AIM

ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

Cardiac Conditions in Obstetric Care

AIM Clinical Refresher Series

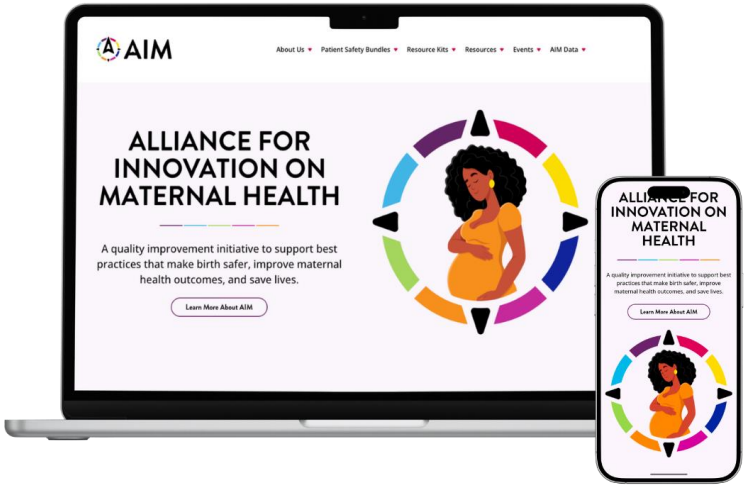
May 13, 2026

AIM

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

TECHNICAL ASSISTANCE CENTER

The Alliance for Innovation on Maternal Health (AIM) is a quality improvement initiative to support best practices that **make birth safer**, **improve maternal health outcomes**, and **save lives**.



The AIM TA Center is supported by a cooperative agreement (Award Number 7 UC4MC55412-01-00) with the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). The contents are those of the authors. They may not reflect the policies of HRSA, HHS, or the U.S. Government.

AIM Cardiac Conditions in OB Care Patient Safety Bundle

Patient Safety Bundle Documents

Patient Safety Bundle

Element Implementation Details

Implementation Resources

Data Collection Plan

Change Package

Learning Modules

Learning Objectives

By the end of this session participants will be able to:

1. **Describe** at least one evidence-based strategy for early recognition and timely management of cardiac complications in maternal health settings.
2. **Integrate** concise, actionable clinical guidance from expert updates into everyday practice to strengthen patient safety and improve maternal health outcomes.
3. **Describe** at least one strategy to support implementation of the AIM Cardiac Conditions in Obstetric Care Patient Safety Bundle across maternal health care settings.

Diana S Wolfe, MD, MPH, FACOG, FACC

Obstetric Director of Maternal Fetal Medicine Cardiology Joint Program

Professor, Obstetrics & Gynecology and Women's Health (Maternal Fetal Medicine)

Professor, Medicine (Cardiology)

Albert Einstein College of Medicine/Montefiore Medical Center

AIM Patient Safety Bundles

Original Research

Pregnancy-Related Mortality in the United States, 2006–2010

Andreea A. Creanga, MD, PhD, Cynthia J. Berg, MD, MPH, Carla Syverson, CNM, MPH, Kristi Seed, BS, F. Carol Bruce, RN, MPH, and William M. Callaghan, MD, MPH

Obstetrics & Gynecology 2015;125:5-12

Pregnancy Related Mortality

Cardiomyopathy	292 (14.6)	2 (1.3)	0 (0.0)	0 (0.0)	33 (5.0)	70 (20.6)	397 (11.8)
Cerebrovascular accident	122 (6.1)	3 (1.9)	0 (0.0)	0 (0.0)	53 (8.0)	29 (8.5)	207 (6.2)
Cardiovascular conditions	288 (14.4)	18 (11.4)	0 (0.0)	7 (7.8)	134 (20.2)	43 (12.7)	490 (14.6)
Noncardiovascular conditions	208 (10.4)	29 (18.4)	0 (0.0)	5 (5.6)	149 (22.4)	37 (10.9)	428 (12.8)
Unknown	97 (4.8)	7 (4.4)	1 (1.0)	2 (2.2)	36 (5.4)	15 (4.4)	158 (4.7)
Total	2,003 (100.0)	158 (100.0)	103 (100.0)	90 (100.0)	664 (100.0)	340 (100.0)	3,358 (100.0)

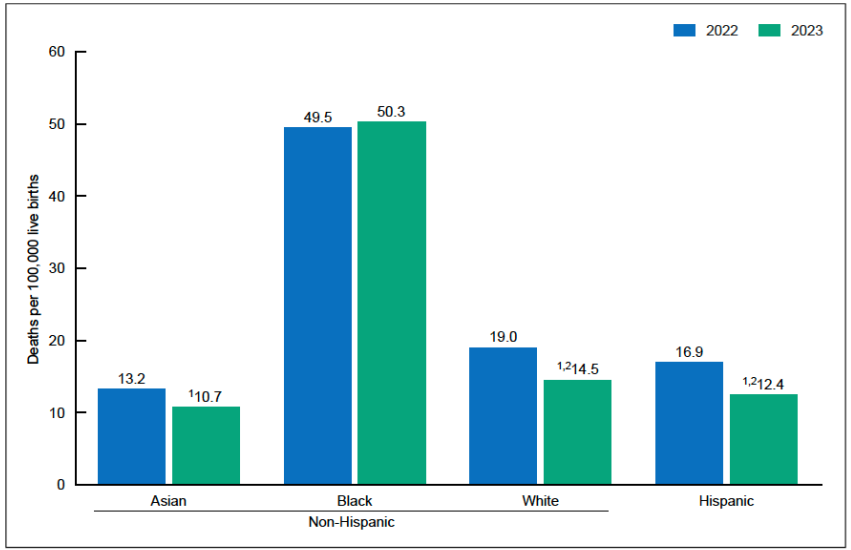
Data are n or n (%).

Obstetrics & Gynecology 2015;125:5-12

- Rate of pregnancy related mortality increased by 27.7% from 2018 to 2022.
- American Indian and Alaska Native women had the highest rate, followed by non-Hispanic Black women.
- Cardiovascular disease was the leading cause of the overall pregnancy-related deaths

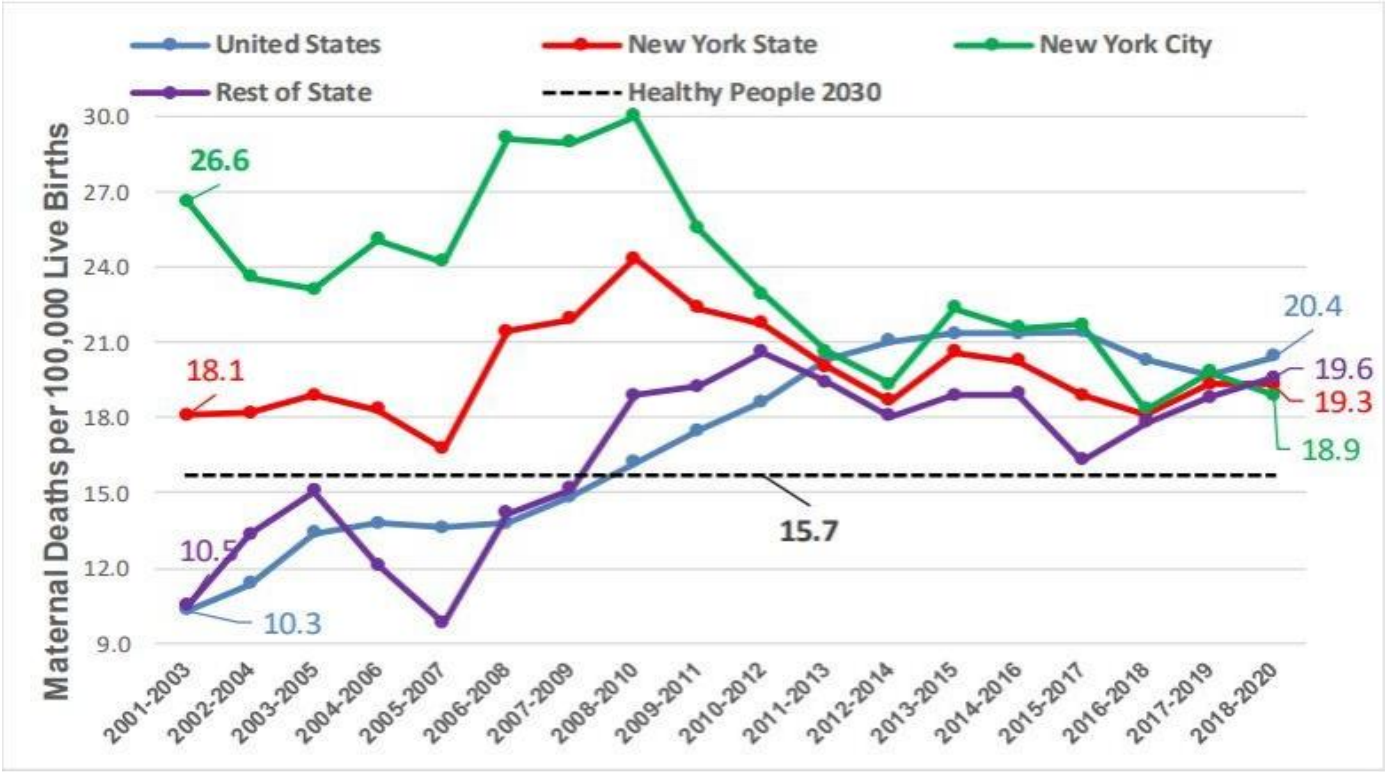
Maternal Mortality Rate, by Race and Hispanic Origin

Figure 2. Maternal mortality rate, by race and Hispanic origin: United States, 2022 and 2023

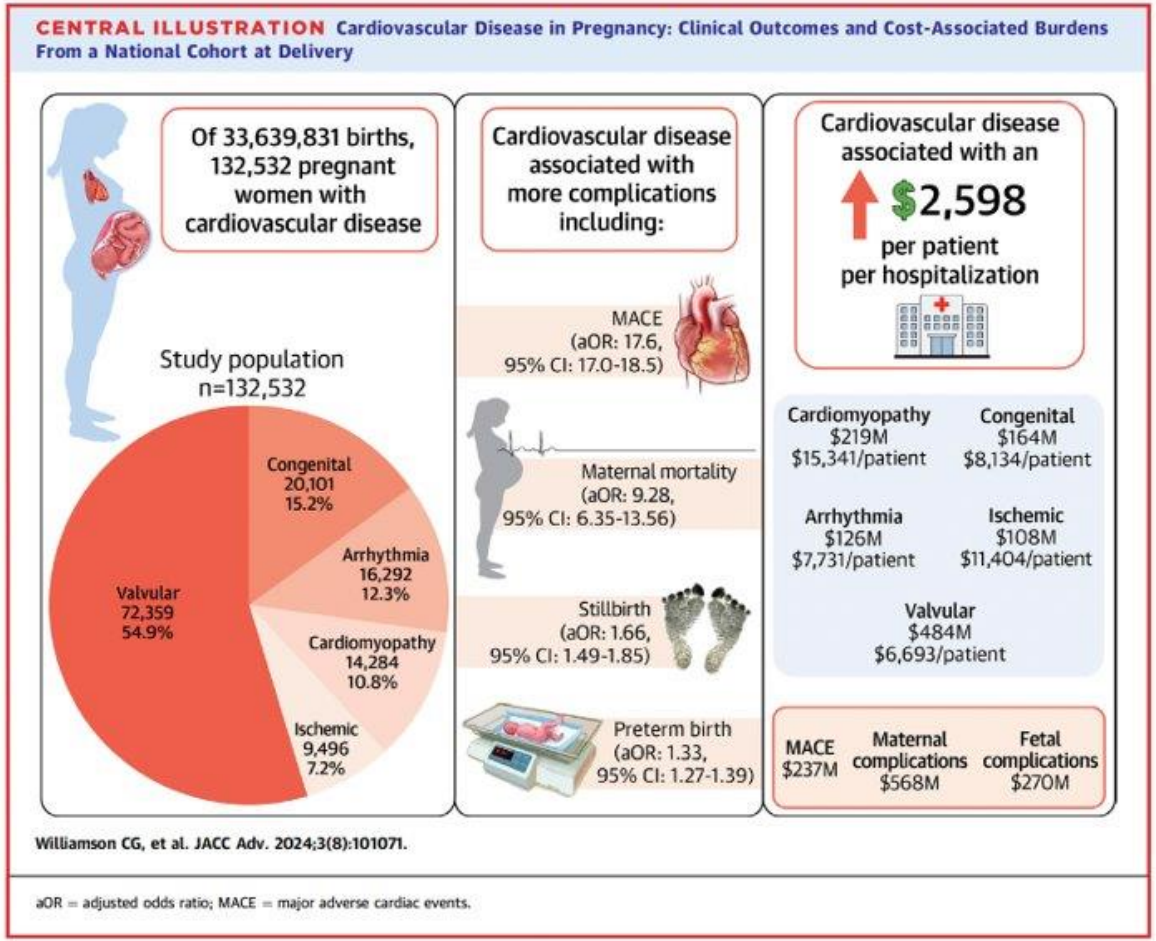


[1]Statistically significant difference from Black non-Hispanic women ($p < 0.05$).
[2]Statistically significant decrease in rate from previous year ($p < 0.05$).
NOTES: Race groups are single race. People of Hispanic origin may be of any race.
SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

