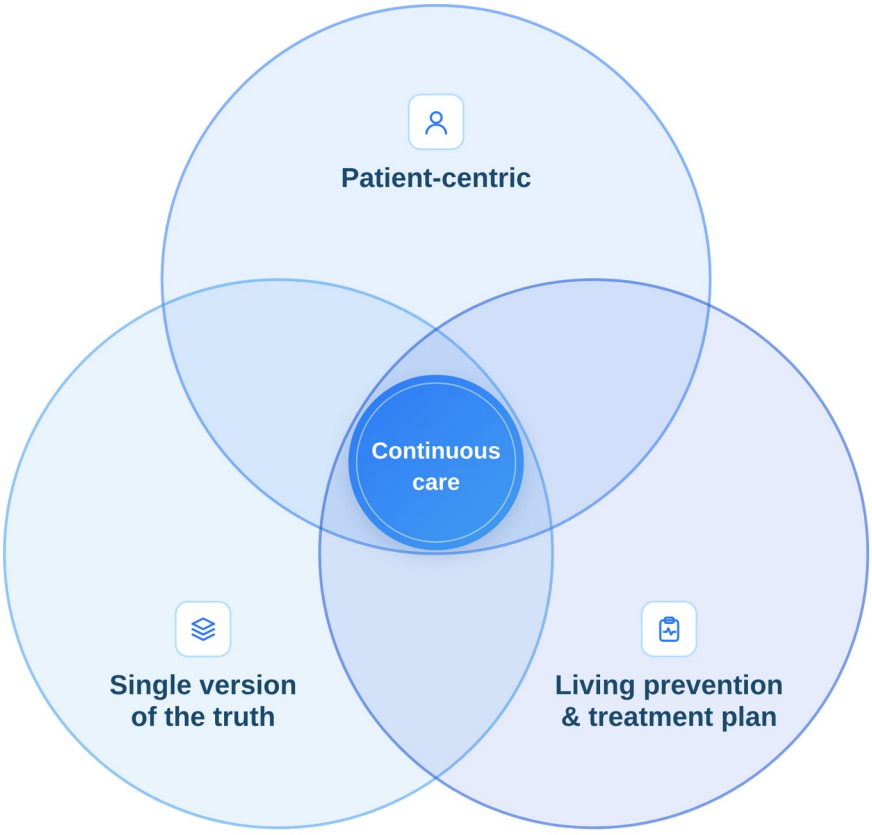
WHITE PAPER

Transforming U.S. healthcare

A patient-centric, AI-enabled model for continuous prevention and treatment



Connect4Patients

October 2026

Executive summary

The United States spends more on health care than any other high-income country and gets less for it. Health spending reached 18.4 percent of gross domestic product in 2025 and is projected to reach 20.6 percent, roughly $9 trillion, by 2034.[1] Measured against nine comparable nations, the United States ranks last in health outcomes: the highest rates of preventable and treatable deaths, and life expectancy more than four years below the ten-country average.[2]

The gap is not explained by a shortage of clinical skill, technology, or research capability. This country has the best hospitals, the best physicians, and the best research centers in the world. The gap is explained by how care is organized. A patient arrives with a symptom. The symptom is treated or referred. The record of what happened scatters across every organization that touched it, and the next clinician starts over. Prevention, in day-to-day practice, has been reduced to a vaccination reminder.

Closing the gap requires three things at once, and none of them works without the other two.

First, patient-centric. The patient has to be inside the system. No one can build a prevention plan for a person who is not participating in it. This is the precondition, not a feature.

Second, single version of the truth. There has to be one longitudinal record. Information from every participating source must be reconciled, cleansed, verified by the patient who knows what is missing, and then presented in plain language to that patient and in clinical detail to the care team. Much of the industry is building longitudinal records. A single version of the truth is one record every clinician, and the patient, can trust.

Third, a living prevention and treatment plan. The plan built on that record has to be continuous rather than episodic. It must be monitored between visits, adjusted as results change, and constrained so that no lifestyle recommendation can contradict the medical record.

