reach Healthcare Foundation in Merriam, Kansas (n.d.), supports efforts to increase cultural competency among providers of health and human services. To address minority health needs even more directly, the Healthcare Foundation of New Jersey (n.d.) funds a nurse-managed health home in a low-income, predominantly Black housing cluster. In Columbia, Maryland, The Horizon Foundation (n.d.) works with the local health department to ensure that undocumented residents receive affordable prenatal care. Geographic patterns of emergency room use are also monitored to improve effectiveness of outreach to vulnerable populations. Through its Safety Net initiative, the Health Care Foundation of Greater Kansas City (n.d.) promotes the integration of medical and social service providers. Extensive referral and case management services are funded to connect a variety of organizations that serve disadvantaged area residents.

Increasing access to healthcare. Most of these and other community-based strategies aimed at achieving better health target one of the most fundamental determinants of health: healthcare access. In contrast to findings about SES and demographic indicators of health, this study revealed that access to healthcare is better in

HLF counties compared to non-HLF counties. Without examining changes in access to care over time, it is difficult to speculate why indicators of healthcare access are better in HLF counties. However, several possible explanations merit mention. First, better access to healthcare in HLF communities may indicate that hospital buyers selected facilities in locations where existing healthcare infrastructure was sound. Serving communities with higher proportions of insured residents, for example, would more likely result in payment for services rendered. A second possibility is that improvements in healthcare access came about post-conversion. For example, the new hospital owners may have altered the location of services and providers upon converting the nonprofit hospital. Similarly, HLF grantmaking efforts may have resulted in lower rates of preventable hospitalizations.

In spite of finding that HLF counties are better insured, have more primary care physicians and dentists per population, and have a lower rate of ACSC, HLFs should include access to healthcare among their strategic priorities for several reasons. First, although this study analyzed the most commonly used indicators of healthcare access, many other factors signify the ability and willingness to access care. For example, awareness of historic transgressions in medicine against Blacks—such as the Tuskegee syphilis trial and experimentation on slaves—has led to distrust of physicians and less participation in clinical trials among Blacks (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003). Limited transportation is also well documented as impeding access to care (Arcury, Preisser, Gesler, & Powers, 2005; Syed, Gerber & Sharp, 2013). Greater understanding of the specific barriers to healthcare access would enable HLFs to tailor grantmaking strategies so that community needs are best addressed. Second, although most HLFs are located in urban areas, HLFs in rural and suburban areas have substantially less access to

healthcare compared to urban HLF counties across all four measures of access. Concentrated in the South, rural HLF communities are especially in need of better access to care. For example, the median ACSC rate in rural HLF counties was 94.4 per 1,000 Medicare enrollees, compared to 61.2 in urban HLF counties. Third, many HLFs have worked since their inception to improve access to healthcare, and their effectiveness may be reflected in current indicators of access, particularly rates of preventable hospitalizations. Withdrawing HLF support from initiatives that facilitate access may have dire consequences for vulnerable populations.

That said, HLFs that support only medical services for the poor will miss important opportunities to address root causes underlying poor health. Furthermore, better access to healthcare services will not sufficiently reduce health disparities among disadvantaged groups (Adler et al., 1993; Gornick, 2002; Lantz, House, Lepkoski, Williams, Mero, & Chen, 1998; Robert Wood Johnson Foundation, 2008). HLFs striving to ensure a more equitable distribution of health and healthcare should pursue social initiatives, which would not only increase access to medical care but also to safe housing, quality education, stable employment, good nutrition, affordable childcare, supportive social networks, and other necessities that make healthy living possible.

#### Study Limitations and Suggestions for Future Research

Several study limitations must be recognized. In an attempt to create a parsimonious list of health determinants for analysis, only a small subset of social, economic, demographic, and access-to-care variables was examined. In selecting factors that are well established in the literature, variables were chosen from among routinely collected data, such as Census data. Other types of data, such as healthcare utilization,

may be helpful in future studies to understand how HLFs might address social determinants of health. To be sure, investigating the causal pathways from poor SES indicators to poor health would equip grantmakers with more meaningful and useful information. It is also noted that the link between some variables and health is bi-directional. For example, not only can unemployment cause poor health, but poor health also increases the likelihood of unemployment. Whether social circumstances and environment are a cause or effect, they are associated with poorer health conditions (Marmot & Wilkinson, 2008).

Another important limitation is that this study does not compare health status, behavior, or outcomes in HLF versus non-HLF counties. It is possible that such measures could reveal communities to have better or worse overall health than was indicated by their health determinants. However, the scope of this study was narrowed to social determinants of health given (1) the abundant evidence of their influence on population-level health (e.g., Adler et al., 1993; CDC, 2011; Gornick, 2002; Jia, Moriarty, & Kanarek, 2009; Marmot & Wilkinson, 2008; Muennig et al., 2010; Robert Wood Johnson Foundation, 2008) and (2) the potential and suitability of HLFs to implement strategies aimed at the causes of poor health status, behavior, and outcomes. Trends in specific medical conditions may be more effectively addressed by hospital and/or public health interventions rather than by HLFs.

An additional limitation of this study concerns how closely the units of analysis (counties) comprise the people residing in the service areas of the converting hospitals, who most often constitute the beneficiaries of HLF grant dollars. The counties and similar jurisdictions where HLFs have been established may not correspond precisely to

the hospital service areas of the converting nonprofit hospitals. Furthermore, although the use of Census data provides reliable statistics about county-level health determinants, the environment with the greatest influence on health may not be reflected through pre-determined geographic units (Lantz & Pritchard, 2010). Finally, it is noted that aggregate findings do not necessarily correspond to individual communities in this study.

Socioeconomic and demographic characteristics of individual HLF counties also may change over time, and counties with more recently established HLFs may have different needs compared to counties in which conversions occurred long ago. HLFs can best serve their communities by regularly assessing local health-related needs and devising strategies that best address these specific needs.

### Conclusion

The post-health reform surge in hospital mergers and acquisitions is expected to generate many new HLFs in communities across the nation (Niggel & Brandon, 2014). These endowments intensify the need for information about how to use grant funds to achieve the biggest improvements in community health and how to design policy that facilitates these strategies. This study reveals that, compared to non-HLF counties, HLF counties have significantly higher proportions of minorities and multiple SES determinants that render them more vulnerable to health disparities and poor health. While addressing social determinants of health is an important component for all health-related grantmaking, it is especially critical for HLFs given these findings and in light of the community origin of these endowments. Devising strategies that reach beyond the boundaries of medical care provision is essential for improving population health. Furthermore, policies requiring HLFs to expend grant funds strictly for medical purposes

may inhibit progress toward better population health by depriving communities of opportunities to remedy the underlying factors contributing to poor health.

Particularly in the South, the financial struggles that led to the sale of nonprofit hospitals may have been a reflection of poorer socioeconomic conditions in the surrounding community. Hence, with the advent of HLFs, some communities with historically minimal resources have new opportunities to address root causes of poor health conditions. Given their abundant resources and their unique charitable health legacy, HLFs are well positioned to alter the health trajectory for some of the nation's most vulnerable populations.

Table 4: Social, economic and demographic indicators of health in counties with and without health legacy foundations

	UNADJUSTED		ADJUSTED			
	HLF <sup>a</sup> (N = 180)	non-HLF <sup>b</sup> (N = 2,551)	HLF (n = 137)	Urban non-HLF (n = 560)	Suburban HLF (n = 30)	Rural non-HLF (n = 1,134)
Unemployment <sup>c</sup>						
median	8.7	8.6	8.6	8.1	9.5	9.6
mean (SD)	9.0 (2.4)	8.7 (3.0)	8.7 (2.3)	8.5 (3.0)	9.8 (2.4)	10.4 (2.4)
p-values		0.275		0.391	0.073*	0.079*
Child Poverty <sup>c</sup>						
median	23.8	25.0	22.8	21.6	25.5	28.4
mean (SD)	23.5 (8.6)	25.5 (9.0)	22.3 (8.2)	22.0 (8.5)	26.2 (9.4)	29.3 (7.3)
p-values		0.004***		0.615	0.644	0.405
Single Parents <sup>c</sup>						
median	34.4	30.4	33.7	32.0	39.2	36.0
mean (SD)	35.2 (10.4)	31.3 (10.1)	34.3 (10.1)	32.4 (9.2)	38.2 (11.1)	38.1 (11.2)
p-values		<0.001***		0.039**	<0.001***	0.010***
Graduation Rate <sup>c</sup>						
median	81.4	84.3	81.4	82.8	83.0	79.9
mean (SD)	80.3 (8.2)	82.6 (10.2)	80.3 (8.1)	81.4 (8.6)	80.3 (9.7)	80.7 (5.7)
p-values		0.003***		0.189	0.188	0.409
Age 65 and older <sup>c</sup>						
median	13.6	15.9	13.1	13.0	14.6	16.1
mean (SD)	13.9 (3.5)	16.3 (4.2)	13.6 (3.9)	13.4 (3.7)	14.5 (1.7)	16.1 (2.0)
p-values		<0.001***		0.445	0.017**	0.098*
Black <sup>d</sup>						
median	10.9	2.6	9.9	5.8	14.9	6.1
mean (SD)	16.5 (16.1)	9.6 (14.8)	15.5 (15.0)	10.9 (13.5)	20.2 (18.2)	18.0 (21.8)
p-values		<0.001***		<0.001***	<0.001***	0.003***
Not English Proficient <sup>d</sup>						
median	1.9	0.8	2.3	1.9	1.2	0.5
mean (SD)	3.2 (3.7)	1.8 (3.0)	3.9 (4.0)	3.6 (4.4)	1.4 (1.2)	0.8 (0.9)
p-values		<0.001***		0.067*	0.051*	0.956

**Sources:** County Health Rankings (University of Wisconsin, 2013); author's database of health legacy foundations. **Notes:** <sup>a</sup> HLF refers to counties where health legacy foundations have been established. <sup>b</sup> non-HLF refers to counties without health legacy foundations. <sup>c</sup> p-values were calculated for two-group t-tests comparing means. <sup>d</sup> p-values were calculated using Mann-Whitney two-group rank sum tests comparing distributions. \*\*\*p < .01; \*\*p < .05; \*p < .10

Table 5: Access to care indicators in counties with and without health legacy foundations

