EVAL

PLATFORM REPORT

EVAL Platform Claims

Authoring speed and cross-institutional reach, measured in production

Production data through April 14, 2026

EVAL Health, LLC · eval.health

2026

Contents

3 **Introduction**

4 **Claim 1 · Rapid No-Code Configuration and Deployment of Clinical Tools**

Market context
Common industry limitations
EVAL benefits
7 Evidence
9 Limitations and considerations

11 **Claim 2 · Cross-Institutional Reach of Published Clinical Content**

Market context
Common industry limitations
EVAL benefits
14 Evidence
18 Limitations and considerations

INTRODUCTION

A no-code platform for clinical content, measured in production

EVAL Health is a no-code clinical content authoring and distribution platform for healthcare teams. The platform enables clinicians, researchers, and professional medical societies to build, version, and publish clinical assessment instruments and clinical decision support tools without writing software code, and to distribute that content through a shared public marketplace that is accessible to clinical users across institutions. EVAL Health launched publicly in October 2025 after a pilot phase beginning January 2025; the platform data underlying the claims in this document is the full operational production dataset through April 14, 2026.

EVAL Health's two primary platform claims address distinct but complementary capabilities of the platform:

Claim 1 — Rapid No-Code Configuration and Deployment of Clinical Tools

Clinicians, researchers, and professional medical societies build and publish patient assessment instruments and clinical decision support tools in hours to days rather than the 6–12 months typically required for custom EHR development, using a visual no-code interface and without writing software code.

Claim 2 — Cross-Institutional Reach of Published Clinical Content

Clinical evaluations published to EVAL Health's public marketplace are discoverable and usable by clinical users at institutions other than the publishing institution, producing measurable cross-institutional dissemination across multiple clinical specialties and six distinct publishing entities.

Each claim is accompanied by a separate Statistical Analysis Plan (SAP) document providing the structured analytical methodology, data sources, sample sizes, and descriptive findings that support the claim.

CLAIM 01

Rapid No-Code Configuration and Deployment of Clinical Tools

ADMINISTRATIVE

EVAL enables clinicians, researchers, and professional medical societies to build and publish patient assessment instruments and clinical decision support tools in hours to days rather than the 6-12 months typically required for custom EHR development. Using a visual, no-code interface, authors configure forms, scoring logic, branching rules, and EHR integration without programming expertise. This rapid configuration capability is particularly valuable for health systems with CDS implementation backlogs and for research institutions needing custom instruments for clinical trials.

KEY FIGURES

134 published clinical evaluations	Distinct assessment instruments and decision support tools published for use, across every publishing tenant. Internal test, quality assurance and staff accounts are excluded.
311 published revisions	A revision is a version published to clinical users. Instruments are revised on the same no-code surface they were built on, so a protocol change is an edit rather than a project.
17.5 hours median build time	From an instrument's first edit to the moment patients could answer it, across 27 customer-authored originals. Custom EHR development of a comparable tool takes 6–12 months.
0 lines of custom EHR code	No custom EHR code was written for any of the 311 revisions, so publishing an instrument never waits on a developer or on an EHR release cycle.

Market Context

Healthcare IT Resource Constraints

- Core EHR implementation and maintenance consumes IT resources for 12-18+ months
- 62% of EHR implementations deemed unsuccessful (KLAS 2025)
- Organizations forced to rely on commercially available tools built for generalized needs rather than institution-specific workflows
- Health systems report massive CDS/ePRO implementation backlogs
- Scarce IT developers and clinical informaticists create bottlenecks

No-Code Platform Growth

- Low-code/no-code healthcare IT market growing rapidly
- Trend toward empowering clinical staff to configure their own workflows
- Healthcare organizations seeking to reduce IT dependency for routine tool configuration

eCOA/ePRO Tool Proliferation

- Systematic scoping review of peer-reviewed ePRO literature identified 221 unique clinical applications developed between 2003-2023 (Hubel et al., 2025)
- Trials require unique questionnaires, scoring algorithms, and data collection protocols
- Pharmaceutical and research organizations need custom instruments for clinical trials

