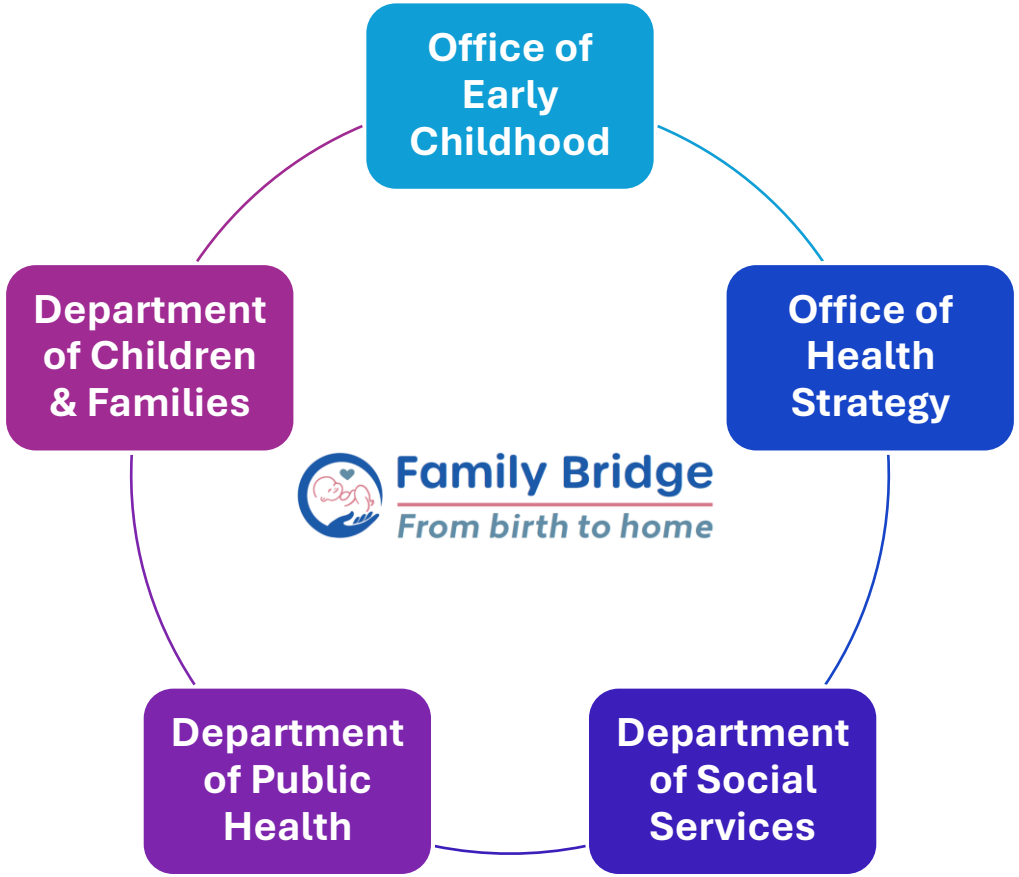
Family Bridge Program

Delivering Whole-Person Care Through Nursing and Community Partnership

What is Family Bridge?

Multi-Agency Collaboration



Family Bridge Overview

Objectives

- Offer prevention-oriented public health resources
- Prevent and address health disparities
- Mitigate stressors impacting families
- Improve maternal and infant health outcomes

Description

- Multiagency collaboration led by OEC established in 2022
- Universal RN and CHW home visiting program
- Derived from the evidence-based Family Connects International model

Eligibility

- All families that give birth at Bridgeport Hospital, St. Vincent's Medical Center, or Backus Hospital and live in the catchment area of the program

Services

- Up to 3 RN home visits
- Complete health and needs assessment and other needed nursing services

- CHW visits to help families access essential resources and connect with parenting groups and health care providers

Funding

- $8 million allocation out of the state's ARPA funds to support (2021)
- CDC Health Disparities Grant
- HHS and the Administration of Children and Families, a Preschool Development Grant Birth through Five

What’s Next?

Sustainability & Evaluation

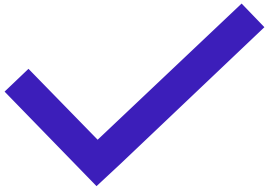
FCI Model Impact

15% increase	in community connections
50% reduction	emergency room visits and hospital overnight stays
44% lower	rates of Child Protective Services investigations
30% reduction	mothers experiencing postpartum depression or anxiety

1. Davenport et al. (2020). 2. Brown et al. (2021). 3. Moore et al. (2021). 4. Family Connects International website. 5. Goodman et al. (2019).

