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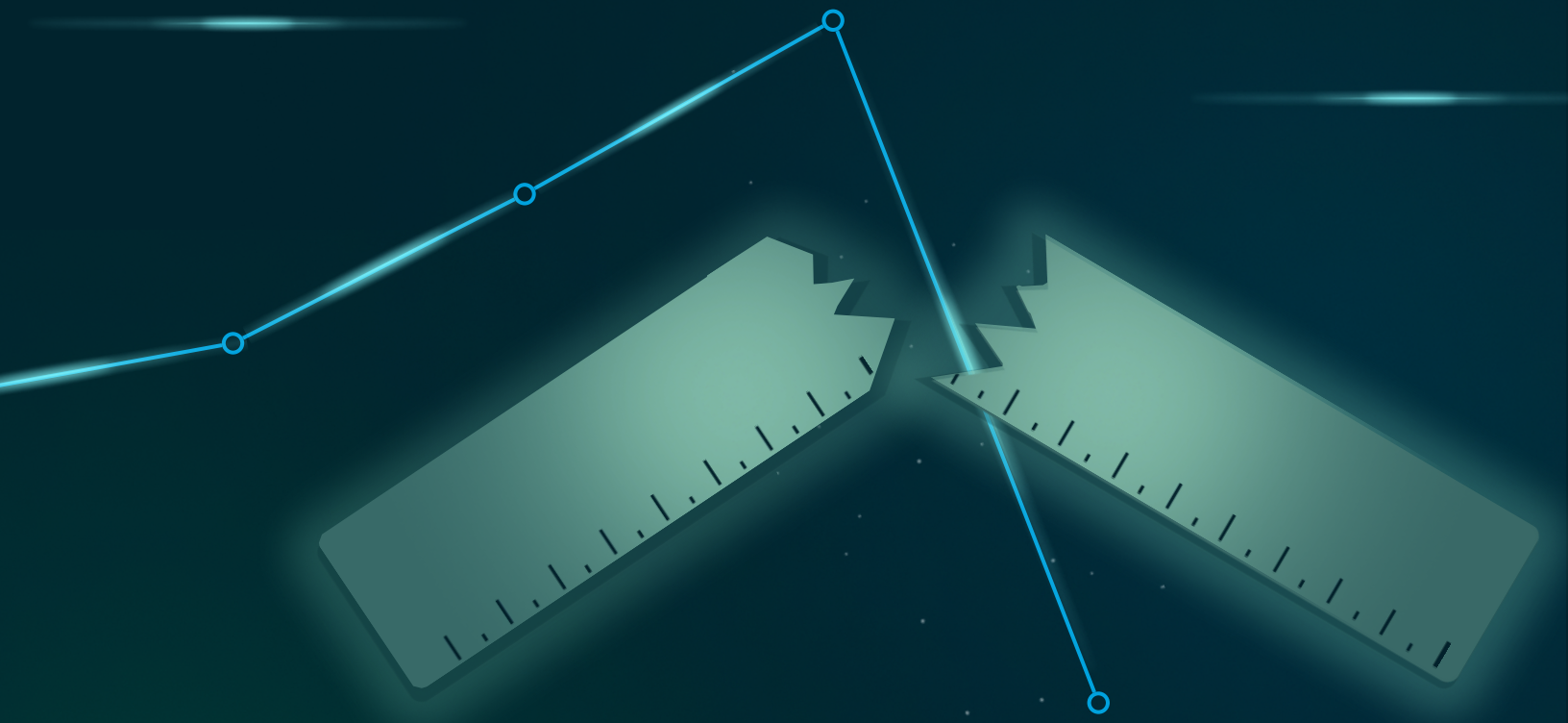

Beyond Google:

The Multi-Channel Playbook for Healthcare Marketers

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Introduction

Most healthcare marketers will tell you Google search advertising got expensive. That's real, but it's not the core problem. It's a symptom of a deeper issue in how teams grow and measure marketing.

Here's the rub: Google ads became the default growth engine in healthcare because it solved a real problem. They made performance easy to see and defend. When a patient searched and clicked your ad, you knew what you paid and what you got. That clarity made search feel safe in an industry where every dollar is questioned and compliance hangs over every campaign.

Under pressure to do more with less, teams focused on what they could control. They refined targeting, improved conversion rates, and tried to squeeze more from people already searching. The goal was precision—reaching the right patients, not just more patients.

But precision has limits when the pool itself is shrinking. You can optimize conversion rates, refine targeting, and improve quality scores—but if:

- CPCs continue to climb as competitors chase finite high-intent keywords
- Zero-click behavior and AI answers **reduce available inventory**
- CAC rises without incremental volume, and growth stalls even as spend increases

That's when the math stops working—costs keep rising, but patient volume does not.

