HEALTH

GP HEALTH WHITE PAPER

The Results Book

Outcomes, accountability, and the case for proactive, physician-led primary care

MEMBER CASE STUDIES · NATIONAL BENCHMARKS · THE ECONOMICS OF AVOIDANCE

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A LETTER FROM YOUR PHYSICIAN

Why this book exists

A member of mine walked into her one-year review this spring and cried. Not because anything was wrong. A year earlier she had arrived with prediabetes, a body mass index of 32, and a quiet fear that she was becoming her diagnosis. Twelve months later her A1c was 5.1%, she had lost a fifth of her body weight, and she had not needed a single emergency room visit, urgent care visit, procedure, or specialist along the way. Her words, not mine: *“We made small changes that I can meet, and that led to big changes I can see.”*

This book is a collection of stories like hers, told with the numbers attached. Healthcare is full of promises. What it lacks is proof, and someone willing to be accountable for results. In the pages that follow, you will find de-identified case studies from real GP Health members: where they started, what we did together, how fast it worked, and what it compares to nationally. You will also find what these outcomes are worth, in the only two currencies that matter: years of healthy life, and dollars that never had to be spent on preventable disease.

> *Data is everywhere now. Judgment, relationship, and accountability are not. That is what GP Health was built to provide.*

Dr. Ahmad Garrett-Price, M.D.
Board-Certified Family Physician · Founder & Chief Physician Officer, GP Health

WHO WE ARE

Mission, vision, and the values behind the results

Our Mission. At GP Health, we believe the power of health and longevity resides in how we live our daily lives. Our mission is to provide a service that takes a proactive and preventive focus on health that allows our members and community to thrive. Our primary care platform of the future leverages technology and a trusted ecosystem of resources to build daily health habits that optimize health and well-being, empowering all to reach their highest quality of life.

Our Vision. Create a future where care is proactive, personal, and transformative. Empower every individual to live healthier, longer, and more fulfilled lives through connection, technology, and compassion. Build a new model of care — one that does not just treat illness, but unlocks human potential.

OUR ETHOS · T.E.A.E.C.P.

Every result in this book was produced by the same sequence of values — the order in which real change happens:

Trust. Before any therapeutic change can occur, trust must be established.

Empathy. The ability to understand and share the feelings of another. A two-way street.

Agency. Ownership of oneself — in this case, taking ownership of one's own health.

Engagement. You must engage for change to happen.

Collaboration. Once you engage, an actual collaboration can begin.

Teamwork & Prevention. Collaboration makes us a team — and together, we prevent disease before it starts.

HOW CARE IS DELIVERED

The GP Health model of care

Every case in this book was managed the same way — and the consistency is the point. GP Health is a physician-led, membership-based primary care and preventive medicine practice. Each member has a named physician who knows their history, designs their plan, and is accountable to their outcomes across a longitudinal arc of care.

WHAT EVERY MEMBER RECEIVES

Time that primary care no longer offers. Sixty- to seventy-minute visits with consistent, structured follow-up. The average primary care visit in the U.S. lasts roughly 18 minutes; behavior does not change in 18 minutes.

Six pillars of daily health. Dietary change (whole-food, plant-predominant), exercise (150 minutes weekly), sleep (7–8 hours nightly), stress reduction, and social connection — built into small, achievable steps.

Precision pharmacotherapy, clinically managed. FDA-approved medications — including GLP-1 therapy where indicated — prescribed, titrated, and sustained inside a physician relationship, not a subscription app.

Prevention on schedule. Cancer screening, kidney and metabolic surveillance, and device support such as continuous glucose monitoring, so problems are found early or never develop at all.

A physician who is accountable. Not a portal. Not a rotating cast of clinicians. One doctor, responsible for your trajectory.

> The named physician relationship is the active ingredient. Technology assists in the background — documentation, pattern recognition, preparation — so that every member-facing minute is human.

THE EVIDENCE

Results at a glance

Six completed member case studies, twelve to seventeen months of longitudinal care each, one pattern. All data comes from real GP Health members, de-identified, with measured labs and vitals.