Common Industry Limitations

Traditional EHR Development Timeline

- Custom workflows require 6-12 months to deliver with full development teams
- Backlog of requests means critical tools delayed months or years
- Changes to clinical protocols require re-entering development queue
- Requires scarce IT developers and clinical informaticists
- Each EHR instance requires custom development (Epic instances are not equal)

Technical Complexity

- Native EHR development environments have rudimentary functionality
- Custom coding required for branching logic, calculations, and conditional displays
- Tools limited by EHR capabilities, diverging from ideal clinical implementation
- Workflow disruption common when tools don't integrate smoothly

Redundant Development

- Health systems independently build identical tools for their specific EHR instances
- Each organization starts from scratch even for standardized instruments
- PHQ-9 built at Stanford provides zero benefit to Cleveland Clinic
- No mechanism to share validated tools across organizations or EHR platforms

Distribution Limitations

- Building a tool "into" an EHR limits ability to distribute beyond that specific EHR (Solomon et al., 2023)
- Published narrative research with novel assessment tools requires others to interpret into a digital tool from scratch for each EHR instance
- Research instruments built for trials at one site cannot be reused at other sites

EVAL Benefits

No-Code Visual Configuration

- Form Builder: Point-and-click interface for creating assessment questions
- Branching Logic: Point-and-click configuration of conditional questions
- No Programming Required: Clinical staff configure tools without software engineering expertise
- Question Types: Multiple choice, Likert scales, text input, numeric scales, checkboxes
- Scoring Algorithms: Visual calculator for defining how responses map to numerical scores

Pre-Built Digital Tools ("evals")

- Common Instruments: PHQ-9, GAD-7,
- Marketplace: Growing library of public

PROMIS, AUDIT-C, and other validated instruments available as starting points

- Customization: Existing tools can be cloned and modified to meet organization-specific needs

clinical assessment tools shared by community

- Validation Preserved: Standardized instruments maintain validated scoring and wording

Rapid Deployment Cycle

- Time-to-Publish: Hours for simple instruments, days to weeks for complex protocols
- Testing Environment: Dedicated staging environment for testing before production deployment
- Iterative Refinement: Revisions authored on same no-code surface, no re-engineering required
- Version Control: Updates to tools don't break existing data or longitudinal tracking

EHR-Agnostic Architecture

- Single Build, Multi-Deploy: Tool configured once works across any EHR platform
- No Vendor Lock-In: Not dependent on specific EHR vendor or version
- Standards-Based Integration: HL7 FHIR and SMART on FHIR OAuth 2.0 for EHR connection
- Multi-Site Research: Same instrument can be deployed across multiple health systems with different EHRs

