HEART RESERVE / NATIONAL PROPOSAL

From pregnancy history to lifelong heart care.

Founded by Lisa Zahakos, RPA-C

OUR GOAL

Make pregnancy history a lasting part of every woman’s heart care, from postpartum through midlife and menopause, so she understands her history, knows her next step and can reach the care she needs.

Our long-term aim is fewer missed opportunities for prevention and better heart health for women.

My sons' fetal surgery and months in the NICU showed me why a mother's care needs its own plan. - Lisa Zahakos, RPA-C

12 months	Up to 500 women	$1.2 million
After agreements and funding	Five willing states, including NJ	Includes the $150,000 NJ pilot

What changes for a woman

A portable Heart Story makes her history and questions easier to share. Her care team agrees the next action, receiving clinician and due date. Navigation helps address barriers; the receiving team confirms completion or a revised plan.

Begin with women affected by hypertension in pregnancy, including NICU mothers. Invite all 50 states to learn; expand implementation only with evidence, local readiness and funding.

WHAT FUNDING SUPPORTS

Clinical review, education, navigation, paid family input, language access and independent evaluation. Lisa would lead education and engagement; designated clinical, fiscal and evaluation leads would own their respective responsibilities.

WHAT WOULD COUNT AS PROGRESS

90% with reviewed history recorded. **90%** of those needing follow-up with an owner and due date for each step. **80%** of all follow-up actions due during observation confirmed completed on time.

Proposed targets, not results. Compare with an agreed baseline; report missing outcomes, access barriers, patient understanding, staff time and cost. This first year cannot establish reduced mortality.

The decision we are asking for

Identify an HHS coordinating contact and convene a working session with willing states, clinicians, families, an evaluator and an eligible fiscal lead. Agree the next decision, its owner and date.

Separate research goal: Test whether pregnancy and reproductive history improve cardiovascular prediction and can support a validated risk-equivalent heart-age tool. This remains separate research; no HEART RESERVE pregnancy-adjusted score is clinically validated.

Proposed only: partners, funding and approvals remain unconfirmed. Clinical care, devices and new prediction software require separate resources.

01 / THE FEDERAL ROLE

A clear request.
A realistic route.

Federal convening can connect the national message with existing state care systems.

White House: convene and refer

Identify the appropriate health-policy staff contact. Refer the proposal to HHS for a working session and assessment of fit with existing maternal-health and chronic-disease prevention work.

HHS and relevant agencies: define the pathway

Consider participation by HRSA, CDC and relevant care-access and research offices as appropriate. Identify a coordinating contact, existing resources, eligible applicants and potential funding routes. No agency commitment is assumed.

States: own delivery

Invite maternal-health or Title V leadership, clinical quality teams, maternity and NICU hosts, receiving primary care and paid family advisers. Confirm care capacity and local priorities before enrolling participants.

Congress: support oversight and lawful funding

Offices can convene constituents and seek agency guidance. Any new appropriation or statutory change would follow the applicable legislative process; a presidential letter does not itself fund the program.

The first working session: five outputs

A coordinating contact; an eligible fiscal lead; a clinical governance plan; transparent five-state selection criteria; and a costed, approved measurement and implementation plan.

The proposal does not seek exclusive federal adoption of HEART RESERVE, a sole-source commercial contract or public use of an unvalidated calculator. Participation would follow applicable eligibility, procurement and grant requirements.

02 / A CARE PATHWAY THAT TRAVELS

Record. Connect. Follow through.

Start with women affected by hypertension in pregnancy, including NICU mothers. Expand clinical scope only after local review.

1. Make the history usable

Offer a short pregnancy-history record and the optional Heart Story visit organizer. Clinical teams confirm relevant diagnoses. For women seen years later, retain that history alongside current risk factors and relevant menopause or reproductive history.

2. Give the next step an owner

The clinical team determines what is indicated and when. Write down a receiving clinician, action, due date and response contact. A navigator helps with scheduling and practical barriers. An infant's NICU stay must never delay maternal evaluation.

3. Close the referral loop

The receiving clinical team confirms completion or a revised clinical plan. Unconfirmed referrals remain visible to the responsible team. Define escalation ownership and coverage before offering monitoring or follow-up support.

Build on existing infrastructure

Use relevant AIM bundles, CDC Hear Her warning-sign education and state Title V priorities. Adapt to the local clinical protocol and referral system. The program does not replace discharge instructions, diagnosis or treatment. [5–8]

Make access part of delivery

Pay parent advisers. Offer phone and paper options, qualified language support and disability access. Ask about coverage, travel, work and childcare. Confirm referral capacity and how clinical care and access supports are paid for before recruitment.

