HEART OF A GIANT FOUNDATION

ANNUAL REPORT 2022

Improving Health Outcomes &
Preventing Chronic Heart Diseases

EMPOWER! MOTIVATE! EDUCATE!

"Truly affordable but high-quality health care tools and services are the only means by which quality health care can be provided to all...
Health care can be made more affordable for the poor without requiring significant new scientific developments, just the intelligent application of current technologies."

Muhammad Yunus

FOUNDER AND EXECUTIVE DIRECTOR LETTER

Working Towards a Healthier Future for Underserved Communities.

On behalf of the Board and Staff of HGF, thank you for contributing to HGF's success over the past few years!

As I navigated the healthcare system during my journey toward receiving my heart transplant, the need for an organization with the mission of the Heart of a Giant Foundation (HGF) became very clear to me. We incorporated in late 2018 to fill the void of available community resources to help empower, motivate, and educate members in our communities towards managing heart-related diseases and achieving better health outcomes. Guided by my personal experience and in-depth research on the availability and accessibility of community resources to support better health outcomes, we began developing solutions that would directly address heart health issues in our communities.

We developed a solid, well-performing organization in the two years that followed. We launched community-based, data-driven, and evidenced-based initiatives and programs that are now positively impacting our community regarding cardiovascular health and overall health.

We committed ourselves to work to eliminate preventable harm attributable to heart diseases and improve chronic health management. In 2020, the IRS recognized HGF as a non-profit, tax-exempt 501(c)(3) organization. A couple of months later, we implemented the pilot of our programs.

Since then, HGF has established itself as a functioning and performing organization with solid operational and program staff, processes, systems, and key partnerships. We are very proud that in such a short time, our team has already begun to significantly change lives in our communities through our education and awareness programs.

Undoubtedly, with the COVID-19 pandemic and recent global economic challenges, the past couple of years have been challenging at all levels, although successful.

Gratefully, our supporters were always ready to step in and provide us with the needed support.

Because of this support, 2022 was a most successful year for HGF. Our health awareness and education programs empowered over 100 people with insights and tools to control their blood pressure.

We sincerely thank all our donors, nonprofit partners, advisors, and others who generously supported us over the past few years. d. Thank you for inspiring and joining us in improving health outcomes in our communities. Thank you for giving so kindly to help us establish our operational infrastructure and program delivery framework. And most importantly, thank you for helping us empower and transform so many lives.

"And now the work begins, and now the joy begins.
Now the years of preparation of tedious study and exciting learning are explained"
Maya Angelou

Over the year ahead, HGF will expand on the work accomplished to date as it relates to awareness and education efforts in person and via webinars. Our initial focus of work focused on two Boston areas - Dorchester and Mattapan.

We supported thousands of individuals via our online and social media platforms and successfully beta-tested our marque program, the Healthy Heart Communities (2HC) Program.

But, thanks to our supporters, we will become active this year in four new communities—the Boston neighborhoods of Roxbury and South Boston and the suburbs of Brookline and Brockton.

HGF will move from the pilot phase and fully launch our flagship Health Hearts Communities (2HC) Program. The 2HC Program will offer free remote patient monitoring (RPM) services and chronic care support at the participants' homes or other familiar places. We will implement at least two cohorts in the 2HC Program to benefit 90 individuals and, indirectly, their relatives. Additionally, we will continue to offer anonymous BP Screening events at least twice monthly and intend to provide screening to at least 480 individuals.

HGF will also deliver at least 14 heart health workshops and 24 educational webinars to reach a minimum of 570 individuals. In addition, audio and video materials from the workshops and the webinars will be disseminated online and via social media.

As you can see, we have a robust service delivery goal for 2023 that will impact and change many individuals, families, and communities by improving health outcomes! We greatly appreciate your commitment and dedication to partnering with us to ensure our mission, vision, and goals are achieved. We look forward to your support and collaboration during a successful 2023.

Somaneh Bouba Diemé
Founder & Executive Director

CONTENTS

WE ARE HEART OF A GIANT

Empowering People! Impacting Communities! Improving Lives!

About Us

The Heart of a Giant Foundation (HGF) is a Boston-based 501(c)(3) tax-exempt organization dedicated to eliminating preventable harm attributable to heart diseases and improving the management of chronic health problems in our communities. HGF empowers community members to manage their health care and well-being actively.