Evidence

(A) Observed Rapid Build Cycle in EVAL Production Data

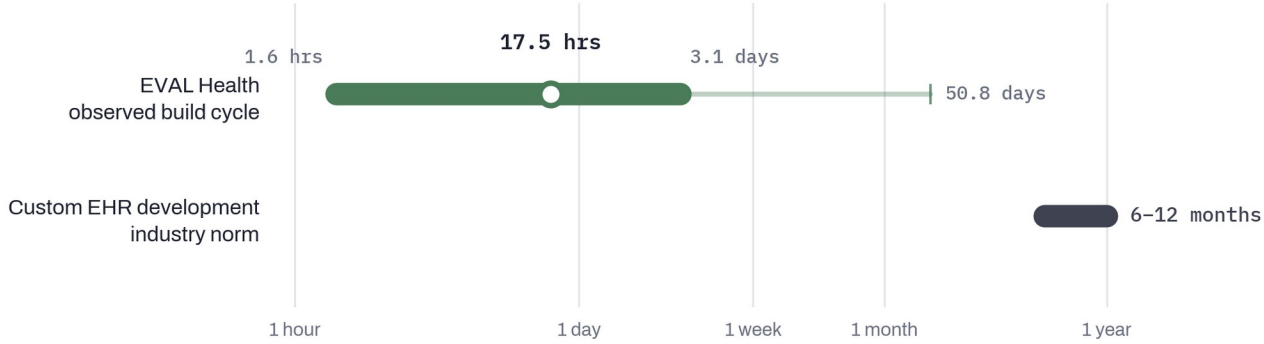
SOURCE

EVAL Health, LLC (2026). Internal production data analysis of platform operational records, extracted 2026-04-14. Analytical cohort prepared via standardized exclusion of internal test, quality assurance, and staff-personal accounts. Methodology, exclusion criteria, and reproducible queries are available on request.

KEY FINDINGS

- 134 published clinical evaluations across 311 published revisions, contributed by 16 distinct clinician or clinician-supervised authors
- Observed median build time of approximately 17.5 hours for customer-authored original published evaluations (n=27); 25th percentile 1.6 hours; 75th percentile 3.1 days; maximum 50.8 days

- Three authorship pathways documented: customer self-service authoring on customer accounts, EVAL-sponsored marketplace publishing (154 revisions by Jennifer Glen, DNP, FNP-BC, in the EVAL Foundation tenant), and paired development with customer clinical teams with ownership transferred on clinical signoff (exemplified by the OSU PAD portfolio, 30 revisions by Kelly M. Rudd, PharmD)
- Credentialed clinician authorship: all non-CEO authors hold clinical credentials (DNP, PharmD, RN) or operate under direct clinician supervision; 4 of 311 revisions by the EVAL Health CEO (software engineer) are separately disclosed
- Zero custom EHR code written across all 311 published revisions
- Analysis is retrospective descriptive; no hypothesis testing or inferential statistics applied



Observed build cycle for customer-authored original published evaluations (n=27), against the industry norm for custom EHR development. Log scale; the bar spans the 25th–75th percentile and the circle marks the median.

RELEVANCE

Directly substantiates the claim with EVAL's own platform data. The filtered production cohort excludes internal test, quality assurance, and staff-personal accounts; all quantitative results are reproducible from the documented analytical methodology.

(B) Peer-Reviewed Platform Use in PAD Clinical Decision Support Development

SOURCE

Rudd, K.M., Glen, J., and Michalski, T. (2025). "Developing an Innovative Clinical Decision Support App for Enhanced Peripheral Artery Disease Management." *Research and Practice in Thrombosis and Haemostasis*, Volume 9 (Supplement S1), May 2025. DOI: 10.1016/j.rpth.2025.102797.

KEY FINDING

Peer-reviewed publication documenting the development of a peripheral artery disease clinical decision support application on the EVAL platform at Oklahoma State University Center for Health Sciences. Lead author is Kelly M. Rudd, PharmD (OSU); co-authors are

EVAL Health's Chief Medical Officer (Jennifer Glen, DNP, FNP-BC) and Chief Executive Officer (Tim Michalski). The PAD clinical decision support work described in the publication corresponds to 12 distinct published tools across 30 published revisions in the EVAL production database, which have served 1,372 VIEW, 44 RESULT, and 36 COMPLETE events through 2026-04-14 — enabling cross-reference verification between peer-reviewed literature and platform data and demonstrating that the tools described prospectively in the publication are in measurable operational use.

RELEVANCE

Peer-reviewed documentation of EVAL platform use at an academic medical center (OSU Center for Health Sciences), with the clinical work led by a credentialed academic pharmacist (Kelly M. Rudd, PharmD) and co-authored by EVAL Health's clinical team per declared conflict of interest. The published work cross-references directly to the platform data in Evidence (A), where Kelly M. Rudd appears as the named author of 30 published revisions.