Connect4Patients provides an AI layer that does this on top of the systems providers already run: Connect4Patients for the patient and Connect4Providers for the care team, two views of one verified record. Hospitals, practices, laboratories, pharmacies, insurers, and device manufacturers keep their current technology. Orion, our AI, runs an agentic fusion and cleansing process across their information, translates it for every audience, immediately turns it into insight for the physician and the patient, and returns a single version of the truth to everyone entitled to see it. The clinician stays in charge throughout. From that record, the prevention and treatment plan coordinates nutrition, movement, sleep, medication, screening,

and chronic condition management into one living plan that every member of the care team can see and only a clinician can sign.

The same infrastructure answers the question employers, health plans, and states are asking. In real time and anonymized, it shows where chronic disease is concentrated in a population, whether prevention programs are changing the trend, and which cohorts to reach next, without exposing any individual's health information.

The value shows up on every side of the transaction. Patients get earlier answers and fewer wasted visits. Physicians get back the minutes they currently spend reconstructing a history, and get paid for prevention work that is already reimbursable. Health systems get one verified picture of every patient, including care delivered outside their own walls. Employers, health plans, and states get a measurable reduction in the chronic disease burden that drives their costs.

The goal is not to replace the U.S. health system. It is to let it work as one, and then to make it the best in the world rather than the most expensive.

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1. What we spend, and where it is headed

The Centers for Medicare & Medicaid Services put national health expenditures at 18.4 percent of gross domestic product in 2025 and project 20.6 percent by 2034. In dollars, that is $5.7 trillion rising to roughly $9 trillion. Health spending is expected to grow faster than the economy every year of that period.

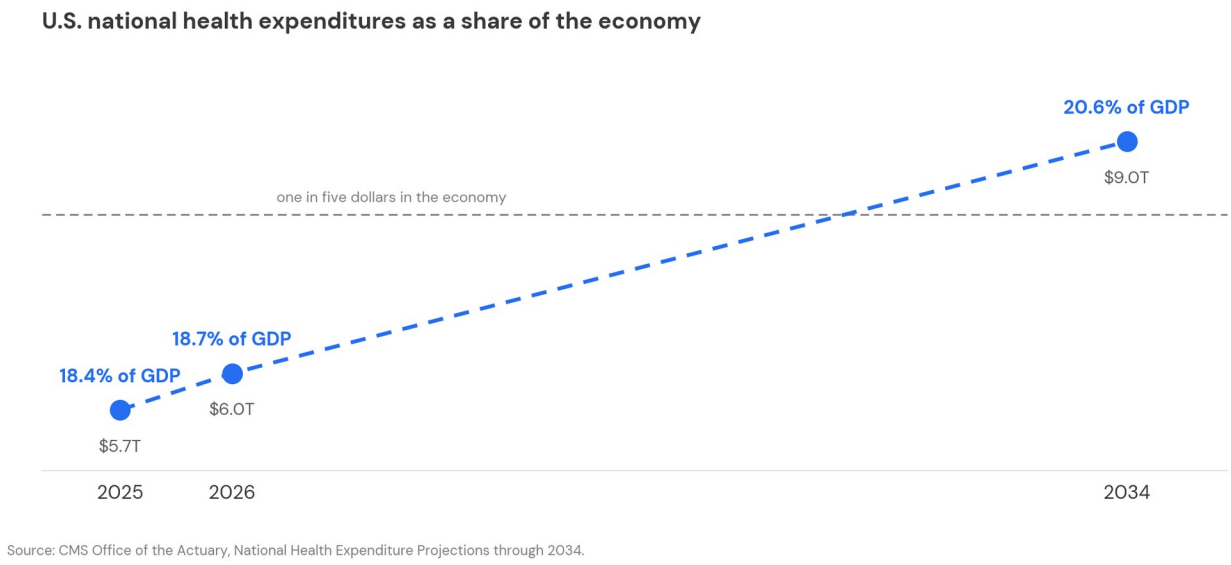


Figure 1. Health care already consumes close to one in five dollars in the U.S. economy, and the share is projected to keep rising.

A trajectory above 20 percent of the economy raises a question that no participant in the system can answer on its own. The issue is not only the size of the number. It is whether the spending produces corresponding gains in health, longevity, and quality of life. If it does not, the growth is structural inefficiency rather than investment.