Our Mission

The mission of the HGF is to achieve better health outcomes for heart diseases and related chronic health conditions in our communities and enhance the quality of life through health education, care support, and connection to community resources.

Our Vision

Our vision is that every community member will access impactful heart health education, quality healthcare support, and community resources that improve their health, quality of life, and the management of chronic heart diseases and related chronic health conditions.

The Problem

High blood pressure –or Hypertension– is a common condition identified by the Centers for Disease Control and Prevention (CDC) as a leading risk factor for heart disease, stroke, kidney disease, and vascular dementia. Heart disease and stroke are the top and fifth-leading causes of death in the US. One person dies every 36 seconds in the United States from cardiovascular disease.*

The Boston Public Health Commission recently found that 25% of Boston adult residents –one in four– reported having hypertension. The percentage of hypertension was higher for the following groups; Black (36%) and Latino (27%) adults, as compared with White adults (20%). The Hypertension rates ranged from 34% to 42% in neighborhoods with predominantly Black people.**

Our Approach

At HGF, we are driven by the African philosophy of Ubuntu, which emphasizes humanity, compassion, and social responsibility. We believe that instilling the philosophy of Ubuntu ("I am because we are") as a core principle of our organization will significantly help improve our communities' overall health and well-being.

Multiple studies have proven that in addition to regular doctor visits, a home-based BP control program run by non-physicians can provide efficient, effective, and rapid control (suggesting an innovative paradigm) for hypertension management. Such programs are effective, sustainable, adaptable, and scalable to fit current and emerging national systems of healthcare.

Accordingly, HGF exists to empower program participants to better manage and facilitate the prevention of high blood pressure (hypertension) through a culturally responsive, community-based, and technology-driven approach that provides comprehensive care tools, community-centered healthcare support, health education, and guidance that engage and guide participants towards better health outcomes.

* Heart Disease Facts by the US CDC
** Health of Boston 2016 - 2017 by City of Boston

Projects & Programs

HGF works at the intersection of healthcare, economics, cultural sensitivity, and social interaction. As such, through our projects and programs below, we apply proven and innovative approaches to promote healthy living, prevent chronic diseases, and achieve improved health outcomes to the highest number of people.

A. Healthy Hearts Communities Program (2HC)

The Healthy Hearts Communities Program (2HC) helps participants and their relatives better manage and prevent high blood pressure through a culturally responsive, community-based, and technology-driven approach that provides comprehensive healthcare support, health education, and guidance.

The 2HC program incorporates successful and customizable Remote Patient Monitoring (RPM) to monitor Blood pressure through and other vital signs through monitoring devices and services to monitor related cardio-metabolic conditions. In addition, we may provide blood glucose monitoring for participants at risk of or living with Diabetes.

The 2HC Program implements services through the following four pillars:

1. Care Support at Home

Our Community Care Team, composed of health professionals, provides personalized clinical care support to address participants' health needs and, when applicable, augment their prescribed care plans at home or a familiar place. They will teach participants how to self-monitor BP at home and make available monitoring systems. Participants will receive sets of home blood monitoring devices to develop the habit of monitoring their blood pressure and other vital signs at home. The biometric data will automatically be communicated to the Program Team. If no remote communications links are available, Care Coordinators will contact the participants to collect the data in person or via phone.

The Community Care Team also leverages audiovisual resources and digital health technology to facilitate, promote, and enhance health education and remote care support. In addition to their personalized level of care, participants can access online tools to help educate, coach and help them track their progress, highlight red flags, and encourage best practices. The team will regularly visit in-person or virtually and contact using other multiple channels to communicate with the participants, including phone or Web messaging. All related communications will be HIPAA-compliant.

Methods of Delivery

Care Support at Home entails the following:

- Care coordination and referral to hypertension treatment programs or cardiology centers (when applicable).
- Heart health education and vital signs monitoring: blood pressure, BMI, glucose, total lipogram, cholesterol, lifestyle diet and nutrition, activity level…
- Risk-factor evaluation and education.
- Personal nutrition evaluation and weight management.
- Medication adherence per the physician's prescription (when applicable).

Expected Outcomes

- Care optimization
- Develop patient advocacy
- Improved patient compliance
- Improved medication adherence
- Improved patient-physician relationships

2. Lifestyle Behavioral Change Support

A healthy weight, a strong heart, general emotional health, and lower blood pressure.

