Maternal Safety Bundle for Severe Hypertension in Pregnancy
Disclaimer: The following material is an example only and not meant to be prescriptive. ACOG accepts no liability for the content or for the consequences of any actions taken on the basis of the information provided.
# KEY ELEMENTS

<table>
<thead>
<tr>
<th>RISK ASSESSMENT &amp; PREVENTION</th>
<th>READINESS &amp; RESPONSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diagnostic Criteria</td>
<td>• Complications &amp; Escalation Process</td>
</tr>
<tr>
<td>• When to Treat</td>
<td>• Further Evaluation</td>
</tr>
<tr>
<td>• Agents to Use</td>
<td>• Change of Status</td>
</tr>
<tr>
<td>• Monitoring</td>
<td>• Postpartum Surveillance</td>
</tr>
</tbody>
</table>
# Types of Hypertension

<table>
<thead>
<tr>
<th>Chronic Hypertension</th>
<th>GESTATIONAL HYPERTENSION</th>
<th>Preeclampsia - Eclampsia</th>
<th>Chronic Hypertension + Superimposed Preeclampsia</th>
</tr>
</thead>
<tbody>
<tr>
<td>- SBP ≥ 140 or DBP ≥ 90</td>
<td>- SBP ≥ 140 or DBP ≥ 90</td>
<td>- SBP ≥ 140 or DBP ≥ 90</td>
<td>- Two severe BP values (SBP ≥ 160 or DBP ≥ 110) obtained 15-60 minutes apart</td>
</tr>
<tr>
<td>- Pre-pregnancy or &lt;20 weeks</td>
<td>- &gt; 20 weeks</td>
<td>- Proteinuria with or without signs/symptoms</td>
<td>- Persistent oliguria &lt;500 ml/24 hours</td>
</tr>
<tr>
<td></td>
<td>- Absence of proteinuria or systemic signs/symptoms</td>
<td>- Presentation of signs/symptoms/lab abnormalities but no proteinuria</td>
<td>- Progressive renal insufficiency</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Unremitting headache/visual disturbances</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Pulmonary edema</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Epigastric/RUQ pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- LFTs &gt; 2x normal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Platelets &lt; 100K</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- HELLP syndrome</td>
</tr>
</tbody>
</table>

*Proteinuria not required for diagnosis eclampsia seizure in setting of preeclampsia*

*5 gr of proteinuria no longer criteria for severe preeclampsia*
DEFINITIONS

SEVERE HYPERTENSION

- Systolic blood pressure ≥ 160 mm Hg or
- Diastolic blood pressure ≥ 110 mm Hg

HYPERTENSIVE EMERGENCY

- Persistent, severe hypertension that can occur antepartum, intrapartum, or postpartum
- Defined as:
  - Two severe BP values (≥ 160/110) taken 15-60 minutes apart
  - Severe values do not need to be consecutive
WHEN TO TREAT

SEVERE HYPERTENSION

SBP $\geq 160$ or DBP $\geq 110$

- Repeat BP every 5 min for 15 min
- Notify physician after one severe BP value is obtained

HYPERTENSIVE EMERGENCY

Persistent, severe hypertension that can occur antepartum, intrapartum, or postpartum
Two severe BP values ($\geq 160/110$) taken 15-60 minutes apart
Severe values do not need to be consecutive

- If severe BP elevations persist for 15 min or more, begin treatment ASAP. Preferably within 60 min of the second elevated value.
- If two severe BPs are obtained within 15 min, treatment may be initiated if clinically indicated
FIRST LINE THERAPIES

- Intravenous labetalol
- Intravenous hydralazine
- Oral nifedipine

Magnesium sulfate not recommended as antihypertensive agent

- Should be used for: seizure prophylaxis and controlling seizures in eclampsia
- IV bolus of 4-6 grams in 100 ml over 20 minutes, followed by IV infusion of 1-2 grams per hour. **Continue for 24 hours postpartum**
- If no IV access, 10 grams of 50% solution IM (5 g in each buttock)
- Contraindications: pulmonary edema, renal failure, myasthenia gravis

Anticonvulsants (for recurrent seizures or when magnesium is C/I):

- **Lorazepam**: 2-4 mg IV x 1, may repeat x 1 after 10-15 min
- **Diazepam**: 5-10 mg IV every 5-10 min to max dose 30 mg
- **Phenytoin**: 15-20 mg/kg IV x 1, may repeat 10 mg/kg IV after 20 min if no response. Avoid with hypotension, may cause cardiac arrhythmias.
- **Keppra**: 500 mg IV or orally, may repeat in 12 hours. Dose adjustment needed if renal impairment.