2. What we get for it

The Commonwealth Fund's 2024 comparison of ten high-income countries placed the United States last overall and last in health outcomes. Americans have the shortest lives and the most avoidable deaths of the countries studied, with life expectancy more than four years below the ten-country average and the highest rates of both preventable and treatable deaths. The Fund's 2026 global comparison found that even at an all-time high of 79 years, U.S. life expectancy ranked third-lowest of the 20 OECD countries studied, ahead of only Mexico and Türkiye.[3]

This is the mismatch that defines the opportunity. The country spending the most is not producing the longest lives or the fewest avoidable deaths. The United States has exceptional physicians, hospitals, medical technology, pharmaceuticals, and research. What it lacks is a way to organize those capabilities around one person, continuously, over time.

3. Why the system produces this result

Care in the United States is usually described as treatment-based. In practice it is narrower than that. It is symptom-based. A person notices something, books an appointment, and receives

roughly fifteen minutes with a physician whose economics require seeing a full schedule of patients every day. The physician addresses the symptom in front of them, or refers it onward. Each clinician in the chain sees the symptom. None of them sees the whole record.

An example from our own company. Greg Brady, our chief executive, went to his physician with a specific complaint: when he stood up quickly, he would see stars and have to catch himself. The presumption was neurological. He was referred to a specialist, and from there to a research center, where testing found nothing. The actual cause was an intermittent irregular heart rhythm. He identified it himself, from his own wearable data, and took it back to his cardiologist.

Nothing in that sequence was incompetent. Every clinician answered the question placed in front of them. The failure was structural: the symptom, the daily rhythm data, and the cardiac history existed in three different places, and no one was looking at them together. The cost of that structure is paid three times over, in referrals that were not needed, in months of delay, and in a condition left untreated while the search went on.

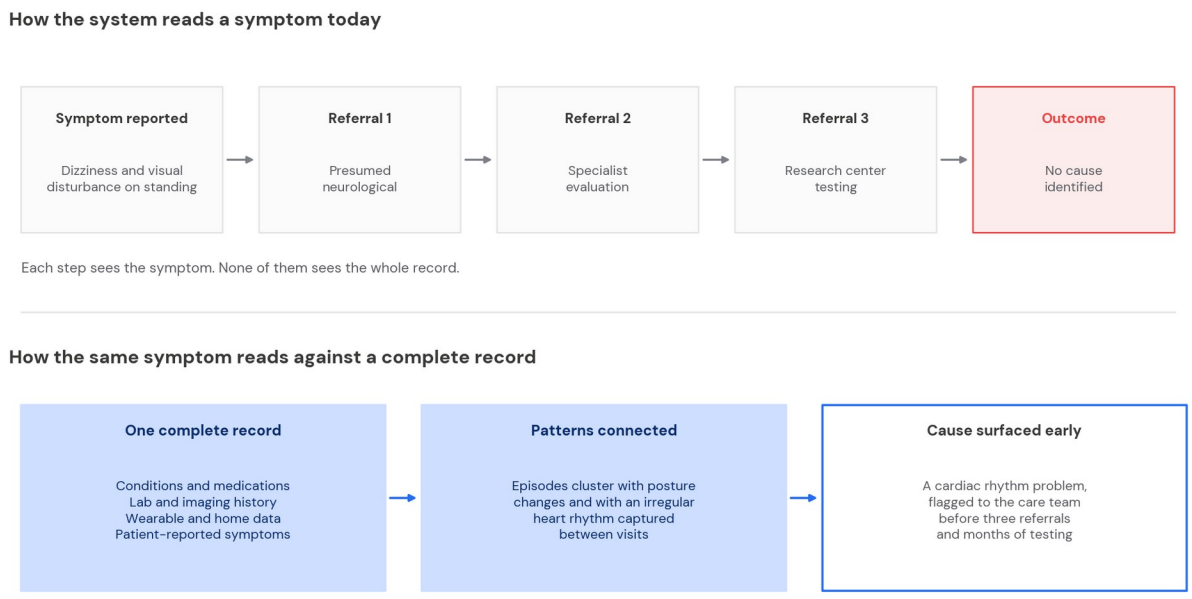


Figure 2. The same symptom, read in isolation and read against a complete record.

The U.S. medical system has to move from treatment-based care to patient-centric, continuous health management, integrating prevention, diagnostic support, and treatment around one trusted record of each patient's medical and lifestyle information.

