

Designing Protocols with Integrated Data

PRESENTED BY DR ANTHONY CLOSE, MARCH 29,
2026

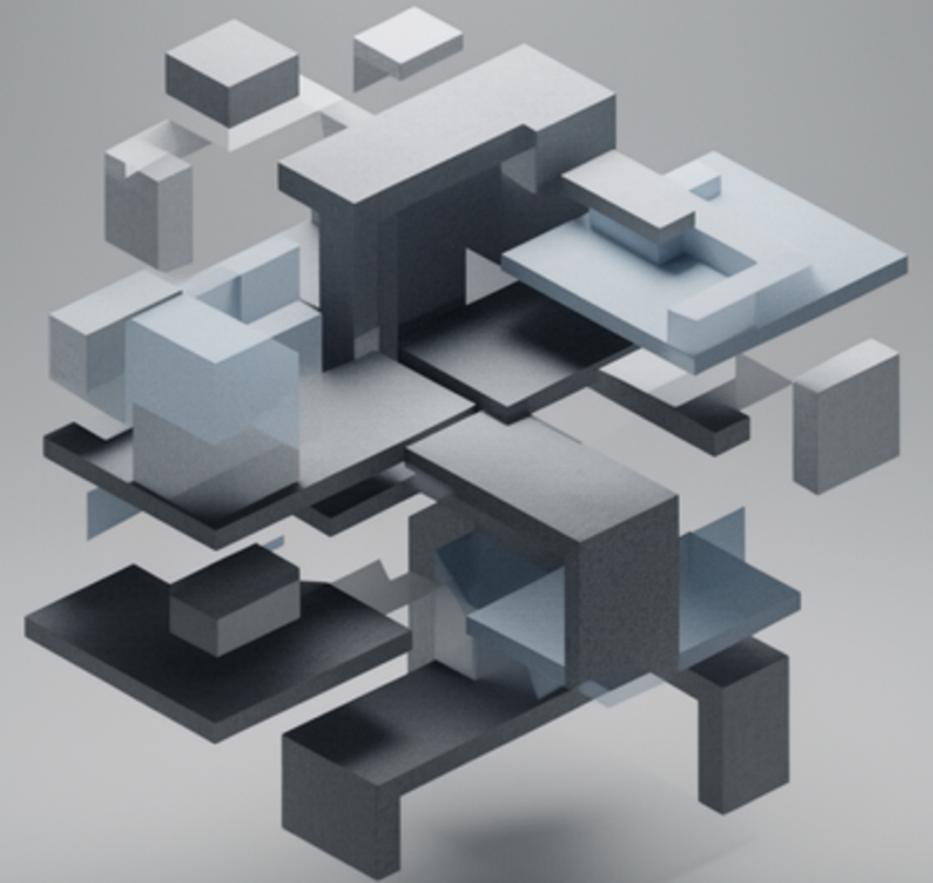


Our Proprietary Models Transform Data Integration

ACTIONABLE PROTOCOL DESIGN

Our models leverage **real-world biomarker**, wearable, and molecular data to design personalized protocols that enhance health outcomes through targeted interventions.

$$P_t = \sum_{j=1}^m \beta_j \cdot Y_{j,\text{norm}}(t)$$





Multi-Source Data Integration. Advanced Python Biostatistical Modeling

BIOMARKER DATA

Clinically validated indicators provide insights into health conditions, enabling tailored protocols that address individual patient needs effectively and efficiently.

WEARABLE DATA

Continuous real-time monitoring delivers dynamic insights on physical activity and health metrics, ensuring data-driven adjustments to protocols based on user behavior.

MOLECULAR DATA

Detailed biological signatures offer in-depth understanding of individual genetic and molecular variations, & neurotransmitter testing enhancing precision in protocol design for personalized treatment plans.

Relentless Iteration. Measurable Evolution.

DYNAMIC PROTOCOL DESIGN ENABLES THE FOLLOWING

- Real-time protocol adaptation
- Detection of non-response and variability
- Iterative refinement based on measured outcomes
- Each intervention is not selected—it is adjusted.

GENE-BASED LIMITATIONS

Gene-based approaches are inherently static. They provide probabilistic insights, not real-time biological state.

Most outputs remain interpretive— suggestions rather than actionable, individualized protocols.

They do not account for current physiology, response variability, or environmental influence.

