

## REFERENCE FRAMEWORK

# Primary Care Orchestration & Execution Platform

## Qualifications and Capabilities

Health systems, provider networks, and state transformation programs are increasingly seeking a category of solution that does not fit neatly into established procurement taxonomies. It is not a telehealth service. It is not an analytics package. It is not an outsourced care management vendor. It is the operating layer that connects those functions and makes them act together on behalf of a defined patient population.

This document describes that category, the Primary Care Orchestration & Execution Platform, and sets out the qualifications and capabilities that distinguish a genuine platform from adjacent solutions that address a portion of the same problem. It is intended as a reference framework for organizations evaluating options, structuring requirements, or building internal alignment on what the category should be expected to deliver.

## DEFINING THE CATEGORY

A Primary Care Orchestration & Execution Platform is a technology and operating layer that sits alongside existing clinical systems and continuously coordinates care for an attributed or defined patient population. It identifies which patients need attention, initiates and manages the work required to reach them, routes that work to the appropriate person or resource, and closes the loop back into the clinical record and the care team's workflow.

The defining characteristic is continuity. Traditional primary care operates episodically: care happens when a patient presents. An orchestration & Execution platform operates continuously, managing the intervals between encounters where chronic conditions progress, care gaps persist, post-discharge risk concentrates, and patients disengage. It does this at population scale, without requiring proportional growth in staffing.

A second defining characteristic is breadth of scope. Orchestration and execution is not a single function performed well. It spans identification, outreach, engagement, escalation, documentation, coordination, and measurement, and it holds those functions together so that no step depends on a person remembering to perform it.

## HOW ORCHESTRATION & EXECUTION DIFFERS FROM ADJACENT SOLUTIONS

Several established solution categories address components of the same underlying problem. Understanding what each contributes, and where each stops, clarifies what orchestration & execution adds.

| SOLUTION CATEGORY                           | WHAT IT ADDRESSES                                                          | WHAT IT LEAVES UNADDRESSED                                                                                                 |
|---------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------|
| <b>Telehealth and virtual care</b>          | Provides a modality for a patient to be seen when they seek care.          | Does not determine which patients need to be seen, initiate contact, or manage the interval between encounters.            |
| <b>Remote patient monitoring</b>            | Captures physiologic data from enrolled patients with specific conditions. | Generates data without an operating layer to interpret it, act on it, or coordinate the resulting work across a care team. |
| <b>Ambient documentation and AI scribes</b> | Reduces documentation burden inside the encounter.                         | Improves the visit but does not extend care beyond it or address the population that never presents.                       |

| SOLUTION CATEGORY                     | WHAT IT ADDRESSES                                                  | WHAT IT LEAVES UNADDRESSED                                                                                                       |
|---------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| Population health analytics           | Identifies risk, stratifies populations, and reports performance.  | Surfaces who needs attention without executing the outreach, engagement, and follow-through that acting on the insight requires. |
| Outsourced care management services   | Adds staffed capacity for a defined subset of patients.            | Scales linearly with headcount and typically operates parallel to, rather than inside, the practice's workflow.                  |
| Patient engagement and outreach tools | Delivers messages, reminders, and campaign-based communication.    | Communicates without clinical logic, escalation pathways, or closed-loop resolution of what the outreach uncovers.               |
| EHR-native population health modules  | Extends the system of record with registries, gaps, and worklists. | Presents work to a care team that must still perform it manually, and generally assumes a single-EHR environment.                |

Each of the above solves a real problem. None of them, individually or in combination, constitutes orchestration or execution. Orchestration is the layer that decides what needs to happen and execution is the layer that causes it to happen, and confirms that it did, coordinating across whichever of these capabilities an organization already owns rather than replacing them.

A practical test: if a solution requires a person to notice something and then initiate the work, it is a tool. If it initiates the work, carries it through, and escalates only what requires human judgment, it is orchestration & execution.

