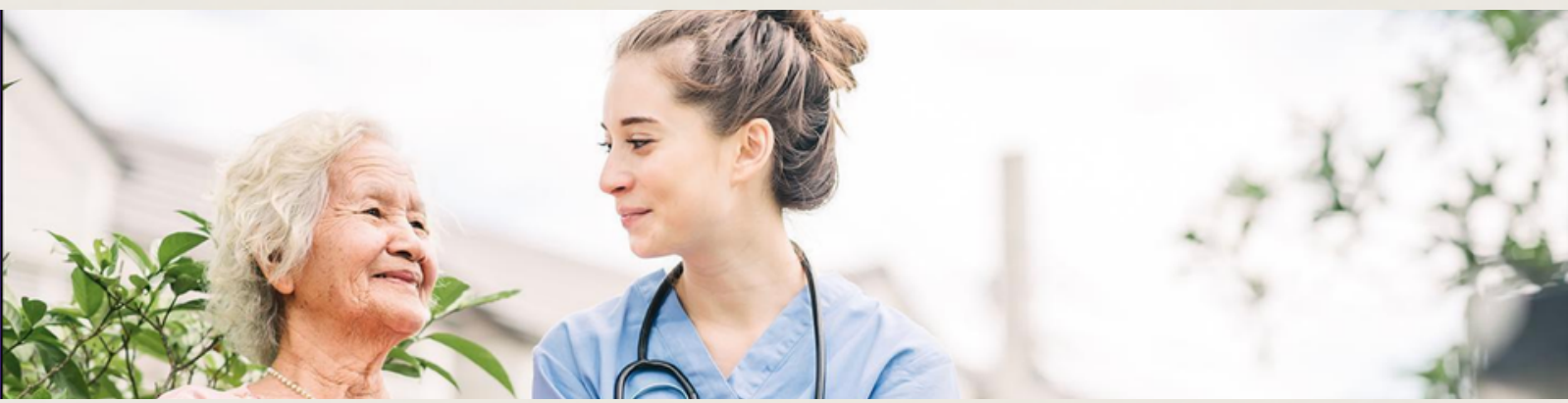




Transforming Heart Failure Care

Through Active Clinical Management Between Visits

Heart failure care is not limited by available therapies; it is limited by the consistent execution of those therapies outside of the clinic.

Patients leave the clinic with a plan, but that plan is not reliably carried out between visits. Medication titration is delayed, changes in condition go unaddressed, and care remains episodic rather than proactive. As a result, patients experience preventable deterioration, avoidable hospitalizations, and suboptimal outcomes.

ISHI delivers a cardiologist-led, virtual heart failure care model that extends clinical management beyond the visit. By combining a multidisciplinary care team, structured workflows, and enabling technology, ISHI operates as an extension of the cardiology practice, supporting active management between visits while keeping the primary cardiologist informed and in control.

This approach shifts heart failure care from episodic intervention to consistent execution, improving patient stability, increasing adherence to guideline-directed therapies, and enabling more scalable care delivery.

What ISHI Is

- A turn-key heart failure clinic
- A cardiologist-led virtual care model for complex cardiac patients
- A multidisciplinary clinical team (HF MD, NP, RN, pharmacist, care navigators)
- An AI-enabled platform supporting risk identification and care coordination

Heart failure care fails between visits, not because of a lack of therapies, but because those therapies are not consistently executed.

The Clinical Problem

Heart failure represents a growing and increasingly complex clinical challenge, both in scale and in the intensity of care required to manage patients effectively over time.

In the United States, heart failure prevalence continues to rise, with millions of patients requiring ongoing management. A significant portion of this population presents with multiple chronic conditions, increasing both clinical complexity and the need for coordinated, longitudinal care. These patients require consistent monitoring, medication adjustment, and support between visits to remain stable.

At the same time, cardiology practices face structural limitations that make this level of care difficult to deliver. Access to specialized heart failure clinicians is limited, care teams are often operating at capacity, and building dedicated heart failure programs requires significant time and resources. As a result, many practices are unable to provide the level of ongoing management that heart failure patients require.

These constraints create a gap between what is clinically recommended and what is operationally feasible. While evidence-based therapies exist and are well understood, they are not consistently implemented in real-world settings.

Key Drivers of the Care Gap

- Rising prevalence of heart failure and aging patient population
- High clinical complexity, with multiple comorbid conditions
- Limited availability of specialized heart failure clinicians
- Care teams operating at or beyond capacity
- Operational barriers to building and scaling heart failure programs

The challenge is not knowing what to do. It is consistently doing it between visits.

