

# Life Sciences Snapshot

A Quarterly Report on  
Financing Trends

Dispatches from Orrick's  
HealthTech Summit  
Q3 2026

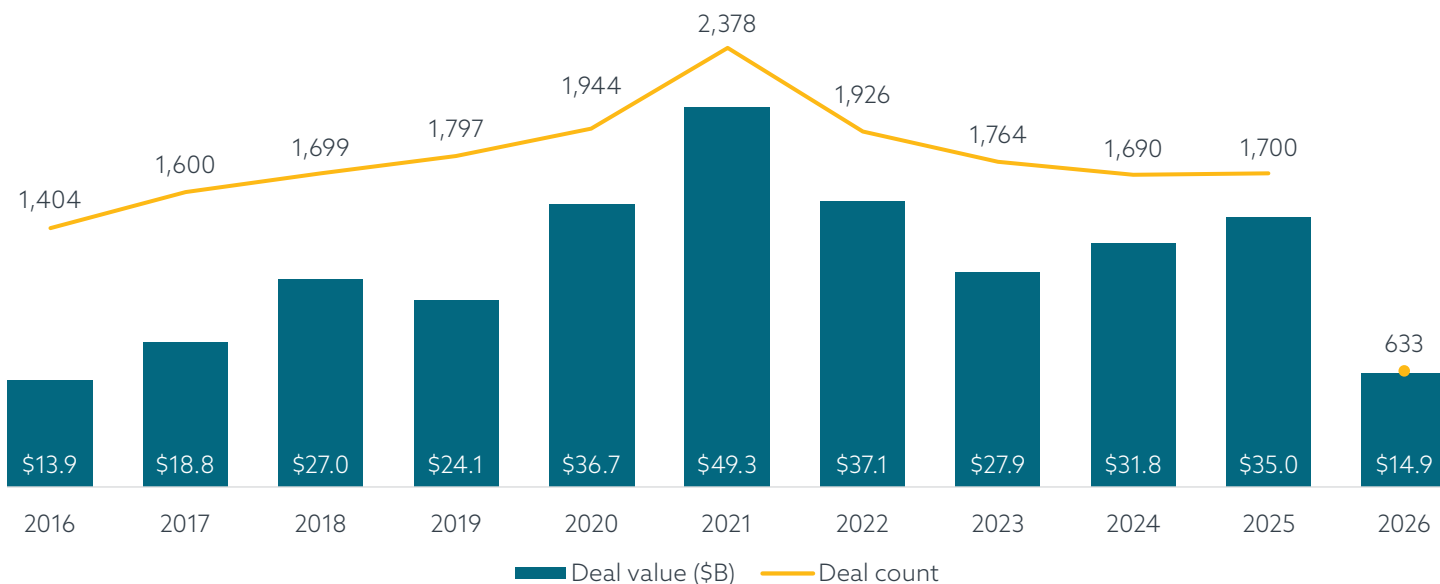


Data provided by



# Key Takeaways

## Life sciences VC deal activity



Source: PitchBook • Geography: US • As of June 5, 2026

US life sciences venture activity has shifted decisively in 2026. After four consecutive years of declining deal volumes, the sector has entered a new phase by Q2, defined by a more durable form of momentum grounded in clinical conviction and measurable value creation. Through Q2 2026, investors have deployed \$14.9 billion across 633 deals, with capital invested nearly tripling relative to reported figures in the previous edition. That acceleration reflects a market that has moved past hesitation and into execution.

The defining characteristic of this cycle is scale. Rounds exceeding \$25 million now account for nearly 90% of total capital deployed—a structural shift that has taken nearly a decade to fully materialize. At the same time, broadening deal sizes across stages signal that capital concentration is not purely a late-stage phenomenon: Early-stage companies are attracting

meaningfully larger checks than at any prior point in the decade. On exits, the picture has changed faster than most forecasters anticipated. IPO activity has gained real traction, and the value these listings have generated has surged. The IPO window, long held shut by macro uncertainty, has begun to open for companies with differentiated science and late-stage data. 2026 is shaping up to be less a boom than an inflection: the year the sector's four-year exit contraction finally reversed.

Key takeaways from this Q2 2026 Life Sciences Snapshot include:

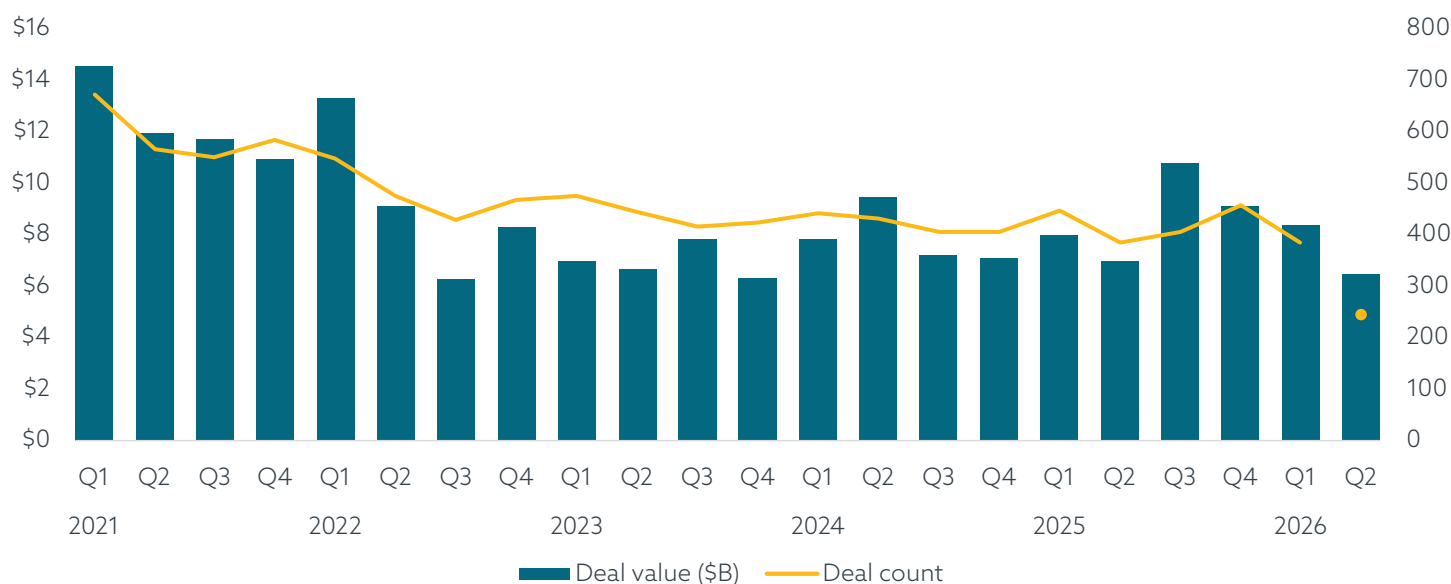
- Deal momentum has returned and broadened. YTD funding of \$14.9 billion across 633 deals reflects a 2.5x increase in deal count and near-tripling of capital deployed since figures were published in the last report, with early- and late-stage financing

each surpassing prior-year figures by more than 3x.

- Capital concentration has become structural. Rounds exceeding \$25 million now represent approximately 90% of capital deployed, up from roughly half a decade ago, with investment theses anchored in products with clear clinical utility and near-term commercialization paths.
- Exits have reached an inflection point: \$18.1 billion generated across 59 exits—more than double the previous report—driven by landmark acquisitions and 14 IPOs YTD, marking the first meaningful reversal of exit volume declines since 2021.

# Market Analysis

## Life sciences VC deal activity by quarter



Source: PitchBook • Geography: US • As of June 5, 2026

US life sciences venture funding has accelerated meaningfully since the previous report published during Q1. Deal counts have grown 2.5x while investors nearly tripled the amount of capital deployed, resulting in \$14.9 billion raised across 633 deals YTD. However, such positive signals warrant a caveat. As stated in [Orrick's prior report](#), Q1 was one of the slowest quarters observed over the past five years, so such robust momentum in activity through Q2 to-date is a function of a low base rather than pure organic momentum. Regardless, the momentum has been undeniable and can be explained by a shift in investor sentiment and, consequently, risk-taking calculus. The IPO window has reopened; AI's mega-IPO announcements from the likes of OpenAI, Anthropic, and SpaceX are rejuvenating optimism around liquidity timelines, and the

S&P Biotech Index (XBI) trailing 12-month price has rallied over 50%.<sup>1</sup> Thus, the latest signals allude to a more positive outlook for the remainder of 2026.

Much of the momentum through Q2 has occurred at the early- and late-stages of financing, where capital invested has more than tripled since figures reported in Orrick's previous life sciences snapshot. One such notable transaction is cardiovascular and orthopedic medical devices developer MiRus's \$1.5 billion late-stage transaction in May. Billion-dollar transactions are rare—only four deals greater than \$1 billion have closed over the past decade—but when investors with the deepest pockets feel bullish about boundary-pushing innovation, it invariably spills over into the broader ecosystem. Anti-aging tech developer Altos Labs' historic \$3

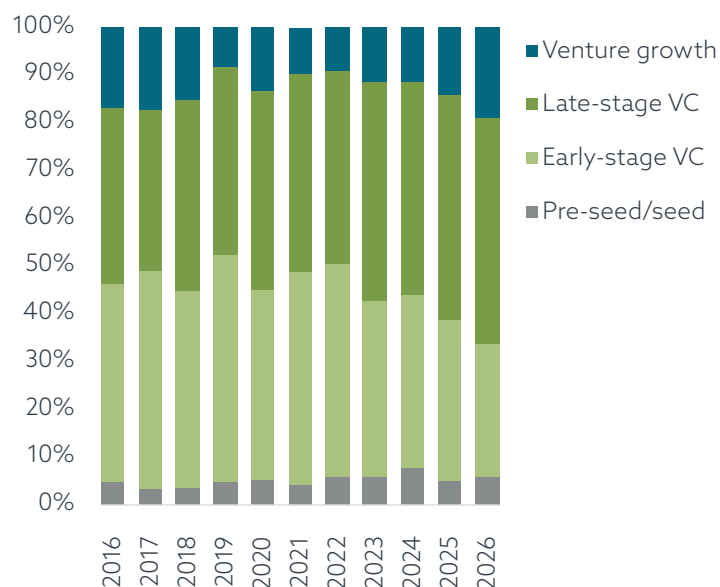
billion deal in 2022 came at a time when cost of capital was still cheap and fund managers were eager to deploy into next-generation, long development-horizon technologies.

Today's life sciences companies no longer benefit from a lower cost of capital and operate in a more complex regulatory environment, with proposed National Institutes of Health (NIH) budget cuts of approximately 40% in fiscal year 2026 raising longer-term questions about the basic science pipeline that has historically seeded early-stage company formation.<sup>2</sup> Against that backdrop, investment theses remain grounded in products that solve immediate, demonstrable clinical problems—such as MiRus's proprietary rhenium alloy heart valve device.