ADDITIONAL REFERENCED LITERATURE

(cited in Market Context and Common Industry Limitations as prior-art characterization of the field; not presented as evidence for EVAL Health's specific outcomes):

- Solomon, J., et al. (2023). "Integrating Clinical Decision Support Into Electronic Health Record Systems Using a Novel Platform (EvidencePoint)." *JMIR Formative Research*, 7:e44065. PMID: 37856193.
- Hubel, N.J., et al. (2025). "Sustainability and Time Trends in Electronic Patient-Reported Outcome Assessment in Routine Cancer Care: Systematic Scoping Review and Follow-Up Survey." *JMIR*, 27:e69398. PMID: 40280556.

Limitations and Considerations

ACKNOWLEDGED LIMITATIONS

1. **Scope Boundary:** This claim addresses technical configuration and first-publish speed only. Does not include:
   - Clinical validation of instrument appropriateness
   - Pilot testing with end users
   - Full production deployment including training and change management

- Post-deployment optimization based on user feedback

The total timeline from initial request to full production includes these additional phases.

2. **Data Maturity and Analysis Type:** EVAL production data cited in Evidence (A) is a retrospective descriptive analysis of early-stage deployment volumes, not a prospective controlled trial. No hypothesis testing or inferential statistics are computed. Sample sizes are small relative to mature clinical content platforms, consistent with Mayo Clinic Platform Solutions Studio guidance permitting internal data for early-stage solutions when sufficiently documented and transparent.

3. **Complexity Variance:** Time savings vary by protocol complexity:

   - Simple: Single questionnaire with straightforward scoring (PHQ-9, GAD-7)
   - Moderate: Branching logic, conditional displays, complex scoring (AUDIT with skip patterns)
   - High: Multi-step workflows, integration with external data, sophisticated clinical decision trees

   Simple instruments show most dramatic time savings; complex protocols still much faster than traditional development but less dramatic percentage improvement.

4. **Organizational Readiness Factors:** Time savings assume:

   - Clear requirements from clinical team
   - Adequate clinical informaticist resources or IT support
   - Appropriate governance processes for tool approval
   - Technical infrastructure for EHR integration already in place

   Organizations without these elements may experience longer timelines.

5. **Initial Learning Curve:** First-time users require training on EVAL platform:

   - User interface familiarization
   - Understanding of configuration options
   - Best practices for form design and workflow integration
   - Testing and validation procedures

   Subsequent tool builds are faster as users gain experience.

CLAIM 02

Cross-Institutional Reach of Published Clinical Content

ADMINISTRATIVE

EVAL enables clinical content published by one institution — a professional medical society, academic medical center, or individual clinician — to reach and be formally used by clinical users at other institutions through a shared public marketplace, without bespoke integration, multi-institution contracting, or per-deployment engineering work. Traditional institution-specific EHR-native clinical tools remain siloed within their publisher's institution; a tool built at one hospital cannot be used by a clinician at a different hospital without rebuilding it there. EVAL's marketplace architecture makes published tools discoverable and usable across institutions from the moment of publication, producing measurable cross-institutional dissemination of validated clinical instruments.

KEY FIGURES

115 public evaluations measured	The scoring cohort: published evaluations that are publicly available, where reach beyond the publisher is the architectural intent. Every reach figure in this claim uses it as the denominator.
50% used at another institution	57 of the 115 have been used by an identified clinical account at another institution, with no integration work at the consuming site. 14% have reached three or more.
388 completed sessions from elsewhere	A completed session means a clinical user filled the instrument in and finished it — the strongest engagement signal recorded. 192 identified, 196 anonymous.
48 · 38 US states · countries reached	Usage from clinical users outside the publishing institution, by geo-IP on the same cohort — reach a single institution's EHR-native tool cannot produce.

