

PATIENT	ASSESSMENT	DATA COMPLETENESS*
Claire Example	3 Oct 2026	81% · Six domains
DOB 18 Apr 1974 · Female · MOCK-001	Comparison: 1 Jul 2026	Illustrative, not a confidence rating

Synthetic demonstration. Patient values, history, completeness and synthesis states are fictional. Not engine-generated; not for clinical use.

CROSS-DOMAIN CLINICAL SYNTHESIS

Why this interpretation? →

Cardiometabolic + autonomic pattern

Elevated BP, HbA1c and hs-CRP coexist with low resting HRV. LDL remains elevated; sleep findings are less pronounced.

Change: four higher-tier findings; two lower-tier sleep findings. [Compare →](#)

Priority findings

Current measurements: 28 Sep 2026

ID	FINDING / SOURCE	RESULT	APPLICABLE CRITERION	RULE TIER [†]
F1	Systolic BP elevation Clinic mean · 3 readings	148 mmHg	≥140 mmHg	Severe · L3
F2	HbA1c elevation Laboratory record	6.6 %	≥6.5%	Moderate · L2
F3	LDL cholesterol elevation Laboratory record	165 mg/dL	160–189 mg/dL	Moderate · L2
F4	hs-CRP elevation Laboratory record	4.2 mg/L	≥3.0 and <10.0 mg/L	Moderate · L2
F5	Reduced resting HRV 5-minute ECG · resting	18 ms	RMSSD 10–19 ms	Moderate · L2
F6	Sleep initiation difficulty 14-night sleep diary	45 min	30–60 min	Moderate · L2

F7 Fasting glucose: 106 mg/dL Mild · L1; criterion 100–125 mg/dL.	F8 Sleep duration: 6.6 h/night Mild · L1; criterion 6–7 h/night.
--	---

Eight current findings. [†]Rule tier is not clinical urgency, a diagnosis or global disease risk.

Six-domain snapshot

Highest finding tier · not a domain score

Cardiovascular Severe · L3 88% data*	Lipids Moderate · L2 80% data*	Metabolic Moderate · L2 90% data*	Inflammation Moderate · L2 75% data*	Autonomic Moderate · L2 70% data*	Sleep Moderate · L2 85% data*
--	--------------------------------------	---	--	---	-------------------------------------

Important missing information: ApoB, orthostatic vitals, sleep-breathing responses and medication history. Missing information is not a normal result. [*Coverage basis →](#)

What changed—and what did not

Mixed trajectory. BP, HbA1c and hs-CRP are higher; resting HRV is lower. LDL is lower but remains in the same tier. Sleep onset is shorter, sleep duration is longer, and reported sleep-aid use is absent.

MARKER / FINDING	24 JUN 2026	28 SEP 2026	COMPARISON
<u>F1</u> Systolic BP (mmHg)	134	148	+14 mmHg · L2 → L3
<u>F2</u> HbA1c (%)	6.2	6.6	+0.4 %-points · L1 → L2
<u>F3</u> LDL-C (mg/dL)	178	165	−13 mg/dL · same L2
<u>F4</u> hs-CRP (mg/L)	2.1	4.2	+2.1 mg/L · L1 → L2
<u>F5</u> Resting RMSSD (ms)	26	18	−8 ms · L1 → L2
<u>F6</u> Sleep latency (min)	70	45	−25 min · L3 → L2
<u>F7</u> Fasting glucose (mg/dL)	102	106	+4 mg/dL · same L1
<u>F8</u> Sleep duration (h/night)	5.5	6.6	+1.1 h/night · L2 → L1
<u>F9</u> Sleep-aid use nights/week	3	0	No longer detected · resolved finding

F1–F8 persist; F9 is no longer detected. Both mock timepoints use the same criteria and collection methods. Sleep values are 14-night summaries ending on the dates shown. No treatment response is inferred.

Clinical considerations

Root-cause and synthesis changes →

BP and autonomic findings
Review the clinic BP average with measurement conditions and low resting HRV. Orthostatic vitals and medication history are unavailable.

Glycemic, lipid and inflammatory findings
Review HbA1c alongside fasting glucose, LDL-C and hs-CRP. The combined pattern does not establish a diagnosis or a common cause.