19%
average total body weight loss across cases with complete weight data (range 14–28%)

5 of 5
members with prediabetes returned to a normal-range A1c

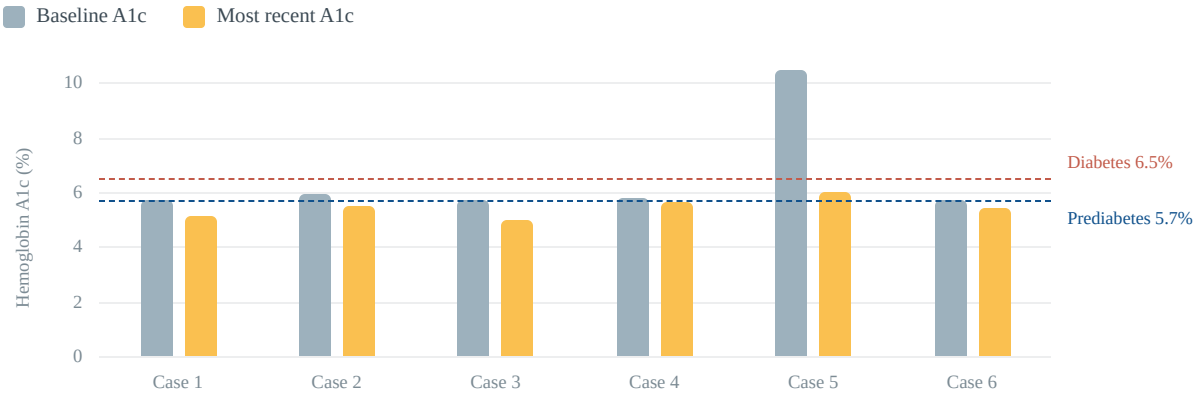
10.5 → 6.0
A1c reversal in the one member who arrived with uncontrolled Type 2 diabetes

0
ER, urgent care, procedures, or specialty referrals across all six cases

200/100 → 130/72
blood pressure recovery from crisis range to normal in twelve months

61 → 79
eGFR recovery — stage 2 CKD returned to normal-range function in five months

EVERY PREDIABETIC MEMBER REVERSED COURSE



National context: fewer than half of U.S. adults with diagnosed diabetes reach common glycemic targets, and most adults with prediabetes never return to normal glucose regulation under usual care. In this panel, every member did.

MEMBER CASE STUDY · 01

Reversing prediabetes, transforming weight

Profile. 61-year-old woman with prediabetes (A1c 5.7%), elevated cholesterol, BMI of 32, and a history of gestational diabetes — a classic high-risk trajectory toward Type 2 diabetes. **Care timeline.** June 2024 – August 2025 (approximately 14 months). **Goals.** Avoid Type 2 diabetes, reduce cholesterol, and achieve at least 5% weight loss. **The plan.** Sixty- to seventy-minute lifestyle-intensive visits across all six pillars, plus clinically managed GLP-1 therapy (semaglutide).

Measure	Baseline	Most recent	Change
Hemoglobin A1c	5.7% (prediabetes)	5.1% (normal)	**Prediabetes reversed**
Weight	183.6 lbs	146.4 lbs	**-37 lbs (20% of body weight)**
BMI	32 (obese range)	25.9	**Out of the obese range**
Total cholesterol	191 mg/dL	179 mg/dL	**Improved**
Acute care utilization	—	—	**Zero ER, urgent care, procedures, or specialty visits**

> **What was avoided:** Progression to Type 2 diabetes — a condition that costs an average of $19,736 per person per year in medical spending, of which about $12,022 is excess cost attributable to the disease itself (American Diabetes Association, 2022 data). Reversal at this stage removes a multi-decade cost and health burden.