Moderate-intensity aerobic exercise has been proven to prevent hypertension and help manage stage 1 hypertension. Dynamic resistance exercises, if done correctly, also contribute to lowering both systolic and diastolic blood pressures*. Physical activity can help control blood pressure and weight, strengthen the heart, and lower stress levels. The aim is to help participants whose medical providers have cleared them to begin participating in physical activity regularly. HGF develop plans tailored to each participant's needs to increase their physical endurance and muscular strength and improve mood by reducing the risk of hypertension and other heart diseases. We help participants develop their individualized SMART goals, and our Community Care Team supports them in achieving them through evidence-based interventions.

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* Ghadieh AS, Saab B. Evidence for exercise training in the management of hypertension in adults. Can Fam Physician. 2015 Mar;61(3):233-9. PMID: 25927108; PMCID: PMC4369613.

A healthy diet and nutrition play a large role in sustaining a healthy weight, healthy emotional state, and well-managed blood pressure. The goal is to help our members with the tools to help them eat better. Our Community Care Team will support participants following a heart-healthy diet, such as the Dietary Approaches to Stop Hypertension (DASH) eating plan. Participants will receive complimentary grocery vouchers to promote healthy shopping and be presented with nutritional lessons and cooking classes.

Sleep disturbances are among heart disease patients' most commonly reported symptoms. Our Care Team will support the participants in improving their quality and quantity of sleep. They will provide recommendations for assessing sleep disturbances and recommend they visit a sleep medicine specialist.**

For the participants who seek to quit smoking, the Care Team will help participants connect with expert quitting information from public health authorities and have them talk to a quit-smoking counselor individually or in a group. They can also get free, confidential coaching through a telephone quitline. Lastly, the team will guide them to their medical team if needed.

Community Care Coordinators will also support those struggling with alcohol abuse. We will recommend that they contact their primary provider or refer them to a local alcohol addiction treatment program.

Methods of Delivery

The Lifestyle and Behavioural Change Support will entail two to three 30-to-60 mins weekly exercise sessions. They will begin in the 2nd month of the program. Activities include exercising, nutrition counseling, and education.

Each member will receive:

- An initial assessment and a fitness level measurement.
- A semi-supervised exercise training program.
- Farmers markets and community and group event opportunities in person or online.
- Dietary and weight management classes.
- For non-gym members, a 3-to-6-month membership at a local gym.

** Improving sleep in patients with heart failure February 3, 2021, By: Olivia Koontz, BSN, RN, and Amy A. Abbott, PhD, RN.
www.myamericannurse.com/improving-sleep-in-patients-with-heart-failure

- Weekly medically-tailored meals delivered by our partners such as Community Servings (If Applicable).

Expected Outcomes

- Increased physical endurance and muscular strength
- Healthier weight and better weight management. Achieve and maintain a healthy weight
- Improved emotional wellbeing and better metabolism

3. Health Literacy and Well-Being

Emotional well-being are critical to maintaining healthy blood pressure. We facilitate health and well-being through access to mental health and other counseling, social workers, activities groups, and partner services. The program utilizes available screening tools to assess the participants' mental health and well-being to identify opportunities to support them and their relatives.

Our Education and Coaching offer thematic health lessons. In addition to the core topics of high blood pressure, heart disease, and diabetes, this component will cover self-care management, self-advocacy, nutrition, and appropriate physical activity. The sessions are designed to meet the needs of community members regardless of educational achievement and health literacy levels. The classes will include: controlling blood pressure, eating heart-healthy, heart attack, stroke, and risk factors, knowing diabetes, learning hands-only CPR, heart health advocacy, and more.

Multiple communication channels will be used, including phone calls, chats, educational videos, lessons, printed guidance materials, activity notebooks, pedometers or apps, cookbooks, and additional resources, all in compliance with HIPAA regulations.

Methods of Delivery

Our Community Care Team work with medical providers and other health professionals, such as dieticians and/or researchers, to support participants. Our partner Social Clinical Worker provides complimentary psychotherapy sessions to the participants, including screening sessions and, where applicable, escalations and referrals.

The Community Care Team will provide the following services to our participants:

- Developing individualized action plans.
- Biometric self-measurements.

- Documentation and use of devices.
- Encourage the use of personal health diary.
- Heart health advocacy.

Expected Outcomes

- Better knowledge of hypertension
- Self-report of improved behaviors
- Improved systolic blood pressure, weight, fasting glucose
- Recommend a therapy plan or if needed, make referrals to a specialist(s)

4. Social Enhancements

HGF believes that social support and network characteristics are important in the onset and management of hypertension. As such, behavioral change interventions should consider participants' social networks.

