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Follow-Up Communication and Postpartum Complications: A Narrative Review of Evidence and Suggested Implementation Strategies

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Abstract

Background: Postpartum complications are a leading cause of maternal mortality and are most likely to occur in the first six weeks; therefore, postpartum follow-up communication has the potential to improve maternal mortality rates through decreased readmissions and complications in the postpartum period.

Objective: The purpose of this literature review is to evaluate the effectiveness of follow-up communication in identifying complications in postpartum women to reduce emergency room visits and readmissions.

Methods: A systematic search between 2018 and 2023 was conducted using CINAHL and Medline databases. Keywords used reflected the patient population, intervention, and outcome and were used in combination with a Boolean search in both databases. A narrative analysis of study characteristics, findings, and themes was performed.

Results: A total of 88 peer-reviewed articles between CINAHL and Medline were retrieved, with 10 studies meeting inclusion criteria. Studies reviewed included three studies that included the pregnant or gynecologic population and seven studies that reflected stroke, heart failure, burn, and trauma patient populations. A study analysis identified four common themes among follow-up communication; reduction in readmission, early identification of complication, cost-analysis of follow-up communication, and evidence-based practice standards.

Conclusion: Limited evidence suggests potential cost savings and earlier complication detection in non-obstetric populations; direct postpartum evidence is sparse. Implementing follow-up communication protocols in the postpartum population may provide opportunities for decreasing maternal mortality, especially within the first six weeks postpartum when nearly half of all maternal deaths occur.

Key Words: Maternal Mortality, Postpartum Period, Pregnancy Complications, Communication, Patient Readmission

Background

Postpartum complications occur disproportionately in the early postpartum period, with more than 70% of pregnancy-related deaths occurring between week one and week six postpartum. This period represents the highest risk window for conditions such as postpartum hemorrhage, infection, cardiomyopathies, thrombotic events, hypertensive disorders, and postpartum mental health complications [1]. Maternal mortality is defined as death in one year of pregnancy and refers to causes being pregnancy-associated, pregnancy-associated but not related, or pregnancy-related [2]. Despite global maternal mortality rates declining by nearly one-third since 2000, maternal mortality still costs an estimated 810 women's lives a day globally, with the majority of deaths occurring in low- and middle-income countries [3]. A comparison between similar high-income countries showed that the leading causes of death were postpartum hemorrhage and hypertensive disorders with factors influencing deaths being provider-related, delay in diagnosis or treatment, and failure in the identification of high-risk individuals [4]. In low- and middle-income countries, postpartum hemorrhage and hypertensive disorders remained the leading causes of death, however, preventable factors included access to an optimal level of care and a lack of evidence-based practices to prevent or treat complications [4].

While global maternal mortality rates have shown a decline in the last 20 years, the United States maternal mortality rate has continued to fluctuate with the rate per 100,000 live births nearly doubling from 9.8 in 2000 to 17.9 in 2024 [5-6]. More than half of all pregnancy-related deaths in the United States occur in the postpartum period between week one and six postpartum [2, 7]. In the United States, the leading causes of pregnancy-related deaths are mental health conditions, postpartum hemorrhage, cardiac conditions and cardiomyopathies, infection, thrombotic or pulmonary embolus, and hypertensive disorders of pregnancy [7]. In comparison to other

developed and high-income nations, the United States had the worst maternal mortality rates in 2022, with especially marked racial disparities between white and non-Hispanic Black women [8, 9]. In 2024, the United States maternal mortality rates among Hispanic, White, and non-Hispanic Black women were 12.1, 14.2, and 44.8 deaths per 100,000 live births respectively [5-6].

While consistent and frequent monitoring exists during pregnancy and childbirth, the one-year postpartum period has significantly lower rates of follow-up care with only one to three visits with a healthcare provider after discharge [2]. This presents a vast discrepancy in health surveillance as more than 70% of pregnancy-related deaths occur in the first six weeks postpartum [2]. Although it is hypothesized that more frequent postpartum contact with healthcare providers may facilitate earlier identification of complications, high-quality postpartum specific trials evaluating structured follow-up calls or text messages are limited. This review therefore examines whether existing evidence supports the assumption that increased communication in the first six weeks postpartum improves early detection of complications.