Evaluation: Outcome Measures

Performance

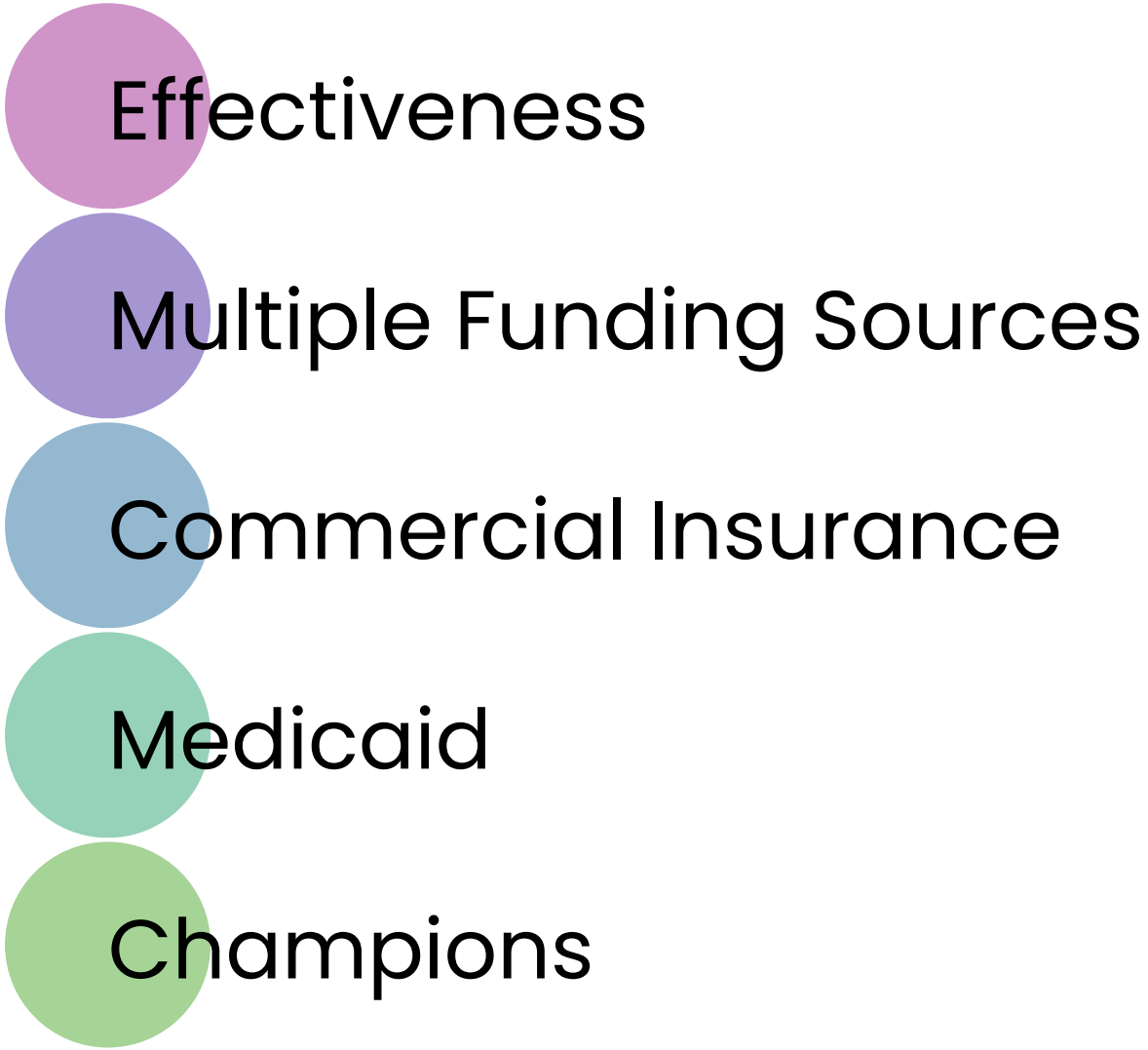


Outcomes

Cost Savings/Cost Avoidance

Sustainability

Landscape Analysis Findings



From the Field: Bridgeport Hospital & Eastern CT

Family Bridge Program: Key Performance Data (2023–2025)