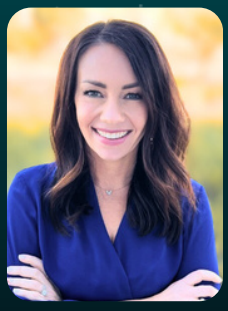
Allison Horn, VP of Marketing at Imagen Dental Partners, puts it bluntly: "If all you do is feed Google last click signals, you're only competing in the same shrinking pool of high intent searches and paying a premium for them." Across 120 dental practices, she's watched this dynamic play out in real time—more spend, higher CPCs, same finite pool of patients.

This playbook explains why Google dependency formed, what it breaks as markets mature, and how healthcare marketers are successfully moving beyond it—to reach patients Google can't surface, improve unit economics through upstream demand creation, and unlock growth that search alone can't deliver.

The shift isn't about abandoning search or chasing experimental channels. It's about building multi-channel infrastructure that creates demand upstream and captures it downstream, with measurement that proves what actually works.

Meet Your Subject Matter Experts

Everything in this playbook comes from the lived experience of healthcare marketers. The four leaders featured here are quoted directly, but the frameworks and examples are informed by conversations with dozens of other operators who've wrestled with the same problems you're trying to solve.



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Chapter 1

The Google Dependency Tax

Search didn't become the center of healthcare marketing by accident. It solved a real problem.

When a patient searched for "orthopedic surgeon near me" and clicked your ad, you knew what you paid and what you got. That clarity mattered in an industry where compliance risk shadows every campaign and CFOs demand proof before releasing budget. Search gave marketers something rare: clean attribution at the moment of conversion.

The idea behind it was simple, too. Search captures clear intent at the exact moment someone is ready to decide. A patient typing that query isn't browsing for fun—they're ready to choose. That kind of intent is worth paying for because people convert quickly, it's easy to trace the click to the visit, and the numbers make sense to finance teams who control the budget.

That clear measurement created a simple feedback loop. Search looked good in last-click reports, so it got more budget. More budget paid for better keywords, tighter targeting, and stronger landing pages. Results improved. Leaders trusted the numbers. Over time, marketing's credibility became tied to search performance.

This wasn't lazy strategy. It was rational risk management.

Over time, teams built entire infrastructures around Google. Budget conversations centered on impression share and conversion rates, not awareness or consideration. The question on everybody's mind shifted from "How do we reach more patients?" to "How do we extract more efficiency from the traffic we're already buying?"

So, what changed? Why doesn't that playbook work anymore?

Why the math doesn't add up anymore

The problem with that strategy is **finite intent doesn't scale indefinitely.**

There are only so many people searching for your service in your market at any given time, and every competitor is bidding on the same terms. As more budgets pile into search, costs rise faster than volume grows.

This isn't a temporary spike—it's structural. CPC inflation reflects the underlying scarcity. It's baked into how the market works.

Healthcare is local, patient populations are fixed, and search volume doesn't double just because more advertisers join the auction. When more players chase the same searches, CPCs go up faster than volume.

Meanwhile, the inventory you can even bid on is shrinking.

- **Zero-click results** mean Google increasingly answers queries directly in search results—addresses, phone numbers, basic information displayed before ads appear
- **AI-generated summaries** accelerate this shift, synthesizing information from multiple sources and serving it up without requiring a click
- Patients get what they need **without visiting a website**, which means fewer opportunities for ads to capture attention

For brands that aren't already top-of-mind, this creates a ceiling that optimization can't break. If you're the third option in a "near me" search, no amount of bidding strategy changes the structural disadvantage. The top two spots absorb most clicks. Patients default to familiar names or the closest location.

Justin Olson, CMO of Smile Partners, described this phenomenon from his time at Face Pace Health, saying: "We see existing customers, existing patients actually coming back to us from non-brand search. They're not typing in 'Fast Pace Health.' They're typing in 'where's another urgent care near me.' We have to win them back."

Read that again.

Patients who've already visited—who've already had an experience with the brand—are searching generically when they need care again. The brand impression didn't stick. The experience didn't create preference. Search dependency doesn't just limit new patient acquisition—it means you're paying to re-acquire patients you've already served.

So what happens when those dynamics collide with growth targets? CAC goes up, but patient volume doesn't. Teams add budget to try to keep up. Bids rise as the auction gets tighter. Impression share stays flat—the ads still show—but new patients don't grow at the same pace. More dollars go in, less growth comes out.

Finance sees rising costs without matching returns, which forces marketing into a defensive posture: protecting what's working rather than expanding reach.

This is where Google dependency hardens into a strategic trap.

Marketing teams know diversification is necessary. But finance looks at the data and sees search as the only channel with reliable, measurable ROI. When marketers propose funding awareness or consideration campaigns, the response is predictable: "Why would we invest in channels that don't convert?"

It's a rational question. And the data supports it.

That's because attribution models credit search for every downstream conversion, regardless of what put the patient into the funnel in the first place. The channels that build familiarity, shape preferences, and create the demand that search captures? They go unmeasured. And what doesn't get measured doesn't get funded.

"**Attribution is the hardest thing in healthcare marketing,**" says Allison Horn, who's spent 19 years in the industry. "We have to get creative telling a story that's as directionally correct as possible." That phrase—"directionally correct"—captures the reality most healthcare marketers face: perfect attribution doesn't exist, so teams default to what's measurable, even when it's misleading.

