Counterpart Health

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# Driving Clinical Excellence in Chronic Disease: Counterpart Assistant's Role in Heart Failure Care

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**Executive Summary**

**Counterpart Health empowers primary care providers (PCPs) to better manage chronic diseases such as heart failure by leveraging its flagship software platform, Counterpart Assistant (CA):**

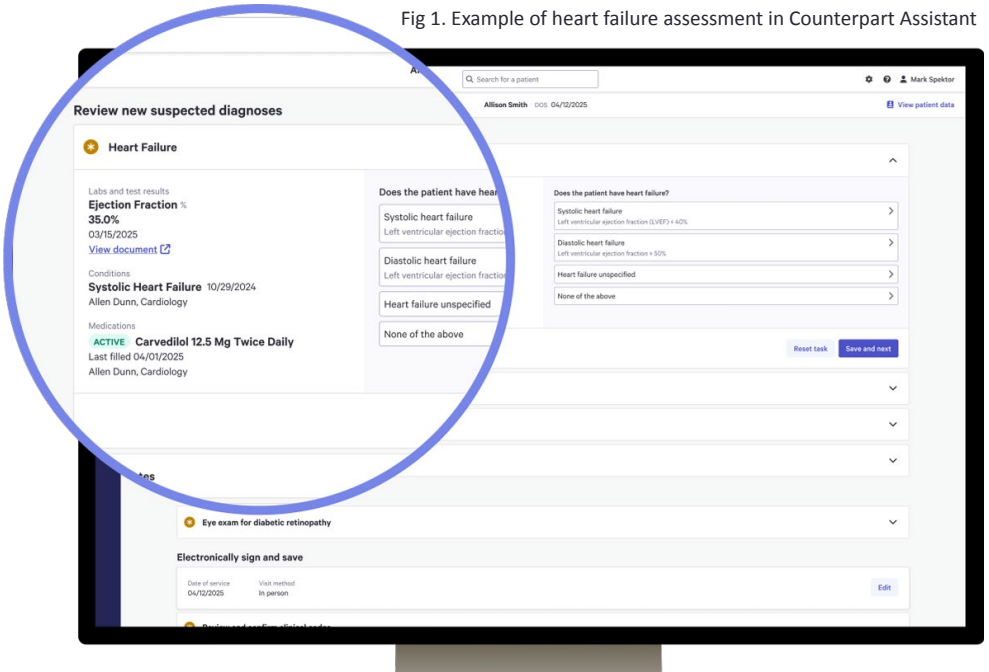
- CA provides actionable insights at the point-of-care, which supports earlier detection of chronic disease, tracking of disease progression and severity, and guideline-based treatment.
- A relationship with a PCP who uses CA was associated with better clinical care for heart failure patients enrolled in Clover Health's Medicare Advantage (MA) plans, including higher rates of outpatient cardiologist visits and in-home care management.
- A relationship with a CA provider was also associated with better clinical outcomes, including a lower average number of all-cause hospitalizations (18% lower) and 30-day readmissions (25% lower).

# Counterpart Assistant supports clinical excellence in chronic disease management

Counterpart Health, via CA, facilitates better chronic disease management by focusing on prevention, earlier detection, and longitudinal management. Congestive Heart Failure (CHF) is one of many chronic conditions that CA helps PCPs assess, track the progression and severity of, and manage. CHF is a prevalent and potentially debilitating chronic condition that poses a substantial burden on patients in the Medicare population. Nearly 12% of people enrolled in Medicare fee-for-service (FFS) had a diagnosis of heart failure in 2022 according to CMS [1, 2]. Heart failure is the leading cause of hospitalization among older adults, and Medicare enrollees with heart failure have the highest readmission rate of any condition [1]. Heart failure management presents significant challenges for patients and healthcare providers, requiring the right level of care and ongoing care management in order to effectively reduce complications such as hospitalizations. Managing chronic conditions like heart failure not only helps maintain a patient's functional capacity and well-being, but is central to controlling overall healthcare costs and delivering value-based care.

