

# Family Connects: A Strategy to Improve Health During the Fourth Trimester

*Fourth Trimester: The three-month period immediately following giving birth. This is a period of physical and emotional transition.*

Family Connects is an evidence-based model that combines engagement and alignment of community service providers with short-term nurse home visiting for newborns. The Family Connects model is designed to be delivered to all families with newborns within a community. It is a voluntary program and is provided at no cost to families. By offering Family Connects to all families in a community, Family Connects improves health outcomes at the population level and normalizes the need for community support.

Since 2018, the American College of Obstetricians and Gynecologists (ACOG) has recommended that postpartum clinical visits occur within the first three weeks. However, most of those giving birth in the United States largely navigate the 4th trimester independently, waiting until 4–6 weeks postpartum to visit their medical provider. As many as 40% do not attend a postpartum medical visit at all, and attendance rates are even lower among those who face barriers to health care access.

As part of its recommendations, the ACOG committee specifically mentioned nurse home visitors as alternative providers of this first postpartum visit, citing research on outcomes from the Family Connects model of universal newborn nurse home visiting.

***Health disparities in our community are prevalent. The most critical visit I've made was to a mom who'd delivered twins. Mom reported that she was seen in the ER after passing a huge clot. She showed me a picture and what I saw was very serious. During our visit, mom was still experiencing bleeding and was rating her pain level high. But this is a time when her pain levels should have been minimal. Mom stated that she was told that the clot was a part of "normal shedding. When she reached out to her provider she was repeatedly told that what was happening was normal after having twins. She was very reluctant to be persistent about the symptoms that she was experiencing. I explained that African-American moms have the highest mortality rate in the United States and explained if she feels like something is not right then she must advocate for herself so that she can be around for her children that need her. I was able to empower her with the knowledge and support to advocate for herself with her doctor and she recovered well!***



-Felicia Watson MSN, BSN, RN,  
Family Connects Nurse



Nurse home visitors can support and advocate for access to postpartum care. Not only do nurses assess for postpartum health issues that need immediate attention, they also educate families on what to expect in the fourth trimester and connect them to follow-up care and a medical home, as needed. Nurses can also assess for social determinants of health (SDOH) and make connections to community programs and resources.



Most families are able to complete the components of the visit in one session, although nurses can make up to three home visits to a family's home, if needed. Four weeks after the final home visit, a Family Connects staff member contacts the caregiver to assess satisfaction with the program, to determine if any new needs have arisen, and to follow up on all community referrals to ensure successful connection.

The medical provider will receive a post-visit report after the Family Connects visit (with patient consent) that will detail the identified opportunities for support. The role of medical providers is important in this partnership because they can follow up with the family at their next medical appointment. Providers will also continue to screen for SDOH as needs can change over time.

### **Key areas covered during a Family Connects nurse visit include:**

- Systematic discussion about the family's supports, strengths, vulnerabilities and needs using the 12-factor Family Support Matrix
- Postpartum health assessment (includes a blood pressure check)
- Infant health check (includes a head-to-toe assessment, including weight, length, and head circumference)
- Reinforcement of connection to the medical home for caregiver and infant to reduce unnecessary emergency department visits
- Breastfeeding support
- Screening for social determinants of health through nurse query and evidence-based screeners regarding:
  - mental health history
  - substance use history
  - previous parenting history
  - interpersonal violence exposure
  - incarceration of parent or partner
  - history of abuse/neglect and involvement of Child Protective Services as a child or adult
- Perinatal mood disorder screening
- Postpartum care, including scheduling medical appointment as needed
- Tobacco cessation referrals
- Safe sleep practices
- Shaken baby syndrome/abusive head trauma education and prevention
- Caregiver-child interaction assessment and coaching
- Supportive guidance about topics relevant to all newborns and maternal health needs
- Assistance with obtaining health insurance coverage/enrolling in Medicaid, child care, and social services
- Collaborative planning for recommendations and referrals to community services as identified by nurse visitor and caregiver(s)

## Supporting literature

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