In the member's words: *"I feel better." "I feel more confident." "We made small changes that I can meet and that led to big changes I can see."*

MEMBER CASE STUDY · 02

From hypertensive crisis to normal vitals

Profile. 37-year-old man presenting with blood pressure in the 200s/100s — crisis range — a resting heart rate of 101, weight of 368 lbs (BMI 51), prediabetes-range A1c, elevated cholesterol, and protein in the urine signaling early kidney stress. **Care timeline.** May 2024 – May 2025 (12 months). **Goals.** Avoid stroke and heart attack. Lower blood pressure, pulse, and weight. Protect kidney function and prevent Type 2 diabetes. **The plan.** Full six-pillar lifestyle intervention with consistent follow-up, plus pharmacotherapy for blood pressure, cholesterol, and weight (GLP-1 therapy).

Measure	Baseline	Most recent	Change
Blood pressure	200/100 (crisis range)	130/72 (best: 110/62)	**Normalized**
Resting heart rate	105 bpm	60 bpm	**Normalized**
Weight	368 lbs	315 lbs	**-53 lbs (15%) in 12 months**
Hemoglobin A1c	5.9% (since 2022)	5.5%	**Prediabetes reversed**
LDL cholesterol	158 mg/dL	81 mg/dL	**-49%**
Triglycerides	215 mg/dL	109 mg/dL	**-49%**
Acute care utilization	—	—	**Zero ER, urgent care, procedures, or specialty visits**

What was avoided: A 37-year-old with crisis-range blood pressure is a stroke or heart attack waiting for a date. The average inpatient admission for a heart attack costs roughly $47,700 among large employer plans (Peterson-KFF), and the lifetime cost of a severe stroke in a younger person has been estimated near $500,000. This member exited the highest-risk category entirely — without a single acute encounter.

MEMBER CASE STUDY · 03

Twenty-eight percent weight loss — and a knee saved

Profile. 55-year-old woman with chronic obesity (BMI 40) despite prior gastric bypass, right knee pain on a path toward joint replacement, neck pain, reflux, prediabetes, and overdue cancer screening — orthopedic, metabolic, and cancer risk stacked together. **Care timeline.** Intervention began April 2025; results shown through October 2025 (7 months). Baseline labs January 2024. **Goals.** Avoid Type 2 diabetes, avoid premature total knee replacement, and reduce weight by at least 5%. **The plan.** Deep-dive lifestyle correction and goal-setting, consistent engagement, clinically managed GLP-1 therapy, and screening brought up to date.

Measure	Baseline	Most recent	Change
Weight	243 lbs (April 2025)	176 lbs (October 2025)	**-67 lbs (28%) in 7 months**
BMI	40	29.3	**Out of the obese range**
Hemoglobin A1c	5.7% (prediabetes)	5.0%	**Prediabetes reversed**
Triglycerides	113 mg/dL	90 mg/dL	**Improved**
Symptoms	Right knee pain, low energy	Pain improved, energy up	**Exercising more, snacking less**
Acute care utilization	—	—	**Zero ER, urgent care, procedures, or specialty visits**

What was avoided: A premature knee replacement — roughly $20,000 for the surgical episode alone before rehabilitation, complications, and weeks of missed work — performed on a patient with BMI 40, where outcomes are demonstrably worse. Weight loss of this magnitude changes both the need for surgery and the prognosis if it is ever required.

MEMBER CASE STUDY · 04

Kidney function restored, medications withdrawn

Profile. 58-year-old man with obesity (326 lbs, BMI 41.9), prediabetes, stage 2 chronic kidney disease, fatty liver disease, hypertension, obstructive sleep apnea, and cervical pain — a profile on a direct path to becoming a chronic high-cost claimant. **Care timeline.** June 2024 – July 2025 (13 months); primary efficacy shown at 5–10 months. **Goals.** Avoid Type 2 diabetes and advanced heart and kidney disease. Improve kidney function, manage sleep apnea, reduce weight by at least 5%, and rebuild daily health habits. **The plan.** Six-pillar lifestyle intervention, pharmacotherapy including GLP-1 therapy, renal ultrasound, physical therapy for cervical pain, and consistent engagement.