That default creates a self-reinforcing cycle. Budgets stay concentrated where attribution looks cleanest. Teams optimize margins on traffic they're already buying instead of expanding the addressable market.

How to escape the Google dependency trap

So what's the way forward? The way out isn't better search optimization. It's recognizing that sustainable growth requires creating demand upstream and capturing it downstream.

Search remains essential—but only as one component of a broader acquisition system, not the entire strategy. This shift changes what success looks like and what questions teams need to answer. Instead of "How do we optimize search?" the question becomes **"How do we expand the pool of people who eventually search?"**

That reframe unlocks multi-channel marketing.

But multi-channel has become one of those terms that means everything and nothing. Teams hear it and think "run ads everywhere" or "test new platforms." Finance hears it and sees uncontrolled spending without accountability. Leadership hears it and worries about losing focus.

The shift from search dependency to multi-channel infrastructure starts with understanding what multi-channel actually means—and why most attempts to "diversify" fail before they ever get the budget to prove themselves.

> "If you look at a patient's healthcare lifecycle, it's a series of funnels."
>
> — Jeremy Rogers,
> VP of Digital Marketing and Experience at IU Health

Chapter 2

The Multi-Channel Opportunity *(and What It Actually Means)*

Ask ten marketers what “multi-channel” means and you’ll get ten different answers. Most of them will be wrong.

Not wrong because the people explaining them are incompetent. Wrong because the term has been watered down to the point of uselessness. Multi-channel has become shorthand for “doing more stuff”—run ads on LinkedIn, test some YouTube pre-roll, throw budget at Meta, maybe try connected TV if there’s money left over.

That approach doesn’t work. It’s expensive, unfocused, and politically dangerous when nothing converts as cleanly as search does.

The teams that really move beyond Google aren’t just adding more channels. **They rethink how they bring patients in:** each channel has a clear job, they track how channels help each other instead of only the last click, and they build a system where channels work together.

That’s what multi-channel actually means. And it’s a fundamentally different operating model than what most healthcare marketers are running today.

What multi-channel is *not*

Multi-channel is not running ads everywhere hoping something sticks. **Budget without strategy is just noise**—and expensive noise that finance will cut the moment performance reviews come around.

It’s not isolated channel tests where a team spins up an Instagram campaign for six weeks, sees it doesn’t convert like search does, and declares “Instagram doesn’t work for us.” That’s not testing multi-channel. That’s testing whether a single tactic can replace an entire system. Of course it fails.

And it's definitely not applying the same KPIs across every platform—judging awareness channels by conversion rate, expecting consideration tactics to deliver immediate ROI, or killing upper-funnel work because it doesn't show up in last-click attribution.

Those approaches fail for the same reason. They treat channels as interchangeable when they're not. A YouTube video that introduces your brand to someone who's never heard of you does not have the same job as a retargeting ad that reminds a recent website visitor to book an appointment. Measuring both by cost per conversion misses the point entirely.

What multi-channel *actually* requires

Multi-channel works when channels have clear roles tied to where patients are in their decision-making process.

But here's what makes healthcare different: patient acquisition isn't a single journey. Jeremy Rogers, VP of Digital Marketing and Experience at IU Health, frames it this way: "It's really not one funnel. If you look at a patient's healthcare lifecycle, it's a series of funnels. You're winning that relationship every time."

Most patients aren't in the market for healthcare services very often—maybe a handful of times per year. But each time they seek care, they're entering a new conversion funnel. You might win them for primary care but lose them for specialty services.

That's why **channel roles matter**. Some channels build awareness—connected TV, programmatic video, audio ads, out-of-home—reaching people who don't know you exist yet. Others support consideration—paid social, display remarketing, email—engaging people actively comparing providers. And conversion channels—search ads, retargeting, call tracking—capture intent when someone is ready to act.

What's important to understand is all three layers are necessary.

Search can't create awareness for people who don't know you exist. Awareness channels can't close someone who's ready to book today. Trying to make one channel do everything is like asking your closer to also prospect and qualify—it's inefficient and it leaves massive gaps.

The patient journey doesn't start when someone opens Google. It starts weeks or months earlier when they're forming preferences, building familiarity, and narrowing their consideration set. By the time they search, they've already decided which brands feel credible and which feel like strangers.

True multi-channel marketing recognizes that reality and designs for it.

Why healthcare marketers need multi-channel

So why does this work when search stalls? Because multiple exposures reduce reliance on single-touch conversion.

Most patients don't see one ad and immediately book an appointment. They see your brand on YouTube while researching symptoms. They scroll past a Facebook ad featuring a patient testimonial. They hear an audio spot on their commute. Then—when they're finally ready—they search, and your brand feels familiar instead of unknown.

That familiarity is what tips the scales. All those upstream touches didn't convert directly, but they shaped the consideration set. They made your search ad more likely to get clicked. They made your website feel credible when someone landed on it. They turned a cold audience into a warm one.

