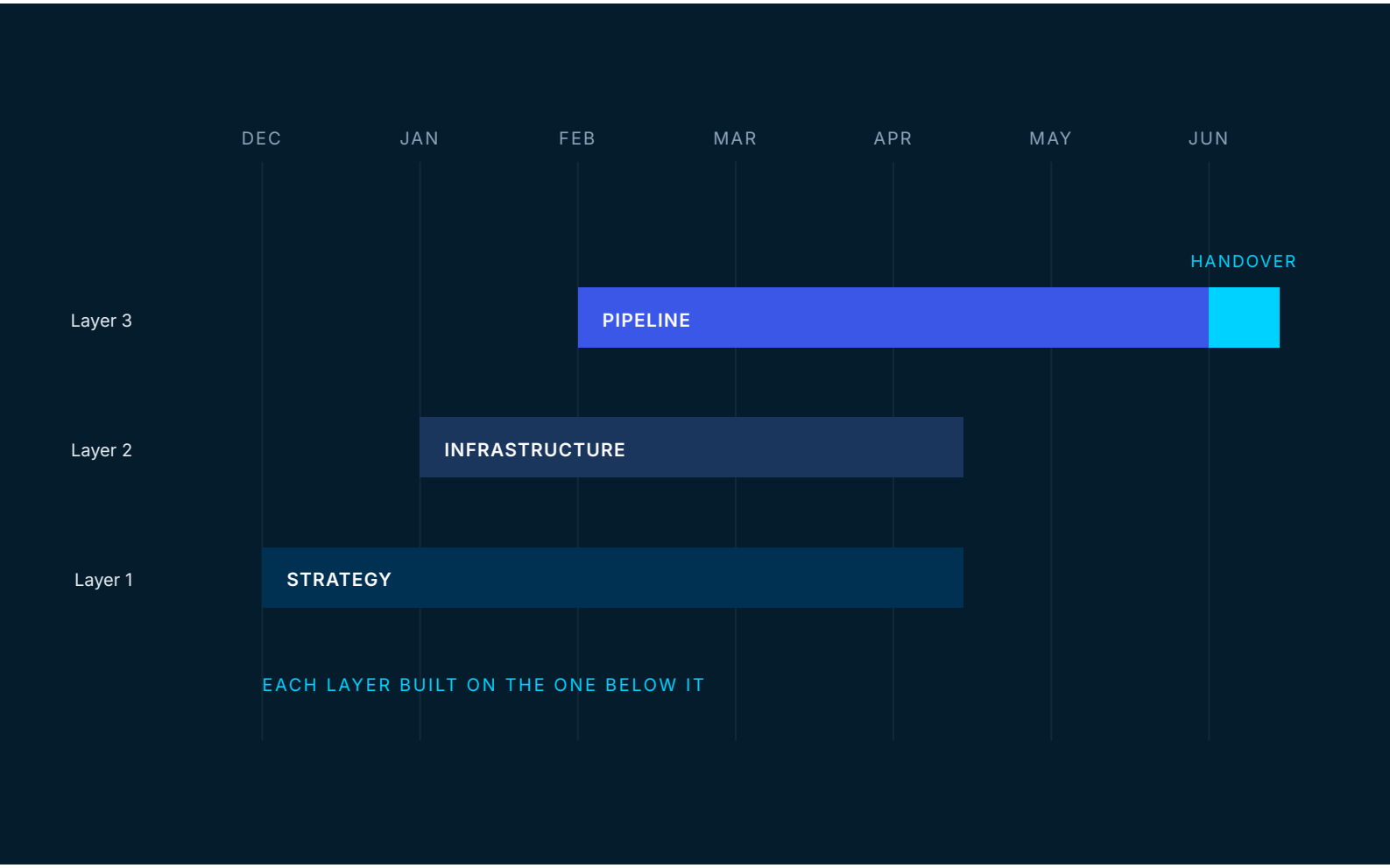
Aviral Prakash

CASE STUDY · GO-TO-MARKET · HEALTHTECH

Building a Go-to-Market Engine from Scratch

How a US-based AI healthtech company went from a ready product with no way to sell it to a repeatable, documented go-to-market engine in seven months.

December 2025 – June 2026



AT A GLANCE

A live product, a board-level revenue target, and no commercial engine to connect the two

The company's patient-engagement product was ready to sell to independent ambulatory practices and health systems. What didn't exist was everything needed to sell it.

All existing revenue came from a separate enterprise product sold to other healthtech organisations. The new product needed a different motion entirely: smaller customers, faster cycles, a different buyer, and markets where the company had no presence. The commercial team had to be built, and the CRM, nominally in place, was in structural disarray.