1: "State Street SPDR S&P Biotech ETF," State Street Investment Management, June 15, 2026.

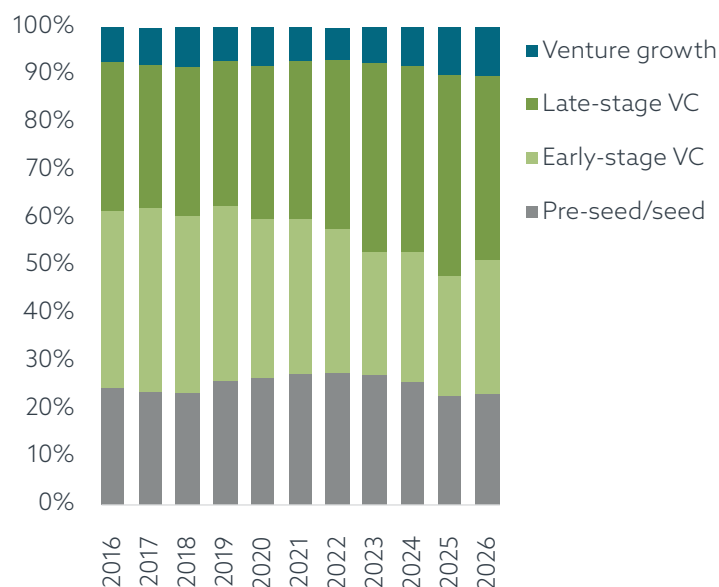
2: "White House Proposes Deep Cuts to HHS in FY2026 Budget, Reducing NIH to 8 Centers," AJMC, Giuliana Grossi, June 4, 2025.

## Share of life sciences VC deal value by stage



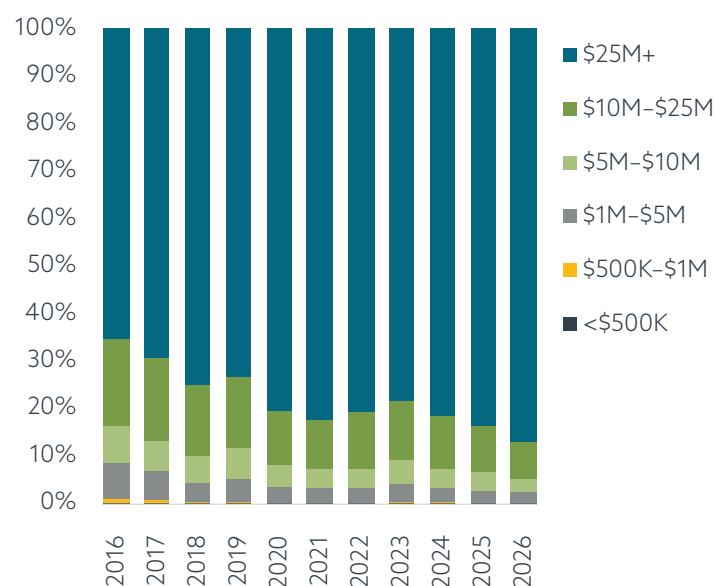
Source: PitchBook • Geography: US • As of June 5, 2026

## Share of life sciences VC deal count by stage



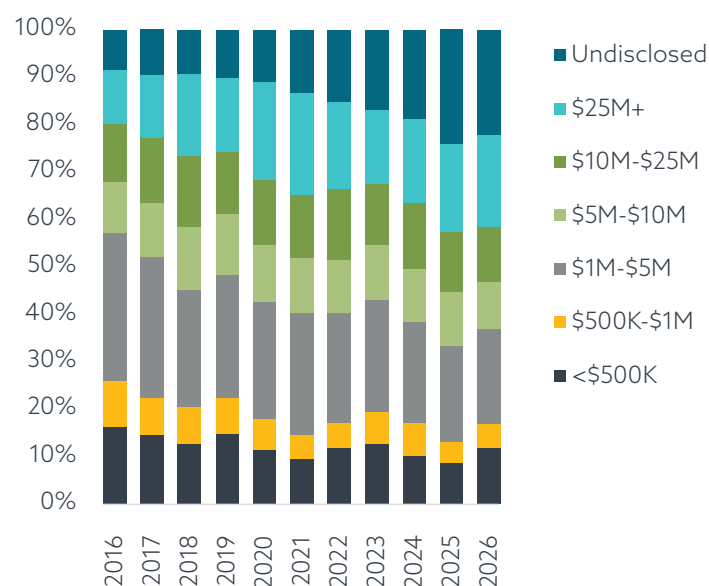
Source: PitchBook • Geography: US • As of June 5, 2026

