# MATERNAL HYPERTENSION INITIATIVE
# FREQUENTLY ASKED QUESTIONS

## IDENTIFICATION AND TREATMENT PROTOCOL

1. **After the first elevated blood pressure (BP), when should a confirmatory BP be taken?**
   Minimal requirements for standard severe hypertension management process starting with initial presentation at your hospital:
   - Notification of physician or primary care provider if systolic BP ≥ 160 and/or diastolic BP ≥ 110 for two measurements 15 minutes apart.
   - After the second elevated reading, treatment should be initiated ASAP (ideally within 60 minutes)—the emergency began with the first measurement of severe hypertension and that should be used as the starting point for the 60-minute timeline).

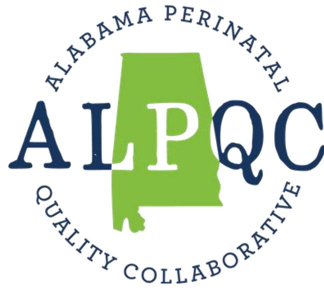
2. **What position should the patient be in when obtaining a blood pressure?**
   ACOG indicates the optimal measurement of BP is obtained when the patient is seated with their legs uncrossed and their feet on the floor. The blood pressure cuff should be positioned so the middle of the cuff is on the upper arm and level with the right atrium/midpoint of the sternum.

3. **Are we only checking manual BPs on patients that are noted to have a BP greater than 140/90?**
   Auscultatory (manual) blood pressure (BP) measurement is considered the most accurate. AHA recommends that oscillometric (automatic devices) are validated with mercury sphygmomanometer. If automated devices are used, we recommend a device that has been validated for use in pregnancy. Your hospital can decide how to implement these in your protocol for the identification of severe range blood pressures.

4. **What is the postpartum period for identification and treatment of severe range BPs?**
   The postpartum period is defined as 6 weeks postpartum.

5. **Do you to monitor patients on cardiac monitors when they are giving labetalol (or hydralazine) IV push?**
   No, it is not required for patients receiving IV Labetalol (or hydralazine) to be on cardiac monitors. There is no data to support cardiac monitoring for the OB population unless they have cardiac disease.

6. **Is it the expectation that if any person needs treatment with IV antihypertensive meds, these patients all need magnesium sulfate?**
   ACOG guidelines state that magnesium sulfate should be used for patients with preeclampsia with persistent severe features.




7. **I feel the treatment "line in the sand" is 20 weeks estimated gestational age but I can't really find a firm recommendation. Could you clarify that for me?**
   Any pregnant or postpartum patient with severe range blood pressures should be treated regardless of gestational age.

8. **What is the guidance on use of Nifedipine in acute lowering of severe range blood pressure?**
   ACOG Committee Opinion 623 page 3 addresses use oral Nifedipine immediate release.

9. For further guidance on identification and treatment of severe hypertension, see AIM DATA FAQS webpage; scroll down to the bottom to the question: "How do I calculate timely treatment (within one hour) of severe hypertension for the Severe Hypertension in Pregnancy bundle?"

INCLUSION CRITERIA

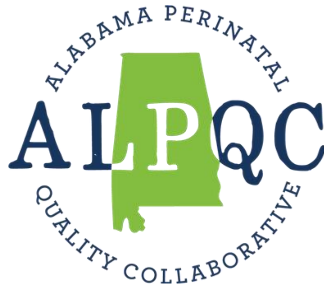
1. **Which patients do we include for this initiative?**
   Include patients that meet the following criteria:
   - Pregnant (during delivery admission) / postpartum (up to 6 weeks after delivery) with sustained elevated systolic ≥160 and/or diastolic BP ≥110 (105) (2 reading 15 mins apart)
   - Any inpatient location (L&D, triage, ED, antepartum, postpartum)
   - Include patients with chronic / gestational HTN

2. **Do we include patients with chronic or gestational hypertension if they did not have pre-eclampsia or eclampsia?**
   Yes, if they meet criteria of persistent severe range blood pressure.

3. **What about the patient that is on hypertensive medications at home before they come in?**
   These patients are included if they have a persistent severe range blood pressure.

4. **What about patients that do not have a problem with initial BP but it happens later in their stay?**
   These patients are included if they have a persistent severe range blood pressure.

5. **On the issue of who to include, if a patient has a solitary BP that is elevated, they should not be included?**
   There are two scenarios at play here:
   a. A patient has one elevated blood pressure, and the BP is either not re-checked or the patient is repositioned to their side – this patient is **NOT** included but we encourage you to review these events as an opportunity for process improvement.




b. A patient has one elevated blood pressure. The blood pressure is re-checked following the accurate blood pressure protocol/guidelines and is no longer in the severe range – do **NOT** include this patient in the data collection.

6. **If you complete the data form on a hypertensive event, do you complete another data form if the patient has another event during their stay?**
   No, only one data form is filled out per patient PER admission - so it's only the first persistent severe range BP event that is included in data collection. If a patient has a repeat admission during the postpartum period (up to 6 weeks post-delivery) and meets inclusion criteria stated above during that repeat admission, an additional data form would need to be completed.