## CORE VALUE DRIVERS

The value of an orchestration & execution platform is realized through the operating model it enables rather than through any individual feature. The drivers below are the outcomes organizations typically pursue when evaluating this category.

| VALUE DRIVER                                          | WHAT IT MEANS IN PRACTICE                                                                                                                                                                                                                       |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Access expansion without proportional hiring          | Population-scale outreach, follow-up, and engagement performed continuously, allowing an organization to serve more patients without adding headcount in proportion to volume. This is the central constraint in workforce constrained markets. |
| Clinicians practicing at the top of their license     | Administrative, coordination, and routine follow-up work is absorbed by the platform, returning clinician and care team time to the decisions that require clinical training.                                                                   |
| Continuity between encounters                         | Chronic condition management, medication adherence, symptom monitoring, and re-engagement of disengaged patients continue in the intervals where episodic care models are silent.                                                               |
| Reliable transitions of care                          | Post-discharge and post-emergency follow-up is initiated as a matter of course rather than depending on available staff capacity on a given day.                                                                                                |
| Care gap and preventive service closure               | Open gaps are identified, patients are contacted, scheduling is routed into existing workflow, and completion is confirmed and documented.                                                                                                      |
| Value-based care performance                          | Quality measure performance, utilization management, and documentation completeness improve as a byproduct of the operating model rather than as a separate initiative.                                                                         |
| Deployment flexibility across organizational maturity | The same capability is delivered to organizations with sophisticated integration environments and to those with limited technical capacity, without requiring the latter to build capability first.                                             |

| VALUE DRIVER                                 | WHAT IT MEANS IN PRACTICE                                                                                                            |
|----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| <b>Sustainability beyond initial funding</b> | Value accrues through retained volume, operating efficiency, and performance in value-based arrangements, so the model can continue. |

## QUALIFICATIONS AND CAPABILITIES

The following five domains describe the qualifications and capabilities that characterize a mature Primary Care Orchestration & Execution Platform. They are intended to be assessed together. Strength in one domain rarely compensates for a material gap in another.

### DOMAIN ONE

#### Organizational Qualifications and Experience

*Establishes whether the organization behind the platform has operated in the environments where it will be deployed, and whether it can sustain a multi-year relationship rather than a software transaction.*

| QUALIFICATION                                          | WHAT DISTINGUISHES A CREDIBLE PLATFORM                                                                                                                                                                                  |
|--------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Healthcare delivery experience</b>                  | Demonstrated history developing, implementing, and supporting technology that changes how care is delivered, not solely how it is documented or reported.                                                               |
| <b>Resource constrained settings</b>                   | Direct experience with resource-constrained providers, such as rural health clinics and independent primary care practices, including the staffing, connectivity, and operational realities specific to those settings. |
| <b>Value-based care and alternative payment models</b> | Experience operating inside risk-bearing and shared-savings arrangements, with an understanding of attribution, quality measure performance, and total cost of care.                                                    |
| <b>Clinical governance</b>                             | Clinician leadership with accountability for the clinical logic embedded in the platform, and a defined process for reviewing and approving that logic.                                                                 |
| <b>Implementation team composition</b>                 | Named team with combined expertise in clinical operations, workflow design, project management, solution configuration, and technical integration, rather than a generalist implementation function.                    |
| <b>Ongoing relationship structure</b>                  | Dedicated implementation leadership, customer success, and technical support maintained through the full term, with continuity of personnel where practical.                                                            |
| <b>Geographic and time zone alignment</b>              | United States based implementation leadership and support resources available during the participating organizations' business hours.                                                                                   |
| <b>Program governance discipline</b>                   | Documented project governance, quality assurance, and risk management processes appropriate to healthcare deployments, with evidence of use rather than existence.                                                      |

### DOMAIN TWO

#### Clinical and Operational Capabilities

*Evaluates whether the platform performs the actual work of orchestration & execution, identifying, engaging, coordinating, and resolving, rather than surfacing work for someone else to perform.*

| CAPABILITY                                  | WHAT DISTINGUISHES A CREDIBLE PLATFORM                                                                                                                 |
|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Continuous engagement between visits</b> | Sustained, clinically directed patient contact in the intervals between encounters, initiated by the platform rather than triggered by a staff member. |

