BLUEBRIX

Cohort Management Platform

Evaluation Checklist

A practical self-audit for healthcare organizations evaluating workflow fit, interoperability, configurability, auditability, and platform coverage for value-based care.

How to use this checklist

Complete each section with the relevant team members. Score every question honestly. Use the scorecard at the end to prioritize your next steps.

SCORE	WHAT IT MEANS	WHAT IT LOOKS LIKE IN PRACTICE
1	**Not in place**	No formal process exists. This is handled ad hoc, from memory, or not at all.
2	**Partial or manual**	A process exists but relies on individual effort, spreadsheets, or inconsistent execution across the team.
3	**Mostly in place**	The process works most of the time for most providers, but gaps appear under volume pressure or with specific payer types.
4	**Fully operational**	Systematic, consistent, and validated across workflows, payers, and programs. Exceptions are caught and logged.

Scoring instructions

Score each of the 20 questions 1-4. Add the four scores in each section for a section total (maximum 16). Add all five section totals for your overall score (maximum 80). Record section totals and your overall score in the Scorecard at the end of this document.

Each section total and overall score maps to an interpretation band in the Scorecard. Use the lowest-scoring sections to set your priorities, not just the overall number.

Assessment

Score each question 1-4. Enter your score in the right-hand column. Add section totals at the end of each group.

A |

Workflow Fit

Why low scores here matter: Platforms that sit outside the care team primary workflow create adoption friction and fail to eliminate the Triage Trap. When coordinators must leave their primary system to consult a separate dashboard, task routing breaks down and manual prioritization reasserts itself, exactly the pattern that cohort management is designed to replace.

What strong looks like: *A section score of 14-16 means tasks and next-best actions are surfaced inside the clinician existing workflow, routing is automated by role and rule, and coordinators spend time on clinical decisions, not hunting for data across disconnected systems.*

#	AREA	OWNER	WHAT TO ASSESS	SCORE 1-4	NOTES
A1	**Worklist and task prioritization**	*Clinical Ops Lead*	Does the platform surface a role-based, prioritized worklist to each care coordinator inside their existing workflow, or does it produce a generic alert queue that requires manual triage every morning?		
A2	**Next-best-action routing**	*Clinical Ops Lead*	When a patient event triggers an action, a discharge, a missed follow-up, an abnormal vital, is the right task automatically routed to the right team member, or does a supervisor manually assign it?		
A3	**EHR workflow integration**	*EHR Admin / IT*	Does the platform operate inside the clinician primary EHR environment, or does it require tab-switching to a separate application? Can coordinators act on a patient without leaving their primary system?		
A4	**Human-in-the-loop escalation**	*Clinical Ops Lead*	Does the platform distinguish between tasks it routes automatically and decisions that require clinical judgment? Are escalation points built into the workflow, not left to the coordinator to identify?		
			Section total (add four scores above x max 16)		

B |

Interoperability & Integration

Why low scores here matter: Nightly batch integration is not interoperability. When a discharge event triggers a TCM task twelve hours after the patient left the building, the follow-up window is already shrinking. Teams working from yesterday data cannot coordinate today care, and every manual reconciliation step adds the friction that cohort management is supposed to remove.

What strong looks like: *A section score of 14-16 means bi-directional data exchange is operating in real time on FHIR R4, HL7 v2, and REST APIs, across EHRs, labs, payers, and imaging systems, without manual exports, batch uploads, or re-entry into a separate system.*

#	AREA	OWNER	WHAT TO ASSESS	SCORE 1-4	NOTES
B1	**Standards-based exchange**	*IT / RCM*	Does the platform integration operate on FHIR R4, HL7 v2, and REST APIs, or does the vendor use FHIR-compatible language without specifying which version or which resource types are supported for bi-directional exchange?		
B2	**Real-time vs. batch data**	*IT / EHR Admin*	When a patient is discharged, how quickly does that event appear as a triggered task in the coordinator queue? Is latency measured in seconds to minutes, or is data refreshed nightly?		
B3	**EHR and payer connectivity**	*IT / RCM*	Does the platform have validated, production-deployed integrations with your specific EHR (e.g., Epic, athenahealth)? Are payer data feeds, claims, eligibility, prior auth status, available in real time without manual imports?		
B4	**SDoH and clinical data integration**	*IT / Clinical Ops*	Does the platform integrate SDoH data, housing, transportation, food security, alongside EHR and claims data into a single patient profile in real time? Or does social determinants data live separately, invisible to the risk model and coordinator workflow?		
			Section total (add four scores above x max 16)		

C |

Configurability

Why low scores here matter: A platform that requires an IT ticket or vendor engagement to update a cohort rule will always be operationally behind. Population health programs evolve constantly, new payer contracts, new HEDIS measure specifications, new CMS quality initiatives arrive faster than development cycles can accommodate. Configuration that lives with the vendor is configuration that works on the vendor schedule, not yours.

