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# HOME PHLEBOTOMY AS ENABLING INFRASTRUCTURE FOR CANCER CARE AT HOME AND DECENTRALIZED CLINICAL TRIALS

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## ABSTRACT

**Importance:** Review about care at home often treats acute hospital-at-home, tele-oncology, home laboratory collection, and decentralized clinical trials as variants of the same model, despite major differences in clinical intensity, payment pathways, and operational risk. **Objective:** To evaluate whether home phlebotomy should be treated as enabling infrastructure for cancer care at home and decentralized clinical trials, with focused assessment of the Cancer Center (a large NCI-designated comprehensive cancer center in the United States) implementation, the National Cancer Institute (NCI) MATCHES program and MSK, and publicly available evidence regarding myOnsite Healthcare. **Evidence Review:** This narrative review was conducted on March 5, 2026, using PubMed, PubMed Central, and official or institutional sources from CMS, MedPAC, NCI, FDA, and a large NCI-designated comprehensive cancer center in the United States. Public myOnsite materials were reviewed separately and classified as company-reported evidence. Twenty-four sources were included: 12 peer-reviewed articles, 6 official policy or regulatory sources, 2 institutional sources, and 4 company-reported sources. **Findings:** National acute hospital-at-home evidence suggests clinical promise but operational and financial fragility. CMS reported lower overall mortality but mixed readmission effects, slightly longer length of stay, and lower 30-day postdischarge spending for more than half of the most common diagnosis-related groups studied.[2] MedPAC documented limited uptake and substantial delivery friction.[3] In contrast, the MSK home phlebotomy study reported 345 patients, 1,464 home visits, and 5,104 specimens, with 1 clotted specimen, 0 hemolyzed specimens, and 147 of 149 surveyed patients (99%) stating they would use the service again or recommend it.[1] The MATCHES/TRACE initiative at MSK embeds home laboratories, remote monitoring, and treatment-at-home elements into tele-oncology research.[9-14] **Conclusions and Relevance:** Home phlebotomy appears more operationally tractable than full inpatient substitution and may represent a high-value enabling layer for oncology care at home and decentralized trials. The strongest near-term opportunity is not generic home visits but protocolized, institution-integrated, specimen-safe execution.

**KEYWORDS:** Home phlebotomy, cancer care at home, decentralized clinical trials, tele-oncology, hospital-at-home.

## INTRODUCTION

Cancer care has become progressively more outpatient, but not necessarily less burdensome. For many patients, the largest remaining friction is not the clinician interaction itself; it is the repeated travel, waiting, bloodwork, and monitoring infrastructure required to make treatment decisions safe. The large NCI-designated comprehensive cancer center, MSK in the United States home phlebotomy implementation study quantified part of that burden, noting that patients with cancer spend a substantial amount of time each month on treatment-related activities and that more than half of that time can be consumed by commuting and waiting.[1]

That observation matters because public discussion of "care at home" often conflates several very different models: acute inpatient substitution, oncology hospital-at-home, tele-oncology follow-up, home-based ancillary services, and decentralized research operations. These models have overlapping rhetoric but different clinical intensity, staffing requirements, capital needs, reimbursement pathways, and failure modes. The literature now suggests that the broad acute hospital-at-home model can produce good outcomes in selected populations, but that its economics remain highly sensitive to payment design and local operating realities.[2-6]

This review focuses on a narrower and arguably more actionable question: whether home phlebotomy should be treated as enabling infrastructure for oncology care at home and decentralized clinical trials. It also evaluates the current evidence around the NCI MATCHES program at a large NCI-designated comprehensive cancer center in the United States, the published MSK's mobile phlebotomy study, what can and cannot be said about myOnsite's involvement, and what adjacent evidence suggests about patient demand and willingness to pay.

## METHODS

This manuscript was developed as a narrative evidence review intended for publication-oriented synthesis rather than as a formal systematic review. Sources were identified on March 5, 2026 through targeted searches of PubMed and PubMed Central and through direct review of official CMS, MedPAC, NCI, FDA, and MSK's web resources. Search domains included acute hospital-at-home economics and outcomes, oncology hospital-at-home, cancer telehealth delivery, mobile or home phlebotomy, decentralized clinical trials, and willingness to pay or preference for home-based care. Priority was given to comparative studies, implementation papers, economic evaluations, and official guidance. Public myOnsite materials were included only for claims specifically concerning a large NCI-designated comprehensive cancer center in the United States-specific workflows or company-reported ongoing support and are explicitly presented as lower-tier evidence subject to confirmation bias and limited external verification.