Limitations of Existing Approaches

A range of solutions has emerged to address gaps in heart failure care, including remote patient monitoring, telehealth, and care management programs. While these approaches improve access to data and communication, they do not fully address the underlying challenge of consistent care execution.

Remote monitoring programs generate valuable clinical data, but often stop short of ensuring that appropriate action is taken. Telehealth expands access to clinicians, but remains episodic in nature, relying on scheduled interactions rather than ongoing oversight. Traditional care models continue to depend on in-clinic visits and already burdened care teams to manage complex patient populations.

As a result, responsibility for ongoing care remains fragmented. Data is collected, but not always acted upon in a timely manner. Opportunities for medication optimization are missed, and early signs of deterioration may not be addressed quickly enough to prevent escalation.

The core limitation across these approaches is not a lack of insight, but a lack of structured, accountable execution. Existing models improve visibility into patient status, but do not consistently ensure that appropriate clinical action is taken.

Where Current Models Fall Short

- Monitoring without consistent intervention
- Episodic care instead of ongoing management
- Dependence on already constrained clinical staff
- Fragmented workflows across care settings
- Limited ownership of outcomes

The Missing Layer

What is needed is not additional data or access, but a model that ensures care is actively delivered between visits.

The ISHI Care Model

ISHI delivers a cardiologist-led, virtual care model designed to extend heart failure management beyond the clinic and ensure that evidence-based therapies are consistently implemented in real-world settings.

Rather than adding burden to existing care teams, ISHI operates as an extension of the cardiology practice. By combining a multidisciplinary clinical team, structured workflows, and enabling technology, ISHI closes the operational gap in heart failure care by ensuring that treatment plans are carried out consistently over time.

Core Components

- **Clinical team:** Cardiologist-led multidisciplinary team managing ongoing patient care and escalation
- **Workflows:** Guideline-aligned titration, risk identification, escalation, and care coordination
- **Monitoring:** Symptom tracking, device monitoring, and structured patient engagement
- **Technology:** Integrated platform with AI-assisted prioritization embedded in clinical workflows

Care Delivery and Impact

ISHI is designed to work in partnership with the primary cardiologist and care team, strengthening existing workflows rather than replacing them.

Patients are enrolled through the cardiology practice, and ISHI assumes responsibility for ongoing monitoring and day-to-day management between visits. Clinical updates, recommendations, and escalation decisions are communicated back to the primary cardiologist, ensuring continuity and alignment across the care team.

This model enables cardiologists to maintain oversight of patient care while offloading the operational burden required to manage complex heart failure populations.

How ISHI Operates in Practice

- Patients are identified and enrolled through the existing practice
- ISHI manages monitoring, check-ins, and clinical workflows
- Changes in patient condition are identified early through structured processes
- Interventions, including medication adjustments and follow-up care, are coordinated
- Recommendations and updates are shared with the primary cardiologist
- Physician oversight is maintained for complex or escalated cases

Impact on Care Delivery

By embedding structured execution into the care model, ISHI enables:

- Earlier identification of clinical risk
- More consistent implementation of guideline-directed therapies
- Reduced burden on internal care teams
- Expanded capacity to manage complex patient populations

Clinical and Operational Outcomes

Early results from the ISHI model demonstrate measurable improvements in both clinical indicators and patient engagement, particularly within complex heart failure populations.

By embedding structured workflows and consistent follow-through into care delivery, ISHI enables earlier intervention, more reliable therapy optimization, and improved patient stability over time.

Clinical Indicators

- Reduction in cardiac pressure trends over time
- Increasing percentage of patients within target ranges
- Improved alignment with guideline-directed medical therapy

Patient Engagement

- 87% of patients remain engaged beyond six months
- Patients contribute an average of seven readings per week
- Ongoing communication supports adherence to care plans

Population Characteristics

- Average patient age of 74
- High prevalence of comorbid conditions
- Patients requiring frequent monitoring and adjustment

Operational Impact

- Offloads routine monitoring and coordination
- Enables proactive patient management
- Expands capacity for complex populations
- Supports additional revenue through virtual care programs

Implications and Conclusion

The ISHI model shifts heart failure care from episodic intervention to structured management between visits.

Traditional care models are constrained by time, staffing, and in-person encounters, often resulting in reactive care. By contrast, ISHI embeds execution into the care model, ensuring clinical plans are actively carried out and adjusted over time.

This enables more predictable patient trajectories, reduced variability in care delivery, improved alignment with value-based care models, and greater efficiency in resource utilization. Heart failure care does not require new therapies. It requires a more effective model for delivering the therapies that already exist.

By combining clinical expertise, structured workflows, and enabling technology, ISHI ensures care plans are consistently executed between visits while preserving physician oversight and reducing operational burden.