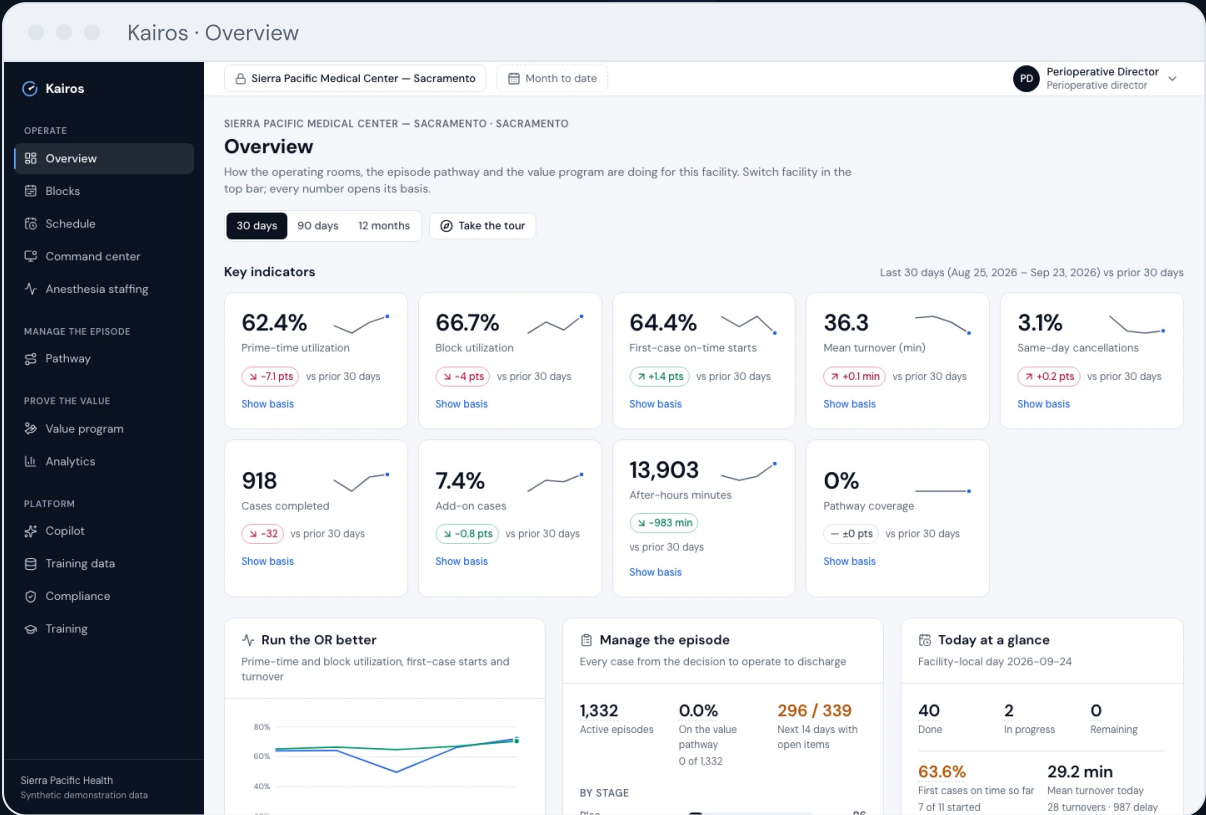




Run the OR better. Manage the whole episode. Prove the savings.

Anesthesia-led perioperative performance: one platform for the operating rooms, every step of the surgical episode, and a value program whose savings a hospital CFO can check line by line.

Discussion draft · September 2026 · Prepared by the founding team with the clinical partner · Synthetic data only



The Overview, signed in as a perioperative director. Every tile opens the arithmetic behind it.

Surgical care is where cost, risk and capacity meet

The perioperative pathway touches almost every hospital cost line — OR minutes, beds, complications, readmissions — yet it is managed one slot at a time.

~1/3

of U.S. healthcare spending is associated with surgical care
Per the clinical partner's framework

28–32%

of the global burden of disease is attributable to conditions requiring surgical care
Per the clinical partner's framework

Risk is discovered too late

Anemia, diabetes, sleep apnea and anticoagulation are too often found on the day of surgery — when the only options are delay, cancel or proceed with more risk.

Incentives are fragmented

Surgeons, anesthesia, the hospital and the payer each optimize their own piece. Nobody is paid to own the whole episode, from the decision to operate to the discharge.

Savings are claimed, not proven

Tools report recovered minutes or projected dollars. A CFO, a surgeon and a payer rarely see the same arithmetic — so shared savings stall at validation.

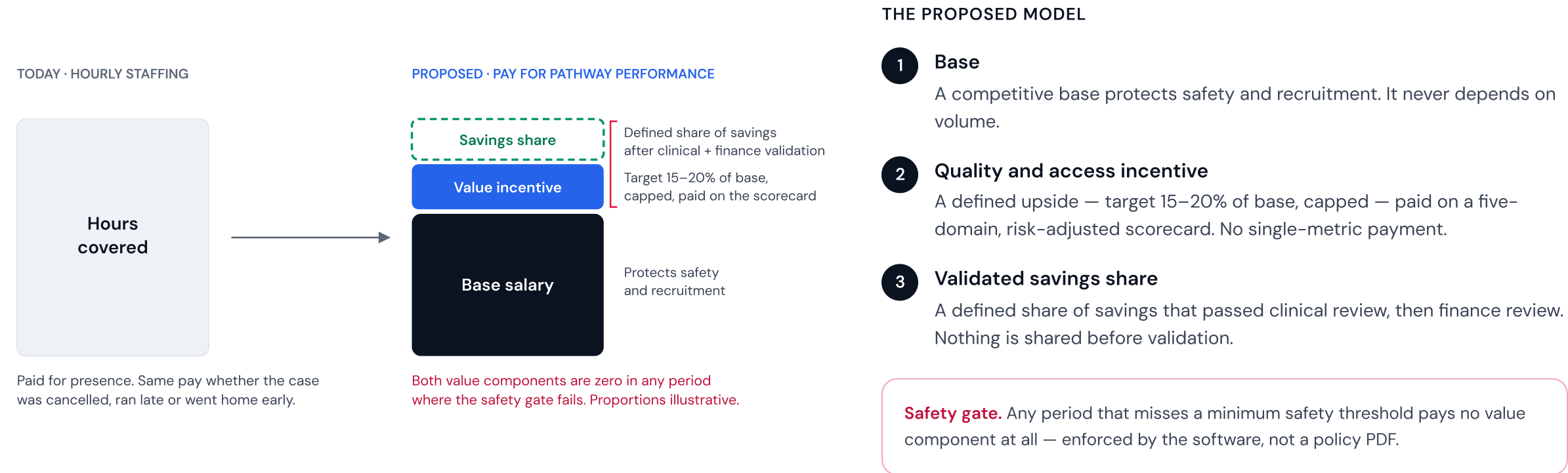
“I need an AI software that cuts down the cost all around and shows the savings.”

The clinical partner — an anesthesiologist who owns hospitals and clinics in California

Surgical-care share of spending and of the global burden of disease: as cited in the clinical partner's framework (Farm to OR Table deck, 2026). Quote: the clinical partner, September 2026.