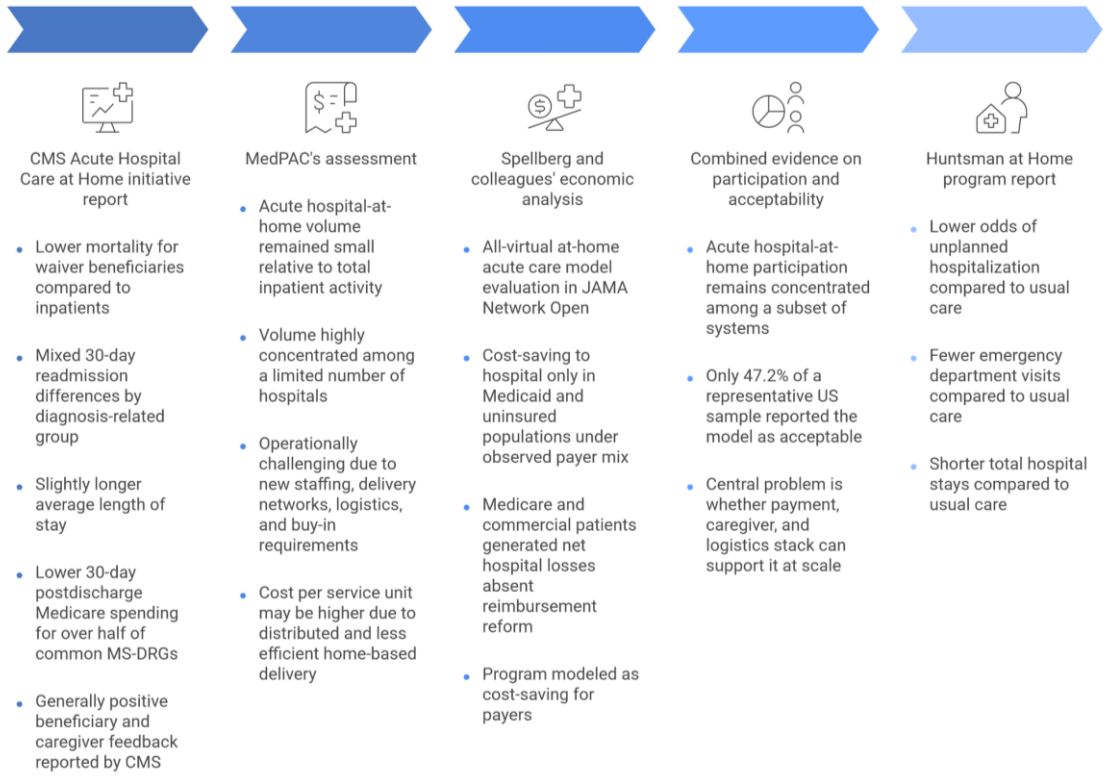
### Broader Hospital-at-Home services importance

Recent US evidence supports neither triumphalism nor dismissal. CMS's 2024 report on the Acute Hospital Care at Home initiative found that beneficiaries treated under the waiver generally had lower mortality than comparison inpatients, mixed 30-day readmission differences by diagnosis-related group, slightly longer average length of stay, and lower 30-day postdischarge Medicare spending for more than half of the most common MS-DRGs studied. CMS also reported generally positive beneficiary and caregiver feedback.[2]

At the same time, MedPAC's assessment was notably more cautious. It documented that acute hospital-at-home volume remained small relative to total inpatient activity, highly concentrated among a limited number of hospitals, and operationally challenging because programs required new staffing, community delivery networks, laboratory and equipment logistics, and institutional buy-in. MedPAC also emphasized that even if beneficiaries receive fewer services at home, the cost per service unit may be higher because home-based delivery is inherently more distributed and less efficient than centralized inpatient care.[3]