PCPs across Clover Health's MA provider network utilize CA to access real-time, patient-specific clinical insights to identify, manage, and treat chronic diseases earlier. The platform combines dozens of different health data sources with the latest clinical guidelines to produce actionable recommendations at the point of care (Figure 1). We have previously published data demonstrating the association between use of the technology, and improved medication adherence, as well as the earlier diagnosis and better management of

Fig 1. Example of heart failure assessment in Counterpart Assistant



chronic diseases such as diabetes and chronic kidney disease.[1] We hypothesized that a relationship with a CA provider might similarly be associated with better clinical care and outcomes for CHF patients.

This paper presents a case study examining CA's role in supporting provider management of CHF patients within the Clover Health MA plans and the associated differences in clinical care and outcomes in 2024. Notably, a relationship with a provider who uses CA was associated with higher rates of both outpatient cardiologist visits and in-home care services in 2024 among members with a CHF diagnosis. Moreover, a relationship with a CA provider was also associated with a lower average number of all-cause hospitalizations and readmissions in 2024 among such members.

**Counterpart Assistant supports prevention, detection, and management of chronic disease**

- Earlier detection and screening
- Evidence-based clinical guidelines
- Clinical insights on disease progression
- Real-time insights for hospitalizations
- Transitions of care
- Readmission prevention and support
- Medication reconciliation
- Annual vaccinations

# Enhancing specialty and home care access for patients with heart failure

A key driver to success in value-based care is the effective management of chronic diseases, including ensuring that the right level of care is given to patients with complex needs. To interrogate whether a relationship with a CA provider was associated with these types of value-based care strategies, we examined healthcare utilization data among two cohorts of patients who were Clover MA plan members in 2024, and for whom Clover data reflected a CHF diagnosis: (1) members were attributed to a PCP that was live on CA in 2024 (the "CA CHF cohort"); and (2) members who did not have any CA touch in 2024, and were attributed to a PCP that was not live on CA in 2024 (the "non-CA CHF cohort").[2] Specifically, we examined the average number of outpatient cardiologist visits among these cohorts, and the average number of in-home care visits. Cardiology specialist consultation and longitudinal care is particularly valuable for patients with advanced conditions like heart failure and can promote treatment concordant with the latest clinical guidelines.

In addition, home-based care is well-documented as an effective proactive approach that effectively meets the complex needs of patients with CHF. Often these patients have multiple comorbid conditions (over 97% of CHF patients have 4 or more chronic conditions), reduced ability to access traditional office-based sites, and thus benefit greatly from access to providers in the home [3]. One clinical study of Medicare patients who received home care services demonstrated a reduction in adverse outcomes, including 9% fewer hospitalizations and 20% fewer emergency department visits [4]. A similar study by the VA of 9,425 patients who received home care similarly found 25% fewer Medicare hospitalizations [5].

**CHF patients attributed to a CA provider had more outpatient cardiologist and in-home care visits on average**

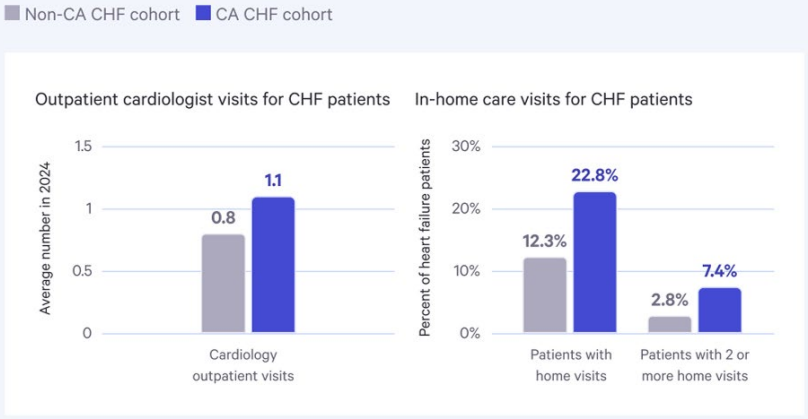



Fig 2

[1] For more details, download previous whitepapers on CA's impact on Clinical Quality/HEDIS, Diabetes, Chronic Kidney Disease, and Medication Adherence at https://www.counterparthealth.com/results.