## Share of life sciences VC deal value by size bucket



Source: PitchBook • Geography: US • As of June 5, 2026

## Share of life sciences VC deal count by size bucket



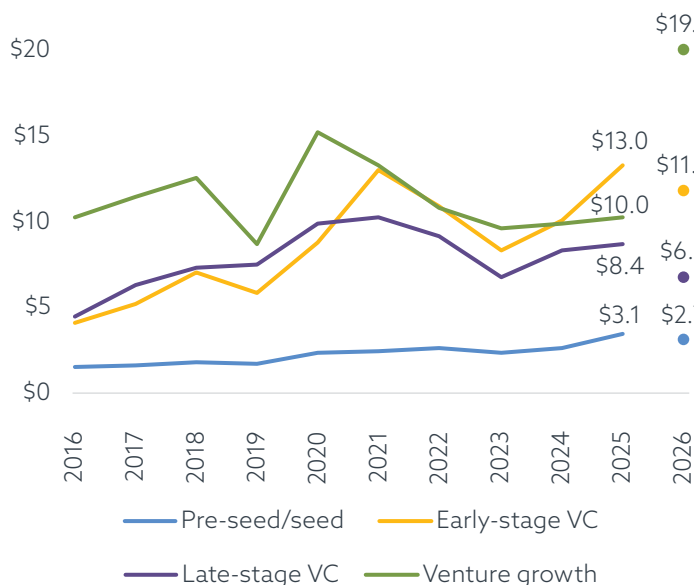
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Those billion-dollar outliers are exceptional, but they reflect a broader structural shift in how capital flows into the sector. A decade ago, nearly half of all capital invested in US life sciences companies came from transactions exceeding \$25 million; that figure is now closer to 90%, and three of the four billion-dollar transactions of the past decade closed within the past four years.

With scale comes volume. The median deal size for venture-growth transactions has reached a decade high of \$19.8 million YTD, compared to \$10 million in 2025, and early-stage companies are not being left behind: Average deal sizes at that stage have grown from \$12.4 million to \$39 million over the same period. These dynamics are also accelerating M&A-driven

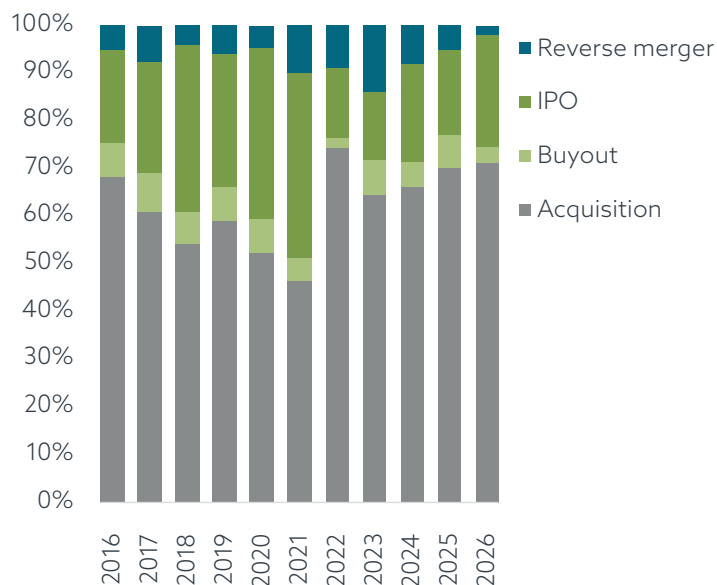
exit outcomes. With NIH-funded nondilutive capital under pressure, early-stage companies are increasingly seeking partnership capital from larger pharmaceutical players, adding a further layer of acquisition and co-development deal flow to an already active market.

## Median life sciences VC deal value (\$M) by stage



Source: PitchBook • Geography: US • As of June 5, 2026

## Share of life sciences VC exit count by type

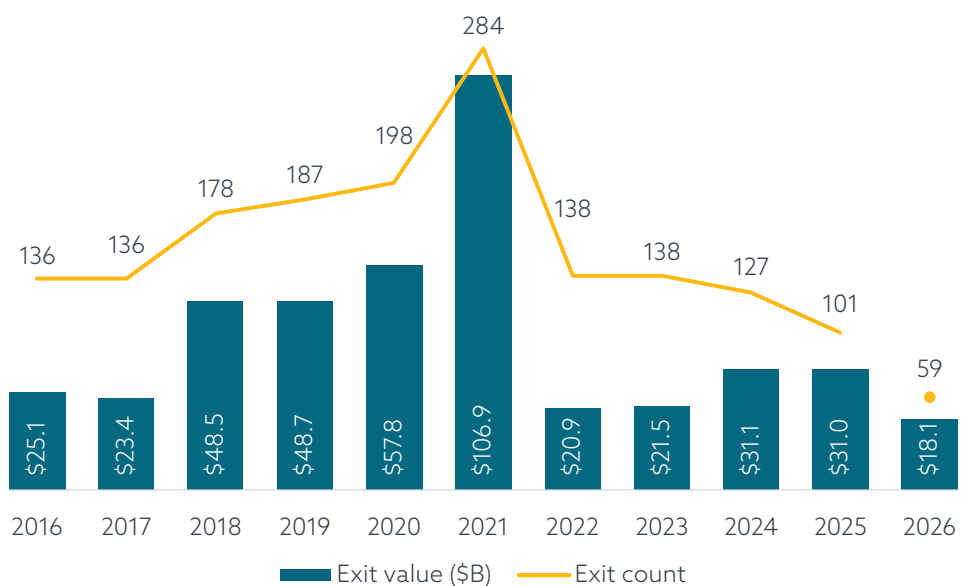


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The exit environment is where the recovery story is most visible. The \$18.1 billion in value generated across 59 exits YTD is more than double reported figures in the previous report, driven by accelerated acquisition and IPO activity in equal measure. On the acquisition side, Gilead's \$6.1 billion purchase of Arcellx and Boston Scientific's announced \$14.7 billion acquisition of Penumbra are representative of the discipline now defining strategic M&A: Acquirers are concentrating on commercial-stage and late-phase assets where revenue visibility is real. For comparison, a mere few months ago, the trajectory of life sciences exit momentum was uncertain, with the market consequences of mega-IPO announcements—including OpenAI, Anthropic, and SpaceX—yet to materialize.

