



Qualitative conclusions should be considered directional only. Quantitative conclusions are based on targeted standards of at least 95% confidence and an error rate of no more than +/- 5%.

Recommendations should be considered opinions only, but they are based on interpretation of the data and the expertise within MarketWise.

Any questions pertaining to this study, its methods, and/or conclusions can be addressed via email to the preparer of this report.

*Disclosure: Mike Haldane serves as Co-Founder and Co-CEO of Senphonix, and Founder and President of MarketWise. Regardless, research design and interpretation were completed with the intent of objective evaluation to guide healthcare decision makers who are assessing automated monitoring technologies.*

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## Report of Findings — Patient Monitoring (Financial View)

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## Executive Summary

Hospitals and health systems across the United States continue to operate under conditions of sustained financial and operational strain. A combination of rising labor costs, persistent workforce shortages, elevated patient acuity, and unpredictable demand volatility has placed extraordinary pressure on already thin operating margins. Much of this pressure lands directly on the clinical workforce, particularly nurses, who are responsible for both direct care and substantial administrative and monitoring tasks. As a result, nurse capacity has emerged as a primary limiter on patient throughput, service availability, and the financial sustainability of inpatient care delivery.

As a follow-on to its 2025 national nursing study, Senphonix commissioned MarketWise to evaluate whether SleeveSense, a new wearable patient monitoring system designed to automate vital signs collection and support continuous physiological monitoring, represents a financially meaningful response to these challenges. The study focused on finance and strategy leaders, including chief financial officers, vice presidents of finance, revenue leaders, and senior operational stakeholders with budget authority or influence. Participants were introduced to a conceptual description of the technology and asked to evaluate the potential financial benefit, assess likelihood of adoption, and articulate conditions required for organizational support.

Survey findings show broad and consistent interest across financial leaders. The vast majority of respondents agreed that reducing nursing time spent on manual vital sign collection would create meaningful financial benefit, either by freeing licensed clinical staff for higher-value tasks or by mitigating reliance on traveler and overtime nurses. Respondents also indicated significant interest in the potential for remote patient monitoring reimbursement as a new or expanded revenue stream, particularly when framed as an extension of discharge workflows and a mechanism to reduce readmissions.

Support for adoption was strong in principle. Most respondents stated that they would back SleeveSense under a subscription-based pricing model, reflecting a trend away from capital investment toward flexible operating expense structures. Respondents recognized that subscription models align cost with clinical utilization and reduce the organizational friction associated with capital approval cycles.

Enthusiasm, however, was accompanied by clear expectations and conditional requirements. Respondents want transparency in pricing and total cost of ownership to avoid unexpected expenses after implementation. They require confidence in data security, including encryption, transmission protocols, and vendor accountability, given the financial and reputational consequences of cybersecurity failure. They expect reliability and validation of clinical accuracy, recognizing that the value proposition depends on nurses trusting and using the system. They also highlighted the need for seamless integration with existing electronic health records and clinical workflows, warning that internal IT capacity is limited and that any new system that adds burden risks undermining adoption.

Finance leaders broadly framed adoption as a shared decision requiring alignment across multiple internal stakeholders. Respondents consistently noted that nursing leadership must confirm bedside value, information technology teams must confirm feasibility and support requirements, and finance departments must validate the business case. Clinical leadership outside nursing may also promote adoption where monitoring improvements align directly with healthcare quality, early intervention, and

patient safety goals.

Taken together, the findings indicate that SleeveSense is entering a receptive but discerning market. Hospital financial leaders are not debating whether automation is necessary; they see it as essential to sustaining operations under workforce constraint. They are prepared to support systems that clearly reduce labor burden, stabilize costs, and present new or underutilized reimbursement opportunities. At the same time, they expect solutions to arrive with the validation, support infrastructure, and risk mitigation required to succeed in environments already operating at capacity.

In short, the primary challenge ahead for SleeveSense is not one of conceptual persuasion, but one of execution. To move from pilot interest to widespread deployment, SleeveSense must demonstrate reliable performance, minimize organizational lift, deliver documented clinical adoption, and provide transparent, predictable economics. If Senphonix can meet these expectations, market conditions suggest that SleeveSense has the potential to scale rapidly across both inpatient and post-acute (outpatient) care settings.

## **1. Background and Market Context**

This study is the second in a two-part research initiative commissioned by Senphonix to understand the operational and financial environment into which SleeveSense is launching. The first study, conducted in early 2025 with front-line nurses and clinical leaders, examined the clinical pressures and workflow realities affecting bedside care. That research revealed overwhelming support for reducing manual vital sign collection and identified nursing burden and burnout as defining risks to quality and retention. The present study builds on those findings by shifting the analytic lens to hospital financial executives, the individuals responsible for determining whether a concept with strong clinical promise also represents a prudent investment. Together, the studies provide complementary insights: 1) one from the workforce that must use the technology; and 2) one from the leaders who must evaluate and fund it.

### **1.1 Operating Conditions in U.S. Health Systems**

Hospitals across the country continue to operate under sustained financial constraints that began before the pandemic and were sharply intensified by its effects. Throughout 2022 and 2023, many systems reported negative or marginal operating margins. Although partial recovery occurred in 2024, most respondents told us that the structural cost base of hospital care has permanently shifted upward. Labor now accounts for a larger share of total operating costs than at any point in the last decade, and wages continue to rise faster than reimbursements.

A second structural change is the normalization of contract labor. Staffing shortages during the pandemic forced hospitals to adopt traveler and agency nursing as a core component of their staffing model rather than a temporary stopgap. These positions often command premiums of 50-100% above full-time nurse salaries, and their cost has meaningfully compressed margin performance across virtually every inpatient service line.

Against this backdrop, respondents consistently described managing labor cost growth as not merely a budgeting exercise, but a determinant of organizational survival. The pressure is felt everywhere: 1) in cost-per-case targets; 2) in reduced access to capital; and 3) in the need to balance staffing reductions with quality and safety obligations that cannot be compromised.

## 1.2 Workforce Scarcity as a Structural Constraint

The nursing workforce shortage is no longer viewed as temporary or cyclical. Independent analyses from organizations such as McKinsey and NSI Nursing Solutions project a persistent shortfall extending through the next decade due to accelerated retirements, stalled education pipeline growth, and mounting burnout. Survey responses echoed these concerns. Finance leaders across markets and system types reported vacancy rates that remain significantly above historical norms and turnover within nursing cohorts that continue to strain scheduling and onboarding capacity.

As a result, hospitals now treat workforce scarcity as a structural reality, not a temporary disruption. Respondents emphasized that even with aggressive recruitment, retention incentives, or supplemental compensation programs, they cannot hire quickly enough or deeply enough to restore pre-pandemic staffing levels. This has changed how organizations view technology. Automation is no longer evaluated only as a pathway to productivity gain; it is increasingly viewed as a solution to a labor problem that cannot be solved through hiring alone.

For this reason, respondents described reclaimed nursing time not as a marginal convenience, but as recovered capacity. Several compared nursing time saved to adding staff positions they cannot realistically fill.

## 1.3 Readmissions, Quality Metrics, and Financial Risk

Labor pressures are further compounded by financial penalties tied to patient outcomes. Under Medicare's Hospital Readmissions Reduction Program, hospitals face reimbursement cuts if patients are readmitted within 30 days for certain high-frequency or high-cost conditions. These penalties are increasingly mirrored in risk-sharing arrangements with commercial payers and in value-based purchasing programs that link payment to performance on quality metrics.

Respondents recognized that avoidable readmissions represent dual costs, including direct reimbursement losses and indirect resource drag, as repeated admissions consume clinician time and capacity that could be utilized elsewhere. They expressed interest in technologies that enable earlier clinical intervention, particularly during the post-discharge window when risk is elevated and real-time monitoring is limited.

At the same time, respondents demonstrated realism about the limits of monitoring. Many acknowledged that readmissions are sometimes influenced by factors outside the hospital's control, including socioeconomic conditions, home support, medication adherence, and behavioral determinants. As a result, most viewed readmission reduction as a meaningful but secondary benefit of SleeveSense. It strengthens the business case, but it is not the sole driver.

## 1.4 Expansion of Remote Patient Monitoring Programs

Remote patient monitoring (RPM) has emerged as a viable reimbursement pathway since Medicare expanded billable CPT codes in 2019. Programs that were niche or experimental five years ago have now become material contributors to revenue in some systems. Respondents reflected this shift. Those with established RPM programs see SleeveSense as an opportunity to expand enrollment, automate data capture, and reduce infrastructure burden. They noted that RPM growth is currently constrained not by

a lack of eligible patients, but by operational bandwidth for device provisioning, patient follow-up, data triage, and ambulatory care team staffing.

Systems without active RPM programs expressed significant interest, though tempered by internal resource limitations. For these organizations, SleeveSense represents a potential entry point into RPM reimbursement without requiring investment in large-scale program development, device procurement, or patient monitoring infrastructure.

Taken together, the responses indicate that SleeveSense creates financial opportunity under two distinct scenarios: 1) accelerating existing RPM capability; and 2) enabling new capability in systems that have been unable to participate due to resource constraints.

### **1.5 The Shift from Capital Acquisition to Operating Expenditure**

A final trend shaping the market context is an observable shift away from capital expenditure toward service-based purchasing. Historically, capital budgets offered a protected pathway to acquire equipment, software, and monitoring platforms. That separation gave hospitals financial room to invest in technology while holding operating budgets constant.

Survey respondents described a departure from that model. Many organizations have tightened capital approvals, delayed refresh cycles, or restricted new capital projects. At the same time, operating budgets, while constrained, offer more flexibility to pilot, adopt, and scale new solutions. Respondents highlighted subscription-based models as particularly attractive because they allow hospitals to align spending with actual utilization, eliminate sunk cost risk, and discontinue or expand deployment based on performance and scale.

This shift is highly favorable to technologies such as SleeveSense. Respondents repeatedly noted that if SleeveSense performs as intended, subscription pricing allows them to recognize value quickly, absorb cost gradually, and avoid long-term commitments until benefits are proven.

## **2. Research Objectives**

The 2025 nursing study confirmed that frontline clinicians overwhelmingly view automated monitoring as a necessary and meaningful intervention. The current study extends that inquiry to hospital financial leadership, whose support is essential for adoption and scaling.

Senphonix engaged MarketWise to understand whether SleeveSense represents a financially compelling innovation when evaluated by executives responsible for stewarding hospital resources, approving technology expenditures, and managing organizational risk. The central objective was to assess whether the financial benefits associated with automated vital sign monitoring are sufficiently clear, credible, and material to justify deployment in systems operating with constrained budgets and limited staffing capacity. More specifically, the research pursued four primary questions.

1. To what extent financial leaders believe that reducing manual vital sign collection and documentation will translate into realized financial savings, either through avoided costs, freed labor capacity, or reduced reliance on contract staffing.

2. Whether respondents would support adoption of SleeveSense if offered under a subscription-based pricing model aligned to patient use, and whether such a model fits within the financial decision frameworks organizations currently favor.
3. Whether incremental revenue generated through remote patient monitoring reimbursement is viewed as a meaningful contributor to a positive financial case, particularly for hospitals already engaged in RPM activity versus those not yet participating.
4. What perceived risks or barriers might slow or prevent adoption, and what assurances or organizational enablers would be necessary for successful deployment.

In addition, the research incorporated open-ended questions designed to surface context that structured questions cannot fully capture, including nuance around risk tolerance, operational capacity, historical experience with technology rollouts, and the conditions under which an innovation can achieve sustained use. Respondents were encouraged to describe concerns, requirements, and/or internal processes in their own words, enabling deeper thematic analysis.