4. What has to change

4.1 Nothing works without the patient

Prevention cannot be delivered to someone who is not participating. A plan for nutrition, movement, sleep, adherence, and screening depends on information only the patient holds: what they actually eat, how they actually move, what they are willing to sustain, what is getting in the way, and what they are trying to achieve. It also depends on the patient keeping their part of the record current, because records are wrong more often than the industry admits.

This is why a patient-centric system is the precondition for a preventive one, and not simply a friendlier interface on top of a clinical one. It is also the least common capability in the market. Most platforms have added AI to a record that the patient never sees, never contributes to, and has no way to flag when it is wrong.

4.2 One longitudinal record, wherever the care happened

The record has to be assembled from everywhere care occurs: practices and physicians, hospitals and health systems, specialists, laboratories, pharmacies, imaging centers, insurers, wearables, and home monitoring devices. The network is designed to bring in major public sources such as Medicaid, so a state’s covered population becomes part of the same verified record. Orion gathers from every participating source, fuses it, reconciles duplicates and contradictions, and flags what is missing or out of date. Fusion and cleansing is where the agentic process operates.

The patient is then brought into the loop to resolve what only they can resolve. The result is a single version of the truth: one longitudinal record rendered two ways at once, plain language for the patient and clinical detail for the care team, with an auditable history of every change. That corrected record propagates back to the participating systems, so the correction is not trapped in one application.

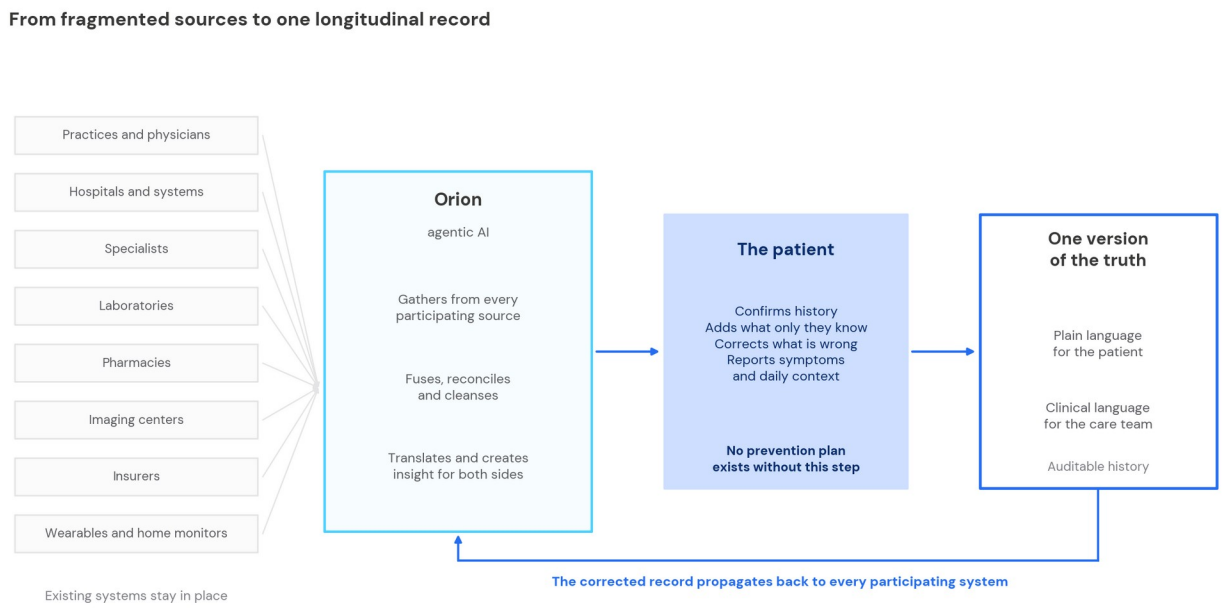


Figure 3. How fragmented information becomes one longitudinal record that both the patient and the care team can trust.

4.3 Two sides of the coin

Connect4Patients and Connect4Providers are not two systems. They are two views of one verified record. The patient sees it in plain language; the physician sees it in clinical terms. When they talk about a lab result or a medication, they are looking at the same facts.

