With decreasing reimbursement and penalties for 30-day readmissions that particularly affect Medicare patients, healthcare systems worry that they will have to absorb unsustainable costs (Hansen, Young, Hinami, Leung, & Williams, 2011). In response, many hospitals are trying to identify low-cost solutions to minimize 30-day readmissions. The complexity of the discharge process coupled with patients’ stress about leaving the hospital as soon as possible causes a higher likelihood of readmission. Nurses, pharmacists, social workers, and other healthcare providers work to give patients all of the information they need before leaving the hospital. However, patients often remain underinformed, problems arise, and they are then readmitted. Readmissions have been linked to poor communication, failure to coordinate and reconcile medications, lack of postdischarge follow-up, and poor planning for care transitions (Berenson, Paulus, & Kalman, 2012; Harrison, Hara, Pope, Young, & Rula, 2011). With the current focus on preventing readmissions, healthcare providers are trying to identify strategies to support patients during the postdischarge period.

Patients with cancer are particularly affected by readmissions because they require inpatient care more often than other patients and have complex needs (e.g., medication, symptom management). The complexity and diversity of care requirements create substantial challenges in planning for appropriate postdischarge support (Mistiaen & Poot, 2006). Implementing postdischarge telephone calls for patients with cancer could serve as a low-cost intervention to address the complex needs of patients during the transition from hospital to home. The goal of the current literature review is to provide an understanding about postdischarge telephone calls in patients with cancer. Findings from this review support the notion that discharge phone calls could improve care continuity for patients transitioning from hospital to home. The literature review outlines information related to telephone call content, timing, and structure for healthcare systems that want to use a postdischarge telephone intervention for patients with cancer. However, additional research is needed to develop and test cancer-specific protocols.

**Telephone Follow-Up**

The literature search strategy included a bifurcated approach to identify a broad range of pertinent publications.
(see Figure 1). Seven articles were identified that examined postdischarge telephone calls to patients with cancer. Diagnoses included hematologic or solid tumor malignancies, lung cancer, prostate cancer, colorectal cancer, and primary rectal cancer. Therapeutic interventions among the patients included chemotherapy, thoracotomy, radical prostatectomy, and colorectal surgery. The articles included four randomized, controlled trials (RCTs); one prospective nonrandomized, controlled trial; one nonrandomized quasi-experimental study; and one qualitative exploratory study. An eighth study involving a retrospective cohort design examined telephone calls postdischarge among patients with chronic disease; that study was included on the basis that cancer is a chronic disease. Table 1 provides more comprehensive details about each of those investigations.

**Telephone Interventions**

Most of the studies used a protocol or structured process for the postdischarge telephone calls (e.g., systematic surveys and instructions, semistructured interviews, structured checklists, preset questionnaires). Harrison, Young, et al.'s (2011) pilot RCT of the CONNECT intervention was the most detailed study reported. In that intervention, the calls were standardized according to a specific protocol. Nurses used a structured checklist to avoid missing important areas of concern, but the checklist left room for individualization. Allowing for individualization provided a more personal telephone call. An automated telephone call lacks flexibility, which may be a reason not to use such a system.

**Number and Timing of Calls**

Specific recommendations regarding the number of telephone calls during the postdischarge period were not identified in the literature. However, multiple calls as opposed to a single telephone call were identified as beneficial. Three studies used a single telephone call, and five studies used multiple calls, ranging from 2–8 calls. The timing of the first telephone call ranged from 2–14 days postdischarge. The CONNECT intervention made telephone calls on days 3 and 10 postdischarge, as well as at 1, 3, and 6 months. Patients who participated in that intervention were satisfied with the number and timing of calls, which were the two factors evaluated for feasibility and acceptability six months into the pilot.

The CONNECT study results indicated that a multiple-call intervention improved quality-of-life scores at six months. Three days postdischarge was found to be the most critical time for a phone call, as patients expressed more of their needs on that day (Harrison, Young, et al., 2011). A prospective RCT using a single telephone call did not have an effect on the outcome measures of patient satisfaction and sense of security (Jenson, Kristensen, Christensen, & Borre, 2011). Those findings suggest that multiple calls may be more satisfying for patients and give them a greater sense of security compared to a single phone call. Patients showed improved overall level of rehabilitation, bowel function, catheter care, wound care, and pain control in the intervention group (Jenson et al., 2011). However, patients still benefited from a single call, as it was better than no call. The single phone call was made on day 3 postdischarge, which is considered the most critical day by the CONNECT intervention.