Awareness of patients' social support and social network can help to develop effective and tailored interventions based on the network characteristics for improving treatment outcomes and lifestyle behaviors. Regarding behavioral adherence, they found that patients with more practical support from friends were likelier to adhere to behavioral recommendations.***

A key component of social enhancements is linking program participants to peers, program alumni, and local health and public health professionals. A community to promote and facilitate peer support and engage in hobbies, community, and cultural activities to promote their overall well-being and health outcomes goals.

Methods of Delivery

- Regular in-person and remote support group activities.
- Access to a virtual community.
- Mix of activities such as Information sessions with health and wellness professionals or peer networking sessions.
- Participation in community and social activities.

*** Thuy LQ, Thanh NH, Trung LH, Tan PH, Nam HTP, Diep PT, An TTH, Van San B, Ngoc TN, Van Toan N. Blood Pressure Control and Associations with Social Support among Hypertensive Outpatients in a Developing Country. Biomed Res Int. 2021 Apr 3;2021:7420985. doi: 10.1155/2021/7420985. PMID: 33884271; PMCID: PMC8041521.

Expected Outcomes

- Meet and learn from other people with high blood pressure and heart diseases
- Nurture a sense of belonging in an engaged community
- Improve patient-physician relationships
- Create a support network
- Promote active and a healthy lifestyle
- Improve the physical and emotional well-being of those at risk and affected by hypertension

B. Blood Pressure Screening and Education Events

Keeping blood pressure numbers within a normal range is vital for health and overall well-being. Our blood pressure screening, education classes, and workshops aim to increase community awareness.

Screenings and educational activities take place at community events and pop-up events. The goal is to conduct screenings during interactions with community members in public. Our Blood Pressure screening and Education events help improve the awareness, detection, and management of high blood pressure, especially for people who may be at increased risk but do not exhibit signs or symptoms before these risks become life-threatening illnesses.

The HGF Team trains participants on monitoring blood pressure at home, distributes heart health educational materials, and provides tips on healthy eating and physical activities. In addition, HGF distributes home blood pressure monitoring machines and other giveaways during community events.

Methods of Delivery

- **Workshops & Webinars:** On the importance of hypertension awareness, signs, causes, potential impact, and resources available to prevent and manage it.

- **Community BP Screening:** Events offered monthly or bi-monthly in partnership with local organizations.

- **Collaborative Strategic Partnerships:** With faith-based organizations, community health centers, and community-based organizations.

- **Additional Modes to Educate & Raise Awareness**: Leverage the power of online and social media to build communities around the cause by helping them understand. Each month, we highlight a specific health topic.

Expected Outcomes

- Participants will demonstrate increased understanding, early identification of signs and symptoms, and knowing how and when to contact a healthcare provider.
- An Increased number of people who know how to self-monitor their blood pressure.
- Peer-to-peer awareness through word of mouth from past participants.
- Individuals will engage in dialogue with others through community engagement (differentiate from leaders). Growing a community of informed participants who can share with others.
- Build a movement and facilitate active community engagement around blood pressure.

C. Heart Health Awareness & Advocacy

We amplify the voices of patients and caregivers to raise awareness, educate and inform changes to enable a culture of care that fosters better health outcomes. We facilitate conversations with inspiring voices of the heart health community, including patients, caregivers, health practitioners, advocacy leaders, and more. Our audience discovers what it means to live or survive with a heart condition and how to enjoy a longer, healthy, quality life after a heart disease diagnosis.

We educate and inform members of the communities we serve to identify, treat and address heart diseases and support and accept those living with cardiovascular conditions.

We use the following modes of communication to facilitate our awareness and advocacy campaigns:

- Blogging
- Podcasting
- Public Speaking
- Meetings
- Social Media
- Others

Amplifying Patients Voices & Championing Heart Health

Methods of Delivery

- Heart of a Giant Blog.
- Living with Heart Disease Podcast on iTunes, Google, Spotify and all other platforms.
- Instagram account, Facebook private community group, Twitter YouTube channel.
- Eventbrite.

Expected Outcomes

- Build community
- Raise awareness
- Motivate people to act, don't ignore high blood pressure
- Normalize high blood pressure, destigmatize the condition
- Helping people learn about heart disease and conditions including warning signs

D. Data Collection and Analysis

HGF has developed a robust data collection process and evaluation plan led by our Senior Epidemiology Research Manager. We evaluate the physiological, behavioral, and socio-emotional health improvements of 2HC Program participants at the beginning, during, and after program completion.

