The $1B Growth Engine Health Systems Are Missing

Evidence-based, human-centered patient activation

2026 REPORT

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Executive Summary

Health systems are sitting on their largest growth opportunity, and it isn't new patient acquisition. It's the patients already in their system who never complete recommended care.

Today, 55% of clinically-appropriate care never reaches completion. Eligible patients miss screenings, delay referrals, and drop off before treatment. **For a median U.S. nonprofit health system, that gap represents roughly $1 billion dollars in unrealized revenue.** These aren't edge cases. They're routine breakdowns happening across every high-value service line.

Three forces drive this problem:

1. **Clinical reality:** care journeys fracture at multiple points, from missed lung cancer screenings to delayed cardiac interventions.
2. **Human psychology:** patients carry fears, cost confusion, symptom normalization, and interpret provider silence as everything is fine. These barriers are real, powerful, and invisible inside current workflows.
3. **Activation gap:** clinical eligibility data lives in one place, behavioral signals in another, and patient-reported concerns are rarely collected. No single function owns whether a patient actually completes care.

Closing this $1 billion dollar growth gap requires a new approach, one rooted in evidence-based, human-centered patient activation.

This means building unified patient phenotypes that go beyond demographics to synthesize clinical signals, behavioral patterns, and self-reported barriers. It means coordinating activation across the full care journey: priming patients before the visit, equipping care teams with actionable insight during the encounter, and ensuring structured follow-up. And it means forging a strategic partnership between marketing and clinical teams around a shared goal: helping patients take the next step.

Digital Health Strategies is a pioneer in patient activation, partnering with over 300 hospitals over the past decade across more than a dozen high-value use cases. This report captures what it takes to convert care gaps into measurable, profitable growth.

Ben Texter
Co-CEO + Co-Founder
Digital Health Strategies

John Simpson
Co-CEO + Co-Founder
Digital Health Strategies

The Problem

Health System Growth is Breaking Down Before Treatment Ever Happens

The human barriers and activation gaps behind missed care

Your next $1B isn't new patients, it's untreated ones.

Your biggest growth opportunity isn't acquiring new patients. It's activating the ones you already have.

Health systems have long pursued growth through M&A, payer contracts, and network expansion. Yet a major growth opportunity is hiding in plain sight: activating existing patients. Roughly 55% of patients do not follow through on recommended care, leaving hundreds of thousands of missed encounters across high-value service lines.

For the median U.S. not-for-profit health system, this unrealized care represents over $1B in revenue within the current patient base. The opportunity is not more net-new patient acquisition, but activating existing patients who already trust the system and have been recommended for care.

55% — **55% of recommended care never reaches patients.** The RAND Corporation found this in 2003. Twenty years later, nothing has changed.[1]

$1B — **~$1 billion in unrealized revenue** is sitting in the EHR of the median U.S. health system.[2]

$270M — **~$270 million in contribution margin.** More than 24x the median system's operating income.[3]

Activating existing patients is the most efficient path to growth

80% — Activating an existing patient costs 80% less than acquiring a new one.[5]

14× — Existing patients are 14X more likely to convert.[6]

The Median U.S. Not-for-Profit Health System[4]

- 825 licensed beds
- $2.2 billion in net patient revenue
- 308,000 unique patients seen annually, drawn from a primary service area of ~500,000 adults, with 750K to 1.1 million total unique records in the EHR
- Operating margin: 0.5%, producing roughly $11 million in operating income
- Payer mix: 45% Medicare, 20% Medicaid, 30% commercial, 5% self-pay

Three forces standing in the way of patient activation.

Capturing growth requires overcoming the forces that prevent patients from reaching treatment.

1 The Clinical Reality

Most recommended care never happens
Care gaps of 50–80% are common across high value service lines.

The care journey breaks down at multiple points
Screenings are never recommended, referrals are never made, and follow-up never happens.

2 Human Psychology

Human barriers delay or prevent care
Patients often normalize symptoms, misunderstand treatment, defer to provider silence, or carry fears they rarely raise.

These barriers are invisible to health systems
These are consumer barriers, not clinical failures, and they often prevent patients from acting.

3 The Activation Gap

Activation requires complete patient intelligence
Effective engagement depends on accurately identifying patients using clinical, behavioral, and consumer data to understand who they are and what will drive action.