	UNADJUSTED		ADJUSTED					
	HLF <sup>a</sup> (N=180)	non-HLF <sup>b</sup> (N=2,551)	HLF (n=137)	non-HLF (n=560)	HLF (n=30)	non-HLF (n=857)	HLF (n=13)	non-HLF (n=1,134)
Uninsured <sup>c</sup>								
median	17.5	18.6	16.4	17.3	19.6	17.8	17.5	19.7
mean (SD)	17.5 (5.4)	19.0 (5.4)	17.2 (5.8)	17.7 (5.7)	18.8 (4.1)	18.3 (5.3)	17.9 (2.7)	20.3 (5.2)
p-values		< 0.001***		0.403		0.551		0.095*
ACSC <sup>d,e</sup>								
median	65.0	75.8	61.2	66.1	77.1	79.3	94.4	81.0
mean (SD)	68.3 (20.5)	81.9 (31.6)	62.6 (15.7)	68.5 (20.7)	79.7 (17.1)	81.8 (27.2)	101.1 (30.2)	88.5 (36.7)
p-values		< 0.001***		0.003***		0.967		0.064*
Primary Care <sup>g,f</sup>								
median	7.5	4.9	7.9	6.5	5.2	5.0	5.1	3.8
mean (SD)	7.7 (3.1)	5.3 (3.4)	8.4 (3.1)	7.2 (4.0)	5.9 (2.0)	5.3 (2.7)	5.2 (1.3)	4.3 (3.2)
p-values		< 0.001***		< 0.001***		0.113		0.034**
Dentists <sup>d,g</sup>								
median	5.6	3.2	6.2	5.0	4.0	3.3	3.4	2.3
mean (SD)	5.6 (2.3)	3.5 (2.4)	6.2 (2.2)	5.3 (2.7)	3.9 (1.2)	3.5 (1.6)	3.1 (1.3)	2.7 (2.2)
p-values		< 0.001***		< 0.001***		0.057*		0.139

**Sources:** County Health Rankings (University of Wisconsin, 2013); author's database of health legacy foundations. **Notes:** <sup>a</sup>HLF refers to counties where health legacy foundations have been established. <sup>b</sup>non-HLF refers to counties without health legacy foundations. <sup>c</sup>p-values were calculated for two-group *t*-tests comparing means. <sup>d</sup>p-values were calculated using Mann-Whitney two-group rank sum tests comparing distributions. <sup>e</sup>ACSC refers to the rate of ambulatory care sensitive conditions. These rates reflect the 2010 rate of preventable hospitalizations per 1,000 Medicare enrollees. <sup>f</sup>The primary care physician rate represents the number of primary care physicians per 10,000 people in a county in 2010. <sup>g</sup>The dentist rate represents the number of dentists per 10,000 people in a county in 2010. \*\*\**p* < .01; \*\**p* < .05; \**p* < .10

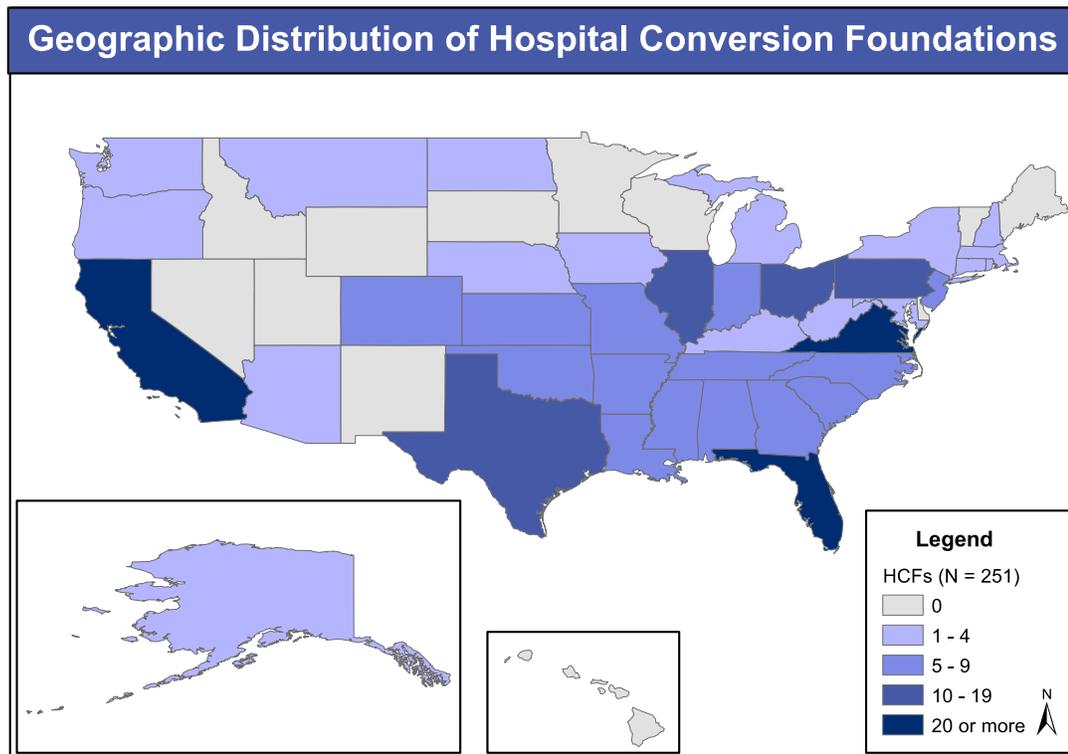


Figure 3: Location of health legacy foundations originating from nonprofit hospitals and health systems

**Source:** Author's database of health legacy foundations.

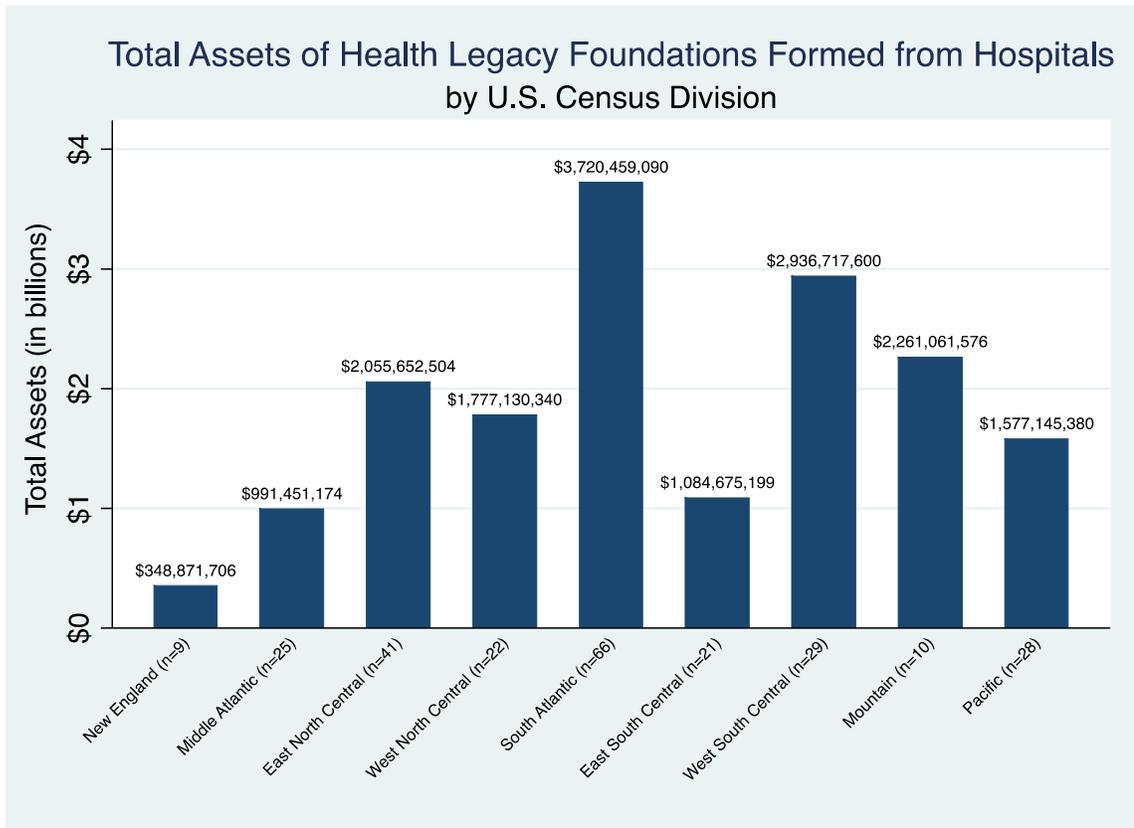


Figure 4: 2010 total assets of health legacy foundations originating from nonprofit hospitals and health systems, by U.S. Census division

**Source:** Author's database of health legacy foundations.

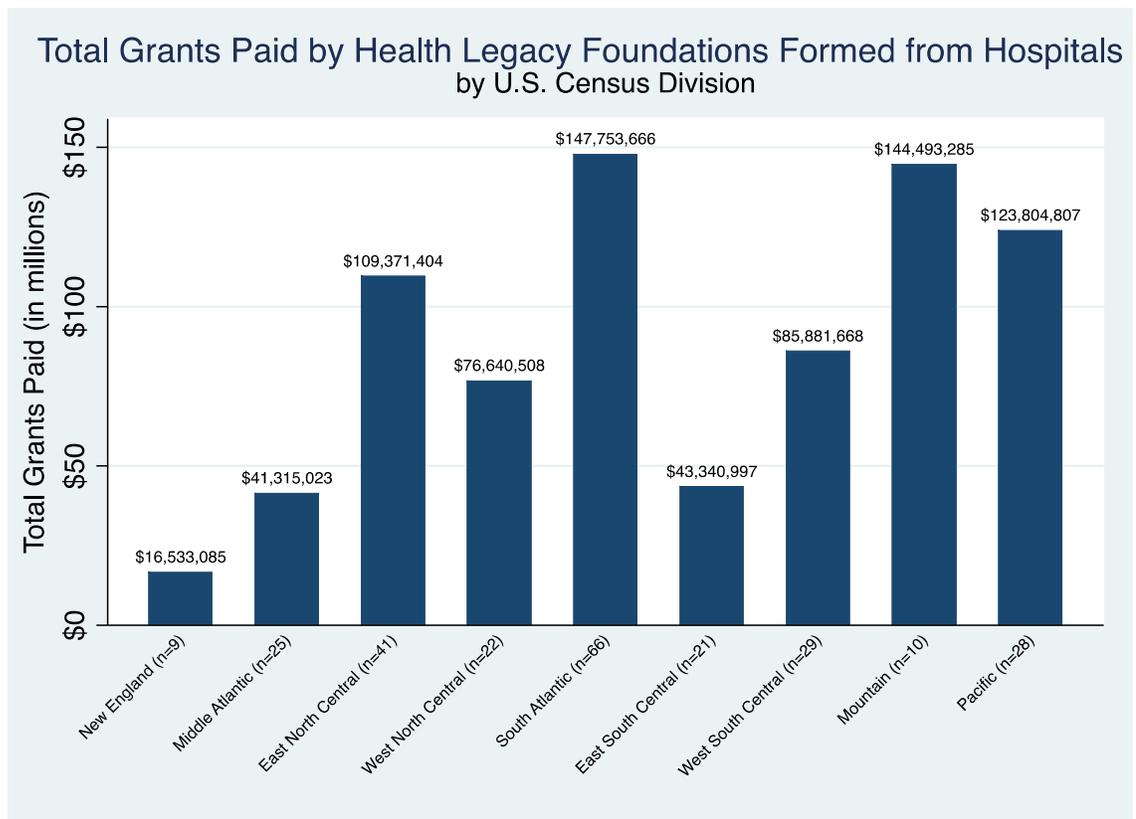


Figure 5: 2010 total grants paid by health legacy foundations originating from nonprofit hospitals and health systems, by U.S. Census division

**Source:** Author's database of health legacy foundations.

## CHAPTER 3: HEALTH LEGACY FOUNDATIONS AND THE PRESERVATION OF NONPROFIT HOSPITAL CHARITABLE HEALTH MISSIONS: PHILANTHROPIC, HEALTH, AND REGULATORY IMPLICATIONS

### Abstract

Healthcare merger and acquisition activity is on the rise, with many nonprofit hospitals selling their assets to for-profit firms. Transaction proceeds will endow many new health legacy foundations (HLFs), which are poised to fill the charitable healthcare void that may be perceived when a community loses its nonprofit hospital. This study explored the charitable health intent of HLFs as revealed through their self-defined missions. Mission statements for 238 HLFs were obtained between 2011 and 2013 from individual HLF websites, tax returns, and grantmaking materials. A qualitative and quantitative content analysis were undertaken to determine how HLFs defined the problems, conditions, or services that grant funding should address, as well as how they identified intended beneficiaries. Although the majority of HLFs adopted an explicit health-related purpose, most depicted health in vague terms. Broadly construed mission statements allow grantmakers the freedom to choose the combination of services and beneficiaries that maximizes utility for their communities. While this flexibility is important for HLFs to address broad health determinants and respond to changing community needs, careful public oversight is critical to ensure that nonprofit healthcare proceeds are strategically redeployed.