The economic analysis by Spellberg and colleagues reinforces that point. In their 2025 JAMA Network Open evaluation of an all-virtual at-home acute care model, the program was cost-saving to the hospital only in Medicaid and uninsured populations under the observed payer mix. Medicare and commercial patients generated net hospital losses absent reimbursement reform, even though the program was modeled as cost-saving for payers.[4] Taken together with evidence that acute hospital-at-home participation remains concentrated among a subset of systems and that only 47.2% of a representative US sample reported the model as acceptable, these data suggest that the central problem in broad hospital-at-home is not simply whether home-based acute care can be clinically safe; it is whether the payment, caregiver, and logistics stack can support it at scale.[5,6]

Oncology-specific acute care at home may perform better than the generalized public debate implies. The Huntsman at Home program reported lower odds of unplanned hospitalization, fewer emergency department visits, shorter total hospital stays, and substantially lower 30-day costs relative to usual care in a real-world comparison.[7] A follow-up subgroup analysis found directionally consistent benefit across a wide spectrum of patient groups, with no subgroup favoring usual care.[8] Even so, these findings arise from a mature, integrated program and should not be naively generalized to every delivery environment.




**Why Home Phlebotomy Is Different From Full Hospital-at-Home**

Home phlebotomy sits in a different operational and economic category from full acute care substitution. A robust mobile laboratory workflow does not require a command center, 24-hour escalation capacity, inpatient nursing intensity, or the full ancillary network required to reproduce hospital-level care in the home. What it does require is different: reliable patient identification, institution-specific ordering and labeling, technician training, specimen handling, courier timing, laboratory receipt, result routing, and accountability for errors. That narrower scope makes home phlebotomy both easier to pilot and easier to justify than a full hospital-at-home service line.[1,3,4]

It also addresses one of the most persistent barriers to moving cancer care out of the clinic. Telehealth can replace the conversational components of oncology visits, but it cannot by itself replace bloodwork, vital signs, toxicity checks, drug administration, or sample-dependent trial procedures. The result is a common operational failure mode: nominal telemedicine that still forces the patient back into the clinic for every lab-dependent decision. The practical consequence is that the patient experiences only a fraction of the promised convenience while the care team still bears the complexity of hybrid care.[9,11,14]

This is why home phlebotomy deserves to be analyzed not as a hospitality feature but as infrastructure. In oncology, blood collection is frequent, standardized, safety-relevant, and often prerequisite to treatment continuation. If the laboratory workflow fails, the broader care-at-home workflow fails with it.

**Comprehensive cancer center in the United States's Home Phlebotomy Implementation**

The strongest currently available implementation evidence comes from a large NCI-designated comprehensive cancer center in the United States. In the published 2024 JNCI Cancer Spectrum study, 345 patients completed 1,464 home laboratory collection visits across New York, New Jersey, Connecticut, and Pennsylvania.[1] Of 5,104 samples collected, there was 1 clotted specimen, 0 hemolyzed specimens, 1 unlabeled specimen, and no cancellations attributed to sample stability, contamination, or other collection deficiencies.[1] These performance metrics exceeded the Department of Pathology and Laboratory Medicine benchmarks used in the evaluation.[1]

The patient-experience results were similarly strong. Among 149 respondents, 147 (99%) said they would use the service again or recommend it to others.[1] The paper is important not merely because satisfaction was high, but because the workflow was embedded into standard care and electronically integrated into ordering and result reporting.[1] In other words, this was not a concierge pilot running around the health system; it was a genuine operations intervention inside a National Cancer Institute Comprehensive Cancer Center.

**MATCHES, TRACE, and the Shift From Televisits to Tele-enabled Care**

A comprehensive cancer center in the United States's mobile phlebotomy work is not an isolated operational experiment. The NCI Telehealth Research Centers of Excellence (TRACE) initiative funds multiple centers to build evidence on telehealth-enabled cancer care, including MATCHES (Making Telehealth Delivery of Cancer Care at Home Effective and Safe) at a large NCI-designated comprehensive cancer center in the United States.[10]