Objective

This literature review aims to evaluate whether increased postpartum communication through phone calls or text messages within the first six weeks postpartum is associated with earlier identification of complications. Secondary aims include identifying evidence gaps, synthesizing themes across heterogenous communication interventions, and assessing whether current evidence supports structured postpartum communication strategies. To ascertain the significance of the problem, a thorough analysis of available and current research was performed. Although the research question focuses on weekly communication during the first six weeks postpartum, existing studies vary substantially in timing, frequency, and modality of follow-up contact. Due to the limited availability of research evaluating postpartum communication via structured weekly calls or texts, a thematic synthesis approach was used to identify common patterns across heterogenous interventions and determine whether any evidence supports the underlying hypothesis.

Methods

A narrative review with systematic search was conducted using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and MEDLINE (Proquest) databases. The search took place between 2021 and 2023 and included published works in English after 2017 to capture the most contemporary evidence on postpartum communication interventions. Search terms reflected the population (e.g., *postpartum, first six weeks postpartum, mothers, discharged* patients) and the intervention/outcome (e.g., *weekly phone calls, follow-up phone calls, postpartum complications, readmission, early identification, emergency room* visits). Boolean operators were used to combine terms, and full search strings for each database are provided in Appendix A. Inclusion and exclusion criteria were clearly defined before the search (Table 1). Studies were included if conducted in the United States, published after 2017, available in full text, and evaluated a follow-up phone call or text-based communication intervention. Abstracts, posters, duplicates, or studies that lacked a follow-up communication component were excluded. Two reviewers independently screened titles and abstracts, with disagreements resolved through discussion and consensus. Full-text review was conducted for all studies meeting initial criteria.

Inclusion Criteria	Exclusion Criteria
English Language	Abstract/poster presentation
Publication after 2017	Duplicates
Peer-Reviewed Articles	Non-Nursing Based
Studied within the United States	No follow-up phone call
Full-text available	

Table 1: Inclusion and Exclusion Criteria

Study Selection

Searches yielded results of 88 peer-reviewed articles between CINAHL and Medline search databases. Ineligible studies were excluded including 28 duplicates, one abstract/poster presentation, seven that were not nursing based, and ten that had no follow-up phone call. Of the remaining 42 studies, title and abstract screening by two reviewers with 32 articles not meeting inclusion criteria (published before 2017, not conducted in the United States, or not available in English). Ten studies remained for full-text review. A PRISMA-style flow diagram summarizing the selection process is provided in Figure 1.