Finally, the study aimed to identify the stakeholders most likely to champion adoption and those positioned to influence or block investment decisions. Because technologies like SleeveSense do not enter an organization through a single authority, mapping the likely path of internal approval is as important as quantifying financial beliefs. Hospitals distribute decision-making across finance, nursing, clinical leadership, operations, and information technology. A solution that appears financially favorable must also be organizationally viable, and understanding the intersection of influence, authority, and risk appetite is central to any successful commercial strategy.

Although this study offers clear directional insights, it should be interpreted as exploratory rather than predictive. Responses reflect viewpoints based on stated understanding of the SleeveSense concept, rather than direct operational experience with a deployed system. Future research, including pilot testing and outcomes measurement, will be necessary to validate financial assumptions and quantify realized return.

### **3. Methodology**

The 2025 nursing research established that nurses perceive automation of vital sign collection as both highly desirable and operationally beneficial. Whereas the prior study focused on those responsible for using SleeveSense at the bedside, this phase evaluates the financial decision makers who determine whether the solution moves from a promising idea to a funded and implemented program. By design, the two studies form a continuous line of inquiry into both clinical readiness and financial will.

#### **3.1 Survey Design**

MarketWise developed a structured online survey instrument that described SleeveSense in clear and neutral terms. A total of 481 individuals began the survey, with 457 completing the survey after the qualifying question (Q1) was applied. Anyone who was not at least somewhat familiar with financial operations within a hospital, was removed. This sample size provided 95% confidence, and an error rate

of no more than +/- 5%. See Figure 1.

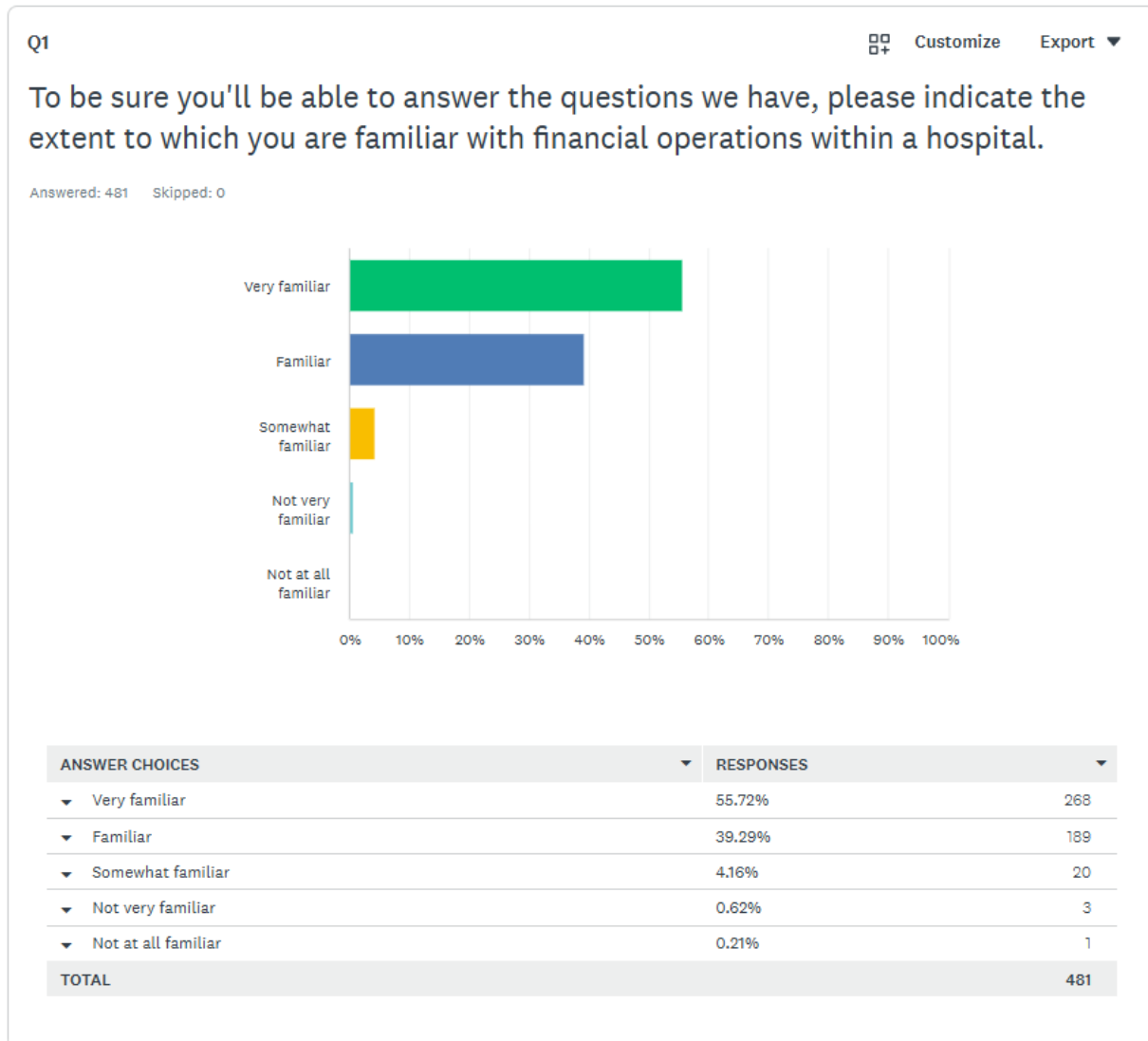


Figure 1 - Qualifying Question.

The survey introduced respondents to SleeveSense through a standardized written prompt. The description explained that SleeveSense is a lightweight mesh sleeve that continuously captures core physiological measurements such as heart rate, respiration, temperature, and movement. It specified that the sleeve transmits vitals automatically to existing electronic health record systems, eliminates the need for manual data entry, and can be worn continuously without removal for charging, showering, exercising, etc. The prompt emphasized that SleeveSense supports both inpatient care and post-discharge monitoring, enabling continuity during the critical 30-day period when readmission risk peaks.

The description was deliberately structured to reflect the intended value proposition without using promotional language. The prompt explicitly noted that SleeveSense is designed to meet HIPAA security expectations and integrate into existing workflows. It also clarified that the system would be priced as a subscription, rather than requiring capital expenditure. Respondents therefore evaluated the concept

based on its stated clinical capabilities, operational intent, and financial model.

### **3.2 Sample and Respondent Profile**

The survey was distributed to leaders embedded in the financial and administrative spine of hospital systems. These individuals represent roles that control or influence resource allocation decisions, weigh opportunity cost, and assess risk associated with new technology deployments. Respondents' titles spanned chief financial officer, vice president of finance, controller, director of finance, revenue cycle leader, hospital administrator, and related positions with responsibility for managing budgets, protecting margins, and evaluating investments.

While the survey captured a cross-section of hospital types, including academic, community, suburban, and rural, respondents shared common functional characteristics. They are responsible for assessing whether proposed solutions yield measurable financial value, and they are accustomed to evaluating whether operational innovation relieves cost pressure, improves throughput, or shifts burden onto internal teams.

### **3.3 Data Collection and Cleaning**

Responses were collected electronically over a defined field period, and results were compiled into a consolidated analysis file that included both structured response items and narrative open-text entries. The raw dataset included instances of partial completion and a small number of nonsensical inputs, including repeated keystrokes and placeholder responses. Consistent with analytic standards, these cases were removed to preserve interpretive accuracy and to ensure that narrative themes reflect genuine respondent insight.

Open responses were reviewed and tagged using a thematic coding process. Analysts identified repeated concepts, grouped related comments, and recorded the frequency with which concerns or perceived benefits surfaced across respondents. This qualitative patterning served as a complement to the structured questions and provided insight into the conditions and dependencies that influence purchase decisions.

### **3.4 Analytic Approach**

Structured responses were analyzed using descriptive statistics to determine the proportion of respondents expressing strong, moderate, or limited belief in the value of automated monitoring. The data was then examined for patterns of association among questions. Pearson product-moment correlation coefficients and Spearman rank-order correlations were calculated to assess the extent to which support for adoption was associated with beliefs about financial benefit. This dual approach helps address the ordinal nature of the response scale while preserving interpretive clarity.

Analysis revealed clear directional relationships. Respondents who rated potential labor savings highly were substantially more likely to indicate support for adopting SleeveSense. The same pattern held for perceived financial value from remote patient monitoring revenue. These relationships suggest that financial leaders are synthesizing cost, capacity, and revenue considerations into a unified assessment of

return, rather than evaluating components independently.

### **3.5 Interpretation Considerations**

Because this was a concept test conducted prior to deployment, the results should be interpreted as directional indicators of readiness, sentiment, and perceived financial value. Respondents evaluated SleeveSense based on description rather than lived operational experience with the device. Actual adoption outcomes will depend on performance validation, organizational capacity, integration execution, and internal championing. The intent of the research was to illuminate decision criteria and financial reasoning, not to project adoption rates or guarantee outcomes.

## **4. Overview of Findings**

The results of the survey demonstrate that financial leaders broadly view automated vital sign monitoring and continuous patient tracking as a practical response to material operational pressure, rather than as a speculative or futuristic technology. This represents an important confirmation of insights from the 2025 nursing study, which found significant enthusiasm among frontline clinicians for relieving manual workload associated with routine vitals. Together, the two bodies of research suggest alignment across both clinical and financial domains regarding the need to reduce burden through automation.

Figure 2 illustrates that a substantial majority of respondents believe that reducing time spent on manual vital sign collection would generate meaningful financial benefit. This pattern held across hospital types and roles. Respondents consistently tied time savings to cost avoidance, particularly in environments experiencing chronic understaffing or where staffed bed capacity functions as a hard limit on throughput and revenue. Unlike conceptual savings categories that sometimes test unevenly, time reclaimed from nursing was widely understood as a direct offset to overtime and traveler utilization.