Over seven months, the work built that engine in a deliberate order: **strategy, then infrastructure, then outreach**. Then it was handed over, fully documented, so the team could run it themselves.

THE ENGAGEMENT

Client: US-based AI healthtech company (anonymised)

Product: AI patient engagement for independent ambulatory practices and health systems

Period: December 2025 – June 2026

Led by: Aviral Prakash, first as A|P's consultant, then embedded full-time as the company's Head of Growth from February 2026

Scope: commercial strategy, revenue operations infrastructure, outbound execution

5.5×
LTV:CAC on the new SMB motion, against a sector benchmark of ≥3.0×.

10.8 mo
CAC payback, against a benchmark of under 18 months.

8 / 164
Meetings booked from call engagements in the new SDR's first month.

2,300+
Misclassified CRM contacts corrected before any new data went in.

What made the difference

- **The market was sized before the target was chased.** The sizing showed the original board target couldn't be reached in 2026. It was revised in March, not discovered at year-end.
- **The ICP was defined by what it excluded.** Practices with 7–25 providers were in; sub-5-provider micro-practices were out. That one decision sharpened every campaign after it.
- **Everything was built to be handed over.** Operating manuals, weekly SOPs and annotated dashboards meant the team ran the engine without its builder.

THE STARTING POINT

Before velocity there was a more basic problem: the engine didn't exist

Leadership had set a board-aligned ARR target for the product that needed a step-change in sales velocity. But there was no ICP, no outbound infrastructure, no market sizing to test the target against, and no unit-economics model to show where capital should go.

Healthcare AI makes this harder. In an independent ambulatory practice the buyer is usually also the end user: a physician-owner weighing a purchase against the daily reality of running a clinic with a small admin team. Trust builds slowly, trial expectations are high, and integration with the existing electronic health record (EHR) is assumed, not negotiable. A commercial model that ignores this creates friction the sales team then has to fight.

EXHIBIT 1

Every part of the commercial engine had to be designed, built or rebuilt

State of each component at the start of the engagement, and what was built

COMPONENT	STARTING POINT	WHAT WAS BUILT	LAYER
Revenue plan	A board-level ARR target	First-principles revenue model by deal size, month by month through 2026	Strategy
ICP	Not defined in usable terms	7–25 provider practices, mid-five-figure deal size; micro-practices excluded	Strategy
Market sizing	None	TAM-SAM-SOM model built from US ambulatory provider data	Strategy
Unit economics	None	First segmented CAC/LTV model across six cost categories	Strategy
CRM	In place, but structurally unreliable	Four-layer rebuild: data, lifecycle automation, hygiene workflows, reporting	Infrastructure
Outbound email	None	Two-domain engine with frequency caps, suppression and a weekly SOP	Infrastructure
Sales motion	Enterprise-style: many stakeholders, long cycles	Four-step SMB motion designed for speed	Infrastructure
SDR function	Did not exist	Role, hiring, onboarding, incentives and a healthcare calling playbook	Pipeline
Campaigns	None for this product	Event ABM, EHR-segment campaign, paid media	Pipeline

Source: A|P engagement records, December 2025 – June 2026

THE APPROACH

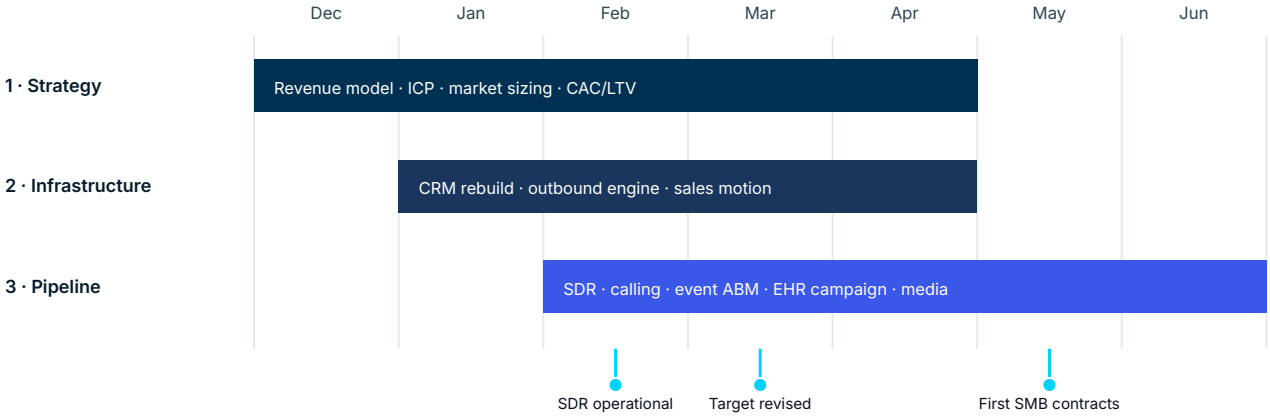
Foundations were built in a fixed order: strategy before infrastructure, infrastructure before outreach