PHASED IMPLEMENTATION

National invitation. Evidence-led expansion.

Timing starts after funding and agreements. Every implementation state needs a feasible clinical pathway.

Months 1-3: select willing settings; confirm costs, baseline, reviewed materials and written responsibilities. **Months 4-9:** enroll and deliver within confirmed capacity. **Months 10-12:** complete observation and publish findings. Recruitment closes early enough for the agreed follow-up windows.

BEFORE ENROLLMENT

A written readiness decision

Clinical and fiscal leads confirm a defined care gap, signed roles, funded response coverage, referral and care-payment capacity, reviewed materials, baseline measures and required approvals. **Decision:** Proceed only when the pathway is ready. Revise scope or defer enrollment if essential capacity is missing.

DURING DELIVERY

A record of problems and action taken

Clinical leads review missed follow-up, response failures and access barriers. The evaluator checks missing data, patient understanding and staff burden against the agreed review schedule. **Decision:** Address gaps before further recruitment. Pause new enrollment if essential clinical response coverage fails or a serious unresolved safety or data issue makes continuation unsafe.

BEFORE EXPANSION

An independent findings and cost report

Review the proposed targets with counts and uncertainty, patient understanding, access differences, staff burden and actual spending. Confirm receiving-care capacity and a funded operating plan for any additional state. **Decision:** Expand, revise or stop based on the full review. Meeting a percentage target alone does not establish clinical benefit or justify expansion.

A national ambition, with local readiness

Invite all 50 states to learn. Expansion toward up to 15 states in months 13-18 and all 50 by month 36 remains conditional on independent review, local capacity and new funding. Reviewed education can be shared without implying an active pilot in every state.

Include DC and territories in planning. Invite Tribal nations and health organizations through their own leadership, respecting sovereignty, consent, priorities and data governance.

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.

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.

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.

06 / ALL 50 STATES / 1 OF 2

A place for every state.

Each state has a dedicated proposal page, official planning resources and a locally testable design question. All participation remains unconfirmed.

State	Rank / 51	State page
Alabama	45	/national-states/alabama.html
Alaska	33	/national-states/alaska.html
Arizona	44	/national-states/arizona.html
Arkansas	47	/national-states/arkansas.html
California	23	/national-states/california.html
Colorado	17	/national-states/colorado.html
Connecticut	4	/national-states/connecticut.html
Delaware	24	/national-states/delaware.html
Florida	39	/national-states/florida.html
Georgia	46	/national-states/georgia.html
Hawaii	9	/national-states/hawaii.html
Idaho	27	/national-states/idaho.html
Illinois	22	/national-states/illinois.html
Indiana	29	/national-states/indiana.html
Iowa	14	/national-states/iowa.html
Kansas	32	/national-states/kansas.html
Kentucky	36	/national-states/kentucky.html
Louisiana	37	/national-states/louisiana.html
Maine	6	/national-states/maine.html
Maryland	12	/national-states/maryland.html
Massachusetts	1	/national-states/massachusetts.html
Michigan	18	/national-states/michigan.html
Minnesota	8	/national-states/minnesota.html
Mississippi	51	/national-states/mississippi.html
Missouri	40	/national-states/missouri.html

Commonwealth Fund, 2024 State Scorecard on Women’s Health and Reproductive Care, Appendix B2. Ranks include 50 states plus DC; 1 is best, 51 is lowest, and published ties are retained. The report generally uses 2021–2022 data. This is a broad women’s-health index, not a maternal heart-health or campaign-performance ranking. Source: Appendix B2, page 5. State pages are proposals; participation is unconfirmed.

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Montana	26	/national-states/montana.html
Nebraska	21	/national-states/nebraska.html
Nevada	48	/national-states/nevada.html
New Hampshire	5	/national-states/new-hampshire.html
New Jersey	19	/national-states/new-jersey.html
New Mexico	41	/national-states/new-mexico.html
New York	10	/national-states/new-york.html
North Carolina	33	/national-states/north-carolina.html
North Dakota	16	/national-states/north-dakota.html
Ohio	29	/national-states/ohio.html
Oklahoma	48	/national-states/oklahoma.html
Oregon	13	/national-states/oregon.html
Pennsylvania	19	/national-states/pennsylvania.html
Rhode Island	3	/national-states/rhode-island.html
South Carolina	38	/national-states/south-carolina.html
South Dakota	29	/national-states/south-dakota.html
Tennessee	43	/national-states/tennessee.html
Texas	50	/national-states/texas.html
Utah	28	/national-states/utah.html
Vermont	2	/national-states/vermont.html
Virginia	25	/national-states/virginia.html
Washington	15	/national-states/washington.html
West Virginia	35	/national-states/west-virginia.html
Wisconsin	11	/national-states/wisconsin.html
Wyoming	42	/national-states/wyoming.html

