

**HEART**  
— OF A —  
**GIANT**

MARCH 1, 2025 -  
FEBRUARY 28, 2026

# 2025 ANNUAL REPORT

**Where Communities Lead Heart Health**

Launched 2020 |  
Boston, Massachusetts

"This report shows what becomes possible  
when communities lead their own health."

**Bouba Diémé, Founder**



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# 2025 IMPACT AT A GLANCE

- **1,302 cardiovascular screening and education** sessions conducted
- **879** unique **participants** reached across **19 locations**
- **31 people** achieved clinically significant **BP reduction** ( $\geq 10$  mmHg)
- **27 people** moved to **lower risk blood pressure (BP) category**
- **22 hypertensive crises** identified and referred to emergency care
- **3.2x better retention than traditional healthcare** (25.5% vs 8%)
- **50+ volunteers** contributed **\$5K in donated** time

# LETTER FROM THE FOUNDER

**Dear Friends, Partners, and Community Members,**

**In 2012**, at age 26, **I received a diagnosis that would change my life forever: left ventricular non-compaction cardiomyopathy**, a rare congenital heart defect. What followed was a **ten-year journey through advanced heart failure**, 6 years of those with a Left Ventricular Assist Device (LVAD) keeping me alive while **I waited for a donor heart** that could fit my 6'8" frame.

During those years of waiting, I came to see Ubuntu in action and learned what it truly means. Having grown up in Mali, Senegal, and South Africa, I first saw **Ubuntu through culture, language, and daily life. But, it was during that long stretch of uncertainty** that the community surrounding and supported me, and made Ubuntu undeniable: **'I am because you are.'** This profound experience showed me that our shared humanity cannot be taught in lessons alone; **it must be lived to be understood.**

That's why, even while connected to the LVAD, even while waiting for my transplant, **I started what would become the Heart of a Giant Foundation. I knew firsthand the gaps in our healthcare system, the lack of early detection**, the barriers to culturally responsive care, and the isolation that comes with chronic illness. **I also knew the power of community to bridge those gaps.**

**In 2025**, we proved what's possible when communities lead their own health. **We conducted 1,302 cardiovascular screenings across 19 locations**, served 879 unique individuals, and achieved a **74% improvement in blood pressure among engaged participants**, with a retention rate 3.2 times the industry standard. **We identified 22 people in hypertensive crisis** and connected them to emergency care that likely saved their lives. We prevented an estimated \$450,000–\$675,000 in downstream healthcare costs on a \$144,540 operating budget, a 3.1:1 to 4.7:1 return on investment.

But most importantly, **we built a model that works**. A four-phase framework that any community can replicate. We demonstrated that when you meet people where they are, honor their culture and language, and build trust through consistency, **health equity becomes achievable**.

## **What 2026 Holds**

As we enter 2026, we are transitioning from a proven community model to a sustainable infrastructure. **Our strategy is focused and honest: stabilize our foundation, formalize our first provider partnerships, and publish three years of outcomes data as evidence for the field**. We are not trying to do everything at once. **We are building the bridge, one pillar at a time**.

*In health,*  
**Somaneh "Bouba" Diemé**

Founder and Chief Inspiration Officer  
***Heart of a Giant Foundation***



# WHO WE ARE: MISSION, VISION & UBUNTU PHILOSOPHY



# OUR MISSION

**Heart of a Giant Foundation (HGF) builds community engagement infrastructure** by bringing together clinical, industry, and lived experience, anchoring our efforts in **trust and cultural understanding to advance cardiovascular health** in the communities that need it most, in Greater Boston and beyond.

# OUR VISION

We envision a world where **communities guide equitable heart health**. In this world, trust, infrastructure, and partnerships **help those most affected by cardiometabolic disease become active leaders in their own health**, not just passive recipients of care.

We strive for a world where your zip code does not decide your chances of surviving heart disease. In this world, **community control is the norm**, not just a goal. Healthcare systems, researchers, and industry all understand that **true health for all is only possible when we work together**. As **Ubuntu** reminds us, **none of us can truly thrive unless everyone does**.



# UBUNTU: "I AM BECAUSE WE ARE"

Guided by the **Ubuntu principle, 'I am because we are,'** Heart of a Giant Foundation understands **healthcare as a shared responsibility.** We partner with community, healthcare systems, researchers, and industry to build community engagement infrastructure, care coordination led by **Community Health Workers who reflect and come from the communities they serve,** and research shaped by the people most affected by cardiometabolic disease. Ubuntu is not a slogan. It guides every element of our work.

# THREE CORE UBUNTU PRINCIPLES

## 1. Patient-Led, Culturally Grounded Care

**Community Health Coaches share backgrounds and languages with those they serve**, building trust that helps patients follow care plans, attend appointments, and **manage their health more effectively over time**.

## 2. Community Sovereignty

**Those most affected by cardiovascular disease actively lead HGF's operations**, partnerships, and resource allocation. With veto power over major decisions, our community advisory boards ensure community priorities directly shape every action we take.