Channel interaction compounds impact in ways that single-channel optimization can't replicate. When awareness channels feed consideration channels, and consideration channels warm up audiences before they hit search, the entire system performs better than any individual piece could alone.

And here's the part that CFOs care about: **demand creation lowers downstream acquisition costs.**

When patients already know your brand before they search, you're not competing purely on price and location. You're competing on preference. That means **higher click-through rates, better conversion rates, and lower CPCs**—because you're not fighting to introduce yourself at the exact moment someone needs to make a decision.

This shows up in unexpected ways. Allison Horn noticed it when reviewing performance at one of Imagen Dental's Ohio practices: "I feel like the patients we're getting are better. They're already informed in what they're looking for."

The practice wasn't hitting its new patient volume target, but something else had changed. "The conversion and case acceptance have increased. They're getting higher average value of new patients. They've had their best production numbers ever."

The upstream awareness work didn't just drive more patients—it drove better-qualified patients who were further along in their decision process, which meant higher treatment acceptance rates and record revenue despite lower raw volume.

That's the strategic case for multi-channel. The logic is sound—multiple exposures create familiarity, channel interaction drives performance, upstream demand lowers downstream costs.

The challenge is that logic doesn't build audiences, design campaigns, or prove ROI to finance. Execution does. And execution requires infrastructure most teams don't have yet.

> "The biggest challenge from a healthcare perspective is sometimes [clean, attributable] data's not easily accessible."
>
> — Allison Horn,
> VP of Marketing at Imagen Dental Partners

Chapter 3

The Primer For Compliant Multi-Channel Strategies

Most multi-channel strategies don't fail because the channels are wrong. They fail before the first impression ever serves—because the plumbing is wrong.

In healthcare, that plumbing problem shows up the same way over and over again:

- **80%** of your paid media budget sits in search, because it's the only thing finance trusts
- The audiences you wish you could build are locked up in EMRs, CRMs, and portals you **can't safely activate**
- "Orchestrating channels" sounds good on slides, but your actual campaigns are still built around whatever Google will reliably measure

The result is predictable: teams launch a few "new channel" tests on top of the old infrastructure, judge them by search-era metrics, and then conclude that multi-channel "doesn't work for us." The strategy gets blamed, but the system was never set up to give it a fair shot.

The teams that succeed don't skip the infrastructure work. They build it first. Then, once everything is in place, channel decisions, creative testing, and even budget conversations with finance get radically easier.

What follows is a practical primer for building your infrastructure.

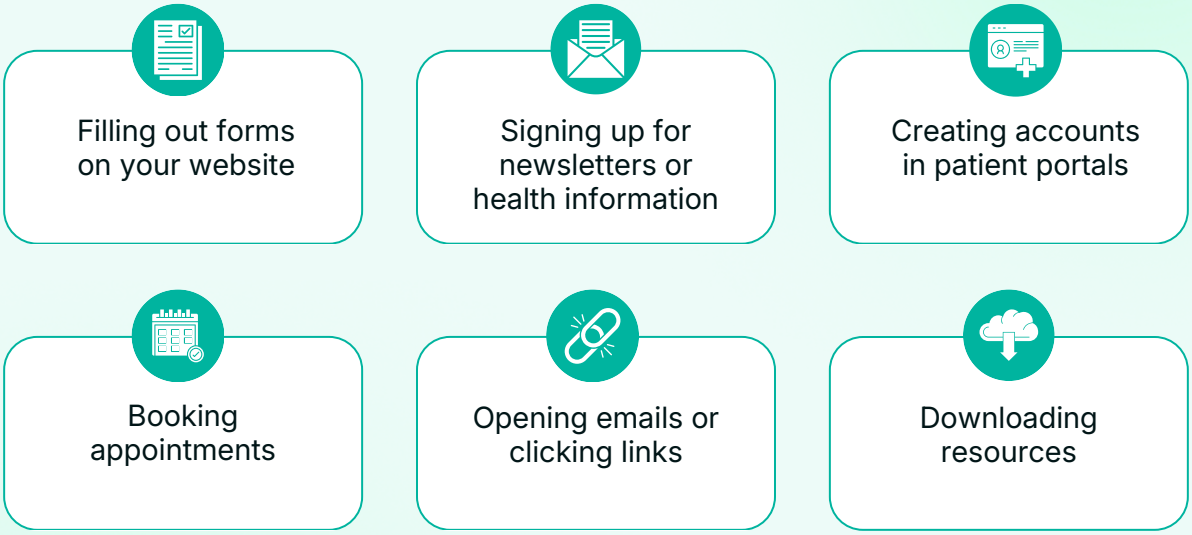
Step 1: Start with the data you control

The foundation is data. Not third-party cookies. Not vendor segments. **Your own first-party data.**

Jeremy Rogers from IU Health is direct about this: “You have to have a very robust first party data strategy. You cannot rely upon third or fourth party data. Not possible.” After a decade leading digital marketing at a major health system, his view is unequivocal: ”If you don’t have a first party data strategy, you’re behind the eight ball right now.”