The patient keeps their own information current, such as which medications they actually take and at what dose. Every change is flagged to the provider in a reconciliation report, and the clinician decides what enters the chart. Access is permission-based, and everyone the patient brings onto the network works from that same verified record, each in the view their role requires. It is one command center for the patient's care.

4.4 Orion: what it does, and how it works

Orion is the AI at the center of Connect4Patients. What it does is specific, and so is what it will not do.

It fuses, cleanses, and translates. Orion resolves duplicates and contradictions across every participating source, flags what is missing, and renders the same information two ways: plain language for the patient, clinical detail for the care team. Neither has to learn the other's vocabulary.

It creates insight immediately, for both sides. Reconciliation is not the end of the work. The moment the record is clean, Orion surfaces what it means: a screening that is overdue, a lab

trend moving the wrong way, a medication interaction, a result that changes the plan. The physician receives a clinical read. The patient receives what it means for them and what to do next. Neither has to know the right question in order to get the answer.

It sees what no single EMR can. Because Orion works across the complete record rather than one system's slice, it can surface what no single EMR shows: a stopped refill, a symptom the patient reported at home, a lab drawn at another health system, connected and flagged for the physician.

It is not an open model. Patient questions stay inside a HIPAA-attested environment, and the provider directs where Orion's research comes from.

It goes to medical research first. When Orion answers a clinical question, it draws on research-grade medical literature before any other source, and it notes where the insight came from. A physician can see the basis for a recommendation rather than trusting an unattributed answer.

The clinician stays in charge. Orion drafts, summarizes, and proposes. It does not diagnose and it does not prescribe. Every clinical decision, and every plan element that becomes an order, carries a clinician's signature. The point of the AI is to give the physician more of what only a physician can do, not to take any of it away.

The physician can see what the patient is asking. With the patient's approval, the questions a patient puts to Orion are visible to their physician. What someone asks at eleven at night is clinical information. It reveals worry, confusion, and symptoms that rarely survive the trip into a fifteen-minute appointment, and it lets the physician address the real concern instead of the one the patient managed to articulate in the room.

4.5 The prevention and treatment plan is a living document

The record is the input. The prevention and treatment plan is what is built from it. Clinical inputs, conditions, medications, labs and monitoring, and clinical guidance, are combined with what the patient brings, diet, movement, life and health goals, preferences, and barriers. The output is one plan: what to do, who is responsible, when it happens, and how it changes as new results arrive.

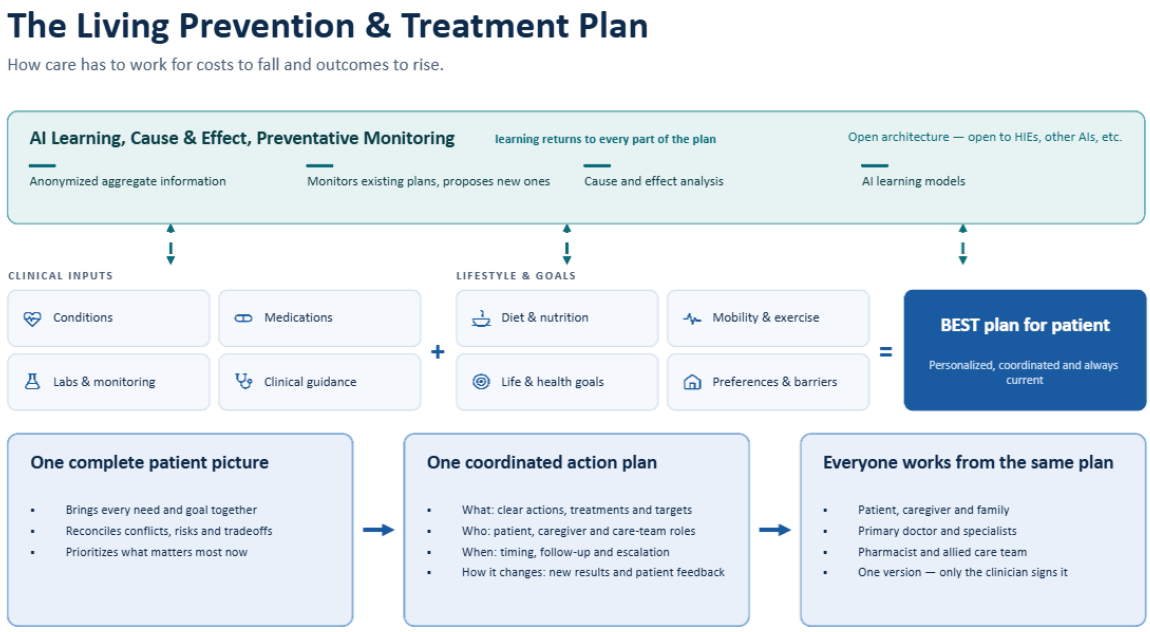


Figure 4. The living prevention and treatment plan. One patient picture, one coordinated action plan, one version everyone works from.