Activation requires orchestration across the care journey
Without coordinated engagement, patients fall through gaps instead of being guided, nurtured, and re-engaged across the care journey.

The opportunity isn't identifying clinically-eligible patients. It's fixing where they drop off, addressing their human barriers, and building the activation layer to bring them to treatment.

Clinically-eligible patients are in the system, but don't reach treatment.

LDCT Lung Screening

Breaks at ***the start.*** The journey never begins.

Eligible → PCP recommends → ✗ Never screened

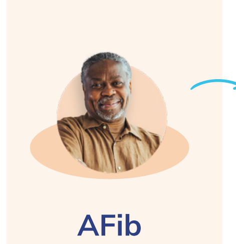
Up to 80% of eligible patients have never been screened,[7] because no provider initiated the conversation or because the patient didn't follow through. Patients who quit smoking years ago don't identify as at-risk, and many providers still operate on pre-2021 eligibility criteria. The journey never starts. For the minority who do screen, there's no recall system to bring them back, so even the most compliant patients silently lapse.

Aortic Stenosis

Breaks at ***the referral.*** The managing physician holds the patient.

Moderate AS documented → Managed by cardiologist → ✗ Never referred to structural heart → ✗ No to TAVR/SAVR

At least 40% of patients who meet criteria for valve replacement never receive it.[8] Disease progression is silent: patients reduce activity gradually without recognizing the change, and when the cardiologist doesn't raise a referral, patients interpret that silence as reassurance. In short visits crowded with competing chronic conditions, the referral often gets deferred. Without a workflow prompt to surface it, it never happens.



AFib

Breaks at ***the handoffs.*** Multiple transitions, multiple points of failure.

Diagnosed at PCP → Managed on rate control Rx → ✗ Never referred to cardiology → ✗ Never reaches EP → ✗ Never treated with ablation

Rate control medications manage symptoms but don't treat the underlying condition, so patients are managed on medication for years without ever being evaluated for ablation. The typical time from diagnosis to ablation exceeds two years. Delaying beyond three years increases recurrence risk by about 40%.[9] Getting to treatment requires referral from PCP to cardiology to electrophysiology, and most systems can't identify where in that chain patients stall.

2 Human Psychology

Patients are human. Their decisions about care reflect that.

Human barriers show up in every high-value service line. They look different every time and must be solved differently.

Psychological Barriers Delaying + Preventing Care...

	Patients normalize symptoms	Patients misunderstand treatment options	Patients defer to provider silence	Patients face financial uncertainty/hidden logistics
LDCT Lung Screening	*"I've had this cough for years. It's just what happens after smoking."*	*"A lung scan? That means they think I have cancer!"*	*"My doctor never mentioned it last time. I guess I don't need it."*	*"I have no idea what it costs or if my insurance covers it."*
Aortic Stenosis	*"I just stopped climbing stairs. I thought that was aging."*	*"Valve replacement? That's major open-heart surgery."*	*"My cardiologist hasn't brought it up, so it must not be serious."*	*"What if I can't afford it? How long is recovery?"*
AFib	*"I'm just tired all the time. Everyone my age is."*	*"Ablation? I thought that was a last resort?"*	*"My doctor put me on medication. I assumed that was the treatment."*	*"I don't even know what it would cost out of pocket."*

3 The Activation Gap

You can't activate what you can't see.

For high-value use cases, fragmented data hides eligibility, behavior, motivations, and what actually drives engagement.

× Lack of comprehensive evidence-based eligibility models

Many patient engagement programs do not comprehensively identify clinically-eligible patients. Clinical eligibility data often lives across multiple systems, not just the EHR, limiting the ability to identify the exact individuals who qualify for services such as AFib treatment, lung cancer screening, specialty pharmacy, cardiology procedures, and other high-value care pathways.

× Clinical data not used as a behavioral signal

Past encounters, medication history, labs, imaging, and care gaps are underutilized as indicators of how patients engage with the healthcare system. Clinical data is treated as static history rather than insight into patient behavior.