This isn’t about privacy regulations alone—it’s about competitive advantage. Third-party data tells you what anonymous cohorts do. **First-party data tells you what your patients do, need, and respond to.**

When a patient interacts with your organization, they leave valuable signals:



This is first-party data—information they’ve given you directly, with context about why they’re interested and what they need. It’s **more accurate, more compliant, and more valuable** than anything a third-party vendor can sell you.

Zero-party data takes it further. It’s what patients tell you on purpose—like what topics they pick in a form, what services they say they care about, or what conditions they’re managing. **They’re telling you what matters to them,** which makes targeting and personalization straightforward instead of guesswork.

This matters because the “cookieless future” isn’t a buzzword anymore. It’s already here.

Browsers block third-party cookies by default. Privacy regulations require explicit consent before tracking. Platforms are locking down data sharing. The targeting methods that worked five years ago don't work now, and healthcare's regulatory constraints make this shift even more urgent.

Teams that control their own data can still build audiences, retarget engaged visitors, and measure cross-channel impact. Teams that don't are stuck casting wider nets with less precision and higher waste.

The first step is collecting and organizing data properly. That means:

- **Server-side tracking** instead of client-side pixels that browsers block
- **Unified patient identifiers** across web visits, email opens, and offline interactions
- **Customer data platform or privacy-compliant infrastructure** that segments audiences and sends data to ad platforms without exposing PHI
- **Data hygiene** so patient records aren't duplicated and key fields aren't missing
- **Consent management** built in from the start—capturing permissions, honoring opt-outs, stripping identifiers before sharing

If your patient records are duplicated, if emails aren't standardized, if you're missing key fields—you'll end up with fragmented audiences and inaccurate attribution. Clean data is what makes everything downstream actually work.

"The biggest challenge from a healthcare perspective is sometimes that data's not easily accessible," says Allison Horn, who manages marketing for 120 practices on different practice management systems. "Every single person is collecting data in a different way. It's garbage in, garbage out."

This isn't just about privacy regulations or cookie deprecation. **Healthcare has fundamental infrastructure problems that make building audiences harder than other industries.** The teams that solve for this—building data warehouses, standardizing collection, unifying identifiers—unlock capabilities competitors can't replicate.

The infrastructure work is unglamorous, but it's non-negotiable. You can't retarget people you can't identify. You can't build lookalike audiences from data you don't control. You can't prove ROI when attribution is broken at the source.

Audience-Based Campaigns in Healthcare

Building lookalike audiences and retargeting segments usually means uploading patient lists to Meta or Google—which creates HIPAA exposure if you're not careful. Most healthcare teams either skip these campaigns entirely or cross their fingers and hope nothing breaks.

If you're using Freshpaint Audiences, you're already set. It handles the server-side work, strips PHI before anything hits advertising platforms, and keeps your compliance team happy.

Step 2: Map campaigns to how patients actually choose care

Once your data foundation is in place, the next step is to design campaigns around how patients actually make decisions.

Most people don't wake up, search for a healthcare provider, and book an appointment that afternoon. Decision-making happens in stages—often over weeks or months—with different questions and different information needs at each point.

Here's how the patient journey (often) maps to channels and metrics:

Stage	Patient Mindset	Channels	What Success Looks Like
Awareness	Problem-aware, not solution-aware. Researching symptoms, exploring options, doesn't know you exist yet.	Connected TV, programmatic video, display ads, audio, direct mail	Reach, frequency, brand lift—not immediate conversions
Consideration	Comparing providers, reading reviews, evaluating proximity and availability. Knows what they need—deciding who to trust.	Paid social, email nurture, retargeting, content	Engagement, time on site, email opens, content downloads
Conversion	Ready to act. Searching for your name, clicking retargeting ads, calling from email. Decision made—just needs to complete action.	Search ads, retargeting, call tracking, conversion-optimized landing pages	Cost per acquisition, conversion rate, appointment volume

Here's what matters: **each stage requires different channels, different creative, and different success metrics.**

Awareness channels win when they reach the right people often enough that your name starts to feel familiar. You measure reach, frequency, and brand lift—not immediate conversions. Expecting awareness campaigns to deliver appointment bookings is like expecting a first date to end in marriage. It misunderstands the job.

Consideration channels succeed when they move people closer to a decision. You measure engagement, time on site, email opens, content downloads—signals that someone is actively evaluating. The goal is to stay relevant while they decide.

Conversion channels succeed when they close ready buyers efficiently. Cost per acquisition, conversion rate, appointment volume—these metrics make sense here because the audience has already been warmed by everything upstream.

But conversion isn't just about getting the click—it's about getting the patient to show up. Allison Horn's team i**ncreased show rates from 51% to over 80%** in one year by focusing on post-booking communication, practice operations, and patient experience. "It's not just marketing," she notes. "It goes into operations and engagement and conversation and validating insurance and being more mindful of are we pulling the right patients in to actually show up."