This pre, during, and post-date will be collected and analyzed at the beginning of each cohort and 3 and 6 months. The first data collection point will be collected at the beginning to provide a baseline for each participant before the Program begins. The second data collection point will be collected after the Program's conclusion. Data will be analyzed through multiple methods. Given the pre-post survey design, t-test analysis will examine the pretest vs. post-test identifying and comparing changes among important study variables. For example, we will examine the difference between body vital signs at baseline and compare them to final body vital signs after the conclusion of the intervention program.

In addition, the study includes a social determinant of health measures and protocols in the follow-up survey after screenings and workshops. This will provide additional insights into the care of the community members we serve.

Institutional Review Board and Protocols

This study aims to identify best practices for screening and referring participants to resources to address social and material needs—the 2HC program partners with an external evaluator to provide data analysis and program evaluation services. The project will be under review by the Wayne State University Institutional Review Board (IRB).

What We Have Accomplished in 2022

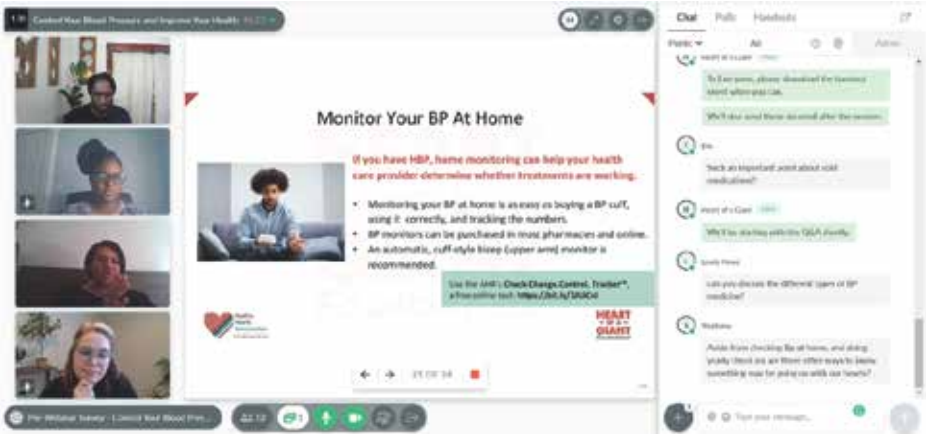
Thankfully, due to the unwavering support of our generous supporters, HGF established itself as a robust and high-performing non-profit organization. In our short existence, we have already significantly improved the lives of some members of our communities. Below are some highlights of what we accomplished in 2022.

51 Webinar Participants

- In early 2022, HGF conducted a 6-webinar series on important heart health information to educate community members.

- 51 people actively participated live in the webinars.

- Afterward, we shared the recordings and disseminated key points through various channels, including websites and social media.



Awareness & Education

Premier Resources Online and on Social Media

Awareness & Education

Instagram

- 136 posts
- 8,868 individuals reached
- 257 new followers

Facebook

- 136 posts
- 40,295 individuals reached

Twitter

- 136 posts
- 5,300 impressions

Youtube

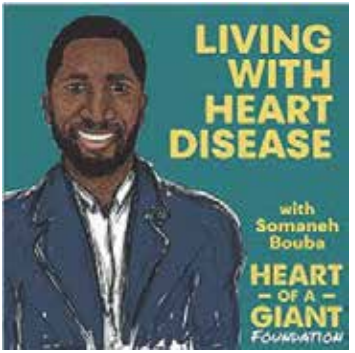
- Educational videos
- Viewed 4510 times
- Gained 81 subscribers

LinkedIn

- 136 page views
- 20 followers
- 60 unique visitors

Living with Heart Disease Podcast

- Downloaded 783 individual times
- 44.4% of which were via Apple Podcasts
- Listeners worldwide include the USA, 57.73%, the UK, Northern Ireland, 14.43%, India, 3.7%
- And more countries, including Australia, Hungary, South Africa, Canada, France, Singapore, and Indonesia



Awareness & Education

Testimonial

"Through my work on HGF, I've gained vast knowledge and insight into how one takes a proactive approach to heart health. Working to help launch the 2HC program has influenced and empowered me to adjust my lifestyle and daily habits, prevent the onset of hypertension in my family, and maintain healthy blood pressure".

