HYPERTENSION SCREENING & EDUCATION

2024 CAMPAIGN REPORT

December 2024

HEART OF A GIANT FOUNDATION

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Hypertension Screening & Education 2024 Campaign Report

Executive Summary

The **Heart of a Giant Foundation** (HGF) conducted the **2024 Hypertension Screening and Education Campaign**, targeting underserved communities across Greater Boston **to raise awareness, provide health screenings, and connect participants with resources to manage hypertension.** This report presents campaign objectives, methodologies, findings, and actionable recommendations for future interventions.

Campaign Reach: 802 screenings were conducted at 58 events across 11 neighborhoods, engaging 635 individual participants. **134+ participants attended follow-up screenings, highlighting strong health engagement.**

Community Partnerships: **Collaborated with 47 community organizations** to maximize reach and engagement and supported 10 once-off events.

Health Impact: **Identified 231 high-risk individuals** (Stage 2 or higher) **were promptly referred** to healthcare providers or local health centers for tailored follow-up care and support **to manage their condition effectively.**

Coaching & Continuous Monitoring: **Monitored 68 participants for 3 to 9 months** to manage blood pressure through education and personalized care. **Findings included 40% in Hypertension Stages 1 or 2 and 10% in crisis**, with some achieving **reductions of up to 72 mmHg.** Future efforts will focus on expanding remote monitoring and tailored programs for underrepresented groups. See the 2024 Campaign Report for details.

INTRODUCTION

Hypertension, often called the **"silent killer,"** disproportionately **impacts underserved populations.** The **Heart of a Giant Foundation's campaign** tackled these disparities by **offering free screenings, health education, and community engagement** to reduce risks and empower individuals across Greater Boston.

Campaign Objectives

1- Raise awareness about hypertension and its risks.

2- Provide free **BP measurements** and **health consultations.**

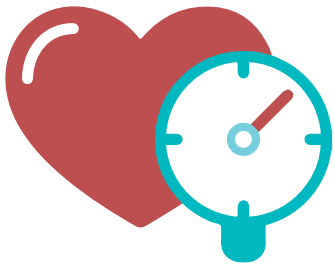
3- Identify at-risk individuals and provide follow-up care referrals.

4- Build trust and foster health literacy within communities.

METHODOLOGY

This report comprehensively analyzes the campaign's findings, encompassing demographic insights, hypertension prevalence, health infrastructure capacity, and recommendations for scalable & sustainable interventions. **The campaign engaged a broad audience through on-site screenings, educational sessions, and community partnerships.** Data collected through manual and digital tools informed the strategy, ensuring responsiveness to community needs.

The campaign, guided by the Massachusetts Department of Public Health and the American Heart Association, **emphasized the importance of regular blood pressure monitoring using validated devices, proper techniques, & consistent follow-ups.** Recognizing that home monitoring complements but does not replace medical consultations, **the initiative adopted a mixed-method approach.** This included recurring & once-off events for maximum community impact, with data securely entered into a HIPAA-compliant database for analysis.



Recurring and Once-Off Community Events

The campaign featured recurring and once-off events strategically organized with trusted community organizations to maximize outreach and engagement.

RECURRING EVENTS

These events fostered trust and continuity, leveraging longstanding partnerships and expanding into new collaborations. **They were held at five key locations:**

- Bethel AME Church
- ABCD Mattapan
- ABCD North Dorchester/Roxbury NOC (1st Year)
- East Boston Senior Center
- Mattapan Farmer's Market

ONCE-OFF EVENTS

These events allowed **flexible scheduling** and enabled **the campaign to reach diverse populations across various locations**. Hosted in collaboration with community partners, they included:

- Abundant Life Church
- Archdiocese of Boston Benefit Fair
- Bos CHW/Lower Neponset/Ryan Park
- Bridgewater State University
- Brockton Fair Grounds
- Madison Park DC Health Fair
- Franklin Park – Breast Cancer Awareness Event
- South Boston Library
- Thelma Burns Building
- Viet Aid Center

This dual-event strategy ensured **consistent outreach to established communities and expanded access to underserved populations.**

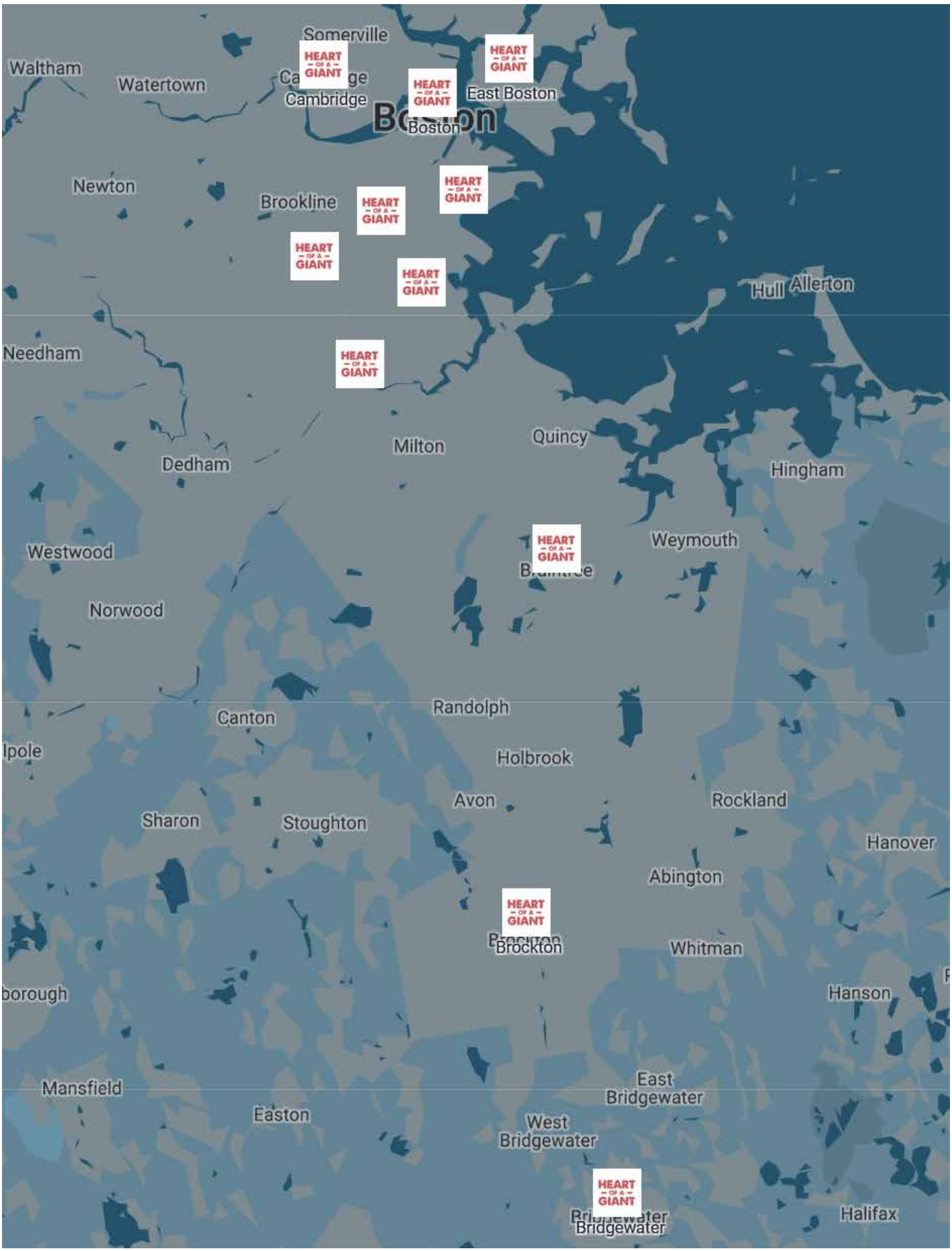


Image 1: Map highlighting neighborhoods served by the campaign.