The biggest mistake teams make is grading every stage by the same metric: immediate conversions. When an awareness campaign doesn't deliver appointments, finance sees inefficiency. But the campaign wasn't designed to convert—it was designed to introduce your brand to people who will search later. Without measurement that captures that contribution, awareness work gets killed before it has a chance to feed the funnel.

Connecting Awareness to Appointments

Proving a YouTube ad from six weeks ago influenced today's appointment booking requires infrastructure most teams don't have—especially when HIPAA limits what you can track.

If you're using Freshpaint Event Tracking, this is already wired up. It connects the dots across channels and devices without exposing PHI, so you can actually measure how awareness drives downstream conversions.

Step 3: Turn awareness into action

The connective tissue between awareness and conversion is **retargeting**.

Someone visits your website after seeing a connected TV ad. They don't book an appointment—they're still researching, comparing options, not quite ready. Without retargeting, they disappear. With retargeting, you stay visible as they continue their decision process.

Retargeting works because most patients don't convert on the first visit. They need multiple touchpoints—**industry data consistently shows 5-7 brand exposures before conversion**. Retargeting creates those exposures systematically instead of hoping people remember you when they're ready.

Multi–channel retargeting in practice looks something like this:

Element	Guideline	Why It Matters
Frequency	5-12 impressions per user per week	Enough to stay visible without creating ad fatigue. Beyond 15 impressions, performance drops significantly.
Timing	7-30 day window after site visit	Too short and people haven't decided. Too long and interest fades.
Channels	Facebook, YouTube, display networks, email	Multi-channel performs better than single-channel because varied touchpoints increase re-engagement odds.
Creative	Dynamic, personalized to what they viewed	Show the specific service someone viewed, highlight reviews, or offer an incentive. Personalization increases CTR and conversion

Then there's **lookalikes audiences**. Once you've retargeted engaged visitors and converted some of them into patients, you can use that high-value audience to find similar people. Platforms like Meta and Google can identify users who share characteristics with your best patients—demographics, behaviors, interests—and let you target them with awareness campaigns.

Lookalike audiences based on actual patients perform significantly better than cold targeting. You're reaching people who are statistically more likely to need your services and convert.

This is how you expand reach without wasting budget on unqualified audiences.

1. Awareness campaigns drive initial visits
2. Retargeting keeps you visible as patients “do their own research”
3. Conversion campaigns close when they’re ready
4. Lookalike audiences scale by finding more people similar to those who’ve converted

This is the system. Channels work together—not in isolation, not competing for credit, but as an integrated acquisition engine where each piece has a clear job and measurement captures how they interact.

Multi-Platform Retargeting Can Gets Messy

Syncing retargeting audiences across Meta, Google, email, and display—while managing consent and stripping PHI—creates operational headaches and compliance risk.

If you’re already using Freshpaint Audiences, this is automated. Build a segment once, and it syncs to your ad platforms with PHI removed and consent honored. No manual exports, no gaps.

Implementation reality check

Building this infrastructure takes work. It requires data foundations most teams don’t have yet. It demands campaign design that maps to patient decision-making instead of channel convenience. It needs retargeting strategies that balance frequency, timing, and creative personalization.

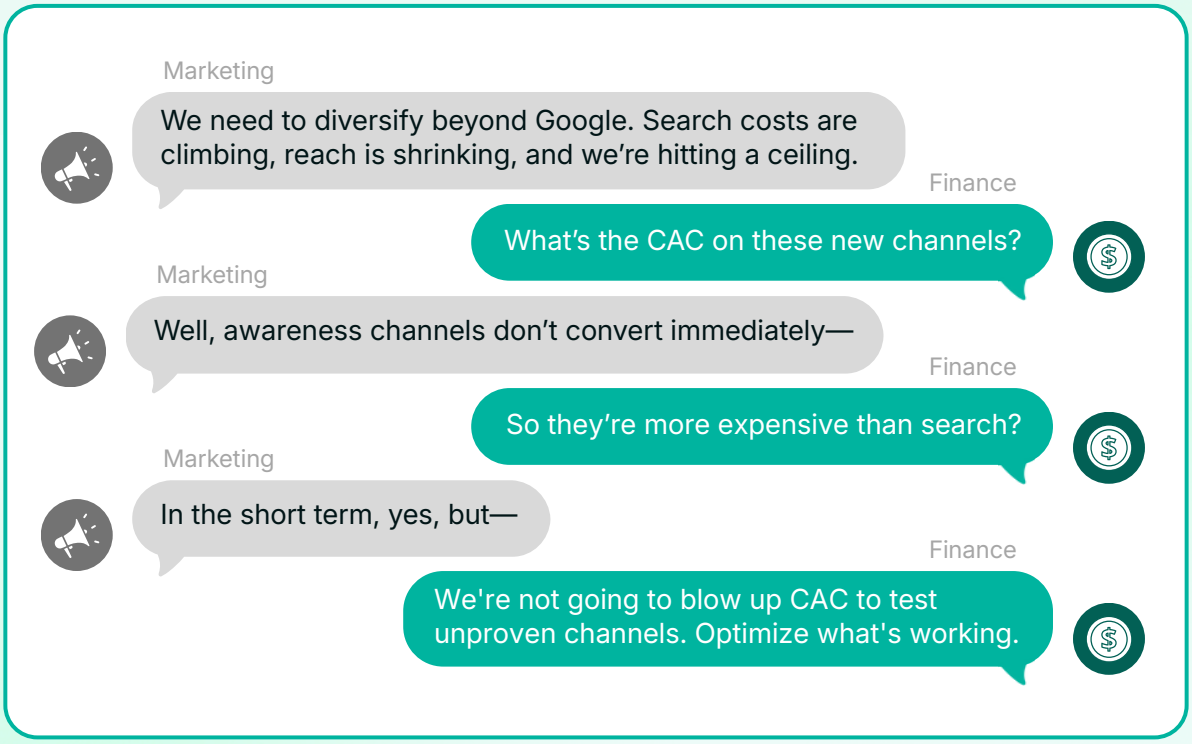
But the alternative is worse: continuing to optimize search campaigns that can’t scale, chasing incremental gains on shrinking inventory, and hoping auction dynamics somehow reverse course.