NYS Three-Year Rolling Average Maternal Mortality Rate

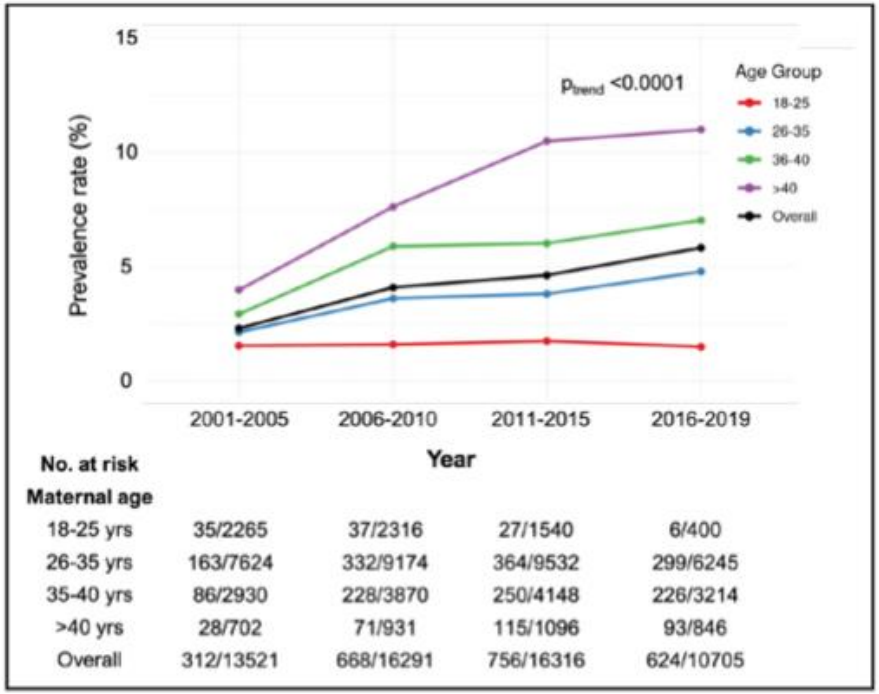


New York State Department of Health. New York State Maternal Mortality Review Report on Pregnancy-Associated Deaths in 2018. 2022. New York State Maternal Mortality Review Report, 2018-2020 (ny.gov)



JACC Advances. 2024;3(8):101071

Trends in Prevalent Maternal Cardiovascular Disease



No. at risk Maternal age				
18-25 yrs	35/2265	37/2316	27/1540	6/400
26-35 yrs	163/7624	332/9174	364/9532	299/6245
35-40 yrs	86/2930	228/3870	250/4148	226/3214
>40 yrs	28/702	71/931	115/1096	93/846
Overall	312/13521	668/16291	756/16316	624/10705

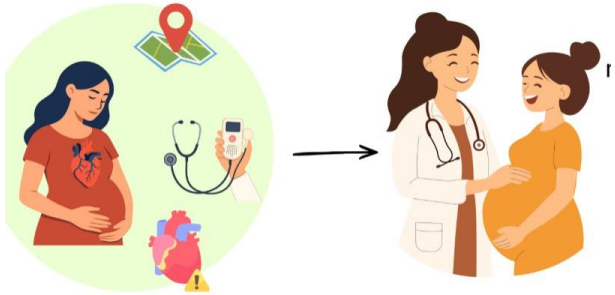
Figure 4. Trends in prevalent maternal cardiovascular disease from 2001 through 2019, stratified by maternal age.
Prevalence rates for preexisting maternal cardiovascular disease from 2001 through 2019 in prespecified time intervals, stratified by maternal age at time of delivery.

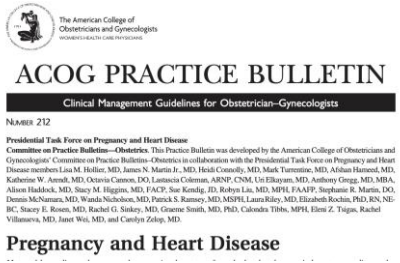
Circulation.2025;152:1044-1055

The Challenge to Detect CVD in Pregnancy

Table 2. How to Differentiate Common Signs and Symptoms of Normal Pregnancy Versus Those That Are Abnormal and Indicative of Underlying Cardiac Disease

	ROUTINE CARE	CAUTION*†	STOP†‡
	Reassurance	Nonemergent Evaluation	Prompt Evaluation Pregnancy Heart Team
History of CVD	None	None	Yes
Self-reported symptoms	None or mild	Yes	Yes
Shortness of breath	No interference with activities of daily living; with heavy exertion only	With moderate exertion, new-onset asthma, persistent cough, or moderate or severe OSA§	At rest; paroxysmal nocturnal dyspnea or orthopnea; bilateral chest infiltrates on CXR or refractory pneumonia
Chest pain	Reflux related that resolves with treatment	Atypical	At rest or with minimal exertion
Palpitations	Few seconds, self-limited	Brief, self-limited episodes; no lightheadedness or syncope	Associated with near syncope
Syncope	Dizziness only with prolonged standing or dehydration	Vasovagal	Exertional or unprovoked
Fatigue	Mild	Mild or moderate	Extreme
Vital signs	Normal		
HR (beats per minute)	<90	90–119	≥120
Systolic BP (mm Hg)	120–139	140–159	≥160 (or symptomatic low BP)
RR (per minute)	12–15	16–25	≥25
Oxygen saturation	>97%	95–97%	<95% (unless chronic)
Physical examination	Normal		
JVP	Not visible	Not visible	Visible >2 cm above clavicle
Heart	S3, barely audible soft systolic murmur	S3, systolic murmur	Loud systolic murmur, diastolic murmur, S4
Lungs	Clear	Clear	Wheezing, crackles, effusion
Edema	Mild	Moderate	Marked





The American College of Obstetricians and Gynecologists

ACOG PRACTICE BULLETIN

Clinical Management Guidelines for Obstetrician–Gynecologists

NUMBER 212

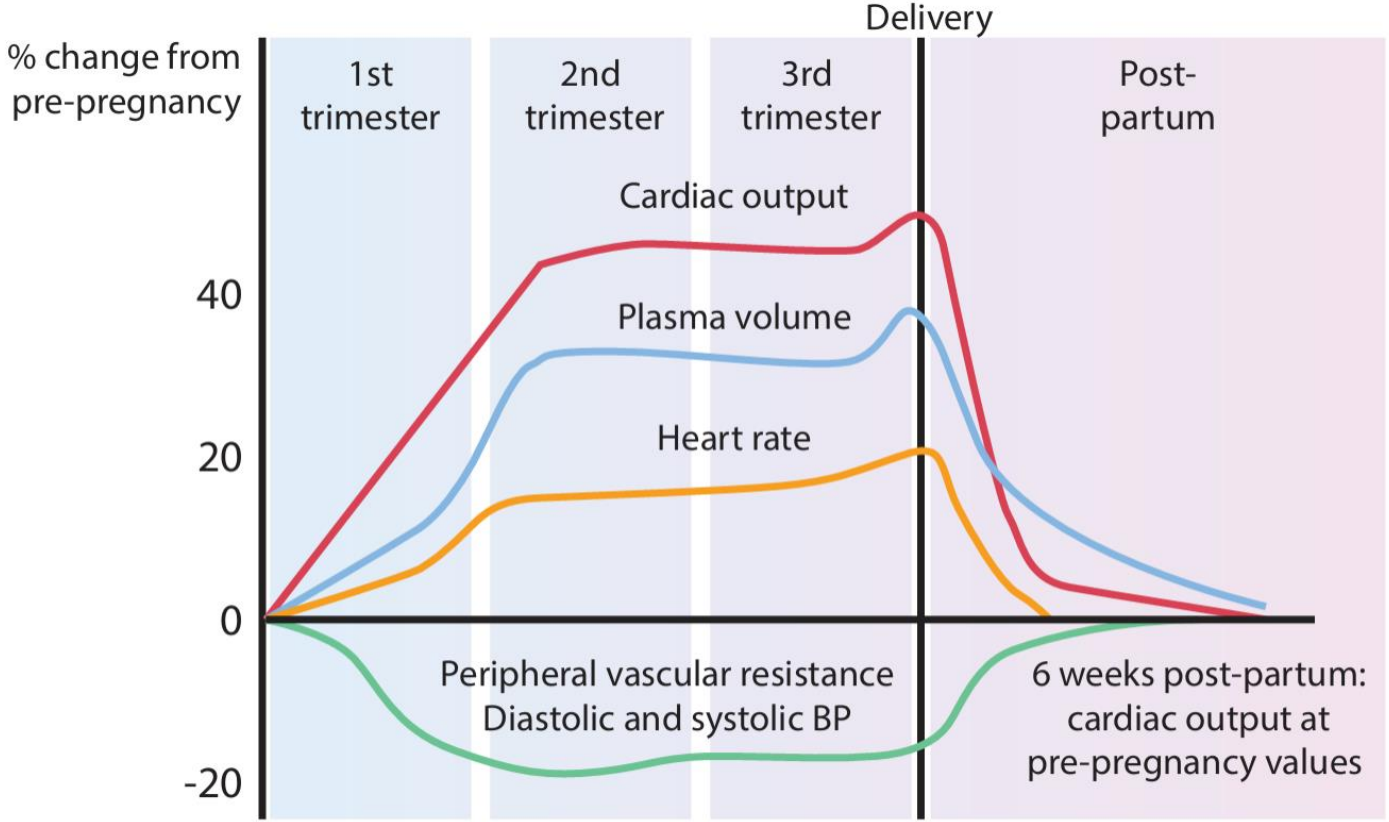
Presidential Task Force on Pregnancy and Heart Disease

Committee on Practice Bulletins—Obstetrics. This Practice Bulletin was developed by the American College of Obstetricians and Gynecologists' Committee on Practice Bulletins–Obstetrics in collaboration with the Presidential Task Force on Pregnancy and Heart Disease members Lisa M. Hollier, MD, James N. Martin Jr., MD, Heidi Connolly, MD, Mark Turrentine, MD, Afshan Hameed, MD, Katherine W. Arendt, MD, Octavia Cannon, DO, Lautascia Coleman, ARNP, CNM, Uri Elkayam, MD, Anthony Gregg, MD, MBA, Alison Haddock, MD, Stacy M. Higgins, MD, FACP, Sue Kendig, JD, Robyn Lu, MD, MPH, FAAFP, Stephanie R. Martin, DO, Dennis McNamara, MD, Wanda Nicholson, MD, Patrick S. Ramsey, MD, MSPH, Laura Riley, MD, Elizabeth Rochon, PhD, RN, NE-BC, Stacey E. Rosen, MD, Rachel G. Sinkey, MD, Graeme Smith, MD, PhD, Calondra Tibbs, MPH, Eleni Z. Tsigas, Rachel Villanueva, MD, Janet Wei, MD, and Carolyn Zelop, MD.