## Introduction

Although investor-owned hospitals account for only one in five U.S. hospitals today, the proportion of for-profit hospitals has steadily increased over the past three decades (American Hospital Association, 2011). Much of this shift has occurred as a result of nonprofit hospitals selling their assets to for-profit firms, with such conversions of ownership peaking in the mid to late 1990s. While the pace of conversion activity has since slowed, the passage of healthcare reform legislation in 2010 appears to have rekindled investors' interest in acquiring nonprofit healthcare facilities. The number of hospital deals announced in 2010 rose to 77, the most since 2001 (Irving Levin Associates, 2011a). In 2011, 92 hospital deals were announced, followed by 94 deals in 2012 (Irving Levin Associates, 2013). Some analysts predict that previous records for healthcare mergers and acquisitions will soon be broken, with profit-oriented investors staking sizable new claims in the nonprofit healthcare arena (Fitch Ratings, 2013; Irving Levin Associates, 2011b).

The current wave of conversion activity revives debates about the merits of nonprofit versus for-profit hospital ownership. Scholars have generated a substantial body of research comparing different ownership types, including studies that examine the community-level impact of hospital conversion. Schlesinger and Gray (2006) identified 275 empirical studies that have been undertaken to determine whether one form of ownership may be superior to another. Despite the broad array of variables explored—including quality of care, costs, type of care, charitable services, efficiency, and more—findings were largely inconclusive (Schlesinger & Gray, 2006). These mixed findings can prove particularly frustrating for community stakeholders weighing the pros and cons of

converting their nonprofit hospital. Regardless of empirical evidence, Americans *perceive* nonprofit hospitals to be more fair and humane than their for-profit counterparts (Schlesinger, Mitchell, & Gray, 2004). Indeed, one of the chief concerns with converting a nonprofit hospital to for-profit status is that investors will forgo community benefits in order to maximize profits (Bell, Snyder & Tien, 1997).

Grounded in the economic theories that distinguish nonprofit and for-profit hospitals, this paper contributes new information to the debate about the pros and cons of hospital conversion by drawing attention to *health legacy foundations* (HLFs). Created with proceeds from the sale of nonprofit healthcare organizations, these foundations are poised to fill the charitable healthcare void that may be perceived when a community loses its nonprofit hospital. Because having a charitable mission represents one of the key principles that distinguishes nonprofit hospitals from their for-profit counterparts (Colombo, 2005; Cryan & Gardner, 1999; Drucker, 1990), examining whether this mission will be aborted after conversion of the healthcare facility—or whether another entity will continue the mission—constitutes an important research question. In theory, if an HLF uses sale proceeds to preserve the nonprofit hospital’s legacy, then the community may not experience a void in charitable healthcare, even if a nonprofit hospital converts to for-profit status.

The key question, then, becomes *what do HLFs intend to do with their fortunes?* Surprisingly little research has been conducted to date about HLFs or their grantmaking pursuits. The purpose of this paper, therefore, is to fill this gap in the literature by describing the purpose of HLFs as revealed through their self-defined missions. Although

community advocates point to several legal doctrines<sup>1</sup> to explain why HLFs *should* pursue the same or similar goals as their converting nonprofit hospitals, HLFs need only pursue a mission that is charitable in nature in order to maintain their tax-exempt status under Section 501(c)(3) of the Internal Revenue Code (U.S. Department of the Treasury, 2011). Because they are created with proceeds from the sale of nonprofit hospitals—which may maximize community benefit predominantly through charitable healthcare services—HLFs are expected to pursue a charitable healthcare mission.

To examine HLF mission statements, this paper will first distinguish the economic theories behind nonprofit hospitals (which may seek to maximize community benefits) versus for-profit hospitals (which seek to maximize profits). Because empirical evidence about the effects of nonprofit to for-profit hospital conversion is mixed and inconclusive, information about the role of HLFs can provide new insight into how ownership conversion affects communities. To this end, a qualitative and quantitative content analysis of 238 HLF mission statements (constituting 94.8% of all known HLFs created from hospitals or health systems) is then described. Next, a discussion of findings will specifically address how HLFs define the nature of their grantmaking (i.e., problems, conditions, or services to pursue with grant dollars), how they identify intended beneficiaries of their services, and whether their mission statements reflect an overall intent to preserve the converting nonprofit hospital's legacy of charitable health services

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<sup>1</sup> Several legal doctrines could potentially be used to direct conversion assets, including charitable trust doctrine, *cy pres* doctrine, and common law doctrine and/or state statutes (which authorize state attorneys general to protect assets for the public interest) (Bell, Snyder & Tien, 1997; Shriber, 1997; Standish, 1998). However, the patchwork application of these doctrines is rife with procedural inadequacies and often conflicts with other bodies of law, such as nonprofit corporation codes (Hernandez, 1998; Standish, 1998).

(broadly construed). After addressing limitations of this analysis, the paper will conclude with a discussion of policy implications.

### Literature Review

In the increasingly competitive healthcare arena, lines that separate nonprofit from for-profit hospitals become blurred (Folland, Goodman, & Stano, 2010; Salamon, 2012). Nonetheless, public concern persists with regard to the differing theoretical motives underlying nonprofit versus for-profit ownership. An organization's mission is its reason for existence (Drucker, 1990; Harrell, 2009), and when a nonprofit hospital converts to for-profit status, both its ownership and its mission change. The overarching concern with conversion is that investors will abandon services that maximize community benefit in order to maximize profits. Needleman (1999) notes that critics characterize conversions as the *commercialization of healthcare*, adding that “[t]here is great fear that in a health system dominated by for-profit institutions, nonprofit norms would be replaced by standards that are less protective of patients” (p. 118). To reveal the extent to which such concerns are justified, the following section will discuss the key economic differences between nonprofit and for-profit hospitals and review empirical evidence related to conversion.

#### Theoretical Motives of Nonprofit Versus For-Profit Hospitals

In exchange for pursuing a charitable purpose and adhering to a host of regulatory standards, nonprofit hospitals enjoy special tax advantages—which include federal and state income tax exemption, property tax exemption, and tax-exempt debt financing—that their for-profit counterparts do not (Colombo, 2005; Horwitz, 2003). These privileges are conferred only when nonprofit hospitals work within economic and political constraints

and when they pass the Internal Revenue Service's (IRS) community benefit standard. Perhaps the most significant economic characteristic that distinguishes a nonprofit from a for-profit hospital is the nondistribution constraint (Folland, Goodman, & Stano, 2010). Nonprofit entities are prohibited from distributing profits to individuals or shareholders and instead must reinvest their surpluses to further their charitable missions. As an altruistic entity, nonprofit hospitals may determine the desired combination of quantity and quality of care to be provided based on how to maximize community benefit (Newhouse, 1970; U.S. Department of the Treasury, 2009a).

Despite strict political and economic constraints, the charitable aspect of nonprofit hospitals appears to have received the greatest attention in the debate about conversion. Prior to 1969, a nonprofit hospital could only receive federal tax exemption by providing medical care to indigent patients. IRS Revenue Ruling 56-185 states that a hospital seeking exemption must be "operated to the extent of its financial ability for those not able to pay for the services rendered" (Colombo, 2005, quoting from IRS Rev Rul 56-185, 1956). This ruling was reexamined, however, in the mid-1960s with the advent of Medicare and Medicaid. Interestingly, policymakers expressed concern over whether there would be sufficient need for charity care once public insurance programs became available. In response, in 1969 the IRS introduced a new standard via Revenue Ruling 69-545, which allows for greater flexibility with regard to charity care so that tax-exempt status for hospitals would not be jeopardized (Colombo, 2005). Known as the *community benefit* standard, this approach to determining tax exemption has been a source of great controversy since its inception more than four decades ago. In essence, a nonprofit hospital must show that it benefits the public by promoting the health of the community it

serves (U.S. Department of the Treasury, 1969). This standard has been widely contested because of its openness to interpretation and its lack of a clear focus on charitable healthcare. Hospitals use a variety of factors to indicate how they meet this standard, including providing treatment of Medicaid and Medicare patients and emergency room treatment to indigent patients. Apart from charity care provided through emergency rooms, however, the IRS has not required nonprofit hospitals since 1969 to provide charity care in order to maintain tax-exempt status.<sup>2,3</sup> As stated in Revenue Ruling 69-545, “(i)n the general law of charity, the promotion of health is considered to be a charitable purpose” (U.S. Department of the Treasury, 1969).

Investor-owned hospitals are quick to point out that they, too, engage in activities that fit this description. Many accept publicly insured patients, treat the medically indigent in their emergency rooms, and recruit local board members to represent the community’s interest (Horwitz, 2003; Sloan, 2001). Moreover, for-profit hospitals operate very similarly to nonprofit hospitals: they provide medical care, operate according to many of the same regulations, derive funding from many (though not all) of the same sources, and serve comparable social functions (Horwitz, 2003; Needleman, 1999). Nevertheless, because they are owned by and operated for the benefit of shareholders, their most fundamental obligation is to their private owners. A firm seeking

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<sup>2</sup> Several states, including Texas, Utah, and Pennsylvania, require nonprofit hospitals to meet minimum requirements for charity care expenditures in order to maintain state tax-exemption (Gray & Schlesinger, 2009; Somerville, Nelson, Mueller, & Boddie-Willis, 2013).

<sup>3</sup> The Patient Protection and Affordable Care Act of 2010 (ACA; P.L. 111-148) outlined several new requirements for nonprofit hospitals to maintain federal tax-exemption. These include conducting a community health needs assessment at least every three years, establishing and publicizing written financial assistance policies, and charging uninsured individuals the same rates that are charged to insured individuals. Nonprofit hospitals are now also prohibited from undertaking extraordinary efforts to collect payment from individuals and must determine whether an individual qualifies for financial assistance before pursuing collections actions (Pryor, Rukavina, Hoffman, & Lee, 2010; U.S. Department of Treasury, 2013).

to increase shareholders' return on their investments will naturally be motivated to increase revenues and decrease costs. While nonprofit hospitals have no apparent incentive to reduce public goods, the profit motive provides a clear rationale for investor-owned entities to reduce or eliminate charitable or otherwise unprofitable services (Baumol & Blinder, 1982; Collins, Gray & Hadley, 2001; Cryan & Gardner, 1999).

