

TWO TIERS · THREE MARKETS — AUSTRALIA · SMALL STATES · UNITED KINGDOM

Land with the data. Expand to the operating system.

Tier 1 — HDAP + HORUS + Bot Automation: every system into one governed read model, decision intelligence on top. Cheap. Fast. No rip-and-replace.

Tier 2 — the full medOS Ultra hospital operating system, landing on data that's already migrated.



Every hospital wants decision intelligence. Nobody wants an HIS replacement project.

1

Replacement is a 2–5 year trauma

Rip-and-replace EMR projects are slow, politically risky, and routinely blow budgets. Boards defer them — and keep deferring them.

2

Meanwhile the data is fragmented

PAS, LIS, RIS, pharmacy, ERP, HR, spreadsheets — each in its own silo. Management decisions run on stale extracts and gut feel.

3

Intelligence needs the data first

Every AI / analytics initiative stalls on the same step: **get all the data into one governed place.** That step is sellable on its own.

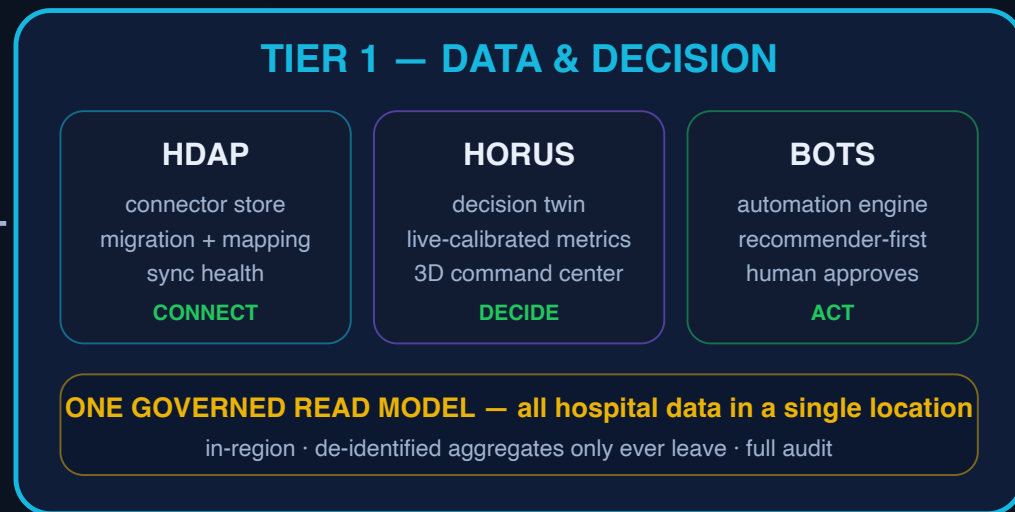
So we split the offer: sell the data consolidation + intelligence layer **first**, beside whatever HIS they run today — and make it the de-risking step for the full platform **later**.

Tier 1 runs beside the incumbent. Tier 2 replaces it — on data already in place.

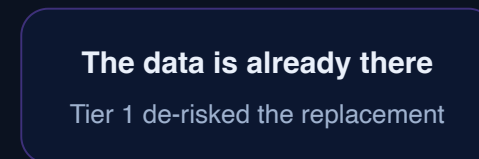
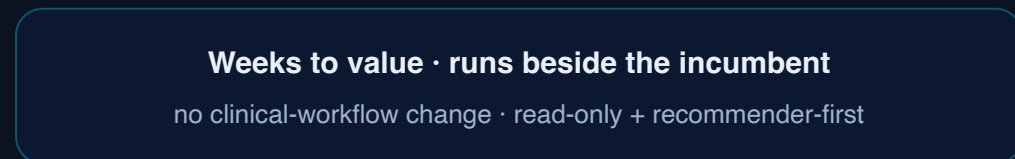
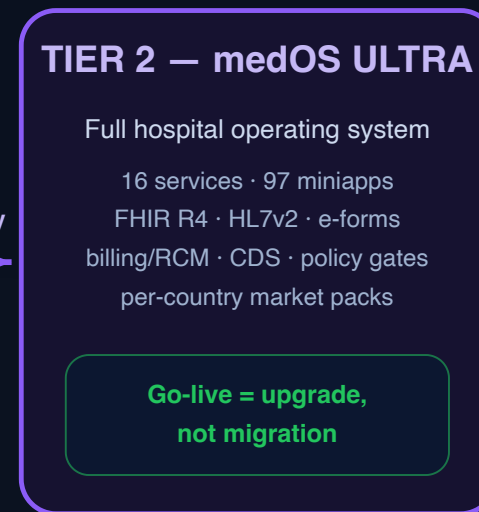
TODAY'S SYSTEMS



read-only
connectors



when ready



Connect → Decide → Act. One admin hub.