*There may be adverse effects and additional contraindications. Clinical judgement should prevail*
Labetalol Algorithm

Trigger: If severe elevations (SBP ≥ 160 or DBP ≥ 110) persist* for 15 min or more OR If two severe elevations are obtained within 15 min and tx is clinically indicated

1. Labetalol 20 mg† IV over 2 minutes
2. Repeat BP in 10 minutes
3. If SBP ≥ 160 or DBP ≥ 110, administer labetalol 40 mg IV over 2 minutes; if BP below threshold, continue to monitor BP closely
4. Repeat BP in 10 minutes
5. If SBP ≥ 160 or DBP ≥ 110, administer labetalol 80 mg IV over 2 minutes; if BP below threshold, continue to monitor BP closely
6. Repeat BP in 10 minutes
7. If SBP ≥ 160 or DBP ≥ 110, administer hydralazine 10 mg IV over 2 minutes; if BP below threshold, continue to monitor BP closely
8. Repeat BP in 20 minutes
9. If SBP ≥ 160 or DBP ≥ 110 at 20 minutes, obtain emergency consultation from specialist in MFM, internal medicine, anesthesiology, or critical care
10. Give additional antihypertensive medication per specific order as recommended by specialist

- Every 10 minutes for 1 hour
- Then every 15 minutes for 1 hour
- Then every 30 minutes for 1 hour
- Then every hour for 4 hours

11. Institute additional BP monitoring per specific order

- Notify provider after one severe BP value is obtained
- Institute fetal surveillance if viable
- Hold IV labetalol for maternal pulse under 60
- Maximum cumulative IV-administered dose of labetalol should not exceed 220 mg in 24 hours
- There may be adverse effects and contraindications. Clinical judgement should prevail.

* Two severe readings more than 15 minutes and less than 60 minutes apart
† Avoid parenteral labetalol with active† asthma, heart disease, or congestive heart failure; use with caution with history of asthma. May cause neonatal bradycardia.
† Active asthma” is defined as:
  1. Symptoms at least once a week, or
  2. Use of an inhaler, corticosteroids for asthma during the pregnancy, or
  3. Any history of intubation or hospitalization for asthma.
§ Hydralazine may increase risk of maternal hypotension.
Hydralazine Algorithm

Trigger: If severe elevations (SBP ≥160 or DBP ≥110) persist* for 15 min or more OR If two severe elevations are obtained within 15 min and tx is clinically indicated

1. Administer hydralazine† 5 mg or 10 mg IV over 2 minutes
2. Repeat BP in 20 minutes
3. If SBP ≥160 or DBP ≥110, administer hydralazine 10 mg IV over 2 minutes
4. Repeat BP in 20 minutes
5. If SBP ≥160 or DBP ≥110, administer labetalol 20 mg* IV over 2 minutes; if BP below threshold, continue to monitor BP closely
6. Repeat BP in 10 minutes
7. If SBP ≥160 or DBP ≥110, administer labetalol 40 mg IV over 2 minutes, and obtain emergency consultation from specialist in MFM, internal medicine, anesthesiology, or critical care
8. Give additional antihypertensive medication per specific order as recommended by specialist
9. Once BP thresholds are achieved, repeat BP:
   - Every 10 minutes for 1 hour
   - Then every 15 minutes for 1 hour
   - Then every 30 minutes for 1 hour
   - Then every hour for 4 hours
10. Institute additional BP monitoring per specific order

- Notify provider after one severe BP value is obtained
- Institute fetal surveillance if viable
- Hold IV labetalol for maternal pulse under 60
- Maximum cumulative IV-administered dose of hydralazine should not exceed 25 mg in 24 hours
- There may be adverse effects and contraindications. Clinical judgement should prevail.