SCREENING & EDUCATION PROCESS

Participants received personalized guidance, including clinical referrals, education on lifestyle changes (diet, exercise, stress management, sleep), and home BP monitoring recommendations. Demographics and health metrics were collected, with **at-risk individuals referred for follow-up care.**

Participant Registration and Health Data: **HGF collects participant data through sign-up forms** that capture demographics such as age, gender, ZIP code, and contact information. **Health data** is manually recorded during screenings and **securely transferred to HGF's HIPAA-compliant database** for analysis and reporting.[1]

Health Screenings and Education: **Certified health coaches used standardized tools** to measure systolic and diastolic blood pressure, heart rate, and other health metrics. They also addressed participants' questions, **provided guidance, and offered strategies** for effectively navigating healthcare systems.

Referrals: **Individuals at risk of hypertension** were provided with follow-up care recommendations and **referred to local healthcare providers** or community health centers.

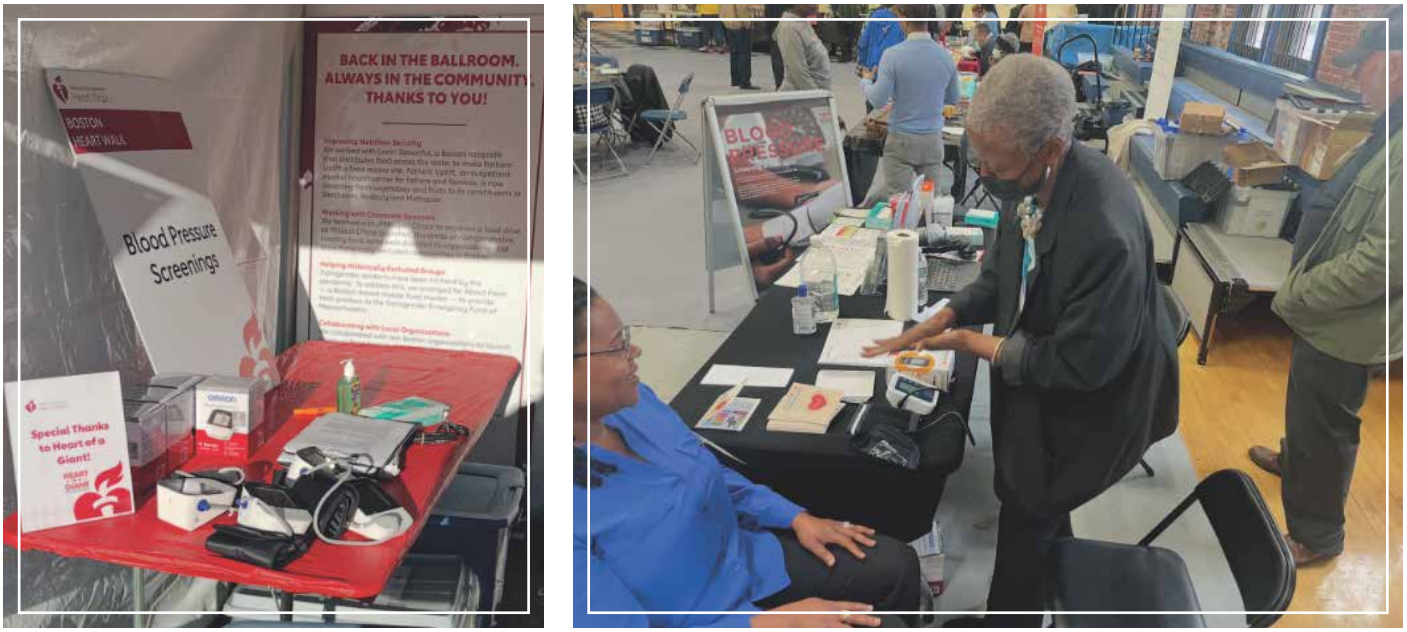


Image 2: Health Coaches interact with participants at screening and education events.

[1] To enhance efficiency and data accuracy, future initiatives will adopt real-time digital data entry via the Essyl CRM system using tablets or smartphones. This transition aims to streamline operations, reduce manual errors, and provide immediate insights for improved decision-making and participant outcomes.

Image 3: Health Coaches at screening and education events interacting with participants.

FINDINGS & TRENDS

Demographics

The campaign served 635 individual participants from diverse backgrounds, with significant representation from Mattapan, Dorchester, and East Boston. Highlights include:

Age Distribution: The campaign engaged a diverse population **aged 18 to 92**, with **40% aged 51 to 70**.

Ethnic Background Diversity: HGF health coaches actively engaged **participants from diverse racial and ethnic backgrounds,** with significant representation from Black and Hispanic communities, along-side White and Asian populations. **This inclusivity reflects the campaign's targeted outreach efforts** to address the unique health needs of underserved groups.

The campaign encompassed a broad range of demographic profiles, economic statuses, and health outcomes, with hypertension prevalence varying significantly across neighborhoods.

Income Levels: HGF served participants across various income levels; however, the majority reported low to moderate incomes, highlighting significant **socioeconomic disparities in healthcare access.**

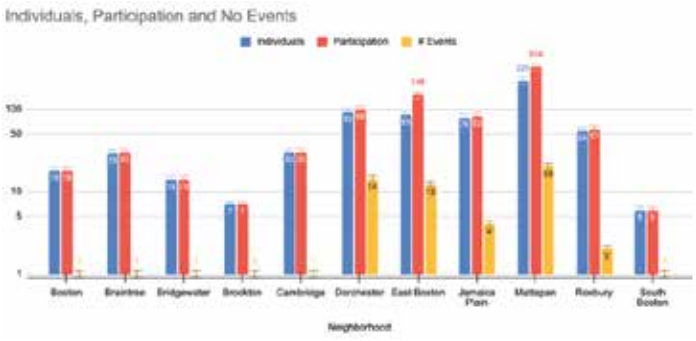


Figure 1: Events and Neighborhood Participation

Hypertension Prevalence

Normal Blood Pressure: 29%
Healthy blood pressure levels.

Elevated Blood Pressure: 13%
At risk of hypertension and requiring lifestyle interventions.

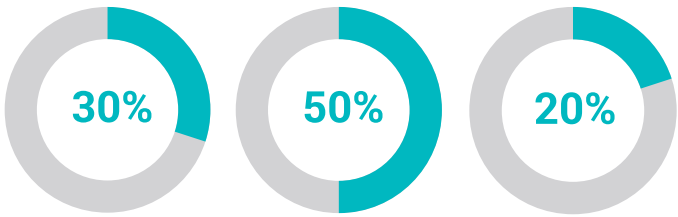
Stage 1 Hypertension: 24%
Moderate risk requiring intervention; referred for education and follow-up care.

Stage 2 Hypertension: 32%
High-risk cases requiring immediate care.

Hypertensive Crisis: 2%
Emergency referrals for urgent medical care.

Medication Adherence

HGF Coaches assessed Adherence based on 60+ participants' self-reported compliance with prescribed hypertension management plans, including medication use and lifestyle modifications.