Hourly staffing pays for presence, not pathway performance

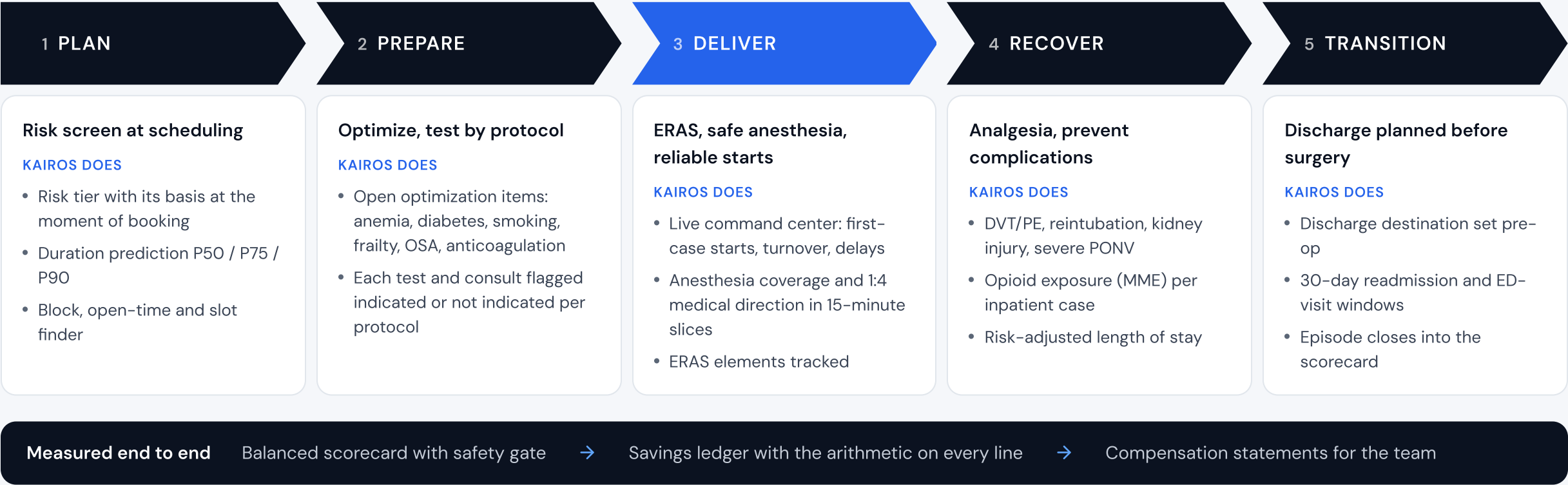
The team best placed to change the episode — anesthesia, which sees every patient before, during and after surgery — is paid the same whether the pathway works or not.



Compensation model: docs/PRODUCT-VISION.md and docs/VALUE-ENGINES.md §7. The demo's seeded plan (anesthesiologist base \$480k, target 17.5%, cap 25%; 30% of validated savings shared) is illustrative.

One accountable team follows the patient through five stages

The clinical partner’s model, made operational: every case sits on a pathway from the decision to operate through discharge, and every stage feeds the scorecard.



Stages: the clinical partner’s Farm to OR Table model (docs/PRODUCT-VISION.md). What Kairos does at each stage: docs/VALUE-ENGINES.md §10 and docs/OPERATIONS-MODULES.md.

Why this is bigger than block scheduling

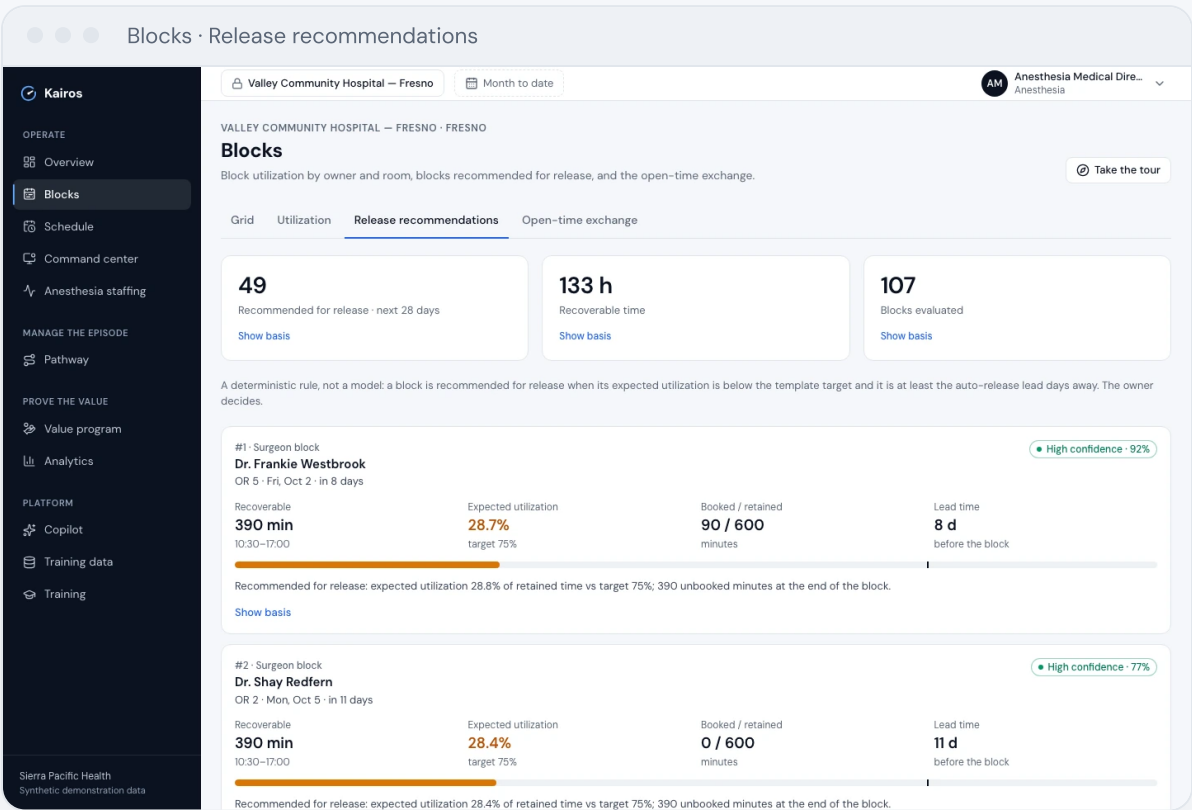
Block-scheduling tools optimize one lever and sell it to the periop director. Kairos treats OR utilization as one of five levers — and still does that lever well, deterministically and with its basis shown.

	BLOCK-SCHEDULING TOOLS	 KAIROS
Unit of optimization	OR block minutes	The surgical episode, from the decision to operate to recovery
Buyer	Perioperative director	Health system and anesthesia partnership, under a value contract
Economic story	Recovered OR capacity	Validated episode savings, shared with the clinical team
Clinical scope	Scheduling	Risk screening, optimization, testing stewardship, ERAS, recovery and discharge
Incentive alignment	None	Scorecard-driven compensation: base, bonus and a share of validated savings
AI	Predictive scheduling	Predictive scheduling and a copilot over the whole episode — briefs, recommendations, savings narratives

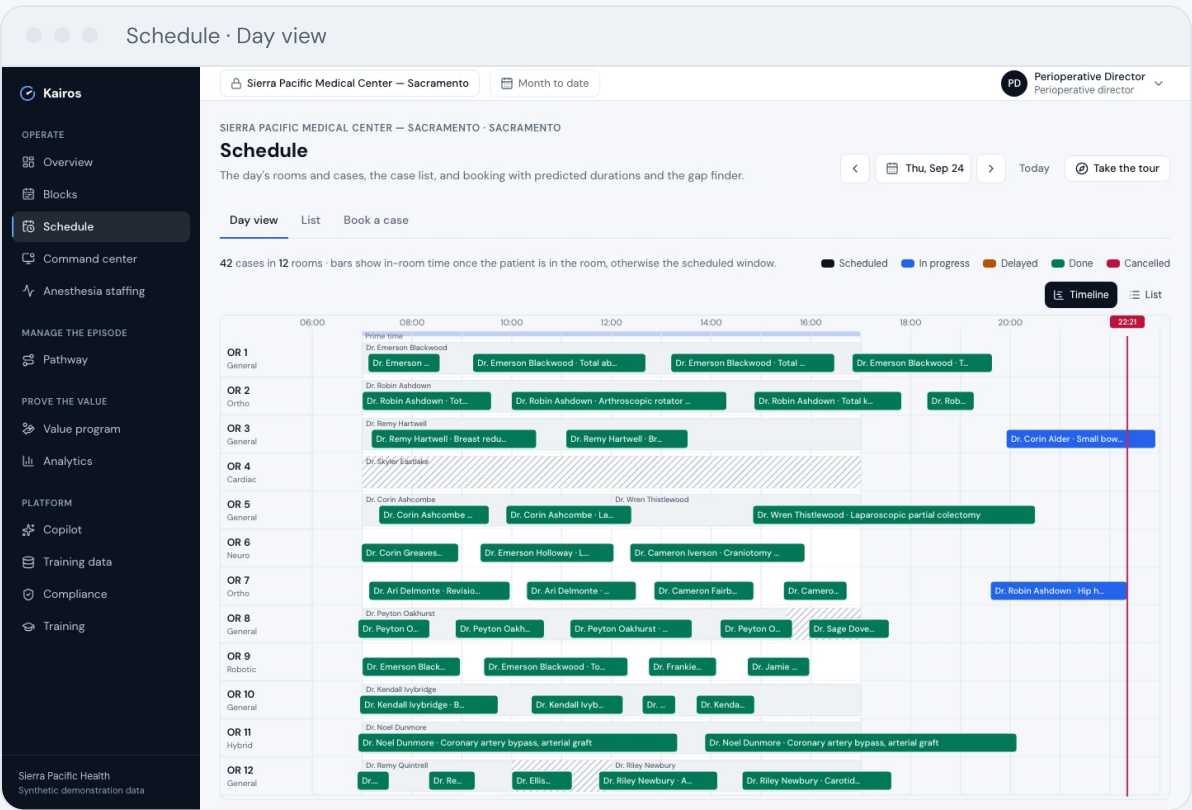
- The buyer is the partnership that can change the episode, not only the office that allocates blocks.
- The economic story ends in validated dollars with a basis — not a projection.
- Multi-facility, multi-organization tenancy from day one: the second hospital is configuration.