× Missing human context from consumer and patient-reported data

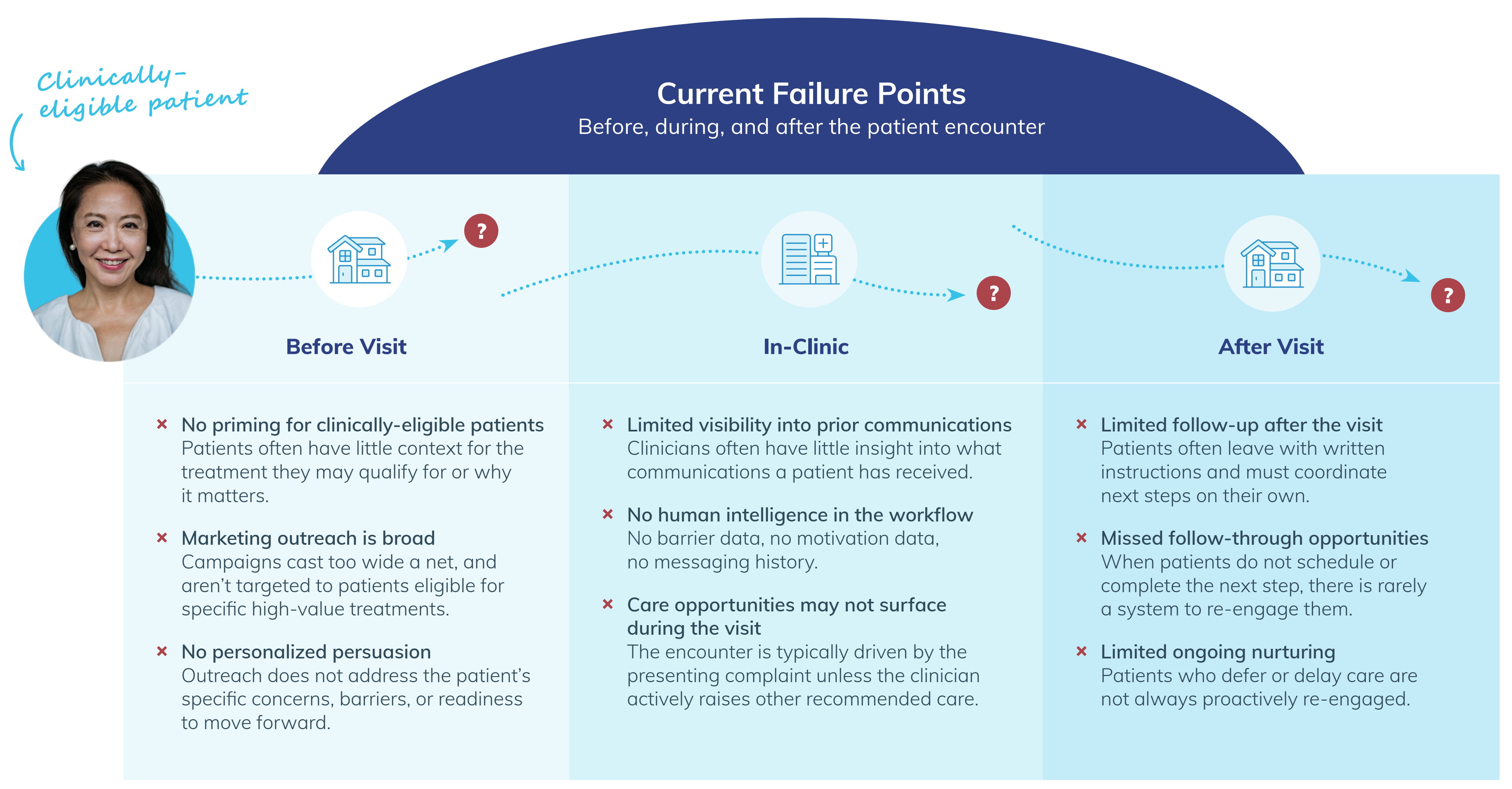
Programs fail to fully incorporate consumer indicators such as income and social determinants alongside patient reported insights about fears, motivations, and knowledge gaps, limiting their ability to understand why patients delay care and what drives action.

× No closed loop activation intelligence

Outreach efforts are rarely connected to real response data, preventing visibility into which channels, messages, and timing actually drive patient engagement.

Activation fails without orchestration across the care journey.

Gaps in coordination, patient-level intelligence, and strategic partnerships prevent and delay care, leading to lost growth and worse outcomes.