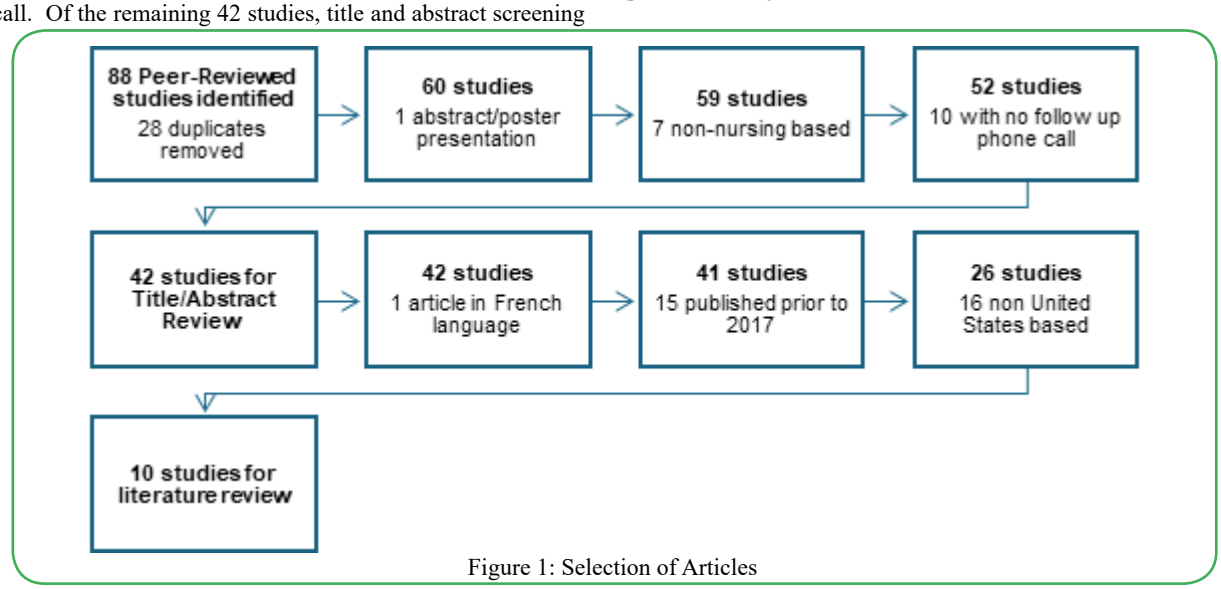


Figure 1: Selection of Articles

The included studies varied substantially in population, intervention timing, frequency, modality, and outcomes with few being postpartum-specific. As a result, a meta-analysis was not feasible, however a narrative synthesis approach was used. Data extraction included study design, sample size, population characteristics, intervention details, variables, outcomes, follow-up duration, and funding. Methodological quality was assessed using the NIH appraisal tool, and a summary of quality is provided in Table 2.

Author	Study Design	Sample Size	Population	Intervention	Variables	Outcomes	Follow-Up Duration	Funding
Hwang, P.J. (2022). Impact of NP follow-up calls on reducing 30-day readmissions in patients with stroke. The Nurse Practitioner, 47(5), 39-46. https://doi.org/10.1097/01.NPR.0000827056.81217.5b [10]	Quality Improvement Project	173 discharged patients, convenience sample, final number 60	Stroke readmissions within 30 days, Pre and post project implementation groups	Adding NP to established discharge call program	Age, gender, race, discharge destination, BE FASTs knowledge	Need for earlier follow up phone calls, NP participation in calls, need to evaluate patient satisfaction and financial savings	Initial meeting, phone calls at 7 and 30 days	N/A
Johnson, K., Razo, S., Smith, J., Cain, A., & Soper, K. (2019). Optimize patient outcomes among females undergoing gynecological surgery: A randomized controlled trial. Applied Nursing Research, 45, 39-44. https://doi.org/10.1016/j.apnr.2018.12.005 [14]	Randomized controlled trial	50 patients undergoing hysterectomy	Patients undergoing hysterectomy from Oct 1, 2017, to March 1, 2018	Evidence based bundle (ERA)/ standard education packet versus standard education packet	Age, type of surgical procedure	Peri-operative education using the ERA bundle can minimize risks and enhance early recovery	Office visit preop, phone call 2-3 days after discharge using teach back method	N/A
Hall, E.T., Maduro, R.S., Morgan, M.K., McGee, G.W., & Zimbro, K.S. (2021). Impact of a telephonic outreach program on patient outcomes within the heart failure community. Journal of Nursing Care Quality, 36(1), 14-19. https://doi.org/10.1097/NCQ.0000000000000488 [11]	Retrospective program evaluation	Convenience sample of 6271 patients admitted with heart failure [HF]	Patients admitted with HF between January 2015 and June 2017	Telephone outreach program [TOP] included patient education and personal follow up via automatic voice calling system.	Age, gender, race, ethnicity, admission and discharge dates, ICU admission, length of stay, and HF related 30-day readmissions.	TOP enhanced discharge program, improved self-management behaviors, and reduced readmissions when all 4 calls were completed	Four phone calls over a 27-day period.	N/A
Duzyj, C.M., Thornburg, L.L., & Han, C.S. (2020). Practice modification for pandemics: A model for surge planning obstetrics. Obstetrics & Gynecology, 136(2), 237-251. https://doi.org/10.1097/AOG.0000000000004004 [19]	Evidence based review	Not available	Early pregnancy, antepartum, intrapartum, and postpartum patients	Telehealth visits	Early pregnancy, antepartum, intrapartum, and postpartum patients	Adjustment in obstetric care may be necessary during pandemics. Telemedicine may assist in improving access models for patients although exact risks and benefits are unknown and need further research.	Practice modifications during pandemic related events.	
Hoyos, J.P., Alaniz, L., Llerenas, M., Mendoza, R., Tay, E., & Barrios, C. (2021). Post-trauma follow-up phone call shows lower readmission rates for patients discharged from emergency department compared to inpatient stay. American Surgeon, 87(11), 1633-1637. https://doi.org/10.1177/00031348211051694 [12]	Single center Retrospective analysis (pilot study)	1328 trauma patients	Trauma patients discharged from inpatient or ED between 2019-2020	Questionnaire script by NP based on common questions asked upon readmission, Rx given	Readmission rates, race, ED or inpatient	Patients discharged from ED were 47% less likely to be readmitted than inpatient counterparts.	One phone call within 3 days of discharge	N/A

Table 2. to be cont...