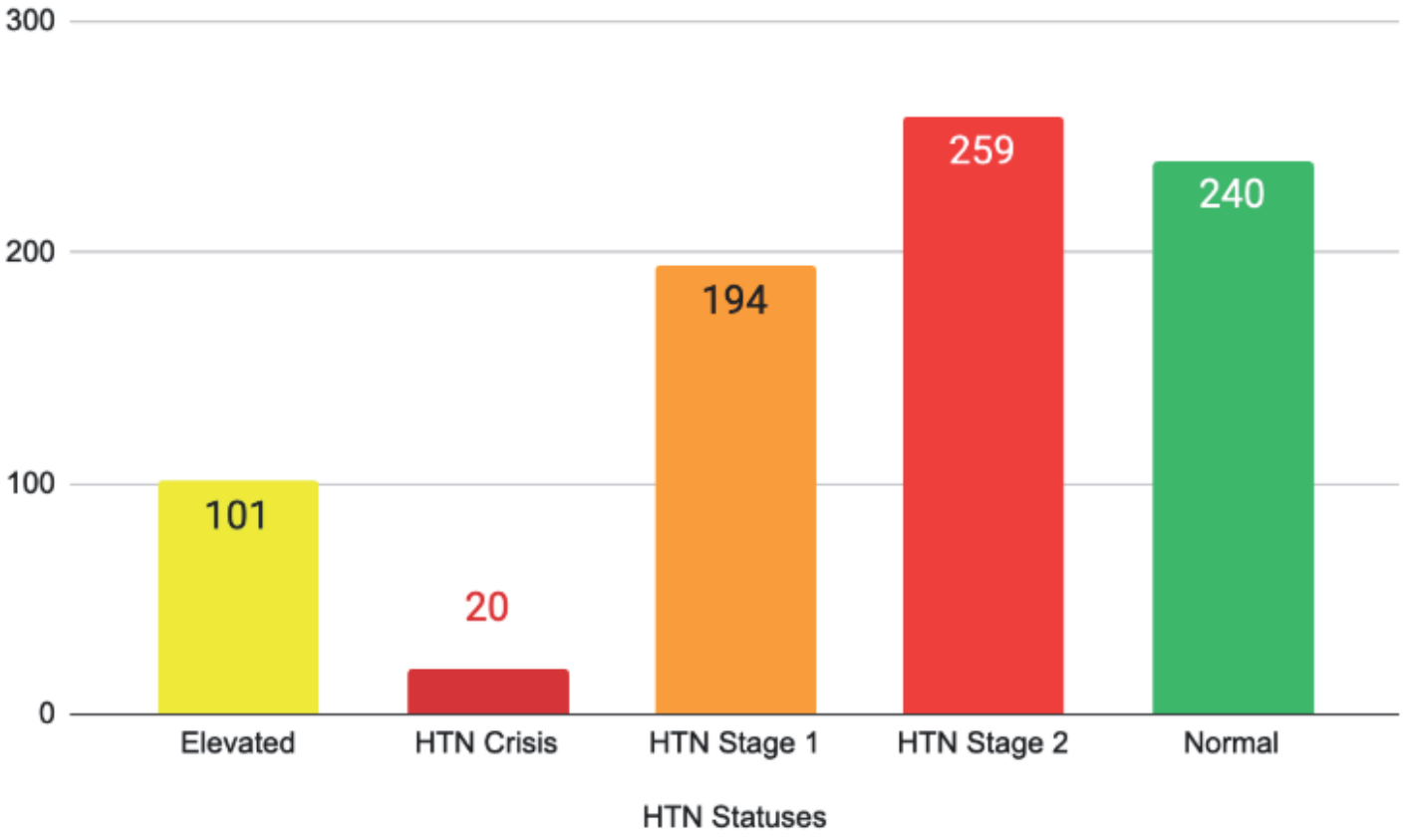


Figure 2: Hypertension Prevalence

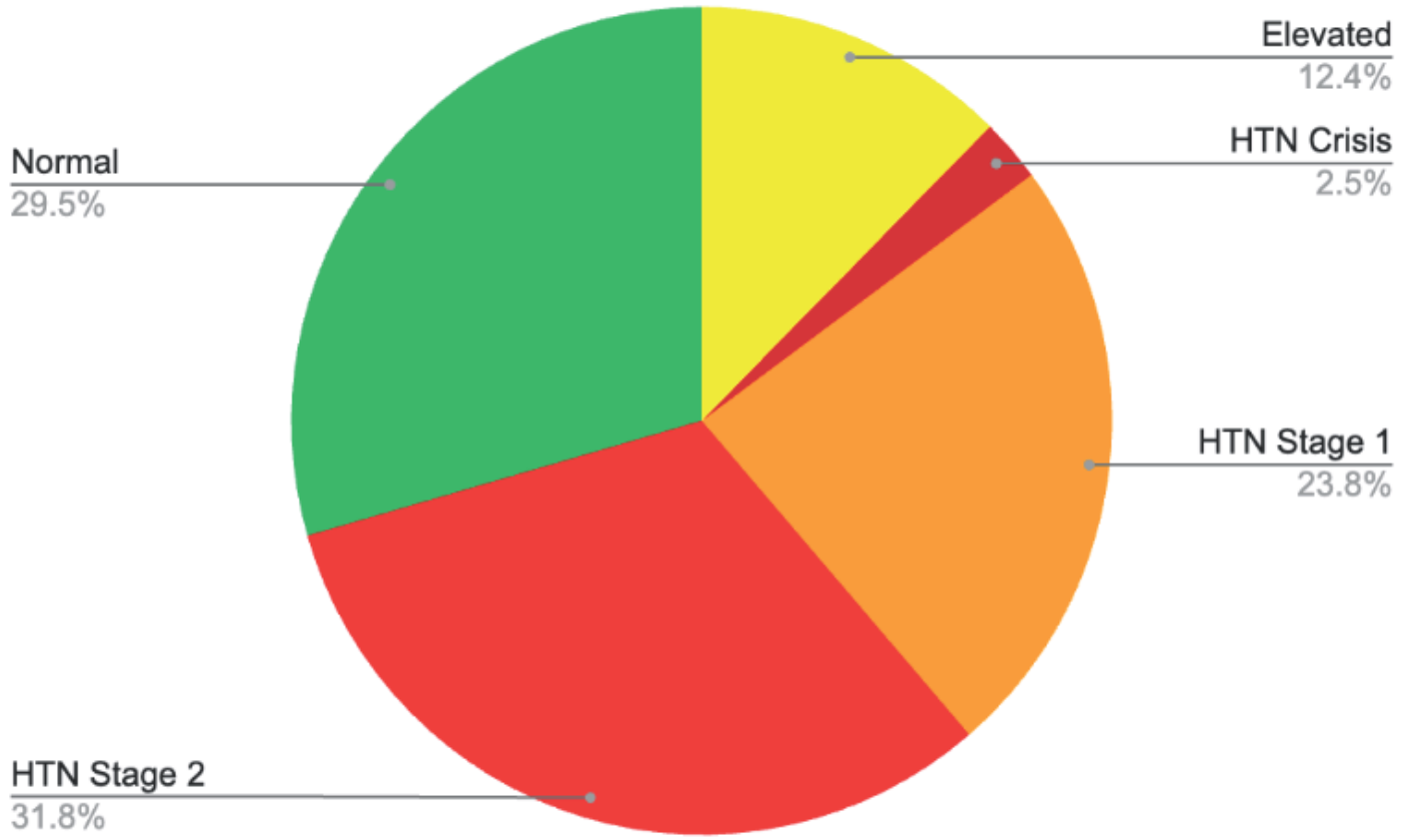


Figure 3: Hypertension Prevalence: Chart

HTN Statuses						
Neighborhood	**Elevated**	**HTN Crisis**	**HTN Stage 1**	**HTN Stage 2**	**Normal**	**Grand Total**
Boston	2		11	3	2	18
Braintree	2		8	10	10	30
Bridgewater	2		5	4	3	14
Brockton	1		1	3	2	7
Cambridge	4		6	11	9	30
Dorchester	7	6	25	39	21	98
East Boston	34	7	31	36	40	148
Jamaica Plain	13	1	18	20	30	82
Mattapan	29	5	75	109	106	324
Roxbury	6	1	13	21	16	57
South Boston	1		1	3	1	6
Grand Total	101	20	194	259	240	814