Sustainable sales performance depends on sequence. Outreach on a broken CRM produces pipeline numbers nobody trusts. Infrastructure built before the ICP is defined gets rebuilt later. Strategy that never meets real deal data stays theoretical. The engagement held this order throughout, even where a fast-moving startup would usually skip ahead.

EXHIBIT 2

Three layers, each built on the one below, over seven months

Approximate active period of each layer



Source: A|P engagement records

WHY THE ORDER MATTERS IN HEALTHCARE

Healthcare buyers are slow to trust and quick to disengage. A badly targeted first touch, such as a micro-practice that was never a fit, or a contact emailed twice in a week, costs more here than in most B2B markets. Getting the strategy and plumbing right first protects the outreach that follows.

WHAT IT RULED OUT

Hiring before the ICP was clear. Scaling email before the domains were isolated. Budgeting campaigns against a target the market couldn't support. Each of these is common in early commercial builds, and each was avoided by sequence rather than by luck.

01

STRATEGY

THE ICP, IN ONE LINE

Independent practices with 7–25 providers, at a mid-five-figure average deal size. Sub-5-provider micro-practices explicitly excluded.

WHY EXCLUDE

Micro-practices were inefficient to serve at an early stage and unlikely to generate the deal data needed to optimise the motion quickly.

LAYER 1

Sizing the market showed the board target couldn't be hit, and the target changed in March, not December

The revenue model came first. It was built from first principles and segmented by deal size: small, medium, large and enterprise. It ran month by month through 2026 and worked backwards from the target to the deal mix needed at realistic win rates, with a ramp for seasonality and each segment's cycle length. Generic SaaS benchmarks were deliberately avoided. The model was adopted as the board-aligned operating plan and drove hiring, campaign budgets and weekly pipeline reviews.

Market sizing then tested the plan. A TAM-SAM-SOM model was built from US ambulatory provider data, segmented by specialty and ownership.

EXHIBIT 3

Two filters on the provider universe left a 2026 opportunity well below the original target



Health-system-employed providers buy through a different procurement channel. Source: A|P engagement records

Leadership revised the target in March 2026, grounding the plan in data rather than optimism. Deciding early rather than at year-end saved months of misdirected effort and moved marketing spend and hiring towards the segment the data supported. It also triggered the design of a sales motion built for small and medium practices, where one physician can be buyer, champion and end user and decisions happen within weeks.

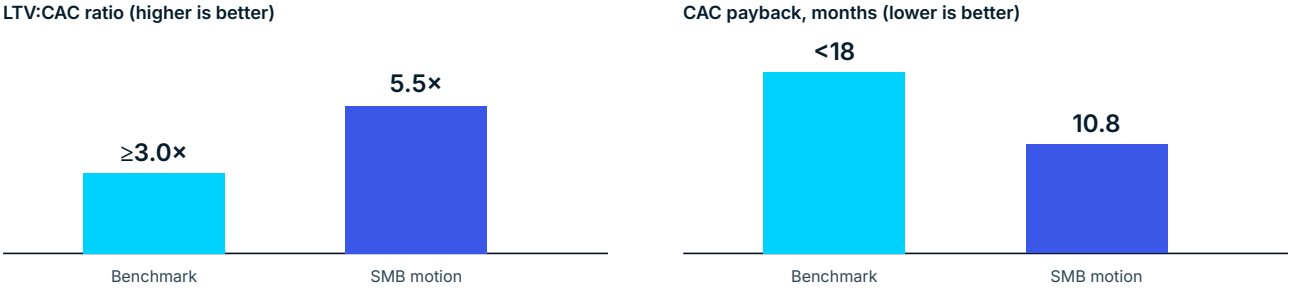
The first segmented unit-economics model showed the SMB motion paid back well inside benchmark

Once the first SMB contracts were signed in May 2026, the company's first segmented CAC/LTV model was built. It covered all sales and marketing activity from December 2025, grouped costs into six categories, and allocated them between the SMB and enterprise motions based on the people and spend directly attributable to each.