What strong looks like: *A section score of 14-16 means clinical operations leaders can create new cohorts, update care pathways, and modify assessment forms through a no-code interface, without IT involvement, and those changes take days, not development cycles, to reach production.*

#	AREA	OWNER	WHAT TO ASSESS	SCORE 1-4	NOTES
C1	**No-code cohort creation**	*Clinical Ops Lead*	Can a clinical operations leader, without IT support, create a new patient cohort based on a combination of diagnosis codes, risk scores, SDoH flags, and engagement history? Walk through the actual user interface.		
C2	**Care pathway modification**	*Clinical Ops Lead / Quality*	When a new payer contract requires a different follow-up timeline or a new care pathway step, who makes that change, how long does it take, and does it require a vendor ticket or a development cycle?		
C3	**Assessment form customization**	*Clinical Ops / IT*	Can clinical leaders modify assessment forms, PHQ-9 administration, SDOH screening, AWV templates, to match payer-specific contract requirements without engineering support or a release cycle?		
C4	**Configuration speed for new contracts**	*Clinical Ops Lead / Quality*	When a new payer contract arrives with different HEDIS measure specifications or quality thresholds, how long does it take to configure the platform to track and close those gaps? Is this measured in days, or is it a development cycle?		
			Section total (add four scores above x max 16)		

D |

Auditability

Why low scores here matter: For any organization billing CCM (CPT 99490/99491) or TCM (CPT 99495/99496), the audit trail is not an administrative nicety, it is a billing prerequisite. Manual time logs are under-documented under volume pressure and difficult to defend in a CMS or payer recoupment scenario. The gap between care delivered and care documented is where earned reimbursement disappears.

What strong looks like: *A section score of 14-16 means every care management touchpoint is auto-captured with a timestamp, the correct CPT code, and payer rule, CCM time minimums are tracked and verified by code type before billing (20 minutes for CPT 99490; 30 minutes for CPT 99491), TCM windows are tracked and alerted proactively, and a full audit record can be produced per patient in under 24 hours.*

#	AREA	OWNER	WHAT TO ASSESS	SCORE 1-4	NOTES
D1	**Automated time capture for CCM/TCM**	*RCM Lead*	Does the platform automatically capture and timestamp care management time, both synchronous contacts and asynchronous activities like care plan updates, or does the coordinator manually log time after the fact?		
D2	**CCM billing gate enforcement**	*RCM Lead / Compliance*	Does the platform enforce CCM billing prerequisites, patient consent on file, an active care plan, and the applicable monthly time minimum (20 minutes for CPT 99490; 30 minutes for CPT 99491), as a workflow gate before a billing event is generated, or is this verified manually?		
D3	**TCM window tracking and alerts**	*RCM Lead / Care Team*	Does the platform track the 2-business-day interactive contact requirement and the 7-day or 14-day face-to-face window for TCM billing? Does it alert the care team when a window is at risk of expiring before it closes?		
D4	**Audit trail export and readiness**	*Compliance Lead / RCM*	If a CMS or payer auditor requested documentation of how a set of claims was coded, every touchpoint, duration, staff member, and contact type, could your team produce that record per patient in under 24 hours?		
			Section total (add four scores above x max 16)		

E |

Reporting & Revenue Visibility

Why low scores here matter: A platform that covers only one or two functional pillars forces organizations to manually reconcile data across systems, introducing the exact gaps that cohort management is designed to eliminate. When billing and care management are disconnected, earned CCM revenue leaks through documentation gaps. And with the HCAHPS Care Coordination composite beginning public reporting in October 2026, platforms that cannot surface whether staff worked well together and stayed informed and up-to-date will have no real-time visibility into the measure before it matters.