The Solution

Introducing a New Category to Drive Growth

Evidence-based, human-centered patient activation

The next growth engine for health systems.

Unify marketing and medicine to close critical care gaps and capture high-value growth.

Marketing is excellent at the top of the funnel.

But its real power is at the bottom, helping the 55% of patients who don't take action get the care they need.

Bottom-of-funnel marketing requires clinical understanding, personal persuasion, and strategic partnerships with care teams. And these are all capabilities health systems can build.

This is an emerging category that enables health system marketers to prevent leakage, drive growth, and save lives.

Current

New

The four components of bottom-of-funnel conversion

1. Evidence-based, human-centered intelligence

Deeper data than a CRM/EHR alone, including patients' own fears, barriers, and motivations

2. Phenotypes, not personas

Clinical + consumer intelligence reveals who patients really are, and what moves them

3. Clinically accurate, persuasive personalization

Personalized, omni-channel outreach tailored to individuals at each moment in the care journey

4. Strategic partnership with care teams

Phenotype-driven messaging embedded into EHR alerts, referral prompts, and personalized scripting

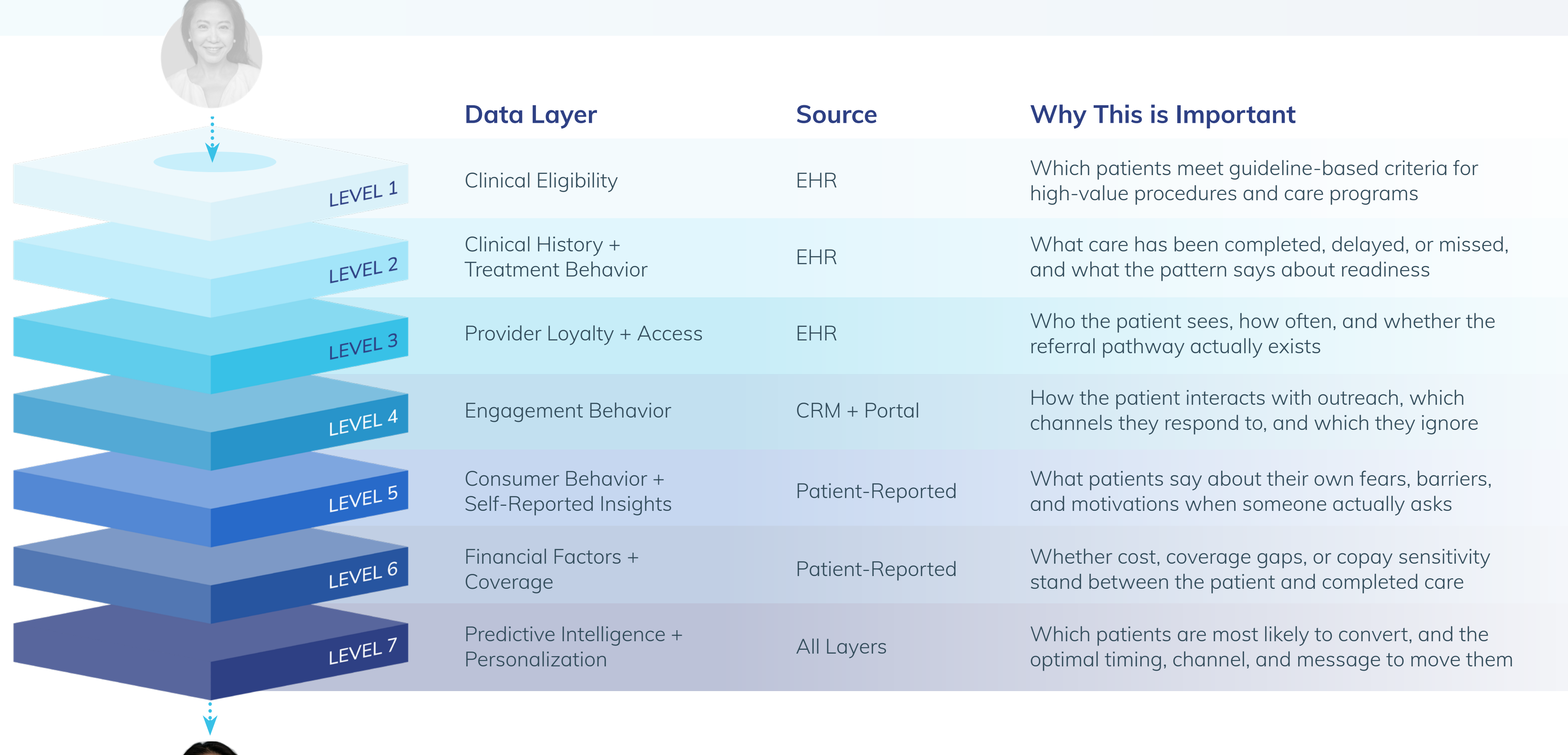
Evidence-based, human-centered intelligence.