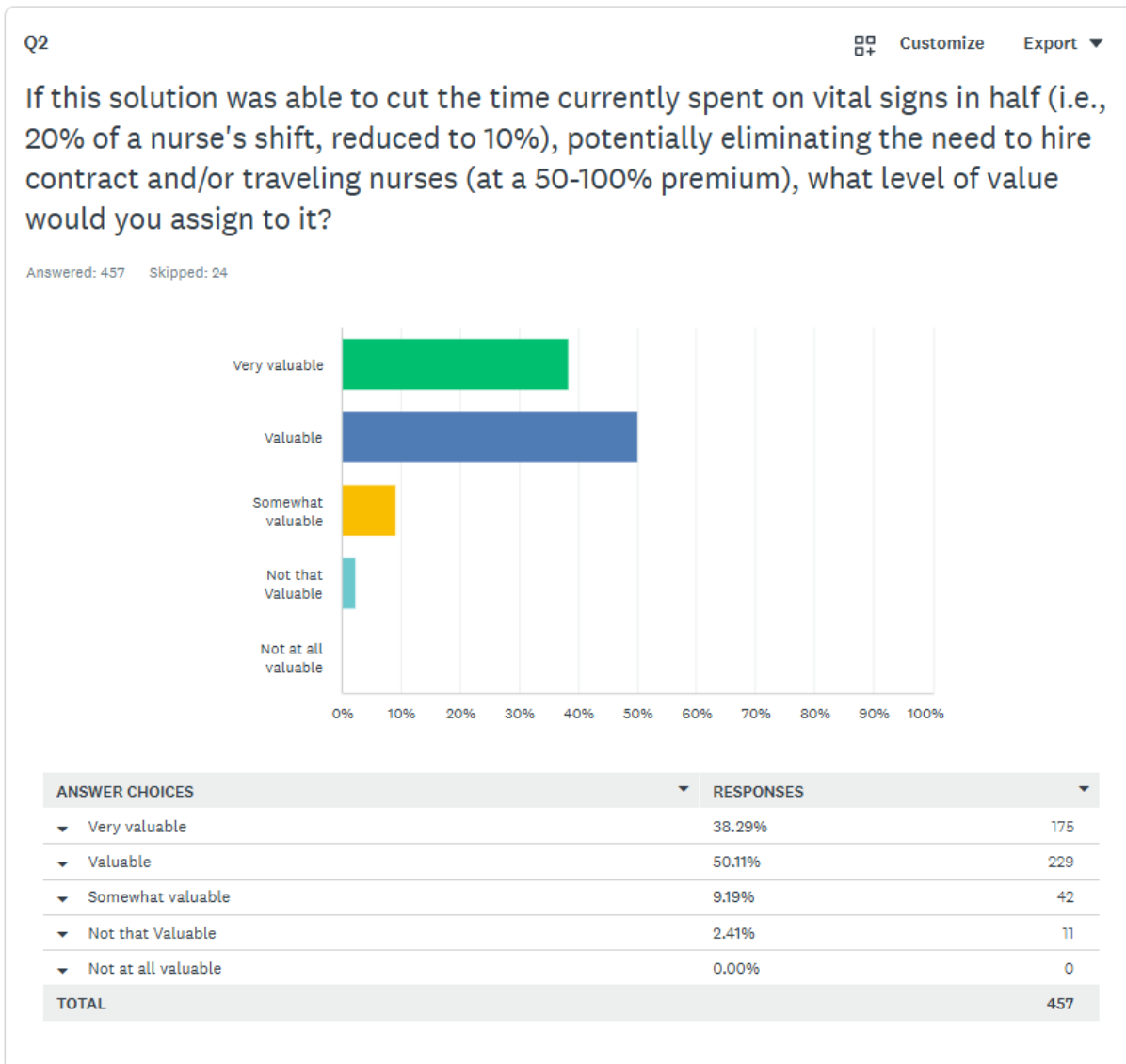


Figure 2 - Enabling Nursing Efficiencies.

Respondents also indicated support for subscription-based access to technology, as shown in Figure 3. Whereas capital purchases can create procurement friction or delay adoption cycles, the ability to pay per patient and treat SleeveSense as an operating expense was viewed as a positive attribute. Respondents suggested that subscription pricing supports flexible scaling, reduces financial exposure if outcomes do not meet expectations, and aligns expenditure with utilization. Many finance leaders emphasized that operating budgets offer more maneuverability than capital budgets, making this model increasingly attractive.

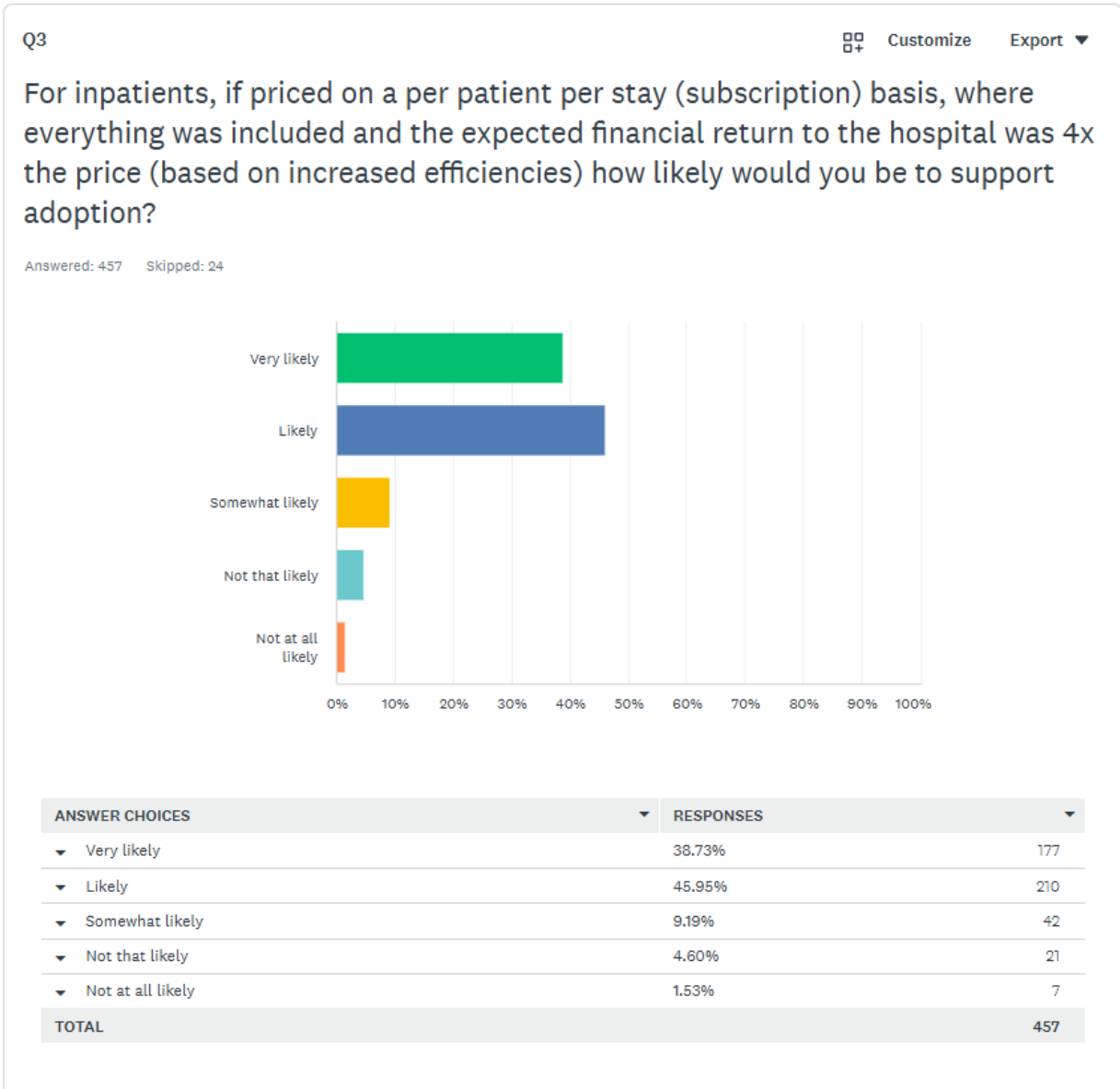


Figure 3 - Acceptance of Subscription Model and Financial Benefit.

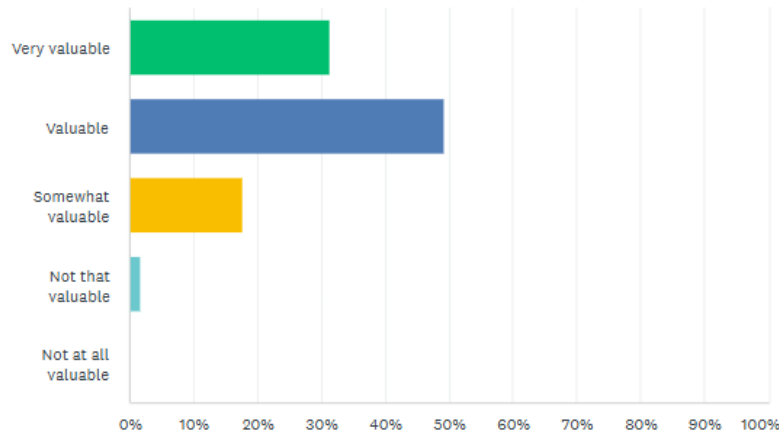
Figure 4 reflects attitudes toward readmission reduction. While the possibility of preventing a portion of avoidable readmissions resonated positively, finance leaders tended to view the benefit as meaningful but supplementary. Respondents recognized that readmissions arise from complex clinical and social drivers, many outside the hospital’s control, but still regarded post-discharge monitoring as an important lever, particularly when paired with early intervention capability. Comments suggest that this benefit strengthens the financial rationale rather than driving it alone.

Q4

Customize Export

If at discharge, high-risk patients were to continue to wear SleeveSense to help avoid hospital readmissions (e.g., a 20% reduction), how valuable would you consider that to be?

Answered: 457 Skipped: 24



ANSWER CHOICES	RESPONSES
Very valuable	31.29% 143
Valuable	49.23% 225
Somewhat valuable	17.72% 81
Not that valuable	1.75% 8
Not at all valuable	0.00% 0
<b>TOTAL</b>	<b>457</b>

Figure 4 - Reducing Hospital Readmissions.

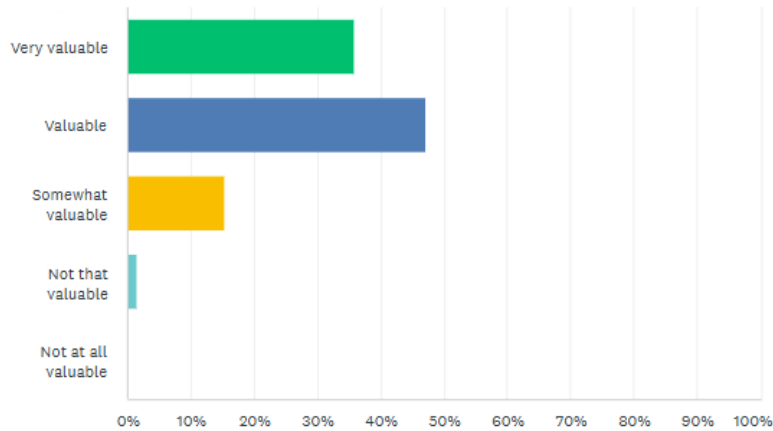
Figure 5 demonstrates that respondents perceive incremental revenue associated with remote patient monitoring as a compelling contributor to value. Those already billing RPM codes recognized immediate opportunity to expand capacity and scale reimbursement pathways. Respondents without existing RPM programs expressed openness to establishing new revenue streams, particularly if SleeveSense reduces the staffing and infrastructure burden associated with launching and maintaining monitoring programs.

Q5

Customize Export

If for those patients benefitting from continuous monitoring, either before or after a hospital stay, your organization could generate incremental revenue of \$1,500+ per patient per year from remote patient monitoring (with existing reimbursement codes), how valuable would you consider that to be?

Answered: 457 Skipped: 24



ANSWER CHOICES	RESPONSES
Very valuable	35.89% 164
Valuable	47.05% 215
Somewhat valuable	15.32% 70
Not that valuable	1.53% 7
Not at all valuable	0.22% 1
<b>TOTAL</b>	<b>457</b>

Figure 5 - Driving Incremental Revenue.

Taken together, these results reflect a market environment in which financial leaders are balancing resource scarcity against operational demand and are actively seeking solutions that enable them to serve more patients without proportionate increases in labor cost. Across every value dimension tested, positive sentiment exceeded neutral or negative response categories by wide margins. Negative sentiment was limited across all structured items, and the number of respondents who indicated that the concept was not financially valuable or who were unlikely to support adoption was negligible.

Equally notable, no respondent indicated through open-ended comments that continuous automated vital sign monitoring is already implemented in a comprehensive or routine manner today. A small number of respondents referenced pilots or partial use cases but confirmed that current workflows still rely primarily on manual vitals collection. This observation reinforces the idea that SleeveSense is not entering an oversaturated category but rather represents a novel offering in a space where demand is building faster than solutions are scaling.