A living document is a different instrument from a care plan printed at discharge. It carries forward, it updates itself as results and daily life change, and it is visible to everyone involved at the same time. When a cardiologist joins the case, they see the plan the patient is already on, including what other members of the care team have set. Today that coordination happens only when one physician calls another, which happens rarely and usually late.

That is what moves care from symptom management to full lifestyle and care management. Instead of a system that reacts to whatever brought the patient in this month, the patient and the care team work from one continuously maintained plan covering nutrition, movement, sleep, medication, screening, and every diagnosed condition at once. It is the largest single improvement available in how care is delivered, and it is not possible without the record underneath it.

Today, prevention happens in passing: a screening reminder once a year, lifestyle advice at the end of a visit, and no one responsible for what happens between appointments. Yet most chronic disease does not begin with a symptom. It begins with a trend: blood pressure creeping up over several visits, a glucose reading drifting toward a prediabetic range. The living plan puts screenings, vaccines, and risk factors beside medications and diagnosed conditions, so a trend becomes actionable when it first appears rather than after it has become a diagnosis.

4.6 The plan can never contradict the medical record

A lifestyle plan generated without the medical record is not just unhelpful; it can be dangerous. A patient with elevated LDL who takes up a high-saturated-fat diet is working against their own cardiac risk. A patient with a knee injury who is given deep knee bends and lunges will make the injury worse. A supplement chosen for one goal can interact with a prescribed medication.

Every recommendation is therefore checked against the record before it reaches the patient. What the patient wants shapes the plan. What the record says constrains it. This is the difference between a wellness application and a clinical prevention tool, and it is the reason the plan has to be built on the reconciled record rather than beside it.

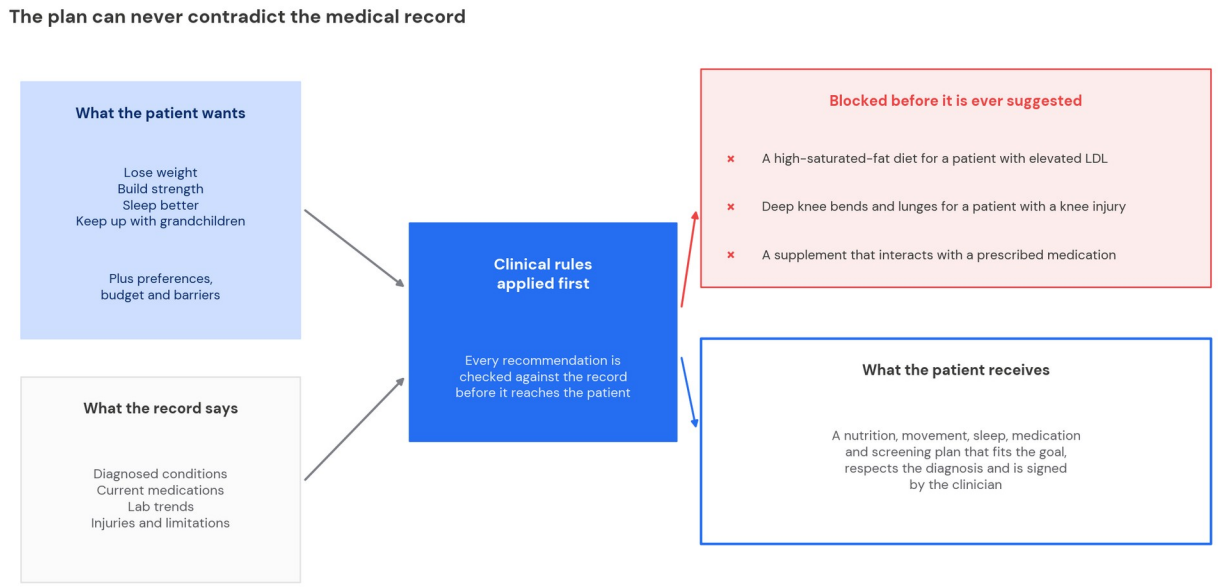


Figure 5. Goals set the direction. The medical record sets the boundaries.