Optional HOMA1-IR: 3.4
Fasting insulin 13.0 μU/mL × glucose 106 mg/dL ÷ 405. No standalone tier, score contribution, core-completeness penalty or independent pattern activation. [Calculation and context →](#)

Ungraded information only

Wearable and CGM context

Separate from the findings above

Glucose time in range, 70–180 mg/dL	72%	CGM · 14–27 Sep · 86% coverage
Wearable sleep efficiency	78%	Ring · 14–27 Sep · 91% coverage

Context-only streams do not activate this mock case’s findings or synthesis. The HRV finding uses a separate clinic ECG measurement, not a consumer-wearable value.

How the findings connect

The Root Cause layer organizes findings into clinical themes. The interpretation pattern brings those themes into the short clinical synthesis on Page 1. These are associations for review—not proof of causation.

Source inputs → canonical signals → rule evaluations → resolved findings

Resolved findings feed domain summaries and, separately, the Root Cause / interpretation pathway. Synthesis does not add a second scoring contribution.

Autonomic–cardiovascular pattern

NEW

F1 + F5: BP 148/88 mmHg + resting RMSSD 18 ms

Blood-pressure elevation and reduced resting HRV are shown together for clinical review; neither is assigned as the cause of the other.

Prior: BP L2 with HRV L1. Current: BP L3 with HRV L2.

Root Cause registry: AUTONOMIC_CARDIOVASCULAR_TENSION

Inflammatory–cardiometabolic pattern

NEW

F1 + F2 + F4: BP elevation + HbA1c 6.6% + hs-CRP 4.2 mg/L

The inflammatory finding is considered alongside glycemic and blood-pressure findings instead of being presented as an isolated lab flag.

Prior: hs-CRP and HbA1c L1. Current: both L2 alongside BP L3.

Root Cause registry: INFLAMMATORY_CARDIOMETABOLIC_LOAD

Lipid–metabolic pattern

PERSISTENT

F1 + F2 + F3: LDL-C 165 mg/dL + HbA1c 6.6% + BP elevation

The lipid finding remains part of the broader cardiometabolic picture even though LDL-C decreased within the same reference tier.

Prior: LDL L2 and BP L2. Current: LDL L2, HbA1c L2 and BP L3.

Root Cause registry: LIPID_METABOLIC_STRAIN

Sleep initiation · persistent

F6 Sleep latency falls from 70 to 45 minutes, but a sleep-onset finding remains.

SLEEP_INITIATION_DIFFICULTY

Sleep-aid use · resolved in mock

F9 Reported use falls from 3 to 0 nights/week. The prior use-related finding is no longer shown as active.

SLEEP_AID_DEPENDENCE

The registry’s “Root Cause” and “dependence” identifiers are not causal or diagnostic conclusions. These fictional activation states and connecting narratives illustrate the reporting experience; they are not reproduced engine outputs.

Blood pressure and autonomic evidence

F1 · CAR

Systolic BP elevation

148 mmHg

Severe · L3

SOURCE → CANONICAL INPUT
148 mmHg · Clinic mean · 3 readings
Measured 28 Sep 2026.

CRITERION AND RULE
≥140 mmHg
SE-CAR-002
R-CAR-BP-L3

RESOLVED FINDING / FAMILY
AGG-CAR-BP-L3
AGG-CAR-BP
Reference tier: Severe (L3).

Measurement record

Seated readings: 146/86, 148/88, 150/90 mmHg; mean 148/88. Prior: 132/80, 134/82, 136/84; mean 134/82. Same fictional cuff protocol.

What the tier means

The systolic result meets the library's Stage 2-range rule. "Severe (L3)" is the Everra tier label, not a hypertensive-emergency classification.

Longitudinal interpretation

The BP finding persists: L2 → L3. The displayed systolic change is +14 mmHg. This mock report does not diagnose hypertension or infer why BP changed.

Source 1 · Guideline-linked systolic range. Contributes to illustrative [C1 autonomic-cardiovascular](#) and [C2 inflammatory-cardiometabolic](#) themes.

Family resolution retains its contributing evidence. Production logic—not the display's highest-tier summary—determines the resolved outcome.

F5 · ANS

Reduced resting HRV

18 ms

Moderate · L2

SOURCE → CANONICAL INPUT
18 ms · 5-minute ECG · resting
Measured 28 Sep 2026.

CRITERION AND RULE
RMSSD 10–19 ms
SE-ANS-002
R-ANS-HRV-L2

RESOLVED FINDING / FAMILY
AGG-ANS-HRV-L2
AGG-ANS-HRV
Reference tier: Moderate (L2).