## 3. Shared Expertise, Collective Evidence

**HGF values lived experience and clinical knowledge equally**. Community members are experts, and when they **co-own data, trust deepens, and engagement becomes more meaningful**.



# WHY UBUNTU WORKS

## BY THE NUMBERS

| MODEL                                      | RETENTION RATE | NOTES                           |
|--------------------------------------------|----------------|---------------------------------|
| Industry Standard<br>(community screening) | 8%             | Published benchmark             |
| Traditional<br>CHW Programs                | 15-20%         | Typical range                   |
| HGF Patient-Led<br>Ubuntu Model            | 25.5%          | 3.2× the standard               |
| HGF - East Boston<br>Senior Center         | 52%            | Our highest-<br>performing site |

# 2025 YEAR IN REVIEW



# 2025 year in review

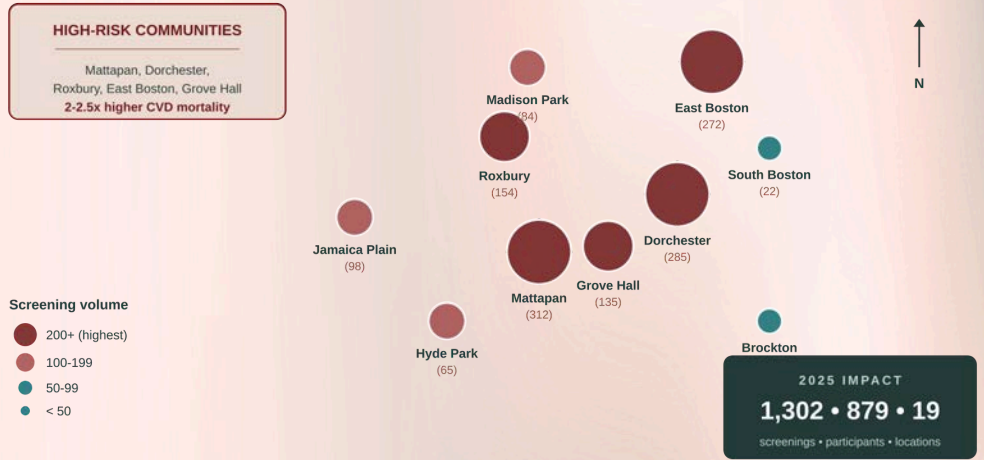
Cardiovascular screening, clinical outcomes, and program impact at a glance



Program metrics reflect calendar year 2025. Crisis Prevention ROI methodology per Haidar et al. (Am J Cardiol 2024).

## Greater Boston coverage

19 screening locations across 10 neighborhoods — community-embedded, highest-risk areas prioritized



CVD mortality rate context per Boston Public Health Commission Health of Boston 2024 report.



THREE-YEAR GROWTH TRAJECTORY (2023-2025)

| METRIC                         | 2023  | 2024   | 2025      | 3-YEAR GROWTH |
|--------------------------------|-------|--------|-----------|---------------|
| Total Screenings               | 322   | 740    | 1,302     | +304%         |
| Unique Participants            | 62    | 650    | 879       | +1,318%       |
| Screening Locations            | 7     | 14     | 19        | +171%         |
| Neighborhoods                  | 1     | 7      | 10        | +900%         |
| Operating Budget               | \$89K | \$103K | \$151,189 | +70%          |
| Hypertensive Crises Identified | 7     | 18     | 22        | +214%         |

Three-year screening growth (2023-2025)

304% increase in annual cardiovascular screenings delivered



322 screenings (2023) → 1,302 screenings (2025) — measured in calendar years.



# **PROGRAMS & CLINICAL IMPACT**

# COMMUNITY CARDIOVASCULAR SCREENINGS

**Our signature program delivers free blood pressure and cardiovascular risk screenings at community-embedded locations across Greater Boston.** Every site is selected based on community input, where people already gather, shop, worship, and connect.

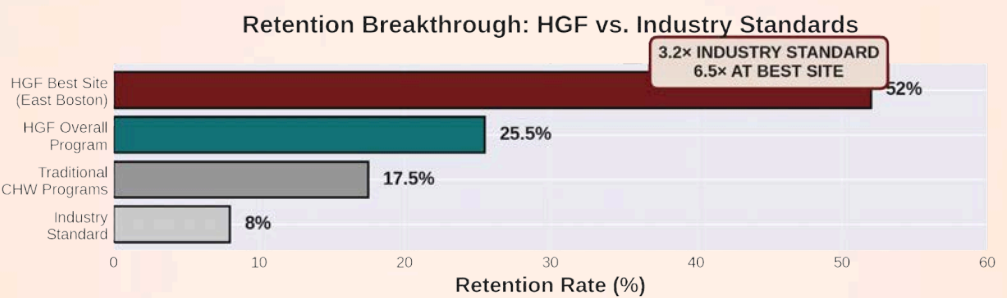
| LOCATION TYPE                   | EXAMPLE SITES                                              | 2025 SESSIONS |
|---------------------------------|------------------------------------------------------------|---------------|
| Farmers Markets                 | Mattapan Square, ,<br>Roxbury, Dorchester                  | 80+           |
| Senior Centers                  | East Boston, Roxbury                                       | 60+           |
| Community Health Centers        | Bowdoin Street Health Center                               | 22+           |
| Faith Communities & Churches    | Multiple Roxbury, Jamaican Plain, & Brockton congregations | 30+           |
| Community Events & Health Fairs | ABCD, NAACP, Omega Men in Action, YMCA and More,           | 40+           |