4.7 A nurse at home, between visits

Once the plan exists, it has to be watched. The closest description of what that feels like to a patient is having a nurse at home. Connected devices and patient-reported information are monitored continuously to separate routine variation from meaningful change. Adherence is tracked. Progress is measured against the goals the patient agreed to. New symptoms are captured when they happen rather than recalled weeks later in an exam room.

Orion turns what it observes into new insights automatically, and puts them in front of the people who can act: a suggestion for the patient, a flag for the care team, a question worth raising at the next appointment. When something warrants professional attention it is escalated rather

than waiting for the next visit. A glucose trend heading toward a prediabetic range is actionable months before a diagnosis. An arrhythmia episode is actionable the day it happens.

For the physician, this is an extension of their own attention into the patient's home, working from that patient's own record and under the physician's direction. For the patient, it is the difference between being managed once a quarter and being supported every day.

5. What this means for each participant

5.1 Patients

Patients see their own history in language they can understand, add what the record is missing, flag what is wrong, report symptoms and changes as they happen, and take part in decisions about a plan built around their goals rather than their last visit. They decide about their lives. Their clinician decides about their chart. The value is earlier answers, fewer repeated tests, fewer referrals that lead nowhere, and a plan that reflects the life they actually live.

5.2 Physicians and practices

The immediate value to a practice is time. A reconciled, summarized patient picture removes the research that currently consumes much of a short appointment, and the physician walks in already oriented. The larger value is continuity: the patient is not starting over, and neither is the physician.

The economics matter as much as the clinical case. Preventive care planning, chronic condition management, behavioral intervention, and remote monitoring are reimbursable activities, and this model generates the documentation and monitoring those services require as a by-product of the work itself. Prevention stops being unpaid effort and becomes billable work that also produces better outcomes. Everyone in the chain benefits: the patient gets a better result, the payer covers less chronic disease, and the employer sees lower cost.

5.3 Health systems

Health systems get one verified picture of each patient across every site and specialty, including care delivered outside their own walls. Care gaps surface between visits, in time to act on them, and every affiliated clinician works from the same record.

The reimbursable prevention work described above adds up across every affiliated practice, and the system sees where its patient population stands rather than one encounter at a time. Connect4Providers works inside the EMRs the system already runs, so nothing has to be replaced.

5.4 Caregivers

Adult children and spouses are frequently the only people coordinating across three physicians who are not coordinating with each other. A caregiver can be given scoped access to the same plan and the same record, so that coordination stops depending on one exhausted family member keeping notes, and so that nothing is lost between one appointment and the next.

5.5 Employers, health plans, and states

For an organization carrying the cost of a population, health care is typically the second-largest line item after salaries, and the cost is driven by chronic disease and disability that prevention can move. For a state, that includes its Medicaid population. Eligibility changes move headcount. Prevention moves per-member cost.

The C4P Healthcare Monitor is the aggregate view of the same infrastructure, and it is live rather than retrospective. Anonymized analytics update in real time as the underlying records do, so an organization is looking at where its population is now rather than at a quarterly report describing where it was. The system learns as it accumulates: which interventions moved which cohorts, which combinations of condition and circumstance predict cost, which programs produced nothing.

A healthcare administrator sits at the center of it. The role is not analytical decoration; it is an operating job with levers. The administrator can push education to a cohort, monitor whether it lands, and let the system promote adherence directly to the people enrolled, including prompting a member to raise a specific insight with their own physician. They can see plan completion and adherence across the population: how many plans exist, how many a provider has verified, and how each goal category is tracking. And they can act in bulk, reaching a cohort with a screening, a vaccination clinic, or a cessation program.

Value is visible on day one. Before a single trend line has had time to move, the administrator can see how much of the population has a complete record, where the care gaps are, which members are overdue for screening, and what the adherence baseline is. Those are findings, not projections, and they are available the week the system turns on.