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Seward, M.W., Simon, D., Richardson, M., Oken, E., & Gillman, M.W., & Hiyert, M. (2018). Supporting healthful lifestyles during pregnancy: A health coach intervention pilot study. BMC Pregnancy and Childbirth, 18(1), 375. https://doi.org/10.1186/s12884-018-2010-z [15]	One arm trial (pilot study)	30 overweight pregnant women	Pregnant women with pre-pregnancy BMI over 25, mean gestational age of 12.5 weeks	Remote health coach to provide support for healthy lifestyles during pregnancy	Age, self-reported BMI, weeks' gestation	Health coaches were helpful in keeping patients motivated and in providing resources.	Baseline survey at enrollment, follow up online surveys and phone interviews every 2-3 weeks.	American Heart Association, National Institutes of Health
Liu, Y., Luciani-Mcgillivray, I., Hughes, M., Raja, A.S., Kaplan, R.S., & Yun, B.J. (2020). Time-driven activity-based costing of emergency department postdischarge nurse calls. Journal of Healthcare Management, 65(6), 419-428. https://doi.org/10.1097/JHM-D-19-00128 [16]	Retrospective analysis	6,698 patients reached by phone and 6,519 patients not reached by phone	Seven-day return rate for patients discharged from ED between July 2018 and March 2019	Partially scripted phone calls after discharge from fast track and split flow ED model (lower acuity)	Age, gender, race, insurance	Post discharge phone calls were associated with decreased return to ED and may be a cost-effective method for lowering return rates to ED		N/A
Hamilton, R.L., Walloch, J.A., Lauer, K., & Zoch, T.W. (2021). Improving care for patients transitioning from hospital acute care to home. Nursing Economics, 39(2), 59-66. doi.10.62116/nec.2021.39.2.59 [17]	QI approach to Transitional Care Management (TCM) service, current care model	2374 Medicare patient discharges	Readmissions within 30 days.	Analysis of TCM including billing codes, readmission data, follow up appointments with PCP	Number of Medicare patients discharged number of 30-day readmissions	Development of TCM processes has improved transition of care from hospital to home. Increase in number of follow up visits with PCP	Phone call 48 hours post discharge, Follow up visits with PCP.	N/A
Johnson, A.M., Jones, S.B., Duncan, P.W., Bushnell, C.D., Coleman, S.W., Mettam, L.H., Kucharska-Newton, A.M., Sissine, M.E., & Rosamond, W.D. (2018). Hospital recruitment for a pragmatics cluster-randomized clinical trial: Lessons learned from the COMPASS study. Trials, 19 Article 74. https://doi.org/10.1186/s13063-017-2434-1 [18]	Cluster Randomized Clinical Trial	41 eligible North Carolina hospitals	Stroke or transient ischemic attack patients from participating hospitals in 2016	Comparison of COMPASS model versus usual care in improving functional outcomes, readmissions, caregiver strain	Eligible Hospital clusters recruitment strategies	Building and maintaining relationships, need for a diverse skill mix, engaging stakeholders in decision making, and significant preparation and planning are needed.	Phone calls by RNs after 2, 30, and 60 days and in person clinic visit at 7-14 days post discharge.	Patient Centered Outcomes Research Institute Project Award, REDcap support, National Institutes of Health
Emanuel, M.L., Laird, J., Savetamal, A., Burton, T., Wenta, S., & Bartos, S. (2019). Identifying burn patient challenges with implementation of follow-up phone calls. Journal of Burn Care & Research, 40(1), S183-S184. https://doi.org/10.1093/jbcr/irz013.320 [13]	Pilot study	52 burn patients discharged over 4 months	Every patient seen or discharged from a Connecticut Burn Center	A phone call from the assistant nurse manager within a week of discharge reviewing post-discharge burn care and follow-up	Visiting nurse assistance and attendance, need for additional intervention or medication, expedited wound center visits	Post-discharge calls were found to assist in identifying patients needing assistance following discharge, specifically with infection, graft failure, and skilled nursing	1 week	N/A