**Callers**

Callers included a clinical pharmacist, RNs with specialized knowledge and certification in oncology, clinical nurse specialists, and an automated system. No outcomes related to the type of caller were assessed. Therefore, little is known as to which caller would provide the most benefit to patients. However, patients have reported satisfaction with nurse-led calls because of nurses' knowledge and clinical background (Chung & Hwang, 2008).

**Outcome Measurement**

Measuring outcomes after an intervention with a validated tool adds credibility to a study. Aubin et al. (2012) conducted a review on care continuity in patients with cancer that included telephone interviews, and they suggested that researchers use only validated instruments in future research to improve analysis. Five of the eight articles in the table of evidence used validated measurement tools.

**Content**

Identifying the most effective topics for use in a postdischarge telephone call can be challenging. All articles in the
TABLE 1. Table of Evidence

<table>
<thead>
<tr>
<th>Study</th>
<th>Objective</th>
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<tbody>
<tr>
<td>Beney et al., 2002</td>
<td>To evaluate the effectiveness of telephone follow-up on physical well-being in patients with cancer</td>
<td>RCT involving 150 participants, 74 of whom were controls. Participants were aged 18 years or older and were patients with hematologic or solid tumor malignancies who were discharged to home after receiving chemotherapy in an inpatient or outpatient setting. Participants were recruited from the University of California–San Francisco Medical Center.</td>
<td>Telephone follow-up call by a clinical pharmacist was made 48–72 hours after discharge. Researchers measured physical well-being, social and family well-being, emotional well-being, functional well-being, overall QOL, and symptom frequency and severity. Measurement tools used included the FACT-G (Cronbach alpha = 0.89) and the Memorial Symptom Assessment Scale (Cronbach alpha = 0.85).</td>
<td>Variance analysis showed no difference in physical well-being between patients who received the intervention and those in the control group. Problems were identified in 46–70 call-back patients.</td>
<td>High-risk patients in the control group may have received a telephone intervention from another healthcare professional unrelated to the RCT. Postintervention QOL scores were evaluated only once. Twenty-seven patients were lost to follow-up, and the global response rate was 82%.</td>
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<tr>
<td>Chung &amp; Hwang, 2008</td>
<td>To examine the differences in outcome between routine health education and health education on self-care, symptom distress, and QOL delivered through telephone-based surveys</td>
<td>Nonrandomized, quasi-experimental trial involving 70 participants, 35 of whom were controls. Participants were aged from 18–65 years and were patients with leukemia who were recruited from a hematology/oncology unit at a medical center in northern Taiwan after they received a cycle of chemotherapy in the hospital.</td>
<td>Usual care was performed, and telephone calls were made by a hematologist/oncology nurse with 10 years of experience at one week and three weeks postdischarge. Systematic surveys and instructions were used. Researchers measured self-care, symptom distress, and QOL. Measurement tools included three self-administered questionnaires at four weeks postdischarge when patients returned to the hospital for blood work, the Self-Care Agency Questionnaire (Cronbach alpha = 0.95), Symptom Distress Scale–Chinese Modified Form (Cronbach alpha = 0.83), and SF-36™–Taiwan version (Cronbach alpha = 0.96).</td>
<td>Symptom distress was significantly lower and QOL was significantly higher for patients who received the intervention as opposed to the control group.</td>
<td>The trial included a nonrandom design and used a small scale. The article does not comment on participants lost to follow-up.</td>
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<tr>
<td>Cleeland et al., 2011</td>
<td>To determine whether at-home symptom monitoring with feedback to clinicians about severe symptoms contributes to more effective postoperative symptom control</td>
<td>Two-armed RCT involving 79 participants, 41 of whom were controls. Participants were patients with lung cancer who underwent a thoracotomy and were recruited from the University of Texas MD Anderson Cancer Center.</td>
<td>Patients rated symptoms twice weekly for four weeks postdischarge via automated telephone calls. For the intervention group, an email alert was sent to the patient clinical team for response, if any, of a subset of symptoms (e.g., pain, disturbed sleep, distress, shortness of breath, constipation) reached a predetermined severity threshold. No alerts were generated for the control group. Researchers measured symptom threshold events, severity, and interference, as well as patient satisfaction with treatment, responsiveness of clinic, and patient assessment of the IVR system. The measurement tool used was the MD Anderson Symptom Inventory (Cronbach alpha = 0.82–0.94).</td>
<td>All participants completed the four-week intervention. The intervention group was found to have greater reduction in symptom threshold events (19% versus 8%), a faster decline in symptom threshold events, and a weekly decrease in symptom interference. Clinicians responded to 84% of email alerts. Both groups reported equally high satisfaction with the automated system and with postoperative symptom control.</td>
<td>No group was monitored without automated telephone calls. The study was small and needs confirmation with a larger sample.</td>
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FACT-C—Functional Assessment of Cancer Therapy–Colorectal; FACT-G—Functional Assessment of Cancer Therapy–General; IVR—interactive voice response; QOL—quality of life; RCT—randomized, controlled trial
### TABLE 1. Table of Evidence (Continued)