The overall pattern of findings suggests that SleeveSense is positioned to meet latent need in an environment that is actively searching for clinically aligned cost management strategies. Financial leaders recognize labor relief, staffing flexibility, and new reimbursement pathways as high-priority levers, and they are signaling readiness to support investment once technology performance and operational feasibility are validated.

## **5. Analytic Approach**

The closed-ended items in the survey provide a quantitative view of how financial leaders perceive the economic potential of SleeveSense. While each question isolated a discrete source of value, the pattern that emerges is one of consistent reinforcement across all areas tested. The results also align closely with feedback from the 2025 nursing study, in which clinicians described manual vital sign collection as burdensome, inefficient, and ripe for automation. Together, the two datasets suggest that decision makers on both the clinical and financial sides of the organization recognize the problem and view automation as a necessary response.

### **5.1 Perceived Value of Reducing Manual Vital Signs Work**

One of the foundational items in the survey asked respondents to evaluate the financial significance of reducing nursing time spent manually collecting and documenting vital signs, decreasing the estimated labor allocation from approximately 20% of a shift to closer to 10% percent. Across the full sample, respondents overwhelmingly reported that such a reduction would deliver meaningful financial benefit. The majority selected the highest value rating available, and those who did not still characterized the benefit positively.

The absence of dissent is notable. Respondents did not question whether nurses are spending that amount of time on vitals; they accepted it as a known constraint that has persisted despite efforts to streamline or automate charting workflows. Many respondents described staff time as one of the few levers remaining under their direct control, given that supply costs and reimbursement rates are largely fixed. Reclaiming nursing capacity is therefore viewed as a cost reduction opportunity, a productivity boost, and a way to protect staffed bed throughput.

Even among respondents who expressed slight caution, the concern was not whether time would be saved but whether internal systems could fully convert saved time into measurable financial return. This suggests that the question for finance leaders is not whether automation matters, but how effectively it can be converted into operational and financial relief.

### **5.2 Likelihood of Supporting SleeveSense Under a Per Patient Subscription Model**

A second question asked respondents to rate their likelihood of supporting SleeveSense if the system delivered an estimated four-to-one return relative to monthly subscription cost. Again, the distribution of responses showed substantial support, with more than 80% reporting that they would be likely or very likely to adopt under such conditions. Only a small fraction selected unlikely or very unlikely.

However, this rating was not driven solely by projected return. Written comments reveal an underlying structural shift in how hospitals prefer to invest. Respondents repeatedly cited the advantages of adopting technology as an operating expense rather than a capital asset. Operating budgets were

described as more flexible, more easily aligned with utilization trends, and less constrained by multi-year planning cycles and competitive prioritization. Several respondents indicated that subscription models allow them to “test before scaling,” which reduces reputational and financial risk.

In effect, support for adoption reflected both belief in the economic payoff and confidence in the procurement path. Financial leaders are signaling that SleeveSense fits the purchasing structures that dominate today’s environment.

### **5.3 Perceived Value of Remote Patient Monitoring Revenue Potential**

Another structured question asked respondents to evaluate the financial value associated with generating new or expanded revenue through remote patient monitoring. The question presented a conservative estimate of fifteen hundred dollars of incremental annual revenue per eligible patient and asked respondents to judge the contribution to financial performance.

Responses were strongly positive. Those already engaged in RPM activity viewed SleeveSense as enabling greater scale without proportional staffing increases, particularly where care management roles are capacity constrained. Respondents not currently billing RPM codes expressed interest in the revenue potential but acknowledged organizational gaps that have prevented program development to date. For these leaders, SleeveSense represents not only a financial opportunity but a pathway into a reimbursement domain that has felt operationally out of reach.

This distribution provides important insight into perceived value drivers. To some respondents, RPM potential is immediate and concrete. To others, it is emerging but compelling. Either way, revenue is seen as part of the solution set rather than a bonus feature.

### **5.4 Perceived Value of Readmission Reduction**

The final benefits question asked respondents to assess the financial contribution of reducing preventable hospital readmissions. Results again skewed positive, although the distribution was flatter compared to the prior items. Respondents linked readmission reduction to both cost avoidance and risk mitigation under value-based and penalty-linked reimbursement models.

However, several respondents noted that readmissions reflect a mix of clinical, behavioral, and social factors that no single technology can fully control. This moderated enthusiasm does not diminish interest, but it calibrates expectations. Finance leaders appear to view readmission reduction as additive; it strengthens the case for adoption but is unlikely to serve as the sole justification. Comments suggest that the most compelling scenario combines workload relief, cost avoidance, and revenue opportunity into a single integrated argument.

### **5.5 Relationship Among Response Patterns**

Quantitative analysis demonstrated that responses across the closed-ended items were not independent. Respondents who believed time savings were highly valuable were substantially more likely to support adoption. Likewise, those who saw RPM reimbursement as a meaningful contributor to value tended to express confidence in other aspects of the concept.

Correlation strength across items reinforces the idea that decision makers are performing a composite

ROI calculation in their evaluation. Rather than discounting one source of benefit due to uncertainty in another, respondents aggregated the potential returns across domains. This pattern suggests that the CFO mindset is holistic: total value matters more than any single driver.

It also explains why positive sentiment showed such consistency across items despite differences in underlying benefit categories.

## **5.6 Significance of Positive Sentiment and Lack of Opposition**

Perhaps the most striking feature of the quantitative data is the scarcity of skepticism. In concept testing of emerging technologies, one typically expects a sizable minority of respondents to register doubt, raise feasibility concerns, or reject the premise outright. That pattern did not emerge in this study. Negative responses were limited across every structured question, and neutral selections tended to reflect uncertainty rather than opposition.

Written comments reflect a similar stance. Even where respondents expressed caution about integration feasibility, security risk, or operational lift, they acknowledged genuine value in the concept and refrained from dismissing the opportunity. This aligns with feedback from the nursing research, where respondents framed automation as necessary, not optional.

Taken together, the quantitative findings suggest a market environment where the question is not whether automation is needed, but how quickly organizations can adopt and operationalize it at scale.

## **6. Interpreting the Relationship Among Variables**

The quantitative findings not only show strong support for the underlying concept, but they also reveal that respondents are processing multiple elements of value as part of a unified financial calculation. Statistical analysis demonstrates that those who perceived high value in labor savings were also significantly more likely to express strong support for adoption overall. In other words, the belief that SleeveSense can relieve nursing burden appears to be the primary driver of willingness to invest.

A similar pattern emerged with perceived remote patient monitoring value. Respondents who believed that RPM can generate meaningful reimbursement expressed higher readiness to support adoption. Although labor savings produced the strongest relationship, RPM represented a close secondary driver. This suggests that respondents who see multiple pathways for economic return are most likely to advocate for implementation.

Readmission reduction showed a positive but more moderate relationship with adoption likelihood. This is consistent with the idea that financial leaders see readmissions as influenced by factors beyond direct monitoring control, such as patient adherence, comorbidities, access to follow up care, and social determinants of health. These leaders understand that monitoring can reduce risk, but they also recognize that monitoring alone cannot eliminate it. As a result, they treat readmission reduction as a reinforcing benefit rather than a central assumption.

Together, these relationships indicate that hospital finance leaders evaluate technologies like SleeveSense across multiple financial dimensions at once. They do not require each benefit to stand independently. Instead, they consider whether the combination of benefits produces sufficient

justification to warrant investment. a solution that delivers staffing relief, risk reduction, and incremental reimbursement has a stronger overall case than one that relies on a single financial promise.

The absence of correlation between demographic factors and sentiment is telling as well. Response patterns did not differ meaningfully across regions or health system types. Leaders who work in large metropolitan hospitals answer much the same way as those working in regional systems or multi-site networks. This suggests that workforce strain and financial pressure are broadly distributed across the country rather than confined to specific markets.

## **7. CFO Logic and Decision Framing**

One of the most important patterns in this research lies beneath the numerical distributions. Hospital finance leaders are not passively reacting to the idea of monitoring. They are actively situating the concept within a shifting economic landscape in which margins are thin, labor is scarce, and risk to patients is rising.

Their written comments reveal a shared understanding that the fundamental challenge facing hospitals is not how to do more with the same number of staff, but how to maintain quality and throughput with fewer available labor hours. Many respondents have already exhausted the traditional levers of cost control. They cannot reduce staffing below safe ratios. They cannot eliminate services that patients depend upon. Instead, they must pursue tools that reduce the time required to accomplish essential work. When they refer to eliminating manual vitals documentation, they are implicitly addressing a reality in which there is not enough nursing labor in the system to meet patient demand.

These leaders also view monitoring as part of a strategic repositioning in which care does not end when a patient leaves the building. Several respondents referenced frustration at losing clinical visibility once a patient has been discharged. They perceive early post discharge deterioration as avoidable loss that creates both financial and human cost. In their view, a technology that allows clinicians to detect warning signs earlier creates multiple forms of value. It preserves capacity, protects reimbursement, and can reduce the need for reactive care.

Their reasoning also reflects an evolved understanding of cost avoidance. Reducing the need to hire an additional full-time nurse or avoiding reliance on contract labor is not framed as soft savings. It is framed as a primary method of balancing staffing ratios and preserving sustainability. When respondents describe labor savings as meaningful, they are referring not only to money, but to organizational survival.

Lastly, the cumulative logic in the response set indicates that financial leaders no longer separate clinical outcomes, operational efficiency, and cost control. They understand that poor staffing conditions can lead to burnout, which in turn increases turnover, forces increased contract staffing and pushes margins further into the red. Automation is viewed not simply as a tool to reduce effort, but as a mechanism to break that cycle.

## **8. Integrated Quantitative and Qualitative Findings**

### **8.1 Overview of Combined Insights**

The findings from this research demonstrate notable alignment between the quantitative evaluations of SleeveSense and the qualitative explanations respondents provided in their written comments. Together, these data streams confirm both the urgency of the problem SleeveSense is designed to address and the complexity involved in turning that promise into durable value within a hospital setting.

The structured survey results reveal near universal agreement that reclaiming nursing time dedicated to manual vital sign collection represents a meaningful financial opportunity. Respondents did not treat this value stream as hypothetical or marginal. Rather, they consistently described labor burden as a structural constraint that touches every aspect of hospital operations, including staffing costs, patient throughput, care quality, and financial sustainability. This recognition is not confined to large systems or specific regions. It appears consistently across organizations with different cost structures, patient populations, and operating environments.

Respondents also demonstrated strong understanding of how SleeveSense could deliver economic returns beyond raw labor savings. The highest ratings clustered around questions concerning traveler avoidance, reduced overtime, readmission mitigation, and remote patient monitoring reimbursement. These value pathways are familiar to financial leaders. They form part of the operating vocabulary of capital planning, budgeting, and revenue cycle strategy. As a result, respondents did not need to learn new concepts to evaluate SleeveSense. They only needed to determine whether the system could reliably activate the value they already recognized.

Despite this broad consensus on value, quantitative correlations among individual questions were more moderate, and adoption likelihood did not move in perfect lockstep with value ratings. This nuance is meaningful. It reflects an environment in which respondents see promise across multiple dimensions but are disciplined in distinguishing belief in a concept from willingness to authorize a purchase. Financial leaders treat SleeveSense as a potentially transformative tool, but one whose performance must be validated in real world care settings before full adoption is justified.

