But there's also this expansion of this dedicated workforce. And nurse practitioners seem to be really driving a lot of this increase in volume. You can see here the comparison between physician decline in

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This is all nurse practitioners that ever did a home. And even if they did one visit in the entire year. And this is those that did 10. So these are more dedicated home-based primary care providers, albeit not much. It's still just 10 visits in the year. But again, you can see there's not much change.

Scope of practice really isn't impacting the volume for either the people that do a little bit, or the people that do a little bit more than a little bit. It's the same. And again, these results are not significant. So moving on to our quality question, does the home-based primary care by NPs differ much from that provided by physicians?

And we first wanted to look at our patient population. Are they sicker? How do they differ? How is that going to impact what their quality outcomes end up being? So here, the green is all Medicare beneficiaries, regardless if you're a home-based primary care patient or not. So think of it as a comparison to the general population. Dark gray is still physicians, blue is nurse practitioners, and the light gray is a team-based approach.

So a little bit by NPs, a little bit by physicians. And this is age. So you can see that their age is about the same for NPs and physicians, but much higher than the general population. In terms of disability, there's not that much difference. They're definitely more disabled than the general population, and NPs maybe still a little bit fewer, but not much.

In terms of frailty, I think this is really important to think about when you hear our later results. The NP patients are more frail. Definitely, all of them that are receiving home-based primary care are more frail than the general population, but the NP patients are a little bit more frail than the physician patient, which echoes Dr.

Nick Porter's [SP] message that NPs actually, yes, in some settings, there seems to be consistent evidence that we're providing care for more complex patient populations. And that's consistent with other papers that have come out specific to the Medicare population.

- So these are forest plots showing the relationship between provider type and care delivery, specifically acute care events. We're going to spend just a moment talking through some interpretation here.

The physician-only group is the reference category, and they're represented as the dot at the line representing basically no relationship. They're at one here.

Okay? And the nurse practitioner-only, and the mixed groups are represented by the dot, and then the error bars. The error bars showing the confidence interval of the point estimate. So the dot and...

Oops, sorry. The dot and the error bars sort of make those look like the TIE fighters from "Star Wars." Right? So you can distinguish a significant result by seeing if the wings of the TIE fighter cross the line of one where the reference category is.

If they do cross that, that's not a statistically significant result. So the models here also demonstrate an interaction term with the beneficiaries whose home was in skilled nursing facility.

And we sort of showed their estimates separately. And the models control for age, and sex, and race frailty, and 30 different co-morbidities. And these models hold state constant. So what this is showing is that the beneficiaries who had NP-only home-based primary care had about 26% higher odds of acute care admission, and about 13% higher odds of an avoidable ED visit.

Here you see that this slide shows the preventive care composites by provider type. Beneficiaries with NP-only care had 22% lower scores in the prevention composite, 24% lower in the chronic care composite, and 4% higher odds of influenza immunization compared to the reference group, which is physician only.

So in a population who are older, and frailer, and sicker than the general population of older adults, it appears that NPs prioritize end-of-life care.

Beneficiaries with NP-only care had more than twofold higher odds of having their advanced care directive counseling done. They had 45% higher odds of being in hospice at the time of their death, and

We're here to provide you with the data. But I hope that this has given you a really good overall sense of this resurgence of this unique setting. Thank you. Happy to take questions.

- [Female] Thank you so much for your presentation. I actually used to do home-based care, so your presentation really resonated. I was wondering about if you refer to this as home-based primary care? How does that overlay with the consensus model? Which looks at primary care and acute care separately for nurse practitioners.

And that your certification is in one area, or the other, or both if you're dual certified. But I'd just be interested in your thoughts on that.

- That's an excellent question. I'm going to turn to the expert on the consensus model for this.

- Yeah. The consensus model has these sort of two tracks in an environment where both skill sets are called upon, and that becomes really difficult. It almost seems like the ideal nurse practitioner has both their acute care certification, as well as their primary care certification.

- So they would do both educational programs?

- So the definition of primary care, especially according to the consensus model, it's longitudinal care has a lot to do with it. And you can provide primary care in an acute care setting in the traditional definition of the consensus model.

And in this particular situation, when care has been moved to the home, it's all gray, right? It's all subjective. And one can make a case one way or the other. But I could see how this could shift more towards primary care for a particularly complex acute population.

- Yeah. And the definition of acute care ePt nBT/F1 12 T025 366.38 Tm0 g0 G[(Y)66(e)7(h. A)66(nd t)7(he)7(de)7(fi)7(n)20(