Market Context

Clinical Content Silo Problem

- Clinical tools are traditionally built by, for, and within a single institution
- No mechanism exists for a tool built at one hospital to be used at a different hospital without each institution engineering a separate copy
- Validated instruments built at one site are routinely rebuilt from scratch at others
- Systematic scoping reviews have documented hundreds of unique ePRO applications independently developed across institutions (Hubel et al., 2025)

Marketplace Demand in Clinical Software

- Clinical calculator platforms (e.g., MDCalc) demonstrate strong cross-institutional demand for shared clinical tools
- No existing platform combines customer authoring, marketplace distribution, and EHR-agnostic deployment for clinical decision-support content
- EHR app marketplaces (Epic App Orchard, Cerner Code) offer partial cross-institutional distribution but only within a single EHR vendor's customer base

Professional Society Content Distribution

- Professional medical societies routinely develop validated clinical instruments for their clinical domains
- Society members work at a wide range of institutions; a society-built clinical tool must reach all of them to serve the society's mission
- Distribution of those instruments to member clinicians at different employers is a persistent operational challenge

Common Industry Limitations

Institution-Level Lock-In

- EHR-native clinical tools are built specifically for one institution's EHR configuration and cannot be shared
- Each institution starts from scratch for every clinical instrument, even when a validated version exists elsewhere

- Health IT literature characterizes this silo pattern as one of the core limitations of EHR-native development (Solomon et al., 2023)

EHR Vendor Lock-In

- A tool built for one EHR vendor cannot be used at an institution on a different EHR without rebuilding
- Cross-vendor clinical content distribution has no standard mechanism
- App-Orchard-style marketplaces are accessible only to that vendor's customers

Publication-to-Practice Gap

- Clinical instruments described in peer-reviewed literature routinely fail to reach frontline clinical practice at scale
- Researchers who develop instruments for specific studies have no practical mechanism to share those instruments as operational clinical tools after publication
- Each interested institution must rebuild a published instrument for local EHR integration

No Measurement of Reach

- Traditional EHR-embedded clinical tools do not produce cross-institutional-reach telemetry by design
- The cross-institutional reach of a clinical instrument is typically estimated through citation counts or survey data rather than directly measured use

EVAL Benefits

Public Marketplace for Clinical Content

- Marketplace-Discoverable: Tools with PUBLIC visibility are discoverable by any clinical user on https://eval.health
- Cross-Institutional by Default: Once a tool is publicly available, any clinician at any institution can access and use it
- Multi-Publisher: Professional societies, academic medical centers, and individual clinicians publish to the same marketplace
- No Integration Work: Using a marketplace tool requires no IT work at the consuming institution

Direct Measurement of Cross-Institutional Reach

- Per-Tool Telemetry: Every published tool has measurable counts of page loads, scored results, and completed sessions
- Geographic Reach Visibility: Geo-IP metadata captures the geographic distribution of use across institutions
- Account Attribution: Interactions from identified clinical accounts can be attributed to the specific account at another institution that used the tool
- Publisher Visibility: Publishers can see how their content is being used across institutions

EHR-Agnostic Delivery

- Web-Based: Tools run in any modern browser with no EHR-specific dependencies
- Single Tool, Multi-Institution: The same publicly available tool serves clinicians at every consuming institution from the same publication record
- SMART on FHIR (optional): EHR-launch integration available where institutions have configured it, without requiring EHR-specific rebuilding

Professional Society Distribution Channel

- Society-Authored Content: Multiple professional societies have published clinical instruments on the EVAL marketplace
- Cross-Domain Content: Sexual medicine, trauma-informed care, mental health screening, anticoagulation, and peripheral arterial disease management are all represented in the marketplace cohort
- Member Clinician Access: Society members at different employers access society-published tools from the same marketplace record