Pregnancy and Heart Disease

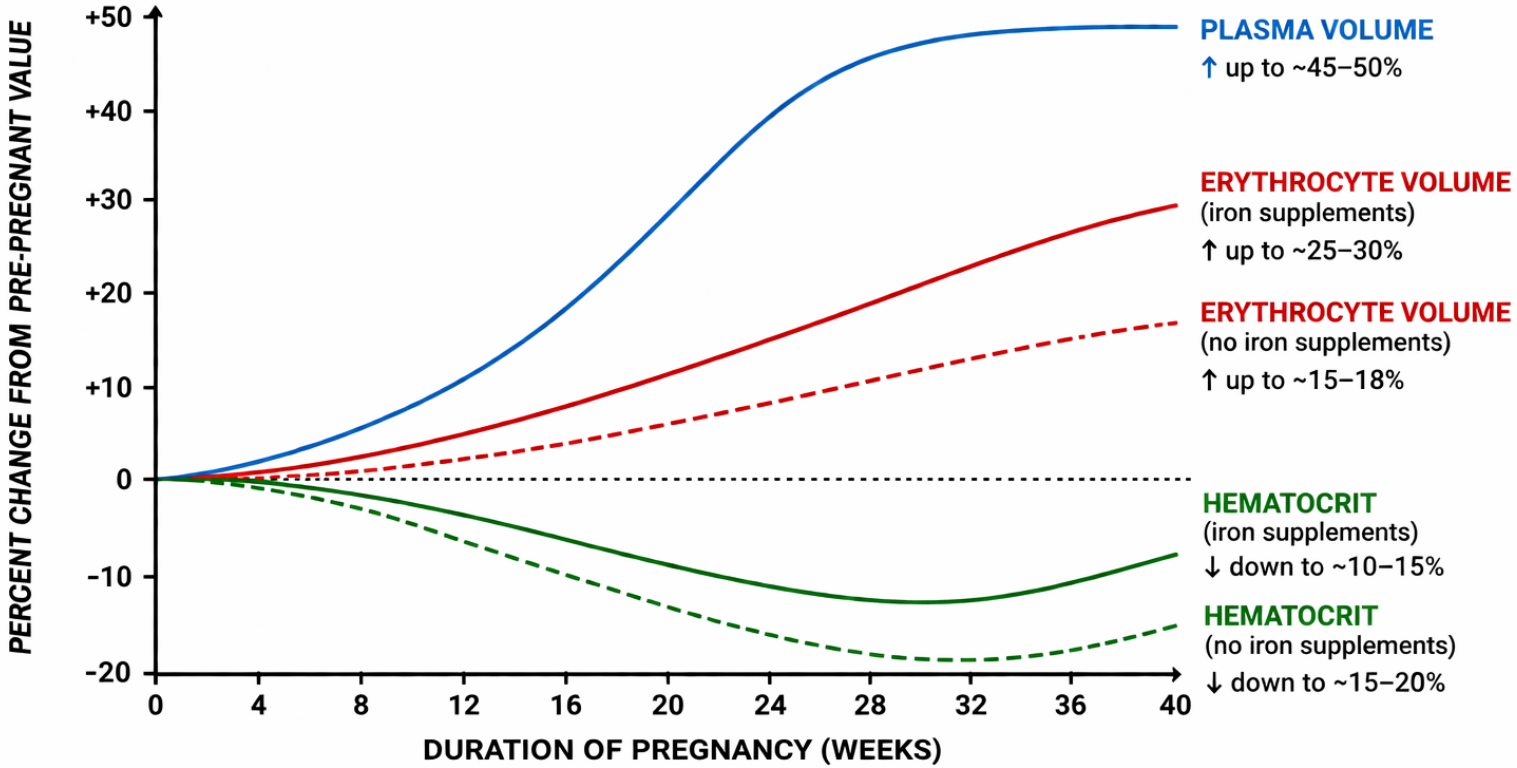
Practice Bulletin 2019, *Pregnancy and Heart Disease*, ACOG

Haemodynamic Changes



2025 ESC Guidelines for Management of cardiovascular disease in pregnancy, *European Heart Journal*, August, 2025

Changes in Maternal Blood Volume and Hematocrit During Pregnancy



Plasma volume increases more than red cell mass, resulting in hemodilution (↓ hematocrit). Iron supplementation blunts the fall in hematocrit.

Pitkin. *Nutritional support in Obstetrics and Gynecology* 1976.

Supine vs. Left Lateral Position in Pregnancy

In supine position:

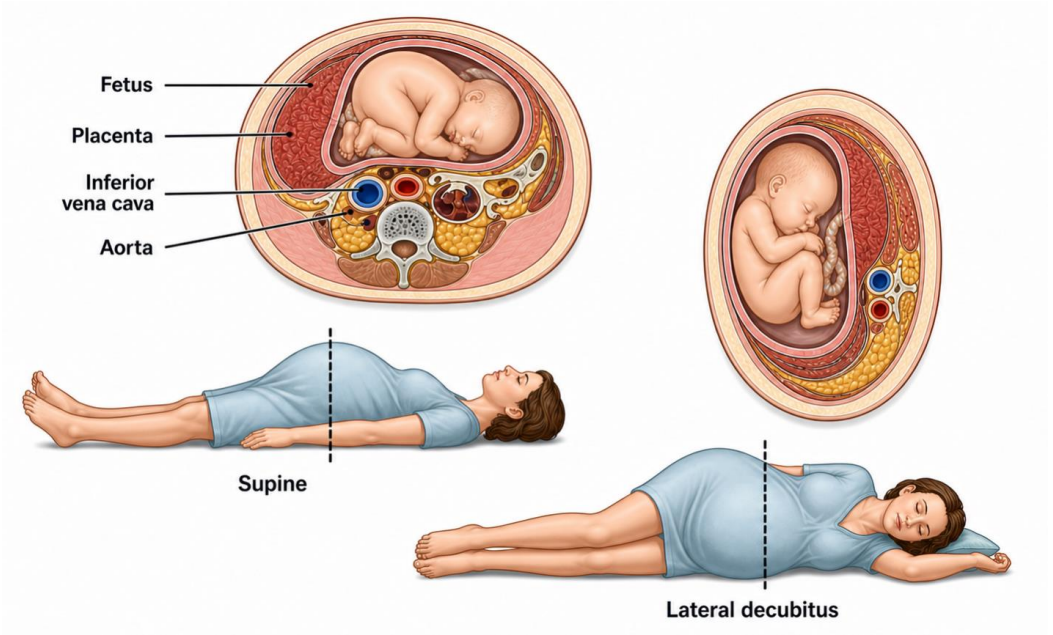
- Cardiac output may decrease by 25–30%
- The gravid uterus compresses the inferior vena cava

This results in:

- ↓ Venous return to the heart
- ↓ Stroke volume
- ↓ Cardiac output

Patients with underlying cardiac disease may not tolerate this reduction.

Left lateral positioning relieves caval compression and restores cardiac output.



Elkayam and Gleicher. *Diagnosis and management of fetal and maternal heart disease*. 1998.

Intrapartum Changes

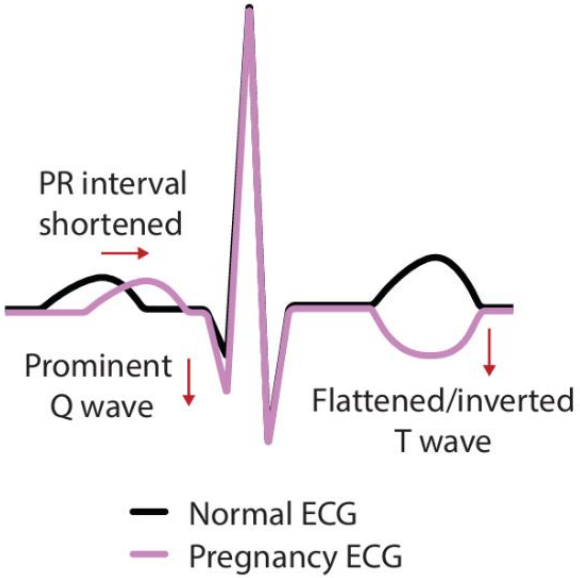
Two main concerns with the cardiovascular changes during Valsalva Maneuver

1. **Increase In Arterial Shear Stress**
2. **Fluctuations In Pre-Load**

Adams JQ, Alexander AM. *Alterations in cardiovascular physiology during labor*. 1958.
Osofsky HF, Williams JA. *Changes in blood volume during parturition and the early postpartum period*. 1964.
Hendricks CH, Quilligan EJ. *Cardiac output during labor*. 1956.

EKG and ECHO changes in Pregnancy

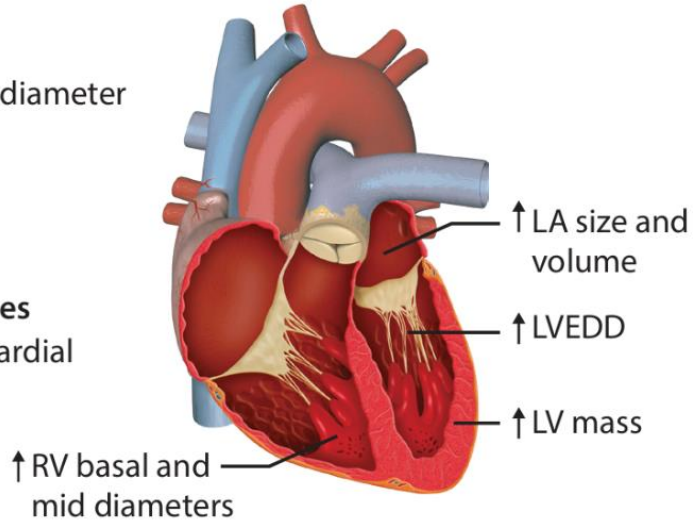
ECG changes



Echocardiographic changes

Unchanged
- Aortic root diameter
- LVEF
- RVEF
- SPAP

Small changes
- Small pericardial effusion



2025 ESC Guidelines for Management of cardiovascular disease in pregnancy, *European Heart Journal*, August, 2025

Consensus Statement

Alliance for Innovation on Maternal Health

Consensus Bundle on Cardiac Conditions in Obstetric Care

Afshan B. Hameed, MD, Alison Haddock, MD, Diana S. Wolfe, MD, MPH, Karen Florio, DO, MPH, Nora Drummond, DNP, CNM, Christie Allen, MSN, BSN, Isabel Taylor, MS, Susan Kendig, JD, MSN, Garssandra Presumey-Leblanc, MS, and Emily Greenwood, MPH

READINESS (EVERY CLINICAL SETTING)

1. Train All Obstetric Care Professionals to Perform a Screen for Cardiac Conditions

Evidence suggests that implementation of a screen for cardiac conditions for pregnant and postpartum people in all clinical care settings is a is a key step toward reducing the burden of maternal mortality due to cardiac conditions.[8] A cardiovascular risk-assessment algorithm developed by the CMQCC (California Maternal Care Quality Collaborative) (see https://www.cmqcc.org/resources-toolkits/toolkits/improving-health-care-response-cardiovascular-disease-pregnancy-and) stratifies pregnant and postpartum patients into low risk and high risk for cardiovascular disease.[9] The algorithm can be applied to all pregnant and postpartum people at their first clinical encounter regardless of gestational age.[10] In a retro-

RECOGNITION AND PREVENTION (EVERY HEALTH CARE PROFESSIONAL AND CLINICAL SETTING)

11. Use Standardized Cardiac Risk-Assessment Tools to Identify and Stratify Risk

Staff training and integration of cardiac risk-assessment tools and documentation into the electronic medical record may support regular utilization of the standardized assessment tools. More detail on standardized cardiac risk assessments can be found in Readiness Element 1.

CMQCC Cardiovascular Disease Toolkit

The CVD Toolkit was developed by CMQCC at Stanford University under contract with CDPH with funding from a federal Title V MCH Block grant.

