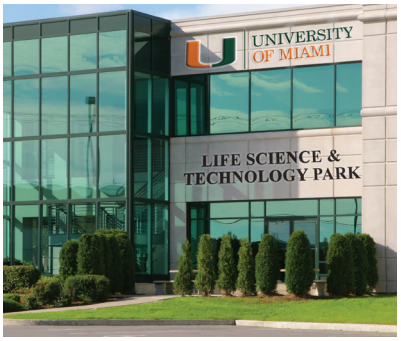
Breakthrough Chronic Care™

Power of Relationships. Power of Hope.

A major advance for working class Americans with chronic illnesses. It significantly improves their doctor-patient relationship and provides state-of-the art treatment plans that can reduce out-of-pocket medical costs.



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UHealth
UNIVERSITY OF MIAMI HEALTH SYSTEM

Our founders are chronic care patients or caregivers. They have experienced first-hand the real world fears, frustrations and stress patients have with their life journey with chronic illness.

Breakthrough **Chronic Care**™ has made a commitment to the working-class Americans with chronic illnesses, and their caregivers to provide dramatically improved concierge care and to reduce their out-of-pocket medical costs no matter what health insurance policy they have. The ***Breakthrough*** **Chronic Care** program starts with an extremely close and personal doctor-patient relationship which allows for superior disease management. Superior management in any field reduces costs and improves quality. We work with the leading research hospitals to find the latest treatment and prevention strategies to share with patients. Our goal is to reduce a patient's out-of-pocket medical costs so significantly that the money they save will pay for ***Breakthrough*** **Chronic Care**.

Over 80% of all healthcare costs in America are attributable to chronic illnesses. **Unfortunately, a significant percentage is paid out-of-pocket by the patient.** Chronic illness is not being effectively treated particularly for working-class Americans with high deductible insurance. Healthcare waste billions of dollars every year. Only 27% of stroke patients with hypertension have their blood pressures under control. People with diabetes are somewhat better with 46% having glycosylated hemoglobin levels within acceptable levels. Coronary heart disease pationts have only 14% who reach recommmended chlesterol levels. Right around 40% of 14% of patients with coronary heart disease reach recommended cholesterol levels. 40% of patients with diabetes and cardiovascular disease suffer from undiagnosed sleep apnea. Similar distressing statistics exist for patients with cancer, chronic kidney disease, arthritis, and fibromyalgia.

The failure to manage chronic illnesses results in the **significantly higher utilization** of all medical services, including *emergency rooms, hospitalizations, surgeries, pharmaceuticals, specialist care, rehab, imaging and lab work*. Seldom have insurers or doctors have been able to provide patients with cost-effective real-world programs which result in better chronic illness management and lower out-of-pocket healthcare costs. Few primary care doctors, found in the insurance company networks, offer personalized

programs and provide the much needed extra time and special care patients with a chronic illness urgently need.

Breakthrough **Chronic Care** has created ***'Concierge'*** **Chronic Care Doctor**™ for working class Americans that can be life-changing. The program can significantly reduce a patient's out-of-pocket medical costs by 33% or more. The company's ***'Concierge'*** **Chronic Care Doctor** progam accomplishes this by providing **superior disease management,** which includes proactive treatment management, pharmaceutical management, nutrition management, weight management and attitude management.

The foundation is our caring ***'Concierge'*** **Chronic Care Doctors** and the extremely close doctor-patient relationship they are committed to providing. Patients receive a highly-organized and extremely personal approach offering unprecedented physical and emotional support. The ***'Concierge'*** **Chronic Care Doctor** utilizes a preventable caring patient-centered model rather than a disease-centered focus as found in acute care today. The benefits of our proprietary model have a positive impact on patient's health, lifestyle, and can significantly reduce out-of-pocket costs.

Studies show the majority of working class Americans with a chronic disease state their **major concern** is "poor" and limited communication with their doctor and the healthcare system in general. They feel they have little control and often feel isolated and depressed. Such a state-of-mind creates a 'toxic stress' for the patient that research shows is extremely harmful, effecting the outcome of their treatment. ***Breakthrough***

Chronic Care has solved this problem. Patients gain immediate and unlimited access to their ***'Concierge'* Chronic Care Doctor** with zero deductibles and zero co-pays. The doctor evaluates patients every 60 days, which includes a 30-minute comprehensive **'support consultation'** to closely monitor their physical condition and provide invaluable emotional support.