Integrate clinical, consumer, and self-reported data to see who this patient really is, and what stands in his or her way.

The challenge isn't acquiring more data. It's connecting clinical eligibility with insights into human behavior.

A CRM shows that a patient clicked on an email. It doesn't explain why they didn't act. **An EHR shows a patient meets clinical criteria. It doesn't reveal why preventive care was delayed for years, prescriptions are filled inconsistently, or that there is unease about what a screening might uncover.**

Answering those questions requires a level of patient intelligence that health systems can bring together to deepen understanding and drive action.



Data Layer	Source	Why This is Important
Clinical Eligibility	EHR	Which patients meet guideline-based criteria for high-value procedures and care programs
Clinical History + Treatment Behavior	EHR	What care has been completed, delayed, or missed, and what the pattern says about readiness
Provider Loyalty + Access	EHR	Who the patient sees, how often, and whether the referral pathway actually exists
Engagement Behavior	CRM + Portal	How the patient interacts with outreach, which channels they respond to, and which they ignore
Consumer Behavior + Self-Reported Insights	Patient-Reported	What patients say about their own fears, barriers, and motivations when someone actually asks
Financial Factors + Coverage	Patient-Reported	Whether cost, coverage gaps, or copay sensitivity stand between the patient and completed care
Predictive Intelligence + Personalization	All Layers	Which patients are most likely to convert, and the optimal timing, channel, and message to move them

Personas inform campaigns. *Phenotypes* convert patients.

Build actionable audiences that tell you who these people really are, and how to motivate them.

A persona is a helpful, but theoretical tool built from demographics and best assumptions. But personas don't exist in the EHR.

A phenotype is derived from evidence: clinical history, care patterns, provider relationships, consumer barriers, fears, motivations, and propensity to convert.

Phenotypes don't describe a general type of person. They are actionable, identifying who will act, what's standing in the way, and what specific actions will move them.

Phenotypes tell you who these patients really are, their unique barriers, and what will motivate them to act at each step of the care journey.

Without that intelligence, conversion is often just guesswork.

Standard Healthcare Marketing Agency

Persona

"Screening Sue"

Demographics	▪ Woman ▪ Aged 55–75 ▪ Insured ▪ HHI: >$100,000
Lifestyle	▪ Likely tobacco-purchaser ▪ Caring for children and older parent
Potential Barriers	▪ Busy lifestyle ▪ Fear of procedures ▪ Cost concerns

- ✕ **No** meaningful segmentation beyond basic demographics
- ✕ **No** clinical + consumer data
- ✕ **No** predictive insight
- ✕ Drives leads, **few** conversions