Measurement record

Current RMSSD 18 ms; prior 26 ms. Both use the same five-minute resting ECG protocol, not overnight ring summaries.

Criterion scope

RMSSD is the specified HRV measure. The library's 10–19 ms interval is an Everra clinical-convention tier; the cited HRV standards do not establish this exact three-tier scale.

Longitudinal interpretation

The HRV finding persists: L1 → L2. The measured value fell by 8 ms. Medication and orthostatic context are unavailable; no autonomic diagnosis is assigned.

Source 5 · Measurement standards and physiologic interpretation. Reference themes include AUTONOMIC_RECOVERY and AUTONOMIC_DYSREGULATION; the mock combines HRV with BP in [C1](#).

Glycemic and lipid evidence

F2 · MET

HbA1c elevation

6.6 %

Moderate · L2

SOURCE → CANONICAL INPUT
6.6 % · Laboratory record
Measured 28 Sep 2026.

CRITERION AND RULE
≥6.5%
SE-MET-006
R-MET-A1C-L2

RESOLVED FINDING / FAMILY
AGG-MET-A1C-L2
AGG-MET-A1C
Reference tier: Moderate (L2).

How to read the finding

HbA1c rises 6.2% → 6.6%, or 0.4 percentage points:
L1 → L2. This is a diabetes-range criterion match, not a diagnosis assigned by the mock.

F7 · SEPARATE FASTING-GLUCOSE FINDING

106 mg/dL · Mild (L1)

Prior 102 mg/dL; criterion 100–125 mg/dL.
Persistent L1, independent of HOMA.

SE-MET-003 → R-MET-GLU-L1
AGG-MET-GLU-L1
Family: AGG-MET-GLU

Source 2 · HbA1c and fasting-glucose cut points.
Reference theme: METABOLIC_DYSREGULATION. Current mock combinations: C2 and C3.

F3 · LIP

LDL cholesterol elevation

165 mg/dL

Moderate · L2

SOURCE → CANONICAL INPUT
165 mg/dL · Laboratory record
Measured 28 Sep 2026.

CRITERION AND RULE
160–189 mg/dL
SE-LIP-002
R-LIP-LDL-L2

RESOLVED FINDING / FAMILY
AGG-LIP-LDL-L2
AGG-LIP-LDL
Reference tier: Moderate (L2).

How to read the finding

LDL-C falls from 178 to 165 mg/dL, but both values remain within the library's 160–189 mg/dL tier. The finding persists at L2.

Supplementary lipid inputs

Other current inputs: HDL-C 60 mg/dL; triglycerides 120 mg/dL. LDL/HDL 2.75 is below the 3.5 ratio trigger, so no ratio finding is shown.

Clinical limitation

Lower LDL-C does not mean the finding resolved or establish treatment success. ApoB and medication history are unavailable.

Source 3 · Library reference for LDL categories.
Reference theme: LIPID_BURDEN; the illustrative cross-domain grouping is C3.

HOMA1-IR · optional, ungraded

13.0 × 106 ÷ 405 = 3.4

Paired fasting insulin 13.0 µU/mL and glucose 106 mg/dL, 28 Sep 2026. Option C: no standalone tier, scoring, core-completeness penalty or independent activation. The glucose finding remains separate.
Source 7.

Inflammatory and sleep evidence

F4 · INF

hs-CRP elevation

4.2 mg/L

Moderate · L2

SOURCE → CANONICAL INPUT
4.2 mg/L · Laboratory record
Measured 28 Sep 2026.

CRITERION AND RULE
≥3.0 and <10.0 mg/L
SE-INF-002
R-INF-CRP-L2

RESOLVED FINDING / FAMILY
AGG-INF-CRP-L2
AGG-INF-CRP
Reference tier: Moderate (L2).

What the result supports

hs-CRP rises from 2.1 to 4.2 mg/L; the corresponding library tier moves from L1 to L2. It does not meet the inspected L3 threshold of ≥10 mg/L.

Interpretation limit

The cause and duration of inflammatory activity are not established by these two fictional measurements. Review history, intercurrent illness and medications before assigning a clinical explanation.

Reference intervals used here

L1: ≥1.0 and <3.0 mg/L.
L2: ≥3.0 and <10.0 mg/L.
L3: ≥10.0 mg/L.