This gap between conceptual enthusiasm and adoption commitment becomes fully visible in the qualitative responses. Respondents consistently described the operational, financial, and organizational conditions that determine whether an innovation like SleeveSense can succeed at scale. These responses deepen the quantitative signals by revealing the constraints that must be satisfied before value can be realized, and the expectations hospitals now apply to vendors entering the clinical automation space.

## **8.2 Financial Value and the Business Case Context**

Respondents repeatedly framed SleeveSense within the financial logic that governs hospital operations today. They did so not by questioning the premise of automated vital sign monitoring, but by mapping the technology to cost drivers and revenue mechanisms they already use and understand.

The first business case domain relates to direct labor relief. Respondents consistently described nursing labor not simply as a cost center, but as the limiting reagent in care delivery. Several referenced scenarios in which bed capacity could not be fully used due to staffing gaps rather than physical or clinical constraints. In this context, freeing nurses from manual data collection is not merely a time saver; it's a capacity multiplier. Respondents viewed the possibility of reclaiming ten percent or more of

nursing time each shift as a deeply relevant operational benefit. Quantitatively, this perspective manifests in overwhelmingly positive value ratings, which often defaulted to the highest scoring option.

The second domain centers on expensive labor substitution. Many financial leaders noted that clinical capacity loss due to administrative burden creates downstream demand for premium labor. Contract and traveling nurses represent direct financial exposure, often at rates 1.5-2x that of full-time baselines. Respondents viewed SleeveSense as a potential tool for reducing dependence on these staffing alternatives. This shift was interpreted not only as cost avoidance, but as a means of stabilizing service levels and protecting margin predictability.

A third domain involves economic value created after an inpatient stay. Respondents linked continuous monitoring to reductions in unplanned readmissions, which can trigger penalties, erode reimbursement, and divert staff from scheduled care. Though they acknowledged that readmission outcomes depend on factors beyond monitoring alone, they understood SleeveSense as an accelerant to earlier intervention. Respondents also recognized the opportunity to generate remote patient monitoring revenue through established CPT billing pathways. For hospitals operating with narrow margins, the possibility of recovering \$1,500 per eligible patient per year is meaningful, especially when multiplied across cohorts.

Collectively, these business case dimensions demonstrate that finance leaders are not waiting for new reimbursement models or internal accounting frameworks to justify SleeveSense. They already have the categories needed to frame and measure return. What remains is long term assurance of the system's ability to operationalize these returns in real settings without creating offsetting costs elsewhere.

### **8.3 Conditions of Adoption Revealed in the Qualitative Data**

The qualitative findings illuminate why respondents did not uniformly elevate adoption likelihood to match the optimism reflected in the value assessments. It is not the concept they question. It is the delivery, execution, and sustainability of implementation.

Respondents consistently described a multi-factor decision environment in which new technology is judged not only by its intended benefit, but by the organizational burden it imposes and the risks it introduces. These leaders view technology adoption as a resource allocation choice that touches multiple domains within the hospital, including nursing, information technology, compliance, legal, and executive management. In such an environment, purchase decisions require convergence across stakeholders with different priorities and thresholds for approval.

Respondents repeatedly emphasized that automation is no longer optional in healthcare. However, automation that is poorly executed, insufficiently supported, or inadequately integrated can reduce efficiency rather than enhance it. As a result, enthusiasm for SleeveSense is consistently conditional. Leaders are prepared to support adoption, but only if several operational criteria are satisfied.

Their written comments reflect two overarching forces shaping this posture. First, hospitals are operating at or near resource limits. Any new initiative that requires additional effort, workarounds, or sustained support risks immediate resistance, regardless of its conceptual value. Second, risk tolerance within healthcare systems has tightened over the past decade. Cybersecurity threats, clinical liability, regulatory enforcement, and vendor instability have collectively created an environment where leaders must plan not only for success but for failure modes.

These realities explain why respondents reserve final commitment until operational evidence accumulates. Rather than being signs of skepticism, their reservations reveal maturity and a disciplined approach to adoption. They understand that value is fully realized only when technologies are both used and trusted by those responsible for delivering care.

## **8.4 Operational Constraints and Decision Barriers**

### **8.4.1 Data Privacy, Cybersecurity, and Trust**

The most frequently cited factor determining adoption readiness was data security. Respondents expressed unambiguous expectation that patient information must be protected against unauthorized access, improper transmission, or unintended exposure. Many referenced lived experiences with cybersecurity incidents or cited the financial consequences of breaches observed at peer institutions. For these respondents, cybersecurity represents a value-destroying risk category powerful enough to outweigh all potential financial benefits.

Respondents sought transparency about encryption methods, storage environments, access controls, and monitoring. They also asked how security would be verified, how vulnerabilities would be identified, and what responsibilities would fall on the vendor versus the hospital. Trust was not assumed simply because the concept was clinically compelling. It must be earned through evidence, certification, and clear communication. Several respondents stated directly that no level of modeled return would justify adoption if the system introduces material security exposure.

### **8.4.2 Pricing Clarity and Cost Predictability**

Respondents widely supported a subscription-based pricing framework. However, they paired that support with a firm expectation that the subscription price functions as an all-inclusive financial commitment, not an entry point for unplanned costs. Their caution stems from prior experiences in which initial projections failed to capture the full cost of technology deployment, including training, configuration, device replacement, or software licensing.

Financial leaders want assurance that the operating expense can be forecast accurately over multiple years and across fluctuating patient census. Under this model, price stability and cost transparency become enablers of adoption. When pricing is complete and predictable, organizations can confidently evaluate and approve investment. When pricing appears fragmented or uncertain, adoption slows or stops.

### **8.4.3 Implementation Workload and EHR Integration**

Multiple respondents addressed the operational burden associated with implementation. Many noted that technologies advertised as quick to deploy often require ongoing IT attention, changes to clinical workflows, or custom integration. Respondents articulated a consistent preference for solutions that integrate into existing systems with minimal internal involvement. They expressed concern that internal IT teams lack spare capacity, and that competing priorities could create implementation delays or post-launch support bottlenecks.

Respondents want clarity about data flow into the electronic health record, the need for custom mapping, the existence of application programming interfaces, and the vendor's capacity to handle

integration and support activities. This concern extends beyond technology to include change management and real-world usability. Respondents are prepared to support SleeveSense only when they believe the system will decrease internal burden rather than increase it.

#### 8.4.4 Reliability and Clinician Trust in Data

Respondents repeatedly stated that SleeveSense will only deliver financial benefit if clinicians trust the data it produces. They noted that inaccurate readings or unreliable alerts would force nurses to revert to manual methods, eliminating any potential for reclaimed time. Reliability was also linked to clinical safety, legal risk, and staff morale. Several respondents described alarm fatigue and false positives as threats to adoption, emphasizing that even rare system failures could undermine trust across clinical teams.

These findings suggest that validation in real clinical environments is a prerequisite for confidence. Respondents do not question whether reliable automated monitoring is possible. They question whether it will persist under the daily operational realities encountered by frontline providers.

#### 8.4.5 Staff Adoption and Organizational Behavior

A defining theme of the qualitative data is that nurses control whether SleeveSense delivers value. Respondents exhibited clear awareness that clinical teams determine whether technology is accepted, used, and sustained. Solutions that add effort or workflow complexity will be resisted regardless of benefits perceived by leadership. In contrast, solutions that simplify tasks and alleviate pressure are likely to become embedded quickly.

Respondents further indicated that adoption requires intentional change management. Training, communication, and user support must be thoughtfully designed and executed. Leaders implicitly recognize that technology does not drive efficiency. People do. When SleeveSense aligns with clinical priorities and respects time pressure at the bedside, adoption becomes natural and voluntary.

#### 8.4.6 Vendor Stability and Service Continuity

The final barrier expressed by respondents concerned vendor maturity and long-term viability. Several referenced prior experiences in which emerging technology firms were acquired or ceased operation, leaving hospitals unsupported. These disruptions impose operational hardship, generate risk, and require costly transition planning.

Respondents want assurance that Senphonix will remain a reliable partner over the lifecycle of the product. This expectation extends beyond technical skill to include customer support, financial backing, governance, and commitment to continuous improvement. Organizations are prepared to integrate SleeveSense into mission critical workflows only when they believe the vendor will stand behind the solution over time.

### 8.5 Implications for Adoption and Timing

The constellation of themes emerging from this research points to a market that is both receptive and rigorous. Finance leaders recognize the need for automation and believe SleeveSense addresses a critical constraint in care delivery. They also understand the multiple financial pathways through which

the solution can generate return. However, they will not advance from conceptual interest to operational adoption until they see aligned conditions, credible evidence, and concrete support structures.

This suggests that the early commercialization strategy for SleeveSense should emphasize demonstration rather than persuasion. Pilot deployments, transparent reporting, credible validation, and clear articulation of cost and support models are likely to be more meaningful than abstract value claims. Respondents are not uncertain about whether SleeveSense could create value. Their uncertainty lies in whether their organizations will be positioned to realize that value without unintended consequences.

Timing therefore becomes a function of trust building and capability proof rather than sales cycle aggressiveness. As SleeveSense demonstrates reliability, data accuracy, and workflow fit in live environments, adoption will accelerate. Conversely, gaps in communication, unclear pricing, or insufficient integration guidance will slow or jeopardize progress.

## **8.6 Synthesis and Forward Implications**

The data from this study indicates that hospitals are prepared for SleeveSense in principle but require validation in practice. The survey responses reflect confidence that SleeveSense can contribute to relieving nursing burden, reducing reliance on contract labor, improving patient outcomes, and supporting new reimbursement pathways. They also describe an environment shaped by constraint, risk sensitivity, and competing operational demands.

SleeveSense is therefore entering a market that is primed for solutions that enhance clinical capacity, streamline workflow, and support new modes of care continuity. However, the market will reward execution far more than concept. Success depends on demonstrating trustworthiness, reliability, and scalability in ways that translate into immediate, observable benefit inside clinical environments.

If Senphonix can meet these conditions, the structural forces driving demand suggest that adoption will not only be possible, but likely to expand rapidly across inpatient and outpatient settings. The alignment between finance leader priorities and SleeveSense capabilities provides a strong foundation. The next phase is to convert perceived value into realized performance.

## **9. Financial Decision Maker Profiles**

While respondents carried varied titles and responsibilities, their written comments and structured selections reveal a set of distinct decision orientations. These orientations are better understood as modes of reasoning than as discrete personas. They reflect the mental frameworks through which financial leaders evaluate risk, prioritize benefit, and determine whether a tool like SleeveSense is worthy of investment. These patterns surfaced repeatedly across narrative responses, regardless of organization size, geography, or reporting structure. Understanding these orientations is essential, because successful adoption requires addressing each thinking style simultaneously within a single organization.

### **9.1 The Operational Realist**

The largest share of respondents can be characterized as operational realists. These leaders evaluate SleeveSense primarily through the lens of workforce strain and clinical throughput. Their reasoning begins with an accepted premise: nursing labor is scarce, overstretched, and expensive to replace. They see manual vital sign collection not as a standard routine, but as a misallocation of expert staff time. Their open text responses frequently expressed exhaustion with stopgap solutions such as overtime and traveler augmentation. For this group, the case for adoption is straightforward. If SleeveSense can demonstrate verified reduction in manual vitals tasking, then investment becomes not a question of interest but of necessity. Their threshold requirement is proof in practice. Once demonstrated, they become powerful internal advocates because SleeveSense gives relief precisely where pressure is greatest.

