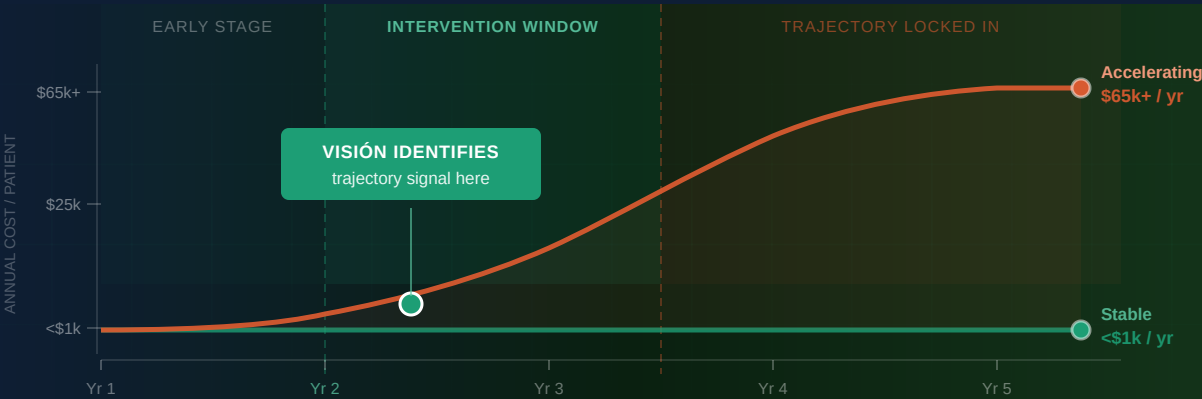


Bending the *Acuity Curve.*

The AI platform that predicts where each patient's disease complexity will be 12 to 24 months from now — and tells care teams exactly what to do about it.

Visión is how you stop explaining costs after they have already risen — and start identifying, 12 to 24 months in advance, the patients whose disease trajectories are quietly building toward your next high-cost cohort.



200M+

Patients in prediction model training dataset

14 Yrs

AI in production across federal & commercial systems

12–24

Month forward prediction horizon per patient

4

Foundational chronic conditions modeled

Every risk tool in your stack is solving the wrong problem.

Chronic disease costs are not rising. They are compounding. Across federal and commercial health systems, the same structural fact holds: 5% of covered lives account for roughly 50% of total spending. Virtually all of them are managing multiple chronic conditions simultaneously.

The instinct is to concentrate resources on those patients. But those patients are already there. Their acuity is locked in. The real opportunity lies upstream: in the larger population whose disease is quietly progressing toward high-cost, high-complexity care.

They look stable today. Conventional risk tools score them as low priority. A patient consuming \$3,000 to \$8,000 per year triggers nothing. No alert fires. No outreach happens. In 12 to 24 months, that patient is consuming \$25,000 to \$70,000 or more annually. Every step of that progression was predictable from clinical signals already present in the data.

TODAY	12-24 MONTHS	WITHOUT INTERVENTION
\$3–8K/yr Patient looks stable. Conventional tools score low priority.	Intervention window Visión DPI identifies trajectory acceleration — while conditions are still manageable.	\$25–70K+/yr High-cost, complex care. Trajectory locked in. Only marginal reduction possible.

The failure is not execution. Health systems have invested billions in care management infrastructure: more staff, expanded coordination teams, new clinical programs. The failure is timing. The tools driving those teams are pointed at the wrong moment in the disease timeline.

The industry has invested billions in execution infrastructure, but everyone is focused on identifying the current patient disease state. No one predicts the trajectory.

52,000 patients. One question. Two radically different answers.

In FY23, 52,000 patients at a southeast regional provider were eligible for ASCVD scoring. Visión applied strict inclusion criteria and isolated 2,596 patients. All scored Moderate Low on the Disease Progression Index (DPI). All had real utilization. None had reached a complex disease state. *Conventional risk stratification said they were clinically identical: stable, not urgent, not a priority for intensive intervention.*

Visión's Disease Progression Index said otherwise. By applying forward-looking trajectory modeling, the Visión platform identified 649 patients whose disease complexity was invisibly accelerating. A retrospective analysis validated those predictions against what actually happened over the next two years.

\$15,459/yr

Average annual cost for the 649 accelerating patients by FY25. Up from \$7,681. A 102% increase in two years.

\$788/yr

Average annual cost for 1,947 stable patients. Same starting score. Same initial cost profile. Same care team.

20×

Cost difference between cohorts by FY25. Invisible to every conventional tool throughout.