Measure	Baseline	Most recent	Change
Kidney function (eGFR)	61 (stage 2 CKD)	79 (normal range)	**Kidney disease staging reversed in 5 months**
Creatinine	1.37	1.09	**Improved**
Weight	326.2 lbs	279 lbs	**-47 lbs (14%) — maintained off weight medication**
Fasting glucose	122 mg/dL	102 mg/dL	**Out of diabetic range**
Hemoglobin A1c	5.8% (prediabetes)	5.6%	**Prediabetes reversed**
Triglycerides	249 mg/dL	147 mg/dL	**-41%**
LDL cholesterol	114 mg/dL	38 mg/dL	**-67%**
Acute care utilization	—	—	**Zero ER, urgent care, procedures, or specialty visits**

What was avoided: Chronic kidney disease progression — among the most expensive trajectories in American medicine. Uncontrolled blood pressure in stage 3–4 CKD adds roughly $10,000 per patient per year, and dialysis, the endpoint of progression, costs a health plan six figures annually per patient. This member moved in the opposite direction: kidney function returned to the normal range, and results held after medications were withdrawn. Chronic high-cost claimant status avoided.

MEMBER CASE STUDY · 05

Uncontrolled Type 2 diabetes brought to target

Profile. 64-year-old woman with uncontrolled Type 2 diabetes (A1c 10.5%, glucose 278), hypertension, high cholesterol, a heart rhythm condition, and depression — the single highest-acuity presentation in this series. **Care timeline.** April 2024 – September 2025 (17 months). **Goals.** Bring diabetes under control, reduce cholesterol and blood pressure, reduce weight by at least 5%, and support mental health — avoiding advanced diabetes and its sequelae. **The plan.** Six-pillar lifestyle intervention; GLP-1 therapy plus SGLT2 inhibitor (metformin stopped for side effects); cognitive behavioral therapy for depression; continuous glucose monitoring; and full preventive screening — diabetic foot and eye exams, colorectal cancer screening, and skin exam, all completed.

Measure	Baseline	Most recent	Change
Hemoglobin A1c	10.5% (uncontrolled)	6.0%	**-4.5 points, at/near target**
Glucose	278 mg/dL	119 mg/dL	**Normalized**
Triglycerides	391 mg/dL	178 mg/dL	**-54%**
HDL cholesterol	33 mg/dL (low)	46 mg/dL (normal)	**Improved**
Total cholesterol	196 mg/dL	146 mg/dL	**-26%**
Mental health	Depression	CBT engaged, more active	**“My mental state has improved”**
Acute care utilization	—	—	**Zero ER, urgent care, procedures, or specialty visits**

What was avoided: The full downstream cost of uncontrolled diabetes: an average of $19,736 per person per year, insulin dependence, and the complication cascade of kidney failure, vision loss, and cardiovascular events. An A1c of 10.5% brought to 6.0% — with lifestyle and behavioral change established, and the ongoing cost of longitudinal diabetic supplies and escalating medication avoided — is among the highest-value outcomes primary care can produce.

MEMBER CASE STUDY · 06

Sustained 21% weight loss, joints and screening protected

Profile. 50-year-old man with obesity (302 lbs, BMI 38.9), high cholesterol, bilateral knee disease, prediabetes, obstructive sleep apnea, and a family history of prostate cancer with no recent PSA on record. **Care timeline.** July 2024 – October 2025 (14+ months, ongoing). **Goals.** Avoid diabetes, reduce cholesterol, reduce joint pain through a minimum 5% weight loss, and close the cancer-screening gap — avoiding both current and future cost. **The plan.** Six-pillar lifestyle intervention (swimming, heavy-bag work); GLP-1 therapy managed across a medication transition (semaglutide, then tirzepatide); statin deferred per member preference with omega-3 support; physical therapy for bilateral knee pain; PSA surveillance established.