## **9.2 The Capacity Maximizer**

A second group sees SleeveSense as a tool to expand system capacity rather than simply reducing workload. These finance leaders tend to think across care transitions, including post discharge periods, and often reference length of stay, avoidable delay, and movement bottlenecks. They perceive automation not only as time saved, but as bed hours recovered and risk reduced during vulnerable recovery windows. This mindset is often present in organizations operating under value-based arrangements or at capacity constraints due to shortages in staffed beds. For these respondents, SleeveSense is attractive because it helps maintain flow when staff cannot physically be everywhere at once. The economic logic is grounded in avoided opportunity loss: every deterioration caught early, every avoidable readmission prevented, preserves clinical and financial bandwidth downstream.

## **9.3 The Revenue Strategist**

A third group concentrates primarily on incremental reimbursement opportunities. These respondents view technology investment through the lens of margin expansion, not just cost control. They are well versed in evolving reimbursement structures and often note that cost reduction alone cannot stabilize hospital margins. For these leaders, remote patient monitoring is strategically appealing because it converts monitoring from a cost center into a recurring revenue channel. Several explicitly referenced the need to develop new revenue streams as traditional inpatient reimbursement growth slows. SleeveSense's appeal for this segment lies in its ability to enable RPM billing without proportional staffing increases or large capital outlays. Adoption is most compelling when the business case ties monitoring activity directly to revenue recognition.

## **9.4 The Risk Controller**

A smaller but highly influential group of respondents can best be described as risk controllers. These individuals evaluate innovation primarily through the lens of threat exposure. They raise questions about cybersecurity, system reliability, regulatory posture, and the consequences of vendor instability. They are not inherently skeptical of new technology; in fact, many expressed optimism. However, their support is conditional. Risk controllers require documented assurances, third party validation, clear boundaries of responsibility, and visibility into how data flows, is secured, and is governed. This group often sits on executive steering committees where a single unresolved concern can delay or derail purchase decisions. SleeveSense must meet their criteria not with broad reassurances, but with specific operational and compliance detail.

## **9.5 The Budget Steward**

Finally, a subset of respondents evaluates SleeveSense through the lens of budgeting discipline more than business model transformation. Budget stewards operate within environments where every dollar must be weighed against competing priorities. They are not opposed to innovation, but they are focused on durability, completeness, and predictability of cost. Their questions tend to focus on what is included, what might not be included, and what downstream expense could emerge. For them, adoption is possible only when pricing clarity, lifecycle cost, replacement assumptions, and scalability are fully understood. They will support adoption once they are convinced SleeveSense will not produce hidden cost absorption over time.

These five orientations coexist within nearly every hospital. A chief financial officer may think like a revenue strategist while a vice president of finance approaches the opportunity as a budget steward. An administrator may embody operational realism while a compliance officer channels a risk controller mindset. SleeveSense succeeds not by satisfying one perspective, but by addressing all of them in parallel and giving each group a compelling reason to say yes.

## **10. The Hospital Buying Pathway**

Adoption of healthcare technology rarely follows a linear decision process. Rather than a single gatekeeper, the organizational pathway for SleeveSense must travel across multiple functional and cultural checkpoints. The survey responses illustrate that adoption will require coalition building rather than isolated approval.

Respondents consistently identified nursing leadership as central to the decision process. Many described the chief nursing officer not only as a key approver but as the individual most likely to champion adoption if nurses experience meaningful relief. They emphasized that frontline acceptance determines whether SleeveSense transitions from concept to everyday tool. This insight reinforces findings from the 2025 nursing research: bedside users determine whether value is realized.

Information technology representatives emerged as equally essential partners. Respondents made clear that integration feasibility, support burden, and EHR connectivity are gating criteria. IT departments must ensure that the system can be deployed and maintained without jeopardizing ongoing strategic projects. Finance leaders themselves acknowledged that their willingness to support funding depends in part on whether IT has the bandwidth and confidence to integrate the system cleanly.

Finance plays the role of evaluator, steward, and aggregator of business case logic. Respondents described their work not as unilateral approval but as a synthesis of feedback from clinical, quality, and technology functions. Several noted that finance endorsement is necessary but insufficient. Approval proceeds only when finance can demonstrate alignment with operational and clinical realities.

Quality and patient safety leaders emerged as a notable decision influence. In open text responses, respondents referenced sepsis detection, fall prevention, and rapid response activation, all domains where continuous monitoring offers tangible benefit. While these leaders may not own budget decisions, they often drive strategic priority setting and elevate innovations that reduce adverse events.

This buying dynamic explains why even very strong positive sentiment does not result in automatic adoption. Respondents view approval as a cross disciplinary act requiring consensus that the technology

mitigates workload, supports throughput, preserves safety, and creates value. Failure of any one stakeholder group to engage can slow or stall adoption.

SleeveSense therefore enters organizations not through a corridor but through a network. Success requires meeting each group with tailored value, evidence, and support. See Figure 6.

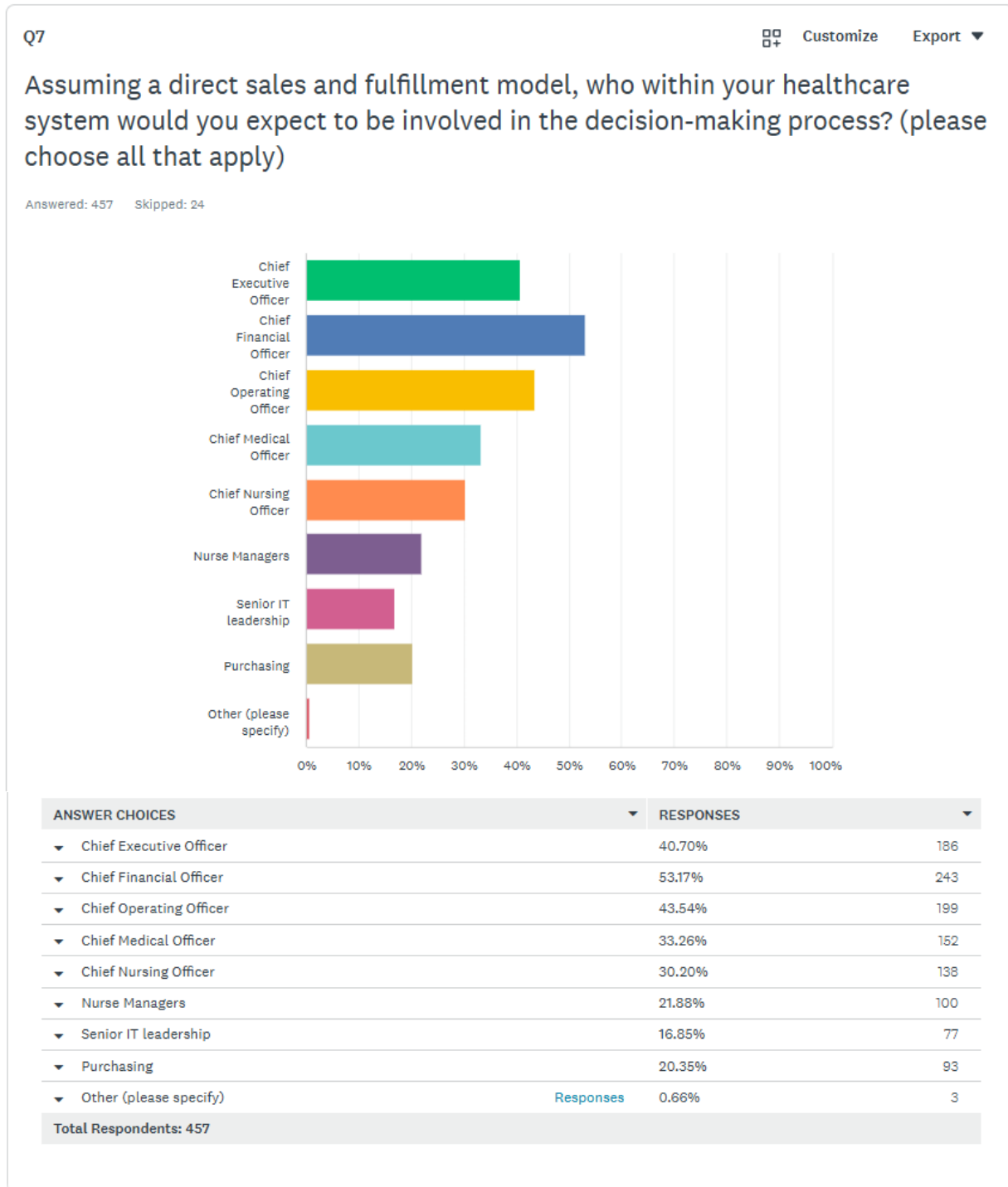


Figure 6 - Involved Executives in Decision-Making.

## **11. Implications for Market Entry and Commercial Messaging**

The combined insights from the survey suggest a highly favorable environment for SleeveSense, provided that Senphonix approaches entry with intentional sequencing and disciplined execution. Market readiness is high, belief in concept validity is strong, and perceived value spans multiple financial dimensions. However, enthusiasm is contingent on performance proof, implementation support, and risk mitigation.

This market is not one in which novelty alone is rewarded. Respondents explicitly rejected speculative value propositions in favor of demonstrated outcomes. Commercial messaging should therefore emphasize validation, transparency, and operational partnership rather than theoretical possibility. Performance claims that can be documented, and ideally quantified, will resonate deeply with CFOs who have heard broad promises and seen narrow delivery from other vendors.

Pricing and cost communication will require clarity and completeness. Respondents indicated that ambiguity, exclusions, or variable cost elements create resistance. Messaging that positions SleeveSense as financially predictable, packaged, and structured to avoid hidden costs will align closely with purchaser priorities.

Integration support will serve as another differentiator. Hospitals want solutions that reduce internal burden. Senphonix has the opportunity to position SleeveSense not only as a monitoring device, but as a supported workflow transition, minimizing lift on IT, facilitating training, and giving clinical users confidence from day one.

Finally, commercial engagement must expand beyond finance. Nursing, IT, population health, care management, and quality teams all have reasons to see SleeveSense as valuable. Senphonix should craft messaging and materials that meet each audience where its concerns lie: workload relief for nurses, interoperability for IT, quality improvement and safety risk reduction for clinical leadership, and ROI validation for finance.

## **12. Recommendations**

The findings of this study point toward several priority actions that will improve adoption likelihood and increase the speed at which SleeveSense can move from concept to implementation. These recommendations focus on demonstrating value, enabling cross functional alignment, and reducing organizational friction.

1. Conduct targeted pilot deployments designed to capture measurable results. Pilots should quantify reclaimed time, contract labor avoided, and system utilization across day and night shifts. They should also collect early indicators of post discharge monitoring benefit and care escalation patterns. Where possible, pilots should include both inpatient and transitional care environments.
2. Establish transparent, stable pricing that eliminates uncertainty and includes all expected cost elements. Clear communication about what the subscription covers, including devices,

replacements, data access, maintenance, and implementation support, removes one of the primary sources of hesitation among budget stewards.

3. Invest in credible integration and onboarding support. This includes technical planning, EHR workflow mapping, staff training, and post implementation troubleshooting. Senphonix should be prepared to meet IT partners with realistic schedules, resource expectations, and documented interoperability pathways.
4. Proactively address risk concerns. Communicating a well-defined security architecture, including encryption, device authentication, access control, data transmission, and audit logs, is essential. Hospitals must understand how data flows and how risk is mitigated. Senphonix should also articulate organizational commitments that reassure customers of long-term stability and support continuity.
5. Engage internal champions across clinical and operational roles. Nurses need to see that SleeveSense removes steps rather than adding them. Clinical leadership needs to understand how monitoring aligns with quality initiatives. IT teams need confidence that integration is feasible. Senphonix should architect early deployments around building and empowering these champions.

