

POSTPARTUM ADVOCATE

Healthier recovery. Care that follows through.

Founded by Lisa Zahakos, RPA-C

HEART RESERVE proposes a \$150,000, 12-month feasibility project with a hospital partner to configure, deliver and evaluate a 90-day Postpartum Advocate service for 50 adults after hypertensive pregnancy, alongside 50 current-care comparison participants. Funding supports approved patient education, staffed follow-through, accessible tools and evaluation. The project will test whether prescribed follow-up is completed and clinically reviewed, patients understand their next steps, and the service can operate at a sustainable cost. Readmissions and paid claims are exploratory outcomes; reductions are goals to test.

Project envelope	Evaluation sample	Service episode
\$150,000 proposed	50 service + 50 current-care participants	90 days after discharge; 12-month project

What the patient receives

A plan she understands; hospital-approved warning-sign teaching; clinician-directed blood-pressure follow-up; help with medicine, appointment and transport barriers; and an identified person responsible for reviewing unfinished care. Pregnancy history and questions stay together in her Heart Story.

Why this is a focused first step

CDC's 2022 review data place 67.9% of pregnancy-related deaths after pregnancy, calculated from the reported 1-6 day, 7-42 day and 43-365 day intervals. This is not a measure of deaths after hospital discharge. The initial hypertension-focused pilot addresses one tractable care gap while preserving urgent assessment and referral for other concerns. [1]

The 90-day episode ends with an accepted continuing-care handoff. A year of monitoring is not included. A hospital-branded edition is proposed within the wider HEART RESERVE platform; surgical recovery would require its own pathway, staffing and price.

Purpose of this packet

Ready for an initial funding, hospital or health-plan discussion. Figures are planning assumptions, subject to quotes and scope. This packet does not establish grant eligibility, an awarded contract, clinical effectiveness or guaranteed savings. The requested next step is a scoped feasibility discussion with the appropriate clinical, technology, evaluation and finance partners.

01 / DELIVERY PLAN

Five phases with decision points

Proposed timing allocation of the existing budget. Months run from project kickoff; overlapping preparation is counted once. These are not contracted milestone-payment terms.

01 • MONTHS 1-2 | \$20,000

Scope & design

Deliverables: written scope, role map, measure definitions and cost assumptions.

Decision: the proposed partner accepts the scope and identifies clinical coverage and a viable data-access route before configuration proceeds.

02 • MONTHS 2-3 | \$45,000

Configure & prepare

Deliverables: approved content, staff training, device workflow and documented rehearsal results.

Decision: the clinical lead confirms coverage, consent and data arrangements; all agreed safety-critical tests pass before enrollment. Unresolved critical failures delay launch.

03 • MONTHS 4-8 | \$45,000

Deliver in stages

Deliverables: activation and follow-up records, patient feedback, barrier outcomes and staff-time logs.

Decision: review the first operational cohort before increasing enrollment. Proceed only when response coverage, workload and patient access remain workable.

04 • MONTHS 9-11 | \$15,000

Complete & hand off

Deliverables: completed or explicitly unknown follow-up status, accepted handoffs and revised training materials.

Decision: the receiving service acknowledges the handoff; unresolved concerns remain visible. Continuing support beyond the paid episode needs funding and ownership.

05 • MONTH 12 + AGREED CLAIMS RUNOUT | \$10,000

Evaluate & decide

Deliverables: operational report, hospital and payer analyses, limitations and a renewal recommendation.

Decision: renew, revise or stop against criteria agreed before enrollment. The evaluation scope and quote must cover the planned claims-runout work; extensions require a revised scope.

\$135,000 scheduled work + \$15,000 planning reserve = \$150,000 total. The reserve is unallocated. Claims-runout work must fit the evaluator's agreed scope; any extension needs a revised estimate.