* Two severe readings more than 15 minutes and less than 60 minutes apart
† Avoid parenteral labetalol with active† asthma, heart disease, or congestive heart failure; use with caution with history of asthma. May cause neonatal bradycardia.
‡ "Active asthma" is defined as:
   a) Symptoms at least once a week, or
   b) Use of an inhaler, corticosteroids for asthma during the pregnancy, or
   c) Any history of intubation or hospitalization for asthma.
† Hydralazine may increase risk of maternal hypotension.
**Oral Nifedipine Algorithm**

Trigger: If severe elevations (SBP ≥ 160 or DBP ≥ 110) persist* for 15 min or more OR If two severe elevations are obtained within 15 min and tx is clinically indicated

1. Oral nifedipine† 10 mg
2. Repeat BP in 20 minutes
3. If SBP ≥ 160 or DBP ≥ 110, administer oral nifedipine 20 mg; If below threshold, continue to monitor BP closely
4. Repeat BP in 20 minutes
5. Give additional round of oral nifedipine 20 mg
6. If SBP ≥ 160 or DBP ≥ 110, administer IV labetalol† 40 mg; If below threshold, continue to monitor BP closely. Obtain emergency consultation from specialist in MFM, internal medicine, anesthesiology, or critical care.
7. Give additional antihypertensive medication per specific order as recommended by specialist
8. Once BP thresholds are achieved, repeat BP:
   - Every 10 minutes for 1 hour
   - Then every 15 minutes for 1 hour
   - Then every 30 minutes for 1 hour
   - Then every hour for 4 hours
9. Institute additional BP monitoring per specific order

- Notify provider after one severe BP value is obtained
- Institute fetal surveillance if viable
- Capsules should be administered orally and not punctured or otherwise administered sublingually
- There may be adverse effects and contraindications. Clinical judgement should prevail.

* Two severe readings more than 15 minutes and less than 60 minutes apart
† Oral nifedipine has been associated with an increase in maternal heart rate and may overshoot hypotension.

Avoid parenteral labetalol with active† asthma, heart disease, or congestive heart failure; use with caution with history of asthma. May cause neonatal bradycardia.

† "Active asthma" is defined as:
   - A symptoms at least once a week, or
   - B use of an inhaler, corticosteroids for asthma during the pregnancy, or
   - C any history of intubation or hospitalization for asthma.
ADDITIONAL THERAPY RECOMMENDATIONS

IF NO IV ACCESS AVAILABLE:

• Initiate algorithm for oral nifedipine, or
• Oral labetalol, 200 mg  *Repeat in 30 min if SBP remains ≥ 160 or DBP ≥ 110 and IV access still unavailable

SECOND LINE THERAPIES (if patient fails to respond to first line tx):

Recommend emergency consult with:

• Maternal Fetal Medicine
• Internal Medicine
• Anesthesiology
• Critical Care
• Emergency Medicine

May also consider:

✓ Labetalol or nicardipine via infusion pump
✓ Sodium nitroprusside for extreme emergencies  *Use for shortest amount of time due to cyanide/thiocyanate toxicity
MONITORING BLOOD PRESSURE

MATERNAL

- Once BP is controlled (<160/110), measure
  - Every 10 minutes for 1 hour
  - Every 15 minutes for next hour
  - Every 30 minutes for next hour
  - Every hour for 4 hours

- Obtain baseline labs:
  - CBC
  - Platelets
  - LDH
  - Liver Function Tests
  - Electrolytes
  - BUN creatinine
  - Urine protein

FETAL

- Fetal monitoring surveillance as appropriate for gestational age
**Hypertensive Emergency Checklist**

**Hypertensive Emergency:**
- Two severe BP values (≥160/110) taken 15-60 minutes apart. Values do not need to be consecutive.
- May treat within 15 minutes if clinically indicated

- Call for Assistance
- Designate team leader, checklist reader, primary RN
- Ensure side rails are up
- Administer seizure prophylaxis
- Antihypertensive therapy within 1 hr for persistent severe range BP
- Place IV; Draw PEC labs
- Antenatal corticosteroids is <34 wks gestation
- Re-address VTE prophylaxis requirement
- Place indwelling urinary catheter
- Brain imaging if unremitting headache or neurological symptoms
- Debrief patient, family, OB team