Comparison: docs/PRODUCT-VISION.md, generalized to the block-scheduling tool category.

Release the time owners will not use, and book cases for how long they really take



49 blocks, 7,980 minutes recommended for release at the pilot hospital over the next 28 days — a deterministic rule with its basis; the owner decides.



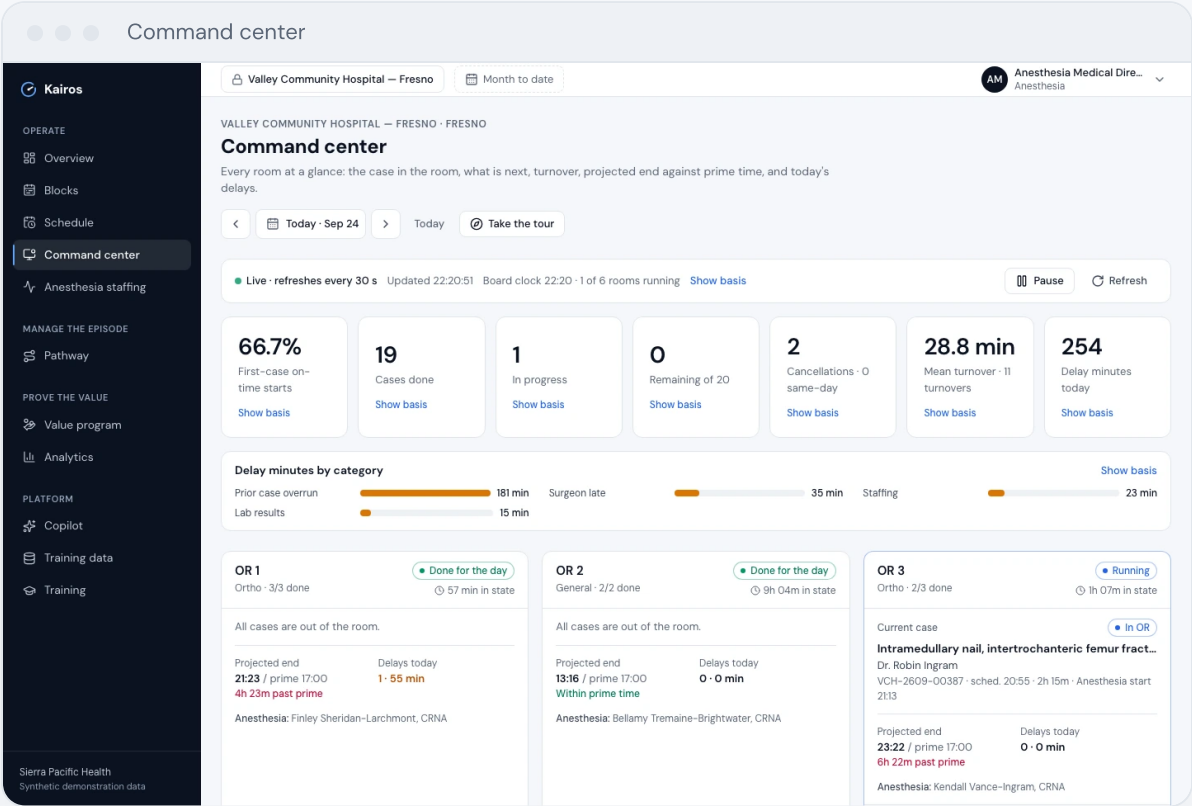
The day view: 42 cases in 12 rooms, block bands, prime time and a live now line. Booking shows P50/P75/P90 predictions and the database itself rejects a double booking.

- Block utilization per owner, raw and adjusted, with a weekday × hour heatmap.
- Release recommendations ranked by recoverable minutes, from the owner's trailing utilization and the facility's booking curve.
- An open-time exchange, and duration predictions that beat surgeons' own estimates.

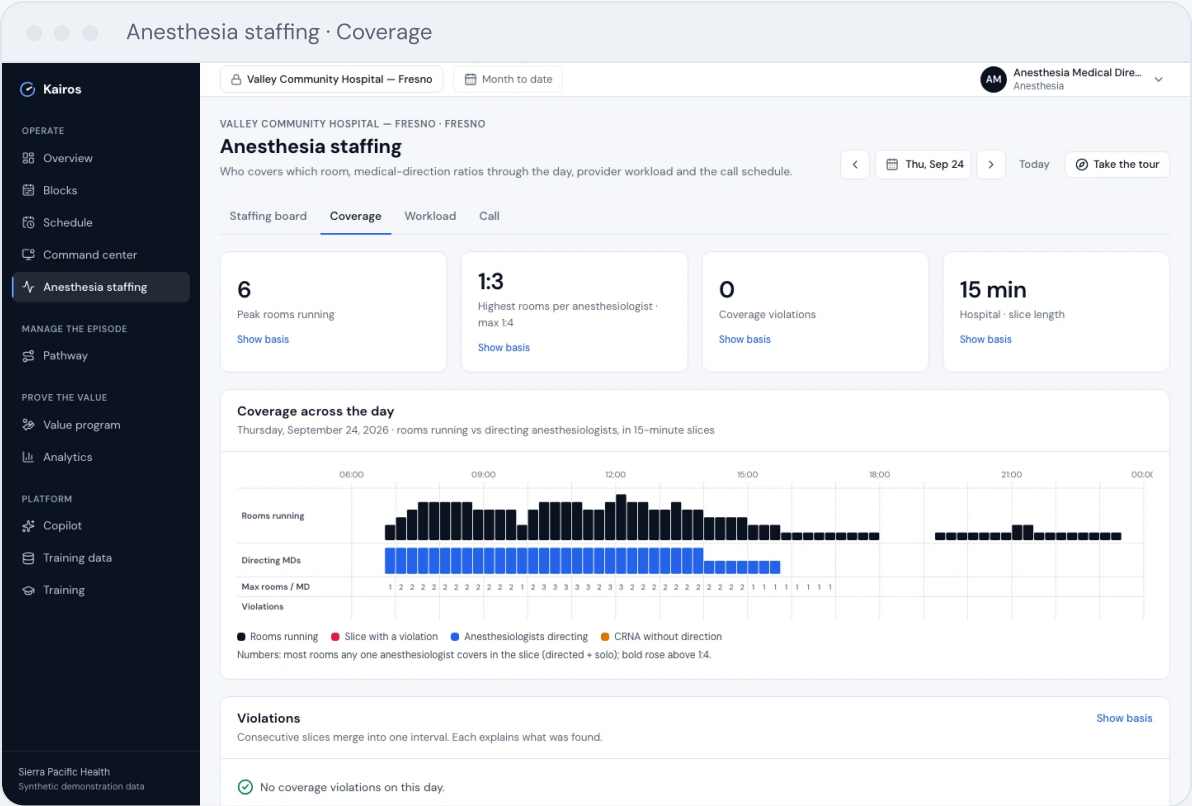
Synthetic data · fictional health system

Blocks → Release recommendations, Valley Community Hospital, next 28 days as of Sep 24, 2026. Schedule: Sierra Pacific Medical Center day view, Sep 24, 2026. Demo script minutes 2–4.