What strong looks like: *A section score of 14-16 means Risk and Quality Intelligence, Care Coordination and Patient Engagement, and Reporting and Compliance share a single unified data model, with real-time HEDIS gap closure, HCAHPS composite performance, denial trends by payer and provider, and Total Cost of Care vs. benchmark visible without stitching data across three systems.*

#	AREA	OWNER	WHAT TO ASSESS	SCORE 1-4	NOTES
E1	**HEDIS gap closure tracking**	*Quality Lead / Clinical Ops*	Does the platform provide real-time HEDIS gap closure tracking by measure, payer contract, and attribution panel, with drill-down to the patient level, without a custom BI report or a separate quality registry?		
E2	**Revenue and denial visibility**	*CFO / RCM Lead*	Does the platform surface denial trends by payer, provider, code type, and clinic location in real time, or does your team investigate individual claims without population-level insight into recurring failure patterns?		
E3	**HCAHPS Care Coordination composite**	*Quality Lead / Compliance Officer*	The HCAHPS Care Coordination composite begins public reporting in October 2026. Does the platform track whether care teams are working well together and staying informed and up-to-date about patient care, or will you be assembling that picture manually when the measurement window has already closed?		
E4	**Total Cost of Care and VBC performance**	*CFO / VBC Lead*	For value-based contracts, is Total Cost of Care performance tracked continuously against benchmark, or is this assembled retrospectively at year-end when the window to act on rising-risk cohorts has already closed?		
			Section total (add four scores above x max 16)		

Scorecard

Transfer your section totals here, then add them for your overall score. Use the interpretation bands to prioritize next steps.

SECTION	FOCUS AREA	PRIMARY OWNER	YOUR TOTAL (MAX 16)
Section A	Workflow Fit	Clinical Ops Lead / Care Coordination Supervisor	
Section B	Interoperability & Integration	IT / EHR Administrator / RCM Lead	
Section C	Configurability	Clinical Ops Lead / Quality Lead	
Section D	Auditability	RCM Lead / Compliance Officer	
Section E	Reporting & Revenue Visibility	CFO / Finance Director / VBC Lead	
		Overall	**/ 80**

Score interpretation

60-80 **Strong foundation**	Your workflows are largely governed and consistent. Focus on closing remaining gaps, particularly in interoperability depth and auditability, to protect VBC contract performance and HCAHPS composite scores.	**RECOMMENDED NEXT STEP** Identify your two lowest-scoring sections and address them systematically. Even strong organizations have blind spots under volume pressure.
40-59 **Meaningful exposure**	Revenue leakage and compliance gaps are present but recoverable. Prioritize sections scoring below 8. The highest-impact fix is usually embedding auditability and real-time workflow routing before evaluating new tooling.	**RECOMMENDED NEXT STEP** Run a focused gap analysis on your lowest-scoring section. Where is the workflow breaking down, before a vendor decision is made?
20-39 **Significant risk**	Multiple workflow failures are compounding. Fragmentation, interoperability gaps, and manual auditability are likely draining a significant portion of collectible revenue. Industry surveys indicate organizations with these gaps commonly lose 10% or more of annual revenue to leakage. A structured platform evaluation is warranted.	**RECOMMENDED NEXT STEP** Share this scorecard with your CFO and compliance lead. The gaps are no longer just operational, they affect VBC contract performance and audit readiness.

Under 20 **Urgent attention required**	The care coordination infrastructure is fragile. Leadership is making decisions without reliable operational visibility. The risk is not just revenue, it is audit exposure and contract underperformance in value-based programs.	**RECOMMENDED NEXT STEP** Escalate to leadership immediately. The cost of inaction exceeds the cost of change. A discovery conversation with a platform specialist is the right next step.

Bring this to your next team conversation

Use the questions below to turn your assessment results into a working agenda. These are most useful when your clinical ops lead, CFO, compliance officer, and IT lead are in the same room.

Which section surprised us the most?

The score that felt unexpected is often where the highest-value fix lives. Explore why expectations were different from operational reality, and whether the gap is a process issue, a technology issue, or both.

Where are we discovering workflow failures, before the patient event or after?

If most coordination breakdowns surface reactively, after a missed TCM window, after a care gap closes without action, the platform is not routing proactively. That single change tends to move quality performance more than any other intervention.

What does our current auditability picture actually look like?

If reconstructing a patient CCM billing record takes more than a day and requires stitching across three systems, the audit trail is a compliance gap, not just an operational inconvenience. That exposure grows with every billing cycle.

Are we ready for October 2026 HCAHPS public reporting?

The Care Coordination composite begins public reporting then. If your platform cannot show today whether care teams are working well together and staying informed about patient care, you will not have enough data to move the measure before it is visible to payers and patients. This is a question for your clinical ops lead and quality lead together.

If we add a new payer contract next quarter, who configures the new cohort and care pathway, and how long will it take?

The honest answer to this question determines whether your platform is an operational asset or an operational constraint. Configuration that requires a vendor ticket will always lag behind the pace of value-based contracting, and the cost shows up in HEDIS performance, not just IT hours.