Evidence

(A) Observed Cross-Institutional Reach in EVAL Production Data

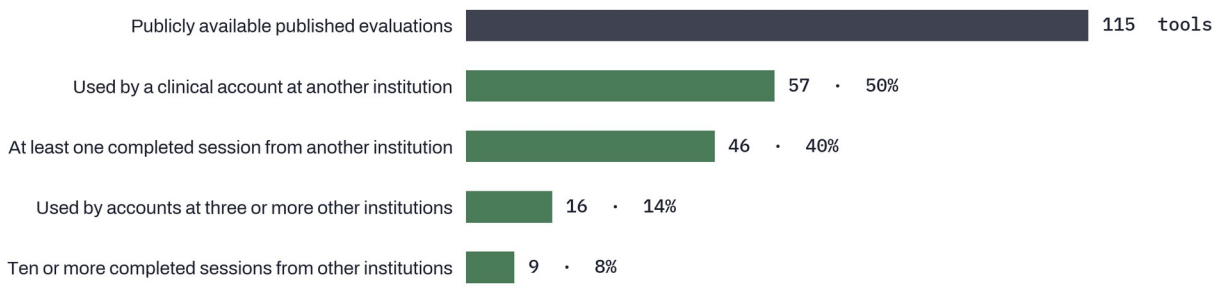
SOURCE

EVAL Health, LLC (2026). Internal production data analysis of platform operational records, extracted 2026-04-14. Analytical cohort prepared via standardized exclusion of internal test, quality assurance, and staff-

personal accounts from both the publisher and the consumer sides of every interaction event. Methodology, exclusion criteria, and reproducible queries are available on request.

KEY FINDINGS

- Scoring cohort of 115 publicly available published clinical evaluations — the primary denominator for all reach metrics, restricted to marketplace-discoverable content where cross-institutional reach is the architectural intent
- 57 of 115 (50%) have been used by at least one clinical account at another institution — defined as an identified account at a different institution than the publisher and not affiliated with EVAL Health
- 16 of 115 (14%) have been used by clinical accounts at three or more other institutions — the primary dissemination-breadth threshold, chosen because it requires engagement from multiple clinical users at different institutions rather than a single curious clinician opening a tool once
- 46 of 115 (40%) have had at least one completed session by a clinical user at another institution; 9 of 115 (8%) have had ten or more completed sessions each; a completed session represents a user who filled in the clinical tool and took the session to completion, which is the strongest engagement signal on the platform
- 388 total completed sessions from users at other institutions across the cohort (192 from identified clinical accounts, 196 from anonymous marketplace users)
- Six distinct publishing entities have achieved cross-institutional reach: the Society for Sexual Medicine of North America (SMSNA), the International Society for the Study of Women's Sexual Health (ISSWSH), the Anticoagulation Forum, Memorial Sloan Kettering Cancer Center, Oklahoma State University Center for Health Sciences, and EVAL Foundation (EVAL Health's in-house marketplace publishing tenant, led clinically by Chief Medical Officer Jennifer Glen, DNP, FNP-BC)
- Geographic reach: usage events from clinical users at other institutions originate from 48 US states and 38 countries
- Single tool with highest cross-institutional reach: SMSNA's ErecTrack, used by 22 distinct clinical accounts at other institutions with 64 completed sessions from users at other institutions
- Analysis is retrospective descriptive; no hypothesis testing or inferential statistics applied



Cross-institutional reach at four thresholds of engagement, against a denominator of 115 publicly available published evaluations (2026-04-14 snapshot).

The 388 completed sessions from users at institutions other than the publisher, by account type.

PUBLISHING ENTITIES WITH CROSS-INSTITUTIONAL REACH

SMSNA Society for Sexual Medicine of North America

ISSWSH International Society for the Study of Women's Sexual Health

Anticoagulation Forum

MSK Memorial Sloan Kettering Cancer Center

OSU CHS Oklahoma State University Center for Health Sciences

EVAL Foundation EVAL Health in-house marketplace publishing tenant

RELEVANCE

Directly substantiates the claim with EVAL's own platform data. The filtered production cohort excludes internal test, quality assurance, and staff-personal accounts on both the publisher and consumer sides, so "external reach" never counts EVAL Health staff consuming other publishers' tools; all quantitative results are reproducible from the documented analytical methodology.