# CLINICAL OUTCOMES BY ENGAGEMENT LEVEL

One of **our most important findings is the dose-response relationship between visit frequency and health improvement.** The more a participant engages with our model, the better the outcome.

| ENGAGEMENT LEVEL   | PARTICIPANTS             | BP IMPROVEMENT RATE (%)                    | AVG BP CHANGE          | SIG. REDUCTION (≥10 MMHG) |
|--------------------|--------------------------|--------------------------------------------|------------------------|---------------------------|
| 1-2 visits         | 655                      | 80+                                        | Minimal                | Insufficient data         |
| 3-5 visits         | 188                      | 60+                                        | -8.7/-4.2 mmHg         | 29 participants (15.4%)   |
| 6-9 visits         | 10                       | 22+                                        | -12.4/-6.1 mmHg        | 2 participants (20%)      |
| 10+ visits         | 6                        | 30+                                        | -1.7 mmHg (stabilized) | 0 (maintained gains)      |
| <b>Key Finding</b> | Dose-response documented | Optimal: 4-6 week intervals over 6+ months |                        |                           |

**Optimal engagement:** 4-6 week screening intervals maintained over 6+ months.  
**Improvement rate increases from 68% (3-5 visits) to 74% (6+ visits).**



Industry standard: Published literature (Smith et al., 2022; CDC, 2023)

# HEALTHCARE SYSTEM VALUE & COST SAVINGS

| METRIC                                              | 2025 VALUE                         |
|-----------------------------------------------------|------------------------------------|
| Crisis Prevention ROI                               | 3.1:1 to 4.7:1                     |
| Estimated healthcare costs prevented (2025)         | \$450,000 to \$675,000             |
| Cost per screening (including in-kind)              | \$111                              |
| Cost per participant served                         | \$141.59                           |
| Cost advantage vs. ED visit for hypertensive crisis | -180× to -540× more cost-effective |
| Emergency department visit baseline cost            | \$20,000-\$60,000                  |
| HGF cost per crisis identified and navigated        | \$111 vs. \$20,000-\$60,000        |

# Prevention vs. crisis: the cost-effectiveness advantage

Community-based screening prevents downstream emergency department costs



Cost ranges per Haidar et al., Am J Cardiol (Oct 2024) and AHA 2024 Heart Disease and Stroke Statistics Update.

# EAST BOSTON SENIOR CENTER: A PROVEN MODEL

**Our partnership with the East Boston Senior Center**, introduced by the American Heart Association in 2022, **demonstrates what sustained community presence can achieve:**

| EAST BOSTON SENIOR CENTER RESULTS | VALUE                          |
|-----------------------------------|--------------------------------|
| Retention rate                    | 52% (vs. 8% industry standard) |
| Total screenings (through 2025)   | 272                            |
| Unique participants               | 129                            |
| Average visits per participant    | 2.11 (program average: 1.48)   |
| Weekly presence since             | 2022                           |
| Crises identified                 | 4 prevented hospitalizations   |

“At Age Strong Boston, **we partner with HGF** to support the East Boston Senior Center, a bilingual community hub, twice a month. **In 2025, HGF helped 198 seniors, connected 23 to primary care, and prevented 4 hospitalizations.** Alongside screenings, **HGF provided health education** on food safety, handwashing, lifestyle changes, and reducing salt and sugar intake. These efforts empower seniors to take charge of their health”.

— **Dr. Judith Thermidor, MD**  
**Director, East Boston Senior Center / Age Strong Boston**

# COMMUNITY VOICES: UBUNTU IN THEIR WORDS

Numbers tell one story. People tell us more. **These are the voices of participants and Community Health Workers who bring Ubuntu to life** in Boston's neighborhoods.

# BEHIND THE NUMBER

## 22 Lives Saved

*"I felt fine. That was the scariest part when I found out what could have happened."*

What scared me most was how normal I felt. At the Mattapan farmers market, HGF found me with a **blood pressure of 198 over 110. The Coach explained what was happening, gave me a note**, helped me call my daughter, and promised to check on me. She called later that day, just like she said. **After I went to the ER and stayed overnight, the doctor told me I was lucky. If I had waited a few more days**, I could have had a stroke. HGF saved my life that day and has kept checking in ever since.