Key terms used in this checklist

Cohort management	The operational layer that groups patients by shared risk, need, or care opportunity and organizes those insights into coordinated workflows, routing, and follow-up. Risk stratification identifies who. Cohort management determines what happens next.
Triage Trap	The operational bottleneck where accurate risk scores exist but the process for ensuring the right patient gets the right care at the right time remains manual. Characterized by jammed alert inboxes, spreadsheet-based prioritization, and coordinator burnout.
FHIR R4 (Fast Healthcare Interoperability Resources)	The current interoperability standard from HL7 International. FHIR R4 defines how healthcare data is structured and exchanged between systems. Bi-directional FHIR R4 integration means both reading from and writing to connected EHRs in real time.
CCM - Chronic Care Management	A CMS program that reimburses providers for non-face-to-face care coordination services for patients with two or more chronic conditions. CCM billing requires documented consent, an active care plan, and a monthly time minimum, 20 minutes for CPT 99490 (non-physician) and 30 minutes of physician time for CPT 99491.
TCM - Transitional Care Management	A CMS program that reimburses providers for care coordination following a discharge from an inpatient or observation setting. TCM billing (CPT 99495/99496) requires an interactive contact within 2 business days of discharge and a face-to-face visit within 7 or 14 days, depending on medical complexity.
HCC - Hierarchical Condition Category	A risk-adjustment methodology used by CMS and many payers to calculate expected healthcare costs. Accurate HCC coding directly affects risk scores, reimbursement rates, and shared savings calculations in value-based contracts.
HEDIS	Healthcare Effectiveness Data and Information Set, a set of performance measures used by health plans and CMS to evaluate quality of care. HEDIS measures include transitions of care follow-up, chronic condition management, and preventive care rates. Performance on HEDIS measures drives CMS Star Ratings and quality bonus payments.
VBC - Value-Based Care	A reimbursement model that ties provider payment to patient outcomes and quality metrics rather than volume of services. VBC contracts typically include shared savings components, quality bonuses, and risk adjustment elements that depend on accurate coding and cohort management.
Total Cost of Care (TCOC)	The aggregate spending for a defined patient population over a measurement period, evaluated against a benchmark. In value-based contracts, organizations that keep TCOC below benchmark may earn shared savings; those that exceed it may share risk.
HCAHPS - Care Coordination Composite	A new composite measure in the updated HCAHPS survey (effective for discharges January 1, 2025) that evaluates whether staff worked well together and stayed informed and up-to-date about patient care. CMS begins public reporting of this composite in October 2026. Organizations without structured coordination workflows in place today will not have enough data to move the measure meaningfully before it is visible to payers and patients.

Your score tells you where the gaps are.

We can show you how to close them.

blueBriX is an enterprise care management platform with integrated EHR and vendor-agnostic agentic AI orchestration, purpose-built for value-based care organizations. Every pillar of this checklist maps to a capability in our platform.

How the platform addresses each pillar

YOUR LOW SCORE AREA	WHAT BLUEBRIX DOES
Pillar A : Workflow Fit	The Care Team Workbench surfaces role-based, prioritized worklists inside the existing care team flow, tasks are routed automatically to the right coordinator with patient context pre-loaded. Coordinators do not switch systems; the next action is already in front of them.
Pillar B : Interoperability & Integration	Built on FHIR R4, HL7 v2, and REST APIs with pre-built connectors for Epic, athenahealth, and Salesforce. Bi-directional exchange operates in real time, a care plan update reflects across connected systems immediately, not after a nightly batch run.
Pillar C : Configurability	Clinical operations leaders modify cohort rules, care pathways, and assessment forms through a no-code interface, without IT tickets or vendor engagement. New payer contracts and quality measure sets can be configured in days, not development cycles.
Pillar D : Auditability	Every care management touchpoint is auto-captured and timestamped, CCM minutes, TCM contact windows, care plan updates, and tied to the correct CPT code and payer rule. The audit trail can be produced per patient for any billing period in under 24 hours.
Pillar E : Reporting & Revenue Visibility	Risk and Quality Intelligence, Care Coordination and Patient Engagement, and Reporting and Compliance share a single unified data model. HEDIS gap closure, HCAHPS Care Coordination composite performance, denial trends by payer and provider, and Total Cost of Care vs. benchmark are available in real time, no BI tool required.

Ready to turn your score into a plan?

Bring your checklist results to a working session with the blueBriX team.

See exactly how blueBriX closes your coordination gaps, live, with your own workflows.

Demo link

This is not a demo with a script. It is a working session designed around your numbers.

Book a working session

bluebrix.health

Or ask your team to forward this document to the person evaluating cohort management platforms.

This checklist is a directional self-audit, not a compliance certification. Statistics cited reflect published industry benchmarks; individual results vary by specialty, payer mix, and care model.