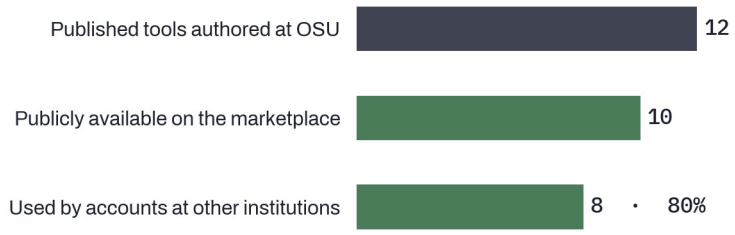
(B) Peer-Reviewed Platform Use and Cross-Institutional Adoption of the OSU PAD Portfolio

SOURCE

Rudd, K.M., Glen, J., and Michalski, T. (2025). "Developing an Innovative Clinical Decision Support App for Enhanced Peripheral Artery Disease Management." *Research and Practice in Thrombosis and Haemostasis*, Volume 9 (Supplement S1), May 2025. DOI: 10.1016/j.rpth.2025.102797.

KEY FINDING

Peer-reviewed publication documenting the development of a peripheral artery disease clinical decision support application on the EVAL platform at Oklahoma State University Center for Health Sciences. The OSU PAD portfolio comprises 12 published tools authored by Kelly M. Rudd, PharmD, of which 10 are publicly available on the marketplace (eligible for the Claim 2 reach denominator) and 2 have restricted visibility (not intended for external discovery). Of the 10 publicly available tools, 8 (80%) have been used by clinical accounts at institutions other than OSU, aggregating to 15 distinct clinical accounts at other institutions and 17 completed sessions from users at other institutions through 2026-04-14. The tools described prospectively in the peer-reviewed publication are in measurable cross-institutional use at the broader clinical community scale the publication anticipated.



The OSU peripheral artery disease portfolio, from publication to use outside the publishing institution.

RELEVANCE

Peer-reviewed documentation of EVAL platform use at an academic medical center (OSU Center for Health Sciences), co-authored by EVAL Health's clinical team per declared conflict of interest. The publication documents the development phase; the EVAL production data in Evidence (A) documents the downstream cross-institutional adoption of the same tools. The two are complementary, not redundant — the peer-reviewed literature establishes that the tools exist and describes their clinical intent; the production data establishes that they have reached clinical users at other institutions.

ADDITIONAL REFERENCED LITERATURE

(cited in Market Context and Common Industry Limitations as prior-art characterization of the field; not presented as evidence for EVAL Health's specific outcomes):

- Solomon, J., et al. (2023). "Integrating Clinical Decision Support Into Electronic Health Record Systems Using a Novel Platform (EvidencePoint)." *JMIR Formative Research*, 7:e44065. PMID: 37856193.

- Hubel, N.J., et al. (2025). "Sustainability and Time Trends in Electronic Patient-Reported Outcome Assessment in Routine Cancer Care: Systematic Scoping Review and Follow-Up Survey." *JMIR*, 27:e69398. PMID: 40280556.

Limitations and Considerations

ACKNOWLEDGED LIMITATIONS

1. **Scope Boundary:** This claim addresses cross-institutional reach of published clinical content only. Does not include:
   - Clinical validation of content appropriateness at consuming institutions
   - Clinical outcome attribution at any consuming institution
   - Patient-level effects at consuming institutions
   - Institutional adoption decision-making processes

   Reach demonstrates that clinical content is discoverable and used across institutions; it does not measure clinical effectiveness at the consuming institution.