02 / COST ESTIMATE

The full pilot budget

Budget line	Planning assumption	Amount
HEART RESERVE content & training	200 hours × \$125	\$25,000
Platform configuration & pilot access	Provisional technology-vendor allowance	\$30,000
Incremental clinical & outreach work	350 hours × \$100, within an existing staffed service	\$35,000
Cuffs & connectivity	50 recipients × \$160	\$8,000
Evaluation & claims analysis	160 hours × \$125	\$20,000
Implementation & contracting review	80 hours × \$125	\$10,000
Language & access support	Provisional allowance	\$7,000
Contingency	11.1% of the \$135,000 direct-cost subtotal	\$15,000
Total illustrative budget	Subject to scope, staffing and quotes	\$150,000

Lisa's program-work estimate

200 hours at \$125 per hour = \$25,000, or 16.7% of the full envelope. This is included above, not an additional charge. Proposed work: 40 hours design (\$5,000); 80 hours content and training (\$10,000); 60 hours content stewardship (\$7,500); 20 hours handoff materials (\$2,500).

The allocation pays for defined company/program deliverables. Compensation classification, benefits, taxes and any allowable indirect costs need the selected agreement's treatment. It is not guaranteed salary, profit or take-home pay. A future episode license or royalty is separately negotiated and, if applicable in the pilot, must be counted once.

\$1,500 per evaluation participant or \$3,000 per service recipient includes development and evaluation. Neither figure is a recurring episode quote.

03 / BUDGET JUSTIFICATION

What each allocation buys

\$25,000 · Content & training

Creates the HEART RESERVE teaching and advocacy materials, prepares staff and supports revisions. The proposed 200 hours are detailed above; confirm the contracting and compensation basis.

\$30,000 · Platform configuration & pilot access

Configures the agreed patient and team workflows and provides pilot access and support. Obtain a written vendor quote, inclusions, integration limits and white-label rights; custom development may change the total.

\$35,000 · Clinical & outreach work

Funds 350 incremental hours for training, outreach, review and handoff within an existing staffed service. Validate workload, coverage and fully loaded rates with the clinical partner. This does not purchase a new 24/7 team.

\$8,000 · Cuffs & connectivity

Allows \$160 for each of 50 service recipients. Confirm validated devices, suitable cuff sizes, delivery, setup, replacement and actual connectivity needs against a supplier quote.

\$20,000 · Evaluation & claims analysis

Funds 160 hours for definitions, data quality, feasibility and experience analysis, and hospital/payer reporting. Confirm data access, analytic effort and the claims-runout schedule before fixing this price.

\$10,000 · Implementation & contracting review

Allows 80 hours for the written scope, responsibilities, agreements and launch review. Confirm whether privacy, security, insurance and any additional specialist reviews are included or separately priced.

\$7,000 · Language & access support

Supports translated or interpreted materials and practical access accommodations. Obtain a scope based on participants' actual needs and avoid duplicating benefits the partner already supplies.

\$15,000 · Planning reserve

Retains flexibility in the commercial planning envelope. It is not automatically an allowable grant budget line; review the chosen funder's rules before submission.

All required benefits, indirect costs, data charges, insurance and support must be priced or documented as committed contributions. Reforecast the total when quotes arrive. The \$35,000 clinical line assumes an existing staffed service. It cannot fund a new 24/7 team.

The \$15,000 reserve is a commercial planning assumption. Federal contingency rules impose specific conditions; some reserve payments are unallowable. Confirm the chosen funder's rules and use genuine supported eligible costs, not a renamed reserve. [4, 5]

04 / VALUE & EVALUATION

One patient goal. Distinct buyer cases.

FOR A GRANT FUNDER

Support feasibility, patient access and measurable learning. Connect each aim to an activity, deliverable, cost and evaluation measure. Describe why grant support is needed and how the service could continue afterward.

FOR A HOSPITAL

Test whether a funded service helps patients complete care and gives staff clear ownership of unfinished work. Measure workload, avoidable hospital expense, necessary care and revenue effects.

FOR AN INSURER

Define what the episode adds to current maternity benefits. Compare full maternal paid claims and additional program costs over the same period, accounting for population differences and claims runoff.