Elle W.

Product Distribution - Healthy Hearts Communities

- Distributed 60 Arm BP home machines. (Donated to us by CVS Health)
- 75 Covid-19 home test kits to families in Boston. (Donated to us by AHA of MA)

Community Anonymous Blood Pressure Screening Events

82 adults screened and educated between September and the end of December.

- 79% of the samples did not fall within the normal blood pressure for most adults, with a systolic pressure of less than 120 and a diastolic pressure of less than 80 (AHA and AMA Recommendations)
- 17 individuals had Normal Blood Pressure readings
- 19 individuals had an Elevated reading
- 21 individuals had a High Stage 1 reading
- 25 individuals reported a High Stage 2 reading

Education & Healthy Hearts Communities


CREATING HOPE &
PROVIDING SOLUTIONS
THROUGH SCIENCE
ADVOCATING TO
CREATE CHANGE IN

Financial Reports

We are proud of our consistent financial growth over the past few years and are poised to see this growth continue in 2023.

2022

Heart of a Giant Foundation
Financial Activity
March - December, 2022

		Total
Income		
Board Contribution	$	18,015.77
Gifts and Donations	$	115,499.62
Total Income	**$**	**133,515.39**
Expenses		
Administrative Expenses	$	4,242.46
Business and Banking Fees	$	1,000.42
Business, Grants and Development	$	2,685.00
Progam and Program Staff	$	15,919.75
Operations (incl. Professional & Legal)	$	18,145.00
Office Supplies & Software	$	1,448.86
Promotional & Marketing	$	9,007.83
Rent & Lease	$	25.00
Tax Payments	$	13.00
Tech & Systems	$	4,562.82
Travel Expenses	$	30.00
Web Tools & Services	$	1,417.36
Total Expenses	**$**	**58,497.50**
Net Operating Income	*$*	*75,017.89*
Other Expenses		
Unrealized Gain or Loss	$	-
Total Other Expenses	$	-
Net Other Income	**$**	**-**
Net Income	**$**	**75,017.89**

2021

Heart of a Giant Foundation
Financial Activity
March 2021 - February 2022

		Total
Income		
Board Contribution	$	34,977.10
Donation In Kind	$	3,599.40
Gift and Donations	$	10,147.49
Total Income	$	48,723.99
Cost of Goods Sold		
Cost of Goods Sold	$	3,599.40
Total Cost of Goods Sold	$	3,599.40
Gross Profit	$	45,124.59
Expenses		
Administrative Expenses	$	1,392.94
Banking Fees	$	1,887.29
Business & Licensing Fees		44.25
Business & Grant Development		1,168.75
Program Staff	$	22,684.94
Insurance		113.75
Professional & Legal Services		1,647.59
Promotional & Marketing	$	9,763.49
Tax Payments		35.00
Tech & Systems	$	3,061.71
Utilities		31.88
Web Services	$	4,293.00
Total Expenses	$	46,124.59
Net Operating Income	-$	1,000.00
Other Expenses		
Unrealized Gain or Loss		0.00
Total Other Expenses	$	0.00
Net Other Income	$	0.00
Net Income	-$	1,000.00

2020

Heart of a Giant Foundation
Financial Activity
March 2020 - February 2021

		Total
Income		
Gifts and Donations		3,500.00
Board Contributions		25,446.38
Total Income	$	28,946.38
Expenses		
Administrative Expenses	$	8,319.64
Banking Fees	$	284.75
Promotional & Legal Services		453.93
Promotional & Marketing		11,920.56
Tax Payments		600.00
Web Services		5,216.32
Total Expenses	$	26,795.20
Net Operating Income	*$*	*2,151.18*
Other Expenses		
Unrealized Gain or Loss		0.00
Total Other Expenses	$	0.00
Net Other Income	*$*	*0.00*
Net Income	$	2,151.18

Our 2023 Goals

In 2023, we will implement the free-of-charge 2HC program, with remote patient monitoring (RPM) component and its associated services, while we continue to improve on our awareness and education efforts.

1. Successfully implement at least 2 cohorts of the 2HC Program, which will benefit at least 90 individuals and their relatives directly and indirectly.

2. Deliver at least 14 heart health workshops and 24 educational webinars, directly reaching more than 570 individuals. In addition, audio and video materials from the workshops and the webinars will be disseminated online and via social media.

