Home Infusion  
Community Oncology Alliance Position Statement

Community Oncology Alliance Position:
The Community Oncology Alliance (COA) fundamentally opposes home infusion of chemotherapy, cancer immunotherapy, and cancer treatment supportive drugs because of serious patient safety concerns. Home infusion by a provider – who may or may not be a trained oncology nurse – and may not recognize and be prepared to treat any adverse reactions – whether simple, significant, or even lethal – that may occur as a common part of an infusion of cancer drugs is of significant concern. Many of the side effects caused by cancer treatment can have a rapid, unpredictable onset that places patients in incredible jeopardy and can even be life-threatening. Home infusion negates the benefits of the expertise and team approach to cancer care, which are the hallmarks of community oncology, within facilities specifically designed for safe and effective cancer drug infusions.

During the COVID-19 (novel coronavirus) pandemic, community oncology practices are taking extreme measures to keep their facilities and providers COVID-19 free so that their patients can be assured of receiving treatment in the safest environments. Oncologists are using telehealth when appropriate to monitor patients and prioritize treatment while working with patients to ensure that the most urgent treatments are delivered.

COA notes that there are other medical specialties and the diseases they treat where the infusion of Medicare Part B drugs at home may be reasonable during the COVID-19 pandemic. As a result, COA currently limits this position and opposition to the home infusion of cancer.

Background:

In the treatment of cancer, infusion therapy, a cornerstone of most cancer care, supplants taking pills or liquid drugs orally with intravenous administration, which distinguishes cancer care from the care of most other diseases. Prior to the early 1980s, infusion therapy was done only in hospitals but now is more commonly conducted in lower-cost outpatient infusion therapy centers (typically a physician-owned or hospital-affiliated outpatient cancer center).

As chemotherapy migrated from the inpatient setting to the outpatient setting, some have suggested that the next logical progression is home infusion. Home
infusion would have a major impact on patient safety and continuity of care. On a fundamental level, a patient’s cancer treatments are ever-changing and require modifications on a routine basis. Patients need face-to-face, high-touch evaluations and re-evaluations with each cycle of treatment for safety, to address adverse side effects, and to determine the efficacy or lack thereof. It makes little sense that a patient’s visit to assess treatment would be separated from a specialized treatment setting under the direction of their physician into an unsupervised home environment.

While cancer treatments, in general, have become less toxic, modern cancer treatments are still very complex and involve combinations that can include chemotherapy, biologics, immunotherapy, and supportive agents (e.g., growth factors). The number of combinations and treatments involved increases the incidence of potential adverse reactions and interactions that could take place. Consider targeted therapies like modern monoclonal antibodies and small molecule inhibitors that have transformed cancer treatment. While these drugs are life-saving for patients, researchers have found that they are also among the top entries for spontaneous adverse drug reports in the FDA Adverse Event Reporting System.¹ For these reasons, and more, the majority of oncologists conclude that home infusion is not appropriate or safe for patients with cancer.

In community oncology practices, an oncology nurse, who has additional training and certification, administers chemotherapy and immunotherapy. Oncology nurses are specifically trained to administer the dangerous medications used in cancer chemotherapy and immunotherapy and to observe, identify, and treat any adverse reactions. In the event of an adverse reaction, a team, including other nurses, oncologists, pharmacists, and even social workers, are available to manage serious infusion reactions. Although adverse reactions are infrequent, they are not rare and do occur. These significant side effects need to be managed expertly for patient safety and comfort. Typical responses require two or more nurses to acutely stabilize the patient depending on the nature of the reaction. In an outpatient infusion center setting, this expertly trained and experienced care team has at hand many options to address any reactions and ensure patient safety. Such teams are not available in the home environment.

Home infusion has inherent limitations in the level of care that can be provided and emergency interventions available to the individuals who are overseeing it. Even when specifying that the administration of drugs would be by a professional specifically trained to administer these therapies, such individuals could not ensure
patient safety without the backup of a team and necessary equipment and supportive drugs. In many areas, there is a shortage of specially trained oncology nurses, further impacting the quality and safety of cancer care in a home setting. Risk-reduction measures for administering chemotherapy in nontraditional health care settings, such as the home, require instituting a two-person dose-verification system; educating everyone who will administer and handle these agents; and developing procedures for securely and appropriately storing chemotherapy agents. The tools used to address adverse reactions, such as oxygen, other drugs to mitigate reactions, or a full care team are not available in the home infusion setting. This makes home infusion too dangerous for many patients with cancer. The need for appropriate support, in the form of emergency medications and/or equipment or supplies, is not feasible. The necessary tools to preserve patient safety simply are not available. Additional issues such as compliance, proper follow-up care, and administrative complexity all make home infusion an inadequate option for patients with cancer.

There are appropriate, specialized applications for chemotherapy administered in the home. Lengthy infusions of chemotherapy drugs using infusion pumps, as is often done in lymphomas and colorectal cancer treatment, are an example. However, these infusions are initiated and discontinued in a qualified cancer treatment center as prescribed and managed by a coordinated cancer care team, and the equipment used (e.g., wearable infusion pumps) is FDA-approved and tested to ensure patient safety and well-being.

**Summary:**

Infusion cancer therapies are complex, composed of multiple combined treatments and therapies, and frequently adjusted to account for factors such as age, weight, comorbidities, prior cycle toxicities, current state of disease, and clinical considerations at the time of treatment. They are also based on the expert, observed opinion of the treating physician who is trained to see and consider multiple factors for each individual patient. Oncology nurses who administer infusion therapies as part of the team are part of this evaluation and management. The ability to address all these factors in the moments before cancer treatment is part of the components of care provided by oncologists and protects the safety of patients and, ultimately, their prognosis.

Home infusion unnecessarily and dangerously separates care administration from the safety of a cancer clinic and the supervision by a physician. Once home infusion
treatment begins, the individual administering the treatments does not have access to the team of providers, additional drugs, tools or equipment to deal with a potential adverse reaction which can be sudden, severe, and life-threatening. The inherent lack of access to an experienced and trained team during home infusion is a threat to patient treatment, outcomes, and safety. Therefore, COA strongly opposes home infusion of chemotherapy, cancer immunotherapy, and supportive drugs. It is not an appropriate option for patients with cancer.

**Date:**
Approved by the Board of Directors of COA on April 8, 2020.

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