Measures to agree before enrollment

Question	Measure and evidence
Did prescribed care happen?	Due BP evaluation completed and clinically reviewed within the clinician-specified window / all participants due. Report missing evidence and timing pathways separately.
Did she understand and get help?	Teach-back, feeling heard, access barriers, unresolved requests and receiving-service acknowledgement. State assessed and unassessed denominators.
Could the service deliver?	Staff minutes, overdue work, delivery failures, response coverage, safety events and differences in reach across relevant groups.
What happened to care use and cost?	Exploratory 30/90-day ED visits, readmissions and total maternal paid claims; full additional program cost. Match population and period and allow claims runoff.

Hospital net value: avoided events x avoidable hospital expense + other avoidable expense + net revenue change - incremental program costs. Payer net value: adjusted current-care claims - program-group claims - additional program costs. Count each cost once. These are evaluation frameworks, not measured results.

A 100-person feasibility project cannot establish a mortality benefit or dependable savings from uncommon events. Specify assignment, analysis, missing data and renewal criteria before recruitment. Necessary emergency assessment is appropriate care, not program failure.

05 / READINESS

Before application or contracting

The concept, work plan, budget, proposed effort and buyer logic are prepared. Complete the following against the actual funding opportunity or buyer's requirements. None of these external commitments is implied by this packet.

Requirement	Still needed
Need & population	Partner-specific eligible volume, local outcomes, access gaps and evidence of unmet need.
Aims & work plan	Named accountable partners, dates, accepted scope and funder-specific measurable aims.
Evaluation	Qualified evaluator's analysis plan, assignment method, missing-data approach, data agreements, necessary oversight/IRB determination and prospective acceptance thresholds.
Budget & justification	Quotes, cost classification, compensation basis, applicable fringe/indirect costs and funder treatment of the reserve.
Team & commitments	Required bios/CVs, effort commitments and signed letters or agreements. Proposed collaboration is not a signed service contract.
Technology & clinical readiness	Verified license rights, privacy/security acceptance, clinical coverage, approved content and passed readiness tests.
Commercial sustainability	Full recurring price, payer coverage or contracting route, renewal terms, sales evidence and post-pilot funding.
Grant eligibility & administration	Chosen notice of funding opportunity, entity eligibility, registrations, deadline, required forms, page limits, certifications and authorized signature.
Submission & recipient access	Verify the intended recipient can open the material; complete the correct portal or delivery process and retain its receipt. This page is not a submission receipt.

A distinct NSF research proposal

The separate pregnancy-history reconstruction pitch needs its own technical experiments, team, schedule and budget. NSF requires substantial research and development; routine white-label configuration alone does not establish fit. The \$150,000 service pilot is not the NSF research budget. [6]

06 / SOURCES & NEXT DISCUSSION

Use the evidence at its proper scale

National burden establishes a reason to evaluate the service. A buyer's local costs, outcomes and actual benefits establish the relevant baseline. No national average is presented here as a HEART RESERVE savings estimate.

1. CDC - Pregnancy-related deaths reviewed by maternal mortality review committees, 2022

Timing is after pregnancy, not after hospital discharge. The 67.9% figure is the sum of three reported postpartum intervals.

2. CDC - Urgent maternal warning signs

Patient education and approved immediate-care routes need to remain available throughout recovery.

3. American Heart Association - Life's Essential 8

The education framework; individualized recovery actions remain with the treating team's plan.

4. eCFR - 2 CFR 200.433, contingency provisions

Applicable federal rules require specific treatment of contingency estimates and reserves.

5. NIH - Develop your budget

Illustrates the need to justify effort and costs using the selected funder's instructions; NIH guidance does not determine eligibility for another grant.

6. NSF - Project Pitch information

Technical novelty, research uncertainty, market need and team capability require a separate research case.

The proposed next discussion

Confirm the hospital population and existing service; demonstrate the current technology; identify the clinical and evaluation leads; request itemized quotes; and choose a funding or purchasing route. Then convert this planning envelope into the recipient's required scope, budget and application.

Sources checked October 22, 2026. Referenced organizations do not endorse HEART RESERVE. This packet is a standalone discussion document and does not require access to the private app.