Measure	Baseline	Most recent	Change
Weight	302 lbs	241 lbs	**-61 lbs (21%) over 14 months**
BMI	38.87	30.9	**Approaching non-obese range**
Hemoglobin A1c	5.7% (prediabetes)	5.4%	**Prediabetes reversed**
Fasting glucose	101 mg/dL	85 mg/dL	**Normalized**
PSA surveillance	None on record	2.9–3.4 (normal), monitored	**Screening gap closed**
Knee pain	Bilateral, worsening	Improving by month 2	**10% weight loss by month 3**
Acute care utilization	—	—	**Zero ER, urgent care, procedures, or specialty visits**

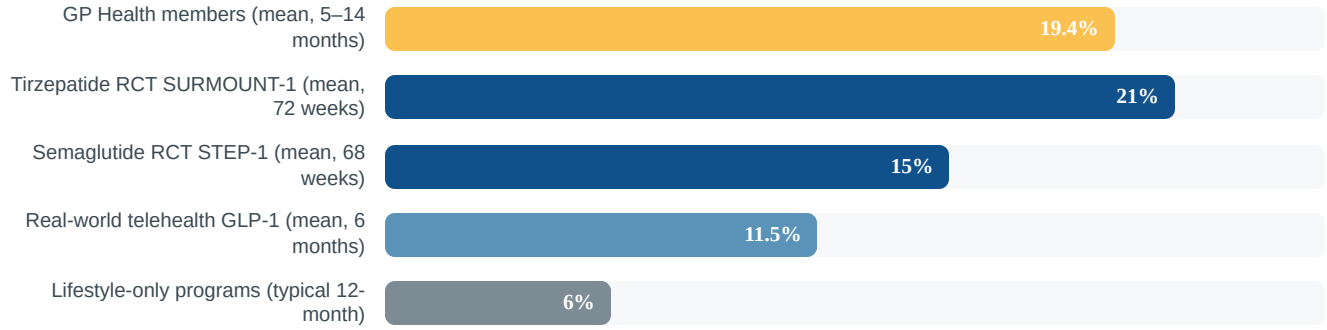
What was avoided: A premature knee replacement with poor prognosis at BMI 39, progression to diabetes, and — given family history — a late-detected prostate cancer. Nationally, 50–70% of GLP-1 users discontinue within twelve months and regain most of the weight; this member sustained therapy through a medication transition and held a 21% loss. Chronic high-cost claimant status avoided.

HOW THIS COMPARES

GP Health results vs. national benchmarks

Case studies matter only in context. Here is the same data set against the best available national comparisons — randomized controlled trials, real-world cohorts, and population statistics.

WEIGHT: TRIAL-LEVEL RESULTS, DELIVERED FASTER, IN THE REAL WORLD



Sources: STEP-1 (semaglutide 2.4 mg, mean 14.9% at 68 weeks); SURMOUNT-1 (tirzepatide, mean approximately 21% at 72 weeks at the highest dose); real-world telehealth cohort of 13,507 patients (mean 11.5% at 6 months); lifestyle-only programs typically produce 5–7% with substantial regain within two years. GP Health mean reflects the five completed cases with full weight data, achieved in 5 to 14 months.

Measure	National reality	GP Health panel
GLP-1 persistence at 12 months	30–50% remain on therapy; discontinuers regain about two-thirds of lost weight within a year	**Therapy sustained and clinically managed in every treated case, including a medication transition**
Prediabetes trajectory	Most adults with prediabetes never return to normal glucose regulation under usual care	**5 of 5 members reversed to normal-range A1c**
Blood pressure control	Fewer than half of U.S. adults with hypertension have it controlled	**Crisis-range hypertension normalized (200/100 to 130/72)**
Kidney function	CKD typically progresses; uncontrolled BP accelerates it	**Stage 2 CKD reversed to normal-range eGFR in 5 months**
Acute care utilization	Top 5% of claimants drive roughly 56% of employer health spending	**Zero ER, urgent care, procedures, or specialty referrals across all cases**

SPEED MATTERS

Velocity to change

Risk compounds while patients wait. A model that produces results in months, not years, does not just improve health — it removes cost from the system earlier. Time-to-result across this panel:

Outcome	GP Health time to result	Typical comparison
10% total body weight loss	**3–5 months (Cases 3, 4, 6)**	~6–12 months in real-world GLP-1 cohorts; often never achieved in lifestyle-only care
15–20%+ total body weight loss	**5–14 months (Cases 1, 3, 6)**	68–72 weeks (16–17 months) in the landmark RCTs
Prediabetes reversal (A1c below 5.7%)	**5–14 months (5 of 5 members)**	Under usual care, prediabetes more often persists or progresses than reverses
Crisis-range BP to normal	**12 months (Case 2)**	Fewer than half of treated U.S. adults ever reach control
Stage 2 CKD to normal-range eGFR	**5 months (Case 4)**	CKD is typically managed as progressive, not reversible
A1c 10.5% to 6.0%	**17 months (Case 5)**	Roughly half of U.S. adults with diabetes reach even an A1c below 7.0%
First measurable symptom relief (joint pain, energy)	**2–3 months (Cases 3, 6)**	Orthopedic pathway: consult, imaging, injection, surgery

> **The pattern:** GP Health members reached landmark-trial outcomes in roughly half the trial timeline — inside ordinary life, not a controlled study — while using zero acute care.

THE FINANCIAL CASE

The economics of avoidance

Every case in this book represents two ledgers: the visible cost of care delivered, and the invisible cost of care that never had to happen. National figures make the second ledger concrete:

What disease costs	National figure
Type 2 diabetes, per person per year	$19,736 in medical spending — $12,022 of it excess cost attributable to diabetes (ADA, 2022)
Heart attack, single inpatient admission	Approximately $47,700 average among large employer plans (Peterson-KFF)
Severe stroke, younger adult, lifetime	Estimated up to $500,000
Total knee replacement, surgical episode	Approximately $20,000 — before rehabilitation, complications, or missed work
CKD with uncontrolled blood pressure	Roughly $10,000 additional per patient per year; dialysis costs six figures annually
High-cost claimants	Average $122,000+ per year each; the top 5% of members drive about 56% of total employer health spend (EBRI)
Unmanaged GLP-1 prescribing	50–70% discontinue within 12 months — the employer pays for the medication, and the weight returns

> **What this panel avoided.** Across six members: five prediabetes-to-diabetes conversions prevented, one uncontrolled diabetic brought to target, one stroke/heart-attack trajectory defused, one CKD progression reversed, two premature knee replacements deferred or avoided, and zero acute-care encounters of any kind. Using conservative national figures, the diabetes conversions alone represent roughly $60,000 per year in recurring avoided cost — every year those members remain healthy — before counting a single avoided admission, procedure, or high-cost claimant trajectory.

A note on honesty: avoided-cost estimates are, by nature, counterfactual. We anchor every figure to published national data, use conservative assumptions, and show our sources — because a financial case that cannot survive scrutiny is not one worth making.

FOR INDIVIDUALS AND FAMILIES

What this means for you

If you saw yourself in these pages — the climbing A1c, the blood pressure reading you did not expect, the knee that is starting to decide what you can do — the most important thing this book demonstrates is that trajectory is not destiny.

A GP Health membership is not a subscription to an app or a menu of lab panels. It is a working relationship with a physician who has the time to understand how you actually live, the clinical range to manage everything from daily habits to modern pharmacotherapy, and the accountability to stay with you until the numbers move. The members in this book did not white-knuckle their way to these results. They made small changes they could meet, with a doctor who never let the plan drift.

THE MEMBERSHIP EXPERIENCE

One physician, your whole picture. Metabolic health, heart and kidney protection, joint preservation, cancer screening, sleep, and mental health — managed together, because that is how your body works.

Visits measured in hours, not minutes. Sixty- to seventy-minute visits and structured follow-up, so the plan fits your life instead of a template.

Modern tools inside a real relationship. GLP-1 therapy, continuous glucose monitoring, mobile lab draws, and biomarker tracking — prescribed and interpreted by your physician, not an algorithm.