**Magnesium Sulfate**
- Contraindications: Myasthenia gravis; avoid with pulmonary edema, use caution with renal failure
- IV access:
  - Load 4-6 grams 10% magnesium sulfate in 100 mL over 20 min
  - Label magnesium sulfate; connect to labeled infusion pump
  - Magnesium sulfate maintenance 1-2 grams/hour
- No IV access:
  - 10 grams of 50% solution IM (5 g in each buttock)

**Antihypertensive Medications**

- For SBP ≥ 160 or DBP ≥ 110
- Labetalol (initial dose: 20 mg); Avoid parenteral labetalol with active asthma, heart disease, or congestive heart failure; use with caution with history of asthma
- Hydralazine (5-10 mg IV* over 2 min); May increase risk of maternal hypotension
- Oral Nifedipine (10 mg capsules); Capsules should be administered orally, not punctured or otherwise administered sublingually
- * Maximum cumulative IV-administered doses should not exceed 220 mg labetalol or 25 mg hydralazine in 24 hours

**Anticonvulsant Medications**

- Lorazepam (Ativan): 2-4 mg IV x 1, may repeat once after 10-15 min
- Diazepam (Valium): 5-10 mg IV q 5-10 min to maximum dose 30 mg

* "Active asthma" is defined as:
- Symptoms at least once a week
- Use of an inhaler, corticosteroids for asthma during the pregnancy
- Any history of intubation or hospitalization for asthma.

Revised July 2017

Safe Motherhood Initiative
**Eclampsia Checklist**

- Call for assistance
- Designate team leader, checklist reader, primary RN
- Ensure side rails are up
- Protect airway + improve oxygenation
- Continuous fetal monitoring
- Place IV; Draw preeclampsia labs
- Ensure medications appropriate given patient history
- Administer magnesium sulfate
- Administer antihypertensive therapy if appropriate
- Develop delivery plan, if appropriate
- Debrief patient, family, and obstetric team

---

**Magnesium Sulfate**

- Contraindications: Myasthenia gravis; avoid with pulmonary edema, use caution with renal failure
- IV access:
  - Load 4-6 grams 10% magnesium sulfate in 100 ml solution over 20 min
  - Label magnesium sulfate; Connect to labeled infusion pump
  - Magnesium sulfate maintenance 1-2 grams/hour
- No IV access:
  - 10 grams of 50% solution IM (5 g in each buttock)

---

**Antihypertensive Medications**

- For SBP ≥ 160 or DBP ≥ 110 (See SmI algorithms for complete management when necessary to move to another agent after 2 doses)
  - Labetalol (initial dose: 20 mg); Avoid parenteral labetalol with active asthma, heart disease, or congestive heart failure; use with caution with history of asthma
  - Hydralazine (5-10 mg IV* over 2 min); May increase risk of maternal hypotension
  - Oral Nifedipine (10 mg capsules); Capsules should be administered orally, not punctured or otherwise administered sublingually

*Active asthma* is defined as:
- Symptoms at least once a week, or
- Use of an inhaler, corticosteroids for asthma during the pregnancy, or
- Any history of intubation or hospitalization for asthma.

---

**Anticonvulsant Medications**

- For recurrent seizures or when magnesium sulfate contraindicated
  - Lorazepam (Ativan): 2-4 mg IV x 1, may repeat once after 10-15 min
  - Diazepam (Valium): 5-10 mg IV q 5-10 min to maximum dose 30 mg

---

**For Persistent Seizures**

- Neuromuscular block and intubate
- Obtain radiographic imaging
- ICU admission
- Consider anticonvulsant medications

---

**Safety Campaigns**

- Safe Motherhood Initiative
- ACOG The American Congress of Obstetricians and Gynecologists

---

* Revised July 2017

---

**EXAMPLE 14**
COMPLICATIONS & ESCALATION PROCESS

MATERNAL (pregnant or postpartum)
• CNS (seizure, unremitting headache, visual disturbance)
• Pulmonary edema or cyanosis
• Epigastric or right upper quadrant pain
• Impaired liver function
• Thrombocytopenia
• Hemolysis
• Coagulopathy
• Oliguria *< 30 ml/hr for 2 consecutive hours

FETAL
• Abnormal fetal tracing
• IUGR

Prompt evaluation and communication: If undelivered, plan for delivery
MONITORING CHANGE OF STATUS