The teams moving beyond Google dependency aren’t just running more channels. They’re building the infrastructure that makes multi-channel marketing measurable, defensible, and scalable. That infrastructure is what unlocks the business case—and what makes CFOs willing to move budget away from search.

Chapter 4

The Business Case For Multi-Channel *(That Won’t Blow Up CAC)*

Here’s the conversation that kills multi-channel strategies before they start:



End of conversation. Budget stays in search. The dependency deepens.

This isn’t finance being difficult. It's finance doing their job. They see a mature, optimized search program delivering measurable ROI. They see proposed "awareness" and "consideration" campaigns that cost more per acquisition and can't prove they contributed to anything.

Jeremy Rogers frames the tension healthcare marketers face: "There's a virtuous combination of the margin and the mission. Many CFOs around the country say: Without margin, there is no mission."

Healthcare operates in this duality—mission-driven organizations that still must prove every dollar drives measurable growth.

That's why the business case for multi-channel can't be theoretical. Finance isn't saying no because they don't understand marketing. They're saying no because most multi-channel business cases are built on the wrong framing.

Teams compare isolated channel performance—YouTube CAC vs. search CAC—when they should be comparing system performance. They optimize for short-term efficiency when they should be modeling long-term growth. They use attribution to prove value when they should be using incrementality.

Making the case for multi-channel isn’t about asking finance to “trust the process.” It’s about changing how you look at the numbers so they actually support diversification.

Why the comparison breaks multi-channel before it starts

New channels appear more expensive early because they are. That's not a failure—it's how acquisition economics work when you're building a new funnel.

When you launch awareness campaigns, you're reaching people who don't know you exist yet. They're not ready to convert. They might not even realize they need your services. You're introducing, familiarizing, planting seeds. That work doesn't show up as immediate appointments, which means cost per acquisition looks high—or infinite if you're only counting last-click conversions.

Meanwhile, your search campaigns have been running for years. The audience is pre-qualified (they're actively searching), the targeting is refined, the landing pages are optimized, and attribution is clean. Of course search looks more efficient. You've had years to optimize it, and you're only capturing people at the exact moment they're ready to convert.

Comparing a brand-new YouTube campaign to a mature search program is like comparing a rookie's first game stats to a veteran's career average. The comparison is inherently unfair.

What makes it worse:

- **Mature programs get a head start:** Your search campaigns perform well partly because awareness work you did years ago (events, word-of-mouth, PR) made your brand familiar. You're harvesting demand that was created upstream—but attribution credits search for 100% of it.
- **Short-term measurement hides long-term value:** A patient who sees your CTV ad today might not book an appointment for two months. If you evaluate the campaign after 30 days, it looks like it failed. If you measure over 90 days and track how awareness drove downstream search volume, the economics change completely.
- **Isolated CAC ignores how channels interact:** When someone sees a YouTube ad, then a Facebook retargeting ad, then searches and converts—what was the CAC? If you only count the search click, you're undervaluing everything that warmed the audience. If you split credit evenly, you're overcounting costs. The whole exercise becomes meaningless when channels are designed to work together.

This is why finance kills multi-channel budgets. The metrics being used to evaluate new channels are designed to make them look inefficient.

How to reframe the economics (so the numbers support diversification)

The first reframe finance needs to see is from isolated channel CAC to blended system performance.

Brian Gould from vybe urgent care explains how this works in practice: "Our brand campaigns help to just smooth out the cost differentials. I look at the brand campaign as one of those several tools we have along with PMax to create an overall cost per booked appointment and cost per visit."

This is the economic logic of multi-channel: awareness campaigns don't need to match search's per-channel efficiency to be worth the investment. If they lower search auction pressure, reduce CPCs, and increase branded search volume, the blended CAC across all channels might be $52—lower than the $60 search delivered when it was the only funded channel and demand was constrained.