Run the day from one screen — including anesthesia coverage



The live board: every room's current case, projected end against prime time, delays by category, turnover and first-case starts.



Coverage in 15-minute slices: rooms running against directing anesthesiologists, the 1:4 medical-direction ratio, and every flagged interval with its basis.

- Record milestones as they happen; delays carry a reason.
- Anesthesia staffing is a first-class module, not an afterthought.
- The same numbers roll into the reliability domain of the scorecard.

Synthetic data · fictional health system

Command center and Anesthesia → Coverage at Valley Community Hospital, Sep 24, 2026 (signed in as the anesthesia medical director). Demo script minutes 4–6.

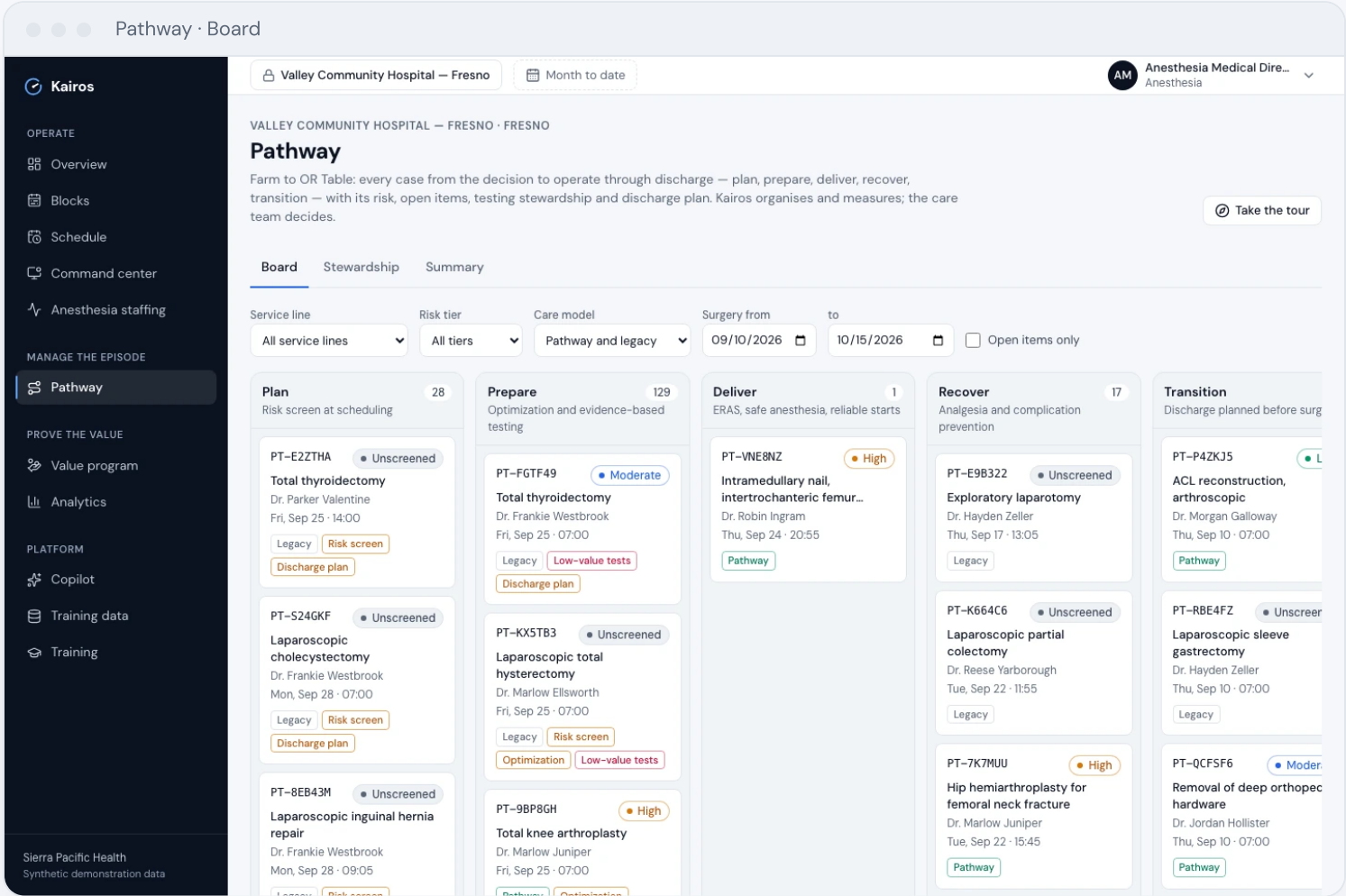
The team manages the episode, not just the slot

Every upcoming case sits on a PLAN → TRANSITION board with its risk tier, open optimization items, testing–stewardship flags and discharge plan — weeks before the day of surgery, when there is still time to act.

- Risk screen at scheduling: a score with its basis, never a clinical conclusion.
- Tests and consults marked indicated or not indicated per protocol; only non-indicated ones count as avoidable.
- ERAS elements, complications and the discharge destination tracked per episode.
- Pathway versus legacy care side by side, so the before/after is visible per service line.

Software organizes, measures and drafts; clinicians decide.

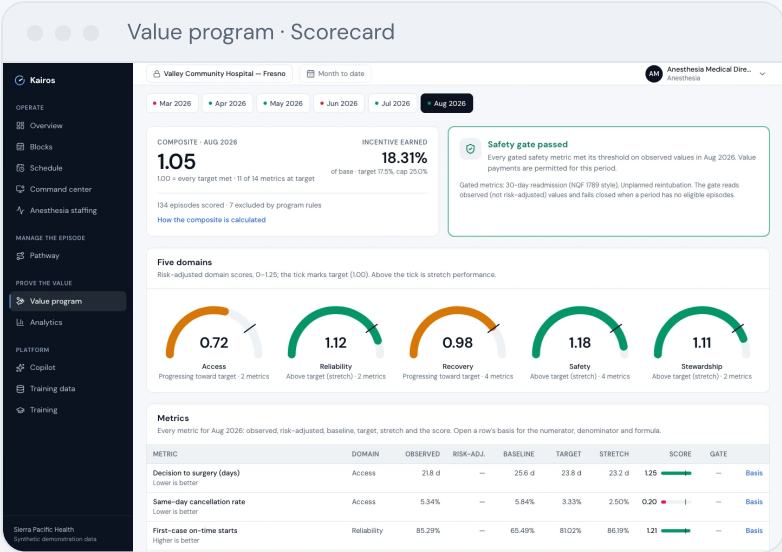
Synthetic data · fictional health system



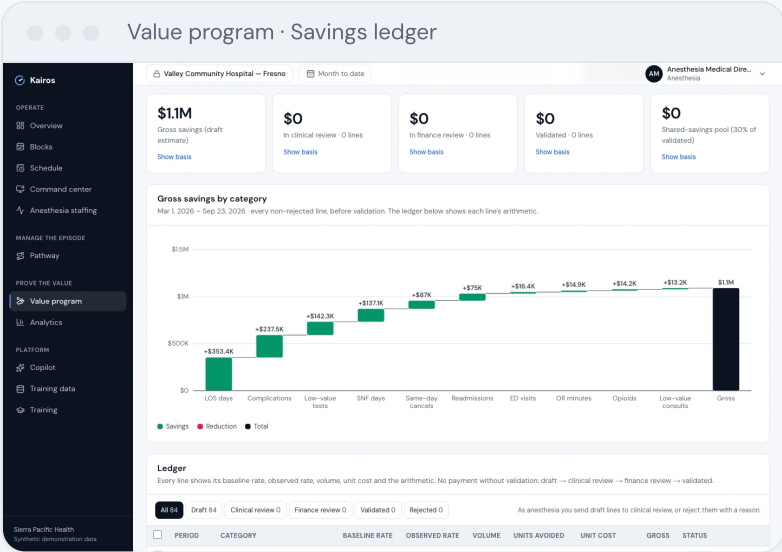
Farm to OR Table as a working board: stage, risk tier and open items on every card.

Pathway board at Valley Community Hospital, surgeries Sep 10 – Oct 15, 2026. Stewardship rule: docs/VALUE-ENGINES.md §9–10. Demo script minutes 6–7.