Table 2: Literature Review Table

Results

An analysis of the ten studies was conducted with common themes identified. The results yielded minimal studies related directly to the postpartum population and follow-up communication, identifying a need for further research. The generalizability of findings to the postpartum population is limited as several included studies evaluated non-postpartum populations (e.g., heart failure, surgical patients). The physiologic trajectory, potential complications, and care needs of these studies differ substantially from the postpartum population which can affect the applicability; however, all the studies evaluated effectiveness of follow-up communication on potential post-discharge complications. Themes that were identified included a reduction in readmission rates following discharge, an earlier identification of complications following discharge, cost-analysis and effectiveness on follow-up communication, and evidence-based practice standards for obstetrical patients.

Reduction in Readmission

A quality improvement project evaluating the impact nurse practitioners have when participating in follow-up phone calls for stroke patients on reducing 30-day readmissions was performed [10]. A sample size of 173 patients from a Comprehensive Stroke Center in south-central Pennsylvania was used during the three-month period where patients would receive follow-up phone calls from the nurse practitioner at seven, 10, and 30 days after discharge. The findings showed a reduction in 30-day readmissions as well as reduced emergency room visits in stroke patients who received phone calls in the post-implementation group [10].

In a retrospective program evaluation of a telephonic outreach program, [11] evaluated the impact a series of phone calls over 27 days to heart failure patients had on readmission rates as well as self-management behaviors. The goal of the study was for patients to be able to better manage heart failure, therefore reducing readmission within 30 days. The study included 12 hospitals in Virginia and Eastern North Carolina with a sample of 6271 adult patients from January 2015 to June 2017. The researchers used a series of four automated phone calls at two, nine, 14, and 27 days post-discharge to survey patients with heart failure maintenance questions. It was found that patients who completed all four phone calls had 11 times lower odds of heart failure-related readmission [11].

A retrospective analysis of discharged trauma patients and the effect follow-up phone calls had on emergency room readmission rates was implemented [12]. The sample included 1328 trauma patients from UCI Medical Center from 2019 to 2020. The initial hypothesis predicted that there would be higher readmission rates to the emergency room with follow-up phone calls in trauma patients. However, the results of the study showed that readmission rates were lower in trauma patients who received follow-up phone calls [12].

Three studies noted a reduction in readmission rates when interventions of follow-up phone calls were utilized [10-12]. In addition, [11] found improved self-management scores in patients who completed all four automated phone calls. Another study discussed how providing phone calls earlier than seven days by a nurse practitioner would be beneficial as the readmissions occurred before the first phone call had taken place post-discharge [11]. A reduction in readmission rates was seen in one study, however, that study was limited in that it was a pilot study [12]. Also, the script was altered throughout the study process, and it was dependent on the patient answering and did not account for readmissions to other emergency rooms or hospitals.

Limitations within these studies existed with a finding that the project time frame of 3 months was too short, the sample size was small, and many participants did not answer the phone [10]. One researcher stated that with the convenience sample acquired in the telephonic outreach program, there were limited covariates to examine the impact of cultural and psychosocial barriers that impact health management [11]. Due to the retrospective nature of the study, [12] found that having multiple nurse practitioners reporting allowed for bias, while a frequently altered script throughout the process provided gaps in data collection.

Early Identification of Complications

A pilot study of follow-up phone calls on 52 patients discharged from a burn center over the course of four months was performed [13]. The follow-up phone calls included questions on general well-being, dressing and wound care, medication, and follow-up appointments. Among the 52 patients within the sample, phone calls identified 21 patients who required additional interventions such as home care visits, nine patients who needed medication or dressing assistance, and 10 who required additional or expedited wound care visits due to pain or risk for infection [13].

In a prospective, comparative, randomized design, [14] evaluated the effect of an enhanced recovery after surgery bundle on improving patient education and patient satisfaction and reducing the length of stay and 30-day readmission in gynecological surgery patients. A sample size of 50 hysterectomy patients from a 28-bed medical-surgical unit was included from October 2017 to March 2018. For the bundle group, follow-up phone calls were provided and included scripted patient education bundles on mobility, pain, appetite, and bowel status as well as a patient satisfaction survey. The findings showed that there were no readmissions and fewer complications identified in the bundle group, whereas the standard education group found no readmissions and more post-surgical complications identified.