[2] One constituent of providers that regularly use CA are those providers employed by Clover Health or its affiliates ("Clover-Employed Providers"). In an effort to disassociate potential impact of having a relationship with a Clover-Employed Provider from the potential impact of CA, specifically, our study excluded members who were attributed to a Clover-Employed Provider.

In our study of Clover MA plan members, we observed that members in the CA CHF cohort had both a higher average number of outpatient cardiologist visits[3] and higher in-home care utilization[4] compared to the non-CA cohort (Figure 2). The CA CHF cohort had an average of 1.1 outpatient cardiologist visits in 2024 versus 0.8 visits in the non-CA CHF cohort, reflecting more frequent longitudinal specialty care (Figure 2A). In addition, 22.8% of members in the CA CHF cohort had at least one in-home care visit in 2024, compared to 12.33% in the non-CA CHF cohort (Figure 2B). Similarly, CA CHF Cohort members were about 2.6 times more likely to have two or more in-home care visits in 2024 compared to members in the non-CA CHF cohort (7.45% in CA CHF cohort vs 2.82% in non-CA CHF cohort, Chi-squared $p < 0.00001$). When analyzing the subset of only established in-home care visits (visits with patients who have an established care relationship with the in-home care provider[5]), the CA CHF cohort showed a 16.83% rate for one or more visits vs 8.73% for the non-CA CHF cohort ($p < 0.00001$). These findings demonstrate that members in the CA CHF cohort were significantly more likely to have established home care that was longitudinal in nature compared to the non-CA CHF cohort.

# Counterpart Assistant use associated with lower hospitalization rates

The clinical burden of CHF in the US is particularly pronounced among older adults and characterized by high rates of hospitalizations, readmissions, and mortality. Heart failure is the leading principal diagnosis for hospitalization among older adults. Nearly one in four patients hospitalized for heart failure are readmitted within 30 days, and about half are readmitted within six months [6]. This high rate of readmission not only underscores the severity and complexity of heart failure but also places a substantial strain on healthcare resources and costs.

We hypothesized that, given the higher average number of outpatient cardiologist and in-home care visits among members in the CA CHF cohort compared to members in the non-CA CHF cohort, a relationship with a CA provider may also be associated with fewer hospital admissions and readmissions. Our study validated this hypothesis. The average number of all-cause 2024 hospitalizations among members in the non-CA CHF cohort was 0.8 compared to 0.66 for the CA CHF cohort (17.5% lower). In addition, 41% of the non-CA CHF cohort had 1 or more hospitalizations in 2024 versus just 35.4% of the CA CHF Cohort ($p < 0.00001$; Figure 3). 30-day readmission data reflected a similar association: the non-CA CHF cohort showed an average number of 30-day readmissions of 0.2 compared to 0.15 for the CA CHF cohort (25% lower).