Every view is segmented the way the organization already reports, by age, sex, region, or site, and by the measures that organization says matter. Critically, the administrator sees aggregated, anonymized information only. No individually identifiable health information is exposed to an employer or a state agency. That separation is a design requirement of the product, not a policy applied afterward.

6. Deploying without replacing existing systems

The U.S. health system includes thousands of organizations with different platforms, workflows, data structures, incentives, and levels of digital maturity. Requiring they all get on one common replacement system would be costly, disruptive, and unrealistic. Connect4Patients is built as a layer over what already exists.

Integration is bidirectional with the electronic medical record systems providers already use, and the provider experience is designed to sit inside the workflow they have rather than beside it. Adoption is incremental: connect the priority data sources, establish and improve each patient's record, introduce goals and monitoring, then extend participation. Value compounds as more sources and participants connect, and practices see value on day one from cleaner patient pictures.

The architecture is deliberately open. Health information exchanges, third-party research models, and other AI systems can feed the learning model. A state that has invested in a health information exchange does not have to abandon it; the exchange becomes one more source, and over time the cost of operating parallel infrastructures can come down.

7. Research, drug safety, and population health

Most real-world evidence available to researchers today is derived from payer data, which describes what was billed rather than what happened to the patient. A reconciled longitudinal clinical and lifestyle record, properly de-identified and governed, describes something closer to the truth.

That makes it possible to study relationships among foods, medications, conditions, treatment responses, lifestyle factors, and long-term outcomes: which populations respond poorly to a given drug, which exposures precede which conditions, which interventions actually change a trend. The applications extend from sharper drug warnings to food supply policy to targeted public health programs.

This only works with strong governance. Appropriate consent, rigorous de-identification, security controls, and explicit data-use policies are prerequisites, not enhancements, and Connect4Patients treats them that way.

8. Summary and value proposition

The United States is not short of medical capability. It has the finest hospitals in the world, physicians trained to a standard no other country exceeds, and research institutions the rest of

the world publishes from. With that inventory, matching other developed nations on cost, outcomes, and life expectancy is not an ambition worth holding. It is a concession. The United States should be better than every one of them, and the only thing standing in the way is that the system has never been organized around the person it treats.

> **With our hospitals, our physicians, and our research centers, the United States should not be striving to equal other countries on cost, outcomes, and longevity. It should be beating them.**

That is what this model is for. A preventive, patient-centric system reduces the avoidable: emergency visits, hospitalizations, complications, duplicated services, medical errors, unnecessary treatment, delays in diagnosis, and the fragmentation that causes most of them. A trusted longitudinal record strengthens coordination and clinical decisions, gives patients a real role, and lets providers deliver more effective care. Over time it slows the growth of health care spending while generating responsibly governed evidence for research and prevention.

The value is specific, and it accrues to everyone at once.

For the patient: one record they can read and keep current, earlier answers, fewer wasted visits and repeated tests, a plan built around their own goals, and daily support between appointments instead of a fifteen-minute conversation every few months.

For the physician: the minutes back that are currently spent reconstructing a history, a patient who arrives prepared, insight drawn from medical research with its source attached, full authority over every clinical decision, and reimbursement for prevention work that is already billable.

For health systems: one verified picture of every patient across sites, specialties, and outside care, care gaps that surface in time to act on them, reimbursable prevention, and nothing to replace.

For the caregiver: scoped access to the same plan and the same record, and an end to coordinating three physicians from a notebook.

For employers, health plans, and states: real-time anonymized analytics, a learning model that improves with use, the ability to push education and promote adherence at population scale, a healthcare administrator with real levers, measurable findings on day one, and a reduction in the chronic disease burden that drives the second-largest line item on the books.

For the country: a route to better outcomes at lower cost that does not require replacing a single existing system.

Connect4Patients delivers that by connecting existing systems to an AI health-management layer rather than replacing them. The result is lower implementation disruption, incremental adoption, more value from technology investments already made, connected systems that share one record, one patient view, continuous engagement, and a foundation that improves as it is used.

What changes is not simply the technology. It is how care functions: prevention and treatment as one continuous model, built around a whole person rather than one condition at a time.

> **The goal is not to replace the health care system. It is to help it work as a unified whole that benefits everyone.**

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Sources

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