A qualitative pilot study was performed that examined the effectiveness of frequent telephonic health coaching for overweight pregnant women in the reduction of weight-related pregnancy complications [15]. A sample of 30 overweight pregnant women in the first trimester was used at a northeastern US clinic from July 2015 to January 2016. Health coaching phone calls were provided every two to three weeks until 36 weeks' gestation and included goal setting and attainment discussions. Health coaches also sent emails or text messages based on participant preference to check in with progress and goals and relayed information to the healthcare provider weekly to ensure consistent communication at appointments. The results showed high participant satisfaction, improved self-efficacy, and improved motivation and attainment of patient goals [15].

Two studies, both saw an earlier identification of complications with more frequent communication [13, 15]. In comparison, another study saw patients in the standard education group with no follow-up phone call had more post-surgical complications; whereas the bundle group was found to have no post-surgical complications before discharge [14]. Another study found that follow-up phone calls helped in identifying a substantial number of complications following discharge for the burn patient, suggesting that detailed and written discharge instructions can be beneficial however, patients often require more assistance to receive optimal care outcomes [13]. Two studies reported higher rates of patient satisfaction in participants that received more follow-up phone calls, suggesting a more trusting relationship between patient and provider [14-15].

One study did not identify any limitations, however suggested that follow-up phone calls may be beneficial in reducing post-burn readmissions and infections [13]. A small sample size and short study duration contributed to the limitations of the study performed by [14]. In addition, due to a non-blinded study, the potential for bias was confounded with the researchers being aware of what group received specified interventions [14]. Seward et al. [15] found that a small sample size including a higher socioeconomic background limited the study, as well as the absence of a control group and baseline data prior to intervention.

Cost-Analysis of Follow-up Communication

Liu et al. [16] performed a quality improvement study that examined the cost-effectiveness of a post-discharge nurse call center in the reduction of emergency room readmissions. The study took place from July 2018 to March 2019 in a large urban, quaternary care, academic, Level 1 trauma center and included a post-discharge nurse call center that was staffed seven days a week with one full-time equivalent registered nurse. Interventions included seven-day return rates to the emergency room, post-discharge calls, and completions of calls as well as other patient demographics. A cost analysis was performed with the national median registered nurse salary, cost of equipment and space for call center, as well as the hospital, provider, and insurance costs of emergency room returns. The findings concluded that the mean cost for a post-discharge phone call was anywhere from $1.20 to $4.69 depending on the length of the call anywhere from 1.1 to 4.3 minutes based on whether the patient was reached. Other findings revealed that the intervention produced an overall savings of $134.89 per patient in reducing readmission [16].

Another quality improvement pilot project looked at increasing transitional care management (TCM) to reduce annual readmissions as well as increased healthcare reimbursement rates from 13% to 50% by using a TCM billing code [17]. The study was performed over three months in 2018 in an integrated health system with a total of 2,374 eligible participants. The intervention included TCM phone calls within 48 hours of discharge by the nurse case manager, a post-discharge appointment with the primary care provider within seven to 14 days, and an improved process of medication reconciliation. Results showed a 30-day readmission reduction rate of 1.1%, and a 50% increase in TCM billing codes showing an increase in reimbursement by $5,601 a month without utilizing any additional staff [17].

Johnson et al. [18] performed a pragmatic, cluster-randomized trial evaluating hospital recruitment strategies for the implementation of the Comprehensive Post-Acute Stroke Services (COMPASS) post-acute stroke care model in improving patient functional status, reducing readmissions, mortality, healthcare utilization, non-adherence, and caregiver role strain. Interventions of the COMPASS study include early discharge planning with TCM, nurse-led follow-up phone calls at two, 30, and 60 days post-discharge, and a follow-up visit at seven to 14 days. The study took place in 41 eligible North Carolina hospitals from September 2015 to September 2016 and found that barriers to hospital recruitment in the COMPASS study were lack of staff and financial resources, healthcare market competition, and lack of understanding of the added clinical value to the patient population. Strategies to address these barriers included tailoring the COMPASS trial to the unique needs and demands of the hospital and engaging in solution and research-based conversations with healthcare administrators [18].