#### Empirical Evidence from Conversion Studies

In light of these differing theoretical motives, scholars have explored the reasons why a nonprofit hospital converts to for-profit status. The literature offers a variety of explanations, including financial hardship, market incentive structures, excessive regulations, the need to improve efficiency, the need to access capital, and the desire to expand market share (Claxton, Feder, Shactman & Altman, 1997; Collins, Gray & Hadley, 2001; Goddeeris & Weisbrod, 1998; Gray, 1993; Hollis, 1997; Salamon, 2012; Spielman, 2011). Gray and Schlesinger's (2012) life-cycle perspective also describes how U.S. healthcare organizations may fluctuate between the nonprofit and for-profit sectors. Healthcare services in their nascent stages are provided almost totally in the nonprofit sector, through which government and philanthropic support enable the provision of new services to address emerging needs. As private demand increases and services stabilize, insurance coverage develops, and investors become attracted to opportunities to profit. Public policies, such as those expanding insurance coverage, have resulted in rapid growth of the for-profit sector. In the final stage of the life cycle, both nonprofit and for-profit hospitals struggle to adapt to financial pressures, often resulting in consolidations or even exiting the market. Nonprofit ownership may increase in this final stage, particularly if for-profit owners succumb to unethical or fraudulent behavior in their

pursuit of profit. However, nonprofit entities have also been guilty of egregious behavior. Cryan and Gardner (1999) discuss how market forces can foster greed and motivate nonprofits to sell to for-profit firms. They cite instances in which key managers and directors obtained stock options, high salaries, and attractive severance packages as a result of selling nonprofit hospitals to investor-owned entities. In any event, the reasons why a nonprofit hospital converts to for-profit ownership may be varied and complex.

Researchers have also employed a variety of measures to determine the effects of nonprofit to for-profit hospital conversion. Horwitz (2003), for example, examined the type of hospital services provided. As she describes, certain types of services are recognized in the hospital industry as being profitable (such as cardiac catheterization and sports medicine), while other services (such as substance abuse treatment and AIDS clinics) are money-losers and therefore must be provided for the purpose of meeting community needs. She found that for-profit hospitals are most likely to offer profitable services, while nonprofit and government-owned hospitals are most likely to offer unprofitable services. Similarly, Needleman (1999) found that nonprofits tend to offer more services aimed at benefiting the community, including specialized care not covered by insurers. Other studies examined services provided to Medicaid and Medicare patients. Interestingly, both Sloan (2001) and Collins, Gray & Hadley (2001) found that the number of publicly insured patients rises—in some cases dramatically—when nonprofit hospitals convert to for-profit status. Some evidence suggests, however, that these increases have no link to community benefit; rather, fraudulent billing, patient routing and other such wrongful practices were undertaken, apparently to maximize profits (Collins, Gray & Hadley, 2001). Recently filed lawsuits against the for-profit hospital

chain Health Management Associates underscore this point. Whistle-blowers describe the firm's elaborate schemes to inflate Medicare and Medicaid payments by admitting patients that arguably did not require inpatient services (Creswell & Abelson, 2014).

Scholars also examined pre- and post-conversion changes in uncompensated care, which may include true charitable healthcare (i.e., care provided without the expectation of payment), uncollected debt, and budget shortfalls from insurance, government programs, and uninsured patients (U.S. Department of the Treasury, 2009a). Although Young, Desai, and Lukas (1997) found no significant difference before and after hospital conversion when measuring uncompensated care, the internal validity and generalizability of their study is questionable. For example, one of their measures of uncompensated care was bad debt, which is influenced by a number of factors, including variation in collection practices and payer mix. The study's narrow sample—which included only seventeen hospitals, all based in California—is another important limitation. A couple of years later, Young and Desai (1999) reexamined the effects of hospital conversion with improved methodologies (i.e., a larger sample that included 43 conversions in three states and additional measures of community benefit). This time, they found significant variance between hospitals, from a 40% decrease to a 40% increase in uncompensated care. A separate team of investigators examined 431 conversions nationwide and found that on average, nonprofit to for-profit conversion was associated with a 13% reduction in uncompensated care (Thorpe, Florence, & Seiber, 2000). These reductions were accompanied by increases in operating margins, which were primarily due to decreased spending. Taken together, this study's findings may

suggest that investor-owned hospitals do, indeed, seek to maximize profit by reducing community benefit costs.

### The Pursuit of Charitable Healthcare

Overall, findings about the effects of nonprofit to for-profit hospital conversion are inconclusive, particularly with regard to community benefit (Needleman, 1999). Debates about conversion impact are largely unresolved because the concept of *community benefit* has never been clearly defined. Not surprisingly, hospitals have interpreted, measured, and reported community benefit activities in vastly different ways since the standard's inception in 1969.<sup>4</sup> Although the community benefit standard was specifically drafted to encompass more than indigent medical care, charitable healthcare has clearly been the bone of contention. As Havighurst (1996) notes, the biggest concern about a nonprofit hospital converting to for-profit status is that charity care for the poor will suffer: "This is really the crux of the debate about the legitimacy of for-profit hospitals..." (p. 35). Likewise, Craig (2008) states that charitable purpose is "at the center of the community benefits debate" (p. 309). Colombo (2005) further points out that some states have enacted their own legislation to determine whether a nonprofit hospital provides sufficient community benefit to warrant tax privileges at the state level. These states have overwhelmingly focused on charitable healthcare as the defining standard.

Whether this charitable healthcare focus will be lost when a nonprofit hospital converts to for-profit status constitutes an important question, particularly given the flurry

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<sup>4</sup> Beginning with the tax year 2009, tax-exempt hospitals are required to file Schedule H with their IRS Form 990. This form provides greater clarification about what hospitals may and may not count as community benefit activities. However, the American Hospital Association reported that the new form fails to enable hospitals to reliably and accurately report community benefits (Fenwick & Lietz, 2010).

of conversion activity that has taken place since the 2010 enactment of the ACA. Profit maximization theory provides a framework for predicting that, under for-profit ownership, charitable healthcare will be forsaken in order to maximize profits. However, when an HLF is established<sup>5</sup> with conversion proceeds, the nonprofit mission is expected to prevail in a community, as the charitable healthcare purpose is essentially transferred from one nonprofit (the hospital) to another (the HLF). Because of this nonprofit legacy, HLFs are expected to pursue a charitable healthcare mission.

### Methods

A content analysis of HLF mission statements was undertaken to determine whether HLFs articulate a desire to fill the charitable healthcare void that may be created when a community loses its nonprofit hospital. Mission statements are ubiquitous throughout the nonprofit sector and provide a common comparison point for diverse organizations (Stemler, Bebell & Sonnabend, 2011). Adopted by boards of trustees to explain their primary purpose, mission statements provide concise descriptions of how organizations intend to carry out their work (Harrell, 2009; Stemler, Bebell & Sonnabend, 2011; U.S. Department of the Treasury, 2009b). Moreover, HLF mission statements are readily available for public inspection via IRS Form 990s and HLF websites. Although the vast majority of HLFs display their mission statements on their websites, several HLFs do not specifically use the phrase *mission statement*. However, for the purposes of this study, statements that were identified as the HLF's *statement of purpose*, *primary objective*, or some analogous phrase were included in the analysis. Mission statements

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<sup>5</sup> Boards of converting nonprofit hospitals have several endowment options for conversion proceeds. Among the 251 HLFs created from conversions of hospitals and health systems, 125 have endowed public charities (such as community foundations or existing hospital foundations), 122 have endowed private foundations, and four have endowed local governmental entities, such as health districts (Niggel & Brandon, 2014).

were analyzed using both quantitative and qualitative content analysis (Zhang & Wildemouth, 2009).

### Conceptualization

The conceptualization of *health legacy foundation* and *charitable healthcare* was also carefully considered before undertaking the analysis. The definition of *health legacy foundation* was adapted from a definition developed by Grantmakers In Health, an educational organization devoted to assisting foundations that fund health purposes. The definition used in this paper differs from that created by Grantmakers In Health<sup>6</sup> because it focuses only on the narrower subset of HLFs that were formed from hospitals and health systems; a reference to governmental entities that manage conversion proceeds has also been added:

Foundations formed from hospital and health system conversions, to include foundations created when nonprofit hospitals convert to for-profit status; foundations created when nonprofit hospitals 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 and government affiliates that receive additional assets from the sale or conversion of a nonprofit hospital or health system (2007, p. iii).

The conceptualization of *charitable healthcare* was derived from definitions provided by the IRS, which regulates federally tax-exempt nonprofit organizations. Because the promotion of health constitutes a charitable purpose (U.S. Department of the Treasury, 1969), a mission statement indicating that the HLF would address *health*,

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<sup>6</sup> The definition developed by Grantmakers In Health (2007) also includes foundations created from the conversion of other healthcare entities, such as health maintenance organizations and nursing homes. Some of the largest HLFs were endowed from health plans. For example, both The California Healthcare Foundation and The California Endowment (with combined assets valued at more than \$4.3 billion in 2010) were formed in 1996 with the conversion of Blue Cross of California (The California Endowment, 2011; Urban Institute, 2011). These foundations award grants across much larger geographic giving areas. By contrast, this paper focuses only on the conversion of nonprofit hospitals, whose grantmaking is typically limited to the converting hospitals' service areas (Niggel & Brandon, 2014).

*healthcare, medicine, wellness*, or other explicitly health-related words was considered a charitable healthcare mission. Additionally, the IRS interprets *charitable* as "...relief of the poor, the distressed, or the underprivileged," as well as "advancement of religion" (U.S. Department of the Treasury, 2011). Therefore, HLFs were also interpreted as having a charitable healthcare mission if they strived to address the health-related needs of certain target populations (i.e., individuals that are low-income or otherwise vulnerable to poor health, or religious adherents). Finally, missions that explicitly referred to the converting nonprofit hospital's mission were considered as pursuing a charitable healthcare purpose.

#### Census of HLFs

The first step of the analysis entailed developing a subset of HLFs that were created only from nonprofit hospital and health system transactions. This subset was drawn from Niggel and Brandon's (2014) larger database of HLFs that were created from transactions involving all types of nonprofit healthcare organizations. A total of 251 distinct HLFs formed from hospital or health system assets were identified for analysis, a number deemed sufficiently manageable for a census rather than a sample. As the descriptive data in Table 6 show, combined assets held by these HLFs in 2010 totaled \$16.8 billion, with mean assets of \$66.7 million per HLF and median assets of \$31.4 million. Grant awards totaling approximately \$789.1 million<sup>7</sup> were distributed in 2010, with a mean payout of \$3.14 million per foundation and a median payout of \$1.18 million. HLFs were concentrated in southern states, where 116 HLFs (46.2%) held combined assets of \$7.7 billion ( $M = \$66.7$  million per HLF; median = \$33.5 million). Average

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<sup>7</sup> Total payout includes all qualifying distributions as reported on IRS Form 990.

annual payout in 2010 was highest in the West (\$7.1 million awarded per HLF), but the highest median payout (\$1.3 million) was among HLFs in the Midwest.