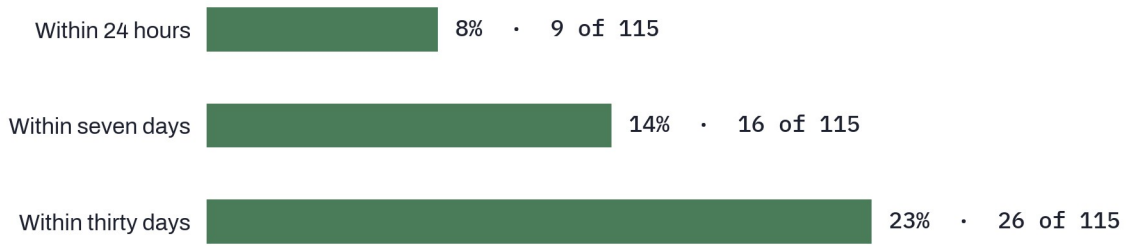
2. **Data Maturity and Analysis Type:** EVAL production data cited in Evidence (A) is a retrospective descriptive analysis of early-stage deployment volumes, not a prospective controlled trial. No hypothesis testing or inferential statistics are computed. Sample sizes are small relative to mature content platforms, consistent with Mayo Clinic Platform Solutions Studio guidance permitting internal data for early-stage solutions when sufficiently documented and transparent.

3. **Long-Tail Adoption Pattern:** 50% of publicly available tools (57 of 115) have zero cross-institutional reach as of the 2026-04-14 snapshot. This is typical of content platforms where discovery and engagement concentrate in a subset of tools, but it is reported openly. The outcome claimed is that a meaningful fraction (14% at the three-other-institutions threshold, 40% at the one-completed-session threshold) has achieved cross-institutional reach — not that every published tool has.

4. **Identified versus Anonymous Traffic:** Activity from identified clinical accounts at other institutions is the primary reach signal because it can be attributed to a specific institutional account. Anonymous marketplace traffic (3,084 page loads on the publicly available cohort) is reported as supporting context but cannot be distinguished from

automated crawler traffic without out-of-scope IP-level analysis. Completed sessions — which require filling in a multi-step clinical form and taking it to completion — are substantially harder to fabricate and are reported in both anonymous and identified forms.

5. **Discovery Speed Variance:** Time from first publication to first use by someone outside the publishing institution varies widely across tools. 9 of 115 publicly available tools (8%) reached a user at another institution within 24 hours of first publication; 16 (14%) within seven days; 26 (23%) within thirty days. The median across all tools with any external use is approximately nine months. The distribution reflects publisher-led promotion patterns: tools reached quickly are typically those whose publisher (SMSNA, ISSWSH, OSU, MSK) ran independent outreach to member clinicians or academic audiences; the long tail reflects content without publisher-led promotion, combined with EVAL Health's stealth-mode operating posture during most of its online history (no social-media, search-engine, or advertising campaigns at the platform level). Rapid discovery is achievable when it happens; the long-tail median reflects the absence of platform-level marketing rather than an architectural limitation on discoverability.



Time from first publication to first use by a clinical user outside the publishing institution. Median across tools with any external use: approximately nine months.

6. **Concentration in a Small Number of High-Reach Tools:** SMSNA's ErecTrack, the single most-used tool, accounts for roughly 17% of all completed sessions from users at other institutions in the cohort. This is significant concentration but not dominant; the distribution of cross-institutional reach across the cohort is not driven by a single tool. The analysis in Evidence (A) reports with-and-without-ErecTrack sensitivity checks to confirm that the broader distribution is robust to removing the single highest-reach tool.

EVAL

NEXT STEPS

Build the assessment your team needs and start sending it this week.

CONTACT US

hello@eval.health

Schedule a demo or a discovery call to review what your clinic needs.

THE FULL ANALYSIS

Statistical analysis plans for both claims, with methodology and exclusion criteria, are available on request.

THE PLATFORM

Learn more about the EVAL platform and browse the free community instruments at https://eval.health.