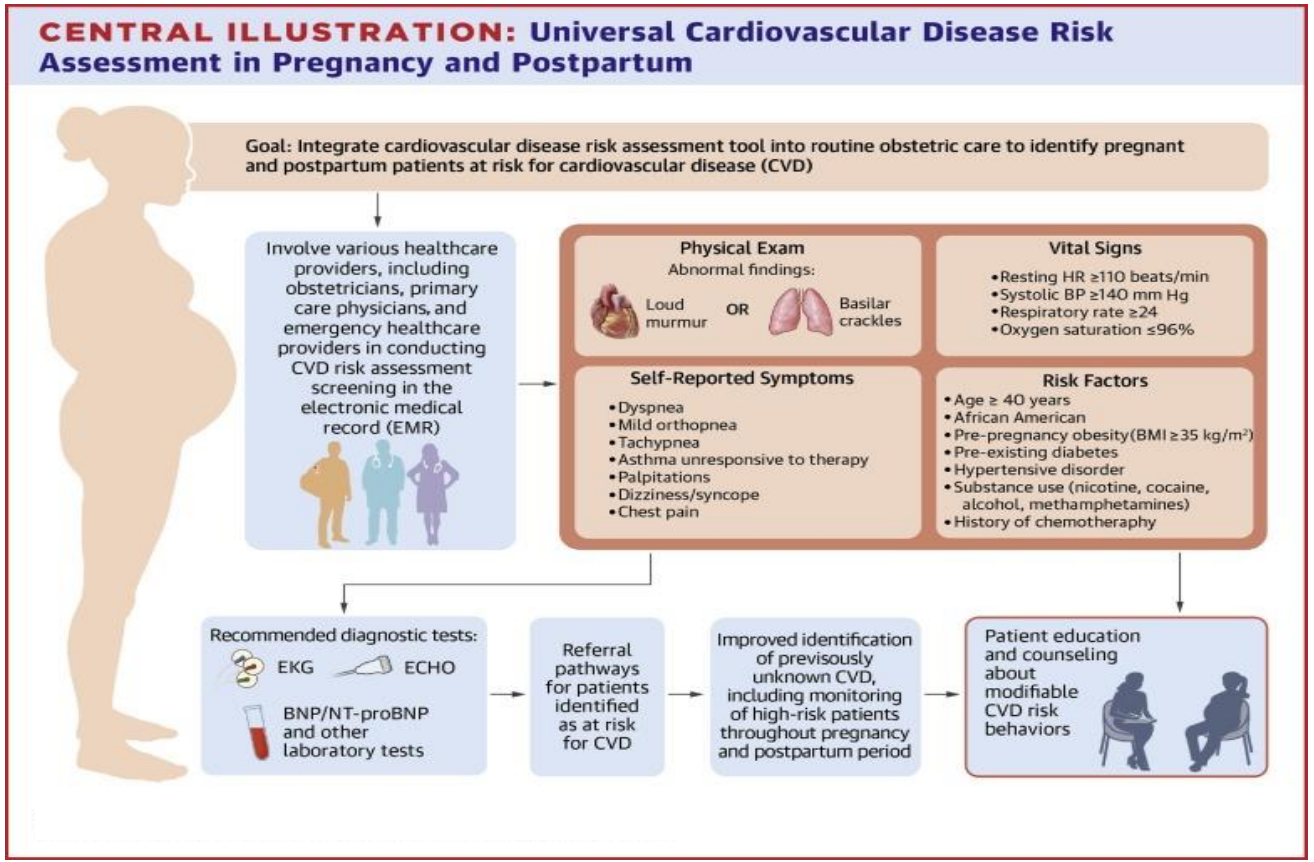
CMQCC
California Maternal
Quality Care Collaborative

Algorithm validated
64 CVD deaths.

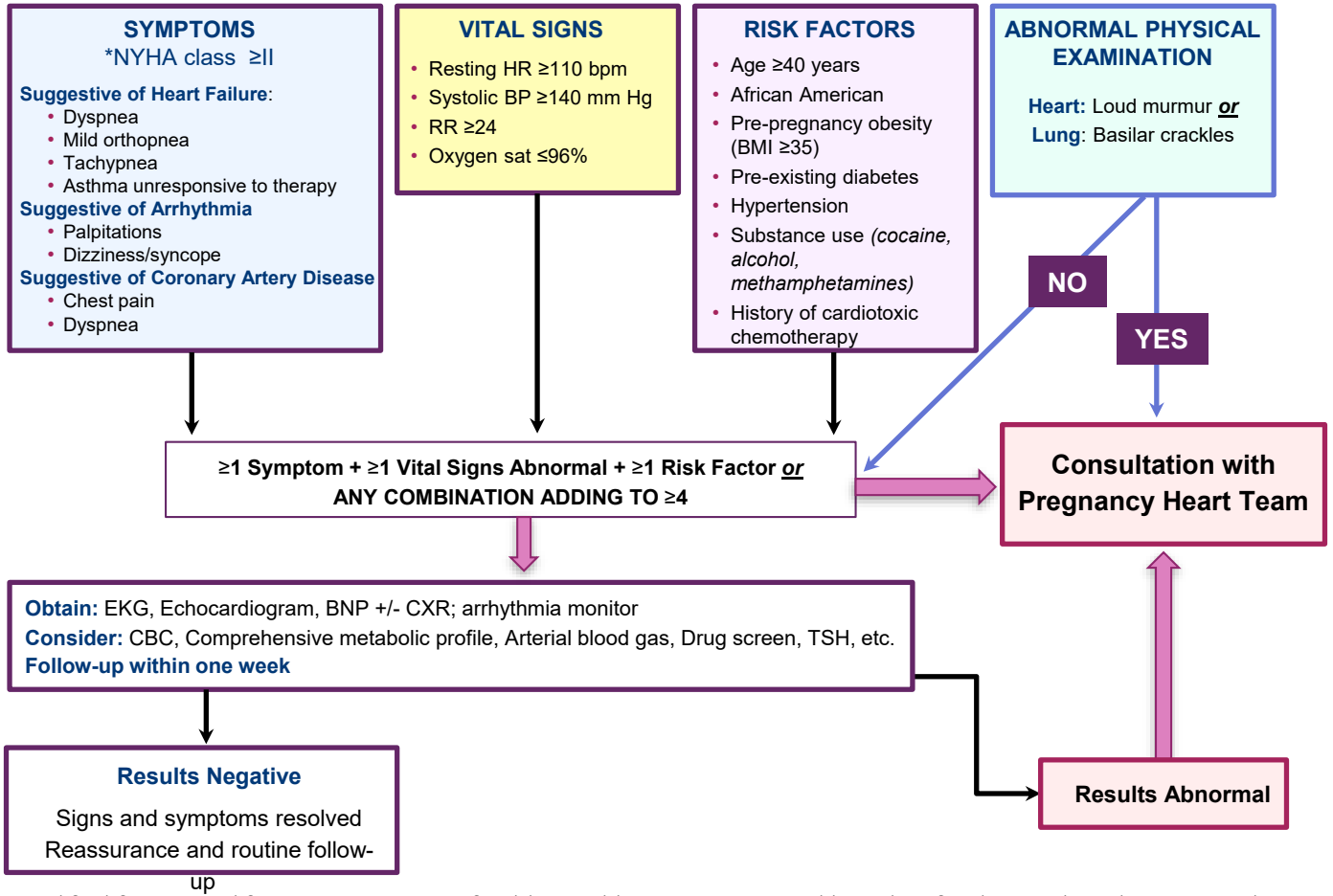
Detection rate 93% in symptomatic cases identified as screen-positive or high risk for CVD.

Reference: Hameed, AB, Morton, CH and A Moore. Improving Health Care Response to Cardiovascular Disease in Pregnancy and Postpartum Developed under contract #11-10006 with the California Department of Public Health, Maternal, Child and Adolescent Health Division. Published by the California Department of Public Health, 2017.