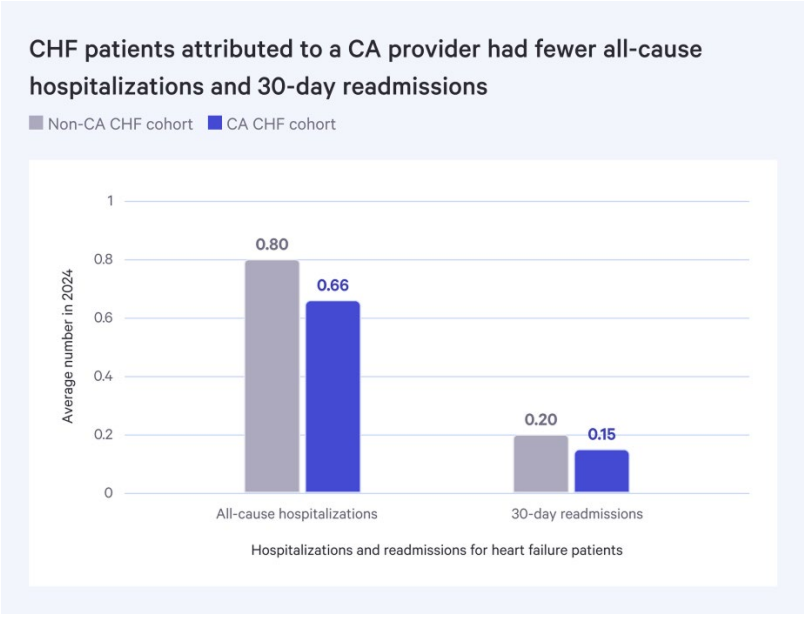



Fig 3

[3] For purposes of this study, a patient was considered to have had an outpatient cardiologist visit, if the Clover MA plan had received a claim for the member with a 2024 date of service from a servicing clinician whose primary speciality is cardiology, including one or more of the following CPT codes: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215.

[4] For purpose of this study, a patient was considered to have had an in-home care visit, if the Clover MA plan had received a claim for the member with a 2024 date of service including one or more of the following CPT codes: 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350. Claims for in-home care provided by Clover-Employed Providers were included in the analysis, and comprised ~83% of the aggregate number of in-home care claims. As noted above, these providers regularly use CA in providing care, including in connection with in-home care visits. Because the non-CA cohort was defined to exclude members who had any CA-powered visit, if a member had a visit with a Clover-Employed provider (including an in-home visit), they were not included in that cohort.

[5] As reflected by the provider billing one or more of CPT codes 99347-50.

11% of the non-CA CHF cohort had 1 or more 30-day readmissions versus 8.2% for the CA CHF cohort ($p < 0.00001$). These results reflect a significant association between having a relationship with a CA provider and lower hospitalizations and readmissions.

# Counterpart Assistant: A transformative platform for detecting and managing chronic disease

In conclusion, CA's focus on early detection, tracking of disease progression and severity, and proactive interventions underscores its role in enabling value-based care at the point of care. This case study validates the Clover Health plans' experience of CA as a transformative platform that empowers PCPs to prevent, detect, and manage chronic diseases, like heart failure. The data presented demonstrates that a CHF patient's relationship with a provider that uses CA is associated with more outpatient cardiologist visits and in-home care visits, reflecting higher levels of care for these complex members.

The data also reflects fewer all-cause and 30-day hospital readmissions among CHF patients attributed to a PCP who utilizes CA. This notable difference in hospitalizations strongly suggests that CA helps support a crucial shift towards proactive and longitudinal care strategies, which are paramount in effectively managing complex chronic conditions like heart failure.

Limitations of this study interpretation include the retrospective nature of this real-world data analysis in which there is no control over data collection or exposure variables. While this analysis attempts to limit bias by comparing cohorts in which CA usage by their PCP is the primary difference, the nature of this retrospective study design means there may be other influencing factors not captured in the dataset.

By facilitating appropriate levels of care such as specialty care and home visits, and supporting less frequent hospitalization, CA proves to be an invaluable asset for PCPs navigating the complexities of chronic disease management. This case study, centered on heart failure patients, serves as an illustration of CA's potential to drive substantial improvements in both patient outcomes and healthcare delivery by fostering proactive, longitudinal clinical care—essential best practices for effectively managing intricate chronic conditions.

Counterpart Assistant generates actionable clinical insights through aggregation, distillation, and curation of health data streams and leveraging proprietary AI technology.

Counterpart Assistant facilitates care delivery for chronic conditions by supporting monitoring of disease progression and best practices for specialty referrals, based on individual patient context.

Use of Counterpart Assistant can improve chronic disease outcomes and reduce healthcare burden through proactive management that can lead to fewer acute episodes requiring hospitalization.

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