| CAPABILITY                                              | WHAT DISTINGUISHES A CREDIBLE PLATFORM                                                                                                                                                                                                                            |
|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Administrative burden reduction</b>                  | Workflow automation that absorbs routine administrative and coordination work, including outreach, scheduling support and follow-up support, so that it no longer consumes care team capacity.                                                                    |
| <b>Clinician efficiency and top of license practice</b> | Supports return of clinician and staff time to work that requires clinical training, with the platform performing the tasks that do not.                                                                                                                          |
| <b>Proactive population identification</b>              | Ongoing identification and prioritization of patients who may benefit from intervention, including rising-risk patients who are not yet visible through utilization-based methods.                                                                                |
| <b>Care navigation and symptom review</b>               | Guided navigation to the appropriate care setting based on clinical risk and available capacity, including structured symptom review that directs a patient to the right level of care rather than defaulting to the emergency department.                        |
| <b>Care gap identification and closure</b>              | Detection of open preventive and chronic care gaps against recognized measure sets, patient outreach, scheduling routed into existing workflow, confirmation of completion, and continuous recalculation of measure status.                                       |
| <b>Longitudinal chronic condition management</b>        | Structured, protocol-based management of chronic conditions over time, including monitoring, adherence support, and escalation on defined clinical triggers.                                                                                                      |
| <b>Transitions of care</b>                              | Follow-up initiated after hospital, emergency department, and other encounters as a standing process, triggered by admission, discharge, and transfer events rather than by manual notification, with escalation of concerns to the appropriate care team member. |
| <b>Cross-setting coordination</b>                       | Coordination of activity across providers, care teams, and care settings, including capability to route to community, social, behavioral health, and virtual care resources an organization already uses or wishes to add.                                        |
| <b>Multi-modal patient communication</b>                | Engagement across communication methods appropriate to the population served, including voice and text, with multilingual and low-literacy options and interfaces that remain usable where bandwidth is limited.                                                  |
| <b>Patient self-service</b>                             | Self-service capability that resolves routine patient needs without consuming staff time, while routing anything requiring clinical judgment to a person.                                                                                                         |
| <b>Workflow integration for care teams</b>              | Relevant patient information and recommended actions presented inside the workflow the care team already uses, rather than in a separate system requiring parallel attention.                                                                                     |
| <b>Human oversight and escalation</b>                   | Clear escalation pathways with defined clinical thresholds, ensuring the platform operates at the direction of and under the supervision of the care team.                                                                                                        |
| <b>Configurable workflows</b>                           | Adaptation to local staffing models, scope of practice, and care delivery processes through configuration rather than custom software development.                                                                                                                |
| <b>Population health management and reporting</b>       | Management and performance reporting for attributed populations, including the measures required by payer, state, or program reporting obligations.                                                                                                               |
| <b>Operational and quality analytics</b>                | Analytics covering clinical performance, quality measures, operational efficiency, accessible to non-technical users without dependence on an analyst queue.                                                                                                      |
| <b>Closed-loop execution from analytics</b>             | Analytics that initiate work rather than only reporting it, so that an identified gap, risk, or outlier generates a task, outreach, or escalation directly, without manual re-entry into another system.                                                          |
| <b>Value-based care support</b>                         | Direct support for performance in shared savings, risk, and quality-based arrangements through the mechanisms above rather than as a separate module, including automated attribution and measure tracking across the attributed population.                      |

| CAPABILITY                                   | WHAT DISTINGUISHES A CREDIBLE PLATFORM                                                                                                                                                |
|----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Utilization and program integrity monitoring | Detection of utilization patterns inconsistent with clinical risk or expected care pathways, with the linked workflow, documentation, and engagement record needed to support review. |

## DOMAIN THREE

### Technology and Interoperability

*Assesses whether the platform can operate across a range of technical environments, including organizations that cannot support a full integration, without degrading the capability delivered.*

| CAPABILITY                            | WHAT DISTINGUISHES A CREDIBLE PLATFORM                                                                                                                                                                                                              |
|---------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| EHR compatibility without replacement | Operates alongside the organization's existing electronic health record. No requirement to replace, migrate, or consolidate systems of record as a condition of deployment.                                                                         |
| EHR neutrality                        | Demonstrated capability across multiple EHR platforms rather than dependence on a single vendor environment, with evidence of production deployments in more than one.                                                                              |
| Non-integrated deployment path        | A functional alternative for organizations that cannot support integration, such as a secure web application, dashboard, embedded interface, or portal, delivering the core capability.                                                             |
| Standards-based interoperability      | Support for current industry-standard exchange methods appropriate to each organization's technical environment, including HL7 and FHIR-based interfaces where available.                                                                           |
| Unified longitudinal record           | A single longitudinal patient record assembled from multiple contributing sources and expressed in a standards-based structure.                                                                                                                     |
| Secure and timely data exchange       | Data movement between systems that is secure and sufficiently current to support the clinical and operational workflows it enables.                                                                                                                 |
| External system connectivity          | Ability to connect with payer, Medicaid, laboratory, pharmacy, imaging, health information exchange, claims, social service network, and remote monitoring device sources as applicable to the deployment.                                          |
| Third-party and future extensibility  | An API-first, cloud-native architecture supporting configurable connection to third-party applications and to technology investments an organization has already made or plans to make.                                                             |
| Analytics across mixed data sources   | Descriptive, predictive, and prescriptive analytics that function using data from integrated sources, non-integrated sources, or a combination, so that organizations at different integration levels are not excluded from performance visibility. |
| Data quality management               | Normalization, validation, reconciliation, and other mechanisms that improve the accuracy and usability of incoming data across contributing sources, including attribution and panel data.                                                         |
| Multi-organization scalability        | Consistent performance, security, and usability when deployed across multiple organizations, with appropriate data separation between them.                                                                                                         |
| Deployment approach determination     | A collaborative process for determining the right deployment model for each organization, integrated or non-integrated, based on technical capability and operational need, documented before implementation begins.                                |
| Technical documentation               | Documentation of the integration or alternative deployment approach, implementation assumptions, and technical prerequisites provided in advance.                                                                                                   |