It is now evident that AI-driven market fervor, compounded by back-to-back announcements of some of history's largest public floats, has become a tide lifting all boats and has effectively reopened the IPO window. Parabilis Medicines' June 2026 Nasdaq listing—the largest

## Life sciences VC exit activity



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US life sciences IPO in history, raising \$770.5 million—is one such signal. In April, Kailera Therapeutics raised \$718.8 million in what was the second-largest life sciences IPO in US history, while Alamar Biosciences closed an upsized April offering at \$219.9 million—both raises emblematic of a market that has regained its appetite for differentiated, late-stage life science

solutions. In total, 14 life sciences IPOs have closed YTD, against 18 in all of 2025. Full-year 2026 is unlikely to mark a return to pre-pandemic exit volumes—years in which 50 or more IPOs per year were routine—but it represents something arguably more significant: the inflection point that has finally broken a four-year streak of exit volume declines.

# Roundtable

## Dispatches from Orrick's HealthTech Summit

On June 3, 2026 Orrick hosted a panel on **"Longevity and AgeTech: Living Longer with a Healthy Brain"** at the Orrick HealthTech Summit in New York City. This annual event, held each year during New York Tech Week and convened this year in collaboration with the AgeTech Collaborative from AARP, included healthtech and digital health founders and investors who engaged in an afternoon of discussion and networking at the Orrick offices in Manhattan.

In follow-up, each panelist was asked to respond to some key questions regarding their takeaways from the panel discussion. The panel was moderated by Jeremy Sherer, a partner in Orrick's Life Sciences & HealthTech Practice, and included as panelists Kathryn Weinmann, Principal at FirstMark; Jacky Susskind, Chief of Staff to the CEO at Inspiren; David Bates, CEO of Linus Health; and Amelia Hay, VP, Startup Programming & Investments at AgeTech Collaborative from AARP. Below are the panelists' responses.

To receive regular updates from Orrick on key developments in life sciences & healthtech, and future event invitations, subscribe to the Orrick email list [here](#). If you would like to be connected with any of the people included in the roundtable below, email [amcquillen@orrick.com](mailto:amcquillen@orrick.com).

### What problem or problems is your company or organization working to solve by promoting longevity through healthtech?

**Amelia Hay:** At the AgeTech Collaborative from AARP, we're focused on helping people live longer, healthier, and more independent lives by supporting innovation that addresses the real needs of older adults and caregivers. The challenge is not a lack of innovation. It's that many promising solutions struggle to reach the people who would benefit most. We work to bridge that gap by connecting startups, enterprises,

researchers, healthcare organizations, investors, and older adults themselves to ensure technologies are designed, validated, and deployed in ways that improve health outcomes, reduce caregiver burden, and support aging on one's own terms.

**Jacky Susskind:** For Inspiren, longevity is not simply about adding years to someone's life. It is about extending healthspan—the years a person can live safely, independently and with dignity. We are focused on a gap that has opened up across

### Panel

#### Contributors



**Kathryn Weinmann**  
Principal, FirstMark



**Jacky Susskind**  
Chief of Staff to the  
CEO at Inspiren



**David Bates**  
CEO, Linus Health



**Amelia Hay**  
VP, Startup  
Programming &  
Investments at  
AgeTech Collaborative  
from AARP



#### Moderator

**Jeremy Sherer**  
Partner, FDA &  
Healthcare Regulatory,  
Life Sciences &  
HealthTech



senior care: the aging population has changed faster than the system built to care for it. Assisted living and memory care homes are now among the most clinically complex care settings in the country: the average resident lives with more than 14 chronic conditions, and over 40% are living with dementia. Yet care teams are still asked to manage that complexity with only periodic, point-in-time visibility into how residents are actually doing.

The consequences are real: falls, the leading cause of lost independence, mostly go unwitnessed; avoidable hospitalizations accelerate decline and often force a permanent move to a higher level of care. Each is a moment where healthspan gets cut short – usually because a subtle change appeared between assessments and no one was positioned to catch it. And each carries a cost, not only to the resident's health and independence but to the families who bear the financial weight of every avoidable decline.

So promoting longevity, for us, is concrete: catching the early sign before it becomes a fall, the fall before it becomes a hospitalization, and the hospitalization before it becomes a permanent loss of independence. We do that by giving care teams continuous, real-time context on each resident so they can intervene earlier. We are not replacing human judgment; instead, we are pointing it where it matters most.

That is what extending healthspan really means: not just more time, but more of the time that matters – and building the infrastructure that lets the people who care for our seniors deliver it.

**David Bates:** Longevity is not just living longer—it is living healthier for longer, and cognitive health is fundamental to maintaining

independence, agency and connection as we age. The problem is that brain health remains too reactive, fragmented and difficult to access. People are often evaluated only after changes have become obvious, and even then, assessment can be disconnected from practical next steps. At Linus Health, our focus is twofold: helping healthcare providers identify cognitive changes earlier and translate those insights into appropriate, longitudinal care, while also giving individuals understandable information and practical guidance so they can take greater agency over their brain health and act on the factors that may shape its trajectory. The broader opportunity is to make high-quality brain health assessment, risk reduction and ongoing support a routine part of healthy aging. Technology is valuable insofar as it gives clinicians and individuals clearer information, expands access to care and turns insight into action.

**Kathryn Weinmann:** One of the biggest problems seniors face in healthcare is the system itself. Despite strong payer coverage as a demographic, many seniors face challenges understanding their benefits, finding the right provider, and getting the support they need to ensure timely, quality care. We are excited to back companies easing the coordination and navigation burdens that strengthen seniors' ability to age in place and proactively address their health needs.