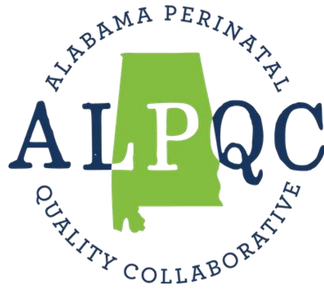
7. **When entering data, we noticed when a patient is transferred to a tertiary care center before delivery, we are unable to enter the data accurately because of unknown data of discharge management.**
   *For patients who are transferred out*, enter data into the data portal on any patients that meet criteria before they were transferred.

   *For patients who are transferred in*, enter data into the data portal ONLY on patients that meet the above requirements at their facility. If a patient has already been started on medications for elevated BP prior to arriving at your facility, do not complete a data form. Some networks have implemented effective solutions in which the hospital that receives the transferred patient fills out the discharge outcomes on patients with new onset severe hypertension identified before transfer and sends that form to the transferring hospital.

8. **If a patient is transferred into our facility for elevated BPs and is treated at another facility then we don't count them, but once at our facility the patient has two severe range blood pressures that we treat, do we count them? Or if it is our transfer team and the patient has two severe range pressures in the ambulance that we treat, do we count them?**
   We ask for the transferring hospital to enter data into the data portal on any patients that meet criteria before they were transferred and then follow up with the receiving hospital to which the patient was transferred in order to obtain patient outcomes (patient education at discharge, follow-up appointment).

9. **If the transferring hospital is not participating in this initiative would that patient just be disregarded completely for data collection?**
   No, please include the patient and include all the information you have available.

10. **If you discover you did miss a severe HTN patient, can you submit into the data portal when you find that patient?**
    Yes, you can enter missed cases when they are discovered, just be sure to enter them under the date when the patient received care so they show up properly in your reports.




**11. What if we identify a patient that has severe range BPs in error (e.g., after initial measurement the nurse measures the patient's arm and finds a larger cuff was needed and then retakes and finds that blood pressure was within normal limits). Should we include this patient?**
No, you identified and corrected an error and would not enter this patient into the data portal.

## DATA USE AGREEMENTS

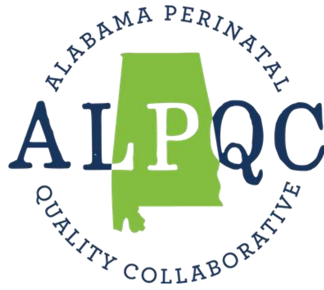
1. **Do we have to have the DUA completed before we can enter data into the data portal?**
   Although you can enter data without first completing the DUA, we ask that you please complete and sign the DUA as part of enrolling in the initiative. This allows ALPQC to share deidentified data with the national AIM initiative for national benchmarking, and share initiative successes with the general public. We have reached out to your hospital team lead to complete this process. If you have questions about the DUA, please reach out to us at info@alpqc.org.

## DATA FORM AND COLLECTION

1. **Is ED/Triage considered inpatient?**
   Yes, ED/Triage is included for this initiative.

2. **Which medications count as HTN treatment?**
   Measure the time to treatment for any patient that meets the inclusion criteria and is treated with an anti-hypertensive agent, most commonly used medications per ACOG guidelines are Labetalol, Hydralazine, or Nifedipine. Do **NOT** measure time to treatment for Magnesium Sulfate – it is not an anti-hypertensive agent.

3. **How do we handle repeat patients?**
   - 1st hospitalization
     - Patient meets criteria: fill out data form for the first persistent severe range BP event
     - Patient does not meet criteria: do not fill out data form
   - 2nd hospitalization (and all subsequent hospitalization)
     - Patient meets criteria: fill out a data form – every new hospitalization should be counted!
     - Patient does not meet criteria: do not fill out data form




PATIENT DISCHARGE EDUCATION AND FOLLOW UP

1. **For the discharge education, is documentation of any education acceptable or does it need to be in any specific format?**
   Your hospital can decide what to use for patient education at discharge. See examples on our Hypertension webpage at alpqc.org/initiatives/htn

2. **For measure (P2: follow-up appointment scheduled for a postpartum BP and symptoms check: Is instructing the patient to schedule an appointment at discharge a "yes" response on the data form?**
   For this measure of appropriate follow up, the appointment should be scheduled for the patient before discharge, ideally within 3 days but if not possible aim for within 7 days of discharge. Instructing the patient to schedule an appointment would therefore be a "no" response on the data form as the appointment was not actually scheduled at discharge.

3. **When does the clock start to measure if a follow-up appointment was made for within 7-14 days of discharge for all women with severe hypertension?**
   Begin counting when the woman is discharged.

4. **If a woman is discharged on the weekend, a follow-up appointment can't be scheduled as most clinics are closed. What should we do in this case?**
   Some hospitals are scheduling follow-up appointments before clinics close on Friday if they know a patient is going to be discharged over the weekend.

5. **What constitutes a follow-up appointment?**
   ACOG indicates a follow-up appointment should be consistent with care provided in the hospital. The follow-up visit should be with provider or nurse in a clinic, hospital, or home care setting.

OTHER

1. **Where can I find questions related to educational topics for use in staff education?**
   You can find great resources by clinical topics at the ALPQC Maternal Hypertension Initiative. There you'll find slides from the monthly team calls. There is also a wealth of resources under the "Maternal HTN Toolkit" menus as well as under the "Key Documents" menu.