## 2025 Fact Sheet



Board of Directors	Who we are	CareMessage is the technology non-profit building the largest patient engagement platform for low- income populations in the United States.
Dourd of Directors		
<b>Kit Kaufman, Chairman</b> Founder, Kit Kaufman, Counsel to Independent Directors	Our Vision	A world where people from low-income populations achieve health equity through increased access to care, improved clinical outcomes, and addressed social drivers of health.
<b>Andrew Principe</b> President, Starling Advisors		
<b>Anne Trester</b> Former Strategy & Financial Director at Google	Our Mission	Leverage technology to improve health equity for people from low-income populations.
<b>Geoff Price</b> Co-founder, Chief Innovation Officer, Board Director, Oak Street Health	2028 Goal	By 2028, CareMessage will improve health equity for 5 million people from low-income populations annually.
<b>Kevin Bromer</b> Executive Director for Data & Technology Investment, Ballmer Group	What we offer	Patient Engagement for Improved Health Equity. Powered by our Health Equity Engine™, the CareMessage platform enables organizations to combine messaging, data, and interoperability to increase access to care, improve clinical outcomes, and address social drivers of health.
<b>Kristina Campbell</b> Chief Financial Officer, Wrapbook		
<b>Mary Pittman, MPH, DrPH</b> Former CEO, Public Health Institute	Year Founded	2012
<b>RADM (Ret.) Michael D. Weahkee</b> Former 10th Director of the Indian Health Service	EIN	27-3252911
<b>Sarah J. DiBoise</b> Deputy General Counsel for Healthcare, Stanford University	Website	www.caremessage.org
	Team	48 Full-time employees and contractors
<b>Dr. Uché Blackstock</b> Founder and CEO, Advancing Health Equity	Annual Budget	2024 - \$12.5 million Roughly 2/3 Core Operating Expenses and 1/3 R&D
<b>Vineet Singal</b> Co-founder and Chief Executive Officer, CareMessage	Funding Model	Earned revenue, institutional and individual donors



## The Problem

In the United States, life expectancy for low-income populations is 10-15 years less than high-income populations. As new technologies have emerged they have not been designed with these populations in mind, widening a digital divide that negatively impacts health equity.

## Our Theory of Change

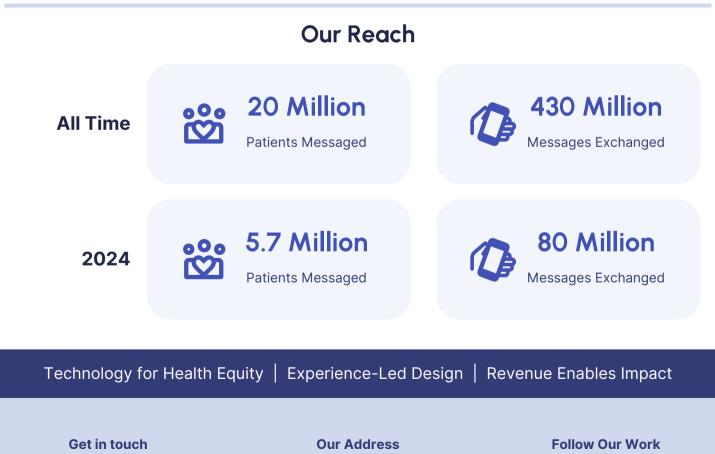
Building Technology to Improve Health Equity Requires a New Type of Organization. We believe technology, when built responsibly and by the people who share those lived experiences, has the power to scale improvements in health equity. This is only possible if your business model allows you to leverage revenue to enable impact.

## **Our Health Equity Framework**

We believe all people should have a fair chance to be healthy, and are focused on three dimensions of health equity we believe to be at the intersection of technology and feasibility of impact:

**Access to Care** - Make healthcare more accessible to low-income populations through tackling availability, affordability, delivery and quality of care.

**Clinical Outcomes** - Drive measurable improvements in behavior and outcomes that impact prevention, screening, incidence, and mortality rates for the conditions that disproportionately affect our target populations. **Social Drivers of Health** - Transform the way healthcare addresses social needs through increased and timely screenings, resource distribution, and delivering support to patients in need.



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