The MATCHES center description is especially useful because it makes explicit what many health systems still treat implicitly: telehealth is not simply video. MATCH-UP, the cluster-randomized pragmatic a NCI-designated cancer center at Home trial for patients with breast or prostate cancer receiving hormone therapy or selected oral treatments, integrates telehealth appointments, home-based laboratory testing, treatment at home, and vital-sign monitoring at home.[9,11] MATCH-IO, the pilot for patients receiving pembrolizumab-based immunotherapy, similarly combines extended-interval in-person treatment with interim telehealth toxicity assessments, remote monitoring devices, and at-home phlebotomy as clinically indicated.[9]

A cancer center in the United States institutional report on this work described a median patient experience score of 9 out of 10, with 94% of participants perceiving benefit and more than three-quarters reporting that at-home visits were less stressful than in-person care.[14] Although institutional news is not equivalent to peer-reviewed comparative research, it provides context for how a cancer center is operationalizing its broader tele-oncology agenda. Importantly, both the trial design language and the patient-facing reporting converge on the same point: home phlebotomy is one of the enabling services that converts telehealth from a communication channel into a care-delivery model.[9,11,14]

**Implications for Decentralized Clinical Trials**

The relevance to decentralized clinical trials is immediate. FDA's final guidance on decentralized elements defines DCTs as trials in which activities occur away from traditional trial sites and explicitly recognizes telehealth visits, in-home visits by remote trial personnel, and use of local health care providers.[15] The guidance also emphasizes that sponsors must coordinate contracted services, document data origin and data flow, identify service providers, and specify which activities occur remotely versus at sites.[15] For home phlebotomy operators, those requirements translate into concrete obligations around protocol-specific training, chain of custody, source attribution, turnaround timing, and data handoff.

In oncology, where trial eligibility and treatment continuation often depend on laboratory thresholds, biospecimen workflows remain one of the hardest components to decentralize cleanly. The JAMA Network Open survey by Daly and colleagues found that oncology lags broader clinical development in adoption of decentralized technologies, but it also identified strong interest in remote approaches that can reduce patient burden and improve trial accessibility.[16] von Itzstein and colleagues similarly noted that telemedicine can improve trial access and efficiency, but that biospecimen collection remains a practical challenge that must be solved for remote models to mature.[17]

This is precisely where home phlebotomy can create disproportionate value. In fee-for-service clinical care, the unit economics of home blood draws may be debated. In trials, the economic logic is different: sponsors purchase adherence, retention, geographic reach, and data completeness, not DRG substitution. If protocol-compliant home laboratory collection reduces missed visits, broadens recruitment, or keeps a participant on study who would otherwise withdraw because of travel burden, it may be valuable even when it does not resemble a conventional reimbursable care service.[15-17]

**Patient Preference**

Direct evidence on willingness to pay for oncology home phlebotomy specifically is still missing, and that gap should be acknowledged rather than papered over. However, several adjacent literatures point in the same direction. In a contingent valuation study of 139 patients with cancer receiving blood transfusions, the median willingness to pay for home transfusion was €26.[5] per patient, with greater willingness to pay among those living farther from the hospital, those with poorer quality of life, and those with prior home-care experience.[18]

Patient-preference evidence from outside oncology also suggests that blood collection is a meaningful source of burden. In a 2022 study of chronic care patients, 71% preferred at-home blood sampling and 31% reported conventional phlebotomy time as burdensome; the at-home approach increased phlebotomy-specific costs but reduced total societal costs because of gains in productivity and reduced travel burden.[19] A systematic review of willingness to pay for telemedicine found that the proportion willing to pay ranged from 19% to 70%, with greater distance from care associated with greater willingness to pay.[20]

The comprehensive cancer center in the United States implementation paper adds an important but distinct signal: acceptability rather than stated willingness to pay. Nearly all surveyed patients said they would use the service again or recommend it.[1] That is not the same as observing out-of-pocket demand, but it is strong evidence that patients perceive value. The most defensible current conclusion is that patient demand for home-based, burden-reducing services is real, but the oncology field still lacks direct home-phlebotomy willingness-to-pay studies that can quantify price

sensitivity, substitution effects, and how those preferences vary by diagnosis, treatment intensity, distance to care, and caregiver availability.

**Strategic Implications for Health Systems, Payers, and Service Operators**

For health systems, the lesson is to disaggregate the category. The economics of full acute hospital-at-home should not be assumed to apply to every home-based service in oncology. The national evidence base shows why: acute hospital-at-home requires high fixed setup, dense operations, and payment models that may or may not reward the hospital for moving care home.[2-6] Home phlebotomy, by contrast, can be evaluated as modular infrastructure with a narrower risk envelope and clearer operational metrics.

