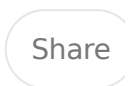
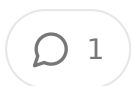
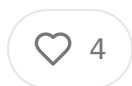


How OpenEvidence compliantly and effectively scaled to \$50M ARR without BAAs or EHR integration: How their unique business model drove hyper-scaling metrics previously considered impossible in health.

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ABSTRACT

OpenEvidence achieved what most healthcare software companies thought impossible: scaling to fifty million in annual recurring revenue within roughly two years of product launch, capturing forty percent of US physicians without requiring business associate agreements or EHR integration during its critical growth phase. The company's trajectory from zero to half a billion in funding and a six billion dollar valuation happened because they understood a subtle regulatory distinction that let them behave like consumer software while everyone else was stuck in enterprise sales cycles. This essay examines the specific mechanics of how they did it, why the approach worked, and why it probably won't work again.

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The Problem With Healthcare Software Distribution

Healthcare software has a distribution problem that's fundamentally different from other enterprise software categories. The root issue isn't that healthcare buyers are conservative or slow, though they are. The issue is that clinical software usually requires two things that create massive friction: business associate agreements under HIPAA and integration with electronic health record systems. These requirements turn what could be fast product-led growth into multi-year enterprise sales cycles.

The typical path looks brutal. You build clinical decision support software that helps doctors make better treatment decisions. To be useful, it needs patient data from the EHR, which means technical integration work. Epic's app orchard review process takes six to nine months just to get listed. Then each health system needs to enable your app, which requires IT approval. Once you're dealing with patient data, you're handling PHI, which means every health system needs their legal team to review and sign your BAA. Their information security team does a vendor assessment. Their clinical leadership needs to see evidence that doctors will actually use it. The whole

process takes twelve to twenty four months per health system, and at the end you might have a few hundred physicians using your software.

This explains why healthcare software companies typically raise a Series A to hire enterprise sales teams before they have real revenue. They spend millions on compliance infrastructure before they know if doctors actually want the product. They modify features based on what hospital administrators think doctors need, rather than what doctors actually need. The result is that most healthcare software companies are still trying to close their tenth customer three years after founding. Ones that succeed usually do it by grinding through enterprise sales, not by achieving viral adoption.

OpenEvidence just bypassed this entire machinery and got to fifty million in ARR in roughly two years.

What HIPAA Actually Requires Versus What Everyone Thinks It Requires

The foundational insight that enabled OpenEvidence's growth was understanding exactly what HIPAA requires rather than assuming it applies to everything clinical. Most people building healthcare software assume that any tool used by doctors for patient care needs HIPAA compliance and BAAs. This assumption is wrong but understandably so because the distinction is subtle.

HIPAA requires a BAA when a vendor creates, receives, maintains, or transmits protected health information on behalf of a covered entity. The key term is protected health information, which has a specific legal definition. PHI means individually identifiable health information. The identifiable part matters. If information does not identify a specific patient, it's not PHI under HIPAA, and HIPAA's requirements do not apply.

This creates a category of clinical software that provides value to doctors without handling patient-specific data. Medical reference tools fall into this category. Calculators can fall into this category if designed carefully. Care coordination tools

might fall here if they avoid patient identifiers. The key is that the software answers clinical questions or provides clinical guidance without needing to know anything about specific patients.

OpenEvidence launched as a medical search engine and evidence synthesis tool. A doctor could ask “what’s the recommended antibiotic for hospital-acquired pneumonia in a patient with penicillin allergy” and get an evidence-based answer with citations to relevant studies and guidelines. That question doesn’t contain PHI. There’s no patient name, no medical record number, no date of birth. The fact that a doctor is thinking about a specific patient when asking the question doesn’t make the question itself PHI. OpenEvidence’s system never received any patient data, so it wasn’t a business associate under HIPAA, and no BAAs were required.

This wasn’t some sketchy legal workaround. It’s actually how HIPAA was designed to work. Medical textbooks don’t need BAAs. UpToDate doesn’t need individual BAAs with every subscribing physician. PubMed doesn’t need BAAs. These are information resources, not systems that process patient data. OpenEvidence started in exactly the same category. It was a knowledge tool, not a workflow tool.