**James, 67, Mattapan**

(One of 22 hypertensive crises identified and referred to emergency care in 2025)

## A 93-Year-Old Teacher

*"I don't need to go anywhere."*

At a community health fair, our team met a sharp **93-year-old former teacher**. Coach Cil, RN, checked her blood pressure and found it dangerously high, **she was in a hypertensive crisis**. Even though there was a risk of stroke or heart attack, the woman said, "I don't need to go anywhere." Andrelle explained the situation calmly in her language and helped arrange for her to get to the hospital right away. After receiving the care she needed, **the woman returned to thank the team**.

# SPOTLIGHT: UBUNTU IN ACTION

**Andrelle Cadet-Piard**

HGF Community Health Coach

Finding your way through the healthcare system can be confusing, especially if you are dealing with health issues. I understand this both as a medical professional and as someone who lives in the community. **When I talk about my own worries, like the risks** of high blood pressure, people pay attention. Sharing these stories helps build trust and **work well with patients.**



**First screening: 168/98.** I was scared. My HGF health coach helped me learn **about salt, stress, and medications in Haitian.** She listened, remembered my family, and **now my blood pressure is 128/82.** I feel more like a person, and my grandchildren will have their healthy grandmother.

**Marie, 58, Dorchester**

(One of 27 participants who normalized blood pressure in 2025)

At one event, **a woman with high blood pressure told Coach Rosie she had lost contact with her clinic** and did not realize she could call to make an appointment. **After Rosie's guidance, the woman reached out to her clinic.** Two weeks later, she returned enthusiastic about her improved well-being. This brief exchange and community support helped her health.

**Cil Weekes-Cabey, RN, Health Operations Manager**

**Privacy & Consent Note**

**All participant stories were shared with written informed consent.** Names and identifying details were changed where requested to protect privacy while honoring authentic experiences. Photos used with explicit permission.

# FINANCIAL OVERVIEW & STEWARDSHIP

**Heart of a Giant Foundation maintains rigorous financial stewardship while maximizing community impact.** The following reflects Heart of a Giant Foundation's fiscal year 2025 (March 1, 2025 - February 28, 2026), consistent with the organization's IRS Form 990-EZ filing. Program activity metrics elsewhere in this report reflect calendar year 2025. Complete financial statements are available upon request.

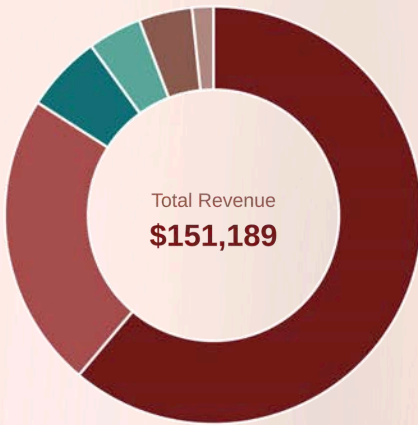
# 2025 REVENUE BREAKDOWN

Total FY2025 revenue of \$151,189 represents a 27% increase over FY2024, with foundation-grant share declining from 80% to 61% as donor and earned-revenue channels grew.

| REVENUE SOURCE                                     | AMOUNT    | % OF TOTAL |
|----------------------------------------------------|-----------|------------|
| Foundation Grants                                  | \$92,450  | 61.1%      |
| Individual & Corporate Donations                   | \$34,633  | 22.9%      |
| Earned Revenue (1099-NEC contracts)                | \$9,036   | 6.0%       |
| In-Kind Contributions (equipment + volunteer time) | \$6,307   | 4.2%       |
| Board & Leadership Giving                          | \$6,263   | 4.1%       |
| Corporate Employee Giving                          | \$2,500   | 1.7%       |
| TOTAL REVENUE                                      | \$151,189 | 100%       |

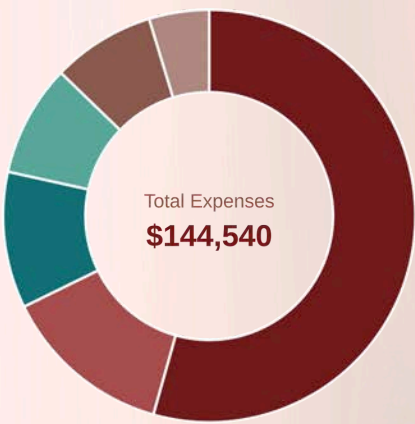
85+ individual donors contributed \$34,633 in FY2025. 50+ volunteers contributed donated time

# FY2025 REVENUE COMPOSITION



- Foundation & Government Grants  
\$92,450 • 61.2%
- Individual & Corporate Donations  
\$34,633 • 22.9%
- Earned Revenue (1099-NEC contracts)  
\$9,036 • 6%
- In-Kind Contributions  
\$6,307 • 4.2%
- Board & Leadership Giving  
\$6,263 • 4.1%
- Employee Giving  
\$2,500 • 1.7%

