Counterpart Health

JULY 2026

Clinical Excellence in Continuity of Care:

A Real-World Analysis of Counterpart Assistant's Role in Post-Hospitalization Follow-up

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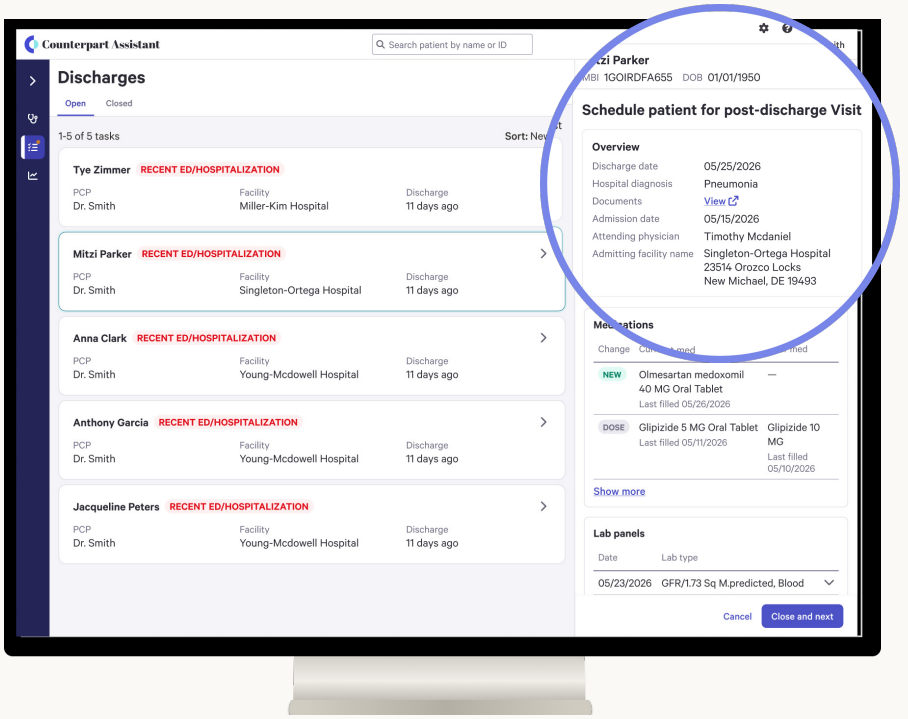
EXECUTIVE SUMMARY

Counterpart Health empowers primary care providers (PCPs) to better manage members after acute utilization through its flagship software platform, Counterpart Assistant (CA). In this real-world analysis, we examined HEDIS® Transitions of Care (TRC) measures and related post-hospital readmission rates among members attributed to a CA-enabled PCP versus members attributed to a PCP who was not using CA:

- **Members attributed to CA-enabled PCPs had higher performance across all HEDIS TRC measures reviewed.** Members in the CA cohort outperformed members in the non-CA cohort on notification of inpatient admission (94.6% vs. 88.8%), patient engagement after inpatient discharge (97.7% vs. 94.9%), receipt of discharge information (59.9% vs. 44.9%), and medication reconciliation post-discharge (93.1% vs. 83.7%). The largest differences were in receipt of discharge information and medication reconciliation, two workflows that are central to safe and timely care after hospitalization.
- **Members with multiple high-risk conditions attributed to CA-enabled PCPs had higher rates of timely follow-up after emergency department visits.** On the HEDIS Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) measure, members in the CA cohort had a seven-day follow-up rate of 77.6%, compared with 71.2% for members in the non-CA cohort. This suggests that CA-enabled workflows may help PCPs and care teams re-engage clinically vulnerable members after acute utilization.
- **Members attributed to CA-enabled PCPs had directionally lower 30-day readmission rates after discharge.** 30-day readmission rates were directionally lower in the CA cohort than in the non-CA cohort (15.4% CA vs. 15.9% non-CA). Among post-acute non-emergency inpatient events, the readmission rate differential was greater, 15.4% in the CA cohort compared with 18.9% in the non-CA cohort.

