Since the 1990s, telephone interventions have been used as a potentially effective way to provide psychosocial care for patients with cancer (Gotay & Bottomley, 1998). That approach was thought to be particularly promising for patients who may not otherwise receive psychosocial care because of factors such as geographic isolation, physical limitations, or a lack of comfort with face-to-face approaches. However, situating routine telephone follow-up supportive care for patients with hematologic malignancies in the literature is complex because the extant research covers many topics with little commonality. The majority of research conducted on telephone follow-up care for patients with cancer focused on clinical care rather than supportive care management. In the clinical literature, most research, with the exception of Compaci, Ysebaert, Obéric, Deurmeeuws, and Laurent’s (2011) study, rarely mentions research for telephone follow-up as supportive care for patients with hematologic malignancies. 

Available research on telephone supportive care in place of clinical care for patients with cancer largely focused on diagnostic groups other than hematologic malignancies (e.g., colorectal cancer, prostate cancer, gynecologic cancers, breast cancer) (Crane-Okada et al., 2012; Cusack & Taylor, 2010; Pistrang, Jay, Gessler, & Barker, 2012; Scura, Budin, & Garfing, 2004). Each type of cancer has specific factors that affect the psychosocial challenges of the disease and its treatment that render the generic term “cancer” meaningless and make generalizations about supportive care strategies less useful. 

Considerable variation exists in the literature for patients’ preferences for supportive services. Telephone support can be offered to patients and caregivers individually or as a group (Gotay & Bottomley, 1998; Walsh & Schmidt, 2003). Extensive research documented the different psychosocial and supportive care needs for patients and caregivers, and participants differed in preferences for an individual or group approach.