We propose a system wide implementation of this algorithm

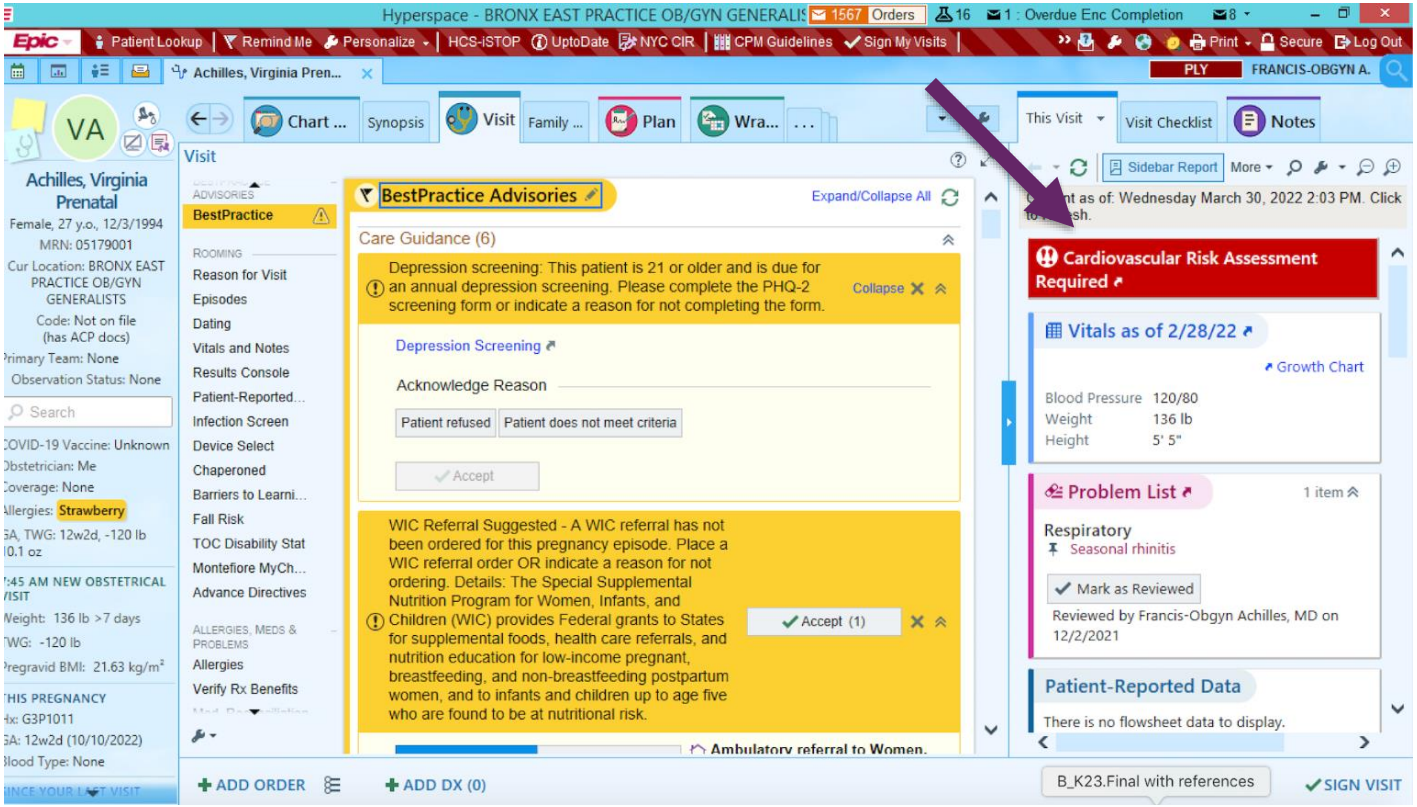


Hameed AB,...Wolfe DS. JACC Adv. 2024;3(8):101055

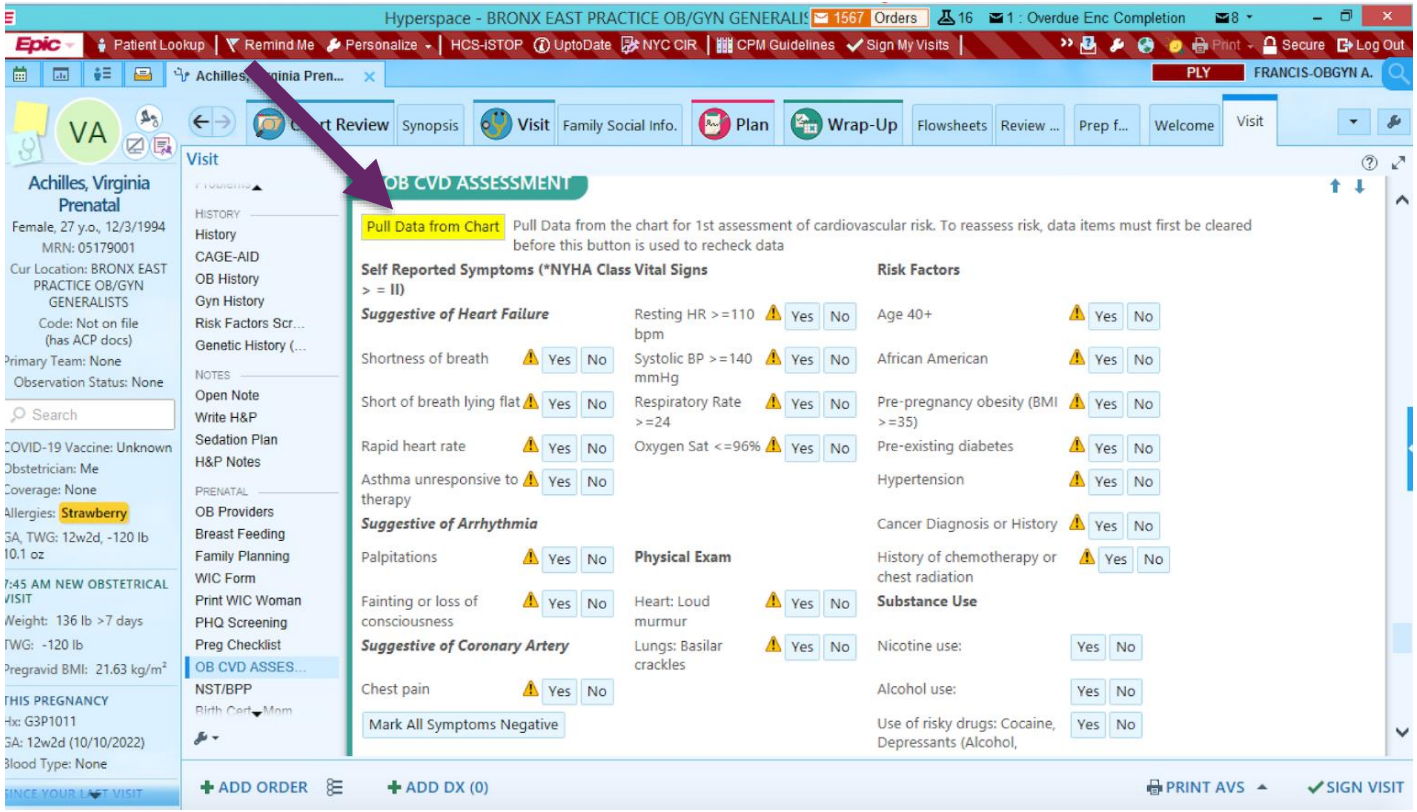


Modified from: ©California Department of Public Health, 2017; supported by Title V funds. Developed in partnership with California Maternal Quality Care Collaborative Cardiovascular Disease in Pregnancy and Postpartum Taskforce.

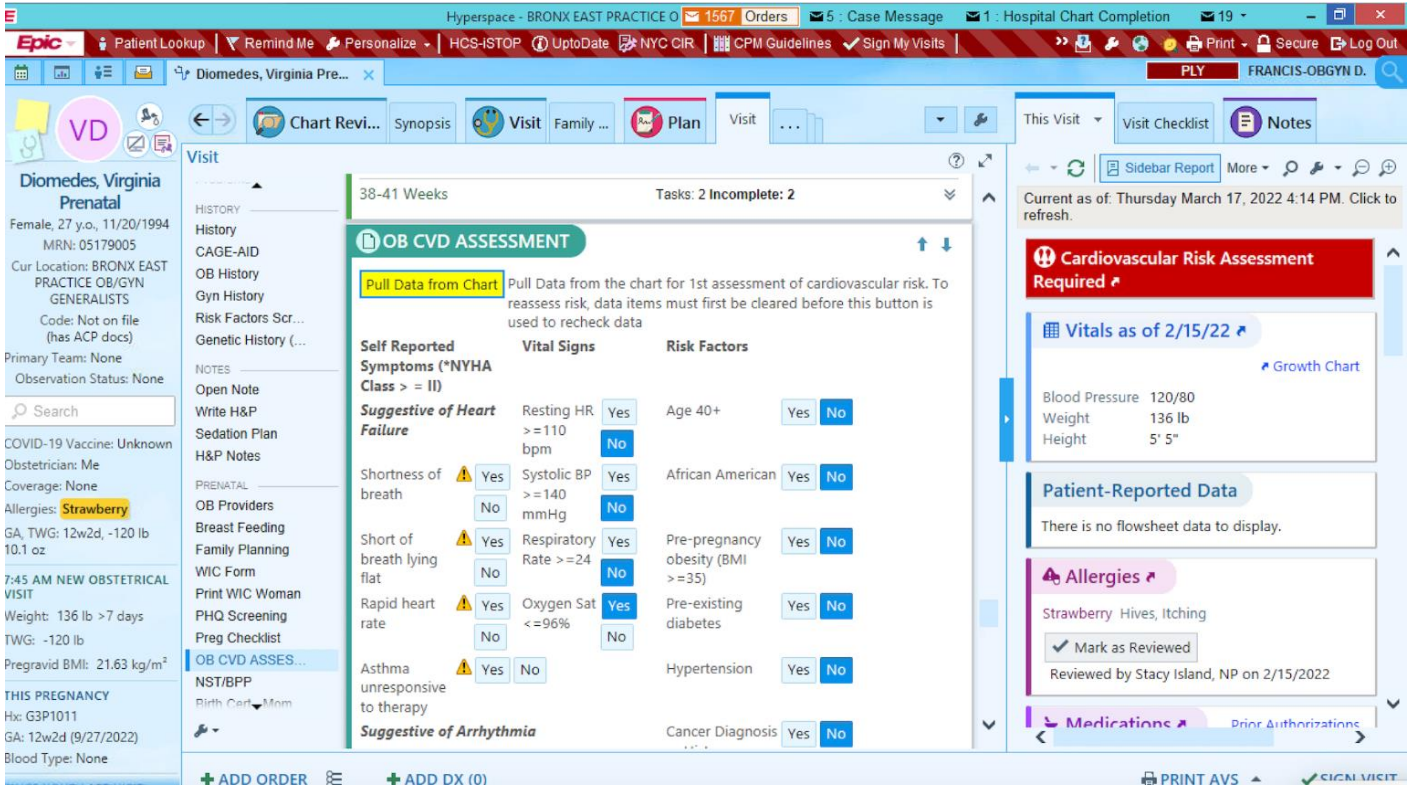
Initial Opening or Chart Visit



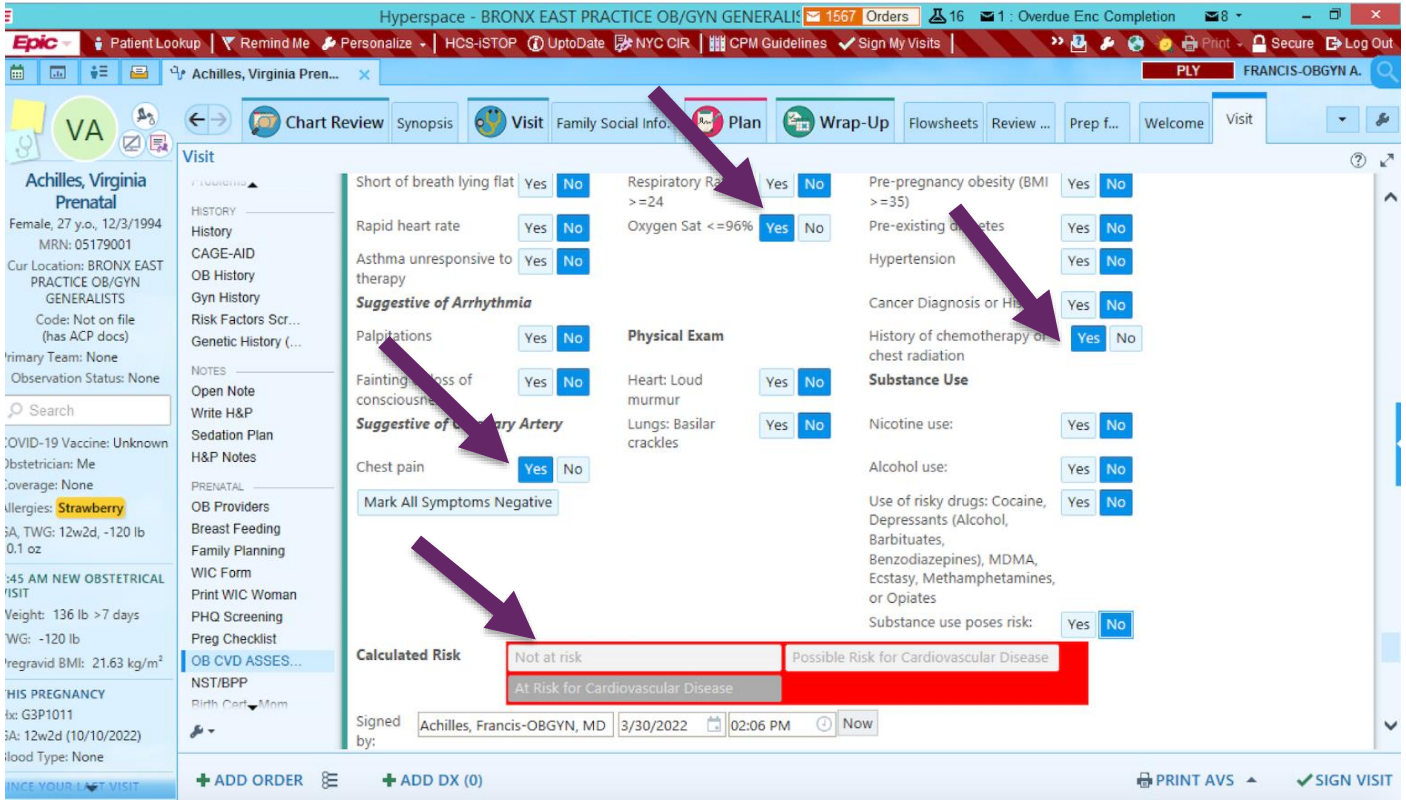
Step 1: Pull Data From Chart



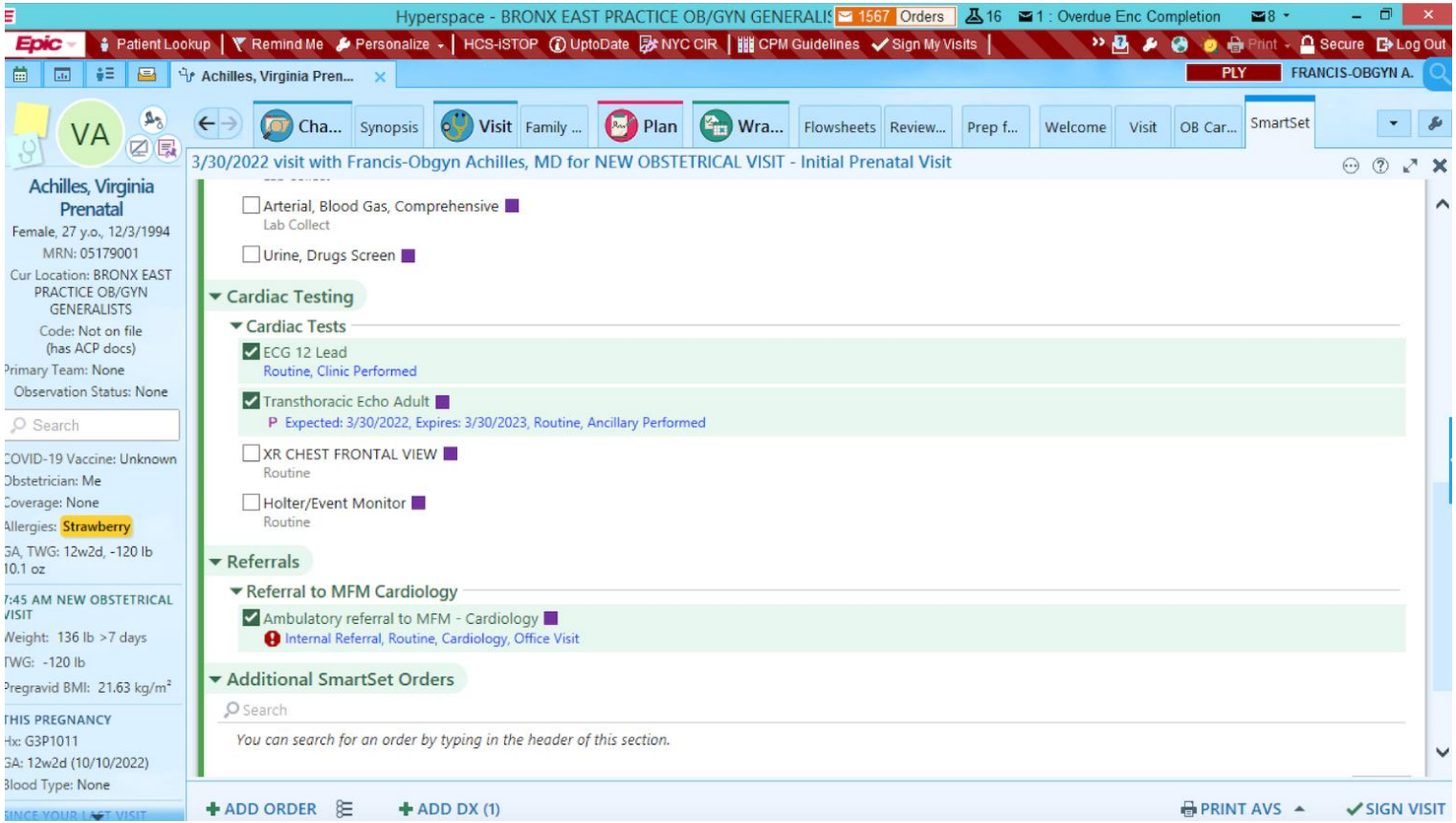
Step 2: Fill Blank Boxes - Symptoms, Risk Factors, Physical Exam