A longitudinal arc. The results in this book took 5 to 17 months. Health is built across a year, and we design membership around that arc.

> **Begin with a conversation.** Visit gphealth.care to request an intake consultation with Dr. Garrett-Price and see whether membership is the right fit for your goals.

FOR EMPLOYERS AND INSTITUTIONS

The accountable partner your health plan is missing

Start with the person, because that is where your costs start too. Case 4 is a 58-year-old employee — the kind on every roster — with obesity, prediabetes, stage 2 kidney disease, fatty liver, hypertension, and sleep apnea. On the standard path, he becomes a chronic high-cost claimant: the top 5% of members who drive roughly 56% of total health spending. Instead, within months, his kidney function returned to normal, his prediabetes reversed, he lost 47 pounds and kept it off after medications were withdrawn — and he generated zero claims beyond primary care.

That is what GP Health sells to an organization: not a wellness program, but an accountable clinical partner that changes the trajectory of the specific employees who will otherwise define your renewal.

THE EMPLOYER VALUE MODEL

Lever	Mechanism	Financial expression
High-cost claimant avoidance	Identify and intensively manage rising-risk employees before the catastrophic claim	**~$75,000 in savings per avoided high-cost claimant**
Managed GLP-1 benefit	Physician-managed prescribing, titration, and persistence — converting drug spend into durable outcomes instead of waste	**Roughly 2.0–2.5x first-year return on the management program in modeled populations**
Reduced downstream utilization	Zero ER, urgent care, procedure, or specialty utilization across the case panel	**Modeled 4–5x return per dollar invested; $2.5M–$10M annualized savings at 500–1,000 member scale**
Productivity and presence	Members report more energy, better mental health, improved function	**Reduced absenteeism and disability exposure — the largest indirect cost of chronic disease**

Contracting is straightforward: a per-member-per-month arrangement scoped to your population's actual risk profile, with quarterly outcome reporting against the same metrics shown in this book. Your CFO gets a defensible model; your employees get a named physician who is accountable to their results.

> **To discuss an employer or institutional partnership,** contact admin@gphealth.care. We will begin with your population data — and a member story.

SOURCES AND STANDARDS

Methodology and honest notes

About the case data. All cases are real GP Health members, de-identified and shared with consent. Values reflect measured vitals and laboratory results documented in the medical record between 2024 and 2025. Care timelines vary by member (5–17 months); dates shown are the actual measurement dates.

About the sample. This is a case series of six completed longitudinal cases — illustrative of the model, not a controlled trial. A seventh member engagement is in progress. Individual results vary with baseline health, engagement, and adherence, and no outcome shown here is a guarantee of future results.

About the benchmarks. Trial comparisons (STEP-1, STEP-5, SURMOUNT-1) are drawn from published randomized controlled trials; real-world GLP-1 outcomes from published cohorts including a 13,507-patient telehealth series; disease costs from the American Diabetes Association 2022 Economic Report, Peterson-KFF Health System Tracker, EBRI high-cost claimant analyses, and peer-reviewed CKD cost literature. Benchmark populations differ from this panel in size and composition; comparisons are directional context, not head-to-head equivalence.

About avoided costs. Avoided-cost figures are counterfactual estimates anchored to published national averages and stated conservatively. Where a range exists in the literature, we use the lower bound or the national mean.

About medications. GLP-1 and other pharmacotherapy referenced in this book are FDA-approved medications prescribed within a physician relationship after individualized clinical evaluation. Medication is one pillar of the model, never the model itself.

About this document. Prepared by GP Health (Garrett-Price Health PLLC) for prospective members, employers, and institutional partners. This material is educational and informational; it is not a substitute for individualized medical care. For questions about sources or methods, contact admin@gphealth.care.

HEALTH

GP HEALTH WHITE PAPER

Health is built in how we live our daily lives.

When it is guided by a physician who knows you and is accountable to your outcomes, the results follow.

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