For oncology centers, the value proposition of home laboratory collection is threefold. First, it directly addresses time toxicity and clinic friction.[1,9,14] Second, it enables more credible tele-oncology pathways by removing one of the main reasons patients must return in person.[9,11,14] Third, it creates infrastructure that can be repurposed for decentralized or hybrid research, where specimen collection is often the limiting step in broadening access.[15-17]

For operators such as myOnsite, the defensible differentiation is not simply the ability to place a phlebotomist in a home. The differentiators that matter are protocol adherence, client-specific workflows, label and LIS integration, courier reliability, specimen integrity, and auditable execution.[1,21-24]

For payers and policymakers, one implication is that reimbursement strategy may need to distinguish between inpatient-substitution models and enabling home services. The former implicate DRGs, medical necessity rules, and caregiver burden. The latter may be better analyzed through the lenses of access, episode efficiency, adherence, and avoidance of unnecessary in-person utilization. More granular payment design may be more productive than forcing every form of home-based care into a single policy bucket.

**Research Gaps**

Several research gaps now stand out. First, the field needs direct oncology-specific economic evaluations of home phlebotomy, including center-level costs, patient-incurred costs, and downstream effects on missed or delayed treatment. Second, willingness-to-pay should be studied directly rather than inferred from adjacent services. Third, comparative implementation studies should examine vendor-operated versus internally staffed home laboratory programs. Fourth, equity analyses should test whether home phlebotomy reduces or reproduces disparities, particularly when digital devices, caregiver support, and language access are part of the model. Fifth, DCT-specific work should quantify how home biospecimen collection affects screen-failure rates, protocol deviations, retention, and data completeness.[1,9,15-20]

**Limitations**

This review has several limitations. It is a narrative synthesis rather than a formal systematic review. The published oncology home phlebotomy literature remains small, and much of the most concrete implementation evidence comes from a single institution. Evidence concerning myOnsite's role in the NCI-designated cancer center in the United States program is triangulated from a peer-reviewed article, a public full-text table label, and current company materials, but we did not locate an independent public contract document or official cancer center in the United States statement explicitly naming the vendor. Finally, willingness-to-pay evidence for home phlebotomy in oncology is indirect; current conclusions rely on adjacent literature from home transfusion, telemedicine, and at-home blood sampling.

## CONCLUSIONS

The current evidence supports a more precise thesis than the general hospital-at-home debate usually allows. Acute hospital-at-home can be clinically promising but economically fragile, particularly in fee-for-service environments.[2-6] Oncology care at home should therefore not be judged solely through the lens of broad inpatient substitution. Instead, the better near-term path may be the progressive relocation of specific, repeatable, high-friction tasks to the home.

Among those tasks, home phlebotomy appears unusually important. The cancer center in the United States implementation demonstrates that an institution-integrated mobile laboratory workflow can achieve high specimen quality and high patient acceptability.[1] The MATCHES program shows that major cancer centers are now designing tele-oncology research around precisely this type of enabling service.[9-14] FDA guidance and the emerging DCT literature suggest that the same operational capability has growing relevance in research settings where geography and travel burden remain major barriers.[15-17]