FIGURE 1

Counterpart Assistant: Delivering post-discharge insights at point-of-care



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Counterpart Assistant supports *more timely and coordinated continuity of care*

Counterpart Health, through CA, helps primary care providers identify care gaps, manage risk, and coordinate care for members with complex clinical needs. The period immediately after an inpatient discharge or emergency department visit is one of the most important windows for intervention, especially in a Medicare population with multiple chronic conditions [1]. Delays in communication between hospitals, PCPs, and care teams can lead to missed follow-up, medication discrepancies, and preventable readmissions [2].

Managing these transitions well requires more than a reminder that a patient was hospitalized. Care teams need timely notification, access to discharge information, medication details, and clear ownership of follow-up work. Without that information, even motivated clinicians may be working from incomplete or delayed data.

Across Clover Health's Medicare Advantage network, PCPs use CA to access patient-specific clinical insights and identify care needs earlier in the workflow. The platform brings together health data from multiple sources and surfaces recommendations at the point of care. For continuity of care, CA is designed to make recent acute utilization visible and actionable by helping providers identify admissions, engage members after discharge, obtain discharge information, and complete medication reconciliation. CA supports this workflow by generating follow-up tasks when patients are discharged from hospitals and by making hospitalization information available to clinicians within their existing workflow. This can include medication information, lab results, procedures, and discharge summaries, when available (Figure 1). In practice, the goal is straightforward: turn acute utilization events into timely, trackable follow-up work for PCPs and care teams.

This real-world analysis examines whether attribution to a CA-enabled PCP was associated with stronger transitions-of-care workflows, higher post-emergency department follow-up rates, and lower subsequent 30-day readmission rates within Clover Health's Medicare Advantage population.

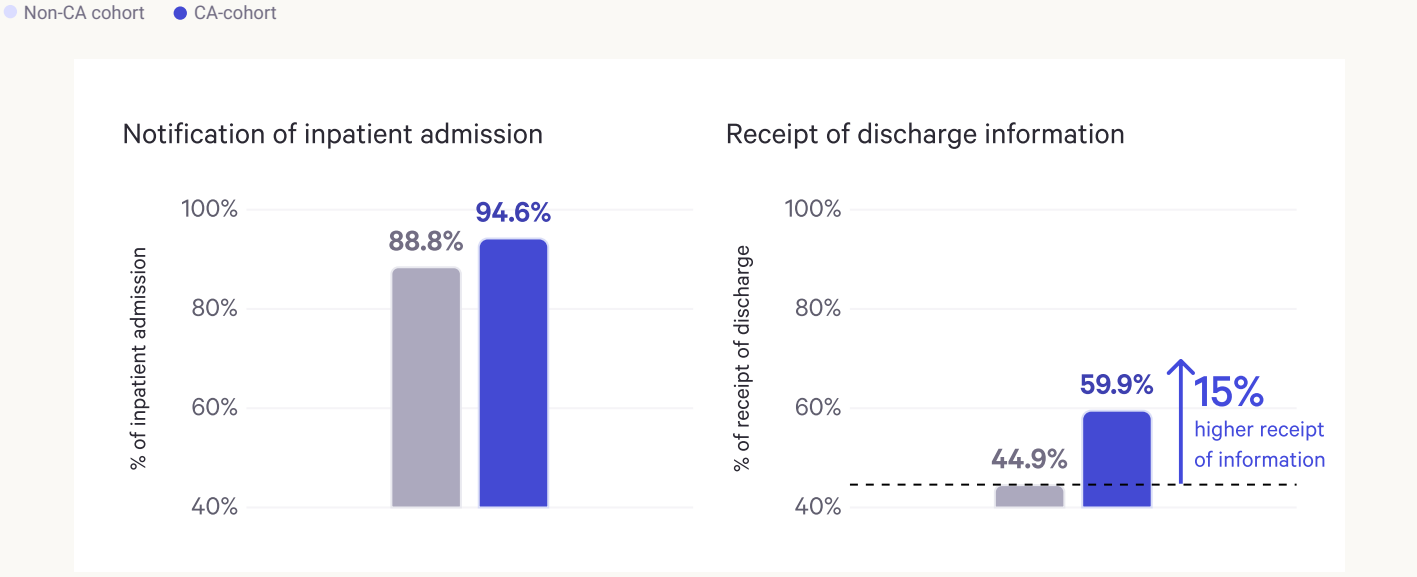
Higher performance across HEDIS transitions-of-care measures

