Revisiting the Postpartum Home Visit: A Call to Action

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Background

Postpartum health care has been reduced to a 48-96 hour hospital stay depending on the type of delivery, followed by a 6 week postpartum clinic visit that marks the end of the postpartum period by all conventional standards. The United States maternal mortality rate continues to climb with a 26.6% increase from 2000 to 2014. Approximately 15-20 % of postpartum women will develop postpartum depression within the first year of after delivery which has generated much discussion surrounding the most effective way to identify those at risk and provide adequate support and management. In light of these statistics the conversation surrounding how to best meet the postpartum needs of women and newborns has been renewed.

In 2018 the American College of Obstetricians and Gynecologists (ACOG) proposed redesigning postpartum care with the goal of providing a more holistic approach to what is known as the 4th trimester, addressing areas such as mood and emotional well-being, maternal infection, infant care and feeding along with addressing sleep and fatigue issues to name a few.

A successful postpartum home visit program addressing the 4th trimester already exists that encompasses many of ACOG's goals. The Duke Family Connects model has been studied in two randomized controlled trials demonstrating improved mother mental health, reduced emergency care for participating infants of 59%, enhanced home environments and greater community connections to programs like Nurse-Family Partnership for continued long-term continuity of care. The Family Connects program studied demonstrated that for each program $1 spent, a savings of $3.04 in emergency care costs was produced.

Content/Action

Postpartum home visits should be incorporated as the standard of care for pregnant women and considered part of the multidisciplinary team that supports and cares for new families during this critical life transition using the Duke Family Connects as a model. Current evidence supports the benefits of providing home nurse visits in reducing readmission rates for both newborns and mothers as well as promoting family bonding.

Lessons Learned

Successful postpartum home visit programs should begin before the family is discharged home. The home visit nurse needs an opportunity to establish rapport with the family and time to assess and evaluate their unique needs prior to delivery. Many women find it challenging and burdensome to make multiple doctors visits once the baby arrives. Home visits are patient centered and scheduled around convenience for the family. A postpartum home visit program can facilitate individualized transition of care plans to community resources for those families that need continued care beyond the 4th trimester.

Implications for Practice

With the Postpartum home visit model as the standard of care, women will have access to quality care that is timely and holistic. Postpartum home visit studies to date reflect improved outcomes for both mom and newborn as well as reduction in cost related to decreased readmissions. Successful programs already exist and include interactions with and assessment of the family prior to delivery. Ultimately, if implemented as part of the standard of care for childbearing families, postpartum home visits could bridge the gap in care during the 4th trimester and reduce maternal and infant morbidity and mortality in the United States.