# FY2025 EXPENSE BREAKDOWN



- Program Delivery (CHWs, education, supplies)  
\$78,592 • 54.4%
- Occupancy, Rent & Utilities  
\$19,354 • 13.4%
- Technology & Systems (Essyl CRM, web, digital)  
\$15,448 • 10.7%
- Marketing & Business Development  
\$12,673 • 8.8%
- General Operations & Administration  
\$11,659 • 8.1%
- Professional & Legal Services  
\$6,814 • 4.7%

Net operating surplus: +\$6,649

# 2025 EXPENSE BREAKDOWN

| EXPENSE CATEGORY                                           | AMOUNT    | % OF TOTAL |
|------------------------------------------------------------|-----------|------------|
| Program Delivery (CHWs, education, supplies, field travel) | \$78,592  | 54.4%      |
| Occupancy, Rent & Utilities                                | \$19,354  | 13.4%      |
| Technology & Systems (Essyl CRM, web, digital tools)       | \$15,448  | 10.7%      |
| Marketing & Business Development                           | \$12,673  | 8.8%       |
| General Operations & Administration                        | \$11,659  | 8.1%       |
| Professional & Legal Services                              | \$6,814   | 4.7%       |
| TOTAL EXPENSES                                             | \$144,540 | 100%       |
| NET OPERATING SURPLUS                                      | \$6,649   | +4.4%      |

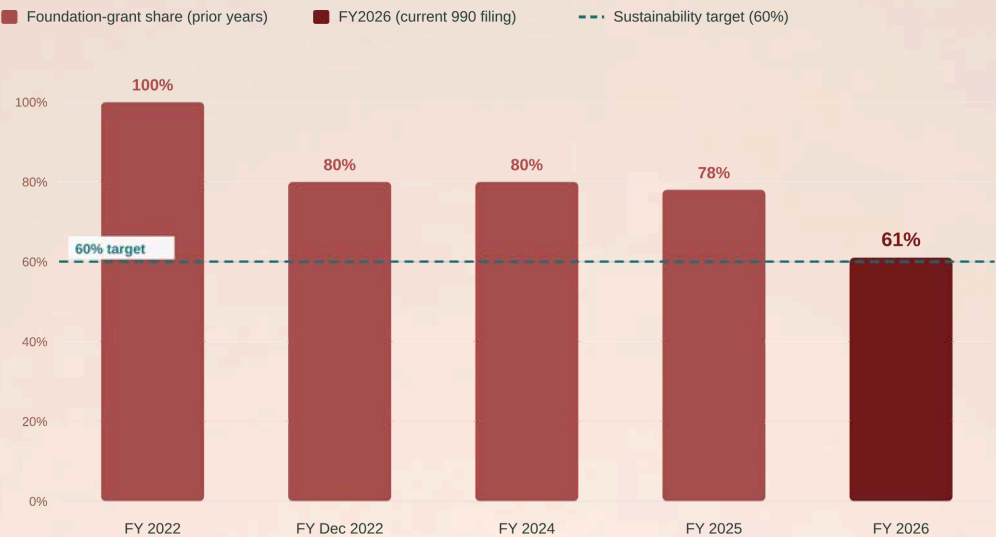
# KEY FINANCIAL EFFICIENCY METRICS

| METRIC                                               | 2025 ACTUAL                         | BENCHMARK               | STATUS            |
|------------------------------------------------------|-------------------------------------|-------------------------|-------------------|
| Program expense ratio                                | 54%                                 | >65% ideal              | Building toward   |
| Administrative/overhead ratio                        | 23%                                 | <35% good               | Excellent         |
| Cost per screening<br><i>(Program-delivery-only:</i> | \$111<br><i>\$60 per screening)</i> | \$300–500<br>(hospital) | Exceptional       |
| Cost per participant served                          | \$164                               | N/A                     | Highly efficient  |
| Crisis Prevention ROI                                | 3.1:1 to 4.7:1                      | >3:1 standard           | Exceeds benchmark |
| Foundation-grant dependency                          | 61%                                 | <60% sustainable        | Nearing target    |
| Individual donor count                               | 85+                                 | -                       | Growing           |

