HEART RESERVE

FIRST-YEAR INVESTMENT AND DELIVERABLES

$1.2 million. Defined work. Visible results.

Planning scenario: five willing states, including New Jersey; up to 500 women over 12 months.

The decision requested

Convene an HHS-led working session. Identify a coordinating contact, eligible fiscal lead and funding route; agree a dated feasibility plan.

Planning allocation	Estimate	Proposed deliverable
Five state demonstrations, up to $150,000 each	$750,000	Local education and navigation, a clinician-approved handoff, and documented follow-up in five prepared settings.
National coordination and education	$150,000	One reviewed education kit, partner training, shared delivery guidance and version control.
Independent evaluation and measurement support	$150,000	An agreed baseline, common measure definitions, data-quality checks and a first-year findings report.
Paid community design and language access	$75,000	Paid patient-adviser participation, qualified language adaptation and testing with intended users.
Accessibility, privacy and secure reporting setup	$50,000	Accessibility checks, approved aggregate reporting arrangements and documented data responsibilities.
Fiscal administration reserve, subject to funder rules	$25,000	An accountable fiscal lead, contract and spending controls, and reconciliation of shared and local costs.

Total: $1,200,000 - $750,000 local delivery + $450,000 shared work.

The total includes New Jersey's $150,000 allowance. Clinical visits, tests, treatment, devices, major media purchases and new prediction software require separate resources. Confirm payment for indicated care before enrollment.

An eligible fiscal lead must cost and approve the final scope. Shared work is charged once; state budgets cover local work outside that shared scope. Founder compensation, if approved, remains inside these allocations and capped at $150,000 across national and state work, with documented effort and no duplicate billing.

At the full planning capacity of 500 participants, $1.2 million averages $2,400 per participant, including shared setup and evaluation. This is planning arithmetic, not a clinical service price or evidence of savings. Lower enrollment raises the average if spending is unchanged.

Build on what already works.

Selected transferable lessons. These studies do not rank entire health systems.

New Jersey: coverage and home visits [2–4]

NJ FamilyCare provides eligible members 12 months of postpartum coverage. Family Connects NJ lists 17 counties in its January 2026 phase, with Union, Hunterdon, Morris and Warren planned for January 2027. Community Alignment Specialists support all counties. The Perinatal Episode of Care is an existing payment and quality program. **Lesson:** Add a portable pregnancy history and a documented connection to indicated care. Enrollment, coverage, a cuff and a staffed monitoring service are separate questions.

New Jersey: MOPP, 2025 [5,6]

A prospective tight-BP-management cohort with remote monitoring was compared with a retrospective usual-care cohort. Hypertension-related ED visits were 3.6% versus 8.4%. **Lesson:** Consider a clinician-owned response pathway. The bundled intervention and nonrandomized comparison do not isolate the effect of the cuff or prove fewer deaths.

Pennsylvania: UPMC, 2024 [7]

An observational cohort associated postpartum remote hypertension monitoring with fewer readmissions and better follow-up. **Lesson:** Plan enrollment, response staffing and medication management together. Association does not establish causation or mortality benefit.

United Kingdom: POP-HT trial [8]

A single-center randomized trial of 220 women needing postpartum antihypertensives found lower 24-hour BP at about nine months: systolic by 6.5 mm Hg and diastolic by 5.8 mm Hg. **Lesson:** A strong example of supported self-monitoring and clinician-guided treatment. Participants and setting limit generalization; mortality reduction was not established.

California: hemorrhage quality collaborative [9]

Across 99 participating hospitals, severe maternal morbidity among hemorrhage patients fell from 22.1% to 18.5%; the absolute reduction was larger for Black patients. **Lesson:** Adopt consistent workflows and stratified evaluation. These are hemorrhage morbidity results, not cardiac or all-cause mortality outcomes.

Australia and CDC Hear Her: education [10,11]

Australia’s Heart Foundation connects pregnancy and menopause with heart risk. CDC Hear Her supplies warning-sign resources, real stories and materials for different audiences. **Lesson:** Use life-stage routes, trusted messengers and accessible handouts. Education materials alone do not demonstrate improved clinical outcomes.

Use the history now.
Test its predictive value separately.

PREVENT: useful, with a defined scope [12,13]

AHA PREVENT estimates cardiovascular disease risk, including heart failure, using cardiovascular, kidney and metabolic factors. Ten-year estimates apply to eligible adults aged 30–79 without known cardiovascular disease; 30-year estimates are limited to ages 30–59. Preeclampsia, gestational diabetes history and preterm delivery are not direct equation inputs. Current diabetes differs from prior gestational diabetes. A low estimate must not dismiss a pregnancy complication or an urgent postpartum symptom.

UK QRISK3 and QR4 [14,15]

QRISK3 estimates ten-year CVD risk for ages 25–84 and includes several conditions beyond traditional risk factors, but has no dedicated preeclampsia, gestational diabetes history or preterm-delivery inputs. QR4 adds predictors including preeclampsia and postnatal depression. These additions are not a comprehensive pregnancy history. UK validation does not establish accuracy for a US postpartum population.