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<td>Harrison et al., 2009</td>
<td>To determine whether telephone follow-up can ensure patient understanding of and adherence to discharge orders and reduce readmission rates</td>
<td>A retrospective cohort study including 30,272 participants, 23,499 of whom were controls. All participants were from a commercial health plan with Medicare Advantage who were enrolled in a chronic disease management program and were hospitalized for any reason in 2008.</td>
<td>The study used a hospital discharge campaign, where participants received a telephone call if they were not readmitted within 14 days of discharge prior to that call. The call was made by an RN to ask specific questions.</td>
<td>Older age, male gender, and increased initial length of hospitalization were associated with an increased likelihood of hospital readmission. The post-discharge telephone call was associated with reduced rates of readmission, with the intervention group being 23% less likely to be readmitted to the hospital than the control group.</td>
<td>The study used a retrospective design, and it cannot conclude that the decrease in readmissions was from the telephone call.</td>
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<td>Harrison, Young, et al., 2011</td>
<td>To determine the effectiveness of a nurse-delivered telephone supportive intervention</td>
<td>Pilot RCT involving 75 participants, 36 of whom were controls. Participants were patients who were surgically treated for colorectal cancer and were recruited from the Royal Prince Alfred Hospital in Sydney, Australia.</td>
<td>Researchers used the CONNECT intervention, which included five calls from a specialist colorectal nurse in the six months after initial hospital discharge. Each call was standardized according to CONNECT protocol. The control group received standard follow-up. Researchers measured unmet supportive care needs; health service use; and QOL at one, three, and six months post-discharge. Measurement tools included the Supportive Care Needs Survey Short Form (Cronbach alpha = 0.87), the FACT-C (Cronbach alpha = 0.85), and the Cancer Survivors’ Unmet Needs Measure (Cronbach alpha = 0.96).</td>
<td>At six months post-discharge, researchers saw a clinically relevant, although nonsignificant, reduction in emergency department visits and hospital readmissions among the intervention group when compared to the control group. Total QOL scores were higher for the intervention group after six months. The use of hospital- and community-based specialists and services was higher in the intervention group as opposed to the control group, but differences were not statistically significant.</td>
<td>The study used a small sample size and a heterogeneous study sample, which led to variability of unmet needs. Self-reported data need verification to enhance reliability of results. Eight participants in the intervention group were lost to follow-up, withdrew from the study, or were excluded because of declining health or death.</td>
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<tr>
<td>Jenson et al., 2011</td>
<td>To investigate whether nurse-led telephone consultations could optimize resources and secure rehabilitation and patient satisfaction after radical prostatectomy</td>
<td>Prospective RCT involving 95 participants, 49 of whom were controls. Participants included men with prostate cancer referred for radical prostatectomy and were recruited from a urology center.</td>
<td>Telephone follow-up calls were made three days postdischarge by two clinical nurse specialists. Calls lasted about 15 minutes, and a semistructured interview style was used. Researchers measured patient satisfaction, sense of security, catheter management, postoperative wound care, pain control, bowel function, and activities of daily living. Patients filled out questionnaires at their two-week postoperative clinic visit.</td>
<td>Telephone follow-up did not increase patient satisfaction or sense of security, and it did not decrease postoperative discomfort for participants in the intervention and control groups. The intervention was found to improve bowel function, catheter care, and pain control in the intervention group. Level of rehabilitation was significantly better in the intervention group as opposed to the control group.</td>