Table 1: HTN Prevalence per Neighborhood

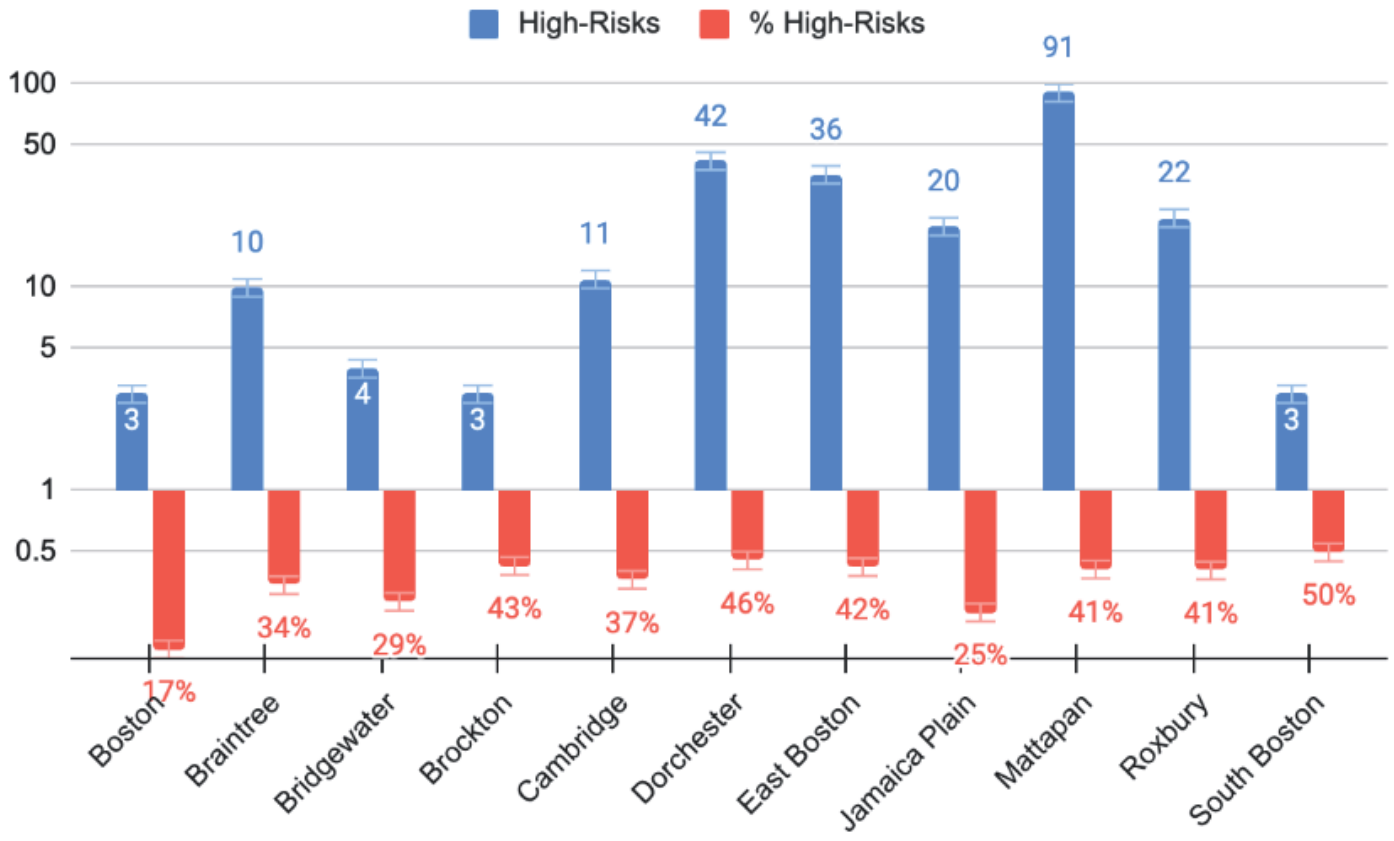


Figure 4: Neighborhood Heatmap: High-Risk Individuals

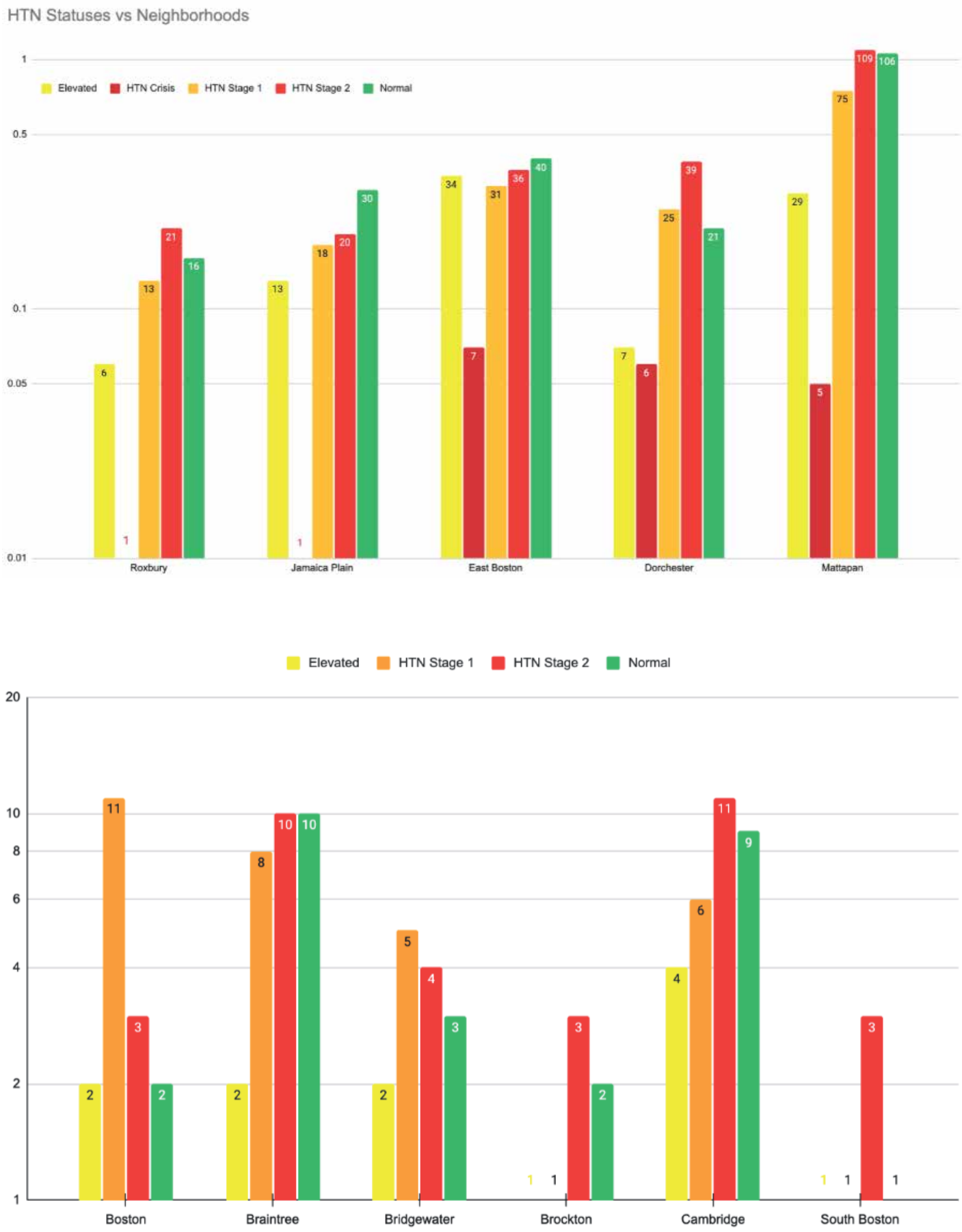


Figure 5: Neighborhood Heatmap

Continuous Blood Pressure Monitoring & Coaching

Team HGF engaged 68 participants from diverse backgrounds this year, focusing on blood pressure monitoring, education, and tailored interventions. Key findings showed **40% of participants in Hypertension Stages 1 or 2, with 10% in crisis.** Positive outcomes included **significant systolic reductions** (up to 72 mmHg), though **challenges like limited improvement in some Stage 2 participants** and **worsening hypertension in others** highlight the need for targeted care.

Future efforts will expand remote monitoring, personalized care, and culturally tailored programs while scaling interventions to underrepresented groups such as Asians, Caucasians, and Dominicans. **Strengthening partnerships, enhancing education, and leveraging data will drive equitable health outcomes and reduce hypertension risks.**

See the Continuous BP Monitoring and Coaching 2024 Campaign Report for more information.

INSIGHTS & RECOMMENDATIONS

Key Insights

Participants shared heartfelt testimonials about **how the campaign motivated them to take control of their health.** For many, this was the first time they were made aware of their hypertension risk. **The initiative empowered individuals to seek care, adopt healthier lifestyles,** and actively engage in their wellness journeys.

Hypertension disproportionately impacts individuals aged 50+ and underserved ethnic groups, highlighting significant health disparities.

Communities like **Mattapan, Dorchester, and Roxbury** showed **the highest prevalence of hypertension,** reflecting historical healthcare inequities and requiring intensified focus and resources.

The average **event attendance was 15 participants, and over 60 individuals on hypertension medication were identified.** However, most reported noncompliance with their treatment plans, with many missing doses before the screenings. **Medication adherence remains a critical gap that requires targeted interventions.**

Hypertension was most prevalent in communities like **Mattapan, Dorchester, and Roxbury,** highlighting longstanding and current healthcare inequities in these areas.

Health coaches emphasized lifestyle changes, including walking, yoga, stress management, and healthier diets, **complemented by nutritional resources,** wellness program referrals, & **support group access.**

Image 4: Health coaches at heart health education and BP workshops.

These findings highlight the need for comprehensive screening and education initiatives to address hypertension risks and improve community health outcomes.

Lessons Learned

The lessons learned and recommendations outlined in this report will inform **future campaigns, ensuring a broader reach, stronger partnerships, & sustainable health outcomes for vulnerable populations.**

Details about the Next Steps are below.

Strengthened Follow-Up Mechanisms:
Stronger referral tracking and healthcare partnerships are essential. While referrals were key to the campaign, follow-up care remains a challenge. Collaborating with local providers and using digital tracking systems will **improve care continuity.**

Targeted Education:
Culturally tailored workshops on nutrition, stress management, and exercise were well-received. Expanding these sessions with content customized to specific cultural and community needs **can enhance engagement and impact.**

Enhance Data Collection Tools:
