

Nurse-Led Telephonic Symptom Support for Patients Receiving Chemotherapy

Andra Davis, PhD, MN, RN, Janice F. Bell, MN, MPH, PhD, FAAN, Sarah C. Reed, PhD, MPH, MSW, Katherine K. Kim, PhD, MPH, MBA, Dawn Stacey, RN, PhD, CON(C), FAAN, and Jill G. Joseph, MD, PhD

PROBLEM STATEMENT: The use of evidence-informed symptom guides has not been widely adopted in telephonic support.

DESIGN: This is a descriptive study of nurse-led support using evidence-based symptom guides during telephone outreach.

DATA SOURCES: Documentation quantified telephone encounters by frequency, length, and type of patient-reported symptoms. Nurse interviews examined perceptions of their role and the use of symptom guides.

ANALYSIS: Quantitative data were summarized using univariate descriptive statistics, and interviews were analyzed using directed descriptive content analysis.

FINDINGS: Symptom guides were viewed as trusted evidence-based resources, suitable to address common treatment-related symptoms. A threshold effect was a reported barrier of the guides, such that the benefit diminished over time for managing recurring symptoms.

IMPLICATIONS FOR PRACTICE: Telephone outreach using evidence-based symptom guides can contribute to early symptom identification while engaging patients in decision making. Understanding nurse activities aids in developing an economical and high-quality model for symptom support, as well as in encouraging nurses to practice at the highest level of preparation.

KEYWORDS symptom management; practice guidelines; patient-centered care; evidence-based practice
ONF, 47(6), E199–E210.

DOI 10.1188/20.ONF.E199-E210

Cancer care is complex, and costs are expected to reach \$246 billion by 2030—an increase of 34% since 2015 (Mariotto et al., 2020). Most people with cancer are older adults (aged older than 65 years) and are often living with at least one comorbidity (Williams et al., 2016). In fact, the top four most prevalent cancers have high rates of comorbidity (lung = 53%, colorectal = 41%, breast = 32%, prostate = 31%) (Williams et al., 2016). Accordingly, providers routinely engage in decision making related to cancer therapy in the context of other complex health conditions while communicating and coordinating care with an evolving cast of primary care providers and specialists (American Society of Clinical Oncology [ASCO], 2016; McCorkle et al., 2011; Nekhyudov et al., 2014).

Not surprisingly, significant gaps in communication and shared decision making remain, and clinicians often misjudge patients' preferences and needs (Levit et al., 2013). At the same time, individuals with cancer indicate the value of being active participants in the making of health-related decisions (Alston et al., 2012). An Institute of Medicine (IOM, 2001) report titled *Crossing the Quality Chasm: A New Health System for the 21st Century* illustrates a relationship among poor care coordination when providers are at multiple sites, inadequate symptom management, medical errors, and higher costs.

Handley et al. (2018) address future reimbursement changes that amplify the need for a more deliberate approach to cancer care delivery and support. These authors highlight predicted reimbursement reductions for outpatient Medicare payments based on efforts to reduce variation by assessing quality of care and evidence of performance improvement. Embedded in Handley et al.'s (2018) five-tiered strategy to reduce acute care utilization is enhanced access to the care team and care coordination, as well as the use of standardized clinical pathways for symptom support.