HDAP — the data activation platform

Connector Store (48-connector catalog: EHR/HIS, LIS, RIS/PACS, claims, ERP — Odoo/SAP, HRM, devices, terminology), live **Connector Activity** with per-run tamper-evident audit, a **topology map** of every feed, supervised migration ETL with a **mapping-review gate**, and an air-gapped upload path for offline sites.



HORUS — the decision twin

An operational + strategic **digital twin of the hospital**, calibrated from the live read model through a registry of metric feeds (occupancy, workforce FTE, supply cost, contribution margin). Scenario agents recommend; **backtesting builds trust**. A 3D command surface for the executive floor.



Bot Automation

The automation engine + **Bot Org Chart**: bots watch events and schedules, draft the follow-through (chase a stale feed, flag a cost anomaly, prepare a report), and file **proposals into a human inbox**. Recommender-first — a person approves anything that writes.

All three are managed from one place — the HDAP hub — and all three run on the same governed read model. Extension substrate (PRM / marketing / insurance bots) is design-stage and sold as roadmap.

Cheap and fast aren't marketing — they're structural.

Read-only by construction

Connectors pull; nothing writes back to the incumbent. No interface-engine negotiation with the EMR vendor, no go-live risk to clinical operations.

No workflow change

Clinicians keep their screens. Tier 1's users are executives, ops managers, and data teams — a far smaller training and change-management surface.

Light regulatory surface

Read-only + recommender-first keeps Tier 1 out of the heaviest clinical-safety classifications (posture — confirm per market, see compliance slide).

The migration IS the product

Every future HIS replacement needs all data extracted, mapped, and validated. Tier 1 sells that step as immediate decision-intelligence value — the buyer pays for the de-risking they'd have to fund anyway.

Deploys anywhere

In-region cloud (per-country residency pinning) or the all-in-one on-prem / air-gapped stack for low-connectivity sites — one compose file, self-signed-cert setup script included.

Fixed-fee, weeks not years

Connector catalog + supervised ETL + seeded dashboards means the land offer can be priced fixed and delivered in weeks. The expensive part — full HIS — is a separate, later decision.

medOS Ultra: the full hospital operating system.

When the hospital decides to replace the incumbent, Tier 1 has already done the hard part: the data is consolidated, mapped, and validated in production. **Go-live becomes an upgrade, not a migration.**

LAYER	WHAT SHIPS
Clinical	OPD/IPD/ER/OR/LR worklists, e-MAR, CDS rules, nursing assessment, Patient 360 (3D), dynamic flowsheets
Revenue	Billing ledger, cashier, coding, claims/RCM pipeline, per-country payor rules as data rows
Ancillary	Lab, pathology, blood bank, imaging/NM, pharmacy + compounding, CSSD, blood-bank forms
Interop	FHIR R4 read/write + subscriptions, HL7v2 ADT/ORM/ORU + MLLP, CCDAs, e-claims
Platform	Policy gates, acknowledgements, scheduling, e-forms, queue/kiosk, 17 locales, RBAC + audit

Country = data, not code

One codebase. Each country is a **market pack**: seeds, payor rates, terminology, compliance profile. Thailand, Philippines, Japan run today; Australia is scaffolded; new countries are pack-sized work, not platform forks.

Priced from a living catalog

150+ modules enumerated in a public pricing/module catalog — Tier 2 proposals are assembled per hospital from the catalog, never bespoke quotes from scratch.

Tier 1 keeps running

HDAP, HORUS and the bots don't get replaced at Tier 2 — they become the intelligence layer of the new OS, now fed natively instead of via connectors.

Australia: onshore data layer beside entrenched EMRs.

The Tier 1 story

Public and large private hospitals run entrenched EMRs that won't be displaced soon. Tier 1 doesn't ask them to: read-only connectors consolidate PAS/LIS/RIS/ERP into an **onshore (ap-southeast-2) read model**, HORUS gives the executive team a live decision surface, bots automate the operational follow-through.

The Tier 2 story

Private hospital groups and day surgeries first — lighter procurement than state health, real appetite for a modern integrated HIS. Medicare/ECLIPSE claims connector is scaffolded in the AU pack; completing it is pack-sized work.

Compliance posture (not legal advice)

Residency	Onshore expected — procurement norm, not statute
Frameworks	Privacy Act 1988 + APPs · My Health Records Act 2012 · state health-records acts · NDB scheme
Retention	~7y adult; minors to 25 (varies by state)
Tier 1 burden	Low — read-only, de-id aggregates only cross tiers
Shipped	medos-australia pack: manifest + complianceProfile, AU terminology/insurer/connector seeds scaffold

Microstates: the national health data platform, in weeks.