Upgrade data collection systems with mobile or tablet-based platforms for real-time data entry, **ensure ease of use** & reliability, & **provide regular staff training** to minimize errors & enhance efficiency.

Leveraging Technology:
Real-time data collection and remote monitoring tools are essential for improved efficiency. **Transitioning to streamlined digital systems and integrating telehealth services will enhance data accuracy and participant outcomes.**

Community Trust:
Long-term partnerships with local organizations foster **trust and increase participation.** Future efforts should **deepen these relationships and expand outreach efforts.**

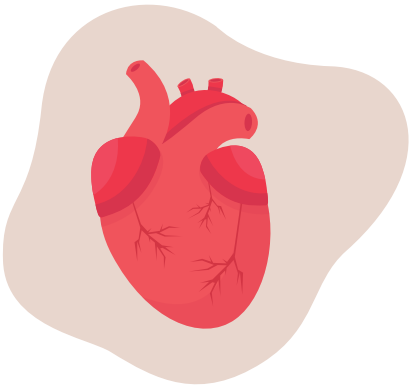
Image 5: Health coaches at heart health education and BP workshops.

Community Impact Stories

The 2024 Hypertension Screening and Education Campaign left a lasting impact on participants and communities, showcasing the importance of accessible, culturally tailored health services. The campaign underscored **the critical role of community-based health programs** through notable instances of addressing acute health crises, managing chronic conditions, and empowering individuals to navigate complex healthcare systems. While the successes were profound, several gaps were identified, accompanied by recommendations to strengthen future efforts and expand the campaign's reach and effectiveness.

1- Immediate Life-Saving Interventions

Heart Attack & Irregular Heartbeats:
Participants displaying signs of heart attacks or irregular heart rhythms during screenings received immediate attention. Health coaches acted swiftly, arranging emergency transport or helping family members drive participants to nearby clinics, **ensuring life-saving care.**



2- Success in Chronic Condition Management

Diabetes Management:
One participant with **dangerously high glucose levels (300+)** attended weekly sessions for two months. Through personalized coaching and a commitment to lifestyle changes, the participant successfully **reduced their glucose levels to 100,** showcasing the campaign's effectiveness in addressing chronic conditions.

3- Navigating Healthcare Systems

Empowering Self-Advocacy:
Many participants sought help navigating the healthcare system, understanding their rights, & advocating for equitable care. In one case, **a non-English speaking participant replaced an inadequate interpreter at a clinic after health coaches provided education on healthcare advocacy.** This empowerment improved their overall care experience.

4- Addressing Language Barriers

Translation Challenges:
Non-English speaking participants, often relying on family members or interpreters, **faced disparities in communication and care.** Younger family members serving as interpreters sometimes lacked the vocabulary to ensure accurate understanding. **HGF collaborated with community leaders to provide better translation support** and advocate for improved systemic language services.

5- Community & Volunteer Support

Collaborative Engagement:
Community leaders and volunteers who assisted with event logistics, participant engagement, and translations greatly benefited the campaign. Their **efforts fostered trust and strengthened the program's effectiveness**, highlighting the power of collaboration in addressing public health challenges.

These moments collectively illustrate the campaign's significant impact, from life-saving interventions to systemic advocacy. They **also provide valuable insights for enhancing future initiatives,** ensuring broader reach and deeper community connections.