# CUMULATIVE IMPACT SINCE LAUNCH (2020–2025)

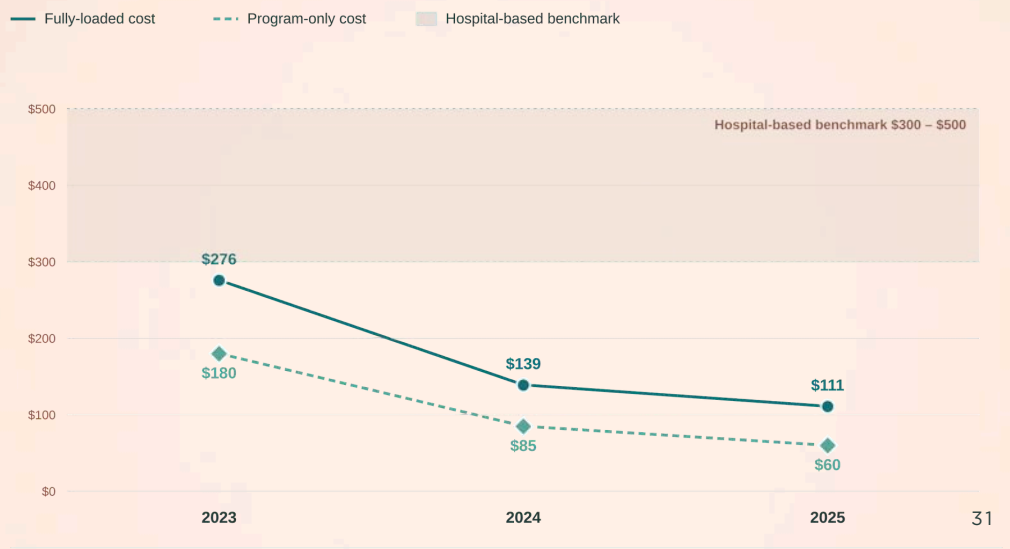
| MEASURE                                   | CUMULATIVE TOTAL |
|-------------------------------------------|------------------|
| Community Members Served (all programs)   | 7,800+           |
| Resources Mobilized                       | \$525,000+       |
| Total Screenings Conducted                | 2,340+           |
| Hypertensive Crises Identified & Referred | 47+              |
| Neighborhoods Reached                     | 10               |
| Years in Continuous Service               | 5                |

# REVENUE DIVERSIFICATION (FY2020–FY2025)



# COST PER SCREENING (FY2020–FY2025)

60% reduction in fully-loaded cost; 3 to 5 times more efficient than hospital-based screening



# OUR TEAM & GOVERNANCE

HGF's work is guided by **passionate professionals who bring together medical expertise, community engagement experience, and a shared commitment to health equity.**

Our multidisciplinary team combines **board-certified physicians, healthcare professionals, community health workers, and operations leaders** to work collaboratively.

# BOARD OF DIRECTORS

**Dr. Malika Fair, MD, MPH, FACEP**

President & Director

Chief Community, Opportunity & Engagement Officer, AAMC.

**Dr. Eméfah C. Loccoh, MD**

Director

Cardiology Fellow, Health Outcomes Researcher | Health Equity Advocate  
Beth Israel Deaconess Medical Center | Harvard Medical School.

**Olivia (Weinstein) Thomas, MS, RDN, LDN**

Director

Director of Nutrition Innovation and Implementation,  
Boston Medical Center.

**Lawrence Vinson III**

Director

National Consultant, Senior Program Manager  
CSH, the Source for Housing Solutions

**Laura Randall, CFRE**

Secretary

Certified Fundraising Executive.

**Somaneh "Bouba" Diemé**

Director

Founder, Heart of a Giant Foundation.

# EXECUTIVE & STAFF

## **Somaneh "Bouba" Diemé**

Founder & Chief Inspiration Officer (Volunteer)

## **Cil Weekes-Cabey, RN**

Health Operations Manager

## **Deanna Biddy, CCHW**

Health Program Manager

## **Stacey Brown**

People Operations Consultant  
*S Brown Consulting LLC*

## **Cherise Moore, MBA, PMP**

Tech & Systems Project Manager

## **Melissa Richardson**

Business Operations Manager

## **Olarinde Williams**

Grants Program Manager

## **Arpoo Eisendrath**

Accounting Manager

## **Financial Manager**

(Position Currently Vacant)

## **Ebele Mogo, PhD**

Senior Program Research Consultant  
*ERIM Consulting*

## **Fundraiser & Development Manager**

(Position Currently Vacant)

# OUR COMMUNITY HEALTH TEAM

**HGF's health team embodies Ubuntu, many began as participants in our programs and now serve as trusted health advocates in their communities. Their lived experience, combined with professional training, fosters the cultural competence and authentic relationships that drive our exceptional outcomes.**



# HEALTH COACHES

**Patricia Nunn**

RN — Lead Health Coach

**Gloria Anderson Armstrong**

RN — Senior Health Coach

**Rosie Weekes**

CMA — Senior Health Coach

**Andrelle Cadet-Piard**

CMA — Senior Health Coach

**Natalee DaCosta**

RN — Community Health Coach

**Joyce Walley Garblah**

Senior Health Coach

**Melanie Sturup**

Oral Hygienist — Community Health Coach

**Thuy Truong Do**

RN, PharmD, RPh — Senior Health Coach

**Shirline Jean**

MSN APRN PMHNP — Behavioral Health Coach  
Psychiatry Wellness Consultant

**Hannah Brooks**

RN — Community Health Coach

# BOARD OF ADVISORS

**Dr. Neal Lakdawala, MD, MBA**

Cardiovascular Medicine, Brigham and Women's Hospital / Harvard Medical School

**Dr. Lucas Marinacci, MD**

Faculty Physician & General Cardiologist, Beth Israel Deaconess Medical Center

**Dr. Lauren Eberly, MD, MPH**

Cardiovascular Medicine Fellow, Perelman School of Medicine, University of Pennsylvania