The ***'Concierge'* Chronic Care Doctor** has a state-of-the-art medical system comprised of innovative and practical content that is **disease specific** to share with patients. They also help coordinate medical scheduling. The ***'Concierge'* Chronic Care Doctor** is completely up-to-date on all aspects of a patients condition, including medications, treatments, diet, daily exercise, sleeping habits and emotional health. They become friend and counselor providing regular medical insight, support and advice on the numerous questions and decisions every patient with a chronic disease must face. They become a guardian angel. They use HIPAA approved social media, Twitter, Facebook, texting and automated calls to reach-out regularly. The ***'Concierge'* Chronic Care Doctor** helps eliminate the depression, the frustration, and the fear that patients with a chronic illness often experience. They filter through the vast amounts of 'fake news' exploited on the Web and social media about dangerous miracles cures concerning a patient's condition.

***Breakthrough* Chronic Care** works with the preeminent chronic illnesses authorities in America to produce cutting-edge treatments and the cost-effective delivery of next generation chronic care. We are utilizing the extensive research and resources available from numerous prestigious organizations including the Group Health Research Institute, Stanford University, University of Michigan and the University of Miami. We have incorporated several proven advances from each institution into ***Breakthrough* Chronic**

Care. Our ***'Concierge'*** **Chronic Care Doctor** delivers a state-of-the-art chronic care management system and curriculum which provides patients with unprecedented quality care. ***Breakthrough*** **Chronic Care** is a major health breakthrough for working-class Americans with chronic illnesses. Our ***'Concierge'*** **Chronic Care Doctor** replaces the confusion and isolation that patients experience with a comprehensive, organized and personalized turn-key system. ***Breakthrough*** **Chronic Care** is based on the following four key chronic care interventions:

1) The ***'Concierge'*** **Chronic Care Doctor** utilizes a specialized chronic illness management system.

The major reason the current system often fails people with chronic illnesses is that America bases the healthcare system on the acute care model. Acute care is designed to diagnose and treat episodic medical conditions. These conditions generally have a sudden onset, last for only a short period, and are usually solved with targeted therapy, either medical or surgical. The physician's focus is on the disease, not the patient. If the primary physician cannot readily treat or diagnose the disease, the patient is often reffered to one or more specialists for further diagnosis and treatment.

Unlike acute illnesses, chronic illnesses have persistent health consequences that last for a substantial period, vary daily as to the degree of severity, impose limits on the patients' lifestyle, and, typically, can be managed but not cured. ***Breakthrough*** **Chronic Care** provides cutting-edge management systems for the most common chronic illnesses, diabetes, cancer, arthritis, chronic kidney disease, heart disease, stroke, and fibromyalgia. Currently, the primary care physician refers patients with chronic illness the appropriate specialist, yet may not become informed of, or participate with the specialist's diagnosis and treatment plan. Often, the specialist's focus is on the acute condition only, and the patient receives little or no consideration of their overall chronic condition.

Specialists may fail to appreciate a patient's weakened physical condition,

compromised immune system, complex daily medication regimen, his/her ability to follow physician instructions and are not aware of feedback from family caregivers who are aware of prior medical episodes.

A failure to address these chronic illness basics leads to an increase in the rates of error, non-compliance, complications, additional treatments and unnecessary hospitalizations that drive significant costs and numerous sick days that are often avoidable.

Breakthrough **Chronic Care** is based, in part, on successful models studied by a "medical think tank" called the Group Health Research Institute. Studies, funded by the Robert Wood Johnson Foundation and conducted over an eleven year period, have focused on a need for a better model for chronic care. The studies concluded that a patient-centered focus rather than the disease-centered focus, was necessary to make chronic care work. Achieving a close doctor-patient relationship is essential.

The goal of our ***'Concierge'* Chronic Care Doctor** is to manage a patient's chronic condition by monitoring overall health, encouraging compliance, building a relationship of trust. We achieve this goal by examining the patients a minimum of every 60 days with a **'support consultation'** rather than seeing them only when the patients are sick.

The ***'Concierge'* Chronic Care Doctor** forms both a professional relationship and an emotional bond with the patient. When a specialist referral is necessary, the ***'Concierge'* Chronic Care Doctor** works directly with the specialist in the coordination, diagnoses, treatment and compliance of the patient's care. This hands-on approach where the ***'Concierge'* Chronic Care Doctor** serves as patient advocate and liaison, results in more successful outcomes, better utilization of health care resources, and lower health care expenditures by the patient. The use of the most common acute illness model in treating chronic illnesses often fails on many levels. Acute episodes involving chronic illness patients require a greater percentage of the available medical resources due to the implementation of emergency room services as well as the possible costly complications that waste billions of health care dollars annually. Implementing a specialized chronic care model which significantly reduces the severity and

incidence of such acute episodic events through close monitoring by the ***'Concierge'* Chronic Care Doctor** makes sense.