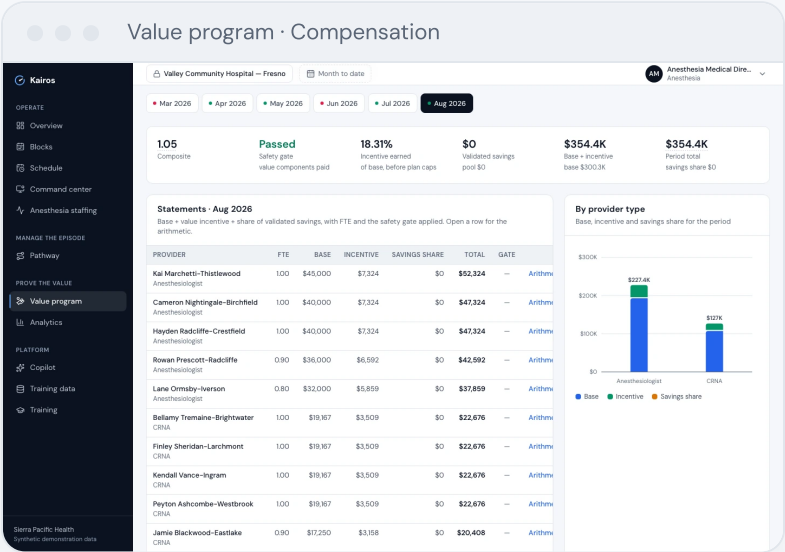
Scorecard with a safety gate → savings with their basis → what the team earns



Composite 1.05, gate passed, 11 of 14 metrics at target — five risk-adjusted domains, no single-metric payment.



\$1.09M gross, \$0 validated — every line shows baseline rate × volume × unit cost, and nothing counts until clinical and finance review.



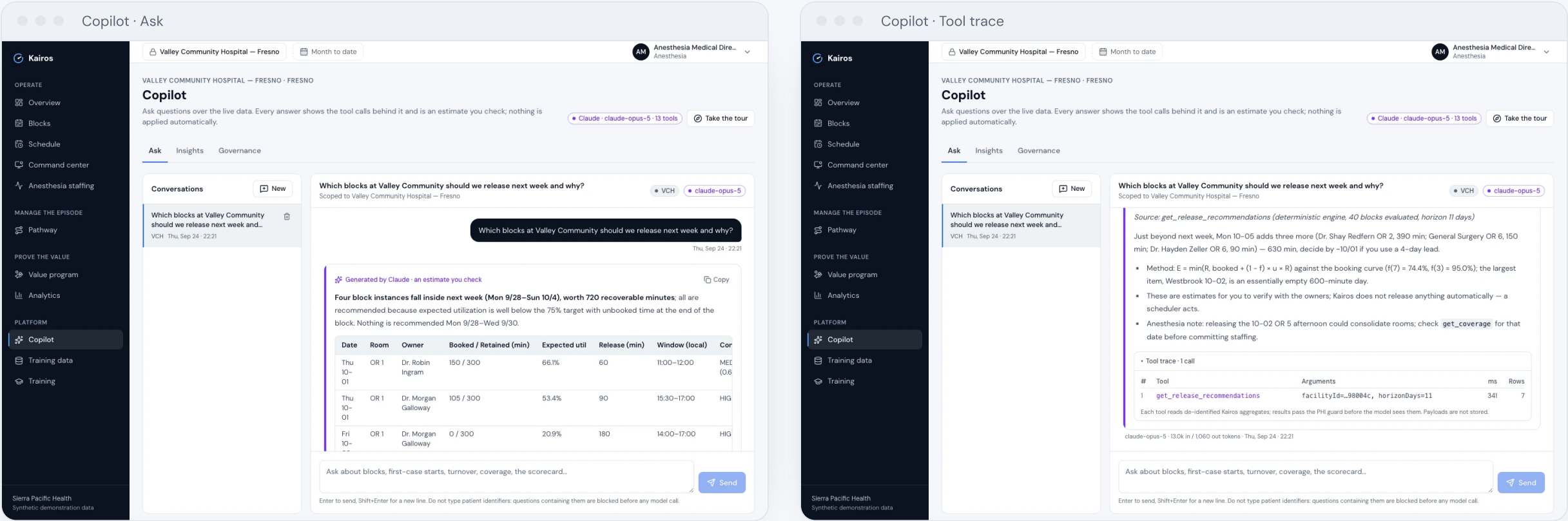
Statements per provider: base + incentive + savings share, with FTE, the gate and the arithmetic one click away.

- Safety gate fails closed: no eligible episodes means no value payment.
- Validation needs two different people: clinical review, then finance review.
- The program cannot activate until counsel approves the gainsharing design.

Synthetic data · fictional health system

Value program → Scorecard, Aug 2026, Valley Community Orthopedics pilot (synthetic); Value program → Savings ledger, Mar 1 – Sep 23, 2026, all lines in draft; Value program → Compensation, Aug 2026, Valley Community anesthesia team. Demo script minutes 7–8.5.

Claude over the live data — with guardrails you can see



Asked in plain English, answered from read-only tools over de-identified aggregates — violet marks machine-generated content.

The tool trace under every answer: which tool ran, with what arguments, how long it took and how many rows it returned.

- De-identified only

A structural type and a guard on every outbound call block identifiers; a blocked call is logged.
- Deterministic numbers

Predictions, recommendations, scorecards and savings are computed by engines; Claude explains, never computes a dollar.
- Nothing auto-applied

Releasing a block, booking a case or validating a saving is always a person's action.
- Governed

Model inventory, intended use and human oversight per ISO/IEC 42001 and the NIST AI RMF.

Copilot, signed in as the anesthesia medical director, Valley Community Hospital, Sep 24, 2026; one question asked for this deck. AI governance: docs/AI-COPILOT.md and docs/COMPLIANCE-REGISTER.md (ISO/IEC 42001, NIST AI RMF). Demo script minutes 8.5–9.5.

A health system of synthetic data, rebuilt from one seed

45,271

surgical cases
18 months of history + six weeks
booked ahead

837,937

rows across 48 tables
CSV or JSON export with a data
dictionary

3 · 24

facilities · operating rooms
Two hospitals and an ASC,
fictional

69 · 45

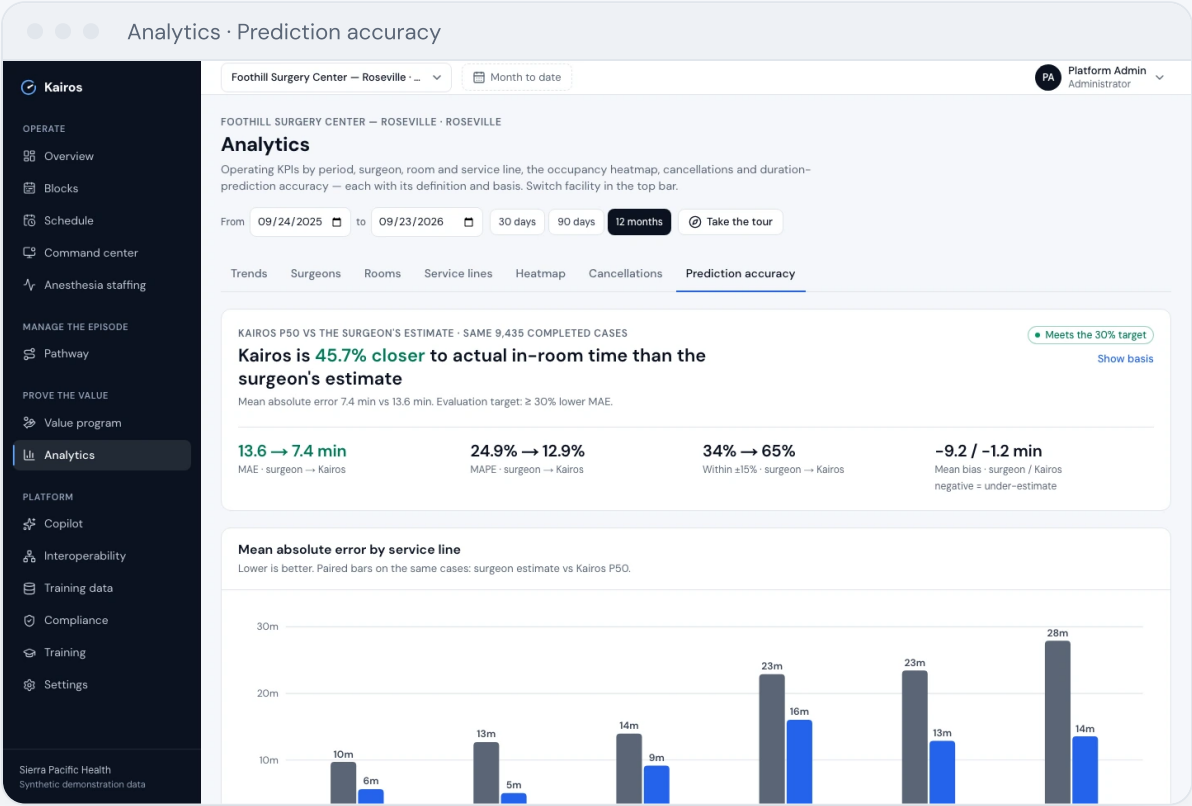
surgeons · anesthesia
providers
Each with speed, estimate bias,
persona