## DOMAIN FOUR

### Security, Privacy and Responsible AI

Covers the security, privacy, and AI governance expectations appropriate to a platform that handles protected health information and applies automated capability to clinical workflows.

| REQUIREMENT                         | WHAT DISTINGUISHES A CREDIBLE PLATFORM                                                                                                                                                                                             |
|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Information security program</b> | Documented security and privacy program appropriate to healthcare data, with independent third-party attestation(SOC 2).                                                                                                           |
| <b>Regulatory compliance</b>        | Support for applicable federal and state privacy and security requirements, including HIPAA, as applicable to the deployment.                                                                                                      |
| <b>Business Associate Agreement</b> | Execution of a BAA or equivalent data protection agreement prior to receiving protected health information or other regulated data.                                                                                                |
| <b>Encryption</b>                   | Current industry-standard encryption of data in transit and at rest.                                                                                                                                                               |
| <b>Access control</b>               | Role-based access, least-privilege principles, secure authentication, and multi-factor authentication for administrative and privileged access.                                                                                    |
| <b>Audit logging</b>                | Logs of user access, administrative activity, data access, and other security-relevant events, retained and available for review.                                                                                                  |
| <b>Incident response</b>            | Documented security incident response and breach notification processes, with notification to the contracting organization and affected participants within contractually defined timeframes.                                      |
| <b>Vulnerability management</b>     | Ongoing vulnerability management, security testing, and timely remediation, including independent penetration testing or equivalent assessment.                                                                                    |
| <b>Business continuity</b>          | Continuity, disaster recovery, backup, and service restoration capability proportionate to the operational criticality of the platform.                                                                                            |
| <b>Data ownership and use</b>       | Clearly defined data ownership, permitted uses, retention, return, and secure deletion. No sale of customer or patient data, and no use for unrelated purposes.                                                                    |
| <b>Subprocessor transparency</b>    | Identification of material subcontractors and subprocessors with access to customer data, with contractual, privacy, and security oversight of each.                                                                               |
| <b>AI transparency</b>              | Clear disclosure of any artificial intelligence, machine learning, predictive analytics, or generative capability used, including intended purpose, data inputs, outputs, known limitations, and how output should be interpreted. |
| <b>Human-in-the-loop design</b>     | AI-enabled functionality designed to support rather than replace clinical and operational judgment, with human review or intervention required for any decision that could materially affect patient care, access, or safety.      |
| <b>Model performance monitoring</b> | Ongoing evaluation for accuracy, reliability, bias, performance drift, and unintended impact across the patient populations and care settings served.                                                                              |
| <b>AI change governance</b>         | Defined processes for approving, testing, updating, and monitoring AI-enabled functionality, with communication of material changes affecting performance, risk, or intended use.                                                  |
| <b>Training data restrictions</b>   | Customer, patient, and participating organization data not used to train or improve generalized AI capability without prior written authorization and appropriate privacy, security, and contractual safeguards.                   |

## DOMAIN FIVE

### Implementation and Enablement

Addresses the capability that most often determines whether a technically sound platform produces results: the ability to deploy it into organizations with limited staff capacity and competing operational priorities.

