WEAR-TECH

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STUDY COMMITTEE ON THE USE OF ARTIFICIAL INTELLIGENCE IN HEALTH CARE

Building AI for care *that stays on the wrist.*

What we have learned building a device people actually wear — where AI helps, what we do to keep it safe, and where the state could help.

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Where AI is *actually* pulling its weight

All four are about one person: someone sent home who needs watching.

01 · PATIENT ONBOARDING

Getting a patient onto remote monitoring

Days/Weeks → minutes

where we are aiming, not yet proven

Eligibility, consent, documentation, device provisioning, and care plan setup are all paperwork-related issues. For post-cardio intervention, transplants, oncology, or any geriatric patient who requires monitoring upon discharge, a manual process that can take days or even weeks to enroll and onboard is a significant gap. This gap could potentially be the difference between catching a problem early and missing it altogether.

02 · ALERT TRIAGE

Knowing when to wake somebody up

A device that watches for falls and wandering can send a lot of alerts, and at times those alerts turn out to be nothing. A device that cries wolf gets switched off, and then it protects nobody. Getting the routing right is what keeps it trusted and in use. AI that's routing based on learned patterns is where we see value.

03 · BILLING & REIMBURSEMENT

Getting the paperwork past the payer

Coding, records, and getting a clean claim out the door. Unglamorous, but it is often what decides whether a small clinic can run a monitoring program at all.

04 · WORKFORCE REACH

Helping a short-handed team cover more

One nurse can safely keep an eye on more residents when the device is watching too. In parts of Wisconsin you cannot hire your way out of the shortage, so this is about people getting care at all.

THE LINE WE DON'T CROSS | We stay out of clinical decisions. Our AI handles process and points a clinician at something worth a look. It does not diagnose, it does not prescribe, and it does not decide.

Most of it *never leaves the wrist*

ON THE DEVICE

It stays on the device

Movements, fall signals, wandering behaviors, health metrics — read continuously, and the AI that reads them runs right there on the device.

IT IS LOCKED EITHER WAY

Encrypted

Encrypted sitting still and encrypted moving. There is no steady stream going up to a server somewhere, and nothing gets pooled by default.

IT LEAVES WHEN IT MATTERS

Someone gets told

When the device sees something worth attention, it tells the care provider. That is the moment data goes anywhere.

WHY I THINK THIS MATTERS TO YOU

Doing the work on the device means the privacy is built into how it is made, not written into a policy nobody reads. Data that never leaves the watch cannot be stolen off a server or quietly used for something else later.

HOW WE TRAIN

We train in closed environments on stripped-down, anonymized data, kept in a controlled and access-based environment.

How we keep ourselves honest — and *what following the rules costs*

WHAT WE DO ON OUR OWN

Somebody owns this by name

A real compliance team, not a side job for an engineer. They keep the audit trail.

Nothing ships undocumented

We write down what it is for, what data it touches, and the line it is not allowed to cross.

A person always sits in between

The system spots the pattern and tells a care provider. The provider is the one who decides.

WHAT IT COSTS A SMALL COMPANY HERE

Fifty sets of rules, one small team

Every state that writes its own version of these rules adds work for us that does nothing for a patient.

Hold us to one strict standard you can check. We would take that over fifty different ones.

ON 2025 SENATE BILL 166

It only reached companies handling 100,000 consumers, and it exempted anyone already under HIPAA. **A company our size fell outside it twice over**. Consumer privacy law is built for advertisers and data brokers, and it is not the right tool for data coming off a device.

ONE APPROACH WORTH A LOOK

Utah's Artificial Intelligence Policy Act (S.B. 149, 2024) runs a learning lab: a company can test AI under a time-limited agreement with the state, with reporting and oversight, and reduced penalties while the test runs.

What happens as these tools get *good at everything*

WHAT THAT MAKES POSSIBLE

Seeing the whole patient at once

The newer tools can look at a chart, a scan and a week of vitals together. A clinic with no specialist on staff gets a second look it would not otherwise have.

Reaching people we currently miss

In much of rural Wisconsin the problem is not cost, it is that nobody is available to look. Anything that travels to those places is about access before it is about savings.

Giving time back to patients

Charting, prior authorization, finding a trial someone qualifies for. Hours a week that currently go to a keyboard instead of a person.

WHERE IT GOES WRONG WITHOUT GUARDRAILS

Wrong, and sure of itself

When a narrow tool like ours fails, someone redoes the paperwork. When a tool that does everything fails across a hundred clinics, people get hurt before anyone notices the pattern.

We stop double-checking

The better these tools look, the less anyone questions them. Nurses and doctors are human — trust builds quietly, and you only find out it went too far after something goes wrong.

Answers with no explanation

If a tool cannot say why it landed somewhere, nobody can argue with it. Not the doctor, not your office, and not the patient it is about.

WHAT I WOULD ASK OF A BILL

Write the rules around what a machine is allowed to **decide**, not around how it is built. Name a specific technology and the bill is dated before it passes. Say instead that certain decisions always need a person answerable for them, and it still works ten years from now.

Five things that would help, and *one to hold us to*

1

Let us learn from data we have stripped down

Anonymized, kept on our own machines, and no more of it than the job needs.

2

Ask to see our work, not to build it your way

Name a technology in the bill and it is dated in two years. Logs you can come inspect never go out of date.

3

Keep the data in the country, and prove it

Someone's health data should not end up on a server overseas, and a company should have to show you it did not.

4

Line Wisconsin up with everyone else

So a company that starts here can sell in every other state without rebuilding the product fifty times.

5

Give us a supervised place to try things

Narrow, non-clinical jobs only, with the state watching and us reporting back — the Utah approach from a moment ago.

6

And hold us to this one

No machine makes a clinical decision on its own. A person stays accountable for every diagnosis, prescription and treatment call — including ours, and no matter how good the models get.

If one thing carries into a bill: treat *keeping the data on the device* as protecting privacy, so a company that builds it that way is not regulated as though it were running a giant database of everybody's health records in the cloud.

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