The practical implication was enormous for distribution. Without BAAs required, OpenEvidence could offer their product directly to individual physicians with zero institutional approval needed. A doctor could verify their NPI, create an account, and start using it in under three minutes. No legal review. No IT security assessment. No procurement process. No vendor evaluation. Just sign up and go.

Compare this to what happens when you do need BAAs. Even if you have a standard BAA ready to go, each health system’s legal team wants to review it. They have questions about data retention, breach notification procedures, audit rights, liability limits. The negotiations take weeks or months. Information security does their assessment, which generates more questions. By the time you’re done, six months have passed and you haven’t added a single user. OpenEvidence completely avoided this by structuring their initial product so it wasn’t handling PHI at all.

The EHR Integration Tax

The other major distribution barrier OpenEvidence avoided was EHR integration. This deserves its own analysis because the conventional wisdom in healthcare is that you must be in the EHR workflow to get physician adoption. This belief is mostly true for certain types of software but not universally true, and the exceptions create opportunities.

EHR integration makes sense for workflow automation tools. If you're automatically generating orders or pre-filling documentation or flagging drug interactions in real time, you need to be embedded in the EHR because that's where those workflows happen. But not all clinical software is workflow automation. Some clinical software supports decision-making that happens before or alongside the EHR workflow.

Think about the actual process of clinical decision-making. A doctor sees a patient, takes a history, does an exam, and thinks about diagnosis and treatment. During this process, questions come up. What does the latest evidence say about this treatment approach? Are there newer therapies I should consider? What are the current guidelines for this scenario? These questions often occur before the doctor ever updates the patient's chart to document anything. They might happen at the bedside during the encounter or immediately after while formulating the plan.

For these information lookup moments, EHR integration doesn't actually help. The doctor doesn't need the software to read data from the chart. They just need a fast way to get an answer to a clinical question. A standalone app on a phone or laptop actually works better than navigating through EHR menus. This was OpenEvidence's product insight: don't compete with the EHR, compete with Google and UpToDate for those moments when doctors need information to make decisions.

The strategic advantage of avoiding EHR integration early on was eliminating that enterprise dependency entirely. Getting into Epic's app orchard takes months. Cerner's marketplace has its own requirements. Even after you're listed, each health system's IT team has to enable your app. Then you need clinical champions to train people on where to find it in the interface. The whole process easily takes a year in a health system.

OpenEvidence skipped all this by being a standalone tool that doctors could discover through word of mouth. A hospitalist in Seattle tries it and finds it helpful. She mentions it to colleagues at a conference. They sign up and start using it at their hospitals in Boston and Atlanta. None of them needed IT permission. None needed vendor assessments. None needed training beyond maybe a two minute product demo. The product spread through professional networks the way consumer apps spread, not through enterprise procurement.

This distribution approach also created different competitive dynamics. Traditional healthcare software moats come from integration complexity and institutional contracts. Once you've integrated with Epic and signed agreements with fifty hospitals, competitors face the same barriers. But you also face those barriers for adoption. OpenEvidence's moat came from network effects among physicians. Over forty percent of US doctors were using it daily, that became the standard. Medical residents learned about it from their attendings. Doctors changing hospitals kept using it because it wasn't tied to any institution. The moat built from user habit and peer adoption rather than from technical lock-in.

There's also a channel conflict advantage to staying out of the EHR initially. EHR vendors view third-party apps with suspicion, especially successful ones. If OpenEvidence had needed EHR integration from day one, they would have been competing with Epic's and Cerner's own clinical content tools. They might have faced pressure to revenue share or encountered subtle distribution barriers. As a standalone tool, they avoided that conflict until they were too big to ignore.

How OpenEvidence Structured Their Product to Avoid Both Barriers

The sequencing of OpenEvidence's product evolution shows sophisticated thinking about how to achieve scale before adding complexity. They didn't try to do everything at once. They started with the minimum viable product that could provide enormous value without touching PHI or requiring integration, then layered in more advanced capabilities once they had leverage.

Phase one from 2023 through April 2025 was purely the medical search and evidence synthesis product. Doctors typed in clinical questions and got evidence-based answers with citations in five to ten seconds. The system searched through thirty five million peer-reviewed papers and clinical guidelines. It synthesized information across multiple studies rather than just returning a list of abstracts. It worked on mobile devices so doctors could use it anywhere. And critically, it never needed any patient data to function.