2) Our 'Concierge' Chronic Care Doctor coordinates care and reduces specialty care fragmentation.

Our ***'Concierge'* Chronic Care Doctor** works to reduce specialty care visits when possible, but there are instances when specialty care is necessary. Our ***'Concierge'* Chronic Care Doctor** works closely with the patient and their insurance company to ensure the delivery of such care in the most cost-effective way possible.

The medical care under the current system is often fragmented and sometimes poorly coordinated. Patients with chronic conditions often receive care from multiple specialists who may work independently from each other. Due to time constraints, specialists may fail to communicate with other members of the team about a specific ailment of the chronic illness patient's care. By functioning in separate treatment plans, called "silos," individual specialist clinicians may not have the complete information about the patient's condition, emotional state, or treatment history, creating a major source of medical errors and eventual costly complications.

The silo-based approach often hampers the delivery of efficient care to chronic care patients. Duplication of lab work occurs in many areas, including radiological testing such as MRIs, CT scans, x-rays, and other testing. Information about a patient's health is rarely centralized, well-organized, or retrievable. Specialist physicians often feel responsible only for the care and services they have provided themselves and fail to integrate the full scope of care that their patients have received. Fragmentation also increases the chances that some services may conflict with others, such as the prescription of off-setting medications.

Chronic illness patients are often frustrated and overwhelmed when they are

referred by their primary care physician to see a specialist. They often need assistance not only with setting up the appointment but also with knowing what records to bring and what questions to ask during the appointment with the specialist. We alleviate and eliminate these anxieties for these patients.

Breakthrough **Chronic Care** has a dedicated team of Case Managers who work closely with each ***'Concierge'*** **Chronic Care Doctor** to coordinate all patient, physician, and vendor communication. Our Case Managers will have offices at the University of Miami Life Science Business Incubator (the "Center"). This world-renowned medical/business incubator has world-class IT support companies as tenants. The "Center," located in the Miami Health District, is the second largest health district in the country. The health district includes Bascom Palmer Eye Institute, University of Miami Hospital, Jackson Memorial Hospital, the VA Hospital and Sylvester Cancer Institute. The Case Manager will coordinate and document all communications between the patient, ***'Concierge'*** **Chronic Care Doctor** specialists, insurance companies, hospitals and outside testing facilities.

Our Case Manager will utilize state-of-the-art electronic records software that provides checklists, pop-ups, and other features that will not only assist in facilitating coordination but also reduce the negative impact of costly care

fragmentation that causes duplication of testing, unnecessary hospitalizations, surgeries and specialty care. ***Breakthrough*** **Chronic Care** will utilize Kareo, Incorporated's electronic medical records system in documenting all communications that our Case Managers enter into this vital function.

The Case Manager ensures that the specialist's office is given a complete electronic patient medical record including patient history, testing performed, prior hospitalizations, current medications, patient notes from the ***'Concierge'*** **Chronic Care Doctor,** and any other information that facilitates the orderly treatment of the patient. The Case Manager will also receive and forward to the ***'Concierge'*** **Chronic Care Doctor** all the medical information generated by the specialist physician.

The ***'Concierge'*** **Chronic Care Doctor** will now have the information to participate in the decision of whether hospitalization or surgery is needed. The Case Manager will also follow-up on the status of incomplete notes and treatment plans by the specialists that may delay timely and effective treatment.

The IT and professional resources provided by the Center will reduce medical errors, complications, and wasted resources caused by medical care fragmentation. Also, when the patient receives care outside the offices of the ***'Concierge'*** **Chronic Care Doctor**, the patient will experience less anxiety and frustration. By reducing patient stress we enhance the possibility of positive medical outcomes and effective chronic disease management, that substantially reduces out-of-pocket costs for patients.

3. Our 'Concierge' Chronic Care Doctor empower patients through educational and management skills.

Breakthrough **Chronic Care** has learned from Stanford University research how to provide state-of-the-art chronic illness training for our ***'Concierge'*** **Chronic Care Doctor** and their chronic illness patients. Our goal is to empower patients

with necessary tools to self-manage their health, improve their health, enhance the quality of their life, and lower out-of-pocket costs. We can accomplish this by offering coaching and community support to supplement the care provided by our ***'Concierge'* Chronic Care Doctor**.

The training consists of different modules for various chronic illnesses, including diabetes, back pain, cancer, heart disease, and arthritis. The modules consist of in-house and web-based training.