Commonwealth Fund, 2024 State Scorecard on Women’s Health and Reproductive Care, Appendix B2. Ranks include 50 states plus DC; 1 is best, 51 is lowest, and published ties are retained. The report generally uses 2021–2022 data. This is a broad women’s-health index, not a maternal heart-health or campaign-performance ranking. Source: Appendix B2, page 5. State pages are proposals; participation is unconfirmed.

07 / THE CALCULATION RESEARCH CASE

What the score captures. What the history can add.

The independent HEART RESERVE candidate is research. It has no fitted clinical coefficients and no demonstrated superiority.

U.S. PREVENT

Uses: Age, sex, blood pressure, cholesterol, BMI, kidney function, diabetes, smoking and treatments; optional UACR, HbA1c and social deprivation.

Boundary: No separate inputs for preeclampsia, historical gestational diabetes or preterm delivery. Clinical guidance can consider pregnancy history alongside the score. PREVENT-Age is already available.

UK QRISK3

Uses: Age, sex, ethnicity, deprivation, blood pressure, lipid ratio, smoking, diabetes, family history and selected diagnoses and medicines.

Boundary: No direct preeclampsia, historical gestational diabetes or preterm-delivery input. It is not a full pregnancy-history assessment.

UK QR4

Uses: Extends cardiovascular prediction with additional conditions, including preeclampsia and postnatal depression.

Boundary: Important progress, but not a complete episode-by-episode reproductive history or a U.S.-validated pregnancy-adjusted age. Publication does not establish universal NHS adoption.

HEART RESERVE research candidate

Uses: Would fit its own coefficients from current measurements, detailed pregnancy episodes, reproductive history and selected additional markers.

Boundary: Clinical weights and the reference-age curve are not fitted. Longitudinal outcomes, external validation, useful clinical decisions and safe communication must still be established.

Sources: AHA PREVENT and its 2026 Quickstart Guide; QRISK3; Hippisley-Cox et al. (QR4, 2024); NICE NG238; current HEART RESERVE independent model package. Different endpoints, horizons and populations prevent direct interchange of these scores.

08 / A CREDIBLE INDEPENDENT STUDY

Use the history. Earn the calculation.

Current measurements

Blood pressure, lipids, BMI, kidney function, diabetes, smoking and treatments; selected optional biomarkers when measured.

Pregnancy episodes

Preeclampsia, gestational hypertension, gestational diabetes, gestational age at delivery, fetal-growth context and pregnancy loss; study timing, recurrence and severity without duplicate penalties.

Reproductive life course

Age at first period, cycle history, diagnosed PCOS, menopause timing and cause. These are candidate features with differing evidence, not automatic added risk years.

Selected additional markers

Family history, measured Lp(a), ApoB, triglycerides and selected inflammation measures. Fit a feasible subset and test added value beyond correlated routine measurements.

What the completed work establishes

Eleven NHANES 2017–2018 files were audited: 2,128 examined women ages 30–79, including 1,775 with prior pregnancy and 157 reporting pregnancy diabetes. These unweighted sample counts establish input feasibility, not predictive performance. No clinical predictions or risk ages were generated.

CARDIA metadata were mapped across 17 domains and 80 variable references. Restricted participant data have not been received. Clinical coefficients, longitudinal outcome fitting, the reference-age curve and external validation remain incomplete.

The separate research request

An eligible investigator and biostatistical team should first confirm data access, chronology, events, missingness and intended-use fit. Compare parsimonious models, quantify calibration and decision benefit, and externally validate before patient use. Test communication and care effects separately. Additional inputs do not guarantee improvement.

No automatic TTTS, twin, menopause or menstrual-history penalty. A model-derived age difference is not biological age or causal years lost. Current pregnancy, recent postpartum concerns and established CVD follow separate clinical pathways; research eligibility must never delay care.

09 / NATIONAL AND INTERNATIONAL LESSONS

A message people repeat. A pathway teams can deliver.

The following are proposed adaptations of observed program features, not transferred effectiveness claims or endorsements.

United States / The Heart Truth

A trusted network carries one message into communities. Use one national clinical core, then give participating organizations a reviewed local host kit and a named coordinator.