EXHIBIT 4

The SMB motion was unit-economics-positive at an early stage

SMB motion vs sector benchmark



Sector benchmarks as used in the engagement (LTV:CAC ≥3.0×; payback under 18 months). Source: A|P engagement records, CAC/LTV model, December 2025 – May 2026

Why this mattered

Continued investment in the SMB motion needed justification, and it needed it early. The model gave leadership the evidence to invest with confidence, based on the company's own cost base rather than an industry average.

Together, the three strategy assets did one job: they connected daily sales activity to monthly targets to the board's annual expectations. That connection was missing at the start.

BUILT TO BE RE-RUN

The revenue model wasn't a one-time deck. It was a decision tool leadership could re-run with updated assumptions every quarter. The CAC/LTV model came with its methodology documented, so the next update doesn't depend on the person who built it.

02

INFRASTRUCTURE

OUTBOUND GUARDRAILS

Two dedicated sending domains. A six-day sending window with an automated Saturday-night shut-off. One email per contact every two weeks. Automatic suppression of customers, unsubscribers and open deals.

SALES MOTION

A four-step SMB motion replaced the enterprise process of many stakeholders, long solutioning and custom integration talks, which was too heavy for practices where one person decides.

LAYER 2

The CRM was rebuilt in four layers so pipeline numbers could be trusted, and so it could run itself

The inherited CRM had more than 2,300 newsletter subscribers misclassified as sales leads, over 1,400 companies with no contacts attached, and a default form stage that created inconsistent lifecycle data. Pipeline numbers were unreliable as a result.

EXHIBIT 5

Each layer of the rebuild depended on the one before it

	LAYER	WHAT WAS DONE
1	Data correction	2,300+ misclassified contacts, 1,400+ orphan companies and incomplete records fixed before any new data was added
2	Lifecycle automation	Company stages update automatically from contact and deal status, with no manual intervention
3	Hygiene workflows	14 autonomous workflows for owner assignment, suppression, internal-employee exclusion and deduplication
4	Reporting	8 master contact lists by EHR platform; 8+ dashboards for funnel health, email performance and calling

Source: A|P engagement records

Every later campaign ran on this foundation without manual lifecycle management: the conference ABM, the EHR-segment campaign and a Google Ads campaign for primary care practices.

The outbound engine was built from zero in parallel. Isolating cold traffic on two dedicated domains protected the main domain's deliverability. Six CRM lists by EHR segment, totalling several thousand contacts, were kept in active rotation, and a seven-step weekly SOP let the team run the engine on its own after handoff.

> **DOCUMENTATION WAS PART OF THE DESIGN, NOT AN AFTERTHOUGHT**
>
> A full operating manual, a weekly campaign SOP and annotated dashboards meant a new team member could run the CRM independently from their first day. At handoff it was described as fully documented, with zero knowledge loss.

03

PIPELINE

THE SDR BUILD

Built in three months: role design, agency coordination, evaluation, references, offer, onboarding and incentive design. A 30-day plan, daily call targets and a variable-pay framework. Operational by February 2026.

FIRST MONTH

8 meetings from 164 outbound call engagements across more than 30 practices.

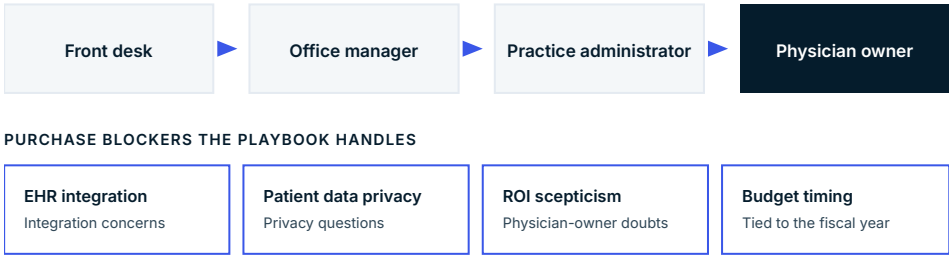
LAYER 3

Generic B2B calling scripts don't survive a practice's front desk, so the playbook was built for healthcare

There was no sales development function before the engagement, and in a trust-heavy sector that gap is expensive. The SDR role was designed and filled, and then given a calling playbook built around how independent practices actually make decisions. The SDR was coached through the first two weeks of live calls.

EXHIBIT 6

Each level of the practice gatekeeper hierarchy needs its own script and objection handling



Source: A|P engagement records, healthcare calling playbook

Systematic phone outbound and prospect nurturing ran at the company for the first time. In the SDR's first month of active outreach, 164 call engagements across more than 30 practices produced 8 booked meetings.