<td>The questionnaire was designed for the study and was not fully validated, and psychometrics were not clearly established.</td>
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FACT-C—Functional Assessment of Cancer Therapy—Colorectal; FACT-G—Functional Assessment of Cancer Therapy—General; IVR—interactive voice response; QOL—quality of life; RCT—randomized, controlled trial
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<td>Young et al., 2010</td>
<td>To assess feasibility, acceptability, and possible effects of a nurse-delivered telephone intervention to reduce unmet needs and improve QOL</td>
<td>Prospective nonrandomized, control trial involving 41 participants, 21 of whom were controls. Participants were patients who underwent surgery for colorectal cancer and were recruited from a hospital in Sydney, Australia.</td>
<td>Researchers used the CONNECT intervention, which included five calls at days 3 and 10 postdischarge and at one, three, and six months postdischarge. Calls were made by nurses with structured checklists that covered six areas (i.e., general health, wound, bowel function, appointments, psychosocial needs, and information needs). The checklist included a conversation starter, but the nurse had flexibility to respond to specific needs. Researchers measured the feasibility and acceptability of the intervention, as well as unmet supportive care needs, psychological distress, and disease-specific QOL. Measurement tools included the Supportive Care Needs Survey Short Form (Cronbach alpha = 0.85) and the FACT-C (Cronbach alpha = 0.86–0.96).</td>
<td>The highest number of needs was recognized on day 3 postdischarge. Patients indicated that the timing of the calls was appropriate, and 85% felt the number of calls was sufficient. FACT-C scores demonstrated improvement over time for the intervention group.</td>
<td>The study used a non-randomized design and a small scale to assess feasibility and acceptability. The intervention group had slightly higher scores than patients in the control group at baseline. Three participants (15% of the intervention group) were lost to follow-up at six months.</td>
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<tr>
<td>Zhang et al., 2012</td>
<td>To explore and describe the content of telephone intervention conversations</td>
<td>Qualitative exploratory study that used content analysis of the 25 intervention phone calls of 12 randomly selected subjects. Fifty-nine participants were in the intervention group of the main study. Participants were patients with primary rectal cancer and permanent colostomy and were recruited from a university-based cancer center in China.</td>
<td>In the main study, phone calls were made by a nurse with 10 years of stoma care experience and stoma care certification. Calls in the qualitative study were guided by protocol developed in the main study. The calls included assessment, intervention, and management options. Each participant received at least two phone calls, one between days 3–7 and one between days 14–20 postdischarge. An additional call was provided between days 23–27 if additional follow-up was needed.</td>
<td>The study identified five themes that may help develop protocol, including education for stoma care, access to stoma care, encouraging self-care, resuming normal living, and general postoperative problems. Those themes could be managed via telephone. Patient information needs were satisfied. Some patients required face-to-face follow-up, but the telephone call allowed for arrangements to be made.</td>
<td>Because the study took place in China, calls may have been better received if they encompassed the family unit as opposed to the individual, according to culture.</td>
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FACT-C—Functional Assessment of Cancer Therapy–Colorectal; FACT-G—Functional Assessment of Cancer Therapy–General; IVR—interactive voice response; QOL—quality of life; RCT—randomized, controlled trial