In evaluating the cost-analysis of follow-up patient communication, results from two studies indicated that the use of follow-up phone calls staffed by a nurse or nurse case manager, decreased healthcare costs while also increasing healthcare reimbursements [16-17]. An additional study also discussed how readmission rates significantly decreased during the call center implementation supporting the cost-effective strategy of follow-up communication in improving outcomes [16]. One group [17] also found that follow-up communication by a registered nurse helped develop a more supportive and caring relationship between patients and provider with more patients attending follow-up appointments where corrective interventions were needed. Johnson et al. [18] found inconclusive results on the impact a widely used follow-up care protocol could have on multiple institutions, with hospital recruitment being the largest barrier to overcome. Building relationships with healthcare stakeholders and having diverse representation with varying skill mixes was suggested as a solution to improve recruitment of hospitals for future project implementation [18].

A lack of a control group was identified in one study as well as finding that race and insurance status varied between participants reached and not reached, indicating a need for more varied socioeconomic backgrounds [16]. One researcher found that the three-month study duration was too short to determine overall cost benefit of follow-up communication [17]. Johnson et al. [18] found that while the study included multiple hospitals and eligible participants, it is limited in that it represents the experiences of only one trial that may not be well duplicated with other populations, providers, or interventions.

Evidence-Based Practice Standards

The American College of Obstetricians and Gynecologists (ACOG) performed an evidence-based review on the pandemic-adjusted modifications in obstetric care focusing on telehealth strategies and modalities considering the coronavirus pandemic [19]. Suggested modifications throughout pregnancy include the use of telephone intake calls, virtual parent education classes, and text messaging updates. Integrating the use of healthcare applications to monitor blood pressure, weight, blood glucose, and diet logs for gestational diabetic and pre-eclamptic patients was also suggested. Modifications in the postpartum state included expanded screening and communication of postpartum depression and mental health disorders with the infant's pediatrician as well as follow-up in-person or telemedicine visits at three and 12 weeks postpartum. There are currently no recommendations for expanded healthcare surveillance past 12 weeks postpartum with ACOG endorsing a decreased length of inpatient hospital stay for obstetric services using enhanced recovery methods to reduce the use of hospital resources during a pandemic.

Discussion

The literature review identified several common themes among eligible studies, notably a reduction in readmissions, early identification of post-discharge complications, and potential cost benefits associated with structured follow-up communication. Although these studies were conducted in non-obstetric populations including heart failure, trauma, stroke, and burn patients, it can be suggested that post-discharge phone calls may improve patient outcomes through several plausible mechanisms [10-12]. Among these studies, it was found that earlier recognition of concerning symptoms, timely medication reconciliation, clarification of discharge instructions, and improved navigation of follow-up care all contributed to improved patient outcomes in diverse populations [10-12]. Emanuel et al. [13] demonstrated that follow-up phone calls facilitated early detection of complications among burn patients while other studies showed that the absence of structured communication was associated with higher complications rates [14]. Seward et al. [15] further highlighted how phone-based health coaching during pregnancy enhanced self-management, goal attainment, and trust in providers, factors that are particularly relevant in the postpartum period, when patients must monitor rapidly evolving physical and emotional changes. Although these findings are encouraging, transferability to the postpartum population requires careful interpretation. Postpartum physiology, complication trajectories, and social contexts differ substantially from those of cardiology, trauma, or surgical populations. For example, postpartum hemorrhage, hypertensive disorders, infection, and mental health conditions often progress quickly and may be under-recognized by patients without structured guidance. Therefore, while reductions in readmissions observed in non-obstetric settings are hypothesis generating, it cannot be assumed to apply directly to postpartum cohorts. In addition, none of these studies meeting inclusion criteria evaluated follow-up phone calls or text messaging specifically during the postpartum period, underscoring a significant evidence gap.

A cost-analysis from two studies [16-17] suggest that follow-up communication programs may be fiscally beneficial, though these findings should be interpreted with caution. Cost savings

demonstrated in non-obstetric populations may not generalize to postpartum care, where reimbursement structures, Transitional Care Management (TCM) billing, and insurance coverage vary widely. Additionally, implementation barriers identified in the literature included staffing constraints, challenges in recruiting hospitals for large collaborative projects, and limited scalability can mirror known obstacles in postpartum care delivery [16-18]. Other barriers likely to affect postpartum follow-up include electronic health record (EHR) integration, language access, digital divide concerns, and inconsistent availability of remote monitoring tools. Furthermore, findings in another study suggested enhanced recovery and postpartum health surveillance up to 12 weeks postpartum, citing the need for healthcare resources in other areas during a pandemic [19].