Pipeline was filled through several channels at once: calling, email, event ABM and paid media. Exhibit 7 shows how tightly each one was targeted.

Every channel narrowed a large raw pool to a small, qualified one before a single message went out

EXHIBIT 7

Precision over volume: from raw lists to qualified targets

Bar length not to scale; figures as recorded



Source: A|P engagement records

Conference ABM

For a flagship US healthcare conference, attendee contacts were extracted, deduplicated, researched with AI assistance and enriched by hand. A 26-branch CRM automation matched organisation type, seniority and role across 13 persona combinations to personalise outreach at scale. Pre-event meetings were confirmed in double digits before the doors opened, and the automation became a reusable template. A four-dimension event evaluation framework was used to build an attendance calendar for 2026 and 2027.

EHR-segment campaign and media

A compliance check added mid-campaign flagged domain mismatches before each send, keeping out-of-ICP contacts out of the sequence. The method is modular and EHR-agnostic, and became the standard for later segment outreach.

In parallel, a media package was evaluated against two competing vendors on reach, ICP fit, formats and cost per estimated impression. It included a newsletter placement, a sponsored webinar with 300 guaranteed registrations and banner ads. Bundling the assets unlocked a **22% discount** to list price, and the scoring framework was documented for reuse.

THE OUTCOME

Seven months later, the team was running a documented commercial engine where none had existed

By June 2026 the company had moved from preparing to sell to being equipped to scale a repeatable go-to-market motion. The CRM, outreach engine, sales motion, SDR function, playbooks, event framework and segment databases were all under the team's independent control.

EXHIBIT 8

Nine assets handed over, each built to be run and improved without its builder

	ASSET	WHAT IT DOES FOR THE TEAM	LAYER
1	Revenue model	Board-aligned operating plan; re-run quarterly with new assumptions	Strategy
2	ICP definition	Decides who gets targeted, and who doesn't	Strategy
3	TAM-SAM-SOM model	Tests any future target against the real market	Strategy
4	CAC/LTV model	Shows where the next dollar of spend should go, by segment	Strategy
5	CRM and hygiene workflows	Trustworthy pipeline data, maintained automatically	Infrastructure
6	Outbound engine and SOP	Segmented cold email at scale, without deliverability risk	Infrastructure
7	SMB sales motion	Four steps, built for fast single-decision-maker deals	Infrastructure
8	SDR function and playbook	Healthcare-specific calling, run in-house	Pipeline
9	Event ABM template and framework	Reusable for any future conference	Pipeline

Source: A|P engagement records, handoff June 2026

The test the engagement was designed against from the start was not activity delivered. It was whether the organisation was **permanently stronger**, able to operate, improve and build on the system without its builder in the room.

WHAT THIS MEANS FOR HEALTHTECH FOUNDERS

In early commercial builds, precision does more work than volume

The engagement reinforced a principle that applies to most early-stage healthtech companies selling into providers: the motion works when the ICP is clear, the process is focused and the trial structure lowers the buyer's commitment risk.

Size the market before you chase the target

A board target is a hypothesis. Testing it against real provider data in month four, not month twelve, is the cheapest correction you will ever make.

Define the ICP by what you exclude

Saying no to micro-practices cost nothing in the short term and sharpened every campaign after it. Most ICPs fail by being too inclusive.

Build the plumbing before the outreach

A clean CRM, isolated sending domains and frequency caps protect a trust-sensitive market from your own mistakes.

Treat handover as a design requirement

If the system needs its builder to keep running, it's a dependency, not an asset. Document from day one.

> **THE SHORT VERSION**
>
> Strategy made the design possible. Infrastructure made it scalable. Outbound programmes made it visible. Documentation made it durable.

NEXT STEP

Building your go-to-market engine?

If you're a healthtech founder with a product that's ready and a commercial engine that isn't, book a 60-minute discovery call. We'll look at where your sequence breaks and what to build first.

Book a discovery call · aviralprakash.com

About A|P

A|P is a healthcare business growth partner working with healthtech founders and independent private hospitals in India. **Aviral Prakash**, founder and principal consultant, holds an MBA from IIM Ahmedabad. He spent more than a decade in growth, pricing and go-to-market roles at Mahindra & Mahindra, Airtel and Enphase Energy, and today works with healthtech companies on growth and go-to-market.

Client details are anonymised. Figures are from engagement records. Benchmarks are the sector benchmarks used in the engagement.