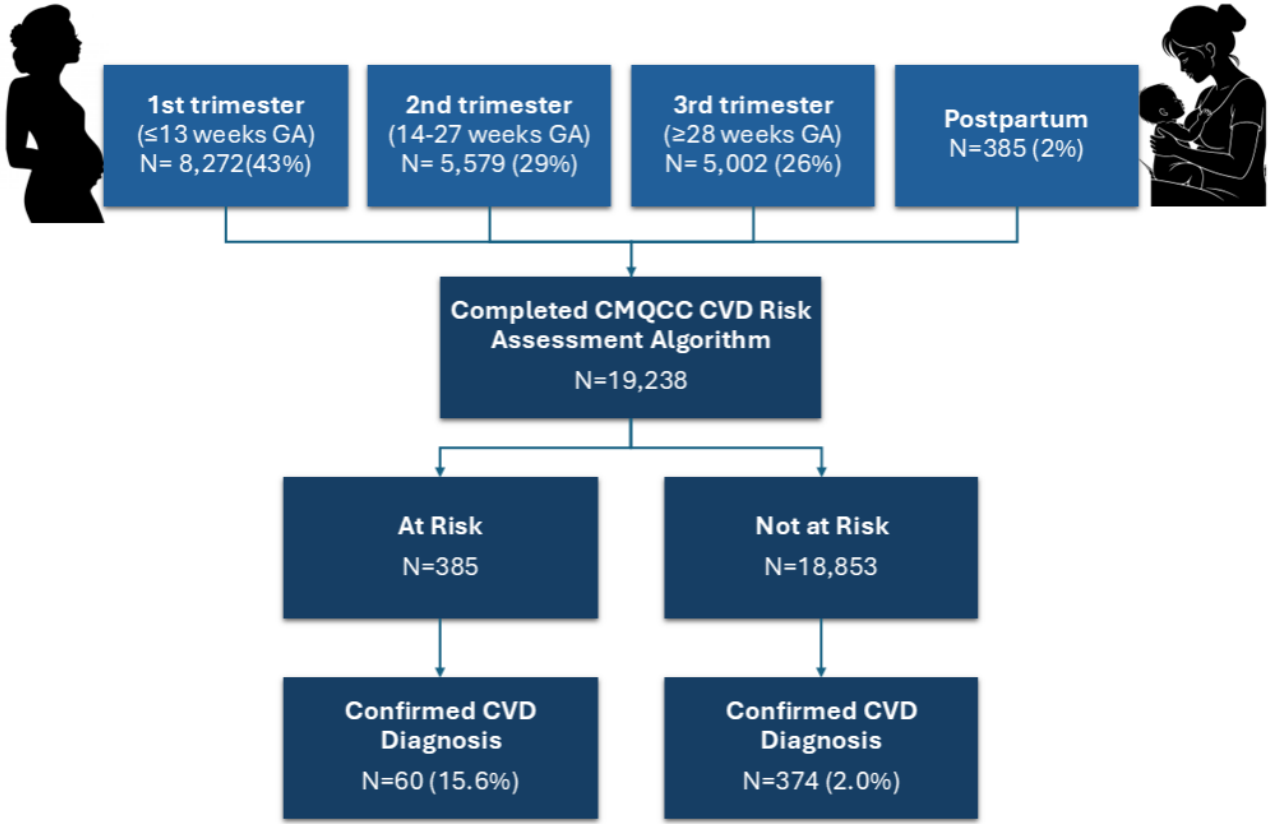


CVD Positive Yes Each Bucket



Order Set


Hyperspace - BRONX EAST PRACTICE OB/GYN GENERALIS
1567 Orders
16
1 : Overdue Enc Completion
Epic
Patient Lookup
Remind Me
Personalize
HCS-iSTOP
UptoDate
NYC CIR
CPM Guidelines
Sign My Visits
Print
Secure
Log Out
Achilles, Virginia Pren...
PLY
FRANCIS-OBGYN A.
VA
Achilles, Virginia
Prenatal
Female, 27 y.o., 12/3/1994
MRN: 05179001
Cur Location: BRONX EAST PRACTICE OB/GYN GENERALISTS
Code: Not on file (has ACP docs)
Primary Team: None
Observation Status: None
Search
COVID-19 Vaccine: Unknown
Obstetrician: Me
Coverage: None
Allergies: Strawberry
GA, TWG: 12w2d, -120 lb 10.1 oz
7:45 AM NEW OBSTETRICAL VISIT
Weight: 136 lb >7 days
TWG: -120 lb
Pregravid BMI: 21.63 kg/m²
THIS PREGNANCY
Hx: G3P1011
GA: 12w2d (10/10/2022)
Blood Type: None
Cha...
Synopsis
Visit
Family ...
Plan
Wra...
Flowsheets
Review...
Prep f...
Welcome
Visit
OB Car...
SmartSet
3/30/2022 visit with Francis-Obgyn Achilles, MD for NEW OBSTETRICAL VISIT - Initial Prenatal Visit
Arterial, Blood Gas, Comprehensive
Lab Collect
Urine, Drugs Screen
Cardiac Testing
Cardiac Tests
ECG 12 Lead
Routine, Clinic Performed
Transthoracic Echo Adult
P Expected: 3/30/2022, Expires: 3/30/2023, Routine, Ancillary Performed
XR CHEST FRONTAL VIEW
Routine
Holter/Event Monitor
Routine
Referrals
Referral to MFM Cardiology
Ambulatory referral to MFM - Cardiology
Internal Referral, Routine, Cardiology, Office Visit
Additional SmartSet Orders
Search
You can search for an order by typing in the header of this section.
ADD ORDER
ADD DX (1)
PRINT AVS
SIGN VISIT



Wolfe, DS…Hammed, AB. *In Press*

Study Cohort

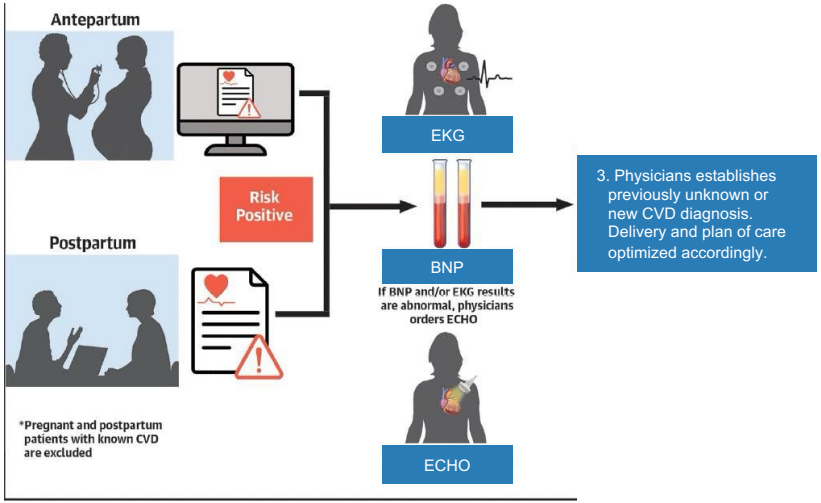
Among 19,238 pregnant and postpartum patients without prior known CVD who were assessed for CVD risk, 2.0% were identified as being at risk for developing CVD

Main Findings

- Among total study population, 2.3% of patients were later confirmed to have CVD
- Physical examination findings were the most predictive elements of the CVD risk assessment

1. Physicians completes CVD risk assessment

2. Physicians orders follow-up cardiac diagnostic testing and patient completes ASAP (within 30 days)



3. Physicians establishes previously unknown or new CVD diagnosis. Delivery and plan of care optimized accordingly.

The Conclusion

The CVD risk assessment algorithm embedded in routine obstetric care demonstrates moderate predictive value and improves identification of undiagnosed CVD, with significant enhancement utilizing physical exam findings.

Calculation of the Positive Predictive Value (PPV)

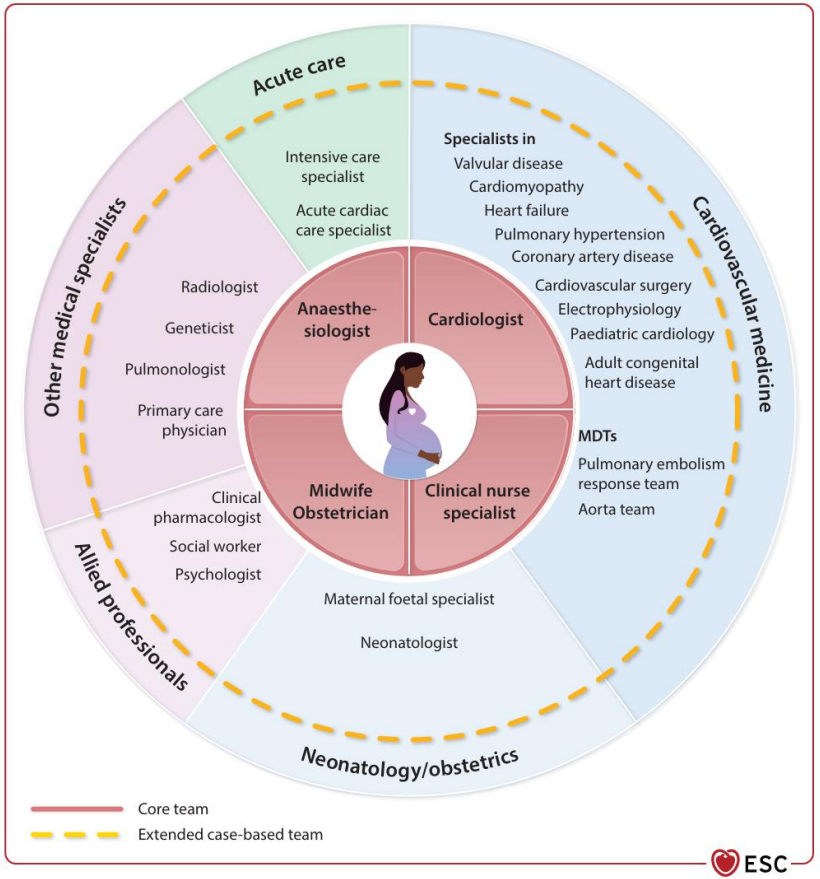
True positive (N= 60)/True positive (n=60) + False positive (n – 325) = 15.6%

Wolfe, DS…Hammed, AB. *In Press*

READINESS (EVERY CLINICAL SETTING)

4. Establish a Multidisciplinary *Pregnancy Heart Team,* or Consultants Appropriate to the Facility's Designated Level of Maternal Care to Care for People Experiencing Cardiac Conditions in Pregnancy and Postpartum

Every facility where a pregnant or postpartum person may present should have a plan for convening a Pregnancy Heart Team or a plan to access one when needed through telehealth or remote consultation. The team can be comprised of onsite obstetric care professionals and subspecialists or wholly or in part as a virtual team in hospitals where subspecialists are not readily available onsite. Table 1 provides examples of suggested team members and roles.