Metric	Isolated Channel View	Blended System View
YouTube CAC	$450 per conversion (looks terrible)	Part of a system that reduced overall CAC from $180 to $165
Search performance	$120 per conversion (looks great in isolation)	Benefits from awareness campaigns driving branded search volume up 40%
Facebook retargeting	$200 per conversion (expensive vs. search)	Converts 35% of people who visited via awareness channels—wouldn't exist without upstream work
Overall result	YouTube and Facebook "underperform" search	System delivers 28% more patients at 8% lower blended CAC

Blended CAC is simple: add up all your marketing spend, then divide by all the new patients you got. It ignores channel silos and looks at how the whole system is doing.

This is the number that matters. If diversification lowers blended CAC while increasing volume, it's working. If it raises blended CAC without meaningful volume growth, it's not.

The second reframe is evaluating patient lifetime value (LTV) across multiple touches instead of immediate conversion value alone.

A patient who converts from search might be worth $1,200 in immediate revenue. But what if they were first introduced to your brand via a CTV ad three months earlier, saw social proof on Facebook two weeks later, and then searched when they needed care? The total LTV might actually be $3,500 when you account for follow-up visits, referrals, and long-term engagement.

This matters even more in healthcare. Jeremy Rogers notes: "The average primary care appointment in our country is a loss leader. You don't make money off of that. Systems make money off of procedures, operations, other types of chronic care services." That first appointment isn't the business model—it's the entry point. The value comes from whether that patient returns for specialty care, procedures, or chronic condition management.

Attribution gives search 100% of the credit for that $1,200 initial visit. But **measuring success by first-appointment CAC misses the entire economic equation**. What matters is whether marketing drives patients who engage across the full care continuum.

Attribution < incrementality

Attribution asks "Which channel gets credit for this patient?" Incrementality asks "Would this patient have come to us without this channel?"

Here's the difference in a healthcare context:

- **Attribution:** Patient sees a YouTube ad, clicks a Facebook retargeting ad, searches on Google, converts. Last-click attribution gives Google 100% credit. Multi-touch spreads credit across all three. Both approaches miss the real question.
- **Incrementality:** Run a holdout test where one audience sees YouTube + Facebook + Search, and a control group only sees Search. Measure the difference in total conversions. If the YouTube + Facebook group delivers 30% more patients, you've proven incrementality—those channels created demand that wouldn't have existed otherwise.

Incrementality tests are harder to run than attribution reports. But they're the only way to prove that diversification actually drives growth instead of just redistributing credit.

Incrementality Testing Isn’t Plug-and-Play

Running holdout tests and connecting ad exposure to appointment bookings gets complicated when privacy regulations limit what you can share with advertising platforms.

If you’re using Freshpaint Ad Performance, it’s built for this—connecting ad data to real patient outcomes while maintaining HIPAA compliance, so you can prove which channels actually create demand.

From multi-channel pilots to full-funnel orchestration

Most healthcare marketing teams will never get permission to blow up their search budgets and rebuild from scratch. That's fine. They don't need to.

What they do need is a defensible way to test whether a multi-channel system actually beats a search-only strategy—using the same metrics finance already trusts: cost per acquisition, patient volume, and real ROI.

That's the inflection point. Multi-channel stops being a side experiment and becomes a shared growth strategy, backed by data instead of hope. And once that happens, the real work begins: **treating "beyond Google" not as a slogan, but as the operating system for how healthcare marketing earns trust, proves impact, and grows responsibly.**

> "If you don't have a first-party data strategy, you're behind the eight ball right now."
>
> — Jeremy Rogers,
> VP of Digital Marketing and Experience at IU Health

Beyond Google Is How Healthcare Marketing Gets Its Credibility Back

Search dependency wasn't a mistake—it was a rational response to a world where Google made performance visible and defensible. For a long time, that visibility was enough.

Today, it isn't. Healthcare marketers are under pressure to do more with fixed budgets, prove what's actually working, and grow demand without increasing risk. In that environment, optimization alone can't carry growth (and neither can a strategy that only captures demand instead of creating it).

The call to "move beyond Google" isn't about chasing new channels or taking bigger bets. It's about regaining visibility: seeing how channels work together, understanding what truly drives patient outcomes, and making budget decisions based on evidence rather than last-click artifacts.

The shift from Google dependency to multi-channel performance requires infrastructure most teams are still building: unified patient data, compliant cross-channel tracking, and measurement that proves what actually drives growth. Freshpaint exists to be that infrastructure—giving healthcare marketers the privacy-first foundation that makes diversification measurable, defensible, and scalable.

If you're ready to prove multi-channel ROI without adding compliance risk, talk to a Freshpaint expert about how teams like Imagen Dental and IU Health are stretching fixed budgets while protecting the strategies that drive growth.

Ready to connect your marketing data to real outcomes?

Meet with us

Visit Freshpaint.io

Contact us at sales@freshpaint.io

Connect with us on Linkedin