Finally, document outcomes and share them broadly. A single successful pilot has limited value unless its findings are translated into case studies, ROI models, workflow maps, and reference feedback that can be used across the organization and across the market.

Taken together, these recommendations focus on meeting customers where they are: capacity constrained, risk aware, and eager for solutions that lift burden without introducing disruption.

## **13. Conclusion**

The results of this research demonstrate that hospital finance leaders are receptive to automated vital sign monitoring and view SleeveSense as a credible response to the pressures facing their organizations. Their responses reflect a sober and pragmatic evaluation of current operating conditions: nurse capacity is constrained, contract labor is costly, and traditional mechanisms of cost control are insufficient to restore margin stability.

Respondents consistently identified recovered nursing time as the most compelling financial driver, but they also expressed confidence in incremental revenue opportunities and risk reduction benefits. The willingness to support adoption under a subscription model further reinforces the alignment between SleeveSense's pricing structure and evolving procurement preferences.

Importantly, enthusiasm is not naïve. Financial leaders articulated clear expectations around clinical adoption, cyber and data security, interoperability, affordability, and vendor stability. They are prepared to support solutions that deliver real world performance and relieve burden, but they will not shoulder the risk of implementation alone.

In a market defined by workforce scarcity and rising operational complexity, technologies that convert manual tasks into automated processes are no longer viewed as optional enhancements. They are

increasingly understood as structural necessities. Hospitals are looking for partners that provide reliability, clarity, and measurable return.

SleeveSense appears well positioned to address these needs. The challenge ahead is execution: proving that the device not only works, but works at scale, with minimal disruption, and with meaningful benefit across clinical, financial, and operational domains. If Senphonix can meet those expectations, the sentiments expressed in this survey strongly suggest that financial leaders will support adoption and that SleeveSense can play a significant role in strengthening the resilience and sustainability of healthcare delivery in the United States.

## Appendix A - Associations and Correlations Between Items

Structured survey responses were analyzed to examine directional relationships between perceived financial value drivers and respondents' stated likelihood of supporting adoption of SleeveSense. Correlation analysis was used to assess whether respondents who attributed higher value to specific benefit categories were also more inclined to support implementation.

Pearson product-moment correlation coefficients were calculated across the primary survey variables using the common five-point response scale applied to each item. Although Pearson correlation is most often associated with continuous variables, it is widely used as an exploratory measure for Likert-type data when responses span the available range. To account for the ordinal nature of the scale and the possibility of non-linear ranking effects, supplementary Spearman rank-order correlations were also calculated. Both methods produced consistent directional patterns, supporting the robustness of the findings. Given the strong clustering of responses at the upper end of the scale, correlation magnitudes should be interpreted as conservative indicators of alignment rather than measures of weak association. As with all correlation-based analyses, these findings indicate association rather than causation.

	Q1: Labor Time Value	Q2: Adoption Likelihood	Q3: Readmission Value	Q4: RPM Revenue Value
Q1: Labor Time Value	1.00	0.15	0.35	0.31
Q2: Adoption Likelihood	0.15	1.00	0.15	0.24
Q3: Readmission Value	0.35	0.15	1.00	0.10
Q4: RPM Revenue Value	0.31	0.24	0.10	1.00

Table A-1. Pearson Correlation Matrix (Five-Point Scale Responses).

Across all value constructs examined, higher perceived value was positively associated with greater likelihood of supporting adoption. Respondents who rated labor savings, remote patient monitoring reimbursement, or readmission reduction more highly were consistently more likely to indicate readiness to support SleeveSense. No inverse or counterintuitive relationships were observed among the core items.

Perceived value associated with reducing manual vital signs workload showed a positive relationship with adoption likelihood. While the magnitude of this association was moderate rather than extreme, the directionality was clear and consistent. Respondents who viewed reclaimed nursing time as financially meaningful were more inclined to support adoption, reinforcing the central role of labor efficiency in financial decision making.

Remote patient monitoring reimbursement value also demonstrated a positive association with likelihood of adoption. Respondents who recognized RPM as a meaningful source of incremental revenue or cost offset were more likely to support implementation. This finding reflects the tendency of financial leaders to favor benefit categories that can be directly modeled against reimbursement structures, even when operational complexity remains.

Perceived value related to readmission reduction exhibited a weaker but still positive relationship with adoption support. Narrative responses help contextualize this pattern. While respondents acknowledged that continuous monitoring may enable earlier intervention and reduce some avoidable readmissions, they also emphasized that readmission outcomes are influenced by multiple clinical, social, and behavioral factors outside the healthcare system’s full control. As a result, readmission reduction appears to function as a reinforcing benefit rather than a primary determinant of adoption.

To further validate these relationships given the ordinal nature of the data, Spearman rank-order correlations were also calculated.

	Q1: Labor Time Value	Q2: Adoption Likelihood	Q3: Readmission Value	Q4: RPM Revenue Value
Q1: Labor Time Value	1.00	0.06	0.33	0.25
Q2: Adoption Likelihood	0.06	1.00	0.08	0.22
Q3: Readmission Value	0.33	0.08	1.00	0.04
Q4: RPM Revenue Value	0.25	0.22	0.04	1.00

Table A-2. Spearman Rank-Order Correlation Matrix.

The Spearman results mirror the Pearson findings in direction and relative magnitude, reinforcing the conclusion that the observed relationships are not artifacts of scale assumptions.

An important interpretive nuance is that the absolute magnitude of correlations is constrained by the distribution of responses rather than a lack of alignment. A large majority of respondents selected values at the upper end of the scale across multiple questions, resulting in limited variance. This ceiling effect naturally attenuates correlation coefficients even when underlying agreement is strong. In practical terms, respondents who rated benefits as “very valuable” versus “valuable” expressed similar levels of adoption support, compressing statistical spread while preserving directional consistency.

Taken together, the correlation analysis suggests that respondents are implicitly conducting a multidimensional business case assessment rather than evaluating each benefit in isolation. Support for adoption increases as multiple forms of value resonate simultaneously. Labor efficiency, revenue opportunity, and quality-linked risk mitigation appear to function as complementary drivers within a cumulative decision framework.

Finally, while respondents frequently use the language of return on investment when discussing financial justification, a more precise framing given SleeveSense’s pricing model is net present value. Because SleeveSense is offered as a subscription service rather than a capital purchase, financial leaders assess recurring operating expense against avoided labor cost, incremental reimbursement, and risk reduction over time. Both quantitative patterns and open-ended commentary indicate that respondents are already applying this logic implicitly when evaluating the overall financial relevance of SleeveSense.

## Appendix B - Thematic Coding Structure

Open text responses were analyzed using an inductive thematic coding process designed to identify recurring patterns in how financial leaders described SleeveSense, articulated conditions for adoption, and surfaced risk considerations. Because individual responses often addressed multiple areas of concern or opportunity, coding was non-exclusive and allowed one response to be categorized under several themes.

### **B.1 Coding Framework and Decision Rules**

Two overarching analytic questions guided the coding structure:

1. What financial opportunities or benefits did respondents associate with SleeveSense?
2. What barriers, requirements, or conditions must be satisfied before a purchase decision could be supported?

Analysts applied codes when a respondent either directly stated a concern or implied a requirement through descriptive language. Statements were assigned to themes regardless of sentiment (for example, a respondent expressing confidence that integration would be simple was coded the same as a respondent expressing concern that integration would be burdensome).

Each code was classified into one of three interpretive categories:

- Value signal, indicating a perceived financial or operational benefit.
- Conditional enabler, indicating that adoption depends on the presence of a specific capability or assurance.
- Barrier or risk, indicating a factor that may obstruct implementation or require additional mitigation.

### **B.2 Primary Themes and Definitions**

Six primary themes emerged through coding. Each theme encompasses common sub-concepts described by respondents.

1. **Data privacy and security:** Comments referencing encryption, HIPAA protection, breach exposure, regulatory scrutiny, or the need for third-party certification. Respondents frequently invoked recent industry breaches and noted that the financial harm of a cybersecurity incident could erase projected savings.
2. **Pricing clarity and cost predictability:** Statements addressing transparency of subscription rates, total cost of ownership, avoidance of hidden fees, or budgetary planning horizons. Respondents expressed comfort with operational expense models but insisted that all elements of deployment be reflected in the subscription price.
3. **Implementation workload and resource requirements:** Comments referencing IT capacity, EHR integration complexity, onboarding, change management, testing, or the need for internal staff to maintain new systems. Respondents associated unexpected effort with erosion of financial benefit.

4. Reliability and clinical data trustworthiness: Statements addressing data quality, false alarms, missed alerts, fallback to manual workflows, liability exposure, and nurse confidence. This theme reflects the belief that financial value disappears when clinical trust collapses.
5. Staff adoption and usability: Comments describing nursing burden, user experience, training, workflow disruption, or cultural readiness. Respondents consistently tied financial return to clinical acceptance, arguing that adoption at the bedside determines whether value is realized.
6. Vendor stability and continuity: Statements referencing corporate viability, product roadmap, acquisition risk, or past negative experiences with early-stage vendors. Respondents implied that long-term support is a prerequisite for adopting systems that could become operationally embedded.

### **B.3 Prevalence and Patterning**

Thematic frequency was distributed across responses as follows (approximate share of comments containing each theme):

- Data privacy and security appeared in nearly half of all comments and was by far the most consistent adoption requirement.
- Pricing clarity and total cost appeared in roughly one-third of responses.
- Implementation workload was referenced at a similar rate, often paired with concerns about IT bandwidth.
- Reliability and usability concerns accounted for a significant share of comments and were often discussed together.
- Vendor continuity emerged less frequently but with strong language where present, suggesting a smaller set of respondents for whom this is a critical gating factor rather than a routine expectation.

Because these themes commonly co-occurred, they should not be interpreted as discrete barriers but as overlapping conditions that collectively shape adoption readiness.

### **B.4 Illustrative Language**

Selected verbatim comments demonstrate the internal logic behind thematic placement:

- Data security: “We would not move forward with anything that could expose us to breach risk. Savings cannot offset that level of exposure.”
- Pricing clarity: “Subscription is fine, but we need to know there will not be cost surprises in year two or three.”
- IT capacity: “Our team has no slack right now. Even a simple system takes sustained effort.”
- Clinical trust: “If nurses do not believe the readings, we will end up doing vitals twice.”
- Adoption dependency: “It needs to reduce work, not create work. Otherwise the staff will not use it.”
- Vendor continuity: “We have been burned before when companies disappear after we invest time integrating them.”

### **B.5 Interpretation**

Taken together, the coding structure reinforces the insight that respondents do not question the value SleeveSense promises to create. Instead, they focus on the conditions that determine whether that value can be realized within their organizations. The co-occurrence of themes within individual responses suggests that financial leaders view adoption as a multi-factor decision rather than a binary vote of support or opposition. The thematic landscape indicates that the primary task ahead is not persuasion, but assurance, demonstration, and mitigation of operational friction.

## **Appendix C - Frequently Asked Questions**

Below is a narrative reformulation of the questions most frequently raised by respondents. These answers are included so that Senphonix can respond directly to the recurring needs of financial decision makers.

### **What is included in the price?**

SleeveSense is provided as a per patient subscription which includes all hardware, consumables, software access, data transmission, technical support, replacements, and warranty coverage, with no additional integration fees, license fees, or upgrade charges.