**Older adults and their caregivers can be skeptical of new technology. What design principles or engagement strategies have you seen successfully build trust and drive adoption? Is there anything counterintuitive you've found, from a user experience perspective, as far as what has (and hasn't) been successful?**

**Amelia Hay:** The companies that see the strongest adoption tend to start with empathy rather than technology. Older adults don't want to learn a new device for the sake of learning a new device. They want solutions that solve a meaningful problem with minimal friction. Simplicity, transparency, accessibility, and clear value are critical. One somewhat counterintuitive lesson is that designing specifically for older adults often results in a better experience for users across all age groups. Features like intuitive navigation, larger touch targets, straightforward onboarding, and human support improve usability across generations. We also see better outcomes when older adults are engaged as co-creators throughout the design process, rather than being treated as an end-user group to test at the very end.

**Jacky Susskind:** They are skeptical for good reason. There is a lot of noise in the industry, and much of what is out there was not designed to meet the needs of the people using it every day: care teams. Building for that end user is what determines whether a tool succeeds or fails – it is the design principle that matters most. Anything that adds a step to the care team's day falls out of use the moment a shift gets busy. What works is technology that embeds into the clinical workflows a community already runs, so that it becomes ingrained in how the work gets done. That also means designing for the realities of the workforce—turnover in senior care is high, so the technology has to be intuitive enough that a new caregiver can use it on their first shift, without weeks of training.

Designing for the user also changes what "good" looks like. Take alerts: the instinct, when care teams are overwhelmed, is to send fewer – but that is not necessarily the solution. What we discovered is that they did not need fewer alerts, they needed

ones that would provide context to inform action. So the goal became precision over volume. At Inspiren, that feedback is what led us to pair alerts with a privacy-protected in-app view which a caregiver can open the instant an alert goes off – so the alert arrives with the context to know what it is and how urgently to respond, not just that something happened. That kind of refinement only comes from staying close to the people using the technology and improving it in response to what we learn. Build around the realities of the person doing the work, and adoption follows.

**David Bates:** Trust is built less by making technology appear futuristic and more by making it understandable, respectful and useful. We focus on plain language, a clear explanation of why someone is being asked to use the technology, and an equally clear next step once they have used it. Clinician endorsement and access to human help can matter as much as the interface itself, as can giving an individual the option to involve a trusted family member without taking away that individual's autonomy.

One counterintuitive lesson is that older adults do not necessarily need less sophisticated technology; they need fewer unexplained choices and fewer opportunities to feel they have made a mistake. Another is that eliminating all friction is not always the right objective. A brief human introduction, confirmation of how information will be used, and an opportunity to discuss the results may add a little friction while substantially increasing trust. What tends not to work is ageist design, excessive gamification, complicated account creation, repeated logins, or a tool that produces a score without its meaning and an understandable next step.

**Kathryn Weinmann:** I often say that some of the best technology for seniors is not branded as such – Uber has done more for senior independence than most people realize. More broadly, technology that serves seniors needs to meet them where they are. Phone calls and texts can be far more effective than another app. What's particularly interesting is that this aligns with trends we are seeing for Gen Z consumers as well. People of all ages have a lot of app fatigue.

**Longevity and AgeTech are regulated by myriad agencies, including CMS, FTC, DOJ, state professional boards and health facility regulators. But there's a common thread there in seeking to keep seniors healthy and safe. What regulatory changes would you like to see that would most accelerate innovation, while still ensuring that we keep our seniors safe?**

**Jacky Susskind:** The most consequential change would be a reimbursement pathway tied to demonstrated outcomes. Assisted living and memory care are largely private-pay, which means operators fund technology out of their own pocket, with no insurer or payer to share the cost. That creates a backwards incentive: they bear the full cost of technology that prevents an emergency room visit or hospitalization, while the savings from that avoided care flow to the rest of the healthcare system. A Medicare or Medicare Advantage pathway for technologies that demonstrably reduce hospitalizations, emergency visits, or other adverse events would fix that. And because it would pay only for proven results, it keeps the focus exactly where it belongs—on whether seniors are actually safer and their health is improving. Reward what keeps residents safe and healthy, and you accelerate the innovation that gets them there.

**David Bates:** The most useful shift would be to reward evidence-based prevention and earlier action rather than waiting until a person has a definitive diagnosis or experiences a crisis. CMS has made meaningful progress by covering detailed cognitive assessment and care planning and, in Traditional Medicare, through the GUIDE model's support for coordinated dementia care and caregivers. In practice, however, we continue to see substantial inconsistency from plan to plan—particularly in Medicare Advantage—and concern among some plans that identifying cognitive impairment will simply expose them to the cost of newer disease-modifying therapies. That concern conflates identification with treatment eligibility and overlooks the value of finding disease while meaningful intervention is still possible. Allowing near-term cost concerns to discourage assessment also risks creating precisely the wrong incentive: people may not be identified until they have progressed beyond the early stage in which current disease-modifying therapies are indicated.

The emerging longer-term evidence further challenges the assumption that earlier identification is simply a gateway to additional expense. In reported four-year data from the Clarity AD long-term extension, 81% of patients who stayed on Leqembi remained in early Alzheimer's disease—MCI due to AD or mild AD dementia—rather than progressing to moderate or severe disease. By comparison, 37.4% of patients in a matched ADNI observational cohort progressed to moderate or severe disease, versus 18.6% in the Leqembi cohort.