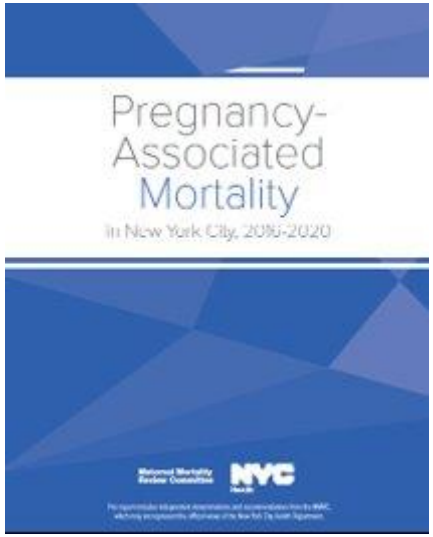
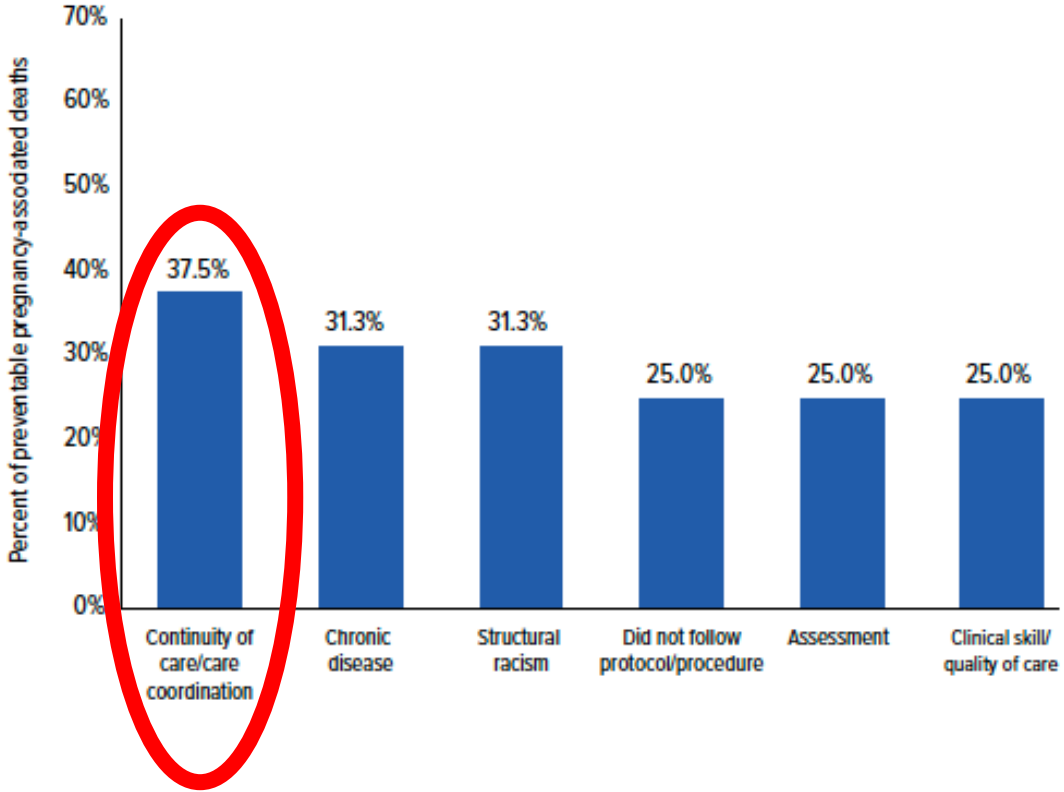
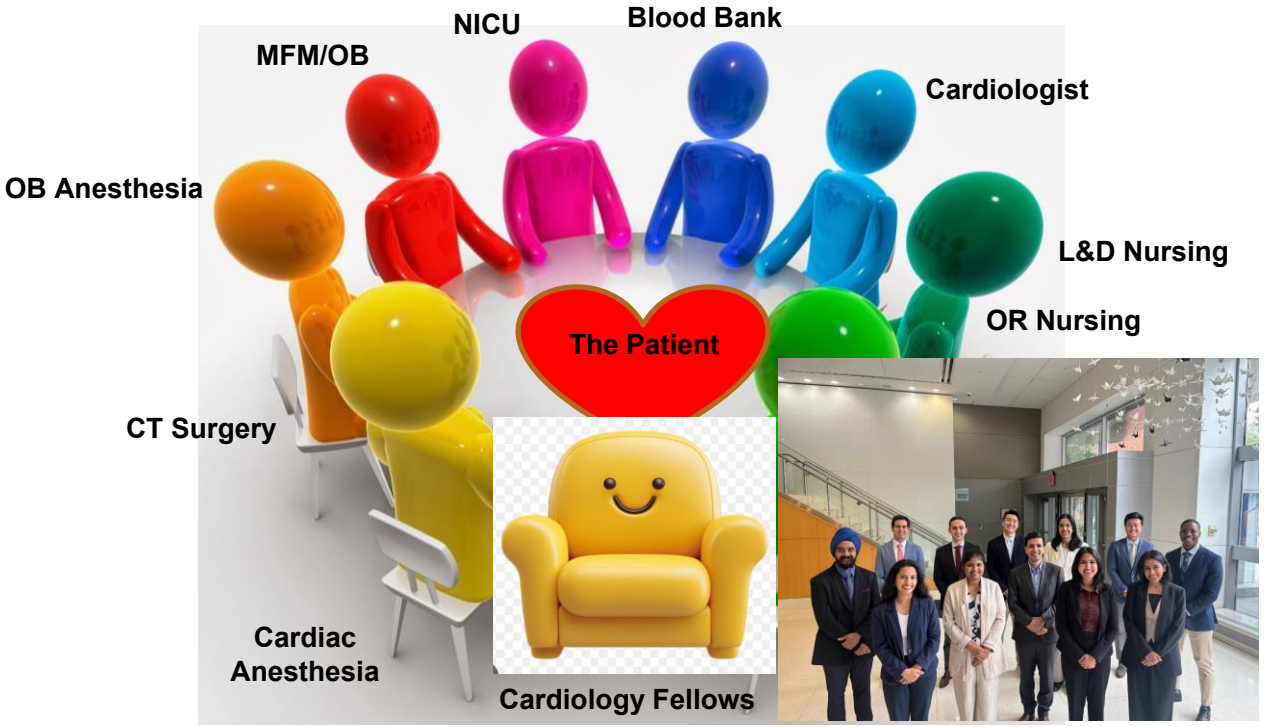


Figure 36. Contributing Factors Among Preventable Deaths Due to Cardiovascular Conditions, NYC, 2016-2020

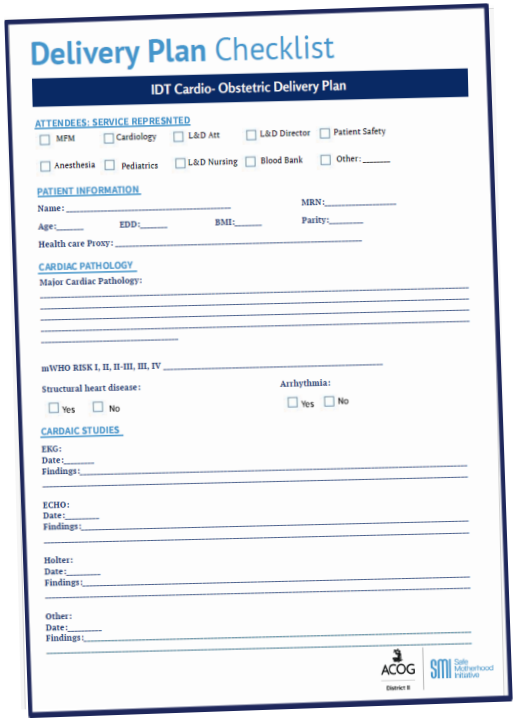


Interdisciplinary Team Meeting in CICU



Hameed AB, Wolfe DS. *Cardio-Obstetrics: A practical guide to care for pregnant cardiac patients.* 2020;5-9.

Checklist for Interdisciplinary Team Delivery Planning



Delivery Plan Checklist

IDT Cardio- Obstetric Delivery Plan

ATTENDEES: SERVICE REPRESENTED

☐ MFM ☐ Cardiology ☐ L&D Att ☐ L&D Director ☐ Patient Safety

☐ Anesthesia ☐ Pediatrics ☐ L&D Nursing ☐ Blood Bank ☐ Other:_____

PATIENT INFORMATION

Name:_____ MRN:_____

Age:_____ EDD:_____ BMI:_____ Parity:_____

Health care Proxy:_____

CARDIAC PATHOLOGY

Major Cardiac Pathology:

mWHO RISK I, II, II-III, III, IV _____

Structural heart disease: ☐ Yes ☐ No

Arrhythmia: ☐ Yes ☐ No

CARDAIC STUDIES

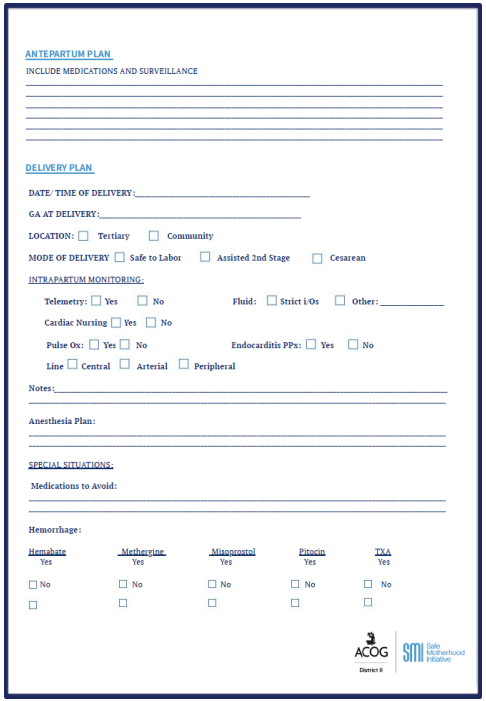
EKG:
Date:_____
Findings:_____

ECHO:
Date:_____
Findings:_____

Holter:
Date:_____
Findings:_____

Other:
Date:_____
Findings:_____

ACOG District II | SMI Safe Motherhood Initiative



ANTEPARTUM PLAN

INCLUDE MEDICATIONS AND SURVEILLANCE

DELIVERY PLAN

DATE/ TIME OF DELIVERY:_____

GA AT DELIVERY:_____

LOCATION: ☐ Tertiary ☐ Community

MODE OF DELIVERY ☐ Safe to Labor ☐ Assisted 2nd Stage ☐ Cesarean

INTRAPARTUM MONITORING:

Telemetry: ☐ Yes ☐ No Fluid: ☐ Strict i/Os ☐ Other:_____

Cardiac Nursing ☐ Yes ☐ No

Pulse Ox: ☐ Yes ☐ No Endocarditis PPx: ☐ Yes ☐ No

Line ☐ Central ☐ Arterial ☐ Peripheral

Notes:_____

Anesthesia Plan:

SPECIAL SITUATIONS:

Medications to Avoid:

Hemorrhage:

Hemabate	Methergine	Misoprostol	Pitocin	TXA
Yes	Yes	Yes	Yes	Yes
☐ No	☐ No	☐ No	☐ No	☐ No
☐	☐	☐	☐	☐

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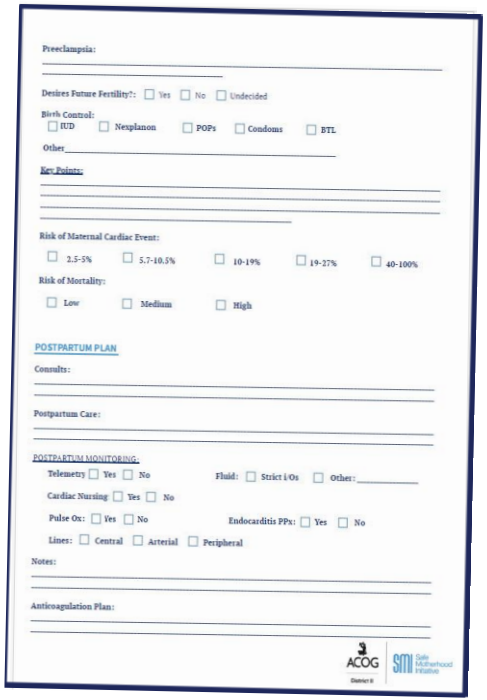

Preeclampsia:

Desires Future Fertility?: ☐ Yes ☐ No ☐ Undecided

Birth Control:
☐ IUD ☐ Nexplanon ☐ POPs ☐ Condoms ☐ BTL

Other_____

Key Points:

Risk of Maternal Cardiac Event:
☐ 2.5-5% ☐ 5.7-10.5% ☐ 10-19% ☐ 19-27% ☐ 40-100%

Risk of Mortality:
☐ Low ☐ Medium ☐ High

POSTPARTUM PLAN

Consults:

Postpartum Care:

POSTPARTUM MONITORING:

Telemetry ☐ Yes ☐ No Fluid: ☐ Strict i/Os ☐ Other:_____

Cardiac Nursing ☐ Yes ☐ No

Pulse Ox: ☐ Yes ☐ No Endocarditis PPx: ☐ Yes ☐ No

Lines: ☐ Central ☐ Arterial ☐ Peripheral

Notes:

Anticoagulation Plan:

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Hameed AB, Wolfe DS. *Cardio-Obstetrics: A practical guide to care for pregnant cardiac patients.* 2020;5-9.