#### Mission Statement Data

In the second step of the analysis, mission statements for each HLF were sought by searching HLF websites, IRS Form 990s, annual reports, core documents (e.g., articles of incorporation and bylaws), grant application forms, press releases, and regional directories of grantmakers. When nonprofit hospital conversion proceeds were given to an existing community foundation, mission statements that could be found for the specific fund established with conversion proceeds were collected. If sale proceeds were used to endow an entirely new community foundation, the mission statement of the community foundation was documented. Mission statements were collected and recorded between September 2011 and December 2013. A total of 238 mission statements were obtained for analysis, representing 94.8% of all HLFs<sup>8</sup> formed from hospitals and health systems.

#### Qualitative Content Analysis

The third step in the study entailed qualitative content analysis, which allowed inductive insight into the meaning conveyed by mission statements. An initial review of missions revealed two key areas along which HLFs focused their work: (1) the nature of their grantmaking (i.e., problems, conditions, or services that grant awards should address), and (2) the population to benefit from grant awards. Regarding the nature of services, two sorts of HLFs emerged: those that pursued an explicitly health-related mission and those that did not. Among HLFs that pursued a health-related mission, goals

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<sup>8</sup> Most of the HLFs for which mission statements could not be found were small operations that did not maintain a website. Others were newly established and presumably had not yet adopted a mission statement.

emerged along a continuum ranging from vague, broadly defined healthcare purposes to specific, narrowly defined health-related purposes. Words and phrases were explored for common themes and to determine their level of health-related specificity. For example, the phrase *to improve quality of life* would allow HLFs to award grants for a variety of purposes (which may or may not include health), while the phrase *to provide prenatal health services* suggests a narrower, health-related intent.

The next step in the qualitative content analysis involved obtaining input from interraters. Interraters completed a survey (see excerpt in Appendix B) about the words and phrases related to grantmaking services and target populations most frequently revealed in the initial review of mission content. A diverse group of twelve students in three different doctoral programs at the University of North Carolina at Charlotte served as interraters for this study. Interraters first considered the type of problem, condition, or services identified in mission statements. For each word or phrase presented, interraters decided whether the HLF seemed to have specific health-related plans in mind or whether the HLF appeared to pursue a vague mission, which would allow a broad array of programs and projects to be funded.

Based on interrater feedback, mission statements were then coded as *broadly defined* if a minimum of 75% of interraters agreed that key words and phrases were either broad or somewhat broad. On the other end of the spectrum, missions were coded as *narrowly defined* if at least 75% of interraters agreed that key words were either narrow or somewhat narrow. When less than 75% of interraters agreed about how to classify the nature of services, the mission was coded as *neutral*. Because many HLFs identified more than one grantmaking focus, coding procedures allowed for multiple interpretations.

For example, a mission statement that included both *healthy behavior* and *chemical dependency* would be recorded as having elements that were broad and narrow. Words and phrases that conceivably could have no health-related connotation (such as *welfare* and *quality of life*) were categorized as health-related only when explicit reference was made to health (e.g., *health-related quality of life*). Figure 6 provides a sample of key words and phrases used to rate the specificity of missions.

After interraters considered the focus of HLF services, they then rated the word choices pertaining to target populations. Among HLFs that identified a specific target population, two distinct groups emerged: populations that were targeted because of economic disadvantage and populations that were targeted because of another demographic characteristic, such as age, gender, race or ethnicity. Interraters strongly agreed about how to rate the language regarding target populations, with all words and phrases either clearly broad or clearly narrow. Figure 7 provides a flowchart that conceptualizes how mission statements identify target populations.

#### Quantitative Content Analysis

The final step in the methodological process involved a quantitative analysis of content. According to Zhang and Wildemouth (2009), quantitative content analysis is widely used in communication science to count manifest textual elements and can serve as a valuable tool for buttressing qualitative content analysis. To this end, elements of the mission statement that emerged in the qualitative analysis were counted. This step entailed determining the number and proportion of HLFs that (1) used an explicit health-related word, such as *health*, *healthcare*, *medicine*, or *wellness*; (2) clearly defined geographical restrictions for recipients of grants, such as specific counties; (3) expressed

a religious purpose or faith-based philosophy; and (4) declared intentions to continue the mission of the converting nonprofit hospital. (Figure 8 provides the coding and analysis for sample HLF mission statements.) In addition, the number of broad, narrow, or neutral health-related textual elements within mission statements (according to interrater agreement) was counted. To test for statistically significant differences between HLF groups (e.g., those with and without religious purposes), two-group *t*-tests of mean asset values were performed using Stata® SE version 11.2.

Finally, to improve coding reliability and ease of interpretation, each statement was also given an overall score with regard to the HLF's degree of focus on healthcare, taking into consideration all elements of the mission statement combined. This separate analysis increased the internal validity of the study in two ways: by supplementing findings revealed through individual components and by considering whether a different connotation might be construed in light of how the words and phrases are grouped together. For example, while the nature of an HLF's services may be construed as broad when viewed independently of other components, the overall mission statement might be perceived as narrow when applied to a carefully restricted target population.

## Results

The analysis of 238 mission statements provides insights into the nature of services pursued through HLF grantmaking, the populations targeted for services, and overall intentions of the HLF to pursue a charitable healthcare purpose. Findings are summarized in Table 7. Combined assets of HLFs that adopted mission statements totaled \$16.4 billion in 2010, with an average of \$68.9 million per foundation. In contrast, mean assets for the thirteen HLFs whose mission statements could not be found were

significantly lower ( $p = 0.009$ ), \$26.5 million. Eleven of these thirteen foundations were located in the South.<sup>9</sup>

Regarding the nature of services, 215 mission statements (90.3%) reflected an explicit health-related purpose, although the intended scope of HLF grantmaking emerged along a continuum ranging from vague to specific. Health-related HLFs held mean assets (\$69.0 million) that were slightly higher than mean assets of HLFs with no explicit health purpose (\$68.0 million), but the difference was not statistically significant ( $p = 0.484$ ). The majority of HLFs with no focus on health were located in the South (52.2%).

With regard to target populations, about one-quarter of HLF mission statements identified intended beneficiaries, with 13.4% targeting the poor and 20.6% targeting other groups (e.g., seniors and racial minorities) that may have health vulnerabilities. Average assets of HLFs that specified target populations were significantly higher compared to HLFs that did not (\$86.2 million versus \$63.1 million;  $p = 0.092$ ). Midwestern HLFs were more than twice as likely than HLFs in the Northeast and West to specify a narrow target population. More than three-quarters of mission statements stipulated geographic parameters for grant awards.

In addition, 34 HLFs (14.3%) alluded to a faith-based purpose. These HLFs were predominantly located in the South and Midwest. Average assets of HLFs that acknowledged religious roots were valued at \$102.0 million in 2010, a significantly higher mean compared to that of other HLFs ( $p = 0.037$ ). Conversely, the 50 HLFs (21.0%) with mission statements that allude to the converting nonprofit hospital's

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<sup>9</sup> A list of states by U.S. Census region and division is provided in Appendix A.

mission hold much lower mean assets, \$58.8 million, although the difference was not statistically significant ( $p = 0.244$ ).

More than half (53.5%) of health-related mission statements contained *only* words and phrases that depicted *health* in a broad sense (e.g., *healthy lifestyles* and *wellness*; results not shown). A small proportion of HLF missions (11.2%) contained *only* words and phrases (e.g., *clinical research*) for which there was no interrater agreement regarding the health-related focus. Only one out of the 215 mission statements with an explicit health-related focus was interpreted to have a single, narrow grantmaking focus: St. Joseph Health Ministries in Lancaster, Pennsylvania, whose mission reads, “St. Joseph Health Ministries improves the health of children in need within Lancaster County. Our primary focus is children’s oral health, which we address through our children’s oral health initiative, Brush. Brush. Smile!<sup>®</sup>” (St. Joseph Health Ministries, 2013). About one-third of mission statements had components with more than one interpretation (e.g., both *broad* and *narrow* components).

While the nature of services and target populations were addressed as individual components within mission statements, entire mission statements of individual HLFs were also examined for overall meaning. This approach led to characterizing 34 of the 238 whole mission statements (14.3%) as narrowly focused on charitable healthcare. Most of these HLFs identified narrow target populations but did not specify the type of services to be provided. This degree of focus varied by geographic region, with 47.0% of narrow mission statements adopted by HLFs in the South, compared to 8.8% in the West. Mean assets of HLFs with narrow missions were notably but not significantly higher than HLFs with less focused purposes (\$78.9 million versus \$67.2 million;  $p = 0.295$ ).

## Discussion

Based on the conceptualization of *charitable healthcare* discussed in the Methods section, this analysis reveals that HLFs overwhelmingly pursue a mission of charitable healthcare. Not only do grantmakers focus on health-related pursuits, but they also appear to target populations that are economically disadvantaged or otherwise vulnerable to poor health. Moreover, many HLFs directly reflect the legacy of the converting nonprofit hospital by restricting grants to the former hospital's geographic service area and by making explicit reference to the converting hospital's mission.

### Broad Versus Narrow Pursuits of Health

To determine the type of problems or conditions that HLFs intended to address, the nature of grantmaking services was first examined. Although the overwhelming majority of HLF mission statements reflected an explicit health-related purpose, most depicted health broadly. In addition, more than a third have adopted mission statements that reflect varying positions along the continuum of health-related foci. In other words, while part of an HLF's grant funds may be designated for a narrow healthcare focus (such as school-based health clinics), other funds may be awarded for health purposes open to broad interpretation (such as *wholeness*). By adopting a mission statement that, either overall or in part, permits a broad interpretation of *health*, HLFs enable greater flexibility in their grantmaking. While such flexibility potentially enables HLFs to respond most efficiently to changing community needs, it also allows grantmakers to fund projects with a questionable connection to community needs. For example, one HLF in Tennessee constructed a \$15-million Renaissance Center,<sup>10</sup> which offers—among

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<sup>10</sup> In November 2013, the Jackson Foundation transferred ownership of The Renaissance Center to a private university. Undergraduate and graduate degree programs are slated to begin in the fall semester of 2014,

other entertainment options—laser light shows simulcast to the music of Pink Floyd (Jackson Foundation website, 2011).

In contrast, adopting a narrow grantmaking focus has a number of advantages (Harrell, 2009; Weisbrod, 1998). First, narrower or more specific grantmaking involves strategic processes that render the foundation's work more measurable. For example, *providing mental health care services for the uninsured and underinsured* is more measurable than *improving overall health*. Greater specificity also subjects foundations to greater accountability, as their grant-funded pursuits are more readily observable. Narrow missions also enable community stakeholders to better monitor HLFs for evidence of *mission drift*, when an organization's resources are used to pursue activities that are only tangentially or not at all related to the mission. Conversely, HLFs with "mission vagueness," as described by Burton Weisbrod (1998), have a wide berth in their charitable pursuits; communities are limited in how they may judge the appropriateness of grant awards.