Gaps Identified

Referral System Challenges: **Non-English-speaking participants had difficulties accessing quality care** due to inadequate translation services and limited partnerships with multilingual clinics. This led to instances where **participants received substandard care or felt underserved.**

Participant Engagement: **The underrepresentation of younger demographics and working populations,** likely due to scheduling conflicts, **reduced the campaign's reach and inclusivity.**

Data Management Inefficiencies: **Reliance on manual data collection delayed follow-ups and increased the risk of errors,** limiting the ability to track participants and ensure timely interventions.

Cultural Sensitivity & Inclusivity: Certain groups, such as Asian populations and younger individuals, were less engaged, highlighting a **need for more inclusive & culturally tailored programs.**

Volunteer & Staff Capacity: **Limited access to health professionals and programmatic expertise among volunteers** occasionally hindered service delivery and participant support.

Healthcare Advocacy & Systemic Barriers: **Participants often lacked awareness of their rights within the healthcare system** or how to navigate available resources, exacerbating **challenges like missed diagnoses and poor-quality care.**

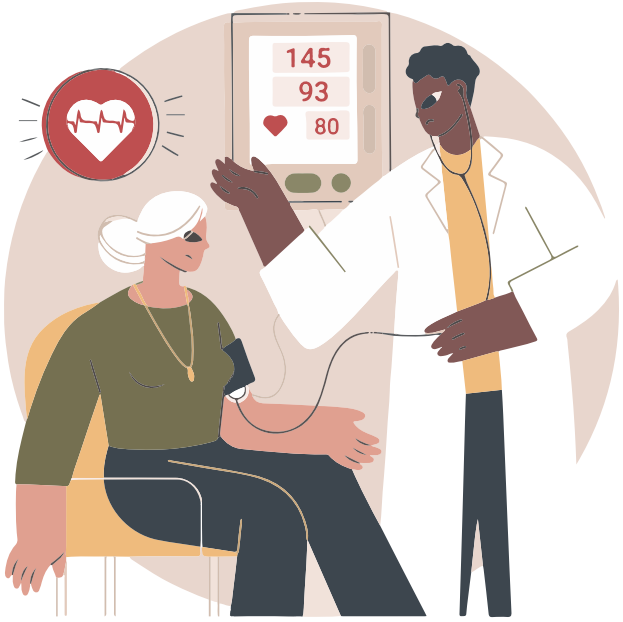
RECOMMENDATIONS FOR IMPROVEMENT

The following recommendations focus on **strengthening systems, expanding reach, and deepening community engagement.**

1- Strengthening Referral Systems

Build Formal Partnerships:
Collaborate with **clinics and specialists with multilingual staff** and culturally sensitive resources.

Develop a Healthcare Directory:
To streamline the referral process and ensure participants access high-quality care, **create a categorized directory of trusted providers by location and specialty.**



2- Enhancing Participant Engagement

Flexible Event Schedules:
Expand session availability to include evenings and weekends, accommodating younger and working populations.

Youth-Specific Programs:
Design **prevention-focused hypertension education for youth,** emphasizing lifestyle choices and early interventions.

3- Modernizing Data Management

Implement the Essyl CRM System:
The adoption of the **Essyl CRM platform for real-time data collection** and follow-up tracking should be expedited.

Enable Mobile Health Monitoring:
Provide participants with **mobile access to their health data for better self-monitoring** and continuity of care.

4- Expanding Cultural Sensitivity Efforts

Collaborate with Community Leaders:
Design programs tailored to underserved groups, addressing specific cultural needs such as dietary preferences and language barriers.

Enhance Coach Training:
Train health coaches to engage participants from diverse backgrounds effectively, **using culturally relevant materials to increase health literacy.**

5- Building Volunteer & Staff Expertise

Recruit Qualified Volunteers:
Engage medical students, retired professionals, and community health workers to enhance capacity.

Comprehensive Training:
To ensure impactful engagement, volunteers, and staff should be **trained in cultural competence, effective communication, and program delivery.**

6- Advocating for Systemic Healthcare Improvements

Mandate Quality Interpreter Services:
Advocate for policies requiring effective interpreter services at healthcare facilities.

Raise Awareness of Community Resources:
Partner with advocacy groups to **educate participants on available resources and heir healthcare rights.**

7- Expanding Community Partnerships

Collaborate with Local Organizations:
Partner with health centers, schools, and community groups to **extend the campaign's reach** and provide comprehensive care.

Engage Schools & Universities:
Strengthen relationships with educational institutions to create awareness and support programs.

8- Investing in Technology

Equip with Digital Tools:
Utilize tablets for real-time data collection **and telehealth platforms** for follow-up care.

Streamline Operations:
Leverage **technology to enhance service delivery** and operational efficiency.

9- Tailoring Educational Programs

Culturally Relevant Workshops:
Offer workshops on diet, exercise, and stress management tailored **to each community's cultural and practical needs.**

Practical Resources:
Provide participants with **tools and guides for healthy lifestyle changes.**

10- Enhancing Follow-Up Protocols

Centralized Tracking System:
Develop a robust system to **monitor referrals and ensure participants receive proper follow-up care.**

Strengthen Partnerships with Specialists:
Collaborate with local clinics and research centers to improve follow-up care.

11- Increasing Funding for Outreach

Pursue Grants & Partnerships:
Seek funding opportunities to scale the campaign and enable more extensive interventions in high-need areas.

Engage Corporate Sponsors:
Partner with businesses to co-sponsor community health events.

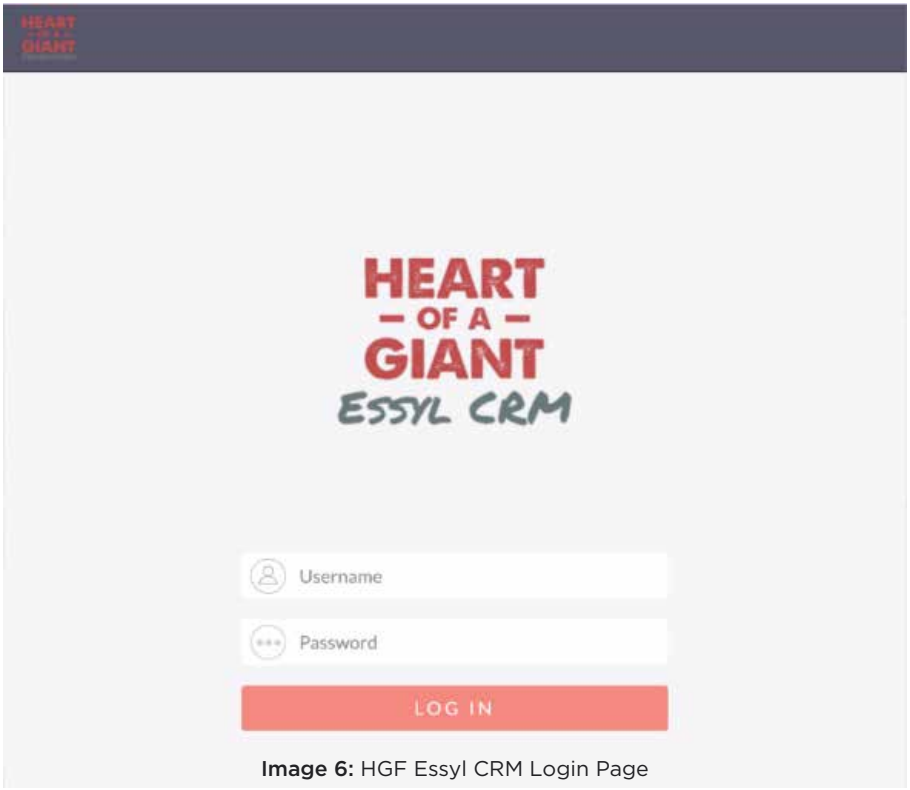


Image 6: HGF Essyl CRM Login Page

Image 7: Concept image of participants using tablets for health screenings

NEXT STEPS: LOOKING AHEAD

The 2024 Hypertension Screening and Education Campaign provided **invaluable insights and opportunities for growth, highlighting the Heart of a Giant Foundation's commitment to promoting health equity and improving outcomes in underserved communities.** To further enhance impact, several strategic initiatives are proposed.