### **Will adopting this solution create additional burden for nurses or IT staff?**

SleeveSense is designed to remove work rather than add it by reducing manual vitals collection which consumes up to twenty percent of nursing time, and implementation typically requires fewer than eight to twelve IT hours, with data written directly into existing EHR fields to avoid additional systems or training burdens.

### **How does SleeveSense connect to the EHR and clinical workflows?**

The system uses standard health data protocols, including FHIR and HL7, to feed directly into Epic, Cerner, Meditech, and similar systems, so vitals appear in existing record fields and staff are not required to adopt new dashboards or documentation tools.

### **How do we know the data is accurate and clinically reliable?**

SleeveSense is undergoing validation against clinical gold standards for heart rate, respiration, temperature, and motion with accuracy testing aligned to FDA requirements.

### **Is patient data private, secure, and HIPAA compliant?**

Yes, all data is encrypted in transit and at rest, access is permission controlled, workflows support HIPAA and HITECH compliance, and no patient information moves outside the care environment without authorization.

### **What happens if the device fails or loses connection?**

The system is designed to fail safely and provides alerts if readings are interrupted so clinicians can intervene, and every device is fully supported with replacement coverage and service.

### **How large is the ongoing financial commitment?**

SleeveSense is entirely operating expense, paid only for patients actively using the service, with no capital expenditure, depreciation, or purchase of inventory. This means that while a healthcare organization may have a supply of sleeves, fees do not begin until a sleeve is registered to a specific patient, whether inpatient or outpatient.

### **Can this solution meaningfully reduce traveler nurse spending or overtime?**

Yes, automation reduces manual vitals collection, which consumes a significant portion of nursing time, helping facilities reduce or avoid contract nurse usage and overtime, particularly during staffing shortages or census surges.

### **What is the potential impact on readmissions and penalties?**

By extending continuous monitoring into inpatient and home settings, SleeveSense increases the probability that complications are detected early, reducing unplanned readmissions and associated financial or quality penalties.

### **Can our organization capture the remote patient monitoring reimbursement opportunity?**

Yes, SleeveSense supports qualifying CPT and HCPCS remote monitoring codes, enabling more than \$1,500 in potential revenue per eligible patient per year, and includes guidance for organizations that are new to RPM workflows.

### **How do we know Senphonix and SleeveSense will be here long term?**

SleeveSense is the first offering of Senphonix, a HealthTech startup founded in 2025. However, although a startup, the management team is very experienced, including seasoned clinicians, medical device design and manufacturing engineers, human factors specialists, FDA experts, hosted and mobile app software developers, cybersecurity experts, healthcare policy executives, financial analysts, pricing experts, customer support personnel, and more.

### **What if patient comfort or compliance becomes a problem?**

The wearable uses breathable medical grade silicon mesh suitable for continuous use. Exact sizing is accomplished by leaving the ends unattached, so that nurses can fit patients regardless of arm size. This is accomplished by a unique design led by Senphonix's human factors team. Early testing has demonstrated comfort and anticipated long-term wear.

### **How difficult is device logistics at scale?**

SleeveSense includes sleeves and the components (chargers, LoRaWAN radios for inpatient use, and a mobile app for outpatients) needed for typical use. Replenishment follows a predictable ordering process.

### **When will the system be fully cleared for commercial use?**

The solution is advancing through FCC electrical testing, UL requirements, and the FDA 510k review process, and status updates are provided during contracting and piloting.

### **What if the financial benefits do not materialize?**

Hospitals start with a defined pilot and measurement plan, and since the model is subscription based, organizations can scale up or scale down based on actual return, rather than being locked into capital commitments.

## Appendix D – Additional Participant Quotes

The following respondent quotations illustrate tone, reasoning patterns, and decision criteria expressed throughout the survey. They are presented to reflect the breadth of sentiment within the sample and are not intended to imply quantitative weighting.

“We are already past the breaking point with our nursing staff. Any solution that gives them time back gets our attention immediately.”

“If nurses spend half the time collecting vitals, we spend half the money on overtime. It really is that simple.”

“Our biggest financial problem is labor, and we cannot ignore anything that gives us capacity back.”

“This is not a nice to have. It is how we are going to survive limited workforce conditions.”

“We are flooding money into travelers. If this actually reduces that need, it pays for itself immediately.”

“We are paying twenty to thirty percent above baseline for staffing coverage. So even a modest reduction in contract need is a meaningful financial lift.”

“We had to shut down beds last quarter because we could not staff them. This is not hypothetical for us.”

“Time is money in a hospital. If you free the time, you free the dollars.”

“If readmissions decline even five percent, the impact is noticeable.”

“We get hit with penalties for bounce-backs that often do not have to happen. If earlier detection avoids one or two a month, that more than pays for the system.”

“Value based contracts punish us when patients return. Continuous monitoring can help, but we have to see it work.”

“If RPM revenue is captured without additional headcount, it becomes a financial win very quickly.”

“We cannot ignore a reimbursement stream that is sitting there unused.”

“We need something that actually translates documented vitals into sustainable dollars. Sometimes that last mile is hard to reach.”

“I need proof that data security is airtight. A breach costs more than a savings line ever will.”

“We are one incident away from a multimillion dollar hit. That colors every technology decision.”

“HIPAA compliant is not enough. We need to understand the architecture.”

“We have cybersecurity on every board agenda now. Nobody signs off on a product unless risk is thoroughly addressed.”

“We do not want another system that promises to be simple and becomes a black hole for IT time.”

“Everybody says they integrate with the EHR until we discover the hidden work.”

“What kills value is not the system, but the support it takes to make it run.”

“It has to be plug-and-play for us. If it is not, it pushes something else off the list.”

“If nurses do not trust the device, it will end up in a drawer, and we will be back where we started.”

“We have tried wearable monitoring before. Clinicians stopped using them because the alerts were noisy.”

“Nurses are exhausted. If a product makes their job easier, they will support it. If it does not, it will quietly die.”

“It will come down to bedside adoption. Dollars only show up if people actually use the tool.”

“If the company behind it does not stick around, we are left holding the bag.”

“We have invested in technology in the past that disappeared when the vendor was acquired. That cannot happen again.”

“If we are going to build our workflow around a vendor, we need to know they will be here in five years.”

“We need a pathway to scale, not just a demo.”

“We have been burned by pilots that worked and then never became real deployments.”

“I am hopeful but cautious. The idea is absolutely right. The execution is where most things fall apart.”

“The concept is strong. Now show us it can operate in the messiness of a real hospital.”

## Appendix E - Stakeholder Involvement Map

Survey respondents identified a consistent set of stakeholders who would participate in, shape, or ultimately approve a decision to adopt SleeveSense. While job titles varied across organizations and system size, comments coalesced into a predictable decision network that reflects how technology adoption unfolds within modern health systems.

Respondents made clear that no single leader or department can advance SleeveSense independently. Instead, adoption requires alignment among clinical users, operational decision makers, financial stewards, and technical enablers. The comments suggest that hospitals consider decisions of this type to be both financially material and operationally consequential, drawing multiple disciplines into the process.

The group most frequently cited as essential to evaluation was nursing leadership, ranging from chief nursing officers to directors of clinical operations and unit-level nurse managers. Respondents agreed that the burden SleeveSense is designed to relieve sits primarily with nursing teams, and therefore nursing has the deepest insight into workflow feasibility, bedside practicality, and clinician acceptance. They implied that nursing carries not only consultation authority but veto authority. If nursing does not believe SleeveSense genuinely removes workload, the system will not take hold in practice, regardless of financial justification.

Information technology leadership represents the second core stakeholder group. Respondents positioned IT not as a supporting voice but as a gatekeeper to technical viability. Chief information officers, chief technology officers, and directors responsible for electronic health record integration and network security were widely identified as essential participants. Respondents expressed the view that IT must determine whether integration is possible with existing systems, whether support capacity exists, and whether deploying SleeveSense introduces risk to networks, infrastructure, or security postures. Several respondents suggested that IT's assessment would significantly influence timing and scope of adoption, even if funding is approved.

Finance leaders appear at the center of the decision-making process. Survey responses confirm that chief financial officers, vice presidents of finance, and budget directors are responsible for evaluating return on investment, scrutinizing pricing models, assessing vendor viability, and sequencing SleeveSense within a portfolio of competing capital and operating expense needs. Respondents framed finance as the discipline that integrates operational benefit with risk exposure and long-term affordability, making it a natural owner of the final business case.

Clinical leadership beyond nursing emerged as the fourth stakeholder category, particularly where patient safety and care quality intersect directly with monitoring capability. Respondents cited chief medical officers, quality and patient safety directors, and occasionally population health or care coordination leaders as potential advocates. These stakeholders may not drive procurement mechanics, but they often provide the clinical rationale necessary to elevate a decision from pilot concept to full deployment. Their endorsement may be particularly influential in environments that prioritize readmission reduction, early deterioration detection, or remote care management.

In several cases, respondents also referenced administrative or operational gatekeepers, including procurement teams, supply chain executives, and legal or compliance leaders responsible for contract

review and risk management. While these functions may enter later in the process, respondents indicated that they play a crucial role in formalizing agreements and ensuring regulatory adherence.

Taken together, these responses depict a multi-layered adoption pathway in which SleeveSense must satisfy the expectations of four primary stakeholder groups and coordinate across several secondary functions. Nursing establishes workflow relevance. Information technology determines feasibility and supportability. Finance validates the business case and risk profile. Clinical leadership connects the solution to patient outcomes and safety. Adoption therefore depends not simply on compelling economics, but on successful alignment across this network of decision makers.

## Appendix F – Solution Overview Used to Ground Participants

To prep survey takers, the following background was provided on the first page of the survey. No further information was provided.

### **Survey of Financial Decision-Making within Healthcare**

**Introduction/Overview of the Solution**

Thank you for participating in this survey! Your input will help us evaluate the potential financial impacts of a unique wearable vital signs monitoring system intended to improve nursing efficiency, support earlier patient interventions, and reduce total cost of care across the healthcare system.

This concept has been evaluated by 400+ licensed nurses nationwide and it received very strong (98%) clinical support. Today, **nurses report spending up to (and sometimes exceeding) 20 percent of their shift manually collecting and documenting vital signs**, and it's a significant point of frustration. The proposed solution automates this process while maintaining clinical quality and patient safety.

The system has been designed for scalability and enterprise adoption, with the following characteristics:

- Continuous patient use** - Soft, breathable, waterproof sleeve designed for extended wear (days, weeks, or months) across all healthcare settings.
- Wireless charging/communications** - Eliminates the need to remove once the nurse fits the patient with the sleeve. Charges while the patient sleeps.
- Automated EHR integration** - Real-time availability of vital signs data via electronic health record systems, eliminating manual effort.
- Alert and escalation support** - Integrates with existing clinical alerting and escalation systems, to keep existing workflow intact.
- HIPAA compliant architecture** - Full encryption to protect patient privacy while data is in transit (to and from Microsoft Azure's HIPAA cloud) and at rest.
- Multi setting transferability** - Moves seamlessly across inpatient, outpatient and in-home settings.
- Regulatory readiness** - Currently progressing through required safety and regulatory pathways, including FCC, UL, and FDA.
- Advanced, patented technology** - Developed in collaboration with a leading academic research institution.
- No capital outlay** - SleeveSense™ is delivered on a per patient subscription basis, allowing health systems to fund its use with cost savings as they go.

As you respond to the following questions, please assume broad support within your healthcare system. ***This survey focuses specifically on financial value from an executive perspective.***

Figure F1 - Solution Description.