64 s

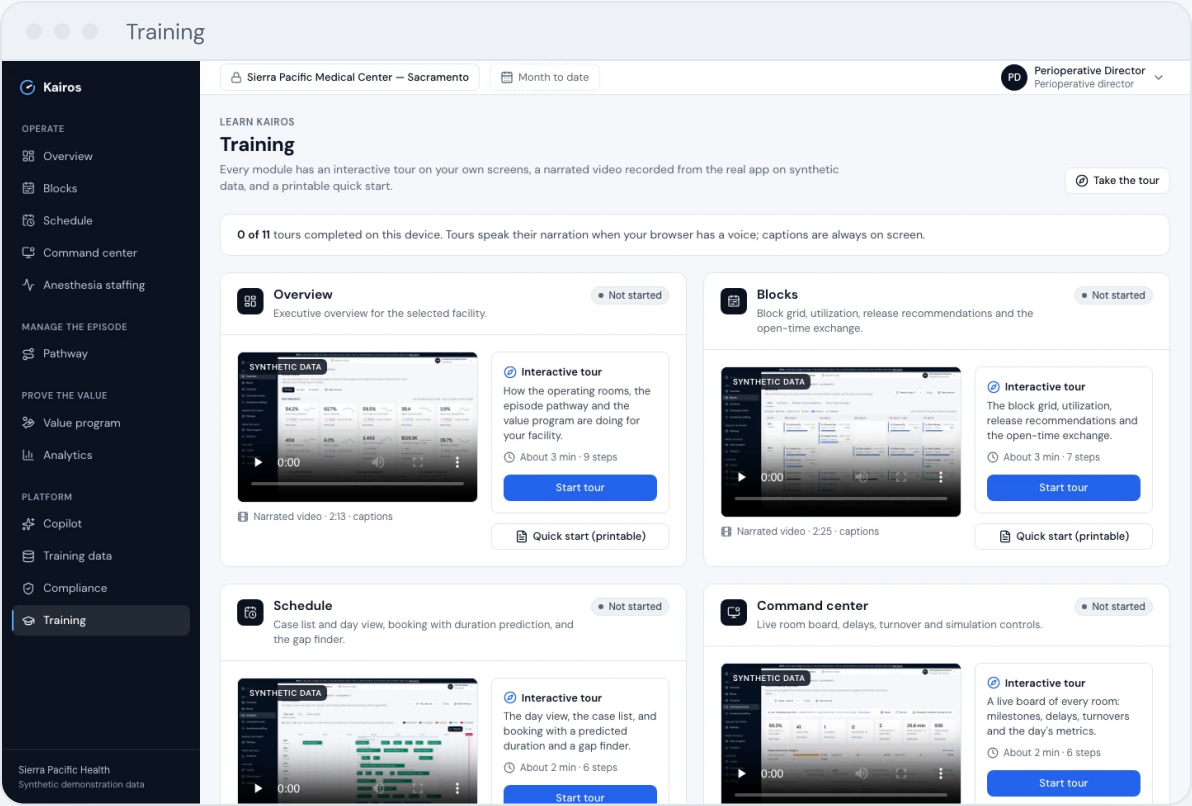
to regenerate everything
Seed 20260924, generator gen-
1.1.0

45.7%

lower error than surgeon
estimates
Best facility; all three clear the
30% target



Kairos P50 versus the surgeon's own estimate on the same completed cases, with the evaluation target shown.



Every module ships with an interactive tour, a narrated video recorded from the real app, and a printable quick start.

Training data → summary (gen-1.1.0, seed 20260924, generated Sep 25, 2026); Analytics → Prediction accuracy, trailing 12 months (Sep 24, 2025 – Sep 23, 2026), mean absolute error of Kairos P50 vs the surgeon's estimate on the same completed cases. Nothing is derived from real records (docs/TRAINING-DATA.md).

Measured, gated, priced and explained — end to end

Valley Community Hospital (fictional) put orthopedics on the pathway on March 1, 2026. Everything below is computed by the platform’s engines from the synthetic dataset.

1.05

August 2026 composite score

Safety gate passed · 11 of 14 metrics at target
· 134 episodes scored

18.31%

incentive earned, of base

Target 17.5%, cap 25% — 0 had the gate failed

45.7%

closer than surgeon estimates

42.4% and 31.5% at the other two facilities;
target ≥ 30%

7,980 min

recommended for release, next 28 days

49 of 107 blocks at the pilot hospital

Five domains, August 2026 — risk-adjusted; the tick is target (1.00)

0.72

Access

Progressing

1.12

Reliability

At or above target

0.98

Recovery

Progressing

1.18

Safety

At or above target

1.11

Stewardship

At or above target

\$1.09M gross savings

identified Mar–Sep across 10 categories and 84 ledger lines — led by length-of-stay days avoided (\$353K), complications avoided (\$237K), low-value tests avoided (\$142K). \$0 validated so far: no line counts until a clinician and then finance sign it off.

Baseline year → August 2026

METRIC	BASELINE	AUG 2026
First-case on-time starts	65.5%	85.3%
Low-value pre-op tests	36.7%	11.8%
Risk-adjusted LOS (O/E)	1.01	0.87
Opioid MME per inpatient case	261	155
30-day readmission	7.4%	4.2%

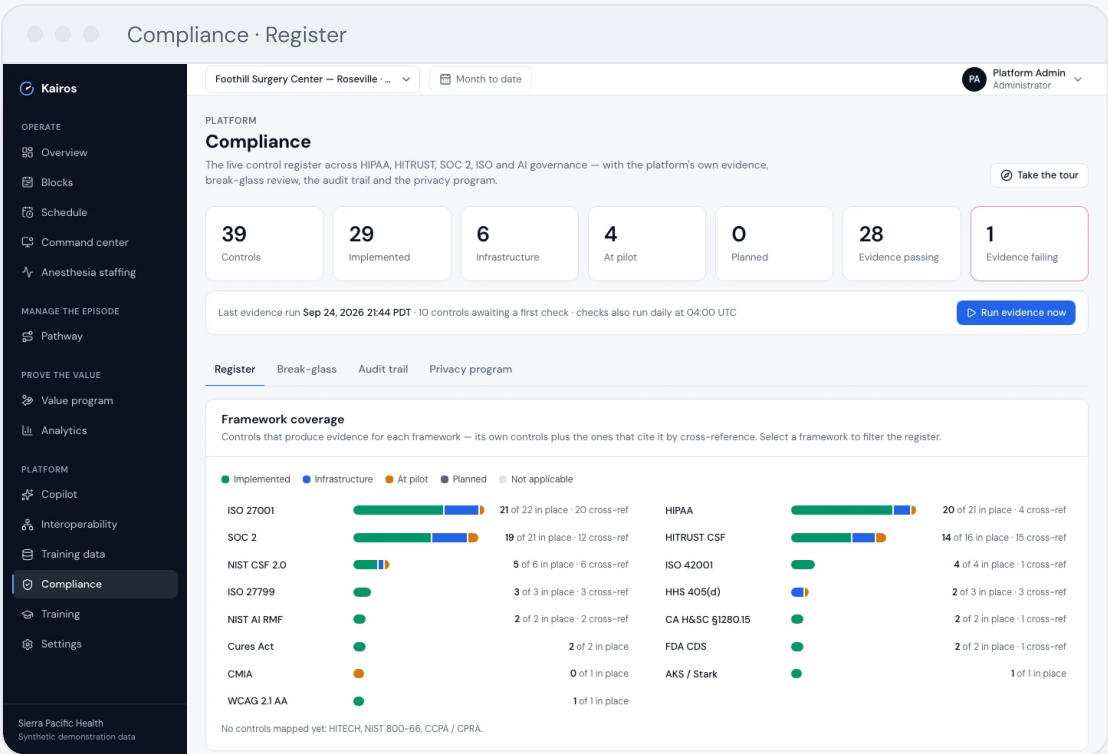


Synthetic, and honest about it.