**Table 1: Summary on home phlebotomy and adjacent home-based care models.**

| Source | Evidence Base | Key Findings | Implication for Home Phlebotomy Thesis |
|---|---|---|---|
| Acute hospital-at-home (national) | CMS 2024 AHCAH report[2] | Lower mortality overall; mixed readmissions by MS-DRG; slightly longer LOS; lower 30-day postdischarge spending for more than half of top MS-DRGs studied. | Clinical promise exists, but results vary by condition and are not equivalent to a universal economic win. |
| Acute hospital-at-home (national) | MedPAC 2024 chapter[3] | Uptake remained small and concentrated; start-up, network, staffing, laboratory, and equipment logistics were persistent barriers; lower service volume at home does not guarantee lower provider costs. | Operational maturity and payment design are major determinants of viability. |
| Acute hospital-at-home (market adoption) | Zikry et al, 2025[5] | Hospital participation continued but remained concentrated and uneven. | Scale is still limited and not representative of all hospitals. |
| Acute hospital-at-home (public acceptance) | Frasco et al, 2024[6] | 47.2% found hospital-at-home acceptable; caregiving capacity varied materially. | Patient and caregiver acceptance cannot be assumed. |
| Home phlebotomy in oncology | Bange et al, 2024[1] | 345 patients; 1,464 visits; 5,104 samples; specimen integrity exceeded benchmarks; 99% of surveyed patients would use again or recommend. | Home lab collection is technically feasible and highly acceptable when integrated into institutional workflow. |
| Tele-oncology infrastructure | MATCHES/MATCH-UP/MATCH-IO[9-14] | NCI-designated cancer center NCI-funded tele-oncology platform embeds home laboratories, remote monitoring, and selected treatment-at-home workflows. | Home phlebotomy is being designed as core infrastructure rather than optional convenience. |
| Decentralized clinical trials | FDA guidance and related literature[15-17] | DCTs require explicit management of local providers, laboratories, at-home visits, data flow, and contracted services. | Home phlebotomy can function as research infrastructure when protocol, chain-of-custody, and data-governance requirements are met. |

**Table 2: Evidence classification for statements about myOnsite's role in the a NCI-designated comprehensive cancer center in the United States ecosystem.**

| Inference | Source Type | What It Mainly Supports |
|---|---|---|
| The published study used an external mobile phlebotomy company. | Peer-reviewed article text[1] | The Methods section states cancer center in the United States 'partnered with a mobile phlebotomy company.' |
| myOnsite was likely the vendor used in the published implementation. | Public full-text table label in PMC[1] | Table 1 is rendered as 'myOnsite sociodemographic information.' |
| myOnsite maintains comprehensive cancer center s-specific operational workflow materials. | Public myOnsite course page[21] | Page describes an 'NCI-designated cancer center Process flow' for specimen collection and return to hospital lab. |
| myOnsite reports its customized labels/EMR workflow benefited cancer center in the United States. | Company news post[23] | Company states its EMR/LIS and label workflow benefited clients. |
| myOnsite states it supports complex partners including organizations. | Company blog[24] | Public 2026 blog references support for complex partners. |

**Table 3: Operational comparison of full acute hospital-at-home, oncology home phlebotomy, and decentralized trial home visits.**

| Dimension | Hospital-at-Home | Home Phlebotomy | DCT Home Visits | Operational Relevance |
|---|---|---|---|---|
| Primary clinical task | Substitute part of inpatient acute care. | Replace repeated clinic-based blood draws and associated logistics. | Enable protocol-required sample collection and selected assessments near or in the home. | Helps define whether the model is a care-delivery line, enabling service, or research utility. |
| Operational intensity | High: 24/7 escalation, physician/nursing oversight, ancillary network. | Moderate: scheduling, phlebotomy, labeling, couriering, laboratory receipt, result routing. | Moderate to high depending on protocol: site coordination, chain of custody, source documentation, local provider oversight. | Home phlebotomy is narrower and therefore easier to pilot than full acute HAH. |
| Core failure mode | Clinical deterioration or inadequate escalation. | Specimen error, missed draw, labeling/courier failure, delayed turnaround. | Protocol deviation, sample mishandling, data-origin ambiguity, missed windows. | Different models fail for different reasons and should not share one generic business case. |
| Payment logic | DRG/episode payment, waiver or contract dependent. | May be embedded in episode budgets, payer programs, self-pay, or vendor contracts. | Sponsor-funded trial infrastructure rather than routine care reimbursement. | Economic value must be matched to the actual purchaser. |
| Patient value | Avoid hospitalization, stay home, potentially lower exposure burden. | Reduce travel, waiting, treatment disruption, and time toxicity. | Reduce trial travel burden; improve participation and retention. | Home blood draws often create immediate, tangible patient value even without full home-based care. |
| Evidence maturity | Growing but mixed and payment-sensitive. | Early but technically strong in oncology implementation literature. | Regulatory framework is clearer than outcomes evidence; operational evidence still maturing. | Home phlebotomy currently has a more tractable evidence-development path than full inpatient substitution. |

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