Regulators should also harmonize definitions of wellness, screening, assessment, clinical decision support and regulated medical-device functions, with requirements proportionate to the clinical risk involved. That should be accompanied by consistent expectations for evidence, privacy, transparency, human oversight, bias testing and ongoing performance monitoring, as well as greater portability of professional licensure for remote care. Seniors are safer when the rules are clear and strong enough to exclude bad actors—not when responsible innovators face a materially different framework in every state or agency.

**Kathryn Weinmann:** I'd like to see more transparency and outcomes tracking so we can rethink payment models and focus on what works while cutting down on fraud, waste, and abuse.

**What are investors looking for in this space? What's unique or different about AgeTech as an area for investment, both compared to the rest of the longevity discussion and more broadly?**

**Amelia Hay:** Investors look beyond the demographic story and focus on execution, validation, and measurable outcomes to ensure a high rate of return on their investments. The longevity economy represents a significant market opportunity, but investors want to see evidence that a solution is solving a real problem, gaining traction with customers, and delivering clear value. Strong go-to-market strategies, scalable business models, and proof points—whether clinical evidence, health outcomes, or ROI—have become essential differentiators. AgeTech is unique

in that it sits at the intersection of healthcare, consumer technology, financial resilience, housing, mobility, and caregiving. In addition, the go-to-market messaging is complex, because the buyer may be a caregiver or provider on behalf of the user – the older adult. The most compelling companies are often those that can demonstrate value across multiple stakeholders, not just older adults and caregivers, but also caregivers, providers, payers, and senior living organizations. This list goes on and on.

**David Bates:** Demographics alone are not an investment thesis. Investors want evidence that a company can reach its users, earn their trust, fit into a real workflow, produce a measurable outcome and capture enough of the value it creates to build a durable business. They are increasingly looking beyond an impressive technology or a large theoretical market and asking about distribution, implementation, reimbursement, clinical evidence, retention, unit economics and the path from pilot to scaled deployment.

AgeTech is distinctive because the user, buyer, payer and beneficiary are frequently different people or organizations. The older adult, an adult child, a health plan, a provider and a senior living operator may all have a role in the same purchasing decision. That can make adoption slower, but it also means trust, evidence, distribution and interoperability can become meaningful competitive advantages. Compared with the broader longevity market, AgeTech is often less about aspirational optimization and more about preserving function, independence and safety under real-world conditions. The strongest businesses tend to begin with a

focused, high-value use case while having the potential to become part of a broader care infrastructure.

**Kathryn Weinmann:** The demographic tailwinds are overwhelming, and senior needs often impact at least two generations: those who need care and their adult children who coordinate it. We are looking for platforms that can serve multiple stakeholders well and focus on habits supporting longevity that make life feel simpler, not more complex.

**Does the fact that many AgeTech solutions geared towards aging-in-place aren't covered by traditional health insurance create challenges for you? Or are you finding that DTC and other pathways are viable, even if outside of the traditional healthcare spending paradigm?**

**Jacky Susskind:** It has not held us back, but it does raise the bar. In most of digital health, there is a third-party payer absorbing some of the cost. In our space there is not – we sell directly to senior living operators, and engage their capital partners where it makes sense. Margins in senior living are thin, so every dollar matters, which means the ROI has to land directly in the operator's P&L. That is a much higher bar than most of digital health has to clear, and it is why most digital health playbooks do not work here. What makes that bar even higher is that the outcomes are real and binary in a way much of digital health is not. A fall is prevented or it is not. A resident is hospitalized or they are not. There is no engagement score or satisfaction metric to anchor on to keep a customer feeling good about the spend. That is a brutal

reality when your product is not delivering – but it is an enormous advantage when it is, because the proof is unambiguous. Value that shows up in a customer's own results, in numbers they can see, does not disappear when a billing rule changes.

**David Bates:** It creates a real challenge, particularly for affordability and equitable access. The difficulty is not only that a service may be uncovered; it is that the value often accrues across several parties. A solution may preserve independence for an older adult, reduce burden for the family and prevent avoidable downstream utilization, while no single payer captures all of those benefits. Direct-to-consumer models can be viable when the need is easy to understand, pricing is transparent, clinical credibility is strong, and people receive meaningful guidance rather than an isolated result. Importantly, DTC describes the patient-access and engagement model, not necessarily the payment model. Ro and Midi illustrate two versions of that approach: Ro combines a consumer-facing experience with cash-pay options and insurance navigation in weight management, while Midi allows patients to access specialty care directly, bills many commercial insurance plans, and also offers a self-pay option.

Direct pay can therefore serve as an access strategy and a learning engine—expanding choice and helping companies understand what people truly value—rather than representing an abandonment of reimbursement. I am particularly enthusiastic about HSAs and FSAs, which give consumers tax-advantaged purchasing power and greater agency over eligible healthcare spending. Direct primary care offers another important pathway. Under the One

Big Beautiful Bill Act, beginning in 2026, qualifying direct primary care arrangements no longer disqualify otherwise eligible individuals from contributing to an HSA, and periodic DPC fees can be paid from HSA funds tax-free. This is an important policy recognition that consumer-directed care can complement insurance rather than simply operate outside it.

Over time, I expect the most resilient models to be hybrid: self-pay, family- or employer-supported, HSA/FSA-funded, and insurance-based access, combined with provider, health-plan, and value-based arrangements where measurable clinical and economic value can be demonstrated. We should continue working to move traditional coverage further upstream, but entrepreneurs should not assume that fee-for-service insurance is the only path to scale.