Another advantage of narrowly construed missions is that having a sharper focus typically requires a higher degree of attention and engagement from the foundation. Strategic grantmakers often award funds through special initiatives in which the foundation plays a large role in project design. Because of the time, effort, and resources invested in strategic pursuits, grantmakers frequently award larger-scale grants over a longer period of time in order to increase the likelihood of effectiveness. Thus, the foundation becomes identified with its mission over time and assumes more control over how its mission is pursued. Ultimately, pursuing a narrow grantmaking purpose leads to

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with classes offered at the Renaissance Center (Jackson Foundation website, 2014). Such educational offerings have a clearer tie to health compared to some of the Center's entertainment offerings.

increased grantmaker effectiveness (Fleishman, 2007; Harrell, 2009). Interestingly, the HLFs that adopted an overall narrow purpose or that specified a focus on faith or disadvantaged populations had considerably higher mean assets compared to HLFs with vague missions. For example, many faith-based HLFs, which are concentrated in the South and Midwest, were formed from health systems rather than stand-alone hospitals; their average assets of \$102.1 million are significantly higher than that of HLFs with no religious purpose. Foundations with greater assets may be more likely to adopt narrow mission statements because their larger and perhaps more sophisticated staffs recognize that more narrowly focused strategies have greater potential for effectiveness. In spite of the advantages associated with pursuing a narrow—rather than a broad—mission, only one HLF (St. Joseph Health Ministries in Lancaster, Pennsylvania) was found to have a single, narrow health-related focus.

#### Other Charitable Pursuits

In addition to providing information about HLFs that pursue health-related missions, the content analysis also sheds light on the nature of services among the 23 foundations that chose *not* to adopt an explicit health purpose. Most of the missions not focused on health enable HLFs to fund a broad array of projects and programs. Examples of such grantmaking purposes include *empowerment* and *positive change*. However, it is important to note that such wording does not preclude HLFs from awarding funds for health-related purposes. In fact, only two foundations appear to have purposely eschewed a direct health focus in their missions: the Jackson Foundation in Dickson, Tennessee, and the Deaconess Community Foundation in Brooklyn, Ohio. Their missions are as follows:

The Jackson Foundation:

The mission of the Jackson Foundation, Inc., is to motivate and educate children and adults through the use of technology in the area of the arts, science, and humanities (Jackson Foundation, 2011).

Deaconess Community Foundation:

Deaconess Foundation provides resources to increase the ability of individuals in Cuyahoga County with the least wealth and opportunity to prepare for, obtain, and maintain employment. Deaconess Foundation is a collaborative partner in philanthropic efforts that strengthen the human services sector in Cuyahoga County. (Deaconess Community Foundation, 2013).

Although education and employment have strong potential to improve health (Marmot & Wilkinson, 2008; Robert Wood Johnson Foundation, 2008; U.S. Department of Health and Human Services [HHS], Healthy People 2020, 2013), these foundations chose not to identify health as a direct priority within their mission statements. Trustees of the Jackson Foundation considered direct healthcare programs when initially developing their priorities, yet they opted instead to focus foremost on education, which they perceived to be the community's single most pressing need (Jaffe & Langley, 1996). Reflecting the traditions of faith upon which the converting nonprofit hospital was built, The Deaconess Community Foundation decided to focus on employment. In fact, Deaconess reported in 2011 that "Unlike many other health care conversion foundations, DCF's mission does not focus on health care. The focus of DCF's mission...is reflective of the hospital's charitable giving activity that has roots in the Evangelical church (a predecessor to the United Church of Christ) and its German culture of help yourself and self-sufficiency" (Deaconess Community Foundation, 2011).

Other HLFs formed from the sale of hospitals originally founded by religious groups, such as Catholic orders and Presbyteries, have also adopted mission statements that reflect their faith-based heritage. Furthermore, many of the mission statements

alluding to religious roots reflect a recurring theme of reducing poverty, with no explicitly health-related purpose. The mission of the Sisters of Charity Foundation of South Carolina provides an example: “In response to God's call and in the spirit of the Sisters of Charity of St. Augustine, the Foundation strategically uses resources to reduce poverty through action, advocacy and leadership” (Sisters of Charity Foundation of South Carolina, 2011). While the Sisters of Charity Foundation of South Carolina may not explicitly mention health in its mission statement, it has often awarded funds for healthcare projects and programs (Urban Institute, 2011). Moreover, targeting indigent populations reflects an explicitly charitable purpose, and poverty alleviation is strongly associated with improvements in health (Marmot & Wilkinson, 2008; Robert Wood Johnson Foundation, 2008; HHS, Healthy People 2020, 2013).

Also among the 23 HLFs that chose not to adopt explicitly health-related mission statements were ten HLFs organized as or affiliated with community foundations. Unlike private foundations, community foundations operate as public charities and are therefore responsible for generating support from the public in order to maintain tax-exempt status (U.S. Department of the Treasury, 2011). By adopting broad mission statements, community foundations are able to attract donors from a broader base of community interests, including the arts and economic development, for instance. HLFs that are managed as donor-advised funds or affiliate organizations at community foundations may adopt separate mission statements that are more narrowly focused on health. For example, the mission of the Jenkins Foundation in Richmond, Virginia, is health-related: “to improve the health of Greater Richmond.” The Jenkins Foundation is a supporting organization of The Community Foundation Serving Richmond and Central Virginia,

whose much broader mission statement does not mention health: “to serve and inspire people to build philanthropy for our region and to engage in our community” (The Community Foundation Serving Richmond and Central Virginia, 2013).

#### Targeted Beneficiaries

In spite of addressing problems or conditions that were broadly defined, HLFs tended to be more restrictive with regard to the intended beneficiaries of grant awards. Many HLF missions targeted low-income populations and/or other populations (e.g., seniors, women, children, and racial/ethnic minorities) that may be perceived as vulnerable to poor health. Furthermore, more than three-quarters of HLFs specified geographical parameters for their grant recipients, usually the converting nonprofit hospital’s service area. Targeting well-defined communities is a significant aspect of an HLF’s charitable legacy: giving away large sums of money every year can have a profound impact when doled out among a relatively small number of people.

Even more promising for communities that fear the loss of charitable health services was the dedication of many HLFs to pursue the mission of the converting nonprofit hospital. More than twenty percent of HLFs adopted mission statements that specifically mentioned the hospital’s mission or charitable works. The Grant Healthcare Foundation in Chicago, Illinois, offered an example: “...to continue the tradition of Grant Hospital of Chicago, founded in 1883, by providing and supporting healthcare services to the people of the Chicago metropolitan area” (Grant Healthcare Foundation website, 2011). However, just as the converting hospital may have fulfilled its community benefit requirements by promoting health in its broadest sense, so too might the HLF support projects and programs with minimal connection to community health needs.

## Study Limitations and Suggestions for Further Research

Several limitations to this study are noted. First, although foundations rarely change their mission statements (Harrell, 2009), an HLF may interpret its own mission statement differently over time. For example, the staff and trustees might interpret terms such as *mental health* and *low-income* in different ways depending on the perspectives of different individuals involved in making funding decisions. Future research regarding how missions are translated into grantmaking decisions within HLFs would help address this potential limitation. Comparing mission statements with actual grants awarded would also help address the varying application of mission statements across HLFs. Surely, some HLFs must rely on their missions more than others to guide their grantmaking decisions. Perhaps most importantly, just because an HLF publicizes the *intent* to serve a certain purpose does not necessarily mean this intention will translate into action. Future research should evaluate the community-level impact of HLFs to determine whether their contributions have made a difference to those whose nonprofit hospitals converted ownership.

## Policy Implications

This analysis contributes important new information to the discussion about nonprofit to for-profit hospital conversion. First, it reveals the intent that the pursuit of charitable healthcare services will not be abandoned after conversion, regardless of any changes made by the converting hospital's new owners. Not only have HLFs overwhelmingly decided that the \$16.8 billion in assets they manage should be dedicated to healthcare purposes, but many also identified disadvantaged populations as intended beneficiaries. Others explicitly referenced a religious purpose or the converting hospital's

mission. All these purposes are deemed charitable by the IRS. Second, this study sheds light on how HLFs plan to interpret *healthcare* when they award grants. Just as the nonprofit hospitals from which they were created were allowed to pursue a broad interpretation of *community benefit*, most HLFs have chosen flexible parameters for their grantmaking. In doing so, grantmakers will be able to choose the combination of services (grant awards) and beneficiaries (target populations) that maximizes utility for their communities.

Yet in spite of having the potential and expressing their intent to efficiently reallocate hospital conversion proceeds, few mechanisms exist to hold HLFs accountable for doing so. Many states have enacted laws addressing nonprofit to for-profit hospital conversions, but oversight has largely focused on transaction processes rather than grantmaking. As a result, some grant funds have been awarded for sub-optimal purposes (Jaffe & Langley, 1996; Miller, 1997; Standish, 1998). Examples include the purchase of two new airplanes to provide local high school students with flying lessons and the construction of a 54-foot by 30-foot space shuttle model to use as a teaching aid (Jaffe & Langley, 1996).

While funding such outlandish projects may occur only rarely, HLF grant dollars that are not used to address health-related needs may result in a net loss of charitable health benefits to the community. For-profit hospital owners might argue that their tax revenues offset any decline in charitable health services, but government revenues are generally spent without regard to the activity or entity that was taxed, and tax revenue would not necessarily translate into health-related benefits. In light of evidence that for-profit owners are less likely to provide either unprofitable medical services or

uncompensated care (Horwitz, 2003; Thorpe, Florence, & Seiber, 2000), allowing HLF grant funds to pay for marching band uniforms, historic preservation, visual arts, church pews, and the like may come at a high opportunity cost. One option for state regulators to help preserve charitable health assets is to require that for-profit purchasers of nonprofit hospitals continue to provide specified benefits after the transaction has taken place. In Louisiana, a joint venture between Rapides Regional Medical Center and Columbia/HCA in the mid-1990s ensured that the new hospital owners would continue to provide charity care, while also setting aside millions to establish a new HLF (Bell, Snyder, & Tien, 1997; The Rapides Foundation, 2013). However, the majority of cases in which state policymakers have intervened in conversion negotiations have resulted in agreements of limited duration, usually three to seven years (Bell, Snyder, & Tien, 1997). Furthermore, some for-profit purchasers have reneged on their agreements (Creswell, 2013).

Although requiring HLFs to fund indigent medical services post-conversion may appear to be a viable alternative, this option, too, could prove problematic. First, funding medical care provided by a nonprofit hospital in the area would constitute helping a competitor of the converting entity. Using funds to work with the for-profit acquirer would potentially violate both the terms of the arms-length conversion agreement and the HLF's tax-exempt status. Although foundations can legally support for-profit businesses (as long as funds are used for a charitable purpose), many HLFs may try to avoid conflicts of interest by funding only public charities (Bader, 1996). Relationships remain complicated, however, between HLFs and the acquirers of their former facilities. A thin line separates grants paid directly to hospitals from those that may be paid to independent nonprofit organizations but still benefit the for-profit hospital's bottom line. For example,

by establishing or supporting indigent health clinics in a community, HLFs are reducing the number of indigent patients who seek care at the hospital. Indeed, emergency rooms are less crowded if there are medical clinics in the vicinity that provide free or low-cost care (Bader, 1996). In this light, HLFs face a unique policy paradox that no other type of philanthropic foundation encounters.