Effective care coordination requires a proactive approach to transitional health, particularly for high-risk populations where recent acute episodes can lead to severe clinical deterioration if left unmanaged. We analyzed whether a relationship with a CA-enabled PCP was associated with stronger execution of core transitions-of-care workflows as measured by the HEDIS TRC domains and the FMC measure [3,4]. By leveraging real-time clinical insights, CA surfaces specific recommendations to providers at the point of care, helping to bridge the gap between acute discharge and outpatient management.

The analysis compared two cohorts of Clover Health Medicare Advantage members: members attributed to PCPs live on Counterpart Assistant, referred to as the CA cohort, and members who had no CA touch and were attributed to PCPs not live on CA, referred to as the non-CA cohort.[1]

FIGURE 2

Higher performance across HEDIS TRC domains among patients with CA-enabled PCPs



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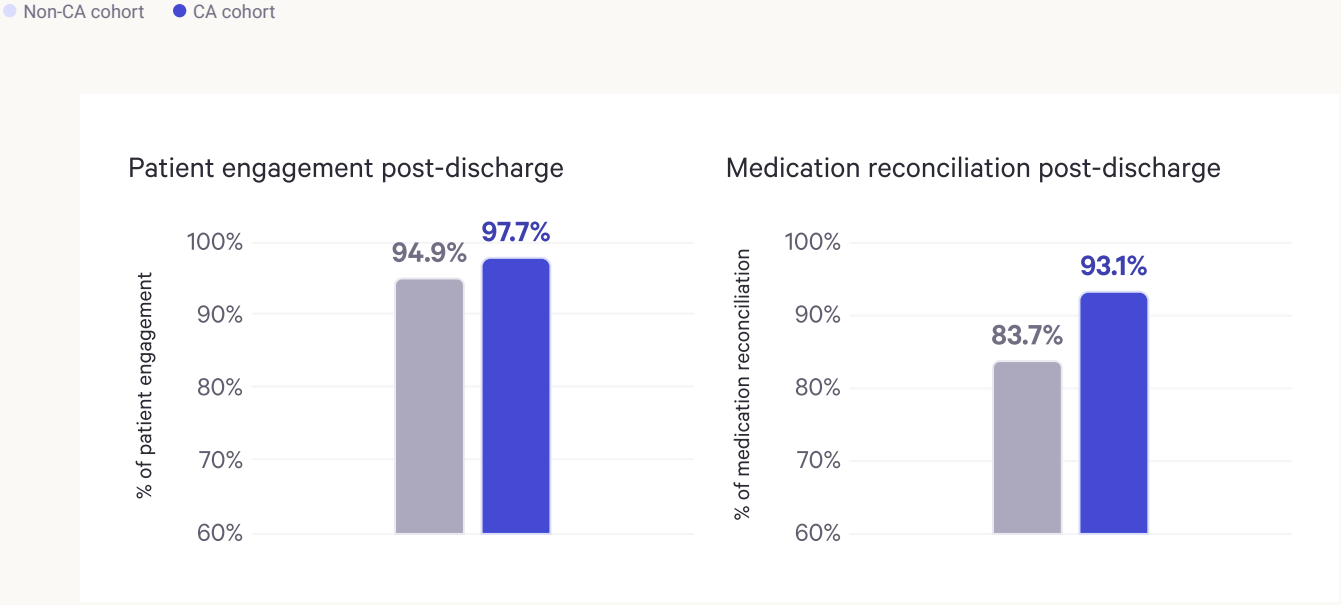
Across the HEDIS TRC domains reviewed, the CA cohort performed better than the non-CA cohort, suggesting that the platform helped enable improvements in information continuity, clinical coordination, and medication safety. Notification of inpatient admission was 94.6% in the CA cohort compared with 88.8% in the non-CA cohort, an absolute difference of 5.9 percentage points (odds ratio 2.23; one-sided Fisher exact $p < 0.05$). Receipt of discharge information showed the largest absolute difference, with 59.9% compliance in the CA cohort compared with 44.9% in the non-CA cohort, a 15.0 percentage point difference (odds ratio 1.83; one-sided Fisher exact $p < 0.01$; Figure 2).