DYNAMIC PROTOCOL DESIGN

ur system operates on measured biology— not prediction.

Protocols are derived from integrated biomarker data, wearable signals, and clinical response—continuously updated through CRI (Clinical Response Intelligence).

Prediction does not equal control. Measurement does.

CORE CONCEPT OF THE CRI

The Composite Response Index (CRI) is a multi-domain, weighted, time-dependent composite index aimed at:

- Integrating diverse biological signals
- Normalizing data across various scales and units
- Monitoring response dynamics over time
- Penalizing instability

It is important to note that CRI is not merely a score; rather, it functions as a system of inference and control.

PARTIAL STRUCTURE

Where each domain is independently computed, normalized, and weighted.

$$CRI_t = w_b B_t + w_p P_t + w_f F_t + w_d D_t$$

DOMAIN EXPANSION

Raw data has no clinical value without interpretation and control. We convert biomarker, wearable, and molecular signals into targeted protocols—designed, measured, and continuously refined against real biological response.

WHAT IF BIOLOGY COULD BE MEASURED AS A SYSTEM—NOT AS FRAGMENTS?

Summary

TRANSLATING DATA INTO PROTOCOLS

Our proprietary models effectively convert complex biomarker, wearable, and molecular data into actionable protocols tailored for precision and personalization.

$$\textit{Trajectory} = \frac{CRI_t - CRI_{t-1}}{\Delta t}$$

CRI IS A MULTI-DOMAIN, TIME-DEPENDENT SCORING SYSTEM THAT INTEGRATES BIOMARKERS, PHYSIOLOGICAL DATA, AND FUNCTIONAL OUTPUTS INTO A SINGLE, VARIANCE-AWARE SIGNAL.

READ THE QUOTE CAREFULLY.

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It measures not only biological state—but response, stability, and trajectory—enabling safe execution of and continuous protocol refinement based on real outcomes

Contact Us for More Information

EMAIL ADDRESS

hello@reallygreatsite

SOCIAL MEDIA

@reallygreatsite

PHONE

123-456-7890

The Close Regeneration Index (CRI) addresses a gap in clinical optimization by providing a unified framework to translate biological data into measurable outcomes. Traditional methods often fail to integrate diverse metrics, but CRI organizes biological information into a composite index that reflects physiological state, trajectory, and stability over time.

Mathematically, CRI normalizes, weights, and aggregates inputs from various domains, allowing for cross-comparison and producing a dynamic score indexed to time. This means that identical lab values can yield different CRI outputs based on individual physiological responses, distinguishing true improvement from temporary fluctuations.

$$P_t = \sum_{j=1}^m \beta_j \cdot Y_{j,\text{norm}}(t)$$

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$$CRI_t = w_b B_t + w_p P_t + w_f F_t + w_d D_t$$

Ultimately, CRI advances regenerative medicine from reactive to structured optimization based on integrated, time-sensitive biological signals.

CRI's dynamic layer evaluates changes over time, detecting stable biological shifts versus short-term noise, transforming the model into an operational tool. **Protocols are executed on and refined continuously based on CRI evolution rather than initial data alone.**

$$P_t = \sum_{j=1}^m \beta_j \cdot Y_{j,\text{norm}}$$

$j = 1$

Developed through extensive clinical application and patient observation, CRI integrates diverse signals and has proven more reliable than single-domain metrics.

Ultimately, CRI advances regenerative medicine from reactive to structured optimization based on integrated, time-sensitive biological signals.

MOST CLINICS



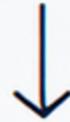
DON'T NORMALIZE DATA PROPERLY
DON'T WEIGHT VARIABLES CLINICALLY



DON'T TRACK LONGITUDINALLY



DON'T INTEGRATE DOMAINS



CRI REQUIRES



STRUCTURED DATA INGESTION



CONSISTENT MEASUREMENT



STATISTICAL NORMALIZATION

ITERATIVE RECALIBRATION



BENEFITS (REAL, NOT MARKETING)



MOST CLINICS:

DON'T NORMALIZE DATA PROPERLY
DON'T WEIGHT VARIABLES CLINICALLY
DON'T TRACK LONGITUDINALLY
DON'T INTEGRATE DOMAINS

CRI REQUIRES:

STRUCTURED DATA INGESTION
CONSISTENT MEASUREMENT
STATISTICAL NORMALIZATION
ITERATIVE RECALIBRATION

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close regenerative index

FROM GUESSWORK TO MEASURED BIOLOGY

PRESENTED BY

DR ANTHONY CLOSE ET AL.