table of evidence except one provided some information about phone call content. Results from the qualitative content analysis by Zhang, Wong, You, and Zheng (2012) suggested that topics addressed in the telephone conversations were appropriately and effectively managed, and information needs were satisfied. Nurses could identify when patients needed face-to-face appointments, and the call enabled them to assess and intervene. Specific areas of call content were identified through the review that would provide a well-rounded telephone phone call intervention for patients with cancer. Researchers found that patient well-being, symptom distress, appointments and referrals, medication adherence, self-care strategies, advice, emotional state, reinforcement of behavior, and psychosocial and information needs should be discussed during the phone call (Beney et al., 2002; Chung & Hwang, 2008; Cleeland et al., 2011; Harrison, Young, et al., 2011; Young et al., 2010; Zhang et al., 2012).

Automated Telephone Calls

The literature search identified automated telephone systems as a low-cost option for improving care continuity after discharge for patients with cancer. In a study by Cleeland et al. (2011), the intervention and control groups received automated telephone calls that prompted participants to rate their symptoms. An email was sent to the patient’s clinical team for participants with symptom
ratings that met a predetermined threshold, indicating that they may need additional supportive care. The advanced practice RNs were responsible for responding to the email alerts. Alerts to clinicians added benefit to the automated system and allowed the clinical team to intervene when necessary. The automated telephone system was acceptable to patients and beneficial for postdischarge symptom monitoring.

Analysis of Selected Related Literature

The authors reviewed related literature to gain additional understanding of telephone interventions. The reports did not use discharge phone calls as defined in the current literature review, but they involved some type of telephone intervention for patients with cancer. Many articles were identified regarding the acceptability and feasibility of post-treatment, nurse-led telephone follow-up in place of regular visits to a clinic (Anderson, 2010; Beaver et al., 2009; Booker et al., 2004; Cusack & Taylor, 2010; Dixon, Pituskin, Fairchild, Ghosh, & Danielson, 2010; Kimman et al., 2011; Livingston, White, Hayman, & Hill, 2006). Telephone follow-up has helped to optimize and streamline care continuity in ambulatory oncology (Wilson & Hubert, 2002). Cox et al. (2006) questioned patients with lung cancer about their follow-up preferences, and the patients said that they would find nurse-led telephone follow-up acceptable.

Nurse-led telephone follow-up has proven to be cost effective and logistically beneficial for high-volume oncology clinics (Kornblith et al., 2006). Patients have reported being highly satisfied with nurse-led telephone follow-up and prefer it for convenience (Beaver, Williamson, & Chalmers, 2010; Shaida et al., 2007). Nurses also are satisfied with telephone follow-up and feel that they are able to meet the needs of patients (Anderson, 2010; Beaver et al., 2010).

When postdischarge telephone calls are made, patients with cancer have experienced reduced distress levels (Kornblith et al., 2006). That finding is particularly important because psychological distress in patients with cancer coincides with medication and symptom management. Symptoms of anxiety and depression can affect physiologic symptoms (e.g., pain) and may interfere with medication schedules and adherence. Therefore, psychological and physiologic symptoms should be considered when deciding which questions to include in a follow-up telephone call postdischarge from hospital to home.

Patients at home do not always report their symptoms to healthcare providers for a variety of reasons, such as fear of being told to go to the emergency department. Asking targeted questions via telephone allows the caller to identify treatment-specific side effects and intervene by offering information, symptom management, and self-care strategies, or by scheduling urgent office visits when needed (Lynch, Marcone, & King, 2010). Knowing that patients should be asked specific questions is valuable when creating questions for a telephone follow-up intervention.

The reviewed literature related to telephone interventions offers insights that are important to remember when developing a pilot project for follow-up telephone calls for patients with cancer postdischarge from hospital to home. Training or education should be provided to callers via inservice programs or role-play scenarios before participating in a telephone follow-up interven-

Implications for Practice

- Evaluate the complex care needs that render many patients vulnerable during the transition from hospital to home.
- Make telephone calls following patients’ discharge from the hospital as a low-cost intervention that may facilitate a more effective transition to home and fewer readmissions.
- Determine the value of postdischarge telephone calls in patients with cancer with the development, implementation, and testing of phone call models, as well as by identifying specific outcome measurements.

Systematic Reviews

Systematic reviews also were assessed as related literature. Those reviews were not limited to patients with cancer; they included patients with diverse diagnoses. Shepperd et al. (2010) reviewed literature on individualized, structured discharge plans and concluded that providing structured discharges “probably brings about small reductions in hospital length of stay and readmissions” (p. 2). Because of a lack of description and diversity in the structure of discharge and outcome measurements, researchers were not able to draw firm conclusions. Ten of the 21 RCTs in that review included telephone follow-up as an intervention. The positive results in that review indicate that postdischarge telephone follow-up can be categorized as a structured discharge intervention that holds potential for decreasing readmissions to the hospital.