[1]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 determining the PCP to which a member was attributed, if any, we used the most recent attribution data available from the Clover MA plans. We then evaluated whether that PCP was "live" on CA during the relevant period, meaning the PCP had an actively registered CA user account during the period.

Medication reconciliation post-discharge was completed for 93.1% of members in the CA cohort compared with 83.7% in the non-CA cohort, a 9.42 percentage point difference (odds ratio 2.63; one-sided Fisher exact $p < 0.01$) [5]. Patient engagement after inpatient discharge was also directionally higher in the CA cohort, 97.7% compared with 94.9%, although this difference did not reach statistical significance during the study period (odds ratio 2.28; one-sided Fisher exact $p = 0.1276$; Figure 3).

FIGURE 3

Stronger post-discharge care engagement among patients with CA-enabled PCPs



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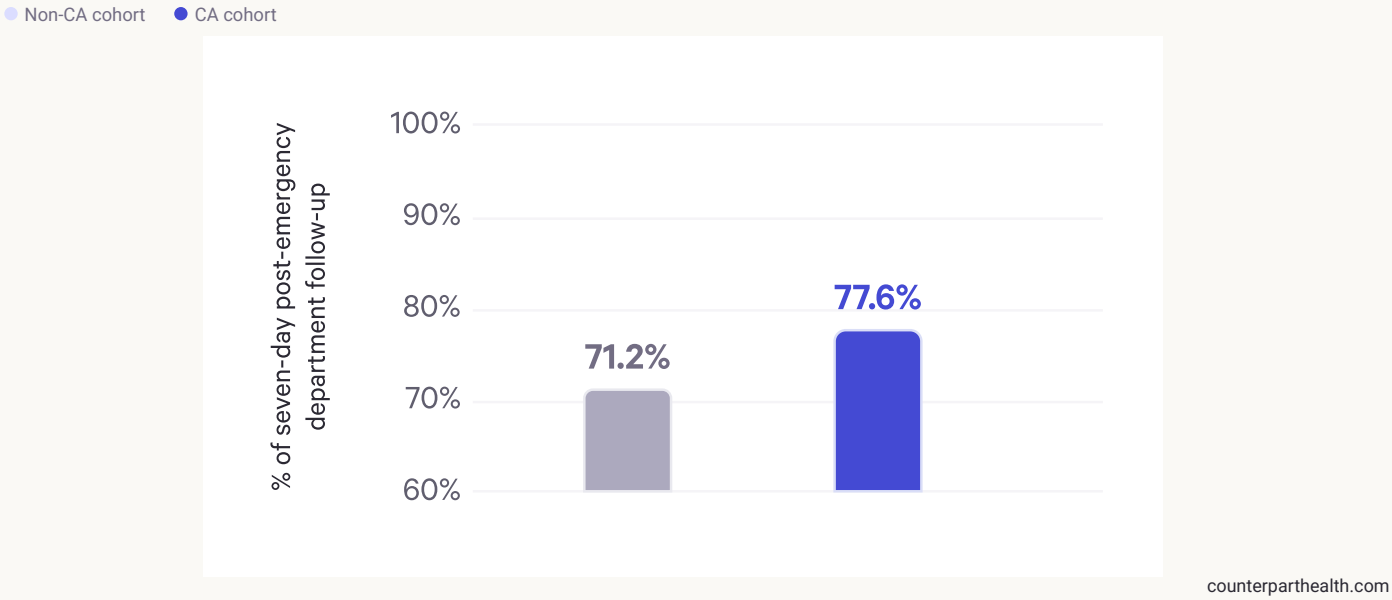
Higher HEDIS follow-up rates after emergency department visits for high-risk patients

Beyond inpatient transitions, timely outpatient intervention following an emergency department visit is a vital component of robust transitional care, particularly for individuals living with complex chronic health profiles. Evaluation of the HEDIS FMC measure, which tracks timely follow-up after emergency department visits among adults with high-risk multiple chronic conditions, revealed substantially better performance for members attributed to CA-enabled PCPs [4].