- 2,400+ total births captured across Bridgeport Hospital/STV tracking period
- ~2,050 eligible births in catchment
- 1,600+ successful contacts
- 1,000+ families enrolled/scheduled
- 1,800+ CHW/RN home visits completed
- 70–85% visit completion rate
- Routine screenings: mental health, substance abuse, IVP
- Quality Assurance and Fidelity to FCI Model >90%
- Quality Improvement: improved cancellation rates, patient satisfaction

Bridging the Gap: Health + Resource Support

Strengthening Maternal-Infant Health

Clinical Assessment & Early Detection

"Luz noticed signs of infection at my C-section incision and told me to go to the ER. I was admitted and put on IV antibiotics."

"Cori saw redness and swelling at my incision and contacted my OB. I was seen the same day and started on antibiotics."

Lactation & Feeding Support

"Jenna helped me with lactation, made sure my baby was doing well, and gave me the support I needed."

"Stephanie explained breastfeeding fully and gave me great tips and tricks."

Postpartum Recovery & Safety

"Luz took my blood pressure, and it was very high. She sent me to the ER — I had no idea anything was wrong."

"I told my nurse things I've never told anyone. She listened, and I felt heard and not alone."

Maternal/Infant Education

"Barbara checked my baby's temperature, made sure I was recovering well, and taught me how to care for myself and my baby."

"Cori educated me on my baby's milestones and answered my medical questions."

"Luz corrected how I was mixing formula and taught me the right way. I didn't know it could be unsafe."

Telehealth Visits

"During a telehealth visit, the nurse recognized my headache and blurry vision were dangerous. She told me to go to the ER immediately — she may have saved my life."

Addressing Social Drivers of Health & Resource Access

SDOH Screening & Barrier Reduction

"my CHW helped me apply for housing, food stamps, and Care 4 Kid – all things I didn't even know I qualified for."

"I finally made it to all my appointments because they helped me with transportation and reminders."

Resource & Benefits Navigation

"Sereader helped me with food banks, maternity leave benefits, my baby's passport, and so many resources."

"Andrea helped me with SNAP, passport applications, and appointments with my doctor."

Material Supports for Basic Needs

"Liliam helped me with resources, diapers, and clothing for my baby."

"I didn't have a safe place for my baby to sleep, my CHW brought me a pack'n'play and taught me how to use it- I finally felt prepared."

System Navigation & Advocacy

"Martin was very prepared and had paperwork that helped me understand how to enroll in many programs."

"I didn't know where to start. My CHW helped me apply for hosing and childcare support- no I can finally feel like I can breathe.

Cultural & Emotional Support

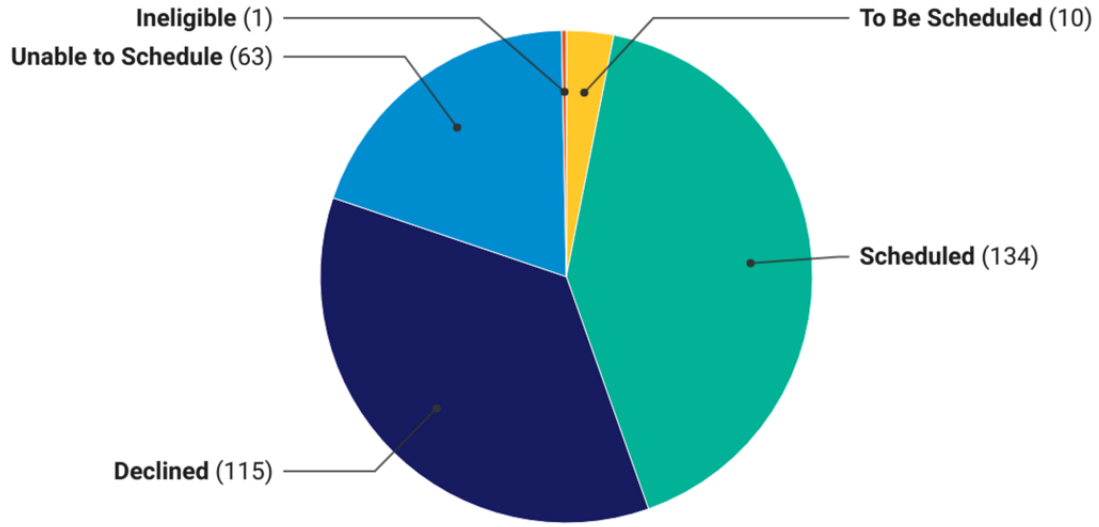
"she understood my culture and never judged me. She made me feel safe and supported during the hardest time of my life"

"Cori showed up on time, went through everything about my baby's health and mine, and answered all my questions. She was very professional."