Collaboration & Partnerships

Engagement with Health Professionals and Researchers: Collaboration with healthcare providers, public health experts, and researchers will facilitate deeper **analysis of campaign data and the development of innovative strategies for hypertension prevention** and management.

Data Sharing Opportunities: Sharing collected data with partners **can foster new approaches to managing hypertension** and identifying high-risk populations.

Digital Transformation in Data Collection

Future initiatives will prioritize a transition to digital data collection, leveraging the bespoke HGF Essyl CRM system.

HIPAA-Compliant: Ensures **secure storage and privacy** of participant data.

Real-Time Data Entry: **Streamlines workflows & minimizes errors** by capturing data directly during events.

Integrated Reporting Tools: Enables **real-time insights** into trends and community needs.

Automated Engagement: **Streamlines follow-ups** with reminders and referrals for participants.

Backup Systems: **Manual forms will remain available to ensure continuity** in case of technical challenges.

These advancements will **increase efficiency, improve data quality, and enable actionable insights** for targeted interventions.

Enhanced Data Collection & Analysis

The campaign utilized **two distinct datasets—event sign-up sheets and clinical measurements.** Enhancing these systems will refine future campaigns.

Event Sign-ups: **Track participant details** such as names, contact information, and neighborhood locations **for improved engagement.**

Measurement Data: To identify and target high-risk zones, **clinical readings** (systolic and diastolic BP, heart rate) and **demographic trends** (age, ZIP code) **should be included.**

Lessons & Strategic Focus

Key takeaways from the campaign emphasize the **profound impact of tailored community engagement.**

Comprehensive Referral Networks: Building relationships with trusted healthcare providers & specialists to **ensure accessible, high-quality follow-up care.**

Culturally Tailored Education Programs: **Expanding resources** designed to meet **diverse communities' unique cultural and linguistic needs.**

Advanced Technology Integration: **Leveraging tools** such as mobile apps for **participant data access and health monitoring.**

Stronger Collaborations: Partnering with universities, clinics, and advocacy organizations to **extend the campaign's reach and impact.**

Looking Ahead

The Heart of a Giant Foundation's digital transformation aligns with its vision for **sustainable community health improvements.** By addressing current gaps and applying lessons learned, **the foundation will continue transforming lives, building trust, and fostering healthier communities** across Greater Boston and beyond. These strategic enhancements aim to **drive systemic change,** ensuring underserved populations receive the care and support they need to thrive.

Conclusion

The 2024 Hypertension Screening and Education Campaign was instrumental in addressing health disparities in Greater Boston's underserved communities. Through education, screenings, & community engagement, **Heart of a Giant Foundation demonstrated a strong commitment** to empowering individuals with the knowledge and resources necessary to combat hypertension. By addressing identified gaps and building on the campaign's strengths through systemic improvements, technological advancements, and deeper community collaborations, **the foundation is well-positioned to enhance its impact,** ensuring equitable healthcare access and improved outcomes for all.

Thank you to our Partners

For more information and updates or to get involved, please visit
our website at www.heartofagiant.org or info@heartofagiant.org

APPENDICES

Appendix A: Campaign Geographic Area

The Greater Boston area and its adjacent cities showcase diverse demographic profiles, economic statuses, and health outcomes. **Hypertension prevalence varies significantly across neighborhoods,** influenced by socioeconomic factors, healthcare infrastructure, and community outreach initiatives.

Table 2 below shares selected Greater Boston neighborhoods' demographic, health, and socioeconomic characteristics. It compares hypertension prevalence, health infrastructure availability, quality, and income distribution. **Differences in population composition, access to care, and hypertension management capacity are evident,** underscoring the need for targeted interventions tailored to each neighborhood's unique challenges and resources.

Key Insights

1- Income & Hypertension

Neighborhoods like Roxbury and Mattapan, with higher proportions of low-income households, exhibit **elevated hypertension prevalence.** Conversely, areas like **Jamaica Plain and Cambridge,** with higher income levels, **show lower rates.**

2- Healthcare Access

Urban hubs like Cambridge benefit from **extensive healthcare infrastructure,** while **suburban towns like Bridgewater** face **limited local facilities,** necessitating travel for care.

3- Community Needs

The findings underscore the **need for tailored interventions, enhanced community outreach, and strengthened healthcare infrastructure in underserved neighborhoods** to address hypertension disparities effectively.

Area	Pop.	Age Distribution (%)	Race/Ethnicity (%)	Key Demographics	Income (L/M/H) (%)
Boston	654,423	<18:20, 18-65:60, 65+:20	White:45, Black:25, Asian:10, Hispanic:20	Diverse city with significant populations of African Americans, Hispanic/Latinx, Asian, and White residents.	Low:30, Medium:50, High:20
Braintree	37,196	<18:15, 18-65:65, 65+:20	White:80, Black:5, Asian:10, Hispanic:5	Suburban, predominantly White	Low:20, Medium:55, High:25
Bridgewater	26,563	<18:18, 18-65:62, 65+:20	White:85, Black:5, Asian:7, Hispanic:3	Suburban, majority White	Low:25, Medium:50, High:25
Brockton	105,643	<18:28, 18-65:55, 65+:17	White:35, Black:45, Asian:5, Hispanic:15	African American, Cape Verdean	Low:50, Medium:40, High:10
Cambridge	118,403	<18:10, 18-65:70, 65+:20	White:60, Black:10, Asian:20, Hispanic:10	Diverse: students, professionals, long-term residents	Low:15, Medium:45, High:40
Dorchester	125,947	<18:25, 18-65:60, 65+:15	White:30, Black:50, Asian:5, Hispanic:15	Diverse: African American, Caribbean, Vietnamese	Low:45, Medium:40, High:15
East Boston	47,489	<18:22, 18-65:65, 65+:13	White:25, Black:10, Asian:5, Hispanic:60	Predominantly Latino, immigrant communities	Low:40, Medium:45, High:15
Jamaica Plain	41,012	<18:20, 18-65:65, 65+:15	White:50, Black:20, Asian:10, Hispanic:20	Young professionals, artists, long-term residents	Low:25, Medium:45, High:30
Mattapan	25,275	<18:30, 18-65:55, 65+:15	White:10, Black:70, Asian:5, Hispanic:15	Predominantly African American, Caribbean	Low:55, Medium:35, High:10
Roxbury	63,672	<18:28, 18-65:58, 65+:14	White:15, Black:65, Asian:5, Hispanic:15	African American, growing Latino community	Low:50, Medium:40, High:10
South Boston	35,852	<18:18, 18-65:62, 65+:20	White:75, Black:10, Asian:5, Hispanic:10	Predominantly Irish-American, growing immigrant communities, gentrifying	Low:25, Medium:50, High:25