**Kathryn Weinmann:** Consumers of all ages have demonstrated a surprisingly high willingness to pay for products that meaningfully impact their quality of life. What's more, we've seen how services with cash pay often have a better consumer experience, driving many to circumvent the system entirely when they can.

**The fragmented nature of senior care facilities, whether assisted living, memory care, skilled nursing or otherwise, can be a massive barrier to technology reaching its full potential. How important is interoperability among point solutions in and around the communities where seniors live and receive their care?**

**Amelia Hay:** Interoperability is essential. Older adults often interact with multiple care settings, service providers, family caregivers, and technologies simultaneously. When systems don't communicate with one another, information becomes

fragmented, workflows become inefficient, and the burden often falls back on the individual or caregiver. Technology delivers the greatest value when it integrates into existing care ecosystems and enables more coordinated, person-centered experiences. The future isn't one platform that does everything. It's a connected ecosystem where solutions can securely share information and work together to support better outcomes. We encourage innovation for single point solutions responding to an acute issue or specific focus in order to fine-tune products. However, we are also seeking technology that can aggregate or integrate multiple solutions for the older adult, whether in their home or in a facility setting.

**Jacky Susskind:** Interoperability is not simply a desirable feature. It is a prerequisite for technology, and especially AI, to reach its potential in senior care. Many operators manage a patchwork of systems spanning electronic health records, emergency call, medication management, staffing, family communication and more. When those systems do not communicate, the caregiver becomes the integration layer. A person has to mentally connect an emergency call, a change in behavior, a missed medication and a resident's clinical history. That is an enormous burden, and it is how important signals get missed.

AI gets exponentially more useful the more context it has. An ambient signal or sensor event becomes clinically meaningful when it can be connected to the right resident, their baseline behavior, care plan and longitudinal record. Without interoperability, technology may identify that something happened. With interoperability, it can help a care team understand why it matters and what to do next.

**David Bates:** Interoperability is essential, but it needs to mean more than checking a box that says a product has an API. In a fragmented care environment, the useful unit of interoperability is the workflow: does the right information reach the primary care clinician, nurse, specialist, care manager, community staff member or family caregiver at the right time, with appropriate consent, and does someone know what action to take? One more dashboard is not interoperability; it is another burden. Solutions should support standards-based data exchange, reliable identity and consent management, closed-loop referrals and a deliberately limited set of information that is genuinely actionable. At the same time, founders should not wait for a perfect, universal platform before delivering value. A pragmatic approach is to begin with one high-value connection and one clearly defined workflow, demonstrate that it improves care, and then build toward a more composable ecosystem.

**Kathryn Weinmann:** Interoperability is critical. Care can only be as comprehensive as the information available.

**What advice would you give to earlier-stage entrepreneurs about the AgeTech space, and working with its many incumbent stakeholders?**

AMELIA HAY: Spend time with older adults, caregivers, and frontline professionals before building and throughout the entire product journey. Too many companies make assumptions about what people need rather than validating those needs directly. It's also important to recognize that adoption cycles can be longer in healthcare and aging services than in other sectors, so patience, fortitude, and partnership matter. The most successful founders

approach the space with humility, curiosity, and a willingness to collaborate with existing stakeholders. If you focus on solving a genuine problem, demonstrate measurable value, and build trust with the people you're serving, you'll be in a much stronger position to scale.

**Jacky Susskind:** In AgeTech, financial impact has to be part of the core value proposition, not a talking point layered on top. The stakeholders you are selling to are running businesses on thin margins, and they have heard every mission-driven pitch there is. The mission gets you in the room, but a durable sales engine requires a value proposition rooted in P&L impact. And the strongest impact works on both sides of the ledger: not just lower costs and fewer hospitalizations, but a better experience for residents and families, which is what fills buildings. Once you deliver on that impact, you win everything after it – the renewal and the expansion. Early-stage entrepreneurs who cannot draw a straight line from their product to the customer's financial results struggle here, no matter how good the mission story is.

The second piece of advice is not to mistake caution for resistance. The stakeholders in this space – operators, caregivers, families—are often slow and deliberate about adopting new technology, and it is easy to read that as being anti-innovation. It is not. These are people responsible for others' lives, and that carefulness is exactly what the responsibility demands. Trust has to be earned on their terms and their timeline. But once it is, and once it is backed by real outcomes, it becomes one of the most durable advantages a company can build – because the same caution that made it hard to earn makes it just as hard for the next entrant to displace.

**David Bates:** Respect incumbent stakeholders without becoming captive to their complexity. Before building, map every participant in the system: who uses the product, who benefits, who pays, who approves it, who supports implementation and who bears risk when something goes wrong. Choose a narrow and painful workflow, connect it to a measurable outcome, and structure any pilot with a budget owner, implementation plan and conversion criteria from the beginning. Otherwise, it is very easy to become trapped in perpetual pilot programs that generate enthusiasm but not adoption.

In AgeTech, evidence, accessibility, security, training and customer success are not supporting functions; they are part of the product. Entrepreneurs should co-design with older adults and caregivers, avoid treating aging as a single persona and remember that distribution is frequently harder than the technology itself. The companies that endure will generally be those that make incumbent organizations more effective while keeping the older adult's autonomy and outcomes at the center.

**Kathryn Weinmann:** Many founders get scared off from building for seniors because conventional wisdom in consumer tech says it's too hard. But it's important to remember that most categories worth building in have had a lot of failures. The best founders will study history enough to understand what to learn from and what has changed. The issue has never been the demographic - there are \$10B+ opportunities in this space for the founders brave enough to build in a patient-first way.

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