Members in the CA cohort experienced significantly higher rates of timely care, achieving a seven-day post-emergency department follow-up rate of 77.6% compared to 71.2% for members in the non-CA cohort. This represents a highly statistically significant absolute difference of 6.35 percentage points (odds ratio 1.40; one-sided Fisher exact $p < 0.001$; Figure 4). Together, these findings are consistent with stronger follow-up workflows among CA-enabled PCPs, effectively closing critical care gaps for clinically vulnerable populations during high-risk post-utilization windows [6].

FIGURE 4

Patients with multiple chronic conditions and a CA PCP experienced higher HEDIS FMC follow-up rates after ED visits



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Counterpart Assistant use associated with *lower readmission rates*

The clinical and financial burden of hospital readmissions is particularly pronounced among older adults with underlying chronic conditions, where an inadequate care transition often leads to rapid clinical deterioration [1,7]. Repeat hospital readmissions not only underscore the complexity of transitional care but also place a substantial strain on healthcare resources, system capacity, and overall expenditures.

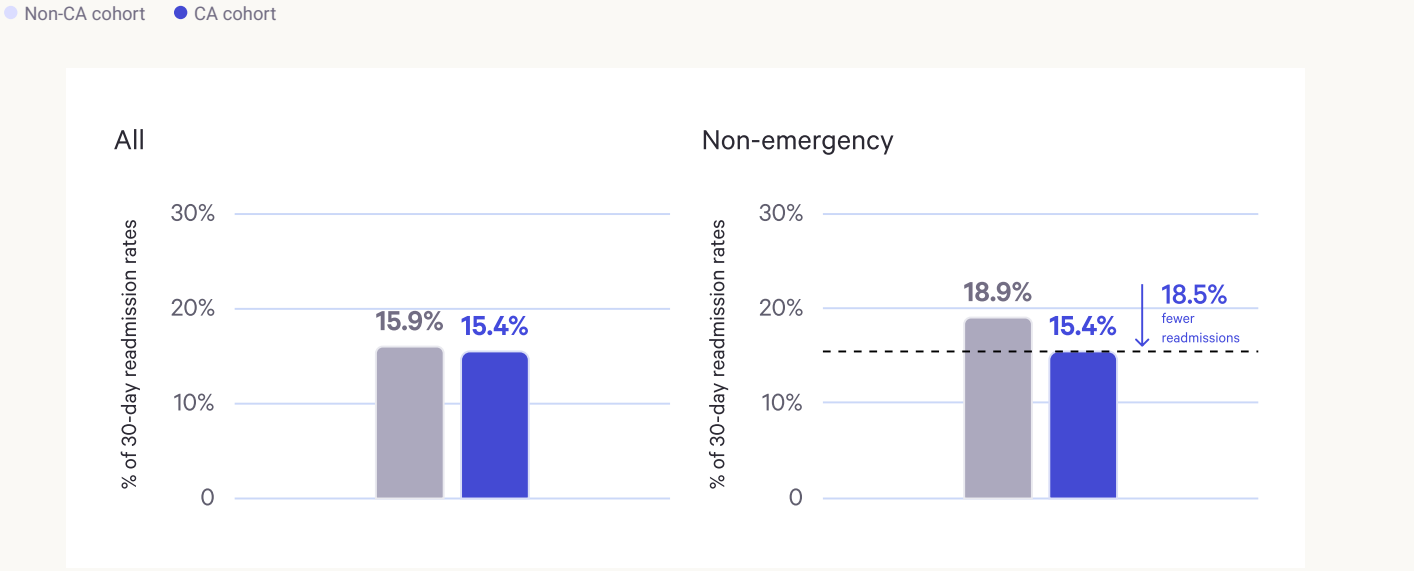
Identifying high-risk patients and supporting proactive, longitudinal follow-up care is one of the most effective strategies for reducing secondary acute episodes that lead to repeat inpatient hospitalizations [8,9]. Given the higher observed performance on transitions-of-care workflows and post-emergency department follow-up in the CA cohort, we also examined whether members attributed to CA-enabled PCPs had lower 30-day readmission rates [10].