Table 2: Demographics, Hypertension, and Healthcare Infrastructure | Data sources

Area	Life Expentency	Hypertension	HTN Prevalence (%)	Health Infrastructure	Types Quality of Health Infrastructure
Boston	80.2 (MA Ave is 80.7) Female 83.0; Male 77.2.	~30-35% of adults have HBP, consistent with national averages.	32	Mix of FQHCs, hospitals, clinics, and community centers	High availability but varies across neighborhoods
Braintree	80.7	Comparable to state averages	25	Several clinics; proximity to larger medical centers. Mostly private clinics, a few community health centers	Moderate, mostly concentrated in private practices
Bridgewater		Reflects state norms	22	Limited: private practices dominate; residents travel for care.	Moderate quality, less accessible in emergencies
Brockton		Higher than state average	40	Home to a major hospital and clinics. Community health centers, some FQHCs	High reliance on FQHCs, moderate capacity
Cambridge	84.9 female; 80.9 male.	Lower than state average	20	World-class hospitals and research centers. High-quality hospitals, clinics, and community services	High quality and accessibility
Dorchester	02121 and 02125 77.8; 02122 and 02124, 78.2.	Higher than Boston average	35	Mix of FQHCs and community health services	Varies significantly, some areas underserved
East Boston	02128, 79.5.	Moderate, increasing lifestyle factors	28	East Boston Neighborhood Health Center, FQHCs and private practices	Moderate accessibility, focus on immigrant care
Jamaica Plain	78	Lower than Boston average	28	Access to major hospitals and health centers. High concentration of clinics and community health centers	High quality, research-linked services
Mattapan	77.3	High, linked to socioeconomic factors	45	Limited; relies on nearby neighborhood facilities. Primarily FQHCs and some clinics	Moderate to low, gaps in advanced care
Roxbury	68.8	Among the highest in Boston	42	Several community health centers; proximity to major hospitals. FQHCs and hospitals	Moderate capacity, struggles with demand
South Boston	02127, 02210; 78.3.	Lower than Boston average	25	Access to health centers and nearby hospitals. Mix of private clinics and community health services	High-quality infrastructure

Table 2: Demographics, Hypertension, and Healthcare Infrastructure | Data sources [2]

Image 8: Banner Boston Walk

[2] U.S. Census Bureau
American Community Survey (ACS)
Massachusetts Department of Public Health (MDPH)
Health Resources and Services Administration (HRSA)
Boston Public Health Commission (BPHC)
Neighborhood-Specific Reports and Initiatives
Centers for Disease Control and Prevention (CDC)
Local Community Health Centers and Hospitals

Appendix B: Details on Equipment, Processes, & Protocols

Details on Equipment & Processes for Hypertension Screenings

The Heart of a Giant Foundation utilized reliable tools and processes to ensure accurate hypertension screenings and participant engagement. Below are the key equipment and materials employed during the campaign.

1- Validated Devices

The Heart of a Giant Foundation (HGF) **employs blood pressure** (BP) **devices listed on the Validated Device Listing** (VDL) on the Validate BP website. This free resource, supported by the American Medical Association (AMA), ensures that patients and healthcare providers can **rely on devices that meet rigorous clinical accuracy standards.**

Using VDL devices, **HGF enhances the precision and reliability of its hypertension screening and management efforts.** This commitment aligns with HGF's mission to deliver accurate and effective health interventions in underserved communities.

2- Blood Pressure Monitors

Omron 5, 7, 10, Platinum, and HEM-907XL Blood Pressure Monitor Series:
These devices provided accurate, user-friendly digital readings.

Features included memory storage for multiple readings and validation for clinical accuracy.

3- Cuffs

Adjustable Arm Cuffs:
Multiple sizes (small, medium, large, X-large, and XXL) were used to **ensure accurate measurements across diverse participants.**

Proper cuff placement was emphasized to avoid false readings.

Image 9: Illustration of HGF's Blood Pressure Screening and Education Equipment

4- Supplementary Tools

Glucose Meters:
Used to **screen participants for diabetes** alongside hypertension screenings.

Containers:
Secure storage for medical tools, ensuring **organization and cleanliness during screenings.**

Data Logging Sheets:
Standardized forms for recording participant BP readings, glucose levels, and other health data.

Facilitated real-time data tracking and post-screening analysis.

5- Educational Materials

Distributed brochures and infographics on:
Hypertension management strategies.
Diabetes awareness and prevention.
Healthy lifestyle choices, including diet & exercise.

Appendix C: Details on Processes for Hypertension Screenings

The Heart of a Giant Foundation (HGF) adheres to established best practices for blood pressure (BP) measurement to enhance accuracy and improve hypertension management. By implementing protocols from the U.S. Preventive Services Task Force (USPSTF), the American Heart Association (AHA), and the Massachusetts Department of Public Health (MDPH), **HGF ensures precise readings and effective patient outcomes.**

Key Practices & Protocols

1- Accurate BP Measurement

Accurate BP measurement is critical for diagnosing and managing hypertension. HGF follows AHA and MDPH guidelines, emphasizing validated techniques and tools.

Patient Preparation: Participants **avoid caffeine, exercise, and smoking** for at least 30 minutes before measurement. They sit quietly for 5 minutes, feet flat on the floor, back supported, and legs uncrossed. The arm is supported at heart level, and the cuff is applied to bare skin.

Measurement Technique: **Properly calibrated and validated devices** with appropriately sized cuffs **are used.** At least two readings are taken 1–2 minutes apart and averaged. If readings differ by more than 5 mmHg, additional measurements are conducted. **HGF ensures arm placement and cuff size are verified for accuracy.**

Follow-Up: **High-risk participants are referred for further medical evaluation or care.**

2- USPSTF Recommendations

HGF incorporates USPSTF protocols to enhance screening precision and reliability.

Screening Frequency: Adults **aged 18–39** with **normal BP and no risk factors** are **screened every 3–5 years.**

Adults **aged 40+ or those at increased risk** (e.g., African Americans, individuals with high-normal BP, or those who are overweight or obese) **undergo annual screenings.**

Confirmation of Diagnosis: **Hypertension diagnosis is confirmed by obtaining BP measurements outside clinical** settings using ambulatory BP monitoring or home BP monitoring before treatment begins.

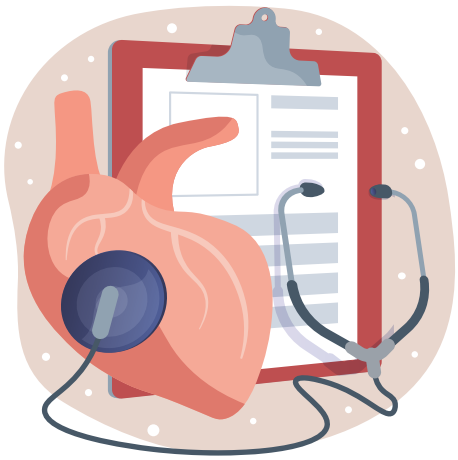
HGF Integration of Evidence-Based Practices

HGF ensures all BP measurements adhere to these high standards.

Preparation & Technique: Participants sit calmly for 5 minutes, and their arm placement and cuff size are checked to ensure accuracy. **Results are logged, explained, and shared with participants.**

Data-Driven Approach: **Two BP readings are recorded per participant, averaged for precision,** and used to inform immediate feedback and referrals.

By incorporating these validated guidelines, **HGF delivers reliable hypertension screening services,** empowering communities with actionable health insights and fostering better long-term outcomes.



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