| CAPABILITY                                        | WHAT DISTINGUISHES A CREDIBLE PLATFORM                                                                                                                                                                                                        |
|---------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Implementation methodology</b>                 | A defined methodology and project plan identifying phases, milestones, dependencies, deliverables, decision points, and responsibilities across all parties.                                                                                  |
| <b>Governance structure</b>                       | Executive sponsorship, project leadership, escalation pathways, meeting cadence, risk management, and status reporting established at the outset.                                                                                             |
| <b>Readiness assessment</b>                       | Organizational, technical, workflow, and data readiness assessed for each participating organization, with identified constraints and dependencies reflected in the plan rather than discovered during deployment.                            |
| <b>Collaborative workflow design</b>              | Workflows designed and configured with each organization to align with local staffing models, scope of practice, care delivery processes, and available technology.                                                                           |
| <b>Fit for resource constrained environments</b>  | An approach built for limited staffing, limited technical capacity, variable connectivity, geographic dispersion, and competing operational priorities, rather than an enterprise methodology applied to smaller organizations.               |
| <b>Change management</b>                          | A structured approach to communication, leadership alignment, frontline participation, resistance management, and adoption risk.                                                                                                              |
| <b>Role-based enablement</b>                      | Enablement designed separately for clinical, operational, administrative, technical, and leadership users.                                                                                                                                    |
| <b>Reusable enablement materials</b>              | User guides, workflow documentation, and enablement resources that the contracting organization and participating organizations may retain and reuse.                                                                                         |
| <b>Local champion development</b>                 | Identification and preparation of local champions, super users, and trainers who can reinforce workflows and sustain adoption after the deployment team steps back.                                                                           |
| <b>Go-live management</b>                         | Defined readiness criteria and structured support for testing, cutover, launch, stabilization, issue triage, and transition to ongoing operations.                                                                                            |
| <b>Assumptions, dependencies and cost drivers</b> | Explicit identification of implementation assumptions, customer responsibilities, resource requirements, prerequisites, travel and onsite support expectations, third-party dependencies, and risks that may affect schedule, scope, or cost. |
| <b>Post-implementation support</b>                | Defined service channels, response expectations, escalation processes, and accountability for resolving operational and technical issues.                                                                                                     |
| <b>Adoption measurement</b>                       | Measurement of implementation progress, user adoption, workflow utilization, and early performance, with results used to identify and remove barriers to successful use.                                                                      |
| <b>Continuous improvement</b>                     | Workflow optimization, refresher enablement, configuration updates, and periodic review of operational performance and user feedback after go-live.                                                                                           |
| <b>Phased expansion</b>                           | Support for phased deployment across additional organizations, sites, populations, or use cases without redesign of the solution or the implementation model.                                                                                 |
| <b>Knowledge transfer</b>                         | Transfer of knowledge sufficient for designated personnel to sustain routine administration, reporting, user support, and agreed configuration activity after implementation.                                                                 |

## DISTINGUISHING QUESTIONS

Where capability claims across solutions begin to sound similar, the following questions tend to separate an orchestration & execution platform from an adjacent solution positioned as one.

- ▶ **Does it initiate, or does it notify?** A platform initiates work and carries it to resolution. A tool notifies a person who must then act.
- ▶ **What happens to patients who never present?** Orchestration reaches the population that does not seek care. Most adjacent solutions only serve patients already in motion.
- ▶ **Does capability degrade without full integration?** Organizations with limited technical capacity should receive the core capability, not a reduced version.
- ▶ **Does it scale with headcount?** If serving more patients requires proportionally more staff, the workforce constraint has not been addressed.
- ▶ **Where does the work land?** Output delivered into the workflow a care team already uses is adopted. Output delivered to a separate system competes for attention it will not receive.
- ▶ **What sustains it after the funding period?** A model dependent on continued external funding is a program. A model that generates operating value is infrastructure.

## APPLYING THE FRAMEWORK

The distinction that matters most in evaluating this category is between solutions that surface work and solutions that perform it. Analytics identify. Engagement tools communicate. Monitoring measures. Orchestration is the layer that determines what needs to happen and execution is the layer that causes it to happen across whichever resources an organization has available, and confirms that it did, continuously, at population scale, and under clinical direction.

Organizations evaluating this category are generally best served by assessing capability across all five domains together. A platform that performs well clinically but cannot deploy into a resource constrained environment will not produce results. A platform that deploys easily but cannot operate without full integration will exclude the organizations that need it most. And a platform that satisfies both but cannot be sustained past an initial funding period will leave the underlying access and workforce challenges unresolved.