The product was immediately useful. Instead of spending twenty minutes searching PubMed and reading abstracts, a doctor could get a synthesized answer with relevant citations in seconds. The value proposition was obvious and the barrier to trying was zero. This combination drove viral adoption through medical professional networks. Doctors who tried it told other doctors about it. No marketing spend was required.

During this phase, OpenEvidence scaled to over one hundred thousand verified physician users in the first year after launch. By July 2024, they were handling three hundred fifty eight thousand physician consultations per month. All of this growth was organic. They weren't spending money on ads or enterprise sales. The unit economics were remarkable: essentially zero customer acquisition cost, minutes to first value, minimal churn because it was free and useful. The only real costs were infrastructure and content partnerships with journals.

In February 2025, OpenEvidence raised a seventy five million dollar Series A led by Sequoia at a one billion dollar valuation. This happened roughly two years after the product launched. For context, most healthcare software companies at the two year mark are still trying to sign their tenth enterprise customer. OpenEvidence had hundreds of thousands of active users and was embedded in the daily workflow of a substantial percentage of US physicians.

Then in April 2025, OpenEvidence announced HIPAA compliance and the availability of BAAs. This marked phase two. They added features that did require handling document upload, encounter transcription through their Visits feature, prior authorization letter generation with patient details. For these advanced features

now functioned as a business associate and required BAAs with healthcare organizations.

The sequencing matters enormously. By April 2025, OpenEvidence already had massive adoption among individual physicians. When they approached health systems about BAAs, the conversation was completely inverted from a normal vendor pitch. They weren't asking IT departments to take a risk on an unproven product. They were responding to demand from physicians who were already using the basic version and wanted the advanced features. The sales motion flipped from push to pull.

This also changed leverage in BAA negotiations. Normally when a small software company asks a major health system to sign a BAA, legal picks apart every clause and the process drags on for months. But when that health system's physicians are already using your product extensively and demanding more features, legal has pressure to move quickly and accept more standard terms. OpenEvidence could also point to months of usage by physicians at that institution without issues, which reduced perceived risk.

By July 2025, just three months after enabling BAAs, OpenEvidence was handling eight and a half million physician consultations per month. That represents roughly twenty four hundred percent growth from July 2024. They announced a two hundred million dollar Series B led by Google Ventures and Kleiner Perkins at a three and a half billion dollar valuation. In October 2025, they raised a Series C at six billion dollars. The entire arc from product launch to six billion dollar valuation took roughly two to two and a half years.

The Growth Numbers and What They Mean

The scale OpenEvidence achieved is genuinely unprecedented for healthcare software. As of mid-2025, they had over four hundred thirty thousand registered US physicians representing about forty percent of all physicians in the country. They were processing over eight million clinical consultations per month. Over one hundred million Americans were treated by a doctor who had used OpenEvidence that year.

The growth rate is what makes this exceptional. From July 2024 to July 2025, monthly consultations grew from three hundred fifty eight thousand to eight and a half million. That's twenty four hundred percent growth in a single year. Consumer apps sometimes hit these growth rates but healthcare tools just don't, specifically because of the distribution barriers discussed earlier.

The revenue progression tells a similar story. Based on available information, OpenEvidence reached approximately fifty million dollars in annualized revenue mid-2025, growing from an estimated eight million dollars at the end of 2024. This kind of growth trajectory is more typical of consumer internet companies than healthcare software businesses. The primary revenue model was pharmaceutical advertising shown to physicians in contextually relevant ways. When a doctor queried about heart failure treatment, showing information about relevant cardiac medications is actually useful rather than intrusive.

The advertising model worked because of the scale and targeting. With eight million monthly consultations and forty percent of US physicians using the platform, OpenEvidence had better reach among doctors than almost any other channel. And they had superior targeting because they knew exactly what clinical questions each doctor was asking in real time. A pharmaceutical company launching a new diabetes drug would pay premium rates to reach endocrinologists and primary care doctors the moment they're researching diabetes treatments. Reports suggest OpenEvidence was achieving CPMs of seventy to one hundred fifty dollars compared to five to ten dollars for typical social media advertising.