Clearly, determining how best to preserve nonprofit healthcare assets for the public benefit has proven challenging. At the federal level, the IRS provides oversight of HLFs, but the amount of resources dedicated to overseeing the tax-exempt nonprofit sector represents a mere fraction of that which is allocated for individual and corporate taxpayer oversight. According to one source, the IRS lacks the personnel required to provide adequate review of nonprofit filings and can barely manage to audit one percent of charitable organizations annually (Fleishman, 2007). In the absence of federal oversight, states have largely assumed responsibility for protecting charitable assets. However, state-level oversight of nonprofit hospital conversions and of their resulting foundations is also subject to a number of limitations (Claxton et al., 1997; Horwitz & Freemont-Smith, 2005; Miller, 1997; Shriber, 1997; Standish, 1998). State attorneys general often lack resources to review and act on complex conversion transactions, and they interpret the duty to protect residual charitable assets in vastly different ways (Cryan & Gardner, 1999; Shriber, 1997). Although many states enacted conversion-related legislation in the late 1990s when conversion activity last peaked, laws vary considerably in their design and enforcement, and no statute comprehensively addresses the range of issues pertaining to conversion proceeds (Shriber, 1997; Standish, 1998). Even among

states that have adopted conversion legislation, the appropriate use of HLF grant funds remains ambiguous, at best (Standish, 1998).

Given the practical and theoretical limitations on state and federal oversight of HLF grantmaking (Claxton et al., 1997; Miller, 1997; Shriber, 1997; Standish, 1998), federal policy that recognizes the unique charitable health legacy of HLFs is warranted. Specifically, in exchange for federal tax exemption, HLFs should be required to adopt missions—and award grant funds—for purposes that have significant potential to improve health, rather than for any cause identified as charitable in the eyes of the IRS. The well-documented array of social and economic determinants of health should be included among acceptable missions. However, to ensure that HLFs address specific, health-related needs, federal law should require HLFs to award grant funds based on the findings of a regularly administered community health needs assessment. Nonprofit hospitals are now required by the ACA to undertake these assessments at least every three years and to publicize results (Pryor, Rukavina, Hoffman, & Lee, 2010; U.S. Department of the Treasury, 2013). Rather than deprive communities of this valuable assessment tool when a nonprofit hospital converts to for-profit status, federal law should require new and existing HLFs to work with community stakeholders, including health providers, to generate these assessments. The relatively small investment of grant funds required for regular assessments would yield high returns in the form of documented evidence of community needs and data for the development and evaluation of HLF strategies.

Perhaps the most important aspect of this recommendation is the increase in HLF accountability to their local communities. Publicizing findings of the community needs

assessment would help empower area residents to hold HLFs accountable for awarding grants that address local health-related needs. By gathering information about a wide array of health determinants, assessments may reveal that root causes of poor health and health disparities should be among grantmakers' top priorities. In any case, community health needs assessments would enable HLFs to develop evidence-based solutions in response to community needs and would facilitate accountability to local stakeholders and federal authorities alike.

As healthcare mergers and acquisitions proliferate in the aftermath of healthcare reform, more communities will require new approaches to protecting the charitable assets that have been amassed over years within nonprofit healthcare institutions. New investor owners—in spite of their pursuit of profit—ideally would not abandon the hospital's prior commitment to serving indigent patients. By redeploying conversion proceeds to pursue a needs-based mission of health, HLFs could potentially preserve a nonprofit hospital's charitable health legacy in perpetuity.

Table 6: 2010 assets and grants paid by health legacy foundations formed from hospitals and health systems, by U.S. Census region

Geographic Area (number of foundations)	2010 Assets			2010 Grants Paid		
	Total	Mean	Median	Total	Mean	Median
United States ( <i>N</i> = 251)	\$16,753,164,569	\$66,745,676	\$31,370,777	\$789,134,443	\$3,143,962	\$1,180,330
Northeast ( <i>n</i> = 34)	\$1,340,322,880	\$39,421,261	\$28,880,674	\$57,848,108	\$1,701,415	\$1,237,125
Midwest ( <i>n</i> = 63)	\$3,832,782,844	\$60,837,823	\$29,120,118	\$186,011,912	\$2,952,570	\$1,319,824
South ( <i>n</i> = 116)	\$7,741,851,889	\$66,740,102	\$33,505,230	\$276,976,331	\$2,387,727	\$1,205,542
West ( <i>n</i> = 38)	\$3,838,206,956	\$101,005,446	\$29,302,448	\$268,298,092	\$7,060,476	\$866,680

**Source:** Author's database of health legacy foundations. **Notes:** Means are reported as per health legacy foundation. Financial data were obtained for 2010 or most recent year available. A list of states by U.S. Census region and division is provided in Appendix A. \*Only health legacy foundations formed from hospitals and health systems were included in this analysis.

Table 7: Summary of findings, mission statement content analysis

	<b>HLFs<sup>a</sup></b>		<b>U.S. Census Regions</b>				
	<b>(N=251)</b>	<b>Mean Assets</b>	<b>Total Assets</b>	<b>Northeast</b>	<b>Midwest</b>	<b>South</b>	<b>West</b>
	<i>n</i> (%)						
<b>Mission Statement</b>	238 (94.8%)	\$68,944,088	\$16,408,692,968	34 (14.3%)	61 (25.6%)	105 (44.1%)	38 (16.0%)
<b>No Mission Identified<sup>b</sup></b>	13 (5.2%)	\$26,497,815	\$344,471,601	0 (0.0%)	2 (15.4%)	11 (84.6%)	0 (0.0%)
<b>Nature of Grantmaking Services</b>							
Explicitly Health-Related	215 (90.3%)	\$69,044,068	\$14,844,474,680	30 (14.0%)	56 (26.0%)	93 (43.3%)	36 (16.7%)
No Health Focus	23 (9.7%)	\$68,009,491	\$1,564,218,288	4 (17.4%)	5 (21.7%)	12 (52.2%)	2 (8.7%)
<b>Target Populations</b>							
Specified (poor/other)	60 (25.2%)	\$86,226,469	\$5,173,588,158	8 (13.3%)	23 (38.4%)	21 (35.0%)	8 (13.3%)
Unspecified	178 (74.8%)	\$63,118,566	\$11,235,104,810	26 (14.6%)	38 (21.3%)	84 (47.2%)	30 (16.9%)
Geographic service area specified	180 (75.6%)	\$68,333,617	\$12,300,051,127	24 (13.3%)	49 (27.2%)	77 (42.8%)	30 (16.7%)
<b>Religious Purpose</b>	34 (14.3%)	\$102,080,261	\$3,470,728,879	2 (5.9%)	15 (44.1%)	14 (41.2%)	3 (8.8%)
<b>Converting Hospital's Mission</b>	50 (21.0%)	\$58,754,321	\$2,937,716,026	7 (14.0%)	14 (28.0%)	24 (48.0%)	5 (10.0%)
<b>Overall Narrow Purpose</b>	34 (14.3%)	\$78,945,174	\$2,684,135,930	4 (11.8%)	11 (32.4%)	16 (47.0%)	3 (8.8%)

**Source:** Author's database of health legacy foundations. **Notes:** Financial data were obtained for 2010 or most recent year available. States for each U.S. Census region are provided in Appendix A. <sup>a</sup>Only health legacy foundations formed from hospitals and health systems were included in this analysis. <sup>b</sup>Missions for these health legacy foundations could not be accessed. Examples of health legacy foundations in this category include smaller health legacy foundations that do not maintain websites and newly established foundations that presumably have not yet adopted mission statements.

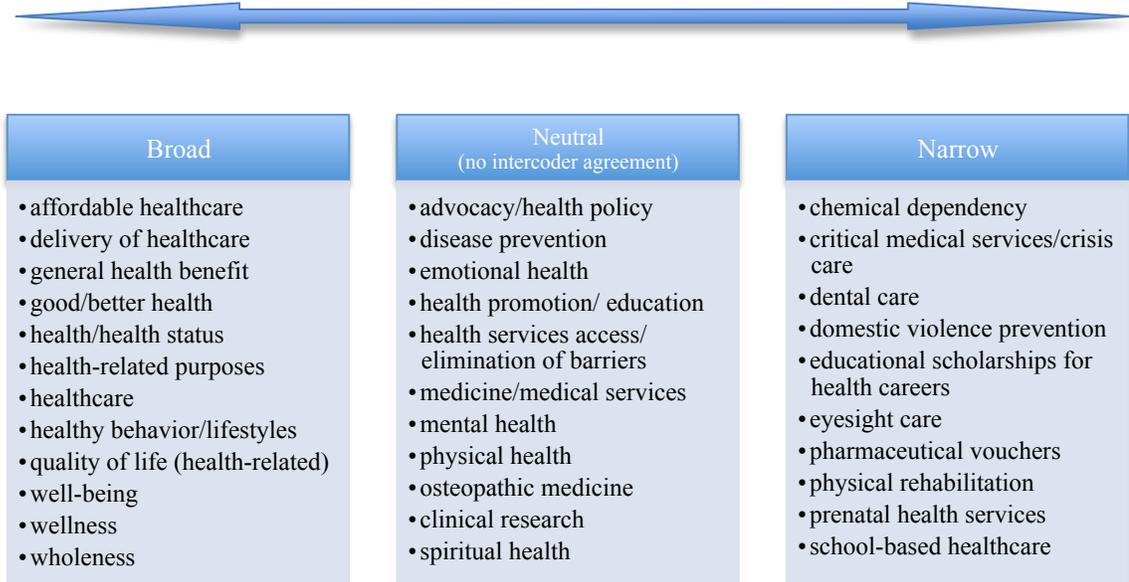


Figure 6: Coding of health-related focus among health legacy foundation mission statements