While these findings are significant and demonstrate the value of post-discharge phone calls, there were no studies meeting inclusion criteria that discussed the direct impact of post-discharge communication during the postpartum period. Equity considerations are also an essential component with follow-up communication in the postpartum period, given the stark racial disparities in pregnancy-related deaths in the United States. Follow-up communication protocols must be intentionally designed to reduce and not further widen these disparities. Strategies may include multilingual scripts, culturally responsive communication, flexible scheduling, integration of community health workers, and hybrid models that combine phone calls, text messaging, and remote monitoring (e.g., blood pressure of glucose tracking). Such approaches may help ensure that postpartum individuals at highest risk receive timely support and guidance.

Future research should prioritize postpartum-specific investigations that evaluate optimal timing, frequency, and modality of communication. Studies are needed to determine whether weekly contact, hybrid call-and-text models, or symptom-specific check-ins (e.g., blood pressure monitoring for hypertensive disorders) are most effective. Research should explore patient-centered assessment strategies, including the types of questions, symptoms, and self-reported findings that best predict early postpartum complications. Additionally, implementing frameworks that could help identify barriers and facilitators to integrate structured postpartum communication into routine care, including staffing models, reimbursement pathways, and digital infrastructure requirements may be beneficial. Overall, while existing literature demonstrates the potential value of post-discharge communication, the absence of postpartum-specific evidence highlights a critical gap. Addressing this gap is essential for developing effective equitable, and scalable postpartum follow-up strategies capable of improving early complication detection and reducing preventable pregnancy-related deaths.

Limitation

Several limitations should be considered when interpreting the findings of this review. The evidence base was highly heterogenous, consisting primarily of non-postpartum populations, which limits the transferability of results to postpartum individuals and highlights the lack of direct postpartum-specific evidence. Studies varies substantially in intervention characteristics and outcome measures, with outcomes including readmissions, emergency department visits, complication identification, patient satisfaction, and cost, making comparisons across studies difficult. Many included studies were limited by small sample sizes, short follow-up periods, and potential selection bias related to convenience sampling or inclusion of only participants successfully contacted after discharge. Additionally, the review was restricted to two databases and to peer-reviewed, English language, US-based studies, excluding non-nursing and gray literature, potentially limiting comprehensiveness of the search. Therefore, the findings should be considered exploratory and hypothesis-generating rather than definitive evidence supporting structured postpartum follow-up communication.

Conclusion

This narrative review identified important gaps in existing literature regarding structured follow-up communication after hospital discharge and its potential relevance to postpartum care. Across non-obstetric populations, including heart failure, trauma, stroke, and burn patients, post-discharge phone calls were consistently associated with reduced readmission, earlier identification of complications, improved self-management, and favorable cost implications. These findings suggest that structured communication may support timely recognition of concerning symptoms and strengthen continuity of care. However, due to the lack of studies that included postpartum cohorts, these themes identified should be considered as hypothesis generating rather than conclusive for postpartum practice.

The review highlights a critical evidence gap: despite the high burden of postpartum complications and the disproportionate number of pregnancy-related deaths occurring within the first six weeks postpartum, there is minimal research examining whether follow-up phone calls or text messaging improve early detection of postpartum complications. As a result, current evidence does not demonstrate that follow-up communication can reduce maternal mortality; rather, it suggests that structured post-discharge contact may enhance early symptom recognition, facilitate timely intervention, and improve care navigation, all mechanisms that could plausibly benefit postpartum individuals.

Future research should prioritize rigorous, postpartum-specific studies that evaluate the effectiveness of follow-up communication in reducing complications and improving early detection. Studies should examine optimal timing, frequency, and modality of communication; identify patient-centered assessment strategies that can reliably detect early postpartum warning signs; and evaluate implementation barriers such as staffing, digital access, language needs, and reimbursement constraints. Equity-focused approaches are essential, given persistent racial disparities in pregnancy-related deaths. Well-designed postpartum communication interventions have the potential to strengthen surveillance during the highest-risk period, but further evidence is needed before definitive conclusions can be drawn.

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Conflicts of Interest

The authors declare no conflicts of interest.

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