**Dr. Shabatun (Saba) Islam, MD**

Cardiology Fellow, Brigham and Women's Hospital

**Dr. Nicole Singh, MD**

Primary Care Physician, Sislen & Associates, Washington, DC

**Dr. Ousmane Dieye, MD**

Cardiovascular Medicine Specialist, Cabinet de Cardiologie SAKINA, Dakar, Senegal

**Myrtise Maurice, MSW, MPH, LICSW**

Clinical Social Worker, Community Health, Perspectives Health Services, LLC

**Prof. Joe Amadi-Echendu**

Engineering & Technology Management, University of Pretoria

**Modou Fall**

Founder & CEO, IANOVA, Dakar, Senegal

**Mamadou Sora**

Customer Success Manager, Athenahealth

**Boston Scientific**

Pro Bono Leadership Consulting Partner



# PARTNERS & SUPPORTERS

**"Ubuntu means partnership, not charity." Our 2025 impact is driven by strategic collaborations with healthcare systems, foundations, community organizations, and individuals who believe that patients and their communities should lead their own health.**



# GOVERNMENT & PUBLIC SECTOR

**Massachusetts Department of Public Health**

2023–Present

**Age Strong Boston (City of Boston)**

2023–Present

# HEALTHCARE SYSTEM & FQHC PARTNERSHIPS

## **Mass General Brigham, MGB**

2022–Present

## **MGB Pressure Check Research Initiative**

2024–Present

## **Boston Medical Center, BMC**

2023–Present

## **Beth Israel Deaconess Medical Center**

2025–Present

## **Bowdoin Street Health Center** (A Federally Qualified Health Center, FQHC)

2025–Present

## **Brockton Neighborhood Health Center** (FQHC)

2023

# COMMUNITY, FAITH & CIVIC ORGANIZATIONS

## **YMCA of Greater Boston**

2024-Present

## **Boys & Girls Clubs of Greater Boston**

2025-Present

## **Action for Boston Community Development (ABCD)**

2022-Present

## **NAACP Health Committee**

2025-Present

## **East Boston Senior Center**

2022-Present

## **Mattapan Food & Fitness Coalition**

2023-Present

## **Madison Park Development Corporation**

2023-Present

## **Omega Men in Action - Cooper Community Garden Center**

2024-Present

## **Vital Connections**

2025-Present

**Bethel AME Church, JP | Abundant Church, Cambridge |  
Twelfth Baptist Church, Roxbury | New Life Christian Church, Brockton |  
Brockton Holy Tabernacle Church**

2022-2025

# ACADEMIC & RESEARCH COLLABORATIONS

**Northeastern University**

2025–Present

**Bridgewater State University**

2024–Present

# PHYSICIAN & PATIENT ADVOCACY NETWORKS

**New England Regional Black Nurses Association (NERBNA)**

2023–Present

**American Heart Association**

2020–2024

# FOUNDATION & INSTITUTIONAL FUNDERS

## **Cummings Foundation**

2025–Present

## **Lenny Zakim Fund**

2023–Present

## **Boston Scientific Foundation**

2023–Present

## **Red Sox Foundation**

2025

## **Adelard A. & Valeda Rae Roy Foundation**

2024–2025

**Corporate Employee Giving**

2020–Present

**Massachusetts Department of Public Health**

2023–Present

**The Boston Foundation**

2023–Present

**Foley Hoag Foundation**

2022–2024

**American Heart Association**

2020–2024

**CVS Health Foundation**

2022

**Blue Cross Blue Shield of MA Foundation**

2021

**Cambridge Savings Charitable Foundation**

2023–2024

**Brookline Community Foundation**

2022

Individual donors (85+) contributed \$20,085 in 2025. 50+ volunteers donated 100+ hours of professional time, valued at \$5,000. **Every contribution, however large or small, helps provide life-saving cardiovascular screenings and health education** in Boston’s most at-risk neighborhoods.

# LOOKING AHEAD: OUR 2026 STRATEGY

## OUR 2026 PRIORITY

**"Become the trusted bridge between communities at high risk of heart disease and the care system, and prove it works."**

Community-led. Clinically grounded. Built on trust.

Five years of proof. Now we build the infrastructure to sustain and grow it. **Our 2026 strategy is focused, honest, and built on what the data shows: the model works;** what it needs now is stable operations, formalized partnerships, and published evidence.

# OUR TWO OPERATING MODEL COMPONENTS

## **Community Care Connect**

HGF teams deliver free cardiovascular screening, health coaching, and care coordination, building patient trust and support between visits. We connect patients to essential health and social resources, maintain individualized care plans, and streamline provider communication. Our comprehensive approach drives measurable, sustained outcomes for high-risk groups in Early CKM. Health systems benefit by meeting target goals, while revenue is generated through provider contracts, care fees, and screening partnerships.