3. Offer at least 24 anonymous BP Screening events for a minimum of 480 individuals in communities in Boston and surrounding areas.

4. Deliver 12 heart health blog posts and 12 Living with Heart Disease podcast episodes.

Our Team

We are who we are and do what we do because of our incredible team!

I sincerely thank our administrative and programmatic teams, our Board of Directors, and our Advisors, for their dedication, tireless work, and support that propelled HGF from an idea to a robust and impactful organization poised to expand its programs and widen its impact.

Board of Directors

Desirée Allen (Chair)
Bouba Diemé (CEO)
Lawrence Vinson
Malika Fair, MD
Modou Fall
Papi Sora (Treasurer)

Board of Advisors

Christopher A. Cahill, J.D., C.F.P, C.A.P
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Neal K Lakdawala, MD, MSc, FAHA
Nicole Singh, MD
Olivia Weinstein, MS, RD, LDN
Shabatun Islam Eras, MD

Executive Team & Staff

Bouba Diemé
Genia Philip
Arpoo Eisendrath

Executive Leadership

Chief Encouragement Officer, CEO
Chief Operations Officer, COO
Chief Financial Officer, CFO

FIscal Manager

Mahsa Imen

People Management

Stacey Brown

Grants & Development

Olarinde Williams

Program Management

Kome Ekor (Program Manager)
Stephany G. Rodriguez
Lewis Howe

Research Management

Megan Hicks, Ph.D.

Communications

Chinye Onwamaka
Elle Williams
Melina Dio

Community Care Team

Sarah Falcone, RN
(Community Care Leader)
Maria Dalomba, NP
(Clinical Care Leader)
Idongesit Obeya, RN
(Social & Health Services Leader)
Andrelle Cadet-Piard, CMA
Sebra Barcuis, RN
Shirline Luxcin Jean, RN
Sumayo Farah, LPN
Thuy Truong Do, RN
Velma Glover, RN
Yesica Santana, RN

Freelancers and Consultants (2020 - 2022)

Fika Msengana
Florencia Mié
Irshika Suthakar
Julie Angulo
Katarzyna Szewczyk
Odile Bernas
Saurabh Bansal
Xiufen Zhou

Our Supporters

We are grateful to the following people and organizations for their unwavering support, partnerships, and generous donations over the years. As our impact grows, we will need more support, collaboration, and volunteers to help us sustain and continue to achieve tangible benefits and change the lives of those in our communities who can benefit from our programs and services. We would love for you to join us on the journey!

Partners

Technical / Technology

American Heart Association (AHA) of Massachusetts
Boston Medical Center's Teaching Kitchen
Health Recovery Solutions
Kala Group Technologies
Meeriad
Wellframe

Community Organizations

ABCD Mattapan
Bethel AME Church, Jamaica Plain MA
Brockton Neighborhood Health Center
Harvard Street Neighborhood Health Center
Jubile
New Life Christian Church Ministries, Brockton MA

Grants & Foundations

AHA Empowered to Serve
AHA Massachusetts
AHA National Hypertension Control Initiative
Blue Cross Blue Shield MA Foundation
Brookline Community Foundation
CVS Health Foundation
Foley Hoag Foundation
Lenny Zakim Foundation

Corporations

CVS Health
FedEx
Vista Print
Walmart

In-Kind Gifts / Services

AHA Massachusetts
CVS Health

Individuals

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Amon M.
Anonymous
Beverly R. D.
Elisea O.
Gloria B.
Hilaire D.
Joyce A. B.
Kamron M.
Kay and Dave B.
Kim K.
Kirby F.
Lurie D.
Neal L.
Nicole S.
Ryan L.
Sandhya G.
Sarah B.
Sean L.
Xiufen Z.

Contact Us

Heart of a Giant Foundation, HGF (EIN: 84-2900386)

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Heartofagiant.org

HGF is dedicated to impacting communities for the better, with a mission to eliminate preventable harm attributable to heart diseases and to improve the management of chronic health conditions in our communities.

HGF works to amplify patient voices; we align resources and a culture of care that fosters better health outcomes — locally and globally. We inform and equip members of communities to address heart diseases and to be supportive and accepting of those living with cardiovascular conditions.

Propublica: https://projects.propublica.org/nonprofits/organizations/842900386
GuideStar: https://www.guidestar.org/profile/84-2900386

HEART
— OF A —
GIANT
FOUNDATION

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to make a gift supporting HGF

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