Hansen et al. (2011) systematically reviewed interventions designed to reduce 30-day rehospitalizations. The review included 43 data-based articles, and follow-up telephone calls postdischarge were the most frequently studied intervention. Telephone calls were included as a component of a discharge bundle or acted as a stand-alone intervention. Discharge bundles involved additional interventions (e.g., a postdischarge hotline, homecare visits, postdischarge telephone calls). Four randomized trials evaluated the effect of discharge bundles that included follow-up telephone calls, and they demonstrated a statistically significant reduction on 30-day readmissions among patients who received the intervention. Studies investigating postdischarge telephone calls as a single intervention were not found to be significant, which suggests that single interventions could be less effective than bundled interventions. Ten of the 17 studies investigating follow-up telephone calls used protocols or scripts as guides. Topics for those calls included symptom and medication review, as well as confirmation of outpatient follow-up plans. Although the review findings were inconclusive, Hansen et al. (2011) noted that all randomized trials demonstrating significant results included postdischarge telephone calls and patient-centered discharge instructions as part of the discharge bundle. The heterogeneity of interventions, lack of specific descriptions, and inconsistent outcome measures are recognized as limitations of that review (Hansen et al., 2011).
Description of the postdischarge phone call process and specific information about the phone call content often is missing from studies. Using postdischarge telephone calls to prevent readmissions appears promising, but reviewing the literature has shown that the multiple variables involved with postdischarge phone calls are inconsistently implemented and documented and, as a result, data on the effectiveness of telephone interventions are limited.

Similar inconsistency and variability were reported in a review that focused on assessing the effects of telephone follow-up within the first month of discharge from the hospital (Mistiaen & Poot, 2006). Mistiaen and Poot (2006) included 33 studies, but many were of low methodologic quality. Of those, four were related to oncology. Telephone calls were made primarily by nurses (22 studies). The amount of calls ranged from one to a series of 32 calls, and calls were made within the first week postdischarge in 28 of the studies. Strict protocols for telephone calls were found in three studies, but no articles described the intervention in detail. All researchers measured outcomes using self-developed tools, which made pooling results impossible. Although some studies found positive results related to telephone follow-up, no consensus existed on who should deliver the telephone call or the time, frequency, length, aim, and structure of the calls. Patients reported that they found follow-up telephone calls valuable, but the effects are not shown in the review. Large-scale, high-quality studies with detailed description of interventions, controls, and outcomes are imperative for demonstrating whether benefit exists from follow-up telephone calls postdischarge from hospital to home.

A review by Aubin et al. (2012), focused on interventions that would improve continuity of care in follow-up for patients with cancer. The review included a meta-analysis of 51 studies and gives insight into the discharge process from hospital to home for patients with cancer. Although reviews of three care models are the primary focus of the review, six specific interventions were examined, and one of those involved telephone follow-up. Aubin et al. (2012) concluded that telephone follow-up does not clearly improve outcomes for patients with cancer, and additional study of telephone follow-up is recommended. Many studies included in the review did not report measureable outcomes secondary to design and intervention variability. However, the review recognized that patients expressed greater satisfaction with nurse-led follow-up as opposed to regular follow-up. Bohnenkamp, McDonald, Lopez, Krupinski, and Blackett (2004) reported increased satisfaction in patients with cancer who had telenursing follow-up versus the group of patients who received postdischarge homecare visits. Aubin et al. (2012) suggested that researchers measure continuity of care using a validated instrument and measure a mix of patient and process outcomes to enhance analysis when performing additional research.

Implications for Nursing

The first days and weeks at home after discharge from the hospital are the most critical for many patients. Rehospitalization can result when a patient encounters difficulties with activities of daily living, information needs, and symptom and medication regimen management. Telephone follow-up can serve as a way to exchange information, provide health education and advice, manage symptoms, recognize complications early, reassure patients, and provide high-quality care (Mistiaen & Poot, 2006). It also could improve care continuity for patients during the transition from hospital to home. The articles in the table of evidence support that statement for patients with cancer.

However, additional research is needed to develop a cancer-specific protocol for telephone calls postdischarge from hospital to home. Determining which population of patients with cancer are readmitted more frequently and for what reasons could help researchers create more targeted and directive telephone calls, which could help decrease readmissions. Oncology nurses can help lead and advance research on telephone follow-up by using their clinical knowledge and patient relationship skills.

Conclusions

Telephone calls postdischarge from the hospital are a structured, cost-effective intervention that could potentially decrease 30-day readmissions. However, current literature does not provide strong support because of poor study quality, variation in the practice of postdischarge telephone calls, variety of outcome measurement, and lack of outcome measurement using validated instruments. Although postdischarge telephone calls are valued by patients, additional research should address study design and outcome measurement issues to prove statistical significance.

References


**Credits**