The divergence point was visible in the DPI data before FY23 ended. A 24-month runway separated low-cost stability from high-cost care. Conventional models kept the window locked. DPI opened it.

What separates Visión from every conventional risk tool

Dimension	Conventional Risk Model	Visión DPI
Core Question	Who has had an ED visit or hospitalization in the past 6 months?	Whose disease biology is progressing toward high-cost care 12–24 months from now?
Prediction Horizon	Backward-looking. Identifies patients who have crossed into high-acuity status.	Forward-looking. 12–24 months before progression locks in.
Intervention Timing	Too late. Disease is advanced, trajectory is fixed.	Optimal. Conditions are still manageable; the trajectory can be bent.
Target Precision	All 2,596 look identical. Stable, not urgent, no priority differentiation.	Identifies the right 649 out of 2,596 that appear identical to conventional tools.
Intervention Guidance	None. Identify who, not what to do.	Precision recommendation based on clinical history, SDOH, prior response, and adherence patterns.

The math favors early intervention by a decisive margin.

Each patient deflected from an accelerating trajectory prevents the cost of care from crossing from roughly \$5,000 per year to \$70,000 or more. The same care coordinator. The same care plan. The same intervention. Applying earlier produces fundamentally different financial and clinical results.

11:1

Projected return on investment, moderate engagement scenario

324

Successful patient engagements required to break even

A conservative 5% engagement rate produces \$12.9M in avoided cost against a \$4.85M investment. A moderate 25% scenario generates \$64.8M. The economics scale linearly with care management capacity.

Breakeven is not aspirational. It requires engaging less than 5% of the identified population. Everything above that is margin.

HOW IT WORKS

THE INTELLIGENCE LOOP

Every care management team drives the same four capabilities every day. The only variable is whether you deploy them 12 months before the cost crisis forms or only after it has already formed. Visión gives that head start across all four.

01 — IDENTIFY

Surface the invisible.

DPI identifies accelerating patients from an identical-looking pool, 12–24 months before trajectory locks in. Monthly rescoring refreshes the list automatically.

02 — RECOMMEND

Know exactly what to do.

Precision guidance grounded in SDOH, prior response, and real-world adherence. Not a generic guideline step. A specific, individual intervention for each patient.

03 — ACT

Engage, not administer.

Automated EHR review and next-step surfacing frees care managers to focus on patient engagement. Throughput increases. Variability disappears.

04 — MONITOR

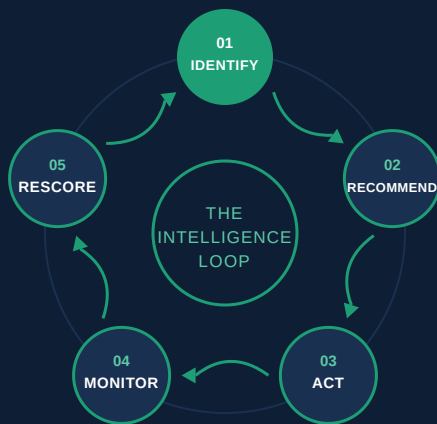
Close the feedback loop.

Adherence tracking and outcomes measurement confirm what is actually working. The curve becomes measurable. Every cycle learns.

Disease Progression Index: a computational biomarker, not a risk score.

DPI is trained on medical records, prescription data, claims history, and social determinants of health for 200 million Americans, then tailored to each health system's specific patient population. It operates across four key chronic conditions that drive the cost burden of chronic care: ASCVD, CKD, Type 2 Diabetes, and COPD.

The core question DPI asks differs from traditional models: whose disease biology is headed toward high-intensity care 12 to 24 months later? It identifies the intervention window before costs rise. The Recommendations Engine then informs care teams not only who to target but also the specific intervention needed to make a difference for each patient.



01 — IDENTIFY

The right patients

DPI identifies accelerating patients from an identical-looking pool — 12–24 months before trajectory locks in. Monthly rescoring refreshes the list.

02 — RECOMMEND

The right intervention

Precision guidance grounded in SDOH, prior response, and real-world adherence — not a generic guideline step. A specific, individual intervention.

03 — ACT

With precision

Automated EHR review and next-step surfacing frees care managers to focus on patient engagement. Throughput increases. Variability disappears.

04 — MONITOR

Every intervention

Adherence tracking and outcomes measurement close the feedback loop on what is actually working. The curve becomes measurable.

05 — RESCORE

Every month

Monthly rescoring continuously refreshes the early-trajectory pool. The loop never stops. The wisdom compounds.

This is how a health system bends the curve.

IDENTIFY. RECOMMEND. ACT. MONITOR.

cogitativo

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