The generator builds a pathway effect into the pilot service line. These figures show that the engines measure it, gate it, price it and explain it correctly from end to end — they are not evidence that the pathway works. The pilot is where that evidence comes from.

Sources: Value program → Scorecard, Aug 2026, Valley Community Orthopedics pilot (synthetic). Analytics → Prediction accuracy, trailing 12 months (Sep 24, 2025 – Sep 23, 2026), mean absolute error of Kairos P50 vs the surgeon’s estimate on the same completed cases. Blocks → Release recommendations, Valley Community Hospital, next 28 days as of Sep 24, 2026. Value program → Savings ledger, Mar 1 – Sep 23, 2026, all lines in draft. Metric pairs: August 2026 observed vs the program’s measured 12-month baseline (Mar 2025 – Feb 2026).

Built to hospital standards — evidenced, not yet certified



39 controls, 28 runtime evidence checks passing and 1 failing — shown, not hidden. Compliance is a live system, not a PDF.

🔒 HIPAA BY DESIGN

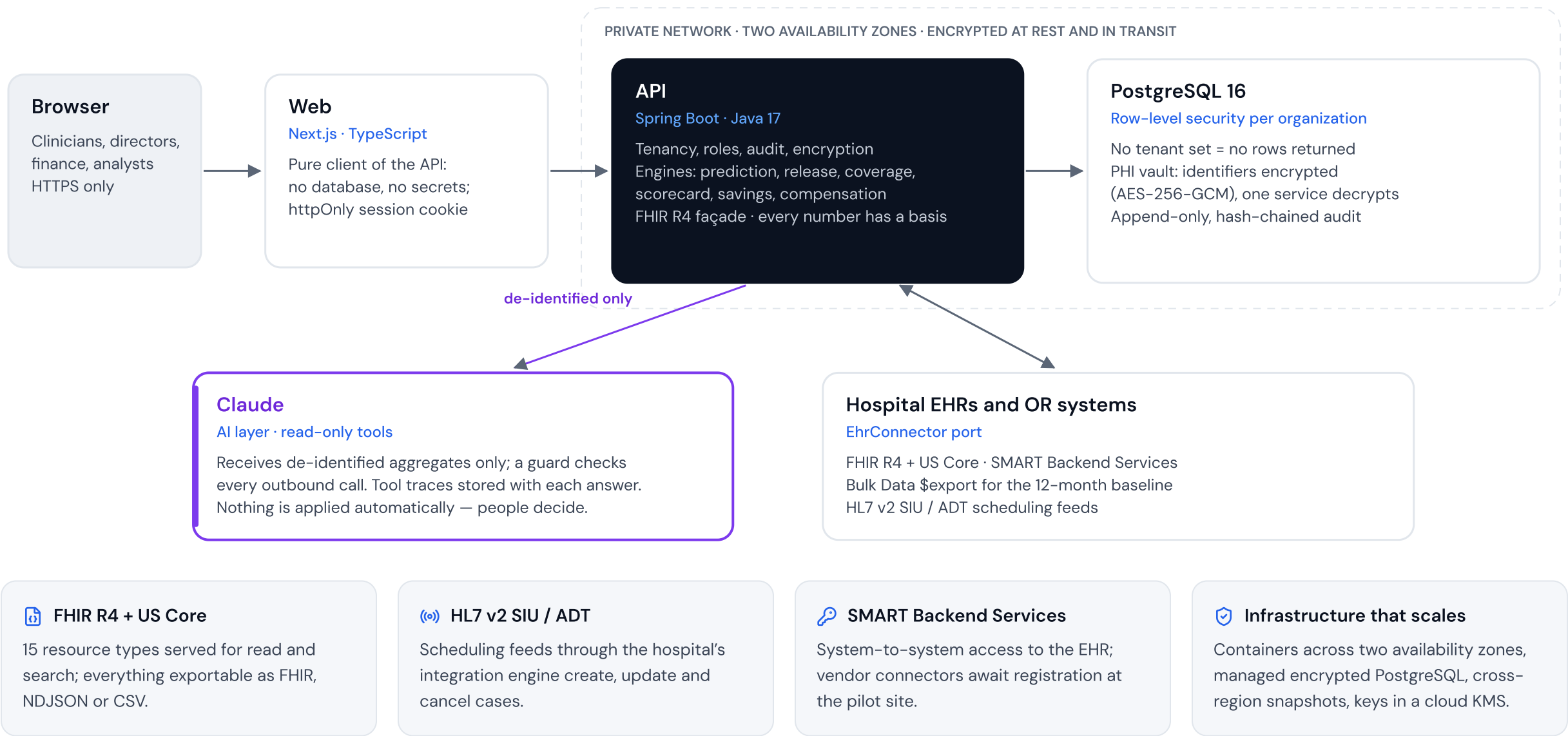
- Identifiers live only in an encrypted vault (AES-256-GCM); one service decrypts, and every decrypt is logged.
- PostgreSQL row-level security: a query without a tenant returns no rows.
- Append-only, hash-chained audit; the database refuses updates and deletes on it.
- 15-minute automatic logoff, lockout, break-glass access with review.

HIPAA and HITECH Privacy, Security and Breach Notification Rules · implemented per NIST SP 800-66 r2	● Designed & evidenced
HITRUST CSF v11 e1 → i1 → r2	● At pilot
SOC 2 Type II Security · Availability · Confidentiality · Privacy	● Designed & evidenced
ISO/IEC 27001, 27002 and 27799 ISMS · Annex A · health informatics	● Designed & evidenced
ISO/IEC 42001 and NIST AI RMF AI management system · AI risk	● Designed & evidenced
NIST CSF 2.0 and HHS 405(d) Govern · Identify · Protect · Detect · Respond · Recover	● Infrastructure
California CMIA, H&SC §1280.15 and CCPA/CPRA Civil Code §56 · Health & Safety Code §1280.15 · Civil Code §1798.82	● At pilot
21st Century Cures Act ONC information blocking	● Designed & evidenced
FDA Clinical Decision Support guidance Non-device CDS (2022)	● Designed & evidenced
Anti-Kickback Statute, Stark Law and CMP gainsharing OIG gainsharing safeguards	● Designed & evidenced

✓ Targets: HITRUST e1 readiness at pilot, i1 in year one; first SOC 2 Type II window after the pilot. WCAG 2.1 AA on every page.

Standards and status: docs/COMPLIANCE-REGISTER.md §1–3 and the public /compliance page. Control counts: Compliance page (admin), last evidence run Sep 24, 2026. No certification or audit has been performed.