LDCT Lung Screening Patient

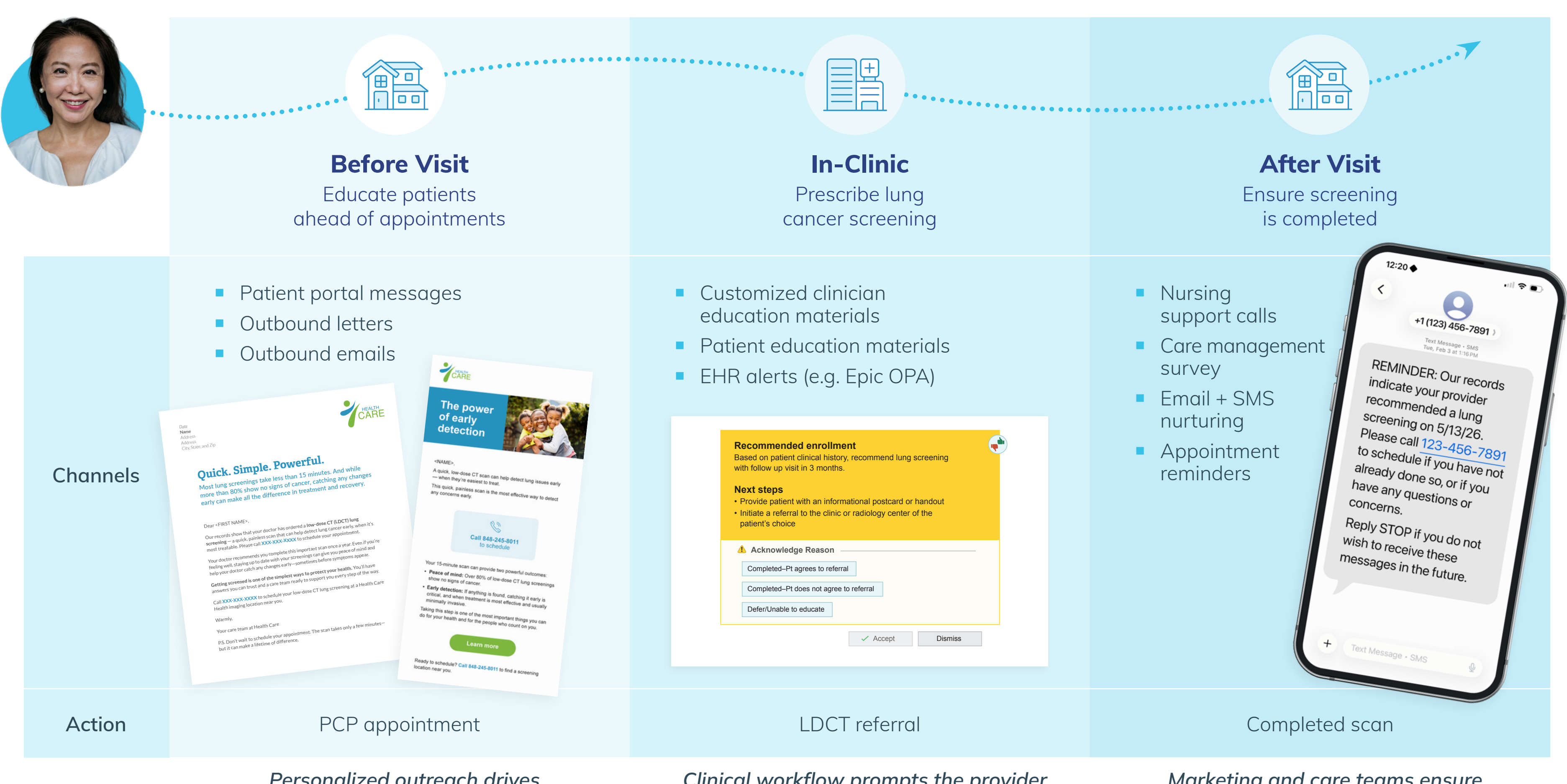
Phenotype

MRN: 123456###

Clinical Signals	▪ Meets USPSTF criteria ▪ Lapsed LDCT (26 months overdue) ▪ Outstanding lung order from PCP
Medication History	▪ Prior Chantix use
Behavioral + Engagement Signals	▪ Sees PCP 3x/yr ▪ Regular portal user ▪ Responds quickly to prior preventive outreach ▪ Prior tobacco-cessation participant
Predictive + Socioeconomic Signals	▪ Commercially insured ▪ Pricing sensitivities ▪ Higher-income ZIP ▪ Stable address
Access Alignment	▪ Lives near LDCT-capable sites with open slots
Activation Strategy	▪ Email + portal » SMS follow-up ▪ Lapsed-screening message + "Schedule Now" link

Clinically accurate, persuasive personalization throughout the care journey.

Deliver the right message, through the right channel, at the right moment in the care journey.



Personalized outreach drives the patient toward the visit

Clinical workflow prompts the provider on next best actions

Marketing and care teams ensure patient gets recommended care

Closing the Last Mile

Strategic partnership between marketing + care teams.

Aligning with care teams drives conversions marketing can't reach.