Once patient is stabilized, consider:

SEIZURE PROPHYLAXIS
- Magnesium sulfate (if not already initiated)

TIMING & ROUTE OF DELIVERY
- Eclampsia → Delivery after stabilization
- HELLP/Severe preeclampsia/
  Chronic hypertension + superimposed
  preeclampsia → Vaginal delivery, if attainable in reasonable amount of time
- ≥ 34 weeks → Deliver

MATERNAL BP
- Continue control with oral agents
- Target range of 140-150/90-100

IF PRETERM (<34 WKS) & EXPECTANT MGMT PLANNED
- Antenatal corticosteroids
- Subsequent pharmacotherapy
- HELLP (Gestational age of fetal viability to 33 6/7 wks)
  - Delay delivery for 24-48 hours if maternal and fetal condition remains stable

✓ Contraindications to delay in delivery for fetal benefit of corticosteroids:
  • Uncontrolled hypertension
  • Eclampsia
  • Pulmonary edema
  • Suspected abruption placenta
  • Disseminated intravascular coagulation,
  • Nonreassuring fetal status
  • Intrauterine fetal demise
<table>
<thead>
<tr>
<th>ON ADMISSION</th>
<th>ASSESSMENT &amp; PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Complete history</td>
<td>✓ Indicate diagnosis of preeclampsia</td>
</tr>
<tr>
<td>✓ Complete physical exam + preeclampsia symptoms:</td>
<td>o If no dx, indicate steps taken to exclude preeclampsia</td>
</tr>
<tr>
<td>o Unremitting headaches</td>
<td>✓ Antihypertensives taken (if any)</td>
</tr>
<tr>
<td>o Visual changes</td>
<td>o Specific medications</td>
</tr>
<tr>
<td>o Epigastric pain</td>
<td>o Dose, route, frequency</td>
</tr>
<tr>
<td>o Fetal activity</td>
<td>o Current fetal status</td>
</tr>
<tr>
<td>o Vaginal bleeding</td>
<td></td>
</tr>
<tr>
<td>✓ Baseline BPs throughout pregnancy</td>
<td>✓ Magnesium sulfate (if initiated for seizure prophylaxis)</td>
</tr>
<tr>
<td>✓ Meds/drugs throughout pregnancy (illicit &amp; OTC)</td>
<td>o Dose, route, duration of therapy</td>
</tr>
<tr>
<td>✓ Current vital signs, inc. O2 saturation</td>
<td>✓ Delivery assessment</td>
</tr>
<tr>
<td>✓ Current and past fetal assessment:</td>
<td>o If indicated, note: timing, method, route</td>
</tr>
<tr>
<td>o FHR monitoring results</td>
<td>o If not indicated, describe circumstances to warrant delivery</td>
</tr>
<tr>
<td>o Est. fetal weight</td>
<td></td>
</tr>
<tr>
<td>o BPP, as appropriate</td>
<td>✓ Antenatal corticosteroids if &lt; 34 weeks of gestation</td>
</tr>
</tbody>
</table>

**NOTE:** Continue ongoing documentation every 30 min until patient stabilized at < SBP 160 or DBP 110
POSTPARTUM SURVEILLANCE

Necessary to prevent additional morbidity as preeclampsia/eclampsia can develop postpartum

INPATIENT

• Measure BP every 4 hours after delivery until stable
• Do not use NSAIDs for women with elevated BP
• Do not discharge patient until BP is well controlled for at least 24 hours

OUTPATIENT

• For pts with preeclampsia, visiting nurse evaluation recommended:
  ✓ Within 3-5 days
  ✓ Again in 7-10 days after delivery (earlier if persistent symptoms)

ANTIHYPERTENSIVE THERAPY

• Recommended for persistent postpartum HTN: SBP ≥ 150 or DBP ≥ 100 on at least two occasions at least 4 hours apart
• Persistent SBP ≥ 160 or DBP ≥ 110 should be treated within 1 hour
Call for assistance

Designate team leader, checklist reader, primary RN

Ensure side rails up

Call OB consult; Document call

Place IV; Draw PEC labs

Administer seizure prophylaxis

Administer antihypertensive therapy

Consider indwelling urinary catheter. Maintain strict I&O

Brain imaging if unremitting headache or neurological symptoms
DISCHARGE PLANNING