The midlife message [10,16]

Pregnancy history remains relevant years later. During the menopause transition, changes in cardiometabolic health make it a useful time to review blood pressure, lipids, glucose and lifetime history with a clinician. Do not tell women that menopause automatically produces a fixed risk increase or that a hormone change can simply be added to a score. Clinical advice must consider the full health history.

What HEART RESERVE can offer now

Education, a portable history and prompts for clinician discussion can proceed with clinical review. Public Heart Story tools are educational. No fitted clinical coefficients, validated pregnancy-adjusted heart age or proven superiority over PREVENT is claimed. The demonstration’s care-process evaluation must remain separate from risk-model validation.

What a credible research study needs

A prespecified target population, prediction horizon and outcomes; longitudinal pregnancy and cardiovascular data; explicit handling of missing history; suitable sample size and event counts; comparison against relevant existing models; independent external validation; calibration, discrimination and clinical usefulness; and subgroup performance. A study should be able to conclude that added history does not improve prediction enough to justify a new model.

Dr. Quintero’s reported willingness to assist, Rutgers discussions and possible Women’s Health Initiative data use are leads for feasibility work. They do not establish institutional partnership, cohort access, data permissions, study approval or funding. Any role or data source must be confirmed in writing.

Count actions. Report each woman's progress.

Agree the baseline, observation window, confirmation method and analysis before enrollment.

Measure / target	What counts	Denominator
History recorded / 90%	Participants with clinically reviewed pregnancy history in the agreed record, including documented uncertainty.	All enrolled participants.
Next step owned / 90%	Participants with a named clinical owner and due date for each indicated next step.	Participants with at least one clinically indicated next step.
Follow-up actions completed / 80%	Unique clinician-indicated follow-up actions confirmed completed within the treating team's timeframe.	All clinician-indicated follow-up actions due during the observation window, including those without confirmation.

Keep the two completion measures distinct

Also report the proportion of women with every due action completed, using women with at least one due action as the denominator. The action-level 80% target must not be presented as the percentage of women whose whole plan was completed.

Missing or changed follow-up

Count each due action once. Keep missing confirmations in the denominator as not confirmed complete. Report late completion, unknown outcomes, withdrawals and clinician-revised plans separately. Prespecify how changes to a clinical plan affect eligibility and timing; do not retroactively remove missed actions to improve the result.

An inspectable first-year report

Report counts and uncertainty, baseline comparisons, patient understanding, unresolved barriers, staff time and spending. Show total cost per participant and per completed action, with startup costs separate. Review access differences where sample size permits; protect small groups.

Accountable delivery

Clinical leads own eligibility, care plans and response. An eligible fiscal lead controls contracts and spending; an independent evaluator owns analysis. Lisa leads education and engagement with paid patient advisers. Use approved clinical systems and aggregate national reporting.

Targets are proposals to agree with partners before enrollment, not clinical standards or achieved results. Use a defined baseline or suitable comparison group and report counts, denominators and uncertainty. This demonstration cannot establish reduced mortality, long-term cardiovascular benefit or a validated prediction model.

Evidence readers can inspect.

Sources accessed October 26, 2026. Click a reference to open the original page.

01 NJ Department of Health. Maternal mortality findings, 2019–2023. January 16, 2026.

02 NJ Department of Health. Reproductive health coverage options.

03 Family Connects NJ. Official county rollout schedule.

04 NJ FamilyCare. Perinatal Episode of Care program.

05 MOPP study, 2025. PubMed PMID 39983612. Rutgers investigator summary.

06 Rutgers. Closely monitoring blood pressure in postpartum mothers. March 6, 2025.

07 UPMC postpartum remote hypertension monitoring cohort, 2024. PMID 38954821.

08 POP-HT randomized clinical trial. JAMA, 2023. PMID 37950919.

09 Main et al. Racial disparities and hemorrhage quality improvement, 2020.

10 Heart Foundation Australia. Cardiovascular risk factors for women.

11 CDC Hear Her. Campaign resources.

12 AHA. PREVENT equations and clinician resources.

13 ACC. CVD Risk Estimator Plus, PREVENT model eligibility.

14 Hippisley-Cox et al. QRISK3 development and validation. BMJ, 2017.

15 Hippisley-Cox et al. QR4 development and validation. Nature Medicine, 2024.

16 AHA. Adverse pregnancy outcomes and cardiovascular disease risk, 2021.

17 Executive Order 14437, October 19, 2026. Federal Register, October 22, 2026.

18 HRSA. State Maternal Health Innovation program.

19 NIH. Simplified review framework for most research project grants.

20 HEART RESERVE. Founder, CV and campaign materials. Independent project source.

Interpretation: the campaign’s budgets, process targets and implementation design are proposals. External studies describe their own interventions and populations. They are not HEART RESERVE outcomes or partner endorsements. Government and insurer pages may change; confirm local service availability and coverage before use.