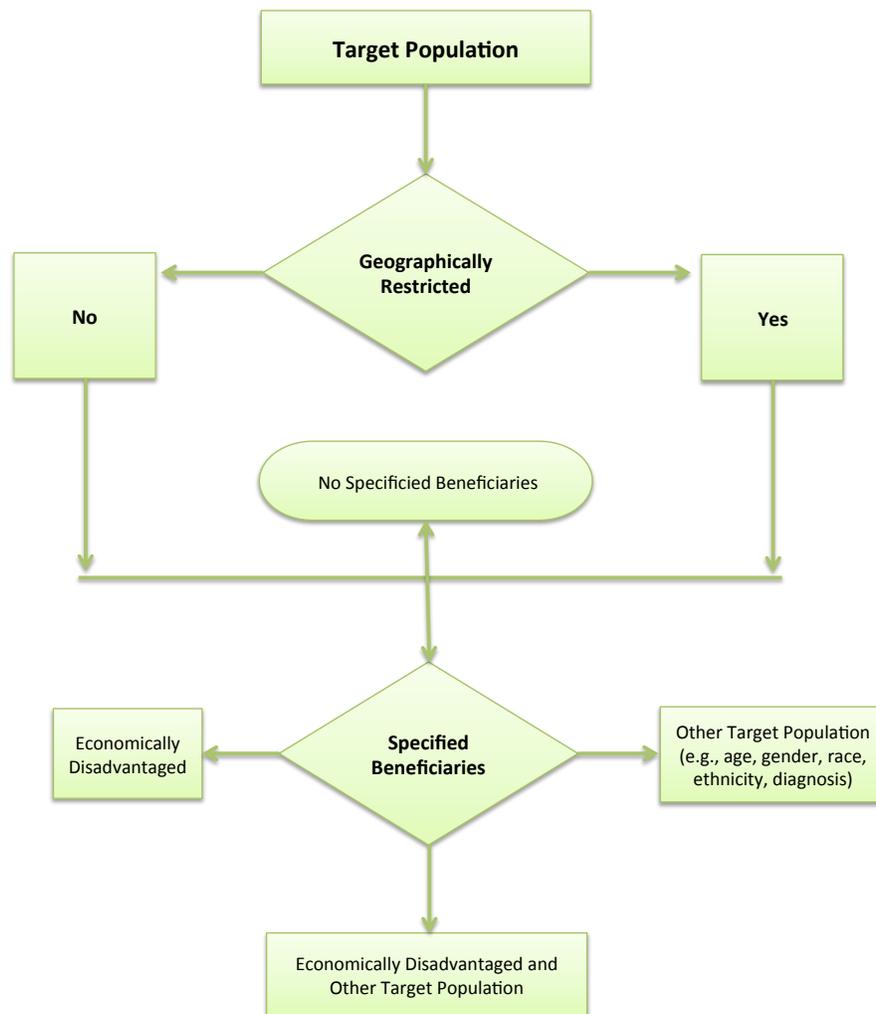


Figure 7: Coding of target populations identified in health legacy foundation mission statements

**Example A – Mission statement of The Health Trust in Silicon Valley, California**

“The mission of The Health Trust is to lead the Silicon Valley community to advance wellness” (The Health Trust website, 2011).

**Coding and Analysis:** This HLF appears to have adopted a broad health-related mission. The nature of services, or the grantmaking purpose, is *to advance wellness*, which interraters strongly agreed evokes a vague health-related focus. While the target population is geographically restricted to the Silicon Valley area, no other focus is provided with regard to intended recipients of grant-funded initiatives. Codes for the quantitative analysis were as follows:

- (1) uses an explicit health-related word =1 (*wellness*)
- (2) defines geographical parameters = 1 (*Silicon Valley community*)
- (3) expresses faith-based philosophy = 0
- (4) refers to the converting nonprofit hospital’s legacy = 0
- (5) gives overall impression of narrow focus on charitable health = 0 (i.e., grants could be awarded for myriad projects)

**Example B – Mission statement of the Ridgecliff Foundation in Lake County, Ohio**

“Ridgecliff Foundation provides grants to mental health agencies, chemical dependency agencies and organizations that have a mental health or chemical dependency component in order to fund programs which promote research, education, and patient care in the field of mental health and chemical dependency in Northeast Ohio. Emphasis is placed on programs affecting children and families, early diagnosis, prevention, dual diagnosis (co-morbidity) and minority populations” (Ridgecliff Foundation website, 2011).

**Coding and Analysis:** This mission statement appears to be narrowly focused in its pursuit of healthcare, with the nature of services revolving around *mental health* and *chemical dependency*. While interraters did not agree about the specificity of several words and phrases (e.g., *mental health* and *research*), other grantmaking parameters are specific (e.g., targeting minorities and dual diagnosis patients). Codes for the quantitative analysis were as follows:

- (1) uses an explicit health-related word =1 (*patient care, mental health, diagnosis*)
- (2) defines geographical parameters = 1 (*Northeast Ohio*)
- (3) expresses faith-based philosophy = 0
- (4) refers to the converting nonprofit hospital’s legacy = 0
- (5) gives overall impression of narrow focus on charitable health = 1 (i.e., grants intended for specific health purposes)

Figure 8: Analysis and coding for sample health legacy foundation mission statements

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## APPENDIX A: METHODOLOGICAL SUPPLEMENT

The following details are provided as a supplement to the Methods section in Chapter 2.

### Data Sources

Niggel & Brandon's (2014) database of HLFs includes information about 306 philanthropic foundations formed from nonprofit healthcare conversions and other transactions. Original sources of information for this database include IRS Form 990s, Grantmakers In Health ([www.gih.org](http://www.gih.org)), The Foundation Center's Foundation Directory Online (<http://fconline.foundationcenter.org>), GuideStar (<http://www.guidestar.org>), the Urban Institute's National Center for Charitable Statistics (<http://nccs.urban.org>), and regional associations of grantmakers. Websites, annual reports and other publications of individual foundations were also used to develop the database.

County Health Rankings & Roadmaps (CHR; University of Wisconsin, 2013) is an online database that compiles health-related information from a variety of national data sources. A collaborative undertaking between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute, this database includes measures of health outcomes, health behavior, clinical care, social and economic factors, and the physical environment. This database has been widely referenced in published research (for examples, see Currie, 2010; Kindig & Cheng, 2013; Marquart, 2011; Peppard et al., 2008). Original sources pertaining to each variable selected for this analysis are identified below.

### Variables

Socioeconomic measures include unemployment, child poverty, single-parent homes, and high school graduation. Unemployment is derived from the 2011 Bureau of

Labor Statistics and represents the total unemployed as a percent of the civilian labor force. To represent income, CHR reports on the percent of children under age 18 living in poverty, as defined by the federal poverty threshold. The original data source for this variable is the Census' Small Area Income and Poverty Estimates for 2011. Median household income was also considered as an indicator of poverty but was eliminated because it was highly correlated with the percent of children living in poverty ( $r > .81$ ). As a measure of limited family and social support, CHR uses two variables: single parent homes and inadequate social support. The percent of children that live in single-parent households, obtained from the American Community Survey's five-year estimates for 2007 – 2011, was employed for this analysis. Inadequate social support was eliminated as a variable due to the high number of missing values. Only three counties were missing values for the single parent variable; substitute values were imputed by averaging values of contiguous counties.

The measure of education selected for this paper is the average freshman graduation rate (AFGR), which is the percent of the ninth-grade cohort that graduates high school in four years, as reported by state Departments of Education and the National Center for Education Statistics. For this variable, a total of 33 values were missing in states across the nation. The average AFGR of all other counties in each respective state was imputed for these missing values. For Hawaii and Nebraska, which had multiple counties without values, AFGR values were taken directly from the US Department of Education ([www2.ed.gov/about/inits/ed/edfacts/state-profiles](http://www2.ed.gov/about/inits/ed/edfacts/state-profiles)) for 2009-2010.

Demographic variables included in this analysis include the percent of the population age 65 and over, percent Black, percent not proficient in English, and rurality.

The 2011 Census population estimates was the original source for percent age 65 and older, percent Black, and percent of the county population living in a rural area. The percent not proficient in English was obtained from the American Community Survey's five-year estimates for 2007-2011. Two counties were missing values for the percent not proficient in English. The average value for each county's respective surrounding counties was used as a substitute value.

Access to healthcare was measured using percent uninsured, preventable hospitalization, and the rate of primary care physicians and dentists in a county. Data for the percent uninsured originally came from Small Area Health Insurance Estimates for 2010 and reflect the percent of the population under age 65 without health insurance. Although CHR employs preventable hospitalizations as an indicator of quality of care, this measure has also been widely used as a measure of access to care (e.g., Brown et al., 2001; Ansari, Laditka, & Laditka, 2006; Hossain & Laditka, 2009). Providing a measure of preventable hospital stays, the age-adjusted rate of ambulatory care sensitive conditions (ACSC) was used in this analysis to indicate access to primary care. This rate represents the number of discharges for ACSC divided by the number of Medicare enrollees, multiplied by 1,000. CHR obtained this rate from the 2010 Dartmouth Atlas of Health Care. Two additional indicators of access to care were also used in this analysis: the rate of primary care physicians and the rate of dentists per county population. CHR obtained both these rates from the Health Resources and Services Administration (HRSA) Area Resource File for 2011-2012. ACSC, primary care physician and dentist rates were each missing approximately 3% of values, with no specific pattern. Each

county's respective state mean was imputed as a substitute value. Rates were then converted to reflect the number of providers per 10,000 people.

States by U.S. Census Region and Division (U.S. Census Bureau, n.d.)

Region 1: Northeast

Division 1  
New England Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Division 2  
Middle Atlantic New Jersey, New York, Pennsylvania

Region 2: Midwest

Division 3  
East North Central Indiana, Illinois, Michigan, Ohio, Wisconsin

Division 4  
West North Central Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota

Region 3: South

Division 5  
South Atlantic Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia

Division 6  
East South Central Alabama, Kentucky, Mississippi, Tennessee

Division 7  
West South Central Arkansas, Louisiana, Oklahoma, Texas

Region 4: West

Division 8  
Mountain Arizona, Colorado, Idaho, New Mexico, Montana, Utah, Nevada, Wyoming

Division 9  
Pacific Alaska, California, Hawaii, Oregon, Washington

## APPENDIX B: INTERRATER SURVEY EXCERPT

Thank you for agreeing to help with the coding component of my qualitative research project. Part of this endeavor involves analyzing mission statements adopted by philanthropic foundations. These statements help guide foundation staff and trustees in their grantmaking decisions. Here are a couple of examples:

“To improve the health and well-being of our community.”

“To fund oral healthcare services for children of low-income families living in Jones County.”

Please read the below words/phrases and circle the number that best corresponds to how you would interpret the mission’s *focus*. As you read the words, think about their degree of specificity with regard to health or healthcare. In other words, does the foundation seem to have specific health-related plans in mind, or has the foundation chosen a vague focus, which would allow them to fund a broad array of programs/projects?

NATURE OF SERVICES / GRANTMAKING Please rate these words/phrases, which are the objects of intended foundation action.		Vague ←————→ Specific				
		Broad/Vague	Somewhat Broad	No opinion	Somewhat Narrow	Narrow/Specific
1	quality of life	1	2	3	4	5
2	critical medical services / crisis care	1	2	3	4	5
3	chemical dependency	1	2	3	4	5
4	wellness	1	2	3	4	5
5	disease prevention	1	2	3	4	5
6	mental health	1	2	3	4	5
7	spiritual health	1	2	3	4	5
8	osteopathic medicine	1	2	3	4	5
9	educational scholarships for health careers	1	2	3	4	5
10	clinical research	1	2	3	4	5
11	health	1	2	3	4	5
12	affordable healthcare	1	2	3	4	5
13	health policy / advocacy	1	2	3	4	5
14	wholeness	1	2	3	4	5
15	health promotion / health education	1	2	3	4	5
16	accessibility of healthcare services	1	2	3	4	5

**TARGET POPULATION**

Please rate the specificity of these words/phrases, which describe the intended recipients of grant-funded projects.

1	individuals	1	2	3	4	5
2	residents of Chester County, SC	1	2	3	4	5
3	vulnerable populations	1	2	3	4	5
4	low-income / economically disadvantaged	1	2	3	4	5
5	seniors / older adults	1	2	3	4	5
6	uninsured / underinsured	1	2	3	4	5