Marketing can prime patients, but completion often depends on moments in the exam room or follow-up. **This requires a strategic partnership between marketing and care teams to identify bottom-of-funnel opportunities and pair persuasive messaging with care team interventions.**

Marketing and care teams stay aligned on the same patients, the same intelligence, and a shared outcome: advancing care.

	Traditional Approach	Marketing + Care Team Collaboration
Patient Lists	× Generic eligibility lists, no prioritization	✓ **Marketing + care teams work off the same lists** Segmented by conversion likelihood, tagged marketing-responsive vs. provider-responsive
Clinical Workflow	× No alerts, no prompts, referrals depend on individual provider memory	✓ **Marketing + care teams deliver the same messaging** EHR-embedded alerts with eligibility criteria and referral prompts at point of care
Patient Interaction	× Generic scripts, no barrier visibility, no knowledge of prior outreach	✓ **Human-centered scripting at the point of care** Personalized scripting matched to phenotype, with visibility into marketing touchpoints
Scheduling + Routing	× Volume processing: get patient off the phone	✓ **Ensure access + coordination for next steps** Last-mile routing: match eligibility to appointment type, access, and workflow
Accountability	× No feedback on whether referrals converted	✓ **Share accountability and ROI** Results reporting that tracks referral-to-completed-care and reinforces behavior

DIGITAL HEALTH
STRATEGIES
What We Do + How We Support Patient Activation

About Digital Health Strategies

We activate complex healthcare data to drive profitable growth and improve lives.

How we power growth

Proven expertise in high-margin use cases

For over a decade, we've driven measurable growth for more than 300 hospitals by activating high-value patients in cardiology, oncology, pharmacy, philanthropy, and beyond.

Data intelligence + activation under one roof

Using insights from over 200 million patient interactions each year, we combine AI-powered data intelligence with proven activation at scale across both marketing channels and clinical workflows.

Performance-aligned, at-risk contracts

We put our fees at risk and directly align our incentives with performance and outcomes.

The power behind our intelligence

30M
U.S. patient records.

20B
First-party data points.

1,400
Clinical signals evaluated per individual.

90
Consumer and self-reported attributes to understand behavior.

Ready to close the gap?
Let's build your activation roadmap.

Email Liz Alcorn, VP Growth
liz.alcorn@digitalhealthstrategies.com

Visit www.digitalhealthstrategies.com

Sources + Methodology

[1]McGlynn et al., The New England Journal of Medicine 2003. Americans receive approximately 54.9% of recommended care across 439 quality indicators. DHS model's median care gap rate across 18 pathways with citable national statistics = ~56%. The structural problem McGlynn identified is persistent and universal.

[2]Based on 42 modeled clinical pathways across 18 service lines. Medicare facility rates establish a conservative floor; systems with favorable commercial mix will realize meaningfully higher per-patient economics. Primary care attribution and unmodeled service lines represent additional upside.

[3]Contribution margin net of direct variable costs. Does not include step-function fixed investments in capacity and staffing.

[4]Moody's Investors Service, FY2023 medians across 214 rated U.S. not-for-profit health systems.

[5]Shapiro W. Patient acquisition vs. retention: Which is more important for healthcare businesses? Forbes (Forbes Agency Council). 2022 Jul 13

[6]Based on DHS client engagements, across 14 clinical and business use cases across 300 hospital clients, including over 7 years of longitudinal data

[7]American Cancer Society. Only 1 in 5 eligible adults in U.S. screened for lung cancer. ACS Pressroom. 2025 Nov 18.

[8]Yohann S, et al. Patient- and process-related contributors to the underuse of aortic valve replacement. Journal of the American Heart Association. 2022;11(12):e025065.

[9]Longer diagnosis-to-ablation time is associated with recurrence of atrial fibrillation after catheter ablation. Journal of Cardiovascular Electrophysiology. 2019 Dec 26.; Diagnosis-to-ablation time in atrial fibrillation: a modifiable factor independently associated with recurrent arrhythmia and repeat ablation after first AF ablation. Journal of Cardiovascular Electrophysiology. 2019 May 21.; Impact of diagnosis-to-ablation time on atrial fibrillation recurrence. European Heart Journal (suppl). 2023 Nov 8

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