Across the study population, 30-day readmissions were directionally lower for members in the CA cohort than the non-CA cohort: 15.4% vs.15.9% (p=0.37). The larger observed difference appeared in post-acute inpatient admissions, where readmissions were 15.4% for CA vs.18.9% for non-CA (p=0.12), an 18.5% relative difference (Figure 5).

This finding suggests CA may have greater impact in planned or non-emergency inpatient episodes, where proactive PCP engagement before and after discharge may be more likely to influence outcomes.

FIGURE 5

Fewer 30-day readmissions among patients attributed to CA-enabled PCPs following hospitalization



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Counterpart Assistant supports *scalable, workflow-driven transitions of care*

This analysis highlights the role CA can play in bridging the gap between acute discharge and outpatient management and underscores its role in enabling effective value-based care at the point of care. Members attributed to CA-enabled PCPs had higher performance across key HEDIS care coordination measures, including notification of inpatient admission, receipt of discharge information, and medication reconciliation post-discharge. They also had higher seven-day follow-up rates after emergency department visits for members with multiple high-risk chronic conditions. The data also reflects directionally fewer 30-day hospital readmissions, particularly within the non-emergency inpatient subset where members attributed to a CA PCP achieved a 15.4% readmission rate compared to 18.9% in the non-CA cohort, representing an 18.5% relative difference in repeat rehospitalizations.

This delta in readmission rates suggests that CA may help support a shift toward proactive and longitudinal care strategies, which are paramount in effectively managing complex care transitions and controlling overall healthcare costs.

By making post-acute needs more visible and actionable within the clinical workflow, Counterpart Assistant supports a more proactive model of care for members during one of the most vulnerable periods in the care journey. These results reinforce the role of technology-enabled primary care in improving coordination, supporting value-based care goals, and helping clinicians better manage complex transitions after hospitalization or emergency department use.

Methods, statistical analysis, and study limitations

This real world analysis utilized a retrospective cohort design to evaluate the association between a member's relationship with a CA PCP and specific clinical process and outcomes related to transitions of care, post-hospitalization follow-up, and subsequent acute care utilization. All analyses examined practice and administrative claims data from Clover Health Medicare Advantage plan members who experienced an acute care event such as an ED visit or inpatient hospitalization for whom this data was available (n = 13,526). We examined clinical process and outcomes of interest, specifically HEDIS TRC follow-up process rates and readmissions for each member over a defined measurement period of 12 months in the 2024 calendar year.

Appropriate statistical methodology was utilized to determine the significance of our findings utilizing standard Python libraries, including NumPy for data handling and SciPy for statistical testing. Because the core HEDIS TRC sub-measures and the FMC follow-up metric reflect binary compliance criteria, we performed a one-sided Fisher exact test to compare performance between the CA cohort and the non-CA cohort. Significance for all statistical tests was assessed at a standard 5% significance level (alpha = 0.05).

Further sensitivity analysis was performed to examine for any differences between cohorts to ensure our findings were not driven by baseline demographic or clinical imbalances. When comparing member attributes in the CA Cohort (n=9740) versus those in the Non-CA Cohorts (n=3786), there were no substantive differences in average age, CA 73.7 years old vs Non-CA 73.0 years old, or sex, CA 53.6% female vs Non-CA 55.6% female. Clinical complexity was also balanced across groups as measured by the average Charlson score (CA 2.86 vs Non-CA 2.95) or Elixhauser Score (CA 6.71 vs Non-CA 7.30) ensuring that the cohorts represented a similar clinical segment of the Medicare Advantage population.

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 or unmeasured factors not fully captured in the dataset.

Additionally, our ability to capture all true transitional care interactions, outpatient follow-up visits, and subsequent readmission events is limited by the administrative claims and clinical data accessible through the health plan. Nevertheless, by optimizing clinical coordination and facilitating appropriate post-utilization follow-up, CA supports PCPs navigating the complexities of transitional care management. This case study serves as a powerful illustration of CA's potential to drive substantial improvements in both patient outcomes and healthcare delivery by fostering proactive, continuous clinical care, which represents an essential best practice for effectively managing vulnerable populations during critical periods of care transition.

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