Beyond advertising, the enterprise BAA model created a higher-value revenue stream. Health systems that wanted their physicians to access advanced features needed enterprise agreements. These were priced per physician and represented significantly higher revenue per user than the ad-supported model. The enterprise motion also created switching costs because once physicians got used to advanced features like document upload and encounter transcription, they'd resist losing access.

The capital efficiency deserves attention. Through their Series C, OpenEvidence raised roughly five hundred million dollars. That sounds like a lot in absolute terms

but it's actually quite efficient given their scale and valuation. Most healthcare software companies raising similar amounts might have ten to twenty million in ARR. OpenEvidence was doing fifty million in ARR on comparable capital raised. The efficiency came from avoiding enterprise sales costs, extended sales cycles, and integration work during their growth phase.

The valuation progression also tells the story. One billion dollars in February 2023 and a half billion in July 2023, six billion in October 2023. The company's valuation increased six fold in eight months. The investors weren't naive capital. Sequoia led the Series A. Google Ventures and Kleiner Perkins co-lead the Series B. These firms have deep healthcare investing experience and saw something genuinely different in OpenEvidence's scaling dynamics.

Why This Window Has Closed

The obvious question is whether this playbook can be replicated. The answer is mostly no for fundamental structural reasons, and definitely no for the specific medical search use case because OpenEvidence has already captured it.

Understanding why helps clarify what was actually special versus what was circumstantial.

The core requirement for avoiding BAAs is that your product genuinely doesn't need PHI to provide value. This is true for medical reference and education tools. It can be true for some clinical calculators and risk scores if designed carefully. It could work for certain care coordination tools if structured to avoid patient identifiers but it's fundamentally not true for most clinical workflow software.

If you're building clinical documentation tools, you need the patient's chart data. If you're optimizing medication orders, you need to know current medications. If you're identifying care gaps, you need to identify patients. All of these require PHI from the start and therefore require BAAs. There's no way around it.

The medical search and evidence synthesis use case OpenEvidence addressed was uniquely suited to the PHI-free model. Doctors constantly have clinical questions

These questions are often generic enough that they don't require patient-specific to answer. The answers come from medical literature and guidelines that are the regardless of which patient prompted the question. This let OpenEvidence provide massive value without knowing anything about specific patients.

Even within the constraints of PHI-free products, OpenEvidence had circumstantial advantages. The medical literature is largely publicly accessible through PubMed journal partnerships, so they could build a comprehensive knowledge base without proprietary data access. Clinical questions have commonality across specialties and practice settings, so the product worked for all physicians rather than being niche. The value proposition was immediate and obvious, get answers in seconds instead of searching for twenty minutes.

The timing also mattered significantly. OpenEvidence launched in 2023 right as language models became capable enough to do sophisticated literature synthesis. Earlier attempts at AI-powered medical search struggled because the underlying technology wasn't good enough. Later attempts will struggle because OpenEvidence already captured the market. There was a narrow window where the technology enabled a new product and the market was still open.

The distribution dynamics also benefited from timing. Physicians were primed to use AI tools by 2023 because ChatGPT had created mainstream awareness. But there weren't yet many clinical AI tools that doctors trusted, which created an opening. OpenEvidence also benefited from being genuinely better than existing alternatives like UpToDate for the specific use case of quick evidence lookups. That performance advantage won't last forever because incumbents will adapt.

The regulatory environment might also shift in ways that close this approach. As clinical tools become more common, there's increasing scrutiny about whether they should be regulated as medical devices or whether HIPAA's definitions of PHI should expand to cover de-identified clinical scenarios. If regulations change to require HIPAA compliance even for tools that don't technically handle identifiable patient data, the distribution advantage disappears.

There are probably a few other healthcare software categories where a similar approach could work. Medical education and continuing education tools might avoid PHI requirements. Clinical trial matching could potentially work with de-identified patient criteria. Second opinion platforms might structure workflows to avoid identifiable data in certain scenarios. But the number of high-value clinical use cases that can provide significant utility without any patient-specific data is quite limited.