United States / Go Red for Women

A recognizable annual action makes participation easy. Use one repeatable action: bring pregnancy history to the next healthcare visit. Share the message and public resources without requiring disclosure of private history.

United States / Hear Her and AIM

Warning-sign education connects with clinical safety workflows. Pair campaign education with the host's existing urgent-care protocol, discharge transition and named clinical owner.

United States / WISEWOMAN

Assessment is connected with referrals, support and evaluation. Plan service capacity and barriers before publicity; track indicated care completed, not only people reached. Verify eligibility before proposing any program linkage.

England / NHS Health Check

Eligible adults are invited to a structured preventive conversation. Build a reliable invitation and return-visit process. Do not wait for age 40 to respond to a pregnancy-related care need; NHS Health Check itself is not a postpartum service.

United Kingdom / QR4 research

Pregnancy-related predictors can be tested in a large longitudinal model. Test the independent HEART RESERVE model against suitable benchmarks and report incremental value. Broader inputs alone do not prove better prediction.

Australia / CVD risk guidance

Risk calculation is followed by clinical interpretation and management. Keep pregnancy and reproductive history visible even when a validated equation has no matching input; the clinical team decides what to do with that information.

Keep the campaign action constant: ASK about pregnancy history, RECORD it durably, and RESPOND with an appropriate clinician-owned next step. Pair public activation with service capacity, paid family design and quarterly aggregate learning.

10 / EVIDENCE, CREDIBILITY AND NEXT STEPS

A strong foundation.
An honest research boundary.

Pregnancy complications are associated with later cardiovascular risk. PREVENT remains a validated clinical assessment tool, and AHA's current calculator already provides PREVENT-Age. Heart Story organizes visit information; HEART RESERVE has not validated a pregnancy-adjusted risk age. Research with potential clinical and academic collaborators is separate from this education proposal. [1–4]

1. CDC: Women and heart disease
Heart disease remains the leading cause of death for women in the United States.

2. AHA: Adverse pregnancy outcomes and cardiovascular risk
Pregnancy complications are associated with later cardiovascular risk; transitions into preventive care matter.

3. AHA: About PREVENT
PREVENT supports clinician assessment using cardiovascular, kidney and metabolic factors.

4. AHA: PREVENT Equations Quickstart Guide, 2026
The current calculator includes PREVENT-Age. A pregnancy-adjusted HEART RESERVE age has not been validated.

5. HRSA: Alliance for Innovation on Maternal Health
AIM offers maternal safety bundles and state implementation infrastructure.

6. HRSA: State Maternal Health Innovation
State task forces, data and local strategies provide a practical coordination route.

7. HRSA: Title V state reports and contacts
State needs assessments and annual reports should guide local design.

8. CDC: Hear Her
Existing urgent maternal warning-sign education should be incorporated through approved local pathways.

9. USAGov: State health departments
Official directory for routing state health department outreach.

10. White House: Contact the President
Official public submission route. This package has not been submitted.

11 / FURTHER SOURCES

Rankings. Campaigns. International comparisons.

11. Commonwealth Fund: 2024 women's-health rankings
Appendix B2 supplies all published ranks, including ties and DC; the report generally uses 2021–2022 data.

12. March of Dimes: 2025 U.S. Report Card
The 2024 U.S. preterm birth rate was 10.4%. This measures preterm birth, not maternal cardiovascular risk.

13. NHLBI: The Heart Truth Healthy Hearts Network
A national network distributes credible heart-health education through local partners.

14. AHA: Go Red for Women / National Wear Red Day
A repeatable public action and partner materials help people participate.

15. CDC: WISEWOMAN
Screening, referrals, coaching and evaluation connect education with services for eligible women.

16. England: NHS Health Check
An invitation-based preventive check for eligible adults ages 40–74; it is not a postpartum program.

17. UK: QRISK3
Published calculator inputs provide the comparison with pregnancy-history candidates.

18. UK: QR4 development and validation, 2024
QR4 added preeclampsia and postnatal depression among its predictors; UK validation is not U.S. validation.

19. Australia: CVD risk assessment and reclassification
Clinical considerations sit alongside the estimated risk, including pregnancy history.

20. NICE: NG238 cardiovascular risk assessment
Current reviewed recommendations reference QRISK3; do not equate QR4 publication with universal NHS adoption.

Founder, current CV and research status:
https://campaign.heartreserve.blog/founder.html
https://campaign.heartreserve.blog/research-pathway.html

Sources checked October 26, 2026. Existing campaign materials require clinical review, qualified translation review and patient testing before institutional distribution. This presidential proposal has not been sent or submitted.