Why Tier 1 is the flagship offer here

Pacific and Indian-Ocean small states, Caribbean nations and Crown dependencies typically run **1–5 hospitals nationally** with thin IT teams, paper or aging systems, and donor-funded digital-health budgets. "Every health record in the country, in one governed place, with a ministry-level dashboard" is a **national project at a Tier 1 price**.

The leapfrog

With no entrenched incumbent to displace, microstates can skip the beside-the-EMR phase entirely and go **straight to Tier 2** — the all-in-one on-prem compose stack is the deployment unit, and the air-gapped path handles unreliable connectivity.

Fit notes

Deploy	On-prem / air-gapped first — single compose file, offline sync-health upload shipped
Compliance	Often AU/NZ- or UK-derived law + donor (WHO / World Bank) requirements — per-nation complianceProfile, verify locally
Language	English packs ready; 17 locales in-app
Channel	Ride the AU orbit (Pacific) and UK orbit (Caribbean / Crown dependencies) — same regional teams, same collateral
Pack	medos-english / medos-universal + thin per-nation manifest

UK: data consolidation beside the trust EPR — private first.

The Tier 1 story

NHS trusts and private groups both struggle with the same fragmentation — EPR + departmental systems + ERP that don't meet. Tier 1 lands as **trust-level (or group-level) data consolidation on UK soil (eu-west-2)** with HORUS on top. Read-only + recommender-first keeps the clinical-safety assessment surface small (posture — confirm with the deploying organisation's Clinical Safety Officer).

Sequencing

Private hospital groups first — commercial procurement, faster cycles. NHS Tier 2 is a long-cycle play entered only after Tier 1 references exist.

Compliance posture (not legal advice)

Residency	UK hosting expected (procurement norm)
Frameworks	UK GDPR + DPA 2018 · NHS DSPT · DTAC · DCB0129 (manufacturer) / DCB0160 (deploying org)
Tier 1 burden	Moderate — DSPT + DTAC apply even read-only; DCB0129 scope reduced by recommender-first
Tier 2 burden	High (NHS) / moderate (private)
To build	medos-uk pack: manifest + complianceProfile, NHS number validation, dm+d/SNOMED-CT UK terminology roadmap

Compliance is configuration, not a per-country fork.

Every market pack declares a `complianceProfile` — residency, retention, consent and masking requirements — and the deployment reads it. The platform's standing rule: **raw patient data never leaves the deployment's jurisdiction; only de-identified aggregates ever cross a tier**, and where residency is hard, even those terminate in-region.

	AUSTRALIA	SMALL STATES	UNITED KINGDOM
Residency	onshore ap-southeast-2	in-country on-prem / air-gapped	UK eu-west-2
Key frameworks	Privacy Act + APPs · MHR Act · NDB	local law + donor requirements	UK GDPR + DPA 2018 · DSPT · DTAC · DCB0129/0160
Tier 1 burden	low	lowest	moderate
Pack status	scaffold shipped	universal pack ready	roadmap

Posture, not legal advice — every framework, retention period and cross-border rule is verified with counsel and the relevant authority per deployment. The same model already covers the hard cases (China/PIPL) — these three markets are the soft end of the spectrum.

Fixed-fee land. Catalog-priced expand.

Tier 1 — the land offer

Fixed fee + subscription. Scoped by connector count, not by ambition: N connectors + supervised migration + HORUS + bot starter pack, delivered in weeks. Pricing anchors against the cost of a BI/data-warehouse project, not an HIS.

Includes: connector store, migration with mapping-review gate, sync-health monitoring, decision twin with live-calibrated metrics, bot automation (recommender-first), executive onboarding.

Tier 2 — the expand offer

Assembled from the module catalog. 150+ enumerated modules; each hospital's proposal is a selection, with the market pack as the per-country base. Tier 1 fee credits toward Tier 2 — the migration they funded is reused, not repeated.

Trigger: incumbent contract renewal, failed upgrade, or a new facility — Tier 1 keeps us in the room until that moment arrives.

SEQ 1

Australia — private groups

Onshore Tier 1 beside the EMR; first references.

SEQ 2

Microstates — both orbits

Pacific via AU, Caribbean via UK; national Tier 1, leapfrog Tier 2.

SEQ 3

UK — private groups

UK-hosted Tier 1; build the medos-uk pack against real demand.

SEQ 4

NHS — long cycle

Enter with Tier 1 references + DSPT/DTAC artifacts in hand.

THE TAKEAWAY

The cheapest first step a hospital can take is also the one that locks in the rest.

Tier 1 puts **every system's data in one governed place** and pays for itself in decision intelligence. From that moment the full **medOS Ultra** replacement is an upgrade on data we already hold — not a migration anyone has to fear.

Land

HDAP + HORUS + bots, fixed fee, weeks, beside the incumbent.

Stay

The twin and the bots become the daily decision surface.

Expand

medOS Ultra go-live on already-migrated data, priced from the catalog.