## **Community Evidence Lab**

The Community Evidence Lab conducts research to validate the model, support replication, and advance payment reform. HGF publishes results independently and with partners to establish itself as a key collaborator in outcomes-based care, and seeks large-scale funding through partnerships, including PCORI, with plans to submit lead applications starting in 2027.

**The two components are mutually reinforcing:** Community Care Connect builds trust and data, while the Community Evidence Lab translates this foundation into evidence that drives provider partnerships, investment and growth.

# 2026 SUCCESS METRICS

| METRIC                     | 2026 TARGET                        | FROM 2025         |
|----------------------------|------------------------------------|-------------------|
| Unique individuals served  | 1,000                              | Up from 879       |
| Participant retention rate | Maintain $\geq 25.5\%$             | Maintained        |
| BP improvement (6+ visits) | Maintain $\geq 74\%$               | Maintained        |
| Provider contracts signed  | 1 paying partnership               | 0 $\rightarrow$ 1 |
| Grant revenue secured      | $\geq$ \$100K single grant         | Pipeline active   |
| CRM standardization        | All 19 sites on the unified system | In progress       |
| White paper published      | Three-year outcomes data           | Q2 target         |
| Full-time ED transition    | June go/no-go decision             | Conditional       |

# LONG-TERM VISION (2027–2028)

| GOAL                     | 2027                                | 2028                               |
|--------------------------|-------------------------------------|------------------------------------|
| Annual Budget            | \$255K–\$310K                       | \$375K–\$750K                      |
| Earned Revenue Share     | 50%                                 | 70%                                |
| Annual Screenings        | 2,000+                              | 4,000–5,000+                       |
| Cities Beyond Boston     | 2–3                                 | 5+                                 |
| CHW Program Partnerships | Training collaborations established | Field placements for 50+ CHWs/year |
| International Operations | Senegal preparation                 | Operational                        |
| Research Publications    | PCORI application                   | Published model                    |
| Annual Budget Goal       | -                                   | \$1M                               |

# 2026 INVESTMENT ASK

| GOAL                                                 | LOW       | HIGH      | FUNDING SOURCES                           |
|------------------------------------------------------|-----------|-----------|-------------------------------------------|
| Full-time Executive Director<br>(June 2026 go/no-go) | \$105,000 | \$135,000 | Multi-year operating grants               |
| Health coaching team<br>expansion (2 part-time CHWs) | \$30,000  | \$30,000  | Healthcare system contracts               |
| Earned-revenue infrastructure<br>(FQHC/RPM/research) | \$40,000  | \$50,000  | Provider service contracts                |
| Data systems & Essyl CRM<br>enhancements Boston      | \$18,000  | \$20,000  | Operating grants                          |
| Research publication &<br>white paper                | \$12,000  | \$12,000  | Research partnerships                     |
| Fundraising & development<br>capacity                | \$20,000  | \$8,000   | Operating grants                          |
| TOTAL                                                | \$225,000 | \$255,000 | Combined philanthropy<br>+ earned revenue |



# HOW TO SUPPORT OUR WORK

**"Ubuntu means I am because we are."** Our impact is made possible by partners, donors, volunteers, and advocates who believe communities should lead their own health. Here is how you can be part of this story.

# FOR INDIVIDUAL DONORS

| YOUR GIFT | WHAT IT FUNDS                                           |
|-----------|---------------------------------------------------------|
| \$50      | 5 cardiovascular screenings                             |
| \$125     | 1 participant served through the full four-phase model  |
| \$500     | 1 hypertensive crisis identified and navigated to care  |
| \$2,500   | 1 Community Health Worker trained                       |
| \$10,000  | 1 permanent screening location for a full year          |
| \$25,000+ | 1 month of full operations - reaching 100+ participants |

**Donate online:** [heartofagiant.org/donate](https://heartofagiant.org/donate) | Tax-deductible | EIN: 84-2900386

# FOR HEALTHCARE PARTNERS

If you are a healthcare system, FQHC, or clinical network, **we are actively pursuing provider referral partnerships, patient engagement contracts, and research collaborations.** We are the community infrastructure you need but cannot build yourself.

**Contact:** [info@heartofagiant.org](mailto:info@heartofagiant.org)

# FOR FOUNDATIONS & CORPORATE FUNDERS

**We are actively seeking bridge funding** (\$50–75K), operating grants (\$100K+), **and multi-year partnerships** with funding partners committed to community-led care, community health worker workforce development, and real-world cardiometabolic outcomes research.

**Contact:** [growth@heartofagiant.org](mailto:growth@heartofagiant.org)

# FOR VOLUNTEERS

**We engage all skilled volunteers across data analysis, communications, grant writing, legal services, accounting, or technology;** medical and health professionals supporting clinical and coaching activities; and community volunteers supporting events and outreach.

**Join:** [heartofagiantfoundation.org/get-involved](https://heartofagiantfoundation.org/get-involved)



# CONTACT INFORMATION



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**“I AM  
BECAUSE  
WE ARE”**



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