DRIPDOK

DATE

EDITION 2026

THE PROBLEM

Modern medicine measures...
but does not integrate.

- Labs are isolated
- Wearables are ignored or misused
- Symptoms are subjective

There is no unified system.





THE CONSEQUENCE



More data does not create clarity. It often increases noise. Founders that aren't physicians which is the 98% in Bali have zero regard for human life.

Without a framework to interpret and connect signals, **additional inputs dilute decision quality** rather than improve it. With zero accountability.

WHAT ACTUALLY HAPPENS

Protocols become **assumption-driven** rather than response-driven. Interventions are applied without understanding whether the system is capable of adapting.

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THE RESULT IS VARIABILITY THAT CANNOT BE EXPLAINED, TRACKED, OR CORRECTED.



DAMAGE CONTROL



Without measurement and integration, there is no feedback loop—only repetition. Your paying for something that absolutely isn't happening while risking your life and wellbeing.

Patients cycle through treatments without clear direction. Apparent improvements are often transient, and true non-response goes undetected.



D R I P D O K

CRI PATIENT RESEARCH



“NORMAL LABS, FAILING PHYSIOLOGY”

A patient presented with persistent fatigue despite completely normal bloodwork, including thyroid, testosterone, and inflammatory markers. Traditional evaluation would have concluded no actionable issue.

CRI revealed a different picture.

While biomarkers were stable, the physiological domain showed suppressed HRV, elevated resting heart rate, and fragmented sleep architecture. More importantly, the dynamics layer showed high variability—daily oscillation rather than consistent recovery. The CRI trajectory remained flat despite multiple interventions.

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What it meant:

Biomarkers alone failed to detect dysfunction. CRI identified a non-biochemical bottleneck, allowing intervention to target the actual limiting system that was misdiagnosed for over 4 decades



DRIPDOK

CRI PATIENT CASES



IMPROVEMENT THAT WASN'T REAL"

A patient undergoing NAD-based therapy showed clear short-term improvement in subjective energy and cognitive clarity. Initial assumption: protocol effective.

CRI showed otherwise.

Although functional scores increased, the physiological domain remained unstable, and variability increased significantly. The dynamics layer penalized the signal due to inconsistency—sharp improvements followed by rapid declines.

The hidden correlation was that perceived improvement was decoupled from physiological stability.

Further analysis revealed that the intervention was producing acute stimulation without sustained adaptation. The CRI trajectory plateaued, then began oscillating.

Protocol was adjusted to reduce acute loading and introduce stabilization strategies. CRI began to show consistent upward progression rather than spikes.

What it meant:

CRI prevented a false positive. Without it, the protocol would have been incorrectly scaled. Instead, it revealed that consistency—not intensity—was the limiting factor.

CRI PATIENT RESEARCH



TWO IDENTICAL PATIENTS, OPPOSITE OUTCOMES”

Two patients presented with nearly identical biomarker profiles: similar inflammatory markers, hormone levels, and metabolic panels. Both were placed on similar protocols.

Traditional expectation: similar outcomes.

CRI diverged rapidly.

Patient A showed steady improvement across all domains, with low variability and positive trajectory. Patient B showed minimal improvement with high fluctuation in physiological signals despite identical interventions.

The hidden correlation emerged in the dynamics layer: Patient B exhibited high variability and poor signal consistency, particularly in HRV and recovery metrics, indicating impaired adaptability.

The issue was not the protocol—it was the system’s ability to respond to the protocol.

Intervention for Patient B was shifted toward foundational stabilization before optimization. Only then did CRI begin to rise.

What it meant:

Identical inputs do not produce identical outputs. CRI revealed that response capacity itself is a variable, not a constant—something most models ignore.



THE SYNTHESIS

SYNTHESIS (WHAT TIES THESE TOGETHER)

IN EACH CASE, THE CRITICAL SIGNAL WAS NOT VISIBLE IN ANY SINGLE DOMAIN.

IT EMERGED FROM:
CROSS-DOMAIN INTEGRATION
TIME-BASED TRACKING
VARIABILITY DETECTION

CRI DOES NOT JUST IDENTIFY WHAT IS WRONG.
IT IDENTIFIES WHERE THE SYSTEM IS FAILING
TO RESPOND.

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