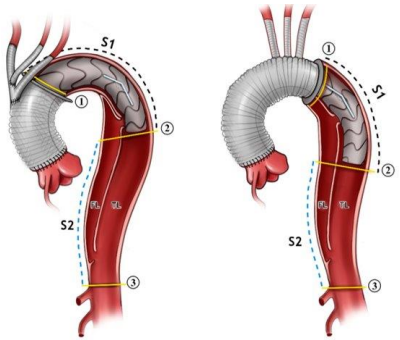
40 yo IVF pregnancy 36 wk 1d presents to ED with Left Arm Tingling

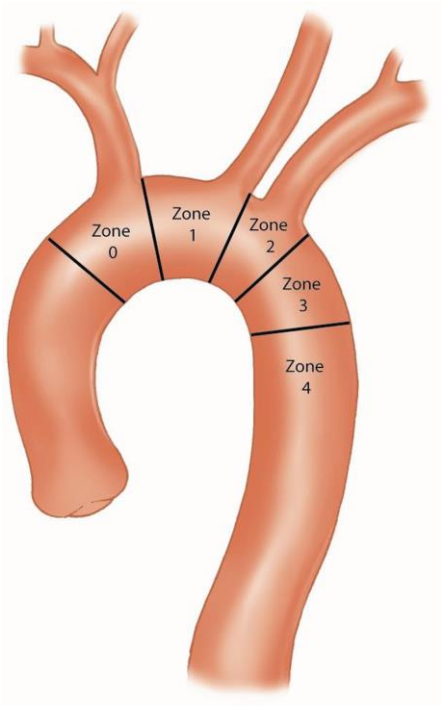
Clinical Challenge

- Full term, viable pregnancy
- Acute type A aortic dissection with root and ascending aneurysm
- Dissection extending into all head vessels
- Left upper extremity mal-perfused due to dynamic obstruction of left subclavian artery
  - Pain, neuromuscular deficits
  - Absent left radial and brachial pulse

Optimal Timing

- Proximal aortic disease
  - Root
  - Hemiarch
  - Arch replacements
- Distal aortic disease and LUE mal-perfusion





Proximal landing zones for aortic arch and upper descending thoracic aorta | Download Scientific Diagram

Montefiore

EINSTEIN
Albert Einstein College of Medicine
OF YESHIVA UNIVERSITY

Obstetric Concerns

Blood Pressures

- Developing Pre-eclampsia?
- Hypotension and Fetal Perfusion

Maternal Cardiac Compromise

- Decreased Cardiac Output
- Potential Cardiac Collapse
- Cardiac Bypass/ ECMO concerns

Fetal Compromise

- Opiate Effects
- Maternal Hypotension
- Reduced Uterine Perfusion
- General Anesthesia

Delivery Considerations

- Rapid Delivery
- Postpartum Hemorrhage
- Surgical approach and planning

Surgical Planning

Skin Incision

- Hx of Stage IV Endometriosis
- Possible Hysterectomy

Midline Vertical Skin Incision w/ Staple Closure

Uterine Incision

- Full-Term
- Breech Presentation

Low Transverse Incision

Postpartum Hemorrhage Risk

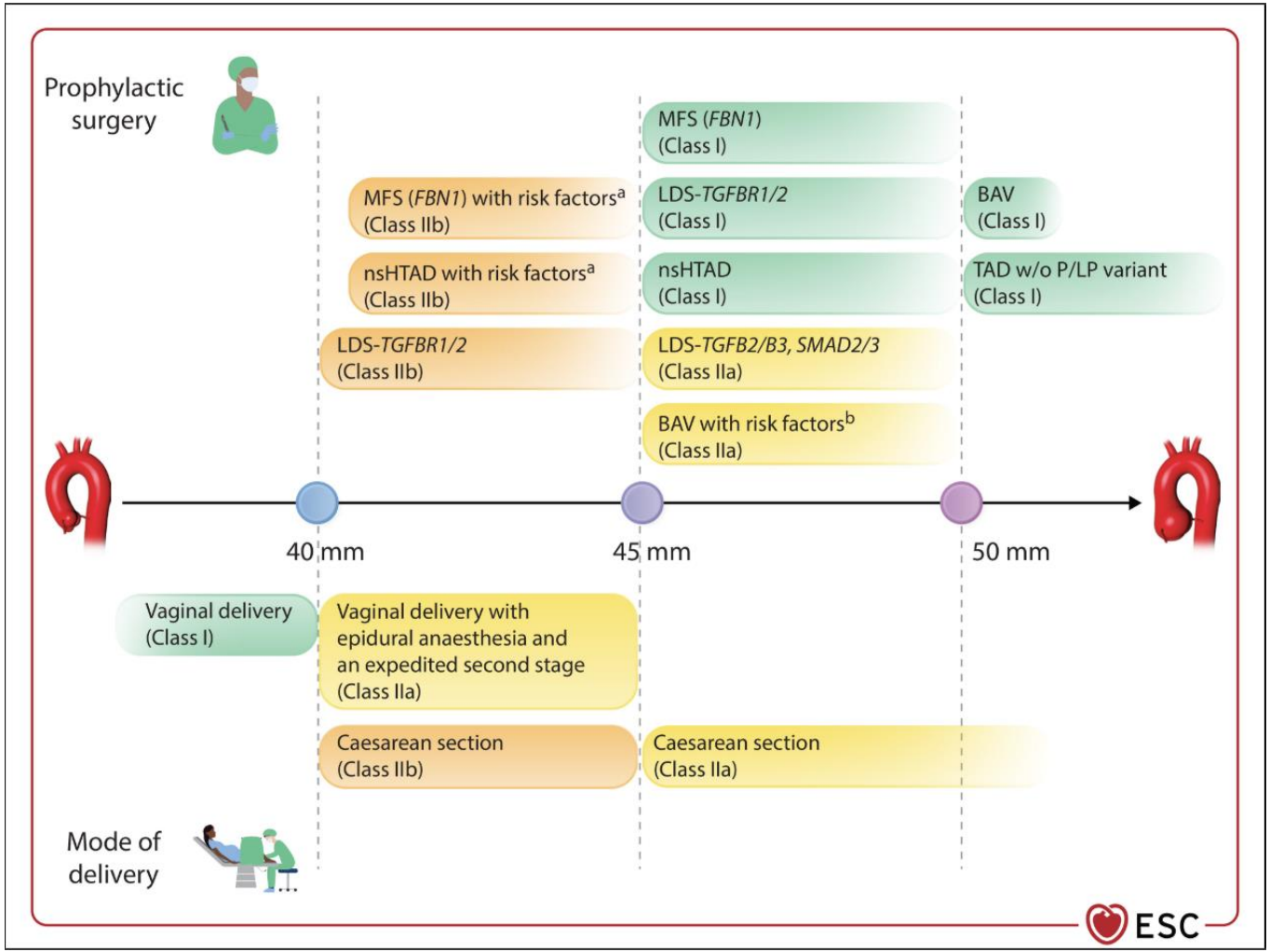
- Patient to be fully heparinized
- Use of inhaled anesthetics

1. **Postpartum oxytocin infusion**
2. **Prophylactic Bakri Balloon Placement**
3. **Vistaseal over hysterotomy**
4. **Staple Closure with GynOnc on standby**

Neonate

- Potential Fetal Compromise
- Unknown Fetal Status

1. **NICU Team on standby in separate OR**
2. **Rapid Delivery**



JOURNAL ARTICLE GUIDELINES

2025 ESC Guidelines for the management of cardiovascular disease and pregnancy: Developed by the task force on the management of cardiovascular disease and pregnancy of the European Society of Cardiology (ESC)

Endorsed by the European Society of Gynecology (ESG)

BAV: bicuspid aortic valve
LDS: Loeys–Dietz syndrome
MFS: Marfan syndrome
nsHTAD: non-syndromic heritable thoracic aortic disease
P/LP: pathogenic/likely pathogenic
TAD: thoracic aortic disease

Risk factors: family history of dissection, rapid aortic growth (≥3 mm/year), uncontrolled hypertension

Interdisciplinary Team

MFM

L&D Nursing

NICU

Anesthesia

Cardiology

Blood Bank

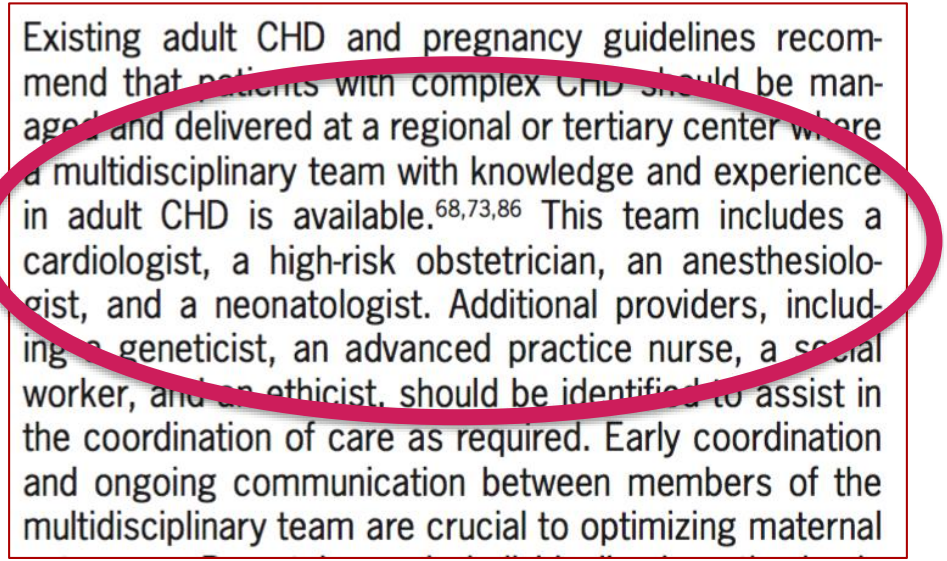
CT Surgery

Patient Safety

Take Home Message

European Heart Journal 2011;32:2147-97

AHA Scientific Statement



Existing adult CHD and pregnancy guidelines recommend that patients with complex CHD should be managed and delivered at a regional or tertiary center where a multidisciplinary team with knowledge and experience in adult CHD is available.[68,73,86] This team includes a cardiologist, a high-risk obstetrician, an anesthesiologist, and a neonatologist. Additional providers, including a geneticist, an advanced practice nurse, a social worker, and an ethicist, should be identified to assist in the coordination of care as required. Early coordination and ongoing communication between members of the multidisciplinary team are crucial to optimizing maternal

Circulation 2017;136:e50-e87

AIM Clinical Refresher Series

Sepsis in Obstetric Care ✓
May 6, 2026

Cardiac Conditions in Obstetric Care ✓
May 13, 2026

Severe Hypertension in Pregnancy
May 20, 2026 at 12:30 - 1:00 PM ET

Safe Reduction of Primary Cesarean Birth
May 27, 2026 at 12:30 - 1:00 PM ET

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SCAN ME

Thank you!

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