Subjects covered include:

- Techniques to deal with problems such as frustration, fatigue, pain, and isolation
- Appropriate exercises for improving strength, flexibility, and endurance
- Appropriate use of medications
- Communicating effectively with friends and health professionals
- Nutrition
- Decision making
- How to evaluate new treatments.

Stanford has found that patients who have participated in their chronic illness programs, when compared to those who did not, demonstrated significant improvements in exercise, cognitive symptom management, and communication with physicians, self-reported general health, fatigue, distress, disability, and social/role activities limitations. Participants also spent fewer days in the hospital and trended toward fewer outpatient visits and hospitalizations. In 2015, Stanford reported that 69% of patients demonstrated less disability, worries about their health, and limitations in their daily activities.

The Stanford program does more than educate the patient about his/her chronic condition. The program helps empower them with self-management tools. The ***'Concierge'* Chronic Care Doctor** regularly re-enforces the patient's crucial role in not only maintaining health but also the importance of setting goals,

establishing action plans, identifying barriers, and solving problems to overcome those barriers. The ***'Concierge'* Chronic Care Doctor** encourages and inspires patients to execute every facet of the Proaction Plan to reach the goals set in each of their bi-monthly 30-minute '**support consultation'.** In between office appointments they stay in close touch with patients using personalized HIPAA approved social media, tweets, texts, email and phone calls with patients.

4) Our 'Concierge' Chronic Care Doctor™ utilizes regular mobile and social media technology to support the patient emotionally.

Our ***'Concierge'* Chronic Care Doctor**s are committed to having real impact on the daily lives of their chronically ill patients. In addition to the patient's 'support consultation' every 60 days, they regularly reach-out using several different social and mobile technologies. Doing so is critically important because studies at the University of Michigan have confirmed the importance of patient interactions with a qualified health care professional at home after the physician visit. Interactions decrease the confusion patients often have over care instructions given to them by their doctor. Medication side effects and other issues that may increase the patient's frustration in their daily care compliance are often not reported until the next doctor's visit. The patient may also feel alone and further isolated from family members and friends since no one can relate to his/her condition. As the patient's emotional health declines, the physical symptoms of his/her chronic illness increase.

The programs developed at the University of Michigan attempt to bridge the gap of medical involvement between doctor appointments. They take advantage of our expanding use of technology to bring people closer. Mobile technology utilized include: telephone messaging, twitter, social media platforms, video conferencing, multi-person interactions, screen sharing, and Skype. The use of technology also helps to reduce the number one barrier to chronic illness management, which is depression.

Our ***'Concierge'* Chronic Care Doctor** will work with the Michigan staff to use their proven programs to reduce all the home factors to facilitate compliance with patients of chronic illness. An important feature of our program is the use of inbound and outbound generated communication to answer questions and concerns, assist in changing medical compliance attitudes and gaining patient trust. For optimum postive impact, communications initiated are personal and confidential, many times from the patient's ***'Concierge'* Chronic Care Doctor** or their staff.

A ***'Concierge'* Chronic Care Doctors** will have an innovative, HIPAA compliant, Facebook page with inspiring patient stories and the latest medical studies and breakthroughs that affect the lives of patients. The content will motivate patients to engage because it is relevant to them. They will feel compelled to share their problems, ideas and feelings. Patients with the same condition sharing their real-world experiences of chronic illness is therapeutic to them and to others.

One of the most effective techniques used at the University of Michigan is telephonic support. Patients request, HIPAA compliant, automated support calls, tweets, and texting on a regular basis from their ***'Concierge'* Chronic Care Doctor**. The communications serve as healthy reminders of the necessity of doing all the necessary little things which result in effective chronic care management. They also help to break the isolation barrier which reduces the

incidence of depressive episodes.

Studies at the University of Michigan show that at home “mobile” communications are highly effective in reducing complications from chronic illnesses. We optimize the positive emotional impact of our social media, tweets, texts, automated telephonic calls, and other cost-effective technological tools by having the communication often originate with the patient’s ***‘Concierge’*** **Chronic Care Doctor**. They are highly personalized and provide unprecedented credibility and peace-of-mind because their medical team is committed to keeping them active and healthy.

Breakthrough **Chronic Care** is committed to providing the most effective care available today for the approximately 30 million working-class Americans with chronic illnesses. TSadly, many of them have inferior disease management that wastes hundreds of billions of healthcare dollars and causes significant and unnecessary human suffering.

Breakthrough **Chronic Care** is timely in an age where doctor visits are shrinking. Patients today have more questions with fewer answers than ever before. This creates **unprecedented stress** that is proven to destroy the immune system. ***Breakthrough*** **Chronic Care** provides a real-world solution that can be life changing for millions of working-class Americans.