Family Bridge Eastern CT Data Reporting

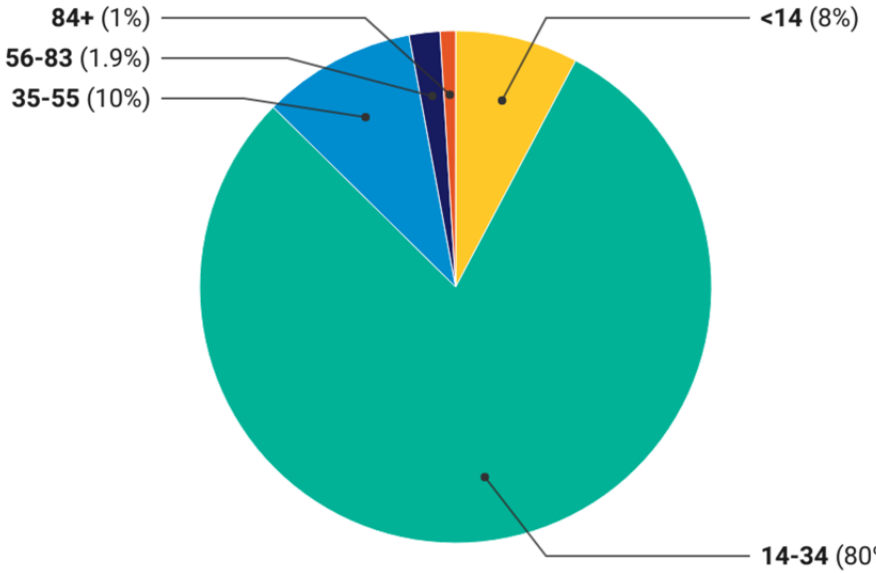
Patient Recruitment Outcomes 01/2025 - 11/2025

Patient Recruitment Outcomes from January 1, 2025 to November 21, 2025.



Infant Age at IHV 01/2025 - 11/2025

Age of infant in days for each In Home Visit that was completed between January 1, 2025 and November 21, 2025.



Family Bridge Eastern CT Success Stories...

RN home visitor completed an In-Home Visit (IHV) with a Spanish speaking family in Willimantic. Clinically, mom presented with elevated blood pressure and scored high on the Edinburgh Post Partum Anxiety and Depression scale. Socially, mom presented with significant housing and food insecurity concerns, including mom and her three children were living in a one room apartment and all three children, including the infant, and mom were sleeping in one bed. Mom has no transportation and is not able to read or write. The RN immediately addressed the hypertension through education and contacting the OB while at the home; additionally, the RN provided mom with postpartum anxiety and depression resources, as well as made the OB aware of the high score. The RN made a referral to the Family Bridge Eastern CT Community Health Worker to address the social health barriers. The CHW made initial contact with the mom and went to the home within two days to determine next steps. The CHW immediately contacted TVCCA's housing program to address the unsafe housing and sleeping concern. Through a strong collaborative effort that involved both internal and external partners, mom was rehomed into a suitable apartment with three bedrooms; appropriate bedding was provided for infant and children as well as essential housing supplies. Mom was put in contact with a diaper bank, WIC, and food pantry. Lastly a referral was made to an Early HeadStart program in Windham County.

At a recent IHV (in home visit) the RN Home Visitor was able to successfully educate and reassure a G2P2 mom that she was in fact breastfeeding her second infant appropriately.

Some of the key takeaways from this visit included:

RN Home Visitor provided mom with hands on education around milk storage

RN Home Visitor was able to observe mom latching her infant in the comfort of the home

RN Home Visitor provided mom with much needed reassurance that her milk production was sufficient for infant (this included the ability to weigh the infant at the home)

Thank you!

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