Source 4 · Source recorded in the rule library; the Everra tier is not a cardiovascular-risk percentage.
Reference theme: INFLAMMATORY_LOAD. The mock groups this with BP and HbA1c in C2.

F6 · SLP

Sleep initiation difficulty

45 min

Moderate · L2

DIARY → SIGNAL → RULE
Latency: 45 min; criterion 30–60 min.
SE-SLP-008 → R-SLP-LAT-L2
AGG-SLP-LAT-L2
Family: AGG-SLP-LAT

Both diary windows contain 14 nights. Prior mean latency was 70 min; current 45 min. The finding remains, moving L3 → L2. No insomnia diagnosis is assigned.

F8 · SLEEP DURATION

6.6 h/night · Mild (L1)

Prior 5.5 h/night (L2). Current criterion: 6–7 h/night. The duration finding persists at a lower tier.

SE-SLP-001 → R-SLP-DUR-L1
AGG-SLP-DUR-L1
Family: AGG-SLP-DUR

F9 · PRIOR FINDING NO LONGER DETECTED

Sleep-aid use: 3 → 0 nights/week

The prior 3–4 nights/week criterion met L2. No current use criterion is met. “Resolved” applies to the use-related finding, not to a diagnosis or confirmed recovery.

Prior: SE-SLP-020 → R-SLP-AID-L2
AGG-SLP-AID-L2
Family: AGG-SLP-AID

Source 6 · Sleep duration is consensus-informed. Latency and aid-use tier intervals shown here are library conventions, not standalone diagnoses.

Review the basis

1. Blood pressure

Whelton PK et al. 2017 ACC/AHA blood-pressure guideline. Hypertension. 2018;71:e13–e115. DOI: 10.1161/HYP.0000000000000065.

Recorded basis for the sample's systolic categories; not a treatment or emergency instruction.

2. Glycemic findings

American Diabetes Association. Diagnosis and Classification of Diabetes: Standards of Care in Diabetes —2024. Diabetes Care. 2024;47(Suppl 1):S20–S42.

Supports the glucose and HbA1c cut points; Everra tier labels are a separate display convention.

3. LDL cholesterol

NCEP Expert Panel. Adult Treatment Panel III final report. Circulation. 2002;106:3143–3421. PMID: 12485966.

Historical reference stored for the L2 LDL rule; not a complete current lipid-management guideline.

4. hs-CRP

Pearson TA et al. Markers of inflammation and cardiovascular disease. Circulation. 2003;107:499–511. PMID: 12551878.

Source recorded in the library; the mock does not infer causation or disease probability.

5. Heart-rate variability

ESC/NASPE Task Force. Heart rate variability: standards of measurement, physiological interpretation and clinical use. Circulation. 1996;93:1043–1065. PMID: 8598068.

The precise RMSSD L1/L2/L3 cutoffs are Everra conventions, not thresholds established by this standards paper.

6. Sleep findings

AASM / Sleep Research Society consensus and clinical sleep literature are the sources named in the inspected sleep library.

Adult sleep-duration consensus is supporting background. The 20–30/30–60/>60-minute latency and aid-use frequency tiers are Everra conventions; no single cited paper validates the full tier set.

7. HOMA1 model

Matthews DR et al. Homeostasis model assessment. Diabetologia. 1985;28:412–419. PMID: 3899825.

Supports the model definition, not a universal cutoff or severity tier. The approved optional, ungraded direction governs this mock.

Data completeness · illustrative display values

CAR 88%, LIP 80%, MET 90%, INF 75%, ANS 70%, SLP 85%. The mean is 81.33%, displayed as 81%. The same mock coverage applies at both timepoints. Optional HOMA is not a missing core input.

The production definition is assessable governed contribution capacity divided by full production capacity for the domain. These simulated outputs demonstrate the interface; they were not calculated from a deployed case or production manifest. Completeness is not confidence, accuracy or disease risk.

Fictional case, reference-based rules

All patient data, history, acquisition records, coverage and activation states were authored for this mockup. Named rules, criteria, tier words and aggregation members use inspected MVP library records; actual Root Cause registry names are retained.

Visual source: Everra UX v1.0 and design tokens. Inter and IBM Plex Mono are embedded. The headline retains the prior PDF's Noto Serif fallback for Source Serif 4.

Not a runtime or validation record

Synthesis prose and activation states are illustrative—not executed or clinically signed-off case outputs, and not a new production specification. Sample v1 · 3 Oct 2026; library references inspected 3 Oct 2026.