All patients receive information on preeclampsia:

✓ Signs and symptoms
✓ Importance of reporting information to health care provider as soon as possible
✓ Culturally-competent, patient-friendly language

All new nursing and physician staff receive information on hypertension in pregnancy and postpartum

FOR PATIENTS WITH PREECLAMPSIA

✓ BP monitoring recommended 72 hours after delivery
✓ Outpatient surveillance (visiting nurse evaluation) recommended:
  o Within 3-5 days
  o Again in 7-10 days after delivery (earlier if persistent symptoms)
POST-DISCHARGE EVALUATION
ELEVATED BP AT HOME, OFFICE, TRIAGE

Postpartum triggers:
• SBP ≥ 160 or DBP ≥ 110 or
• SBP ≥ 140-159 or DBP ≥ 90-109 with unremitting headaches, visual disturbances, or epigastric/RUQ pain

• Emergency Department treatment (OB/MICU consult as needed)
• AntiHTN therapy suggested if persistent SBP > 150 or DBP > 100 on at least two occasions at least 4 hours apart
• Persistent SBP > 160 or DBP > 110 should be treated within 1 hour

Good response to antiHTN treatment and asymptomatic

Admit for further observation and management (L&D, ICU, unit with telemetry)

Signs and symptoms of eclampsia, abnormal neurological evaluation, congestive heart failure, renal failure, coagulopathy, poor response to antihypertensive treatment

Recommend emergency consultation for further evaluation (MFM, internal medicine, OB anesthesiology, critical care)
CONCLUSION

- **Systolic BP ≥ 160 or diastolic BP ≥ 110** warrant:
  - Prompt evaluation at bedside
  - Treatment to decrease maternal morbidity and mortality

- Risk reduction and successful clinical outcomes require avoidance/management of severe systolic and diastolic hypertension in women with:
  - Preeclampsia
  - Eclampsia
  - Chronic hypertension + superimposed preeclampsia

- Increasing evidence indicates that standardization of care improves patient outcomes
### Severe Hypertension Slide Deck

<table>
<thead>
<tr>
<th>Slide</th>
<th>Change</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>REVISED</td>
<td>Definition of hypertensive emergency</td>
</tr>
</tbody>
</table>
| 6     | REVISED | When to treat following:  
- One severe hypertensive value  
- Hypertensive emergency |
| 7     | ADDED   |  
- Oral nifedipine as first line therapy option  
- Mag sulfate and anticonvulsant recommendations |
| 8     | ADDED   |  
- BP check 10 min after second 80 mg dose of labetalol  
- Language on adverse effects and use of clinical judgement |
| 9     | REVISED | BP check timeframes  
ADDED - Language on adverse effects and use of clinical judgement |
| 10    | ADDED   | - Oral nifedipine algorithm |
| 11    | ADDED   |  
- Use of oral nifedipine algorithm if no IV access  
- Second line therapies: Labetalol or nicardipine infusion pump, sodium nitroprusside |
| 13–14, 19 | REVISED | Streamlined format |
| 16    | ADDED   | - Target range for maternal BP |
| 18    | ADDED   |  
- Included under postpartum surveillance:  
- Antihypertensive meds  
- Recommendations for outpatients w/ preeclampsia |

### Algorithms
(Labetalol, Hydralazine, Oral Nifedipine)

Available online in printable, PDF format; July 2017 changes reflective of latest ACOG guidance

### Checklists
(Hypertensive Emergency, Eclampsia, Postpartum Preeclampsia – ED)

Available online in printable, PDF format; July 2017 changes reflective of latest ACOG guidance
References


Maurice L. Druzin, MD; Laurence E. Shields, MD; Nancy L. Peterson, RNC, PNNP, MSN; Valerie Cape, BSBA. “Preeclampsia Toolkit: Improving Health Care Response to Preeclampsia.” California Maternal Quality Care Collaborative Toolkit to Transform Maternity Care. Developed under contract #11-10006 with the California Department of Public Health; Maternal, Child and Adolescent Health Division; Published by the California Maternal Quality Care Collaborative, November 2013.


Safe Motherhood Initiative

District II