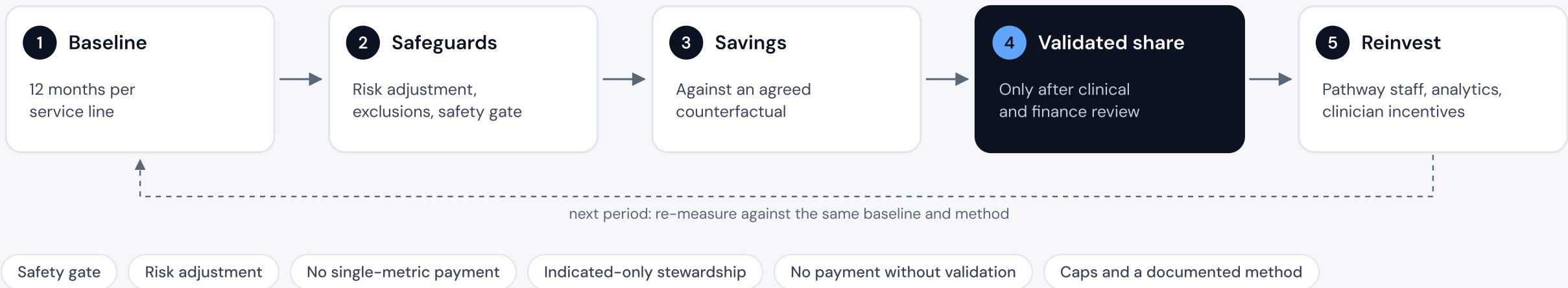
One API owns every rule; the AI sees de-identified aggregates only



Architecture: docs/ARCHITECTURE.md. Interoperability: docs/INTEROPERABILITY.md (15 FHIR R4 resource types in the live CapabilityStatement). Infrastructure: docs/DEPLOYMENT.md; the 99.9% availability figure is a design target, not a measured service level.

Gainsharing with safeguards — and a revenue model to agree together

The value program follows the clinical partner’s five-step gainsharing design; the software enforces the OIG safeguards so counsel reviews a method, not a promise.



HOW KAIROS EARNS — OPTIONS FOR DISCUSSION Not decided

Option A · Platform subscription

An annual subscription per facility (tiered by operating rooms), covering the operations modules, the pathway, the value program, the copilot and support.

Option B · Subscription + success component

A lower subscription plus a defined, capped component tied to independently validated savings — only after the hospital’s own clinical and finance review.

Option C · Implementation

A one-time fee for the EHR connection, the 12-month baseline load and value-program set-up, alongside either option above.

Gainsharing steps: docs/PRODUCT-VISION.md. Safeguards as implemented: docs/VALUE-ENGINES.md §9. Revenue options are for discussion only — nothing is decided, and any success-based fee needs the same counsel review as the gainsharing design.

One hospital, one service line, twelve months

Start at one small hospital with a high-volume elective service line, measurable variation and engaged surgeons. Multi-facility tenancy exists from day one, so the second hospital is configuration, not engineering.

PHASE	THE CLINICAL PARTNER'S PLAN	KAIROS DELIVERS
O–90 days	Choose one service line; baseline metrics; map the workflow; define governance	Connect the OR schedule (HL7 v2 or FHIR); load 12 months of history; agree metric definitions, exclusions and safety thresholds; data-use agreement and legal review of the gainsharing design
Months 4–6	Build the pathway: pre-op triage, ERAS order sets, discharge planning	Pathway board live for the service line; risk screen at scheduling; testing–stewardship flags; release recommendations and open–time exchange; command center and anesthesia coverage
Months 7–12	Measure and refine: monthly dashboard, case review, validate savings	Monthly scorecard with the safety gate; savings through clinical and finance validation; compensation statements; CFO narrative; prediction–accuracy review
Year 2	Scale what works: add procedures, expand partners, introduce the incentive pool	Second service line and second hospital as configuration; multi-facility benchmarks; HITRUST i1 and SOC 2 Type II windows; incentive pool activated

WHAT THE PILOT NEEDS FROM THE HOSPITAL

- An HL7 v2 SIU feed or FHIR R4 access to the OR schedule
- 12 months of history for the baseline
- Agreed metric definitions, exclusions and safety thresholds
- A data-use agreement and business associate agreement
- Counsel's review of the gainsharing design
- A clinical reviewer and a finance reviewer for validation

Phases: the clinical partner's twelve-month pilot, mapped to Kairos deliverables in docs/PRODUCT-VISION.md. Hospital requirements: docs/DEMO-SCRIPT.md talking points.

Clinical credibility and the ability to build and run it



The founding team

Large-scale system build-out and healthcare experience

- Builds and runs the platform: product, engineering, data and AI
- The security, privacy and compliance program and its evidence
- Cloud infrastructure, integration with the hospital's EHR
- Commercial operations and the path to certification



The clinical partner

An anesthesiologist who owns hospitals and clinics in California

- OR-optimization expertise and the Farm to OR Table model
- The pilot site, the service line and clinical governance
- Metric definitions, protocols and case review with the team
- Relationships into large hospital systems for year two

TOGETHER

Design the pilot and the value program, sit on its governance, and take a proven result to the large systems the clinical partner already knows.

TO BE AGREED

Equity, funding, roles and governance of the company.

Roles as discussed; nothing here is a commitment. Names are intentionally omitted.

A working platform, built in one intensive build cycle

14

modules, end to end
API, web, tests and docs for each

39

compliance controls
with runtime evidence checks

15

FHIR R4 resource types
plus HL7 v2 SIU/ADT ingest

13

narrated training videos
and 11 interactive tours

45,271

synthetic cases
regenerated from a seed in about a minute

BUILT AND DEMONSTRABLE

Overview

Blocks

Schedule

Command center

Anesthesia staffing

Pathway

Value program

Analytics

Copilot

Interoperability

Training data

Compliance

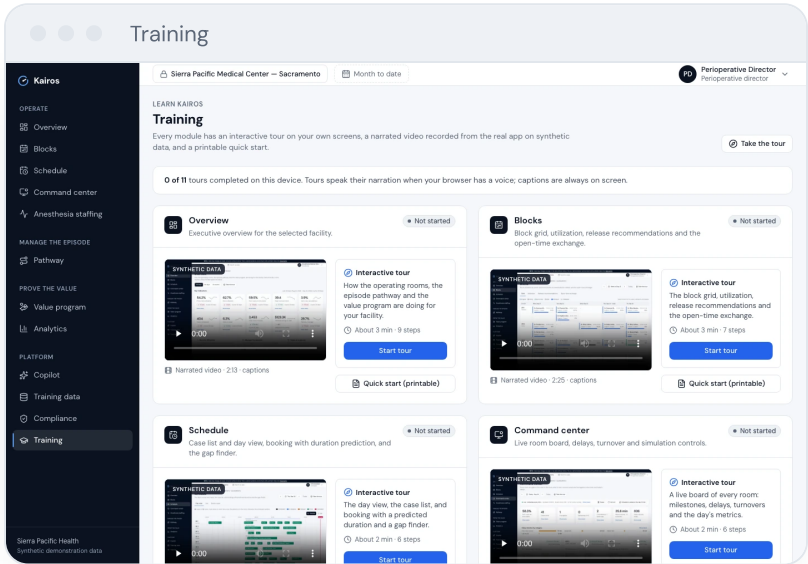
Training

Settings

Seven demo roles, three fictional facilities, multi-organization tenancy, a public site with security, privacy, terms and compliance disclosures.

SECOND ITERATION — BEFORE REAL PATIENT DATA

- Live EHR connectors at the pilot site (vendor registration, integration-engine feed)
- Multi-factor sign-in required for anyone with patient-data access
- Envelope encryption with managed keys for the identifier vault
- A dedicated cloud account with full account-level logging and threat detection
- Business associate agreement and zero-retention terms with the AI vendor
- A named privacy officer and a tested incident exercise
- Demo accounts removed; data-use agreement and a data-quality gate on real feeds



Every module ships with a tour, a narrated video and a quick start.

Module list: the signed-in navigation. Counts: Compliance page, FHIR CapabilityStatement, training manifest, Training data summary. Before-real-data list: docs/RISK-REGISTER.md (actions due before the pilot) and docs/INTEROPERABILITY.md.

Five decisions to start the pilot

1

Agree the pilot site and service line
One hospital; one high-volume elective line with measurable variation and engaged surgeons.

2

Sign a data-use agreement
With a business associate agreement, before any real data moves.

3

Counsel reviews the gainsharing design
Anti-Kickback, Stark and CMP review of the value program — required before it can activate.

4

Open EHR access
An HL7 v2 SIU feed or FHIR R4 access, and 12 months of history for the baseline.

5

Decide the brand name
Kairos is a working name.



Software organizes, measures and drafts; clinicians decide. Let's prove it at one hospital.

Contact: admin@nestworthy.ai

Kairos is a working name for software in beta. Every product figure in this deck comes from a synthetic, fictional health system; none is a result at a real hospital. Market figures are as cited in the clinical partner's framework. Kairos is not a medical device and does not provide medical, legal or financial advice. This deck is a discussion draft, not an offer of securities.