The meta lesson is that there are occasionally windows in healthcare technology where new capabilities enable distribution models that bypass traditional gatekeepers. Mobile health apps in the early 2010s were one such window. Patients and doctors could download apps without institutional approval, creating opportunities that didn't exist before. AI tools in 2023 through 2024 were another window, specific for products that could provide clinical value without data integration. These windows tend to be temporary because once a category gets established, the dynamics shift toward more regulation and more competition.

Implications for Healthcare Software Strategy

OpenEvidence's trajectory offers several strategic lessons for anyone building or evaluating healthcare software, though the specific playbook probably won't repeat. The high-level insight is that challenging assumptions about necessary distribution barriers can create enormous value if you find the right category and execution.

The first implication is about product design and regulatory strategy. Most healthcare software teams assume they need full HIPAA compliance from day one because their product will eventually handle PHI. This leads to building compliance infrastructure before achieving product-market fit. A better approach might be to ask whether your core value proposition actually requires PHI or whether there's a useful PHI-free version that could drive initial adoption. If you can deliver value without PHI, you can achieve fast distribution and validate product-market fit before adding compliance complexity.

This doesn't mean ignoring compliance or cutting corners. It means understanding exactly what regulations require for your specific product design rather than assuming maximum regulation applies. The key question isn't "is this a clinical tool" but rather "does the core functionality require creating, receiving, maintaining, or transmitting identifiable patient data." If the answer is no, you might have a distribution advantage.

The second implication is about distribution strategy and unit economics. Products that can scale through individual adoption rather than institutional procurement have fundamentally different economics. Customer acquisition cost should be near zero if you're achieving organic viral growth. Time to value should be minutes, not months. Implementation costs should be minimal. If you're building a direct-to-clinician product but need significant marketing spend or complex onboarding, something is wrong with product-market fit.

The challenge is that direct-to-clinician products have different monetization constraints. OpenEvidence could monetize through pharmaceutical advertising because they had scale and the engagement patterns worked for that model. Most clinical tools won't have that option. Many will eventually need to monetize through institutional subscriptions, which brings back the need for enterprise sales capabilities. The strategic question is whether you can achieve enough individual adoption for free that institutions feel pull to purchase rather than needing push sales.

The third implication is about competitive dynamics and moats. Traditional healthcare software moats come from integration complexity and institutional relationships. These are real but they also slow initial adoption. Direct-to-clinician products have weaker moats in some ways because competitors can build similar standalone tools. But they have stronger moats in other ways because user habits and network effects among clinicians create stickiness that's hard to displace. The key is reaching critical mass quickly enough that you become the standard before competitors can copy you.

The fourth implication is about sequencing and timing. OpenEvidence didn't try everything at once. They started with the minimum product that could provide value.

without PHI, achieved scale, then added advanced features that required BAAs once they had leverage. This sequencing only works if the minimal version truly solve a painful problem. Too many products try to start minimal without ensuring the minimal version is actually valuable enough to drive adoption.

The timing element is also crucial. Healthcare tends to adopt new technologies slowly but occasionally there are windows where new capabilities enable a strategy to bypass traditional gatekeepers. The teams that win are the ones who recognize these windows early and execute fast enough to capture them before the window closes. A challenge for strategists is identifying what the next such window might be and whether they can move quickly enough to exploit it.

The final implication is about risk and variance. Traditional healthcare software is predictable but slow growth and long sales cycles but also relatively predictable outcomes if you execute on enterprise sales. Direct-to-clinician products are high variance. If they achieve product-market fit with individuals, they can scale incredibly fast with great economics. But if they don't achieve that fit, there's no enterprise motion to fall back on. You either get viral adoption or you get nothing. For some teams and some strategies, this risk profile is attractive because the upside is dramatically higher.

OpenEvidence represents a rare but important case study in healthcare software distribution strategy. By finding a clinical use case that provided significant value without requiring PHI handling or EHR integration, they achieved consumer-grade scaling velocity in what's normally an enterprise software category. The specific playbook won't work for most healthcare software because most clinical use cases require PHI and integration by their nature. But the meta lesson about carefully analyzing which barriers are actually necessary versus which are assumed to be necessary should inform how healthcare software gets built. The next breakthrough healthcare software company probably won't look like OpenEvidence specifically but it might share the characteristic of finding creative ways around traditional distribution barriers through careful product design and regulatory understanding rather than just accepting that healthcare software has to be slow.



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